# ITEM 2: REGISTRAR'S PACKAGE

**Proposed Regulations for the Board of Medicine**
**(18 VAC 85-20-10 et seq.)**
**Basis, Purpose, Substance, Issues & Estimated Impact**

1. **Basis of the Regulation**

Title 54.1, Chapters 24 and 29 of the *Code of Virginia* provide the basis for this regulation.

Chapter 24 establishes the general powers and duties of the health regulatory boards including the power to establish qualifications for licensure and the responsibility to promulgate regulations.

Chapter 29 establishes the definitions and requirements for the practice of these regulated professions and specifies the powers and duties of the Board of Medicine.

**2. Statement of Purpose:**

The purpose of these regulations is to protect the public health, safety, and welfare by establishing continuing competency requirements for those seeking to renew active licensure in these professions and by establishing an inactive license and the criteria for reactivation.

**3. Substance of Regulation:**

**18 VAC 85-20-22.**

Amendments to these sections establish a biennial fee of $100 for an inactive license and a late fee of $25 for each renewal cycle for such license.

**18 VAC 85-20-230. Renewal of active license.**

An amendment is proposed to require evidence of competency competency for renewal of an active license as stated in 18 VAC 85-20-235.

**18 VAC 85-20-235. Continuing competency requirements for renewal of an active license.**

This new section requires the following: a) Completion of an Continuing Competency Assessment and Activity Form showing as assessment of practice needs and at least 100 hours of continuing learning activities; b) exemption for newly licensed practitioners for their first renewal; c) retention of records for 6 years and a random audit by the board; and d) provisions for an extension or exemption for all or part of the requirements.

**18 VAC 85-20-236. Inactive license.**

Amendments are proposed to allow a practitioner to request an inactive license without requiring evidence of continuing competency. Such a license does not entitle the licensee to perform any act which would require a license to practice.

**18 VAC 85-20-240. Reinstatement of an inactive or lapsed license.**

The proposed amendment would add requirements for reinstatement of an inactive or lapsed license to active status to include: evidence of continuing competency hours equal to the number of years of inactivity, not to exceed four years; and passage of the applicable examination for practitioners who have not engaged in active practice for more than four years.

**4. Issues of the Regulation:**

**1) Type and amount of continuing competency requirements**

In its response to the request of HJR 68 of the 1996 General Assembly, the Board of Medicine conducted a study of the need to require some evidence of continuing competency as a condition for renewal of licenses. In doing so, it consulted a wide range of persons and sources about the type, purpose, and efficacy of continuing medical education. Through the literature review and information gathered at a public hearing and focus group meetings, the Board concluded that the current system of accrediting continuing education courses does not guarantee physician learning or a change in clinical outcomes. The study concluded that the value of continuing education lies in those courses and activities which are practice-specific or clinically based and which address the specific needs of the learner-practitioner. The Board recommended against a legislative mandate for specific hours, methods, or content of continuing education for licensees of the Board, but it did recommend a statutory provision for it to consider various alternatives to ensure continued practitioner competence.

Based on the findings and recommendations of the study report, House Bill 2444 was passed by the 1997 General Assembly without a dissenting vote. With the Governor's signature, Chapter 227 amended the medical practice act by adding §54.1-2912.1, which mandates that the Board promulgate regulations for the establishment of continuing competency requirements. To carry out that mandate, the Board appointed a Committee on Continued Practitioner Competence with representation from the three medical schools, the professional societies or associations, and physician members of the Board.

The goal of the committee's work and the intent of the Board was to develop requirements that would: 1) encourage learner-directed continuing education through which the physician can identify a practice question or problem, seek the learning activity which provides needed information or teaches a new skill, and thereby, enhance his expertise or ability to practice; 2) offer a choice of content and form that is flexible enough to meet the needs of the physician-learner in any type of practice in any location in Virginia; and 3) assure the public that physicians are maintaining their skills and competencies.

As a result of its work over a six-month period, the Committee recommended and the Board adopted a requirement which is aimed at involving the physician as a continuing learner who is consistently assessing the questions and problems encountered in his practice and then making a

determination about the knowledge and skills needed to address those issues. In making the assessment, the practitioner is asked to consider issues of ethics, standards of care, patient safety, new medical technology, communication with patients, the changing health care system, and other topics influencing practice.

The 100 required hours are divided into two types: (1) In Type 1 continuing learning activities, the 50 hours required biennially must be offered by an accredited sponsor or organization which is sanctioned by the profession and which provides documentation of hours to the practitioner. At least 25 of the Type 1 hours must be earned in face-to- face group settings such as grand rounds, hospital staff meetings or scientific sessions of professional societies. The remaining hours may be in any type of self-learning activity, provided they are documented by the accredited sponsor or sanctioned organization; and (2) In Type 2 continuing learning activities, the 50 hours required biennially may or may not be approved by an accredited sponsor or organization but shall be activities considered by the learner to be beneficial to practice or to continuing learning; physicians document their own participation on the attached form.

After the activity is completed, the practitioner should indicate on the form provided by the Board the predicted outcome. He should indicate whether he will: a) make a change in his practice, b) not make a change in his practice, and/or c) needs additional information on this topic.

In its adoption of these requirements, the Board is responding to the research which indicates that the most effective continuing learning occurs when it is self-directed and designed to be practitioner-specific. It is also most effective if there has been some assessment of practitioner's needs and some evaluation of outcome and possible effects on practice. In addition, the Board is cognizant of the need to have at least half of these continuing learning hours validated through some accrediting body or sponsor. From its experience with disciplinary cases, the Board is aware that practitioners who engage in substandard care or have other disciplinary problems are often not associated with other practitioners or involved in any professional group. Therefore, the Board is requiring that at least 25 hours each biennium be earned in face-to-face settings such as grand rounds, hospital staff meetings or courses offered by professional societies.

**2) Requirements for reactivation of an inactive or lapsed license.**

Along with requirements for continuing competency for renewal of licenses, the Board is proposing an inactive license for those practitioners who are now retired or out-of-state and have no intention of engaging in active practice in the Commonwealth. In doing so, requirements for reactivation of such a license are necessary to ensure that practitioners are competent to resume practice. The Board determined that it was necessary for a practitioner whose license has been inactive or lapsed for up to four years to provide evidence of continuing competency hours equal to the amount of time the license has not been active. If a practitioner has not engaged in active practice for more than four years, the Board has concerns about his knowledge and skills and his ability to provide safe, effective care to patients. The Board is proposing that such a practitioner take an applicable examination designed for the purpose of testing a practitioner's ability to provide safe care.

**Advantages to the licensees:**

The proposed continuing competency requirements are intended to provide some assurance to the public that licensees of the Board are maintaining current knowledge and skills, while providing the maximum amount of flexibility and availability to licensees. Those members of the Board that piloted the program and utilized the Assessment and Activity Form concluded that the average practitioner already engages in enough learning activities to meet the requirements and should only have to maintain documentation of those activities and hours. Seventy-five of the 100 hours may be earned by the practitioner on his own time and schedule. Twenty-five of the hours must involve the practitioner in some interaction with his peers. The resources for earning the hours and engaging in the required learning are numerous and readily available in all parts of Virginia.

**Disadvantages to the licensees:**

For a small minority of practitioners who do not currently engage in any continuing learning in their profession, these requirements will represent an additional burden. However, it was determined by enactment of the statute and by the Board's concurrence that those practitioners and their patients would greatly benefit from continuing learning requirements, and that the public is better protected if there is some assurance of that effort.

**Advantages or disadvantages to the public:**

There are definite advantages of the proposed amended regulations to the public, which will have greater assurance that the licensees for the Board are engaged in activities to maintain and improve their knowledge and skills in providing care to their patients.

## 5. Estimated Impact of the Regulations

A. Projected number of persons affected and their cost of compliance:

The approximate numbers of licensees affected by these regulations are as follows:

26,478 - Licensed in medicine and surgery
719 - Licensed in osteopathy
490 - Licensed in podiatry
1,421 - Licensed in chiropractic
32,516 total affected licensees

The cost for compliance will vary greatly depending on the practitioner and the type of continuing learning activities chosen. Membership in the American Medical Association, through which continuing education courses can be accredited and the Journal (JAMA) is available, costs approximately $400 a year. Membership in the Richmond Academy of Medicine, the Medical Society of Virginia or other such organizations, which provide continuing education courses to their members, typically costs $200 to $400. However, membership is not required to receive credit for courses; numerous courses may be obtained through other sponsors and are available to any physician. Registration for such courses may cost approximately $100 a day for 4 to 5 hours of credit.

The New England Journal of Medicine, which is available at most libraries, offers 50 hours of Category 1 AMA credit through a home study activity for only $90. That would satisfy half of the credits required for renewal of licensure in Virginia.

Courses are also available without any charge through a hospital or other health care organization which provides continuing education for persons on staff. Since the physician will be required to obtain 50 hours per biennium of Type 1 continuing learning (Type 1 must be accredited and documented by an accredited body), the costs for earning those hours could typically range from $100 to any amount the practitioner wishes to spend each biennium. The vast majority of physicians (estimated to be 85 to 90%) already obtain sufficient hours and will incur no additional costs.

Since at least 25 hours of continuing learning must take place in group settings by which the practitioner interacts with his peers, it may necessitate some loss of income through time away from practice. However, since the practitioner may make the choice of his activities and experiences, many of those hours could be obtained in the evenings or on the weekend. In a typical weekend conference, the practitioner would earn 12-15 hours of continuing education credits. Therefore, the practitioner could meet his continuing learning requirements with minimal impact on practice.

The 50 hours of Type 2 continuing learning is self-directed and self-recorded; it does not require accreditation or sponsorship. It may be obtained by reading scholarly journals, sitting on hospital committees, observing another practitioner do a procedure, and a variety of other methods – all of which can be accomplished at no costs to the practitioner.

There would also be some very minimal costs involved with maintaining records. With the promulgation of these regulations, the Board will send each doctor the required form for assessment of practice needs and planning the activities to meet those needs. The form will also be available on the Board's Website and may by downloaded into a file on the individual's personal computer. The doctor will have to maintain that form and the documentation of continuing learning activities for a period of six years.

B. Cost to the agency for implementation:

Impact on Board revenue:

For those practitioners who are now retired or who are living out-of-state, there may be a percentage who would choose to take the inactive status and avoid the renewal requirements for continuing learning. Since the board has no information on practice activity, it is not known how many licensees would do so. To get some estimate of the percentage of active and inactive physicians, the Board has looked at figures provided by the Federation of State Medical Boards. Their information shows a wide range of ratios of active to inactive, fees, and continuing education requirements. For the purpose of this analysis, five states, which are similar in the number of licensed medical doctors and also require continuing education for renewal, were selected for comparison. (The figures shown are for '95-'96; the Federation is in the process of updating its information)

| State | Percentage of inactive | Active license fee |
|---|---|---|
| Massachusetts | 5% | $270/biennium |
| Maryland | 10.5% | $400/biennium |

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| Georgia | 17% | $105/biennium |
| Illinois | 17.5% | $300 (resident)/triennium<br>$600 (non-resident)/triennium |
| Florida | 21% | $355/biennium |

The active renewal fee in Virginia is $125/biennium; the proposed inactive renewal fee is $100/biennium; so the cost of licensure renewal should not be a major factor in a physician's decision to seek inactive status.

If the percentage of inactive licensure in Virginia rose to the average of the five states cited above (approximately 14%), the loss of revenue for the Board in a biennium would be $92,673. In a biennial budget of over $8 million with a surplus of over $2 million ('96-'98), the loss of revenue should not impact the operations of the Board or cause the Board to need to increase its fees.

For those practitioners who have not engaged in practice for more than four years and apply to the Board to reactivate their licensees (5 –10 per biennium), there will be an additional costs of $500 to take the SPEX or other applicable examination to indicate competency to reenter practice.

Impact on Board expenditures:

It would be expected that there will be additional costs to the Board for compliance enforcement. The Board will conduct a 1 to 2% audit of its licensees at the conclusion of each biennium. Each practitioner selected for the audit will be required to submit the required documentation of continuing learning activities. There will be some staff time involved in review of the documentation and in communicating with licensee about their deficiencies. No additional personnel will be required to accomplish this activity.

It is also expected that a small percentage of licensees selected for audit will result in a disciplinary case being opened. From the experience of boards within the agency that currently have continuing competency requirements for renewal, the majority of those cases (estimated to be 100 per biennium) will probably be settled with a pre-hearing consent order. In those cases, the only costs would be for charges back to the Board from the Administrative Proceedings Division (APD) of the Department. Costs for cases that do result in an informal conference committee proceeding (estimated to be 10 to 15 per year) would include travel expenses and per diem for board members as well as costs for the services of APD. Informal conference committees typically hear several cases in a day, so the costs per case for board member and APD time would be minimized.

Cost estimates for disciplinary cases related to the failure to comply with continuing competency regulations range from $100 to cases resulting in pre-hearing consent orders to $500 per case for those that result in an informal conference committee. All expenses relating to enforcement of these regulations can be absorbed in the existing budget of the Board of Medicine.

The Board will incur approximately $10,000 in cost for printing and mailing final amended regulations to licensees and other interested parties. There will be no additional cost for conducting a public hearing, which will be held in conjunction with a scheduled committee or board meeting.

C. Cost to local governments:

There will be no impact of these regulations on local government.

D. Fiscal Impact Prepared by the Department of Planning and Budget:

(Attached)

E. Agency Response:

The agency concurs with the analysis of the Department.