

**VIRGINIA BOARD OF MEDICINE
EXECUTIVE COMMITTEE MINUTES**

Friday, August 7, 2015

Department of Health Professions

Henrico, VA

CALL TO ORDER: The meeting convened at 8:33 a.m.

MEMBERS PRESENT: Kenneth Walker, MD, President & Chair
Barbara Allison-Bryan, MD, Vice-President
Randy Clements, DPM
Deborah DeMoss Fonseca
Stuart Mackler, MD
Wayne Reynolds, DO

MEMBERS ABSENT: Lorri Kleine, JD
Kevin O'Connor, MD, Secretary-Treasurer

STAFF PRESENT: William L. Harp, MD, Executive Director, Board of Medicine
Jennifer Deschenes, JD, Deputy Executive Director for Discipline
Alan Heaberlin, MPA, Deputy Executive Director for Licensure
Colanthia Morton Opher, Operations Manager
Lynn Taylor, Administrative Assistant
Erin Barrett, JD, Assistant Attorney General
David Brown, DC, DHP Director

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

Call to Order

Dr. Walker called the meeting to order.

Roll Call

Ms. Taylor called the roll; a quorum was declared.

Emergency Egress Procedures

Dr. Allison-Bryan provided the emergency egress procedures.

Public Comment on Agenda Items

Dr. Walker welcomed the public in attendance and opened the floor for comment.

There was no public comment.

Approval of the Agenda

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

unanimously.

Gavel Presentations

Dr. Mackler presented an honorary gavel to Wayne Reynolds, DO, for his service as Board President from 2014-2015.

Dr. Reynolds presented an honorary gavel to Kenneth Walker, MD, for his service as Board President for 2015-2016.

APPROVAL of the DECEMBER 5, 2014 MINUTES

Dr. Allison-Bryan moved to accept the minutes of December 5, 2014. The motion was seconded and carried unanimously.

DHP Director's Report—David E. Brown, DC

Dr. Brown reported that the Health Practitioners' Monitoring Program was recently audited, and that the report is currently being vetted with stakeholders. He anticipates that, within the month, the report and a plan for implementation of specific recommendations will be released.

Dr. Brown reminded the Committee of the September 28th Board Member Development training date. He stated that this training is intended to help board members hone their skills. These interactive training sessions will cover topics such as how to run a meeting, particularly disciplinary hearings. Dr. Brown also mentioned the annual New Board Member Orientation in October and that it will provide a broader view of the agency.

Dr. Brown updated the Committee on the Governor's Task Force on Prescription Drug and Heroin Abuse. He advised that the PMP has been in the center of this effort with mandatory registration. As a result of the PMP's efforts, dentists are now required to report to the PMP, and PMP is working with pharmacy software developers to assist with the integration process. Dr. Brown stated that PMP recently became interoperable with its 17th state - Maryland, and noted that we were the first state that Maryland has partnered with to share information across state lines.

Dr. Brown asked the Committee to consider the issue of mandated continuing education for selected practitioners that prescribe opioids. He stated that the Board can work with the PMP to establish criteria to identify prescribers that would benefit from specific, required CME. Dr. Brown then referred to proposed statutory language that would accomplish this.

§54.1-2912.1. Continued competency and office-based anesthesia requirements

C. The Board shall require two hours of continuing education on topics such as pain management, responsible opioid prescribing, or addiction diagnosis and management, for certain prescribers of controlled substances each biennium. The prescribers to whom the requirement shall apply shall be determined by the Board in consideration of prescribing data from the Prescription Monitoring Program. Prescribers so designated shall be informed of the number of continuing education hours required no later than January 1 of each odd year.

During the discussion, Dr. Allison-Bryant agreed with the idea theoretically, but wondered about its practicality. Dr. Reynolds raised a question about the placement of PMP reports in the medical record.

Ms. Yeatts advised that DHP will be submitting a bill to address the placement of PMP reports in medical records. Also submitted will be language to require pharmacies to report their dispensing to the PMP every 24 hours to improve the data available to practitioners for treatment decisions.

Dr. Harp noted that mandating opioid CME was last discussed at the August 2013 Executive Committee. The Committee agreed that practitioners that prescribed large quantities should be required to take continuing education on the use of opioids. However, the argument could be made that those that write in large quantities already know what they're doing; it is the prescribers that write fewer prescriptions that may benefit from education.

The members agreed that such a small number of mandated continuing education hours would not be burdensome, even if all practitioners were required to do so.

Dr. Brown concluded by saying that the Board could host quality continuing education on its website for the convenience of its licensees.

Executive Director's Report— William L. Harp, MD

Revenue and Expenditures Report

Dr. Harp advised that the Board had \$9.3 million at the end of June, and will be voting on a fee reduction for the next biennial renewals at the October 22, 2015 Full Board meeting.

Health Practitioners' Monitoring Program

Dr. Harp stated that the participation level of this program has been decreasing in the last several years; it has dropped from around 600 to its current number of 493. Medicine's number of participants, which previously had been between 140-150, is currently at 119.

Federation of State Medical Boards Liaison Program

Dr. Harp referred to correspondence from Dr. J. Daniel Gifford, MD, FSMB Chair, which asked the Board to designate a representative to serve as a two-way communicator with FSMB's Board of Directors. Kenneth Walker, MD has agreed to serve as the Board's liaison representative to FSMB. Steve Heretick, JD has been identified as the FSMB Liaison Director to the Virginia Board.

Dr. Walker said that he looks forward to serving and welcomed any comments and/or suggestions. He reminded the members that all communication should be sent to Board staff and not directly to him.

Competency in Opioid Prescribing

Dr. Harp summarized a letter from Dr. Art Van Zee in which he asks that the Board give consideration to require a basic level of knowledge and proficiency in opioid prescribing. Dr. Van Zee was a valuable member of the ad hoc that promulgated regulations for chronic pain

management; he is currently serving on the Governor's Task Force on Prescription Drug and Heroin Abuse. Dr. Harp stated that the letter was not meant to conflict with the proposed statutory language on CME presented by Dr. Brown, but to give audience to Dr. Van Zee's comments.

New Business

Chart of Regulatory Actions

Ms. Yeatts reviewed the Board's pending regulations as of July 28, 2015, highlighting the Regulations Governing the Practice of Genetic Counselors. Ms. Yeatts advised that the proposed regulations were scheduled to come before the Committee today; however, there are some unresolved issues with the "conscious clause". The draft regulations will be reviewed again by the Advisory Board on Genetic Counseling and presented to the Full Board in October.

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

Regulatory Action – Adoption of Exempt Regulations

Ms. Yeatts briefly reviewed SB1120 and advised that the revisions for licensure and supplemental training for graduates of non-approved medical schools are exempt from the provisions of the Administrative Process Act. They are exempt since it is necessary to revise the regulations to conform to the changes in the law.

After discussion, Dr. Mackler moved to accept the amended regulations as presented. The motion was seconded and carried unanimously.

Regulatory Action – Adoption of Final Regulations Correction of cites in regulations

Ms. Yeatts explained that legislation in HB1818 changed the term "respiratory care practitioner" to "respiratory therapist". This action is exempt from the provisions of the Administrative Process Act as it is necessary to conform the regulations to the changes in the law. Ms. Yeatts acknowledged that neither the respiratory community nor the Board has decided upon a professional abbreviation, since R.T. has been traditionally used by the radiologic professions.

Dr. Allison-Bryan moved to accept the amended regulations as presented. The motion was seconded and carried unanimously.

Proposed Regulations for Office-Based anesthesia

Ms. Yeatts acknowledged the petition for rulemaking from the Medical Society of Virginia in which MSV proposed several amendments to the regulations. She presented two letters of public received from the podiatry community.

Ms. Yeatts walked the Committee through each of the following sections of the regulations and discussed the proposed changes at length. (Proposed revisions are underlined.)

Project 4198 - NOIRA

BOARD OF MEDICINE

Requirements for office-based anesthesia

18VAC85-20-320. General provisions.

A. Applicability of requirements for office-based anesthesia.

1. The administration of topical anesthesia, local anesthesia, minor conductive blocks, or minimal sedation/anxiolysis, not involving a drug-induced alteration of consciousness other than minimal preoperative tranquilization, is not subject to the requirements for office-based anesthesia. A health care practitioner administering such agents shall adhere to an accepted standard of care as appropriate to the level of anesthesia or sedation, including evaluation, drug selection, administration and management of complications.

2. The administration of moderate sedation/conscious sedation, deep sedation, general anesthesia, or regional anesthesia consisting of a major conductive block are subject to these requirements for office-based anesthesia. The administration of 300 or more milligrams of lidocaine or equivalent doses of local anesthetics shall be deemed to be subject to these requirements for office-based anesthesia.

3. Levels of anesthesia or sedation referred to in this chapter shall relate to the level of anesthesia or sedation intended and documented by the practitioner in the pre-operative anesthesia plan.

B. A doctor of medicine, osteopathic medicine, or podiatry administering office-based anesthesia or supervising such administration shall:

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1. Perform a preanesthetic evaluation and examination or ensure that it has been performed;
2. Develop the anesthesia plan or ensure that it has been developed;
3. Ensure that the anesthesia plan has been discussed with the patient or responsible party pre-operatively and informed consent obtained;
4. Ensure patient assessment and monitoring through the pre-, peri-, and post-procedure phases, addressing not only physical and functional status, but also physiological and cognitive status;
5. Ensure provision of indicated post-anesthesia care; ~~and~~
6. Remain physically present or immediately available, as appropriate, to manage complications and emergencies until discharge criteria have been met; and
7. Document any complications occurring during surgery or during recovery in the medical record.

C. All written policies, procedures and protocols required for office-based anesthesia shall be maintained and available for inspection at the facility.

MOTION: Dr. Mackler moved to accept the recommended revisions to 18VAC85-20-320-General Provisions as presented. The motion was seconded and carried unanimously.

18VAC85-20-340. Procedure/anesthesia selection and patient evaluation.

A. A written protocol shall be developed and followed for procedure selection to include but not be limited to:

1. The doctor providing or supervising the anesthesia shall ensure that the procedure to be undertaken is within the scope of practice of the health care practitioners and the capabilities of the facility.

2. The procedure or combined procedures shall be of a duration and degree of complexity that shall not exceed four hours and that will permit the patient to recover and be discharged from the facility in less than 24 hours. The procedure or combined procedures may be extended for up to eight hours if the anesthesia is provided by an anesthesiologist or a CRNA.

3. The level of anesthesia used shall be appropriate for the patient, the surgical procedure, the clinical setting, the education and training of the personnel, and the equipment available. The choice of specific anesthesia agents and techniques shall focus on providing an anesthetic that will be effective, appropriate and will address the specific needs of patients while also ensuring rapid recovery to normal function with maximum efforts to control post-operative pain, nausea or other side effects.

B. A written protocol shall be developed for patient evaluation to include but not be limited to:

1. The preoperative anesthesia evaluation of a patient shall be performed by the health care practitioner administering the anesthesia or supervising the administration of anesthesia. It shall consist of performing an appropriate history and physical examination, determining the patient's physical status classification, developing a plan of anesthesia care, acquainting the patient or the responsible individual with the proposed plan and discussing the risks and benefits.

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2. The condition of the patient, specific morbidities that complicate anesthetic management, the specific intrinsic risks involved, and the nature of the planned procedure shall be considered in evaluating a patient for office-based anesthesia.

3. Patients who have pre-existing medical or other conditions that may be of particular risk for complications shall be referred to a facility appropriate for the procedure and administration of anesthesia. Nothing relieves the licensed health care practitioner of the responsibility to make a medical determination of the appropriate surgical facility or setting.

C. Office-based anesthesia shall only be provided for patients in physical status classifications for Classes I, II and III. Patients in Classes IV and V shall not be provided anesthesia in an office-based setting.

MOTION: Dr. Allison-Bryan moved to accept the recommended revisions to 18VAC85-20-340-Procedure/Anesthesia Selection and Patient Evaluation as presented. The motion was seconded; the vote was 3-3; the motion failed. Concern was expressed over the allowance of up to “eight hours” for procedures. Some members felt that this was too long and may jeopardize patient safety. Mr. Jurgensen stated that during the two-year discussion, the family practice and plastic surgery groups came together and took into consideration the clinical setting, surgical techniques, and the condition of a patient before arriving at the eight-hour compromise.

Dr. Harp pointed out that these procedures would require the attendance of an anesthesiologist or a CRNA.

MOTION: Dr. Clements moved to amend the proposed number of hours in 18VAC85-20-340- Procedure/anesthesia selection and patient evaluation to “four”, and require that a CRNA

or anesthesiologist be present for extended procedures. The motion was seconded and carried unanimously.

18VAC85-20-350. Informed consent.

A. Prior to administration, the anesthesia plan shall be discussed with the patient or responsible party by the health care practitioner administering the anesthesia or supervising the administration of anesthesia. Informed consent for the nature and objectives of the anesthesia planned shall be in writing and obtained from the patient or responsible party before the procedure is performed. Such consent shall include a discussion of discharge planning and what care or assistance the patient is expected to require after discharge. Informed consent shall only be obtained after a discussion of the risks, benefits, and alternatives, contain the name of the anesthesia provider and be documented in the medical record.

B. The surgical consent forms shall be executed by the patient or the responsible party and shall contain a statement that the doctor performing the surgery is board certified or board eligible by one of the American Board of Medical Specialties boards, the Bureau of Osteopathic Specialists of the American Osteopathic Association, or the American Board of foot and Ankle Surgery. The forms shall either list which board or contain a statement that the doctor performing the surgery is not board certified or board eligible.

C. The surgical consent forms shall indicate whether the surgery is elective, medically necessary, or if a consent is obtained in an emergency, the nature of the emergency.

Ms. Yeatts acknowledged the alternative language to include the list of pathways that a podiatric practitioner may be credentialed, but cautioned against going outside the list in the Code.

MOTION: Dr. Reynolds moved to accept the recommendations to 18VAC85-20-350-Informed Consent as presented. The motion was seconded and carried unanimously.

18VAC85-20-370. Emergency and transfer protocols.

A. There shall be written protocols for handling emergency situations, including medical emergencies and internal and external disasters. All personnel shall be appropriately trained in and regularly review the protocols and the equipment and procedures for ~~handling~~ handling emergencies.

B. There shall be written protocols for the timely and safe transfer of patients to a prespecified hospital or hospitals within a reasonable proximity. For purposes of this section “reasonable proximity” shall mean that a licensed general hospital capable of providing necessary services is normally accessible within 30 minutes of the office. There shall be a written or electronic transfer agreement with such hospital or hospitals.

MOTION: Dr. Mackler moved to accept the recommendations to 18VAC85-20-370-Emergency and transfer protocols as presented above. The motion was seconded and carried unanimously.

18VAC85-20-380. Discharge policies and procedures.

A. There shall be written policies and procedures outlining discharge criteria. Such criteria shall include stable vital signs, responsiveness and orientation, ability to move voluntarily, controlled pain, and minimal nausea and vomiting.

B. Discharge from anesthesia care is the responsibility of the health care practitioner providing or the doctor supervising the anesthesia care and shall only occur when:

1. ~~patients have~~ The patient has met specific physician-defined criteria; and
2. The health care practitioner providing or the doctor supervising the anesthetic care has given the order for discharge.

C. Written instructions and an emergency phone number shall be provided to the patient. Patients shall be discharged with a responsible individual who has been instructed with regard to the patient's care.

D. At least one person trained in advanced resuscitative techniques shall be immediately available until all patients are discharged.

MOTION: Dr. Reynolds moved to accept the recommendations to 18VAC85-20-380-Discharge policies and procedures as presented above. The motion was seconded and carried unanimously.

Announcements

No announcements

Next scheduled meeting: September 8, 2015

Adjournment: With no other business to conduct, the meeting adjourned at 10:18 a.m.

Wayne Reynolds, MD
President

William L. Harp, MD
Executive Director

Colanthia Morton Opher
Operations Manager