--- FINAL APPROVED --

VIRGINIA BOARD OF MEDICINE

LEGISLATIVE COMMITTEE MINUTES

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

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

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

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

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

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

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

MEMBERS ABSENT:
Alvin Edwards, PhD
Jane Hickey, JD

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

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

EMERGENCY EGRESS INSTRUCTIONS

Dr. Taminger provided the emergency egress instructions.

APPROVAL OF MINUTES OF JANUARY 19, 2018

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

ADOPTION OF AGENDA

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

PUBLIC COMMENT

There was no public comment

DHP DIRECTOR'S REPORT

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

EXECUTIVE DIRECTOR'S REPORT

No report.

NEW BUSINESS

1. **Review of Guidance Documents**

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

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

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

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

adopted February 23, 2012 – staff recommends reaffirmation

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

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

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

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

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

Section 54.1-2961 of the Code of Virginia provides:

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

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

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

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

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

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

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

5. What are "Type 1" hours?

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

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

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

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

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

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

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

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

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

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

Section 54.1-2400(14)

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

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

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

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

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

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

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

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

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

2. **Periodic review of regulations**

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

18VAC85-20-26. Patient records.

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

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

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

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

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

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

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

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

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

18VAC85-20-29. Practitioner responsibility.

A. A practitioner shall not:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. For licensure in chiropractic.

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

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

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

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

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

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

2. Has received a degree from the institution.

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

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

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

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

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

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

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

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

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

Part IV. Licensure: Examination Requirements.

18VAC85-20-140. Examinations, general.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Pay a registration fee of $10; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ANNOUNCEMENTS

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

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

Next meeting – January 11, 2019

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

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

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William L. Harp, MD
Executive Director

_____
Colanthia Morton Opher
Recording Secretary