Meeting of the Virginia Board of Medicine

February 17, 2022
8:30 a.m.

Virginia Department of Health Professions

Board of Medicine

Thursday, February 17, 2022 @ 8:30 a.m.
Perimeter Center
9960 Mayland Drive, Suite 201
Board Room 4
Henrico, VA 23233

New Business:

====No motion needed to adjourn if all business has been conducted====

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

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

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

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

Board Room 4

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

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

Agenda Item: **Approval of Minutes of the October 14, 2021**

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

Action: Motion to approve minutes.

---DRAFT UNAPPROVED---

VIRGINIA BOARD OF MEDICINE
FULL BOARD MINUTES

October 14, 2021 **Department of Health Professions** **Henrico, VA 23233**

CALL TO ORDER: Mr. Marchese called the meeting to order at 8:30 a.m.

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

MEMBERS PRESENT:
L. Blanton Marchese, President
David Archer, MD, Vice-President
James Arnold, DPM
Amanda Barner, MD, Secretary-Treasurer
Manjit Dhillon, MD
Alvin Edwards, MDiv, PhD
Madge Ellis, MD (late arrival)
Jane Hickey, JD
Oliver Kim, JD
Jacob Miller, DO
Pradeep Pradhan, MD
Milly Rambhia, MD
Karen Ransone, MD
Jenifer Rathmann, DC
Brenda Stokes, MD
Ryan Williams, MD
Khalique Zahir, MD

MEMBERS ABSENT: Joel Silverman, MD

STAFF PRESENT:
William L. Harp, MD - Executive Director
Jennifer L. Deschenes, JD - Deputy Executive Director for Discipline
Colanthia M. Opher - Deputy Executive Director for Administration
Michael Sobowale, LLM – Deputy Executive Director for Licensure
Barbara Matusiak, MD - Medical Review Coordinator
David Brown, DC – DHP Director
Elaine Yeatts – DHP Senior Policy Analyst
Erin Barrett, JD - Assistant Attorney General & Board Counsel

OTHERS PRESENT:
Clark Barrineau, MSV
Wayne Halblieb - Senior Assistant Attorney General
Erin Weaver – Assistant Attorney General
Sean Murphy – Assistant Attorney General
Anne Joseph – Administrative Proceedings Division
Michael Parsons – Administrative Proceeding Division

---DRAFT UNAPPROVED---

EMERGENCY EGRESS: Dr. Archer provided the emergency egress procedures for Board Room 4.

DISCIPLINARY MATTERS FOR THE BOARD'S CONSIDERATION

The following licensees were presented to the Board by the Office of the Attorney General and the DHP Administrative Proceedings Division in consideration for summary suspension:

1 – CL, R.T, ("Respondent") Licensed to practice respiratory therapy in the Commonwealth – upon presentation of the statement of allegations, Dr. Ransone moved to summarily suspend the license. The motion was seconded by Dr. Edwards and passed unanimously by the 16 Board members present.

2 – KB, D.C. ("Respondent") Licensed to practice chiropractic in the Commonwealth – upon presentation of the statement of allegations, Dr. Edwards moved to summarily suspend the license. The motion was seconded by Dr. Miller and passed unanimously by the 16 Board members present.

3 – SB, D.O. (Respondent") Licensed to practice osteopathic medicine and midwifery in the Commonwealth – upon presentation of the statement of allegations, Dr. Williams moved to summarily suspend the license. The motion was seconded by Dr. Miller and passed unanimously by the 17 Board members present.

4 – CM, M.D. ("Respondent") Licensed to practice medicine in the Commonwealth – upon presentation of the statement of allegations, Dr. Williams moved to summarily suspend the license. The motion was seconded by Dr. Ransone and passed unanimously by the 17 Board members present.

INTRODUCTION OF NEW BOARD MEMBERS

Dr. Harp asked the four new Board members, Madge Ellis, MD from Salem in the 9th Congressional District, Oliver Kim, JD, Citizen Member from Alexandria, Pradeep Pradhan, MD from Danville in the 5th Congressional District, and Jenifer Rathmann, DC from Blacksburg, to introduce themselves to their colleagues on the Board.

APPROVAL OF THE JUNE 24, 2021 MINUTES

Dr. Edwards moved to approve the June 24, 2021 minutes as presented. The motion was properly seconded and carried unanimously.

ADOPTION OF THE AGENDA

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

PUBLIC COMMENT

Clark Barrineau, Assistant Vice President of Government Affairs and Public Policy at the Medical Society of Virginia (MSV), addressed the Board with comments from MSV regarding its request for the Board to consider revising the mental health question on the license application. Mr. Barrineau advised that since the submission of their comments to the Board, several other Virginia medical associations have written letters of support for the revision of the question.

REPORT OF THE DHP DIRECTOR -- David Brown, DC

Dr. Brown welcomed the new Board members and passed along a gentle reminder that while they are serving, they will find that the interests of the public and their profession will overlap. However when a Board member comes to a meeting, he/she must take off other hats and be laser-focused on the protection of the public. He noted that when he served on the Board of Medicine, it was one of the most rewarding experiences of his career, and that you get out of it what you put in.

Dr. Brown reminded the members that with the ending of the state of emergency, all boards are back to meeting in-person. He said DHP has submitted a bill requesting authorization to hold some meetings virtually. Stay tuned for further information. He also mentioned that the Conference Center will be getting upgrades to its audio/visual system in the near future.

He stated that this has been a hard year. But on the positive side, COVID-19 led some boards to adopt new efficiencies in their processes. DHP enabled most agency personnel to telework, and in anticipation of becoming more digital, the landscape of how the boards are currently operating may become the norm.

Dr. Allison-Bryan spoke to the Board about the healthcare workforce, which has become a critical issue. She said that during the state of emergency, waivers for applicants and licensees, including out-of-state licensees, created greater access to care for patients in the Commonwealth. She said that the Virginia Hospital and Healthcare Association is looking into how to continue those efforts by welcoming refugees in Virginia and determining how they might be incorporated into the healthcare workforce. She concluded with an update on where Virginia ranks in vaccinations.

REPORTS OF OFFICERS AND EXECUTIVE DIRECTOR

PRESIDENT

Mr. Marchese had no report.

VICE-PRESIDENT

Dr. Archer had no report.

SECRETARY-TREASURER

Dr. Barner had no report.

---DRAFT UNAPPROVED---

EXECUTIVE DIRECTOR

Dr. Harp provided an update on the following items:

- FY 2021 Financial Report – Dr. Harp covered the Board's Revenue and Expenditures for Fiscal Year 2021. Medicine finished the year under budget. He reminded the Board that if the reserve funds exceed 10% of what is needed for the next biennium, it must reduce fees. The Board has reduced its renewal fees for the last 4 biennia.

- Waivers for Electronic Prescribing of Opioids – Licensees were notified in the March 2021 Board Briefs that all prescribers of opioids should be prepared to submit opioid prescriptions electronically by July 1, 2021 or have a waiver. Since the Board Briefs went out, the interpretation of the law has been amended to indicate that a waiver lasts 12 months from the date it was granted. Dr. Harp noted that at the beginning, 100 or more requests were received most weeks. Now requests are down to about 2 per week.

- Implicit Bias – At the Board's request, an item on implicit bias, with resources, was placed in the September 2021 Board Briefs. Legislation has been submitted that will authorize the Board to require a 2-hour selected continuing education topic each biennium for renewal.

COMMITTEE AND ADVISORY BOARD REPORTS

Committee Appointments

Dr. Harp reviewed the new assignments to the Legislative and Credentials Committees.

Executive Committee

Dr. Arnold moved to accept the Executive Committee meeting minutes of August 6, 2021 as presented. The motion was properly seconded and carried unanimously.

Credentials Committee

Dr. Stokes moved to accept the Credentials Committee meeting minutes of September 20, 2021 as presented. The motion was properly seconded and carried unanimously.

OTHER REPORTS

Board Counsel

Ms. Barrett provided an update to the Board on the following litigation:

Merchia v. Board of Medicine et al.
Zackrison v. Ali et al.

Board of Health Professions

This report was for informational purposes only.

Podiatry Report

Dr. Arnold reported on his attendance at the Virginia Podiatric Medical Association meeting. He noted there were approximately 126 other attendees, including practicing podiatrists, residents and one student. He also reported that 114 Podiatric Medical Assistants have taken the Radiologic Technologist-Limited certification course and examination in the last 14 months. Dr. Arnold passed along the VPMA's gratitude to Beulah Archer, licensing specialist, for her continued assistance, accessibility, and willingness to help with the licensing process of the podiatric limited rad techs. Additionally, Dr. Arnold noted that VPMA is closely monitoring the actions of the Joint National Task Force related to DPM's taking the USMLE exam.

Chiropractic Report

No report.

Committee of the Joint Boards of Nursing and Medicine

This report was for informational purposes only.

Break

Mr. Marchese called for a recess at 9:41 a.m.; the meeting reconvened at 9:53 a.m.

NEW BUSINESS:

1. **Regulatory and Legislative Issues**

Chart of Regulatory Actions

Ms. Yeatts provided an update on the status of regulatory actions as of October 6, 2021, noting that the Regulations Governing the Licensure of Surgical Assistants and Certification of Surgical Technologists have moved to the Governor's Office.

Regulatory/Policy Actions – 2021 General Assembly

Ms. Yeatts did a quick review of the Board's emergency regulations and exempt regulations. She and Dr. Brown provided an overview of the non-regulatory actions, e.g. workgroups, which involve professions at the Board of Medicine.

2. **Recommendation on Adoption of Fast-Track Regulations – Licensed Acupuncturists**

Ms. Yeatts stated that the proposed changes were only to conform the regulations to changes in the names of national acupuncture credentialing bodies.

MOTION: Dr. Arnold moved to accept the recommendation of the Advisory Board on Acupuncture for regulatory amendments to conform the name changes of credentialing bodies by fast-track action. The motion was properly seconded and carried unanimously.

3. **Further Data from the 2020 Physician Workforce Survey**

Dr. Yetty Shobo presented her findings on the questions generated by her presentation at the June 24, 2021 Board meeting. She provided resources to locate the data on physicians by specialty, by county/city, education debt by gender and race/ethnicity, the ratio of income to debt, and the density of physicians across the state. Dr. Shobo advised that while her data did not address the question of whether the quality of care was better or worse during the pandemic, the Virginia Health Information site does have data for all hospitals that include patient ratings of the hospital's efficiency and satisfaction with their experience.

4. **Medical Society of Virginia Request to Revise Mental Health Question on Applications**

Dr. Harp referred to the communication received from the Medical Society of Virginia respectfully requesting that the Board consider revision of the mental health questions currently on the application for licensure. It is MSV's position that the current question obfuscates the issues of illness and impairment.

The exact questions up for discussion were:

"Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? Currently means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing physician."

"Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? Currently means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing physician."

After a lengthy discussion, Dr. Harp said that the Board's concern is about safe and competent practice, not diagnosis.

Ms. Barrett stated that these questions were all reviewed by the Office of the Attorney General (OAG) to ensure that they were compliant with the ADA. As a board in the Executive Branch, Medicine's duty is to protect the public. During the OAG analysis, there was a recognized tension between the Board's questions and the ADA. However, there is no recommendation to change the current language. Ms. Barrett went on to say that, even with the best of intentions, moving the words around could affect its current ADA compliance.

MOTION: Dr. Stokes moved that the questions remain as written and that this issue be referred to the Credentials Committee for further review. The motion was properly seconded and carried unanimously.

Additionally, the Board unanimously agreed that the "Board's Perspective on Mental Health Treatment" article in the September Board Briefs be sent out again by blast email.

5. Recommendations from the Credentials Committee on Streamlining the Licensing Process

Dr. Miller provided the highlights of the September 20, 2021 Credentials Committee meeting that discussed what the post-pandemic licensing process should look like. At that meeting, the Committee reviewed and revised the licensing processes for the 5 professions identified as essential during the pandemic - MD, DO, DPM, PA, and RT. He stated that the accommodations made by waiving certain requirements for the 5 professions significantly sped up the licensing process to ensure that Virginia had an adequate healthcare workforce during COVID-19. He said there has been no evidence that streamlining of the process has led to an increase in complaints.

MOTION: Dr. Miller moved to accept the recommendations of the Credentials Committee as presented. The motion was properly seconded and carried unanimously.

6. DHP Draft Policy on Meetings Held with Electronic Participation

Mr. Marchese reminded the Board that during the state of emergency, the Board, Advisory Boards, and Committees were authorized to hold meetings virtually. However, since the expiration of the Executive Order, all meetings have gone back to in-person. Seeing the benefit of virtual meetings, DHP has developed a draft policy document to provide the boards with guidance on holding meetings with some electronic participation. The draft DHP policy was before the Board for acceptance or revision as the members saw fit.

MOTION: After review of the draft, Dr. Edwards moved that the Board accept the DHP policy as written. The motion was properly seconded and carried unanimously.

7. Licensing Report

Michael Sobowale advised that on October 12, 2021, there were 78,290 current active and current inactive licensees, 61% of which were physicians. He stated that 7,697 licenses were issued in the last Fiscal Year, which was 379 more than were issued in the previous year. Since January 1st, 2021, the Board has licensed 6,532 applicants.

8. Discipline Report

Ms. Deschenes provided a brief report on the status of cases as of October 4, 2021.

9. Announcements

Mr. Marchese reminded the Board members to respond to emails from Discipline staff regarding their available dates to serve on hearing committees and panels.

10. Adjournment

With no other business to discuss, the meeting adjourned at approximately 11:34 p.m.

Blanton Marchese
President, Chair

William L. Harp, MD
Executive Director

Colanthia Morton Opher
Recording Secretary

Agenda Item: **Director's Report**

Staff Note: None.

Action: Informational presentation. No action required.

Agenda Item: **Report of Officers**

Staff Note:

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

Action: Informational presentation. No action required.

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

Staff Note: All items for information only

Action: None.

VIRGINIA DEPARTMENT OF HEALTH

OFFICE OF THE CHIEF MEDICAL EXAMINER

"To promote and protect the health of all Virginians"

Fatal Drug Overdose Quarterly Report

3RD QUARTER 2021

Edition 2021.3

Publication Date:
January 2022

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

METHODS, CONSIDERATIONS, AND LIMITATIONS

This quarterly report contains the most recent number of drug related deaths in Virginia for the previous quarter. **The numbers represented in this report are preliminary, subject to change, and are most likely slightly under reported at the time of publication** due to operational practices and limitations (specifically case turnaround time for reports) within the agency; therefore updates and/or changes to numbers previously published in past reports should be expected. It is highly recommended that when citing these data and reports, the edition number is included.

Data analyzed in the report is obtained from the Virginia Medical Examiner Database System (VMEDS). VMEDS is an internal agency database which contains detailed information on all deaths reported to the OCME. Data presented in this report is based upon accepted cases of either full autopsy or external exams. All manners of fatal drug overdoses (accident, homicide, suicide, and undermined) are included in this report.

Due to the nature of law enforcement and OCME death investigation, all deaths presented in this report are based upon locality of occurrence and not residential status of the decedent. The numbers and rates of these death by locality of injury and drug name/drug category are available in separate documents (http://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology/).

This report compiles data on drugs causing or contributing to death in fatal drug overdose cases. This report does not include data on drugs detected, but not contributing or causing death.

Often, drug-related deaths have more than one drug causing or contributing to death. Therefore, deaths in which multiple categories of drugs caused or contributed to death will be represented once within each drug category, but multiple times within the entire report. Example: a fatal cocaine, heroin, and alprazolam overdose death will be counted in the cocaine summary, the heroin summary, and the benzodiazepine summary.

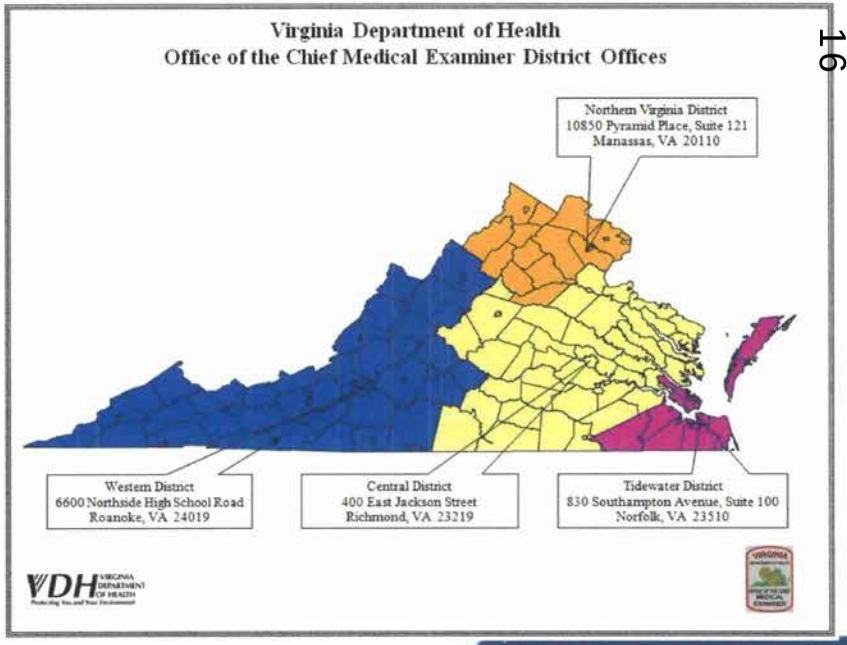
Prescription Opioids analyzed in this report include buprenorphine, codeine, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, oxycodone, oxymorphone, pentazocine, propoxyphene, tapentadol, and tramadol and are included in the category of 'Prescription Opioids'. Benzodiazepines analyzed in this report include adinazolam, alprazolam, bromazolam, clonazepam, clonazolam, deschloroetizolam, diazepam, etizolam, flualprazolam, flubromazolam, flubromazepam, flurazepam, lorazepam, meclonazepam, midazolam, nordiazepam, oxazepam, phenazepam, temazepam, and triazolam and are included in the category of 'Benzodiazepines'

Projected estimates for 2021 (entire year) are calculated based upon initial counts by quarter, average toxicology turnaround time at the time of the report, the date of data analysis, and previous quarter fatality trend review.

Rate calculations are based upon Virginia population projections. These population estimates came from the Virginia Department of Health, Division of Health Statistics (http://www.vdh.virginia.gov/HealthStats/stats.htm).

Quarters are based upon calendar year and are defined as follows:

- Quarter 1 (Q1)- January 1st - March 31st
- Quarter 2 (Q2)- April 1st - June 30th
- Quarter 3 (Q3)- July 1st - September 31st
- Quarter 4 (Q4)- October 1st - December 31st



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Protecting You and Your Environment

MAIN TAKEAWAYS

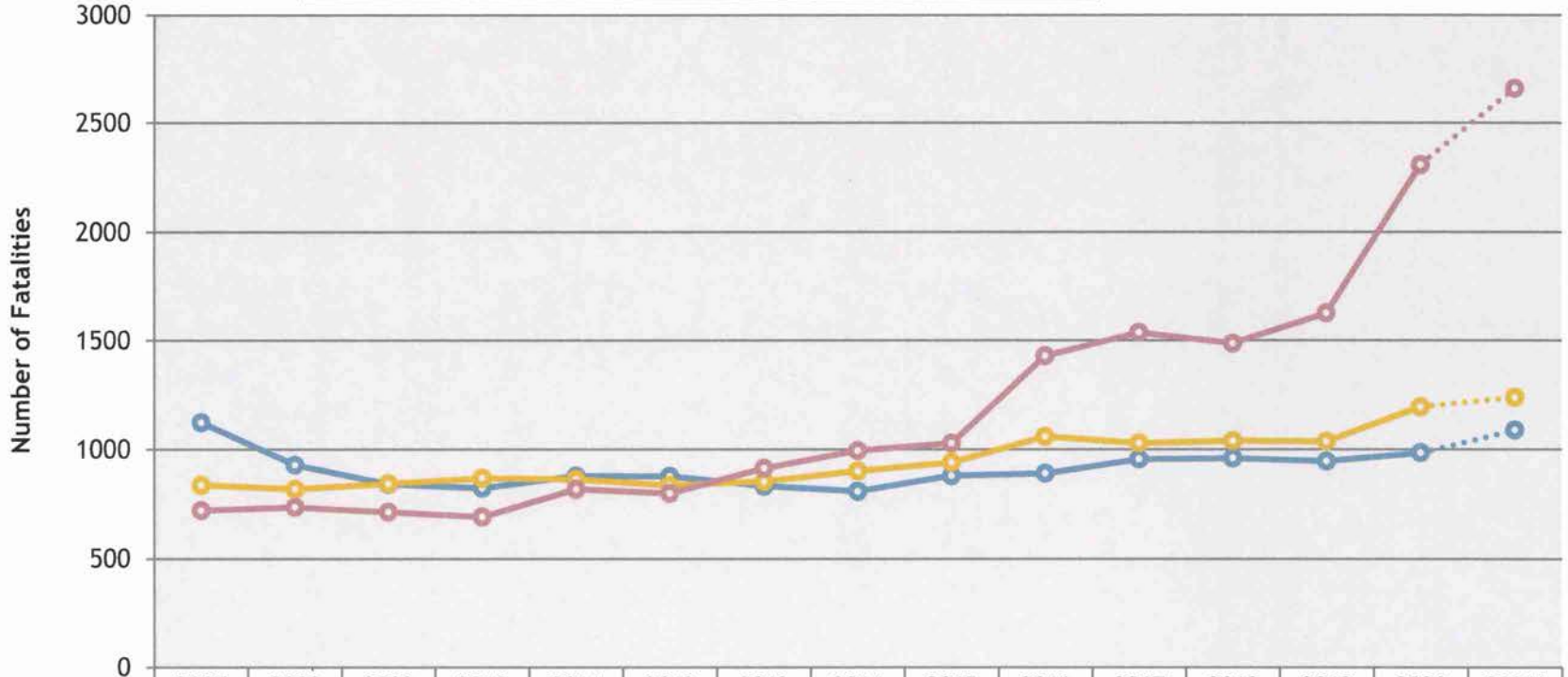
- Fatal drug overdose has been the leading method of unnatural death in Virginia since 2013
- Opioids, specifically illicit fentanyl, have been the driving force behind the large increases in fatal overdoses since 2013
- In 2015 statewide, the number of illicit opioids deaths surpassed prescription (Rx) opioid deaths. This trend continued at a greater magnitude in 2016 to present
- There has not been a significant increase or decrease in fatal prescription (Rx) opioid overdoses over the 14 year time span (2007-2020)
- Fentanyl (prescription, illicit, and/or analogs) caused or contributed to death in 71.8% of all fatal overdoses in 2020
- Fatal non-opioid illicit drug overdoses are on the rise. In 2020 compared to 2019, fatal cocaine overdoses increased 33.2% and fatal methamphetamine overdoses increased 96.0%
- Preliminary numbers from Q1 2021 identified the largest number of fatal drug overdoses, all substances, ever seen in Virginia (n=688). Since the beginning of the COVID-19 pandemic in March 2020, fatal overdoses increased significantly and continue to remain record breaking through 2021. Fatal overdoses, all substances, increased 41.9% in 2020 compared to 2019

TOP 3 METHODS OF UNNATURAL DEATH

The leading methods of unnatural death in Virginia since 2007 have been motor vehicle collisions, gun-related deaths, and fatal drug overdoses (these methods of death include all manners of death: accident, homicide, suicide, and undetermined). In 2013, fatal drug overdose became the leading method of unnatural death in the Commonwealth. This trend has continued to worsen at a greater magnitude due mainly to illicit opioids (heroin, illicit fentanyl, and fentanyl analogs).

Total Number of Motor Vehicle, Gun, and Drug Related Fatalities by Year of Death, 2007-2021*

Data for 2021 is a Predicted Total for the Entire Year



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021*
Motor Vehicle Related	1124	928	841	823	878	877	832	808	879	890	955	960	947	984	1088
Gun Related	836	818	843	868	863	835	852	901	940	1058	1028	1038	1036	1195	1238
Fatal Drug Overdose	721	735	713	690	819	799	914	994	1028	1428	1537	1486	1627	2309	2660

[1] Top 3 methods of death (motor vehicles, guns, and drugs) include all manners of death (accident, homicide, suicide, and undetermined)

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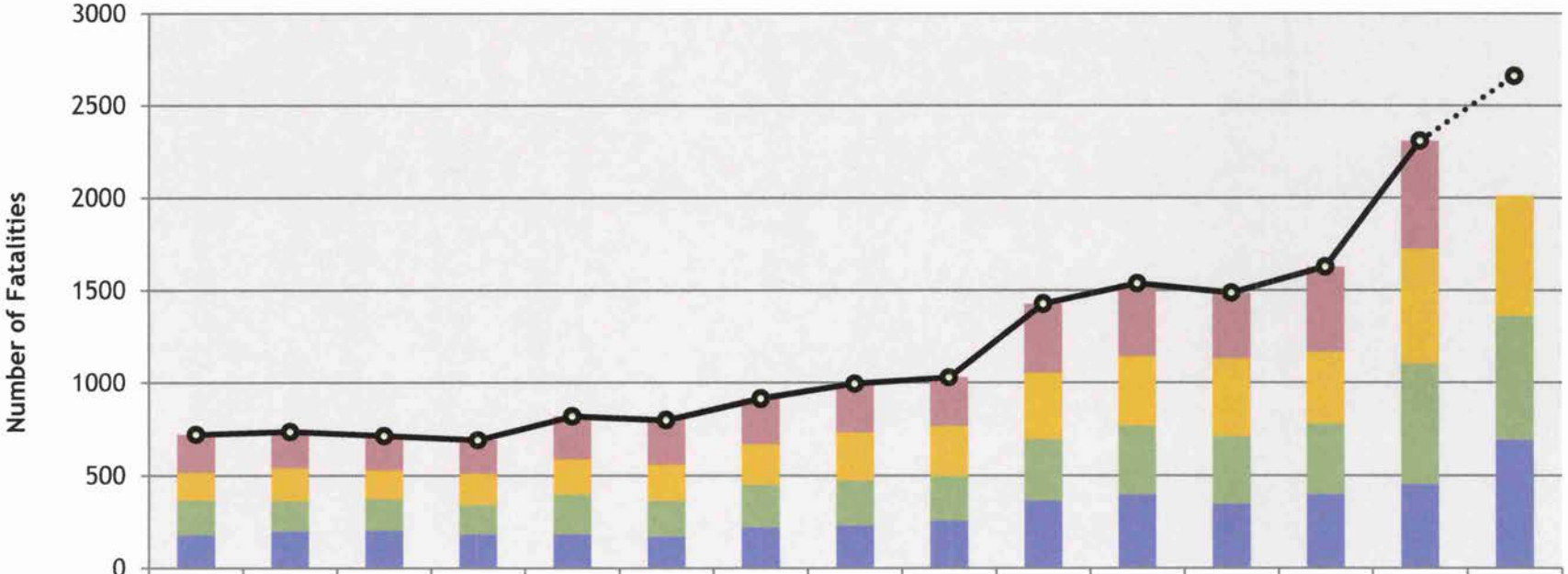
ALL DRUGS

The total number of fatal drug overdoses statewide has increased each year. In 2013, fatal drug overdose became the number one method of unnatural death in the Commonwealth, surpassing both motor vehicle-related fatalities and gun-related fatalities. In 2014, fatal drug overdose became the leading cause of accidental death in Virginia. The preliminary total of all fatal overdoses, all substance, in 2020 compared to 2019 increased by 41.9%---a record setting statistic.

Total Number of Fatal Drug Overdoses by Quarter and Year of Death, 2007-2021*

Data for 2021 is a Predicted Total for the Entire Year



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021*
Q4	205	195	183	179	232	240	248	263	262	375	393	354	459	585	
Q3	152	180	157	170	191	199	217	257	270	359	376	423	389	624	649
Q2	188	162	172	159	215	190	230	246	243	332	371	363	380	647	674
Q1	176	198	201	182	181	170	219	228	253	362	397	346	399	453	688
Total Fatalities	721	735	713	690	819	799	914	994	1028	1428	1537	1486	1627	2309	2660

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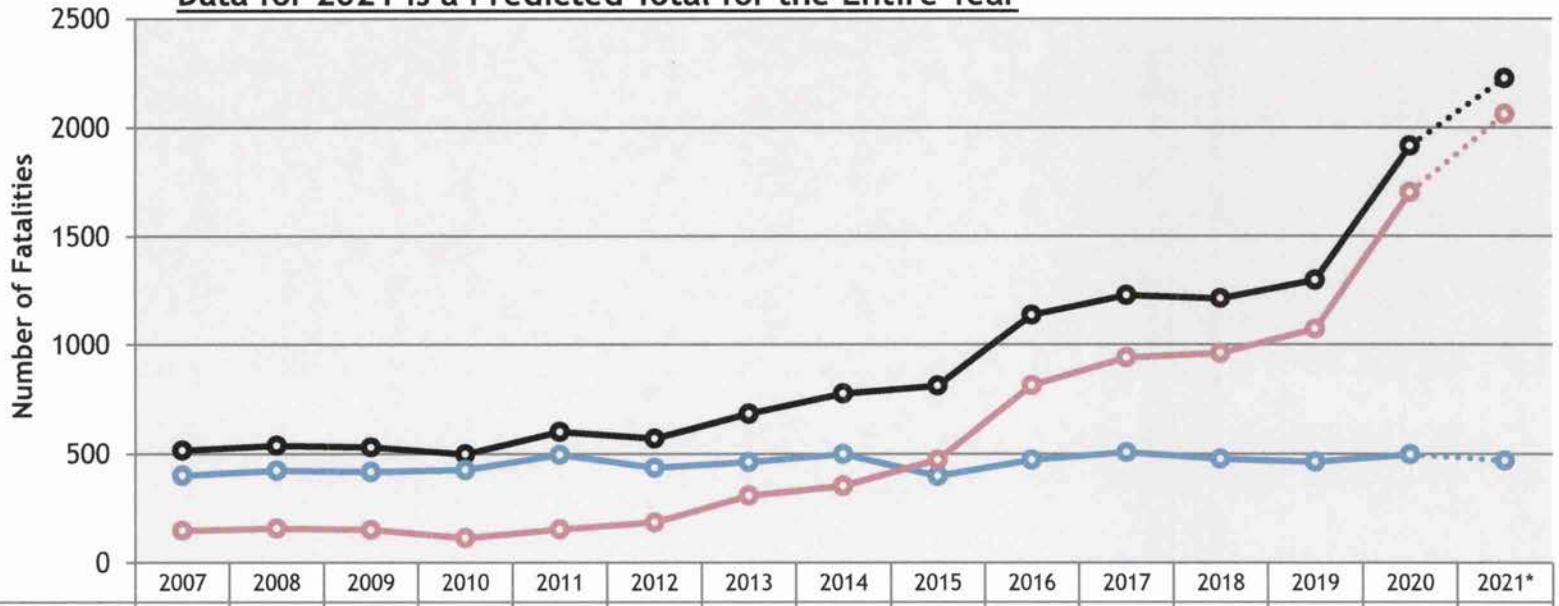
OPIOIDS- A DIFFERENT PERSPECTIVE

Prescription opioids are a group of drugs that are commercially made by pharmaceutical companies in certified laboratories that act upon the opioid receptors in the brain. Historically, fentanyl has been one of these drugs. However, in late 2013, early 2014, illicitly made fentanyl began showing up in Virginia and by 2016, most fatal fentanyl overdoses were of illicit production of the drug. Separating fentanyl from the grouping of prescription opioids for this reason demonstrates a slight decrease in fatal prescription opioid overdoses in 2015 and a dramatic increase in the number of fatal fentanyl and/or heroin overdoses. This has caused the significant rise in all fatal opioid overdoses in the Commonwealth since 2012.

Total Number of Prescription Opioid (Excluding Fentanyl), Fentanyl and/or Heroin, and All Opioid Overdoses by Year of Death, 2007-2021*

Data for 2021 is a Predicted Total for the Entire Year



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021*
All Opioids	516	538	530	498	601	572	684	775	812	1138	1229	1215	1298	1915	2226
Prescription Opioids (excluding fentanyl)	401	422	417	426	496	435	460	499	398	472	507	477	462	497	469
Fentanyl and/or Heroin	148	157	150	112	153	185	309	353	471	813	939	961	1073	1702	2061

[1] 'All Opioids' include all versions of fentanyl, heroin, prescription opioids, and opioids unspecified

[2] Illicit and pharmaceutically produced fatal fentanyl overdoses are represented in this analysis. This includes all different types of fentanyl analogs (acetyl fentanyl, furanyl fentanyl, etc.)

[3] 'Prescription Opioids (excluding fentanyl)' calculates all deaths in which one or more prescription opioids caused or contributed to death, but excludes fentanyl from the **required list** of prescription opioid drugs used to calculate the numbers. However, given that some of these deaths have multiple drugs on board, some deaths may have fentanyl in addition to other prescriptions opioids, and are therefore counted in the total number. Analysis must be done this way because by excluding all deaths in which fentanyl caused or contributed to death, the calculation would also exclude other prescription opioid deaths (oxycodone, methadone, etc.) from the analysis and would thereby undercount the actual number of fatalities due to these true prescription opioids.

Commonwealth of Virginia

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

Ivermectin Letter from FDA

1 message

Lisa A. Robin (FSMB) <LRobin@fsmb.org> Fri, Dec 17, 2021 at 2:27 PM
To: "Lisa A. Robin (FSMB)" <LRobin@fsmb.org>

Dear Member Board Executive Directors and Chairs,

Please find the attached letter sent to the FSMB and the National Association of Boards of Pharmacy for sharing with our member boards.

If you have any questions regarding the attached letter or have other questions, please contact the compounding staff at the FDA by email (Compounding@fda.hhs.gov).

Thank you,

Lisa

Lisa Robin

Chief Advocacy Officer

Federation of State Medical Boards

2101 L Street NW | Suite 800 | Washington, DC 20037

202-463-4006 direct | 817-602-1112 mobile

lrobin@fsmb.org | www.fsmb.org

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70 Boards. One Mission.

Ivermectin Letter to FSMB Final.pdf
190K

U.S. FOOD & DRUG ADMINISTRATION

December 13, 2021

Humayun J. Chaudhry, DO, MS, FACP, FACOI
President and Chief Executive Officer
Federation of State Medical Boards
400 Fuller Wiser Road, Suite 300
Euless, TX 76309
hchaudhry@fsmb.org

Dear Dr. Chaudhry:

The purpose of this letter is to bring to the attention of the Federation of State Medical Boards information related to drug products containing ivermectin being offered for sale with claims that such products treat or prevent "Coronavirus Disease 2019" (COVID-19). Recently, FDA has received complaints about compounding pharmacies selling drug products containing ivermectin, claiming that they can treat or prevent COVID-19.

Ivermectin tablets are FDA-approved for humans at very specific doses to treat some parasitic worms, and there are FDA-approved topical (on the skin) formulations for head lice and skin conditions like rosacea. However, the FDA has neither authorized nor approved any ivermectin drug product for use in preventing or treating COVID-19. Although clinical trials assessing ivermectin tablets for the prevention or treatment of COVID-19 in people are ongoing, currently available data do not show that ivermectin is safe or effective for the prevention or treatment of COVID-19.

Additionally, as the agency has previously explained, there are many side effects associated with ivermectin, including skin rash, nausea, vomiting, diarrhea, stomach pain, facial or limb swelling, neurologic adverse events (dizziness, seizures, confusion), sudden drop in blood pressure, severe skin rash potentially requiring hospitalization and liver injury (hepatitis).

Using ivermectin products in preventing or treating COVID-19 may pose risks to patient health or lead to delays in getting effective treatment of COVID-19. Drug products that claim to treat or prevent COVID-19 but are not proven safe and effective for those purposes can place consumers at risk of serious harm.

We are also sending this letter to the National Association of Boards of Pharmacy to facilitate communication among associations with shared goals regarding these matters.

U.S. FOOD & DRUG ADMINISTRATION

We look forward to continuing to work with you on matters related to drug compounding. If you have questions, please contact the Office of Compounding Quality and Compliance at compounding@fda.hhs.gov.

Sincerely,

Shannon N. Glueck -S

Digitally signed by Shannon N. Glueck -S
DN: c=US, o=U.S. Government, ou=HHS, ou=FDA, ou=People, 0.9.2342.19200300.100.1.1=2002034167, cn=Shannon N. Glueck -S
Date: 2021.12.13 11:31:42 -05'00'

Shannon Glueck, PharmD
Acting Branch Chief
Branch 4
Division of Compounding II
Office of Compounding Quality and Compliance
Office of Compliance
Center for Drug Evaluation and Research

U.S. Food and Drug Administration
10903 New Hampshire Avenue
Silver Spring, MD 20993
www.fda.gov

January 28, 2022 Reciprocity Meeting

One Uniform Agreement

Three Distinctive Applications

- Fitness questions
- Criminal background check
- COVID vaccination requirement

License Verifications

- "Pinging" License Lookup can save staff time
- For pending discipline, contact the Board
- Verification staff identified
- Verification email box
- VeriDoc may be a good alternative

Equivalency by years practiced for IMG's

- No equivalency review for IMG's with reciprocity
- Maryland 2 years of postgraduate training
- DC 3 years of postgraduate training

Next Meeting March 4th

- Chart of processes
- Preliminary Agreement
- IT consultation

OCCUPATIONALTHERAPY
LICENSURE COMPACT

Welcome! We are excited about your state joining the Occupational Therapy Compact (OT Compact).

The OT Compact facilitates the interstate practice of Occupational Therapy while maintaining state oversight of the profession and offering enhanced public protection.

Once the OT Compact is fully operational, licensed Occupational Therapists and Occupational Therapy Assistants will be able to apply for a compact privilege to practice in any OT Compact member states.

We are currently working toward convening the first OT Compact Commission meeting in the third quarter of 2022. The interstate commission's first order of business will be to establish rules and bylaws and implement the shared interstate licensure data system. This setup process typically takes 12 to 16 months, meaning the Commission will likely begin issuing privileges to practice in 2023.

OT Compact member states:

- Colorado
- Georgia
- Maine
- Maryland
- Missouri
- New Hampshire
- North Carolina
- Ohio
- Virginia
- Wisconsin

Legislation is currently pending in 12 states so additional members are likely this year.

As part of participating in OT Compact, your State Occupational Therapy Regulatory Authority must appoint a representative to serve as your state's Commissioners on the OT Compact Commission. As stated in Section 8(B)(1) of the OT Compact legislation:

1. Each Member State shall have and be limited to one (1) delegate selected by that Member State's Licensing Board.

2. The delegate shall be either:

    a. A current member of the Licensing Board, who is an Occupational Therapist, Occupational Therapy Assistant, or public member; or

OCCUPATIONALTHERAPY
LICENSURE COMPACT

b. An administrator of the Licensing Board.

In appointing your commissioner, please consider the following:

1. **Availability of your Representative:** It is expected that the first year will busy with an in-person or virtual OT Compact Commission meeting, conference calls, committee assignments and emails as the governing documents and implementation components for the OT Compact are created.
2. **Ongoing Participation:** After the initial year, the Commission must meet at least once a year. As the Commission is an ongoing entity, providing continuity of representation will make this a more cohesive and functional group.
3. **Knowledge of State Statutes/Regulations and OT Compact Legislation:** It will be helpful to have a working knowledge of your State Statutes and Regulations and of OT Compact to assist the Commission in the development of governing documents and to guide the decision-making process regarding specific components of OT Compact.
4. **Conflict of Interest:** A state should consider if any real or potential conflict of interest exists when selecting a commissioner.

Again, CSG expects to convene the first OT Compact Commission meeting in the third quarter of 2022. Until the OT Compact has a formal commission structure The Council of State Governments will work with the member states to deal with administrative and logistical tasks leading up to the initial Commission meeting. Member states will be updated regularly as planning progresses and additional states enact the OT Compact. Please contact Isabel Eliassen (ieliassen@csg.org), Matt Shafer (matthew.shafer@csg.org) or me with questions or for assistance.

Thank you again and we look forward to working with you.

Dan Logsdon
Director, The National Center for Interstate Compacts
The Council of State Governments
859-229-3210 (m)
dlogsdon@csg.org

Looking for Doctor Information Online

A survey and ranking of state medical and osteopathic board websites in 2021

Informed Patient Institute

Carol Cronin
Informed Patient Institute

Patient Safety Action Network
Patient Driven, Patient Led

Lisa McGiffert
Patient Safety Action Network

January 2022

Informed Patient Institute and Patient Safety Action Network News Release

For immediate release: January 11, 2022

Contact: Lisa McGiffert, Patient Safety Action Network
lmcgpsan@gmail.com
512-415-5405

Looking for Doctor Information Online in 2021
Most States Fail to Give Complete Doctor Information to the Public

A 2021 review of state medical board websites found that full information about a physician's practice history online is incomplete and accessing information is too difficult for the average person to navigate. The review was done by patient safety advocates with the Informed Patient Institute and the Patient Safety Action Network, both national patient-focused nonprofits working on patient safety and quality.

The report, *Looking for Doctor Information Online: A Survey and Ranking of State Medical and Osteopathic Board Websites in 2021*, evaluated how well 64 state medical and osteopathic boards did in providing online information to the public. Medical boards are state agencies established to protect the public from the unprofessional, improper and incompetent practice of medicine. They also license doctors and other health professionals and investigate complaints from the public.

States were ranked on the amount of information they have on their Physician Profiles—individual web pages that provide a variety of information about each licensed doctor. Every state medical board has a website and a Physician Profile.

The report can be found here:
https://www.informedpatientinstitute.org/pdf/LookingForDoctorInformationOnline%20-%20Jan2022.pdf

Sixteen criteria about information on Physician Profiles were used to rank state websites. Most states failed to include even half of the information the public needs to fully assess their doctors. These findings highlight the challenge for people to learn why their doctors were put on probation, whether they had been repeatedly sued for malpractice or convicted of crimes. The partial findings are below and the full chart ranking is attached.

Highest scoring states

Florida Medical Board (12 of 16 criteria)
Florida Osteopathic Board (12 of 16 criteria)
Maryland Medical Board (12 of 16 criteria)
New Jersey Medical Board (12 of 16 criteria)

Lowest scoring states

Indiana Medical Board (2 of 16 criteria)
Alaska Medical Board (3 of 16 criteria)

Michigan Medical Board (3 of 16 criteria)
Michigan Osteopathic Board (3 of 16 criteria)

"Would you want to know if your doctor had been disciplined and why? Whether they had malpractice settlements? Whether they could no longer practice at a hospital because of some safety concern by the hospital? Or, whether they had a criminal record?" asked Lisa McGiffert, Board Chair of the Patient Safety Action Network. "The reality is that most states only provide a sliver of this pertinent information that may tell a doctor's history of harming or putting patients at risk."

All states provided information on disciplinary actions taken by medical boards on their Physician Profiles, and many provided links to legal documents that spell out the details of the actions. While this was an improvement compared to past reviews of these websites, only a handful summarized this information for the public in plain English on the Physician Profile.

Few states provided information on malpractice payouts, hospital adverse actions, criminal convictions and information from other states. The report also found that many sites used technical language that made them difficult to navigate and had other barriers to accessing complete information about doctors.

"Unfortunately, there remains too much secrecy around a physician's history," said Carol Cronin, Executive Director of the Informed Patient Institute. "As state agencies charged with public protection, medical boards should have easy-to-find Physician Profiles with complete information about a doctor's ability to practice medicine safely."

The report makes recommendations to state medical boards to expand information on Physician Profiles, advocate for transparency when state law prohibits disclosure of important public information, improve website usability, simplify complaint filing and improve transparency around medical board activities.

###

The report, authored by Carol Cronin, Executive Director of the Informed Patient Institute (IPI) (https://www.informedpatientinstitute.org/) and Lisa McGiffert, Board President, Patient Safety Action Network (PSAN) (https://www.patientsafetyaction.org/) builds on comparable work published in 2016 https://www.informedpatientinstitute.org/Seeking%20Doctor%20Information%20Online.pdf.

The project was overseen by the Medical Board Roundtable—a national coalition of patient and consumer advocates interested in increasing public awareness and responsiveness of state medical boards to patients, families and the public. For more information: https://www.patientsafetyaction.org/medical-board-round-table

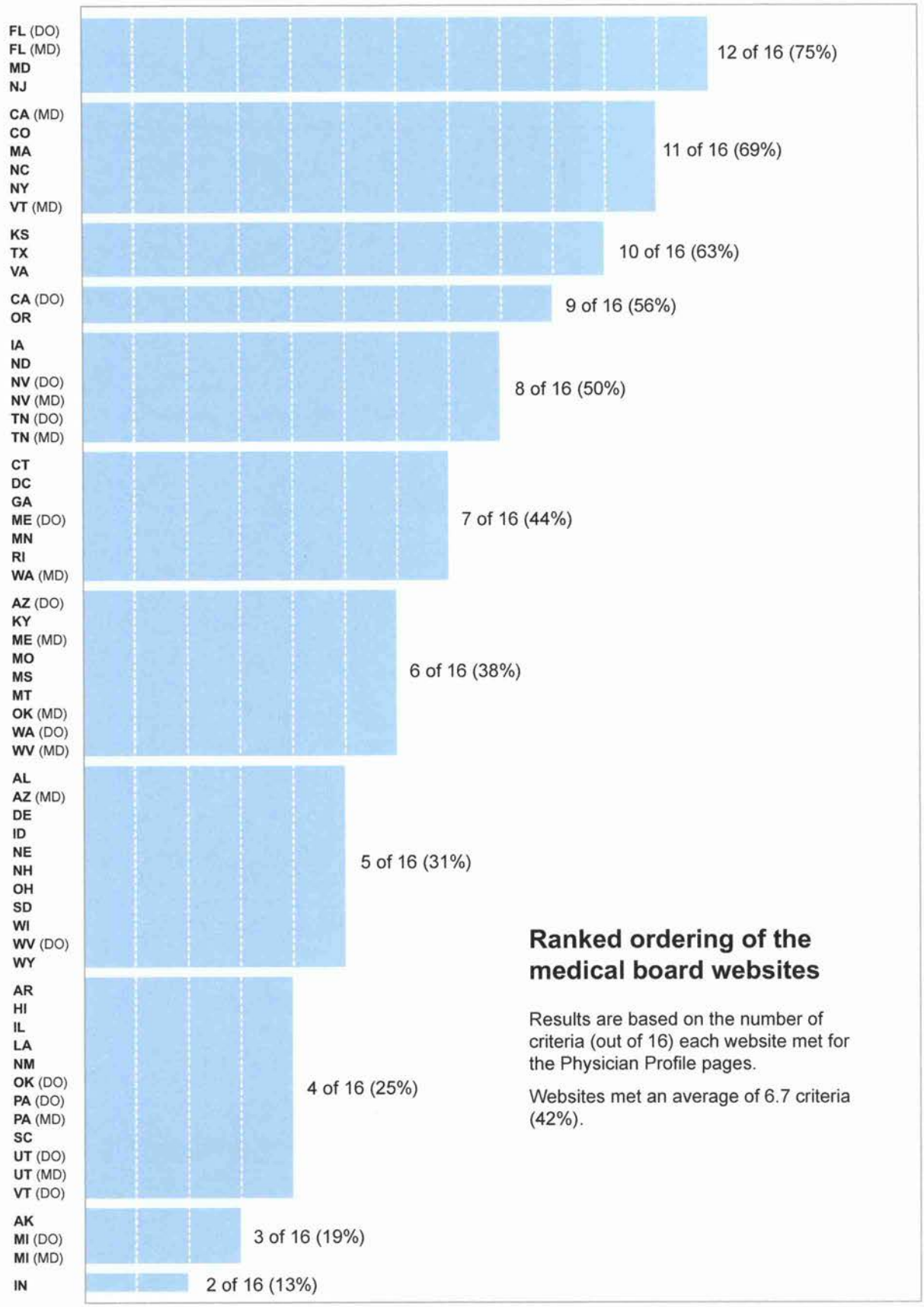

Figure 3: Results of scoring the Physician Profiles on 16 criteria. All criteria were evaluated as "yes" the profile meets the criteria, or "no" it does not.

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

Staff Note: Please note Committee assignments and minutes of meetings since October 14, 2021.

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

VIRGINIA BOARD OF MEDICINE

Committee Appointments

2021-2022

EXECUTIVE COMMITTEE (8)
L. Blanton Marchese, President, Chair
David Archer, MD, **Vice-President**
Amanda Barner, MD, **Secretary/Treasurer**
Alvin Edwards, PhD
Jane Hickey, JD
Karen Ransone, MD
Joel Silverman, MD
Brenda Stokes, MD

LEGISLATIVE COMMITTEE (7)
David Archer, MD, Vice-President, Chair
James Arnold, DPM
Jane Hickey, JD
Oliver Kim, LLM
Jacob Miller, DO
Joel Silverman, MD
Ryan Williams, MD

CREDENTIALS COMMITTEE (9)
Jacob Miller, DO, Chair
Manjit Dhillon, MD
Alvin Edwards, PhD
Madge Ellis, MD
Jane Hickey, JD
Pradeep Pradhan, MD
Milly Rambhia, MD
Jennifer Rathmann, DC
Khalique Zahir, MD

FINANCE COMMITTEE
L. Blanton Marchese, **President**
David Archer, MD, **Vice-President**
Amanda Barner, MD, **Secretary/Treasurer**

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

CHIROPRACTIC COMMITTEE
Jennifer Rathmann, DC

BOARD OF HEALTH PROFESSIONS
Brenda Stokes, MD

COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
David Archer, MD, **Vice-President**
Blanton Marchese, **President**
Ryan Williams, MD

---DRAFT UNAPPROVED---

VIRGINIA BOARD OF MEDICINE
EXECUTIVE COMMITTEE MINUTES

Friday, December 3, 2021 Department of Health Professions Henrico, VA

CALL TO ORDER: Mr. Marchese called the meeting of the Executive Committee to order at 8:32 a.m.

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

MEMBERS PRESENT:
Blanton Marchese – President, Chair
David Archer, MD – Vice-President
Amanda Barner, MD - Secretary-Treasurer
Alvin Edwards, MDiv, PhD
Jane Hickey, JD
Karen Ransone, MD
Joel Silverman, MD
Brenda Stokes, MD

MEMBERS ABSENT: None

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

OTHERS PRESENT:
W. Scott Johnson - Hancock Daniel & MSV
Scott Castro - MSV
Jennie Wood – Discipline Case Manager

EMERGENCY EGRESS INSTRUCTIONS

Dr. Archer provided the emergency egress instructions for Board Room 4.

---DRAFT UNAPPROVED---

COVID INSTRUCTIONS

Mr. Marchese reminded members about the policy of wearing a mask while inside the building, unless eating or drinking.

APPROVAL OF MINUTES OF AUGUST 6, 2021

Dr. Edwards moved to approve the minutes from August 6, 2021 as presented. The motion was seconded and carried unanimously.

ADOPTION OF AGENDA

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

PUBLIC COMMENT

Mr. Marchese opened the floor for public comment. There was no comment.

DHP DIRECTOR'S REPORT

Dr. Allison-Bryan provided a COVID-19 update:

- At this time, Virginia is ranked 10th in the nation in having the most vaccinated individuals. Currently, 88.4% of adults have had at least 1 shot.
- COVID cases are stable, however Henrico County is still in a high transmission zone. The new variant, Omicron, is beginning to spread to those who are vaccinated. So far, it has caused mild symptomatology.
- DHP's involvement with COVID medicinals is to prevent stockpiling. With no authority for enforcement, DHP is just monitoring. Federal agencies are buying the doses at this time.
- Two new vaccines are in the pipeline. Both have some side effects, and have not yet been approved.

Dr. Brown provided the following information:

- Addressed the building's new security team
- Provided information on an upgrade to the audio in the conference center by spring 2022
- Spoke to study reports for the General Assembly:
    - Reviewed RD625 – Report on the Implementation of 2018 HB793: Nurse Practitioners; Practice Agreements – due October 1, 2021
        - Reported that on July 20, 2021, the Board of Nursing meeting approved the draft report as written. On August 6, 2021, the Board of Medicine Executive Committee accepted some draft modifications to HB793, but not all.

- Reviewed SD12 – Report on Midwifery Regulatory/Licensing Framework
  - Reviewed the new Licensed Certified Midwife as being essentially the same as a Certified Nurse Midwife. There is now a program in Virginia that will graduate Licensed Certified Midwives.
  - Licensed Midwives (Certified Professional Midwives) favored a Board of Midwifery with Certified Nurse Midwives and Licensed Certified Midwives. Dr. Brown stated that the low number of midwives would make an autonomous board costly. The midwives would like to know the cost a separate board would entail.
  - The question if the Certified Nurse Midwives and Licensed Certified Midwives would be solely under Board of Nursing or under the Committee of the Joint Boards remains unresolved.
- Reviewed HD18 – Report on Advanced Practice Registered Nurses
  - Provides clarification of Code titles for nurses.
  - The APRN (advanced practice registered nurse) Compact is not yet operational.
- Reviewed RD620 – Report on the Development of Recommendations for Possible Statewide Protocols for Pharmacists to Initiate Treatment for Tobacco Cessation and other Specific Conditions: HB2079 – due October 15, 2021
  - Dr. Brown stated that nothing was agreed upon, and Dr. Stokes added that there were good points brought up.
  - Elaine Yeatts added that a concern is the overload on the staff at pharmacies.
  - Dr. Stokes stated that pharmacists want to act on a CLIA test result. A physician's approach is more comprehensive and ensures less opportunity for misdiagnosis/mistreatment.
  - Dr. Allison-Bryan added that Dr. Stokes was very instrumental in the meeting and represented the Board of Medicine well.
  - Lastly, she stated that the report on bridging from an ER visit to treatment for opioid addiction is on the DHP website under "About" then "News".

PRESIDENT'S REPORT

Mr. Marchese reported that he and Kathy Scarbalis, Chair of the Advisory Board on Physician Assistants, attended the FSMB Physician Assistant Compact meeting on November 18th to develop consensus model legislation for states to use. He noted that the final document should be ready by March 2022.

EXECUTIVE DIRECTOR'S REPORT

Dr. Harp covered an item on mental health treatment for health care professionals that was in the 93rd edition of the Board Briefs and a blast email. He also shared comments received by the Board in response to the blast email. Mr. Marchese asked if the Board will be putting out a Q & A, to which Ms. Barrett replied that it would be up to the Board. Dr. Harp informed the Board that the language used in the email was directly quoted from the law.

---DRAFT UNAPPROVED---

Dr. Brown questioned if the language in the Code deters physicians from seeking medical help and treatment. Additionally, he stated that the Board of Medicine did address the possible need to change the language on its applications. He asked what other states ask on their applications, and how all professions help with mental health issues of their licensees? At the upcoming full Board meeting, there should be an update on this topic.

Ms. Deschenes addressed the need to distinguish between voluntary admission and involuntary admission. She stressed the need to change how reporting is viewed by licensees so as not to have them see it negatively. Mr. Marchese asked if the Board has any people who are specialized in recognizing these cases. Ms. Deschenes replied no, but states that these cases, like all cases, are carefully reviewed.

Dr. Harp referred to an email sent from Ms. Ali Walker, along with her letter in response to the blast email regarding mental health treatment for healthcare professionals. Dr. Joel Silverman states that the email was a step in the right direction, but still more work needs to be done to encourage people to get help.

Dr. Harp reviewed the FSMB Annual Survey findings and pointed out that Virginia's responses to the "5 most important topics to the Board at this time", "Procedure and Regulation Changes due to COVID-19", "Complaints and Actions Related to COVID-19", "Media Topics", "Diversity, Equity and Inclusion", and "Opioid Abuse Prevention" were similar to those of other boards of medicine.

Dr. Harp reviewed a letter from the Department of Veterans Affairs and its efforts to establish National Standards of Practice (NSP) for VA healthcare providers. He pointed out that the VA would include state boards in the derivation of standards.

Dr. Harp reviewed the "Chart of Regulatory Actions" and progress on reciprocity talks with Washington, D.C. and Maryland. Reciprocity requirements discussed so far with DC and MD are no disciplinary actions, a criminal background check, vaccination for COVID-19, and verification of the license in the other state. Virginia does not require a criminal background check or COVID vaccination at this time. Virginia's licensure by endorsement requires the applicant to submit license verifications from all states in which he/she has been licensed. The Credentials Committee has recommended the requirement be reduced to verification from the most recent state. DC, MD and Virginia will meet on January 28, 2022 is to achieve consensus on what should be required in the reciprocity agreement.

Dr. David Archer asked why Virginia does not have reciprocity with North Carolina and West Virginia, since Virginia shares boundaries with those states as well. Dr. Harp replied that West Virginia, Kentucky, Tennessee, and North Carolina are not interested in creating another pathway for licensure at this time, given that they are members of the Interstate Medical Licensure Compact.

Dr. Harp told the Board that a question had been raised about putting a licensee's degree on his/her license. Presently, allied healthcare licenses do not display the licensee's degree.

MD, DO, DPM and DC licenses display the degree. The Credentials Committee recommended that the Board maintain the status quo for now.

NEW BUSINESS

1. Regulatory and Legislative Issues – Elaine Yeatts

Ms. Yeatts presented the chart of regulatory actions as of November 17, 2021. She noted that regulations for the SB1189 Occupational Therapy Compact are still not approved. They are currently in the Governor's office.

Ms. Yeatts also stated that the NOIRA for HB1953 Licensure of Certified Midwives is also in the Governor's office.

Both of these items were for informational purposes only and did not require any action.

2. Recommendations from the Credentials Committee – Michael Sobowale, LLM

Mr. Sobowale referred to p. 31 for the meeting minutes of the November 8, 2021 Credentials Committee meeting. He then referred to the charts on pp. 38-39 and reviewed the recommendations for each profession as to which documents must be a primary-source verified, those for which copies can be accepted, and ones that are no longer needed.

MOTION: Dr. Edwards moved to accept the recommendations of the Credentials Committee as presented. The motion was seconded and carried unanimously.

3. Recommendation on Adoption of Fast-Track Regulation

Ms. Yeatts highlighted the changes necessary to implement the vote above for licensure by endorsement, PA licensure, and Radiological Technology as stated in Project 7034 – Fast-Track. It revises the language as follows:

- AMEND - 18VAC85-20-141. Licensure by endorsement (No. 3). Revises the language to state that only "the most recent license" must be verified and "is" in good standing.
- AMEND - 18VAC85-50-50. Licensure: entry requirements and application (A-4): Revises the language to state that "if licensed or certified in any other jurisdiction, verification that there has been no disciplinary action taken or pending in that" jurisdiction.
- AMEND - 18VAC85-101-28. Licensure requirements (B): Revising the language to state that "the application shall include verification that there has been no disciplinary action taken or pending in that jurisdiction."

MOTION: Dr. Edwards moved to adopt the above as a fast-track action. The motion was seconded and carried unanimously.

---DRAFT UNAPPROVED---

ANNOUNCEMENTS

Everyone was reminded to submit the Expense Reimbursement Voucher within 30 days after completion of travel (CAPP Topic 20335, State Travel Regulations, p. 7).

The next meeting of the Executive Committee will be April 8, 2022 @ 8:30 a.m.

ADJOURNMENT

With no additional business, the meeting adjourned at 10:18 a.m.

Blanton Marchese
President

William L. Harp, MD
Executive Director

Deirdre C. Brown
Recording Secretary

--- DRAFT UNAPPROVED---

VIRGINIA BOARD OF MEDICINE
LEGISLATIVE COMMITTEE MINUTES

Friday, January 14, 2022 | Department of Health Professions | Henrico, VA

CALL TO ORDER: Dr. Archer called the meeting of the Legislative Committee to order at 8:30 a.m.

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

MEMBERS PRESENT:
David Archer, MD, Vice-President, Chair
James Arnold, DPM
Jane Hickey, JD
Oliver Kim, LLM

MEMBERS ABSENT:
Jacob Miller, DO
Joel Silverman, MD
Ryan Williams, MD

STAFF PRESENT:
William L. Harp, MD, Executive Director
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 Senior Deputy Director
Elaine Yeatts, DHP Senior Policy Analyst
Erin Barrett, JD, DHP Senior Policy Analyst

OTHERS PRESENT:
Eleni Poulos, MWC
Scott Castro, MSV

EMERGENCY EGRESS INSTRUCTIONS

Dr. Archer provided the emergency egress instructions.

APPROVAL OF MINUTES OF MAY 21, 2021

Dr. Arnold moved to approve the meeting minutes of May 21, 2021 as presented. The motion was seconded by Ms. Hickey and carried unanimously.

ADOPTION OF AGENDA

Ms. Hickey moved to accept the agenda as presented. The motion was seconded by Dr. Arnold and carried unanimously.

--- DRAFT UNAPPROVED---

PUBLIC COMMENT

There was no public comment.

DHP DIRECTOR'S REPORT

Dr. Allison-Bryan announced that she was presenting in Dr. Brown's place since he was attending a subcommittee at the General Assembly. She noted that his presence there was to provide insight and information on bills concerning the DHP and the boards. Dr. Allison-Bryan spoke about the transition of the incoming Administration as well as changes at DHP. She introduced Erin Barrett, JD as the new DHP Policy Analyst. She also provided a brief update on COVID, noting the uptick in cases due to Omicron. She added that Virginia still has one of the nation's highest vaccination rates and one of the lowest per capita death rates from COVID. Dr. Allison-Bryan concluded her report with an update on a workgroup she led to look at **HB420 - Opioid-related emergencies; evidence-based best practices in the emergency department** and was pleased to report that their recommendations were incorporated verbatim in legislation.

NEW BUSINESS

1. Report of the 2022 Session of the General Assembly – Ms. Yeatts

Ms. Yeatts advised that the agency is following 72 bills in this year's session and highlighted those that directly affected the Board or might be of interest to the Committee. After her report, Ms. Yeatts fielded questions from the members regarding several bills, including the Legislative Committee's role in the legislative process. She stated that the Committee may offer comments and recommendations which could be reflected in DHP's Legislative Action Summary. For bills that members feel strongly about, she suggested they reach out to their respective legislators as an individual, not as a member of the Board of Medicine, to discuss their concerns.

2. Consideration of Reciprocity with Maryland and the District of Columbia – Dr. Harp

Dr. Harp noted that there has been a growing interest among medical providers, medical associations, medical boards and the members of the General Assembly in facilitating practice across jurisdictional lines with Maryland and DC. He provided an overview of the meetings held between the executive directors and noted for the Committee a very enthusiastic article published by the Medical Society of the District of Columbia on December 15, 2021 applauding efforts towards reciprocity.

Dr. Harp pointed out that Virginia's application asks questions in a broader fashion, rather than a more specific, detailed one. However, Virginia's questions appear to cover all of the required elements in Maryland and DC's questions. The Committee discussed the similarities and differences in the licensing requirements. After discussion, the Committee unanimously agreed that it felt positive about continuing to the next steps with Maryland and the District. Dr. Harp said that the Committee's discussion was helpful and will provide guidance for Board staff in the upcoming January 28th meeting with the executive directors of Maryland and DC.

--- DRAFT UNAPPROVED---

This item was for discussion only and did not require a motion.

3. Joint Commission on Health Care "Review of the Interstate Medical Licensure Compact" – Dr. Harp

Dr. Harp advised the members that in the 2021 Session of the General Assembly, Delegate Dan Helmer put forth HJ531 for the Joint Commission on Healthcare to study the advisability of Virginia joining the Interstate Medical Licensure Compact. On August 2, 2021, Barbara Allison-Bryan, MD, Blanton Marchese, Michael Sobowale, Colanthia Morton Opher, and he met with Jeff Lunardi, Executive Director for the Joint Commission and Ashley Williams, who was assisting with the study. Dr. Harp then referred the Committee to Mr. Lunardi's report in the packet which reviewed the findings of the study. In addition to the Board of Medicine, other sources included the IMLC Commission and the Office of the Attorney General. Dr. Harp advised that the report was unalterable.

This report was for discussion only and did not require a motion.

ANNOUNCEMENTS

No Announcements.

NEXT MEETING

May 6, 2022

ADJOURNEMENT

With no other business to conduct, the meeting adjourned at 10:22 a.m.

_____
David Archer, MD
Vice-President, Chair

_____
William L. Harp, MD
Executive Director

_____
Colanthia Morton Opher
Recording Secretary

DRAFT UNAPPROVED

VIRGINIA BOARD OF MEDICINE

CREDENTIALS COMMITTEE BUSINESS MEETING

Monday, November 8, 2021 Department of Health Professions Henrico, VA

CALL TO ORDER: Dr. Miller called the meeting to order at 9:16 a.m.

MEMBERS PRESENT:
Jacob Miller, DO - Chair
Khalique Zahir, MD
Jane Hickey, JD
Pradeep Pradhan, MD
Alvin Edwards, PhD

STAFF PRESENT:
William L. Harp, MD - Executive Director
Michael Sobowale, LL.M. - Deputy Executive Director, Licensing

GUESTS PRESENT:
Andrew Densmore - Medical Society of Virginia
Ben Traynham – Hancock, Daniel, Johnson, P.C.

Call to Order

Dr. Miller called the meeting to order at 9:16 am.

Emergency Egress

Dr. Miller read the emergency egress instructions.

Roll Call

Mr. Sobowale called the roll; a quorum was declared.

Approval of Minutes

Dr. Edwards moved approval of the minutes of the September 20, 2021 meeting with an amendment to the minutes to change Ms. Hickey's first name to Jane instead of "Janet". Motion was seconded by Dr. Zahir. Minutes approved.

Approval of the Agenda

Ms. Hickey moved approval of the agenda as presented. Dr. Zahir seconded the motion. The agenda was unanimously approved.

Public Comment

None

Overview

Dr. Harp provided brief comments on the purpose of the meeting. He reminded members that when the Committee met on September 20th, certain recommendations were made with regards to further streamlining the licensing process for five professions whose licensing processes were expedited during the pandemic - MD, DO, DPM, PA, and RT. The recommendations made at that meeting were ratified by the full board at the meeting held on October 14, 2021. Part of the recommendations made by the Committee at the last meeting was for the issue to be presented to the various Advisory Boards overseeing the allied health professions under the Board of Medicine for a discussion and for them to determine if any recommendation could be made on ways to streamline their licensing requirements. Any recommendations made is to be presented back to the Committee for consideration and approval. Part of the Committee's task at the meeting is to consider and approve the recommendations received from the various Advisory Boards.

New Business:

1. **Consider Licensure Requirements Recommendations from Advisory Boards**

   The Committee reviewed the licensure requirements in each allied health profession's regulations and advisory board recommendations on licensure documents required of applicants during the application process consisting of documents for which primary-source verification is required, documents for which copies could be accepted, and documents that are no longer necessary to be provided by an applicant in the application process.

   After a presentation of the recommendations made the Advisory Boards overseeing the twelve allied professions on Genetic Counseling, Occupational Therapy, Licensed Acupuncture, Radiologic Technology, Athletic Training, Licensed Professional Midwives, Polysomnographic Technology, and Surgical Assisting and upon full discussion, the Committee unanimously voted upon a motion made by Dr. Edwards, seconded by Dr. Zahir, to approve the recommendations presented for each allied profession as follows:

Genetic Counseling

A license applicant should submit primary source verification of the following documents: Professional Education /School Transcripts, American Board of Genetic Counseling (ABGC) or American Board of Medical Genetics (ABMG) Certificate, ABGC Active Candidate status letter for temporary license applicants, National Practitioner Data Bank (NPDB) self-query report and one state license verification.

Copies of the following documents could be accepted: Other state license verifications, if submitted; a digitally-certified electronic copy of the NPDB report in lieu of a mailed report, and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine.

It is no longer necessary for applicants to submit a "Form B" employment verification.

Occupational Therapy and Occupational Therapist Assistant

A license applicant should submit primary source verification of the following documents: professional education/ school transcripts, National Board for Certification in Occupational Therapy (NBCOT) Certificate, Test of English as a Foreign Language (TOEFL) result and Program Director's letter verifying completion of professional education for an internationally-trained applicant, National Practitioner Data Bank (NPDB) self-query report and one state license verification.

Copies of the following documents could be accepted: Other state license verifications, if submitted; a digitally-certified electronic copy of the NPDB report in lieu of a mailed report, and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine.

It is no longer necessary for applicants to submit a "Form B" employment verification.

Licensed Acupuncture

A license applicant should submit primary source verification of the following documents: professional education /school transcripts, National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM), Test of English as a Foreign Language (TOEFL) result and United States evaluation of international professional education for an internationally-trained applicant, National Practitioner Data Bank (NPDB) self-query report and one state license verification.

Copies of the following documents could be accepted: Other state license verifications, if submitted; a digitally-certified electronic copy of the NPDB report in lieu of a mailed report, and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine.

It is no longer necessary for applicants to submit a "Form B" employment verification.

Radiologic Technology, Radiologic Technology-Limited, and Radiologic Assistant

A radiologic technology license applicant should submit primary source verification of the following documents: proof of professional education /school transcripts, American Registry of Radiologic Technologists (ARRT) or Nuclear Medicine Technology Certification Board (NMTCB) certification, National Practitioner Data Bank (NPDB) self-query report and one state license verification.

A radiologic technology- limited license applicant should submit primary source verification of the following documents: proof of professional education /school transcripts, American Registry of Radiologic Technologists (ARRT) certification, National Practitioner Data Bank (NPDB) self-query report and one state license verification.

A radiologic assistant license applicant should submit primary source verification of the following documents: American Registry of Radiologic Technologists (ARRT) certification, current certification in Advanced Cardiac Life Support (ACLS), National Practitioner Data Bank (NPDB) self-query report and one state license verification.

For these professions, copies of the following documents could be accepted: Other state license verifications, if submitted; a digitally-certified electronic copy of the NPDB report in lieu of a mailed report, and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine.

It is no longer necessary for applicants to submit a "Form B" employment verification. Also, pursuant to 18VAC85-101-27, radiologic assistants are graduates of an ARRT-recognized educational program prior to being allowed to sit for the ARRT certifying examination leading to the radiologic assistant credential. It is no longer necessary for a radiologic assistant license applicant to present school transcripts in the application process.

Athletic Training

The Advisory Board on Athletic Training did not form a quorum at their meeting held on October 7, 2021 but the Committee accepted the consensus reached during deliberation by members in attendance at the meeting as follows: A license applicant should submit primary source verification of the following documents: A credential issued by the National Athletic Trainers' Board of Certification (BOC), National Practitioner Data Bank (NPDB) self-query report and one state license verification.

Copies of the following documents could be accepted: Other state license verifications, if submitted; a digitally-certified electronic copy of the NPDB report in lieu of a mailed report, and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine.

It is no longer necessary for applicants to submit a "Form B" employment verification.

Licensed Professional Midwives

The Advisory Board on Midwifery did not form a quorum at their meeting held on October 8, 2021 but the Committee accepted the consensus agreed to during deliberation by members in attendance at the meeting as follows: A license applicant should submit primary source verification of the following documents: Certification from North American Registry of Midwives (NARM), National Practitioner Data Bank (NPDB) self-query report and one state license verification.

Copies of the following documents could be accepted: Other state license verifications, if submitted; a digitally-certified electronic copy of the NPDB report in lieu of a mailed report, and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine.

It is no longer necessary for applicants to submit a "Form B" employment verification.

Polysomnographic Technology

A license applicant should submit primary source verification of the following documents: evidence of one of three credentialing pathways: 1. current certification as a Registered Polysomnographic Technologist (RPSGT) by the Board of Registered Polysomnographic Technologists; 2. documentation of the Sleep Disorders Specialist credential from the National Board of Respiratory Care (NBRC-SDS); or 3. a professional certification or credential approved by the board from an organization or entity that meets the accreditation standards of the Institute for Credentialing Excellence belonging to the National Organization for Competency Assurance. In addition, they must provide primary source evidence of current certification in Basic Cardiac Life Support (BCLS), National Practitioner Data Bank (NPDB) self-query report and one state license verification.

Copies of the following documents could be accepted: Other state license verifications, if submitted; a digitally-certified electronic copy of the NPDB report in lieu of a mailed report, and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine.

It is no longer necessary for applicants to submit a "Form B" employment verification. Also, it is no longer necessary to a notarized BCLS certificate as a copy will suffice.

Licensed Surgical Assistant and Certified Surgical Technologist

A license applicant as a surgical assistant should submit primary source verification of the following evidence of one of three credentialing pathways: 1. a current credential as a surgical assistant or surgical first assistant issued by the National Board of Surgical Technology and Surgical Assisting (NBSTSA) or the National Commission for Certification of Surgical Assistants (NCCSA) or their successors; 2. successful completion of a surgical assistant training program during the applicant's service as a member

of any branch of the armed forces of the United States; or 3. practice as a surgical assistant in the Commonwealth at any time in the six months immediately prior to July 1, 2020.

An applicant registering with the Board for certification as a surgical technologist should submit primary source verification of the following evidence of one of three credentialing pathways: 1. a current credential as a surgical technologist issued by the National Board of Surgical Technology and Surgical Assisting (NBSTSA) or its successor; 2. successful completion of a training program for surgical technology during the applicant's service as a member of any branch of the armed forces of the United States; or 3. practice as a surgical technologist at any time in the six months immediately prior to July 1, 2021.

For these professions, copies of the following documents could be accepted: a notarized copy of the NBSTSA credential, if mailed by the applicant and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine.

It is no longer necessary for applicants to submit a "Form B" employment verification. Also, it is no longer necessary to a notarized BCLS certificate as a copy will suffice.

Behavior Analyst and Assistant Behavior Analyst

The Advisory Board on Behavior Analysis did not form a quorum to hold their meeting scheduled on October 4, 2021 but upon a motion made by Jane Hickey, seconded by Dr. Miller, the Committee unanimously voted to adopt the same requirements listed for the rest of the allied professions as follows: in addition to submitting primary source verification of current certification or credential as a Board Certified Behavior Analyst (BCBA) or Board Certified Assistant Behavior Analyst (BCaBA) issued by the Behavior Analyst Certification Board (BACB), a license applicant should also provide primary source verification of the National Practitioner Data Bank (NPDB) self-query report and one state license verification.

Copies of the following documents could be accepted: Other state license verifications, if submitted; a digitally-certified electronic copy of the NPDB report in lieu of a mailed report, and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine.

It is no longer necessary for applicants to submit a "Form B" employment verification.

The Committee also noted that if the advisory board have a different set of recommendations apart from these, they should be presented back to the Board.

2. **Contiguous States License Reciprocity**

   Dr. Harp led the discussion. He reminded members of the passage into legislation of Senate Bill 757/House Bill 1701 of 2020 which allows the Board of Medicine to enter into reciprocal agreements with states that are contiguous to Virginia for the licensure of medical doctors, doctors of osteopathic medicine, physician assistants and nurse practitioners. He has contacted the Board Executives of the various states that are situated contiguously to Virginia, including the Board Executives in Pennsylvania, Delaware, and Kentucky. So far, only the District of Columbia and Maryland have expressed a strong interest in entering into a reciprocal agreement with Virginia.

   During subsequent meetings held with the Board executives in Maryland and the District of Columbia, it was mentioned that there may be some limitations to terms in the reciprocal licensure agreement that may eventually be formed regarding issuing a license by reciprocity to international medical school graduates. Part of the consideration is that Virginia requires just a year of postgraduate training in order to license an international medical school graduate, whereas Maryland and the District of Columbia either require more year of postgraduate training or an internationally-trained medical school graduate could not apply for a license in their state.

Jane Hickey encouraged the Board to continue in its effort to pursue licensure reciprocity with contiguous jurisdictions. Dr. Pradhan mentioned that he could see the advantages of pursuing licensure reciprocity with contiguous states in terms of increased patient access to care and the ability of the provider to readily provide care for patients that may be situated in a border state. Dr. Zahir discussed that the issue of licensure reciprocity is very important for the Board to pursue, especially for providers and patients located in the "DMV" area where there is a lot of population.

Upon full discussion of the issue and a motion made by Dr. Zahir, the Committee voted to recommend for the Board to agree in principle to form a reciprocal licensure agreement with Maryland and the District of Columbia. Dr. Pradhan seconded the motion. There were no abstentions. Dr. Miller voted 'No'.

3. **Designation of Professional Credential on License**
Dr. Harp led the discussion. Board staff have been made aware that other Boards under the umbrella of the Department of Health Professions may not be following the same procedure followed by the Board of Medicine of including the professional credential of the licensee on the wall certificate and license issued. Members discussed that there could be a blurring of the lines with the public and unsuspecting consumers of medical services of the type of professional credential that a treating provider actually holds if the credential is not displayed on the license issued. The consensus of the members was to leave credential designation on licenses issued by the Board. Upon a motion by Dr. Pradhan, seconded by Dr. Zahir, the Committee unanimously voted for the Board to keep credential designation on licenses issued by the Board of Medicine.

With no additional business, the meeting adjourned 10:58 a.m.

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Jacob Miller, DO
Chair

_____

William L. Harp, MD
Executive Director

_____

Michael Sobowale, LL.M.
Deputy Executive Director, Licensing

<< DRAFT >>

ADVISORY BOARD ON GENETIC COUNSELING
Minutes
October 4, 2021

The Advisory Board on Genetic Counseling met on Monday, October 4, 2021 at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Lori Swain - Chair
Tahnee Causey, GC - Vice-Chair
Marilyn Foust, MD
Lydia Higgs, GC

MEMBERS ABSENT: Martha Thomas, GC

STAFF PRESENT: William L. Harp, MD, Executive Director
Michael Sobowale, LLM, Deputy Director, Licensure
Elaine Yeatts, DHP Senior Policy Analyst
Colanthia Opher, Deputy Director, Administration
Delores Cousins, Licensing Specialist

GUESTS PRESENT: None

Call to Order

Lori Swain, Chair, called the meeting to order at 1p.m.

Emergency Egress Procedures

Dr. Harp announced the emergency egress instructions.

Roll Call

Roll was called; a quorum was declared.

Introduction of Members and Staff

Dr. Harp asked Board staff and the Advisory Board members to introduce themselves.

Approval of Minutes

Marilyn Foust moved to adopt the minutes of the October 5, 2020 meeting. Tahnee Causey seconded the motion. By unanimous vote, they were approved as presented.

Adoption of Agenda

Tahnee Causey moved to adopt the agenda. Marilyn Foust seconded the motion. By unanimous vote, the agenda was adopted.

Public Comment on Agenda Items

None

New Business

1. 2021 Legislative Update and 2022 Proposals

   Dr. Harp provided an update on legislative actions from the 2021 General Assembly that held interest to members and spoke to 2022 legislative proposals.

2. Report of Regulatory Actions

   Dr. Harp gave the report in Elaine Yeatts' absence. He made special mention of the repeal of the conscience clause for genetic counselors by the 2021 General Assembly. Conforming the regulations to the Code will be an exempt regulatory action.

3. Review of Licensure Requirements

   Michael Sobowale said this topic was placed on the Advisory Board's agenda at the request of the Credentials Committee for the Advisory Board to review the licensing requirements and application questions to determine if they can be further streamlined. The Credentials Committee met on September 20, 2021 to review and recommend which documents required in the licensing process should be primary-source verified, which ones may be submitted as copies, and those that are no longer be needed in the licensing process. The Credentials Committee will be making recommendations on how the licensing process for all professions could be streamlined. The Committee asked that any recommendation made by the Advisory Board be reported at its next meeting on November 8th.

   Members reviewed current licensure requirements for genetic counselors and it was the consensus of members that digital opportunity for submission of required documents in the licensing process made sense. Members also agreed that the application process could be simplified for applicants while still protecting the public.

After discussion, and upon a motion made by Tahnee Causey, seconded by Lydia Higgs, the Advisory Board voted to recommend that a license applicant should submit primary source verification of the following documents: Professional Education /School Transcripts, American Board of Genetic Counseling (ABGC) or American Board of Medical Genetics (ABMG) Certificate, ABGC Active Candidate status letter for temporary license applicants, National Practitioner Data Bank (NPDB) self-query report and one state license verification.

Copies of the following documents could be accepted: Other state license verifications, if submitted; a digitally-certified electronic copy of the NPDB report in lieu of a mailed report, and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine.

It is no longer necessary for applicants to submit a "Form B" employment verification.

4. **Correspondence:**

a. CE Requirements

Members discussed correspondence received from Martha Thomas regarding whether continuing education credits completed in the previous license renewal cycle should count towards license renewal in the current cycle, even though a certificate of course completion may not yet have been issued or received.

It was the consensus of members that the issue can be addressed by asking the licensee who is the subject of a continuing education audit to provide an explanation that clarifies the status of credit hours earned.

b. Exam Candidate Temporary Licensure

Tahnee Causey brought up the issue of a new graduate who took the national board examination and failed prior to applying for a temporary license with the Board. The Board's regulation states that an exam candidate who has been granted an active candidate status by the American Board of Genetic Counseling (ABGC) could apply for a temporary license with the Board. Ms. Higgs felt that this was a violation of the spirit of the law.

Ms. Causey will contact the ABGC to find out if an exam candidate's active candidate status could be renewed and report her findings back to the Board at the next meeting.

5. **Approval of 2022 Meeting Calendar**

Marilyn Foust moved to approve the proposed meeting dates for the Advisory Board on the 2022 Board calendar. Lydia Higgs seconded. The schedule of meetings was unanimously approved.

6. **Election of Officers**

   Marilyn Foust moved to nominate Tahnee Causey as Chair and Lydia Higgs as Vice-Chair. Lydia Higgs seconded the motion. Members unanimously approved the slate of officers nominated.

Announcements:

Next Scheduled Meeting:

The next scheduled meeting is Monday January 31, 2022 @ 1pm.

Adjournment

With no other business to conduct, the meeting adjourned @2:46pm.

Lori Swain, Citizen, Chair

William L. Harp, MD, Executive Director

Michael Sobowale, LLM, Deputy Director

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ADVISORY BOARD ON OCCUPATIONAL THERAPY

Minutes
October 5, 2021

The Advisory Board on Occupational Therapy met on Tuesday, October 5, 2021 at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT:	Breshae Bedward, Chair Dwayne Pitre OT, Vice-Chair Kathryn Skibek, OT
MEMBERS ABSENT:	Raziuddin Ali, MD Karen Lebo, Citizen
STAFF PRESENT:	William L. Harp, MD, Executive Director Michael Sobowale, Deputy Executive Director, Licensure Elaine Yeatts, DHP Senior Policy Analyst ShaRon Clanton, Licensing Specialist
GUESTS PRESENT:	Kendall R. Michalofski - Macaulay & Jamerson & VOTA

Call to Order

Breshae Breward, OTR, Chair called the meeting to order at 10:02 a.m.

Emergency Egress Procedures

Dr. Harp announced the emergency egress instructions.

Roll Call

Roll was called, and a quorum was declared.

Approval of Minutes

Ms. Skibek moved to approve the minutes of the January 26, 2021 meeting. The motion was seconded by Mr. Pitre. By unanimous vote, the minutes were approved as presented.

Adoption of Agenda

Mr. Pitre moved to approve the adoption of the agenda. The motion was seconded by Ms. Skibek. By unanimous vote, the agenda was adopted as presented.

Public Comments

Ms. Michalofski introduced herself to the Board. She expressed that she was present at the meeting on behalf of the Virginia Occupational Therapy Association (VOTA) to hear more about any concern for implementation of the Occupational Therapy Interjurisdictional Licensure Compact that she can report back to members.

New Business

1. 2021 Legislative Update and 2022 Proposals

   In Elaine Yeatts' absence, Dr. Harp provided an update on legislative actions from the 2021 General Assembly of interest to the Advisory Board members and 2022 legislative proposals. No action was required.

2. Report of Regulatory Actions

   Dr. Harp gave a brief report of the laws from the 2021 General Assembly that will require regualtory action by the Board of Medicine. He made special mention of the emergency regulations for Board adoption for the occupational therapy interjurisdictional compact. The emergency regulations must be in place by December 23, 2021.

3. Update on Occupational Therapy Interjurisdictional Compact Implementation

   Elaine Yeatts provided an update on implementation of the OT compact, which came with a requirement for emergency regulations. They are currently with the Secretary of HHR for review, and they should be in effect by December 23, 2021. The law passed by the General Assembly, which provided the authorization to join the compact, does not become effective until January 1, 2022. The occupational therapy criminal background check requirement will only be for those applying for a privilege under the Compact, not to all OT applicants.

4. Review of Licensure Requirements

   Michael Sobowale provided a brief overview. This topic was placed on the Advisory Board's agenda pursuant to the request of the Credentials Committee for each Advisory Board overseeing each profession at the Board of Medicine to review their licensing

requirements and application questions to determine if they are in line with current practice. The Committee first met on September 20, 2021 to review and recommend which documents required in the licensing process must be primary-source verified, ones that may be submitted as copies, and those that may no longer be useful in the licensing process. The Committee will be making recommendations on how the licensing process at the Board of Medicine could be further streamlined. The Committee asked that any recommendation made by the Advisory Board should be reported back to the Committee at its next meeting.

Members reviewed current licensure requirements for occupational therapists and occupational therapy assistants and it was the consensus of members that the application process could be simplified for applicants while still protecting the public.

After discussion, and upon a motion by Kathryn Skibek, seconded by Mr. Pitre, the Advisory Board voted to recommend that a license applicant should submit primary source verification of the following documents: professional education/ school transcripts, National Board for Certification in Occupational Therapy (NBCOT) Certificate, Test of English as a Foreign Language (TOEFL) result and Program Director's letter verifying completion of professional education for an internationally-trained applicant, National Practitioner Data Bank (NPDB) self-query report and one state license verification.

Copies of the following documents could be accepted: Other state license verifications, if submitted; a digitally-certified electronic copy of the NPDB report in lieu of a mailed report, and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine.

It is no longer necessary for applicants to submit a "Form B" employment verification.

5. Approval of 2022 Meeting Calendar

Kathryn Skibek moved to approve the proposed meeting dates for the Advisory Board on the 2022 Board calendar. Mr. Pitre seconded. The schedule of meetings was unanimously approved.

6. Election of Officers

Ms. Breward nominated Mr. Pitre as Chair. Ms. Skibek seconded. Mr. Pitre nominated Kathryn Skibek as Vice-Chair. Ms. Breward seconded. By unanimous vote, members approved the slate of officers nominated.

Announcements:

Ms. Clanton provided the licensing statistics report. The number of current active licensed occupational therapists is 4,079. There are 1,732 occupational therapy assistants. The total number of new occupational therapists licensed from January 1, 2021 to present was 181. There have been 71 occupational therapy assistants licensed this year.

Next Meeting date:

February 1, 2022 @ 10:00 a.m.

Adjournment:

With no other business to conduct, the meeting adjourned at 11:24 a.m.

_____ _____

Breshae Breward, Chair William L. Harp, MD, Executive Director

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ShaRon Clanton, Licensing Specialist

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ADVISORY BOARD ON RESPIRATORY THERAPY

Minutes
October 5, 2021

The Advisory Board on Respiratory Therapy met on Tuesday, October 5th, 2021 at 1:00 pm in the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Daniel Gochenour, RRT, Chair
Santiera Brown-Yearling RRT, Vice-Chair
Shari Toomey, RRT

MEMBERS ABSENT: Bruce K. Rubin, MD
Denver Supinger, Citizen

STAFF PRESENT: William L. Harp, MD, Executive Director
Elaine Yeatts, DHP Senior Policy Analyst
Michael Sobowale, LLM, Deputy Director, Licensure
Colanthia Opher, Deputy Director, Administration
Delores Cousins, Licensing Specialist

GUESTS PRESENT: None

Call to Order

Daniel Gochenour, Chair, called the meeting to order at 1:08 p.m.

Emergency Egress Procedures

Dr. Harp announced the emergency egress instructions.

Roll Call

The roll was called, and a quorum was declared.

Approval of the January 26, 2021 Minutes

Santiera Brown-Yearling moved to approve the minutes. Shari Toomey seconded the motion. By unanimous vote, the minutes were approved as presented.

Adoption of Agenda

Santiera Brown-Yearling moved to adopt the agenda. Shari Toomey seconded the motion. By unanimous vote, the agenda was approved as presented.

Public Comment on Agenda Items

None

New Business

1. 2021 Legislative Update and 2022 Proposals

Elaine Yeatts provided an update on legislation from the 2021 General Assembly that was of interest to members, as well as legislative proposals for the 2022 Session. No action was required.

2. Update on VSRC's Request for Advanced Practice RT New Profession Assessment

Elaine Yeatts discussed the response from the Director of the Department of Health Professions on behalf of the agency to the request received from the Virginia Society for Respiratory Care (VSRC) for Advanced Practice Respiratory Therapist assessment as a new profession. She asked members to refer to the criteria listed in the Agency's policies and procedures for the determination of the need to regulate health occupations and professions. As there are so few APRT's, it is premature to have the Board of Health Professions conduct a study. Further, Ms. Yeatts said that studies conducted by the agency from 2015 to 2019 showed that there was only a 1% growth in the number of RT's practicing in Virginia.

3. Respiratory Therapy Workforce and Staffing

Mr. Gochenour led the discussion. He shared the concern of hospital managers who participated in an informal survey on respiratory therapist staffing in Virginia. The results of the survey showed that employers are facing some challenges filling respiratory therapist positions in their facilities due to an insufficient applicant pool.

The Advisory Board members were in agreement that there was a need to bring awareness of the profession to the public; this has generally been the responsibility of the professional association. It was proposed that DHP's Healthcare Workforce Study report could be disseminated to high schools, and the information could also be sent to the Virginia Society for Respiratory Care to be used as a sort of healthcare occupational roadmap with various groups. It was also suggested that the profession could find a patron to sponsor a bill to authorize the Board to issue a six-month temporary license to new graduates prior to passing the National Board of Respiratory Care exam, similar to the Occupational Therapy License Applicant authorization.

4. Review of Licensure Requirements

Michael Sobowale said this topic was placed on the Advisory Board's agenda at the request of the Credentials Committee for the Advisory Board to review the licensing requirements and application questions to determine if they can be further streamlined. The Credentials Committee met on September 20, 2021 to review and recommend which documents required in the licensing process should be primary-source verified, which ones may be submitted as copies, and those that are no longer be needed in the licensing process. The Credentials Committee will be making recommendations on how the licensing process for all professions could be streamlined. The Committee asked that any recommendation made by the Advisory Board be reported at its next meeting on November 8th.

The Credentials Committee had recommended at the September 20th meeting that a respiratory therapist license applicant should submit primary source verification of the following documents: professional education/ school transcripts, National Board for Respiratory Care (NBRC) Certificate, National Practitioner Data Bank (NPDB) self-query report and one state license verification.

Copies of the following documents could be accepted: Other state license verifications, if submitted; a digitally-certified electronic copy of the NPDB report in lieu of a mailed report, and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine.

It is no longer necessary for applicants to submit a "Form B" employment verification.

Members concurred that the recommendations made by the Committee pertaining to the application process for respiratory therapist license applicants could simplify the application process for them while still protecting the public.

5. Approval of 2022 Meeting Calendar

Shari Toomey moved to approve the proposed meeting dates for the Advisory Board on the 2022 calendar. Santiera Brown-Yearling seconded the motion. The schedule was unanimously approved.

6. Election of Officers - Daniel Gochenour

   Daniel Gochenour nominated Santiera Brown-Yearling as Chair, and Shari Toomey seconded the motion. Santiera Brown-Yearling nominated Shari Toomey as Vice-Chair, and Daniel Gochenour seconded. By unanimous vote, the Advisory Board approved the slate of officers as nominated.

Announcements:

Delores Cousins provided the licensing statistics report. There are 3,9777 current active respiratory therapists and 119 current inactive.

Next Scheduled Meeting:

The next scheduled meeting will be February 1, 2022 @ 1pm.

Adjournment

There being no other business, the meeting was adjourned at 2:39 pm.

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Daniel Gochenour, RRT, Chair

_____
William L. Harp, MD, Executive Director

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Delores Cousins, Licensing Specialist

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ADVISORY BOARD ON ACUPUNCTURE
Minutes
October 6, 2021

The Advisory Board on Acupuncture met on Wednesday, October 6, 2021, at 10:00 a.m. at the Department of Health Professions at 9960 Mayland Drive, Henrico, VA 23233.

MEMBERS PRESENT: Janet Borges, LAc, Chair
R. Keith Bell, LAc
Luke Robinson, DO

MEMBERS ABSENT: Sharon Crowell, LAc, Vice-Chair
Beth Rodgers, Citizen

STAFF PRESENT: William L. Harp, MD, Executive Director
Michael Sobowale, LLM, Deputy Executive Director, Licensure
Colanthia Opher, Deputy Executive Director, Administration
Elaine Yeatts, DHP Senior Policy Analyst
Beulah Baptist Archer, Licensing Specialist

GUESTS PRESENT: None

Call to Order

Janet Borges, Chair, called the meeting to order at 10:12 am.

Emergency Egresss Procedures

Dr. Harp announced the Emergency Egress Procedures.

Roll Call

The roll was called; a quorum was declared.

Approval of Minutes

Keith Bell moved to approve the minutes from the January 27, 2021 meeting. Dr. Robinson seconded. The minutes were approved as presented.

Adoption of Agenda

Keith Bell moved to adopt the agenda. Dr. Robinson seconded. The agenda was adopted as presented.

Public Comment

No public comment.

New Business

1. 2021 Legislative Update and 2022 Proposals

   Ms. Yeatts and Dr. Harp provided an update on legislative actions from the 2021 General Assembly that were of interest to members, including 2022 legislative proposals. She reported that currently, nine pieces of DHP legislation are proposed, including one that would allow the boards in the Department of Health Professions to hold electronic meetings.

2. Certifying Organizations Name Changes

   Mrs. Yeatts presented proposed changes in the names of certifying organizations for Acupuncture in the Board's regulations. The Advisory Board members were in agreement that the proposed changes would reflect a more accurate representation of the profession than the current names. Ms. Yeatts advised that for the changes to move forward, the process is that the Advisory Board recommends amendments to regulations to the full Board of Medicine for approval. Once the full Board approves the language change, the proposed amendments will be posted for public comment prior to other steps in the regulatory process.

   After discussion, Keith Bell moved to recommend a fast-track action for the changes to the names of the certifying bodies in the regulations. The motion was seconded by Dr. Robinson and carried.

3. Review of Licensure Requirements

   Michael Sobowale said this topic was placed on the Advisory Board's agenda at the request of the Credentials Committee for the Advisory Board to review the licensing requirements and application questions to determine if they can be further streamlined. The Credentials Committee met on September 20, 2021 to review and recommend which documents required in the licensing process should be primary-source verified, which ones may be submitted as copies, and those that are no longer be needed in the licensing process. The Credentials Committee will be making recommendations on how the licensing process for all professions could be streamlined. The Committee asked that any recommendation made by the Advisory Board be reported at its next meeting on November 8th.

Members reviewed current licensure requirements for licensed acupuncturists and were in agreement that there should be a digital opportunity for submission of required documents in the licensing process. Members also agreed that the application process could be simplified for applicants while still protecting the public.

After discussion, and upon a motion by Ms. Borges, seconded by Dr. Robinson, the Advisory Board voted to recommend that a license applicant should submit primary source verification of the following documents: professional education /school transcripts, National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM), Test of English as a Foreign Language (TOEFL) result and United States evaluation of international professional education for an internationally-trained applicant, National Practitioner Data Bank (NPDB) self-query report and one state license verification.

Copies of the following documents could be accepted: Other state license verifications, if submitted; a digitally-certified electronic copy of the NPDB report in lieu of a mailed report, and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine.

It is no longer necessary for applicants to submit a "Form B" employment verification.

4. Approval of 2022 Meeting Calendar

Keith Bell moved to accept the proposed meeting dates for the Advisory Board on the 2022 calendar. Dr. Robinson seconded, and the motion carried.

5. Election of Officers

Keith Bell nominated Janet Borges as Chair. Dr. Robinson seconded. The motion carried. Janet Borges remains Chair of the Acupuncture Advisory Board.

Janet Borges nominated Keith Bell as Vice-Chair. Dr. Robinson seconded. The motion carried. Keith Bell is Vice-Chair of the Acupuncture Advisory Board.

Announcements

Beulah Archer provided the acupuncture licensing report. The Board has 429 current active licensees with 127 out-of-state. There are 5 currently inactive acupuncturists.

Next Scheduled Meeting:

February 2, 2022, at 10:00 a.m.

Adjournment

With no other business to conduct, Janet Borges adjourned the meeting at 11:44 am.

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Janet L. Borges, L. Ac., Chair

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

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Beulah Baptist Archer, Licensing Specialist

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ADVISORY BOARD ON RADIOLOGIC TECHNOLOGY
Minutes
October 6, 2021

The Advisory Board on Radiologic Technology met on Wednesday, October 6, 2021, at 1:00 p.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, Virginia.

MEMBERS PRESENT:	Rebecca Keith, RT, Chair Joyce O. Hawkins, RT, Vice-Chair Uma Prasad, MD
MEMBERS ABSENT:	David Roberts, RT
STAFF PRESENT:	William L. Harp, MD, Executive Director Michael Sobowale, Deputy Executive Director, Licensure Colanthia Opher, Deputy Executive Director, Administration Elaine Yeatts, DHP Senior Policy Analyst Beulah Baptist Archer, Licensing Specialist
GUESTS PRESENT:	Danyell Gardner, RT – ECPI

Call to Order

Rebecca Keith called the meeting to order at 1:02 pm. She requested a moment of silence for former Advisory Board citizen member, William Quarles, Jr.

Emergency Egress Procedures

Dr. Harp gave the emergency egress procedures.

Roll Call

Beulah Archer called the roll. A quorum was established.

Approval of Minutes

Dr. Prasad moved to approve the minutes from the October 7, 2020 meeting. Ms. Hawkins seconded, and the motion carried.

Adoption of Agenda

Dr. Prasad moved to adopt the agenda. Joyce Hawkins seconded, and the agenda was adopted.

Public Comment

Mr. Gardner inquired about the laws governing the regulation of medical assistants and the credentials required for 3-D post-processing. He opined that as long as the procedure is performed by a qualified licensed individual, it should be okay. He also expressed concern regarding the quality of training received in proprietary educational programs.

New Business

1. 2021 Legislative Update and 2022 Proposals

   Ms. Yeatts provided an update on legislative actions from the 2021 General Assembly that were of interest to the Advisory Board and spoke to 2022 DHP legislative proposals. She reported that nine pieces of legislation have been proposed, including one that would allow the Boards at the Department of Health Professions to hold electronic meetings.

2. VSRC'S Petition to Amend Regulations pertaining to Continuing Education

   Ms. Yeatts advised the Advisory Board that any amendments it recommended would have to be presented to the Full Board of Medicine for approval. The next scheduled meeting of the Board is October 14, 2021.

   After a full discussion, Dr. Prasad moved to table the topic. The motion was seconded by Ms. Hawkins and carried.

3. Review and Discussion of Correspondence re: 3D Post-Processing of Medical Images

   The Advisory Board discussed that radiologists have to be licensed with the state for which they read images. The members agreed that 3-D post-processing of medical images should be done by a trained and licensed individual. However in Virginia, if the processing of images is done in a hospital under the supervision of a radiologist, a license is not required. If post-processing occurs outside a hospital, the radiologic technologist would need a license. Members were in agreement that Virginia 3-D post-processors of medical images be licensed for interstate transmission of 3D post-processed medical images.

4. Clarification of Nuclear Medicine Technologist Licensure

   The Advisory Board agreed that nuclear medicine technologists using equipment that emits ionizing radiation working outside a hospital setting need to be licensed in Virginia.

5. Review of Licensure Requirements

   Michael Sobowale said this topic was placed on the Advisory Board's agenda at the request of the Credentials Committee for the Advisory Board to review the licensing requirements and application questions to determine if they can be further streamlined. The Credentials Committee met on September 20, 2021 to review and recommend which documents required in the licensing

process should be primary-source verified, which ones may be submitted as copies, and those that are no longer be needed in the licensing process. The Credentials Committee will be making recommendations on how the licensing process for all professions could be streamlined. The Committee asked that any recommendation made by the Advisory Board be reported at its next meeting on November 8th.

Members reviewed current licensure requirements for radiologic assistants, radiologic technologists as well as limited radiologic technologists and were in agreement that the application process could be simplified for applicants while still protecting the public. After discussion, and upon a motion made by Joyce Hawkins, seconded by Rebecca Keith, members agreed to make the following recommendations to the Credentials Committee:

A radiologic technology license applicant should submit primary source verification of the following documents: proof of professional education /school transcripts, American Registry of Radiologic Technologists (ARRT) or Nuclear Medicine Technology Certification Board (NMTCB) certification, National Practitioner Data Bank (NPDB) self-query report and one state license verification from the most recent state in which the applicant recently obtained a license.

Upon a motion by Ms. Hawkins, seconded by Dr. Prasad, members voted unanimously in favor of putting forward recommendations that a radiologic technology- limited license applicant should submit primary source verification of the following documents: proof of professional education /school transcripts, American Registry of Radiologic Technologists (ARRT) certification, National Practitioner Data Bank (NPDB) self-query report and one state license verification from the most recent state in which the applicant recently obtained a license.

Upon a motion by Ms. Hawkins, seconded by Ms. Keith, members voted unanimously in favor of putting forward recommendations that a radiologic assistant license applicant should submit primary source verification of the following documents: American Registry of Radiologic Technologists (ARRT) certification, current certification in Advanced Cardiac Life Support (ACLS), National Practitioner Data Bank (NPDB) self-query report and one state license verification. Also, pursuant to 18VAC85-101-27, radiologic assistants are graduates of an ARRT-recognized educational program prior to being allowed to sit for the ARRT certifying examination leading to the radiologic assistant credential. It is no longer necessary for a radiologic assistant license applicant to present school transcripts in the application process.

For each profession under radiologic technology, copies of the following documents could be accepted: Other state license verifications, if submitted; a digitally-certified electronic copy of the NPDB report in lieu of a mailed report, and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine.

It is no longer necessary for applicants to submit a "Form B" employment verification.

6. Approval of Meeting Calendar

Dr. Prasad moved to approve the proposed meeting dates for the Advisory Board on the 2022 calendar. Ms. Hawkins seconded, and the motion carried.

7. Election of Officers

Rebecca Keith nominated Joyce Hawkins as Chair. Dr. Prasad seconded, and the motion carried. Joyce Hawkins is Chair of the Radiologic Technology Advisory Board.

Ms. Keith nominated Dr. Prasad as Vice-Chair. Ms. Hawkins seconded, and the motion carried. Dr. Prasad is Vice-Chair of the Radiologic Technology Advisory Board.

Announcements

Beulah Archer gave a report on licenses issued for Radiologic Technology. There are 3,407 current active rad techs and 28 current inactive in Virginia. There are 939 current active with out-of-state addresses and 16 current inactive out-of- state.

Next Meeting Date

February 2, 2022 at 1:00 p.m.

Adjournment

With no other business to conduct, Rebecca Keith adjourned the meeting 3:33 pm.

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Rebecca Keith, RT Chair William L. Harp, MD, Executive Director

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Beulah Baptist Archer, Licensing Specialist

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ADVISORY BOARD ON ATHLETIC TRAINING
Minutes
October 7, 2021

The Advisory Board on Athletic Trainer met on Thursday, October 7th, 2021 at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: David Pawlowski, AT, Chair
Deborah Corbatto, AT

MEMBERS ABSENT: Trilizsa Trent, Vice-Chair
Michael Puglia, AT
Jeffrey Roberts, MD

STAFF PRESENT: William L. Harp, MD, Executive Director
Michael Sobowale, LLM, Deputy Executive Director, Licensure
Colanthia Opher, Deputy Executive Director, Administration
Delores Cousins, Licensing Specialist

GUESTS PRESENT: Rose Schmieg, Chair, VATA Government Affairs
Chris Jones, VATA President
Kimberly Hinton - William & Mary
Mark Hinton - University of Virginia
Ashley Doozan - University of Virginia

Call to Order

David Pawlowski called the meeting to order at 10:11 a.m.

Emergency Egress Procedures

Dr. Harp gave the emergency egress procedures.

Roll Call

Delores Cousins called the roll. A quorum was not established. Dr. Harp noted that even though there was no quorum present for meeting, members present could have a discussion on the items on the agenda but cannot take action on any of them.

Approval of Minutes

No vote was held to approve the minutes of the October 8, 2020 meeting. This item was tabled until the next scheduled meeting on February 3, 2022.

Adoption of Agenda

There was no vote to adopt the agenda, as a quorum was not established.

Public Comment

Rose Schmieg, DHSc, provided an update on the curriculum of the Commission on Accreditation of Athletic Training Education (CAATE). She mentioned intravenous fluids and wound suturing as two new skill sets that are being taught in athletic training curricula.

Dr. Harp suggested that for these procedures to be included within the scope of practice for Athletic Trainers, there would need to be a legislative change in the Code of Virginia.

Mark Hinton spoke to members about the use of dry needling by athletic trainers. He stated that dry needling is a mechanical modality and, in his opinion, it is within the AT scope to use as a mechanical modality. Dr. Harp responded that "devices" are controlled by the Drug Control Act under the Board of Pharmacy. He suggested that the Virginia Athletic Trainers Association file a petition for rule-making with the Department of Health Professions and outline what the profession would want to see regulated.

New Business

1. 2021 Legislative Update and 2022 Proposals

   Dr. Harp provided an update on legislative actions from the 2021 General Assembly that were of interest to members and mentioned 2022 legislative proposals.

2. BHP Study on Regulation of Diagnostic Medical Sonographers,

   Dr. Harp presented an update on major findings of the Board of Health Professions (BHP's) study on the need to regulate diagnostic medical sonographers in Virginia. BHP did not recommend additional state regulation of medical sonographers.

3. Dry Needling

   The discussion on this topic was captured in the Public Comment section above.

4. Review of Licensure Requirements

Michael Sobowale said this topic was placed on the Advisory Board's agenda at the request of the Credentials Committee for the Advisory Board to review the licensing requirements and application questions to determine if they can be further streamlined. The Credentials Committee met on September 20, 2021 to review and recommend which documents required in the licensing process should be primary-source verified, which ones may be submitted as copies, and those that are no longer be needed in the licensing process. The Credentials Committee will be making recommendations on how the licensing process for all professions could be streamlined. The Committee asked that any recommendation made by the Advisory Board be reported at its next meeting on November 8th.

There was not a quorum at this meeting to vote on how the application process for athletic training could be further streamlined. However, the consensus of the members present was as follows:

A license applicant should submit primary source verification of the following documents: A credential issued by the Board of Certification for the Athletic Trainer, National Practitioner Data Bank (NPDB) self-query report, and one state license verification.

Copies of the following documents could be accepted: Other state license verifications, if submitted; a digitally-certified electronic copy of the NPDB report in lieu of a mailed report, and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine.

It is no longer necessary for applicants to submit a "Form B" employment verification.

5. Team Up for Sports Safety (TUFSS) Initiative

   Dr. Harp mentioned that the TUFFS initiative is moving forward.

6. Approval of 2022 Meeting Calendar

   There was no vote on the proposed meeting dates for the Advisory Board on the 2022 Board calendar. The item was tabled until the next scheduled meeting on February 3, 2022.

7. Election of Officers

   This item was tabled until the next scheduled meeting on February 3, 2022.

Announcements:

Delores Cousins gave a report on licensing statistics. There are 1,417 current active athletic trainers with 253 out-of-state. There have been 175 athletic trainers licensed this calendar year.

Next Meeting Date:

The next scheduled meeting will be February 3, 2022 at 10:00 a.m.

Adjournment

Mr. Pawlowski adjourned the meeting @ 11:43 a.m.

David Pawlowski, AT, Chair

William L. Harp, MD, Executive Director

Delores Cousins, Licensing Specialist

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ADVISORY BOARD ON PHYSICIAN ASSISTANTS
Minutes
October 7, 2021

The Advisory Board on Physician Assistants met on Thursday, October 7, 2021 at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT:	Kathleen Scarbalis, PA-C, Chair James B. Carr, PA-C, Vice-Chair Portia Tomlinson, PA-C Frazier W. Frantz, MD Tracey Dunn, Citizen
MEMBERS ABSENT:	None
STAFF PRESENT:	William L. Harp, MD, Executive Director Michael Sobowale, Deputy Executive Director, Licensure Colanthia M. Opher, Deputy Director, Administration ShaRon Clanton, Licensing Specialist
GUESTS PRESENT:	Kelsey Wilkinson, Medical Society of Virginia

Call to Order

Ms. Scarbalis called the meeting to order at 1:04 pm.

Emergency Egress Procedures

Dr. Harp announced the emergency egress procedures.

Roll Call

Roll was called, and a quorum was declared.

Approval of Minutes

Ms. Tomlinson moved to approve the minutes of the January 28, 2021 meeting. The motion was seconded by Ms. Dunn and carried unanimously.

Adoption of Agenda

Ms. Tomlinson moved to adopt the meeting agenda. The motion was seconded by Ms. Dunn and was carried.

Public Comments

Kelsey Wilkinson with the Medical Society of Virginia introduced herself to the Board; she made no comment on agenda items.

New Business

1. 2021 Legislative Update and 2022 Proposals

   Dr. Harp provided an update on legislative actions from the 2021 General Assembly that were of interest to members, including 2022 legislative proposals. He made special mention of the provision which allows a student physician assistant to practice under the supervision of the faculty.

2. Report of Regulatory Actions

   Dr. Harp reviewed the draft amendments to the regulations in 18VAC85-50 et seq. to conform the regulations to the Code. The amendments will be submitted as an exempt regulatory action.

3. Update on FSMB Initiative on Physician Assistant Licensure Compact

   Ms. Scarbalis reported on the meeting held on July 26, 2021 to review model legislation for the Compact and submitted public comments. The topic has generated a lot of interest among physician assistants. The next meeting to be held on November 18th will be to review and incorporate all comments received on the draft model legislation.

4. Update on DMAS Medicaid Enrollment for Physician Assistants

   Ms. Scarbalis reported that physician assistants are able to apply for a Virginia Department of Medical Assistant Services (DMAS) enrollment number for fee-for-service billing effective September 1, 2021.

5. Request to Consider Change to Physician Assistant Ratio per Patient Care Team Physician

Ms. Tomlinson stated that she is satisfied with the written explanation provided by Board staff in response to her request that can be submitted to the Virginia Academy of Physician Assistants to try to find a patron to champion the legislative change. The Board of Medicine cannot change the limit written in the Code.

6. Review of Licensure Requirements

Michael Sobowale said this topic was placed on the Advisory Board's agenda at the request of the Credentials Committee for the Advisory Board to review the licensing requirements and application questions to determine if they can be further streamlined. The Credentials Committee met on September 20, 2021 to review and recommend which documents required in the licensing process should be primary-source verified, which ones may be submitted as copies, and those that are no longer be needed in the licensing process. The Credentials Committee will be making recommendations on how the licensing process for all professions could be streamlined. The Committee asked that any recommendation made by the Advisory Board be reported at its next meeting on November 8th.

The Credentials Committee had recommended at the September 20th meeting that a physician assistant license applicant should submit primary source verification of the following documents: professional education/ school transcripts but delete the use of "Form L" to collect this information, National Commission on Certification of Physician Assistants (NCCPA) Certificate, National Practitioner Data Bank (NPDB) self-query report, and one state license verification.

Copies of the following documents could be accepted: Other state license verifications, if submitted; a digitally-certified electronic copy of the NPDB report in lieu of a mailed report, and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine. It is no longer necessary for applicants to submit a "Form B" employment verification.

Members were in consensus that the recommendations made by the Committee pertaining to the application process for physician assistant license applicants could simplify the application process for them while still protecting the public.

After discussion, Ms. Tomlinson moved that the Advisory Board should accept the recommendation of the Credentials Committee that physician assistant license applicants only submit one license verification instead of requesting a license verification from multiple states. Dr. Frantz seconded the motion. The motion carried. Mr. Carr moved that the Advisory Board should also accept the recommendation of the Credentials Committee that physician assistants license applicants can begin to submit a digitally certified copy of the NPDB self-query report, in lieu of a mailed original copy. The motion was seconded by Ms. Tomlinson. The motion carried.

7. Approval of 2022 Meeting Calendar

Mr. Carr moved to approve the proposed meeting dates for the Advisory Board on the 2022 calendar. Ms. Tomlinson seconded. The schedule of meetings in 2022 was unanimously approved.

8. Election of Officers

Ms. Tomlinson moved that both Kathy Scarbalis and James Carr continue as Chair and Vice-Chair respectively. The motion was seconded by Ms. Dunn. Approval of the motion was unanimous.

Announcements:

Next Meeting date: February 3, 2022 @ 1:00 pm.

Adjournment:

With no other business to conduct, the meeting was adjourned at 2.20 pm.

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Kathleen Scarbalis, PA-C, Chair

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William L. Harp. MD, Executive Director

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ShaRon Clanton, Licensing Specialist

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ADVISORY BOARD ON MIDWIFERY
Minutes
October 8, 2021

The Advisory Board on Midwifery met on Friday, October 8, 2021, at 10:00 a.m., at the Department of Health Professions, Perimeter Center; 9960 Mayland Drive, Henrico, Virginia, 23233.

MEMBERS PRESENT: Rebecca Banks, CPM, Vice-Chair
Erin Hammer, CPM

MEMBERS ABSENT: Kim Pekin, CPM, Chair
Ami Keatts, M.D.
Natasha Jones, MSC, Citizen

STAFF PRESENT: William L. Harp, MD, Executive Director
Michael Sobowale, LLM, Deputy Executive Director, Licensure
Elaine Yeatts, DHP Senior Policy Analyst
Colanthia Opher, Deputy Executive Director, Administration
Beulah Baptist Archer, Licensing Specialist

GUESTS PRESENT: Marinda Schindler, Virginia Midwives Alliance
Kelsey Wilkinson, Medical Society of Virginia

Call to Order

Rebecca Banks called the meeting to order at 10:10 a.m. and made brief remarks noting the lack of a quorum for the meeting.

Emergency Egress Procedures

Dr. Harp announced the Emergency Egress Procedures.

Roll Call

The roll was called; no quorum was declared. Dr. Harp noted that even though there was no quorum present for the meeting, the members could discuss the items on the agenda but not take action on any of them.

Approval of Minutes

No vote was held to approve the minutes of the May 28, 2021 meeting as there was no quorum. This item was tabled until the February 4, 2022 meeting.

Adoption of Agenda

There was no vote to adopt the agenda as a quorum was not established.

Public Comment

No public comment.

New Business

1. **2021 Legislative Update and 2022 Proposals**

   Dr. Harp provided an update on legislative actions from the 2021 General Assembly that held interest for members and briefly mentioned 2022 legislative proposals.

2. **Update on High-Risk Pregnancy Disclosures Guidance Document**

   Ms. Yeatts reported that revised Guidance Document 85-10 on high-risk pregnancy disclosures became effective on August 19, 2021. It was later posted on the Board of Medicine website on September 20, 2021.

3. **Licensed Certified Midwives**

   Ms. Yeatts discussed the legislation passed by the 2021 General Assembly for regulation of a new category of midwives, the Licensed Certified Midwife to be jointly regulated by the Board of Nursing and the Board of Medicine. She highlighted a provision in the legislation which required the Department of Health Professions (DHP) to convene a workgroup to discuss an appropriate regulatory framework for all three midwifery professions. The DHP report is due back to the Governor and the General Assembly by November 1, 2021.

4. **Report of Midwifery Regulatory Study Workgroup**

   Dr. Harp reported that the Midwifery Regulatory Structure Workgroup met on two occasions to discuss options for regulating the different midwifery professions under the Board of Nursing and Board of Medicine. He reported that there was no consensus reached on how these professions might be regulated by the two boards. The decision, for now, was to keep the status quo until other acceptable options could be decided upon.

5. **Review of Licensure Requirements**

Michael Sobowale said this topic was placed on the Advisory Board's agenda at the request of the Credentials Committee for the Advisory Board to review the licensing requirements and application questions to determine if they can be further streamlined. The Credentials Committee met on September 20, 2021 to review and recommend which documents required in the licensing process should be primary-source verified, which ones may be submitted as copies, and those that are no longer be needed in the licensing process. The Credentials Committee will be making recommendations on how the licensing process for all professions could be streamlined. The Committee asked that any recommendation made by the Advisory Board be reported at its next meeting on November 8th.

There was lack of a quorum at this meeting to vote on how the application process for certified professional midwives license applicants could be further streamlined. However, consensus reached by members present was as follows:

A license applicant should submit primary source verification of the following documents: Certification from the North American Registry of Midwives (NARM), National Practitioner Data Bank (NPDB) self-query report, and one state license verification.

Copies of the following documents could be accepted: Other state license verifications, if submitted; a digitally-certified electronic copy of the NPDB report in lieu of a mailed report, and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine.

It is no longer necessary for applicants to submit a "Form B" employment verification and a "Form A" Claims History Form.

6. **Approval of Meeting Calendar**

There was no vote on the proposed meeting dates for the Advisory Board on the 2022 calendar. This item was tabled to the next scheduled meeting on February 4, 2022.

7. **Election of Officers**

Announcements:

Ms. Archer provided the licensing report. There are 74 current active licensed midwives in Virginia, with 25 out-of-state. There is 1 inactive out-of-state midwife for a grand total of 100 licensed midwives.

Next Meeting Date:

February 4, 2022, at 10:00 a.m.

Adjournment

Rebecca Banks adjourned the meeting at 11:49 a.m.

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Rebecca Banks, CPM, Vice-Chair

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William L. Harp, MD
Executive Director

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Beulah Baptist Archer, Licensing Specialist

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ADVISORY BOARD ON POLYSOMNOGRAPHIC TECHNOLOGY
Minutes
October 8, 2021

The Advisory Board on Polysomnographic Technology met on Friday, October 8, 2021 at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Abdul Amir, MD, Chair
Ronnie Hayes, RPSGT, Vice Chair
Hannah Tyler, RPSGT
Raid Mohaidat, Citizen

MEMBERS ABSENT: Jonathan Clark, RPSGT

STAFF PRESENT: William L. Harp, MD, Executive Director
Michael Sobowale, LLM, Deputy Director, Licensure
Colanthia Opher, Deputy Director, Administration
Delores Cousins, Licensing Specialist

GUESTS PRESENT: None

Call to Order

Dr. Amir called the meeting to order at 1:03 p.m.

Emergency Egress Procedures

Dr. Harp announced the emergency egress procedures.

Roll Call

Roll was called, and a quorum was declared.

Approval of Minutes

Ronnie Hayes moved to approve the minutes of the October 9, 2020 meeting. The motion was seconded by Raid Mohaidat and carried.

Adoption of Agenda

Ronnie Hayes made a motion to adopt the meeting agenda. The motion was seconded by Dr. Amir and carried.

Public Comment

None

New Business

1. 2021 Legislative Update and 2022 Proposals

   Dr. Harp provided an update on legislative actions from the 2021 General Assembly that were of interest to members and briefly mentioned several 2022 DHP legislative proposals.

2. Discussion of Dentists Testing, Treating, and Diagnosing Sleep Apnea

   Advisory Board members discussed a position paper issued by the American Academy of Dental Sleep Medicine (AADSM) which addresses the use by dentists of home sleep apnea tests to diagnose sleep apnea. Members discussed that in order for dentists to treat sleep apnea, they would need to have some specialized training in that area. They were concerned that patients with more complex issues may not be properly managed by those using home sleep apnea tests and possibly jeopardizing the overall health of the patient. The Advisory Board concluded that it will wait for the outcome of the Board of Dentistry's discussion of this issue before revisiting it again.

3. Review of Licensure Requirements

   Michael Sobowale said this topic was placed on the Advisory Board's agenda at the request of the Credentials Committee for the Advisory Board to review the licensing requirements and application questions to determine if they can be further streamlined. The Credentials Committee met on September 20, 2021 to review and recommend which documents required in the licensing process should be primary-source verified, which ones may be submitted as copies, and those that are no longer be needed in the licensing process. The Credentials Committee will be making recommendations on how the licensing process for all professions could be streamlined. The Committee asked that any recommendation made by the Advisory Board be reported at its next meeting on November 8th.

   Members reviewed current licensure requirements for polysomnographic technology license applicants and it was the consensus of members that the application process could be simplified for applicants while still protecting the public. The Board reached a consensus as follows:

License applicants should submit primary-source verification of the following documents: evidence of one of three credentialing pathways: 1. current certification as a Registered Polysomnographic Technologist (RPSGT) by the Board of Registered Polysomnographic Technologists; 2. documentation of the Sleep Disorders Specialist credential from the National Board of Respiratory Care (NBRC-SDS); or 3. a professional certification or credential approved by the Board from an organization or entity that meets the accreditation standards of the Institute for Credentialing Excellence belonging to the National Organization for Competency Assurance. In addition, they must provide primary-source evidence of current certification in Basic Cardiac Life Support (BCLS), National Practitioner Data Bank (NPDB) self-query report and one state license verification.

Copies of the following documents could be accepted: Other state license verifications, if submitted; a digitally-certified electronic copy of the NPDB report in lieu of a mailed report, and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine.

It is no longer necessary for applicants to submit a "Form B" employment verification. Also, it is no longer necessary to provide a notarized BCLS certificate as a copy will suffice.

Approval of Meeting Calendar

Raid Mohaidat voiced concern that there is a religious conflict with the time that the Advisory Board meetings are currently held. Some members are unable to attend meetings due to this conflict.

Following discussion, Ronnie Hayes moved to approve the dates scheduled for the Advisory Board on the 2022 meeting calendar and to change future meetings to start at 2:30 pm, instead of the current 1:00 p.m. Dr. Amir seconded the motion, and it carried.

Election of Officers

Ronnie Hayes moved that Dr. Amir continue as Chair. The motion was seconded by Raid Mohaidat. Raid Mohaidat moved that Ronnie Hayes continue as Vice-Chair. The motion was seconded by Dr. Amir. By unanimous vote, members approved the slate of officers presented.

Announcements:

Delores Cousins gave the licensing statistics report. The Board currently has 472 licensees total with 350 current active in Virginia and 122 out-of-state.

Next Scheduled Meeting:

The next scheduled meeting will be February 4, 2022 @ 2:30 p.m.

Adjournment

There being no other business, the meeting was adjourned at 2:13 p.m.

Abdul Amir, MD, Chair

William L. Harp, MD, Executive Director

Delores Cousins, Licensing Specialist

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ADVISORY BOARD ON SURGICAL ASSISTING
Minutes
October 12, 2021

The Advisory Board on Surgical Assisting met on Tuesday, October 12, 2021 at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Deborah Redmond, LSA - Chair
Jessica Wilhelm, LSA - Vice-Chair
Srikanth Mahavadi, MD
Nicole Meredith, RN

MEMBERS ABSENT: Thomas Gochenour, LSA

STAFF PRESENT: William L. Harp, MD, Executive Director
Michael Sobowale, LLM, Deputy Director, Licensure
Delores Cousins, Licensure Specialist

GUESTS PRESENT: David B. Jennette, NSAA
Kelsey Wilkinson, Medical Society of Virginia

Call to Order

Deborah Redmond called meeting to order at 10:04 a.m.

Emergency Egress Procedures

Dr. Harp announced the emergency egress procedures.

Roll Call

Delores Cousins called the roll, and a quorum was declared.

Approval of Minutes

Nicole Meredith moved to approve the minutes of the June 1, 2021 meeting as presented. Dr. Mahavadi seconded the motion. The motion carried.

Adoption of Agenda

Jessica Wilhelm moved to approve the agenda as presented. Dr. Mahavadi seconded the motion. The motion carried.

Public Comment

David Jennette, Chief Administrative Officer for the National Surgical Assistant Association (NSSA), provided brief comments on NSSA's licensed surgical assistant renewal process. He mentioned that surgical assistants can obtain National Commission for the Certification of Surgical Assistants (NCCSA) credits through its recertification process. The Board can validate continuing education units or courses taken, as verified by the NCCSA. He also expressed NSSA's support of the National Center for Competency Testing's (NCCT) request to add it as a credentialing pathway for surgical technologists, in addition to the National Board of Surgical Technology and Surgical Assisting.

New Business

1. 2021 Legislative Update and 2022 Proposals

   Dr. Harp provided an update on legislative actions from the 2021 General Assembly that were of interest to members and briefly mentioned several 2022 DHP legislative proposals.

2. Regulatory Report

   Dr. Harp gave a brief report of the regulatory actions for the Board of Medicine from the 2021 General Assembly. He made special mention of the action voted upon by the Advisory Board at the June meeting to amend regulations to conform its regulation to the 2021 legislation for certification of surgical technologists and approve an amendment for surgical assistants consistent with other licensed professions.

3. Correspondence re: NCCT Credential, Renewal Application & Licensure/Certification

   Ms. Redmond led the discussion. The correspondence received by the Board pertaining to renewal application for surgical assistants have been addressed to her satisfaction prior to the meeting. It was discussed that NCCT could have sought to be added as a credentialing organization prior to the passage of the legislation and approval of regulations for surgical technologists.

4. Review of Licensure/Certification Requirements

   Michael Sobowale said this topic was placed on the Advisory Board's agenda at the request of the Credentials Committee for the Advisory Board to review the licensing requirements and application questions to determine if they can be further streamlined. The Credentials Committee met on September 20, 2021 to review and recommend

which documents required in the licensing process should be primary-source verified, which ones may be submitted as copies, and those that are no longer be needed in the licensing process. The Credentials Committee will be making recommendations on how the licensing process for all professions could be streamlined. The Committee asked that any recommendation made by the Advisory Board be reported at its next meeting on November 8th.

Members reviewed current licensure requirements for surgical assistants and certification of surgical technologists. It was the consensus of members that the application process could be simplified for applicants while still protecting the public. The Board approved licensure requirements as follows:

A license applicant as a surgical assistant should submit primary-source verification of the following evidence of one of three credentialing pathways: 1. a current credential as a surgical assistant or surgical first assistant issued by the NBSTSA or NCCSA or their successors; 2. successful completion of a surgical assistant training program during the applicant's service as a member of any branch of the armed forces of the United States; or 3. practice as a surgical assistant in the Commonwealth at any time in the six months immediately prior to July 1, 2020.

An applicant registering with the Board for certification as a surgical technologist should submit primary-source verification of the following evidence of one of three credentialing pathways: 1. a current credential as a surgical technologist issued by the NBSTSA or its successor; 2. successful completion of a training program for surgical technology during the applicant's service as a member of any branch of the armed forces of the United States; or 3. practice as a surgical technologist at any time in the six months immediately prior to July 1, 2021.

For these professions, copies of the following documents could be accepted: a notarized copy of the NBSTSA or NCCSA credential, if mailed by the applicant, and supporting documentation for any question answered 'Yes' on the application form that is deemed non-routine.

It is no longer necessary for applicants to submit a "Form B" employment verification.

5. Approval of 2022 Meeting Calendar

Nicole Meredith moved to approve the proposed meeting dates for the Advisory Board for 2022. Dr. Mahavadi seconded the motion. The schedule of meetings in 2022 was unanimously approved.

6. Election of Officers

Jessica Wilhelm moved to nominate Deborah Redmond to continue as Chair. The motion was seconded by Dr. Mahavadi. Ms. Redmond moved to nominate Jessica

Wilhelm as Vice-Chair. Dr. Mahavadi seconded the motion. The slate of officers was unanimously approved.

Announcements:

Delores Cousins provided licensing statistics as follows: there are currently 395 licensed surgical assistants total with 337 current active in Virginia and 58 out-of-state. There are currently 269 registered surgical technologists in total, with 259 current active in Virginia and 10 out-of-state.

Next Scheduled Meeting:

The next scheduled meeting will be February 7, 2022 @ 10:00 a.m.

Adjournment

There being no other business, the meeting was adjourned at 11:35 a.m.

_____
Deborah Redmond LSA, Chair

_____
William L. Harp, MD, Executive Director

_____
Delores Cousins, Licensing Specialist

---DRAFT ---

ADVISORY BOARD ON BEHAVIOR ANALYSIS
Minutes
January 31, 2022

The Advisory Board on Behavior Analysis met on Monday, January 31, 2022, at 10:00 a.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, Virginia.

MEMBERS PRESENT: Christina Giuliano, LBA
Mark Llobell, Citizen Member
Jerita Dubash, D.O.
Autumn Kaufman, LBA

MEMBERS ABSENT: Steven Hoprich, LaBA

STAFF PRESENT: William L. Harp, M.D., Executive Director
Michael Sobowale, LL.M., Deputy Executive Director
Colanthia M. Opher, Deputy Executive Director
Elaine Yeatts, DHP Senior Policy Analyst
Erin Barrett, J.D.
Beulah Baptist Archer, Licensing Specialist

GUESTS PRESENT: Christy Evanko, VABA

CALL TO ORDER

Christina Giuliano called the meeting to order at 10:02 a.m.

EMERGENCY EGRESS PROCEDURES

Dr. Harp announced the emergency egress procedures.

ROLL CALL

Beulah Archer called the roll. A quorum was established.

APPROVAL OF MINUTES OF OCTOBER 5, 2020

Mark Llobel moved to approve the minutes from the October 5, 2020 meeting. Jerita Dubash seconded. Motion carried.

---DRAFT ---

ADOPTION OF AGENDA

Mark Llobell moved to adopt the agenda. Jerita Dubash seconded. The agenda was adopted as presented.

PUBLIC COMMENT

Christy Evanko provided public comment expressing the Virginia Behavior Analysts members' support for House Bill 751 which adds practitioners of behavior analysis to the list of individuals required to report suspected adult or child abuse or neglect. She also stated that members were pleased about House Joint Resolution 151 which designates the week of March 20, in 2022 and in each succeeding year, as Behavior Analysis Week in Virginia.

NEW BUSINESS

1. Report of Regulatory Actions and 2022 General Assembly

   There were no regulatory actions affecting the Board but Mrs. Yeatts discussed various bills of interest currently pending in the General Assembly in the current legislative session. She highlighted HB 444 that amends existing provisions concerning holding of electronic meetings.

2. Behavior Analysis Licensure Requirements

   Mr. Sobowale discussed the newly streamlined licensure process for the behavior analysis advisory board to include only one primary-source state license verification, BACB professional certification, and acceptance of a digitally-certified copy of the National Practitioner Data Bank report.

3. Approval of 2022 Meeting Calendar

   Mark Llobell motioned to adopt the 2022 meeting calendar. Autumn Kaufman seconded. Motion carried.

4. Election of Officers

   Christina Giuliano opened the floor for nominations. Mark Llobell motioned to keep the current officers in place. Autumn Kaufman seconded. Motion carried. Christina Giuliano remains Chair and Autumn Kaufman remains vice-chair.

ANNOUNCEMENTS

None

NEXT MEETING DATE

---DRAFT ---

May 23, 2022 @ 10:00 p.m.

ADJOURNMENT

There being no other business, Christina Giuliano adjourned the meeting 10:45 a.m.

Christina Giuliano, LBA Chair

William L. Harp, MD, Executive Director

Beulah Baptist Archer, Recording Secretary
On behalf of Pam Smith, Licensing Specialist

---DRAFT ---

ADVISORY BOARD ON RADIOLOGIC TECHNOLOGY
Minutes
February 2, 2022

The Advisory Board on Radiologic Technology met on Wednesday, February 2, 2022, at 1:00 p.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia. 23233.

MEMBERS PRESENT: Joyce O. Hawkins, RT, Chair
Rebecca Keith, RT, Vice-Chair
Uma Prasad, MD

MEMBERS ABSENT: David Roberts, RT

STAFF PRESENT: William L. Harp, MD - Executive Director
Michael Sobowale, LLM - Deputy Director for Licensing
Colanthia Opher - Deputy Director for Administration
Elaine Yeatts - DHP Senior Policy Analyst
Erin Barrett, JD - DHP Senior Policy Analyst
Beulah Baptist Archer - Licensing Specialist

GUESTS PRESENT: Nicholas "Nick" G. Gimmi R.T. (R)(CT), BSRT

CALL TO ORDER

Joyce Hawkins called the meeting to order at 1:00 p.m.

EMERGENCY EGRESS PROCEDURES

Dr. Harp gave the emergency egress procedures.

ROLL CALL

Beulah Archer called the roll. A quorum was established.

APPROVAL OF MINUTES – October 6, 2021

Joyce Hawkins requested to change the acronym, "***VSRC***" on page 2 under "New Business" to "***VSRT***". Rebecca Keith moved to approve the minutes with the suggested change. Dr. Prasad seconded. The minutes were approved with the suggested amendment.

ADOPTION OF AGENDA

Rebecca Keith moved to approve and amend the agenda. Dr. Prasad seconded. The agenda was adopted as amended.

PUBLIC COMMENT

Mr. Nicholas "Nick" Gimmi spoke in support of maintaining the ARRT credentials for initial licensure and renewal of licensure. He addressed the importance of maintaining concrete oversight of continuing education credits for all ARRT-certified technologists. He read a letter written by Mary Loritsch, former Advisory Board member and RT Program Director, in support of this measure.

OLD BUSINESS

ARRT Credentials for License Renewal

Rebecca Keith moved that this matter be removed from the table for discussion. Dr. Prasad seconded, and the motion carried.

Ms. Yeatts suggested that the following questions should be asked and additional information gathered before the Advisory Board can consider bringing the topic up for a full discussion:

- What is required to maintain ARRT certification?
- What is the advantage to the patient from a public safety standpoint with regards to licensees maintaining their continuing education through the ARRT and their oversight of continuing education credits?
- What does the Board do if you don't maintain your ARRT certificate?

From a data standpoint,

- How many radiologic technology licensees of the Board have not maintained their ARRT certifications?
- What is the number of those licensed in Virginia do not have a Virginia address?

Members discussed tabling the matter for further discussion at the May meeting.

NEW BUSINESS

1. **Report of Regulatory Actions and 2022 General Assembly**

   Ms. Yeatts stated that there are currently no regulatory actions affecting the Board. She then discussed current bills pending in the 2022 General Assembly highlighting those that were of interest to members.

Announcements:

Licensing Statistics
Beulah Baptist Archer provided the following report:

Limited Radiologic Technologist	Virginia	Current Active	449
	Virginia	Current Inactive	19
	Out of State	Current Active	22
	Out of State	Current Inactive	1
Total			**491**
Radiologic Technologist	Virginia	Current Active	3,302
	Virginia	Current Inactive	30
	Out of State	Current Active	948
	Out of State	Current Inactive	15
Total			**4,295**
Radiologist Assistant	Virginia	Current Active	12
	Out of State	Current Active	1
Total			**13**

Next Meeting Date

Next Scheduled Meeting: May 25, 2022 at 1:00 p.m.

Adjournment

With no other business to conduct, Joyce O. Hawkins adjourned the meeting 2:33 p.m.

Joyce O. Hawkins, RT, Chair

William L. Harp, MD, Executive Director

Beulah Baptist Archer, Licensing Specialist

<< DRAFT >>

ADVISORY BOARD ON SURGICAL ASSISTING
Minutes
February 7, 2022

The Advisory Board on Surgical Assisting met on Monday, February 7, 2022 at 10:00 a.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Deborah Redmond, LSA - Chair
Jessica Wilhelm, LSA - Vice-Chair
Srikanth Mahavadi, MD
Nicole Meredith, RN
Thomas Gochenour, LSA

MEMBERS ABSENT: None

STAFF PRESENT: William L. Harp, MD - Executive Director
Michael Sobowale, LLM - Deputy Executive Director, Licensure
Colanthia M. Opher - Deputy Executive Director, Administration
Elaine Yeatts - DHP Senior Policy Analyst
Erin Barrett, JD - DHP Senior Policy Analyst
Delores Cousins - Licensing Specialist

GUESTS PRESENT: Hunter Jamerson – Virginia Association of Surgical Assistants

CALL TO ORDER

Deborah Redmond called the meeting to order at 10:00 am.

EMERGENCY EGRESS PROCEDURES

Dr. Harp gave the emergency egress procedures.

ROLL CALL

Roll was called, and a quorum was declared.

PUBLIC HEARING

Deborah Redmond opened the floor for public comment on the proposed regulations that amend the current regulations for surgical assistants to achieve consistency with other licensed professions.

Hunter Jamerson spoke in support of the proposed regulations and stated that he believes they are appropriate for the profession. Ms. Yeatts reminded members that public comment can still be received up until April 1, 2022. After the public comment period is over, the Advisory Board will review the comment received at its May meeting and make a recommendation to the full Board for adoption at its June meeting.

Hearing no other comment, Ms. Redmond closed the public hearing.

APPROVAL OF MINUTES

Thomas Gochenour moved to approve the minutes of the October 12, 2021 meeting. Srikanth Mahavadi seconded the motion. The minutes were approved as presented.

ADOPTION OF AGENDA

The agenda was accepted as presented.

PUBLIC COMMENT

Mr. Jamerson commented on House Bill 598. He stated that under current law, certified surgical technologist is a trademarked credential. He informed members that Chester Career College is currently seeking accreditation to train surgical technologists. He expressed support for HB598 which extends the grandfathering clause for those who had previously been practicing as a surgical technologist or attended a surgical technologist training program any time prior to October 1, 2022 to register with the Board for certification by December 31, 2022.

NEW BUSINESS

1. Report of Regulatory Actions and 2022 General Assembly

   Ms. Yeatts discussed various bills of interest in the 2022 Session. She highlighted House Bill 598 which extends the grandfather clause for surgical technologists until December 31, 2022.

2. Grace Period for Registration of Surgical Technologists

   Ms. Redmond stated that this topic has already been covered by the discussion held on House Bill 598. No further action required.

3. Graduate Students and Licensure

Members discussed recommending to the Board of Medicine that it support a proposal to allow SA/ST students who have graduated from a program to begin practicing as a surgical assistant or surgical technologist while waiting to sit for the national certification examination. This would be similar to the "license-applicant" status that occupational therapy and other professions have in their law. The graduate SA/ST would be allowed to practice for 3 to 6 months or until failure of the exam. Passage of the exam during the same period would lead to licensure.

4. Reinstatement of Certification for Surgical Technologists

Mr. Sobowale informed members that the Board currently lacks a certification reinstatement process for surgical technologists. He asked members to consider putting in place regulations that would provide guidance on how a surgical technologist whose registered certification with the Board has expired can apply to the Board to have the certification reinstated for practice after the expiration period. After a brief discussion, members decided to table the item and add the topic for additional discussion on the agenda at the May meeting.

ANNOUCEMENTS

Licensing Statistics

Delores Cousins gave a report on licenses issued for licensed surgical assistants and certified surgical technologists. There are currently 410 active licensed surgical assistants in Virginia and 72 out of state, for a total of 482. There are 577 certified surgical technologists in Virginia and 72 out of state, for a total of 649.

Next Meeting Date:

The next meeting is scheduled to be held on Tuesday, May 31, 2022 at 10:00 a.m.

ADJOURNMENT

With no other business to conduct, Deborah Redmond adjourned the meeting at 11:16 a.m.

Deborah Redmond, LSA, Chair

William L. Harp, MD, Executive Director

Delores Cousins, License Specialist

Agenda Item: **Other Reports**

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

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

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

Virginia Department of Health Professions
Board of Health Professions

Draft Meeting Minutes

Full Board Meeting
December 2, 2021

Call to Order
The December 2, 2021, Virginia Board of Health Professions (Board) meeting was called to order at 9:46 a.m. at the Department of Health Professions (DHP), Perimeter Center, 9960 Mayland Drive, 2nd Floor, Board Room 2, Henrico, Virginia 23233.

Presiding Officer – James Wells, RPh, Chair

Board Members Present
Barry Alvarez, LMFT, Board of Counseling
Margaret Lemaster, RDH, Board of Dentistry
Mitchell Davis, NHA, Board of Long-Term Care Administrators
Brenda Stokes, MD, Board of Medicine
Sarah Melton, PHARMD, Board of Pharmacy
Allen Jones, Jr., DPT, PT, Board of Physical Therapy
Steve Karras, DVM, Board of Veterinary Medicine
Carmina Bautista, MSN, FNP-BC, BC-ADM, Citizen Member
Sahil Chaudhary, Citizen Member

Members Not Present
Alison King, PhD, CCC-SLP, Board of Audiology & Speech Language-Pathology
Kenneth Hickey, MD, Board of Funeral Directors and Embalmers
Ann Gleason, PhD, Board of Nursing
Helene Clayton-Jeter, OD, Board of Optometry
Susan Wallace, PhD, Board of Psychology
Michael Hayter, LCSW, CSAC, SAP, Board of Social Work
Sheila Battle, MHS, Citizen Member
Martha Rackets, PhD, Citizen Member

Staff Present
Leslie L. Knachel, Executive Director, Board of Health Professions
David E. Brown, DC, Agency Director
Barbara Allison-Bryan, MD, Chief Deputy Director
Elaine Yeatts, Sr. Policy Analyst
Charis Mitchell, Assistant Attorney General, Board Counsel
Sylvia Robinson, Administrative Assistant
Corie Tillman Wolf, JD, Executive Director, Boards of Funeral Directors & Embalmers, Long-Term Care Administrators and Physical Therapy
Jay Douglas, MSM, RN, CSAC, FRE, Executive Director, Board of Nursing
Jaime Hoyle, JD, Executive Director, Boards of Counseling, Psychology and Social Work
Sandra Reen, Executive Director, Board of Dentistry
William Harp, MD, Executive Director, Board of Medicine

Public Present
No public attended.

Establishment of Quorum
With ten board members present, a quorum was established.

Mission Statement
Mr. Wells read the Department of Health Professions' mission statement.

Introductions
Since its last meeting, the Board received multiple new board member appointments, a new executive director and new board staff. Mr. Wells requested that all members in attendance introduce themselves.

Ordering of Agenda
The agenda was accepted as presented.

Public Comment
There were no requests to provide public comment.

Approval of Minutes
Mr. Wells opened the floor to any edits or corrections regarding the draft minutes from the January 21, 2021 Nominating Committee meeting minutes and the May 13, 2021 Full Board meeting minutes. Hearing none, Mr. Wells stated that the minutes were approved as presented.

Director's Report – David E. Brown, D.C., Director
Dr. Allison-Bryan provided an update on current COVID-19 statistics. Based on this information, Dr. Brown advised that DHP employees would not be returning to the office on January 3, 2022, as originally planned.

Dr. Brown presented Dr. Elizabeth Carter, Chief Data Scientist for the agency, with a plaque for her many years of service as the Executive Director for the Board of Health Professions.

Legislative and Regulatory Report – Elaine Yeatts
Ms. Yeatts provided an overview of the agency's regulatory boards' current actions, 2021 general assembly regulatory/policy actions and reports submitted to the general assembly.

Policy Action – Consideration of Electronic Meeting Policy
Ms. Yeatts provided information on the purpose of the Electronic Meeting policy.

Dr. Jones, Jr. made a motion to adopt the Electronic Meeting Policy as presented. Dr. Stokes seconded the motion. The motion carried unanimously.

Board Discussion Items

Review of § 54.1-2510. Powers and Duties of Board of Health Professions
Ms. Knachel provided a review of the Powers and Duties of the Board of Health Professions.

Practitioner Self Referral: Peninsula Vascular Center, PC

Closed Session - A motion was made by Dr. Karras to convene a closed meeting to reach a decision in the matter regarding the agency subordinate recommendation for the Application for Practitioner Self-Referral Advisory Opinion for Peninsula Vascular Center, PC. Additionally, Dr. Karras moved that Ms. Knachel and Ms. Mitchell attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded by Dr. Stokes. The motion carried unanimously. Mr. Wells did not attend the closed meeting.

Reconvene – Dr. Karras moved that the Board certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded by Mr. Chaudhary. The motion carried unanimously.

Decision - Dr. Jones, Jr., made a motion to adopt the Practitioner Self-Referral recommendation for Peninsula Vascular Center, PC as presented. Dr. Stokes seconded the motion. The motion carried with nine votes in favor of the motion. Mr. Wells abstained.

Amendments to Guidance Document 75-4 Bylaws

Ms. Knachel reviewed the recommended amendments to Guidance Document 75-4 Bylaws. Based on the current bylaws, a vote on the proposed changes will be taken at the next meeting of the Board.

Board Member Training

Ms. Knachel asked that the Board discuss training recommendations for board members. The Board requested training be provided on Conflict of Interest, FOIA and Sanction Reference Points.

Format for Individual Board Reports

Ms. Knachel presented information regarding board reports and opened the floor to discussion. Meeting minutes, report topics and executive director recommendations were discussed. The Board requested that Ms. Knachel discuss format options with the Board Executive Directors and present options at the next meeting.

Board Counsel Report

Ms. Mitchell stated she had nothing to report.

Board Chair's Report

Mr. Wells thanked the board members for their attendance at the meeting and the good work that the Board does in service to the Commonwealth.

Staff Reports

Executive Director's Report

Ms. Knachel reviewed the proposed 2022 board meeting calendar dates. She was asked to review with Mr. Wells the committee assignments and provide an explanation of the responsibilities for each of the Board's Committees.

New Business

There was no new business to report.

Next Meeting
The next full board meeting is scheduled for Tuesday, March 29, 2022.

Adjournment
With no objection, Mr. Wells adjourned the meeting at 12:00 p.m.

_____

Leslie L. Knachel, Executive Director Date

DRAFT

Quality
Safety
Integrity

Licensure
Regulation
Practice

FEDERATION OF PODIATRIC MEDICAL BOARDS

2021 Fall Meeting Agenda

1. Roll Call & Introductory Remarks
2. Vision & Mission Statements
3. Announcements and Updates
4. Joint Task Force
5. Member Boards Round Robin
6. Adjournment

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Quality
Safety
Integrity

Licensure
Regulation
Practice

Federation of Podiatric Medical Boards

Roll Call & Introductory Remarks

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Roll Call

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Introductory Remarks

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Introductory Remarks

Barbara A. Campbell, DPM

- President, **FPMB**
- President, **Arizona** State Board of Podiatry Examiners

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Quality
Safety
Integrity

Licensure
Regulation
Practice

Federation of Podiatric Medical Boards

Vision and Mission Statements

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Vision Statement

The FPMB is an empowering leader, helping Member Boards work independently and collectively to promote and protect the public's podiatric health, safety, and welfare.

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Mission Statement

To be a leader in improving the quality, safety, and integrity of podiatric medical health care by promoting high standards for podiatric physician licensure, regulation, and practice.

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Quality
Safety
Integrity

Licensure
Regulation
Practice

Federation of Podiatric Medical Boards

Announcements & Updates

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Presentation Objectives

ANNOUNCEMENTS

- New Member/Affiliate Boards
- Executive Board Vacancy in 2022
- Important Dates/Reminders

UPDATES

- Primary Source Verification *(Licensure)*
- Applicant / Application Statistics

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ANNOUNCEMENT

New Member/ Affiliate Boards

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New Member Board

U.S. Virgin Islands Board of Medicine

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New Affiliate Member

College of Physicians and Surgeons of British Columbia

Amalgamated with the College

of Podiatric Surgeons of British

Columbia on August 31, 2020

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ANNOUNCEMENT

Executive Board Vacancy in 2022

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Board Vacancy in 2022

ARTICLE IV. BOARD OF DIRECTORS

SECTION A. MEMBERSHIP AND TERMS

TERMS: Directors-at-Large shall each serve for a term of four (4) years and shall be eligible to be reelected to one (1) additional term.

SECTION B. NOMINATIONS

Nominees must be members or employees of a **dues-paid** Member Podiatric Medical Board at the time of election, and must not have previously served on the FPMB Board of Directors during the previous three (3) years.

Nomination and application process begins in early 2022.

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Board Vacancy in 2022 *(cont.)*

Opportunity to Serve on Additional Boards and Committees

- **National Board of Podiatric Medical Examiners (NBPME)**
  - Two NBPME Board Members are selected from FPMB nominations
- **Continuing Education Committee (CEC) of the Council on Podiatric Medical Education (CPME)**
  - One CEC committee members selected from FPMB nominations
- **Federation of State Medical Boards (FSMB)**
  - Eligibility for appointment to FSMB Standing and Special committees or other appointive capacities

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ANNOUNCEMENT

Important Dates/Reminders

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Important Dates/Reminders

- **Member Board Update Forms**
  - September 30, 2021
- **FY 2021-2022 Member Dues**
  - October 31, 2021
- **Nominations/Applications for FPMB Board Position**
  - Early 2022
- **2022 Annual Meeting**
  - Mid-May 2022

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UPDATE

Primary Source Verification *(Licensure)*

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Primary Source Verification (Licensure)

The FPMB reports all APMLE examinations (Part I/CSPE/II/III) results, and disciplinary actions, to Member Boards.

Reports Ordered via Online System
100.00%

FPMB - Median Report Processing Time
< 1 business hour

Member Boards - Electronic Delivery
53

Member Boards - Median Download Time
4.2 business hours

Statistics above based on data from Q1-Q3 2021

122

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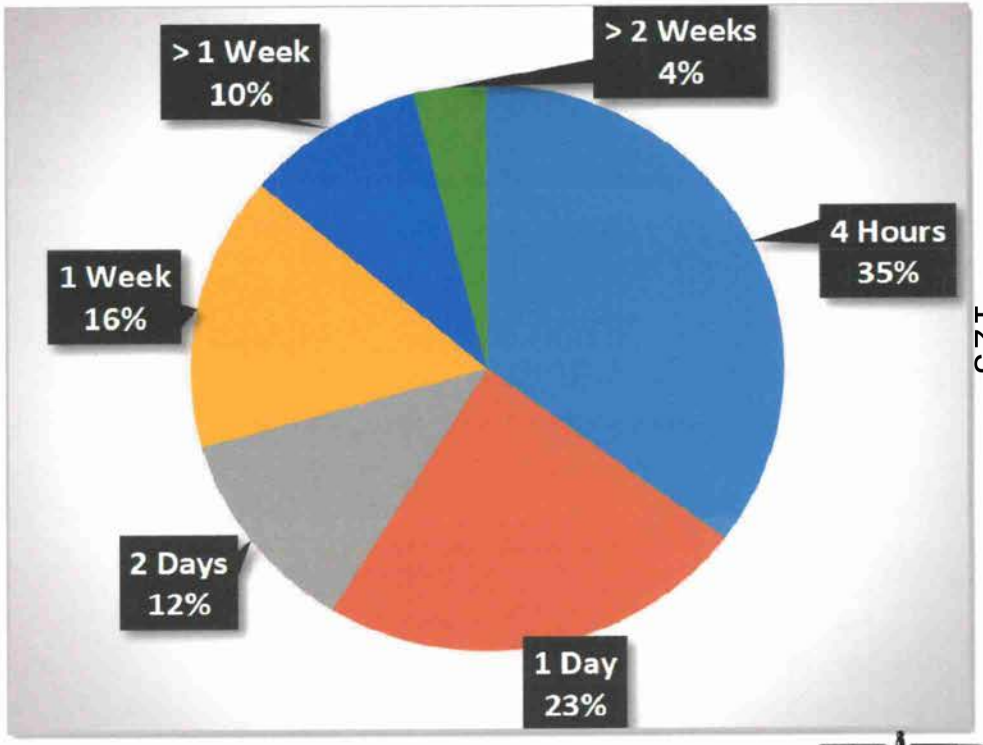
Primary Source Verification (Licensure) *(cont.)*

The FPMB is the **easiest** and **fastest** part of the licensure process:

- **Online ordering** provides 24/7/365 convenience to podiatrists.
- FPMB processes report requests **expeditiously**.
- **Electronic delivery** ensures Member Boards receive reports instantly.

"This licensing stuff is so onerous these days. Your platform is the easiest!!"



Member Board report download time in Q1-Q3 2021

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UPDATE

Applicant / Application Statistics

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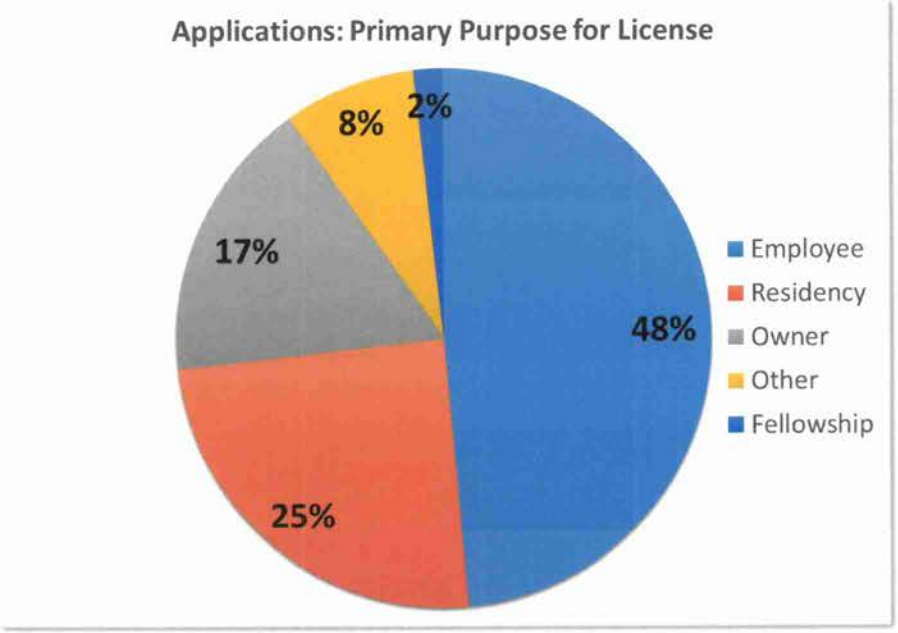
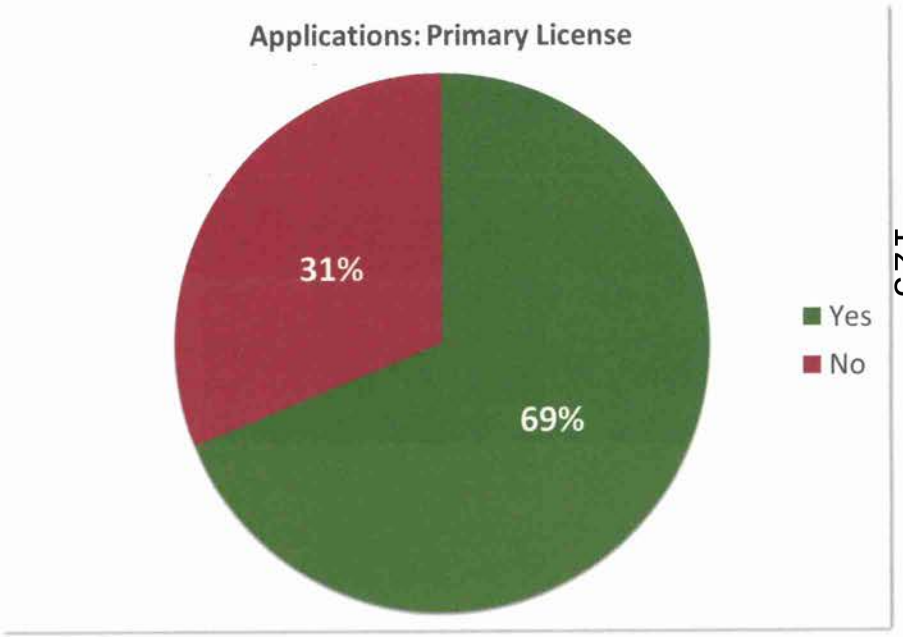
Applicant / Application Statistics





**** NEW from the FPMB Data Initiative (all data from Q3 2021) ****

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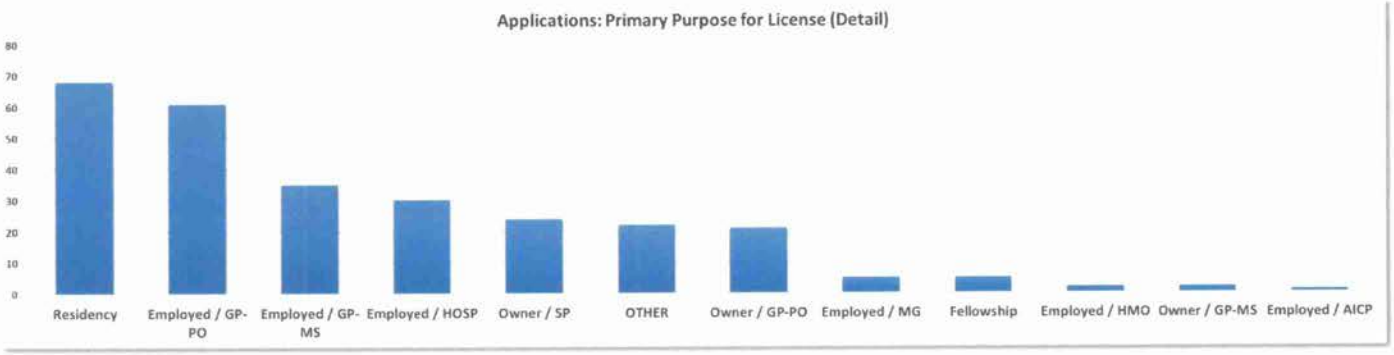
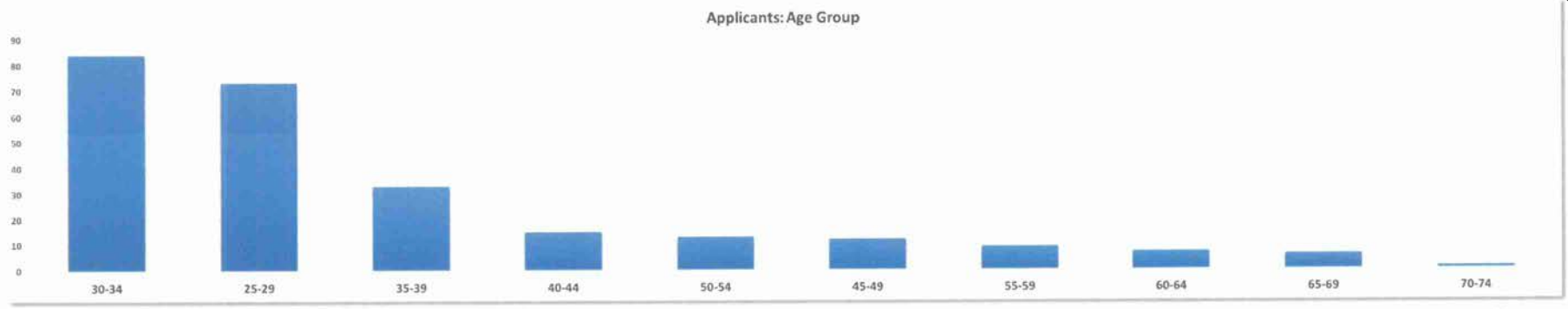
Applicant / Application Statistics *(cont.)*



PRIMARY PURPOSE KEY:

Residency: Residency
Fellowship: Fellowship
Owner / SP: Owner / Solo Practice
Owner / GP-PO: Owner / Group Practice-Podiatry Only
Owner / GP-MS: Owner / Group Practice-Multi Specialty
Employed / GP-PO: Employed / Group Practice-Podiatry Only
Employed / GP-MS: Employed / Group Practice-Multi Specialty
Employed / HOSP: Employed / Hospital
Employed / HMO: Employed / HMO
Employed / HP: Employed / Health Plan
Employed / MG: Employed / Military or Government
Employed / AICP: Employed / Academic Institution, participating in Clinical Practice
Employed / AIRT: Employed / Academic Institution, Research/Teaching, Only (no Clinical Practice)
Retired: Retired
OTHER: Other (specify)



**** NEW from the FPMB Data Initiative (all data from Q3 2021) ****

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Announcements and Updates

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Quality
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Joint Task Force of Orthopaedic Surgeons and Podiatric Surgeons

(White Paper & AMA Resolution)

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Presentation Objectives

- The "Big Picture" – Parity & Challenges
- Joint Task Force, White Paper, and AMA Resolution
- APMA Statement to Licensing Boards

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Presentation Objectives *(cont.)*

- Relevance to FPMB Member Boards
- Implications and Discussion

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The "Big Picture": Parity & Challenges

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The "Big Picture": Parity & Challenges *(cont.)*

- The APMA is involved in physician parity, including the issues of scope of practice, inequitable reimbursement, hospital privileging, etc.
- In 2006, APMA established "Vision 2015," a multifaceted plan to achieve physician parity

apma
Advancing foot and ankle medicine and surgery

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The "Big Picture": Parity & Challenges *(cont.)*

- Podiatry experiences challenges to parity, including scope of practice, that fail to recognize the education, training, and experience of today's podiatrist
- **Examples:**
  - **American Academy of Orthopaedic Surgeons (AAOS)**
    - Tips for Limiting Scope of Practice Expansion *(June 2015)*
    - Concerns Regarding S. 2175, Department of Veterans Affairs Provider Equity Act *(February 2016)*
  - **American Orthopaedic Foot & Ankle Society (AOFAS)**
    - If You're Not at the Table, You're on the Menu *(Spring 2019)*

AAOS
AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

AOFAS
AMERICAN ORTHOPAEDIC FOOT & ANKLE SOCIETY®

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Joint Task Force, White Paper, and AMA Resolution

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Joint Task Force, White Paper, & Resolution

The **Joint Task Force of Orthopaedic Surgeons and Podiatric Surgeons (Joint Task Force)** was formed in 2018 by **AAOS**, **ACFAS**, **AOFAS**, and **APMA** with two objectives:

1. To further mutually beneficial policy initiatives, both on the state and federal level, and to help mitigate differences
2. To compare the education and training of current and future graduates of podiatric medical schools, with the goal of reaching consensus on options for education, training, and certification of podiatric surgeons that may lead to recognition of podiatrists as physicians

AAOS
American Academy of Orthopaedic Surgeons

American College of Foot and Ankle Surgeons®
Proven leaders. Lifelong learners. Changing lives.

AOFAS American Orthopaedic Foot & Ankle Society®

apma
Advancing foot and ankle medicine and surgery

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Joint Task Force, White Paper, & Resolution *(cont.)*

- On May 6, 2021, the Joint Task Force unanimously endorsed a white paper, which addresses the goal of equivalency in education pathways and certification, and a resolution for consideration and approval at an American Medical Association (AMA) House of Delegates
  - "RESOLVED, … whether CPME accreditation standards are comparable to Liaison Committee on Medical Education (LCME) standards and sufficient to meet requirements which would allow DPMs to take all parts of the USMLE."

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APMA Statement to Licensing Boards

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APMA Statement to Licensing Boards

Statement to Licensing Boards (May 10, 2021)

James R. Christina, DPM, APMA Executive Director/CEO

"It will certainly take several more years until we will even know if NBME will grant podiatrists access to take the USMLE ... If and when we gain access to the USMLE, ... [h]ow this will eventually affect podiatrists and their licensure is unknown at this point ... For now, and the foreseeable future, the podiatry licensing boards will be the only ones licensing podiatrists for practice and any change to the exam used (APMLE from the NBPME) would have to go through state legislatures."

apma

Advancing foot and ankle medicine and surgery

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Relevance to FPMB Member Boards

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Relevance to FPMB Member Boards *(cont.)*

- The white paper and AMA resolution focus on access to the USMLE, a medical licensure exam for allopathic physicians
- APMA's announcement of the AMA resolution noted:
  - "[The] APMA strongly believes that DPMs are physicians and surgeons whose education and training are comparable to the education and training of MDs and DOs. [The] association therefore supports a uniform model for licensing to demonstrate to health-care consumers that DPMs have met the same rigorous standards as other physicians."

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Relevance to FPMB Member Boards *(cont.)*

- Licensing exams, scope of practice, physician definition in statutes, etc. all intersect with state licensing and regulatory boards, as well as the mission of the FPMB:
  - To be a leader in improving the quality, safety, and integrity of podiatric medical health care by promoting high standards for **podiatric physician licensure, regulation, and practice**.

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Implications and Discussion

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Implications and Discussion

- The FPMB is a member of the **Federation of State Medical Boards (FSMB)** that co-sponsors the USMLE with NBME
- FSMB has shared with the FPMB the USMLE's response to the Joint Task Force request for USMLE eligibility

Federation of STATE MEDICAL BOARDS

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Implications and Discussion *(cont.)*

- *Podiatric education and training, while comprehensive for the advancement of quality podiatric care, may be too narrow given the USMLE's focus on the generalized practice of medicine across all medical and surgical specialties.*
- *Opening USMLE to DPMs is not permitted under the contractual agreement between FSMB and NBME establishing USMLE, which limits eligibility to students and graduates of medical school.*
- *We must respectfully decline your request.*

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Implications and Discussion *(cont.)*

- What engagement have you had with the Joint Task Force or any organization regarding the USMLE effort?
  - Has the FPMB effort to organization and publicize information related to this effort been helpful to your understanding?
- What is your view of pursuing the USMLE eligibility direction now?
- If a path forward still exists *(i.e., changes to education and a USMLE contract change)* that would lead to DPMs having access to the USMLE, how might this impact:
  - Licensure, including scope of practice, CMEs, etc.
  - Statutes, regulations, and rules
  - Structure of podiatric licensing and regulatory boards

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Implications and Discussion *(cont.)*

- What path(s) should be pursued that would move podiatry towards parity, particularly with scope of practice?
  - Scope of practice is specifically relevant to state licensing and regulatory boards of podiatry
  - Greater consistency in scope of practice nationally is consistent with increased license portability, a key component to occupational licensure reform and multi-state licensure (i.e., compacts)

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Joint Task Force of Orthopaedic Surgeons and Podiatric Surgeons - White Paper

Improving the Standardization Process for Assessment of Podiatric Medical Students and Residents by Enabling Them to Take the USMLE

According to the National Board of Medical Examiners (NBME), "All medical boards in the United States accept a passing score on the United States Medical Licensure Examination (USMLE) as evidence that an applicant demonstrates the core competencies to practice medicine. As a result, healthcare consumers throughout the nation enjoy a high degree of confidence that their doctors have met a common standard." Patients, as well as referring health care professionals should be able to have the same high degree of confidence that Doctors of Podiatric Medicine (DPMs) have also met this common standard as they provide medical and surgical care to patients within their scope of practice. To accomplish this goal, and be considered physicians within their scope of practice, DPMs should be required to receive sufficient education and training to allow them to take and pass the USMLE.

Medical associations have long supported a uniform standard for licensing, including a public position saying that changes in licensure by non-MD/DO practitioners must be based on education, training, and experience, to ensure patient safety. This is the same position held by the American Podiatric Medical Association and the American College of Foot and Ankle Surgeons.

In 1961, podiatric medicine underwent its own version of allopathic medicine's Flexner Report. This was known as the Selden Commission Report, which led to advances in faculty development and improvements in podiatric education, Hospital-based postgraduate podiatric training programs were instituted in 1956, and these training programs have been officially approved by the Council on Podiatric Medical Education (CPME) as podiatric residency programs since 1965. Subsequently, efforts to advance podiatric training and education have continued, leading to increased standardization of podiatric residency training and expansion to mandatory three-year, comprehensive programs in 2013.

Once licensed, DPMs can independently diagnose and treat human ailments within their scope of practice, which includes performing surgery in ambulatory and hospital settings, writing prescriptions, and ordering diagnostic studies. To be considered physicians, DPMs should take and pass the three-part USMLE. Following the model of MD and DO graduates, meeting this common standard along with the successful completion of state licensure requirements is essential to maintaining public trust.

There is a lack of consensus among the four organizations as to whether DPMs should currently be considered to be physicians. All four organizations agree that DPMs that meet the four goals listed at the end of this white paper would be considered physicians within their scope of practice. This white paper does not address the different uses of the term physician within both state and federal laws and should not be construed as supporting the removal of any rights currently held by DPMs, nor supporting any effort to prevent DPMs from practicing under their title, status, or scope of practice as currently recognized by state and federal law and non-governmental entities. Furthermore, all four organizations agree that irrespective of their differences with

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respect to the current definition of the term physician, that DPMs, similar to MDs, and DOs, should not be restricted in their ability to appropriately take care of patients within their respective scope of practice, nor in their access to patients based upon type of insurance.

In conclusion, the undersigned believe that the care of patients will be assured by requiring basic medical education that would allow for qualifying DPMs to take and pass all 3 parts of the USMLE. Further, we believe that the question of whether DPMs should be defined as physicians should be decided by mutually agreed upon standards of education, training, and passage of USMLE part 1-3 as opposed to future legislation.

We agree to the following in order for DPMs to be recognized as physicians within their scope of practice by all four organizations:

1. DPMs must pass all 3 parts of the USMLE.

2. Accreditation of colleges of podiatric medicine should meet comparable standards to the Liaison Committee on Medical Education (LCME). We will accept the NBME's determination on whether the CPME accreditation standards are comparable to LCME and sufficient to meet requirements which would allow DPMs to take all parts of the USMLE.

3. CPME approval of podiatric residency programs should meet comparable standards to the Accreditation Council for Graduate Medical Education (ACGME).

4. Board certification for DPMs should meet comparable standards as set forth by the American Board of Medical Specialties (ABMS).

Endorsed, 2020 by: The American Academy of Orthopaedic Surgeons (AAOS), the American College of Foot and Ankle Surgeons (ACFAS), the American Orthopaedic Foot & Ankle Society (AOFAS), and the American Podiatric Medical Association (APMA).

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Joint Task Force of Orthopaedic Surgeons and Podiatric Surgeons - American Medical Association Resolution A-21

Improving the Standardization Process for Assessment of Podiatric Medical Students and Residents by Initiating a Process Enabling Them to Take the USMLE

Introduced by the American Orthopaedic Foot & Ankle Society (AOFAS) and the American Academy of Orthopaedic Surgeons (AAOS)

Whereas, according to the National Board of Medical Examiners (NBME), "All medical boards in the United States accept a passing score on the United States Medical Licensure Examination (USMLE) as evidence that an applicant demonstrates the core competencies to practice medicine. As a result, healthcare consumers throughout the nation enjoy a high degree of confidence that their doctors have met a common standard;" and

Whereas, medical associations have long supported a uniform standard for licensing, including a public position saying that changes in licensure by non-MD/DO practitioners must be based on education, training, and experience, to ensure patient safety. This is the same position held by the American Podiatric Medical Association (APMA) and the American College of Foot and Ankle Surgeons (ACFAS); and

Whereas, patients, as well as referring physicians should be able to have the same high degree of confidence that Doctors of Podiatric Medicine (DPMs) have also met this common standard as they provide medical and surgical care to patients within their scope of practice; and

Whereas, to accomplish this goal, and be considered physicians, DPMs should be required to receive sufficient education and training to take and pass all three parts of the USMLE; and

Whereas, AAOS, AOFAS, APMA, and ACFAS have collaborated and agreed upon the pathway for qualified DPM graduates to take all three parts of the USMLE; and

Whereas, the decision as to whether DPM students and graduates would be permitted to take the USMLE rests with the NBME and would be based in part on whether Council on Podiatric Medical Education (CPME) accreditation standards are comparable to Liaison Committee on Medical Education (LCME) standards and sufficient to meet NBME requirements; and

Whereas, our AMA has the resources to objectively study these standards and if earned, its support would be beneficial to this process; and therefore be it

RESOLVED, that our American Medical Association study, with report back at the 2021 Interim House of Delegates Meeting, whether CPME accreditation standards are comparable to Liaison Committee on Medical Education (LCME) standards and sufficient to meet requirements which would allow DPMs to take all parts of the USMLE.

APMA & ACAFS: **Frequently Asked Questions**

How and when was this initiated and what was the process?
In 2018 a task force was created consisting of leaders from the American Academy of Orthopaedic Surgeons (AAOS), the American College of Foot and Ankle Surgeons (ACFAS), the American Orthopaedic Foot & Ankle Society (AOFAS), and the American Podiatric Medical Association (APMA) to find common ground on the many clinical and policy initiatives that mutually benefit both groups and most importantly our patients. Additionally in 2019, Resolution 4-19 established that the national joint task force will endeavor to enlist the American Medical Association (AMA) to facilitate discussions with the National Board of Medical Examiners (NBME) on allowing DPMs to sit for the United States Medical Licensing Exam (USMLE). The resolution unanimously passed the APMA House of Delegates (HOD). It was endorsed by the American Board of Podiatric Medicine, the American Board of Foot and Ankle Surgery, and ACFAS, and was cosponsored by the APMA Board of Trustees, the American Podiatric Medical Students' Association, and 25 state component societies.

Since 2019, the Joint Task Force of Orthopaedic and Podiatric Surgeons, comprised of two members from each organization's leadership (AAOS, ACFAS, AOFAS, and APMA), began drafts of both the white paper and the AMA resolution. Over the course of two years and extensive review and edits, the joint task force members and their organizations' boards approved the documents released May 6, 2021.

Will access to the USMLE restrict DPMs' scope of practice? No. As the white paper states, "…DPMs, similar to MDs, and DOs, should not be restricted in their ability to appropriately take care of patients within their respective scope of practice, nor in their access to patients based upon type of insurance."

What happens if the resolution passes at the June 2021 AMA HOD meeting?
For you and your practice, there will be no immediate impact. This is a very long process that will take years to complete. The June 2021 AMA HOD is somewhat unique because it is a virtual meeting, which restricts the number of resolutions for consideration. The AMA 2021 "Prioritization Matrix" designates resolutions as either Top, High, Middle, Low, or Not a Priority. Therefore, not every resolution submitted will be heard. The first hurdle is that the resolution gets prioritized to be heard at this HOD. If it is accepted and placed on the priority list, it will be read on the floor of the HOD, options will be heard from AMA members (it could possibly go back to the AMA Council on Medical Education), and/or a vote will proceed. If all of this occurs and the resolution is ultimately approved at the June 2021 HOD, it simply requires AMA to conduct a study with the results presented at the November 2021 HOD. *That study would not be conducted by LCME or NBME, nor would it guarantee that NBME would accept a recommendation that podiatric students and graduates have access to the USMLE.*

What happens if the resolution does NOT pass at the June 2021 AMA HOD?
If it is not considered at the June 2021 HOD, it may be considered at the November 2021 Interim AMA HOD. Depending on whether the meeting is virtual, additional challenges could occur. If the resolution is introduced and does not pass, it is the end of the resolution. A different resolution could potentially be introduced at a future AMA HOD with modifications to satisfy the concerns that caused it not to pass.

Why was this process kept confidential and why did it exclude other stakeholders?

The resolution and white paper took more than two years to gain approval by AAOS, AOFAS, ACFAS, and APMA and required that all organizations would have to agree to any statement before being released. Meticulous review and vetting were conducted by joint task force members and boards from all four organizations, including professional staff and legal counsel. Because of extensive opinions and perspectives on this topic, the joint task force decided it was necessary to keep conversations confidential in order to gain consensus. Other stakeholders will and are being included now that the joint announcement has been published.

How is this going to impact podiatric medical schools? Will schools be required to adjust their curricula to help students pass the USMLE?
In the short term, there is no impact. This process will be a long one. If AMA approves the resolution, conversations and strategies will need to be developed and will require input from a larger group of stakeholders (deans, schools, etc.). Comparability of residency training standards and board certification are far in the future. It is certainly possible some curriculum changes may be required to sufficiently prepare graduates to pass the USMLE. This process may also result in a change in testing and preparation.

Is this white paper about defining the term physician?
No. The purpose of this white paper is not to address the different uses of the term physician within both state and federal laws and should not be construed as supporting the removal of any rights currently held by DPMs, nor supporting any effort to prevent DPMs from practicing under their title, status, or scope of practice as currently recognized by state and federal law and non- governmental entities. If we get access to the USMLE, we will then be able to use those results to further confirm our physician definition. This scenario is similar to what the osteopathic physicians did many years ago.

Are DPMs admitting our education and training are deficient?
No. DPMs' education and training are solid. If DPMs were perceived as being deficient by MDs and DOs, AAOS and AOFAS would not have supported efforts underway to get access to the USMLE, nor would APMA and ACFAS have agreed with this pathway. In 2011, the California Medical Association, the California Orthopedic Association, the Osteopathic Physicians and Surgeons of California, and the California Podiatric Medical Association formed a Physicians and Surgeons Joint Task Force. Its goal was to evaluate podiatric training and education and compare them to those of MDs and DOs. After completing site visits at both podiatric medical schools in California and at four residency programs, the team of MDs, DOs, and PhDs responsible for the evaluation concluded that podiatric education and training produced physicians whose skills were indistinguishable from practitioners of other regional specialties of medicine (such as ophthalmology and otolaryngology).

Does the option to take the USLME down the road make our licensing boards obsolete? No. Speculating about taking the USMLE and how that might affect licensing boards is so far into the future that no one has the answers. For now, podiatry licensing boards will be the only entities licensing podiatrists for practice, and any change to the exam used (APMLE from the NBPME) would have to go through every state legislature. APMA and ACFAS will always protect our current licensees and their ability to practice.

Joint Task Force on Orthopaedic Surgeons & Podiatric Surgeons
Talking Points Supporting 2021 AMA Resolution

EXPLAINING THE RESOLUTION

More than two years ago the 2019 American Podiatric Medical Association (APMA) House of Delegates passed Resolution 4-19, establishing that a national joint task force will work with the American Medical Association (AMA) to start discussions with the National Board of Medical Examiners (NBME) about allowing DPMs to sit for the United States Medical Licensing Exam (USMLE). That resolution was supported unequivocally by the leadership of the American College of Foot and Ankle Surgeons (ACFAS).

The subsequently created Joint Task Force of Orthopaedic Surgeons and Podiatric Surgeons between the American Association of Orthopaedic Surgeons (AAOS), the American Orthopaedic Foot and Ankle Society (AOFAS), ACFAS, and APMA, has now crafted a resolution for consideration at the AMA House of Delegates Annual Meeting in June 2021.

Submitted by AAOS and AOFAS, the resolution directs AMA to study whether Council on Podiatric Medical Education (CPME) accreditation standards for graduate medical education are comparable to Liaison Committee on Medical Education (LCME) standards. Should AMA determine comparability between CPME and LCME accreditation standards, future resolutions would direct that AMA recommend to the NBME that graduates of CPME-accredited colleges of podiatric medicine be allowed to take the USMLE.

UNDERSTANDING WHY

DPMs should not be restricted in the application of their specialty. The task force member organizations all agree that DPMs should not be restricted in their ability to appropriately care for patients within their respective scope of practice, nor in their access to patients based upon type of insurance.

Licensure should be based on education, training, and experience. AMA has long supported a uniform standard for licensing, including a public position stating that changes in licensure must be based on education, training, and experience to ensure patient safety. This is the same position held by APMA and ACFAS.

Patient safety always comes first. DPMs are driven by the desire to enrich the physician-patient relationship. Patients, as well as referring health-care professionals, should be able to have the same high degree of confidence that DPMs have met common standards as they provide medical and surgical care to patients within their scope of practice. Patients should be reassured knowing that DPMs are confident in their pursuit of higher medical education with their commitment to USMLE standards.

The wheels of change turn slowly. The evolution of the profession shows that DPMs have advanced their field of medicine. Since 1961, podiatric medicine has taken actions to advance podiatric training and education, leading to increased standardization of podiatric residency training and expansion to mandatory three-year, hospital-based medical and surgical residency programs. In addition to their rigorous four-year medical education, three-year hospital-based surgical residency, and other postgraduate accreditations, DPMs can attain advanced certification in foot and ankle medicine or surgery, or both.

Will this be required for everyone? Taking the USMLE would be optional. DPMs who choose not to take the USMLE are by no means diminished in their competency or ability to practice. The intention is that the USLME could be taken by enrollees or graduates from a CPME-accredited college of podiatric medicine.

Why are orthopedists working with us on this? Despite our belief that our education and training is comparable to allopathic and osteopathic medicine, the orthopedic community has proposed this process to evaluate our education and training and has agreed that if these processes are comparable, they will recognize DPMs as physicians. This process could set the bar for all other providers seeking recognition commensurate with education and training.

SUBSTITUTE RESOLUTION #4-19 (Directive)
PODIATRIC PHYSICIANS' ACCESS TO USMLE TESTING

WHEREAS, One of the highest priorities sought by the American Podiatric Medical Association (APMA) and APMA component societies has been the attainment of parity (equivalency) with MD and DO physicians;

WHEREAS, The California Physician and Surgeon Joint Task Force, composed of representatives of the California Podiatric Medical Association (CPMA), the California Medical Association (CMA), the Osteopathic Physicians and Surgeons of California (OPSC), and the California Orthopaedic Association (COA), have been pursuing a pathway for graduates of podiatric medical schools and podiatric residency programs to obtain a California Physician's and Surgeon's Certificate (the same plenary medical license as held by MDs and DOs);

WHEREAS, A four-point pathway to achieve this license was agreed upon by all four organizations at the conclusion of the California Joint Task Force meeting in 2018;

WHEREAS, One of the key components of these four points created a new pathway whereby graduates from Council on Podiatric Medical Education (CPME)-accredited podiatric medical schools can obtain a plenary medical license by passing either the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX);

WHEREAS, Currently, only graduates of medical or osteopathic medical schools may sit for these examinations;

WHEREAS, It was further agreed by all four California organizations that the most effective way to achieve the goal of having the National Board of Medical Examiners (NBME) or National Board of Osteopathic Medical Examiners (NBOME) allow DPMs to sit for the USMLE or the COMLEX examinations was to have CMA and OPSC secure the support of their parent national associations, the American Medical Association (AMA) and American Osteopathic Association (AOA), and thus form a broad coalition of national medical, osteopathic, podiatric, and orthopedic associations which would then jointly petition the National Board of Medical Examiners (NBME)/National Board of Osteopathic Medical Examiners (NBOME) to allow DPMs to sit for their national examinations;

WHEREAS, At the conclusion of California's 2018 Joint Task Force meeting, all four associations agreed to pass the task of forming a broad coalition to meet with NBME and NBOME to the newly formed National Joint Task Force of Orthopedic Surgeons and Podiatric Surgeons (national task force);

WHEREAS, The CMA (the largest AMA Component) and OPSC agreed to assist the national task force in forming the broad coalition needed to meet with NBME and NBOME;

WHEREAS, The national task force has held preliminary discussions and agreed to the need for DPMs to be allowed to sit for national medical/osteopathic examinations; and

WHEREAS, To date, the national task force has yet to declare official formation of a broad coalition of national medical and osteopathic associations;

RESOLVED, That the American Podiatric Medical Association (APMA) representatives to the National Joint Task Force of Orthopedic Surgeons and Podiatric Surgeons [consisting of APMA, American College of Foot and Ankle Surgeons (ACFAS), American Academy of Orthopaedic Surgeons (AAOS), and American Orthopaedic Foot and Ankle Society (AOFAS)] continue to advocate for the involvement of the American Medical Association (AMA) and American Osteopathic Association (AOA) with the national joint task force;

RESOLVED, That the APMA representatives to the national task force continue to work with representatives from the California Medical Association, the Osteopathic Physicians and Surgeons of California, and the California Orthopedic Association to assist with the involvement of the American Medical Association (AMA) and American Osteopathic Association (AOA) with the national joint task force;

RESOLVED, That the national joint task force work with AMA to facilitate discussions with the National Board of Medical Examiners (NBME) to allow podiatric medical students to be eligible to take the United States Medical Licensing Examination (USMLE); and

RESOLVED, That the task force issue a progress report to this House at the 2020 APMA House of Delegates.

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October 19, 2021

Michael Aronow, MD
Jeff DeSantis, DPM
Steve Ross, MD
John Steinberg, DPM

Dear Drs. Aronow, DeSantis, Ross, Steinberg:

We write as a follow up to your September 22 conversation with our colleague, Dr. Alex Mechaber. He shared with us his notes from the conversation as well as a copy of the joint task force white paper and talking points to the AMA's resolution. These helped us better understand the background and context of your request.

We have since spoken at length with Dr. Mechaber, reviewed the materials you provided, and conferred with Drs. Humayun "Hank" Chaudhry and Peter Katsufrakis, President and CEO, respectively, of the Federation of State Medical Boards (FSMB) and the NBME – the two organizations that co-sponsor the USMLE program. In considering whether or not Doctors of Podiatric Medicine (D.P.M.) may be eligible to take the USMLE, there were several factors we considered before making our determination.

First and foremost, the USMLE has been designed from the start with items and content appropriate for the licensing model utilized for the general practice of medicine in the United States. Although most physicians today are specialty-board certified in one or more areas of medicine and surgery and/or have a discrete focus for their practice, the medical license issued by all state and territorial medical boards does not impose such limitations on their practice. Because all physicians (M.D. and D.O.) are required to possess knowledge of all aspects of the general practice of medicine to be eligible for a medical license, the content of the USMLE is intentionally expansive in its breadth and coverage of physician knowledge and skills (e.g., pediatrics, obstetrics-gynecology, cardiology, endocrinology, etc.).

Podiatric education and training, while comprehensive for the advancement of quality podiatric care, may be too narrow given the USMLE's focus on the generalized practice of medicine across all medical and surgical specialties. This difference is of critical importance. The *Standards for Educational and Psychological Testing Standard 11.11 states, "If evidence based on test content is a primary source of validity evidence supporting the use of a test for selection into a particular job, a similar inference should be made about the test in a new situation only if the job and situation are substantially the same as the job and situation where the original validity evidence was collected."* (p. 181). Licensing examination content, in other words, should align appropriately with the knowledge and skills required of individuals to operate successfully in a given field, subject area or profession.

Second, we understand you are interested in presenting this matter to the USMLE's Composite Committee, the policy-setting body for the USMLE program. Given that the nature of your request (opening USMLE to DPMs) is not permitted under the contractual agreement between FSMB and NBME establishing USMLE, which limits eligibility to students and graduates of medical school, presenting the request would be ineffective.

While we understand and empathize with the challenges you face in creating transformative change within the podiatry licensure process, we must respectfully decline your request.

Yours very sincerely,

Mike Jodoin
VP, USMLE
National Board of Medical Examiners

Dave Johnson
Chief Assessment Officer
Federation of State Medical Boards

Quality
Safety
Integrity

Licensure
Regulation
Practice

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Member Boards Round Robin

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Round Robin Objectives

- Process Overview
- Prioritized Topics
- Ranked Topics

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Process Overview

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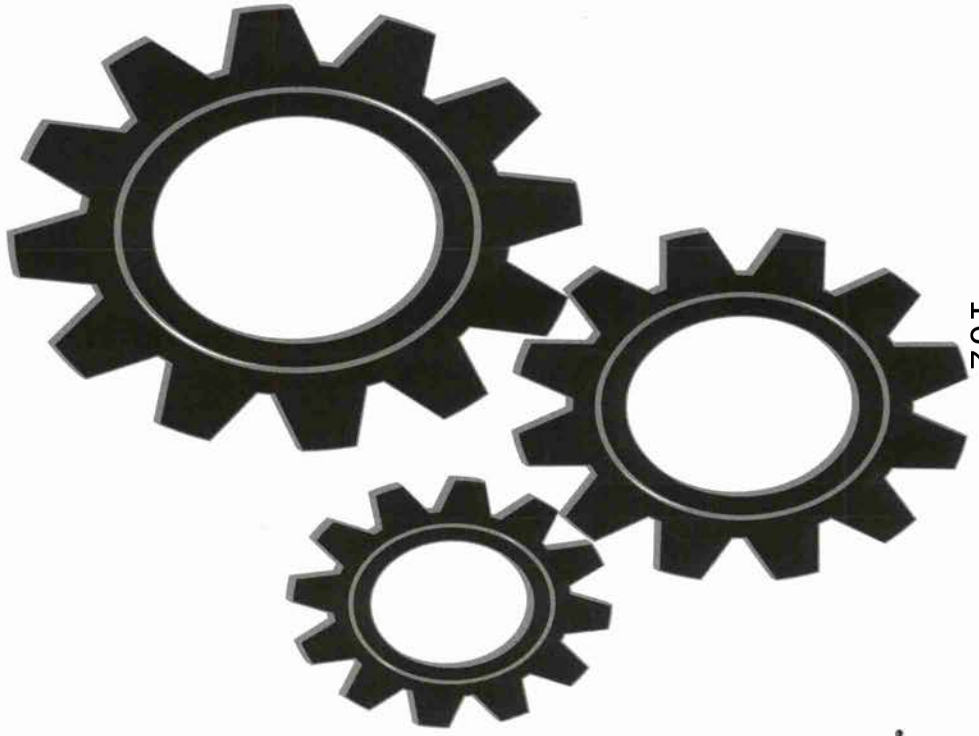
Process Overview

- FPMB provides its Member Boards with invaluable opportunities to engage with each other
- Round Robins offer Member Boards a unique opportunity for information sharing *(updates)* and mutual assistance *(questions)* in real-time



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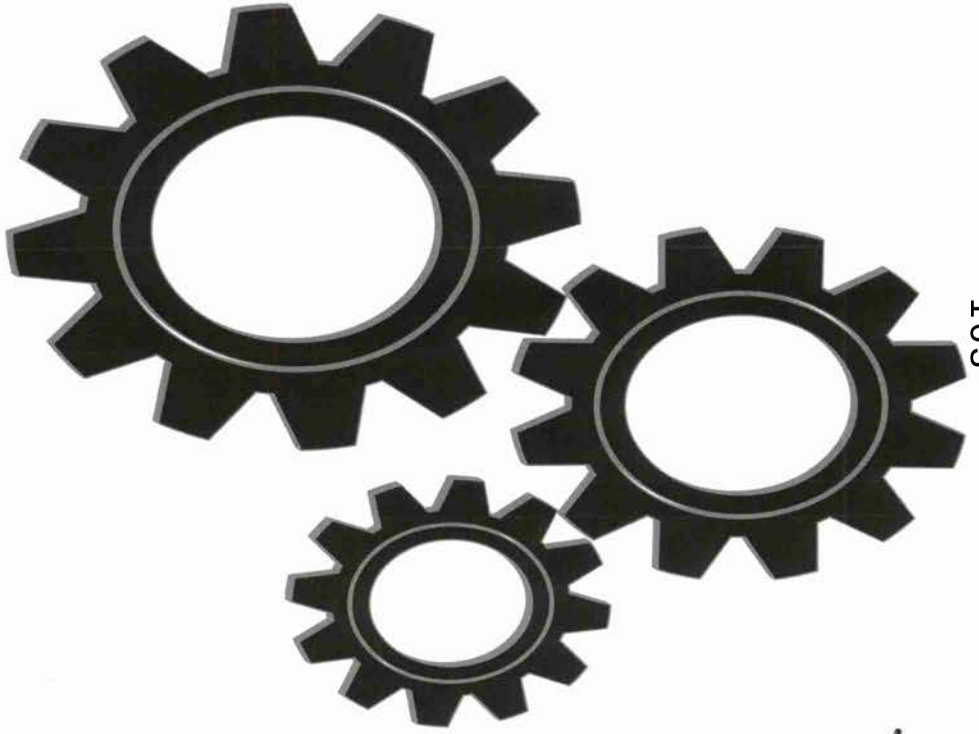
Process Overview *(cont.)*

- While RSVPing, meeting participants are offered the opportunity to identify:
  - Updates/issues about their Board/state
  - Topics/questions for other Boards/states/FPMB



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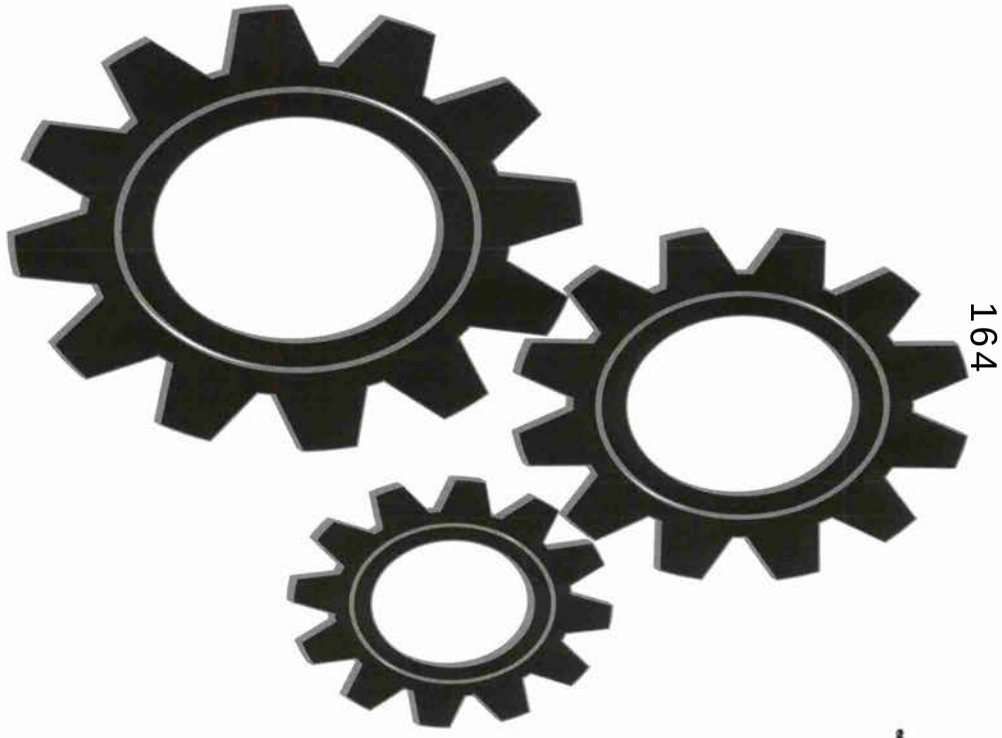
Process Overview *(cont.)*

- FPMB reviews responses received and:
  - Prioritizes topics that are particularly timely, important, and of national interest
  - Categorizes remaining responses for meeting participants to rank based on their interest



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Prioritized Topics

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Prioritized Topics

- Scope of Practice
- Licensing Examinations
- CMEs

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Prioritized Topics *(cont.)*

SCOPE OF PRACTICE

- Modernization commensurate with education, training, and experience
- Oversight of physician extenders *(i.e., medical assistants)*
- ABPM is concerned that a handful of states are using board certification as a requirement for a podiatrist to have access to the full scope of podiatric practice.
- Concerns about other professions efforts to limit scope of practice
- Scope of practice and CPT code inclusion in scope questions by licensees to the board
- Vaccinations

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Prioritized Topics *(cont.)*

LICENSING EXAMINATIONS

- APMLE Part II Clinical Skills Patient Encounter *(CSPE)* currently suspended
- NBPME is reviewing options and ensuring pathways for progression and licensure for its students and residents
  - Recent stakeholder survey was sent to FPMB Member Boards
- Any unresolved licensing issues?

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Prioritized Topics *(cont.)*

CMES

- Temporary or permanent pandemic-related changes in requirements *(i.e., exemptions, online vs. in-person, etc.)* given termination of emergency orders in some states
- Maintenance of Certification via certification or recertification exam conducted by American Board of Foot and Ankle Surgery *(ABFAS)* or American Board of Podiatric Medicine *(ABPM)*
- Failure rate of new applications with oral exams
- CE Broker – tool for licensees to track their continuing education that also sends renewal reminders

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Ranked Topics

(based on participant polling)

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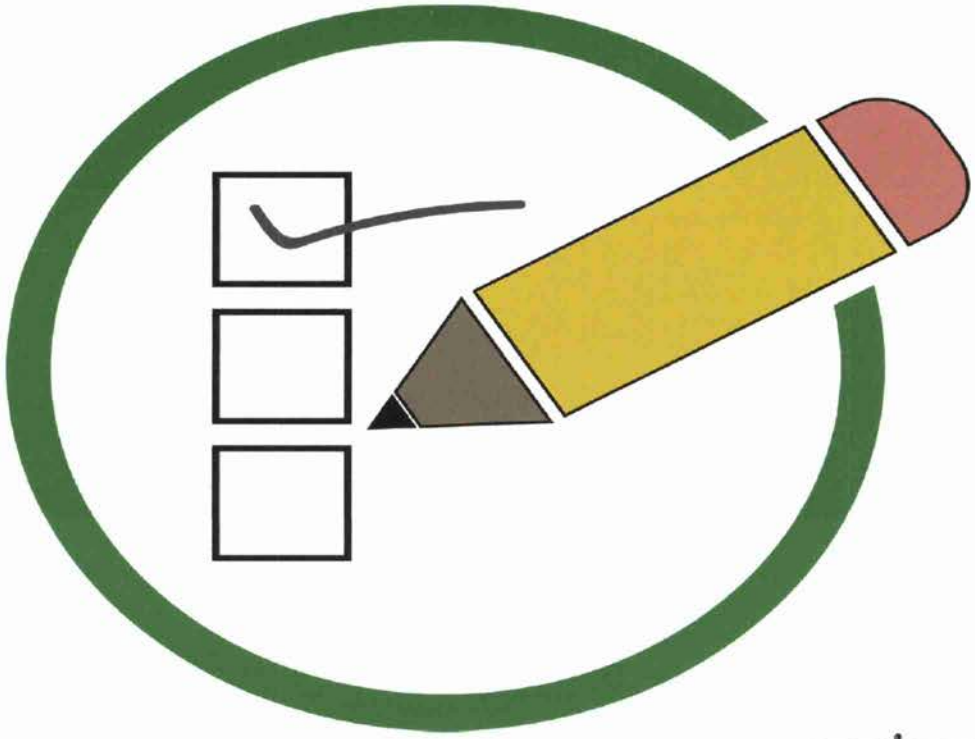
Ranked Topics

1. Complaints / Discipline / Physician Re-Entry
2. Board Governance and Operations
3. Licensure and Regulation
4. Telemedicine
5. Controlled Substances / Opioids / PDMP



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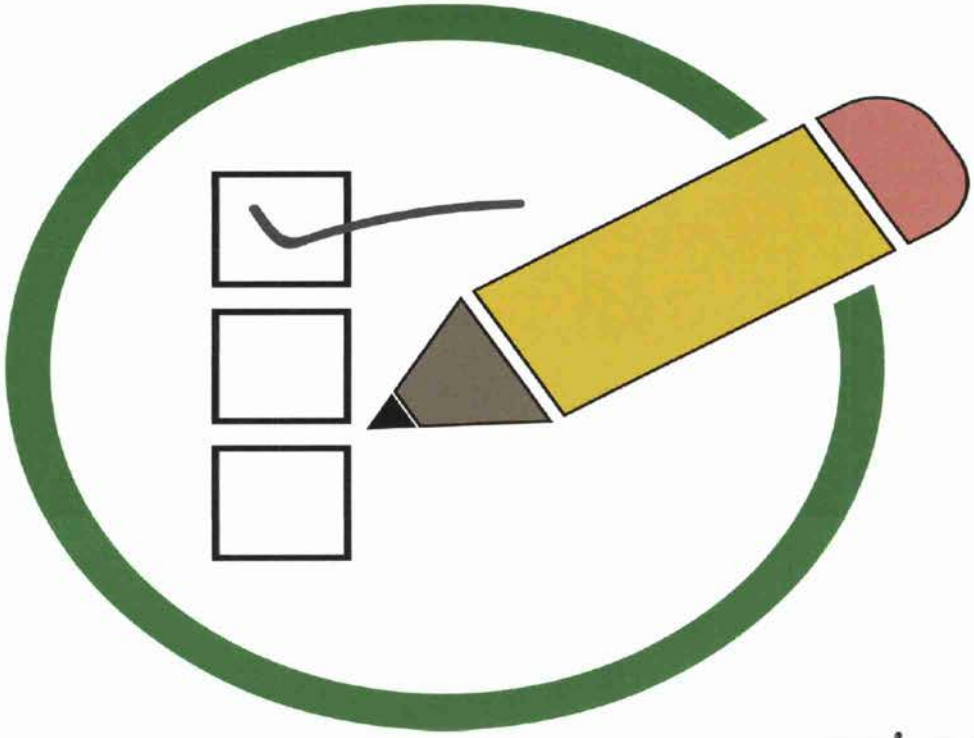
Ranked Topics *(cont.)*

COMPLAINTS / DISCIPLINE /

PHYSICIAN RE-ENTRY

- How do boards review specific cases – decisions made by one board member or a group of board members?
- Who does the investigations of complaints?
- What are the statutory requirements?
- What are the timeframe requirements?
- Does your board have a physician re-entry program?



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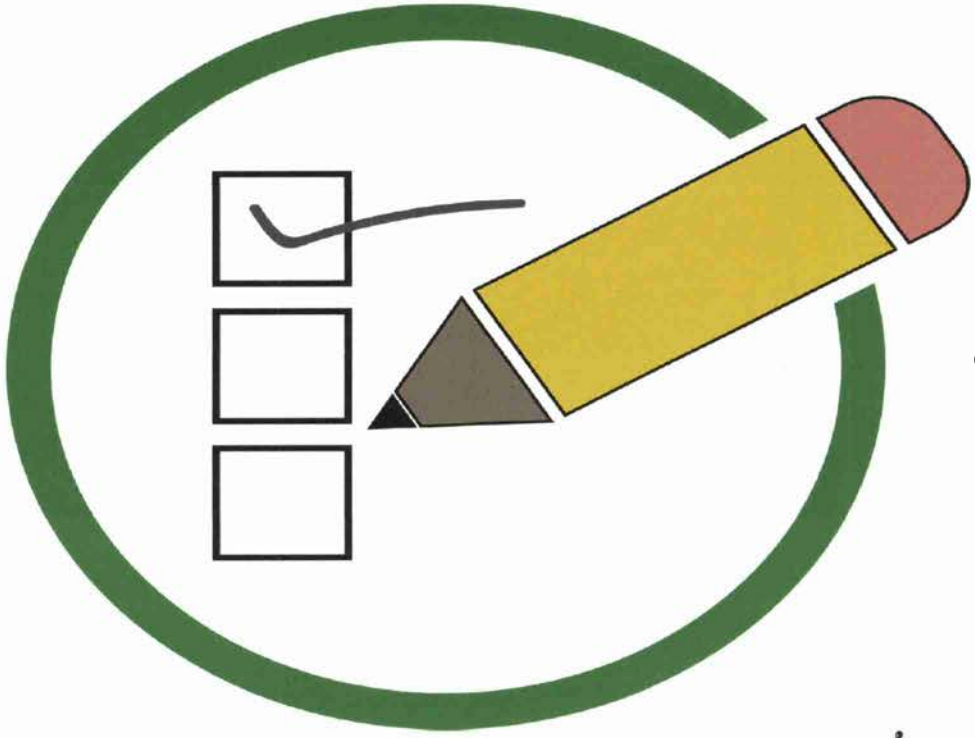
Ranked Topics *(cont.)*

BOARD GOVERNANCE AND OPERATIONS

- How are you filling board vacancies, especially public members?
- How are you onboarding new board members?
- What are your experiences and recommendations related to sunset reviews?
- What are your document retention policies and schedules *(i.e., expired license and complaint files)*?



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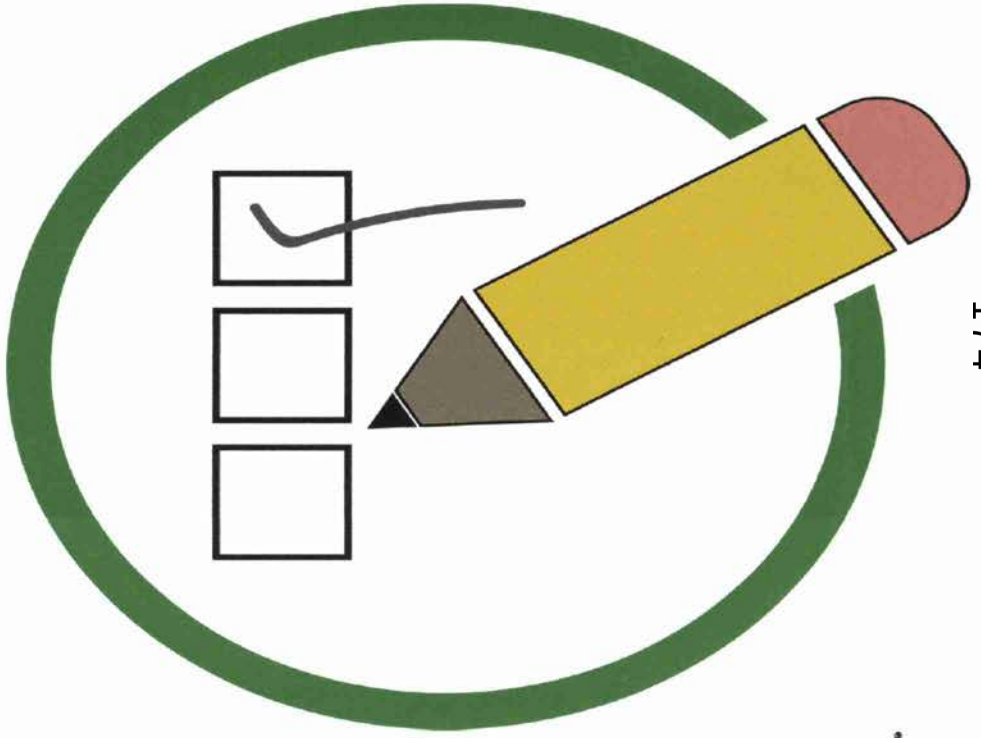
Ranked Topics *(cont.)*

LICENSURE AND REGULATION

- Any changes to initial and renewal licensure requirements?
- Any new developments regarding reciprocity and/or increasing license portability?
- Adoption of criminal history forms
- Any additional training requirements *(i.e., recognition of abuse/human trafficking)* or new trends *(i.e., diversity, equity, and inclusion)*?
- Authorization to perform x-rays



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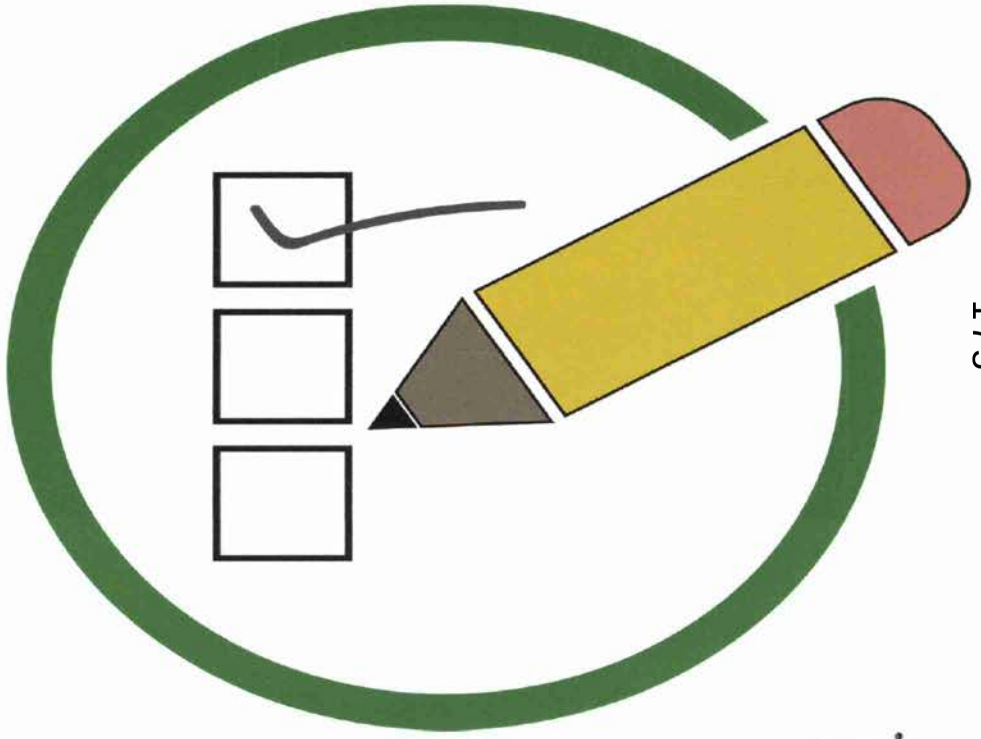
Ranked Topics *(cont.)*

TELEMEDICINE

- Any new legislation and/or requirements?
- What is allowed *(ex: audio-only)*?
- Any increases in complaints made to Member Boards?



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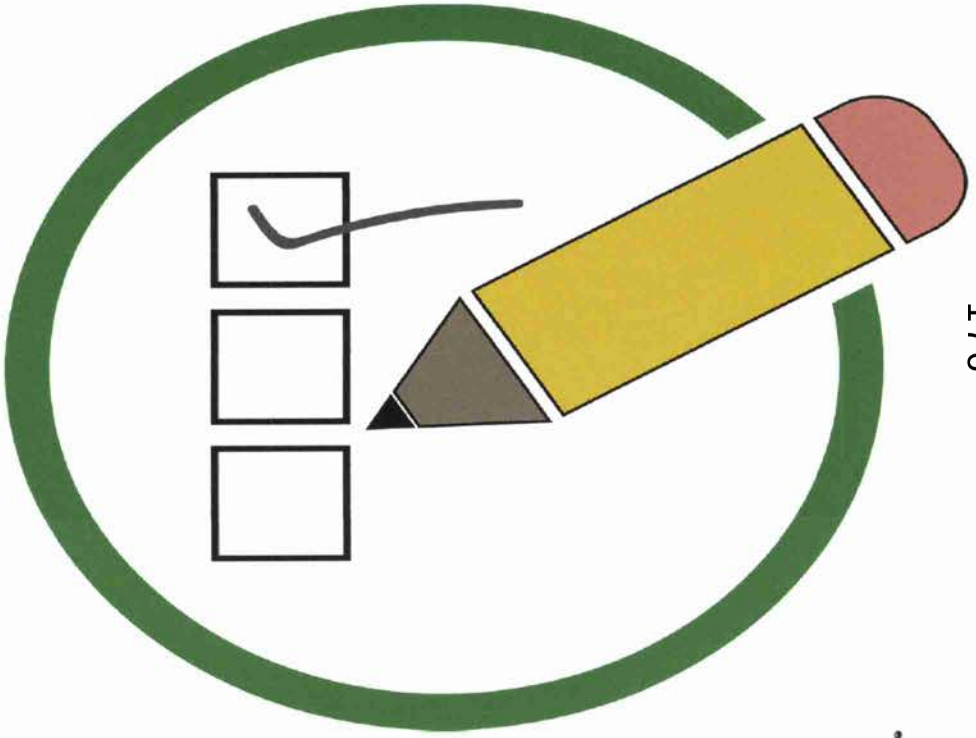
Ranked Topics *(cont.)*

CONTROLLED SUBSTANCES / OPIOIDS / PDMP

- Any new legislation and requirements?
- Any mandatory training?
- Any mandatory electronic prescribing / HER PDMP requirements?
- Physician drug use and abuse



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Member Boards Round Robin

Additional Round

Robin Topics

(time permitting)

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Quality
Safety
Integrity

Licensure
Regulation
Practice

Adjournment

Thank you very much for your preparation, participation, and engagement.

The FPMB is an empowering leader,
helping Member Boards
work independently and collectively
to promote and protect the public's
podiatric health, safety, and welfare.

We Need YOUR Feedback!

A link to a post-meeting survey will be emailed to you. Your important feedback is welcome and appreciated.

Thank you again, stay safe, and be well. The FPMB is here for you!

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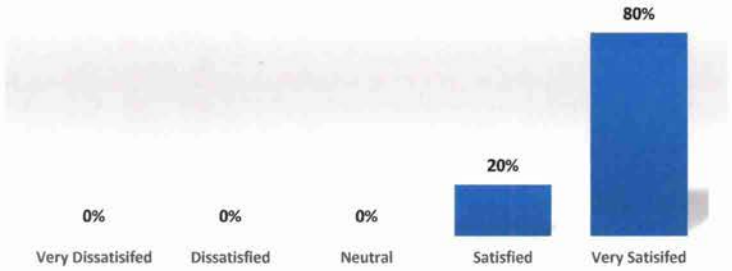
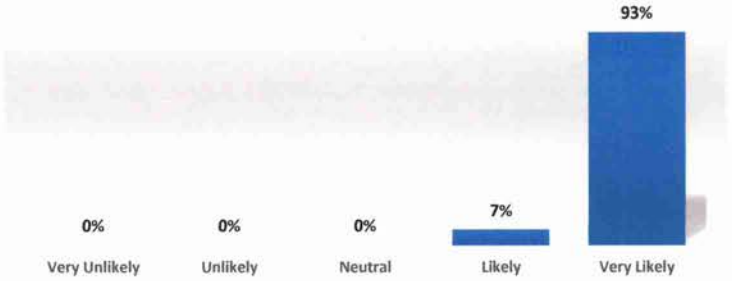
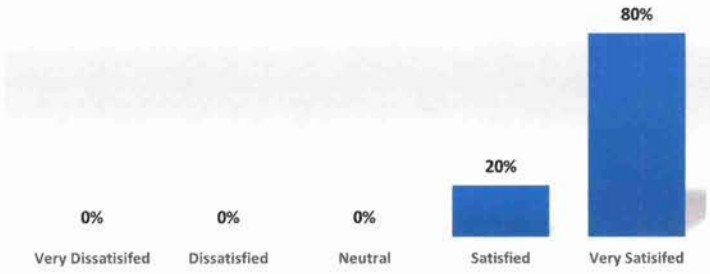
Overall, how satisfied were you with the Fall Meeting?



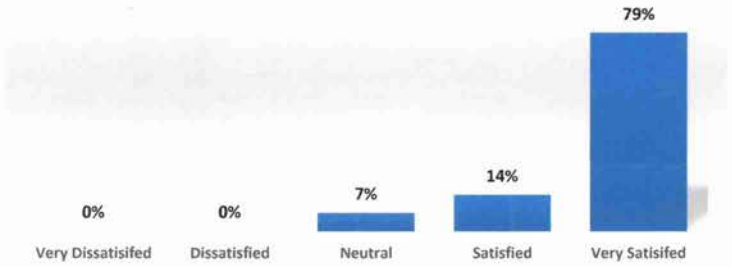
How likely would you attend the next FPMB Meeting?



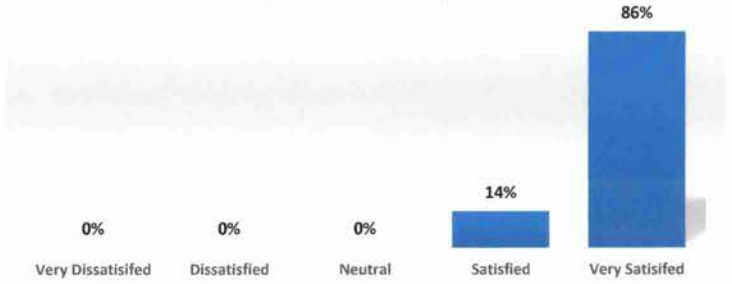
How satisfied were you with the Round Robin discussion?



How satisfied were you with the Announcements & Updates?



How satisfied were you with the Joint Task Force presentation/discussion?



Why should Member Boards participate in FPMB meetings?

- Informative, and because it brings a feeling of camaraderie across the profession.
- There are common issues which others have dealt with. It is helpful to hear their solutions
- The FPMB is the one organization that serves every single practitioner, and it is essential you stay informed about the state of the profession. This board is the best resource to track the economics of the profession
- Very educational
- This meeting is the only way boards can exchange information about all aspects of medical board real time.
- To keep up to date on current practices and procedures
- It seems inherent in the participation, to have interest in national level activity
- Discussion of common problems shared by the member boards is helpful in addressing issues and solving problems for each board. Having the ability to see the participants in a virtual setting may give executive directors and board presidents more impetus and confidence in contacting other board's executive directors for assistance with an issue.
- It's great to be able to hear the challenges of other Boards as well as their rules and procedures.
- There is tremendous value in learning what is occurring in other jurisdiction as much of what is shared is advantageous to other jurisdictions.
- It is good to hear from other member states that they are having the same issues we are here. I used to think that the issues are exclusive to my state because we are so small compared to other states, but the issues are shared by all, not just the small states.
- You all help navigate national issues and give perspective on shared problems and act as a facilitator of information on how to handle challenging issues, rules, and law implementation.
- To better understand the issues affecting the profession, the regulation of such profession, and to gain insight into issues that are coming or may be coming

What did you like MOST about the Fall Meeting?

- The summary of where we are at nationally –a big picture survey of our shared interests
- Hearing concerns over the Joint Task Force white paper/AMA resolution
- Learning about other jurisdictions' procedures
- Level of participation, exchange, and engagement in all the discussions
- The Round Robin is fantastic
    - I love to hear the voices of the other states
    - Ranking the topics helped to focus discussion
    - Many participants shared good thoughts and idea
    - Good job of timing and moderating
- It was virtual, very comfortable
- You run a hell of an efficient and organized meeting!!!

VIRGINIA COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
FORMAL HEARING
MINUTES
October 13, 2021

TIME AND PLACE: The formal hearing of the Committee of the Joint Boards of Nursing and Medicine was convened at 10:02 A.M., in Board Room 2, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

MEMBERS PRESENT: Ann Tucker Gleason, PhD; Board of Nursing, Chairperson
Blanton L. Marchese; Board of Medicine
David Archer, M.D.; Board of Medicine
Ryan Williams, M.D.; Board of Medicine

STAFF PRESENT: Jay P. Douglas, MSM, RN, CSAC, FRE; Executive Director
Robin L. Hills, DNP, RN, WHNP; Deputy Executive Director for Advance Practice
Charlette N. Ridout, RN, MS, CNE; Nursing Probable Cause Reviewer/Education Program Inspector
Cathy Hanchey, Senior Licensing/Discipline Specialist

OTHER PRESENT: Erin Barrett, Assistant Attorney General, Committee Counsel

ESTABLISHMENT OF A QUORUM: With four members of the Committee present, a quorum was established.

CONSIDERATION OF AGENCY SUBORDINATE RECOMMENDATIONS:

Mark-Allen Clark, LNP **0024-166868**
Mr. Clark submitted a written response.

CLOSED MEETING: Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 10:07 A.M., for the purpose of consideration of the agency subordinate recommendations. Additionally, Mr. Marchese moved that Ms. Douglas, Ms. Ridout, Ms. Hanchey, and Ms. Barrett, Committee counsel, attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded by Dr. Williams and carried unanimously.

RECONVENTION: The Committee reconvened in open session at 10:12 A.M.

DRAFT

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded by Dr. Williams and carried unanimously.

Mr. Marchese moved the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate and issue an Order of Reprimand to Mark-Allen Clark. The motion was seconded by Dr. Williams and carried unanimously.

Dolores Lorraine Williams Johnson, LNP **0024-164367**
Ms. Williams submitted a written response.

CLOSED MEETING: Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 10:07 A.M., for the purpose of consideration of the agency subordinate recommendation. Additionally, Mr. Marchese moved that Ms. Douglas, Ms. Ridout, Ms. Hanchey, and Ms. Barrett, Committee counsel, attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded by Dr. Williams and carried unanimously.

RECONVENTION: The Committee reconvened in open session at 10:12 A.M.

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded by Dr. Williams and carried unanimously.

Mr. Marchese moved the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate and issue an Order of Reprimand to **Dolores Lorraine Williams Johnson**. The motion was seconded by Dr. Williams and carried unanimously.

Virginia Committee of the Joint Boards of
Nursing and Medicine – Formal Hearing
October 13, 2021

Nakeshia Lynn Mouzon, LNP **0024-170001**
Ms. Mouzon did not appear.

CLOSED MEETING: Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 10:07 A.M., for the purpose of consideration of the agency subordinate recommendation. Additionally, Mr. Marchese moved that Ms. Douglas, Ms. Ridout, Ms. Hanchey, and Ms. Barrett, Committee counsel, attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded by Dr. Williams and carried unanimously.

RECONVENTION: The Committee reconvened in open session at 10:12 A.M.

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded by Dr. Williams and carried unanimously.

Mr. Marchese moved the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate and issue an Order of Reprimand to **Nakeshia Lynn Mouzon**. The motion was seconded by Dr. Williams and carried unanimously.

CONSIDERATION OF CONSENT ORDER:

David Peter Young, LNP **0024-073770**

Dr. Williams moved that the Committee of the Joint Boards of Nursing and Medicine accept the consent order for Voluntary Surrender for Indefinite Suspension of David Peter Young's right to renew his license to practice as a nurse practitioner in the category of certified registered nurse anesthetist in the Commonwealth of Virginia. The motion was seconded by Mr. Marchese, and the motion carried unanimously.

Virginia Committee of the Joint Boards of
Nursing and Medicine – Formal Hearing
October 13, 2021

FORMAL HEARING:

Michael Scott Addair, LNP Reinstatement Applicant 0024-167226

Mr. Addair appeared and was accompanied by his attorney, Brian Vieth, and Ashley Blevins.

David Kazzie, Adjudication Specialist for the Department of Health Professions, represented the Commonwealth. Ms. Barrett was legal counsel for the Committee. Racheal Steck, court reporter with Veteran Reporters, recorded the proceeding.

Marcella Luna, Investigator Supervisor, Department of Health Professions, participated and testified.

CLOSED MEETING: Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine convene a closed meeting pursuant to Section 2.2-3711(A)(27) of the *Code of Virginia* at 11:30 A.M. for the purpose of deliberation to reach a decision in the matter of Michael Scott Addair. Additionally, Mr. Marchese moved that Ms. Ridout, Ms. Hanchey, and Ms. Barrett, Committee Counsel, attend the closed meeting because their presence in the closed meeting is deemed necessary, and their presence will aid the Committee in its deliberations. The motion was seconded by Dr. Williams and carried unanimously.

RECONVENTION: The Committee reconvened in open session at 11:46 A.M.

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded by Dr. Williams and carried unanimously.

ACTION: Dr. Williams moved to approve the application of **Michael Scott Addair** for reinstatement to practice as a nurse practitioner in the category of certified registered nurse anesthetist in the Commonwealth of Virginia. The basis for this decision will be set forth in a final Order which will be sent to Mr. Addair at his address of record. The motion was seconded by Mr. Marchese and carried unanimously.

This decision shall be effective upon the entry by the Board of a written Order stating the findings, conclusions, and decision of this formal hearing quorum.

ADJOURNMENT: The meeting was adjourned at 11:48 A.M.

Robin L. Hills

Robin Hills, DNP, RN, WHNP
Deputy Executive Director for Advance Practice
Virginia Board of Nursing

Agenda Item: **Regulatory Actions**

Staff Note: Ms. Yeatts will speak to the Board of Medicine actions underway.

Action: None.

Status of Regulatory Actions - Board of Medicine

Chapter		Action / Stage Information
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic Regulations Governing the Licensure of Radiologic Technology Regulations Governing the Practice of Physician Assistants	Licensure by endorsement - expedited process [Action 5890] Fast-Track - *Register Date: 2/14/22* *Effective: 4/1/22*
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic	Conversion therapy [Action 5412] Final - *Register Date: 1/3/22* *Effective: 2/2/22*
[18 VAC 85 - 80]	Regulations for Licensure of Occupational Therapists	Implementation of the OT Compact [Action 5797] Emergency/NOIRA - *Register Date: 1/17/22* *Comment period on NOIRA ends:* 2/16/22
[18 VAC 85 - 110]	Regulations Governing the Practice of Licensed Acupuncturists	Name changes for accrediting bodies [Action 5869] Fast-Track - *Register Date: 1/31/22* *Effective: 3/18/22*
[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] Proposed - *Register Date: 1/31/22* Public hearing: 2/7/22 Comment period ends: 4/1/22
[18 VAC 90 - 30]	Regulations Governing the Licensure of Nurse Practitioners	Changes relating to clinical nurse specialists as nurse practitioners [Action 5800] Fast-Track - *Register Date: 1/17/22* *Effective: 4/1/22*
[18 VAC 90 - 30]	Regulations Governing the Licensure of Nurse Practitioners	Unprofessional conduct/conversion therapy [Action 5441] Final - *Register Date: 1/3/22* *Effective: 2/2/22*
[18 VAC 90 - 40]	Regulations for Prescriptive Authority for Nurse Practitioners	Waiver for electronic prescribing [Action 5413] Final - *Register Date: 1/3/22* *Effective: 2/2/22*

[18 VAC 90 - 70]	Regulations Governing the Practice of Licensed Certified Midwives	New regulations for licensed certified midwives [Action 5801] NOIRA - *Register Date: 1/17/22* *Comment on NOIRA ends: 2/16/22* *Proposed regs to go to:* *Jt. Boards on 4/20* *Nursing on 5/17* *Medicine on 6/16*

Bills Considered in the 2022 General Assembly

Board of Medicine

*** An updated report with Bill status will be given at the Board meeting

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HB 27 COVID-19 vaccination status; mandatory COVID-19 vaccination prohibited, discrimination prohibited.

Chief patron: Anderson

Summary as introduced:

COVID-19 vaccination status; mandatory COVID-19 vaccination prohibited; discrimination prohibited. Prohibits the State Health Commissioner and the Board of Health, the Board of Behavioral Health and Developmental Services, the Department of Health Professions and any regulatory board therein, and the Department of Social Services from requiring any person to undergo vaccination for COVID-19 and prohibits discrimination based on a person's COVID-19 vaccination status with regard to education or public employment and in numerous other contexts.

HB 45 Health carriers; licensed athletic trainers.

Chief patron: Ware

Summary as introduced:

Health carriers; licensed athletic trainers. Requires health insurers and health service plan providers whose policies or contracts cover services that may be legally performed by a licensed athletic trainer to provide equal coverage for such services when rendered by a licensed athletic trainer. This bill is a recommendation of the Health Insurance Reform Commission.

HB 80 Healthcare Regulatory Sandbox Program; established, report, sunset date.

Chief patron: Davis

Summary as introduced:

Healthcare Regulatory Sandbox Program; established. Requires the Department of Health to establish the Healthcare Regulatory Sandbox Program to enable a person to obtain limited access to the market in the Commonwealth to temporarily test an innovative healthcare product or service on a limited basis

without otherwise being licensed or authorized to act under the laws of the Commonwealth. Under the Program, an applicant requests the waiver of certain laws, regulations, or other requirements for a 24-month testing period, with an option to request an additional six-month testing period. The bill provides application requirements, consumer protections, procedures for exiting the Program or requesting an extension, and recordkeeping and reporting requirements. The bill requires the Department to provide an annual report to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health that provides information regarding each Program participant and that provides recommendations regarding the effectiveness of the Program. The bill has an expiration date of July 1, 2027.

HB 102 Prescriptions; off-label use.

Chief patron: Greenhalgh

Summary as introduced:

Prescriptions; off-label use. Provides that a licensed health care provider with prescriptive authority may prescribe, administer, or dispense a drug that has been approved for a specific use by the U.S. Food and Drug Administration for an off-label use when the health care provider determines, in his professional judgement, that such off-label use is appropriate for the care and treatment of the patient, and prohibits a pharmacist from refusing to dispense a drug for off-label use if a valid prescription is presented. The bill also requires the Board of Health to include in regulations governing hospitals a provision that no hospital shall deny, revoke, terminate, diminish, or curtail in any way any professional or clinical privilege to a health care provider with prescriptive authority solely on the grounds that such health care provider prescribes, administers, or dispenses a drug that has been approved for a specific use by the U.S. Food and Drug Administration for an off-label use.

HB 145 Physician assistants; practice.

Chief patron: Head

Summary as introduced:

Practice of physician assistants. Removes the requirement that physician assistants appointed as medical examiners practice as part of a patient care team. For hospice program licensing, the bill adds physician assistants to the list of hospice personnel who may be part of a medically directed interdisciplinary team. The bill removes a reference to physician assistants in the definition of patient care team podiatrist. Finally, the bill permits physician assistants working in the field of orthopedics as part of a patient care team to utilize fluoroscopy for guidance of diagnostic and therapeutic procedures, provided other requirements are met.

HB 192 Opioids; repeals sunset provisions relating to prescriber requesting information about a patient.

Chief patron: Hodges

Summary as introduced:

Prescription of opioids; sunset. Repeals sunset provisions for the requirement that a prescriber registered with the Prescription Monitoring Program request information about a patient from the Program upon initiating a new course of treatment that includes the prescribing of opioids anticipated, at the onset of treatment, to last more than seven consecutive days.

HB 213 Optometrists; allowed to perform laser surgery if certified by Board of Optometry.

Chief patron: Robinson

Summary as introduced:

Optometrists; laser surgery. Allows an optometrist who has received a certification to perform laser surgery from the Board of Optometry (the Board) to perform certain types of laser surgery of the eye and directs the Board to issue a certification to perform laser surgery to any optometrist who submits evidence satisfactory to the Board that he (i) is certified by the Board to prescribe for and treat diseases or abnormal conditions of the human eye and its adnexa with therapeutic pharmaceutical agents pursuant to Code requirements and (ii) has satisfactorily completed such didactic and clinical training programs provided by an accredited school or college of optometry that includes training in the use of lasers for the medically appropriate and recognized treatment of the human eye as the Board may require.

HB 243 Medicine, osteopathy, chiropractic, and podiatric medicine; requirements for practitioners.

Chief patron: Adams, D.M.

Summary as introduced:

Practitioners of medicine, osteopathy, chiropractic, and podiatric medicine; requirements. Increases the duration of postgraduate training required issuance of a license to practice medicine, osteopathy, chiropractic, or podiatric medicine from 12 months to 36 months requires every practitioner licensed to practice medicine, osteopathy, chiropractic, and podiatric medicine to obtain and maintain coverage by or to be named insured on a professional liability insurance policy with limits equal to the current limitation on damages set forth in the Code of Virginia.

HB 264 Public health emergency; out-of-state licensees, deemed licensure.

Chief patron: Head

Summary as introduced:

Public health emergency; out-of-state licensees; deemed licensure. Provides that when the Board of Health has entered an emergency order for the purpose of suppressing nuisances dangerous to the public health or communicable, contagious or infectious diseases or other dangers to the public life and health, a practitioner of a profession regulated by the Board of Medicine who is licensed in another state, the District of Columbia, or a United States territory or possession and who is in good standing with the applicable regulatory agency in that state, the District of Columbia, or that United States territory or possession shall not be prevented or prohibited from engaging in the practice of that profession in the Commonwealth with a patient located in the Commonwealth when (i) such practice is for the purpose of providing continuity of care through the use of telemedicine services and (ii) the patient is a current patient of the practitioner with whom the practitioner has previously established a practitioner-patient relationship.

The bill also provides that when the Board of Health has entered an emergency order for the purpose of suppressing nuisances dangerous to the public health or communicable, contagious or infectious diseases or other dangers to the public life and health, individuals licensed or certified to practice medicine, osteopathic medicine, or podiatry or as a physician assistant, respiratory therapist, advanced practice registered nurse, registered nurse, licensed practical nurse, or nurse aide by another state, the District of Columbia, or a United States territory or possession shall be deemed to be licensed or certified to practice in the Commonwealth for a period of 30 days when certain criteria are met.

HB 285 Clinical nurse specialist; practice agreements.

Chief patron: Adams, D.M.

Summary as introduced:

Clinical nurse specialist; practice agreements. Provides that a nurse practitioner licensed by the Boards of Medicine and Nursing in the category of clinical nurse specialist who does not prescribe controlled substances or devices may practice in the practice category in which he is certified and licensed without a written or electronic practice agreement, provided that he (i) only practice within the scope of his clinical and professional training and limits of his knowledge and experience and consistent with the applicable standards of care, (ii) consult and collaborate with other health care providers based on the clinical condition of the patient to whom health care is provided, and (iii) establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers. The bill also

provides that a nurse practitioner licensed by the Boards in the category of clinical nurse specialist who prescribes controlled substances or devices shall practice in consultation with a licensed physician in accordance with a practice agreement between the nurse practitioner and the licensed physician.

HB 286 Nurse practitioners; declaration of death and cause of death.

Chief patron: Adams, D.M.

Summary as introduced:

Nurse practitioners; declaration of death and cause of death. Authorizes autonomous nurse practitioners, defined in the bill, to declare death and determine cause of death; allows nurse practitioners who are not autonomous nurse practitioners to pronounce the death of a patient in certain circumstances; and eliminates the requirement for a valid Do Not Resuscitate Order for the deceased patient for declaration of death by a registered nurse, physician assistant, or nurse practitioner who is not an autonomous nurse practitioner.

HB 304 Abortion; born alive human infant, treatment and care, penalty.

Chief patron: Freitas

Summary as introduced:

Abortion; born alive human infant; treatment and care; penalty. Requires every physician licensed by the Board of Medicine who attempts to terminate a pregnancy to (i) exercise the same degree of professional skill, care, and diligence to preserve the life and health of a human infant who has been born alive following such attempt as a reasonably diligent and conscientious health care practitioner would render to any other child born alive at the same gestational age and (ii) take all reasonable steps to ensure the immediate transfer of the human infant who has been born alive to a hospital for further medical care. A physician who fails to comply with the requirements of this act is guilty of a Class 4 felony and may be subject to disciplinary action by the Board of Medicine. The bill also requires every hospital licensed by the Department of Health to establish a protocol for the treatment and care of a human infant who has been born alive following performance of an abortion and for the immediate reporting to law enforcement of any failure to provide such required treatment and care.

HB 527 Interstate Medical Licensure Compact and Commission; created.

Chief patron: Helmer

Summary as introduced:

Interstate Medical Licensure Compact. Creates the Interstate Medical Licensure Compact to create a

process for expedited issuance of a license to practice medicine in the Commonwealth for qualifying physicians to enhance the portability of medical licenses while protecting patient safety. The bill establishes requirements for coordination of information systems among member states and procedures for investigation and discipline of physicians alleged to have engaged in unprofessional conduct. The bill creates the Interstate Medical Licensure Compact Commission to administer the compact.

HB 537 Telemedicine; out of state providers, behavioral health services.

Chief patron: Batten

Summary as introduced:

Telemedicine; out of state providers; behavioral health services. Allows certain practitioners of professions regulated by the Boards of Medicine, Counseling, Psychology, and Social Work who provide behavioral health services and who are licensed in another state, the District of Columbia, or a United States territory or possession and in good standing with such regulatory agency to engage in the practice of that profession in the Commonwealth with a patient located in the Commonwealth when (i) such practice is for the purpose of providing continuity of care through the use of telemedicine services and (ii) the practitioner has previously established a practitioner-patient relationship with the patient. The bill provides that a practitioner who provides behavioral health services to a patient located in the Commonwealth through use of telemedicine services may provide such services for a period of no more than one year from the date on which the practitioner began providing such services to such patient.

HB 555 Health care providers; transfer of patient records in conjunction with closure, etc.

Chief patron: Hayes

Summary as introduced:

Health care providers; transfer of patient records in conjunction with closure, sale, or relocation of practice; electronic notice permitted. Allows health care providers to notify patients either electronically or by mail prior to the transfer of patient records in conjunction with the closure, sale, or relocation of the health care provider's practice. Current law requires health care providers to provide such notice by mail.

HB 580 Covenants not to compete; health care professionals, civil penalty.

Chief patron: VanValkenburg

Summary as introduced:

Covenants not to compete; health care professionals; civil penalty. Adds health care professionals as a category of employee with whom no employer shall enter into, enforce, or threaten to enforce a covenant not to compete. The bill defines health care professional as any physician, nurse, nurse practitioner, physician's assistant, pharmacist, social worker, dietitian, physical and occupational therapist, and medical technologist authorized to provide health care services in the Commonwealth. The bill provides that any employer that violates the prohibition against covenants not to complete with an employee health care professional is subject to a civil penalty of $10,000 for each violation.

HB 598 Registered surgical technologist; criteria for registration.

Chief patron: Hayes

Summary as introduced:

Registered surgical technologist; criteria for registration. Requires the Board of Medicine to register as a surgical technologist any applicant who has practiced as a surgical technologist or attended a surgical technologist training program at any time prior to October 1, 2022, and registers with the Board by December 31, 2022. Under current law, an applicant who practiced as a surgical technologist at any time in the six months prior to July 1, 2021, and registered by December 31, 2021, is eligible for certification by the Board. The bill also provides that no person shall use the designation "C.S.T." or any variation thereof unless such person (i) is certified by the Board and (ii) has successfully completed an accredited surgical technologist training program and holds a current credential as a certified surgical technologist from the National Board of Surgical Technology and Surgical Assisting or its successor.

HB 745 Respiratory therapists; practice pending licensure.

Chief patron: Bell

Summary as introduced:

Respiratory therapists; practice pending licensure. Provides that a person who has graduated from an accredited respiratory therapy education program may practice with the title "Respiratory Therapist, License Applicant" or "RT-Applicant" until he has received a failing score on any examination required by the Board for licensure or six months from the date of graduation, whichever occurs sooner.

HB 864 Professions and occupations; proof of identity to obtain a license, etc.

Chief patron: Lopez

Summary as introduced:

Professions and occupations; proof of identity. Replaces the requirement for proof of citizenship to obtain a license, certificate, registration, or other authorization issued by the Commonwealth to engage in a business, trade, profession, or occupation with a requirement to provide proof of identity. The bill contains technical amendments.

HB 896 Nurse practitioner; patient care team provider.

Chief patron: Adams, D.M.

Summary as introduced:

Nurse practitioner; patient care team provider. Replaces the term "patient care team physician" with the term "patient care team provider" in the context of requirements for collaboration and consultation for nurse practitioners and provides that a nurse practitioner who is authorized to practice without a practice agreement may serve as a patient care team provider providing collaboration and consultation for nurse practitioners who are not authorized to practice without a practice agreement. Currently, only a licensed physician may provide collaboration and consultation, as evidenced by a practice agreement, for a nurse practitioner.

The bill also eliminates authority of a physician on a patient care team to require a nurse practitioner practicing as part of a patient care team to be covered by a professional liability insurance policy and the requirement that a nurse practitioner practicing without a practice agreement obtain and maintain coverage by or be named insured on a professional liability insurance policy.

HB 921 Controlled substances; prescriber may establish practitioner-patient relationship.

Chief patron: Orrock

Summary as introduced:

Prescribing controlled substances; practitioner-patient relationship; telemedicine. Provides that a prescriber may establish a practitioner-patient relationship for the purpose of prescribing Schedule II through V controlled substances via synchronous interaction with a patient and for the purpose of prescribing Schedule VI controlled substances via asynchronous interaction. The terms "synchronous interaction" and "asynchronous interaction" are defined in the bill.

HB 931 Virginia Birth-Related Neurological Injury Compensation Act; publication of disciplinary actions.

Chief patron: Robinson

Summary as introduced:

Virginia Birth-Related Neurological Injury Compensation Act; publication of disciplinary actions; award eligibility. Requires, to the extent permissible by state and federal law, the Board of Medicine to publish on its website disciplinary action taken against a physician as a result of an investigation under the Virginia Birth-Related Neurological Injury Compensation Act (the Act). The bill also permits compensation under the Act for birth-related neurological injury deaths occurring up to a person's eighteenth birthday; current law limits awards to such deaths occurring during the person's infancy.

HB 939 Necessary drugs and devices; Commissioner of Health to authorize administration and dispensing.

Chief patron: Robinson

Summary as introduced:

Commissioner of Health; administration and dispensing of necessary drugs and devices during public health emergency. Allows the Commissioner of Health to authorize persons who are not authorized by law to administer or dispense drugs or devices to do so in accordance with protocols established by the Commissioner when the Board of Health has made an emergency order for the purpose of suppressing nuisances dangerous to the public health and communicable, contagious, and infectious diseases and other dangers to the public life and health. Current law limits the Commissioner's ability to make such authorizations to circumstances when the Governor has declared a disaster or a state of emergency or the United States Secretary of Health and Human Services has issued a declaration of an actual or potential bioterrorism incident or other actual or potential public health emergency.

HB 981 Health professions, certain; licensure by endorsement.

Chief patron: Scott, P.A.

Summary as introduced:

Certain health professions; licensure by endorsement. Requires the Boards of Dentistry, Medicine, and Nursing to grant an application by endorsement to any applicant who is licensed, certified, or registered in another state, the District of Columbia, or a United States territory or possession upon submission of evidence satisfactory to such board. Currently, the Boards of Dentistry, Medicine, and Nursing are authorized but not required to grant a license, certification, or registration by endorsement for applicants wishing to practice regulated professions.

HB 1105 Practitioners, licensed; continuing education related to implicit bias and cultural competency.

Chief patron: McQuinn

Summary as introduced:

Board of Medicine; implicit bias and cultural competency. Requires all practitioners licensed by the Board of Medicine to complete two hours of continuing education in each biennium on topics related to implicit bias and cultural competency.

HB 1245 Nurse practitioners; practice without a practice agreement, repeals sunset provision.

Chief patron: Adams, D.M.

Summary as introduced:

Nurse practitioners; practice without a practice agreement; repeal sunset. Repeals the sunset provision on the bill passed in 2021 that reduces from five to two the number of years of full-time clinical experience a nurse practitioner must have to be eligible to practice without a written or electronic practice agreement.

HB 1307 Kratom products; prohibited acts, civil penalty.

Chief patron: Fowler

Summary as introduced:

Kratom; prohibited acts; civil penalty. Provides that no person that sells, prepares, manufactures, distributes, or maintains kratom products, as defined in the bill, or advertises, represents, or holds itself out as selling, preparing, manufacturing, distributing, or maintaining kratom products shall prepare, distribute, sell, or expose for sale (i) any kratom product that is includes or is packed with a substance that is not kratom and that affects the quality or strength of the kratom product or that contains any poisonous or otherwise deleterious ingredient; (ii) any kratom product that contains a level of 7-hydroxymitragynine in the alkaloid fraction that is greater than two percent of the overall alkaloid composition of the product or any synthetic alkaloids or other synthetically derived compounds of the kratom plant; (iii) any kratom extract that contains levels of residual solvents that are higher than is allowed in Chapter 467 of current edition of the United States Pharmacopeia; or (iv) any kratom product that does not provide labeling directions necessary for safe and effective use by consumers, including a recommended serving size. The bill provides that any person that violates the provisions of the bill shall be subject to a civil penalty in the

amount of $100 for a first violation, a civil penalty in the amount of $200 for a second violation, and a civil penalty in the amount of $500 for a third or subsequent violation.

HB 1323 Pharmacists; initiation of treatment with and dispensing and administration of vaccines.

Chief patron: Orrock

Summary as introduced:

Pharmacists; initiation of treatment with and dispensing and administration of vaccines. Provides that a pharmacist may initiate treatment with, dispense, or administer to persons three years of age or older in accordance with a statewide protocol developed by the Board of Pharmacy in collaboration with the Board of Medicine and the Department of Health vaccines included on the Immunization Schedule published by the Centers for Disease Control and Prevention or that have a current emergency use authorization from the U.S. Food and Drug Administration, and provides that the pharmacist may cause such vaccines to be administered by a pharmacy technician or pharmacy intern under the direct supervision of the pharmacist. The bill also requires the Department of Medical Assistance Services and accident and sickness insurance providers to provide reimbursement for such service in an amount that is no less than the reimbursement amount for such service by a health care provider licensed by the Board of Medicine.

HB 1359 Health care; consent to services and disclosure of records.

Chief patron: Byron

Summary as introduced:

Health care; consent to services and disclosure of records. Eliminates authority of a minor to consent to medical or health services needed in the case of outpatient care, treatment, or rehabilitation for medical illness or emotional disturbance and the disclosure of medical records related thereto. The bill also provides that an authorization for the disclosure of health records shall remain in effect until such time as it is revoked in writing to the person in possession of the health record subject to the authorization; shall include authorization for the release of all health records of the person created by the health care entity to whom permission to release health records was granted from the date on which the authorization was executed; and shall include authorization for the person named in the authorization to assist the person who is the subject of the health record in accessing health care services, including scheduling appointments for the person who is the subject of the health record and attending appointments together with the person who is the subject of the health record. The bill also provides that every health care

provider shall make health records of a patient available to any person designated by a patient in an authorization to release medical records and that a health care provider shall allow a person to make an appointment for medical services on behalf of another person, regardless of whether the other person has executed an authorization to release medical records, provided that such health care provider shall not release protected health information to the person making the appointment for medical services on behalf of another person unless such person has executed an authorization to release medical records to the person making the appointment.

SB 73 COVID-19; prescriptions for hydroxychloroquine and ivermectin for treatment.

Chief patron: Chase

Summary as introduced:

Prescriptions for hydroxychloroquine and ivermectin for treatment of COVID-19. Provides that licensed health care providers with prescriptive authority may prescribe, administer, or dispense hydroxychloroquine and ivermectin to a patient with a clinical diagnosis of COVID-19. The bill prohibits the Board of Medicine from initiating a disciplinary action against a licensed health care provider solely for prescribing, administering, or dispensing hydroxychloroquine or ivermectin to a patient with a clinical diagnosis of COVID-19, provided such clinical diagnosis and treatment has been documented in the patient's medical record by such licensed health care provider.

SB 148 Public health emergencies; expands immunity for health care providers.

Chief patron: Norment

Summary as introduced:

Public health emergencies; immunity for health care providers. Expands immunity provided to health care providers responding to a disaster to include actions or omissions taken by the provider as directed by any order of public health in response to such disaster when a local emergency, state of emergency, or public health emergency has been declared.

SB 169 Practical nurses, licensed; authority to pronounce death.

Chief patron: Peake

Summary as introduced:

Licensed practical nurses; authority to pronounce death. Extends to licensed practical nurses the

authority to pronounce the death of a patient, provided that certain conditions are met. Current law provides that physicians, registered nurses, and physician assistants may pronounce death.

SB 313 Cannabis products; retail sale of by certain pharmaceutical processors & industrial hemp processors.

Chief patron: Ebbin

Summary as introduced:

Retail sale of cannabis products by certain pharmaceutical processors and industrial hemp processors; sunset. Allows certain pharmaceutical processors and industrial hemp processors to sell, under the oversight of the Board of Directors of the Virginia Cannabis Control Authority (the Board), cannabis products at retail to unregistered persons who are 21 years of age or older without the need for a written certification. The bill directs the Board to adopt and enforce regulations governing such sales that shall model certain Board of Pharmacy regulations and comply with other requirements set forth in the bill. The bill requires pharmaceutical processors and industrial hemp processors engaging in such sales to pay a $1 million fee and collect a 21 percent excise tax, both of which shall ultimately be allocated to the Virginia Cannabis Control Authority to be used to assist independent cannabis retailers located in designated rural and urban opportunity zones. The bill also requires such pharmaceutical processors and industrial hemp processors to submit and comply with a plan describing how the processor will educate consumers about responsible consumption of cannabis products and incubate independent cannabis retailers or support and educate persons that wish to participate in the cannabis market. The bill has a delayed effective date of January 1, 2023, and shall expire when pharmaceutical processors and industrial hemp processors engaging in the sale of cannabis products pursuant to the provisions of the bill are authorized by the Virginia Cannabis Control Authority to apply for and be granted licenses to cultivate, manufacture, wholesale, and sell at retail to consumers 21 years of age or older retail marijuana and retail marijuana products.

SB 317 Out-of-state health care practitioners; temporary authorization to practice.

Chief patron: Favola

Summary as introduced:

Out-of-state health care practitioners; temporary authorization to practice; licensure by reciprocity for physicians; emergency. Allows a health care practitioner licensed in another state or the District of Columbia who has submitted an application for licensure to the appropriate health regulatory board to temporarily practice for a period of 90 days pending licensure, provided that certain conditions are met.

The bill directs the Department of Health Professions to pursue reciprocity agreements with jurisdictions that surround the Commonwealth to streamline the application process in order to facilitate the practice of medicine. The bill requires the Department of Health Professions to annually report to the Chairmen of the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions the number of out-of-state health care practitioners who have utilized the temporary authorization to practice pending licensure and have not subsequently been issued full licensure. The bill contains an emergency clause.

EMERGENCY

SB 350 Health records; patient's right to disclosure.

Chief patron: Surovell

Summary as introduced:

Health records; patient's right to disclosure. Requires a health care entity to include in its disclosure of an individual's health records any changes made to the health records and an audit trail for such records if the individual requests that such information be included in the health records disclosure.

SB 369 Telemedicine services; practitioners licensed by Board of Medicine.

Chief patron: Stuart

Summary as introduced:

Telemedicine services; practitioners licensed by Board of Medicine. Allows a practitioner of a profession regulated by the Board of Medicine who is licensed in another state, the District of Columbia, or a United States territory or possession and who is in good standing with the applicable regulatory agency in that state, the District of Columbia, or that United States territory or possession to engage in the practice of that profession in the Commonwealth with a patient located in the Commonwealth when (i) such practice is for the purpose of providing continuity of care through the use of telemedicine services and (ii) the patient is a current patient of the practitioner with whom the practitioner has previously established a practitioner-patient relationship.

SB 408 Sentencing documents; transmission to the DHP and DBHDS.

Chief patron: Dunnavant

Summary as introduced:

Transmission of sentencing documents to the Department of Health Professions and Department of

Behavioral Health and Developmental Services. Provides that the attorney for the Commonwealth or his designee shall request the clerk of the court to transmit certified copies of sentencing documents to the Director of the Department of Health Professions or to the Director of the Department of Behavioral Health and Developmental Services when a practitioner or person who is licensed by a health regulatory board or the Department of Behavioral Health and Developmental Services has been convicted of a felony, crime involving moral turpitude, or crime that occurred during the course of practice for which such practitioner or person is licensed. The bill also provides that no clerk shall charge for copying or making for or furnishing to the Department of Health Professions or Department of Behavioral Health and Developmental Services a certified copy of a criminal judgment order or criminal sentencing order.

SB 414 Nurse practitioners; patient care team physician supervision capacity increased.

Chief patron: Kiggans

Summary as introduced:

Nurse practitioners; patient care team physician supervision capacity increased. Increases from six to 10 the number of nurse practitioners a patient care team physician may supervise at any one time in accordance with a written or electronic practice agreement.

SB 511 Opioid treatment program pharmacy; medication dispensing, registered nurses.

Chief patron: Suetterlein

Summary as introduced:

Opioid treatment program pharmacy; medication dispensing; registered nurses. Allows a registered nurse practicing at an opioid treatment program pharmacy to perform the duties of a pharmacy technician, provided that all take-home medication doses are verified for accuracy by a pharmacist prior to dispensing.

SB 594 Medicaid participants; treatment involving the prescription of opioids, payment.

Chief patron: Pillion

Summary as introduced:

Medicaid participants; treatment involving the prescription of opioids; payment. Prohibits licensed providers from requiring payment from Medicaid participants for the prescription of an opioid for the

management of pain or the prescription of buprenorphine-containing products, methadone, or other opioid replacements approved for the treatment of opioid addiction by the U.S. Food and Drug Administration for medication-assisted treatment of opioid addiction, regardless of whether the provider participates in the state plan for medical assistance.

SB 621 Cannabis products; retail sales by certain pharmaceutical processors.

Chief patron: Dunnavant

Summary as introduced:

Retail sale of cannabis products by certain pharmaceutical processors; sunset. Allows certain pharmaceutical processors to, under the oversight of the Board of Pharmacy, sell cannabis products at retail to unregistered persons who are 21 years of age or older without the need for a written certification. The bill provides that such sales will be subject to existing Board of Pharmacy regulations and other requirements set forth in the bill. The bill requires pharmaceutical processors engaging in such sales to collect a 21 percent excise tax, to be deposited into the general fund, and pay a $1 million fee, to be deposited into the account of the Virginia Cannabis Control Authority and used to assist independent cannabis retailers located in designated rural and urban opportunity zones. The bill also requires such pharmaceutical processors to submit and comply with a plan describing how the pharmaceutical processor will, in its health service area, educate consumers about responsible consumption of cannabis products and incubate independent cannabis retailers or support and educate persons that wish to participate in the cannabis market. The bill directs the Board of Directors of the Virginia Cannabis Control Authority to promulgate regulations governing sales, cultivation, extraction, processing, manufacturing, wholesaling, and other related activities conducted pursuant to the provisions of the bill and provides that, upon the effective date of such regulations, oversight of such activities shall transfer from the Board of Pharmacy to the Board of Directors of the Virginia Cannabis Control Authority. The bill expires when pharmaceutical processors engaging in the sale of cannabis products pursuant to the provisions of the bill are authorized by the Virginia Cannabis Control Authority to apply for and be granted licenses to cultivate, manufacture, wholesale, and sell at retail to consumers 21 years of age or older retail marijuana and retail marijuana products.

SB 668 Death with Dignity Act; penalties.

Chief patron: Hashmi

Summary as introduced:

Death with Dignity Act; penalties. Allows an adult who has been determined by an attending physician and consulting physician to be suffering from a terminal condition to request medication for the purpose of ending his life in a humane and dignified manner. The bill requires that a patient's request for medication to end his life be given orally on two occasions, that such request be in writing, signed by the patient and two witnesses, and that the patient be given an express opportunity to rescind his request. The bill requires that before a patient is prescribed medication to end his life, the attending physician must (i) confirm that the patient is making an informed decision; (ii) refer the patient to a capacity reviewer if the physician is uncertain as to whether the patient is making an informed decision; (iii) refer the patient to a consulting physician for confirmation or rejection of the attending physician's diagnosis; and (iv) inform the patient that he may rescind the request at any time. The bill provides that neither a patient's request for medication to end his life in a humane and dignified manner nor his act of ingesting such medication shall have any effect upon a life, health, or accident insurance policy or an annuity contract. The bill makes it a Class 2 felony (a) to willfully and deliberately alter, forge, conceal, or destroy a patient's request, or rescission of request, for medication to end his life with the intent and effect of causing the patient's death or (b) to coerce, intimidate, or exert undue influence on a patient to request medication for the purpose of ending his life or to destroy the patient's rescission of such request with the intent and effect of causing the patient's death. Finally, the bill grants immunity from civil or criminal liability and professional disciplinary action to any person who complies with the provisions of the bill and allows health care providers to refuse to participate in the provision of medication to a patient for the purpose of ending the patient's life.

SB 671 Pharmaceutical processors; amends the definition of "cannabis oil."

Chief patron: Dunnavant

Summary as introduced:

Pharmaceutical processors. Amends the definition of "cannabis oil" by removing the requirement that only oil from industrial hemp be used in the formulation of cannabis oil. The bill requires the Board of Pharmacy to publish monthly on its website information including the number of practitioners, patients, registered agents, and parents or legal guardians of patients in each health service area who have registered with the Board, the number of written certifications issued, the number of pending applications for registrations, and the pace at which the Board is approving registrations. The bill directs the Board to promulgate numerous regulations related to pharmaceutical processors.

SB 672 Pharmacists and pharmacy technicians; prescribing, dispensing, etc. of controlled substances.

Chief patron: Dunnavant

Summary as introduced:

Pharmacists and pharmacy technicians; prescribing, dispensing, and administering of controlled substances. Allows pharmacists and pharmacy technicians under the supervision of a pharmacist to initiate treatment with and dispense and administer certain drugs devices, and tests in accordance with a statewide protocol developed by the Board of Pharmacy in collaboration with the Board of Medicine and the Department of Health. The bill directs the Board of Pharmacy to establish such protocol by November 1, 2022, and to promulgate regulations to implement the provisions of the bill within 280 days of its enactment.

SB 676 Associate physicians; licensure and practice.

Chief patron: DeSteph

Summary as introduced:

Licensure and practice of associate physicians. Authorizes the Board of Medicine to issue a two-year license to practice as an associate physician to an applicant who is 18 years of age or older, is of good moral character, has graduated from an accredited medical school, has successfully completed Step 1 and Step 2 of the United States Medical Licensing Examination, and has not completed a medical internship or residency program. The bill requires all associate physicians to practice in accordance with a practice agreement entered into between the associate physician and a physician licensed by the Board and provides for prescriptive authority of associate physicians in accordance with regulations of the Board.

SB 711 Prescriptions; off-label use.

Chief patron: Chase

Summary as introduced:

Prescriptions; off-label use. Provides that a licensed health care provider with prescriptive authority may prescribe, administer, or dispense a drug that has been approved for a specific use by the U.S. Food and Drug Administration for an off-label use when the health care provider determines, in his professional judgment, that such off-label use is appropriate for the care and treatment of the patient and prohibits a pharmacist from refusing to dispense a drug for off-label use if a valid prescription is presented.

SB 759 Drug Control Act; adds certain chemicals to the Act.

Chief patron: Newman

Summary as introduced:

Drug Control Act; Schedule I; Schedule II; Schedule IV; Schedule V. Adds certain chemicals to the Drug Control Act. The Board of Pharmacy has added these substances in an expedited regulatory process. A substance added via this process is removed from the schedule after 18 months unless a general law is enacted adding the substance to the schedule.

Agenda Item: Review of Guidance Document 85-5 "Guidance on Questions about Medical Records"

Staff Note: On the following pages, you will find Board of Medicine Guidance Document 85-5 about medical records. This document was last updated on August 10, 2017, so it is time for the Board to adopt and updated version. Board staff has reviewed the existing document in light of Section 32.1-127.1:03 of the Code of Virginia. The section is titled Health Records Privacy and governs the management of an individual's health records. After review, Board staff believes that the document is consistent with the Code and still provides helpful guidance to the public and practitioners alike.

Action: Adopt the current document or suggest revisions.

Guidance document: 85-5 Revised: August 10, 2017

Virginia Board of Medicine

Guidance on Questions about Medical Records

Who owns the medical record - the practitioner or the patient?

Virginia Code § 32.1-127.1:03 declares that medical records are the "property of the health care entity maintaining them". The law recognizes "an individual's right of privacy in the content of his medical record" and makes the practitioner responsible for ensuring that the patient's records are only released in accordance with the law.

The definition of "record" is expansive and includes all written, printed or electronically recorded material, maintained by a provider in the course of providing health services to an individual, as well as the substance of any communication between the individual and provider during the course of providing services. It also includes other information acquired by the provider about the patient in connection with the provision of health care services to the patient, including records obtained from or created by another health care provider.

Note: The law does not apply to health care records created in connection with the Workers Compensation Act or to records of minors, except as issues concerning minors' records are specifically addressed in the statute. Virginia Code § 54.1-2969 addresses when a minor is deemed to be an adult for the purpose of accessing or authorizing the disclosure of medical records related to certain medical or health services.

How do I get a copy of my medical record?

A request for copies of medical records must be in writing, dated and signed by the person making the request, and include a reasonable description of the records sought. If someone is making a request on your behalf, he or she must provide evidence of the authority to receive the records (such as a power of attorney). The provider must accept a photocopy, facsimile, or other copy of the original signed by the requester as if it were an original (Virginia Code § 32.1-127.1:03).

Upon receipt of such a request, the health care provider has 30 days to do one of the following:

1. *provide copies of the records or allow electronic access to the requested health records to any requester authorized to receive them in electronic format if so requested;*
2. *inform the requester if the information does not exist or cannot be found;*
3. *inform the requester of the provider who now maintains the records; or*
4. *deny the records for specific reasons set out in Section F of the statute.*

§ 32.1-127.1:03 also provides that the patient's physician or clinical psychologist may make a notation in a patient's record that furnishing of the records "would be reasonably likely to endanger the life or physical safety of the individual or another person, or that such health record makes reference to a person other than a health care provider and the access requested would be

reasonably likely to cause substantial harm to such referenced person." If a patient's request for his record is denied for this reason, the provider must permit the record to be copied and reviewed by a provider, selected by the patient, of similar background to the individual who made the notation in the chart, and that practitioner may make a judgment as to whether the records should be made available to the patient.

What will I be charged for a copy of my medical record?

If an individual requests a copy of his health record from a health care entity, the health care entity may impose a *reasonable cost-based fee, which shall include only the cost of supplies for and labor of copying the requested information, postage when the individual requests that such information be mailed, and preparation of an explanation or summary of such information as agreed to by the individual.* For the purposes of this section, "individual" includes a person with authority to act on behalf of the individual who is the subject of the health record in making decisions related to his health care.
If an attorney or insurer requests a copy in conjunction with civil litigation, the charges are set in § 8.01-413 of the *Code of Virginia.*

How long does a provider have to keep a medical record?

Regulations of the Board (18VAC85-20-26) state that practitioners must maintain a patient record for *a minimum of six years* following the last patient encounter with the following exceptions:

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

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

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

Practitioners must post information or in some manner inform all patients concerning the time frame for record retention and destruction. Patient records can only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.

Agenda Item: Presentation on "The Nurse Practitioner Workforce"

Staff Note: Board of Medicine members have expressed interest in the development of the Nurse Practitioner workforce in Virginia. Dr. Yetty Shobo of the Department of Health Professions' Healthcare Workforce Data Center will present the most recent data on this important topic. Dr. Shobo's slides can be found in the following pages. Her presentations are always succinct and provide great clarity.

Action: No vote to be taken. Questions and discussion as appropriate.

Department of Health Professions

The Nurse Practitioner Workforce

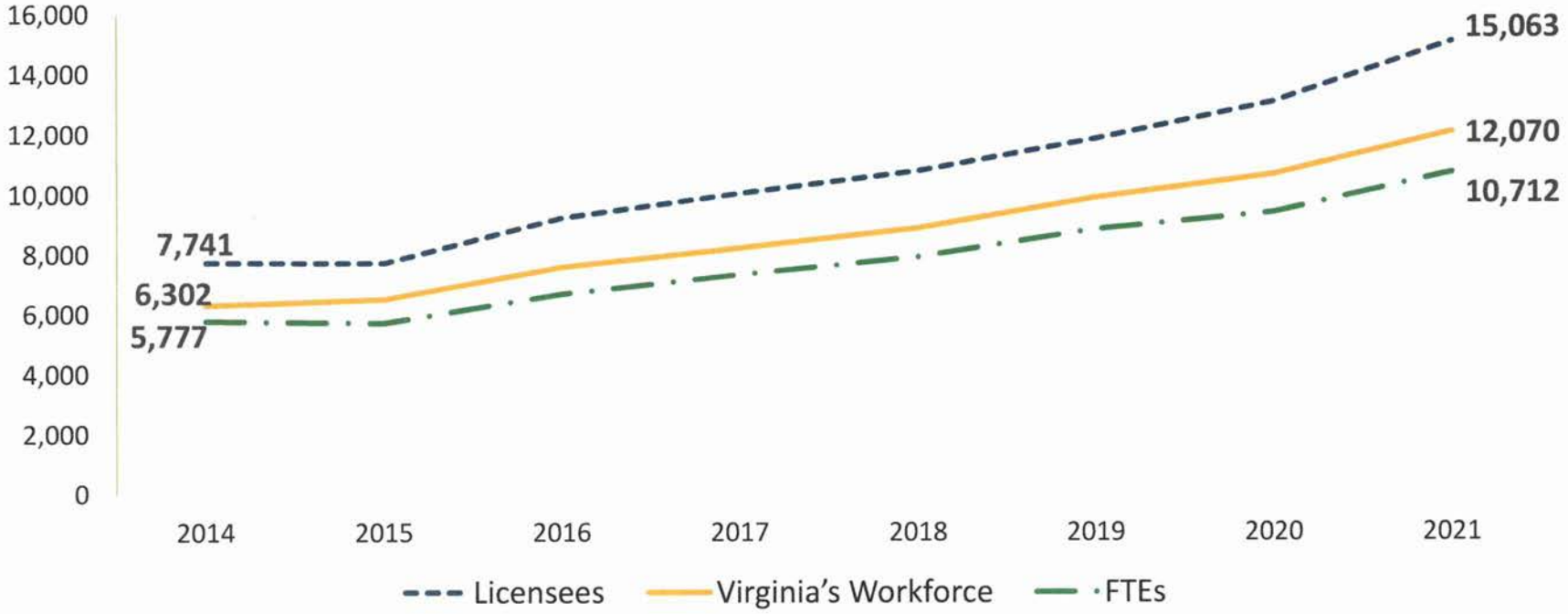
Yetty Shobo, PhD

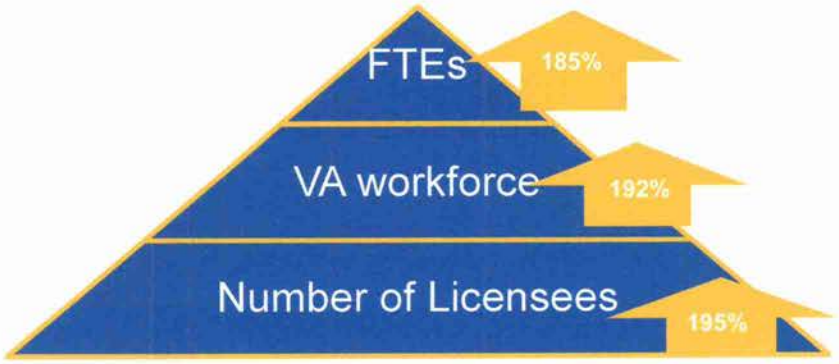
Joint Boards of Nursing and Medicine Meeting

February 17, 2022

Department of Health Professions

Trends in the NP Workforce





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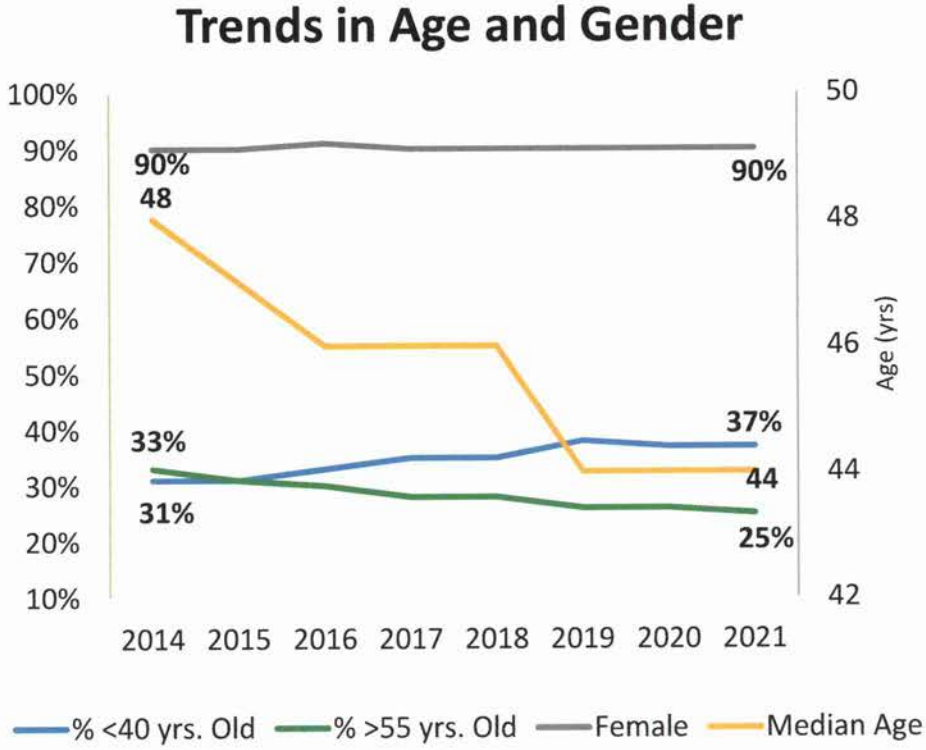
Findings - NPs

Percent female is stable

Younger workforce



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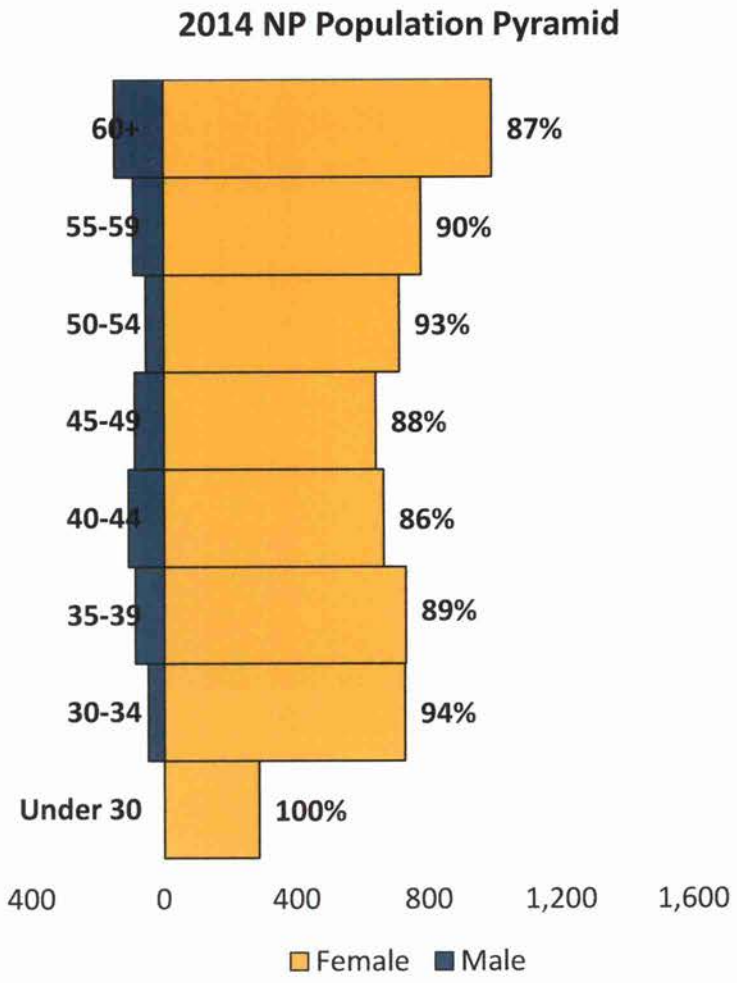
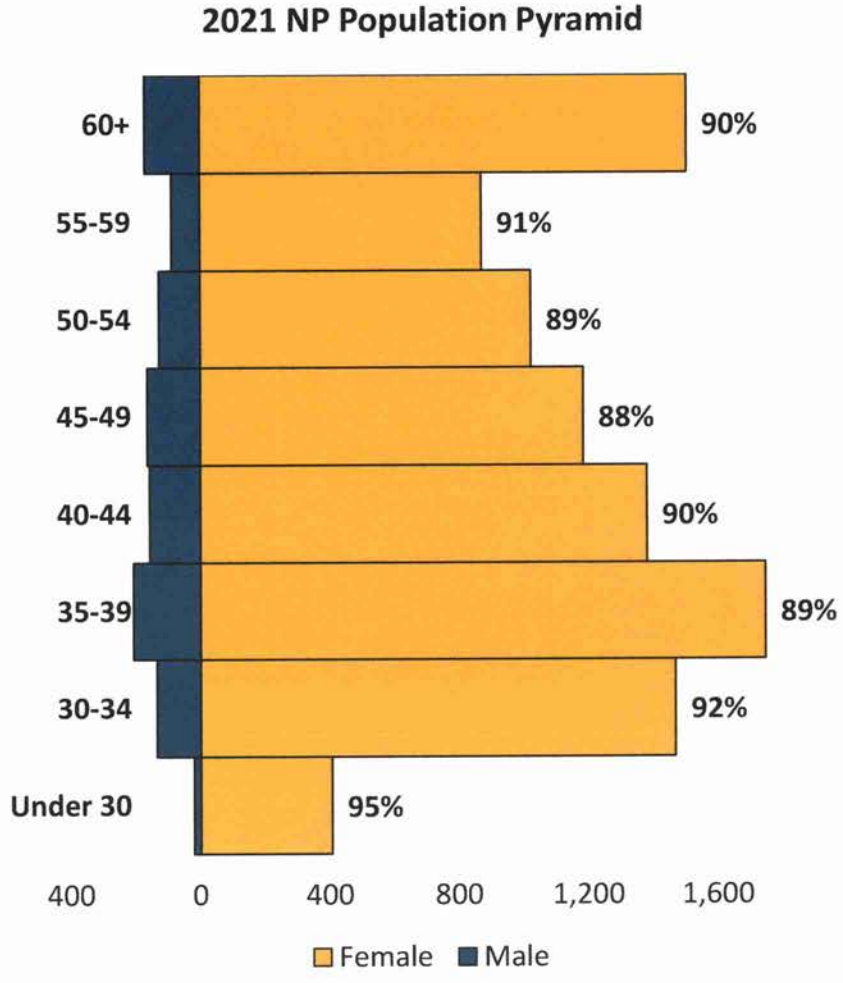
Department of Health Professions





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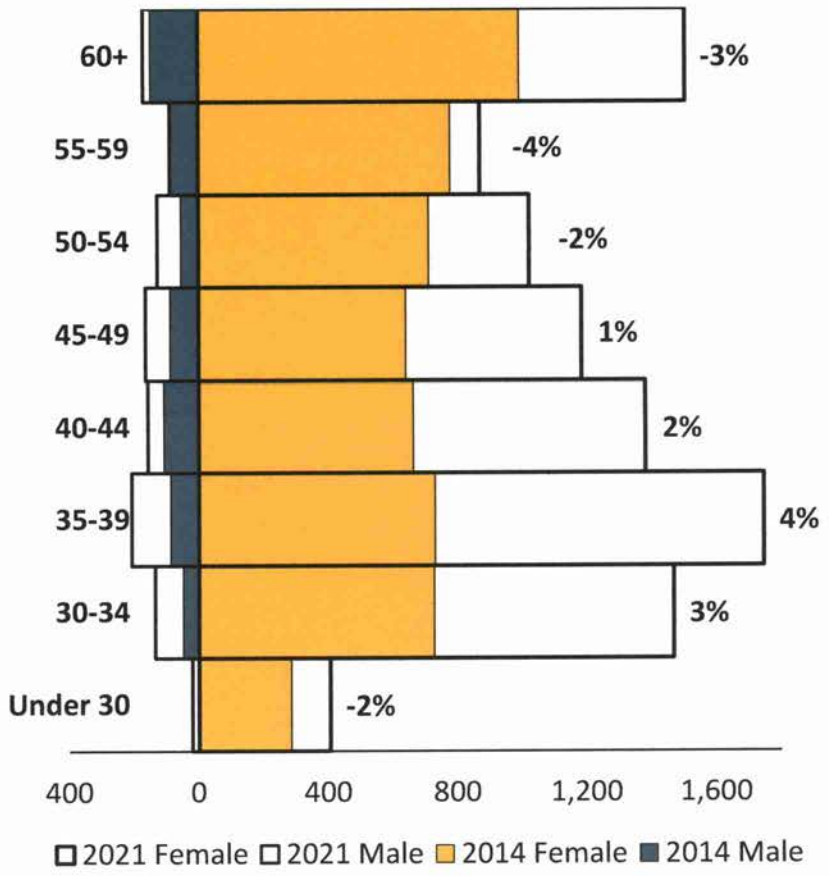
Numerical gain at all age groups

Proportional gain at younger age groups

2014 versus 2021 NP Population Pyramid



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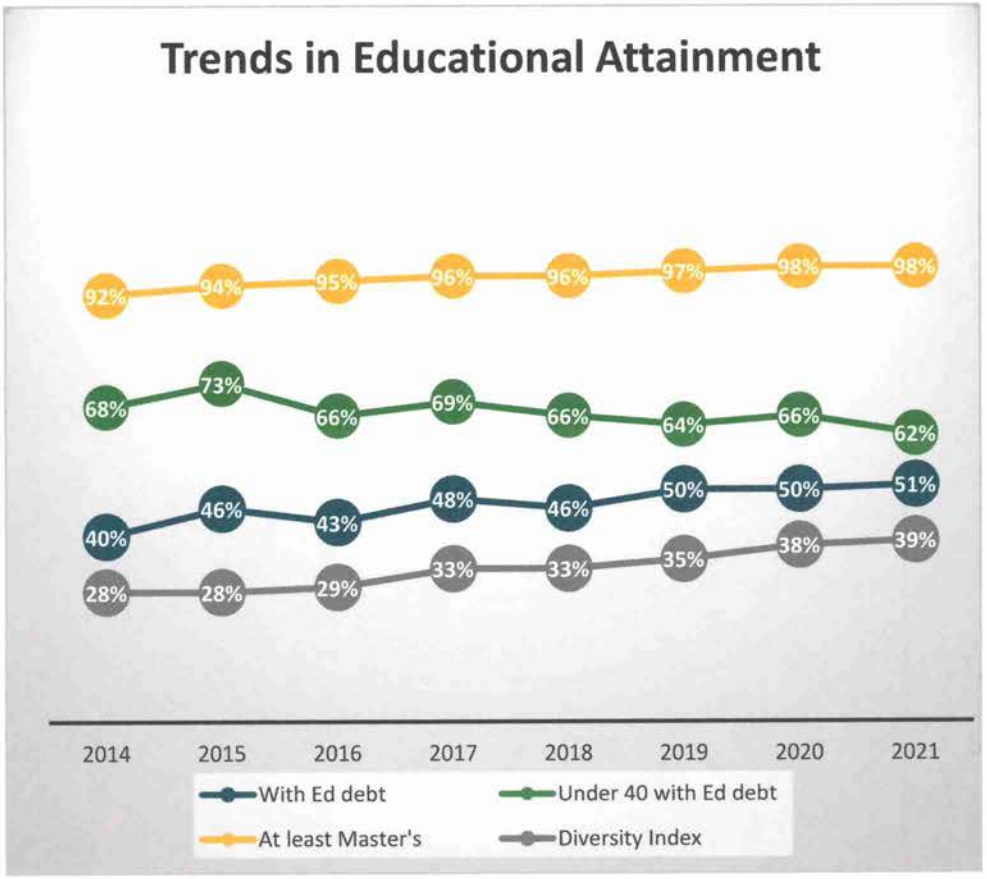
Findings - NPs

- Educational attainment stable
- Increasing % with debt
- Increasing diversity



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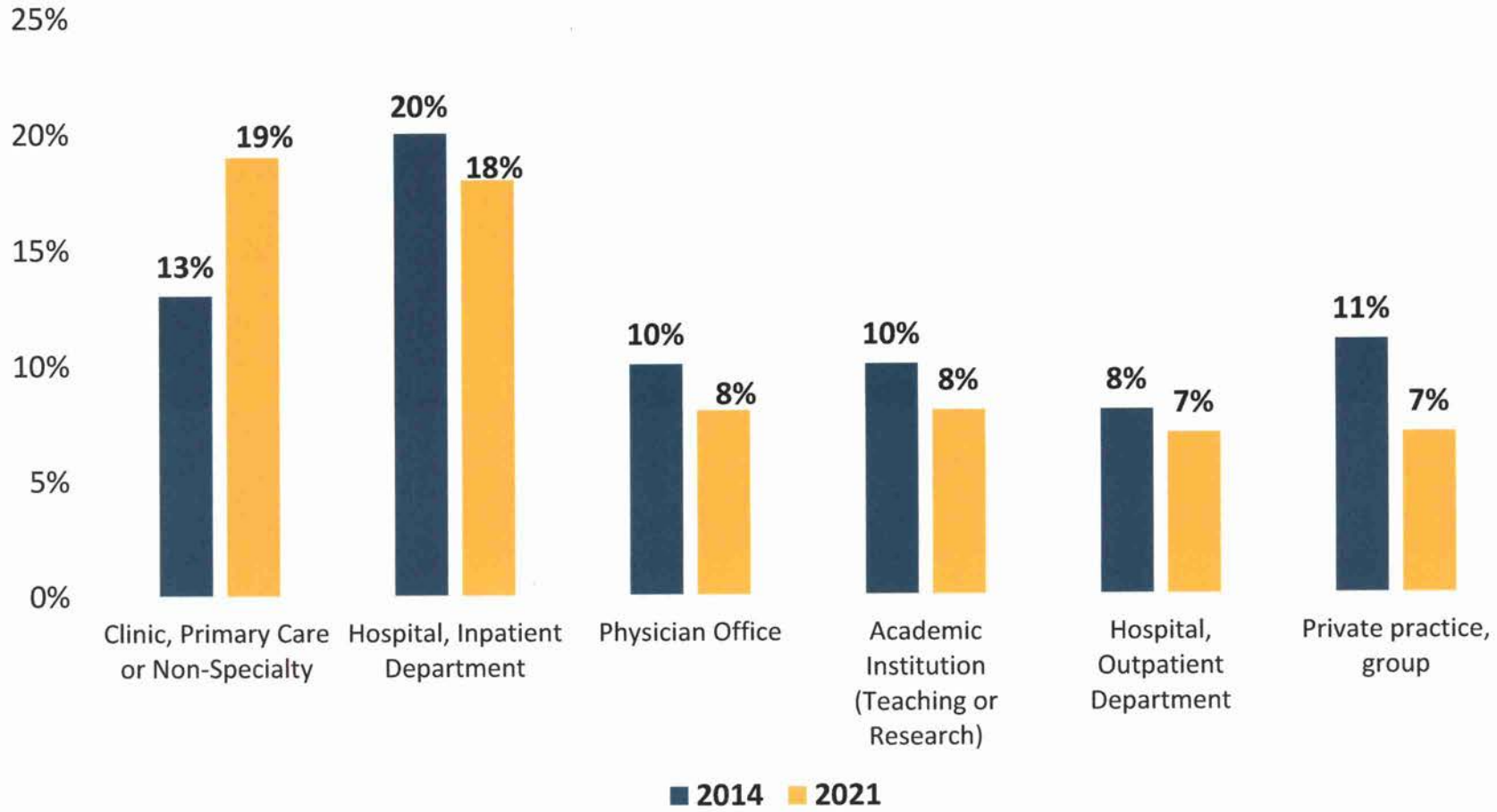
2014 vs. 2021 Work Locations



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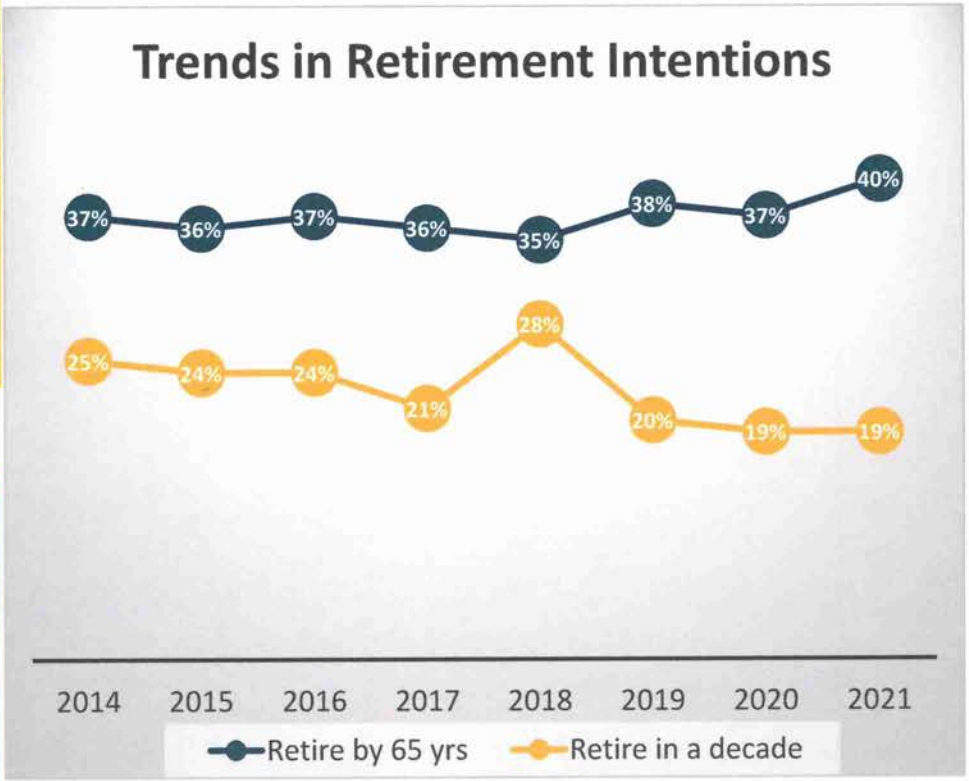
Retirement Intentions

Percent retiring in the next decade stable

Those retiring by age 65 increased



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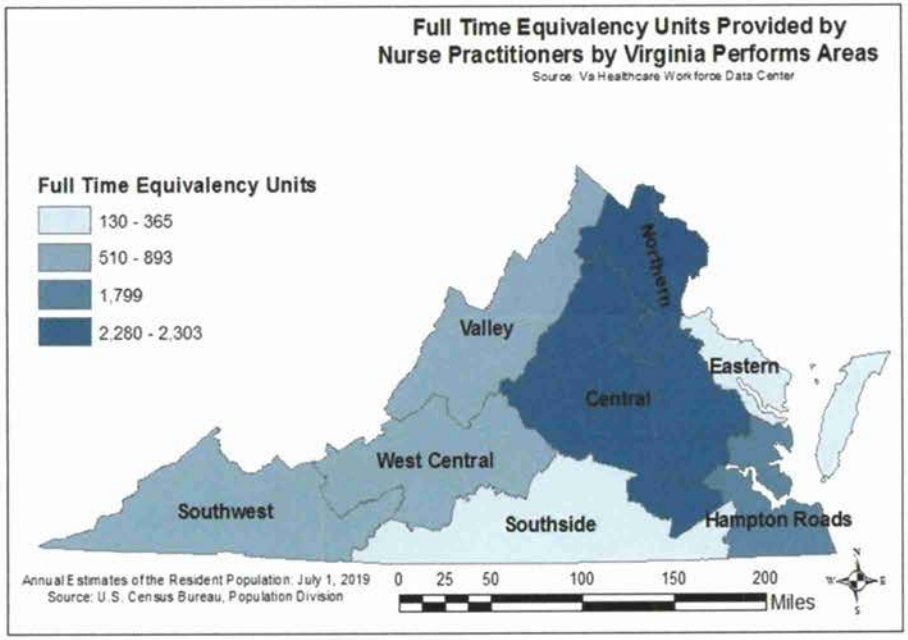

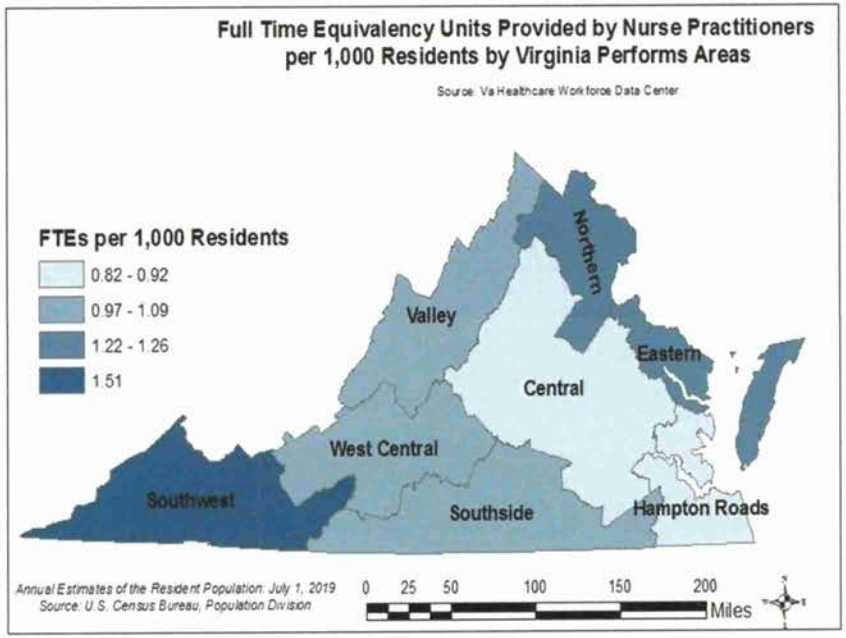

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Nurse Practitioners by Specialty: 2020 & 2021 Data

NP Workforce by Specialty

15,056 NPs licensed in 2020 and 2021

- 2,211 (14%) CRNA
- 421 (3%) CNM
- 12,410 (83%) CNP

12,070 (80%) in state's workforce; 10,712 FTEs

- 77% CRNA
- 81% CNM
- 81% CNP

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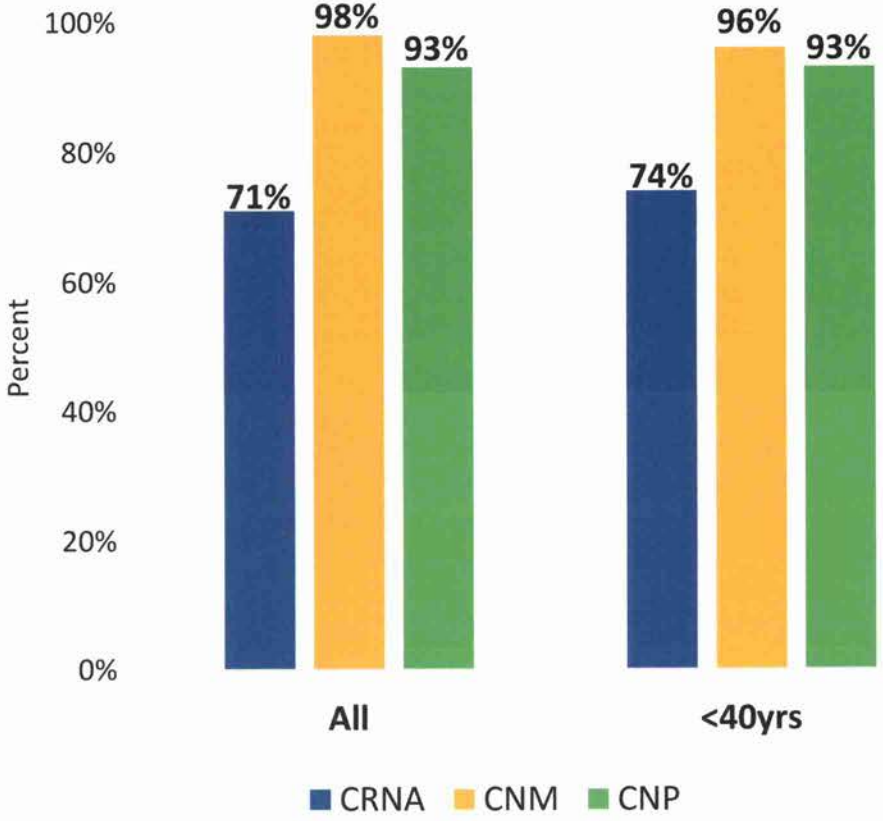
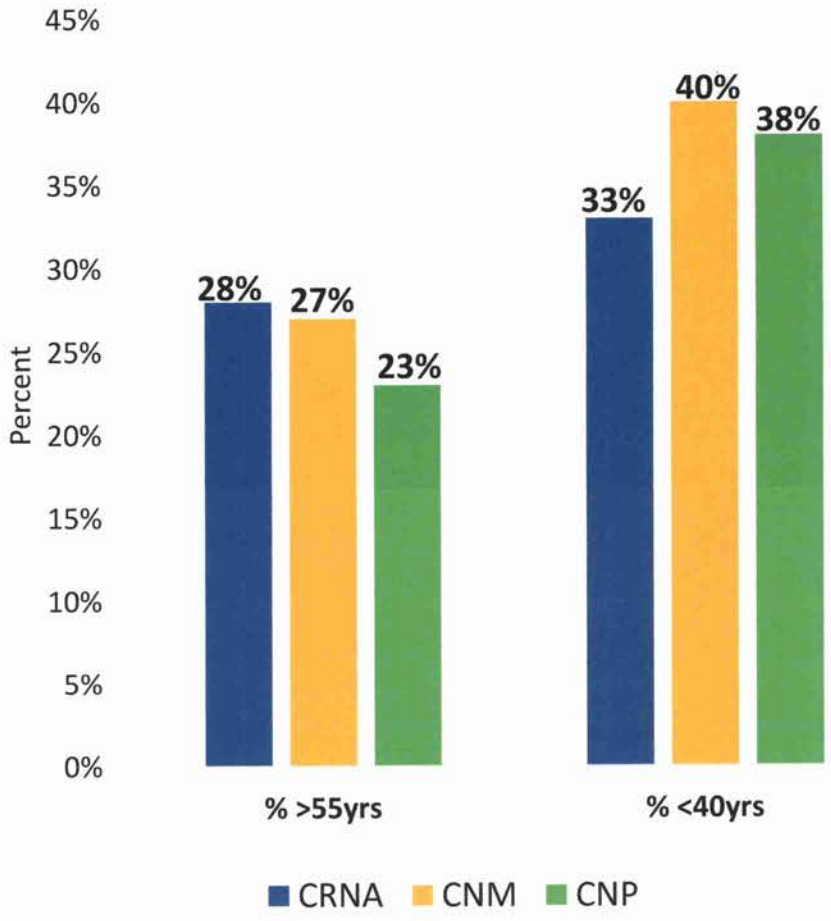
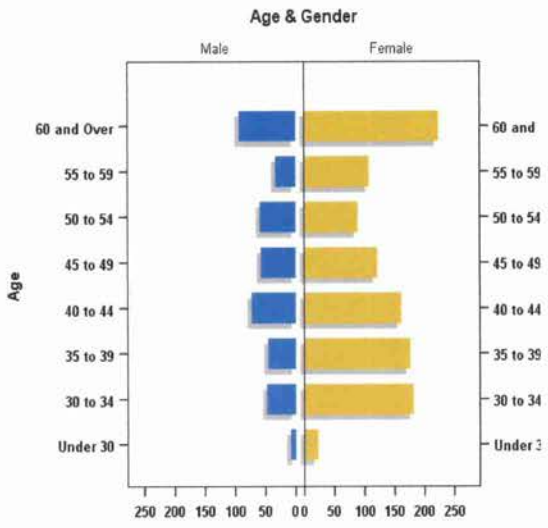
Percent Female



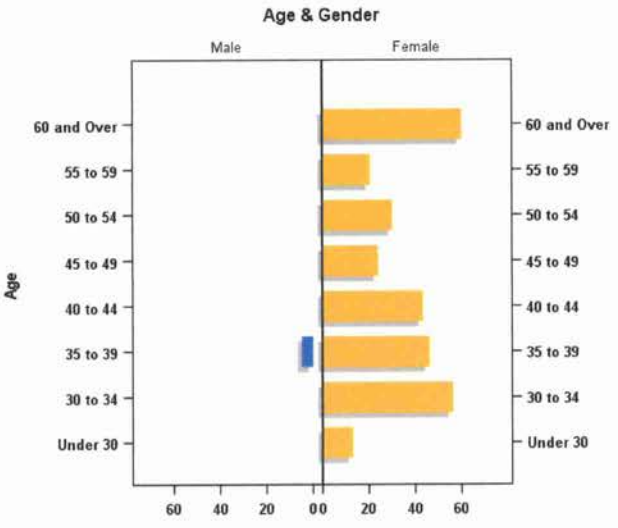
Age Distribution



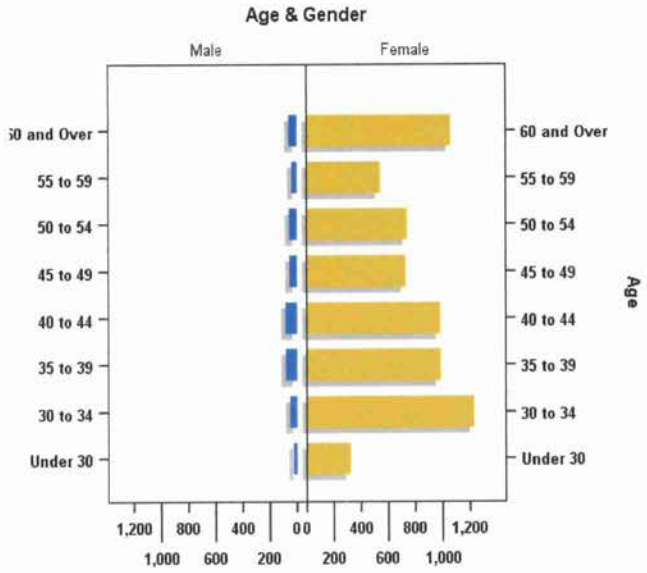
Age and Gender Distribution



CRNA



CNM



CNP

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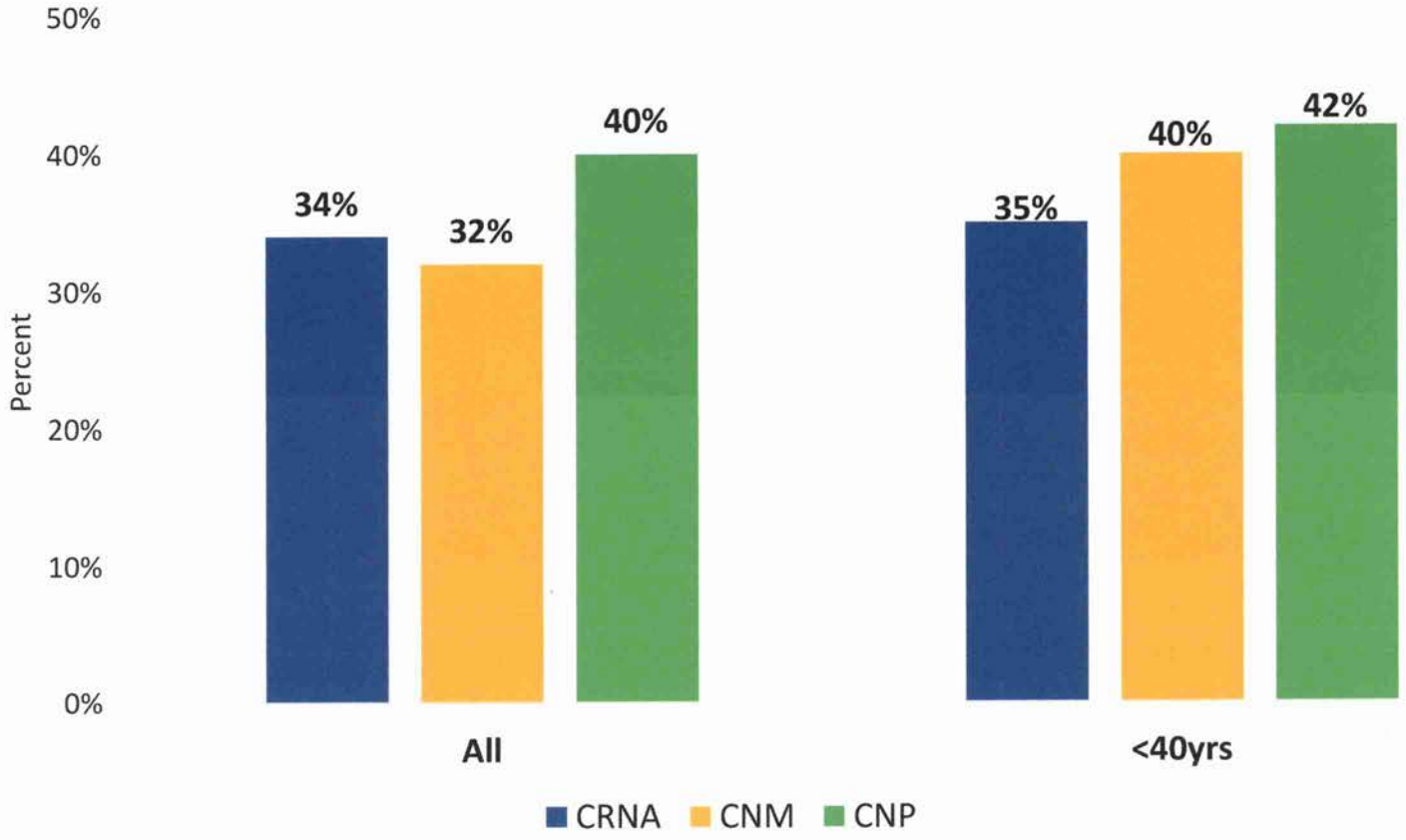
Diversity Index



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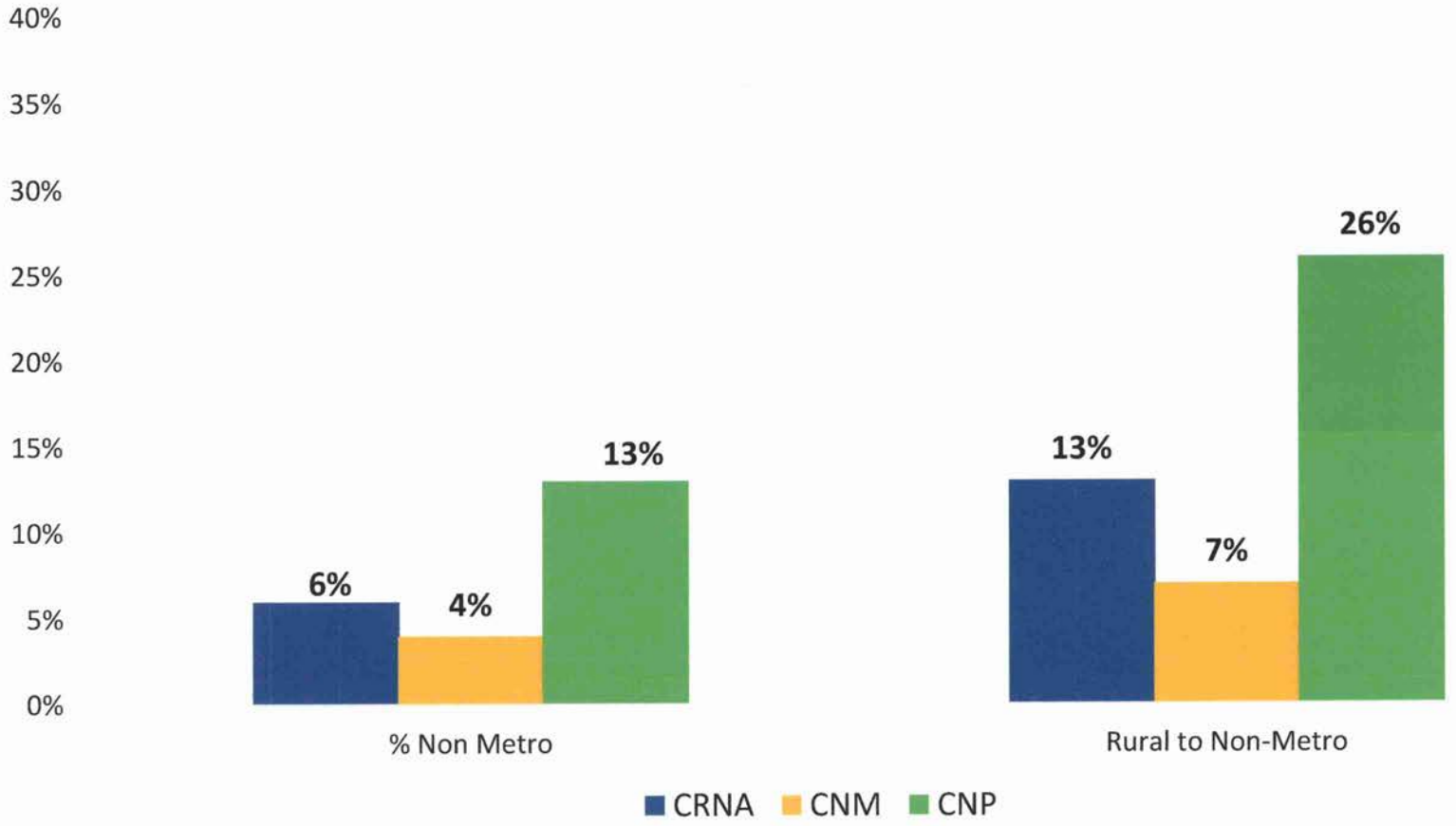
Current Metro Status



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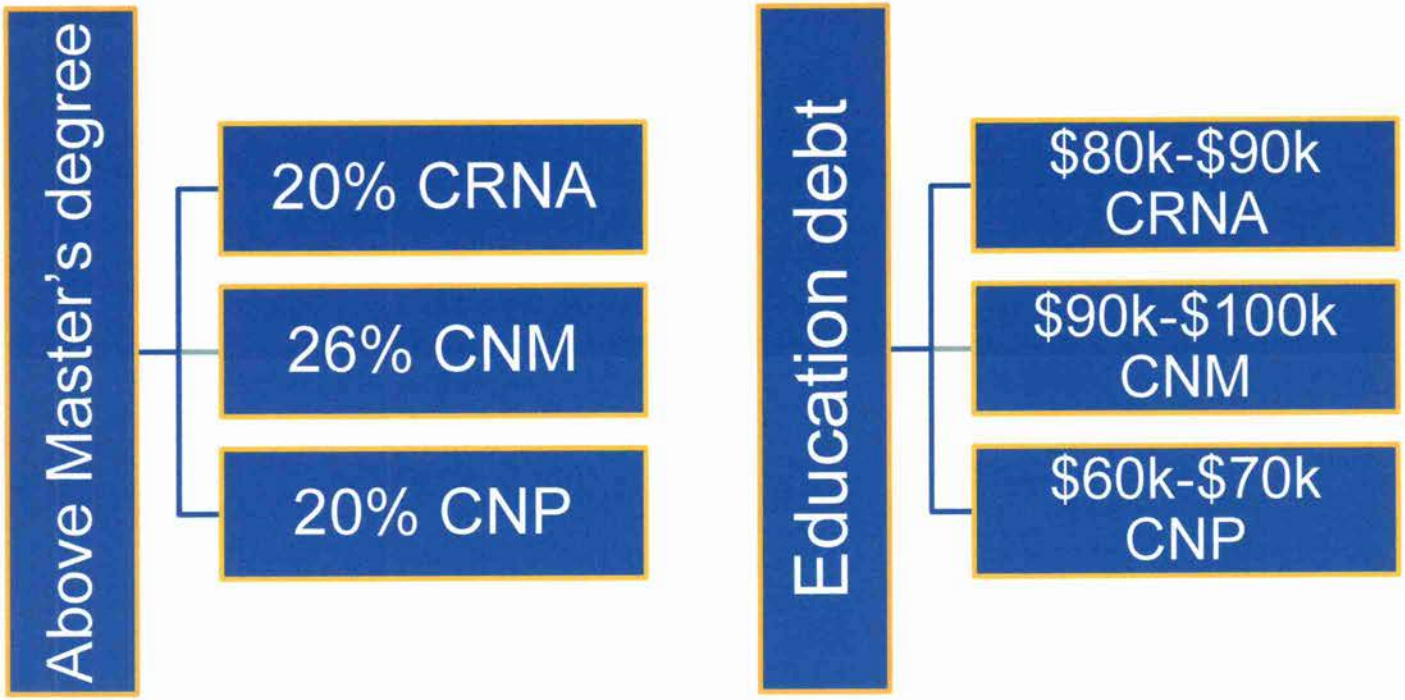
Education and Debt



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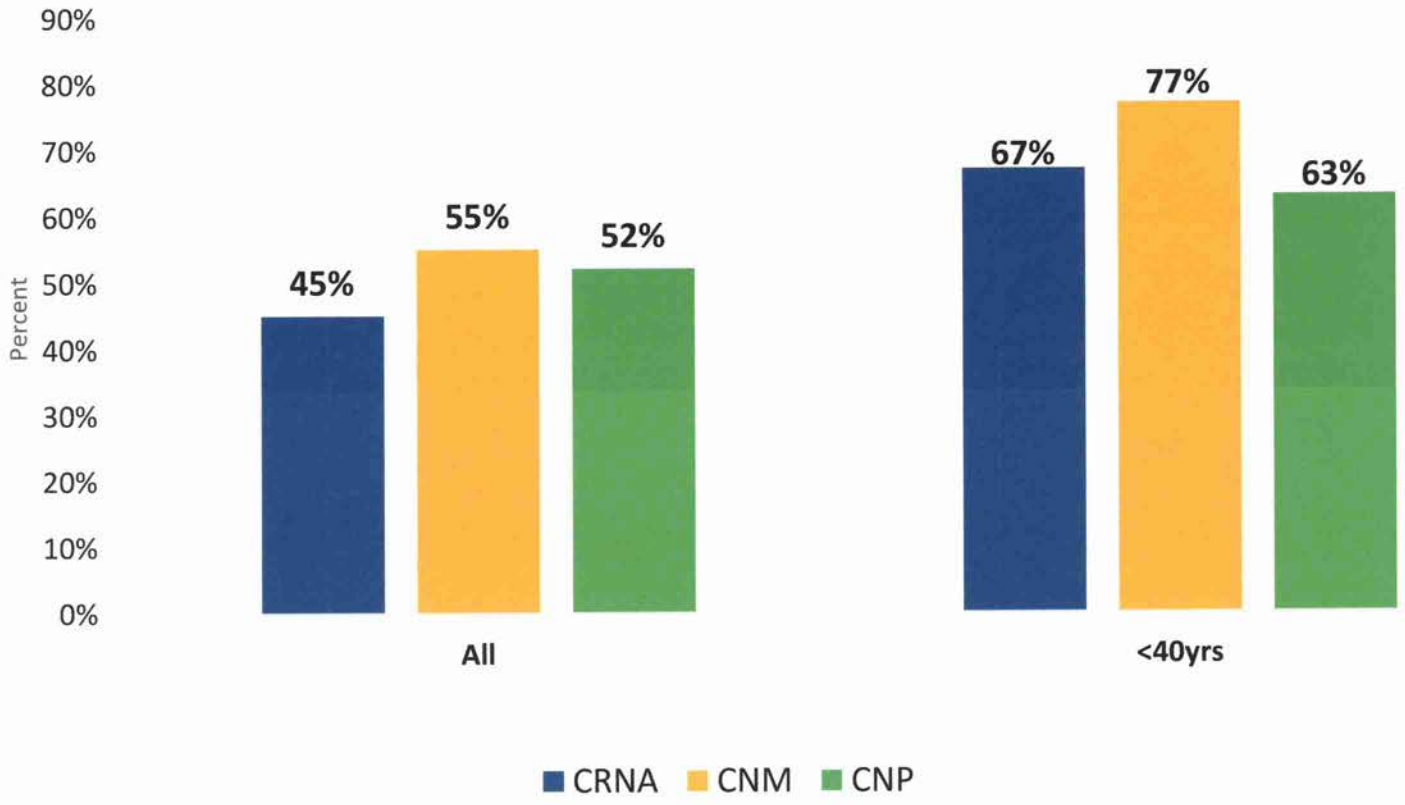
Education Debt



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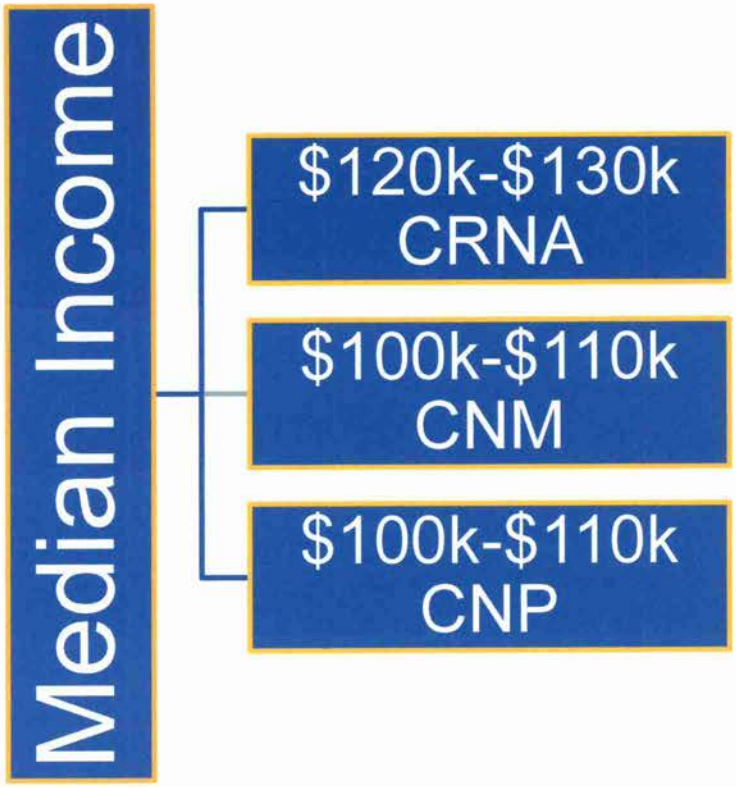
Median Income



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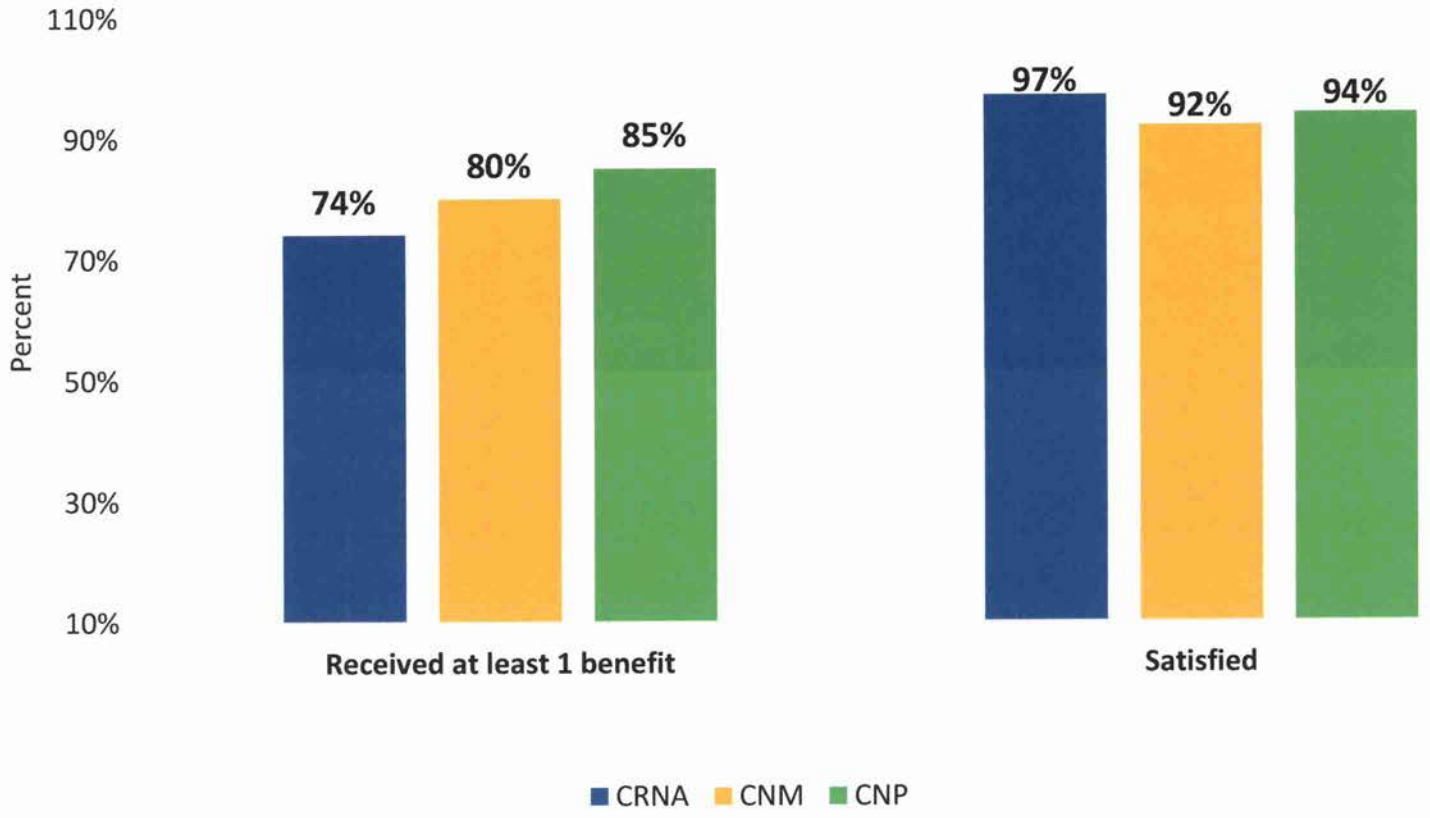
Employment Quality



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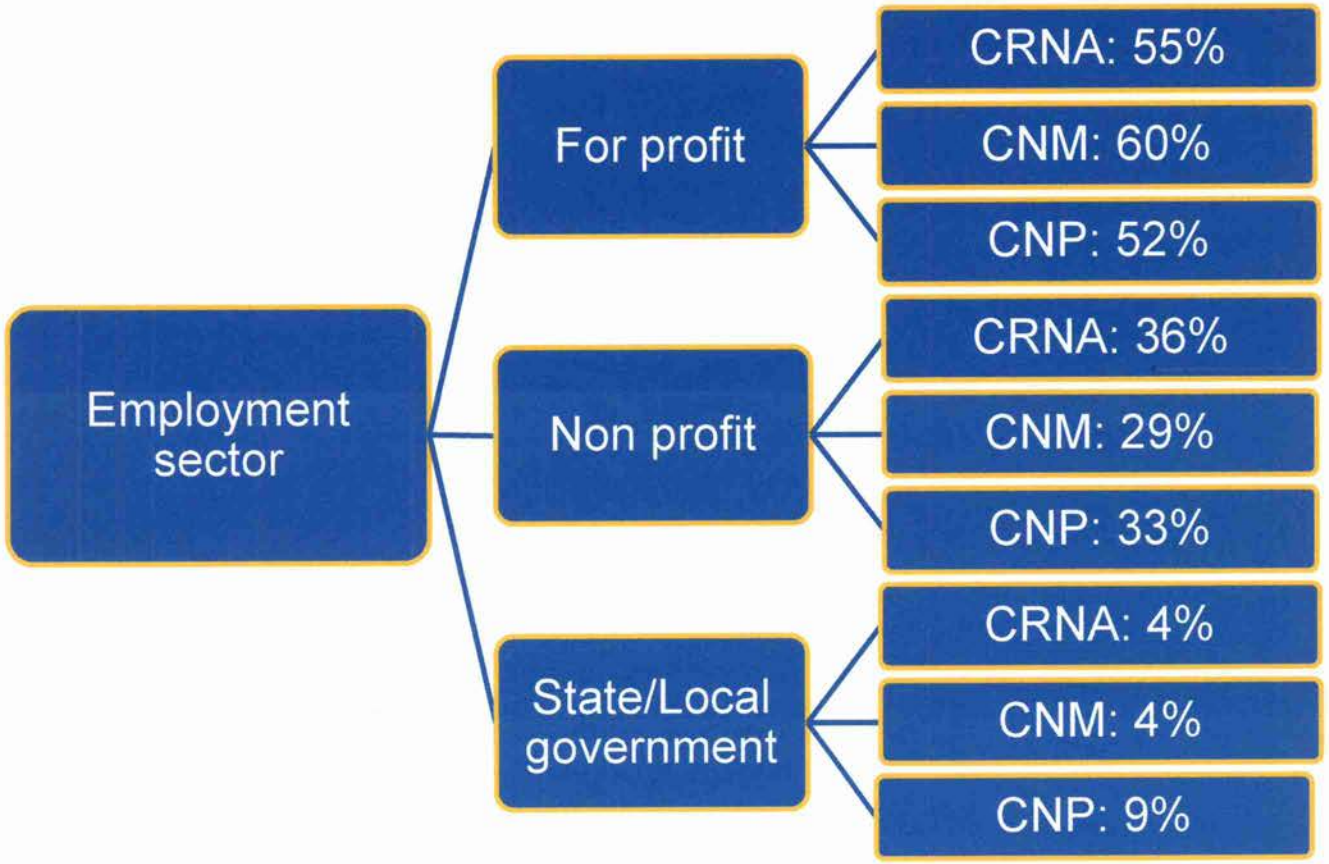
Primary Employment Sector



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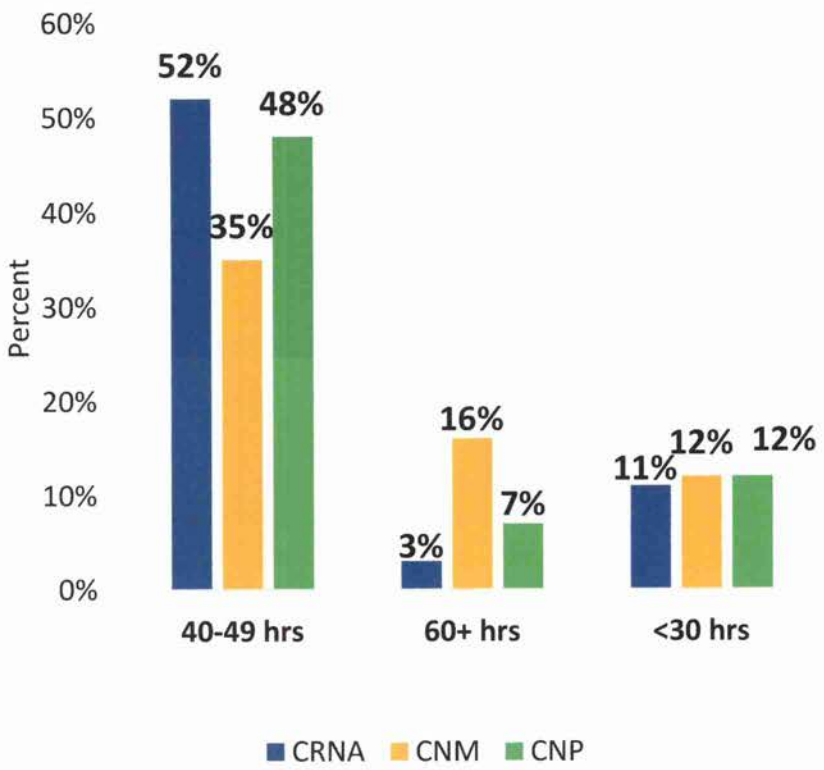
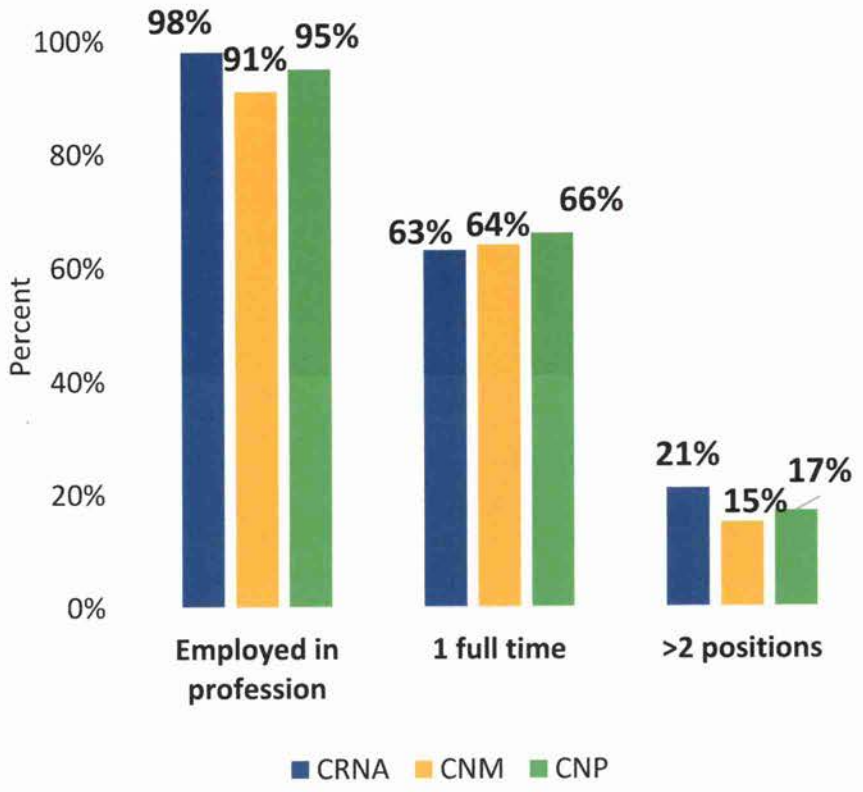
Hours Worked



Current Employment



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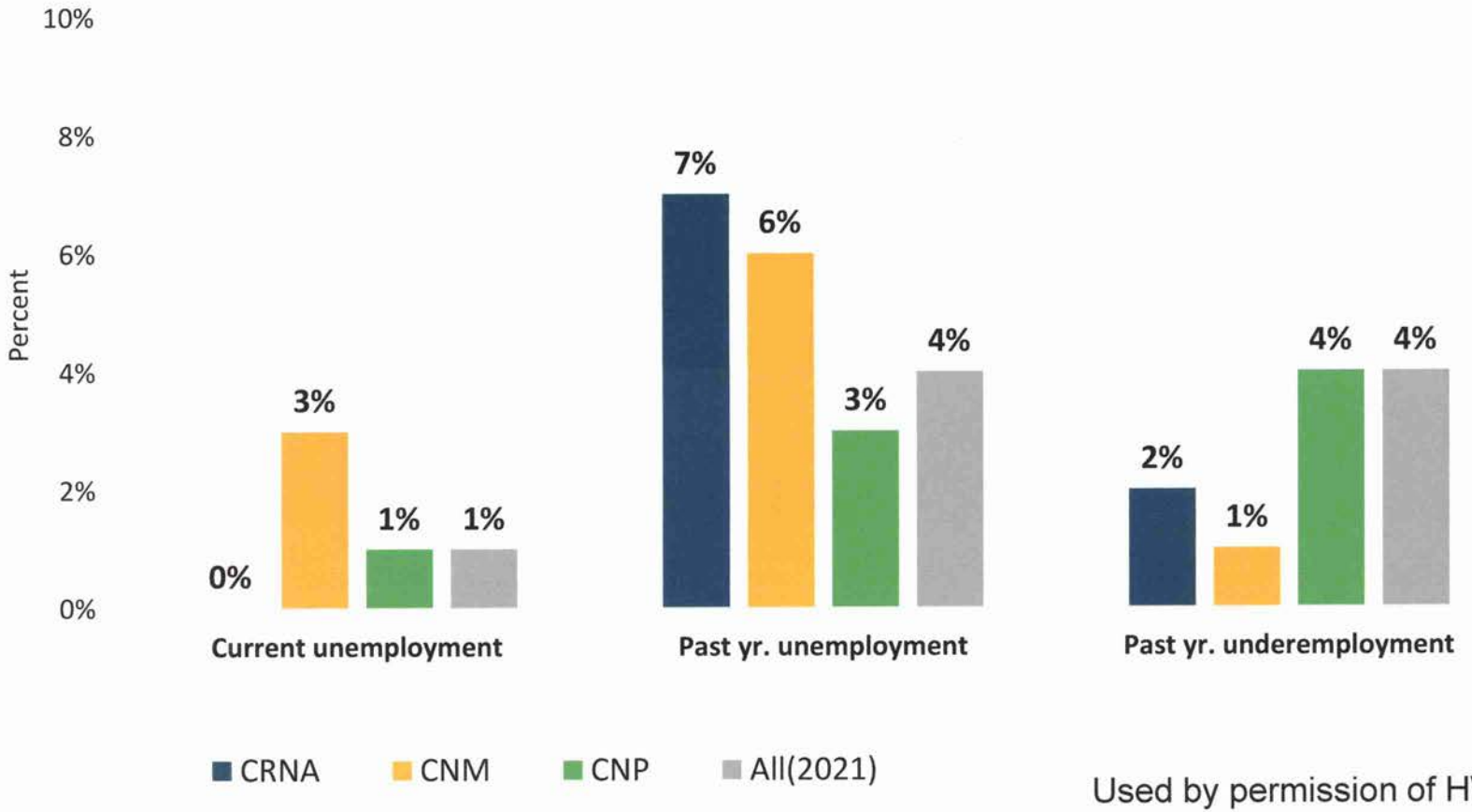
Unemployment and Underemployment



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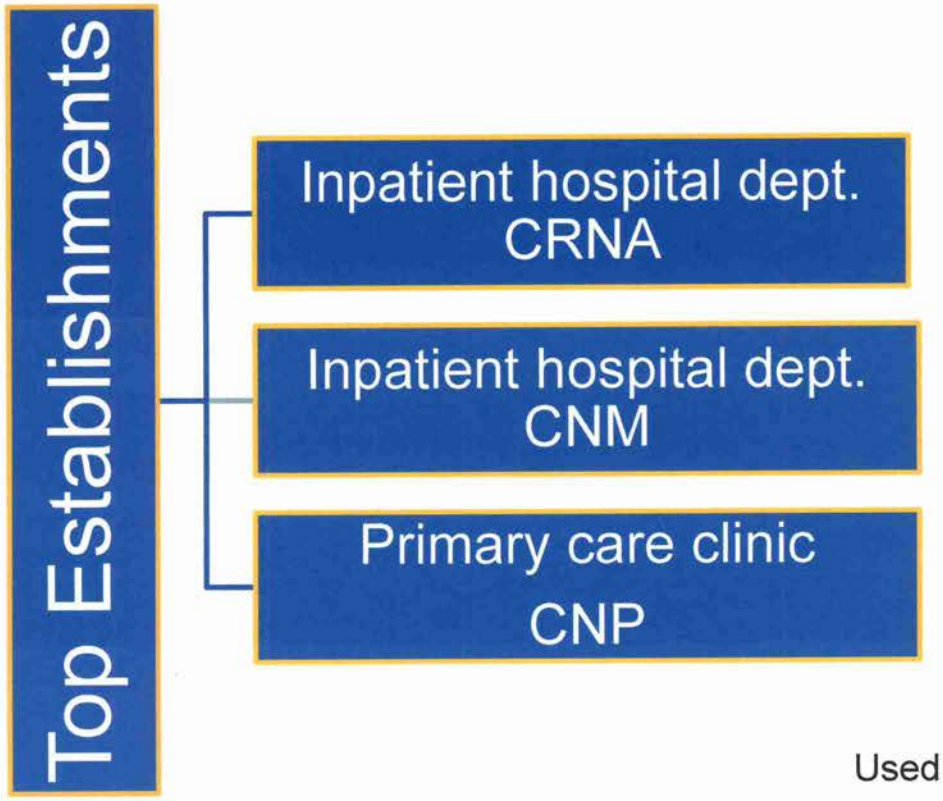
Top Establishments



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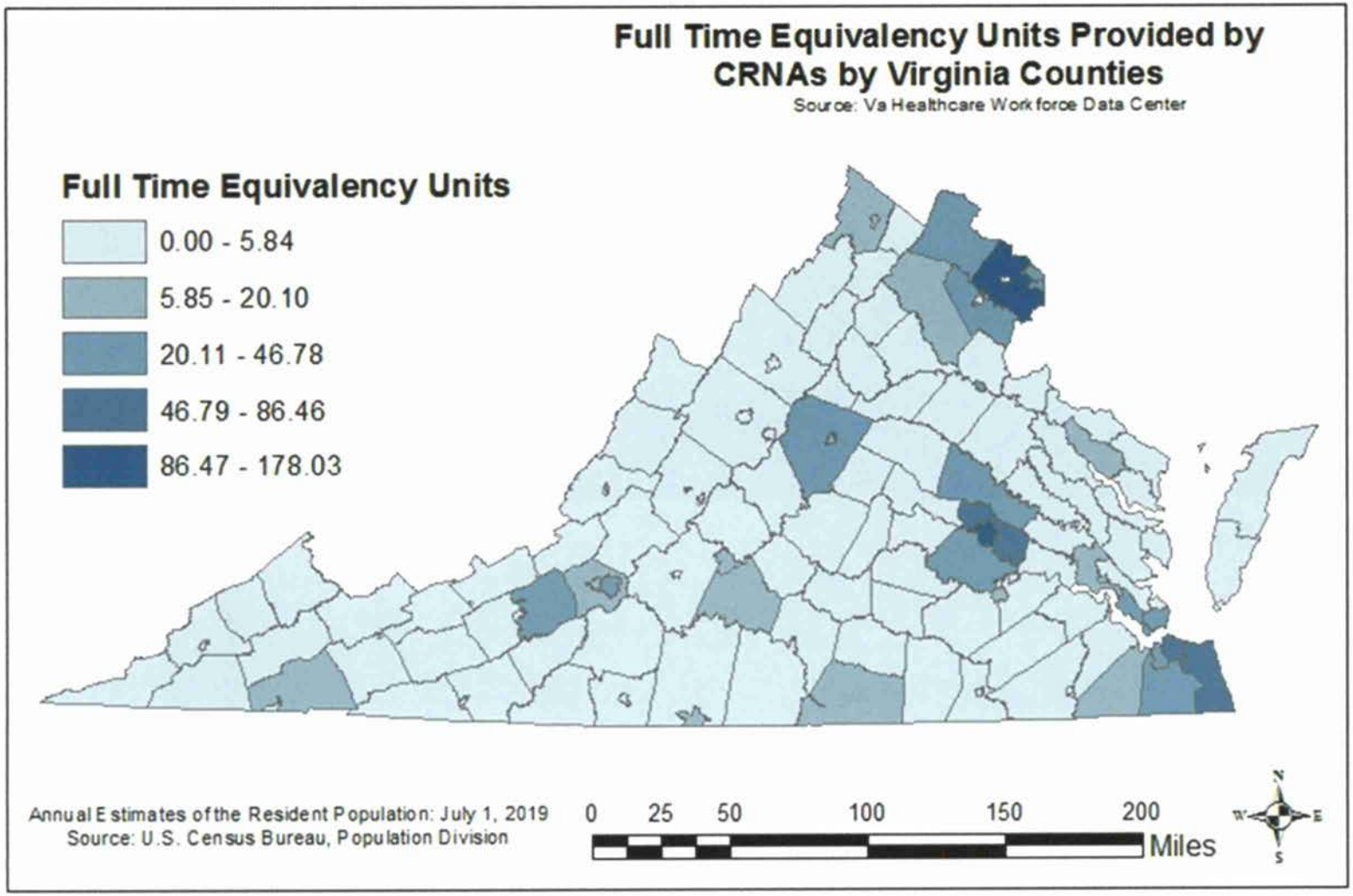

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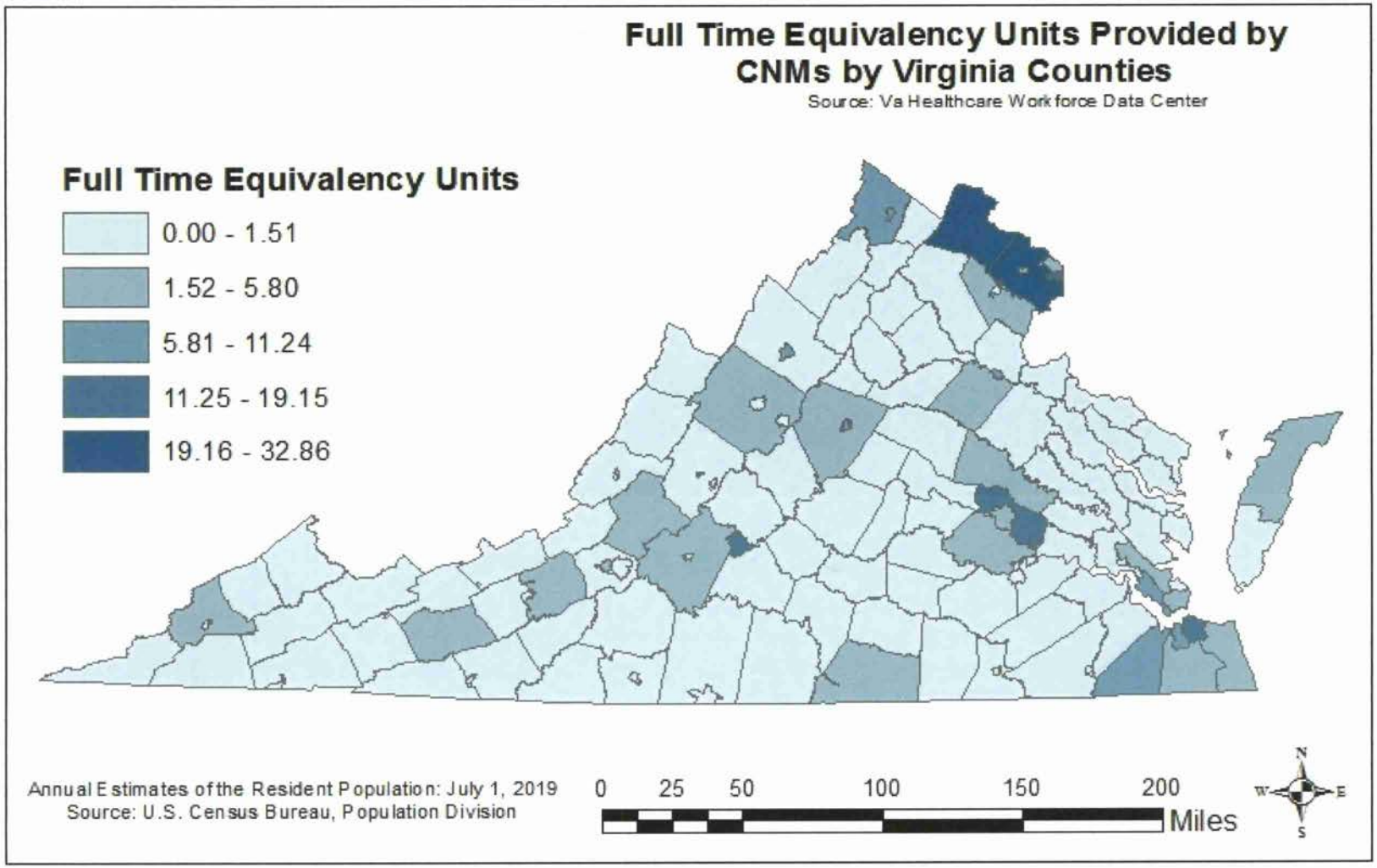

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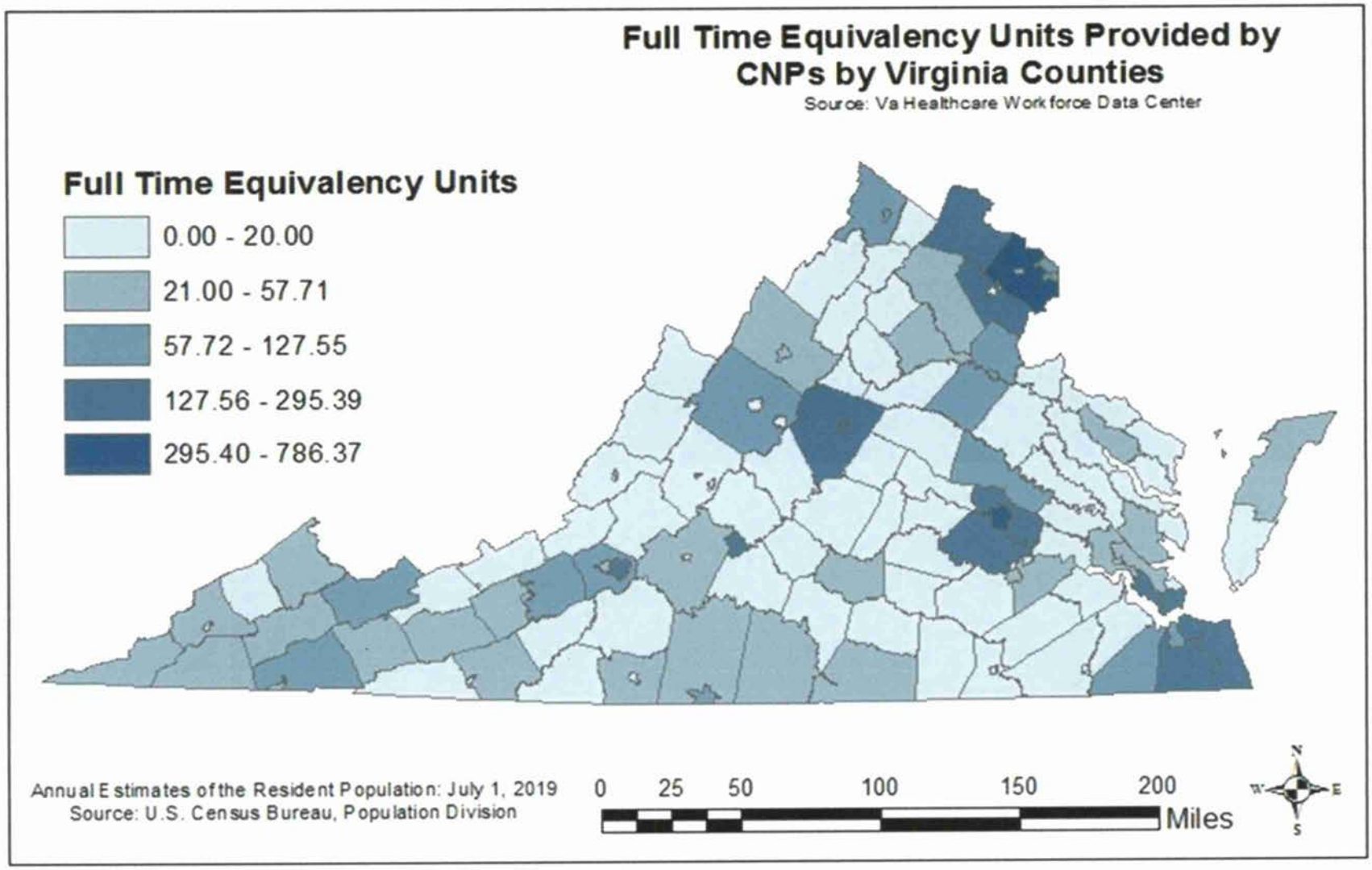

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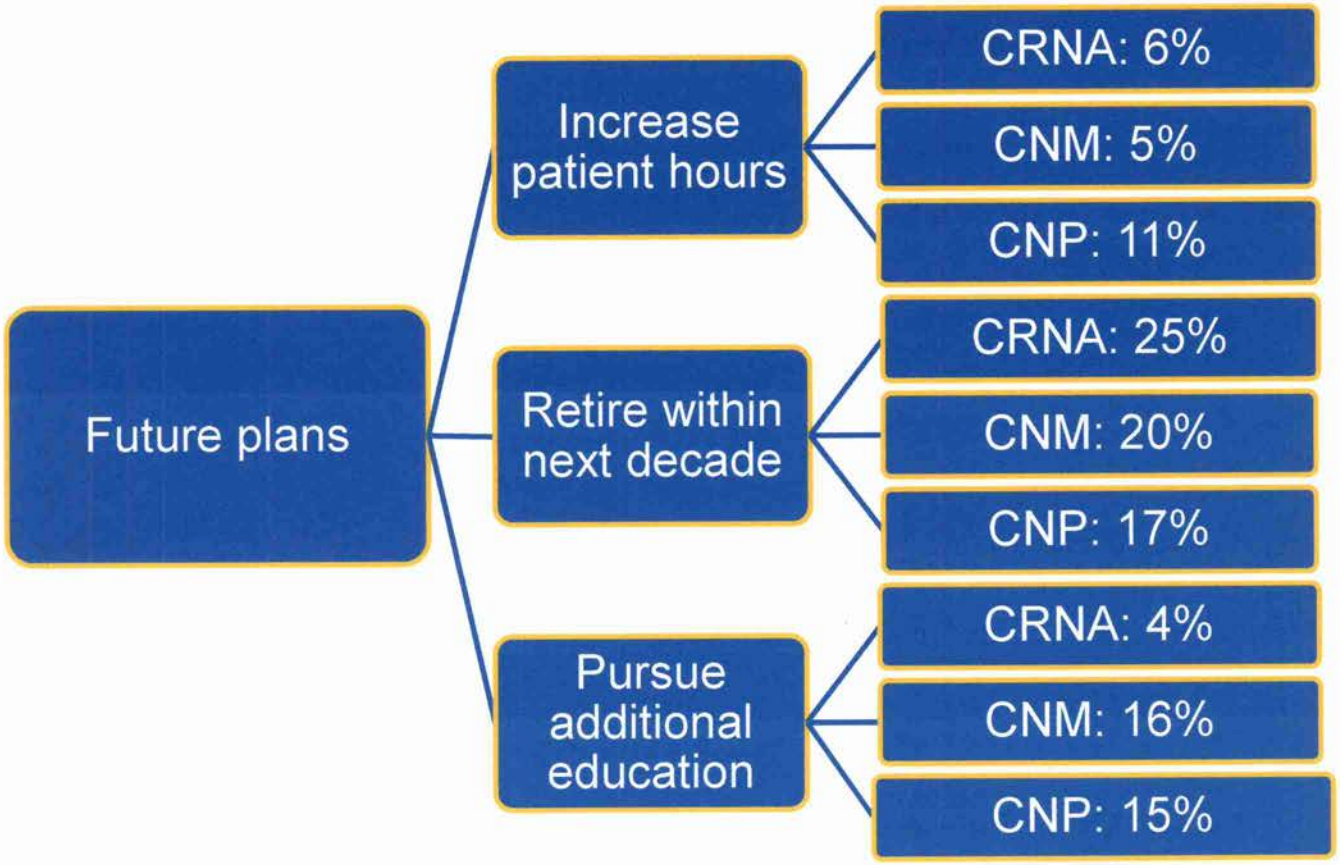
Future Plans



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Conclusion

The three groups have good employment prospects

However, significant differences by group on some measures

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Questions?

Agenda Item: **Licensing Report**

Staff Note: Mr. Sobowale will provide information on note-worthy licensing matters.

Action: None anticipated.

Agenda Item: **Discipline Report**

Staff Note: Ms. Deschenes will provide information on discipline matters.

Action: Consent orders may be presented for consideration.

Agenda Item: Appointment of the Nominating Committee

Staff Note: At the February meeting, a Nominating Committee is appointed by the Board per the bylaws. Committee members receive communications, **one at a time**, from Board members seeking office for the coming year. They also interview candidates the morning of the Board meeting to finalize the slate of officers for the Board's consideration. In the following pages, you will find the bylaws, which include a section on Elections and the Nominating Committee.

Action: The Chair will call for volunteers who wish to serve on the Committee and ensures the Board agrees with their appointment.

VIRGINIA BOARD OF MEDICINE

BYLAWS

PART I: THE BOARD

Article I – Members

The appointment and limitations of service of the members shall be in accordance with Section 54.1-2911 of the Code of Virginia.

Article II - Officers of the Board

Section 1. Offices and Titles – Officers of the Board shall consist of a president, vice-president and secretary/treasurer. All shall be elected by the Board for a term of one year. The term of each office shall begin at the conclusion of the June Board meeting and end at the conclusion of the subsequent June Board meeting.

A. President: The president shall preserve order and preside at all meetings according to parliamentary rules, the Virginia Administrative Process Act, and the Virginia Freedom of Information Act. The president shall appoint the members of the Executive Committee, Credentials Committee, Finance Committee, Committee of the Joint Boards of Medicine and Nursing, and ad hoc committees of the Board. He shall sign his name as president to the certificates authorized to be signed by the president.

B. Vice President: The vice president shall act as president in the absence of the president. The vice president shall preserve order and preside at all meetings of the Legislative Committee according to parliamentary rules, the Virginia Administrative Process Act, and the Virginia Freedom of Information Act. He shall, in consultation with the president, appoint the members of the Legislative Committee and shall sign his name as vice-president to the certificates authorized to be signed by the vice-president.

C. Secretary/Treasurer: The secretary/treasurer shall be knowledgeable of budgetary and financial matters of the Board. The secretary/treasurer shall preserve order and preside at all meetings of the Finance Committee according to parliamentary rules, the Virginia Administrative Process and the Virginia Freedom of Information Act. He shall sign his name as secretary/treasurer to the certificates authorized to be signed by the secretary/treasurer.

D. The officers of the Board shall faithfully perform the duties of their offices and shall coordinate with staff regularly on matters pertaining to their offices.

E. Order of succession: In the event of a vacancy in the office of president, the vice president shall assume the office of president for the remainder of the term. In the event of a vacancy in the office of vice president, the secretary/treasurer shall assume the office of vice president for the remainder of the term. In the event of a vacancy of

the office of secretary/treasurer, the president shall appoint a board member to fill the vacancy for the remainder of the term.

F. The Executive Director shall keep true records of all general and special acts of the Board and all papers of value. When a committee is appointed for any purpose, he shall notify each member of his appointment and furnish any essential document or information at his command. He shall conduct the correspondence of the Board when requested and shall sign certificates authorized to be issued by the Board and perform all such other duties as naturally pertain to his position.

Article III - Meetings

Section 1. Frequency of meetings: The Board shall meet at least three times a year.

Section 2. Order of Business Meetings - The order of business shall be as follows:

Call to order

Roll call

Approval of minutes of preceding regular Board meeting and any called meeting since the last regular meeting of the Board

Adoption of Agenda

Public Comment Period

Report of Officers and Executive Director:
- President
- Vice President
- Secretary/Treasurer
- Executive Director

Report of Committees:
- Executive Committee
- Legislative Committee
- Credentials Committee
- Finance Committee
- Other Standing Committees
- Ad Hoc Committees

Report of Advisory Boards
- Acupuncture
- Athletic Training
- Midwifery
- Occupational Therapy
- Physician Assistant
- Radiological Technology

Respiratory Care
Behavior Analysis
Polysomnographic Technology
Genetic Counseling

Old Business

New Business

Election of Officers

Article IV – Committees

Section 1. Standing committees. The standing committees of the Board shall consist of the following:

Executive Committee
Legislative Committee
Credentials Committee
Finance Committee
Committee of the Joint Boards of Medicine and Nursing
Other Standing Committees

A. **Executive Committee**. The Executive Committee shall consist of the president, vice-president, the secretary-treasurer and five other members of the board appointed by the president. The Executive Committee shall include at least two citizen members. The president shall serve as chairman of the Executive Committee. In the absence of the Board, the executive committee shall have full powers to take any action and conduct any business as authorized by § 54.1-2911 of the Code of Virginia. Five members of the executive committee shall constitute a quorum.

B. **Legislative Committee**. The Legislative Committee shall consist of seven Board members appointed by the vice-president of the Board in consultation with the President. The vice president of the Board or his designee will serve as chair. The committee shall consider all questions bearing upon state and federal legislation, and regulations. The Legislative Committee shall recommend changes in the law and regulations as it may deem advisable and, at the direction of the Board, shall take such steps as may further the desire of the Board in matters of legislation and regulations. The committee shall submit proposed changes in the rules and regulations of the Board in writing to all Board members prior to any scheduled meeting of the Board.

C. **Credentials Committee**. The Credentials Committee shall consist of nine members of the Board appointed by the President and shall satisfy itself that applicants for licensure by endorsement or by examination fulfill the requirements of the Board. The Committee shall review the credentials of the applicants who may fail to meet the requirements of the Board as specified in statute or regulation. The Committee may hear credentialing issues in accordance with §2.2-4019, §2.2-4020 and §2.2-4021 and guidelines adopted by the Board.

D. **Finance Committee**. The Finance Committee shall consist of the secretary/treasurer, two other members appointed by the president and the Executive Director shall act ex officio to the committee. This committee shall be responsible for making recommendations to the Board regarding all financial matters. The committee shall meet as necessary.

E. **Committee of the Joint Boards of Medicine and Nursing.** The Committee shall be appointed in accordance with § 54.1-2957.01 of the Code of Virginia and shall function as provided in the Regulations Governing the Licensure of Nurse Practitioners (18VAC 90-30-30).

F. Members appointed to a committee shall faithfully perform the duties assigned to the committee. Committee chairs shall regularly communicate with staff on matters pertaining to the committee.

Section 2. Ad Hoc Committees.

A. The Board or any of its standing committees may establish such ad hoc committees as are deemed necessary to assist the Board or committee in its work.

B. The members of an ad hoc committee shall be appointed by the chair of the board or committee creating the ad hoc committee. The chair may appoint members to an ad hoc committee who are not members of the board when it serves the purpose of the committee.

C. All members of an ad hoc committee shall have full and equal voting rights.

D. Members appointed to a committee shall faithfully perform the duties assigned to the committee. Committee chairs shall regularly communicate with staff on matters pertaining to the committee.

Article V – Elections

The Board shall appoint a Nominating Committee at its February meeting. The committee shall present the names of candidates for office to the Board for election at its June meeting. In the event that the offices are vacated and succession is not possible, the Board shall appoint the Nominating Committee which will develop a slate of candidates for the Board's consideration at its next meeting.

Amendments to Bylaws

Amendments to these bylaws may be proposed by presenting the amendments in writing to all board members seven calendar days prior to any scheduled board meeting.

DRAFT

Virginia's Licensed Nurse Practitioner Workforce: Comparison by Specialty

Healthcare Workforce Data Center

December 2021

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233
804-597-4213, 804-527-4466(fax)
E-mail: ***HWDC@dhp.virginia.gov***

Follow us on Tumblr: ***www.vahwdc.tumblr.com***
Get a copy of this report from:
http://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/

Over 8,500 Licensed Nurse Practitioners voluntarily participated in the 2020 and 2021 surveys. *Without their efforts the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Joint Boards of Nursing and Medicine express our sincerest appreciation for their ongoing cooperation.*

Thank You!

Virginia Department of Health Professions

David E. Brown, DC
Director

Barbara Allison-Bryan, MD
Chief Deputy Director

Healthcare Workforce Data Center Staff:

Dr. Elizabeth Carter, PhD	Yetty Shobo, PhD	Rajana Siva, MBA	Christopher Coyle, BA
Executive Director	*Deputy Director*	*Data Analyst*	*Research Assistant*

Joint Boards of Nursing and Medicine

Chair

Marie Gerardo, MS, RN, ANP-BC
Midlothian

Members

David Archer, MD
Norfolk

Laurie Buchwald, MSN, WHNP, NCMP, FNP
Radford

Ann Tucker Gleason, PhD
Zion Crossroads

Blanton L. Marchese
North Chesterfield

Ryan Williams, MD
Suffolk

Executive Director, Board of Medicine

William Harp, MD

Executive Director, Board of Nursing

Jay P. Douglas, MSM, RN, CSAC, FRE

Contents

Results in Brief

This is a special report created for the Committee of the Joint Boards of Nursing and Medicine. The report uses data from the 2020 and 2021 Nurse Practitioner Surveys. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place during a two-year renewal cycle on the birth month of each respondent. Therefore, approximately half of all NPs have access to the survey in any given year. Two years' worth of data, therefore, will allow all eligible Nurse Practitioners (NPs) the opportunity to complete the survey. The 2020 survey occurred between October 2019 and September 2020; the 2021 survey occurred between October 2020 and September 2021. The survey was available to all renewing NPs who held a Virginia license during the survey period and who renewed their licenses online. It was not available to those who did not renew, including NPs who were newly licensed during the survey period.

This report breaks down survey findings for certified registered nurse anesthetists (CRNA), certified nurse midwives (CNM), and Certified Nurse Practitioners (CNPs). CNPs make up the highest proportion of NPs. Over 80% of NPs are CNPs whereas CNMs constitute only 3% of NPs. The full time equivalency units are also similarly distributed by specialty.

Nine of ten NPs are female; CNMs are nearly all female whereas slightly less than three-quarters of CRNAs are female; 93% of CNPs are female. The median age of all NPs is 44. The median age of CRNAs is 46 and the median age for CNPs is 44. CNMs have the lowest median age, 42. In a random encounter between two NPs, there is a 39% chance that they would be of different races or ethnicities, a measure known as the diversity index. CNMs were the least diverse with 32% diversity index; CRNAs and CNPs had 34% and 40% diversity indices, respectively. Overall, 12% of NPs work in rural areas. CNPs had the highest rural workforce participation; 13% of CNPs work in rural areas compared to 6% and 4% of CRNAs and CNMs, respectively.

CRNAs had the highest educational attainment with 19% reporting a doctorate degree; only 13% of CNMs and 12% of CNPs did. Surprisingly, CNMs reported the highest median education debt of $90k-$100k, and more than half of CNMs had education debt. Over half of CNPs also reported education debt although they had the lowest median at $60k-$70k. CRNAs had $80-$90k in education debt but only 45% of them had education debt.

CRNAs also reported the highest median annual income; they reported $120k-$130k in median income. The average for all other NPs is $100k-$110k. Further, 85% of CRNAs reported more than $120,000 in income compared to 34% of CNMs and 25% of CNPs. However, only 74% of CRNAs received at least one employer-sponsored benefit compared to 80% of CNMs and 85% of CNPs. Overall, 94% of NPs are satisfied with their current employment situation. However, only 92% of CNMs were satisfied compared to 97% of CRNAs and 94% of CNPs. A third of all NPs reported employment instability in the year prior to the survey, with CRNAs being most likely to report employment instability.

CRNAs had the highest participation in the private sector, 91% of them worked in the sector compared to 89% of CNMs and 85% of CNPs. Meanwhile, CRNAs had the lowest percent working in federal, state, or local government. CRNAs and CNMs were most likely to be working in the inpatient department of hospitals whereas CNPs were most likely to work in primary care clinics. Only 12% of CRNAs used at least one form of electronic health record or telehealth compared to 28% of CNMs and 44% of CNPs. A quarter of CRNAs plan to retire within the next decade compared to 20% of CNMs and 17% of CNPs. About 43%, 34% and 38% of CRNAs, CNMs, and CNPs, respectively, plan to retire by the age of 65. Meanwhile, 2%, 6%, and 6% of CRNAs, CNMs, and CNPs, respectively, do not intend to retire.

In 2018, the General Assembly authorized the Joint Boards of Nursing and Medicine to promulgate regulations that would permit qualified nurse practitioners to practice autonomously after the completion of five years of clinical experience as a nurse practitioner under a practice agreement. The bill required that the Boards provide information regarding the practice of autonomously practicing NPs to committees of the General Assembly by November 2021. That report, which includes demographic, complaint, and disciplinary data, and suggested modifications to the provisions of the law, is now available[1].

[1] https://rga.lis.virginia.gov/Published/2021/RD625/PDF

A Closer Look:

This report uses data from the 2020 and 2010 Nurse Practitioner Surveys, and licensure data retrieved in October 2021. Two years of survey data were used to get a complete portrait of the NP workforce since NPs are surveyed every two years in their birth month. Thus, every NP would have been eligible to complete a survey in only one of the two years. Newly licensed NPs do not complete the survey so they are excluded from the survey. From the licensure data, 2,211 of NPs reported their first specialty as CRNA; 421 had a first specialty of CNM, 12,410 had other first specialties. However, 2 CNMs reported two additional specialties and 55 reported one additional specialty. Eight CRNAs also reported one other specialty. "At a Glance" shows the break down by specialty. Over 83% are CNPs and about 3% are CNMs.

At a Glance:

Licensed NPs

Total:	15,056
CRNA:	2,211
CNM:	421
CNP:	12,410

Response Rates

All Licensees: (2020 & 2021)	58%

Source: Va. Healthcare Workforce Data Center

Response Rates	CRNA	CNM	CNP	Total
Completed Surveys 2020	665	126	3,232	**4,023**
Completed Surveys 2021	718	132	3,707	**4,557**
Response Rate, all licensees	63%	61%	56%	**57%**

Source: Va. Healthcare Workforce Data Center

Our surveys tend to achieve very high response rates. An average of 57% of NPs submitted a survey in both 2020 and 2021. As shown above, the response rate was highest for CRNAs and lowest for CNPs.

Not in Workforce in Past Year	CRNA	CNM	CNP	All 2021
% of Licensees not in VA Workforce	23%	20%	19%	**20%**
% in Federal Employee or Military:	9%	28%	14%	**14%**
% Working in Virginia Border State or DC	16%	19%	27%	**21%**

Source: Va. Healthcare Workforce Data Center

CRNAs were most likely to not be working in the state workforce whereas CNPs were most likely to be working in border states.

Definitions

1. **The Survey Period:** The survey was conducted between October 2019 and September 2020, and between October 2020 and September 2021, on the birth month of each renewing practitioner.
2. **Target Population:** All NPs who held a Virginia license at some point during the survey period.
3. **Survey Population:** The survey was available to NPs who renewed their licenses online. It was not available to those who did not renew, including NPs newly licensed during the survey time frame.

A Closer Look:

At a Glance:

2020 and 2021 Workforce

Virginia's NP Workforce:	12,070
FTEs:	10,712

Workforce by Specialty

CRNA:	1,709
CNM:	341
CNP:	10,046

FTE by Specialty

CRNA:	2.053
CNM:	333
CNP:	8,956

Source: Va. Healthcare Workforce Data Center

Definitions

1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time during the survey timeframe or who indicated intent to return to Virginia's workforce at any point in the future.
2. **Full Time Equivalency Unit (FTE):** The HWDC uses 2,000 (40 hours for 50 weeks) as its baseline measure for FTEs.
3. **Licensees in VA Workforce:** The proportion of licensees in Virginia's Workforce.
4. **Licensees per FTE:** An indication of the number of licensees needed to create 1 FTE. Higher numbers indicate lower licensee participation.
5. **Workers per FTE:** An indication of the number of workers in Virginia's workforce needed to create 1 FTE. Higher numbers indicate lower utilization of available workers.

Virginia's NP Workforce								
	CRNA		CNM		CNP		All (2020)	
Status	#	%	#	%	#	%	#	%
Worked in Virginia in Past Year	1,696	99%	325	95%	9,824	98%	11,783	98%
Looking for Work in Virginia	12	1%	16	5%	222	2%	287	2%
Virginia's Workforce	**1,709**	**100%**	**341**	**100%**	**10,046**	**100%**	**12,070**	**100%**
Total FTEs	**2,053**		**333**		**8,956**		**10,712**	
Licensees	**2,112**		**421**		**12,410**		**15,063**	

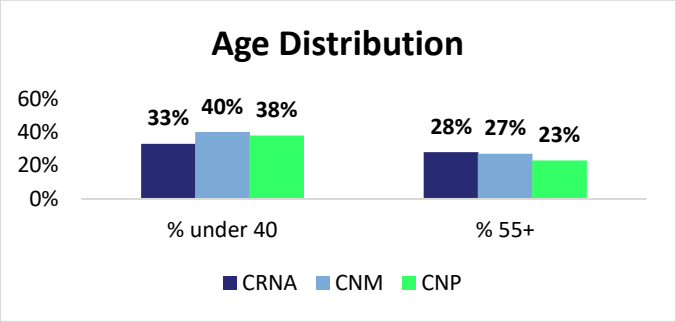
Source: Va. Healthcare Workforce Data Center

CNPs provided about 80% of the nurse practitioner FTEs in the state. CRNAs provided 16% whereas CNMs provided 3% of the FTEs. 5% of CNMs in the state's workforce were looking for work compared to 2% or less of the other NPs.

A Closer Look (All Nurse Practitioners in 2021):

Age & Gender						
	Male		Female		Total	
Age	#	% Male	#	% Female	#	% in Age Group
Under 30	20	5%	406	95%	425	4%
30 to 34	135	8%	1,469	92%	1,603	15%
35 to 39	207	11%	1,746	89%	1,953	18%
40 to 44	157	10%	1,382	90%	1,539	14%
45 to 49	164	12%	1,185	88%	1,348	13%
50 to 54	127	11%	1,023	89%	1,150	11%
55 to 59	88	9%	871	91%	959	9%
60 +	170	10%	1,506	90%	1,676	16%
Total	**1,066**	**10%**	**9,588**	**90%**	**10,654**	**100%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

% Female:	90%
% Under 40 Female:	91%

% Female by Specialty

CRNA:	71%
CNM:	98%
CNP:	93%

% Female <40 by Specialty

CRNA:	74%
CNM:	96%
CNP:	93%

Source: Va. Healthcare Workforce Data Center

CNMs have lowest median age of 42; median age is 46 for CRNAs and 44 for CNPs.

Age & Gender by Specialty												
	CRNA				CNM				CNP			
	Female		Total		Female		Total		Female		Total	
Age	#	% Female	#	% in Age Group	#	% Female	#	% in Age Group	#	% Female	#	% in Age Group
Under 30	14	75%	18	1%	13	100%	13	4%	341	92%	371	4%
30 to 34	162	76%	213	14%	56	100%	56	19%	1,421	94%	1,513	17%
35 to 39	187	71%	262	17%	46	91%	51	17%	1,402	94%	1,500	17%
40 to 44	195	77%	253	17%	43	100%	43	14%	1,299	93%	1,405	16%
45 to 49	111	66%	169	11%	24	100%	24	8%	985	92%	1,066	12%
50 to 54	107	64%	167	11%	30	100%	30	10%	934	91%	1,022	11%
55 to 59	105	73%	143	9%	21	100%	21	7%	675	95%	710	8%
60 +	191	67%	284	19%	60	100%	60	20%	1,262	95%	1,331	15%
Total	**1,071**	**71%**	**1,509**	**100%**	**293**	**98%**	**298**	**100%**	**8,320**	**93%**	**8,917**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look (All Nurse Practitioners in 2021):

Race & Ethnicity (2021)					
Race/ Ethnicity	Virginia*	NPs		NPs under 40	
	%	#	%	#	%
White	61%	8,243	77%	3,028	76%
Black	19%	1,220	11%	441	11%
Asian	7%	630	6%	251	6%
Other Race	0%	106	1%	37	1%
Two or more races	3%	186	2%	70	2%
Hispanic	10%	324	3%	164	4%
Total	**100%**	**10,709**	**100%**	**3,991**	**100%**

* Population data in this chart is from the US Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2019.

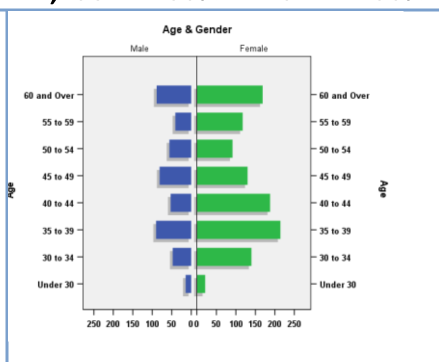
Source: Va. Healthcare Workforce Data Center

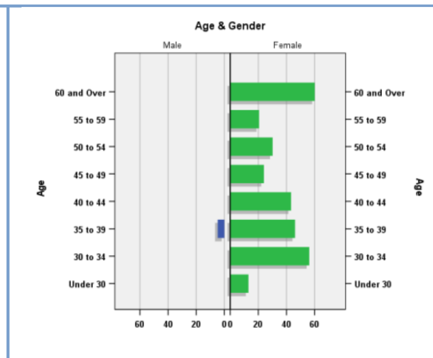
At a Glance:

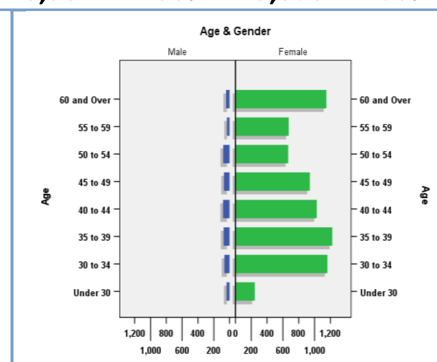
2021 Diversity
Diversity Index: 39%
Under 40 Div. Index: 41%

Diversity by Specialty
CRNA: 34%
CNM: 32%
CNP: 40%

Age, Race, Ethnicity & Gender												
	CRNA				CNM				CNP			
Race/ Ethnicity	NPs		NPs under 40		NPs		NPs under 40		NPs		NPs under 40	
	#	%	#	%	#	%	#	%	#	%	#	%
White	1,207	81%	394	80%	244	81%	91	75%	6,844	76%	2,548	75%
Black	100	7%	29	6%	39	13%	21	17%	1,124	13%	412	12%
Asian	94	6%	27	5%	1	0%	0	0%	469	5%	200	6%
Other Race	20	1%	9	2%	3	1%	2	2%	88	1%	27	1%
Two or more races	29	2%	13	3%	2	1%	2	2%	155	2%	70	2%
Hispanic	45	3%	22	4%	11	4%	5	4%	271	3%	136	4%
Total	**1,495**	**100%**	**494**	**100%**	**300**	**100%**	**121**	**100%**	**8,951**	**100%**	**3,393**	**100%**







Source: Va. Healthcare Workforce Data Center

A Closer Look:

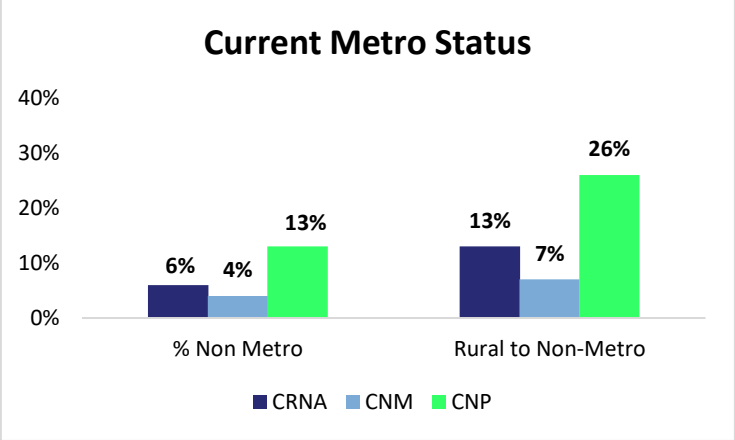
At a Glance:

Rural Childhood

CRNA:	28%
CNM:	32%
CNP:	36%
All:	34%

Non-Metro Location

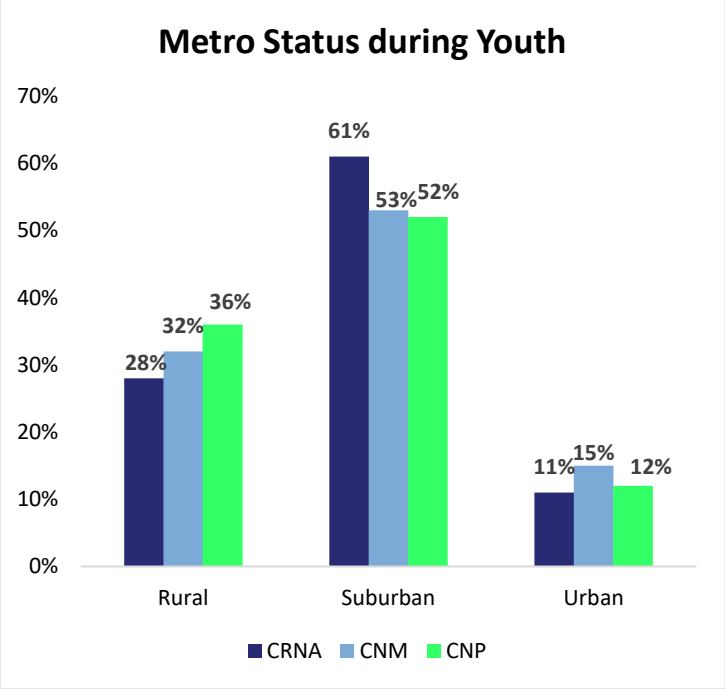
CRNA:	6%
CNM:	4%
CNP:	13%
All:	12%



Source: Va. Healthcare Workforce Data Center

	HS in VA	Prof. Ed. in VA	HS or Prof in VA	NP Degree in VA
CRNA	32%	35%	39%	44%
CNM	31%	33%	40%	27%
CNP	48%	55%	60%	55%
All (2021)	**44%**	**51%**	**56%**	**52%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

CNPs were most likely to have been educated in the state. CNMs were least likely to have obtained their NP education in the state. Also, CNPs had the highest percent reporting a non-metro work location.

A Closer Look:

At a Glance:

Median Educational Debt

CRNA:	$80k-$90k
CNM:	$90k-$100k
CNP:	$60k-$70k

Source: Va. Healthcare Workforce Data Center

CNMs were most likely to carry education debt; 55% and 77% of all CNMs and of CNMs under age 40, respectively, had education debt. Their median debt at $90k-$100k was also the highest. CNPs had the lowest median education debt although over half of them also reported education debt.

	Highest Degree							
	CRNA		CNM		CNP		All (2021)	
Degree	#	%	#	%	#	%	#	%
NP Certificate	126	9%	6	2%	91	1%	225	2%
Master's Degree	1,054	72%	211	72%	6,942	79%	8,159	78%
Post-Masters Cert.	15	1%	40	14%	740	8%	753	7%
Doctorate of NP	193	13%	28	10%	775	9%	1,043	10%
Other Doctorate	88	6%	8	3%	222	3%	303	3%
Post-Ph.D. Cert.	0	0%	0	0%	1	0%	2	0%
Total	**1,476**	**100%**	**293**	**100%**	**8,771**	**100%**	**10,485**	**100%**

Source: Va. Healthcare Workforce Data Center

Amount Carried	Educational Debt							
	CRNA		CNM		CNP		All (2021)	
	All NPs	NPs < 40	All NPs	NPs < 40	All NPs	NPs < 40	All NPs	NPs < 40
None	55%	33%	45%	23%	48%	37%	49%	38%
$20,000 or less	6%	3%	5%	4%	8%	8%	8%	7%
$20,000-$29,999	3%	1%	2%	0%	4%	5%	4%	5%
$30,000-$39,999	3%	6%	2%	2%	4%	6%	4%	6%
$40,000-$49,999	3%	6%	3%	2%	4%	5%	4%	5%
$50,000-$59,999	2%	3%	7%	11%	4%	4%	3%	3%
$60,000-$69,999	2%	2%	2%	0%	4%	6%	4%	5%
$70,000-$79,999	2%	4%	3%	7%	4%	6%	4%	6%
$80,000-$89,999	2%	3%	2%	0%	3%	4%	3%	3%
$90,000-$99,999	2%	3%	1%	1%	3%	4%	3%	4%
$100,000-$109,999	2%	4%	6%	11%	3%	3%	3%	3%
$110,000-$119,999	2%	4%	1%	2%	2%	3%	2%	2%
$120,000 or more	15%	29%	20%	37%	9%	10%	11%	13%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Employed in Profession

CRNA:	98%
CNM:	91%
CNP:	95%

Involuntary Unemployment

CRNA:	0%
CNM:	3%
CNP:	1%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

	Current Weekly Hours			
Hours	CRNA	CNM	CNP	All (2021)
0 hours	1%	6%	3%	3%
1 to 9 hours	1%	4%	2%	2%
10 to 19 hours	3%	1%	3%	2%
20 to 29 hours	7%	7%	7%	7%
30 to 39 hours	24%	16%	21%	20%
40 to 49 hours	52%	35%	48%	48%
50 to 59 hours	8%	16%	11%	11%
60 to 69 hours	2%	11%	4%	4%
70 to 79 hours	0%	3%	1%	1%
80 or more hours	1%	2%	2%	1%
Total	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center

Over half of CRNAs work 40-49 hours and 12% work more than 50 hours whereas about 32% of CNMs work more than 50 hours. Close to half of CNPs work 40-49 hours and 17% work more than 50 hours.

	Current Positions							
	CRNA		CNM		CNP		All (2021)	
Positions	#	%	#	%	#	%	#	%
No Positions	20	1%	16	6%	283	3%	327	3%
One Part-Time Position	217	15%	43	15%	1,192	14%	1,500	15%
Two Part-Time Positions	55	4%	7	2%	284	3%	338	3%
One Full-Time Position	922	63%	183	64%	5,633	66%	6,634	65%
One Full-Time Position & One Part-Time Position	201	14%	28	10%	1,039	12%	1,204	12%
Two Full-Time Positions	2	0%	2	1%	36	0%	46	0%
More than Two Positions	53	4%	6	2%	126	1%	192	2%
Total	**1,470**	**100%**	**285**	**100%**	**8,593**	**100%**	**10,241**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

	Employer-Sponsored Benefits*			
Benefit	**CRNA**	**CNM**	**CNP**	**All (2021)**
Signing/Retention Bonus	27%	21%	13%	15%
Dental Insurance	57%	51%	63%	62%
Health Insurance	58%	56%	65%	63%
Paid Leave	64%	70%	75%	73%
Group Life Insurance	53%	40%	51%	51%
Retirement	69%	64%	72%	73%
Receive at least one benefit	**74%**	**80%**	**85%**	**81%**
*Wage and salaried employees receiving from any employer at time of survey.				

Source: Va. Healthcare Workforce Data Center

At a Glance:

Median Income

CRNA:	$120k-$130k
CNM:	$100k-$110k
CNP:	$100k-$110K
All (2021):	$100k-$110k

Percent Satisfied

CRNA:	97%
CNM:	92%
CNP:	94%

Source: Va. Healthcare Workforce Data Center

CRNAs reported $120k-$130k in median income. All other NPs, including CNMs, reported $100k-$110k in median income. CNMs were the least satisfied with their current employment situation whereas CRNAs were the most satisfied. 3% of CNMs reported being very dissatisfied whereas 2% or less of the other NPs reported being very dissatisfied.

	Income			
Annual Income	**CRNA**	**CNM**	**CNP**	**All (2021)**
Volunteer Work Only	0%	1%	1%	1%
Less than $40,000	2%	7%	5%	4%
$40,000-$49,999	0%	2%	2%	2%
$50,000-$59,999	1%	1%	3%	2%
$60,000-$69,999	1%	5%	4%	4%
$70,000-$79,999	1%	5%	6%	6%
$80,000-$89,999	1%	8%	9%	7%
$90,000-$99,999	2%	10%	14%	11%
$100,000-$109,999	4%	14%	19%	16%
$110,000-$119,999	3%	11%	13%	12%
$120,000 or more	85%	34%	25%	35%
Total	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Employment Instability in Past Year				
In the past year did you . . .?	**CRNA**	**CNM**	**CNP**	**All (2021)**
Experience Involuntary Unemployment?	7%	6%	3%	4%
Experience Voluntary Unemployment?	4%	6%	5%	5%
Work Part-time or temporary positions, but would have preferred a full-time/permanent position?	2%	1%	4%	4%
Work two or more positions at the same time?	20%	13%	18%	17%
Switch employers or practices?	6%	10%	9%	8%
Experienced at least 1	**32%**	**29%**	**30%**	**30%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Involuntarily Unemployed

CRNA: 7%
CNM: 3%
CNP: 3%

Underemployed

CRNA: 2%
CNM: 3%
CNP: 4%

Over 2 Years Job Tenure

CRNA: 69%
CNM: 48%
CNP: 53%

Source: Va. Healthcare Workforce Data Center

Job Tenure at Location						
Tenure	**CRNA**		**CNM**		**CNP**	
	Primary	Secondary	Primary	Secondary	Primary	Secondary
Not Currently Working at this Location	1%	5%	3%	3%	3%	7%
< 6 Months	5%	8%	6%	10%	8%	15%
6 Months-1 yr	6%	12%	12%	16%	12%	16%
1 to 2 Years	18%	24%	29%	28%	24%	21%
3 to 5 Years	28%	28%	24%	23%	24%	22%
6 to 10 Years	16%	10%	12%	15%	14%	12%
> 10 Years	25%	12%	14%	5%	15%	8%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center

CNMs were most likely to be paid by salary or commission. Over 75% of them were paid that way, compared to 55% of CRNAs and 69% of CNPs.

Forms of Payment				
Primary Work Site	**CRNA**	**CNM**	**CNP**	**All (2021)**
Salary/ Commission	55%	79%	69%	66%
Hourly Wage	36%	14%	26%	28%
By Contract	10%	7%	5%	6%
Unpaid	0%	0%	1%	0%
Total	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

% in Top 3 Regions

CRNA:	78%
CNM:	74%
CNP:	70%

2 or More Locations Now

CRNA:	29%
CNM:	21%
CNP:	22%

Source: Va. Healthcare Workforce Data Center

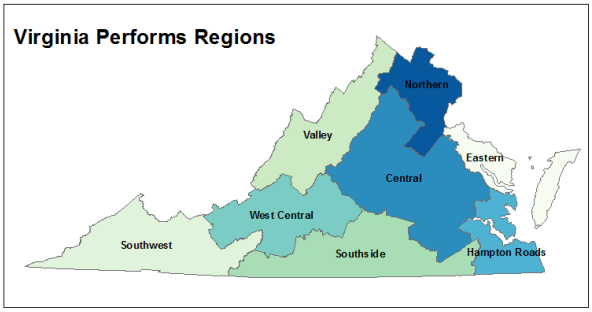
For primary work locations, Northern Virginia has the highest proportion of CNMs and CRNAs whereas CNPs were most concentrated in both the Central and Northern Virginia regions.

A Closer Look:

Regional Distribution of Work Locations

Virginia Performs Region	CRNA		CNM		CNP	
	Primary	Secondary	Primary	Secondary	Primary	Secondary
Central	27%	20%	19%	29%	25%	20%
Eastern	1%	0%	1%	0%	2%	2%
Hampton Roads	22%	24%	21%	14%	18%	17%
Northern	30%	28%	33%	15%	26%	23%
Southside	3%	2%	1%	0%	4%	3%
Southwest	3%	3%	1%	4%	7%	7%
Valley	2%	2%	10%	8%	6%	5%
West Central	9%	7%	14%	5%	10%	10%
Virginia Border State/DC	1%	4%	0%	18%	1%	3%
Other US State	2%	8%	0%	7%	1%	10%
Outside of the US	0%	1%	0%	0%	0%	0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center



Number of Work Locations Now*

Locations	CRNA		CNM		CNP	
	#	%	#	%	#	%
0	25	2%	22	8%	361	4%
1	1,012	69%	202	72%	6,307	74%
2	177	12%	37	13%	1,098	13%
3	195	13%	18	7%	644	8%
4	31	2%	0	0%	76	1%
5	8	1%	2	1%	17	0%
6 +	17	1%	1	0%	49	1%
Total	**1,464**	**100%**	**281**	**100%**	**8,551**	**100%**

Source: Va. Healthcare Workforce Data Center

*At survey completion (birth month of respondents)

A Closer Look:

Sector	Location Sector							
	CRNA		CNM		CNP		All (2021)	
	Primary	Sec	Primary	Sec	Primary	Sec	Primary	Sec
For-Profit	55%	66%	60%	53%	52%	63%	52%	63%
Non-Profit	36%	26%	29%	28%	33%	26%	34%	26%
State/Local Government	4%	3%	4%	12%	9%	8%	8%	7%
Veterans Administration	2%	0%	0%	0%	3%	0%	3%	0%
U.S. Military	2%	4%	5%	7%	2%	1%	2%	3%
Other Federal Government	0%	0%	1%	0%	2%	1%	1%	1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center

CRNAs had the highest participation in the private sector, 91% of them worked in the sector compared to 89% of CNMs and 85% of CNPs. Meanwhile, CRNAs had the lowest percent working in state, local or federal government.

At a Glance:
(Primary Locations)

For-Profit Primary Sector

CRNA:	55%
CNM:	60%
CNP:	52%

Top Establishments

CRNA:	Inpatient Department
CNM:	Inpatient Department
CNP:	Clinic, Primary Care

Source: Va. Healthcare Workforce Data Center

Electronic Health Records (EHRs) and Telehealth				
	CRNA	CNM	CNP	All (2021)
Meaningful use of EHRs	11%	21%	33%	24%
Remote Health, Caring for Patients in Virginia	1%	14%	25%	6%
Remote Health, Caring for Patients Outside of Virginia	0%	3%	6%	2%
Use at least one	**12%**	**28%**	**44%**	**28%**

Source: Va. Healthcare Workforce Data Center

More than a quarter of the state NP workforce used at least one EHR. 6% also provided remote health care for Virginia patients. CNPs were most likely to report using at least one EHR or telehealth whereas CRNAs were least likely to report doing so likely because of the nature of their job.

Establishment Type	Location Type							
	CRNA		CNM		CNP		All (2020)	
	Primary	Sec	Primary	Sec	Primary	Sec	Primary	Sec
Clinic, Primary Care or Non-Specialty	0%	1%	13%	2%	22%	16%	19%	12%
Hospital, Inpatient Department	39%	29%	19%	45%	15%	14%	18%	18%
Physician Office	1%	4%	13%	3%	9%	5%	8%	5%
Academic Institution (Teaching or Research)	11%	4%	8%	10%	7%	10%	8%	9%
Private practice, group	3%	2%	19%	9%	8%	5%	7%	4%
Hospital, Outpatient Department	12%	11%	3%	0%	6%	3%	7%	5%
Clinic, Non-Surgical Specialty	0%	2%	6%	5%	4%	4%	4%	3%
Ambulatory/Outpatient Surgical Unit	18%	28%	0%	0%	1%	1%	4%	6%
Long Term Care Facility, Nursing Home	0%	0%	0%	0%	4%	6%	3%	6%
Hospital, Emergency Department	3%	4%	0%	0%	2%	5%	3%	5%
Mental Health, or Substance Abuse, Outpatient Center	0%	0%	0%	0%	3%	3%	2%	2%
Private practice, solo	0%	0%	3%	2%	2%	3%	2%	1%
Hospice	0%	0%	0%	0%	1%	4%	1%	3%
Other Practice Setting	12%	12%	15%	24%	12%	12%	14%	21%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center

The inpatient department of a hospital was the most mentioned primary work establishment for NPs on average. This result was driven primarily by CRNAs and CNMs. For CNPs, primary care clinic was the most mentioned primary work establishment.

At a Glance:
(Primary Locations)

Patient Care Role

CRNA:	95%
CNM:	87%
CNP:	87%

Education Role

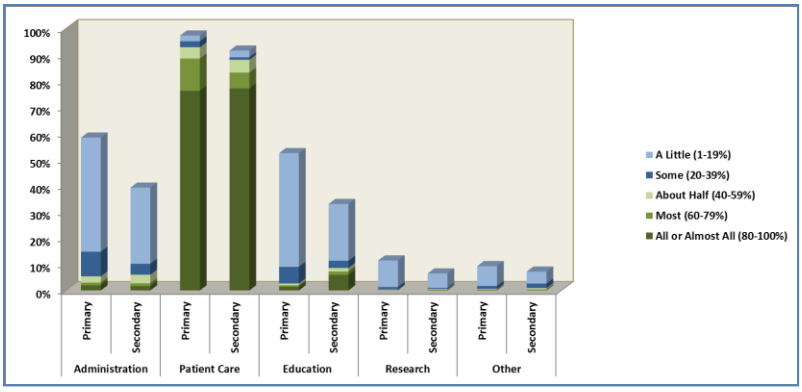
CRNA:	1%
CNM:	4%
CNP:	2%

Admin Role

CRNA:	1%
CNM:	3%
CNP:	3%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

On average, 88% of all NPs fill a patient care role, defined as spending 60% or more of their time on patient care activities. CRNAs were most likely to fill a patient care role; 95% of CRNAs filled such role compared to 87% of CNMs and CNPs.

Patient Care Time Allocation								
Time Spent	**CRNA**		**CNM**		**CNP**		**All (2021)**	
	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site
All or Almost All (80-100%)	89%	91%	66%	75%	73%	74%	75%	77%
Most (60-79%)	6%	2%	21%	0%	14%	7%	13%	6%
About Half (40-59%)	1%	2%	2%	6%	5%	4%	4%	3%
Some (20-39%)	1%	0%	4%	2%	3%	2%	3%	2%
A Little (1-20%)	2%	0%	2%	2%	2%	3%	2%	3%
None (0%)	1%	4%	5%	13%	3%	9%	3%	8%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Future Plans						
	CRNA		CNM		CNP	
2 Year Plans:	#	%	#	%	#	%
Decrease Participation						
Leave Profession	8	0%	0	0%	105	1%
Leave Virginia	57	3%	17	5%	293	3%
Decrease Patient Care Hours	167	10%	43	13%	836	8%
Decrease Teaching Hours	3	0%	1	0%	87	1%
Increase Patient Care Hours	103	6%	18	5%	1,113	11%
Increase Teaching Hours	76	4%	68	20%	1,213	12%
Pursue Additional Education	72	4%	53	16%	1,479	15%
Return to Virginia's Workforce	6	0%	11	3%	63	1%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement within 2 Years

CRNA: 8%
CNM: 7%
CNP: 5%

Retirement within 10 Years

CRNA: 25%
CNM: 20%
CNP: 17%

Source: Va. Healthcare Workforce Data Center

43%, 34% and 38% of CRNAs, CNMs, and CNPs, respectively, expect to retire by the age of 65. Further, 29%, 23%, and 25% of CRNAs, CNMs, and CNPs, respectively, aged 50 or over expect to retire by the same age. Meanwhile, 2%, 6%, and 6% of CRNAs, CNMs, and CNPs, respectively, do not plan to retire at all.

Expected Retirement Age	CRNA		CNM		CNP		All (2021)	
	All NPs	NP >50 yrs	All NPs	NP >50 yrs	All NPs	NP >50 yrs	All NPs	NP >50 yrs
Under age 50	1%	-	4%	-	2%	-	2%	-
50 to 54	3%	1%	1%	0%	3%	0%	3%	0%
55 to 59	9%	3%	9%	8%	8%	4%	9%	4%
60 to 64	30%	25%	20%	15%	25%	21%	26%	22%
65 to 69	39%	45%	37%	47%	38%	41%	38%	41%
70 to 74	13%	19%	19%	26%	14%	20%	14%	20%
75 to 79	2%	4%	4%	1%	3%	5%	3%	4%
80 or over	0%	1%	0%	1%	1%	2%	1%	1%
I do not intend to retire	2%	2%	6%	2%	6%	8%	5%	7%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

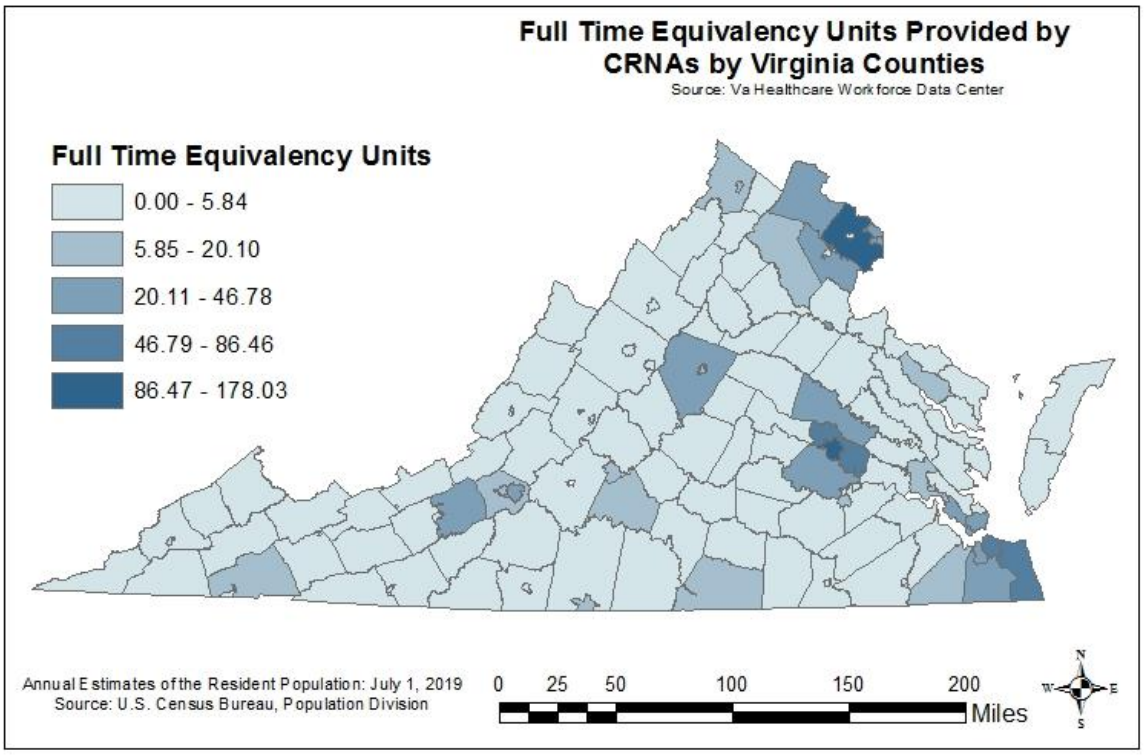
Source: Va. Healthcare Workforce Data Center

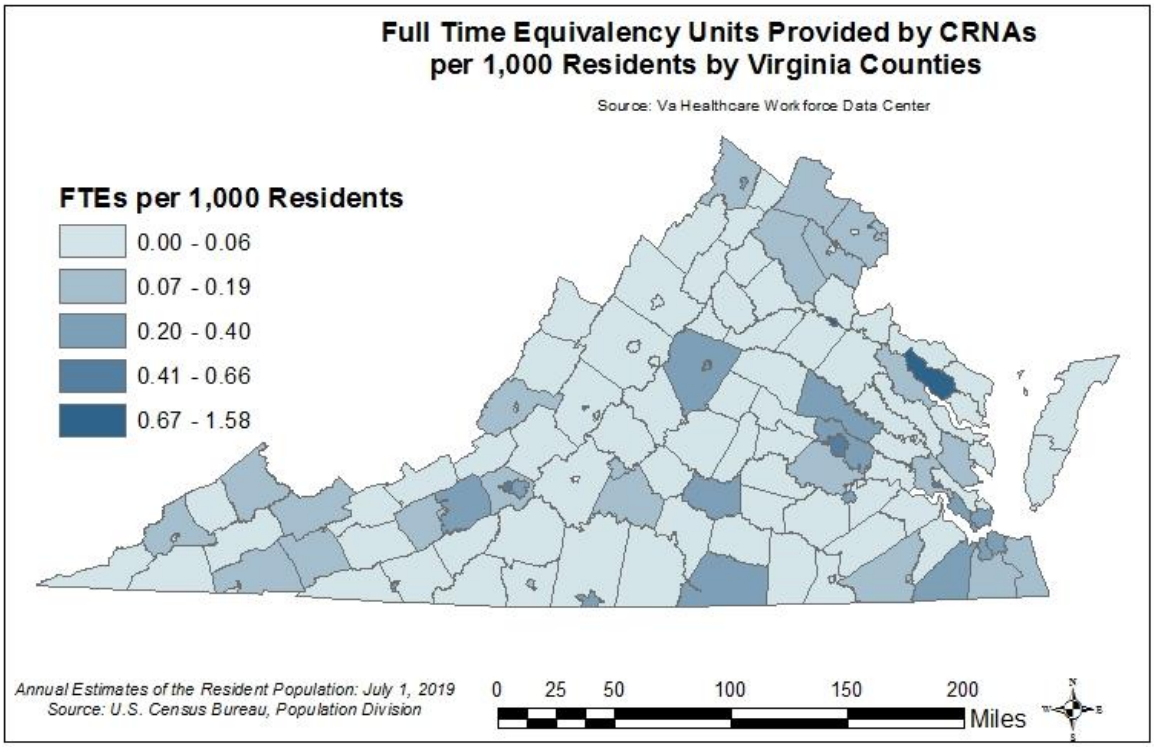
	Time to Retirement							
	CRNA		CNM		CNP		All (2021)	
Expect to retire within. . .	#	%	#	%	#	%	#	%
2 years	109	8%	17	7%	334	5%	451	5%
5 years	53	4%	10	4%	224	3%	314	4%
10 years	156	12%	25	10%	713	10%	863	10%
15 years	157	12%	33	13%	783	11%	998	11%
20 years	196	15%	18	7%	890	12%	1,135	13%
25 years	164	13%	29	11%	1,054	14%	1,238	14%
30 years	190	15%	39	15%	1,098	15%	1,318	15%
35 years	160	12%	38	15%	1,030	14%	1,160	13%
40 years	58	4%	15	6%	547	7%	559	6%
45 years	17	1%	5	2%	196	3%	229	3%
50 years	4	0%	5	2%	79	1%	84	1%
55 years	0	0%	0	0%	11	0%	8	0%
In more than 55 years	0	0%	3	1%	9	0%	13	0%
Do not intend to retire	30	2%	16	6%	437	6%	428	5%
Total	**1,294**	**100%**	**254**	**100%**	**7,404**	**100%**	**8,797**	**100%**

Source: Va. Healthcare Workforce Data Center

Using these estimates, retirement will begin to reach over 10% of the current workforce every 5 years by 2036. Retirement will peak at 15% of the current workforce around 2051 before declining to under 10% of the current workforce again around 2061.

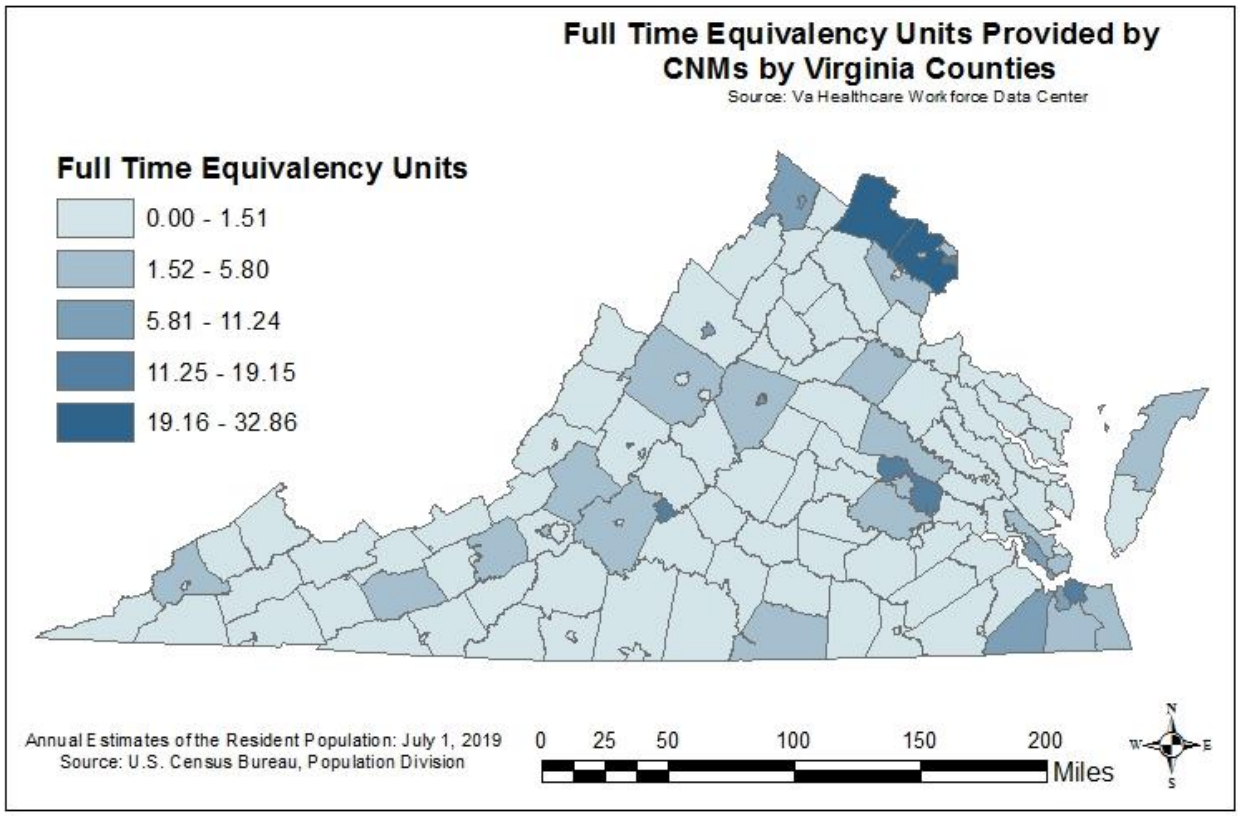
Map of Full Time Equivalency Units – Certified Nurse Anesthetists

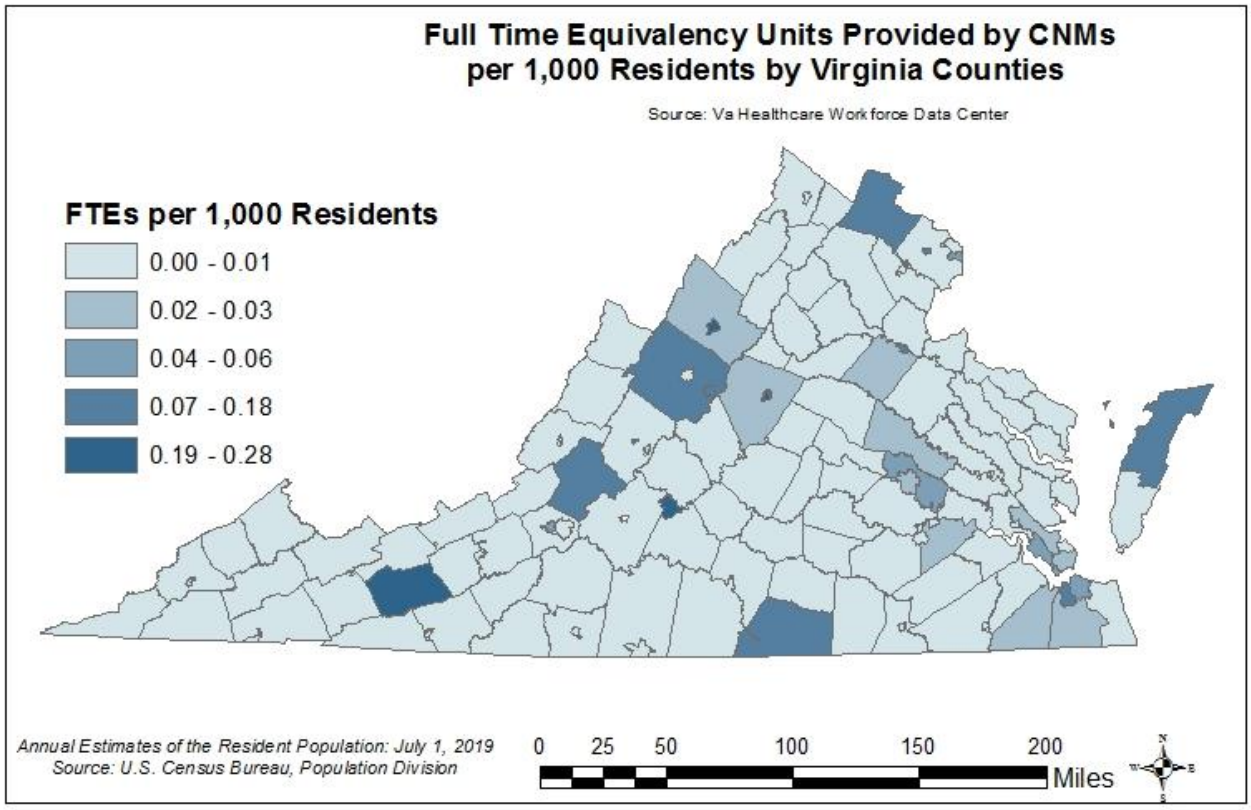




Note: Maps show reported work hours in primary and secondary locations of respondents who provided a response to the relevant question. Map may not reflect hours worked by all nurse practitioners licensed in the state since response rate was less than 100%.

Map of Full Time Equivalency Units – Certified Nurse Midwives





Map of Full Time Equivalency Units – Certified Nurse Practitioners