Meeting of the Virginia Board of Medicine

June 16, 2022
8:30 a.m.

Virginia Department of Health Professions

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

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Board Room 4

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Board of Medicine

Thursday, June 16, 2022 @ 8:30 a.m.
Perimeter Center
9960 Mayland Drive, Suite 201
Board Room 2
Henrico, VA 23233

Call to Order and Roll Call

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

Agenda Item: Approval of Minutes of the February 17, 2022

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

February 17, 2022	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:
Blanton Marchese – President, Chair
David Archer, MD – Vice-President
James Arnold, DPM
Amanda Barner, MD - Secretary-Treasurer
Manjit Dhillon, MD
Madge Ellis, MD
Jane Hickey, JD
Oliver Kim, JD, LLM
Jacob Miller, DO
Pradeep Pradhan, MD
Milly Rambhia, MD
Karen Ransone, MD
Jennifer Rathmann, DC
Joel Silverman, MD
Brenda Stokes, MD
Ryan Williams, MD
Khalique Zahir, MD

MEMBERS ABSENT: Alvin Edwards, MDiv, PhD

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
Barbara Allison-Bryan, MD - DHP Deputy Director
Elaine Yeatts - DHP Senior Policy Analyst
Erin Barrett – DHP Senior Policy Analyst
Charis Mitchell, JD – Assistant Attorney General

OTHERS PRESENT:
Jennie Wood – Discipline Case Manager
Sean Murphy, JD – Assistant Attorney General
Scott Castro - MSV

---DRAFT UNAPPROVED---

EMERGENCY EGRESS INSTRUCTIONS

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

COVID INSTRUCTIONS

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

DISCILPLINARY MATTER FOR THE BOARD'S CONSIDERATION

The Board received information from Sean Murphy, JD, Assistant Attorney General, regarding Michael D. Pollock, DC, license number 0104-000305, in order to determine whether Dr. Pollock's continued practice of chiropractic constituted a substantial danger to public health and safety. Mr. Murphy provided details of the case to the Board for its consideration.

On a motion by Dr. Williams and duly seconded by Dr. Arnold, the Board voted unanimously to summarily suspend Dr. Pollock's license simultaneous with the institution of proceedings for a formal administrative hearing pursuant to Section 54.1-2408.1 of Code of Virginia.

APPROVAL OF MINUTES OF OCTOBER 14, 2021

Dr. Ransone moved to approve the minutes from October 14, 2021 as presented. The motion was properly seconded and carried unanimously.

INTRODUCTION OF NEW BOARD COUNSEL

Mr. Marchese announced Elaine Yeatts' retirement from the Department of Health Professions and stated that Erin Barrett will become the Senior Policy Analyst for DHP.

ADOPTION OF AGENDA

The agenda was approved as presented.

PUBLIC COMMENT

None.

DHP DIRECTOR'S REPORT

Dr. Allison-Bryan reviewed the statistics on COVID, stating that the Commonwealth has overcome the second peak of the Omicron variant. She said that the second peak was 288% higher than the first peak of COVID, but deaths were significantly lower. She also shared that 81% of Virginians are vaccinated, and COVID cases in Virginia are currently down 70%.

She also addressed teleworking, hybrid meetings, and other changes that came with COVID. She noted that the attitude towards telemedicine has changed in a positive way, and it may be time to take another look at existing guidance documents.

Lastly, she reiterated the earlier announcement of Elaine Yeatts' retirement and added that she will also be resigning from her position as DHP Senior Deputy on March 1, 2022.

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.

EXECUTIVE DIRECTOR

Dr. Harp reviewed the following topics:

- Office of the Chief Medical Examiner Fatal Drug Overdose Report for the 3rd Quarter of 2021
    - Dr. Harp briefly reviewed the report on the top 3 methods for unnatural death. He noted that in 2013, drug overdose became the number 1 method of unnatural death, ahead of motor vehicle accidents and guns. Data also showed that in 2015, fentanyl and/or heroin surpassed prescription opioids as the cause of overdose death. The rise in overdose deaths since is chiefly driven by illicit fentanyl and heroin. There were 471 deaths from illicit substances in 2015, and this year it is expected to be 2061. The total number of deaths from overdose for 2021 is projected to be 2660.
    - This report was for informational purposes only and did not require action.
- US Food & Drug Administration (FDA) Ivermectin Letter
    - This report was for informational purposes only and did not require action.
- Reciprocity Update

  - Dr. Harp provided an update on the reciprocity efforts with Maryland and Washington, DC. He stated that all applications will ask their own questions. Maryland and DC both require background checks, and DC requires COVID vaccination.
  - This report was for informational purposes only and did not require action.

- Occupational Therapy Compact

  - Dr. Harp stated that Virginia was the first state to join the OT Compact and it appears that the required number of jurisdictions (10) has joined, so efforts to develop parameters for the Compact can now begin. Michael Sobowale is a possibility to serve as the Board's representative. How to proceed will be discussed at the Advisory Board on Occupational Therapy meeting in May.
  - This report was for informational purposes only and did not require action.

- Website Ranking

  - The ranking of state boards for transparency of information on their websites, a joint effort of the Patient Safety Action Network and the Informed Patient Institute, indicates that Virginia meets 10 of the 16 criteria used in the ranking. That places Virginia at #11 in the ranking of 64 medical board websites.
  - This report was for informational purposes only and did not require action.

- Board Member Reappointments

  - Dr. Harp noted the members whose terms will expire on June 30, 2022 and are eligible for reappointment. He said that Board staff has provided a response to the Office of the Secretary of the Commonwealth that all members eligible for reappointment wished to continue their service on the Board. Board staff has not yet gotten specific instructions about whether applications for reappointment are required or not.

COMMITTEE AND ADVISORY BOARD REPORTS

Dr. Miller moved to accept all reports en bloc. The motion was properly seconded and carried unanimously.

OTHER REPORTS

Board of Health Professions

Meeting Minutes for the December 2, 2021 Board of Health Professions meeting were provided in the packet. Dr. Stokes made brief comment.
This report was for informational purposes only.

Podiatry Report

Dr. Arnold shared the Federation of Podiatric Medical Boards (FPMB) 2021 Fall Meeting agenda packet. He noted that FPMB would like to have podiatric medical students take the USMLE, without changing the podiatric scope of practice.

Chiropractic Report

No report.

Committee of the Joint Boards of Nursing and Medicine

The written report was for informational purposes only.

NEW BUSINESS

REGULATORY AND LEGISLATIVE ISSUES – Elaine Yeatts

CHART OF REGULATORY ACTIONS

Elaine Yeatts presented the chart of regulatory actions as of February 17, 2022. She noted that the fast-track regulations for 18 VAC 85-20 Licensure by Endorsement – expedited process, will take effect on April 1, 2022.

BREAK

Mr. Marchese called for a recess at 10:17 a.m.; the meeting reconvened at 10:30 a.m.

REGULATORY/POLICY ACTIONS – 2022 GENERAL ASSEMBLY

Elaine Yeatts gave a quick overview on the 2022 General Assembly and fielded questions from the members on topics of interest.

GUIDANCE DOCUMENT 85-5 - GUIDANCE ON QUESTIONS CONCERNING MEDICAL RECORDS

Ms. Yeatts presented Guidance Document 85-5, Guidance on Questions about Medical Records, stating it was last reviewed on August 10, 2017. Board staff reviewed the current document and believes that it is consistent with the current Code of Virginia and still provides helpful guidance to the public and practitioners alike.

Dr. Miller moved to retain the document as written. The motion was properly seconded and carried unanimously.

—DRAFT UNAPPROVED—

2021 NURSE PRACTIONERS WORKFORCE/SPECIALTY COMPARISON PRESENTATION

Dr. Yetty Shobo gave a PowerPoint presentation on "The Nurse Practitioner Workforce", highlighting trends in age, gender, educational attainment, specialties and retirement intentions.

LICENSING REPORT

Michael Sobowale noted the increase in the number of licensees at the Board. As of February 15, 2022, the Board had 79,724 licensees, not counting nurse practitioners. He said that thus far in 2022, the Board has licensed 342 new MDs and DOs, 50 by endorsement. And so far in 2022, a total of 925 new licenses for all professions have been issued. Lastly he stated that the number of current active in-state MDs and DOs is 25,023. Current out-of-state MDs and DOs are 19, 459. Current inactive MDs and DOs total 1,763.

DISCIPLINE REPORT

Ms. Deschenes provided a brief report on the status of disciplinary cases as of February 1, 2022.

APPOINTMENT OF THE NOMINATING COMMITTEE

Mr. Marchese asked for volunteers who wished to serve on the Committee. Dr. Ransone, Ms. Hickey, Dr. Miller, and Dr. Zahir volunteered and were approved by acclamation.

SPECIAL RECOGNITION

Mr. Marchese led a special recognition for Dr. Barbara Allison-Bryan and Elaine Yeatts for their years of service with the Department of Health Professions. Both were presented with flowers and given a standing ovation for all they had done for the Board of Medicine.

ANNOUNCEMENTS

Mr. Marchese reminded the members to submit their Travel Expense Reimbursement Vouchers within 30 days after completion of their trip. Additionally, all should see Ms. Opher for badge verification after the meeting.

ADJOURNMENT

With no additional business, the meeting adjourned at 11:06 a.m.

---DRAFT UNAPPROVED---

Blanton Marchese
President

William L. Harp, MD
Executive Director

Deirdre C. Brown
Recording Secretary

Agenda Item: **Presentation of BOX**

Staff Note: None.

Action: Informational presentation. No action required.

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: **Update on Reciprocal Licensing with Maryland and DC**

Staff Note: None.

Action: Informational presentation. No action required.

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

Staff Note: Please note Committee assignments and minutes of meetings since February 17, 2022.

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, April 8, 2022 | Department of Health Professions | Henrico, VA

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

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

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

MEMBERS ABSENT:
David Archer, MD – Vice-President
Jane Hickey, JD

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 C. Brown - Executive Assistant
Erin Barrett, JD – DHP Senior Policy Analyst

OTHERS PRESENT:
Jennie Wood – Discipline Staff
W. Scott Johnson - Hancock Daniel & Medical Society of Virginia

EMERGENCY EGRESS INSTRUCTIONS

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

APPROVAL OF MINUTES OF DECEMBER 3, 2021

Dr. Edwards moved to approve the minutes from December 3, 2021 as presented. The motion was seconded by Dr. Ransone and carried unanimously.

ADOPTION OF AGENDA

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

PUBLIC COMMENT

Mr. Marchese opened the floor for public comment. There was none.

PRESIDENT'S REPORT

No report.

EXECUTIVE DIRECTOR'S REPORT

Dr. Harp had been asked by Dr. Brown to provide an update on DHP. He reported that there were no updates about administration transitions from the Governor's office. He also spoke to the following:

- DHP leadership is pleased with the new security service in the building.
- On Monday, April 4, 2022, everyone returned to the office. Teleworking, up to 3 days a week may be approved by supervisors, if one's job is amenable to telework.
- During the pandemic, original materials were able to leave the building to facilitate telework. Effective immediately, original materials are to be returned to the building.
- Elaine Yeatts' DHP retirement celebration was held on April 1, 2022 in the building.
- Looking forward, Liz Carter and Ralph Orr will be retiring on July 1, 2022.

Dr. Harp then gave an overview of the Cash Balance Report and reminded the Committee that the Board cannot have more than 10% in cash reserves. Currently the Board is in the 4th biennial decrease of renewal fees for all its professions. On June 30, 2022, the decrease in renewal fees will continue.

Next, Dr. Harp covered the Revenue and Expenditures Summary. He highlighted that the Board's "Total Fee Revenue" for the period of July 1, 2021 through December 31, 2021 was 21.03% of that anticipated for FY2022. He pointed out that this was an even year when most of the fee revenue comes in, so the % of fee revenues will be going up throughout the year. Dr. Harp then pointed out the "Total Computer Hardware and Software" item and that 100.92% of monies budgeted had already been spent. He said that this expense was to setup robotic responses called BOTs, which initially will generate automatic responses to applicants about their status updates. Lastly, Dr. Harp gave a brief overview on the "Allocated Expenditures" at the end of the Revenue and Expenditures Summary.

NEW BUSINESS

1. Report of the 2022 General Assembly – Erin Barrett

---DRAFT UNAPPROVED---

Ms. Barrett reviewed the 2022 General Assembly with the Executive Committee, highlighting several bills that have passed or are still pending. She also presented a handout of the "Virginia Regulatory Town Hall – Current Actions Underway" as of April 5, 2022. Ms. Barrett then reviewed the following bills for the Committee as being passed or still pending:

- HB 192 Opioids; repeals sunset provisions relating to prescribers requesting information about a patient from the Prescription Monitoring Program. It was passed by both houses.
- HB 191 Health Workforce Development; creates the position of Special Advisor to the Governor. Ms. Barrett stated that this bill is pending and has been moved to the Special Session.
- HB 213 Optometrists; allowed to preform laser surgery if certified by Board of Optometry. Ms. Barrett stated that this bill did pass, but will not have an immediate effect.
- HB 264 Public health emergency; out-of-state licenses, deemed licensure. Authorizes medical professionals legally licensed in another jurisdiction to deliver telemedicine services with Virginia patients with whom he/she has an established relationship.
- HB 286 Nurse practitioners; declaration of death and cause of death.
- HB 896 Nurse practitioners; patient care team provider. Ms. Barrett said that there is a lot of misinformation that is being sent out regarding this bill.
- HB 1323 Pharmacists; initiation of treatment with and dispensing and administration of vaccines. Ms. Barrett did state that the Board of Medicine will take the lead on this and establish a panel of Board members and VDH representatives by this summer.
- SB 169 Practical nurses, licensed; authority to pronounce death for a patient in hospice, etc. Ms. Barrett did point out that this bill provides limited authority.
- SB 317 Out-of-State health care practitioners; temporary authorization to practice. This bill allows an applicant to practice for 90 days pending licensure.
- SB 480 Administrative Process Act; final orders, electronic retention. Ms. Barrett added that as of July 1, 2022, documents may be scanned then shredded.
- SB 511 Opioid treatment program pharmacy; medication dispensing, registered/licensed practical nurses.

Aside from the above bills being passed, Ms. Barrett did state that HB 1245 - Nurse practitioners; practice without a practice agreement; which repeals the sunset provision still remains pending. This bill has been moved to the Special Session, since agreement on this bill was not reached in conference.

These items were for informational purposes only and did not require any action.

2. Approval of Proposed Regulations for Implementation of the Occupational Therapy Interjurisdictional Compact – Erin Barrett

Ms. Barrett stated that this is an approval of proposed regulations, not final regulations, for implementation of the Occupational Therapy Interjurisdictional Compact. She reviewed the language for definitions under the compact. 1) "Compact" means the Occupational Therapy Interjurisdictional Licensure Compact." 2) "Compact privilege" means the same as the definition of the term in 54.1-2956.71 of the Code of Virginia." 3) "Practitioner" means an occupational

therapist or occupational therapy assistant licensed in Virginia or an occupational therapist or occupational assistant practicing in Virginia with a compact privilege."

MOTION: Dr. Edwards moved to approve the amended regulations as presented. The motion was properly seconded by Dr. Ransone and carried unanimously.

3. Review and Approval of Revised Guidance Document 85-9 – Dr. Harp

Dr. Harp reviewed current Guidance Document 85-9 on USMLE Step Attempts which allows 6 attempts at each Step. He reported that as of July 1, 2021, NBME and FSMB has reduced the number of attempts at each USMLE Step from 6 to 4 for all applicants applying on July 1, 2021 or thereafter. The new USMLE policy allows a one-time exception for a 5th attempt at one of the Step exams. Sponsorship by a state board is required for USMLE's consideration of an additional attempt.

Dr. Harp proposed a new version of 85-9, which includes that the Board, in its discretion, could support a one-time 5th attempt of a USMLE Step exam. Dr. Edwards moved to approve, and Dr. Ransone seconded. Dr. Silverman then questioned the need for an exception and the rationale for allowing a 5th attempt. He stated concerns of legal consequences and suggested that there should only be 4 attempts allowed, no exceptions. Dr. Harp referred the Committee to the language on page 34 that indicates the document does not authorize an extra attempt at Step 3. He further pointed out that an applicant requesting an exception must have passed all 3 Steps previously and only needs Step 1 or Step 2 to bring his/her scores into line with Virginia's 10-year requirement. Mr. Sobowale said that about 2% of the applicants email him, requesting a waiver. Ms. Deschenes then asked Mr. Sobowale, "How many other states have exceptions?" to which Mr. Sobowale replied, 45 or 46 states have time limits to pass the USMLE.

MOTION: Dr. Edwards moved to approve the revised Guidance Document 85-9. The motion was properly seconded by Dr. Ransone. After discussion, 5 approved and 1 opposed.

4. Update on Reciprocal Licensing with Maryland and the District of Columbia – Dr. Harp

Dr. Harp updated the Committee on the status of reciprocal licensing with Maryland and the District of Columbia. He said that the meeting scheduled for Friday, April 1, 2022 had been rescheduled to April 28, 2022. He described the draft application for reciprocity generally as having far fewer questions and documents required than the traditional and endorsement applications. He said he hopes to be able to present the draft application at the June Board meeting. Ms. Deschenes said that there is a statutory foundation for reciprocity, so no regulations should be needed.

ANNOUNCEMENTS

----DRAFT---

VIRGINIA BOARD OF MEDICINE

CREDENTIALS COMMITTEE BUSINESS MEETING

Tuesday, June 7, 2022 | Department of Health Professions | Henrico, VA

CALL TO ORDER: Dr. Miller called the meeting to order at 10:01 a.m.

MEMBERS PRESENT:
Jacob Miller, DO - Chair
Khalique Zahir, MD
Jane Hickey, JD
Manjit Dhillon, MD
Alvin Edwards, PhD
Milly Rambhia, MD

MEMBERS ABSENT:
Madge Ellis, MD
Pradeep Pradhan, MD
Jennifer Rathmann, DC

STAFF PRESENT:
William L. Harp, MD - Executive Director
Michael Sobowale, LLM - Deputy Director for Licensing
Colanthia M. Morton - Deputy Director for Administration

GUESTS PRESENT:
Kelsey Wilkinson - Medical Society of Virginia
Blanton Marchese – President, Board of Medicine
David Brown, DC - DHP Director

Emergency Egress

Dr. Harp gave 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". The motion was seconded by Ms. Hickey, and the minutes were approved.

Dr. Edwards moved approval of the minutes of the November 8, 2021 meeting as presented. The motion was seconded by Ms. Hickey, and the minutes were approved.

Approval of the Agenda

Dr. Edwards moved approval of the meeting agenda. Ms. Hickey seconded the motion. The agenda was unanimously approved.

Public Comment

While there was no public comment, Dr. Harp acknowledged the presence of Blanton Marchese and Dr. Brown who may wish to comment on a couple of agenda items.

New Business:

1. **Review of Virginia's Questions on Mental Health and Substance Abuse on Initial Application**

Dr. Harp introduced the topic. He referred to the Medical Society of Virginia's letter of September 22, 2021 asking that the Board consider changing the mental health question on the initial licensure application and the article in the September Board Briefs. He pointed out the mental health questions asked by Virginia's surrounding jurisdictions he surveyed, highlighted the information provided by the U.S Surgeon General's office which offered suggested approaches for governmental entities to address worker burnout, mental health, and substance abuse. He referred members to the information in the Toolkit for State Medical Boards on how to make licensure questions less threatening and less intrusive. Finally, he referred to several points in an article in Virginia Business written by Katherine Schulte which highlights the stigma perceived by health care professionals and the barriers to seeking help and discussing their mental health struggles.

Dr. Brown offered that while the questions currently asked by the Board on initial license applications have been deemed ADA-compliant by the Attorney General's office, the fact that MSV has reached out to the Board regarding this issue is indicative that the Board needs to ensure that it has language that serves its purpose of public protection and avoids language that might discourage physicians and other health care professionals from seeking needed treatment. Placing articles in Board Briefs is good but might not have the far-reaching effect desired as history has shown that very few recipients read them. Also, articles should not be taken as level-setting for what the Board is trying to achieve by visiting this topic.

Mr. Marchese offered that perhaps the Board needs to ask whether its mental health questions can be framed in a less intrusive way. He proposed as part of the Board's efforts to soften the perception of licensees and applicants that the Board is punitive in its approach. He said

conduct educational visits, town halls if you will, to groups of licensees and students.

Dr. Miller stated that the Committee has three questions to tackle regarding this topic:

1. Does the Board need to ask mental health competency questions?
2. Are the questions currently being asked appropriate?
3. Are there better ways for the Board to ask these questions so physicians are not discouraged from seeking treatment?

Dr. Rambhia added that the Board should be asking what information is gleaned from the current questions. What percentage of physicians answer yes to these questions, and how would the Board know that the questions are being answered correctly? What is the implication to the applicant of answering a mental health competency question in the affirmative? Is the idea of conducting educational visits a long-term, viable and sustainable solution? Clarity and transparency for a license applicant answering a mental health competency question in the affirmative are vital concerns. Another alternative would be partnering with medical sub-specialty societies to reinforce a positive message. Dr. Rambhia proposed that the Board consider using an attestation language in the application that emphasizes supportive language around mental health self-recognition while encouraging license applicants to seek help as North Carolina has done in its license application.

Dr. Zahir stated that physicians are willing to learn and be educated. He proposed that if there are continuing education courses on mental health issues that physicians are mandated to take in Board regulations, this might be a viable solution. Ms. Hickey offered that the Board still needs to ask mental health competency questions on license applications but a question on substance abuse should be viewed separately from a mental/physical impairment question. Dr. Dhillon suggested that the mental health question currently being asked is too general. The phrase, "...medical condition..." should be looked at more closely.

Dr. Brown suggested the Committee should consider recommending that the Board combine the separate physical and mental health questions into one question. The Committee should also consider recommending that the word, "condition" be removed and look closely at the word, "currently" in the question. How does the Board define "currently"? He is supportive of the proposal to place an attestation statement in the application that uses supportive language around mental health treatment.

Dr. Miller called on the Kelsey Wilkinson, representative from the Medical Society of Virginia (MSV), to offer comments. Ms. Wilkinson stated that MSV runs a safety-net program that addresses all these issues.

After full discussion, the Committee made general recommendations to be submitted to the full Board as follows:

1. The Board should continue to ask the three questions currently being asked on the

license application on substance abuse, mental health, and physical impairment but remove the word, "condition" from the questions.
2. The Board should consider including supportive language in an attestation statement to be added to the license application for applicants to take care of their own health and well-being and include options for that, using the North Carolina example.
3. The Board should consider removing the 2nd statement in the three questions which attempts to provide the definition of "currently" as it may be read as punitive and prohibitive to the Board's desire to encourage license applicants to seek treatment, if needed.
4. In conjunction with MSV Foundation, Dr. Harp to explore educational opportunities and develop programs to help educate physicians and students.

2. **Delegation of Review of Non-Routine Information to Staff**

Dr. Harp called upon Mr. Marchese to introduce the topic. Mr. Marchese discussed the current process of review of information that the Board considers as non-routine in an application. Both he and Ms. Hickey currently review all information flagged by staff as non-routine in every application submitted to the Board. Also, some applicants choose to provide supportive materials to explain their answer to a question. It is necessary that some discretion be given to Board staff to review an affirmative response to questions and the supportive information provided. Usually an administrative decision to issue a license can be made, streamline the licensing process, and shorten the time for issuance of a license.

The Committee reviewed each question asked on the MD/DO license application and decided to recommend to the full Board as follows:

1. Questions number 6-10, change the wording of "Have you ever…" to "within the last ten years". If the answer is "Yes", a Board member has to review; otherwise, staff can license.
2. Question number 11 has to be reviewed by a board member.
3. Question number 12, change the wording of "Have you ever…" to "within the last ten years". If the answer is "Yes", a Board member has to review; otherwise, staff can license.
4. Question number 13-20, if the applicant is currently working with an unrestricted license in other state(s), staff can license.
5. For the malpractice question in question number 21, add to the question that the narrative or letter of explanation provided has to be limited to 250 words. If the malpractice claim is under ten (10) years, the application has to be reviewed by a Board member.

3. **Update on Reciprocity Negotiations with Maryland and the District of Columbia**

Dr. Harp provided an update on Virginia's reciprocity negotiations with Maryland and the District of Columbia (DC). There was a meeting held with board representatives from these jurisdictions on June 2nd to further discuss this issue. The Memorandum of Understanding being prepared by DC's legal counsel was not ready at this meeting.

Virginia reported that it has its draft questions to be asked on the reciprocity application ready, which consists of only six (6) questions. The other two jurisdictions requested to see a copy of Virginia's questions and also agreed to a brief application for their own jurisdictions with few supporting documents required. There are still some barriers left in terms of addressing technological interface among the various jurisdictions and legal.

Announcements:

Dr. Harp reminded members about reimbursement for travel to the meeting. The Commonwealth is requiring that travel claims be timely submitted for processing within thirty (30) days of travel in order for it to be paid.

With no additional business, the meeting was adjourned 12:37 pm.

Jacob Miller, DO
Chair

William L. Harp, MD
Executive Director

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

---DRAFT ---

ADVISORY BOARD ON BEHAVIOR ANALYSIS

Minutes
May 23, 2022

The Advisory Board on Behavior Analysis met on Monday, May 23, 2022, at 10:00 a.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, Virginia.

MEMBERS PRESENT:	Christina Giuliano, LBA, Chair Mark Llobell, Citizen Member Jerita Dubash, D.O. - [Joined at 10:20 am] Autumn Kaufman, LBA
MEMBERS ABSENT:	None
STAFF PRESENT:	William L. Harp, M.D., Executive Director Michael Sobowale, LLM, Deputy Director for Licensing Colanthia M. Opher, Deputy Director for Administration Erin Barrett, JD, DHP Senior Policy Analyst Pam Smith, Licensing Specialist
GUESTS PRESENT:	Christy Evanko, VABA Amanda Randall Kate Lewis Ting Bentley Shantel Pugliese Eli Newcomb, LBA Brian (no last name provided) Jennifer (no last name provided)

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

Pam Smith called the roll. A quorum was established.

APPROVAL OF MINUTES OF JANUARY 31, 2022

Mark Llobel moved to approve the minutes from the January 31, 2022 meeting. Autumn Kaufman seconded, and the motion carried.

ADOPTION OF AGENDA

Mark Llobell moved to adopt the agenda. Autumn Kaufman seconded. The agenda was adopted as presented.

PUBLIC COMMENT

Christina Giuliano announced that the public comment period has closed on the petition for rulemaking that requests an amendment to Board of Medicine regulation 18VAC85-150-60 on the licensure requirements for behavior analysts and assistant behavior analysts. No public comment would be taken on this agenda item during the meeting.

Christy Evanko provided public comment on the time it takes to process applications for behavior analysis.

NEW BUSINESS

1. **Legislative Update from the 2022 General Assembly**

   Erin Barret indicated that currently there were no regulatory actions affecting the profession. She gave an update on 2 bills at the General Assembly. HB1245 repeals the sunset provision in a bill passed in 2020 that reduced the years from 5 to 2 of full-time clinical experience that a nurse practitioner must have to be eligible to practice without a practice agreement. HB191 would have created the position of Special Advisor to the Governor for Health Workforce Development and also create a Virginia Health Workforce Development Fund to address various health workforce issues in Virginia. Neither bill passed in the Regular Session and were sent to the Special Session for further consideration.

2. **Petition for Rulemaking**

   Closed Session
   Christina Giuliano announced that, pursuant to Section 2.2-3711 (A) (7) of the Code of Virginia, it is appropriate that the Advisory Board convene a closed session to obtain legal consultation and briefings by Board staff members because actual or probable litigation had been threatened. Christina Giuliano moved to convene a closed meeting. Additionally, she moved that the Board/DHP staff present attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Advisory Board in its deliberations. The motion was duly seconded by Autumn Kaufman. The motion carried.

Reconvene
Mark Llobell moved to certify that the matters discussed in the preceding closed session met the requirements of Virginia Code Section §2.2-3712. Autumn Kaufman seconded the motion, and the motion carried. The Advisory Board re-convened in open session to continue its discussion on the petition for rulemaking.

Discussion
An Advisory Board member stated that the Qualified Applied Behavior Analysis credential (QABA) does not meet the requirements for comprehensive practice in the field of behavior analysis. QABA's restriction chiefly to autism does not meet the definition of an appropriate accrediting body's requirements for practice in the field of behavior analysis. Another questioned how disciplinary actions taken by the QABA credentialing board are reported and to which entities they are reported. It was stated that the Advisory Board does not want to run the risk of having an applicant disciplined by another accrediting body unrecognized by the Board of Medicine and have the applicant subsequently apply for a license without the Board's knowledge of the disciplinary action. This would be contrary to the Board's mission to ensure safe and competent patient care by licensed healthcare professionals by enforcing standards of practice. It was noted that comments during the public comment period from recognized experts reinforced the standards in the Board's regulations for accreditation of behavior analysis. It was also stated that QABA's certification criteria do not meet the licensure requirements in the Board's regulations to protect the public in Virginia. By allowing applicants to be credentialed for practice in behavior analysis apart from what is already written in regulations by the Board, the Board is opening the door to lesser quality of care for patients in Virginia.

Erin Barrett stated that the regulations are currently in conflict with the law. Based on the petition, members may choose to initiate a Notice of Intended regulatory Action (NOIRA) to include a definition of acceptable nationally accredited entities for behavior analysts in the definition section. Forming a Regulatory Advisory Panel to discuss the definition of what is considered "nationally accredited" was discussed.

Mark Llobell moved that the Advisory Board recommend to the full Board to initiate rulemaking in response to the petition to conform the regulation with the language in 54.1-2957.16 and to define the term, "nationally accredited to certify practitioners of behavior analysis." The Advisory Board also recommended a Regulatory Advisory Panel be appointed to assist with the definition. The motion was seconded by Dr. Dubash, and the motion carried.

3. Adoption of Bylaws

Erin Barrett stated that since all the Advisory Boards will be recommending adoption of Bylaws to the full Board, it would be more efficient, process-wise, for all the Bylaws for each Advisory Board to be covered in a uniform Guidance Document. Mark Llobell moved that the Bylaws for the Advisory Board to be placed into a single Guidance Document as suggested. Autumn Kaufman seconded, and the motion carried.

ANNOUNCEMENTS

Michael Sobowale provided the licensing statistical report. For licensed behavior analysts, there is a total of 2, 067 with 1,443 current active in Virginia and 1 current inactive. 615 are current active out-of-state, and 3 are current inactive out-of-state. There are currently a total of 223 licensed assistant behavior analysts. 193 are current active in Virginia; 2 are current inactive, and 28 are current active out-of-state.

NEXT MEETING DATE

September 19, 2022 @ 10:00 a.m.

ADJOURNMENT

There being no other business, Christina Giuliano adjourned the meeting 11:27 a.m.

Christina Giuliano, LBA Chair

William L. Harp, MD, Executive Director

Michael Sobowale, Recorder

<< DRAFT >>

ADVISORY BOARD ON GENETIC COUNSELING
Minutes
May 23, 2022

The Advisory Board on Genetic Counseling met on Monday, May 23, 2022 at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Tahnee Causey, GC, Chair
Lydia Higgs, GC, Vice-Chair
Martha Thomas, GC
Lori Swain, Citizen

MEMBERS ABSENT: None

STAFF PRESENT: Michael Sobowale, LLM, Deputy Director for Licensure
Erin Barrett, JD, DHP Senior Policy Analyst
Colanthia Opher, Deputy Director for Administration
Delores Cousins, Licensure Specialist

GUESTS PRESENT: None

Call to Order

Tahnee Causey called the meeting to order at 1:07p.m.

Emergency Egress Procedures

Erin Barrett announced the emergency egress instructions.

Roll Call

Roll was called; a quorum was declared.

Approval of the October 4, 2021 Minutes

Lydia Higgs moved to adopt the minutes. Martha Thomas seconded, and the motion passed.

Adoption of Agenda

Lori Swain moved to adopt the Agenda. Martha Thomas seconded, and the motion passed.

Public Comment on Agenda Items

None

NEW BUSINESS

1. **Legislative Update from the 2022 General Assembly**

   Erin Barrett covered relevant legislation from the Session, including SB317.

2. **Discussion of Failed Certification Examination and Temporary Licensure**

   Tahnee Causey led this discussion.

3. **Consider Adoption of Bylaws**

   Michael Sobowale indicated that no discussion was needed.

Announcements:

Delores Cousins gave statistics:
- Issued-license-count 1/1/2021 to 12/31/2021 = 102
- Issued-license-count 1/1/2022 to 5/23/2022 = 55
- License status count = 518

Next Scheduled Meeting:

The next scheduled meeting will be September 19, 2022 @ 1pm.

Adjournment

With no other business to conduct, the meeting was adjourned @ 1:51p.m.

Tahnee Causey, GC, Chair

William L. Harp, MD, Executive Director

Michael Sobowale, LLM, Deputy Director

ADVISORY BOARD ON OCCUPATIONAL THERAPY
Board of Medicine
Tuesday, May 24, 2022 @ 10:00 a.m.
9960 Mayland Drive, Henrico, Virginia

MEMBERS PRESENT:	Dwayne Pitre, OT, Chair Kathryn Skibek, OT, Vice-Chair Breshae Bedward, OT Karen Lebo, Citizen Member
MEMBERS ABSENT:	Raziuddin Ali, MD
STAFF PRESENT:	Michael Sobowale, Deputy Director for Licensing Colanthia M. Opher, Deputy Director for Administration Erin Barrett, JD, DHP Senior Policy Analyst ShaRon Clanton, Licensing Specialist
GUESTS PRESENT:	Heidi Hull, OT, NBCOT

CALL TO ORDER

Dwayne Pitre called the meeting to order at 10:04 a.m.

EMERGENCY EGRESS PROCEDURES

Michael Sobowale announced the Emergency Egress Instructions.

ROLL CALL

Roll was called, and a quorum was declared.

APPROVAL OF MINUTES DATED May 25, 2021

Ms. Skibek moved to approve the minutes dated October 5, 2021. The motion was seconded by Ms. Bedward. The question was called, and the minutes were approved as presented.

ADOPTION OF AGENDA

Ms. Bedward moved to approve the adoption of the agenda. The motion was seconded by Ms. Lebo. The agenda was adopted as presented.

PUBLIC COMMENTS ON AGENDA ITEMS (15 minutes)

None

NEW BUSINESS

1. **2022 Legislative Update and 2023 Proposals**

   Erin Barrett discussed SB317 from the 2022 Session. It provides a 90-day authorization for a licensed OT or OTA licensed in another state to practice in Virginia without a license under certain conditions. Should the individual apply for a permanent Virginia license, he/she could be granted another 60 days to work on the authorization prior to licensure.

2. **Update on Compact Implementation**

   Mr. Sobowale suggested the members address the issue of a delegate to represent Virginia for the Compact. After discussion, Ms. Bedward nominated Michael Sobowale. The motion was seconded by Ms. Skibek and passed.

3. **Discuss Amendment to Guidance Document 85-17**

   Ms. Barrett presented Guidance Document 85-17 – Guidance o Supervisory Responsibilities of an Occupational Therapist - to the Advisory. Ms. Bedward moved to amend Answer 7 to include occupational therapist assistants. The motion was seconded by Ms. Skibek and approved.

4. **Consider Amendment to Bylaws for the Advisory Board**

   Ms. Barrett recommended to the Advisory that OT be part of a uniform set of bylaws for all 11 Advisory Boards. Ms. Skibek's moved this recommendation; it was seconded by Ms. Bedward and approved.

ANNOUNCEMENTS

Ms. Clanton said there are 3,806 current active OT's in Virginia with 51 current inactive. The total number of OTA's in Virginia is 1,587 with 22 inactive.

Next Meeting date: September 20, 2022 @ 10:00 a.m.

Adjournment:

Meeting was adjourned at 10:47 a.m. by Dwayne Pitre.

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Dwayne Pitre, Chair

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

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ShaRon Clanton, Licensing Specialist

<< DRAFT >>

ADVISORY BOARD ON RESPIRATORY THERAPY
Minutes
May 24, 2022

The Advisory Board on Respiratory Therapy met on Tuesday, May 24, 2022 at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

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

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

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

GUESTS PRESENT: Sherleen Bose

Call to Order

Santiera Brown-Yearling called the meeting to order at 1:05 p.m.

Emergency Egress Procedures

Emergency Egress Procedures were presented by Dr. Harp

Roll Call

Roll was called, and a quorum was declared.

Approval of the October 5th, 2021 Minutes

Shari Toomey moved to approve the minutes, whch were seconded by Daniel Gochenour and passed.

Adoption of Agenda

Shari Toomey moved to adopt the agenda. Daniel Gochenour seconded the motion, which was approved.

Public Comment on Agenda Items

None

Healthcare Workforce Data Center presentation by Dr. Yetty Shobo

Dr. Shobo did her usual comprehensive presentation on demographics and answered questions from the Advisory Board members and staff.

New Business

1. Legislative Update from the 2022 General Assembly

   Erin Barrett presented relevant legislation from the Session. She highlighted HB745 that authorizes new RT graduates to practice for 6 months without a license or until they get a failing score on the NBRC exam. She also covered SB317 which authorizes out-of-state licensed RT's to practice in Virginia for 90 days.

2. Discussion of Licensing Process for Respiratory Therapists

   Daniel Gochenour commented on the effect of HB745 and the positive effect it will have on the respiratory care workforce.

3. Consider Amendment to Bylaws for the Advisory Board

   Erin Barrett suggested the process to review and update the Advisory Board's bylaws be done in conjunction with the 10 other Advisory Boards, so one guidance document could be presented to the Board of Medicine for approval. The Advisory agreed with this approach.

Announcements:

Delores Cousins provided statistics.

- 1/1/2021 to 12/31/2021 - 346 initial applications; 34 reinstatement applications

- 1/1/2022 to 5/24/2022 - 156 initial applications; 15 reinstatement applications
- License count - 2,996 Virginia current active; 83 Virginia current inactive
- License count - 1,096 out-of-state current active; 25 out-of-state current active
- License count - 1 probation current

Next Scheduled Meeting:

The next scheduled meeting will be September 20, 2022 @ 1pm.

Adjournment

Santiera Brown-Yearling adjourned the meeting @ 2:12 pm.

Lori Swain, Citizen, Chair

William L. Harp, MD, Executive Director

Michael Sobowale, LLM, Deputy Director

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ADVISORY BOARD ON RADIOLOGIC TECHNOLOGY
Virginia Board of Medicine
May 25, 2022

The Advisory Board on Radiologic Technology met on Wednesday, May 25, 2022, at 1:00 p.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, Virginia.

MEMBERS PRESENT:
Joyce O. Hawkins, RT, Chair
Uma Prasad, MD
David Roberts, RT

MEMBERS ABSENT:
Rebecca Keith, RT, Vice-Chair

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

GUESTS PRESENT

None

CALL TO ORDER

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

EMERGENCY EGRESS PROCEDURES

Ms. Hawkins provided the emergency egress procedures.

ROLL CALL

Beulah Archer called the roll. A quorum was established.

APPROVAL OF MINUTES FROM FEBRUARY 2, 2022

Dr. Prasad moved to approve the minutes. David Roberts seconded. The minutes were approved as presented.

ADOPTION OF AGENDA

Joyce Hawkins requested the correction of "AART" to "ARRT".

David Roberts moved to approve the amended agenda. Dr. Prasad seconded. The agenda was adopted with the amendment.

PUBLIC COMMENT

There was no public comment.

2021 WORKFORCE DATA PRESENTATION

Dr. Shobo provided data for current employment trends across various demographics, i.e., age, gender, education debt, income, and retirement plans.

NEW BUSINESS

1. **Legislative Updates from the 2022 General Assembly**

   Ms. Barrett discussed SB317 which allows a rad tech from another state to practice for 90 days contingent upon an employer's letter to the Board of Medicine attesting to the individual's good standing in the other state and nonrevealing NPDB report. If the individual has applied for a permanent license, an additional 60 days can be granted.

2. **Review the Use of "Form L" in the License Application Process**

   Ms. Hawkins addressed the Advisory regarding the removal of Form L from the current application process. After review of the regulations that govern the practice of radiologic technology, the members voted to eliminate Form L, as the ARRT requires successful completion of at least an Associate's degree for certification.

   Dr. Prasad moved to remove Form L. David Roberts seconded. The motion carried.

3. **Discussion of the Licensing Process for Radiologic Technology**

   David Roberts and Ms. Hawkins reiterated how SB317 will resolve major staffing issues for Virginia hospitals by hiring contract workers.

4. **Additional Information on ARRT Certification/Data**

   The Advisory discussed current ARRT certification for renewal. Ms. Hawkins asked for statistics to clarify the numbers of Rad Techs who attest to ARRT certification at renewal. Dr. Harp advised that the Board could get the numbers during the 2023 renewal period if the questions about ARRT and CE were bifurcated.

---DRAFT ---

5. **Updating of the Bylaws for the Advisory Board**

Erin Barrett suggested that the Advisory's bylaws be covered by a single, general guidance document for all advisory boards, approved by the Board of Medicine. Dr. Prasad made the motion, and David Roberts seconded. The motion carried.

ANNOUNCEMENTS

Beulah Baptist Archer provided the license count for radiologic technology.

Limited Radiologic Technologist	Virginia	Current Active	468
	Virginia	Current Inactive	19
	Out of State	Current Active	23
	Out of State	Current Inactive	1
Total			**511**
Radiologic Technologist	Virginia	Current Active	3415
	Virginia	Current Inactive	30
	Out of State	Current Active	1,045
	Out of State	Current Inactive	15
Total			**4,505**
Radiologist Assistant	Virginia	Current Active	12
	Out of State	Current Active	4
Total			**16**

Colanthia Morton Opher advised the Board to submit all travel vouchers within 30 days.

Next Scheduled Meeting: September 21, 2022 @ 1:00 p.m.

Adjournment

Ms. Hawkins adjourned the meeting 2:10 p.m.

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Joyce O. Hawkins, RT Chair

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William L. Harp, MD, Executive Director

—DRAFT —

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Beulah Baptist Archer, Recording Secretary

ADVISORY BOARD ON PHYSICIAN ASSISTANTS
Board of Medicine
Thursday, May 26, 2022 @ 1:00 p.m.
9960 Mayland Drive, Henrico, VA

MEMBERS PRESENT:	Kathleen Scarbalis, PA-C, Chair James B. Carr, PA-C, Vice-Chair Frazier W. Frantz, MD
MEMBERS ABSENT:	Portia Tomlinson, PA-C Tracy Dunn, Citizen Member
STAFF PRESENT:	William L. Harp, MD, Executive Director Michael Sobowale, LLM, Deputy Director for Licensing Erin Barrett, DHP Senior Policy Analyst Colanthia M. Opher, Deputy Director for Administration ShaRon Clanton, Licensing Specialist
GUESTS PRESENT:	Robert Glasson, VAPA Jenna Rolfs Sara Nicely, Virginia Academy of Physician Assistants Jonathan Williams, Lobbyist, VAPA Laura Hart, PA A. Rutherford

Call to Order

Ms. Scarbalis called the meeting to order at 1:05 p.m.

Emergency Egress Procedures

Dr. Harp provided the emergency egress instructions.

Roll Call

Roll was called with all Advisory Board members present. A quorum was established.

Approval of Minutes January 28, 2021

Dr. Frantz moved to adopt the minutes. The motion was seconded by Mr. Carr, and the motion carried.

Adoption of Agenda

Mr. Carr moved to adopt the meeting agenda. The motion was seconded by Dr. Frantz and carried.

Public Comment on Agenda Items (15 minutes)

Ms. Nicely said that she would like to present proposed legislation for the 2023 Session to the full Board in October, which among other things would no longer require practice agreements in certain facilities.

2021 Workforce Data Presentation-Yetty Shobo, PhD

Dr. Shobo did her usual comprehensive presentationof statistics on the physician assistant workforce and answered questions from the Advisory Board members, staff and guests.

New Business

1. Legislative Update from the 2022 General Assembly

   Erin Barrett presented an overview of the legislation from the 2022 Session. She noted HB145 which removed the practice agreement when PA's serve as local medical examiners. She also spoke to SB317 and its 90-day authorization to practice in Virginia for out-of-state PA's without holding a Virginia license.

2. Report of Regulatory Actions

   Erin Barrett presented the new regulatory requirements for licensure by endorsement, pointing out that only verification of licensure from the most recent state will be required.

3. Review of the Physician Assistant Licensure Compact

   Ms. Scarbalis provided an update on the progress with the PA Compact, including a PA Licensure Compact Fact Sheet. The PA Compact is similar to the Interstate Medical Licensure Compact.

4. Correspondence: Review of VAPA Proposal for 2023 General Assembly

   Ms. Nicely and Mr. Williams spoke to proposed 2023 Legislation which would remove the PA/physician ratio, as well as the requirement for a practice agreement in certain institutional settings.

5. Discussion of the License Reinstatement Process for Physician Assistants

   Mr. Sobowale explained that there has been no fee, application or regulations for PA's to reinstate from a license lapsed over two years. This needs to be corrected, so that PA's do not have to file another initial application if their license requires reinstatement.

6. Review of Bylaws for the Advisory Board on Physician Assistants

   Ms. Barrett spoke to the proposal that a uniform bylaws document be memorialized in a Board of Medicine guidance document for all 11 Advisory Boards. The Advisory agreed.

Announcements

Stats were announced:

- License Count for Virginia PA's - Current Active 3,898 & Current Inactive 19
- PA's Out-of-State - Current Active 1,490 & Current Inactive 40
- Licenses Issued between 1/1/2022 & 5/26/2022 - 316

Next Scheduled Meeting: September 22, 2022 @ 1:00 p.m.

Adjournment

With no other business to conduct, the meeting was adjourned at 2:38 p.m.

Kathleen Scarbalis, PA-C, Chair

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

ShaRon Clanton, Licensing Specialist

<< DRAFT >>

ADVISORY BOARD ON SURGICAL ASSISTING
Minutes
May 31, 2022

The Advisory Board on Surgical Assisting met on Tuesday, May 31, 2022 at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Deborah Redmond, CSA, Chair
Jessica Wilhelm, CSA
Nicole Meredith, RN, Citizen Member

MEMBERS ABSENT: Thomas Gochenour, CSA
Srikanth Mahavadi, MD

STAFF PRESENT: William L. Harp, M.D., Executive Director
Michael Sobowale, LLM, Deputy Director for Licensure
Erin Barrett, JD, DHP Senior Policy Analyst

GUESTS PRESENT: Hunter Jamerson, NSAA

Call to Order

Deborah Redmond called the meeting to order at 10:21 a.m.

Emergency Egress Procedures

Dr. Harp announced the emergency egress instructions.

Roll Call

The roll was called; a quorum was declared.

Approval of Minutes from February 7, 2022

Nicole Meredith moved to approve the minutes. Jessica Wilhelm seconded. The minutes carried as presented.

Adoption of Agenda

Jessica Wilhelm moved to adopt the agenda. Nicole Meredith seconded. The agenda was adopted as presented.

Public Comment on Agenda Items

Hunter Jamerson, representing the National Surgical Assistants Association (NSAA), expressed its support for provisional licensure of surgical assistants in the licensure process. Hospitals requiring licensure upon hiring would benefit from this, as well as newly graduated surgical assistants.

NEW BUSINESS

1. **Legislative Update from the 2022 General Assembly**

   Erin Barrett discussed SB317 and the temporary authorization of a licensed individual from another state to practice in Virginia without a license for 90 days. If the individual applies for a permanent license, an additional 60 days can be added. Colanthia Morton Opher added that a new fillable form is now on the Board's website for employers to fill out and send to a dedicated email box.

2. **Discussion of HB598**

   Ms. Barrett explained that this bill extends licensure by grandfathering until December 31, 2022, but the law authorizing the Board to issue a license does not become effective until July 1, 2022.

3. **Regulatory Action: Recommended Adoption of Final Regulations for Surgical Assistants**

   Ms. Barrett provided a basic outline of the standard regulatory process. After discussion, members agreed to approve the adoption of a Notice of Intended Regulatory Action (NOIRA) to make modifications to the regulations for licensure of surgical assistants and registration of surgical technologists as follows: 1) add definitions as necessary; 2) conform fees for licensure to other professions under the Board; 3) add requirements for continuing competency for surgical assistants/technologists licensed under the grandfathering provision; 4) provide for an inactive license and for reactivation or reinstatement of a license; 5) provide for a restricted volunteer license or voluntary practice by out-of-state practitioners; and 6) provide for renewal from registration of surgical technologists. Finally, the Board will adopt standards of practice similar to those for other licensed professions under its jurisdiction and consider the code of ethics specific to surgical assistants, including provisions on maintenance of confidentiality and patient records.

Nicole Meredith moved to recommend a NOIRA. Jessica Wilhelm seconded. The motion was adopted as presented.

4. **Discussion of Provisional License, Renewal, Inactive License, and Reactivation**

Deborah Redmond led the discussion and suggested changes be made to the existing application for registration of surgical assistants similar to that of provisional licensure. This pathway would allow a prospective graduate to apply for licensure, as well as accept a job offer whose employer requests proof of licensure. Jessica Wilhelm discussed the national certifying board's processes of issuing the current certification only after the student has graduated. Michael Sobowale discussed that there are no CE attestations in the renewal processes which do need to be put in place.

5. **Discussion of Inactive Certification and Reinstatement Requirements for Surgical Technologists**

Michael Sobowale explained that there are currently no procedures in place for activating certification or reinstatement of expired surgical technologist certifications, and that each case is handled as a new application. Mr. Sobowale indicated that there is language in the proposed regulations to serve as a basis for instructions to implement a reinstatement application.

Announcements

Beulah Baptist Archer provided the following licensure totals for licensed surgical assistants and surgical technologists.

Licensed Surgical Assistants		Surgical Technologist	
Current active in Virginia	486	Current active in Virginia	994
Current Active out of state	88	Current active out of state	195
Total	**574**		**1,189**

Next Scheduled Meeting: September 26, 2022, at 10:00.

Adjournment

With no other business to conduct, Deborah Redmond adjourned the meeting at 11:20 a.m.

Deborah Redmond, CSA, Chair	William L. Harp, MD, Executive Director
Beulah Baptist Archer, Recording Secretary	Michael O. Sobowale, LLM Deputy Executive Director, Licensure

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

Call to Order
The March 29, 2022, Virginia Board of Health Professions meeting was called to order at 10:03 a.m. at the Department of Health Professions (DHP), Perimeter Center, 9960 Mayland Drive, 2nd Floor, Board Room 4, Henrico, Virginia 23233.

Presiding Officer
James Wells, RPh

Members Present
Sahil Chaudhary, 1st Vice Chair, Citizen Member
Brenda L. Stokes, MD, 2nd Vice Chair, Board of Medicine
Barry Alvarez, LMFT, Board of Counseling
Sheila E. Battle, MHS, Citizen Member
A. Tucker Gleason, PhD, Board of Nursing
Michael Hayter, LCSW, CSAC, SAP, Board of Social Work
Kenneth Hickey, MD, Board of Funeral Directors & Embalmers
Allen R. Jones, Jr., DPT, PT, Board of Physical Therapy
Steve Karras, DVM, Board of Veterinary Medicine
Alison R. King, PhD, CCC-SLP, Board of Audiology & Speech-Language Pathology
Sarah Melton, PHARMD, Board of Pharmacy
Martha S. Rackets, PhD, Citizen Member
Susan Wallace, PhD, Board of Psychology

Members Absent
Carmina Bautista, MSN, FNP-BC, BC-ADM, Citizen Member
Helene D. Clayton-Jeter, OD, Board Chair, Board of Optometry
Mitchel Davis, NHA, Board of Long-Term Care Administrators
Margaret Lemaster, RDH, Board of Dentistry

Staff Present
Leslie L. Knachel, Executive Director
David E. Brown, D.C., Agency Director
Elaine Yeatts, Senior Policy Analyst DHP
Erin Barrett, Senior Policy Analyst DHP
Charis Mitchell, Assistant Attorney General, Board Counsel
Laura Jackson, Board Administrator
Laura Paasch, Licensing & Operations Administrative Specialist

Public Present
W. Scott Johnson
Ben Trayham

Establishment of Quorum
With fourteen board members out of eighteen present, a quorum was established.

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

Ordering of Agenda
Mr. Wells opened the floor to any changes to the agenda. Hearing none, 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 additions or corrections regarding the draft minutes from the Full Board Meeting on December 2, 2021. Hearing none, the minutes were approved as presented.

Agency Director's Report
Dr. Brown advised the Board that Dr. Allison-Bryan retired on March 1st. He spoke about the decline in COVID-19 numbers; therefore, the agency will start its "new normal" on April 4, 2022. He indicated that conference center and additional security upgrades will be occurring in the near future.

Ms. Knachel recognized Ms. Yeatts' pending retirement and her service to DHP and the Commonwealth. Erin Barrett will replace Ms. Yeatts as of April 1, 2022.

Policy Analyst's Report
Ms. Yeatts' provided updates on the 2022 General Assembly & Regulatory Actions.

Ms. Knachel presented the amendments to Guidance Document 75-4 Bylaws that were presented at the December 2, 2021, board meeting.

Dr. Jones made a motion to accept the changes to Guidance Document 75-4 Bylaws as presented The motion was seconded by Dr. Stokes. The motion carried unanimously.

Discussion Items
<u>Format for Individual Board Reports</u>
Ms. Knachel gave an update on the format for the individual board reports at Board of Health Professions' meetings. The consensus of the board members is that the Board Executives will provide a brief summary of board actions to be reported. Information on

board statistics will not be included in the reports. The minutes will reflect the information provided in each report.

Board Counsel Report
Ms. Mitchell had no information to report to the Board.

Board Chair Report
Mr. Wells thanked Dr. Jones and Dr. Rackets for their years of service on the Board of Health Professions and to the Commonwealth.

Staff Reports
Ms. Knachel reported that the next meeting is scheduled for September 27, 2022. The meeting will include reports from the Enforcement and Finance Divisions and officer elections.

New Business
No new business was reported.

Next Meeting
The next full board meeting is scheduled for Tuesday, September 27, 2022.

Adjournment
Hearing no objections, Mr. Wells adjourned the meeting at 11:07 a.m.

VIRGINIA BOARD OF NURSING
COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
BUSINESS MEETING MINUTES
February 16. 2022

TIME AND PLACE: The meeting of the Committee of the Joint Boards of Nursing and Medicine was convened at 9:00 A.M., February 16, 2022 in Board Room 2, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

MEMBERS PRESENT: Marie Gerardo, MS, RN, ANP-BC; Board of Nursing - Chair
Laurie Buchwald, MSN, WHNP, FNP; Board of Nursing
Ann Tucker Gleason, PhD; Board of Nursing
Blanton Marchese, Board of Medicine
David Archer, MD; Board of Medicine
Ryan Williams, MD; Board of Medicine

MEMBERS ABSENT: None

ADVISORY COMMITTEE MEMBERS PRESENT: Kevin E. Brigle, RN, NP
Mark Coles, RN, BA, MSN, NP-C
Komkwuan P. Parachabutr, DNP, FNP-BC, WHNP-BC, CNM

STAFF PRESENT: Jay P. Douglas, MSM, RN, CSAC, FRE; Executive Director; Board of Nursing
Robin L. Hills, DNP, RN, WHNP; Deputy Executive Director for Advanced Practice; Board of Nursing
Huong Vu, Operations Manager; Board of Nursing
Breana Renick, Administrative Support Specialist

OTHERS PRESENT: Charis Mitchell, Assistant Attorney General; Board Counsel
Barbara Allison-Bryan, MD, Department of Health Professions Chief Deputy
William L. Harp, MD, Executive Director; Board of Medicine
Elaine Yeatts, DHP Policy Analyst
Erin Barrett, DHP Policy Analyst

IN THE AUDIENCE: None

INTRODUCTIONS: Committee members, Advisory Committee members and staff members introduced themselves.

ESTABLISHMENT OF A QUORUM:
Ms. Gerardo called the meeting to order and established that a quorum was present.

ANNOUNCEMENT: Ms. Gerardo noted the announcement as presented on the Agenda:
Laurie Buchwald, MSN, WHNP, FNP, was appointed to the Board of Nursing on September 17, 2021 to replace Louise Hershkowitz. Ms.

Buchwald's first term will expire on June 30, 2025. Ms. Buchwald was appointed by Ms. Gerardo, Board of Nursing President, to the Committee of the Joint Boards of Nursing and Medicine as a nurse practitioner Committee Member on September 20, 2021.

Ms. Buchwald shared her professional background and stated her appreciation to serve on the Committee.

REVIEW OF MINUTES: The minutes of the June 16, 2021 Business Meeting, August 6, 2021 Summary Suspension Telephone Conference Call, and the October 13, 2021 Formal Hearing were reviewed. Dr. Archer moved to accept the minutes as presented. The motion was seconded by Dr. Williams and passed unanimously.

DIALOGUE WITH AGENCY DIRECTOR: Dr. Allison-Bryan noted that Dr. Brown is at the General Assembly and then reported the following:

COVID Update

- Cases fell 42% nationwide and 30% in Virginia past week.
- Cases fell 70% in Virginia over the past month
- Hybrid immunity seems to be more beneficial than natural immunity or vaccine alone
- The positive testing rate was at 38% and has now decreased to 11%
- 90% of adults are fully vaccinated of which 50% are boosted
- 60% of 5-17 year olds have been vaccinated

General Assembly

- So far it has been a dynamic session with many bills that affect DHP being considered
- Delegate Adams presented two (2) opposing bills:
  - **HB243** – increasing duration of physician postgraduate training from 12 moths to 36 months AND requiring physicians to obtain professional liability insurance
  - **HB896** – giving autonomous NPs to serve as a patient care team provider allowing them to enter into a practice agreement with new grads AND eliminating professional liability insurance requirement for autonomous NPs.

Transition within DHP

Both Drs. Brown and Allison-Bryan received 120 days letter from the new Administration requesting that they both continue serving at DHP while the new Administration makes its decision.

Dr. Allison-Bryan noted that Dr. Brown has expressed his interest in remaining in the DHP Director position.

Dr. Allison-Bryan stated that she started at DHP on March 1, 2018 and will retire as of March 1, 2022.

Dr. Allison-Bryan added that the new sound system will be replaced by summer of 2022.

Ms. Gerardo thanked Dr. Allison-Bryan for her service to DHP.

PUBLIC COMMENT: No public comments were received.

LEGISLATION/ REGULATIONS:

B1 Chart of Regulatory Actions:
Ms. Yeatts reviewed the Chart provided in the agenda noting that the new certified midwife profession will be regulated by the Committee of the Joint Boards. Ms. Yeatts added that the proposed regulations will be considered by the Committee of the Joint Boards at its April 20, 2022 meeting, by the Board of Nursing at its May 17, 2022 meeting, and by the Board of Medicine at its June 16, 2022 meeting.

Yetty Shobo, PhD, Deputy Executive Director, Healthcare Workforce Data Center, joined the meeting at 9:30 AM

B2 Report of the 2022 General Assembly (GA):
Ms. Yeatts reviewed the 2021 GA report provided in the agenda.

Ms. Yeatts stated that she will be retiring as of April 1, 2022 and Ms. Barrett has been hired as her replacement.

Dr. Archer thanked Ms. Yeatts for the report and asked if she perceived an increase in regulatory actions regarding healthcare professionals.

Ms. Yeatts replied that she did not think so and added that members of the GA are more receptive to allow practitioners to practice to the full extent of the education and training.

Ms. Gerardo thanked Ms. Yeatts for her services to the Boards.

NEW BUSINESS:

Healthcare Workforce Data Center (HWDC) Reports
Dr. Yetty Shobo presented on the nurse practitioner survey reports. She stated that 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 licensee.

Dr. Shobo provided key findings of the 2021 reports which will be posted on the DHP website upon approval:

- ❖ Virginia's Licensed Nurse Practitioner Workforce: 2021
  - o Trends in the NP Workforce
  - o Trends in Age and Gender
  - o Trends in Educational Attainment
  - o Trends in Work Locations
  - o Trends in Retirement Intentions

- ❖ Virginia's Licensed Nurse Practitioner Workforce: Comparison by Specialty

  - o NP Workforce by Specialty
  - o Age and Gender Distribution
  - o Education and Debt
  - o Median Income
  - o Primary Employment Sector
  - o Top Establishments
  - o Future Plans

Dr. Williams asked if there are data on pre-licensure income and debt level for all the specialties. Dr. Shobo replied that it was not part of the survey.

Mr. Marchese asked how many NP programs started in the last 10 years. Ms. Douglas stated that the Board does not regulate NP programs but estimated that there are 10-15 Schools/Colleges of Nursing that offer NP programs in Virginia.

Dr. Gleason asked if there is plan to increase access to care to rural areas. Dr. Allison-Bryan encouraged Committee members to review the HB793 report available on HWDC website, which includes the distribution of the NP workforce per capita throughout the Commonwealth.

Mr. Marchese asked how mobile the NP workforce is. Dr. Shobo replied the NP workforce is very mobile.

Dr. Williams moved to accept the reports as presented. The motion was seconded by Ms. Buchwald and passed unanimously.

RECESS: The Committee recessed at 10:35 A.M.

Ms. Yeatts, Ms. Barrett, and Dr. Allison-Bryan left the meeting at 10:35 A.M.

RECONVENTION: The Committee reconvened at 10:49 A.M.

Members of Advisory Appointment:
- Thokizeni Lipato, MD (1st term ended 2021)
- Janet L. Setnor, CRNA (1st term ended 2021)

Ms. Gerardo invited Ms. Douglas to proceed with the recommendations for filling these 2 open advisory committee positions.

Ms. Douglas stated that Dr. Olivia Mansilla's CV is presented for the Committee's consideration and action for the physician position on the Advisory Committee to replace Dr. Lipato.

Ms. Douglas stated that Dr. Jean Snyder's CV is presented for the Committee's consideration and action for the CRNA position on the Advisory Committee to replace Ms. Setnor.

Ms. Douglas noted that the recommendation for Jean Snyder was from Adrienne Hartgerink, DNP, MSN, CRNA, Virginia Association of Nurse Anesthetists (VANA) President. Ms. Douglas added that Dr. Snyder provided expert witness service to the Board of Nursing from time to time.

Mr. Marchese moved to accept the appointment of Dr. Mansilla for the physician position on the Advisory Committee. The motion was seconded by Ms. Buchwald and passed unanimously.

Mr. Marchese moved to accept the appointment of Dr. Snyder for the CRNA position on the Advisory Committee. The motion was seconded by Dr. Archer and passed unanimously.

ENVIRONMENTAL SCAN – ADVISORY COMMITTEE MEMBERS

Ms. Gerardo asked for the updates from the Advisory Committee Members.

Mr. Coles noted that HB1245, which repeals the sunset provision on the bill that was passed in 2021, is hopeful in keeping with the trend.

Mr. Brigle shared that the credentialing process at VCU has been streamlined due to NPs acquiring the autonomous practice designation.

Dr. Archer noted that nurses are leaving hospital at a high speed and asked if that is also going on across the Commonwealth. Mr. Coles noted that at Sentara where he is employed, there has been a high turnover of nurses due in no small part to the recruitment by companies, particularly travel nursing companies, offering significant pay increases.

Ms. Douglas agreed that it is a trend in Virginia and nationally. She also noted that due to this recruitment of seasoned nurses and other factors, the

health systems are experiencing a significant experience gap with the high rate of employment of novice nurses.

Ms. Gerardo thanked Advisory Committee Members for their participation.

The Members of the Advisory Committee and Dr. Harp left the meeting at 11:00 A.M.

AGENCY SUBORDINATE RECOMMENDATION CONSIDERATION

Dr. Hills left the meeting at 11:05 AM

CLOSED MEETING: Dr. Gleason 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 11:05 A.M., for the purpose of consideration of the agency subordinate recommendations. Additionally, Dr. Gleason moved that Ms. Douglas, Ms. Vu, Ms. Renick and Ms. Mitchell, Board counsel, attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded by Mr. Marchese and carried unanimously.

RECONVENTION: The Board reconvened in open session at 11:23 A.M.

Dr. Gleason 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 and carried unanimously.

Daphne Carol Jenkins, LNP **0024-164470**
Ms. Jenkins did not appear.

Dr. Gleason moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to reprimand **Daphne Carol Jenkins** and to assess a monetary penalty of $4,000.00 to be paid to the Board within 120 days from the date of entry of the Order. The motion was seconded by Dr. Williams and carried unanimously.

Vickie Lynn Boyd Stevens, LNP **0024-175507**
Ms. Stevens did not appear but submitted a written response.

Dr. Archer moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to reprimand **Vickie Lynn Boyd Stevens**, to require Ms. Stevens to complete approved courses of at least five credit hours each in the subjects of chronic pain management, prescribing of opioids, and medical recordkeeping within 90 days from the date of entry of the Order, and to read and provide a written summary of Drug Laws for Practitioners and Regulations for Prescriptive Authority for Nurse Practitioners: Part VI Management of Chronic Pain (18VAC90-40-180 through -240) within 90 days from the date of entry of the Order. The motion was seconded by Ms. Buchwald and carried unanimously.

Maria Theresa Lee, LNP **0024-174900**
Ms. Lee did not appear.

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to take no sanction against **Maria Theresa Lee.** The motion was seconded by Dr. Williams and carried unanimously.

Oluwakemi Olubunmi Osidele, LNP **0024-172973**
Ms. Osidele did not appear.

Dr. Williams moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to reprimand **Oluwakemi Olubunmi Osidele**. The motion was seconded by Ms. Buchwald and carried unanimously.

Ms. Gerardo noted the next meeting is on Wednesday, April 20, 2022, in Board Room 2.

Ms. Gerardo added that the Committee will conduct informal conferences scheduled at 1:00 pm and the Committee Members are Ms. Gerardo, Ms. Buchwald and Dr. Williams.

ADJOURNMENT: As there was no additional business, the meeting was adjourned at 11:26 A.M.

Jay P. Douglas, MSM, RN, CSAC, FRE
Executive Director

VIRGINIA BOARD OF NURSING
COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
BUSINESS MEETING MINUTES
April 20, 2022

TIME AND PLACE:	The meeting of the Committee of the Joint Boards of Nursing and Medicine was convened at 9:00 A.M., April 20, 2022 in Board Room 2, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia.
MEMBERS PRESENT:	Marie Gerardo, MS, RN, ANP-BC; Board of Nursing - **Chair** Laurie Buchwald, MSN, WHNP, FNP; Board of Nursing Ann Tucker Gleason, PhD; Board of Nursing David Archer, MD; Board of Medicine Blanton Marchese; Board of Medicine Ryan Williams, MD; Board of Medicine
MEMBERS ABSENT:	None
ADVISORY COMMITTEE MEMBERS PRESENT:	Kevin E. Brigle, RN, NP Sarah Hobgood, MD Stuart Mackler, MD Komkwuan P. Parachabutr, DNP, FNP-BC, WHNP-BC, CNM Jean Snyder, DNaP, CRNA
STAFF PRESENT:	Robin L. Hills, DNP, RN, WHNP; Deputy Executive Director for Advanced Practice; Board of Nursing Claire Morris, RN, LNHA – **joined at 11:00 A.M.** Huong Vu, Operations Manager; Board of Nursing
OTHERS PRESENT:	Charis Mitchell, Assistant Attorney General; Board Counsel David Brown, DO, DHP Director – **joined at 9:10 A.M.** Erin Barrett, DHP Policy Analyst
IN THE AUDIENCE:	Kassie Schroth, McGuireWoods Consulting Ben Traynham, Hancock Daniel & Johnson Kelsey Wilkinson, Medical Society of Virginia (MSV) Becky Bowers-Lanier, Lobbyist for Virginia Association of Clinical Nurse Specialists (VACNS) Karen Kelly, President Elect, Virginia Chapter of American College of Nurse Midwives Lisa Armstrong, Adjudication Specialist, DHP Administrative Proceedings Division (APD)
INTRODUCTIONS:	Committee members, Advisory Committee members and staff members introduced themselves.

Virginia Board of Nursing
Committee of the Joint Boards of Nursing and Medicine – Business Meeting
April 20, 2022

ESTABLISHMENT OF A QUORUM:
Ms. Gerardo called the meeting to order and established that a quorum was present.

ANNOUNCEMENT: Ms. Gerardo noted the announcements as presented on the Agenda:

- **Olivia Mansilla, MD's** nomination to the Advisory Committee of the Joint Boards of Nursing and Medicine was accepted on February 16, 2022 serving the first term ends through December 2026.
- **Jean Snyder, DNaP, CRNA**'s nomination to the Advisory Committee of the Joint Boards of Nursing and Medicine was accepted on February 16, 2022 serving the first term ends through December 2026.

Ms. Gerardo noted that Dr. Mansilla had other commitments so she is unable to attend this meeting.

Dr. Snyder shared her professional background and stated her appreciation for being selected to serve on the Advisory Committee.

Ms. Gerardo asked staff if there are any additional announcements. Dr. Hills stated that the Business meeting scheduled for June 15, 2022 has been cancelled but the Committee of the Joint Boards will conduct its disciplinary proceeding(s) and she will poll Committee of Joint Boards Members for their availability.

REVIEW OF MINUTES: The minutes of the February 16, 2022 Business Meeting, February 16, 2022 Informal Conference, and the March 31, 2022 Regulatory Advisory Workgroup Meeting – Licensed Certified Midwife were reviewed. Dr. Archer moved to accept the minutes as presented. The motion was seconded by Dr. Williams and passed unanimously.

PUBLIC COMMENT: No public comments were received.

LEGISLATION/
REGULATIONS:

B1 Chart of Regulatory Actions:
Ms. Barrett reviewed the Chart provided in the agenda noting that the new certified midwife profession proposed regulations will be considered by the Committee of the Joint Boards later on today.

B2 Report of the 2022 General Assembly (GA):
Ms. Barrett reviewed the 2022 GA report provided in the agenda noting that most of these bills have been passed and there is no action needed by the Committee.

Ms. Barrett clarified that the use of the pronoun "he" in the Code is required by the statute.

Dr. Brown joined the meeting at 9:10 A.M.

Ms. Barrett highlighted the following bills:
HB192 (prescription of opioids) – the Governor amended the law to sunset in 2027
HB1245 (Nurse practitioners; practice without a practice agreement, repeals sunset provision) – This bill did not get resolved during the regular session so it is slated to be considered again during the upcoming special session called by the Governor.

Dr. Brown added that the marijuana bill as passed in 2021 for adult recreational use of non-medical marijuana will require 2-3 years to become fully implemented; consequently, implementation of the bill may be modified due to the change in control of the House. Dr. Brown noted that medical program is planned for implementation in 2023.

DIALOGUE WITH AGENCY DIRECTOR:

Dr. Brown reported the following:

- Dr. Allison-Bryan has retired from DHP.
- COVID update – numbers have settled down tremendously and as of April 19, 2022, masks are not required on flights.
- DHP – staff has returned to the building as of April 4 with the option of working remotely up to three days a week. It is anticipated that the new Administration will provide further guidance.
- New Security – feedback regarding the new security team for the building has been positive. The building is also moving toward stricter visitor security screening.
- Conference Center update – Although supply chain issues have slowed down obtaining audio equipment, installation of the new system is anticipated in late summer.

NEW BUSINESS:

C1 Licensed Certified Midwife DRAFT Regulations (4/14/2022 VERSION)

Attachments: 1) ACNM Standards for the Practice of Midwifery
2) Va. Code §§54.1-2957.04 and 54.1-2900 (Definitions)

Ms. Gerardo invited Ms. Barrett to proceed.

Ms. Barrett noted that the proposed draft regulations basically mirror the nurse practitioner regulations. A significant variation is that the section on Buprenorphine prescribing was omitted because LCMs are not included in

the list of providers who may obtain a SAMHSA waiver at the federal level.

Ms. Barrett reviewed each section of the proposed draft regulations and suggested additional amendments in order to be alignment with the statute:

18VAC90-70-70 (on page 4 of the draft regulations)

- Item 1 → deleting "***or certificate***"
- Item 1 → deleting "***and***"

18VAC90-70-100.B (on page 6 of the draft regulations)

Item c → deleting "***or certificate***"

Dr. Williams motioned to recommend the proposed draft regulations for licensed certified midwives as amended to the Board of Nursing and the Board of Medicine for adoption. The motion was seconded by Ms. Buchwald and carried unanimously.

RECESS: The Committee recessed at 10:03 A.M.

RECONVENTION: The Committee reconvened at 10:19 A.M.

NCSBN APRN Roundtable on April 12, 2022 (verbal report):
Dr. Hills stated that she attended the meeting virtually and reported 3 Takeaways from the meeting:

1. Results of a survey of 7,500 APRNs on the Impact of COVID-19 Pandemic on APRN Practice conducted by the Associate Dean for Clinical Scholarship at Vanderbilt University were presented.
   - All 50 states & all 4 APRN roles represented
   - APRN workforce took on an expanded leadership role and was deployed in unique ways during the pandemic
   - What was of particular interest was that institutional restrictions were reported by APRNs during the COVID crisis even in states where no practice agreement is required.
2. "The Great Resignation" or "The Great Awakening", like the healthcare workforce in general, has had a significant nationwide impact on the APRN workforce
3. Strategies for addressing the lack of diversity in the APRN workforce were presented

Dr. Hills notes that the National Task Force (NTF) on Quality Nurse Practitioner Education has developed a new set of standards designed to ensure quality in graduate programs that prepare nurse practitioners. She added that she will forward the information to interested Committee Members. Ms. Buchwald said she would like the information.

APRN Compact Update **(verbal report):**
Dr. Hills provided background including that the APRN Compact was adopted by the NCSBN membership in August 2020

- 2021 Legislative Session
    - APRN Compact bills were introduced in Delaware and North Dakota
    - Both bills were enacted into law with nearly unanimous legislative support
- 2022 Legislative Session
    - APRN Compact bills were introduced and passed in Maryland and Utah
- Seven state legislative enactments needed for the compact to become effective

ENVIRONMENTAL SCAN – ADVISORY COMMITTEE MEMBERS

Ms. Gerardo asked for updates from the Advisory Committee Members.

Dr. Parachabutr thanked the Committee for moving quickly on the Licensed Certified Midwife regulations

Dr. Snyder reported that many Virginia CRNAs moved to NY and NJ to work during the pandemic due to fewer regulatory barriers to practice.

Mr. Brigle is awaiting the outcome of HB1245

C2 Nurse Practitioners – CY2021 Statistics:
Ms. Gerardo asked if anyone has any questions regarding the CY2021 statistics. No questions were raised.

Dr. Hills notes that as April 14, 2021, the total number of autonomous practice designations that have been issued is 2037.

Ms. Gerardo thanked Advisory Committee Members for their participation.

The Members of the Advisory Committee, Dr. Brown, Ms. Barrett and the public left the meeting at 10:31 A.M.

RECESS: The Committee recessed at 10:31 A.M.

RECONVENTION: The Committee reconvened at 11:00 A.M.

Ms. Morris joined the meeting at 11:00 A.M.

AGENCY SUBORDINATE RECOMMENDATION CONSIDERATION

Dr. Hills left the meeting at 11:01 AM

CLOSED MEETING: Dr. Gleason 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 11:01 A.M., for the purpose of consideration of the agency subordinate recommendations. Additionally, Dr. Gleason moved that Ms. Morris, Ms. Vu, and Ms. Mitchell, Board counsel, attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded by Dr. Archer and carried unanimously.

RECONVENTION: The Board reconvened in open session at 11:28 A.M.

Dr. Gleason 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 Mr. Marchese and carried unanimously.

Dr. Hills rejoined the meeting at 11:28 A.M.

Amy Elizabeth Kubler, LNP **0024-175068**
Ms. Kubler did not appear but submitted a written response.

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to reprimand **Amy Elizabeth Kubler**. The motion was seconded by Dr. Williams and carried unanimously.

Ann Marie Smoot, LNP **0024-177208**
Ms. Smoot did not appear but submitted a written response.

Dr. Archer moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to reprimand **Ann Marie Smoot**, to require Ms. Smoot to provide written proof satisfactory to the Committee of the Joint Boards of successful completion of approved courses of at least five contact hours each in the subjects of 1) chronic pain management/prescribing of opioids, 2) ethical, legal and professional issues and 3) medical recordkeeping within 90 days from the date of entry of the Order, and to read and provide a written summary of Drug Laws for Practitioners, Regulations for Prescriptive Authority for Nurse Practitioners: Part VI Management of Chronic Pain

(18VAC90-40-180 through -240), and Board of Nursing Guidance Document 90-56: Practice Agreement Requirements for Licensed Nurse Practitioners within 90 days from the date of entry of the Order. The motion was seconded by Ms. Buchwald and carried unanimously.

Amy Austin Dickenson, LNP **0024-172952**
Ms. Dickenson did not appear.

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine modify the recommended decision of the agency subordinate to reprimand **Amy Austin Dickenson** and to require Ms. Dickenson to enter into a Contract within 60 days from the date of entry of the Order with the Virginia Health Practitioners' Monitoring Program (HPMP) and remain in compliance with terms and conditions of the HPMP for the time specified by the HPMP. The motion was seconded by Dr. Williams and carried unanimously.

ADJOURNMENT: As there was no additional business, the meeting was adjourned at 11:31 A.M.

Robin L. Hills, DNP, RN, WHNP
Deputy Executive Director for Advanced Practice

Agenda Item: Current Legislative and Regulatory Actions/Considerations

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

Action: If any action is required, guidance will be provided.

Board of Medicine
Current Regulatory Actions

VAC	Stage	Subject Matter	Date submitted*	Office; time in office**	Notes
18VAC85-80	Proposed	Implementation of OT Compact	4/12/2022	Attorney General 42 days	Adoption of regulations to replace emergency regulations
18VAC85-160	Proposed	Changes consistent with a licensed profession	Register date: 12/30/2021		Proposed regulations consistent with surgical assistants changing from certification to licensure

* Date submitted to current location
** As of May 24, 2022

Agenda Item: Initiation of Periodic Reviews

Action needed:

- Motion to initiate a periodic review of the following chapters:
  - Chapter 15, Delegation to agency subordinate;
  - Chapter 20, Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic;
  - Chapter 40, Respiratory Therapists;
  - Chapter 50, Physician Assistants;
  - Chapter 80, Occupational Therapists;
  - Chapter 101, Radiologic Technology;
  - Chapter 110, Acupuncture;
  - Chapter 120, Athletic Trainers;
  - Chapter 130, Licensed Midwives;
  - Chapter 140, Polysomnographic Technologists;
  - Chapter 150, Behavior Analysts;
  - Chapter 160, Surgical Assistants and Surgical Technologists; and
  - Chapter 170, Genetic Counselors

Agenda Items: Amend Guidance Document 85-17

Included in your agenda package are:

Clean version of amendments to Guidance Document 85-17 recommended by Advisory Board

Track changes version of amendments recommended by Advisory Board

Action needed:

- Motion to amend Guidance Document 85-17 as recommended by Advisory Board

Guidance document: 85-17

Revised: June 16, 2022
Effective: August 18, 2022

Board of Medicine

Guidance on Supervisory Responsibilities of an Occupational Therapist

Question 1: If an occupational therapist supervises occupational therapy assistants and other unlicensed personnel, who is responsible for the patient care and outcome?

> Answer 1: The occupational therapist is responsible for the care and treatment provided to the patient by any licensed or unlicensed health-care providers under the supervision of the occupational therapist. 18VAC85-80-110(A)(1).

Question 2: What can an occupational therapist delegate to an occupational therapy assistant or any unlicensed health care provider?

> Answer 2: There is not a list of procedures that may or may not be delegated. An occupational therapist may not delegate any task that requires a clinical decision or the knowledge, skills and judgment of a licensed occupational therapist. Occupational therapists may only delegate those tasks that do not require professional judgment and can be properly and safely performed by an appropriately trained occupational therapy assistant. 18VAC85-80-110(A)(3).

Question 3: How many personnel may an occupational therapist supervise at any one time?

> Answer 3: An occupational therapist my supervise up to six occupational therapy personnel, including no more than three occupational therapy assistants, at any one time. 18VAC85-80-110(C).

Question 4: How often must the occupational therapist meet with the occupational therapy assistant to review and evaluate treatment and progress of the individual patients?

> Answer 4: At a minimum, the occupational therapist must meet with the occupational therapy assistant at least once every 10th treatment session or 30 calendar days, whichever occurs first. However, this is a minimum requirement. The frequency of these meetings should be determined by the complexity of patient needs, number and diversity of patients, demonstrated competency and experience of the assistant. Check with your chief medical officer or other personnel to determine if there is a hospital policy on frequency of meetings, methods of delegation, and content of supervision. 18VAC85-80-110(B).

Question 5: Who must sign patient treatment notes?

> Answer 5: Occupational therapy assistants shall document all treatment notes in the patient record performed by the assistant. Those notes must be countersigned by the supervising occupational therapist at the time of review and evaluation. 18VAC85-80-110(D).

Question 6: Who can supervise unlicensed personnel?

Answer 6: An occupational therapist or an occupational therapy assistant may supervise unlicensed personnel. 18VAC85-80-111(A).

Question 7: What procedures may unlicensed personnel perform?

Answer 7: Unlicensed personnel may perform nonclient-related tasks such as clerical duties or room preparation. They may perform client-related tasks that, in the judgment of the supervising occupational therapist or supervising occupational therapy assistant, have no potential to adversely impact the patient or the patient's treatment plan. 18VAC85-80-111(B).

Guidance document: 85-17 AdoptedRevised: February 15, 2018June 16, 2022
Effective: August 18, 2022

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Board of Medicine

Guidance on Supervisory Responsibilities of an Occupational Therapist

Question 1: AsIf an Ooccupational Ttherapist supervises who supervised Ooccupational Ttherapy Aassistants and other unlicensed personnel, who is responsible for the patient care and outcome?

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Answer 1: -The Ooccupational Ttherapist is responsible for the care and treatment provided to the patient by any licensed or unlicensed health-care providers under the supervision of the Ooccupational Ttherapist. 18VAC85-80-110(A)(1). *(18VAC85-80-110)(1) Supervisory responsibilities of an occupational therapist.*

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Question 2: What can an occupational therapist delegate to an occupational therapy assistant or any unlicensed health care provider?

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Answer 2: -There is not a list of procedures that may or may not be delegated. -An occupational therapist may not delegate any task that requires a clinical decision or the knowledge, skills and judgment of a licensed occupational therapist. Occupational therapists may only delegate those tasks that do not require professional judgment and can be properly and safely performed by an appropriately trained occupational therapy assistant. 18VAC85-80-110(A)(3). *(18VAC85-80-110(3)) Supervisory responsibilities of an occupational therapist.*

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Question 3: -How many personnel may an occupational therapist supervise at any one time?

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Answer 3: -An occupational therapist my supervise up to six occupational therapy personnel, including no more than three occupational therapy assistants, at any one time. 18VAC85-80-110(C). *(18VAC85-80-110(C)) Supervisory responsibilities of an occupational therapist.*

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Question 4: How often must the occupational therapist meet with the occupational therapy assistant to review and evaluate treatment and progress of the individual patients?

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Answer 4: --At a minimum, the occupational therapist must meet with the occupational therapy assistant at least once every 10th treatment session or 30 calendar days, whichever occurs first. -However, this is a minimum requirement. and tThe frequency of these meetings should be determined by the complexity of patient needs, number and diversity of patients, demonstrated competency and experience of the assistant. --Check with your chief medical officer or other personnel to determine if there is a hospital policy on frequency of meetings, methods of delegation, and content of supervision. 18VAC85-80-110(B). *(18VAC85-80-110(B)) Supervisory responsibilities of an occupational therapist.*

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Question 5: -Who must sign patient treatment notes?

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Answer 5: –Occupational therapy assistants shall document all treatment notes in the patient record performed by the assistant. Those notes must—~~and~~ be countersigned by the supervising occupational therapist at the time of review and evaluation. 18VAC85-80-110(D).

~~*(18VAC85-80-110(D)) Supervisory responsibilities of an occupational therapist*~~

Question 6: -Who can supervise unlicensed personnel?

Answer 6: –An occupational therapist or an occupational therapy assistant may supervise unlicensed personnel. 18VAC85-80-111(A).

~~*(18VAC85-80-111(A)) Supervision of unlicensed occupational therapy personnel.*~~

Question 7: -What procedures may unlicensed personnel perform?

Answer 7: –Unlicensed personnel may perform nonclient-related tasks such as clerical duties or room preparation. -They may perform client-related tasks that, in the judgment of the supervising occupational therapist or supervising occupational therapy assistant, have no potential to adversely impact the patient or the patient's treatment plan. 18VAC85-80-111(B).

~~*(18VAC85-80-111(B)(1) and (2)) Supervision of unlicensed occupational therapy personnel.*~~

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Agenda Items: Adoption of final regulations for licensure of surgical assistants

Included in your agenda package are:

- Town Hall summary page of proposed stage;
- Comments received on Town Hall following publication of proposed stage;
- Written comment received by the Board; and
- Text of proposed final regulations.

Action needed:

- Motion to adopt final regulations.

Agencies | Governor

Department of Health Professions

Board of Medicine

Regulations Governing the Licensure of Surgical Assistants and Registration of Surgical Technologists [18 VAC 85 - 160]

Action: Amendments for surgical assistants consistent with a licensed profession

Proposed Stage

Action 5639 / Stage 9324

Edit Stage   Withdraw Stage   Go to RIS Project

Documents		
Proposed Text	1/27/2022 9:31 am	Sync Text with RIS
Agency Background Document	7/16/2021	Upload / Replace
Attorney General Certification	7/29/2021	
DPB Economic Impact Analysis	9/13/2021	
Agency Response to EIA	9/28/2021	Upload / Replace
Governor's Review Memo	12/30/2021	
Registrar Transmittal	12/30/2021	

Status	
Incorporation by Reference	No
Exempt from APA	No, this stage/action is subject to Article 2 of the *Administrative Process Act*
Attorney General Review	Submitted to OAG: 7/16/2021 Review Completed: 7/29/2021 Result: Certified
DPB Review	Submitted on 7/29/2021 Economist: Larry Getzler Policy Analyst: Jerry Gentile Review Completed: 9/13/2021
Secretary Review	Secretary of Health and Human Resources Review Completed: 10/10/2021
Governor's Review	Review Completed: 12/30/2021 Result: Approved
Virginia Registrar	Submitted on 12/30/2021 **The Virginia Register of Regulations** Publication Date: 1/31/2022 **Volume: 38 Issue: 12**
Public Hearings	**02/07/2022 10:05 AM**
Comment Period	**Ended 4/1/2022**

5 comments

Contact Information	
Name / Title:	William L. Harp, M.D. / *Executive Director*
Address:	9960 Mayland Drive Suite 300 Richmond, VA 23233
Email Address:	**william.harp@dhp.virginia.gov**
Telephone:	(804)367-4558 FAX: (804)527-4429 TDD: ()-

This person is the primary contact for this board.

This stage was created by Elaine J. Yeatts on 07/16/2021 at 1:07pm
This stage was last edited by Elaine J. Yeatts on 07/16/2021 at 1:07pm

Agencies | Governor

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Department of Health Professions

Board of Medicine

Regulations Governing the Licensure of Surgical Assistants and Registration of Surgical Technologists [18 VAC 85 - 160]

Action	**Amendments for surgical assistants consistent with a licensed profession**
Stage	**Proposed**
Comment Period	Ends 4/1/2022

5 comments

All good comments for this forum **Show Only Flagged**

Back to List of Comments

Commenter: David Jennette 2/18/22 9:50 am

18VAC85-160-60 Renewal of licensure for a surgical assistant

I am a Licensed Surgical Assistant currently practicing in Suffolk, Virginia. I support all of the Board's proposed recommendations for Surgical Assistant License renewal, particularly requiring the completion of 38 hours of continuing education that can be validated by the National Surgical Assistant Association.

CommentID: **119497**

Commenter: Sharon Sprouse 2/18/22 11:23 am

18VAC85-160-60 Renewal of licensure for a surgical assistant

I support this language. As an employer of Surgical Assistants. American Surgical Professionals is one of the largest employers of Surgical Assistants in the world. I want to maintain a highly professional standard for our profession. Please feel free to contact me if you have questions or need anything.

CommentID: **119529**

Commenter: Christopher C. Cogswell LifeNet Health 2/21/22 8:55 am

18VAC85-160-60 Renewal of licensure for a Surgical Assistant

I am a Certified and Licensed Surgical Assistant currently practicing throughout Virginia with the Organ Procurement Organization, LifeNet Health. I emphatically support all of the Board's proposed recommendations for Surgical Assistant Licensure renewal, particularly requiring the

completion of 38 continuing education that can be validated by the Nation Surgical Assistant Association.

CommentID: **119950**

Commenter: Susan Summers 2/24/22 11:08 am

18VAC85-160-60 Renewal of licensure for a surgical assistant

I am a licensed surgical assistant practicing in the Hampton Roads area, and I am currently the President of the Virginia Association of Surgical Assistants. I support the board's recommendations for surgical assistant license renewal, particularly the 38 hours of continuing education credits that can be validated by the National Surgical Assistant Association.

CommentID: **120162**

Commenter: LaTanya Sykes 2/25/22 5:00 pm

18VAC85-160-60 Renewal of licensure for a surgical assistant

I am a Licensed Surgical Assistant currently practicing in Portsmouth, VA and currently the Vice President of the Virginia Association of Surgical Assistants. As Surgical Assistants I think it is an ethical practice to remain current in our profession. Therefore, I support all of the Board's proposed recommendations for Surgical Assistant License renewal, particularly requiring the completion of 38 hours of continuing education that can be validated by the National Surgical Assistant Association.

Thank you,
LaTanya Sykes, LSA, MSA, CSA
ldsykes94@gmail.com
757-218-7542

CommentID: **120237**

6 West Dry Creek Circle, Ste 200 Littleton, CO 80120
800.637.7433 | 303.694.9130
(F) 303.694.9169 www.ast.org

April 1, 2022

William L. Harp, M.D.
Executive Director
Board of Medicine
9960 Mayland Drive, Suite 300
Richmond, VA 23233

Re: 18VAC85-160, Regulations Governing the Licensure of Surgical Assistants and Certification of Surgical Technologists (amending 18VAC85-160-40, 18VAC85-160-60; adding 18VAC85-160-65 through 18VAC85-160-130).

Dear Dr. Harp:

The Association of Surgical Technologists (AST) appreciates the opportunity to comment regarding 18VAC85-160, Regulations Governing the Licensure of Surgical Assistants and Certification of Surgical Technologists.

AST is a national, non-profit organization that represents the interests of over 70,000 surgical technologists who hold the Certified Surgical Technologist® (CST) credential. Today, surgical technologists are working in one of the fastest growing professions in the country. The US Bureau of Labor Statistics projects that the surgical technology profession to grow 9% from 2018-2028, which is faster than the average of all other occupations, and it is anticipated that the volume of surgery will increase exponentially due to the expanding senior population.[1] There are 109,000[2] surgical technologists employed nationwide including 2,080[3] in Virginia in 2020.

As the oldest and most widely recognized professional organization for surgical technologists, AST's primary purpose is to ensure that surgical technologists have the knowledge and skills to administer patient care of the highest quality.

I. **Surgical Assistant & Surgical Technologist Licensure/Certification Fees – 18VAC85-160-40**

The Virginia Board of Medicine (Board) is proposing to increase the initial licensure fee for surgical assistants from $75 to $130. Additionally, the Board is proposing to increase the renewal licensure fee for

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[1] https://www.bls.gov/ooh/healthcare/surgical-technologists.htm
[2] https://www.bls.gov/oes/current/oes292055.htm
[3] https://www.bls.gov/oes/current/oes_va.htm#31-0000

surgical assistants from $70 to $135. The current fee for certification of surgical technologists is $75 with a renewal fee of $35. The Board is not amending the fees for surgical technologists.

Inflation is wiping out any wage increases for workers.[4] As the costs of groceries, gas, and other living costs are on the rise, any increase in pay workers receive is being wiped out by the rising cost of inflation. Yet, the Board is proposing to increase the initial licensure fee of surgical assistants by 73% and increase their renewal fee by 92%.

AST requests the Board keep current initial and renewal licensure fees of surgical assistants at $75 and $70 respectfully. At the same time, AST requests the Board change the fees for surgical technologists to an initial fee of $35 and a renewal fee of $30.

II. Attestation for Surgical Technologists – 18VAC85-160-65

The Board is proposing to require surgical technologists to "attest" that their credential is current at the time of renewal; however, the proposed changes do not indicate how the attestation would occur. AST requests the Board provide detail on what surgical technologists are required to do to conform to this requirement.

AST is committed to working with the Board on this and other regulatory efforts regarding regulations impacting surgical assistants and surgical technologists. If you have any questions regarding this letter, please contact Josephine M. Colacci, Esq. with any questions at 303-325-2540 or josephine.colacci@ast.org.

Sincerely,

Bill Teutsch, CAE, FASAHP
CEO/Executive Director
Association of Surgical Technologists

[4] https://www.forbes.com/advisor/personal-finance/pay-raises-dont-match-high-inflation/

Project 6696 - Proposed

Board Of Medicine

Amendments for surgical assistants consistent with a licensed profession

Part I

General provisions

18VAC85-160-40. Fees.

A. The following fees have been established by the board:

1. The fee for licensure as a surgical assistant shall be $130 or certification as a surgical technologist shall be $75.

2. The fee for renewal of licensure ~~or certification~~ as a surgical assistant shall be ~~$70~~ $135 and for certification as a surgical technologist, it shall be $70. Renewals shall be due in the birth month of the licensee or certificate holder in each even-numbered year. ~~For 2020, the renewal fee shall be $54.~~

3. The additional fee for processing a late renewal application within one renewal cycle shall be ~~$25~~ $50 for a surgical assistant and $25 for a surgical technologist.

4. The handling fee for a returned check or a dishonored credit card or debit card shall be $50.

5. The fees for inactive license renewal shall be $70 for a surgical assistant and $35 for inactive certification renewal for a surgical technologist.

6. The fee for reinstatement of a surgical assistant license that has been lapsed for two years or more shall be $180; for a surgical technologist certification, it shall be $90.

7. The fee for a letter of good standing or verification to another jurisdiction for a license shall be $10.

8. The fee for reinstatement of licensure as a surgical assistant pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

B. Unless otherwise provided, fees established by the board are not refundable.

Part II

Requirements for licensure or certification

18VAC85-160-60. Renewal of licensure for a surgical assistant.

A. A surgical assistant who was licensed based on a credential as a surgical assistant or surgical first assistant issued by the National Board of Surgical Technology and Surgical Assisting or the National Commission for the Certification of Surgical Assistants or their successors shall attest that the credential is current at the time of renewal.

B. A surgical assistant who was licensed based on successful completion of a surgical assistant training program during the person's service as a member of any branch of the armed forces of the United States or based on practice as a surgical assistant in the Commonwealth at any time in the six months immediately prior to July 1, 2020, shall attest to completion of 38 hours of continuing education recognized by the National Surgical Assistant Association at the time of biennial renewal.

18VAC85-160-65. Renewal of certification for a surgical technologist.

A. A surgical technologist who was certified based on certification as a certified surgical technologist from the National Board of Surgical Technology and Surgical Assisting or its successor shall attest that the credential is current at the time of renewal.

B. A surgical technologist who was certified based on successful completion of a training program for surgical technology during the person's service as a member of any branch of the armed forces of the United States, or based on practice as a surgical technologist at any time in the six months prior to July 1, 2021, shall attest to completion of 30 hours of continuing education recognized by the Association of Surgical Technologists at the time of biennial renewal.

18VAC85-160-70. Reinstatement or reactivation of surgical assistant licensure.

A. A licensed surgical assistant who holds a current, unrestricted license in Virginia shall, upon a request on the renewal application and submission of the required fee, be issued an inactive license. The holder of an inactive license shall not be required to maintain hours of active practice or meet the continued competency requirements of 18VAC85-160-60 and shall not be entitled to perform any act requiring a license to practice surgical assisting in Virginia.

B. An inactive licensee may reactivate his license upon submission of the following:

1. An application as required by the board;

2. A payment of the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure; and

3. Documentation of completed continued competency hours as required by 18VAC85-160-60.

C. A surgical assistant who allows his license to lapse for a period of two years or more and chooses to resume his practice shall submit a reinstatement application to the board and information on any practice and licensure or certification in other jurisdictions during the period in which the license was lapsed and shall pay the fee for reinstatement of licensure as prescribed in 18VAC85-160-40.

D. The board reserves the right to deny a request for reactivation or reinstatement to any licensee who has been determined to have committed an act in violation of § 54.1-2915 of the Code of Virginia or any provisions of this chapter.

E. A surgical assistant whose license has been revoked by the board and who wishes to be reinstated shall make a new application to the board and payment of the fee for reinstatement of his license as prescribed in 18VAC85-160-40 pursuant to § 54.1-2408.2 of the Code of Virginia.

Part III

Standards of conduct

18VAC85-160-80. Confidentiality.

A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a patient. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.

18VAC85-160-90. Patient records.

A. Practitioners shall comply with the 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 the patient's personal representative in a timely manner and in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.

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

D. Practitioners who are employed by a health care institution or other entity in which the individual practitioner does not own or maintain the practitioner's own records shall maintain patient records in accordance with the policies and procedures of the employing entity.

E. Practitioners who are self-employed or employed by an entity in which the individual practitioner does own and is responsible for patient records shall:

1. Maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:

a. Records of a minor child 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;

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

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

2. Post information or in some manner inform all patients concerning the timeframe 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, the practitioner 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.

18VAC85-160-100. Communication with patients; termination of relationship.

A. Communication with patients.

1. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately present information to a patient or the patient's legally authorized representative in understandable terms and encourage participation in decisions regarding the patient's care.

2. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a treatment or procedure provided or directed by the practitioner in the treatment of any disease or condition.

3. Practitioners shall adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from patients prior to involving them as subjects in human research with the exception of retrospective chart reviews.

B. Termination of the practitioner/patient relationship.

1. The practitioner or the patient may terminate the relationship. In either case, the practitioner shall make the patient record available, except in situations where denial of access is allowed by law.

2. A practitioner shall not terminate the relationship or make the practitioner's services unavailable without documented notice to the patient that allows for a reasonable time to obtain the services of another practitioner.

18VAC85-160-110. Practitioner responsibility.

A. A practitioner shall not:

1. Perform procedures or techniques that are outside the scope of his practice or for which the practitioner is not trained and individually competent;

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

3. Engage in an egregious pattern of disruptive behavior or 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; or

4. 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 subdivision A 3 of this section.

18VAC85-160-120. Sexual contact.

A. For purposes of § 54.1-2915 A 12 and A 19 of the Code of Virginia and this section, sexual contact includes sexual behavior or verbal or physical behavior that:

1. May reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the patient, or both; or

2. May reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it.

B. Sexual contact with a patient.

1. The determination of when a person is a patient for purposes of § 54.1-2915 A 19 of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the patient-practitioner relationship is terminated.

2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient does not change the nature of the conduct nor negate the statutory prohibition.

C. Sexual contact between a practitioner and a former patient after termination of the practitioner-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence of emotions derived from the professional relationship.

D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care. For purposes of this section, key third party of a patient means spouse or partner, parent or child, guardian, or legal representative of the patient.

E. Sexual contact between a supervisor and a trainee shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care.

18VAC85-160-130. Refusal to provide information.

A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation.

Agenda Item: Fast-Track action related to reinstatement of surgical technologists

Included in your agenda package are:

Draft language related to reinstatement of surgical technologist certificate

Staff note: Recommended action by the Advisory Board on Surgical Assisting

Action needed:

- Motion to adopt fast-track action

Project 7236 - Fast-Track

Board of Medicine

Reinstatement of Certification as a Surgical Technologist

18VAC85-160-75. Reinstatement or reactivation of surgical technologist certification.

A. A certified surgical technologist who holds a current, unrestricted certificate in Virginia shall, upon a request on the renewal application and submission of the required fee, be issued an inactive certificate. The holder of an inactive certificate shall not be entitled to perform any act requiring a certification to practice surgical technology in Virginia.

B. An inactive certificate holder may reactivate his certificate upon submission of the following:

1. An application as required by the board;

2. A payment of the difference between the current renewal fee for inactive certification and the renewal fee for active certification; and

3. Documentation of completed continued competency hours as required by 18VAC85-160-65.

C. A surgical technologist who allows his certificate to lapse for a period of two years or more and chooses to resume his practice shall submit a reinstatement application to the board and information on any practice and licensure or certification in other jurisdictions during the period in which the certificate was lapsed and shall pay the fee for reinstatement of certification as prescribed in 18VAC85-160-40.

D. The board reserves the right to deny a request for reactivation or reinstatement to any certificate holder who has been determined to have committed an act in violation of § 54.1-2915 of the Code of Virginia or any provisions of this chapter.

E. A surgical technologist whose certificate has been revoked by the board and who wishes to be reinstated shall make a new application to the board and payment of the fee for reinstatement of his certificate as prescribed in 18VAC85-160-40 pursuant to § 54.1-2408.2 of the Code of Virginia.

Agenda Item: Consideration of legislative proposal for surgical assistant and surgical technologist applicants

Included in your agenda package are:

Draft legislative proposal regarding provisional practice of surgical assistants and surgical technologists pending application approval

Action needed:

- Motion to submit legislative proposal for review

2023 Session of the General Assembly

Department of Health Professions

A BILL to amend the *Code of Virginia* by amending §§ 54.1-2956.12 and 54.1-2956.13, relating to practice pending certification as a surgical technologist and practice pending licensure as a surgical assistant.

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2956.12 of the *Code of Virginia* is amended and reenacted as follows:

§ 54.1-2956.12. ~~Registered~~ Certified surgical technologist; use of title; certification ~~registration~~.

A. No person shall hold himself out to be a surgical technologist or use or assume the title of "surgical technologist" or "certified surgical technologist," or use the designation "S.T." or any variation thereof, unless such person is certified by the Board. 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.

B. The Board shall certify as a surgical technologist any applicant who presents satisfactory evidence that he (i) 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, (ii) has successfully completed a training program for surgical technology during the person's service as a member of any branch of the armed forces of the United States, or (iii) has practiced as a surgical technologist or attended a surgical technologist training program at any time prior to October 1, 2022, provided he registers with the Board by December 31, 2022.

C. Notwithstanding subsection A, a person who has successfully completed an accredited surgical technologist training program may practice with the title "Surgical Technologist, Certificate Applicant" until he has received a failing score on any examination for national certification by the National Board of Surgical Technology and Surgical Assisting or its successor or six months from the date of program completion, whichever occurs sooner. Any person practicing pursuant to this subsection shall be identified with the title "Surgical Technologist, Certificate Applicant" on any identification issued by an employer and in conjunction with any signature in the course of his practice.

§ 54.1-2956.13. Licensure of surgical assistant; practice of surgical assisting; use of title.

A. A. No person shall engage in the practice of surgical assisting or use or assume the title "surgical assistant" unless such person holds a license as a surgical assistant issued by the Board.

Nothing in this section shall be construed as prohibiting any professional licensed, certified, or registered by a health regulatory board from acting within the scope of his practice.

B. The Board shall establish criteria for licensure as a surgical assistant, which shall include evidence that the applicant:

1. Holds a current credential as a surgical assistant or surgical first assistant issued by the National Board of Surgical Technology and Surgical Assisting, or the National Commission for Certification of Surgical Assistants or their successors;

2. Has successfully completed a surgical assistant training program during the person's service as a member of any branch of the armed forces of the United States; or

3. Has practiced as a surgical assistant in the Commonwealth at any time in the six months immediately prior to July 1, 2020.

C. For renewal of a license, a surgical assistant who was licensed based on a credential as a surgical assistant or surgical first assistant issued by the National Board of Surgical Technology and Surgical Assisting, or the National Commission for the Certification of Surgical Assistants or their successors shall attest that the credential is current at the time of renewal.

D. Notwithstanding the provisions of subsection A, a person who has graduated from a surgical assisting program as required to take a national certification examination given by the entities listed in subsection B 1 may practice with the title "Surgical Assistant, License Applicant" until he has received a failing score on the national certification examination or six months from the date of graduation, whichever occurs sooner. Any person practicing pursuant to this subsection shall be identified with the title "Surgical Assistant, License Applicant" on any identification issued by an employer and in conjunction with any signature in the course of his practice.

Agenda Item: Consideration of regulations for licensure of licensed certified midwives

Included in your agenda package are:

Relevant portions of Virginia Code § 54.1-2900.

Virginia Code § 54.1-2957.04.

Proposed regulations adopted by the Board of Nursing.

Action needed:

- Motion to adopt proposed regulations governing the licensure of licensed certified midwives.

Relevant excerpts from Va. Code § 54.1-2900:

"Licensed certified midwife" means a person who is licensed as a certified midwife by the Boards of Medicine and Nursing.

"Practice of licensed certified midwifery" means the provision of primary health care for preadolescents, adolescents, and adults within the scope of practice of a certified midwife established in accordance with the Standards for the Practice of Midwifery set by the American College of Nurse-Midwives, including (i) providing sexual and reproductive care and care during pregnancy and childbirth, postpartum care, and care for the newborn for up to 28 days following the birth of the child; (ii) prescribing of pharmacological and non-pharmacological therapies within the scope of the practice of midwifery; (iii) consulting or collaborating with or referring patients to such other health care providers as may be appropriate for the care of the patients; and (iv) serving as an educator in the theory and practice of midwifery.

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 29. Medicine and Other Healing Arts

§ 54.1-2957.04. Licensure as a licensed certified midwife; practice as a licensed certified midwife; use of title; required disclosures.

A. It shall be unlawful for any person to practice or to hold himself out as practicing as a licensed certified midwife or use in connection with his name the words "Licensed Certified Midwife" unless he holds a license as such issued jointly by the Boards of Medicine and Nursing.

B. The Boards of Medicine and Nursing shall jointly adopt regulations for the licensure of licensed certified midwives, which shall include criteria for licensure and renewal of a license as a certified midwife that shall include a requirement that the applicant provide evidence satisfactory to the Boards of current certification as a certified midwife by the American Midwifery Certification Board and that shall be consistent with the requirements for certification as a certified midwife established by the American Midwifery Certification Board.

C. The Boards of Medicine and Nursing may issue a license by endorsement to an applicant to practice as a licensed certified midwife if the applicant has been licensed as a certified midwife under the laws of another state and, pursuant to regulations of the Boards, the applicant meets the qualifications for licensure as a licensed certified midwife in the Commonwealth.

D. Licensed certified midwives shall practice in consultation with a licensed physician in accordance with a practice agreement between the licensed certified midwife and the licensed physician. Such practice agreement shall address the availability of the physician for routine and urgent consultation on patient care. Evidence of a practice agreement shall be maintained by the licensed certified midwife and provided to the Board upon request. The Board shall adopt regulations for the practice of licensed certified midwives, which shall be in accordance with regulations jointly adopted by the Boards of Medicine and Nursing, which shall be consistent with the Standards for the Practice of Midwifery set by the American College of Nurse-Midwives governing the practice of midwifery.

E. Notwithstanding any provision of law or regulation to the contrary, a licensed certified midwife may prescribe Schedules II through VI controlled substances in accordance with regulations of the Boards of Medicine and Nursing.

F. A licensed certified midwife who provides health care services to a patient outside of a hospital or birthing center shall disclose to that patient, when appropriate, information on health risks associated with births outside of a hospital or birthing center, including but not limited to risks associated with vaginal births after a prior cesarean section, breech births, births by women experiencing high-risk pregnancies, and births involving multiple gestation. As used in this subsection, "birthing center" shall have the same meaning as in § 54.1-2957.03.

G. A licensed certified midwife who provides health care to a patient shall be liable for the midwife's negligent, grossly negligent, or willful and wanton acts or omissions. Except as otherwise provided by law, any (i) doctor of medicine or osteopathy who did not collaborate or consult with the midwife regarding the patient and who has not previously treated the patient for this pregnancy, (ii) physician assistant, (iii) nurse practitioner, (iv) prehospital emergency medical personnel, or (v) hospital as defined in § 32.1-123, or any employee of, person providing services pursuant to a contract with, or agent of such hospital, that provides screening and stabilization health care services to a patient as a result of a licensed certified midwife's negligent, grossly negligent, or willful and wanton acts or omissions shall be immune from liability for acts or omissions constituting ordinary negligence.

2021, Sp. Sess. I, cc. 200, 201.

Proposed regulations adopted by Board of Nursing: May 17, 2022

Project 7056 - Proposed

Board of Nursing

New regulations for licensed certified midwives

Chapter 70

Regulations Governing the Practice of Licensed Certified Midwives

Part I

GENERAL PROVISIONS

18VAC90-70-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Acute pain" means pain that occurs within the normal course of a disease or condition or as the result of surgery for which controlled substances containing an opioid may be prescribed for no more than three months.

"Approved program" means a midwifery education program that is accredited by the Accreditation Commission for Midwifery Education or its successor.

"Boards" means the Virginia Board of Nursing and the Virginia Board of Medicine.

"Chronic pain" means nonmalignant pain that goes beyond the normal course of a disease or condition for which controlled substances containing an opioid may be prescribed for a period greater than three months.

"Committee" means the Committee of the Joint Boards of Nursing and Medicine.

"Licensed certified midwife" means an advanced practice midwife who is jointly licensed by the Boards of Medicine and Nursing pursuant to § 54.1-2957.04 of the Code of Virginia.

"MME" means morphine milligram equivalent.

"Practice agreement" means a written or electronic statement, jointly developed by the consulting licensed physician and the licensed certified midwife, that describes the availability of the physician for routine and urgent consultation on patient care.

"Prescription Monitoring Program" means the electronic system within the Department of Health Professions that monitors the dispensing of certain controlled substances.

18VAC90-70-20. Delegation of Authority.

A. The boards hereby delegate to the executive director of the Virginia Board of Nursing the authority to issue the initial licensure and the biennial renewal of such licensure to those persons who meet the requirements set forth in this chapter and to grant extensions or exemptions for compliance with continuing competency requirements as set forth in 18VAC90-70-90(E) and (F). Questions of eligibility shall be referred to the Committee of the Joint Boards of Nursing and Medicine.

B. All records and files related to the licensure of licensed certified midwives shall be maintained in the office of the Virginia Board of Nursing.

18VAC90-70-30. Committee of the Joint Boards of Nursing and Medicine.

A. The Committee of the Joint Boards of Nursing and Medicine, appointed pursuant to 18VAC90-30-30 and consisting of three members appointed from the Board of Medicine and three members appointed from the Board of Nursing, shall administer the Regulations Governing the Licensure of Certified Midwives, 18VAC90-70-10 et seq.

B. In accordance with 18VAC90-30-30, the committee may, in its discretion, appoint an advisory committee. The advisory committee shall include practitioners specified in 18VAC90-30-30.

18VAC90-70-40. Fees.

Fees required in connection with the licensure of certified midwives are:

1. Application	$125
2. Biennial licensure renewal	$80
3. Late renewal	$25
4. Reinstatement of licensure	$150
5. Verification of licensure to another jurisdiction	$35
6. Duplicate license	$15
7. Duplicate wall certificate	$25
8. Handling fee for returned check or dishonored credit card or debit card	$50
9. Reinstatement of suspended or revoked license	$200

Part II

LICENSURE

18VAC90-70-50. Licensure, general.

A. No person shall perform services as a certified midwife in the Commonwealth of Virginia except as prescribed in this chapter and when licensed by the Boards of Nursing and Medicine.

B. The boards shall license applicants who meet the qualifications for licensure as set forth in 18VAC90-70-60 or 18VAC90-70-70.

Proposed regulations adopted by Board of Nursing: May 17, 2022

18VAC90-70-60. Qualifications for initial licensure.

An applicant for initial licensure as a licensed certified midwife shall:

1. Submit evidence of a graduate degree in midwifery from an approved program;
2. Submit evidence of current certification as a certified midwife by the American Midwifery Certification Board;
3. File the required application; and
4. Pay the application fee prescribed in 18VAC90-70-40.

18VAC90-70-70. Qualifications for licensure by endorsement.

An applicant for licensure by endorsement as a licensed certified midwife shall:

1. Provide verification of a license as a certified midwife in another United States jurisdiction with a license in good standing, or, if lapsed, eligible for reinstatement;
2. Submit evidence of current certification as a certified midwife by the American Midwifery Certification Board;
3. File the required application; and
4. Pay the application fee prescribed in 18VAC90-70-40.

18VAC90-70-80. Renewal of licensure.

A. Licensure of a licensed certified midwife shall be renewed biennially.

B. The renewal notice of the license shall be sent to the last known address of record of each licensed certified midwife. Failure to receive the renewal notice shall not relieve the licensee of the responsibility for renewing the license by the expiration date.

C. The licensed certified midwife shall attest to current certification as a certified midwife by the American Midwifery Certification Board and submit the license renewal fee prescribed in 18VAC90-70-40.

D. The license shall automatically lapse if the licensee fails to renew by the expiration date. Any person practicing as a certified midwife during the time a license has lapsed shall be subject to disciplinary actions by the boards.

18VAC90-70-90. Continuing competency requirements.

A. In order to renew a license biennially, a licensed certified midwife shall hold a current certification as a certified midwife by the American Midwifery Certification Board.

B. A licensed certified midwife shall obtain a total of eight hours of continuing education in pharmacology or pharmacotherapeutics for each biennium.

C. The licensed certified midwife shall retain evidence of compliance with this section and all supporting documentation for a period of four years following the renewal period for which the records apply.

D. The boards shall periodically conduct a random audit of at least 1.0% of their licensed certified midwives to determine compliance. The licensed certified midwives selected for the audit shall provide the evidence of compliance and supporting documentation within 30 days of receiving notification of the audit.

E. The boards 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 submitted prior to the renewal date.

F. The boards may delegate to the committee the authority to grant an exemption for all or part of the continuing education requirements in subsection (B) for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

18VAC90-70-100. Reinstatement of license.

A. A licensed certified midwife whose license has lapsed may be reinstated within one renewal period by payment of the current renewal fee and the late renewal fee.

B. An applicant for reinstatement of license lapsed for more than one renewal period shall:

1. File the required application and reinstatement fee; and

2. Provide evidence of current professional competency consisting of:

a. Current certification by the American Midwifery Certification Board;

b. Continuing education hours completed during the period in which the license was lapsed, equal to the number required for licensure renewal during that period, not to exceed 120 hours; or

c. If applicable, a current, unrestricted license as a certified midwife in another jurisdiction.

C. An applicant for reinstatement of a license following suspension or revocation shall:

1. Petition for reinstatement and pay the reinstatement fee; and

2. Present evidence that he is competent to resume practice as a licensed certified midwife in Virginia, to include:

a. Current certification by the American Midwifery Certification Board; and

b. Continuing education hours taken during the period in which the license was suspended or revoked, equal to the number required for licensure during that period, not to exceed 120 hours.

The committee shall act on the petition pursuant to the Administrative Process Act (§ 2.2-4000, et seq. of the Code of Virginia).

Proposed regulations adopted by Board of Nursing: May 17, 2022

Part III

PRACTICE OF LICENSED CERTIFIED MIDWIVES

18VAC90-70-110. Practice of licensed certified midwives.

A. All licensed certified midwives shall practice in accordance with a written or electronic practice agreement as defined in 18VAC90-70-10.

B. The written or electronic practice agreement shall include provisions for the availability of the physician for routine and urgent consultation on patient care.

C. The practice agreement shall be maintained by the licensed certified midwife and provided to the boards upon request. For licensed certified midwives providing care to patients within a hospital or health care system, the practice agreement may be included as part of documents delineating the licensed certified midwife's clinical privileges or the electronic or written delineation of duties and responsibilities; however, the licensed certified midwife shall be responsible for providing a copy to the boards upon request.

D. The practice of licensed certified midwives shall be consistent with the standards of care for the profession and with the applicable laws and regulations.

E. The licensed certified midwife shall include on each prescription issued or dispensed his signature and Drug Enforcement Administration (DEA) number, when applicable.

F. The licensed certified midwife shall disclose to patients at the initial encounter that he is a licensed certified midwife. Such disclosure may be included on a prescription or may be given in writing to the patient.

G. A licensed certified midwife who provides health care services to a patient outside of a hospital or birthing center shall disclose to that patient, when appropriate, information on health risks associated with births outside of a hospital or birthing center, including but not limited to risks

associated with vaginal births after a prior cesarean section, breech births, births by women experiencing high-risk pregnancies, and births involving multiple gestation.

H. The licensed certified midwife shall disclose, upon request of a patient or a patient's legal representative, the name of the consulting physician and information regarding how to contact the consulting physician.

Part IV

PRESCRIBING

18VAC90-70-120. Prescribing for self or family.

A. Treating or prescribing shall be based on a bona fide practitioner-patient relationship, and prescribing shall meet the criteria set forth in §54.1-3303 of the Code of Virginia.

B. A licensed certified midwife shall not prescribe a controlled substance to himself or a family member, other than Schedule VI as defined in §54.1-3455 of the Code of Virginia, unless the prescribing occurs in an emergency situation or in isolated settings where there is no other qualified practitioner available to the patient, or it is for a single episode of an acute illness through one prescribed course of medication.

C. When treating or prescribing for self or family, the licensed certified midwife shall maintain a patient record documenting compliance with statutory criteria for a bona fide practitioner-patient relationship.

18VAC90-70-130. Waiver for electronic prescribing.

A. A prescription for a controlled substance that contains an opioid shall be issued as an electronic prescription consistent with § 54.1-3408.02 of the Code of Virginia, unless the prescription qualifies for an exemption as set forth in subsection C of § 54.1-3408.02.

B. Upon written request, the boards may grant a one-time waiver of the requirement of subsection A of this section for a period not to exceed one year, due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the prescriber, or other exceptional circumstances demonstrated by the prescriber.

Part V

MANAGEMENT OF ACUTE PAIN

18VAC90-70-140. Evaluation of the patient for acute pain.

A. The requirements of this part shall not apply to:

1. The treatment of acute pain related to (i) cancer, (ii) sickle cell, (iii) a patient in hospice care, or (iv) a patient in palliative care;

2. The treatment of acute pain during an inpatient hospital admission or in a nursing home or an assisted living facility that uses a sole source pharmacy; or

3. A patient enrolled in a clinical trial as authorized by state or federal law.

B. Nonpharmacologic and non-opioid treatment for pain shall be given consideration prior to treatment with opioids. If an opioid is considered necessary for the treatment of acute pain, the practitioner shall give a short-acting opioid in the lowest effective dose for the fewest possible days.

C. Prior to initiating treatment with a controlled substance containing an opioid for a complaint of acute pain, the prescriber shall perform a history and physical examination appropriate to the complaint, query the Prescription Monitoring Program as set forth in § 54.1-2522.1 of the Code of Virginia, and conduct an assessment of the patient's history and risk of substance misuse as a part of the initial evaluation.

Proposed regulations adopted by Board of Nursing: May 17, 2022

18VAC90-70-150. Treatment of acute pain with opioids.

A. Initiation of opioid treatment for patients with acute pain shall be with short-acting opioids.

1. A prescriber providing treatment for a patient with acute pain shall not prescribe a controlled substance containing an opioid in a quantity that exceeds a seven-day supply as determined by the manufacturer's directions for use, unless extenuating circumstances are clearly documented in the medical record. This shall also apply to prescriptions of a controlled substance containing an opioid upon discharge from an emergency department.

2. An opioid prescribed as part of treatment for a surgical procedure shall be for no more than 14 consecutive days in accordance with manufacturer's direction and within the immediate perioperative period, unless extenuating circumstances are clearly documented in the medical record.

B. Initiation of opioid treatment for all patients shall include the following:

1. The practitioner shall carefully consider and document in the medical record the reasons to exceed 50 MME per day.

2. Prior to exceeding 120 MME per day, the practitioner shall document in the medical record the reasonable justification for such doses or refer to or consult with a pain management specialist.

3. Naloxone shall be prescribed for any patient when risk factors of prior overdose, substance misuse, doses in excess of 120 MME per day, or concomitant benzodiazepine are present.

C. Due to a higher risk of fatal overdose when opioids are used with benzodiazepines, sedative hypnotics, carisoprodol, and tramadol (an atypical opioid), the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the

medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.

D. Buprenorphine is not indicated for acute pain in the outpatient setting, except when a prescriber who has obtained a SAMHSA waiver is treating pain in a patient whose primary diagnosis is the disease of addiction.

18VAC90-70-160. Medical records for acute pain.

The medical record shall include a description of the pain, a presumptive diagnosis for the origin of the pain, an examination appropriate to the complaint, a treatment plan, and the medication prescribed or administered to include the date, type, dosage, and quantity prescribed or administered.

Part VI

MANAGEMENT OF CHRONIC PAIN

18VAC90-70-170. Evaluation of the chronic pain patient.

A. The requirements of this part shall not apply to:

1. The treatment of chronic pain related to (i) cancer, (ii) sickle cell, (iii) a patient in hospice care, or (iv) a patient in palliative care;

2. The treatment of chronic pain during an inpatient hospital admission or in a nursing home or an assisted living facility that uses a sole source pharmacy; or

3. A patient enrolled in a clinical trial as authorized by state or federal law.

B. Prior to initiating management of chronic pain with a controlled substance containing an opioid, a medical history and physical examination, to include a mental status examination, shall be performed and documented in the medical record, including:

1. The nature and intensity of the pain;

2. Current and past treatments for pain;

3. Underlying or coexisting diseases or conditions;

4. The effect of the pain on physical and psychological function, quality of life, and activities of daily living;

5. Psychiatric, addiction, and substance misuse histories of the patient and any family history of addiction or substance misuse;

6. A urine drug screen or serum medication level;

7. A query of the Prescription Monitoring Program as set forth in § 54.1-2522.1 of the Code of Virginia;

8. An assessment of the patient's history and risk of substance misuse; and

9. A request for prior applicable records.

C. Prior to initiating opioid analgesia for chronic pain, the practitioner shall discuss with the patient the known risks and benefits of opioid therapy and the responsibilities of the patient during treatment to include securely storing the drug and properly disposing of any unwanted or unused drugs. The practitioner shall also discuss with the patient an exit strategy for the discontinuation of opioids in the event they are not effective.

18VAC90-70-180. Treatment of chronic pain with opioids.

A. Nonpharmacologic and non-opioid treatment for pain shall be given consideration prior to treatment with opioids.

B. In initiating opioid treatment for all patients, the practitioner shall:

1. Carefully consider and document in the medical record the reasons to exceed 50 MME per day;

2. Prior to exceeding 120 MME per day, the practitioner shall document in the medical record the reasonable justification for such doses or refer to or consult with a pain management specialist;

3. Prescribe naloxone for any patient when risk factors of prior overdose, substance misuse, doses in excess of 120 MME per day, or concomitant benzodiazepine are present; and

4. Document the rationale to continue opioid therapy every three months.

C. Buprenorphine mono-product in tablet form shall not be prescribed for chronic pain.

D. Due to a higher risk of fatal overdose when opioids, including buprenorphine, are given with other opioids, benzodiazepines, sedative hypnotics, carisoprodol, and tramadol (an atypical opioid), the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.

E. The practitioner shall regularly evaluate for opioid use disorder and shall initiate specific treatment for opioid use disorder, consult with an appropriate health care provider, or refer the patient for evaluation for treatment if indicated.

18VAC90-70-190. Treatment plan for chronic pain.

A. The medical record shall include a treatment plan that states measures to be used to determine progress in treatment, including pain relief and improved physical and psychosocial function, quality of life, and daily activities.

B. The treatment plan shall include further diagnostic evaluations and other treatment modalities or rehabilitation that may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

C. The prescriber shall record in the medical records the presence or absence of any indicators for medication misuse or diversion and take appropriate action.

18VAC90-70-200. Informed consent and agreement to treatment of chronic pain.

A. The practitioner shall document in the medical record informed consent, to include risks, benefits, and alternative approaches, prior to the initiation of opioids for chronic pain.

B. There shall be a written treatment agreement, signed by the patient, in the medical record that addresses the parameters of treatment, including those behaviors that will result in referral to a higher level of care, cessation of treatment, or dismissal from care.

C. The treatment agreement shall include notice that the practitioner will query and receive reports from the Prescription Monitoring Program and permission for the practitioner to:

1. Obtain urine drug screen or serum medication levels, when requested; and

2. Consult with other prescribers or dispensing pharmacists for the patient.

D. Expected outcomes shall be documented in the medical record including improvement in pain relief and function or simply in pain relief. Limitations and side effects of chronic opioid therapy shall be documented in the medical record.

18VAC90-70-210. Opioid therapy for chronic pain.

A. The practitioner shall review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health at least every three months.

B. Continuation of treatment with opioids shall be supported by documentation of continued benefit from the prescribing. If the patient's progress is unsatisfactory, the practitioner shall assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

C. Practitioners shall check the Prescription Monitoring Program at least every three months after the initiation of treatment.

D. The practitioner shall order and review a urine drug screen or serum medication levels at the initiation of chronic pain management and thereafter randomly at the discretion of the practitioner but at least once a year.

E. The practitioner shall regularly evaluate for opioid use disorder and shall initiate specific treatment for opioid use disorder, consult with an appropriate health care provider, or refer the patient for evaluation for treatment if indicated.

18VAC90-70-220. Additional consultation.

A. When necessary to achieve treatment goals, the prescriber shall refer the patient for additional evaluation and treatment.

B. When a practitioner makes the diagnosis of opioid use disorder, treatment for opioid use disorder shall be initiated or the patient shall be referred for evaluation and treatment.

18VAC90-70-230. Medical records.

The prescriber shall keep current, accurate, and complete records in an accessible manner and readily available for review to include:

1. The medical history and physical examination;

2. Past medical history;

3. Applicable records from prior treatment providers or any documentation of attempts to obtain those records;

4. Diagnostic, therapeutic, and laboratory results;

5. Evaluations and consultations;

6. Treatment goals;

7. Discussion of risks and benefits;

8. Informed consent and agreement for treatment;

9. Treatments;

10. Medications, including date, type, dosage and quantity prescribed, and refills;

11. Patient instructions; and

12. Periodic reviews.

Part VII

DISCIPLINARY PROVISIONS

18VAC90-70-240. Grounds for disciplinary action against the license of a certified midwife.

The boards may deny licensure or relicensure, revoke or suspend the license, or place on probation, censure, reprimand, or impose a monetary penalty on a licensed certified midwife for the following unprofessional conduct:

1. Has had his license to practice midwifery in this Commonwealth or in another jurisdiction revoked or suspended or otherwise disciplined;

2. Has directly or indirectly held himself out or represented himself to the public that he is a physician, or is able to, or will practice independently of a physician;

3. Has performed procedures or techniques that are outside the scope of practice as a licensed certified midwife and for which the licensed certified midwife is not trained and individually competent;

4. Has violated or cooperated in the violation of the laws or regulations governing the practice of medicine, nursing, or certified midwifery;

5. Has become unable to practice with reasonable skill and safety as the result of physical or mental illness or the excessive use of alcohol, drugs, narcotics, chemicals, or any other type of material;

6. Has violated or cooperated with others in violating or attempting to violate any law or regulation, state or federal, relating to the possession, use, dispensing, administration, or distribution of drugs;

7. Has failed to comply with continuing competency requirements as set forth in 18VAC90-70-90;

8. Has willfully or negligently breached the confidentiality between a practitioner and a patient. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the practitioner shall not be considered negligent or willful;

9. Has engaged in unauthorized use or disclosure of confidential information received from the Prescription Monitoring Program; or

10. Has practiced as a licensed certified midwife during a time when the practitioner's certification as a certified midwife by the American Midwifery Certification Board has lapsed.

18VAC90-70-250. Hearings.

A. The provisions of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) shall govern proceedings on questions of violation of 18VAC90-70-240.

B. The Committee of the Joint Boards of Nursing and Medicine shall conduct all proceedings prescribed herein and shall take action on behalf of the boards.

Proposed regulations adopted by Board of Nursing: May 17, 2022

18VAC90-70-260. Delegation of proceedings.

A. Decision to delegate. In accordance with §54.1-2400(10) of the Code of Virginia, the committee may delegate an informal fact-finding proceeding to an agency subordinate upon determination that probable cause exists that a licensed certified midwife may be subject to a disciplinary action.

B. Criteria for delegation. Cases that involve intentional or negligent conduct that caused serious injury or harm to a patient may not be delegated to an agency subordinate, except as may be approved by the chair of the committee.

C. Criteria for an agency subordinate.

1. An agency subordinate authorized by the committee to conduct an informal fact-finding proceeding may include current or past board members, professional staff, or other persons deemed knowledgeable by virtue of their training and experience in administrative proceedings involving the regulation and discipline of health professionals.

2. The Executive Director of the Board of Nursing shall maintain a list of appropriately qualified persons to whom an informal fact-finding proceeding may be delegated.

3. The committee may delegate to the executive director the selection of the agency subordinate who is deemed appropriately qualified to conduct a proceeding based on the qualifications of the subordinate and the type of case being heard.

Documents Incorporated by Reference (18VAC90-70)

Standards for the Practice of Midwifery, revised 2011, American College of Nurse-Midwives

Midwifery practice as conducted by certified nurse-midwives (CNMs) and certified midwives (CMs) is the independent management of women's health care, focusing particularly on pregnancy, childbirth, the post partum period, care of the newborn, and the family planning and gynecologic needs of women. The CNM and CM practice within a health care system that provides for consultation, collaborative management, or referral, as indicated by the health status of the client. CNMs and CMs practice in accord with the Standards for the Practice of Midwifery, as defined by the American College of Nurse-Midwives (ACNM).

STANDARD I

MIDWIFERY CARE IS PROVIDED BY QUALIFIED PRACTITIONERS
The midwife:

1. Is certified by the ACNM designated certifying agent.
2. Shows evidence of continuing competency as required by the ACNM designated certifying agent.
3. Is in compliance with the legal requirements of the jurisdiction where the midwifery practice occurs.

STANDARD II

MIDWIFERY CARE OCCURS IN A SAFE ENVIRONMENT WITHIN THE CONTEXT OF THE FAMILY, COMMUNITY, AND A SYSTEM OF HEALTH CARE.
The midwife:

1. Demonstrates knowledge of and utilizes federal and state regulations that apply to the practice environment and infection control.
2. Demonstrates a safe mechanism for obtaining medical consultation, collaboration, and referral.
3. Uses community services as needed.
4. Demonstrates knowledge of the medical, psychosocial, economic, cultural, and family factors that affect care.
5. Demonstrates appropriate techniques for emergency management including arrangements for emergency transportation.
6. Promotes involvement of support persons in the practice setting.

STANDARD III

MIDWIFERY CARE SUPPORTS INDIVIDUAL RIGHTS AND SELF-DETERMINATION WITHIN BOUNDARIES OF SAFETY
The midwife:

1. Practices in accord with the Philosophy and the Code of Ethics of the American College of Nurse-Midwives.
2. Provides clients with a description of the scope of midwifery services and information regarding the client's rights and responsibilities.

3. Provides clients with information regarding, and/or referral to, other providers and services when requested or when care required is not within the midwife's scope of practice.
4. Provides clients with information regarding health care decisions and the state of the science regarding these choices to allow for informed decision-making.

STANDARD IV

MIDWIFERY CARE IS COMPRISED OF KNOWLEDGE, SKILLS, AND JUDGMENTS THAT FOSTER THE DELIVERY OF SAFE, SATISFYING, AND CULTURALLY COMPETENT CARE.
The midwife:

1. Collects and assesses client care data, develops and implements an individualized plan of management, and evaluates outcome of care.
2. Demonstrates the clinical skills and judgments described in the ACNM Core Competencies for Basic Midwifery Practice.
3. Practices in accord with the ACNM Standards for the Practice of Midwifery.

STANDARD V

MIDWIFERY CARE IS BASED UPON KNOWLEDGE, SKILLS, AND JUDGMENTS WHICH ARE REFLECTED IN WRITTEN PRACTICE GUIDELINES AND ARE USED TO GUIDE THE SCOPE OF MIDWIFERY CARE AND SERVICES PROVIDED TO CLIENTS.
The midwife:

1. Maintains written documentation of the parameters of service for independent and collaborative midwifery management and transfer of care when needed.
2. Has accessible resources to provide evidence based clinical practice for each specialty area which may include, but is not limited to, primary health care of women, care of the childbearing family, and newborn care.

STANDARD VI

MIDWIFERY CARE IS DOCUMENTED IN A FORMAT THAT IS ACCESSIBLE AND COMPLETE.
The midwife:

1. Uses records that facilitate communication of information to clients, consultants, and institutions.
2. Provides prompt and complete documentation of evaluation, course of management, and outcome of care.
3. Promotes a documentation system that provides for confidentiality and transmissibility of health records.
4. Maintains confidentiality in verbal and written communications.

STANDARD VII

MIDWIFERY CARE IS EVALUATED ACCORDING TO AN ESTABLISHED PROGRAM FOR QUALITY MANAGEMENT THAT INCLUDES A PLAN TO IDENTIFY AND RESOLVE PROBLEMS.
The midwife:

1. Participates in a program of quality management for the evaluation of practice within the setting in which it occurs.

2. Provides for a systematic collection of practice data as part of a program of quality management.
3. Seeks consultation to review problems, including peer review of care.
4. Acts to resolve problems identified.

STANDARD VIII

MIDWIFERY PRACTICE MAY BE EXPANDED BEYOND THE ACNM CORE COMPETENCIES TO INCORPORATE NEW PROCEDURES THAT IMPROVE CARE FOR WOMEN AND THEIR FAMILIES.

The midwife:

1. Identifies the need for a new procedure taking into consideration consumer demand, standards for safe practice, and availability of other qualified personnel.
2. Ensures that there are no institutional, state, or federal statutes, regulations, or bylaws that would constrain the midwife from incorporation of the procedure into practice.
3. Demonstrates knowledge and competency, including:
   a) Knowledge of risks, benefits, and client selection criteria.
   b) Process for acquisition of required skills.
   c) Identification and management of complications.
   d) Process to evaluate outcomes and maintain competency.
4. Identifies a mechanism for obtaining medical consultation, collaboration, and referral related to this procedure.
5. Maintains documentation of the process used to achieve the necessary knowledge, skills and ongoing competency of the expanded or new procedures.

Source: Division of Standards and Practice
Approved: ACNM Board of Directors, March 8, 2003;
Revised and Approved: ACNM Board of Directors, December 4, 2009
Revised and Approved: ACNM Board of Directors, September 24, 2011

(Supersedes the ACNM's Functions, Standards and Qualifications, 1983 and Standards for the Practice of Nurse-Midwifery 1987, 1993. Standard VIII has been adapted from the ACNM's Guidelines for the Incorporation of New Procedures into Nurse-Midwifery Practice)

Agenda Items: Consideration of response to petition for rulemaking

Included in your agenda package are:

- Petition for rulemaking from Michael Moates;
- Public comment received by the Board; and
- Public comment posted on Town Hall in response to the petition.

Staff note:

The Advisory Board on Behavior Analysis recommended that the Board initiate a rulemaking to: (1) make the regulation correspond with the language in Va. Code § 54.1-2957.16(B)(1); and (2) to define "nationally accredited to certify practitioners of behavior analysis" in the Regulations Governing the Practice of Behavior Analysis.

The Advisory Board also recommended that a Regulatory Advisory Panel be convened to assist in drafting a regulatory definition of "nationally accredited to certify practitioners of behavior analysis."

Action needed:

Motion to either:

- Initiate rulemaking (accept the recommendation of the Advisory Board); or
- Take no action.

Request for Comment on Petition for Rulemaking

Promulgating Board: **Board of Medicine**

Regulatory Coordinator: Elaine J. Yeatts
(804)367-4688
elaine.yeatts@dhp.virginia.gov

Agency Contact: William L. Harp, M.D.
Executive Director
(804)367-4558
william.harp@dhp.virginia.gov

Contact Address: Department of Health Professions
9960 Mayland Drive
Suite 300
Richmond, VA 23233

Chapter Affected:

18 vac 85 - 150: **Regulations Governing the Practice of Behavior Analysis**

Statutory Authority: State: §§ 54.1-2400 and 54.1-2957.16

Date Petition Received 02/16/2022

Petitioner Michael Moates

Petitioner's Request

To remove the specific requirement for BACB certification and accept certification from an entity that is nationally accredited to certify practitioners of behavior analysis.

Agency Plan

In accordance with Virginia law, the petition will be filed with the Register of Regulations and published on March 14, 2022 and posted on the Virginia Regulatory Townhall at www.townhall.virginia.gov. Comment on the petition will be requested until April 13, 2022 and may be posted on the Townhall or sent to the Board. Following receipt of all comments on the petition to amend regulations, the matter will be considered by the Advisory Board on Behavior Analysis on May 23, 2022, which will make a recommendation to the full Board for its meeting on June 16, 2022.

Publication Date 03/14/2022 *(comment period will also begin on this date)*

Comment End Date 04/13/2022

COMMONWEALTH OF VIRGINIA
Board of Medicine

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4600 (Tel)
(804) 527-4426 (Fax)

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition. If the board has not met within that 90-day period, the decision will be issued no later than 14 days after it next meets.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix,)

Moates, Michael S

Street Address	Area Code and Telephone Number	
2700 Colorado Boulevard #1526	817-999-7534	
City	**State**	**Zip Code**
Denton	Texas	76210
Email Address (optional)	**Fax (optional)**	
michaelsmoates@gmail.com		

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

Title of Regulations: 18VAC85-150-10 et seq. - REGULATIONS GOVERNING THE PRACTICE OF BEHAVIOR ANALYSIS

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

Amend 18VAC85-150-60. Licensure requirement. to match the statute.
Remove requirement for BACB certification and change language to say "entity that is nationally accredited to certify practitioners of behavior analysis" per statute. The statute requires this language in the regulation as it says "The Board shall establish criteria for licensure as a behavior analyst, which shall include, but not be limited to, the following:"

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is <u>other</u> legal authority for promulgation of a regulation, please provide that Code reference.

2014 Virginia Code
Title 54.1 - Professions and Occupations
§ 54.1-2957.16. Licensure of behavior analysts and assistant behavior analysts

Signature: [signature]

Date: 14 Feb 2022

Barrett, Erin <erin.barrett@dhp.virginia.gov>

Fwd: QABA in VA (public comment)

2 messages

Harp, William <william.harp@dhp.virginia.gov> Wed, Mar 23, 2022 at 11:31 AM
To: Erin Barrett <erin.barrett@dhp.virginia.gov>

FYI

---------- Forwarded message ---------
From: **Alena Barosa** <alenabarosa@autismts.com>
Date: Wed, Mar 23, 2022 at 11:03 AM
Subject: QABA in VA (public comment)
To: william.harp@dhp.virginia.gov <william.harp@dhp.virginia.gov>

Hello, Mr. Harp.

Hope you are having a wonderful Wednesday. I was unable to find a way to make a public comment about the petition regarding QABA in Virginia online. I decided to email you instead.

I have been a BCBA through BACB since 2016. I was a BCaBA (assistant) and RBT (technician) before that as well. I have been serving individuals on the autism spectrum since 2014. Although we are an applied behavior analysis clinic and are qualified to work with all populations, all of our patients (and we have several hundreds of them) have the diagnosis of autism.

In 2020, when the COVID-19 pandemic affected us the most, we were unable to conduct the regular training process for onboarding our staff. We continued operating with extra precautions during the pandemic, as we were the essential employees status. The BACB shut down their testing sites and everyone going through training had to wait indefinitely to take the test. Our HR department looked for other options and discovered QABA. We consulted with our insurance provider and were told that both ABATs (QABA) and RBTs (BACB) were qualified to deliver behavior analytic services. Since then we have been training ABATs exclusively. QABA offered proctored testing online and an overall intimate experience: when we had questions, we could speak to an actual person, not an automated service. Our individuals did not need to drive to the testing site in another town and could instead take their exam in our administrative building. When a new person gets hired, that individual completes the 40-hour instruction under a certified staff member The training includes both the theory and the hands-on (in-vivo) training. We have designed a competency checklist for our trainees as well and evaluate their performance daily. Once all of the trainees satisfy the mastery criteria, they receive a certificate of completion. This certificate then qualified them to sign up for the exam. Following their passing, they are able to be fully onboarded.

A few years ago, I was given an opportunity to become a QBA through QABA. I became dual-certified, as I am presently both a QBA and BCBA. I also became a continuing education provider through QABA. We recently recertified our first ABAT using our CEU platform. Since most of all ABA patients are autistic, I do not understand the argument of QABA being "more autism based." I have many friends in other countries who were able to become certified through QABA, as such designation was not available through BACB in their home countries. I see a lot of value in QABA. As a relatively new entity, it continues to evolve and improve.

Please let me know if you have any questions or concerns.

Regards,

Alena Barosa

Board Certified Behavior Analyst (BCBA)

Autism Therapeutic Services
Phone: (910) 484-1711/ 1722 (work)

(910) 568-7945 (cell)
(919) 869-1685 (fax)
Website: www.autismts.com

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Barrett, Erin <erin.barrett@dhp.virginia.gov> Wed, Mar 23, 2022 at 11:36 AM
To: "Harp, William" <william.harp@dhp.virginia.gov>

Received. Thank you.

Erin L. Barrett, JD
Senior Policy Analyst

Virginia Department of Health Professions
9960 Mayland Drive
Suite 300
Richmond, Virginia 23233-1463
email: erin.barrett@dhp.virginia.gov

[Quoted text hidden]

April 13, 2022

Virginia Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, VA 23233

Subject: Comments regarding behavior analyst certifying organizations

Colleagues:

I am writing on behalf of the Association for Behavior Analysis International (ABAI) which is the international professional organization for behavior analysis, the natural science of behavior, and its Licensing Committee. ABAI is uniquely positioned to address questions that arise regarding the practice and profession of behavior analysis.

We have been asked to comment regarding the discussion occurring in Virginia related to organizations issuing certification to behavior analysts. We recognize the concern possibly arising that some organizations may certify individuals as being sufficiently qualified when, in reality, a person does not possess the knowledge or supervised experience to provide appropriate services for clients. We think that identifying specific certifying organizations as holding acceptable certifying criteria to be unwise as the number of behavior analyst certifying organizations may shift over time and we would not want to take action might contribute to restricting timely decisions being made in Virginia regarding qualifications. To be clear, we cannot endorse any particular organization that certifies behavior analysts. We can, though, describe some considerations that we believe are important when reviewing such organizations.

Given that the rationale for licensing behavior analysts is protection of the public, of utmost importance is ascertaining how well a behavior analyst certification issued by an organization promotes protecting the public. How might that be evident? Some facets of how that be done are summarized immediately below with more details discussion following. Some essential factors include:

1. Making sure that the certification criteria are relevant to the area in which licensure would be provided, specifically relevance to behavior analysis, *per se*.

2. Ensuring that the knowledge, competencies, examination content, and supervised experience requirements for behavior analyst licensure are intended to apply broadly and not just be relevant or especially relevant to a subset of the population.

3. Determining that expected supervisory experience maximizes the likelihood that trainees have adequate relevant experience to develop the complex skills needed to provide effective and safe services needed by the public.

4. Ensuring the results of certification examinations accurately reflect the knowledge of a candidate for certification and then licensure.

5. Exploring whether the certifying organization has and enforces a code of ethics for people that it certifies.

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6. Considering how certification decisions by an organization could facilitate financial gain accruing to private parties.

7. Addressing whether the behavior analyst certifying organization is accredited by a nationally or internationally recognized organization that accreditss organizations that issue professional credentials, a necessary but not sufficient factor for adequate protection of the public.

Expanded consideration of those factors follows.

1. **Making sure that the certification criteria are relevant to the area in which licensure would be provided, specifically relevance to behavior analysis, *per se*.** If the license issued to behavior analysts is an unrestricted license (i.e., behavior analysts are not restricted to providing their services to only a subset of the populations such as Autistic people or minors), then the criteria for the certification required for behavior analyst must pertain completely to behavior analysis, rather than some other profession or to behavior analysis **plus** some other topic. Issuance of an unrestricted license requires that licensees' training and experience NOT be restricted to or primarily emphasize only one subset of the population; this is essential so that licensed behavior analysts will have received broad training that will facilitate their ability to provide appropriate and effective services to a broad array of clients. A crucial implication of this expectation for certificants is that the competencies a behavior analyst has received must reflect the fully range of behavior analysis, and not be restricted to or primarily emphasize what is relevant to only a subset of the population to whom behavior analysis services should be provided and that will seek behavior analysis services. The same holds true for the required training, supervised experience, and testing of persons to be certified. A behavior analyst certification program can contribute to protecting the public by having requirements that ensure that behavior analysts are prepared to provide the services people need in a manner that is safe, effective, and ethical. Inadequate standards increase the risk that certified behavior analysts will provide services and conduct themselves in ways that could cause some form of harm to the people to whom services are provided. The information to address this set of concerns should be readily available in the publicly available information provided by a certifying organization such as on its website. If the information is not readily available or what is available indicates that the issues mentioned here are not adequately addressed, then one should proceed with great caution regarding whether that organization is operating openly and is likely to provide the best available protection for the public.

2. **Ensuring that the knowledge, competencies, examination content, and supervised experience requirements for behavior analyst licensure are intended to apply broadly and not just be relevant or especially relevant to a subset of the population, is not sufficient to maximize protection of the public.** The expected knowledge, competencies, examination content, and supervised experience requirements for behavior analyst licensure must validly reflect what actually is necessary for provision of effective behavior analysis services. The state of the art procedures are well articulated and available from a variety of sources pertaining to examination development and professional credentialing (e.g., the Council on Licensure, Enforcement & Regulation, www.clearhq.org). In brief, the knowledge, competencies, examination content, and supervised experience requirements for behavior analyst licensure should be derived from a systematic, validated representative query of persons practicing behavior analysis with preliminary item development by subject matter experts (SMEs). The findings from such surveys should be reviewed by SMEs, revised as needed and then, when any preliminary surveys are shown to be adequately broad and to be psychometrically reliable and valid, the finalized survey should be administered to a large representative group of behavior analysts. An important consideration in this regarding is that the validation sample is sufficiently representative. That is, the validation sample definitely should not be limited primarily to employees and associates of one company or organization nor to persons known to be working primarily with only a subset of the population. The validation of the items for competencies, examination content, and supervised experience must involve reasonable statistical procedures currently standard for professional examinations, a time consuming and potentially costly undertaking. Failure to do so could result in certification criteria that are too lenient, resulting in inadequately prepared persons being licensed and allowed to provide services to the public, causing harm due to inappropriate services being provided or failure to provide needed services. On the other hand, similar methodological inadequacy could result in certification criteria that are too stringent, resulting in too few adequately prepared persons being licensed and allowed to provide services to the public, causing harm due to restricting unduly the number of professionals

available to provide behavior analysis services to persons needing them, resulting in avoidable reduction in quality of life and/or safety for persons not receiving needed behavior analysis services. Information relevant to this set of concerns should be readily available in the publicly available information provided by a certifying organization such as on its website. If the information is not readily available or if the procedures for determining the knowledge, competencies, examination content, and supervised experience requirements for behavior analyst licensure lack the rigor briefly summarized here, then one should proceed with great caution regarding whether that organization is operating openly and is likely to provide the best available protection for the public.

3. **Determining that expected supervisory experience maximizes the likelihood that trainees actually have adequate relevant experience to develop the complex skills needed to provide the effective and safe services needed by the public.** Such supervised experience requires persons who could be certified and, thus, licensed, and should explicitly mandate that a large percentage of supervised experience involves direct service provision to clients/ patients. A trainee must not be allowed to possibly satisfy the supervised experience requirements without having demonstrated under rigorous expectations that they, in fact, can provide effective behavior analysis services. Such could happen by the certifying organization allowing trainees to count large amounts of time in activities other than service delivery, while recognizing that some time for activities of that sort is necessary. Another level of threat to the adequacy of supervised experience involves the trainee's supervisor not being required to possess credentials reflecting their having the knowledge and skills necessary to adequately evaluate the trainee's activities as behavior analyst services, *per se*. A supervisor with license or credentials in another profession without also having credentials in behavior analysis is highly unlikely to be adequately prepared to supervise a trainee to competently and safely provide behavior analysis services. A trainee without adequate supervised experience represents a high risk of causing harm because, if licensed, that person, would provide inappropriate services or fail to provide needed services. Further, without sufficient supervision the person would likely act outside their scope of practice and scope of competence, resulting in inadequate referrals for services from other disciplines (e.g., physicians, speech language pathologists). The information to address this set of concerns should be readily available in the publicly available information provided by a certifying organization such as on its website. If the information is not readily available or what is available indicates that the requirements for supervised experience are inadequate, then one should proceed with great caution regarding whether that organization is operating openly and is likely to provide the best available protection for the public.

4. **Ensuring the results of certification examinations accurately reflect the knowledge of a candidate for certification and then licensure.** A crucial step in realizing that outcome is ensuring that the examination results of behavior reflect that a person having the knowledge of behavior analysis necessary to pass the examination, being certified, licensed as a behavior analyst, and then independently provide services to people. That is on contrast to someone obtaining a passing score fallaciously due to cheating in some manner while taking the test. Thus, information should be readily available regarding the conditions and monitoring of administration of the examination. That information should make clear that the person taking a test is directly monitored, preferably in person and not virtually in locations such as in the United States where staffed, secure testing centers are available. Examination administered solely virtually should be considered more vulnerable to results being affected by extraneous influences. Such influences could result in an examination score of a candidate being falsely inflated to the level of a passing score despite the fact that the persons lacks sufficient knowledge or has acted unethically. As a result, that person lacks knowledge regarding behavior analysis to criteria worthy of receiving a license to practice behavior analysis and is likely harm recipients of their services due to providing inappropriate services or failing to provide needed services. If information regarding the conditions and monitoring of examination administration is not readily available or what is available indicates that the requirements for examination are inadequate, then one should proceed with great caution regarding whether that organization is taking all reasonable precautions to ensure the validity of testing and of validity of examination results, information needed to determine whether the organization's certification is likely to provide the best available protection for the public.

5. **Exploring whether the certifying organization has and enforces a code of ethics for people that it certifies.** A code of ethics articulates in written form, expectations- including general principles- for how certificants are to interact with people and conduct themselves (e.g., honestly, within their scope of competence). The point of a code of ethics or conduct is to have standards by which behavior analysts are held accountable for their behavior. Persons violating the code very often behave in ways that harm the public in various ways

including physically, financially, emotionally. Just having a code of ethics or conduct by itself is not enough. If the certifying organization's code is aspirational, and is not accompanied by actions being taken when a violation is substantiated to correct the violator's inappropriate behavior or remove their certification and, thus, their authorization to provide behavior analysis services, then the public has much more limited protection from harm by behavior analysts acting unethically than they should and could have. Information should be readily available providing the code of ethics or conduct *and* regarding enforcement of the code, sanctions having actually been taken regarding certificants shown to have violated it. If the code is not presented or no information is provided clearly indicating that certificants violating the code have been experiencing and/ or will experience meaningful sanctions for doing so, then that certifying organization is falling short of what it could and should do to help protect the public from harm by behavior analysts acting unethically, allowing them to continue doing so and harming increasingly more people.

6. **Considering how certification decisions by an organization could facilitate financial gain accruing to private parties.** Certifying organizations that are nonprofit with their financial information readily available to the public seem less likely to tailor certification criteria and decisions in a manner that increases the likelihood of candidates being certified. Specifically, when the volume of certificants is accompanied by increased revenue for private parties, the certification criteria are likely to be adjusted be easily met, resulting in an accompanying increase in revenue due to the number of people applying for certification being increasing due to the criteria for gaining and maintain certification being considered relatively easy.

7. **Addressing whether the behavior analyst certifying organization is accredited by a nationally or internationally recognized organization that accredit organizations that issue professional credentials, a necessary but not sufficient factor for adequate protection of the public.** Such accreditation organizations have specific standards for credentialing organizations in various professions and industries. Those standards address numerous factors including, very broadly, the organization's governance, administration, clearly stated standards for its credentials (basis and development of them), assessment development and administration procedures, personnel matters, financial resources, financial management, quality assurance program, updating of standards, defensibility from challenges, and numerous other factors. In the United States two of the organizations most often accrediting organizations that provide professional credentials are the National Commission for Certifying Agencies (*NCCA*), the accrediting body of the Institute for Credentialing Excellence (ICE) and the American National Standards Institute (ANSI) and its subsidiary ANSI National Accreditation Board (ANAB). One of these organizations should accredit any behavior analyst certifying organization. That said, note should be taken that a certifying organization being certified does not ensure that it adequately addresses the issues raised above. Accreditation of a behavior analyst certification organization is necessary but in itself is not sufficient to ensure that a credential from it provides all the protection of the public that can and should be provided. The points above illustrate specific ways potential protection of the public can be optimized or limited by a behavior analyst certifying organization.

We would be happy to provide additional information and engage in discussion regarding this important issue of selecting what behavior analyst certifying organizations provide credentials suitable for being the foundation of behavior analyst licensure. My contact information is provided below.

Thank you for your consideration.

Gordon Bourland, PhD, BCBA-D, LBA

Gordon Bourland, Ph.D., BCBA-D, LBA
Chair, ABAI Licensing Committee

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P.O. Box 173486
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Association of

Professional Behavior Analysts

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MEMO

TO: William Harp, MD
Executive Director, Virginia Board of Medicine
william.harp@dhp.virginia.gov

Elaine Yeatts
Senior Policy Analyst, Virginia Department of Health Professions
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Pam Smith
Licensing Specialist, Virginia Board of Medicine
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Gina Green

FROM: Gina Green, PhD, BCBA-D
Chief Executive Officer, Association of Professional Behavior Analysts
Gina@apbahome.net

DATE: March 31, 2022

RE: Petition titled "Certification for licensure as practitioners of behavior analysis" filed 2/16/2022 and posted on Virginia Regulatory Townhall (www.townhall.virginia.gov)

Recently we learned of the above-referenced petition, which asks the Board of Medicine to revise the regulations governing licensure to practice behavior analysis professionally in Virginia "To remove the specific requirement for BACB [Behavior Analyst Certification Board] certification and accept certification from an entity that is nationally accredited to certify practitioners of behavior analysis." In response to the request for comments on that petition, I am writing on behalf of the Association of

Professional Behavior Analysts (APBA) to urge the Board of Medicine and the Advisory Board on Behavior Analysis to reject the petition because the requested changes contradict the laws and regulations for many of the professions that are regulated by the Board of Medicine and well-established practices in the credentialing of healthcare and human services professionals. That rationale is elaborated later. First, please allow me to provide some context and facts to address some of the disinformation that has been posted on the Regulatory Townhall site for the petition (https://townhall.virginia.gov/L/Comments.cfm?petitionid=359).

About APBA

- This organization is a 501(c)(6) nonprofit professional association incorporated in the District of Columbia. Its mission is to support and advance the science-based practice of applied behavior analysis (ABA). APBA is an autonomous organization, not an "arm," branch, subsidiary, or component of any other entity.
- Like many other professional associations, APBA advocates for public policies that affect its constituents. That includes but is not limited to laws to license or otherwise regulate practitioners of ABA. APBA is not, however, a "lobbying" firm or organization. Indeed, the organization has not paid for any professional lobbying services in its 14-year+ history thus far.
- The material on the "About Us" page at www.apbahome.net, including the information about the BACB (www.bacb.com) and the history of the profession, is factual and is well-documented in numerous articles in peer-reviewed professional journals and other professional outlets.
- Like most other professional associations, APBA collaborates with many nonprofit organizations on public policy, educational, and other endeavors. They include our Affiliate organizations, trade associations, consumer advocacy organizations, and the BACB, as appropriate. We also collaborate with legislators, regulators, service agency administrators, consumers, and other stakeholders on public policies affecting the practice of ABA. One relevant example is Virginia's behavior analyst licensure law.
- APBA publishes the Model Behavior Analyst Licensure Act. Like model licensure acts and licensure laws for most professions, it includes provisions for licensing individuals to practice the profession *generally*, without reference to any particular client populations, service recipients, settings, funding sources, etc. Accordingly, the model licensure act proposes that any certifying entity that is recognized in behavior analyst licensure laws or rules should credential individuals to practice ABA, full stop -- as opposed to, say, delivering some behavioral interventions to individuals who have a specific diagnosis or using just the subset of behavior analytic concepts and procedures that apply to serving a single client population. The BACB meets those and other important criteria (discussed later), so the APBA model act proposes to make current certification by the BACB the principal qualification for a state-issued license to practice ABA professionally. The basic rationale for that position is summarized in the model licensure act as follows:

  > Licensure requirements in many professions include completion of specified degrees, coursework, and supervised experiential training as well as passage of a valid and reliable professional examination in the subject matter. Those requirements are typically set by the profession, and are often derived from job analysis studies involving many members of the profession as well as input from experts in the subject matter, psychometrics, and applicable laws. The BACB's certification programs have all of those features and are accredited by the National Commission on Certifying Agencies, which means that the programs meet rigorous standards that are grounded in case law and best practices in professional credentialing.

Professional credentialing (certification and licensure) in healthcare and human services

The current Virginia behavior analyst licensure regulations specify

> **18VAC85-150-60. Licensure requirement.**
> An applicant for a license to practice as a behavior analyst or an assistant behavior analyst shall hold current certification as a BCBA® or a BCaBA® obtained by meeting qualifications and passage of the examination required for certification as a BCBA® or a BCaBA® by the BACB.

The Board of Medicine is urged to retain that regulation as written because it is consistent with the licensure laws and/or regulations of several other healthcare professions that are regulated by the Board, which specify that a certification issued by a national certifying entity is accepted or required for the state-issued license. A few examples are shown here:

Profession	Certifying Entity
Athletic Trainer	National Athletic Trainers' Association Board of Certification https://bocatc.org
Midwife	American Midwifery Certification Board https://www.amcbmidwife.org
Occupational Therapist, Occupational Therapist Assistant	National Board for Certification in Occupational Therapy https://www.nbcot.org
Physician Assistant	National Commission on Certification of Physician Assistants https://www.nccpa.net
Registered Surgical Technologist	National Board of Surgical Technology and Surgical Assisting https://www.nbstsa.org

Like the BACB, these certifying entities are independent **nonprofit** organizations, not privately held for-profit companies or components or subsidiaries of such companies. Some of these professional certifying entities have spun off of nonprofit professional associations, which is common. To my knowledge, none have spun off of, are operated by, or are subsidiaries of private for-profit companies or organizations. As you are no doubt aware, per IRS regulations, nonprofit (tax exempt) organizations must serve and be accountable to the public; have no owners, shareholders, or investors; and must use any surplus revenues to further their mission, i.e., to benefit the communities they serve.

The BACB and many other nonprofit professional certifying entities in healthcare and human services

- are governed by independent, volunteer boards composed mainly of certified members of the profession, with some consumer or other public members and in some cases, members of related professions;
- make their nonprofit status, board election procedures, bylaws, other governing policies, and standards transparent;
- set eligibility requirements for the certifications they issue as well as other standards for their certificants;
- have their certification programs accredited by the National Commission for Certifying Agencies (NCCA), which is the first entity to develop standards for accrediting professional certification programs in healthcare;
- work closely with nonprofit professional associations in their fields; and

- conduct, commission, and/or use profession-wide practice or job task analyses (JTAs) to identify the knowledge, skills, and abilities involved in practicing the profession (again *generally*, without restriction or reference to specific subsets of clients or other service recipients), and to determine the contents of the certification exams. The JTAs typically involve large numbers of subject matter experts and other credentialed members of the profession as well as experts in psychometrics. Results of JTAs may influence certification eligibility requirements (e.g., degrees, coursework, supervised practical training) and therefore the content of college and university courses and programs to prepare students for obtaining the certification (and often, state licensure). Most certifying entities repeat the JTA every few years and make detailed reports of the most recent JTAs and the resulting task lists or exam content outlines readily available in professional journals or other publications or on their websites. For examples, please see the following with respect to some of the certification entities that are incorporated in Board of Medicine licensure laws and/or regulations:
  - American Midwifery Certification Board JTA - https://www.amcbmidwife.org/docs/default-source/task-analysis/2017-task-analysis-report.pdf?sfvrsn=7aaa6e17_2
  - National Board for Certification in Occupational Therapy practice analysis for Occupational Therapist Registered - https://www.nbcot.org/-/media/NBCOT/PDFs/2017-Practice-Analysis-Executive-OTR.ashx?la=en&hash=42CC69FEB1F23F480B90A733E031DAEB5D5AD1FD
  - National Board for Certification in Occupational Therapy exam content outline for Occupational Therapist Registered - https://www.nbcot.org/-/media/NBCOT/PDFs/2017_OTR_Outline.ashx?la=en&hash=C6C7BA6D95DFF67A5D2396ABB4EEF65038E01585
  - National Board of Surgical Technology and Surgical Assisting job analysis for Certified Surgical Technologist – https://www.nbstsa.org/sites/nbstsa/files/pdf/2018%20NBSTSA%20CST%20JA%20Report%20-%20Summary2.pdf
  - National Board of Surgical Technology and Surgical Assisting exam content for Certified Surgical Technologist – https://www.nbstsa.org/sites/nbstsa/files/pdf/2021_CST_ContentOutline.pdf

The BACB has conducted several JTAs of the practice of ABA over the past 20+ years, using the same well-established procedures and standards as the other certifying entities cited earlier and many others. Reports of some of the BACB's JTAs have been published in peer-reviewed professional journals (see "BACB-Authored Publications about BACB Activity" at https://www.bacb.com/about/bacb-resources/); others have been published in BACB newsletters (e.g., see https://www.bacb.com/wp-content/uploads/2020/05/BACB_Newsletter_05_2011.pdf and https://www.bacb.com/wp-content/uploads/2020/05/January2017-newsletter-200828.pdf). The current task lists (certification exam content outlines) can be found at https://www.bacb.com/task-lists/. It is important to note that, like the task lists and exam outlines resulting from JTAs for most healthcare and human services professions, the BACB task lists make no mention of any client diagnoses, classifications, etc. Instead they describe the concepts, principles, and procedures involved in practicing ABA with *any* client or service recipient.

The characteristics of nonprofit certifying entities like those just described afford many important legal and other safeguards for certificants, consumers, employers, funders, and governments. That is likely

one reason the credentials they issue are accepted or required for licensure in healthcare and human services professions in many states. To take just one example, the National Board for Certification in Occupational Therapy states that its certifications are required for licensure in occupational therapy in all 50 U.S. states. Relatedly, the American Psychological Association's Criteria for the Recognition of Organizations that Provide Certifications in Specialties and Subspecialties in Professional Psychology has as its first criterion "The certifying body is a **non-profit** organization that has **published bylaws, standards, and procedures** and is governed by an **independent board of directors**, with specified procedures for selection and tenure of board members such that control does not rest with one individual or group of individuals indefinitely" (emphases added).

In sum, APBA advocates for current certification by the BACB to be the principal qualification for obtaining and maintaining state-issued licenses to practice ABA because the BACB has all the characteristics just described. That is, the BACB is an independent, nonprofit certifying organization that has long used well-established procedures and standards to (a) identify competencies for practicing ABA; (b) set educational and experiential training, ethical, and other standards; and (c) develop, evaluate, and manage psychometrically and legally validated professional examinations in the subject matter.

Evaluating certification programs in the practice of behavior analysis

At the behest of some state regulators, some of our Affiliate organizations, and others, in 2018 APBA developed Guidelines for Evaluating Credentials in the Practice of Applied Behavior Analysis. We respectfully offer them in case the Board of Medicine and Advisory Board on Behavior Analysis find them helpful for evaluating requests to revise the requirement for licensure in behavior analysis that is currently in regulation 18VAC85-150-60. With respect, we also offer the following suggestions for exercising due diligence with regard to companies that issue certifications in the practice of ABA that are purported to be "equivalent" to those issued by the BACB by reviewing information that is available through public sources:

- Check the company's website for information about key characteristics, including its for-profit or nonprofit status, mission, governing board and policies, operations, staff, history, relationship to other companies or organizations (may be embedded in the bios of board members and staff, job task analysis reports, or documents available from other sources; see below), reports of job task analyses, task lists or exam contents, eligibility requirements and how they are determined, other standards and how they are determined, accreditation of its certification programs, and the like.
- To check the nonprofit status of a company, search for its name at https://www.irs.gov/charities-non-profits/search-for-tax-exempt-organizations. If that search brings up the company's name, click on it to access information about it. Review documents such as annual tax returns (990s) for information like the name and address of the principal officer and the names of the company's officers, directors, trustees, and key employees.
- If the company is for-profit, try to find out who owns it and who benefits from the profits.
- If you know the state(s) in which the company is incorporated or doing business, you can probably find information about it by searching the website of the state agency that regulates business entities, such as the Secretary of State. (For instance, the California Secretary of State has a Business Search feature at https://businesssearch.sos.ca.gov. It allows you to search by corporation name, LP/LLC name, or entity number; you might have to search with more than one of those filters). If the company is found, you should be able to see what type of organization it is, the address, and the principal agent or owner. If available, peruse documents like the company's original registration and recent corporate filings for additional information.

- If the company has trademarked any titles, names, or brands, search for them in the trademark database of the U.S. Patent and Trademark Office, https://www.uspto.gov/trademarks/search. If the company is found, search the records on that site for information about the company's goods and services, the owner, and the address.
- If reports of job task analyses or exam content outlines can be obtained, compare the content with the corresponding BACB documents (most recent JTA report at https://www.bacb.com/wp-content/uploads/2020/05/January2017-newsletter-200828.pdf; current task lists [certification exam content outlines] at https://www.bacb.com/task-lists/). In particular, look for evidence that
  - the JTA pertained to the practice of professionals rather than paraprofessionals/technicians, and to the practice of ABA with any category of client or service recipient rather than just one or a few;
  - the characteristics and numbers of individuals to whom the JTA survey was sent and the subject matter experts involved indicate that they were representative of the profession as a whole;
  - the task list or exam content outline describes the entire array of concepts, principles, and procedures involved in practicing ABA professionally with any client or service recipient.

Thank you very much for considering this input. If we can provide additional information or answer any questions, please don't hesitate to ask.

cc: Virginia Association for Behavior Analysis – admin@virginiaaba.org

Barrett, Erin <erin.barrett@dhp.virginia.gov>

Fwd: BCBA Licensure Requirements

1 message

Harp, William <william.harp@dhp.virginia.gov> Wed, Apr 6, 2022 at 11:11 AM
To: Erin Barrett <erin.barrett@dhp.virginia.gov>

Here's another comment on the BA petition.

---------- Forwarded message ---------
From: **Ann Flippin** <ann.flippin@ascv.org>
Date: Wed, Apr 6, 2022 at 10:30 AM
Subject: BCBA Licensure Requirements
To: <william.harp@dhp.virginia.gov>

Dear Dr. Harp,

I am the Executive Director of the Autism Society of Virginia, a non-profit with a mission to support, empower, and build connections for our local autism community.

I have read and considered the proposed petition, and I disagree with the conclusion that the path to licensure as a behavior analyst in Virginia should be modified in the manner the petition describes.

The current process of certification by the BACB as a BCBA/BCaBA ensures that providers serve individuals with the highest quality of care and quality and mitigate the risk of harm. A shift to less strict requirements is a step in the wrong direction.

We advocate that current licensure requirements remain the same - only be conducted by the BACB at this time.

Sincerely,

Ann Flippin

Ann Flippin
Executive Director
Autism Society Central Virginia
8730 Stony Point Pkwy, Ste 150
Richmond, VA 23235
804-257-0192
ann.flippin@ascv.org
www.ascv.org

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Disclaimer: The Autism Society Central Virginia is a locally funded organization serving individuals with Autism Spectrum Disorders, their families and professionals who work with them in the greater metro Richmond area. All information provided is for informational purposes only. We do not promote or endorse any program, treatment or provider.

Note: If you are receiving this message in error or no longer wish to receive our emails, please reply to this email by typing in "Remove From List" in the subject line.

April 8, 2022

William L. Harp, M.D.
Executive Director
Board of Medicine
Virginia Department of Health Professions
9960 Mayland Drive, Suite 300
Henrico, VA 23233

Dear Dr. Harp,

I am writing in reference to the "Public Petition for Rulemaking: Certification for licensure as practitioners of behavior analysis." The post behavior and rhetoric on the public comment webpage has become quite incendiary and unprofessional, so I have opted not to communicate via the webpage. Instead of correcting the large number of misstatements about the BACB, I thought I would let you know that if you have any questions or concerns about the BACB or its activity you may send them directly to me at carr@bacb.com. We have worked with your board for a decade in the verification of BACB certificants for licensure applications and have found the relationship to be very productive. Please know that you may always contact me if we can be of assistance.

Sincerely,

James E. Carr, Ph.D., BCBA-D
Chief Executive Officer

cc: Erin Barrett, Senior Policy Analyst

Virginia Department of Health Professions,
Board of Medicine
Perimeter Center
9960 Maryland Drive, Suite 300
Henrico, Virginia 23233

Attention: William L. Harp, MD

RE: Public Petition for Rulemaking: Certification for Licensure as Practitioners of Behavioral Analysis

Dear Dr. Harp and Board Members,

I am writing to ask that you oppose this petition.

I am a practicing Board Certified Behavior Analyst (BCBA), and Licensed Behavior Analyst (LBA), by the Board of Medicine, and have spent the last 10 years of my career practicing in the State of Virginia, and nearly 15 years working with individuals with developmental disabilities using Applied Behavior Analysis (ABA). I am also a Professor of Ethics in the ABA Program at Capella University. I hold myself and other practitioners who hold the BCBA and LBA credentials to a high standard of upholding our ethical obligations to our clients, their families, and the field of behavior analysis. Additionally I am certified by the International Behavior Analysis Organization (IBAO) as an International Behavior Analyst (IBA). I qualified for that credential because of the existing BACB credential that I hold, and it was a matter of filling out an application and paying a fee, no additional coursework or clinical supervision hours were required.

I have serious concerns about the potential removal of the Behavior Analyst Certification Board (BACB) credential from law to qualify for the LBA credential in Virginia. While I am not opposed to other boards and credentialing bodies being considered in the future and added to the legislation, my request would be that for the protection of our clients and quality of service delivery that those standards be the same or higher as the BACB requirements currently in place. To reduce the standards would be detrimental to the quality of services being delivered in Virginia currently.

I also have concerns that the agency the petitioner is advocating as a qualifying credentialing board is itself not operating in an ethical manner. The BACB prohibits conflicts of interest and if conflicts exist, they should be clearly identified and mitigated. Any board added to the legislation should also be of non-profit status so their financial status and data are transparent to consumers, and so that no conflict of interest exists in any shareholders having financial gain over the number of certificates they certify.

LBA's in Virginia can work in a variety of service areas. I for one, work with children with histories of trauma and various developmental disabilities. Others can specialize in autism, behavioral gerontology, animal training, lactation consulting, and the list goes on. We are ethically bound to practice within our scope of competence, and under the supervision of a

qualified professional if we wish to expand our scope of practice. Isolating our licensure or allowing individuals with training in only one service category (i.e. autism) would also harm the field and our consumers, and cause confusion to individuals seeking services.

Not all data are created equal. The BACB is transparent about their demographic data, exam pass rates, university programs, and the process by which they continually task analyze and improve the standards that qualify for their credential. Any certifying body that the Board of Medicine considers to qualify for the LBA credential should have the same or an equally rigorous process.

I strongly suggest that the Board of Medicine demonstrate due diligence in investigating the rigor of other companies and organizations which are issuing credentials for behavior analytic practitioners, as the organization mentioned in this petition will likely not be the last to petition the Board of Medicine to qualify for a license in Virginia. I mentioned earlier that I am also certified by another certifying body, and that organization does not hold the same standards as the BACB. I would not feel comfortable with an LBA qualifying under the standards of the IBAO alone either.

In conclusion, reducing the standards would only harm consumers. If the Board of Medicine wishes to consider other organizations and certifying bodies, I encourage you to please hold them to the same standards that exist in our practice currently.

Best regards,

Katherine (Kitti) Robinson, EdD, BCBA-D, LBA, IBA

Children's Neurological Services
2114 Dabney Road
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(804) 673-9600
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(804) 436-2685

Dear Dr. Harp,

As a pediatric neurologist, I often refer my patients to Applied Behavior Analysis (ABA) Providers. It is important that providers that are licensed to practice ABA are rigorously qualified. I am not in favor of the petition to add any certifications to the regulations beyond those of the Behavior Analyst Certification Board (BACB) at this time. A license protects consumers and ensures that the provider is well-qualified to deliver the services for which s/he is licensed. Including certifications from an organization that is for-profit, non-transparent, focused on one diagnosis, and less rigorous than the current option would not be safe for the patients I refer. Please help protect consumers who receive ABA services by ensuring that licensed providers are well-qualified.

Sincerely,

Dr. Ronald David M.D.

Barrett, Erin <erin.barrett@dhp.virginia.gov>

Fwd: ANSI Comment for Petition Certification for licensure as practitioners of behavior analysis

1 message

Harp, William <william.harp@dhp.virginia.gov> Thu, Mar 31, 2022 at 4:07 PM
To: Erin Barrett <erin.barrett@dhp.virginia.gov>

HI Erin:

Here is a comment from the QABA Credentialing Board.

Thanks, WLH

---------- Forwarded message ---------
From: **Hollie Benincosa** <hbenincosa@qababoard.com>
Date: Thu, Mar 31, 2022 at 3:01 PM
Subject: ANSI Comment for Petition Certification for licensure as practitioners of behavior analysis
To: <william.harp@dhp.virginia.gov>

Hello Mr. Harp,

I wanted to share the public comment that was submitted by ANSI (ANAB). I believe you will find the comment very compelling.

Commenter: Vijay Krishna, ANSI National Accreditation Board

Comments from ANSI National Accreditation Board

Ref: Petition for Rulemaking: Certification for licensure as practitioners of behavior analysis: Regulations Governing the Practice of Behavior Analysis (18 VAC 85-150)

Dear Board Members,

As the Board considers the petition for certification for licensure as practitioners of behavior analysis, the ANSI National Accreditation Board (ANAB) would like to provide information relating to the international/national standard for assessing the competence of personnel certification bodies and the accompanying accreditation requirements.

The ANSI National Accreditation Board (ANAB) is an affiliate of the American National Standards Institute (ANSI) and the largest multi-disciplinary accreditation body in the western hemisphere, with more than 2,500 organizations accredited in approximately 80 countries. ANSI oversees the creation, promulgation, and use of thousands of norms and guidelines that directly affect businesses in nearly every sector: from acoustical devices to construction equipment, from roads and bridges to energy distribution, and healthcare. ANAB accredits personnel certification bodies based on the international standard ISO/IEC 17024: *Conformity assessment- Requirements for bodies operating certification of persons*. This standard is also adopted as an American National Standard. ANAB has accredited over 225 programs under this standard including several in the healthcare sector such as those offered by the American Board of Multiple Specialties in Podiatry, ASCP Board of Certification, Inteleos, Lymphology Association of North America, National Board of Certification in Occupational Therapy, ABRET Neurodiagnostic Credentialing and Accreditation, AONN Foundation for Learning, and Academy of Lactation Policy and Practice. A complete listing of all accredited programs can be found at https://anabpd.ansi.org/Accreditation/credentialing/personnel-certification/ALLdirectoryListing?menuID=2&prgID=201&statusID=4

The ANAB accreditation process – itself based on an international standard (ISO/IEC 17011: *Requirements for accreditation bodies accrediting conformity assessment bodies*) – is extremely rigorous and ensures that only those organizations that meet the stringent requirements under the standard are accredited. Independent third-party accreditation is an "accountability mechanism" to ensure the quality and legitimacy of organizations offering credentials. ANAB accreditation provides an added layer of legal defensibility against invalid claims. The accountability and transparency built into the ANAB process support conformity assessment attestations and can result in reduced liability insurance.

Benefits of Accrediting Credentialing Organizations to ISO/IEC 17024

Accreditation is a key component of an effective standardization system, assuring industry and governmental decision-makers that credentialing organizations are competent and their results can be trusted. The standard was developed by the International Organization for Standardization (ISO) based on the need for public protection by establishing that individuals have the required competencies to perform
their job. The standard has been recognized by several U.S. federal agencies as a critical requirement for personnel certification bodies that offer certification in areas related to public health, environment, and
national security. ANAB is a signatory to the International Accreditation Forum (IAF) Multilateral Recognition Arrangement for ISO/IEC 17024, which brings global acceptance of its accreditation program,

The following are the key requirements under the standard:

- **Credibility**: The certification examination must be fair, valid, and reliable. A valid test correctly measures whether an individual has the necessary competencies for the job. Validity is an indicator to establish that the process measures what is intended to measure. Exam reliability shows that the test measures a person's abilities in a consistent manner.
- **Impartiality**: The certification body should establish its structure, policies, and procedures to ensure impartiality and objectivity and manages conflict of interest arising from certification activities.
- **Independence**: The certification functions should be independent of training to ensure that confidentiality, information security, and impartiality are not compromised.
- **Transparency**: The certification body is required to have an active complaints process to resolve complaints against its activities as well as complaints against individuals that it has certified.
- **Accountability**: As per the standard, the certification body should have a due process for taking away the credential for unethical or incompetent behavior.
- **Balanced representation of stakeholders**: The standard requires that the certification body should involve key stakeholders in making certification-related decisions. Additionally, subject matter experts (SMEs) should be involved in creating the certification scheme requirement based on a valid job or practice analysis.
- **Certification scheme**: The standard requires a certification body to demonstrate that, in the development and review of the certification scheme the following are included:

a) the involvement of appropriate experts;
b) the use of an appropriate structure that fairly represents the interests of all parties significantly concerned, without any interest predominating;
c) the identification and alignment of prerequisites, if applicable, with the competence requirements;
d) the identification and alignment of the assessment mechanisms with the competence requirements;
e) a job or practice analysis that is conducted and updated to:

- identify the tasks for successful performance;
- identify the required competence for each task;
- identify prerequisites (if applicable);
- confirm the assessment mechanisms and examination content;
- identify the re-certification requirements and interval.

- **Other requirements**: The standard is very comprehensive and covers all aspects of certification including test security, recertification, resource requirement, confidentiality, the competence of personnel involved

with the certification activities, financial requirements, and use of certificates and logo marks. Further, the certification body should develop a management system for continual improvement of its certification program.

To ensure that the credentials they promote meet industry and quality standards, many federal and state agencies rely on ANAB accreditation. Some examples include:

- Virginia Department of Health as specified in 12VAC5-421-55 of the Virginia Food Regulations requires ANSI/ANAB accredited Certified Food Protection Manager (CFPM).
- ANAB's 17024 accreditation is the only program recognized by the U.S. Department of Defense (DoD) under DoD 8570 for Information Assurance.
- ANAB's 17024 accreditation program is recognized by the White House National Science and Technology Committee on Forensic Science as meeting the highest standard in accreditation.
- ANAB's 17024 accreditation is recognized by the U.S. Occupational Safety and Health Administration (OSHA) for crane operator certification and by New York, West Virginia, and California in licensing requirements for crane operators.
- ANAB's 17024 accreditation is a requirement for licensing of elevator inspectors in several states.
- ANAB's 17024 accreditation is recognized under the North American Securities Administrators Association (NASAA) model rule on the use of senior-specific certifications and professional designations.
- ANAB's 17024 accreditation is recognized by the U.S. Department of Energy (DOE) as the accreditor under the Better Building Workforce Guidelines.
- The U.S. Department of Health and Human Services selected ANAB as the approved accreditor for its Health Information Technology (HIT) Certification Program.

ANAB has accredited the QABA Credentialing Board under ISO/IEC 17024 for (a) Applied Behavior Analysis Technician, (b) Qualified Autism Services Practitioner- Supervisor (QASP-S) and Qualified Behavior Analyst (QBA). These programs have demonstrated compliance with the stringent requirements of the standard.

We support the petition to amend the regulation to accept certification from an entity that is nationally recognized to certify practitioners of behavior analysis. We recommend ANAB be recognized as an accreditation body for the licensing of Applied Behavior Analysis and the QABA certification programs accredited by ANAB be included in the licensing of Applied Behavior Analysis.

Please feel free to contact me for any additional questions or clarification.

Sincerely,

Vijay Krishna, MBA, ED.D.

Vice President, Credentialing
ANSI National Accreditation Board
1899, L Street Suite 1100, Washington DC 20036.

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Hollie Benincosa, MAFP

Executive Director
QABA Credentialing Board

Office: (877) 220-1839

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Website: qababoard.com . **Email:** hbenincosa@qababoard.com

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Barrett, Erin <erin.barrett@dhp.virginia.gov>

Behavior Analyst Board Petition

2 messages

Kate Lewis <k8lewis2013@gmail.com> Wed, Apr 13, 2022 at 9:32 AM
To: "Harp, William" <william.harp@dhp.virginia.gov>
Cc: erin.barrett@dhp.virginia.gov

Hi Dr. Harp,

I hope you are doing well. I am writing to you in concern about the current petition to the Board around removing the specific requirement for BACB certification and accepting certification from an entity that is nationally accredited to certify practitioners of behavior analysis.

I am highly concerned about this petition in regards to protecting our consumers. If this were to go through, then other credentialing entities that are not as rigorous as the BACB would be allowed to be licensed, making it even more confusing for consumers to identify quality providers. The fact that the agency making this petition is a for profit is also of great concern, due to the lack of transparency of a for profit versus a nonprofit. For profits, are just that, for profit, therefore they may change their criteria and standards based on what is in the best interest for the agency and not necessarily for the consumer. I'm also concerned that the agency making this petition certification is aligned specifically with autism services. Allowing this type of certification for licensure does not protect consumers of behavior analytic services. Not all consumers have a diagnosis of autism and thus those with this credential would not be qualified to serve them, which could lead to ineffective services.

I thank you for your time and consideration of my concerns.

Sincerely,
Kate Lewis

--
Kate Lewis, MS, BCBA, LBA
540-505-2486

Harp, William <william.harp@dhp.virginia.gov> Wed, Apr 13, 2022 at 9:43 AM
To: Kate Lewis <k8lewis2013@gmail.com>
Cc: Erin Barrett <erin.barrett@dhp.virginia.gov>

Thanks, Kate. Hope you and yours are doing well. WLH
[Quoted text hidden]

Barrett, Erin <erin.barrett@dhp.virginia.gov>

Petition: Certification for licensure as practitioners of behavior analysis

1 message

Justin Creech <justincreechpbc@gmail.com> Wed, Apr 13, 2022 at 7:59 AM
To: william.harp@dhp.virginia.gov, erin.barrett@dhp.virginia.gov

Good morning,

I'm writing to oppose the petition proposed by the petitioner of QABA as I do not believe it is in the public interest and will cause confusion for individuals seeking behavior analysis services. Furthermore, the BACB upholds rigorous standards which protects consumers. I feel we would be putting consumer safety at risk by adding QABA as a certification for licensure to practice behavior analysis.

Thank you for the opportunity to comment.

Justin

--
Justin Creech, MA, BCBA, LBA
BACB 1-18-29916
VA Licensed Behavior Analyst #0113001228

Barrett, Erin <erin.barrett@dhp.virginia.gov>

Alternate Certifications for Licensure of Behavior Analysts

1 message

Austin, Kira <kaustin2@rvaschools.net> Wed, Apr 13, 2022 at 2:37 PM
To: "erin.barrett@dhp.virginia.gov" <erin.barrett@dhp.virginia.gov>, "william.harp@dhp.virginia.gov" <william.harp@dhp.virginia.gov>

Good afternoon,

I am reaching out to express my concerns with the petition regarding alternate certifications under the umbrella for licensure for Behavior Analysts in Virginia.
Typically I would provide public comment, but it appears that the public comment forum has been overrun by personal attacks and misinformation. I cannot speak to the motivation behind this individual's actions, but I assure you, from an ethical and professional lens, it is not typical behavior of the Behavior Analysts I know in Virginia.

I have been a behavior analyst in Virginia since 2015 and have served in private day schools for students with disabilities, public schools as well as at the Virginia Department of Education Training and Technical Assistance Centers. Recently, VDOE in partnership with ODU created a network of Licensed Behaviors Analysts working in public schools. In spite of the fact that we have an Autism Center for Excellence, the decision to work with ODU was made in an effort to separate the practice of behavior analysis from becoming synonymous with autism. Yes, ABA has been shown to be effective treatment for students on the spectrum, but the science of behavior analysis has been shown to be effective in organizational management, addiction treatment, maintaining healthy lifestyles, and a vast array of other facets of human life.

While I am not writing on behalf of this network, I can share some information that we have learned from both my previous experiences as well as information gathered from our members, As we developed the network and gathered information needed to effectively support these professionals, we heard some common themes. Many were the only Behavior Analyst in their division and were seeking peer support to increase their capacity. Some did not feel that they were being utilized to their full extent within the division. Many were seen as "firefighters" who were expected to move from crisis to crisis to support teams after the student was already at risk for placement in a more restrictive environment.

Part of our work with this network has been to promote the use of Behavior Analysis in schools because we know that our skill set can improve teacher practice and ultimately outcomes for children. It is important, when promoting a practice, to have a level of quality control over the practice you are promoting. This not only benefits the practitioners, but ultimately, and more importantly benefits and protects the consumer.

Part of our effort has been to help school division leadership understand the potential impact that having Licensed Behavior Analysts on staff can bring, not just for students with disabilities, but for entire school divisions in developing capacity for supporting students in the least restrictive environment and supporting students with the most significantly challenging behavior. Behavior Analysts are uniquely qualified to address these needs and support schools because of the rigorous training and supervision requirements.

Licensure provides a level of protection to the consumer. When an individual is licensed by the state, it infers that the professional has met certain standards that have been developed, peer reviewed, and systematically updated and improved as the field advances and applications of the science change. In a field like behavior analysis, this often means our clients/students are some of the most vulnerable members of the population and should be afforded the most protection.

My concern with the current petition is that it would allow for-profit companies to enter the field without some of the protections that a not-for-profit organization would bring, therefore decreasing the level of consumer protection.
If alternative certifications are to be approved, those certifications should come from a non-profit that has established professional standards of practice, bylaws, standards and procedures. The organization should have an unpaid governing body of credentialed behavior analysts as well as consumers of behavior analytic practice, and be independent of other organizations in making decisions about the organizations credentialing program.

Offering licensure to private entities does not allow for the transparency and consumer protection afforded by nonprofits and puts consumers at risk. At any time, a company can be bought and sold to private equity or staffing firms whose driving force is profit, not supporting and protecting practitioners and consumers.

In short, I support the Virginia Association for Behavior Analysis's (VABA) Position on Credentials to Serve as Qualification for Licensure to Practice Behavior Analysis in Virginia.

Thank you for your time and consideration.

--

Kira Austin, PhD, BCBA, LBA
She/Her/Hers
Board Certified Behavior Analyst
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Barrett, Erin <erin.barrett@dhp.virginia.gov>

Please Oppose the Petition

1 message

Lisa Falke <lfalke@waynesboro.k12.va.us> Wed, Apr 13, 2022 at 10:07 AM
To: erin.barrett@dhp.virginia.gov, william.harp@dhp.virginia.gov

Hi!

I'd like to express my concerns about expanding the options for certification regarding behavior analysis. I have been practicing as a BCBA for 13 years. I have worked in multiple sectors across TX, WA, MA and VA and supervised other BCBAs and students. I have concerns about the discrepancy in requirements between certifying bodies and the deterioration in services that could occur by allowing less qualified, practiced or educated individuals to become licensed. The BACB, the current most prominent and long-standing certification body, has very stringent requirements for supervised hours, educational background and education criteria for certification in an effort to maintain quality. When you compare their qualifications for certification, they far outweigh those of other, newer certifying bodies. There is a big push to quickly create behavior analysts because of the great need for the specialty and profits that can be made by certifying bodies and I worry that speed and profits will be prioritized over quality of services provided if we lessen the criteria for certification and allow for other certifications. Please do not remove the requirement for board certification through the BACB. It is an important quality indicator that our field cannot lose. Yes, I want more families and children served, but I want them served well, with quality behavior analysis and practice. Behavior analysts have a huge impact and an important role in families' lives. If not done well, they can do a lot of damage and ruin the reputation of behavior analysis. Please help keep the quality of services high by opposing the petition to expand the options for certification outside the BACB. Thank you for your time.

Sincerely,
Lisa Falke, M.S. in Behavior Analysis, BCBA, LBA

Lisa Falke, M.S., BCBA, LBA
Pronouns: She/Her
Behavior Analyst
Waynesboro Public Schools
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(540) 946-4670 ext. 121
UVA Autism Drive: https://autismdrive.virginia.edu/#/home

PUBLIC COMMENT

TO: William Harp, MD
Executive Director, Virginia Board of Medicine
william.harp@dhp.virginia.gov

FROM: Shantel Pugliese, M.S., BCBA, LBA
Assistant Director
The Faison Center

DATE: April 13, 2022

RE: Public Petition for Rulemaking:
Certification for Licensure as Practitioners of Behavior Analysis

Dear Dr. Harp,

This petition was filed with the request "to remove the specific requirement for BACB certification and accept certification from an entity that is nationally accredited to certify practitioners of behavior analysis." As someone who was certified by the Behavior Analyst Certification Board (BACB) in 2012, became licensed to practice in Virginia in 2013, and is currently serving as Secretary on the Virginia Association for Behavior Analysis ("VABA") board of directors, I oppose the Petition.

The Petition proposed another credentialing organization, Qualified Applied Behavior Analysis ("QABA"), which does not meet the same standards that are adhered to by the BACB. First, the BACB is an independent 501(c)(3) nonprofit organization that provides **transparency** to its certificants as well as the general public. Some examples of how they provide transparency include, but are not limited to, 1) they maintain an updated certificant registry where consumers and other practitioners can find and *verify* a certificant's status, 2) they publish the total number of certificants per year as well as updated demographic data, 3) they conduct job analysis studies, share the results, and use the data to further refine the requirements toward certification, and 4) they maintain a thorough process for ethics violations, including a database that allows the public to search for certificants who have received disciplinary actions. At the time of this writing, I am not able to locate any similar information on the QABA Credentialing Board's website.

Second, the BACB provides **rigorous standards** for coursework and supervision required for certification. To become a Board Certified Behavior Analyst, the BACB requires *315 hours* of coursework in *behavior analysis*. Coursework must be completed in an accredited university degree program or a course sequence that has been verified by the Association for Behavior Analysts International (ABAI). The BACB's supervision standards require certificants to complete either *2000 hours* of supervision with *5%* of the hours directly supervised by an active Board Certified Behavior Analyst, or *1500 hours* with *10%* of the hours directly supervised. In contrast, to become a Qualified Behavior Analyst (QBA), the QABA Credentialing Board requires *270 hours* of coursework with a minimum of 20 hours in *autism core knowledge*. Coursework can be obtained by a provider approved by QABA and does not appear to require accreditation or an affiliation with a university. Additionally, the QABA's supervision standards

require one to complete *1500* hours with *5%* of the hours directly supervised by a QBA or "a licensed practitioner within the scope of ABA." Given this information alone, the standards set forth by the QABA credentialing board do not meet or compare to the standards set forth by the BACB.

Third, the BACB's standards for obtaining a credential are based in the field of **behavior analysis** and are not specific to one population. Practitioners who are certified by the BACB are then able to work with a multitude of populations. Many of my colleagues and peers work in various areas such as the juvenile justice system, behavioral pediatrics, behavioral medicine, and organizational behavior management. As stated in their mission, QABA's Credentialing Board provides certifications that are focused on one population (i.e., autism). The principles and concepts of behavior that make up the foundation of our field are intended to improve socially significant behavior across all individuals. If we limit the practice of behavior analysis to the field of autism, we will limit the impact licensed behavior analysts can make throughout the Commonwealth of Virginia.

It is for the reasons shared above that I oppose the Petition and believe that consumers in Virginia will be best protected by keeping the regulation as is and requiring only BACB Certification for licensure.

Sincerely,

Shantel Pugliese, M.S., BCBA, LBA

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April 13, 2022

Virginia Department of Health Professions,
Board of Medicine
Perimeter Center
9960 Maryland Drive, Suite 300
Henrico, Virginia 23233

Attention: William L. Harp, MD

RE: Public Petition for Rulemaking:
Certification for Licensure as Practitioners of Behavioral Analysis

Dear Dr. Harp:

We are writing in connection with the above-referenced petition, which requests the Board "[t]o remove the specific requirement for BACB [Behavior Analyst Certification Board] Certification and accept certification from an entity that is nationally accredited to certify practitioners of behavior analysis." The Virginia Association for Behavior Analysis ("VABA") opposes the Petition because it is not in the public interest and will likely cause confusion among individuals seeking applied behavior analysis services. VABA urges the Board to keep the current requirements in place without modification. The alternative credentialing program proposed by the petitioner — the Qualified Applied Behavior Analysis Credentialing Board ("QABA") – is not as rigorous as the programs currently required by Virginia law. The proposed credentialing program focuses on only a subset of behavior analysis practices and one population served by behavior analysts, and the proposed credentialing entity does not have the transparency and accountability of the BACB, the entity whose certifications are currently accepted as qualification for licensure to practice behavior analysis in Virginia. (see below).

VABA is a 501(c)(6) non-profit professional association organized in the Commonwealth of Virginia to promote and support the practice, research, and dissemination of behavior analysis throughout the Commonwealth. Its goals include strengthening the diversity and cultural competence within VABA and the behavior analysis profession across the Commonwealth and advocating for the science of behavior analysis in the Commonwealth.

18 VAC 85-150-60, which sets forth the current requirements for licensure of behavior analysts in Virginia, states:

18VAC85-150-60. Licensure requirement.

An applicant for a license to practice as a behavior analyst or an assistant behavior analyst shall hold current certification as a BCBA® or a BCaBA® obtained

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Dallas Reynolds, *Student Member Rep.*

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by meeting qualifications and passage of the examination required for certification as a BCBA® or a BCaBA® by the BACB.

That Board of Medicine regulation requires applicants for licensure to meet the qualifications established by and pass the examination required by BACB. The BACB is an independent non-profit corporation organized under Section 5.01(c)(3) of the United States Internal Revenue Code for the specific purpose of credentialing behavior analysts, including establishing educational and experiential standards for behavior analysis and serving to protect the public through the provisions of standards for the practice of behavior analysis. The BACB's certification programs are accredited by the National Commission for Certifying Agencies ("NCCA"), the accreditation body of the Institute for Credentialing Excellence. NCCA's standards for the accreditation of certification programs were the first standards developed for professional certification programs to help ensure the health, welfare, and safety of the public. The Petition seeks to revoke that requirement and have the Board of Medicine accept certifications issued by the QABA Board as qualification for licensure or other unspecified organizations.

As set forth in the attached "Position on Credentials to serve as Qualification for Licensure to Practice Behavior Analysis in Virginia," (Exhibit A) VABA believes the credentials issued by the BACB should remain the only certifications that are accepted as qualification, at this time, for licensure to practice behavior analysis in the Commonwealth because (i) the BACB's stated mission is to protect consumers of behavior analysis services; (ii) the BACB's governance structure -- including its bylaws, policies, and procedures -- is transparent and readily available to regulators and the general public; and (iii) in setting the eligibility requirements and contents of the examinations required to obtain its certifications, the BACB has used the same standards and procedures as most professions, and its certification requirements (degrees, coursework in the subject matter, passage of a professional examination in the subject matter) parallel requirements for licensure in many professions. As with other professions, the BACB certifications are in the practice of behavior analysis with any clients or service recipients. At present there is no other entity that operates certification programs in the practice of behavior analysis that are equivalent or comparable to the BACB's programs.

Unlike the BACB and the certifying entities whose credentials are accepted as qualification for licensure in several other professions regulated by the Board of Medicine, the QABA Board is not an independent nonprofit organization; rather, it appears to be operated under the auspices of a privately held for-profit autism services company, though that is not disclosed on its website or in its materials. Although the names of QABA board members are published on its website, neither its ownership, structure, governing policies, nor detailed procedures it followed to determine the eligibility and other requirements for obtaining its certifications are readily available publicly, and its certification programs are not accredited by the NCCA. Information on its website shows clearly that the certifications issued by the QABA Board are in autism intervention.

In addition to the manner in which the two organizations are structured, the standards established by the BACB for obtaining and maintaining its certifications are substantially more

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rigorous than those imposed by QABA. The BACB requires applicants for certification to complete specific coursework in the full array of concepts, principles, and procedures involved in the practice of behavior analysis, either as part of a graduate program accredited by the nonprofit Association for Behavior Analysis International ("ABAI") or a course sequence that has been verified by ABAI to meet BACB certification coursework requirements. In contrast, QABA accepts "coursework" from non-university sources that are not accredited by any professional association or other accrediting body. Additionally, course content in areas other than behavior analysis is required. For example, 20 of a required 270 hours of approved coursework is specific to autism. The BACB also requires significantly more supervised practical training in behavior analysis than does QABA. A comparison of QABA and BACB certification requirements and organizational structures and operations is attached to this letter (Exhibit B).

Consistent with its mission to serve behavior analysts in Virginia and to support and protect the public, VABA opposes the Petition and believes the public is best served by keeping 18 VAC 85-150-60 as is, i.e., maintaining the BACB as qualification for licensure for behavior analysts and assistant behavior analysts in Virginia, as no other organization meets the standards expressed in this letter at this time.

Please contact Christy at admin@virginiaaba.org or 804-723-1182 with any questions.

Very truly yours,

Ting Bentley, BCBA, LBA
At-large Representative, VABA

Justin Creech, BCBA, LBA
Committee Member, VABA

Christine D. Evanko, BCBA, LBA
Administrative Director, VABA

Einar Ingvarsson, BCBA, LBA
Committee Member, VABA

Elizabeth Matthews, BCBA, LBA
At-large Representative, VABA

Eli Newcomb, BCBA, LBA
Committee Member, VABA

Brian Phelps, BCBA, LBA
Committee Member, VABA

Shantel Pugliese, BCBA. LBA
Secretary, VABA

Dr. Amanda Randall, BCBA-D, LBA
President, VABA

Dallas Reynolds
Student Representative, VABA

Dr. Katherine Robinson, BCBA-D, LBA
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Position on Credentials to Serve as Qualification for Licensure to Practice Behavior Analysis in Virginia

The Virginia Association for Behavior Analysis (VABA or VirginiaABA) is the professional organization for behavior analysts in the Commonwealth of Virginia. Based on best practices in professional credentialing as well as our profession's ethical and practice standards, it is VABA's position that certifications and other credentials should be accepted as evidence of qualification for licensure to practice behavior analysis in this state only if they are issued by a non-profit credentialing organization that has all of the following features and safeguards:

- A mission to protect consumers of behavior analysis services by establishing professional standards of practice
- Published, publicly available bylaws, standards, and procedures
- A governing body (typically a Board of Directors) whose voting members are
    - Unpaid
    - Credentialed (certified and/or licensed) behavior analysts representing the range of practitioners in the field and 1-2 consumers of behavior analytic services
    - Selected or elected in accordance with procedures specified in the bylaws
    - Independent of any other organizations or entities in making decisions about the organization's credentialing programs
- Key leadership personnel who are credentialed professional behavior analysts
- A well-established track record in managing credentialing programs for practitioners of behavior analysis
- Credentialing programs that are accredited by the National Commission for Certifying Agencies (NCCA) of the Institute for Credentialing Excellence or American National Standards Institute. Accreditation by the NCCA is preferred because that organization
    - Was the first to develop standards for professional certification programs
    - From its inception in 1977, designed its standards to (a) ensure the health, welfare, and safety of the public; (b) to be consistent with the Standards for Educational and Psychological Testing; and (c) to be applicable to all professions and industries
    - Requires certifying bodies to demonstrate that they are free of undue influence from any other body and are autonomous in making decisions about certification activities
    - has been accrediting professional credentialing programs in behavior analysis and similar professions for many years.
- Requirements and standards for each credential that have been derived from job (or occupational) analysis studies that

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- Involved subject matter experts in behavior analysis and psychometrics (test construction) and large numbers of practitioners of behavior analysis
- Were designed to identify the knowledge, skills, and abilities (KSAs) required to practice behavior analysis generally, not with any specific client or service recipient population(s) or in any specific settings
- Were conducted in accordance with standards and procedures that are widely accepted and followed by other similar professions
- Resulted in a comprehensive list of KSAs (often called a task list) that is publicly available
- Are published and available to the public

- Credentialing requirements set by the organization's governing body that include
  - Completion of a degree or degrees
  - Successful completion of specified coursework in behavior analysis
  - Successful completion of specified experiential training in delivering behavior analytic services to clients under the supervision of credentialed professional behavior analysts
  - Passage of an objective, valid, and reliable professional examination in behavior analysis that is derived from the applicable job analysis study and managed in ways that assure the security of exam items, administrations, and results
  - Continuing education in behavior analysis to maintain the credential
  - Adherence to ethical and disciplinary standards that have been developed by professional behavior analysts, are publicly available, and are enforced by the organization in accordance with publicly available procedures

The Behavior Analyst Certification Board (BACB) meets all of the foregoing criteria. It has been operating programs to credential practitioners of behavior analysis since 1998 and has conducted and published several job analysis studies. Its programs to certify practitioners at the paraprofessional, bachelor's-degree assistant, and advanced-degree independent practitioner levels are accredited by the NCCA. At present the BACB is the only entity with accredited programs for credentialing individuals to practice behavior analysis generally, without limitation or reference to any specific population(s) of service recipients, settings, funding sources, or the like. Those features as well as the requirements for the assistant and independent professional credentials parallel requirements for licensure in many other professions. The credentials issued by the BACB therefore constitute sound, legally defensible qualifications for licensure to practice behavior analysis professionally in this state.

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Association of Professional Behavior Analysts (2018). *Guidelines for evaluating credentials in the practice of applied behavior analysis.* *https://cdn.ymaws.com/www.apbahome.net/resource/collection/1FDDBDD2-5CAF-4B2A-AB3F-DAE5E72111BF/APBA_Guidelines_EvaluatingCredentials_180906.pdf*

Behavior Analyst Certification Board. www.bacb.com

Institute for Credentialing Excellence (2010). *Defining features of quality certification and assessment-based certificate programs.* Available for downloading at *https://www.credentialingexcellence.org/page/certificate-vs-certification*

NCCA Accreditation. https://www.credentialingexcellence.org/page/ncca

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Comparison of Certifications Issued by Behavior Analyst Certification Board and Qualified Applied Behavior Analysis Credentialing Board

Certifying body	Behavior Analyst Certification Board (BACB; bacb.com)	Qualified Applied Behavior Analysis (QABA) Credentialing Board (qababoard.com)
Type of organization	Independent 501(c)(3) **nonprofit** https://www.bacb.com/about/	Not shown on website, which describes the entity as an "agency" with an address in Utah (https://qababoard.com/about/). No organization by that or a similar name comes up in a search of the Utah Division of Corporations and Commercial Code Business Search (https://secure.utah.gov/bes/index.html). A search for Qualified Applied Behavior Analysis Credentialing Board in the US Patent and Trademark Office trademark database (https://www.uspto.gov/trademarks/search) reveals that the owner is Elevated Autism Services Team, LLC with a California address. A search for that company on the CA Secretary of State Business Search reveals that it is a private, **for-profit** out-of-state Limited Liability Corporation. Recent filings show an agent, but the owner is not identified.
Structure and functions of governing board	Volunteer Board of Directors, elected by certificants in accordance with **bylaws published on website**. Currently 10 Directors are credentialed practitioners of behavior analysis; 1 is a consumer. https://www.bacb.com/about/bacb-governance/	Board of Directors shown on website have a variety of backgrounds. **No bylaws or other policies governing election, selection, or operations of the Board are available** on the site. https://qababoard.com/leadership/
Certification for individuals with at least a master's degree	Board Certified Behavior Analyst® (BCBA®) https://www.bacb.com/bcba/	Qualified Behavior Analyst (QBA)
Certification program accredited by	National Commission for Certifying Agencies (**NCCA**) https://www.bacb.com/about/#Accreditation	American National Standards Institute (ANSI) National Accreditation Board (**ANAB**) https://qababoard.com/about/

Report of recent job or occupational analysis study for this certification	https://www.bacb.com/wp-content/uploads/2020/05/January2017-newsletter-200828.pdf Also see published reports of previous studies at https://www.bacb.com/about/bacb-resources/	**Not found** on website or in publications
Task list/exam content for this certification	https://www.bacb.com/wp-content/uploads/2020/08/BCBA-task-list-5th-ed-211019.pdf	**Not found** on website
Current certification eligibility requirements		
1. Education	Four pathways: (1) degree from a master's or doctoral program accredited by the Association for Behavior Analysis International (ABAI) + supervised fieldwork in behavior analysis; or (2) graduate degree from an institution in the US that is listed in the Council for Higher Education Accreditation database or institutions outside the US whose degrees meet certain requirements + coursework and supervised fieldwork in behavior analysis; or (3) graduate degree from an institution in the US that is listed in the Council for Higher Education Accreditation database or institutions outside the US whose degrees meet certain requirements + at least 3 years in a full-time faculty position in behavior analysis + supervised fieldwork in behavior analysis; or (4) doctoral degree conferred at least 10 years ago from an institution in the US that is listed in the Council for Higher Education Accreditation database or institutions outside the US whose degrees meet certain requirements + at least 10 years of postdoctoral experience in behavior analysis + 500 hours of supervised fieldwork in behavior analysis.	Minimum of a master's or higher degree from an accredited university for higher education.
2. Coursework	**315** hours of coursework in behavior analysis, not specific to any client population(s), setting(s), etc. Course content must cover (a) BACB Ethics Code and Code-Enforcement System; Professionalism; (b) Philosophical Underpinnings; Concepts and Principles;	**270** hours or 18 semester credits of coursework in ABA, psychology, special education, or a related field, including 8 hours of "supervision coursework." Minimum of 5 hours must be in ethics and minimum of 20 hours must be in autism core knowledge. Other content

	(c) Measurement, Data Display, and Interpretation; Experimental Design; (d) Behavior Assessment; (e) Behavior-Change Procedures: Selecting and Implementing Interventions; and (f) Personnel Supervision and Management. Coursework must be completed in an ABAI-accredited university degree program, an ABAI Verified Course Sequence, or via other university courses approved by the BACB.	areas are Legal, Ethical and Professional Considerations; Core Principles of ABA; Antecedent Interventions; Skill Acquisition; Behavior Reduction; Data Collection Analysis; Assessment; Training and Supervision https://qababoard.com/qualified-behavior-analyst-credential/ https://qababoard.com/wp-content/uploads/QBA-Competencies-Worksheet-January-2022.pdf Coursework may be obtained from providers approved by QABA, which include a mix of private companies, some behavior analysis organizations, and some universities. No information about accreditation of those providers, degree programs, or courses by an external 3rd party could be found on the website.
3. Supervised fieldwork	For education pathways 1 – 3, **2000 hours with 5% oversight** or **1500 hours with 10% oversight**. For pathway 4 (doctoral degree), 500 hours. Supervisor must be either (a) an active BCBA without current disciplinary sanctions who has been certified for at least one year and meets an ongoing supervision CEU requirement; or (b) an active BCBA without current disciplinary sanctions who has been certified for less than one year and is receiving consultation on a monthly basis from a qualified consulting supervisor; or (c) a licensed or registered psychologist certified by the American Board of Professional Psychology in Behavioral and Cognitive Psychology who was tested in applied behavior analysis; or (d) an authorized Verified Course Sequence instructor. All supervisors must complete	**1500 hours with 5% oversight.** 900 hours must be in "supervisory role or program development. "Up to 600 hours may be 1:1 direct care, but direct care hours are not necessary…" (https://qababoard.com/wp-content/uploads/QBA-Supervision-Log-January-2022.pdf). Supervisor may be a QBA, "Certified Behavior Analyst from an accredited certifying body," or "…a licensed practitioner within the scope of ABA" (https://qababoard.com/qualified-behavior-analyst-credential/).

	an 8-hour supervision training before supervising fieldwork for candidates. For additional details (e.g., acceptable supervision activities, documentation requirements), see https://www.bacb.com/supervision-and-training/	
4. Examination	Pass computer-based exam in behavior analysis administered and proctored by Pearson VUE at secure testing centers. The exam comprises **185** multiple-choice questions, 10 of which are unscored.. Candidates have 4 hours to complete the examination. Content areas examined are outlined in the job task analysis cited above and mirror those listed under Coursework above. For additional information, see https://www.bacb.com/examination-information/	Pass exam taken in applicant's home or work place on their computer, proctored by Examity. The examination consists of **125** questions. 100 questions are live and scored; 25 pretest questions are not scored. Candidates have 3 hours to complete the exam. https://qababoard.com/taking-examinations/
5. Continuing education required to renew certification	32 continuing education units (CEUs) issued by BACB- authorized providers each 2-year recertification cycle. Must include 4 CEUs in ethics and for approved supervisors, 3 CEUs in supervision. Requirements for authorized CE providers are at https://www.bacb.com/authorized-continuing-education-providers/	32 CEUs issued by approved or non-preapproved providers (presenters in a "related field") each 2-year recertification cycle. A minimum of 3 hours must be in ethics. https://qababoard.com/renewal/ Requirements for approved CE providers are at https://qababoard.com/become-an-approved-continuing-education-provider/
Ethics and disciplinary procedures	All BCBAs must comply with the Ethics Code for Behavior Analysts. That code and enforcement procedures can be found at https://www.bacb.com/wp-content/uploads/2020/08/BCBA-task-list-5th-ed-211019.pdf. Disciplinary actions taken by the BACB are posted at https://www.bacb.com/wp-content/uploads/2020/08/BCBA-task-list-5th-ed-211019.pdf A history of the development of the Ethics Code and extensive resources are available at	Must agree to work under QABA Code of Ethics https://qababoard.com/qualified-behavior-analyst-credential/ https://qababoard.com/wp-content/uploads/Code-of-Ethics-03-25-21.pdf No information about disciplinary actions taken by the QABA Board or the development of its code of ethics could be found on the website.

	https://www.bacb.com/ethics-information/ethics-resources/	
Details provided in	BCBA® Handbook https://www.bacb.com/wp-content/uploads/2022/01/BCBAHandbook_220110.pdf	https://qababoard.com/wp-content/uploads/QBA-Candidate-Handbook-March-2022.pdf

PUBLIC COMMENT

TO: William Harp, MD
Executive Director, Virginia Board of Medicine
william.harp@dhp.virginia.gov

Erin Barrett
Senior Policy Analyst
erin.barrett@dhp.virginia.gov

FROM: Eli Newcomb, M.Ed., LBA, BCBA
Director of Education & Research
The Faison Center

DATE: April 11, 2022

RE: Petition titled "Certification for licensure as practitioners of behavior analysis" filed 2/16/2022 and posted on Virginia Regulatory Townhall:
https://townhall.virginia.gov/l/viewpetition.cfm?petitionid=359

In response to the petition surrounding requirements for licensure as a behavior analyst, I am in touch to recommend the Virginia Board of Medicine vote against this petition, for reasons I will outline below. First, some brief background information and context:

I was one of the (4) behavior analyst members of the workgroup convened to assist this very board in developing regulations for the licensing of behavior analysts in Virginia, per HB 1106 in 2012. At that time, our workgroup was in receipt of considerable input, including a few points of contention, none of which are material to this petition. Of note, however, is that the specific inclusion of the Behavior Analyst Certification Board® (BACB) was not one of the sources of contention. To the best of my knowledge, other bodies certifying behavior analysts did not come along until 2012/2013, a couple of which I am aware of at present.

In addition to my work in Virginia—in the areas of specialized education, autism and intellectual disabilities, and behavioral research I would also bring to your attention that I was elected by my peers to the BACB's Board of Directors and served a three-year term spanning 2016-2019. I have also served as a volunteer Subject Matter Expert for the BACB. I share this for two reasons: (1) disclosure of such relationships, potential conflicts of interest, etc. are considered best practice within my field, along with many other fields; (2) this process, including stakeholders, should be promoting transparency and for reasons I will outline later, lack of transparency is one of my primary concerns with this petition.

My four concerns with the petition are as follows:

(1) The licensing of a subspecialty is problematic: My profession is comprised of multiple subspecialties such as Autism and Intellectual/Developmental Disabilities, Behavioral Gerontology, Behavioral Pediatrics, Behavior Analysis in Sports, Brain Injury Rehabilitation, Clinical Behavior Analysis, Education, Health and Fitness, Organizational

Behavior Management, Prevention/Intervention in Child Maltreatment, Sustainability, and the Treatment of Substance Use Disorder. In performing research related to the merits of this petition I became more familiar with two other accredited entities that credential behavior analysts. The first is the *Behavioral Intervention Certification Council* (BICC) and the second is the *Qualified Applied Behavior Analyst Certification Board* (QABA).

In referencing BICC's website, "The mission of BICC is to enhance public protection by developing and administering a certification program consistent with the needs of behavior analysts to recognize individuals who are qualified to treat the deficits and behaviors associated with **autism spectrum disorder** [emphasis added] using the principles and procedures of applied behavior analysis." Similarly, the stated mission of QABA reads as follows: "The Qualified Applied Behavior Analysis Credentialing Board (QABA) is an agency whose mission is to establish the highest standard of care and empower all professionals who provide behavioral intervention services **to individuals with autism spectrum disorders and related disabilities** [emphasis added]. Through access, transparency, and dedication to best practice, QABA provides all communities opportunity for consistent high-level care."

I believe the Board of Medicine would encounter tremendous administrative difficulties as ambiguity with practice oversight if it were to license a broad discipline when certification in one subspecialty becomes accepted. While there may be exceptions, I am not aware of professions within healthcare or human services in which narrow certification allows for a path to broad licensure. Furthermore, I believe that such an allowance for the licensing of behavior analysts in Virginia would have detrimental effects to our discipline overall and, more importantly, the protection of consumers.

(2) Standards of other credentialing boards **do not** appear to meet or exceed what we currently have through the Behavior Analyst Certification Board. Given QABA appears to be promoting this petition, I will cite just a few comparative examples between them and current/BACB standards and regarding the master's level credentials:

a. The required coursework hours are approximately 17% greater with the BACB's credential (315 hours vs. 270).
b. While the BACB requires a candidate's coursework to be taken through a verified university sequence or accredited university program (both through the *Association for Behavior Analysis International*), I have been unsuccessful in locating a similar or parallel process with QABA.
c. Regarding the coursework hours themselves, the BACB requires these to be behavior analytic and according to QABA's website, they also accept "...psychology, special education, or a related field" within the 270 required hours.
d. The BACB's requirements for supervised fieldwork hours are 33% greater (2000 hours vs. 1500).
e. For test security, the BACB administers examinations to BCBA and BCaBA candidates **in-person** using *Pearson VUE*. In contrast, QABA administers examinations in the candidate's home using *Examity*, which I speculate is less secure.

(3) Entities certifying behavior analysts must have the controls we can rely on through non-profit status and for-profit alternatives come at the cost of transparency. There are several reasons I remain committed to keeping non-profit status a mainstay in behavior analysis credentialing; here are what I view to represent the most crucial:

   a. Unlike non-profit entities whose revenue is reinvested into the interests and mission of the company, for-profit entities are designed to generate profits for the owners, investors, and, when applicable, shareholders. It is of great concern to me when revenue rather than consumer protection is the first priority.
   b. Ownership may be unknown, difficult to determine, or ambiguous. When this is the case, potential conflicts of interest are difficult to determine and/or may not be disclosed. For instance, what if the owner of a for-profit credentialing company simultaneously owns or has a leadership position in a human service company that employs and must regularly hire new behavior analysts?
   c. The BOM and the general public will not be able to appraise what ownership's motivations are and whether they are in the best interest of consumers and our profession.
   d. The BOM and the general public will be unaware of any future sale of the for-profit entity, to whom, and what future ownership's interests are.
   e. For-profit status of certification boards within medicine, allied health professions, and human services is highly unusual and uncustomary. Behavior analysis is a growing field and I see no reason to deviate from this norm.
   f. For-profit entities do not promote the same level of transparency we minimally expect from non-profit counterparts. There is no clearer example I can provide than to use this very petition and related town hall commentary to exemplify this point:
      i. For as I performed my own research on QABA, I became aware that multiple QABA board members and the owner were promoting their alternative certification without any mention or acknowledgement of their affiliation, relationship, etc. The disclosure of such relationships and potential conflicts of interest is considered best practice within my field, along with many other fields. Why keep this information from the public?
      ii. In addition, I also become aware that the petitioner recently founded and/or holds the title of Executive Director at a new certification company called the "Global Institute for Behavior Practitioners and Examiners." This company appears to have multiple aims, one of which is to, "Certify individuals in specialty areas of the behavioral sciences." This, again, points to a concerning lack of transparency and causes me to wonder about motivations and what consumer protections may be jeopardized if this petition were not opposed by the BOM.

(4) Approving the petition and changing the regulation offers little or no benefit to balance the three costs outlined above. What are potential benefits? More providers for consumers who need behavior analytic services.

As with many other states in the U.S., the demand for licensed behavior analysts in Virginia remains high. The BACB continues to certify new professionals at a high rate

and the number of licensed behavior analysts and licensed assistant behavior analysts in Virginia now far exceeds 1,900. In contrast, there are very few QABA certified professionals in Virginia that would be eligible for a license. Recently I searched the QABA certificant registry and observed that there were 53 QABA certificants residing in Virginia. Forty-seven of the 53 were expired (most several years ago). Of the six holding active certifications, three were technicians, therefore only the remaining 3 would be eligible for a license if this petition were approved by the BOM. Amid multiple, serious concerns, it seems that the net benefit to the Virginia consumer base would be three new licensed behavior analysts in a pool nearing 2,000.

Lastly, when our workgroup was set to the task of drafting regulations—a decade ago—and when I recently reoriented myself to the statute, I was reminded that the word "or" rather than "and" was used in reference to the certifying entity. The section I am referring to reads as follows:

> *"B. The Board shall establish criteria for licensure as a behavior analyst, which shall include, but not be limited to, the following: 1. Documentation that the applicant is currently certified as a Board Certified Behavior Analyst by the Behavior Analyst Certification Board* ***or*** [emphasis added] *any other entity that is nationally accredited to certify practitioners of behavior analysis…"*

From my point of view, the last decade of licensing behavior analysts in Virginia has been successful. We need a reputable, high quality, and accountable certifying entity—and we have one. We do not need multiple entities and the statute does not require it of the BOM. For all of these reasons, I respectfully ask the Board of Medicine to retain that regulation as written and vote against this petition. Thank you for your consideration of these points and my input.

Yeatts, Elaine <elaine.yeatts@dhp.virginia.gov>

VABA position paper in response to petitioner

2 messages

John Salay <john.salay@familyinsight.net> Mon, Mar 21, 2022 at 4:06 PM
To: "Yeatts, Elaine J. (DHP)" <Elaine.Yeatts@dhp.virginia.gov>

Hi Elaine,
I hope you are doing well. I was told that you were accepting correspondence in regards to the petition pasted below because of the personal nature of the petitioner's rebuttal comments. If not, please let me know and I will post this. Family Insight, as one of the largest providers of ABA services in VA, strongly supports the attached VABA position paper. If the petition is successful, it will be very disruptive and work against the board's mission to serve and protect the public.
Best regards,

Public Petition for Rulemaking: Certification for licensure as practitioners of behavior analysis

View petition details

◆ **In Progress!** Opened on **3/14/2022** and closes at 11:59pm on **4/13/2022**

John Salay, LCSW

Chief Compliance Officer
Director of Government Affairs and Advocacy

cell: 804-405-6055
fax: 804-658-4255

2820 Waterford Lake Drive
Suite 102
Midlothian, VA 23112

Credentials for Licensure Position Statement.docx
28K

Yeatts, Elaine <elaine.yeatts@dhp.virginia.gov> Mon, Mar 21, 2022 at 4:13 PM
To: John Salay <john.salay@familyinsight.net>

John

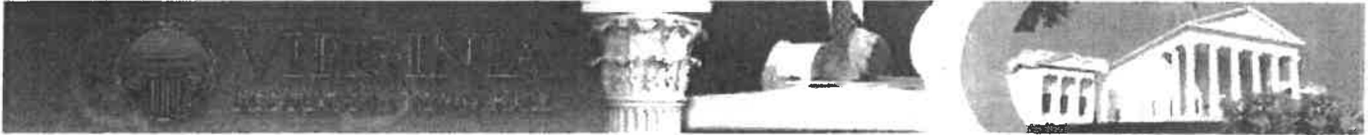
Thank you for the comment. It will be included with comments given to the Board.

[Quoted text hidden]

--

Elaine J. Yeatts
Senior Policy Analyst
Department of Health Professions
(804) 367-4688

Agencies | Governor



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Department of Health Professions

Board of Medicine

Regulations Governing the Practice of Behavior Analysis [18 VAC 85 - 150]

123 comments

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Commenter: Anonymous 3/16/22 1:11 pm

Include QABA Credentialing parallel to the BACB

The Qualified Applied Behavior Analysis Credentialing Board (QABA) has international accreditation through the American National Standards Institute (ANSI), the golden standard for accreditation.

I agree with the amended language to state that a "certifying body is an entity nationally accredited by ANSI or the NCCA". Many other states have this included in their language including New Jersey, Texas, and others. If you include the name and certifications of the BACB, then QABA and its certifications should be named too, to prevent a monopoly.

QABA certifications and exams have gone through psychometric processes after being created by subject matter experts. Annual analyses of these exams are performed by a psychometrician to confirm reliability and validity. A rigorous annual surveillance (audit) is performed by ANSI to confirm QABA continues to meet the standards for continued accreditation.

CommentID: **120781**

Commenter: Autism Business Association 3/16/22 1:58 pm

We support equal and fair criteria for ABA licensing

Greetings, I am the executive director of the non profit called the Autism Business Association that represents ABA providers nationally and we strongly support providers using accredited certifications with the BACB and QABA Board. National Accreditation is a fair and equally rigorous criteria which is recognized in most state licensing as the criteria. The licensing statutes are for NCCA and ANSI accredited ABA certifications.

CommentID: **120782**

Commenter: ABSI 3/16/22 2:08 pm

QABA State License

We support the state measure that is considering adding the QABA for their state license.

CommentID: **120783**

Commenter: Michael Moates, MA, QBA, LBA, QMHP-T, Ed.D. Candidate 3/16/22 2:23 pm

Global Institute for Behavior Practitioners and Examiners (Non-Profit Organization) Comment

Global Institute for Behavior Practitioners and Examiners

Michael Moates, MA, QBA, IBA, LBA, QMHP-T/R

14 March 2022

SUBJECT: MEMORANDA FOR VIRGINIA BOARD OF MEDICINE ON BEHAVIOR ANALYSIS LICENSING

To whom it may concern:

My name is Michael Moates, and I am the individual who wrote to the Board of Medicine to request the rule change that is currently open for comment. I am also the founder of the non-profit organization the Foundation for Transformation DBA Global Institute for Behavior Practitioners and Examiners. I am writing you today to share my comments regarding the requested change in 18VAC85-150-50, and 18VAC85-150-60. To start, the rule is illegal and contrary to the statute. According to 54.1-2957.16, the Board of Medicine "**SHALL INCLUDE**" the following language "Documentation that the applicant is currently certified as a Board-Certified Behavior Analyst by the Behavior Analyst Certification Board or **any other entity that is nationally accredited to certify practitioners of behavior analysis;**" The boards current rules to not include this language as the statute legally requires. That means that the Board of Medicines rules is illegal under the statute. The same is true for the Board of Medicine Assistant Behavior Analyst rule.

But let's move on from the fact that the rule is illegal and talk about the problems not allowing other organizations who are accredited creates for the practice of behavior analysis:

- Most professions of mental health if not all are regulated by the states and not external certification boards. The top 6 mental health fields are medicine, psychology, counseling, social work, marriage and family therapy, and chemical dependency. While some states may require an applicant to pass a board exam, certification is not usually a requirement of licensure. But the BACB will not allow individuals to take their exam unless they plan to get certified. Further, the BACB is a monopoly that has engaged in anti-competitive behavior through collusion with the Association of Professional Behavior Analysts.
- The Behavior Analyst Certification Board and Association for Professional Behavior Analyst have a history of advocating against allowing other organizations who are accredited to certify behavior analysis claiming that they are Autism specific, but the Behavior Analyst Certification

Board posts data on its website showing the field of the practitioners it certifies. 72% of its certificants are practitioners in the field of Autism Spectrum Disorder and 10% choose not to identify. That leaves 12% of individuals to work in other fields. The BACB is a mainly Autism focused agency. This leaves very little room for individuals that want to work in changing behaviors of gambling, addiction, brain injury rehabilitation, correction and rehabilitation, and many other areas. It leaves no room for those interested in forensic behavior analysis, behavior analysis research, child abuse/welfare analysis, psychiatric/mental hospital behavior analysis, animal behavior, and many other areas. To put it into perspective here are the other fields tracked by the Behavior Analyst Certification Board:

Number of Behavior Analysts Certified by the BACB in the United States of America:

s/Fitness – 39	Organizational - 365	Education - 6701
: Policy – 49	Research - 19	Corrections - 49
vision - 177	Intellectual Disability - 2734	Child Welfare - 99
t Training - 493	Higher Education - 642	Pediatrics - 458
al Behavior Analysis - 1762	Gerontology - 62	Addiction – BACB Doesn't Track
al - BACB Doesn't Track	Prevention Behavior - BACB Doesn't Track	Life Coaching - BACB Doesn't Track
'rofit - BACB Doesn't Track	LGBTQ - BACB Doesn't Track	Learning Disability - BACB Doesn't Track
l Behavior - BACB Doesn't Track	Environment Preserv - BACB Doesn't Track	Security Analysis - BACB Doesn't Track

- The BACB is governed by a board of directors that would personally benefit from the restriction of behavior practitioners. Half of the board members own their own business or are in leadership positions at companies that would benefit from the lack of service providers because that would make them the go to choose.
- The BACB seeks to oust other qualified supervisors from supervising behavior technicians, assistant behavior analysts, and aspiring behavior analysts. While psychologists, psychiatrists, social workers, professional counselors, and other related fields retain the right to practice behavior analysis, the BACB does not recognize them as supervisors of behavior analysis. They recognize their certified BCBA's and their approved VC Instructors. But a psychiatrist at a mental health institution engaged in the reduction of maladaptive behaviors cannot supervise technicians according to the organization.
- Their ally and lobbying arm the Association of Professional Behavior Analysts is claims to "Representing the interests of appropriately credentialed professional and paraprofessional practitioners of applied behavior analysis" but really what they mean is we are here to advance the promotion the Behavior Analyst Certification Board and we will fight to block any other types

of certified practitioners. Their about us page reads like a propaganda advertisement for the BACB.

- The much more inspired Association for Behavior Analysis International seeks to work with and recognize various credentialing boards including the American Psychological Association, National Association of School Psychologists, Qualified Applied Behavior Analysis Credentialing Board, Behavioral Intervention Certification Council, and International Behavior Analysis Organization. The reality of it is the BACB has no intention of collaborating with the mental health community. They lack diversity shown by their closing off certification from the international community and unwillingness to work with other mental health fields. If we don't address this now it, they will continue to harm the field of behavior analysis.
- The BACB lacks diversity and is even getting worse at its standards for diversity. 85% of certificants are female with just over 13% of certificants as male. 0.38% are American Indian/Natives. 6.61% are Asian. 9% of Behavior Analysts are African American. 21% are Hispanic. This is a real problem for disadvantaged communities and people who prefer a male analyst in healthcare. The BACB used to certify analysts globally. The no longer do and are even cutting down on the international community. This means individuals who want to practice internationally will be unable to because they cannot under any circumstances become certified.
- The BACB advocates against other organizations who seek to certify behavior practitioners but let's look at who is in favor of adding additional organizations. These include the State of Hawaii Council on Developmental Disabilities, the Behavioral Intervention Certification Council, Hawai'i Psychological Association, Qualified Applied Behavior Credentialing Board, the Department of Defense, Hawaii Association of Marriage and Family Therapists, Center for Autism and Related Disorders, Autism Behavior Services on behalf of military families, and individuals concerned about providing supervision within their scope of practice. You can read 100's of comments here and below that is the policy of the Department of Defense: https://www.capitol.hawaii.gov/Session2017/Testimony/SB739_TESTIMONY_CPH_02-24-17.PDF

https://manuals.health.mil/pages/DisplayManualHtmlFile/2020-11-25/AsOf/TO15/C18S4.html

- The BACB and APBA will attempt to mislead you into believing that requiring certification from one organization is routine, but this is entirely inaccurate. What is typically required is the passage of an examination by an organization. Unfortunately, the BACB is not like most organizations that offer examinations because they do not allow individuals to take the exam based on the federal or state government requirements nor do they allow individuals to take the exams without becoming certified by their agency. The BACB differs in this from other organizations such as National Board for Certified Counselors, Association of State and Provincial Psychological Boards, Association of Social Work Boards, International Certification and Reciprocity Consortium, Educational Testing Service, and many others. These cover Counseling, Psychology, Social Work, and Chemical/Substance Abuse, and School Psychology. These agencies are the leaders in mental health, and they allow individuals who are qualified to take their exams without requiring certification. In the case of Advanced Nurse Practitioners, there are multiple boards that are accepted for APRN practice.

It is with this consideration I ask you to approve my request that individuals certified as behavior analysts by NCCA or ANSI be allowed to use that certification to apply for licensure.

Very Respectfully,

Michael Moates, MA, QBA, IBA, LBA, QMHP-T/R
Virginia Licensed Behavior Analyst
Adjunct College Professor
Doctor of Education Candidate
Student Health Advisory Committee
Senior Member, Civil Air Patrol, United States Air Force Auxiliary
Certified Accreditation Evaluator, Distance Education Accreditation Commission
CommentID: **120784**

Commenter: B.Jaramillo, BCBA, QBA 3/16/22 2:33 pm

QABA Virginia State License

I support the state measure that is considering adding the QABA for their state license.

CommentID: **120785**

Commenter: Dr. Rosa Patterson, QBA 3/16/22 2:49 pm

ADD QABA to Licensing for ABA

Greetings, My name is Dr. Rosa Patterson and I am a Qualified Behavior Analyst certified with the QABA. I am licensed across states and would support and encourage the addition of the QABA to licensure in the state of Virginia. In doing so would allow individuals the option to pursue licensure with the state of Virginia who are certified with the QABA and increase access to care for those in need of our behavioral services.

CommentID: **120787**

Commenter: Eric Linder, Former CA Legislator 3/16/22 3:02 pm

Support for QABA Licensing

I'd like to encourage support for licensure for QABA.

Including licensure for QABA will help countless military families with behavioral health needs, and will prevent a monopoly for many behavioral services.

CommentID: **120788**

Commenter: Jessica Swanson, MA, BCBA, QBA, LBA, CAS 3/16/22 3:10 pm

Approve "nationally accredited certifying body" verbiage

Amending the verbiage for behavior analysis licensure to include "nationally accredited certifying body" is important to consumer. With national shortages and wait list of providers across the country, allowing more than one board to certify is critical to ensure care is provided to those that need ABA.

CommentID: **120789**

Commenter: Dr. Valencia Church-Williams, Ed.D, QBA, CAS 3/16/22 4:27 pm

Expand Opportunities for Service Provision for Clients & Their Families

Despite the rising prevalence of ASD (estimates at 1%> currently), there are still too few qualified providers, too few institutions providing the necessary course work, and too few credentialing entities to keep up with the exploding needs. Eliminating BACB's monopoly would open the practice to up to more qualified applicants with more diverse educational and professional experiences. We need to continue to hold practitioners to high standards of ethics, service delivery, and academic preparation, but we must debunk the myth that only institutions with "verified course sequences" know how to provide this preparation and that only the BACB knows how to assess applicants knowledge and proficiency for the practice. Just as there are multiple pathways to becoming credentialed in other professional fields, this should also hold true in behavior analytics. This would serve to expand exposure to the broader public about evidence-based practices, provide more qualified practitioners in the field, and more access to services, particularly to families in rural and remote communities.

CommentID: **120790**

Commenter: Heather Smith, Autism Behavior Services Inc. 3/16/22 6:18 pm

Strongly Agree to Add QABA to Virginia

Greetings,

My name is Heather Smith. I am in strong support of adding the QABA to Virginia's approved providers. In doing so would allow individuals the option to pursue licensure with the state of Virginia who are certified with the QABA and increase access to care for those in need of our behavioral services. We know the access to care is facing limitation challenges, and opening up

the opportunity for additional Board Certified providers to license would greatly benefit those in need of essential medical services in behavioral health.

CommentID: **120793**

Commenter: Beatriz Querol-Cintron, BCBA, LABA, QABA 3/16/22 8:18 pm

Support for other credentialing agencies (i.e., QABA)

This is to increase access for practitioners and foster the diversity, equity, inclusion initiative.

CommentID: **120794**

Commenter: Home Link International Inc 3/16/22 9:41 pm

VIRGINIA PUBLIC COMMENT FOR LICENSING- INCLUSION OF QABA CREDENTIALING

ATTENTION:
William L. Harp, M.D.
Executive Director

Dear sir,

I am a holder of Qualified Behavior Analysis Credential, practicing the Science of Applied Behavior Analysis in the State of New Jersey write to support having the QBA/ QASP-S/ABA-Tech recognized parallel to the BCBA/ BCaBA/RBT and therefore should either

[i] be included in the licensing law like BACB or

[ii] amendment be made to the language for licensing in the state of Virginia to remove the BACB language and include the following: "nationally accredited certifying body" so QBAs would be included.

The QABA Task lists are comparable with that of BACB, Practicum supervision experience hours requirements are equivalent to that of BACB. Also, the Task Lists include additional requirements and emphasis on Autism. Above all, QABA credentialing LIKE THAT OF BACB is approved by ANSI.

Please do not hesitate to reach me should you have any questions. Email: Home-linkinc@itc-aba

Yours sincerely,

Dr. Usifo Edward Asikhia, QBA.

Home Link International Inc.

629 E. Wood Street Suite 205

Vineland NJ 08360

CommentID: **120796**

Commenter: Misty Kieschnick 3/16/22 11:11 pm

This change is necessary to provide to the growing number of mental health and disability issues..

I am a teacher at our alternative discipline center and the growing expansion of challenges/disabilities exceed the narrow limit of BACB certification. As it stands now, there are such long wait lists and behavior can be used in a variety of fields. The diversity of qualified practitioners will allow for fields outside of Autism to received beneficial services.

I support the language of accredited bodies of behavior analysts.

CommentID: **120797**

Commenter: Ira Heilveil 3/16/22 11:43 pm

End the monopoly!

It is fundamentally wrong for a single, specific certification body to monopolize the ability to obtain a license or practice in Virginia. Other boards exist that have even higher standards (for example, the QABA board is accredited by ANSI), and should be allowed an even playing field. Simply allowing the BACB to be the only certification board represents a guild mentality that should not work its way into Virginia regulations.

CommentID: **120798**

Commenter: Theodore A. Hoch, Ed.D., B.C.B.A.-D., L.B.A. 3/17/22 6:56 pm

Great concern regarding the QABA credential - Part 1

I share with you an email exchange between Ms. Hollie Benincosa, Executive Director of the QABA Credentialing Board, and myself, from December 2021. I will gladly share the original emails with you at your request.

From Ms. Benincosa, on 30 December 2021:

Hello Theodore,

As QABA continues to grow both nationally and internationally, there is a great need for more coursework providers who offer the QABA coursework options to meet the demands of certification.

As a VCS provider for the BACB, I believe you already have a majority of the coursework to offer the Qualified Behavior Analyst (QBA), parallel to the BCBA; and the QASP-S, parallel to the BCaBA, for those seeking certification. Many students are researching universities and providers that have this coursework so they do not have to question their education and take supplemental coursework to meet the QABA standards. Being a QABA Coursework Provider is beneficial to both George Mason University and the students. Students will have the confidence to know that George Mason University provides the courses needed to become certified with QABA. Attached are the QBA Competency Standards along with the QASP-S standards.

As a Pre-Approved Coursework Provider, your university will be added to our ever growing list of approved providers for students. You may review this list of providers on our website at https://qababoard.com/pages/qaba-community/. QABA also markets new providers on our social media as Spotlight Providers (Facebook, Instagram, and LinkedIn).

Since the BACB has pulled out of the international credentialing program, many students are contacting QABA since we are the only internationally accredited credentialing board for applied behavior analysis. With accreditation through ANSI, who meets the ISO 170124 standards, we have certificants in more than 29 countries (and growing)! Certificants in various countries,

including the US, can move to another country and know that their certificate is recognized worldwide.

To review the requirement to become a QABA Pre-Approved Coursework Provider, please visit our website at https://qababoard.com/guidelines-for-abat-or-qasp-coursework-providers/. The initial application fee is $200 USD with an annual renewal fee of $100 USD.

If you would like any additional information or have questions, please do not hesitate to contact me.

Have a safe and wonderful New Year!
Hollie

My reply, from 30 December 2021:
Thank you -

I looked through the materials on your website and available at the links there. A coupe of questions:

1) 3890 of the 5748 individuals listed as credentialed on your public registry either have expired credentials, or credentials that will expire on 1 January 2022. This means that effective 2 Jan 2022, 1858 individuals will hold active credentials through our organization. Is this correct?

2) In which states / countries would the QBA credential meet requirements for behavior analyst licensure?

3) On the bottom of the QABA Public Registry, there is a statement that ends with this line: "In addition, these individuals are providing behavior health services under the supervision of a certified professional or licensed professional with ABA or ASD in the scope of their field." Is this statement to be interpreted to mean that practitioners with QBA or other credentialing through your organization may not work independently, under their own credential, and must work under supervision of another professional?

4) It appears that most providers of coursework listed on your webpage are not university programs, but are private entities. Is this correct?

Thanks, and best wishes -

Ted Hoch

I received no reply.

I am greatly concerned with the puffery I saw that the QABA's website that day, and with the manner in which claims were made regarding number of credentialed folks. It appeared that a large number of those counted included parties whose credentials had expired and not been renewed.

I'm also concerned regarding the extent to which "training" is accepted to become a QABA, which is not university coursework, should my reading of their website on that date have been correct.

The required coursework and supervised experience needed to become a QABA is much less rigorous and has far less depth than that required to become a BCBA or BCABA. Indeed, the Board can view this for themselves by visiting the QABA's website (https://qababoard.com/pages/qaba-community/) and by visiting the BACB's website (www.bacb.com) and the Association for Behavior Analysis' website (www.abainternational.org - please review sections pertaining to Verified Course Sequences - VCSs - and Accredited Programs).

It is imperative to protect the citizens of the Commonwealth by ensuring that those providing behavior analysis services are adequately credentialed. I do not believe the the QABA credential is comparable to the BCBA or BCABA credential, and it should not be substitutable for either of those credentials for those seeking LBA or LABA licensure.

I will gladly forward the original email correspondence between Ms. Benincosa and myself to the Board, should the Board request.

CommentID: **120808**

Commenter: Michael Moates, MA, QBA, LBA, QMHP-T, Ed.D. Candidate 3/17/22 10:30 pm

Response to Theodore A. Hoch, Ed.D., B.C.B.A.-D., L.B.A.

Let me start by saying that I think that if Dr. Hoch is going to post emails between himself and Executive Director Benincosa that he should publish all emails and give the full context. He posted a single email to fit his narrative without giving context.

But allow me to address something he/ Executive Director Benincosa stated:

- As QABA continues to grow both nationally and internationally, there is a great need for more coursework providers who offer the QABA coursework options to meet the demands of certification.
    - Mrs. Benincosa is absolutely correct. As each day goes by, the Behavior Analyst Certification Board becomes less and less diverse. They are pulling out of the international market, have **less than 6,500 BCBA's that are male, less than 200 American Indians, less than 3,000 African Americans, and have nearly 40,000 White Behavior Analysts.** (Behavior Analyst Certification Board, nd). Seen here: https://www.bacb.com/bacb-certificant-data/ The fact that a professor from George Mason University is advocating against diversity is deeply troubling to me.

- QABA has done extensive research and has multiple board that work in conjunction with approval of course sequences. As a Virginia Licensed Behavior Analyst and Qualified Behavior Analyst by the QABA, I can tell you first hand that there is a rigorous process by which they evaluate all coursework that is consider for both the coursework for licensure and coursework for continuing education. Seen here: https://qababoard.com/guidelines-for-abat-or-qasp-coursework-providers/ and here https://qababoard.com/become-an-approved-continuing-education-provider/
- Mr. Hoch asks about the number of individuals with expiring credentials. There are around 2,000 individuals certified and that is just QABA. My petition relates to any certified entities who are accredited to certify behavior analysts. There are an additional nearly 4,000 individuals certified by the Behavior Intervention Certification Council. Seen here: https://behavioralcertification.org/search-registry/ Part of the reason the number of

credentials are expiring is due to the fact that the BACB has engaged in illegal anti-competitive behavior and formed a monopoly by lobbying across the United States.

- Mr. Hoch asks in what countries/states, the QABA certification would meet the requirements. Keeping in mind that there are still roughly 20 states that do not license behavior analysts these states have QABA practitioners. The Military Healthcare Service and Tricare recognize QABA as meeting certification to practice ABA and that is the same for many other insurance companies as well. Seen here: https://manuals.health.mil/pages/DisplayManualHtmlFile/2021-03-26/AsOf/TO15/C18S4.html Also, to Mr. Hoch's point, there is an issue of the BACB holding a monopoly over the practice of behavior analysis but again 85% of their certified are Autism practitioners leaving very little room for supervision in other areas with some even less than 50 supervisors in the United States. Seen here: https://www.bacb.com/bacb-certificant-data/
- Mr. Hoch asks about independent practice of Qualified Behavior Analysts but if he had done his due diligence like most scholars and professors do, he would have looked at the QBA standards which state "QBA certificants are mastery-level interventionists with advanced knowledge of applied behavior analysis (ABA) and have training and experience with individuals with autism spectrum disorders (ASD). QBAs provide program planning, assessment, data analysis and direct-care oversight for all aspects of behavior programs. Additionally, QBAs supervise the direct-care instructional staff (ABAT/behavior technicians), mid-tier supervisors (QASP-S), and collaborative care providers." The statement he is referencing is likely something that was inputted prior to the QBA creation. Can be seen here: https://qababoard.com/qualified-behavior-analyst-scope/
- He ask about the individuals who offer coursework for certification. QABA does not require you to be a university to teach coursework for the certifications and neither does the BACB. In fact, the RBT (offered by the BACB) is a 40 hour sequence taught by a BCBA similar to a QBA. Seen here: https://www.bacb.com/wp-content/uploads/2022/01/RBTHandbook_220112.pdf The BCaBA/BCBA coursework is limited to institutions listed in CHEA (United States **ONLY**). But, many of the CHEA members are not "university programs" as Mr. Hoch put it. In addition, in order to be a QBA, you have to have a Masters Degree that meets the educational requirements of 270 hours of coursework. As an adjunct professor myself, I can tell you that colleges and accreditation boards allow individuals at the Masters level to teach college classes. The benefit here is to allow individuals who live outside of the United States to have more opportunities to learn. In addition, QBA's have much diversity in teaching in native languages across the world whereas the BACB does not. Here is an example of the what makes up CHEA membership: Academy of Hair Design. Seen here: https://www.chea.org/academy-hair-design There is no way that you can tell me an organization like this is more qualified to teach behavior analysis than a Qualified Behavior Analyst with 1500 hours of experience, a masters or doctorate degree, and has passed a rigorous psychometric exam. To Mr. Hoch's point, why does the BACB allow non-accredited institutions to offer academic coursework for credit?
- It is interesting that Mr. Hoch invokes the name of the "Association for Behavior Analysis" presumably the Association for Behavior Analysis International which recognizes various other credentialing boards including QABA, BICC, IBAO, and various mental health fields. So I believe that argument is invalid. You can see that here: https://www.abainternational.org/media/188058/abaimembershipform_2022.pdf
- Mr. Hoch claims the requirements to become a "QABA" presumably "QBA" is less rigorous so lets compare them side by side:

Qualified Behavior Analyst Qualified Applied Behavior Analysis Credentialing Board	Board Certified Behavior Analyst Behavior Analyst Certification Board
Cost: Application $350 Exam: Free Coursework Evaluation: Free Total $350	Cost: Application $245 Exam $125 Coursework Evaluation $100 Total is $370 - $470[1]
Certification Countries: Certification is available globally Fully translated exams, documents, and applications are provided to diverse cultures	Certification Countries: Beginning in 2023 Certification is Limited to: US, Canada, Australia, and the United Kingdom Does not provide translated exams/documents
Education: Master's degree or higher	Education: Master's degree or higher Doctorate – for BCBA-D Designation
Recommendation from Supervisor to Be Certified	No Such Requirement
Completed Background Check	No Such Requirement
Coursework: 270 Hours in specific coursework Areas: 20 Hours Autism Spectrum Disorder 20 Hours Legal Professional and Ethics 20 Hours Core Principals of Applied Behavior Analysis 30 Hours Antecedent Interventions 40 Hours Skill Acquisition 30 Hours Behavior Reduction Interventions 30 Hours Data Collection Analysis 45 Hours Assessment 20 Hours Training and Supervision	Coursework: 315 Hours in specific coursework Areas: 45 Hours of Ethics/Professionalism 90 Hours Philosophical Underpinnings; Concepts & Principles 45 Hours Measurement, Data Collection 45 Hours Assessment 60 Hours Behavior Intervention 30 Hours Personnel Supervision and Management
Field Work Experience: 1500 Clock Hours (5% oversight) 750 Hours Must Be in Supervision/Oversight Role Supervision Conducted By: Qualified Behavior Analyst Board Certified Behavior Analyst Board Certified Behavior Analyst – Doctoral Licensed Behavior Analyst Other Licensed/Certified Professionals with Behavior Analysis in their Scope of Practice (Board Certified Psychologists, School Psychologists,	Field Work Experience: 2000 Clock Hours (5% oversight) 1500 Concentrated Clock Hours (10% oversight) 60% of Hours Must Be in "Unrestricted Activities" Supervision Conducted By: Board Certified Behavior Analyst Board Certified Behavior Analyst – Doctoral Board Certified Psychologist American Board of Professional Psychology in Behavioral and Cognitive Psychology Verified Course Sequence Instructor

Psychiatrists, Social Worker, Professional/Mental Health Counselors[2])	
Must Pass the Qualified Behavior Analyst Exam 3 Hours to Complete Exam 125 Questions 1.4 Minutes per question	Must Pass the Board-Certified Behavior Analyst Exam 4 Hours to Complete Exam 185 Questions 1.2 Minutes per question
Agreement to Follow Code of Ethics[3]	Agreement to Follow Code of Ethics[4]
Bi-Annual Renewal	2 Year Renewal Period
Renewal Requirements: 32 Continuing Education Units New Background Investigation	Renewal Requirements: 32 Continuing Education Units (4 in Ethics, 3 in Supervision) No Background Investigation
Program Accreditation: American National Standards Institute[5] (Affiliated with the United States Department of Education)	Program Accreditation: National Commission for Certifying Agencies (NCCA is Accredited by American National Standards Institute)
Recognition: Association for Behavior Analysis International Department of Defense	Recognition: Association for Behavior Analysis International Department of Defense

[1] There has been discussion that the BACB is a non-profit and QABA is not. Let me clarify that the BACB charges more and makes more of a profit than QABA.

[2] Having a diverse group of supervisors is important. ABA is not just Autism, it is used for developmental disabilities, behavior modification, etc... This includes prisons, psychiatric hospitals, schools, rehabilitation, organizational change, animal behavior and more...

[3] https://qababoard.com/wp-content/uploads/Code-of-Ethics-03-25-21.pdf

[4] https://www.bacb.com/wp-content/uploads/2020/11/Ethics-Code-for-Behavior-Analysts-210902.pdf

[5] https://anabpd.ansi.org/Accreditation/FileServer.aspx?Dirtype%20=%20Attachment&Id=182217&File=QABA%20Certificate.pdf&type=cert

If Professor Hoch is going to comment it would be beneficial if he at least did some basic scholarly research. Also, various times through out his comments, he references on "becoming a QABA." This is not a credential and a basic reading of the website would tell you that. QABA is the organization. ABAT is the technician level. QASP-S is the Bachelor Level. QBA is the Masters level.

I intend to file a Freedom of Information Act request to get the emails between Mr. Hoch and Mrs. Benincosa with George Mason University. I would ask the board to do the same or take Mr. Hoch on his offer to review all the emails. Manipulating emails by only posting one part of them to get what you want is not productive and it does not give the board a full picture.

There is no threat to the commonwealth unless the board continues to allow the BACB's lack of diversity to be dictator. Mr. Hoch would benefit from less providers because more individuals would see him at his practice. Seen here: https://www.psychologytoday.com/us/therapists/theodore-a-hoch-reston-va/448748

It is also important to note that at George Mason University where Mr. Hoch claims to represent their certificate, the one that he claims is designated for BACB certification and therefor licensure is actually listed as a "15-credit non-licensure certificate." The university does not even recognize the course sequence as one that should lead to licensure. You can see that here directly in there catalog: https://catalog.gmu.edu/colleges-schools/education-human-development/school-education/applied-behavior-analysis-graduate-certificate/ and archived here:

https://web.archive.org/web/20220122013237/https://catalog.gmu.edu/colleges-schools/education-human-development/school-education/applied-behavior-analysis-graduate-certificate/

I think it is important to note a few things as well:

1. Mr. Hoch does not hold a degree or certificate in behavior analysis. Seen here: https://cehd.gmu.edu/assets/files/cv/230.pdf
2. The pathway by which he became a Board Certified Behavior Analyst does not require a single course in behavior analysis. Seen here as he does not have a degree/certificate in behavior analysis: https://www.bacb.com/wp-content/uploads/2022/01/BCBAHandbook_220110.pdf
3. Mr. Hoch's degrees in psychology were prior to any licensure requirements for behavior analysis so he got grandfathered in but would not qualify today and will not qualify in the future. Seen here: https://www.bacb.com/wp-content/uploads/2022/03/BACB_March2022_Newsletter-220316.pdf
4. Mr. Hoch has Licenses in Virginia Applied Psychologist and Virginia Licensed Professional Counselor. But he would not meet the licensing requirements for either of these licenses. All in all, Mr. Hoch only has his license due to grandfather clauses.
5. He has made misrepresentations on his post and can't even identify the credential he is talking about.

His comments must be disregarded.

Further the statute leaves no interpretation. The language in the statute "shall" be included in the rules.

There are also many issues of litigation to consider here:

1. Anti-trust monopoly.
2. EOC Violations.
3. Diversity Discrimination.
4. Finally, the challenging of the rule given the statute language.

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CommentID: **120810**

Commenter: Emily Wilson, Blossom Behavioral Services 3/21/22 8:24 am

We owe it to service recipients to push for more rigorous requirements.

The QBA certification does not meet the standard for a Licensed Behavior Analyst in the state of Virginia. The current BCBA program standards--especially with regard to accruing supervised fieldwork--should be significantly more rigorous than they are in order to adequately protect consumers. A move to less stringent requirements is a step in the wrong direction when there is still work to be done to move practitioners in Virginia toward compassionate, thorough, and effective behavioral service delivery.

CommentID: **120829**

Commenter: Caroline Salzman, BCBA, LBA 3/21/22 10:58 am

Do not allow QBA as a part of VA Licensure

A public and non-profit credentialing organization is essential to the integrity of Behavior Analysis as a discipline. The Behavior Analyst Certification Board requires the highest standards of its certificants to both obtain and maintain certification. Licenses are issued for the protection of the clients, consumers, students, and stakeholders that we serve. Any modification to the standards of licensure would threaten that protection.

CommentID: **120830**

Commenter: Michael Moates, MA, QBA, IBA, LBA, QMHP-T 3/21/22 11:25 am

Reply to Caroline Salzman, BCBA, LBA

To be honest, this comment is not even worth the board's time. Mrs. Salzman doesn't attempt to address any concerns with adding the QBA to the boards requirements. She attempts to use shock words without any citations or facts to scare the Board of Medicine into not adding the QBA or following the **LEGAL STATUTE.** This is required by law and is not open for negotiation.

The QABA is a public board that is open to review by any public entity. It is accredited by ANSI who reviews its entire process for awarding certifications. It is so interesting that she claims the BCBA requires "high standards" that the QBA does not have when she does not attempt at all to lay these standards out for the board to review.

She says "Any modification to the standards of licensure would threaten that protection." Presumably she is referencing the BCBA standards. It is important to note that the standards are constantly changing. The BACB changed its standards as recently as January 2022 of this year. Further, let's talk about what is not healthy or safe for clients. The BACB has already announced its standards for certification for the year 2032 over 10 years from now. How is that healthy or safe when we don't know how the science of behavior analysis will evolve? That is an unsafe approach. The board should really consider wether this is the right approach. See: https://www.bacb.com/wp-content/uploads/2022/03/BACB_March2022_Newsletter-220316.pdf

CommentID: **120832**

Commenter: Michael Moates, MA, QBA, IBA, LBA, QMHP-T, EdD Candidate 3/21/22 11:58 am

Further Reading with Quotes for the Board to Consider

"The BACB does not appear to have the money, staff, time, or legal authority to provide the necessary ethical oversight, especially with the literally thousands of members of the Association of Behavior Analysis International (ABAI) and/or BCBAs who practice both within the United States and around the world."

"To further complicate matters, the BCBA credential is not consistent with the generally accepted concept of board certification as recognized in the fields of medicine, psychology, and other human service professions."

See: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2854065/

"One issue of regulatory concern is that often discussed in behavior analytic circles is that Behavior Analyst Certification Board (BACB) offers a national license. This is false. BACB is not licensing, nor could the BCBA ever be a national license for behavior analysts. Licensure falls under the states rights or powers. It is the prevue of each state to restrict trade within its

borders. United States v. Lopez, 514 U.S. 549 (1995) held that the federal government only has the right to create laws that effect interstate commerce."

The federal government recognizes QABA and BICC as certification boards of behavior analysis.

See: https://www.abainternational.org/media/177713/luiselli.pdf

"The BAMLA defines who a professional behavior analyst is, categorizing the knowledge, skills, experiences, and abilities. In addition, it clarifies that a behavior analyst is a person who functions within a particular scope of practice. Finally, it helps to define the profession within a scope of practice that highlights the uniqueness of applied behavior analysis. The BAMLA further specifies the common commitments to expect from a behavior analyst in adherence to an ethical code and generally accepted behavior analytic positioning papers."

"However, for a number of logistical reasons, the BACB can only enforce adherence to the Professional Disciplinary Standards, (not adherence to the Guidelines for Responsible Conduct) and it relies heavily on information from local responsible sources in reviewing allegations against certificants" (BACB). Thus, BCBA will not investigate most forms of impairment, for they are ethical issues."

See: https://www.abainternational.org/media/177719/pritchard.pdf

Something else that MUST be noted is that there appears to be no research on the BACB certification requirements outside of those who are certified by the BACB. Thus, all research completed is biased and must be evaluated for its implicit bias.

Also, for the record, I personally reached out to the BACB to seek their help in making sure that the standards represent everyone not just BCBA's and was ignored.

There are many complaints with regards to customer service because the BACB is not interested in engaging with its community but rather they seek to dominate the industry.

References:

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https://www.abainternational.org/media/177719/pritchard.pdf

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CommentID: **120833**

Commenter: Anon 3/21/22 2:44 pm

Suggestion

I was directed to this form by my organization, and when reading through the comments I must say that this is akin to "insert unsavory word here" measuring contest. Personally, it isn't about which organization is handing out certifications, if singular or multiple - that's not important. What does matter is the consumers we serve, and for better or for worse, the BACB is leading the industry (at least in America), in terms of gold standard. That being the case, if QABA can demonstrate equivalent or superior standards, with evidence, then I see no qualms about also allowing them to practice within the state of Virginia. However, that's not to say that other boards won't try to do the same as I'm sure each of them purports a certain gold standard.

We do have a shortage of practitioners, and the consumers outnumber us a lot. Allowing other individuals with equivalent education/experience only expands our reach to our service population. I do not think however, this is something that can be voted on within a townhall meeting. There needs to be a review of processes and standards to ensure that QABA reaches the bar set forth by the industry.

To the individual who wrote about the lack of diversity within the BACB, I must say that I was not aware of this and I'm quite surprised by this. I'm even more curious to see the metrics of their exam and whether it is standardized from a stats perspective. I very curious about the representative sample they may have used. Then again, there several factors that may account for this discrepancy. But enough on that tangent.

Thanks -

Leozihno

CommentID: **120834**

Commenter: Michael Moates 3/21/22 6:18 pm

Response to Anon

I wholeheartedly wish the goals for licensure were focused on does each certification meet the need for the field. Unfortunately, the BACB and its lobbying arm the APBA, are constantly making derogatory remarks regarding other certification boards including QABA and BICC. These statements require a factual based response and sometimes to defend we must show why the other board would not be a good fit as a standalone board.

The goal should be a collaborative community by which various entities participate and work together. Until the BACB recognizes, like Virginia, that Psychologists, Psychiatrists, and other medical/mental health supervisors are qualified to provide supervision we are going to continue running into this problem.

The BACB is a closed off wall and they do not collaborate well with others.

I do disagree with anon when it comes to the statement about reviewing the standards of QABA or BICC for that matter. That has already been done. ANSI and NCCA have certified that QABA and BICC, respectively, meet the standards to issue certifications. They also meet various other administrative, structural, financial, etc... requirements.

To show anon about the diversity, here is the attachments from the BACB on BCBA's:

American Indian / Alaska Native 0.28%
Asian 6.85%
Black 3.93%
Hispanic / Latinx 10.56%
Native Hawaiian /Pacific Islander 0.38%
White 70.05%
No Answer 7.95%

Male 13.04%
Female 85.22%
Nonbinary 0.35%
Other 0.09%
No Answer 1.30%
CommentID: **120835**

Commenter: Anonymous 3/22/22 9:23 am

Re: Misty Kieschnick

You are right, there is a need for more behavior analyst in the field to support the consumers. Just like there is a need for more teachers and doctors. However, the answer isn't to set the standards lower so anyone could do the job. Behavior Analysis is a complex field and we need our best and brightest contributing. If we set our standards lower, we may meet the goal of having more BA, but at what cost?

CommentID: **120837**

Commenter: Michael Moates, MA 3/22/22 12:50 pm

Reply to Anon

No one has provided a single shred of evidence that the standards are lower. You guys keep saying that. I say to you. Prove it. Cite empirical evidence. Cite research. Cite anything. We have shown that the BACB is not diverse and does not represent the population. We have done so through the BACB's own data. You guys come here and treat us like less. You dehumanize us and you provide no evidence. Show the board. Show the board what you are saying. If you can't, kindly sit down.

In addition, just because some standards may be different does not make them deficient. The BACB cannot create rules that will work across all 50 states. It is simply impossible. Every state has its own rules on scope of practice and supervising providers. The BACB has no way of adapting unless they create different rules for every state.

The board should disregard all comments that are not supported by evidence and research. These statements of less or deficient are not based in fact and frankly, the law is clear on what the requirements are. Period.

CommentID: **120839**

Commenter: Michael Moates, MA 3/22/22 12:58 pm

Comment to Board

To the Board of Medicine:

Have you noticed how everyone who is commenting against this action is doing so anonymously? That should be a major **RED** flag.

CommentID: **120840**

Commenter: Crystal Peterson Barker 3/23/22 9:21 am

Additional Credentialing Agencies

Good Morning,

I am absolutely in favor of additional credentialing boards being added as long as they meet the following criteria: 1.) are a not for profit organization, 2.) are not disability specific (this is extremely important since we do serve a diverse population of individuals with ABA services throughout the state), and 3.) as long as it meets or exceeds the rigor of the BACB standards for certification.

CommentID: **120843**

Commenter: Michael Moates, MA 3/23/22 11:29 am

Reply to Crystal Peterson Barker

I agree with certain aspects of the statement made by Crystal Peterson Barker. Here are some things I think are important to address.

First, I do not agree with the non-profit language. There are many for-profit institutions that provide valuable training, education, etc. I also believe this language is unclear. Is she referencing not-for-profit, non-profit, non-government-organization, state non-profit, or 501(c)3 exempt organizations? Many of the colleges that teach ABA programs that are approved by the ABAI and to that point they are not less, they are accredited and are used by the BACB themselves.

Second, I agree wholeheartedly with the language about not being disability specific. I think this is an area where the BACB fails. As previously stated, nearly 80% of those certified by the BACB are Autism Practitioners and that leaves very little room for others to get supervision in areas such as gambling, forensic analysis, sex addiction, ADHD, animal behavior, etc.

Finally, I wholeheartedly disagree with the last statement. The BACB is not the one who should determine what the standards are for behavior analysis. The federal government gave this job to the states in the US Constitution. Further, the BACB has many deficiencies as previously stated. These include lack of provider types, lack of diversity in gender and race, and lack of supervision by state-approved providers.

The state should determine the standard with input from various sources including consumers of behavior analysis, various certification organizations, educational entities, independent behavior analysts, and accreditation boards ANSI and NCCA.

CommentID: **120844**

Commenter: C. DuVall 3/23/22 11:11 pm

Concerns with Proposed Changes

I have read and considered the proposed changes described and the follow-up arguments posed, and I disagree with the conclusion that the path to licensure as a behavior analyst in Virginia should be modified in the manner the petition describes.

The key argument, as I understand it, is that the Board should expand the qualifying components required to become licensed in Virginia and that they should do this by expanding the certification requirements to include other credentialing bodies related to the field of behavior analysis.

The process of certification by the BACB as a BCBA/BCaBA and licensure as an LBA/LaBA in VA is rigorous, I agree. But I believe the best means to ensure that we can serve the communities and individuals (no matter the application of the science) with the highest quality of care and quality and mitigate the risk of harm is to ensure that these criteria remain rigorous.

If we, as representatives of the field on both sides of this discussion, feel that the current process towards licensure as a behavior analyst or assistant behavior analyst in Virginia should change but cannot agree which certification or credentialing body best defines the minimum criteria then, I recommend the Virginia Department of Health Professions – Board of Medicine launch a data-driven investigation and adopt the most rigorous standards and examination criteria to determine eligibility for licensure.

Thank you for considering my opinion,

C. DuVall

CommentID: **120851**

Commenter: Michael Moates, MA, QBA, LBA 3/28/22 9:00 am

Another Reason Alternatives Must Be Considered - Shocking Children

I think it is extremely important to act in an ethical way. Treating clients with dignity and respect is something that we should strive for. Children are not lab rats to be tested on, nor are they to be treated with disrespect based on disability.

I think it is important for the board to consider this when evaluating credentials it approves as alternatives.

According to Wikipedia, "The Judge Rotenberg Center (JRC, founded in 1971 as the Behavior Research Institute) is an institution in Canton, Massachusetts, United States, housing people with developmental disabilities, emotional disorders, and autistic-like behaviors. The center has been condemned for torture by the United Nations Special Rapporteur on Torture. The JRC is known for its use of the graduated electronic decelerator (GED), a device that administers electric shocks to residents through remote control. The device was designed by Matthew Israel, the institute's founder."

<u>The JRC Continues to shock students as of today 28 March 2022.</u>

The Board of Directors is made up of:

Henry Slucki, Ph.D.

Thomas Brady

Jessica E. Van Stratton, Ph.D., BCBA-D, LBA

Richard Malott, Ph.D., BCBA-D

Josh Pritchard, Ph.D., BCBA-D

Jeffrey Sánchez

Ronald Van Houten, Ph.D.

W. Joseph Wyatt, Ph.D.

On Staff:

Nathan Blenkush, PhD, BCBA-D

It is important to note that the BACB is aware of these allegations and yet at least 3 board members remain and at least 1 on staff remain. I don't know about the Virginia Board of Medicine but I certainly don't condone torture and I think there should be alternatives in the field.

The Board needs to watch these:

https://www.youtube.com/watch?v=PUhPMNdnOW8

https://www.youtube.com/watch?v=XV5D2ZL0icM

This is not who we are. It is not who we want to be. It is a human rights violation. The BACB has taken no action against the individuals allowing this to happen. Alternatives must be put into place to protect the human rights issues being faced.

CommentID: **120876**

Commenter: Anon 3/28/22 3:09 pm

Statement

While conducting research to assist me with forming an opinion on this serious matter, I found that the QABA website did not address several important matters, yet those same items are easy to locate on the BACB website. Here are several examples:

The petitioner mentioned a concern with a lack of diversity. BACB certificant data and demographic data can be found at the following site:

https://www.bacb.com/bacb-certificant-data/

And yes, the field is dominated by white females, but I would like to point out that is also true for many care-taking type professions like education and nursing. This is an issue that needs to be addressed at a different level than this forum allows. I was not able to locate any demographic information on the QABA website - so how are we to know that they are any more diverse?

https://www.census.gov/newsroom/stories/certified-neruses-day.html

BACB information regarding ethics violations can be found here:

https://www.bacb.com/services/o.php?page=100180

It is important for the safety of those we support to have total transparency and accountability - the BACB makes it easy to access the ethics codes, any violations, and support with reporting violations. I could not locate ethics violations on the QABA website. There is a simple form for complaints found here:

https://qababoard.com/wp-content/uploads/QABA-Complaint-Form.pdf

However, there is nothing specific about ethics violations for those unfamiliar with the codes to assist them with reporting. The ethics codes are found in the packet for certification - but that made it very difficult to locate and again, how would a person unfamiliar with the website like a parent locate them and determine what information the need to determine if a violation had occurred?

To be clear, I am not against the QABA - I am only pointing out inconsistencies and misinformation in the claims made by the petitioner. This matter should not be taken lightly, and I hope more rigorous research is conducted before a final decision is made.

CommentID: **120904**

Commenter: Michael Moates 3/28/22 5:58 pm

Response to Anon

I was going to be done responding to people and just share information but since another anonymous user (again should be a red flag for the board) addressed me I would like to respond.

First the respondent has many inaccurate claims.

Again, trying to tell other organizations they have to be exactly like the BACB will lead to the same problems the BACB has. But moreover, had the respondent looked they would have found that QABA has an entire operation in Africa working with people of color to get certified as practitioners. Can be seen here: https://qababoard.com/pages/qaba-in-africa/

QABA has an international standards committee made up of both men and women of color. See here: https://qababoard.com/pages/qaba-international-standards-committee/

The website is offered in 13 different languages supporting people around the world. Same with the coursework and exams. They are offered across the world to diverse backgrounds including

both men and women of color.

The represent: The United States, Spain, Philippines, Africa, Nigeria, Ecuador, South Korea, India, Brazil, Czech Republic, Peru, Japan, Pakistan, Egypt, UAE, Poland, Kenya, and Saudi Arabia.

The BACB is pulling out of the international market making it more **White Americans.** Don't allow yourself to be fooled by misinformation. The BACB is doing nothing to fix this problem and it is a problem for the board because if the law gets struck down because the BACB discriminates against people of color that will cause issues for the board. See: https://www.bacb.com/global-certification/.

Further, the BACB is not attempting to fix the problem at all. They are actually making it more likely that it will be worse by pulling out of the international market. Organizations that represent other mental health fields like the NBCC have organizations across the world like EBCC in Europe. See: https://europeanbcc.eu/. There are US Citizens abroad to including military families, international students, and member of the families of the State Department who should be able to get certified while their families are serving our country.

Anon really does not want to talk about ethics while the BACB allows individuals that it certifies to send electric shocks through children in an attempt to change their behavior.

Also, had anon even done basic research he would have found the following resources on the QABA website. See:

https://qababoard.com/code-of-ethics/

https://qababoard.com/wp-content/uploads/Code-of-Ethics-03-25-21.pdf

https://qababoard.com/wp-content/uploads/QABA-Complaint-Form.pdf

Ultimately the QABA Board does not have the jurisdiction to prosecute such claims and so that would be left to the states or the federal government. It does seem odd that someone on behalf of the BACB did not address my previous statement about the electric current the BACB allows to go through the bodies of kids.

Traditionally, the individual wanting to file a complaint would do so with the Board of Medicine as they have the appropriate jurisdiction. They have an entire form dedicated to it here: https://www.dhp.virginia.gov/PractitionerResources/Enforcement/

All anon had to do to locate that content was go to the about us section of the website. They took 30 seconds so they could write a negative review here.

Here are some other things to note:

ANSI accreditation - https://anabpd.ansi.org/Accreditation/FileServer.aspx?Dirtype%20=%20Attachment&Id=182217&File=QABA%20Certificate.pdf&type=cert

https://anabpd.ansi.org/Accreditation/credentialing/personnel-certification/AllDirectoryDetails?&prgID=201&OrgId=2168&statusID=4

They had to meet these requirements: https://www.ihf-fih.org/resources/pdf/Conformity_assessment-General_requirements_for_bodies_operating_certification_of_persons.pdf

All in all. Another misguided individual attempting to hide behind the keyboard and attack other entities. It has no basis and Virginia law is clear. They clearly spend 30 seconds on the QABA website and then started writing.

CommentID: **120924**

Commenter: Anonymous 3/29/22 9:35 am

On the Petitioner's "Responses"

The trend appears to continue, in that the petitioner finds it necessary to respond to reasonable comments and concerns by citing "inaccurate claims" and the like, however, fails to address the essence and substance of the comments themselves.

Here's just one example:

Previously, the petitioner expressed concerns that BACB certificants, overall, lack diversity. A recent comment pointed out that QABA does not include measures of diversity on its own website for their certificant base. Instead of addressing this, the petitioner instead claimed that "QABA has an entire operation in Africa working with people of color to get certified as practitioners" and then shares a link. That may be so, but when you access the link, you land on a page of with very little information and no specifics. In addition, the "Learn More" button on the page merely links you back to the different certifications offered by QABA, nothing more.

The petitioner then argues that "QABA has an international standards committee made up of both men and women of color." While that sounds great, how does that specifically address the fact that the petitioner continues to claim that BACB certificants, overall, lack diversity—all the while fails to produce QABA certificant data on diversity?

The bigger point here is this: Like several previous "responses," it is difficult to make sense of what's being presented because they are replete with logical fallacies. More often than not, we are seeing multiple attempts to invalidate a point by presenting nonsymmetrical data, strawman arguments, or information that is completely off-topic.

CommentID: **120944**

Commenter: Michael Moates, MA 3/29/22 9:51 am

Reply to Anon

I am done replying to all of these anon users who are to scared to put their name to their posts. My hunch is they are all BACB certified. I am not going to engage in whataboutism. I brought up concerns and they are trying to turn the tables.

I can tell you that **QABA or BICC does not condone shocking minor children** for maladaptive behaviors like the BACB.

CommentID: **120946**

Commenter: Michael Moates, Global Institute for Behavior Practitioners and Examiners 3/30/22 8:04 pm

Similar Discussions of Counseling

The BACB is not the first organization who has tried to write itself into the law.

A similar thing is happening right now in the Commonwealth Board of Counseling where the CACREP accreditation board is trying to make itself required for licensure and of 134 Comments not 1 supports the the restriction of one certification board.

Just like with the BACB, CACREP similarly thinks that it is better than everyone else and want to block off providers during the COVID 19 crisis.

See:

https://townhall.virginia.gov/L/comments.cfm?stageid=8872

CommentID: **121020**

Commenter: Michael Moates, MA 3/30/22 8:46 pm

328 OPPOSE SINGLE BOARD

SEE THIS AMAZING PIECE OF WORK TO:

328 VOTE AGAINST ONE SINGLE BOARD.

https://townhall.virginia.gov/L./comments.cfm?stageid=7071&sort=change

CommentID: **121025**

Commenter: Vijay Krishna, ANSI National Accreditation Board 3/31/22 2:00 pm

Comments from ANSI National Accreditation Board

Ref: Petition for Rulemaking: Certification for licensure as practitioners of behavior analysis: Regulations Governing the Practice of Behavior Analysis (18 VAC 85-150)

Dear Board Members,

As the Board considers the petition for certification for licensure as practitioners of behavior analysis, the ANSI National Accreditation Board (ANAB) would like to provide information relating to the international/national standard for assessing the competence of personnel certification bodies and the accompanying accreditation requirements.

The ANSI National Accreditation Board (ANAB) is an affiliate of the American National Standards Institute (ANSI) and the largest multi-disciplinary accreditation body in the western hemisphere, with more than 2,500 organizations accredited in approximately 80 countries. ANSI oversees the creation, promulgation, and use of thousands of norms and guidelines that directly affect businesses in nearly every sector: from acoustical devices to construction equipment, from roads and bridges to energy distribution, and healthcare. ANAB accredits personnel certification bodies based on the international standard ISO/IEC 17024: *Conformity assessment- Requirements for bodies operating certification of persons*. This standard is also adopted as an American National Standard. ANAB has accredited over 225 programs under this standard including several in the healthcare sector such as those offered by the American Board of Multiple Specialties in Podiatry, ASCP Board of Certification, Inteleos, Lymphology Association of North America, National Board of Certification in Occupational Therapy, ABRET Neurodiagnostic Credentialing and Accreditation, AONN Foundation for Learning, and Academy of Lactation Policy and Practice. A complete listing of all accredited programs can be found at https://anabpd.ansi.org/Accreditation/credentialing/personnel-certification/ALLdirectoryListing?menuID=2&prgID=201&statusID=4

The ANAB accreditation process – itself based on an international standard (ISO/IEC 17011: *Requirements for accreditation bodies accrediting conformity assessment bodies*) – is extremely rigorous and ensures that only those organizations that meet the stringent requirements under the standard are accredited. Independent third-party accreditation is an "accountability mechanism" to ensure the quality and legitimacy of organizations offering credentials. ANAB accreditation provides an added layer of legal defensibility against invalid claims. The accountability and transparency built into the ANAB process support conformity assessment attestations and can result in reduced liability insurance.

Benefits of Accrediting Credentialing Organizations to ISO/IEC 17024

Accreditation is a key component of an effective standardization system, assuring industry and governmental decision-makers that credentialing organizations are competent and their results can be trusted. The standard was developed by the International Organization for Standardization (ISO) based on the need for public protection by establishing that individuals have the required competencies to perform
their job. The standard has been recognized by several U.S. federal agencies as a critical requirement for personnel certification bodies that offer certification in areas related to public health, environment, and

national security. ANAB is a signatory to the International Accreditation Forum (IAF) Multilateral Recognition Arrangement for ISO/IEC 17024, which brings global acceptance of its accreditation program,

The following are the key requirements under the standard:

- **Credibility**: The certification examination must be fair, valid, and reliable. A valid test correctly measures whether an individual has the necessary competencies for the job. Validity is an indicator to establish that the process measures what is intended to measure. Exam reliability shows that the test measures a person's abilities in a consistent manner.
- **Impartiality**: The certification body should establish its structure, policies, and procedures to ensure impartiality and objectivity and manages conflict of interest arising from certification activities.
- **Independence**: The certification functions should be independent of training to ensure that confidentiality, information security, and impartiality are not compromised.
- **Transparency**: The certification body is required to have an active complaints process to resolve complaints against its activities as well as complaints against individuals that it has certified.
- **Accountability**: As per the standard, the certification body should have a due process for taking away the credential for unethical or incompetent behavior.
- **Balanced representation of stakeholders**: The standard requires that the certification body should involve key stakeholders in making certification-related decisions. Additionally, subject matter experts (SMEs) should be involved in creating the certification scheme requirement based on a valid job or practice analysis.
- **Certification scheme**: The standard requires a certification body to demonstrate that, in the development and review of the certification scheme the following are included:

a) the involvement of appropriate experts;
b) the use of an appropriate structure that fairly represents the interests of all parties significantly concerned, without any interest predominating;
c) the identification and alignment of prerequisites, if applicable, with the competence requirements;
d) the identification and alignment of the assessment mechanisms with the competence requirements;
e) a job or practice analysis that is conducted and updated to:

- identify the tasks for successful performance;
- identify the required competence for each task;
- identify prerequisites (if applicable);
- confirm the assessment mechanisms and examination content;
- identify the re-certification requirements and interval.
- **Other requirements**: The standard is very comprehensive and covers all aspects of certification including test security, recertification, resource requirement, confidentiality, the competence of personnel involved with the certification activities, financial requirements, and use of certificates and logo marks. Further, the certification body should develop a management system for continual improvement of its certification program.

To ensure that the credentials they promote meet industry and quality standards, many federal and state agencies rely on ANAB accreditation. Some examples include:

- Virginia Department of Health as specified in 12VAC5-421-55 of the Virginia Food Regulations requires ANSI/ANAB accredited Certified Food Protection Manager (CFPM).
- ANAB's 17024 accreditation is the only program recognized by the U.S. Department of Defense (DoD) under DoD 8570 for Information Assurance.
- ANAB's 17024 accreditation program is recognized by the White House National Science and Technology Committee on Forensic Science as meeting the highest standard in accreditation.

- ANAB's 17024 accreditation is recognized by the U.S. Occupational Safety and Health Administration (OSHA) for crane operator certification and by New York, West Virginia, and California in licensing requirements for crane operators.
- ANAB's 17024 accreditation is a requirement for licensing of elevator inspectors in several states.
- ANAB's 17024 accreditation is recognized under the North American Securities Administrators Association (NASAA) model rule on the use of senior-specific certifications and professional designations.
- ANAB's 17024 accreditation is recognized by the U.S. Department of Energy (DOE) as the accreditor under the Better Building Workforce Guidelines.
- The U.S. Department of Health and Human Services selected ANAB as the approved accreditor for its Health Information Technology (HIT) Certification Program.

ANAB has accredited the QABA Credentialing Board under ISO/IEC 17024 for (a) Applied Behavior Analysis Technician, (b) Qualified Autism Services Practitioner- Supervisor (QASP-S) and Qualified Behavior Analyst (QBA). These programs have demonstrated compliance with the stringent requirements of the standard.

We support the petition to amend the regulation to accept certification from an entity that is nationally recognized to certify practitioners of behavior analysis. We recommend ANAB be recognized as an accreditation body for the licensing of Applied Behavior Analysis and the QABA certification programs accredited by ANAB be included in the licensing of Applied Behavior Analysis.

Please feel free to contact me for any additional questions or clarification.

Sincerely,

Vijay Krishna, MBA, ED.D.

Vice President, Credentialing
ANSI National Accreditation Board
1899, L Street Suite 1100, Washington DC 20036.
CommentID: **121046**

Commenter: Anonymous 4/4/22 12:15 pm

Disagree

I disagree to add QABA. The BCBA helps make sure that BCBA's, BCaBA's, and RBT's are practicing within their scope and that they are providing ethical services to their clients. ABA has a bad rap from the past and with the help of the BACB it is helping change the way people look at ABA therapy. We need to continue to on providing ethical practices of ABA with clear guidelines and qualifications for everyone that is practicing ABA.

CommentID: **121077**

Commenter: Anonymous 4/4/22 3:30 pm

High Standards are Necessary

CommentID: **121079**

Commenter: Michael Moates, MA 4/4/22 3:31 pm

Response to Last Anon

Breakdown of last response:

I disagree to add QABA.

The BCBA helps make sure that BCBA's, BCaBA's, and RBT's are practicing within their scope and that they are providing ethical services to their clients. - If this statement is true, why does the BACB continue to allow certified members who shock and electrocyte children with Autism.

ABA has a bad rap from the past and with the help of the BACB it is helping change the way people look at ABA therapy. - Really? Again, shocking minor children. If that is the change you want then you would literally be a sadist.

We need to continue to on providing ethical practices of ABA with clear guidelines and qualifications for everyone that is practicing ABA. - Thank you for making me laugh today. The BACB has no idea what ethics are. They literally certify people who shock children.

Here is the video: https://www.youtube.com/watch?v=-aUlhWmDPel

Here are the BCBA's: https://www.judgerc.org/board-of-directors.html

Jessica E. Van Stratton, Ph.D., BCBA-D, LBA

Richard Malott, Ph.D., BCBA-D

Josh Pritchard, Ph.D., BCBA-D

Ronald Van Houten, Ph.D.

W. Joseph Wyatt, Ph.D.

Nathan Blenkush, PhD, BCBA-D

CommentID: **121080**

Commenter: Anonymous 4/4/22 6:15 pm

QABA transparency?

It's curious that six people affiliated with QABA, including its owner, have posted on this page in support of the QABA position. Yet none of them have disclosed their relationship with QABA. Interesting business ethics.

Andrew Patterson, Executive Director of the Autism Business Association, owns the shell corporation (Elevated Autism Services Team LLC) that owns QABA

Ira Heilveil – filed paperwork in California for Elevated Autism Services Team

Rosa Patterson – wife of QABA owner, Andrew Patterson

Eric Linder – current QABA board member

Jessica Swanson – current QABA board member

Valencia Church-Williams – current QABA board member

CommentID: **121083**

Commenter: Dr. Valencia Church-Williams 4/4/22 7:46 pm

Re:QABA transparency?

I think that an example of "transparency" would be not posting derisive comments about others anonymously.

I am a public official with several public social media accounts and a website that is heavily trafficked. I am not difficult to find and my intentions are difficult to discern. I am also a proud member of QABA board and it was never a secret. However, my posting included my own thoughts and opinions and do not necessarily reflect the stance of the QABA board. This is why I did not mention my affiliation in the post.

"Anonymous", should you have other questions/comments/concerns please feel free to reach out to me directly at vchurchwilliams@thebridgeconsultinggroupllc.com.

CommentID: **121084**

Commenter: Anonymous 4/4/22 8:55 pm

Breaking News - Anonymous Calls Out People Who Use Their Name While Being Anonymous

Breaking News - Anonymous Calls Out People Who Use Their Name While Being Anonymous

CommentID: **121085**

Commenter: Anonymous 4/5/22 8:45 am

I support the anonymous comments.

I support anyone who comments anonymously! The evidence in the comments is clear. If you comment, either way, you will be attacked.

I also DO NOT support allowing this change to occur in Virginia. We must protect the consumers.

CommentID: **121087**

Commenter: Anonymous 4/5/22 9:27 am

There is absolutely no evidence...

... that consumers will be hurt by being diverse, allowing collaboration, and opening up the field to those who are qualified.

CommentID: **121088**

Commenter: Anonymous, Public School Division 4/5/22 10:29 am

I do not support the QABA licensure.

I do not support the QABA licensure.

CommentID: **121093**

Commenter: Anonymous 4/5/22 10:37 am

People Clearly Don't Understand This Is Not A Vote

This is not a vote... your "vote" does not matter. The purpose of this form is to give facts and opinion so the board can determine what is appropriate.

CommentID: **121094**

Commenter: Hannah Robicheau, LBA 4/6/22 4:51 pm

Disheartened

I want to start off by saying that the following is my opinion as an individual behavior analyst, and as such, only represents that, as is the purpose of legislative comment forums. My comments are entirely directed to the board that will review this petition. If someone feels that it is his/her/their best option to attempt to correct my personal opinion, or that somehow my personal opinion as a behavior analyst is threatening, then I am truly sorry that that is the position that that individual feels that they are in. Providing behavioral health services to people in need should never result in practitioners needing to be on the defensive/offensive. We're able to be most effective when we work together. It is clear to me that there are many passionate voices willing to speak on this topic, as there should be. No petition or legislative matter should be met with ambivalence. I also appreciate any issue that could push behavior analysis further and occasion self-reflection to improve our field.

I am incredibly disheartened by a few things (not all, but many) regarding this petition and the process. Primarily, the divisiveness and cutting down of one another as professionals and even people, in a public forum. Regardless of one's opinion on the content of this petition, I am concerned about the commentary being a reflection of our field and the practitioners therein. I wonder what members of the public may be turned off from all of us behavior analysts, who already may have a reputation for not working together for the common good outside of ABA. I am also concerned about the underrepresentation of individuals/families receiving services in public comment forums. And finally, there are ALWAYS things to improve on, for every board, certifying entity, etc., because people are imperfect, and we are the ones who make decisions.

I admit to not being as familiar with the QABA as I am with the BACB, so let me preface with that. I also wasn't as concerned about the petition before reading this forum as I am now. I would like to think that I approached from a position of wanting to learn more, and trying to figure out where the opposition is coming from, while being as objective as possible (knowing there's an intrinsic bias as I'm certified by the BACB). From reading the QABA code of ethics, it's evident that there are many similarities between the BACB code of ethics. I started there because it's often the lifeblood of an organization, and an organization's values can be made clear by reading what guides the practice of the certificant participating in that credential. What I saw was a great start to an ethical code (very similar to previous iterations of the BACB's code of ethics and professional conduct). I wasn't able to (upon first glance) see many differences in intent. When I looked for how data was used and incorporated, I saw an underrepresentation of reliance on data and function to drive decision making. I also didn't see any information regarding assent, and there wasn't any information that I could spot other than in the research section that spoke to obtaining informed consent from the client/guardian, and/or what to do if the individual receiving services declines. Additionally, with an international entity, some of the aspects of the ethical code may conflict with country laws, but there is no guidance to say which should be followed. For example, there are currently 71 countries that criminalize homosexuality/bisexuality, and 15 that criminalize gender fluidity/trans expression, yet the code of ethics gives no guidance on how to balance that and anti-discrimination policies.

https://www.humandignitytrust.org/lgbt-the-law/map-of-criminalisation/

The other component that is concerning to me is the limitation of the code of ethics and QABA credential to apply to treating "individuals with autism spectrum disorders and related disorders." If a practitioner with a QABA credential were to decide to work with animal training, or informing public safety policy, what would prevent that person from doing so if under the same license? It would then fall to the public/employer to determine the appropriateness of that practitioners experience given the role that he/she/they are in, which takes away the regulation and protection inherent in licensure for the public. One could say that if that practitioner is practicing within his/her/their "scope," that it shouldn't matter, however, the QABA code of ethics (per the introduction), applies to practitioners working with "individuals with autism spectrum disorders and related disorders."

After some poking around, I was able to find information about what happens if a complaint is made on the website. If I was a consumer, I would have difficulty being able to figure out how to use the QABA board for protection using the complaint process, especially because the complaint form is only to be used between certificants, and the website states that complete information up to and including the complaint-filer's certification number would need to be submitted. Though I truly appreciate the intent to expand services throughout the world given how lucky we are in the United States to even be having this conversation, how is the complaint made by individuals worldwide who can't read or speak other languages? Who is explaining all of this to them so that they benefit from protection as well? What if the person needing to submit a complaint (the purpose of any credentialing board) is a member of the public and is unable to bring issues to the attention of the board? How are cultural norms identified and incorporated, and ensuring that women and children, LGBTQ+ youth, and others who may be disempowered in this country and across the world are able to be protected from unethical practices? I couldn't easily find the infrastructure around any of these questions (which is the lens a consumer would use), which worries me. Keeping ABA practice within the US is not the best course of action either, to be sure. I would, however, want to ensure first that no harm could possibly be done to those impacted by ABA services, especially if one is an ambassador of ABA throughout the world.

I am all in favor of having credentialing that is the optimal balance of protection for consumers, and easier access to services for individuals who would benefit from them, but not if there aren't enough protections in place for the individuals that ABA impacts. I worry that it may be a little too hasty and to narrow a focus for the QABA to be included in certifying entities for licensure in Virginia before some of these questions have thorough and easy to find answers.

Thank you for your consideration of my comment.

CommentID: **121097**

Commenter: Anonymous 4/6/22 5:30 pm

My Opinion...

No organization is perfect both have flaws. But both the BACB and QABA have high standards and are accredited. We should let them both practice. They have meet the requirements of the accreditation boards and have 3rd party review by reputable NGO's.

CommentID: **121098**

Commenter: Michael Moates, MA 4/6/22 10:25 pm

Update from the BACB

I received a letter from the attorney of the BACB in the last few days.

When confronted about the BCBA's certified running the center that shocks children, the BACB says "The BACB also does not have jurisdiction over service delivery agencies." So I guess the BACB will allow the leaders shocking children to stay certified in violation of their own ethics code.

I am happy to send this email to the board to review.

Did you know that the BCBA has given up discipling behavior analysts... see:

https://www.bacb.com/services/o.php?page=100180

The entire purpose of the BACB was to provide competent behavior analysts but they don't even enforce their own ethics code anymore with the exception of line technicians.

If they will not punish someone for leading an organization shocking those with Autism where is the line?

CommentID: **121099**

Commenter: Anonymous 4/7/22 10:21 am

re: "BACB Update"

Please check facts. The webpage cited by the petitioner as showing that the BACB does not enforce its ethics code with anyone except RBTs actually shows just the opposite.

CommentID: **121100**

Commenter: Michael Moates, MA 4/7/22 11:01 am

Reply to Anon

Like I said, I have a letter from their attorneys. They will not take action against the BCBA's that run the center shocking children.

I am happy to provide this to the committee. I wish I had the ability to upload here.

CommentID: **121101**

Commenter: Anonymous 4/7/22 1:44 pm

Spain

I was jotting at the requirements and they look almost the same for the other two agencies. It is upsetting that I and many others who practise with high-functioning clients are unable to do so because we live in a country that the current certifying entity does not recognise me here in Spain. They dont like my schooling from Queen's University Belfast.

CommentID: **121103**

Commenter: Anonymous 4/7/22 2:28 pm

Re: "Similar discussions of counseling"

Worth noting: The discussion the petitioner referenced regarding people who are licensed to practice counseling (by a different VA board) is about entities that accredit university training

programs, not "boards" or other entities that certify individuals. And both of the accrediting entities under discussion there are nonprofits.

CommentID: **121104**

Commenter: Michael Moates, MA 4/7/22 4:22 pm

Anon is wrong

The Anon is confused and understandable given their likely not in the counseling field.

Currently, the Board of Counseling (ie the counseling field) allows anyone who meets their requirements to become counselors. This is not attributed to any 3rd party agency or accreditation. The purpose of the post was to show that Virginia limiting services only harms the community.

You can see the requirements here:
https://www.dhp.virginia.gov/Forms/counseling/LPC/LPC_Licensure_Process_Handbook.pdf

I am sure anon has motives for trying to block other boards and we might know what those were if they were not hiding behind a keyboard.

You have to ask yourself why this person continues to comment without using their name or affiliation while constantly attacking others. There is a reason this is happening.

Further, more likely than not this is going to end up in the courts because under the First Amendment of the US Constitution the government cannot force association with a organization.

Further, the 10th Amendment gives the powers not delegated to the United States to the states, not corporations such as the Behavior Analyst Certification Board or the Association of Professional Behavior Analysts.

See the following court cases:

Time Warner Cable Inc. v. Hudson

Serafine v Branaman

See the following laws:

First Amendment to the United States Constitution - Religion

First Amendment to the United States Constitution - Association

Violation of the First Amendment to the United States Constitution - Speech

Violation of the Due Process Clause of the Fifth and Fourteenth Amendments of the US Constitution

Civil Rights Act of 1964 - Race

Civil Rights Act of 1964 - Disability

Civil Rights Act of 1964 - Sex

Civil Rights Act of 1964 – National Origin

42 USC 1985

15 USC 2 the Clayton Act

CommentID: **121106**

Commenter: Michael Moates, MA 4/7/22 6:27 pm

Additional Concerns About the Practice of ABA

Relevant to more reasons why we need additional alternative certifications, I provide the board with this:

1. First, the Virginia Board of Behavior Analysis actually recognizes members that are not BCBA's for full membership. In fact, they go as broad as to allow people from other related fields full membership and voting privileges. You can see here: https://virginiaaba.org/membership/?r=1719&wcm_redirect_to=page&wcm_redirect_id=1719
2. You can also see the above in their bylaws here: https://virginiaaba.org/wp-content/uploads/2018/10/VABA-Bylaws-revised-2018.pdf
3. They will now advocate against QABA because they are not a tax-exempt non-profit, neither are they. You can verify this here: https://www.irs.gov/charities-non-profits/tax-exempt-organization-search
4. I have grave concerns about the leadership as well. It seems as though all of them would benefit from the limitation of additional behavior analysts. For example:
    1. Board President Amanda Randall, BCBA charges $6,000+ for speaking engagements https://web.archive.org/web/20220407211546/https://atlanticspeakersbureau.com/dr-amanda-randall-autism/
    2. Treasurer Jennifer Wade, BCBA would personally benefit from less providers because her practice would be more in demand. https://web.archive.org/web/20220407212542/https://littleleaves.org/meet-our-team/
    3. Member at Large Elizabeth Matthews, BCBA would personally benefit from less providers because her practice would be more in demand. https://web.archive.org/web/20220407212542/https://littleleaves.org/meet-our-team/
    4. Member at Large Tiffanie Johnson, BCBA would personally benefit from less providers because her practice would be more in demand. https://web.archive.org/web/20220407213727/https://rcghealthnetwork.com/team/
    5. Member at Large Kevin Schock, BCBA would personally benefit from less ABA providers because there would be less to challenge his book and research. Further he can call himself one of the few experts. https://web.archive.org/web/20220407213956/https:/www.amazon.com/Functional-Behavioral-Assessment-Diagnosis-Treatment/dp/0826106048/ref=sr_1_1?qid=1649367542&refinements=p_27%3AKeven+M.+Schock+MA++BCBA&s=books&sr=1-1
    6. Member at Large Ting Bentley would personally benefit from less providers because her practice would be more in demand. https://web.archive.org/web/20220407214418/https://www.getanswersnow.com/our-clinicians/ting-b
    7. Administrative Director Christy Evanko, BCBA would personally benefit from less providers because her practice would be more in demand.

https://web.archive.org/web/20220407214423/http://www.snowflakesaba.com/about-us

At first, I thought how could someone be no narcissistic and think that they are better than everyone else but then I realized this is actually about the money. Instead of allowing those focused on money, speaking engagements, and book deals, the board should focus on authorizing those who intend to help people for the public good. Who want to make a difference.

CommentID: **121107**

Commenter: Anonymous 4/7/22 6:36 pm

Harassment

Now Michael Moates is harassing the association leadership in the state. It is definitely consistent with his past history.

https://heavy.com/news/2018/12/michael-moates/

CommentID: **121108**

Commenter: Michael Moates, MA 4/7/22 6:42 pm

Something Else That Is A Bit Confusing

Why would the Virginia ABA Board be against alternative certification when 3 of its board members are certified by alternative behavior analysis entites:

https://www.credential.net/16a0b1f4-e7fa-46a7-bd4d-07d614acfdfb#gs.wn3de7

https://www.credential.net/163b6e0f-9f59-4adc-bcce-2732c2004a1e#gs.wn3bkc

https://www.credential.net/a0e50d97-44ed-435d-95ca-827526f966d0#gs.wn39jq

CommentID: **121109**

Commenter: Michael Moates, MA 4/8/22 10:23 am

Hypocrite, much?

It's interesting that Anon want to talk about personal attacks when they post this:

https://townhall.virginia.gov/L/viewcomments.cfm?commentid=121083

Being concerned about the type of practitioners we are bringing into behavior analysis is reasonable. They should be less concerned with book deals, speaking engagements, etc and more client focused.

CommentID: **121110**

Commenter: Anonymous 4/9/22 11:14 am

Anonymous

Why are there so many statements being made regarding work by the QABA in other countries? Isn't the work of the Virginia Board of Medicine concerned with services provided in Virginia only?

Further, in a prior comment, the commenter pointed out that fewer hours of both coursework and of supervised experience are required to qualify one to sit for the exam offered by the QABA than by the BACB. Remarkably, in his "rebuttal" to this comment, Mr. Moates included a table in which he actually provided the data to prove this point. Also remarkably, he highlighted other content in that table, which had nothing to do with the point that less education and less training is required to become a QABA than to become a BCBA.

CommentID: **121111**

Commenter: Anonymous 4/9/22 11:18 am

Regarding the comment, "Something Else that is a Bit Confusing"

If one bothers to check, one would find that the three individuals you cite are also Board Certified Behavior Analysts, and became Board Certified Behavior Analysts prior to becoming credentialed IBAs. They did not use their IBA credential to meet requirements for their licensure as behavior analysts in Virginia. Indeed, at least two of those parties were BCBAs years before the IBA credential was available.

CommentID: **121112**

Commenter: Anonymous 4/9/22 11:27 am

Regarding "Additional Concerns About the Practice of ABA"

Sadly, this comment appears to confuse the reader by misstating the name of the Virginia Association for Behavior Analysis (a professional organization) as the "Virginia Board of Behavior Analysis" (which certainly sounds like some kind of credentialing board, doesn't it?). There is no "Virginia Board of Behavior Analysis. Of course the Virginia Association for Behavior Analysis will accept parties who are not BCBAs as members - just as ABAI and many other professional organizations do.

Further, despite apparent misstatements in a number of the other "rebuttals," it does not appear that any of the commenters thus far has made any statement in favor of reducing the number of licensed behavior analysts in Virginia. Instead they appear to be concerned with ensuring the quality and depth of preparation for those who do become licensed, and, as Mr. Moates demonstrated in his "rebuttal" to a prior comment, fewer hours of training, with less behavior analytic content, and fewer hours of supervised experience are required to sit for the QABA credentialing exam.

CommentID: **121113**

Commenter: Anonymous 4/9/22 11:32 am

Shock

The practice of using electric shock in behavioral treatment (other than ECT, which is never administered by behavior analysts as it is far beyond their scope of competence) has been contrary to Virginia statues for many years. It is not used here. One wonders why, again, in numerous "rebuttals," the commenter brings up matters not occurring in Virginia to persuade the Board of Medicine on a decision regarding conduct of professionals within Virginia.

CommentID: **121114**

Commenter: Anonymous 4/9/22 12:09 pm

Regarding "There is absolutely no evidence."

After the gentleman who initiated this action commented on the lack of fortitude of those posting anonymously, another anonymous poster posted:

There is absolutely no evidence...
... that consumers will be hurt by being diverse, allowing collaboration, and opening up the field to those who are qualified.

Interestingly, this poster was not met with the stern finger wagging that other anonymous posters received.

Regardless, those in favor of including those holding this lesser credential as their highest credential in the licensed behavior analyst pool have provided no evidence, whatsoever, that the current pool of licensed behavior analysts in Virginia are lacking in diversity, do not welcome collaboration, and are opposed to opening the field to those who are qualified. Have they even studied this?
CommentID: **121115**

Commenter: Anonymous 4/9/22 2:01 pm

Proved his point

At this time it would appear Mr Moates has just given everyone enough proof as to why not just anyone should be able to practice ABA. The BCBAs I have encountered over the years understand the seriousness of teaching alternative behavior without the use of punishment. Mr. Moates your comments on here are both punishing and unprofessional. You are not representing an ethical behavior analyst, and looking at some your fake credentials explains a lot.

CommentID: **121116**

Commenter: Michael Moates, MA 4/11/22 10:11 am

Letter to Congress

I am going to put the previous anon's maladaptive behavior on extinction and not reply to them.

Here is a letter that was sent to Congress this morning:

https://gibpe.org/wp-content/uploads/2022/04/Letter.pdf

CommentID: **121119**

Commenter: Anonymous 4/11/22 1:02 pm

BACB VS. QABA

The Virginia Board of Medicine issues licenses for those individuals who have obtained and continue to maintain the required qualifications needed to practice Behavior Analysis. The BACB is a governing board that focuses on the implementation of the science, not solely for treating

symptoms of Autism. The BACB currently has 37,859 individuals who hold a BCBA credential globally. The QABA registry shows that of the 5,953 registered practitioners, only 53 are from Virginia. Of the 53 listed practitioners, 47 of them have expired certifications leaving only 6 with current credentials. Of the 6 individuals with an active certification in the state of Virginia, none of them appear to also hold the BCBA credential through the BACB. There are individuals listed on the registry that do not hold a bachelor's degree, let alone a masters which does not align with their requirements listed for credentialing. To obtain the BCBA credential, all individuals must obtain a master's degree to ensure they have had ample exposure and knowledge within Applied Behavior Analysis.

The QABA credentialing board states that they are "validated in all aspects of ABA with specialization in Autism". Obtaining a credential through the BACB and a license through Virginia's Board of Medicine ensures that the license holder is trained and has demonstrated competence with implementing behavior analysis. This is a major discrepancy that should not be overlooked when providing licensure through the state's governing board.

Creating additional opportunities to extend the privilege of being licensed in the State of Virginia should be based on qualifications and experience implementing the science of Applied Behavior Analysis not solely based on experiences with individuals on the Spectrum. If there are individuals that belong to the QABA that actually reside in the state of Virginia, they should be invested in following the outlined procedures and experience requirements set forth by the state. The matter of credentialing and licensing through the state of Virginia should be reserved for actual residents of the state. There is no need for individuals outside of the Commonwealth of Virginia to be concerned with our licensing practices. If holding a QABA credential is sufficient for the state where you reside, then continue focusing your energy and ethical practices where you have been recognized to do so.

CommentID: **121121**

Commenter: Michael Moates, MA 4/11/22 1:41 pm

Litigation Filed

Litigation on this matter has been filed in federal court. I ask the board to let the courts determine the outcome.

Various constitutional issues have been raised and likely because the board has failed to include the language required by the law, the rule will likely be stricken by the court.

CommentID: **121122**

Commenter: Dr. Ed Tiller, VACP president 4/11/22 2:47 pm

VACP position on ABA petition for rule making

We hold that current certification requirements are necessary to ensure that qualified practitioners, knowledgeable in the principle's behavior analysis, and who meet the certification standards of the Behavior Analysis Certification Board are necessary to protect Virginia's consumers and regulate the kinds of services they receive. We strongly urge the Board to deny the petitioner's request.

Sincerely

Edward H Tiler PhD

President

CommentID: **121172**

Commenter: Michael Moates, MA 4/11/22 3:12 pm

VACP Not Valid

VACP comments are not valid.

The standing committee on Publication has the mission of "Disseminate psychological knowledge, BOD policy decisions, member activities, and state and national ethical, legal and regulatory information to all members"

The independent comment of one director should not be taken as to represent the whole organization.

Mr. Tiller does not have the unilateral authority to make such a comment on behalf of the organization. Further, Mr. Tiller is not a behavior analyst nor a behavioral psychologist. His areas are psychotherapy and marriage/family.

See the bylaws:

https://www.vapsych.org/vacp-by-laws

CommentID: **121187**

Commenter: Anonymous 4/11/22 9:16 pm

Past behavior predicting future behavior.

So, a suit has been filed in federal court. He has filed other suits before, and the outcomes were not in his favor. Nothing new there.

He's also billing himself as a Professor, in the letter he sent to Congress. He's not new to politics, and it's a good thing that the President, Vice President, Senators, and Representatives to whom he addressed his letter have nothing else to do and will act swiftly on his letter. Why is it, though, that when one searches the university at which he claims to be a professor, the site says that there are no results to be found?

I hope he gets help. He seems empty. Very sad,

CommentID: **121297**

Commenter: Anonymous 4/11/22 9:23 pm

It is remarkable that the QABA chose him as their spokesperson and petitioner.

Out of all of the undoubtedly intelligent, well educated, professional folks whom the QABA could have chosen to be their spokesperson and petitioner in this matter, they chose him. Remarkable. Even more remarkable is that they've kept him. How, exactly, is his display of grandiosity helpful to them and their cause?

CommentID: **121298**

Commenter: Anonymous 4/11/22 9:31 pm

Careful! The sands are shifting!

So, it began with "QABA is the same as BCBA."

Then, it became "QABA is better than BCBA because of other things being done in other parts of the world."

Then, he made the mistake of laying out in a rebuttal the point that was made regarding lesser education and supervised experience being required to become a QABA.

Then, more doubling down on diversity and things going on elsewhere in the world.

Then, it became about shock - which is already illegal in Virginia.

Now, there's allegedly a federal lawsuit, submitted by a failed politician and failed journalist who has a penchant for claiming credentials he doesn't actually have (such as BCBA or Professor).

Doesn't appear that there is very much solid substance to anything of this.

What hasn't changed is that the BCBA credential requires greater educational attainment and greater supervised experience than does the QABA credential. Another thing that hasn't changed is that, unlike the QABA, the BACB does not list on their certificate registry the names of individuals whose credentials have expired and not been renewed. They don't have to. It's a solid credential, that those holding it wish to renew.

CommentID: **121300**

Commenter: Anonymous 4/11/22 9:32 pm

Some of these anonymous comments are pretty good!

Put them on extinction? Why put Anonymous on extinction? Those comments by Anonymous are the most interesting and spot on comments that have been made! You really should read them!

CommentID: **121301**

Commenter: Michael Moates, MA 4/12/22 9:16 am

It is sad the BACB Anon Rep has to lie and defame

It is sad the BACB Anon Rep has to lie and defame because he can't get real facts.

I am emailing the department more info about the university I am at. Since the Anon has been stalking me.

Here you will see in the BACB database the expired credentials (See under status Inactive/Expired):

https://www.bacb.com/services/o.php?page=101135

Here is a screenshot of their lies:

https://ibb.co/TgZByQZ

Regarding the shock, the BACB is the one who allows this to happen. The point was not about Virginia law but rather who Virginia associates with. Do you really want to be attached to an organization certifying those engaged in the practice of shocking children?

This is the BACB and its certified:

https://www.youtube.com/watch?v=Ko-ip3MImik

Court case was filed in the district court on 11 April 2022. I am happy to provide the board with the details.

CommentID: **121333**

Commenter: Michael Moates, MA 4/12/22 9:38 am

Police Report Filed

For the written record, I have filed a police report for the stalking and harassment of the anon user. The user has taken these issues beyond this forum in an attempt to illegally intimidate me. It will not work. This has been provided to the Board of Medicine.

CommentID: **121335**

Commenter: Anonymous 4/12/22 10:45 am

There is no "Anon"

Anyone can post comments here anonymously, and a quick review of the anonymous posts shows that they were authored by several different people, including some QABA promoters.

CommentID: **121344**

Commenter: Anonymous 4/12/22 11:00 am

There is an anon

Just because it assigns a different number does not mean it is not a different person... see next post

CommentID: **121346**

Commenter: Anonymous 4/12/22 11:00 am

See

Different number same person

CommentID: **121347**

Commenter: Anonymous 4/12/22 12:19 pm

Yes, include new language

I am in favor of the language petition to be more inclusive of other accredited certifying entities for ABA certification.

CommentID: **121358**

Commenter: Anonymous 4/12/22 1:06 pm

Shaping versus coercion

Rather than shaping responses with factual discussion, some prefer to coerce. This is not how an ethical behavior analyst behaves.

CommentID: **121361**

Commenter: Prof. Michael Moates, MA, QBA, LBA, LMHP 4/12/22 1:13 pm

My last post and apologies

To everyone,

I am walking away from this comment board. My rules petition remains in place and I remain willing to work with anyone who wants to collaborate to make the field of behavior analysis.

When I started this petition, I started it for multiple reasons. I and others have been in the field of behavior analysis for 8 years, starting in 2015 as an undergraduate student. As I would go on, I found that various other boards were being attacked for various reasons from being to Autism specific to being not as rigorous.

It felt very dehumanizing to me and my colleagues. No board (BACB, QABA, BICC, IBCCES) run the same and I think that is a good thing. If everyone was the same there would be no diversity or standards for different people.

I also believe that it should be the responsibility of the state to determine what it needs. I think that one certification board cannot cover all aspects of various states needs. It just doesn't seem possible to me.

I am grateful that the Board of Medicine issued me a License Behavior Analyst Credential after reviewing my qualifications as they have done with others from various boards.

I think each of the boards have their own strengths. For me personally, just based on my religion cannot associate with one of the organizations based on their practices.

I think it is important that we note that in Virginia, there are nearly 17,000 people with Autism. (https://www.easterseals.com/explore-resources/living-with-autism/profiles-virginia.html) There are currently around 1,400 behavior analysts in the State of Virginia. This does not include those not working in Autism or those working as college professors without private practice. That means just to cover Autism the average BCBA would have to take a caseload of at least 11 clients. That is if every licensed person took on 10.23 clients. This also does not account for how the BCBA's are spread out through the state.

I think we can all agree that we all want what is best for our clients. We want them to get the best services from the best people.

I am ashamed of the role I played in getting this discussion so heated. I offer context but not an excuse. Reading comments that degrade your certification or education really hurts and it gets personal. I do not agree with the center shocking children and I do recognize this is not happening in Virginia. What I will say is I don't want to be associated with it at all. There are BCBA's leading this practice and I don't want to be part of the BACB organization. That should not mean that there are no alternatives.

I personally and sincerely apologize to the following:

Dr. Hoch, I apologize to you sir for attacking your position. I will be sending an email withdrawing my request for the emails this afternoon. I, as a QBA, would be more than willing to work with you to collaborate on requirements that we can both be happy and live with.

Ms. Salzman, I apologize to you for discounting your comment. I do agree with you that licenses are in place to protect our clients. We all want what is best for them. I don't think anyone is out to harm a client and if they are they should be reported.

Ms. Robicheau, I wholeheartedly agree with you. Your comment inspired me to take the approach that I am this morning. Thank you for making me a better man. Thank you for challenging me to be a better person.

Dr. Tiller, I apologize to you for discounting your position. You are allowed to have your opinion as we all are and my statement was uncalled for.

To the Virginia ABA Board, I apologize to each of you. I know that you are fighting for what you think is best and I think you should have a platform to do that.

Here is what I learned from this discussion:

- I learned that I could be more humble. My first action was to attack and that is not okay.
- I have learned that feeling personally attacked are not acceptable reasons to lash out at others. I essentially gave others what I was feeling.
- I have learned about the QABA organization and who it is affiliated with.
- I learned about the demographics related to race, gender, and speciality of the BACB.
- I learned about the dangers of how our field can become abusive such as shocking children or other various way of engaging in positive punishment.
- I learned about information that various boards do not post that could be helpful to the common goal of providing students with good and diverse practice.
- Instead of talking about one board being better than the other maybe a collation should have been formed and standards discussed.

Here are some thoughts I ask others to consider:

- Is it fair that someone might not want to associate with the BACB while they still credential those engaged in the shocking practice?
- Can standards be equal even if they are not exactly 100% the same? Just like with the various national and regional college accreditation boards?
- If someone is a member of the Virginia ABA does that association have a duty to fight for all of its members and not just the majority?
- Are there issues across all certification boards where the focus is Autism and could we benefit from having providers in other diverse fields?
- Could it be beneficial to comment using our real names, certifications, and affiliations so that others can see potential biases?
- Could other fields be effective supervisors in behavior analysis? A psychiatrists at a hospital working on behavior change? A substance abuse counselor working to decrease drug abuse? A counselor using behavior therapy to decrease the maladaptive behaviors in a person?
- Is threatening someone, calling their employers, certification boards, etc the way to approach disagreement?
- Is attacking each other going to make the field better?
- Could you attack someone without having all of the information and making assumptions?

What I wish I had seen more of:

- I wish I had seen more collaboration from the BACB, QABA, BICC, IBCCES.
- I wish that the decencies for each board had been addressed.

- I would have like to have seen the board hold a meeting on this issue with open discussion from all parties interested.

I feel like we have to lead by example. We are supposed to be the people who work to decrease maladaptive behaviors and I can say here I am one of the people having them and I deeply apologize to everyone for how I acted. My hope is that we can work together.

I stand by my statement that one group leading the entire practice is not in the best interest of the clients. It does not give them options. It provides insurance companies with less options. It creates less competition which creates a situation where there is no fighting to raise the bar or standard if you will.

I do not feel comfortable with the BACB for multiple reasons and so my hope is that an alternative can be allowed so that others who are uncomfortable or want a different type of analyst have that option.

I take responsibility for my actions and I apologize.

Prof. Michael Moates, MA, QBA, LBA, LMHP (thank you to VABA for letting me know about the LMHP)

CommentID: **121362**

Commenter: Adam Warman 4/12/22 2:35 pm

Concerns

While I have read the commentary here regularly, I have been reluctant to post commentary due to the combative, inflammatory, and ad hominem posture of responses to valid concerns. But I cannot in good faith let the deadline pass without adding voice to the concerns others have made regarding the petition at hand.

Others have made these points more eloquently, so I will be brief. My concerns echo many others and include:

1. The process of becoming eligible for and attaining certification under QABA is not sufficiently rigorous as to protect consumers. Insufficient fieldwork is required, insufficient breadth of coursework in behavior analysis is required, and the examination itself has insufficient security protocols in place.
2. QABA's for-profit status raises grave concerns for me, as the motive must necessarily be retaining profit margins. This can easily lead to damaging policy changes and relaxation of rigor. Additionally, it means that the company can be sold or acquired by a bad actor. Combined with other transparency concerns, this status makes it quite difficult to determine who is actually steering the ship.
3. Behavior analysis is a broad field and licensure allows for practice in the entirety of the scope of practice. QABA's intense focus on autism interventions does not provide the background and experience required to ensure consumer protection in all areas of behavior analytic practice.
4. Many of the consumers of behavior analytic treatment, along with those that fund that treatment, are already faced with complicated decisions in choosing between various providers, multiple evidence-based practice approaches, and treatment outcome data. The one thing they can currently be assured of is that the professional providing the intervention has been credentialed by a rigorous certification board and licensed by a responsible board of medicine. While I am not in vigorous opposition to other credentialing pathways being accepted for Virginia licensure, the QABA is not the correct choice.

CommentID: **121369**

Commenter: Anonymous 4/12/22 4:59 pm

End the Monopoly

Behaviorist serve a population that is consists of more than children and more than people with Autism. People with the LBA/LABA credential are recognized as the "gold standard" in Virginia, yet have difficulties supporting adults through their transitional phases of life. This is in part due to their limited field opportunities. If Virginia intends to meet the DOJ's expectations of being person centered and provide ongoing adequate support, there need to be more avenues available to be considered a licensed behaviorist than going through the BACB.
As it currently stands, there are services where LBA/LABAs are providing the same work as other credentials, but because the BACB is the "gold standard", this credential earns more. Unless the state plans to serve the consumers directly, it is time for a change. There is already a shortage and it is growing by the day. I am speaking as someone who began the process to earn LBA credentials and didn't complete them with only 2 courses and supervision left to obtain. My choice was due to the limited services "ABA" places LBA/LABAs into. All professionals who want to provide ethical service should be able to do so and earn a decent living doing so.

CommentID: **121380**

Commenter: Elizabeth Matthews, BCBA, LBA 4/12/22 5:39 pm

Petition Opposed

I am a long time Virginia resident, I have been practicing behavior analysis for almost 20 years, and I do not support this petition. We have worked hard in the Commonwealth to establish a high expectation of care for the individuals and families we serve.
My concerns are solely rooted in protection of the consumers and are in line with those mentioned previously by others.

-Certification standards should be equal to or greater than those currently established and set by the BACB.
-Certifying entities should hold a non-profit status to ensure transparency.
-Certifying bodies should not be associated with any specific diagnosis.

These expectations are met through the BACB requirement and quality services are supported and provided through the current process.
CommentID: **121383**

Commenter: Anonymous 4/12/22 9:10 pm

it is simple

text from the law enacted by the legislature

"Documentation that the applicant is currently certified as a Board Certified Behavior Analyst by the Behavior Analyst Certification Board or any other entity that is nationally accredited to certify practitioners of behavior analysis;" the text is required to be in the rule. It is not. the rule is not lawful.

the board understood this because it has been included the langauge for years

https://law.justia.com/codes/virginia/2014/title-54.1/section-54.1-2957.16/

https://law.justia.com/codes/virginia/2015/title-54.1/section-54.1-2957.16/

https://law.justia.com/codes/virginia/2016/title-54.1/chapter-29/section-54.1-2957.16/

https://law.justia.com/codes/virginia/2017/title-54.1/chapter-29/section-54.1-2957.16/

https://law.justia.com/codes/virginia/2018/title-54.1/chapter-29/section-54.1-2957.16/

https://law.justia.com/codes/virginia/2019/title-54-1/chapter-29/section-54-1-2957-16/

https://law.justia.com/codes/virginia/2020/title-54-1/chapter-29/section-54-1-2957-16/

https://law.justia.com/codes/virginia/2021/title-54-1/chapter-29/section-54-1-2957-16/

it continues to be in the language today

this was never about what is best

they ganged up to try to block behavior analysts from even being able to renew the licenes by copying and pasting the same post

copied from this

people used to think for themselves

its interesting that they think the rules should not apply to them

https://virginiaaba.org/public-comment-due-6-27-18/

https://www.townhall.virginia.gov/l/viewcomments.cfm?commentid=65428

https://www.townhall.virginia.gov/l/viewcomments.cfm?commentid=65452

https://www.townhall.virginia.gov/l/viewcomments.cfm?commentid=65507

https://www.townhall.virginia.gov/l/viewcomments.cfm?commentid=65507

CommentID: **121394**

Commenter: G. Bourland, Assoc. for Behavior Analysis International Licensing Committee 4/12/22 11:46 pm

Comments regarding behavior analyst certifying organizations

April 12, 2022

Virginia Board of Medicine

9960 Mayland Drive, Suite 300

Henrico, VA 23233

Subject: Comments regarding behavior analyst certifying organizations

Colleagues:

I am writing on behalf of the Association for Behavior Analysis International (ABAI) which is the international professional organization for behavior analysis, the natural science of behavior, and its Licensing Committee. ABAI is uniquely positioned to address questions that arise regarding the practice and profession of behavior analysis.

We have been asked to comment regarding the discussion occurring in Virginia related to organizations issuing certification to behavior analysts. We recognize the concern possibly arising that some organizations may certify individuals as being sufficiently qualified when, in reality, a person does not possess the knowledge or supervised experience to provide appropriate services for clients. We think that identifying specific certifying organizations as holding acceptable certifying criteria to be unwise as the number of behavior analyst certifying organizations may shift over time and we would not want to take action might contribute to restricting timely decisions being made in Virginia regarding qualifications. To be clear, we cannot endorse any particular organization that certifies behavior analysts. We can, though, describe some considerations that we believe are important when reviewing such organizations.

Given that the rationale for licensing behavior analysts is protection of the public, of utmost importance is ascertaining how well a behavior analyst certification issued by an organization promotes protecting the public. How might that be evident? Some facets of how that be done are summarized immediately below with more details discussion following. Some essential factors include:

1. Making sure that the certification criteria are relevant to the area in which licensure would be provided, specifically relevance to behavior analysis, *per se*.

2. Ensuring that the knowledge, competencies, examination content, and supervised experience requirements for behavior analyst licensure are intended to apply broadly and not just be relevant or especially relevant to a subset of the population.

3. Determining that expected supervisory experience maximizes the likelihood that trainees have adequate relevant experience to develop the complex skills needed to provide effective and safe services needed by the public.

4. Ensuring the results of certification examinations accurately reflect the knowledge of a candidate for certification and then licensure.

5. Exploring whether the certifying organization has and enforces a code of ethics for people that it certifies.

6. Considering how certification decisions by an organization could facilitate financial gain accruing to private parties.

7. Addressing whether the behavior analyst certifying organization is accredited by a nationally or internationally recognized organization that accredits organizations that issue professional credentials, a necessary but not sufficient factor for adequate protection of the public.

Expanded consideration of those factors follows.

1. **Making sure that the certification criteria are relevant to the area in which licensure would be provided, specifically relevance to behavior analysis, *per se*.** If the license issued to behavior analysts is an unrestricted license (i.e., behavior analysts are not restricted to providing their services to only a subset of the populations such as Autistic people or minors), then the criteria for the certification required for behavior analyst must pertain completely to behavior analysis, rather than some other profession or to behavior analysis **plus** some other topic. Issuance of an unrestricted license requires that licensees' training and experience NOT be restricted to or primarily emphasize only one subset of the population; this is essential so that licensed behavior analysts will have received broad training that will facilitate their ability to provide appropriate and effective services to a broad array of clients. A crucial implication of this expectation for certificants is that the competencies a behavior analyst has received must reflect the fully range of behavior analysis, and not be restricted to or primarily emphasize what is relevant to only a subset of the population to whom behavior analysis services should be provided and that will seek behavior analysis services. The same holds true for the required training, supervised experience, and testing of persons to be certified. A behavior analyst certification program can contribute to protecting the public by having requirements that ensure that behavior analysts are

prepared to provide the services people need in a manner that is safe, effective, and ethical. Inadequate standards increase the risk that certified behavior analysts will provide services and conduct themselves in ways that could cause some form of harm to the people to whom services are provided. The information to address this set of concerns should be readily available in the publicly available information provided by a certifying organization such as on its website. If the information is not readily available or what is available indicates that the issues mentioned here are not adequately addressed, then one should proceed with great caution regarding whether that organization is operating openly and is likely to provide the best available protection for the public.

2. **Ensuring that the knowledge, competencies, examination content, and supervised experience requirements for behavior analyst licensure are intended to apply broadly and not just be relevant or especially relevant to a subset of the population, is not sufficient to maximize protection of the public.** The expected knowledge, competencies, examination content, and supervised experience requirements for behavior analyst licensure must validly reflect what actually is necessary for provision of effective behavior analysis services. The state of the art procedures are well articulated and available from a variety of sources pertaining to examination development and professional credentialing (e.g., the Council on Licensure, Enforcement & Regulation, www.clearhq.org). In brief, the knowledge, competencies, examination content, and supervised experience requirements for behavior analyst licensure should be derived from a systematic, validated representative query of persons practicing behavior analysis with preliminary item development by subject matter experts (SMEs). The findings from such surveys should be reviewed by SMEs, revised as needed and then, when any preliminary surveys are shown to be adequately broad and to be psychometrically reliable and valid, the finalized survey should be administered to a large representative group of behavior analysts. An important consideration in this regarding is that the validation sample is sufficiently representative. That is, the validation sample definitely should not be limited primarily to employees and associates of one company or organization nor to persons known to be working primarily with only a subset of the population. The validation of the items for competencies, examination content, and supervised experience must involve reasonable statistical procedures currently standard for professional examinations, a time consuming and potentially costly undertaking. Failure to do so could result in certification criteria that are too lenient, resulting in inadequately prepared persons being licensed and allowed to provide services to the public, causing harm due to inappropriate services being provided or failure to provide needed services. On the other hand, similar methodological inadequacy could result in certification criteria that are too stringent, resulting in too few adequately prepared persons being licensed and allowed to provide services to the public, causing harm due to restricting unduly the number of professionals available to provide behavior analysis services to persons needing them, resulting in avoidable reduction in quality of life and/or safety for persons not receiving needed behavior analysis services. Information relevant to this set of concerns should be readily available in the publicly available information provided by a certifying organization such as on its website. If the information is not readily available or if the procedures for determining the knowledge, competencies, examination content, and supervised experience requirements for behavior analyst licensure lack the rigor briefly summarized here, then one should proceed with great caution regarding whether that organization is operating openly and is likely to provide the best available protection for the public.

3. **Determining that expected supervisory experience maximizes the likelihood that trainees actually have adequate relevant experience to develop the complex skills needed to provide the effective and safe services needed by the public.** Such supervised experience requires persons who could be certified and, thus, licensed, and should explicitly mandate that a large percentage of supervised experience involves direct service provision to clients/ patients. A trainee must not be allowed to possibly satisfy the supervised experience requirements without having demonstrated under rigorous expectations that they, in fact, can provide effective behavior analysis services. Such could happen by the certifying organization allowing trainees to count large amounts of time in activities other than service delivery, while recognizing that some time for activities of that sort is necessary. Another level of threat to the adequacy of supervised experience involves the trainee's supervisor not being required to possess credentials reflecting their having the knowledge and skills necessary to adequately evaluate the trainee's activities as behavior

analyst services, *per se*. A supervisor with license or credentials in another profession without also having credentials in behavior analysis is highly unlikely to be adequately prepared to supervise a trainee to competently and safely provide behavior analysis services. A trainee without adequate supervised experience represents a high risk of causing harm because, if licensed, that person, would provide inappropriate services or fail to provide needed services. Further, without sufficient supervision the person would likely act outside their scope of practice and scope of competence, resulting in inadequate referrals for services from other disciplines (e.g., physicians, speech language pathologists). The information to address this set of concerns should be readily available in the publicly available information provided by a certifying organization such as on its website. If the information is not readily available or what is available indicates that the requirements for supervised experience are inadequate, then one should proceed with great caution regarding whether that organization is operating openly and is likely to provide the best available protection for the public.

4. **Ensuring the results of certification examinations accurately reflect the knowledge of a candidate for certification and then licensure.** A crucial step in realizing that outcome is ensuring that the examination results of behavior reflect that a person having the knowledge of behavior analysis necessary to pass the examination, being certified, licensed as a behavior analyst, and then independently provide services to people. That is on contrast to someone obtaining a passing score fallaciously due to cheating in some manner while taking the test. Thus, information should be readily available regarding the conditions and monitoring of administration of the examination. That information should make clear that the person taking a test is directly monitored, preferably in person and not virtually in locations such as in the United States where staffed, secure testing centers are available. Examination administered solely virtually should be considered more vulnerable to results being affected by extraneous influences. Such influences could result in an examination score of a candidate being falsely inflated to the level of a passing score despite the fact that the persons lacks sufficient knowledge or has acted unethically. As a result, that person lacks knowledge regarding behavior analysis to criteria worthy of receiving a license to practice behavior analysis and is likely harm recipients of their services due to providing inappropriate services or failing to provide needed services. If information regarding the conditions and monitoring of examination administration is not readily available or what is available indicates that the requirements for examination are inadequate, then one should proceed with great caution regarding whether that organization is taking all reasonable precautions to ensure the validity of testing and of validity of examination results, information needed to determine whether the organization's certification is likely to provide the best available protection for the public.

5. **Exploring whether the certifying organization has and enforces a code of ethics for people that it certifies**. A code of ethics articulates in written form, expectations- including general principles- for how certificants are to interact with people and conduct themselves (e.g., honestly, within their scope of competence). The point of a code of ethics or conduct is to have standards by which behavior analysts are held accountable for their behavior. Persons violating the code very often behave in ways that harm the public in various ways including physically, financially, emotionally. Just having a code of ethics or conduct by itself is not enough. If the certifying organization's code is aspirational, and is not accompanied by actions being taken when a violation is substantiated to correct the violator's inappropriate behavior or remove their certification and, thus, their authorization to provide behavior analysis services, then the public has much more limited protection from harm by behavior analysts acting unethically than they should and could have. Information should be readily available providing the code of ethics or conduct *and* regarding enforcement of the code, sanctions having actually been taken regarding certificants shown to have violated it. If the code is not presented or no information is provided clearly indicating that certificants violating the code have been experiencing and/ or will experience meaningful sanctions for doing so, then that certifying organization is falling short of what it could and should do to help protect the public from harm by behavior analysts acting unethically, allowing them to continue doing so and harming increasingly more people.

6. **Considering how certification decisions by an organization could facilitate financial gain accruing to private parties.** Certifying organizations that are nonprofit with their financial information readily available to the public seem less likely to tailor certification criteria and

decisions in a manner that increases the likelihood of candidates being certified. Specifically, when the volume of certificants is accompanied by increased revenue for private parties, the certification criteria are likely to be adjusted be easily met, resulting in an accompanying increase in revenue due to the number of people applying for certification being increasing due to the criteria for gaining and maintain certification being considered relatively easy.

7. **Addressing whether the behavior analyst certifying organization is accredited by a nationally or internationally recognized organization that accredit organizations that issue professional credentials, a necessary but not sufficient factor for adequate protection of the public.** Such accreditation organizations have specific standards for credentialing organizations in various professions and industries. Those standards address numerous factors including, very broadly, the organization's governance, administration, clearly stated standards for its credentials (basis and development of them), assessment development and administration procedures, personnel matters, financial resources, financial management, quality assurance program, updating of standards, defensibility from challenges, and numerous other factors. In the United States two of the organizations most often accrediting organizations that provide professional credentials are the National Commission for Certifying Agencies (*NCCA*), the accrediting body of the Institute for Credentialing Excellence (ICE) and the American National Standards Institute (ANSI) and its subsidiary ANSI National Accreditation Board (ANAB). One of these organizations should accredit any behavior analyst certifying organization. That said, note should be taken that a certifying organization being certified does not ensure that it adequately addresses the issues raised above. Accreditation of a behavior analyst certification organization is necessary but in itself is not sufficient to ensure that a credential from it provides all the protection of the public that can and should be provided. The points above illustrate specific ways potential protection of the public can be optimized or limited by a behavior analyst certifying organization.

We would be happy to provide additional information and engage in discussion regarding this important issue of selecting what behavior analyst certifying organizations provide credentials suitable for being the foundation of behavior analyst licensure. My contact information is provided below.

Thank you for your consideration.

Gordon Bourland, PhD, BCBA-D, LBA

Gordon Bourland, Ph.D., BCBA-D, LBA

Chair, ABAI Licensing Committee

CommentID: **121401**

Commenter: Anonymous 4/13/22 8:37 am

for clarity ABAI recognizes QABA BICC IBAO NASP APA

https://www.abainternational.org/media/188058/abaimembershipform_2022.pdf

https://www.abainternational.org/events/annual-2022.aspx

https://www.abainternational.org/events/international/call-for-submissions/panel-submission-guidelines.aspx

https://www.abainternational.org/welcome.aspx

they have partnered with QABA by going through their ceu process

https://qababoard.com/qaba-ceu-providers/

they have also partnered with NASP

https://www.nasponline.org/professional-development/nasp-approved-provider-program/nasp-approved-provider-directory

and the APA

https://cesaoas.apa.org/cesaApprovedSponsors?_ga=2.14116343.176634169.1649853364-1566104547.1648687600

CommentID: **121406**

Commenter: Kate Lewis 4/13/22 9:14 am

Petition Concerns

I have been a working BCBA in Virginia since 2005. I became licensed as soon as it was required in VA in 2012. I do not support this petition. I echo others concerns. We have worked very hard in this state to develop rigorous standards that uphold our practice. My concerns with this petition are rooted in the protection of consumers. I will reiterate some key points that others have already made.

- Certification standards should be equal or greater than those established and set by the BACB
- Certifying entities should be non-profits to ensure transparency
- Certifying bodies should not be associated with a specific diagnosis, those ensuring that the license is protecting all consumers of behavior analytic practice

CommentID: **121409**

Commenter: Lawerence B. Watson, Psy.D. 4/13/22 9:30 am

Support for Petiton

I support this petition. There is simply no basis for stating that other certifications is less. It seems that one group "the popular kids in school" have this self righteous view of themselves.

CommentID: **121410**

Commenter: Arlondo Ortiz Ramirez 4/13/22 9:42 am

Long overdue

End the monopoly. This will be the greatest thing VA can do. It will force BCBA's to fight for being the best service providers rather than the only option. That is what you need to see. BCBA's should not be THE ONLY OPTION. Patients should have choices and that requires everyone to be held to a higher standard. This appears to be a BACB QABA battle but when you read the the request it actually seeks to give patients the right to choose who their provider is and that is a good thing.

CommentID: **121412**

Commenter: Lisa Falke 4/13/22 9:53 am

Oppose the Petition

Hi! I have concerns about the discrepancy in requirements between certifying bodies and the deterioration in services that could occur by allowing less qualified, practiced or educated

individuals to become licensed. The BACB, the current most prominent and long-standing certification body, has very stringent requirements for certification in an effort to maintain quality. When you compare their qualifications for certification, they far outweigh those of other, newer certifying bodies. There is a big push to quickly create behavior analysts because of the great need for the specialty and profits that can be made by certifying bodies and I worry that speed and profits will be prioritized over quality of services provided if we lessen the criteria for certification as other bodies have done. Please do not remove the requirement for board certification through the BACB. It is an important quality indicator that our field cannot lose. Thank you for your time.

CommentID: **121413**

Commenter: Ross Norris DLitt 4/13/22 10:02 am

Not Yay Nor Nay - Seek Advice of Relate Fields

Good Morning Medicine Board

Have you considered how the only persons that are against this are those that are certified by the Behaviour Analyst Certification Board? Those that are for are QABA. The board shall seek input from unrelated parties on this upmost important matter. The for and against persons have a bias for why they want or do not want their certification on the approved list.

Encourage you to seek outside input. Look at the standards in other related fields such as psychology, counselling, psychoanalysis, etc. See how they operate and model after that.

- RN

CommentID: **121414**

Commenter: Sammy Linderson: ABA Student 4/13/22 10:17 am

BACB Only Creates Single Standard Without Need For Improvement

I support the action placed on the table. Arlando said it best. Multiple standards means there are people working to be the best. One standard means there is no need to improve because we control the licensure.

In a more personal note, it would be nice to have the choice of getting approved by the best org.

CommentID: **121415**

Commenter: Virginia Association for Behavior Analysis 4/13/22 12:03 pm

Public Comment on this Petition

The mission of the Virginia Association for Behavior Analysis (VABA or VirginiaABA) is to promote and support the practice, research, and dissemination of behavior analysis throughout the Commonwealth of Virginia. VABA recognizes that the law and regulations to license practitioners of behavior analysis afford important protections for consumers, funders, the state, and the profession, and that the law and regulations apply to the practice of behavior analysis regardless of client population, setting, funding source, and the like.

VABA has adopted a "Position on Credentials to Serve as Qualification for Licensure to Practice Behavior Analysis"(http://virginiaaba.org/wp-content/uploads/2022/03/Position-on-Credentials.pdf) that we feel is important when evaluating certifications that are to be accepted for licensure. Here

are some highlights:
– Entities that certify professional practitioners of ABA should be nonprofit organizations. Internal Revenue Service regulations require nonprofit (tax exempt) organizations to serve and be accountable to the public; have no owners, shareholders, or investors; and use any surplus revenues to benefit the communities they serve. The organization should be governed by an independent board of volunteer directors and make its bylaws and other governing policies available to the public. That is, nonprofit credentialing organizations must be **transparent** about how they are governed and operated, how their credentialing and other standards are developed and implemented, and other aspects of their credentialing programs. That allows applicants for and holders of the credentials, consumers, employers, funders, and governments to easily access critical information about the organization. The overwhelming majority of U.S. organizations that issue professional certifications in healthcare and human services are nonprofits. A notable example is the American Psychological Association's Criteria for the Recognition of Organizations that Provide Certifications in Specialties and Subspecialties in Professional Psychology, which has as its first criterion "The certifying body is a **non-profit** organization that has **published bylaws, standards, and procedures** and is governed by an **independent board of directors**, with specified procedures for selection and tenure of board members such that control does not rest with one individual or group of individuals indefinitely" (emphases added). https://www.apa.org/ed/graduate/specialize/recognition-criteria.pdf
– Certifying entities should conduct job analysis studies using well-established procedures and standards to identify the competencies required to practice ABA with **any** client or service recipient, not just a subset (e.g., those with a specific diagnosis). The studies should involve large numbers of subject matter experts, credentialed members of the profession, and experts in psychometrics (test construction and validation). The resulting list of competencies should drive the contents of the professional examinations that are required to obtain the certifications. It may also inform decisions about other certification eligibility requirements (often called task lists or exam outlines), and related standards should be readily available to the public. These job analysis studies should be regularly repeated to ensure they are keeping up with the profession.

At this time, we do not know of any certification organizations beyond the Behavior Analyst Certification Board (BACB) that meet these criteria. Therefore, we do not support the petition. Thank you for your consideration.

CommentID: **121424**

Commenter: Kim Jung 4/13/22 12:50 pm

Support for Rulemaking

I endorse the rulemaking process to include various types of certification. The government should set standards not those who can get rich off them.

CommentID: **121428**

Commenter: Raymond Henderson 4/13/22 1:49 pm

Yes

I am in favor of this request.

I note the Board of Med does not require cert. for the practice of various other occupations.

CommentID: **121434**

Commenter: Jody Liesfeld 4/13/22 2:18 pm

Oppose the petition

While I am not opposed to other entities seeking licensure, the fact of that matter is that the scope of a Licensed Behavior Analyst surpasses the autism specific training of a QABA certificate. We must maintain high standards to protect the clients we serve, and at this time, the BACB is the only certification body that adheres to such standards

CommentID: **121435**

Commenter: Raheed Morishani 4/13/22 2:36 pm

Misnomer

So awkward. Some saying autism specific. It's not. It's better. Includes all the elements of Behavior Analysis while having component of autism as additional requirement. The autism pieces is xtra. It does not make up the other components.

Behavior Analysis + Autism not Autism Behavior Analysis

CommentID: **121436**

Commenter: Courtney Vaughan 4/13/22 2:46 pm

Concerns

As a Board Certified Behavior Analyst and a Licensed Behavior Analyst in the state of Virginia I believe the following:

- Certification standards should be equal or greater than those established and set by the BACB
- Certifying entities should be non-profits to ensure transparency
- Certifying bodies should not be associated with a specific diagnosis

CommentID: **121438**

Commenter: Rosi Talleia 4/13/22 3:04 pm

Why the lie

You should ask if you choose to have an organization that keeps reposting the same lies without doing proper research as the group working with kids who have behavior challenges. It shows they don't know research or consistency. It interesting that they make autism the center focus when as stated in previous comments the BACB is focus on Autism 80% BCBA autism.

CommentID: **121440**

Commenter: James Santoyo 4/13/22 3:05 pm

Oppose

I've been practicing as a Licensed Behavior Analyst in Virginia since 2013 and I oppose this petition. The individuals who receive our services deserve the best protection and utmost quality of care and treatment. To provide a high level of protection to consumers of behavior analytic services, the following should be adhered to by credentialing boards that are accepted as qualification for licensure:

1) Credentialing boards should have standards that are equal to or greater than those currently required by Virginia law.

2) Credentialing boards should hold non-profit status to ensure transparency with consumers, regulators, and the general public.

3) Credentialing boards should focus on certifying individuals in *behavior analysis* and not one specific population.

At this time, the only credentialing board that meets these criteria is the Behavior Analyst Certification Board (BACB).

CommentID: **121441**

Commenter: Zac Larson 4/13/22 3:12 pm

Copy Paste Repeat

Copy paste repeat is what the opposition is doing as if this is a vote lol.

They will spread the misinformation in an attempt to get their way. The law is clear. The rule violates the law.

CommentID: **121442**

Commenter: Lina Toma? 4/13/22 3:14 pm

So much Narcissism

Hey look at us. We are the BACB and we are better than everyone else so let us bully you into following only our rules. End the monopoly! Create competition for high standards.

CommentID: **121443**

Commenter: Lina Tomas 4/13/22 3:21 pm

Name

My name is Lina Tomas apparently you can't put the S with the apostrophe.

CommentID: **121444**

Commenter: Anonymous 4/13/22 3:29 pm

Confusion on autism-focused credentials?

Some individuals advocating for the petition (for QABA credentials specifically, in most cases), have been calling into question the honesty of other commenters who have pointed out the autism-focus of their credentials. I'm not sure what the confusion is about, but the autism-focus is written front-and-center on QABA's website (https://qababoard.com/). In its own Mission Statement, which reads:

"The Qualified Applied Behavior Analysis Credentialing Board (QABA®) is an internationally-accredited credentialing agency dedicated to ensuring the highest standard of care ***among professionals providing applied behavioral analysis (ABA) services for individuals with autism spectrum disorders and related disabilities."***

Even QABA's middle tier/bachelor's level credential has autism in its very name, the Qualified **Autism** Service Practitioner-Supervisor (QASP-S)?

I hope this helps clear up any lingering confusion.

CommentID: **121446**

Commenter: Anonymous 4/13/22 3:32 pm

Interesting.

Interestingly, some of the most recent comments are from people who cannot be found on any social media platform or registry. My question to the Board of Medicine is, how do you verify that the comments are not from made-up people.

Can anyone guess who the newest ANON comments are from? It doesn't take a rocket scientist to figure that one out. Will the real narcissist please stand up?

CommentID: **121447**

Commenter: Hollie Benincosa 4/13/22 3:34 pm

In favor of petition

I am in favor of the petition and to include accredited certifying bodies who meet the highest standards tp certify professionals in the field of applied behavior analysis. I believe it is important for consumers to have a choice.

CommentID: **121448**

Commenter: Emily Rotola 4/13/22 3:56 pm

Not in Favor

As a Board Certified Behavior Analyst licensed to practice in the state of Virginia, I felt compelled to comment and express my lack of favor for the petition "to remove the specific requirement for BACB certification and accept certification from an entity that is nationally accredited to certify practitioners of behavior analysis". The scope of practice for a Licensed Behavior Analyst in the state of Virginia as specified in the Regulations Governing the Practice of Behavior Analysis (18VAC85-150-110) includes "Design, implementation, and evaluation of environmental modifications using the principles and methods of behavior analysis to produce socially significant improvement in *human behavior* including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior; and 2. Supervision of licensed assistant behavior analysts and unlicensed personnel". This scope of practice far outreaches the world of Autism – touching, but certainly not limited to behavioral gerontology, behavioral pediatrics, treatment of substance abuse disorders, brain injury rehabilitation, education, environmental sustainability, health and fitness, and organizational behavior management. QABA's website states they are a credentialing agency "dedicated to ensuring the highest standard of care among professionals providing applied behavior analysis services *for individuals with autism spectrum disorders and related disabilities."* This specification within QABAs language – and therefore their training and scope of practice – of course presents a disservice to those seeking professional service within the many other fields a BCBA is qualified to provide service to. When I have an injury to a bone, an orthopedic surgeon is my best bet – for any other ailment, I want a more globally trained doctor. We have a responsibility to those seeking service within behavioral pediatrics, substance abuse disorders, TBI, among others – to ensure their service is being provided by a behavior analyst with training in that field – not limited to autism. I value a world in which there are enough trained and competent providers to serve

everyone needing behavior analytic services – I do not value a world in which we compromise that service just to increase quantity of providers.

CommentID: **121449**

Commenter: Michael Moates, MA 4/13/22 4:00 pm

Clarity

Thank you to my colleagues for bringing this to my attention. I had not intended to comment anymore and I do with the intention of being respectful but there seems to be some confusion and misinformation.

I just want to clarify that my petition was not directed at any one agency. Not the BACB, QABA, BICC, etc

My petition referenced any organization that is accredited by ANSI or NCCA in behavior analysis. The goal was to bring the rule into compliance of the statute which requires the language used in the statute to be listed in the rule and it is not.

Having Autism coursework in addition to behavior analysis coursework should not disqualify someone, it should be considered an asset as long as it is in addition to the other required coursework/testing requirements.

It is for both QABA and BICC in my opinion.

Here are the competencies:

QBA: https://qababoard.com/wp-content/uploads/QBA-Competency-Standards-2022.pdf

QASP-S: https://qababoard.com/wp-content/uploads/QASP-S-Competency-Standards-January-2022.pdf

BCAP: https://behavioralcertification.org/wp-content/uploads/2021/03/BCAP-Candidate-Handbook-20210218.pdf

Here are the scopes of practice:

QBA: https://qababoard.com/qualified-behavior-analyst-scope/

QASP-S: https://qababoard.com/qasp-s-scope/

Also, ANSI has clearly stated that the QABA credentials are not Autism certificates but rather Behavior Analysis certifications.

See: https://townhall.virginia.gov/L/viewcomments.cfm?commentid=121046

See: https://anabpd.ansi.org/Accreditation/credentialing/personnel-certification/AllDirectoryDetails?&prgID=201&OrgId=2168&statusID=4

Some have asked about job analysis:
https://www.behavioralcertification.org/Content/Documents/Job_Analysis_Executive_Summary_2017.pdf

Also, something else I thought of, the FBI Behavior Analysis Unit is located in Quantico, Virginia. Has the Board of Medicine considered asking them for input?

Autism is one piece of each credential. They are tested in the Applied Behavior Analysis areas separately. Having Autism in the name does not make it only autism it just makes it a additional specialization.

I respect the anonymous commenters passion. I agree with them that if the board has reason to suspect foul play they should investigate who is commenting. The IP address, location, etc is all

information that is traceable. If they all are having related locations, IP's, etc the board should not consider the comments.

You would have to be pretty uneducated to not know these kinds of things can be tracked.

I do not believe this is the case and I also suggest that there are many BCBA's also randomly commenting today. I believe that this is because it is the last day of the commenting period and many others have posted on various websites and social media.

I leave it to the board and IT to investigate and I hope they will. The board should only consider comments that are accurate.

CommentID: **121450**

Commenter: Kaitlyn Poten Behavior Asst 4/13/22 4:04 pm

Chicken Soup for the Soul

If the BACB is so determined to be the best why are they so scared of competition over the best standards?

CommentID: **121451**

Commenter: Council of Autism Service Providers 4/13/22 4:08 pm

CASP Public Comment on Behavior Analysis Petition

I write to you today on behalf of The Council of Autism Service Providers (CASP) and our member organizations in Virginia which are serving children and adults diagnosed with autism spectrum disorder. CASP is a **non-profit** association of organizations committed to providing evidence-based care to individuals with autism. CASP represents the autism provider community to the nation at large, including government, payers, and the general public. We provide information and education and **promote standards that enhance quality of care.** Of particular interest to our members is the coverage of evidence-based care, including applied behavior analysis (ABA) for autistic individuals of all ages in both private health insurance plans as well as through Medicaid.

As a stakeholder who has worked in Virginia since 2008, I was part of the drafting process of Virginia's autism insurance law[1] not only during its original passage but in every subsequent amendment. The statute read in its original form and in every amended form to date that:

Treatment for autism spectrum disorder" shall be identified in a treatment plan and includes the following care prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) ***applied behavior analysis when provided or supervised by a board-certified behavior analyst*** *who shall be licensed by the Board of Medicine. The prescribing practitioner shall be independent of the provider of applied behavior analysis.*

This language specifically references that applied behavior analysis is provided or supervised by a **board-certified behavior analyst**. The legislative intent was to adhere to generally accepted standards[2] of care specific to medically necessary applied behavior analysis for individuals diagnosed with an autism spectrum disorder.

These standards indicate that:

ABA is a specialized behavioral health treatment approach and most graduate or postgraduate

training programs in psychology, counseling, social work, or other areas of clinical practice do not provide in-depth training in this discipline.

The formal training of professionals certified by the Behavior Analyst Certification Board (BACB) is similar to that of other medical and behavioral health professionals. That is, they are initially trained within academia and then begin working in a supervised clinical setting with clients. As they gradually demonstrate the competencies necessary to manage complex clinical problems across a variety of clients and medical environments, they become independent practitioners. In summary, Behavior Analysts undergo a rigorous course of training and education, including an "internship" period in which they work under the direct supervision of an experienced Behavior Analyst.

The BACB is a ***nonprofit*** *501(c)(3) corporation established to meet professional credentialing needs identified by Behavior Analysts, governments, and consumers of behavior analysis services. The mission of the BACB is to protect consumers of behavior analysis services worldwide by systematically establishing, promoting, and disseminating professional standards. The BACB has established uniform content, standards, and criteria for the credentialing process that are designed to meet:*

- *The legal standards established through state, national, and case law;*
- *The accepted standards for certification programs; and*
- *The "best practice" and ethical standards of the behavior analysis profession.*

The BCBA and BCaBA certification programs are currently accredited by the National Commission for Certifying Agencies (NCCA), the accreditation arm of the Institute for Credentialing Excellence. NCCA reviews and oversees all aspects related to ensuring the development and application of appropriate credentialing processes.

Appropriate credentialing and certification are not only critical to the safety and well-being of consumers who are prescribed applied behavior analysis therapy by their licensed physician or psychologist, but also to the effectiveness of the intervention itself.

We strongly encourage you to continue to follow generally accepted standards of care and thus deny the petitioner's request to remove the specific requirement for BACB certification and accept certification from an entity that is nationally accredited to certify practitioners of behavior analysis.

Should you need additional information, please do not hesitate to contact me.

Sincerely,

Judith Ursitti

Vice President of Government Affairs

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[1] https://lis.virginia.gov/cgi-bin/legp604.exe?201+ful+CHAP0305

[2] Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers (2nd ed.)

CommentID: **121452**

Commenter: Anonymous 4/13/22 4:16 pm

Note of Intimate Relationship

Check out the intimate relationship between the BACB and CASP -https://www.bacb.com/tag/casp/

https://www.bacb.com/asd-practice-guidelines-find-new-home-with-casp/

Here - we will let you take over our autism standards and you in turn will support us in the future. Pay for play.

CommentID: **121453**

Commenter: A concerned parent 4/13/22 4:53 pm

Game of who is bigger

All of the boards on this post should be removed. You are all selfish and not at all worried our kids. This is horrifying.

CommentID: **121454**

Commenter: Beth Newcomb 4/13/22 8:38 pm

Oppose Petition

As a Licensed Behavior Analyst living and practicing in Virginia, I share the concerns that others have noted with regard to rigor of standards and a certification that is associated with only a single diagnosis. For the protection of the consumers of behavior analysis in the state of Virginia, a certification entity must be non-profit and transparent in their operations. Therefore, I oppose this petition.

CommentID: **121457**

Commenter: Ken Crum, ServiceSource 4/13/22 8:42 pm

Behavior Analysis Comments

ServiceSource is a large day and employment services provider in Northern Virginia. We support hundreds of individuals with developmental disabilities, behavioral health needs as well as people with sensory and physical disabilities. Due to the pandemic, there are increased behavioral support needs and a lack of resources to address concerns. Additionally, there is a significant financial strain placed on providers to hire or contract with licensed/certified behaviorists.

ServiceSource supports the continued emphasis on strict bylaws, qualifications and other requirements that are implemented by a single entity, since this provides a structure of how services, plans, and interventions are outlined. It also ensures that the qualification process and educational requirements are heavily monitored, ensuring that the behavioral health professional undergoes rigorous and high-quality training. The qualification process is dictated by certain bylaws, ethic codes, and principles of applied behavior analysis, something that can be overlooked by entities unfamiliar or new to ABA principles.

We also support acquiring a more diverse workforce and recommend increasing the number of behavioral health professionals with specialties in differing concentrations and we believe that their basis of ABA knowledge should be consistent and monitored by a single entity.

Ultimately, it would be beneficial for behavioral health professionals providing services to Virginians be accredited under one national entity. With additional accreditation boards, there is no guarantee ensuring services rendered are based on rigorously tested and empirical based studies, and the potential for pseudoscience or bogus interventions may grow exponentially.

CommentID: **121458**

Commenter: Katherine Robinson 4/13/22 8:58 pm

Opposed

As a Licensed Behavior Analyst in the state of Virginia since 2012, I share the concerns of many of my fellow LBA's currently practicing within the Commonwealth. While I am not opposed to the BOM considering other certifying bodies in the future, I am opposed to removing the language that requires a certification by the BACB to qualify for the LBA or LABA credential. Removing the current language would allow for the reduction in qualifications, training, and standards that are in place to protect consumers. Removing the language would ultimately harm consumers by allowing other certifying bodies who have lower standards to hold the same license and practice with less experience and clinical education and training requirements.

CommentID: **121460**

Commenter: W. S. Harris 4/13/22 9:03 pm

Support

The board should adopt this simply because clients and their families should have the right to their choice of provider.

CommentID: **121461**

Commenter: Jabrad M Rahad 4/13/22 9:08 pm

Consent Violations

The medicine board should not violate the consent of the client by coercing them to get treatment by one entity.

Do better.

CommentID: **121462**

Commenter: Jennifer Wade, M.Ed, BCBA, LBA 4/13/22 11:41 pm

Oppose the Petition

Good evening,

I have worked in the field of ABA in the Commonwealth of Virginia for over 20 years. I have been a Board Certified Behavior Analyst since 2010 and became a Licensed Behavior Analyst in 2012, when licensure became available. I am heavily invested in our community, our clients, our families, and our profession.

I agree with many of the remarks of others in opposition to the petition. For me, the area that is most concerning is this: At a time when our field is being flooded with new practitioners, we

CANNOT lower our standards. For the sake of our clients and for the sake of our field, we must ensure that professionals practicing in our Commonwealth are held to the same standards (or higher) than those that are currently in place. The Board and the relevant Working Group worked tirelessly a decade ago to create the licensure requirements and guidance documents that exist to this day. If those need to be amended with proper consideration and for valid reasons, so be it. Lowering the expectation for coursework and supervised fieldwork is unacceptable and not a valid reason to revise what is currently in place.

Thank you for your consideration.

CommentID: **121466**

Commenter: Prof. Michael Moates, MA, QBA, LBA, LMHP 4/13/22 11:58 pm

Give Patients the Right to Choose and Raise the Standard By Adding Competition

Board of Medicine:

I am so glad this is over. I want to leave you with some final thoughts to consider.

I am so tired of being degraded, dehumanized, threatened, stalked, etc. Members from the BACB have called my employer, certification board, etc. They have stalked me online. It just was extremely unprofessional behavior for an organization that is wanting to set the standard.

In spite of this, we all pushed through. We fought till the end and when the board takes up this action, we know that they will do so with all of the information.

Final Points:

Behavior Analyst Certification Board (Wants to be the popular kid but is really the bully):

- 70% of BCBA's are white, less than 1% are American Indian, less than 1% are Pacific Islander, 10% are Hispanic, 6% are Asian, and 3% are black. There is no diversity. https://www.bacb.com/bacb-certificant-data/
- 86% of BCBA's are female, 12% are male, with the rest as other or not identified. There is an issue of finding male therapists. https://www.bacb.com/bacb-certificant-data/
- 72% of are focused on Autism Spectrum Disorder. https://www.bacb.com/bacb-certificant-data/
- The BACB is withdrawing from the international market. https://www.bacb.com/global-certification/
- The BACB does not offer its testing in other languages besides English. https://www.bacb.com/global-certification/
- The BACB does not recognize clinical psychiatrists engaged in behavior analysis as supervisors. https://www.bacb.com/bcba-handbook
- The BACB does not accept CEU's from Psychiatrists, Psychologists, etc... only its BCBA's. They would not allow you as doctors to even teach continuing education courses https://www.bacb.com/wp-content/ACE-Provider-Handbook
- The BACB continues to certify the leadership at the Judge Rotenberg Center that is shocking children. https://www.youtube.com/watch?v=Ko-ip3MImik
- The United Nations has designated practices lead by BCBA's as torture. We treat prisoners at Guantanamo Bay better. https://abcnews.go.com/Nightline/shock-therapy-massachussetts-school/story?id=11047334

- The BCBAs on this board are (the BACB has been notified and they have stated they intend to do nothing about this):
  - **Board of Directors: Henry Slucki, Ph.D.**

    Jessica E. Van Stratton, Ph.D., BCBA-D, LBA

    Richard Malott, Ph.D., BCBA-D

    Josh Pritchard, Ph.D., BCBA-D

    Ronald Van Houten, Ph.D.

    W. Joseph Wyatt, Ph.D.

    On Staff:

    Nathan Blenkush, PhD, BCBA-D

- The BACB seeks to oust other qualified supervisors from supervising behavior technicians, assistant behavior analysts, and aspiring behavior analysts. While psychologists, psychiatrists, social workers, professional counselors, and other related fields retain the right to practice behavior analysis, the BACB does not recognize them as supervisors of behavior analysis. https://www.bacb.com/wp-content/ACE-Provider-Handbook
- The BACB has already stated its standards for 10 years from now despite not knowing how academic research will present. https://www.bacb.com/wp-content/mar2022_Newsletter
- They are trying to build an anti-competitive licensure monopoly.
- The BACB threatens other non-profits who attempt to work in behavior analysis.
- The BACB leadership team is 100% white people. https://www.bacb.com/about/staff-leadership/
- The BACB talks negatively about other boards calling them Autism specific. This is just libelous as stated by ANSI. https://townhall.virginia.gov/L/viewcomments.cfm?commentid=121046 No comment on this discussion post has provided evidence that alternative certification boards are acting in bad faith or unethically.
- No poster has provide evidence that any other board is less qualified.
- The BACB cannot possibly meet the requirements of different populations across all 50 states.
- BCBA's personally benefit from less providers. They have long waitlists which hurts the client. ABA treatment is more effective the earlier it starts.
- Here is a BCBA being arrested for assault. https://www.kktv.com/2021/11/10/behavior-analyst-loses-license-this-11-call-action/

Qualified Applied Behavior Analysis Credentialing Board (Top Alternative, the A Student):

- The QABA Board has not only each of the requirements of the BACB however they have even more requirements.
- They are not an autism specific board. Autism is in addition to the behavior analysis requirements. https://qababoard.com/wp-content/uploads/QBA-Competency-Standards-2022.pdf

- They require a psychometric exam. https://qababoard.com/taking-examinations
- The require supervision experience hours. https://qababoard.com/wp-content/uploads/QABA-Supervision-Log-January-2022.pdf
- They require a federal and state background check. https://qababoard.com/background-attestation-form/
- They require a masters degree. https://qababoard.com/wp-content/uploads/QBA-Candidate-Handbook-March-2022.pdf
- They require coursework in applied behavior analysis. https://qababoard.com/wp-content/uploads/QBA-Competencies-Worksheet-January-2022.pdf
- They have an ethics code. https://qababoard.com/code-of-ethics/
- They are run by an independent board of directors. https://qababoard.com/leadership/
- They also have an international standards committee. https://qababoard.com/pages/qaba-international-standards-committee/
- They have an Africa based operation. https://qababoard.com/pages/qaba-in-africa/
- They are accredited by ANSI in Behavior Analysis. https://qababoard.com/
- They are recognized by the Department of Defense. https://manuals.health.mil/pages/DisplayManualHtmlFile/2021-03-26/AsOf/TO15/C18S4.html
- Exam and certification materials are offered in alternative languages. https://www.qababoard.net/
- QABA offers discounts to 3rd world countries that are developing the practice of behavior analysis. https://www.youtube.com/watch?v=fL4n_hgW4lc
- They have a designated scope of practice and competency requirements. https://qababoard.com/wp-content/uploads/QBA-Competency-Standards-2022.pdf
- There is no evidence that QABA is less qualified. In fact, they require more educational subjects than the BACB. It could also be argued an organization that is not entangled with the certification of people shocking children is better.

Behavioral Intervention Certification Council:

- They have additional requirements beyond what the BACB requires. https://www.behavioralcertification.org/Content/Documents/BCAP_Exam_Content_Outline.pdf
- They are accredited by NCCA. https://ice.learningbuilder.com/Public/MemberSearch/ProgramVerification?model.MemberName=behavior&SearchAliases=false&model.Role=&model.MemberRoleLabel=&attr.Industry=&attr.Name=&performSearch=true
- They require supervision experience. https://behavioralcertification.org/wp-content/uploads/2021/10/BCAT_2_year_documentation_of_supervision-2.pdf
- They require at least a masters degree. https://behavioralcertification.org/wp-content/uploads/2021/03/BCAP-Candidate-Handbook-20210218.pdf
- They require behavior analysis coursework. https://behavioralcertification.org/wp-content/uploads/2021/03/BCAP-Candidate-Handbook-20210218.pdf
- They have a code of conduct. https://www.behavioralcertification.org/Content/Documents/BICC_Code_of_Conduct_20

19_2020.pdf

- They require passage of a psychometric exam. https://behavioralcertification.org/wp-content/uploads/2021/03/BCAP-Candidate-Handbook-20210218.pdf
- They have an independent board of directors. https://behavioralcertification.org/about-us-autism-spectrum-disorder/board-directors/
- They have conducted a job analysis. https://www.behavioralcertification.org/Content/Documents/Job_Analysis_Executive_Summary_2017.pdf
- They require a background check. https://www.behavioralcertification.org/Content/Documents/SaferPlaces_Disclosure_and_Authorization.pdf
- They have a designated scope of practice and competency requirements. https://www.behavioralcertification.org/Content/Documents/BCAP_Exam_Content_Outline.pdf

International Behavior Analysis Organization:

- They are not an autism specific board.
- They require a psychometric exam or you can qualify based on accredited BCBA or QBA equivalency. https://theibao.com/docs/IBA-Exam-Procedures-v101.pdf
- The require supervision experience hours. https://theibao.com/docs/IBA-Requirements-v101-ENG.pdf
- They require a masters degree or additional experience. https://theibao.com/docs/IBA-Requirements-v101-ENG.pdf
- They require coursework in applied behavior analysis. https://theibao.com/docs/IBA-Requirements-v101-ENG.pdf
- They have an ethics code. https://theibao.com/docs/IBAO-Ethical-Guidelines-V100.pdf
- They are run by an advisory board. https://theibao.com/professional_advisory_board
- Exam and certification materials are offered and being developed in alternative languages.
- They have a designated scope of practice and competency requirements. https://theibao.com/docs/IBA-REOs-V100.pdf
- They are not currently accredited. This information is provided to the board for reference.

Third Party Boards:

- The Virginia Association for Behavior Analysis requires a masters degree only for membership. https://virginiaaba.org/choose-membership/
- The Association for Behavior Analysis International recognizes QABA, BICC, and IBAO in addition to the BACB. https://www.abainternational.org/media/188058/abaimembershipform_2022.pdf

State of Virginia:

- The State of Virginia is already has already recognized alternative certifications we are simply asking you to codify it in the rules to be consistent.
- The law requires the board by saying "shall include" "Documentation that the applicant is currently certified as a Board-Certified Behavior Analyst by the Behavior Analyst Certification Board or **any other entity that is nationally accredited to certify**

practitioners of behavior analysis;" (Emphasis Added)
http://www.dhp.virginia.gov/media/dhpweb/docs/med/leg/Ch29_Medicine.pdf

- No other mental health board in Virginia requires certification by one entity. See: https://www.dhp.virginia.gov/counseling/ https://www.dhp.virginia.gov/counseling/counseling_laws_regs.htm https://www.dhp.virginia.gov/psychology/psychology_laws_regs.htm
- Most other Virginia Licensing Boards offered grandfather periods for previously practicing professionals where the Behavior Analysis occupation was not provided the same. See: § 54.1-3509, § 54.1-3514,
- It is likely unlawful to force association to one organization under the First Amendment.
- It is likely unlawful for a government entity to force association that is a violation of someones religious beliefs. Re shocking children and the First Amendment.
- Given the above, there is a pending court preliminary injunction to strike down any law that only allows for licensure via the BACB. If the board wants to protect itself it might consider adding an alternative.
- More certification boards would allow your constituents the choice to choose their providers.
- More certification boards would require the BACB to compete and raise the bar/standard to meet other certification boards which require additional courses, experiences, and even simple things like a background check.
- More providers would also decrease the waitlists for ABA services. Search for waitlist using the find feature and you will see these providers have a "long" "extensive" waitlists. https://www.leapahead.org/ https://www.greenboxaba.org/ https://www.chattanoogaautismcenter.org/outpatient-clinic http://learnwithmasc.org/about-us/services/ https://villagemindset.org/staff/stacie-dizzley-streeter-bcba/ https://www.blueridgehorizonaba.com/locations
- News articles on the same. https://www.localdvm.com/news/virginia/local-clinics-join-forces-to-combat-aba-practitioner-shortage-as-autism-cases-climb/

Quotes:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2854065/

"The BACB does not appear to have the money, staff, time, or legal authority to provide the necessary ethical oversight, especially with the literally thousands of members of the Association of Behavior Analysis International (ABAI) and/or BCBAs who practice both within the United States and around the world."

"To further complicate matters, the BCBA credential is not consistent with the generally accepted concept of board certification as recognized in the fields of medicine, psychology, and other human service professions."

This is stated by their own certified people.

Michael Dorsey, PhD, BCBA

Michael Weinberg, PhD, BCBA

Thomas Zane, PhD, BCBA

Megan Guidi, MSEd, BCBA

https://www.abainternational.org/media/177713/luiselli.pdf

"One issue of regulatory concern is that often discussed in behavior analytic circles is that Behavior Analyst Certification Board (BACB) offers a national license. This is false. BACB is not licensing, nor could the BCBA ever be a national license for behavior analysts. Licensure falls under the states rights or powers. It is the prevue of each state to restrict trade within its borders. United States v. Lopez, 514 U.S. 549 (1995) held that the federal government only has the right to create laws that effect interstate commerce."

This is stated by their own certified people.

Joseph Cautilli, PhD, BCBA-D

Halina Dziewulska, MSEd. BCBA

I respectfully ask you to help us give patients the **right to choose.** Give them the opportunity to have increased quality care by **raising competition that forces people to compete to be the best provider.** I encourage you to look at links and documents also feel free to reach out to me should you have any question. There were a lot of statements made in this comments section. Very few actually included references or documentation to back up such claims.

Help me step in to the future and:

Empower your patients with the right to choose by raising the bar of competition. More standards = forcing people to be the best.

Very Respectfully,

Prof. Michael Moates, MA, QBA, IBA, LBA, LMHP

Global Institute for Behavior Practitioners and Examiners, a non-profit organization

Doctor of Education Candidate

University Professor

Student Health Advisory Committee

Senior Member, Civil Air Patrol, United States Air Force Auxiliary

Certified Accreditation Evaluator

CommentID: **121468**

Commenter: Christy Evanko 4/14/22 12:00 am

Comment

My name is Christy Evanko. This comment is not on behalf of any organization for which I work or am a member but is solely my comment. I do not work for the Behavior Analyst Certification Board in any manner, but I want do disclose that I am a certificant. I was born in Virginia, moved away, but have lived here for over 20 years since moving back. I am committed to Virginians and their safety as I hope I have shown with my prior actions. I am a practitioner, but I am also a past consumer of behavior analysis services and those services were life-changing for my family. I will always be grateful.

I have been so dismayed by reading the comments in both the incorrect usage of behavior analytic terms to prove one's point and the vitriol that that been applied when someone posts. The point of public comment is for people to share their opinions so that the Board can make an informed decision. I don't feel that in this particular process, people felt comfortable sharing their opinions, and I am concerned that the process has been impeded, both by people not posting for fear of retribution and people posting under false names to further a narrative. My experience

with the Board of Medicine is that they are a thoughtful group who looks at all angles and understands the law. I am hopeful they will go through this comment and explore all the relevant issues, despite the many distractions and attempts to redirect.

DHP licenses are about the safety of the consumer.

- It is my opinion that understanding and applying the science of behavior analysis is a powerful responsibility that should not be taken lightly.
- It is my opinion that there has been too much focus on using the science to "cure" a disorder and not enough focus on changing behavior to create a better life for someone and the people around them, despite any diagnosis.
- It is my opinion as a consumer that I want to know I'm protected because the person who is providing services is certified by an organization that is transparent and has educational experiences that are rigorous and evaluated by ongoing job analysis studies – studies that, as a consumer, I have easy access to.
- It is my opinion that if the Board of Medicine amends its regulations to include *any* nationally-accredited certification that it will lead to a race to the bottom from for-profit companies that place their requirements just below the lowest one that exists, so that people who are trying to escape putting in the necessary work (based on rigorous job analysis studies) will choose that certification over a more difficult one. I'm not saying that any current company is doing this, but that the potential exists if there are not safeguards in place.
- It is my opinion that it *would* be safe for another certification company to be accepted for licensure in Virginia, but that company would need to be non-profit/transparent, and the certification would need to be irrespective of diagnosis (meaning that there is not specific coursework required with respect to a diagnosis because diagnosis is not in our scope), have rigorous requirements based on job analysis studies, and require education from independently evaluated providers (e.g., universities).

This is a public comment forum, and these are my opinions. This science and this field are important to me, and I trust the Board will consider the decision carefully with the consumer/patient in mind.

Thank you,

Christy

CommentID: **121469**

Commenter: Prof. Michael Moates, MA, QBA, LBA, LMHP 4/14/22 12:01 am

Give Patients the Right to Choose and Raise the Standard By Adding Competition

Apparently you can add comments after the deadline lol.

CommentID: **121470**

Commenter: Prof. Michael Moates, MA, QBA, LBA, LMHP 4/14/22 12:02 am

Give Patients the Right to Choose and Raise the Standard By Adding Competition

It appears it did not post correctly.

Here:

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I am so tired of being degraded, dehumanized, threatened, stalked, etc. Members from the BACB have called my employer, certification board, etc. They have stalked me online. It just was extremely unprofessional behavior for an organization that is wanting to set the standard.

In spite of this, we all pushed through. We fought till the end and when the board takes up this action, we know that they will do so with all of the information.

Final Points:

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- The United Nations has designated practices lead by BCBA's as torture. We treat prisoners at Guantanamo Bay better. https://abcnews.go.com/Nightline/shock-therapy-massachussetts-school/story?id=11047334
- The BCBAs on this board are (the BACB has been notified and they have stated they intend to do nothing about this):
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    Jessica E. Van Stratton, Ph.D., BCBA-D, LBA

    Richard Malott, Ph.D., BCBA-D

    Josh Pritchard, Ph.D., BCBA-D

    Ronald Van Houten, Ph.D.

    W. Joseph Wyatt, Ph.D.

    On Staff:

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- The BACB has already stated its standards for 10 years from now despite not knowing how academic research will present. https://www.bacb.com/wp-content/mar2022_Newsletter
- They are trying to build an anti-competitive licensure monopoly.
- The BACB threatens other non-profits who attempt to work in behavior analysis.
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- The BACB talks negatively about other boards calling them Autism specific. This is just libelous as stated by ANSI. https://townhall.virginia.gov/L/viewcomments.cfm?commentid=121046 No comment on this discussion post has provided evidence that alternative certification boards are acting in bad faith or unethically.
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Qualified Applied Behavior Analysis Credentialing Board (Top Alternative, the A Student):

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- They require a masters degree. https://qababoard.com/wp-content/uploads/QBA-Candidate-Handbook-March-2022.pdf
- They require coursework in applied behavior analysis. https://qababoard.com/wp-content/uploads/QBA-Competencies-Worksheet-January-2022.pdf
- They have an ethics code. https://qababoard.com/code-of-ethics/
- They are run by an independent board of directors. https://qababoard.com/leadership/
- They also have an international standards committee. https://qababoard.com/pages/qaba-international-standards-committee/
- They have an Africa based operation. https://qababoard.com/pages/qaba-in-africa/
- They are accredited by ANSI in Behavior Analysis. https://qababoard.com/
- They are recognized by the Department of Defense. https://manuals.health.mil/pages/DisplayManualHtmlFile/2021-03-26/AsOf/TO15/C18S4.html

- Exam and certification materials are offered in alternative languages. https://www.qababoard.net/
- QABA offers discounts to 3rd world countries that are developing the practice of behavior analysis. https://www.youtube.com/watch?v=fL4n_hgW4lc
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Behavioral Intervention Certification Council:

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- They are accredited by NCCA. https://ice.learningbuilder.com/Public/MemberSearch/ProgramVerification?model.MemberName=behavior&SearchAliases=false&model.Role=&model.MemberRoleLabel=&attr.Industry=&attr.Name=&performSearch=true
- They require supervision experience. https://behavioralcertification.org/wp-content/uploads/2021/10/BCAT_2_year_documentation_of_supervision-2.pdf
- They require at least a masters degree. https://behavioralcertification.org/wp-content/uploads/2021/03/BCAP-Candidate-Handbook-20210218.pdf
- They require behavior analysis coursework. https://behavioralcertification.org/wp-content/uploads/2021/03/BCAP-Candidate-Handbook-20210218.pdf
- They have a code of conduct. https://www.behavioralcertification.org/Content/Documents/BICC_Code_of_Conduct_2019_2020.pdf
- They require passage of a psychometric exam. https://behavioralcertification.org/wp-content/uploads/2021/03/BCAP-Candidate-Handbook-20210218.pdf
- They have an independent board of directors. https://behavioralcertification.org/about-us-autism-spectrum-disorder/board-directors/
- They have conducted a job analysis. https://www.behavioralcertification.org/Content/Documents/Job_Analysis_Executive_Summary_2017.pdf
- They require a background check. https://www.behavioralcertification.org/Content/Documents/SaferPlaces_Disclosure_and_Authorization.pdf
- They have a designated scope of practice and competency requirements. https://www.behavioralcertification.org/Content/Documents/BCAP_Exam_Content_Outline.pdf

International Behavior Analysis Organization:

- They are not an autism specific board.
- They require a psychometric exam or you can qualify based on accredited BCBA or QBA equivalency. https://theibao.com/docs/IBA-Exam-Procedures-v101.pdf

- The require supervision experience hours. https://theibao.com/docs/IBA-Requirements-v101-ENG.pdf
- They require a masters degree or additional experience. https://theibao.com/docs/IBA-Requirements-v101-ENG.pdf
- They require coursework in applied behavior analysis. https://theibao.com/docs/IBA-Requirements-v101-ENG.pdf
- They have an ethics code. https://theibao.com/docs/IBAO-Ethical-Guidelines-V100.pdf
- They are run by an advisory board. https://theibao.com/professional_advisory_board
- Exam and certification materials are offered and being developed in alternative languages.
- They have a designated scope of practice and competency requirements. https://theibao.com/docs/IBA-REOs-V100.pdf
- They are not currently accredited. This information is provided to the board for reference.

Third Party Boards:

- The Virginia Association for Behavior Analysis requires a masters degree only for membership. https://virginiaaba.org/choose-membership/
- The Association for Behavior Analysis International recognizes QABA, BICC, and IBAO in addition to the BACB. https://www.abainternational.org/media/188058/abaimembershipform_2022.pdf

State of Virginia:

- The State of Virginia is already has already recognized alternative certifications we are simply asking you to codify it in the rules to be consistent.
- The law requires the board by saying "shall include" "Documentation that the applicant is currently certified as a Board-Certified Behavior Analyst by the Behavior Analyst Certification Board or **any other entity that is nationally accredited to certify practitioners of behavior analysis;" (Emphasis Added)** http://www.dhp.virginia.gov/media/dhpweb/docs/med/leg/Ch29_Medicine.pdf
- No other mental health board in Virginia requires certification by one entity. See: https://www.dhp.virginia.gov/counseling/ https://www.dhp.virginia.gov/counseling/counseling_laws_regs.htm https://www.dhp.virginia.gov/psychology/psychology_laws_regs.htm
- Most other Virginia Licensing Boards offered grandfather periods for previously practicing professionals where the Behavior Analysis occupation was not provided the same. See: § 54.1-3509, § 54.1-3514,
- It is likely unlawful to force association to one organization under the First Amendment.
- It is likely unlawful for a government entity to force association that is a violation of someones religious beliefs. Re shocking children and the First Amendment.
- Given the above, there is a pending court preliminary injunction to strike down any law that only allows for licensure via the BACB. If the board wants to protect itself it might consider adding an alternative.
- More certification boards would allow your constituents the choice to choose their providers.
- More certification boards would require the BACB to compete and raise the bar/standard to meet other certification boards which require additional courses, experiences, and

even simple things like a background check.

- More providers would also decrease the waitlists for ABA services. Search for waitlist using the find feature and you will see these providers have a "long" "extensive" waitlists. https://www.leapahead.org/ https://www.greenboxaba.org/ https://www.chattanoogaautismcenter.org/outpatient-clinic http://learnwithmasc.org/about-us/services/ https://villagemindset.org/staff/stacie-dizzley-streeter-bcba/ https://www.blueridgehorizonaba.com/locations
- News articles on the same. https://www.localdvm.com/news/virginia/local-clinics-join-forces-to-combat-aba-practitioner-shortage-as-autism-cases-climb/

Quotes:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2854065/

"The BACB does not appear to have the money, staff, time, or legal authority to provide the necessary ethical oversight, especially with the literally thousands of members of the Association of Behavior Analysis International (ABAI) and/or BCBAs who practice both within the United States and around the world."

"To further complicate matters, the BCBA credential is not consistent with the generally accepted concept of board certification as recognized in the fields of medicine, psychology, and other human service professions."

This is stated by their own certified people.

Michael Dorsey, PhD, BCBA

Michael Weinberg, PhD, BCBA

Thomas Zane, PhD, BCBA

Megan Guidi, MSEd, BCBA

https://www.abainternational.org/media/177713/luiselli.pdf

"One issue of regulatory concern is that often discussed in behavior analytic circles is that Behavior Analyst Certification Board (BACB) offers a national license. This is false. BACB is not licensing, nor could the BCBA ever be a national license for behavior analysts. Licensure falls under the states rights or powers. It is the prevue of each state to restrict trade within its borders. United States v. Lopez, 514 U.S. 549 (1995) held that the federal government only has the right to create laws that effect interstate commerce."

This is stated by their own certified people.

Joseph Cautilli, PhD, BCBA-D

Halina Dziewulska, MSEd. BCBA

I respectfully ask you to help us give patients the **right to choose.** Give them the opportunity to have increased quality care by **raising competition that forces people to compete to be the best provider.** I encourage you to look at links and documents also feel free to reach out to me should you have any question. There were a lot of statements made in this comments section. Very few actually included references or documentation to back up such claims.

Help me step in to the future and:

Empower your patients with the right to choose by raising the bar of competition. More standards = forcing people to be the best.

Very Respectfully,

Prof. Michael Moates, MA, QBA, IBA, LBA, LMHP

Global Institute for Behavior Practitioners and Examiners, a non-profit organization

Doctor of Education Candidate

University Professor

Student Health Advisory Committee

Senior Member, Civil Air Patrol, United States Air Force Auxiliary

Certified Accreditation Evaluator

CommentID: **121471**

Agenda Items: Consideration of response to petition for rulemaking

Included in your agenda package are:

- Petition for rulemaking from Michael Schultz;
- Public comment received by the Board; and
- Public comment posted on Town Hall in response to the petition.

Action needed:

Motion to either:

- Initiate rulemaking; or
- Take no action.

Request for Comment on Petition for Rulemaking

Promulgating Board: **Board of Medicine**

Regulatory Coordinator: Erin L. Barrett
(804)367-4688
erin.barrett@dhp.virginia.gov

Agency Contact: William L. Harp, M.D.
Executive Director
(804)367-4558
william.harp@dhp.virginia.gov

Contact Address: Department of Health Professions
9960 Mayland Drive
Suite 300
Richmond, VA 23233

Chapter Affected:

18 vac 85 - 20:	**Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic**

Statutory Authority: State: Chapter 29 of Title 54.1

Date Petition Received 03/23/2022

Petitioner Michael J. Schultz

Petitioner's Request

The petitioner requests that the Board amend its regulations to: (1) prohibit physicians, podiatrists, and chiropractors from refusing to provide medical care to patients or prospective patients if those individuals or their accompanying representatives refuse to wear masks; (2) prohibit physicians, podiatrists, and chiropractors from enforcing any requirements for patients, prospective patients, or patient representatives to wear masks to receive medical care, including when following policies of insurers or organizations or when following guidance issued by the Centers for Disease Control, local health departments, or the Virginia Department of Health; (3) prohibit physicians, podiatrists, and chiropractors from refusing to provide medical care to any patient or prospective patient based on the vaccination status of the patient or patient representative for any COVID-19 vaccine or for any vaccine under Emergency Use Authorization status; and (4) prohibit physicians, podiatrists, and chiropractors from refusing to provide medical care to any patient or prospective patient who refuses to disclose whether they have received any vaccine, including any COVID-19 vaccine.

Agency Plan

The petition for rulemaking will be published in the Virginia Register of Regulations on April 11, 2022 and on the Virginia Regulatory Townhall. Public comment will open on April 11, 2022 and will close on May 11, 2022. The Board will consider the petition and all comments in

support or opposition at its next meeting on June 17, 2022. The petitioner will be notified of the Board's decision after that meeting.

Publication Date 04/11/2022 *(comment period will also begin on this date)*

Comment End Date 05/11/2022

COMMONWEALTH OF VIRGINIA
Board of Medicine

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4600 (Tel)
(804) 527-4426 (Fax)

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition. If the board has not met within that 90-day period, the decision will be issued no later than 14 days after it next meets.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle Initial, Suffix,)
SCHULTZ, MICHAEL J.

Street Address 8019 OAK BRIDGE LANE	**Area Code and Telephone Number** 617-817-3224	
City FAIRFAX STATION	**State** VA	**Zip Code** 22039
Email Address (optional) mj_schultz@hotmail.com	**Fax (optional)**	

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

   Virginia Board of Medicine regulations GOVERNING THE PRACTICE OF MEDICINE, OSTEOPATHIC MEDICINE, PODIATRY AND CHIROPRACTIC, Part II. Standards of Professional Conduct, "Section 18VAC85-20-29. Practitioner responsibility. Paragraph A. A practitioner shall not"

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

   See attached summary of the proposed amendments to the existing regulation and associated rationale as Attachment 1.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

   Section 54.1-2400 of the Code of Virginia.

Signature: [signature] **Date:** 3/18/22

March 2019

ATTACHMENT 1

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule

I propose to amend the existing regulation under Virginia Board of Medicine regulations GOVERNING THE PRACTICE OF MEDICINE, OSTEOPATHIC MEDICINE, PODIATRY AND CHIROPRACTIC, Part II. Standards of Professional Conduct, "**18VAC85-20-29. Practitioner responsibility. Paragraph A. A practitioner shall not**" by adding 4 new clauses under paragraph A. to read as follows:

"5. Prohibit, or refuse to provide medical care to, or consult with, a patient (or prospective patient) based upon the patient's, prospective patient's, family member's, or authorized patient representative's (including Parental Guardian's) choice to not wear a mask. A mask shall be considered any covering across the face that is intended solely as a means of potential infection control.

6. Enact, implement, enforce, or execute any practitioner-authored, insurer-required, or organizational policy, instruction, or guidance (including, but not limited to, guidance issued by the Centers for Disease Control, local County or municipality Board of Health, or Virginia Department of Health) that prohibits patients, prospective patients, family members, or authorized patient representatives to receive medical care based solely upon an individual's choice to not wear a mask, as outlined in 5., above.

7. Refuse to provide medical care to a patient or prospective patient at any location in the Commonwealth, including hospitals, based upon that patient's, prospective patient's, family member's, or authorized patient representative's vaccination status for the virus that causes COVID-19 (SARS-CoV-2) disease, or any other vaccine, where such vaccine is under either Emergency Use Authorization or full approval status as determined by the United States Food and Drug Administration (FDA), and/or the Virginia Department of Health, or Virginia Board of Medicine.

8. Deny medical care for any patient or prospective patient, based upon that patient's, prospective patient's, family member's, or authorized patient representative's refusal to provide an answer (if so questioned) on their vaccination status for the virus that causes COVID-19 disease, or for any other vaccine. This prohibition applies to the practitioner, any employee or subordinate of the practitioner, any employee of a hospital, any contract worker, or volunteer, at any facility licensed to practice medicine in the Commonwealth of Virginia.

RATIONALE

These regulations are necessary due to the thousands upon thousands of examples in Virginia where patients and prospective patients were denied their right to necessary medical care solely because of their individual choice to not take the COVID-19 vaccine, or their choice to not wear a mask during a visit to a licensed medical practitioner or medical facility. Both mask wearing and the vaccine have now been shown (based on years of peer-reviewed scientific studies and empirical data) to be largely ineffective in preventing contracting of the virus that causes COVID-19 disease, or in preventing transmission to others. Numerous studies provide the factual basis behind these statements:

https://www.lifesitenews.com/news/47-studies-confirm-inefectiveness-of-masks-for-covid-and-32-more-confirm-their-negative-health-effects
https://aapsonline.org/mask-facts/

https://www.cidrap.umn.edu/news-perspective/2020/04/commentary-masks-all-covid-19-not-based-sound-data
https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6936a-H.pdf
https://www.cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3949410
https://brownstone.org/articles/more-than-150-comparative-studies-and-articles-on-mask-ineffectiveness-and-harms/
https://lcaction.org/vaccine#cases

Prior to February 2020, no citizen in the Commonwealth of Virginia was required to wear a mask as a condition to receiving necessary medical care. For example, no patients were denied treatment for the seasonal flu by a general practitioner or family doctor if they had not received a flu shot that year, or were not wearing a mask. No pediatrician would deny treatment of a child for pertussis if they were not wearing a mask. Yet, unfortunately these instances surrounding COVID-19 occurred thousands of times across the Commonwealth within the past 2 years by practitioners, and still continue to happen to this day, even when all mask restrictions in the Commonwealth have been lifted by the Virginia Board of Health. I myself am still required to wear a mask to see my surgeon for post-surgery follow up appointments after receiving ankle surgery in February 2022 here in Fairfax County, over 3 weeks ago, despite the Centers for Disease Control lifting most mask guidelines and states such as New York, Massachusetts, Florida, and Texas now having no mask mandates. Why does Virginia still allow this? I am a survivor of COVID-19 disease from August of 2021, and have recovered fully, with documented natural immunity through antibody testing. My practitioner still will not accept any of that information as relevant, and assumes all patients as possibly infected (an unethical and unscientific practice, by the way), and therefore requires me to wear a mask in his office, even threatening patients (through administrative staff) with cancelling a necessary medical appointment if they do not comply, despite **overwhelming evidence** that masking does almost nothing to stop the spread of the COVID-19 virus or prevent transmission. It is unconscionable that licensed practitioners, their subordinates, and administrative or office employees can still refuse to treat patients if the patient chooses to not wear a mask. This discriminatory practice must end immediately.

One of the main principles of the Hippocratic oath is to First, Do No Harm. Demanding that a patient wear a mask (when multiple, peer-reviewed studies documenting the adverse effects of mask wearing is well established), is harmful to a patient and violates patient autonomy. It must be their choice to wear a mask, not mandated by an individual practitioner, when local and State Boards of Health have lifted masking restrictions for all business establishments. Patient autonomy and patient rights must be respected by that practitioner.

It is also ridiculous and an outrage to patient rights that some licensed practitioners can still demand that patients, prospective patients, or family members accompanying them wear a mask as a precondition to receiving treatment, (and as a consequence, can refuse or deny treatment for a patient when they exercise their right to not wear one), when it is now state law in Virginia that no child who attends a school is required to wear a mask (Senate Bill 739). If a child has the legal right to not have to wear a mask while in a school environment, of which that child is potentially indoors for periods of up to 6-8 hours a day, five days a week, in close proximity to potentially *hundreds* of other children each day,

how can the Virginia Board of Medicine still allow medical practitioners to continue these blatantly discriminatory and coercive practices of mandatory mask wearing, or demand proof of a COVID-19 vaccination in order for a patient to obtain medical care? ***How do children now have this right, but somehow patients now do not?***

Requiring a patient to wear a mask indoors for a doctor's appointment, medical procedure, or for any duration of time in a medical facility (for example, as a visitor), was rarely, if ever required on a widespread, Commonwealth basis prior to 2020. At this point continuance of these policies is nonsensical. The facts are clear: masks and the COVID-19 vaccine do not stop transmission, nor prevent transmission of the virus that causes COVID-19 disease. The Virginia Board of Medicine has an obligation to put an end to unethical, coercive, and discriminatory practices by practitioners requiring mask wearing and demanding proof of vaccination as a precondition to receiving necessary medical care.

Barrett, Erin <erin.barrett@dhp.virginia.gov>

Fwd: Petition 3/23/22

1 message

Harp, William <william.harp@dhp.virginia.gov> Wed, Apr 20, 2022 at 5:55 PM
To: Erin Barrett <erin.barrett@dhp.virginia.gov>

FYI

---------- Forwarded message ---------
From: **Annette Lane** <laneacupuncture@gmail.com>
Date: Wed, Apr 20, 2022 at 5:47 PM
Subject: Petition 3/23/22
To: <william.harp@dhp.virginia.gov>

Regarding the petition of 3/23/22:

Prohibition of requirements for mask wearing, receipt of vaccines, and disclosure of vaccine status to receive medical care

I oppose any regulation which would forbid health care providers from following health department and CDC guidance.

I oppose regulations which would make it impossible for health care providers to do everything they can to prevent the transmission of infectious diseases.

I oppose regulations which would undermine access to health care for immune-compromised patients or those with co-morbidities.

I oppose regulations which would make it impossible for health care providers to choose not to treat patients who will not share their full health histories.

Thank you,

Annette Lane

Licensed Acupuncturist.

Barrett, Erin <erin.barrett@dhp.virginia.gov>

Re: Petition 362 - "Prohibition of requirements for mask wearing, receipt of vaccines, and disclosure of vaccine status to receive medical care"

1 message

Harp, William <william.harp@dhp.virginia.gov> Wed, Apr 13, 2022 at 8:26 AM
To: Mark Bodzislaw <acudoc213@gmail.com>, Erin Barrett <erin.barrett@dhp.virginia.gov>

Thank you, Dr. Bodzislaw. WLH

On Wed, Apr 13, 2022 at 8:24 AM Mark Bodzislaw <acudoc213@gmail.com> wrote:

Dear Dr. Harp,

I have recently been informed of a petition to the Virginia Board of Medicine, Petition #362 "Prohibition of requirements for mask wearing, receipt of vaccines, and disclosure of vaccine status to receive medical care".

I object to passing this petition in that:

I oppose any regulation which would forbid health care providers from following health department and CDC guidance.

I oppose regulations which would make it impossible for health care providers to do everything they can to prevent the transmission of infectious diseases.

I oppose regulations which would undermine access to health care for immune-compromised patients or those with comorbidities.

I oppose regulations which would make it impossible for health care providers to choose not to treat patients who will not share their full health histories.

In summary, I believe the passage of this petition would potentially hurt the medical profession by endangering those who might need protection. The use of masks, as well as the efficacy of the COVID-19 and other vaccines, has been shown to provide additional protection, especially to those most vulnerable.

With respect, I ask that you please strongly consider the ramifications of allowing this petition to pass and object to such action.

I have provided a public comment on the Petition site, as well, but wanted to make a direct plea to you as this issue is of the utmost importance.

Sincerely,
***Dr. Mark Bodzislaw**, DAOM, L.Ac., Dip.Ac.*
Nationally Board Certified Licensed Acupuncturist (NCCAOM)®
Commonwealth of Virginia License #0121000889
Mark Bodzislaw Contemporary Oriental Medicine Facebook Page
***"Health is a state of body, Wellness is a state of being."** ~ J. Stanford*

4200 INNSLAKE DRIVE, SUITE 203, GLEN ALLEN, VIRGINIA 23060-6772
P.O. BOX 31394, RICHMOND, VIRGINIA 23294-1394
(804) 965-1227 FAX (804) 965-0475

SUBMITTED ONLINE AT https://townhall.virginia.gov/L/Comments.cfm?petitionid=362

May 6, 2022

William L. Harp, M.D.
Executive Director
Board of Medicine
9960 Mayland Drive, Suite 300
Henrico Virginia 23233

Re: Comment on Petition for Rulemaking: Prohibition of Requirements for Mask Wearing, Receipt of Vaccines, and Disclosure of Vaccine Status to Receive Medical Care

Dear Dr. Harp,

For reasons discussed in further detail below, the Virginia Hospital & Healthcare Association (VHHA) urges the Board of Medicine to reject the petitioner's request to amend its regulations to prohibit requirements for mask wearing, receipt of vaccines, or disclosure of vaccine status.

The ability to require patients or prospective patients or their accompanying representatives to wear masks when present in health care settings, including physician offices or clinics and hospital inpatient and outpatient departments, is essential to proper infection control practices necessary for the protection of patients, staff, and the public. Interference with this ability could not only expose individuals to disease, disability, or death, but could also result in health care providers being liable for negligence and being out of compliance with applicable laws and regulations that require proper infection control practices.

For example, the Medicare conditions of participation for hospitals at 42 CFR § 482.42 require hospitals to have active hospital-wide programs for the surveillance, prevention, and control of infectious diseases and such programs must demonstrate adherence to nationally recognized infection prevention and control guidelines, such as those established from time to time by the Centers for Disease Prevention and Control (CDC). Depending upon the circumstances, proper infection control practices may require the wearing of masks in sterile and non-sterile environments and in patient care and non-patient care areas. As we have seen with COVID-19, wearing of masks in health care settings has been and continues to be included in guidelines adopted by the CDC.

Current CDC guidelines for COVID-19 have included masking as a recognized source control in healthcare settings and continue to prefer that it be applied universally. It has recently, however, included some allowances for individuals who are up to date with all recommended COVID-19 vaccine doses in healthcare facilities located in counties with low to moderate community transmission. Similarly, health care providers who are up to date with all recommended COVID-19 vaccine doses can chose not to wear masks when they are in well-defined areas that are restricted from patient access (e.g., staff meeting rooms, kitchen), but are instructed to wear source control when they are in areas of the healthcare facility where they could encounter patients (e.g., hospital cafeteria, common halls/corridors). CDC continues to instruct that the safest practice is for patients and visitors to wear masks, particularly if at risk for severe disease or are unvaccinated.

Accordingly, it is the case now, and would likely be for any future pandemics or outbreaks of infectious disease, that health care settings, including hospitals, will be required to enforce masking requirements in order to maintain proper infection control practices and compliance with applicable regulations. The requested regulations' prohibition on mask wearing requirements would be in direct interference with such obligations. The regulations would also appear to place health care providers in the untenable position of either complying with the regulations or violating other applicable requirements as the prohibitions are to apply even "when following policies of insurers or organizations or when following guidance issued by the Centers for Disease Control, local health departments, or the Virginia Department of Health."

Further, as demonstrated by the CDC guidance, it will be necessary to inquire about or request disclosure of vaccination status of patients or prospective patients or accompanying representatives to determine whether applicable requirements are being complied with. If it is determined that an individual is not vaccinated, additional steps would be required to ensure compliance, including, but not limited to requests for the individual to wear a mask. Consequently, the requested regulations' prohibition on disclosure of whether they have received any vaccine would likewise be in direct interference with existing obligations.

As it relates to any prohibition against disclosure of vaccination status or provision of medical care to any patient or prospective patient based on the vaccination status of the patient, vaccination may be clinically indicated to produce the best possible outcome for a patient, could be a contraindication for treatment, or serve as an appropriate factor in scarce resource allocations. As such, information about vaccination status cannot and should not be eliminated from clinical decision-making. Ultimately, the patient controls consent to receiving any vaccination, but vaccination status is clinically relevant and there should not be interference in communication about vaccination status between patients or potential patients and their health care providers.

Virginia's hospitals and health systems strive to provide the best possible care experience for patients and visitors in the least restrictive manner possible; however, it is essential that they retain the flexibility to implement proper infection control practices when necessary in response to threats to the health and safety of those patients and visitors and their dedicated staff. The requested regulations would be in conflict with this mission and are therefore not supported by VHHA. We again respectfully urge you to reject the petitioner's request.

Sincerely,

R. Brent Rawlings
Senior Vice President and General Counsel

Agencies | Governor

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Department of Health Professions

Board of Medicine

Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic [18 VAC 85 - 20]

37 comments

All good comments for this forum **Show Only Flagged**

Back to List of Comments

Commenter: Vic N 4/12/22 6:44 am

Agreed

I have multiple files with links to actual medical data from all around the world. All of it indicates that the pandemic was not what it was, and there are so many questions that the medical community cannot or will not answer. I am more than happy to meet and show the amount of data indicating that not only are these measures not the end all cure all thing, but the vaccines obviously have side effects, that there are questions on the efficacy of the vaccine and usefulness in certain demographics.

We don't need control oriented useless helps. Basic infection suggestions work.

CommentID: **121318**

Commenter: Elaine Wolf Komarow 4/12/22 11:33 am

Adopting this petition would be detrimental to public safety

It is an important rule in healthcare to do no harm. Universal masking, following health guidelines, and being able to have a complete medical history before treatment are critical to doing no harm. Forcing vulnerable individuals and their families to receive medical care in facilities with unmasked individuals or go without medical care does harm. Many health care providers have died due to workplace exposure to infectious diseases. Forbidding them from protecting themselves is wrong and would contribute to existing shortages of providers. I strongly oppose any regulation which would forbid health care providers from doing their utmost to prevent the spread of infectious disease.

CommentID: **121352**

Commenter: Prof. Michael Moates, MA, QBA, LBA, LMHP 4/12/22 1:40 pm

Things to Consider - Agree in Part and Disagree in Part

The request is asking the Board/State to implement a rule that would take away a doctors right to impose its requirements on its patients. Further, it would require the doctor to put themselves at

risk. The state cannot possibly know every circumstance where wearing a mask may come up and to put this rule into place would be detrimental because it is over broad and not specific.

I also believe that this rules petition would be contrary to Virginia law. Under 18VAC85-20-29. Practitioner responsibility, it states:

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

But by forcing doctors to allow people refusing to wear a mask in to their practice, the would be knowingly requiring their subordinates to allow this practice. That would not only endanger the doctor, the other employees, but also the other patients.

I do believe doctors should have the freedom to treat patients who engage in the willing treatment of their provider. I do believe there are exceptions to this rule. For example, under the Americans with Disabilities Act, accommodations must be made for a person who can't wear a mask due to health disabilities such as needing oxygen, having asthma, COPD, or other respiratory problems.

There should be a complaint process for doctors who are not compliant with the ADA but outside of that, doctors should have the freedom to decide what is best for their patients so long as they do not discriminate based on anything protected under the Civil Rights Act.

I do agree with the petitioner that a patient should have the right to refuse any vaccine. I also agree that a doctor should not be able to refuse care based on this practice. If this were the case, every time a new vaccine came out a doctor could terminate the doctor-patient relationship and that would cause havoc.

Prof. Michael Moates, MA, QBA, LBA, LMHP

CommentID: **121364**

Commenter: Amy Rautner 4/13/22 8:02 am

medical care needs to be safe and available for the most vulnerable patients equally

While a mask is an inconvenience, it's an important and simple way to limit transmission of air borne pathogens, especially to protect vulnerable patients. I oppose regulations which would undermine access to health care for immune-compromised patients or those with co-morbidities.

CommentID: **121403**

Commenter: Chelsea T 4/13/22 8:08 am

Agree

I'm really glad that requests like this are finally being made to regulate demands that healthcare practitioners can make of their patients. In regards to vaccination requirements— I believe it is unconstitutional to require patients to receive vaccinations and it violates bodily autonomy. Vaccinations should be a personal choice not a requirement.
I believe asking patients to disclose their vaccination status is wrong as well.
In regards to masking, I don't believe there is any harm in asking patients (without medical conditions that would impair their breathing) to wear a mask but I think that should be at the discretion of the medical health provider and not a generic blanket requirement.

CommentID: **121404**

Commenter: Mark Bodzislaw 4/13/22 8:22 am

In Opposition to Petition #362

I have recently been informed of a petition to the Virginia Board of Medicine, Petition #362 "Prohibition of requirements for mask wearing, receipt of vaccines, and disclosure of vaccine status to receive medical care".

I object to passing this petition in that:

I oppose any regulation which would forbid health care providers from following health department and CDC guidance.

I oppose regulations which would make it impossible for health care providers to do everything they can to prevent the transmission of infectious diseases.

I oppose regulations which would undermine access to health care for immune-compromised patients or those with comorbidities.

I oppose regulations which would make it impossible for health care providers to choose not to treat patients who will not share their full health histories.

In summary, I believe the passage of this petition would potentially hurt the medical profession by endangering those who might need protection. The use of masks, as well as the efficacy of the COVID-19 and other vaccines, has been shown to provide additional protection, especially to those most vulnerable.

With respect, I ask that you please strongly consider the ramifications of allowing this petition to pass and object to such action.
CommentID: **121405**

Commenter: Mary (Katie) Clifton 4/13/22 8:38 am

I oppose this legislation

I oppose any regulation which would forbid health care providers from following health department and CDC guidance.

I oppose regulations which would make it impossible for health care providers to do everything they can to prevent the transmission of infectious diseases.

I oppose regulations which would undermine access to health care for immune-compromised patients or those with co-morbidities.

I oppose regulations which would make it impossible for health care providers to choose not to treat patients who will not share their full health histories.

CommentID: **121407**

Commenter: Kim Gallagher 4/13/22 9:07 am

I oppose this petition

I oppose any regulation which would forbid health care providers from following health department and CDC guidance.

CommentID: **121408**

Commenter: Anonymous 4/13/22 9:31 am

Disagreed

I oppose regulations which would make it impossible for health care providers to do everything they can to prevent the transmission of infectious diseases.

CommentID: **121411**

Commenter: Anonymous 4/13/22 10:41 am

Agree

Completely on board with this legislation. Long overdue. The covid vaccines do not work, masks do not filter virus-sized particles anyways, and no one should be required to disclose vaccine status.

CommentID: **121417**

Commenter: Sarah Faggert 4/13/22 12:36 pm

I Oppose This Petition

If adopted, this rule would prevent providers from gathering all of the information necessary to best service their clients. And it would prevent them from employing protocols widely known to prevent the spread of infectious disease.

It is the duty of practitioner's to uphold the safety of both themselves and their patients.

CommentID: **121427**

Commenter: Jennifer Hart Capen 4/13/22 12:50 pm

Agee

Agree.

CommentID: **121429**

Commenter: Dr. Pippa Chapman, ChiroWorks, Inc. 4/13/22 1:13 pm

Opposed

I oppose any legislation that prohibits a licensed health care provider from following guidelines issued by the Virginia Dept of Health or the Centers for Disease Control. As a health care provider, I base decisions about my clinic, my own health, the health of my patients and my staff on these guidelines. To prohibit me from doing so interferes with my ability to provide safe care to may patients and a safe environment for myself and my staff to work. Should this pass, and it becomes illegal for me to follow guidelines issued by these organizations, it may well be time for me to change to a career that does not put my own health at risk. Our health care providers have been through enough the past two years. Let's not risk losing anymore of that vital work force because of ongoing threats and hostile work environments, for which I believe this regulation will contribute.

CommentID: **121431**

Commenter: Justin Flinner 4/13/22 2:56 pm

Opposition to Petition 362

I strongly oppose the adoption of petition 362. The suggested changes within this petition would undermine access to health care for immune-compromised patients or those with co-morbidities and would place more people at unnecessary risk including us healthcare practitioners. If our goal is to bring the pandemic to a close, we must be attentive to the health of everyone in the state of Virginia and work together. New variants will continue to rise and will continuously put more people at risk. By forcing us to change our policies that are in place for patient-practitioner protection, it should be common sense that adopting such measures would be a threat to public safety. If we are in fact a community of care providers that pledge to "do no harm", this would clearly be a move in the wrong direction.

CommentID: **121439**

Commenter: Anonymous 4/13/22 11:06 pm

Oppose any regulation that endangers patients and practitioners alike

Practitioners should have the choice to follow CDC guidelines and safe practice protocols. Patients are free to choose a provider who aligns with their thinking on mask requirements but it is not okay to take the right away from office practices. Masks are a health protective device — requiring them is not discriminatory but discerning. Safety and welfare are the right of every individual. Freedom to endanger others is not.

CommentID: **121464**

Commenter: Pam 4/14/22 9:15 am

VDH

Please refrain from your irresponsible use of misguided education of children

CommentID: **121481**

Commenter: Anonymous 4/14/22 10:06 am

opposed

I believe it should be up to the individual.

CommentID: **121539**

Commenter: Virginian 4/14/22 11:23 am

No masks, eg.

As a Virginian, I believe it should be up to the business. Freedom of choice has been destroyed by many of our leaders overreaching the last two years.

CommentID: **121577**

Commenter: Layne Stevanus 4/14/22 12:54 pm

Agree-Mask and Vaccinations should not be required

I agree with the petition as masks and vaccinations should not be required to receive medical care. People should be given the freedom to decide if they want to wear a mask to get vaccinated after receiving information about these items. The government or medical facilities should not be able to force people to get vaccinated or wear a mask.

CommentID: **121612**

Commenter: Jennifer Yeh 4/14/22 3:55 pm

I oppose this petition

I oppose any regulation which would forbid health care providers from following health department and CDC guidance.

I oppose regulations which would make it impossible for health care providers to do everything they can to prevent the transmission of infectious diseases.

I oppose regulations which would undermine access to health care for immune-compromised patients or those with co-morbidities.

I oppose regulations which would make it impossible for health care providers to choose not to treat patients who will not share their full health histories.

CommentID: **121662**

Commenter: Sharon Crowell 4/15/22 8:52 am

Oppose

I am an immuno-compromised health care provider serving a vulnerable patient population. Compliance with CDC recommendations regarding disclosure of vaccination status, masking to permit transmission of pathogens, and other infectious disease protocols is vital for my own safety and that of my patients. Health care workers are already at risk every single day. There is no reason to increase that risk by allowing this petition to move forward.

CommentID: **121740**

Commenter: S Crowell 4/15/22 9:06 am

Oppose - Typo Correction

In my previous comment I meant to say "..masking to PREVENT transmission of pathogens...,"

CommentID: **121743**

Commenter: Michael J Schultz 4/17/22 8:28 pm

Petitioner's Response to Comments - Part 1

As the petitioner who has submitted the proposed regulation, I feel the need for clarification and context on my initial proposal, and some much-needed responses to comments published in opposition. There is quite a bit of unsupported statements out there made by parties in opposition to the petition claiming this petition will somehow "endanger patients," by allowing individuals, not practitioners, to make the medical choice as to whether they must wear a mask or not. I will attempt to call these comments out to point out the illogic or fallacy of their arguments. There also is the issue of the Board of Medicine's receipt of my petition and the actual language posted by the Board. The Virginia Board of Medicine didn't post exactly word for word what my petition originally proposed. The Board paraphrased a good portion of my proposal, and changed my language in certain phrases, which I feel was dishonest. It did not reflect the actual proposed language, which I will repeat below. In addition, the Transmittal Sheet as published also didn't include the rationale behind why I feel this regulation is necessary, which provides much needed context and supporting background. I do appreciate the comments on both sides, but as the petitioner, I feel that by not posting the rationale behind my proposal, the Virginia Board is deliberately withholding necessary supporting information critical to supporting my position.

First, my original proposed language and the rationale. This is word for word, Proposed Clause 5:

Original version: A practitioner shall not: "5. Prohibit, or refuse to provide medical care to, or consult with, a patient (or prospective patient) based upon the patient's, prospective patient's, family member's, or authorized patient representative's (including Parental Guardian's) choice to not wear a mask. A mask shall be considered any covering across the face that is intended solely as a means of potential infection control."

The Board's paraphrased version, made to appear that a patient is refusing to wear a mask: "(1) prohibit physicians, podiatrists, and chiropractors from refusing to provide medical care to patients or prospective patients if those individuals or their accompanying representatives refuse to wear masks."

The distinction here is critical. Under current Virginia state public health regulation and Executive Orders, there is no longer any public health crisis requiring an employer to mandate its employees, nor ordinary citizens, to wear masks as a condition of citizenship, let alone the ability to receive necessary medical care, worship at a religious institution, attend school, or to participate in commerce, for that matter. The decision to wear a mask is that of <u>the patient's, prospective patient's, or the family member's alone</u>. A practitioner has no legal or ethical right to force or make decisions for the patient, ***especially if the patient does not have informed consent on the efficacy of masks.*** The decision is the individual's right. My proposed regulation *does not* state that a patient is prohibited from wearing a mask if *they* choose; on the contrary, if they want to wear a mask, they are free to do so. But a practitioner has <u>no legal authority under existing Virginia state law or Board of Medicine regulation</u> to demand that a patient, prospective patient, or family member accompanying them do so, especially since this type of tyrannical behavior never was practiced or allowed prior to 2020, and definitely since all Executive Orders mandating mandatory masking in Virginia have now been lifted.

One commenter claims that if a patient does not wear a mask, this somehow puts a practitioner somehow in a position under 18VAC85-20-29, Practitioner responsibility, that they are knowingly jeopardizing patient safety: The commenter claims "A practitioner shall not 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." The commenter claims that "... by forcing doctors to allow people refusing to wear a mask in to their practice, the would be knowingly requiring their subordinates to allow this practice. That would not only endanger the doctor, the other employees, but also the other patients." Given the fact that there is documented evidence that mask wearing actually can make a patient sick (https://www.sciencedaily.com/releases/2015/04/150422121724.htm; https://www.aier.org/article/the-dangers-of-masks/; https://www.aier.org/article/masking-a-careful-review-of-the-evidence/; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7490318/), then how would a practitioner explain that forcing one to wear a mask is actually a net positive for the patient's health, or is not putting the doctor at risk? If you demand that a patient wears a mask upon entry to your practice and will not treat a patient if they do not wear a mask, but in the process of that patient being required to wear a mask, they actually do get sick from wearing a face mask, how does that protect anyone?

This practice however (forced masking as a condition of participating in commerce or receipt of medical care) continues to this day because all patients in many practitioners' offices are considered "guilty until proven innocent," or unethically assumed to have COVID-19 and require them to wear a mask, without even asking if a patient has symptoms, or has previously had COVID-19, recovered, and now possesses natural immunity (a documented medical fact the FDA and Pfizer, manufacturer of one of the COVID-19 "vaccines," have been forced to admit: http://Youtube.com/watch?v=5eJ5TIT6zvk). Do practitioners demand every patient prior to entry into an office take precautions against the flu before they enter their practice? Norovirus? Rotavirus? What about tuberculosis? HIV? Pertussis? Meningitis? Pneumonia? Strep throat? Each of these infectious diseases are highly contagious, but infection control practices to stop the spread of these diseases are not mandated by a practitioner prior to one receiving care, especially for care unrelated to infectious disease.

As a resident of the Commonwealth for the past 14 years, I can tell you first hand I never had to wear a mask as a condition of receiving care prior to 2020, and prior to 2020 I have had multiple outpatient surgeries, emergency room visits, doctor's appointments, had the flu, attended children well child visits, my children's births, attended physical therapy appointments, and had literally hundreds of interactions with medical staff and other patients, all while either being injured, sick, contagious, or healthy. Not once was I forced to wear a mask, even during the height of raging flu seasons.

Patient autonomy must be respected. Up until 2020, all practitioners in the Commonwealth respected that decision. No practitioner has the authority to act as a defacto member of a Board of Health, as they have no legal authority to enforce a mask requirement that only the Board of Health, Board of Labor and Industry or the State legislature have the authority to enforce. But sadly, this situation still remains today with practitioners (especially in Fairfax County), acting as defacto agents of the State or County Board of Health, continuing to demand patients wear masks as a "public health protection measure," or claiming "it's company policy" when no such evidence exists as to the efficacy of masking preventing one from contracting the virus that causes COVID-19, nor stopping the spread of the COVID-19 virus. Despite unsubstantiated claims to the contrary from opposers of my petition claiming masks have been effective in stopping the virus, the evidence does not exist.

Proposed Clause 6

Here is the original text as I proposed, stating a Practitioner shall not:

"6. Enact, implement, enforce, or execute any practitioner-authored, insurer-required, or organizational policy, instruction, or guidance (including, but not limited to, guidance issued by the Centers for Disease Control, local County or municipality Board of Health, or Virginia Department of Health) that prohibits patients, prospective patients, family members, or authorized patient representatives to receive medical care based solely upon an individual's choice to not wear a mask, as outlined in 5., above."

The Board's paraphrased version: "(2) prohibit physicians, podiatrists, and chiropractors from enforcing any requirements for patients, prospective patients, or patient representatives to wear masks to receive medical care, including when following policies of insurers or organizations or when following guidance issued by the Centers for Disease Control, local health departments, or the Virginia Department of Health;"

One can obviously see the difference in my proposal. My proposal simply limits a practitioner from enacting, implementing, enforcing, or executing any practitioner-authored, insurer-required, or organizational policy, instruction, or guidance prohibiting patients, prospective patients, family members, or authorized patient representatives to receive medical care *based solely upon an individual's choice to not wear a mask.* The proposal does not claim outright that a practitioner cannot place some necessary restrictions on the receipt of care, for example, providing necessary body temperature screening. **However, given the fact that the State of Virginia has now revoked (as of March 23, 2022) the Virginia Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus that Causes COVID-19, under Virginia Code 16VAC25-220, based on emerging scientific and medical evidence that the current widespread variants of the virus no longer constitute a grave danger to employees in the workplace,** it logically follows that no practitioner can still retain or enact such outdated policies continuing masking from the previous finding of a grave danger, when the emerging scientific and medical evidence *proves that a grave danger no longer exists.* If masks are now deemed not required for employees in the workplace by the State of Virginia, how can patients be subjected to a different standard by their practitioner, when they interact with those same employees on a daily basis?

For background, commenters need to know that the Virginia Department of Labor and Industry on February 16, 2022, through the Virginia Safety and Health Codes Board, adopted a proposed finding that there is no longer a continued need for the Virginia Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus that Causes COVID-19, under Virginia Code 16VAC25-220, based on emerging scientific and medical evidence that the current widespread variants of the virus no longer constitute a grave danger to employees in the workplace under Va. Code §40.1-22(6a), and as discussed in the U. S. Supreme Court's decision in National Federation of Independent Businesses, et al., Applicants v. Department of Labor, Occupational Safety and Health Administration, et al. The supporting public comment period has passed and is posted at https://townhall.virginia.gov/L/ViewNotice.cfm?gnid=2373.

Under Governor Youngkin's Executive Order, the Virginia Standard for Infectious Disease Prevention of the SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220, which previously established requirements for employers to control, prevent, and mitigate the spread of SARS-CoV-2, the virus that causes COVID-19, among employees and employers, including provisions for employer mandatory masking, has now been repealed. On March 22, 2022, the proposed revocation of that Standard was finalized. The link showing the revoked standard is located here: http://register.dls.virginia.gov/details.aspx?id=10202.

The rationale that I originally proposed behind my petition is of utmost relevance, and so I post it here:

"These regulations are necessary due to the thousands upon thousands of examples in Virginia where patients and prospective patients were denied their right to necessary medical care solely because of their individual choice to not take the COVID-19 vaccine, or their choice to not wear a mask during a visit to a licensed medical practitioner or medical facility. Both mask wearing and the vaccine have now been shown (based on years of peer-reviewed scientific studies and empirical data) to be largely ineffective in preventing contracting of the virus that causes COVID-19 disease, or in preventing transmission to others. Numerous studies provide the factual basis behind these statements:

https://www.lifesitenews.com/news/47-studies-confirm-inefectiveness-of-masks-for-covid-and-32-more-confirm-their-negative-health-effects
https://aapsonline.org/mask-facts/
https://www.cidrap.umn.edu/news-perspective/2020/04/commentary-masks-all-covid-19-not-based-sound-data
https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6936a-H.pdf
https://www.cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3949410
https://brownstone.org/articles/more-than-150-comparative-studies-and-articles-on-mask-ineffectiveness-and-harms/
https://lcaction.org/vaccine#cases

Prior to February 2020, no citizen in the Commonwealth of Virginia was required to wear a mask as a condition to receiving necessary medical care. For example, no patients were denied treatment for the seasonal flu by a general practitioner or family doctor if they had not received a flu shot that year, or were not wearing a mask. No pediatrician would deny treatment of a child for pertussis if they were not wearing a mask. Yet, unfortunately these instances surrounding COVID-19 occurred thousands of times across the Commonwealth within the past 2 years by practitioners, and still continue to happen to this day, even when all mask restrictions in the Commonwealth have been lifted by the Virginia Board of Health. I myself am still required to wear a mask to see my surgeon for post-surgery follow up appointments after receiving ankle surgery in February 2022 here in Fairfax County, over 3 weeks ago, despite the Centers for Disease Control lifting most mask guidelines and states such as New York, Massachusetts, Florida, and Texas now having no mask mandates. Why does Virginia still allow this? I am a survivor of COVID-19 disease from August of 2021, and have recovered fully, with documented natural immunity through antibody testing. My practitioner still will not accept any of that information as relevant, and assumes all patients as possibly infected (an unethical and unscientific practice, by the way), and therefore requires me to wear a mask in his office, even threatening patients (through administrative staff) with cancelling a necessary medical appointment if they do not comply, despite **overwhelming evidence** that masking does almost nothing to stop the spread of the COVID-19 virus or prevent transmission. It is unconscionable that licensed practitioners, their subordinates, and administrative or office employees can still refuse to treat patients if the patient chooses to not wear a mask. This discriminatory practice must end immediately.

One of the main principles of the Hippocratic oath is to First, Do No Harm. Demanding that a patient wear a mask (when multiple, peer-reviewed studies documenting the adverse effects of mask wearing is well established), is harmful to a patient and violates patient autonomy. It must be their choice to wear a mask, not mandated by an individual practitioner, when local and State Boards of Health have lifted masking restrictions for all business establishments. Patient autonomy and patient rights must be respected by that practitioner.

It is also ridiculous and an outrage to patient rights that some licensed practitioners can still demand that patients, prospective patients, or family members accompanying them wear a mask as a precondition to receiving treatment, (and as a consequence, can refuse or deny treatment for a patient when they exercise their right to not wear one), when it is now state law in Virginia that no child who attends a school is required to wear a mask (Senate Bill 739). If a child has the legal right to not have to wear a mask while in a school environment, of which that child is potentially indoors for periods of up to 6-8 hours a day, five days a week, in close proximity to potentially *hundreds* of other children each day, how can the Virginia Board of Medicine still allow medical practitioners to continue these blatantly discriminatory and coercive practices of mandatory mask wearing, or demand proof of a COVID-19 vaccination in order for a patient to obtain medical care? ***How do children now have this right, but somehow patients now do not?***

Requiring a patient to wear a mask indoors for a doctor's appointment, medical procedure, or for any duration of time in a medical facility (for example, as a visitor), was rarely, if ever required on a widespread, Commonwealth basis prior to 2020. At this point continuance of these policies is nonsensical. The facts are clear: masks and the COVID-19 vaccine do not stop transmission, nor prevent transmission of the virus that causes COVID-19 disease. The Virginia Board of Medicine has an obligation to put an end to unethical, coercive, and discriminatory practices by practitioners requiring mask wearing and demanding proof of vaccination as a precondition to receiving necessary medical care."

CommentID: **121794**

Commenter: Michael J Schultz 4/17/22 8:51 pm

Petitioner's Response to Comments - Part 2

Response to Specific Commenters In Opposition to Prohibiting Masking

As the petitioner, I feel the need to respond to multiple commenters claiming, without evidence, that masking is effective in stopping transmission of the COVID-19 virus, and masking "protects vulnerable populations." Comments such as "Compliance with CDC recommendations regarding disclosure of vaccination status, masking to permit transmission of pathogens, and other infectious disease protocols is vital for my own safety and that of my patients," or "I oppose regulations which would undermine access to health care for immune-compromised patients or those with co-morbidities," completely ignore the vast body of scientific evidence clearly established by hundreds of peer-reviewed studies on the efficacy of masks and completely deny the concept of patient autonomy. This proposed regulation does *not* undermine access to health care for immune-compromised patients or any patients *in any way*. No one will be denied medical treatment if a practitioner is prohibited from *forcing* someone to wear a useless mask against their will – on the contrary, this regulation would actually ensure that practitioners cannot ***deny*** treatment to those who choose to not wear a mask and need such care, since denying individuals the right to receive compassionate medical care on that basis alone is unethical. Multiple other proven, effective infection control protocols can be put in place to adequately protect immunocompromised patients, such as enhanced hand washing, and temperature screening. Nowhere in this petition does it state practitioners are forbidden from treating immune-compromised patients who choose to not wear a mask. In fact, practitioners in the Commonwealth (and across the United States, for that matter) routinely treated *tens of millions* of immune-compromised patients, without wearing a mask prior to 2020, and no practitioners denied treatment of someone who chose to not wear a mask or refused to take an experimental "vaccine." Statements about undermining access to health care are pure hyperbole and unsupported by facts.

Nothing in the petition states practitioners can't treat individuals who also refuse to disclose if they have not received the COVID-19 "vaccine" (practitioners currently by and large do not ask (as a precondition to receiving care) if you have been vaccinated for any infectious disease as a condition of treating you for any ailment, injury, or illness regardless), and no commenter has provided any evidence showing that those who don't take the COVID-19 "vaccine" or refuse to disclose whether they have taken it are driving COVID-19 infection rates higher than "vaccinated" patients. What this regulation does is return to the **patient** the autonomy and decision as to whether they will wear a mask, not the Practitioner. This returns to the **patient** the decision whether they will be able to receive life-saving treatment, regardless of their vaccination status, not the Practitioner. Unfortunately what the public has also seen over the past two years is egregious behavior by some practitioners refusing to treat patients or prospective patients because they have refused to receive the COVID-19 "vaccine," which has been proven by recent FDA Freedom of Information Act disclosures over the past 2 months to have dangerous side effects in many immunocompromised and otherwise healthy patients (https://childrenshealthdefense.org/defender/1-million-covid-vaccine-injuries-27000-deaths-reported-vaers-cdc-data/ and here: https://childrenshealthdefense.org/defender/pfizer-vaccine-injuries-more-severe-people-under-55/.

There have been cases across the country, and even in the Commonwealth of Virginia, where individuals who needed life-saving organ transplants that were removed from an organ donor recipient list at the last minute because the individual chose not to receive the COVID-19 "vaccine." This removal was due to a hospital or practitioner making the discriminatory (and highly unethical) decision to deny that person life-saving medical care because of the patient's choice to not receive a COVID-19 "vaccine." This proposed regulation would prohibit that discriminatory behavior by practitioners. Here is the evidence: https://theroanokestar.com/2022/02/04/unvaccinated-patients-denied-organ-transplants-everywhere/. Now where are the claims by opponents of this petition of "undermining access to health care for immune-compromised patients or those with co-morbidities?"

Hundreds of peer reviewed studies show little to no evidence of the efficacy of mask wearing on stopping transmission or receipt of the virus that causes COVID-19, and of many other respiratory diseases. These links below are just a sampling of the overwhelming body of literature demonstrating the futility of enforcing masking as an infection control technique against the virus that causes COVID-19, both in medical facilities and in the general population.

1. "CDC data shows 85% of those who contracted COVID-19 during July 2020 were mask wearers." https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6936a5-H.pdf

2. "The COVID-19 pandemic has led to critical shortages of medical-grade PPE. Alternative forms of facial protection offer inferior protection": https://pubmed.ncbi.nlm.nih.gov/32371574/

3. "There is moderate certainty evidence that wearing a mask probably makes little or no difference to the outcome of laboratory-confirmed influenza compared to not wearing a mask." https://pubmed.ncbi.nlm.nih.gov/33215698/

4. Disposable surgical face masks for preventing surgical wound infection in clean surgery

"We included three trials, involving a total of 2106 participants. There was no statistically significant difference in infection rates between the masked and unmasked group in any of the trials." https://pubmed.ncbi.nlm.nih.gov/27115326/

5. Disposable surgical face masks: a systematic review

"Two randomized controlled trials were included involving a total of 1453 patients. In a small trial there was a trend towards masks being associated with fewer infections, whereas in a large trial there was no difference in infection rates between the masked and unmasked group." https://pubmed.ncbi.nlm.nih.gov/16295987/

6. Evaluating the efficacy of cloth facemasks in reducing particulate matter exposure

"Our results suggest that cloth masks are only marginally beneficial in protecting individuals from particles<2.5 μm." Scientific studies show the COVID-19 virus is approx. 0.125 μm in diameter. https://pubmed.ncbi.nlm.nih.gov/27531371/

7. Comparison of the Filter Efficiency of Medical Nonwoven Fabrics against Three Different Microbe Aerosols

"The filter efficiencies against influenza virus particles were the lowest"

"We conclude that the filter efficiency test using the phi-X174 phage aerosol may overestimate the protective performance of nonwoven fabrics with filter structure compared to that against real pathogens such as the influenza virus" https://pubmed.ncbi.nlm.nih.gov/29910210/

8. The efficacy of standard surgical face masks: an investigation using "tracer particles"

"Since the microspheres were not identified on the exterior of these face masks, they must have escaped around the mask edges and found their way into the wound". Human albumin cells, aka aborted fetal tissue, is much larger than the virus and still escaped the mask. https://pubmed.ncbi.nlm.nih.gov/7379387/

9. Using half-facepiece respirators for H1N1

"Increasing the filtration level of a particle respirator does not increase the respirator's ability to reduce a user's exposure to contaminants" https://pubmed.ncbi.nlm.nih.gov/19927872/

10. Why Masks Don't Work Against COVID-19

https://www.citizensforfreespeech.org/why_masks_don_t_work_against_covid_19?fbclid=IwAR0Qviyvt6BObOgaMij03Cj0fgTcm_gm5jhXcMkO8GcH3Kur-bwib0o8rf8

11. Masks Don't Work: A Review of Science Relevant to COVID-19 Social Policy

https://www.rcreader.com/commentary/masks-dont-work-covid-a-review-of-science-relevant-to-covide-19-social-policy?fbclid=IwAR0Qviyvt6BObOgaMij03Cj0fgTcm_gm5jhXcMkO8GcH3Kur-bwib0o8rf8

12. Face masks to prevent transmission of influenza virus: a systematic review

There is less data to support the use of face masks or respirators to prevent becoming infected. https://pubmed.ncbi.nlm.nih.gov/20092668/

13. Use of face masks by non-scrubbed operating room staff: a randomized controlled trial:
Surgical site infection rates did not increase when non-scrubbed personnel did not wear face masks.
2010 Study article: https://pubmed.ncbi.nlm.nih.gov/20575920/

14. Surgical face masks in modern operating rooms – a costly and unnecessary ritual?

When the wearing of face masks by non-scrubbed staff working in an operating room with forced ventilation seems to be unnecessary. https://pubmed.ncbi.nlm.nih.gov/1680906/

15. Masks: a ward investigation and review of the literature

Wearing multi-layer operating room masks for every visit had no effect on nose and throat carriage rates. https://pubmed.ncbi.nlm.nih.gov/2873176/

16. Masks for prevention of viral respiratory infections among health care workers and the public: PEER umbrella systematic review. Meta analysis review that says there is limited evidence to suggest that the use of masks may reduce the risk of spreading viral respiratory infections. https://pubmed.ncbi.nlm.nih.gov/32675098/

17. Modeling of the Transmission of Coronaviruses, Measles Virus, Influenza Virus, Mycobacterium tuberculosis, and Legionella pneumophila in Dental Clinics

Evidence to suggest that transmission probability is strongly driven by indoor air quality, followed by patient effectiveness and the least by respiratory protection via mask use. https://pubmed.ncbi.nlm.nih.gov/32614681/

18. Nonpharmaceutical Measures for Pandemic Influenza in Nonhealthcare Settings-Personal Protective and Environmental Measures

The use of face masks, either by infected or non-infected persons, does not have a significant effect on influenza transmission. https://pubmed.ncbi.nlm.nih.gov/32027586/

19. Effectiveness of personal protective measures in reducing pandemic influenza transmission: A systematic review and meta-analysis

Meta analyses suggest that regular hand hygiene provided a significant protective effect over face masks and their insignificant protection. https://pubmed.ncbi.nlm.nih.gov/28487207/

20. Effectiveness of N95 respirators versus surgical masks against influenza: A systematic review and meta- analysis

Use of n95 respirators compared to surgical masks is not associated with a lower risk of laboratory confirmed influenza.
https://pubmed.ncbi.nlm.nih.gov/32167245/

21. Adolescents' face mask usage and contact transmission in novel Coronavirus

Face mask surfaces can become contamination sources. People are storing them in their pockets, bags, putting them on tables, people are reusing them etc. This is why this study is relevant:
https://pubmed.ncbi.nlm.nih.gov/32582579/

22. Visualizing the effectiveness of face masks in obstructing respiratory jets

Loosely folded face masks and "bandana style" face coverings provide minimum stopping capability for the smallest aerosolized droplets. This applies to anyone who folds or shoves a mask into their pockets or bag. It also applies to cloth and homemade cloth masks: https://pubmed.ncbi.nlm.nih.gov/32624649/

23. Use of surgical face masks to reduce the incidence of the common cold among health care workers in Japan: a randomized controlled trial. Face mask use in healthcare workers has not been demonstrated to provide benefit in terms of colds symptoms or getting colds.
https://pubmed.ncbi.nlm.nih.gov/19216002/

24. A cluster randomized trial of cloth masks compared with medical masks in healthcare workers

Penetration of cloth masks by influenza particles was almost 97 percent and medical masks 44 percent. So cloth masks are essentially useless, and "medical grade" masks don't provide adequate protection.
https://pubmed.ncbi.nlm.nih.gov/25903751/

25. Effectiveness of Adding a Mask Recommendation to Other Public Health Measures to Prevent SARS CoV-2 Infection in Danish Mask Wearers : A Randomized Controlled Trial

"The recommendation to wear surgical masks to supplement other public health measures did not reduce the SARS-CoV-2 infection rate among wearers by more than 50 percent in a community with modest infection rates, some degree of social distancing, and uncommon general mask use": https://pubmed.ncbi.nlm.nih.gov/33205991/

26. Mask mandates and use are not associated with slower state-level COVID-19 spread during COVID-19 growth surges.
https://www.medrxiv.org/content/10.1101/2021.05.18.21257385v1

In addition to the numerous internet citations provided above that document overwhelming evidence that masking does not prevent the contracting of the virus, nor stop transmission, of particular relevance is a comment submitted by Mr. Mark Fraser, PhD, Aerosol Scientist and OSHA Safety Officer in support of revoking the Virginia Standard for Infectious Disease Prevention of the SARSCoV-2 Virus That Causes COVID-19 (16VAC25-220). Mr. Fraser's comment shows that masking is completely ineffective as a means of infection control against the SARS-CoV-2 Virus, summarized below: (https://townhall.virginia.gov/L/viewcomments.cfm?commentid=120823)

"The Standard, subsection 40(G), specifies the mandated Personal Protective Equipment (PPE): "employees shall wear a face covering or surgical mask that covers the nose and mouth to contain the wearer's respiratory droplets and help protect others and potentially themselves." This selection of PPE was unfortunate because these types of masks bear no certification of effectiveness against germs and viruses and, in fact, were known to be ineffective against these pathogens at the beginning of the COVID outbreak[1]. . . Sufficient data have been acquired to allow the performance of Mask Mandates to be assessed. The unmistakable conclusion is that COVID infections were driven largely by seasonal and endemic factors, whereas Mask Mandates had no discernable impact on infections here in the U.S.[4] . . .

The Standard also failed to address the possibility of short and long-term health issues raised by prolonged use of PPE. These issues include: difficulty in breathing, skin rashes, and CO2 intoxication.4

Conclusions: Considering the PPE specified under the Standard provided little or no protection against the SARS-CoV-2 virus and long-term use presents health risks to employees, the Standard should be revoked."

So, since masking has been overwhelmingly shown through multiple peer reviewed studies to have not stopped or slowed the spread of the virus that causes COVID-19, why does the Board of Medicine still allow practitioners to force patients to wear one as a condition to receiving care?

Several commenters have stated that any patient or prospective patient doesn't have to wear a mask, as they could seek a practitioner that aligns with their philosophy on mask wearing if they choose not to wear one. While this sounds feasible in theory, unfortunately if there are only a minimal number of practitioners in one's local area, patients would be unfairly discriminated against for their choice should all practitioners demand that a mask be worn, even just in order to be seen for an initial appointment! In reality in densely populated locations such as Fairfax County, there is no way for a patient or prospective patient to adequately research or filter practitioners for this option without an exhaustive time and resource-intensive search. No practitioners in the Commonwealth advertise "mask free," or "masks optional," on their websites, or in their practice's literature, or brochures. There is no county government, or Association of medical providers, or medical guild that advertises "mask free" practitioners. So, while this initially sounds like a reasonable option for patients to have their autonomy respected, in reality this is an undue burden that patients or prospective patients must not be required to bear in order to simply receive compassionate, unrestricted medical care. The more reasonable option is to simply prohibit practitioners from acting as defacto agents of the Local or State Board of Health, where they have not been accorded any authority under Virginia State law or Board of Health regulation to continue to force masking on patients.

In addition, as explained in my rationale submitted to the Board, forced masking violates patient autonomy by requiring a patient to wear ineffective facial masks that actually can be shown to make individuals sick, as is clearly outlined in multiple studies cited in the above internet links (for example, University of New South Wales. (2015, April 22). Cloth masks: Dangerous to your health? ScienceDaily. Retrieved March 19, 2022 from https://www.sciencedaily.com/releases/2015/04/150422121724.htm

How is it ethical (or in the interest of patient safety) then, to force a patient to wear a mask as a condition to receiving care, when that mask can actually make them sicker than they are to begin with, or possibly negatively contribute to their health? No practitioner is checking a patient for proper fit and wear, quality of mask, or cleanliness of mask, to begin with. So, even on that basis alone, forced masking must be prohibited as a condition of receiving care.

CommentID: **121795**

Commenter: Michael Moates, MA, QBA, LBA, LMHP 4/19/22 12:55 pm

Is this Petition Invalid Now?

Yesterday, a judge ruled that it was illegal for the government to force a mask mandate on anyone. Would that not apply to private healthcare providers?

The government cannot force anyone to wear a mask nor can they force anyone to not wear a mask. This is up to the choice of the treating physician and what they are willing to do.

See: 8:21-cv-01693-KKM-AEP in the United States District Court Middle District of Florida - Tampa Division

https://s3.documentcloud.org/documents/21636220/047124235804.pdf

Government entities cannot force someone to give up their own rights to treat a patient. Similarly in, Masterpiece Cakeshop v. Colorado Civil Rights Commission, the Supreme Court rules that a government entity cannot violate the rights of the seller to protect the rights of the purchaser.

CommentID: **121842**

Commenter: Roy Berkowitz 4/23/22 4:16 pm

Oppose this strongly

Healthcare policy needs to follow CDC and health dept guidelines to protect older, at risk and the Immunocompromised population . We need to use that science to take care of one another. Virginians can always choose to get care at providers who choose not to follow the guidelines.

CommentID: **121854**

Commenter: Sarah Morrison 4/24/22 1:55 am

Oppose strongly as needed.

For protection of vulnerable health workers and other patients, another patient should not be able to make the decision to expose them to their potential or real communicable illness. I do think it could be up to the health practitioner or facility at this point, however, so that those who refuse to comply can try to find a like-minded caregiver and fellow patients.

CommentID: **121855**

Commenter: Michael Milano 4/26/22 10:56 am

Unthinkable

This proposal is really hard to even believe. It is a direct attack on selfless healthcare workers and systems whom, often at their own risk, have worked so hard to stay as "healthy as possible" during this time of COVID. Who better to make decisions about health protocols than those who work in healthcare systems and see not only the data but also the human toll on caretakers and patients? Why would we legislate against wisdom and the communal good?

CommentID: **121868**

Commenter: Chris Wahl 4/26/22 3:21 pm

Nonsensical, Unwise, and Narrow-Minded

Healthcare workers have been the backbone of our process of helping those who suffer from Covid get well, or have care as they are dying. They've witnessed much suffering and have made tremendous sacrifices to stay healthy so they can minister to those who have had Covid. We don't know what the next virus will be, and the current one is not yet quiet. Why put healthcare workers at risk like this? They are doing their best to be there for us and are interested in the good of all, and that is what should be supported.

CommentID: **121870**

Commenter: Gerald N Fisette 4/26/22 6:34 pm

Prohibition of requirements for mask wearing, receipt of vaccines, and disclosure of vaccine status

I oppose this proposed rule. I trust the CDC, and would hope any Virginia rule making would be consistent with current research and guidance of one of the pre-eminent disease control agencies in the world.

CommentID: **121874**

Commenter: Michael Moates 4/29/22 8:32 pm

Violation of Constitutional Law

Short answer: Forcing a doctor to allow anyone on their property regardless of reason is a violation of the Constitution.

CommentID: **121893**

Commenter: Anonymous 5/1/22 7:08 pm

In support of this Petition

I fully support this petition. I've read many of the comments in opposition to this proposed regulation by commenters and they are not based on facts or common sense. Many in opposition state this would harm healthcare workers if the regulation would be allowed to pass. I have two questions to ask these commenters (and the Board of Medicine):

First, if you truly believe that your mask wearing as a practitioner or healthcare worker protects you from the Coronavirus, why does it matter if a patient wears a mask or not? Is it not the patient's decision? The state of Virginia has already stated that the grave danger to employers does not exist anymore from this virus based on their repeal of the Safety and Health Codes Board Standard for Infectious Disease Prevention of the SARSCoV-2 Virus That Causes COVID-19 (16VAC25-220) on March 21, 2022 (http://register.dls.virginia.gov/details.aspx?id=10202).

Second, where in the Virginia Board of Medicine regulations or Virginia constitution (or anywhere for that matter) does a practitioner get to dictate what a patient's acceptable risk tolerance level is? Does your neighbor get to dictate to you that you drive a Volvo as opposed to a Ford? No, they cannot, and neither can a practitioner demand that a patient wear a mask, or demand they receive a "vaccine" in order to receive life-saving treatment, such as a liver transplant. Commenters in opposition to this petition are conveniently ignoring the fact that if a healthcare worker (or a patient for that matter) wants to wear a mask, this regulation DOES NOT STOP THEM IN ANY WAY. If you want to wear a mask and you feel it protects you, by all means, go ahead. This petition just prohibits a *practitioner* from *demanding* that you as a *patient must* wear one in order for the patient to receive necessary compassionate medical care.

CommentID: **121896**

Commenter: R. Brent Rawlings on behalf of Virginia Hospital & Healthcare Association 5/6/22 4:54 pm

Comment on Petition for Rulemaking: Prohibition of Requirements for Mask Wearing, Receipt of Vaccine

May 6, 2022

William L. Harp, M.D.
Executive Director
Board of Medicine
9960 Mayland Drive, Suite 300
Henrico Virginia 23233

Re: Comment on Petition for Rulemaking: Prohibition of Requirements for Mask Wearing, Receipt of Vaccines, and Disclosure of Vaccine Status to Receive Medical Care

Dear Dr. Harp,

For reasons discussed in further detail below, the Virginia Hospital & Healthcare Association (VHHA) urges the Board of Medicine to reject the petitioner's request to amend its regulations to prohibit requirements for mask wearing, receipt of vaccines, or disclosure of vaccine status.

The ability to require patients or prospective patients or their accompanying representatives to wear masks when present in health care settings, including physician offices or clinics and hospital inpatient and outpatient departments, is essential to proper infection control practices necessary for the protection of patients, staff, and the public. Interference with this ability could not only expose individuals to disease, disability, or death, but could also result in health care providers being liable for negligence and being out of compliance with applicable laws and regulations that require proper infection control practices.

For example, the Medicare conditions of participation for hospitals at 42 CFR § 482.42 require hospitals to have active hospital-wide programs for the surveillance, prevention, and control of infectious diseases and such programs must demonstrate adherence to nationally recognized infection prevention and control guidelines, such as those established from time to time by the Centers for Disease Prevention and Control (CDC). Depending upon the circumstances, proper infection control practices may require the wearing of masks in sterile and non-sterile environments and in patient care and non-patient care areas. As we have seen with COVID-19, wearing of masks in health care settings has been and continues to be included in guidelines adopted by the CDC.

Current CDC guidelines for COVID-19 have included masking as a recognized source control in healthcare settings and continue to prefer that it be applied universally. It has recently, however, included some allowances for individuals who are up to date with all recommended COVID-19 vaccine doses in healthcare facilities located in counties with low to moderate community transmission. Similarly, health care providers who are up to date with all recommended COVID-19 vaccine doses can chose not to wear masks when they are in well-defined areas that are restricted from patient access (e.g., staff meeting rooms, kitchen), but are instructed to wear source control when they are in areas of the healthcare facility where they could encounter patients (e.g., hospital cafeteria, common halls/corridors).
CDC continues to instruct that the safest practice is for patients and visitors to wear masks, particularly if at risk for severe disease or are unvaccinated.

Accordingly, it is the case now, and would likely be for any future pandemics or outbreaks of infectious disease, that health care settings, including hospitals, will be required to enforce masking requirements in order to maintain proper infection control practices and compliance with applicable regulations. The requested regulations' prohibition on mask wearing requirements would be in direct interference with such obligations. The regulations would also appear to place health care providers in the untenable position of either complying with the regulations or violating other applicable requirements as the prohibitions are to apply even "when following policies of insurers or organizations or when following guidance issued by the Centers for Disease Control, local health departments, or the Virginia Department of Health."

Further, as demonstrated by the CDC guidance, it will be necessary to inquire about or request disclosure of vaccination status of patients or prospective patients or accompanying representatives to determine whether applicable requirements are being complied with. If it is determined that an individual is not vaccinated, additional steps would be required to ensure compliance, including, but not limited to requests for the individual to wear a mask. Consequently, the requested regulations' prohibition on disclosure of whether they have received any vaccine would likewise be in direct interference with existing obligations.

As it relates to any prohibition against disclosure of vaccination status or provision of medical care to any patient or prospective patient based on the vaccination status of the patient, vaccination may be clinically indicated to produce the best possible outcome for a patient, could be a contraindication for treatment, or serve as an appropriate factor in scarce resource allocations. As such, information about vaccination status cannot and should not be eliminated from clinical decision-making. Ultimately, the patient controls consent to receiving any vaccination, but vaccination status is clinically relevant and there should not be interference in communication about vaccination status between patients or potential patients and their health care providers.

Virginia's hospitals and health systems strive to provide the best possible care experience for patients and visitors in the least restrictive manner possible; however, it is essential that they retain the flexibility to implement proper infection control practices when necessary in response to threats to the health and safety of those patients and visitors and their dedicated staff. The requested regulations would be in conflict with this mission and are therefore not supported by VHHA. We again respectfully urge you to reject the petitioner's request.

Sincerely,
R. Brent Rawlings
Senior Vice President and General Counsel

CommentID: **121923**

Commenter: Doris Knick 5/7/22 4:45 pm

AGREE ??% Medical Choices must remain private

No medical procedure is one size fits all. Masks have proven to do more harm than good. Fauci is a psychopathic narcissist who should not be trusted. Medicine has become political and weaponized. Vaccines should never be mandatory as the vaccine manufacturers are not liable. No placebo studies were done on any. This is Experimental EUA is creating mass genocide. There has never been truly informed consent to any biologic. The inserts are not shown to the people. If bodily autonomy is attacked what freedom does anyone have? Can you comply your way to freedom? When doctors get paid to jab children that is a conflict of interest! We must end this violation of the Constitution. Thank you for making an amendment as good legislation have been blocked by politicians who get paid by big pharmaceutical lobbyists.

CommentID: **121930**

Commenter: Clark Barrineau on behalf of the Medical Society of Virginia 5/10/22 9:41 am

MSV Comment on Petition for Rulemaking: Prohibition of Requirement for Mask Wearing, Receipt of Vac

William L. Harp, M.D.
Executive Director
Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, VA 23233

Re: Comment on Petition for Rulemaking: Prohibition of Requirement for Mask Wearing, Receipt of Vaccines, and Disclosure of Vaccine Status to Receive Medical Care

Dear Dr. Harp,

On behalf of the Commonwealth's physicians, PAs, residents, and medical students, the Medical Society of Virginia (MSV) respectfully opposes Petition 362. The petitioner's request would prohibit requirements for mask wearing, receipt of vaccines, or disclosure of vaccine status—jeopardizing the health and wellness of Virginia's providers and patients.

The decision to maintain masking in healthcare settings by the CDC is evidence-based and in the best interest of the patient and the healthcare team. Healthcare settings should continue to abide by CDC guidelines. Similarly, the healthcare community strongly encourages all individuals to get vaccinated against COVID-19.

Physician practices, like any other business in the Commonwealth, have the autonomy to do what is best for their business and staff. The petition's ask would limit that freedom. When the mask mandate is lifted for healthcare settings, physician offices will continue to have the right to require

patients seeking care in their space to wear a mask or be vaccinated -- the choice is theirs to either implement or not.

As an organization of healthcare providers, the MSV is supportive of measures that aim to protect Virginians from serious illness, reduce the rate of hospitalizations, and ease the overall burden on our healthcare system. We, therefore, respectfully ask you reject the petitioner's request.

Sincerely,

Clark Barrineau
Assistant Vice President of Government Affairs and Policy
The Medical Society of Virginia

CommentID: **121953**

Commenter: Anonymous 5/10/22 9:16 pm

Fully support this proposal

As further evidence the CDC "guidelines" in terms of required masking and forced "vaccinations" referenced by multiple commenters that supposedly are so effective and necessary in preventing COVID-19 infections are utterly worthless, Bill Gates, former CEO of Microsoft Corp, declared that he contracted COVID-19 today. He is fully "vaccinated"and boosted. Add this to the list of millions of others who are fully "vaccinated" and boosted who have contracted this virus. Here is a list of others:

1. Hillary Clinton
2. Current Secretary of Defense Lloyd Austin
3. Comedian Stephen Colbert
4. Current Commandant of the Marine Corps David Berger
5. Chairman of the Joint Chiefs of Staff Mark Milley
6. Senator Elizabeth Warren
7. White House Press Secretary Jenn Psaki

Need I go on? When does this nonsense with forced masking and forced "vaccinations" in order to receive necessary medical treatment end? THE STATE OF VIRGINIA HAS DECLARED THE GRAVE DANGER FROM THIS VIRUS HAS ENDED. IT IS TIME TO RETURN TO NORMAL. WILL THE BOARD OF MEDICINE RETURN TO NORMAL OR REMAIN STUCK IN THE PAST RELYING ON OUTDATED DATA?

CommentID: **122000**

Commenter: Eric Andrew Horwitz 5/11/22 1:41 pm

My mother once told me that seagulls thought the parking lot was the ocean

Then I realized they would have instantly realized their mistake but for a fishlike memory.

Perhaps trusting experts and their self-refuting statements is the best of all possible worlds.

CommentID: **122009**

Agenda Item: Report of the Credentials Committee

Staff Note: At the October 2021 Board meeting, a motion was made and passed to refer the review of the Board's questions about mental health and substance abuse on its initial application to the Credentials Committee. The Credentials Committee met on June 7, 2022 to consider its questions and also to consider if review of non-routine information could be delegated to staff in the licensing process.

Credentials suggested that the questions be revised in the following way:

1. Remove "condition" to emphasize that the Board is not interested in a diagnosis/condition, but rather with impairment.
2. Work in a positive "attestation" that is encouraging to seek help if needed.
3. Remove the definition of "currently" which lacks clarity.

In regards to delegation of non-routine information to Board staff:

1. For questions 6-10 & 12, a threshold of 10 years is considered reasonable for delegation.
2. Questions 11, 13-18 & 21 will continue to be reviewed by a Board member.

In the following pages, you will find the original request for review of the application questions from MSV, Virginia's questions and those of our surrounding jurisdictions, an excerpt from the Surgeon General's Advisory addressing healthcare worker burnout, a Toolkit for State Boards on this topic, an article from Virginia Business, and the MD/DO initial application.

Action: Review and discuss the recommendation from the Credentials Committee for approval or revision.

September 22, 2021

William L. Harp, M.D., Executive Director
CC: Michael Sobowale, Deputy Executive Director- Licensure
Via Electronic Mail: medbd@dhp.virginia.gov, michael.sobowale@dhp.virginia.gov

Re: The Medical Society of Virginia's Request to Change the Mental Health Question for the Board of Medicine Licensure Application

Dear Dr. Harp:

As you know, the Medical Society of Virginia (MSV) represents Virginia's physicians, PAs, residents, and medical students of all specialties and localities across the Commonwealth. Many of these clinicians have raised concerns over the language in the medical licensure application regarding mental health and the unintended consequence on Virginia's healthcare providers.

Thousands of medical students and practitioners who live with mental illness remain silent, untreated, or undiagnosed due to fear of stigma or threat to their medical license. The COVID-19 pandemic has only further increased burnout to historic levels. When applying for a medical license in Virginia, physicians are asked to attest to their mental and medical fitness to practice by answering yes or no to the following question: *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.* This line of questioning may cause physicians to forego seeking psychological or psychiatric care when they are suffering from depression, anxiety, or professional burnout for fear of losing or never receiving their license.

Virginia's current question obfuscates the issues of illness and impairment[1]. Virginia's language affirms the belief that mental health illness undermines a provider's ability to do their job, implying that illness and impairment are comparable to one another. The Federation of State Medical Boards and the National Academy of Sciences, Engineering, and Medicine have acknowledged the language used by many state licensing boards inadvertently discriminates against physicians with mental illness and may not be in compliance with the Americans with Disabilities Act (ADA).[2]

Neighboring states such as Maryland, Washington D.C., North Carolina, and Kentucky, and Maine have already implemented language changes on their applications that are more physician-friendly.

The Medical Society of Virginia respectfully asks the Board to consider the following change to the mental competency question on the licensure application:

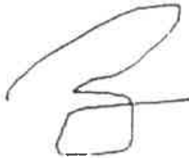
[1] Physician-Friendly States for Mental Health: A Review of Medical Boards; Research Project by Pamela Wible, M.D., and Arianna Palermini, OMS2. Copyright 2019.
[2] Physician Wellness and Burnout, *available at*: https://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf

"Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients? Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation?".

This is the same language as used by Maryland and New Jersey. This small language change will have a positive impact on our healthcare system. Supporting physician interventions enhances the patient experience of care and reduces costs from decreased physician productivity, high turnover rates, and the adverse consequences of medical errors.[3] Organizations such as the Lorna Breen Heroes Foundation, the American Psychiatric Association, the American College of Physicians, the AMA, and dozens of state medical societies across the country have been strong advocates for removing barriers to mental health services and removing the stigma for providers—and this requested change would align with these principled efforts.

We are happy to support the efforts of the Board and appreciate your attention to this important issue. To discuss this matter further, please contact Clark Barrineau, Assistant Vice President of Government Affairs and Health Policy at the Medical Society of Virginia, at cbarrineau@msv.org or 704-609-4948.

Sincerely,



Arthur J. Vayer, MD
President, The Medical Society of Virginia

CC:
Clark Barrineau, Assistant Vice President of Government Affairs and Health Policy/ MSV
W. Scott Johnson, Esquire/ Hancock, Daniel & Johnson, General Counsel/ MSV
Benjamin H. Traynham, Esquire/ Hancock, Daniel & Johnson
Tyler S. Cox, Government Affairs Manager/ Hancock, Daniel & Johnson
Kelsey Wilkinson, Government Affairs Manager/ MSV

[3]Brower K.J. (2017) Organization-Level Interventions to Promote Physician Health and Well-Being: From Taking Care of Physicians to Giving Care to Patients. In: Brower K., Riba M. (eds) Physician Mental Health and Well-Being. Integrating Psychiatry and Primary Care. Springer, Cham.

MENTAL HEALTH AND SUBSTANCE ABUSE QUESTIONS

Virginia

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.

DC

Have you ever engaged in any conduct that either indicated an impairment, or actually impaired, your ability to practice your profession?

Have you ever entered into a monitoring program for purposes of monitoring your abuse of alcohol, drugs, or other controlled substances?

Kentucky

Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?

Maryland

Do you currently have any condition or impairment (including but not limited to substance abuse, alcohol abuse, or a physical, mental , emotional or nervous disorder or condition) that in any way affects your ability to practice your profession in a safe, competent, ethical, and professional manner?

North Carolina

In the past five (5) years, have you used or consumed any controlled substance or other prescription drug that you obtained through illegal or improper means? (If you are an anonymous participant in the NC Professionals Health Program and are in compliance with your agreement, you may answer "no" to this question.)

In the past five (5) years, have you used or consumed any illicit or illegal drugs including, but not limited to cocaine, heroin, ecstasy, LSD, mescaline, psilocybin, PCP and/or marijuana? (If you are an anonymous participant in the NC Professionals Health Program and are in compliance with your agreement, you may answer "no" to this question.)

In the past five (5) years, have you used alcohol or other substances in a manner that could in any way impair or limit your ability to practice medicine with reasonable skill and safety or have you been told you were impaired by your use of alcohol or other substances in a manner that could impair or limit your ability to practice medicine with skill and safety? (If you are an anonymous participant in the NC Professionals Health Program and are in compliance with your agreement, you may answer "no" to this question.)

Tennessee

COMPETENCY INFORMATION PLEASE ANSWER THE FOLLOWING QUESTIONS.
*If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application.
For the purposes of these questions, the following phrases or words have the following meanings:
1. "Ability to practice your profession" is to be construed to include all of the following: a. The cognitive capacity to make appropriate clinical diagnoses and treatment decisions, exercise reasonable medical judgment, and keep abreast of medical education; b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. "Medical Condition" includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.
3. "Minor Traffic Offense" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.
4. "Chemical substances" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
5. "Currently" does not mean on the day of or even in the weeks or months preceding the completion of the application; rather, it means within the past two years or recently enough so that the use of drugs or alcohol or other medical conditions may have an ongoing impact on one's functioning as a physician).
6. "Illegal use of illicit or controlled substances" means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.
QUESTIONS: YES NO
1. Do you currently have any condition that is causing impairment that affects your ability to practice medicine with reasonable skill and safety in a competent, ethical and professional manner? (You may answer no if you are being appropriately treated and are not impaired.)
2. Do you currently use any medications or substances (legal, OTC, prescribed or illicit) which in any way impairs or limits your ability to practice medicine with reasonable skill and safety in a competent, ethical and professional manner? If so, please list: ______________________________ [If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.] PH 3115 Rev. 9/18 Application - Page 5 of 6 Pages RDA 10137 COMPETENCY INFORMATION CONTINUED QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation. Affirmative response requires final documents or orders from the issuing states, courts, and/or agencies. YES NO
3. During the past two years, did you engage in any activity involving substances, either alcohol or controlled/illicit drugs, that has created or might create a challenging pathway for you in your current or future professional career if continued? If so and you answer "yes" to this question, the Board is prepared to offer an evaluation by the Tennessee Medical Foundation's Physicians Health Program to determine the best pathway to licensure for you as you begin or continue your career in the State of Tennessee. It should be noted, however, that if such activity is not revealed, but manifests at some later time in your career, the Board, in its role as the protector of the health, safety and welfare of people in the State of Tennessee, will be able to pursue a disciplinary action on your license.

4. Are you currently participating in a Professional Health Program (PHP) or similar type program that provides monitoring and advocacy for you for a physical, mental health or substance use disorder which has caused you impairment?
5. Have you ever been diagnosed as having or have you ever been treated for a paraphilia or other type disease of a predatory nature such as, but not limited to pedophilia, exhibitionism, voyeurism, etc.?

West Virginia (Renewal Questions)

- been addicted to, or received treatment for the use or misuse of, prescription drugs and/or illegal chemical substances,
- been dependent upon alcohol or received treatment for alcohol dependency? (You may answer "no" if you are a participant in a written voluntary agreement with the West Virginia Medical Professionals Health Program, Inc., the West Virginia Board of Medicine designated physician health program.) If you have gone through a rehabilitation program during the two-year registration period, you MUST have that program furnish this Board a report of your treatment and progress.
- had any interruption in your practice of medicine which might reasonably be expected by an objective person to currently impair your ability to carry out the duties and responsibilities of the medical profession in a manner consistent with standards of conduct for the medical profession?
- had anything occur which might reasonably be expected by an objective person to currently impair your ability to carry out the duties and responsibilities of the medical profession in a manner consistent with the standards of conduct for the medical profession?

Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce

What Federal, State, Local and Tribal Governments Can Do

Address punitive policies that deter health workers from seeking mental health and substance use care. Many health workers are often reluctant to seek formal care for mental health or substance use conditions because of concerns about losing their license, credentialing, and careers. Priority opportunities include:

Support national, state, and local education and awareness campaigns on burnout, moral distress, and well-being. For example, the Health Worker Mental Health Initiative from the CDC's National Institute for Occupational Safety and Health (CDC/NIOSH) aims to improve awareness about mental health and substance use challenges in health workers and offer strategies for prevention, screenings, and services.

Build on and evaluate the impact of investments such as The Dr. Lorna Breen Health Care Provider Protection Act 2022 which establishes grants and requires other activities to improve mental and behavioral health among health care providers.

Examine state health professional licensing board questions in applications and renewal forms for licensure so that health workers are only asked about "conditions that currently impair the clinicians' ability to perform the job," as recommended by The Joint Commission in 2020, Federation of State Medical Boards, and aligned with the American with Disabilities Act. It is critical that when licensing boards do make these changes that they effectively communicate this to health professionals.

Ensure that state boards and legislatures approach burnout from a nonpunitive lens. This includes considering offering options for "safe haven" non-reporting for applicants receiving appropriate treatment for mental health or substance use challenges. They should also prevent public disclosure of health workers' illness or diagnosis as part of any board process, regularly communicate the value of health worker well-being, and help clarify with applicants that any investigation is not the same as disciplinary undertaking.

How to Improve Licensure Questions & Better Support Your Health Workforce

A Toolkit for State Medical Boards

THE EFFECT OF INVASIVE LICENSURE QUESTIONS ON PHYSICIANS

THE PROBLEM

Clinicians aren't seeking mental health care, despite the traumatic, exhausting experience of the past two years. They fear losing their license, stigma, discrimination, or privacy violations in the workplace.

A recent Medscape survey of 13,000 physicians found that 43 percent said the reason they had not sought help for burnout or depression was because they "don't want to risk disclosure to the medical board."

WHAT DOCTORS SAY

"I'm afraid that if I spoke to a therapist, I'd have to report receiving psychiatric treatment to credentialing or licensing boards."

"Physicians cannot seek help for these issues because if we do that, these temporary issues will follow us for the rest of our careers."

"I feel I should know how to deal with this myself, even though I wish I didn't have to."

Why Physicians Kept Their Suicidal Thoughts Secret, *Medscape 2022*

ARE THESE QUESTIONS PROTECTING THE PUBLIC?

In short, NO.

While these invasive questions were originally developed with good intent, it is a misconception that they are protecting the public. In many cases, it actually has the opposite effect.

Though there is no data demonstrating that these questions protect the public, it is well-documented that they often lead to physicians not seeking care. This, in turn, negatively impacts patients, as the margin of error in medical situations is significantly reduced when doctors and nurses are not burnt out or suffering from untreated mental health strains.

Burnout Among Health Care Professionals: A Call to Explore and Address This Underrecognized Threat to Safe, High-Quality Care, National Academy of Medicine

THREE STEPS TO MENTAL HEALTH SUPPORT & REFORM

There are many State Medical Boards that have eliminated invasive language, just as there are still many that have invasive language on their applications. In this toolkit, you will find three actionable steps that every board must take to ensure that they are adequately supporting the health workforce in their state.

Review all licensure applications, addendums, and peer review forms (if applicable).

Remove invasive or stigmatizing language around mental health and substance abuse.

Disclose these changes and assure physicians that it is safe for them to seek care.

1. AUDIT

Review every application your board issues, including training, renewal, initial, educational, supplemental / addendum, and peer review forms (where applicable).

You should look for the following:

- Questions that contain invasive or stigmatizing language and disclosure requests around a physician's health, well-being, or substance use.
- Questions that ask about a physician's history of "time off" or "breaks in practice."
- Questions prying into substance use at all, beyond illegal usage and penalties.
- Language that references mental health explicitly in any way that's not supportive (see next page for recommended language). There is no reason to separate mental and physical health unless you're encouraging physicians to seek treatment if and as needed.
- Questions that ask about past usage or experiences.
- Unnecessary asterisks or fine print (i.e., "current impairment can be any time in the last 5 years").

2. CHANGE

Remove any invasive or stigmatizing language around mental health and substance abuse.

Option 1: Ask one question consistent with FSMB's Recommended Language that addresses all mental and physical health conditions as one, with no added explanations, asterisks, or fine print:

> "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)"

Option 2: Refrain from asking probing questions about an applicant's health altogether.

Option 3: Implement an Attestation Model, like that used in North Carolina (see their language below) and Mississippi. This uses supportive language around mental health from the Board and holds physicians accountable to their well-being, making it clear that their self-care is patient care. Offer "safe haven" non-reporting options to physicians who are under treatment and in good standing with a recognized physician health program (PHP) or other appropriate care provider.

> "Important: The Board recognizes that licensees encounter health conditions, including those involving mental health and substance use disorders, just as their patients and other health care providers do. The Board expects its licensees to address their health concerns and ensure patient safety. Options include seeking medical care, self-limiting the licensee's medical practice, and anonymously self-referring to the NC Physicians Health Program (www.ncphp.org), a physician advocacy organization dedicated to improving the health and wellness of medical professionals in a confidential manner. The failure to adequately address a health condition, where the licensee is unable to practice medicine within reasonable skill and safety to patients, can result in the Board taking action against the license to practice medicine."

3. COMMUNICATE

Disclose these changes and assure physicians that it is safe for them to seek care.

Identify the appropriate channel(s) of communication and trusted messenger(s) for each key audience (licensees, health systems, and the FSMB).

Craft your message and ensure that in communicating these changes, licensure applicants are first met with supportive language so they know it is safe to seek mental health care. Sample language in reaching out to licensees is below.

> "Your State Medical Board recognizes the hardships of the last several years of the pandemic and urges you to seek the mental health care and support that you need. It is in the best interest of yourself, your patients, and your colleagues to take care of your physical and mental well-being, and we want to assure you that it is safe and encouraged to seek this care. As a protective and supportive measure, we have recently removed all unnecessary questions about mental health from all of our licensure applications."

Begin direct, specific, and transparent communications (via text, mail, or email) with your audiences.

- Establish a designated communications channel for licensees in-state to update them in real-time on the new licensure language.
- Make applications available and easily accessible to the public on the medical board's website. ***Applications that are only behind online portals inhibit transparency***, so it's important to ensure that applications are also accessible in full directly on your site.
- Reach out and encourage state health systems to follow your lead in changing invasive questions on credentialing applications and communicating to their workforces their and the state's changes.
- Once your board has adopted the changes, we recommend that you communicate back to FSMB so that they can help share your successes and positive changes with other boards and promote best practices nationally.

Contact us: We will provide you with a full social media toolkit to help you share out your support of physicians' well-being and any updated language you may have to share via Facebook and/or Twitter. Reach out to us at social@participant.com.

Running on empty

Health care professionals struggle with stress, burnout

Published May 29, 2022 by Katherine Schulte

inScott Austin, nurse manager of the UVA Health COVID unit, sought wellness training for his team in 2020. Photo by Christine Kueter/U.Va. School of Nursing

First, doctors say they're sorry for calling.

Dr. Allison Cotton, a psychiatrist in Reno, Nevada, co-founded the national Physician Support Line in March 2020 to provide peer mental health support to physicians. She says their impulse to apologize shows the need for the service.

"They're apologizing for using a resource which is literally created for them because somebody else might need it more than them," she explains.

During the COVID-19 pandemic's early days, doctors called about feeling exhausted and overwhelmed, which later evolved into sorrow over losing patients.

"When I take calls, a lot of the comments that I hear are things like, 'I don't think I can take losing another patient,'" Cotton says. "The ruminating thoughts that they have are things like holding people's hands while they die alone, having to then tell the families, over and over and over again."

Another thing Cotton has heard "numerous times" she says, "is having husband, wife and adult child all in the ICU altogether, and then they all just are gone, so watching generations of families pass away."

Now, she gets more calls from people who are leaving medicine and are heartbroken about it.

Health care professionals in Virginia have experienced the same pain and stress. The pandemic exacerbated the existing burnout problem in health care, which in turn worsened the labor shortage as people left the industry for lower-stress jobs. In late May, U.S. Surgeon General Dr. Vivek Murthy released an advisory titled Addressing Health Worker Burnout.

"As the burnout and mental health crisis among health workers worsens," Murthy wrote, "this will affect the public's ability to get routine preventive care, emergency care and medical procedures."

Health care systems rushed to respond, implementing wellness programs and peer support groups, as well as offering counseling to employees.

"We can't be all that we want to be to everybody," says Dr. Sandy Simons, who, prior to the pandemic, in 2015, sought treatment for depression. An emergency medicine practitioner at Bon Secours' Richmond Community Hospital, Simons was featured on the cover of Virginia Business' July 2020 issue for a story about front-line health care workers in the pandemic.

Having previously established boundaries between her work and personal lives, Simons was able to appreciate her contributions during the pandemic. She feels that physicians can compartmentalize well.

"We're generally, for better or for worse, pretty good at turning it off when we come home," she says. "But I think for me the big thing in the pandemic was that when I came home, you didn't have all of the ways that you typically decompress: the gym and seeing friends and seeing family."

Health systems recognize their employees' struggles.

"They've been running a marathon like it's a 40-yard sprint," says Paul Hudgins, senior vice president and chief human resources officer for Roanoke-based Carilion Clinic. "Like other health care organizations' staff ... they're tired and fatigued, and they've done an incredible job self-sacrificing in many ways during this entire pandemic."

Medscape's Physician Burnout & Depression Report 2022 found that 47% of physicians said they felt burnt out in their jobs in 2021, up from 42% in 2020. A March 2021 study published in the Journal of Advanced Nursing found that 34% of nearly 19,000 nurses studied were experiencing emotional exhaustion because of the pandemic.

Cotton says that doctors calling the hotline have expressed shifting emotions and frustrations, including a sense of personal failure and anger at their hospitals, politicians and even themselves "for any number of things — for not setting better boundaries, for neglecting [their] children and living away from them for six months."

Instead of "burnout," some doctors including Cotton, prefer the term "moral injury," referring to instances when a workplace asks employees to oppose their values, such as requiring them to spend an unreasonable amount of time away from their families.

The problem of physicians' stress gained national attention following the suicide of Dr. Lorna M. Breen, who killed herself in April 2020 at her family's Charlottesville home.

The head of emergency medical services for several New York-Presbyterian system campuses in New York City, Breen "was a victim of this guilt that you feel when you can't see more patients, you can't work another hour, you can't go another 10 minutes without eating or using the restroom," Cotton says. "My personal belief is that this moral injury contributed to her ultimate suicide."

Stigma and silence

Health care professionals face a deep-rooted professional stigma against seeking help for — let alone discussing — their mental health struggles.

"There is a culture in medicine of 'It's not about you anymore.' ... There is a shared understanding that as a physician, you will make sacrifices so that your patients get the best treatment possible," Cotton explains, including missing significant family events or otherwise straining personal relationships.

About 20% of physicians reported to Medscape that they worried they would be shunned by colleagues if they sought help for depression, and 43% of physicians said they would not seek help for depression for fear someone would disclose it to the medical board.

State medical license applications often ask whether the applicant has sought treatment for a mental illness. In Virginia, applicants must disclose whether they currently have a mental health condition that affects their abilities to perform the obligations and responsibilities of their professional practice safely and competently.

Consequentially, many Virginia physicians falsely assumed that if they sought help for a mental illness, a therapist or colleague might be legally compelled to report them to the state board, says Clark Barrineau, the Medical Society of Virginia's assistant vice president of government affairs and health policy.

"Rather than seek that help, and particularly put that risk on themselves, they said, 'I just won't,'" Barrineau says.

In September 2021, the Virginia Board of Medicine released a brief meant to dispel that misconception, telling doctors, "Get help if you need it." Practitioners aren't required to self-report.

Wellness focus

Along with increasing pay and benefits — including parental leave — to combat the existing labor shortage, health systems in Virginia have fortified employee assistance and wellness programs.

"We really feel that having the right culture is the best way to retain staff and attract staff," says Toni Ardabell, chief of clinical enterprise operations for Inova Health System.

Bon Secours, Carilion Clinic, Inova and Sentara Healthcare offer emergency assistance funds for employees in need. Virginia Commonwealth University Health offers crisis packages that, depending on an employee's needs, can range from child care assistance to temporary housing.

Sentara placed employee assistance program counselors into its hospitals so that they are accessible to employees and can connect providers to free counseling for stress management, caregiver fatigue and more. Carilion Clinic has also increased its number of EAP counselors.

Pediatric emergency director Dr. Lisa Uherick developed Carilion's "Healthy People Heal People" initiative, implemented in October 2020, which boosts the system's emergency medicine team with supports like wellness workshops and an "adopt a front-line team" program.

Prior to the pandemic, Bon Secours was already offering employee wellness programs, like LifeMatters, a 24/7 program providing resources such as confidential counseling, legal and financial consultations. In May 2021, the system launched Called to Shine, an employee recognition program. Supervisors award employees points that can be redeemed for items varying from T-shirts to NFL game tickets.

"It's really about that teamwork, collaboration and making people feel like we're giving them something different and we're a family," says Cassie Lewis, chief nursing and quality officer for Bon Secours' Hampton Roads market.

Inova employees make rounds with a "thank you cart" with goodies for clinical staff. Both Inova and Bon Secours offer quiet spaces for employees to take breaks, and several health systems now have mobile apps to help employees build resiliency to stress. At VCU Health, therapy dogs sometimes pay a visit.

Peer support

Aside from apps and formal programs, peer support has also become important at Virginia health systems.

In May 2020, Bon Secours started Caring for Colleagues, a confidential peer support group for physicians and advanced practice clinicians that allows a participant to call or text a volunteer. Carilion's Healthy People Heal People program includes peer support groups, and VCU Health expanded its Stress First Aid training systemwide in February 2021.

UVA Health combined existing trainings in 2017 to form its Wisdom & Wellbeing program, which teaches resiliency skills, works to reduce unnecessary work stressors and provides Stress First Aid training.

"We can't just say, 'Suck it up and go back to work' anymore," says Scott Austin, nurse manager of the UVA Health COVID-19 unit. "We can't just keep saying that to health care workers."

During summer 2020, Austin contacted a Wisdom & Wellbeing co-founder. In addition to ever-changing COVID protocols, his nurses faced significantly increased workloads as other staff stayed out of the unit.

"They went from just being bedside nurses, doing their assessments and giving medications and being there for the patients, to adding in being housekeepers, being dietary folks, being phlebotomists," he says. One technique Austin learned is texting his nurses to gather, pause and talk about their feelings when they're in the "orange" on the system's stress continuum, which ranges from green to red.

During 2020 and 2021, Austin saw more than 10 nurses leave his unit, although not all exited purely in response to COVID-related stressors. As of April, no nurses had left the unit this year, an outcome he attributes to the Wisdom & Wellbeing program.

Grief counseling

In addition to other well-being efforts and programs, some Virginia health systems have added bereavement support for health care workers who have lost loved ones or patients. Bon Secours, a Catholic-affiliated health system, has clergy circulating on "compassion rounds," and UVA Health's chaplaincy is open 24/7. Carilion has chaplains on call who can be paged to arrive within 30 minutes to assist caregivers.

In 2021, Inova hired more behavioral health nurse practitioners for debriefs after units faced difficult issues, like someone bringing a weapon into a hospital.

Health care professionals face vitriol from upset patients. One study published in the American Association of Occupational Health Nursing

Inc.'s journal in August 2021 found that 51.2% of registered nurses surveyed who cared for COVID patients experienced physical violence at least once, and 73% experienced verbal abuse.

Although the pandemic jumpstarted these programs and raised public awareness, the shift in culture among health care professionals has been slow to spark. Health care professionals are reluctant to talk publicly about the mental health help they've received.

"I think it is going to be kind of a generational shift," Barrineau acknowledges. "A lot of those things are built in almost culturally to the medical profession."

Students and residents are part of the change. VCU Health extended benefits such as caregiver leave to its residents during the pandemic, and Inova has had student wellness representatives for several years.

Bon Secours' Simons says she disclosed to her current employer that she takes an antidepressant medication.

"I did it on my own, but I hope that in today's environment, people feel more comfortable reaching out to colleagues or to their hospitals," she says, "because at the end of the day, [there are] good people in health care."

Related Stories

Revised 7/21 MD and DO

Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463
Phone: (804) 367-4600
Fax: (804) 527-4426
Email: medbd@dhp.virginia.gov

Application for a license **To Practice Medicine and Surgery OR Osteopathy and Surgery**

To the Board of Medicine of Virginia: I hereby make application for a license to practice as an (please circle one) MD or a DO in the Commonwealth of Virginia and submit the following statements:

1. Name in Full (Please Print or Type)

Last	First	Middle
Date of Birth _____ _____ _____ MO DAY YEAR	Social Security No. or VA Control No.*	Maiden Name if applicable
Public Address: This address will be public information:	House No. Street or PO Box	City State and Zip
Board Address: This address will be used for Board Correspondence and may be the same or different from the public address.	House No. Street or PO Box	City State and Zip
Work Phone Number	Home/Cell Phone Number	Email Address
Professional School Name and Location	Professional School Graduation Date	Professional School Degree

Please submit address changes in writing immediately to medbd@dhp.virginia.gov

Please attach check or money order payable to the Treasurer of Virginia for $302.00. Applications will not be processed without the fee. Do not submit fee without an application. **IT WILL BE RETURNED.**

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

APPROVED BY: ____

Date

LICENSE NUMBER	PROCESSING NUMBER	FEE
MD- 0101-		**$302.00**
DO – 0102-		**$302.00**

*In accordance with §54.1-116 Code of Virginia, you are required to submit your Social Security Number or your control number** issued by the *Virginia* Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires that this number be shared with other state agencies for child support enforcement activities. NO LICENSE WILL BE ISSUED TO ANY INDIVIDUAL WHO HAS FAILED TO DISCLOSE ONE OF THESE NUMBERS.

**In order to obtain a Virginia driver's license control number, it is necessary to appear in person at an office of the Department of Motor Vehicles in Virginia. A fee and disclosure to DMV of your Social Security Number will be required to obtain this number.

2. List in chronological order all professional practices including each location of service since graduation, including internships, residencies, hospital affiliations and absences from work. Also list all periods of non-professional activity or employment. **PLEASE ACCOUNT FOR ALL TIME.** If engaged in private practice, list all clinical affiliations.

From	To	Name and Address of Location Where Service was Provided	Position Held

3. Do you intend to engage in the active practice of medicine in the Commonwealth of Virginia? ☐ Yes ☐ No

   If Yes, give location ______________________________

4. List all jurisdictions in which you have been issued a license to practice medicine: include all active, inactive, expired, suspended or revoked licenses. Indicate number and date issued.

Jurisdiction	Number Issued	Active/Inactive/Expired

5. Which of the following have you taken: ☐National Board Examination ☐USMLE 1 ☐USMLE 2 ☐USMLE 3 ☐FLEX ☐LMCC ☐ State Equivalency ☐ COMLEX

QUESTIONS MUST BE ANSWERED. If any of the following questions (6-18) is answered **Yes**, explain and Substantiate with documentation.

		Yes	No
6.	Have you ever been denied a license or the privilege of taking a licensure/competency examination by any testing entity or licensing authority?	☐	☐
7.	Have you ever been convicted of a violation of/or pled Nolo Contendere to any federal, state, or local statute, or regulation or ordinance, or entered into an plea bargaining relating to a felony or misdemeanor? (Excluding traffic violations, except convictions for driving under the influence.) **Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, does not have to be disclosed.**	☐	☐
8.	Have you ever been denied privileges or voluntarily surrendered your clinical privileges for any reason?	☐	☐
9.	Have you ever been placed on a corrective action plan, placed on probation or been dismissed or suspended or requested to withdraw from any professional school, training program, hospital, etc?	☐	☐
10.	Have you ever been terminated from employment or resigned in lieu of termination from any training program, hospital, healthcare facility, healthcare provider, provider network or malpractice insurance carrier?	☐	☐
11.	Do you have any pending disciplinary actions against your professional license/certification/permit/registration related to your practice of medicine?	☐	☐
12.	Have you voluntarily withdrawn from any professional society while under investigation?	☐	☐
13.	Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner?	☐	☐
14.	Within the past five years, have you been disciplined by any entity?	☐	☐
15.	Do you currently have any physical 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.	☐	☐
16.	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.	☐	☐
17.	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.	☐	☐

		Yes	No
18.	Within the past five years, have you any condition or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity?	☐	☐
19.	Have you requested a certification report from ECFMG?	☐	☐
20.	Have you requested a current report (Self Query) from NPDB?	☐	☐

21.	Have you had any malpractice paid claims in the past ten (10) years, or do you have any pending malpractice suits? If so, please provide a narrative for each paid claim or pending case during this time period.	☐	☐

22.	Are you a spouse of someone who is on a federal active duty orders pursuant to Title 10 of the U.S. Code or of a veteran who has left active-duty service within one year of submission of this application and who is accompanying your spouse to Virginia or an adjoining state of the District of Columbia?	☐	☐
23.	Are you active duty military?	☐	☐

24. AFFIDAVIT OF APPLICANT

I, ____, am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospitals, institutions, or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Virginia Board of Medicine any information, files or records requested by the Board in connection with the processing of individuals and groups listed above, any information which is material to me and my application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension, or revocation of my license to practice medicine and surgery or osteopathic surgery in the Commonwealth of Virginia.

I have carefully read the laws and regulations related to the practice of my profession which are available at www.dhp.virginia.gov and **I understand that fees submitted as part of the application process shall not be refunded.**

______________________________ Signature of Applicant

______________________________ Date

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: **Approval of the 2023 Meeting Calendar**

Staff Note: For your review.

Action: Motion to accept or recommend alternate dates.

Virginia Board of Medicine

PROPOSED - 2023 Board Meeting Dates

February 23-25	DHP/Richmond, VA	BR Rooms TBA
		BR Rooms TBA
		BR Rooms TBA
June 22-24	DHP/Richmond, VA	BR Rooms TBA
		BR Rooms TBA
		BR Rooms TBA
October 19-21	DHP/Richmond, VA	BR Rooms TBA
		BR Rooms TBA

Times for the above meetings are 8:30 a.m. to 5:00 p.m.

April 7	DHP/Richmond, VA	BR Rooms - 4/TR2
August 4	DHP/Richmond, VA	BR Rooms - 4/TR2
December 1	DHP/Richmond, VA	BR Rooms - 4/TR2

Times for the above meetings are 8:30 a.m. to 5:00 p.m.

January 13	DHP/Richmond, VA	BR Rooms - 4/TR 2
May 5	DHP/Richmond, VA	BR Rooms - 4/TR 2
September 1	DHP/Richmond, VA	BR Rooms - 4/TR 2

Times for the above meetings are 8:30 a.m. to 1:00 p.m.

January - TBA	May - TBA	September - TBA
February - TBA	June - TBA	October - TBA
March - TBA	July - TBA	November - TBA
April - TBA	August - TBA	December - TBA

Times for the Credentials Committee meetings - TBA

February 22	April 26	June 14	October 25	December 13

Advisory Board on:

Mon –February 6	June 12	October 2
Mon - February 6	June 12	October 2
Tues – February 7	June 13	October 3
Tues - February 7	June 13	October 3
Wed - February 8	June 14	October 4
Wed - February 8	June 14	October 4
Thurs - February 9	June 15	October 5
Thurs - February 9	June 15	October 5
Fri - February 10	June 16	October 6
Fri - February 10	June 16	October 6
Mon - February 13	June 19	October 10

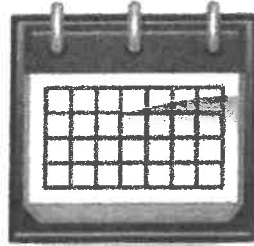
Agenda Item: **Report of the Nominating Committee**

Staff Note: The Committee met at 7:45 a.m. to develop a slate of officers for next year.

Action: Approve the slate as presented or develop an alternate slate.

Next Meeting Date of the Full Board is

October 6th – 8th



Please check your calendars and advise staff of any known conflicts that may affect your attendance.

The travel regulations require that "travelers must submit the Travel Expense Reimbursement Voucher **within 30 days after completion of their trip**". (CAPP Topic 20335, State Travel Regulations, p.7). If you submit your reimbursement after the 30 day deadline, please provide a justification for the late submission and be aware that it may not be approved.

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