Meeting of the Virginia Board of Medicine

October 18, 2018
8:30 a.m.

Department of Health Professions

Board of Medicine

Thursday, October 18, 2018 @ 8:30 a.m.
Perimeter Center
9960 Mayland Drive, Suite 201
Board Room 2
Henrico, VA 23233

New Business:

8. Consent Order for Consideration by the Board

9. Adjournment

PERIMETER CENTER CONFERENCE CENTER
EMERGENCY EVACUATION OF BOARD AND TRAINING ROOMS
(Script to be read at the beginning of each meeting.)

PLEASE LISTEN TO THE FOLLOWING INSTRUCTIONS ABOUT EXITING THESE PREMISES IN THE EVENT OF AN EMERGENCY.

In the event of a fire or other emergency requiring the evacuation of the building, alarms will sound.

When the alarms sound, leave the room immediately. Follow any instructions given by Security staff

Board Room 2

Exit the room using one of the doors at the back of the room. (Point) Upon exiting the room, turn **RIGHT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

You may also exit the room using the side door (**Point**), turn **Right** out the door and make an immediate **Left**. Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

Agenda Item: **Approval of Minutes of the June 14, 2018**

Staff Note: Draft minutes that have been posted on Regulatory Townhall and the Board's website are presented. Review and revise if necessary.

Action: Motion to approve minutes.

---DRAFT UNAPPROVED---

VIRGINIA BOARD OF MEDICINE
FULL BOARD MINUTES

June 14, 2018 Department of Health Professions Henrico, VA 23233

CALL TO ORDER: Dr. O'Connor called the meeting of the Board to order at 8:40 a.m.

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

MEMBERS PRESENT:
Kevin O'Connor, MD, President
Ray Tuck, DC, Vice-President
Lori Conklin, MD, Secretary-Treasurer
Syed Ali, MD
David Archer, MD
Randy Clements, DPM
Alvin Edwards, PhD
David Giammittorio, MD
Jane Hickey, JD
Jacob Miller, DO
David Taminger, MD
Svinder Toor, MD
Martha Wingfield

MEMBERS ABSENT:
Isaac Koziol, MD
Maxine Lee, MD
Kenneth Walker, MD

STAFF PRESENT:
William L. Harp, MD, Executive Director
Jennifer Deschenes, JD, Deputy Executive Director, Discipline
Barbara Matusiak, MD, Medical Review Coordinator
Alan Heaberlin, Deputy Executive Director, Licensing
Colanthia M. Opher, Operations Manager
Cheryl Clay, Administrative Assistant
Sherry Gibson, Administrative Assistant
Trasean Boatwright, Administrative Assistant
Barbara Allison-Bryan, MD, DHP Deputy Director
Elaine Yeatts, DHP Senior Policy Analyst
Erin Barrett, JD, Assistant Attorney General

OTHERS PRESENT:
Jerry Gentile, DPB
Scott Johnson, MSV
Ryan LaMura, VHHA
Tanner Howell, VATA

EMERGENCY EGRESS

Dr. Tuck provided the emergency egress procedures for Conference Room 2.

APPROVAL OF THE FEBRUARY 15, 2018 MINUTES

Dr. Archer requested that the minutes of February 15, 2018 be amended to indicate his attendance. Dr. Edwards moved to approve the minutes as amended. The motion was seconded and carried unanimously.

ADOPTION OF THE AGENDA

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

PUBLIC COMMENT ON AGENDA ITEMS

There was no public comment.

DHP DIRECTOR'S REPORT- Barbara Allison-Bryan, MD

Dr. Allison-Bryan told the Board that she recently recognized that she has a "pronoun" problem. When speaking to other boards in the agency, she finds herself saying, "when **we** did this or that". She commented that what she learned while on the Board of Medicine has and will continue to serve her well in her capacity as Deputy Director of DHP.

She informed the members that DHP has completed the move of the receptionist desk to the 1st floor of the building. It is more welcoming and addresses safety issues for DHP staff and board members. In addition to the reception area, the IT department and other support systems were relocated to the 1st floor, freeing up a large amount of space on the 3rd floor for boards.

Dr. Allison-Bryan reported the Federation of State Medical Boards conducted a survey of board members and found that 75% feel unsafe. Some reported verbal threats, others physical threats, linked to the contentious work that boards do. She said the safety of our building is being assessed by outside experts. Recently, Lisa Hahn, Chief Financial Officer, toured the building with the state police and received recommendations, to include a check-in location. Also mentioned were metal detectors and security cameras. Additionally, DHP ID badges will be made more restrictive in the future, allowing access only during certain hours and days of the week.

She also provided an update on the expansion of Medicaid, the progress on cannabis-based oils, the application method for oil processors, and the autonomous nurse practitioner regulations.

REPORT OF OFFICERS AND EXECUTIVE DIRECTOR

PRESIDENT

Dr. O'Connor thanked Dr. Brown for supporting the Virginia delegation's attendance at the Federation of State Medical Boards (FSMB) Annual Meeting. He noted that Virginia was well-represented by current and former Board of Medicine members and staff. He said Virginia continues to have a significant presence and influence at FSMB, and that Virginia is thought to be a model for many initiatives and finding middle ground on topics such as PMP usage and opioid prescribing.

He said that board transparency, physician burnout, PMP requirements and the opioid crisis continue to be front and center concerns for all states. A new area of concern is the use of stem cells for which very little guidance exists and is seen as a treatment that is ripe for abuse. FSMB has developed a guidance document that he is willing to share with anyone who is interested.

Dr. O'Connor announced that Dr. Ken Walker was elected to the FSMB Nominating Committee.

He ended his report by encouraging the Board members to be more active in the Board's application review process.

VICE-PRESIDENT'S REPORT

Dr. Tuck reported on his attendance at the Federation of Chiropractic Licensing Boards (FCLB) Annual Meeting. He noted that the composition of the Virginia Board, which allows and encourages the professions to work together, is a great model for the rest of the country.

SECRETARY-TREASURER'S REPORT

Dr. Conklin had no report.

EXECUTIVE DIRECTOR'S REPORT

Dr. Harp began his report by noting that he has been attending FSMB annual meetings since 2000, and he thinks that this year's lineup of speakers was the best yet.

Revenue and Expenditures

Dr. Harp referred to the cash balance of April 30, 2018, noting that it was less than last year at this time. He explained that revenues lag behind expenditures in the first half of even years due to lower revenues in the odd years. He also pointed out that the Board's cash balance will continue to decline since the law requires that an overage of > 10% calls for a reduction of fees. In compliance, the Board has reduced the renewal fees for 3 biennia in a row.

Enforcement Hours

Dr. Harp informed the members that the Board is receiving approximately 40-75 more complaints per month.

A number of years ago, complaints were down as low as 1400-1500 per year. However, this year there may be 2400 or more.

APD Hours

Dr. Harp reviewed the APD report and pointed out that Medicine continues to be the leading user of APD hours.

HPMP Participation

Dr. Harp compared the 2017 and 2018 fiscal years, stating that there are a few more participants this fiscal year than last.

Cobalt Poisoning

Dr. Harp reminded the members of Dr. Brown's comments at the April Executive Committee meeting when he reported that Delegate Orrock had asked the Board to develop information to educate licensees about cobalt poisoning. With the assistance of Hugh Bryan, MD, Board staff put together an article (pages 34-35) that appeared in the April Board Briefs. Although the article was written primarily for the orthopedic community to provide facts about cobalt and chromium poisoning, it will also be helpful to primary care providers. No comment had been received until June 13th when Board staff was asked to electronically provide the article to the leadership of the Virginia Orthopedic Society.

Dr. Toor asked how many cases the Board had received on cobalt poisoning. Dr. Harp responded that he could not recall any complaints about cobalt poisoning. He added, that based the available literature, there have not been many cases in the States. The most informative article on this topic was from the UK and reported 16 cases.

Dr. Allison-Bryan stated that it is her understanding that metal-on-metal implants are rarely used in Virginia, and have been or will be taken off the market.

Review of Applications

Dr. Harp advised that, for the last 2 months, members have been coming to the Board to review license applications containing adverse information. He thanked the Credentials Committee and others that have made themselves available. He said that the new system was created to improve every aspect of the credentialing process.

FSMB Nominating Committee

Dr. Harp noted that Dr. Walker should be congratulated on his successful run for a position on the FSMB Nominating Committee. His presence will ensure that Virginia's voice continues to be heard in terms of direction and leadership of FSMB.

FCLB Letter of Commendation

Dr. Harp said Dr. Tuck is to be congratulated for the FCLB letter of commendation sent to Governor Northam for Dr. Tuck's attendance and work at the FCLB 92nd annual meeting.

Avoidance of the Appearance of Conflict of Interest

Dr. Harp explained that several years ago, a board member was seen talking to a legislator at a social event. At the time, there was a hot topic being discussed at DHP. An individual who had a strong interest in the issue witnessed the interaction and voiced some concern. Dr. Harp stated that care should always be taken to avoid the appearance of conflict of interest. If a Board member does express an opinion on a topic, make sure to say that it is your personal opinion and that you are not speaking for the Board.

Probable Cause and Application Review

Dr. Harp encouraged the members to give some time to license application review and discipline case review with Dr. Matusiak.

Plaque Presentation

Dr. O'Connor presented plaques to Dr. Allison-Bryan and Dr. Clements for their dedication and service to the Board. In their absence, Dr. O'Connor also acknowledged the service of Dr. Lee, Dr. Koziol and Mr. Jenkins. He remarked that one of the great joys of being on the Board was getting the opportunity to work alongside a great group of practitioners, and that their expertise will be missed.

COMMITTEE and ADVISORY BOARD REPORTS

Dr. Conklin moved to accept all the minutes en bloc. The motion was seconded and carried.

OTHER REPORTS

Board Counsel

Erin Barrett, AAG provided an update on the status of the following cases:

Clowdis v. Virginia Board of Medicine

Merchia v. Virginia Board of Medicine

Garada v. Virginia Board of Medicine

Board of Health Professions

No report.

Podiatry Report

Dr. Clements reported on a conference call with the Federation of Podiatric Medical Boards (FPMB). He said the only items of note were FPMB's efforts on an interstate compact license and consolidation of board scores.

Chiropractic Report

Dr. Tuck had earlier given his report.

Committee of the Joint Boards of Nursing and Medicine

Dr. O'Connor reported on the Board of Nursing Regulatory Advisory Panel (RAP) established for the purpose of discussing the implementation of HB 793 – Autonomous practice for certain nurse practitioners. Dr. O'Connor noted that the RAP consisted of 9 members, 6 of whom were nurse practitioners. He said that Ms. Yeatts' report would provide more details.

New Business:

1. Regulatory and Legislative Issues

- **Chart of Regulatory Actions**

Ms. Yeatts reviewed the chart on the status of regulations for the Board as of May 31, 2018. She said that the Governor's office is diligently working on a large backlog of regulations.

This report was for informational purposes only and did not require any action by the Board.

- **Notice of Periodic Review of Regulations – Request for Comment**

Ms. Yeatts reported that the Notices of Periodic Review for the following regulations are being published for comment.

18 VAC 85-15 Regulations Governing Delegation to an Agency Subordinate
18 VAC 85-20 Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic
18 VAC 85-40 Regulations Governing the Practice of Respiratory Therapists
18 VAC 85-50 Regulations Governing the Practice of Physician Assistants
18 VAC 85-80 Regulations for Licensure of Occupational Therapists
18 VAC 85-101 Regulations Governing the Licensure of Radiologic Technology
18 VAC 85-110 Regulations Governing the Practice of Licensed Acupuncturists
18 VAC 85-120 Regulations Governing the Licensure of Athletic Trainers
18 VAC 85-130 Regulations Governing the Practice of Licensed Midwives
18 VAC 85-150 Regulations Governing the Practice of Behavior Analysis

The purpose of this review is to determine whether a regulation should be retained in its current form,

amended, or repealed.

Ms. Yeatts advised that the comment period runs from May 28, 2018 until June 27, 2018, and all comment will be reviewed by the Legislative Committee in September.

- **Notice of Request for Comment on Draft Regulations – HB 793**

Ms. Yeatts confirmed that the Boards of Medicine and Nursing are seeking public comment on the Draft Regulations to implement HB 793 to authorize nurse practitioners who meet certain qualifications to practice without a practice agreement with a patient care team physician.

The Comment period will be open from May 22, 2018 to June 21, 2018.

Ms. Yeatts said that the Board of Nursing will consider the Draft Regulations on July 17, 2018 and the Board of Medicine on August 3, 2018. She noted that to comply with the second enactment clause in the bill that requires regulations to be in effect within 280 days, the Boards will be adopting emergency regulations. If the Board of Nursing and the Executive Committee of the Board of Medicine do not agree on the adoption of the regulations as presented, another meeting of the Joint Committee and comment period will occur.

This report was for informational purposes only and did not require any action.

- **Legislative Proposal - Genetic Counseling**

Ms. Yeatts provided a brief account of the issues discussed by the Advisory Board on Genetic Counseling.

She said that years ago, the examination for genetic counselors was given by the American Board of Medical Genetics (ABMG). When the ABMG became part of the American Board of Medical Specialties in 1993, it could no longer certify genetic counselors, only physicians. A new organization, the American Board of Genetic Counseling (ABGC) was formed, and all who had passed the ABMG examination were grandfathered into ABGC certification.

The Advisory Board also discussed revising Section 18VAC85-170-60 of the Regulations Governing Genetic Counseling due to the concern that the language regarding the "expiration of active candidate status" could be confusing.

To address these two issues, the following draft legislation to amend is being recommended:

§ 54.1-2957.19. Genetic counseling; regulation of the practice; license required; licensure; temporary license

C. An applicant for licensure as a genetic counselor shall submit evidence satisfactory to the Board that the applicant (i) has earned a master's degree from a genetic counseling training program that is accredited by the Accreditation Council of Genetic Counseling, or its predecessor organizations, and (ii) holds a current, valid certificate issued by the American Board of Genetic Counseling or American Board of Medical Genetics to practice genetic counseling.

E. The Board may grant a temporary license to an applicant who has been granted Active Candidate Status by the American Board of Genetic Counseling and has paid the temporary license fee. Temporary licenses shall be valid for a period of up to one year. ~~An applicant shall not be eligible for temporary license renewal upon expiration of Active Candidate Status as defined by the American Board of Genetic Counseling.~~ A temporary license shall expire twelve months from issuance or upon failure of the American Board of Genetic Counseling examination, whichever comes first. A person practicing genetic counseling under a temporary license shall be supervised by a licensed genetic counselor or physician.

After a brief discussion, Dr. Edwards moved to adopt the draft legislation as proposed. The motion was seconded and carried unanimously.

- **Legislative Proposal – Board of Medicine Impaired Physicians Program**

Ms. Yeatts gave credit to the Board of Medicine staff for noticing outdated language in §54.1-2909 that references an agreement for an Impaired Physicians Program which has not been utilized since the advent of the Health Practitioners Monitoring Program.

Additionally, the requirement in 54.1-2909 of presidents of all professional societies to report is redundant of language found in §54.1-2908, so it can be deleted.

The proposed amendments are as follows:

§ 54.1-2909. Further reporting requirements; civil penalty; disciplinary action.

B. The following persons and entities are subject to the reporting requirements set forth in this section:

1. Any person licensed under this chapter who is the subject of a disciplinary action, settlement, judgment or evidence for which reporting is required pursuant to this section;

2. Any other person licensed under this chapter, except as provided ~~in the protocol agreement entered into by the Medical Society of Virginia and the Board for the Operation of the Impaired Physicians Program~~; by a contract agreement with the Health Practitioner Monitoring Program;

~~3. The presidents of all professional societies in the Commonwealth, and their component societies whose members are regulated by the Board, except as provided for in the protocol agreement entered into by the Medical Society of Virginia and the Board for the Operation of the Impaired Physicians Program;~~

Dr. Toor moved to adopt the draft legislation as proposed. The motion was seconded and carried unanimously.

- **Legislative Proposal – Athletic Training**

Ms. Yeatts reported that the Advisory Board on Athletic Training had identified the need to clarify the definition of the "practice of athletic training" to fully reflect the scope of AT professional activity. In addition to working with athletes at all levels of activity, athletic trainers also work in military, corporate and other settings on injuries and conditions resulting from occupational activity. The current definition allows for such

practice but the Advisory Board believes it should stated more clearly.

§ 54.1-2900. Definitions.

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

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

This draft legislative proposal was approved by acclamation.

2. Review of the Board of Medicine Bylaws

Dr. Harp stated that every several years the Board reviews its Bylaws for currency. He noted that Behavior Analysts and Genetic Counselors need to be added to the "Report of the Advisory Boards."

He also pointed out that the authority of the Vice-President to appoint members to the Legislative Committee in consultation with the President should also appear in the language describing the formation of the Legislative Committee. Dr. O'Connor agreed that the language should be consistent.

Dr. Edwards moved to accept the amendments to the existing bylaws. The motion was seconded and carried unanimously.

3. Appointment of Committee to Determine CME for 2019-2020

Dr. Harp noted that in 2016, the General Assembly passed HB 829 which authorized the DHP Director to provide information from the Prescription Monitoring Program (PMP) to the Board of Medicine about prescribers who meet a certain threshold for prescribing covered substances for the purpose of requiring relevant continuing education. The threshold is to be determined by the Board of Medicine in consultation with the PMP. This law made it possible for the Board to fulfill the requirement found in § 54.1-2912.1 (C).

§ 54.1-2912.1. (Effective until July 1, 2022) Continued competency and office-based anesthesia requirements.

C. The Board shall require prescribers identified by the Director of the Department of Health Professions pursuant to subdivision C 10 of § 54.1-2523 to complete two hours of continuing education in each biennium on topics related to pain management, the responsible prescribing of covered substances as defined in § 54.1-2519, and the diagnosis and management of addiction. Prescribers required to complete continuing education pursuant to this subsection shall be notified of such requirement no later than January 1 of each odd-numbered year.

Dr. Harp said the committee would need to meet in the fall of 2018, such that prescribers licensed by the Board of Medicine can be notified by January 1, 2019.

After stating that he would be willing to participate, Dr. O'Connor asked for volunteers. Dr. Conklin and Dr. Taminger both agreed to join him on the committee.

4. Licensing Report

In Mr. Heaberlin's absence, Dr. Harp provided the up-to-date number of practitioners currently licensed by the Board.

He emphasized that the Board has 23 license types it issues to over 70,000 licensees, and over 80,000 if you include the nurse practitioners.

Dr. Harp said that in 2017, the Board issued 6,300 initial licenses. Roughly the same number is expected for this year.

This report was informational only and did not require any action.

5. Discipline Report

Ms. Deschenes went over the status of pending cases at the Board, APD and Enforcement level.

This report was informational only and did not require any action.

BREAK: Dr. O'Connor called a 15-minute break at 9:43 a.m.; the meeting reconvened at 10:02 a.m.

6. Hearing Etiquette

Jennifer Deschenes, JD and Erin Barrett, JD provided a brief, extremely informative presentation on "Hearing Protocol". The presentation covered the purpose of disciplinary hearings, avoiding the appearance of impropriety, the difference between open and closed session, formal and. informal hearings, procedural mysteries, grounds for appeal and more.

Dr. Allison-Bryan suggested that pages 1-8 of the presentation be periodically provided to all Board members. She stated that the points are a good refresher for seasoned members and great tips for newly-appointed members.

7. Approval of the Proposed 2019 Meeting Calendar

Ms. Opher noted that the proposed date of May 17th for the Legislative Committee fell on a state holiday and suggested it be moved to May 11th.

The amended proposed meeting calendar was accepted by acclamation.

8. Report of the Nominating Committee

Dr. Clements, Chair of the Nominating Committee, presented the slate of officers:

- Kevin O'Connor, MD – President
- Ray Tuck, DC, – Vice-President
- Lori Conklin, MD – Secretary-Treasurer

With no other nominations from the floor, the Board unanimously accepted the slate as presented.

9. Announcements

Dr. O'Connor encouraged the members to mark their calendars for the next Full Board meeting scheduled for October 18, 2018 at 8:30, and to remember to submit their travel vouchers by July 9, 2018.

Dr. Harp announced that Alan Heaberlin, Deputy Executive Director for Licensing, will be leaving the Board at the end of July.

10. Adjournment

With no other business to discuss, Dr. O'Connor adjourned the meeting of the Full Board at 10:40 a.m.

Kevin O'Connor, MD
President, Chair

William L. Harp, MD
Executive Director

Colanthia Morton Opher
Recording Secretary

Agenda Item:	**Comments from Dan Carey, MD, Secretary of Health and Human Resources**
Staff Note:	The Board is honored to have Dr. Carey join the Board this morning and provide comments about Health and Human Resources' efforts in a number of different areas.
Action:	None anticipated.

Agenda Item: **Director's Report**

Staff Note: None.

Action: Informational presentation. No action required.

Some Proposed Modules for
2018/2019 DHP Board Development Library

Probable Cause

- A new Probable Cause Video will be coming out
- Communicating from the Board to APD the what, where, and how it is "more likely than not" that a violation of law or regulation has taken place

Overview of Conflict of Interest §2.2 – 3100 - 3131 (COI) and Travel Reimbursement

- Purpose
- Examples of possible conflicts
- What is prohibited under law
- Confidentiality
- Gifts
- Financial disclosure
- Recusal

Top Ten Characteristics of an Effective Board Member

- The role of gubernatorial appointees on a health regulatory board or advisory committee
- Protect the public
- Be professional
- Be analytical
- Be consistent
- Prepare for meetings
- Confidentiality
- Know the DHP mission
- Know your board
- Internal and external communication

Board Member Etiquette and Behavior at IFCs and Formal Hearings

- Board of Medicine Presentation June, 2018

Sanction Reference Points (SRP) NOTE: Video under development

- History
- Walk through your board's SRP as they vary by board
- Review select case scenarios and complete related SRP for group discussion

An Overview of Virginia's Legislative Process

- DHP's authority
  - Regulations
  - Disciplinary action
  - A review of DHP's website

- DHP's legislative process
- An overview of Virginia's Legislative Information System (LIS)
- Understanding the legislative session
- How a DHP bill becomes law
- What to expect in the 2019 legislative session

Understanding the Freedom of Information Act

- History
- E-mails, meetings
- Review and discussion of FOIA Advisory Council materials

The Enforcement Division

- Who they are
- What they do
- How they do it

Chairing an Effective Meeting

- Preparation
- Procedures
- Managing the Unexpected
- Roberts' Rules or not?

Agenda Item: **Report of Officers and Executive Director**

Staff Note:

- President
- Vice-President
- Secretary-Treasurer
- Executive Director

Action: Informational presentation. No action required.

Agenda Item: **Executive Director's Report**

Staff Note: All items for information only

Action: None.

	102- Medicine
Board Cash Balance as June 30, 2017	$ 10,051,272
YTD FY18 Revenue	7,915,858
Less: YTD FY18 Direct and Allocated Expenditures	7,781,612
Board Cash Balance as June 30, 2018	10,185,518

Virginia Department of Health Professions

Cases Received, Open, & Closed

Quarterly Breakdown

Quarter 4 - Fiscal Year 2018

The "Received, Open, Closed" table below shows the number of received and closed cases during the quarters specified and a "snapshot" of the cases still open at the end of the quarter.

Quarter Date Ranges	
Quarter 1	July 01 - September 30
Quarter 2	October 1 - December 31
Quarter 3	January 1 - March 31
Quarter 4	April 1 - June 30

	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	CURRENT Q4 2018
Audiology/Speech Pathology												
Number of Cases Received	5	1	2	5	11	9	5	5	2	5	4	6
Number of Cases Open	7	8	5	6	16	23	22	17	7	12	11	14
Number of Cases Closed	8	0	5	4	1	2	6	10	11	1	5	3
Counseling												
Number of Cases Received	24	21	32	26	27	17	40	35	28	37	31	45
Number of Cases Open	91	108	117	116	98	69	58	56	61	72	84	102
Number of Cases Closed	31	11	25	27	44	43	60	42	26	29	23	33
Dentistry												
Number of Cases Received	107	67	110	89	118	67	88	94	84	93	91	124
Number of Cases Open	388	302	310	310	265	258	259	266	277	254	256	249
Number of Cases Closed	154	162	105	89	164	90	93	91	78	119	100	135

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Funeral Directing												
Number of Cases Received	22	20	21	12	8	12	9	22	12	8	12	13
Number of Cases Open	37	41	45	37	41	38	35	39	38	40	35	28
Number of Cases Closed	14	19	18	21	10	17	15	20	14	7	18	24
Long Term Care Administrators												
Number of Cases Received	18	12	21	19	16	12	9	18	15	24	13	16
Number of Cases Open	48	49	56	67	59	61	58	56	71	90	94	74
Number of Cases Closed	9	9	27	7	12	11	13	20	5	8	8	31
Medicine												
Number of Cases Received	324	288	374	398	375	389	402	358	423	411	551	541
Number of Cases Open	613	582	601	636	640	665	682	628	755	796	934	902
Number of Cases Closed	408	337	369	374	386	384	401	391	297	407	443	575

Virginia Department of Health Professions

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Nurse Aide												
Number of Cases Received	173	170	203	214	154	139	169	165	156	123	118	137
Number of Cases Open	287	302	326	401	400	360	356	370	438	455	301	285
Number of Cases Closed	213	176	198	165	168	207	189	166	94	109	276	158
Nursing												
Number of Cases Received	400	478	484	423	461	425	412	447	415	427	447	444
Number of Cases Open	958	965	1,027	1,046	1,008	1,020	1,004	1,075	1,155	1,115	1,179	1,246
Number of Cases Closed	410	495	452	422	516	471	448	420	352	458	397	414
Optometry												
Number of Cases Received	6	5	8	8	7	15	10	4	8	9	17	8
Number of Cases Open	27	20	23	25	27	28	35	36	26	23	32	31
Number of Cases Closed	7	13	5	8	5	16	4	4	20	12	8	9

Virginia Department of Health Professions

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	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	CURRENT Q4 2018
Pharmacy												
Number of Cases Received	126	141	122	115	178	119	179	146	143	160	171	213
Number of Cases Open	363	355	366	377	431	386	355	309	302	271	287	319
Number of Cases Closed	94	144	110	95	123	164	204	192	148	185	162	199
Physical Therapy												
Number of Cases Received	14	17	9	6	8	9	7	21	6	15	9	4
Number of Cases Open	28	27	28	20	24	24	28	39	36	44	48	50
Number of Cases Closed	4	17	7	9	4	9	5	9	10	7	2	4
Psychology												
Number of Cases Received	19	18	19	14	18	26	13	22	23	23	28	26
Number of Cases Open	78	84	74	68	76	87	49	34	46	44	52	57
Number of Cases Closed	8	12	32	20	9	17	52	38	16	24	19	24

Virginia Department of Health Professions

Cases Received, Open, & Closed

Quarterly Breakdown

Quarter 4 - Fiscal Year 2018

The "Received, Open, Closed" table below shows the number of received and closed cases during the quarters specified and a "snapshot" of the cases still open at the end of the quarter.

Quarter Date Ranges	
Quarter 1	July 01 - September 30
Quarter 2	October 1 - December 31
Quarter 3	January 1 - March 31
Quarter 4	April 1 - June 30

	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017	Q1 2018	Q2 2018	Q3 2018	CURRENT Q4 2018
Social Work												
Number of Cases Received	22	31	19	15	19	12	28	21	14	27	15	34
Number of Cases Open	95	126	120	127	78	70	54	39	39	48	52	71
Number of Cases Closed	27	8	27	8	62	17	46	39	15	19	11	18
Veterinary Medicine												
Number of Cases Received	37	63	59	38	67	63	74	55	52	51	63	51
Number of Cases Open	163	172	198	197	210	209	227	232	230	240	235	198
Number of Cases Closed	53	63	42	42	56	65	57	53	57	41	70	91
Agency Totals												
Number of Cases Received	1,297	1,332	1,483	1,382	1,467	1,314	1,445	1,413	1,381	1,413	1,570	1,662
Number of Cases Open	3,183	3,141	3,296	3,433	3,373	3,298	3,222	3,196	3,481	3,504	3,600	3,626
Number of Cases Closed	1,440	1,466	1,422	1,291	1,560	1,513	1,593	1,495	1,143	1,426	1,542	1,718

Virginia Department of

Health Professions

Average Age of Cases Closed

Fiscal Year Summary

Quarter 4 - Fiscal Year 2018

The average age of cases closed is a measurement of how long it takes, on average, for a case to be processed from entry to closure. These calculations include only cases closed within the quarter specified.

Quarter Date Ranges	
Quarter 1	July 01 - September 30
Quarter 2	October 1 - December 31
Quarter 3	January 1 - March 31
Quarter 4	April 1 - June 30

	FY 2014	Change Between FY15 & FY14	FY 2015	Change Between FY16 & FY15	FY 2016	Change Between FY16 & FY17	FY 2017	Change Between FY17 & FY18	FY 2018
Audiology/Speech Pathology	59.9	65.4%	99.0	67.4%	165.8	39.1%	230.5	14.7%	264.5
Counseling	215.2	20.0%	258.3	22.0%	315.0	-18.4%	257.2	-30.5%	178.9
Dentistry	317.9	-11.0%	282.9	-1.4%	278.9	-7.4%	258.1	-16.1%	216.5
Funeral Directing	178.0	-16.7%	148.3	28.2%	190.1	16.4%	221.3	17.8%	260.7
Long Term Care Administrator	175.8	7.2%	188.5	12.7%	212.4	45.0%	307.9	14.7%	353.3
Medicine	156.6	9.2%	171.0	-0.9%	169.5	-17.2%	140.4	-0.3%	139.9
Nurse Aide	203.7	-29.6%	143.4	0.5%	144.2	33.4%	192.2	22.5%	235.6
Nursing	178.5	8.7%	194.0	3.4%	200.6	-1.9%	196.8	14.5%	225.2
Optometry	223.6	-23.7%	170.7	19.6%	204.2	-17.7%	168.0	118.7%	367.4
Pharmacy	136.7	19.0%	162.6	-20.7%	129.0	103.5%	262.5	-36.0%	167.9
Physical Therapy	147.2	22.0%	179.7	-5.9%	169.1	58.9%	268.6	-11.2%	238.5
Psychology	158.3	15.4%	182.7	89.0%	345.2	-8.3%	316.6	-53.1%	148.6
Social Work	172.0	33.4%	229.4	11.0%	254.7	47.4%	375.3	-40.5%	223.1
Veterinary Medicine	174.8	31.6%	230.0	48.4%	341.4	-12.6%	298.2	4.6%	311.8
AGENCY	181.5	3.0%	186.8	4.5%	195.3	6.1%	207.2	-4.2%	198.4

Virginia Department of

Health Professions

Cases Closed in Less than One Year

Fiscal Year Summary

Quarter 4 - Fiscal Year 2018

The percent of cases closed in fewer than 365 days shows, from the total of all cases closed during the specified period, the percent of cases that were closed in less than one year. In comparing two time periods, if the change is positive there was a higher percent of cases closed in under a year in the first period than in the previous period.

Quarter Date Ranges	
Quarter 1	July 01 - September 30
Quarter 2	October 1 - December 31
Quarter 3	January 1 - March 31
Quarter 4	April 1 - June 30

	FY 2014	Change Between FY15 & FY 14	FY 2015	Change Between FY16 & FY 15	FY 2016	Change Between FY16 & FY 17	FY 2017	Change Between FY17 & FY 18	FY 2018
Audiology/Speech Pathology	100.0%	-3.2%	96.8%	3.3%	100.0%	-10.5%	89.5%	-10.6%	80.0%
Counseling	87.6%	-12.6%	76.6%	-25.8%	56.8%	35.0%	76.8%	13.8%	87.4%
Dentistry	65.1%	11.1%	72.4%	0.0%	72.4%	3.4%	74.8%	13.9%	85.2%
Funeral Directing	90.8%	5.4%	95.7%	-6.0%	90.0%	-14.4%	77.1%	0.5%	77.4%
Long Term Care Administrator	88.6%	1.6%	90.0%	-6.4%	84.2%	-19.0%	68.3%	-38.9%	41.7%
Medicine	91.7%	-1.0%	90.8%	-1.7%	89.3%	5.0%	93.7%	0.1%	93.8%
Nurse Aide	96.1%	-0.1%	96.0%	-2.2%	94.0%	-9.4%	85.1%	-3.0%	82.5%
Nursing	92.3%	-2.2%	90.3%	-4.7%	86.1%	0.7%	86.7%	-9.7%	78.3%
Optometry	83.3%	4.0%	86.7%	4.9%	90.9%	-1.4%	89.7%	-29.4%	63.3%
Pharmacy	92.0%	-4.3%	88.0%	4.4%	91.9%	-15.6%	77.6%	14.6%	89.0%
Physical Therapy	95.4%	-5.6%	90.0%	3.4%	93.0%	-33.3%	62.1%	25.3%	77.8%
Psychology	93.7%	0.1%	93.8%	-49.5%	47.3%	21.8%	57.6%	60.0%	92.2%
Social Work	92.7%	-8.3%	85.0%	-28.4%	60.9%	-15.3%	51.5%	57.1%	81.0%
Veterinary Medicine	95.2%	5.1%	100.0%	-37.6%	62.4%	16.7%	72.8%	-9.2%	66.2%
AGENCY	91.3%		90.9%		89.5%		83.9%	0.7%	84.5%

Criteria for this report:
License Status = Current Active, Current Inactive, Probation - Current Active, Adverse Findings - Current Active, Current Active-RN Privilege and Expiration Date >= Today or is null.

License Count Report for Medicine

Board	Occupation	State	License Status	License Count
Medicine				
	Assistant Behavior Analyst			
	Assistant Behavior Analyst	Virginia	Current Active	146
	Assistant Behavior Analyst	Out of state	Current Active	13
	Total for Assistant Behavior Analyst			159
	Athletic Trainer			
	Athletic Trainer	Virginia	Current Active	1,375
	Athletic Trainer	Virginia	Current Inactive	2
	Athletic Trainer	Out of state	Current Active	315
	Athletic Trainer	Out of state	Current Inactive	2
	Total for Athletic Trainer			1,694
	Behavior Analyst			
	Behavior Analyst	Virginia	Current Active	843
	Behavior Analyst	Virginia	Current Inactive	2
	Behavior Analyst	Out of state	Current Active	216
	Total for Behavior Analyst			1,061
	Chiropractor			
	Chiropractor	Virginia	Current Active	1,353
	Chiropractor	Virginia	Current Inactive	26
	Chiropractor	Out of state	Current Active	234
	Chiropractor	Out of state	Current Inactive	90
	Total for Chiropractor			1,703
	Genetic Counselor			
	Genetic Counselor	Virginia	Current Active	89
	Genetic Counselor	Out of state	Current Active	100
	Total for Genetic Counselor			189
	Genetic Counselor-Temporary			
	Genetic Counselor-Temporary	Virginia	Current Active	5
	Total for Genetic Counselor-Temporary			5
	Interns & Residents			
	Interns & Residents	Virginia	Current Active	2,691
	Interns & Residents	Out of state	Current Active	510
	Total for Interns & Residents			3,201
	Licensed Acupuncturist			
	Licensed Acupuncturist	Virginia	Current Active	407
	Licensed Acupuncturist	Out of state	Current Active	126
	Licensed Acupuncturist	Out of state	Current Inactive	9
	Total for Licensed Acupuncturist			542
	Licensed Midwife			
	Licensed Midwife	Virginia	Current Active	66
	Licensed Midwife	Out of state	Current Active	19
	Total for Licensed Midwife			85

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License Count Report for Medicine

Board	Occupation	State	License Status	License Count
Medicine				
	Limited Radiologic Technologist			
	Limited Radiologic Technologist	Virginia	Current Active	533
	Limited Radiologic Technologist	Virginia	Current Inactive	30
	Limited Radiologic Technologist	Out of state	Current Active	30
	Limited Radiologic Technologist	Out of state	Current Inactive	1
	Total for Limited Radiologic Technologist			594
	Medicine & Surgery			
	Medicine & Surgery	Virginia	Current Active	21,721
	Medicine & Surgery	Virginia	Current Inactive	391
	Medicine & Surgery	Virginia	Probation - Currer	3
	Medicine & Surgery	Out of state	Current Active	13,943
	Medicine & Surgery	Out of state	Current Inactive	1,122
	Total for Medicine & Surgery			37,180
	Occupational Therapist			
	Occupational Therapist	Virginia	Current Active	3,255
	Occupational Therapist	Virginia	Current Inactive	41
	Occupational Therapist	Out of state	Current Active	769
	Occupational Therapist	Out of state	Current Inactive	49
	Total for Occupational Therapist			4,114
	Occupational Therapy Assistant			
	Occupational Therapy Assistant	Virginia	Current Active	1,326
	Occupational Therapy Assistant	Virginia	Current Inactive	11
	Occupational Therapy Assistant	Out of state	Current Active	228
	Occupational Therapy Assistant	Out of state	Current Inactive	8
	Total for Occupational Therapy Assistant			1,573
	Osteopathy & Surgery			
	Osteopathy & Surgery	Virginia	Current Active	1,751
	Osteopathy & Surgery	Virginia	Current Inactive	6
	Osteopathy & Surgery	Out of state	Current Active	1,634
	Osteopathy & Surgery	Out of state	Current Inactive	80
	Total for Osteopathy & Surgery			3,471
	Physician Assistant			
	Physician Assistant	Virginia	Current Active	3,084
	Physician Assistant	Virginia	Current Inactive	4
	Physician Assistant	Out of state	Current Active	903
	Physician Assistant	Out of state	Current Inactive	21
	Total for Physician Assistant			4,012
	Podiatry			
	Podiatry	Virginia	Current Active	393
	Podiatry	Virginia	Current Inactive	9
	Podiatry	Virginia	Probation - Currer	1
	Podiatry	Out of state	Current Active	110
	Podiatry	Out of state	Current Inactive	26
	Total for Podiatry			539
	Polysomnographic Technologist			
	Polysomnographic Technologist	Virginia	Current Active	378
	Polysomnographic Technologist	Out of state	Current Active	117

License Count Report for Medicine

Board	Occupation	State	License Status	License Count
Medicine				
	Total for Polysomnographic Technologist			495
	Radiologic Technologist			
	Radiologic Technologist	Virginia	Current Active	3,511
	Radiologic Technologist	Virginia	Current Inactive	28
	Radiologic Technologist	Out of state	Current Active	904
	Radiologic Technologist	Out of state	Current Inactive	7
	Total for Radiologic Technologist			4,450
	Radiologist Assistant			
	Radiologist Assistant	Virginia	Current Active	9
	Radiologist Assistant	Out of state	Current Active	3
	Total for Radiologist Assistant			12
	Respiratory Therapist			
	Respiratory Therapist	Virginia	Current Active	3,119
	Respiratory Therapist	Virginia	Current Inactive	71
	Respiratory Therapist	Out of state	Current Active	806
	Respiratory Therapist	Out of state	Current Inactive	28
	Total for Respiratory Therapist			4,024
	Restricted Volunteer			
	Restricted Volunteer	Virginia	Current Active	68
	Restricted Volunteer	Out of state	Current Active	22
	Total for Restricted Volunteer			90
	Surgical Assistant			
	Surgical Assistant	Virginia	Current Active	226
	Surgical Assistant	Out of state	Current Active	22
	Total for Surgical Assistant			248
	Surgical Technologist			
	Surgical Technologist	Virginia	Current Active	281
	Surgical Technologist	Out of state	Current Active	11
	Total for Surgical Technologist			292
	University Limited License			
	University Limited License	Virginia	Current Active	19
	University Limited License	Out of state	Current Active	1
	Total for University Limited License			20
Total for Medicine				69,753

Virginia HPMP
September 2018 Monthly Report

Board	License	Census (September 30, 2018)		#Admissions	
		Number	Percentage of Total	Req[1]	Vol[2]
	LPN	37	8.5	1	
	RN	221	50.6	4	1
	LNP	16	3.7		
Nursing Total		**274**	**62.7**	**5**	**1**
CNA Total	CNA	**7**	**1.6**		
	DO	9	2.1		
	Intern/Resident	11	2.5		
	MD	73	16.7		1
	PA	7	1.6		
	Lic Rad Tech	1	0.2		
	DC	3	0.7		
	OT	4	0.9		
	OTA	1	0.2		
	RT	2	0.5		
	DPM	1	0.2		
	LBA	1	0.2		
Medicine Total		**113**	**25.9**	**0**	**1**
	Pharmacist	15	3.4		
	Pharm Tech	1	0.2		
	Intern	0	0.0		
Pharmacy Total		**16**	**3.7**	**0**	**0**
	DDS	9	2.1		
	DMD	1	0.2		
	RDH	4	0.9		
Dentistry Total		**14**	**3.2**	**0**	**0**
Social Work Total	LCSW	**3**	**0.7**		
	LCP	1	0.2		
	SOTP	1	0.2		
Psychology Total		**2**	**0.5**		
Optometry Total	OD	**2**	**0.5**		
Veterinary Medicine Total	DVM	**1**	**0.2**		
Audiology & Speech-Language Path Total	SLP	**1**	**0.2**		
	PT	2	0.5		
	PTA	2	0.5		
Physical Therapy Total		**4**	**0.9**		
TOTALS		**437**	**274**	**5**	**2**

Req[1]: Required (Board Referred, Board Ordered, Investigation)

Vol[2]: Voluntary (No known DHP involvement at time of intake)

Virginia Department of Health Professions
Input of Case Hours by Department
For Use in Allocation of Department 305- ***Enforcement*** Costs
For the Fiscal Year Ended June 30, 2019

	Fiscal Month No.	1	2	3	4	5	6	7	8	9	10	11	12	Annual
	Month Name	July	August	September	October	November	December	January	February	March	April	May	June	Total
Dept. No.	Dept. Name													
101	Nursing	1,729.00	1,758.25	1,716.50										5,203.75
102	Medicine	1,881.00	2,274.33	1,606.30										5,761.63
103	Dentistry	421.00	632.75	500.05										1,553.80
104	Funeral Directors and Emba	138.00	154.00	103.00										395.00
105	Optometry	46.75	12.25	45.50										104.50
106	Veterinary Medicine	345.25	341.58	273.00										959.83
107	Pharmacy	1,236.65	1,549.13	1,163.35										3,949.13
108	Psychology	52.00	41.75	46.00										139.75
109	Professional Counselors	191.50	216.25	179.50										587.25
110	Social Work	121.50	118.00	76.75										316.25
112	Cerified Nurse Aids (State	612.50	480.50	388.70										1,481.70
114	Nursing Home Administrator	105.75	108.75	136.50										351.00
115	Audiology and Speech Lang	13.50	18.00	32.00										63.50
116	Physical Therapy	21.75	36.25	55.00										113.00
118	Va. Pharm Processor Pgm	-	-	-										-
	Total	6,916.15	7,741.79	6,322.15	-	-	-	-	-	-	-	-	-	20,980.090

Description of Allocation Method

Sources & Notes
Note: Number of hours = Investigative Hours + Manpower Analysis Hours (#'s come from monthly statistical reports from Enforcment (Tamika)
The source for these numbers is a VDHP spreadsheet titled *Allocation 305 & 306.xls*

Maximus report of April 11, 2002 recommended using the average of the current and two prior months in computing the allocation factor.

Virginia Department of Health Professions
Input of Case Hours by Department
For Use in Allocation of Department 306- ***Administrative Proceedings*** Costs
For the Fiscal Year Ended June 30, 2019

	Fiscal Month No.	1	2	3	4	5	6	7	8	9	10	11	12	Annual
	Month Name	July	August	September	October	November	December	January	February	March	April	May	June	Total
Dept. No.	Dept. Name													
101	Nursing	427.25	572.50	623.50										
102	Medicine	929.95	959.00	903.75										
103	Dentistry	84.25	72.00	89.00										
104	Funeral Directors and Emba	7.00	25.50	53.00										
105	Optometry	18.50	0.75	0.25										
106	Veterinary Medicine	46.25	20.25	36.75										
107	Pharmacy	246.25	239.50	194.75										
108	Psychology	22.50	74.50	15.00										
109	Professional Counselors	89.25	8.00	74.00										
110	Social Work	17.50	0.00	0.00										
112	Cerified Nurse Aids (State	111.25	114.25	91.00										
114	Nursing Home Administrator	29.50	27.25	18.50										
115	Audiology and Speech Lang	11.50	14.25	14.75										
116	Physical Therapy	5.25	30.50	23.25										
118	Va. Pharm Processor Pgm													
	Total	2,046.20	2,158.25	2,137.50	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Description of Allocation Method

Notes & Sources
Number of Hours = weekly log sheet totals provided monthly by APD - Susan Brooks
The source for these numbers is a VDHP spreadsheet titled *Allocation 305 & 306.xls*

Note 10/22/17- Set up 118 with $1

Commonwealth of Virginia

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

Re: FSMB Call for Nominations - Virginia Board of Medicine

1 message

Harp, William <william.harp@dhp.virginia.gov> Mon, Oct 1, 2018 at 2:44 PM
To: Kenneth Walker <kjwalk@gmail.com>

Ken:

I look forward to the discussion.

Bill

On Mon, Oct 1, 2018 at 1:53 PM Kenneth Walker <kjwalk@gmail.com> wrote:

Dear Bill:

As a member of the Federation of State Medical Boards (FSMB) Nominating Committee, I am writing to ask for your help.

The FSMB's Call for Nominations letter was sent to you recently. This is our first solicitation for elected positions in this important umbrella organization uniting the 70 state medical, osteopathic, and U.S. territory boards. The FSMB programs support member boards by providing political advocacy, policy and guideline formulation, educational programs, and extensive licensure and credentialing resources.

Good leadership is vital to ensuring FSMB's ability to continually meet the challenges and opportunities in the evolving landscape of medical regulation. As a leader of your board, you are in an ideal position to identify potential candidates to serve in an elected position on the FSMB Board of Directors or Nominating Committee.

As a national organization, we are looking for diverse representation of members from all geographic areas possessing the various skill sets, knowledge, and experience necessary to continue to advance the FSMB as a national organization.

I hope that you will take a moment to consider promising members who serve on your Board and would be interested in serving in an elected position. New leaders are critical to ensure that FSMB continues to carry out its mission of serving as the national resource and unified voice of all U.S. state medical and osteopathic boards.

Over the next few weeks I will contact you by phone to discuss potential candidates from your board who might wish to consider running for an elected position on the FSMB Board of Directors or Nominating Committee.

In the interim, please do not hesitate to contact me by cell phone at 540 922 2132 (please leave a message if I do not answer immediately), or by email at kjwalk@gmail.com for questions or further information.

I look forward to speaking with you soon, and on behalf of the FSMB, to thank you for your thoughtful consideration.

Sincerely,

Ken Walker M.D.
Member FSMB Nominating Committee
Member Virginia Board of Medicine

Sen. Scott Surovell: Time for Virginia to Label "Harmful and Ineffective" LGBT "Conversion Therapy" as "Unprofessional Conduct"

By **lowkell** - October 5, 2018

This SHOULD be a no brainer, as "conversion therapy" is – as Sen. Scott Surovell states in the following letter to Virginia Department of Health Professions David Brown – a "dangerous and discredited practice...harmful and ineffective," with "[g]ay and transgender youth who are subjected to [it] fac[ing] traumatic consequences such as depression, low self-esteem, substance abuse, and even suicide." If that doesn't qualify as "unprofessional conduct," I'm not sure what would...

SENATE OF VIRGINIA

SCOTT A. SUROVELL
36TH SENATORIAL DISTRICT
PART OF FAIRFAX, PRINCE WILLIAM,
AND STAFFORD COUNTIES
POST OFFICE BOX 789
MOUNT VERNON, VIRGINIA 22121
(571) 249-4484

COMMITTEE ASSIGNMENTS:
GENERAL LAWS AND TECHNOLOGY
LOCAL GOVERNMENT
REHABILITATION AND SOCIAL SERVICES

October 4, 2018

David E. Brown, D.C.
Department of Health Professions
Perimeter Center
9960 Maryland Dr., Ste 300
Richmond, VA 23233

RE: Adding Conversion Therapy To The Standards Of Practice; Unprofessional Conduct

Director Brown:

It is my understanding that the Department has convened a working group to consider adding conversion therapy conversion therapy or sexual orientation change efforts to the Unprofessional Conduct section of each licensing board's Standards of Practice. I am writing in support of that effort.

"Conversion therapy" means any practices or treatments that seek to change an individual's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender. Conversion therapy does not include counseling that provides assistance to a person undergoing gender transition, or counseling that provides acceptance, support, and understanding of a person or facilitates a person's coping, social support, and identity exploration and development, including sexual-orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as such counseling does not seek to change an individual's sexual orientation or gender identity.

Conversion therapy is a dangerous and discredited practice aimed at changing a person's sexual orientation or gender identity. Numerous health associations, including the American American Psychiatric Association, the American Psychological Association, the American Counseling Association, the National Association of Social Workers, the American Academy of Pediatrics, and the American Association for Marriage and Family Therapy deem conversion therapy a harmful and ineffective practice. Gay and transgender youth who are subjected to conversion therapy face traumatic consequences such as depression, low self-esteem, substance abuse, and even suicide.

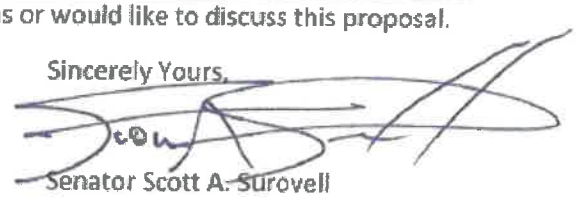
Nine other states and Washington, D.C. passed legislation to protect LGBT youth from conversion therapy. Because state-licensed practitioners could otherwise prey on parents and legal guardians who are not aware that conversion therapy subjects their children to serious harm, the state has a compelling interest in ensuring that licensed health care providers follow professional standards of care and do not engage in dangerous practices that have no scientific basis and put patients at risk.

I have introduced legislation to achieve this twice in the last three years. I have recorded both hearings on my legislation and uploaded them to my YouTube Channel if you would like to watch the discussion. The primary opposition articulated by State Senators has been that issues like this should be dealt with through professional licensing instead of by legislation. This is exactly what your Department is considering, and I wholeheartedly support this effort.

By adding these practices to the Unprofessional Conduct section, the boards would do nothing to prohibit pastoral services provided by religious or faith officials.

As the primary sponsor of this legislation, I would appreciate it if your office would **keep me appraised of all notices, hearings, or proposed rules regarding this issue**. Please contact me directly if you have any questions or would like to discuss this proposal.

Sincerely Yours,

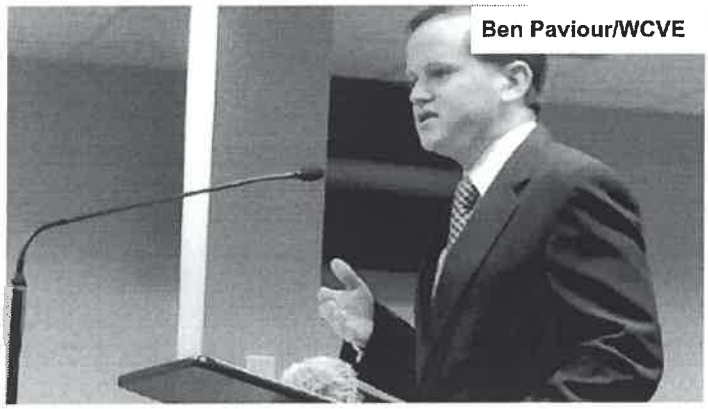


Senator Scott A. Surovell
36th District

cc: Delegate Patrick Hope
Ms. Vee Lamneck, Equality Virginia

Conversion Therapy Gets New Attention From Virginia Regulatory Boards

October 05, 2018 -- Ben Paviour



Shawn McGuire, grassroots director of the Family Foundation

Critics of homosexual conversion therapy urged key state health boards to regulate the practice at an emotional meeting at the Department of Health Professions today (10/5).

The Conversion Therapy Workgroup took shape after Republican-led committees in the General Assembly quashed legislation banning the controversial process for people under the age of 18.

The Board of Medicine, Behavioral Health Board, and Board of Nursing will now consider whether to adopt any regulations of the practice for that age group.

Representatives of those boards at the meeting voiced general support for regulations, but it may be up to two years before any are adopted.

Ted Lewis heads the LGBTQ support non-profit Side by Side and teared up as he addressed the conversion therapy work group. "Something like conversion therapy furthers this notion that being LGBTQ is wrong," he said.

Lewis said that 70 percent of the youth that he works with have contemplated suicide. "I'm sorry for being emotional today," he said. "We lost another one of our youth last month, and I'm tired of burying our children."

Casey Pick, a senior advocacy fellow at a national crisis support organization called The Trevor Project, said that the group had been contacted by 2,500 Virginians in the past year--the second highest total in the South.

She pointed to findings that teens undergoing conversion therapy were far more likely to commit suicide.

"It's the probably the most concrete example of, this is not something we're going to accept, and we're going to attempt to change you, fix you---various different ways of rejecting who the child is," she said in an interview.

Some Christian speakers called any regulation a government overreach and an attack on the authority of parents.

Mechanicsville Baptist Church Pastor Ted Williams called the regulations "nothing more than an attempt to silence the evangelical church and chip away at our freedom."

Williams said conversion therapy practitioners he knew were "compassionate, skilled, and have only the interest of their clients in mind."

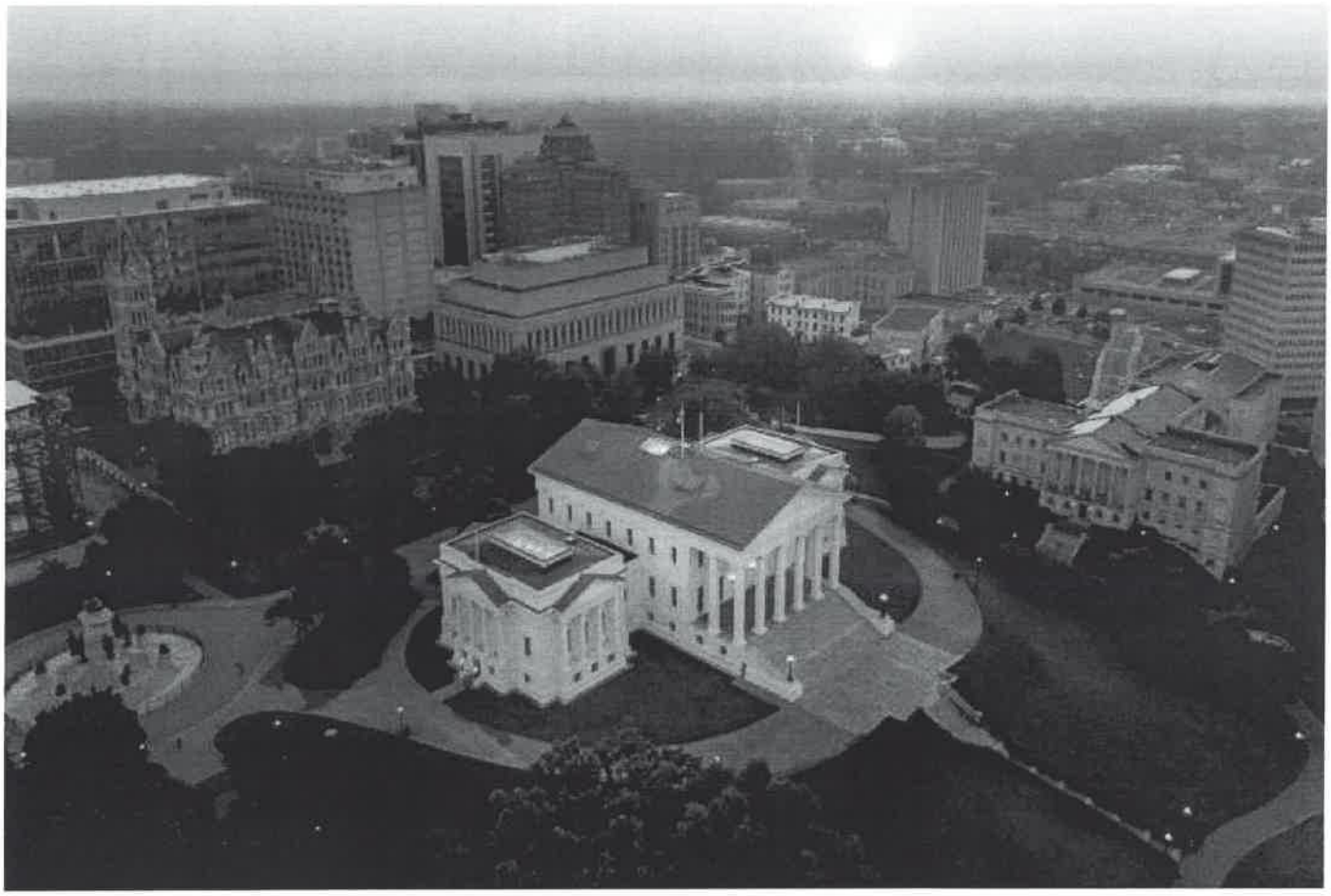
Shawn McGuire, grassroots director of the Family Foundation, said he spoke in a personal capacity, as someone who experienced "unwanted homosexual attractions."

McGuire said the he found the homo- and hetero- identities inherent in conversion therapy to be constraining, but said it wasn't the government's job to intervene in what he saw as a moral question.

"These regulations would impose the idea of LGBTQ+ identity in law," he said. "That would require people to respond in the idea that there is a distinction between men and women in state law."

The General Assembly has consistently stopped efforts to outlaw conversion therapy. But state licensing boards might be able to do it themselves.

By
Katie O'Connor
-
October 8, 2018



The sun rises over the Virginia Capitol. (Ned Oliver/Virginia Mercury)

Conversion therapy, aimed at changing sexual orientation, has been widely deemed ineffective and potentially harmful by nearly every medical professional organization — yet it's still legal in most of the country, including Virginia.

Efforts to outlaw its use on minors by licensed professionals over the past five years have been stymied by Virginia's General Assembly, where a bill has consistently failed to get past committees on party-line votes.

But Virginia's regulatory boards might be able to achieve the same result without the General Assembly's action.

The Department of Health Professions held a conversion therapy workgroup meeting Friday to consider potential regulations that its different boards — such as the Board of Medicine and Board of Psychology — could enact to prohibit conversion therapy on those under 18 by a clinician licensed by the state.

The idea of prohibiting the practice through regulations was brought up by some legislators during General Assembly sessions, said Dr. David Brown, director of the Department of Health Professions, prompting the work group's formation.

The heads of the boards largely agreed that regulations are necessary, and the next step will be to discuss the proposed language during their respective board meetings over the next several months.

Conversion therapy is defined as treating a patient in an attempt to intentionally change his or her sexual orientation or gender identity. In the past it included practices such as electric-shock therapy, which Herb Stewart, chair of the Board of Psychology, said, "can only be described as torture."

Today, it is a form of counseling and psychotherapy aimed at eliminating patients' sexual desires. It is also referred to as "sexual-orientation change efforts."

And those on both sides of the debate have vehement opinions on the practice.

More than two dozen people spoke during a public comment period that lasted more than 90 minutes at Friday's meeting, sharing personal stories of how conversion therapy helped them or how it, in many cases, did boundless harm that took years or decades to heal.

Sen. Amanda Chase, R-Chesterfield, speaks during a Department of Health Professions work group meeting on conversion therapy.

Some, particularly those aligned with faith organizations, claim that conversion therapy is a form of free speech, and that prohibiting its practice is denying religious counselors the ability to "affirm natural sexual expressions," as one opponent of banning the practice said.

"My position is: embracing the idea that LGBTQ+ identity is a category of humanity is where the real harm is done," said Sean Maguire, director of grassroots for the Family Foundation. "Don't take away the freedom of religious counselors to share the truth about what they deeply believe is the truth of human nature."

But opponents of the practice pointed to the fact that numerous professional organizations state that conversion therapy is medically useless and, in some cases, dangerous. Many gave personal testimonies of their experience.

"Conversion therapy broke my identity down to nothing," said Adam Trimmer, who was treated with the therapy as a teen. He said he attempted suicide and that it took him years to get past the resulting damage.

"Nobody should ever have to go through therapy because of therapy," he said.

The members of the work group, who represented an array of state licensing boards, all said the testimonies they heard from both sides were compelling.

"But it's incredibly important to separate emotion from science," said Dr. Kevin O'Connor, president of the Board of Medicine. "It's also important to understand that being gay or lesbian isn't a disease that needs correcting."

Sen. Amanda Chase, R-Chesterfield, spoke twice during Friday's meeting, reminding the workgroup "where the General Assembly stands," on the issue, since a bill banning the therapy has been consistently killed.

She said that an unintended consequence of prohibiting conversion therapy through regulation could be that parents don't bring their kids to professionals for help. Some parents believe homosexuality is a sin, she said, and they need more options.

Del. Patrick Hope, D-Arlington, who has introduced legislation to ban conversion therapy on minors in four of the past five General Assembly sessions, pointed out that the bills' failure reflects the makeup of the committees and subcommittees, and that it is not a reflection of the General Assembly.

He reiterated that the regulations are just for children and adolescents, not adults, and that the state should make a concerted effort to protect children.

Several heads of various boards reported that they have not received any complaints related to conversion therapy, and Chase pointed to that as a reason why regulations are not needed.

But Elaine Yeatts, senior policy analyst for the Department of Health Professions, said minors are not likely to make complaints.

"I think it's probably unrealistic to expect that you may be getting complaints from a child or even an adolescent," she said. "And in many cases, they have been brought to this therapy by an adult, and the adult is not likely to be filing a complaint."

The work group members also reiterated that regulations would not prevent church leaders from counseling members of their congregations — it would simply stop someone with a license to practice from using that license to attempt to change a patient's sexual orientation.

Though work group members largely agreed that regulations are necessary, some expressed concerns that the regulations could prevent providers from offering counseling on identity exploration entirely.

They discussed the wording of the proposed regulations to make it clear that the prohibition would be specifically on a practitioner aiming to change their patient's sexual orientation or gender identity.

"This is a vulnerable population that is likely not to report, and it is a practice which is demonstrably harmful," O'Connor said. "It doesn't limit access to therapies if the parents choose to seek that therapy. It's simply not licensed by our licensing boards."

Previous article Report takes a dim view of Dominion's grid 'transformation'
Next article Constitutional amendments on this year's ballot deal with tax breaks for military families, homeowners in flood-prone areas

Katie O'Connor
Katie, a Manassas native, has covered health care, commercial real estate, law, agriculture and tourism for the Richmond Times-Dispatch, Richmond BizSense and the Northern Virginia Daily. Last year, she was named an Association of Health Care Journalists Regional Health Journalism Fellow, a program to aid journalists in making national health stories local and using data in their reporting. She is a graduate of the College of William and Mary, where she was executive editor of The Flat Hat, the college paper, and editor-in-chief of The Gallery, the college's literary magazine.

Agenda Item: **Committee and Advisory Board Reports**

Staff Note: Please note Committee assignments and minutes of meetings since June 14, 2018.

Action: Motion to accept minutes as reports to the Board.

VIRGINIA BOARD OF MEDICINE

Committee Appointments

2018-2019

EXECUTIVE COMMITTEE (8)
Kevin O'Connor MD, President, Chair
Syed Salman Ali, MD
David Archer, MD
Lori Conklin, MD, Secretary/Treasurer
Alvin Edwards, PhD
Jane Hickey, JD
Ray Tuck, DC, Vice-President
Kenneth Walker, MD

LEGISLATIVE COMMITTEE (7)
Ray Tuck, Jr., DC, Vice-President, Chair
Alvin Edwards, PhD
David Giammittorio, MD
Jane Hickey, JD
Karen Ransone, MD
David Taminger, MD
Svinder Toor, MD

CREDENTIALS COMMITTEE (9)
Kenneth Walker, MD, Chair
James Arnold, DPM
Manjit Dhillon, MD
Jane Hickey, JD
L. Blanton Marchese
Jacob Miller, DO
Brenda Stokes, MD
David Taminger, MD
Martha Wingfield

FINANCE COMMITTEE
Kevin O'Connor, MD, President
Ray Tuck, Jr., DC, Vice-President
Lori Conklin, MD - Secretary/Treasurer

BOARD BRIEFS COMMITTEE
William L. Harp, M.D., Ex Officio

CHIROPRACTIC COMMITTEE
Ray Tuck, Jr., DC - Secretary/Treasurer

BOARD OF HEALTH PROFESSIONS
Kevin O'Connor, MD

COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
Lori Conklin, MD
Kevin O'Connor, MD
Kenneth Walker, MD

--- DRAFT UNAPPROVED --

VIRGINIA BOARD OF MEDICINE
EXECUTIVE COMMITTEE MINUTES

Friday, August 3, 2018 Department of Health Professions Henrico, VA

CALL TO ORDER: Dr. O'Connor called the meeting to order at 8:32 a.m.

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

MEMBERS PRESENT:
Kevin O'Connor, MD, President
Nathaniel Tuck, Jr., DC, Vice-President
David Archer, MD
Alvin Edwards, MDiv, PhD
Jane Hickey, JD
Kenneth Walker, MD

MEMBERS ABSENT:
Syed Salman Ali, MD
Lori Conklin, MD, Secretary-Treasurer

STAFF PRESENT:
William L. Harp, MD, Executive Director
Jennifer Deschenes, JD, Deputy Director, Discipline
Colanthia Morton Opher, Deputy Director, Administration
Barbara Matusiak, MD, Medical Review Coordinator
David Brown, DC, DHP Director
Barbara Allison-Bryan, MD, DHP Deputy Director
Elaine Yeatts, DHP Senior Policy Analyst
Erin Barrett, JD, Assistant Attorney General

OTHERS PRESENT:
Kurt Elward, MD, President, MSV
Ralston King, MSV
W. Scott Johnson, JD, MSV
Cynthia Fagan, VCNP
Morgan McDowell, VCNP
Mary Baker, VCNP
Brekk MacPherson, VCNP
Rebekah Compton, VCNP
Richard Grossman, VCNP
Ryan LaMura, VHHA
Sara Heisler, VHHA
Aimee Perron Seibert, VA College of Emergency Physicians
Del Bolin, VAFP & VCOM
Hunter Jamerson, VAFP
Rosie Taylor-Lewis, VCNP
Sam Bartle, MD, VA Chapter, American Academy of Pediatrics

EMERGENCY EGRESS INSTRUCTIONS

Dr. Tuck provided the emergency egress instructions.

APPROVAL OF MINUTES OF APRIL 13, 2018

Dr. Edwards moved to approve the meeting minutes of April 13, 2018 as presented. The motion was seconded and carried unanimously.

ADOPTION OF AGENDA

Dr. Tuck moved to adopt the agenda as presented. The motion was seconded and carried unanimously.

PUBLIC COMMENT

Prior to opening the floor for comment, Dr. O'Connor announced that the comment period for the Regulations for Autonomous Practice by Nurse Practitioners had closed. No comment would be received at this meeting on the NP regulations.

There was no public comment.

DHP DIRECTOR'S REPORT

Dr. Brown gave a quick summary of projects that Dr. Allison-Bryan has been working on over the past several months. He stated that, as Chief Deputy, she has increased the bandwidth of the Director's office. He noted that Dr. Allison-Bryan came into the position with a strong background on the opioid crisis, its challenges and the opioid regulations. She has continued her work on the crisis with other agencies and the Deputy Secretary. He noted Dr. Allison-Bryan's strong presentation abilities, as acknowledged by the correspondence from Carilion in the agenda packet. Additionally, she has been involved with reviewing and developing security measures for the agency.

Dr. Allison-Bryan gave an update on the work that she's been doing with the Henrico Police and the Virginia State Police to address safety issues and security concerns for the building, personnel and the public. She acknowledged that the work performed by the Board members can be very threatening, especially when the respondent's livelihood hangs in the balance. She stated that they had completed one walk-through and discussed placement of security cameras to create a safer work environment.

Dr. Allison-Bryan informed the members about the launch of Virginia's Emergency Department Care Coordination (EDCC) Program and stated that every physician will be touched by it. As of June 30th, all 122 emergency departments across Virginia were connected, giving them the ability of near real-time communication and collaboration among health care providers. Dr. Allison-Bryan added that when a patient presents to the ER, a NarxCare ribbon will appear with the patient's EMR and PMP history, providing an abuse risk score. NarxCare should be helpful in identifying potential drug misuse and abuse.

Dr. Allison-Bryan also spoke to the interoperability and integration of the PMP and noted that Virginia is up to 30 states and counting. The Commonwealth has a model PMP and, in conjunction with the Department of Health, will be producing 5 short videos that will provide an important resource to the deans of medical schools. Updates on this effort will be provided as the project progresses.

PRESIDENT'S REPORT

Dr. O'Connor reported that the licensing of art therapists is under consideration by the Board of Health Professions. A decision will be made at the next BHP meeting.

EXECUTIVE DIRECTOR'S REPORT

Revenue and Expenditures

Dr. Harp reported that the Board is solid in its budgeting, revenues, and expenditures. He stated that the Board has voted to reduce renewal fees across all professions for the last three biennia.

Committee Appointments

Dr. Harp announced the appointment of new Board members.

- James Arnold, DPM of Winchester succeeding Randy Clements
- Manjit Dhillon, MD, succeeding David Taminger in the 4th District
- L. Blanton Marchese of Chesterfield, succeeding James Jenkins as citizen member
- Karen Ransone, MD succeeding Barbara Allison-Bryan in the 1st District
- Brenda Stokes, MD succeeding Maxine Lee in the 6th District
- David Taminger, MD succeeding Ike Koziol in the 7th District

Committee Appointments

Dr. Harp reviewed the appointments to the Executive, Legislative and Credentials Committees. He noted that all new Board members start out on Credentials. However, Dr. Ransone, with her experience as a past president of the Board of Medicine, has been appointed to the Legislative Committee.

Letter from Dr. Koziol

Dr. Harp read to the Committee Dr. Koziol's letter regarding his decision to resign from the Board. Dr. Koziol had very kind words for his colleagues at the Board.

Letter from Virginia Tech Carilion

Dr. Harp said that he would like to follow up on Dr. Brown's kudos to Dr. Allison-Bryan; she was a hit at Carilion. Dr. Clements, former podiatrist on the Board, helped facilitate participation in Carilion's Grand Rounds for faculty and housestaff, as well as the incoming

residents' orientation. Dr. Allison-Bryan and Dr. Harp were impressed with what the school is doing to educate students, residents, faculty and staff, not only about opioids, but all areas of medicine.

Case Review

Dr. Harp announced that Dr. Matusiak is requesting the assistance of any available Board members for probable cause review after the meeting.

NEW BUSINESS

Chart of Regulatory Actions

Ms. Yeatts reviewed the Chart of Regulatory Actions as of July 17, 2018.

She reported that the final Regulations Governing Prescribing of Opioids and Buprenorphine will go into effect August 8, 2018. The Licensure by Endorsement regulations will go into effect September 5, 2018.

This report was for informational purposes only.

Regulatory Action – Adoption of Exempt Actions to conform to changes in the Code of Virginia

Polysomnographic Technologists

Ms. Yeatts reviewed the legislation passed by the 2018 General Assembly and the proposed amendments to conform the regulations to the changes in the Code for polysomnographic technologists.

Part II - Requirements for Licensure as a Polysomnographic Technologist

A student enrolled in an educational program in polysomnographic technology or a person engaged in a traineeship from the practice of polysomnographic technology, provided that such student or trainee is under the direct supervision of a licensed polysomnographic technologist or a licensed doctor of medicine or osteopathic medicine.

1. Any such student or trainee shall be identified to patients as a student or trainee in polysomnographic technology.
2. Such student or trainee shall be required to have a license to practice after 18 months from the start of the educational program or traineeship or six months from the conclusion of such program or traineeship, whichever is earlier.

MOTION: Dr. Edwards moved to adopt the new section as presented such that the regulations conform to the language of the law. The motion was seconded and carried unanimously.

Surgical Assistants

Ms. Yeatts reviewed the legislation passed by the 2018 General Assembly and the proposed amendments to conform the regulations to the changes in the Code for surgical assistants.

18VAC85-160-60-Renewal of registration for a surgical assistant

A surgical assistant who was registered based on a credential as a surgical assistant or surgical first assistant issued by the National Board of Surgical Technology and Surgical Assisting, the National Surgical Assistant Association, or the National Commission for the Certification of Surgical Assistants or their successors shall attest that the credential is current at the time of renewal.

MOTION: Dr. Edwards moved to adopt the new language as presented so that the regulations conform to the language of the law. The motion was seconded and carried unanimously.

Regulatory – Emergency Action on regulations for autonomous practice for nurse practitioners

Dr. O'Connor introduced the topic by advising that "the law is the law" and the Regulatory Advisory Panel and the Board of Nursing have vetted the language that is now before the Committee. At this time, the Board of Medicine's responsibility is to craft, with some specificity, the definition of full-time employment.

Ms. Yeatts explained the regulatory process and said that the Board of Nursing has already adopted the draft regulations in the packet; the Board of Medicine can adopt as them as presented or consider amendments. If there are proposed amendments, they would be revisited at the next meeting of the Board of Nursing and at the October Board of Medicine meeting.

Ms. Yeatts walked the members through the proposed regulations and the following summary of the public comment.

SUMMARY – PUBLIC COMMENT ON 5-17-17 DRAFT NP REGS (HB793)

Virginia Healthcare Foundation

- Encourage a regulatory approach for transition to practice that does not exceed a total of 5 years of collaboration for an NP who is licensed in more than one specialty area (category)

- Customized/individualized approach when reviewing applications - Develop a framework for review when considering each NP's individual level of training, credentials and work experience
- Wants a system that promotes NP's adding an additional licensure category, especially for categories that are needed to expand access to care, such as Psych MHNP

Medical Society of Virginia

- 10,000 hours – ½ the time a medical resident practices in 5 years
- 2nd specialty attestation – limit past hours to 10% (or 1,000 hours)
- Detail needed re "specialty area and/or patient population must be aligned" between patient care team physician and NP while under practice agreement – Specialty crosswalk provided
- Adherence to National *Specialty* Certifications
- Prescribing Limitations – proper/education/training and experience prior to prescribing
- Attestation – Give physician the option to provide a rationale for their refusal to sign
- Core Competencies – nothing in the draft that ensures an NP has achieved the basic competencies for autonomous practice – Robust standard needed to define competencies

Virginia Academy of Family Physicians

- Shares MSV concerns
- 2,000 year/10,000 total hours – same as MSV
- Patient population and specialty/category alignment – regulations need to spell out how aligned while under the collaborative Practice Agreement – same as MSV
- Prescribing Limitations – same as MSV
- Attestation – same as MSV
- Guidance document identifying the core competencies that should be met prior to autonomous practice

Virginia Hospital and Healthcare Association

- Definition of FT experience – supports 1,600 year/8,000 total hours
- Content of attestation – supports an approach that limits the attestation to those elements required by the statute
- Other evidence – provide examples of other evidence that would demonstrate applicant met requirements

UVA Health System

- Multiple Attestations – Paragraph D 18VAC90-30-86 is confusing—"If the hours of practice are applicable to the patient population and in practice areas included within each of the categories of licensure and certification, those hours may be counted towards a 2nd attestation."
    - Possible Interpretations: 5 years in each attestation area, or one 5-year period could apply concurrently for each attestation area. Clarity needed. Maybe a minimum amount of time?

  - Suggest open-ended question on attestation form to describe the populations and practice areas worked
  - Specify patient population and practice area on the license
  - System to share information with hiring entities and credentials by secure electronic means

- Licensure by endorsement –
  - Virginia doesn't currently issue a separate RN license to nurses with multistate privilege. Can a RN with multi-state privilege be the basis for issuing an autonomous NP license?
  - Will NP under supervision in another state impact endorsement?
- Practice Agreements – Provides editorial changes to 18VAC90-30-120 A & C (page 2 of letter)
- Consider substituting "independent" for "autonomous", i.e. "licensed independent practitioners"

American Academy of Pediatrics

- Amendment: "While a party to such practice agreement, the patient care team physician routinely practiced with a patient population *and in a primary care or specialty practice area* included within the category, as specified in 18VAC90-30-70 . . ."
- Reverse FT – should be 2,000/10,000 hours
- NPs need to show proficiency before they transition – need for ongoing competency and how that is measured, i.e. continuing education

Virginia College of Emergency Physicians

- 5 years FT should be 2,000 year/10,000 total hours
- Specifications for MD specialty and NP licensure – "patient population" is not clear enough Acute/emergent/primary/chronic/preventative? Clear guidelines needed
- Requesting an amendment with same verbiage as American Academy of Pediatrics re: primary/specialty practice
- Attestation of 5 years – clear, objective, and reproducible – NP's need board certification exams like those of MD's

80 Letters from Physicians/Medical Students

- Same as MSV list of 6 areas of concern

70 other commenters (numerous NP's) in support of current regulations – no further barriers to practice – support regulations as recommended by the RAP

Dr. O'Connor advised that he, Dr. Conklin, and Dr. Mackler were the only physicians on the RAP, which enjoyed a robust discussion that covered all the topics in the summary. The members of the RAP agreed with the dual hours, but where the rubber met the road was with the 5-year requirement.

Dr. Archer said that his concern is with the attestation and its validity. He said that in a residency, you have years of opportunity to evaluate a practitioner's competency. With the nurse practitioner, there doesn't appear to be anything substantial, therefore it is not a quantitative approach.

Ms. Yeatts stated that, first, the nurse practitioner's competency is established when they are issued a license to practice. They would have had to provide adequate proof of examination, national credentialing, board certification, to be jointly licensed by the Board of Medicine and Nursing. Second, there is nothing in the law that requires a patient care team physician to attest to the nurse practitioner's competency.

Dr. Archer stated that, when a student graduates from medical school, he/she serves a 1 year internship, followed by 3-5 years in a residency/fellowship program. All along the way, his/her clinical knowledge is being assessed by multiple physicians. So why aren't the nurse practitioners held to the same standard? He would like some objective documentation that they are competent.

Ms. Barrett said that ship has sailed. The General Assembly has already determined what the physician and nurse practitioner can do, and there is no option to go beyond it. As per the law, the physician and nurse practitioner are limited to:

> (i) that the patient care team physician has served as a patient care team physician on a patient care team with the nurse practitioner pursuant to a practice agreement meeting the requirements of this section and § 54.1-2957.01; (ii) that while a party to such practice agreement, the patient care team physician routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed; and (iii) the period of time for which the patient care team physician practiced with the nurse practitioner under such a practice agreement.

Dr. Walker asked if it would be advantageous to go through each of the comments listed in the summary.

Dr. O'Connor said that the Committee has that option. However, what's on the table is the total number of hours per week that constitutes Full-Time, and what constitutes 5 years of training.

Dr. Walker asked whether the Committee has the ability to substitute "independent" for "autonomous".

Dr. Allison-Bryan said that there is no correct word. Independent implies that you work alone, and autonomy is a matter of substance.

Dr. Walker said that if we are unable to make any other changes to the regulations, then he withdraws his question.

Dr. Brown noted that the public comment covered many things. And though there is no need to discuss every comment, if a concern strikes a chord, it should be identified for discussion. In the same vein, there should be some hesitancy to set a precedent to discuss all comments for any issue.

Dr. O'Connor stated that the battle was lost when the Governor signed the bill.

Ms. Barrett reminded the members that this might not be the last time these draft regulations come before the Board of Medicine. She said that both Medicine and Nursing must adopt the same regulations. But if that does not happen, they will bounce between the two boards until a version or compromise that each can live with is adopted.

Dr. O'Connor said that if the regulations were accepted as presented today, then the emergency regulations are done. The definition of 5 years as noted in the regulations and ability to do cross-attestation would be fixed.

Ms. Hickey asked if the number of hours could be supplemented over more than a 5-year span.

Ms. Yeatts stated that the rationale for the number of hours being considered is based on the fact that, in a hospital setting, 32 hours per week is viewed as full-time. That equates to 1,600 work hours a year, accounting for 2 weeks off.

Ms. Hickey clarified that, if the proposed hours were changed to 40 hours weekly and the nurse practitioner worked 35 hours, they would be required to work 5 ½ years to accomplish the total number of hours required before being able to practice autonomously. She felt that those parameters were acceptable.

Dr. O'Connor said that the physicians on the RAP felt strongly that 40 hours should be the requirement; however, there was no spirit of compromise from other members of the Panel.

Dr Archer agreed that 5 years is arbitrary, but adequate; it is full-time employment. He said that he didn't think that 32 hours per week was enough, and 40 may be too much to ask. He said that 36 should be the logical option.

Dr. O'Connor stated that an offered compromise was rejected. Neither the physicians, nor the nurse practitioners were happy, so it was probably the right choice.

Dr. Tuck agreed.

Dr. Archer said while there's an agreement that the average number of work hours is 2,000 per year, no one works that.

Dr. Walker said that 5 years isn't sufficient, and 10 years is way too much. Personally, he can live with something between 6-10 years.

Dr. O'Connor advised that 9,000 hours is five years.

Dr. Tuck stated that 9,000 hours is a reasonable compromise.

By acclamation, all the members agreed that 9,000 hours should be the proposed amendment.

Dr. O'Connor advised that the second issue up for discussion is how overlapping practice hours can be used for attestation of a second specialty category. The RAP proposal is to use them all.

Ms. Hickey questioned how the hours are calculated if a patient is working in family practice and sees psychiatric patients.

Dr. O'Connor advised that the team physician attests that the hours performed were mental health hours.

Ms. Hickey asked if a nurse practitioner with a certification in psychiatry works in family medicine, and 30% of the patient population is mental health, would she need to work more than 5 years before practicing autonomously?

Ms. Yeatts confirmed that the attestation is dependent on the patient population as to whether or not the hours would count.

Dr. Walker asked if a family NP strictly worked for an ENT practice for 5 years and then returns to a family practice, is there a mechanism to address competency?

Ms. Barrett advised that, you as a practitioner licensed in medicine and surgery, have no limitation on your license and nothing to prevent you from changing specialties. Similarly, there is nothing in the Code that authorizes you to ask for proof of the nurse practitioner's competency. If the licensee wishes to be certified as an autonomous family NP, then he/she would have to practice for 5 years.

Ms. Yeatts referred to the draft regulations that a NP can only practice within the scope of his/her clinical/professional training, limits of knowledge and experience, and consistent with the applicable standards of care.

MOTION: Dr. Edwards moved to amend the existing emergency regulations to indicate that 5 years of clinical training equates to 9,000 hours. The motion was seconded and opened for discussion.

Dr. Archer stated his dissatisfaction with requiring a licensee to go back and obtain additional hours if he/she wants to change specialties.

Dr. Allison-Bryan said that, to become at Medication-Assisted Treatment (MAT) provider, one would need to obtain a waiver, which can only be obtained by taking a SAMHSA-approved course. Then, and only then, can a NP provide MAT in a collaborative practice.

Dr. Archer asked if the entire 5 years are accepted or just a portion.

Ms. Yeatts stated that the situation is dependent on whether there is overlap with the family practice attestation.

After some additional discussion, the motion passed 4 to 2, with Dr. Archer and Dr. Edward opposing.

Executive Director Note: Although discussed above, no motion was made to amend the recommendation of the RAP concerning acceptance of 100% of applicable hours on an attestation for a second specialty.

Consideration of Statutory Amendments

Ms. Yeatts advised that Code Section 54.1-2923.1 refers to an outdated program for impaired practitioners.

MOTION: Dr. Edwards moved to recommend deletion of 54.1-2923.1. The motion was seconded and carried unanimously.

ANNOUNCEMENTS

The next meeting of the Committee will be December 7, 2018 at 8:30 a.m.

ADJOURNMENT

With no additional business, the meeting adjourned at 9:58 a.m.

Kevin O'Connor, MD
President, Chair

William L. Harp, MD
Executive Director

Colanthia M. Opher
Recording Secretary

--- DRAFT UNAPPROVED --

VIRGINIA BOARD OF MEDICINE

LEGISLATIVE COMMITTEE MINUTES

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

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

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

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

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

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

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

MEMBERS ABSENT:
Alvin Edwards, PhD
Jane Hickey, JD

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

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

EMERGENCY EGRESS INSTRUCTIONS

Dr. Taminger provided the emergency egress instructions.

APPROVAL OF MINUTES OF JANUARY 19, 2018

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

ADOPTION OF AGENDA

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

PUBLIC COMMENT

There was no public comment

DHP DIRECTOR'S REPORT

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

EXECUTIVE DIRECTOR'S REPORT

No report.

NEW BUSINESS

1. **Review of Guidance Documents**

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

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

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

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

adopted February 23, 2012 – staff recommends reaffirmation

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

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

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

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

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

Section 54.1-2961 of the Code of Virginia provides:

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

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

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

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

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

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

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

5. What are "Type 1" hours?

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

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

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

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

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

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

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

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

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

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

Section 54.1-2400(14)

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

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

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

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

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

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

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

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

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

2. **Periodic review of regulations**

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

18VAC85-20-26. Patient records.

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

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

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

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

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

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

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

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

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

18VAC85-20-29. Practitioner responsibility.

A. A practitioner shall not:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. For licensure in chiropractic.

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

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

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

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

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

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

2. Has received a degree from the institution.

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

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

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

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

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

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

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

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

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

Part IV. Licensure: Examination Requirements.

18VAC85-20-140. Examinations, general.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Pay a registration fee of $10; and

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

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

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

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

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

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

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

a. Up to 15 of the Type 2 continuing education hours may be satisfied through delivery of services, without compensation, to low-income individuals receiving services through a local health department or a free clinic organized in whole or primarily for the delivery of health services. One hour of continuing education may be credited for one hour of providing such volunteer services. For the purpose of continuing education credit for voluntary service, documentation by the health department or free clinic shall be acceptable.

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

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

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

D. The board shall periodically conduct a random audit of its active licensees to determine compliance. The practitioners selected for the audit shall provide all supporting documentation within 30 days of receiving notification of the audit.

E. Failure to comply with these requirements may subject the licensee to disciplinary action by the board.

F. The board may grant an extension of the deadline for continuing competency requirements for up to one year for good cause shown upon a written request from the licensee prior to the renewal date.

G. The board may grant an exemption for all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

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

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

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

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

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

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

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

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

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

ANNOUNCEMENTS

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

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

Next meeting – January 11, 2019

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

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

William L. Harp, MD
Executive Director

Colanthia Morton Opher
Recording Secretary

ADVISORY BOARD ON MIDWIFERY
Minutes
September 21, 2018

The Advisory Board on Midwifery met on Friday, September 21, 2018, at 10:00 a.m., at the Department of Health Professions, Perimeter Center; 9960 Mayland Drive, Henrico, Virginia, 23233.

MEMBERS PRESENT:	Kim Pekin, CPM, Chair Mayanne Zielinski, CPM
MEMBERS ABSENT:	Ami Keatts, M.D. Natasha Jones, MSC Maya Gunderson, CPM
STAFF PRESENT:	William L. Harp, M.D. Executive Director Colanthia Morton, Deputy for Administration Elaine Yeatts, DHP Senior Policy Analyst Beulah Baptist Archer, Licensing Specialist
GUESTS PRESENT:	None

CALL TO ORDER

Kim Pekin called the meeting to order at 10:05 a.m.

EMERGENCY EGRESS PROCEDURES – Dr. Harp announced the Emergency Egress Procedures.

ROLL CALL –Beulah Baptist Archer called the roll, and no quorum was declared.

APPROVAL OF MEETING MINUTES OF FEBRUARY 2, 2018

No quorum declared, so the minutes were not approved.

ADOPTION OF THE AMENDED AGENDA

No vote was taken.

PUBLIC COMMENT ON AGENDA ITEMS

No public comment

NEW BUSINESS

1. **NARM Announces End of Internationally Educated Midwife Route Legislative Update**

   Kim Pekin reported that the end of IEM will have no bearing on the Virginia licensure process, and that any midwife seeking licensure will have to obtain the proper CPM certification.

2. **Periodic Review of Regulations Elaine Yeatts reminded the Advisory Board that the regulatory review occurs every four years as mandated by the Governor's office.**

   Changes to page 9-*18VAC85-130-31 Current Name and Address are as follows:* Replace "mailed" with "sent" to include electronic mail.

   Recent change noted to*18VAC85-130-45* to allow a student midwife to request an extension up to 10 years.

   Changes to *18VAC85-130-81*, which is accompanied by a 68-page Guidance Document should be reviewed prior to 2019.

   Mayanne Zielinski *asked whether access to and ownership of client records are synonymous. Adult records are maintained for six years and records for children eighteen years.*

   Elaine Yeatts - Changes to Guidance Document 85-26, 85-27

   Newborn Screening Results #4 Guidance Document 85-27 – Ms. Zielinski discussed an avenue by which the results are disseminated to CPM's.

   Kim Pekin requested an update to the contact for the VDH and Early Hearing Detection and Intervention Hearing Program with Jennifer MacDonald, Public Health Nurse.

3. Board Member Badges

   Colanthia Morton advised the Advisory Board that new ID badges will include the new logo, however, they are not yet available. Current identification badges will suffice until the new badges are received.

4. Election of Officers –No quorum declared, so no vote.

ANNOUNCEMENTS

No announcements.

NEXT MEETING DATE

January 25, 2019, at 10:00 a.m.

ADJOURNMENT

Kim Pekin adjourned the meeting.

Kim Pekin, CPM, Chair

William L. Harp, MD
Executive Director

Beulah Baptist Archer, Licensing Specialist

ADVISORY BOARD ON BEHAVIOR ANALYSTS
Minutes
October 1, 2018

The Advisory Board on Behavior Analysts met on Monday, October 1, 2018 at 10:00 a.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT:	Kate Lewis, MS, BCBA, LBA, Chair Amanda Kusterer, BCaBA Asha Patton Smith, MD Christina Giuliano, BCBA Gary Fletcher, Citizen Member
MEMBERS ABSENT:	None
STAFF PRESENT:	William L. Harp, M.D., Executive Director Elaine Yeatts, DHP Senior Policy Analyst Colanthia Morton Opher, Deputy for Administration Denise Mason, Licensing Specialist
GUESTS PRESENT:	Christy Evanko, BCBA, VABA Keven Schock, EPIC Developmental Services Joshua Baker, PSCA

CALL TO ORDER

Ms. Lewis called the meeting to order at 10:06 a.m.

EMERGENCY EGRESS PROCEDURES

Dr. Harp announced the Emergency Egress Procedures.

ROLL CALL

Ms. Mason called the roll, and a quorum was declared.

ADOPTION OF AGENDA

The agenda was amended to reflect that Ms. Lewis is Chair of the Advisory Board. Ms. Giuliano moved to make the correction. The motion was seconded and carried.

APPROVAL OF MINUTES OF JUNE 5, 2017 and JANUARY 29, 2018

Dr. Smith moved to approve the minutes for the June 5, 2017 meeting. The motion was seconded and carried. An amendment was suggested to the January 29, 2018 minutes to reflect Ms. Evanko's title as a BCBA.

PUBLIC COMMENT

Ms. Evanko thanked the Board for reviewing the regulations.

NEW BUSINESS

1. Periodic Review of the Regulations

Ms. Yeatts covered the comments from Regulatory Town Hall, particularly those submitted by APBA, and asked the Advisory to note any comment that she had not covered.

She then opened the discussion of the regulations by pointing out that in 18VAC85-150-30, the word "mailed" needed to be replaced with "sent."

Next was 18VAC85-150-70, which does not require current BACB certification for the renewal of a license. After a lengthy discussion, Ms. Kusterer moved to amend the regulation to require current BACB certification for renewal of licensure. The motion was seconded and carried 3-2.

18VAC85-150-90 was discussed since there is no requirement that BACB certification be current for reactivation or reinstatement. Ms. Guiliano moved that the language regarding current BACB certification suggested for renewal be incorporated into this section as well. The motion was seconded and carried.

2. Carr & Noski (2017) "Professional Credentialing of Behavior Analysts"

Dr. Harp stated that this topic was information for the Advisory Board's review. Ms. Kusterer pointed out that the second paragraph of the Conclusions would be good support for requiring BACB certification as discussed above.

3. Board Member Badges

Dr. Harp told the Advisory Board that the Department of Health Professions would no longer be issuing Board member badges. Board members will now be given a temporary badge when working at DHP which will be turned in upon completion of their duties.

4. 2019 Meeting Calendar

Mr. Opher pointed out that the next Advisory Board meeting was scheduled for January 21, 2019, which is a holiday. She asked the Board members if they would be able to attend on the alternative date of January 28, 2019 at 10:00 am. All members agreed to the change.

6. Election of Officers

Dr. Smith nominated Ms. Lewis to service as Chair of the Advisory Board. The motion was seconded and carried. Dr. Smith also nominated Ms. Kusterer to serve as Vice-Chair of the Advisory Board. The motion was seconded and carried.

Announcements

Ms. Opher informed the Advisory Board that there are currently 1,055 Behavior Analysts and 156 Assistant Behavior Analysts licensed by the Virginia Board of Medicine.

Next Meeting Date

The Advisory Board's next meeting is January 28, 2019 at 10:00 a.m.

Adjournment

The meeting was adjourned at 12:13 p.m.

Kate Lewis, MS, BCBA, LBA,
Chair

William L. Harp, M.D.
Executive Director

Denise W. Mason, Licensing Specialist

DRAFT UNAPPROVED

ADVISORY BOARD ON GENETIC COUNSELING
MINUTES

October 1, 2018

The Advisory Board on Genetic Counseling met on Monday, October 1, 2018, at 1:00 p.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT:	John Quillin, PhD, MPH, MS, Chair Matthew Thomas, ScM, CGC Heather Creswick, MS, CGC Marilyn Foust, MD Lori Swain, Citizen Member, Vice-Chair
MEMBER ABSENT:	None
STAFF PRESENT:	William L. Harp, MD, Executive Director, Elaine Yeatts, DHP Senior Policy Analyst Colanthia Morton Opher, Deputy for Administration Denise Mason, Licensing Specialist
GUESTS PRESENT:	Gail-Ann Samuel, Student

CALL TO ORDER

Dr. Quillin called the meeting to order at 1:08 p.m.

EMERGENCY EGRESS PROCEDURES

Dr. Harp announced the Emergency Egress Instructions.

ROLL CALL

Denise Mason called the roll, and a quorum was declared.

DRAFT UNAPPROVED

APPROVAL OF MINUTES OF JUNE 4, 2018

Ms. Swain moved to approve the minutes of June 4, 2018. The motion was seconded and carried.

ADOPTION OF AGENDA

Dr. Quillin moved to approve the amended agenda. The motion was seconded and carried.

PUBLIC COMMENT

None

NEW BUSINESS

1. **Periodic Review of Regulations**

Ms. Yeatts led the Advisory in a review of the current regulations. She also informed the Advisory of the amendment to the Code of Virginia §54.1-2957.19 that removes "An applicant shall not be eligible for temporary license renewal upon expiration of Active Candidate Status as defined by American Board of Genetic Counseling."

2. **Board member badges**

Dr. Harp told the Advisory Board that the Board of Medicine would no longer be issuing member badges. Board members will now be given a temporary badge that is to be returned at the end of each meeting.

3. **Meeting Calendar**

Mr. Opher brought to the attention of the Advisory that the next meeting was scheduled for January 21, 2019, which is a holiday. She apologized and asked the Advisory members if they would be able to attend on of January 28, 2019 at 1:00 p.m. All members agreed to the change.

DRAFT UNAPPROVED

4. **Election of Officers**

Mr. Thomas nominated Dr. Quillin to serve as Chair of the Advisory Board. The nomination was seconded and carried. Mr. Thomas also nominated Ms. Swain to service as Vice-Chair of the Advisory Board. The moation was seconded and carried.

ANNOUNCEMENTS

Denise Mason announced that there are 188 Genetic Counselors holding licenses with the Virginia Board of Medicine; 100 of 188 the licensed Genetic Counselors are out of state. There have been 5 temporary licenses issued.

NEXT MEETING DATE

January 28, 2018 at 1:00 p.m.

ADJOURNMENT

The Advisory Board meeting was adjourned at 11:51 p.m.

John Quillin, PhD, MPH, MS Chair

William L. Harp, M.D., Executive Director

Denise Mason, Licensing Specialist

DRAFT UNAPPROVED

ADVISORY BOARD ON OCCUPATIONAL THERAPY
Minutes
October 2, 2018

The Advisory Board on Occupational Therapy met on Tuesday, October 2, 2018 at 10:00 a.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Kathryn Skibek, OT, Chair
Breshae Bedward, OT, Vice-Chair
Raziuddin Ali, M.D.
Dwayne Pitre, OT
Karen Lebo, JD, Citizen Member

MEMBERS ABSENT: None

STAFF PRESENT: William L. Harp, M.D., Executive Director
Colanthia Morton Opher, Deputy for Administration
ShaRon Clanton, Licensing Specialist

GUESTS PRESENT: Lindsay Walton

CALL TO ORDER

Kathryn Skibek called the meeting to order at 10:12 a.m.

EMERGENCY EGRESS PROCEDURES

Dr. Harp announced the Emergency Egress Instructions.

ROLL CALL

Roll was called, and a quorum was declared.

APPROVAL OF MINUTES OF January 30, 2018 1-3

Karen Lebo moved to adopt the minutes as written. The motion was seconded and carried.

ADOPTION OF AGENDA

Dr. Ali moved to adopt the amended agenda. The motion was seconded and carried.

PUBLIC COMMENT ON AGENDA ITEMS

None

NEW BUSINESS

1. Periodic review of regulations

   Dr. Harp reviewed the regulations with the Advisory Board. The members requested that the NBCOT descriptions of Fieldwork Supervision as Type 2 continuing education be addressed for licensees by an FAQ.

2. New ACOTE Accreditation Standards Adopted

   Ms. Skibek gave an overview of the degrees accepted from Community Colleges and Universities for OT's and OTA's.

3. NBCOT Report of Results on Licensure Processing Times

   Dr. Harp went over stats given by each state for licensure processing. Virginia is in line with most other states in terms of length of time to licensure.

4. OT License Credit for Student Supervision 36

   The Advisory Board agreed with the standards set by NBCOT and asked that an FAQ be created.

5. AOTA's Commission on Practice Seeks Input on OT Practice Framework
   By August 31

   Ms. Skibek stated the review was done every 5 years.

6. Board Member Badges ----

   Dr. Harp informed the Advisory that DHP would no longer be issuing badges to Board members. Ms. Lebo and Dr. Ali returned their badges to Ms. Opher.

7. 2019 Meeting calendar

   Ms. Opher briefly went over the calendar of meetings for 2019.
   45

8. Election of Officers ----

   Ms. Skibek moved to elect Ms. Bedward as Chair and Mr. Pitre as Vice-Chair. Both were elected by acclamation.

ANNOUNCEMENTS:

None

NEXT MEETING DATE

January 22, 2019, 10:00 a.m.

ADJOURNMENT

The meeting of the Advisory Board was adjourned at 11:05 a.m.

Kathryn Skibek, OT, Chair

William L. Harp, M.D.
Executive Director

ShaRon Clanton, Licensing Specialist

DRAFT UAPPROVED

Advisory Board on Respiratory Therapy
Minutes
October 2, 2018

The Advisory Board on Respiratory Therapy met on Tuesday, October 2, 2018 at 1:00 p.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland, Suite 201, Drive, Henrico, VA

MEMBERS PRESENT:	Shari Toomey, RRT, Chair Daniel Gochenour, RRT, Vice Chair Bruce Rubin, MD Santiera Brown, RRT Denver Supinger
MEMBERS ABSENT:	None
STAFF PRESENT:	William L. Harp, M.D., Executive Director Elaine Yeatts, DHP Senior Policy Analyst Colanthia Morton Opher, Deputy for Administration Denise Mason, Licensing Specialist
GUESTS PRESENT:	Yetty Shobo, PhD, Healthcare Workforce Data Center Mark Hickman, CSG

Call TO ORDER

Dr. Harp called the meeting to order at 1:02 p.m.

EMERGENCY EGRESS PROCEDURES

Dr. Harp announced the Emergency Egress Procedures.

ROLL CALL

The Advisory Board members introduced themselves, and a quorum was declared.

APPROVAL OF MINUTES OF JANUARY 30, 2018

Dr. Rubin moved to approve the minutes of January 30, 2018. The motion was seconded and carried.

ADOPTION OF AGENDA

Ms. Supinger moved to adopt the agenda. The motion was seconded and carried.

PUBLIC COMMENT ON AGENDA ITEMS

None

NEW BUSINESS

1. **Periodic Review of Regulations**

Ms. Yeatts reviewed several regulations with the Advisory Board starting with:

18VAC85-40-10, Definitions

18VAC85-40-25, Current name and address, the word "mailed" needed to be replaced with "sent."

18VAC85-40-35, renewal fee reductions when the Board's revenue exceeds expenditures by more than 10%.

18VAC-85-40-45, Education requirements

18VAC-85-40-50, Examination requirements

18VAC-85-40-60, Renewal/ Reinstatement of license, fee for reinstatement of a pursuant to §54.1-2408.2 of the Code of Virginia shall be $2,000.

18VAC-85-40-61, Inactive license

18VAC-85-40-66, Continuing education requirements

18VAC85-40-70, Scope of Practice, to maintain a patient's record for a minimum of six years following the last patient encounter with exceptions

Ms. Supinger moved to approve the change from "mailed" to "sent." The motion was seconded and carried.

2. **Virginia's Respiratory Therapist Workforce: 2017 Elizabeth Carter, PhD**

Dr. Shobo provided a PowerPoint presentation for the Advisory Board that reviewed the trends in the respiratory therapist workforce. She said that the respiratory workforce has declined slightly over the past two years. She mentioned that Virginia respiratory therapists were slightly less likely to hold an Associate degree. There are no changes in the median income of respiratory therapists.

3. Board Member Badges

Dr. Harp told the Advisory Board that the Department of Health Professions would no longer be issuing Board member badges. Board members will now be given a temporary badge when working at DHP which will be turned in upon completion of their duties.

4. 2019 Meeting Calendar

The Advisory Board's next meeting is January 22, 2019 at 1:00 p.m.

5. Election of Officers

Ms. Supinger nominated Ms. Toomey to serve as Chair of the Advisory Board. The motion was seconded and carried. Dr. Rubin nominated Daniel Gochenour to serve as Vice-Chair of the Advisory Board. The motion was seconded and carried.

ANNOUNCEMENTS

Ms. Mason informed the Advisory Board that there are currently 4,016 Respiratory Therapists licensed by the Virginia Board of Medicine.

NEXT SCHEDULED MEETING

January 22, 2019 at 1:00 p.m.

ADJOURNMENT

The meeting of the Advisory Board adjourned at 2:11p.m.

Shari Toomey, RRT, Chair

William L. Harp, M.D.,
Executive Director

Denise Mason, Licensing Specialist

<< DRAFT UNAPPROVED >>

ADVISORY BOARD ON ACUPUNCTURE

The Advisory Board on Acupuncture met on Wednesday, October 3, 2018, at 10:00 a.m. at the Department of Health Professions at 9960 Mayland Drive, Henrico, VA 23233.

MEMBERS PRESENT: Lynn Almloff, L. Ac., Chair
Janet L. Borges, L.Ac., Vice-Chair
Sharon Crowell, L.Ac.
Chheany Ung, M.D.
Leslie Rubio, Citizen Member

MEMBERS ABSENT: None

STAFF PRESENT: William L. Harp, M.D., Executive Director
Colanthia Opher Morton, Deputy for Administration
Elaine Yeatts, DHP Senior Policy Analyst
Beulah Baptist Archer, Licensing Specialist

GUESTS PRESENT: Matthew P. Stanley, ASVA

CALL TO ORDER

Lynn Almloff called the meeting to order.

EMERGENCY EGRESS PROCEDURES

Dr. Harp announced the Emergency Egress Procedures.

ROLL CALL - The roll was called, and a quorum was declared.

APPROVAL OF THE MINUTES FROM January 31, 2018.

Janet Borges moved to approve the minutes. The motion was seconded and carried.

ADOPTION OF AGENDA

Sharon Crowell moved to adopt the agenda. It was seconded and carried.

PUBLIC COMMENT ON AGENDA ITEMS

There was no public comment.

NEW BUSINESS

1. **Periodic review of regulations**

Ms. Yeatts explained the 4-year process of mandatory, periodic regulatory review. She said regulations may be retained with no changes or amendments could be recommended by the Advisory Board. Any recommended changes would go to the full Board for consideration on October 18th. She then led the Advisory Board through the regulations.

Following a periodic review of Chapter 110, the Advisory Board voted to recommend the following amendments:

Section 36 Insert "to be" and delete, 'mailed' and insert 'sent'.

("...All notices required by law or by this chapter *to be* given by the board to any such licensee shall be validly given when *sent* to...")

Section 80

Replace Practical Examination of Point Location Evaluation Skills (PEPLS) test with "... Point Location Examination."

Section 180

Replace "vitamins, minerals or food" with the word' dietary" to read, "dietary supplements".

Education Requirements

Ms. Yeatts clarified the following:

Attaining education after 1990, section B applies.
Attaining education after 1999, section C applies.
Attaining education after 2011, section D applies.

The hours in the regulations for acupuncture coursework are still accurate with ACAOM.

Foreign Graduates

Beulah Archer stated that the process for reviewing and authenticating foreign education is through credentials-evaluating organizations to ensure that they meet the American equivalent.

Fee Reductions

Ms. Yeatts explained that fee reductions must occur when revenues exceed expenditures by 10%. Fee reduction can be done as an exempt action. Renewal fees will be reduced in 2019.

2. Board Member Badges

Dr. Harp advised that badges will no longer issued by DHP. Visitor badges will be issued to Board members while they are here on business and will return them upon departure.

3. 2019 Meeting Calendar

All dates were satisfactory to the Advisory Board members.

4. Election of Officers

Lynn Almloff nominated Janet Borges as Chair. The nomination was seconded and carried.

Lynn Almloff nominated Sharon Crowell as Vice-Chair. The nomination was seconded and carried.

ANNOUNCMENTS

No announcements.

NEXT SCHEDULED MEETING:

January 23, 2019 at 10:00 a.m.

ADJOURNMENT

Lynn Almloff adjourned the meeting.

Lynn Almloff, L.Ac., Chair

William L. Harp, M.D., Executive Director

Beulah Baptist Archer, Licensing Specialist

DRAFT UNAPPROVED

ADVISORY BOARD ON ATHLETIC TRAINING
MINUTES

October 4, 2018

The Advisory Board on Athletic Training met on Thursday, October 4, 2018, at 10:00 a.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT:	Sara Whiteside, AT, Chair Michael Puglia, AT Jeffrey Roberts, MD
MEMBERS ABSENT:	Deborah B. Corbatto, AT, Vice-Chair Trilizsa Trent
STAFF PRESENT:	William L. Harp, MD, Executive Director Colanthia Morton Opher, Deputy for Administration Elaine Yeatts, DHP Senior Policy Analyst
GUESTS PRESENT:	Scott Powers, VATA Chris Young, VATA Tanner Howell, VUU/VATA Kristian Hill, VATA Chris Jones Caitlin Carnell, MD, PGY-4

CALL TO ORDER

Sara Whiteside called the meeting to order at 10:07 a.m.

EMERGENCY EGRESS PROCEDURES

Dr. Harp announced the Emergency Egress Instructions.

ROLL CALL

Colanthia Opher called the roll, and a quorum was declared.

APPROVAL OF MINUTES OF JUNE 7, 2018

Mr. Puglia moved to approve the minutes of June 7, 2018 as presented. The motion was seconded and carried unanimously.

ADOPTION OF AGENDA

Mr. Puglia asked that the agenda be amended to include a discussion of the CDC Recommendations from the 2018 Guidelines on the Diagnosis and Management of Mild Traumatic Brain Injury Among Children. The motion was seconded and carried unanimously.

PUBLIC COMMENT ON AGENDA ITEMS

All comments received were from VATA members requesting clarity on the definition of direction by a physician of an athletic trainer.

Ms. Yeatts stated that there is language in the regulation that provides direction to students, but no definitive definition of what the physician, the athletic trainer and the patient can expect in terms of "direction."

It was noted that there has been some difficulty with third party reimbursement. Some payers view the AT practice act to be too vague with medical direction poorly defined, and do not see AT services as being medically supported.

Dr. Harp stated that there are advantages to the scope of practice being vague; making it too specific could have unintended consequences.

After discussion, Ms. Yeatts stated that the fact that there is no language to define "direction" is problematic. She suggested that during the review of the regulations, the Advisory Board should recommend language to address this issue, and as long as the definition does not restrict the practice and would protect the public, it should be able to be added. She also noted that once the proposal has been adopted by the Board of Medicine, it may help the AT community with their issue.

NEW BUSINESS

1. Periodic review of regulations

Ms. Yeatts advised that the Board is required to review the regulations every 4 years. Notice of the review was posted, and one comment was received. However, it was noted that the comment was not in direct relation to the periodic review, but a concern about oversight of AT's that travel with teams.

After a brief discussion, Ms. Yeatts walked the members through each section of the regulations and the following notations were made:

18VAC85-120-30. Current name and address.

Ms. Yeatts advised that to permit the Board of send an electronic renewal notice to the licensee, the word "mailed" would be changed to "sent".

18VAC85-120-35. Fees.

Ms. Yeatts stated that due to a significant surplus held by the Board of Medicine, the upcoming renewal fees for the next biennium have been reduced.

18VAC85-120-10. Definitions.

Ms. Yeatts suggested that the definition of direction be included as **noted** below:

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

Mr. Puglia moved that the above language be submitted to the full Board of Medicine for approval. The motion was seconded and carried unanimously.

There were no additional proposed amendments to the regulations.

2. Board Member Badges

Dr. Harp announced that badges will no longer be issued to Board members. Members will be provided a badge to use while they are onsite and will turn them in prior to leaving the building.

3. 2019 Meeting Calendar

Ms. Opher asked that any conflicts be given to her as soon as possible so she can find an alternate date.

4. Election of Officers

Ms. Whiteside nominated Mr. Puglia for Chair; the nomination was seconded and carried unanimously. Mr. Puglia nominated Ms. Corbatto as Vice-Chair; the nomination was seconded and carried unanimously.

5. **CDC Recommendation from 2018 Guidelines on the Diagnosis and Management of Mild Traumatic Brain Injury Among Children**

Mr. Puglia advised that the recommendations follow what athletic trainers already know. The one change was in the language. It was decided that the word "concussion" be replaced with the term "mild traumatic brain injury" across the board.

This topic was for informational purposes only and did not require any action.

ANNOUNCEMENTS

Ms. Opher provided the license count for ATs.

NEXT MEETING DATE

January 24, 2019 at 10 a.m.

ADJOURNMENT

The meeting adjourned at 11:37 a.m.

Sara Whiteside, AT, Chair

William L. Harp, M.D., Executive Director

Colanthia M. Opher, Recording Secretary

DRAFT UNAPPROVED

ADVISORY BOARD ON PHYSICIAN ASSISTANTS

Board of Medicine
Thursday October 4, 2018, 1:00 PM
9960 Mayland Drive, Suite 201
Richmond, VA - Training Room 2

The Advisory Board on Physician Assistants met Thursday, October 4, 2018 at 1:00 p.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, Virginia.

MEMBERS PRESENT:	Portia Tomlinson, PA-C, Chair Rachel Carlson, PA-C, Vice-Chair Frazier W. Frantz, MD Thomas Parish, PA-C Tracey Dunn, Citizen Member
MEMBERS ABSENT:	None
STAFF PRESENT:	William L. Harp, MD, Executive Director Colanthia Morton Opher, Deputy for Administration Elaine Yeatts, DHP Senior Policy Analyst ShaRon Clanton, Licensing Specialist Jennifer Deschenes, Deputy for Discipline
GUESTS PRESENT:	Rose Rutherford, VAPA Robert Glasgow, PA-C, VAPA W. Scott Johnson, JD, MSV Michael Goodman, JD, Goodman Allen

Call to Order-Portia Tomlinson, PA-C Chair

Ms. Tomlinson called the meeting to order.

Emergency Egress Procedures-Alan Heaberlin

Dr. Harp provided the emergency egress instructions.

Roll Call

Roll was called, and a quorum was declared.

Approval of Minutes 1-2

Ms. Carlson moved to adopt the minutes of February 1, 2018 as written. The motion was seconded and carried.

Adoption of Agenda

Mr. Parish added an amendment to the agenda; the amended agenda was approved.

Public Comment on Agenda Items

None

NEW BUSINESS

1. **Periodic review of regulations-Elaine Yeatts**

   Mrs. Yeatts reviewed the regulations with the Advisory Board. The members recommended the following changes be presented to the Board on October 18, 2018.

   18VAC85-50-10. Definitions. Add "Supervision" means the supervising physician *licensed in the Commonwealth* has on going, regular communication with the physician assistant on the care and treatment of patients, is easily available, and can be physically present or accessible for consultation with the physician assistant with one hour."

   18VAC85-50-115. Responsibilities of the physician assistant. B. In the second sentence, strike who has registered with the board.

   18VAC85-50-130. Qualifications for approval of prescriptive authority.
   Change in 2. Maintain a practice agreement acceptable to the board prescribed in accordance with 18BAC85-50-101. Strike out following sentence and number 3. Change number 4 to number 3.
   18VAC85-50-140. Approved drugs and devices. B. End first sentence at practice agreement, and strike remaining portion of sentence to read: "The physician assistant may prescribe only those categories of drugs and devices included in the practice agreement."

2. **Virginia's Licensed Physician Assistant Workforce**

   Dr. Carter gave a brief description and overall review of the workforce report.

3. **Request for Advisory Opinion or Guidance re PA** Supervision

   Ms. Deschenes spoke on the letter dated July 31, 2018 from Mike Goodman, JD.

4. **Board member badges**

   Dr. Harp briefed the Advisory on the decision to no longer issue badges to Board members. Mr. Parrish turned his badge in to Mrs. Morton Opher.

5. 2019 Meeting Calendar

Members requested a change in date for the meeting scheduled May 23, 2019.

6. Election of Officers

Mr. Parrish moved that Ms. Tomlinson remain Chair. Ms. Dunn moved that Mr. Parrish serve as Vice Chair. The motion was seconded and carried.

Announcements

None

Adjournment

Meeting adjourned at 2:51 p.m.

Next meeting date:

January 24, 2019 @ 1:00 p.m.

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Portia Tomlinson, PA-C, Chair

_____

William L. Harp, M.D., Executive Director

_____

ShaRon Clanton, Licensing Specialist

---DRAFT UNAPPROVED---

ADVISORY BOARD ON POLYSOMNOGRAPHIC TECHNOLOGY
Minutes
October 5, 2018

The Advisory Board on Polysomnographic Technology met on Friday, October 5, 2018 at 1:00 p.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Jonathan Clark, RPSGT, Chair
Debbie Akers, RPSGT, Vice-Chair
Anna Rodriquez, RPSGT
Marie Quinn, Citizen Member

MEMBERS ABSENT:

STAFF PRESENT: Colanthia Morton, Deputy for Administration
Denise Mason, Licensing Specialist

GUESTS PRESENT: None

CALL TO ORDER

Jonathan Clark called the meeting to order at 1:01 p.m.

EMERGENCY EGRESS PROCEDURES

Ms. Opher announced the Emergency Egress Procedures.

ROLL CALL

Denise Mason called the roll; a quorum was declared.

APPROVAL OF MINUTES FROM FEBRUARY 2, 2018

Ms. Akers moved to adopt the minutes as presented. The motion was seconded and carried unanimously.

ADOPTION OF AGENDA

Ms. Rodriquez moved to adopt the agenda. The motion was seconded and carried unanimously.

PUBLIC COMMENT ON AGENDA ITEMS

None

NEW BUSINESS

1. **Periodic review of regulations**

Ms. Opher reviewed the regulations with the Advisory Board pointing out that in 18VAC85-140-30, **Current name and Address**, the word "mailed" needed to be replaced with the word "sent".

Next, Ms. Opher advised that on July 1, 2018, the law allowing for an exemption for students/interns engaged in the practice of polysomnographic technology became effective.

As such, 18VAC85-140-45, will be added under **Requirements for licensure as a Polysomnographic Technologist**, and will read as follows:

Any student enrolled in an educational program in polysomnographic technology or person engaged in a traineeship is not required to hold a license to practice polysomnographic technology, provided that such student or trainee is under the direct supervision of a licensed polysomnographic technologist or a licensed doctor of medicine or osteopathic medicine.

Any student or trainee shall be identified to patients as a student or trainee in polysomnographic technology.

A student or trainee is required to have a license to practice after 18 months from the start of the educational program or traineeship or six months from the conclusion of such program or traineeship, whichever is earlier.

2. **Board Member Badges**

Ms. Opher advised the members that the Department of Health Professions would no longer be issuing board member badges. Board members will now be given a temporary badge when working at DHP which will be turned in upon completion of their duties.

3. **2019 Meeting Calendar**

Ms. Opher pointed out that the next Advisory Board meeting was scheduled for January 25, 2019. She asked the Board members to contact her if there was a conflict in the meeting dates.

4. **Election of Officers**

Ms. Akers nominated Mr. Clark to serve as Chair for 2018-2019. The motion was seconded and carried. Ms. Rodriquez moved to retain Ms. Akers as Vice-Chair for 2018-2019. The motion was seconded and carried.

ANNOUNCEMENTS

Ms. Mason informed the Advisory Board that there are currently 495 Polysomnographic Technologists licensed by the Virginia Board of Medicine, 117 of which are out of state.

NEXT SCHEDULED MEETING

January 25, 2019 @ 1 p.m.

ADJOURNMENT

The meeting of the Advisory Board adjourned at 1:45 p.m.

_____
Jonathan Clark, Chair

_____
William Harp, Executive Director

_____
Denise W. Mason, Licensing Specialist

Agenda Item: **Other Reports**

- Assistant Attorney General*
- Board of Health Professions
- Podiatry Report*
- Chiropractic Report*
- Committee of the Joint Boards of Nursing and Medicine

Staff Note: *Reports will be given orally at the meeting

Action: These reports are for information only. No action needed unless requested by presenter.

Virginia Department of Health Professions

APPROVED

Board of Health Professions
Regulatory Research Committee
Meeting & Public Hearing

June 26, 2018
8:30 a.m. - Board Room 4
9960 Mayland Dr., Henrico, VA 23233

In Attendance	Yvonne Haynes, LCSW, Board of Social Work
	Martha S. Perry, MS, Citizen Member
	James Wells, RPH, Citizen Member
	Jacquelyn M. Tyler, RN, Citizen Member
Absent	All members present
DHP Staff	Elizabeth A. Carter, PhD, Executive Director BHP
	Yetty Shobo, PhD, Deputy Executive Director BHP
Observers	Clara Keane, Arlington, VA
	Anne Mills, Alexandria, VA
	Amber Golden, Richmond, VA
	Terri Giller, Richmond, VA
	Yonsenia White, Fredericksburg, VA
	Laura Taumisto, Staunton, VA
	Monika Burkholder, Staunton, VA
	Cassandra Crane, Henrico, VA
	Darlene Green, Staunton, VA
	Leila Saadeh, VATA
	Sydney Haton, Norfolk, VA
	Rebecca Reiss, Norfolk, VA
	Becky Bowers-Lanier, VCA
Speakers	Kancha Orr, Spotsylvania, VA
	Gretchen Graves, VATA
	Carol Olson, VATA
	Ann Mills, Alexandria, VA
Emergency Egress	Dr. Carter

Virginia Department of Health Professions

APPROVED

Call to Order

Chair Mr. Wells **Time** 8:31 a.m.

Quorum Quorum established

Public Comment

Speaker - Kandra Orr, Board Certified Art Therapist

Ms. Orr is in favor of licensure of art therapists in Virginia. See Appendix 1 for additional comment from Ms. Orr.

Speaker – Gretchen Graves, Credentialed Art Therapist

Ms. Graves is in favor of licensure of art therapists in Virginia. See Appendix 1 for additional comment from Ms. Graves.

Speaker - Carol Olson, Board Certified Art Therapist, President - Virginia Art Therapy Association

Ms. Olson is in favor of licensure of art therapists in Virginia. See Appendix 1 for additional comment from Ms. Olson.

Speaker – Ann Mills, Registered and Board Certified Art Therapist

Ms. Mills is licensed in DC, Maryland and New York and lives in Virginia. Ms. Mills is in favor of licensure of art therapists in Virginia. See Appendix 1 for additional comment from Ms. Mills.

Approval of Minutes

Presenter Mr. Wells

Discussion

The February 27, 2018 committee meeting minutes were approved with no revisions. All members in favor, none opposed.

Art Therapist Workplan Review

Presenter Mr. Wells

Discussion

Ms. Jackson provided an update on the request from committee members at the February 27, 2018 meeting seeking additional information on risk of harm to the consumer and economic impact of licensure. Ms. Jackson stated that no new information is available regarding risk of harm. The actual number of art therapists in Virginia is unknown, but considered to be relatively low. Inclusion with

another profession, more specifically a behavioral sciences profession, would allow for the cost of licensure to be relatively low. Existing behavioral sciences application fees range from $165 - $200.

New Business

Presenter Mr. Wells

Discussion

There was no new business.

August 23, 2018 Next Committee Meeting

Presenter Mr. Wells

Discussion

Mr. Wells announced the next committee meeting would be held on August 23, 2018.

Adjourned

Adjourned 9:21 a.m.

Chair James Wells, R.Ph.

Signature: _____ Date: _____/_____/_____

Board Executive Director Elizabeth A. Carter, Ph.D.

Signature: _____ Date: _____/_____/_____

VIRGINIA:

BOARD OF HEALTH PROFESSIONS

Regulatory Research Committee Meeting & Public Hearing

PUBLIC HEARING:

Invitation for Public Comment on the Review of the Need for Regulation of the Practice of Art Therapy in Virginia

* * * * * * * *

The matter in the above-titled hearing came on for hearing on Tuesday, June 26, 2018, at the U.S. Department of Health Professions Office, Perimeter Center, 9960 Mayland Drive, Boardroom 4, Henrico, Virginia, 23233, before Denise M. Holt, VCR No. 0315066.

Board of Health Profession Board Members:

James Wells, Chairperson
Elizabeth Carter
Jacquelyn M. Tyler
Martha S. Rackets
Lisette P. Carbajal
Maribel Ramos
Kevin P. O'Connor
Yvonne Haynes

MR. WELLS: Good morning. My name is Jim Wells, and I am the Chair of the Regulatory Research Committee, and this is a public hearing to receive public comment on the Board's review of the need for regulation for the practice of art therapy in Virginia. The Code of Virginia authorizes the Board of Health Professions to advise the Governor, the General Assembly and Department of Health Professions' Director on matters related to health care professions, occupations, and professions.

Accordingly, the Board is conducting this review and will provide recommendation on the competency of Virginia art therapists to practice art therapy. At this time, I will call on persons who signed up to comment. As you come up, please, as I call your name, come forward, tell us your name and where you are from. And in the interest of time, we do have a meeting after this.

We want to hear from all of you. We definitely do. If there are similar comments, or if there's a spokesman for a particular setup, if you could maybe limit it to that. So I will call on the first person, and is it Kendra Orr?

MS. ORR: Yes.

MR. WELLS: Yes, ma'am. If you would state your name and affiliation please.

MS. ORR: My name is Kendra Orr. I'm from Spotsylvania, Virginia. I'm a board certified art therapist.

I feel very strongly that our therapists need to be licensed in order to address the current mental health crisis. According to the CDC, since 1999, the suicide rate in the U.S. has gone up across all racial and ethnic groups, in both men and women, in both cities and rural areas and across all age groups.

Overall, the suicide rate has increased nearly 30 percent. Twenty-five states have suicide rate increases of more than 30 percent, and suicide is one of the leading causes of death and is on the rise. Among adolescents, suicide is the third leading cause of death and has been rising. Depression and anxiety is affecting college students at alarming rates.

As noted in Collegiate Center of Mental Health, anxiety and depression are the top reasons that college students seek counseling, and nearly one in five university students are affected with anxiety and depression. Youth mental health is worsening. Rates of youth with severe depression increased from nearly 6 percent in 2012 to over 8 percent in 2015. And even with severe depression, 63 percent of youth are left with no or insufficient treatment.

In Virginia alone, the suicide rate among children has increased 29 percent in 2016, the highest it's been in 18 years. In adults, one in five adults have a mental health condition, which is over 40 million Americans. There's a

serious mental health workforce shortage. In states with the lowest work force, there's up to six times the individuals to only one mental heath professional, which includes psychiatrists, psychiatrists, social workers, counselors and psychiatric nurses. The agency that I work with in the Stafford-Fredricksburg area, there's currently a two-month waiting list for people who need mental health support.

Licensing our therapists would provide another tier of healers to address the mental health crisis. Also, these statistics are imposing an increasing burden on children's hospitals and pediatricians. As suicide rates have risen in Virginia, Governor Northam has signed legislation calling on state officials to report how they're addressing the problem.

On a personal level, as a registered art therapist, when I moved to Virginia 22 years ago, the lack of licensing made our therapy positions difficult to find. In desperation, I began teaching public high school instead. If I had a license as an art therapist at the time, I could have found work and maybe helped hundreds of people. Art therapy work was hard to find, still is, largely due to the fact that mental health agencies in Virginia are reticent to hire art therapists because of the lack of licensing.

Given the increasing rate of anxiety, depression, trauma, and suicide nationwide and in Virginia, I think licensing our therapists in Virginia would provide

substantially more mental health professionals and better access to mental health treatment for adults, children, and adolescents. Thank you.

MR. WELLS: I apologize. We were running a little bit late, and we have one piece of business we have to take care of. Ms. Carter?

MS. CARTER: In the event of an emergency in which we have to evacuate the building, you can go out that door right there or this door right here, make an immediate right, go across the parking lot into the fence and stand. Sorry. It has happened. We have had calls. This is so you know what to do. Thank you.

MR. WELLS: One other thing that I didn't say is that this is a formal public hearing, but it's also informal. If any members have any questions that they would like to ask any of the speakers as we go, please feel free, and hopefully you all are willing to answer some back-and-forth questions that we might have questions about. Okay. Our second speaker is Gretchen Graves.

MS. GRAVES: Good morning, good morning. I'm Gretchen Graves. I am a credentialed art therapist who lives here in Richmond. I work at the Children's Hospital at MCV. I have been driving this study for a while. I went through and I did find a few inaccuracies in this, and I would like to address a couple of them now, and I will send all of the

inaccuracies that I saw to Miss Lawrence; is that okay?

Okay. Thank you. One of the most important ones that I did notice is on page 8, under credentialing. Can you all hear me? The second paragraph, it states to maintain ATCB certification, art therapists must complete a yearly minimum of six continuing credits. We wish it was 20 per year, which comes out to be a hundred continuing education credits for every five years. And we have to renew our credentialing every five years, and so that is how that worked. And I felt like that was a pretty important piece, because that speaks to how we are monitored under our credentialing.

On page 9, under education, the first paragraph, I think there was a typo or a misunderstanding. The first sentence says education to practice as an art therapist requires a minimum of a master's degree in a program accredited by the Art Therapy Credentials Board. And actually, the programs are accredited by the Education Program Approval Board, which currently is in a five-year transition to have accrediting going external with CAAHEP.

And I apologize, but I don't remember what that acronym stands for. But it is an external accrediting board for educational programs. There were a few other minor details. I will forward those to Miss Lawrence, but those didn't seem quite as important to me as the other thing.

I also want to point out a few facts that recently were uncovered that speaks to art therapists and public protection. In Psychology Today, for example, there are 232 clinicians advertising that they provide art therapy in Virginia. However, only 29 of them, like a tenth almost, were actually credentialed art therapists. So there is a lot of people going out there and expressing that they're doing art therapy, and they're not.

And the thing that is very important about that is that we are trained with certain modalities to use with certain populations. We understand that we're not gonna go use specific materials with, for example, substance abuse people. There's just some materials you don't want to use with certain populations. And if you are not a trained art therapist, you may not understand that, and you could cause a lot more harm than good for your client in the end.

So it's very important, and there was another statistic. Recently, the Virginia Art Therapy Association just did a study of graduates or students -- graduate student survey, and it had 23 participants in it. So one of the questions they said -- that they asked was does the lack of licensure in Virginia pose a barrier in staying in Virginia once you graduate.

Well, out of all those people, 18 of them said yes, they were gonna move out of Virginia to seek states that have

license -- for example -- Maryland has licensure. Washington, D.C. is moving forward with art therapy licensure. North Carolina is moving forward with art therapy licensure. These are pulling very viable, very trained mental health service people out of our state. We need good mental health people in our state. And I think that's all I have to say right now. Thank you.

MS. ORR: CAAHEP is the Commission on Accreditation of Allied Health Education Programs. It's CAAHEP.

MS. CARTER: We're familiar with that organization.

MS. ORR: Great. Thank you.

MR. WELLS: The next speaker is Carol Olson.

MS. OLSON: Hi, I'm Carol Olson. I'm a board certified art therapist and a certified art therapy supervisor as well as several other credentials. And I am also the president of the Virginia Art Therapy Association. There are a lot of people working on this issue to get art therapy licensing in Virginia. I agreed with everything my peers have said. I have been working in this field for a long time.

Right now, very recently, there are concerns that we are trying to get people credentialed, finish their educations, go into practice, provide ethical services that we face in an unregulated field. I think it's time for us to be regulated. We seek that as a group of people, which is

why several of our members are here with us. We want to be engaged more formally in the mental health system. There are a lot of us who have been in practice for a long time.

We face people out there with absolutely no education and no degrees, marketing themselves as art therapists and calling themselves counselors who don't know what they're doing. And we, as a profession, end up then seeing these people afterward, and we have to kind of undo potential damage to the clients. We feel that the popularity of art therapy is rising right now. We hear about it in the news.

It's effective in multiple treatment issues, especially trauma, and we are trying to ensure that the best trained people are providing competent services in particular modalities, and we hope that you will take our application seriously and work with us on this. Any questions?

MR. WELLS: Ms. Olson, walk me through. You said that you were board certified, and you said that you were credentialed; what are you able to do now? What can you do now that differentiates you from me? What is available to you now?

MS. OLSON: Well, in Virginia nothing, that's why we're here. Right. So the National Art Therapy Association, in an effort to help art therapists practice in their states, you know, now offer a national test in what we call board

certification. So we spend, as outlined in our application, hours, just like any other mental health professional.

So I've done the same thing twice. So I've gone through practice for two years under the supervision of an art therapist, and I took a national exam. And I do a hundred hours every five years, 20 hours a years, of additional certification classes to maintain my board certification to allow me to call myself an art therapist.

But in Virginia, actually you could call yourself an art therapist and charge money and see people and do counseling without any education at all, and that's the difference. We would like Virginia to recognize us as a health profession and have title protection, and we could be regulated and address issues of fraud and protect the public.

I would like there to be a difference between us. And I'm an artist too, but I had never called myself a therapist before I went through the extensive degrees and training that I did.

MR. WELLS: So currently there is a national board exam?

MS. OLSON: The Art Therapy Credentials Board does a national test that people take to call themselves art therapists.

MR. WELLS: Are there programs in Virginia?

MS. OLSON: There's Eastern Virginia Medical School

that has an art therapy program, and George Washington University has their art therapy program within Virginia, northern Virginia. We have a few undergraduate programs as well in Virginia. Our field considers entry into the field as a professional after the completion of a master's degree and after supervision.

MR. WELLS: Thank you.

MS. RACKETS: I was curious -- my name is Martha Rackets. I work at a licensed substance abuse agency in Virginia, and I'm curious about what the previous speaker and also what you were speaking to around adding art therapists into the work force in Virginia, and what some of the experience barriers are by your profession in becoming employed in Virginia in agencies, in licensed agencies for mental health or substance abuse or facilities; given that they are licensed facilities and sometimes the requirement is that they're hiring licensed mental health practitioners, and you know, if that is an experience or something that is brought up in your meetings or your profession.

I'm just curious to hear some of the concerns. I know that at the agency that I work at, it is a barrier. We're looking for licensed mental health practitioners, and art therapists don't qualify, unless they have a dual license in something else. So I was just curious if you could speak to that.

MS. OLSON: Definitely. As Gretchen said, you can join me for a few questions. We spend a lot of time as professionals, spend a lot of time mentoring people and supervising them, just to have to watch them move to another state in order to practice. So it is something that we talk about in meetings all the time, is how to keep people in Virginia. For me, when I moved here, I knew I was gonna stay here. I mean, I had to go the extra effort to get another degree and another licensure just to maintain employment here.

So it is a huge factor. We have to have a licensed person. We want art, so they will call and hire a non-licensed person and allow them to do art therapy and, you know, they get around the regulation that way. They still call it art therapy all the time. They can hire that person much cheaper. They have very little training, and generally they don't realize that the staff is gonna have to come in and help that person when you have clients in crisis.

I mean, many factors can happen. Their behavior is not regulated, so they have dual relationships with clients and other inappropriate behavior. They are not regulated. We can't do anything about that, but we have to repair the damage. So we do face losing the work force. I work at an agency now and have a hard time finding counselors for these reasons.

There's a whole slew of counselors in Virginia that would love to work, and they have the appropriate training, and they're under supervision, and they maintain themselves under supervision. We behave like licensed professional counselors. We are seeking education, staying in supervision, and are engaging in supervision as well, and maintaining all of the education requirements that we have.

So we would like to be formalized. We would like to have title protection as part of that. We sent you a list of all the private practitioners who are not art therapists who set up private practice in Virginia, who call themselves art therapists, and we feel they are defrauding the public.

MR. WELLS: Comment or questions?

MR. O'CONNOR: Hi. I am Kevin O'Connor with the Board of Medicine. I am sort of new to this process. So, how many states license art therapists currently?

UNIDENTIFIED SPEAKER: We have the same licenses in seven states, and three states have our license under counseling specialization in art therapy, and then we have title protection, which has been an additional. It's growing.

MR. O'CONNOR: Also, help me understand the intersection or the spectrum between art therapy, music therapy, counseling occupational therapy and physical therapy; tell me how those all intersect. Many people would

say music therapy falls into that as counseling or physical therapy or occupational therapy. So help me understand. If we're going to be licensing art therapists, the next people to be here would be music therapists.

MS. ORR: Well, other than separate lobbying efforts, we see ourselves distinctly. We started distinctly. So we can sometimes be lumped under the realm of what might include art and us, music, dance, theater. So a lot of it is because they are growing out in separate fields, because they are not being regulated. People start associations because states would not listen to us when we're saying like, these particular modalities are extremely effective with working with clients across the range of mental health issues, across the range of ages, across the range of ethnicities.

And so we're watching, you know, just really who creates a lobbying group to push their field forward, and we started as art therapy, and it certainly is a very defined field, and certainly other people are using creative means.

MR. O'CONNOR: I guess that is my point. We are talking about expressive therapy and seeing how that is used for mental health counseling. It's also used, to some extent, for rehabilitation, stroke rehab, that sort of thing. That group is also served by other expressive therapists, and so, why you and why not everyone else?

MS. GRAVES: Well, music therapists are trained and

credentialed differently than art therapists. Music therapists graduate from, I think, even undergraduate degrees. They can sit credentially for a music therapy credential; that is not the same as art therapists.

MR. O'CONNOR: I don't mean to interrupt, but the population we serve is the same. It can be the same.

MS. GRAVES: Yes.

MR. WELLS: So if the purpose is to regulate the service provided to a population, where does that line stop? Where does dance therapy stop? And it could be said that next year we will be regulating dance therapists because they serve a similar population with similar goals.

MS. OLSON: Well, we serve all populations, and we work with many other medical and psychiatric professionals when working with a client. I guess I'm not sure why we would have to be lumped in with them.

MR. O'CONNOR: Well, I'm not putting you on the hot seat here.

MS. OLSON: That's okay, I understand.

MR. O'CONNOR: You lump this all together and call it expressive therapists, and so I have had some experience in northern Virginia where we have a very active art therapy population and a very active music therapy population, and they serve the same population. They do it as inpatient and outpatient. So I'm just trying to wrap my head around why we

should regulate one group that provides this bundle of services and not regulate another or a third.

MS. GRAVES: Well, counselors and OTS and PTs are regulated, am I not correct?

MS. OLSON: They are regulated. So, I mean, we are fine if you regulate music therapists.

MS. GRAVES: Yeah, we're good with that.

MS. OLSON: We're not saying you shouldn't actually. I mean, like she said, it's really different training. We see ourselves different, much like, you know, there are different levels of other types of therapists out there. You know, substance abuse is regulated separately than mental health counseling in that they overlap and tend to, you know, really cross realms sometimes.

We would support music therapy being regulated as well. We're advocating right now within our own. So we don't see it as competitive or different. We see it as complementary.

MS. RAMOS: A quick question. If art therapists were regulated, what is the impact on the work force, and do you have specific numbers? How would that help meet the demand?

MS. GRAVES: I don't know if we have specific numbers at this time. But as I stated earlier about, you know, the projection of students coming out of the two very

large graduate programs that we have in the state, I think that we would retain more licensed therapists in our state than if we didn't regulate. Like I said, deregulate it, they will leave.

MS. OLSON: So you look at these graduating classes, on average, between 25 to 30 people graduate from each school in Virginia. So on average, that's 50 to 60 art therapists graduating each year from schools, as well as the potential of people who go to other art schools -- art therapy schools outside of Virginia that want to come back to practice.

So when we state it that way, you have a force of people who would come out looking for jobs that would go elsewhere, because we don't have the ability to provide them what they need or salary stability. You know, in this realm, it's a mixed bag of what people can expect to earn as well.

MS. CARBAJAL: Speaking about the population that art therapy serves, can you talk to me a little bit about how it serves our seniors, especially those with cognitive impairment. Are there programs that would benefit this certain population?

MS. OLSON: Yeah. Actually that was one of my specialty areas was working with the elderly and dementia. And there have been a couple of times I've been able to work on special grants within the population, and I would love to really formalize that service for the various agencies.

Art therapy is a great way of working with those with dementia and other aging-process issues. Actually, I made a small film about it. I will send it to you. Because it can help with orientation. It can help with different family issues. I have done a mix of different ways of using art in helping the elderly.

And, you know, I have worked in programs outside of Virginia as well in rehabilitation. So it's a very effective means with other modalities as well. So it would be a great way to, you know, expand the ability of working with the elderly in a very broad population. It is a very effective means of working with them.

MR. CARBAJAL: So you view yourself as working in nursing homes?

MS. OLSON: Yes.

MS. SAADEH: Hi. My name is Leila Saadeh. I am the vice president of the Virginia Art Therapy Association. I just wanted to speak with you, Dr. O'Connor; is that okay? I would just hate for art therapy to be bundled up into dance therapy, music therapy, because we are, in fact, very different. The only thread of similarity is that we come from an art space practice. So art therapists are trained as psychotherapists. We have the same training as LPC counselors -- anyone who wants to be a psychotherapist.

In my experience in working with music therapists,

we are very different. They don't have the counseling in the psychotherapy, psychopathology, training, and education.

MS. OLSON: They have a bachelor's degree, is that correct?

MS. SAADEH: Which is different. So I just want to make that clear with you. I know that dance, music, art is very expressive, but we are actually very different. And that also ties in with the populations that we serve. We can serve anyone who has a mental health diagnosis, a chronic illness diagnosis. Autism is extremely valuable, which as we all know, is increasing in numbers, and there's a huge need for professionals who serve that population.

So I won't keep talking about all the people that we can serve, because we can really serve anyone who needs any sort of help. As where other expressive therapies are a little bit more limited, but I can't speak to you on that. I appreciate it.

MR. WELLS: Is there anyone else who wishes to speak who is not on the list? Yes, ma'am.

MS. MILLS: Good morning. My name is Ann Mills, and I am a registered and board certified art therapist. I work in Alexandria, Virginia. I am licensed in the District of Columbia, Maryland, and New York. I am the former chair of the Research Committee, former chair of the Nominating Committee, the former director of the graduate program in Art

Therapy at George Washington University.

I am unable to work in Virginia. I am a proud Virginian, and I would like to work in Virginia. I have an example of harm done to a patient by a non-art therapist, an example that has been repeated any number of times over the 30 years of my career. I am a trauma therapist. I specialize in trauma therapy.

I have been approached by allied mental health professionals who will say well, I had this or that clinical challenge with a client, and I didn't know what else to do. So I got out some letterhead and gave them a pen and asked them to draw what happened, draw some horrible, traumatic event.

So a specific of one of those was a survivor of severe trauma became mute and unable to speak. She then drew it for her therapist, not an art therapist, on letterhead. And then the mental professional showed me a picture and asked for sort of a curbside consult on it. And then after she drew this, she withdrew and hid in a corner and started banging her head. The patient started banging her head against the wall and seemed not to hear me when I begged her to stop.

So eventually, I put a pillow between her head and the wall, and that is how the session ended. And what would you have done as an art therapist that would have been

different? So I find this appalling. I am very concerned that this kind of thing happens to clinicians when they get stuck, and this is where we would hold as art therapists that we would receive appropriate referrals due to practices that are inherent in our profession and the characteristics of the clients we serve as outlined on page 8 of the report.

This is the kind of thing where we feel we have something special. We know we have something special to offer in our hands, our skilled hands. We can help people. It's a powerful tool, visual arts. As you know, it can retraumatize people in untrained hands. Sometimes people work beyond their areas of competence and their scope of practice. We don't want them hurting people.

My private practice is in the District of Columbia. I was grandfathered in as an LPC. But then just for fun, I took the national counseling exam, just to kind of have that legitimacy as well and passed that. Two-thirds of my practice is people who live in Virginia. People seeking referrals to art therapists call me weekly because they want help for daughters who are dieting themselves to death, or husbands whose explosive anger has caused them to be fired.

In Virginia, a licensed art therapist should be able to help with support, and with your support, we will. I wanted to also mention that I am also a researcher as well as a clinician.

I am the director of the archive of the International Collection of Drawings, standardized drawings. Our policy is that only mental health professionals and art therapy students may administer this particular assessment. We do not allow artists and lay people to administer this assessment.

I would like to say a word about CAAHEP. CAAHEP for me personally would impose the impossible. It's already an impossible standard for me to become an LPC in Virginia. CAAHEP would make it that much more difficult. Thanks very much. Any questions for me? Thank you.

MR. WELLS: Is there anyone else who would like to speak or respeak?

MS. GRAVES: We're all art therapists. We come from all over the state, and this is a small, small spattering of what we have. Last time, the American Art Therapy Association put together our numbers, we estimate there's at least 300 or greater art therapists in our Commonwealth that we know of. Only that we know. There's probably many out there. But without things like licensure and stuff, they may not come out of the woodwork and join the associations and things like that.

MR. WELLS: Thank you.

MS. GRAVES: Thank you.

MR. WELLS: Okay. I want to thank all of who came

today and took time to comment. We will consider all of the comments prior to submitting any recommendations. Written comment will be accepted until 5 p.m. on July 27, and this concludes our hearing this morning.

HEARING CONCLUDED

CERTIFICATE OF COURT REPORTER

I, DENISE HOLT, hereby certify that the foregoing hearing was taken down by me in stenotype and therefore reduced to typewriting; that I am neither related to, nor employed by any of the parties to which this public hearing was taken; and further, than I am not a relative or employee or employed by the parties hereto, nor financially or otherwise interested in the outcome of the action.

Given under my hand this 26th day of June, 2018.

_____

Denise Holt

0315066

Virginia Department of Health Professions

APPROVED

Board of Health Professions
Full Board Meeting

June 26, 2018
10:00 a.m. - Board Room 4
9960 Mayland Dr, Henrico, VA 23233

In Attendance	Lisette P. Carbajal, Citizen Member
	Helene D. Clayton-Jeter, OD, Board of Optometry
	Yvonne Haynes, LCSW, Board of Social Work
	Mark Johnson, DVM, Board of Veterinary Medicine
	Allen R. Jones, Jr., DPT, PT, Board of Physical Therapy
	Ryan Logan, RPh, Board of Pharmacy
	Kevin P. O'Connor, MD, Board of Medicine
	Martha S. Perry, MS, Citizen Member
	Maribel E. Ramos, Citizen Member
	Herb Stewart, PhD, Board of Psychology
	Jacquelyn Tyler, RN, Citizen Member
	Laura P. Verdun, MA, CCC-SLP, Board of Audiology & Speech-Language Pathology
	James Wells, RPh, Citizen Member
Absent	Kevin Doyle, EdD, LPC, LSATP, Board of Counseling
	Derrick Kendall, NHA, Board of Long-Term Care Administrators
	Trula E. Minton, MS, RN, Board of Nursing
	James D. Watkins, DDS, Board of Dentistry
	Junius Williams, Jr., MA, Board of Funeral Directors and Embalmers
DHP Staff	Barbara Allison-Bryan, Deputy Director, DHP
	David Brown, Director, DHP
	Elizabeth A. Carter, Ph.D., Executive Director BHP
	Jaime Hoyle, Executive Director Behavioral Sciences Boards, DHP
	Laura L. Jackson, MSHSA, Operations Manager, BHP
	Ralph Orr, Director, Prescription Monitoring Program (PMP)
	Diane Powers, Communications Director, DHP
	Corie Tillman Wolf, Executive Director, Boards of Funeral Directors and Embalmers, Physical Therapy, Long-Term Care Directors, DHP
	Yetty Shobo, PhD, Deputy Executive Director BHP
	Elaine Yeatts, Senior Policy Analyst DHP

Virginia Department of Health Professions

APPROVED

OAG Representative	Not present
Presenters	Ralph Orr, Director, Prescription Monitoring Program (PMP)
Speakers	No speakers signed-in
Observers	No observers signed-in
Emergency Egress	Dr. Carter

Call to Order

Chair: Dr. Clayton-Jeter **Time** 10:05 a.m.

Quorum Established

Public Comment

Discussion

There was no public comment

Approval of Minutes

Presenter Dr. Clayton-Jeter

Discussion

The February 27, 2018 Full Board meeting minutes were approved with no revisions. All members in favor, none opposed.

Welcome

Presenter Dr. Clayton-Jeter

Dr. Clayton-Jeter recognized new Board member Dr. Kevin O'Connor with the Board of Medicine; Reappointed board members Allen R. Jones, Jr, Board of Physical Therapy; Martha S. Rackets, Citizen Member; Jacquelyn M. Tyler, Citizen Member and herself, Helene D. Clayton-Jeter, Board of Optometry. Retiring board members are Yvonne Haynes, Board of Social Work; Laura Verdun – Board of Audiology & Speech-Language Pathology; and Junius Williams, Jr., Board of Funeral Directors & Embalmers. All were welcomed and thanked for their commitment in serving the Commonwealth.

Directors Report

Presenter Dr. Brown

Discussion

Dr. Brown thanked the board members for their devoted service to their respective board as well as the Board of Health Professions. Dr. Brown updated the Board on the new appointees within the Administration.

Dr. Brown informed the Board that the agency has completed the move of the reception area from the third floor to the newly renovated first floor area. Additional changes include new agency ID badges with the agency logo for staff and board members. Dr. Brown informed the board that the Board of

Pharmacy will monitor production of the THC oils, monitoring who and what can be prescribed and allowing five processors to obtain a permit. Dr. Brown informed the Board that community health workers are under evaluation to be regulated. Lastly, there is a bill that may require ER doctors to check with PMP before prescribing narcotics and evaluate the need for the availability of naloxone for patients receiving narcotic medications. Dr. Allison-Bryan and Ms. Hahn have been working on security measures for reception staff as well as third floor staff with Virginia State Police and Henrico Police.

Legislative and Regulatory Report

Presenter Ms. Yeatts

Discussion

Ms. Yeatts advised the Board of updates to regulations and General Assembly legislative actions relevant to DHP.

Prescription Monitoring Program (PMP)

Presenter Mr. Orr

Discussion

Mr. Orr provided a PowerPoint presentation, updating the board on the work of the PMP. Attachment 1.

Regulatory Research Committee

Presenter Mr. Wells

Discussion

Mr. Wells updated the Board on the work of the Committee and the status of the Art Therapist public hearing and ongoing study.

Executive Directors Report

Presenter Dr. Carter

Board Budget

Dr. Carter stated that the Board is operating within budget.

Agency Performance

Dr. Carter reviewed the agencies performance measures in relation to clearance rate, age of pending caseload and time to disposition.

Sanction Reference Points (SRP) - Update

Dr. Carter advised of the boards currently undergoing SRP revisions.

Policies and Procedures

Dr. Carter provided an update on BHPs policies and procedures, specifically in relation to sunrise reviews.

Healthcare Workforce Data Center

Presenter Dr. Shobo

Discussion

Dr. Shobo provided a PowerPoint presentation overview of Virginia Physician's and their differences. She also advised the Board that the center is up to date on all survey reports and posting of the workforce briefs.

Board Reports

Presenter Dr. Clayton-Jeter

Board of Audiology & Speech Language Pathology

Dr. Clayton-Jeter provided an overview of the Boards of Audiology & Speech-Language Pathology. Attachment 2.

Board of Counseling
Dr. Doyle was not present.

Board of Dentistry
Dr. Watkins was not present.

Board of Funeral Directors & Embalmers
Mr. Williams was not present.

Board of Long Term Care Administrators
Mr. Kendall was not present.

Board of Medicine
Dr. O'Connor reported on the joint boards of Medicine and Nursing and the status of Nurse Practitioners and independent practice.

Board of Nursing
Ms. Minton was not present.

Board of Optometry
Dr. Clayton-Jeter presented an update on the Board of Optometry. Attachment 3.

Board of Pharmacy

Mr. Logan reported on the status of regulation of pharmaceutical processors.

Board of Physical Therapy
Dr. Jones, Jr., reported that at May 1, 2018 meeting the Board discussed: The Board accepted revisions from the Legislative/Regulatory Committee regarding Direct Access Patient Attestation and Medical Release forms; The Board recently revised, repealed and/or re-adopted sixteen (16) Guidance Documents; and The Board voted to pursue legislation to enact the Physical Therapy Licensure Compact. This legislation would allow agreement between member states to improve access to physical therapy

services for the public by increasing the mobility of eligible physical therapy providers to work in multiple states.

Board of Psychology

Renewals began in June and will bring more revenue to the Board. Customer satisfaction survey percentages went back up to 92% for this quarter. A vote on PSYPACT is being put off until the July meeting.

Board of Social Work

Ms. Haynes was not present.

Board of Veterinary Medicine

Dr. Johnson reported the status of the board. Attachment 4

New Business

Presenter Dr. Clayton-Jeter

Dr. Clayton-Jeter stated that due to board member vacancies there are now positions on the Education, Nominating and Regulatory Research Committees. Board members interested in these openings need to contact the Board office.

August 23, 2018 Next Full Board Meeting

Presenter Dr. Clayton-Jeter

Dr. Clayton-Jeter announced the next Full Board meeting date as August 23, 2018

Adjourned 1: 06 p.m.

Acting Chair Allen R. Jones, Jr., DPT, PT

Signature: _____ Date: ____/____/____

Board Executive Director Elizabeth A. Carter, Ph.D.

Signature: _____ Date: ____/____/____

Virginia Department of Health Professions

DRAFT

Board of Health Professions Regulatory Research Committee Meeting

August 23, 2018
9:00 a.m. - Board Room 4
9960 Mayland Dr., Henrico, VA 23233

In Attendance	Martha S. Perry, MS, Citizen Member
	James Wells, RPH, Citizen Member
	Jacquelyn M. Tyler, RN, Citizen Member
Absent	Vacant seat
	Vacant seat
DHP Staff	Elizabeth A. Carter, PhD, Executive Director BHP
	Laura J. Jackson, MSHSA, Operations Manager BHP
	Jaime Hoyle, Executive Director, Behavioral Sciences Boards
	Diane Powers, Director of Communications DHP
Observers	Carol Olson, VATA
	Sarah Deaver, AATA
	Spencer Powers, Hanover CSB, VATA
	Terri Giller, VATA
	Gioia Chitton, Potomac Art Therapy Assoc.
	Gretchen Graves, VATA
	Laura Tuomisto, Shenandoah Art Therapy, LLC
	Monika Burkholder, Shenandoah Art Therapy, LLC
	Darlene Green, Hospice of The Piedmont Art Therapy
	Leila Saadeh, VATA
	Marcia DuBois, VA Dept. for Aging & Rehabilitative Services (DARS)
Emergency Egress	Dr. Carter

Call to Order

Chair	Mr. Wells	**Time**	9:01 a.m.
Quorum	Quorum established		

Public Comment

There was no public.

Approval of Minutes

Presenter Mr. Wells

Discussion

The June 26, 2018 committee meeting minutes were approved with no revisions. All members in favor, none opposed.

Art Therapist Study Review

Presenter Ms. Jackson

Discussion

Ms. Jackson presented the final report on the Art Therapist study.

Review of Criteria for Evaluating the Need for Regulation – Art Therapists

Presenter Mr. Wells

Criterion One: Risk for Harm to the Consumer

The Committee deemed that the unregulated practice of the profession poses the potential for significant harm to the public especially in consideration of the vulnerability of the patients the profession serves.

Criterion Two: Specialized Skills and Training

The Committee determined that specialized skills and training exist to distinguish the profession. The profession now requires master's degree level education and training through accredited programs, such as those existing at Eastern Virginia Medical School and George Washington University in Virginia. The required coursework includes diagnosis as well as treatment aspects of care. Additionally, the profession has developed a national, psychometrically sound competency examination.

Criterion Three: Autonomous Practice

Art therapists practice autonomously as well as within teams.

Criterion Four: Scope of Practice

The Committee concluded that the profession's scope of practice is defined with sufficient specificity even though other behavioral health professions employ some of the same tools and modalities. Licensure statutes and regulations would serve to better assure the public of professional practice standards and a clearer understanding of what "art therapy" constitutes.

Criterion Five: Economic Impact

The Committee considered the economic impact to the public of licensure costs to be small. The increase in Virginia's supply of art therapist practitioners would likely result from removal of the current barrier to practice which *also* requires licensure as a Licensed Professional Counselor, Licensed Marriage and Family Therapist, or similar profession. Lack of standalone licensure has restricted the potential supply of these mental health professionals in Virginia. This situation has driven students and graduates of George Washington University and Eastern Virginia Medical School art therapy programs to look to other states where art therapist licensure without the additional burden of obtaining licensure as another profession exists.

Criterion Six: Alternatives to Regulation

The Committee determined that no alternatives to licensure were considered to be commensurate with the public's protection.

Criterion Seven: Least Restrictive Regulation

The Committee concluded that all criteria were met and, as such, licensure is the least restrictive level.

Motion

After Committee discussion and review of The Criteria, a motion was made by Ms. Rackets to adopt a separate license for Art Therapists to practice in Virginia. The motion was properly seconded by Ms. Tyler. All members were in favor, none opposed.

Mr. Wells will present the findings and recommendation of licensure to the Full Board at the scheduled 10:00 a.m. Full Board meeting.

Policies and Procedures Update

Presenter Dr. Carter

Discussion

Dr. Carter reviewed the changes made to the Departments Policies and Procedures and advised that it will be taken to the Full Board at the December 4, 2018 meeting for approval.

New Business

Presenter Mr. Wells

Discussion

There was no new business.

December 4, 2018 Next Committee Meeting

Presenter Mr. Wells

Discussion

Mr. Wells announced the next committee meeting will be held December 4, 2018.

Adjourned

Adjourned 9:51 a.m.

Chair James Wells, RPh

Signature: _____ Date: _____/_____/_____

Board Executive Director Elizabeth A. Carter, Ph.D.

Signature: _____ Date: _____/_____/_____

THE VIRGINIA BOARD OF HEALTH PROFESSIONS
THE VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

Study into the Need to Regulate Art Therapists in the Commonwealth of Virginia

August 2018

Virginia Board of Health Professions
9960 Mayland Dr, Suite 300
Richmond, VA 23233-1463
(804) 367-4403

CONTENTS

AUTHORITY

At its August 31, 2017 meeting, the full Board of Health Professions considered a request to review the need to regulate art therapists in the Commonwealth of Virginia. At this meeting, the Regulatory Research Committee (RRC) received approval to move forward with the study. At its December 7, 2017 meeting, the RRC adopted the workplan and began work on the study. The study is being conducted pursuant to the following authority:

Code of Virginia Section 54.1-2510 assigns certain powers and duties to the Board of Health Professions. Among them are the power and duty:

7. To advise the Governor, the General Assembly and the Director on matters relating to the regulation or deregulation of health care professions and occupations;

12. To examine scope of practice conflicts involving regulated and unregulated professions and advise the health regulatory boards and the General Assembly of the nature and degree of such conflicts;

Pursuant to these powers and duties, the Board of Health Professions and its Regulatory Research Committee conduct a sunrise review into the need to regulate art therapists in the Commonwealth of Virginia.

THE CRITERIA AND THEIR APPLICATION

The Board of Health Professions has adopted the following criteria and guidelines to evaluate the need to regulate health professions. Additional information and background on the criteria are available in the Board of Health Professions Guidance Document 75-2 *Appropriate Criteria in Determining the Need for Regulation of Any Health Care Occupations or Professions, revised February 1998* available on the Board's website: https://www.dhp.virginia.gov/bhp/guidelines/75-2.doc

CRITERIA FOR EVALUATING THE NEED FOR REGULATION

CRITERION ONE: RISK FOR HARM TO THE CONSUMER

The unregulated practice of the health occupation will harm or endanger the public health, safety or welfare. The harm is recognizable and not remote or dependent on tenuous argument. The harm results from: (a) practices inherent in the occupation, (b) characteristics of the clients served, (c) the setting or supervisory arrangements for the delivery of health services, or (d) from any combination of these factors.

CRITERION TWO: SPECIALIZED SKILLS AND TRAINING

The practice of the health occupation requires specialized education and training, and the public needs to have benefits by assurance of initial and continuing occupational competence.

CRITERION THREE: AUTONOMOUS PRACTICE

The functions and responsibilities of the practitioner require independent judgment and the members of the occupational group practice autonomously.

CRITERION FOUR: SCOPE OF PRACTICE

The scope of practice is distinguishable from other licensed, certified and registered occupations, in spite of possible overlapping of professional duties, methods of examination, instrumentation, or therapeutic modalities.

CRITERION FIVE: ECONOMIC IMPACT

The economic costs to the public of regulating the occupational group are justified. These costs result from restriction of the supply of practitioner, and the cost of operation of regulatory boards and agencies.

CRITERION SIX: ALTERNATIVES TO REGULATION

There are no alternatives to State regulation of the occupation which adequately protect the public. Inspections and injunctions, disclosure requirements, and the strengthening of consumer protection laws and regulations are examples of methods of addressing the risk for public harm that do not require regulation of the occupation or profession.

CRITERION SEVEN: LEAST RESTRICTIVE REGULATION

When it is determined that the State regulation of the occupation or profession is necessary, the least restrictive level of occupational regulation consistent with public protection will be recommended to the Governor, the General Assembly and the Director of the Department of Health Professions.

APPLICATION OF THE CRITERIA

In the process of evaluating the need for regulation, the Board's seven criteria are applied differently, depending upon the level of regulation which appears most appropriate for the occupational group. The following outline delineates the characteristics of licensure, certification, and registration (the three most commonly used methods of regulation) and specifies the criteria applicable to each level.

- Licensure - Licensure confers a monopoly upon a specific profession whose practice is well defined. It is the most restrictive level of occupational regulation. It generally involves the delineation in statute of a scope of practice which is reserved to a select group based upon their possession of unique, identifiable, minimal competencies for safe practice. In this sense, state licensure typically endows a particular occupation or profession with a monopoly in a specified scope of practice.
    - **Risk**: High potential, attributable to the nature of the practice.
    - **Skill & Training**: Highly specialized accredited post-secondary education required; clinical proficiency is certified by an accredited body.
    - **Autonomy**: Practices independently with a high degree of autonomy; little or no direct supervision.
    - **Scope of Practice**: Definable in enforceable legal terms.
    - **Cost**: High
    - **Application of the Criteria**: When applying for licensure, the profession must demonstrate that Criteria 1 - 6 are met.

- Statutory Certification - Certification by the state is also known as "title protection." No scope of practice is reserved to a particular group, but only those individuals who meet certification standards (defined in terms of education and minimum competencies which can be measured) may title or call themselves by the protected title.
    - **Risk**: Moderate potential, attributable to the nature of the practice, client vulnerability, or practice setting and level of supervision.
    - **Skill & Training**: Specialized; can be differentiated from ordinary work. Candidate must complete education or experience requirements that are certified by a recognized accrediting body.
    - **Autonomy**: Variable; some independent decision-making; majority of practice actions directed or supervised by others.
    - **Scope of Practice**: Definable, but not stipulated in law.
    - **Cost**: Variable, depending upon level of restriction of supply of practitioners.
    - **Application of Criteria**: When applying for statutory certification, a group must satisfy Criterion 1, 2, 4, 5, & 6.

- Registration - Registration requires only that an individual file his name, location, and possibly background information with the State. No entry standard is typically established for a registration program.
    - **Risk**: Low potential, but consumers need to know that redress is possible.
    - **Skill & Training**: Variable, but can be differentiated for ordinary work and labor.
    - **Autonomy**: Variable.
    - **Application of Criteria**: When applying for registration, Criteria 1, 4, 5, & 6 must be met.

OVERVIEW

This preliminary document provides an overview of the profession, including recent changes affecting the profession. It also highlights some of the key areas of concern. Its purpose is to inform Committee members and the public during the public comment period. Interested parties may also review the sunrise proposal submitted by the Virginia Art Therapy Association. A full report, incorporating public comment and final recommendations, will be issued at the end of the study period.

DESCRIPTION OF THE PROFESSION

Art Therapy is an integrative mental health and human services profession that enriches the lives of individuals, families, and communities through active art-making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship. (AATA)

Art Therapy, facilitated by a professional art therapist, effectively supports personal and relational treatment goals as well as community concerns. Art Therapy is used to improve cognitive and sensory-motor functions, foster self-esteem and self-awareness, cultivate emotional resilience, promote insight, enhance social skills, reduce and resolve conflicts and distress, and advance societal and ecological change. (AATA)

Since the beginning of human history art has been an instrument for symbolism and self-expression, a medium for communicating thoughts and ideas. In the 1940s, psychologist Margaret Naumburg's work was based on the idea of using art to release the unconscious by encouraging free association. She started referring to her work as art therapy, a form of symbolic speech that the patient was encouraged to interpret and analyze. In 1944, Austrian born Edith Kramer, a student of art, painting, drawing and sculpture became a US citizen and founded the art therapy graduate program at New York University. (Art Therapy Journal)

By the middle of the 20th century, art therapy programs were in many mental health facilities and hospitals. It was observed that this form of therapy could promote emotional, developmental, and cognitive growth in children. The discipline has continued to grow, becoming an important tool for assessment, communication, and treatment of children and adults. (Art Therapy Journal)

The American Art Therapy Association (AATA) is a 501(c)(3) not-for-profit, non-partisan, professional and educational organization dedicated to the growth and development of the art therapy profession. Nearly 5,000 professional art therapists and students are part of the American Art Therapy national network. The AATA has established its own set of standards for art therapy education and practice. (AATA)

Art as therapy should not be confused with art in therapy as they are two distinct concepts. Art as therapy is an integrative mental health and human services profession that enriches the lives of individuals, families, and communities through active art-making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship. Art in therapy embodies the idea that art making is, in and of itself, therapeutic and that the creative process is a growth-producing experience. (Malchiodi, 2013)

A major concern of trained art therapists is that there are therapists utilizing "art as therapy" who are not masters' level clinicians in visual art or theories and techniques of human development, psychology, and counseling. (AATA)

Art therapists are trained in the use of art media and provide these counseling and psychotherapeutic principles to individuals, groups and families. Training involves identifying and assessing each client's needs in order to implement therapeutic art interventions to meet the clients psychological, developmental, behavioral, physical and emotional functioning needs.

Scope of Practice and Overlap

In Virginia, Licensed Professional Counselors (LPCs) and Marriage and Family Therapists (MFTs) are mental health professions licensed by the Board of Counseling. These two professions have laws and regulations in place where the applicant must meet course work requirements, experience requirements and a passing grade on the licensing exam to obtain licensure. Art therapy also has private credentialing requirements in education and experience as well as passing an exam to obtain credentialing, the difference being that state licensure is currently not available for this mental health profession.

Art therapy differs from counseling and marriage and family therapy in that its practice incorporates art media and the creative process. This form of therapy involves art processes and art materials in combination with psychotherapy, engaging and promoting the use of art in the healing process. Art therapy also allows individuals who are unable to express themselves verbally with a therapeutic way to engage their mind, body and spirit, promoting healing.

Art therapists currently work in Virginia, some with a license in counseling or marriage and family therapy, with additional credentialing in art therapy. Credentialed art therapist working in Virginia work as art therapists in many settings, while others represent themselves as providing "art therapy" but do not have the education or credentials to use the title "art therapist".

The practice of art therapy is specific in its scope of practice (Appendix 2) and regulation of this profession could negatively affect individuals with licenses to practice counseling or marriage and family therapy who are utilizing "art therapy" during treatment without having the education and credentialing to do so. This would also negatively affect individuals utilizing the term "art therapy" when they do not hold the necessary credentials to do so.

Typical work settings for art therapists are similar to those they worked in while obtaining supervision hours, private practice, inpatient and outpatient mental health facilities, schools and detention centers, and other settings where mental health practitioners practice. Art therapists often work in teams and interact with social workers, physical therapists, psychologists and medical providers such as nurses and doctors. Within these settings, art therapists serve a diverse group of individuals, from all ages and populations.

Unsupervised practice depends on the level of training of the art therapist and the treatment setting they are working in. Should the art therapist have a private practice all treatment would likely be unsupervised, holding the art therapist accountable for the job they perform. However, when treating patients in a clinical environment or school setting within which they are employed, there would be some level of being both supervised and unsupervised, holding both parties accountable for the job being performed. Virginia currently cannot hold art therapists legally

liable for improper conduct or unethical practice as no standards have been established for this unlicensed profession. Art therapist currently follow the Code of Ethics (Appendix 3) established by the ATCB.

Section 1.1.6 of the Code of Ethics prohibit engaging in therapy practices or procedures beyond scope of practice[1], experience, training, and experience. Patients requiring services outside of this scope are referred out to seek the services of another provider. Referral to see an art therapist might come from another health practitioner, such as a doctor. Children's Hospital of Richmond at VCU provides art therapy to young patients as a creative outlet to help them express their emotions and cope with the pain and stress of treatment. VCU understands the healing value of art and artistic traditions and how art therapists are able to apply their special knowledge of human development and psychology, clinical practice, and spiritual and cultural customs, to help children and their families deal with the impact of complex medical conditions on their lives. (Children's Hospital, 2018)

CREDENTIALING

The ATCB develops and administers board certification exams for art therapists who have met the education and supervision requirements to become credentialed as a Registered Art Therapist (ATR). The exam covers the following domains: Administrative and Therapeutic Environments, Initial Interview and Evaluation Assessment, Art Therapy Treatment and Services, Professional Practice and Ethics, and Theory and Therapeutic Applications. This exam is psychometrically sound and administered at locations across the United States four times each year.

To maintain ATCB certification art therapists must complete a yearly minimum of 20 continuing education (CE) credits, during a five (5) year recertification cycle, equivalent to 100 hours of approved continuing education during the recertification cycle. Six of these credits must be in ethics during each cycle. CE audits are performed on 10 percent of those applying for recertification.

ATCB credentialing allows for easy recognition of individuals who are Master's degree trained and qualified to practice art therapy.

[1] "Scope of practice" is a term, which generally references specific state statutes, which describe the permissible activities of the regulated occupation or profession.

Credentials - National Level

Credential	Description
Provisional Registered Art Therapist (ATR-Provisional)	Individuals who have completed a degree (or education requirements for the ATR-Provisional) and are engaged in a supervisory relationship with a qualified supervisor(s). The ATR-Provisional is not a required credential to apply for the ATR.
Registered Art Therapist (ATR)	Individuals who meet established standards, with successful completion of advanced specific graduate-level education in art therapy and supervised, post-graduate art therapy experience.
Board Certification (ATR-BC)	Individuals who complete the highest-level art therapy credential by passing a national examination, demonstrating comprehensive knowledge of the theories and clinical skills used in art therapy.
Art Therapy Certified Supervisor (ATCS)	Experienced Board Certified Art Therapists who provide clinical supervision and have acquired specific training and skills in clinical supervision.

*AATA Credentials and Licensure

EDUCATION

Education to practice as an art therapist requires a minimum of a master's degree in a program accredited by the AATA's Educational Programs Approval Board (EPAB). After obtaining the necessary education, 1,000 hours of post-graduate clinical experience under the supervision of a credentialed art therapist is required. Private, national certification is available from an independent certification board.

Educational training in psychopathology with children, adolescents and adults provide the art therapist the ability to learn the criteria for psychiatric diagnoses, allowing them to recognize behavioral and art indicators of functional and organic disorders. Practice includes the application of art therapy principles and methods in diagnosis, prevention, treatment and amelioration of psychological problems and emotions. They often work in team settings that allow them to contribute to collective diagnosis and treatment plans. Treatment plans are designed and implemented based on the art therapists level of training and the practice setting.

Art therapists must undergo individual and group supervised training as part of their education. The AATA requires that students complete 100 hours of supervised practicum, and 600 hours of supervised art therapy clinical internship to obtain their degree. Credentialing as a registered art therapist (ATR) requires 1,000 hours (if individual graduated from an AATA/EPAB), or 1,500 hours (if individual graduated from a non-approved art

therapy program) of direct contact practice supervised by a credentialed art therapist, another licensed mental health provider or an Art Therapy Certified Supervisor (ATCS), 100 hours of which half must be supervised by an ATCS or an ATR-BC credentialed supervisor. While under supervision, the facility in which they are obtaining supervision is legally accountable and held liable for the supervisee's actions. Supervision practice agreements follow the ATCB Code of Ethics, Conduct and Disciplinary Procedures established policy.

The American Art Therapy Association (AATA), Inc., offers program and curriculum standards for each Master's degree program. All AATA programs must be approved by the AATA Education Program Approval Board (EPAB). There are two AATA EPAB approved art therapy Master's degree programs in Virginia:

- George Washington University's Columbian College of Arts and Sciences' Art Therapy Master's Degree Program in Alexandria, Virginia offering a Master's in Art Therapy (with a thesis option); a Master's in Art Therapy Practice and a combined Bachelor of Arts/Masters of Arts in Art Therapy, enrolling approximately 20 students per year (George Washington University, 2017); and
- Eastern Virginia Medical Schools Art Therapy & Counseling Program in Norfolk, Virginia, a Post Master's program (Appendix 1) 2016-2017 school year enrollment listed 34 students. (Eastern Virginia Medical School, 2018)

There is currently a five-year transition for approved EPAB programs to transition to a new program with external accreditation through the Commission on Accreditation of Allied Health Education Programs (CAAHEP).

It is important to note that undergraduate and Doctoral degree programs in art therapy do not undergo a formal review and approval process by the EPAB. Certificate art programs are offered online but do not provide the level of education necessary to obtain credentialing as an art therapist.

There are currently 35 colleges and/or universities in the United States and Canada with ATCB approved master's degree art therapy programs.

Art Therapy Programs – US and Canada

State	Master's Degree Program	Undergraduate Degree Program	Doctoral Program
California	3		1
*Canada	1		
Colorado	1		
Connecticut	1		
District of Columbia	1		
Florida	1	1	1
Illinois	3		
Indiana	1		
Kansas	1		
Kentucky	1		
Massachusetts	2		1

State	Master's Degree Program	Undergraduate Degree Program	Doctoral Program
Michigan	1		
Minnesota	1		
New Jersey	1		
New Mexico	1		
New York	7	2	
Ohio	1	2	
Oregon	1		
Pennsylvania	3	6	1
South Carolina		1	
Tennessee		6	
Virginia	1	2	
Washington	1		
Wisconsin	1	2	1
Total Programs	35	22	5

Source: American Art Therapy Association-Approved Programs

REGULATION

Currently seven states require art therapists to be licensed as art therapists. There are five states that license art therapists under a related license, and three states that recognize art therapists for purposes of state hiring and/or title protection. Currently, 17 states are considering art therapist licensure. (AATA)

In Virginia, there are no laws, regulations or standards of practice that exist for the practice of art therapy. Credentialed art therapists that are employed in Virginia as counselors or marriage and family therapists would be under the laws and regulations of the Board of Counseling. Employers of art therapists have applicable standards of practice that must be followed to comply with state laws. State agencies and hospitals that employ art therapists would have an established code of conduct along with regulations that apply to that entity.

The Art Therapy Credentials Board administers the ATCB Examination (ATCBE) which is a national exam taken for Board Certification and, in some cases, needed for state licensure. The board certification proficiency exam provides credentialing for board certified art therapists (ATR-BC) and is administered yearly by paper and pencil at the AATA conference as well as computer based testing which is offered several times per year at different testing locations. Test by exception is offered for an additional fee for individuals wishing to take the exam outside the scheduled time frame.

Professional regulation may have more of an impact when it comes to disciplining impaired, unethical or incompetent art therapists, and those practicing art therapy without credentialing, removing them from practice.

Licensure by Title

State	Licensure Title
Delaware	Licensed Professional Art Therapist (LPAT) and Licensed Associate Art Therapist (LAAT)
Kentucky	Professional Art Therapy License (LPAT)
Maryland	Professional Clinical Art Therapy License (LPCAT)
Mississippi	Professional Art Therapy License (LPAT)
New Jersey	Professional Art Therapy License (LPAT)
New Mexico	Professional Art Therapist License (LPAT)
New York	Creative Arts Therapist License (LCAT)
Oregon	Licensed Art Therapist (LAT) and Licensed Certified Art Therapist (LCAT)
Pennsylvania	Art therapy defined in regulation as a qualifying "closely related field" for the professional counseling license (LPC)
Texas	Professional Counselor with Specialization in Art Therapy License (LPC-AT)
Utah	Art therapists with clinical art therapy master's degrees recognized by the Utah Division of occupational and Professional Licensing as meeting the education requirements for the Associate Clinical Mental Health Counselor license
Wisconsin	Registered Art Therapist with License to Practice Psychotherapy

*American Art Therapy Association-Credentials and Licensure

Risk of Harm

Due to the low number of states that license or utilize title protection for art therapists, and the Art Therapy Credentials Board, Inc. (ATCB) requirement that all ATCB credential holders self-report any violations of the ATCB Code of Ethics, Conduct and Disciplinary Procedures, the level of reported cases is negligible.

Information regarding disciplinary action against art therapists was not readily accessible. Many states that license or provide title protection group these individuals under another closely related mental health category such as licensed marriage and family therapist or licensed mental health counselor. Virginia does not delineate disciplinary actions or complaints against practitioners with art therapist credentials. Since 2008, Kentucky has reported a total of six cases, five pertaining to practicing art therapy without a license. The sixth case was dismissed.

Harm may be attributed to providers practicing art therapy without the necessary skill set, master's degree education, supervision and ethical standards necessary to obtain credentialing from the ATCB. Untrained providers of art therapy can cause potential harm to their clients' emotional wellbeing, as they do not understand how to assess, diagnose and treat patients utilizing art material.

Overall, art therapists do not utilize dangerous equipment while performing within their practice guidelines. There are however, basic art tools, such as paint and glue, which contain toxic chemicals that could cause harm should they be inhaled or ingested, scissors which have sharp edges capable of causing cuts or punctures, and objects such as clay, if thrown, could be considered potentially dangers. It is the responsibility of the art therapist to understand the ability of the patient, the specific art therapy tools deemed safe to use with that patient, and the environment within which the therapy session takes place.

The potential for fraud does exist in Virginia, as there are no existing laws or regulations regarding this profession. Virginia does not acknowledge the profession of art therapy, does not codify a scope of practice, nor does it provide any form of title protection for individuals practicing as art therapists. This lack of delineation between professions creates confusion for the public at large. Consumers are not able to determine actual credentialed art therapists with academic and clinical training who are safe to practice art therapy versus those that claim to be art therapists but have no training.

Art therapists in Virginia do not qualify for direct third party payments. However, they are able to receive payment for their services under another behavioral sciences license or indirectly through their employer.

The ATCB Code of Ethics, Conduct and Disciplinary Procedures (Appendix 3) was updated in 2016 to reflect standards established by the NCCA. Compliance with these standards of ethics is required to protect the patient, the employer and the art therapist. The Code consists of 18 principles and standards of conduct and is enforced by the ATCB. All ATCB credential holders and applicants are required to self-report any violation referred to in the ATCB Code of Ethics, Conduct, and Disciplinary Procedures document. The Code is enforced through a written grievance process and reviewed by a discipline hearing panel of three members who review the matter and provide a written decision. Based on the decision there is an appeals process. If certification or registration is revoked, the individual is not eligible to apply for certification or registration for a minimum of three years.

Virginia does not have a peer review mechanism for art therapists, however, credentialed art therapists are subject to review according to the ATCB Code of Ethics, Conduct and Disciplinary Procedures as stated above. Grounds for discipline are explained in section II. Disciplinary Procedures, Item 4. Standards of Conduct, Grounds for Discipline. (Appendix 3)

Legal offenses that would preclude a practitioner from practice include: sexual offenses involving a child, homicide 1st degree, and kidnapping. Additional serious offenses are in section 5.2.12 of Appendix 3.

Economic Impact

Wages & Salaries

Profession	Median Wage
Art Therapist	*$31K-$64K
Licensed Professional Counselor	*$50K-$60K
Family & Marriage Therapist	*$50K-$60K

Source: *Bureau of Labor Statistics – 2016 Data
**DHP Healthcare Workforce Data Center – 2017 Data

Available compensation data on the profession is subsumed within broader behavioral health providers' categories. Nationally, estimates for art therapists' salaries ranged from $32,000 - $58,000 with a median income of $43,400. The U.S. Department of Labor Bureau of Labor Statistics shows that in Virginia the median salary per year is $42,410 with a salary range of $31,440 up to $64,240. Location influences pay, as Washington, DC, New York and

Philadelphia receive salaries above the national average, while Pittsburgh, Milwaukee and Denver receive salaries below the national average. Also affecting pay is the number of years of experience the individual has invested in the profession. Depending on the size of the employers' workforce, some art therapists receive benefits, such as medical and dental coverage.

Art therapist salaries appear to be lower than that of other comparable, mental health providers with a master's degree. According to the Department of Health Professions Healthcare Workforce Data Center (DHP HWDC, 2017) survey for Licensed Professional Counselors, the median income for both licensed professional counselors and marriage and family therapists for 2017 was $50,000 - $60,000. An art therapists work environment is similar to that of other therapists and counselors, so the lower than average wages are not aligned in the profession.

A national internet search for credentialed art therapists provided a varying rate of services ranging from $90 for a 50-minute session to $125 for a 55-minute session. An initial intake assessment fee ranged from $0 to $150. These prices are similar in range to those being charged by similar behavioral health specialists.

Art Therapist Session Fees

State	Session Fee	Session Length
Richmond, VA	*$95	Not available
Washington, DC	**$120	60 minutes
New Orleans, LA	***$120	60 minutes
Laramie, WY	****$125	55 minutes

Sources: *Mind-Body Art Essentials, **Work of Art Therapy, ***NOLA Art Therapy and Counseling, LLC, ****Wyoming Art Therapy and Medical Counseling, LLC

WORKFORCE ADEQUACY

According to the AATA, there are nearly 5,000 professional art therapists and students as members of the American Art Therapy national network. Virginia currently has 131 members. Of this, 91 are members at the professional level, 37 at the student level and 9 are associate members or retired. This would lead one to believe that there are at least 91 individuals credentialed to practice art therapy, with 37 students currently enrolled in an art therapy credentialed program that could be added to the workforce.

Whether there is a shortage or an oversupply of these practitioners in Virginia is unknown. The profession-distinct supply and demand data are not available to make such assessment. It can be determined however, that as a mental health provider already providing care to individuals in Virginia, that they do provide care to individuals in need of this unique type of mental health care.

Discussion of Economic Impacts

In Virginia, individuals who have dual licensure in counseling and art therapy are able to bill for their services and qualify for third-party payment as licensed professional counselors or marriage and family therapists, but are not allowed to directly bill for services otherwise.

Licensure of art therapists in Kentucky, Maryland and Mississippi allows them to receive Medicaid reimbursement for their services. Pennsylvania and Texas allow for private insurance and state program reimbursement as art therapists are licensed as professional counselors. In Maryland, art therapists are able to receive reimbursement from private insurers. One goal of licensure of art therapists in Virginia is for the profession to be able to receive third-party payment for the services they provide.

In 2014, the AATA petitioned the Standard Occupational Classification Policy Committee (SOCPC) requesting that the occupational classification for art therapy be changed from occupation code "recreational therapy" to a separate classification as a mental health profession. The Committee rejected the request siting that existing policy prevents providing a separate defined classification for any occupation or profession for which the Bureau of Labor Statistic or the Census Bureau cannot collect data. In 2018 the Standard Occupational Classification (SOC) System-Revision for 2018 announced that the federal governments revised occupational codes, including reclassification of art therapists from being classified as "recreational therapists" (under code 29-1125) will now be classified as "Therapists: All Other" (sub-code 29-1125. Effective January 1, 2018, this change in SOC code according to the AATA will: require federal and state agencies and private employers to redefine job descriptions, pay levels and hiring guidelines; require insurers to re-evaluate how art therapy services are defined and covered for individual and group insurance plans; and may open additional approaches for state licensing and regulation. (AATA)

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APPENDIX

APPENDIX 1 - EASTERN VIRGINIA MEDICAL SCHOOL – ART THERAPY & COUNSELING PROGRAM CURRICULUM

Art Therapy & Counseling Program
Course Sequence

*Courses and sequence are subject to change

FIRST YEAR

Semester 1 - Fall
AT 516 Clinical Case Conference (1)
AT 521 Individual Counseling & Psychotherapy (3)
AT 524 Processes & Materials of Art Psychotherapy I (4)
AT 528 Theories of Human Psychological Development (3)
AT 530 Psychopathology (3)
AT 534 Introduction of the History & Theory of Art Therapy (1)
AT 548 Assessment (3)
AT 550 Practica Fieldwork (1)

Semester 2 - Spring
AT 513 Research Methods (3)
AT 520 Group Counseling & Psychotherapy (3)
AT 529 Case Presentation Skills (1)
AT 547 Individual Supervision I (1)
AT 549 Processes & Materials of Art Psychotherapy II (4)
AT 551 Practicum I (.5)
AT 555 Internship I (2.5)
AT 561 Child Counseling & Psychotherapy Skills (1) or
AT 563 Adolescent Counseling & Psychotherapy Skills (1) or
AT 565 Adult Counseling & Psychotherapy Skills (1)
AT 567 Group Supervision Counseling & Psychotherapy w/Children (1.5)or
AT 670 Group Supervision Counseling & Psychotherapy w/Adoles (1.5)or
AT 667 Group Supervision Counseling & Psychotherapy w/Adults (1.5)

Summer Semester
AT 607 Capstone I (1)

SECOND YEAR

Semester 3 - Fall
AT 607 Capstone II (1)
AT 617 Clinical Case Conference II (1.5)
AT 636 Cultural Competency (3)
AT 646 Individual Supervision II (1)
AT 650 Practicum II (.5)
AT 656 Internship II (2.5)
AT 660 Child Counseling & Psychotherapy Skills (1) or
AT 662 Adolescent Counseling & Psychotherapy Skills (1) or
AT 664 Adult Counseling & Psychotherapy Skills (1)
AT 569 Group Supervision Counseling & Psychotherapy w/Children (1.5) or
AT 672 Group Supervision Counseling & Psychotherapy w/Adoles (1.5) or
AT 669 Group Supervision Counseling & Psychotherapy w/Adults (1.5)

Semester 4 - Spring
AT 607 Capstone III (1)
AT 617 Ethics & Professionalism (3)
AT 647 Individual Supervision III (1)
AT 649 Creativity, Symbolism & Metaphor (3)
AT 651 Practicum III (.5)
AT 657 Internship III (2.5)
AT 661 Child Counseling & Psychotherapy Skills (1) or
AT 663 Adolescent Counseling & Psychotherapy Skills (1) or
AT 665 Adult Counseling & Psychotherapy Skills (1)
AT 571 Group Supervision Counseling & Psychotherapy w/Children (1.5)or
AT 674 Group Supervision Counseling & Psychotherapy w/Adoles (1.5) or
AT 673 Group Supervision Counseling & Psychotherapy w/Adults (1.5)

Electives and Specialization Courses
AT 533/633 Clinical Specialities (varies)
AT 535/635 Art Therapy in the Schools (1)
AT 562/652 Medical Art Therapy (1)
AT 615 Family Counseling & Psychotherapy (3)**
AT 638 Countertransference/Jung (1)
AT 639 Exploration of the Psyche (1)
AT 655 Trauma Informed Art Therapy (1)
AT 632 Addictions (3)**
AT 634 Career Counseling (3)**

**Optional coursework for graduation; required for licensure
***Number in parentheses designates number of credits

APPENDIX 2 - SCOPE OF PRACTICE AMERICAN ART THERAPY ASSOCIATION

Typical functions performed and services provided by art therapists according to scope of practice as defined by the American Art Therapy Association include, but are not limited to:

(a) The use of psychotherapeutic principles, art media, and the creative process to assist individuals, families, or groups in:

(1) Increasing awareness of self and others;

(2) Coping with symptoms, stress, and traumatic experiences;

(3) Enhancing cognitive abilities; and

(4) Identifying and assessing clients' needs in order to implement therapeutic intervention to meet developmental, behavioral, psychological, and emotional needs.

(b) The application of art therapy principles and methods in the diagnosis, prevention, treatment, and amelioration of psychological problems and emotional or psychological conditions that include, but are not limited to:

(1) Clinical appraisal and treatment during individual, couples, family or group sessions which provide opportunities for engagement through the creative process;

(2) Using the process and products of art creation to tap into client's inner fears, conflicts and core issues with the goal of improving physical, psychological and emotional functioning and well-being; and

(3) Using art therapy assessments to determine treatment goals and implement therapeutic art interventions which meet developmental, psychological, and emotional needs; an

(c) The employment of art media, the creative process and the resulting artwork to assist clients to:

(1) Reduce psychiatric symptoms of depression, anxiety, post traumatic stress, and attachment disorders;

(2) Enhance neurological, cognitive, and verbal abilities, develop social skills, aid sensory impairments, and move developmental capabilities forward in specific areas;

(3) Cope with symptoms of stress, anxiety, traumatic experiences and grief;

(4) Explore feelings, gain insight into behaviors, and reconcile emotional conflicts;

(5) Improve or restore functioning and a sense of personal well-being;

(6) Increase coping skills, self-esteem, awareness of self and empathy for others;

(7) Healthy channeling of anger and guilt; and

(8) Improve school performance, family functioning and parent/child relationship.

APPENDIX 3 - ATCB CODE OF ETHICS, CONDUCT, AND DISCIPLINARY PROCEDURES

ART THERAPY CREDENTIALS BOARD, INC. | ATCB

September 2016

Code of Ethics, Conduct, and Disciplinary Procedures

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PREAMBLE

The Art Therapy Credentials Board (ATCB) is a nonprofit organization that seeks to protect the public by issuing registration, board certification, and clinical supervisor credentials to practitioners in the field of art therapy who meet certain established standards. The Board is national in scope and includes academicians, practitioners, supervisors, and a public member who work to establish rigorous standards that have a basis in real world practice. The ATCB art therapy registration, board certification, and clinical supervisor credentials, hereinafter sometimes referred to as credentials, are offered to art therapists from a wide variety of practice disciplines, who meet specific professional standards for the practice of art therapy.

The Code of Ethics, Conduct, and Disciplinary Procedures is designed to provide art therapists and credential applicants with a set of Ethical Standards (Part I, Section 1) to guide them in the practice of art therapy, as well as Standards of Conduct (Part I, Section 2) to which every credentialed art therapist and credential applicant must adhere. The ATCB may decline to grant, withhold, suspend, or revoke the credentials of any person who fails to adhere to the Standards of Ethics and Conduct (Part I, Section 3). Credentialed art therapists and credential applicants are expected to comply with ATCB Standards of Ethics and Conduct.

The ATCB does not guarantee the job performance of any credential holder or applicant. The ATCB does not express an opinion regarding the competence of any registered or board certified art therapist or art therapy certified supervisor. Rather, registration, board certification or super-visor certification offered through an ATCB program constitutes recognition by the ATCB that, to its best knowledge, an art therapist or applicant meets and adheres to minimum academic preparation, professional experience, continuing education, and professional standards set by the ATCB.

I. CODE OF ETHICS AND CONDUCT

1. General Ethical Standards

The Art Therapy Credentials Board endorses the following general ethical principles, which shall guide the conduct of all art therapists who seek to obtain or maintain credentials under the authority of the ATCB.

1.1 Responsibility to Clients

1.1.1 Art therapists shall advance the welfare of all clients, respect the rights of those persons seeking their assistance, and make reasonable efforts to ensure that their services are used appropriately.
1.1.2 Art therapists will not discriminate against or refuse professional services to individuals or groups based on age, gender, gender identity, gender expression, sexual orientation, ethnicity, race, national origin, culture, marital/partnership status, language preference, socioeconomic
status, citizenship or immigration status, disability, religion/spirituality, or any other basis.
1.1.3 At the outset of the client-therapist relationship, art therapists must discuss and explain to clients the rights, roles, expectations, and limitations of the art therapy process.

1.1.4 Art therapists respect the rights of clients to make decisions and assist them in understanding the consequences of these decisions. Art therapists advise their clients that decisions on whether to follow treatment recommendations are the responsibility of the client. It is the professional responsibility of the art therapist to avoid ambiguity in the therapeutic relationship and to ensure clarity of roles at all times.
1.1.5 Art therapists continue a therapeutic relationship only so long as they believe that the client is benefiting from the relationship. It is unethical to maintain a professional or therapeutic relationship for the sole purpose of financial remuneration to the art therapist or when it becomes reasonably clear that the relationship or therapy is not in the best interest of the client.
1.1.6 Art therapists must not engage in therapy practices or procedures that are beyond their scope of practice, experience, training, and education.
1.1.7 Art therapists must not abandon or neglect clients receiving services. If art therapists are unable to continue to provide professional help, they must assist the client in making reasonable alternative arrangements for continuation of services.
1.1.8 Art therapists shall ensure regular contact with clients and prompt rescheduling of missed sessions.
1.1.9 Art therapists shall make all attempts to ensure there are procedures in place or follow recommendations for a "professional will" that suggests the handling of client documentation and art, if applicable, in the event of their unexpected death or inability to continue practice. Art therapists shall recognize the harm it may cause if clients are unable to access services in such a situation and identify individuals who can assist clients with obtaining services and with appropriate transfer of records. These written procedures shall be provided to the client.
1.1.10 Art therapists shall provide clients with contact information for the Art Therapy Credentials Board.
1.1.11 Art therapists are familiar with state requirements and limitations for consent for treatment. When providing services to minors or persons unable to give voluntary consent, art therapists seek the assent of clients and/or guardians to services, and include them in decision making as much as possible. Art therapists recognize the need to balance the ethical rights of clients to make choices, their capacity to give consent or assent to receive services, and parental or familial legal rights and responsibilities to protect these clients and make decisions on their behalf.
1.1.12 Art therapists should obtain qualified medical or psychological consultation for cases when such evaluation and/or administration of medication is required. Art therapists must not provide services other than art therapy unless certified or licensed to provide such other services.
1.1.13 Practitioners of art therapy must conform to relevant federal, provincial, state, and local statutes and ordinances that pertain to the provision of independent mental health practice. Laws vary based upon the location of the practice. It is the sole responsibility of the independent practitioner to conform to these laws. Art therapists shall be knowledgeable about statutes and/or laws that pertain to art therapy and mental health practice in any jurisdiction (state, province, country) in which they practice.
1.1.14 Art therapists must seek to provide a safe, private, and functional environment in which to offer art therapy services. This includes, but is not limited to: proper ventilation, adequate lighting, access to water supply, knowledge of hazards or toxicity of art materials and the effort needed to safeguard the health of clients, storage space for client artworks and secured areas for any hazardous materials, monitored use of sharps, allowance for privacy and confidentiality, and compliance with any other health and safety requirements according to state and federal agencies that regulate comparable businesses.

1.2 Professional Competence and Integrity
1.2.1. Art therapists must maintain high standards of professional competence and integrity.
1.2.2 Art therapists must keep informed and updated with regard to developments in the field which relate to their practice by engaging in educational activities and clinical experiences. Additionally, art therapists shall seek regular consultation and/or supervision with fellow qualified professionals.
1.2.3 Art therapists shall assess, treat, or advise only in those cases in which they are competent as determined by

their education, training, and experience.
1.2.4 Art therapists shall develop and improve multicultural competence through ongoing education and training. Art therapists shall use practices in accordance with the client's or group's age, gender, gender identity, gender expression, sexual orientation, ethnicity, race, national origin, culture, marital/partnership status, language preference, socioeconomic status, immigration/citizenship status, disability, religion/spirituality, or any other identity factor.
1.2.5 Art therapists shall communicate in ways that are both developmentally and culturally sensitive and appropriate. When clients and/or art therapists have difficulty understanding each other's language, art therapists shall attempt to locate necessary translation/interpretation services.
1.2.6 Art therapists will obtain client's written consent to communicate with other health care providers for the purpose of collaborating on
client treatment.
1.2.7 Art therapists, because of their potential to influence and alter the lives of others, must exercise special care when making public their professional recommendations and opinions through testimony or other public statements.
1.2.8 Art therapists must seek appropriate professional consultation or assistance for their
personal problems or conflicts that may impair or affect work performance or clinical judgment.
1.2.9 Art therapists must not distort or misuse their clinical and research findings.
1.2.10 Art therapists shall file a complaint with the ATCB when they have reason to believe that another art therapist is or has been engaged in conduct that violates the law or the Standards of Ethics and Conduct contained in this Code. This does not apply when the belief is based upon information obtained in the course of a therapeutic relationship with a client and voluntary, written authorization for disclosure of the information has not been obtained; however, this does not relieve an art therapist from the duty to file any reports required by law.
1.2.11 Art therapists shall notify the ATCB of any disciplinary sanctions imposed upon themselves or another art therapist by another professional credentialing agency or organization, when such sanctions come to their attention.
1.2.12 Art therapists shall not knowingly make false, improper, or frivolous ethics or legal complaints against colleagues or other art therapists.

1.3 Responsibility to Students and Supervisees
1.3.1 Art therapists must instruct their students using accurate, current, and scholarly information and at all times foster the professional growth of students and advisees.
1.3.2 Art therapists as teachers, supervisors, and researchers must maintain high standards of scholarship and present accurate information.
1.3.3 Art therapists must not permit students, employees, or supervisees to perform or to represent themselves as competent to perform professional services beyond their education, training, experience, or competence, including multicultural and diversity competence.
1.3.4 Art therapists who act as supervisors are responsible for maintaining the quality of their supervision skills and obtaining consultation or supervision for their work as supervisors whenever appropriate.
1.3.5 Art therapists are aware of their influential position with respect to students and supervisees, and they avoid exploiting the trust and dependency of such persons. Art therapists, therefore, shall not engage in a therapeutic relationship with their students or supervisees.
1.3.6 Art therapists do not condone or engage in sexual harassment, which is defined as unwelcome comments, gestures, or physical contact of a sexual nature.
1.3.7 Art therapists who offer and/or provide supervision must:
1.3.7.1 Ensure that they have proper training and supervised experience, contemporary continuing education and/or graduate training in clinical supervision;

1.3.7.2 Ensure that supervisees are informed of the supervisor's credentials and professional status as well as all conditions of supervision as defined/outlined by the supervisor's practice, agency, group, or organization;
1.3.7.3 Ensure that supervisees are aware of the current ethical standards related to their professional practice, including the ATCB Code of Ethics, Conduct, and Disciplinary Procedures;
1.3.7.4 Ensure regular contact with supervisees and prompt rescheduling of missed supervision sessions;
1.3.7.5 Provide supervisees with adequate feedback and evaluation throughout the supervision process;
1.3.7.6 Ensure that supervisees inform their clients of their professional status, the name and contact information of their supervisors, and obtain informed consent from their clients for sharing disguised client information and artwork or reproductions as necessary with their supervisors;
1.3.7.7 Ensure that supervisees obtain client consent to share client artwork or reproductions in supervision;
1.3.7.8 Establish procedures with their supervisees for handling crisis situations.
1.3.9 Art therapy supervisors shall provide supervisees with a professional disclosure statement that advises supervisees of the supervisor's affirmation of adherence to this Code of Ethics, Con-duct, and Disciplinary Procedures, and instructions regarding how the supervisee should address any dissatisfaction with the supervision process including how to file a complaint with the ATCB, the ATCB's address, telephone number, and email address.

1.4 Responsibility to Research Participants
1.4.1 Art therapists who are researchers must respect the dignity and protect the welfare of participants in research.
1.4.2 Researchers must be aware of and comply with federal, provincial, state, and local laws and regulations, agency regulations, institutional review boards, and professional standards governing the conduct of research.
1.4.3 Researchers must make careful examinations of ethical acceptability in planning studies. To the extent that services to research participants may be compromised by participation in research, investigators must seek the ethical advice of qualified professionals not directly involved in the investigation and observe safeguards to protect the rights of research participants.
1.4.4 Researchers requesting potential participants' involvement in research must inform them of all risks and aspects of the research that might reasonably be expected to influence willingness to participate, and must obtain a written acknowledgment of informed consent, reflecting an understanding of the said risks and aspects of the research, signed by the participant or, where appropriate, by the participant's parent or legal guardian. Researchers must be especially sensitive to the possibility of diminished consent when participants are also receiving clinical services, have impairments which limit understanding and/or communication, or when participants are children.
1.4.5 Researchers must respect participants' freedom to decline participation in or to withdraw from a research study at any time. This principle requires thoughtful consideration when investigators or other members of the research team are in positions of authority or influence over participants. Art therapists, therefore, must avoid relationships with research participants outside the scope of the research.
1.4.6 Art therapists must treat information obtained about research participants during the course of the research protocol as confidential unless the participants have previously and reasonably authorized in writing that their confidential information may be used. When there is a risk that others, including family members, may obtain access to such information, this risk, together with the plan for protecting confidentiality, must be explained to the participants as part of the above stated procedure for obtaining a written informed consent.

1.5 Responsibility to the Profession
1.5.1 Art therapists must respect the rights and responsibilities of professional colleagues and should participate in activities that advance the goals of art therapy.
1.5.2 Art therapists must adhere to the ATCB standards of the profession when acting as members or employees of third-party organizations.
1.5.3 Art therapists must attribute publication credit to those who have contributed to a publication in proportion to their contributions and in accordance with customary professional publication practices.

1.5.4 Art therapists who author books or other materials that are published or distributed must cite persons to whom credit for original ideas is due.
1.5.5 Art therapists who author books or other materials published or distributed by a third party must take reasonable precautions to ensure that the third party promotes and advertises the materials accurately and factually.
1.5.6 Art therapists are encouraged, whenever possible, to recognize a responsibility to partictipate in activities that contribute to a better community and society, including devoting a portion of their professional activity to services for which there is little or no financial return.
1.5.7 Art therapists are encouraged, whenever possible, to assist and be involved in developing laws and regulations pertaining to the field of art therapy that serve the public interest and in changing such laws and regulations that are not in the public interest.
1.5.8 Art therapists are encouraged, whenever possible, to promote public understanding of the principles and the profession of art therapy through presentations to general audiences, mental health professionals, and students. In making such presentations, art therapists shall accurately convey to the audience members or students the expected competence and qualifications that will result from the presentations, as well as, the differences between the presentation and formal studies in art therapy.
1.5.9 Art therapists must cooperate with any ethics investigation by any professional organization or government agency, and must truthfully represent and disclose facts to such organizations or agencies when requested or when necessary to preserve the integrity of the art therapy profession.
1.5.10 Art therapists should endeavor to ensure that the benefits and limitations are correctly conveyed by any institution or agency of which they are employees.
1.5.11 Art therapists are accountable at all times for their behavior. They must be aware that all actions and behaviors of the art therapist reflect on professional integrity and, when inappropriate, can damage the public trust in the art therapy profession. To protect public confidence in the art therapy profession, art therapists avoid behavior that is clearly in violation of accepted moral and legal standards.

2. Standards of Conduct

The Art Therapy Credentials Board prescribes the following standards of conduct, which shall guide the conduct of all art therapists who seek to obtain or maintain credentials under the authority of the ATCB.

2.1 Confidentiality

2.1.1 Art therapists shall inform clients of the purpose and limitations of confidentiality.
2.1.2 Art therapists shall respect and protect confidential information obtained from clients, including, but not limited to, all verbal and/or artistic expression occurring within the client-therapist relationship.
2.1.3 Art therapists shall protect the confidentiality of the client-therapist relationship in all matters.
2.1.4 Art therapists shall not disclose confidential information without the client's explicit written consent unless mandated by law or a court order. In these cases, confidences may be disclosed only as legally and reasonably necessary in the course of that action. All disclosures of information shall be documented in the client's file, including the identity of the recipient, the basis upon which the information was disclosed, and a description of the information disclosed.
2.1.5 If there is reason to believe that the client or others are in immediate, serious danger to health or life, any such disclosure shall be made consistent with state and federal laws that pertain to the protection and welfare of the client or others. Art therapists strive to disclose information in a way that ensures respect for the client and integrity for the therapeutic relationship.
2.1.6 In the event that art therapists believe it is in the interest of a client to disclose confidential information, they shall seek and obtain written authorization from the client or the client's legal guardian, before making any disclosures, unless such disclosure is required by law.

2.1.7 For the purpose of collecting information on harm caused to clients or possible violations of ATCB rules and its Code of Ethics, Conduct, and Disciplinary Procedures by art therapists or those falsely claiming to have an ATCB credential, art therapists may disclose such information without the client's explicit written consent if the information is disguised so that the identity of the client is fully protected.
2.1.8 Art therapists shall maintain client treatment records for a reasonable period of time consistent with federal and state laws, agency regulations and sound clinical practice. Records shall be stored or disposed of in ways that maintain client confidentiality.
2.1.9 Whenever possible, a photographic representation should be maintained, in accordance with the provisions set forth in 2.2.2 of this document on consent to photograph, for all work created by the client that is relevant to document the therapy if maintaining the original artwork would be difficult.
2.1.10 When the client is a minor, any and all disclosure or consent shall be made to or obtained from the parent or legal guardian of the client, except where otherwise provided by state law. Care shall be taken to preserve confidentiality with the minor client and to refrain from disclosure of information to the parent or guardian that might adversely affect the treatment of the client, except where otherwise provided by state law or when necessary to protect the health, welfare, or safety of the minor client.
2.1.11 Client confidentiality must be maintained when clients are involved in research, according to Part I, Section 1.4 of this code of practice.
2.1.12 Independent practitioners of art therapy must sign and issue a written professional disclosure statement to a client upon the establishment of a professional relationship. Such disclosure statement must include, but need not be limited to, the following information: education, training, experience, professional affiliations, credentials, fee structure, payment schedule, session scheduling arrangements, information pertaining to the limits of confidentiality and the duty to report. The name, address, and telephone number of the ATCB should be written in this document along with the following statement, "The ATCB oversees the ethical practice of art therapists and may be contacted with client concerns." It is suggested that a copy of the statement be retained in the client's file.

2.2 Use and Reproduction of Client Art Expression and Therapy Sessions
2.2.1 Art therapists shall take into consideration the benefits and potential negative impact of photographing, videotaping, using other means to duplicate, and/or display and/or broadcast client artwork with the client's best interest in mind. Art therapists shall provide to the client and/or parent or legal guardian clear warnings about the art therapist's inability to protect against the use, misuse, and republication of the art product and/or session by others once it is displayed or posted.
2.2.2 Art therapists shall not make or permit any public use or reproduction of a client's art therapy sessions, including verbalization and art expression, without express written consent of the client or the client's parent or legal guardian.
2.2.3 Art therapists shall obtain written informed consent from a client, or when applicable, a parent or legal guardian, before photographing the client's art expressions, making video or audio recordings, otherwise duplicating, or permitting third-party observation of art therapy sessions.
2.2.4 Art therapists shall use clinical materials in teaching, writing, electronic formats and
public presentations only if a written authorization has been previously obtained from the client, client's parent, or legal guardian.
2.2.5 Art therapists shall obtain written, informed consent from a client or, when appropriate, the client's parent or legal guardian, before
displaying the client's art in galleries, healthcare facilities, schools, the Internet or other places.
2.2.6 Only the client, parent or legal guardian may give signed consent for use of client's art or information from sessions and treatment, and only for the specific uses, and in the specific communication formats, designated in the consent. Once consent has been granted, art therapists shall ensure that appropriate steps are taken to protect

client identity and disguise any part of the notes, art expression or audio or video recording that reveals client identity unless the client, parent or legal guardian specifically designates in the signed consent that the client's identity may be revealed. The signed consent form shall include conspicuous language that explains the potential that imagery and information displayed or used in any form may not be able to be permanently removed if consent is later revoked.

2.3 Professional Relationships

2.3.1 Art therapists shall not engage in any relationship, including through social media, with current or former clients, students, interns, trainees, supervisees, employees, or colleagues that is exploitative by its nature or effect.

2.3.2 Art therapists shall make their best efforts to avoid, if it is reasonably possible to do so, entering into non-therapeutic or non-professional relationships with current or former clients, students, interns, trainees, supervisees, employees, or colleagues or any family members or other persons known to have a close personal relationship with such individuals such as spouses, children, or close friends.

2.3.3 In the event that the nature of any such relationship is questioned, the burden of proof shall be on the art therapist to prove that a non-therapeutic or non-professional relationship with current or former clients, students, interns, trainees, supervisees, employees, or colleagues is not exploitative or harmful to any such individuals.

2.3.4 Exploitative relationships with clients include, but are not limited to, borrowing money from or loaning money to a client, hiring a client, engaging in a business venture with a client, engaging in a romantic relationship with a client, or engaging in sexual intimacy with a client.

2.3.5 Art therapists shall take appropriate professional precautions to ensure that their judgment is not impaired, that no exploitation occurs, and that all conduct is undertaken solely in the client's best interest.

2.3.6 Art therapists shall not use their professional relationships with clients to further their own interests.

2.3.7 Art therapists shall be aware of their influential position with respect to students and supervisees, and they shall avoid exploiting the trust and dependency of such persons. Art therapists, therefore, shall not provide therapy to students or supervisees contemporaneously with the student/supervisee relationship.

2.3.8 Art therapists must not knowingly misuse, or allow others to misuse, their influence when engaging in personal, social, organizational, electioneering or lobbying activities.

2.3.9 Art therapists do not condone or engage in sexual harassment, which is defined as unwelcome comments, gestures, or physical contact of a sexual nature.

2.3.10 Art therapists shall be aware of and take into account the traditions and practices of other professions with which they work and cooperate fully with them.

2.3.11 Art therapists who have a private practice, but who are also employed in an agency or group practice must abide by and inform clients of the agency's or group practice's policies regarding self-referral.

2.3.12 Any data derived from a client relationship and subsequently used in training or research shall be so disguised in such a way that the client's identity is fully protected. Any data which cannot be so disguised may be used only as expressly authorized by the client's informed and voluntary consent.

2.4 Financial Arrangements

2.4.1 Independent practitioners of art therapy shall seek to ensure that financial arrangements with clients, third party payers, and supervisees are understandable and conform to accepted professional practices.

2.4.2 If a client wishes to access insurance coverage for art therapy services out of state, art therapists shall advise clients that it is the client's responsibility to confirm coverage before beginning services.

2.4.3 Art therapists must not offer or accept payment for referrals.

2.4.4 Art therapists must not exploit their clients financially.

2.4.5 Art therapists must represent facts truthfully to clients, third party payers, and supervisees regarding services rendered and the charges thereof.

2.4.6 Art therapists who intend to use collection agencies or take legal measure to collect fees from clients who do

not pay for services as agreed upon must first inform clients in writing of such intended actions and offer clients the opportunity to make payment.
2.4.7 Art therapists may barter only if the relationship is not exploitive or harmful and does not place the art therapist in an unfair advantage, if the client requests it, and if such arrangements are an accepted practice among professionals within the community. Art therapists should consider the cultural implications of bartering and discuss relevant concerns with clients and document such agreements in a clear written contract.
2.4.8 Art therapists shall not accept gifts from clients except in cases when it is culturally appropriate or therapeutically relevant to the specific client. Prior to acceptance, art therapists shall consider the value of the gift and discuss the gift-giving with the client. The art therapist shall document the matter, including all consideration and the client discussion in the client's record.

2.5 Advertising
2.5.1 Art therapists shall provide sufficient and appropriate information about their professional services to help the layperson make an informed decision about contracting for those services.
2.5.2 Art therapists must accurately represent their competence, education, earned credentials, training, and experience relevant to their professional practice.
2.5.3 Art therapists must ensure that all advertisements and publications, whether in print, directories, announcement cards, newspapers, radio, television, electronic format such as the Internet, or any other media, are formulated to accurately convey, in a professional manner, information that is necessary for the public to make an informed, knowledgeable decision.
2.5.4 Art therapists must not use names or designations for their practices that are likely to confuse and/or mislead the public concerning the identity, responsibility, source, and status of those under whom they are practicing, and must not hold themselves out as being partners or associates of a firm if they are not.
2.5.5 Art therapists must not use any professional identification (such as a business card, office sign, letterhead, or telephone or association directory listing) if it includes a statement or claim that is false, fraudulent, misleading or deceptive. A statement is false, fraudulent, misleading or deceptive if it: fails to state any material fact necessary to keep the statement from being misleading; is intended to, or likely to, create an unjustified expectation; or contains a material misrepresentation of fact.
2.5.6 Art therapists must correct, whenever possible, false, misleading, or inaccurate information and representations made by others concerning the art therapist's qualifications, services, or products.
2.5.7 Art therapists must make certain that the qualifications of persons in their employ are represented in a manner that is not false, misleading, or deceptive.
2.5.8 Art therapists may represent themselves as specializing within a limited area of art therapy only if they have the education, training, and experience that meet recognized professional standards to practice in that specialty area.

2.6 Measurement and Evaluation
2.6.1 Art therapists shall use or interpret only the specific assessment instruments for which they have the required education and supervised experience.
2.6.2 Art therapists must provide instrument specific orientation or information to an examinee prior to and following the administration of assessment instruments or techniques so that the results may be placed in proper perspective with other relevant factors. The purpose of testing and the explicit use of the results must be made known to an examinee prior to testing.
2.6.3 In selecting assessment instruments or techniques for use in a given situation or with a particular client, art therapists must carefully evaluate the specific theoretical bases and characteristics, validity, reliability and appropriateness of each instrument.
2.6.4 When making statements to the public about assessment instruments or techniques, art therapists must

provide accurate information and avoid false claims or misconceptions concerning the instrument's reliability and validity.
2.6.5 Art therapists must follow all directions and researched procedures for selection, administration and interpretation of all evaluation instruments and use them only within proper contexts.
2.6.6 Art therapists must be cautious when interpreting the results of instruments that possess insufficient technical data, and must explicitly state to examinees the specific limitations and purposes for the use of such instruments.
2.6.7 Art therapists must proceed with caution when attempting to evaluate and interpret performance of any person who cannot be appropriately compared to the norms for the instrument.
2.6.8 Because prior coaching or dissemination of assessment instruments can invalidate test results, art therapists are professionally obligated to maintain test security.
2.6.9 Art therapists must consider psychometric limitations when selecting and using an instrument, and must be cognizant of the limitations when interpreting the results. When tests are used to classify clients, art therapists must ensure that periodic review and/or retesting are conducted to prevent client stereotyping.
2.6.10 Art therapists recognize that test results may become obsolete, and avoid the misuse of obsolete data.
2.6.11 Art therapists must not appropriate, reproduce, or modify published assessment instruments or parts thereof without acknowledgement and permission from the publisher, except as permitted by the fair educational use provisions of the U.S. copyright law.
2.6.12 Art therapists who develop assessment instruments for the purpose of measuring personal characteristics, diagnosing, or other clinical uses shall provide test users with a description of the benefits and limitations of the instrument, appropriate use, interpretation, and information on the importance of basing decisions on multiple sources rather than a single source.

2.7 Documentation
Art therapists must maintain records that:
2.7.1 Are in compliance with federal, provincial, state, and local regulations and any licensure requirements governing the provision of art therapy services for the location in which the art therapy services are provided.
2.7.2 Are in compliance with the standards, policies and requirements at the art therapist's place of employment.
2.7.3 Include essential content from communication with/by the client via electronic means.

2.8 Termination of Services
2.8.1 Art therapists shall terminate art therapy when the client has attained stated goals and objectives or fails to benefit from art therapy services.
2.8.2 Art therapists must communicate the termination of art therapy services to the client, client's parent or legal guardian.

2.9 Electronic Means
2.9.1 Art therapists must inform clients of the benefits, risks, and limitations of using information technology applications in the therapeutic process and in business/billing procedures. Such technologies include but are not limited to computer hardware and software, faxing, telephones, the Internet, online assessment instruments, and other technological procedures and devices. Art therapists shall utilize encryption standards within Internet communications and/or take such precautions to reasonably ensure the confidentiality of information transmitted, as in 2.9.5.6.
2.9.2 When art therapists are providing technology-assisted distance art therapy services, the art therapist shall make a reasonable effort to determine that clients are intellectually, emotionally, and physically capable of using the application and that the application is appropriate for the needs of clients.
2.9.3 Art therapists must ensure that the use of technology in the therapeutic relationship does not violate the laws of any federal, provincial, state, local, or international entity and observe all relevant statutes.

2.9.4 Art therapists shall seek business, legal, and technical assistance when using technology applications for the purpose of providing art therapy services, particularly when the use of such applications crosses provincial, state lines or international boundaries.
2.9.5 As part of the process of establishing informed consent, art therapists shall do the following:
2.9.5.1 Inform clients of issues related to the difficulty of maintaining the confidentiality of electronically transmitted communications, and the difficulty in removing any information or imagery that has been posted electronically if consent is later revoked.
2.9.5.2 Inform clients of all colleagues, supervisors, and employees (including Information Technology [IT] administrators) who might have authorized access to electronic transmissions.
2.9.5.3 Inform clients that, due to the nature of technology assisted art therapy, unauthorized persons may have access to information/art products that clients may share in the therapeutic process.
2.9.5.4 Inform clients of pertinent legal rights and limitations governing the practice of a profession across state/provincial lines or international boundaries.
2.9.5.5 Inform clients that Internet sites and e-mail communications will be encrypted but that there are limitations to the ability of encryption software to help ensure confidentiality.
2.9.5.6 When the use of encryption is not possible, art therapists notify clients of this fact and limit electronic transmissions to general communications that are not client specific.
2.9.5.7 Inform clients if and for how long archival storage of transaction records are maintained.
2.9.5.8 Discuss the possibility of technology failure and alternate methods of service delivery.
2.9.5.9 Inform clients of emergency procedures, such as calling 911 or a local crisis hotline, when the art therapist is not available.
2.9.5.10 Discuss time zone differences, and cultural or language differences that might impact service delivery.
2.9.5.11 If a client wishes to access insurance coverage for technology-assisted distance art therapy services, art therapists shall advise clients that it is the client's responsibility to confirm coverage before beginning services.
2.9.5.12 Inform clients that communication will be included in client documentation as mentioned in 2.7.3.
2.9.6 Art therapists maintaining sites on the Internet shall do the following:
2.9.6.1 Regularly check that electronic links are working and professionally appropriate.
2.9.6.2 Provide electronic links to the ATCB and other relevant state, provincial, and or international licensure and professional certification boards to protect consumer rights and facilitate addressing ethical concerns.
2.9.6.3 Strive to provide a site that is accessible to persons with disabilities

2.10 Social Media

2.10.1 Art therapists who maintain social media sites shall clearly distinguish between their personal and professional profiles by tailoring information specific to those uses and modifying who can access each site.
2.10.2 Art therapists do not disclose or display confidential information through social media.

3. Eligibility for Credentials

As a condition of eligibility for and continued maintenance or renewal of any ATCB credential, each applicant, registrant, certificant, or certified supervisor agrees to the following:

3.1 Compliance with ATCB Standards, Policies and Procedures

3.1.1 No person is eligible to apply for or main-tain credentials unless in compliance with all ATCB eligibility criteria as stated in the ATR, ATR-BC, and ATCS applications, as well as all other ATCB rules and standards, policies and procedures, including, but not limited to, those stated herein, and including timely payment of fees and any other requirements for renewal of credentials.
3.1.2 Each applicant, registrant, or certificant bears the burden for showing and maintaining compliance at all times.

The ATCB may deny, decline to renew, revoke, or otherwise act upon credentials when an applicant, registrant, or certificant is not in compliance with all ATCB stan-dards, policies, and procedures.

3.2 Complete Application

3.2.1 The ATCB may make administrative requests for additional information to supplement or complete any application for credentials or for renewal of existing credentials. An applicant must truthfully complete and sign an application in the form provided by the ATCB, must provide the required fees, and must provide additional information as requested.

3.2.2 The applicant, registrant, or certificant must provide written notification to the ATCB within 60 days of occurrence of any change in name, address, telephone number, and any other facts bearing on eligibility for credentials, including but not limited to: filing of any civil or criminal charge, indictment or litigation involving the applicant, registrant, or certificant; disposition of any civil or criminal charge, indictment or litigation involving the applicant, registrant, or certificant, including but not limited to, dismissal, entry of a judgment, conviction, plea of guilty, plea of nolo contendere, or disciplinary action by a licensing board or professional organization.

3.2.3 An applicant, registrant, or certificant will provide information requested by the Ethics Officer.

3.2.4 An applicant, registrant, or certificant must not make and must correct immediately any statement concerning his or her status that is or becomes inaccurate, untrue, or misleading.

3.2.5 All references to "days" in ATCB standards, policies and procedures shall mean calendar days. Communications required by the ATCB shall be transmitted by certified mail, return receipt requested, or other verifiable method of delivery.

3.2.6 The applicant, registrant, or certificant shall provide the ATCB with documentation of compliance with ATCB requirements as requested by the ATCB through its President or Executive Director.

3.3 Property of ATCB and Eligibility Determination

3.3.1 All examinations, certificates, and registration or certification cards of the ATCB, the name Art Therapy Credentials Board, all marks and terms of credentials, and all abbreviations relating thereto, are all the exclusive property of the ATCB and may not be used in any way without the express prior written consent of the ATCB.

3.3.2 ATCB applicants, registrants, or certificants who share, use, or alter ATCB examinations, certificates, and registration or certification cards of the ATCB, the name Art Therapy Credentials Board, all marks and terms of credentials, and all abbreviations relating thereto, are subject to disciplinary sanctions that may include but are not limited to denial, declined renewal, or revocation of ATCB credentials and may be subject to civil or criminal prosecution.

3.3.3 In case of suspension, limitation, relinquishment, or revocation of ATCB credentials, or as otherwise requested by the ATCB, a person previously holding an ATCB credential shall immediately relinquish, refrain from using, and correct at his or her expense any and all outdated or otherwise inaccurate business cards, stationery, advertisements, or other use of any certificate, logo, emblem, and the ATCB name and related abbreviations.

3.4 Pending Criminal or Administrative Proceedings

3.4.1 An applicant, registrant, or certificant shall provide written notification to the ATCB of the filing in any court of any information, complaint, or indictment charge of a felony or with a crime related to the practice of art therapy or the public health and safety, or the filing of any charge or action before a state or federal regulatory agency or judicial body directly relating to the practice of art therapy or related professions, or to a matter described in Part I, Section 4.1. Such notification shall be within 60 days of the filing of such charge or action, and shall provide written documentation of the resolution of such charge within 60 days of resolution.

3.5 Criminal Convictions

3.5.1 Applicants who meet all criteria as delineated in the current ATCB credential applications and who have not

had sanctions imposed by the ATCB or other governmental authority, insurance carrier, professional organization, or credentialing board, or been convicted of a serious criminal offense, or been listed on a governmental abuse

registry will be considered eligible for an ATCB credential upon submission of all application materials and fees. All other applicants will be subject to review by the ATCB and demonstration of their fitness to practice art therapy and that they do not pose a risk to the public.

II. DISCIPLINARY PROCEDURES

4. Standards Of Conduct: Discipline Process

4.1 Grounds For Discipline

4.1.1 The ATCB may deny or revoke credentials or otherwise take action with regard to credentials or an application for credentials under the following circumstances:
4.1.1.1 Failure to observe and comply with the Standards of Ethics and Conduct stated herein;
4.1.1.2 Failure to meet and maintain eligibility for ATCB credentials;
4.1.1.3 Irregularity in connection with any ATCB examination;
4.1.1.4 Failure to pay fees required by the ATCB;
4.1.1.5 Unauthorized possession of, use of, or access to ATCB examinations, certificates, registration or certification cards, logos, the name Art Therapy Credentials Board, all marks and terms of credentials, and all abbreviations relating thereto, and any variations thereof, and any other ATCB documents and materials;
4.1.1.6 Obtaining, maintaining, or attempting to obtain or maintain credentials by a false or misleading statement, failure to make a required statement, fraud, or deceit in an application, reapplication, or any other communication to the ATCB;
4.1.1.7 Misrepresentation of status of ATCB credentials;
4.1.1.8 Failure to provide any written information required by the ATCB;
Failure to cooperate with the ATCB or anybody established or convened by the ATCB at any point from the inception of an ethical or disciplinary complaint through the completion of all proceedings regarding that complaint;
4.1.1.10 Habitual use of alcohol, any drug or any substance, or any physical or mental condition, which impairs competent and objective professional performance;
4.1.1.11 Gross negligence in the practice of art therapy or other related professional work; including, but not limited to, sexual relationships with clients, and sexual, physical, social, or financial exploitation;
4.1.1.12 Limitation or sanction (including but not limited to discipline, revocation, or suspension by a regulatory board or professional organization) in a field relevant to the practice of art therapy;
4.1.1.13 ?The conviction of, or plea of guilty or plea of nolo contendere to, (i) any felony or (ii) any crime related to the practice of art therapy, the therapist's professional qualifications, or public health and safety. Convictions of this nature include but are not limited to those involving rape, sexual abuse of a patient or vulnerable person, actual or threatened use of a weapon or violence, and the prohibited sale, distribution or use of a controlled substance;
4.1.1.14 Failure to update information in a timely manner, including any violation referred to in this section, to the ATCB;
4.1.1.15 Failure to maintain confidentiality as required in the Standards of Ethics and Conduct, by any ATCB policy or procedure, or as otherwise required by law; or
4.1.1.16 Other violation of an ATCB standard, policy, or procedure stated herein or as stated in the ATCB candidate brochure or other material provided to applicants, registrants, or certificants.

4.2 Release of Information

4.2.1 Each applicant, registrant, and certificant agrees to cooperate promptly and fully in any review of eligibility or credential status, including submitting such documents and information deemed necessary to

confirm the information in an application.
4.2.2 The individual applicant, registrant, or certificant agrees that the ATCB and its officers, directors, committee members, employees, ethics officers, and agents, may communicate any and all information relating to an ATCB application, registration or certification, and review thereof, and any imposed public disciplinary sanctions to state and federal authorities, licensing boards, and employers, and may communicate any imposed public disciplinary sanctions and the status of
a registrant's or certificant's credential to the public.

4.3 Waiver
4.3.1 An applicant, registrant, or certificant releases, discharges, exonerates, indemnifies, and holds harmless the ATCB, its officers, directors, committee members, employees, ethics officers, and agents, and any other persons from and against all claims, damages, losses, and expenses, including reasonable attorneys' fees, for actions of the ATCB arising out of applicant's application for or participation in the ATCB registration and/or certification programs and use of ATCB trademarks or other references to the ATCB registration and/or certification programs, including but not limited to the furnishing or inspection of documents, records, and other information and any investigation and review of applications or credentials by the ATCB.

4.4 Reconsideration of Eligibility and Reinstatement of Credentials
4.4.1 If eligibility or credentials are denied, revoked, or suspended for a violation of the Standards of Ethics and Conduct, eligibility for credentials may be reconsidered by the Board of Directors, upon application, on the following basis:
4.4.1.1 In the event of a felony conviction, no earlier than five years from and after the exhaustion of appeals, completion of sentence by final release from confinement, probationary or parole status, or satisfaction of fine imposed, whichever is later;
4.4.1.2 In any other event, at any time following imposition of sanctions, at the sole discretion of the Board of Directors.
4.4.2 In addition to other facts required by the ATCB, such an applicant must fully set forth the circumstances of the decision denying, revoking, or suspending eligibility or credentials as well
as all relevant facts and circumstances since the decision.
4.4.3 The applicant bears the burden of demonstrating by clear and convincing evidence of rehabilitation and absence of danger to others.

4.5 Deadlines
4.5.1 The ATCB requires its applicants, registrants, and certificants to meet all deadlines imposed by the ATCB, especially in regard to submission of fees, renewal or recertification applications, required evidence of continuing education, and sitting for its examinations. On rare occasions, circumstances beyond the control of the applicant, registrant or certificant, or other extraordinary conditions may render it difficult, if not impossible, to meet ATCB deadlines.
4.5.2 An applicant, registrant, or certificant who wishes to appeal a missed deadline must transmit a written explanation and make a request for a reasonable extension of the missed deadline along with the appropriate fees with full relevant supporting documentation, to the ATCB Executive Director, to the attention of the ATCB National Office.
4.5.3 The Board of Directors shall determine at the next meeting of the Board, in its sole discretion and on a case-by-case basis, what, if any, recourse will be afforded based on the circumstances described and the overall impact on the profession of art therapy. No other procedures shall be afforded for failure to meet ATCB deadlines.
4.5.4 The ATCB shall make every effort to follow the time requirements set forth in this document. However, the ATCB's failure to meet a time requirement shall not prohibit the final resolution of any ethics matter.

5. DISCIPLINARY PROCEDURES

5.1 Appointment of Disciplinary Hearing Panel

5.1.1 The ATCB Board of Directors may authorize an Ethics Officer and a Disciplinary Hearing Panel to investigate or consider alleged violations of the Standards of Ethics and Conduct contained in this Code or any other ATCB standard, policy or procedure. The ATCB Board of Directors shall appoint the chair of the Disciplinary Hearing Panel.
5.1.2 The Disciplinary Hearing Panel shall be composed of three members, including the chair. The membership of the Disciplinary Hearing Panel shall be drawn from ATCB registrants and certificants, except that one member of the Disciplinary Hearing Panel shall be a public member who shall not be an ATCB registrant or certificant.
5.1.3 The initial appointments to the Disciplinary Hearing Panel shall be for terms of three years as determined by the ATCB Board of Directors. Thereafter, a panel member's term of office on the panel shall run for three years and may be renewed. Once a member of the Disciplinary Hearing Panel begins to participate in the review of a matter, the panel member shall remain part of the Disciplinary Hearing Panel for that particular matter even if the review extends beyond the expiration of his or her term.
5.1.4 A Disciplinary Hearing Panel member may not serve simultaneously as Ethics Officer and may not serve on any matter wherein an actual or apparent conflict of interest or the Panel Member's impartiality might reasonably be questioned.
5.1.5 When a party to a matter before the Disciplinary Hearing Panel requests that a member of the panel, other than the chair, self-recuse, a final decision on the issue of recusal shall be made by the chair, subject to review as hereinafter provided. In the event a request is made that the chair self-recuse, the decision shall be made by the ATCB President, subject to review as hereinafter provided.
5.1.6 Panel action shall be determined by majority vote.
5.1.7 When a Panel member is unavailable to serve by resignation, disqualification, or other circumstance, the President of the ATCB shall designate another registrant or certificant, or public member, if applicable, to serve as an interim member for a particular matter or for the duration of the panel member's unexpired term whichever is appropriate.

5.2 Submission of Allegations

5.2.1 Any person concerned about a possible violation of the ATCB Standards of Ethics and Conduct, or other ATCB standard, policy or procedure, may initiate a written grievance, in as much detail and specificity as possible, including identifying the person(s) alleged to be involved and the facts concerning the alleged conduct. The written grievance should be accompanied by all available documentation. The grievance should be addressed to the Executive Director. A person initiating a grievance shall be referred to as the complainant.
5.2.2 The written grievance must identify by name, address, and telephone number of the complainant making the information known to the ATCB, and others who may have knowledge of the facts and circumstances concerning the alleged conduct. The ATCB may provide for the submission of grievances on forms to be supplied by the Executive Director.
5.2.3 The Executive Director shall forward the grievance to the Public Member of the ATCB Board of Directors (the "Public Member") for further action. The Public Member may initiate grievances that shall be handled in the manner provided hereinafter for the review and determination of all grievances.
5.2.4 The Public Member shall review the allegations and supporting information and make a determination of the merits of the allegations, after such further inquiry as considered appropriate, and after consultation with ATCB legal counsel as needed.
5.2.5 The Public Member may direct the ATCB Executive Director to assist with factual investigations or with administrative matters related to the initial review of allegations.
5.2.6 If the Public Member determines that the allegations are frivolous or fail to state a violation of the Standards of Ethics and Conduct, or that the ATCB lacks jurisdiction over the grievance or the person(s) complained about, the

ATCB shall not take further action and shall notify the complainant.
5.2.7 If the Public Member determines that probable cause may exist to deny eligibility for credential or that probable cause exists of a failure to comply with the Standards of Ethics and Conduct or any other ATCB policy or procedure, the Public Member shall forward in writing all details of the allegations to one of the Ethics Officers.
5.2.8 The Ethics Officer shall review the allegations and supporting information provided and may make such further inquiry, as deemed appropriate.
5.2.9 The Ethics Officer may seek the assistance of the Executive Director to research precedents in the ATCB's files, as reasonably determined to be necessary in making a determination regarding probable cause of a violation of the Standards of Ethics and Conduct, any other ATCB policy or procedure, or other misconduct. The Ethics Officer may direct the ATCB Executive Director to assist with factual investigations or with administrative matters related to the review of allegations.
5.2.10 If the Ethics Officer concurs that probable cause may exist to deny eligibility or that probable cause exists of a failure to comply with the Standards of Ethics and Conduct or any other ATCB policy or procedure, the Ethics Officer shall transmit written notification containing the allegations and findings to the full Disciplinary Hearing Panel, the complainant and the applicant, certificant or registrant. All written notices to the applicant, registrant or certificant shall be sent by certified mail, return receipt requested, to their addresses listed in the ATCB records. However if the Ethics Officer, in agreement with the Public Member, determines that the probable violation(s) are minor or technical in nature and have neither caused nor presented a danger of serious harm to a client or the public, the Ethics Officer may choose to resolve the complaint by the issuance of an advisory letter to the registrant or certificant setting out the identified probable violations and recommendations on corrective or preventative measures that should be implemented by the registrant or certificant in the future. All such advisory letters shall be maintained as part of the registrant's or certificant's file and may be taken into consideration of the sanctions to be assessed in connection with any future complaints brought against the registrant or certificant. Advisory letters shall not be made public.
5.2.11 If the Ethics Officer determines that probable cause does not exist to deny eligibility or that that probable cause does not exist of a failure to comply with the Standards of Ethics and Conduct or any other ATCB policy or procedure, or that the ATCB lacks jurisdiction over the complaint or the person(s) against whom the complaint was made, the Ethics Officer shall direct ATCB to take no further action and shall notify in writing the Board, the applicant, registrant, or certificant, and complainant, if any.
5.2.12 If upon referral of a grievance from the Public Member the Ethics Officer determines that reasonable cause exists that a registrant or certificant has had a license or certification revoked or suspended or has been charged, indicted, placed on deferred adjudication, community supervision, probation, or convicted of an offense listed below or determines that there is a serious concern for the protection and safety of the public, the Ethics Officer shall present to the Disciplinary Hearing Panel a recommendation for summary suspension of the registrant's or certificant's registration or certification. If approved by a majority vote of the Disciplinary Hearing Panel, the Ethics Officer shall notify the registrant or certificant in writing by certified mail, return receipt requested, of the summary suspension at the registrant's or certificant's address listed in the ATCB records. The suspension shall be effective three (3) days after the date of mailing.
Summary suspension shall be considered for all serious offenses including but not limited to the following:
(A) capital offenses;
(B) sexual offenses involving a child victim;
(C) felony sexual offenses involving an adult victim who is a client (one or more counts);
(D) multiple counts of felony sexual offenses involving any adult victim;
(E) homicide 1st degree;
(F) kidnapping;
(G) arson;
(H) homicide of lesser degrees;

(I) felony sexual offenses involving an adult victim who is not a client (single count);
(J) attempting to commit listed crimes;
(K) any felony or misdemeanor offenses potential physical harm to others and/or animals;
(L) felony or misdemeanor alcohol and drug offenses;
(M) all other felony offenses not listed.
A registration or certification summarily suspended shall remain suspended until final resolution of all criminal charges and a final decision of all complaints by the ATCB.
5.2.13 The ability of a complainant to withdraw a complaint shall be governed by the following standards:
(A) The complaint may be withdrawn in the initial stage of the examination by the Public Member Director; however, the Public Member Director or the ATCB reserves the right to refile the complaint if, in his or her judgment, there is concern for the protection of the public.
(B) Once the complaint has moved to an Ethics Officer for review, it cannot be withdrawn; however, the complainant cannot be forced to assist further.
5.3 Procedures of the Disciplinary HearingPanel
5.3.1 Upon receipt of notice from the Ethics Officer containing a statement of the complaint allegations and the finding(s) that probable cause may exist to deny eligibility for credential or question compliance with the Standards of Conduct or any other ATCB policy or procedure, the applicant, registrant, or certificant shall have thirty (30) days after receipt of the notice to notify the Ethics Officer in writing that the applicant, registrant, or certificant disputes the allegations of the complaint and to request review by written submissions to the Disciplinary Hearing Panel, a telephone conference with the Disciplinary Hearing Panel, or an in-person hearing (held at a time and place to be determined by the panel), with the respondent bearing the respondent's own ex-penses for such hearing.
5.3.2 If the applicant, registrant, or certificant (respondent) does not contest the allegations of the complaint, the respondent may still request review by written submissions to the Disciplinary Hearing Panel, a telephone conference with the Disciplinary Hearing Panel, or an in-person hearing (held at a time and place to be determined by the panel), with the applicant, registrant, or certificant bearing the respondent's own expenses for such hearing, concerning the appropriate sanction(s) to be applied in the case.
5.3.3 If the applicant, registrant, or certificant does not submit a written statement contesting
the allegations or notify the board of a request for review by written submission, telephone conference or in-person hearing as set forth in this paragraph, then the Disciplinary Hearing Panel shall render a decision based on the evidence available and apply sanctions as it deems appropriate.
5.3.4 If the applicant, registrant, or certificant requests a review, telephone conference, or hearing, the following procedures shall apply:
5.3.4.1 The Ethics Officer shall forward the allegations and any written statement from the applicant, registrant, or certificant to the Disciplinary Hearing Panel, and shall present the allegations and any substantiating evidence, examine and cross-examine witnesses, and otherwise present the matter during any hearing of the Disciplinary Hearing Panel.
5.3.4.2 The Disciplinary Hearing Panel shall then schedule a written review, or telephone or in-person hearing as requested by the applicant, registrant, or certificant, allowing for an adequate period of time for preparation, and shall send by certified mail, return receipt requested, a notice to the applicant, registrant, or certificant and the complainant. The notice shall include a statement of the standards allegedly violated, the procedures to be followed, and the date for submission of materials for written review, or the time and place of any hearing, as determined by the Disciplinary Hearing Panel. The applicant, registrant, or certifi-cant and the complainant may request a change in the date of any hearing for good cause, which shall not unreasonably be denied.
5.3.4.3 The Disciplinary Hearing Panel shall maintain a verbatim audio, video, or written transcript of any telephone or in-person hearing.
5.3.4.4 During any proceeding before the Disciplinary Hearing Panel, all parties may consult with and be

represented by counsel at their own expense. At any hearing, all parties or their counsel may make opening statements, present relevant documents or other evidence and relevant testimony, examine and cross-examine witnesses under oath, make closing statements, and present written briefs as scheduled by the Disciplinary Hearing Panel.

5.3.4.5 The Disciplinary Hearing Panel shall determine all evidentiary and procedural matters relating to any hearing or written review. Formal rules of evidence shall not apply. Relevant evidence may be admitted. The chair, subject to the majority vote of the full panel, shall determine disputed questions regarding procedures or the admission of evidence. All decisions shall be made on the record.

5.3.4.6 The burden shall be upon the ATCB to demonstrate a violation by preponderance of the evidence.

5.3.4.7 Whenever there is a reasonable concern that the mental or behavioral abilities of the applicant, registrant, or certificant may be impaired, calling into question the ability to competently, safely and professionally provide art therapy services, the respondent may be required to undergo a mental or behavioral health examination at the respondent's own expense. The report of such an examination shall become part of the evidence considered.

5.3.4.8 The Disciplinary Hearing Panel shall issue a written decision following any telephone or in-person hearing or written review and any submission of briefs. The decision shall contain findings of fact, a finding as to the truth of the allegations, and any sanctions applied. It shall be mailed by certified mail, return receipt requested, to the applicant, registrant, or certificant and complainant.

5.3.4.9 If the Disciplinary Hearing Panel finds that the allegations have not been proven by a preponderance of the evidence, no further action shall be taken, and the applicant, registrant, or certificant, and the complainant, if any, shall be notified by certified mail.

5.3.4.10 If the Disciplinary Hearing Panel finds that the allegations have been proven by a preponderance of the evidence it shall assess one or more appropriate public sanctions as set forth below:

(1) deny, refuse to issue, or refuse to renew a registration or certification;
(2) revoke or suspend a registration or certification;
(3) probate a suspension of a registration or certification;
(4) issue a reprimand.
(5) publish the rule violation and the sanction imposed;
(6) require mandatory remediation through specific education, treatment, and/or supervision;
(7) require that the registrant or certificant take appropriate corrective action(s);
(8) provide referral or notice to governmental bodies of any final determination made by the ATCB; or
(9) other corrective action.

The Disciplinary Hearing Panel will determine the length of the probation or suspension. If the Disciplinary Hearing Panel probates the suspension of a registration or certification, it may require the registrant or certificant to:

(1) report regularly to the Ethics Officer on matters that are conditions of the probation;
(2) limit practice to the areas prescribed by the Disciplinary Hearing Panel; or
(3) complete additional educational requirements, as required by the Disciplinary Hearing Panel to address the areas of concern that are the basis of the probation.
(4) provide periodic progress reports from the registrant's or certificant's health care providers.
(5) provide periodic supervision reports from the registrant's or certificant's supervisor.

All public sanctions shall be listed on the ATCB's website and accessible to the general public and/or published in the ATCB's official publication.

5.3.4.11 An individual whose registration or certification is revoked is not eligible to apply for a registration or certification for a minimum of three years after the date of revocation. The ATCB may consider the findings that resulted in revocation and any other relevant facts in determining whether to deny the application if an otherwise complete and sufficient application for a registration, or certification is submitted after three years have elapsed since revocation.

5.3.4.12 A voluntary surrender of a registration or certification accepted by the ATCB in response to a grievance or complaint shall be deemed to be an admission to the alleged violations and may be considered as such by the Disciplinary Hearing Panel in rendering its decision.

5.4 Appeal Procedures

5.4.1 If the decision rendered by the Disciplinary Hearing Panel is not favorable to the applicant, registrant, or certificant (respondent), the respondent may appeal the decision to the ATCB Board of Appeals by submitting to the Executive Director a written appeal statement within thirty (30) days following receipt of the decision of the Disciplinary Hearing Panel. The Disciplinary Hearing Panel shall grant any reasonable requests for extensions.

5.4.2 The Disciplinary Hearing Panel may file a written response to the appeal with the Executive Director.

5.4.3 The Executive Director shall immediately forward any appeal documents to the ATCB Board of Appeals.

5.4.4 The ATCB Board of Appeals by majority vote shall render a decision on the record without further hearing, although written briefs may be submitted on a schedule reasonably determined by the Board of Appeals. On matters on which the ATCB Public Member has initiated a complaint or performed the initial review, the Public Member shall not be part of the ATCB Board of Appeals.

5.4.5 The decision of the ATCB Board of Appeals shall be rendered in writing following receipt and review of briefs. The decision shall contain findings of fact, findings as to the truth of the allegations, and any sanctions applied and the decision shall be final.

5.4.6 The decision of the ATCB Board of Appeals shall be communicated to the applicant, registrant, or certificant by certified mail, return receipt requested. The complainant, if any, shall be notified of the Board of Appeals' final decision.

5.5 Bias, Prejudice, Impartiality

5.5.1 At all times during the ATCB's handling of any matter, the ATCB shall extend impartial review. If at any time during the ATCB's review of a matter an applicant, registrant, certificant, or any other person identifies a situation where the judgment of a reviewer may be biased or prejudiced or impartiality may be compromised (including employment with a competing organization), such person shall immediately report such matter to the Executive Director or President of the ATCB.

5.5.2 In matters where impartiality may be compromised, the reviewer shall self-recuse.

APPENDIX 4 – PUBLIC COMMENT

NOTE: The next section of the report will incorporate oral comments received during the Public Hearing held on June 26, 2018 and a summary of written comments received until 5:00 p.m. on July 27, 2018. The Regulatory Research Committee's next meeting is scheduled for August 23, 2018 where it will consider recommendations to the Full Board.

Virginia Department of Health Professions

DRAFT

August 23, 2018
BHP Full Board Meeting

Board of Health Professions Full Board Meeting

August 23, 2018
10:00 a.m. - Board Room 4
9960 Mayland Dr, Henrico, VA 23233

In Attendance	Kevin Doyle, EdD, LPC, LSATP, Board of Counseling
	Allen R. Jones, Jr., DPT, PT, Board of Physical Therapy
	Derrick Kendall, NHA, Board of Long-Term Care Administrators
	Trula E. Minton, MS, RN, Board of Nursing
	Kevin P. O'Connor, MD, Board of Medicine
	Martha S. Perry, MS, Citizen Member
	Herb Stewart, PhD, Board of Psychology
	Jacquelyn Tyler, RN, Citizen Member
	Laura P. Verdun, MA, CCC-SLP, Board of Audiology & Speech-Language Pathology
	James Wells, RPh, Citizen Member
Absent	Lisette P. Carbajal, Citizen Member
	Helene D. Clayton-Jeter, OD, Board of Optometry
	Mark Johnson, DVM, Board of Veterinary Medicine
	Ryan Logan, RPh, Board of Pharmacy
	Maribel E. Ramos, Citizen Member
	James D. Watkins, DDS, Board of Dentistry
	Vacant – Board of Social Work
	Vacant – Board of Funeral Directors and Embalmers
DHP Staff	Barbara Allison-Bryan, Deputy Director, DHP
	David Brown, Director, DHP
	Elizabeth A. Carter, Ph.D., Executive Director BHP
	Jaime Hoyle, Executive Director Behavioral Sciences Boards, DHP
	Laura L. Jackson, MSHSA, Operations Manager, BHP
	Elaine Yeatts, Senior Policy Analyst DHP
	Diane Powers, Communications Director, DHP
	Corie Tillman Wolf, Executive Director, Boards of Funeral Directors and Embalmers, Physical Therapy, Long-Term Care Directors, DHP
OAG Representative	Charise Mitchell

Presenters	Amy Marschean, DARS
	Dr. Richard Lindsay, Lindsay Institute for Innovations in Caregiving
	Christine Jensen, PhD, Riverside
	Stephanie Willinger, Deputy Director,
	Stephanie Willinger, Deputy Executive Director Licensing, Board of Nursing
	Na'im Campbell, Backgrounds Investigation Supervisor, CBC Unit DHP
Speakers	No speakers signed-in
Observers	Sarah Deaver, AATA
	Kandra Orr
	Terri Giller, VATA
	Darlene Green, VATA
	Carol Olson, VATA
	Gretchen Graves, VATA
Media	Katie O'Connor, Virginia Mercury
Emergency Egress	Dr. Carter

Call to Order

Acting Chair: Dr. Jones, Jr. **Time** 10:02 a.m.

Quorum Established

Public Comment

Discussion

There was no public comment

Approval of Minutes

Presenter Dr. Jones, Jr.

Discussion

The June 26, 2018 Full Board meeting minutes were approved with no revisions. All members in favor, none opposed.

Welcome

Presenter Dr. Jones, Jr.

Dr. Allen R. Jones, Jr. was acting Chair for this meeting as Dr. Clayton-Jeter is out of the state on business. He thanked the board members for their commitment to the Commonwealth and thanked staff for their work and dedication to DHP.

Directors Report

Presenter Dr. Brown

Discussion

Dr. Brown stated that the agency is gearing up for the 2019 legislative session.

In follow-up to the 2018 session:

- Dr. Brown briefed the Board on an upcoming e-prescribing meeting;
- Dr. Allison-Bryan will be meeting with stakeholders to take a preliminary look into regulating community health workers;
- DHP will be convening a meeting of the Behavioral Sciences Unit, Board of Nursing and Board of Medicine to come up with a common set of regulations regarding conversion therapy for minors;
- A workgroup will be convening to see how the PMP may be automated for greater efficiency in ER physicians notifying prescribers of a patient overdose;
- In lieu of yearly board member orientation, DHP will be initiating at the board level, 45 minute board member orientation sessions to train board members on changes relevant to the board and the agency;
- Ms. Hahn and Dr. Allison-Bryan are continuing to work with Virginia State Police and the Henrico County Crime Prevention Environmental Divide Unit to establish agency safety protocol.

Invited Presentations

Presenter Ms. Marschean

Virginia Family Caregivers

Dr. Richard Lindsay provided a PowerPoint presentation on the status of today's caregiving community. Ms. Marschean followed up with an overview of the Virginia Department for Aging and Rehabilitative Services report on Recommendations for Improving Family Caregiver Support in Virginia 2018. Dr. Jenson provided details of different approaches Riverside is taking to support their staff of caregivers.

Criminal Background Checks

Presenter Ms. Willinger

Discussion

Ms. Willinger provided a PowerPoint presentation on how the Virginia Board of Nursing obtained authority and the methods and impact on public safety of criminal background checks. The Board of Pharmacy is also utilizing CBCs for applicants seeking a Pharmaceutical Processor permit. *Attachment 1*

***Break**

Regulatory Research Committee - Art Therapist Study Recommendation

Presenter Mr. Wells

Discussion

Mr. Wells provided information regarding the Committee's recommendation to license Art Therapists in Virginia. He stated that the burden of regulation was justified and proof of The Criteria was supported.

Motion

A motion was made to accept the recommendation of the Regulatory Research Committee to license Art Therapists in Virginia was made and by a vote of eight (8) members in favor, one (1) opposed, was properly seconded.

Legislative and Regulatory Report

Presenter Ms. Yeatts

Discussion

Ms. Yeatts advised the Board that there are 13 proposals to move forward in the 2019 legislative session. Updates to regulations and General Assembly legislative actions relevant to DHP were also provided. *Attachment 2*

***Lunch**

Executive Directors Report

Presenter Dr. Carter

Board Budget

Dr. Carter stated that the Board is operating within budget.

Agency Performance

Dr. Carter reviewed the agencies performance measures in relation to clearance rate, age of pending caseload and time to disposition.

Sanction Reference Points (SRP) - Update

Dr. Carter advised that the Board of Long Term Care had just completed its latest SRP revisions, and the Board of Dentistry is next.

Policies and Procedures

Dr. Carter discussed the updating of the Board's sunrise policies and procedures guidance document, and that the matter will be placed on the December agenda for the full Board's consideration and vote.

New FTE Allocation

Dr. Carter advised the Board of a new FTE to the unit. Dr. Allison-Bryan added that the agency's statistical analysis and data reporting functions are returning to BHP. The new data analyst position will focus on data validation, analysis and reporting, methods documentation, and providing technical analytic support related to agency performance measures, strategic planning, and support for DHP HWDC increasing users.

Healthcare Workforce Data Center (HWDC)

Presenter Dr. Carter

Discussion

Dr. Carter stated that all 2017 profession workforce surveys have been approved by the respective Board and are posted on the agencies website. HWDC collaboration with VLDS is still ongoing. The HWDC released its first newsletter in August with quarterly reports to follow.

Board Reports

Presenter Dr. Jones, Jr.

Board of Audiology & Speech Language Pathology

Ms. Verdun was not in attendance.

Board of Counseling

Dr. Doyle stated that the Board of Counseling is convening a Supervisor's Summit on September 7, 2018 that will allow an opportunity to explain the laws and regulations around supervision. He stated that the board is also registering Qualified Mental Health Professionals. With the additional of QMHPs, the Board of Counseling now has an applicant count of over 24,000. He stated that the Behavioral Sciences Boards would also be participating in the conversion therapy for minor's workgroup.

Board of Dentistry

Dr. Watkins was not in attendance.

Board of Funeral Directors & Embalmers

The seat for this Board is currently vacant.

Board of Long Term Care Administrators

Mr. Kendall stated that the Board has finalized its revisions to the Sanction Reference Point manual and that the periodic review of the Regulations Governing the Practice of Nursing Home Administrators was in its final stage at the Secretary's Office. He was happy to announce that the Board has no vacancies at this time.

Board of Medicine

Dr. O'Connor reported that the board has five (5) new members. The Executive Committee met August 3, 2018 and discussed autonomous practice for Nurse Practitioners; the Board is currently undergoing a periodic review of regulations; and the Board of Medicine will be participating in the conversion therapy for minor's workgroup.

Board of Nursing

Ms. Minton attended the 40th annual NCSBN national meeting and was very excited to announce that Ms. Douglas, Executive Director for the Board of Nursing, has been appointed to the NCSBN Board. She also advised that the NCSBN is working to address the role of nurses working with patients who use medical marijuana. She also discussed that "Nursing Now" is a global campaign that aims to improve health by raising the profile of nursing worldwide.

Board of Optometry

Dr. Jones, Jr. provided the report as follows:

*Next meeting is scheduled for July 13, 2018.

Complaints FY2016: Received 13
Complaints FY2017: Received 36

Licenses (in state/out of state based on address of record provided by licensee)
FY2017: Total – 1,921 TPA – 1,148/390 DPA – 27/90 Professional Designations – 266
Y-T-D FY2018: Total – 1,929 TPA – 1,168/400 DPA – 20/84 Professional Designations – 257

Continuing Education: Audit has not yet commenced.

Regulatory Changes: The Board adopted emergency regulations for the prescribing of opioids, which became effective on 10/30/17. The final replacement regulations under review in the Secretary's office. In addition, a periodic review is in the proposed stage and is still under consideration by the administration.

In response to a petition for rulemaking, the Board moved forward with a NOIRA to add inactive licenses to the regulations.

Board of Pharmacy

Mr. Logan was not in attendance.

Board of Physical Therapy

Dr. Jones, Jr., reported that he is no longer the President of the Board, that Arkena Daily was appointed President at the August 16, 2018 meeting. He stated that the Virginia Board of Physical Therapy was chosen as one of two Boards across the country to receive the 2018 Excellence in Regulation Award from the Federation of State Boards of Physical Therapy (FSBPT). The Boards guidance documents have been reviewed and updated. The Board voted to pursue legislation to enact the Physical Therapy Licensure Compact.

Board of Psychology

Dr. Stewart stated they have approximately 6,500 applicants. The Board has a member seat specific to applied psychologist and due to the low number in the profession, this seat has been vacant for an extended period of time. The board is considering requesting reallocation of the seat. The Board is performing a top to bottom review of existing regulations and has submitted for a one-time fee reduction. The Board of Psychology will also be participating in the conversion therapy for minor's workgroup. In July, the Board voted to endorse PSYPAC and it has been added to 2019 legislation.

Board of Social Work

The seat for this Board is currently vacant.

Board of Veterinary Medicine

Dr. Johnson was not in attendance.

New Business

Presenter Dr. Jones, Jr.

There was no new business to discuss.

Next Full Board Meeting – December 4, 2018

Presenter Dr. Jones, Jr.

Dr. Jones, Jr. announced the next Full Board meeting date as December 4, 2018.

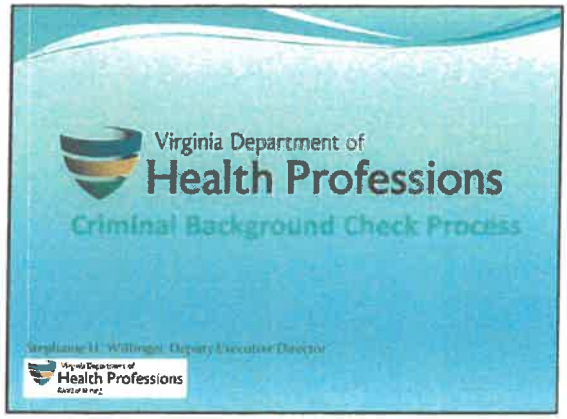
Adjourned 1:26 p.m.

Acting Chair Allen R. Jones, Jr., DPT, PT

Signature: _____ Date: _____/_____/_____

Board Executive Director Elizabeth A. Carter, Ph.D.

Signature: _____ Date: _____/_____/_____



Objectives

- Authority for Criminal Background Checks ("CBCs")
- Method for CBCs
- CBCs and impact on public safety
- Terms, Tools and Resources used by VBON in the Criminal Background Check ("CBC") process
- Identify how CBC information may be utilized in licensure decision making

Who?

- Applicants seeking initial licensure from the Board of Nursing for Registered Nurse (RN), License Practical Nurse (LPN) and Licensed Massage Therapist (LMT)(applicants includes licensure by exam, endorsement and reinstatement).
- Applicants seeking a Pharmaceutical Processor permit from the Board of Pharmacy (applicants include all owners/operators).

Current Authority for CBCs (DHP)

- Virginia Code § 54.1-3035.1 (Effective 1/1/16):

The Board shall require each applicant for licensure as a practical nurse, registered nurse or licensed massage therapist to submit fingerprints and provide personal descriptive information to be forwarded along with his fingerprints through the Central Criminal Records Exchange to the Federal Bureau of Investigation for the purpose of obtaining criminal history record information...

- Virginia Code § 54.1-3442.6 (Starting in 8/18):

The Board shall require an applicant for a pharmaceutical processor permit to submit to fingerprinting and provide personal descriptive information to be forwarded along with his fingerprints through the Central Criminal Records Exchange to the Federal Bureau of Investigation for the purpose of obtaining criminal history record information...

Licensed Massage Therapist added effective January 1, 2017.

How?

- **Fingerprint-based** and entail a state (through Virginia State Police or VSP) and FBI (national) search.
- DHP CBC vendor is Fieldprint VA.
- Applicants request fingerprint appointment through Fieldprint VA (secure web-based portal).
- Fingerprinting is done via electronic transmission or *Live Scan* service.
- *Live Scan* service is available to our applicants in over 1,200 sites around the US, Virgin Islands and Puerto Rico.

Why?

- Required by law.
- Fingerprint-based CBCs are objective and reliable.
- Casts a wider 'net' to include more than just single state criminal history information.
- Applicants with criminal histories may omit information on applications.
- Allows better 'vetting' of applicant backgrounds in the interest of public safety.

What?

- **Criminal background check(CBC) –**using fingerprints (biometrics), a search for evidence of an individual's criminal history in the national criminal history record files (FBI) and state criminal justice data repositories (VSP).
- **Criminal conviction record** means criminal history information obtained from a variety of sources pertaining to an individual's conviction of a crime.
- **Source Documents –** Includes arrest reports, charging documents, pre-sentence reports, plea agreements, sentencing reports, court conviction documents, probation reports.
- **FBI identification record-**a listing of certain information taken from fingerprint cards, submitted to and retained by the FBI. If a criminal offense, the identification record includes the date arrested or received, the arrest charge, and the disposition of the arrest if known to the FBI *and as submitted* by agencies having criminal justice responsibilities.
- **RAP Sheet-**Record of Arrests and Prosecution as maintained by state and federal databases (e.g. FBI/VSP).

What is a considered a Criminal Conviction?

- The final judgement on a verdict or finding of guilty, plea of guilty, or a plea of *nolo contendere* and does not include a final judgment which has been *expunged* by pardon, reversed, set aside or otherwise rendered nugatory (See Black's Law Dictionary).
- In Virginia, a "conviction" occurs upon a verdict or finding of guilt, the pronouncement of sentence, and the entry of the final order by the trial court (See Rule 1:1 Virginia Supreme Court).

Disclosure

License/Permit Applicants are required to disclose:

- Any convictions (as defined).

Applicants are not required to disclose:

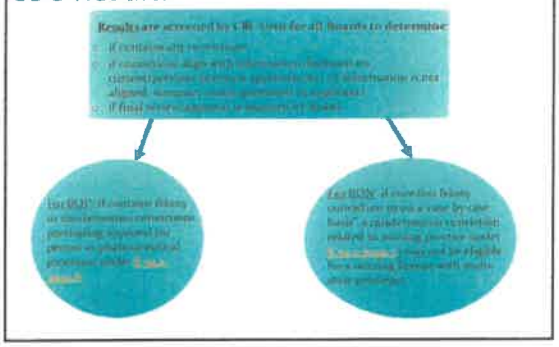
- Arrests if not convicted and no further action resulted from the arrest(s).
- However, if an applicant was fingerprinted upon arrest for a criminal offense, it will show up on a 'RAP' sheet.

How long?

DHP receives CBC Results:

- **24-48 hours** to receive electronic response for those applicants **without** arrest/conviction history.
- **15-30 days** to receive 'hard copy' results for those applicants **with** arrest/conviction history mailed to DHP CBC Unit by VSP.

CBC Results



Convictions Referred for Board Actions under § 54.1-3007

- Conviction of any felony or any misdemeanor involving "moral turpitude" (lying, cheating, stealing, etc.).
- Convictions that indicate a possible impairment or pattern of impairment (DUI, drug possession, etc.).
- Convictions not disclosed on current or previous applications.
  - Failure to disclose convictions may be considered *fraud or deceit in procuring or attempting to procure a license.*

Screening Applications for Determination

For Nursing:

- License applications are screened case by case and there are NO absolute bars to obtaining a nursing or massage therapist license. However, the following factors are considered:
  - Number and/or pattern of convictions.
  - Nature of convictions.
  - Recency of convictions (See: BON Guidance 90-19 and BON Guidance 90-59).
- RN/LPN license applications are screened for felony convictions and misdemeanor convictions related to nursing practice. If determined, applicant is only eligible for a *single state* license (VA only), as part of the new Uniform Licensure Requirements (ULRs) under the *Enhanced Nurse Licensure Compact* (eNLC).

For Pharmacy:

- Applicants with any felony conviction(s) or any offense referenced in section F of Virginia Code § 54.1-3442.6 are not eligible for a permit to operate a pharmaceutical processor.

See also DHP joint Statement with the VBON with regard to the impact of criminal histories on licensure (or employment) at: [illegible]

On the Horizon

CBCs for Board of Physical Therapy:

- Board of Physical Therapy contemplating entering the Physical Therapy Compact which would require CBCs for licensure applicants similar to requirements of Enhanced Nurse Licensure Compact (eNLC).
- CBC requirement would have to be included in any proposed legislation to revise laws/regulations.

Attachment 2

Board **Board of Audiology and Speech-Language Pathology**

Chapter		Action / Stage Information
[18 VAC 30 - 21]	Regulations Governing the Practice of Audiology and Speech-Language Pathology	Endorsement requirements [Action 5007] Fast-Track - *Register Date: 8/6/18* [Stage 8225]

Board **Board of Counseling**

Chapter		Action / Stage Information
[18 VAC 115 - 20]	Regulations Governing the Practice of Professional Counseling	Credential review for foreign graduates [Action 5089] NOIRA - *At Governor's Office* [Stage 8338]
[18 VAC 115 - 20]	Regulations Governing the Practice of Professional Counseling	Acceptance of doctoral practicum/internship hours towards residency requirements [Action 4829] Proposed - *Register Date: 8/6/18* [Stage 8140]
[18 VAC 115 - 30]	Regulations Governing the Certification of Substance Abuse Counselors	Updating and clarifying regulations [Action 4691] Proposed - *At Governor's Office* [Stage 8021]
[18 VAC 115 - 70]	Regulations Governing the Registration of Peer Recovery Specialists [under development]	Initial regulations for registration [Action 4890] Proposed - *At Secretary's Office* [Stage 8296]
[18 VAC 115 - 80]	Regulations Governing the Registration of Qualified Mental Health Professionals [under development]	Initial regulations for registration [Action 4891] Proposed - *DPB Review in progress* [Stage 8297]

Board **Board of Dentistry**

Chapter		Action / Stage Information
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Change in renewal schedule [Action 4975] NOIRA - *Register Date: 8/6/18* [Stage 8169]
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Amendment to restriction on advertising dental specialties [Action 4920] NOIRA - *Register Date: 8/6/18* [Stage 8235]
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Administration of sedation and anesthesia [Action 5056] NOIRA - *Register Date: 8/6/18* [Stage 8292]
[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Prescribing opioids for pain management [Action 4778] Proposed - *Register Date: 7/9/18* [Stage 8060]

[18 VAC 60 - 21]	Regulations Governing the Practice of Dentistry	Conforming rules to ADA guidelines on moderate sedation [Action 4748] Final - *At Governor's Office* [Stage 8233]
[18 VAC 60 - 25]	Regulations Governing the Practice of Dental Hygienists	Continuing education for practice by remote supervision [Action 4917] Fast-Track - *Register Date: 8/6/18* [Stage 8288]
[18 VAC 60 - 30]	Regulations Governing the Practice of Dental Assistants	Education and training for dental assistants II [Action 4916] NOIRA - *Register Date: 8/6/18* [Stage 8069]

Board **Board of Funeral Directors and Embalmers**

Chapter		Action / Stage Information
[18 VAC 65 - 20]	Regulations of the Board of Funeral Directors and Embalmers	Students assisting with embalming [Action 5105] Fast-Track - *DPB Review in progress* [Stage 8360]
[18 VAC 65 - 20]	Regulations of the Board of Funeral Directors and Embalmers	Clarification of permission to embalm and refrigeration of human remains [Action 4765] Final - *At Governor's Office* [Stage 8282]
[18 VAC 65 - 20]	Regulations of the Board of Funeral Directors and Embalmers	CE credit for board meetings [Action 4806] Final - *At Secretary's Office* [Stage 8283]
[18 VAC 65 - 40]	Regulations for the Funeral Service Intern Program	Oversight of funeral intern program [Action 4895] NOIRA - *Register Date: 8/6/18* [Stage 8183]

Board **Department of Health Professions**

Chapter		Action / Stage Information
[18 VAC 76 - 20]	Regulations Governing the Prescription Monitoring Program	(E) Definition of covered substances [Action 5088] Final - *Register Date: 9/3/18* [Stage 8337]

Board **Board of Long-Term Care Administrators**

Chapter		Action / Stage Information
[18 VAC 95 - 20]	Regulations Governing the Practice of Nursing Home Administrators	Periodic review [Action 4723] Final - *At Secretary's Office* [Stage 8173]

Board **Board of Medicine**

Chapter		Action / Stage Information
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine,	Supervision and direction for laser hair removal [Action 4860] Proposed - *At Governor's Office* [Stage 8174]

	Podiatry, and Chiropractic	
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic	Licensure by endorsement [Action 4716] Final - *Register Date: 8/6/18* [Stage 8266]
[18 VAC 85 - 21]	Regulations Governing Prescribing of Opioids and Buprenorphine	Initial regulations [Action 4760] Final - *Register Date: 7/9/18* [Stage 8216]
[18 VAC 85 - 50]	Regulations Governing the Practice of Physician Assistants	Definitions of supervision and weight loss rules [Action 4943] Fast-Track - *Register Date: 8/6/18* [Stage 8217]
[18 VAC 85 - 130]	Regulations Governing the Practice of Licensed Midwives	Practical experience under supervision [Action 4944] Fast-Track - *Register Date: 8/6/18* [Stage 8115]
[18 VAC 85 - 170]	Regulations Governing the Practice of Genetic Counselors	Temporary licensure [Action 5066] Fast-Track - *At Secretary's Office* [Stage 8308]

Board **Board of Nursing**

Chapter		Action / Stage Information
[18 VAC 90 - 19]	Regulations Governing the Practice of Nursing	Clarification of 90-day authorization to practice [Action 5058] Fast-Track - *At Secretary's Office* [Stage 8294]
[18 VAC 90 - 19]	Regulations Governing the Practice of Nursing	Clinical nurse specialist requirement for registration [Action 5059] Fast-Track - *At Secretary's Office* [Stage 8295]
[18 VAC 90 - 27]	Regulations Governing Nursing Education Programs	Definition of full approval and timing of criminal background checks for nursing education programs [Action 4926] Fast-Track - *Register Date: 8/6/18* [Stage 8077]
[18 VAC 90 - 30]	Regulations Governing the Licensure of Nurse Practitioners	Supervision and direction of laser hair removal [Action 4863] Proposed - *At Secretary's Office* [Stage 8259]
[18 VAC 90 - 40]	Regulations for Prescriptive Authority for Nurse Practitioners	Elimination of separate license for prescriptive authority [Action 4958] NOIRA - *Register Date: 7/23/18* [Stage 8137]
[18 VAC 90 - 40]	Regulations for Prescriptive Authority for Nurse Practitioners	Prescribing of opioids [Action 4797] Proposed - *Register Date: 7/9/18* [Stage 8063]

Board **Board of Optometry**

Chapter	Action / Stage Information

[18 VAC 105 - 20]	Regulations of the Virginia Board of Optometry	Inactive licenses [Action 5006] NOIRA - *Register Date: 8/6/18* [Stage 8224]
[18 VAC 105 - 20]	Regulations of the Virginia Board of Optometry	Periodic review [Action 4780] Proposed - *At Governor's Office* [Stage 8042]
[18 VAC 105 - 20]	Regulations of the Virginia Board of Optometry	Prescribing of opioids [Action 4892] Proposed - *At Secretary's Office* [Stage 8222]

Board **Board of Pharmacy**

Chapter		Action / Stage Information
[18 VAC 110 - 20]	Regulations Governing the Practice of Pharmacy	Brown bagging and white bagging [Action 4968] NOIRA - *Register Date: 8/6/18* [Stage 8158]
[18 VAC 110 - 20]	Regulations Governing the Practice of Pharmacy	Delivery of dispensed prescriptions; labeling [Action 5093] NOIRA - *At Governor's Office* [Stage 8346]
[18 VAC 110 - 20]	Regulations Governing the Practice of Pharmacy	Controlled substances registration for naloxone and teleprescribing [Action 4789] Proposed - *Register Date: 7/9/18* [Stage 8101]
[18 VAC 110 - 20]	Regulations Governing the Practice of Pharmacy	Periodic review result of Chapters 20 and 50; Promulgation of Chapters 16 and 25 [Action 4538] Proposed - *At Governor's Office* [Stage 8119]
[18 VAC 110 - 20]	Regulations Governing the Practice of Pharmacy	Requirement for applicants and licensees to have an e-profile ID number [Action 4909] Proposed - *Register Date: 9/17/18* [Stage 8253]
[18 VAC 110 - 20]	Regulations Governing the Practice of Pharmacy	Increase in fees [Action 4938] Proposed - *At Secretary's Office* [Stage 8270]
[18 VAC 110 - 20]	Regulations Governing the Practice of Pharmacy	Rescission of pharmacy permit [Action 5080] Fast-Track - *At Agency* [Stage 8328]
[18 VAC 110 - 20]	Regulations Governing the Practice of Pharmacy	Prohibition against incentives to transfer prescriptions [Action 4186] Final - *At Governor's Office* [Stage 7888]
[18 VAC 110 - 20]	Regulations Governing the Practice of Pharmacy	Response to petitions for rulemaking [Action 4694] Final - *At Governor's Office* [Stage 8157]
[18 VAC 110 - 20]	Regulations Governing the Practice of Pharmacy	(E) Scheduling of drugs or chemicals [Action 5082] Final - *Register Date: 8/6/18* [Stage 8330]

[18 VAC 110 - 50]	Regulations Governing Wholesale Distributors, Manufacturers and Warehousers	Delivery of Schedule VI prescription devices [Action 5084] Emergency/NOIRA - *AT Attorney General's Office* [Stage 8333]
[18 VAC 110 - 50]	Regulations Governing Wholesale Distributors, Manufacturers and Warehousers	(E) Registration of nonresident warehousers and nonresident third party logistics providers [Action 5083] Final - *AT Attorney General's Office* [Stage 8331]
[18 VAC 110 - 60]	Regulations Governing Pharmaceutical Processors	New regulations [Action 4695] Emergency/NOIRA - *AT Attorney General's Office* [Stage 8332]

Board **Board of Physical Therapy**

Chapter		Action / Stage Information
[18 VAC 112 - 20]	Regulations Governing the Practice of Physical Therapy	Practice of dry needling [Action 4375] Proposed - *At Governor's Office* [Stage 8144]
[18 VAC 112 - 20]	Regulations Governing the Practice of Physical Therapy	Type 2 CE credit for attendance at board meetings or hearings [Action 4971] Fast-Track - *At Secretary's Office* [Stage 8164]

Board **Board of Psychology**

Chapter		Action / Stage Information
[18 VAC 125 - 20]	Regulations Governing the Practice of Psychology	Periodic review amendments [Action 4897] Proposed - *At Secretary's Office* [Stage 8298]

Board **Board of Social Work**

Chapter		Action / Stage Information
[18 VAC 140 - 20]	Regulations Governing the Practice of Social Work	Hours of ethics for continuing education [Action 5010] NOIRA - *Register Date: 8/6/18* [Stage 8228]
[18 VAC 140 - 20]	Regulations Governing the Practice of Social Work	Examination requirements [Action 5011] Fast-Track - *Register Date: 8/6/18* [Stage 8230]
[18 VAC 140 - 20]	Regulations Governing the Practice of Social Work	BSW and LSW licensure [Action 5070] Fast-Track - *DPB's fast-track authorization pending* [Stage 8344]

Board **Board of Veterinary Medicine**

Chapter		Action / Stage Information
[18 VAC 150 - 20]	Regulations Governing the Practice of Veterinary	Reinspection for reinstatement [Action 5017]

	Medicine	Fast-Track - *Register Date: 8/6/18* [Stage 8242]
[18 VAC 150 - 20]	Regulations Governing the Practice of Veterinary Medicine	Prescribing of opioids [Action 4808] Final - *Register Date: 7/9/18* [Stage 8240]

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What is an Action?

Showing: 6 actions/stages currently being created, amended, or repealed for the Board of Medicine.

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Board of Medicine

Chapter	Action / Stage Information
Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic [18 VAC 85 - 20]	Action: Supervision and direction for laser hair removal Stage: Proposed - *Register Date: 10/29/18*
Regulations Governing the Practice of Physician Assistants [18 VAC 85 - 50]	Action: Definitions of supervision and weight loss rules Stage: Fast-Track - *Register Date: 8/6/18*
Regulations Governing the Practice of Licensed Midwives [18 VAC 85 - 130]	Action: Practical experience under supervision Stage: Fast-Track - *Register Date: 8/6/18*
Regulations Governing the Practice of Polysomnographic Technologists [18 VAC 85 - 140]	Action: Exemption for student/intern in polysomnographic technology (E) Stage: Final - *Register Date: 10/15/18*
Regulations Governing the Registration of Surgical Assistants and Surgical Technologists [18 VAC 85 - 160]	Action: Requirement for renewal of registration for surgical assistants (E) Stage: Final - *Register Date: 10/15/18*
Regulations Governing the Practice of Genetic Counselors [18 VAC 85 - 170]	Action: Temporary licensure Stage: Fast-Track - *At Governor's Office*

Agenda Item: Final Regulatory Action on Prescribing of Opioids and Buprenorphine by Nurse Practitioners

Included in your agenda package are:

Copy of Comments on proposed regulations

Copy of summary of comment

Copy of proposed regulations with suggested amendments

Proposed Action:

Adoption of final regulations as presented in agenda package or other amendments as adopted by the Board.

Boards of Medicine and Nursing

Summary of Public Comment on Regulations

Proposed regulations to replace emergency regulations for prescribing of opioids and buprenorphine by nurse practitioners were published on July 9, 2018 with comment requested until September 7, 2018. A public hearing was conducted on July 17, 2018. The following comments were received:

Commenter	Comment
Windy Y. Carson-Smith, Esq. Virginia Council of Nurse Practitioners	• Regulations are onerous and impede nurse practitioner (NP) ability to properly treat and diagnose pain. Other states are using guidance documents for prescribing, such as the guidance from the Centers for Disease Control. • Recommended revamping rulemaking to focus on refining the prescribing process to: 1) limit and provide alternative to prescribing narcotics; 2) using the existing prescription monitoring program to inform prescribers; 3) develop and utilize existing evidence-based program which have proven to reduce the use of opioids for management of pain; and 4) support the Governor's multifaceted program to address opioid abuse and addiction. The commenter provided a state-by-state chart on state response to opioid prescribing for those states that authorize NPs to prescribe Schedule II drugs.
Kurtis S. Elward, M.D. President Medical Society of Virginia	• Requests that the changes that were made in final regulations for physicians be also adopted in regulations for NPs, including an exclusion for sickle cell patients and changes in the frequency of urine drug screens • Supports continued supervision by a physician trained in substance abuse for medication-assisted treatment. NPs who are authorized to practice autonomously An equivalent of five years of practice with a SAMHSA-waivered physician would be required to practice collaboratively to prescribe buprenorphine until at least 2022.

Final regulations will be adopted by the Board of Medicine on October 18, 2018 and by the Board of Nursing on November 13, 2018.

MSV℠ MEDICAL SOCIETY OF VIRGINIA

VIA ELECTRONIC MAIL
Elaine Yeatts
Senior Policy Analyst
Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, VA 23233

July 31, 2018

Re: Prescribing of Opioids & Buprenorphine– Nurse Practitioner Regulations

Dear Ms. Yeatts:

I am writing to you as President of the Medical Society of Virginia (MSV) that serves as the voice for more than 30,000 physicians, residents, medical students, physician assistants and physician assistant students. Specifically, we wish to comment on the proposed text of the final regulations regarding prescribing of opioids and buprenorphine as it pertains to Nurse Practitioners. These regulations include 18 VAC 90-40-10 *et seq*.

You will recall that the MSV was instrumental in working with the Department of Health Professions (DHP) and many other stakeholders in developing the regulations governing prescribing of opioids and buprenorphine by licensees of the Board of Medicine. These Emergency Regulations became effective March 2017. At that point-in-time and throughout this process many efforts were made to ensure that the identical Emergency Regulations are in place for Physicians, Physician Assistants, Nurse Practitioners and Dentists. The proposal being considered by the Boards of Medicine and Nursing are to replace the Emergency Regulations for Nurse Practitioners (NPs) with final regulations.

When the Board of Medicine recently considered final regulations for Physicians and Physician Assistants, there were several changes that were accepted to improve patient care. These changes included an exclusion for patients being treated for sickle cell, anemia and changes to the frequency at which certain urine drug screenings are to be obtained.

The Medical Society respectfully but strongly requests that the final regulations being considered for Nurse Practitioners be amended to mirror the changes made by the Board of Medicine to the final regulations, noted above. We continue to fully support consistency and uniformity of the final regulations for all prescribers. Substance abuse and medication-assisted treatment are complex medical conditions. Completing SAMSHA is only part of the foundation which clinicians should have in treating these individuals who usually have other comorbid medical, behavioral and social issues. Supervision by a physician trained in substance abuse care is vital to the optimal treatment of these high risk individuals.

Nurse Practitioners and Physician Assistants were recently granted the ability to apply for a waiver to prescribe buprenorphine under the Comprehensive Addiction and Recovery Act (CARA), which was signed into law in July 2016, allowing NPs and PAs to begin applications to treating up to 30 patients beginning in early 2017.[i] CARA requires that NPs and PAs are licensed under state law to prescribe schedule III, IV, or V medications for the treatment of pain; they complete at least 24 hours of training and "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.[ii]" Given that NPs will be required to complete 5 years of collaborative practice with the population before being able to practice autonomously, NPs would be required to practice collaboratively to prescribe buprenorphine until at least 2022. Given that the regulations for autonomous practice have yet to be finalized, it is paramount that we honor the intent of the CARA Act and encourage collaboration to best serve patients.

In addition to federal law requirements, the Department of Medical Assistance Services (DMAS) requires licensed physician assistants or nurse practitioners who have completed the 24 hours of training required by SAMSHA to obtain a waiver to prescribe buprenorphine for opioid use disorder to only prescribe buprenorphine pursuant to a practice agreement with a waivered doctor of medicine or doctor of osteopathic medicine for Medicaid patients. [iii]

Thank you in advance for your consideration of the important points in this communication. Should you have any questions or if we may be a resource to DHP in this process, please do not hesitate to contact us.

Very truly yours,

Kurtis S. Elward, M.D., M.P.H., FAAFP

cc: Lauren Bates-Rowe, Assistant Vice President of Health Policy, MSV
Ralston C. King, Assistant Vice President or Government Affairs, MSV
W. Scott Johnson, Esquire, Hancock, Daniel & Johnson, PC
Tyler S. Cox, Manager, Government Affairs, Hancock, Daniel & Johnson, PC

[i] https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/qualify-np-pa-waivers
[ii] https://www.gpo.gov/fdsys/pkg/PLAW-114publ198/pdf/PLAW-114publ198.pdf
[iii] http://www.dmas.virginia.gov/files/links/330/Opioid%20Treatment%20Services%20Provider%20Manual%20Supplement.pdf

August 1, 2018

Elaine Yeatts, Senior Policy Analyst
Virginia Department of Health Professions
9960 Mayland Drive
Henrico, Virginia 23233

Re: Comments of Virginia Council of Nurse Practitioners on Opioid Regulation

Dear Ms. Yeatts:

The following capture my verbal comments presented at the July 17th Board of Nursing meeting. Please let me know if you need any additional information from me.

Best regards,

Windy Y. Carson-Smith, Esq.
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Thank you for the opportunity to respond to the proposed regulations on behalf of the Virginia Council of Nurse Practitioners. Given the existing opioid crisis in this country, we recognize a need for action. While we appreciate the Board of Medicine to address the opioid crisis, many states are adopting regulations to address this issue, none of which are quite as demanding or onerous as those currently being proposed. We believe that, if implemented, these regulations will impede nurse practitioners' ability to properly diagnose and treat pain. We have reviewed other states' regulations and have noted the following trends:

- Most states have developed multidisciplinary approaches to regulation[1] and rely on voluntary professional guidelines, such as the Washington State Guidelines for

[1] VCNP, Chart on Opioid Prescribing and NP Regulation, July 2018.

Prescribing Opioids[2] or the CDC Guidelines for Prescribing Opioids for Pain[3], or they have created their own using these documents as their base;

- Virtually every state, including Virginia, are using existing prescription monitoring programs and improving functionality. Many databases could not provide real time data – now most have that ability. As in the CDC guidelines, states are mandating review of patients' files in the database prior to prescribing;
- Board and State legislatures focus on improving the ability of prescribers to prescribe mandating and teaching providers how to diagnose pain for prescribing;
- In states with mandated limits on the dosages prescribed, most provide practitioners with the option of exceptions when the diagnosis requires such; and
- In states where additional regulations have been imposed, those regulations are based on improving the education of the prescriber and mandate more continuing education for nurse prescribers.[4]

Finally, the approach taken by the Medical Board seems inconsistent with the multipronged approach currently advocated by Governor Northam and health-related agencies. This proposal seems out of sync with the omnibus policy approach currently being utilized and funded by state and federal government. And, there is no documentation that controlling prescribing in this limited, narrow fashion will reduce opioid drug use. For these and other reasons, we strongly recommend reconsideration of this approach to regulating nurse prescribers and advocate working with the Administration on a comprehensive multidisciplinary approach.

Prescribing Guidelines

Nursing confronted opioid and narcotic prescribing long before the opioid crisis. When nurse practitioners negotiated prescribing authority, many state regulators required additional pharmacotherapeutic and pharmacology courses and continuing education for nurses to prescribe Schedule II substances.[5] States like New Jersey and Michigan specifically limited amounts of Schedule II drugs nurses could prescribe, while others limited Schedule II authority for nurse prescribers altogether.[6] When the opioid crisis emerged, state boards of nursing proactively reviewed those regulations, provided additional courses and workshops and worked both independently and with other health professions to develop guidelines and tools to address this crisis.

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[2] Interagency Guideline on Prescribing Opioids for Pain, http://www.agencymeddirectors.wa.gov/files/2015amdgopioidguideline.pdf

[3] CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

[4] See attached chart, Opioid Prescribing and NP Regulation

[5] Reference to my table.

[6] Nurse table

Omnibus State opioid prescribing guidelines have been developed in stages. Earlier guides (pre-2005) were developed with specific recommendations detailing dosages for specific conditions.[7] Early state guidelines focused on how prescribers could safely and effectively prescribe and manage chronic opioid analgesic therapy (COAT). More recent data and guidelines suggest that the focus should also be on preventing the inappropriate transition from acute and subacute opioid use to chronic opioid use and avoiding COAT altogether when other alternatives for treating pain may be equally effective and safer in the long-term.

Like the Washington Interagency and the CDC Guidelines, the emergency Virginia guidelines are detailed, cumbersome, and have specific limitations on the patient population they cover. The CDC guideline addresses primary care clinicians who are treating patients with chronic pain (i.e., pain lasting >3 months or past the time of normal tissue healing) in outpatient settings. Prescriptions by primary care clinicians account for nearly half of all dispensed opioid prescriptions, and the growth in prescribing rates among these clinicians has been above average.[8] The emergency Virginia guidelines address pain associated with specific disease, but do not and cannot cover all diseases, pain, and patient response. For example, a pediatric cancer patient's pain and an adult cancer patient's pain are vastly different. Early stage cancer versus end stage cancer patients differ considerably. Should the opioid prescribing for pain differ based on care setting? Should I receive a differing dosage if I choose hospice or home care over a hospital setting?

Although the focus is on primary care clinicians, because clinicians work within team-based care, the recommendations refer to and promote integrated pain management and collaborative working relationships with other providers (e.g. behavioral health providers, pharmacists, and pain management specialists). All regulators and policy makers acknowledge that the transition from the use of opioid therapy for acute pain to chronic pain is hard to predict and identify, and virtually all guidelines proposed or used by states are intended to inform clinicians who are considering prescribing opioid pain medication for painful conditions that can or have become chronic. Few guidelines address generational distinctions in pain and pain management.

Both Board guidelines, which are in excess of 50 pages long, stress their limitations on setting specific parameters for drugs and focus instead on teaching the prescribing process.

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[7] Federation of State Medical Boards chart on State Pain Regulation, http://www.fsmb.org/globalassets/advocacy/key-issues/pain-management-by-state.pdf

[8] Levy B, Paulozzi L, Mack KA, Jones CM. Trends in opioid analgesic-prescribing rates by specialty, U.S., 2007–2012. Am J Prev Med 2015;49:409–13.

As noted in both, when the ability to properly diagnose and prescribe is developed, there seems to be a diminished and more precise usage of opioids by all providers. While we appreciate the Board of Medicine's promulgation of similar regulations for the Board of Medicine, we suggest a method for ongoing review of the regulations to ensure that options exist to allow prescribers to adequately diagnose and prescribe.

The Governor's Multifaceted Program to Address Opioid Crisis in Virginia

Since entering office, Governor Northam has been actively engaged in the battle to contain the opioid crisis. Almost immediately after election, Virginia was tapped by the National Governor's Association to participate in a workgroup designed to study and address the opioid crisis. Shortly thereafter, Virginia received another $9.76 million in federal grant funding to help fight the opioid epidemic. This is the second consecutive year that the Department of Behavioral Health and Developmental Services (DBHDS) received a State Targeted Response Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Department of Health and Human Services. The continued funding will help Virginia's Community Services Boards (CSBs) provide many of the services and supports needed to fight the opioid crisis, including prevention, treatment, and recovery services for Virginians struggling with addiction across the Commonwealth.

The grant money will be used to continue efforts from the previous year to purchase medication, support medical staff necessary to prescribe and oversee clinical treatment, and to remove barriers to accessing treatment, such as transportation. These funds will also help provide the counseling and case management necessary to help individuals with opioid addiction stabilize their lives and begin the process of recovery.

This year's grant permits additional resources to be directed toward prevention of opioid use through strengthening existing local community coalitions that have formed across the Commonwealth to address addiction and rising drug overdose rates.

Grant funds will be used to fight the opioid epidemic in the following ways:

- DBHDS will allocate roughly half of the total grant funds to 24 locally-run community services boards—the organizations that are responsible for providing community-based behavioral health services. This will increase access to medically assisted treatment (MAT), which is the evidence-based gold standard for treatment of opioid addiction.
- $1.8 million will be used to support new and existing evidence-based strategic prevention framework grantees. These grantees, all of which are local community

coalitions, will address community gaps to prevent further drug and heroin abuse. The prevention funding will also support media campaigns in communities most impacted by the overdose crisis in Virginia.
- The remaining funding will support the development of partnerships with hospitals that will connect individuals who overdose with peers in recovery as well as continued funding of warm lines that offer peer support and information to callers.

The 24 CSBs were selected as part of the grant application, based on statistical measures of need. Amounts to each community are currently being determined and will be based on specific needs as assessed by overdose rates and other factors.

MAT and other addiction treatments are part of DBHDS' System Transformation Excellence and Performance (STEP-VA) plan, an innovative program for individuals with behavioral health disorders featuring a uniform set of required services, consistent quality measures, and improved oversight in all Virginia communities. The next phases of STEP-VA include completing the work required for all of Virginia's CSBs to implement Same Day Access, the installment of primary care screening and tight linkages to medical providers in all CSBs, addressing existing gaps in outpatient services, and including ensuring ongoing medication assisted treatment for substance use disorders.

The Virginia Commonwealth University School of Medicine's Department of Health Behavior and Policy evaluated the results of the program's first nine months, from April through December 2017. Highlights include:

- 16,600 Medicaid members received treatment for substance use disorder, a nearly two-thirds increase over the same nine months of the previous year.
- Of those, more than 10,500 members were treated for opioid addiction, a 51 percent increase from the same period of 2016.
- The total number of prescriptions for opioid pain medications for Medicaid members declined by nearly one-third over the evaluation period.
- Hospital emergency department visits by Medicaid members due to opioid use declined by nearly one-third, to 3,100 in the nine-month study period in 2017.

ARTS, Addictions Recovery Treatment Systems, encompasses a variety of innovative strategies and new models of care that have significantly increased treatment capacity. Virginia was the fourth state to obtain permission from federal health officials to use Medicaid funds for residential treatment facilities with more than 16 beds, greatly increasing access to residential services. It is one of the first states in the nation to fully integrate its substance use treatment services into managed care plans along with physical and mental health services.

"Other states and national policymakers recognize the progress we are making in Virginia to develop innovative treatment and recovery solutions," said Dr. Jennifer Lee, DMAS Director. "The new treatment models developed through the ARTS program are increasing access to services across the Commonwealth. Just as important, these new models are grounded in evidence-based practices that ensure the most effective care is available for our citizens."

The ARTS program strengthened qualifications for providers and increased reimbursement rates for those who follow research-guided treatment regimens. The Virginia Department of Health (VDH) and the Virginia Department of Behavioral Health and Developmental Services (DBHDS)

And, Governor Ralph Northam recently announced interconnectivity between the Commonwealth's secure Prescription Monitoring Program (PMP) database and North Carolina's Controlled Substance Reporting System, RxSentry. As a result, pharmacists and prescribers in both states will be able to see the prescription history of patients who may utilize health providers or pharmacists in both jurisdictions, improving the quality of care and decreasing the risk of prescription drug diversion. The interoperability is provided through Prescription Monitoring Program Interconnect™ (PMPi), a service of the National Association of Boards of Pharmacy (NABP). Other states interoperable with Virginia include: Alabama, Arizona, Connecticut, Delaware, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, New Mexico, New York, North Dakota, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Washington D.C., and West Virginia. These states are all part of a national network of 43 PMPs supported by NABP's PMPi.

In addition to expanding the interconnectivity of the PMP, the Commonwealth currently offers grants to promote integration of the PMP into electronic health records and other health platforms to promote use of the database. And Virginia health regulatory boards that license practitioners authorized to prescribe opioids to their patients and law enforcement officers also use the PMP to support investigations related to doctor shopping, diversion, and inappropriate prescribing and dispensing.

Conclusion

The Governor and other states' legislative and regulatory bodies are structuring their responses to the opioid crisis as multidisciplinary and patient-focused. They are using evidence-based strategies and approaches. They are using new and existing tools and publications to improve prescribing.

We support this approach and we strongly recommend review and revamping of the rulemaking to focus on:

- Refining the prescribing process to limit and provide alternatives to prescribing narcotics
- Using the existing prescription monitoring program (PMP) to inform prescribers of patients' drug history
- Develop and utilize existing evidence-based programs which have proven that with additional education and prescribing standards, reductions in the use of opioids for the management of pain occurs; and
- Support the Administration's multifaceted program to address opioid abuse and addiction.

Per my testimony, please find enclosed the state-by-state chart on state responses to opioid prescribing. It is limited to those states which have granted nurses the authority to prescribe Schedule II drugs.

Again, thank you for the opportunity to testify and to provide written testimony.

End Notes

Deniece A. Jukiewicz, Aisha Alhofaian, Zenora Thompson, Faye A. Gary, Reviewing opioid use, monitoring, and legislature: Nursing perspectives, International Journal of Nursing Sciences, 4:4 (2017), 430-436.
https://www.sciencedirect.com/science/article/pii/S2352013217300571

L.Leahy, The opioid epidemic: what does it mean for nurses?
J Psychosoc Nurs Ment Health Serv, 55 (1) (2017), pp. 18-23, 10.3928/02793695-20170119-03

Randall Hudspeth, Understanding Opioid Prescribing Practices of Advanced Practice Registered Nurses, (2010) *Journal of Nursing Regulation*, 1 (3), pp. 28-32.

Project 5096 - Other Action

BOARD OF NURSING

Prescribing of opioids

Part IV

Disciplinary Provisions

18VAC90-30-220. Grounds for disciplinary action against the license of a licensed nurse practitioner.

The boards may deny licensure or relicensure, revoke or suspend the license, or take other disciplinary action upon proof that the nurse practitioner:

1. Has had a license or multistate privilege to practice nursing in this Commonwealth or in another jurisdiction revoked or suspended or otherwise disciplined;

2. Has directly or indirectly represented to the public that the nurse practitioner is a physician, or is able to, or will practice independently of a physician;

3. Has exceeded the authority as a licensed nurse practitioner;

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

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

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

7. Has failed to comply with continuing competency requirements as set forth in 18VAC90-30-105;

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

9. Has engaged in unauthorized use or disclosure of confidential information received from the Prescription Monitoring Program, the electronic system within the Department of Health Professions that monitors the dispensing of certain controlled substances.

Part I

General Provisions

18VAC90-40-10. Definitions.

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

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

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

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

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

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

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

"MME" means morphine milligram equivalent.

"Nonprofit health care clinics or programs" means a clinic organized in whole or in part for the delivery of health care services without charge or when a reasonable minimum fee is charged only to cover administrative costs.

"Nurse practitioner" means an advanced practice registered nurse who has met the requirements for licensure as a nurse practitioner as stated in 18VAC90-30.

"Practice agreement" means a written or electronic agreement jointly developed by the patient care team physician and the nurse practitioner for the practice of the nurse practitioner that also describes the prescriptive authority of the nurse practitioner, if applicable. For a nurse practitioner licensed in the category of certified nurse midwife, the practice agreement is a statement jointly developed with the consulting physician.

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

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

Part V

Management of Acute Pain

18VAC90-40-150. Evaluation of the patient for acute pain.

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

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

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

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

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

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

18VAC90-40-160. Treatment of acute pain with opioids.

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

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

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

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

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

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

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

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

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

18VAC90-40-170. Medical records for acute pain.

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

Part VI

Management of Chronic Pain

18VAC90-40-180. Evaluation of the chronic pain patient.

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

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

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

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

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

1. The nature and intensity of the pain;

2. Current and past treatments for pain;

3. Underlying or coexisting diseases or conditions;

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

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

6. A urine drug screen or serum medication level;

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

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

9. A request for prior applicable records.

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

18VAC90-40-190. Treatment of chronic pain with opioids.

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

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

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

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

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

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

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

D. Due to a higher risk of fatal overdose when opioids, including buprenorphine, are given with other opioids, benzodiazepines, sedative hypnotics, carisoprodol, and tramadol [(an atypical

opioid)], the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.

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

18VAC90-40-200. Treatment plan for chronic pain.

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

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

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

18VAC90-40-210. Informed consent and agreement for treatment of chronic pain.

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

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

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

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

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

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

18VAC90-40-220. Opioid therapy for chronic pain.

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

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

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

D. The practitioner shall order and review a urine drug screen or serum medication levels at the initiation of chronic pain management and [~~at least every three months for the first year of treatment~~ thereafter randomly at the discretion of the practitioner, ~~and~~ but] at least [~~every six months thereafter~~ once a year] .

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

18VAC90-40-230. Additional consultation.

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

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

18VAC90-40-240. Medical records.

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

1. The medical history and physical examination;

2. Past medical history;

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

4. Diagnostic, therapeutic, and laboratory results;

5. Evaluations and consultations;

6. Treatment goals;

7. Discussion of risks and benefits;

8. Informed consent and agreement for treatment;

9. Treatments;

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

11. Patient instructions; and

12. Periodic reviews.

Part VII

Prescribing of Buprenorphine

18VAC90-40-250. General provisions.

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

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

C. Nurse practitioners who have obtained a SAMHSA waiver shall only prescribe buprenorphine for opioid addiction pursuant to a practice agreement with a SAMHSA-waivered doctor of medicine or doctor of osteopathic medicine [unless the nurse practitiioner has been authorized by the boards for autonomous practice] .

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

18VAC90-40-260. Patient assessment and treatment planning.

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

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

18VAC90-40-270. Treatment with buprenorphine.

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

1. When a patient is pregnant;

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

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

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

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

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

D. Due to a higher risk of fatal overdose when buprenorphine is prescribed with other opioids, benzodiazepines, sedative hypnotics, carisoprodol, and tramadol [(an atypical opioid)], the

prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.

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

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

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

H. Practitioners shall take steps to reduce the chances of buprenorphine diversion by using the lowest effective dose, appropriate frequency of office visits, pill counts, and checks of the Prescription Monitoring Program. The practitioner shall also require urine drug screens or serum medication levels at least every three months for the first year of treatment and at least every six months thereafter.

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

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

18VAC90-40-280. Special populations.

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

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

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

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

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

18VAC90-40-290. Medical records for opioid addiction treatment.

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

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

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

Agenda Item: Proposed Regulatory Action – Prescriptive Authority

Staff note:

The NOIRA that was published indicated that the Boards would likely repeal Chapter 40, Regulations for Prescriptive Authority for Nurse Practitioners, and the necessary provisions would be incorporated into a new Part in Chapter 30, Regulations Governing the Licensure of Nurse Practitioners.

However, since there are two emergency actions amending Chapter 40 currently in process, staff recommends amending Chapter 40 in this action at this time. When all actions (opioid regulations and autonomous practice) are completed, repeal Chapter 40 and incorporate provisions into Chapter 30 so there is one regulatory source for nurse practitioners.

Included in agenda package:

Copy of Code section on prescriptive authority for nurse practitioners

Copy of draft proposed amendments

Board action:

To adopt the proposed amendments as drafted or as revised by the Board. (Board of Nursing adopted the proposed amendments at its September meeting)

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 29. Medicine and Other Healing Arts

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

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

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

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

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

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

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

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

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

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

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

1991, cc. 519, 524; 1992, c. 409; 1995, c. 506; 1999, c. 745; 2000, c. 924; 2005, c. 926; 2006, c. 494; 2012, c. 213; 2016, c. 495; 2018, c. 776.

Project 5352 - NOIRA

BOARD OF NURSING

Elimination of separate license for prescriptive authority

18VAC90-40-20. Authority and administration of regulations.

A. The statutory authority for this chapter is found in §§ 54.1-2957.01, 54.1-3303, 54.1-3401, and 54.1-3408 of the Code of Virginia.

B. Joint boards of nursing and medicine.

1. The Committee of the Joint Boards of Nursing and Medicine shall be appointed to administer this chapter governing prescriptive authority.

2. The boards hereby delegate to the Executive Director of the Virginia Board of Nursing the authority to issue the initial authorization ~~and biennial renewal~~ to those persons who meet the requirements set forth in this chapter and to grant extensions or exemptions for compliance with continuing competency requirements as set forth in subsection E of 18VAC90-40-55. Questions of eligibility shall be referred to the committee.

3. All records and files related to prescriptive authority for nurse practitioners shall be maintained in the office of the Board of Nursing.

18VAC90-40-50. ~~Renewal of prescriptive authority.~~ (Repealed.)

~~An applicant for renewal of prescriptive authority shall:~~

~~1. Renew biennially at the same time as the renewal of licensure to practice as a nurse practitioner in Virginia.~~

~~2. Submit a completed renewal form attesting to compliance with continuing competency requirements set forth in 18VAC90-40-55 and the renewal fee as prescribed in 18VAC90-40-70.~~

18VAC90-40-55. Continuing competency requirements.

A. ~~In order to renew prescriptive authority, a~~ A licensee with prescriptive authority shall meet continuing competency requirements for biennial renewal as a licensed nurse practitioner. Such requirements shall address issues such as ethical practice, an appropriate standard of care, patient safety, and appropriate communication with patients.

B. A nurse practitioner with prescriptive authority shall obtain a total of eight hours of continuing education in pharmacology or pharmacotherapeutics for each biennium in addition to the minimal requirements for compliance with subsection B of 18VAC90-30-105.

C. The nurse practitioner with prescriptive authority shall retain evidence of compliance and all supporting documentation for a period of four years following the renewal period for which the records apply.

D. The boards shall periodically conduct a random audit of its licensees to determine compliance. The nurse practitioners selected for the audit shall provide the evidence of compliance and supporting documentation within 30 days of receiving notification of the audit.

E. The boards may delegate to the committee the authority to grant an extension or an exemption for all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

18VAC90-40-60. ~~Reinstatement of prescriptive authority.~~ (Repealed.)

~~A. A nurse practitioner whose prescriptive authority has lapsed may reinstate within one renewal period by payment of the current renewal fee and the late renewal fee.~~

~~B. A nurse practitioner who is applying for reinstatement of lapsed prescriptive authority after one renewal period shall:~~

~~1. File the required application;~~

~~2. Provide evidence of a current, unrestricted license to practice as a nurse practitioner in Virginia;~~

~~3. Pay the fee required for reinstatement of a lapsed authorization as prescribed in 18VAC90-40-70; and~~

~~4. If the authorization has lapsed for a period of two or more years, the applicant shall provide proof of:~~

~~a. Continued practice as a licensed nurse practitioner with prescriptive authority in another state; or~~

~~b. Continuing education, in addition to the minimal requirements for current professional certification, consisting of four contact hours in pharmacology or pharmacotherapeutics for each year in which the prescriptive authority has been lapsed in the Commonwealth, not to exceed a total of 16 hours.~~

~~C. An applicant for reinstatement of suspended or revoked authorization shall:~~

~~1. Petition for reinstatement and pay the fee for reinstatement of a suspended or revoked authorization as prescribed in 18VAC90-40-70;~~

~~2. Present evidence of competence to resume practice as a nurse practitioner with prescriptive authority; and~~

~~3. Meet the qualifications and resubmit the application required for initial authorization in 18VAC90-40-40.~~

18VAC90-40-70. Fees for prescriptive authority.

~~A. The following fees have been established by the boards:~~

~~1. Initial issuance of prescriptive authority~~	~~$75~~
~~2. Biennial renewal~~	~~$35~~
~~3. Late renewal~~	~~$15~~
~~4. Reinstatement of lapsed authorization~~	~~$90~~
~~5. Reinstatement of suspended or revoked authorization~~	~~$85~~
~~6. Duplicate of authorization~~	~~$15~~
~~7. Return check charge~~	~~$35~~

~~B. For renewal of licensure from July 1, 2017, through June 30, 2019, the following fee shall be in effect:~~

~~Biennial renewal~~	~~$26~~

The fee for initial issuance of prescriptive authority shall be $35.

18VAC90-40-110. Disclosure.

A. The nurse practitioner shall include on each prescription ~~written~~ issued or dispensed his signature and the Drug Enforcement Administration (DEA) number, when applicable. If his practice agreement authorizes prescribing of only Schedule VI drugs and the nurse practitioner does not have a DEA number, he shall include the prescriptive authority number as issued by the boards.

B. The nurse practitioner shall disclose to patients at the initial encounter that he is a licensed nurse practitioner. Such disclosure may be included on a prescription pad or may be given in writing to the patient.

C. The nurse practitioner shall disclose, upon request of a patient or a patient's legal representative, the name of the patient care team physician and information regarding how to contact the patient care team physician.

Part IV

Discipline

18VAC90-40-130. Grounds for disciplinary action.

A. The boards may deny approval of prescriptive authority~~, revoke or suspend authorization,~~ or take other disciplinary actions against a nurse practitioner who:

1. Exceeds his authority to prescribe or prescribes outside of the written or electronic practice agreement with the patient care team physician or, for certified nurse midwives, the practice agreement with the consulting physician;

2. Has had his license as a nurse practitioner suspended, revoked, or otherwise disciplined by the boards pursuant to 18VAC90-30-220; or

3. Fails to comply with requirements for continuing competency as set forth in 18VAC90-40-55.

B. Unauthorized use or disclosure of confidential information received from the Prescription Monitoring Program shall be grounds for disciplinary action.

Agenda Item: ***Periodic review of Chapter 20*: Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry and Chiropractic**

Staff note:

At its meeting on September 7, 2018, the Legislative Committee reviewed Chapter 20 pursuant to Executive Order 14 (2018). There were recommendations for edits and clarifications, but no substantive amendments were recommended.

Enclosed is:

Copy of Notice of Periodic Review

Copy of draft amended as recommended by the Legislative Committee

Action:

A motion that to adopt amendments to Chapter 20, Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry and Chiropractic pursuant to a periodic review by a fast-track action.

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VIRGINIA REGULATORY TOWN HALL

Logged in as
Elaine J. Yeatts

Agency **Department of Health Professions**

Board **Board of Medicine**

Chapter **Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic [18 VAC 85 – 20]**

Edit Review

Review 1647

Periodic Review of this Chapter

Includes a Small Business Impact Review

Date Filed: 4/30/2018

Review Announcement

Pursuant to Executive Order 17 (2014) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Board of Medicine is conducting a periodic review and small business impact review of 18VAC85-20-10 et seq., Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic.

The review of this regulation will be guided by the principles in Executive Order 17 (2014). http://dpb.virginia.gov/regs/EO17.pdf

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

The comment period begins May 28, 2018, and ends on June 27, 2018.

Comments may be submitted online to the Virginia Regulatory Town Hall at http://www.townhall.virginia.gov/L/Forums.cfm. Comments may also be sent to Elaine Yeatts, Senior Policy Analyst, 9960 Mayland Drive, Henrico, VA 23233 Telephone: (804) 367-4688, FAX: (804) 527-4434; email address: Elaine.yeatts@dhp.virginia.gov

Comments must include the commenter's name and address (physical or email) information in order to receive a response to the comment from the agency. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

Public Comment Period

Begin Date: 5/28/2018 End Date: 6/27/2018

Comments Received: 0

Review Result

Pending

Attorney General Certification

Result of Review: Certified

Project 5663 - none

BOARD OF MEDICINE

Periodic review

18VAC85-20-26. Patient records.

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

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

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

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

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

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

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

E. ~~From October 19, 2005, practitioners~~ Practitioners shall post information or in some manner inform all patients concerning the time frame for record retention and destruction. Patient records

shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.

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

18VAC85-20-29. Practitioner responsibility.

A. A practitioner shall not:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. For licensure in chiropractic.

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

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

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

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

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

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

2. Has received a degree from the institution.

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

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

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

~~5.~~6. Has completed one year of satisfactory postgraduate training as an intern, resident, or clinical fellow. The one year shall include at least 12 months in one program or institution approved by an accrediting agency recognized by the board for internship or residency training or in a clinical fellowship acceptable to the board in the same or a related field.

The board may substitute continuous full-time practice of five years or more with a limited professorial license in Virginia and one year of postgraduate training in a foreign country in lieu of one year of postgraduate training.

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

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

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

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

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

Part IV

Licensure: Examination Requirements

18VAC85-20-140. Examinations, general.

A. The Executive Director of the Board of Medicine or his designee shall review each application for licensure and in no case shall an applicant be licensed unless there is evidence that the applicant has passed an examination equivalent to the Virginia Board of Medicine

examination required at the time he was examined and meets all requirements of Part III (18VAC85-20-120 et seq.) of this chapter. If the executive director or his designee is not fully satisfied that the applicant meets all applicable requirements of Part III of this chapter and this part, he shall refer the application to the Credentials Committee for a determination on licensure.

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

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

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

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

2. An applicant who graduated from January 31, 1991, to January 31, 1996, shall document successful completion of Parts I, II, and III of the National Board of Chiropractic Examiners examination (NBCE).

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

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

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

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

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

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

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

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

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

1. Successfully complete the preliminary academic education required for admission to examinations given by the board in his particular field of practice, and submit a letter of

confirmation from the registrar of the school or college conferring the professional degree, or official transcripts confirming the professional degree and date the degree was received.

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

3. Submit evidence of a standard Educational Commission for Foreign Medical Graduates (ECFMG) certificate or its equivalent if the candidate graduated from a school not approved by an accrediting agency recognized by the board.

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

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

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

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

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

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

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

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

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

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

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

4. Pay a registration fee of $10; and

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

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

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

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

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

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

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

a. Up to 15 of the Type 2 continuing education hours may be satisfied through delivery of services, without compensation, to low-income individuals receiving services through a local health department or a free clinic organized in whole or primarily for the delivery of health services. One hour of continuing education may be credited for one hour of providing such volunteer services. For the purpose of continuing education credit for voluntary service, documentation by the health department or free clinic shall be acceptable.

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

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

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

D. The board shall periodically conduct a random audit of its active licensees to determine compliance. The practitioners selected for the audit shall provide all supporting documentation within 30 days of receiving notification of the audit.

E. Failure to comply with these requirements may subject the licensee to disciplinary action by the board.

F. The board may grant an extension of the deadline for continuing competency requirements for up to one year for good cause shown upon a written request from the licensee prior to the renewal date.

G. The board may grant an exemption for all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

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

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

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

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

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

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

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

Agenda Item: Adoption of fast-track action

Staff Note:

During the periodic review of regulations, it was noted that the regulation for providing notices to licensees needs to be amended for consistency with the Board's authority to email notices (including renewal notices).

In 2018, the Code of Virginia was amended:

§ 54.1-2904. Biennial renewal of licenses; copies; fee; lapsed licenses; reinstatement; penalties.

A. Every license granted under the provisions of this chapter shall be renewed biennially as prescribed by the Board. The Board shall send *by mail or electronically* notice for renewal of a license to every licensee. Failure to receive such notice shall not excuse any licensee from the requirements of renewal. The person receiving such notice shall furnish the information requested and submit the prescribed renewal fee to the Board. Copies of licenses may be obtained as provided in the Board's regulations.

Included in agenda package:

Amendments to all regulations under the Board to replace "mailed" with "sent"

Action: Adoption of amended regulation as a fast-track action

Project 5696 - none

BOARD OF MEDICINE

Electronic notices

18VAC85-20-21. Current addresses.

Each licensee shall furnish the board his current address of record. All notices required by law or by this chapter to be ~~mailed~~ given by the board to any such licensee shall be validly given when ~~mailed~~ sent to the latest address of record given by the licensee. Any change in the address of record or the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-40-25. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by this chapter to be given by the board to any such licensee shall be validly given when ~~mailed~~ sent to the latest address of record provided or served to the licensee. Any change of name or change in the address of record or public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-50-21. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by this chapter to be given by the board to any such licensee shall be validly given when ~~mailed~~ sent to the latest address of record provided or served to the licensee. Any change of name or address of record or the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-80-25. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by this chapter to be given by the board to any such licensee shall be validly given when ~~mailed~~ sent to the latest address of record provided or served to the licensee. Any change of name or address of record or the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-101-26. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by this chapter to be given by the board to any such licensee shall be validly given when ~~mailed~~ sent to the latest address of record provided or served to the licensee. Any change of name or address of record or the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-110-36. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by this chapter to be given by the board to any such licensee shall be validly given when ~~mailed~~ sent to the latest address of record provided or served to the licensee. Any change of name or address of record or the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-120-30. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by these regulations to be ~~mailed~~ given by the board to any such licensee shall be validly given when ~~mailed~~ sent to the latest address of record given to the board. Any change of name or address of record or the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-130-31. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by this chapter to be given by the board to any such licensee shall be validly given when ~~mailed~~ sent to the latest address of record provided or served to the licensee. Any change of name or address of record or the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-140-30. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by this chapter to be given by the board to any such licensee shall be validly given when ~~mailed~~ sent to the latest address of record provided or served to the licensee. Any change of name or change in the address of record or public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-150-30. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by this chapter to be given by the board to any such licensee shall be validly given when ~~mailed~~ sent to the latest address of record provided or served to the licensee. Any change of name or change in the address of record or public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-160-30. Current name and address.

Each registrant shall furnish the board his current name and address of record. All notices required by law or by this chapter to be given by the board to any such registrant shall be validly given when ~~mailed~~ sent to the latest address of record provided or served to the registrant. Any change of name or address of record or public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-170-30. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by this chapter to be given by the board to any such licensee shall be validly given when ~~mailed~~ sent to the latest address of record provided or served to the licensee. Any change of name or change in the address of record or public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

Agenda Item: ***Periodic review of Chapter 150*: Regulations Governing the Practice of Behavior Analysis**

Staff note:

At its meeting on October 1, 2018, the Advisory Board for Behavior Analysis reviewed Chapter 110 pursuant to Executive Order 14 (2018).

Significant amendments were recommended by the Association of Professional Behavior Analysts (APBA) to defer licensure, renewal, and ethical standards to those of the Behavior Analyst Certification Board (BACB).

After much discussion, the Advisory Board recommended amendments to require maintenance of current certification by the BACB for renewal of licensure. The vote was 3-2 with the MD member and the citizen member voting in opposition.

The current continuing education requirements are identical to those required for BACB certification, so there would be no change in continuing competency. No re-examination is required. The BA or ABA would be required to pay the BACB $185 each biennium in order to renew his/her license with the Board.

Enclosed is:

Copy of Comment from the APBA

Action:

Acceptance of the Advisory Board recommendation with a motion to adopt a Notice of Intended Action to require licensed behavior analysts and licensed assistant behavior analysts to maintain board certification in order to renew or reinstate a license; or

No action on the recommendation for amendment

Colanthia Opher

From: Harp, William
Sent: Monday, June 25, 2018 9:52 AM
To: Colanthia D. Morton
Subject: Fwd: Regulations Governing the Practice of Behavior Analysis
Attachments: APBA comments -VA BA Licensure Regs12272017.doc

Flag Status: Flagged

For the October Advisory on Behavior Analysis

Thanks

---------- Forwarded message ----------
From: **Board of Medicine, yy** <medbd@dhp.virginia.gov>
Date: Mon, Jun 25, 2018 at 9:36 AM
Subject: Fwd: Regulations Governing the Practice of Behavior Analysis
To: William Harp <william.harp@dhp.virginia.gov>, Elaine Yeatts <elaine.yeatts@dhp.virginia.gov>

---------- Forwarded message ----------
From: **Gina Green** <ggreen3@cox.net>
Date: Sun, Jun 24, 2018 at 5:35 PM
Subject: Regulations Governing the Practice of Behavior Analysis
To: medbd@dhp.virginia.gov

Board of Medicine,

As the professional organization for practitioners of applied behavior analysis (ABA), the Association of Professional Behavior Analysts (APBA) has been working on public policies affecting the practice of ABA in many jurisdictions for several years. That includes most of the laws to license or otherwise regulate that practice that have been adopted in 30 U.S. states to date. We understand from our Affiliate the Virginia Association for Behavior Analysis that public comments on the proposed Regulations Governing the Practice of Behavior Analysis may be submitted through tomorrow, June 25. I have reviewed the proposed regulations carefully, and respectfully request your consideration of the suggested revisions that are indicated on the attached version of the proposed regulations with Word's revision tracking feature. I have also inserted comments to explain the rationale for the proposed revisions and to offer suggestions for the consideration of additional revisions. The recommended revisions are designed to ensure that *all* applicants for licensure — whether initial, renewal, or reinstatement — have their status as currently certified in good standing by the Behavior Analyst Certification Board (BACB) verified directly with the BACB. That will in turn ensure that all VA Licensed Behavior Analysts and Licensed Assistant Behavior Analysts have met the degree, coursework, supervised experiential training, continuing education, supervision, and ethical and disciplinary standards set by the profession and have passed the international professional examination in the practice of ABA, even as those requirements change over time as a result of the job analysis studies the BACB must repeat every few years in order to maintain the accreditation of its credentialing programs by the National Commission on Certifying Agencies of

the Institute for Credentialing Excellence. Adoption of the recommended revisions will also prevent confusion on the part of consumers by ensuring that all licensees have met the same objective, verifiable, legally defensible standards regardless of when they are licensed or re-licensed, and will save licensees time and money by minimizing differences between requirements for maintaining their BACB certifications and their state-issued licenses. Last but certainly not least, adopting the recommended revisions will be cost-effective for the Board of Medicine, as all the Board will need to do to verify that an applicant meets all current professional standards is search for the individual's name at https://www.bacb.com/verify-certification/. The BACB has also established efficient procedures for coordinating with state licensing boards on disciplinary matters.

APBA is very grateful for the opportunity to comment on the proposed regulations. If I can answer any questions or provide additional information, please do not hesitate to contact me.

Sincerely yours,

Gina Green, PhD, BCBA-D
Chief Executive Officer
Association of Professional
Behavior Analysts
3443 Camino del Rio South
Suite 210
San Diego, CA 92108
www.apbahome.net

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF BEHAVIOR ANALYSIS

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18VAC85-150-10 et seq.

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

Effective Date: December 27, 2017

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

(804) 367-4600 (TEL)
(804) 527-4426 (FAX)
email: medbd@dhp.virginia.gov

TABLE OF CONTENTS

Part I
General Provisions

18VAC85-150-10. Definitions.

A. The following words and terms when used in this chapter shall have the meanings ascribed to them in § 54.1-2900 of the Code of Virginia:

Board

Practice of behavior analysis

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

"BACB" means the Behavior Analyst Certification Board, Inc.

"BCBA®" means a Board Certified Behavior Analyst®.

"BCaBA®" means a Board Certified Assistant Behavior Analyst®.

18VAC85-150-20. Public participation.

A separate board regulation, 18VAC85-11, entitled Public Participation Guidelines, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.

18VAC85-150-30. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by this chapter to be given by the board to any such licensee shall be validly given when mailed to the latest address of record provided or served to the licensee. Any change of name or change in the address of record or public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-150-40. Fees.

A. The following fees have been established by the board:

1. The initial fee for the behavior analyst license shall be $130; for the assistant behavior analyst license, it shall be $70.

2. The fee for reinstatement of the behavior analyst license that has been lapsed for two years or more shall be $180; for the assistant behavior analyst license, it shall be $90.

3. The fee for active license renewal for a behavior analyst shall be $135; for any assistant behavior analyst, it shall be $70. The fees for inactive license renewal shall be $70 for a

behavior analyst and $35 for an assistant behavior analyst. Renewals shall be due in the birth month of the licensee in each odd-numbered year. For 2019, the renewal of an active license as a behavior analyst shall be $108, and the renewal fee for an inactive license shall be $54; the renewal fee for an active license as an assistant behavior analyst shall be $54, and the renewal fee for an inactive license shall be $28.

4. The additional fee for processing a late renewal application within one renewal cycle shall be $50 for a behavior analyst and $30 for an assistant behavior analyst.

5. The fee for a letter of good standing or verification to another state for a license shall be $10.

6. The fee for reinstatement of licensure pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

7. The fee for a returned check shall be $35.

8. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

B. Unless otherwise provided, fees established by the board shall not be refundable.

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

18VAC85-150-50. Application requirements.

An applicant for licensure shall submit the following on forms provided by the board:

1. A completed application and a fee as prescribed in 18VAC85-150-40.

~~2. Verification of certification as required in 18VAC85-150-60.~~

2. Verification of practice as required on the application form.

3. If licensed or certified in any other jurisdiction, verification that there has been no disciplinary action taken or pending in that jurisdiction.

4. Verification by the Board that the applicant is not listed at http://info.bacb.com/o.php?page=100180 as having been sanctioned by the BACB for disciplinary reasons ~~from the BACB on disciplinary action taken or pending by that body~~.

Commented [Official1]: Instead of having applicants assert that they are currently certified by the BACB, the Board of Medicine should verify that directly by going to https://www.bacb.com/verify-certification/.

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Commented [Official2]:

Commented [Official3]: This is unnecessary, as

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18VAC85-150-60. Licensure requirement.

An applicant for a license to practice as a behavior analyst or an assistant behavior analyst shall ~~hold~~ have current certification as a BCBA® or a BCaBA® verified with the BACB by the Board.

~~obtained by meeting qualifications and passage of the examination required for certification as a BCBA® or a BCaBA® by the BACB.~~

Part III
Renewal and Reinstatement

18VAC85-150-70. Renewal of licensure.

A. Every behavior analyst or assistant behavior analyst who intends to maintain an active license shall biennially renew his license each odd-numbered year during his birth month and shall:

~~1. Submit the prescribed renewal fee; and~~

~~2. Have current certification as a BCBA® or BCaBA® verified with the BACB by the Board.~~

2. Attest to having met the continuing education requirements of 18VAC85-150-100.

B. The license of a behavior analyst or assistant behavior analyst that has not been renewed by the first day of the month following the month in which renewal is required is lapsed. Practice with a lapsed license may be grounds for disciplinary action. A license that is lapsed for two years or less may be renewed by payment of the renewal fee, a late fee as prescribed in 18VAC85-150-40, and documentation of compliance with continuing education requirements.

18VAC85-150-80. Inactive licensure.

A behavior analyst or assistant behavior analyst who holds a current, unrestricted license in Virginia shall, upon a request on the renewal application and submission of the required fee, be issued an inactive license. The holder of an inactive license shall not be entitled to perform any act requiring a license to practice as a behavior analyst or assistant behavior analyst in Virginia.

18VAC85-150-90. Reactivation or reinstatement.

A. To reactivate an inactive license or to reinstate a license that has been lapsed for more than two years, a behavior analyst or assistant behavior analyst shall submit evidence of competency to return to active practice to include one of the following:

1. ~~Information or~~Verification by the Board of continued practice in another jurisdiction as a licensed behavior analyst or a licensed assistant behavior analyst or ~~with certification~~ as a BCBA® or BCaBA® during the period in which the license has been inactive or lapsed;

~~2. Verification with the BACB by the Board of current certification as a BCBA® or BCaBA®.~~

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Commented [Office4]: It's essential to verify that applicants for renewal are currently certified by the BACB to ensure that all licensees meet the standards set by the profession even as those standards change over time.

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Commented [Office5]: The language regarding continuing education and recertification by passage of a BACB exam is unnecessary if current BACB certification is the principal requirement for reactivation or reinstatement, as everyone who is currently certified by the BACB must have already passed the exam and met BACB CE requirements.

~~2. Sixteen hours of continuing education for each year in which the license as a behavior analyst or 10 hours for each year in which the license as an assistant behavior analyst has been inactive or lapsed, not to exceed three years; or~~

~~3. Recertification by passage of the BCBA® or the BCaBA® certification examination from the BACB.~~

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B. To reactivate an inactive license, a behavior analyst or assistant behavior analyst shall pay a fee equal to the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure.

C. To reinstate a license that has been lapsed for more than two years, a behavior analyst or assistant behavior analyst shall file an application for reinstatement and pay the fee for reinstatement of his license as prescribed in 18VAC85-150-40. The board may specify additional requirements for reinstatement of a license so lapsed to include education, experience, or reexamination.

D. A behavior analyst or assistant behavior analyst whose licensure has been revoked by the board and who wishes to be reinstated shall make a new application to the board, fulfill additional requirements as specified in the order from the board, and make payment of the fee for reinstatement of his licensure as prescribed in 18VAC85-150-40 pursuant to § 54.1-2408.2 of the Code of Virginia.

E. The board reserves the right to deny a request for reactivation or reinstatement to any licensee who has been determined to have committed an act in violation of § 54.1-2915 of the Code of Virginia or any provisions of this chapter.

18VAC85-150-100. Continuing education requirements.

A. In order to renew an active license, a behavior analyst shall attest to having completed 32 hours of continuing education and an assistant behavior analyst shall attest to having completed 20 hours of continuing education ~~as approved and documented by a sponsor recognized by the BACB~~ within the last biennium. Four of the required hours shall be related to ethics in the practice of behavior analysis. Up to two continuing education hours may be satisfied through delivery of behavior analysis services, without compensation, to low-income individuals receiving services through a local health department or a free clinic organized in whole or primarily for the delivery of health services. One hour of continuing education may be credited for three hours of providing such volunteer services. For the purpose of continuing education credit for voluntary service, the hours shall be approved and documented by the health department or free clinic.

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Commented [Official]: If current BACB certification is required for renewal, this language is unnecessary, as all licensees will have met the BACB's CE requirements. Additionally, as written this language sort of reflects the BACB CE requirements that are in place today, but not entirely accurately. For instance, there are 3 types of BACB CEUs, only one of which is CEUs issued by providers who are approved by the BACB. Additionally, the BACB CE requirements change periodically. Better to simply delete this language rather than having to change the rules every time the BACB CE requirements change.

Commented [Office2]: Strongly recommend deleting the exemption from the CE requirement. All BCBAs and BCaBAs must meet the BACB's CE requirements in order to maintain their certifications, which is consistent with best practices in professional credentialing. So as long as these rules require current BACB certification for licensees at every phase (initial, renewal, reinstatement), there is no reason to exempt any licensees from the requirement to obtain CEUs.

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

CB. The practitioner shall retain in his records the completed form with all supporting documentation for a period of four years following the renewal of an active license.

DC. The board shall periodically conduct a random audit of its active licensees to determine compliance. The practitioners selected for the audit shall provide all supporting documentation within 30 days of receiving notification of the audit.

Commented [Official]: If this provision is left as is, it will be essential for everyone involved to understand that CEUs earned by this pathway will not be accepted by the BACB to verify completion of the CE requirement for maintaining BACB certification.

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D. Failure to comply with these requirements may subject the licensee to disciplinary action by the board.

E. The board may grant an extension of the deadline for continuing education requirements, for up to one year, for good cause shown upon a written request from the licensee prior to the renewal date.

G. The board may grant an exemption from all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

Part IV
Scope of Practice

18VAC85-150-110. Scope of practice.

The practice of ~~a behavior analyst~~behavior analysis includes the ~~:~~

~~A. 1.~~ Design, implementation, and evaluation of environmental modifications using the principles and methods of behavior analysis to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

~~B. Licensed behavior analysts are authorized to practice independently. Licensed assistant behavior analysts must practice under the supervision of licensed behavior analysts who are approved as supervisors by the BACB.~~ ~~and~~

~~2. Supervision of licensed assistant behavior analysts and unlicensed personnel.~~

18VAC85-150-120. Supervisory responsibilities.

~~A. A.~~ The licensed behavior analyst is ultimately responsible and accountable for ~~client care and outcomes~~all services delivered under his ~~or her~~ clinical supervision.

~~B. Only licensed behavior analysts who are currently approved by the BACB to supervise BCaBAs may supervise licensed assistant behavior analysts.~~

~~B~~C. There shall be a written supervisory agreement between the licensed behavior analyst and the licensed assistant behavior analyst that shall address:

1. The domains of competency within which services may be provided by the licensed assistant behavior analyst; and

2. The nature and frequency of the supervision of the practice of the licensed assistant behavior analyst by the licensed behavior analyst.

A copy of the written supervisory agreement shall be maintained by the licensed behavior analyst and the licensed assistant behavior analyst and made available to the board upon request.

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Commented [Office9]: Suggested revisions are to make it clear that the practice of behavior analysis is the same regardless of which class of licensee is involved, and to specify which classes of licensees can engage in that practice independently vs. under supervision

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Commented [Office10]: See https://www.bacb.com/board-requests-for-supervisors/ and https://www.bacb.com/wp-content/ethics-code-for-supervision-of-BCaBAs.pdf
LBAs and LABAs who fail to comply with these requirements risk losing their BACB certifications and therefore their VA licenses.

C. Delegation shall only be made if, in the judgment of the licensed behavior analyst, the task or procedures can be properly and safely performed by an appropriately trained assistant behavior analyst or other person, and the delegation does not jeopardize the health or safety of the client.

D. Supervision activities by the licensed behavior analyst include:

Commented [Office11]: Some of these requirements differ from the BACB's supervision requirements, which will create confusion. It would be cleaner and clearer for all concerned to have the rules state simply that all supervision of LABAs shall comport with the supervision requirements set by the BACB.

1. Direct, real-time observation of the supervisee implementing behavior analytic assessment and intervention procedures with clients in natural environments and/or training others to implement them, with feedback from the supervisor.

2. One-to-one, real-time interactions between supervisor and supervisee to review and discuss assessment and treatment plans and procedures, client assessment and progress data and reports, published research, ethical and professional standards and guidelines, professional development needs and opportunities, and relevant laws, regulations, and policies.

3. Real-time interactions between a supervisor and a group of supervisees to review and discuss assessment and treatment plans and procedures, client assessment and progress data and reports, published research, ethical and professional standards and guidelines, professional development needs and opportunities, and relevant laws, regulations, and policies.

4. Informal interactions between supervisors and supervisees via telephone, electronic mail, and other written communication are encouraged but may not be considered formal supervision.

For the purposes of this subsection, "real-time" shall mean live and person-to-person.

E. The frequency and nature of supervision interactions are determined by the individualized assessment or treatment plans of the clients served by the licensed behavior analyst and the assistant behavior analyst but shall occur not less than once every four weeks with each supervision session lasting no less than one hour.

18VAC85-150-130. Supervision of unlicensed personnel.

A. Unlicensed personnel may be supervised by a licensed behavior analyst or a licensed assistant behavior analyst who is currently approved as a supervisor by the BACB.

Commented [Office12]: See comment above

B. Unlicensed personnel may be utilized to perform:

1. Nonclient-related tasks, including but not limited to clerical and maintenance activities and the preparation of the work area and equipment; and

2. 3. Certain routine client-related tasks that, in the opinion of and under the supervision of a licensed behavior analyst or a licensed assistant behavior analyst, have no potential to adversely impact the client or the client's treatment plan,

3. and do not constitute the practice of behavior analysis.

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Part V
Standards of Professional Conduct

Commented [Office13]: Somewhere in this Part it should be specified that all licensees must adhere to the BACB's Professional and Ethical Compliance Code for Behavior Analysts (again, given that all licensees must be BACB-certified, they must comply with the Code in order to maintain both their certification and licensure).

18VAC85-150-140. Confidentiality.

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

18VAC85-150-150. Client records.

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

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

C. Practitioners shall properly manage and keep timely, accurate, legible, and complete client records.

D. Practitioners who are employed by a health care institution, educational institution, school system, or other entity in which the individual practitioner does not own or maintain his own records shall maintain client records in accordance with the policies and procedures of the employing entity.

E. Practitioners who are self-employed or employed by an entity in which the individual practitioner owns and is responsible for client records shall:

1. Maintain a client record for a minimum of six years following the last client encounter with the following exceptions:

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

b. Records that have previously been transferred to another practitioner ~~or health care provider~~ or provided to the client or his legally authorized representative; or

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

2. Post information or in some manner inform all clients concerning the time frame for record retention and destruction. Client records shall only be destroyed in a manner that protects client confidentiality, such as by incineration or shredding.

3. When closing, selling, or relocating his practice, meet the requirements of § 54.1-2405 of the Code of Virginia for giving notice that copies of records can be sent to any like-

regulated provider of the client's choice or provided to the client or legally authorized representative.

18VAC85-150-160. Practitioner-client communication; termination of relationship.

A. Communication with clients.

1. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately present information to a client or his legally authorized representative in understandable terms and encourage participation in decisions regarding the client's care.

2. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a treatment or procedure provided or directed by the practitioner.

3. Before an initial assessment or intervention is performed, informed consent shall be obtained from the client or his legally authorized representative. Practitioners shall inform clients or their legally authorized representative of the risks, benefits, and alternatives of the recommended procedure that a reasonably prudent practitioner would tell a client.

a. Informed consent shall also be obtained if there is a significant change to a therapeutic procedure or intervention performed on a client that is not part of routine, general care and that is more restrictive on the continuum of care.

b. In the instance of a minor or a client who is incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent shall be informed and the consent documented.

c. An exception to the requirement for consent prior to performance of a procedure or intervention may be made in an emergency situation when a delay in obtaining consent would likely result in imminent harm to the client.

4. Practitioners shall adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from clients prior to involving them as subjects in human research with the exception of retrospective chart reviews.

B. Termination of the practitioner-client relationship.

1. The practitioner or the client may terminate the relationship. In either case, the practitioner shall make the client record available, except in situations where denial of access is allowed by law.

2. A practitioner shall not terminate the relationship or make his services unavailable without documented notice to the client that allows for a reasonable time to obtain the services of another practitioner.

18VAC85-150-170. Practitioner responsibility.

Agenda Item: Adoption of fast-track action – Acupuncture regs

Staff Note:

The Advisory Board on Acupuncture conducted a periodic review of regulations. There are two amendments recommended; neither is substantive:

1) The name of the Point Location examination has changed, so the regulation needs to be consistent with the name used by the national examination; and
2) The section on use of vitamins, minerals and food supplements needs to be clarified to include herbs and herbal supplements. The term "dietary supplements" used by the FDA is inclusive of all of those, so the regulation is amended to simply refer to "dietary supplements."

The Advisory was unanimous in support of these amendments with a vote of 5-0.

Included in agenda package:

Amendments to Chapter 110, Regulations Governing the Practice of Licensed Acupuncturists

Action: Adoption of amended regulation as a fast-track action

Project 5714 - none

BOARD OF MEDICINE

Chapter 100 periodic review

18VAC85-110-80. Examination requirements for licensure.

The examination requirements for licensure shall consist of:

1. Passing the NCCAOM comprehensive written examination, resulting in current, active certification by the NCCAOM at the time the application is filed with the board;

2. Passing the ~~Practical Examination of~~ Point Location ~~Skills (PEPLS) test~~ Examination; and

3. Completing the CNT course as administered by the CCAOM.

18VAC85-110-180. ~~Vitamins, minerals and food~~ Dietary supplements.

A. The recommendation or direction for the use of ~~vitamins, minerals or food~~ dietary supplements and the rationale for that recommendation shall be documented by the practitioner. The recommendation or direction shall be based upon a reasonable expectation that such use will result in a favorable patient outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use.

B. ~~Vitamins, minerals, or food~~ Dietary supplements, ~~or a~~ used singly or in combination ~~of the three~~, shall not be sold, dispensed, recommended, prescribed, or suggested in doses that would be contraindicated based on the individual patient's overall medical condition and medications.

C. The practitioner shall conform to the standards of his particular branch of the healing arts in the therapeutic application of ~~vitamins, minerals or food~~ dietary supplement therapy.

Agenda Item: Adoption of fast-track action – Athletic Trainer regs

Staff Note:

The Advisory Board on Athletic Training conducted a periodic review of regulations. In the course of the meeting, questions were raised by several athletic trainers in attendance about the meaning of the requirement for "direction" by a physician. Direction is specified in the statutory definition of the practice of athletic training but not further defined in regulation.

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

The National Board of Certification for the Athletic Trainer has recently adopted model language for regulation. The definition of "direction" recommended by the Advisory Board is consistent with the definition in model rules and consistent with current practice that is in accordance with the law.

The Advisory was unanimous in support of these amendments with a vote of 3-0.

Included in agenda package:

Amendments to Chapter 120, Regulations Governing the Practice of Athletic Trainers

Action: Adoption of amended regulation as a fast-track action

Project 5716 – Fast-track

BOARD OF MEDICINE

Periodic review chapter 120

Part I

General Provisions

18VAC85-120-10. Definitions.

In addition to words and terms defined in § 54.1-2900 of the Code of Virginia, the following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

"Advisory board" means the Advisory Board on Athletic Training to the board as specified in § 54.1-2957.5 of the Code of Virginia.

"Athletic trainer" means a person licensed by the Virginia Board of Medicine to engage in the practice of athletic training as defined in § 54.1-2900 of the Code of Virginia.

"Board" means the Virginia Board of Medicine.

"Direction" means authorization by a doctor of medicine, osteopathic medicine, podiatry, chiropractic, or dentistry for care and treatment by a verbal order if the doctor or dentist is present or by written order, telecommunication, plans of care, protocols, or standings orders if the doctor or dentist is not present.

"NATABOC" means the National Athletic Trainers' Association Board of Certification.

"Student athletic trainer" means a person enrolled in an accredited bachelor's or master's level educational program in athletic training.

Part IV

Standards of Practice

18VAC85-120-110. Individual responsibilities.

A. The athletic trainer's responsibilities are to evaluate the individual being treated, plan the treatment program, and administer and document treatment within the limit of his professional knowledge, judgment and skills and in accordance with the practice of athletic training as set forth in § 54.1-2900 of the Code of Virginia.

B. An athletic trainer practices under the direction of the individual's physician or under the direction of any doctor of medicine, osteopathy, chiropractic, podiatry, or dentistry.

Agenda Item: Adoption of fast-track action –Physician Assistant regs

Staff Note:

The Advisory Board on Physician Assistants conducted a periodic review of regulations. Amendments are recommended to delete outdated language, primarily related to the changes in law and regulation for prescriptive authority. PAs are no longer required to submit practice agreement for approval by the Board.

The Advisory was unanimous in support of these amendments with a vote of 5-0.

Included in agenda package:

Amendments to Chapter 50, Regulations Governing the Practice of Physician Assistants

Action: Adoption of amended regulation as a fast-track action

Project 5717 – Fast-track

BOARD OF MEDICINE

Periodic review Chapter 50

18VAC85-50-115. Responsibilities of the physician assistant.

A. The physician assistant shall not render independent health care and shall:

1. Perform only those medical care services that are within the scope of the practice and proficiency of the supervising physician as prescribed in the physician assistant's practice agreement. When a physician assistant is to be supervised by an alternate supervising physician outside the scope of specialty of the supervising physician, then the physician assistant's functions shall be limited to those areas not requiring specialized clinical judgment, unless a separate practice agreement for that alternate supervising physician is approved and on file with the board.

2. Prescribe only those drugs and devices as allowed in Part V (18VAC85-50-130 et seq.) of this chapter.

3. Wear during the course of performing his duties identification showing clearly that he is a physician assistant.

B. An alternate supervising physician shall be a member of the same group or professional corporation or partnership of any licensee who supervises a physician assistant or shall be a member of the same hospital or commercial enterprise with the supervising physician. Such alternating supervising physician shall be a physician licensed in the Commonwealth who ~~has registered with the board and who~~ has accepted responsibility for the supervision of the service that a physician assistant renders.

C. If, due to illness, vacation, or unexpected absence, the supervising physician or alternate supervising physician is unable to supervise the activities of his assistant, such supervising physician may temporarily delegate the responsibility to another doctor of medicine, osteopathic medicine, or podiatry.

Temporary coverage may not exceed four weeks unless special permission is granted by the board.

D. With respect to assistants employed by institutions, the following additional regulations shall apply:

1. No assistant may render care to a patient unless the physician responsible for that patient has signed the practice agreement to act as supervising physician for that assistant. ~~The board shall make available appropriate forms for physicians to join the practice agreement for an assistant employed by an institution.~~

2. Any such practice agreement as described in subdivision 1 of this subsection shall delineate the duties which said physician authorizes the assistant to perform.

3. The assistant shall, as soon as circumstances may dictate, report an acute or significant finding or change in clinical status to the supervising physician concerning the examination of the patient. The assistant shall also record his findings in appropriate institutional records.

E. Practice by a physician assistant in a hospital, including an emergency department, shall be in accordance with § 54.1-2952 of the Code of Virginia.

Part V

Prescriptive Authority

18VAC85-50-130. Qualifications for approval of prescriptive authority.

An applicant for prescriptive authority shall meet the following requirements:

1. Hold a current, unrestricted license as a physician assistant in the Commonwealth;

2. ~~Submit~~ Maintain a practice agreement acceptable to the board as prescribed in 18VAC85-50-101 and § 54.1-2952.1 of the Code of Virginia. ~~This practice agreement must be approved by the board prior to issuance of prescriptive authority~~; and

3. ~~Submit evidence of successful passing of the NCCPA exam; and~~

4. ~~.~~ Submit evidence of successful completion of a minimum of 35 hours of acceptable training to the board in pharmacology.

18VAC85-50-140. Approved drugs and devices.

A. The approved drugs and devices which the physician assistant with prescriptive authority may prescribe, administer, or dispense manufacturer's professional samples shall be in accordance with provisions of § 54.1-2952.1 of the Code of Virginia:

B. The physician assistant may prescribe only those categories of drugs and devices included in the practice agreement ~~as submitted for authorization~~. The supervising physician retains the authority to restrict certain drugs within these approved categories.

C. The physician assistant, pursuant to § 54.1-2952.1 of the Code of Virginia, shall only dispense manufacturer's professional samples or administer controlled substances in good faith for medical or therapeutic purposes within the course of his professional practice.

Agenda Item: Guidance documents – Periodic Review

Included in the agenda package:

Listing of Board of Medicine Guidance Documents with notation of recommendation by Legislative Committee

Only those Guidance Documents that are recommended for revision are included

Staff note:

Guidance documents, like regulations, need to be reviewed periodically for continued applicability. On September 7, 2018, the Legislative Committee reviewed all guidance documents that had not been revised/adopted within the past four years.

Recommended actions are listed beside each document. Those for which revisions are recommended by the Committee are included in your package.

Action:

Adoption of the recommended actions for guidance documents as noted on the listing in the agenda package.

Adoption of revised guidance documents as included in the agenda package

BOARD OF MEDICINE GUIDANCE DOCUMENTS

STAFF RECOMMENDATIONS

Copies of the following documents may be viewed during regular workdays from 8:15 a.m. until 5 p.m. at the offices of the Department of Health Professions, 9960 Mayland Drive, Suite 300, Henrico, VA 23233. Copies may also be downloaded from the board's web page at http://www.dhp.virginia.gov/medicine or the Regulatory Town Hall at http://www.townhall.virginia.gov or requested by email at medbd@dhp.virginia.gov. Questions regarding interpretation or implementation of these documents or requests for copies may be directed to William L. Harp, M.D., Executive Director of the Board, at the address above or by telephone at (804) 367-4600. Copies are free of charge.

Guidance Documents:

http://www.dhp.virginia.gov/medicine/medicine_guidelines.htm

85-1, Bylaws of the Board of Medicine, revised June 14, 2018

85-2, Assistant Attorney General Opinion of October 25, 1986 on who can do a school physical examination **Recommendation: Retain**

85-3, Completing Form B, Employment Verification, adopted December 1, 2017

85-4, Acceptance of Providers of Approved Continuing Education (PACE) for chiropractic CE, adopted February 19, 2015

85-5, Guidance of questions concerning medical records, revised August 10, 2017

85-6, Guidance on competency assessments for three paid claims, revised July 2, 2011 **Recommendation: Reaffirm**

85-8, Authority for physician assistants to write Do Not Resuscitate Orders, adopted February 23, 2012 **Recommendation: Reaffirm**

85-9, Policy on USMLE Step attempts, adopted October 24, 2013 **Recommendation: Reaffirm**

85-10, High-risk pregnancy disclosures for licensed midwives, revised October 22, 2015

85-11, Sanctioning Reference Points Instruction Manual, revised by Board, August 2011

85-12, Telemedicine, revised June 22, 2017 **Recommendation: Revise**

85-13, Board motion, Guidelines on Performing Procedures on the Newly Deceased for Training Purposes, January 22, 2004 **Recommendation: Revise**

85-14, Procedure for enforcement of continuing competency requirements, adopted June 18, 2015

85-15, Board motion, Guidelines Concerning the Ethical Practice of Surgery and Invasive Procedures, January 22, 2004 **Recommendation: Revise**

85-16, Questions and Answers on Continuing Competency Requirements for the Virginia Board of Medicine, revised December 3, 2007 **Recommendation: Revise**

85-17, Guidance on supervisory responsibilities of an occupational therapist, adopted February 15, 2018

85-18, Practitioners' Help Section, - Definitions and explanations for terminology used in Practitioner Profile System and Frequently Asked Questions, revised November 22, 2010 **Recommendation: Repeal**

85-19, Practitioner Information System - Glossary of Terms, revised November 22, 2010 **Recommendation: Reaffirm**

85-20, Official Opinion of the Attorney General, December 1992 on employment of surgeon by a nonstock, nonprofit corporation **Recommendation: Retain**

85-21, Official Opinion of the Attorney General, May 1995 on employment of physician by a for profit corporation **Recommendation: Retain**

85-23, Policy of the Virginia Board of Medicine on the Use of Confidential Consent Agreements, October 9, 2003 **Recommendation: Revise**

85-24, Board motion, Adoption of FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain, revised October 24, 2013 **Recommendation: Repeal**

85-25, Board motion, Process for Delegation of Informal Fact-finding to an Agency Subordinate, October 14, 2004 **Recommendation: Repeal**

85-26, Laws Pertaining to the Practice of Licensed Midwives, revised June 20, 2013 **Recommendation: Revise**

85-27, Role of Licensed Midwives in Newborn Hearing Screening, Documentation, and Reporting, revised June 20, 2013 **Recommendation: Revise**

85-28, Authority for licensed midwives to order tests, revised October 26, 2017 **Recommendation: Revise**

Guidance document: 85-12 Revised:

Virginia Board of Medicine

Telemedicine

Section One: Preamble.

The Virginia Board of Medicine ("Board") recognizes that using telemedicine services in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these services can enhance medical care by facilitating communication between practitioners, other health care providers, and their patients, prescribing medication, medication management, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice. With the exception of prescribing controlled substances, the Virginia General Assembly has not established statutory parameters regarding the provision and delivery of telemedicine services. Therefore, practitioners must apply existing laws and regulations to the provision of telemedicine services. The Board issues this guidance document to assist practitioners with the application of current laws to telemedicine service practices.

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method used to enable practitioner-to-patient communications. For the purpose of prescribing controlled substances, a practitioner using telemedicine services in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the practitioner-patient relationship as defined in Virginia Code § 54.1-3303. A practitioner should conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine services as a component of, or in lieu of, in-person provision of medical care, while others are not. The practitioner is responsible for making this determination, and in doing so must adhere to applicable laws and standards of care.

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine services in the practice of medicine. The Board is committed to ensuring patient access to the convenience and benefits afforded by telemedicine services, while promoting the responsible provision of health care services.

It is the expectation of the Board that practitioners who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;
- Adhere to recognized ethical codes governing the applicable profession;
- Adhere to applicable laws and regulations;

- In the case of physicians, properly supervise non-physician clinicians when required to do so by statute; and
- Protect patient confidentiality.

Section Two: Establishing the Practitioner-Patient Relationship.

The practitioner-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that practitioners recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a practitioner-patient relationship. Where an existing practitioner-patient relationship is not present,[1] a practitioner must take appropriate steps to establish a practitioner-patient relationship consistent with the guidelines identified in this document, with Virginia law, and with any other applicable law.[2] While each circumstance is unique, such practitioner-patient relationships may be established using telemedicine services provided the standard of care is met.

A practitioner is discouraged from rendering medical advice and/or care using telemedicine services without (1) fully verifying and authenticating the location and, to the extent possible, confirming the identity of the requesting patient; (2) disclosing and validating the practitioner's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine services. An appropriate practitioner-patient relationship has not been established when the identity of the practitioner may be unknown to the patient.

Section Three: Guidelines for the Appropriate Use of Telemedicine Services.
The Board has adopted the following guidelines for practitioners utilizing telemedicine services in the delivery of patient care, regardless of an existing practitioner-patient relationship prior to an encounter.

Licensure:

The practice of medicine occurs where the patient is located at the time telemedicine services are used, and insurers may issue reimbursements based on where the practitioner is located. Therefore, a practitioner must be licensed by, or under the jurisdiction of, the regulatory board of the state where the patient is located and the state where the practitioner is located. Practitioners who treat or prescribe through online service sites must possess appropriate licensure in all jurisdictions where patients receive care. To ensure appropriate insurance coverage, practitioners must make certain that they are compliant with federal and state laws and policies regarding reimbursements.

Evaluation and Treatment of the Patient:

[1] This guidance document is not intended to address existing patient-practitioner relationships established through in-person visits.
[2] The practitioner must adhere not only to Virginia law defining a practitioner-patient relationship, but the law in any state where a patient is receiving services that defines the practitioner-patient relationship.

A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, which treatment includes the issuance of prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional, in-person encounters. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:

Evidence documenting appropriate patient informed consent for the use of telemedicine services must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following:

- Identification of the patient, the practitioner, and the practitioner's credentials;
- Types of activities permitted using telemedicine services (e.g. prescription refills, appointment scheduling, patient education, etc.);
- Agreement by the patient that it is the role of the practitioner to determine whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine services, such as encrypting date of service, password protected screen savers, encrypting data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

Medical Records:

The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-practitioner communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine services. Informed consents obtained in connection with an encounter involving telemedicine services should also be filed in the medical record. The patient record established during the use of telemedicine services must be accessible to both the practitioner and the patient, and consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records and Exchange of Information:

Written policies and procedures should be maintained for documentation, maintenance, and transmission of the records of encounters using telemedicine services. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the practitioner addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication,

such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Section Four: Prescribing:

Prescribing controlled substances requires the establishment of a bona fide practitioner-patient relationship in accordance with § 54.1-3303 (A) of the Code of Virginia. Prescribing controlled substances, in-person or via telemedicine services, is at the professional discretion of the prescribing practitioner. The indication, appropriateness, and safety considerations for each prescription provided via telemedicine services must be evaluated by the practitioner in accordance with applicable law and current standards of practice and consequently carries the same professional accountability as prescriptions delivered during an in-person encounter. Where such measures are upheld, and the appropriate clinical consideration is carried out and documented, the practitioner may exercise their judgment and prescribe controlled substances as part of telemedicine encounters in accordance with applicable state and federal law.

Prescriptions must comply with the requirements set out in Virginia Code §§ 54.1-3408.01 and 54.1-3303(A). Prescribing controlled substances in Schedule II through V via telemedicine also requires compliance with federal rules for the practice of telemedicine. Practitioners issuing prescriptions as part of telemedicine services should include direct contact for the prescriber or the prescriber's agent on the prescription. This direct contact information ensures ease of access by pharmacists to clarify prescription orders, and further facilitates the prescriber-patient-pharmacist relationship.

For the purpose of prescribing Schedule VI controlled substances, "telemedicine services" is defined as it is in § 38.2-3418.16 of the Code of Virginia. Under that definition, *"telemedicine services," as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.*

Section Five: Guidance Document Limitations.

Nothing in this document shall be construed to limit the authority of the Board to investigate, discipline, or regulate its licensees pursuant to applicable Virginia statutes and regulations. Additionally, nothing in this document shall be construed to limit the Board's ability to review the delivery or use of telemedicine services by its licensees for adherence to the standard of care and compliance with the requirements set forth in the laws and regulations of the Commonwealth of Virginia. Furthermore, this document does not limit the Board's ability to determine that certain situations fail to meet the standard of care or standards set forth in laws and regulations despite technical adherence to the guidance produced herein.

Statutory references:

§ 54.1-3303. Prescriptions to be issued and drugs to be dispensed for medical or therapeutic purposes only.

A. A prescription for a controlled substance may be issued only by a practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine who is authorized to prescribe controlled substances, or by a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed physician assistant pursuant to § 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32.

B. A prescription shall be issued only to persons or animals with whom the practitioner has a bona fide practitioner-patient relationship or veterinarian-client-patient relationship.

A bona fide practitioner-patient relationship shall exist if the practitioner has (i) obtained or caused to be obtained a medical or drug history of the patient; (ii) provided information to the patient about the benefits and risks of the drug being prescribed; (iii) performed or caused to be performed an appropriate examination of the patient, either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically; and (iv) initiated additional interventions and follow-up care, if necessary, especially if a prescribed drug may have serious side effects. Except in cases involving a medical emergency, the examination required pursuant to clause (iii) shall be performed by the practitioner prescribing the controlled substance, a practitioner who practices in the same group as the practitioner prescribing the controlled substance, or a consulting practitioner. In cases in which the practitioner is an employee of the Department of Health and is providing expedited partner therapy consistent with the recommendations of the Centers for Disease Control and Prevention, the examination required by clause (iii) shall not be required.

A practitioner who has established a bona fide practitioner-patient relationship with a patient in accordance with the provisions of this subsection may prescribe Schedule II through VI controlled substances to that patient, provided that, in cases in which the practitioner has performed the examination required pursuant to clause (iii) by use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically, the prescribing of such Schedule II through V controlled substance is in compliance with federal requirements for the practice of telemedicine.

For the purpose of prescribing a Schedule VI controlled substance to a patient via telemedicine services as defined in § 38.2-3418.16, a prescriber may establish a bona fide practitioner-patient relationship by an examination through face-to-face interactive, two-way, real-time communications services or store-and-forward technologies[3] when all of the following conditions are met: (a) the patient has provided a medical history that is available for review by the prescriber; (b) the prescriber obtains an updated medical history at the time of prescribing; (c) the prescriber makes a diagnosis at the time of prescribing; (d) the prescriber conforms to the standard of care expected of in-person care as appropriate to the patient's age and presenting condition, including when the standard of care requires the use of diagnostic

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

testing and performance of a physical examination, which may be carried out through the use of peripheral devices appropriate to the patient's condition; (e) the prescriber is actively licensed in the Commonwealth and authorized to prescribe; (f) if the patient is a member or enrollee of a health plan or carrier, the prescriber has been credentialed by the health plan or carrier as a participating provider and the diagnosing and prescribing meets the qualifications for reimbursement by the health plan or carrier pursuant to § 38.2-3418.16; and (g) upon request, the prescriber provides patient records in a timely manner in accordance with the provisions of § 32.1-127.1:03 and all other state and federal laws and regulations. Nothing in this paragraph shall permit a prescriber to establish a bona fide practitioner-patient relationship for the purpose of prescribing a Schedule VI controlled substance when the standard of care dictates that an in-person physical examination is necessary for diagnosis. Nothing in this paragraph shall apply to: (1) a prescriber providing on-call coverage per an agreement with another prescriber or his prescriber's professional entity or employer; (2) a prescriber consulting with another prescriber regarding a patient's care; or (3) orders of prescribers for hospital out-patients or in-patients.

Any practitioner who prescribes any controlled substance with the knowledge that the controlled substance will be used otherwise than medicinally or for therapeutic purposes shall be subject to the criminal penalties provided in § 18.2-248 for violations of the provisions of law relating to the distribution or possession of controlled substances.

§ 54.1-3408.01. Requirements for prescriptions.

A. The written prescription referred to in § 54.1-3408 shall be written with ink or individually typed or printed. The prescription shall contain the name, address, and telephone number of the prescriber. A prescription for a controlled substance other than one controlled in Schedule VI shall also contain the federal controlled substances registration number assigned to the prescriber. The prescriber's information shall be either preprinted upon the prescription blank, electronically printed, typewritten, rubber stamped, or printed by hand.

The written prescription shall contain the first and last name of the patient for whom the drug is prescribed. The address of the patient shall either be placed upon the written prescription by the prescriber or his agent, or by the dispenser of the prescription. If not otherwise prohibited by law, the dispenser may record the address of the patient in an electronic prescription dispensing record for that patient in lieu of recording it on the prescription. Each written prescription shall be dated as of, and signed by the prescriber on, the day when issued. The prescription may be prepared by an agent for the prescriber's signature.

This section shall not prohibit a prescriber from using preprinted prescriptions for drugs classified in Schedule VI if all requirements concerning dates, signatures, and other information specified above are otherwise fulfilled.

No written prescription order form shall include more than one prescription. However, this provision shall not apply (i) to prescriptions written as chart orders for patients in hospitals and long-term-care facilities, patients receiving home infusion services or hospice patients, or (ii) to a prescription ordered through a pharmacy operated by or for the Department of Corrections or the Department of Juvenile Justice, the central pharmacy of the Department of Health, or the central outpatient pharmacy operated by the Department of Behavioral Health and Developmental Services; or (iii) to prescriptions written for patients residing in adult and juvenile detention centers, local or regional jails, or work release centers operated by the Department of Corrections.

B. Prescribers' orders, whether written as chart orders or prescriptions, for Schedules II, III, IV, and V controlled drugs to be administered to (i) patients or residents of long-term care facilities served by a Virginia pharmacy from a remote location or (ii) patients receiving parenteral, intravenous, intramuscular, subcutaneous or intraspinal infusion therapy and served by a home infusion pharmacy from a remote location, may be transmitted to that remote pharmacy by an electronic communications device over telephone lines which send the exact image to the receiver in hard copy form, and such facsimile copy shall be treated as a valid original prescription order. If the order is for a radiopharmaceutical, a physician authorized by state or federal law to possess and administer medical radioactive materials may authorize a nuclear medicine technologist to transmit a prescriber's verbal or written orders for radiopharmaceuticals.

C. The oral prescription referred to in § 54.1-3408 shall be transmitted to the pharmacy of the patient's choice by the prescriber or his authorized agent. For the purposes of this section, an authorized agent of the prescriber shall be an employee of the prescriber who is under his immediate and personal supervision, or if not an employee, an individual who holds a valid license allowing the administration or dispensing of drugs and who is specifically directed by the prescriber.

Guidance Document 85-13

Adopted: January 22, 2004
Revised:

Virginia Board of Medicine

Guidelines on Performing Procedures on the Newly Deceased for Training Purposes

Section 54.1-2961 of the Code of Virginia provides:

E. The Board of Medicine shall adopt guidelines concerning the ethical practice of physicians practicing in emergency rooms, surgeons, and interns and residents practicing in hospitals, particularly hospital emergency rooms, or other organizations operating graduate medical education programs. These guidelines shall not be construed to be or to establish standards of care or to be regulations and shall be exempt from the requirements of the Administrative Process Act (§ 2.2-4000 et seq.). The Medical College of Virginia of Virginia Commonwealth University, the University of Virginia School of Medicine, the Eastern Virginia Medical School, the Medical Society of Virginia, and the Virginia Hospital and Health Care Association shall cooperate with the Board in the development of these guidelines.

The guidelines shall include, but need not be limited to (i) the obtaining of informed consent from all patients or from the next of kin or legally authorized representative, to the extent practical under the circumstances in which medical care is being rendered, when the patient is incapable of making an informed decision, after such patients or other persons have been informed as to which physicians, residents, or interns will perform the surgery or other invasive procedure; (ii) except in emergencies and other unavoidable situations, the need, consistent with the informed consent, for an attending physician to be present during the surgery or other invasive procedure; (iii) policies to avoid situations, unless the circumstances fall within an exception in the Board's guidelines or the policies of the relevant hospital, medical school or other organization operating the graduate medical education program, in which a surgeon, intern or resident represents that he will perform a surgery or other invasive procedure that he then fails to perform; and (iv) policies addressing informed consent and the ethics of appropriate care of patients in emergency rooms. Such policies shall take into consideration the nonbinding ban developed by the American Medical Association in 2000 on using newly dead patients as training subjects without the consent of the next of kin or other legal representative to extent practical under the circumstances in which medical care is being rendered.

Therefore, as guidance to its licensees, the Virginia Board of Medicine has endorsed the ethical guideline on performing procedures on the newly deceased for training purposes adopted by the American Medical Association in June, 2001, as follows:

"Physicians should work to develop institutional policies that address the practice of performing procedures on the newly deceased for purposes of training. Any such policy should ensure that the interests of all the parties involved are respected under established and clear ethical guidelines. Such policies should consider rights of patients and their families, benefits to trainees and society, as well as potential harm to the ethical sensitivities of trainees, and risks to staff, the institution and the profession associated with performing procedures on the newly deceased without consent. The following considerations should be addressed before medical trainees perform procedures on the newly deceased:

(1) The teaching of life-saving skills should be the culmination of a structured training sequence, rather than relying on random opportunities. Training should be performed

under close supervision, in a manner and environment that takes into account the wishes and values of all involved parties.
(2) Physicians should inquire whether the deceased individual had expressed preferences regarding handling of the body or procedures performed after death. In the absence of previously expressed preferences, physicians should obtain permission from the family before performing such procedures. When reasonable efforts to discover previously expressed preferences of the deceased or to find someone with authority to grant permission for the procedure have failed, physicians must not perform procedures for training purposes on the newly deceased patient.

In the event post-mortem procedures are undertaken on the newly deceased, they must be recorded in the medical record."[1]

[1] American Medical Association, Council on Ethical and Judicial Affairs, Code of Medical Ethics, Opinion 8.181, "Performing Procedures on the Newly Deceased for Training Purposes," adopted June 2001.

Adopted: January 22, 2004
Revised:

Virginia Board of Medicine
Guidance Document 85-15

Guidelines Concerning the Ethical Practice of Attending Physicians and Fellows, Residents and Interns

Explanation of the nature and risk of an operation to the patient or to the patient's representative is essential.

Before surgery or an invasive procedure is performed, informed consent should be obtained from the patient in accordance with the policies of the health care entity. Patients should understand the indications for the surgery or invasive procedure, the risk involved, and the result that is hoped to be attained. In the instance of a minor or a patient who is incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent should be informed and the consent of the person documented. An exception to the requirement for consent prior to or during the performance of surgery or an invasive procedure may be made if a delay in obtaining consent would likely result in imminent harm to the patient.

Under the usual and customary arrangement with patients, and with reference to the usual form of consent to surgery or an invasive procedure, it is the attending physician to whom the patient grants consent and who is obligated to perform the surgery or invasive procedure. With the consent of the patient or another legally authorized person available to give consent, it is ethical for the attending physician to delegate the performance of some or all aspects of the surgery or invasive procedure to the fellow, resident, intern or assistant provided this is done under the physician's supervision as described in the supervising policy of the Accreditation Council for Graduate Medical Education (ACGME). If some or all of the surgery or procedure is to be delegated to another health care provider or if care of the patient is to be turned over to another attending physician, the patient or the legally authorized person available to give consent is entitled to be so informed and to give documented consent.

It is unethical to mislead a patient as to the identity of the doctor who performs the surgery or invasive procedure. If the identified attending physician cannot perform the surgery or invasive procedure due to any unusual or emergency reasons, the patient or another legally authorized person available to give consent must be fully informed and given another opportunity to accept or reject the replacement physician.

Supervision of trainees (fellows, residents and interns) by attending physicians

The attending physician has both an ethical and a professional responsibility for the overall care of the individual patient and for the supervision of any trainee involved in the care of the patient. Although senior trainees require less direction than their junior counterparts, even the most senior ~~must~~ should be supervised. A chain of command that emphasizes graded authority and increasing responsibility as experience is gained ~~must~~ should be established.

Judgments on this delegation of responsibility ~~must~~ should be made by the attending physician who is ultimately responsible for the patient's care; such judgments ~~shall~~ should be based on the attending physician's direct observation and knowledge of each trainee's skills and ability.

To ensure the fulfillment of these responsibilities, the following principles of supervision ~~must~~ should be operative within a training program.

1. Supervision of trainees ~~must~~ should be specified in the bylaws, policies, procedures, rules and/or regulations of the department which ~~must~~ should not be less demanding that those of the institution.
2. Evidence that adequate supervision exists within a program ~~must~~ should be provided in the form of signed notes in the patient charts and/or other such records.
3. Proper supervision ~~must~~ should not conflict with progressively more independent decision-making on the part of the trainee; thus, the degree of supervision may vary with the clinical circumstances and the training level of the trainee. However, to exercise their responsibilities properly, members of the teaching staff always ~~must~~ should be immediately available for consultation and support.

For the purposes of this guidance document, "invasive procedure" shall mean any diagnostic or therapeutic procedure performed on a patient that is not part of routine, general care and for which the usual practice within the institution is to document specific informed consent from the patient or surrogate decision-maker prior to proceeding.

Virginia Board of Medicine **Guidance Document 85-16**

Revised:

Questions and Answers on Continuing Competency Requirements for the Virginia Board of Medicine

1. **When must I have the required number of continuing competency hours completed in order to renew my license?**

   In your birth month in even years. You will be required to sign a certification on your renewal form that you have met the continuing competency requirements. Falsification on the renewal form is a violation of law and may subject you to disciplinary action.

2. **Am I required to send in evidence of my continuing competency hours at the time I renew?**

   No. The Board will randomly select licensees for a post-renewal audit. If selected, you would be notified by mail that documentation is required and given a time frame within which to comply.

3. **When do the continuing competency requirements begin?**

   Hours must be obtained within the two years immediately preceding renewal. You may not count any hours obtained prior to 24 months preceding renewal nor may you carry over excess hours to the following biennium.

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

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

5. **What are "Type 1" hours?**

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

6. **What are "Type 2" hours?**

   Type 2 hours (no more than 30 each biennium) are those earned in self-study, attending professionally related meetings, research and writing for a journal, learning a new procedure, sitting with the hospital ethics panel, etc. They are activities chosen by the practitioner based on assessment of his/her practice. They do not have to be sponsored by an accrediting organization, but must be recorded by the practitioner on the form provided by the Board.

7. **Where do I obtain the instructions and forms for continuing competency requirements?**

   Forms and instructions can be downloaded from the Board's website at: www.dhp.virginia.gov/medicine/medicine_forms.htm. Records may be maintained electronically, but

copies of documentation and forms will be necessary if a practitioner is audited following a renewal cycle. Forms may also be copied.

8. **Is it possible for a practitioner to earn accredited hours that are sanctioned by the profession but are outside the specialty area in which he/she practices?**

   Yes. For example, a pediatrician or a surgeon could receive credit for documented hours sponsored by the American Academy of Family Practice.

9. **What if I have earned the AMA Physician Recognition Award or have been recertified by my specialty board? Would that count for my continuing competency hours?**

   Yes. Provided the Board has documented proof that the requirements to obtain the AMA award (or other similar awards) or specialty board certification are equal to or exceed those required for renewal of licensure. It would only be necessary to submit evidence of having such an award or certification.

10. **What if I am newly licensed? Do I still have to obtain the full 60 hours of continued competency?**

    No. There is an exemption for those persons and for anyone practicing solely without pay in a practice (free clinic, rescue squad, etc.) that is under the direction of a fully licensed physician.

11. **What if I become ill or incapacitated and unable to complete my continuing competency requirements prior to renewal?**

    Upon written request from the practitioner explaining the circumstances, the Board may grant an extension or exemption for all or part of the required hours.

12. **What if I am now retired and don't want to obtain continuing competency hours but don't want to give up my license?**

    You may request an inactive license from the Board, beginning with your next renewal. It is important to note that **holding an inactive license does not authorize anyone to engage in the practice of medicine, osteopathy, podiatry or chiropractic in Virginia**. If you intend to practice at all in Virginia, even on a part-time or non-compensatory basis, you must retain your active license.

13. **What happens if I take inactive licensure status and later decide to reactivate?**

    A practitioner seeking to reactivate a license must pay the active renewal fee and obtain the number of hours which would have be required for the years in which the license was inactive (not to exceed four years). If the practitioner has not been engaged in active practice for more than four years, he/she must pass a special purpose examination in his area of licensure.

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

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

    The Code of Virginia also requires certain prescribers identified by the Director of the Department of Health Professions to complete two hours of Type 1 continuing education in each biennium on topics

related to pain management, the responsible prescribing of covered substances, and the diagnosis and management of addiction. Prescribers who are required to complete such continuing education for the coming biennium are notified no later than January 1 of each odd-numbered year.

Guidance Document 85-23 **Revised:**

Virginia Board of Medicine on

Use of Confidential Consent Agreements

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

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

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

Guidance Document: 85-26 Revised: 10/18/2018

Board of Medicine

Guidance Document on Compliance with Law for Licensed Midwives

The following sections of the Code of Virginia have been identified as applicable to the practice of a licensed midwife. *The listing is not intended to be all-inclusive but should be regarded as a reference for the legal responsibilities of a midwife*. Each section is listed as an electronic link to the actual language in the Code. Every licensed midwife should familiarize herself with these and any other legal responsibilities relating to her care of an expectant mother and her newborn child.

Below the listing of Code sections may be found links and contact information that may be used for additional resources on compliance with law and regulation.

§ 32.1-49. Tuberculosis required to be reported.

§ 32.1-60. Prenatal tests required.

§ 32.1-61. Definition.

§ 32.1-62. Procedure upon infant's birth.

§ 32.1-63. Duty of physician, midwife or nurse noting ophthalmia neonatorum.

§ 32.1-64.1. Virginia Hearing Impairment Identification and Monitoring System.

§ 32.1-65. Certain newborn screening required.

§ 32.1-66. Commissioner to notify physicians; reports to Commissioner.

§ 32.1-73. Failure to comply with provisions; grounds for revocation of license or permit.

§ 32.1-127.1:03. Health records privacy.

§ 32.1-134.01. Certain information required for maternity patients.

§ 32.1-257. Filing birth certificates; from whom required; signatures of parents.

§ 32.1-257.1. Parents to report social security account number at time of child's birth.

§ 32.1-264. Reports of fetal deaths; medical certification; investigation by medical examiner; confidentiality of information concerning abortions.

§ 32.1-285.1. Death of infants under eighteen months of age; autopsies required; definition of Sudden Infant Death Syndrome.

§ 54.1-2403.01. Routine component of prenatal care.

§ 54.1-2403.02. Prenatal education; cord blood banking.

§ 54.1-2403.1. Protocol for certain medical history screening required.

§ 63.2-1509. Requirement that certain injuries to children be reported by physicians, nurses, teachers, etc.; penalty for failure to report.

For additional information or guidance on compliance with law in Chapter 32.1 of the Code of Virginia, contact: Cornelia Deagle, VDH's Director of the Division of Child and Family Health, at cornelia.deagle@vdh.virginia.gov or (804) 864-7691.

You may access further information and additional resources at:
http://www.vdh.virginia.gov/vdhlivewell/women/ and
http://www.vdh.virginia.gov/vdhlivewell/infants-children-and-teens/.

Guidance document: 85-27 Revised:

Board of Medicine
Guidance Document
Role of Licensed Midwives in Newborn Hearing Screening, Documentation, and Reporting

1. Record risk indicators for hearing loss, as recommended by the Joint Committee on Infant Hearing in the most recent position statement.
    a. That statement can be found at the following Web site: http://www.jcih.org/ .
    b. Clarifications for these risk indicators can be found on the Virginia Department of Health (VDH) Virginia Early Hearing Detection and Intervention Web site, under, http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/hearing/hospitals.htm, Hospital Protocols for Newborn Hearing Screening as well as Risk Indicators for Progressive or Delayed-Onset Hearing Loss.

2. Report infants with risk indicators, regardless of whether or not the CPM conducts a physiological newborn hearing screening, to the VDH Early Hearing Detection and Intervention (EHDI) Program.
    a. Screening/Audiological Reporting Form (revised 01/12) can be downloaded from http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/hearing/audiologists.htm
    b. Instructions can be downloaded from http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/hearing/audiologists.htm

3. Conduct initial physiological hearing screen or refer to an audiologist for the initial hearing screen.

    a. If the CPM elects to perform the physiological newborn hearing screening, the results should be reported on the same form referenced in 2. a. above.
    b. If the CPM elects to perform the physiological newborn hearing screening and the parent refuses the screening, this also should be reported on the above-referenced form.

4. The results of the newborn hearing screening conducted by the CPM can be reported on the form, in Section E. Parent refusal should be noted in the same section. When the form is revised, screening results can be recorded in Section E; refusals should be recorded under Notes/Comments. The CPM should not use this form to report results of screening conducted by other parties.

5. If the CPM elects to refer the infant for the physiological newborn hearing screening, a list of audiologists approved for full assessment can be found on the program Web site www.vahealth.org/hearing by selecting the Audiological Facilities tab or by visiting the Early Hearing Detection and Intervention Pediatric Audiology Links to Services (EHDIPALS) web site http://www.ehdipals.org/SmartTool/EP_SmartTool.aspx

6. Information about newborn hearing screening equipment can be found on the National Center for Hearing Assessment and Management (NCHAM) Web site, http://www.infanthearing.org/screening/equipment.html . NCHAM is the National Resource Center for Early Hearing Detection and Intervention and is supported by grant funding from the U.S. Department of Health and Human Services, Maternal and Child Health Bureau.

7. Questions regarding protocols and the VDH EHDI Program management can be directed to Jennifer MacDonald, Program Manager, at 804-864-7729 or jennifer.macdonald@vdh.virginia.gov. Questions about managing referrals can be directed to Daphne Miller, toll free at 866-493-1090.

Agenda Item:	**VCA - Request for Approval to Offer TYPE I CEs to Chiropractors**
Staff Note:	The Virginia Chiropractic Association seeks approval from the Board of Medicine as a provider of Type 1 continuing education. Type 1 education is that which is offered by an accredited sponsor or organization sanctioned by the profession. On the following pages you will find a letter from Julie Connolly, Executive Director for the VCA and the regulations regarding chiropractic CE. Note that the regulations include language "or any other organization approved by the Board."
Action:	Discuss and vote yea or nay.

The Unified VCA Virginia Chiropractic Association
Favoring the Health of Virginians

PO Box 15
Afton, VA 22920
Phone 540-932-3100
Fax 540-932-3101
www.virginiachiropractic.org

MEMORANDUM

TO: William L. Harp, MD
Executive Director
Virginia Board of Medicine

FROM: Julie K. Connolly, FICC
Executive Director
Virginia Chiropractic Association

DATE: August 7, 2018

RE: *REQUEST FOR BOARD OF MEDICINE APPROVAL FOR VIRGINIA CHIROPRACTIC ASSOCIATION AS AN ORGANIZATION TO OFFER TYPE 1 CONTINUING EDUCATION TO CHIROPRACTORS*

As permitted by the Virginia Board of Medicine regulations, the Virginia Chiropractic Association (VCA) respectfully requests the Board to approve VCA as an organization to offer Type 1 clinical hours for chiropractors. 18VAC 85-20-235, continued competency requirements for renewal of an active license, specifically section A.1.a, states "Type 1 hours in chiropractic shall be clinical hours that are approved by the Council on Chiropractic Education or any other organization approved by the board (emphasis added.)

As Virginia's only statewide professional organization for chiropractors, VCA provides, arranges, coordinates and offers the vast majority of Type 1 continuing education hours. Courses offered area available to all Virginia licensed doctors of chiropractic and in various parts of the Commonwealth. Our programs and course offerings are highly regarded nationally, regionally and in Virginia.

To assist chiropractors licensed in more than one state, the Board has previously approved an organization called "PACE." VCA works closely with PACE but believes allowing our organization to directly provide Type 1 continuing education will result in a greater number of offerings with more diversity.

For the above reasons, the Virginia Chiropractic Association respectfully requests the Virginia Board of Medicine add VCA as an approved organization to provide Type 1 continuing education for chiropractors.

Should you have any questions or wish to discuss, please don't hesitate to contact me (phone 540-932-3100, email jconnolly@virginiachiropractic.org).

Sincerely,

Julie K. Connolly, FICC
Executive Director
Virginia Chiropractic Association

Colanthia Opher

From: Harp, William
Sent: Thursday, August 9, 2018 9:18 AM
To: Colanthia D. Morton
Subject: Fwd: Type 1 CE for Chiropractors
Attachments: To Dr Harp from UVCA 8-7-18 Signed.pdf

For the October Board

---------- Forwarded message ----------
From: **Julie Connolly** <jconnolly@virginiachiropractic.org>
Date: Wed, Aug 8, 2018 at 4:08 PM
Subject: Type 1 CE for Chiropractors
To: william.harp@dhp.virginia.gov

Dear Dr. Harp:

Please see our attached letter requesting approval for the Virginia Chiropractic Association as an organization to offer Type 1 CE to Doctors of Chiropractic.

Should you have any questions or comments, please don't hesitate to contact me at 540-932-3100 or via email, jconnolly@virginiachiropractic.org.

We look forward to your feedback. On behalf of the UVCA's Board of Directors, thank you for your time and consideration.

Warm regards,

Julie

Unified VCA

Julie K Connolly, FICC

Executive Director

Unified Virginia Chiropractic Association

PO Box 15, Afton, VA 22920

Phone 540-932-3100

Fax 540-932-3101

Email jconnolly@virginiachiropractic.org

www.virginiachiropractic.org

Ensuring the Health of Virginians

The Unified VCA's Mission:

Helping Doctors of Chiropractic deliver exceptional care.

The Unified VCA's Vision:

Chiropractic positioned as a highly regarded health care profession that improves and advances public health and well-being.

Virginia Administrative Code
Title 18. Professional and Occupational Licensing
Agency 85. Board of Medicine
Chapter 20. Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic

18VAC85-20-235. Continued Competency Requirements for Renewal of an Active License.

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

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

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

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

2. No more than 30 of the 60 hours may be Type 2 activities or courses, which may or may not be approved by an accredited sponsor or organization but which shall be chosen by the licensee to address such areas as ethics, standards of care, patient safety, new medical technology, and patient communication. Up to 15 of the Type 2 continuing education hours may be satisfied through delivery of services, without compensation, to low-income individuals receiving services through a local health department or a free clinic organized in whole or primarily for the delivery of health services. One hour of continuing education may be credited for one hour of providing such volunteer services. For the purpose of continuing education credit for voluntary service, documentation by the health department or free clinic shall be acceptable.

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

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

D. The board shall periodically conduct a random audit of its active licensees to determine compliance. The practitioners selected for the audit shall provide all supporting documentation within 30 days of receiving notification of the audit.

E. Failure to comply with these requirements may subject the licensee to disciplinary action by the board.

F. The board may grant an extension of the deadline for continuing competency requirements for up to one year for good cause shown upon a written request from the licensee prior to the renewal date.

G. The board may grant an exemption for all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

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

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

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

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

Historical Notes
Derived from Volume 16, Issue 04, eff. December 8, 1999; amended, Virginia Register Volume 20, Issue 10, eff. February 25, 2004; Volume 23, Issue 11, eff. April 21, 2007; Volume 23, Issue 25, eff. September 20, 2007; Volume 29, Issue 04, eff. November 21, 2012; Volume 33, Issue 11, eff. March 9, 2017.

Agenda Item:	**Proposed Recommendations for the report of the Virginia Maternal Mortality Review Team**
Staff Note:	On the following pages you will find an e-mail from Melanie Rouse, PhD, Maternal Mortality Projects Coordinator for the Office of the Chief Medical Examiner with proposed recommendations for the Board of Medicine and DHP, a preliminary response from Dr. Harp, and an article from the president and past-president of the American College of Obstetricians and Gynecologists.
Action:	Discuss and further refine the response to Dr. Rouse.

Colanthia Opher

From: Harp, William
Sent: Friday, August 24, 2018 9:37 AM
To: Melanie Rouse; Brown, David; Kevin Oconnor; Barbara Allison-Bryan; Colanthia D. Morton
Subject: Fwd: Virginia Maternal Mortality Review Team - Request for Comment on Recommendations for Virginia Board of Medicine

Dear Dr. Rouse:

Thank you for your message and the opportunity to comment on the proposed recommendations for the report of the Virginia Maternal Mortality Review Team.

The mission of the Board of Medicine is to protect the public vis-a-vis its licensees by licensing and regulating over 70,000 individuals in 21 professions, and another 10,000 nurse practitioners jointly with the Board of Nursing. All the professions have continuing competency requirements that are specific to the profession. Since continuing education (CE) hours were mandated for renewal of one's license in 1998, the Board has expected its licensees to select CE hours/courses that are applicable to their day-to-day work. By choosing wisely, licensees will be better prepared to safely and competently care for their patients in alignment with the mission of the Board.

The Board is aware of and shares your concern over maternal mortality and morbidity. Chronic conditions such as obesity, hypertension, diabetes, heart disease, substance abuse, and depression have an impact, as well as advanced age at delivery and increased C-section rates. Most providers that care for women of child-bearing age likely do choose CE that addresses these issues and more.

Presently the Board of Medicine mandates 60 hours of CE each biennium for its doctors. As stated above, doctors are encouraged and expected to select CE that will help them care for their patients. Currently, there are only 2 mandated topics. One is in regulation, and the other is in the Code. The first required CE pertains to anesthesia. If a doctor provides or supervises anesthesia in his/her office, then s/he must obtain 4 hours of CE every biennium prior to renewal of his/her license. The second is the requirement to obtain 2 hours of opioid CE on pain management, responsible prescribing of controlled substances, and the diagnosis and management of addiction.

Over the years, the Board of Medicine has been reluctant to add required topics, relying on its licensees to know best what focused educational topics will benefit their patients.

This is a preliminary response that you requested by August 31st, but I will see that the Team's recommendations are put before the full Board for consideration at its meeting on October 18th.

With kindest regards,

William L. Harp, MD
Executive Director
Virginia Board of Medicine

---------- Forwarded message ----------
From: **Rouse, Melanie** <melanie.rouse@vdh.virginia.gov>
Date: Fri, Aug 10, 2018 at 1:29 PM
Subject: Virginia Maternal Mortality Review Team - Request for Comment on Recommendations for Virginia Board of Medicine
To: yy Board of Medicine <medbd@dhp.virginia.gov>

Dear Dr. Harp:

I am the coordinator for Virginia's Maternal Mortality Review Team. This multidisciplinary Team represents a collaborative effort between the Virginia Department of Health's Office of the Chief medical Examiner and Family Health Services. The Team's mission is to review all deaths to Virginia residents who were pregnant when they died or who had been pregnant in the year before their death. The purpose of these reviews is to recommend strategies to prevent similar deaths in the future.

The Team is developing consensus recommendations for addressing chronic conditions during pregnancy and the postpartum period. Some of these recommendations support the work and are critical to the mission of the Department of Health Professions and the Virginia Board of Medicine. The Team would like to give you an opportunity to review these recommendations and provide feedback prior to finalizing them.

The following recommendations have been proposed for the Department of Health Professions and the Virginia Board of Medicine:

1. This recommendation is directed to the Virginia Board of Medicine. All healthcare providers licensed by the Board of Medicine should be required receive and maintain training (through continuing medical education requirements) in the contemporary management of chronic diseases in women of childbearing age within the scope of practice in their specialty.

2. This recommendation is directed to the Virginia Board of Medicine. All providers of care to women of childbearing age should be trained in and engage in Screening, Brief Intervention and Referral to Treatment (SBIRT) for substance abuse, mental illness, domestic violence and trauma at the initiation of care.

3. This recommendation is directed to the Department of Health Professions. Given that women with chronic diseases have worse outcomes during pregnancy and the postpartum period, we recommend that board certifiers promote and incentivize the use of established prescribed management algorithms for standards of care for the treatment of pregnant and postpartum women through required Continued Medical Education. These should include the management of hypertension, heart failure, and hemorrhage.

If you have any questions, need additional information, or wish to comment, please let me know by August 31, 2018. The Team will meet in September to finalize the recommendations.

Thank you so much for your consideration of these items.

Regards,

Melanie Rouse

--

Melanie J. Rouse, PhD
Maternal Mortality Projects Coordinator
Office of the Chief Medical Examiner
737 North 5th Street, Suite 301
Richmond, VA 23219
Phone: 804.205.3857
Fax: 804.786.1877

Commonwealth of Virginia

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

Bill..... a timely piece that came in today. David Giammittorio

1 message

David C Giammittorio, MD <drgmmtto@gmail.com> Mon, Aug 20, 2018 at 8:59 AM
To: "Harp, William L. (DHP)" <William.Harp@dhp.virginia.gov>

SA

by Lisa M. Hollier, MD, MPH, and Haywood L. Brown, MD
August 19, 2018

There are nearly 4 million births a year in the U.S., and almost 60% of those deliveries occur at hospitals with fewer than 1,000 births a year. That amounts to roughly 3 births a day -- compared to 11 a day at a major metropolitan hospital -- and for hospitals in extremely rural areas it's even less than that.

The most recent notable articles about the increases in maternal morbidity -- "Deadly Deliveries" in *USA Today* and the "Lost Mothers" series by *ProPublica* and *NPR* -- have raised public awareness and concern among U.S. women, providers, and communities about the dangers of childbirth. In those articles is a search for answers.

> While maternal deaths rarely occur due to a single factor, we can point to specific contributors, including a greater prevalence of comorbidities in women, such as obesity, hypertension, diabetes, and heart disease. Other factors may include the advancing age of women having children and increases in cesarean delivery rates.
>
> Additionally, lack of access to care and the fragmentation of prenatal and delivery services in many rural communities have become risk factors for a large number of women across the country. Health outcomes are worse and healthcare disparities are more pronounced because poverty and lack of resources are more common in many rural communities.

Cardiovascular disease, substance abuse, opioid addiction, depression, and suicide are also leading contributors to the maternal mortality problem in the U.S., and we are

seeing these issues emerge in rural populations at alarming rates. Team-based and coordinated care is fundamental to addressing these conditions and is an important element in a quality-focused and safety-focused obstetrical practice.

Healthcare providers and obstetrical teams must know how to consistently manage common preventable pregnancy complications, such as hemorrhage, hypertension, and thromboembolism. For example, in cases of severe hypertension, hospitals and staff must be trained and have access to appropriate medication to lower blood pressure, which must be given in a timely manner based on hospital protocol. Every hospital, regardless of size, should have best practices for treating hemorrhage and prevention guidance for thromboembolism, which must be followed for every woman undergoing cesarean delivery.

Through the Alliance for Innovation on Maternal Health (AIM), best practices in maternal care, or safety bundles, are being rapidly adopted by an increasing number of hospitals across the U.S. This program relies on state teams, comprised of hospitals, state health departments, perinatal quality collaboratives and provider groups, and focuses on maternal safety and quality improvement. And it's working. Four states that were the first to join the AIM initiative have shown early signs of improvement in severe maternal morbidity.

However, there is more work to be done. It is critical that delivery services develop protocols based on these AIM bundles and have a team-based model for assessing risks, regardless of hospital size. Hospital leadership must insist on obstetrical quality and safety team training and maintenance programs in every hospital, regardless of level. There must also be systems in place to collaborate and communicate with other hospitals in the region.

The American College of Obstetricians and Gynecologists (ACOG) Levels of Maternal Care(LoMC) program helps facilitate these efforts. This program assesses the complexity of maternity care that a hospital is able to provide. It also supports collaboration with other institutions within a region to ensure women, particularly those with high-risk pregnancies, can be transferred to a facility that best meets their needs. States and hospitals are increasingly adopting the LoMC format, and Texas recently

mandated that hospitals have a level of care designation for maternity services to receive payment from the Medicaid program.

ACOG supports the use of telemedicine to assist communities and providers in implementing AIM, LoMC, and community-based care in clinics and hospitals to streamline protocols, guidelines, and collaborations for consultation and referral. For every maternal death, there are at least 50 near deaths, and these programs are designed to help prevent or address cases of severe morbidity in addition to preventing mortality.

Through these efforts and others, hospital leadership, obstetrical providers and community advocates are working toward the common goal of ensuring healthy birth outcomes for women and families, regardless of where they live.

Lisa M. Hollier, MD, MPH, and Haywood L. Brown, MD, are the president and immediate past president, respectively, of ACOG, the nation's leading group of physicians providing healthcare for women. It is a private, voluntary, nonprofit membership organization of more than 58,000 members.

LAST UPDATED 08.17.2018

Comment

--
David Giammittorio, MD
CEO, The Physician and Midwife Collaborative Practice
4660 Kenmore ave suite 902
Alexandria VA 22304
571-483-4301
drgmmtto@gmail.com

Agenda Item:	**Licensing Report**
Staff Note:	Staff will update the Board on licensing issues.
Action:	None anticipated.

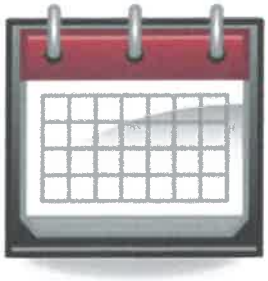
Agenda Item: **Discipline Report**

Staff Note: Ms. Deschenes will provide information on discipline matters.

Action: None anticipated.

Next Meeting Date of the Full Board is

February 14-16, 2019



Please check your calendars and advise staff of any known conflicts that may affect your attendance.

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

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

November 21, 2018