Legislative Committee Meeting

Virginia Board of Medicine

January 15, 2021

8:30 a.m.

AGENDA
VIRTUAL MEETING of the Legislative Committee

Virginia Board of Medicine
Friday, January 15, 2021, 8:30 a.m.

Page

Call to Order – Blanton Marchese – Vice-President, Chair

Roll Call

Adoption of Agenda

Public Comment on Agenda Items (15 minutes)

New Business

Supplemental Information

Following page 83 is supplemental information provided to the members after the initial posting of this agenda.

Announcements

Next Meeting: May 21, 2021

Adjournment

--- DRAFT UNAPPROVED---

VIRGINIA BOARD OF MEDICINE

LEGISLATIVE COMMITTEE MINUTES

Friday, January 31, 2020 | Department of Health Professions | Henrico, VA

CALL TO ORDER: Dr. Conklin called the meeting of the Legislative Committee to order at 8:33 a.m.

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

MEMBERS PRESENT:
Lori Conklin, MD, Vice-President & Chair
David Giammittorio, MD
Jane Hickey, JD
Jacob Miller, DO
Kevin O'Connor, MD
Brenda Stokes, MD

MEMBERS ABSENT: Svinder Toor, MD

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

OTHERS PRESENT: Kathy Martin, MSV

EMERGENCY EGRESS INSTRUCTIONS

Dr. Conklin provided the emergency egress instructions.

APPROVAL OF MINUTES OF SEPTEMBER 6, 2019

Dr. Giammittorio moved to approve the meeting minutes of September 6, 2019 as presented. The motion was seconded and carried unanimously.

ADOPTION OF AGENDA

Dr. O'Connor 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 provided a brief update on the monitoring of bills and visits to the General Assembly. She said it has been validating for DHP staff as they felt their contributions were heard, providing a valuable voice in the legislative process. Though they provided no opinions, they have been able to provide technical assistance to facilitate better outcomes for the bills that will affect the Agency.

EXECUTIVE DIRECTOR'S REPORT

Dr. Harp gave an overview of the Board's finances and informed the Board members of the FSMB Annual Meeting, April 29 to May 2, 2020. He also reminded them that a Nominating Committee will need to be constituted at the full Board meeting to develop the slate of officers for 2020-2021.

NEW BUSINESS

1. Chart of Regulatory Actions

Ms. Yeatts reviewed the Board's regulatory activity as of January 20, 2020. This report was for informational purposes only and did not require any action.

2. Report of the 2020 General Assembly

Ms. Yeatts reviewed the proposed legislation in the 2020 Session and highlighted those below that will have a direct effect on the Board of Medicine:

- HB 42 – Health care providers; screening of patients for prenatal and postpartum depression, training.
- HB 188 - Health care services; payment estimates.
- HB 277 – Abortion; born alive human infant, treatment and care, penalty.
- HB 362 – Physician assistant; capacity determinations.
- HB 385 – Chiropractic, practice of; clarifies definition.
- HB 386 – Conversion therapy; prohibited by certain health care providers.
- HB 471 – Health professionals; unprofessional conduct, reporting.
- HB 517 – Collaborative practice agreements; adds nurse practitioners and physician assistants.
- HB 601 – Administrative Process Act; review of occupational regulations.
- HB 626 – Opioids; prescribing, required patient disclosures.
- HB 967 – Military service members; expediting the issuance of credentials to spouses.
- HB 982 – Professions and occupations; licensure by endorsement.
- HB 1040 – Naturopathic doctors; Board of Medicine to license and regulate.
- HB 1060 – Ultrasound prior to abortion; physician civil penalty exemption.

- HB 1084 – Surgical Assistants; definition, licensure.
- HB 1449 – Physicians; medical specialty board certification options.
- HB 1506 – Pharmacists; prescribing, dispensing, and administration of controlled substances.
- HB 1551 – Abortion; fetal dismemberment prohibited.
- HB 1683 - Diagnostic medical sonography; definition, certification.
- HB 1701 – Practice of medicine; license not required, person licensed in a contiguous state.
- SB 1079 – Board of Medicine; medically unnecessary chaperones.

3. Petition for Rulemaking – Lee Tannenbaum, M.D.

Ms. Yeatts referred to the copy of the petition submitted by Lee Tannenbaum, MD who is the Senior Medical Director for ARS addiction treatment facilities. Dr. Tannenbaum is asking the Board to consider an amendment to 18VAC85-21-150(I) Treatment with Buprenorphine for Addiction that will increase the maximum dose of buprenorphine to 32 mg per day.

Ms. Yeatts noted that comments were received for and against this amendment.

The members agreed that there was not enough evidence to support increasing the dosage beyond 24 mg daily.

MOTION: After the discussion, Dr. O'Connor moved to take no regulatory action and authorized staff to relay the decision and explanation for denial to Dr. Tannenbaum.

4. Petition for Rulemaking – Virginia Academy of Physician Assistants (VAPA).

Ms. Yeatts noted that the Virginia Academy of Physician Assistants (VAPA) is requesting an amendment to 18VAC85-50-160 Disclosure. Specifically, VAPA is requesting the removal of the requirement for the patient care team physician's name to be on Schedule II-V prescriptions.

MOTION: Dr. Miller moved to take no regulatory action and authorized staff to relay the decision and explanation for denial to the VAPA.

5. Recommendation on Conversion Therapy

Ms. Yeatts provided the following staff note: The Board submitted Guidance Document 85-7, Practice of Conversion Therapy, for publication in the Register of Regulations and posted it on the Virginia Regulatory Town Hall with the request for public comment from November 11, 2019 to December 11, 2019. During that time, there were 726 comments posted.

438 comments were in **support** of the Board's guidance document which notes that conversion therapy has no scientific basis, is not supported by any medical or mental health professional organization, and has been shown to be ineffective, harmful, unethical and destructive to individuals and families.

238 comments were in **opposition** to the Board's guidance document noting any prohibition of practice is a violation of an individual's freedom of religion and free speech. Patients should have the right to receive medical care or counseling for unwanted sexual feelings. Parents have the fundamental right to make decisions for their children.

MOTION: After discussion, Dr. O'Connor moved to recommend that the Board reaffirm Guidance Document 85-7, Practice of Conversion Therapy. The motion was properly seconded and carried unanimously.

6. FSMB Strategic Plan

Dr. O'Connor informed the members that he had served on the Special Committee on Strategic Planning. He said the 2015 Strategic Plan was solid, but needed some tweaking due to changes in technology, the blurring of scopes of practice, and the creation of the Interstate Medical Licensure Compact. He noted that FSMB has the ability to collect and mine data that could be a good resource for the boards. Additionally, he encouraged as many members as possible to attend the FSMB Annual Meeting in the spring and get involved wherever possible.

The Committee members noted their support of the Draft Strategic Plan as presented.

ANNOUNCEMENTS

Committee members were reminded to stay for probable cause review

NEXT MEETING

May 22, 2020

ADJOURNEMENT

With no other business to conduct, the meeting adjourned at 9:31 a.m.

Lori Conklin, MD
Vice-President, Chair

William L. Harp, MD
Executive Director

Colanthia Morton Opher
Recording Secretary

Agenda Item:
Regulatory Actions - Chart of Regulatory Actions
As of January 8, 2021

Board of Medicine

Chapter		Action / Stage Information
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic	Conversion therapy [Action 5412] Proposed - *At Governor's Office for 4 days*
[18 VAC 85 - 21]	Regulations Governing Prescribing of Opioids and Buprenorphine	Waiver for e-prescribing of an opioid [Action 5355] Final - *At Governor's Office for 3 days*
[18 VAC 85 - 50]	Regulations Governing the Practice of Physician Assistants	Practice with patient care team physician [Action 5357] Final - *At Governor's Office for 4 days*
[18 VAC 85 - 160]	Regulations Governing the Licensure of Surgical Assistants and Registration of Surgical Technologists	Amendments for surgical assistants consistent with a licensed profession [Action 5639] NOIRA - *At Governor's Office for 3 days*

Agenda Item: Reconsideration of the Interstate Medical Licensure Compact

Staff Note: At its May 2016 meeting, the Legislative Committee considered the Interstate Medical Licensure Compact to assess its advantages and disadvantages for the Board of Medicine, its licensees, and patients in terms of access to care. After a full discussion, the Committee recommended to the Board not to join the Compact at that time, but rather to develop regulations for licensure by endorsement. In August 2019, a DHP Telemedicine Workgroup and Dr. Brown suggested that the Board might wish to revisit the idea of joining the Compact.

In the following pages, you will find:

- Legislative Committee Minutes from May 20, 2016
- DHP Telemedicine Workgroup Draft Minutes from August 5, 2019
- Description of the Interstate Medical Licensure Compact (IMLC)
- List of IMLC Frequently Asked Questions (FAQ's)
- Selected IMLC FAQ's
- Reports from the IMLC
- List of State Licensing Fees
- Extract from the Federation of State Medical Boards 2018 Physician Census
- Emails from David Clark, Operations Manager IMLCC
- Statistics for IMLC and Licensure by Endorsement

Action: Discuss and arrive at a recommendation for consideration by the Full Board

--- FINAL APPROVED --

VIRGINIA BOARD OF MEDICINE

LEGISLATIVE COMMITTEE MINUTES

Friday, May 20, 2016 | Department of Health Professions | Henrico, VA

CALL TO ORDER: The meeting convened at 8:35 a.m.

ROLL CALL: Ms. Opher called roll, but a quorum was not established until 8:41 a.m.

MEMBERS PRESENT:
Barbara Allison-Bryan, MD, Vice-President, Chair
Syed Salman Ali, MD
Lori Conklin, MD
Ray Tuck, DC

MEMBERS ABSENT:
David Giammittorio, MD
The Honorable Jasmine Gore
Maxine Lee, MD

STAFF PRESENT:
William L. Harp, MD, Executive Director
Jennifer Deschenes, JD, Deputy Director, Discipline
Alan Heaberlin, Deputy Director, Licensure
Barbara Matusiak, MD, Medical Review Coordinator
Colanthia Morton Opher, Operations Manager
Lynn Taylor, Discipline Administrative Assistant
Sherry Gibson, Administrative Assistant
David Brown, DC, Agency Director
Elaine Yeatts, DHP Senior Policy Analyst
Erin Barrett, JD, Assistant Attorney General

OTHERS PRESENT:
W. Scott Johnson, HDJN
Kirsten Roberts, MSV
Mike Jurgensen, MSV

EMERGENCY EGRESS INSTRUCTIONS

Dr. Allison-Bryan provided the emergency egress instructions.

ADOPTION OF AGENDA

The agenda was amended to include approval of the May 15, 2015 meeting minutes that were not approved at the January meeting due to the lack of a quorum.

--- FINAL APPROVED --

APPROVAL OF MINUTES OF MAY 15, 2015 and JANUARY 13, 2016

Dr. Conklin moved to approve the meeting minutes of May 15, 2015 as presented. The motion was seconded and carried unanimously.

Dr. Ali moved to approve the meeting minutes of January 13, 2016 as presented. The motion was seconded and carried unanimously.

PUBLIC COMMENT

There was no public comment.

FURTHER COMMENT

Elaine Yeatts announced that she and Dr. Brown recently met with the Office of the Secretary of Health and Human Resources and learned that the office-based anesthesia regulations had been approved at that level; they will be forwarded to the Governor for approval.

Dr. Allison-Bryan acknowledged Mike Jurgensen's retirement from the Medical Society of Virginia and remarked that his integrity, communication skills, institutional knowledge on office-based anesthesia, and commitment to the quality of care in Virginia will be missed. Mr. Jurgensen received a standing ovation from the Committee members and Board staff.

NEW BUSINESS

Interstate Medical Licensure Compact

Ms. Barrett began the discussion by noting some concerns from a legal perspective. When the licensure Compact was first presented, it was described as being based on a model similar to the Nurse Licensure Compact. An application to the nursing Compact gives one a multi-state license in all states participating in the Compact unless a barrier issue is identified. The medical Compact requires physicians to obtain a license in every state in which they intend to practice. As such, participation in the Compact would require the Board to create and implement a new licensing process for those physicians applying through the Compact.

Ms. Barrett asked the members to consider the overall purpose of the Compact and whether or not it would be beneficial to the Commonwealth. Ms. Barrett referred to SECTION 8 (b) COORDINATED INFORMATION SYSTEM that reads –

> *Notwithstanding any other provision of law, member boards shall report to the Interstate Commission any public action or complaints against a licensed physician who has applied or received an expedited license through the Compact.*

--- FINAL APPROVED --

APPROVAL OF MINUTES OF MAY 15, 2015 and JANUARY 13, 2016

Dr. Conklin moved to approve the meeting minutes of May 15, 2015 as presented. The motion was seconded and carried unanimously.

Dr. Ali moved to approve the meeting minutes of January 13, 2016 as presented. The motion was seconded and carried unanimously.

PUBLIC COMMENT

There was no public comment.

FURTHER COMMENT

Elaine Yeatts announced that she and Dr. Brown recently met with the Office of the Secretary of Health and Human Resources and learned that the office-based anesthesia regulations had been approved at that level; they will be forwarded to the Governor for approval.

Dr. Allison-Bryan acknowledged Mike Jurgensen's retirement from the Medical Society of Virginia and remarked that his integrity, communication skills, institutional knowledge on office-based anesthesia, and commitment to the quality of care in Virginia will be missed. Mr. Jurgensen received a standing ovation from the Committee members and Board staff.

NEW BUSINESS

Interstate Medical Licensure Compact

Ms. Barrett began the discussion by noting some concerns from a legal perspective. When the licensure Compact was first presented, it was described as being based on a model similar to the Nurse Licensure Compact. An application to the nursing Compact gives one a multi-state license in all states participating in the Compact unless a barrier issue is identified. The medical Compact requires physicians to obtain a license in every state in which they intend to practice. As such, participation in the Compact would require the Board to create and implement a new licensing process for those physicians applying through the Compact.

Ms. Barrett asked the members to consider the overall purpose of the Compact and whether or not it would be beneficial to the Commonwealth. Ms. Barrett referred to SECTION 8 (b) COORDINATED INFORMATION SYSTEM that reads –

> *Notwithstanding any other provision of law, member boards shall report to the Interstate Commission any public action or complaints against a licensed physician who has applied or received an expedited license through the Compact.*

Ms. Barrett remarked that the Board receives a significant number of complaints that are non-actionable and currently mandated confidential. This provision would require the Board to report complaints which might raise confidentiality concerns as well as needing an amendment to 54.1-2400 for authorization to meet this provision of the Compact.

SECTION 10 – DISCIPLINARY ACTIONS

(d) – *If a license granted to a physician by a member board is revoked, surrendered or relinquished in lieu of discipline, or suspended, then any license(s) issued to the physician by any other member of the board(s) shall be suspended automatically and immediately without further action necessary by the other member board(s), for ninety (90) days upon entry of the order by the disciplining board, to permit the member board(s) to investigate the basis for the action under the Medical Practice Act of that state. A member board may terminate the automatic suspension of the license it issued prior to the completion of the ninety (90) day suspension period in a manner consistent with the Medical Practice Act.*

Ms. Barrett said that this language would override the language of §54.1-2409 Mandatory suspension or revocation; reinstatement; hearing for reinstatement, which currently requires the practitioner to apply to the Board for reinstatement of the license. Further, the Compact language would shift the burden of proof and the processing timeline from the respondent to the Board.

Ms. Yeatts pointed out that, based on the definition of "current significant investigative information" in the Nurse Licensure Compact, investigative information indicating that the nurse represents an immediate threat to public health and safety is reportable, not complaints.

Ms. Barrett advised that if the Board wishes to craft new language, she recommended the word "complaint" be removed.

Dr. Harp, speaking to the process and fiscal impact, advised that he spoke with the Chair of the Compact Commission who was not yet able to say how the application process would be implemented and how the fees would be structured and distributed.

Dr. Tuck questioned the process of the Commission collecting the licensing fees for the boards and then distributing them when it appears that the boards will be responsible for the lion's share of the work done in the new process. Ms. Yeatts advised that the Nurse Compact language was written so that all fees stay in Virginia.

Mr. Heaberlin advised that he ran a statistical report on approximately 110 license applicants and found that only 37 would have been eligible to participate in the Compact. He recalls at the introduction of the process being told that 80% of applicants would benefit from this option. Mr. Heaberlin noted that he does not see participation in the Compact as beneficial for Virginia. He also pointed out that with so many postgraduate programs in Virginia, the intern/residents would not be eligible for Compact licensure because they are not board certified. Mr. Heaberlin also noted that he reviews a significant percentage of

applications that have "criminal convictions" for incidents that occurred, usually prior to or in medical school, such as DUI, reckless driving, cursing in public, and even one for dogs running loose without dog tags. He questioned whether such offenses should prevent eligibility for an expedited licensure process.

Mr. Heaberlin questioned the protocol for an applicant who chooses Virginia as his home state and applies to another Compact state and Virginia's responsibility for completing yet another criminal background check in support of a letter of qualification.

Dr. Brown asked for clarification on the "expedited process" and what typically holds up the application process.

Mr. Heaberlin explained the Federation Credentialing Verification Service (FCVS) is a repository for all static documents. For a fee, FCVS will forward that information to the state to which you are applying. What causes the processing delay are employment verification forms required from each employer for the last five years and the verifications from other state boards. These items are essential to the licensing process and neither will be hastened by the Compact. It will still be up to the applicant to see that these items are sent to the Board.

During the Committee's discussion about the benefit of participating in the Compact, Ms. Deschenes stated that, based on the discussions surrounding the creation of a national license, FSMB started looking for ways to enhance license portability (which it had piloted for years) and to preserve the authority of the state medical boards. Ms. Deschenes advised that prior to her employment with the Board, there was language in the law that allowed for a reciprocal license but regulations had never been written. She suggested that the Committee consider the regulatory approach as an option. Regulations could allow an applicant with an unrestricted license and no disciplinary action to obtain an expedited license. The fees would stay in Virginia.

Elaine referred to §54.1-103. Additional training of regulated persons; reciprocity; endorsement.

A. The regulatory boards within the Department of Professional and Occupational Regulation and the Department of Health Professions may promulgate regulations specifying additional training or conditions for individuals seeking certification or licensure, or for the renewal of certificates or licenses.

B. The regulatory boards may enter into agreements with other jurisdictions for the recognition of certificates and licenses issued by other jurisdictions.

C. The regulatory boards are authorized to promulgate regulations recognizing licenses or certificates issued by other states, the District of Columbia, or any territory or possession of the United States as full or partial fulfillment of qualifications for licensure or certification in the Commonwealth.

Dr. Allison-Bryan advised that the Compact Commission is fairly large with 2 representatives from each jurisdiction and expressed some concern about the structure. A number of states that have signed on to the Compact are some of the less populous states in which patients sometimes have to drive long distances to see a physician. Dr. Harp noted that the Compact was also in response to states that wanted to utilize telemedicine to enhance access to care. Physicians who provide telemedicine and communications companies have lobbied for greater license portability, be it a national license or through expedited licensure by state boards.

Dr. Brown suggested that the identified issues and concerns be communicated to the Commission to signal the Board's hesitancy of signing onto the Compact without knowing all of the details. Dr. Brown also suggested that a representative from FSMB be asked to come back and update the Board on the progress of the Compact.

Dr. Allison-Bryan posed the question of "what are Virginia's needs and how do we address the expedited process without entering into the Compact?"

After a brief discussion, Dr. Allison-Bryan stated that she does not see inviting a representative from FSMB to speak to the Board as fruitful; however, we should send them correspondence advising them of our position and why.

Dr. Conklin moved to recommend to the Full Board that it not adopt the Interstate Medical Licensure Compact. The motion was seconded and carried unanimously.

Dr. Ali moved to recommend to the Full Board that the current licensure process be reviewed and the issue of reciprocity be explored for the purpose of addressing an expedited process in place of the Compact.

With the Committee agreeing that access was at the forefront of this issue, Dr. Tuck suggested that two work groups be created, one to review the expedited licensure process and the second to evaluate how to improve access to services.

Dr. Tuck and Dr. Ali both agreed to serve on work groups to address these issues.

Dr. Ali moved to recommend to the Full Board that it create an ad hoc committee to study how the Board might, through its licensure processes, reciprocity with other states, and other innovative ways, address the issue of improving access to health care services across the state. The motion was seconded and passed unanimously.

ANNOUNCEMENTS

There were no additional announcements.

Next meeting – September 26, 2016

--- FINAL APPROVED --

Adjournment - With no other business to conduct, the meeting adjourned at 10:35 a.m.

Barbara Allison-Bryan, MD
Vice-President, Chair

William L. Harp, MD
Executive Director

Colanthia M. Opher
Recording Secretary

Virginia Department of
Health Professions

DHP Telemedicine Workgroup

Monday, August 5, 2019

Perimeter Center, 2nd Floor Conference Center, Henrico, Virginia
Board Room 4 10:00 a.m.

DRAFT MEETING MINUTES

In Attendance:

Workgroup Convener
David Brown, Department of Health Professions

Workgroup Members
Barbara Allison-Bryan, Virginia Dept. of Health Professions
Heather Anderson, Virginia Dept. of Health
Clark Barrineau, Medical Society of Virginia
Kelly Cannon, Virginia Hospital and Health Care Association
Jennifer Faison, Virginia Association of Community Service Boards
William Harp, Virginia Board of Medicine
Caroline Juran, Virginia Board of Pharmacy
Laura Kornegay, Virginia Dept. of Health
Brian McCormick, Dept. of Medical Assistance Services
Kevin O'Connor, Virginia Board of Medicine
Karen Rheuban, University of Virginia
Kim Roe, Virginia Rural Health Association
Elaine Yeatts, Virginia Dept. of Health Professions

Staff
Laura Jackson, Virginia Board of Health Professions

Call to Order and Introductions:

Dr. Brown called the meeting to order at 10:03 a.m. He welcomed everyone, provided emergency egress information, and asked the workgroup members to introduce themselves.

Public Comment:

Dr. Brown called on individuals wishing to provide public comment. Three people provided oral comment, a fourth was provided in writing.

Ben Knotts, Americans for Prosperity: Stated that the Richmond Times Dispatch reported on a frightening scenario, which involves an increasing demand for care that is being matched with a decreasing supply. He stated that in Virginia there are 80 practitioners per 100,000 people. He stated that telemedicine provides more people with care, which in turn reduces the number of ER visits. Telemedicine could be a massive economic boom for Virginia.

Conor Norris, Knee Center for the Study of Occupational Regulation: Stated that there is a shortage of healthcare practitioners, with a growing demand outweighing the available supply, leading to the need to expand access to telehealth care. He stated that occupational licensing's goal is to provide the public with trusted and reliable practitioners, however, exams and fees sometimes prevent people from entering the medical field, while existing licensure requirements make it more expensive for professionals licensed outside of Virginia to provide telemedicine in Virginia.

Claudia Tellet, Medical Society of Northern Virginia: Stated that the Medical Society of Northern Virginia's goal is to extend license reciprocity to other states and was shocked by the bill not passing. They believe that telemedicine is the future and a way to extend healthcare. She stated that a high concentration of physicians are located in NOVA and telemedicine would provide these physicians and specialists with an opportunity to extend some of that specialty into more rural areas.

Comment Four: Was provided in writing from The Heartland Institute stating that telemedicine is the future of healthcare, allowing physicians to offer quality care to patients anywhere, anytime. (Attachment 1)

Discussion of Public Comment and Agenda Packet Materials:

Dr. Brown asked the workgroup members to provide their thoughts on what they had heard from the public.

Overview and Background:

Dr. Brown reviewed the letters submitted by Delegate Orrock pertaining to HB 2128 (Guzman) which requested the Dept. of Health Professions undertake a review of the practice of telemedicine in the Commonwealth and develop recommendations for changes in laws and

regulations governing the practice of telemedicine to maximize access to health care while protecting the health and wellbeing of its citizens and HB 1790 (Kilgore) request to study and determine the appropriate application of state laws and regulations to the practice of telemedicine.

Regulatory Issues:

Dr. Brown referred to the Federation of Medical Boards (FSMB) Telemedicine Policies provided in the meeting packet on page 32. Dr. Brown provided additional information on Kentucky's Telehealth Act and Maryland's use of physician's in adjoining states, similar to a compact.

Dr. Rheuban stated that adding telemedicine in Virginia is a hot topic. She stated that telemedicine: improves access to quality care, is not lesser care, providers are not held at a lesser standard and the level of care is the same in person or via technology. She also stated that we need to get the message out regarding telemedicine and that we need to be thoughtful how we advance while still protecting our patients. Dr. Rheuban also noted that barriers such as broadband connectivity, reimbursement, and the huge demand for behavioral health services exist.

Dr. O'Connor stated that the Virginia Board of Medicine has streamlined the physician licensing process by initiating licensure by endorsement and that the fees are very reasonable.

Dr. Harp provided comment that telemedicine requires quick processing of a license. He stated that Virginia joining the compact would still have legal, economic and personnel issues, issues that could be addressed by licensure by endorsement. He stated that licensure under the compact took 55 days and that the Virginia Board of Medicine will be there quickly, with 30 days being the measure.

Dr. Harp provided information on Maryland's Statute 14302. He said that their Board of Medicine stated to him that this statute does not apply to telemedicine. Dr. Harp also stated that a physician in Virginia might consult with an out of state or foreign country physician, as long as the Virginia physician remains in charge of the patients care. Dr. Harp also stated that Pennsylvania statute 42234 provide that a physician may obtain a license to cross the state line and practice in Pennsylvania.

In 2016, significant regulatory changes needed to be made and Virginia went with quicker licensure. The compact requires an "all or nothing" approach, which is prohibitive and costly, so Virginia went with licensure by endorsement in 2018.

Dr. Brown posed the question, "Would membership in the compact be an incentive to apply for licensure in Virginia" and "could there be a specific license in Virginia for telemedicine"? Ms. Roe stated that she does not see the need for it.

Dr. Allison-Bryan noted that compact laws supersede state laws.

Ms. Faison stated that telepsychiatry has the ability to decrease the existing burden, but is uncertain about reciprocity for contiguous states. She also noted that licensing is not standing in the way as community service boards are providing care by telehealth.

Mr. Barrineau stated that MSV supports the Board of Medicine to treat telemedicine the same as medicine and that physicians should have 100% local control.

Ms. Juran noted that endorsement is quicker than any compact for the Board of Pharmacy.

Ms. Kornegay stated that access to health care in rural areas is filled with barriers, but that requiring a Virginia license for telemedicine is not one. Telemedicine barriers include difficulty in obtaining reimbursement, troublesome bandwidth and the cost of connection fees and paying support staff.

11:15 Break
11:32 Reconvened

Final Comments on Regulation:

Ms. Yeatts stated that Virginia could convene a meeting with neighboring states to discuss licensure by reciprocity rather than by endorsement. Ms. Yeatts provided that there are currently provisions in statute that would allow for reciprocity.

Reimbursement Issues:

Dr. Rheuban provided historical information on reimbursement in Virginia, and information on an upcoming federal grant opportunity.

Mr. McCormick provided information regarding school health services and reimbursement and that a telepresenter is an individual who must be present at the time of service and noted some specific times when one is required.

Ms. Faison stated that telepsychiatry should be reimbursable as it helps eliminate barriers such as transportation. She stated that billing time for the psychiatrist is reimbursable but the other

person "the telepresenter" in the room is not reimbursed. She stated that they must be enrolled with DMAS to receive reimbursement.

Dr. Rheuban stated that services covered by insurance should be reimbursable. She also noted that there should be parity for both, while improving communication and identifying areas of underutilization.

Other Issues:

Broadband issues are being addressed by the Governor and the FCC.

Next Steps

Dr. Brown suggested the following recommendations; which the group was in agreement with:

- Virginia should look again at the medical compact
- Upcoming federal funding opportunities should be explored
- Medicaid recommendation for the general assembly – remote monitoring funding
- Broadband – look for state/federal funding
- Restrictive Medicare rules – look to federal legislators for support
- Explore regional medical licensure reciprocity with border states
- Identify areas of confusion with existing laws
- Telemedicine should be held to the same standards as in person care
- Licensure should continue to be required in Virginia for a Virginia patient.

Closing Comments:

Dr. Brown stated that he sees no need for the committee to meet again.

Adjourn:

With no further business to discuss, Dr. Brown adjourned the meeting at 12:18 p.m.

Interstate Medical Licensure Compact (https://www.imlcc.org)

A Faster Pathway to Physician Licensure

(marketing@imlcc.net 621-9464)

Introduction

The mission of the Compact is to increase access to health care – particularly for patients in underserved or rural areas. The Compact makes it possible to extend the reach of physicians, improve access to medical specialists, and leverage the use of new medical technologies, such as telemedicine. While making it easier for physicians to obtain licenses to practice in multiple states, the Compact also strengthens public protection by enhancing the ability of states to share investigative and disciplinary information.

The Compact currently includes 29 states (/participating-states/), the District of Columbia and the Territory of Guam. In these jurisdictions, physicians are licensed by 43 different medical and osteopathic boards. Other states are currently in the process of introducing legislation to adopt the Compact.

Who developed the Compact?

Recognizing that physicians will increasingly practice in multiple states as a result of telemedicine, U.S. state medical boards in 2013 began actively discussing the idea of creating the Compact in order to help streamline traditional medical-license application processes.

The idea was embraced by a diverse range of state boards, and over the next several years the groundwork was laid for the creation of the Compact. With assistance from the Federation of State Medical Boards, a group of state medical board executives, administrators and attorneys drafted a model compact – which was introduced publicly in the fall of 2014. State legislatures soon began adopting it, and in April 2017, the Compact became operational.

How does the Compact work?

Physicians can qualify to practice medicine across state lines within the Compact if they meet the Compact's eligibility requirements. Physicians who are eligible can qualify to practice medicine in multiple states by completing just one application within the Compact, receiving separate licenses from each state in which they intend to practice.

The licensing is all state-based. The Commission does not issue a "Compact license" or a nationally recognized medical license for physicians.

Only states who have formally joined the Compact can participate in this streamlined licensure process. In order to participate in the Compact, states must pass legislation authorizing it.

How does the Compact streamline licensure?

States that participate in the Compact are able to streamline licensure by using an expedited process to share information with each other that physicians have previously submitted in their State of Principal License (SPL) -- the state in which a physician holds a full and unrestricted medical license.

Before physicians can participate in the Compact, they must designate an SPL, complete an application, and then receive a formal Letter of Qualification from that state, verifying that they meet the Compact's strict eligibility requirements. Physicians cannot obtain licenses through the Compact without completing these steps.

After verifying a physician's eligibility for the Compact, the SPL shares this information with additional states where the physician wants to practice medicine. By using expedited information-sharing, participating states are able to significantly speed up the licensure process.

What are the eligibility requirements for physicians who want to participate in the Compact?

The first requirement for physicians to participate in the Compact is to hold a full, unrestricted medical license in a Compact member-state that can serve as a declared State of Principal License (SPL). In order to designate a state as an SPL, physicians must ensure that at least ONE of the following apply:

- The physician's primary residence is in the SPL
- At least 25% of the physician's practice of medicine occurs in the SPL

The SPL has the authority to determine if a physician meets any or all of the qualifications listed above. See the Compact map (/participating-states/) on our homepage to see states the states that are currently participating.

Physicians must maintain their SPL status at all times. Physicians may change the location of their SPL -- through a process known as "redesignation" – after they receive a Letter of Qualification to participate in the Compact.

In addition to designating an SPL, physicians must:

- Have graduated from an accredited medical school, or a school listed in the International Medical Education Directory
- Have successfully completed ACGME- or AOA-accredited graduate medical education
- Passed each component of the USMLE, COMLEX-USA, or equivalent in no more than three attempts for each component
- Hold a current specialty certification or time-unlimited certification by an ABMS or AOABOS board

In addition, physicians must:

- Not have any history of disciplinary actions toward their medical license
- Not have any criminal history
- Not have any history of controlled substance actions toward their medical license
- Not currently be under investigation

Approximately 80% of U.S. physicians meet the criteria for licensure through the Compact.

Each physician is responsible for making a self-determination of eligibility prior to applying to participate in the Compact, and they must confirm that they understand the Compact rules.

For further clarification, please refer to our Compact Policies, Rules and Laws section (/compact-policies-rules-and-laws/).

The Compact treats all physicians equally without preference for specialty. Any physician from a Compact state who meets the qualifications of the Compact is eligible for licensure in any other Compact state and is responsible for obeying all statutory laws and administrative rules of the state.

Who administers the Compact?

The Compact is an agreement among sovereign states, with the Interstate Medical Licensure Commission serving as an independent coordinating organization that administers the Compact on the states' behalf. The Commission is made up of representatives from each participating Compact state.

It is important to note that while the Commission oversees the work of coordinating multi-state licensing activity within the Compact, it does not actually issue individual medical licenses. Licenses are issued by the states that participate in the Compact – not by the Commission itself.

Each participating Compact state sends two representatives to the Commission. These commissioners must be either a physician member of a medical or osteopathic physician licensing board, a public member of such a board, or an executive director or administrator of such a board.

If a state has only one medical board, then both commissioners must come from that board. But if it has two boards -- a medical board and an osteopathic board -- then each board gets one seat.

The Commission is the sole entity administering the Compact's bylaws, rules, policies, and advisory opinions. No other governmental agency or private entity has control over how the Compact is administered.

The Commission is governed by the terms of the Compact, which provides the authority for the Commission to create bylaws, rules, and policies for self-governance. Commissioners must function within the terms and limitations of the Compact and the bylaws, rules, and policies which the Commission approves.

How can states join the Compact?

To participate in the Compact, a state's legislature must introduce and enact a bill authorizing the state to join. The language of the compact must be consistent in each state that joins.

States participating in the Compact make an affirmative and informed choice to accept the Compact's terms – made possible by the formal legislation, adopted and signed into law.

In addition, you can visit the Compact map (/participating-states/) on our homepage, where you will find links to the legislation each of the currently participating states passed in order to join the Compact.

Other resources available at this website that may be helpful include our FAQs (/faqs/), Glossary of Terms (/about/glossary-of-key-terms/), and our Compact Policies, Rules and Laws section (/compact-policies-rules-and-laws/).

For more information

If you are affiliated with a state medical board, or are a policy maker or legislator, visit Information for States (/information-for-states/) to learn more about the process of how states can join the Compact.

If you are a physician interested in learning how to participate in the Compact, visit Information for Physicians (/information-for-physicians/).

If you would like information about the Interstate Medical Licensure Compact Commission (IMLCC), the entity that governs and administers the Compact, visit About the IMLC Commission (/imlc-commission/about-the-imlc-commission/).

Direct inquiries about the Compact or the IMLC Commission to Executive Director Marschall Smith at imlccexecutivedirector@imlcc.net (mailto:imlccexecutivedirector@imlcc.net).

You also may call 303-898-1144.

The Commission's mailing address is 5401 South Prince Street, Office 111, Littleton, CO 80120.

IMLCC.org (https://www.imlcc.org/)

For customer service:
IMLCC – Support Unit
(Noon to 4 PM Eastern Time)

inquiry@imlcc.net (mailto:inquiry@imlcc.net)

303-997-9842 (tel:303-997-9842) or

720-621-9464 (tel:720-621-9464)

Go

Apply (https://www.imlcc.org/apply/)

Renew (https://www.imlcc.org/renew/)

LOQ Reapply (https://www.imlcc.org/loq-re-apply/)

Add States (https://www.imlcc.org/add-states/)

Redesignate (https://www.imlcc.org/redesignate/)

Quick Links

Home (https://www.imlcc.org/)

About (https://www.imlcc.org/a-faster-pathway-to-physician-licensure/)

FAQs (https://www.imlcc.org/faqs/)

Contact Us (https://www.imlcc.org/support-contacts/)

IMLC Commission (https://www.imlcc.org/imlc-commission/about-the-imlc-commission/)

News (https://www.imlcc.org/news/press-releases-and-publications/)

Interstate Medical Licensure Compact (https://www.imlcc.org)

Frequently Asked Questions

(mailto:imlcc@imlcc.net) 621-9464)

GENERAL FAQs ABOUT THE COMPACT

What is an interstate compact?

Where did the Interstate Medical Licensure Compact come from?

What does the Compact do?

Does the Compact supersede a state's authority over the practice of medicine in any way?

Who's in charge of the Compact?

How can I participate in Interstate Medical Licensure Commission meetings or decisions?

How can I contact the Interstate Medical Licensure Commission directly?

FAQs FOR PHYSICIANS

Who is eligible to participate in the Compact?

Do physicians who use the Compact licensure process have to participate in Maintenance of Certification (MOC)?

How is a State of Principal License defined?

What does a physician need to do to get a license through the Compact?

What happens when a physician applies?

What happens if a physician's eligibility is not confirmed?

Can a physician apply for more than one license at a time through the Compact?

How long is a Letter of Qualification (LOQ) valid?

What if a physician wants to add another license later? Does the process repeat?

How does a physician renew licenses received through the Compact?

What are the responsibilities of the physician in the application and licensing process?

FAQs FOR STATES

What are the responsibilities of the State of Principal License in licensing?

What are the responsibilities of the Interstate Medical Licensure Commission in licensing?

What are the responsibilities of the Compact licensing states beyond licensing?

IMLCC.org (https://www.imlcc.org/)

For customer service:
IMLCC – Support Unit
(Noon to 4 PM Eastern Time)

inquiry@imlcc.net (mailto:inquiry@imlcc.net)

303-997-9842 (tel:303-997-9842) or

720-621-9464 (tel:720-621-9464)

Go

Apply (https://www.imlcc.org/apply/)

Renew (https://www.imlcc.org/renew/)

LOQ Reapply (https://www.imlcc.org/loq-re-apply/)

Add States (https://www.imlcc.org/add-states/)

Redesignate (https://www.imlcc.org/redesignate/)

Quick Links

Home (https://www.imlcc.org/)

About (https://www.imlcc.org/a-faster-pathway-to-physician-licensure/)

FAQs (https://www.imlcc.org/faqs/)

Contact Us (https://www.imlcc.org/support-contacts/)

IMLC Commission (https://www.imlcc.org/imlc-commission/about-the-imlc-commission/)

News (https://www.imlcc.org/news/press-releases-and-publications/)

What does a physician need to do to get a license through the Compact?

Physicians who want to use the Compact to acquire licenses must apply for participation using this website. They are asked to provide demographic and professional information and select a State of Principal License where they already have a license. The State of Principal License must be a state currently participating in the Compact.

Physicians are charged a non-refundable administrative fee when applying to participate in the Compact, and they must pay additional fees for each state in which they would like to be licensed. Physicians must also submit fingerprints to the designated criminal justice agency in their State of Principal License, so that a criminal background check can be conducted.

How much does it cost to participate in the Compact?

The cost to participate in the Compact is $700.00 PLUS the cost of a license(s) in any Compact state where a physician wants to practice. All fees are non-refundable. Physicians can compare the fee structures for each participating state at our **What Does it Cost to Participate in the Compact?** page.

Physicians should check their eligibility BEFORE applying. If they are found to be ineligible after starting the application process, their application fee will not be refunded.

How long is a Letter of Qualification (LOQ) valid?

The Letter of Qualification (LOQ) is valid for 365 days from its date of issuance to request expedited licensure in a Compact member state. There are no waivers of this time limit. A

physician who has been issued an LOQ by a State of Principal License attesting the physician is qualified for expedited licensure through the Compact may apply for a new LOQ after 365 days from issuance of the initial LOQ. Upon request for a new letter of qualification, a physician will not be required to demonstrate current specialty board certification.

What if a physician wants to add another license later? Does the process repeat?

At any time during the one-year period when a Letter of Qualification is valid, a physician can return to this website and request additional Compact member states for licensure. The physician will be required to pay licensure fees for each of the states chosen plus a $100 fee for requesting additional state licensure -- in addition to the state's licensing fee. The Interstate Medical Licensure Commission then notifies the new states that the physician is eligible for licensure. The license issuance process is the same as for initial state selections.

If the LOQ expires, the physician will need to reapply and pay a new application fee. If a license is requested for an additional state(s) during that year, the $100 application fee plus the state application fee is due.

How does a physician renew licenses received through the Compact?

Participating Compact physicians receive a separate notice from each state where they are licensed when it is time to renew that license. Participating physicians must renew licenses obtained through the Compact by using the Compact website. They can click on the Renew tab in the "Go" bar at the top of the Compact homepage. There, they will be asked to complete a

short form at the Renew page and pay their renewal fee. They then complete a short attestation and affidavit, and receive a payment receipt. Upon completion of the renewal process, an email is sent to the renewing state to verify that the physician has complied with all renewal requirements. After verification, the renewing state communicates directly with the physician to confirm licensure.

What are the responsibilities of the State of Principal License in licensing?

Under the terms of the compact, the SPL must conduct the primary-source verification of the applying physician's qualifications, verify eligibility and either issue a Letter of Qualification to the Interstate Medical Licensure Commission or notify the Commission that the applicant is ineligible.

What are the responsibilities of the Compact licensing states in licensing?

After a physician has been approved for licensure with a Letter of Qualification from the SPL and selects the Compact states where he or she wants to be licensed, these "licensing states" receive a notification from the Interstate Medical Licensure Commission.

When a licensing state receives a Letter of Qualification for a physician seeking licensure in that state via the Compact, the licensing state is expected to process the LOQ and issue the license promptly. This means each licensing state must have procedures and processes in place to enter information associated with the LOQ into its information database, generate a license, and

account for license fees received. A licensing state also must report the licensure to the Interstate Medical Licensure Commission.

Each licensing state must notify the licensee 90 days in advance when a license issued via the compact is due to expire. Licensing states also are expected to work with the Commission to facilitate timely renewal of licenses granted via the Compact.

After issuing a license to a physician holding a Letter of Qualification, the issuing state medical board may ask for additional information to fulfill their respective medical practice act and their operational requirements. The license holder is required to comply with these requests, and failure to do so may result in action against the license by the issuing board.

What are the responsibilities of the Interstate Medical Licensure Commission in licensing?

The Commission acts as an information repository and exchange between member states. The Commission collects fees from physicians and transfers licensure fees to member states. The Commission also collects data about physician applications for licensure and actual licensure via the Compact.

What are the responsibilities of the Compact licensing states beyond licensing?

All state medical and osteopathic boards participating in the Compact are required to share complaint/investigative information with each other. If any participating board takes action against the physician who received a license via the Compact, all boards within the Compact are notified and authorized to take similar action through their regular complaint process.

Interstate Medical Licensure Compact

Information Release – June 2, 2020

IMLCC Data Study – Year 3

The Interstate Medical Licensure Compact Commission (IMLCC) has conducted its annual data study of selected completed applications. The data study looks at applications which were completed during a time frame of April 1st to March 31st of a 12-month period. The most recent study looked at applications completed between April 1, 2019 and March 31, 2020. A completed application is defined as an application started by the physician and all requested licenses have been issued or the physician failed to meet the qualification requirements and the application was declined.

The Compact's process, which was engaged in April 2017, has been used by more than 7,400 physicians who were able to secure more than 9,400 medical licenses in Compact member states through March 31, 2020. There are 29 states, the District of Columbia and the U.S. Territory of Guam who are members of the Compact – a map of the Compact member states can be found at www.imlcc.org. To use the expedited licensure process, a physician must meet nine requirements and hold an active unrestricted license in a Compact member state where they live or are employed.

Data Questions	April 2018 Results	April 2019 Results	April 2020 Results
Number of completed applications included in the data study	654	2,845	2,995
Average number of licenses obtained per applicant	3	3	1.6
Percent who obtain one or two licenses	68	64	80
Percent who obtain three or more licenses	32 *With 13% obtaining 7 or more licenses.*	36 *With 13% obtaining 7 or more licenses*	20 *With 6% obtaining 7 or more licenses*
Percent of applications with a determination that the physician did not meet the eligibility requirements	11	10	16

Interstate Medical Licensure Compact

Data Questions	April 2018 Results	April 2019 Results	April 2020 Results
Percentage of the applications which were additional license requests using the original Letter of Qualification but a separate application	11	20	26
Average number of days from application received to Letter of Qualification (LOQ) issued	34 *With 33% obtained in 15 days or less*	36 *With 32% obtained in 15 days or less*	37 *With 34% obtained in 15 days or less*
Average number of days from the date an applicant is determined to be qualified to the date the requested licenses are issued	15 *With 46% of the licenses issued in 7 days or less*	19 *With 51% of the licenses issued in 7 days or less*	20 *With 51% obtained in 7 days or less*

Additional information regarding applications received and licenses issued reported month by month and by member board will be posted on the IMLCC website at https://www.imlcc.org/news/press-releases-and-publications/

Please contact Marschall Smith at imlccexecutivedirector@imlcc.net with questions.

Interstate Medical Licensure Compact

June 2, 2020 -- For Immediate Release - IMLCC Data Study - Supplemental Information - Page 1

A review of the 2,995 applications that were completed between April 1, 2019 and March 31, 2020 reveal the following:

Applications received by month

Month	Count
January 2019*	78
February 2019*	140
March 2019*	198
April 2019	246
May 2019	255
June 2019	226
July 2019	251
August 2019	332
September 2019	289
October 2019	350
November 2019	338
December 2019	281
January 2020	11
Total	**2995**

Please note that the data study is for applications completed between April 2019 and March 2020, some applications were initiated prior to the data study window, as indicated by a (*). Likewise, there are licenses that were issued prior to the data study window from applications initiated prior to the data study window, as indicated by a (**).

A review of the 4,805 licenses issued from the applications listed above reveal the following:

Licenses Issued by month

Month	Count
January 2019**	4
February 2019**	0
March 2019**	38
April 2019	340
May 2019	421
June 2019	332
July 2019	463
August 2019	509
September 2019	426
October 2019	464
November 2019	421
December 2019	539
January 2020	492
February 2020	218
March 2020	138
Total	**4,805**

Interstate Medical Licensure Compact

IMLCC Data Study - Supplemental Information – Page 2

A review of 2,286 Letters of Qualification (LOQ) issued reveal the following (in alphabetic order):

Letters of Qualification issued by Compact member boards

Member Board	Count
Alabama Board of Medical Examiners	80
Arizona Board of Osteopathic Examiners	30
Arizona Medical Board	158
Colorado Medical Board	219
Idaho Board of Medicine	70
Illinois Division of Financial and Professional Regulation	248
Iowa Board of Medicine	70
Kansas Board of Healing Arts	62
Maine Board of Licensure in Medicine	48
Maine Board of Osteopathic Licensure	4
Maryland Board of Physicians	69
Michigan Board of Medicine	35
Michigan Board of Osteopathic Medicine and Surgery	10
Mississippi State Board of Medical Licensure	47
Montana Board of Medical Examiners	35
Nebraska Board of Medicine and Surgery	80
Nevada State Board of Medical Examiners	90
Nevada State Board of Osteopathic Medicine	20
New Hampshire Board of Medicine	44
North Dakota Board of Medicine	23
South Dakota Board of Medical and Osteopathic Examiners	68
Tennessee Board of Medical Examiners	168
Tennessee Board of Osteopathic Examiners	22
Utah Osteopathic Physician and Surgeons Licensing Board	10
Utah Physicians Licensing Board	147
Washington Board of Osteopathic Medicine and Surgery	22
Washington Medical Quality Assurance Commission	175
Wisconsin Medical Examining Board	161
West Virginia Board of Medicine	33
West Virginia Board of Osteopathy	8
Wyoming Board of Medicine	30
Total	**2,286**

Interstate Medical Licensure Compact

IMLCC Data Study – Supplemental Information – Page 3

A review of 4,805 licenses issued, from the 2,286 Letters of Qualification, reveal the following:

Licenses issued by Compact member boards

Member Board	Count
Arizona Board of Osteopathic Examiners	39
Arizona Medical Board	285
Colorado Medical Board	299
Georgia Composite Medical Board	2
Idaho State Board of Medicine	226
Illinois Division of Financial and Professional Regulation	303
Iowa Board of Medicine	232
Kansas State Board of Healing Arts	156
Maine Board of Licensure in Medicine	103
Maine Board of Osteopathic Licensure	16
Maryland Board of Physicians	126
Medical Licensure Commission of Alabama	200
Michigan Board of Medicine	79
Michigan Board of Osteopathic Medicine and Surgery	10
Minnesota Board of Medical Practice	245
Mississippi State Board of Medical Licensure	158
Montana Board of Medical Examiners	209
Nebraska Board of Medicine and Surgery	170
Nevada State Board of Medical Examiners	253
Nevada State Board of Osteopathic Medicine	30
New Hampshire Board of Medicine	122
North Dakota Board of Medicine	129
Oklahoma Board of Osteopathic Examiners	2
Oklahoma State Board of Medical Licensure and Supervision	1
South Dakota Board of Medical and Osteopathic Examiners	126
Tennessee Board of Medical Examiners	201
Tennessee Board of Osteopathic Examiners	24
Utah Osteopathic Physician and Surgeons Licensing Board	16
Utah Physicians Licensing Board	133
Vermont Board of Medical Practice	4
Vermont Board of Osteopathic Physicians and Surgeons	4
Washington Board of Osteopathic Medicine and Surgery	34
Washington Medical Quality Assurance Commission	238
Wisconsin Medical Examining Board	330
West Virginia Board of Medicine	103
West Virginia Board of Osteopathy	13
Wyoming Board of Medicine	184
Total	**4,805**

Please contact Marschall Smith at imlccexecutivedirector@imlcc.net with questions.

ARIZONA MEDICAL BOARD	$500.00	ARIZONA M.D.
COLORADO MEDICAL BOARD	$400.00	COLORADO
GEORGIA COMPOSITE MEDICAL BOARD	$500.00	GEORGIA
GUAM BOARD OF MEDICAL EXAMINERS	$400.00	GUAM
IDAHO BOARD OF MEDICINE	$319.00	IDAHO
ILLINOIS DIVISION OF PROFESSIONAL REGULATIO N	$500.00	ILLINOIS
IOWA BOARD OF MEDICINE	$450.00	IOWA
KANSAS BOARD OF HEALING ARTS	$300.00	KANSAS
KENTUCKY BOARD OF MEDICAL LICENSURE	$300.00	KENTUCKY
MAINE BOARD OF LICENSURE IN MEDICINE	$700.00	MAINE M.D.
MAINE BOARD OF OSTEOPATHIC MEDICINE	$350.00	MAINE D.O.
MARYLAND BOARD OF PHYSICIANS	$790.00	MARYLAND
MICHIGAN BOARD OF MEDICINE	$361.00	MICHIGAN M.D.
MICHIGAN BOARD OF OSTEOPATHIC MEDICINE AN D SURGERY	$361.00	MICHIGAN D.O.
MINNESOTA BOARD OF MEDICAL PRACTICE	$392.00	MINNESOTA
MISSISSIPPI STATE BOARD OF MEDICAL LICENSUR E	$600.00	MISSISSIPPI

NEVADA STATE BOARD OF MEDICAL EXAMINERS	$375.00	NEVADA M.D.
NEVADA STATE BOARD OF OSTEOPATHIC MEDICIN E	$300.00	NEVADA D.O.
NEW HAMPSHIRE BOARD OF MEDICINE	$300.00	NEW HAMPSHIRE
NORTH DAKOTA BOARD OF MEDICINE	$200.00	NORTH DAKOTA
OKLAHOMA STATE BOARD OF MEDICAL LICENSUR E & SUPERVISION	$500.00	OKLAHOMA M.D.
OKLAHOMA STATE BOARD OF OSTEOPATHIC EXA MINERS	$575.00	OKLAHOMA D.O.
SOUTH DAKOTA BOARD OF MEDICAL AND OSTEOPATHIC EXAMINERS	$400.00	SOUTH DAKOTA
TENNESSEE BOARD OF MEDICAL EXAMINERS	$510.00	TENNESEE M.D.
TENNESSEE BOARD OF OSTEOPATHIC EXAMINATIO N	$410.00	TENNESEE D.O.
UTAH OSTEOPATHIC PHYSICIANS & SURGEONS	$200.00	UTAH D.O.
UTAH PHYSICIANS & SURGEONS LICENSING BOAR D	$200.00	UTAH M.D.
VERMONT BOARD OF MEDICAL PRACTICE	$650.00	VERMONT M.D.
VERMONT BOARD OF OSTEOPATHIC PHYSICIANS	$500.00	VERMONT D.O.
WASHINGTON MEDICAL COMMISSION	$491.00	WASHINGTON M. D.

WEST VIRGINIA BOARD OF MEDICINE	$400.00	WEST VIRGINIA M. D.
WEST VIRGINIA BOARD OF OSTEOPATHIC MEDICIN E	$100.00	WEST VIRGINIA D. O.
WISCONSIN MEDICAL EXAMINING BOARD	$75.00	WISCONSIN
WYOMING BOARD OF MEDICINE	$600.00	WYOMING

IMLCC.org (https://www.imlcc.org/)

For customer service:
IMLCC – Support Unit
(Noon to 4 PM Eastern Time)

inquiry@imlcc.net (mailto:inquiry@imlcc.net)

303-997-9842 (tel:303-997-9842) or

720-621-9464 (tel:720-621-9464)

Go

Apply (https://www.imlcc.org/apply/)

Renew (https://www.imlcc.org/renew/)

LOQ Reapply (https://www.imlcc.org/loq-re-apply/)

Add States (https://www.imlcc.org/add-states/)

Redesignate (https://www.imlcc.org/redesignate/)

Quick Links

Home (https://www.imlcc.org/)

About (https://www.imlcc.org/a-faster-pathway-to-physician-licensure/)

FAQs (https://www.imlcc.org/faqs/)

Contact Us (https://www.imlcc.org/support-contacts/)

IMLC Commission (https://www.imlcc.org/imlc-commission/about-the-imlc-commission/)

News (https://www.imlcc.org/news/press-releases-and-publications/)

fsmb FEDERATION OF STATE MEDICAL BOARDS

PHYSICIAN CENSUS

Overview

RESOURCES

Current Physician Census

2016 Physician Census

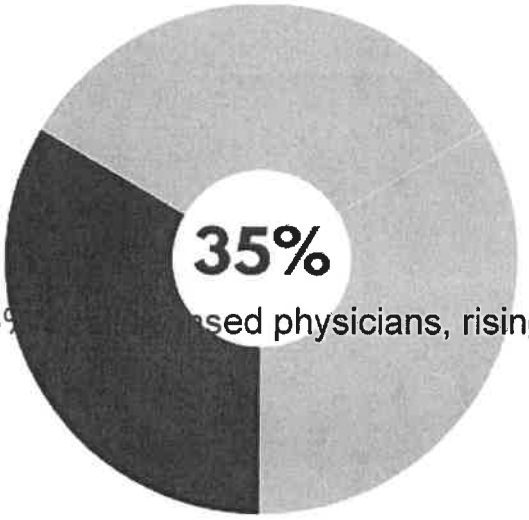
Home / Physician Census

PHYSICIAN CENSUS

The FSMB's biennial Census of Actively Licensed Physicians in the United States provides the nation with the most comprehensive compilation of physician license and demographic information available.

fsmb STATE MEDICAL BOARDS

Female physicians now account for more than one-third of all licensed physicians



Female Physicians

In 2018, female physicians accounted for 35% of all licensed physicians, rising from 30% in 2010.

fsmb

985,026

licensed physicians in the United States

Commonwealth of Virginia

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

IMLCC - Information requested

1 message

Dave Clark <dave.clark@imlcc.net> Wed, Dec 30, 2020 at 6:04 PM
To: william.harp@dhp.virginia.gov

Hello Dr. Harp,

Thank you for your call today, here is the information that you requested:

1. The IMLCC's first application was in April 2017.

2. Total licenses issued = 14,868 through November 30, 2020.

3. Total physicians that have submitted a request for a letter of qualification = 8,271 through November 30, 2020.

4. Average time for the IMLCC:
Upon submission of a request for a letter of qualification = 30 to 40 days, but this is dependent upon the applicant getting their fingerprints completed in a timely manner, and the no issues with running the background check.

Upon request of a license once the LOQ is issued, approximately 2 weeks, but many boards issue licenses within just a few days of the request.

Please reach out if you need anything else.

Happy New Year,
Dave

--
David Clark
Operations Manager
Interstate Medical Licensure Compact Commission

5401 S. Prince Street, #111
Littleton, Colorado 80120
303-997-9842 (office)
720-621-9464 (cell phone)

---------- Forwarded message ---------
From: **Dave Clark** <dave.clark@imlcc.net>
Date: Tue, Jan 5, 2021 at 2:12 PM
Subject: Re: Another Question
To: Harp, William <william.harp@dhp.virginia.gov>

Hello Dr. Harp,

Each year we conduct a data study regarding our volume, and this information is published on our website. I have attached two links below which provide details regarding our volume.

IMLCC-Information-Release-3-year-anniversary-Data-Study-6-2020.pdf

IMLCC-Information-Release-Data-Study-Supplemental-Information-6-2020-3.pdf

If you need any other information, please let me know.

Thank you,
Dave

--
David Clark
Operations Manager
Interstate Medical Licensure Compact Commission

5401 S. Prince Street, #111
Littleton, Colorado 80120
303-997-9842 (office)
720-621-9464 (cell phone)

On Tue, Jan 5, 2021 at 10:55 AM Harp, William <william.harp@dhp.virginia.gov> wrote:
Hi Dave:

Thanks for the call and your email response last week.

Might you have the data on the number of physicians that got
1 additional license
2 additional licenses
3 or more additional licenses?

Again, thanks very much!

Bill
William L. Harp, MD
Executive Director
Virginia Board of Medicine

STATISTICS FOR THE COMPACT

The Compact accepted its first application 3.75 years ago (April 2017).

The total number of licenses issued through November 2020 was 14,868.

The total number of physicians applying through November 2020 was 8,271.

The 2018 Federation of State Medical Boards Physician Census tabulated 985,026 MD's & DO's.

According to the American Association of Medical Colleges, there are 20,000 medical graduates each year in the United States.

Using 1,000,000 as the denominator for licensed physicians, the percentage of physicians that have utilized the Compact to obtain additional licenses is 0.83%.

The average length of time from application to licensure is 30-50 days.

STATISTICS FOR LICENSURE BY ENDORSEMENT

The application for licensure by endorsement was posted on December 26, 2018.

To date, 881 MD's and DO's have been licensed by endorsement.

There are currently 41,126 active MD and DO licenses.

The number licensed by endorsement in 2 years represents 2.14% of active MD's and DO's.

The average length of time from application to licensure is 51.5 days for MD's and 49.75 days for DO's. The Board has discerned two groups that apply through endorsement. There are those that want a license quickly, and 1 day is the record. The other group is those that want an easy way to apply with less documentation; they are not interested in speed. Some allow their application to sit for months.

Agenda Item: Continuing Education on Human Trafficking

Staff Note: This issue was raised by a Board of Medicine member for consideration. It would appear that Texas, Florida, Michigan and perhaps Ohio have a continuing education requirement for physicians and other healthcare providers in order to learn how to identify victims of human trafficking and respond appropriately. The Board included information on human trafficking in its April 2015 Board Briefs, but has not emphasized it since.

In the following pages, you will find:

- Association of American Medical Colleges article on the physician's role in identifying human trafficking
- Texas Medical Board Continuing Education (CE) requirement
- Texas Statute on CE requirement
- Texas List of Approved Training Courses
- American Medical Association on Medical Education on Human Trafficking
- Examples of Continuing Education on Human Trafficking – SOAR & Florida courses
- Excerpt from the April 2015 Board Briefs that includes the Polaris Project Medical Assessment Tool

Action: Discussion and consideration of requiring continuing education on human trafficking or taking another approach to inform the Board's licensees

AAMC

HEALTH CARE (/TOPIC/HEALTH-CARE) | COMMUNITY ENGAGEMENT (/TOPIC/COMMUNITY-ENGAGEMENT)

Physicians Can Play Crucial Role in Identifying Human-Trafficking Victims

Martha M. Jablow, special to AAMCNews

May 2, 2017

Physicians are uniquely positioned to recognize and help patients who may be victims of human trafficking. But awareness and education are critical first steps.

A laborer worked 19 hours a day to repay an insurmountable debt to his employer. When he fell off a 10-foot platform on a construction job, he broke his back. Emergency physicians treated him with painkillers but overlooked the fact that he was chronically malnourished with signs and symptoms of tuberculosis.

A 17-year-old went to an emergency department (ED) with a gunshot wound to the leg. Her male companion told the provider it was the result of a drive-by shooting. No further questions were asked about the cause.

These are real-life stories of patients in this country who were treated but not identified by physicians as victims of human trafficking. There can be many overlooked signs, according to the human trafficking experts who provided these examples, including recurring sexually transmitted infections, suspicious burns, or even poor eye contact.

The U.S. Department of Homeland Security describes human trafficking as "modern-day slavery (that) involves the use of force, fraud, or coercion." The involuntary acts may be of a sexual nature or related to labor. Many Americans assume that trafficking is a problem only on foreign soil, but this is not so.

Laura Lederer, JD, surveyed 125 survivors of trafficking for a 2014 study (https://www.annalsofhealthlaw.com/annalsofhealthlaw/vol_23_issue_1?pg=1#pg1) in the *Annals of Health Law* about their experiences with health care providers. Close to 90% of the victims, ages 14 to 60, sought medical care during their ordeals for symptoms including cardiovascular and respiratory problems, flashbacks, depression, anxiety, nightmares, and feelings of shame and guilt. Yet, more than half said their providers did not ask about their personal circumstances. "Health care providers were not trained about trafficking and not asking the right questions to identify victims," Lederer concluded.

In the gunshot victim's case, the girl's pimp told the ED staff she was shot in a drive-by shooting. In reality, he shot her because she resisted doing something he ordered, Lederer said. Two years later, he shot her in the other leg, took her to the same ED, and again said it was a drive-by shooting. In neither case did health care providers question whether she was a trafficking victim.

"We can use our diagnostic skills from other forms of interpersonal violence to help us identify trafficking survivors.... Physicians should look for other 'pattern recognition pieces' beyond patients' presenting signs or symptoms."

Hanni Stoklosa, MD, MPH
Brigham and Women's Hospital

Physicians typically "don't have human trafficking on their radar," said Hanni Stoklosa, MD, MPH, an emergency medicine physician at Brigham and Women's Hospital and an instructor in emergency medicine at Harvard Medical School. But, she added, "Human trafficking doesn't need to be siloed." At Harvard, Stoklosa said she teaches her medical students that trafficking has many dimensions that can present in pediatrics, EDs, urgent care settings, orthopaedics, or infectious diseases.

Keith Horvath, MD, senior director of clinical transformation for Health Care Affairs at the AAMC, would add that it's best practice to ask certain screening questions during any patient encounter, regardless of the circumstances. "Having physicians routinely ask questions like 'Do you feel safe at home?' will increase their awareness of trafficking-related injuries and illnesses," he said.

"We can use our diagnostic skills from other forms of interpersonal violence to help us identify trafficking survivors," said Stoklosa, also executive director of HEAL Trafficking (https://healtrafficking.org/), a network of health professionals who developed a toolkit to aid clinical staff on how to respond to suspected trafficking victims in health care settings.

Raising awareness through the medical curriculum

A 2014 report from the International Labour Organization estimated that 21 million men, women, and children (https://www.ilo.org/global/topics/forced-labour/lang--en/index.htm) worldwide are trafficking victims. Several academic medical institutions are taking steps to increase awareness about the problem and how physicians can identify and help victims.

Tonya Chaffee, MD, MPH, clinical professor of pediatrics at University of California, San Francisco, said that medical educators have become much better at recognizing the impact of social issues on health and in teaching medical students to "see the whole picture." "We've learned from domestic violence. [Our response to human trafficking] is in its infancy and about 10 years behind domestic violence," she added.

Recognizing the Signs of Sex Trafficking

Physicians can be "frontline players" in identifying victims of sex or labor trafficking, said Tonya Chaffee, MD, MPH, of the University of California, San Francisco. The following are several signs and symptoms of sex trafficking victims Chaffee noted in an upcoming presentation she prepared called "The Health Care Provider's Role in Addressing Modern Day Slavery":

Physical symptoms

- Sexually transmitted infections
- Recurrent pregnancies
- Somatization symptoms, such as headaches, abdominal pain, and vaginitis
- Other injuries related to physical or sexual abuse

Behavioral symptoms

- Depressed mood or flat affect
- Anxiety and panic attacks
- Anger or aggression toward health care team
- Poor mental status, often due to isolation or sleep deprivation

Other signals

- Tattoos (used for branding)
- Malnutrition
- Evidence of physical or sexual trauma
- Poor dentition
- Unexplained or conflicting stories regarding injuries

Some medical schools are integrating content about human trafficking into their classes. As part of the core curriculum at the University of Vermont Larner College of Medicine, for example, second-year students work with faculty physicians and nonprofit organizations on semester-long research projects that focus on identifying victims, barriers to health care for vulnerable populations, and an electronic screening tool for human trafficking.

Stanford School of Medicine created a set of educational resources (https://humantraffickingmed.stanford.edu/) to familiarize medical personnel with the scope of the issue.

The University of Miami Miller School of Medicine established an intradisciplinary victim services clinic seven years ago. A small grant to run a symposium about human trafficking ultimately led to a comprehensive program for survivors. "We built a medical home," said JoNell Potter, PhD, professor of clinical obstetrics and gynecology. Students at the medical school learn about trafficking through participation in clinics and grand rounds at a local hospital where victims now obtain primary care, gynecological and other specialty care, and psychiatric services, she said.

Hilary Friedlander said she had no familiarity with trafficking as a first-year medical school student at Albert Einstein College of Medicine in 2015. Then, along with several fellow students, she attended a conference of the American Medical Women's Association on the topic.

"We were blown away by what we heard." Friedlander said. "We were not aware of the scope of the problem, and we didn't realize that physicians could play such an important role [in helping victims]." The students believed their colleagues were probably as uninformed as they were, so they created a three-part model (lectures, small group meetings, and videos) to educate first- and second-year students. They took their model to Einstein faculty who were "really receptive," Friedlander said.

Now a third-year student, Friedlander's initial interest in trafficking victims has developed into a project that teaches Einstein medical students about signs of trafficking and how to respond.

What can physicians do?

At the national level, the U.S. Department of Health and Human Services (HHS) has taken steps to increase awareness about trafficking. It held a symposium in 2008 on victims' health needs and committed to a federal strategic action plan for victims' services. The Trafficking Awareness Training for Health Care Act was passed in 2015 as part of the Justice for Victims of Trafficking Act. And earlier this year, HHS created the Office on Trafficking in Persons (OTIP), which introduced SOAR (https://www.globalcenturion.org/programs/educationawarenessadvocacy/soar-training-on-human-trafficking-for-health-care-providers/) (Stop. Observe. Ask. Respond.), a project to train health care professionals in human trafficking knowledge and skills.

"Physicians usually want to fix everything, but the goal is not to get disclosure. It's to help the patient feel safe and confident enough to come back [for further care]."

Tonya Chaffee, MD, MPH
University of California, San Francisco

What can a clinician do when trafficking is suspected? "Providers need to have their radar out to identify and respond appropriately," Lederer said. "They should separate victims from the suspected trafficker and question them to find out more about what happened." Health care providers don't take the place of law enforcement officers, but physicians can ask questions, she said, such as, "Can you leave your work if you want to? Have you ever been hurt or threatened? Do you know how to get help if you need it?"

Stoklosa noted that some victims may tell a physician they have been sexually assaulted, but the physician doesn't recognize it as trafficking. "Physicians should look for other 'pattern recognition pieces' beyond patients' presenting signs or symptoms. Those may include malnourishment, broken bones, fear, or anxiety." Aggression and anger are common as well, stemming from feelings of shame, she said.

The list of possible physical signs Friedlander prepared for medical students at Einstein includes recurrent sexually transmitted infections, a number of pregnancies, bruises or burns, or addiction. Behavioral signs on the list are poor eye contact, relating a story that appears scripted or rehearsed, and a companion who seems to control the patient.

According to Chaffee, "Physicians usually want to fix everything, but the goal is not to get disclosure. It's to help the patient feel safe and confident enough to come back [for further care]." Or as Friedlander has learned, "Patients need to play an active role in decision making. Avoid the rescue fantasy. Our goal is not to save but to assist."

AAMC Association of American Medical Colleges

655 K Street, NW, Suite 100 Washington, DC, 20001-2399

Continuing ED Requirements

Many practitioners are required to obtain continuing education to maintain active licensure.

For information on specific continuing education requirements per license type, please select the proper link above.

** New CME Requirements **

New Opioid CME Requirements

During the 86th legislative session, in an effort to combat the opioid crisis in Texas, there were multiple bills passed requiring physicians, physician assistants and other licensees to complete certain specific opioid related continuing medical education. These new CME requirements related to opioids will be part of the Opioid Workgroup being formed by TMB to address the on-going public health crisis in a comprehensive, multi-faceted approach. **This requirement applies to the renewal of a license on or after September 1, 2020.**

New Human Trafficking Prevention CME Requirement

House Bill 2059 (86th Legislature) requires physicians, physician assistants, and any licensee of the TMB's advisory boards or committees that provide direct patient care, to complete a human trafficking prevention course approved by the Texas Health and Human Services Commission (HHSC). **This requirement applies to the renewal of a license on or after September 1, 2020.**

HHSC is the approving body for the human trafficking prevention requirement. HB 2059 requires HHSC to approve training courses on human trafficking, including at least one that is free of charge, post a list of approved trainings on its website and update the list of approved trainings as necessary.

HHSC now has an approved course available, which is free of charge, that satisfies the requirements for all licensees impacted by HB 2059.

› See HHSC's Health Care Practitioner Human Trafficking Training page to access the course and for more information about this requirement.

New Human Trafficking Prevention CME Requirement

House Bill 2059 (86th Legislature) requires physicians, physician assistants, and any licensee of the TMB's advisory boards or committees that provide direct patient care, to complete a human trafficking prevention course approved by the Texas Health and Human Services Commission (HHSC). **This requirement applies to the renewal of a license on or after September 1, 2020.**

HHSC is the approving body for the human trafficking prevention requirement. HB 2059 requires HHSC to approve training courses on human trafficking, including at least one that is free of charge, post a list of approved trainings on its website and update the list of approved trainings as necessary.

HHSC now has an approved course available, which is free of charge, that satisfies the requirements for all licensees impacted by HB 2059.

- See HHSC's Health Care Practitioner Human Trafficking Training page to access the course and for more information about this requirement.

H.B. No. 2059

AN ACT

relating to required human trafficking prevention training as a condition of registration permit or license renewal for certain health care practitioners.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subtitle A, Title 3, Occupations Code, is amended by adding Chapter 116 to read as follows:

CHAPTER 116. TRAINING COURSE ON HUMAN TRAFFICKING PREVENTION

Sec. 116.001. DEFINITIONS. In this chapter:

(1) "Commission" means the Health and Human Services Commission.

(2) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.

(3) "Health care practitioner" means an individual who holds a license, certificate, permit, or other authorization issued under this title to engage in a health care profession and who provides direct patient care.

Sec. 116.002. REQUIRED TRAINING COURSE ON HUMAN TRAFFICKING PREVENTION FOR CERTAIN HEALTH CARE PROVIDERS. (a) A health care practitioner, other than a physician or nurse, within the time prescribed by commission rule shall successfully complete a training course approved by the executive commissioner on identifying and assisting victims of human trafficking.

(b) The executive commissioner shall:

(1) approve training courses on human trafficking prevention, including at least one course that is available without charge; and

(2) post a list of the approved training courses on the commission's Internet website.

(c) The executive commissioner shall update the list of approved training courses described by Subsection (b) as necessary and consider for approval training courses conducted by health care facilities.

Sec. 116.003. TRAINING REQUIRED FOR LICENSE RENEWAL. A health care practitioner, other than a physician or nurse, shall successfully complete a training course described by Section 116.002 as a condition for renewal of a license issued to the health care practitioner under this title.

SECTION 2. Subchapter B, Chapter 156, Occupations Code, is amended by adding Section 156.060 to read as follows:

Sec. 156.060. CONTINUING EDUCATION IN HUMAN TRAFFICKING PREVENTION. (a) A physician licensed under this subtitle who submits an application for renewal of a registration permit and who designates a direct patient care practice must complete, as part of the hours of continuing medical education required for compliance with Section 156.051(a)(2), a human trafficking prevention course approved by the executive commissioner of the Health and Human Services Commission under Section 116.002.

(b) The board shall designate the human trafficking prevention course required by Subsection (a) as a medical ethics or professional responsibility course for purposes of complying with

continuing medical education required by Section 156.051(a)(2).

(c) The board shall adopt rules to implement this section.

SECTION 3. Subchapter G, Chapter 301, Occupations Code, is amended by adding Section 301.308 to read as follows:

Sec. 301.308. CONTINUING EDUCATION IN HUMAN TRAFFICKING PREVENTION. (a) As part of a continuing competency program under Section 301.303, a license holder who provides direct patient care shall complete a human trafficking prevention course approved by the executive commissioner of the Health and Human Services Commission under Section 116.002.

(b) The board shall adopt rules to implement this section.

SECTION 4. As soon as practicable after the effective date of this Act, the executive commissioner of the Health and Human Services Commission shall approve and post on the commission's Internet website the list of approved human trafficking prevention training courses and adopt rules necessary to implement Chapter 116, Occupations Code, as added by this Act.

SECTION 5. (a) As soon as practicable after the effective date of this Act, the applicable licensing agency shall provide notice to a health care practitioner of the human trafficking prevention training required under Chapter 116, Occupations Code, as added by this Act.

(b) Notwithstanding Section 116.002, Occupations Code, as added by this Act, a health care practitioner is not required to comply with that section before September 1, 2020.

SECTION 6. Sections 156.060 and 301.308, Occupations Code, as added by this Act, apply only to the renewal of a registration

permit to practice medicine or the renewal of a license to practice nursing on or after September 1, 2020. The renewal of a registration permit or license before that date is governed by the law in effect immediately before the effective date of this Act, and the former law is continued in effect for that purpose.

SECTION 7. This Act takes effect September 1, 2019.

President of the Senate

Speaker of the House

I certify that H.B. No. 2059 was passed by the House on May 10, 2019, by the following vote: Yeas 134, Nays 7, 2 present, not voting.

Chief Clerk of the House

I certify that H.B. No. 2059 was passed by the Senate on May 22, 2019, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

APPROVED: _____

Date

_____

Governor

TEXAS
Health and Human Services

Approved Human Trafficking Training Courses for Health Care Practitioners

House Bill 2059, 86th Legislature, Regular Session, 2019, requires Health and Human Services (HHS) to approve training courses on human trafficking. This list will be expanded as more courses are approved. If you need assistance with any of the courses listed here, please contact the training organization directly. Not all professions are required to claim continuing education (CE) credit for human trafficking courses. If your profession is not explicitly listed in the Credit/Special Note column, please refer to your board's regulations for CE.

ORGANIZATION	COURSE TITLE	COURSE LENGTH	COST	DELIVERY METHOD	CREDIT/SPECIAL NOTE	EFFECTIVE DATES
Elite Professional Education	A Clinician's Guide to Recognizing and Responding to Human Trafficking in Texas	1 hour	$11.95	Online/Print	• Nursing - 1 contact hour • Pharmacist - 1 contact hour • Pharmacy Technicians - 1 contact hour • Dentists - 1 CE hour • Dental Assistants - 1 CE hour • Dental Hygienists - 1 CE hour • Psychologists -1 CE credit • Physical Therapists - 1 CCU • Physical Therapist Assistants - 1 CCU • Occupational Therapists - 1 contact hour • Occupational Therapy Assistants - 1 contact hour • Social Workers - 1 CE hour • Licensed Professional Counselors - 1 CE hour	12/9/2020 – 12/9/2022

					• Chemical Dependency Counselors - 1 CE hour • Marriage and Family Therapists - 1 CE hour • Massage Therapists - 1 CE hour • Respiratory Therapists - 1 contact hour	
InforMed	A Clinician's Guide to Recognizing and Responding to Human Trafficking in Texas	1 hour	$10	Online/Print	1.0 *AMA PRA Category 1 Credit™*	9/29/2020 – 9/29/2022
Innovative Educational Services www.cheapceus.com	Human Trafficking Training - Texas	1 hour	$4.95	On-Line Video, On-Demand	Intended Audience: • Physical Therapists • Physical Therapist Assistants • Occupational Therapists • Occupational Therapy Assistants	12/1/2020 – 12/1/2022
National Association of Pediatric Nurse Practitioners	Human Trafficking: Raising Awareness to Identify Victims in the Clinical Setting	1 hour	Free	Online and In-Person To request a training, click here: https://www.napnappartners.org/contact	N/A	11/12/2020 – 11/12/2022
NetCe	Human Trafficking and Exploitation: The Texas Requirement	5 contact hours	$20	Online/Print	• *AMA PRA Category 1 Credit™*: 5 credits • ACPE: 5 credits • ANCC: 5 contact hours • ASWB: 5 clock hours • APA: 5 credits	10/22/2020 – 10/22/2022

					• NBCC: 2 clock hours • ADA: 5 CE credits • AGD: 5 CE hours • IPCE: 5 credits IACET: 0.5 CEUs	
National Human Trafficking Training and Technical Assistance Center	SOAR to Health and Wellness	1 hour	Free	Online (Course ID: 1087568) Online for Health Stream users	• Physicians – maximum of 1.0 *AMA PRA Category 1 Credit™* • Pharmacists/Pharmacy Technicians – 1.0 contact hour (0.10 CEUs) • Nurses – 1.0 contact hour • Psychologists – 1.0 CE credit • Dentists – 1.0 CE credit • Social Workers – 1.0 cultural competency CE credit • Public Health Professionals – 1.0 CPH credit • Health Education Specialists – 1.0 entry-level CECH • Healthcare Team – 1.0 Interprofessional Continuing Education credit	4/1/2020 – 4/1/2022
National Human Trafficking Training and Technical Assistance Center	SOAR for Health Care	1 hour	Free	Online (Course ID: 1087547) Online for Health Stream users	• Physicians – maximum of 1.0 *AMA PRA Category 1 Credit™* • Pharmacists/Pharmacy Technicians – 1.0 contact hour (0.10 CEUs) • Nurses – 1.0 contact hour • Psychologists – 1.0 CE credit • Dentists – 1.0 CE credit • Public Health Professionals – 1.0 CPH credit • Health Education Specialists – 1.0 entry-level CECH • Healthcare Team – 1.0 Interprofessional Continuing Education credit	7/1/2020 – 7/1/2022

Ransomed Life of Texas	Human Trafficking: Training for Healthcare Professionals & Support Staff	1.5 hours	Free	In Person/ Webinar	N/A	10/13/2020 – 10/13/2022
Ransomed Life of Texas	Human Trafficking: Training for School Nurses & Educational Support Staff	2 hours	Free	In Person/ Webinar	N/A	10/22/2020 – 10/22/2022
Texas Medical Association	Identifying Human Trafficking in Texas: What Physicians Need to Know	1 hour	Free for TMA members / $349 for non-members	PDF download	1.0 *AMA PRA Category 1 Credit*™ 1 Ethics Credit	10/7/2020 – 10/7/2022
Texas Nurse Practitioners	Human Trafficking: Raising Awareness to Identify Victims in the Clinical Setting	1 hour	Online- $25 TNP members/ $75 non-members, $199 included in full TNP Conference	Online	American Association of Nurse Practitioners, Accredited - 1.0 CE hours	9/22/2020 – 9/22/2022
Unbound	Identifying and Responding to Victims of Human Trafficking in a Clinical Setting	1 hour	Free	Online and In-Person	1.0 CNE hours accredited by Texas Nurses Association through June 3, 2021	10/7/2020 – 10/7/2022

Medical Education on Human Trafficking/Slavery

The U.S. Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.

The American Medical Association (AMA) encourages the education of physicians about human trafficking which should include how to identify and report cases of suspected human trafficking to appropriate authorities, and how to address the victim's medical, legal, and social needs. Educational training on human trafficking addresses the Liaison Committee on Medical Education (LCME) standards and meets Accreditation Council for Graduate Medical Education (ACGME) requirements.

LCME Standards

http://lcme.org/publications/
Standard 7: Curricular Content
The faculty of a medical school ensure that the medical curriculum provides content of sufficient breadth and depth to prepare medical students for entry into any residency program and for the subsequent contemporary practice of medicine. (Core educational objective)

7.5: Societal Problems
The faculty of a medical school ensure that the medical curriculum includes instruction in the diagnosis, prevention, appropriate reporting, and treatment of the medical consequences of common societal problems.

ACGME Common Program Requirements

https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf
IV.B.1.c) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. (Core)

Programs that Monitor the Effectiveness of Efforts to Combat Human Trafficking

A number of programs have been created to increase awareness of the signs and symptoms of human trafficking and to monitor how these educational efforts are addressing the needs of victims. These programs are listed below.

Office on Trafficking in Persons: U.S. Department of Health and Human Services, Administration for Children and Families

www.acf.hhs.gov/programs/endtrafficking/initiatives/federal-plan

The Federal Strategic Action Plan on Services to Victims of Human Trafficking in the United States (Plan) highlights ongoing efforts to combat human trafficking at home and abroad and provides information on the effectiveness and of these programs.

SOAR to Health and Wellness Training

www.acf.hhs.gov/programs/endtrafficking/initiatives/soar

Following the January 2014 release of the U.S. government's Federal Strategic Action Plan on Services for Victims of Human Trafficking in the United States: 2013-2017, the U.S. Department of Health and Human Services launched the SOAR to Health and Wellness Network, a pilot initiative to educate health care professionals on how to identify and serve victims of trafficking.

The Rescue & Restore Victims of Human Trafficking Campaign: U.S. Department of Health and Human Services, Administration for Children and Families

www.acf.hhs.gov/programs/endtrafficking/resource/rescue-restore-campaign-tool-kits

The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals. This website provides background information and guidance for health care practitioners in identifying and communicating with victims of human trafficking.

Evidence-Based Mental Health Treatment for Victims of Human Trafficking, ASPE, U.S. Department of Health and Human Services

https://aspe.hhs.gov/report/evidence-based-mental-health-treatment-victims-human-trafficking

This website examines the evidence-based research for treating common mental health conditions experienced by victims of human trafficking.

Centers for Disease Control and Prevention: Injury Prevention & Control, Division of Violence Prevention

www.cdc.gov/violenceprevention/sexualviolence/trafficking.html
This website provides information and resources specific to understanding sex trafficking.

HEAL Trafficking

https://healtrafficking.org/
HEAL Trafficking comprises a united group of over 2,600 survivors and multidisciplinary professionals in 35 countries dedicated to ending human trafficking and supporting its survivors. The HEAL Education and Training Committee focuses on educating health care providers about trafficking and making relevant, evidenced-based training resources more accessible for health-care providers.

Human Trafficking and the Institute on Healthcare and Human Trafficking

https://www.magmutual.com/learning/article/human-trafficking-and-institute-healthcare-and-human-trafficking
The Institute for Healthcare and Human Trafficking (IHHT) provides assistance to medical and behavioral health professionals seeking information on all types of human trafficking (labor/sex; children/adults; domestic/international). The goals of IHHT are: 1) to raise awareness among health professionals about human trafficking; 2) to increase the ability of professionals to recognize potential victims and respond appropriately; and 3) to contribute to the body of research on human trafficking.

Educational Programs and Resources for Physicians

The following educational programs and resources are also available to help physicians with identifying and addressing the needs of human trafficking victims.

American College of Obstetricians and Gynecologists/Committee on Health Care for Underserved Women

https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Human-Trafficking?IsMobileSet=false
This website provides background information about human trafficking and a list of resources for health-care providers.

Stanford Medicine/Human Trafficking

http://humantraffickingmed.stanford.edu/
This website provides educational resources to familiarize health-care providers with the scope of the issue.

University of Miami Miller School of Medicine

http://obgyn.med.miami.edu/research/thrive-clinic

The University of Miami Miller School of Medicine established a multidisciplinary medical clinic, called THRIVE (Trafficking Healthcare Resources and Interdisciplinary Victim Services and Education), in 2015 to respond to the health care needs of survivors of human trafficking. The clinic began as a pilot project after faculty began receiving requests from law enforcement, shelter services, and other community agencies to examine some of the survivors who needed medical care. Medical students learn about trafficking through participation in clinics and grand rounds at a local hospital where victims now obtain primary care, gynecological, and other specialty care and psychiatric services.

Larner College of Medicine at the University of Vermont

http://www.givewaytofreedom.org/initiatives/UVM-Medical-School.php

One of the core curriculum requirements for second year medical students is that they work closely with a community non-profit or service organization, as well as a faculty physician, on a semester long research project that focuses on identifying victims, barriers to health care for vulnerable populations, and an electronic screening tool for human trafficking. *Give Way To Freedom* has been chosen by the University of Vermont Medical School to collaborate on public health projects such as human trafficking in collaboration with the United Way.

Albert Einstein College of Medicine/Sex Trafficking: A Global Issue

https://einstein.yu.edu/intranet/around-campus/487/sex-trafficking-a-global-issue/

A project about the signs of trafficking and how to respond is offered at Albert Einstein College of Medicine.

Addressing Human Trafficking in the Health Care Setting: Catholic Health Initiatives and the Massachusetts General Hospital Human Trafficking Initiative

www.catholichealthinitiatives.org/addressing-human-trafficking-course/story_html5.html

This concise web-based course is designed to help health-care providers identify, assess, and respond to suspected victims of human trafficking.

Physicians Against the Trafficking of Humans (PATH)

https://www.amwa-doc.org/our-work/initiatives/human-trafficking/

The American Medical Women's Association founded Physicians Against the Trafficking of Humans (PATH) to help educate physicians, residents, and medical students about issues surrounding human trafficking.

Caring for Trafficked Persons: Guidance for Health Providers: International Organization for Migration, United Nations Global Initiative to Fight Trafficking in Persons, and the London School of Hygiene and Tropical Medicine

http://publications.iom.int/system/files/pdf/ct_handbook.pdf

This handbook provides practical, non-clinical guidance to help concerned health providers understand the phenomenon of human trafficking, recognize some of the health problems associated with trafficking, and consider safe and appropriate approaches to providing health care for trafficked persons. It outlines the health provider's role in providing care and describes some of the limitations of his or her responsibility to assist.

Human Trafficking: Guidebook on Identification, Assessment, and Response in the Health Care Setting: Massachusetts General Hospital Human Trafficking Initiative and the Massachusetts Medical Society

www.massmed.org/Patient-Care/Health-Topics/Violence-Prevention-and-Intervention/Human-Trafficking-(pdf)

A guidebook on identification, assessment, and response in the health-care setting.

National Human Trafficking Resource Center: Polaris Project

https://traffickingresourcecenter.org

In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project maintains the National Human Trafficking Resource Center, which provides:

A Comprehensive Human Trafficking Assessment
http://traffickingresourcecenter.org/sites/default/files/Comprehensive%20Trafficking%20Assessment.pdf

Webinar on Recognizing and Responding to Human Trafficking in a Healthcare Context
http://traffickingresourcecenter.org/resources/recognizing-andresponding-human-trafficking-healthcare-context

SOAR for Public Health

To access this content, you first need to create an account. If you already have an account, please login.

Web-Based Training - Self-Study | ID 1087564 | Skill Level: Introductory | 1h

(411 Ratings)

Individuals who are at risk, currently experiencing, or have experienced trafficking access a variety of services. The SOAR framework is a trauma-informed, culturally and linguistically appropriate response to human trafficking. It provides public health professionals with tailored information on how to identify and respond to human trafficking within their field. **BEFORE PROCEEDING PRINT THESE INSTRUCTIONS.** soar online instructions for train.11132020.508e.pdf

Show More

Details

Learning Objectives

SOAR *Online* is jointly provided by the Postgraduate Institute for Medicine and the U.S. Department of Health and Human Services. The module is a collaboration between the Administration for Children and Families Office on Trafficking in Persons and the HHS Office on Women's Health, supported by the National Human Trafficking Training and Technical Assistance Center. The SOAR trainings are developed in collaboration with subject matter experts in the field, those with lived experiences, and partner organizations.

Credits Available

- Physicians – maximum of 1.0 *AMA PRA Category 1 Credit*™
- Pharmacists/Pharmacy Technicians – 1.0 contact hour (0.10 CEUs)
- Nurses – 1.0 contact hour
- Psychologists – 1.0 CE credit
- Dentists – 1.0 CE credit

- Public Health Professionals – 1.0 CPH credit
- Health Education Specialists – 1.0 entry-level CECH
- Healthcare Team – 1.0 Interprofessional Continuing Education credit

For accreditation information, read the attached document.

accreditation information_soar for public health_june 2020 relaunch.pdf

After completing the SOAR for Public Health module, learners will be able to:

- Describe the types of trafficking in the United States
- Recognize possible indicators of trafficking in public health settings
- Identify trauma-informed screening tools and techniques for use by public health professionals
- Develop a trafficking response protocol for your organization and community using a public health model
- Assess the needs of individuals who are at risk of trafficking or who may have experienced trafficking and coordinate services within a multidisciplinary network of service providers

PRINT THIS FIRST

soar online instructions for train 11132020 508c.pdf

This document provides instructions on how to complete all of the course requirements, obtain evidence of course completion, and receive continuing education credits.

Core Competencies for Public Health Professionals

Core Competencies for Public Health Professionals

Attributes

SOAR for Health Care

To access this content, you first need to create an account. If you already have an account, please login.

Web-Based Training - Self-Study | ID 1087547 | Skill Level: Introductory | 1h

(4846 Ratings)

Individuals who are at risk, currently experiencing, or have experienced trafficking access a variety of services. The SOAR framework is a trauma-informed, culturally and linguistically appropriate response to human trafficking. It provides health care professionals with tailored information on how to identify and respond to human trafficking within their field. **BEFORE PROCEEDING PRINT THESE INSTRUCTIONS.** soar online instructions for train 11132020 508e.pdf

Show More

Details

Learning Objectives

SOAR *Online* is jointly provided by the Postgraduate Institute for Medicine and the U.S. Department of Health and Human Services. The module is a collaboration between the Administration for Children and Families Office on Trafficking in Persons and the HHS Office on Women's Health, supported by the National Human Trafficking Training and Technical Assistance Center. The SOAR trainings are developed in collaboration with subject matter experts in the field, those with lived experiences, and partner organizations

Credits Available

- Physicians – maximum of 1.0 *AMA PRA Category 1 Credit™*
- Pharmacists/Pharmacy Technicians – 1.0 contact hour (0.10 CEUs)
- Nurses – 1.0 contact hour
- Psychologists – 1.0 CE credit
- Dentists – 1.0 CE credit

- Public Health Professionals – 1.0 CPH credit
- Health Education Specialists – 1.0 entry-level CECH
- Healthcare Team – 1.0 Interprofessional Continuing Education credit

For accreditation information, read the attached document.

accreditation information_soar for health care_june 2020 relaunch 508.pdf

After completing the SOAR for Health Care module, learners will be able to:

- Describe the types of trafficking in the United States
- Recognize possible indicators of trafficking in health care settings
- Identify trauma-informed screening tools and techniques for use by health care providers
- Develop a trafficking response protocol for your organization
- Assess the needs of individuals who are at risk of trafficking or who may have experienced trafficking and coordinate services within a multidisciplinary network of service providers

PRINT THIS FIRST

soar online instructions for train 11132020 508c.pdf

This document provides instructions on how to complete all of the course requirements, obtain evidence of course completion, and receive continuing education credits.

Core Competencies for Public Health Professionals

Core Competencies for Public Health Professionals

Attributes

SOAR to Health and Wellness Training

Many individuals who have experienced trafficking come into contact with health care and social service professionals during and after their exploitation, but still remain unidentified. The SOAR training equips professionals with skills to identify, treat, and respond appropriately to human trafficking.

By applying a public health approach, SOAR seeks to build the capacity of communities to identify and respond to the complex needs of individuals who have experienced trafficking and understand the root causes that make individuals, families, and communities vulnerable to trafficking.

After attending SOAR training, you will be able to:

- **S**top – Describe the scope of human trafficking in the United States
- **O**bserve – Recognize the verbal and non-verbal indicators of human trafficking
- **A**sk – Identify and interact with individuals who have experienced trafficking using a victim-centered and trauma-informed approach
- **R**espond – Respond effectively to potential human trafficking in your community by identifying needs and available resources to provide critical support and assistance

"Real life scenarios…make you think about how to put these skills and knowledge into action." "I had no prior training or knowledge of human trafficking. I did not even realize people were trafficked for labor purposes. I just thought that this occurred in other places,

when in reality it can be in the city that I live in." "Enjoyed the interactive platform, thought provoking questions asked, and having a survivor [facilitator]. Extremely well delivered by all speakers."

Who Should Take SOAR Training?

SOAR is for anyone interested in learning how to recognize and respond to human trafficking in health care or social service settings. Trainings will be available for:

- Health care providers
- Social workers
- Public health professionals
- Behavioral health professionals

How Do I Attend SOAR Training?

The SOAR training is delivered either in-person or online . Choose a training that best suits your work and your professional role.

The HHS SOAR training program is administered by OTIP in partnership with the HHS Office on Women's Health , through the National Human Trafficking Training and Technical Assistance Center.

The Office on Trafficking in Persons thanks the 2014 and 2016 SOAR technical working groups for their hard work and contributions to the development of this training.

Last Reviewed Date: September 24, 2019

Was this page helpful? Yes No Next

Continuing Medical Education
COLLEGE of MEDICINE

HUMAN TRAFFICKING CME OVERVIEW

Human Trafficking CME

Each healthcare provider licensed by one of the named Boards must complete a one hour continuing education (CE) course on human trafficking that has been specifically approved by their Board for this purpose. The course must be completed by January 1, 2021 and will count towards the required CE for renewal.

You can find more information on this website:
http://www.flhealthsource.gov/humantrafficking/

Provider: **University of Florida**

Title: "Human Trafficking Prevention CME"

URL: https://xms.dce.ufl.edu/reg/groups/All/course.aspx?c=11108&ug=9

Cost: $25.00

Provider: **Baptist Health South Florida**

Title: "Detecting and Responding to Human Trafficking" (2.0 Credits)

URL: https://cmeonline.baptisthealth.net/content/detecting-and-responding-human-trafficking-1

Cost: $0

Provider: **OnCourse Learning**

Title: "Human Trafficking: Bringing Light to a Hidden Nightmare" (2.0 Credits)

URL: https://www.continuingeducation.com/course/cmez60249/human-trafficking-bringing-light-to-a-hidden-nightmare/

Cost: $24.00

Provider: **OnCourse Learning**

Title: "Human Trafficking" (1.0 Credit)

URL: https://www.continuingeducation.com/course/cmez60249/human-trafficking-bringing-light-to-a-hidden-nightmare/

Cost: $15.00

Provider: **OnCourse Learning**

Title: "Human Trafficking: Identification and Assessment of Victims Essential" (1.0 Credit)

URL: https://www.continuingeducation.com/course/cmez759/human-trafficking/

Cost: $15

Provider: **InforMed**

Title: "2019 Florida Human Trafficking Program" (1.0 Credit)

URL: https://flht.cme.edu/index.aspx

Cost: $12.50

Recent studies found that nearly 97% of online drug sellers are operating illegally, and one in two websites selling medicine online peddle counterfeit drugs. Consumers, lured by the cheap drugs promised on rogue websites, may end up paying a higher price than anticipated, as medications may be counterfeit, ineffective, or adulterated with other ingredients, including potentially toxic chemicals. The problem is significant, with an estimated one in six Americans purchasing drugs online without a valid prescription at some point.

Experts agree that education is the key to combating the problem effectively. As trusted health care providers, physicians and pharmacists play a key role in educating consumers regarding the risks associated with purchasing medications online from an unverified source. This program offers providers the information necessary to protect patients from illegal online drug sales. Input for this activity was provided by the U.S. Food and Drug Administration, faculty from the University of California at San Diego, LegitScript and the Federation of State Medical Boards.

More Online CME offerings from the Federation of State Medical Boards

ER/LA Opioid Education - http://www.fsmb.org/policy/education-meetings/er-la-opioids

FSMB Pain Policies and Online Education - http://www.fsmb.org/policy-and-education/education-meetings/pain-policies

FREE CME SPONSORED BY THE MEDICAL SOCIETY OF VIRGINIA FOUNDATION

The Medical Society of Virginia Foundation is sponsoring an Extended-Release/Long-Acting Opioid Risk Evaluation and Mitigation Strategy conferences for prescribers throughout the Commonwealth on September 12th in Northern Virginia. There is no fee for this conference; it offers 3.0 hours of AMA PRA Category I credit. Click on the link below for more information. http://foundation.msv.org/Foundation/Initiatives/OpioidREMS-Education.aspx

VIRGINIA DEPARTMENT OF HEALTH "EBOLA--FREQUENTLY ASKED QUESTIONS"

http://www.vdh.virginia.gov/epidemiology/ebola/

ANTI-HUMAN TRAFFICKING INFORMATION AND MEDICAL ASSESSMENT TOOL

Human trafficking exists in the United States, whether it is labor trafficking or sex trafficking. The Polaris Project runs the National Human Trafficking Resource Center (NHTRC) which provides a 24-hour, confidential, toll-free number that a healthcare provider can call to get information, find services, or report a tip. The number is 1-888-373-7888. The Polaris Project provides the following Medical Assessment Tool to assist healthcare providers when they encounter individuals they suspect might be trafficked. Further information is available at www.PolarisProject.org

Medical Assessment Tool | Polaris Project

Signs to Look Out For

Patient is reluctant to explain or has inconsistencies when asked about his/her injury
Patient is not aware of his/her location (i.e. what city or state he/she is in)
Patient has someone speaking for him/her
Patient shows signs of physical or sexual abuse, medical neglect, untreated STIs and/or torture Patient exhibits fear, anxiety, depression, submission, tension, nervousness and/or avoids eye contact Patient is under 18 and is engaging in commercial sex or trading sex for something of value
Patient has an unusually high number of sexual partners for his/her age
For a more comprehensive list, consult Polaris Project's Potential Red Flags and Indicators Document

First Response

Attend to medical needs and treatment – if patient is admitted follow same protocol.

Once medical concerns are assessed / treated

If possible get patient alone to discuss questions with a social worker or medical professional.

Have you ever been forced to do work you didn't want to do?
Have you ever been forced to have sex to pay off a debt?
Does anyone hold your identity documents (i.e. driver's license/passport) for you? Why?
Have physical abuse or threats from your employer made you fearful to leave your job?
Has anyone lied to you about the type of work you would be doing?
Were you ever threatened with deportation or jail if you tried to leave your situation?
For a more comprehensive list, consult Polaris Project's Generic Trafficking Assessment

YES to any of the above questions:

Call National Human Trafficking Resource Center (NHTRC) Hotline **1-888-3737-888**
(24/7 and access to 170 languages)
Ask for assistance with assessment questions and next steps.
Indicate which questions you used from above.

NO to above questions:

Refer to social services as applicable.

Not Perceived as Trafficking Situation

Refer to social services as applicable.

Assessment of Potential Danger

Ask the Hotline to assist in assessing level of danger. Be vigilant of immediate environment – who is watching, calling, etc.
Questions to Consider:
Is the trafficker present? (i.e. in the waiting room/outside)
What will happen if the patient does not return to the trafficker?
Does the patient believe he/she or a family member is in danger?
Is the patient a minor?

No Perceived Danger

The Hotline can help determine appropriate next steps /referrals.

Perceived Danger

The Hotline can assist in determining next steps. You may need to involve law enforcement for victim safety. The Hotline can assist in determining appropriate, sensitive law enforcement contacts.

Resources

The Hotline may not have your local resources in their database so use what you know as well.

This publication was made possible in part through Grant Number 90XR0012/02 from the Anti-Trafficking in Persons Division, Office of Refugee Resettlement, U.S. Department of Health and Human Services (HHS). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Anti-Trafficking in Persons Division, Office of Refugee Resettlement, or HHS.

Next Meeting Date of the Legislative Committee is

May 21, 2021

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 **within 30 days after completion of their trip"**. (CAPP Topic 20335, State Travel Regulations, p.7). If you submit your reimbursement after the 30 day deadline, please provide a justification for the late submission.

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

February 14, 2021

Supplemental Information

2021 SESSION

HJ 531 Study; Joint Commission on Health Care.

Introduced by: **Dan I. Helmer** | **all patrons** ... **notes** | **add to my profiles**

SUMMARY AS INTRODUCED:

Study; Joint Commission on Health Care; advisability of the Commonwealth's joining the Interstate Medical Licensure Compact; report. Directs the Joint Commission on Health Care to study the advisability of the Commonwealth's joining the Interstate Medical Licensure Compact (the Compact), including the legal effects of joining of the Compact in the Commonwealth and possible positive and negative outcomes resulting from the adoption of the Compact, and develop recommendations as to whether the Commonwealth should join the Compact. The Joint Commission on Health Care shall complete its work by November 30, 2021, and submit an executive report of its findings and conclusions no later than the first day of the 2022 Regular Session of the General Assembly.

FULL TEXT

01/09/21 House: Prefiled and ordered printed; offered 01/13/21 21102370D pdf

HISTORY

01/09/21 House: Prefiled and ordered printed; offered 01/13/21 21102370D

01/09/21 House: Committee Referral Pending

2021 SESSION

HB 1769 Health care providers, certain; licensure or certification by endorsement.

Introduced by: **Nicholas J. Freitas** | **all patrons** ... **notes** | **add to my profiles**

SUMMARY AS INTRODUCED:

Certain health care providers; licensure or certification by endorsement. Requires the Board of Medicine to issue a license or certificate by endorsement to an applicant who holds a valid, unrestricted license or certificate under the laws of another state, the District of Columbia, or a United States territory or possession with which the Commonwealth has not established a reciprocal relationship upon endorsement by the appropriate board or other appropriate authority of such other state, the District of Columbia, or United States territory or possession and a determination by the Board of Medicine that the applicant's credentials are satisfactory to the Board of Medicine and the examinations and passing grades required by such other board or authority are fully equal to those required by the Board of Medicine.

FULL TEXT

12/28/20 House: Prefiled and ordered printed; offered 01/13/21 21100648D pdf | impact statement

HISTORY

12/28/20 House: Prefiled and ordered printed; offered 01/13/21 21100648D

12/28/20 House: Referred to Committee on Health, Welfare and Institutions

01/13/21 House: Assigned HWI sub: Health Professions

Public Comment:

The Medical Society of Virginia has long understood the complexity and complications of Virginia joining the Interstate Medical Licensure Compact (ILMC).

The MSV believes that the current law, which allows for appropriate discretion on behalf of the Board of Medicine (The Board) to issue licenses by endorsement to qualifying physicians wishing to practice in Virginia strikes an effective balance between convenience, affordability, and most importantly, patient protection.

The MSV supports the current code in allowing for the Board to deny licenses by endorsement based on regulatory or statutory grounds, including if an applicant was currently under investigation for criminal conduct in another state or territory. If Virginia were to join the ILMC, we would urge that the Board be able to reject applicants with disciplinary issues. Further, as the Board consider its review, we urge the Board to explore options as how providers would avoid double jeopardy issues as it relates to past discipline in other states. Additionally, we believe it would be prudent to further examine how the IMLC would interact with licensure by endorsement to ensure balance between patient safety and attracting high quality providers as well as how it would impact the cost of maintaining medical license in Virginia.

MSV members also have concerns about increased costs for licensure renewals under the ILMC, which are as high as $700 per year for physicians participating in the compact in other states. Our members continue to believe that the licensure by endorsement and licensure renewal process as it exists in current Code is effective. Given the increased costs and that current law is already working, we ask that any involvement in the ILMC by providers be voluntary.

The Board has studied the ILMC carefully over the years and has repeatedly chosen to not participate. As the Board examines the issue once again, the MSV is confident the Board will take careful consideration of the issues above to ensure patients and providers are protected across the Commonwealth and we will continue to be a resource for the Board to achieve those goals. To that end, the MSV has reached out to the Honorable Delegate Helmer to be a resource of information as he pursues passage of HJ 531.