Meeting of the Virginia Board of Medicine

June 24, 2021
8:30 a.m.

Virginia Department of
Health Professions

Board of Medicine

Thursday, June 24, 2021 @ 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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Approval of Minutes from October 22, 2020 2

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Public Comment on Agenda Items

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- Vice-President
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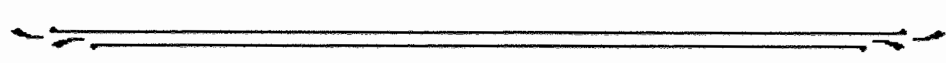

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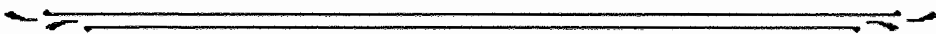

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====No motion needed to adjourn if all business has been conducted====

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

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

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

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

Board Room 2

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

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

You may also exit the room using the side door (**Point**), turn **Right** out the door and make an immediate **Left**. Follow the corridor to the emergency exit at the end of the hall.

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

---DRAFT UNAPPROVED---

VIRGINIA BOARD OF MEDICINE
FULL BOARD MINUTES

October 22, 2020	**Department of Health Professions**	**Henrico, VA 23233**

CALL TO ORDER: Dr. Tuck called the meeting to order at 8:35 a.m.

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

MEMBERS PRESENT:
Lori Conklin, MD, President
L. Blanton Marchese, Vice-President
David Archer, MD, Secretary-Treasurer
James Arnold, DPM
Amanda Barner, MD
Manjit Dhillon, MD
Alvin Edwards, MDiv, PhD
Jane Hickey, JD
Jacob Miller, DO
Milly Rambhia, MD
Karen Ransone, MD
Brenda Stokes, MD
Ray Tuck, DC
Kenneth Walker, MD
Ryan Williams, MD

MEMBERS ABSENT:
Joel Silverman, MD
Martha Wingfield

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

OTHERS PRESENT:
W. Scott Johnson, JD – Medical Society of Virginia
Ben Traynham, JD – Medical Society of Virginia

EMERGENCY EGRESS

Dr. Conklin provided the emergency egress procedures for Board Room 2.

INTRODUCTION OF NEW BOARD MEMBERS AND STAFF

For the benefit of the new members, Dr. Tuck asked all Board members and staff to introduce themselves. Dr. Harp provided very brief bios for Ms. Wingfield and Dr. Silverman.

APPROVAL OF THE FEBRUARY 20, 2020 MINUTES

Dr. Edwards moved to approve the February 20, 2020 minutes as presented. The motion was properly seconded and carried unanimously.

ADOPTION OF THE AGENDA

Ms. Yeatts requested an amendment to the agenda to include consideration of a NOIRA for the surgical assistant/surgical technologist regulations. Dr. Edwards moved to accept the agenda as amended. The motion was properly seconded and carried unanimously.

PUBLIC COMMENT

Scott Johnson, JD, representing the Medical Society of Virginia, addressed the members and provided a summary of the successful launch of MSV's SafeHaven™ program. Mr. Johnson stressed that the program is a resource for physicians and physician assistants seeking professional support to address burnout, career fatigue, and mental health issues without fear of repercussion to their license.

NOMINATING COMMITTEE REPORT

Dr. Walker, Chair of the Nominating Committee, presented the recommended slate of officers for 2020-2021: President-Lori Conklin; Vice-President-Blanton Marchese; Secretary/Treasurer-David Archer. No nominations arose from the floor. The vote to approve the slate of officers was unanimous. Dr. Tuck ceremoniously passed the gavel to Dr. Conklin who graciously accepted it and all responsibilities of the Presidency.

DHP DIRECTOR'S REPORT- Barbara Allison-Bryan, MD, DHP Chief Deputy

Dr. Allison-Bryan provided the members with an overview of the DHP's approach to the pandemic, the status of activities relative to cannabis oils, and the Commonwealth's plan for COVID-19 vaccines. She also acknowledged the installation of Sterling Ransone, MD as President-Elect of the American Academy of Family Medicine and extended her congratulations to the "First Lady of Family Practice", Karen Ransone, MD.

REPORTS OF OFFICERS AND EXECUTIVE DIRECTOR

PRESIDENT

Dr. Tuck commended Board staff on its work under these unusual circumstances.

---DRAFT UNAPPROVED---

VICE-PRESIDENT'S REPORT

Dr. Conklin expressed thanks to her colleagues for the opportunity to serve as President of the Board.

SECRETARY-TREASURER'S REPORT

Mr. Marchese had no report.

EXECUTIVE DIRECTOR'S REPORT

Dr. Harp provided an update on:

1- Board Cash Balance as of August 31 – Dr. Harp commented that for the last 3 biennia, there have been reductions in renewal fees by approximately 20% in order to bring the Board into compliance with the law governing its cash reserves.
2- Electronic Advisory Board Meetings – 10 virtual meetings were held the week of October 5-9. The Advisory Board on Midwifery asked that its wish to continue with the virtual format in the future be expressed to Dr. Brown
3- Reciprocal Licensing Agreements – SB757 and HB1701 required the Board to assess the possibilities of reciprocal licensing agreements with Virginia's contiguous states. At this time, only Maryland and the District of Columbia are amenable to a reciprocal licensing agreement. The information and options will be presented to the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions by November 1.
4- HB42 Article on Depression in Women – the 2020 General Assembly session tasked the Board with disseminating annually communication to every practitioner who provides primary, maternity, obstetrical or gynecological health care services reiterating the standard of care pertaining to prenatal or postnatal depression or other depression in women. This article will be included in the next edition of the Board Briefs.
5- Waiver requests for Opioid Prescribing – 4 communications to licensees have been sent out since December 2019. To date, the Board has received over 2,000 requests, most of which have been granted.
6- Ad Hoc on Opioid Continuing Education – in 2018, the Ad Hoc Committee approved a packet to satisfy the mandatory 2-hour requirement of CE for opioids. Since notification to the licensees is required to be sent out by January 1 of the odd years, an ad hoc committee will need to be established for a virtual meeting. Those interested in serving should contact Dr. Conklin or Dr. Harp.
7- FSMB John H. Clark, MD Leadership Award – with the Board's approval, Dr. Harp will be nominating Kevin O'Connor, MD for this award for his efforts with the spearheading of the telemedicine guidance document, the opioid regulations, his work with the Joint Boards of Nursing and Medicine, and his commitment to the Board's licensing and discipline processes.
8- Annual Report to MSV and VCA – a report providing a snapshot of the Board's licensing, discipline, legislative, and workgroup activity over the last year was provided to both MSV and VCA.
9- American Oncology Network Response – Dr. Harp reviewed his response to Ms. Freeman who requested clarification in regards to the practice "physician compounding of sterile drug products

without a pharmacist present in the office." Additionally, he announced that revision to USP Chapter 797 has been postponed until further notice. An ad hoc committee to discuss USP Chapter 800 may need to be scheduled.

10- Council on State Governments Response – Dr. Harp noted this email demonstrates the types of organizations that the Board converses with regularly. The Council on State Governments wanted to know what steps the Board had taken during COVID-19, how they were helpful, and if any will be continued post-COVID.

11- Federation of State Medical Boards (FSMB) – Virginia's Board Data Survey was provided to the Board members for informational purposes only.

12- Board Member and Board Staff participation in Interagency Projects – Dr. Harp gave a quick run-down of the projects:

- Jennifer Deschenes, JD – worked with the Board of Pharmacy to revise Chapters 33 and 34 to make them more user-friendly and handled several high-profile discipline cases
- Michael Sobowale, LLM – worked with the VCU Performance Management and prepared for and implemented 10 virtual Advisory Board meetings
- Colanthia Opher – Opioid Waiver Notifications, staff training for electronic meetings, and managing the Licensure by Endorsement process
- Karen Ransone, MD – worked with the behavioral boards on mental health for children
- Jacob Miller, DO and Brenda Stokes, MD – worked with the Board of Pharmacy on the HB1506 protocols for dispensing and treatment by pharmacists
- Board staff served on and interacted with some of the VDH State Telehealth Plan subgroups - remote patient monitoring, criteria for use, and delivery
- Drs. Tuck, Ransone and Walker for their work on the Committee of the Joint Boards of Nursing and Medicine
- Board staff coordination with the Supreme Court to update the certification form for cannabis oils and the list of professionals for malpractice panels

COMMITTEE and ADVISORY BOARD REPORTS

Dr. Tuck moved to accept all the minutes en bloc. The motion was properly seconded and carried unanimously.

OTHER REPORTS

Board Counsel

For the new Board members, Erin Barrett, AAG briefly explained her role at the Board and generally how discipline cases are handled. She also addressed the steps taken when a Board member is named in a lawsuit. She then provided an update on the status of several ongoing court cases.

Ms. Deschenes reminded the members how advantageous it is to have Board Counsel in closed sessions. Following AG advice, looking at the evidence, and reaching a solid decision strengthens the Board's position if a case is appealed to a state or federal court.

Board of Health Professions (BHP)

Ms. Yeatts explained the functions of the BHP, one of which is the study of new professions. She stated that the 2020 General Assembly did not pass bills concerning the licensure of diagnostic ultrasonographers and naturopaths. However, the bills were carried over to the 2021 Session with the proviso that BHP would study the professions as to whether they met the criteria for licensure. The Board recommended against licensure for ultrasonographers and naturopaths. Ms. Yeatts noted that there was no discussion about the anesthesia assistant profession.

This report was for informational purposes only.

Podiatry Report

Dr. Arnold advised that the national podiatric meeting was canceled, but anticipates that smaller meetings may be scheduled.

Chiropractic Report

Dr. Tuck advised that NBCE held their annual meeting virtually.

Committee of the Joint Boards of Nursing and Medicine

This report was for informational purposes only.

Break

Dr. Conklin called for a recess at 10:11 a.m.; the meeting reconvened at 10:29 a.m.

New Business:

1) Regulatory and Legislative Issues

- **Chart of Regulatory Actions**

Ms. Yeatts provided an update on the status of regulatory actions as of October 15, 2020. She extended her thanks to Dr. Miller and Dr. Stokes for a job well done representing the Board of Medicine with their work on the HB1506 protocols. This report was for informational purposes only and did not require action.

- **Report from the 2020 General Assembly**

Ms. Yeatts reviewed legislation from the 2020 Session of the General Assembly. She reviewed the bills that directly affect the Board of Medicine and fielded questions from Board members.

- **Regulatory Action – Proposed rules for Prohibition on the Practice of Conversion Therapy**

Ms. Yeatts reviewed the NOIRA's and the supporting documentation. She noted that there was no comment received for either the Nurse Practitioner NOIRA or the Medicine NOIRA.

MOTION: Dr. Ransone moved that the Board adopt the proposed amendments to 18VAC90-30 (Nurse Practitioners) as presented. The motion was properly seconded and passed unanimously.

MOTION: Dr. Miller moved that the Board adopt the proposed amendments to 18VAC85-20 (Medicine) as presented. The motion was properly seconded and passed unanimously.

- **Petition for Rulemaking – Virginia Society of Radiologic Technologists (VSRT)**

Ms. Yeatts informed the Board that VSRT is requesting an amendment to the renewal, reinstatement or reactivation requirements in the regulations for a licensee to hold current ARRT and/or NMTCB credentials in good standing for biennial renewal, reinstatement, or reactivation of a license. She advised that the Advisory Board on Radiologic Technology recommended no action be taken now to allow time for information-gathering and additional study. Ms. Yeatts noted that this petition had been previously presented to the Executive Committee.

MOTION: After a brief discussion, Dr. Edwards moved to accept the recommendation of the Advisory Board to take no action at this time. The motion was properly seconded and carried unanimously.

- **Recommendation on Adoption of a NOIRA for Surgical Assistant/Surgical Technologist regulations**

Ms. Yeatts advised that the Advisory Board on Surgical Assistants met on October 16, 2020 and approved adoption of a NOIRA and identified the proposed amendments to the regulations for licensure of surgical assistants and registration of surgical technologists.

MOTION: After a brief discussion, Dr. Miller moved to adopt the NOIRA as recommended by the Advisory Board. The motion was properly seconded and carried unanimously.

2. Licensing Report - Michael Sobowale

Michael Sobowale provided an update on the licensing trends for the last 2 fiscal years. The Board requested that a breakdown of licenses issued to telehealth practitioners be available at its next meeting.

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

3. Discipline Report – Jennifer Deschenes

Ms. Deschenes provided a quick overview of cases currently open by stage as of October 2, 2020.

4. Proposed 2021 Board Meeting Dates

The proposed dates for 2021 were approved en bloc. Staff was asked to check on alternate dates for the April 9, 2021 Executive Committee meeting.

5. Adjournment

With no other business to discuss, the meeting adjourned at approximately 11:05 a.m.

Lori Conklin, MD President, Chair	William L. Harp, MD Executive Director
Colanthia Morton Opher Recording Secretary	

		102- Medicine
Board Cash Balance as June 30, 2020	$	9,298,608
YTD FY21 Revenue		7,393,056
Less: YTD FY21 Direct and Allocated Expenditures		7,355,870
Board Cash Balance as April 30, 2021	$	9,335,795

Virginia Department of Health Professions
Revenue and Expenditures Summary
Department 10200 - Medicine
For the Period Beginning July 1, 2020 and Ending April 30, 2021

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
4002400	Fee Revenue				
4002401	Application Fee	1,345,337.00	1,414,774.00	69,437.00	95.09%
4002402	Examination Fee	3,047.00	-	(3,047.00)	0.00%
4002406	License & Renewal Fee	6,021,750.00	6,273,362.00	251,612.00	95.99%
4002407	Dup. License Certificate Fee	6,850.00	3,375.00	(3,475.00)	202.96%
4002409	Board Endorsement - Out	660.00	49,820.00	49,160.00	1.32%
4002421	Monetary Penalty & Late Fees	14,485.00	94,179.00	79,694.00	15.38%
4002432	Misc. Fee (Bad Check Fee)	235.00	175.00	(60.00)	134.29%
	Total Fee Revenue	7,392,364.00	7,835,685.00	443,321.00	94.34%
4003000	Sales of Prop. & Commodities				
4003002	Overpayments	250.00	-	(250.00)	0.00%
4003020	Misc. Sales-Dishonored Payments	442.00	-	(442.00)	0.00%
	Total Sales of Prop. & Commodities	692.00	-	(692.00)	0.00%
	Total Revenue	7,393,056.00	7,835,685.00	442,629.00	94.35%
5011110	Employer Retirement Contrib.	159,558.41	189,919.65	30,361.24	84.01%
5011120	Fed Old-Age Ins- Sal St Emp	78,992.90	93,721.45	14,728.55	84.28%
5011140	Group Insurance	15,200.10	17,599.75	2,399.65	86.37%
5011150	Medical/Hospitalization Ins.	173,436.53	222,548.88	49,112.35	77.93%
5011160	Retiree Medical/Hospitalizatn	12,745.86	14,710.24	1,964.38	86.65%
5011170	Long term Disability Ins	6,234.24	8,011.82	1,777.58	77.81%
	Total Employee Benefits	446,168.04	546,511.79	100,343.75	81.64%
5011200	Salaries				
5011230	Salaries, Classified	1,107,362.61	1,313,413.93	206,051.32	84.31%
5011250	Salaries, Overtime	6,339.19	-	(6,339.19)	0.00%
	Total Salaries	1,113,701.80	1,313,413.93	199,712.13	84.79%
5011300	Special Payments				
5011340	Specified Per Diem Payment	5,000.00	-	(5,000.00)	0.00%
5011380	Deferred Compnstn Match Pmts	4,695.40	8,817.60	4,122.20	53.25%
	Total Special Payments	9,695.40	8,817.60	(877.80)	109.96%
5011400	Wages				
5011410	Wages, General	48,780.34	102,000.00	53,219.66	47.82%
	Total Wages	48,780.34	102,000.00	53,219.66	47.82%
5011530	Short-trm Disability Benefits	28,432.51	-	(28,432.51)	0.00%
	Total Disability Benefits	28,432.51	-	(28,432.51)	0.00%
5011600	Terminatn Personal Svce Costs				
5011620	Salaries, Annual Leave Balanc	3,570.20	-	(3,570.20)	0.00%
5011630	Salaries, Sick Leave Balances	146.82	-	(146.82)	0.00%
5011640	Salaries, Cmp Leave Balances	163.52	-	(163.52)	0.00%
5011660	Defined Contribution Match - Hy	4,133.61	-	(4,133.61)	0.00%
	Total Terminatn Personal Svce Costs	8,014.15	-	(8,014.15)	0.00%
5011930	Turnover/Vacancy Benefits		-	-	0.00%
	Total Personal Services	1,654,792.24	1,970,743.32	315,951.08	83.97%

Virginia Department of Health Professions
Revenue and Expenditures Summary
Department 10200 - Medicine
For the Period Beginning July 1, 2020 and Ending April 30, 2021

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
5012000	Contractual Svs				
5012100	Communication Services				
5012110	Express Services	-	5,997.00	5,997.00	0.00%
5012120	Outbound Freight Services	4,084.95	-	(4,084.95)	0.00%
5012140	Postal Services	65,661.00	66,802.00	1,141.00	98.29%
5012150	Printing Services	49.51	3,026.00	2,976.49	1.64%
5012160	Telecommunications Svcs (VITA)	8,704.14	10,500.00	1,795.86	82.90%
5012170	Telecomm. Svcs (Non-State)	945.00	-	(945.00)	0.00%
5012190	Inbound Freight Services	112.22	35.00	(77.22)	320.63%
	Total Communication Services	79,556.82	86,360.00	6,803.18	92.12%
5012200	Employee Development Services				
5012210	Organization Memberships	6,829.00	7,228.00	399.00	94.48%
5012240	Employee Trainng/Workshop/Conf	1,784.00	4,283.00	2,499.00	41.65%
	Total Employee Development Services	8,613.00	11,511.00	2,898.00	74.82%
5012300	Health Services				
5012360	X-ray and Laboratory Services	-	2,298.00	2,298.00	0.00%
	Total Health Services	-	2,298.00	2,298.00	0.00%
5012400	Mgmnt and Informational Svcs	-			
5012420	Fiscal Services	125,232.67	119,963.00	(5,269.67)	104.39%
5012430	Attorney Services	2,872.50	-	(2,872.50)	0.00%
5012440	Management Services	1,085.38	1,797.00	711.62	60.40%
5012460	Public Infrmtnl & Relatn Svcs	14.00	-	(14.00)	0.00%
5012470	Legal Services	2,735.10	5,579.00	2,843.90	49.02%
	Total Mgmnt and Informational Svcs	131,939.65	127,339.00	(4,600.65)	103.61%
5012500	Repair and Maintenance Svcs				
5012510	Custodial Services	2,735.58	-	(2,735.58)	0.00%
5012530	Equipment Repair & Maint Srvc	11,571.95	1,705.00	(9,866.95)	678.71%
	Total Repair and Maintenance Svcs	14,307.53	1,705.00	(12,602.53)	839.15%
5012600	Support Services				
5012630	Clerical Services	78,333.54	160,729.00	82,395.46	48.74%
5012640	Food & Dietary Services	4,487.01	12,698.00	8,210.99	35.34%
5012660	Manual Labor Services	15,063.05	24,912.00	9,848.95	60.47%
5012670	Production Services	90,495.50	153,625.00	63,129.50	58.91%
5012680	Skilled Services	334,430.55	531,779.00	197,348.45	62.89%
	Total Support Services	522,809.65	883,743.00	360,933.35	59.16%
5012800	Transportation Services				
5012820	Travel, Personal Vehicle	8,416.24	25,626.00	17,209.76	32.84%
5012830	Travel, Public Carriers	439.49	4,170.00	3,730.51	10.54%
5012850	Travel, Subsistence & Lodging	4,695.33	21,524.00	16,828.67	21.81%
5012880	Trvl, Meal Reimb- Not Rprtble	2,629.50	7,407.00	4,777.50	35.50%
	Total Transportation Services	16,180.56	58,727.00	42,546.44	27.55%
	Total Contractual Svs	773,407.21	1,171,683.00	398,275.79	66.01%
5013000	Supplies And Materials				

Virginia Department of Health Professions
Revenue and Expenditures Summary
Department 10200 - Medicine
For the Period Beginning July 1, 2020 and Ending April 30, 2021

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
5013100	Administrative Supplies				
5013110	Apparel Supplies	113.32	-	(113.32)	0.00%
5013120	Office Supplies	18,153.48	14,609.00	(3,544.48)	124.26%
5013130	Stationery and Forms	-	3,614.00	3,614.00	0.00%
	Total Administrative Supplies	18,266.80	18,223.00	(43.80)	100.24%
5013300	Manufctrng and Merch Supplies				
5013350	Packaging & Shipping Supplies	-	94.00	94.00	0.00%
	Total Manufctrng and Merch Supplies	-	94.00	94.00	0.00%
5013400	Medical and Laboratory Supp.				
5013420	Medical and Dental Supplies	16.26	-	(16.26)	0.00%
	Total Medical and Laboratory Supp.	16.26	-	(16.26)	0.00%
5013500	Repair and Maint. Supplies				
5013510	Building Repair & Maint Materl	42.85	-	(42.85)	0.00%
5013520	Custodial Repair & Maint Matrl	5.91	-	(5.91)	0.00%
	Total Repair and Maint. Supplies	48.76	-	(48.76)	0.00%
5013600	Residential Supplies				
5013620	Food and Dietary Supplies	-	528.00	528.00	0.00%
5013630	Food Service Supplies	-	1,129.00	1,129.00	0.00%
	Total Residential Supplies	-	1,657.00	1,657.00	0.00%
5013700	Specific Use Supplies				
5013730	Computer Operating Supplies	142.58	166.00	23.42	85.89%
	Total Specific Use Supplies	142.58	166.00	23.42	85.89%
	Total Supplies And Materials	18,474.40	20,140.00	1,665.60	91.73%
5015000	Continuous Charges				
5015100	Insurance-Fixed Assets				
5015160	Property Insurance	-	485.00	485.00	0.00%
	Total Insurance-Fixed Assets	-	485.00	485.00	0.00%
5015300	Operating Lease Payments				
5015340	Equipment Rentals	5,943.06	7,200.00	1,256.94	82.54%
5015350	Building Rentals	641.60	-	(641.60)	0.00%
5015360	Land Rentals	-	100.00	100.00	0.00%
5015390	Building Rentals - Non State	125,613.50	144,636.00	19,022.50	86.85%
	Total Operating Lease Payments	132,198.16	151,936.00	19,737.84	87.01%
5015500	Insurance-Operations				
5015510	General Liability Insurance	-	1,828.00	1,828.00	0.00%
5015540	Surety Bonds	-	108.00	108.00	0.00%
	Total Insurance-Operations	-	1,936.00	1,936.00	0.00%
	Total Continuous Charges	132,198.16	154,357.00	22,158.84	85.64%
5022000	Equipment				
5022100	Computer Hrdware & Sftware				
5022170	Other Computer Equipment	11,598.07	-	(11,598.07)	0.00%
5022190	Development Tools Purchases	15.00	-	(15.00)	0.00%

Virginia Department of Health Professions
Revenue and Expenditures Summary
Department 10200 - Medicine
For the Period Beginning July 1, 2020 and Ending April 30, 2021

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
	Total Computer Hrdware & Sftware	11,613.07	-	(11,613.07)	0.00%
5022200	Educational & Cultural Equip				
5022240	Reference Equipment	-	829.00	829.00	0.00%
	Total Educational & Cultural Equip	-	829.00	829.00	0.00%
5022600	Office Equipment				
5022610	Office Appurtenances	-	125.00	125.00	0.00%
5022620	Office Furniture	822.45	-	(822.45)	0.00%
5022640	Office Machines	-	1,250.00	1,250.00	0.00%
5022680	Office Equipment Improvements	-	17.00	17.00	0.00%
	Total Office Equipment	822.45	1,392.00	569.55	59.08%
5022700	Specific Use Equipment				
5022740	Non Power Rep & Maint- Equip	9.62	-	(9.62)	0.00%
	Total Specific Use Equipment	9.62	-	(9.62)	0.00%
	Total Equipment	12,445.14	2,221.00	(10,224.14)	560.34%
	Total Expenditures	2,591,317.15	3,319,144.32	727,827.17	78.07%
	Allocated Expenditures				
30100	Data Center	688,396.60	1,126,420.08	438,023.48	61.11%
30200	Human Resources	79,805.46	84,716.17	4,910.71	94.20%
30300	Finance	356,992.98	435,541.60	78,548.62	81.97%
30400	Director's Office	121,904.72	156,493.77	34,589.05	77.90%
30500	Enforcement	2,054,189.51	2,522,862.12	468,672.61	81.42%
30600	Administrative Proceedings	940,794.68	1,278,297.24	337,502.56	73.60%
30700	Impaired Practitioners	28,781.86	48,292.08	19,510.22	59.60%
30800	Attorney General	335,937.87	350,592.62	14,654.75	95.82%
30900	Board of Health Professions	101,167.75	117,795.97	16,628.22	85.88%
31100	Maintenance and Repairs	1,746.68	10,911.33	9,164.65	16.01%
31300	Emp. Recognition Program	671.57	5,693.26	5,021.69	11.80%
31400	Conference Center	6,595.59	1,580.92	(5,014.67)	417.20%
31500	Pgm Devlpmnt & Implmentn	47,567.31	70,163.00	22,595.70	67.80%
	Total Allocated Expenditures	4,764,552.57	6,209,360.17	1,444,807.60	76.73%
	Net Revenue in Excess (Shortfall) of Expenditures	$ 37,186.28	$ (1,692,819.49)	$ (1,730,005.77)	2.20%

COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

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TEL (804) 367- 4400
FAX (804) 527- 4475

June 9, 2021

Ms. Maggie Quinn
Federation of State Medical Boards
2101 L Street NW, Suite 800
Washington, DC 20037

Dear Maggie:

I hope this finds you and yours doing well.

At its May 21st meeting, the Legislative Committee of the Virginia Board of Medicine had the opportunity to review and discuss the draft Physician Assistants Licensure Compact. The Committee's comment is as follows.

1. In the Definitions Section, it would be helpful to further define "current significant investigative information" to help boards understand the threshold for reporting.

2. Regarding Section 4, currently the Virginia Board of Medicine does not require criminal background checks for any of its applicants. The Department of Health Professions does have a Criminal Background Check (CBC) Section that performs checks for the Board of Nursing, in service of the Nursing Compact requirement. Utilizing the existing CBC may facilitate Medicine's adoption of the PA Compact.

3. In Section 6, "joint investigations" would require a statutory change to the Code of Virginia.

4. In Section 7, the Committee noted that fees have not been established, a factor that the Board of Medicine usually likes to know prior to making a decision about joining any effort.

I hope these are helpful to FSMB.

With kindest regards,

Blanton Marchese, Vice-President

William L. Harp, MD, Executive Director

BM/cmo

FSMB ANNOUNCES 2020-2021 AWARD RECIPIENTS

Annual awards recognize distinguished service to medical regulation

WASHINGTON, D.C. (April 30, 2021) The Federation of State Medical Boards (FSMB) has announced the recipients of its annual awards, which were presented during its virtual Annual Meeting on Thursday, April 29. Each year, the awards recognize outstanding leadership and service to the field of medical regulation.

The FSMB cancelled its in-person Annual Meeting in 2020, due to the pandemic, and is holding this year's meeting online. Recipients of both the 2020 awards and the 2021 awards were recognized during this year's meeting. A full recording recognizing each awardee is **available here**.

The John H. Clark, MD Leadership Award

The John H. Clark, MD Leadership Award recognizes outstanding and exemplary leadership, commitment and contribution in advancing the public good at the state medical board level.

The 2021 recipients are:

- **George M. Abraham, MD, MPH**, Massachusetts Board of Registration in Medicine
- **Keith E. Loiselle**, Pennsylvania State Board of Medicine
- **Kevin Paul O'Connor, MD**, Virginia Board of Medicine

Full Board - 2020-2021

David Archer, MD, Secretary-Treasurer
2nd Term Expires June 2024
District: 2 - Norfolk

James Arnold, DPM
1st Term Expires June 2022
Podiatrist – Cross Junction

Amanda Barner, MD
1st Term Expires June 2022
District: 11 – Dumfries

Lori D. Conklin, MD, President
2nd Term Expires June 2021
District: 5 – Charlottesville

Manjit Dhillon, MD
2nd Term Expires June 2024
District: 4 - Chester

Alvin Edwards, PhD
2nd Term Expires June 2023
Citizen Member - Charlottesville

Madge Ellis, MD
1st Term Expires June 2024
District: 9 - Salem

Jane Hickey, JD
2nd Term Expires June 2023
Citizen Member – Richmond

L. Blanton Marchese, Vice-President
Unexpired Term Expires 2021
Citizen Member – N. Chesterfield

Jacob W. Miller, DO
1st Term Expires June 2024
Osteopath – Virginia Beach

Milly Rambhia, MD
1st Term Expires June 2022
District: 8 – Falls Church

Karen Ransone, MD
1st Term Expires June 2024
District 1 – Cobbs Creek

Joel Silverman, MD
1st Term Expires June 2023
District: 7 - Richmond

Brenda Stokes, MD
1st Term Expires June 2022
District: 6 - Lynchburg

Nathaniel Ray Tuck, Jr., DC
2nd Term Expires June 2021
Chiropractor - Blacksburg

Ryan P. Williams
1st Term Expires June 2023
District: 3 – Suffolk

Martha S. Wingfield
1st Term Expires June 2021
Citizen Member - Ashland

Khalique Zahir, MD
1st Term Expires June 2022
District: 10 – Mclean

VIRGINIA BOARD OF MEDICINE

Committee Appointments

2020-2021

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

LEGISLATIVE COMMITTEE (7)
L. Blanton Marchese, Vice-President, Chair
James Arnold, DPM
Amanda Barner, MD
Lori Conklin, MD, **President**
Joel Silverman, MD
Ray Tuck, Jr., DC
Ryan Williams, MD

CREDENTIALS COMMITTEE (9)
Jacob Miller, DO, Chair
Manjit Dhillon, MD
Madge Ellis, MD
Jane Hickey, JD
L. Blanton Marchese, **Vice-President**
Milly Rambhia, MD
Brenda Stokes, MD
Martha Wingfield
Khalique Zahir, MD

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

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

CHIROPRACTIC COMMITTEE
Ray Tuck, Jr., DC

BOARD OF HEALTH PROFESSIONS
Brenda Stokes, MD

COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
David Archer, MD, **Secretary/Treasurer**
Lori Conklin, MD, **President**
Karen Ransone, MD

---DRAFT UNAPPROVED---

VIRGINIA BOARD OF MEDICINE MINUTES

VIRTUAL - Ad Hoc Committee on Opioid Continuing Education

Tuesday, December 1, 2020 | Department of Health Professions | Henrico, Virginia

CALL TO ORDER: The meeting of the Ad Hoc Committee convened at 12:05 p.m.

MEMBERS PRESENT:
Lori Conklin, MD, Chair
James Arnold, DPM
Robin Hills, DNP
Portia Tomlinson, PA-C
Kenneth Walker, MD
Khalique Zahir, MD

MEMBERS ABSENT: None

STAFF PRESENT:
William L. Harp, MD, Executive Director
Colanthia M. Opher, Deputy Executive Director of Administration

OTHERS PRESENT:
Barbara Allison-Bryan, MD, DHP Deputy Director
Valentina Vega, Policy Analyst, MSV

SUMMARY OF MEETING:

Dr. Conklin called the meeting to order. The roll was called, and a quorum was declared. Dr. Harp provided the Emergency Egress Instructions for those in the building.

Dr. Walker moved to approve the minutes of November 27, 2018 as presented. The motion was seconded and carried unanimously.

Ms. Hills moved to adopt the agenda as presented. The motion was seconded and carried unanimously.

There was no public comment.

The members reviewed the requirement of Code Section 54.1-2912.1 which authorizes the Board of Medicine to require 2 hours of continuing education on controlled substances each biennium.

The Committee briefly discussed the trends noted in communications with Board staff and the Prescription Monitoring Program. Staff commented that it appears that the required CE has had a positive impact on prescriber decision-making and prescriber behavior. Staff supported the continuation of the requirement for all licensees with prescriptive authority.

---DRAFT UNAPPROVED---

After discussion of the Ad Hoc Committee's history since 2016 and the 2022 sunset date of this requirement, the Committee unanimously agreed to recommend to the Executive Committee an updated list of mostly free, online CE resources for the 2021-2022 biennium.

The updated package would include:

- Boston University Scope of Pain Course
- New England Journal of Medicine Knowledge+ Course
- CDC Interactive Training Series for Healthcare Providers
- Stanford University BRAVO Course on How to Taper Opioids
- SAMHSA SBIRT – Screening, Brief Intervention, and Referral to Treatment
- UpToDate – "Prescription of Opioids for Acute Pain in Opioid-Naïve Patients"
- National Academy of Science – "Association between medical cannabis laws and opioid overdose mortality has reversed over time"

The Committee also agreed that, in addition to the above suggestions, licensees should have the option of selecting activities they deem valuable to their day-to-day practice. Dr. Harp identified the two items to be formalized as 1) who is required to get the CE, and 2) what CE are they required to get. He reiterated that Board staff recommends that the requirement be for all licensees with prescribing authority under Medicine's jurisdiction.

MOTION: Dr. Walker moved that all prescribers licensed under the Board of Medicine, whether or not they hold a DEA, be required to obtain the 2 hours of CE for the biennium. The motion was seconded and carried unanimously.

MOTION: Dr. Walker moved that the list of courses be suggestions for licensees, but not require licensees to use them. Additionally, that this information be included in the notification to the licensee and posted on the Board's website. The motion was seconded and carried unanimously.

Next Steps: Dr. Walker asked if the suggested list would include reading the Board of Medicine Regulations Governing Prescribing Opioids and Buprenorphine. Dr. Harp stated that the Board could continue to point the licensees to reading the regulations, the FAQs and viewing the 7 min. NarxCare video.

With no further business to discuss, the meeting was adjourned at 12:53 p.m.

____
Lori Conklin, MD, Chair

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

____
Colanthia M. Opher, Recording Secretary

---FINAL APPROVED---

VIRGINIA BOARD OF MEDICINE
EXECUTIVE COMMITTEE MINUTES – VIRTUAL MEETING

Friday, December 4, 2020 Department of Health Professions Henrico, VA

CALL TO ORDER: Dr. Conklin called the virtual 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:
Lori Conklin, MD - President
Blanton Marchese – Vice-President
David Archer, MD - Secretary-Treasurer
Alvin Edwards, MDiv, PhD
Jane Hickey, JD
Karen Ransone, MD
Joel Silverman, MD
Brenda Stokes, MD

MEMBERS ABSENT: None

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

OTHERS PRESENT:
W. Scott Johnson, JD – Medical Society of Virginia
Jerry Canaan, JD
Jennie Wood – Board of Medicine staff
Jerry Gentile
Richard Grossman
Ben Traynham, JD – Hancock Daniel

EMERGENCY EGRESS INSTRUCTIONS

Dr. Harp provided the emergency egress instructions for those in the building.

APPROVAL OF MINUTES OF AUGUST 7, 2020

Dr. Edwards moved to approve the meeting minutes from August 7, 2020 as presented. The motion was seconded by Dr. Ransone and carried unanimously.

ADOPTION OF AGENDA

Dr. Conklin advised that item number 2 under new business had been tabled. Dr. Ransone moved to adopt the amended agenda as presented. The motion was seconded by Dr. Edwards and carried unanimously.

PUBLIC COMMENT

There was no public comment.

DHP DIRECTOR'S REPORT

Dr. Allison-Bryan provided an update on the status of marijuana processors and the Governor's recent announcement of his support of legalizing recreational use in adults. She also gave a progress report on the development, approval, availability and distribution of the COVID-19 vaccine.

PRESIDENT'S REPORT

No report.

EXECUTIVE DIRECTOR'S REPORT

Dr. Harp advised Dr. Conklin that Dr. Silverman was able to hear others in the meeting but was unable to unmute for votes. Dr. Harp said he would assist Dr. Silverman by routing his attendance through Dr. Harp's iPhone.

Dr. Harp reported that the Board is in good financial shape. He briefly reviewed the investigative hours reported by the Enforcement and Administrative Proceedings Divisions. He commended Brenda Stokes, MD for her work on the Board of Pharmacy's Workgroups, her steadfast attendance at Credentials Committee hearings and disciplinary hearings, and most recently her appointment by Governor Northam as the Board of Medicine's representative on the Board of Health Professions.

NEW BUSINESS

Chart of Regulatory Actions

The chart was for review only.

Adoption of Final Regulations for Physician Assistants

Ms. Yeatts advised that the proposed amendments are identical to the emergency regulations that became effective on October 1, 2019. There were no comments on the NOIRA or the proposed regulations to replace the emergency regulations.

MOTION: Dr. Edwards moved to adopt the proposed final regulations to replace emergency regulations for the practice of physician assistants with patient care team physicians. The motion was seconded by Dr. Ransone and carried unanimously.

Regulatory Action – Waiver of Requirement for Electronic Prescribing

Ms. Yeatts stated that this action is to replace emergency regulations, which became effective on September 18, 2019, with permanent regulations. She noted that there were two comments received, both in support of the proposed regulations. She also pointed out the one difference between the emergency and proposed final regulations was an added reference to the exemptions from electronic prescribing in the Code.

MOTION: Ms. Hickey moved to adopt the final regulations for waivers as amended. The motion was seconded by Dr. Ransone and carried unanimously.

Guidance Document – Repeal of 85-3 regarding FORM B's

Ms. Yeatts explained that to facilitate and expedite licensure during the COVID pandemic, the Board discontinued the use of the FORM B to collect information about employment performance. The FORM B has been one of the most time-consuming aspects of applying for a license, and the Board is recommending elimination of this requirement on a permanent basis. Therefore, it would be appropriate for the Board to repeal the guidance document which provides instructions on how to fill out a FORM B.

Dr. Harp added that any performance issues important enough to impact licensing should be picked up on the required National Practitioner Data Bank report.

MOTION: Dr. Stokes moved to repeal Guidance Document 85-3 as presented in the agenda packet. The motion was seconded by Mr. Marchese and carried unanimously.

Regulatory Action – Approval for a Notice of Periodic Review

Ms. Yeatts noted that Regulation 18VAC110-40: Regulations Governing Collaborative Practice Agreements, are dually adopted by Pharmacy and Medicine. Following the 4-year review schedule, the Board of Pharmacy is preparing to initiate periodic reviews for all its regulations and will be adopting a Notice of Periodic Review of the Collaborative Practice regulation on December 10th.

MOTION: Dr. Edwards moved to approve a Notice of Periodic Review for Regulation 18VAC110-40: Regulations Governing Collaborative Practice. The motion was seconded by Mr. Marchese and carried unanimously.

Approval of the Recommendation from the Ad Hoc Committee on Opioid CE

Dr. Conklin provided an overview of the meeting of the Ad Hoc Committee on Opioid CE. She reviewed the trends in communications noted by Board staff and the PMP. She said the Ad Hoc recommended that all Board of Medicine licensees with prescribing authority be required

to obtain the 2 hours in the next biennium, and that the CE resources listed be made available. She also stated that the Ad Hoc agreed this requirement should extend past 2022.

Dr. Conklin said that a notification email would be sent by January 1, 2021 to the identified licensees, notifying them of the requirement and providing them with suggested resources recognized as Type 1.

MOTION: Dr. Edwards moved to accept the recommendation from the Ad Hoc Committee on Opioid CE to include the reading of the regulations, reading of the FAQs, and watching the NARX Care modules and to only claim the amount of time spent on each module. Additionally, to authorize Dr. Harp to wordsmith the email notification to licensees and include pertinent resources. The motion was seconded by Dr. Ransone and carried unanimously.

ANNOUNCEMENTS

There were no announcements.

The next meeting of the Executive Committee will be April 9, 2021 @ 8:30 a.m.

ADJOURNMENT

With no additional business, the meeting adjourned at 9:16 a.m.

Lori Conklin, MD
President, Chair

William L. Harp, MD
Executive Director

Colanthia M. Opher
Recording Secretary

--- FINAL APPROVED---

VIRGINIA BOARD OF MEDICINE

LEGISLATIVE COMMITTEE MINUTES – Virtual Meeting

Friday, January 15, 2021 | Department of Health Professions | Henrico, VA

CALL TO ORDER: Mr. Marchese called the meeting of the Legislative Committee to order at 8:38 a.m.

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

MEMBERS PRESENT:
Blanton Marchese, Vice-President, Chair
Lori Conklin, MD, President
James Arnold, DPM
Amanda Barner, MD
Joel Silverman, MD
Ryan Williams, MD

MEMBERS ABSENT: Ray Tuck, DC

STAFF PRESENT:
William L. Harp, MD, Executive Director
Jennifer Deschenes, JD, Deputy Director for Discipline
Colanthia Morton Opher, Deputy Director for Administration
Michael Sobowale, LLM, Deputy Director for Licensing
Barbara Matusiak, MD, Medical Review Coordinator
Elaine Yeatts, DHP Senior Policy Analyst
Erin Barrett, JD, Assistant Attorney General

OTHERS PRESENT:
Scott Castro - MSV
Jerry Canaan, JD
Ben Traynham, JD-MSV

EMERGENCY EGRESS INSTRUCTIONS

Mr. Marchese provided the emergency egress instructions.

APPROVAL OF MINUTES OF JANUARY 31, 2020

Dr. Conklin moved to approve the meeting minutes of January 31, 2020 as presented. The motion was seconded and carried unanimously.

ADOPTION OF AGENDA

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

PUBLIC COMMENT

Scott Castro, Director of Health Policy for the Medical Society of Virginia (MSV), addressed the Committee members and voiced support for the current Code that allows the Board to deny licenses by endorsement based on regulatory or statutory grounds. Mr. Castro also stated that if Virginia were to join the ILMC, MSV urges that 1) the Board be able to reject applicants with disciplinary issues, and 2) the Board explore options as to how providers would avoid double jeopardy issues as it relates to past discipline in other states. Additionally, Mr. Castro voiced MSV's concern over the increased costs for licensure renewals under the ILMC. It is their belief that the license by endorsement pathway and license renewal process as they exist in the current Code is effective. In closing, Mr. Castro advised that MSV has reached out to the patron, Delegate Dan Helmer, stating its willingness to be a resource in regards to HJ 531.

EXECUTIVE DIRECTOR'S REPORT

Dr. Harp reminded the Committee of the expectation that Board of Medicine members are to continue serving until their successor has been named. The law governing the Board states that if a member moves from the Congressional District of appointment to another, the seat in the District of appointment becomes vacant. Dr. Walker has moved from the 9th to the 5th, so the 9th District seat is now considered vacant. He will be missed.

NEW BUSINESS

1. Chart of Regulatory Actions

Ms. Yeatts reviewed the Board's regulatory activity as of January 14, 2021. This report was for informational purposes only and did not require any action.

2. Report of the 2021 General Assembly

Ms. Yeatts reviewed the proposed legislation in the 2021 Session and highlighted those below **(active links)**

- **HB 1737 Nurse practitioners; practice without a practice agreement.**
- **HB 1747 Clinical nurse specialist; licensure of nurse practitioners as specialists, etc.**
- **HB 1769 Health care providers, certain; licensure or certification by endorsement.**
- **HB 1795 Counseling, Board of; licensure of professional counselors without examination.**
- **HB 1817 Certified nurse midwives; practice.**
- **HB 1913 Career fatigue and wellness in certain health care providers; programs to address, civil immunity.**
- **HB 1953 Licensed certified midwives; definition of practice, licensure, report.**
- **HB 1959 Medication abandonment and increasing patient medication adherence; options for reducing rates.**
- **HB 1987 Telemedicine.**
- **HB 1988 Board of Pharmacy; pharmaceutical processors; processing and dispensing cannabis oil.**
- **HB 2005 Disposition of the remains of a decedent; persons to make arrangements for funeral and disposition.**

--- FINAL APPROVED---

- **HB 2039 Practice as a physician assistant.**
- **HB 2044 Naturopathic doctors; license required.**
- **HB 2061 Virginia Immunization Information System; health care entities; required participation.**
- **HB 2079 Pharmacists; initiation of treatment; certain drugs and devices.**
- **HB 2220 Surgical technologist; certification; use of title.**
- **HB 2259 Professions and occupations; licensure by Governor.**
- **HB 2272 Department of Health Professions; naturopathic doctors.**
- **HJ 531 Study; Joint Commission on Health Care.**
- **SB 1107 Medical malpractice; limitation on recovery.**
- **SB 1178 Genetic counseling; conscience clause.**
- **SB 1187 Department of Health Professions; practice of physical therapy.**
- **SB 1189 Licensure of occupational therapists; Occupational Therapy Interjurisdictional Licensure Compact.**
- **SB 1192 Department of Health Professions; naturopathic doctors.**

After the presentation, Ms. Yeatts responded to a Committee member who asked the rationale behind the bill to allow the Governor to overrule the Board. Ms. Yeatts stated she is unable to accurately reflect the reason behind this bill.

3. Reconsideration of Interstate Medical Licensure Compact

Mr. Marchese noted that the DHP Telemedicine Workgroup that met August 5, 2019 suggested that the Board take a fresh look at the Interstate Medical Licensure Compact (Compact). Mr. Marchese provided some history about the Compact and said there are currently 29 member states plus the District of Columbia and Guam. The Compact originated in response to calls for license portability as well as some issues at the national level. The purpose of the Compact is to facilitate physicians practicing across state lines. The way the Compact is written, licensure is left up to the state. The structure of the Compact is dissimilar to the Nursing Compact which allows nurses to cross state lines to work. The Board of Medicine decided in 2016 to try a licensure by endorsement pathway instead of joining the Compact at that time. There are some components of the Compact that are in conflict with the Code of Virginia, including reporting complaints to the Compact before they have been thoroughly investigated.

Dr. Harp pointed the Committee to page 34 of the agenda packet and stated that the average number of licenses obtained per applicant for 2018 and 2019 was 3%, but in 2020 it dropped to 1.6%. Given the pandemic and the wish to practice telemedicine across state lines, one would think that the average number of licenses per physician would have increased in 2020. He stated that the Compact was designed for the cream of the crop – many years of practice, no disciplinary history, board certified, etc. He noted that the licensure by endorsement pathway has similar requirements and has done what the Board expected it to do, to provide an expeditious pathway and save money for applicants applying to Virginia.

Additionally, Dr. Harp referred to HJ 531 that asks the Joint Commission on Health Care to study the advantages and disadvantages of Virginia participating in the Compact.

Dr. Conklin said that she would support sending a recommendation to the Full Board to again vote "no" on Virginia joining the Compact, since the Board already has a pathway that is expeditious, more economically feasible, and maintains Board oversight.

Dr. Harp asked Ms. Yeatts if, in light of the study to be conducted by the Joint Commission on Health Care this year, would it be necessary to send a letter to the Commission stating that the Board will cooperate and provide information as needed.

Ms. Yeatts advised that she can see both sides of this issue. Communicating to the Commission in 2021, that the Board again affirms its position might be beneficial to the work of the Commission. She also mentioned that there are members of the General Assembly who think that the Board is acting for its own self-preservation by not affirming the Compact.

After discussion about what could serve as a rationale for its decision, Dr. Harp advised that he would draft a document to include history and statistics for review by counsel, appropriate Board members, and staff for presentation to the Full Board.

4. Continuing Education on Human Trafficking.

Dr. Conklin advised that, in order to renew her Texas license, she was required to complete 1 hour of continuing education in human trafficking. She said that human trafficking encompasses not only the sex trade but other occupational endeavors as well. People who come across the border are at higher risk for being exploited. She stated that prior to this training, as a physician who interviews patients prior to surgery, she would not have known how to recognize a victim of human trafficking. She then noted that, according to the Institute for Human Trafficking in Fairfax, over 25 million Americans are victims of human trafficking. Virginia ranks 6th in the nation in open cases of trafficking. More incredibly, she said that the human trade business makes more profit each year than Apple, Microsoft, Samsung and Exxon combined.

Dr. Conklin said if the Board is unable to make this training a requirement, can the Board make this information available to the licensees by posting the course information on the website? She added that it would be preferable to require an hour every biennium, but even a one-time requirement would suffice since it is a well-known problem in the Commonwealth.

After discussion, the Committee agreed that it would be acceptable to add it as a one-time requirement, understanding that it would require an action by the General Assembly with an amendment to the regulations.

Ms. Yeatts advised that this Board does not have the authority in the Code to set an annual requirement for continuing education. She agreed that this is a worthy endeavor, but thinks the best alternative is to add educational resources to the Board Briefs and the Board's webpage. Dr. Harp agreed that placing these in the Board Briefs and on the website with a link to the appropriate courses is the best avenue to take.

Ms. Deschenes stated the Board was asked to mandate continuing education (CE) on this topic previously, and it respectfully declined. Many organizations, agencies and entities have important information to disseminate and occasionally ask the Board to create a CE requirement for Board licensees. Mandatory CE on multiple topics can overwhelm licensees. The Board's stance on continuing education has been that licensees know best which CE will

--- FINAL APPROVED---

benefit them in their practice, thereby ensuring that their practice will be safer for the citizens of the Commonwealth. She also agreed that the Board Briefs, which are going directly to practitioners' mailboxes, will make it easier them to access the educational resources.

Mr. Marchese confirmed the consensus of the members that placing an article in the Board Briefs is the action to take with the hope that it gains some attention and that practitioners will take the initiative to read it.

ANNOUNCEMENTS

No Announcements.

NEXT MEETING

May 21, 2021

ADJOURNEMENT

With no other business to conduct, the meeting adjourned at 9:56 a.m.

____
Blanton Marchese
Vice-President, Chair

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William L. Harp, MD
Executive Director

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Colanthia Morton Opher
Recording Secretary

<<<DRAFT UNAPPROVED>>>

ADVISORY BOARD ON OCCUPATIONAL THERAPY

Minutes
January 26, 2021
Electronic Meeting

The Advisory Board on Occupational Therapy held a virtual meeting on Tuesday, January 26, 2021 hosted at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT:	Breshae Bedward, Chair Dwayne Pitre OT, Vice-Chair Kathryn Skibek, OT
MEMBERS ABSENT:	Raziuddin Ali, MD Karen Lebo, JD, Citizen Member
STAFF PRESENT:	William L. Harp, MD, Executive Director Michael Sobowale, LLM, Deputy Director, Licensing Elaine Yeatts, DHP Senior Policy Analyst Jennifer Deschenes, Deputy Director, Discipline ShaRon Clanton, Licensing Specialist
GUESTS PRESENT:	Chris McCormick, Public Lindsay Sessa, Public

CALL TO ORDER

Breshae Breward, Chair, called the meeting to order at 10:15a.m.

EMERGENCY EGRESS PROCEDURES

Breshae Breward announced the emergency egress instructions for those that may be attending the virtual meeting in the Perimeter Center.

ROLL CALL

Roll was called, and a quorum declared.

APPROVAL OF MINUTES of OCTOBER 6, 2020

Ms. Skibek moved to approve the minutes of the October 6, 2020 meeting. Mr. Pitre seconded the motion. By roll call vote, the minutes were approved as presented.

ADOPTION OF AGENDA

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

PUBLIC COMMENTS ON AGENDA ITEMS (15 minutes)

None

NEW BUSINESS

1. **Report of the 2021 General Assembly**

   Elaine Yeatts provided a report from the 2021 General Assembly. She discussed bills that were of interest to the Advisory Board.

2. **AOTA Proposed Revision to the Definition of Occupational Therapy Practice**

   Breshae Beward provided a review of the proposed revision from the American Occupational Therapy Association (AOTA).

ANNOUNCEMENTS:

ShaRon Clanton provided the licensing report. The Board has a total of 3,549 current active occupational therapists and 1,448 occupational therapy assistants.

Next Meeting Date

Next scheduled meeting date: May 25, 2021 at 10:00 a.m.

ADJOURNMENT

With no other business to conduct, Breshae Bedward adjourned the meeting at 11:08 a.m.

Breshae Breward, Chair

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

ShaRon Clanton, Licensing Specialist

<<<DRAFT UNAPPROVED>>>

ADVISORY BOARD ON RESPIRATORY THERAPY

Minutes
January 26, 2021
Electronic Meeting

The Advisory Board on Respiratory Therapy held a virtual meeting on Tuesday, January 26, 2021 hosted at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Daniel Gochenour, RRT, Chair
Santiera Brown-Yearling, RRT, Vice-Chair
Bruce K. Rubin, MD
Denver Supinger, Citizen Member

MEMBERS ABSENT: Shari Toomey, RRT

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

GUESTS PRESENT: None

Call to Order

Daniel Gochenour, RRT and Chair, called the meeting to order at 1:05 pm.

Emergency Egress Procedures

Dr. Harp announced the emergency egress instructions for those individuals that may be attending the virtual meeting in the Perimeter Center.

Roll Call

The roll was called, and a quorum was declared.

Approval of Minutes

Bruce Rubin moved to approve the minutes of October 6, 2020 meeting. Santiera Brown-Yearling seconded. By roll call vote, the motion was approved.

Adoption of Agenda

Bruce Rubin moved to adopt the agenda. Santiera Brown-Yearling seconded. By roll call vote, the motion carried.

Public Comment on Agenda Items

None

New Business

1. **Report of the 2021 General Assembly**

   Elaine Yeatts provided a report from the 2021 General Assembly and discussed bills that were of interest to the Advisory Board.

2. **Advanced Practice Respiratory Therapist Credential**

   Daniel Gochenour discussed the need for the Advisory Board to follow up on the presentation it heard on this topic at its October 6, 2020 meeting.

   It was recommended that the Board of Medicine put together a legislative proposal to be carried by a sponsor for consideration at the 2022 General Assembly.

Announcements

Delores Cousins provided the licensing report. The Board of Medicine has 3,166 Virginia active respiratory therapist licenses and 922 out-of-state active licenses.

Next Scheduled Meeting:

Next scheduled meeting date: May 25, 2021.

Adjournment

With no other business to conduct, Daniel Gochenour adjourned the meeting at 2:02 p.m.

Daniel Gochenour, RRT, Chair

William L. Harp, MD, Executive Director

Delores Cousins, Licensing Specialist

<<<DRAFT UNAPPROVED>>>

ADVISORY BOARD ON ACUPUNCTURE

Minutes

January 27, 2021

Electronic Meeting

The Advisory Board on Acupuncture held a virtual meeting on Wednesday, January 27, 2021, at 10:00 a.m. at the Department of Health Professions at 9960 Mayland Drive, Henrico, VA 23233.

MEMBERS PRESENT: Janet L. Borges, LAc, Chair
Sharon Crowell, LAc, Vice-Chair
Luke Robinson, DO
Beth Rodgers, Citizen Member

MEMBERS ABSENT: R. Keith Bell, LAc

STAFF PRESENT: William L. Harp, M.D., Executive Director
Michael Sobowale, LLM, Deputy Director, Licensing
Elaine Yeatts, DHP Senior Policy Analyst
Beulah Baptist Archer, Licensing Specialist

GUESTS PRESENT: Joseph Schibner, IV, LAc

CALL TO ORDER

Janet Borges, LAc and Chair, called the meeting to order at 10:00 a.m.

EMERGENCY EGRESS PROCEDURES

Janet Borges announced the emergency egress procedures for those who may be attending the virtual meeting in the Perimeter Center.

ROLL CALL - The roll was called, and a quorum was declared.

APPROVAL OF MINUTES FROM OCTOBER 7, 2020

Sharon Crowell moved to approve the minutes from the October 7, 2020 meeting. Dr. Luke Robinson seconded. By roll call vote, the minutes were approved as presented.

ADOPTION OF AGENDA

Beth Rodgers moved to adopt the agenda. Sharon Crowell seconded. By roll call vote, the agenda was adopted.

PUBLIC COMMENT ON AGENDA ITEMS

Joseph Schibner, IV, LAc and President of the new Lotus School of Integrated Professions in Richmond, made a presentation on the need for the Advisory Board to have a regulatory amendment that covers direct supervision of acupuncture students in an educational, clinical setting. This issue was fully discussed with the resolution being that the Lotus School can develop its own supervisory requirements to guide its faculty with regard to the Board of Medicine's delegation statute, 54.1-2901(A)(6), coupled with graduated skills and capabilities of students.

NEW BUSINESS

1. **Report of the 2021 General Assembly**

   Elaine Yeatts discussed bills in the 2021 General Assembly with interest to the Advisory Board.

2. **Regulations Governing the Practice of Licensed Acupuncturists**

   There was no need to suggest a regulatory amendment based on public comment received at the meeting and discussion.

ANNOUNCMENTS

Ms. Archer provided the acupuncture licensing report. The Board has 435 current active licensees with 130 out-of-state. There are 8 current inactive licenses.

NEXT SCHEDULED MEETING:

May 26, 2021, at 10:00 a.m.

ADJOURNMENT

Janet Borges adjourned the meeting at 11:00 a.m.

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Janet L. Borges, L. Ac., Chair	William L. Harp, M.D., Executive Director

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Beulah Baptist Archer, Licensing Specialist

<<< DRAFT UNAPPROVED>>>

ADVISORY BOARD ON PHYSICIAN ASSISTANTS
Minutes
January 28, 2021
Electronic Meeting

The Advisory Board on Physician Assistants held a virtual meeting on Thursday, January 28, 2021 hosted at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT:	Kathleen Scarbalis, PA-C, Chair James B. Carr, PA-C, Vice Chair Portia Tomlinson, PA-C Tracey Dunn, Citizen Member
MEMBERS ABSENT:	Frazier W. Frantz, MD
STAFF PRESENT:	William L. Harp, MD, Executive Director Michael Sobowale, LLM, Deputy Executive Director Elaine Yeatts, DHP Senior Policy Analyst ShaRon Clanton, Licensing Specialist Nearia Davis, Administrative Assistant
GUESTS PRESENT:	Valentina Vega, Public Tim Faerber, Public

Call to Order

Ms. Scarbalis called the meeting to order at 10:00 a.m.

Emergency Egress Procedures

Dr. Harp provided the emergency egress instructions for individuals who may be attending the virtual meeting in the Perimeter Center.

Roll Call

Roll was called, and a quorum was declared.

Approval of Minutes from October 8, 2020

Ms. Tomlinson moved to adopt the minutes. The motion was seconded by Mr. Carr. By roll call vote, the minutes were approved as presented.

Adoption of Agenda

Ms. Scarbalis moved to adopt the meeting agenda with the addition of an update on the physician assistant licensure compact under 'old business' on the agenda. The motion was seconded by Mr. Carr. By roll call vote, the revised agenda was approved unanimously.

Public Comment on Agenda Items (15 minutes)

None

Old Business

Ms. Scarbalis is part of a work group convened by the Federation of State Medical Boards (FSMB) to draft a physician assistant licensure compact. There was discussion of a mutual recognition model for license portability. Draft model legislation may be ready for presentation at the 2022 General Assembly session.

New Business

1. **Report of the 2021 General Assembly**

   Ms. Yeatts provided an overview of bills of interest to the Advisory Board. She also mentioned that permanent regulations for collaborative practice for physician assistants with patient care team physicians/podiatrists will go into effect on March 16, 2021.

2. **Physician Assistant Participation in the Virginia Newborn Screening Program**

   Kathleen Scarbalis led the discussion. A physician assistant had contacted expressing difficulty with accessing the data in the Virginia Newborn Screening Program. Dr. Harp said he researched the issue and that physician assistants will be added to the list of health care providers with access to the data in the Program.

Announcements

Ms. Clanton reported that there are 3,602 current active licensees as of today.

Next Scheduled Meeting: May 27, 2021 @ 1:00 p.m.

Adjournment

With no other business to conduct, the meeting adjourned at 1:50 p.m.

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Kathleen Scarbalis, PA-C, Chair

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

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ShaRon Clanton, Licensing Specialist

<<<DRAFT UNAPPROVED>>>

ADVISORY BOARD ON MIDWIFERY
Minutes
January 29, 2021
Electronic Meeting

The Advisory Board on Midwifery met virtually on Friday, January 29, 2021, at 10:00 a.m., at the Department of Health Professions, Perimeter Center; 9960 Mayland Drive, Henrico, Virginia, 23233.

MEMBERS PRESENT:	Kim Pekin, CPM, Chair Rebecca Banks, CPM, Vice-Chair Erin Hammer, CPM Natasha Jones, MSC, Citizen Ami Keatts, M.D.
MEMBERS ABSENT:	None
STAFF PRESENT:	William L. Harp, MD, Executive Director Michael Sobowale, LLM, Deputy Director Elaine Yeatts, DHP Senior Policy Analyst Beulah Baptist Archer, Licensing Specialist
GUESTS PRESENT:	None

CALL TO ORDER

Kim Pekin called the meeting to order at 10:02 a.m.

EMERGENCY EGRESS PROCEDURES

Dr. Harp announced the emergency egress procedures for those who may be attending the virtual meeting in the Perimeter Center.

ROLL CALL –The roll was called, and a quorum was declared.

APPROVAL OF MEETING MINUTES of OCTOBER 9, 2020

Becky Banks moved to approve the October 9, 2020 minutes. Ami Keatts seconded the motion. By roll call vote, the motion to approve the minutes carried unanimously.

ADOPTION OF THE AGENDA

Ami Keatts moved to adopt the agenda. Becky Banks seconded the motion. By roll call vote, the agenda was approved.

PUBLIC COMMENT ON AGENDA ITEMS

Tammi McKinley, President of the Virginia Midwife Alliance, made a presentation to the Advisory Board addressing the support of the American College of Obstetricians and Gynecologists (ACOG) for midwives to have access to life-saving medications.

Becky Banks made a motion to add this item to the agenda for discussion under new business. Ami Keatts seconded. By roll call vote, the amendment to add this item to the agenda was approved.

OLD BUSINESS

A. Review of High-Risk Pregnancy Disclosures - Guidance Document 85-10

Kim Pekin discussed suggested revisions to the guidance document. Dr. Harp said it would be best to convene an Ad Hoc Committee for review of the proposed revisions. The Ad Hoc would include 2 Board of Medicine members and 2 members of the Advisory to finalize changes to the guidance document. He thought this meeting could be a virtual one.

Ms. Yeatts advised that the final recommendations will have to be reviewed by the Full Board, and thereafter posted for 40 days of public comment prior to the guidance document being approved.

Becky Banks made a motion to convene an Ad Hoc Committee to review the suggested revisions to the guidance document. Ami Keatts seconded. By roll call vote, the motion was approved.

B. Discuss Guidance Document for Perinatal and Postpartum Screening for Depression.

Dr. Harp directed the Advisory Board's attention to the November 2020 Board Briefs article on this topic. He suggested that it be disseminated to the midwifery community rather than developing a guidance document.

NEW BUSINESS

1. Report of the 2021 General Assembly - Elaine Yeatts

Ms. Yeatts discussed bills of interest in the General Assembly, including Senate Bill 1320 that creates a new profession, Licensed Certified Midwifery. This new category of midwifery does not have medical/nursing training, but does take the same credentialing exam as Certified Nurse Midwives.

A workgroup of the Boards of Medicine and Nursing will be convened to study the licensure and regulation for the 3 different midwifery professions and report its findings to the Governor and General Assembly by November 1, 2021.

2. Access to COVID-19 Vaccines and PPE for Licensed Midwives

Advisory Board members conveyed the difficulty in getting clear guidance for vaccination sites in Virginia for midwives. It was pointed out that the Department of Health was leading the vaccination effort and information would most likely be forthcoming in the near future. Acquisition of PPE for midwives has not presented any problems.

ANNOUNCEMENTS

Beulah Archer provided the licensing report. The total number of licensees is 97, with 70 current active with Virginia addresses, 26 current active out-of-state, and 1 current inactive.

NEXT MEETING DATE

May 28, 2021, at 10:00 a.m.

ADJOURNMENT

Kim Pekin adjourned the meeting at 11:39 a.m.

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Kim Pekin, CPM, Chair

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William L. Harp, MD
Executive Director

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Beulah Baptist Archer, Licensing Specialist

<<<DRAFT UNAPPROVED>>>

ADVISORY BOARD ON SURGICAL ASSISTING

Minutes
February 2, 2021
Electronic Meeting

The Advisory Board on Surgical Assisting held a virtual meeting on Tuesday, February 2, 2021 hosted at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

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

MEMBERS ABSENT: None

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

GUESTS PRESENT: David Jennette, CSA, NSAA
Ben Traynham, JD, MSV

Call to Order

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

Emergency Egress Procedures

Deborah Redmond called on Dr. Harp to announce the emergency egress procedures for those who may be attending the virtual meeting in the Perimeter Center.

Roll Call

The roll was called, and a quorum was declared.

Approval of Minutes

Nicole Meredith moved to approve the minutes of the October 16, 2020 meeting. Jessica Wilhelm seconded. By roll call vote, the minutes were approved as presented.

Adoption of Agenda

Thomas Gochenour moved to adopt the agenda. Nicole Meredith seconded. By roll call vote, the agenda was adopted as presented.

Public Comment on Agenda Items

None

OLD BUSINESS

Michael Sobowale discussed the surgical assistant license application which is currently in use for new license applicants. There was discussion to amend question number 11 on the Surgical Assistant Licensure Application to ask about "past or pending disciplinary actions….". The suggested change will be incorporated into the license application.

NEW BUSINESS

1. **Report of the 2021 General Assembly**

   Elaine Yeatts provided a report from the 2021 General Assembly and highlighted bills that were of interest to the Advisory Board.

2. **Notice of Intended Regulatory Action (NOIRA)**

   Elaine Yeatts provided an update on the pending Notice of Intended Regulatory Action to the Advisory Board. She estimated that it would likely take another eighteen 18 months for the regulations to become effective.

3. **Standard Operating Procedures**

   Deborah Redmond wanted to discuss standard operating procedures as suggested on the National Surgical Assistant Association (NSAA) website. Ms. Redmond proposed to bring this item for discussion at the June meeting.

ANNOUNCEMENT

Delores Cousins provided the licensing report. The Board of Medicine has a total of 306 actively licensed surgical assistants with 37 out-of-state. There are 220 registered surgical technologists with 7 located out-of-state.

Next Scheduled Meeting:

Next scheduled meeting date: May 25, 2021.

Adjournment

With no other business to conduct, Deborah Redmond adjourned the meeting at 10:42 am.

Deborah Redmond, LSA, Chair

William L. Harp, MD, Executive Director

Delores Cousins, License Specialist

---DRAFT UNAPPROVED---

VIRGINIA BOARD OF MEDICINE
EXECUTIVE COMMITTEE MINUTES – VIRTUAL MEETING

Friday, April 9, 2021 | Department of Health Professions | Henrico, VA

CALL TO ORDER: Mr. Marchese called the virtual meeting of the Executive Committee to order at 8:33 a.m.

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

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

MEMBERS ABSENT: Lori Conklin, MD – President, Chair

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
David Brown, DC - DHP Director
Barbara Allison-Bryan, MD - DHP Deputy Director
Elaine Yeatts - DHP Senior Policy Analyst
Erin Barrett, JD - Assistant Attorney General

OTHERS PRESENT:
Richard Grossman
Valentina Vega
Jennie Wood – Board Staff
Ben Traynham, JD – Hancock Daniel
Tamika Hines - Board Staff
Christina ...
LeVar Bowers
Clark Barrineau -MSV
Alicia Cundiff –Spotts Fain
Scott Castro - MSV
K. Wilkinson

EMERGENCY EGRESS INSTRUCTIONS

Mr. Marchese provided the emergency egress instructions for those in the building.

MOMENT OF SILENCE

The Board observed a moment of silence for the passing of the Honorable William E. Quarles, Jr., member of the Board of Medicine's Advisory Board on Radiologic Technology.

PUBLIC HEARING

Mr. Marchese opened the floor for public comment on the proposed regulations prohibiting Conversion Therapy.

Hearing no comment, Mr. Marchese reminded everyone that comment can still be posted on Regulatory Townhall or sent by email to Elaine Yeatts, Policy until April 16, 2021.

APPROVAL OF MINUTES OF DECEMBER 4, 2020

Dr. Ransone moved to approve the meeting minutes from December 4, 2020 as presented. The motion was seconded by Dr. Edwards and carried unanimously.

ADOPTION OF AGENDA

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

PUBLIC COMMENT

The Board acknowledged written comment submitted by the Medical Society of Virginia (MSV). The letter supported the recommendation of the Board's Legislative Committee not to join the Interstate Medical Licensure Compact at this time and encouraged the Executive Committee to confirm it. Additionally, MSV voiced its continued support of the licensure by endorsement pathway as well as revision of the medical malpractice question to better focus on paid claims or pending claims. MSV commented that the revision would not disqualify an applicant solely on the basis of a frivolous or retributive lawsuit.

DHP DIRECTOR'S REPORT

Dr. Brown provided an update on Diversity, Equity and Inclusion (DEI) in the Commonwealth and at DHP. He advised that Governor Northam appointed Dr. Underwood to a cabinet level position as the Chief Diversity Officer for Virginia. The 2021 General Assembly passed legislation mandating that all state agencies adopt a strategic plan on DEI. DHP was one of the pilot agencies to develop this process, which is consistent with DHP's past efforts addressing other government-wide issues. Dr. Brown said that several years ago, the agency was mandated to do a succession planning report. One of the weaknesses identified was the lack of diversity in senior management. Since that time, this issue has been addressed by expanding the hiring process to ensure a more diverse pool of applicants for positions that have a path to leadership in the agency. He noted that the last in-house staff training day in 2019 was entirely devoted to DEI issues, that there is an ongoing series of Lunch and Learns on unconscious bias, and that DHP has established an internal DEI Council. DHP intends to

present this topic at the next in-person board member training with assistance from organizations that support the boards in DHP, such as the Federation of State Medical Boards (FSMB).

Dr. Brown then provided an update on the recently approved legislation to legalize adult use of marijuana. He said it has been signed into law even though some of the programmatic effects are a couple of years away. Effective July 1, 2021, possession of small amounts of marijuana will be legal. The law will need to be re-enacted next year as the legislators will take a careful look at it this year. The law also reflected a change in the Governor's original idea by creating a new agency to regulate marijuana. The new agency will not only regulate adult use, but it will also regulate medical use. Accordingly, the pharmaceutical processor program will be transferred from the Board of Pharmacy to the new agency in 2023. The entire scope of these processes is expected to be in effect in 2024. Dr. Brown also provided an update to the changes in the medical cannabis oil-based program.

Dr. Allison-Bryan provided an update on the vaccine efforts in Virginia. She noted that 1/3 of the population has gotten at least one shot of vaccine. The numbers continue to go up daily, nearly 80,000 a day. The big news is that all of Virginia will enter Phase 2 on April 18. Dr. Allison-Bryan then shared a website called the Kaiser Family Foundation COVID Website. She said that it looks at some of the demographics related to the vaccine. The website is updated every two weeks, and it addresses some very interesting questions. In February, vaccine hesitancy among different ethnic/racial groups equalized, and now the African-American population is getting the vaccine at a higher rate. Dr. Allison-Bryan thinks this speaks well of the efforts that the local health departments have put into education and reassurance about the vaccines.

Dr. Edwards commented on the statement about the health departments' efforts to educate and reassure the African-American population about the vaccine. He said there were some vaccination disparities, and that it was not until the pastors' council got involved and approached Dr. Oliver, Commissioner of Health. The pastors explained what they thought was going on, and subsequently more African-Americans were able to obtain the vaccine. Mr. Marchese said that from his observation, the trust level in the African-American community changed once the churches got involved.

Dr. Ransone asked what role physicians will play once it is legal for adults to possess marijuana. Dr. Brown said there is an expectation that there will always be a role for the physician-supervised medical use of cannabis. The medical program is moving forward witn the pharmaceutical processors having up to 5 additional dispensaries in their region. As far as adult use goes, localities may have opt-in or opt-out choices.

Dr. Harp added the law regarding medicinal marijuana products requires that the Supreme Court to work with the Board of Medicine to update the certificate form, DC-307. The revised form should be available July 1, 2021 and most likely the language will refer to cannabis products instead of cannabis-based oils.

PRESIDENT'S REPORT

No report.

EXECUTIVE DIRECTOR'S REPORT

Dr. Harp provided a brief report on the Board's finances, case hours for Enforcement and Administrative Proceedings, and the Health Practitioners' Monitoring Program.

Dr. Harp also provided an update on opioid waiver requests, electronic meetings, and reciprocity with contiguous jurisdictions.

Dr. Brown informed the members that the COVID-19 landscape is improving quickly with some geographic variance throughout the state. He said that as the Commonwealth is opening up, DHP will revisit the policy on resuming in-person meetings.

Dr. Harp ended his report by announcing that FSMB has awarded the John H. Clark, MD Award for Leadership to Kevin O'Connor, MD, past president of the Board of Medicine.

NEW BUSINESS

1. Chart of Regulatory Actions and Reaffirmation of Guidance Document 85-14

Ms. Yeatts presented the chart for review only.

She then addressed Guidance Document 85-14 – Enforcement of Continuing Competency Requirements, and said that every 4 years, guidance documents must be reviewed and reaffirmed, amended, or repealed. She noted that staff recommends the Board reaffirm the current guidance in 85-14.

MOTION: Dr. Stokes moved to reaffirm 85-14 as included in the agenda packet. The motion was seconded by Dr. Ransone and carried unanimously.

2. Recommendation from the Legislative Committee regarding the Interstate Medical Licensure Compact (IMLC)

Mr. Marchese reminded the members of the letter of support received from MSV presented during public comment. He said that the Legislative Committee met on January 15, 2021 and discussed the advantages and disadvantages of joining the IMLC. After deliberation, the recommendation of the Legislative Committee was not to join the IMLC at this time.

MOTION: Dr. Ransone moved to confirm the recommendation of the Legislative Committee not to join the IMLC at this time. The motion was seconded by Dr. Archer and carried unanimously.

3. Recommendation of the Advisory Board on Midwifery regarding Guidance Document 85-10

Dr. Harp said this was a pro forma item; it was originally to be addressed at the February Board meeting. He provided the history on the development of Guidance Document 85-10. The

document is due to be reviewed for reaffirmation or possible updating. Dr. Harp said the Advisory Board had already identified some points in the document that may need to be updated. The original document was developed by a work group of Advisory Board members and Board of Medicine members. Repeating this process will ensure that agreed upon, evidence-based revisions will occur. At this time, no date has been set, but it is anticipated that Dr. Barner, Dr. Archer, Kim Pekin, CPM, Becky Banks, CPM, Erin Hammer, CPM, and Dr. Conklin as chair will constitute this work group.

MOTION: Dr. Ransone moved to approve the formation of a work group of 3 Advisory Board members and 3 Board of Medicine members to review and revise Guidance Document 85-10. The motion was seconded by Dr. Stokes and carried unanimously.

4. Recommendations from Board Staff on the Licensure by Endorsement Pathway

Dr. Harp reminded the Committee of the requirements for licensure by endorsement. He then said endorsement is supposed to be the "express train", with no equivocal information or answers. He pointed out that the current structure of the application intends that all the answers be "No", including the malpractice question. Staff has noticed that there are applications where the answer to the current malpractice question is "No", but NPDB comes back with a report that may indicate there are other malpractice suits that have been closed. Staff thinks that the application, the applicants and the process would be better served if the current question was changed to "**Have you had any malpractice paid claims in the last 10 years, or do you have any pending malpractice suits?"** Dr. Harp stated that this change would provide better protection for the public, close a loophole, and make the application more pristine. He then suggested that this same language be used in the traditional pathway application.

MOTION: Dr. Ransone moved to accept the suggested language change for both the endorsement and the traditional applications. The motion was seconded by Dr. Edwards and carried unanimously.

Dr. Harp said when the Board contemplated joining the IMLC in 2016, speed of licensure was one aspect that was considered. In 2021, the question remains if the Board can, through endorsement, match or exceed the speed that the Compact provides. Dr. Harp stated that as the Board has gained experience with the endorsement process, it has become evident that there are two groups that apply through endorsement - those who want a license quickly and those that want an easier process. The IMLC is about expeditious licensure, and going forward, if the Board is to compare licensure by endorsement to the Compact, he suggested a binary count to capture more accurate processing times for endorsement. Staff considered processing times and agreed that 45 days or less to licensure would be about speed, and longer than 45 days to licensure would reflect the group that wanted an easy pathway. Being able to separate these 2 groups statistically would provide a clearer picture for the Board as it assesses the endorsement pathway and the IMLC in the future.

MOTION: Dr. Archer moved to accept the binary count with 45 days being the breakpoint. Dr. Ransone seconded.

Dr. Stokes asked for clarification of the process for applications over 45 days.

Mr. Sobowale said there are some individuals that submit required documentation in the 12th month of an endorsement application. This inflates the numbers for endorsement processing times. The plan will be to send a reminder at the 30-day mark to all who have applied through endorsement. After 45 days, those who have not responded to the notification will be moved to the traditional pathway.

Mr. Marchese reminded the members that the burden is on the applicant to get their supporting documentation to the Board, and that with this notification, staff is going above and beyond to move the process along.

Dr. Archer asked if it would be advantageous to add a checkbox for the applicant to indicate if their desire was to obtain the license quickly, thereby giving staff some preview as to what the intentions were. If so, staff could complete the process in 45 days or less.

Following up on Mr. Sobowale's comments and Dr. Archer's question, Dr. Harp stated that there was no way to exclude any applicant that qualifies for licensure by endorsement with a checkbox at the beginning of the application process. He also stated that after 45 days, incomplete applications should not be transitioned to the traditional pathway, but rather kept in endorsement and just provide the binary numbers which will be helpful when revisiting the Compact. Moving an application to the traditional pathway after 45 days may ruffle some feathers.

After some discussion, the motion carried unanimously.

Licensing Report

Mr. Sobowale provided statistics from July 2020 to the present. The Board has issued over 5,000 new licenses, more than half of which were in the 5 expedited professions. He noted that last fall the Board gained a new profession, licensed surgical assistants. Mr. Sobowale said that across all the professions, the license processing time is approximately 60 days from start to finish. From April 1, 2020 to April 1, 2021, there have been 2,787 MD licenses and 508 DO licenses issued with the number of days ranging from 1 – 366 days. For the first quarter of this year, the Board has issued 421 MD and 82 DO licenses. This report was for information only and did not require any action.

Mr. Marchese expressed his appreciation for the expertise and knowledge Mr. Sobowale brings to the job, and the work he is doing to streamline the licensing process.

Discipline Report

Ms. Deschenes briefly went over the discipline numbers pre-pandemic and during COVID-19. She pointed to the notable number of 97 PHCO's in 2020 compared to 68 in 2019. Adjudication has not slowed much during the pandemic. She noted that one concern is the formal hearings that need to be scheduled; most of them are not amenable to being held virtually.

ANNOUNCEMENTS

There were no announcements.

The next meeting of the Executive Committee will be August 6, 2021 @ 8:30 a.m.

ADJOURNMENT

With no additional business, the meeting adjourned at 10:16 a.m.

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Blanton Marchese Vice- President	William L. Harp, MD Executive Director

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Colanthia M. Opher
Recording Secretary

---DRAFT UNAPPROVED---

VIRGINIA BOARD OF MEDICINE MINUTES

VIRTUAL - Ad Hoc Committee for Guidance Document 85-10

Monday, May 17, 2021 | Department of Health Professions | Henrico, Virginia

CALL TO ORDER: The meeting of the Ad Hoc Committee convened at 10:03 a.m.

MEMBERS PRESENT:
Brenda Stokes, MD, Chair
Kim Pekin, CPM – (Joined at 10:10 a.m.)
Rebecca Banks, CPM
Erin Hammer, CPM
David Archer, MD
Amanda Barner, MD

MEMBERS ABSENT: None

STAFF PRESENT:
William L. Harp, MD, Executive Director
Colanthia M. Opher, Deputy Executive Director of Administration
Michael O. Sobowale, Deputy Executive Director, Licensing
Elaine Yeatts, DHP Senior Policy Analyst

OTHERS PRESENT: None

SUMMARY OF MEETING:

Dr. Stokes called the meeting to order at 10:03 am. The roll was called, and a quorum was declared. Dr. Stokes provided the Emergency Egress Instructions for those in the building.

Dr. Harp provided historical background on the development of Guidance Document 85-10 by the original Ad Hoc Committee on Midwifery. He also presented the charge to the current Ad Hoc Committee.

Ms. Banks moved to adopt the agenda as presented. The motion was seconded and carried unanimously.

There was no public comment.

The Committee discussed all 35 sections of Guidance Document 85-10, carefully reviewing the recommended revisions from the Advisory Board on Midwifery, and suggested changes to the following:

- Section 7. Body Mass Index
- Section 9. Chronic Obstructive Pulmonary Disease and Asthma
- Section 10. Ectopic Pregnancy
- Section 11. Essential Chronic Hypertension
- Section 12. Genital Herpes
- Section 14. HIV Positive Status or AIDS

- Section 17. Incomplete Spontaneous Abortion
- Section 18. Isoimmunization
- Section 21. Platelet Count
- Section 22. Position Presentation other than Vertex
- Section 23. Pre-Eclampsia/Eclampsia
- Section 25. VBAC (Vaginal Birth After Cesarian)
- Section 26. Mental Health Issues
- Section 27. Rupture of Membranes
- Section 32. Significant Glucose Intolerance
- Section 33. Uncontrolled Hyperthyroidism
- Section 34. Uterine Ablation
- Section 35. Uterine Anomaly

After discussion and upon a motion made by Dr. Archer and seconded by Ms. Pekin, the Committee unanimously agreed by roll call vote to accept the proposed changes.

Dr. Harp informed the Committee that the next steps will be for Board staff to edit current Guidance Document 85-10 to incorporate the changes made and send a draft copy to the members to be reviewed for any additional edits or approval, as necessary.

With no further business to discuss, the meeting was adjourned at 12:17 p.m.

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Brenda Stokes, MD, Chair

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

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Michael O. Sobowale, Recording Secretary

--- DRAFT UNAPPROVED---

VIRGINIA BOARD OF MEDICINE

LEGISLATIVE COMMITTEE MINUTES – Virtual Meeting

Friday, May 21, 2021 | Department of Health Professions | Henrico, VA

CALL TO ORDER: Mr. Marchese called the meeting of the Legislative Committee to order at 8:37 a.m.

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

MEMBERS PRESENT:
Blanton Marchese, Vice-President, Chair
Lori Conklin, MD, President
James Arnold, DPM
Amanda Barner, MD
Joel Silverman, MD

MEMBERS ABSENT:
Ray Tuck, DC
Ryan Williams, MD

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

OTHERS PRESENT:
Karin Addison
Mark Hickman
Cal Whitehead
Dora Muhammad
Tierra Langley
Galina Varchena
Abbot Granoff, MD
Kassie Schroth
Ali Faruk
Jerry Canaan, JD
Jamie Lockhart
Graham McMahon, MD
Michael Keverline, MD
Frank Cotter, MD
Christopher West
Michaela she/her
Valentina Vega, MSV

--- DRAFT UNAPPROVED---

Richard Grossman
Kimberly Dyke-Harsley
Ben Traynham, JD
Scott Castro, MSV

EMERGENCY EGRESS INSTRUCTIONS

Mr. Marchese provided the emergency egress instructions.

APPROVAL OF MINUTES OF JANUARY 15, 2021

Dr. Arnold moved to approve the meeting minutes of January 15, 2021 as presented. The motion was seconded by Dr. Conklin and carried unanimously.

ADOPTION OF AGENDA

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

PUBLIC COMMENT

Frank Cotter, MD, Chairman of the Virginia Ambulatory Surgery Association, spoke in favor of the Board establishing an ad hoc committee to study the standard of care for eye surgeries in ambulatory surgery centers and physicians' offices.

Michael Keverline, MD, President, Virginia Society of Eye Physicians & Surgeons - spoke in favor of the Board establishing an ad hoc committee to study the standard of care for eye surgeries in ambulatory surgery centers and physicians' offices.

Abbot Granoff, MD – spoke in favor of the Board developing a guidance document on the prescribing of benzodiazepines.

Dora Muhammad, Congregation Engagement Director and Health Equity Program Manager for the Virginia Interfaith Center for Public Policy - spoke in favor of legislation, regulation, or a guidance document to require implicit bias training for all Board of Medicine licensees.

Tierra Langley, Member of the Task Force with Virginia Interfaith Center for Public Policy - spoke in favor of legislation, regulation, or a guidance document to require implicit bias training for all Board of Medicine licensees.

Ali Faruk, Director of Public Policy with Families Forward Virginia, spoke in favor of legislation, regulation, or a guidance document to require implicit bias training for all Board of Medicine licensees.

Galina Varchena, Policy Director NARAL Pro-Choice Virginia, spoke in favor of legislation, regulation, or a guidance document to require implicit bias training for all Board of Medicine licensees.

Kimberly Dyke-Harsley spoke in favor of legislation, regulation, or a guidance document to require implicit bias training for all Board of Medicine licensees and evaluation after the training.

Graham McMahon, MD, President, Accreditation Council for Continuing Medical Education, offered a brief synopsis of the continuing education tracking service ACCME can provide to the Board and its licensees.

The floor closed for Public Comment at 9:17 a.m.

DHP DIRECTOR'S REPORT

Dr. Brown provided an update on the efforts to address COVID-19, vaccine numbers and changes in mask requirements. He also provided an overview of the work accomplished by the state and the agency on DEI and anticipates that DEI will be part of the next in-person Board member training.

Dr. Conklin asked Dr. Brown if the Department of Health could be encouraged to wait before reporting a positive COVID result to the CDC until a follow-up second test result has been completed. Dr. Brown asked for a summary addressing the issue, and he will forward it to the right people.

EXECUTIVE DIRECTOR'S REPORT

Dr. Harp announced the appointment of Madge Ellis, MD, a general surgeon from the 9th Congressional District, who is replacing Ken Walker MD. Additionally, he said that the Full Board meeting and all hearings scheduled for June 24th & 25th will be in-person.

NEW BUSINESS

1. Regulatory Actions in Process

Ms. Yeatts reviewed the Board's regulatory actions in process for the Board. This report was for information only and did not require any action.

2. Regulatory/Policy Actions from the 2021 General Assembly

Ms. Yeatts reviewed the regulatory/policy actions of the 2021 Session that require action by the Board.

Department of Health Professions
Regulatory/Policy Actions – 2021 General Assembly
Board on Medicine

EMERGENCY REGULATIONS:

Legislative source	Mandate	Promulgating agency	Board adoption date	Effective date Within 280 days of enactment

SB1189	Occupational therapy compact	Medicine	8/6/21	**By 12/23/21**

EXEMPT REGULATORY ACTIONS

Legislative source	Mandate	Promulgating agency	Adoption date	Effective date
HB1737	Revise autonomous practice reg consistent with 2 years	Nursing & Medicine	N – 7/20/21 M – 8/6/21	
HB1747	Licensure of CNS as nurse practitioners – Amend Chapters 30 and 40 Delete sections of Chapter 20 with reference to registration of CNS	Nursing & Medicine	N – 7/20/21 M – 8/6/21	
HB1817	Autonomous practice for CNMs with 1,000 hours	Nursing & Medicine	N – 7/20/21 M – 8/6/21	
HB2039	Conform PA regs to Code	Medicine	10/14/21	
HB2220	Change registration of surgical technologists to certification	Medicine	10/14/21	
SB1178	Delete reference to conscience clause in regs for genetic counselors	Medicine	10/14/21	

APA REGULATORY ACTIONS

Legislative source	Mandate	Promulgating agency	Adoption date	Effective date
HB1953	Licensure of certified midwives	Nursing & Medicine	NOIRA Nursing – 7/20/21 Medicine – 8/6/21	Unknown

NON-REGULATORY ACTIONS

Legislative source	Affected agency	Action needed	Due date
HB793 (2018)	Medicine & Nursing	To report data on the number of nurse practitioners who have been authorized to practice without a practice agreement, the geographic and specialty areas in which nurse practitioners are practicing without a practice agreement, and any complaints or disciplinary actions taken against such nurse practitioners, along with any recommended modifications to the requirements of this act including any modifications to the clinical experience requirements for practicing without a practice agreement	November 1, 2021
HB1987	Boards with prescriptive authority	Revise guidance documents with references to 54.1-3303	As boards meet after July 1
HB2079	Pharmacy (with Medicine & VDH)	To establish protocols for the initiation of treatment with and dispensing and administering of drugs, devices, controlled paraphernalia, and supplies and equipment available over-the-counter by pharmacists in accordance with § 54.1-3303.1. Such protocols shall address training and continuing education for pharmacists regarding the initiation of treatment with and	Concurrent with emergency regulations

		dispensing and administering of drugs, devices, controlled paraphernalia, and supplies and equipment.	

3. Request from the Virginia Society of Eye Physicians and Surgeons and the Virginia Ambulatory Surgery Association

Mr. Marchese reminded the members of the public comments from Dr. Cotter and Dr. Keverline at the top of the meeting.

The members briefly discussed whether consideration had been given to establishing an ad hoc to review the practice of other office surgeries. Dr. Harp confirmed that in 2009-2011, the Board did look at the practice of office-based plastic surgery but did not move forward with regulations.

MOTION: After further discussion, Dr. Conklin moved that an ad hoc committee not be established at this time. The motion was seconded by Dr. Arnold and passed 4-0-1 with one abstention.

4. Request for a Guidance Document on Benzodiazepines

Mr. Marchese referred to the information in the packet and comments provided by Dr. Granoff.

Dr. Silverman acknowledged the legitimate role that benzodiazepines have in treating anxiety, withdrawal states, insomnia, and agitation. He also pointed out that benzodiazepine overdoses have risen between 500-600% since 2010. He said there is evidence that deaths have also tragically increased. Evidence also shows that some practitioners are not properly assessing their patients to determine if indications for the use of benzodiazepines exist. Virginia physicians have full latitude to use these medications within the standard of care as their judgment determines. Therefore, he does not recommend the establishment of an ad hoc to develop a guidance document for benzodiazepines.

Dr. Conklin stated that the CDC guidelines don't prevent a physician from prescribing any medication necessary for patient care. Unfortunately, the prescribing pendulum has swung in the opposite direction due to fear of coming before the Board for improper prescribing of controlled substances. She does not feel that a guidance document on benzodiazepines will alleviate prescribers' concerns. She is not sure how to change the physicians' perception of the Board and prescribing. It may be more productive for the state societies to address this issue with their membership.

MOTION: With no further discussion, Dr. Barner moved that a guidance document not be developed at this time. The motion was seconded by Dr. Silverman and passed unanimously.

Request from the Virginia Interfaith Center for Public Policy

Mr. Marchese referred to the public comment and email communications provided in the agenda packet on this topic. He acknowledged the importance of this issue and the efforts

being made by the Governor and state agencies to address inequities. He noted that the only mandated specific Continuing Education requirement is the 2 hours on the proper prescribing of opioids.

Dr. Conklin reminded the members of a previous meeting at which a request to mandate continuing education in human trafficking was discussed. She recalled that the Board did not have the authority to require it; to require it would take an action of the General Assembly.

Erin Barrett, JD confirmed that the Board doesn't prescribe specific continuing medical education hours unless they are required by statute. There is also a policy issue to consider in that there are many subjects that would be beneficial for licensees. The Board can't make them all a requirement; however, it can encourage licensees to obtain specific training.

Ms. Yeatts advised that Pharmacy is the only board that has legislation that authorizes it to annually determine a specific topic for continuing education. In order for the Board of Medicine be able to exercise that authority, the regulations would need to be amended. Ms. Yeatts noted that, as an alternative, the Board could provide links to implicit bias training in its Board Briefs.

Dr. Silverman supports pursuing the issue. To say that physicians understand what training they need does not apply in this area. If bias is unconscious, then to believe that a physician would think that he/she needs training is unreasonable. Second, because bias effects the health of such a large population of patients, implicit bias training becomes a broader and more generic issue. Simply suggesting implicit bias training in the Board Briefs is very unlikely to have any impact. Finding an avenue to pursue this as a requirement would be beneficial.

Dr. Barner agreed with Dr. Silverman and stated that the increased rate of maternal mortality in Black women across the nation, but especially in Virginia, is close to her heart. She supports anything that the Board decides to proceed with to address these biases such as adding topics or links to free CME to the website, publishing them in the Board Briefs, or even incentivizing obtaining continuing education on this topic.

Dr. Brown added that the issues being raised around maternal mortality are a top priority for the Governor. Dr. Brown also agreed that making requirements in response to specific legislation is a slow process. Because the Board of Medicine gets requests regularly, if interested, it should seek authority similar to the Board of Pharmacy. He also stated that he very much supports the issue of addressing implicit bias, and what he's learned is that we all have it. It's how we're wired. The best thing to do is to become aware of that fact.

MOTION: With no additional discussion, Dr. Silverman moved that Board staff compile a list of continuing education on this topic to be included in the next Board Briefs. He added that the matter should be on the agenda of the next Full Board meeting to get clear guidance on the law and identify potential options for implementation. The motion was seconded by Dr. Barner and passed unanimously.

Accreditation Council for Continuing Medical Education Project

Mr. Marchese referred to the comments received from Dr. McMahon and the information in the packet describing the ACCME process for collecting and tracking CME's.

During the discussion, the Committee was unable to identify a need for joining the project at this time.

Dr. Harp stated that MD audits require the submission of multiple printed certificates from 300+ physicians. Manual processing is quite burdensome for the staff. In 2008, the idea was floated that the Physician Profile system could house a space for physicians to record their CE, which would allow a 100% audit. That approach was not pursued because it was seen as a burden to practitioners. The difference between what the Board has considered in the past and what was presented at this meeting is that joining the ACCME would not incur expense to the Board or the practitioner. All the practitioner would have to do is provide minimal information at the time of a CME event/activity. The CME provider would report the credit hours to ACCME. Board staff would then have access to the stored data.

Mr. Marchese asked about the risk and clarified that if the Board voted to join the ACCME project, would it be the sole source of verification that licensees have to provide evidence of their CE hours.

Dr. Arnold voiced some concern about the idea that this will be at no cost to anyone as someone has to get paid for entering the data. There is also the possibility of not all data being entered.

Dr. Brown said that it was a good discussion to hear, but it is important to recognize this is an administrative decision. With Dr. Harp being tasked with performing an audit, it is up to him how to carry it out. It's important to separate out administrative decisions from policies that the Board should determine. Secondly, auditing of continuing education is not an issue unique to the Board of Medicine. In trying to find a way to streamline the auditing process, it would be preferable to find a solution that is standardized to help all boards in DHP.

Dr. Harp stated that the ACCME project does have possibilities for the audit function and provides a convenient response to the Board for licensees who choose to use it.

MOTION: After the discussion, Dr. Conklin moved to send the ACCME Project to the Full Board for consideration. The motion was seconded by Dr. Arnold and passed unanimously.

<u>Request for Comment on Physician Assistant Licensure Compact</u>

Mr. Marchese said that the Federation of State Medical Boards is requesting comment on the draft language of the Physician Assistant Licensure Compact. He noted that clarity would need to be provided regarding discipline information that is to be shared and also the requirement for a criminal background check (CBC), which Medicine does not currently require in Virginia.

Ms. Barrett stated that the language is set up similarly to the nurse compact. The only issues she noticed from a legal standpoint, in addition to what Mr. Marchese pointed out, are joint investigations which will require a Code change in 2400.2 – Confidentiality statute. Aside from that, this actually gives the licensees a compact privilege and allows movement between states without obtaining a license from each state. Ms. Yeatts agreed with Ms. Barrett's statements.

Dr. Arnold also pointed out that the Board could be assessed an open-ended fee.

--- DRAFT UNAPPROVED---

ACTION: Mr. Marchese noted that comments are due to FSMB by June 14th. The Committee unanimously agreed that Dr. Harp, along with the appropriate staff, develop talking points capturing the issues communicated during the discussion for Mr. Marchese's signature and submission to FSMB.

ANNOUNCEMENTS

No Announcements.

NEXT MEETING

September 3, 2021

ADJOURNEMENT

With no other business to conduct, the meeting adjourned at 10:32 a.m.

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Blanton Marchese
Vice-President, Chair

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William L. Harp, MD
Executive Director

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Colanthia Morton Opher
Recording Secretary

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ADVISORY BOARD ON OCCUPATIONAL THERAPY
Minutes
May 25, 2021
Electronic Meeting

The Advisory Board on Occupational Therapy held a virtual meeting on Tuesday, May 25, 2021 hosted at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Breshae Bedward, OT, Chair
Dwayne Pitre OT, Vice-Chair
Kathryn Skibek, OT

MEMBERS ABSENT: Raziuddin Ali, MD
Karen Lebo, JD, Citizen Member

STAFF PRESENT: William L. Harp, MD, Executive Director
Michael Sobowale, Deputy Director-Licensing
Colanthia M. Opher, Deputy Director - Administration
Yetty Shobo, PhD, Healthcare Workforce Data Center
ShaRon Clanton, Licensing Specialist

GUESTS PRESENT: Alexander Macaulay, JD - VOTA
Kristen Neville - AOTA

CALL TO ORDER

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

EMERGENCY EGRESS PROCEDURES

Dr. Harp announced the emergency egress instructions for those that may be attending the virtual meeting in the Perimeter Center.

ROLL CALL

The roll was called, and a quorum was declared.

APPROVAL OF MINUTES OF JANUARY 26, 2021

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

ADOPTION OF AGENDA

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

PUBLIC COMMENTS ON AGENDA ITEMS (15 minutes)

Mr. Macaulay and Ms. Neville both spoke in support of the new legislation, which makes Virginia the first state in the nation to join the Occupational Therapy Interstate Compact.

WORKFORCE DATA PRESENTATION

Yetty Shobo, PhD presented the workforce data for occupational therapists and occupational therapy assistants from the 2020 survey. The survey showed an increasing number of younger licensees, but a persistently low racial/ethnic diversity makeup in the workforce. The survey also showed a minimal negative effect of the COVID-19 pandemic on the workforce. Practitioners surveyed showed higher educational debt and stagnating income.

NEW BUSINESS

1. Report of the 2021 General Assembly

Dr. Harp provided a summary report of the newly passed laws from the 2021 General Assembly.

2. Chart of Regulatory/Policy Actions for Board of Medicine

Dr. Harp provided a review of the chart of regulatory and policy actions to be acted upon by the Board of Medicine pursuant to the laws passed in the 2021 General Assembly.

3. Amendments to Regulations for Implementation of OT Interstate Compact

The Advisory Board discussed that the regulations for the OT Interstate Compact were well covered by the law. It did consider what the fees should be for an initial OT/OTA compact privilege and a renewal of the compact privilege. The Advisory Board thought $75 would be

appropriate for both. Ms. Skibek moved to approve the fees of $75 to be included in the regulations. The motion was seconded by Mr. Pitre. By roll call vote, the motion was approved.

ANNOUNCEMENTS:

Ms. Opher reported that there are a total of 4,079 current, active occupational therapists and 1,732 occupational therapy assistants. In addition, Mr. Sobowale reported that, so far in 2021, the Board has licensed 181 occupational therapists and 171 occupational therapy assistants.

Next Meeting Date

Next scheduled meeting date: October 5, 2021 at 10:00 a.m.

ADJOURNMENT

With no other business to conduct, Ms. Bedward adjourned the meeting at 11:23 a.m.

Breshae Bedward, OT, Chair

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

ShaRon Clanton, Licensing Specialist

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ADVISORY BOARD ON MIDWIFERY
Minutes
May 28, 2021
Electronic Meeting

The Advisory Board on Midwifery held a virtual meeting on Friday, May 28, 2021 hosted at the Department of Health Professions, Perimeter Center; 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT:
Kim Pekin, CPM, Chair
Rebecca Banks, CPM, Vice-Chair
Erin Hammer, CPM
Natasha Jones, MSC, Citizen

MEMBERS ABSENT:
Ami Keatts, M.D.

STAFF PRESENT:
William L. Harp, M.D., Executive Director
Michael Sobowale, LL.M., Deputy Director
Colanthia Morton Opher, Deputy Director
Beulah Baptist Archer, Licensing Specialist

GUESTS PRESENT:
Ben Traynham, JD, MSV
Idiko Baugus, CPM
Jeni Rector, The Village Midwives
Pamela Pilch, Esq., VFAM
Karen Kelly, LCPM

Call to Order

Kim Pekin called the meeting to order at 10:05 a.m.

Emergency Egress Procedures

Dr. Harp announced the Emergency Egress Procedures.

Roll Call

The roll was called, a quorum was declared.

Approval of Minutes of January 29, 2021

Rebecca Banks moved to approve the minutes of the January 29, 2021 meeting. Erin Hammer seconded. By roll call vote, the minutes were approved as presented.

Adoption of the Agenda

Natasha Jones moved to adopt the agenda. The motion was seconded by Rebecca Banks. By roll call vote, the agenda was approved as presented.

Public Comment on Agenda Items (15 Minutes)

Pamela Pilch, from Virginia Families for Access to Midwifery (VFAM) asked the Advisory Board keep their organization abreast of regulatory Licensed Certified Midwives legislation.

Ben Traynham, Esq., provided a brief discussion of House Bill 1913, which advocates for and protects doctors seeking a safe haven for assistance when reporting effects of career fatigue.

New Business

1. Summary of Legislation from the 2021 General Assembly

Dr. Harp discussed bills of interest that were passed into law in the 2021 General Assembly with particular attention to the legislation providing for Virginia to join the Occupational Therapy Interstate Compact. He also specially highlighted HB1817 which establishes autonomous practice for certified nurse midwives with 1,000 practice hours.

2. Chart of regulatory and Policy Actions for Board of Medicine

Dr. Harp briefly reviewed the calendar dates of future policy and regulatory actions to be taken by the Board of Medicine subsequent to various bills from the 2021 General Assembly.

3. HB 1953 Licensed Certified Midwives

During a discussion of this legislation, Karen Kelly, LCPM, was called upon by the Chair to provide clarification on the education and American Midwifery Certification Board (AMCB) credentials for licensed certified midwives and certified nurse midwives. She explained that hospital experience is not required for licensed certified midwives.

4. Update from the Ad Hoc Committee on Guidance Document 85-10

Kim Pekin led the discussion. Mr. Sobowale informed the Advisory Board that the final changes approved by the Ad Hoc Committee have been completely incorporated into the

final revised document. Dr. Harp explained that a thirty (30) day public comment period takes place prior to posting of the final guidance document.

Announcements

Ms. Archer provided the licensing report. The Advisory Board has a total of 100 licensed midwives, 72 of which are currently in Virginia, and 27 current, active midwives have out-of-state addresses. There is 1 inactive out-of-state licensee.

Kim Pekin announced that her term on the Advisory Board will end in June 2021. Dr. Harp advised that she may continue to serve on the Advisory Board until a replacement is named.

Next Meeting Date

The next scheduled meeting date and time is October 8, 2021, at 10:00 a.m.

Adjournment

With no other business to conduct, Kim Pekin adjourned the meeting at 10:52 a.m.

Kim Pekin, CPM, Chair

William L. Harp, Executive Director

Beulah Baptist Archer, Licensing Specialist

<< DRAFT >>

ADVISORY BOARD ON SURGICAL ASSISTING
Minutes
June 1, 2021

The Advisory Board on Surgical Assisting held a virtual meeting on Tuesday, June 1, 2021 hosted at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Deborah Redmond, LSA, Chair
Thomas Gochenour, LSA
Nicole Meredith, RN
Jessica Wilhelm, LSA

MEMBERS ABSENT: Srikanth Mahavadi, MD

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

GUESTS PRESENT: Jerry Gentile, DPB
Brent Rawlings, JD, VHHA
Steven Hammond
Ben Traynam, JD, MSV
Ashley Smith

Call to Order

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

Emergency Egress Procedures

Dr. Harp announced the emergency egress instructions.

Roll Call

The roll was called; a quorum was declared.

Approval of Minutes

Nicole Meredith moved to approve the minutes of the February 2, 2021 meeting. Jessica Wilhelm seconded. By roll call vote, the minutes were approved with a minor amendment to the date of the next scheduled meeting listed on page 3.

Adoption of Agenda

Thomas Gochenour moved to adopt the agenda. Nicole Meredith seconded the motion. By roll call vote, the agenda was approved as presented.

Public Comment on Agenda Items

None

New Business

1. Legislation from the 2021 General Assembly

   Elaine Yeatts provided a report from the 2021 General Assembly and highlighted legislation that was of interest to the Advisory Board.

2. Regulatory and Policy Actions for the Board of Medicine

   Elaine Yeatts reviewed the calendar dates of future policy and regulatory actions to be taken by the Board of Medicine pursuant to various bills passed by the 2021 General Assembly.

3. Regulatory Amendments for Certification of Surgical Technologists

   Elaine Yeatts discussed the new legislation, which elevated surgical technologists from a registered profession to a certified one. The legislation contains a "grandfathering" provision, which provides a pathway for those who have been practicing as a surgical technologist within the six months prior to July 1, 2021. This is in lieu of a credential issued by the NBSTSA or completion of an accredited training program. To qualify for grandfathering, a surgical technologist must apply for certification with the Board by December 31, 2021.

   Ms. Yeatts presented a draft of proposed amendments to conform Board regulations to the changes in the law for the certification of surgical technologists.

4. Proposed Regulations Pursuant to a Notice of Intended Regulatory Action (NOIRA)

   Ms. Yeatts presented the proposed amendments to the Regulations for Licensure of Surgical Assistants for discussion, along with the regulatory amendments for Certification of Surgical Technologists, pursuant to a Notice of Intended Regulatory

Action that will be published for public comment. The proposed amendments establish requirements for maintenance of credential at the time of renewal of licensure or certification. As worded, those who were grandfathered in will be exempt from a current "certification credential" at the time of renewal.

After discussion, Thomas Gochenour moved to recommend adoption of the proposed amendments to the Regulations for Licensed Surgical Assistants and Certified Surgical Technologists to the Board of Medicine. Jessica Wilhelm seconded. By roll call vote, the motion was approved.

Announcements

Licensing Statistics:

Delores Cousins reported that there are 361 current, active surgical assistants and 235 current, active surgical technologists. Michael Sobowale added that there were 52 newly licensed surgical assistants and 3 newly registered surgical technologists in the 1st quarter of 2021.

Next Scheduled Meeting:

Deborah Redmond announced that the next scheduled meeting will be held on Tuesday, October 12, 2021 @ 10:00am

Adjournment

With no other business to conduct, Deborah Redmond adjourned the meeting at 11:32am.

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Deborah Redmond, LSA, Chair

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William L. Harp, MD, Executive Director

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Delores Cousins, License Specialist

Virginia Department of
Health Professions
Board of Health Professions

Board of Health Professions
Full Board Meeting
August 20, 2020 at 11:00 a.m.
Virtual WebEx Meeting
9960 Mayland Dr, Henrico, VA 23233

DRAFT

Due to the COVID-19 declared state of emergency and consistent with Amendment 28 to HB29 (Budget Bill for 2018-2020) and the applicable provisions of § 2.2-3708.2 in the provisions of Freedom of Information Act, the Board convened a virtual meeting to consider such regulatory and business matters as presented on the agenda necessary for the board to discharge its lawful purposes, duties and responsibilities

An audio file of this meeting may be found here.

In Attendance

Virtual- Sahil Chaudhary, Citizen Member
Virtual- Helene Clayton-Jeter, OD, Board of Optometry
Virtual- Kevin Doyle, EdD, LPC, LSATP, Board of Counseling
Virtual- Louise Hershkowitz, CRNA, MSHA, Board of Nursing
In-Person- Allen Jones, Jr., DPT, PT, Board of Physical Therapy, Board Chair
Virtual- Derrick Kendall, NHA, Board of Long-Term Care Administrators
Virtual- Ryan Logan, RPh, Board of Pharmacy
Virtual- Kevin O'Connor, MD, Board of Medicine
Virtual- Martha Rackets, PhD, Citizen Member
Virtual- John Salay, MSW, LCSW, Board of Social Work
Virtual- Herb Stewart, PhD, Board of Psychology
In-Person- James Wells, RPh, Citizen Member

Absent

Sheila E. Battle, MHS, Citizen Member
Louis Jones, FSL, Board of Funeral Directors and Embalmers
Steve Karras, DVM, Board of Veterinary Medicine
Alison King, PhD, CCC-SLP, Board of Audiology & Speech-Language
Maribel Ramos, Citizen Member
Vacant-Board of Dentistry

DHP Staff

Virtual- Barbara Allison-Bryan, MD, Deputy Director DHP
Virtual- David Brown, DC, Director DHP
In-Person- Elizabeth A. Carter, PhD, Executive Director BHP
Virtual- Jay Douglas, MSM, RN, CSAC, FRE, Executive Director, Board of Nursing
In-Person- Laura Jackson, MSHSA, Operations Manager BHP
Virtual- Yetty Shobo, PhD, Deputy Executive Director BHP

DHP Staff Cont'd.

Virtual- Corie E. Tillman-Wolf, JD, Executive Director Boards of Funeral Directors and Embalmers, Long-Term Care Administrators and Physical Therapy

Virtual- Elaine Yeatts, Senior Policy Analyst DHP

OAG

Virtual- Charis Mitchell, Assistant Attorney General

Virtual Attendees

Ashley Wright
Baron Glassgow
Ben Traynham
C. Barrineau
James Pickral
Jo Twombly
Lauren Schmitt
Marie Rodgriguez
Mark
Melika Zand
Sarah Giardenelli
Sheila
Traci Hobson
Unidentified Call-in User 11
Unidentified Call-in User 12
Unidentified Call-in User 13
Unidentified Call-in User 7
Unidentified Call-in User 8

Call to Order

Dr. Jones, Jr., Board Chair
Time: 11:04 a.m.
Quorum: Established

Agenda

The agenda was approved by acclamation as presented.

Public Comment

No public comment was received by the Board office prior to the August 19, 2020 5:00 p.m. deadline.

Approval of Minutes

On properly seconded motion by Dr. Clayton-Jeter, the minutes from the June 25, 2020 meeting were approved as presented.

Director's Report

Dr. Brown stated that the Department has held several virtual meetings since the onset of COVID-19 and the closing of the Perimeter Center Building to the public. DHP is following government mandated protocols to keep individuals safe and leveraging teleworking to the extent possible. The Enforcement and APD divisions and the Boards are keeping abreast of the incoming cases and disciplinary hearings.

Legislative and Regulatory Report

Ms. Yeatts provided an overview of current legislative and regulatory actions. She also noted that the change made to the Boards Bylaws (Guidance document 75-4) are effective today.

Board Chair Report

Dr. Jones, Jr., thanked Dr. Stewart for filling in as Chair for the June 25, 2020 meeting. He thanked staff for all their efforts in keeping the boards up and running during this pandemic. He noted that the Fall election of officers will usher in the new position of 2nd Chair.

Board Study Into the Need to Regulate Diagnostic Medical Sonographer

Mr. Wells provided an overview of the Diagnostic Medical Sonographer study findings. He advised that after reviewing the study materials that the Regulatory Research Committee deemed that Criterion One: Risk for Harm to the Consumer was not met. There was insufficient evidence of harm attributable to the practice of diagnostic medical sonography by individuals credentialed to justify their regulation by the state. However, the Regulatory Research Committee did have concern about the use of 3-D ultrasound medical devices by unlicensed people taking "Keepsake" fetal sonograms. This matter is being referred to the full Board for further discussion.

Motion: Dr. Doyle moved and Dr. O'Connor seconded acceptance of the Regulatory Research Committee's findings.
Discussion and Amended Motion: Upon discussion, an amendment was made to the original motion to table the discussion of the fetal imaging concerns to the November 10, 2020 agenda. The motion was properly seconded, all members voted in favor, none opposed.

Board Study into the Need to Regulate Naturopathic Doctors

Mr. Wells provided an overview of the Naturopathic Doctor study findings. He stated that the Committee found sufficient evidence of all six criterion and recommended, under criterion seven, licensure of the profession. The Committee requested that the scope of practice include physical exams, ordering lab tests and interpretation of lab tests, ordering x-rays or other videography but with the interpretation by another qualified practitioner. Further, there should be no prescriptive authority for legend drugs. The profession should be regulated under the Board of Medicine. Also, lay practitioners who are not licensed under this chapter should not be precluded from (i) providing natural health consulting on Ayurvedic medicine, traditional naturopathic therapies, herbalism, nutritional advice, or homeopathy, or (ii) from selling vitamins and herbs, provided the person or lay practitioner does not use any title prohibited under § 54.1-2956.14.

A motion to approve the Committees recommendations was made by Mr. Salay and properly seconded.

After discussion and review of the Criteria, the Board voted on the Committee's recommendations. Five members (Dr. Doyle, Ms. Hershkowitz, Mr. Salay, Dr. Rackets, and Mr. Wells) were in favor of licensure, six members (Dr. O'Connor, Dr. Clayton-Jeter, Mr. Logan, Dr. Jones, Jr., Dr. Stewart, Mr. Chaudhary) opposed licensure. The motion failed.

Executive Director's Report

Due to time constraints, Dr. Carter requested that the Executive Director's Report be carried over to the November 10, 2020 meeting.

Healthcare Workforce Data Center

Due to time constraints, Dr. Carter requested that the Healthcare Workforce Data Center report also be carried over to the November 10, 2020 meeting.

Individual Board Reports

Board of Medicine - Dr. O'Connor stated that the Board cancelled all June meetings and had just recently begun board hearings. He provided that disciplinary hearings are stacking up so the October meeting
(hopefully to be held in person) will have a full schedule to include informal conferences. Dr. O'Connor commended Board staff for keeping up with credentialing of the boards professions.

Board of Nursing - Ms. Hershkowitz (Attachment 2)

Board of Optometry - Dr. Clayton-Jeter (Attachment 3)

Board of Audiology & Speech-Language Pathology - no report

Board of Counseling - Dr. Doyle (Attachment 4)

Board of Funeral Directors & Embalmers - no report

Board of Long-Term Care Administrators - no report

Board of Pharmacy - Mr. Logan reported that the Board of Pharmacy held a virtual meeting and public hearing on June 16, 2020. He stated that the Board is receiving approximately 100 applications for registered patients weekly.

Board of Psychology - Dr. Stewart (Attachment 5)

Board of Social Work - Mr. Salay (Attachment 6)

Board of Physical Therapy - Dr. Jones, Jr. (Attachment 7)

Board of Veterinary Medicine - no report

Board of Dentistry - vacant

New Business	There was no new business.
Next Full Board Meeting	Dr. Jones, Jr. advised the Board that the next meeting is scheduled for November 10, 2020 at 10:00 a.m.
Adjourned	The meeting adjourned at 1:26 p.m.
Vice Chair Signature	Allen Jones, Jr., DPT ________________________________ ____/____/____
Board Exec. Director Signature	Elizabeth A. Carter, PhD ________________________________ ____/____/____

VIRGINIA BOARD OF NURSING
COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
VIRTUAL BUSINESS MEETING
MINUTES
December 9, 2020

TIME AND PLACE: The virtual meeting of the Committee of the Joint Boards of Nursing and Medicine via Webex was called to order at 9:00 A.M., December 9, 2020.

Due to COVID-19 declared state of emergency and consistent with Amendment 28 to HB29 (Budget Bill for 2018-2020) and the applicable provision of §2.2-3708.2 in the Freedom of Information Act, the Committee convened a virtual meeting to consider such regulatory and business matters as was presented on the agenda for the Committee to discharge its lawful purposes, duties, and responsibilities.

COMMITTEE MEMBERS PARTICIPATED VIRTUALLY:
Louise Hershkowitz, CRNA, MSHA; Chair
Ann Tucker Gleason, PhD
Karen Ransone, MD
Lori Conklin, MD
David Archer, MD

MEMBERS ABSENT: Marie Gerardo, MS, RN, ANP-BC

ADVISORY COMMITTEE MEMBERS PARTICIPATEDG VIRTUALLY:
Kathleen Bailey, RN, CNM, MA, MS
Kevin E. Brigle, RN, NP
David Alan Ellington, MD
Thokozeni Lipato, MD
Stuart Mackler, MD
Janet L. Setnor, CRNA

STAFF PARTICIPATED VIRTUALLY:
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
Stephanie Willinger; Deputy Executive Director for Licensing; Board of Nursing
Huong Vu, Executive Assistant; Board of Nursing
Sally Ragsdale, Discipline Specialist

OTHERS PARTICIPATED VIRTUALLY:
Erin Barrett, Assistant Attorney General; Board Counsel
David Brown, DO, Director; Department of Health Professions

Barbara Allison-Bryan, MD; Chief Deputy, Department of Health Professions
Elaine Yeatts, Policy Analyst; Department of Health Professions
William L. Harp, MD, Executive Director; Board of Medicine
Yetty Shobo, PhD, Deputy Executive Director; Board of Health Professions

PUBLIC PARICIPATED VIRTUALLY:

Jerry J. Gentile, Department of Planning Budget
Gerald C. (Jerry) Canaan, II, Esq. Byrne Legal Group
Ben Traynham, Hancock, Daniel & Johnson, PC
Valentina Vega, Health Policy Analyst, Medical Society of Virginia
Kassie Schroth, Virginia Association of Nurse Anesthetists
Juliane Condrey, Lobbyist, Virginia Public Access Project (VPAP)
JoAnne Collins
Scott Castro, Director of Health Policy, Medical Society of Virginia

ESTABLISHMENT OF A QUORUM:

Ms. Hershkowitz called the meeting to order and established that a quorum consisting of 5 members was present.

ANNOUNCEMENT:

Ms. Hershkowitz noted the announcement as stated in the Agenda that was provided electronically:

- Lori Conklin, MD replaced Nathaniel Ray Tuck, Jr., DC
- David Archer, MD replaced Kenneth Walker, MD

Ms. Hershkowitz welcomed Drs. Conklin and Archer to the Committee of the Joint Boards. Both Drs. Conklin and Archer provided their brief background information.

There were no additional announcements.

REVIEW OF MINUTES:

Ms. Hershkowitz stated that staff provided the following document electronically:

- **A1** October 21, 2020 Business Meeting
- **A2** October 21, 2020 Formal Hearing

Ms. Hershkowitz asked of the Committee have any questions regarding the minutes. Dr. Ransone indicated that first name of Dr. Tuck was spelled incorrectly on the October 21, 2020 Business Meeting minutes. Staff will make the correction.

Dr. Ransone moved to accept the minutes as presented and amended. The motion was properly seconded. A roll call was taken and the motion carried unanimously.

PUBLIC COMMENT:

Ms. Hershkowitz said that as indicated in the meeting notice on Regulatory Townhall and in the agenda package, comments will be received during this public comment period from those persons who submitted an email to Huong Vu no later than 8 am on December 9, 2020 indicating that they wish to offer comment.

Ms. Hershkowitz asked if any email requests had been received. Ms. Vu reported that no email requests for public comment were received as of 8 am today and no one is present on the call to make comment.

DIALOGUE WITH AGENCY DIRECTOR:

Dr. Brown reported the following:
Staffing issues – VDH and Virginia Hospital Healthcare Association initiated a recent discussion about staffing issues that are emerging due to the surge in COVID-19 at various facilities and other states.
Emerging issues are:

- Facilities have to quarantine clinical staff
- Staff COVID-19 exposure
- Staff burn out
- Increase in retiring clinical staff during COVID-19
- Nurses are termination full-time employment in order to be hired by Staffing Agencies that offer significantly higher compensation

DHP encourages retired practitioners to join the Medical Reserved Corps (MRC). VDH will send a communication to selected licensees to recruit to the MRC soon. Also nursing and medical students are being looked at to help with the surge.

Marijuana – Virginia has an active medical marijuana program. Four pharmaceutical processors have been permitted, two of which are making the products available to patients who receive certifications from providers who are registered with the Board of Pharmacy. The big change in the last year was that the General Assembly (GA) removed the low THC potency cap on medical marijuana products in 2019.

Legislation was introduced in the upcoming GA allowing marijuana flowers to be distributed in Virginia. In addition, the Governor has endorsed Virginia moving forward with adult use of recreational marijuana.

The Secretary of Health workgroup, the Secretary of Agriculture workgroup, and the Joint Legislative Audit & Review Commission (JLARC) all agreed that medical marijuana and recreational marijuana should be regulated by the same state agency.

Dr. Allison-Bryan reported on the COVID-19 vaccines as follows:
- Two vaccines have moved from Phase Three to Active Phase for emergency use authorization and will be available within next week
- Detailed information regarding distribution of the vaccines is available in a 50-page report on the VDH website
- Healthcare workers who have immediate contact (within 6 feet) with COVID patients, workers and clients in long-term care facilities will be given the vaccines first
- CVS and Walgreen pharmacists have signed up to go into long-term care facilities to administer the vaccines (referred to as closed point distribution)

Dr. Allison-Bryan encouraged practitioners to sign up with Medical Reserved Corp to distribute the vaccines. She has done so.

Dr. Conklin expressed concern regarding absence of THC potency cap in patients undergoing anesthesiology as psychotropic drugs interact with anesthesia medications.

Dr. Brown said that he has not heard of discussion regarding a cap and added that he is aware that the Medical Advisory Committee is reviewing the science on the health effects of marijuana.

Dr. Conklin asked who do people notify about the adverse effects of the vaccine?

Dr. Allison-Bryan noted that in the trial, adverse effects were very rare. She suspected that this information will be distributed at the time of vaccine administration.

LEGISLATION/ REGULATIONS:

Ms. Hershkowitz stated that staff have provided the following documents electronically:
- **B1** Regulatory Update
- **B2** Report of the 2021 General Assembly

Ms. Hershkowitz invited Ms. Yeatts to proceed.

Ms. Yeatts reviewed the chart of Regulatory Actions as provided in the agenda. She reported that the conversion therapy legislation continues to move through the process.

Ms. Hershkowitz inquired as to how many waivers for electronic prescribing have been approved. Ms. Willinger reported that, at the last meeting, 233 waivers had been approved.

Ms. Yeatts reviewed the report of 2021 General Assembly that was provided in the agenda noting that two bills were introduced that DHP is aware of and both bills have direct impact on nurse practitioners (NP).

HB1737 (Nurse practitioners; practice without a practice agreement)

Ms. Yeatts stated that the bill reduces the requirement in the number of years of full-time clinical experience from five years to two that NPs must have to be eligible to practice without a practice agreement. Ms. Yeatts noted that the 2-year clinical practice requirement is currently in effect as an Executive Order provision due to COVID-19. Ms. Yeatts added that the impact of this bill would be an increase in the number NPs eligible to apply for the autonomous practice designation on their NP licenses.

HB1747 (Clinical nurse specialist; licensure of nurse practitioners as specialists, etc.)

Ms. Yeatts explained that this bill will allow an advance practice registered nurse who is registered by the Board of Nursing as a clinical nurse specialist (CNS) to be licensed as a NP in the category of a clinical nurse specialist with prescriptive authority and will be regulated by the Committee of the Joint Boards of Nursing and Medicine.

Dr. Conklin inquired as to the title of the CNS, is it required of CNS to take specialized testing in order to obtain the distinction or years of experience in this specialty.

Ms. Douglas replied that currently as part of eligibility for registration as a CNS, an individual has to take a national clinical nurse specialist certification examination. The educational preparation does include a pharmacology component. Ms. Douglas added that, at the national level, CNSs are not licensed as NPs and in many states CNSs have prescriptive authority and they are regulated under the sole regulation of the Boards of Nursing. She also reported that there are about 400 CNSs in Virginia and the number has been steady for many years.

Mr. Brigle asked if there has been any complaint about the reduction from five years to two years since the emergency waiver was issued. Ms. Douglas stated that she was not aware of any. Dr. Hills added that there have only been a handful of inquiries regarding the waiver.

POLICY FORUM: Dr. Carter, Healthcare Workforce Data Center (HWDC) Executive Director, and Dr. Shobo, PhD, HWDC Deputy Executive Director

Ms. Hershkowitz said that Drs. Carter and Shobo have provided the following reports electronically:

- Virginia's Licensed Nurse Practitioner Workforce: 2020

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

Ms. Hershkowitz stated that staff requested Committee and Advisory Members to submit questions in advance regarding the reports but none were received. Ms. Hershkowitz asked if Committee members have any questions for Dr. Shobo about the reports. None was received.

Ms. Herhskowitz said that the reports will be presented to the full Board of Nursing at its next business meeting. Ms. Hershkowitz thanked Drs. Carter and Shobo for their work.

NEW BUSINESS:

Board of Nursing Executive Director Report:

- Ms. Gerardo, the Chair of the Committee of the Joint Boards of Nursing and Medicine, was elected as Board of Nursing President at the December 2, 2020 meeting. The President's term will begin on January 1, 2021.
- 1,070 autonomous practice designations were issued so far. The Board received some inquiries regarding workforce issues such as facilities wanting to recruit retired NPs back into the workforce with the current COVID-19 situation. There are about 2,150 NPs whose licenses have been expired within the last four years and remain expired compared to about 20,000 registered nurses whose licenses have expired. There are about five NPs in the voluntary restricted licensure category.
- Ms. Willinger has been working with NCSBN regarding uploading advanced practice registered nurse licensure and discipline data into the national database called NURSYS. The target date is planned for the end of this year to have a test file ready for uploading. This will allow states to verify NP licensure in Virginia for applicants and discipline information.
- Legislation passed last year that Ms. Douglas and Dr. Harp were involved in surveying contiguous states with the idea of pursuing reciprocity agreements. Ms. Douglas surveyed states in which Boards of Nursing regulate NPs and the report has been compiled and submitted to the General Assembly. Responses received indicate interest in participation in the NCSBN APRN compact as the avenue for ease of mobility state to state and permanent practice across state lines.
- The Board has been receiving written and phone inquiries regarding DEA number, telehealth, family NPs serving as hospitalists, and autonomous practice requirements. NPs continue to have difficulty in obtaining verification from physicians for their five years of practice under a collaborative agreement because physicians either move or retire. The Board is looking at documentation alternatives that NPs can provide.

Ms. Hershkowitz asked if any Committee or Advisory Members have any questions for Ms. Douglas.

Dr. Conklin asked how the Board can make sure that no sub-standard care will be provided by NPs who only have two years of supervision before autonomous practice can occur.

Ms. Douglas stated that, as with all professions, the quality of the program does vary but the required clinical components for advanced practice education programs do remain the same. Ms. Douglas added that the national certifying bodies assess the NP's competency through the certification examination process.

Ms. Hershkowitz was in agreement with Ms. Douglas and noted that the requirements for NP competency are being revised.

Dr. Hills reiterated that the determination of competency is through the certifying body.

Ms. Bailey said that although education changes but the requirements for certification remain the same.

Ms. Setnor noted that the requirement for certification is more rigorous. She also reminded that safety is not a concern in other states in which NPs have two or less years of experience.

C1 Revision of Guidance Document (GD) 90-11
Continued Competency Violations for Nurse Practitioners:
Ms. Hershkowitz stated that staff has provided the electronic copy of GD 90-11 and asked Dr. Hills to proceed.

Dr. Hills noted that staff are recommending editorial changes that assist with implementation.

Dr. Gleason asked if the statement about missing continuing education (CE) hours is not counted toward the current year required CE hours for renewal. Ms. Douglas replied that the standard language of the Confidential Consent Agreement (CCA) will include that statement.

Dr. Ransone moved to accept the revision of GD 90-11 as presented. The motion was properly seconded by Dr. Gleason. A roll call was taken and the motion carried unanimously.

Re-appointment of Advisory Committee Members:
Ms. Hershkowitz stated the following Advisory Committee Members are eligible for re-appointment with their first term ending in 2020:

- Mr. Kevin Brigle, RN, NP
- Mr. Mark Coles, RN, BA, MSN, NP-C
- Dr. David Ellington, MD
- Dr. Stuart Mackler, MD

Ms. Hershkowitz said that pursuant to 18VAC90-30-30(B), appointment to the advisory committee shall be for four years; members may be appointed for one additional four-year period. Ms. Hershkowiz noted that all four Advisory Members have expressed interest in re-appointment to the Advisory Committee.

Dr. Ransone moved to re-appointed all four Advisory Members as presented to the Advisory Committee. The motion was properly seconded by Dr. Conklin. A roll call was taken and the motion carried unanimously.

ENVIRONMENTAL SCAN: Ms. Hershkowitz asked for the updates from the Advisory Committee Members.

Mr. Brigle shared that the full practice authority via the autonomous practice designation has expedited the credentialing process at VCU.

Ms. Bailey shared that the Virginia Affiliate of the American College of Nurse Midwives (ACNM) has two policy issues that will be introduced to the 2021 General Assembly in an effort to improve access to healthcare, they are:

1 Independent practice for Certified Nurse-Midwives (CNMs) – currently in Virginia, CNMs must practice in consultation with a physician through a practice agreement. 28 states do not require this agreement. The independent practice will expand the ability of CNMs to practice in rural and underserved areas without this restrictive requirement
2 Licensure for Certified Midwives (CMs) – in the US, CMs have the same education as CNMs and sit for the same certification examination.

Ms. Setnor shared that several hundred CRNAs volunteered to be in the Medical Reserved Corps doing COVID testing and will stand by to help with vaccination process. Ms. Hershkowitz noted that she herself has volunteered with the Medical Reserved Corps to help out.

The Advisory Committee Members, Dr. Harp and Ms. Yeatts, left the meeting at 10:07 A.M.

RECESS: The Committee recessed at 10:07 A.M.
RECONVENTION: The Committee reconvened at 10:15 A.M.

AGENCY SUBORDINATE RECOMMENDATION CONSIDERATION

Renee Marie Messina Essary, LNP 0024-168282

Ms. Essary did not appear but written response was submitted.

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)(28) of the *Code of Virginia* at 10:17 A.M., for the purpose to reach a decision in the matter of Renee Marie Messina Essary. Additionally, Dr. Gleason moved that Ms. Douglas, Dr. Hills, Ms. Willinger, Ms. Vu, Ms. Ragsdale and Ms. Barrett 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 properly seconded by Dr. Ransone. A roll call was taken and the motion carried unanimously.

RECONVENTION: The Board reconvened in open session at 10:31 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 properly seconded by Dr. Ransone. A roll call was taken and the motion carried unanimously.

Dr. Conklin moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to reprimand Renee Marie Messina Essary. The motion was properly seconded by Dr. Ransone. A roll call was taken and the motion carried unanimously.

CONSENT ORDER CONSIDERATION

Jennifer Renae Perry Battani, LNP Reinstatement Applicant 0024-164919

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)(28) of the *Code of Virginia* at 10:34 A.M., for the purpose to reach a decision in the matter of Jennifer Renae Perry Battani. Additionally, Dr. Gleason moved that Ms. Douglas, Dr. Hills, Ms. Willinger, Ms. Vu, Ms. Ragsdale and Ms. Barrett 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 properly seconded by Dr. Ransone. A roll call was taken and the motion carried unanimously.

RECONVENTION: The Board reconvened in open session at 10:50 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 properly seconded by Dr. Conklin. A roll call was taken and the motion carried unanimously.

Dr. Conklin moved that Committee of the Joint Boards of Nursing and Medicine to reject the consent order of Jennifer Renae Perry Battani. The motion was properly seconded by Dr. Ransone. A roll call was taken and the motion carried with four votes in favor of the motion. Dr. Gleason opposed the motion.

POSSIBLE SUMMARY SUSPENSION CONSIDERATION

James Schliessmann, Senior Assistant Attorney General, joined the meeting to present the case regarding Charmayne Lanier-Eason, LNP (cases # 194486 and 200282).

Ms. Hershkowitz asked Mr. Schliessmann to proceed with the presentation of the case.

Dr. Ransone moved to summarily suspend the license of Charmayne L. Lanier-Eason to practice as a nurse practitioner in the Commonwealth of Virginia. The motion was properly seconded by Dr. Conklin. A roll call was taken and the motion carried unanimously.

ADJOURNMENT: As there was no additional business, the meeting was adjourned at 11:02 A.M.

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

VIRGINIA BOARD OF NURSING
COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
VIRTUAL BUSINESS MEETING
MINUTES
April 21, 2021

TIME AND PLACE: The virtual meeting of the Committee of the Joint Boards of Nursing and Medicine via Webex was called to order at 9:00 A.M., April 21, 2021.

Due to COVID-19 declared state of emergency and consistent with Amendment 28 to HB29 (Budget Bill for 2018-2020) and the applicable provision of §2.2-3708.2 in the Freedom of Information Act, the Committee convened a virtual meeting to consider such regulatory and business matters as was presented on the agenda for the Committee to discharge its lawful purposes, duties, and responsibilities.

COMMITTEE MEMBERS PARTICIPATED VIRTUALLY:
Marie Gerardo, MS, RN, ANP-BC; Chair
Ann Tucker Gleason, PhD
Louise Hershkowitz, CRNA, MSHA
David Archer, MD
Lori Conklin, MD
Karen Ransone, MD

MEMBERS ABSENT: None

ADVISORY COMMITTEE MEMBERS PARTICIPATEDG VIRTUALLY:
Kevin E. Brigle, RN, NP
Mark Coles, RN, BA, MSN, NP-C
David Alan Ellington, MD
Sarah Hobbgood, MD
Stuart Mackler, MD
Janet L. Setnor, CRNA

STAFF PARTICIPATED VIRTUALLY:
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, Executive Assistant; Board of Nursing
Sally Ragsdale, Discipline Specialist

OTHERS PARTICIPATED VIRTUALLY:
Erin Barrett, Assistant Attorney General; Board Counsel
David Brown, DO, Director; Department of Health Professions
Barbara Allison-Bryan, MD; Chief Deputy, Department of Health Professions

Elaine Yeatts, Policy Analyst; Department of Health Professions
William L. Harp, MD, Executive Director; Board of Medicine
Ann Tiller, Board of Nursing Compliance Manager
Patricia Dewey, RN, BSN; Board of Nursing Case Manager
Christine Smith, RN, MSM; Nurse Aide/RMA Education Program Manager
Randall Mangrum, DNP, RN; Nursing Education Program Manager

PUBLIC PARICIPATED VIRTUALLY:

W. Scott Johnson, Esquire/Hancock, Daniel & Johnson, PC
Clark Barrineau, Assistant Vice President of Government Affair, Medical Society of Virginia (MSV)
Gerald C. (Jerry) Canaan, II, Esq. Byrne Legal Group
Julianne Condrey, Lobbyist, Virginia Public Access Project (VPAP)
Kassie Schroth, Virginia Association of Nurse Anesthetists (VANA)
Richard Grossman, Virginia Council of Nurse Practitioners (VCNP)
Becky Bower-Lanier,
Cynthia Ward
Sarah W. Taylor
Lisa Jamerson
Erin M. Smith
Cindy Difranco
Komkwuan Paruchabutr
14349****16
17032****20
18048****27
18048****30
18043****59
14436****66
18048****77

ESTABLISHMENT OF A QUORUM:

Ms. Gerardo called the meeting to order and established that a quorum consisting of six members was present.

ANNOUNCEMENT:

Ms. Gerardo noted the announcement as stated in the Agenda that was provided electronically:

- Resignation of CNM Advisory Committee Member, Kathleen Bailey, RN, CNM, MA, MS due to relocation

There were no additional announcements.

REVIEW OF MINUTES:

Ms. Gerardo stated that staff provided the following document electronically:

- **A1** December 9, 2020 — Business Meeting
- **A2** February 8, 2021 — Formal Hearing
- **A3** February 17, 2021 — Formal Hearing

Ms. Gerardo asked of the Committee have any questions regarding the minutes. None was noted.

Dr. Ransone moved to accept the minutes as presented. The motion was properly seconded by Dr. Conklin. A roll call was taken and the motion carried unanimously.

PUBLIC COMMENT:

Ms. Gerardo said that as indicated in the meeting notice on Regulatory Townhall and in the agenda package, comments will be received during this public comment period from those persons who submitted an email to Huong Vu no later than 8 am on April 21, 2021 indicating that they wish to offer comment.

Ms. Gerardo noted that written comment from Medical Society of Virginia was received via email and the Committee will take into consideration. Ms. Gerardo asked if any additional email requests had been received. Ms. Vu reported that no additional email requests for public comment were received as of 8 am today and no one is present on the call to make comment.

DIALOGUE WITH AGENCY DIRECTOR:

Dr. Brown reported the following:
Marijuana – effective July 1, 2021, possession of marijuana in Virginia will be legal. The 2021 General Assembly (GA) also passed the bill allowing marijuana flowers to be distributed in Virginia.

The 2022 Session of the General Assembly (GA) will consider the new cannabis authority to regulate recreational and medical marijuana with the anticipation that Board of Pharmacy will turn the authority over to the new administration in 2023.

Dr. Allison-Bryan reported on the COVID-19 vaccines as follows:

- Virginia is now in Phase 2
- 25% plus of adult Virginians have received vaccination
- 5.5 millions dosages were administered
- Vaccine hesitancy was noted from political and not racial discrepancy

Dr. Archer asked who will take the lead in educating practitioners about marijuana's dosage and how it can be used.

Dr. Brown said that he is not certain but anticipating that pharmacists will take the lead.

LEGISLATION/
REGULATIONS:

Ms. Gerardo stated that staff have provided the following documents electronically:

- **B1** Regulatory Update
- **B2** Report of the 2021 General Assembly
- **B3** Unprofessional Conduct/Conversion Therapy (18VAC-90-30)

Ms. Gerardo invited Ms. Yeatts to proceed.

Ms. Yeatts noted that **B1** and **B3** are provided for information only, no action needed.

Ms. Hershkowitz inquired if the Conversion Therapy regulations are consistent with other boards. Ms. Yeatts replied yes.

Ms. Yeatts reviewed the report of 2021 General Assembly (**B2**) that was provided in the agenda noting the following bills:

HB 1737 (Nurse practitioners; practice without a practice agreement) - reduces from five to two the number of years of full-time clinical experience a nurse practitioner must have to be eligible to practice without a written practice agreement. The bill has an expiration date of July 1, 2022.

HB 1747 Clinical nurse specialist; licensure of nurse practitioners as specialists – effective July 1, 2021. Changes from the requirement of registration as clinical nurse specialists to the licensure as nurse practitioners in the category of clinical nurse specialists by the Boards of Medicine and Nursing and authorize prescriptive authority. Practice Agreement is required.

HB 1817 Certified nurse midwives; practice – eliminated the requirement that certified nurse midwives practice pursuant to a practice agreement who has practiced 1,000 hours or more.

HB 1953 Licensed certified midwives; clarifies definition, licensure – directs the Boards of Medicine and Nursing to establish criteria for the licensure and renewal of a license as a certified midwife, and requires licensed certified midwives to practice in consultant with a license physician in accordance with a practice agreement. The bill also directs DHP to convene a work group to study the licensure and regulation of certified nurse midwives, certified midwives, and certified professional midwives, and to submit its findings and conclusions to the Governor and the General Assembly by November 1, 2021.

SB 1189 Occupational therapists; licensure – Authorizes Virginia to become a signatory to the Occupational Therapy Interjurisdictional

Licensure Compact. The bill will be effective on January 1, 2022 and Virginia is one of the first states to have Occupational Therapy Compact.

Dr. Archer inquired as if Virginia plans to issue identification card for COVID-19 vaccination. Dr. Allison-Bryan replied that she has not heard of such plan.

Ms. Gerardo inquired if CNS has to have practice agreement even without prescriptive authority. Ms. Yeatts replied yes.

Dr. Archer asked if there is a table available that lists all the categories of nurse practitioners that can be shared. Ms. Douglas said that it will be shared once it is updated by the new legislation. Ms. Douglas added that the Board plans to communicate to all CNSs regarding the change on July 1, 2021

Ms. Hershkowitz inquired about the DHP study will be conducted regarding regulation of Midwifery in Virginia. Dr. Brown responded that the workplan is still being developed.

Dr. Ransone asked why CNMs are only required to have 1000 hours in order to practice without the practice agreement while other categories of NPs are required 2 years. Dr. Brown responded this was the negotiated postion.

NEW BUSINESS:

Board of Nursing Executive Director Report:

- Board staff receive increased inquiries regarding advanced practice registered nurses (APRNs).
- Tthe Compact for APRN was voted on at the NCSBN in August 2020. North Dakoda has passed legislation to join. Delaware is in the process.
- Guam becomes First US Territory to enact Nurse Licensure Compact (NLC).
- Grants for compact development are available by the Department of Defense for selected professions such as teaching, social work and massage therapy

Virtual NCSBN APRN Roundtable April 6, 2021 Report:

Ms. Douglas reported that the Roundtable focused heavily on the educational preparation of APRN's.

Dr. Hills reported that the new edition of the National Task Force NP program criteria were presented as well as the AACN Essentials

Ms. Hershkowitz reported that the Roundtable also discussed about the effects of COVID pandemic on APRN education.

Future Regulatory & Administrative Process related to 2021 Legislation – table provided in **B2**

C1 – Licensure Statistics related to Advanced Practice Registered Nurses:
Ms. Douglas noted that this is provided for information only. Ms. Douglas added that about 260 waivers related to electronic prescribing were approved.

Appointment of CNM Advisory Committee Member to replace Kathleen J. Bailey, RN, CNM, MA, MS – Recommendation of Komkwuan P. Paruchabutr, DNP, FNP-BC, WHNP-BC, CNM from Virginia Affiliate of ACNM:

Ms. Gerardo noted that Ms. Bailey has informed staff of her resignation effective on April 1, 202, a recommendation of Dr. Paruchabutr from the Virginia Affiliate of ACNM to replace Ms. Bailey for the unexpired term ends 2024, and the CV was provided to Committee Members in advance.

Ms. Gerardo noted that pursuant to 18VAC90-30-30.B, appointment to the Advisory Committee shall be for four years; members may be appointed for one additional four-year period.

Ms. Gerardo asked Ms. Barrett about Dr. Paruchabutr's eligibility to the Advisory Committee since Dr. Paruchabutr only holds a VA registered nurse license, not a VA nurse practitioner license.

Ms. Barrett replied that the Committee can view Dr. Paruchabutr eligible since she does not vote or participate in disciplinary matters.

Ms. Hershkowitz moved to appoint Dr. Paruchabutr as CNM Member to the Advisory Committee. The motion was properly seconded by Dr. Archer. A roll call was taken and the motion carried unanimously.

ENVIRONMENTAL SCAN: Ms. Gerardo asked for the updates from the Advisory Committee Members.

None was shared.

Mr. Coles asked in regard to HB 1737 for nurse practitioners who are coming up with two years of clinical, can they apply now for autonomous practice? Ms. Douglas replied that there will be an opportunity to apply prior to July 1, 2021, however, the Board cannot issue licenses prior to that date. Information will be communicated to licensees.

Mr. Coles noted that regarding the report due on November 1, 2021 as required by HB 793, the VCNP would share data as needed. Ms. Douglas

stated that the Board has to report specific data referenced in the enactment clause. However, recommendations will be discussed at the June meeting.

Ms. Gerardo thanked Advisory Committee Members for their participation in the meeting and reminded everyone that the next meeting is scheduled for Wednesday, June 16, 2021.

The Advisory Committee Members, Dr. Brown, Dr. Allision-Bryan, Dr. Harp and Ms. Yeatts, left the meeting at 10:23 A.M.

RECESS: The Committee recessed at 10:23 A.M.

RECONVENTION: The Committee reconvened at 10:32 A.M.

AGENCY SUBORDINATE RECOMMENDATION CONSIDERATION

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)(28) of the *Code of Virginia* at 10:33 A.M., for the purpose to reach a decision in the matter of Agency Subordinate Recommendations. Additionally, Dr. Gleason moved that Ms. Douglas, Dr. Hills, Ms. Vu, and Ms. Barrett 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 properly seconded by Dr. Ransone. A roll call was taken and the motion carried unanimously.

RECONVENTION: The Board reconvened in open session at 11:01 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 properly seconded by Ms. Hershkowitz. A roll call was taken and the motion carried unanimously.

#1 – Linda Q. Morrill, LNP **0024-053267**

Ms. Morrill did not participate.

Dr. Ransone moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to

reprimand Linda Q. Morrill. The motion was properly seconded by Ms. Hershkowitz. A roll call was taken and the motion carried unanimously.

#2 – April Jae Stein Brittain, LNP **0024-134372**

Ms. Brittain did not participate.

Dr. Gleason moved that the Committee of the Joint Boards of Nursing and Medicine modify the recommended decision of the agency subordinate to reprimand April Jae Stein Brittain and to require Ms. Brittain to complete 10 hours of Board approved continuing education (CE) regarding documentation and proper prescribing within 90 days from entry of the Order. These CEs are above the requirement of licensure renewal. The motion was properly seconded by Dr. Conklin. A roll call was taken and the motion carried unanimously.

#3 – Georgienne Castle Neale, LNP **0024-166304**

Ms. Neale did not participate.

Dr. Ransone moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to indefinitely suspend the license of Georgienne Castle Neale to practice as a nurse practitioner in the Commonwealth of Virginia. The motion was properly seconded by Ms. Hershkowitz. A roll call was taken and the motion carried unanimously.

#4 – Stacy Lee Smith Riedt, LNP **0024-168687**

Ms. Riedt did not participate.

Dr. Ransone moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to reprimand Stacy Lee Smith Riedt. The motion was properly seconded by Ms. Hershkowitz. A roll call was taken and the motion carried unanimously.

#5 – Kimberly Dawn Washbourne, LNP **0024-166086**

Ms. Washbourne did not participate.

Dr. Ransone moved that the Committee of the Joint Boards of Nursing and Medicine reject the recommended decision of the agency subordinate and refer the matter of Kimberly Dawn Washbourne to a formal hearing. The motion was properly seconded by Dr. Conklin. A roll call was taken and the motion carried unanimously.

ADJOURNMENT: As there was no additional business, the meeting was adjourned at 11:06 A.M.

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

DISCIPLINARY ACTIONS PERTAINING TO

AUTONOMOUS LICENSED NURSE PRACTITIONERS (ALNP)

AS OF APRIL 30, 2021

In preparation for presentation to the Joint Boards on June 16, 2021, Board of Health Professions/HWDC staff requested a listing of all Licensed Nurse Practitioners who were issued the autonomous practice designations as of April 30, 2021. The first designation was issued on February 6, 2019. A search of License Lookup for the period January 1, 2019 to April 30, 2021 revealed public disciplinary records on five (5) individuals hereinafter referred to a Respondent A, B, C, D and E. The following is a brief summary. [1]

Respondent A - Family Practice and Authorization to Prescribe. An Order issued December 3, 2020 required participation in the Health Practitioners Monitoring Program.

Respondent B – Adult Acute Geriatric and Authorization to Prescribe. An order issued December 11, 2020 required participation in the Health Practitioners Monitoring Program.

Respondent C – Family Practice and Authorization to Prescribe. An order issued September 13, 2019 rendered a Reprimand for prescribing outside of a bona-fide practitioner-patient relationship and outside of an emergency and failing to document the rationale in the patient's record.

Respondent D – Family Practice and Authorization to Prescribe. An order issued November 20, 2020 rendered a Reprimand and approved course in opiate prescribing regarding a case of continued opiate prescribing for a patient with a history of opioid addiction and noncompliance with pain management. On February 22, 20201, the Board notified the Respondent of compliance with the order.

Respondent E[2] – Family Practice (out of state). Mandatory suspension issued July 21, 2020 for felony criminal conviction for conspiracy to commit Medicaid fraud.

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[1] NOTE: The data for the analyses in this report only cover the period February 6, 2019 to April 30, 2021 to coincide with the first designation issued and to allow sufficient time for analysis and reporting prior to the June 16, 2021 meeting of the Joint Boards. Results may differ with other timeframes.

[2] Respondent E's license was mandatorily suspended under the authority of the Department of Health Professions Director. For further information on mandatory suspension, reference *Code of Virginia* §54.1-2409 (accessible at https://law.lis.virginia.gov/vacode/title54.1/chapter24/section54.1-2409/.

Complaints, Violations, and Case Categories

To provide information on complaints received, the staff also analyzed the agency's disciplinary case tracking data[3] referencing "Cases Received" in the system during the February 6, 2019 to April 30, 2021 period. The complaints received per 1,000 licensees' rates for the agency, board, and profession levels follow.

Additionally, because complaints do not necessarily equate to substantiated misconduct, staff also determined the rate of case closed with a final disposition of violation per 1,000 licensees. This measure provides additional insight into boards' assessments of actual harm to the public. Here, too, the results are at the agency, board, and profession level.

Finally, staff also analyzed the categories of cases with a violation final disposition to provide additional information on the types of cases involved. The Appendix provides a listing and description of the case categories.

AGENCY

As indicated in the table below, the agency received 15,510 complaints within the jurisdiction of a licensing board. As of April 30, 2021, the majority (73.5%) had been resolved.

Received (within Jurisdiction, only)	Closed	Violation	Complaint [4] Rate/1k Lic	Violation Rate/ 1k Lic	Licensees .[5]
15,510	11,400 (73.5% of received)	1,571 (14% of closed)	35.27	3.57	439,644

The rate of all complaints received per 1,000 licensees within boards' jurisdiction was 35.27, and the overall violation rate was 3.57.

The following page provides a breakout by Board of the respective rates per 1,000 licensee.

[3] Data are from the agency's standard monthly download of internal disciplinary case processing data from the MLO system.

[4] The Rate of Complaints Received per 1,000 Licensees and Rate of Violations per 1,000 Licensees are similar to the standard measures tracked in the DHP Biennial Report under Appendix B – Complaints Against Licensees and C – Violations. They are calculated, respectively, as follows: (#Cases Received/#Licensees) x 1,000 and (#Cases with Violation final disposition/#Licensee)s x 1,000. Note: Here, the #Licensees refers to the count of licensees as of March 31, 2021 rather than June 30, 2021 due to the timing of the review.

[5] The number of licensees is from March 31, 2021, the latest full quarter for which there are data.

BOARD

Complaints Received Rate per 1,000 Licensees by Board

Board	Rate/1k	Board	Rate/1k
ASLP	5.46	**Optometry**	42.55
Counseling	22.78	**Pharmacy**	38.57
Dentistry	70.06	**Physical Therapy**	8.40
FD&E	58.30	**Psychology**	54.47
LTCA	83.11	**Social Work**	20.67
Medicine	60.79	**Veterinary Medicine**	97.9
Nursing	25.10		

The complaint rate ranged from a low of 5.46 for the Board of Audiology and Speech-Language Pathology to a high of 97.9 for the Board of Veterinary Medicine. For the Board of Nursing, the rate was 25.10. The average (mean) was 45.24.

As noted earlier, board findings of violation constitute substantiated evidence of harm to the public due to professional misconduct. A board renders its final disposition when the investigation is complete, evidence reviewed, and adjudication processes completed. A violation final disposition confirms that the licensee has engaged in professional misconduct.

The table below shows rate of violation per 1,000 licensees by board for those cases received and closed during the period.

Violation Rate per 1000 Licensees by Board

Board	Rate/1k	Board	Rate/1k
ASLP	0.88	**Optometry**	1.93
Counseling	0.87	**Pharmacy**	16.7
Dentistry	2.62	**Physical Therapy**	0.96
FD&E	5.64	**Psychology**	1.02
LTCA	3.96	**Social Work**	0.25
Medicine	2.83	**Veterinary Medicine**	0.12
Nursing	2.42		

The violation rates were much lower than the complaint rates, and range from a low for Veterinary Medicine of 0.12 to a high for Pharmacy (includes facility violations). The Board of Nursing's rate is a 2.42. The average (mean) across all boards is 3.02.

PROFESSIONS

Within the agency, there are over 60 regulated professions in addition to a number of facility types. The following tables provide a rank ordering of the rate of complaints and of violations per 1,000 licensees for 51 professions.[6 7]

Profession	Complaint Rate/1KLic	Profession	Violation Rate/1KLic
Ltd Radiologic Technologist	1.84	Ltd Radiologic Technologist	0
Clinical Nurse Specialist	2.45	Lic. Clinical Social Worker	0.37
Speech-Language Pathologist	4.27	Dental Hygienist	0.49
Dental Hygienist	4.76	Sub Abuse Tx Practitioner	0.51
Occupational Therapist	5.36	Occupational Therapy Asst	0.59
Physician Selling CS	5.38	Intern & Resident	0.59
Occupational Therapy Asst	5.87	Behavioral Analyst	0.6
Sub Abuse Tx Practitioner	7.11	Physician Assistant	0.6
Radiologic Technologist	8.32	Speech-Language Pathologist	0.85
Physical Therapist	8.95	Physical Therapist	0.95
Physical Therapist Asst	10.16	Lic Clinical Psychologist	0.96
Athletic Trainer	10.27	QMHP-Child	0.99
QMHP-Child	11.22	Lic Professional Counselor	0.99
Respiratory Therapist	12.46	Lic Marriage & Family Therapist	1.05
Behavioral Analyst	13.24	Occupational Therapist	1.07
Intern & Resident	13.82	QMHP-Adult	1.32
School Speech-Language Pathologist	14.74	Physical Therapist Asst	1.37
Restricted Volunteer	15.15	Respiratory Therapist	1.44
Registered Nurse	15.35	Veterinary Technician	1.69
QMHP-Adult	18.58	Athletic Trainer	1.71
Polysomnographic Technologist	20.28	Lic. Nurse Practitioner	1.71
Veterinary Technician	20.3	Registered Nurse	1.72
Lic Massage Therapist	20.49	Physician Selling CS	1.79
Pharmacy Technician	20.78	Certified Nurse Aide	2.29
Pharmacist	21.7	TPA Optometrist	2.33
Lic Acupuncturist	24.39	Clinical Nurse Specialist	2.45
Lic. Clinical Social Worker	26.48	School Speech-Language Pathologist	2.46
Certified Nurse Aide	30.6	Doctor of Osteopathy	2.64

[6] Facility cases are excluded.
[7] A profession was included if there was at least one case during the period. Note that only closed cases applied to the violation rate.

Profession	Complaint Rate/1KLic	Profession	Violation Rate/1KLic
Physician Selling Drugs	30.67	Assisted Living Facility Administrator	2.9
Lic. Marriage & Family Therapist	31.41	Nursing Home Administrator	3.01
Lic. Practical Nurse	37.18	Medicine & Surgery	3.33
Physician Assistant	37.78	Autonomous Lic Nurse Practitioner	3.35
Lic Nurse Practitioner	39.76	Lic. Practical Nurse	3.77
Lic Professional Counselor	44.03	Radiologic Technologist	4.05
Medication Aide	45.59	Pharmacist	4.27
TPA Optometrist	48.83	Sex Offender Tx Provider	4.47
Lic. Clinical Psychologist	59.56	Genetic Counselor Temp	4.68
Funeral Service Intern	70.18	Dentist	4.76
Doctor of Osteopathy	70.96	Lic Massage Therapist	4.95
Chiropractor	71.47	Lic Acupuncturist	5.22
Funeral Service Licensee	71.93	Medication Aide	6.32
Sex Offender Tx Provider	76.06	Funeral Service Licensee	6.37
Autonomous Lic Nurse Practitioner	89.69	Chiropractor	6.81
Medicine & Surgery	92.85	Veterinarian	7.59
Assisted Living Facility Administrator – Administrator-in-Training	93.02	Pharmacy Technician	10.12
Assisted Living Administrator	97.1	Polysomnographic Technologist	12.17
Nursing Home Administrator	107.54	Physician Selling Drugs	12.27
Veterinarian	125.06	Podiatrist	12.64
Dentist	131.41	Restricted Volunteer	15.15
Podiatrist	158.84	Funeral Service Intern	17.54
Genetic Counselor Temp	222.2	Assisted Living Facility Administrator— Administrator-in-Training	46.51

The complaint rate per 1,000 licensees ranges from 1.87 for Limited Radiologic Technologist to 222.2 for Genetic Counselor Temporary. Note that the violation rate is lower, with a range of near 0 for Limited Radiologic Technologist to 46.51 for Assisted Living Administrator – Administrator-in-Training. The respective average (mean) for each measure is 43.68 and 4.66. Note the arrows indicating the approximate locations of these means in the rankings above.

For Autonomous Licensed Nurse Practitioner, the complaint rate is 89.84 and violation rate is 3.36. This is higher than average complaint rate but lower than average violation rate. These rates are similar to Medicine & Surgery (M.D.s) where the complaint rate is 92.85 and violation rate is 3.33.

Case Categories

As indicated earlier, staff also analyzed the categories among cases with a finding of violation.

For Autonomous Licensed Nurse Practitioners, see the summary on page 1 for the details. They involve Inability to Safely Practice and Drug-Related, Patient Care.

The following information enables comparison at the agency, board, and profession level. For the sake of simplicity, the board and profession levels narrow to the Board of Nursing, Board of Medicine, Licensed Nurse Practitioner (with collaborative practice), Registered Nurses and Medicine & Surgery (MDs). Other boards and professions can be included in subsequent reports if desired.

AGENCY

The top ten (10) categories across all boards are ranked below. Those that respectively constitute 5% or more are highlighted. It is important to note that only three (3) are considered "complaints" in that the licensing boards, themselves, docket cases with categories related to license issuance or renewal (i.e., continuing education, reinstatement, and eligibility) and compliance cases in follow up to previous orders.

1. **Business Practice Issues**
2. **Inability to Safely Practice**
3. ~~**Continuing Education**~~
4. ~~**Reinstatement**~~
5. **Drug-Related, Patient Care**
6. ~~**Eligibility**~~
7. Abuse, Abandonment & Neglect
8. Criminal Activity
9. Unlicensed Activity
10. Standard of Care – Diagnosis/Treatment

NOTE: The remaining lists only include the categories that constitute 5% or more of the cases.

BOARD OF NURSING (excluding CNAs)

1. **Inability to Safely Practice**
2. ~~**Reinstatement**~~
3. ~~**Eligibility**~~
4. **Drug-Related, Patient Care**
5. **Abuse, Abandonment & Neglect**
6. **Criminal Activity**
7. **Action by Another Board – Patient Care**
8. ~~**Compliance**~~

BOARD OF MEDICINE

1. **Unlicensed Activity**
2. **Inability to Safely Practice**
3. **Drug-Related-Patient Care**
4. **Standard of Care-Diagnosis/Treatment**
5. **Abuse, Abandonment & Neglect**
6. ~~**Reinstatement**~~
7. **Criminal Activity**

LICENSED NURSE PRACTITIONER (COLLABORATIVE ONLY)

1. **Drug-Related-Patient Care**
2. **Inability to Safely Practice**
3. ~~**Reinstatement**~~
4. **Action-by-Another Board, Patient Care**
5. **Criminal Activity**
6. ~~**Eligibility**~~

REGISTERED NURSES

1. **Inability to Safely Practice**
2. ~~**Reinstatement**~~
3. **Action by Another Board, Patient Care**
4. **Criminal Activity**
5. **Abuse, Abandonment & Neglect**
6. ~~**Eligibility**~~

MEDICINE & SURGERY (M.D)

1. **Inability to Safely Practice**
2. **Drug-Related, Patient Care**
3. **Standard of Care, Diagnosis/Treatment**
4. **Criminal Activity**
5. **Reinstatement**
6. **Abuse/Abandonment/Neglect**
7. **Standard of Care, Surgery**

Staff will review this draft with the Joint Board of Nursing and Medicine at the June 16, 2021 as part of a presentation that also includes a separate statistical report on Autonomous Licensed Nurse Practitioners specialties and geographic distribution.

Neither report is final at this time. Any future report(s) will incorporate the Joint Board's feedback.

[illegible] DISCIPLINE Complaint Types in MLO

Every disciplinary case entered in MLO must be assigned at least one *Complaint Type*. Most cases will require only one, but others will need several types to accurately reflect all aspects of the case. There is no limit on the number of complaint types that can be entered. Users entering the complaint types in MLO should include as many of the **Patient Care Complaint Types and Non-Patient Care Complaint Types** as are active concerns. Many of the numbered complaint types have one or more subtypes which are identified by a + symbol. Users should also include as many of the subtypes that are active concerns. Complaint types and subtypes must be **reviewed and changed** when needed to accurately address the current issues in each case as it proceeds through *Intake, Investigation, Probable Cause Review, Administrative Proceedings* and *Closure*.

Follow these rules for entering multiple case types:

1. **Enter all applicable Patient Care Complaint Types.** Enter the types in numerical order.
2. **When + symbols and subtypes** are shown, use one or more of the sub-types as applicable to the case.
3. Enter any **Non-Patient Care Complaint Types and subtypes.** Enter the types in numerical order.

PATIENT CARE Complaint types: #1-14

1. **INABILITY TO SAFELY PRACTICE:** Impairment due to use of alcohol, illegal substances, or prescription drugs or incapacitation due to mental, physical or medical conditions.
   - + **Death associated**
2. **DRUG RELATED – PATIENT CARE:** Dispensing in violation of DCA (to include dispensing for non-medicinal purposes, excessive prescribing, not in accordance with dosage, filling an invalid prescription, or dispensing without a relationship), prescription forgery, drug adulteration, patient deprivation, stealing drugs from patients, or personal use.
   - + **Improper compounding or MDR** (mixing/diluting/reconstituting formulation)
   - + **Death associated**
3. **ABUSE/ABANDONMENT/NEGLECT:** Any sexual assault, mistreatment of a patient, inappropriate termination of provider/patient relationship, leaving a patient unattended in a health-care environment, failure to do what a reasonable person would do in a similar situation.
   - + **Sexual misconduct involved**
   - + **Death associated**
4. **STANDARD OF CARE – SURGERY:** Improper/unnecessary performance of surgery, improper patient management, and other surgery-related issues.
   - + **Death associated**
   - + **Sedation/Anesthesia associated**
5. **STANDARD OF CARE – DIAGNOSIS/TREATMENT:** Instances in which the diagnosis/treatment was improper, delayed, or unsatisfactory. Also includes failure to diagnose/treat as well as other diagnosis/treatment related issues.
   - + **Death associated**
6. **STANDARD OF CARE – MEDICATION/PRESCRIPTION:** Prescribing, labeling, dispensing, and administration errors. Also includes improper management of patient regimen and failure to provide counseling as well as other medication/prescription related issues.
   - + **Death associated**
7. **STANDARD OF CARE – MALPRACTICE REPORTS:** a judgment or settlement as well as other malpractice related issues.
   - + **Death associated**
8. **STANDARD OF CARE – EXCEEDING SCOPE:** practicing outside the permitted functions of license granted.
   - + **Death associated**
9. **STANDARD OF CARE – OTHER:** cases involving patient care that cannot fit adequately into any other standard of care case type. *Must have supervisor's approval before using this code.*
   - + **Sexual misconduct involved**
10. **INAPPROPRIATE RELATIONSHIP:** Dual, sexual or other boundary issue. Including inappropriate touching and written or oral communications.
11. **UNLICENSED ACTIVITY:** Practicing a profession or occupation without holding a valid license as required by statute or regulation to include: practicing on a revoked, suspended, lapsed, non-existent or expired license, as well as aiding and abetting the practice of unlicensed activity.
    - + **Expired license**
    - + **Suspended/revoked license**
    - + **No license**
    - + **Delegation to unlicensed staff**

12. **MISAPPROPRIATION OF PATIENT PROPERTY**: stealing or use of patient property without authorization.

   + **Fraudulent documentation**

13. **FRAUD – PATIENT CARE**: Performing unwarranted/unjust services or the falsification/alteration of patient records.

   + **Fraudulent documentation**

14. **ACTION BY ANOTHER BOARD – PATIENT CARE**: Disciplinary action by another state or jurisdiction when the underlying act is a patient care case as defined above. This code must be accompanied by another patient care case code that best describes the underlying offense.

   + **Death associated**

NON-PATIENT CARE Complaint types: #50-64

50. **CRIMINAL ACTIVITY**: Felony or misdemeanor arrest, charges pending, or conviction.

   + **Death associated**

51. **HPMP**: Dismissal, vacated stay and non-compliance.

52. **DRUG RELATED- NON-PATIENT CARE**: Theft or diversion of drugs when a patient is not involved (e.g., pharmacies, hospitals, or facilities).

53. **FRAUD – NON-PATIENT CARE**: Improper patient billing, mishandling of pre-need funds, fee splitting, and falsification of licensing/renewal documents.

   + **Fraudulent documentation**

54. **BUSINESS PRACTICE ISSUES**: Advertising, default on guaranteed student loan, solicitation, records, inspections, audits, self-referral of patients, required report not filed, prescription blanks, or disclosure. Using a VA protected title such as MD, without a license, but not practicing in VA.

   + **Failure to address sexual misconduct**
   + **Failure to report patient events**
   + **Failure to supervise patient care**
   + **Hospital failure to report**
   + **Nursing home failure to report**
   + **ALF failure to report (Assisted Living Facility)**
   + **Other institution failure to report**
   + **Licensee failure to report**

55. **DRUG RELATED – SECURITY**: Failure to maintain security of controlled substances.

56. **COMPLIANCE**: Violation of a board order term or probation violation.

57. **MISAPPROPRIATION OF PROPERTY – NON-PATIENT CARE**: stealing or use of property that does not belong to a patient without authorization.

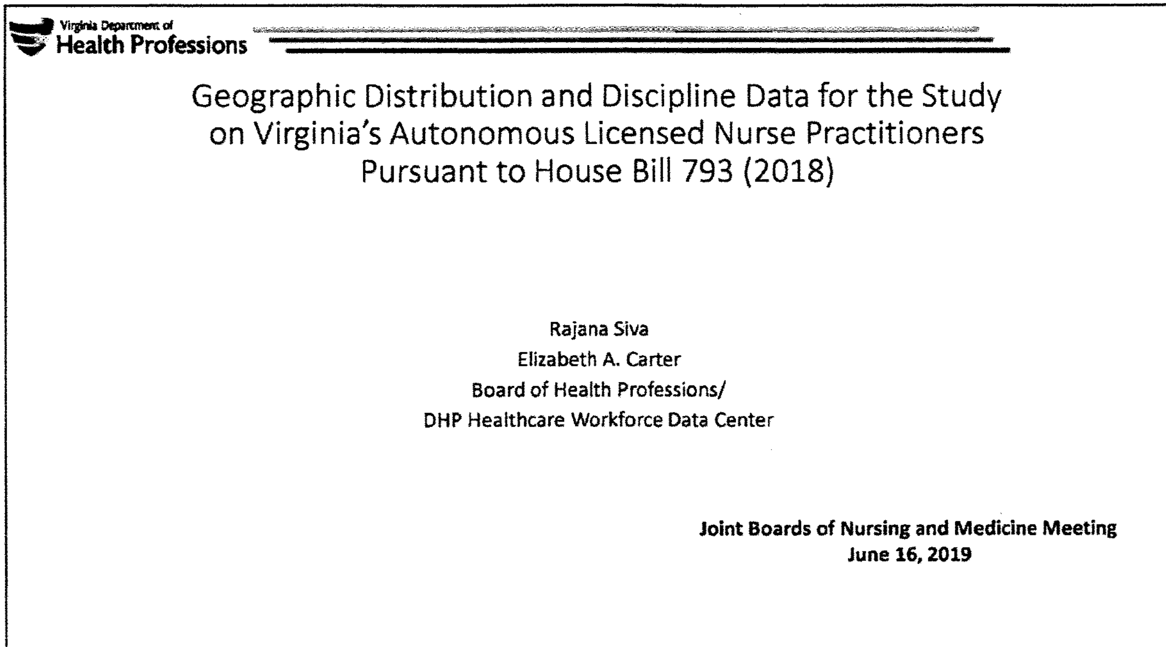
58. **CONFIDENTIALITY BREACH**: disclosing unauthorized client information without permission or necessity.

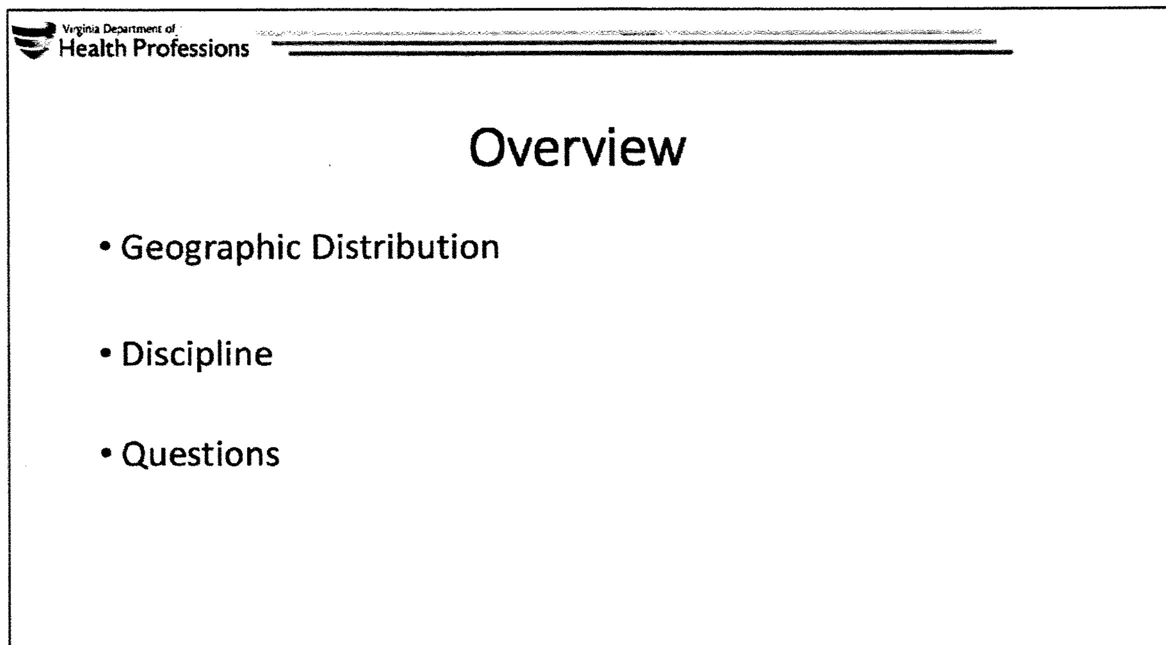
59. **CONTINUING COMPETENCY REQUIREMENT NOT MET**: Failure to obtain or document CE requirements.

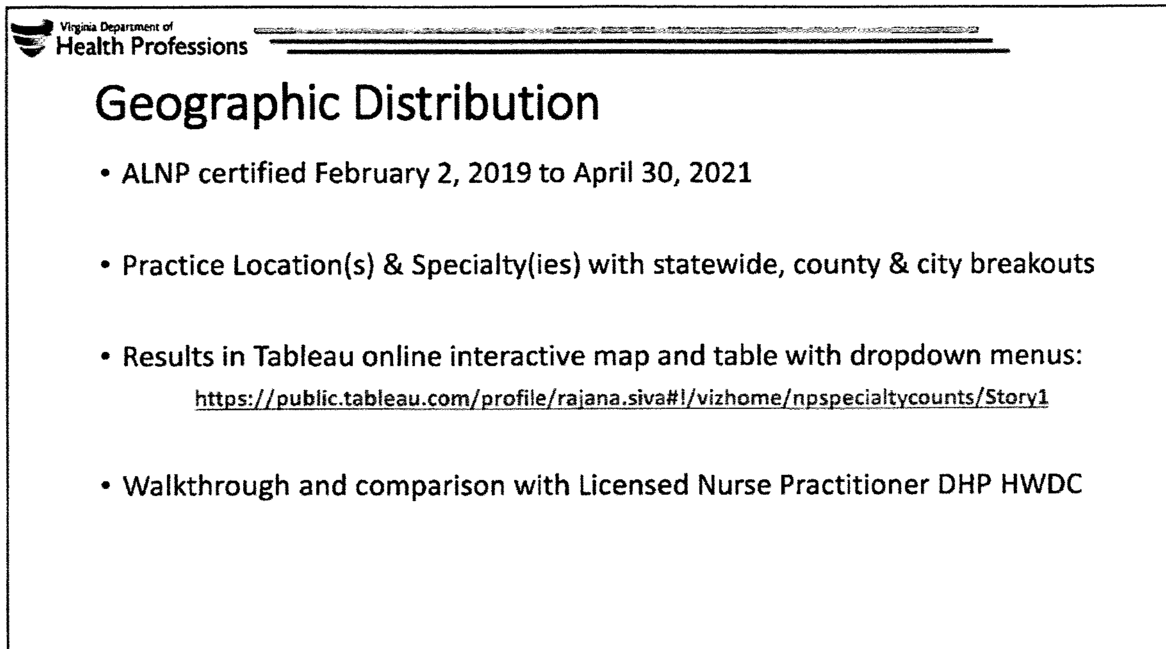
60. **DISHONORED CHECK**: Check with insufficient funds submitted to agency.

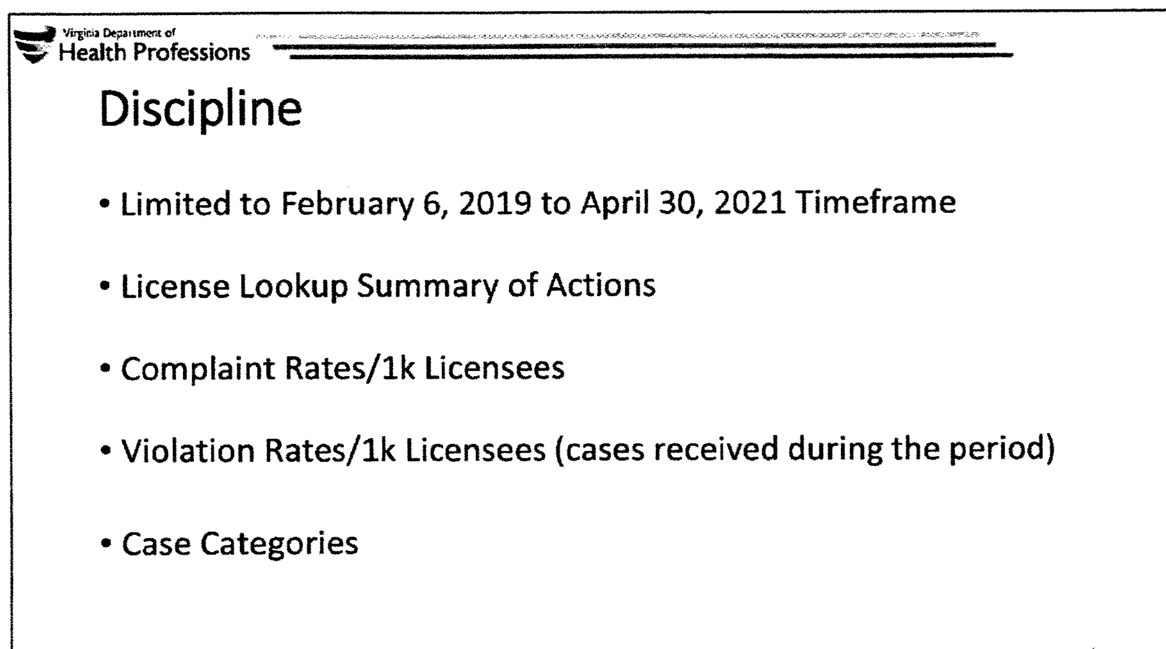
61. **RECORDS RELEASE**: Failure or delay in the release of patient records. Charging excessive fees for records requests.

62. **ACTION BY ANOTHER BOARD – NON-PATIENT CARE**: Disciplinary action by another state or jurisdiction when the underlying act is a non-patient care case. This code must be accompanied by another non-patient care Complaint Type code that best describes the underlying offense.


Virginia Department of
Health Professions
Geographic Distribution and Discipline Data for the Study on Virginia's Autonomous Licensed Nurse Practitioners Pursuant to House Bill 793 (2018)
Rajana Siva
Elizabeth A. Carter
Board of Health Professions/
DHP Healthcare Workforce Data Center
Joint Boards of Nursing and Medicine Meeting
June 16, 2019


Virginia Department of
Health Professions
Overview
• Geographic Distribution
• Discipline
• Questions


Virginia Department of
Health Professions
Geographic Distribution
• ALNP certified February 2, 2019 to April 30, 2021
• Practice Location(s) & Specialty(ies) with statewide, county & city breakouts
• Results in Tableau online interactive map and table with dropdown menus:
https://public.tableau.com/profile/rajana.siva#!/vizhome/npspecialtycounts/Story1
• Walkthrough and comparison with Licensed Nurse Practitioner DHP HWDC


Virginia Department of
Health Professions
Discipline
• Limited to February 6, 2019 to April 30, 2021 Timeframe
• License Lookup Summary of Actions
• Complaint Rates/1k Licensees
• Violation Rates/1k Licensees (cases received during the period)
• Case Categories

Virginia Department of Health Professions

QUESTIONS?

Virginia Department of Health Professions

QUESTIONS?

Elizabeth A. Carter, Ph.D.
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Executive Director for the Virginia Board of Health Professions
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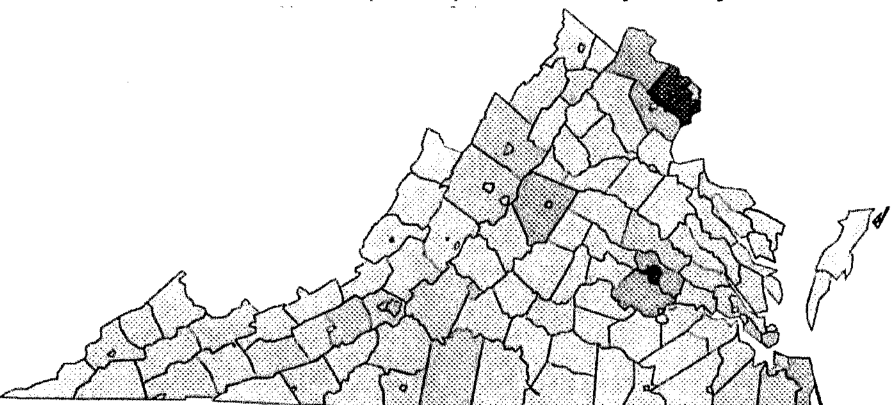
NP headcount

Specialty Breakouts by City   Specialty Breakouts by County

Specialty Breakouts by County



Specialty: All

County (group)	Null	Autonom..	Autonom..	Autonom..	Autonom..	Autonom..	Autonom..	Autonom..	Autonom..
Accomack County		1	0	7	0	0	2	0	0
Albemarle County		9	5	20	1	1	4	6	0
Alexandria County		0	4	12	0	0	0	3	0
Alleghany County	0	0	0	0	0	0	0	0	0
Amelia County		0	0	1	0	0	0	0	0
Amherst County		1	1	0	0	0	0	1	0
Appomattox County		0	0	0	0	0	0	1	0
Arlington County		3	6	13	0	0	0	4	0
Augusta County		3	0	15	0	0	0	3	0
Bath County	0	0	0	0	0	0	0	0	0
Bedford County		2	2	9	0	0	0	1	0
Bland County		0	0	1	0	0	0	0	0
Botetourt County	0	0	0	0	0	0	0	0	0
Bristol County		0	0	1	0	0	0	0	0
Brunswick County	0	0	0	0	0	0	0	0	0
Buchanan County		4	0	6	0	0	0	0	0
Buckingham County	0	0	0	0	0	0	0	0	0

Specialty: All

The maps and tables on this page and the next are still Snapshots of the what the online Tableau online interactive will look like during the presentation on the geographic distribution of Autonomous Licensed Nurse Practitioners and their specialties.

If you would like to become familiar with this online tool, the current version may be accessed at:

https://public.tableau.com/profile/rajana.siva#!/vizhome/npspecialtycounts/Story1

Tableau allows viewers to select all or a specific specialty in both maps and accompanying tables.

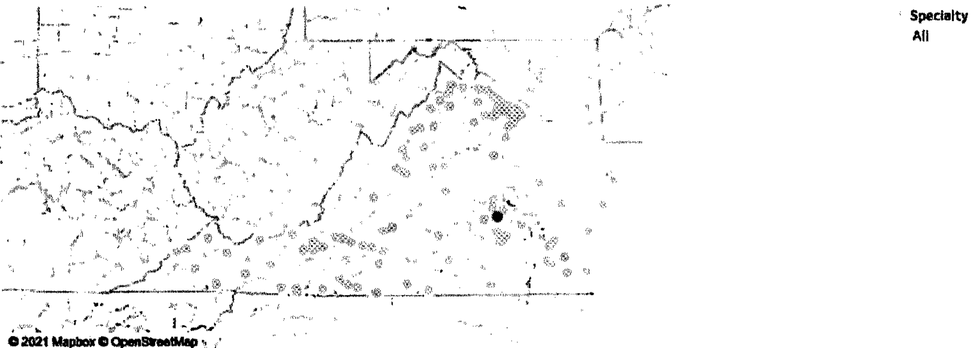
PLEASE NOTE that the mapping is being recolored to better distinguish county-level detail for the reader and should appear clearer at the June 16, 2021 meeting.

Thank you for your patience.

NP headcount

Specialty Breakouts by City | Specialty Breakouts by County

Specialty Breakouts by City



Specialty
All

Sheet 2

City (group)	Specialty Autonomo..	Autonomo..	Autonomo..	Autonomo..	Autonomo..	Autonomo..	Autonomo..	Autonomo..
Abindgon			5				1	
Alexandria		4	12				3	
Alta Vista			3					
Annandale	1							
Ashburn		1	3					
Ashland		1	1					
Axton			1					
Barboursville	2							
Bassett			1					
Berryville			1					
Blackburg		2	2					
Bluefield			2					
Bridgewater			1					
Broadway			2					
Cana			1					
Carrollton			2					

Virginia's Licensed Nurse Practitioner Workforce: 2020

Healthcare Workforce Data Center

November 2020

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233
804-597-4213, 804-527-4466(fax)
E-mail: *HWDC@dhp.virginia.gov*

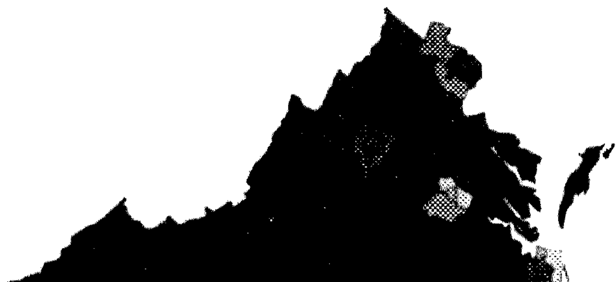
Follow us on Tumblr: *www.vahwdc.tumblr.com*
Get a copy of this report from:
http://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/

Accessible at: www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/Dashboards/TrendsinHealthcareWorkforceFTEUnits

2020 Healthcare Workforce Full Time Equivalency Units in Virginia

(Drag mouse to select multiple counties from map and select professions from dropdown box)

Professions: Nurse Practitioner



unty	2012	2013	2014	2015	2016	2017	2018	2019	2020
comack County	[illegible]	0.0	16.3	[illegible]	9.7	12.9	29.4	25.7	32.7
bemarle County	0.0	0.0	[illegible]	[illegible]	162.1	[illegible]	[illegible]	178.7	209.2
xandria City	[illegible]	0.0	74.5	118.2	[illegible]	108.1	124.3	[illegible]	[illegible]
eghany County	0.0	0.0	17.9	23.0	21.6	[illegible]	5.7	30.0	11.5
elia County	0.0	[illegible]	5.5	3.8	[illegible]	0.0	6.2	0.6	[illegible]
herst County	0.0	0.0	7.6	0.0	9.6	19.3	4.6	16.7	5.0
pomattox County	[illegible]	0.0	5.6	0.0	4.8	0.2	0.0	0.0	[illegible]
lington County	0.0	0.0	[illegible]	166.2	136.4	159.3	105.6	162.3	172.7
gusta County	0.0	0.0	73.0	49.0	56.4	44.1	60.9	59.9	[illegible]
th County	0.0	0.0	0.4	7.7	4.3	5.4	8.0	25.2	9.7
dford City	[illegible]	0.0	4.0	6.3	0.0	5.9	1.5	[illegible]	4.0
dford County	0.0	0.0	17.6	5.4	8.3	9.2	28.7	15.9	22.1
and County	0.0	0.0	5.0	27.5	2.2	13.2	24.4	16.9	16.4
tetourt County	0.0	0.0	10.0	2.1	10.7	14.0	6.8	8.8	12.9
istol City	0.0	0.0	7.8	5.1	40.4	1.9	9.1	6.5	16.3
unswick County	0.0	0.0	10.5	5.9	4.4	2.7	1.8	8.1	4.9
chanan County	0.0	0.0	6.5	11.3	13.9	14.0	17.5	10.8	35.1

Need vaccine? Learn how to get your shot at Vaccinate.Virginia.gov or call 1-877-VAX-IN-VA. Mon-Sat 8am - 6pm. Language translation available, TTY users dial 7-1-1.
¿Necesitas vacunarte? Entérate cómo conseguir tu vacuna en Vaccinate.Virginia.gov o llamando al 1-877-829-4682 de Lun-Sáb 8am-6pm. Traducción disponible en tu idioma. Usuarios de TTY pueden marcar al 7-1-1.

SHORTAGE DESIGNATION RESOURCES

Shortage Designations

Quick Links

HRSA's Shortage Designation Overview
HPSA Mapping Tool
Find Shortage Areas by Address
Find HPSA's by Locality
Find MUA's by Locality
Virginia HPSA Factsheet

Find Job Openings in Shortage Areas

Shortage Designations

The Division of Social Epidemiology, through the Virginia Primary Care Office, develops reviews and submits applications for federally designated shortage areas. A large and diverse number of state and federal programs reference these shortage areas to determine eligibility, the amount of awards, and for other purposes. There are several types of shortage areas, covering different specialties, and targeting different constituents.

Shortage Area Types:

- Health Professional Shortage Area (HPSA)
- Medically Under-served Areas/Populations (MUA/P)
- Governor Designation

Shortage Area Specialties:

- Primary Care
- Dental Health
- Mental Health

Shortage Area Targets:

- Geographic Areas
- Populations
- Facilities

Examples of Programs that reference shortage areas:

- Medicare Bonus Payment Program
- National Health Service Corps
- Virginia State Loan Repayment
- J-1 Visa Program
- NURSE Corps
- Federally Qualified Health Centers
- Rural Health Clinics

For more information about Virginia's shortage areas contact Anna Riggan at anna.riggan@vdh.virginia.gov.

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DRAFT

Virginia's Physician Workforce: 2020

Healthcare Workforce Data Center

January 2021

Virginia Department of Health Professions
Healthcare Workforce Data Center
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Henrico, VA 23233
804-597-4213, 804-527-4466 (fax)
E-mail: **HWDC@dhp.virginia.gov**

Follow us on Tumblr: ***www.vahwdc.tumblr.com***
Get a copy of this report from:
http://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/

35,072 Physicians voluntarily participated in this survey. *Without their efforts the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Medicine express our sincerest appreciation for your ongoing cooperation.*

Thank You!

Virginia Department of Health Professions

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The Physician Workforce: At a Glance:

The Workforce

Licensees:	47,194
Virginia's Workforce:	26,593
FTEs:	26,122

Survey Response Rate

All Licensees:	74%
Renewing Practitioners:	89%

Demographics

% Female:	39%
Diversity Index:	54%
Median Age:	51

Background

Rural Childhood:	18%
Med. School in VA:	22%
Residency in VA:	27%

Top Certifications

Internal Medicine:	29%
Family Medicine:	15%

Finances

Median Inc.:	$225k - $250
Health Benefits:	69%
Median Ed Debt:	$0k

Current Employment

Employed in Prof.:	95%
Hold 1 Full-time Job:	69%
Satisfied?:	93%

Job Turnover

Switched Jobs in 2020:	5%
Employed over 2 yrs:	70%

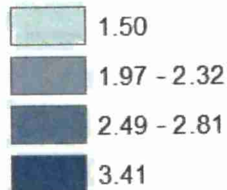
Primary Roles

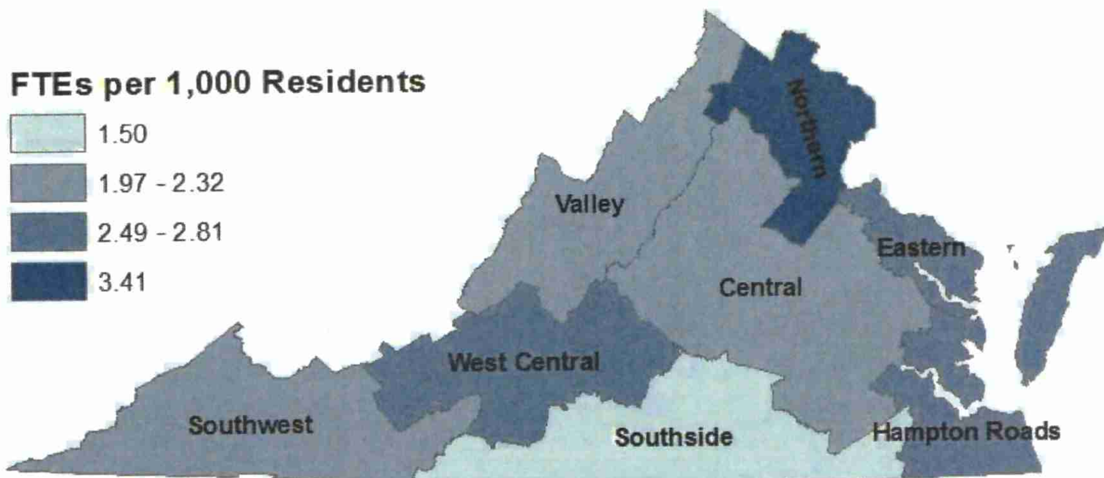
Patient Care:	82%
Administration:	5%
Education:	1%

Source: Va. Healthcare Workforce Data Center

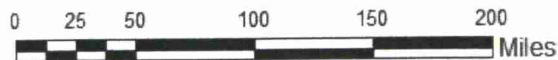
Full Time Equivalency Units Provided by Physicians per 1,000 Residents by Virginia Performs Regions

Source: Va Healthcare Workforce Data Center





Annual Estimates of the Resident Population: July 1, 2019
Source: U.S. Census Bureau, Population Division



Results in Brief

A total of 35,072 physicians voluntarily took part in the 2020 Physician Workforce Survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place on a respondent's birth month during even-numbered years for physicians. These survey respondents represent 74% of the 47,194 physicians who are licensed in the state and 89% of renewing practitioners. The HWDC estimates that 26,593 physicians participated in Virginia's workforce during the survey period. Virginia's physician workforce provided 26,122 "full-time equivalency units" during the survey period.

Females are 39% of all physicians and 50% of physicians under the age of 40. The median age of the physician workforce is 51. In a random encounter between two physicians, there is a 54% chance that they would be of different races or ethnicities. Overall, 7% of Virginia's physicians work in non-metro areas of the state.

The majority of physicians carry no educational debt. However, the median debt among those who do is between $110,000 and $120,000. The median annual income of physicians is between $225,000 and $250,000. Ninety-five percent of physicians are currently employed in the profession, and involuntary unemployment is nearly nonexistent. More than 9 out of 10 physicians indicated that they are satisfied with their current employment situation, including 59% who indicated they are "very satisfied".

Half of all physicians work at a for-profit establishment, while 10% work for the federal government. Group private practices currently employ 35% of all physicians in Virginia, the most of any establishment type in the state. The inpatient (16%) and outpatient (13%) departments of hospitals are also common establishment types for Virginia's physician workforce. One-third of all physicians expect to retire by the age of 65; 9% of the current workforce expect to retire in the next two years, while half of the current workforce expect to retire by 2040.

Summary of Trends

There were very few changes in survey results in the 2020 survey compared to the 2014 survey. However, Virginia's licensed physicians, physician workforce, and physician's FTE increased. A significant increase in the number of survey respondents was also noted.

The most recent survey results also indicate that there is more gender diversity among older Virginia physicians. The percent of physicians that were female increased from 36% in 2014 to 39% in 2020; the percent female for physicians under age 40 declined from 52% in 2014 to 50% in 2020. The racial and ethnic diversity index for all physicians, which had increased from 51% in 2014 to 54% in 2018, remained at 54%. The index, however, declined for those under age 40; the index, which had dropped from 60% in 2014 to 59% in 2016 and 2018, declined to 57% in 2020. This is still the same as the diversity index in Virginia though.

The educational and rural background results were nearly identical in the past four surveys. However, slightly more physicians reported board certification. For example, the percent reporting certification in Internal Medicine increased from 23% in 2014 to 29% in 2020. The geographical distribution of physicians was very similar in all the surveys as well, with the highest concentration in Northern Virginia followed by Central Virginia and Hampton Roads.

The median income for physicians increased in the 2020 survey; the median income, which increased from $175k-$200k in the 2014 survey to $200k-$225k in both the 2016 and 2018 surveys, is now $225k-$250k. There was a slight decline in the percent of physicians under age 40 reporting educational debt. The percent of physicians who were satisfied with their current employment situation stayed at 93% in 2020 after declining from 94% in 2014. A slightly higher percent of physicians reported working in the non-profit sector; 31% reported working in the non-profit sector in 2020 compared to 26% in 2014.

The number of physicians who reported using telemedicine has increased significantly, from 10% in 2016 to 36% in 2020. The percent with a collaborative practice agreement with a nurse practitioner and physician assistant also increased from 15% to 21% and 10% to 14%, respectively, between 2016 and 2020.

A Closer Look:

Licensees		
License Status	#	%
Renewing Practitioners	39,629	84%
New Licensees	3,381	7%
Non-Renewals	4,184	9%
All Licensees	**47,194**	**100%**

Source: Va. Healthcare Workforce Data Center

HWDC surveys tend to achieve very high response rates. 89% of renewing physicians submitted a survey. These represent 74% of physicians who held a license at some point in 2020.

Response Rates			
Statistic	Non Respondents	Respondent	Response Rate
By Age			
Under 35	2,247	1,702	43%
35 to 39	2,223	3,809	63%
40 to 44	1,628	4,690	74%
45 to 49	1,169	4,716	80%
50 to 54	1,053	4,629	82%
55 to 59	901	4,110	82%
60 to 64	848	4,008	83%
65 and Over	2,053	7,408	78%
Total	**12,122**	**35,072**	**74%**
New Licenses			
Issued in 2020	3,381	0	0%
Metro Status			
Non-Metro	418	1,448	78%
Metro	4,755	19,976	81%
Not in Virginia	6,945	13,642	66%

Source: Va. Healthcare Workforce Data Center

Definitions

1. **The Survey Period:** The survey was conducted throughout 2020 on the birth month of each respondent.
2. **Target Population:** All physicians who held a Virginia license at some point in 2020.
3. **Survey Population:** The survey was available to physicians who renewed their license online. It was not available to those who did not renew, including physicians newly licensed in 2020.

Response Rates	
Completed Surveys	35,072
Response Rate, all licensees	74%
Response Rate, Renewals	89%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed Physicians

Number: 47,194
New: 7%
Not Renewed: 9%

Response Rates

All Licensees: 74%
Renewing Practitioners: 89%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Workforce

2020 Physician Workforce:	26,593
FTEs:	26,122

Utilization Ratios

Licensees in VA Workforce:	56%
Licensees per FTE:	1.81
Workers per FTE:	1.02

Source: Va. Healthcare Workforce Data Center

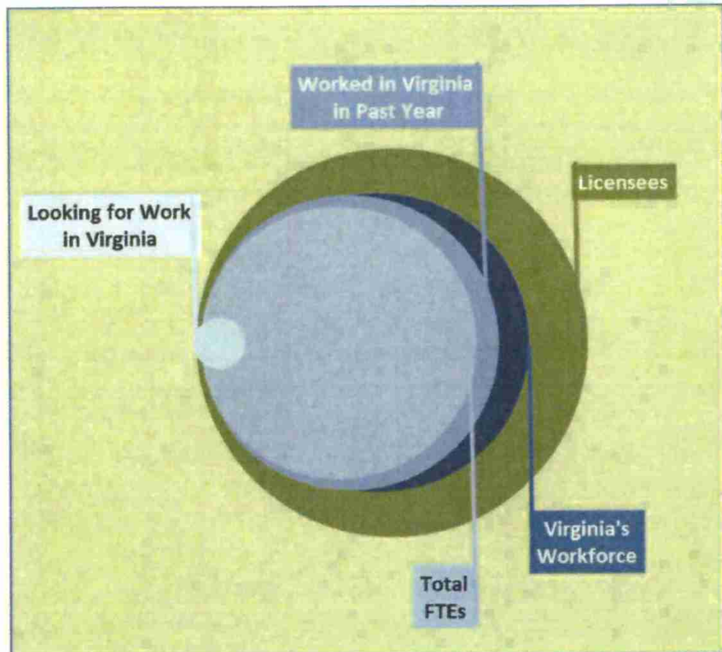
Definitions

1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time in the past year or who indicated intent to return to Virginia's workforce at any point in the future.
2. **Full Time Equivalency Unit (FTE):** The HWDC uses 2,000 (40 hours for 50 weeks) as its baseline measure for FTEs.
3. **Licensees in VA Workforce:** The proportion of licensees in Virginia's Workforce.
4. **Licensees per FTE:** An indication of the number of licensees needed to create 1 FTE. Higher numbers indicate lower licensee participation.
5. **Workers per FTE:** An indication of the number of workers in Virginia's workforce needed to create 1 FTE. Higher numbers indicate lower utilization of available workers.

Virginia's Physician Workforce		
Status	**#**	**%**
Worked in Virginia in Past Year	26,302	99%
Looking for Work in Virginia	291	1%
Virginia's Workforce	**26,593**	**100%**
Total FTEs	**26,122**	
Licensees	**47,194**	

Source: Va. Healthcare Workforce Data Center

This report uses weighting to estimate the figures in this report. Unless otherwise noted, figures refer to the Virginia Workforce only. For more information on HWDC's methodology visit: www.dhp.virginia.gov/hwdc



Source: Va. Healthcare Workforce Data Center

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 35	911	48%	989	52%	1,900	8%
35 to 39	1,582	51%	1,523	49%	3,106	13%
40 to 44	1,630	52%	1,505	48%	3,135	14%
45 to 49	1,606	55%	1,320	45%	2,926	13%
50 to 54	1,668	60%	1,137	41%	2,806	12%
55 to 59	1,528	62%	933	38%	2,461	11%
60 to 64	1,649	69%	730	31%	2,379	10%
65 +	3,481	80%	854	20%	4,335	19%
Total	**14,057**	**61%**	**8,990**	**39%**	**23,047**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender
% Female: 39%
% Under 40 Female: 50%

Age
Median Age: 51
% Under 40: 22%
% 55+: 40%

Diversity
Diversity Index: 54%
Under 40 Div. Index: 57%

Source: Va. Healthcare Workforce Data Center

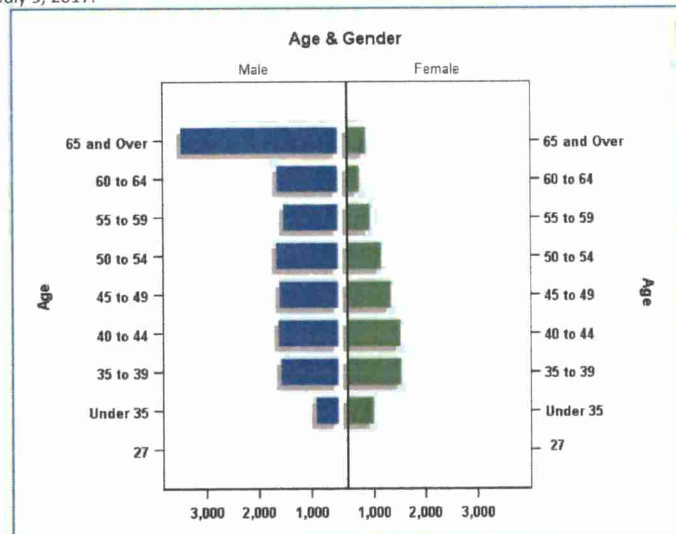
Race & Ethnicity					
Race/ Ethnicity	Virginia*	Physicians		Physicians Under 40	
	%	#	%	#	%
White	61%	14,577	65%	2,973	61%
Black	19%	1,664	7%	280	6%
Asian	7%	4,163	19%	1,111	23%
Other Race	0%	815	4%	171	4%
Two or more races	3%	419	2%	146	3%
Hispanic	10%	829	4%	199	4%
Total	**100%**	**22,467**	**100%**	**4,879**	**100%**

* Population data in this chart is from the US Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 9, 2017.

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two physicians, there is a 54% chance that they would be of a different race/ethnicity (a measure known as the diversity index). For Virginia's population as a whole, the comparable number is 57%.

22% of all physicians are under the age of 40, and half of these professionals are female. In addition, there is a 57% chance that two randomly chosen physicians from this group would be of a different race or ethnicity.



Source: Va. Healthcare Workforce Data Center

Background

At a Glance:

Childhood
Urban Childhood: 23%
Rural Childhood: 18%

Virginia Background
HS in Virginia: 22%
Med. School in VA: 22%
Init. Residency in VA: 27%

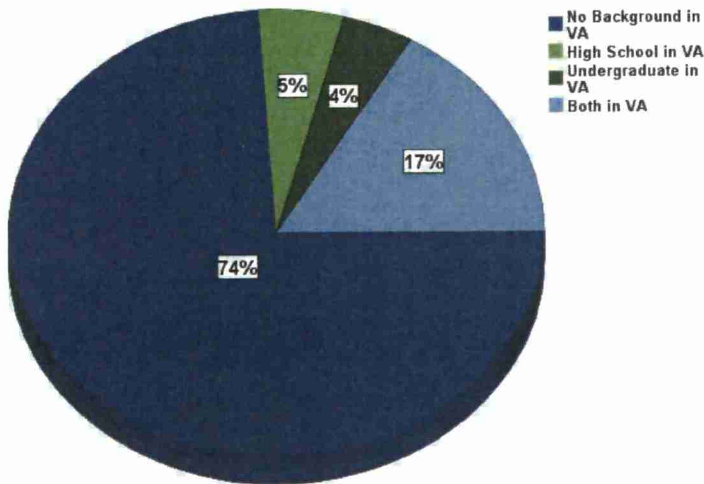
Location Choice
% Rural to Non-Metro: 14%
% Urban/Suburban to Non-Metro: 6%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Primary Location: USDA Rural Urban Continuum		Rural Status of Childhood Location		
Code	Description	Rural	Suburban	Urban
	Metro Counties			
1	Metro, 1 million+	15%	61%	24%
2	Metro, 250,000 to 1 million	26%	54%	20%
3	Metro, 250,000 or less	23%	60%	17%
	Non-Metro Counties			
4	Urban pop 20,000+, Metro adjacent	31%	44%	25%
6	Urban pop, 2,500-19,999, Metro adjacent	34%	44%	22%
7	Urban pop, 2,500-19,999, non adjacent	40%	37%	23%
8	Rural, Metro adjacent	40%	42%	18%
9	Rural, non adjacent	29%	45%	26%
	Overall	**18%**	**59%**	**23%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

18% of physicians grew up in self-described rural areas, and 14% of these professionals currently work in non-metro counties. Overall, 7% of Virginia's physician workforce work in non-metro areas of the state.

Top Ten States for Physician Recruitment

Rank	All Physicians			
	Medical School	#	Initial Residency	#
1	Virginia	4,735	Virginia	5,929
2	Outside U.S./Canada	4,537	New York	2,067
3	Pennsylvania	1,547	Washington, D.C.	1,828
4	Washington, D.C.	1,210	Pennsylvania	1,539
5	New York	1,177	Maryland	1,156
6	Maryland	912	North Carolina	927
7	North Carolina	719	Ohio	741
8	Ohio	544	California	633
9	Tennessee	456	Michigan	592
10	Texas	451	Texas	554

Source: Va. Healthcare Workforce Data Center

22% of physicians went to medical school in Virginia, while 27% completed their initial residency in the state.

Rank	Licensed in the Past 5 Years			
	Medical School	#	Initial Residency	#
1	Outside U.S./Canada	1,125	Virginia	1,392
2	Virginia	922	New York	518
3	Pennsylvania	368	Pennsylvania	352
4	New York	235	Maryland	279
5	Washington, D.C.	224	Washington, D.C.	277
6	Maryland	211	North Carolina	189
7	Florida	147	Ohio	175
8	West Virginia	147	Michigan	169
9	Tennessee	140	Texas	140
10	Ohio	140	Illinois	128

Source: Va. Healthcare Workforce Data Center

Among physicians who have been licensed in the past five years, 22% received their medical degree in Virginia, while 27% completed their initial residency in the state.

44% of licensed physicians did not participate in Virginia's workforce in 2020. 93% of these physicians worked at some point in the past year, including 89% who currently work as physicians.

At a Glance:

Not in VA Workforce

Total:	20,681
% of Licensees:	44%
Federal/Military:	29%
VA Border State/DC:	18%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Medical Schools		
School	#	%
Virginia Commonwealth	2,415	12%
University of Virginia	1,548	8%
Eastern VA Medical School	1,173	6%
Georgetown University	654	3%
George Washington Univ.	546	3%
Uniformed Services Univ. of the Health Sciences	522	3%
Virginia College of Osteopathic Medicine	483	2%
University of Maryland	391	2%
Drexel University	329	2%
Jefferson Medical College	320	2%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Top Medical Schools

VCU:	12%
UVA:	8%
East. Va. Med. School:	6%

Top Certifications

Internal Medicine:	29%
Family Medicine:	15%
Pediatrics:	12%

Source: Va. Healthcare Workforce Data Center

Over two-thirds of physicians do not carry any educational debt. For those with debt, median is $110K to $120K. However, among physicians who are under the age of 40, 59% carry education debt. The median debt is between $200,000 and $210,000.

Educational Debt				
Amount Carried	All Physicians		Physicians under 40	
	#	%	#	%
None	13,136	70%	1,589	41%
$50,000 or less	1,248	7%	279	7%
$50,001-$100,000	1,060	6%	287	7%
$100,001-$150,000	868	5%	245	6%
$150,001-$200,000	574	3%	259	7%
$200,001-$250,000	531	3%	300	8%
More than $250,000	1,244	7%	955	24%
Total	18,661	100%	3,914	100%

Source: Va. Healthcare Workforce Data Center

Top 10 Board Certifications		
Area	#	%
Internal Medicine	6,433	29%
Family Medicine	3,393	15%
Pediatrics	2,624	12%
Surgery	2,051	9%
Psychiatry/Neurology	1,705	8%
Emergency Medicine	1,444	6%
Anesthesiology	1,142	5%
Obstetrics/Gynecology	1,090	5%
Radiology	1,002	4%
Orthopedic surgery	591	3%
At Least One Certification	22,314	85%

Source: Va. Healthcare Workforce Data Center

Over one-quarter of Virginia's physician workforce holds a board certification in Internal Medicine. Overall, 85% of Virginia's physician workforce report at least one board certification.

A Closer Look:

At a Glance:

Gov't Programs

Medicare Participant: 18%
Medicare Non-Participating Provider: 66%
Medicaid Participant: 63%

Medical Services

Telemedicine: 36%
Meaningful Use of EHRs: 32%
CPA - NP: 21%

Source: Va. Healthcare Workforce Data Center

Admitting Privileges		
Number of Facilities	#	%
Zero	9,239	44%
One	7,073	34%
Two	2,417	12%
Three	1,136	5%
Four or more	1,139	5%
Total	**21,004**	**100%**

Source: Va. Healthcare Workforce Data Center

18% of Virginia's physician workforce participates in the Medicare program, while 66% are non-participating Medicare providers, that is, they do not accept Medicare reimbursement across all services but do so on a case-by-case basis. In addition, 63% of physicians participate in Virginia's Medicaid program.

Medical Services/Activities		
Service	#	%
Telemedicine or Remote Consulting	9,614	36%
Achieve Meaningful Use of EHRs	8,406	32%
Collaborative Practice Agreement – Nurse Practitioner	5,453	21%
Collaborative Practice Agreement – Physician Assistant	3,625	14%
Participate in an Accountable Care Organization	3,289	12%
Collaborative Practice Agreement - Pharmacist	804	3%
At least One Service	**14,262**	**54%**

Source: Va. Healthcare Workforce Data Center

Gov't Program Participation		
Medicare Participating Provider		
Yes	4,702	18%
No	21,613	82%
Total	**26,315**	**100%**
Medicare Non-Participating Provider		
Yes	17,258	66%
No	9,058	34%
Total	**26,316**	**100%**
Medicaid Participating Provider		
Yes	16,461	63%
No	9,854	37%
Total	**26,315**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Employment Situation

At a Glance:

Employment
Employed in Profession: 95%
Involuntarily Unemployed: <1%

Positions Held
1 Full-Time: 69%
2 or more Positions: 14%

Weekly Hours:
40 to 49: 31%
60 or more: 23%
Less than 30: 10%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Current Work Status		
Status	#	%
Employed, capacity unknown	45	0%
Employed in a medicine or osteopathy related capacity	21,257	95%
Employed, NOT in a medicine or osteopathy related capacity	185	1%
Not working, reason unknown	0	0%
Involuntarily unemployed	39	<1%
Voluntarily unemployed	215	1%
Retired	584	3%
Total	22,325	100%

Source: Va. Healthcare Workforce Data Center

95% of physicians are currently employed in the profession, and less than 1% are involuntarily unemployed. Over two-thirds of all physicians currently hold one full-time job, while 14% have multiple positions. Just 31% of physicians work between 40 and 49 hours per week, while slightly less than one-quarter work at least 60 hours per week.

Current Positions		
Positions	#	%
No Positions	838	4%
One Part-Time Position	2,855	13%
Two Part-Time Positions	765	4%
One Full-Time Position	14,961	69%
One Full-Time Position & One Part-Time Position	1,810	8%
Two Full-Time Positions	94	0%
More than Two Positions	394	2%
Total	21,717	100%

Source: Va. Healthcare Workforce Data Center

Current Weekly Hours		
Hours	#	%
0 hours	838	4%
1 to 9 hours	420	2%
10 to 19 hours	592	3%
20 to 29 hours	1,093	5%
30 to 39 hours	2,281	11%
40 to 49 hours	6,237	31%
50 to 59 hours	4,320	21%
60 to 69 hours	2,842	14%
70 to 79 hours	841	4%
80 or more hours	933	5%
Total	20,397	100%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Income		
Hourly Wage	#	%
Volunteer Work Only	296	2%
Less than $50,000	641	4%
$50,000-$99,999	1,398	8%
$100,000-$149,999	1,695	10%
$150,000-$199,999	2,383	14%
$200,000-$249,999	3,201	19%
$250,000-$299,999	2,077	12%
$300,000-$349,999	1,745	11%
$350,000-$399,999	1,117	7%
$400,000 or more	2,098	13%
Total	**16,651**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Earnings
Median Income: $225k-$250k

Benefits
Employer Health Ins.: 69%
Employer Retirement: 69%

Satisfaction
Satisfied 93%
Very Satisfied: 59%

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	#	%
Very Satisfied	12,870	59%
Somewhat Satisfied	7,341	34%
Somewhat Dissatisfied	1,205	6%
Very Dissatisfied	364	2%
Total	**21,779**	**100%**

Source: Va. Healthcare Workforce Data Center

The typical physician earned between $225,000 and $250,000 in 2020. In addition, among physicians who received either an hourly wage or a salary at their primary work location, 69% received health insurance and 69% had access to a retirement plan.

Employer-Sponsored Benefits			
Benefit	#	%	% of Wage/Salary Employees
Health Insurance	12,964	61%	69%
Retirement	12,957	61%	69%
Paid Vacation	11,350	53%	62%
Dental Insurance	11,401	54%	63%
Group Life Insurance	9,208	43%	51%
Paid Sick Leave	8,819	41%	49%
Signing/Retention Bonus	3,378	16%	20%
At Least One Benefit	**15,501**	**73%**	**82%**

*From any employer at time of survey.
Source: Va. Healthcare Workforce Data Center

A Closer Look:

Underemployment in Past Year		
In the past year did you . . .?	#	%
Experience Involuntary Unemployment?	315	1%
Experience Voluntary Unemployment?	833	3%
Work Part-time or temporary positions, but would have preferred a full-time/permanent position?	559	2%
Work two or more positions at the same time?	3,454	13%
Switch employers or practices?	1,202	5%
Experienced at least one	**5,501**	**21%**

Source: Va. Healthcare Workforce Data Center

1% of Virginia's physicians experienced involuntary unemployment at some point in the past year. By comparison, Virginia's average monthly unemployment rate was 6.0%.[2]

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at this Location	621	3%	273	5%
Less than 6 Months	777	4%	478	9%
6 Months to 1 Year	1,365	6%	486	9%
1 to 2 Years	3,477	16%	1,036	19%
3 to 5 Years	4,388	21%	1,205	22%
6 to 10 Years	3,449	16%	822	15%
More than 10 Years	7,075	33%	1,158	21%
Subtotal	**21,152**	**100%**	**5,459**	**100%**
Did not have location	323		20,994	
Item Missing	5,118		141	
Total	**26,593**		**26,593**	

Source: Va. Healthcare Workforce Data Center

63% of physicians received a salary at their primary work location, while 16% earned income from their own business or practice.

At a Glance:

Unemployment Experience 2020
Involuntarily Unemployed: 1%
Underemployed: 2%

Turnover & Tenure
Switched Jobs: 5%
New Location: 15%
Over 2 years: 70%
Over 2 yrs, 2nd location: 58%

Employment Type
Salary/Commission: 63%
Business/Pract. Income: 16%
Hourly Wage: 14%

Source: Va. Healthcare Workforce Data Center

70% of physicians have worked at their primary location for more than 2 years—the job tenure normally required to get a conventional mortgage loan.

Employment Type		
Primary Work Site	#	%
Salary/ Commission	10,446	63%
Business/ Practice Income	2,616	16%
Hourly Wage	2,361	14%
By Contract	813	5%
Unpaid	276	2%
Subtotal	**16,511**	**100%**

Source: Va. Healthcare Workforce Data Center

[1] As reported by the US Bureau of Labor Statistics, the non-seasonally adjusted monthly unemployment rate rose from 2.8% in February 2020 to a high of 10.8% in April 2020. More recently, it fell to 4.6% in November 2020 and this rate was preliminary at the time of publication. December's unemployment rate was not available at the time of this publication.

Work Site Distribution

At a Glance:

Concentration
Top Region: 30%
Top 3 Regions: 74%
Lowest Region: 1%

Locations
2 or more (2020): 26%
2 or more (Now*): 25%

Source: Va. Healthcare Workforce Data Center

30% of all physicians work in Northern Virginia, the most of any region in the state. In addition, one-quarter of all physicians work in Central Virginia.

Number of Work Locations				
Locations	Work Locations in Past Year		Work Locations Now*	
	#	%	#	%
0	290	1%	756	4%
1	15,472	73%	15,308	72%
2	2,088	10%	2,155	10%
3	2,602	12%	2,452	12%
4	406	2%	300	1%
5	188	1%	149	1%
6 or More	283	1%	210	1%
Total	**21,328**	**100%**	**21,328**	**100%**

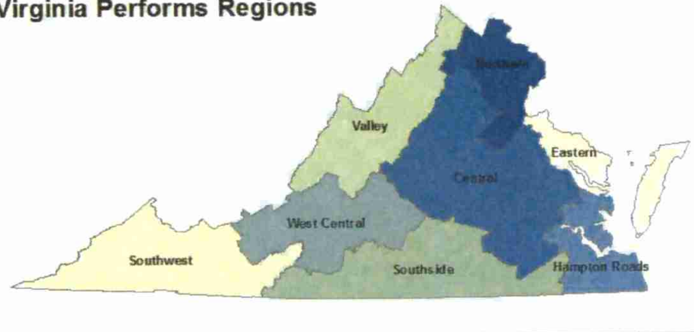
*At the time of survey completion, December 2020.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Regional Distribution of Work Locations				
Virginia Performs Region	Primary Location		Secondary Location	
	#	%	#	%
Central	5,216	25%	977	18%
Eastern	258	1%	91	2%
Hampton Roads	4,065	19%	924	17%
Northern	6,206	30%	1,684	31%
Southside	494	2%	148	3%
Southwest	658	3%	201	4%
Valley	1,120	5%	237	4%
West Central	2,301	11%	490	9%
Virginia Border State/DC	264	1%	226	4%
Other US State	293	1%	405	8%
Outside of the US	9	0%	17	0%
Total	**20,884**	**100%**	**5,400**	**100%**
Item Missing	5,172		102	

Source: Va. Healthcare Workforce Data Center



25% of all physicians currently have multiple work locations, while 26% of physicians have had at least two work locations over the past year.

A Closer Look:

Sector	Location Sector			
	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	9,632	50%	2,940	58%
Non-Profit	6,031	31%	1,524	30%
State/Local Government	1,576	8%	294	6%
Veterans Administration	599	3%	112	2%
U.S. Military	1,179	6%	140	3%
Other Federal Government	163	1%	41	1%
Total	19,180	100%	5,051	100%
Did not have location	323		20,994	
Item Missing	7,090		547	

Source: Va. Healthcare Workforce Data Center

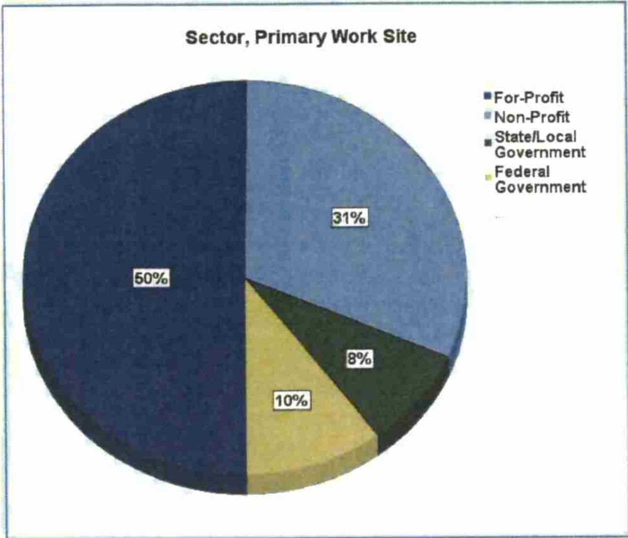
At a Glance:
(Primary Locations)

Sector
For Profit: 50%
Federal: 10%

Top Establishments
Group Private Practice: 35%
Hospital – Inpatient: 16%
Hospital – Outpatient: 13%

Source: Va. Healthcare Workforce Data Center

81% of all physicians work in the private sector, including 50% who work at for-profit establishments. Another 10% of Virginia's physician workforce work for the federal government.



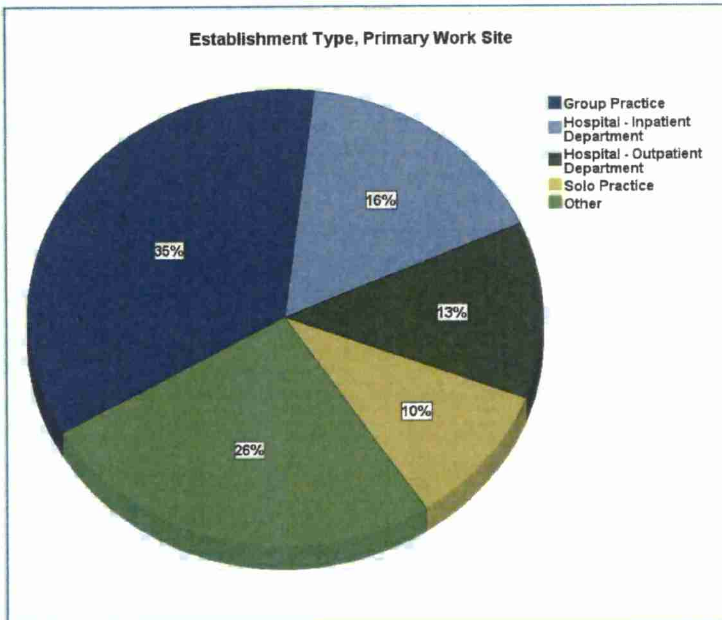
Source: Va. Healthcare Workforce Data Center

Establishment Type	Location Type			
	Primary Location		Secondary Location	
	#	%	#	%
Group Practice	6,663	35%	1,573	32%
Hospital - Inpatient Department	3,091	16%	900	18%
Hospital - Outpatient Department	2,383	13%	519	10%
Solo Practice	1,884	10%	396	8%
Hospital - Emergency Department	1,331	7%	443	9%
Community Clinic/Outpatient Care Center	854	5%	266	5%
Medical/Osteopathic School or Parent University	667	4%	103	2%
Mental Health Facility	208	1%	69	1%
Insurance Organization	169	1%	45	1%
Nursing Home/Long-Term Care Facility	140	1%	79	2%
Outpatient Surgical Center	110	1%	68	1%
Supplier Organization	18	0%	17	0%
Other	1,390	7%	503	10%
Total	**18,908**	**100%**	**4,981**	**100%**
Did Not Have a Location	323		20,994	

Source: Va. Healthcare Workforce Data Center

Group private practices are the most common establishment type among Virginia's physicians with a primary work location. The inpatient and outpatient departments of hospitals are also typical primary establishment types.

Private insurance is the most accepted payment type among Virginia physicians.



Source: Va. Healthcare Workforce Data Center

Accepted Forms of Payment		
Payment	#	%
Private Insurance	17,301	93%
Cash/Self-Pay	15,822	85%
Medicare	15,685	85%
Medicaid	15,452	83%

Source: Va. Healthcare Workforce Data Center

Time Allocation

At a Glance:
(Primary Locations)

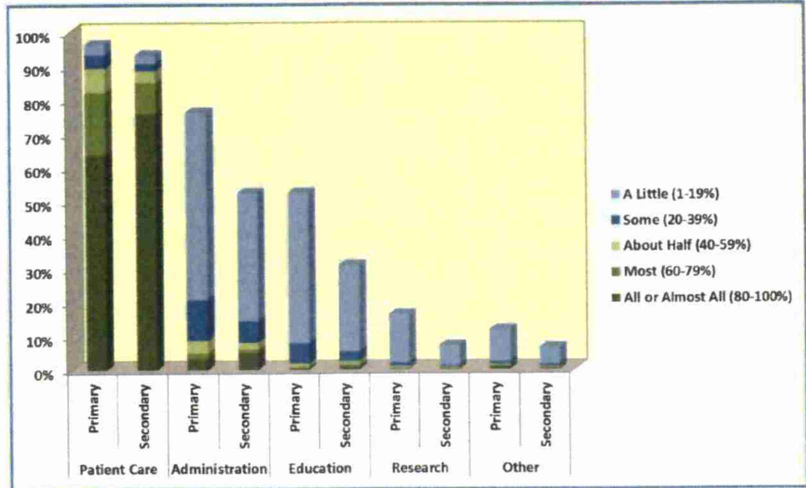
A Typical Physician's Time
Patient Care: 80%-89%
Administration: 1%-9%
Education: 1%-9%

Roles
Patient Care: 82%
Administrative: 5%
Education: 1%

Patient Care Physicians
Median Admin Time: 1%-9%
Ave. Admin Time: 1%-9%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

The typical physician spends most of their time in patient care activities. In fact, 82% of all physicians fill a patient care role, defined as spending at least 60% of their time in that activity. Another 5% of physicians fill an administrative role.

Time Allocation										
Time Spent	Patient Care		Admin.		Education		Research		Other	
	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site
All or Almost All (80-100%)	64%	76%	3%	5%	0%	1%	0%	0%	1%	0%
Most (60-79%)	18%	9%	2%	1%	0%	1%	0%	0%	0%	0%
About Half (40-59%)	7%	3%	4%	2%	1%	1%	0%	0%	0%	0%
Some (20-39%)	4%	2%	12%	6%	6%	3%	1%	0%	1%	1%
A Little (1-20%)	3%	3%	56%	38%	45%	26%	14%	6%	9%	5%
None (0%)	4%	7%	24%	48%	47%	69%	84%	93%	88%	93%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Number of Patients/Week
Primary (Median): 50-75
Secondary (Median): 1-25

Accepts New Patients?
Primary: 59%
Secondary: 49%

Medicare/Medicaid
New Medicare Patients: 68%
New Medicaid Patients: 73%

Source: Va. Healthcare Workforce Data Center

59% of physicians are accepting new patients at their primary work location.

A Closer Look:

Patient Care Activities Predominantly Primary Care?				
Response	Primary Location		Secondary Location	
	#	%	#	%
Yes	7,234	42%	1,452	36%
No	11,782	58%	3,444	64%
Total	**19,016**	**100%**	**4,896**	**100%**
Question Inapplicable to Respondent	1,607		21,383	

Source: Va. Healthcare Workforce Data Center

Accepting New Patients? Yes				
Response	Primary Location		Secondary Location	
	#	%	#	%
I can accept some additional patients	6,077	31%	1,035	20%
I can accept many additional patients	5,573	28%	1,516	29%
No/Not Applicable				
I do not manage my patient load at this location	5,563	28%	1,824	35%
I do not provide patient care at this location	1,790	9%	685	13%
I cannot accept any additional patients	829	4%	147	3%
Total	**19,832**	**100%**	**5,207**	**100%**

Source: Va. Healthcare Workforce Data Center

Patients Visits Per Week				
Number of Visits	Primary Location		Secondary Location	
	#	%	#	%
None	1,792	9%	660	13%
1 to 24	3,427	17%	2,408	46%
25 to 49	4,424	22%	1,073	21%
50 to 74	4,140	21%	516	10%
75 to 99	2,836	14%	225	4%
100 to 124	1,882	9%	176	3%
125 to 149	639	3%	45	1%
150 or more	758	4%	107	2%
Total	**19,898**	**100%**	**5,210**	**100%**

Source: Va. Healthcare Workforce Data Center

The typical physician treats between 25 and 49 patients per week at their primary work location.

New Patient Capacity				
Number of Patients	Primary Location		Secondary Location	
	#	%	#	%
Less than 50	4,100	36%	1,021	41%
50 to 99	2,581	23%	542	22%
100 to 199	1,820	16%	366	15%
200 to 299	786	7%	138	5%
300 to 399	350	3%	68	3%
400 to 499	318	3%	66	3%
500 to 749	364	3%	51	2%
750 to 999	119	1%	25	1%
1,000 or more	838	7%	238	9%
Total	**11,276**	**100%**	**2,515**	**100%**

Source: Va. Healthcare Workforce Data Center

Among physicians who are accepting new patients at their primary work location, 36% can accept no more than 50 patients, while 23% can accept between 50 and 99 new patients.

Accepting New Medicare/Medicaid Patients?				
Response	Primary Location		Secondary Location	
	#	%	#	%
Medicaid				
Yes	8,622	74%	1,979	77%
No, I am not a Medicaid provider	2,174	19%	437	17%
No, I am a Medicaid Provider, but am not accepting new Medicaid patients	780	7%	143	6%
Total	**11,576**	**100%**	**2,559**	**100%**
Medicare				
Yes	15,602	59%	-	-
No	10,713	41%	-	-
Total	**26,315**	**100%**	**-**	**-**

Source: Va. Healthcare Workforce Data Center

Among physicians who are accepting new patients at their primary work location, 74% are accepting new Medicaid patients and 59% are accepting new Medicare patients.

Status Change for New Medicaid Patients in Past Year?				
Response	Primary Location		Secondary Location	
	#	%	#	%
Yes	537	5%	159	6%
No	11,090	95%	2,409	94%
Total	**11,627**	**100%**	**2,568**	**100%**

Source: Va. Healthcare Workforce Data Center

Among physicians who are accepting new patients at their primary work location, 95% have seen no change in their status concerning new Medicaid patients over the past 12 months.

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All Physicians		Physicians Over 50	
	#	%	#	%
Under age 50	208	1%	-	-
50 to 54	548	3%	51	1%
55 to 59	1,504	8%	372	4%
60 to 64	3,788	21%	1,570	16%
65 to 69	6,200	34%	3,441	36%
70 to 74	3,005	17%	2,140	22%
75 to 79	1,012	6%	793	8%
80 or over	462	3%	385	4%
I do not intend to retire	1,267	7%	777	8%
Total	17,994	100%	9,529	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All Physicians

Under 65: 34%

Under 60: 14%

Physicians 50 and over

Under 65: 21%

Under 60: 4%

Time until Retirement

Within 2 years: 9%

Within 10 years: 31%

Half the workforce: By 2040

Source: Va. Healthcare Workforce Data Center

One-third of all physicians expect to retire before the age of 65, while another third plan on working until at least age 70. Among physicians who are age 50 and over, 21% still expect to retire by age 65, while 42% plan on working until at least age 70.

Within the next two years, just 1% of Virginia's physicians expect to leave the profession and 3% plan on leaving the state to practice medicine elsewhere. Meanwhile, 7% of physicians plan on increasing patient care hours, and 4% also plan to pursue additional educational opportunities.

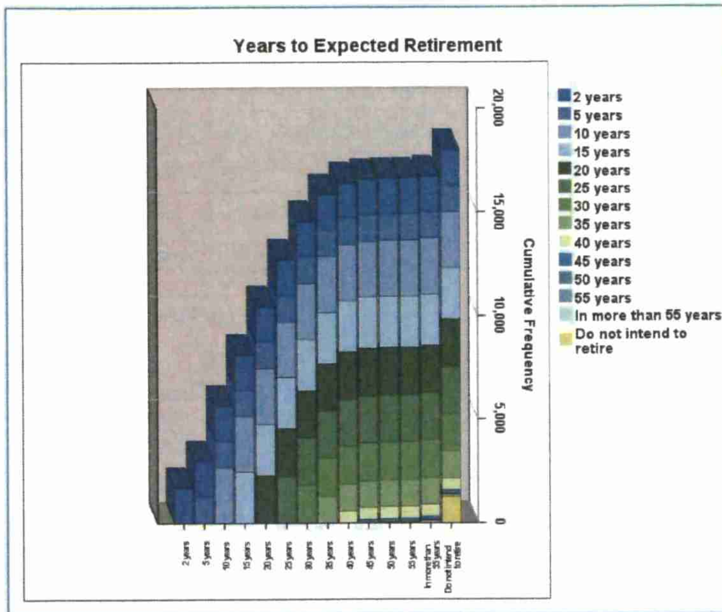
Future Plans		
Two-Year Plans:	#	%
Decrease Participation		
Leave Profession	299	1%
Leave Virginia	724	3%
Decrease Patient Care Hours	2,561	10%
Decrease Teaching Hours	213	1%
Increase Participation		
Increase Patient Care Hours	2,115	8%
Increase Teaching Hours	1,731	7%
Pursue Additional Education	1,142	4%
Return to Virginia's Workforce	86	0%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for physicians. 9% of physicians expect to retire within the next two years, while 31% plan on retiring in the next ten years. Half of the current physician workforce expect to be retired by 2040.

Time to Retirement			
Expect to retire within. . .	#	%	Cumulative %
2 years	1,696	9%	9%
5 years	1,285	7%	17%
10 years	2,686	15%	31%
15 years	2,471	14%	45%
20 years	2,304	13%	58%
25 years	2,261	13%	71%
30 years	1,841	10%	81%
35 years	1,288	7%	56%
40 years	577	3%	91%
45 years	160	1%	92%
50 years	50	0%	92%
55 years	6	0%	92%
In more than 55 years	99	1%	93%
Do not intend to retire	1,267	7%	100%
Total	**17,994**	**100%**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Using these estimates, retirement will begin to reach 10% of the current workforce starting in 2030. Retirement will peak at 15% of the workforce around the same time before declining to under 10% of the current workforce again around 2055.

Full-Time Equivalency Units

At a Glance:

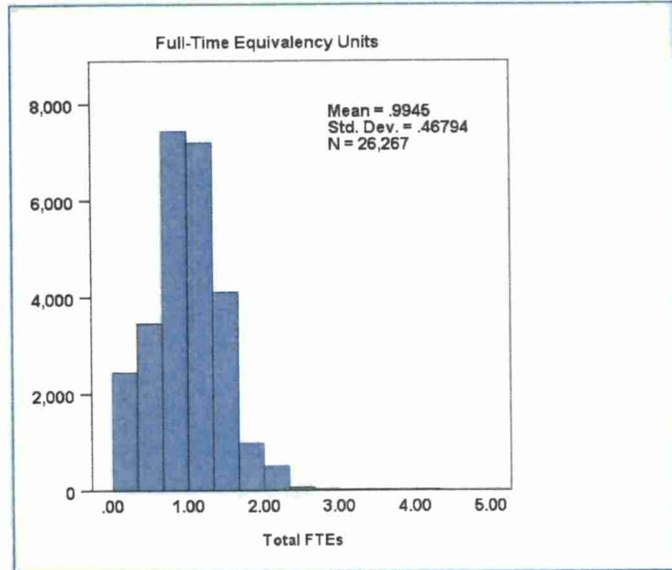
FTEs
Total: 26,122
FTEs/1,000 Residents[3]: 3.06
Average: 0.99

Age & Gender Effect
Age, Partial Eta[4]: Small
Gender, Partial Eta[4]: Small

Partial Eta[4] Explained:
Partial Eta[4] is a statistical measure of effect size.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

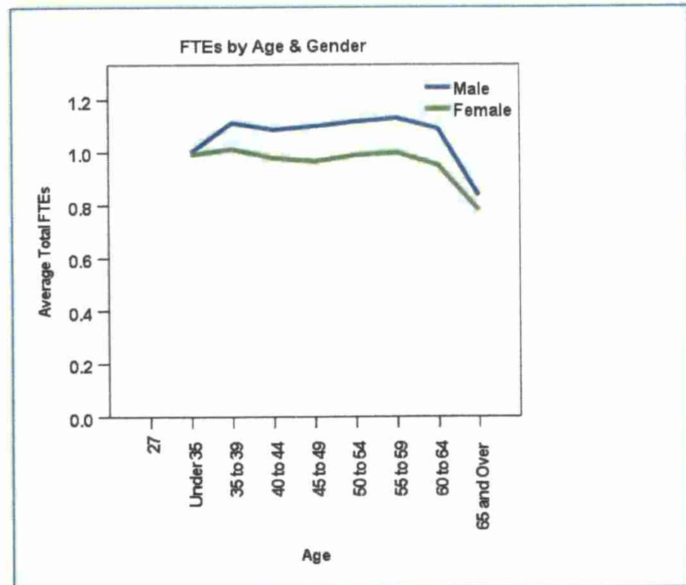


Source: Va. Healthcare Workforce Data Center

The typical physician provided 0.99 FTEs in 2020, or approximately 39.6 hours per week for 52 weeks. Although FTEs appear to vary by age and gender, statistical tests did not verify that a difference exists.[4]

Full-Time Equivalency Units		
Age	Average	Median
Age		
Under 30	0.99	0.96
30 to 34	1.10	1.13
35 to 39	1.02	0.96
40 to 44	1.02	0.94
45 to 49	1.05	0.96
50 to 54	1.07	1.01
55 to 59	1.02	0.97
60 and Over	0.79	0.65
Gender		
Male	1.03	1.05
Female	0.97	0.97

Source: Va. Healthcare Workforce Data Center

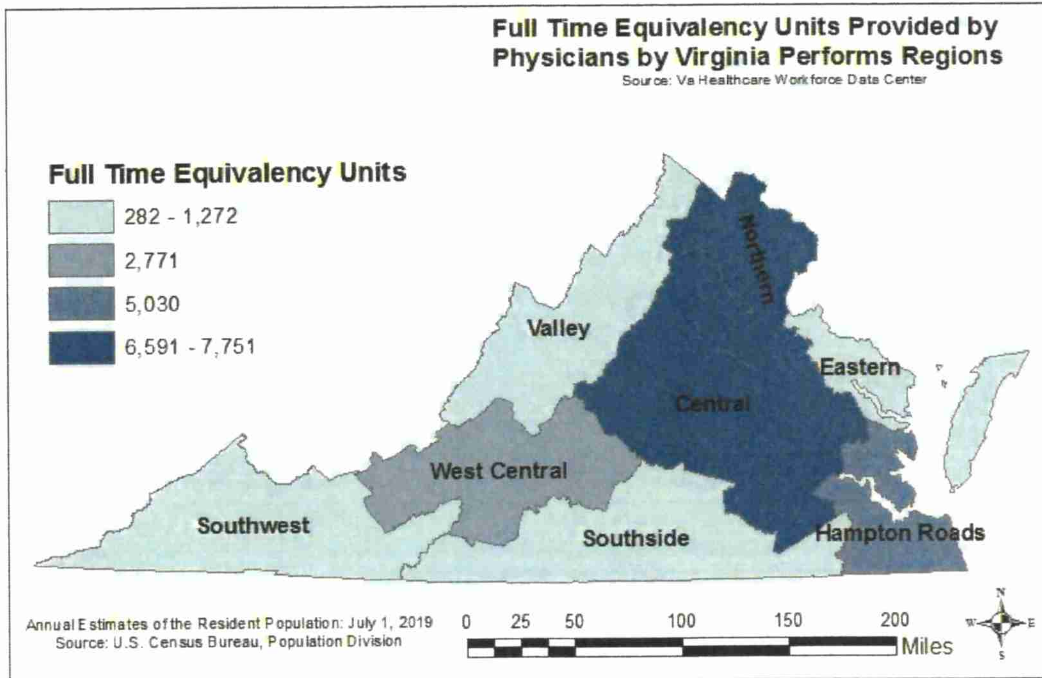


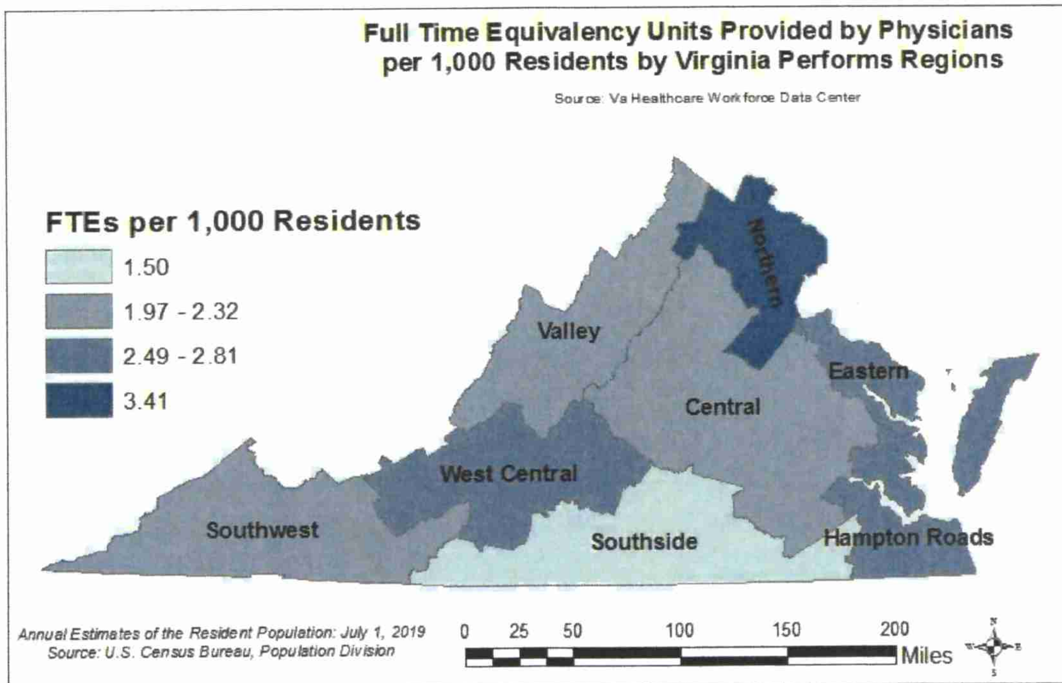
Source: Va. Healthcare Workforce Data Center

[3] Number of residents in 2019 was used as the denominator.
[4] Due to assumption violations in Mixed between-within ANOVA (Levene's Test was significant).

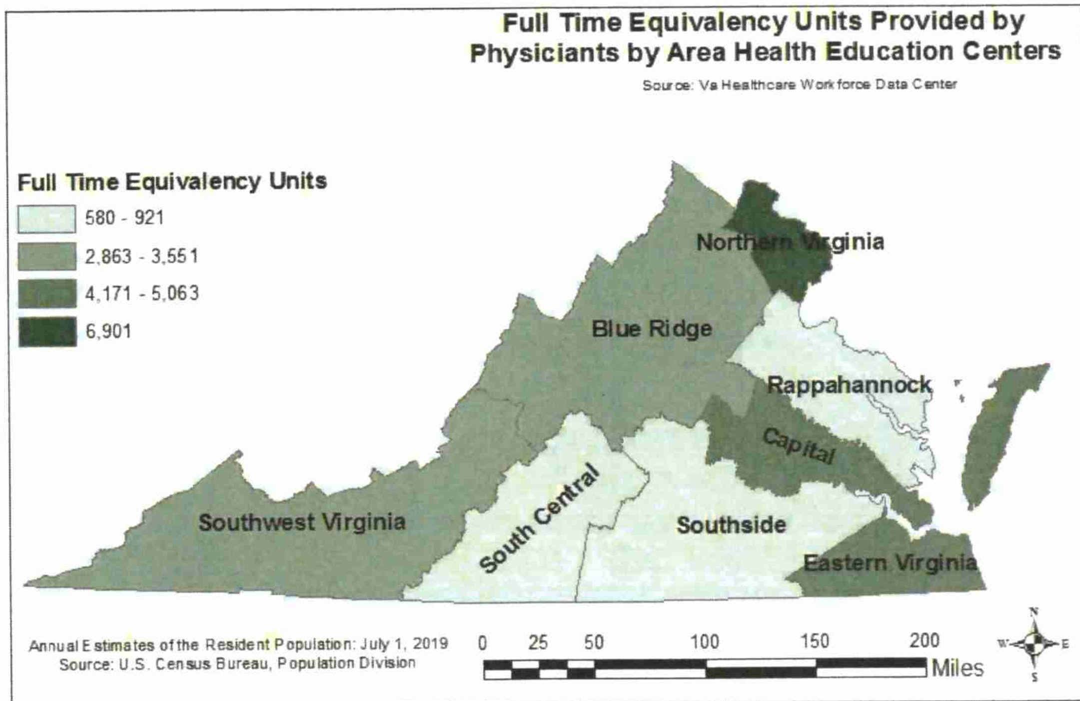
Maps

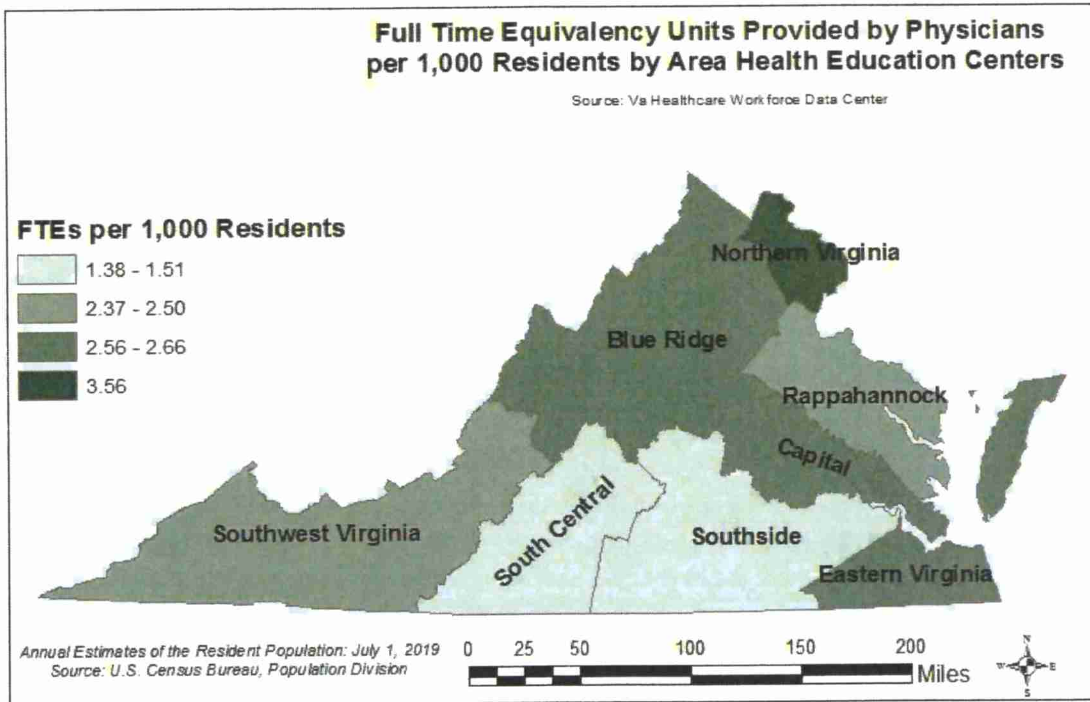
Virginia Performs Regions



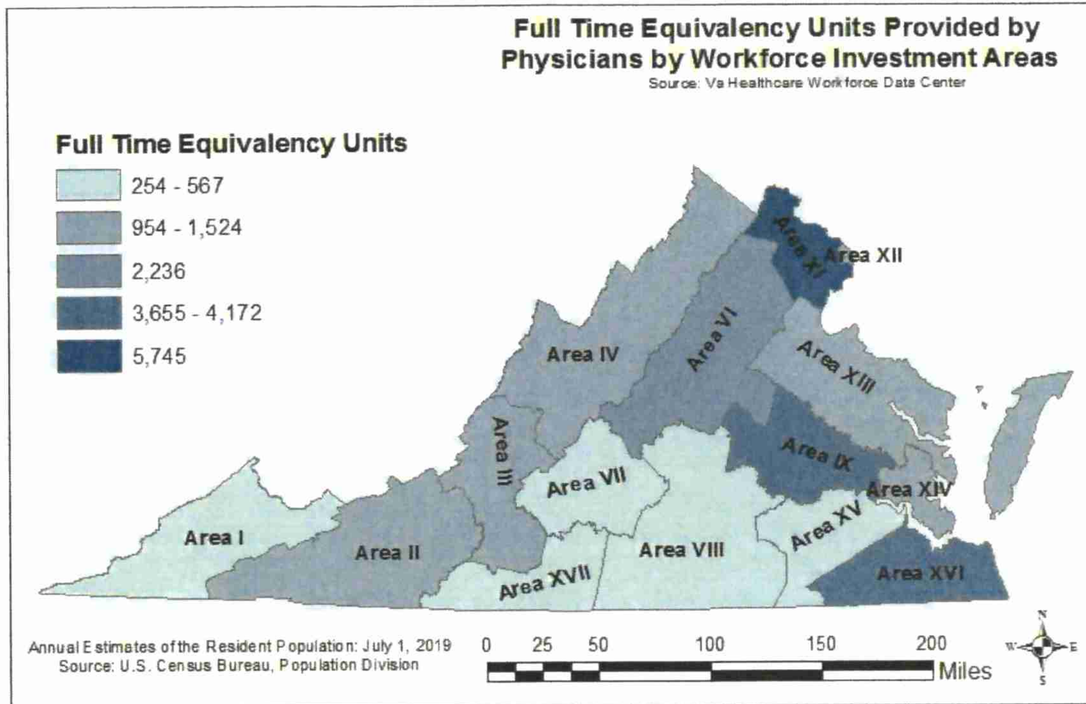


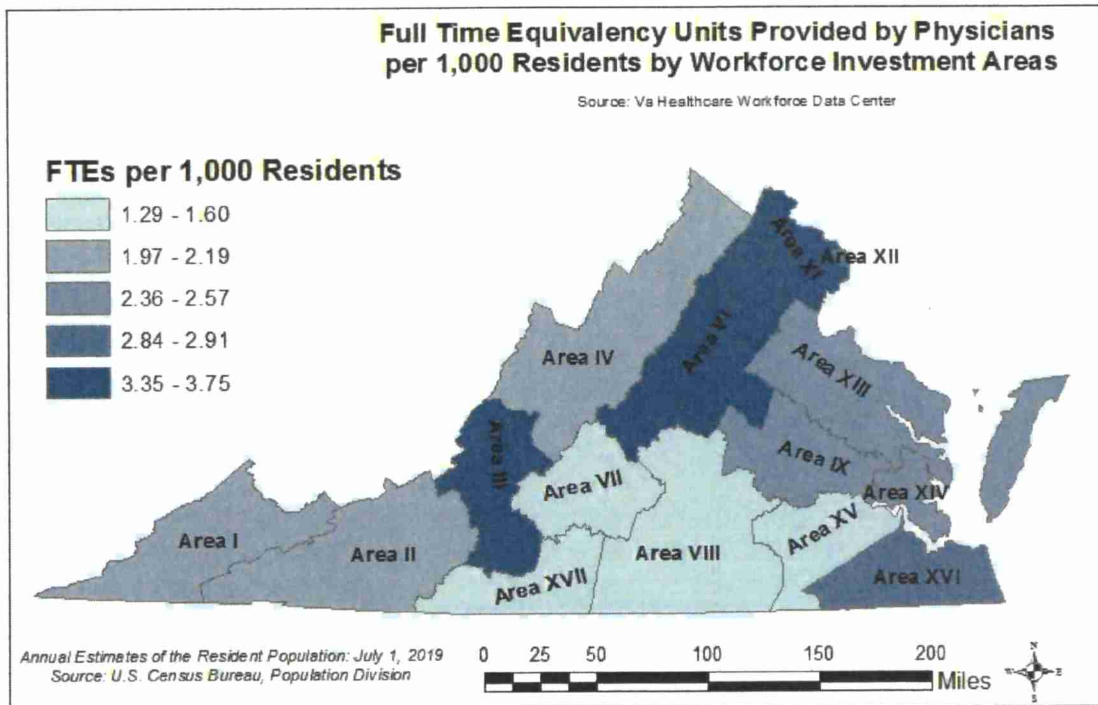
Area Health Education Center Regions



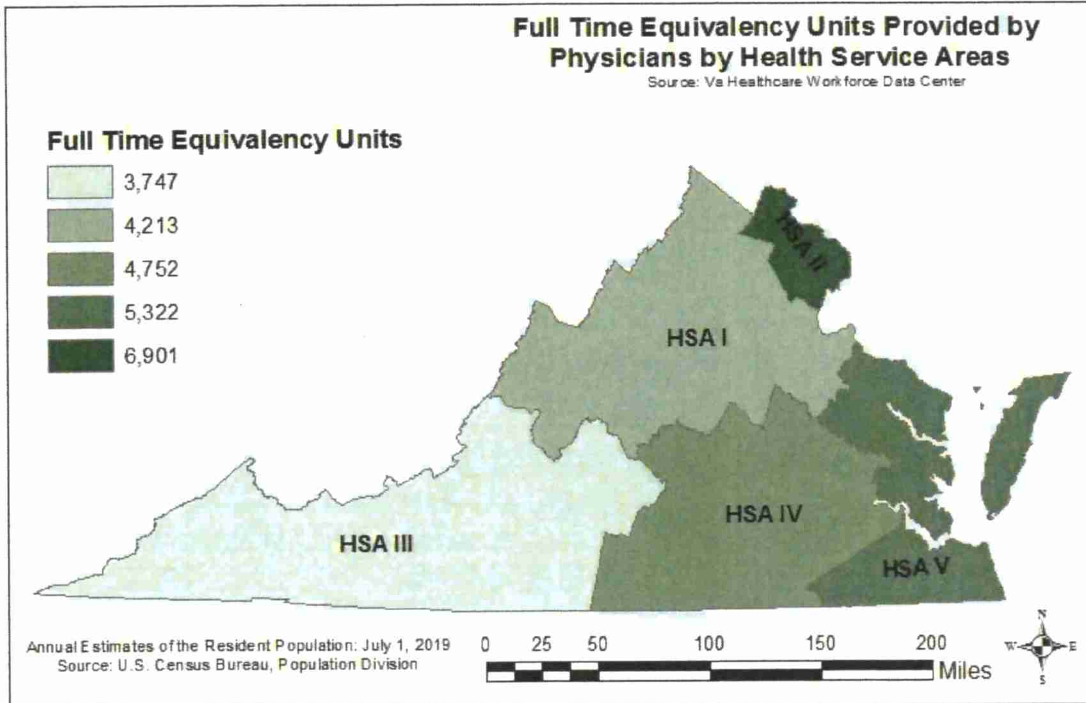


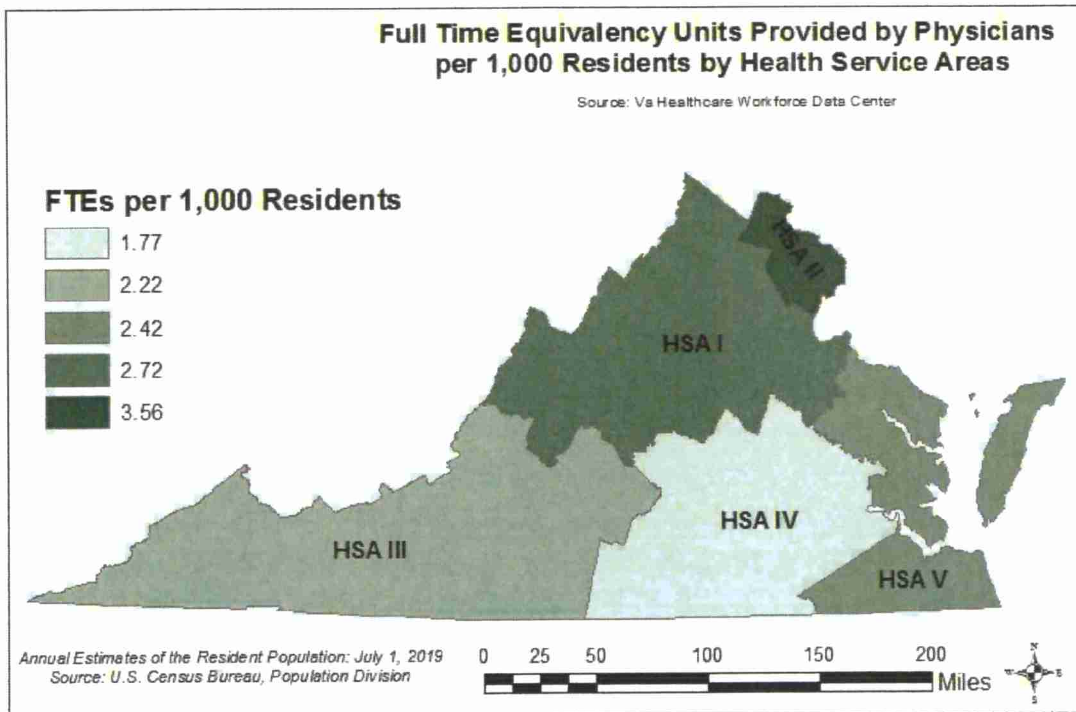
Workforce Investment Areas



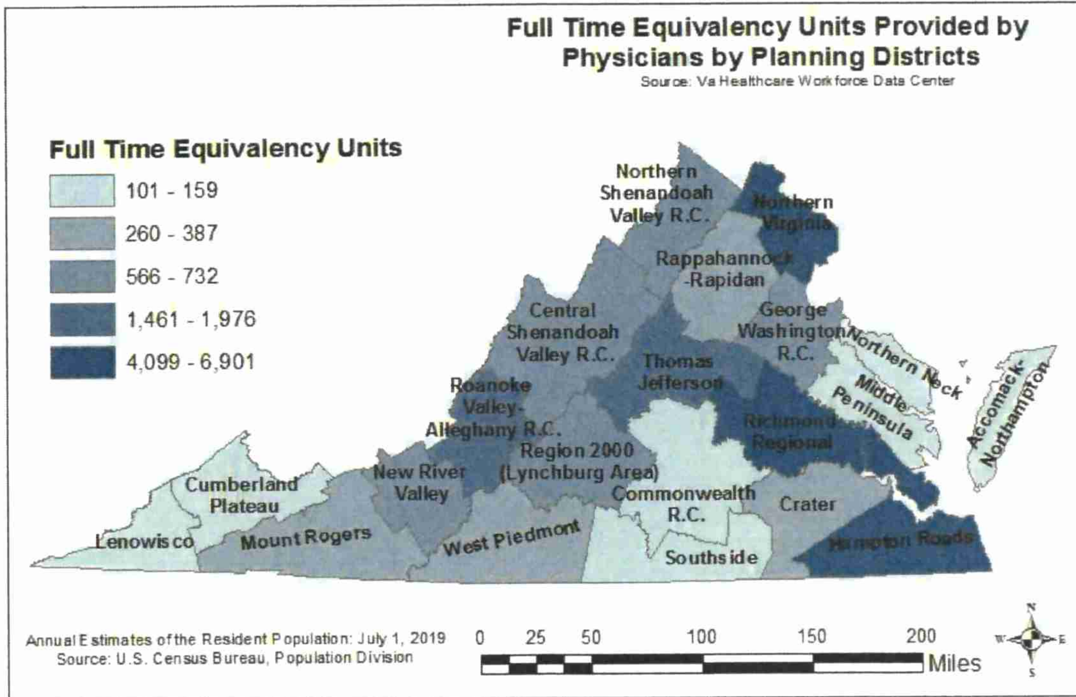


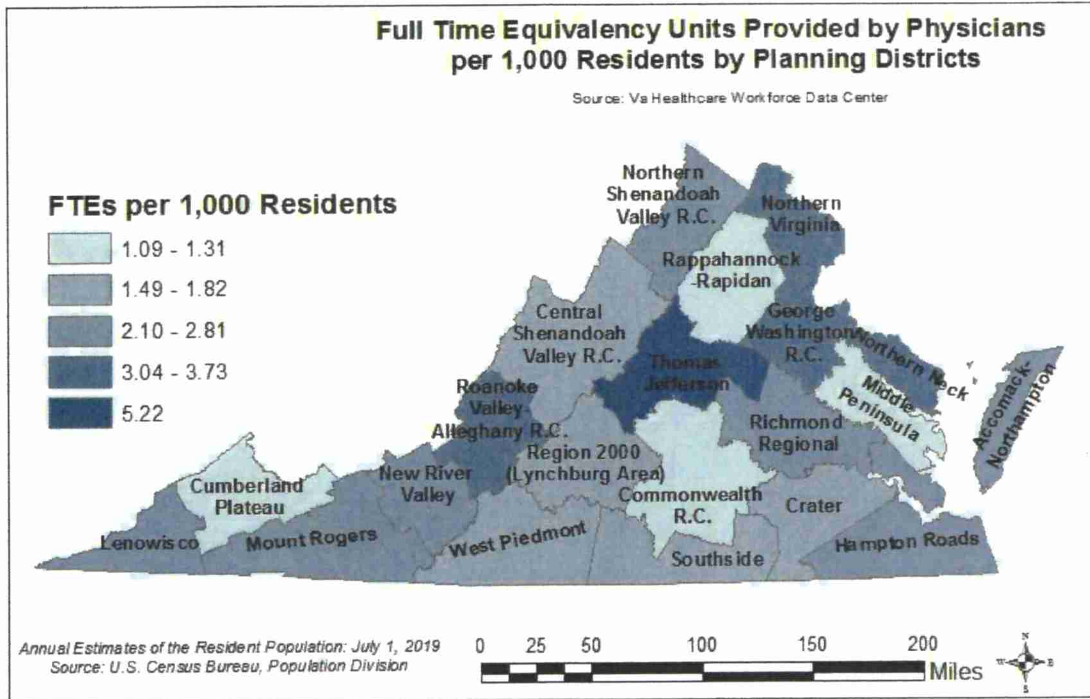
Health Services Areas





Planning Districts





Appendices

Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min	Max
Metro, 1 million+	18,507	81.10%	1.23306	1.11022	2.126109
Metro, 250,000 to 1 million	2,372	78.63%	1.27185	1.145145	2.192993
Metro, 250,000 or less	3,852	80.53%	1.241779	1.118071	2.141144
Urban pop 20,000+, Metro adj	223	82.96%	1.205405	1.08532	2.078425
Urban pop 20,000+, nonadj	0	NA	NA	NA	NA
Urban pop, 2,500-19,999, Metro adj	593	78.75%	1.269807	1.143306	2.189471
Urban pop, 2,500-19,999, nonadj	362	87.02%	1.149206	1.03472	1.981524
Rural, Metro adj	509	69.55%	1.437853	1.294611	2.479224
Rural, nonadj	179	70.95%	1.409449	1.269036	2.430248
Virginia border state/DC	9,035	70.15%	1.425529	1.283514	2.457974
Other US State	11,552	63.23%	1.581599	1.424037	2.727079

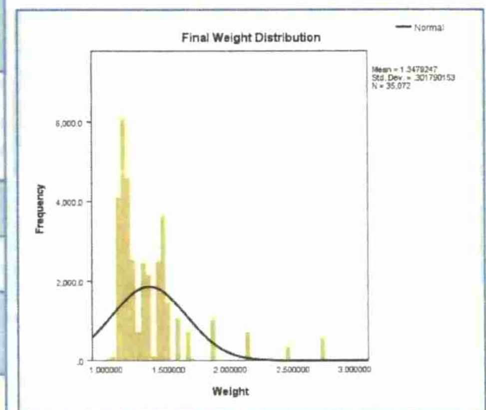
Source: Va. Healthcare Workforce Data Center

See the Methods section on the HWDC website for details on HWDC Methods: www.dhp.virginia.gov/hwdc/

Final weights are calculated by multiplying the two weights and the overall response rate:

Age Weight x Rural Weight x Response Rate = Final Weight.

Overall Response Rate: 0.74315



Source: Va. Healthcare Workforce Data Center

Age	Age Weight			Total Weight	
	#	Rate	Weight	Min	Max
Under 35	3,949	43.10%	2.320212	1.981524	2.727079
35 to 39	6,032	63.15%	1.583618	1.352453	1.861318
40 to 44	6,318	74.23%	1.347122	1.150479	1.58335
45 to 49	5,885	80.14%	1.24788	1.065723	1.466705
50 to 54	5,682	81.47%	1.227479	1.048301	1.442727
55 to 59	5,011	82.02%	1.219221	1.041248	1.433022
60 to 64	4,856	82.54%	1.211577	1.03472	1.424037
65 and Over	9,461	78.30%	1.277133	1.090706	1.501088

Source: Va. Healthcare Workforce Data Center

Agenda Item:
Regulatory Actions - Chart of Regulatory Actions
As of June 14, 2021

		Action / Stage Information
[18 VAC 85 - 20]	Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic	Conversion therapy [Action 5412] Proposed - *Register Date: 2/15/21* *Comment period closed: 4/16/21* *Board to adopt final regs: 6/24/21*
[18 VAC 85 - 21]	Regulations Governing Prescribing of Opioids and Buprenorphine	Waiver for e-prescribing of an opioid [Action 5355] Final - *Register Date: 5/10/21* *Effective: 6/9/21*
[18 VAC 85 - 160]	Regulations Governing the Licensure of Surgical Assistants and Registration of Surgical Technologists	Amendments for surgical assistants consistent with a licensed profession [Action 5639] NOIRA - *Register Date: 3/1/21* *Comment closed: 3/31/21* *Board to adopted proposed regs: 6/24/21*

Department of Health Professions
Regulatory/Policy Actions – 2021 General Assembly
Board on Medicine

EMERGENCY REGULATIONS:

Legislative source	Mandate	Promulgating agency	Board adoption date	Effective date Within 280 days of enactment
SB1189	Occupational therapy compact	Medicine	8/6/21	**By 12/23/21**

EXEMPT REGULATORY ACTIONS

Legislative source	Mandate	Promulgating agency	Adoption date	Effective date
HB1737	Revise autonomous practice reg consistent with 2 years	Nursing & Medicine	N – 7/20/21 M – 8/6/21	
HB1747	Licensure of CNS as nurse practitioners – Amend Chapters 30 and 40 Delete sections of Chapter 20 with reference to registration of CNS	Nursing & Medicine	N – 7/20/21 M – 8/6/21	
HB1817	Autonomous practice for CNMs with 1,000 hours	Nursing & Medicine	N – 7/20/21 M – 8/6/21	
HB1988	Changes to pharmaceutical processors	Pharmacy	7/6/21	By Sept. 1st
HB2218/SB1333	Sale of cannabis botanical products	Pharmacy	7/6/21	By Sept. 1st
HB2039	Conform PA regs to Code	Medicine	6/24/21	After July 1
HB2220	Change registration of surgical technologists to certification	Medicine	6/21/21	After July 1
SB1178	Delete reference to conscience clause in regs for genetic counselors	Medicine	6/24/21	After July 1

APA REGULATORY ACTIONS

Legislative source	Mandate	Promulgating agency	Adoption date	Effective date
HB1953	Licensure of certified midwives	Nursing & Medicine	NOIRA Nursing – 7/20/21 Medicine – 8/6/21	Unknown

NON-REGULATORY ACTIONS

Legislative source	Affected agency	Action needed	Due date
HB1747	Nursing	Notification to registered certified nurse specialists that they must have a practice agreement with a physician before licensure as a nurse practitioner as of July 1, 2021	After March 31, 2021
HB793 (2018)	Medicine & Nursing	To report data on the number of nurse practitioners who have been authorized to practice without a practice agreement, the	November 1, 2021

		geographic and specialty areas in which nurse practitioners are practicing without a practice agreement, and any complaints or disciplinary actions taken against such nurse practitioners, along with any recommended modifications to the requirements of this act including any modifications to the clinical experience requirements for practicing without a practice agreement	
SB431	Behavioral health/medicine/legal	Continuance of study of mental health services to minors and access to records *Requested an extension of 2020 study*	November 1, 2021
Budget bill	Department	To study and make recommendations regarding the oversight and regulation of advanced practice registered nurses (APRNs). The department shall review recommendations of the National Council of State Boards of Nursing, analyze the oversight and regulations governing the practice of APRNs in other states, and review research on the impact of statutes and regulations on practice and patient outcomes.	November 1, 2021
HB1953	Department	To convene a work group to study and report on the licensure and regulation of certified nurse midwives, certified midwives, and certified professional midwives to determine the appropriate licensing entity for such professionals.	November 1, 2021
HB1987	Boards with prescriptive authority	Revise guidance documents with references to 54.1-3303	As boards meet after July 1
HB2079	Pharmacy (with Medicine & VDH)	To establish protocols for the initiation of treatment with and dispensing and administering of drugs, devices, controlled paraphernalia, and supplies and equipment available over-the-counter by pharmacists in accordance with § 54.1-3303.1. Such protocols shall address training and continuing education for pharmacists regarding the initiation of treatment with and dispensing and administering of drugs, devices, controlled paraphernalia, and supplies and equipment.	Concurrent with emergency regulations
HB2079	Pharmacy	To convene a work group to provide recommendations regarding the development of protocols for the initiation of treatment with and dispensing and administering of drugs, devices, controlled paraphernalia, and supplies and equipment by pharmacists to persons 18 years of age or older, including (i) controlled substances, devices, controlled paraphernalia, and supplies and equipment for the treatment of diseases or conditions for which clinical decision-making can be guided by a clinical	November 1, 2021

		test that is classified as waived under the federal Clinical Laboratory Improvement Amendments of 1988, including influenza virus, urinary tract infection, and group A Streptococcus bacteria, and (ii) drugs approved by the U.S. Food and Drug Administration for tobacco cessation therapy, including nicotine replacement therapy. The work group shall focus its work on developing protocols that can improve access to these treatments while maintaining patient safety.	

Future Policy Actions:

HB2559 (2019) - requires the Secretary of Health and Human Resources to convene a work group to identify successes and challenges of the electronic prescription requirement and offer possible recommendations for increasing the electronic prescribing of controlled substances that contain an opioid and to report to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by November 1, 2022.

Agenda Item: Regulatory Action –Final rules for Prohibition on Practice of Conversion therapy

Included in your package:

- Copy of proposed announcements on Townhall
- There were no comments on Medicine or Nurse Practitioner proposed regulations
- Copy of Code of Virginia, as amended in the 2020 General Assembly
- Copy of proposed regulations for Medicine and Nurse Practitioners

Note: Nurse Practitioner regulations were adopted by the Board of Nursing on May 18th

Board Action:

Motion to adopt final amendments for 18VAC85-20 (Practice of Medicine) and to final amendments for 18VAC90-30 (Nurse Practitioners)

Virginia.gov Agencies | Governor

VIRGINIA REGULATORY TOWN HALL

Agency / Department of Health Professions

Board / Board of Medicine

Chapter / **Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic** [18 VAC 85 - 20]

Action: Conversion therapy

Proposed Stage

Action 5412 / Stage 9121

Edit Stage | Withdraw Stage | Go to RIS Project

Documents

Document	Date	
Proposed Text	2/10/2021 8:12 am	Sync Text with RIS
Agency Background Document	10/27/2020 (modified 12/4/2020)	Upload / Replace
Attorney General Certification	10/30/2020	
DPB Economic Impact Analysis	12/11/2020	
Agency Response to EIA	1/15/2021	Upload / Replace
Governor's Review Memo	1/15/2021	
Registrar Transmittal	1/15/2021	

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: 10/27/2020 Review Completed: 10/30/2020 Result: Certified
DPB Review	Submitted on 10/30/2020 Economist: Jini Rao Policy Analyst: Jeannine Rose Review Completed: 12/11/2020
Secretary Review	Secretary of Health and Human Resources Review Completed: 1/4/2021
Governor's Review	Review Completed: 1/15/2021 Result: Approved
Virginia Registrar	Submitted on 1/15/2021 The Virginia Register of Regulations Publication Date: 2/15/2021 Volume: 37 Issue: 13
Public Hearings	04/09/2021 8:35 AM
Comment Period	Ended 4/16/2021

Virginia.gov Agencies | Governor

Agency: Department of Health Professions

Board: Board of Nursing

Chapter: **Regulations Governing the Licensure of Nurse Practitioners [18 VAC 90 - 30]**

Action: Unprofessional conduct/conversion therapy

Proposed Stage

Action 5441 / Stage 9120

Edit Stage | Withdraw Stage | Go to RIS Project

Documents

Document	Date	
Proposed Text	2/10/2021 8:04 am	Sync Text with RIS
Agency Background Document	10/27/2020	Upload / Replace
Attorney General Certification	10/30/2020	
DPB Economic Impact Analysis	12/11/2020	
Agency Response to EIA	1/15/2021	Upload / Replace
Governor's Review Memo	1/15/2021	
Registrar Transmittal	1/15/2021	

Status

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Exempt from APA	No, this stage/action is subject to Article 2 of the *Administrative Process Act*
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DPB Review	Submitted on 10/30/2020 Economist: Jini Rao Policy Analyst: Jeannine Rose Review Completed: 12/11/2020
Secretary Review	Secretary of Health and Human Resources Review Completed: 1/4/2021
Governor's Review	Review Completed: 1/15/2021 Result: Approved
Virginia Registrar	Submitted on 1/15/2021 The Virginia Register of Regulations Publication Date: 2/15/2021 Volume: 37 Issue: 13
Public Hearings	03/23/2021 10:30 AM
Comment Period	Ended 4/16/2021 0 comments

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 24. General Provisions

§ 54.1-2409.5. Conversion therapy prohibited.

A. As used in this section, "conversion therapy" means any practice or treatment that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender. "Conversion therapy" does not include counseling that provides acceptance, support, and understanding of a person or facilitates a person's coping, social support, and identity exploration and development, including sexual-orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as such counseling does not seek to change an individual's sexual orientation or gender identity.

B. No person licensed pursuant to this subtitle or who performs counseling as part of his training for any profession licensed pursuant to this subtitle shall engage in conversion therapy with a person under 18 years of age. Any conversion therapy efforts with a person under 18 years of age engaged in by a provider licensed in accordance with the provisions of this subtitle or who performs counseling as part of his training for any profession licensed pursuant to this subtitle shall constitute unprofessional conduct and shall be grounds for disciplinary action by the appropriate health regulatory board within the Department of Health Professions.

2020, cc. 41, 721.

Virginia.gov Agencies | Governor

Proposed Text

highlight

Action: Conversion therapy
Stage: Proposed 2/10/21 8:12 AM [latest]

18VAC85-20-10 Definitions
A. The following words and terms when used in this chapter shall have the meanings ascribed to them in § 54.1-2900 of the Code of Virginia:

Board

Healing arts

Practice of chiropractic

Practice of medicine or osteopathic medicine

Practice of podiatry

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

"Approved institution" means any accredited school or college of medicine, osteopathic medicine, podiatry, or chiropractic located in the United States, its territories, or Canada.

"Conversion therapy" means any practice or treatment as defined in § 54.1-2409.5 A of the Code of Virginia.

"Principal site" means the location in a foreign country where teaching and clinical facilities are located.

18VAC85-20-29 Practitioner responsibility
A. A practitioner shall not:

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

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

3. Exploit the practitioner and patient relationship for personal gain; or

4. Engage in conversion therapy with a person younger than 18 years of age.

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 2 of this section.

Proposed Text

highlight

Action: Unprofessional conduct/conversion therapy
Stage: Proposed 2/10/21 8:04 AM [latest]

18VAC90-30-10 Definitions

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

"Approved program" means a nurse practitioner education program that is accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs/Schools, American College of Nurse Midwives, Commission on Collegiate Nursing Education, or the National League for Nursing Accrediting Commission or is offered by a school of nursing or jointly offered by a school of medicine and a school of nursing that grant a graduate degree in nursing and that hold a national accreditation acceptable to the boards.

"Autonomous practice" means practice in a category in which a nurse practitioner is certified and licensed without a written or electronic practice agreement with a patient care team physician in accordance with 18VAC90-30-86.

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

"Certified nurse midwife" means an advanced practice registered nurse who is certified in the specialty of nurse midwifery and who is jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner pursuant to § 54.1-2957 of the Code of Virginia.

"Certified registered nurse anesthetist" means an advanced practice registered nurse who is certified in the specialty of nurse anesthesia, who is jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner pursuant to § 54.1-2957 of the Code of Virginia, and who practices under the supervision of a doctor of medicine, osteopathy, podiatry, or dentistry but is not subject to the practice agreement requirement described in § 54.1-2957.

"Collaboration" means the communication and decision-making process among members of a patient care team related to the treatment and care of a patient and includes (i) communication of data and information about the treatment and care of a patient, including exchange of clinical observations and assessments, and (ii) development of an appropriate plan of care, including decisions regarding the health care provided, accessing and assessment of appropriate additional resources or expertise, and arrangement of appropriate referrals, testing, or studies.

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

"Consultation" means the communicating of data and information, exchanging of clinical observations and assessments, accessing and assessing of additional resources and expertise, problem solving, and arranging for referrals, testing, or studies.

"Conversion therapy" means any practice or treatment as defined in § 54.1-2409.5 A of the Code of Virginia.

"Licensed nurse practitioner" means an advanced practice registered nurse who has met the requirements for licensure as stated in Part II (18VAC90-30-60 et seq.) of this chapter.

"National certifying body" means a national organization that is accredited by an accrediting agency recognized by the U.S. Department of Education or deemed acceptable by the National Council of State Boards of Nursing and has as one of its purposes the certification of nurse anesthetists, nurse midwives, or nurse practitioners, referred to in this chapter as professional certification, and whose certification of such persons by examination is accepted by the committee.

"Patient care team physician" means a person who holds an active, unrestricted license issued by the Virginia Board of Medicine to practice medicine or osteopathic medicine.

"Practice agreement" means a written or electronic statement, jointly developed by the collaborating patient care team physician and the licensed nurse practitioner that describes the procedures to be followed and the acts appropriate to the specialty practice area to be performed by the licensed nurse practitioner in the care and management of patients. The practice agreement also describes the prescriptive authority of the nurse practitioner, if applicable. For a nurse practitioner licensed in the category of certified nurse midwife, the practice agreement is a statement jointly developed with the consulting physician.

18VAC90-30-220 Grounds for disciplinary action against the license of a licensed nurse practitioner

The boards may deny licensure or relicensure, revoke or suspend the license, or take other disciplinary action upon proof that the nurse practitioner:

1. Has had a license or multistate privilege to practice nursing in this Commonwealth or in another jurisdiction revoked or suspended or otherwise disciplined;

2. Has directly or indirectly represented to the public that the nurse practitioner is a physician, or is able to, or will practice independently of a physician;

3. Has exceeded the authority as a licensed nurse practitioner;

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

5. Has become unable to practice with reasonable skill and safety to patients as the result of a 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 18VAC90-30-105;

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; ~~or~~

9. Has engaged in unauthorized use or disclosure of confidential information received from the Prescription Monitoring Program, the electronic system within the Department of Health Professions that monitors the dispensing of certain controlled substances; or

10. Has engaged in conversion therapy with a person younger than 18 years of age.

Agenda Item: Adoption of proposed regulations for surgical assistant/surgical technologist regulations

Included in agenda package:

Copy of Notice of Intended Regulatory Action (NOIRA) posted on Townhall
There were no comments on the NOIRA.

Copy of proposed regulations as recommended by the Advisory Board of Surgical Assistants

Staff note:

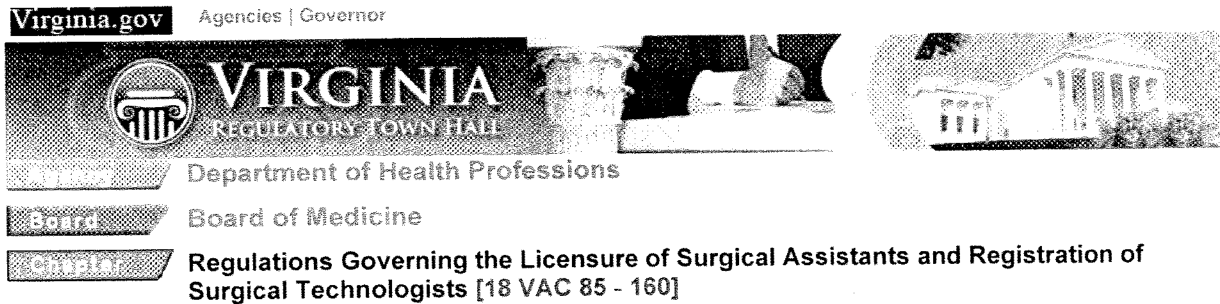
The NOIRA stated that proposed regulations will: 1) add definitions as necessary; 2) conform fees for licensure to other professions under the Board; 3) add requirements for continuing competency for surgical assistants licensed under a grandfathering provision; 4) provide for an inactive license and 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 of registration of surgical technologists. Finally, the Board will adopt standards of practice similar to those for other licensed professions under its jurisdiction and will also consider the code of ethics specific to surgical assistants.

The Advisory Board on Surgical Assistants met on June 1, 2021 and recommended modifications to regulations for the licensure of surgical assistants and certification of surgical technologists.

Board action:

The Board may: 1) adopt proposed regulations as recommended by the Advisory Board; or 2) take other action as stated in a motion before the Board.

Virginia.gov Agencies | Governor



Agency Department of Health Professions

Board Board of Medicine

Chapter **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

Notice of Intended Regulatory Action (NOIRA)

Action 5639 / Stage 9122

Edit Stage | Withdraw Stage | Go to RIS Project

Documents

Preliminary Draft Text	None submitted	Sync Text with RIS
Agency Background Document	10/27/2020 (modified 10/28/2020)	Upload / Replace
Governor's Review Memo	2/5/2021	
Registrar Transmittal	2/5/2021	

Status

Public Hearing	Will be held at the **proposed** stage
Exempt from APA	No, this stage/action is subject to Article 2 of the *Administrative Process Act*
DPB Review	Submitted on 10/27/2020 Policy Analyst: Jerry Gentile Review Completed: 11/3/2020
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Project 6696 - NOIRA

Board Of Medicine

Amendments for surgical assistants consistent with a licensed profession

Chapter 160

Regulations Governing the Licensure of Surgical Assistants and Registration of Surgical Technologists

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 ~~registration~~ certification as a surgical technologist shall be $75.

2. The fee for renewal of licensure ~~or registration~~ as a surgical assistant shall be ~~$70~~ $135, and certification as a surgical technologist $70. Renewals shall be due in the birth month of the licensee or ~~registrant~~ 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 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, pay the fee for reinstatement of licensure as prescribed in 18VAC85-160-40, and provide documentation of continued competency hours as required by 18VAC85-160-60.

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 18VAC85-160-60 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 his 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 his 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 his 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 time frame for record retention and destruction. Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.

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

18VAC85-160-100. 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 his 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 his 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 he 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 their 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, but is not limited to, 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: Exempt Regulatory Action - Genetic Counselors

Included in agenda package:

Copy of SB1178 and section of Code that was repealed

Amendments to 18VAC85-170-150

Staff note:

In promulgating regulations for the licensure of genetic counselors in 2014, the Board adopted subsection B of section 170 to implement the "conscience clause" that was included in the original legislation. Now that section of the Code has been repealed, the regulation can also be repealed.

Board action:

Motion to adopt the amendment to delete subsection B of section 150.

CHAPTER 240

An Act to repeal § 54.1-2957.21 of the Code of Virginia, relating to genetic counseling; conscience clause.

[S 1178]

Approved March 18, 2021

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2957.21 of the Code of Virginia is repealed.

Repealed:

§ 54.1-2957.21. Conscience clause.

Nothing in this chapter shall be construed to require any genetic counselor to participate in counseling that conflicts with their deeply-held moral or religious beliefs, nor shall licensing of any genetic counselor be contingent upon participation in such counseling. Refusal to participate in counseling that conflicts with the counselor's deeply-held moral or religious beliefs shall not form the basis for any claim of damages or for any disciplinary or recriminatory action against the genetic counselor, provided the genetic counselor informs the patient that he will not participate in such counseling and offers to direct the patient to the online directory of licensed genetic counselors maintained by the Board.

Amendment to Regulations Governing Genetic Counseling to conform to changes in Code

SB1178 – repeal of conscience clause

18VAC85-170-150. Practitioner-patient communication; conscience clause; 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 his legally authorized representative in understandable terms and encourage participation in decisions regarding the patient's care.

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

3. When a genetic procedure is recommended, informed consent shall be obtained from the patient in accordance with the policies of the health care entity. Practitioners shall inform patients of the risks, benefits, and alternatives of the recommended procedure that a reasonably prudent practitioner practicing genetic counseling in Virginia would tell a patient.

a. In the instance of a minor or a patient who is incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent shall be informed and the consent documented.

b. An exception to the requirement for consent prior to performance of a genetic procedure may be made in an emergency situation when a delay in obtaining consent would likely result in imminent harm to the patient.

c. For the purposes of this provision, "genetic procedure" means any diagnostic or therapeutic procedure performed on a patient that is not part of routine, general care and for which the usual practice within the health care entity is to document specific informed consent from the patient or surrogate decision maker prior to proceeding.

4. 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. ~~Exercise of the conscience clause.~~

~~1. Notwithstanding provisions of subsection A of this section, a practitioner may exercise the conscience clause pursuant to requirements of § 54.1-2957.21 of the Code of Virginia. If a genetic counselor has deeply held moral or religious beliefs that may prevent him from participating in genetic counseling, he shall immediately inform a prospective patient with specificity about any associated limitations on counseling resulting therefrom, prior to the initiation of the patient-practitioner relationship and shall:~~

~~a. Offer to refer the patient to another licensed health care practitioner with a relevant scope of practice and direct the patient to the online directory of licensed genetic counselors maintained by the board;~~

~~b. Immediately notify any referring practitioner, if known, of this refusal to participate in genetic counseling for the patient; and~~

~~c. Alert the patient and the referring practitioner if the referral is time sensitive.~~

~~2. If, during the course of patient care, the genetic counselor encounters a situation in which his deeply held moral or religious beliefs would prevent him from participating in counseling, he shall immediately inform the patient with specificity about any associated limitations on counseling and shall:~~

~~a. Document the communication of such information in the patient record;~~

~~b. Offer to refer the patient to another licensed health care practitioner with a relevant scope of practice and direct the patient to the online directory of licensed genetic counselors;~~

~~c. Immediately notify any referring practitioner, if known, of such refusal and referral of the patient; and~~

~~d. Alert the patient and the referring practitioner if the referral is time sensitive.~~

~~C.~~ 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 his services unavailable without documented notice to the patient that allows for a reasonable time to obtain the services of another practitioner.

Agenda Item: Exempt Regulatory Action – Certification of surgical technologists

Included in your agenda package are:

Copy of the legislation passed in 2021 General Assembly (HB2220)

Copy of the regulation to be adopted by the Board as an exempt action to conform regulation to changes in the statute.

Board action:

Motion to amend regulations for surgical technologists to change from registration to certification

CHAPTER 230

An Act to amend and reenact § 54.1-2956.12 of the Code of Virginia, relating to surgical technologist; certification; use of title.

[H 2220]
Approved March 18, 2021

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 surgical technologist; use of title; registration.

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

B. The Board shall ~~register~~ *certify* as a ~~registered~~ 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 ~~technologist training program~~ *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 at any time in the six months prior to July 1, ~~2014~~ *2021*, provided he registers with the Board by December 31, ~~2016~~ *2021*.

Project 6800 - Final

Board Of Medicine

Change from registration to certification for surgical techs

Chapter 160

Regulations Governing the Licensure of Surgical Assistants and ~~Registration~~ Certification of Surgical Technologists

18VAC85-160-30. Current name and address.

Each licensee or ~~registrant~~ certificate holder shall furnish the board his current name and address of record. All notices required by law or by this chapter to be given by the board to any such licensee or ~~registrant~~ certificate holder shall be validly given when sent to the latest address of record provided or served to the licensee or ~~registrant~~ certificate holder. Any change of name or address of record or public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-160-40. Fees.

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

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

2. The fee for renewal of licensure or ~~registration~~ certification shall be $70. Renewals shall be due in the birth month of the licensee or ~~registrant~~ 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.

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

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

18VAC85-160-51. Requirements for ~~registration~~ certification as a surgical technologist.

A. An applicant for ~~registration~~ certification as a surgical technologist shall submit a completed application and a fee as prescribed in 18VAC85-160-40 on forms provided by the board.

B. An applicant for ~~registration~~ certification as a surgical technologist shall provide satisfactory evidence of:

1. Successful completion of an accredited surgical technologist training program and ~~A~~ a current credential as a certified surgical technologist from the National Board of Surgical Technology and Surgical Assisting or its successor; or

2. Successful completion of a ~~surgical technologist~~ training program for surgical technology during the applicant's service as a member of any branch of the armed forces of the United States.

Agenda Item: Exempt Regulatory Action - Physician Assistants

Included in agenda package:

Copy of legislation passed by the 2021 General Assembly (HB2039)

Draft of amendments to conform 18VAC85-50 (Regulations) to changes in the Code.

Action: Adoption of amended regulation as an exempt action

CHAPTER 210

An Act to amend and reenact §§ 54.1-2902, 54.1-2950.1, 54.1-2951.1, 54.1-2951.2, 54.1-2952, 54.1-2952.1, 54.1-2953, and 54.1-2972 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 54.1-2951.4, relating to practice as a physician assistant.

[H 2039]

Approved March 18, 2021

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2902, 54.1-2950.1, 54.1-2951.1, 54.1-2951.2, 54.1-2952, 54.1-2952.1, 54.1-2953, and 54.1-2972 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 54.1-2951.4 as follows:

§ 54.1-2902. Unlawful to practice without license.

It ~~shall be~~ *is* unlawful for any person to practice medicine, osteopathic medicine, chiropractic, *or* podiatry~~,~~ or as a ~~physician's or podiatrist's~~ *physician* assistant in the Commonwealth without a valid unrevoked license issued by the Board ~~of Medicine~~.

§ 54.1-2950.1. Advisory Board on Physician Assistants; membership; qualifications.

The Advisory Board on Physician Assistants shall consist of five members to be appointed by the Governor as follows: three members shall be licensed physician assistants who have practiced their professions in Virginia for not less than three years prior to their appointments; one shall be a physician who ~~supervises~~ *collaborates with* at least one physician assistant; and one shall be a citizen member appointed from the Commonwealth ~~at-large~~ *at large*. ~~Beginning July 1, 2011, the Governor's appointments shall be staggered as follows: two members for a term of one year, one member for a term of two years, and two members for a term of three years. Thereafter, appointments~~ *Appointments* shall be for four-year terms. Vacancies occurring other than by expiration of term shall be filled for the unexpired term. No person shall be eligible to serve on the Advisory Board for more than two successive terms

§ 54.1-2951.1. Requirements for licensure and practice as a physician assistant; licensure by endorsement.

A. The Board shall promulgate regulations establishing requirements for licensure as a physician assistant that shall include the following:

1. Successful completion of a physician assistant program or surgical physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant;

2. Passage of the certifying examination administered by the National Commission on Certification of Physician Assistants; and

3. Documentation that the applicant for licensure has not had his license or certification as a physician assistant suspended or revoked and is not the subject of any disciplinary proceedings in another jurisdiction.

B. The Board may issue a license by endorsement to an applicant for licensure as a physician assistant if the applicant (i) is the spouse of an active duty member of the Armed Forces of the United States or the Commonwealth,

(ii) holds current certification from the National Commission on Certification of Physician Assistants, and (iii) holds a license as a physician assistant that is in good standing, or that is eligible for reinstatement if lapsed, under the laws of another state.

C. Every physician assistant shall practice as part of a patient care team and shall ~~enter into~~ *provide care in accordance with* a written or electronic practice agreement with ~~at least~~ one *or more* patient care team ~~physician~~ *physicians* or patient care team ~~podiatrist~~ *podiatrists*.

A practice agreement shall include acts pursuant to § 54.1-2952, provisions for the periodic review of patient charts or electronic health records, guidelines for collaboration and consultation among the parties to the agreement and the patient, periodic joint evaluation of the services delivered, and provisions for appropriate physician input in complex clinical cases, in patient emergencies, and for referrals.

A practice agreement may include provisions for periodic site visits by a patient care team physician or patient care team podiatrist who is part of the patient care team at a location other than where the licensee regularly practices. Such visits shall be in the manner and at the frequency as determined by ~~a~~ *the* patient care team physician or patient care team podiatrist who is part of the patient care team.

D. Evidence of a practice agreement shall be maintained by the physician assistant and provided to the Board upon request. The practice agreement may be maintained in writing or electronically~~;~~ and may be a part of credentialing documents, practice protocols, or procedures.

§ 54.1-2951.2. Issuance of a license.

The Board shall issue a license to the physician assistant to practice ~~as part of a patient care team~~ in accordance with § 54.1-2951.1.

§ 54.1-2951.4. Exception to physician assistant license requirement; physician assistant student.

The provisions of § 54.1-2902 shall not be construed as prohibiting a physician assistant student who is enrolled in a physician assistant education program accredited by the Accreditation Review Commission on Education for the Physician Assistant or its successor agency from engaging in acts that constitute practice as a physician assistant.

§ 54.1-2952. Role of patient care team physician or patient care team podiatrist on patient care teams; services that may be performed by physician assistants; responsibility of licensee; employment of physician assistants.

A. A patient care team physician or patient care team podiatrist licensed under this chapter may serve on a patient care team with physician assistants and shall provide collaboration and consultation to such physician assistants. No patient care team physician or patient care team podiatrist shall be allowed to collaborate or consult with more than six physician assistants on a patient care team at any one time.

Service as part of a patient care team by a patient care team physician or patient care team podiatrist shall not, by the existence of such service alone, establish or create vicarious liability for the actions or inactions of other team members.

B. Physician assistants may practice medicine to the extent and in the manner authorized by the Board. A patient care team physician or patient care team podiatrist shall be available at all times to collaborate and consult with

physician assistants. Each patient care team shall identify the relevant physician assistant's scope of practice and an evaluation process for the physician assistant's performance.

C. Physician assistants appointed as medical examiners pursuant to § 32.1-282 shall only function as part of a patient care team that has a licensed doctor of medicine or osteopathic medicine who has been appointed to serve as a medical examiner pursuant to § 32.1-282.

D. Any professional corporation or partnership of any licensee, any hospital and any commercial enterprise having medical facilities for its employees that are supervised by one or more physicians or podiatrists may employ one or more physician assistants in accordance with the provisions of this section.

Activities shall be performed in a manner consistent with sound medical practice and the protection of the health and safety of the patient. Such activities shall be set forth in a practice agreement~~ between the physician assistant and the patient care team physician or patient care team podiatrist~~ and may include health care services that are educational, diagnostic, therapeutic, or preventive, including establishing a diagnosis, providing treatment, and performing procedures. Prescribing or dispensing of drugs may be permitted as provided in § 54.1-2952.1. In addition, a physician assistant may perform initial and ongoing evaluation and treatment of any patient in a hospital, including its emergency department, in accordance with the practice agreement, including tasks performed, relating to the provision of medical care in an emergency department.

~~The patient care team physician who collaborates and consults with a physician assistant shall retain exclusive control of and responsibility for the physician assistant. The~~ *A* patient care team physician or the on-duty emergency department physician shall be available at all times for collaboration and consultation with both the physician assistant and the emergency department physician. No person shall have responsibility for any physician assistant who is not employed by the person or the person's business entity.

E. No physician assistant shall perform any acts beyond those set forth in the practice agreement or authorized as part of the patient care team. No physician assistant practicing in a hospital shall render care to a patient unless the physician responsible for that patient ~~has signed the practice agreement~~ *is available for collaboration or consultation.* pursuant to regulations of the Board~~, to act as a physician on a patient care team for that physician assistant. Every licensee, professional corporation or partnership of licensees, hospital, or commercial enterprise that employs a physician assistant shall be fully responsible for the acts of the physician assistant in the care and treatment of human beings~~.

F. Notwithstanding the provisions of § 54.1-2956.8:1, a licensed physician assistant who (i) is working in the field of radiology as part of a patient care team, (ii) has been trained in the proper use of equipment for the purpose of performing radiologic technology procedures consistent with Board regulations, and (iii) has successfully completed the exam administered by the American Registry of Radiologic Technologists for physician assistants for the purpose of performing radiologic technology procedures may use fluoroscopy for guidance of diagnostic and therapeutic procedures.

§ 54.1-2952.1. Prescription of certain controlled substances and devices by licensed physician assistants.

A. In accordance with the provisions of this section and pursuant to the requirements of Chapter 33 (§ 54.1-3300 et seq.), a licensed physician assistant shall have the authority to prescribe controlled substances and devices as set forth in Chapter 34 (§ 54.1-3400 et seq.)~~;~~ *and as* provided ~~that the physician assistant has entered into and is, at the time of writing a prescription, a party to~~ *in* a practice agreement ~~with a licensed patient care team physician or patient~~

~~care team podiatrist that provides for collaboration and consultation regarding the prescriptive practices of the physician assistant~~. Such practice agreements shall include a statement of the controlled substances the physician assistant is or is not authorized to prescribe and may restrict such prescriptive authority as deemed appropriate by the patient care team physician or patient care team podiatrist.

B. It shall be unlawful for the physician assistant to prescribe controlled substances or devices pursuant to this section unless such prescription is authorized by the practice agreement and the requirements in this section.

C. The Board of Medicine, in consultation with the Board of Pharmacy, shall promulgate such regulations governing the prescriptive authority of physician assistants as are deemed reasonable and necessary to ensure an appropriate standard of care for patients.

The regulations promulgated pursuant to this section shall include, at a minimum, (i) such requirements as may be necessary to ensure continued physician assistant competency, which may include continuing education, testing, and any other requirement and shall address the need to promote ethical practice, an appropriate standard of care, patient safety, the use of new pharmaceuticals, and appropriate communication with patients, and (ii) a requirement that the physician assistant disclose to his patients his name, address, and telephone number and that he is a physician assistant. If a patient or his representative requests to speak with the patient care team physician or patient care team podiatrist, the physician assistant shall arrange for communication between the parties or provide the necessary information.

D. This section shall not prohibit a licensed physician assistant from administering controlled substances in compliance with the definition of "administer" in § 54.1-3401 or from receiving and dispensing manufacturers' professional samples of controlled substances in compliance with the provisions of this section.

§ 54.1-2953. Renewal, revocation, suspension, and refusal.

The Board may revoke, suspend, or refuse to renew a license to practice as a physician assistant for any of the following:

1. Any action by a physician assistant constituting unprofessional conduct pursuant to § 54.1-2915;

2. Practice by a physician assistant other than as part of a patient care team, including practice without entering into a practice agreement with ~~at least~~ one *or more* patient care team ~~physician~~ *physicians* or patient care team ~~podiatrist~~ *podiatrists*;

3. Failure of the physician assistant to practice in accordance with the requirements of his practice agreement;

4. Negligence or incompetence on the part of the physician assistant or other member of the patient care team ~~under his supervision~~;

5. Violation of or cooperation in the violation of any provision of this chapter or the regulations of the Board; or

6. Failure to comply with any regulation of the Board required for licensure of a physician assistant.

§ 54.1-2972. When person deemed medically and legally dead; determination of death; nurses' or physician assistants' authority to pronounce death under certain circumstances.

A. A person shall be medically and legally dead if:

1. In the opinion of a physician duly authorized to practice medicine in the Commonwealth, based on the ordinary standards of medical practice, there is the absence of spontaneous respiratory and spontaneous cardiac functions and, because of the disease or condition that directly or indirectly caused these functions to cease, or because of the passage of time since these functions ceased, attempts at resuscitation would not, in the opinion of such physician, be successful in restoring spontaneous life-sustaining functions, and, in such event, death shall be deemed to have occurred at the time these functions ceased; or

2. In the opinion of a physician, who shall be duly licensed to practice medicine in the Commonwealth and board-eligible or board-certified in the field of neurology, neurosurgery, or critical care medicine, when based on the ordinary standards of medical practice, there is irreversible cessation of all functions of the entire brain, including the brain stem, and, in the opinion of such physician, based on the ordinary standards of medical practice and considering the irreversible cessation of all functions of the entire brain, including the brain stem, and the patient's medical record, further attempts at resuscitation or continued supportive maintenance would not be successful in restoring such functions, and, in such event, death shall be deemed to have occurred at the time when all such functions have ceased.

B. A registered nurse or a physician assistant ~~who practices under the supervision of a physician~~ may pronounce death if the following criteria are satisfied: (i) the nurse is employed by or the physician assistant works at (a) a home care organization as defined in § 32.1-162.7, (b) a hospice as defined in § 32.1-162.1, (c) a hospital or nursing home as defined in § 32.1-123, including state-operated hospitals for the purposes of this section, (d) the Department of Corrections, or (e) a continuing care retirement community registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2; (ii) the nurse or physician assistant is directly involved in the care of the patient; (iii) the patient's death has occurred; (iv) the patient is under the care of a physician when his death occurs; (v) the patient's death has been anticipated; (vi) the physician is unable to be present within a reasonable period of time to determine death; and (vii) there is a valid Do Not Resuscitate Order pursuant to § 54.1-2987.1 for the patient who has died. The nurse or physician assistant shall inform the patient's attending and consulting physicians of ~~his~~ *the patient's* death as soon as practicable.

The nurse or physician assistant shall have the authority to pronounce death in accordance with such procedural regulations, if any, as may be promulgated by the Board of Medicine; however, if the circumstances of the death are not anticipated or the death requires an investigation by the Office of the Chief Medical Examiner, the nurse or physician assistant shall notify the Office of the Chief Medical Examiner of the death and the body shall not be released to the funeral director.

This subsection shall not authorize a nurse or physician assistant to determine the cause of death. Determination of cause of death shall continue to be the responsibility of the attending physician, except as provided in § 32.1-263. Further, this subsection shall not be construed to impose any obligation to carry out the functions of this subsection.

This subsection shall not relieve any registered nurse or physician assistant from any civil or criminal liability that might otherwise be incurred for failure to follow statutes or Board of Nursing or Board of Medicine regulations.

C. The alternative definitions of death provided in subdivisions A 1 and ~~A~~ 2 may be utilized for all purposes in the Commonwealth, including the trial of civil and criminal cases.

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF PHYSICIAN ASSISTANTS

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-50-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Revised Date:

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18VAC85-50-10. Definitions.

A. The following words and terms shall have the meanings ascribed to them in § 54.1-2900 of the Code of Virginia:

"Board."

"Collaboration."

"Consultation."

"Patient care team physician."

"Patient care team podiatrist."

"Physician assistant."

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

"Group practice" means the practice of a group of two or more doctors of medicine, osteopathy, or podiatry licensed by the board who practice as a partnership or professional corporation.

"Institution" means a hospital, nursing home or other health care facility, community health center, public health center, industrial medicine or corporation clinic, a medical service facility, student health center, or other setting approved by the board.

"NCCPA" means the National Commission on Certification of Physician Assistants.

"Practice agreement" means a written or electronic agreement developed by ~~the~~ one or more patient care team ~~physician~~ physicians or ~~podiatrist~~ podiatrists and the physician assistant that defines the relationship between the physician assistant and the ~~physician~~ physicians or ~~podiatrist~~ podiatrists, the prescriptive authority of the physician assistant, and the circumstances under which ~~the~~ a physician or podiatrist will see and evaluate the patient.

18VAC85-50-40. General requirements.

A. No person shall practice as a physician assistant in the Commonwealth of Virginia except as provided in this chapter.

B. All services rendered by a physician assistant shall be performed only in accordance with a practice agreement with ~~a doctor~~ one or more doctors of medicine, osteopathy, or podiatry licensed by this board to practice in the Commonwealth.

18VAC85-50-101. Requirements for a practice agreement.

A. Prior to initiation of practice, a physician assistant and ~~his~~ one or more patient care team ~~physician~~ physicians or ~~podiatrist~~ podiatrists shall enter into a written or electronic practice

agreement that spells out the roles and functions of the assistant and is consistent with provisions of § 54.1-2952 of the Code of Virginia.

1. ~~The patient care team physician or podiatrist shall be a doctor of medicine, osteopathy, or podiatry licensed in the Commonwealth who has accepted responsibility for the service that a physician assistant renders.~~

~~2.~~ Any such practice agreement shall take into account such factors as the physician assistant's level of competence, the number of patients, the types of illness treated by the ~~physician~~ physicians or ~~podiatrist~~ podiatrists, the nature of the treatment, special procedures, and the nature of the ~~physician~~ physicians or ~~podiatrist~~ podiatrists availability in ensuring direct physician or podiatrist involvement at an early stage and regularly thereafter.

~~3.~~ 2. The practice agreement shall also provide an evaluation process for the physician assistant's performance, including a requirement specifying the time period, proportionate to the acuity of care and practice setting, within which the ~~physician~~ physicians or ~~podiatrist~~ podiatrists shall review the record of services rendered by the physician assistant.

~~4.~~ 3. The practice agreement may include requirements for periodic site visits by licensees who supervise and direct ~~the~~ a patient care team physician or podiatrist to collaborate and consult with physician assistants who provide services at a location other than where the physician or podiatrist regularly practices.

B. The board may require information regarding the degree of collaboration and consultation by the patient care team ~~physician~~ physicians or ~~podiatrist~~ podiatrists. The board may also require ~~the~~ a patient care team physician or podiatrist to document the physician assistant's competence in performing such tasks.

C. If the role of the physician assistant includes prescribing drugs and devices, the written practice agreement shall include those schedules and categories of drugs and devices that are within the scope of practice and proficiency of the patient care team ~~physician~~ physicians or ~~podiatrist~~ podiatrists.

D. If the initial practice agreement did not include prescriptive authority, there shall be an addendum to the practice agreement for prescriptive authority.

E. If there are any changes in consultation and collaboration, authorization, or scope of practice, a revised practice agreement shall be entered into at the time of the change.

18VAC85-50-110. Responsibilities of the patient care team physician or podiatrist.

~~The~~ A patient care team physician or podiatrist shall:

1. Review the clinical course and treatment plan for any patient who presents for the same acute complaint twice in a single episode of care and has failed to improve as expected. The A

physician or podiatrist shall be involved with any patient with a continuing illness as noted in the written or electronic practice agreement for the evaluation process.

2. ~~Be responsible for all invasive procedures.~~

~~a. Under supervision, a physician assistant may insert a nasogastric tube, bladder catheter, needle, or peripheral intravenous catheter, but not a flow-directed catheter, and may perform minor suturing, venipuncture, and subcutaneous intramuscular or intravenous injection.~~

~~b. All other invasive procedures not listed in subdivision 2 a of this section must be performed under supervision with the physician in the room unless, after directly observing the performance of a specific invasive procedure three times or more, the a patient care team physician or podiatrist attests on the practice agreement to the competence of the physician assistant to perform the specific procedure without direct observation and supervision.~~

~~3. Be responsible for all prescriptions issued by the physician assistant and attest to the competence of the assistant to prescribe drugs and devices.~~

~~4.~~ Be available at all times to collaborate and consult with the physician assistant.

18VAC85-50-115. Responsibilities of the physician assistant.

A. The physician assistant shall not render independent health care and shall:

1. Perform only those medical care services that are within the scope of the practice and proficiency of the patient care team physician or podiatrist as prescribed in the physician assistant's practice agreement. When a physician assistant is working outside the scope of specialty of the patient care team physician or podiatrist, then the physician assistant's functions shall be limited to those areas not requiring specialized clinical judgment, unless a separate practice agreement has been executed for ~~that~~ an alternate patient care team physician or podiatrist.

2. Prescribe only those drugs and devices as allowed in Part V (18VAC85-50-130 et seq.) of this chapter.

3. Wear during the course of performing his duties identification showing clearly that he is a physician assistant.

B. ~~An alternate patient care team physician or podiatrist shall be a member of the same group, professional corporation, or partnership of any licensee who is the patient care team physician or podiatrist for a physician assistant or shall be a member of the same hospital or commercial enterprise with the patient care team physician or podiatrist. Such alternating physician or podiatrist shall be a physician or podiatrist licensed in the Commonwealth who has accepted responsibility for the service that a physician assistant renders.~~

~~C.~~ If, due to illness, vacation, or unexpected absence, the patient care team physician or podiatrist or alternate physician or podiatrist is unable to supervise the activities of his physician assistant, such patient care team physician or podiatrist may temporarily delegate the responsibility to another doctor of medicine, osteopathic medicine, or podiatry.

Temporary coverage may not exceed four weeks unless special permission is granted by the board.

~~D.~~ C. With respect to physician assistants employed by institutions, the following additional regulations shall apply:

1. No physician assistant may render care to a patient unless the physician or podiatrist responsible for that patient ~~has signed the practice agreement to act as patient care team physician or podiatrist for~~ is available for collaboration and consultation with that physician assistant.

2. Any such practice agreement as described in subdivision 1 of this subsection shall delineate the duties which said patient care team physician or podiatrist authorizes the physician assistant to perform.

~~E.~~ D. Practice by a physician assistant in a hospital, including an emergency department, shall be in accordance with § 54.1-2952 of the Code of Virginia.

Agenda Item: Guidance document – Revision of 85-10

Included in the agenda package:

Copy of guidance document on Disclosures by Licensed Midwives for High-Risk Pregnancy Conditions

Staff note:

The Code of Virginia specifies:

§ 54.1-2957.11. Requirements for disclosure.

Any person practicing as a licensed midwife shall provide disclosure of specific information in writing to any client to whom midwifery care is provided. Such disclosure shall include (i) a description of the midwife's qualifications, experience, and training; (ii) a written protocol for medical emergencies, including hospital transport, particular to each client; (iii) a description of the midwives' model of care; (iv) a copy of the regulations governing the practice of midwifery; (v) a statement concerning the licensed midwife's malpractice or liability insurance coverage; (vi) a description of the right to file a complaint with the Board of Medicine and the procedures for filing such complaint; and (vii) such other information as the Board of Medicine determines is appropriate to allow the client to make an informed choice to select midwifery care.

In 2013-14, a workgroup comprised of physicians and licensed midwives developed the original guidance document listing the high-risk conditions for which disclosure by a midwife is required.

The document was recently reviewed by another workgroup that met on May 17th; that group consisted of three members of the Advisory Board on Midwifery and three representatives of this Board - Drs. Stokes, Archer, and Barner.

The enclosed document includes updated references and other changes as recommended by the workgroup.

Action:
A motion to approve Guidance document 85-10 as recommended by the workgroup and the Advisory Board on Midwifery

Guidance document: 85-10 Effective:

Disclosures by Licensed Midwives for High-Risk Pregnancy Conditions

Virginia Board of Medicine

The Code of Virginia (Law) requires that licensed midwives "disclose to their patients, when appropriate, options for consultation and referral to a physician and evidence-based information on health risks associated with birth of a child outside of a hospital or birthing center." Regulations for Licensed Midwives specify that:

> *Upon initiation of care, a midwife shall review the client's medical history in order to identify pre-existing conditions or indicators that require disclosure of risk for home birth. The midwife shall offer standard tests and screenings for evaluating risks and shall document client response to such recommendations. The midwife shall also continually assess the pregnant woman and baby in order to recognize conditions that may arise during the course of care that require disclosure of risk for birth outside of a hospital or birthing center.*

The risk factors or conditions that require disclosures are listed in regulation. If any of these conditions or factors are presented, the midwife is to:

> *1) Request and review the client's medical history, including records of the current or previous pregnancies;*
>
> *2) Disclose to the client the risks associated with a birth outside of a hospital or birthing center; and*
>
> *3) Provide options for consultation and referral.*

Regulations require that if the risk factors or criteria have been identified that may indicate health risks associated with birth of a child outside a hospital or birthing center, the midwife must provide evidence-based information on such risks and must document in the client record the assessment of all health risks that pose a potential for a high risk pregnancy and, if appropriate, the provision of disclosures and evidence-based information. **The disclosure for intrapartum risk factors should be given to a client at the first prenatal visit.**

For each of the risk factors or conditions identified, this guidance document provides evidence-based information and a format to record in a client's record the disclosure of information and options for consultation and referral.

To access the evidence-based information and disclosure for a particular conditions or risk factor, click on the link in the index below. The midwife may then print the form for that condition or risk factor for presentation and discussion with the client and have the form signed for inclusion in the client record.

A Work Group comprised of members of the Board of Medicine and the Advisory Board on Midwifery has developed this information to assist licensed midwives in satisfying the requirements of Code Section 54.1-2957.9(iv), which requires midwives to disclose to their patients options for consultation and referral to a physician and evidence-based information on health risks associated with the birth of a child outside of a hospital. This information does not constitute medical advice, diagnosis, opinion or treatment. Individuals should consult a qualified health care provider for advice regarding a medical condition.

Intrapartum Risk Factors

1. Abnormal fetal cardiac rate or rhythm
2. Active cancer
3. Acute or chronic thrombophlebitis
4. Anemia (hematocrit less than 30 or hemoglobin less than 10 at term)
5. Any pregnancy with abnormal fetal surveillance tests
6. Blood coagulation defect
7. Body Mass Index (BMI) equal to or greater than 30
8. Cardiac disease
9. Chronic obstructive pulmonary disease or other pulmonary disorders
10. Ectopic pregnancy
11. Essential chronic hypertension over 140/90
12. Genital herpes or partner with genital herpes
13. History of hemoglobinopathies
14. HIV positive status or AIDS
15. Inappropriate fetal size for gestation – Macrosomia (Large for gestational age)
16. Inappropriate fetal size for gestation – IUGR (Small for gestational age)
17. Incomplete spontaneous abortion
18. Isoimmunization to blood factors
19. Multiple gestation
20. Persistent severe abnormal quantity of amniotic fluid
21. Platelet count less than 120,000
22. Position presentation other than cephalic at term or while in labor
23. Pre-eclampsia/eclampsia
24. Pregnancy lasting longer than 42 completed weeks with an abnormal non-stress test
25. VBAC (vaginal birth after cesarian) previous uterine incision or myomectomy
26. Mental Health [illegible]
27. Rupture of membranes 24 hours before the onset of labor
28. Seizure disorder requiring prescriptive medication

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29. Severe liver disease -- active or chronic
30. Severe renal disease - active or chronic
31. Significant 2nd or 3rd trimester bleeding
32. Significant glucose intolerance (Preexisting diabetes, gestational diabetes, PCOS)
33. Uncontrolled hyperthyroidism
34. Uterine ablation (endometrial ablation)
35. Uterine anomaly

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Intrapartum Risk Factors

Preamble:

The Midwives Model of Care® recognizes the client/patient as the primary decision maker in all aspects of her care and respects her autonomy. This is supported within a model of well-informed, shared decision-making in order to achieve optimal clinical outcomes. Disclosure of risks is an integral part of the informed consent process, as outlined by NARM (the *North American Registry of Midwives*).

> ***"If a midwife supports a client's choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process." – NARM***

Licensed midwives are trained experts in the management of low-risk pregnancy and birth outside of the hospital. Certain conditions may present increased risk to mother and/or baby. The risks listed below apply to birth in any setting, and are not all-inclusive. The condition/risk factor listed may require medications and treatments outside of the scope of practice of Virginia Licensed Midwives and, thus may necessitate consultation with a physician, additional testing, and careful consideration for the appropriateness of birth in an out-of-hospital setting. Some conditions in pregnancy should be optimally managed and supported by a multidisciplinary team that may include midwives, obstetricians, perinatologists, family physicians, psychologists, social workers, and spiritual advisors.

Conditions requiring on-going medical supervision or on-going use of medications

Clients with chronic medical conditions, on prescribed medications, or under medical care for a time-limited problem that coincides with pregnancy should be advised to consult with their treating healthcare providers regarding the impact of these conditions and medications on pregnancy, as well as any impact pregnancy may have on their other diagnosed conditions. Women who choose not to disclose information regarding any medical conditions they have or medications that they are taking may increase their risk of complications.

Current substance abuse (including alcohol and tobacco)

Obstetrical complications of cigarette smoking include:

- Growth restriction (IUGR)
- Spontaneous abortion (miscarriage)
- Sudden infant death syndrome (SIDS)

Alcohol abuse leads to:

- Nutritional deficiencies
- Fetal alcohol syndrome

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In addition to increased risk of preterm labor and baby being small for gestational age, complications resulting from abusing other drugs include:

- Heroin and cocaine consumption result in medical, nutritional and social neglect
- Cocaine and amphetamine cause hypertension, placental abruption
- Intravenous abuse also increases the risk of contracting infectious disease.[1]
- Maternal substance use of opioids, benzodiazepines, barbiturates, and alcohol can cause NAS (Neonatal abstinence syndrome).[2] NAS is a set of drug withdrawal symptoms that affect the central nervous, gastrointestinal, and respiratory systems in the newborn when separated from the placenta at birth.

Documented Intrauterine growth retardation (IUGR)/small for gestational age (SGA) at term

Complications[3] for the growth-restricted fetus include:

- Prematurity
- Perinatal morbidity
- Stillbirth

"IUGR is a serious problem, regardless of why the baby is small. About 20% of stillborn babies are IUGR, and perinatal mortality for growth-restricted infants may be 6 to 10 times higher than for those of normal size. Most IUGR stillbirths occur after the 36th week of pregnancy and before labor begins."[4]

Suspected uterine rupture

Consequences of uterine rupture:

- There have been no reported maternal deaths due to uterine rupture
- Overall, 14 percent to 33 percent of women will need a hysterectomy when the uterus ruptures
- Approximately 6 percent of uterine ruptures will result in perinatal death
- This is an overall risk of intrapartum fetal death of 20 per 100,000 women undergoing trial of labor after previous cesarean section
- "For term pregnancies, the reported risk of fetal death with uterine rupture is less than 3 percent. Although the risk is similarly low, there is insufficient evidence to quantify the neonatal morbidity directly related to uterinerupture."[5]

Prolapsed cord or cord presentation

Prolapsed cord is a term describing a cord that is passing through the cervix at the same time or in advance of the fetal presenting part. This occurs in approximately 1.4-6.2 per 1000 of pregnancies. Although uncommon, it is considered a true obstetrical emergency most often necessitating a caesarean delivery. Prolapsed cord is associated with other complications of pregnancy and delivery as well.

Pregnancy and substance abuse, G. Fischer, M. Bitschnau, A. Peternell, H. Eder, A. Topitz. Archives of Women's Mental Health. August 1999, Volume 2, Issue 2, pp 57-65.
Casper, Tammy, and Megan W. Arbour. "Identification of the Pregnant Woman Who Is Using Drugs: Implications for Perinatal and Neonatal Care." Journal of Midwifery & Women's Health (2013).
Lerner, Jodi P. "Fetal growth and well-being." Obstetrics and gynecology clinics of North America 31.1 (2004): 159-176.
Frye, Anne, Holistic Midwifery, Volume I, Labrys Press, Portland, OR, 2006, p. 990
Guise, Jeanne-Marie, et al. "Vaginal birth after cesarean: new insights." (2010).

Fetal risks:

- Hypoxia
- Stillbirth/death

Suspected complete or partial placental abruption

Placental abruption results from a cascade of pathophysiologic processes ultimately leading to the separation of the placenta prior to delivery. Pregnancies complicated by abruption result in increased frequency[6] of:

- Low birth weight
- Preterm delivery
- Stillbirth
- Perinatal death

Suspected placental previa

Pregnancies complicated with placenta previa had significantly higher rates[7] of

- Second-trimester bleeding
- Pathological presentations
- Placental abruption
- Congenital malformations
- Perinatal mortality
- Cesarean delivery
- Apgar scores at 5 minutes lower than 7
- Placenta accreta
- Postpartum hemorrhage
- Postpartum anemia
- Delayed maternal and infant discharge from the hospital

Suspected chorioamnionitis

Chorioamnionitis is a potentially serious complication:[8]

- Chorioamnionitis is a major risk factor in the event of preterm birth, especially at earlier gestational ages, contributing to prematurity-associated mortality and morbidity
- Increased susceptibility of the lung for postnatal injury, which predisposes for bronchopulmonary dysplasia.
- Chorioamnionitis is associated with cystic periventricular leukomalacia, intraventricular hemorrhage and cerebral palsy in preterm infants
- Prenatal inflammation/infection has been shown a risk factor for neonatal sepsis

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Ananth, Cande V., et al. "Placental abruption and adverse perinatal outcomes." JAMA: the journal of the American Medical Association 282.17 (1999): 1646-1651.
Sheiner, E., et al. "Placenta previa: obstetric risk factors and pregnancy outcome." Journal of Maternal-Fetal and Neonatal Medicine 10.6 (2001): 414-419.
Thomas, Wolfgang, and Christian P. Speer. "Chorioamnionitis: important risk factor or innocent bystander for neonatal outcome?" Neonatology 99.3 (2010): 177-187.

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Pre-eclampsia/eclampsia

Complications of preeclampsia include:

- Eclampsia
- HELLP (hemolysis, elevated liver enzymes, low platelets) syndrome
- Liver rupture
- Pulmonary edema
- Renal failure
- Disseminated intravascular coagulopathy (DIC)
- Hypertensive emergency
- Hypertensive encephalopathy
- Cortical blindness

Maternal complications occur in up to 70% of women with eclampsia and include: [9]

- DIC
- Acute renal failure
- Hepatocellular injury
- Liver rupture
- Intracerebral hemorrhage
- Cardiopulmonary arrest
- Aspiration pneumonitis
- Acute pulmonary edema
- Postpartum hemorrhage
- Maternal death rates of 0-13.9% have been reported

Fetal complications in preeclampsia are directly related to gestational age and the severity of maternal disease and include increased rates of: [10]

- Preterm delivery
- Intrauterine growth restriction
- Placental abruption
- Perinatal death

Thick meconium stained amniotic fluid without reassuring fetal heart tones and birth is not imminent

Meconium staining of the amniotic fluid is a common occurrence during labor. Although a large proportion of these pregnancies will have a normal neonatal outcome, its presence may be an indicator of fetal hypoxia and has been linked to the development of: [11]

- Cerebral palsy

Norwitz, Errol R., Chaur-Dong Hsu, and John T. Repke. "Acute complications of preeclampsia." Clinical obstetrics and gynecology 45.2 (2002): 308-329.
de Souza Rugolo, Ligia Maria Suppo, Maria Regina Bentlin, and Cleide Enoir Petean Trindade. "Preeclampsia: effect on the fetus and newborn." Neoreviews 12.4 (2011): e198-e206.
Rahman, Shimma, Jeffrey Unsworth, and Sarah Vause. "Meconium in labour." Obstetrics, Gynaecology & Reproductive Medicine 23.8 (2013): 247-252.

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- Seizures
- Meconium aspiration syndrome

Abnormal auscultated fetal heart rate pattern unresponsive to treatment or inability to auscultate fetal heart tones

Sustained abnormal fetal heart rate patterns include bradycardia (abnormally low heart rate) and decelerations in the baby's heart rate. Additionally, tachycardia (abnormally high heart rate) is abnormal, and can also be an indication for the need for further evaluation. Historically, a 30-minute rule from decision-to-incision time for emergent cesarean delivery in the setting of abnormal FHR pattern has existed; however, the scientific evidence to support this threshold is lacking.

Excessive vomiting, dehydration, or exhaustion unresponsive to treatment

- Sufficient fluid intake during labor may prevent hemoconcentration, starvation, and activation of the thrombogenic and fibrinolytic system[12]
- With extreme exhaustion, the chances of fetal distress and non-progressive labor are greatly increased
- Bleeding during or after the placental birth, followed by shock, are much more likely to occur when the woman and her uterus are exhausted[13]
- Maternal exhaustion is diagnosed with a combination of ketonuria, elevated temperature, and elevated pulse. This condition is also known as ketoacidosis, in that the mother's blood becomes abnormally acidic and less able to carry oxygen. Unless this condition is reversed, fetal distress will result[14]

Blood pressure greater than 140/90 which persists or rises and birth is not imminent

Women with chronic hypertension are at increased risk of: [15]

- Superimposed preeclampsia (25% risk)
- Preterm delivery
- Fetal growth restriction or demise
- Placental abruption
- Congestive heart failure
- Acute renal failure
- Seizures
- Stroke
- Death

Maternal fever equal to or greater than 100.4°

Fever can indicate infection. Fever in labor is associated with: [16]

- Early neonatal and infant death
- Hypoxia

Watanabe, Takashi, et al. "Effect of labor on maternal dehydration, starvation, coagulation, and fibrinolysis." Journal of perinatal medicine 29.6 (2001): 528-534.
Frye, Anne, Holistic Midwifery, Volume II, Labrys Press, Portland, OR, 2004, p. 1055.
Davis, Elizabeth, Heart and Hands: A Midwife's Guide to Pregnancy and Birth, Celestial Arts, New York, NY, 2004, p. 141.
Hypertension. 2003; 41: 437-445 Published online before print February 10, 2003, doi: 10.1161/01.HYP.0000054981.03589.E9 PETROVA, Anna, et al. "Association of maternal fever during labor with neonatal and infant morbidity and mortality." Obstetrics and gynecology 98.1 (2001): 20-27.

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- Infection-related death. These associations were stronger among term than preterm infants
- Meconium aspiration syndrome
- Hyaline membrane disease
- Neonatal seizures
- Assisted ventilation

Labor or premature rupture of membrane (PROM) less than 37 weeks according to due date

Premature rupture of membranes before 37 weeks' gestation (and where there is at least an hour between membrane rupture and the onset of contractions and labor) can have consequences for both the mother and the baby:

Risks to Baby:

- Neurologic injury
- Infection
- Respiratory Distress
- Death
- Increased need for neonatal intensive care services

Maternal Risks:

- Infection
- Prolonged Labor
- C-Section
- Death

Because the out-of-hospital birth setting does not provide for immediate access to medications, surgery, and consultation with a physician, there may be increased risks to mother and/or baby if any of these conditions present during the birth. In some communities, the lack of availability of a seamless, cooperative hospital transfer process adds additional risk during intrapartum transfer.

I understand that the intrapartum risks may not be apparent until labor, and my opportunity for referral to a physician, should I choose that, would be limited to hospital transfer and transfer of care to the physician on call at that facility.

I have received and read this document, discussed it with my midwife, and my midwife has answered my questions to my satisfaction.

Client____________________________________ Date ________________

Midwife___________________________________ Date ________________

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Guidance document: 85-10 Effective:

1. ABNORMAL FETAL CARDIAC RATE OR RHYTHM

Preamble:

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> ***"If a midwife supports a client's choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence- based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process." – NARM***

Licensed midwives are trained experts in the management of low-risk pregnancy and birth outside of the hospital. Certain conditions may present increased risk to mother and/or baby. The risks listed below apply to birth in any setting, and are not all-inclusive. The condition/risk factor listed may require medications and treatments outside of the scope of practice of Virginia Licensed Midwives and, thus may necessitate consultation with a physician, additional testing, and careful consideration for the appropriateness of birth in an out-of-hospital setting. Some conditions in pregnancy should be optimally managed and supported by a multidisciplinary team that may include midwives, obstetricians, perinatologists, family physicians, psychologists, social workers, and spiritual advisors.

Disclosure of risks related to: Abnormal fetal cardiac rate or rhythm

Fetal rhythm abnormalities (fetal heart rates that are irregular, too fast or too slow):

- occur in up to 2% of pregnancies
- usually identified by the obstetrical clinician who detects an abnormal fetal heart rate or rhythm using a Doppler or stethoscope
- majority have isolated premature atrial contractions which may spontaneously resolve
- sustained tachyarrhythmia (rapid) or bradyarrhythmia (slow) may be of clinical significance
    - may indicate severe systemic disease
    - may have the potential to compromise the fetal circulation
    - May require intensive antepartum and/or neonatal care

As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client________________________________ Date ______________

Midwife______________________________ Date ______________

Congenital heart disease: Rhythm abnormalities of the fetus. Lisa K Hornberger, David J Sahn. Heart 2007;93:10 1294-1300 doi:10.1136/hrt.2005.069369

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Guidance document: 85-10 Effective:

2. ACTIVE CANCER

Preamble:

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Disclosure of risks related to: Active Cancer

Maternal risks:

- maternal infection due to immune suppression,
- deep vein thrombosis and pulmonary embolism during pregnancy and especially after delivery
- hemorrhage at delivery.

Fetal risks:

- Intrauterine growth restriction
- Preterm birth
- Fetal health effects from exposure to maternal medications

As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client____________________________________ Date ________________

Midwife___________________________________ Date ________________

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http://www.nlm.nih.gov/medlineplus/cancerandpregnancy.html J Obstet Gynaecol Can. 2013 Mar;35(3):263-80.

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3. Acute or Chronic Thrombophlebitis

Preamble:

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Deep vein thrombosis (DVT) and pulmonary embolism (PE) are collectively known as venous thromboembolism (VTE). VTE occurs more frequently in pregnant women, with an incidence of 0.5 to 2.0 per 1000 pregnancies, four to five times higher than in the non-pregnant population. The risk for VTE is further elevated in the postpartum period.

The risk for VTE in pregnancy is increased in women with:

- Prior history of VTE
- Advanced maternal age
- Collagen-vascular disease, especially antiphospholipid antibody syndrome
- Obesity (BMI > 30)
- Multiparity
- Hypercoaguable state
- Nephrotic syndrome
- Operative delivery
- Prolonged bed rest
- Hematologic disorders (hemoglobin SS and SC disease, polycythemia, thrombotic thrombocytopenic purpura, paroxysmal nocturnal hemoglobinuria, and some dysfibrinogenemias).
- Maternal medical conditions (diabetes, heart disease, inflammatory bowel disease)
- Smoking
- Preeclampsia

Maternal complications:

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- hypoxemia
- post-phlebitic syndrome
- pulmonary infarction
- death

As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client______________________________ Date ______________

Midwife______________________________ Date ______________

Chisholm CA, James AH, Ferguson JE. Thromboembolic disorders. In: Evans AE, Manual of Obstetrics, 8th edition. 2014, Wolters Kluwers Health.

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4. Anemia (Hematocrit less than 30 or Hemoglobin less than 10 at term)

Preamble:

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Disclosure of risks related to: Anemia (hematocrit less than 30 or hemoglobin less than 10 at term)

The World Health Organization (WHO) estimates that worldwide, 42% of pregnant women are anemic.[17]

Current knowledge indicates that iron deficiency anemia in pregnancy is a risk factor for preterm delivery and subsequent low birth weight, and possibly for inferior neonatal health. Data are inadequate to determine the extent to which maternal anemia might contribute to maternal mortality.[18]

...a woman who is already anemic is unable to tolerate blood loss that a healthy woman can.[19]

Maternal Risks related to severe or untreated anemia:

- need for blood transfusion(s), resulting from a hemorrhage (significant blood loss) during delivery
- postpartum depression

Fetal/Neonatal Risks related to maternal severe or untreated anemia:

- prematurity
- low-birth-weight
- anemia
- developmental delays

Benoist B, McLean E, Egli I, et al. Worldwide Prevalence of Anaemia 1993-2005. Geneva, Switzerland: World Health Organization; 2008.
Allen, Lindsay H. "Anemia and iron deficiency: effects on pregnancy outcome." The American journal of clinical nutrition 71.5 (2000): 1280s-1284s.
McCormick, M. L., et al. "Preventing postpartum hemorrhage in low-resource settings." International journal of gynecology & obstetrics 77.3 (2002): 267-275.

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Guidance document: 85-10 Revised: 5/21

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client____ Date __________________

Midwife_______________________________________ Date __________________

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5. Any Pregnancy with abnormal Fetal Surveillance Tests

Preamble:

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Disclosure of risks related to: Pregnancy with abnormal Fetal Surveillance Tests

There is no benefit in continuing a pregnancy at or post term after fetal surveillance is found to be non-reassuring. The recommendation is delivery (Price, 2014)." Abnormal stress tests at any point in pregnancy are associated with an increased risk of poor outcomes in pregnancy and during labor and delivery. Babies with diagnosed or undiagnosed anomalies are more likely to have abnormal test results requiring specialized care before or after delivery. Antepartum testing results, with regard to the overall clinical picture, should be taken seriously.

Risks to fetus:

- Stillbirth
- Asphyxia
- Fetal Acidosis
- Low Apgar scores
- Respiratory distress
- Surgical delivery
- Meconium Aspiration
- Death

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client____ Date ________________

Midwife____ Date ________________

O'Neill, E. T. (2012). Antepartum evaluation of the fetus and fetal well-being. *Clinical Obstetrics and Gynecology , 55* (3), 722.
Preboth, M. (2000). Practice Guidelines ACOG Guidelines on Antepartum Fetal Surveillance . *Am Fam Physician* .
Price, A. (2014, January). MSN CNM. Assistant Clinical Professor VCUMC. (B. Sheets, Interviewer)
Singh, T. (2008). The prediction of intra-partum fetal compromise in prolonged pregnancy. *Journal of Obstetrics and Gynecology , 28* (8), 779-782

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6. BLOOD COAGULATION DEFECT

Preamble:
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Disclosure of risks related to: Blood coagulation defect

Hereditary thrombophilia, or predisposition to thrombosis, ranges from the common (Factor V Leiden heterozygosity, present in 1-15% of pregnant women) to the rare (antithrombin deficiency occurring in 0.02%). The risk of deep vein thrombosis or pulmonary embolism (collectively known as venous thromboembolism or VTE) ranges from 0.1-7% of pregnancies. The maternal medical history determines the management during pregnancy, which can include anticoagulation with injections of heparin throughout the pregnancy and post-partum period.

The presence of one of these disorders may contribute to the risk of obstetric complications as well, including:

- IUGR
- preeclampsia
- stillbirth
- Frequent fetal surveillance is recommended in most cases, as well as timed delivery in the last week before the estimated date of delivery.

Alternatively, disorders of maternal hemostasis (such as von Willebrand disease) increase the risk of blood loss at delivery, and as hereditary disorders also increase the risk for abnormal bleeding in the newborn.

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_______________________________________ Date____________________
Midwife _____________________________________ Date ____________________

Inherited Thrombophilia in Pregnancy. Practice Bulletin 138, November 2013. American College of Obstetricians and Gynecologists.

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7. BODY MASS INDEX (BMI) EQUAL TO OR GREATER THAN 30

Preamble:

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Disclosure of risks related to: Body Mass Index (BMI) equal to or greater than 30

Obesity is defined as having a BMI of 30 or higher. The number of obese women in the United States has increased greatly during the past 25 years. Obesity has also become a major health concern for pregnant women. More than one half of pregnant women are overweight or obese.

Risks of Obesity Include:

- Birth defects – Babies born to obese mothers have an increased risk of having birth defects, such as heart defects and neural tube defects.
- Macrosomia – In this condition, the baby is larger than normal. This can increase the risk of the baby being injured during birth. For example, the baby's shoulder can become entrapped after the head is delivered. Macrosomia also increases the risk of cesarean birth.
- Preterm Birth – Problems associated with a mother's obesity may mean that the baby will need to be delivered early. Preterm infants have an increased risk of health problems, including breathing problems, eating problems, and developmental and learning difficulties later in life.
- Stillbirth – The risk of stillbirth increases the higher the mother's BMI.
- High Blood Pressure
- Preeclampsia – Preeclampsia is a serious illness for both the woman and her baby. Although gestational hypertension is the most common sign of preeclampsia, this condition affects all organs of the body. The kidneys and liver may fail. In rare cases, stroke can occur. The fetus is at risk of growth problems and problems with the placenta. It may require early delivery, even if the baby is not fully grown. In severe cases, the woman, baby, or both may die.

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- Gestational Diabetes – High blood glucose (sugar) levels during pregnancy increase the risk of having a very large baby and a cesarean delivery. Women who have had gestational diabetes have a higher risk of having diabetes in the future, as do their children.
- Challenges in Prenatal Care – Obesity can make it more difficult for the midwife to assess fetal position and fetal growth.
- Challenges in Labor Management – Obesity can create challenges in moving the woman quickly in the event of an emergency during the birth, and can make auscultation of fetal heart tones more difficult.

As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client____ Date ________________

Midwife____ Date ________________

Bhattacharya, Sohinee, et al. "Effect of Body Mass Index on pregnancy outcomes in nulliparous women delivering singleton babies." BMC public Health 7.1 (2007): 168.

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8. Cardiac Disease

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Disclosure of risks related to: Cardiac Disease

Most women tolerate the cardiovascular changes of pregnancy without difficulty. Pregnancy in a patient with significant cardiac disease is associated with significant risk. Despite occurring in only 0.2-4% of pregnancies, cardiac disease is associated with up to 30% of maternal deaths. A pregnant patient with cardiac disease will benefit from the coordinated care of a multidisciplinary team including perinatologists, cardiologists and anesthesiologists. In particular, adults with repaired congenital heart disease may pose complex management scenarios. They may require specialized cardiac monitoring during labor and birth, and some cardiac conditions are associated with a high enough risk of labor complications that cesarean is recommended.

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- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client______________________________ Date ____________

Midwife______________________________ Date ____________

Nanda S, Nelson-Piercy C, Mackillop L. Cardiac disease in pregnancy. Clin Med 2012;12:553-560.

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9. CHRONIC OBSTRUCTIVE PULMONARY DISEASE OR OTHER PULMONARY DISORDERS

Preamble:

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Chronic Obstructive Pulmonary Disease (COPD) or other pulmonary disorders affect approximately 4% to 6% of adults of all ages and is one of the most common medical conditions complicating pregnancy.

RISKS

- Preterm birth
- Decreased birth weight
- Increased neonatal and maternal death

As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client ______________________________ Date ______________

Midwife______________________________

Leighton, B, Fish, J, *Glob. libr. women's med., (ISSN: 1756-2228)* 2008; DOI 10.3843/GLOWM.10170

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Guidance document: 85-10 Revised: 5/21

10. ECTOPIC PREGNANCY (1)

Preamble:

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> ***"If a midwife supports a client's choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process." – NARM***

Licensed midwives are trained experts in the management of low-risk pregnancy and birth outside of the hospital. Certain conditions may present increased risk to mother and/or baby. The risks listed below apply to birth in any setting, and are not all-inclusive. The condition/risk factor listed may require medications and treatments outside of the scope of practice of Virginia Licensed Midwives and, thus may necessitate consultation with a physician, additional testing, and careful consideration for the appropriateness of birth in an out-of-hospital setting. Some conditions in pregnancy should be optimally managed and supported by a multidisciplinary team that may include midwives, obstetricians, perinatologists, family physicians, psychologists, social workers, and spiritual advisors.

Today, about 1 in 50 pregnancies is ectopic. An ectopic pregnancy occurs when a fertilized egg grows outside of the uterus most commonly in the tube. As the pregnancy grows, it can rupture (burst). If this occurs, it can cause major internal bleeding. This can be life threatening and needs to be treated. If there is evidence of ectopic pregnancy, medical and surgical interventions are available, and a referral should be made to an appropriate health provider. If there is a positive pregnancy test with follow-up ultrasound showing no intrauterine pregnancy, then referral should be made to an appropriate healthcare provider.

RISKS

- Fallopian tube damaged, leading to an increased likelihood of having another ectopic pregnancy in the future.
- Ruptured ectopic pregnancy (when the fallopian tube splits) and severe internal bleeding, which can lead to shock.
- Death

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client________________________________ Date ______________

Midwife_______________________________ Date ______________

Sivalingam VN, Duncan WC, Kirk E, *et al*, Diagnosis and management of ectopic pregnancy, *Journal of Family Planning and Reproductive Health Care* 2011;37:231-240.

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11. ESSENTIAL CHRONIC HYPERTENSION (1)

Preamble:

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Elevated blood pressure, systolic >140 or diastolic >90 or both, that predates conception or is diagnosed before 20 weeks of gestation.

MATERNAL RISKS

- Preterm delivery
- Placental abruption
- Preeclampsia
- Eclampsia
- Seizures
- Maternal congestive heart failure
- Acute renal failure
- Death

FETAL RISKS

- Fetal growth restriction
- Fetal death

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Guidance document: 85-10 Revised: 5/21

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- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client____ Date ________________

Midwife____ Date ________________

Bramham, Kate, et al. "Chronic hypertension and pregnancy outcomes: systematic review and meta-analysis." Bmj 348 (2014).

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12. GENITAL HERPES OR PARTNER WITH GENITAL HERPES

Preamble:

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Disclosure of Risks Related to: Genital Herpes

Because of its serious and potentially lethal risks to the fetus and neonate, pregnant women and their partners should be tested for ***HSV - Herpes Simplex Virus*** (HSV1 & HSV2).

In women with a previous diagnosis of genital herpes, cesarean delivery to prevent neonatal HSV infection is not indicated if there are NO genital lesions at the time of labor. In an effort to reduce cesarean deliveries performed for the indication of genital herpes, the use of oral acyclovir or valacyclovir near the end of pregnancy to suppress genital HSV recurrences has become increasingly common in obstetric practice. Several studies with small sample sizes suggest that suppressive acyclovir therapy during the last weeks of pregnancy decreases the occurrence of clinically apparent genital HSV disease at the time of delivery, with an associated decrease in cesarean delivery rates for the indication of genital HSV. ***However, because viral shedding still occurs (albeit with reduced frequency), the potential for neonatal infection is not avoided completely, and cases of neonatal HSV disease in newborn infants of women who were receiving antiviral suppression recently have been reported.***[20]

Genital HSV, especially in primary infections, may be dangerous to the neonate if infected during delivery, as it can cause a severe neonatal disease.[21]

The frequency of neonatal infection ranged from 31% to 44% for primary first-episode, and 1 to 3% in recurrent.

Kimberlin, David W., et al. "Guidance on management of asymptomatic neonates born to women with active genital herpes lesions." Pediatrics 131.2 (2013): e635-e646.

Meytal Avgil, Asher Ornoy, Herpes simplex virus and Epstein-Barr virus infections in pregnancy: consequences of neonatal or intrauterine infection, Reproductive Toxicology, Volume 21, Issue 4, May 2006, Pages 436-445, ISSN 0890-6238, http://dx.doi.org/10.1016/j.reprotox.2004.11.014.

Risks of HSV infection to the fetus include:

- intrauterine fetal demise (the death of the fetus while in the uterus)
- skin scars (cutaneous manifestations),
- ophthalmologic findings (chorioretinitis, microphtalmia),
- neurological involvement (causing brain damage)

The clinical presentation of infants with neonatal HSV infection, that is almost invariably symptomatic and frequently lethal, is a direct reflection of the site and extent of viral replication.[22]

Risks of HSV infection to the neonate (newborn) include:

- death
- neurologic (brain) damage (intracranial calcifications, microcephaly, seizures, encephalomacia),
- growth restriction,
- psychomotor development impairment
- skin vesicles or scarring,
- eye lesions resulting in vision loss and/or blindness (chorioretinitis, microphthalmia, cataracts),
- hearing loss and/or deafness

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client____ Date ________________

Midwife_______________________________________ Date ________________

Anzivino, Elena, et al. "Herpes simplex virus infection in pregnancy and in neonate: status of art of epidemiology, diagnosis, therapy and prevention." Virol J 6.1 (2009): 1-11.

Brown ZA, Wald A, Morrow RA, Selke S, Zeh J, Corey L. Effect of serological status and cesarean delivery on transmission rates of herpes simplex virus from mother to infant. JAMA. 2003;289(2):203.

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13. HISTORY OF HEMOGLOBINOPATHIES

Preamble:

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> ***"If a midwife supports a client's choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process." – NARM***

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Disclosure of risks related to: History of hemoglobinopathies

Hemoglobinopathies include sickle cell disease and its variants as well as alpha and beta thalassemia. The involvement of a multidisciplinary team including perinatologists, hematologists and anesthesiologists can allow for development of a plan to screen for and manage complications.

Maternal risks include:

- cerebral vein or deep vein thrombosis
- anemia and vaso-occlusive crisis
- pneumonia
- pyelonephritis
- transfusion
- pregnancy induced hypertension
- postpartum infection, sepsis, and systemic inflammatory response syndrome
- cesarean delivery

Fetal risks include:

- preterm birth and its consequences including low birth weight
- intrauterine growth restriction
- abruption placentae
- stillbirth

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- genetic risk assessment is also recommended for individuals identified as carriers for hemoglobinopathy, as they may be at risk to have affected offspring.

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client____ Date ______________

Midwife____ Date ______________

Villers, Margaret S., et al. "Morbidity associated with sickle cell disease in pregnancy." American journal of obstetrics and gynecology 199.2 (2008): 125-e1.
Naik, Rakhi P., and Sophie Lanzkron. "Baby on board: what you need to know about pregnancy in the hemoglobinopathies." ASH Education Program Book 2012.1 (2012): 208-214.
John C. Morrison and Marc R. Parrish. "Sickle Cell Disease and Other Hemoglobinopathies" Protocols for High-Risk Pregnancies (2010): 158-159.
American College of Obstetricians and Gynecologists, Practice Bulletin 78, "Hemoglobinopathy in Pregnancy," January 2007

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14. HIV POSITIVE STATUS OR AIDS

Preamble:

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Disclosure of risks related to: HIV positive status with AIDS

HIV transmission from mother to child during pregnancy, labor and delivery, or breastfeeding is known as perinatal transmission and is the most common route of HIV infection in children. When HIV is diagnosed before or during pregnancy, perinatal transmission can be reduced to less than 1% if appropriate medical treatment is given, the virus becomes undetectable, and breastfeeding is avoided.[23]

Recommended medical treatment includes antiretroviral medication taken throughout pregnancy and during labor, regular monitoring of the maternal viral load, cesarean delivery for viral load > 1000 copies/mL, and initiation of antiretroviral medication for the newborn shortly after birth.

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- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client_______________________________________ Date ________________

Midwife______________________________________ Date ________________

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http://www.cdc.gov/hiv/risk/gender/pregnantwomen/index.html

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15. INAPPROPRIATE FETAL SIZE FOR GESTATION – MACROSOMIA (LARGE FOR GESTATIONAL AGE)

Preamble:

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Disclosure of Risks Related to: Inappropriate Fetal Size for Gestation – Macrosomia (Large for Gestational Age)

Macrosomia (meaning ***big body***), is arbitrarily defined as a birth weight of more than 4,000 g (8 lb, 13 oz). Also known as ***large for gestational age***, fetal macrosomia complicates more than 10 percent of all pregnancies in the United States.[24]

Risks to the mother related to macrosomia include:

- increased risk of uterine rupture after previous cesarean section or other uterine surgery;
- increased likelihood of induction at or before 40 weeks;
- increased likelihood of an operative delivery: forceps, vacuum, or cesarean section;
- trauma to vagina and/or perineum; including perineal and/or vulvar lacerations, 3rd or 4th degree episiotomy, short or long-term urinary or fecal incontinence;
- increased blood loss and/or postpartum hemorrhage,
- damage to the coccyx (tailbone)

Risks to the baby related to macrosomia at the time of birth include:

- shoulder dystocia (the baby gets stuck at the shoulders after the delivery of the head), which may result in trauma to the baby including:
  - broken clavicle (collar) bone(s);
  - brachial plexus injury, temporary or permanent nerve damage (sensory and motor) to either one or both shoulders, arms, and hands;
  - cerebral palsy;
  - hypoxia, resulting in permanent brain damage;
  - death.
- injuries related to operative delivery (forceps, vacuum, or cesarean section) including:
  - bruising and/or injury to the scalp, head and/or face;

MARK A. ZAMORSKI, M.D., M.H.S.A., and WENDY S. BIGGS, M.D., University of Michigan Medical School, Ann Arbor, Michigan. Am Fam Physician. 2001 Jan 15;63(2):302-307.

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  - temporary weakness in the facial muscles (facial palsy);
  - external eye and/or ear trauma;
  - broken clavicle (collar) bone(s);
  - brachial plexus injury (see description above);
  - cerebral palsy;
  - skull fracture;
  - bleeding within the skull;
  - seizures;
  - lacerations (during cesarean section) to the baby's presenting part
- immature lungs and breathing problems, if the due date has been miscalculated and the infant is delivered before 39 weeks of gestation;
- need for special care in the neonatal intensive care unit (NICU);

Risks to the newborn related to macrosomia and later childhood risks:

- higher than normal blood sugar level (impaired glucose tolerance);
- childhood obesity (research suggests that the risk of childhood obesity increases as birth weight increases);
- metabolic syndrome (a group of conditions: increased blood pressure, a high blood sugar level, excess body fat, abnormal cholesterol levels; that occur together, increasing the risk of heart disease, stroke and diabetes later in life.

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client______________________________ Date ______________

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16. Inappropriate Fetal Size for Gestation – IUGR (Small for Gestational Age)

Preamble:

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Disclosure of Risks Related to: Inappropriate Fetal Size for Gestation – IUGR (Small for Gestational Age)

IUGR (Intrauterine Growth Restriction) is a serious problem, regardless of why the baby is small. About 20% of stillborn babies are IUGR, and perinatal mortality for growth-restricted infants may be 6 to 10 times higher than for those of normal size. Most IUGR stillbirths occur after the 36th week of pregnancy and before labor begins.[25]

Risks to the baby related to IUGR, known as Small for Gestation Age:

- low birth weight (LBW);
- difficulty handling the stresses of vaginal delivery;
- decreased oxygen levels (hypoxia);
- hypoglycemia (low blood sugar);
- low resistance to infection;
- low APGAR scores (a test given immediately after birth to evaluate the newborn's physical condition and determine need for special medical care);
- meconium aspiration (inhalation of stools passed while in the uterus), which can lead to breathing problems, lung surfactant dysfunction, chemical pneumonitis, and persistent pulmonary hypertension;
- trouble maintaining body temperature (hypothermia);
- abnormally high red blood cell count;
- admission to NICU;
- long-term growth problems;
- intrauterine fetal demise (fetal death prior to labor);

Frye, Anne, Holistic Midwifery, Volume I, Labrys Press, Portland, OR, 2006, p. 990

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- stillbirth (fetal death during labor or birth).

Risks to the mother related to IUGR:

- increased stress related to fetal monitoring and surveillance (serial ultrasounds and non-stress testing);
- premature labor;
- premature birth (delivery of the fetus before 37 weeks gestation);
- induction and early delivery, before 40 weeks;
- cesarean section.

As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_______________________________________ Date ______________

Midwife_______________________________________ Date ______________

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17. INCOMPLETE SPONTANEOUS ABORTION OR INCOMPLETE MISCARRIAGE (10)

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Spontaneous abortion also known as early pregnancy loss refers to a miscarriage that happens before 20 weeks of gestation and is seen in 13% to 20% of all diagnosed pregnancies. Incomplete spontaneous abortion occurs when some tissue is retained in the uterus. Medication or a procedure may be needed to remove the tissue.

STILLBIRTH OR INTRAUTERINE FETAL DEMISE (IUFD)

Fetal death that happens after 20 weeks of gestational age is called stillbirth and has a rate of 3.2 per 1000 births. Medical intervention is needed for delivery.

MATERNAL FETAL RISKS OF EARLY OR LATE FETAL LOSS

- Infection
- Hemorrhage
- Maternal coagulopathy
- Gestational trophoblastic disease
- Rh isoimmunization

As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.

A Work Group comprised of members of the Board of Medicine and the Advisory Board on Midwifery has developed this information to assist licensed midwives in satisfying the requirements of Code Section 54.1-2957.9(iv), which requires midwives to disclose to their patients options for consultation and referral to a physician and evidence-based information on health risks associated with the birth of a child outside of a hospital. This information does not constitute medical advice, diagnosis, opinion or treatment. Individuals should consult a qualified health care provider for advice regarding a medical condition.

Guidance document: 85-10 Revised: 5/21

- ❑ Decline consultation with a physician regarding my risk factors.

Client____ Date ________________

Midwife____ Date ________________

Metz, Torri D., et al. "Obstetric care consensus# 10: management of stillbirth:(replaces practice bulletin number 102, March 2009)." *American journal of obstetrics and gynecology* 222.3 (2020): B2-B20.

American College of Obstetricians and Gynecologists' Committee on Practice Bulletins—Gynecology. "ACOG Practice Bulletin No. 200: Early Pregnancy Loss." *Obstetrics and gynecology* vol. 132,5 (2018): e197-e207. doi:10.1097/AOG.0000000000002899

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18. ISOIMMUNIZATION TO BLOOD FACTORS

Preamble:

The Midwives Model of Care® recognizes the client/patient as the primary decision maker in all aspects of her care and respects herautonomy. This is supported within a model of well-informed, shared decision-making in order to achieve optimal clinical outcomes. Disclosure of risks is an integral part of the informed consent process, as outlined by NARM (the *North American Registry of Midwives*).

> ***"If a midwife supports a client's choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process." – NARM***

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Disclosure of risks related to: Isoimmunization to blood factors

Pregnant women with a negative Rh blood type (O-, A-, B-, AB-) or with other atypical antibodies have significant fetal and neonatal risk factors. Clinical manifestations of RhD haemolytic disease (HDN) range from asymptomatic mild anemia to hydrops fetalis or stillbirth associated with severe anemia and jaundice.[26]

Use of anti-D immune globulin for prevention of D has decreased the risk of isoimmunization. Routine treatment includes prophylactic dosage at 28 weeks of gestation, after delivery of a D-positive newborn and at any significant bleeding. Testing for Rh typing should be performed with every pregnancy because revisions in lab procedures may present as a change in the Rh blood type.

Risks to the baby related to maternal isoimmunization include:

- destruction of fetal red blood cells (hemolysis);
  - mild to moderate hemolysis manifests as increased indirect bilirubin (red cell pigment).
  - severe hemolysis leads to red blood cell production by the spleen and liver.
- severe anemia;
- hepatic circulatory obstruction (portal hypertension);
- placental edema, interfering with placental perfusion;
- ascites (accumulation of fluid in the abdominal cavity);
- hepatomegaly (swelling of the liver);
- increased placental thickness;
- polyhydramnios (increased amniotic fluid);
- hydrops (fetal heart failure);
- anasarca (extreme generalized edema);

- effusions (abnormal accumulation of fluid);
- intrauterine fetal demise (fetal death);
- stillbirth.

As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client____ Date ______________

Midwife____ Date ______________

Urbaniak, S. J., and M. A. Greiss. "RhD haemolytic disease of the fetus and the newborn." Blood reviews 14.1 (2000): 44-61.

Sandler SG, Li W, Langeberg A, Landy HJ. New laboratory procedures and Rh blood type changes in a pregnant woman. Obstet Gynecol. 2012;119(2 Pt 2):426.

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19. MULTIPLE GESTATION

Preamble:

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Disclosure of risks related to: Multiple gestation

Maternal risks:

- Anemia
- Hemorrhage
- Preeclampsia
- Gestational diabetes
- Cesarean delivery

Fetal risks:

- Twin-to-twin transfusion syndrome (TTTS) in monochorionic twins
- Vanishing twin/death of one fetus
- Congenital anomalies
- Hydramnios
- Preterm birth
- Malpresentation
- Small for gestational age
- Umbilical cord prolapse
- Neonatal intensive care unit admission

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As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client_______________________________________ Date ________________

Midwife______________________________________ Date ________________

Rao, Anita, Shanthi Sairam, and Hassan Shehata. "Obstetric complications of twin pregnancies." Best Practice & Research Clinical Obstetrics & Gynaecology 18.4 (2004): 557-576.

Spellacy, W. N. "Antepartum complications in twin pregnancies." Clinics in perinatology 15.1 (1988): 79-86.

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20. Persistent severe abnormal quantity of amniotic fluid (oligohydramnios and polyhydramnios)

Preamble:

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Disclosure of risks related to: Persistent severe abnormal quantity of amniotic fluid

Oligohydramnios (decreased amniotic fluid) may be caused by fetal anomalies (bladder outlet obstruction, renal agenesis), premature rupture of the membranes, or placental insufficiency occurring de novo or as a consequence of maternal conditions such as hypertension.

Maternal risks:

- antepartum hospitalization
- induction of labor
- cesarean delivery

Fetal risks:

- pulmonary hypoplasia (underdevelopment of the lungs)
- limb contractures
- abnormal fetal heart rate patterns
- acidosis
- neonatal intensive care unit admission
- need for surgical intervention if anomalies present
- stillbirth or neonatal death

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Polyhydramnios (increased amniotic fluid) is most commonly idiopathic (no identifiable cause) but may be seen in maternal diabetes (especially uncontrolled or with large for gestational age fetus) and with fetal anomalies (diaphragmatic hernia, intestinal obstruction).

Maternal risks:

- cesarean delivery
- post-partum hemorrhage

Fetal risks:

- malpresentation
- neonatal intensive care unit admission
- need for surgical intervention if anomalies present
- neonatal hypoglycemia
- stillbirth and neonatal death

As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client_______________________________________ Date _______________

Midwife_______________________________________ Date _______________

Shanks, Anthony, et al. "Assessing the optimal definition of oligohydramnios associated with adverse neonatal outcomes." Journal of Ultrasound in Medicine 30.3 (2011): 303-307.
Magann EF, Sandlin AT, Ounpraseuth ST. Amniotic fluid and the clinical relevance of the sonographically estimated amniotic fluid volume: oligohydramnios. J Ultrasound Med 2011;30:1573-85.
Moore, Thomas R. "Abnormal Amniotic Fluid Volume." Protocols for High-Risk Pregnancies (2010): 399.

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21. PLATELET COUNT LESS THAN 120,000

Preamble:

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> ***"If a midwife supports a client's choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process." – NARM***

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Disclosure of risks related to: Platelet count less than 120,000

Platelet disorders in pregnancy include those that are time-limited to pregnancy (gestational thrombocytopenia, HELLP syndrome) and those that may pre-date or be newly diagnosed during the pregnancy (idiopathic thrombocytopenic purpura (ITP), thrombotic thrombocytopenic purpura (TTP)). With the exception of gestational thrombocytopenia, all of these platelet disorders place the mother at increased risk for blood loss and need for transfusion.

Gestational thrombocytopenia: occurs in 7-8% of pregnancies and accounts for 70-80% of cases of thrombocytopenia in pregnancy, typically diagnosed in the third trimester, rarely associated with platelet counts below 70,000, not associated with increased risks of bleeding in the mother or fetus, platelet counts return to normal after delivery.

It is important to differentiate gestational thrombocytopenia from more serious platelet disorders:

- ITP: chronic disorder associated with:
  - fluctuating platelet counts that may be lower than 50,000
  - need for steroid or immune globulin treatment and platelet transfusion to avoid excess blood loss at delivery, particularly surgical delivery.

- TTP: acute or chronic disorder generally associated with:
  - severe thrombocytopenia of 20,000 or less
  - hepatic impairment
  - renal impairment
  - CNS impairment
  - increased risk of death for both mother and fetus.

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- HELLP syndrome: an acute condition occurring in up to 2% of pregnancies, usually seen in the setting of preeclampsia, and characterized by:
  - thrombocytopenia
  - elevated liver enzymes
  - hemolytic anemia
  - potential for severe maternal illness including:
    - liver failure
    - hepatic subcapsular hematoma
    - excess maternal blood loss
    - seizure
    - maternal death
    - preterm birth
    - intrauterine growth restriction
    - fetal death

As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client______________________________________ Date ______________

Midwife______________________________________ Date ______________

Gernsheimer T, James AH, Stasi R. How I treat thrombocytopenia in pregnancy. Blood 2013;121:38-47.
Thrombocytopenia during pregnancy. Importance, diagnosis and management. Boehlen F. Hamostaseologie. 2006 Jan;26(1):72-4

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22. Position Presentation Other Than Cephalic at Term or While in Labor

Preamble:

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Presentation Risks

Non-cephalic presentations occur in less than 4% of all pregnancies. This would include breech, transverse lie, and compound presentations. Non-cephalic presentations are associated with congenital abnormalities of the baby, multiple pregnancies, placenta previa, and uterine abnormalities. These associations may increase risk to the mother/baby in addition to the actual risks associated with non-cephalic delivery.

C-section has become the standard mode of delivery for babies in non-cephalic positions. Physicians and midwives may not have adequate training in the vaginal delivery of non-cephalic presentations further increasing the risk of injury or death to both mother and baby. A transverse presentation is considered incompatible with vaginal delivery. Posterior, Brow, and Face presentations are associated with complicated delivery and increased maternal and/or fetal complications and may require C-section if the fetal malpresentation does not resolve.

Disclosure of risks related to: Position presentation other than vertex at term or while in labor:

Risks to Babies:

- Low APGAR scores
- Ruptured organs (kidney, liver)
- Neck Trauma
- Genital edema
- Prematurity
- Cord Prolapse
- Respiratory distress
- Stillbirth

- Head entrapment
- Edema to face and skull
- Tracheal damage
- Increased NICU admission rates
- Shoulder/arm trauma
- Hip and leg trauma
- Intracranial hemorrhage
- Death

Maternal Risks:

- C-section
- Prolonged/Dysfunctional labor
- Placenta abruption
- Increased risk of deep lacerations

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client____ Date ________________

Midwife____ Date ________________

de Leeuw, J. (2002). Mortality and early morbidity for abdominal and vaginal deliveries in breech presentation. *Journal of Obstetrics and Gynaecology*, *22* (2), 127-139.

Tidy, C. R. (2010). *patient.co.uk/doctor/malpresentations*. Retrieved from patient.co.uk.

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23. PRE-ECLAMPSIA/ECLAMPSIA

Preamble:

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Disclosure of risks related to Pre-eclampsia:

Pre-eclampsia is a leading cause of death in pregnant women and occurs in 5% of all pregnancies. The management of pre-eclampsia may require medication and monitoring unavailable in an out of hospital setting.

Maternal Risks:

- Hypertension leading to brain injury
- Liver Failure
- Kidney Failure
- HELLP Syndrome
    - HELLP syndrome: an acute condition occurring in up to 2% of pregnancies, usually seen in the setting of preeclampsia, andcharacterized by:
    - thrombocytopenia
    - elevated liver enzymes
    - hemolytic anemia
    - potential for severe maternal illness including: liver failure, hepatic supscapular hematoma, excess maternal blood loss, seizure, maternal death, preterm birth, intrauterine growth restriction, fetal death.
- Clotting problems (DIC)
- Pulmonary edema
- Seizure (Eclampsia)
- Stroke
- Placental Abruption
- C-section
- Death

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Fetal Risks:

- Small for gestational age (IUGR)
- Premature Birth
- Stillbirth

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- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client____ Date ________________

Midwife____ Date ________________

American College of Obstetricians and Gynecologists. (2011). *Frequently Aksed Questions: Pregnancy: High Blood Pressure During Pregnancy.* ACOG.
Cunningham, C. L. (2010). *Williams Obstetrics* (23rd Edition ed.). New York, NY: McGraw-Hill.
Frye, A. (1998). *Holistic Midwifery* (Vol. 1). Portland, OR: Labry's Press.
Gernsheimer T, James AH, Stasi R. How I treat thrombocytopenia in pregnancy. Blood 2013;121:38-47.
Thrombocytopenia during pregnancy. Importance, diagnosis and management. Boehlen F. Hamostaseologie. 2006 Jan;26(1):72-4

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24. Pregnancy Lasting Longer than 42 Completed Weeks with an Abnormal Stress Test

Preamble:

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Pregnancy is considered to be postdates at 42 weeks of gestation. There is limited research available to outline the risks of a pregnancy continuing beyond 42 weeks ***with*** an abnormal stress test. Current medical standard of practice is that beginning at 41 weeks, a non-stress test (NST) be combined with other indicators of fetal well-being, i.e., amniotic fluid index (AFI) or biophysical profile (BPP). There is no benefit in continuing a pregnancy at or post term after fetal surveillance is found to be non-reassuring. The recommendation is delivery. (Price, 2014)

Maternal Risks:

- Oligohydramnios
- Medical induction
- C-section
- Prolonged labor
- Complicated delivery such as: Shoulder dystocia

Fetal Risk

- Large size leading to risks associated with macrosomia
- uteroplacental insufficiency
- Asphyxia
- Infection
- Neonatal acidemia

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- Low Apgar
- Birth Injury
- Stillbirth
- Postmaturity/Dysmaturity syndrome
- Fetal distress
- Meconium Aspirtation
- Death

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- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client____ Date __________________

Midwife_______________________________________ Date __________________

Hilder, C. T. (1998). Prolonged Pregnancy: evaluating gestation-specific risks of fetal and infact mortality. *BJOG* .
O'Neill, E. T. (2012). Antepartum evaluation of the fetus and fetal well-being. *Clinical Obstetrics and Gynecology* , *55* (3), 722.
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25. VBAC (VAGINAL BIRTH AFTER CESARIAN) PREVIOUS UTERINE INCISION OR MYOMECTOMY (8)

Preamble:

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> ***"If a midwife supports a client's choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process." – NARM***

Licensed midwives are trained experts in the management of low-risk pregnancy and birth outside of the hospital. Certain conditions may present increased risk to mother and/or baby. The risks listed below apply to birth in any setting, and are not all-inclusive. The condition/risk factor listed may require medications and treatments outside of the scope of practice of Virginia Licensed Midwives and, thus may necessitate consultation with a physician, additional testing, and careful consideration for the appropriateness of birth in an out-of-hospital setting. Some conditions in pregnancy should be optimally managed and supported by a multidisciplinary team that may include midwives, obstetricians, perinatologists, family physicians, psychologists, social workers, and spiritual advisors.

Because the uterine scar for most caesarian sections is low on the uterus, women who undergo TOLAC (trial of labor after cesarean), are able to give birth vaginally 60–80% of the time. But if problems arise during TOLAC, the baby may need to be born by emergency cesarean delivery. Because uterine rupture can be sudden and unexpected labor outside of a hospital can delay delivery and increase the risk of injury and death for both mother and baby in an emergency. Some surgery for fibroids can result in a similar risk for uterine rupture. An unknown type of prior uterine scar is a contraindication for TOLAC outside of the hospital setting so review of prior surgical records is essential part of the evaluation.

RISKS

Maternal risks

- Maternal hemorrhage
- Infection
- Thromboembolism
- Placenta accreta
- Death
- Emergency hysterectomy

Fetal risks

- Hypoxic Ischemic Encephalopathy
- Stillbirth

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- Perinatal death
- Neonatal death
- Respiratory morbidity
- Transient tachypnea
- Hyperbillirubinemia

The probability that a woman attempting TOLAC will achieve VBAC depends on her individual combination of factors.

Selected Clinical Factors Associated with Trial of Labor after Previous Cesarean Delivery Success

Increased Probability of Success

- Prior vaginal birth
- Spontaneous labor

Decreased Probability of Success

- Recurrent indication for initial cesarean delivery (labor dystocia)
- Increased maternal age
- Maternal obesity
- Preeclampsia
- Short interpregnancy interval
- Increased neonatal birth weight

As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client_______________________________________ Date ______________

Midwife_____________________________________ Date ______________

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26. MENTAL HEALTH ISSUES

Preamble:

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> ***"If a midwife supports a client's choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process." – NARM***

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Clients with clinically-diagnosed and self-reported mental health issues such as:

- Depression
- Panic/anxiety
- Obsessive-compulsive traits
- Schizophrenia

should be counseled about the stresses of pregnancy and the postpartum period. Clients who are taking psychiatric medication should be made aware that some potential for birth defects may exist and are advised to discuss the risks and benefits of continuing their drugs during pregnancy with their provider.

Risks associated with pregnancy and psychiatric disorders include:

- Poor maternal health
- Poor outcomes for babies including poor fetal growth and development
- Maternal psychiatric medication side effects
- Increased potential for some birth defects

Clients who are taking psychiatric medication are advised to discuss the risks and benefits of continuing their drugs during pregnancy with their mental health provider.

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As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client____ Date ___________________

Midwife____ Date ___________________

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27. RUPTURE OF MEMBRANES 24 HOURS BEFORE THE ONSET OF LABOR (7)

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The risk of prolonged rupture of membranes is chorioamnionitis. The risk increases with the delay between rupture of membranes and delivery.

MATERNAL COMPLICATIONS

- cesarean delivery
- endomyometritis
- wound infection
- pelvic abscess
- postpartum hemorrhage
- bacteremia, most commonly involving GBS

Rarely

- septic shock
- disseminated intravascular coagulation
- adult respiratory distress syndrome

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- maternal death

FETAL COMPLICATIONS

- fetal death
- neonatal sepsis

NEONATAL COMPLICATIONS

- perinatal death
- asphyxia
- early onset neonatal sepsis
- septic shock
- pneumonia
- intraventricular hemorrhage
- cerebral palsy

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- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client______________________________ Date ______________

Midwife______________________________ Date ______________

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28. SEIZURE DISORDER REQUIRING PRESCRIPTIVE MEDICATION

Preamble:

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Disclosure of risks related to: Seizure disorder requiring prescriptive medication

Most pregnancies are uneventful in women with epilepsy, and most babies are delivered healthy with no increased risk of obstetric complications in women. When controlled, there does not appear to be an increased risk for intrauterine growth restriction, preeclampsia, preterm birth or stillbirth compared to women without seizure disorder.

Fetal risks:

- With uncontrolled seizures:
  - Intrauterine growth restriction
  - Preterm birth
  - Stillbirth
- Some medications are associated with an increased risk of birth defects

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- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client______________________________ Date ______________

Midwife_____________________________ Date ______________

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29. SEVERE LIVER DISEASE -- ACTIVE OR CHRONIC

Preamble:

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Disclosure of risks related to: Severe liver disease -- active or chronic

Liver disease occurs in approximately 3% of pregnancies. It may be chronic or occurring coincident with pregnancy, such as viral hepatitis or drug-induced hepatotoxicity, or pregnancy specific such as HELLP syndrome, intrahepatic cholestasis of pregnancy or acute fatty liver of pregnancy.

Severe liver disease:

- is usually acute in onset
- can be life-threatening to the mother
- associated with a high risk ofstillbirth
- If hypertension has preceded the onset of HELLP syndrome, fetal growth restriction may also be present.

As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client____________________________________ Date ______________

Midwife__________________________________ Date ______________

Liver Disease in Pregnancy, Cleveland Clinic Disease Management Project, Jamilé Wakim-Fleming, August 10, 2010.
Joshi D, James A, Quaglia A et al. Liver Disease in Pregnancy. Lancet 2010;375:594-605.

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30. SEVERE RENAL DISEASE -- ACTIVE OR CHRONIC

Preamble:

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> ***"If a midwife supports a client's choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process." – NARM***

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Disclosure of risks related to: **Severe Renal Disease — Active or Chronic**

Renal disease is associated with increased risks of both maternal and fetal adverse outcomes. These risks, which rise with the severity of preexisting renal disease, include:

Maternal:

- Hypertension
- abruptio placentae
- deterioration of renal function including permanent end-stage renal failure;

Fetal:

- Intrauterine growth restriction
- abruptio placentae
- stillbirth

As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

❑ Consult with a physician regarding my risk factors.

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Guidance document: 85-10 Revised: 5/21

- ❑ Decline consultation with a physician regarding my risk factors.

Client____ Date ________________

Midwife____ Date ________________

Williams DJ, Davison JM. Renal Disorders. In: Creasy & Resnick's Maternal-Fetal Medicine, Principles and Practice. 6th edition, 2009: Saunders Elsevier.

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31. SIGNIFICANT 2ND OR 3RD TRIMESTER BLEEDING

Preamble:

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Significant 2nd or 3rd trimester bleeding is often associated with potentially serious conditions, including placenta previa, placenta abruption, and vasa previa.

Medical management and ultrasound is indicated to rule out and/or monitor potentially serious conditions associated with significant bleeding.

Maternal Risk Factors:

- C-section
- Hemorrhage
- Anemia
- Hypovolemic Shock
- Death
- Coagulation Defects (DIC)
- Damage to Kidneys and Brain

Fetal Risk Factors:

- Poor fetal growth (IUGR)
- Birth Defects

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- Premature Birth
- Anemia
- Hypovolemic Shock
- Stillbirth

As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client____ Date ________________

Midwife_______________________________________ Date ________________

American College of Obstetricians and Gynecologists. (2011).*Frequently Asked Questions in Pregnancy: Bleeding During Pregnancy.* ACOG.
Karim, S. e. (1998). Effects of first and second trimester vaginal bleeding on pregnancy outcome.". *JPMA* .
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Oylese, Y. (2010). Third Trimester Bleeding. *Protocols for High Risk Pregnancies* .

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32. SIGNIFICANT GLUCOSE INTOLERANCE (PREEXISTING DIABETES, GESTATIONAL DIABETES, PCOS)

Preamble:

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> ***"If a midwife supports a client's choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process." – NARM***

Licensed midwives are trained experts in the management of low-risk pregnancy and birth outside of the hospital. Certain conditions may present increased risk to mother and/or baby. The risks listed below apply to birth in any setting, and are not all-inclusive. The condition/risk factor listed may require medications and treatments outside of the scope of practice of Virginia Licensed Midwives and, thus may necessitate consultation with a physician, additional testing, and careful consideration for the appropriateness of birth in an out-of-hospital setting. Some conditions in pregnancy should be optimally managed and supported by a multidisciplinary team that may include midwives, obstetricians, perinatologists, family physicians, psychologists, social workers, and spiritual advisors.

Disclosure of risks related to: Significant glucose intolerance

Pre-gestational diabetes mellitus (Type 1 or Type 2) affects approximately 1% of pregnancies, with an incidence rising with the incidence of type 2 diabetes in younger adults. Gestational diabetes is diagnosed in 5-7% of pregnancies.

Risk factors for GDM: occurs more commonly in women with a family history of diabetes, prior personal history of glucose intolerance including prior gestational diabetes, obesity, and maternal age over 25.

Maternal risks:

- Hypertension
- Antepartum hospitalization
- Induction of labor
- Cesarean dellivery
- Uncontrolled diabetes may result in:
  - kidney damage
  - retinopathy resulting in vision loss
  - peripheral nerve damage.

Fetal risks:

- Even when controlled, pre-gestational diabetes is associated with an increased risk of miscarriage and major congenital anomalies. This risk rises with poorer control around the time of conception.
- Throughout pregnancy, diabetes is associated with increased risks of:

A Work Group comprised of members of the Board of Medicine and the Advisory Board on Midwifery has developed this information to assist licensed midwives in satisfying the requirements of Code Section 54.1-2957.9(iv), which requires midwives to disclose to their patients options for consultation and referral to a physician and evidence-based information on health risks associated with the birth of a child outside of a hospital. This information does not constitute medical advice, diagnosis, opinion or treatment. Individuals should consult a qualified health care provider for advice regarding a medical condition.

- hypertensive disorders
- large for gestational age babies
- stillbirth
- abnormal progression of labor
- cesarean delivery
- shoulder dystocia with resultant brachial plexus injury

- Due to these risks, more frequent ultrasound examinations and antepartum testing of fetal well-being may be indicated in the newborn period:
  - hypoglycemia
  - hyperbilirubinemia
  - polycythemia

Timing of delivery:

- Pre-gestational diabetes, and uncontrolled gestational diabetes: between 37 and 39 weeks, individualized
- Controlled gestational diabetes: between 39 and 41 weeks, individualized

As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ☐ Consult with a physician regarding my risk factors.
- ☐ Decline consultation with a physician regarding my risk factors.

Client________________________________ Date ____________

Midwife________________________________ Date ____________

Pre-gestational Diabetes Mellitus. American College of Obstetricians and Gynecologists, Practice Bulletin 60, March 2005.
Gestational Diabetes Mellitus. American College of Obstetricians and Gynecologists, Practice Bulletin 137, August 2013.
Landon MB, Gabbe SG. Gestational Diabetes Mellitus. Obstet Gynecol 2011;118:1379-93.

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33. UNCONTROLLED HYPERTHYROIDISM

Preamble:

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Hyperthyroidism occurs in 0.2% of pregnancies; Graves' disease accounts for 95% of these cases.

The signs and symptoms of hyperthyroidism include nervousness, tremors, tachycardia, frequent stools, excessive sweating, heat intolerance, weight loss, goiter, insomnia, palpitations, and hypertension.

<u>RISKS</u>

- Premature delivery
- Severe preeclampsia
- Heart failure
- Maternal death
- Low birth weight
- Fetal death
- Abnormal thyroid function in the newborn

Thyroid storm is a medical emergency and occurs in 1% of pregnant patients with hyperthyroidism and can be triggered by infection, labor or delivery.

RISKS

- Shock
- Stupor
- Coma

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Guidance document: 85-10 Revised: 5/21

As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client____ Date ______________

Midwife_______________________________________ Date ______________

http://www.acog.org/Resources_And_Publications/Practice_Bulletins/Committee_on_Practice_Bulletins_--_Obstetrics/Thyroid_Disease_in_Pregnancy

Casey, Brian M., and Kenneth J. Leveno. "Thyroid disease in pregnancy." Obstetrics & Gynecology 108.5 (2006): 1283-1292.

American Thyroid Association (ATA): Guidelines of the American Thyroid Association for the Diagnosis and Management of Thyroid Disease During Pregnancy and Postpartum (2017). Topic 112934, Version 7.0

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34. Uterine Ablation (Endometrial ablation)

Preamble:

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Disclosure of risks related to Uterine Ablation (Endometrial Ablation):

Endometrial Ablation is a procedure accompanied by sterilization or the strong recommendation for continuous contraception. Pregnancy after ablation is rare and therefore there is little research, and the maternal and fetal complications are poorly defined. The general recommendation is that pregnancy is contra-indicated once endometrial ablation has been performed.

Maternal Risks:

- Miscarriage
- Ectopic pregnancy
- Placenta accreta
- Manual/Surgical removal of placenta
- Hemorrhage
- Uterine rupture
- C-section
- Hysterectomy
- Death

Fetal Risks:

- Prematurity
- Death
- Possible increase in anomalies
- Malpresentation

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As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client____ Date ________________

Midwife____ Date ________________

American College of Obstetricians and Gynecologists. (2013).*Frequently Asked Questions: Special Procedures: Endometrial Ablation.* ACOG.

Jenny, S. L. (2006). Pregnancy after endometrial ablation: English literature review and case report . *The Journal of Minimally Invasive Gynecology* , *13* (2), 88-91.

Laberge P. (2008, Oct). Serious and deadly complications from pregnancy after endometrail ablation reports and review of the literature. *J Gynecology Obstertics Biological Reproduction (Paris)* .

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35. UTERINE ANOMALY

Preamble:

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Disclosure of risks related to: Uterine anomaly

Women with a uterine anomaly (uterine septum, unicornuate uterus, bicornuate uterus, uterine didelphys) are at risk for

- PTB (preterm birth)
- Fetal presentation other than cephalic
- Hemorrhage
- Retained placenta
- Maternal urinary tract malformation
- Miscarriage
- Restricted fetal growth
- Cesarean delivery
- Pregnancy-associated hypertension

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- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client____ Date _______________

Midwife_______________________________________ Date _______________

Laufer, M, DeCherney, A. Congenital Uterine Anomalies: Clinical Manifestations and Diagnosis, Dec 2019.

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Agenda Item: Request from Virginia Society of Eye Physicians and Surgeons & Virginia Ambulatory Surgery Association

Staff Note: The Legislative Committee discussed this issue at its May 21, 2021 virtual meeting. In the following pages, you will find email communications from representatives of VSEPS and VASA requesting the Board to be involved in the setting of a single standard of care for eye surgeries that occur in ambulatory surgery centers and physicians' offices. Public comment is anticipated.

Action: The Legislative Committee voted not to recommend that the Board establish a work group as requested. The Board can accept the recommendation or vote to establish a work group to set a single standard of care, either by regulation or guidance document.

Colanthia Opher

From:	Harp, William <william.harp@dhp.virginia.gov> on behalf of Harp, William
Sent:	Monday, May 3, 2021 8:51 AM
To:	Colanthia D. Morton
Subject:	Fwd:
Attachments:	VASA VSEPS letter to Dr. Harp final.docx

Hi Co-Co:

For the Legislative Committee:

---------- Forwarded message ---------
From: **Addison, Karin** <Karin.Addison@troutman.com>
Date: Fri, Apr 30, 2021 at 4:25 PM
Subject: RE:
To: Harp, William <william.harp@dhp.virginia.gov>, Cal Whitehead <cal@commonwealthstrategy.net>, Mark Hickman <mark@commonwealthstrategy.net>, Yeatts, Elaine <elaine.yeatts@dhp.virginia.gov>
Cc: Clark Barrineau <cbarrineau@msv.org>

Good afternoon Dr. Harp,

Thank you for your time discussing this issue with us. Attached is a joint letter from the Virginia Ambulatory Surgery Association and the Virginia Society of Eye Physicians and Surgeons asking the Board of Medicine to convene a workgroup to discuss current standard of care, review existing patient safety requirements for outpatient and office-based procedures, and identify any deficiencies in patient protections.

Please let me know if you have any questions and we look forward to working together on this!

Karin

Karin T. Addison

Director - State Affairs

Direct: 804.697.2236 | Mobile: 804.306.7421
karin.addison@troutman.com

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troutman pepper strategies
1001 Haxall Point, PO Box 1122

Virginia Ambulatory Surgery Association

April 30, 2021

Dear Dr. Harp:

According to the Ambulatory Surgery Center Association, more than half of all surgeries performed in the United States are done in an outpatient setting. In recognition of the growing trend toward lowering the cost of health care as well as ongoing concerns about COVID infections acquired in the hospital setting, it is reasonable to expect even more procedures in the future will be performed in Ambulatory Surgical Centers (ASCs) or the physician office-based environment.

As you well know, the practice of medicine and surgery is governed by rigorous patient safety criteria at both the state and federal levels. Surgeons are also influenced by professional ethical standards, accreditation requirements, payor policy, and even legal pressures. The purpose of these and additional factors is to promote safe and effective outcomes for Virginians. However, as medical science and technology advance, the laws and regulations may not consistently apply to surgical care provided in different settings. Professionals and facilities have different combinations and layers of rules.

Our organizations have begun a dialogue about these issues with the common interest in patient safety. We agree that Virginians deserve the proper standard of care and expectations wherever they receive surgical care. Patient safety must not be compromised by changing the location of the surgery.

We believe it is appropriate and timely to have a discussion between regulators and the regulated community about the growth of outpatient/ambulatory care and the settings in which the care is provided. Using an example familiar to us, cataract surgery has been one of the top two most common codes performed at ASCs on Medicare beneficiaries since at least 2008. There is a growing shift of this and other procedures from hospitals and ASC's to office procedure rooms. The Board of Medicine has a role to ensure patient safety standards reflect a Virginia standard of care by licensed physicians regardless of the location of care, in the same way the Board reviewed and provided guidance and regulation of office-based anesthesia.

The following areas deserve discussion:

- Infection control
- Life Safety and emergency management
- Nursing and anesthesia standards and personnel
- Power backup

We respectfully petition the Board of Medicine to discuss current standard of care, review existing patient safety requirements for outpatient and office-based procedures, and identify any deficiencies in patient protections. We urge you to convene an ad-hoc work group of interested specialty societies, other relevant stakeholders, and the Medical Society of Virginia. Thank you for your consideration and we look forward to assisting the Board in reviewing ambulatory surgery safety standards in Virginia.

Sincerely,

Michael Keverline MD
President
Virginia Society of Eye Physicians & Surgeons

Frank Cotter
Frank Cotter MD
Chairman
Virginia Ambulatory Surgery Association Subcommittee on Office Based Surgery

Cc: Medical Society of Virginia

Richmond, VA 23218-1122
troutmansandersstrategies.com

From: Harp, William <william.harp@dhp.virginia.gov>
Sent: Thursday, March 25, 2021 4:10 PM
To: Addison, Karin <Karin.Addison@troutman.com>; Cal Whitehead <cal@commonwealthstrategy.net>; Mark Hickman <mark@commonwealthstrategy.net>; Yeatts, Elaine <elaine.yeatts@dhp.virginia.gov>
Subject:

EXTERNAL SENDER

Dear All:

I hope everyone is doing well.

Subsequent to our conversation several weeks ago, I communicated with Elaine Yeatts and Lori Conklin, MD, current President of the Board. We noted that the 2003 Office-Based Anesthesia regulations addressed many of the issues that put patients at risk when undergoing procedures outside hospitals and ambulatory surgery centers. The regulations establish standards for all practitioners providing and/or supervising anesthesia in their offices. In a broad sense, the regulations are helpful in defining the standard of care for anesthesia in the office setting. At the Board of Medicine, we believe that a single standard of care exists for surgery as well, indeed for all patient care.

The reason that I say the anesthesia regulations help "in a broad sense" is that the Board of Medicine is authorized to determine the standard of care in any case that comes before it. Based on the facts in each case, the Board determines how the law and regulations are to be applied in a fair and equitable way, using the principles of evidence-based medicine.

During our conversation several weeks ago, we noted that there are countless procedures done in office settings and that regulations or a guidance document for office-based surgery would most likely be a statement of general surgical/operative/procedural safety principles. Such principles are taken into account now during the probable cause review of any complaint/investigation at the Board. If the expertise to do a thorough standard of care review does not exist on Board staff or the Board itself, an outside expert medical reviewer can be engaged to review the evidence in the case and offer opinion on whether the expected standard was met or not, and how much deviation from the standard occurred.

The Board hopes that any differences between your two organizations can be resolved through negotiations. For the Board to become involved, there would need to be a request for regulations or a guidance document to address office-based surgery. All this said, the Board stands ready to address a request for rule-making or guidance on this issue.

I hope this is helpful to you.

With kindest regards,

William L. Harp, MD

Executive Director

Virginia Board of Medicine

On Thu, Mar 25, 2021 at 10:33 AM Addison, Karin <Karin.Addison@troutman.com> wrote:

Hi Dr. Harp, we are preparing our follow up information and formal letter. Are there any updates from your end? Please feel free to call me at (804) 306-7421.

Thanks!

Karin

Karin T. Addison

Director - State Affairs

Direct: 804.697.2236 | Mobile: 804.306.7421
karin.addison@troutman.com

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1001 Haxall Point, PO Box 1122
Richmond, VA 23218-1122
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Agenda Item: Request for a guidance document on benzodiazepines

Staff Note: The Legislative Committee discussed this issue at its May 21, 2021 meeting. In the following pages, you will find email communications with Abbot Granoff, MD, an article written by Dr. Granoff, and articles from the National Institute on Drug Abuse and the National Institutes of Health. There may be public comment.

Action: The Legislative Committee voted not to recommend that the Board of Medicine pursue the development of a guidance document on benzodiazepines. The Board can accept the recommendation or vote to develop a guidance document as requested.

Colanthia Opher

From:	abbot <agranoff@cox.net> on behalf of abbot
Sent:	Tuesday, May 11, 2021 8:19 AM
To:	Harp, William
Cc:	Colanthia D. Morton
Subject:	Re: 9:40 AM Email
Flag Status:	Flagged

Dr Harp
How do I log in? I can't imagine 5 minutes to be enough time to present my issue and answer any questions he Board may have.

Abbot Granoff, MD
agranoff@cox.net

On May 11, 2021, at 7:50 AM, Harp, William <william.harp@dhp.virginia.gov> wrote:

Dear Dr. Granoff:

Thank you for your message.

The Legislative Committee will meet virtually at 8:30 AM on Friday, May 21st. The Board will include the email string and your article in its agenda packet.

Public comment will be received at the top of the meeting. There are a number of other issues that the Committee will be discussing that day. It is customary to allow each person that wishes to offer public comment to speak for 5 minutes. You will be afforded that opportunity.

I hope this is helpful to you.

With kindest regards,

William L. Harp, MD
Executive Director
Virginia Board of Medicine

On Sat, May 8, 2021 at 4:05 PM abbot <agranoff@cox.net> wrote:
Dr Harp:

It appears to me that you are putting obstacles in my path to try to get this information to the Board. You asked for supporting data.Then told me it is too much and can't be used because of copyright infringement.

The main points that I want the Board to deal with are:

I have found refusal of many Virginia practitioners to prescribe the benzodiazepines because of false and misleading information. The bottom line to the Board for my request is this. I would appreciate the Board making a statement that there are many myths and misconceptions regarding the bezodiazepines.
1.They are not addictive.
2.They can cause physiological dependence as do many other medications including antidepressants, antihypertensives, anticonvulsants.
3.They do not cause dementia.
4.Withdrawal from them is usually mild lasting no longer than 2-3 weeks. Seizures from withdrawal are rare.
5.They are very safe and effective for anxiety disorders especially panic disorder.
6.They are abused by 0.5% of people usually in association to street drugs and alcohol.
7.They can be used long term when appropriate.
8.They are being underutilized.
9.The Board has no rules against their use when properly prescribed.

You can use the DSM-5 pages 48-484, 550-556. the "APA Task Force Report on Benzodiazepines," or use my article with 45 citations "Benzodiazepines as a First Line Treatment for Anxiety Disorders" which summarizes them all. A copy is attached.

I would like to address the Board. Please let me know the time, date and place. How much time ould I get to do this?

Sincerely,

Abbot Granoff, MD
agranoff@cox.net

On May 7, 2021, at 4:56 PM, Harp, William <william.harp@dhp.virginia.gov> wrote:

Dear Dr. Granoff:

Your email had 4 attachments.

The first is the cover of an issue of "Advances in Psychiatric Treatment"

The second is a GIF that cannot be opened.

The third and fourth are copies of the preceding email string, which will be copied and placed in the agenda packet.

I ask if you have received permission to copy and distribute the first and second attachments. If you have not, the Board of Medicine cannot publish those in an agenda packet. And even if you have, the Board, in an abundance of caution

about protecting the intellectual property of others, would have to get permission to use copies in its meeting packets. And that is not the role of the Board.

You may wish to summarize whatever is in the GIF during your public comment time.

I hope this is helpful to you.

Kindest regards, WLH

Colanthia Opher

From:	Harp, William <william.harp@dhp.virginia.gov> on behalf of Harp, William
Sent:	Tuesday, May 11, 2021 7:51 AM
To:	Colanthia D. Morton
Subject:	Fwd: 9:40 AM Email
Attachments:	Benzo Article complete pdf.pdf

In case I did not send this previously.

This has his article attached.

---------- Forwarded message ---------
From: **abbot** <agranoff@cox.net>
Date: Sat, May 8, 2021 at 4:05 PM
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To: Harp, William <william.harp@dhp.virginia.gov>

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You may wish to summarize whatever is in the GIF during your public comment time.

I hope this is helpful to you.

Kindest regards, WLH

April 20. 2020

Dear Dr. Harp:

Thank you for your reply to my concerns regarding the prescribing of benzodiazepines by physicians licensed in Virginia.

However there are a number of areas that are vague and might lead to confusion, concern and fear to prescribe them. I would appreciate your clarification of these issues.

Dear Dr. Granoff:

Thank you for your message.

You indicate that you and patients that contact your office have had difficulty in finding practitioners that will prescribe benzodiazepines. You ask for the Board's policies on the prescribing of benzodiazepines.

The prescribers licensed by the Board of Medicine, including doctors of medicine, osteopathic medicine and podiatry, physician assistants and nurse practitioners are authorized by their Virginia license to prescribe Schedule VI drugs. To prescribe Schedule II through V drugs, a practitioner must be currently registered with the Drug Enforcement Administration (DEA). Benzodiazepines are Schedule IV, so to prescribe them requires current registration with the DEA.

The Board of Medicine has no laws that specifically speak to benzodiazepines.

In the Board of Medicine Regulations "Governing Prescribing of Opioids and Buprenorphine", benzodiazepines are mentioned in the following subsections - 18VAC85-21-40(C) Treatment of Acute Pain with Opioids and 18VAC85-21-70(D) Treatment of Chronic Pain with Opioids. Here is the text of these subsections.

C. Due to a higher risk of fatal overdose when opioids are prescribed 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.

From my research there are no definitive articles that conclusively show that there is *"a higher risk of fatal overdose when opioids are prescribed with benzodiazepines."* It appears that this is theoretical since both substances can produce respiratory depression with benzodiazepines at the low end of the scale and Fentanyl at the high end.

I have spoken to the CDC section that puts out these statistics. They use death certificates only. These come from physicians and others of varying backgrounds and training. This can skew their conclusions to a negative slant toward the benzodiazepines. They don't look at blood to see all substance ingested nor blood levels of them at OD. Some patients in drug programs who are prescribed Suboxone or Methadone also get opiates on the street which often contain Fentanyl. They know when not to use them because of an upcoming "random" blood check. Sometimes they are caught but can cheat the system.

For example I am attaching an article from the NIH. It is a bit misleading since it doesn't detail the amount of benzo in a patient's blood at OD or the prescribed amount per day. Other NIH and CDC articles combine benzos, sedatives and hypnotics and assume their use at OD. They even add the information if the person filled an RX within 30 days of OD, again not taking a blood level or listing the prescribed dosage.

Look at the chart, which was produced by the CDC, at the bottom of the article from NIH. The graph shows the total opioid deaths, the opioid deaths without benzodiazepines and the opioid deaths with benzodiazepines. The amount of total opioid deaths above the deaths without benzodiazepines and deaths with benzodiazepines appear to be similar amounts. They don't list other medications or abused street drugs or alcohol. This begs the question. Are benzos in combination with opioids really responsible for the deaths? Are there other factors or chemicals involved?

I have treated patients on Suboxone prescribed by drug clinics with benzodiazepines, some at relatively high levels without any problems with respiratory depression. Some have been on them for years having them prescribed prior to my accepting them as patients. I have recently stopped accepting new patients on Suboxone or Methadone because I find some of them unreliable and I don't find it worth the risk to them or me, especially with the new proposed Board/PMP guidelines.

I believe more studies with reliable information including blood levels of all medications and street drugs including alcohol at OD necessary to discern the adverse effect of benzodiazepines in combination with opioids. Assigning the blame of OD on benzodiazepines is similar to the common myths and misconceptions of adverse effects of the benzodiazepines. See my attached article, "Benzodiazepines as a Fist Line Treatment for Anxiety Disorders."

The other concern in the C paragraph is the statement to *"document in the medical records a tapering plan…"*. Is this for tapering the opioid or the benzo? Patients with Panic Disorder and Generalized Anxiety Disorder usually require their medication for a lifetime. Requiring tapering by the Board of the benzo is an inappropriate requirement by the Board which will scare the physician from prescribing them in the first place.

National Institute on Drug Abuse

Advancing Addiction Science

Revised March 2018

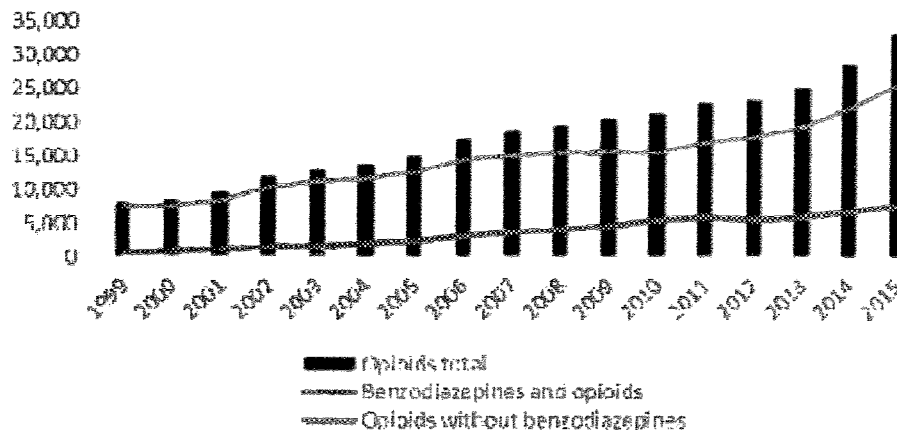
More than 30 percent of overdoses involving opioids also involve benzodiazepines, a type of prescription sedative commonly prescribed for anxiety or to help with insomnia. Benzodiazepines (sometimes called "benzos") work to calm or sedate a person, by raising the level of the inhibitory neurotransmitter GABA in the brain. Common benzodiazepines include diazepam (Valium), alprazolam (Xanax), and clonazepam (Klonopin), among others.

Every day, more than 115 Americans die after overdosing on opioids.[1] However, between 1996 and 2013, the number of adults who filled a benzodiazepine prescription increased by 67%, from 8.1 million to 13.5 million.[2] The quantity obtained also increased from 1.1 kg to 3.6 kg lorazepam-equivalents per 100,000 adults. Combining opioids and benzodiazepines can be unsafe because both types of drug sedate users and suppress breathing—the cause of overdose fatality—in addition to impairing cognitive functions. In 2015, 23 percent of people who died of an opioid overdose also tested positive for benzodiazepines (see graph).[3] Unfortunately, many people are prescribed both drugs simultaneously. In a study of over 300,000 continuously insured patients receiving opioid prescriptions between 2001 and 2013, the percentage of persons also prescribed benzodiazepines rose to 17 percent in 2013 from nine percent in 2001.[4] The study showed that people concurrently using both drugs are at higher risk of visiting the emergency department or being admitted to a hospital for a drug- related emergency.

Previous studies have also highlighted the dangers of co-prescribing opioids and benzodiazepines. A cohort study in North Carolina found that the overdose death rate among patients receiving both types of medications was 10 times higher than among those only receiving opioids.[5] In a study of overdose deaths in people prescribed opioids for noncancer pain in Canada, 60 percent also tested positive for benzodiazepines.[6] A study among U.S. veterans with an opioid prescription found that receiving a

benzodiazepine prescription was associated with increased risk of drug overdose death in a dose-response fashion.[7]

In 2016, the Centers for Disease Control and Prevention (CDC) issued new guidelines for the prescribing of opioids.[8] They recommend that clinicians avoid prescribing benzodiazepines concurrently with opioids whenever possible. Both prescription opioids and benzodiazepines now carry FDA "black box" warnings on the label highlighting the dangers of using these drugs together. People being prescribed any medications should inform their doctors about all of the other drugs and medications they use, and patients should consult with their doctors about the potential dangers of using various medications and substances together, including the use of alcohol.



Source: Centers for Disease Control and Prevention (CDC). Multiple Cause of Death, 1999-2015.

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This page was last updated March 2018

NIH...Turning Discovery Into Health®

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 of these medications if prescribed.

The Board has no guidance document on benzodiazepines.

This is not accurate as per Board C and D paragraphs above and the PMP regulations below. The Board is requiring a tapering dose of benzodiazepines. The Board needs a guidance document for the use of benzodiazepines. This can be the APA PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH PANIC DISORDER or the DSM-V section on Substance Use Disorders; Sedative, Hypnotic, or Anxiolytic Use Disorder. DSM-V. 2013, P:481-484,550-556.
I find this section of the DSM-V very enlightening.

The Virginia Prescription Monitoring Program receives dispensing reports from pharmacies on all "covered substances." At this time, covered substances include Schedules II, III and IV; those in Schedule V for which a prescription is required; naloxone, all drugs of concern, and cannabidiol oil or THC-A oil dispensed by a pharmaceutical processor in Virginia

Effective July 1, 2022, the following check of the PMP for benzodiazepines will be required by Section 54.1-2522.1 of the Code of Virginia. Here is the relevant text.
"B. Prescribers registered with the Prescription Monitoring Program shall, at the time of initiating a new course of treatment to a human patient that includes the prescribing of benzodiazepine or an opiate anticipated at the onset of treatment to last more than 90 consecutive days, request information from the Director for the purpose of determining what, if any, other covered substances are currently prescribed to the patient.

Why are benzodiazepines being lumped with opiates here? According to the DSM-V only 0.5% of people taking benzodiazepines abuse them. All patients taking a benzodiazepine are being

lumped with those taking an opiate in combination. This requirement puts fear into the prescriber who will be hesitant or refuse to prescribe them.

What about patients taking a benzo, sedative or hypnotic that aren't taking an opiate?

The Director of the Department of Health Professions, who has responsibility for the Prescription Monitoring Program, was granted the following authority by the General Assembly in 2016.

54.1-2523.1. Criteria for indicators of misuse; Director's authority to disclose information; intervention.

A. The Director shall develop, in consultation with an advisory panel which shall include representatives of the Boards of Medicine and Pharmacy, the Department of Health, the Department of Medical Assistance Services, and the Department of Behavioral Health and Developmental Services, criteria for indicators of unusual patterns of prescribing or dispensing of covered substances by prescribers or dispensers and misuse of covered substances by recipients and a method for analysis of data collected by the Prescription Monitoring Program using the criteria for indicators of misuse to identify unusual patterns of prescribing or dispensing of covered substances by individual prescribers or dispensers or potential misuse of a covered substance by a recipient. The Director, in consultation with the panel, shall annually review controlled substance prescribing and dispensing patterns and shall (i) make any necessary changes to the criteria for unusual patterns of prescribing and dispensing required by this subsection and (ii) report any findings and recommendations for best practices to the Joint Commission on Health Care by November 1 of each year.

B. In cases in which analysis of data collected by the Prescription Monitoring Program using the criteria for indicators of misuse indicates an unusual pattern of prescribing or dispensing of a covered substance by an individual prescriber or dispenser or potential misuse of a covered substance by a recipient, the Director may, in addition to the discretionary disclosure of information pursuant to § 54.1-2523:

1. Disclose information about the unusual prescribing or dispensing of a covered substance by an individual prescriber or dispenser to the Enforcement Division of the Department of Health Professions; or

2. Disclose information about the specific recipient to (i) the prescriber or prescribers who have prescribed a covered substance to the recipient for the purpose of intervention to prevent misuse of such covered substance or (ii) an agent who has completed the Virginia State Police Drug Diversion School designated by the Superintendent of State Police or designated by the chief law-enforcement officer of any county, city, or town or campus police department for the purpose of an investigation into possible drug diversion.

The Board of Medicine expects its licensees to meet the standard of care in all specialties of medicine with all diagnoses and treatments. The Board has the authority to decide whether the standard of care was met in any case that comes before it, depending on the facts in the case and an evidence-based assessment of the practitioner's decision-making and skill. As you can

see from the above, the Board does not have a monolithic statement about benzodiazepines. Each case that alleges problematic prescribing of benzodiazepines will be reviewed for whether the care met, exceeded, or fell below the standard expected.

I hope this message helps to clarify the Board's policies for you.

With kindest regards,

William L. Harp, MD
Executive Director
Virginia Board of Medicine

The last several paragraphs of your letter regarding the Virginia Prescription Monitoring Program are so negatively vague that I believe this has and will scare all physicians from prescribing benzodiazepines.

The Board does not describe the standards of care in which benzodiazepines can be properly prescribed without getting into trouble with the Board. This is probably why I found it very difficult to get a benzodiazepine prescribed to me and for patients that call my office with the same complaint.

I am attaching a copy of my article "Benzodiazepines as a First Line Treatment for Anxiety Disorders." In it I cite the NIH, DEA, and APA. They all say that benzodiazepines are **not** addictive and no tolerance is built to them causing the dose to be continually increased. Patients can become dependent on them. Patients become dependent on any medication for any chronic medical illness. Panic Disorder, Generalized Anxiety Disorder and OCD are chronic medical illnesses. The Board is making it difficult for patients suffering from these illnesses from getting proper treatment. Benzodiazepines are safer and better tolerated than the antidepressants and have fewer side effects.

I'm also snail mailing you a copy of my book, "Panic Attacks and Phobias - A Consumer's Guide" and a copy of my DVD "Panic Attacks and Phobias Conquered - Patients Share Their Victories." There are very few and poorly designed studies comparing the benzodiazepines to antidepressants in the treatment of the Anxiety Disorders. These are lifetime illnesses that require lifetime treatment. Putting a limit on how long a benzodiazepine can be prescribed is the same as putting a limit on how long a patient can be put on insulin, antihypertensives, anti-inflammatories, bronchodilators, etc. That is clearly unreasonable and would never be tolerated by the medical community. Don't patients with Anxiety Disorders or Affective Disorders remain on an antidepressant for a lifetime?

Instead of prescribing a benzodiazepine physicians are now using a myriad of medications off label to augment the antidepressants when they don't work such as Abilify, Seroquel, Geodon,

Topamax, Neurontin and others. These are some of the ones I have found patients on when they come to me for treatment. The Board's actions and proposed actions are creating unexpected and dangerous problems when a safe and effective medication class is available - benzodiazepines.

I hope these concerns have caused you to consider the negative effects that the Board and the PMP have put on physicians prescribing benzodiazepines and correct the reluctance of those who would properly prescribe them if the rules weren't so confusing and alarming.

Sincerely,

Abbot Granoff, MD

Plain Language Summary
Benzodiazepines as a First Line Treatment for Anxiety Disorders
By Abbot Lee Granoff, MD Board Certified Psychiatrist

Benzodiazepine tranquilizers have been around since 1960. These include: Xanax (alprazolam), Klonopin (clonazepam), Valium (diazepam), Ativan (lorazepam) and Librium (chlordiazepoxide).

These are the most effective medications with the least amount of side effects for the treatment of Anxiety Disorders: Generalized Anxiety Disorder, Panic Disorder, Agoraphobia, Social Phobia, School Phobia and brief periods of stress.

There are many myths and misconceptions about these very safe and useful medications from doctors, non-physician mental health workers and the media. The American Psychiatric Association, Nation Institute of Health and DEA have produced documents showing their safety. They are not addictive, do not produce tolerance (the need to continually increase the dose) and are rarely abused. Most of the abuse comes from mixing them with alcohol and street drugs. They have much fewer side effects compared to the SSRI, tricyclic and other antidepressants. When they are dosed properly there are often no side effects. They can be safely used long term and even a lifetime.

Because of misinformation, doctors are reluctant to and even fear prescribing them. As a result, this useful class of medications, benzodiazepines, are currently underutilized.

This article helps to correct that misinformation and is a guide for properly prescribing them.

Abstract

Benzodiazepines have become a pariah in the treatment of Anxiety Disorders. There are many myths and misconceptions about them. Increasingly it is dogma rather than research or clinical experience that benzodiazepines are addicting, abused and dangerous. The APA, NIH and DEA have produced documents that contradict these misunderstandings. This information along with juried medical reports and physician experience seems to be continually overlooked despite the scientific validity of the evidence.

This article attempts to provide both the scientific evidence and the over 44 years of experience of a private practice psychiatrist that benzodiazepines are a safe and effective class of medications. The lack of physician, media and public understanding along with marketing by benzodiazepine competitors has relegated these medications to a scorned second-class status. Many doctors that have seldom or ever prescribed benzodiazepines have strongly held, rigid and negative beliefs about them.

This article also attempts to explain how to prescribe the benzodiazepines safely and effectively.

The benzodiazepines are safe for short and long-term use, even a lifetime. They are the most effective medications with the least amount of side effects for the treatment of most Anxiety Disorders. Fear of the benzodiazepines has led them to be markedly underutilized.

Benzodiazepines as a First-Line Treatment for Anxiety Disorders

Many articles, medical presenters and the media perpetuate the myth about "addiction," dependence meaning addiction, building tolerance, inappropriate use of and abuse of benzodiazepines.[1,2,3,4] Physiologic adaptation and discontinuance syndrome can occur.[5,6,7,8] However, these can also occur with many drugs: steroids, anticoagulants, beta blockers, anti-inflammatories, many psychotropic drugs, sedative hypnotics, opioids.[6,7] Objectivity and consistency of terminology would lead us to use the same terminology for the same process, yet many physicians use the more pejorative terms of addiction, dependency, drug seeking and withdrawal when referring to the benzodiazepines.

Chronic use of a benzodiazepine for treating a medical condition is not an addiction. It is more appropriately considered dependence. Unfortunately, these terms are often used interchangeably. DSM-5 **does not** consider benzodiazepines taken appropriately under medical supervision a Substance Use Disorder.[7] Its **essential feature is "continual use of the substance despite significant substance-related problems."**[7]

Pharmacological criteria requires tolerance, "a markedly increased dose of the substance to achieve the desired effect," in addition to withdrawal.[7] "Symptoms of tolerance and withdrawal occurring during appropriate medical treatment with prescribed medications are specifically ***not*** counted when diagnosing Substance Use Disorder.[7] Normal, expected pharmacological tolerance and withdrawal during the course of medical treatment **has been known to lead to an erroneous diagnosis of addiction."**[7]

Prevalence for Sedative, Hypnotic, or Anxiolytic Use Disorder is 0.5% or less among American adults with the exception of Native Americans and Alaska Natives at 0.8%.[7] Medical presenters, the medical literature and the media make it seem like abuse is rampant and out of control.

Using any medication long term or even a lifetime is not addiction. Patients are **dependent** on their medications to treat any chronic medical condition of any organ system. Benzodiazepines are no different. When a person develops Panic Disorder which can lead to phobias, this author prescribes alprazolam as a first-line treatment. The average dose is 2-3mg per day with a range of 1/16-12mg per day. For Generalized Anxiety Disorder this author prescribes diazepam as a first-line treatment. The average dose is 10-20mg per day with a range of 2-60mg per day.[6,8] This author has successfully done this for over 44 years in his private psychiatric practice with a 98+% return to a full functioning life.[8] Panic Disorder, Agoraphobia, Social Phobia and Generalized Anxiety Disorder are usually lifetime conditions requiring lifetime treatment.

SSRIs do not cure Panic Disorder in 6 months to 2 years as first claimed by the manufacturers of paroxetine (FDA approved 1996) and sertraline (FDA approved 1997). They had to withdraw that claim. Alprazolam the last benzodiazepine produced became generic in 1993. The major anxiolytic marketing for the SSRIs began toward the end of the proprietary life of alprazolam. There was no pharmaceutical company left to counter those false claims. The manufacturers of SSRIs made billions with their supposedly non-addictive, temporarily used drugs that don't produce withdrawal. These usually have to be taken for a lifetime also.

Many Affective Disorders and Schizophrenia are also lifetime disorders requiring lifetime psychotropics. Literature directly comparing SSRIs with one another, other antidepressants and benzodiazepines is scarce.[4,8,9,10] No pharmaceutical company would want to fund studies of their proprietary drug compared to a generic one which would most likely be shown to be more effective and less costly. The few articles that do exist do not take into account comorbid diagnoses of Affective Disorders or OCD. They're usually short term and therefore don not take into account the long term treatment that is often necessary.

Patients can become dependent on benzodiazepines and SSRIs and other antidepressants. The brain produces its own benzodiazepine.[42,43] There are binding sites for it on the chloride ion channel and the GABA molecule. GABA also has a binding site on the chloride ion channel. When both are present the chloride channel

opens wider to allow negatively charged chloride ions to flow from outside to inside the nerve cell membrane causing it to become less excitable which translates to less anxiety.[11] Since Anxiety Disorders have a strong genetic predisposition one can postulate that these patients cannot produce enough of their own benzodiazepine to prevent the occurrence of an Anxiety Disorder. This can be compared to diabetes. Adding a therapeutic dose of a benzodiazepine puts that part of the brain chemistry back into balance alleviating symptoms.

Withdrawal from benzodiazepines is often misunderstood. According to the DSM-5 Benzodiazepine Discontiuance Syndrome can be divided into three categories: rebound, recurrence and withdrawal. SeeTable 1.[7]

Benzodiazepine Discontinuance Syndrome
Table 1

Symptom Category	Type of Symptom	Severity Compared to Original	Course
Rebound	Same as original	More	Rapid onset, temporary
Recurrence	Same as original	Same	Very gradual onset, stays
Withdrawal	New symptom	Variable	Lasts 2-4 weeks

Benzodiazepines can produce withdrawal or rebound discontinuance syndrome if abruptly withdrawn because their half-life is relatively short. By reducing the dose slowly there is minimal or no rebound or withdrawal. The original symptoms will return. This is **not** withdrawal as is often falsely claimed. If a more rapid discontinuation is necessary benzodiazepines can be stopped abruptly. A tapering dose equivalent of phenobarbital over 10 days will prevent seizures and withdrawal as per this authors experience.

SSRI's can also produce severe withdrawal if discontinued. This happens less frequently because their half-life is much longer. However, it happens often enough to be considered a serious problem, especially with paroxetine and the SNRI venlafaxine, since their half-life is shorter.

Birth defects in humans using benzodiazepines is somewhat controversial. Some studies show no increased incidence.[12,13,14,15] Some show benzodiazepines to be safe.[16,17,18] Some studies show the information to be inconclusive.[15,19,20,21] The same rate of birth defects occurs in neonates of women who take a benzodiazepine vs those who don't.[12] They are the same wide ranging types. No one type stands out.[12] The early reference to increased incidence to cleft palate with diazepam has been later shown to be incorrect.[18,19,22,23,24]

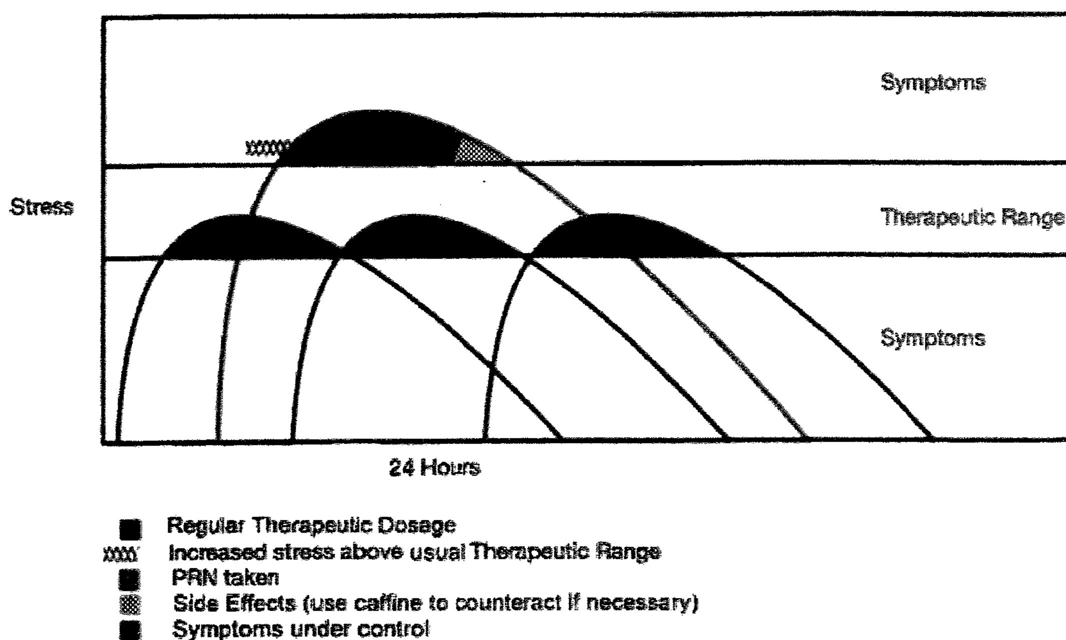
The seemingly higher level of benzodiazepine related birth defects vs other medications has been correlated with the higher number of women taking a benzodiazepine during pregnancy. When a birth defect occurs the first question asked the mother is to list the medications taken during pregnancy.

There is no clear correlation with neonatal lethargy, sedation or weight loss.[25] These can occur without the mother having taken a benzodiazepine.[14] There are a few reports in the literature showing a benzodiazepine blood level in a neonate from the placental blood where this has occurred. However, other drugs, alcohol or a combination might be the cause. One also has to consider the effect on the fetus of high cortisol and adrenalin levels in untreated women with an Anxiety Disorder.

This author has treated over 2,000 patients with Anxiety Disorders in his private psychiatric practice. He finds benzodiazepines to be the most effective and least toxic medications for Anxiety Disorders. In his extensive experience and the experience of others they do **not** result in tolerance to anxiolytic effects, requiring higher dosing to achieve the initial effect as often stated.[5,6,7,8,26,27,28,29,30,31,32,33,34,35,36]

The dosage remains stable at the patients usual therapeutic range as long as stress (physical, psychological and environmental) remains stable.[8,26] If stress increases the dose has to be increased to go into the new therapeutic range. It remains there as long as that increased stress remains. When that stress is alleviated the dose returns to the usual therapeutic range. See Figure 1.

Figure 1
Benzodiazepine Dosing



Conversely, if stress decreases the dose can be decreased to a new lower therapeutic range without discontinuation syndrome.(Figure 1) Clinically this is seen when a patient becomes sedated at their usual therapeutic dose or begins skipping doses. Approximately 20% of this author's patients reduce or discontinue their dosage over time.[8] Not all benzodiazepine users become dependent and most discontinuance symptoms are not severe.[5,6,7,8,26] The therapeutic benefits from long-term use outweighs

the risk.[26] Individuals who take a therapeutic doses of a benzodiazepine rarely increase their dose, or take drugs for pleasure.[5,6,7,8,26,34,36]

The misconception of "addiction" might come from the fact that patients do build some tolerance to the **sedating** effect after 3-5 days of a stable dose.

The dose can then be increased if necessary to a therapeutic one. Intermittent usage does not produce that tolerance. This can lead to sub-therapeutic dosing for the Anxiety Disorders. Retaining their sedative effect HS at higher doses when used for their hypnotic properties for sleep disorders is helpful.

Tolerance to sedation does not continue to occur with increasing dosage.[6,7,8,26] If the dose goes beyond the therapeutic range sedation will remain. This is one way to find the top of therapeutic range. If anxiety symptoms remain, the bottom of therapeutic range has not been achieved. When this author's patients are at therapeutic range they tell him they don't feel like they are taking any medication: no sedation, no anxiety, no side effects.[8]

The side effect profile for benzodiazepines includes sedation, cognitive impairment, psychomotor impairment and short-term memory loss. All of these are dose related and usually occur when the therapeutic dose has been surpassed. Lowering the dose to the therapeutic range generally eliminates them. The side-effect profile for SSRI antidepressants includes insomnia, sexual dysfunction, weight gain, sedation, agitation, fatigue. Tricyclic antidepressants most commonly produce anticholinergic side effects (dry mouth, constipation) and weight gain. Lowering the dose of either of these medication types does not eliminate them. In this author's experience they can exacerbate panic attacks in about 1/3 of patients, they are ineffective in another 1/3 and they do work in the final 1/3. The ones in which they work usually have an Affective Disorder or OCD as a primary diagnosis with an Anxiety Disorder as a secondary diagnosis.[8,9] Research does not take this into account when comparing medications which can lead to faulty conclusions.

According to the "APA Task Force Report on Benzodiazepines"[5] and the DEA[34] they are used appropriately by the greater majority of patients.[6,7,8,26,27,28,29,32,34,36]
Few abuse them but abusers do so along with alcohol and street drugs at the same time. The media, public perception, non-physician mental health workers and physicians have fallen into the false belief that they are addictive and dosage has to be continually increased.[6,8] Patients who take benzodiazepines chronically at their therapeutic dose report few if any side effects but their panic and anxiety are gone. They can then desensitize to their phobias more easily in real life situations. CBT desensitization with benzodiazepines appears more effective than CBT without medications or CBT with antidepressants. This needs more long-term study. Slow breathing or relaxation techniques don't work when a panic attack occurs in the middle of a tunnel or on top of a bridge. Patients taking a benzodiazepine can return to a fully productive life. It is therapeutically effective for patients to take PRNs to cover occasional brief periods of

increased stress. If they do not, breakthrough panic attacks can occur. When that stress abates they can return to their therapeutic dose.(Figure1)

There is concern benzodiazepines are being **under prescribed or ineffectively prescribed.**[4,5,40,44]

When using PRNs patients should take 1 or 2 pills, place them in plastic wrap and put them in their wallet which is always with them. If breakthrough anxiety or panic occurs, they have it readily available. Placing it under the tongue helps get it into the system more rapidly. This puts them in control of their illness rather than their illness controlling them. This empowerment speeds recovery to a fully functional life and helps extinguish phobias. If this stress is alleviated before the higher dose has time to metabolize and sedation occurs, the patients can then use some caffeine to titrate the sedation down. (Figure 1) Otherwise, caffeine should be avoided. It will increase anxiety and panic and reduce the effectiveness of the benzodiazepine.

If PRN use is more frequent than weekly or bi-weekly, one may consider raising the daily dosage to put the patient into a higher level of therapeutic range. It is prudent for the prescriber to look for the etiology of the increased need in areas of stress (physical, psychological and environmental). Once found, appropriate treatment should ensue.

The most common reason for treatment failure with benzodiazepines is too low a dose that is taken too infrequently.[8] Often times this occurs because of the fear of prescribing them in the first place. Physicians who do not understand how they work and properly prescribe them come to faulty conclusions about their effectiveness. They often scare the patient by telling them the benzodiazepines are addictive and should be used sparingly. This often leads to the prescription of an SSRI, tricyclic or off label prescription of a myriad medications with more significant side effects. PRN benzodiazepines are also often needed here.

It is generally not appropriate to prescribe benzodiazepines to alcoholics or drug abusers. They are the most likely to abuse them. However, some patients who are self-medicating with alcohol to treat their Anxiety Disorders might benefit from them. Antabuse should be given along with the benzodiazepine especially in the early stages of treatment to prevent alcohol use.

It may be potentially dangerous to combine a benzodiazepine with an opiate. This is theorized to cause respiratory depression and death. This conclusion needs more study since this combination is often taken at appropriately prescribed doses without adverse sequelae. Research literature on this speculation is sparse and opioid overdose is the more likely primary cause of death. Fentanyl is more potent and deadlier than other opiates and is often added to opiates to increase their effect. It is not included in the reports in opioid deaths. There are limited animal studies. More are definitely needed.

The conclusion about combining benzodiazepines and opiates is similar to the one regarding teratogenicity. Just because a benzodiazepine is present does not mean it is

causal to any adverse event that occurs. The negative bias toward the benzodiazepines seem to make them causal even without proof. This is speculation not science. Science must prove that speculation. Blood levels should be taken when patients OD on opiates since there are many substances that could in combination with opiates cause an adverse and deadly effect. The CDC which produces graphs and charts regarding opioid deaths uses death certificates from various practitioners of widely differing training and knowledge. They will even include a person who has filled a benzodiazepine prescription within 30 days of the OD not stating the dosage or knowing if the benzodiazepine was ingested at time of OD!

As people age they must be observed for dementia. If they have it, reduce or discontinue their dosage of benzodiazepine as needed. Clinical judgement is necessary. The myth that they cause dementia including Alzheimer's Disease is perpetuated by poorly designed research. Read the British Medical Journal article 2014; 349:g 5205 "Benzodiazepine use and risk of Alzheimer's disease: case-control study."[37] At the end of the article the authors themselves state this "might not be causal." Read this authors critique of that study in the BMJ. You will find it under "Response."[38] These critiques only appear online and are somewhat difficult to locate which minimizes their corrective effect. Psychiatric News picked up on this article in their Oct 2014 edition "Long Term Use of Benzodiazepines May Be Linked to Alzheimer's."[39] They did not publish this author's critique letter to them. Major TV news along with the NYTimes and other newspapers picked up on this faulty conclusion as though it was fact, needlessly scaring the public and physicians and starting a new myth. Letters to them went unheeded.

A recent study of benzodiazepines and dementia found no correlation but found they "might have protective effect against dementia."[45]

Patients should always have a 10-14 day supply so they won't run short and experience discontinuance syndrome if they have to cancel an appointment due to illness, weather or other unforeseen circumstances. This prevents their fear of running out of them. Insurance companies and many physicians often won't let patients have this buffer amount of their prescription. This might be causing some of the unnecessary desperation seen in patients fomenting the myth of addiction. If missing appointments happens too often consider abuse. If it is present switch to an SSRI.

In order to discontinue a benzodiazepine, slowly reduce the dosage by perhaps 10-15% every week. To discontinue more quickly, prescribe an equivalent Phenobarbital dosage and taper it over 10 days to cover withdrawal and seizures. Premorbid anxiety symptoms usually return. This is **not** withdrawal as is often incorrectly concluded. This withdrawal myth is too prevalent. Withdrawal lasts 1-4 weeks.[7] Benzodiazepines can produce withdrawal but so can SSRIs. Proper prescribing can minimize or alleviate it.

Withdrawal can also occur with a number of other medications: steroids, anticoagulants, beta blockers, anti-inflammatories, many psychotropic drugs, sedative hypnotics, opioids.[6,7]

If there is an increased street use of benzodiazepines, this author speculates that it may be because physicians have become fearful of prescribing them. Patients with Anxiety Disorders where SSRIs or other treatments are ineffective and benzodiazepines are may seek them on the street. This could happen when they can't find a physician willing to prescribe them or experienced enough to prescribe at proper therapeutic levels.

There are few studies comparing benzodiazepines to antidepressants in treating Anxiety Disorders. When they do occur they are usually short-term, 5-8 weeks and they don't take into account comorbid Affective Disorders or OCD. These are usually lifetime disorders that can wax and wane. Brief studies along with comorbid illness may produce inaccurate conclusions. Since we are yet unable to fix the gene(s) that cause them, lifetime treatment is often necessary.

When comparing benzodiazepines to antidepressants to treat Anxiety Disorders for side effects, efficacy and tolerability, the benzodiazepines win hands down. To perpetuate the myths of addiction, abuse and dementia scares physicians and the public from these very safe and useful medications. They have been available since 1960 and have been safely prescribed to millions of patients. They are currently underutilized. This can be corrected with knowledge and training.

New research is needed to help clear up the confusion, bias and misunderstandings regarding the benzodiazepines. This should be unbiased research that is not funded by the pharmaceutical or addiction industry. It should compare patients with Anxiety Disorders **without** comorbid Affective Disorders or OCD with the use of benzodiazepines vs antidepressants or other current medications d'jour. In addition studies are needed for patients that have been on a benzodiazepine long term and compare their incidence of dementia to patients who have not been on any psychotropic.

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Agenda Item: Request from the Virginia Interfaith Center for Public Policy

Staff Note: The Legislative Committee heard public comment and discussed this topic at its May 21, 2021 meeting. In the following pages, you will find email communications with Dora Muhammad, Congregation Engagement Director & Health Equity Program Manager for the Virginia Interfaith Center for Public Policy. Her request is that the Board of Medicine, in support of maternal and infant health, require its licensees to take implicit bias training. The article on "Perinatal and other Depression in Women" that appeared in the November 2020 Board Briefs is included for your review.

Additionally, you will find a descriptive article from Today's Hospitalist, a peer-reviewed study from PubMed, an article from the American College of Physicians, a study from VCU School of Medicine, a list of resources from UNC Health Sciences Library, a free online CME from Stanford University School of Medicine, the Implicit Bias Training Facilitator Guide from the American Academy of Family Physicians website, a description of the California Medical Association's efforts, cultural competency information from the Oregon Medical Board website, and an article from Scientific American that expounds upon the VCU article and calls for improved approaches to training.

Action: The Legislative Committee recommended that this issue be referred to the Board for further consideration. The Board can vote to pursue legislation mandating continuing education in implicit bias, pursue regulation or a guidance document to address the request, or suggest another approach.

Colanthia Opher

From: Harp, William <william.harp@dhp.virginia.gov> on behalf of Harp, William
Sent: Tuesday, May 4, 2021 4:41 PM
To: Colanthia D. Morton
Subject: Fwd: Meeting Request

---------- Forwarded message ---------
From: **Dora Muhammad** <dora@virginiainterfaithcenter.org>
Date: Tue, May 4, 2021 at 4:08 PM
Subject: Re: Meeting Request
To: Harp, William <william.harp@dhp.virginia.gov>

Thank you so much!

Dora Muhammad
Congregation Engagement Director
Health Equity Program Manager
Virginia Interfaith Center for Public Policy
1716 East Franklin Street
Richmond, VA 23223
(804) 643-2474 ext. 106
#LearnPrayAct #HealthCareHope
#FaithfulCitizens #EndRacism

The Virginia Interfaith Center for Public Policy advocates economic, racial, social and environmental justice in Virginia's policies and practices through education, prayer, and action. VICPP is a non-partisan coalition of more than 700 faith communities working for a more just society. Learn. Pray. Act.

From: Harp, William <william.harp@dhp.virginia.gov>
Sent: Tuesday, May 4, 2021 2:13 PM
To: Dora Muhammad <dora@virginiainterfaithcenter.org>
Subject: Re: Meeting Request

Dear Ms. Muhammad:

It has been decided that your request will be discussed by the Board of Medicine's Legislative Committee on Friday, May 21st.

The meeting will be virtual, and the Committee will take public comment at the top of the meeting. Speakers will be limited to 5 minutes.

Here is the notice of the meeting on Regulatory Town Hall. The notice says "physical location." That is being changed to "virtual." Prior to the meeting, instructions on how to join the meeting will be posted on Town Hall.

https://townhall.virginia.gov/L/ViewMeeting.cfm?MeetingID=31737

Kindest regards,

William L. Harp, MD
Executive Director
Virginia Board of Medicine

On Mon, May 3, 2021 at 8:48 AM Harp, William <william.harp@dhp.virginia.gov> wrote:
Dear Ms. Muhammad:

Thank you for your message.

You may be interested in the lead article in the November 2020 Board Briefs about perinatal depression. Delegate Ibraheem S. Samirah wanted to highlight the issues of depression in women of minorities before, during and after pregnancy. The article included links to resources for practitioners. Here is the link to the November 2020 Board Briefs.

https://www.dhp.virginia.gov/media/dhpweb/docs/med/News/archive/BoardBrief91.pdf

I hope this is helpful to you.

Kindest regards, WLH

On Fri, Apr 30, 2021 at 9:32 AM Dora Muhammad <dora@virginiainterfaithcenter.org> wrote:
Thank you for the response and the specific guidance on options. Before I pursued legislation, we try to determine if it is necessary based on the position or protocols of the affected governmental body and what avenues are open to work with them as a stakeholder if they have the authority to make policy changes without legislation. Since the MMRT listed this recommendation under the Board and not the GA, I read that as legislative action was not necessary.

Is/would the Board welcome and support such legislation? Has it considered or been presented with the other mandates for clinical trainings that the MMRT recommended? When I spoke with the program manager in December, she was not aware whether any follow-up had been done in that regard by members of the MMRT?

Dora Muhammad
Congregation Engagement Director
Health Equity Program Manager
Virginia Interfaith Center for Public Policy
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From: Harp, William <william.harp@dhp.virginia.gov>
Sent: Friday, April 30, 2021 9:16 AM
To: Dora Muhammad <dora@virginiainterfaithcenter.org>; Brown, David <david.brown@dhp.virginia.gov>; Yeatts, Elaine <elaine.yeatts@dhp.virginia.gov>
Subject: Fwd: Meeting Request

Dear Ms. Muhammad:

Thank you for your message. I do not believe a meeting would enhance the Board's response below, but thanks for the offer.

I see 3 ways forward with your request.

1. Contact a delegate or senator in the General Assembly and have them carry a bill to require education on implicit bias for all Board of Medicine licensees.

2. File a request for rule-making. The process for developing and approving new regulations can take up to 2 years. However, if you wish to pursue this course, here is the link for filing.
https://www.dhp.virginia.gov/media/dhpweb/docs/med/leg/Petition_Medicine.pdf

3. The Board of Medicine can publish how to access educational courses on implicit bias in its newsletter that goes to all licensees, including nurse practitioners. Any information you can provide to the Board about courses would be most appreciated.

I hope this is helpful to you.

With kindest regards,

William L. Harp, MD
Executive Director
Virginia Board of Medicine

---------- Forwarded message ---------
From: **Dora Muhammad** <dora@virginiainterfaithcenter.org>
Date: Fri, Apr 23, 2021 at 5:25 PM
Subject: Meeting Request
To: medbd@dhp.virginia.gov <medbd@dhp.virginia.gov>
Cc: Coco.Morton@dhp.virginia.gov <Coco.Morton@dhp.virginia.gov>

Good afternoon Mr. Harp,

I would like to schedule a meeting with you to discuss one of the primary recommendations that is a part of our maternal health PUSH campaign and get your feedback on the feasibility of its implementation at the Virginia Board of Medicine. It is establishing a requirement of implicit bias training for all health professionals licensed by the Board. The Virginia Maternal Mortality Review Team, in its 2019 report, included a recommendation to the Board to mandate a set of clinical trainings to improve the maternal mortality rates of Black women. This would only partially improve birth outcomes for Black women in Virginia. I would like to discuss with you the significant impact that a mandate for implicit bias training would bear on their maternal mortality.

For the past several years, I have led this campaign which has involved several key elements such as planning and coordinating the Governor's Office's maternal health listening tour stop in my county, a statewide petition to Dr. Carey, and organizing a maternal health coalition to give testimony before the General Assembly. Our PUSH campaign achieved a major success during this year's legislative session of the General Assembly. I drafted a budget amendment that would enact the federal option under CHIP that would provide for coverage of prenatal care to undocumented expectant mothers, an overlooked and marginalized group of women excluded from access to these essential services.

Like the General Assembly, the Virginia Board of Medicine holds a unique position to leverage its authority to help reverse the tragic rising trend of pregnancy-related deaths of Black women in Virginia. Attached are my policy briefs on prenatal care and implicit bias as a quick reference. I look forward to hearing from you!

Dora Muhammad
Congregation Engagement Director
Health Equity Program Manager
Virginia Interfaith Center for Public Policy
1716 East Franklin Street
Richmond, VA 23223
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Virginia Board of Medicine

9960 Mayland Drive, Suite 300

Henrico, VA 23233

804-367-4600

The Virginia Board of Medicine currently licenses: Acupuncturists, Athletic Trainers, Behavior Analysts, Assistant Behavior Analysts, Doctors of Chiropractic, Doctors of Medicine and Surgery, Doctors of Osteopathic Medicine and Surgery, Doctors of Podiatry, Genetic Counselors, Interns & Residents, Midwives, Nurse Practitioners*, Occupational Therapists, Occupational Therapy Assistants, Physician Assistants, Polysomnographic Technologists, Radiological Technologists, Radiological Technologists Limited, Radiologist Assistants, Respiratory Therapists, Surgical Assistants & Surgical Technologists (*Jointly with the Board of Nursing)

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Elaine J. Yeatts
Senior Policy Analyst
Department of Health Professions
(804) 367-4688

PERINATAL AND OTHER DEPRESSION IN WOMEN

The 2020 Session of the General Assembly passed HB 42 which requires the Board of Medicine to "annually issue a communication to every practitioner licensed by the Board who provides primary, maternity, obstetrical, or gynecological health care services reiterating the standard of care pertaining to prenatal or postnatal depression or other depression. Such communication shall encourage practitioners to screen every patient who is pregnant or who has been pregnant within the previous five years for prenatal or postnatal depression or other depression, as clinically appropriate and shall provide information to practitioners regarding the factors that may increase susceptibility of certain patients to prenatal or postnatal depression or other depression, including racial and economic disparities, and encourage providers to remain cognizant of the increased risk of depression for such patients."

HB 42 echoes the recommendation of the 2016 US Preventive Services Task Force that pregnant women and postpartum women should be screened for depression, and it adds women that have been pregnant in the last 5 years. The bill seeks to be preventive, so it encourages practitioners to identify women at risk for depression. Screening and identification is important since many women do not seek treatment for depression. The practitioner is in the important position of being able to refer women at risk for depression to counseling and for further evaluation. This initiative is particularly relevant for minority women, a group that has not been screened as often.

Remember that postpartum depression can cause intense feelings of sadness, anxiety or despair that prevent new mothers from being able to do their daily tasks. Practitioners should be aware of the risk factors for perinatal depression, factors that can be clinical or social. Here are some to keep in mind.

Clinical Risk Factors

- Personal or family history of depression
- History of physical or sexual abuse
- Unplanned or unwanted pregnancy
- Current stressful life events
- Pregestational or gestational diabetes
- Complications during pregnancy

Social Risk Factors

- Low socioeconomic status
- Lack of social or financial support
- Adolescent parenthood

Additionally, you should know that 1 in 7 women has perinatal depression. Preexisting depression, psychiatric illness prior to pregnancy, and symptoms during pregnancy are the strongest predictors of perinatal depression. Data show that a previous episode of postpartum depression predicts a second episode 50% of the time. A previous episode of postpartum psychosis predicts a recurrence 80-90% of the time. African-American women meet criteria for depression more than other ethnic groups and are 3 times more likely to die from pregnancy-related causes. And 1 in 3 migrant women from low and middle income countries have perinatal mental health issues.

It is recommended that women who exhibit 1 or more of the following should be referred for counseling or further evaluation.

- History of depression
- Current depressive symptoms
- Low income
- Adolescent or single parenthood
- Recent intimate partner violence
- Elevated anxiety symptoms
- History of significant negative life events

A useful tool to help with the identification of postpartum depression is the Edinburgh Postnatal Depression Scale. You can find it at:

https://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf

And for women that are no longer in the perinatal period, the Patient Health Questionnaire-9 and the Beck Depression Inventory BDI) are useful tools. You can find them at:

https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf

https://www.ismanet.org/doctoryourspirit/pdfs/Beck-Depression-Inventory-BDI.pdf

The following 2 questions are recommended as a quick screen for a past history of depression, a significant risk factor. If the answers are "yes" for a pregnant or postpartum woman, consider referral for counseling or further evaluation.

- Was there ever a period of time when you were feeling depressed or down or when you lost interest in pleasurable activities most of the day, nearly every day, for at least 2 weeks?
- Has a health care professional ever told you that you were depressed? Have you ever taken a medication for depression?

In all cases, interventions should be tailored to the risk.

References

Massachusetts General Hospital Center for Women's Mental Health

- Perinatal Depression: How Do We Define High Risk? (Part 1) February 27, 2019 – Ruta Nonacs, MD, PhD
- Perinatal Depression: How Do We Define High risk? (Part 2) March 20, 2019 – Ruta Nonacs, MD, PhD

Perinatal depression screening practices in a large health system: identifying current state and assessing opportunities to provide more equitable care – Archives of Women's Mental Health, May 5, 2020 – Abbey Sidebottom et al.

Racial Disparities in Perinatal Depression in an Underserved Los Angeles County Population [3OP] – Obstetrics and Gynecology, May 6, 2017 – Anna K. Celaya, MD, MPH et al.

Research Gaps in Perinatal Mental Health: U.S. Racial & Ethnic Disparities and Neglected Global Populations - Mental Health Task Force at the Harvard Chan School, August 19, 2016 – Sarah Hodin, MPH, CD (DONA), LCCE

Unconscious bias in patient care

How underlying assumptions can affect patients and colleagues

By **Phyllis Maguire** - October 2016

Published in the October 2016 issue of Today's Hospitalist

MOST OF US pride ourselves on being able to recognize explicit bias when we see it, whether it is overt racism, homophobia, ageism or sexism. But the reality is that our unconscious biases—tied to many of those same issues and more, including people's weight, socioeconomic status and physical disabilities—can make spotting bias difficult.

Speaking at this year's Society of Hospital Medicine meeting, René Salazar, MD, professor of medical education and assistant dean for diversity at the University of Texas at Austin Dell Medical School, pointed this out: Unconscious, implicit bias is not only more prevalent but "just as problematic" as the conscious, explicit type.

That's because, despite our best intentions, "we all hold unconscious beliefs about various social and ethnic groups," Dr. Salazar said, "even though such beliefs are incompatible with our conscious values. It's important to acknowledge that."

It's also important to work to identify and manage such blind spots. Otherwise, he added, unconscious biases can derail your workplace as well as your ability to deliver patient care.

"We all hold unconscious beliefs about various social and ethnic groups."

René Salazar, MD
University of Texas at Austin Dell Medical School

Reinforcing biases

What exactly qualifies as unconscious bias? According to Dr. Salazar, unconscious bias refers to social stereotypes that individuals form outside their conscious awareness. "Bias stems from our tendency to organize social roles by categories," he said, noting that forming biases is a normal aspect of human life driven by natural survival instincts. "Biases develop over time, and many factors contribute including where you grew up, your friends and family, and other patterns of experience you had when you were young."

Bias is also constantly bolstered by the omnipresent media. By way of an example, Dr. Salazar showed two news photographs taken in New Orleans after Hurricane Katrina. The caption of one stated that the young black man shown in the photo was seen wading through chest-deep water after looting a grocery story.

The other caption, which referred to a photo of a young white man and woman, noted that they were wading through chest-deep water "after finding bread and soda from a local grocery store."

"How these messages are presented in the media can have a profound effect," Dr. Salazar pointed out. "Those messages can constantly reinforce unconscious bias in a negative way." Unconscious biases can become particularly problematic for physicians because they are perfectly set up to be vulnerable to them. For one, the culture of medicine does not highlight self-care or self-examination. In addition, stress—a constant in medical practice—is a great way to activate bias.

"At the end of the day after several admissions, you're really running on reserves," Dr. Salazar pointed out. "We're often stressed, making high-stakes decisions and multitasking."

And as clinicians, "We're trained to think a certain way, which is all about pattern recognition," he added. That can push physicians to be even more swayed by unconscious bias.

Unconscious bias on the job

Unconscious biases also fuel what Dr. Salazar called "microaggressions," subtle experiences that aren't necessarily overt, but can nonetheless set the tone for a work environment.

"Individually, microaggressions may not seem very powerful," he said. "But over time, they may collectively contribute to a hostile work environment." In a group of rounding medical students, for example, young women may repeatedly be asked to remove trays from patient rooms.

Unconscious biases can also have an enormous impact on hiring and job-performance evaluations.

In one 2000 study, Dr. Salazar pointed out, "blind" orchestra auditions—in which musicians played behind a screen to conceal their gender—led to a 50% increase in the number of women advancing beyond the preliminary rounds. Further, implementing a blind audition strategy led to a 25% increase in the hiring of women musicians.

Then there was a 2004 study titled, "Are Emily and Greg More Employable than Lakisha and Jamal?" In that study, researchers sent out four fictitious resumes in response to real help-wanted ads. The resumes all listed the same educational references and qualifications, but had different names.

The result: "Emily" and "Greg" garnered 50% more callbacks for interviews compared to "Lakisha" and "Jamal" across the entire spectrum of jobs advertised, from cashiers to executives. Researchers concluded that racial bias may have contributed to the findings.

As for gender bias, studies have found that women pay a motherhood penalty in terms of hiring and job evaluation, with women who have children being perceived as being less competent and receiving lower starting salaries. For men, on the other hand, having children "was almost the reverse," Dr. Salazar said. "They were not penalized, and they sometimes benefited in their careers from being fathers."

Research has also repeatedly zeroed in on the gender gap in women physicians' compensation and advancement. A study in the November 2013 issue of Academic

Medicine, for instance, found that early-career physician researchers who were women earned $31,000 less than their male counterparts. The authors wrote that the disparity could not be fully explained "by specialty, academic rank, work hours, or even spousal employment."

State of the science

As for health disparities, Dr. Salazar said that more than two dozen studies dating back to 1995 have looked at the impact of unconscious bias on medical decision-making. Two-thirds of that research found evidence of either conscious or unconscious race bias.

In a study in the September 2007 issue of the Journal of General Internal Medicine, for instance, researchers used clinical vignettes and other tools to assess doctors' perceptions of both fictitious black and white patients presenting with acute coronary syndrome. While the physicians in the study reported no explicit racial bias, findings revealed that more of them perceived African-American patients as being less cooperative in general, and less cooperative specifically with medical procedures. As doctors' pro-white bias increased, their likelihood of treating white patients— but not black ones—with thrombolysis also rose.

Another study, this one published in the November 2015 issue of JAMA Pediatrics, found stark disparities in pain management in emergency departments in children diagnosed with appendicitis. Researchers found that black patients were far less likely to receive opioids than white ones (12% vs. 34%).

And in research published in the May 2011 issue of the International Journal of Obesity, researchers gauged the bias and care recommendations made by medical students for both obese and non-obese virtual patients. The authors found that the obese patients routinely received more negative stereotyping and were expected to have less anticipated adherence.

"Think about being the patient at the other end of that discussion," said Dr. Salazar. "If you realize your provider has a negative perception of you, what's the likelihood that you're going to follow through with any recommendations he or she makes? It basically rips the alliance apart."

Increasing personal awareness

What can doctors do? The first and most important step, said Dr. Salazar, is to become aware of your own unconscious biases.

An invaluable tool to help you do so is the implicit association test (IAT), which was introduced in 1998 and has now been used by more than 15 million participants. There are more than a dozen IATs that people can take online to gauge their perceptions of different ethnic groups, gender, sexual identity, disability, skin tone, weight, religion and many others.

The test, which measures the time it takes to match representatives of social groups to particular attributes, has been vigorously tested in terms of its reliability and validity. According to Dr. Salazar, the test can enhance people's motivation to reduce the influence of bias by letting them privately recognize their unconscious biases.

Dr. Salazar offered his own experience as an example: A frequent taker of IATs, he has become aware of his unconscious bias against obese patients. That awareness came to mind recently when he was rounding as a ward attending in the ICU with a morbidly obese patient.

"I found myself not wanting to examine the patient, but I was able to catch myself before I did something consequential," he said. "Because I could acknowledge that bias, I was able to pause and then treat the patient, doing everything I would do for any other. Think about the impact on those residents and students if I had failed to do an exam, and what message I would have been giving them."

What to do

In his own practice, Dr. Salazar also tries to incorporate mindfulness in his daily routine as a strategy to reduce stress and anxiety. One technique he uses is taking a 30-second pause between seeing different patients "to clear my mind."

Education is also key. Several medical schools across the U.S. include unconscious bias training in their curriculum. For more than a decade, for example, the University of California, San Francisco (where Dr. Salazar used to teach) has included sessions on unconscious bias in its curriculum for first-year medical students. Training includes having students take an IAT, then discuss their results in small groups.

That helps students more effectively break down their individual experiences. And in 2013, the UCSF office of diversity and outreach launched a campus-wide unconscious bias training program to increase awareness among faculty, staff, students and trainees.

Dell Medical School, which enrolled its inaugural class in July, is using a similar approach. Sessions on unconscious bias are planned for the first-year doctoring course and will also be included as part of the interprofessional education curriculum.

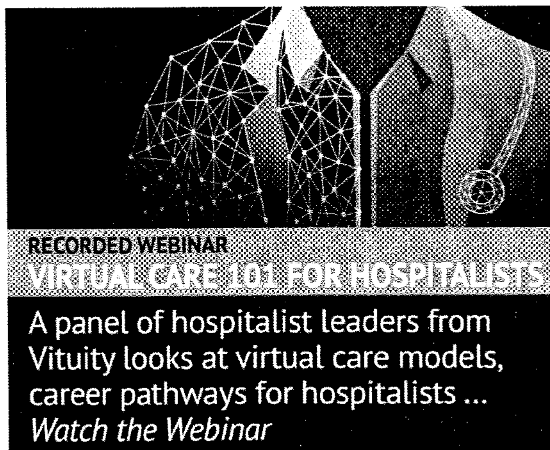
Further fixes include enhancing emotional regulation skills, in part through stress-reducing techniques, and communication training. Such training can improve physicians' ability to build partnerships with patients by working to find common ground.

Dr. Salazar noted that institutions also have a big role to play. Dell Medical School, for instance, provides unconscious bias training to members of the school's admissions committee. It also plans to hold training for its residency program admissions committees and core faculty.

"You may not be able to change these biases, but you can minimize their impact," said Dr. Salazar. "You can take what you've learned and start to think about them differently."

Phyllis Maguire is Executive Editor of Today's Hospitalist.

How should you deal with racist patients?



FULL TEXT LINKS

Review BMC Med Ethics. 2017 Mar 1;18(1):19. doi: 10.1186/s12910-017-0179-8.

Implicit bias in healthcare professionals: a systematic review

Chloë FitzGerald [1], Samia Hurst [2]

Affiliations

PMID: 28249596 PMCID: PMC5333436 DOI: 10.1186/s12910-017-0179-8

Free PMC article

Abstract

Background: Implicit biases involve associations outside conscious awareness that lead to a negative evaluation of a person on the basis of irrelevant characteristics such as race or gender. This review examines the evidence that healthcare professionals display implicit biases towards patients.

Methods: PubMed, PsychINFO, PsychARTICLE and CINAHL were searched for peer-reviewed articles published between 1st March 2003 and 31st March 2013. Two reviewers assessed the eligibility of the identified papers based on precise content and quality criteria. The references of eligible papers were examined to identify further eligible studies.

Results: Forty two articles were identified as eligible. Seventeen used an implicit measure (Implicit Association Test in fifteen and subliminal priming in two), to test the biases of healthcare professionals. Twenty five articles employed a between-subjects design, using vignettes to examine the influence of patient characteristics on healthcare professionals' attitudes, diagnoses, and treatment decisions. The second method was included although it does not isolate implicit attitudes because it is recognised by psychologists who specialise in implicit cognition as a way of detecting the possible presence of implicit bias. Twenty seven studies examined racial/ethnic biases; ten other biases were investigated, including gender, age and weight. Thirty five articles found evidence of implicit bias in healthcare professionals; all the studies that investigated correlations found a significant positive relationship between level of implicit bias and lower quality of care.

Discussion: The evidence indicates that healthcare professionals exhibit the same levels of implicit bias as the wider population. The interactions between multiple patient characteristics and between healthcare professional and patient characteristics reveal the complexity of the phenomenon of implicit bias and its influence on clinician-patient interaction. The most convincing studies from our review are those that combine the IAT and a method measuring the quality of treatment in the actual world. Correlational evidence indicates that biases are likely to influence diagnosis and treatment decisions and levels of care in some circumstances and need to be further investigated. Our review also indicates that there may sometimes be a gap between the norm of impartiality and the extent to which it is embraced by healthcare professionals for some of the tested characteristics.

Conclusions: Our findings highlight the need for the healthcare profession to address the role of implicit biases in disparities in healthcare. More research in actual care settings and a greater homogeneity in methods employed to test implicit biases in healthcare is needed.

Keywords: Attitudes of health personnel; Healthcare disparities; Implicit bias; Prejudice; Stereotyping.

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Addressing Implicit Bias Within the Medical Curricula

RACHANA RAGHUPATHY

ACP Council of Student Members and Physician Well-being and Professional Fulfillment Committee

— MEDICAL SCHOOL —
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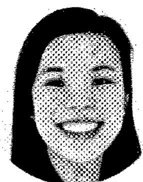
2022



EMILY LEE

Studies have shown that a majority of medical students have a more negative perception of lesbian and gay people than they do heterosexual people (1, 2). Perceived discrimination from health care providers and denial of health care altogether are common experiences among LGBTQ+ patients, which contributes to health disparities. As our social landscape changes, many medical institutions are evaluating how they can address this issue. For example, Northeast Ohio Medical University in Rootstown, Ohio, invited members of the local LGBTQ+ community to speak on their own experiences with health care professionals—the good, the bad, and the ugly. Many of the trans patients who attended the session cited the tactlessness of their physicians when discussing particular sensitive topics, such as sexual health or past medical procedures. Students learned how poor word choice and composure during such delicate conversations can seed mistrust toward not only the physician but also the health care system as a whole. They also learned how important it is to acknowledge the weight of our words and how our patients may perceive our unconscious behaviors.

Many studies acknowledge the role of implicit bias in exacerbating health outcomes (3-5). Patients affected are predominantly racial and ethnic minorities, individuals who identify on the LGBTQ+ spectrum, women (especially women of color), and individuals who are disabled. Negative outcomes

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range from higher morbidity and mortality rates to reports of lower satisfaction in the quality of healthcare delivered.

The consequence of unconscious bias in healthcare stems from early on in medical training. A *New England Journal of Medicine* perspective by Harvard Medical Student LaShyra Nolen titled "How Medical Education Is Missing the Bull's-eye" reflects that the medical education system has been disproportionately (and in many cases unconsciously) representing the heterogeneity of the general population within medical teachings, whether through mannequins used in CPR training or discussions of variation in presentation of infectious skin rashes on different skin tones (6).

We should therefore reform medical school curricula to include opportunities for students to think critically about implicit biases, their consequences to patient care, and strategies to mitigate their impact. These changes are imperative for both the education of the student and optimal care of patients.

An important first step to change implicit bias is to identify the biases present. Such tools as the implicit association test (IAT) are used across medical schools to better understand one's own social biases as a starting point to minimize their effects.

Group discussions are also important for facilitating critical self-reflection on power and privilege while considering solutions to address implicit biases in health care. These conversations can occur multiple times per year and should try to feature minority community members who can share their experiences on their minority status and health care delivery. Activities such as this can foster introspection on how to approach such patients with confidence while also acknowledging the importance of being sensitive to the patients' experience. Ultimately, this will not only instill within patients a sense of trust in their providers but also lead to better adherence to treatment plans and improved perceived quality of care.

For example, in order to address a diverse patient population and gain knowledge of disease presentation across skin types and colors as addressed in Ms. Nolen's article, such resources as BrownSkinMatters and VisualDx may be used (7). Professors may consider adding information or images to their teaching material to instruct students on physical variations in presentation. In addition, instructors can encourage students to practice their physical

examination techniques and basic life support skills on a variety of individuals and mannequins of different sex, size, skin color, and other factors.

Unfortunately, although vital to address this issue early in medical training, many of these changes cannot happen overnight. It will take advocacy, persistence, and perseverance.

Students, contact your school's curriculum committee and start a conversation on changes or adjustments that could help address this issue—no request is too small. Gather your peers to brainstorm ideas of changes you would like to see, whether extensions of the ideas listed here or some of your own. Use your voice to shape your education.

Medical school faculty and curriculum advisers, please understand how important your role is in addressing these implicit biases and ensuring the best care possible for future patients. If you feel that your current curriculum does not provide adequate education on the topic of bias in health care, please consider adjusting your curriculum to better prepare students to care for the heterogeneous patient population they will inevitably see in the future.

To all of our readers, please take the time to recognize your voice. Understand the power you have to change your own implicit biases, as well as those within your circle. Continue to challenge each other to identify where implicit biases may be taking hold in your everyday life, continue to educate yourself on the topic, and continue to listen and reflect. Change does take time. Be patient.

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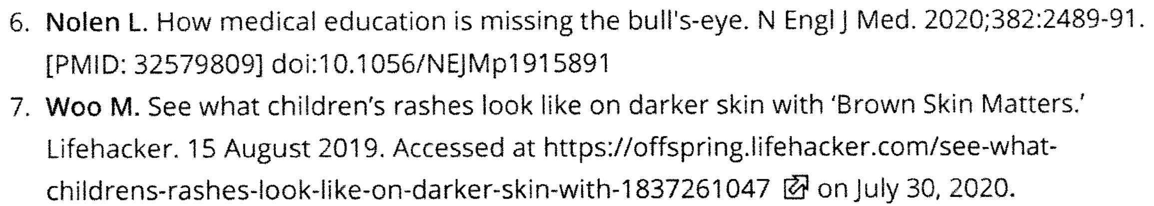

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VCU NEWS

Sunday, June 13, 2021

Most implicit bias training in health care lacks proper foundation, research finds

In a forthcoming paper in The Lancet, a VCU psychology professor says such training should be grounded in a clinical translational framework to address racial and ethnic disparities in health care.

Though an increasing number of medical schools and health care organizations are starting to incorporate implicit bias training in their curriculums, current training is not grounded in a framework where research findings translate to clinical treatment, according to a VCU psychology professor's latest research. (Getty Images)

By **Brian McNeill**
University Public Affairs
804-827-0889
bwmcneill@vcu.edu

Wednesday, May 20, 2020

An increasing number of medical schools and other health care organizations are starting to incorporate implicit bias training in their curriculums to help health care professionals recognize any unconscious prejudice and attitudes they may have toward certain groups of people. However, current training is not grounded in a framework where research findings translate to clinical treatment, raising a serious concern about the effectiveness of the training, according to new research by a Virginia Commonwealth University psychology professor.

Nao Hagiwara, Ph.D., an associate professor in the **Department of Psychology**, was principal author of the paper, "A Call for Grounding Implicit Bias Training in Clinical and Translational Frameworks," which will publish in The Lancet in June.

It is necessary for health care professionals to be aware of their internal bias and be intrinsically motivated to reduce it, but that is not sufficient in addressing the negative impacts bias can have on patient care, Hagiwara said.

Effective implicit bias training should draw from basic research in social psychology and social cognition and follow the translational stages from research to clinical treatment. Failure to recognize and address gaps in this approach reduces the effectiveness of the training, Hagiwara said.

Hagiwara's work, as well as that by other researchers, provides evidence that higher levels of provider implicit bias, particularly prejudice, are associated with more negative communication behaviors during interactions with minority patients and can contribute to racial and ethnic disparities in health care through poor patient-provider communication, Hagiwara said.

The key to improving patient care for minorities and reducing health care disparities is to develop evidence- and theory-based training programs to help providers manage their communication behaviors, she said.

"We believe training should focus on replacing negative communication behaviors associated with implicit prejudice with positive communication behaviors and providing relevant opportunities to practice new communication behaviors over time," Hagiwara said.

About VCU and VCU Health

Virginia Commonwealth University is a major, urban public research university with national and international rankings in sponsored research. Located in downtown Richmond, VCU enrolls more than 30,000 students in 233 degree and certificate programs in the arts, sciences and humanities. Twenty-two of the programs are unique in Virginia, many of them crossing the disciplines of VCU's 11 schools and three colleges. The VCU Health brand represents the VCU health sciences academic programs, the VCU Massey Cancer Center and the VCU Health System, which comprises VCU Medical Center (the only academic medical center in the region), Community Memorial Hospital, Tappahannock Hospital, Children's Hospital of Richmond at VCU, and MCV Physicians. The clinical enterprise includes a collaboration with Sheltering Arms Institute for physical rehabilitation services. For more, please visit ***www.vcu.edu*** *and* ***vcuhealth.org****.*

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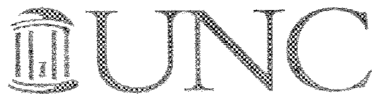

Implicit Bias: Implicit Bias in Health and Medicine

Provides resources on implicit bias, also called unconscious bias.

Implicit Bias in Medicine

"To achieve health equity, health care organizations have a responsibility to mitigate the effect of implicit bias in all interactions and at all points of contact with patients. This is important because implicit bias has the potential to impact not only outcomes of care, but also whether patients will return for services or even seek care at the organization in the first place."

Institute for Healthcare Improvement

Test Yourself for Bias

- Implicit Association Test
  From Project Implicit. Includes the following IAT tests: Weight, Skin-tone, Gender-Career, Presidents, Race, Age, Asian, Sexuality, Transgender, Gender-Science, Arab-Muslim, Religion, Disability, Weapons.
- Test Yourself for Hidden Bias
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- The Social Determinants of

How Does Implicit Bias Affect Health Care?

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Articles

These articles were selected, in part, to reflect a range of different biases and health professions. This list is in no way meant to be comprehensive. See "Researching Implicit Bias" tab for suggested search terms and places to search for additional articles.

- A Systematic Review of the Impact of Physician Implicit Racial Bias on Clinical Decision Making
  Dehon E. A systematic review of the impact of physician implicit racial bias on clinical decision making. Academic emergency medicine. 08/2017;24(8):895-904. doi: 10.1111/acem.13214.
- Implicit bias in healthcare professionals: A systematic review
  FitzGerald C. Implicit bias in healthcare professionals: A systematic review. BMC

Books in Catalog

The books below are available in the UNC Chapel Hill Libraries. If you aren't affiliated with UNC, contact your local library for these and other books on implicit bias.

Books

Seeing patients : unconscious bias in health care by Augustus A. White; David Chanoff
Call Number: RD27.35.W53 A3 2011
ISBN: 9780674049055
Publication Date: 2011-01-15

Health and Implicit Bias
Dr. Denise Rodgers, Rutgers University, on Your Health Radio
22:09 minutes

- Implicit Bias : A Factor in Health Communication
  With Dr. Winston Wong, Kaiser Permanente
  19:58 minutes
- Implicit Bias in Health Care: Consequences and Remedies
  With Dr. Brenda J. Allen, University of Colorado, Denver
  41:17 minutes
- Bias, Black Lives and Academic Medicine
  Dr. David Ansell on Your Health Radio (August 1, 2015)
  21:42 minutes

medical ethics. 12/2017;18(1). doi: 10.1186/s12910-017-0179-8.

- Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review
  Hall, W. J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., Eng, E., Day, S. H., ... Coyne-Beasley, T. (2015). Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. American journal of public health, 105 (12), e60-76.
- Non-conscious bias in medical decision making: what can be done to reduce it?
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- Reducing racial bias among health care providers: lessons from social-cognitive psychology
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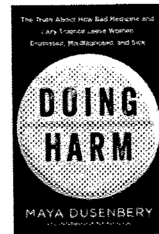
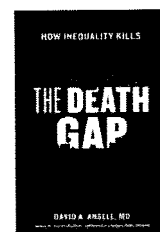
- The associations of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care
- Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients



Doing harm : the truth about how bad medicine and lazy science leave women dismissed, misdiagnosed, and sick by Maya Dusenbery
Call Number: RA564.85 .D88 2017
ISBN: 9780062470805
Publication Date: 2018-03-06

- Listen to author Maya Dusenbery on Your Health Radio



Videos

- Weight Bias in Health Care
  From Yale University
  16:56 minutes
- Exploring Unconscious Bias in Academic Medicine
  With Howard Ross, from the American Association of Medical Colleges
  29:23 minutes
- Is the "obesity crisis" just a disguise for a deeper problem?
  TedMed talk with Dr. Peter Attia
  16:15 minutes
- Implicit Bias and Social Categorization in Medicine
  Mountain West Aids Education and Training Center webinar

Green AR, Carney DR, Pallin DJ, Ngo LH, Raymond KL, Iezzoni LI, Banaji MR. Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. J Gen Intern Med. 2007 Sep;22(9):1231-8.

- Racism as a determinant of health: a protocol for conducting a systematic review and meta-analysis
  Paradies Y, Priest N, Ben J, Truong M, Gupta A, Pieterse A, Kelaher M, Gee G. Racism as a determinant of health: a protocol for conducting a systematic review and meta-analysis. Syst Rev. 2013 Sep 23;2:85.
- The influence of implicit bias on treatment recommendations for 4 common pediatric conditions: pain, urinary tract infection, attention deficit hyperactivity disorder, and asthma
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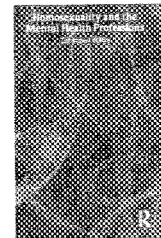
Readings

- The Scarlet F: Why Fat Shaming Harms Health and How We Can Change the Conversation
  Harvard Public Health
- Science of Equality Report: Addressing Implicit Bias, Racial Anxiety, and

The death gap : how inequality kills by David A. Ansell
Call Number: RA418.3.U6 A57 2017
ISBN: 9780226428154
Publication Date: 2017-04-21



Homosexuality and the mental health professions : the impact of bias by Group for the Advancement of Psychiatry Staff (Contribution by); Jack Drescher (Editor)
Call Number: RC558 .H655 2000

with Dr. Naomi Shike
18:53 minutes

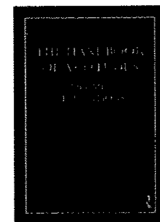
- Implicit Racial Bias in Healthcare
Children's National Hospital Grand Rounds recording with Dr. Tiffani Johnson (February 24, 2016)
1:02:11 minutes
- Implicit Bias in Health Care
Northwest Heart Failure Collaborative webinar (October 19, 2016)
1:25:03 minutes

Stereotype Threat in Education and Health Care
Berkeley Haas Institute and the Perception Institute

- Education to Identify and Combat Racial Bias in Pain Treatment by Brian B. Drwecki
AMA J Ethics. 2015;17(3):221-228. doi: 10.1001/journalofethics.2015.17.3.medu1-1503.
- Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review
Hall WJ, Chapman MV, Lee KM, et al. Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review. Am J Public Health. 2015;105 (12):e60-76.
- The Science of Equality, Volume 1: Addressing Implicit Bias, Racial Anxiety, and Stereotype Threat in Education and Health Care
By Rachel D. Godsil, Linda R. Tropp, Phillip Atiba Goff, john a. powell (November, 2014)
- Reflections on bias in health care
Blog post from Health and Wellness by Dr. David Hilden (February 25, 2016)
- How does implicit bias by physicians affect patients' health care? by Tori DeAngelis
From the American Psychological Association

ISBN: 0881633186
Publication Date: 2000-03-01

Unequal treatment : confronting racial and ethnic disparities in health care by Institute of Medicine Staff (Contribution by)
Call Number: RA563.M56 U53 2003
ISBN: 030908265X
Publication Date: 2002-11-27



The handbook of attitudes.

Online Course

- Conscious & Unconscious Biases in Health Care
  From the National Center for Cultural Competence at Georgetown University

- Sneaky bias: what you don't know may hurt you (and your patients)
  American Physical Therapy Association

Volume 2, Applications
Call Number: ONLINE
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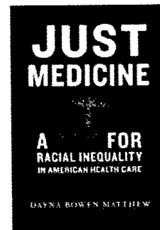
CHAPTER 6: Doing Harm to Some: Patient and Provider Attitudes and Healthcare Disparities



Just medicine : a cure for racial inequality in American health care by Dayna Bowen Matthew
Call Number: ONLINE
ISBN: 9781479896738
Publication Date: 2015-12-11

Teeth : the story of beauty, inequality, and the struggle for oral health in America by Mary Otto
Call Number: RK58.5 .O88 2016 and ONLINE
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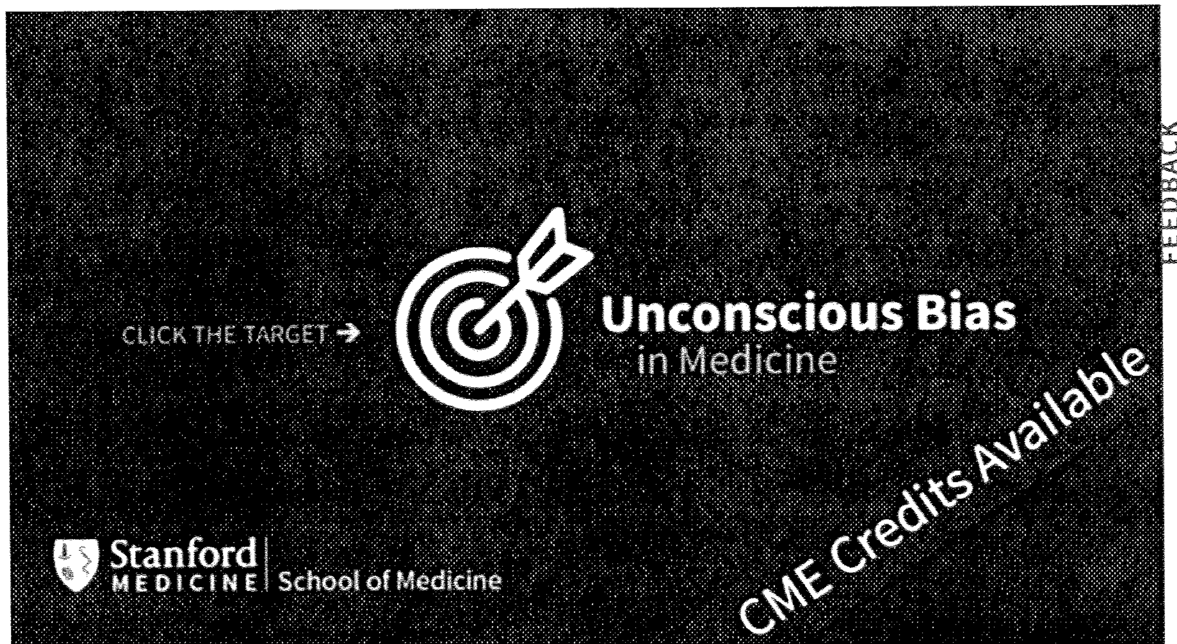
Unconscious Bias in Medicine (CME)

SOM-YCME0027

STANFORD SCHOOL OF MEDICINE



Description

Internet Enduring Material Sponsored by the Stanford University School of Medicine. Presented by the Office of Faculty Development and Diversity at Stanford University School of Medicine

This CME activity provides education on unconscious bias in the academic medicine workplace. Existing research on unconscious bias will provide a science-based view of this seemingly non-science topic. Case studies with examples of unconscious bias, self-assessment opportunities, and exploring bias busting strategies will enable learners to understand how to bring the content into their own unique environments.

Who Should Enroll

This course is designed to meet the educational needs of physicians from all specialties as well as other Health Care Professionals.

Learning Objectives

At the conclusion of this activity, participants should be able to:

- Describe the effects of unconscious bias in everyday interactions with patients, students, colleagues, and team members.
- Apply specific "bias-busting" techniques that can be used in the medical and academic environment.
- Identify where personal unconscious biases may reside across gender, race/ethnicity, and/or cultural attributes in the workplace.
- Develop strategies to correct personal unconscious biases in daily interactions.

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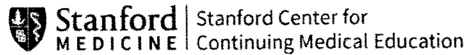

Unconscious Bias in Medicine

Date & Location

Tuesday, May 23, 2017, 12:00 AM - Tuesday, May 23, 2023, 12:00 AM PST, Online Course

Overview

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This CME activity provides education on unconscious bias in the academic medicine workplace. Existing research on unconscious bias will provide a science-based view of this seemingl examples of unconscious bias, self assessment opportunities, and exploring bias busting strategies will enable learners to understand how to bring the content into their own unique e

Intended Audience

This course is designed to meet the educational needs of physicians from all specialties as well as other Health Care Professionals.

Registration

Orginal Release Date: May 23, 2017
Reviewed Date: May 5, 2020
Expiration Date: May 23, 2023
Estimated Time to Complete: 1.00 Hour
Registration Fee: FREE

Credits

AMA PRA Category 1 Credits™(1.00 hours), Non-Physician Participation Credit (1.00 hours)

Objectives

1. Describe the effects of unconscious bias in everyday interactions with patients, students, colleagues, and team members.
2. Apply specific "bias-busting" techniques that can be used in the medical and academic environment.
3. Identify where personal unconscious biases may reside across gender, race/ethnicity, and/or cultural attributes in the workplace.
4. Develop strategies to correct personal unconscious biases in daily interactions.

Accreditation

In support of improving patient care, Stanford Medicine is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharn Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team. Credit Designation American Medical Association (AMA) Stanford Medicine designates this AMA PRA Category 1 Credits TM. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Additional Information

Cultural and Linguistic Competency

The planners and speakers of this CME activity have been encouraged to address cultural issues relevant to their topic area for the purpose of complying with California Assembly Bill 11 of Medicine Multicultural Health Portal contains many useful cultural and linguistic competency tools including culture guides, language access information and pertinent state and fed Multicultural Health Portal: http://lane.stanford.edu/portals/cultural.html

Bibliography

Williams DR, Wyatt R. Racial Bias in Health Care and Health Challenges and Opportunities. JAMA. 2015;314(6):555-556. doi:10.1001/jama.2015.9260

For a complete list, please view the References/Bibliography page in the Course.

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Implicit Bias Training

FACILITATOR GUIDE

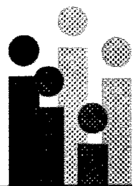
We cannot achieve the change we seek without first becoming aware that a change is necessary.

Bias is state of mind tightly woven into our preexisting psychosocial fabric. I am proud of the work being done by the AAFP Center for Diversity and Health Equity to help our members serve others by creating the Implicit Bias Training program.

I sincerely hope our members will use this innovative tool to objectively expand their awareness of how implicit bias can be the least obvious but most devastating social determinant of health outcomes.

– **Gary L. LeRoy, MD, FAAFP**
AAFP President 2019–2020

The EveryONE Project®
Advancing health equity in every community



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Ann Spicer, Executive Vice President, Ohio Academy of Family Physicians
ATW Health Solutions, Inc.

Patients
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SECTION 1: Overview

PLEASE NOTE:

This section corresponds with the "Overview" PowerPoint presentation available online at www.aafp.org/implicit-bias.

Implicit bias, defined as, "the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner," is a contributing factor to health disparities.[1] Family physicians should make an effort to explore their own implicit biases so they can identify unconscious decisions and actions that may negatively affect the communities they serve.

Common types of implicit bias include the following[2]:

- **Affinity** - Preference for people who share qualities with you or someone you like
- **Anchoring** - Tendency to rely too heavily on the first piece of information offered when you are making decisions
- **Attribution** - Tendency to attribute other people's successes to luck or help from others and attribute their failures to lack of skill or personal shortcomings
- **Beauty** - Assumptions about people's skills or personality based on their physical appearance and tendency to favor people who are more attractive
- **Confirmation** - Selective focus on information that supports your initial opinion(s)
- **Conformity** - Tendency to be swayed too much by the views of other people
- **Contrast** - Assessment of two or more similar things by comparing them with one another rather than looking at their individual merits
- **Gender** - Preference for one gender over the other
- **Halo** - Focus on one particularly positive feature about a person that clouds your judgement
- **Horns** - Focus on one particularly negative feature about a person that clouds your judgement

The American Academy of Family Physicians (AAFP) recommends educating physicians about implicit bias and strategies to address it to support culturally appropriate, patient-centered care and reduce health disparities.[1]

Gaps in Medical Education

Research has shown that implicit bias is pervasive among all health care professionals and has deleterious effects on patient health.[3] However, formal medical education and training curricula are often void of content that provides a framework for identifying and mitigating implicit bias in clinical practice. Faculty who actively seek to incorporate this topic in training often face barriers, such as a limited number of subject matter experts who can provide instruction.[4,5] Health care professionals also lack opportunities to demonstrate bias mitigation strategies in practice or to engage with patients who can share experiences of encountering implicit bias in clinical settings.[4,6,7]

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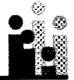


The Need for Implicit Bias Training

To achieve health equity and reduce disparity in health outcomes, particularly those that are the result of interactions with the health care system, health care professionals need to know the following:

- The pervasiveness of implicit bias among all health care professionals[5]
- The purpose of implicit bias self-assessments and how to use them, including how to interpret the results[5,7]
- How to interpret findings of implicit bias research[6]
- How implicit bias affects patients and their interactions with health care professionals[4]
- How to apply techniques for mitigating the effects of implicit bias[3,7,8]

Goals of Implicit Bias Training

Implicit bias training should be viewed as one component of an organization's widespread, overarching strategy for implementing structural and institutional changes to achieve equitable health outcomes for its community. The primary goals of this training are:

- To promote awareness of implicit bias among all members of the health care team
- To provide resources for moderating the negative effects of implicit bias on patient care

Core training components include an overview of what implicit bias is and how it operates (specifically in the health care setting); tools for self-assessment; and strategies that can be used to reduce bias within the clinic and/or health care system.

This course includes prework that should be completed online by participants prior to the first session. In-person training activities include self-assessments, case studies, small-group discussions, and development of conscious mitigation strategies to overcome implicit bias. Based on the preferences of your organization, these activities can be conducted as a full-day training event or as a series that focuses on individual sections (or combinations of sections) over a number of training sessions.

All training materials, including videos, PowerPoint presentations, and additional resources, are available online at www.aafp.org/implicit-bias.

Learning Objectives

- Increase self-awareness by reflecting on the results of the implicit bias self-assessment
- Demonstrate conscious mitigation strategies to overcome implicit bias
- Apply implicit bias reduction skills to case studies
- Understand the effect of implicit bias on real-life patients

Standards of Conduct

Individuals who use these implicit bias training materials are viewed as AAFP representatives. The AAFP expects its faculty to meet high ethical standards and to personify the ideals represented by the organization. Professionalism is the standard of conduct for the AAFP, and each member of the AAFP community has a responsibility to act with integrity, compassion, and respect for others. Honoring this responsibility and being accountable constitute the essence of professionalism.

FACILITATOR TIP
More information about AAFP faculty roles and responsibilities is available online in the AAFP's Faculty Handbook for Live CME Activities.

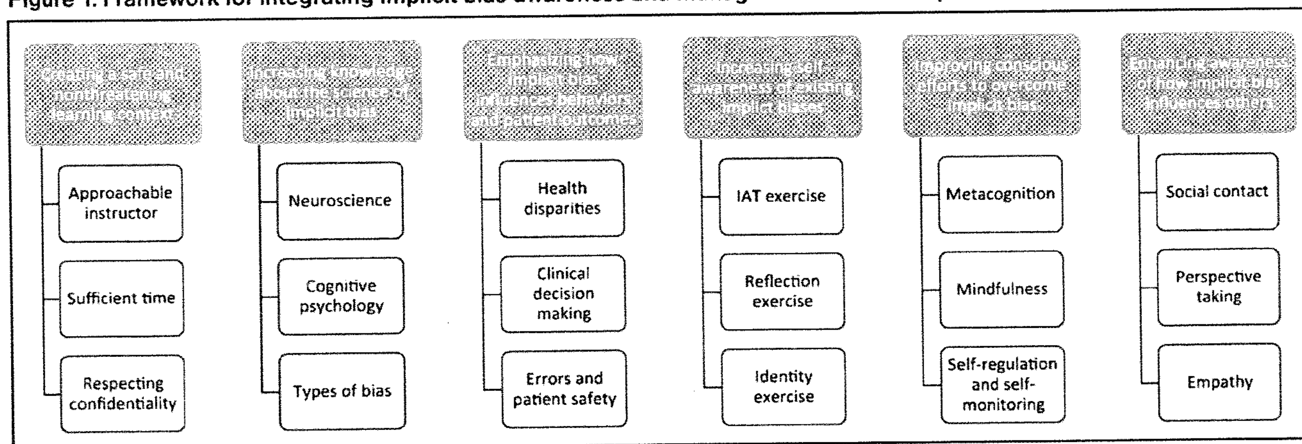
Facilitators and learners should be mindful of the following when participating in implicit bias training:

- The AAFP opposes all discrimination in any form, including, but not limited to, that on the basis of actual or perceived race, color, religion, gender, sexual orientation, gender identity, ethnic affiliation, health, age, disability, economic status, body habitus, or national origin.
- All participants should avoid voicing political opinions, stereotypes, jokes, or comments that could be perceived as offensive. At times, you may feel an impulse to lighten a topic. However, following live activities, learners often report that they did not appreciate jokes, especially those that are political in nature.
- Learners will likely include advanced practice professionals, nurses, and physicians from other specialties. Please keep this in mind as you make references.

Framework

This training is based on a six-part actionable framework for integrating implicit bias awareness and management into health professional education (*Figure 1*).

Figure 1. Framework for integrating implicit bias awareness and management into health professional education



IAT = implicit association test.
Reprinted with permission from Sukhera J, Watling C. A framework for integrating implicit bias recognition into health professions education. Acad Med. *2018;93(1):35-40.*

Implicit bias training should be used as part of an ongoing individual and organizational commitment to change, not as a "check the box" compliance activity.

Target Audiences

Learners should come prepared with some fundamental knowledge of what implicit bias is and how it impacts health outcomes. This training is designed to increase learner competence while creating an environment that supports self-reflection and personal growth. It has been developed with primary care physicians and their practice teams in mind. However, it can be used by all health care and mental health professionals, especially those providing care to patients who may be at greater risk of exposure to implicit bias because of the following:

- Age
- Body habitus
- Color
- Disability
- Economic status
- Gender identity
- Immigration status
- Mental health
- Nationality
- Race/Ethnicity
- Religion
- Sexual orientation

Course Evaluation
At the end of the course, you will ask learners to reflect on the training and provide feedback. A customizable CME Activity Evaluation Form from the AAFP is available online at www.aafp.org/cme/creditsys/about/tools.html#templates.

FACILITATOR TIP

Be sure that you provide sufficient time so learners don't feel rushed. Also, be aware that the types of health care professionals in the group may have varying levels of power and influence. With this in mind, attempt to create an environment where everyone's voice and opinions are heard and valued.

Learner Activity: Implicit Bias Pop Quiz

In this activity, you will address some common misconceptions by countering false statements with facts about implicit biases and the effectiveness of implicit bias training. You may allow time for learners to share other opinions they have heard so that you can provide clarification or point them to one of the recommended readings for further reference.

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SECTION 2: Course Prework for Learners

Learner Activity: Implicit Association Test

The Implicit Association Test (IAT) (available online at https://implicit.harvard.edu/implicit/takeatest.html) is a series of free, publicly available computer-based exercises developed by Project Implicit®, a long-term research project based at Harvard University. The test asks participants to associate words with images to assess participants' automatic associations between concepts by measuring the time and latency of their responses. While the IAT is considered more reliable and valid than survey evaluations, it is designed to be used as a prompt to trigger self-reflection, discussion, and awareness of personal biases, not as a metric for measuring implicit bias or evaluating curricular outcomes.

The following IATs are available online:

- Age
- Arab-Muslim
- Asian
- Disability
- Gender-Career
- Gender-Science
- Native
- Presidents
- Race
- Religion
- Sexuality
- Skin-tone
- Weapons
- Weight

Select one of these tests and have all learners complete it online before the course begins. During the training session, you will use the discussion questions on Page 14 to facilitate a conversation about the learners' results.

Learner Activity: Self-Evaluation Forms

Two self-evaluation forms are provided in the participant guide to help learners evaluate their susceptibility to relying on implicit bias and their orientation toward bias mitigation strategies. One form is designed for use by clinicians and the other is designed for use by health educators. During the training session, you can invite learners to share and discuss their self-evaluations in the context of their IAT results, if time allows.

Before the course begins, each learner should complete the appropriate form in the participant guide. The forms are also available online at www.aafp.org/implicit-bias.

> The self-evaluation forms are made available with the permission of The Ohio State University Kirwan Institute for The Study of Race and Ethnicity. Please note that the forms are not intended for use as a formal metric of performance; instead, they are created for individual use by those seeking to mitigate implicit bias and increase their capacity for introspection and reflection.

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SECTION 3:
Creating a Safe and Inclusive Learning Environment

PLEASE NOTE:

This section corresponds with the "Creating a Safe and Inclusive Learning Environment" PowerPoint presentation available online at www.aafp.org/implicit-bias.

Training sessions focused on bias, stereotypes, racism, and privilege pose some risks for both learners and facilitators because individuals are asked to disclose and confront attitudes and beliefs that they feel are socially unacceptable, especially among health care professionals. These risks are magnified for faculty who may feel that their personal identity inhibits their ability to provide effective training. To create a safe and welcoming environment for learners, faculty conducting implicit bias training must be secure in their level of expertise. Regardless of their identity, faculty should be seen by learners as approachable, nonthreatening, open minded, inspiring, knowledgeable, and encouraging. When uncomfortable situations arise and powerful emotions such as defensiveness, shame, and fear emerge, a facilitator who openly addresses the discomfort and proactively avoids reinforcing these feelings will help enrich the learning experience.

Facilitators may experience pressure to role model skills, demonstrate strong content knowledge, and navigate unforeseen challenges during training with ease. Faculty are chosen based on their background, identity, and past personal experience discussing implicit bias. However, it is important to set the expectation that everyone, including facilitators, can learn more about this topic. Learners should be empowered to participate actively in the training session. While faculty can create the learning experience, the entire group is responsible for conducting critical reflection and guiding the discourse.

Learner Activity: Identity Signs

Developed by The Safe Zone Project, the Identity Signs activity encourages participants to reflect on their own social identities and gives them an opportunity to learn from each other. This level of understanding and connection among learners helps to foster the safe, inclusive environment necessary to proceed to the more challenging elements of implicit bias training.

The Safe Zone Project offers the Identity Signs activity and other free online resources at https://thesafezoneproject.com/.

Setup

1) Print out an identity sign for each of the following:
   - Sexual Orientation
   - Race
   - Gender Identity
   - Class
   - Biological Sex
   - National Origin
   - Immigration Status
2) Hang up the identity signs around the room or place the signs on tables as tents.
3) Ensure the room is set up in such a way that participants can easily move around the room to stand under the different signs or near the tabletop signs.

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Goals and Learning Outcomes

- To create a space for participants to talk about their experiences and their identities in a more personal way than they might otherwise
- To provide an opportunity for participants to learn directly from each other
- To highlight that people with similar identities can experience different levels of salience and self-awareness, and can be differently impacted by their intersecting identities
- To talk about how we experience our identities on a day-to-day basis
- To highlight how everyone may experience pain, ostracism, or discrimination, yet feel it within the context of different identities

Process Steps

1) Frame the activity for learners:
   - **If you hang identity signs around the room:** Say, "We are going to be doing an activity now that requires us to move around the room. I'm going to read a statement and then you're going to answer that statement by placing yourself under one of the signs that I've hung up around the room. The statements relate to your experience of these identities. We'll then have a chance to talk in small groups and reflect as a large group. This activity is a way to explore the parts of your identity that give you privilege and those that don't. There are likely some that you have never had to think about before."
   - **If you place identity signs on tables as tents:** Say, "We are going to be doing an activity now that requires us to move around the room. I'm going to read a statement and then you're going to answer that statement by placing yourself by one of the signs that are on the tables. The statements relate to your experience of these identities. We'll then have a chance to talk in small groups and reflect as a large group. This activity is a way to explore the parts of your identity that give you privilege and those that don't. There are likely some that you have never had to think about before."
2) State the ground rules for this activity:
   - What you share within the context of the group is confidential, honored, and respected.
   - Use "I" statements to avoid speaking for another person or for an entire group.
   - Focus on your own experiences and avoid critiquing others' experiences.
   - Be honest and willing to share. If you tend to be quiet in groups, challenge yourself to share.
   - Resist the desire to interrupt.
   - Be mindful of time.
3) Invite participants to stand up and prepare to move around the room. Let learners know that if anyone has any mobility concerns or needs to sit down when they get to a new place in the room, they are welcome to grab a seat nearby and do that.
4) Read the first statement and allow time for participants to move around to their different signs.
5) Invite learners to notice where others in the group are standing.
6) At this point, you have a choice between Option 1, which fosters more conversation, and Option 2, which moves more quickly:
   a. **Option 1:** Invite learners to connect in pairs or small groups with others who moved to the same identity sign and discuss what came up for them when they were thinking through the statement. After two to four minutes, ask if anyone would like to share the thought process behind their choice with the large group.
   b. **Option 2:** Invite learners to share the thought process behind their choice with the large group.
7) Read the next statement, repeating the process from Step 4.
8) After you've finished reading all the statements that you want the group to work through, invite learners back to their seats.
9) Using the provided questions, reflect on the activity as a large group.

Statements

1) The part of my identity that I am most aware of on a daily basis is ______________________.
2) The part of my identity that I am the least aware of on a daily basis is ______________________.
3) The part of my identity that I wish I knew more about is ______________________.
4) The part of my identity that provides me the most privilege is ______________________.
5) The part of my identity that I believe is the most misunderstood by others is ______________________.
6) The part of my identity that I feel is difficult to discuss with others who identify differently is ______________________.
7) The part of my identity that makes me feel discriminated against is ______________________.

Reflection Questions

- How did it feel to do this activity?
- What did you find surprising?
- What do you want to explore further?

Wrap-up

To conclude this activity, it is helpful to summarize some of the major points that were brought up in the group discussion and to thank everyone for their honesty/vulnerability in what they were willing to name or share during the activity itself. Even if some people don't share verbally, moving under/near the identity signs may bring up a lot of emotion or may take a lot of courage; therefore, it is good to highlight your appreciation of the group's participation.

Intersectionality Theory

Individuals who do not consider themselves members of a minority group should not feel discouraged from taking the lead on providing implicit bias training, nor should individuals who are members of a minority group feel obligated to serve as facilitators. Individuals' contributions to this shared learning experience must not be reduced to the value of a single identity (e.g., race, gender, orientation). Every person's identity is comprised of multiple parts that intersect, are inseparable, and are shaped by the person's interactions with others and with societal structures. This is a central premise of intersectionality theory, a framework that aims to identify how systems impact marginalized populations based on socially constructed categories, such as class, race, and gender.

In primary care, intersectionality theory can be applied in clinical and health service research to explore how patients' multiple complex social positions impact their health.[9] As one researcher notes, "Relational identifications are always overlapping, intersecting, and variant in ways that make it impossible to view each variable as separate 'pure' causalities...of receiving and accessing primary health care."[9] Health care professionals participating in implicit bias training should engage in activities aimed at understanding social categories and the ways in which people in these social categories relate to and interact with one another. This engagement will enable participants to transform their understanding of both the power dynamics that shape care delivery and the health inequities their patients experience.

FACILITATOR TIP

More information on intersectionality theory is available in The Promise of Intersectionality Theory in Primary Care *by Zowie Davy [*Qual Prim Care. *2011;19(5):279-281].*

SECTION 4: Evidence of Implicit Bias

PLEASE NOTE:

This section corresponds with the "Science and Health Effects of Implicit Bias" PowerPoint presentation available online at www.aafp.org/implicit-bias.

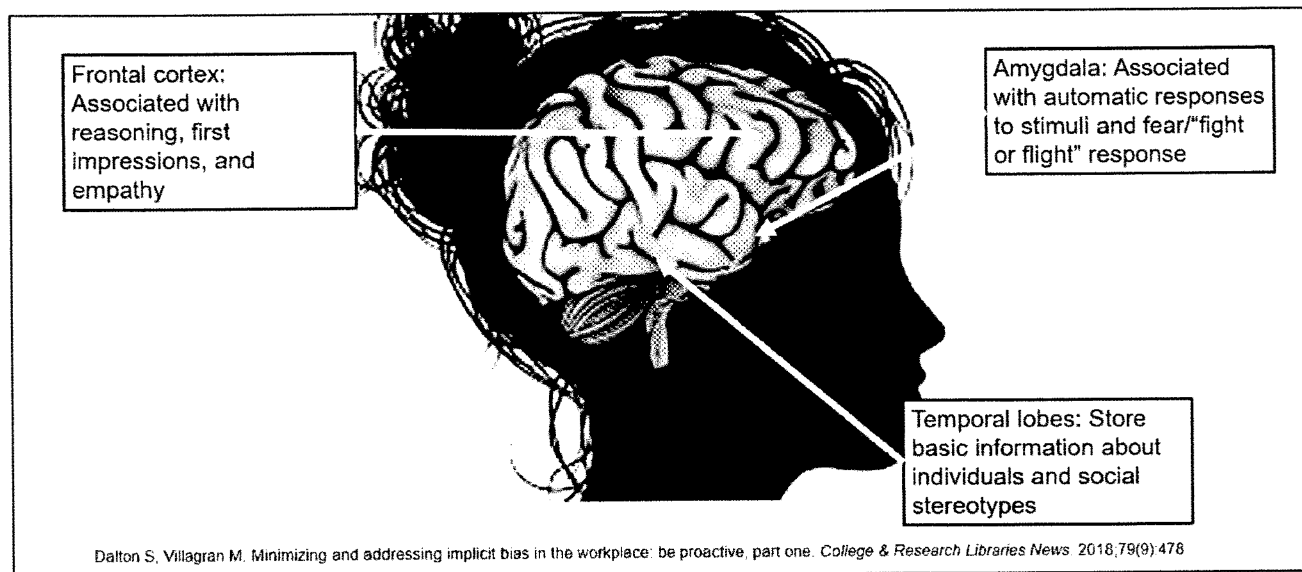
The Neuroscience of Implicit Bias

An understanding of the neurobiological and cognitive psychology aspects of implicit bias provides a scientific context that is relevant to prior medical knowledge. This can reduce the tendency of health care professionals to underestimate the effects of implicit bias.

Medical research has revealed that implicit bias is found throughout the brain. There are useful aspects of implicit bias that pertain to instinctual behaviors of environmental adaptation and survival, such as being able to quickly assess and respond to dangerous stimuli. However, automatic responses to facial stimuli, combined with social conditioning, can result in bias against individuals, often based on race. Acknowledging that we all have biases is the first step toward reducing our reliance on generalizations or stereotypes.

Researchers believe that three regions of the brain relate to the activation of implicit bias (*Figure 2*).[10]

Figure 2. Regions of the brain related to implicit bias activation



Dalton S, Villagran M. Minimizing and addressing implicit bias in the workplace: be proactive, part one. *College & Research Libraries News*. 2018;79(9):478

FACILITATOR TIP

For more information on the neuroscience of implicit bias, read Chapter 2: Implicit Bias and Health Disparities in Just Medicine: A Cure for Racial Inequality in American Health Care *by Dayna Bowen Matthew.*

Implicit Bias and Patient Outcomes

Pointing out the relationship between implicit bias and patient outcomes is a key component of training because it will motivate learners to mitigate bias in the delivery of health care and medical education. Citing statistics on disparities, current research, and references to specific literature on the impact of implicit bias on clinical decision-making helps lay the groundwork for learners. A conceptual framework depicting how bias operates in the interaction between health care professionals and patients is provided in the corresponding PowerPoint presentation.

Implicit biases modify the relationship between health care professionals and patients by decreasing trust, self-efficacy, understanding, and satisfaction.[11] This affects the patient's ability to self-manage and adhere to treatment, and it limits the health care professional's level of cultural proficiency, patient centeredness, and job satisfaction.

Learners should be encouraged to conduct a systematic evaluation of patient outcomes in their practice/organization to identify disparities (e.g., by race/ethnicity, socioeconomic status, gender). If disparities exist, the practice or organization should develop an overarching quality or performance improvement strategy to reduce disparity gaps and achieve health equity.

Studies examining the health outcomes of implicit bias have revealed significant effects. For example:

- Studies have found that when students enter medical school, they harbor implicit biases toward minority patients and their level of bias remains constant or increases over time.[12]
- In a study by Hoffman et al. involving a sample group of white medical students and residents, half endorsed false beliefs about biological differences between black people and white people.[13] As a result, they viewed black patients' pain levels as lower than white patients' pain levels and made less accurate treatment recommendations for black patients.
- A study of cardiologists by Daugherty et. al. found that implicit gender bias was associated with differences in simulated clinical decisions about cardiac testing for hypothetical male and female patients who had similar likelihoods of obstructive coronary artery disease.[14]
- Studies by Kogan et al. and others have shown that the implicit biases of health care professionals toward women of color, particularly African-American women, are a contributing factor for racial/ethnic disparities in adverse maternal and child health outcomes and affect rates of racial/ethnic disparities in contraception use[15]; access to and quality of prenatal care[16-18]; and clinical decision-making in the intrapartum and postpartum periods.[19]

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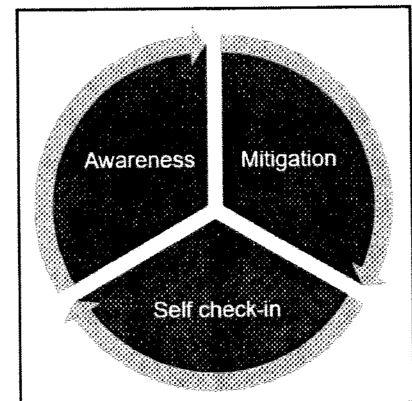
SECTION 5:
Strategies to Mitigate Implicit Bias in Clinical Practice

PLEASE NOTE:
This section corresponds with the "Mitigating Implicit Bias in Clinical Practice" PowerPoint presentation available online at www.aafp.org/implicit-bias.

Increasing Self-Awareness

Mitigating implicit bias in clinical practice is a deliberate, ongoing process that requires self-awareness and self-regulation (*Figure 3*). It requires health care professionals to check in with themselves on a regular basis to ensure that they are acting based on a rational assessment of clinical situations rather than on stereotypes and prejudices.

Figure 3. Process to mitigate implicit bias in clinical practice



Learner Activity: Denmark Kangaroo Orange

This exercise will help prepare learners to discuss the results of their Implicit Association Test.

1) Ask learners to record their responses to the series of prompts below. Allow enough time between prompts and at the end for learners to accurately calculate their responses.
2) Following the prompts, ask learners how many of them ended up with the phrase "Denmark Kangaroo Orange." On average, about 70%-90% of participants will respond with this phrase.
3) If any learners ended up with a different phrase, ask them to share.
4) List some of the other possible word choices learners who ended up with "Denmark Kangaroo Orange" could have selected for each letter.
5) Ask learners what they think this exercise reveals about how our culture, beliefs, and/or experiences shape our responses and how this might cause us to generalize or perpetuate stereotypes, even if we know that these types of bias exist.

Key takeaways for learners from this activity include the following:

- Cultural norms, language, and experiences shape our individual knowledge and decision-making.
- Shared knowledge between "like" individuals and or groups (e.g., in clinical consults among health care professionals) may drive confirmation bias.

Prompts

1) Think of a number between 1 and 10.
2) Add 2.
3) Double the number.
4) Subtract your original number.
5) Add 8.
6) Subtract your original number.
7) Divide by 3.
8) Find the corresponding letter of the alphabet (1=A, 2=B, 3=C, etc.).
9) Think of a country that starts with that letter.
10) Think of an animal that starts with last letter of the country.
11) Think of a fruit that starts with the last letter of the animal.

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Learner Activity: Implicit Association Test Discussion

This discussion of learners' Implicit Association Test (IAT) results will reinforce the fact that implicit bias is pervasive. We all have these biases and removing all bias is impossible.

1) Share the results of your own IAT test.
2) Invite the group to share and discuss their results. Use the following questions to guide the discussion:
   a. Was anyone disturbed by their results? If so, please explain.
   b. How did your results make you feel? Please explain.
   c. Do your results make you feel differently about how you approach patient care? If so, how?

Learner Activity: Social Perspective-Taking Surveys

In the participant guide, two surveys are provided to help learners take the social perspective of others and recognize privilege in their personal lives, at work, and in the lives of others. Doing so will help them develop greater empathy and be more aware of implicit bias and its effect on patients.

The first survey is the Privilege and Responsibility Curricular Exercise (PRCE), which was designed for use by health care professionals (see *Appendix A*). The second survey should be used by medical students and residents; it focuses on how racial privilege influences the experience of a physician in training (see *Appendix B*).

1) Select the appropriate survey to use for your participants.
2) Direct learners to read each statement and select those that they feel describe their experience.
3) Ask them to count their total number of affirmative responses, write the number in the space below the survey, and stand when they are finished.
4) Once all learners are standing, ask them to sit down in order of their respective totals. Start by saying, "Please sit if your total is less than 5," then move on to less than 10, and so on. Only individuals with the greatest privilege (i.e., the highest total) should still be standing at the end of the exercise.
5) Invite the group to reflect on the exercise using the following questions:
   a. What types of identities are reflected in these statements?
   b. What stood out to you?
   c. Were there any statements that you had never thought of before? If so, which ones?
   d. Were there any statements that you had thought about before? Please explain.
   e. Are there any statements you really wanted to select but couldn't?
   f. Are there any statements you would add? If so, why?
   g. Why is this important to the work we do as health care professionals?

Building Empathy

Increasing empathy for others is essential to recognizing and managing implicit bias.[4] Empathy brings patients and health care professionals together within the context of shared experiences, helping to protect patients against stereotyping and discrimination. It also shifts the position of power that health care professionals hold in the relationship so that providers and patients can share decision-making.

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Video Activity: Building Empathy

You'll find the videos used in these activities online at www.aafp.org/implicit-bias.

Observing the impact of implicit bias on patients can help increase health care professionals' empathy, particularly for marginalized patients.

1) Instruct learners to record their reactions as they watch a series of videos (**available online at www.aafp.org/implicit-bias**) in which patients share their diverse experiences with bias, discrimination, and racism during encounters with the health care system and health care professionals.
2) Following the videos, have them break into small groups to share their reactions and discuss whether learning about these patient experiences will influence how they will interact with patients in the future.

Video Activity: Observing Implicit Bias

Making a differential diagnosis requires health care professionals to gather information from a variety of sources, such as medical records, consultation with colleagues, and research from peer-reviewed medical literature. During this process, implicit biases begin to affect clinical decision-making, even before the clinical encounter with the patient begins.

1) Instruct learners to record instances of verbal and nonverbal indicators (e.g., statements, language, eye contact, facial expressions) of implicit bias while they watch two videos (**available online at www.aafp.org/implicit-bias**) that depict students discussing a case and two residents in consultation with their attending physician regarding a patient:
   a. "Inclusion in the Classroom"
   b. "Explicit Bias in Residency"
2) Following the videos, guide learners in a group discussion of their observations and their recommendations for alternative approaches to the situation shown.

Practicing Mindfulness

The nature of medical education and training can easily lead to a high level of cognitive overload and automatization. While both are often viewed as an expected effect of learning, indicating a mastery of the medical knowledge, they are often associated with negative outcomes for both individuals and society, such as stereotyping, prejudice, and bias. For clinicians, incorporating mindfulness techniques (e.g., mindful breathing or movement, body scan meditation) into daily practice promotes self-awareness and assessment, as well as regulation of emotions and behaviors. It helps them pay greater attention to their present experiences and consider whether bias is operating in their clinical decision-making.

Studies have shown that mindfulness practice can help address implicit bias by "reducing the likelihood that implicit biases will be activated in the mind, increasing [health care professionals'] awareness of and ability to control responses to implicit biases once activated, [and] increasing self-compassion and compassion toward patients."[3] These outcomes are consistent with functional and structural magnetic resonance imaging (MRI) studies showing changes in the core regions of the brain associated with self-regulation of awareness, attention, and emotion.

Mindfulness is "the practice of maintaining a nonjudgmental state of heightened or complete awareness of one's thoughts, emotions, or experiences on a moment-to-moment basis."[20]

MINDFULNESS TRAINING CENTERS AND RESOURCES

If you are selecting faculty to teach learners about mindfulness as part of the implicit bias training, look for individuals who have documentation that they are trained, qualified, or certified in teaching mindfulness-based programs (MBPs). According to the Midwest Alliance for Mindfulness, "[MBPs] are evidence-based mind-body programs that train participants in the cultivation of mindfulness in order to support well-being, address the causes of human distress, and offer pathways to relieving suffering. They are informed by theories and practices from contemplative traditions, science, medicine, psychology, and education."[21]

A list of mindfulness training centers and resources is available online at www.aafp.org/implicit-bias.

Activating Goals That Promote Fairness and Equality

The Family Physicians' Creed

I am a family physician
one of many across this country.

This is what I believe:
You, the patient
are my first professional responsibility
whether man, woman or child
ill or well
seeking care, healing or knowledge.

You and your family deserve
high quality, affordable health care
including treatment, prevention
and health promotion.

I support access to health care for all.

The specialty of family medicine
trains me to care for the whole person
physically and emotionally, throughout life
working with your medical history and family dynamics
coordinating your care with other physicians when necessary.

This is a promise to you.

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Like the creeds of other health care professions, *The Family Physicians' Creed* reflects a commitment to egalitarian goals of equality, freedom, intelligence, respect for tradition, and humility. Associating these goals with minority groups is one way of controlling implicit biases and stereotypes. When activated, these goals undermine and counteract stereotypes before they are unconsciously or consciously recalled.

Learner Activity: Goal Activation

The objective of this activity is to demonstrate how health care professionals can activate goals that promote fairness and equality and associate them with tasks they perform daily when interacting with patients from minority groups (e.g., meeting and interviewing patients).

1) Have learners complete the short survey provided in the participant guide. On the survey, they will rate the importance of the four statements in *Table 1* on a scale from Strongly Agree to Strongly Disagree.
2) Ask learners to select one goal from the survey (perhaps one they rated as Strongly Agree) and write a short description of a real-life personal experience involving an individual or group (e.g., an African-American male, a transgender woman, immigrants) in which they failed to live up to the ideals of that goal.
3) Ask learners to imagine a fictitious experience with the same individual or group from their first description that would affirm the goal they selected. Instruct them to write a description of the imagined positive experience.
4) Invite learners to share their descriptions in a group discussion, but do not require them to do so.

Table 1. Statements of professional values for health care professionals

Statements
1) The health care professional's main responsibility is to each individual patient rather than to society.
2) It is the responsibility of society to provide everyone with the best available health care.
3) Society should allow patients who are willing to pay more to purchase more expensive treatments.
4) It is unfair, in principle, for some people to have different health care than others for the same problems.

Adapted with permission from Beach MC, Meredith LS, Halpern J, Wells KB, Ford DE. Physician conceptions of responsibility to individual patients and distributive justice in health care. Ann Fam Med. *2005;3(1):53-59.*

Collecting Counter-Stereotypical Information

Collecting information that is opposite of cultural stereotypes about the attitudes and behaviors of a group can help limit implicit biases. This information allows for the development of new associations that eventually become automatically activated when meeting a patient from the stereotyped group. One way for health care professionals to collect counter-stereotypical information is by engaging meaningfully with colleagues from stereotyped groups who exemplify attitudes and behaviors that defy the stereotype. Another way for health care professionals to collect counter-stereotypical information is by individualizing patients (e.g., by documenting unique stories or reminders in their patients' charts). They should try to find shared experiences or common identities with patients and use that information to fill in knowledge gaps instead of making inferences and assumptions.

Learner Activity: Countering Stereotypical Information

This activity focuses on developing skills in countering stereotypical information. The two case studies below are presented in the participant guide. Each case involves a patient from a sexual or racial minority group who is struggling to manage a health condition.

1) Ask learners to review the case studies and identify at least one cultural stereotype about each patient that could create problems with diagnosis and treatment.
2) Instruct learners to generate questions to ask each patient that could reveal the degree to which the individual deviates from the cultural stereotype identified.

Case 1

Ismael is a 29-year-old male with history of HIV infection, depression, posttraumatic stress, and methamphetamine dependence. Today, he is presenting for a follow-up visit at an HIV specialty clinic where family medicine residents rotate in their second year. Three years ago, when Ismael was adherent to his regimen and daily Narcotics Anonymous (NA) meetings, his viral load was less than 40 copies/mL (undetectable) and his CD4 count was above 500 cells/µL (normal range). A month ago, a new resident asked Ismael, "When was the last time you used meth?" Ismael admitted he had used it the previous weekend.

Case 2

You are on an overnight when the emergency department attending calls you with an admission. He starts with, "Hey doc, sorry, but I've got a lame one for you. A 23-year-old African-American male came in claiming he's in a 'sickle cell crisis' again, even though he was just here last week. I think he's just drug seeking, but he's tachycardic so I couldn't discharge him. I gave him some naproxen but not any opiates. He looks disheveled like one of those gangster dudes and I think he's just abusing them."

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SECTION 6: Case Studies

Case studies are often used as an instructional tool in implicit bias training because they provide an opportunity for learners to apply the skills they learn in training to real scenarios. The two cases presented in the participant guide describe situations in which implicit bias played a role in adverse health outcomes involving a mother and child.

1) Instruct learners to read the case studies and identify where and how implicit bias may have impacted the health outcomes for the patient described. Remind them of the common types of implicit bias (see Page 3).
2) Allow time for learners to discuss the case studies in small groups. Ask them to describe different approaches they could have used to change the outcome.

Additional cases are available online at www.aafp.org/implicit-bias.

Case 1: Ashley

Ashley is a 29-year-old G2P0010 woman with a history of a spontaneous pregnancy loss at six weeks gestation two years ago. She presents to the clinic today for a new OB visit at approximately eight weeks gestation. Ashley is a former high school and college softball player and is very active. She exercises five to six times per week for 60-90 minutes, with activities including CrossFit, cycling, and swimming. She has been vegan since college and benefited from her Division I school's nutrition program, so she is very well-versed in her body's nutritional needs. Ashley eats a wide range of fruits and vegetables, whole grains, and plant-based protein. She takes a prenatal vitamin with iron and also takes supplemental B12, "just to be sure."

First OB Visit

At the beginning of the visit, Ashley's weight and height are measured. She is 180 lbs. and her height is 5'5", which puts her body mass index (BMI) at 30 kg/m^2. The nurse measures Ashley's vital signs and comments, "I'm surprised your heart rate and your blood pressure are so normal, given your size." Ashley is taken aback but decides not to say anything because she doesn't want to make a scene. She hasn't even met her physician yet.

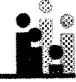
The physician enters, congratulates Ashley on her pregnancy, takes a medical and obstetric history, and performs the exam. The physician then starts to talk about Ashley's current weight and BMI, as well as her expected and target weight gain. The physician goes into extensive detail about the importance of regular exercise and ways to cut back on junk food, soda, and calories so Ashley can stay within the guidelines. The physician also recommends that Ashley see a dietician to make sure she doesn't gain too much weight. Ashley declines the dietician referral and tells the physician about her vegan diet and her exercise schedule. The physician looks at her skeptically and says, "OK, we'll see how things go, but I think you should see the dietician." Ashley decides not to ask any more questions about her pregnancy or what to expect. She also doesn't mention to the physician that her sister had blood clots during her pregnancy. She leaves the visit feeling unheard and unseen.

16-week OB Visit

At her 16-week visit, Ashley has gained 5 lbs., but she really feels good. She has continued to do CrossFit, but she is only going twice a week instead of three times and she is not doing any of the high-intensity exercises. In addition, she has reduced her weight-lifting load so that she can lift without holding her breath/doing Valsalva maneuver. She has continued to jog and swim and is doing these activities more often to balance the decrease in CrossFit activity. The first thing the physician mentions to Ashley is that she has gained too much weight. She is told she needs to eat less, exercise more, and stop drinking soda and eating junk food. Ashley is offered a referral to the dietician again. She declines, feeling demoralized.

20-week OB Visit

At her 20-week visit, Ashley is feeling more winded when she exercises. She used to be able to run six miles without stopping, but now she can barely make it a half mile. Although she was able to do the entire CrossFit set last week, she hasn't been able to finish a full workout



this week. She has some swelling in her left leg, and she has gained another 5 lbs. She mentions the shortness of breath, leg swelling, and decrease in exercise tolerance to her physician, who tells her that it's likely because of the pregnancy and her weight gain. Ashley is advised to eat less salt and elevate her legs more. When she asks if salt would make just one leg swell, her physician smiles, pats her arm, and then leaves the room without answering her question.

Outcomes

That night, Ashley develops significant right-sided chest pain and shortness of breath. She calls an ambulance that takes her to the nearest emergency department (ED). She tells the ED physician that she has had worsening shortness of breath, difficulty with her usual exercise routine, and swelling in her left leg. The physician asks Ashley if she has any history of blood clots, and she replies that her sister had blood clots during a pregnancy earlier this year. The ED physician orders a computed tomography (CT) scan and blood tests. However, before any of the tests can be done, Ashley loses consciousness and goes into pulseless electrical activity (PEA) arrest. The ED staff performs resuscitation per advanced cardiac life support (ACLS) protocol but they are unable to obtain a pulse. After 50 minutes, a time of death is called.

Explanation of Bias

This case of maternal mortality illustrates biases that are very common in medicine:

- Weight bias (i.e., unreasonable, negative attitudes, beliefs, assumptions, and judgments about individuals who are overweight or obese[22])
- Attribution bias
- Anchoring bias
- Confirmation bias

The medical staff caring for Ashley had an **attribution bias** that her BMI of 30 meant that she was not exercising regularly or eating healthy foods. Therefore, they decided that her symptoms of shortness of breath and leg swelling must be related to her weight, weight gain (**anchoring bias**), and dietary indiscretion. Because Ashley felt disrespected and unheard, she didn't tell her care team about an important historical detail—her sister's pregnancy-related blood clots—that could have helped mitigate the staff's **confirmation bias** that her dyspnea was related to her weight and being out of shape. This might have saved her life.

Case 2: Tasha

Tasha is a 22-year-old G2P0101 African-American woman at 24+4 weeks gestation who is brought in by ambulance to the Labor and Delivery (L&D) unit because of severe back and abdominal pain and reports of contractions. She arrives in L&D in significant pain. The primary nurse (Nurse #1) is quite attentive to Tasha and seems very concerned, but the second nurse (Nurse #2), who is more experienced, seems distracted and unconcerned when she meets the paramedics in the triage room. After the paramedics move Tasha onto the triage bed, Nurse #2 asks her, "What made you call the ambulance?" Tasha says that she doesn't have a car and has been having severe pain in her lower abdomen/pelvis and back that comes and goes, like contractions.

Intake by Nurses

Nurse #1 puts Tasha on the monitor and places her hand on Tasha's abdomen. Because she is less experienced, she is not sure if she is feeling contractions since Tasha is only 24+4 weeks. She turns to Nurse #2 for confirmation. Nurse #2 palpates for contractions for about a minute and tells Tasha, "I don't feel any contractions, but we'll watch you on the monitor for a while."

Tasha tells both nurses that she thinks she might be having some discharge or leaking fluid. She says, "It started this morning, but there's no bleeding." Neither nurse does a cervical check. They ask Tasha about drug use, domestic violence, and whether or not she is with the father of the baby, and then they ask to collect a urine specimen. They obtain a verbal order for acetaminophen and hydroxyzine (Vistaril) from the laborist who is attending because the resident is finishing with a delivery.

Resident Interview

Twenty minutes later, the resident has finished the delivery and is informed by Nurse #2 that Tasha needs to be seen. Nurse #2 says, "She took an ambulance here because she thought she was having contractions, but she isn't. No contractions on the monitor and I don't feel any either. She's having some discharge and probably has BV [bacterial vaginosis]. I don't know why these people always have to take the ambulance here for stuff like this. She could have gone to the clinic."

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The resident is only on the second week of L&D and is inexperienced. During an extensive interview, Tasha tells the resident that her first birth, which was about a year ago, was at 36 weeks gestation. The resident asks Tasha if she has been on progesterone, but Tasha doesn't know what that is. She doesn't think her physician ever mentioned it to her. In Tasha's prenatal record, the resident finds a note from her outpatient physician stating that Tasha did not have reliable transportation and hinting that black patients were almost never consistent about coming in for injections. The physician opted not to initiate progesterone.

Tasha continues to be in pain. However, per the nursing staff who saw her right after she came in, she appears more comfortable after the acetaminophen and hydroxyzine. She does not have any contractions on tocometry, although no one has palpated her abdomen since the initial assessment about 75 minutes earlier. Tasha tells the resident about her vaginal discharge and that she is possibly leaking fluid. She confirms that she does not use drugs or alcohol.

Outcomes

The resident leaves the room to have the nurse collect supplies to do a pelvic exam that includes an Amnisure, fetal fibronectin swab, wet prep, and gonorrhea/chlamydia. While the resident is on the phone calling an attending physician, a code blue is called to Tasha's room. Nurse #1 is in the room when Tasha starts having significant abdominal pain and yells, "I need to push!" The resident, laborist, and many nurses run into Tasha's room. They pull back her sheets to find that Tasha has delivered onto the bed an infant who appears to be 24-25 weeks and has minimal respiratory effort.

The resident clamps and cuts the umbilical cord and rushes the baby to the warmer just as the neonatal intensive care unit (NICU) staff arrives, including a neonatologist who happened to be in house. They start resuscitation immediately, including intubation and administration of surfactant.

Tasha's infant girl, Lily, is able to be resuscitated and remains in the NICU with assisted ventilation and blood pressure support for the next five days. However, she suffers a grade IV intraventricular hemorrhage and bilateral pneumothoraces. On her sixth day of life, she has increasing oxygen needs and pressor support. Her mother opts to withdraw life-sustaining support, and Lily dies.

Explanation of Bias

This case of premature birth and neonatal death highlights a number of concerning biases regarding the patient's race and socioeconomic status:

- Confirmation bias
- Anchoring bias
- Conformity bias

Because of Tasha's **race and socioeconomic status**, her outpatient physician assumed that she would not comply with progesterone therapy to prevent preterm delivery. The physician did not provide Tasha with information about possible treatment options so that she could have a say in her care. Nurse #2 had a **confirmation bias** that she was not feeling contractions because she didn't see contractions on the monitor. In addition, she didn't believe that Tasha was having contractions because she had an **anchoring bias** that "these people" use ambulances in nonemergent situations. Nurse #1 was affected by **conformity bias**. Initially, she was concerned that Tasha might be in preterm labor, but she allowed Nurse #2's opinions to influence her own assessment. The resident was also affected by **conformity bias**, delaying a pelvic exam based on the nurse's assessment that Tasha's case was less urgent because she was not in preterm labor. The resident and Nurse #1 were more susceptible to this type of bias due to their inexperience.

SECTION 7: Additional Reading

The following reading list is provided for individuals who wish to deepen their understanding of implicit bias, its effect on health outcomes, and training interventions.

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APPENDIX A.

Social Perspective-Taking Survey For Health Care Professionals

Directions: Read each of the statements below and select those that you feel describe your experience. Count your total number of affirmative responses and write it in the space below. When you are finished, please stand.

- ☐ If I should need to move, I can be pretty sure of renting or purchasing a home in an area that I can afford and in which I would want to live.
- ☐ If I ask to talk to the person in charge, I will be facing a person similar to me.
- ☐ If I walk towards a security checkpoint in the airport, I can feel that I will not be looked upon as suspect.
- ☐ If I walk into an emergency room, I can expect to be treated with dignity and respect.
- ☐ If I walk through a parking garage at night, I don't have to feel vulnerable.
- ☐ I can easily buy posters, postcards, picture books, greeting cards, dolls, toys, and children's magazines featuring people who look like me.
- ☐ I can easily trust that anyone I'm speaking to will understand the meaning of my words.
- ☐ I can feel confident that my patients feel that I am qualified upon first impression.
- ☐ When a patient asks where I'm from, I simply think that it's because they're being friendly.
- ☐ My employer gives days off for the holidays that are most important to me.
- ☐ I can come to work early or stay late whenever needed and know that my children will be cared for.
- ☐ I can speak in a roomful of hospital leaders and feel that I am heard.
- ☐ I can go home from most meetings feeling somewhat engaged, rather than isolated, out-of-place, or unheard.
- ☐ I can look at the cafeteria menu and expect to see that the special of the day reflects my culture's traditional foods.
- ☐ My age adds to my credibility.
- ☐ My body stature is consistent with an image of success.
- ☐ I can bring my spouse or partner to an office gathering without thinking twice.
- ☐ I can be sure that if I need legal or medical help, my race will not work against me.
- ☐ I can take a job with an affirmative action employer without having coworkers on the job suspect that I got it because of race or gender.
- ☐ I feel confident that if I don't understand something then it wasn't written clearly enough for most others to understand.
- ☐ I can feel confident that if a family member requires hospital or emergency treatment, they would be treated with dignity and respect even if they don't mention my connection with the hospital.
- ☐ I have no medical conditions or cultural/religious dietary restrictions that require special arrangements or that make others see me as different.

Total ___________

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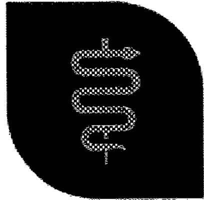
APPENDIX B.
Social Perspective-Taking Survey For Medical Students and Residents

Directions: Read each of the statements below and select those that you feel describe your experience. Count your total number of affirmative responses and write it in the space below. When you are finished, please stand.

- ☐ I have been taught since an early age that people of my own race can become doctors.
- ☐ Throughout my education, I could succeed academically without people questioning whether my accomplishments were attributable to affirmative action or my own abilities.
- ☐ During college and medical school, I never struggled to find professors and academic role models who shared my race.
- ☐ When I applied to medical school, I could choose from many elite institutions that were founded to train inexperienced doctors of my race by "practicing" medicine on urban and poor people of color.
- ☐ I am reminded daily that my medical knowledge is based on the discoveries made by people who looked like me without being reminded that some of the most painful discoveries were made through inhumane and nonconsensual experimentation on people of color.
- ☐ When I walk into an exam room with a person of color, patients invariably assume I am the doctor in charge, even if the person of color is my attending.
- ☐ If I respond to a call for medical assistance on an airplane, people will assume I am really a physician because of my race.
- ☐ Every American hospital I have ever entered contained portraits of department chairs and hospital presidents who are physicians of my race, reminding me of my race's importance since the founding of these institutions.
- ☐ Even if I forget my identification badge, I can walk into the hospital and know that security guards will probably not stop me because of the color of my skin.
- ☐ When I travel to and from the hospital late at night as required by my job, I do not fear that I will be stopped, delayed, unjustly detained, inappropriately touched, injured, or killed by the police because of my race.
- ☐ I can attend most professional meetings confident that I will be surrounded by physicians who look like me, and that we will likely have mutual acquaintances who also share our race.
- ☐ I can speak my native language in my own dialect in professional settings without being viewed as uneducated or out-of-place.
- ☐ I know that I can leave the impoverished area where I work without being accused of abandoning my community.
- ☐ I can criticize medical institutions without being cast as a cultural outsider.
- ☐ I can name racism in my professional workspace and not be accused of being angry, potentially violent, or excessively emotional.
- ☐ When patients tell me they are "glad to have a white doctor," I am not personally threatened, and I can choose to confront their racism or ignore it.
- ☐ I can pretend that health disparities don't affect me or my family without acknowledging that we accrue benefits from a system that systematically favors our skin color.

Total ___________

Reprinted with permission from Romano MJ. White privilege in a white coat: how racism shaped my medical education. Ann Fam Med. *2018;16(3):261-263*



Cultural & Linguistic Competency and Implicit Bias Standards

The California Medical Association (CMA) **believes** that there are basic cultural and linguistic competencies that are essential to providing quality and accessible care, and also acknowledges that society at large, including the house of medicine, has embedded and endemic structural racism and biases that affect the care that an individual receives.

To that end, CMA's continuing medical education (CME) team (**CMA CME**) convened an advisory council of CME and health equity experts in October 2020 to update the cultural and linguistic competency (CLC) standards and create standards for implicit bias (IB) that reduce health disparities, as well as comply with state law. (**Presentation of draft standards & process**)

The final standards are expected to be released in August 2021, and California CME provider organizations will have until January 1, 2022, to meet all components to comply with state law.

Background on State Law

Business and Professions (B&P) Code Section 2190.1 also requires CMA CME to update CLC standards and develop IB standards for inclusion in CME activities. Section 2190.1 (b)(3) of state law states that: "Associations that accredit continuing

medical education courses shall develop standards before July 1, 2006, for compliance with the requirements of paragraph (1). The associations may develop these standards in conjunction with an advisory group that has expertise in cultural and linguistic competency issues."

Assembly Bill (AB) 1195 (Coto, 2005) and **AB 241** (Kamlager-Dove, 2019) are codified via B&P 2190.

Contact

Email **cmestandards@cmadocs.org** with questions or for more information.

Resources

- CLC/IB draft **standards**
- CLC/IB draft **best practices**
- **Informational packet**
- **CLC/IB survey results**
- **Presentation on draft standards & process** (April 2021)

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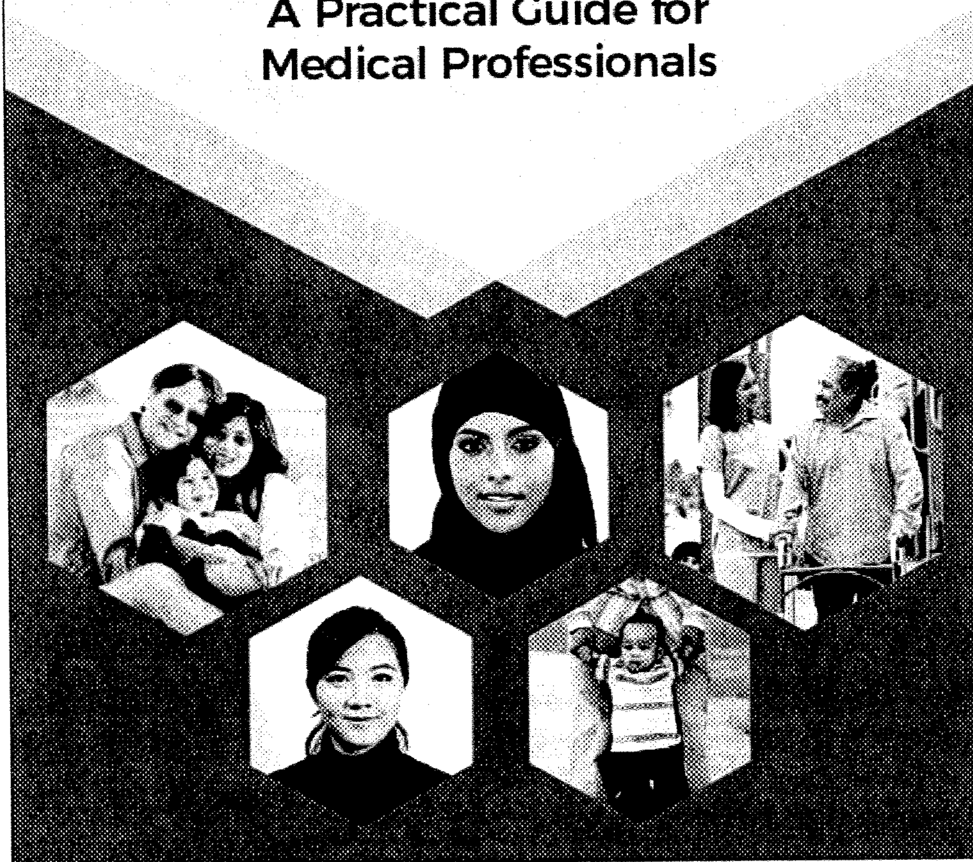
OREGON MEDICAL BOARD

CULTURAL COMPETENCY

A Practical Guide for Medical Professionals



Cultural competency is a life-long process of examining values and beliefs while developing and applying an inclusive approach to health care practice in a manner that recognizes the context and

complexities of provider-patient interactions and preserves the dignity of individuals, families, and communities.

The Oregon Medical Board has a Statement of Philosophy on **Cultural Competency** and published the **Cultural Competency: A Practical Guide for MedicalProfessionals** booklet in June 2017.

Hard copies of the publication are available free of charge. Please fill out the **Cultural Competency Guide Order Form** and return to the OMB.

Mandatory Cultural Competency Continuing Education

In 2019 (HB 2011), the Oregon Legislature mandated cultural competency continuing education for health care professionals starting July 1, 2021. Under the requirement, Oregon Medical Board licensees must complete cultural competency continuing education as a condition of licensure as required in OAR 847-008-0077.

Licensees required to comply: All Oregon physicians, physician assistants, and acupuncturists whose license is at a practicing status must meet this requirement. The only exceptions are licensees in residency training and volunteer camp licensees. Licensees with a "retired" status do not have to meet the requirement because their license is not at a practicing status.

Number of hours: Licensees must complete an average of at least one hour of cultural competency education per year during an audit period. An audit period is two renewal cycles, for example every four years for most licensees. Required hours will be based on the number of years licensed during the audit period; any portion of a year licensed will require one hour of cultural competency education. For example, a licensee who has been licensed for 3.5 years during the audit period will be required to obtain four hours of cultural competency education. Hours may be obtained at any time during the audit period. For example, either one four-hour experience, or four one-hour courses taken annually, would satisfy the requirement.

Educational opportunities: The cultural competency continuing education may, but does not have to, be accredited continuing medical education (CME). The law was written to allow a wide array of courses or experiences, which may include: courses delivered in-person or electronically, experiential or service learning, cultural or linguistic immersion, volunteering in a rural clinic, completing an employer's cultural competency training, attending an event with members of an underserved community to discuss health care access issues, or **courses approved by the Oregon Health Authority**.

Tracking completion: Licensees may track educational hours on an **OMB record keeping form**. During license renewal (annually or biennially depending on the license), licensees will attest to completing the required hours by checking a box and reporting the number of hours obtained. The OMB will audit for compliance every other renewal cycle with the first audit being conducted during the Fall 2023 renewal cycle. The cultural competency audit will be included within the existing audit for CME compliance. Beginning in 2023 and every other renewal cycle thereafter, audited licensees will be asked to also produce documentation of their cultural

competency educational experiences. Documentation may be a course certificate, the OMB record keeping form, or other documentation.

Fall 2023: For the first audit period during the Fall 2023 renewal cycle, licensees will be requried to report 2 hours of cultural competency education. Licensees may report hours for courses or experiences completed during the calender year starting January 1, 2021.

Continuing Education Resources

- **OMB Record Keeping Form**
- **Oregon Health Authority Approved Courses**

American Medical Association Recognizes Racism as Public Health Threat

A new policy from the American Medical Association (AMA) acknowledges racism's role in perpetuating health inequities and inciting harm against historically marginalized communities and society as a whole. Specifically, the policy recognizes racism in its systemic, cultural, interpersonal, and other forms as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care. Read more about the AMA's policy **here**.

The Legacy of Dr. Unthank

DeNorval Unthank, MD, was an African American doctor who lived life boldly facing adversity and improving the lives of Oregonians. Dr. Unthank graduated from high school at the age of 16, attended the University of Michigan for his undergraduate studies, and went on to Howard University where he earned his medical degree in 1926.

Dr. Unthank moved his family to Portland, Oregon, in 1929 where he would be the only African American doctor for over 10 years of his medical career. Dr. Unthank persistently served the

Portland area and went from not being allowed in hospitals to eventually being on staff at four Portland area hospitals. The Oregon State Medical Society named him Doctor of the Year in 1958. Dr. Unthank retired from his practice in 1970 having served a richly multicultural group of patients.

Alongside an influential medical career were Dr. Unthank's numerous contributions to Civil Rights. He cofounded the Portland Urban League in 1945 and was accepted as the first African American member of the Portland City Club. Additionally, he was a driving force behind the Oregon Civil Rights Bill passed in 1953. In 1977, Dr. Unthank passed away having greatly impacted medicine and Civil Rights in Oregon.

BEHAVIOR & SOCIETY

The Problem with Implicit Bias Training

It's well motivated, but there's little evidence that it leads to meaningful changes in behavior

By Tiffany L. Green, Nao Hagiwara on August 28, 2020

Credit: Nicola Katie *Getty Images*

While the nation roils with ongoing protests against police violence and persistent societal racism, many organizations have released statements promising to do better. These promises often include improvements to hiring practices; a priority on retaining and promoting people of color; and pledges to better serve those people as customers and clients.

As these organizations work to make good on their declarations, implicit bias training is often at the top of the list. As the thinking goes, these nonconscious prejudices and stereotypes are spontaneously and automatically activated and may inadvertently affect how white Americans see and treat Black people and other people of color. The hope is

that, with proper training, people can learn to recognize and correct this damaging form of bias.

In the health care industry, implicit bias is among the likely culprits in many persistent racial and ethnic disparities, like infant and maternal mortality, chronic diseases such as diabetes, and more recently, COVID-19. Black Americans are about 2.5 times more likely to die from COVID-19 relative to whites, and emerging data indicate that Native Americans are also disproportionately suffering from the pandemic. Implicit biases may impact the ways in which clinicians and other health care professionals diagnose and treat people of color, leading to worse outcomes. In response to these disparities, Michigan and California have mandated implicit bias training for some health professionals.

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There's just one problem. We just don't have the evidence yet that implicit bias training actually works.

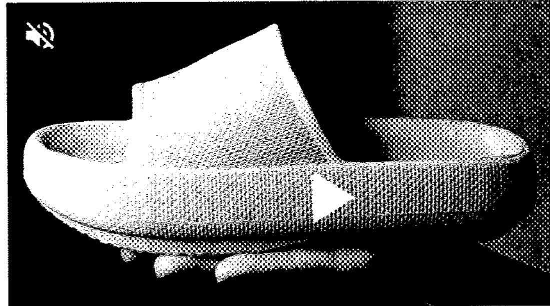
To be sure, finding ways to counter unfair treatment is critical. The evidence is clear that implicit prejudice, an affective component of implicit bias (i.e., feeling or emotion) exists among health care providers with respect to Black and/or Latinx patients, as well as to dark-skinned patients not in those categories. In turn, these biases lower the quality of

patient-provider communication and result in lower satisfaction with the healthcare encounter.

But while implicit bias trainings are multiplying, few rigorous evaluations of these programs exist. There are exceptions; some implicit bias interventions have been conducted empirically among health care professionals and college students. These interventions have been proven to lower scores on the Implicit Association Test (IAT), the most commonly used implicit measure of prejudice and stereotyping. But to date, none of these interventions has been shown to result in permanent, long-term reductions of implicit bias scores or, more importantly, sustained and meaningful changes in behavior (i.e., narrowing of racial/ethnic clinical treatment disparities).

Even worse, there is consistent evidence that bias training done the "wrong way" (think lukewarm diversity training) can actually have the opposite impact, inducing anger and frustration among white employees. What this all means is that, despite the widespread calls for implicit bias training, it will likely be ineffective at best; at worst, it's a poor use of limited resources that could cause more damage and exacerbate the very issues it is trying to solve.

So, what should we do? The first thing is to realize that racism is not just an individual problem requiring an individual intervention, but a structural and organizational problem that will require a lot of work to change. It's much easier for organizations to offer an implicit bias training than to take a long, hard look and overhaul the way they operate. The reality is, even if we could reliably reduce individual-level bias, various forms of institutional racism embedded in health care (and other organizations) would likely make these improvements hard to maintain.



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Explicit, uncritical racial stereotyping in medicine is one good example. We have known for many years that race is a social construct rather than a proxy for genetic or biological differences. Even so, recent work has identified numerous cases of race-adjusted clinical algorithms in medicine. In nephrology, for example, race adjustments that make it appear as if Black patients have better kidney function than they actually do can potentially lead to worse outcomes such as delays in referral for needed specialist care or kidney transplantation. Other more insidious stereotyping characterizes Native Americans and African Americans as more likely to be "noncompliant" with diet and lifestyle advice. These characterizations of noncompliance as a function of attitudes and practices completely ignore structural factors such as poverty, segregation and marketing—factors that create health inequities in the first place.

Meaningful progress at the structural and institutional levels takes longer than a few days of implicit bias training. But there are encouraging examples of individuals who have fought successfully for structural change within their health care organizations. For example, medical students at the University of Washington successfully lobbied for race to be removed as a criterion for determining kidney function—a process that took many years. Their success may have important implications for closing gaps in disparities among patients with renal disease. And innovative new programs like the Mid-Ohio

Farmacy have linked health care providers with community-based organizations, and help providers address food insecurity among their low-income patients—an issue that disproportionately impacts people of color. (Doctors can write a "food prescription" that allows their patients to purchase fresh produce.)

None of this, of course, means that we should give up on trying to understand implicit bias or developing evidence-based training that successfully reduces discriminatory behaviors at the individual level. What it does mean is that we need to lean into the hard work of auditing long-standing practices that unfairly stigmatize people of color and fail to take into account how health inequities evolve. Creating organizations that value equity and ultimately produce better outcomes for people of color will be long, hard work, but it's necessary and it's been a long time coming.

Agenda Item: Impacting Continuity of Care by Additions to Guidance Document 85-12 on Telemedicine

Staff Note: The site of practice is considered to be the patient's location. Virginia requires an out-of-state physician to hold a license with the Board to treat patients located in the Commonwealth through telemedicine. During COVID-19, through Executive Order 57, Governor Northam authorized out-of-state providers with established provider-patient relationships to continue to follow their Virginia patients through telemedicine. Now that the emergency is coming to an end, out-of-state providers are asking what will happen in regards to telemedicine follow-up. Two additions to Guidance Document 85-12 are suggested to further clarify the Board's law on this matter. In the following pages, you will find EO57, an email from Sheppard Pratt illustrative of the concern about telemedicine follow-up, Guidance Document 85-12, Code of Virginia Section 54.1-2901(A)(15), and HB 1987 which clearly states what is and what is not telemedicine.

Action: For the Board to discuss and choose to add clarifying language to 85-12 or not.

Commonwealth of Virginia
Office of the Governor

Executive Order

THIRD AMENDED NUMBER FIFTY-SEVEN (2021)

LICENSING OF HEALTH CARE PROFESSIONALS IN RESPONSE TO NOVEL CORONAVIRUS (COVID-19)

FURTHER EXTENSION OF CERTAIN WAIVERS

Importance of the Issue

It is anticipated that COVID-19 will continue to place increased demands on the Commonwealth's health professional workforce that will require additional personnel, **including for the administration of COVID-19 vaccines. Continuing both the authorization of** out-of-state licensed professionals to **provide** care to the citizens of the Commonwealth **and the availability of** telehealth will assist in meeting that demand, **as will allowing** physician assistants to practice **outside of** a practice agreement and **allowing licensed practical nurses to administer vaccines without supervision. Partnerships** in **vaccine administration between private and public entities will also expand our capacity to vaccinate. Allowing temporary nurse aides** to **qualify to transition into certified nurse aides will help address a key workforce need.**

Directive

Therefore, by virtue of the authority vested in me by the Constitution of Virginia and §44-146.17 of the *Code of Virginia*, during the state of emergency declared in Amended Executive Order 51, I hereby order the following:

1. **Notwithstanding any contrary provision in Title 54.1 of the *Code of Virginia*,** a license issued to a health care practitioner by another state, and in good standing with such state, shall be deemed to be an active license issued by the Commonwealth to provide health care or professional services as a health care practitioner of the same type for which such license is issued in another state. Such license is permissible, provided the health care practitioner is engaged by a hospital (or an affiliate of such hospital where both share the same corporate parent), licensed nursing facility, dialysis facility, **the Virginia Department of Health (VDH),** or a local or district health department for the

purpose of assisting that facility with public health and medical disaster response operations. Hospitals, licensed nursing facilities, dialysis facilities, **and health departments** must submit to the applicable licensing authority each out-of-state health care practitioner's name, license type, state of license, and license identification number within a reasonable time of such healthcare practitioner providing services at the applicable **facility in the Commonwealth.**

2. Health care practitioners with an active license issued by another state may provide continuity of care to their current patients who are Virginia residents through telehealth services. Establishment of a relationship with a new patient requires a Virginia license unless pursuant to paragraph 1 of this Order.

3. Physician assistants licensed in the Commonwealth of Virginia with two or more years of clinical experience may practice in their area of knowledge and expertise and may prescribe without a written or electronic practice agreement.

4. A healthcare practitioner may use any non-public facing audio or remote communication product that is available to communicate with patients. This exercise of discretion applies to telehealth provided for any reason regardless of whether the telehealth service is related to the diagnosis and treatment of COVID-19.

5. **A licensed practical nurse may administer the COVID-19 vaccine without the supervision of a registered nurse or licensed medical practitioner.**

6. **Licensed health professionals of health systems or hospitals whose scope of practice includes administration of the vaccine and who have administered the COVID-19 vaccine in the health system or hospital setting may administer the COVID-19 vaccine at any point of distribution held in collaboration between the health system or hospital and a local health department without additional training.**

7. **A local health department may collaborate with a federal health facility, whether civilian or military, for the purpose of COVID-19 vaccine administration. Federal personnel whose scope of practice includes vaccination may serve with the Medical Reserve Corps after a training and skills assessment as required by VDH.**

8. **Temporary nurse aides practicing in long term care facilities under the federal Public Health Emergency 1135 Waiver may be deemed eligible by the Board of Nursing to take the National Nurse Aide Assessment Program examination upon submission of a completed application, the employer's written verification of competency and employment as a temporary nurse aide, and provided no other grounds exist under Virginia law to deny the application.**

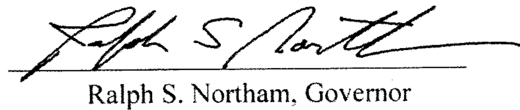
With the exception of healthcare practitioners volunteering with the Medical Reserve Corps, nothing in this Order designates the healthcare practitioners above as agents of the Commonwealth.

These actions are in concert with, and further the provisions of **Amended** Executive Order 51 in marshalling all resources and appropriate preparedness, response, and recovery measures to respond to the emergency.

Effective Date of this Executive Order

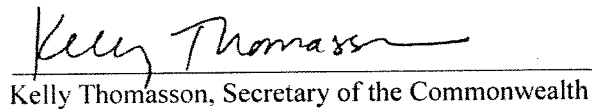
This Executive Order shall be effective **immediately** and shall remain in full force and effect for the duration of the state of emergency as declared in Amended Executive Order 51 unless sooner amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia, this **11th** day of **March, 2021**.



Ralph S. Northam, Governor

Attest:



Kelly Thomasson, Secretary of the Commonwealth

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

Fwd: FW: End of state of emergency and continuity of care question

1 message

Harp, William <william.harp@dhp.virginia.gov> Fri, Jun 11, 2021 at 1:17 PM
To: "Colanthia D. Morton" <CoCo.Morton@dhp.virginia.gov>, nicholas.dunphy@sheppardpratt.org

Dear Mr. Dunphy:

Thank you for your question.

The authorization for out-of-state providers to continue care with their Virginia patients through telemedicine is in Governor Northam's Executive Order 57. If the emergency is declared over, then the authorization will be over as well, unless the Governor says otherwise.

The Virginia Board of Medicine meets on June 24th and will discuss if there is any way to impact this situation through its Guidance Document 85-12 on Telemedicine.

This is the extent to which I can respond to your question at this time.

With kindest regards,

William L. Harp, MD
Executive Director
Virginia Board of Medicine.

---------- Forwarded message ---------
From: **Colanthia Opher** <coco.morton@dhp.virginia.gov>
Date: Fri, Jun 11, 2021 at 12:56 PM
Subject: FW: End of state of emergency and continuity of care question
To: Harp, William <william.harp@dhp.virginia.gov>

-----Original Message-----
From: Nick Dunphy <nicholas.dunphy@sheppardpratt.org>
Sent: Friday, June 11, 2021 6:32 AM
To: coco.morton@dhp.virginia.gov
Subject: End of state of emergency and continuity of care question

Good morning. My name is Nicholas Dunphy and I am the Chief Compliance Officer for the Sheppard Pratt Health System in Maryland. My question is that if the state of emergency in Virginia is allowed to expire on June 30th, will that immediately remove the ability for an out of state licensed physician in good standing to provide telehealth services to an existing patient who he has treated in Maryland but is now returning to Virginia for the purposes of continuity of care? Will there be any notice or wind down period? Thanks

Nick

Sent from my iPhone
Please be green and think before printing this email, thank you.

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Virginia Board of Medicine

Telemedicine

Section One: Preamble.

The Virginia Board of Medicine ("Board") recognizes that using telemedicine services in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these services can enhance medical care by facilitating communication between practitioners, other health care providers, and their patients, prescribing medication, medication management, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice. With the exception of prescribing controlled substances, the Virginia General Assembly has not established statutory parameters regarding the provision and delivery of telemedicine services. Therefore, practitioners must apply existing laws and regulations to the provision of telemedicine services. The Board issues this guidance document to assist practitioners with the application of current laws to telemedicine service practices.

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method used to enable practitioner-to-patient communications. For the purpose of prescribing controlled substances, a practitioner using telemedicine services in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the practitioner-patient relationship as defined in Virginia Code § 54.1-3303. A practitioner should conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine services as a component of, or in lieu of, in-person provision of medical care, while others are not. The practitioner is responsible for making this determination, and in doing so must adhere to applicable laws and standards of care.

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine services in the practice of medicine. The Board is committed to ensuring patient access to the convenience and benefits afforded by telemedicine services, while promoting the responsible provision of health care services.

It is the expectation of the Board that practitioners who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;
- Adhere to recognized ethical codes governing the applicable profession;
- Adhere to applicable laws and regulations;

- In the case of physicians, properly supervise non-physician clinicians when required to do so by statute; and
- Protect patient confidentiality.

Section Two: Establishing the Practitioner-Patient Relationship.

The practitioner-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that practitioners recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a practitioner-patient relationship. Where an existing practitioner-patient relationship is not present,[1] a practitioner must take appropriate steps to establish a practitioner-patient relationship consistent with the guidelines identified in this document, with Virginia law, and with any other applicable law.[2] While each circumstance is unique, such practitioner-patient relationships may be established using telemedicine services provided the standard of care is met.

A practitioner is discouraged from rendering medical advice and/or care using telemedicine services without (1) fully verifying and authenticating the location and, to the extent possible, confirming the identity of the requesting patient; (2) disclosing and validating the practitioner's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine services. An appropriate practitioner-patient relationship has not been established when the identity of the practitioner may be unknown to the patient.

Section Three: Guidelines for the Appropriate Use of Telemedicine Services.
The Board has adopted the following guidelines for practitioners utilizing telemedicine services in the delivery of patient care, regardless of an existing practitioner-patient relationship prior to an encounter.

Licensure:

The practice of medicine occurs where the patient is located at the time telemedicine services are used, and insurers may issue reimbursements based on where the practitioner is located. Therefore, a practitioner must be licensed by, or under the jurisdiction of, the regulatory board of the state where the patient is located and the state where the practitioner is located. Practitioners who treat or prescribe through online service sites must possess appropriate licensure in all jurisdictions where patients receive care. To ensure appropriate insurance coverage, practitioners must make certain that they are compliant with federal and state laws and policies regarding reimbursements.

Evaluation and Treatment of the Patient:

[1] This guidance document is not intended to address existing patient-practitioner relationships established through in-person visits.
[2] The practitioner must adhere not only to Virginia law defining a practitioner-patient relationship, but the law in any state where a patient is receiving services that defines the practitioner-patient relationship.

A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, which treatment includes the issuance of prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional, in-person encounters. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:

Evidence documenting appropriate patient informed consent for the use of telemedicine services must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following:

- Identification of the patient, the practitioner, and the practitioner's credentials;
- Types of activities permitted using telemedicine services (e.g. prescription refills, appointment scheduling, patient education, etc.);
- Agreement by the patient that it is the role of the practitioner to determine whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine services, such as encrypting date of service, password protected screen savers, encrypting data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

Medical Records:

The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-practitioner communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine services. Informed consents obtained in connection with an encounter involving telemedicine services should also be filed in the medical record. The patient record established during the use of telemedicine services must be accessible to both the practitioner and the patient, and consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records and Exchange of Information:

Written policies and procedures should be maintained for documentation, maintenance, and transmission of the records of encounters using telemedicine services. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the practitioner addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the

communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Section Four: Prescribing:

Prescribing controlled substances requires the establishment of a bona fide practitioner-patient relationship in accordance with § 54.1-3303 (A) of the Code of Virginia. Prescribing controlled substances, in-person or via telemedicine services, is at the professional discretion of the prescribing practitioner. The indication, appropriateness, and safety considerations for each prescription provided via telemedicine services must be evaluated by the practitioner in accordance with applicable law and current standards of practice and consequently carries the same professional accountability as prescriptions delivered during an in-person encounter. Where such measures are upheld, and the appropriate clinical consideration is carried out and documented, the practitioner may exercise their judgment and prescribe controlled substances as part of telemedicine encounters in accordance with applicable state and federal law.

Prescriptions must comply with the requirements set out in Virginia Code §§ 54.1-3408.01 and 54.1-3303(A). Prescribing controlled substances in Schedule II through V via telemedicine also requires compliance with federal rules for the practice of telemedicine. Practitioners issuing prescriptions as part of telemedicine services should include direct contact for the prescriber or the prescriber's agent on the prescription. This direct contact information ensures ease of access by pharmacists to clarify prescription orders, and further facilitates the prescriber-patient-pharmacist relationship.

For the purpose of prescribing Schedule VI controlled substances, "telemedicine services" is defined as it is in § 38.2-3418.16 of the Code of Virginia. Under that definition, *"telemedicine services," as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.*

Section Five: Guidance Document Limitations.

Nothing in this document shall be construed to limit the authority of the Board to investigate, discipline, or regulate its licensees pursuant to applicable Virginia statutes and regulations. Additionally, nothing in this document shall be construed to limit the Board's ability to review the delivery or use of telemedicine services by its licensees for adherence to the standard of care and compliance with the requirements set forth in the laws and regulations of the Commonwealth of Virginia. Furthermore, this document does not limit the Board's ability to determine that certain situations fail to meet the standard of care or standards set forth in laws and regulations despite technical adherence to the guidance produced herein.

Statutory references:

§ 54.1-3303. Prescriptions to be issued and drugs to be dispensed for medical or therapeutic purposes only.

A. A prescription for a controlled substance may be issued only by a practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine who is authorized to prescribe controlled substances, or by a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed physician assistant pursuant to § 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32.

B. A prescription shall be issued only to persons or animals with whom the practitioner has a bona fide practitioner-patient relationship or veterinarian-client-patient relationship.

A bona fide practitioner-patient relationship shall exist if the practitioner has (i) obtained or caused to be obtained a medical or drug history of the patient; (ii) provided information to the patient about the benefits and risks of the drug being prescribed; (iii) performed or caused to be performed an appropriate examination of the patient, either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically; and (iv) initiated additional interventions and follow-up care, if necessary, especially if a prescribed drug may have serious side effects. Except in cases involving a medical emergency, the examination required pursuant to clause (iii) shall be performed by the practitioner prescribing the controlled substance, a practitioner who practices in the same group as the practitioner prescribing the controlled substance, or a consulting practitioner. In cases in which the practitioner is an employee of the Department of Health and is providing expedited partner therapy consistent with the recommendations of the Centers for Disease Control and Prevention, the examination required by clause (iii) shall not be required.

A practitioner who has established a bona fide practitioner-patient relationship with a patient in accordance with the provisions of this subsection may prescribe Schedule II through VI controlled substances to that patient, provided that, in cases in which the practitioner has performed the examination required pursuant to clause (iii) by use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically, the prescribing of such Schedule II through V controlled substance is in compliance with federal requirements for the practice of telemedicine.

For the purpose of prescribing a Schedule VI controlled substance to a patient via telemedicine services as defined in § 38.2-3418.16, a prescriber may establish a bona fide practitioner-patient relationship by an examination through face-to-face interactive, two-way, real-time communications services or store-and-forward technologies[3] *when all of the following conditions are met: (a) the patient has provided a medical history that is available for review by the prescriber; (b) the prescriber obtains an updated medical history at the time of prescribing; (c) the prescriber makes a diagnosis at the time of prescribing; (d) the prescriber conforms to the standard of care expected of in-person care as appropriate to the*

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

patient's age and presenting condition, including when the standard of care requires the use of diagnostic testing and performance of a physical examination, which may be carried out through the use of peripheral devices appropriate to the patient's condition; (e) the prescriber is actively licensed in the Commonwealth and authorized to prescribe; (f) if the patient is a member or enrollee of a health plan or carrier, the prescriber has been credentialed by the health plan or carrier as a participating provider and the diagnosing and prescribing meets the qualifications for reimbursement by the health plan or carrier pursuant to § 38.2-3418.16; and (g) upon request, the prescriber provides patient records in a timely manner in accordance with the provisions of § 32.1-127.1:03 and all other state and federal laws and regulations. Nothing in this paragraph shall permit a prescriber to establish a bona fide practitioner-patient relationship for the purpose of prescribing a Schedule VI controlled substance when the standard of care dictates that an in-person physical examination is necessary for diagnosis. Nothing in this paragraph shall apply to: (1) a prescriber providing on-call coverage per an agreement with another prescriber or his prescriber's professional entity or employer; (2) a prescriber consulting with another prescriber regarding a patient's care; or (3) orders of prescribers for hospital out-patients or in-patients.

Any practitioner who prescribes any controlled substance with the knowledge that the controlled substance will be used otherwise than medicinally or for therapeutic purposes shall be subject to the criminal penalties provided in § 18.2-248 for violations of the provisions of law relating to the distribution or possession of controlled substances.

§ 54.1-3408.01. Requirements for prescriptions.

A. The written prescription referred to in § 54.1-3408 shall be written with ink or individually typed or printed. The prescription shall contain the name, address, and telephone number of the prescriber. A prescription for a controlled substance other than one controlled in Schedule VI shall also contain the federal controlled substances registration number assigned to the prescriber. The prescriber's information shall be either preprinted upon the prescription blank, electronically printed, typewritten, rubber stamped, or printed by hand.

The written prescription shall contain the first and last name of the patient for whom the drug is prescribed. The address of the patient shall either be placed upon the written prescription by the prescriber or his agent, or by the dispenser of the prescription. If not otherwise prohibited by law, the dispenser may record the address of the patient in an electronic prescription dispensing record for that patient in lieu of recording it on the prescription. Each written prescription shall be dated as of, and signed by the prescriber on, the day when issued. The prescription may be prepared by an agent for the prescriber's signature.

This section shall not prohibit a prescriber from using preprinted prescriptions for drugs classified in Schedule VI if all requirements concerning dates, signatures, and other information specified above are otherwise fulfilled.

No written prescription order form shall include more than one prescription. However, this provision shall not apply (i) to prescriptions written as chart orders for patients in hospitals and long-term-care facilities, patients receiving home infusion services or hospice patients, or (ii) to a prescription ordered through a pharmacy operated by or for the Department of Corrections or the Department of Juvenile Justice, the central pharmacy of the Department of Health, or the central outpatient pharmacy operated by the Department of Behavioral Health and Developmental Services; or (iii) to prescriptions written for patients residing in adult and juvenile detention centers, local or regional jails, or work release centers operated by the Department of Corrections.

B. Prescribers' orders, whether written as chart orders or prescriptions, for Schedules II, III, IV, and V controlled drugs to be administered to (i) patients or residents of long-term care facilities served by a Virginia pharmacy from a remote location or (ii) patients receiving parenteral, intravenous, intramuscular, subcutaneous or intraspinal infusion therapy and served by a home infusion pharmacy from a remote location, may be transmitted to that remote pharmacy by an electronic communications device over telephone lines which send the exact image to the receiver in hard copy form, and such facsimile copy shall be treated as a valid original prescription order. If the order is for a radiopharmaceutical, a physician authorized by state or federal law to possess and administer medical radioactive materials may authorize a nuclear medicine technologist to transmit a prescriber's verbal or written orders for radiopharmaceuticals.

C. The oral prescription referred to in § 54.1-3408 shall be transmitted to the pharmacy of the patient's choice by the prescriber or his authorized agent. For the purposes of this section, an authorized agent of the prescriber shall be an employee of the prescriber who is under his immediate and personal supervision, or if not an employee, an individual who holds a valid license allowing the administration or dispensing of drugs and who is specifically directed by the prescriber.

§ 54.1-2901. Exceptions and exemptions generally.

A. The provisions of this chapter shall not prevent or prohibit:

15. Any legally qualified out-of-state or foreign practitioner from meeting in consultation with legally licensed practitioners in this Commonwealth;

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CHAPTER 301

*An Act to amend and reenact §§ **32.1-325**, **38.2-3418.16**, and **54.1-3303** of the Code of Virginia, relating to telemedicine.*

[H 1987]
Approved March 24, 2021

Be it enacted by the General Assembly of Virginia:

1. That §§ **32.1-325**, **38.2-3418.16**, and **54.1-3303** of the Code of Virginia are amended and reenacted as follows:

§ **32.1-325**. Board to submit plan for medical assistance services to U.S. Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time, and submit to the U.S. Secretary of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of 21, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of $3,500 for the individual and an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for the payment for family planning services on behalf of women who were Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning services shall begin with delivery and continue for a period of 24 months, if the woman continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the purposes of this section, family planning services shall not cover payment for abortion services and no funds shall be used to perform, assist, encourage or make direct referrals for abortions;

8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

9. A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance, which shall include a requirement that such entities (i) obtain accurate contact information, including the best available address and telephone number, from each applicant for medical assistance, to the extent required by federal law and regulations, and (ii) provide each applicant for medical assistance with information about advance directives pursuant to Article 8 (§ **54.1-2981** et seq.) of Chapter 29 of Title 54.1, including information about the purpose and benefits of advance directives and how the applicant may make an advance directive;

10. A provision for breast reconstructive surgery following the medically necessary removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

11. A provision for payment of medical assistance for annual pap smears;

12. A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

13. A provision for payment of medical assistance which provides for payment for 48 hours of inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

14. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician, physician assistant, or nurse practitioner and in the durable medical equipment provider's possession within 60 days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons age 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen;

16. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast;

17. A provision, when in compliance with federal law and regulation and approved by the Centers for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid program and may be provided by school divisions;

18. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant center where the surgery is proposed to be performed have been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living;

19. A provision for payment of medical assistance for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;

20. A provision for payment of medical assistance for custom ocular prostheses;

21. A provision for payment for medical assistance for infant hearing screenings and all necessary audiological examinations provided pursuant to § **32.1-64.1** using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such provision shall include payment for medical assistance for follow-up audiological examinations as recommended by a physician, physician assistant,

nurse practitioner, or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss;

22. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. **106-354**), for certain women with breast or cervical cancer when such women (i) have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v) have not attained age 65. This provision shall include an expedited eligibility determination for such women;

23. A provision for the coordinated administration, including outreach, enrollment, re-enrollment and services delivery, of medical assistance services provided to medically indigent children pursuant to this chapter, which shall be called Family Access to Medical Insurance Security (FAMIS) Plus and the FAMIS Plan program in § **32.1-351**. A single application form shall be used to determine eligibility for both programs;

24. A provision, when authorized by and in compliance with federal law, to establish a public-private long-term care partnership program between the Commonwealth of Virginia and private insurance companies that shall be established through the filing of an amendment to the state plan for medical assistance services by the Department of Medical Assistance Services. The purpose of the program shall be to reduce Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid for such services through encouraging the purchase of private long-term care insurance policies that have been designated as qualified state long-term care insurance partnerships and may be used as the first source of benefits for the participant's long-term care. Components of the program, including the treatment of assets for Medicaid eligibility and estate recovery, shall be structured in accordance with federal law and applicable federal guidelines;

25. A provision for the payment of medical assistance for otherwise eligible pregnant women during the first five years of lawful residence in the United States, pursuant to § 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. **111-3**);~~ and~~

26. A provision for the payment of medical assistance for medically necessary health care services provided through telemedicine services, as defined in § **38.2-3418.16**, regardless of the originating site or whether the patient is accompanied by a health care provider at the time such services are provided. No health care provider who provides health care services through telemedicine services shall be required to use proprietary technology or applications in order to be reimbursed for providing telemedicine services.

For the purposes of this subdivision, "originating site" means any location where the patient is located, including any medical care facility or office of a health care provider, the home of the patient, the patient's place of employment, or any public or private primary or secondary school or postsecondary institution of higher education at which the person to whom telemedicine services are provided is located*; and*

*27. A provision for payment of medical assistance for remote patient monitoring services provided via telemedicine, as defined in § **38.2-3418.16**, for (i) high-risk pregnant persons; (ii) medically complex infants and children; (iii) transplant patients; (iv) patients who have undergone surgery, for up to three months following the date of such surgery; and (v) patients with a chronic health condition who have had two or more hospitalizations or emergency department visits related to such chronic health condition in the previous 12 months. For the purposes of this*

subdivision, "remote patient monitoring services" means the use of digital technologies to collect medical and other forms of health data from patients in one location and electronically transmit that information securely to health care providers in a different location for analysis, interpretation, and recommendations, and management of the patient. "Remote patient monitoring services" includes monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other patient physiological data, treatment adherence monitoring, and interactive videoconferencing with or without digital image upload.

B. In preparing the plan, the Board shall:

1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured.

2. Initiate such cost containment or other measures as are set forth in the appropriation act.

3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

4. Examine, before acting on a regulation to be published in the Virginia Register of Regulations pursuant to § **2.2-4007.05**, the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

5. Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq. "Enforcement of Compliance for Long-Term Care Facilities With Deficiencies."

6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or other technology that complies with the requirements set forth in § **38.2-3407.4:2** be issued to each recipient of medical assistance services, and shall upon any changes in the required data elements set forth in subsection A of § **38.2-3407.4:2**, either reissue the card or provide recipients such corrective information as may be required to electronically process a prescription claim.

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ **2.2-4006** et seq.) of Chapter 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § **2.2-4002**, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments that are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

D. The Director of Medical Assistance Services is authorized to:

1. Administer such state plan and receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or contract, with any provider who has been convicted of or otherwise pled guilty to a felony, or pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider as required by 42 C.F.R. § 1002.212.

4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or contract, with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of or otherwise pled guilty to any violation of § **32.1-314**, **32.1-315**, **32.1-316**, or **32.1-317**, or any other felony or has been excluded from participation in any federal program pursuant to 42 C.F.R. Part 1002.

5. Terminate or suspend a provider agreement with a home care organization pursuant to subsection E of § **32.1-162.13**.

For the purposes of this subsection, "provider" may refer to an individual or an entity.

E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R. § 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative Process Act (§ **2.2-4000** et seq.). All such requests shall be in writing and be received within 15 days of the date of receipt of the notice.

The Director may consider aggravating and mitigating factors including the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients. In cases in which an agreement or contract is terminated pursuant to subsection D, the Director may determine the period of exclusion and may consider aggravating and mitigating factors to lengthen or shorten the period of exclusion, and may reinstate the provider pursuant to 42 C.F.R. § 1002.215.

F. When the services provided for by such plan are services which a marriage and family therapist, clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist, duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

G. The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance services as may be permitted by federal law to establish a program of family assistance whereby children over the age of 18 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

H. The Department of Medical Assistance Services shall:

1. Include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of 21 who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an exception, with procedural requirements, to mandatory enrollment for certain children between birth and age three certified by the Department of Behavioral Health and Developmental Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

3. Utilize, to the extent practicable, electronic funds transfer technology for reimbursement to contractors and enrolled providers for the provision of health care services under Medicaid and the Family Access to Medical Insurance Security Plan established under § **32.1-351**.

4. Require any managed care organization with which the Department enters into an agreement for the provision of medical assistance services to include in any contract between the managed care organization and a pharmacy benefits manager provisions prohibiting the pharmacy benefits manager or a representative of the pharmacy benefits manager from conducting spread pricing with regards to the managed care organization's managed care plans. For the purposes of this subdivision:

"Pharmacy benefits management" means the administration or management of prescription drug benefits provided by a managed care organization for the benefit of covered individuals.

"Pharmacy benefits manager" means a person that performs pharmacy benefits management.

"Spread pricing" means the model of prescription drug pricing in which the pharmacy benefits manager charges a managed care plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.

I. The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

J. Except as provided in subdivision A 1 of § **2.2-4345**, the provisions of the Virginia Public Procurement Act (§ **2.2-4300** et seq.) shall not apply to the activities of the Director authorized by subsection I of this section. Agreements made pursuant to this subsection shall comply with federal law and regulation.

§ **38.2-3418.16**. Coverage for telemedicine services.

A. Notwithstanding the provisions of § **38.2-3419**, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine services, as provided in this section.

B. As used in this section:

"Originating site" means the location where the patient is located at the time services are provided by a health care provider through telemedicine services.

"Remote patient monitoring services" means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

"Telemedicine services" as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, or consulting with other health care providers regarding a patient's diagnosis or treatment, regardless of the originating site and whether the patient is accompanied by a health care provider at the time such services are provided. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire. *Nothing in this section shall preclude coverage for a service that is not a telemedicine service, including services delivered through real-time audio-only telephone.*

C. An insurer, corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

D. An insurer, corporation, or health maintenance organization shall not be required to reimburse the treating provider or the consulting provider for technical fees or costs for the provision of telemedicine services; however, such insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through face-to-face consultation or contact. No insurer, corporation, or health maintenance organization shall require a provider to use proprietary technology or applications in order to be reimbursed for providing telemedicine services.

E. Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of telemedicine services, provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan. Any such utilization review shall not require pre-authorization of emergent telemedicine services.

F. An insurer, corporation, or health maintenance organization may offer a health plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services, provided that the deductible, copayment, or coinsurance does not exceed the deductible, copayment, or coinsurance applicable if the same services were provided through face-to-face diagnosis, consultation, or treatment.

G. No insurer, corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

H. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2021, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

I. This section shall not apply to short-term travel, accident-only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under federal governmental plans.

J. The coverage required by this section shall include the use of telemedicine technologies as it pertains to medically necessary remote patient monitoring services to the full extent that these services are available.

K. Prescribing of controlled substances via telemedicine shall comply with the requirements of § **54.1-3303** and all applicable federal law.

§ **54.1-3303**. Prescriptions to be issued and drugs to be dispensed for medical or therapeutic purposes only.

A. A prescription for a controlled substance may be issued only by a practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine who is authorized to prescribe controlled substances, or by a licensed nurse practitioner pursuant to § **54.1-2957.01**, a licensed physician assistant pursuant to § **54.1-2952.1**, or a TPA-certified optometrist pursuant to Article 5 (§ **54.1-3222** et seq.) of Chapter 32.

B. A prescription shall be issued only to persons or animals with whom the practitioner has a bona fide practitioner-patient relationship or veterinarian-client-patient relationship. If a practitioner is providing expedited partner therapy consistent with the recommendations of the Centers for Disease Control and Prevention, then a bona fide practitioner-patient relationship shall not be required.

A bona fide practitioner-patient relationship shall exist if the practitioner has (i) obtained or caused to be obtained a medical or drug history of the patient; (ii) provided information to the patient about the benefits and risks of the drug being prescribed; (iii) performed or caused to be performed an appropriate examination of the patient, either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically; and (iv) initiated additional interventions and follow-up care, if necessary, especially if a prescribed drug may have serious side effects. Except in cases involving a medical emergency, the examination required pursuant to clause (iii) shall be performed by the practitioner prescribing the controlled substance, a practitioner who practices in the same group as the practitioner prescribing the controlled substance, or a consulting practitioner.

A practitioner who has established a bona fide practitioner-patient relationship with a patient in accordance with the provisions of this subsection may prescribe Schedule II through VI controlled substances to that patient~~, provided that, in cases in which the practitioner has performed the examination required pursuant to clause (iii) by use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically, the~~*.*

A practitioner who has established a bona fide practitioner-patient relationship with a patient in accordance with the provisions of this subsection may prescribe Schedule II through VI controlled substances to that patient via telemedicine if such prescribing is in compliance with federal requirements for the practice of telemedicine and, in the case of the prescribing of ~~such~~ *a* Schedule II through V controlled substance ~~is in compliance with federal requirements for the practice of telemedicine~~*, the prescriber maintains a practice at a physical location in the Commonwealth or is able to make appropriate referral of patients to a licensed practitioner located in the Commonwealth in order to ensure an in-person examination of the patient when required by the standard of care.*

~~For the purpose of prescribing a Schedule VI controlled substance to a patient via telemedicine services as defined in §~~ **38.2-3418.16**~~, a~~ *A* prescriber may establish a bona fide practitioner-patient relationship *for the purpose of prescribing Schedule II through VI controlled substances* by an examination through face-to-face interactive, two-way, real-time communications services or store-and-forward technologies when all of the following conditions are met: (a) the patient has provided a medical history that is available for review by the prescriber; (b) the prescriber obtains an updated medical history at the time of prescribing; (c) the prescriber makes a diagnosis at the time of prescribing; (d) the prescriber conforms to the standard of care expected of in-person care as appropriate to the patient's age and presenting condition, including when the standard of care requires the use of diagnostic testing and performance of a physical examination, which may be carried out through the use of peripheral devices appropriate to the patient's condition; (e) the prescriber is actively licensed in the Commonwealth and authorized to prescribe; (f) if the patient is a member or enrollee of a health plan or carrier, the prescriber has been credentialed by the health plan or carrier as a participating provider and the diagnosing and prescribing meets the qualifications for reimbursement by the health plan or carrier pursuant to § **38.2-3418.16**; ~~and~~ (g) upon request, the prescriber provides patient records in a timely manner in accordance with the provisions of § **32.1-127.1:03** and all other state and federal laws and regulations~~. Nothing in this paragraph shall permit a prescriber to establish a bona fide practitioner-patient relationship for the purpose of prescribing a Schedule VI controlled substance when the standard of care dictates that an in-person physical examination is necessary for diagnosis~~*; (h) the establishment of a bona fide practitioner-patient relationship via telemedicine is consistent with the standard of care, and the standard of care does not require an in-person examination for the purpose of diagnosis; and (i) the establishment of a bona fide practitioner patient relationship via telemedicine is consistent with federal law and regulations and any waiver thereof.* Nothing in this paragraph shall apply to~~:~~ (1) a prescriber providing on-call coverage per an agreement with another prescriber or his prescriber's professional entity or employer; (2) a prescriber consulting with another prescriber regarding a patient's care; or (3) orders of prescribers for hospital out-patients or in-patients.

For purposes of this section, a bona fide veterinarian-client-patient relationship is one in which a veterinarian, another veterinarian within the group in which he practices, or a veterinarian with whom he is consulting has assumed the responsibility for making medical judgments regarding the health of and providing medical treatment to an animal as defined in § **3.2-6500**, other than an equine as defined in § **3.2-6200**, a group of agricultural animals as defined in § **3.2-6500**, or bees as defined in § **3.2-4400**, and a client who is the owner or other caretaker of the animal, group of agricultural animals, or bees has consented to such treatment and agreed to follow the instructions of the veterinarian. Evidence that a veterinarian has assumed responsibility for making medical judgments regarding the health of and providing medical treatment to an animal, group of agricultural animals, or bees shall include evidence that the veterinarian (A) has sufficient knowledge of the animal, group of agricultural animals, or bees to provide a

general or preliminary diagnosis of the medical condition of the animal, group of agricultural animals, or bees; (B) has made an examination of the animal, group of agricultural animals, or bees, either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically or has become familiar with the care and keeping of that species of animal or bee on the premises of the client, including other premises within the same operation or production system of the client, through medically appropriate and timely visits to the premises at which the animal, group of agricultural animals, or bees are kept; and (C) is available to provide follow-up care.

C. A prescription shall only be issued for a medicinal or therapeutic purpose in the usual course of treatment or for authorized research. A prescription not issued in the usual course of treatment or for authorized research is not a valid prescription. A practitioner who prescribes any controlled substance with the knowledge that the controlled substance will be used otherwise than for medicinal or therapeutic purposes shall be subject to the criminal penalties provided in § **18.2-248** for violations of the provisions of law relating to the distribution or possession of controlled substances.

D. No prescription shall be filled unless a bona fide practitioner-patient-pharmacist relationship exists. A bona fide practitioner-patient-pharmacist relationship shall exist in cases in which a practitioner prescribes, and a pharmacist dispenses, controlled substances in good faith to a patient for a medicinal or therapeutic purpose within the course of his professional practice.

In cases in which it is not clear to a pharmacist that a bona fide practitioner-patient relationship exists between a prescriber and a patient, a pharmacist shall contact the prescribing practitioner or his agent and verify the identity of the patient and name and quantity of the drug prescribed.

Any person knowingly filling an invalid prescription shall be subject to the criminal penalties provided in § **18.2-248** for violations of the provisions of law relating to the sale, distribution or possession of controlled substances.

E. Notwithstanding any provision of law to the contrary and consistent with recommendations of the Centers for Disease Control and Prevention or the Department of Health, a practitioner may prescribe Schedule VI antibiotics and antiviral agents to other persons in close contact with a diagnosed patient when (i) the practitioner meets all requirements of a bona fide practitioner-patient relationship, as defined in subsection B, with the diagnosed patient and (ii) in the practitioner's professional judgment, the practitioner deems there is urgency to begin treatment to prevent the transmission of a communicable disease. In cases in which the practitioner is an employee of or contracted by the Department of Health or a local health department, the bona fide practitioner-patient relationship with the diagnosed patient, as required by clause (i), shall not be required.

F. A pharmacist may dispense a controlled substance pursuant to a prescription of an out-of-state practitioner of medicine, osteopathy, podiatry, dentistry, optometry, or veterinary medicine, a nurse practitioner, or a physician assistant authorized to issue such prescription if the prescription complies with the requirements of this chapter and the Drug Control Act (§ **54.1-3400** et seq.).

G. A licensed nurse practitioner who is authorized to prescribe controlled substances pursuant to § **54.1-2957.01** may issue prescriptions or provide manufacturers' professional samples for controlled substances and devices as set forth in the Drug Control Act (§ **54.1-3400** et seq.) in good faith to his patient for a medicinal or therapeutic purpose within the scope of his professional practice.

H. A licensed physician assistant who is authorized to prescribe controlled substances pursuant to § **54.1-2952.1** may issue prescriptions or provide manufacturers' professional samples for controlled substances and devices as set forth in the Drug Control Act (§ **54.1-3400** et seq.) in good faith to his patient for a medicinal or therapeutic purpose within the scope of his professional practice.

I. A TPA-certified optometrist who is authorized to prescribe controlled substances pursuant to Article 5 (§ **54.1-3222** et seq.) of Chapter 32 may issue prescriptions in good faith or provide manufacturers' professional samples to his patients for medicinal or therapeutic purposes within the scope of his professional practice for the drugs specified on the TPA-Formulary, established pursuant to § **54.1-3223**, which shall be limited to (i) analgesics included on Schedule II controlled substances as defined in § **54.1-3448** of the Drug Control Act (§ **54.1-3400** et seq.) consisting of hydrocodone in combination with acetaminophen; (ii) oral analgesics included in Schedules III through VI, as defined in §§ **54.1-3450** and **54.1-3455** of the Drug Control Act (§ **54.1-3400** et seq.), which are appropriate to relieve ocular pain; (iii) other oral Schedule VI controlled substances, as defined in § **54.1-3455** of the Drug Control Act, appropriate to treat diseases and abnormal conditions of the human eye and its adnexa; (iv) topically applied Schedule VI drugs, as defined in § **54.1-3455** of the Drug Control Act; and (v) intramuscular administration of epinephrine for treatment of emergency cases of anaphylactic shock.

J. The requirement for a bona fide practitioner-patient relationship shall be deemed to be satisfied by a member or committee of a hospital's medical staff when approving a standing order or protocol for the administration of influenza vaccinations and pneumococcal vaccinations in a hospital in compliance with § **32.1-126.4**.

K. Notwithstanding any other provision of law, a prescriber may authorize a registered nurse or licensed practical nurse to approve additional refills of a prescribed drug for no more than 90 consecutive days, provided that (i) the drug is classified as a Schedule VI drug; (ii) there are no changes in the prescribed drug, strength, or dosage; (iii) the prescriber has a current written protocol, accessible by the nurse, that identifies the conditions under which the nurse may approve additional refills; and (iv) the nurse documents in the patient's chart any refills authorized for a specific patient pursuant to the protocol and the additional refills are transmitted to a pharmacist in accordance with the allowances for an authorized agent to transmit a prescription orally or by facsimile pursuant to subsection C of § **54.1-3408.01** and regulations of the Board.

2. That the Department of Medical Assistance Services shall adopt regulations for reimbursement for telemedicine services delivered through audio-only telephone, which shall include regulations for (i) services that may be delivered via audio-only telephone, (ii) reimbursement rates for services delivered via audio-only telephone, and (iii) such other regulations as the Department of Medical Assistance Services may deem necessary.

3. That the Department of Medical Assistance Services shall promulgate and adopt uniform regulations for remote patient monitoring for all Medicaid managed care organizations to implement and follow.

Virginia Board of Medicine
PROPOSED - 2022 Board Meeting Dates

Full Board Meetings

February TBA	DHP/Richmond, VA	Board Rooms TBA
June TBA	DHP/Richmond, VA	Board Rooms TBA
October 6-8	DHP/Richmond, VA	Board Rooms TBA

Times for the above meetings are 8:30 a.m. to 5:00 p.m.

Executive Committee Meetings

April 8	DHP/Richmond, VA	Board Rooms TBA
August 5	DHP/Richmond, VA	Board Rooms TBA
December 2	DHP/Richmond, VA	Board Rooms TBA

Times for the above meetings are 8:30 a.m. to 5:00 p.m.

Legislative Committee Meetings

January 14	DHP/Richmond, VA	Board Rooms TBA
May 6	DHP/Richmond, VA	Board Rooms TBA
September 16	DHP/Richmond, VA	Board Rooms TBA

Times for the above meetings are 8:30 a.m. to 1:00 p.m.

Credentials Committee Meetings

January 5	May 10	September 7
February 9	June 7	October 19
March 9	July 12	November (TBA)
April 13	August 17	December (TBA)

Times for the Credentials Committee meetings - TBA

Joint Boards of Medicine and Nursing

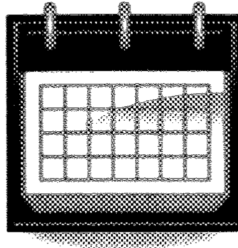
TBA

Advisory Board on:

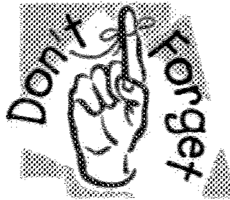
Board			Time
Behavioral Analysts			**10:00 a.m.**
Mon -January 31	May 23	September 19	
Genetic Counseling			**1:00 p.m.**
Mon - January 31	May 23	September 19	
Occupational Therapy			**10:00 a.m.**
Tues – February 1	May 24	September 20	
Respiratory Care			**1:00 p.m.**
Tues - February 1	May 24	September 20	
Acupuncture			**10:00 a.m.**
Wed - February 2	May 25	September 21	
Radiological Technology			**1:00 p.m.**
Wed - February 2	May 25	September 21	
Athletic Training			**10:00 a.m.**
Thurs - February 3	May 26	September 22	
Physician Assistants			**1:00 p.m.**
Thurs - February 3	May 26	September 22	
Midwifery			**10:00 a.m.**
Fri - February 4	May 27	September 23	
Polysomnographic Technology			**1:00 p.m.**
Fri - February 4	May 27	September 23	
Surgical Assisting			**10:00 a.m.**
Mon - February 7	Tues – May 31	September 26	

Next Meeting Date of the Full Board is

October 14-16, 2021



Please check your calendars and advise staff of any known conflicts that may affect your attendance.



If you are not a state employee, you are eligible for a $50.00 per diem and reimbursement of your mileage.

The travel regulations require that "travelers must submit the Travel Expense Reimbursement Voucher with 30 days after completion of their trip". (CAPP Topic 20335, State Travel Regulations, p.7)

In order for the agency to be in compliance with the state travel regulations, please submit your request for today's meeting no later than

July 24, 2021

See Co-Co for guidelines on submitting your travel voucher electronically.