Meeting of the Virginia Board of Medicine

October 6, 2022
8:30 a.m.

Virginia Department of
Health Professions

PERIMETER CENTER CONFERENCE CENTER
EMERGENCY EVACUATION OF BOARD AND TRAINING ROOMS

(Script to be read at the beginning of each meeting.)

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Board Room 2

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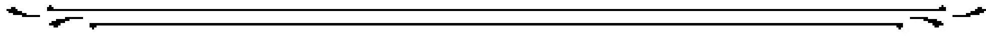

Board of Medicine

Thursday, October 6, 2022 @ 8:30 a.m.
Perimeter Center
9960 Mayland Drive, Suite 201
Board Room 2
Henrico, VA 23233

Call to Order and Roll Call

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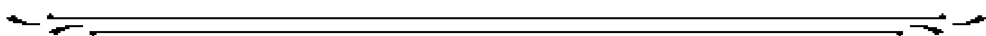

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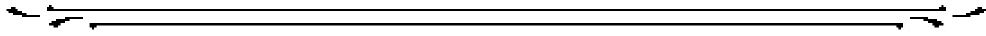

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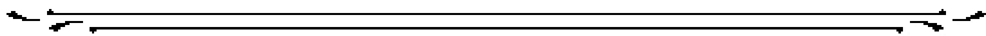
====No motion needed to adjourn if all business has been conducted====



Agenda Item: **Approval of Minutes of the June 16, 2022**

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

Action: Motion to approve minutes.

---DRAFT UNAPPROVED---

VIRGINIA BOARD OF MEDICINE
FULL BOARD MINUTES

June 16, 2022 | Department of Health Professions | Henrico, VA 23233

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

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

MEMBERS PRESENT:
Blanton Marchese – President & Chair
James Arnold, DPM
Amanda Barner, MD - Secretary-Treasurer
Manjit Dhillon, MD
Jane Hickey, JD
Oliver Kim, JD
Jacob Miller, DO
Pradeep Pradhan, MD
Milly Rambhia, MD
Karen Ransone, MD
Jennifer Rathmann, DC
Joel Silverman, MD
Brenda Stokes, MD
Ryan Williams, MD
Khalique Zahir, MD

MEMBERS ABSENT:
David Archer, MD – Vice-President
Alvin Edwards, MDiv, PhD
Madge Ellis, MD

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

OTHERS PRESENT:
Jennie Wood – Board Staff
Tamika Hines - Board Staff
India Clark – Board Staff
Shermin Uzair – Board Staff

---DRAFT UNAPPROVED---

Christy Evanko – Virginia Association for Behavior Analysis
W. Scott Johnson, JD – Hancock Daniel & Johnson, P.C.
Kelsey Wilkinson – Medical Society of Virginia

EMERGENCY EGRESS INSTRUCTIONS

Dr. Barner provided the emergency egress instructions for Board Room 2.

APPROVAL OF MINUTES OF FEBRUARY 17, 2022

Dr. Ransone moved to approve the minutes from February 17, 2022 as presented. The motion was properly seconded by Dr. Miller and carried unanimously.

ADOPTION OF AGENDA

Dr. Ransone moved to approve the agenda as presented. The motion was properly seconded by Dr. Miller and carried unanimously.

PUBLIC COMMENT

None.

PRESENTATION ON BOX

Michelle Schmitz, Director of DHP Enforcement, gave a presentation on BOX for the Board members. The demonstration will help Board members with remote review of Board documents.

DHP DIRECTOR'S REPORT

Dr. Brown reminded the Board of Dr. Allison-Bryan's retirement from DHP, her practice as a pediatrician, and how she will be greatly missed. He reported that DHP is still in transition with the Youngkin Administration. He said that right now the focus for the Administration has been the budget of the Commonwealth. On its agenda, the Administration wants all agencies to review and reduce their regulations by 25%. Dr. Brown emphasized that DHP has many gubernatorial appointees, many professions, many regulations, and many meetings. He noted that it will be a lot of work to go through all the regulations and decide what can be removed. Governor Youngkin is also interested in healthcare workforce issues, especially maximizing access to Primary Care and Behavioral Health professionals. The appointments of the DHP Director and DHP Senior Deputy have not yet been addressed.

---DRAFT UNAPPROVED---

REPORTS OF OFFICERS AND EXECUTIVE DIRECTOR

PRESIDENT

Mr. Marchese reported that Jane Hickey, Michael Sobowale and he attended the Federation of State Medical Boards Annual Meeting in New Orleans April 28-30, In addition, he gave an update on HB1323 and said that he needs to appoint 3 Board members from Medicine to serve alongside 3 Board members from Pharmacy in a Work Group to further develop the Statewide Pharmacy Protocols. The meeting will be held August 8, 2022. Lastly, Mr. Marchese took a moment to acknowledge Dr. Stokes for her time and dedication to the Board. Dr. Harp added that Dr. Stokes had been redistricted, and her first term expires at the end of the month.

VICE-PRESIDENT

No report.

SECRETARY-TREASURER

No report.

EXECUTIVE DIRECTOR

Dr. Harp provided an update on Reciprocal Licensing with Maryland and DC:

- He said that pursuant to 2020 legislation, Virginia, Maryland and DC have been meeting virtually throughout 2021 and 2022. The 2022 General Assembly again tasked the Board with pursuing reciprocal licensing in the region. At the last tri-jurisdictional meeting on June 3, 2022, plans were made to have a draft Memorandum of Understanding and draft applications by the next meeting on June 24, 2022.
- Dr. Harp stated that Virginia IT and Maryland IT talked about a licensing process that would utilize "pinging" for license verifications. However, Maryland currently has system issues, and DC's IT plate is full. The coordination of IT systems will take a while to get going, but the Boards can begin with a manual process that designates an employee with a dedicated email box and phone number to process license verifications.
- Dr. Harp informed the Board that Maryland has 8,000 physicians licensed in Virginia, and 7,000 licensed in DC. The Maryland Executive Director proposed a three-in-one license. Dr. Harp said this would require an initial license to be issued through a traditional pathway in one jurisdiction with the other two states then reciprocating. In regard to draft applications, Virginia's traditional application has 17 questions, whereas the draft reciprocal application has 7 questions. Maryland and DC require criminal background checks, and DC requires evidence of COVID-19 vaccination.

---DRAFT UNAPPROVED---

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

COMMITTEE AND ADVISORY BOARD REPORTS

Dr. Harp stated that on p. 41 of the agenda packet, "Robert Glasson" needed to be corrected to "Robert Glasgow."

Dr. Ransone moved to accept all reports en bloc since February 17, 2022. The motion was properly seconded by Dr. Miller and carried unanimously.

OTHER REPORTS

Board Counsel

Charis Mitchell, JD reported that the Office of the Attorney General is still searching for a permanent Board of Medicine Counsel.

This report was for informational purposes only.

Board of Health Professions

No report.

Meeting Minutes for the March 29, 2022 Full Board meeting were in the agenda packet on pages 50-52.

Podiatry Report

No report.

Chiropractor Report

Dr. Rathmann reported that she attended the Federation of Chiropractic Licensing Boards Annual Conference in May. She said a number of interesting topics were presented and discussed.

This report was for informational purposes only.

Committee of Joint Boards of Nursing and Medicine

No report

---DRAFT UNAPPROVED---

Meeting Minutes for the February 16, 2022 meeting were in the agenda packet on pages 53-59. Meeting Minutes for the April 20, 2022 meeting were on pages 60-66.

NEW BUSINESS

1. **Current Legislative and Regulatory Actions/Considerations - Erin Barrett**

Current Regulatory Actions

Ms. Barrett presented the chart of regulatory actions as of May 24, 2022 noting the following:

18 VAC 85-80 – Proposed regulations for the implementation of the OT Compact have been in the Office of the Attorney General for 42 days. They are to replace the current emergency regulations.

18VAC85-160 – Proposed regulations were published in the Register 12/30/2021 to conform the regulations with the law that moves surgical assistants from certification to licensure.

2. **Initiation of Periodic Review**

Ms. Barrett reminded the Board that its regulations need to be reviewed and revised at least every 4 years. She said Board of Medicine Regulations Chapters 15, 20, 40, 50, 80, 101, 110, 120, 130, 140, 150, 160, and 170 are up for periodic review.

ACTION: Dr. Williams moved to review the following chapters: 15, 20, 40, 50, 80, 101, 110, 120, 130, 140, 150, 160, and 170. The motion was properly seconded by Dr. Ransone and carried unanimously.

3. **Amending Guidance Document 85-17**

Ms. Barret reviewed Guidance Document 85-17 Supervisory Responsibilities of an Occupational Therapist, and pointed out minor revisions to some of the answers to questions in the document.

ACTION: Dr. Ransone moved to amend Guidance Document 85-17 as recommended by Ms. Barrett. The motion was properly seconded by Dr. Dhillon and carried unanimously.

4. **Adoption of Final Regulations for Licensure of Surgical Assistants**

Ms. Barrett referred Board members to the Town Hall summary page for the text of proposed final regulations for the licensure of surgical assistants. She reviewed the changes as shown.

ACTION: Dr. Arnold moved to adopt final regulations for the licensure of surgical assistants. The motion was properly seconded by Dr. Stokes and carried unanimously.

5. **Fast-Track Action Related to Reinstatement of Surgical Technologists**

    This action was to address the lack of a reinstatement process for surgical technologists.

ACTION: Dr. Arnold moved to adopt the fast-track action. The motion was properly seconded by Dr. Stokes and carried unanimously.

6. **Consideration of Legislative Proposal for Surgical Assistant & Surgical Technologist Applicants**

    Dr. Arnold inquired about the pass rate of surgical technologists and assistants. Ms. Barrett said that one school reported the pass rate to be approximately 90%. Dr. Stokes asked the typical wait time for students to receive their scores, and Ms. Barrett responded that it could be a couple of weeks. Dr. Williams asked if the allowance could be 3 months, instead of 6 months. Dr. Harp said the professions that have this provision to practice prior to passing their exam all have 6 months.

ACTION: Dr. Ransone moved to refer this proposal to the Legislative Committee for review. The motion was properly seconded by Dr. Miller and carried unanimously.

7. **Consideration of Regulations for Licensure of Licensed Certified Midwives**

    Ms. Barrett explained to the Board the differences between a "licensed midwife" and a "licensed certified midwife" to ensure that the Board members understood.

ACTION: Dr. Williams moved to adopt proposed regulations governing the licensure of licensed certified midwives. The motion was properly seconded by Dr. Stokes and carried unanimously.

8. **Consideration of Response to Petition for Rule-Making – QBAB**

    Ms. Barrett presented the Board the recommendations from the Advisory Board on Behavior Analysis. She said the Advisory Board is requesting that the Board initiate rule-making to conform the regulations with the language in Section 54.1-2957.16(B)(1) of the Code of Virginia, and further to define entities that are "nationally accredited to certify practitioners of behavior analysis".

ACTION: Dr. Miller moved to refer this matter to the Legislative Committee. The motion was properly seconded by Dr. Zahir and carried unanimously.

9. Consideration of Response to Petition for Rule-making – Masking

Ms. Barrett presented the Board with the petition for rule-making on masking from Michael Schulz. The petitioner requested that physicians, podiatrists, and chiropractors be prohibited from refusing medical care to patients who refuse to wear a mask, from enforcing any requirements to wear masks to receive medical care, to prohibit refusal of patient care based on vaccination status or to those who refuse to disclose their vaccination status, including any COVID-19 vaccine.

Dr. Silverman stated he wanted to deny the petition due to the importance of preserving medical judgement and decision-making of a practitioner. Several Board members agreed and stated their concerns. Ms. Deschenes stated that the Board does not have authority over hospitals. After much discussion, the Board moved to a vote.

ACTION: Dr. Silverman suggested that the petition be denied. The motion was properly seconded by Dr. Stokes and carried unanimously.

BREAK

Mr. Marchese called for a recess at 10:10 a.m. The meeting reconvened at 10:25 a.m.

10. Credentials Committee Considerations

Mental Health and Substance Abuse Questions

Dr. Miller reviewed the Credentials Committee's report from its June 7, 2022 meeting. Regarding the questions, he said the Committee's recommendation was to remove the term "condition" but keep the word "impairment." It also recommended that there should be an encouraging attestation "to seek help if needed". The third recommendation was that the definition of "currently" be removed from the application as it appeared ambiguous.

ACTION: Dr. Miller moved that DHP and OAG give further consideration to the suggested revisions. The motion was properly seconded by Dr. Ransone and carried unanimously.

Delegation of Review of Non-Routine Information to Board Staff

The suggested revisions from the Credentials Committee were discussed.

ACTION: Dr. Miller moved to accept the recommendation of the Credentials Committee to delegate the review of limited non-routine information to Board staff. The motion was properly seconded by Dr. Stokes and carried unanimously.______

11. Licensing Report

---DRAFT UNAPPROVED---

Mr. Sobowale reported to the Board that as of June 15, 2022, there were a total of 82,090 current active and inactive licensees. He noted that 62% of the licensees are MD's, DO's, and DPM's. Mr. Sobowale stated that the Board has issued 4,136 new licenses since the last Board meeting in February, with over half being MD's and DO's. Currently, the average time for processing is 81.07 days with a median of 67 days. He pointed out that the volume of applications continues to increase without additional staffing resources. In the last year, over 10,000 licenses have been issued.

12. Discipline Report

Ms. Deschenes provided a brief report on the status of cases as of June 1, 2022 and gave a brief overview on the transition to BOX. She then asked the Board members to review the Consent Orders at their desks.

ACTION: Dr. Arnold moved to approve the Consent Orders. The motion was properly seconded by Dr. Williams and carried unanimously.

13. Approval of the 2023 Meeting Calendar

ACTION: Dr. Ransone moved to accept the calendar. The motion was properly seconded by Dr. Miller and carried unanimously.

14. Nominating Committee Report

Dr. Ransone stated that the Nominating Committee met this morning at 7:45 a.m. to develop a slate of officers for next year. The following slate was proposed: Dr. Arnold for Secretary-Treasurer, Dr. Barner for Vice-President, and Mr. Marchese as President.

ACTION: Dr. Miller moved to approve the slate as presented. The motion was properly seconded by Dr. Williams and carried unanimously.

15. Announcements/Reminders

Mr. Marchese reminded Board members that the next full Board meeting will be held October 6, 2022. He also reminded members to submit their travel Expense Reimbursement Vouchers within 30 days after completion of their trip (CAPP Topic 20335, State Travel Regulations, p. 7).

ADJOURNMENT

With no additional business, the meeting adjourned at 10:45 a.m.

---DRAFT UNAPPROVED---

____
William L. Harp, MD
Executive Director

Agenda Item: **Report of Officers**

Staff Note:

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

Action: Informational presentation. No action required.

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

Staff Note: Please note Committee assignments and minutes of meetings since June 16, 2022.

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

EXECUTIVE COMMITTEE (8)

L. Blanton Marchese, President, Chair
David Archer, MD, **Vice-President**
Alvin Edwards, PhD, **Secretary/Treasurer**
Jane Hickey, JD
Karen Ransone, MD
Joel Silverman, MD
Jacob Miller, DO
Ryan Williams, MD

LEGISLATIVE COMMITTEE (7)

David Archer, MD, Vice-President, Chair
Randy Clements, DPM
Jane Hickey, JD
Oliver Kim, LLM
Manjit Dhillon, MD
Joel Silverman, MD
William Hutchens, MD

CREDENTIALS COMMITTEE (9)

Jacob Miller, DO, Chair
Peter Apel, MD
Alvin Edwards, PhD, **Secretary/Treasurer**
Hazem Elariny, MD
William Hutchens, MD
Jane Hickey, JD
Krishna Madiraju, MD
Pradeep Pradhan, MD
Jennifer Rathmann, DC

FINANCE COMMITTEE

L. Blanton Marchese, **President**
David Archer, MD, **Vice-President**
Alvin Edwards, PhD, **Secretary/Treasurer**

BOARD BRIEFS COMMITTEE

William L. Harp, M.D., Ex Officio

CHIROPRACTIC COMMITTEE

Jennifer Rathmann, DC

BOARD OF HEALTH PROFESSIONS

Vacant

COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE

Blanton Marchese, **President**
Joel Silverman, MD
Ryan Williams, MD

---DRAFT UNAPPROVED---

VIRGINIA BOARD OF MEDICINE
EXECUTIVE COMMITTEE MINUTES

Friday, August 5, 2022 | Department of Health Professions | Henrico, VA

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

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

MEMBERS PRESENT:
Blanton Marchese – President, Chair
David Archer, MD
Alvin Edwards, MDiv, PhD
Jane Hickey, JD
Joel Silverman, MD

MEMBERS ABSENT: Karen Ransone, MD

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 E. Brown, DC – DHP Director
Barbara Matusiak, MD - Medical Review Coordinator
Deirdre C. Brown - Executive Assistant
Erin Barrett, JD – DHP Senior Policy Analyst

OTHERS PRESENT:
Jennie Wood – Discipline Staff
W. Scott Johnson, JD - Hancock Daniel & Johnson, PC
Ben Traynham, JD - Hancock Daniel & Johnson, PC
Fran Bradford, JD - McGuireWoods

EMERGENCY EGRESS INSTRUCTIONS

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

APPROVAL OF MINUTES OF APRIL 8, 2022

Dr. Edwards moved to approve the minutes from April 8, 2022 as presented. The motion was seconded by Ms. Hickey and carried unanimously.

ADOPTION OF AGENDA

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

PUBLIC COMMENT

Mr. Marchese opened the floor for public comment; there was none.

DHP DIRECTOR'S REPORT

Dr. Brown reported that Governor Youngkin is interested in decreasing regulation. He stated that this gives DHP an opportunity to look at and simplify what we do. Governor Youngkin has established the Office of Regulatory Management, which will be meeting in October. Erin Barrett, DHP Senior Policy Analyst, will be attending the meeting. Also, Dr. Brown shared that the agency has seen a lot of changes, including bringing Human Resources back in-house and hiring a new Director for the Healthcare Workforce Data Center and a new Director for the Prescription Monitoring Program.

PRESIDENT'S REPORT

Mr. Marchese had no report.

EXECUTIVE DIRECTOR'S REPORT

Dr. Harp shared with the Board that Michael Sobowale, Deputy for Licensure, is recruiting for a licensing supervisor with interviews to occur later this month.

The biennial budget for FY23-24 has been submitted and includes the request for a full-time licensing specialist to work the front end of the application process. Also, in the spring of each year, the Board begins to receive applications from students graduating medical school and others who need Internship/Residency/Fellowship training licenses. This year, the Board received 1,200 applications for training licenses. As usual, other licensing staff had to pitch in to help. To remedy this situation, getting a temporary employee each March for 4 months would be a big help. This position has been included in the budget.

Dr. Harp announced that there will be a Statewide Pharmacy Protocols Work Group meeting on Monday, August 8, 2022. The Board of Pharmacy was in charge of this effort for the last 2 years and produced 7 protocols. The legislation from the 2022 Session requires another 3 protocols to be developed. In the meeting there will be three Board of Medicine members, three Board of Pharmacy members, and one pharmacist and one physician from VDH.

Dr. Harp updated the Committee on the changes in Board membership. The Board bid farewell to Jim Arnold, DPM, Amanda Barner, MD, Milly Rambhia, MD, Brenda Stokes, MD and Khalique Zahir, MD as they were not reappointed for second terms. The newly appointed members are Peter Apel, MD, Randy Clements, DPM, Hazem Elariny, MD, Bill Hutchens, MD, and Krishna Madiraju, MD.

Dr. Harp stated that the OCME quarterly report on opioid overdose deaths indicates that in the last 15 years, deaths from prescribed opioids have been flat. Currently, fentanyl is responsible for 76% of the fatal opioid overdoses.

NEW BUSINESS

1. Exempt Action Based on HB145 (Physician Assistant Practice) – Erin Barrett

Exempt changes to regulations governing physician assistants based on changes from 2022 legislation (HB145)

MOTION: Dr. Edwards moved to adopt the exempt regulatory changes as presented. The motion was properly seconded by Ms. Hickey and carried unanimously.

2. Exempt Action Based on HB598 (Surgical Technologists) – Erin Barrett

Exempt changes to regulations governing surgical technologist certification based on changes from 2022 legislation (HB598)

MOTION: Dr. Edwards moved to adopt the exempt regulatory changes as presented. The motion was properly seconded by Dr. Archer and carried unanimously.

3. Approval of Bylaws for All Advisory Boards – Erin Barrett

Draft Guidance Document 85-3

MOTION: Dr. Edwards moved to adopt the newly derived Guidance Document 85-3. The motion was properly seconded by Ms. Hickey and carried unanimously.

4. Consideration of Response to Petition for Rulemaking – Erin Barrett

Ms. Barrett reviewed the petition for rulemaking from Michael Moates, public comment that was received by the Board, and public comment posted on Town Hall in response to the petition. Ms. Barrett shared with the Board that Virginia Code 54.1-2409.5 already prohibits conversion therapy and that the use of the graduated electronic decelerator would be dealt with as a standard of care issue in the disciplinary process.

MOTION: Dr. Edwards moved to take no action on the petition. The motion was properly seconded by Dr. Archer and carried unanimously.

5. Adoption of Fast-Track Action Regarding Clinical Nurse Specialists – Erin Barrett

Exempt changes to 18VAC90-30-125 regarding practice agreements for clinical nurse specialists.

Chapter 197 of the 2022 Acts of Assembly.

MOTION: Ms. Hickey moved to adopt the fast-track regulatory change to the requirement for practice agreements by clinical nurse specialists as presented. The motion was properly seconded by Dr. Edwards and carried unanimously.

6. Vacant Offices on the Board – Dr. Harp

The Board voted in a new slate of officers at the Full Board meeting held on June 16, 2022. However, the first terms of the individuals elected to the offices of Vice-President and Secretary-Treasurer expired June 30, 2022; they were not reappointed. The Board of Medicine Bylaws, Guidance Document 85-1, make provisions for filling the offices of those that were not reappointed. But the Bylaws are not completely clear on the best way to proceed at this juncture. The options appear to be as follows:

1. The President appoints a Secretary-Treasurer, but not a Vice-President.
2. The newly appointed Secretary-Treasurer fills the Vice-President position, and the President then appoints a second individual for Secretary-Treasurer.
3. Appoint a Nominating Committee to develop a slate for the vacant offices for discussion/approval at the October Full Board meeting.

Mr. Marchese then opened the floor for discussion. Dr. Brown commented that the Committee may wish to wait until the October Full Board meeting to fill the positions. Mr. Marchese expressed concern for leadership of the Legislative Committee in September. The Committee members agreed that the best option would be to make the decision today.

MOTION: Dr. Edwards moved to allow the President to appoint a Secretary-Treasurer, who would then fill the Vice-President position. Then the President would appoint a second individual for Secretary-Treasurer. The motion was properly seconded by Dr. Silverman and carried unanimously.

Dr. Harp then stated that since the work of the Nominating Committee, the prepared slate, and the vote were all public, Mr. Marchese may wish to make the appointments in the meeting. Mr. Marchese then called for anyone interested in the Secretary-Treasurer seat. Dr. Archer acknowledged his interest. Hearing no others, Mr. Marchese appointed Dr. Archer as the Secretary-Treasurer. Dr. Archer immediately moved to the Vice-President position. Then Mr. Marchese appointed Dr. Edwards as the Secretary-Treasurer of the Board.

7. Update on Reciprocity – Dr. Harp

Dr. Harp briefly reviewed the meeting that occurred June 3, 2022 and provided an update from the July 22, 2022 meeting.

At the July meeting, a draft Memorandum of Agreement (MOA) prepared by the DC Board Counsel was reviewed; all jurisdictions provided suggestions that will be incorporated. Board Counsels and the boards for all 3 jurisdictions will need to approve the MOA. Applications will be individualized for each jurisdiction and will be kept as brief as possible. The group agreed upon an optimistic start date of January 1, 2023 for the reciprocal licensing pathway.

Ms. Barrett noted that regulations were not required since the Board has already been given authority for reciprocal licensing in statute.

ACTION: For informational purposes only.

ANNOUNCEMENTS

All were reminded to submit their Travel Expense Reimbursement Vouchers within 30 days after completion of their trip (CAPP Topic 20335, State Travel Regulations, p. 7).

The next meeting of the Executive Committee will be December 2, 2022 @ 8:30 a.m.

ADJOURNMENT

With no additional business, the meeting adjourned at 9:27 a.m.

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William L. Harp, MD
Executive Director

VIRGINIA BOARD OF MEDICINE
LEGISLATIVE COMMITTEE MINUTES

Friday, September 16, 2022 — Department of Health Professions — Henrico, VA

CALL TO ORDER: Dr. Archer called the meeting of the Legislative Committee to order at 8:32 a.m.

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

MEMBERS PRESENT:
David Archer, MD Vice-President & Chair
Manjit Dhillon, MD
Oliver Kim, LLM
Joel Silverman, MD

MEMBERS ABSENT:
J. Randy Clements, DPM
Jane Hickey, JD
William Hutchens, MD

STAFF PRESENT:
William L. Harp, MD - Executive Director
Jennifer Deschenes, JD - Deputy Exec. Director for Discipline
Colanthia Morton Opher - Deputy Director for Administration
Michael Sobowale, LLM - Deputy Director for Licensing
Barbara Matusiak, MD - Medical Review Coordinator
Deirdre Brown - Executive Assistant
Erin Barrett, JD - DHP Senior Policy Analyst
W. Brent Saunders, JD – Senior AAG & Board Counsel

OTHERS PRESENT:
W. Scott Johnson - Hancock Daniel

EMERGENCY EGRESS INSTRUCTIONS

Dr. Archer provided the emergency egress instructions.

INTRODUCTION

Dr. Archer introduced W. Brent Saunders, JD, new Board Counsel. Mr. Saunders provided brief comments about his work before arriving at OAG.

APPROVAL OF MINUTES OF January 14, 2022

Dr. Dhillon moved to approve the meeting minutes of January 14, 2022 as presented. The motion was seconded by Mr. Kim and carried unanimously.

ADOPTION OF AGENDA

Dr. Dhillon moved to accept the agenda as presented. The motion was seconded by Mr. Kim and carried unanimously.

PUBLIC COMMENT

W. Scott Johnson of Hancock Daniel presented to all Committee members a letter from the Medical Society of Virginia (MSV) regarding the periodic review of 18VAC85-20. In the letter, MSV stated that it is in favor of creating a more streamlined regulatory environment. He asked the Committee to vote favorably for the proposed changes that would be presented by Ms. Barrett

DHP DIRECTOR'S REPORT

Dr. Brown stated that he did not have much to report to the Committee. He said that today is the first day of Governor Youngkin's request, through the Office of Regulatory Management, to begin reducing the regulations to be less burdensome for Virginians.

NEW BUSINESS

1. Recommendations of Periodic Review – Erin Barrett

Ms. Barrett informed the Board that periodic review on the Board's regulations is done every four years, usually in the month of June.

In Chapter 15 of the Board's regulations, she suggested eliminating subsection (5) from 18VAC85-15-20.

Dr. Silverman moved to recommend to the Board that Chapter 15 be retained with the revision suggested by Ms. Barrett. The motion was seconded by Dr. Dhillon and carried unanimously.

Ms. Barrett then proceeded to Chapter 20, beginning review with revision of 18VAC85-20-26 requesting to eliminate subsection (F). For 18VAC85-20-28, the Board discussed eliminating subsection (2) and to change the language in subsection (1) to incorporate part of subsection (2). Next, Ms. Barrett recommended that Sections (A), (B), (C), and (D) be eliminated from 18VAC85-20-30.

Dr. Dhillon moved to recommend the above revisions to the full Board. The motion was seconded by Dr. Silverman and carried unanimously.

Ms. Barrett then reviewed suggested revisions for 18VAC85-20-40, 18VAC85-20-50, 18VAC85-20-60, 18VAC85-20-70, and 18VAC85-20-90.

Dr. Silverman moved to recommend the revisions to the full Board for consideration. The motion was seconded by Mr. Kim and carried unanimously.

Ms. Barrett then reviewed 18VAC85-20-120, 18VAC85-20-131, 18VAC85-20-140, and 18VAC85-20-141. The Committee discussed 18VAC85-20-131 and agreed that they would like the regulation to stay in place at this time. The Board discussed 18VAC85-20-141 and agreed with the suggested revisions.

Dr. Dhillon moved to recommend the revisions to the Board. The motion was second by Dr. Silverman and carried unanimously.

Ms. Barrett reviewed 18VAC85-20-210.

Dr. Silverman moved to recommend the suggested revisions to the Board. The motion was seconded by Mr. Kim and carried unanimously.

Ms. Barrett reviewed 18VAC85-20-225.

Dr. Silverman moved to recommend deletion to the Board as suggested. The motion was seconded by Dr. Dhillon and carried unanimously.

Ms. Barrett reviewed 18VAC85-20-235.

Dr. Silverman moved to recommend the revision to the Board. The motion was seconded by Dr. Dhillon and carried unanimously.

Ms. Barrett reviewed 18VAC85-20-285.

Dr. Silverman moved to recommend deletion of this section to the Board. The motion was seconded by Dr. Dhillon and carried unanimously.

Ms. Barrett reviewed 18VAC85-20-330, 18VAC85-20-340, and 18VAC85-20-350. Stating that 18VAC85-20-350 will be moved under 18VAC85-20-330.

Dr. Silverman moved to recommend the revisions to the Board. The motion was seconded by Mr. Kim and carried unanimously.

Ms. Barrett reviewed 18VAC85-20-390.

Dr. Dhillon moved that the revision be recommended to the Board. The motion was seconded by Dr. Silverman and carried unanimously.

Ms. Barrett then asked that the Committee to recommend the revisions to Chapter 15 and Chapter 20 as a Fast-Track Regulatory Action to the Board.

Dr. Dhillon moved to accept the fast- track recommendation as presented. The motion was seconded by Dr. Silverman and carried unanimously.

2. Recommendation of Approval of Revisions to Guidance Document 85-1 - Ms. Barrett

Ms. Barrett presented suggested revisions to 85-1. After discussion, it was recommended to add Surgical Assistants to the "Report of Advisory Boards" list.

Dr. Dhillon moved to recommend the revision of 85-1 to the Board as presented. The motion was seconded by Dr. Silverman and carried unanimously.

3. Recommendation of Approval of Revisions to Guidance Document 85-4 - Ms. Barrett

Dr. Silverman moved to recommend the revisions to 85-4 to the Board as presented. The motion was seconded by Dr. Dhillon and carried unanimously.

4. Recommendation of Approval of Revisions to Guidance Document 85-6 - Ms. Barrett

Dr. Silverman moved to recommend the revision of 85-6 to the Board as presented. The motion was seconded by Mr. Kim and carried unanimously.

5. Recommendation of Approval of Revisions to Guidance Document 85-8 - Ms. Barrett

Dr. Dhillon moved to recommend the revision of 85-8 to the Board as presented. The motion was seconded by Mr. Kim and carried unanimously.

6. Recommendation of Approval of Revisions to Guidance Document 85-13 - Ms. Barrett

Dr. Dhillon moved to recommend the revision of 85-13 to the Board as presented. The motion was seconded by Dr. Silverman and carried unanimously.

7. Recommendation of Approval of Revisions to Guidance Document 85-15- Ms. Barrett

Dr. Dhillon moved to recommend the revision to 85-15 to the Board as presented. The motion was seconded by Dr. Silverman and carried unanimously.

8. Recommendation of Approval of Revisions to Guidance Document 85-16 - Ms. Barrett

Dr. Silverman moved to recommend the revision to 85-16 to the Board as presented. The motion was seconded by Dr. Dhillon and carried unanimously.

9. Recommendation of Approval of Revisions to Guidance Document 85-19 - Ms. Barrett

Dr. Silverman moved to recommend repeal of 85-19 to the Board as presented. The motion was seconded by Dr. Dhillon and carried unanimously.

10. Recommendation of Approval of Revisions to Guidance Documents 85-2, 85-20 and 85-21 - Ms. Barrett

Dr. Silverman moved to recommend the revisions to Guidance Doc 85-2, 85-20, 85-21 to the Board as presented. The motion was seconded by Mr. Kim and carried unanimously.

11. Recommendation of Approval of Revisions to Guidance Document 85-23 - Ms. Barrett

Dr. Dhillon moved to recommend the suggested revision of 85-23 to the Board as presented. The motion was seconded by Dr. Silverman and carried unanimously.

ANNOUNCEMENTS

Ms. Deschenes presented 2 Consent Orders to the Committee for its consideration.

NEXT MEETING

January 23, 2023

ADJOURNEMENT

With no other business to conduct, the meeting adjourned at 10:15 a.m.

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William L. Harp, MD
Executive Director

---DRAFT UNAPPROVED---

Statewide Pharmacy Protocols
Work Group

Monday, August 8, 2022	Department of Health Professions	Henrico, VA

CALL TO ORDER: Dr. Miller called the meeting to order at 9:08 a.m.

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

MEMBERS PRESENT:
Jacob Miller, DO, Chair – Board of Medicine
Laura Forlano, MD – Department of Health
William Hutchens, MD – Board of Medicine
William Lee, DPh, MPA, FASCP – Board of Pharmacy
Patricia Richards-Spruill, RPh – Board of Pharmacy
Joel Silverman, MD –Board of Medicine
Stephanie Wheawill, PharmD – Department of Health
Ling Yuan, PharmD – Board of Pharmacy

MEMBERS ABSENT: None

STAFF PRESENT:
William L. Harp, MD, Executive Director – Board of Medicine
Caroline Juran, RPh – Executive Director - Board of Pharmacy
Colanthia Morton Opher, Deputy Executive Director for Administration
Erin Barrett, DHP Senior Policy Analyst
Danielle Sangiuliano, Administrative Assistant

OTHERS PRESENT:
Jennifer Deschenes, JD
Michael Sobowale, LLM

EMERGENCY EGRESS INSTRUCTIONS

Dr. Harp welcomed the members and provided the emergency egress instructions.

INTRODUCTION OF WORK GROUP MEMBERS

Dr. Miller asked everyone around the table to introduce themselves and provide a brief overview of their background, after which he identified the eight members designated to vote on agenda items.

ADOPTION OF AGENDA

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

PUBLIC COMMENT ON AGENDA ITEMS

Dr. Miller opened the floor for public comment. There being none, the floor was closed.

CHARGE OF THE WORK GROUP

Dr. Harp reminded the members that the work group was formed to address HB1323 from the 2022 Session which seeks to amend and reenact §§32.1-325, 54.1-3303.1, and 54.1-3321 of the Code relating to pharmacists; initiation of treatment with and dispensing and administration of vaccines. Dr. Harp noted that the Board of Pharmacy had led the Statewide Pharmacy Protocols work group for the last 2 years and produced 7 protocols that became effective in 2021. The 2022 law has 3 new protocol requirements.

54.1-3303.1 – Initiating of treatment with and dispensing and administering of controlled substances by pharmacists

54.1-3303.1(A)

Notwithstanding the provisions of 54.1-3303, a pharmacist may initiate treatment with, dispense, or administer the following drugs, devices, controlled paraphernalia, and other supplies and equipment to persons 18 years of age or older with whom the pharmacist has a bona fide pharmacist-patient relationship and in accordance with a statewide protocol developed by the Board in collaboration with the Board of Medicine and the Department of Health and set forth in regulations of the Board:

7. Vaccines included on the Immunization Schedule published by the Centers for Disease Control and Prevention and vaccines for COVID-19

10. Nicotine replacement and other tobacco cessation therapies, including controlled substances as defined in the Drug Control Act (§ 54.1-3400 et seq.), together with providing appropriate patient counseling; and

11. Tests for COVID-19 and other coronaviruses.

54.1-3303.1(B)

Notwithstanding the provisions of § 54.1-3303, a pharmacist may initiate treatment with, dispense, or administer the following drugs and devices to persons three years of age or older in accordance with a statewide protocol as set forth in regulations of the Board:

1. Vaccines included on the Immunization Schedule published by the Centers for Disease Control and Prevention and vaccines for COVID-19; and

2. Tests for COVID-19 and other coronaviruses.

The italicized language in the sections below may or may not need to be incorporated into new and existing protocols.

54.1-3303.1(C))

A pharmacist who initiates treatment with or dispenses or administers a drug or device pursuant to this section shall notify the patient's primary health care provider that the pharmacist has initiated treatment with such drug or device or that such drug or device has been dispensed or administered to the patient, provided that the patient consents to such notification. *No pharmacist shall limit the ability of notification to be sent to the patient's primary care provider by requiring use of electronic mail that is secure or compliant with the federal Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.).* If the patient does not have a primary health care provider, the pharmacist shall counsel the patient regarding the benefits of establishing a relationship with a primary health care provider and provide information regarding primary health care providers, including federally qualified health centers, free clinics, or local health departments serving the area in which the patient is located. If the pharmacist is initiating treatment with, dispensing, or administering injectable or self-administered hormonal contraceptives, the pharmacist shall counsel the patient regarding seeking preventative care, including (i) routine well-woman visits, (ii) testing for sexually transmitted infections, and (iii) pap smears.

54.1-3303.1(D)

A pharmacist who administers a vaccination pursuant to *subdivisions A 7 and B 1* shall report such administration to the Virginia Immunization Information System in accordance with the requirements of § 32.1-46.01.

54.1-3303.1(E)

A pharmacist who initiates treatment with, dispenses, or administers drugs, devices, controlled paraphernalia, and other supplies and equipment pursuant to this section shall obtain a history from the patient, including questioning the patient for any known allergies, adverse reactions, contraindications, or health diagnoses or conditions that would be adverse to the initiation of treatment, dispensing, or administration.

54.1-3303.1(F)

A pharmacist may initiate treatment with, dispense, or administer drugs, devices, controlled paraphernalia, and other supplies and equipment pursuant to this section through telemedicine services, as defined in § 38.2-3418.16, in compliance with all requirements of § 54.1-3303 and consistent with the applicable standard of care.

54.1-3303.1(G)

A pharmacist who administers a vaccination to a minor pursuant to subdivision B 1 shall provide written notice to the minor's parent or guardian that the minor should visit a pediatrician annually.

And,

54.1-3321 Registration of pharmacy technicians

8. *Under the supervision of a pharmacist, meaning the supervising pharmacist is at the same physical location of the technician or pharmacy intern, and consistent with the requirements of § 54.1-3303.1, administration of the following drugs and devices to persons three years of age or older as set forth in regulations of the Board: vaccines included on the Immunization Schedule published by the Centers for Disease Control and Prevention and vaccines for COVID-19;*

For clarification, Dr. Miller advised that the Work Group would review and make recommendations to the draft protocols, after which development of regulations and updates will fall under the purview of the Board of Pharmacy.

Vaccines

Dr. Miller led the members in a discussion of vaccines while referring to the existing Pharmacist Vaccine State Protocol that became effective December 22, 2021, the CDC Recommended Child and Adolescent Immunization Schedule, the CDC information on COVID-19 vaccines, the HHS renewal of the public health emergency on April 12, 2022, and the draft Vaccine Statewide Protocol.

After a robust discussion, the Work Group members unanimously agreed to the following modification of the draft document identified as the "Vaccine Statewide Protocol" which addresses the administration of vaccines to persons 3 years of age or older to become effective upon the expiration of the provisions of the federal Declaration Under the PREP Act. Ms. Juran indicated she would recommend to the Board of Pharmacy that it amend the current "Pharmacist Vaccine Statewide Protocol", which addresses administration of vaccines to persons 18 years of age and older, in a similar manner.

PATIENT INCLUSION CRITERIA

Amend the first bullet to reflect the following:

An individual 3 years of age or older whose immunization history is incomplete or unknown and for whom a vaccine is recommended at his or her age in accordance with the most current Child and Adolescent Immunization Schedule or the Adult Immunization Schedule published by the CDC *inclusive of additional information for COVID-19 vaccination.*

Amend the third bullet to reflect the following:

PATIENT EXCLUSION CRITERIA

The following patients are NOT eligible for vaccines under this protocol:

- An individual who ~~is fully vaccinated~~ *has received all CDC recommended doses for their age, medical condition or other indicators.*

Break

The Work Group took a 15-minute break and reconvened at 10:37 a.m.

Nicotine Replacement and other Tobacco Cessation Therapies

The Work Group reviewed two articles created by the American Cancer Society on nicotine replacement and prescription medicines for tobacco cessation, existing protocols from Oregon, North Carolina, Indiana, and Utah, as well as a draft "Virginia Board of Pharmacy Pharmacist Statewide Protocol for Tobacco Cessation."

After discussion, the Work Group unanimously agreed to:

1. Adopt the proposed "Virginia Board of Pharmacy Pharmacist Statewide Protocol for Tobacco Cessation" to be derived by staff from the Oregon Protocol with the presentation of information similar to that used in the North Carolina Protocol. This will standardize the process and systematically identify at-risk patients.

2. Include guidance on patient counseling; and,

3. Include the requirement for the pharmacist to notify the patient's primary care provider.

COVID-19 Testing

Dr. Miller acknowledged the pharmacist's ability to currently conduct COVID-19 testing, and pointed out that the purpose of this protocol was to address the addition of individuals 3 years and older.

It was noted that this protocol does not become effective until the federal emergency ends.

After discussion, the Work Group unanimously agreed to adopt the draft Virginia Board of Pharmacy Pharmacist Statewide Protocol for Coronavirus Testing with the following amendments:

FIRST PARAGRAPH

Consistent with Virginia Code Section 54.1-3303.1 and CLIA requirements administered by the U.S. Food and Drug Administration, a pharmacist may initiate ~~treatment with, dispense, or~~ *and* administer tests for COVID-19 and other coronaviruses to persons ~~18~~ 3 years of age or older.

RECORDKEEPING

The pharmacist shall maintain records in accordance with 18VAC110-21-46 and *shall report all positives to the local or state health department in accordance with 32.1-36 and 12VAC5-90.*

EXCLUSIONS

Nothing shall preclude a pharmacist, pharmacy technician, or pharmacy intern under the supervision of a pharmacist, meaning that the pharmacist is at the same physical location as the pharmacy technician or pharmacy intern, from performing CLIA-waived tests in accordance with the Food and Drug Administration's CLIA requirements.

Adjournment

Dr. Miller provided the travel reimbursement instructions to the Work Group. With no other business to conduct the meeting adjourned at 11:29 a.m.

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William L. Harp, MD
Executive Director

ADVISORY BOARD ON BEHAVIOR ANALYSIS

Minutes
September 19, 2022

The Advisory Board on Behavior Analysis met on Monday, September 19, 2022, at 10:00 a.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, Virginia.

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

MEMBERS ABSENT: None

STAFF PRESENT: William L. Harp, M.D., Executive Director
Michael Sobowale, LL.M., Deputy Executive Director
Colanthia M. Opher, Deputy Executive Director
Erin Barrett, J.D., DHP Senior Policy Analyst
Pam Smith, Licensing Specialist [Joined at 10:26 am]

GUESTS PRESENT: Christy Evanko, VABA

CALL TO ORDER

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

EMERGENCY EGRESS PROCEDURES

Dr. Harp announced the emergency egress procedures.

ROLL CALL

Michael Sobowale called the roll. A quorum was established.

APPROVAL OF MINUTES OF MAY 23, 2022

Mark Llobell moved to approve the minutes from the May 23, 2022 meeting. Jerita Dubash seconded. Motion carried.

ADOPTION OF AGENDA

Autumn Kaufman moved to adopt the agenda. Jerita Dubash seconded. The agenda was adopted as presented.

PUBLIC COMMENT

None.

NEW BUSINESS

1. **Periodic Review of Regulations Governing the Practice of Behavior Analysis**

   Erin Barrett led the discussion. She presented her recommendations to delete current provisions in 18VAC85-150-20, 18VAC85-150-110 (1) (2), 18VAC85-150-150 E.3., 18VAC85-150-160 (A) (2), and 18VAC85-150-180. Most of these provisions are in the law, therefore it is unnecessary to repeat them in regulation. Christina Giuliano and Mark Llobell both stated that the regulatory provision in 18VAC85-150-160 (A) (2) should be retained for its clarification.

   Christina Giuliano moved that the Board recommend these changes as discussed to the full Board. Mark Llobell seconded. Motion passed.

2. **Review of Bylaws for Advisory Board**

   Erin Barrett presented the uniform Bylaws for all the Advisory Boards that were approved at the June full Board meeting for information only. The Bylaws are slated to become effective on September 29, 2022.

3. **Approval of 2023 Meeting Calendar**

   Mark Lobell moved to adopt the 2023 meeting calendar. Jerita Dubash seconded. Motion passed.

4. **Election of Officers**

   Autumn Kaufman nominated Christina Giuliano as Chair. Mark Lobell seconded. Motion passed. Mark Llobell nominated Autumn Kaufman as Vice-Chair. Christina Giuliano seconded. Motion passed.

ANNOUNCEMENTS

Michael Sobowale provided the license statistics report. There are currently a total of 247 licensed assistant behavior analysts of which 214 are current active in Virginia and 2 are current inactive. 31 are current active out of state. For licensed behavior analysts, there are a total of 2, 290 of which 1,548 are

current active in Virginia, 1 is current inactive, 738 are current active out of state and 3 are current inactive out of state.

NEXT MEETING DATE

February 6, 2023 @ 10:00 a.m.

ADJOURNMENT

There being no other business, Christina Giuliano adjourned the meeting 10:36 a.m.

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William L. Harp, MD, Executive Director

<< DRAFT >>

ADVISORY BOARD ON GENETIC COUNSELING
Minutes
September 19, 2022

The Advisory Board on Genetic Counseling met on Monday, September 19, 2022 at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

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

MEMBERS ABSENT: Lori Swain, Citizen Member

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

GUESTS PRESENT: None

Call to Order

Tahnee Causey, Chair, called the meeting to order at 1:03 pm.

Emergency Egress Procedures

Dr. Harp announced the emergency egress instructions.

Roll Call

Roll was called; a quorum was declared.

Approval of Minutes

Lydia Higgs moved to adopt the minutes of the May 23, 2022 meeting. Martha Thomas seconded the motion. Motion passed.

Adoption of Agenda

Martha Thomas moved to adopt the agenda. Lydia Higgs seconded the motion. Motion passed.

Public Comment on Agenda Items

None

New Business

1. **Periodic Review of Regulations Governing the Practice of Genetic Counseling**

   Erin Barrett led the discussion. She presented her recommendations to delete current provisions in 18VAC85-170-10 B. - Definition of Conscience Clause, 18VAC85-170-20, 18VAC85-170-100 (D), 18VAC85-170-110, 18VAC85-170-140 (E) (3), 18VAC85-170-150A. (3)(a)(b)(c), 18VAC85-170-160 (A) (1), and 18VAC85-170-170. Most of these provisions are in the law, therefore it is unnecessary to repeat them in regulation. Members discussed retaining the language provision in 18VAC85-170-150 A. (2) and amending language in 18VAC85-170-150A. (3) to state, "*When a genetic or diagnostic test is recommended, documented informed consent shall be obtained from the patient in accordance with the policies of the health care entity and consistent with the standard of care. 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.*"

   Martha Thomas moved that the Advisory Board recommend these changes as discussed to the full Board. Lydia Higgs seconded. Motion passed.

2. **Review of Bylaws for Advisory Board**

   For information only, Erin Barrett presented the uniform Bylaws for all Advisory Boards that the full Board approved at its June meeting. The Bylaws are slated to become effective on September 29, 2022.

3. **Approval of 2023 Meeting Calendar**

   Lydia Higgs moved to adopt the 2023 meeting calendar. Martha Thomas seconded. Motion passed.

4. **Election of Officers**

   Tahnee Causey moved to nominate Lydia Higgs as Chair and Martha Thomas as Vice-Chair. Martha Thomas seconded the motion. Motion passed.

Announcements:

License statistics

Michael Sobowale provided the license statistics report. There is a total of 7 temporarily-licensed genetic counselors 6 of which are current active in Virginia with 1 current active out-of-state. For fully-licensed genetic counselors, there is a total of 543, 124 of which are current active in Virginia with 418 current active out-of-state. There is 1 current inactive out-of-state.

Next Scheduled Meeting

The next scheduled meeting is Monday, February 6, 2023 @ 1pm.

Adjournment

With no other business to conduct, the meeting adjourned at 1:48pm.

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William L. Harp, MD, Executive Director

ADVISORY BOARD ON OCCUPATIONAL THERAPY

Minutes
September 20, 2022

The Advisory Board on Occupational Therapy met on Tuesday, September 20, 2022 at 10:00 am at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, Virginia.

MEMBERS PRESENT: Dwayne Pitre, OT, Chair
Kathryn Skibek, OT, Vice-Chair
Breshae Bedward, OT
Karen Lebo, Citizen Member [Joined at 10:06 am]

MEMBERS ABSENT: Raziuddin Ali, MD

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

GUESTS PRESENT: None

CALL TO ORDER

Dwayne Pitre, OTR, Chair called the meeting to order at 10:03 a.m.

EMERGENCY EGRESS PROCEDURES

Dr. Harp announced the emergency egress instructions.

ROLL CALL

Roll was called, and a quorum was declared.

APPROVAL OF MINUTES OF May 24, 2022

Kathryn Skibek moved to approve the minutes from the May 24, 2022 meeting. Breshae Bedward seconded. The motion carried.

ADOPTION OF AGENDA

Kathryn Skibek moved to adopt the meeting agenda as presented. Breshae Bedward seconded. The motion carried.

PUBLIC COMMENT

None

NEW BUSINESS

1. **Periodic Review of Regulations Governing the Practice of Occupational Therapy**

   Erin Barrett led the discussion. She presented her recommendations to retain or amend current provisions with suggested changes in 18VAC85-80-10, 18VAC85-80-20, 18VAC85-80-26 (A) (3), 18VAC85-80-35 (3), 18VAC85-80-65 (4), 18VAC85-85-80-71 (1) (A) (2), 18VAC85-85-80-71 (D), 18VAC85-80-72 (B) (3), 18VAC85-80-73 (D), 18VAC85-80-80 (B), (C), (D), 18VAC85-80-90 (A), 18VAC85-80-100, 18VAC85-80-140 (E) (2), and 18VAC85-80-140 (F). Some of these regulations are either obsolete or already in the law; therefore, it is unnecessary to repeat them in regulation.

   Kathryn Skibek moved to retain and amend Chapter 80 with the suggested changes discussed. Breshae Bedward seconded. The motion passed.

2. **Review of Bylaws for the Advisory Boards**

   Erin Barrett presented the uniform Bylaws for all Advisory Boards that the full Board approved at its June meeting. This was for information only, since the Bylaws are slated to become effective on September 29, 2022.

3. **Update on Implementation of the Occupational Therapy Licensure Compact**

   Michael Sobowale presented an update. Virginia is represented on the Rules and Compliance Committees of the Compact Commission. The first meeting of the Rules Committee is scheduled for October 18th. Additional information regarding the Compact can be found on the website - otcompact.org. Given the work currently being done to develop a Secretariat for the compact, it is estimated that member states may not begin to issue compact privileges until late 2023 or early 2024.

4. **Approval of 2023 Meeting Calendar**

   Breshae Bedward moved to adopt the 2023 meeting calendar. Kathryn Skibek seconded. The motion passed.

5. **Election of Officers**

Kathryn Skibek nominated Mr. Pitre as Chair. Karen Lebo seconded. Karen Lebo nominated Kathryn Skibek as Vice-Chair. Breshae Bedward seconded. The motion passed.

Announcements:

License Statistics

ShaRon Clanton provided the license statistics report. There are a total of 1,793 occupational therapy assistants. 1,552 are current active in Virginia; 25 are current inactive. There are 205 current active out-of-state and 11 current inactive out-of-state. For occupational therapists, there is a total of 4, 928 of which 3, 823 are current active in Virginia, and 59 are current inactive. 975 are current active out-of-state with 70 are current inactive out-of-state. One licensee is current active on probation.

Next Scheduled Meeting

The next scheduled meeting date is February 7, 2023 @ 10:00 a.m.

Adjournment:

With no other business to conduct, the meeting adjourned at 11:27 a.m.

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

<< DRAFT >>

ADVISORY BOARD ON RESPIRATORY THERAPY
Minutes
September 20, 2022

The Advisory Board on Respiratory Therapy met on Tuesday, September 20, 2022 at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

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

MEMBERS ABSENT: Denver Supinger, Citizen Member

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

GUESTS PRESENT: None

CALL TO ORDER

Santiera Brown-Yearling called the meeting to order at 1:08 p.m.

EMERGENCY EGRESS PROCEDURES

Dr. Harp announced the emergency egress procedures.

ROLL CALL

Delores Cousins called the roll. A quorum was established.

APPROVAL OF MINUTES OF MAY 24, 2022

Shari Toomey moved to approve the minutes from the May 24, 2022 meeting. Daniel Gochenour seconded. The motion passed.

ADOPTION OF AGENDA

Shari Toomey moved to adopt the agenda as presented. Bruce Rubin seconded the motion, which passed unanimously.

PUBLIC COMMENT ON AGENDA ITEMS

None

New Business

1. **Periodic Review of Regulations Governing The Practice of Respiratory Therapy**

   Erin Barrett led the discussion. She presented her recommendations to retain or amend current provisions with suggested changes in 18VAC85-40-10, 18VAC85-40-20, 18VAC85-40-30, 18VAC85-40-55 (4), 18VAC85-40-70, 18VAC85-40-86(E) (2), (3), 18VAC85-40-87(B), and 18VAC85-40-89. Some of these provisions are in the law; therefore, it is unnecessary to repeat them in regulation. Members discussed retaining the current language in 18VAC85-40-86(E) as respiratory therapists can be self-employed, and also, 18VAC85-40-87(B) given the discussion surrounding advanced level respiratory therapy practice in the future.

   Daniel Gochenour made a motion to retain and amend Chapter 40 with the suggested changes discussed. Shari Toomey seconded. The motion passed

2. **Review of Bylaws for the Advisory Boards**

   Erin Barrett presented the uniform Bylaws for all Advisory Boards that the full Board approved at its June meeting. Since the Bylaws are slated to become effective on September 29, 2022, this was for information only.

3. **Discussion of Contiguous State Licensure**

   Shari Toomey stated that the American Association for Respiratory Care has had some discussions about developing a respiratory therapy licensure compact. Since Virginia does not have reciprocal licensing, she suggested that developing such a licensure pathway might make it more convenient for respiratory therapists living in contiguous states to work in Virginia. A compact would make licensure more expeditious and convenient for eligible applicants. Erin Barrett stated that compacts are created by state legislatures in the various states that agree to form a compact. There is no true reciprocity in other states and across the healthcare professions in general.

4. **APPROVAL OF 2023 MEETING CALENDAR**

Shari Toomey moved to adopt the 2023 meeting calendar. Daniel Gochenour seconded. The motion passed.

5. **ELECTION OF OFFICERS**

Dr. Rubin made a motion to retain the current officers. Santiera Brown-Yearling and Shari Toomey, for second terms. Daniel Gochenour seconded. The motion passed.

ANNOUNCEMENTS:

License Statistics

Delores Cousins provided the license statistics report. There are a total of 4,428 respiratory therapists. 3,051 are current active in Virginia with 83 current inactive. 1,268 are current active out-of-state with 25 are current inactive out-of-state. 1 is current active on probation.

Next Scheduled Meeting:

The next scheduled meeting date is February 7, 2023 @ 1pm.

ADJOURNMENT

With no other business to conduct, the meeting adjourned at 2:20 pm.

William L. Harp, MD, Executive Director

<< DRAFT >>

ADVISORY BOARD ON ACUPUNCTURE
Minutes
September 21, 2022

The Advisory Board on Acupuncture met on Wednesday, September 21, 2022 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

MEMBERS ABSENT: R. Keith Bell, LAc - Vice-Chair
Luke Robinson, DO
Sharon Crowell, LAc
Beth Rodgers - Citizen Member

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

GUESTS PRESENT: Floyd Herdrich, LAc
Sean Orr, LAc

CALL TO ORDER

Janet L. Borges called the meeting to order at 10:06 am.

EMERGENCY EGRESS PROCEDURES

Dr. Harp announced the emergency egress procedures.

ROLL CALL

The roll was called; no quorum was declared.

APPROVAL OF THE MINUTES

The October 6, 2021 minutes were not approved as a quorum was not present.

ADOPTION OF AGENDA

The meeting agenda was not adopted for lack of a quorum.

PUBLIC COMMENT ON AGENDA ITEMS

None

NEW BUSINESS

1. Periodic Review of Regulations Governing the Practice of Licensed Acupuncturists

   Mrs. Barrett discussed the mandatory four-year review of Chapter 18 VAC 85-110 to determine whether this regulation should be repealed, amended or retained in its current form, without impacting public safety. The review of the regulations will be guided by the principles in Executive Order 14 as amended July 16, 2018.

   She presented her recommendations to amend or delete current provisions in 18VAC85-110-20, 18VAC85-110- 145, 18VAC85-110-161, 18VAC85-110-176, 18VAC85-110-177, 18VAC85- 110-179, and 18VAC85-110-181. Some of these provisions are in the law, and it is unnecessary to repeat them in regulation. Janet Borges suggested amended language in 18VAC85-110-80 to state as follows:

   1. Passing the NCCAOM examination, resulting in current, active certification by the NCCAOM at the time the application is filed with the Board;
   2. Delete language "Passing the Point Location Examination" since this is already part of the required NCCAOM certification examination.

   Ms. Barrett will present the revisions discussed for amending Chapter 110 to the Board of Medicine with a recommendation for adoption.

2. Review of Bylaws for Advisory Boards

   Erin Barrett presented the uniform Bylaws for all Advisory Boards that the full Board approved at its June meeting. Since the Bylaws are slated to become effective on September 29, 2022, this was for information only.

3. Approval of the 2023 Meeting Calendar

   The 2023 meeting calendar was not approved as a quorum was not present.

4. Election of Officers

   There was no quorum to elect officers.

ANNOUNCMENTS

Licensing Statistics

Beulah Archer provided the acupuncture licensing report. The Board has 449 current active licensees with 135 out of state current active licensees. There are 5 current inactive licenses.

Next Scheduled Meeting

The next scheduled meeting is February 8, 2023, at 10:00 a.m.

ADJOURNMENT

Janet L. Borges adjourned the meeting at 11:05 a.m.

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

ADVISORY BOARD ON RADIOLOGICAL TECHNOLOGY
Minutes
September 21, 2022

The Advisory Board on Radiological Technology met on Wednesday, September 21, 2022, at 1:00 p.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, Virginia.

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

MEMBERS ABSENT:
David Roberts, RT

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

GUESTS PRESENT:
None

CALL TO ORDER

Joyce Hawkins called the meeting to order at 1:02 p.m.

EMERGENCY EGRESS PROCEDURES

Dr. Harp announced the emergency egress instructions.

ROLL CALL

Beulah Archer called the roll. A quorum was declared.

APPROVAL OF MINUTES

Dr. Prasad moved to adopt the minutes of the May 25, 2022 meeting. Rebecca Keith seconded the motion. The motion passed.

ADOPTION OF AGENDA

Rebecca Keith moved to adopt the agenda. Dr. Prasad seconded the motion and passed unanimously.

PUBLIC COMMENT ON AGENDA ITEMS

None

New Business

1. Periodic Review of Regulations Governing the Practice of Radiologic Technologists

   Erin Barrett discussed the mandatory four-year review of Chapter 18VAC 85-101 to determine whether this regulation should be repealed, amended or retained in its current form, without impacting public safety. The review of the regulations will be guided by the principles in Executive Order 14 as amended July 16, 2018. There were six public comments received during the public comment period all in favor of retaining the Chapter as written.

   Erin Barrett presented her recommendations to amend or delete current provisions in 18VAC85-101-20, 18VAC85-101-145 (4), 18VAC85-101-162, and 18VAC85-101-163 (D). Some of these provisions are in the law, therefore it is unnecessary to repeat them in regulation

   Rebecca Keith moved that the Advisory Board make a recommendation to the full Board to retain and amend Chapter 101 with the changes discussed. Dr. Prasad seconded. The motion passed.

2. Review of Bylaws for Advisory Board

   Erin Barrett presented the uniform Bylaws for all Advisory Boards that the full Board approved at its June meeting. Since the Bylaws are slated to become effective on September 29, 2022, this was for information only.

3. Discuss Onset of Educational Practices to Fill Gaps in Available Radiologic Technologists

   Joyce Hawkins expressed concern about limited-radiologic technology programs that may be started in hospitals to help with the short staffing or rad techs. She noted that radiologic technologists in hospitals do not have to be licensed, and according to the regulations, cannot teach limited programs without a license.

   Dr. Harp suggested that a reminder be placed in Board Briefs regarding limited radiologic technology licensees practicing only in the authorized anatomical scope of practice printed on their licenses.

4. Approval of 2023 Calendar

   Rebecca Keith moved to adopt the 2023 meeting calendar. Dr. Prasad seconded. The motion passed.

---DRAFT ---

5. Election of Officers

By acclamation, members approved the current officers to continue to serve: Joyce Hawkins as Chair and Uma Prasad as Vice-Chair.

ANNOUNCEMENTS

Licensing Statistics

Beulah Baptist Archer provided the license count for radiological technology as follows:

Limited Radiologic Technologist	Virginia	Current Active	483
	Virginia	Current Inactive	19
	Out of State	Current Active	23
	Out of State	Current Inactive	1
Total			**526**
Radiologic Technologist	Virginia	Current Active	3,559
	Virginia	Current Inactive	28
	Out of State	Current Active	1192
	Out of State	Current Inactive	15
Total			**4,794**
Radiologist Assistant	Virginia	Current Active	12
	Out of State	Current Active	4
Total			**16**

Next Scheduled Meeting

The next scheduled meeting is February 8, 2023 at 1:00 p.m.

ADJOURNMENT

With no other business to conduct, the meeting adjourned at 1:48 pm.

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William L. Harp, MD, Executive Director

<< DRAFT >>

ADVISORY BOARD ON ATHLETIC TRAINER

Minutes

September 22, 2022

The Advisory Board on Athletic Training met on Thursday, September 22, 2022 at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: David Pawlowski, AT, Chair
Trilizsa Trent - Vice-Chair
William Powers, AT
Michael Goforth, AT [Joined Electronically]

MEMBERS ABSENT: Jeffrey Roberts, MD

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

GUESTS PRESENT: None

Call to Order

David Pawlowski, Chair called the meeting to order at 10:26 am. The delayed start was due to technological issues.

Emergency Egress Procedures

Dr. Harp announced the emergency egress instructions. He welcomed new members and stated, for the record, that Michael Goforth had submitted a request to join the meeting electronically from Blacksburg, Virginia. Mr. Goforth cited his personal reason for the request as duties of his employment that he could not miss. His request was presented to the Chair, and Mr. Pawlowski approved participation by A-V setup.

Roll Call

Roll was called; quorum was declared.

Approval of Minutes

Scott Powers moved to adopt the minutes of the October 7, 2021 meeting. Trilizsa Trent seconded the motion. The motion passed.

Adoption of Agenda

Scott Powers moved to adopt the agenda. Trilizsa Trent seconded the motion. The motion passed.

Public Comment on Agenda Items

None

New Business

1. Periodic Review of Regulations Governing the Practice of Athletic Trainers

   Erin Barrett discussed the mandatory four-year review of Chapter 18VAC 85-120 to determine whether this regulation should be repealed, amended or retained in its current form, without impacting public safety. The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018). There were two public comments received during the comment period. The first comment suggested that NATABOC be deleted from Chapter 120 and replaced with BOC. This would require a change to language in the Code of Virginia. The second comment suggested a change to the use of the term, "Student Athletic Trainer" to "Athletic Training Student". This would require an additional review before a global change can be made to the Chapter as a recommendation to the full Board.

   Ms. Barrett then presented her recommendations to amend or delete current provisions in 18VAC85-120-10, 18VAC85-120-20, 18VAC85-120-35 (10), 18VAC85-120-40, 18VAC85-120-85 (4), 18VAC85-120-120, 18VAC85-120-130(B)(2), 18VAC85-120-140, 18VAC85-120-155, 18VAC85-120-156, and 18VAC85-120-157(C). Some of these provisions are in the law, therefore it is unnecessary to repeat them in regulation. Members discussed not to delete provisions in 18VAC85-120-157(C) and 18VAC85-120-155.

   Scott Powers moved that the Advisory Board retain and amend Chapter 120 with the changes discussed as a recommendation to the full Board. Trilizsa Trent seconded the motion. The motion passed.

2. Review of Bylaws for Advisory Boards

   Erin Barrett presented the uniform Bylaws for all Advisory Boards that the full Board approved at its June meeting. Since the Bylaws are slated to become effective on September 29, 2022, this was for information only.

3. Update from the BOC CARE Conference

   David Pawlowski presented an update from the BOC Care Conference which was attended by Daniel Carroll, President of the Virginia Athletic Trainers' Association. He thought some of the guidelines for athletic training regulatory language discussed during the conference might be useful to incorporate into Virginia's regulations in the future.

4. Discussion of Athletic Trainers Utilizing Emergency Inhalers

   David Pawlowski introduced the topic. In order to add this into the scope of practice for athletic trainers in Virginia, it will have to be done through legislation.

5. Discussion of Licensure Process, Temporary Authorization, Provisional License and Supervision

   Scott Powers discussed confusion in some quarters of the athletic training community about provisional licensure for athletic trainers. Once they have passed the BOC examination and are awaiting issuance of a full license, is the provisional license holder still operating under the "supervision and control" of an athletic trainer or can they engage in independent practice? It was suggested that the word, "*control*" be stricken from 18VAC85-120-80(A) and the sentence, "*if licensed or certified by another jurisdiction in the United States, documentation that his license or certificate is current and unrestricted*", be stricken from the regulation for temporary authorization to practice under 18VAC85-120-75.

   Scott Powers moved to approve that these changes be added as part of the recommendations to the full Board to amend or delete current provisions in Chapter 120. Trilizsa Trent seconded the motion. The motion carried.

6. Approval of 2023 Meeting Calendar

   Scott Powers moved to adopt the 2023 meeting calendar. Trilizsa Trent seconded the motion. The motion passed.

7. Election of Officers
   Scott Powers nominated David Pawlowski to remain as Chair. Trilizsa Trent seconded the motion. The motion passed. Scott Powers nominated Trilizsa Trent to remain as Vice-Chair. David Pawlowski seconded the motion. The motion passed.

Announcements:

<u>License Statistics</u>:

Delores Cousins provided the license statistics report. There are a total of 1,483 current active Virginia licenses with 5 current inactive. There are 309 current active out-of-state and 6 inactive out-of-state.

Next Scheduled Meeting:

The next scheduled meeting is February 9, 2023 at 10:00 am.

Adjournment

With no other business to conduct, the meeting adjourned at 11:34 am.

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William L. Harp, MD, Executive Director

ADVISORY BOARD ON PHYSICIAN ASSISTANTS
Minutes
September 22, 2022

MEMBERS PRESENT:	Justin Hepner, PA Erin Myers, PA-C Tracy Dunn - Citizen Member Lucy Treene, PA-C
MEMBERS ABSENT:	Frazier W. Frantz, MD
STAFF PRESENT:	William L. Harp, MD - Executive Director Michael Sobowale, LLM - Deputy Director for Licensure Erin Barrett, JD - DHP Senior Policy Analyst Colanthia M. Opher - Deputy Director for Administration ShaRon Clanton - Licensing Specialist
GUESTS PRESENT:	Robert Glasson, VAPA Kathleen Scarbalis, PA-C Clark Barrineau - MSV Jonathan Williams - VAPA Ben Traynham, JD - MSV

Call to Order

Dr. Harp called the meeting to order at 1:03 p.m. He asked members present, 3 of whom were newly-appointed, to introduce themselves.

Emergency Egress Procedures

Dr. Harp provided the emergency egress instructions.

Roll Call

Roll was called; a quorum was established.

Approval of Minutes

Justin Hepner moved to approve the minutes of the May 26, 2022 meeting. Lucy Treene seconded. The motion passed.

Adoption of Agenda

Erin Myer moved to adopt the meeting agenda as presented. Justin Hepner seconded. The motion passed.

Public Comments:

Old Business

1. Update on the Physician Assistant Licensure Compact

Kathleen Scarbalis, immediate past Chair of the Advisory Board, commented on the progress of the physician assistant licensure compact. She explained that the development of the physician assistant compact is being spearheaded by the Council of State Governments (CSG) and currently modeled after the Interstate Medical Licensure Compact. Draft legislation is currently being written that will simultaneously be distributed to all the states when it is ready. The goal is to get Virginia to be one of the first seven (7) states to participate.

2. VAPA Legislative Proposal

Jonathan Williams commented that VAPA hopes to introduce the legislative proposal to eliminate practice agreements in certain institutional settings where credentialing and privileging provide oversight. Also sought will be elimination of the 1:6 ratio of a patient care team physician to physician assistants in the 2023 legislative session.

New Business

1. **Periodic Review of Regulations Governing the Practice of Physician Assistants**

   Mrs. Barrett discussed the mandatory four-year review of Chapter 18 VAC 85-50 to determine whether this regulation should be repealed, amended or retained in its current form, without impacting public safety. The review of the regulations will be guided by the principles in Executive Order 14 as amended July 16, 2018. There was one public comment received seeking to edit and reflect the correct title, "Physician Assistant" in the listing of table of contents on page 4 of the regulations. There was also a request to remove the reference to supervision in Part B of 18VAC85-50-115 to read, "...collaborate or consult with [his] physician assistant...". The changes sought will be

incorporated into the entire changes recommended by the Advisory Board from a review of the entire regulations.

Ms. Barrett then presented her recommendations to amend or delete current language provisions in 18VAC85-50-10(B), 18VAC85-50-30, 18VAC85-50-35(2), 18VAC85-50-40, 18VAC85-50-59(4), 18VAC85-50-61(D), 18VAC85-50-101(A), 18VAC85-50-115(B), 18VAC85-50-116, 18VAC85-50-178, 18VAC85-50-180, 18VAC85-50-181, and 18VAC85-50-182. Some of these provisions are in the law, and it is unnecessary to repeat them in regulation.

Justin Hepner moved that the Advisory Board recommend to the full Board to retain and amend Chapter 50 with suggested changes as discussed. Lucy Treene seconded. The motion passed.

2. Review of Bylaws for Advisory Boards

Erin Barrett presented the uniform Bylaws for all Advisory Boards that the full Board approved at its June meeting. Since the Bylaws are slated to become effective on September 29, 2022, this was for information only.

3. Approval of 2023 Meeting Calendar

Erin Myers moved to approve the 2023 meeting calendar. Lucy Treene seconded. The motion passed.

4. Election of Officers

Tracy Dunn nominated Justin Hepner as Chair. Lucy Treene seconded. The motion passed. Erin Myers self-nominated as Vice-Chair. Lucy Treene seconded. The motion passed.

Announcements

License Statistics

ShaRon Clanton provided the licensing report. The Board has issued a total of 574 physician assistant licenses in 2022. There are currently a total of 5,724 licensees with 4, 049 current active in Virginia and 19 inactive. There are 1, 618 current active out-of-state with 38 are inactive out-of-state.

Next Scheduled Meeting

The next scheduled meeting is February 9, 2023 at 1:00 p.m.

Adjournment

With no other business to conduct, the meeting was adjourned at 2:07 p.m.

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

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ADVISORY BOARD ON MIDWIFERY
Minutes
September 23, 2022

The Advisory Board on Midwifery met on Friday, September 23, 2022 at 10:00 a.m. at the Department of Health Professions, Perimeter Center; 9960 Mayland Drive, Henrico, Virginia, 23233.

MEMBERS PRESENT: Rebecca Banks, LM - Vice-Chair
Ildiko Baugus, LM

MEMBERS ABSENT: Ami Keatts, M.D.
Erin Hammer, LM

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

GUESTS PRESENT: Adrienne Ross
Misty Ward, LM

Call to Order

Rebecca Banks called the meeting to order at 10:11 a.m.

Emergency Egress Procedures

Dr. Harp announced the emergency egress instructions.

Roll Call

The roll was called; no quorum was declared.

Approval of Minutes

The minutes were not approved as no quorum was present.

Adoption of Agenda

The agenda was not adopted as no quorum was present.

Public Comment

No public comment was received at the outset of the meeting. Public comment was reopened for Misty Ward later in the meeting. Ms. Ward inquired whether the Advisory Board had a mechanism to remove members who do not attend meetings. Dr. Harp explained that the Governor appoints and has the authority to remove Advisory Board members. Ms. Ward indicated she may be in touch with the Governor.

New Business

1. **Periodic Review of Regulations Governing the Practice of Licensed Midwives**

   Mrs. Barrett discussed the mandatory four-year review of Chapter 130 to determine whether this regulation should be repealed, amended or retained in its current form, without impacting public safety. The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018). There were a number of comments received during the public comment period. She said only those that referenced a section of the regulations were meaningful to the process. She pointed out that authorization for midwives to possess and administer medications would be a matter for the General Assembly.

   Ms. Barrett then presented her recommendations to amend or delete current language provisions in 18VAC85-130-30(10), 18VAC85-130-100(G), 18VAC85-130-110, 18VAC85-130-130, 18VAC85-130-140, and 18VAC85-130-150. Some of these provisions are in the law, and it is unnecessary to repeat them in regulation. These suggested revisions were discussed thoroughly with the members of the Advisory Board in attendance. Although a quorum was not available to make the suggested revisions a recommendation from the Advisory Board, Ms. Barrett said she will present them to the Board of Medicine with a recommendation for adoption.

2. **Review of Bylaws for Advisory Boards**

   Erin Barrett presented the uniform Bylaws for all Advisory Boards that the full Board approved at its June meeting. Since the Bylaws are slated to become effective on September 29, 2022, this was for information only.

3. **Discuss Process for Additions to High Risk Pregnancy Disclosures Guidance Document**

   Rebecca Banks stated that Guidance Document 85-10 on Disclosures in High-Risk Pregnancy Conditions needed to be updated. Dr. Harp provided general guidance on the process for updating guidance documents. Ms. Banks and Ms. Baugus indicated they would forward a few items that they believed required revision and any additions as well. Historically, updates to this document have been addressed by an ad hoc committee consisting of equal numbers of Advisory Board members and Board of Medicine members. The committee would be appointed by the Board of Medicine

President. Further detail about the process will be sought from Ms. Barrett, DHP Senior Policy Analyst.

4. **Approval of 2023 Calendar**

The 2023 meeting was not approved as no quorum was present.

5. **Election of Officers**

Officers were not elected as no quorum was present.

Announcements

License statistics

Beulah Baptist Archer provided the license count for licensed midwifery, as follows:

Current active midwives in Virginia	79
Current active out of state	29
Current inactive out of state	1
Total	109

Next Scheduled Meeting

The next scheduled meeting is February 10, 2023 @ 10:00 a.m.

Adjournment

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

William L. Harp, MD Executive Director

<< DRAFT >>

ADVISORY BOARD ON POLYSOMNOGRAPHIC TECHNOLOGY
Minutes
September 23, 2022

The Advisory Board on Polysomnographic Technology met on Friday, September 23, 2022 at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

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

MEMBERS ABSENT: Jonathan Clark, RPSGT

STAFF PRESENT: William L. Harp, MD - Executive Director
Michael Sobowale, LLM - Deputy Director for Licensure
Colanthia Opher - Deputy Director for Administration

GUESTS PRESENT: None

Call to Order

Dr. Amir called the meeting to order at 2:36 p.m.

Emergency Egress Procedures

Dr. Amir announced the emergency egress procedures.

Roll Call

Roll was called; a quorum was declared.

Approval of Minutes

Ronnie Hayes moved to approve the minutes of the October 8, 2021 meeting. Hannah Tyler seconded. The motion carried.

Adoption of Agenda

Ronnie Hayes made a motion to adopt the meeting agenda. Raid Mohaidat seconded. The motion carried.

Public Comment

None

New Business

1. Periodic Review of Regulations Governing the Practice of Polysomnographic Technologists

   Erin Barrett discussed the mandatory four-year review of Chapter 18 VAC 85-140 to determine whether this regulation should be repealed, amended or retained in its current form, without impacting public safety. The review of the regulations will be guided by the principles in Executive Order 14 as amended July 16, 2018. There was no public comment received during the comment period. Ms. Barrett presented her recommendations to amend or delete current language provisions in 18VAC85-140-10 (C), 18VAC85-140-20, 18VAC85-140-110, 18VAC85-140-140(E)(3), 18VAC85-140-150(A)(2), (3), (4), 18VAC85-140-150(B), and 18VAC85-140-170. Some of these provisions are in the law, and it is unnecessary to repeat them in regulation.

   Dr. Amir moved that the Advisory Board recommend to the full Board to retain and amend Chapter 140 with suggested changes as discussed. Ronnie Hayes seconded. The motion carried.

2. Review of Bylaws for Advisory Boards

   Erin Barrett presented the uniform Bylaws for all Advisory Boards that the full Board approved at its June meeting. Since the Bylaws are slated to become effective on September 29, 2022, this was for information only.

3. Approval of 2023 Meeting Calendar

   Ronnie Hayes moved to approve the 2023 meeting calendar. Hannah Tyler seconded. The motion carried.

4. Election of Officers

   Dr. Amir nominated Ronnie Hayes for Chair. Hannah Tyler seconded. Dr. Amir then nominated Hannah Tyler for Vice-Chair. Ronnie Hayes seconded. Both motions carried.

Announcements:

Next Scheduled Meeting

The next scheduled meeting is February 10, 2023 at 2:30 p.m.

Adjournment

There being no other business, the meeting was adjourned at 2:28 p.m.

William L. Harp, MD, Executive Director

Agenda Item: Other Reports

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

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

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

VIRGINIA BOARD OF NURSING
COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
FORMAL HEARING
MINUTES
July 20, 2022

TIME AND PLACE: The hearing of the Committee of the Joint Boards of Nursing and Medicine was called to order at 4:36 P.M., on July 20, 2022.

COMMITTEE MEMBERS:
Ann Tucker Gleason, PhD; Board of Nursing; Joint Boards Member
Laurie Buchwald, MSN, WHNP, FNP; Board of Nursing; Joint Boards Member
James Hermansen-Parker, MSN, RN, PCCN-K; Board of Nursing
L. Blanton Marchese; Board of Medicine; Joint Boards Member

STAFF:
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
Lakisha Goode, Senior Discipline Specialist; Board of Nursing

OTHERS: Charis Mitchell, Assistant Attorney General; Counsel to the Committee

ESTABLISHMENT OF A QUORUM: Dr. Gleason called the meeting to order and established that a quorum consisting of 4 members was present.

FORMAL HEARING: **Keith Allen Jenkins, LNP Reinstatement Applicant 0024-172243**

Mr. Jenkins appeared.

Anne Joseph, Adjudication Consultant, Administrative Proceedings Division, represented the Commonwealth. Ms. Mitchell was legal counsel for the Committee of the Joint Boards. Kim Taylor, court reporter with Farnsworth and Taylor, recorded the proceedings.

Joyce Johnson, Senior Investigator, Enforcement Division, was present and testified.

CLOSED MEETING: Mr. Hermansen-Parker 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 5:22 P.M., for the purpose to reach a decision regarding the matter of **Keith Allen Jenkins**. Additionally, Mr. Hermansen-Parker moved that Ms. Douglas, Dr. Hills, Ms. Goode and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was properly seconded by Mr. Marchese and carried unanimously.

RECONVENTION: The Committee reconvened in open session at 5:37 P.M.

Mr. Hermansen-Parker 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. Buchwald and carried unanimously.

ACTION: Ms. Marchese moved to approve the application of **Keith Allen Jenkins** for reinstatement of his license to practice as a nurse practitioner in the category of adult/geriatric primary care nurse practitioner in the Commonwealth of Virginia. The motion was properly seconded by Mr. Hermansen-Parker and carried unanimously.

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

ADJOURNMENT: The meeting was adjourned at 5:40 P.M.

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

DRAFT

Agenda Item: **Current Legislative and Regulatory Actions/Considerations**

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

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

Agenda Items: Consideration of response to petition for rulemaking

Included in your agenda package are:

- Petition for rulemaking from Todd Lacksonen;
- Public comment received by the Board;
- Public comment posted on Town Hall in response to the petition.
- 18VAC85-21-40.

Action needed:

Motion to either:

- Initiate rulemaking; or
- Take no action.

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COMMONWEALTH OF VIRGINIA
Board of Medicine

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

(804) 367-4600 (Tel)
(804) 527-4426 (Fax)
Coco.Morton@dhp.virginia.gov

Petition for Rule-making

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

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

Petitioner's full name (Last, First, Middle initial, Suffix,)
Todd Lacksonen/Opiant Pharmaceuticals

Street Address	**Area Code and Telephone Number**	
8732 Tayport Drive	614 582 3003	
City	**State**	**Zip Code**
Dublin	Ohio	43017
Email Address (optional)	**Fax (optional)**	
tlacksonen@opiant.com		

Respond to the following questions:

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

   18VAC85-21-40. Treatment of acute pain with opioids.
   3. Naloxone shall be prescribed for any patient when risk factors of prior overdose, substance misuse, doses in excess of 120 MME/day, or concomitant benzodiazepine is present.

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

   We suggest the substitution of "naloxone" with "all FDA-approved opioid-reversal agents" to assure optimal clinical choices for physicians treating patients who by definition (and policy intent) are at a greater risk of overdose.

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

   § 54.1-2400. General powers and duties of health regulatory boards section 6: To promulgate regulations in accordance with the APA Act (§ 2.2-4000 et seq.) that are reasonable and necessary to administer effectively the regulatory process

Signature: DocuSigned by: Todd Lacksonen 64CEC94C1D0A40D...

Date: July 27, 2022

September 14, 2022
L. Blanton Marchese, MD
President, Virginia Board of Medicine
9960 Maryland Drive, Suite 300
Henrico, Virginia 23233
RE: Comments in Support of Petition 372

Dear President Marchese and members of the Board,

Currently, I serve as Chief Scientific Officer at Opiant Pharmaceuticals. While serving as the Director of the National Institute on Drug Abuse's Division of Therapeutics and Medical Consequences, I led the team developing the 4mg naloxone nasal spray that is now the 'gold standard' for treating opioid overdose.

On behalf of my organization and the dedicated researchers who contributed to the development of the 4mg naloxone nasal spray, we wish to offer our support for the proposed amendment to the Commonwealth of Virginia's Board of Medicine co-prescribing rule (18VAC85-21-70) that would expand the current rules governing co-prescribing of naloxone under certain conditions to also include anticipated future FDA-approved overdose treatments that are different from naloxone. The proposed agent agnostic language is intended to ensure that physicians have all therapeutic options available when contemplating the most suitable opioid overdose reversal agent.

High-potency synthetic opioids like fentanyl are now responsible for almost 90% of opioid overdose deaths in the United States, and innovative reversal agents are being developed which may be better suited to reverse an overdose caused by synthetic opioids. As these agents become available, they will offer practitioners additional choices to offer to their patients, but the existing rule currently limits those options. We ask that the language be expanded to the drug class instead of being limited to naloxone. Updated language suggestions include:

- *"FDA-approved opioid reversal agent,"* consistent with recent Substance Abuse and Mental Health Services Administration (SAMHSA) grant notices of funding opportunities.
- *"Naloxone or other opioid antagonist,"* which is consistent with other Virginia code sections.

The following are references of the Virginia statutes that reference opioid antagonists:

- **§ 18.2-251.03. Arrest and prosecution when experiencing or reporting overdoses.**
- **§ 54.1-3408. Professional use by practitioners.**
- **§ 32.1-45.4. Comprehensive harm reduction programs.**
- **§ 32.1-127. Regulations.**

This language update in the Virginia Board of Medicine Rules is necessary because there are multiple overdose reversal agents products in development that utilize active ingredients other than naloxone. An example of one of these innovative products is Opiant's nalmefene nasal spray, which we are in the process of filing our NDA. This rule will ensure that physicians in Virginia can exercise their clinical judgement and select any reversal agent they deem appropriate.

When updated, the co-prescribing provisions of the rule will allow all opioid-reversal agents to be considered and ensures that Virginians are not left without critical tools to combat opioid overdose.

Updating Molecule-Specific Language:

In 2017, the National Institute of Health asked to "work with private partners to develop stronger, longer-acting formulations of antagonists, including naloxone, to counteract the very-high-potency synthetic opioids that are now claiming thousands of lives each year.[1]" Opiant and other innovators in overdose reversal want to ensure that Virginia residents will be able to access any FDA-approved reversal agent.

Co-Prescription

Co-prescription of opioid overdose reversal agents is one of the most effective strategies available for preventing overdose death. According to research published in the *Annals of Internal Medicine*[2], patients who received an opioid overdose antagonist with their long-term opioid prescription had 47% fewer opioid-related emergency room visits after six months and 63% fewer after one year, compared to patients who did not receive it an opioid antagonist. Co-prescription rules exist in 15 states and have been seen as an effective way to identify at-risk individuals and ensure they receive a consultation on an overdose reversal agent.

This administrative rule change will help ensure that Virginians have access to all opioid reversal agents. We would be happy to answer any questions or address concerns any members of the Board may have. Thank you for your consideration.

Sincerely yours,

Phil Skolnick, PhD., DSc. (hon.)
Chief Scientific Officer

[1] (Nora D. Volkow, 2017)
[2] (Phillip O. Coffin, Emily Behar, Christopher Rowe, Glenn-Milo Santos, & Diana Coffa, 2016)

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Agency Department of Health Professions

Board Board of Medicine

Chapter Regulations Governing Prescribing of Opioids and Buprenorphine [18 VAC 85 - 21]

2 comments

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

Back to List of Comments

Commenter: Victor McKenzie Jr 9/19/22 2:24 pm

Updating the term "Naloxone"

SAARA of VA's mission is to transform Virginia communities through hope, education, and advocacy for addiction prevention, treatment, and recovery. SAARA is the leading voice in Virginia on substance use disorder and recovery. We provide individuals and communities with education, advocacy, and support.

We support the proposed co-prescribing rule (18VAC85-21-70) regarding the treatment of chronic pain with opioids that states: "Naloxone shall be prescribed for any patient when risk factors of prior overdose, substance misuse, doses in excess of 120 MME/day, or concomitant benzodiazepine is present." The rule will ensure that those receiving exceptionally high doses of opioid medication are educated on the potential risk for overdose. People receiving high doses of opioid medications are at elevated risk for overdose and providing a reversal agent can reduce that risk significantly.

We are asking the Board to update this rule by changing the term "naloxone" to either:

- "*Naloxone or other opioid antagonist,*" which is consistent with other Virginia code sections
- "*FDA-approved opioid reversal agent,*" consistent with recent Substance Abuse and Mental Health Services Administration (SAMHSA) grant notices of funding opportunities.

Main Points

- This update would turn the co-prescription rule into line with language in **§ 18.2-251.03, § 54.1-3408, § 32.1-45.4, and § 32.1-127**
- Several organizations are currently working on reversal agents that utilize molecules other than naloxone
    - Virginians need access to these innovative therapies, and this rule must allow physicians maximum flexibility to provide any reversal agent that they deem appropriate
    - Naloxone-specific language in this rule would create a barrier to new reversal agents for physicians and people at risk of overdose
        - These products from innovative organizations have the potential to be valuable tools to combat the overdose crisis.
- Recently, the National Institute on Drug Abuse (NIDA) reported that 1 in 20 people who present in an emergency room for an overdose die in the next year of an overdose. Two-thirds of those individuals die from a subsequent opioid-related overdose. NIDA's data demonstrates that the people at the highest risk of overdose do not have sufficient access to reversal agents even after being in a hospital for a previous overdose.
- Fentanyl is now responsible for the majority of overdoses and it is clear that faster, stronger, and longer-acting reversal agents are needed in order to counter it

- According to research published in the Annals of Internal Medicine, patients who received an opioid overdose antagonist with their long-term opioid prescription had 47% fewer opioid-related emergency room visits after six months and 63% fewer after one year, compared to patients who did not receive an opioid antagonist.
    - Physicians must be able to provide any reversal agent, not just naloxone for this co-prescribing rule to be as effective as possible.

CommentID: **128875**

Commenter: Todd Lacksonen, Opiant Pharmaceuticals 9/19/22 2:34 pm

Comments in Support of Petition 372

Dear President Marchese and members of the Board,

Currently, I serve as Chief Scientific Officer at Opiant Pharmaceuticals. While serving as the Director of the National Institute on Drug Abuse's Division of Therapeutics and Medical Consequences, I led the team developing the 4mg naloxone nasal spray that is now the 'gold standard' for treating opioid overdose.

On behalf of my organization and the dedicated researchers who contributed to the development of the 4mg naloxone nasal spray, we wish to offer our support for the proposed amendment to the Commonwealth of Virginia's Board of Medicine co-prescribing rule (18VAC85-21-70) that would expand the current rules governing co-prescribing of naloxone under certain conditions to also include anticipated future FDA-approved overdose treatments that are different from naloxone. The proposed agent agnostic language is intended to ensure that physicians have all therapeutic options available when contemplating the most suitable opioid overdose reversal agent.

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claiming thousands of lives each year.[1]" Opiant and other innovators in overdose reversal want to ensure that Virginia residents will be able to access any FDA-approved reversal agent.

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This administrative rule change will help ensure that Virginians have access to all opioid reversal agents. We would be happy to answer any questions or address concerns any members of the Board may have. Thank you for your consideration.

Sincerely yours,

Phil Skolnick, PhD., DSc. (hon.)
Chief Scientific Officer

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[1] (Nora D. Volkow, 2017)

[2] (Phillip O. Coffin, Emily Behar, Christopher Rowe, Glenn-Milo Santos, & Diana Coffa, 2016)

CommentID: **128876**

Virginia Administrative Code
Title 18. Professional And Occupational Licensing
Agency 85. Board of Medicine
Chapter 21. Regulations Governing Prescribing of Opioids and Buprenorphine

18VAC85-21-40. Treatment of acute pain with opioids.

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

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

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

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

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

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

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

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.

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

Statutory Authority

§§ 54.1-2400 and 54.1-2928.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 34, Issue 23, eff. August 8, 2018.

Website addresses provided in the Virginia Administrative Code to documents incorporated by reference are for the reader's convenience only, may not necessarily be active or current, and should not be relied upon. To ensure the information incorporated by reference is accurate, the reader is encouraged to use the source document described in the regulation.

As a service to the public, the Virginia Administrative Code is provided online by the Virginia General Assembly. We are unable to answer legal questions or respond to requests for legal advice, including application of law to specific fact. To understand and protect your legal rights, you should consult an attorney.

Agenda Items: Issue periodic review decision and adoption of fast-track regulatory changes recommended by Legislative Committee for Chapter 15 and Chapter 20

Included in your agenda package are:

- Notices of periodic review
- Revisions to Chapters 15 and 20 recommended by Legislative Committee

Staff note: Legislative Committee recommended retaining Chapters 15 and 20 with amendments.

Action needed:

- Motion to retain Chapters 15 and 20 with amendments;

- Motion to adopt changes recommended by Legislative Committee to those two chapters as fast-track regulatory changes.

Virginia.gov Agencies | Governor

Agency Department of Health Professions

Board Board of Medicine

Chapter Regulations Governing Delegation to an Agency Subordinate [18 VAC 85 - 15]

Edit Review

Review 2146

Periodic Review of this Chapter

Includes a Small Business Impact Review

Date Filed: 6/16/2022

Review Announcement

Pursuant to Executive Order 14 (as amended July 16, 2018) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, this regulation is undergoing a periodic review.

The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018). http://TownHall.Virginia.Gov/EO-14.pdf.

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

In order for you to receive a response to your comment, your contact information (preferably an email address or, alternatively, a U.S. mailing address) must accompany your comment. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

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

Publication Information and Public Comment Period

Published in the Virginia Register on 7/18/2022 [Volume: 38 Issue: 24]

Comment Period begins on the publication date and ends on 8/17/2022

Comments Received: 0

Review Result

Pending

Attorney General Certification

Pending

This periodic review was created by Erin Barrett on 06/16/2022 at 12:23pm

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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]**

Edit Review Review 2147

Periodic Review of this Chapter

Includes a Small Business Impact Review

Date Filed: 6/16/2022

Review Announcement

Pursuant to Executive Order 14 (as amended July 16, 2018) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, this regulation is undergoing a periodic review.

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Pending

This periodic review was created by Erin Barrett on 06/16/2022 at 12:24pm

Commonwealth of Virginia

REGULATIONS

GOVERNING DELEGATION TO AN AGENCY SUBORDINATE

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-15-10 et seq.

Statutory Authority: § 54.1-2400 of the *Code of Virginia*

Revised Date: July 27, 2005

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

(804) 367-4600 (TEL)
(804) 527-4426 (FAX)
email: medbd@dhp.virginia.gov

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18VAC85-15-10. Decision to delegate informal fact-finding proceedings to an agency subordinate.

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

18VAC85-15-20. Criteria for delegation.

Cases that may be delegated to an agency subordinate shall be limited to those involving:

1. The practitioner profile system;
2. Continuing competency;
3. Advertising;
4. Compliance with board orders;
5. ~~Default on a federal or state-guaranteed educational loan or on a work-conditional scholarship or grant for the cost of a health professional education;~~ or
6. Failure to provide medical records.

18VAC85-15-30. Criteria for an agency subordinate.

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

B. The executive director shall maintain a list of appropriately qualified persons to whom an informal fact-finding proceeding may be delegated.

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

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF MEDICINE, OSTEOPATHIC MEDICINE, PODIATRY AND CHIROPRACTIC

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-20-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Revised Date: April 1, 2022

9960 Mayland Drive, Suite 300
Henrico, VA 23233-2463

(804) 367-4600 (TEL)
(804) 527-4426 (FAX)
email: medbd@dhp.virginia.gov

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Part I. General Provisions.

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.

~~**18VAC85-20-20. Public Participation Guidelines.**~~

~~A separate board regulation, 18VAC85-11, entitled Public Participation Guidelines, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.~~

18VAC85-20-21. Current addresses.

Each licensee shall furnish the board his current address of record. All notices required by law or by this chapter to be given by the board to any such licensee shall be validly given when sent to the latest address of record given by the licensee. Any change in the address of record of the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-20-22. Required fees.

A. Unless otherwise provided, fees established by the board shall not be refundable.

B. All examination fees shall be determined by and made payable as designated by the board.

C. The application fee for licensure in medicine, osteopathic medicine, and podiatry shall be $302, and the fee for licensure in chiropractic shall be $277.

D. The fee for a temporary authorization to practice medicine pursuant to § 54.1-2927 B (i) and (ii) of the Code of Virginia shall be $25.

E. The application fee for a limited professorial or fellow license issued pursuant to 18VAC85-20-210 shall be $55. The annual renewal fee shall be $35. For renewal of a limited professorial or fellow license in 2020, the fee shall be $30. An additional fee for late renewal of licensure shall be $15.

F. The application fee for a limited license to interns and residents pursuant to 18VAC85-20-220 shall be $55. The annual renewal fee shall be $35. For renewal of a limited license to interns and residents in 2020, the fee shall be $30. An additional fee for late renewal of licensure shall be $15.

G. The fee for a duplicate wall certificate shall be $15; the fee for a duplicate license shall be $5.

H. The fee for biennial renewal shall be $337 for licensure in medicine, osteopathic medicine, and podiatry and $312 for licensure in chiropractic, due in each even-numbered year in the licensee's birth month. An additional fee for processing a late renewal application within one renewal cycle shall be $115 for licensure in medicine, osteopathic medicine, and podiatry and $105 for licensure in chiropractic. For renewal of licensure in 2020, the fee shall be $270 for licensure in medicine, osteopathic medicine, and podiatry and $250 for licensure in chiropractic.

I. The fee for requesting reinstatement of licensure or certification pursuant to § 54.1-2408.2 of the Code of Virginia or for requesting reinstatement after any petition to reinstate the certificate or license of any person has been denied shall be $2,000.

J. The fee for reinstatement of a license issued by the Board of Medicine pursuant to § 54.1-2904 of the Code of Virginia that has expired for a period of two years or more shall be $497 for licensure in medicine, osteopathic medicine, and podiatry ($382 for reinstatement application in addition to the late fee of $115) and $472 for licensure in chiropractic ($367 for reinstatement application in addition to the late fee of $105). The fee shall be submitted with an application for licensure reinstatement.

K. The fee for a letter of verification of licensure shall be $10, and the fee for certification of grades to another jurisdiction by the board shall be $25. Fees shall be due and payable upon submitting a request for verification or certification to the board.

L. The fee for biennial renewal of an inactive license shall be $168, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $55 for each renewal cycle. For renewal of an inactive license in 2020, the fee shall be $135.

M. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $75, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $25 for each renewal cycle. For renewal of a restricted volunteer license in 2020, the fee shall be $60.

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

Part II. Standards of Professional Conduct.

18VAC85-20-25. Treating and prescribing for self or family.

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

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

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

18VAC85-20-26. Patient records.

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

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

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

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

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

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

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

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

~~F. When a practitioner is closing, selling or relocating his practice, 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.~~

Commented [VP1]: In code, not necessary to repeat here.

18VAC85-20-27. Confidentiality.

A. 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.

B. Unauthorized use or disclosure of confidential information received from the Prescription Monitoring Program shall be grounds for disciplinary action.

18VAC85-20-28. Practitioner-patient communication; 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 inform a patient or his legally authorized representative of his medical diagnoses, prognosis and prescribed treatment or plan of care in understandable terms. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure prescribed or directed by the practitioner in the treatment of any disease or condition.

2. ~~A practitioner shall present information relating to the patient's care to a patient or his legally authorized representative in understandable terms and encourage participation in the decisions regarding the patient's care.~~

~~3.~~ Before surgery or any invasive procedure is performed, 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 surgery or invasive procedure that a reasonably prudent practitioner in similar practice 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 surgery or an invasive 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, "invasive procedure" shall mean 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.~~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 a copy of the patient record available, except in situations where denial of access is allowed by law.

2. Except as provided in § 54.1-2962.2 of the Code of Virginia, 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.

18VAC85-20-29. 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 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 A 2 of this section.

18VAC85-20-30. Advertising ethics.

~~A. Any statement specifying a fee, whether standard, discounted or free, for professional services which does not include the cost of all related procedures, services and products which, to a substantial likelihood, will be necessary for the completion of the advertised service as it would be understood by an ordinarily prudent person shall be deemed to be deceptive or misleading, or both. Where reasonable disclosure of all relevant variables and considerations is made, a statement of a range of prices for specifically described services shall not be deemed to be deceptive or misleading.~~

> **Commented [VP2]:** Related to chiropractors in the 1990s. Consider removing all but E and F, combining those two

~~B. Advertising a discounted or free service, examination, or treatment and charging for any additional service, examination, or treatment which is performed as a result of and within 72 hours of the initial office visit in response to such advertisement is unprofessional conduct unless such professional services rendered are as a result of a bona fide emergency. This provision may not be waived by agreement of the patient and the practitioner.~~

~~C. Advertisements of discounts shall disclose the full fee that has been discounted. The practitioner shall maintain documented evidence to substantiate the discounted fees and shall make such information available to a consumer upon request.~~

~~D. A licensee shall disclose the complete name of the specialty board which conferred the certification when using or authorizing the use of the term "board certified" or any similar words or phrase calculated to convey the same meaning in any advertising for his practice.~~

~~E.~~ A licensee of the board shall not advertise information which is false, misleading, or deceptive. For an advertisement for a single practitioner, it shall be presumed that the practitioner is responsible and accountable for the validity and truthfulness of its content. For an advertisement for a practice in which there is more than one practitioner, the name of the practitioner or practitioners responsible and accountable for the content of the advertisement shall be documented and maintained by the practice for at least two years. Documentation, scientific and otherwise, supporting claims made in an advertisement shall be maintained and available for the board's review for at least two years.

~~F. Documentation, scientific and otherwise, supporting claims made in an advertisement shall be maintained and available for the board's review for at least two years.~~

~~18VAC85-20-40. Vitamins, minerals and food supplements.~~

Commented [VP3]: 54.1-2963 says board "shall have authority to promulgate regulations," not that it "shall promulgate."

~~A. The recommendation or direction for the use of vitamins, minerals or food supplements and the rationale for that recommendation shall be documented by the practitioner. The recommendation or direction shall be based upon a reasonable expectation that such use will result in a favorable patient outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use.~~

~~B. Vitamins, minerals, or food supplements, or a combination of the three, shall not be sold, dispensed, recommended, prescribed, or suggested in doses that would be contraindicated based on the individual patient's overall medical condition and medications.~~

~~C. The practitioner shall conform to the standards of his particular branch of the healing arts in the therapeutic application of vitamins, minerals or food supplement therapy.~~

~~18VAC85-20-50. Anabolic steroids.~~

~~A practitioner shall not sell, prescribe, or administer anabolic steroids to any patient for other than accepted therapeutic purposes.~~

Commented [VP4]: Redundant of general requirements to prescribe for therapeutic purposes.

18VAC85-20-60 to 18VAC85-20-70. [Repealed]

~~18VAC85-20-80. Solicitation or remuneration in exchange for referral.~~

~~A practitioner shall not knowingly and willfully solicit or receive any remuneration, directly or indirectly, in return for referring an individual to a facility or institution as defined in §37.2-100 of the Code of Virginia, or hospital as defined in §32.1-123 of the Code of Virginia. Remuneration shall be defined as compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by Title 42, §1320a-7b(b) of the United States Code, as amended, or any regulations promulgated thereto.~~

Commented [VP5]: 54.1-2962.1 says all of this already. Further says "Board shall adopt regulations as necessary to carry out provisions of this section." Arguable that this is not necessary if it just repeats what is in statute.

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

Commented [VP6]: Very specific to a problem from the 90s.

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

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

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

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

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

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

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

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

18VAC85-20-91. Practice and supervision of laser hair removal.

A. A doctor of medicine or osteopathic medicine may perform or supervise the performance of laser hair removal upon completion of training in the following:

1. Skin physiology and histology;

2. Skin type and appropriate patient selection;

3. Laser safety;

4. Operation of laser device to be used;

5. Recognition of potential complications and response to any actual complication resulting from a laser hair removal treatment; and

6. A minimum number of 10 proctored patient cases with demonstrated competency in treating various skin types.

B. Doctors of medicine or osteopathic medicine who have been performing laser hair removal prior to August 7, 2019, are not required to complete training specified in subsection A of this section.

C. A doctor who delegates the practice of laser hair removal and provides supervision to a person other than a licensed physician assistant or licensed nurse practitioner shall ensure that such person has completed the training required in subsection A of this section.

D. A doctor who performs laser hair removal or who supervises others in the practice shall receive ongoing training as necessary to maintain competency in new techniques and laser devices. The doctor shall ensure that persons the doctor supervises also receive ongoing training to maintain competency.

E. A doctor may delegate laser hair removal to a properly trained person under the doctor's direction and supervision. Direction and supervision shall mean that the doctor is readily available at the time laser hair removal is being performed. The supervising doctor is not required to be physically present but is required to see and evaluate a patient for whom the treatment has resulted in complications prior to the continuance of laser hair removal treatment.

F. Prescribing of medication shall be in accordance with § 54.1-3303 of the Code of Virginia.

18VAC85-20-100. 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 which:

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.

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 shall mean: spouse or partner, parent or child, guardian, or legal representative of the patient.

E. Sexual contact between a medical supervisor and a medical 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.

18VAC85-20-105. 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.

Part III. Licensure: General and Educational Requirements.

18VAC85-20-110. [Repealed]

18VAC85-20-120. Prerequisites to licensure.

Every applicant for licensure shall:

1. Meet the educational requirements specified in 18VAC85-20-121 or 18VAC85-20-122 and the examination requirements as specified for each profession in 18VAC85-20-140;

2. File the complete application and appropriate fee as specified in 18VAC85-20-22 with the executive director of the board; and

3. File the required credentials with the executive director as specified below:

a. Graduates of an approved institution shall file:

(1) Documentary evidence that he received a degree from the institution; and

(2) A ~~complete~~ chronological record of all professional activities since graduation from professional school or the last ten years, whichever is less. ~~, giving location, dates, and types of services performed.~~

b. Graduates of an institution not approved by an accrediting agency recognized by the board shall file:

(1) Documentary evidence of education as required by 18VAC85-20-122;

(2) A translation made and endorsed by a consul or by a professional translating service of all such documents not in the English language; and

(3) A complete chronological record of all professional activities since graduation from professional school or the last ten years, whichever is less. ~~, giving location, dates, and types of services performed.~~

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

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

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

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

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

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

C. For licensure in chiropractic.

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

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

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

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

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

2. Has received a degree from the institution.

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

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

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

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

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

1. Has fulfilled the requirements of subdivisions A 1 and A3 through A 6 of this section;

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

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

18VAC85-20-130. [Repealed]

18VAC85-20-131. Requirements to practice acupuncture.

A. To be qualified to practice acupuncture, licensed doctors of medicine, osteopathic medicine, podiatry, and chiropractic shall first have obtained at least 200 hours of instruction in general and basic aspects of the practice of acupuncture, specific uses and techniques of acupuncture, and indications and contraindications for acupuncture administration. At least 50 hours of the 200 hours of instruction shall be clinical experience supervised by a person legally authorized to practice acupuncture in any jurisdiction of the United States. Persons who held a license as a physician acupuncturist prior to July 1, 2000, shall not be required to obtain the 50 hours of clinical experience.

B. The use of acupuncture as a treatment modality shall be appropriate to the doctor's scope of practice as defined in §54.1-2900 of the Code of Virginia.

Part IV. Licensure: Examination Requirements.

18VAC85-20-140. Examinations, general.

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

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

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

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

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

2. An applicant who graduated from January 31, 1991, to January 31, 1996, shall document successful completion of Parts I, II, and III of the National Board of Chiropractic Examiners examination (NBCE).

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

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

E. Applicants who sat for the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensure Examination (COMLEX-USA) shall provide evidence of passing all steps within a 10-year period unless the applicant is board certified in a specialty approved by the American Board of Medical Specialties or the Bureau of Osteopathic Specialists of the American Osteopathic Association.

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

18VAC85-20-141. Licensure by endorsement.

To be licensed by endorsement, an applicant shall:

1. Hold at least one current, active ~~unrestricted~~ license in a United States jurisdiction or Canada ~~for the five years immediately preceding application to the board~~;

2. Have been engaged in active practice, defined as two out of the last five years ~~an average of 20 hours per week or 640 hours per year, for five years after postgraduate training and~~ immediately preceding application, where such practice is not required to be consecutive;

Commented [VP7]: Or "uninterrupted"?

3. Verify that the most recent license held in another United States jurisdiction or in Canada are in good standing, defined as current and unrestricted or, if lapsed, eligible for renewal or reinstatement;

4. Hold current certification by one of the following:

a. American Board of Medical Specialties;

b. Bureau of Osteopathic Specialists;

c. American Board of Foot and Ankle Surgery;

d. American Board of Podiatric Medicine;

e. Fellowship of Royal College of Physicians of Canada;

f. Fellowship of the Royal College of Surgeons of Canada; or

g. College of Family Physicians of Canada;

5. Submit a current report from the U.S. Department of Health and Human Services National Practitioner Data Bank; and

6. Have no grounds for denial based on provisions of § 54.1-2915 of the Code of Virginia or regulations of the board, or have any disciplinary restrictions on a current, active license.

18VAC85-20-150 to 18VAC85-20-200. [Repealed]

Part V. Limited or Temporary Licenses.

18VAC85-20-210. Limited licenses to foreign medical graduates.

A. A physician who graduated from an institution not approved by an accrediting agency recognized by the board applying for a limited professorial license or a limited fellow license to practice medicine in an approved medical school or college in Virginia shall:

1. Submit evidence of authorization to practice medicine in a foreign country.

2. Submit evidence of a standard Educational Commission for Foreign Medical Graduates (ECFMG) certificate or its equivalent. Such required evidence may be waived by the Credentials Committee or its designee based on other evidence of medical competency and English proficiency.

3. Submit a recommendation from the dean of an accredited medical school in Virginia that the applicant is a person of professorial or of fellow rank whose knowledge and special training meet the requirements of §54.1-2936 of the Code of Virginia.

B. The limited professorial license or limited fellow license applies only to the practice of medicine in hospitals and outpatient clinics where medical students, interns or residents rotate and patient care is provided by the medical school or college recommending the applicant. A limited professorial license or limited fellow license shall be valid for one year. Renewals shall be based upon the recommendation of the dean of the medical school and continued full-time service as a faculty member or employment as a fellow, although a limited fellow license may not be renewed more than twice.

~~1. The limited professorial license shall be valid for one year and may be renewed annually upon recommendation of the dean of the medical school and upon continued full-time service as a faculty member.~~

~~2. The limited fellow license shall be valid for one year and may be renewed not more than twice upon the recommendation of the dean of the medical school and upon continued full-time employment as a fellow.~~

Commented [VP8]: Somewhat redundant. Combined both into B.

C. An individual who has practiced with a limited professorial license for five continuous years may have a waiver when applying for a full license to practice medicine in the Commonwealth of

Virginia. The limited professorial licensee applying for a full license shall meet the requirements of 18VAC85-20-120 and 18VAC85-20-122.

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

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

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

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

3. Submit evidence of a standard Educational Commission for Foreign Medical Graduates (ECFMG) certificate or its equivalent if the candidate graduated from a school not approved by an accrediting agency recognized by the board.

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

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

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

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

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

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

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

Any doctor of medicine, osteopathic medicine, podiatry or chiropractic who does not hold a license to practice in Virginia and who seeks registration to practice under subdivision A 27 of §54.1-2901

of the Code of Virginia on a voluntary basis under the auspices of a publicly supported, all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people shall:

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

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

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

4. ~~Pay a registration fee of $10; and~~

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

18VAC85-20-226. Restricted volunteer license.

A. Any doctor of medicine, osteopathic medicine, podiatry or chiropractic who held an unrestricted license issued by the Virginia Board of Medicine or by a board in another state as a licensee in good standing at the time the license expired or became inactive may be issued a restricted volunteer license to practice without compensation in a clinic that is organized in whole or in part for the delivery of health care services without charge in accordance with §54.1-106 of the Code of Virginia.

B. To be issued a restricted volunteer license, a doctor of medicine, osteopathic medicine, podiatry or chiropractic shall submit an application to the board that documents compliance with requirements of §54.1-2928.1 of the Code of Virginia and the application fee prescribed in 18VAC85-20-22.

C. The licensee who intends to continue practicing with a restricted volunteer license shall renew biennially during his birth month, meet the continued competency requirements prescribed in subsection D of this section, and pay to the board the renewal fee prescribed in 18VAC85-20-22.

D. The holder of a restricted volunteer license shall not be required to attest to hours of continuing education for the first renewal of such a license. For each renewal thereafter, the licensee shall attest to 30 hours obtained during the two years immediately preceding renewal with at least 15 hours of Type 1 activities or courses offered by an accredited sponsor or organization sanctioned by the profession and no more than 15 hours of Type 2 activities or courses.

Part VI. Renewal of License; Reinstatement.

18VAC85-20-230. Renewal of an active license.

A. Every licensee who intends to maintain an active license shall renew his license biennially during his birth month, meet the continued competency requirements prescribed in 18VAC85-20-235, and pay to the board the renewal fee prescribed in 18VAC85-20-22.

B. An additional fee to cover administrative costs for processing a late application shall be imposed by the board as prescribed in subsection H of 18VAC85-20-22.

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

A. In order to renew an active license biennially, a practitioner shall attest to completion of at least ~~60~~ 30 hours of continuing learning activities within the two years immediately preceding renewal. ~~as follows:~~

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

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

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

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

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

~~b. Type 2 hours may include teaching in a health care profession field.~~

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

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

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

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

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

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

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

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

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

18VAC85-20-236. Inactive license.

A doctor of medicine, osteopathic medicine, podiatry or chiropractic who holds a current, unrestricted license in Virginia may, 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 continuing competency requirements and shall not be entitled to perform any act requiring a license to practice medicine, osteopathic medicine, podiatry or chiropractic in Virginia.

18VAC85-20-240. Reinstatement of an inactive or lapsed license.

A. A practitioner whose license has been lapsed for two successive years or more and who requests reinstatement of licensure shall:

1. File a completed application for reinstatement;

2. Pay the reinstatement fee prescribed in 18VAC85-20-22; and

3. Provide documentation of having completed continued competency hours equal to the requirement for the number of years, not to exceed four years, in which the license has been lapsed.

B. An inactive licensee may reactivate his license upon submission of the required application, payment of the difference between the current renewal fee for inactive licensure and the current renewal fee for active licensure, and documentation of having completed continued competency hours equal to the requirement for the number of years, not to exceed four years, in which the license has been inactive.

C. If a practitioner has not engaged in active practice in his profession for more than four years and wishes to reinstate or reactivate his license, the board may require the practitioner to pass one of the following examinations. For the purpose of determining active practice, the practitioner shall

provide evidence of at least 640 hours of clinical practice within the four years immediately preceding his application for reinstatement or reactivation.

1. The Special Purpose Examination (SPEX) given by the Federation of State Medical Boards.

2. The Comprehensive Osteopathic Medical Variable Purpose Examination—USA (COMVEX-USA) given by the National Board of Osteopathic Examiners.

3. The Special Purposes Examination for Chiropractic (SPEC) given by the National Board of Chiropractic Examiners.

4. A special purpose examination or other evidence of continuing competency to practice podiatric medicine as acceptable to the board.

D. The board reserves the right to deny a request for reinstatement or reactivation 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.

18VAC85-20-250 to 18VAC85-20-270. [Repealed]

Part VII. Practitioner Profile System.

18VAC85-20-280. Required information.

A. In compliance with requirements of §54.1-2910.1 of the Code of Virginia, a doctor of medicine, osteopathic medicine, or podiatry licensed by the board shall provide, upon initial request or whenever there is a change in the information that has been entered on the profile, the following information within 30 days:

1. The address and telephone number of the primary practice setting and all secondary practice settings with the percentage of time spent at each location;

2. Names of medical, osteopathic or podiatry schools and graduate medical or podiatric education programs attended with dates of graduation or completion of training;

3. Names and dates of specialty board certification, if any, as approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of the American Osteopathic Association or the Council on Podiatric Medical Education of the American Podiatric Medical Association;

4. Number of years in active, clinical practice in the United States or Canada following completion of medical or podiatric training and the number of years, if any, in active, clinical practice outside the United States or Canada;

5. The specialty, if any, in which the physician or podiatrist practices;

6. Names of hospitals with which the physician or podiatrist is affiliated;

7. Appointments within the past 10 years to medical or podiatry school faculties with the years of service and academic rank;

8. Publications, not to exceed 10 in number, in peer-reviewed literature within the most recent five-year period;

9. Whether there is access to translating services for non-English speaking patients at the primary and secondary practice settings and which, if any, foreign languages are spoken in the practice;

10. Whether the physician or podiatrist participates in the Virginia Medicaid Program and whether he is accepting new Medicaid patients;

11. A report on felony convictions including the date of the conviction, the nature of the conviction, the jurisdiction in which the conviction occurred, and the sentence imposed, if any; and

12. Final orders of any regulatory board of another jurisdiction that result in the denial, probation, revocation, suspension, or restriction of any license or that results in the reprimand or censure of any license or the voluntary surrender of a license while under investigation in a state other than Virginia while under investigation, as well as any disciplinary action taken by a federal health institution or federal agency.

13. Any final disciplinary or other action required to be reported to the board by health care institutions, other practitioners, insurance companies, health maintenance organizations, and professional organizations pursuant to §§ 54.1-2400.6, 54.1-2908, and 54.1-2909 that results in a suspension or revocation of privileges or the termination of employment.

B. Adjudicated notices and final orders or decision documents, subject to §54.1-2400.2 F of the Code of Virginia, shall be made available on the profile. Information shall be posted indicating the availability of unadjudicated notices and of orders that have not yet become final.

C. For the sole purpose of expediting dissemination of information about a public health emergency, an email address or facsimile number shall be provided, if available. Such addresses or numbers shall not be published on the profile and shall not be released or made available for any other purpose.

~~**18VAC85-20-285. Voluntary information.**~~

~~A. The doctor may provide names of insurance plans accepted or managed care plans in which he participates.~~

~~B. The doctor may provide additional information on hours of continuing education earned, subspecialties obtained, and honors or awards received.~~

18VAC85-20-290. Reporting of medical malpractice judgments and settlements.

A. In compliance with requirements of § 54.1-2910.1 of the Code of Virginia, a doctor of medicine, osteopathic medicine, or podiatry licensed by the board shall report all medical malpractice judgments and settlements of more than $10,000 in the most recent 10-year period within 30 days of

the initial payment. A doctor shall report a medical malpractice judgment or settlement of less than $10,000 if any other medical malpractice judgment or settlement has been paid by or for the licensee within the preceding 12 months. Each report of a settlement or judgment shall indicate:

1. The year the judgment or settlement was paid.

2. The specialty in which the doctor was practicing at the time the incident occurred that resulted in the judgment or settlement.

3. The total amount of the judgment or settlement in United States dollars.

4. The city, state, and country in which the judgment or settlement occurred.

B. The board shall not release individually identifiable numeric values of reported judgments or settlements but shall use the information provided to determine the relative frequency of judgments or settlements described in terms of the number of doctors in each specialty and the percentage with malpractice judgments and settlements within the most recent 10-year period. The statistical methodology used will include any specialty with more than 10 judgments or settlements. For each specialty with more than 10 judgments or settlements, the top 16% of the judgments or settlements will be displayed as above average payments, the next 68% of the judgments or settlements will be displayed as average payments, and the last 16% of the judgments or settlements will be displayed as below average payments.

C. For purposes of reporting required under this section, medical malpractice judgment and medical malpractice settlement shall have the meanings ascribed in § 54.1-2900 of the Code of Virginia. A medical malpractice judgment or settlement shall include:

1. A lump sum payment or the first payment of multiple payments;

2. A payment made from personal funds;

3. A payment on behalf of a doctor of medicine, osteopathic medicine, or podiatry by a corporation or entity comprised solely of that doctor of medicine, osteopathic medicine, or podiatry; or

4. A payment on behalf of a doctor of medicine, osteopathic medicine or podiatry named in the claim where that doctor is dismissed as a condition of, or in consideration of the settlement, judgment or release. If a doctor is dismissed independently of the settlement, judgment or release, then the payment is not reportable.

18VAC85-20-300. Noncompliance or falsification of profile.

A. The failure to provide the information required by 18VAC85-20-280 and 18VAC85-20-290 within 30 days of the request for information by the board or within 30 days of a change in the information on the profile may constitute unprofessional conduct and may subject the licensee to disciplinary action by the board.

B. Intentionally providing false information to the board for the physician profile system shall constitute unprofessional conduct and shall subject the licensee to disciplinary action by the board.

Part VIII. Office-Based Anesthesia.

18VAC85-20-310. Definitions.

"Advanced resuscitative techniques" means methods learned in certification courses for Advanced Cardiopulmonary Life Support (ACLS), or Pediatric Advanced Life Support (PALS).

"Deep sedation" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients often require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

"General anesthesia" means a drug-induced loss of consciousness during which patients are not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive-pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

"Local anesthesia" means a transient and reversible loss of sensation in a circumscribed portion of the body produced by a local anesthetic agent.

"Minimal sedation/anxiolysis" means a drug-induced state during which a patient responds normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are usually not affected.

"Moderate sedation/conscious sedation" means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are usually required to maintain a patent airway, and spontaneous ventilation is usually adequate. Cardiovascular function is usually maintained.

"Monitoring" means the continual clinical observation of patients and the use of instruments to measure and display the values of certain physiologic variables such as pulse, oxygen saturation, level of consciousness, blood pressure and respiration.

"Office-based" means any setting other than (i) a licensed hospital as defined in §32.1-123 of the Code of Virginia or state-operated hospitals or (ii) a facility directly maintained or operated by the federal government.

"Physical status classification" means a description used in determining the physical status of a patient as specified by the American Society of Anesthesiologists. Classifications are Class 1 for a normal healthy patient; Class 2 for a patient with mild systemic disease; Class 3 for a patient with severe systemic disease limiting activity but not incapacitation; Class 4 for a patient with incapacitating systemic disease that is a constant threat to life; and Class 5 for a moribund patient not expected to live 24 hours with or without surgery.

"Regional anesthesia" means the administration of anesthetic agents to a patient to interrupt nerve impulses without the loss of consciousness and includes minor and major conductive blocks.

"Minor conductive block" means the injection of local anesthesia to stop or prevent a painful sensation in a circumscribed area of the body (local infiltration or local nerve block), or the block of a nerve by refrigeration. Minor conductive nerve blocks include, but are not limited to, peribulbar blocks, pudenal blocks and ankle blocks.

"Major conductive block" means the use of local anesthesia to stop or prevent the transmission of painful sensations from large nerves, groups of nerves, nerve roots or the spinal cord. Major nerve blocks include, but are not limited to epidural, spinal, caudal, femoral, interscalene and brachial plexus.

"Topical anesthesia" means an anesthetic agent applied directly to the skin or mucous membranes, intended to produce a transient and reversible loss of sensation to a circumscribed area.

18VAC85-20-320. General provisions.

A. Applicability of requirements for office-based anesthesia.

1. The administration of topical anesthesia, local anesthesia, minor conductive blocks, or minimal sedation/anxiolysis, not involving a drug-induced alteration of consciousness other than minimal preoperative tranquilization, is not subject to the requirements for office-based anesthesia in this part. A health care practitioner administering such agents shall adhere to an accepted standard of care as appropriate to the level of anesthesia or sedation, including evaluation, drug selection, administration, and management of complications.

2. The administration of moderate sedation/conscious sedation, deep sedation, general anesthesia, or regional anesthesia consisting of a major conductive block is subject to these requirements for office-based anesthesia in this part. The administration of 300 milligrams or more of lidocaine or equivalent doses of local anesthetics shall be deemed to be subject to these requirements for office-based anesthesia in this part.

3. Levels of anesthesia or sedation referred to in this chapter shall relate to the level of anesthesia or sedation intended and documented by the practitioner in the preoperative anesthesia plan.

B. A doctor of medicine, osteopathic medicine, or podiatry administering office-based anesthesia or supervising such administration shall:

1. Perform a preanesthetic evaluation and examination or ensure that it has been performed;

2. Develop the anesthesia plan or ensure that it has been developed;

3. Ensure that the anesthesia plan has been discussed with the patient or responsible party preoperatively and informed consent has been obtained;

4. Ensure patient assessment and monitoring through the preprocedure, periprocedure, and post-procedure phases, addressing not only physical and functional status, but also physiological and cognitive status;

5. Ensure provision of indicated post-anesthesia care;

6. Remain physically present or immediately available, as appropriate, to manage complications and emergencies until discharge criteria have been met; and

7. Document any complications occurring during surgery or during recovery in the medical record.

C. All written policies, procedures, and protocols required for office-based anesthesia shall be maintained and available for inspection at the facility.

18VAC85-20-330. Qualifications of providers.

A. Doctors who utilize office-based anesthesia shall ensure that all medical personnel assisting in providing patient care are appropriately trained, qualified and supervised, are sufficient in numbers to provide adequate care, and maintain training in basic cardiopulmonary resuscitation.

B. All providers of office-based anesthesia shall hold the appropriate license and have the necessary training and skills to deliver the level of anesthesia being provided.

1. Deep sedation, general anesthesia or a major conductive block shall be administered by an anesthesiologist or by a certified registered nurse anesthetist. If a major conductive block is performed for diagnostic or therapeutic purposes, it may be administered by a doctor qualified by training and scope of practice.

2. Moderate sedation/conscious sedation may be administered by the operating doctor with the assistance of and monitoring by a licensed nurse, a physician assistant or a licensed intern or resident.

C. Additional training.

1. On or after December 18, 2003, the doctor who provides office-based anesthesia or who supervises the administration of anesthesia shall maintain current certification in advanced resuscitation techniques.

2. Any doctor who administers office-based anesthesia without the use of an anesthesiologist or certified registered nurse anesthetist shall obtain four hours of continuing education in topics related to anesthesia within the 60 hours required each biennium for licensure renewal, which are subject to random audit by the board.

D. Prior to administration, the anesthesia plan shall be discussed with the patient or responsible party by the health care practitioner administering the anesthesia or supervising the administration of anesthesia. Informed consent for the nature and objectives of the anesthesia planned shall be in writing and obtained from the patient or responsible party before the procedure is performed. Such consent shall include a discussion of discharge planning and what care or assistance the patient is expected to require after discharge. Informed consent shall only be obtained after a discussion of the risks, benefits, and alternatives, contain the name of the anesthesia provider, and be documented in the medical record.

18VAC85-20-340. Procedure/anesthesia selection and patient evaluation.

A. A written protocol shall be developed and followed for procedure selection to include but not be limited to:

1. The doctor providing or supervising the anesthesia shall ensure that the procedure to be undertaken is within the scope of practice of the health care practitioners and the capabilities of the facility.

2. The procedure or combined procedures shall be of a duration and degree of complexity that shall not exceed four hours and that will permit the patient to recover and be discharged from the facility in less than 24 hours. The procedure or combined procedures may be extended for up to eight hours if the anesthesia is provided by an anesthesiologist or a certified registered nurse anesthetist.

3. The level of anesthesia used shall be appropriate for the patient, the surgical procedure, the clinical setting, the education and training of the personnel, and the equipment available. The choice of specific anesthesia agents and techniques shall focus on providing an anesthetic that will be effective and appropriate and will address the specific needs of patients while also ensuring rapid recovery to normal function with maximum efforts to control post-operative pain, nausea, or other side effects.

B. A written protocol shall be developed for patient evaluation to include but not be limited to:

1. The preoperative anesthesia evaluation of a patient shall be performed by the health care practitioner administering the anesthesia or supervising the administration of anesthesia. It shall consist of performing an appropriate history and physical examination, determining the patient's physical status classification, developing a plan of anesthesia care, acquainting the patient or the responsible individual with the proposed plan, and discussing the risks and benefits.

2. The condition of the patient, specific morbidities that complicate anesthetic management, the specific intrinsic risks involved, and the nature of the planned procedure shall be considered in evaluating a patient for office-based anesthesia.

3. Patients who have pre-existing medical or other conditions that may be of particular risk for complications shall be referred to a facility appropriate for the procedure and administration of anesthesia. Nothing relieves the licensed health care practitioner of the responsibility to make a medical determination of the appropriate surgical facility or setting.

C. Office-based anesthesia shall only be provided for patients in physical status classifications for Classes I, II and III. Patients in Classes IV and V shall not be provided anesthesia in an office-based setting.

~~**18VAC85-20-350. Informed consent.**~~

Commented [VP9]: (A) is moved to 330. B and C are redundant of provisions in 28

~~A. Prior to administration, the anesthesia plan shall be discussed with the patient or responsible party by the health care practitioner administering the anesthesia or supervising the administration of anesthesia. Informed consent for the nature and objectives of the anesthesia planned shall be in writing and obtained from the patient or responsible party before the procedure is performed. Such consent shall include a discussion of discharge planning and what care or assistance the patient is expected to require after discharge. Informed consent shall only be obtained after a discussion of~~

~~the risks, benefits, and alternatives, contain the name of the anesthesia provider, and be documented in the medical record.~~

~~B. The surgical consent forms shall be executed by the patient or the responsible party and shall contain a statement that the doctor performing the surgery is board certified or board eligible by one of the American Board of Medical Specialties boards, the Bureau of Osteopathic Specialists of the American Osteopathic Association, the American Board of Podiatric Medicine, or the American Board of Foot and Ankle Surgery. The forms shall either list which board or contain a statement that doctor performing the surgery is not board certified or board eligible.~~

~~C. The surgical consent forms shall indicate whether the surgery is elective or medically necessary. If a consent is obtained in an emergency, the surgical consent form shall indicate the nature of the emergency.~~

18VAC85-20-360. Monitoring.

A. A written protocol shall be developed for monitoring equipment to include but not be limited to:

1. Monitoring equipment shall be appropriate for the type of anesthesia and the nature of the facility. At a minimum, provisions shall be made for a reliable source of oxygen, suction, resuscitation equipment and emergency drugs.

2. In locations where anesthesia is administered, there shall be adequate anesthesia apparatus and equipment to ensure appropriate monitoring of patients. All equipment shall be maintained, tested and inspected according to manufacturer's specifications, and backup power shall be sufficient to ensure patient protection in the event of an emergency.

3. When anesthesia services are provided to infants and children, the required equipment, medication and resuscitative capabilities shall be appropriately sized and calibrated for children.

B. To administer office-based moderate sedation/conscious sedation, the following equipment, supplies and pharmacological agents are required:

1. Appropriate equipment to manage airways;

2. Drugs and equipment to treat shock and anaphylactic reactions;

3. Precordial stethoscope;

4. Pulse oximeter with appropriate alarms or an equivalent method of measuring oxygen saturation;

5. Continuous electrocardiograph;

6. Devices for measuring blood pressure, heart rate and respiratory rate;

7. Defibrillator; and

8. Accepted method of identifying and preventing the interchangeability of gases.

C. In addition to requirements in subsection B of this section, to administer general anesthesia, deep sedation or major conductive blocks, the following equipment, supplies and pharmacological agents are required:

1. Drugs to treat malignant hyperthermia, when triggering agents are used;

2. Peripheral nerve stimulator, if a muscle relaxant is used; and

3. If using an anesthesia machine, the following shall be included:

a. End-tidal carbon dioxide monitor (capnograph);

b. In-circuit oxygen analyzer designed to monitor oxygen concentration within breathing circuit by displaying oxygen percent of the total respiratory mixture;

c. Oxygen failure-protection devices (fail-safe system) that have the capacity to announce a reduction in oxygen pressure and, at lower levels of oxygen pressure, to discontinue other gases when the pressure of the supply of oxygen is reduced;

d. Vaporizer exclusion (interlock) system, which ensures that only one vaporizer, and therefore only a single anesthetic agent can be actualized on any anesthesia machine at one time;

e. Pressure-compensated anesthesia vaporizers, designed to administer a constant non-pulsatile output, which shall not be placed in the circuit downstream of the oxygen flush valve;

f. Flow meters and controllers, which can accurately gauge concentration of oxygen relative to the anesthetic agent being administered and prevent oxygen mixtures of less than 21% from being administered;

g. Alarm systems for high (disconnect), low (subatmospheric) and minimum ventilatory pressures in the breathing circuit for each patient under general anesthesia; and

h. A gas evacuation system.

D. A written protocol shall be developed for monitoring procedures to include but not be limited to:

1. Physiologic monitoring of patients shall be appropriate for the type of anesthesia and individual patient needs, including continuous monitoring and assessment of ventilation, oxygenation, cardiovascular status, body temperature, neuromuscular function and status, and patient positioning.

2. Intraoperative patient evaluation shall include continuous clinical observation and continuous anesthesia monitoring.

3. A health care practitioner administering general anesthesia or deep sedation shall remain present and available in the facility to monitor a patient until the patient meets the discharge criteria. A health care practitioner administering moderate sedation/conscious sedation shall routinely monitor a patient according to procedures consistent with such administration.

18VAC85-20-370. Emergency and transfer protocols.

A. There shall be written protocols for handling emergency situations, including medical emergencies and internal and external disasters. All personnel shall be appropriately trained in and regularly review the protocols and the equipment and procedures for handling emergencies.

B. There shall be written protocols for the timely and safe transfer of patients to a prespecified hospital or hospitals within a reasonable proximity. For purposes of this section, "reasonable proximity" shall mean that a licensed general hospital capable of providing necessary services is normally accessible within 30 minutes of the office. There shall be a written or electronic transfer agreement with such hospital or hospitals.

18VAC85-20-380. Discharge policies and procedures.

A. There shall be written policies and procedures outlining discharge criteria. Such criteria shall include stable vital signs, responsiveness and orientation, ability to move voluntarily, controlled pain, and minimal nausea and vomiting.

B. Discharge from anesthesia care is the responsibility of the health care practitioner providing or the doctor supervising the anesthesia care and shall only occur when:

1. The patient has met specific physician-defined criteria; and

2. The health care practitioner providing or the doctor supervising the anesthetic care has given the order for discharge.

C. Written instructions and an emergency phone number shall be provided to the patient. Patients shall be discharged with a responsible individual who has been instructed with regard to the patient's care.

D. At least one person trained in advanced resuscitative techniques shall be immediately available until all patients are discharged.

18VAC85-20-390. Reporting requirements.

The doctor administering the anesthesia or supervising such administration shall report to the board within 30 days any incident relating to the administration of anesthesia that results in patient death, either intraoperatively or within the immediate 72-hour postoperative period or in transport of a patient to a hospital for a stay of more than 24 hours.

~~Part IX. Mixing, Diluting or Reconstituting of Drugs for Administration.~~

~~18VAC85-20-400. Requirements for immediate-use sterile mixing, diluting or reconstituting.~~

~~A. For the purposes of this chapter, the mixing, diluting, or reconstituting of sterile manufactured drug products when there is no direct contact contamination and administration begins within 10 hours of the completion time of preparation shall be considered immediate-use with the exception of drugs in fat emulsion for which immediate use shall be one hour. If manufacturers' instructions~~

~~or any other accepted standard specifies or indicates an appropriate time between preparation and administration of less than 10 hours, the mixing, diluting or reconstituting shall be in accordance with the lesser time. No direct contact contamination means that there is no contamination from touch, gloves, bare skin or secretions from the mouth or nose. Emergency drugs used in the practice of anesthesiology and administration of allergens may exceed 10 hours after completion of the preparation, provided administration does not exceed the specified expiration date of a multiple use vial and there is compliance with all other requirements of this section.~~

~~B. Doctors of medicine or osteopathic medicine who engage in immediate-use mixing, diluting or reconstituting shall:~~

~~1. Utilize the practices and principles of disinfection techniques, aseptic manipulations and solution compatibility in immediate-use mixing, diluting or reconstituting;~~

~~2. Ensure that all personnel under their supervision who are involved in immediate-use mixing, diluting or reconstituting are appropriately and properly trained in and utilize the practices and principles of disinfection techniques, aseptic manipulations and solution compatibility;~~

~~3. Establish and implement procedures for verification of the accuracy of the product that has been mixed, diluted, or reconstituted to include a second check performed by a doctor of medicine or osteopathic medicine, or by a physician assistant or a registered nurse who has been specifically trained pursuant to subdivision 2 of this subsection in immediate-use mixing, diluting, or reconstituting. Mixing, diluting, or reconstituting that is performed by a doctor of medicine or osteopathic medicine, or by a specifically trained physician assistant or registered nurse or mixing, diluting, or reconstituting of vaccines does not require a second check;~~

~~4. Provide a designated, sanitary work space and equipment appropriate for aseptic manipulations;~~

~~5. Document or ensure that personnel under his supervision document in the patient record or other readily retrievable record that identifies the patient; the names of drugs mixed, diluted or reconstituted; and the date of administration; and~~

~~6. Develop and maintain written policies and procedures to be followed in mixing, diluting or reconstituting of sterile products and for the training of personnel.~~

~~C. Any mixing, diluting or reconstituting of drug products that are hazardous to personnel shall be performed consistent with requirements of all applicable federal and state laws and regulations for safety and air quality, to include but not be limited to those of the Occupational Safety and Health Administration (OSHA). For the purposes of this chapter, Appendix A of the National Institute for Occupational Safety and Health publication (NIOSH Publication No. 2004-165), Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings is incorporated by reference for the list of hazardous drug products and can be found at www.cdc.gov/niosh/docs/2004-165.~~

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

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

~~B. Doctors of medicine or osteopathic medicine who engage in low-risk, medium-risk, or high-risk mixing, diluting, or reconstituting of sterile products shall comply with all applicable requirements of the USP Chapter 797. Subsequent changes to the USP Chapter 797 shall apply within one year of the official announcement by USP.~~

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

~~18VAC85-20-420. Responsibilities of doctors who mix, dilute or reconstitute drugs in their practices.~~

~~A. Doctors of medicine or osteopathic medicine who delegate the mixing, diluting or reconstituting of sterile drug products for administration retain responsibility for patient care and shall monitor and document any adverse responses to the drugs.~~

~~B. Doctors who engage in the mixing, diluting or reconstituting of sterile drug products in their practices shall disclose this information to the board in a manner prescribed by the board and are subject to unannounced inspections by the board or its agents.~~

Agenda Items: Issue periodic review decision and adoption of fast-track regulatory changes recommended by the advisory board

Included in your agenda package are:

- Notice of periodic review
- Recommended revisions to Chapter 40

Staff Note: Advisory board recommended to retain Chapter 40 with amendments.

Action needed:

- Motion to retain Chapter 40 with amendments;

- Motion to adopt changes recommended by advisory board as fast-track regulatory changes.

Virginia.gov Agencies | Governor

Agency	Department of Health Professions
Board	Board of Medicine
Chapter	Regulations Governing the Practice of Respiratory Therapists [18 VAC 85 - 40]

Edit Review

Review 2148

Periodic Review of this Chapter

Includes a Small Business Impact Review

Date Filed: 6/16/2022

Review Announcement

Pursuant to Executive Order 14 (as amended July 16, 2018) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, this regulation is undergoing a periodic review.

The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018). http://TownHall.Virginia.Gov/EO-14.pdf.

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

In order for you to receive a response to your comment, your contact information (preferably an email address or, alternatively, a U.S. mailing address) must accompany your comment. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

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

Publication Information and Public Comment Period

Published in the Virginia Register on 7/18/2022 [Volume: 38 Issue: 24]

Comment Period begins on the publication date and ends on 8/17/2022

Comments Received: 0

Review Result

Pending

Attorney General Certification

Pending

This periodic review was created by Erin Barrett on 06/16/2022 at 12:24pm

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF RESPIRATORY THERAPISTS

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-40-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Revised Date: March 5, 2020

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

(804) 367-4600 (TEL)
(804) 527-4426 (FAX)
email: medbd@dhp.virginia.gov

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Part I. General Provisions.

18VAC85-40-10. 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"

"Qualified medical direction"

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

"AARC" means the American Association for Respiratory Care.

"Accredited educational program" means a program accredited by the Commission on Accreditation for Respiratory Care or any other agency approved by the NBRC for its entry level certification examination.

"Active practice" means a minimum of 160 hours of professional practice as a respiratory therapist within the 24-month period immediately preceding renewal or application for licensure if previously licensed or certified in another jurisdiction. The active practice of respiratory care may include supervisory, administrative, educational or consultative activities or responsibilities for the delivery of such services.

~~"Advisory board" means the Advisory Board on Respiratory Care to the Board of Medicine as specified in §54.1-2956 of the Code of Virginia.~~

"NBRC" means the National Board for Respiratory Care, Inc.

"Respiratory therapist" means a person as specified in §54.1-2954 of the Code of Virginia.

~~**18VAC85-40-20. Public participation.**~~

~~A separate board regulation, 18VAC85-11, entitled Public Participation Guidelines, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.~~

18VAC85-40-25. Current name and address.

Each licensee 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 shall be validly given when sent to the latest address of record provided or served to the licensee. 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.

~~**18VAC85-40-30. Violations.**~~

~~Any violation of Chapter 29 of Title 54.1 of the Code of Virginia shall be subject to the statutory sanctions as set forth in the Act.~~

18VAC85-40-35. Fees.

The following fees are required:

1. The application fee, payable at the time the application is filed, shall be $130.

2. The biennial fee for renewal of active licensure shall be $135 and for renewal of inactive licensure shall be $70, payable in each odd-numbered year in the license holder's birth month. For 2021, the fee for renewal of an active license shall be $108 and the fee for renewal of an inactive license shall be $54.

3. The additional fee for late renewal of licensure within one renewal cycle shall be $50.

4. The fee for reinstatement of a license issued by the Board of Medicine pursuant to §54.1-2904 of the Code of Virginia, which has lapsed for a period of two years or more, shall be $180 and must be submitted with an application for licensure reinstatement.

5. The fee for reinstatement of a license pursuant to §54.1-2408.2 of the Code of Virginia shall be $2,000.

6. The fee for a duplicate license shall be $5, and the fee for a duplicate wall certificate shall be $15.

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

8. The fee for a letter of good standing/verification to another jurisdiction shall be $10; the fee for certification of grades to another jurisdiction shall be $25.

9. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $35, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $15 for each renewal cycle.

Part II. Requirements for Licensure as a Respiratory Therapist.

18VAC85-40-40. Licensure requirements.

An applicant for licensure shall submit the following on forms provided by the board:

1. A completed application and a fee as prescribed in 18VAC85-40-35.

2. Verification of professional education in respiratory care as required in 18VAC85-40-45.

3. Verification of practice as required on the application form.

4. Evidence of passage of the national examination as required in 18VAC85-40-50.

5. If licensed or certified in any other jurisdiction, documentation of active practice as a respiratory therapist or documentation of 20 hours of continuing education within the 24-month period immediately preceding application and verification that there has been no disciplinary action taken or pending in that jurisdiction.

18VAC85-40-45. Educational requirements.

An applicant for licensure shall:

1. Be a graduate of an accredited educational program for respiratory therapists; or

2. Hold current credentialing as a Certified Respiratory Therapist (CRT) or a Registered Respiratory Therapist (RRT) from the NBRC or any other credentialing body determined by the board to be equivalent.

18VAC85-40-50. Examination requirements.

An applicant for a license to practice as a licensed respiratory therapist shall submit to the board evidence that the applicant has passed the NBRC entry level examination for respiratory care, or its equivalent as approved by the board.

18VAC85-40-55. Registration for voluntary practice by out-of-state licensees.

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

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

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

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

~~4. Pay a registration fee of $10; and~~

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

Part III. Renewal and Reinstatement.

18VAC85-40-60. Renewal of license.

A. Every licensed respiratory therapist intending to continue his licensure shall biennially in each odd-numbered year in his birth month:

1. Register with the board for renewal of his license;

2. Pay the prescribed renewal fee at the time he files for renewal;

3. Attest that he has engaged in active practice as defined in 18VAC85-40-10 or present other documented evidence acceptable to the board that he is prepared to resume practice; and

4. Attest to having met the continuing education requirements of 18VAC85-40-66.

B. A respiratory therapist whose licensure has not been renewed by the first day of the month following the month in which renewal is required shall pay a late fee as prescribed in 18VAC85-40-35.

18VAC85-40-61. Inactive license.

A licensed respiratory therapist 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 entitled to perform any act requiring a license to practice respiratory care in Virginia.

18VAC85-40-65. Reactivation or reinstatement.

A. To reactivate an inactive license or to reinstate a license that has been lapsed for more than two years, a respiratory therapist shall submit evidence of competency to return to active practice to include one of the following:

1. Information on continued practice in another jurisdiction during the period in which the license has been inactive or lapsed;

2. Ten hours of continuing education for each year in which the license has been inactive or lapsed, not to exceed three years; or

3. Recertification by passage of an examination from NBRC.

B. To reactivate an inactive license, a respiratory therapist shall pay a fee equal to the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure.

C. To reinstate a license which has been lapsed for more than two years, a respiratory therapist shall file an application for reinstatement and pay the fee for reinstatement of his licensure as prescribed in 18VAC85-40-35. The board may specify additional requirements for reinstatement of a license so lapsed to include education, experience or reexamination.

D. A respiratory therapist whose licensure has been revoked by the board and who wishes to be reinstated shall make a new application to the board, fulfill additional requirements as specified in the order from the board and make payment of the fee for reinstatement of his licensure as prescribed in 18VAC85-40-35 pursuant to §54.1-2408.2 of the Code of Virginia.

E. 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.

18VAC85-40-66. Continuing education requirements.

A. In order to renew an active license as a respiratory therapist, a licensee shall attest to having completed 20 hours of continuing education within the last biennium as follows:

1. Courses approved and documented by a sponsor recognized by the AARC;

2. Courses directly related to the practice of respiratory care as approved by the American Medical Association for Category 1 CME credit; or

3. A credit course of post-licensure academic education relevant to respiratory care offered by a college or university accredited by an agency recognized by the U.S. Department of Education.

Up to two continuing education hours may be satisfied through delivery of respiratory therapy services, without compensation, to low-income individuals receiving services through a local health department or a free clinic organized in whole or primarily for the delivery of health services. One hour of continuing education may be credited for three hours of providing such volunteer services. For the purpose of continuing education credit for voluntary service, the hours shall be approved and documented by the health department or free clinic.

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

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

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

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

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

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

18VAC85-40-67. Restricted volunteer license.

A. A respiratory therapist who held an unrestricted license issued by the Virginia Board of Medicine or by a board in another state as a licensee in good standing at the time the license expired or became inactive may be issued a restricted volunteer license to practice without compensation in a clinic that is organized in whole or in part for the delivery of health care services without charge in accordance with §54.1-106 of the Code of Virginia.

B. To be issued a restricted volunteer license, a respiratory therapist shall submit an application to the board that documents compliance with requirements of §54.1-2928.1 of the Code of Virginia and the application fee prescribed in 18VAC85-40-35.

C. The licensee who intends to continue practicing with a restricted volunteer license shall renew biennially during his birth month, meet the continued competency requirements prescribed in subsection D of this section, and pay to the board the renewal fee prescribed in 18VAC85-40-35.

D. The holder of a restricted volunteer license shall not be required to attest to hours of continuing education for the first renewal of such a license. For each renewal thereafter, the licensee shall attest to obtaining 10 hours of continuing education as approved and documented by a sponsor recognized by the AARC or in courses directly related to the practice of respiratory care as approved by the American Medical Association for Category 1 CME credit within the last biennium.

Part IV. Scope of Practice.

18VAC85-40-70. Individual responsibilities.

Practice as a licensed respiratory therapist means, upon receipt of written or verbal orders from a qualified practitioner and under qualified medical direction, the evaluation, care and treatment of patients with deficiencies and abnormalities associated with the cardiopulmonary system. This practice shall include, but not be limited to, ventilatory assistance and support; the insertion of artificial airways ~~without cutting tissue~~ and the maintenance of such airways; the administration of medical gases ~~exclusive of general anesthesia~~; topical administration of pharmacological agents to the respiratory tract; humidification; and administration of aerosols. The practice of respiratory care shall include such functions shared with other health professionals as cardiopulmonary resuscitation; bronchopulmonary hygiene; respiratory rehabilitation; specific testing techniques required to assist in diagnosis, therapy and research; and invasive and noninvasive cardiopulmonary monitoring.

18VAC85-40-80. [Repealed]

Part V. Standards of Professional Conduct.

18VAC85-40-85. 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.

18VAC85-40-86. Patient records.

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

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

C. Practitioners shall properly manage 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 owns and is responsible for patient records shall~~:~~

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

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

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

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

~~2. From October 19, 2005, 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.~~

~~3. 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.~~

18VAC85-40-87. Practitioner-patient communication; 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 medication, treatment, or procedure provided or directed by the practitioner in the treatment of any disease or condition.

3. Before an invasive procedure is performed, 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 respiratory care 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 an invasive 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, "invasive procedure" shall mean 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. 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.

18VAC85-40-88. 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 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 A 3 of this section.

~~**18VAC85-40-89. Solicitation or remuneration in exchange for referral.**~~

~~A practitioner shall not knowingly and willfully solicit or receive any remuneration, directly or indirectly, in return for referring an individual to a facility or institution as defined in §37.2-100 of the Code of Virginia, or hospital as defined in §32.1-123 of the Code of Virginia.~~

~~Remuneration shall be defined as compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by Title 42, §1320a-7b(b) of the United States Code, as amended, or any regulations promulgated thereto.~~

18VAC85-40-90. 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 which:

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.

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 shall mean: 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.

18VAC85-40-91. 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 Items: Issue periodic review decision and adoption of fast-track regulatory changes recommended by the advisory board

Included in your agenda package are:

- Notice of periodic review
- Public comment received
- Recommended revisions to Chapter 50

Staff Note: Advisory board recommended to retain Chapter 50 with amendments.

Action needed:

- Motion to retain Chapter 50 with amendments;

- Motion to adopt changes recommended by advisory board as fast-track regulatory changes.

Agency Department of Health Professions

Board Board of Medicine

Chapter Regulations Governing the Practice of Physician Assistants [18 VAC 85 - 50]

Edit Review

Review 2149

Periodic Review of this Chapter

Includes a Small Business Impact Review

Date Filed: 6/16/2022

Review Announcement

Pursuant to Executive Order 14 (as amended July 16, 2018) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, this regulation is undergoing a periodic review.

The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018). http://TownHall.Virginia.Gov/EO-14.pdf.

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

In order for you to receive a response to your comment, your contact information (preferably an email address or, alternatively, a U.S. mailing address) must accompany your comment. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

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

Publication Information and Public Comment Period

Published in the Virginia Register on 7/18/2022 [Volume: 38 Issue: 24]

Comment Period begins on the publication date and ends on 8/17/2022

Comments Received: 1

Review Result

Pending

Attorney General Certification

Pending

This periodic review was created by Erin Barrett on 06/16/2022 at 12:25pm

August 16, 2022

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

Dear Dr. Harp:

On behalf of the Virginia Academy of PAs, please find the following suggested amendments to the Regulations Governing the Practice of Physician Assistants (18 VAC 85-50):

- Page 2 – Remove the apostrophe and letter s to reflect the correct title "Physician Assistant" in the heading "Part II. Requirements for Practice As a Physician~~'s~~ Assistant."

- Page 4 – Remove the apostrophe and letter s to reflect the correct title "Physician Assistant" in the heading "Part II. Requirements for Practice As a Physician~~'s~~ Assistant."

- Page 8 – Remove the reference to supervision in Part B of 18VAC85-50-115. Responsibilities of the physician assistant:

> "B. If, due to illness, vacation, or unexpected absence, a patient care team physician or podiatrist or alternate physician or podiatrist is unable to ~~**supervise the activities of**~~ **collaborate or consult with** his physician assistant, such patient care team physician or podiatrist may temporarily delegate the responsibility to another doctor of medicine, osteopathic medicine, or podiatry."

Thank you for your consideration.

Respectfully,

Jonathan R. Williams
Executive Director

250 West Main Street • Suite 100 • Charlottesville, VA 22902
P. 434.977.3716 • F. 434.979.2439 • www.vapa.org • vapa@vapa.org

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

Fwd: Periodic Review Comments - Virginia Academy of PAs

3 messages

Harp, William <william.harp@dhp.virginia.gov> Tue, Aug 16, 2022 at 10:49 AM
To: Jonathan Williams <Jonathan.Williams@easterassociates.com>, Erin Barrett <erin.barrett@dhp.virginia.gov>

Good morning, Jonathan:

Hope all is well, and thanks for the letter of VAPA comment.

WLH

---------- Forwarded message ---------
From: **Jonathan Williams** <Jonathan.Williams@easterassociates.com>
Date: Tue, Aug 16, 2022 at 10:43 AM
Subject: Periodic Review Comments - Virginia Academy of PAs
To: William L. Harp - Va Department of Health Professions (WILLIAM.HARP@DHP.VIRGINIA.GOV) <william.harp@dhp.virginia.gov>

Dr. Harp,

Please find attached a letter on behalf of the Virginia Academy of PAs that includes suggested amendments to the Regulations Governing the Practice of Physician Assistants. We submit these comments as part of the ongoing Periodic Review as required by Executive Order 14.

Thank you for your consideration.

Jonathan

Jonathan R. Williams

Executive Director

434-906-1779

VAPA Periodic Review Comments (8-16-22).pdf

Jonathan Williams <Jonathan.Williams@easterassociates.com> Wed, Aug 17, 2022 at 9:25 AM
To: "Harp, William" <william.harp@dhp.virginia.gov>, Erin Barrett <erin.barrett@dhp.virginia.gov>

Dr. Harp/Erin,

We caught an additional issue with the current regulations. There are two sections where just the word "assistant" is used instead of "physician assistant." Is that just Virginia parlance, or can the following be amended by adding "physician"?

Page 5

18VAC85-50-56. Renewal of license.

B. Any physician assistant who allows his NCCPA certification to lapse shall be considered not licensed by the board. Any such ***physician*** assistant who proposes to resume his practice shall make a new application for licensure.

Page 7

18VAC85-50-101. Requirements for a practice agreement.

A. Prior to initiation of practice, a physician assistant and one or more patient care team physicians or podiatrists shall enter into a written or electronic practice agreement that spells out the roles and functions of the ***physician*** assistant and is consistent with provisions of § 54.1-2952 of the Code of Virginia.

Thank you for your consideration.

Jonathan

Jonathan R. Williams
Executive Director
434-906-1779

From: Harp, William <william.harp@dhp.virginia.gov>
Date: Tuesday, August 16, 2022 at 10:49 AM
To: Jonathan Williams <Jonathan.Williams@easterassociates.com>, Erin Barrett <erin.barrett@dhp.virginia.gov>
Subject: Fwd: Periodic Review Comments - Virginia Academy of PAs

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Harp, William <william.harp@dhp.virginia.gov> Wed, Aug 17, 2022 at 9:26 AM
To: Jonathan Williams <Jonathan.Williams@easterassociates.com>
Cc: Erin Barrett <erin.barrett@dhp.virginia.gov>

Thanks, Jonathan. WLH
[Quoted text hidden]

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Board **Board of Medicine**

Chapter **Regulations Governing the Practice of Physician Assistants [18 VAC 85 - 50]**

1 comments

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Commenter: Jonathan Williams, Virginia Academy of PAs 8/16/22 10:42 am

Periodic Review - Regulations Governing the Practice of Physician Assistants

On behalf of the Virginia Academy of PAs, please find the following suggested amendments to the Regulations Governing the Practice of Physician Assistants (18 VAC 85-50):

- Page 2 – Remove the apostrophe and letter s to reflect the correct title "Physician Assistant" in the heading "Part II. Requirements for Practice As a Physician~~'s~~ Assistant."
- Page 4 – Remove the apostrophe and letter s to reflect the correct title "Physician Assistant" in the heading "Part II. Requirements for Practice As a Physician~~'s~~ Assistant."
- Page 8 – Remove the reference to supervision in Part B of 18VAC85-50-115. Responsibilities of the physician assistant:

  "B. If, due to illness, vacation, or unexpected absence, a patient care team physician or podiatrist or alternate physician or podiatrist is unable to ~~supervise the activities of~~ **collaborate or consult with** his physician assistant, such patient care team physician or podiatrist may temporarily delegate the responsibility to another doctor of medicine, osteopathic medicine, or podiatry."

CommentID: **127260**

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: April 1, 2022

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

(804) 367-4600 (TEL)
(804) 527-4426 (FAX)
email: medbd@dhp.virginia.gov

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Part I. General Provisions.

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 one or more patient care team physicians or podiatrists and the physician assistant that defines the relationship between the physician assistant and the physicians or podiatrists, the prescriptive authority of the physician assistant, and the circumstances under which a physician or podiatrist will see and evaluate the patient.

18VAC85-50-20. (Repealed.)

18VAC85-50-21. Current name and address.

Each licensee 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 shall be validly given when sent to the latest address of record provided or served to the licensee. Any change of name or address of record or the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

~~18VAC85-50-30. Public participation guidelines.~~

~~A separate board regulation, 18VAC85-11, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.~~

18VAC85-50-35. Fees.

Unless otherwise provided, the following fees shall not be refundable:

1. The initial application fee for a license, payable at the time application is filed, shall be $130.
2. The biennial fee for renewal of an active license shall be $135 and for renewal of an inactive license shall be $70, payable in each odd-numbered year in the birth month of the licensee. ~~For 2021, the fee for renewal of an active license shall be $108, and the fee for renewal of an inactive license shall be $54.~~
3. The additional fee for late renewal of licensure within one renewal cycle shall be $50.
4. A restricted volunteer license shall expire 12 months from the date of issuance and may be renewed without charge by receipt of a renewal application that verifies that the physician assistant continues to comply with provisions of § 54.1-2951.3 of the Code of Virginia.
5. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.
6. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.
7. The handling fee for a returned check or a dishonored credit card or debit card shall be $50.
8. The fee for a letter of good standing or verification to another jurisdiction shall be $10.
9. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $35, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $15 for each renewal cycle.

Part II. Requirements for Practice As a Physician~~'s~~ Assistant.

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 one or more doctors of medicine, osteopathy, or podiatry licensed by this board to practice in the Commonwealth.

18VAC85-50-50. Licensure: entry requirements and application.

A. The applicant seeking licensure as a physician assistant shall submit:

1. A completed application and fee as prescribed by the board.

2. Documentation of successful completion of an educational program as prescribed in § 54.1-2951.1 of the Code of Virginia.

3. Documentation of passage of the certifying examination administered by the National Commission on Certification of Physician Assistants.

4. If licensed or certified in any other jurisdiction, verification that there has been no disciplinary action taken or pending in that jurisdiction.

B. The board may issue a license by endorsement to an applicant for licensure 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.

18VAC85-50-55. Provisional licensure.

Pending the outcome of the next examination administered by the NCCPA, an applicant who has met all other requirements of 18VAC85-50-50 at the time his initial application is submitted may be granted provisional licensure by the board. The provisional licensure shall be valid until the applicant takes the next subsequent NCCPA examination and its results are reported, but this period of validity shall not exceed 30 days following the reporting of the examination scores, after which the provisional license shall be invalid.

18VAC85-50-56. Renewal of license.

A. Every licensed physician assistant intending to continue to practice shall biennially renew the license in each odd numbered year in the licensee's birth month by:

1. Returning the renewal form and fee as prescribed by the board; and

2. Verifying compliance with continuing medical education standards established by the NCCPA.

B. Any physician assistant who allows his NCCPA certification to lapse shall be considered not licensed by the board. Any such physician assistant who proposes to resume his practice shall make a new application for licensure.

18VAC85-50-57. Discontinuation of employment.

If for any reason the physician assistant discontinues working with a patient care team physician or podiatrist, a new practice agreement shall be entered into in order for the physician assistant either to be reemployed by the same practitioner or to accept new employment with another patient care team physician or podiatrist.

18VAC85-50-58. Inactive licensure.

A. A physician 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.

1. The holder of an inactive license shall not be required to maintain certification by the NCCPA.
2. An inactive licensee shall not be entitled to practice as a physician assistant in Virginia.

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

1. The required application;
2. Payment of the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure for the biennium in which the license is being reactivated; and
3. Documentation of having maintained certification or having been recertified by the NCCPA.

C. The board reserves the right to deny a request for reactivation 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.

18VAC85-50-59. Registration for voluntary practice by out-of-state licensees.

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

1. File a complete application for registration on a form provided by the board at least five business days prior to engaging in such practice. An incomplete application will not be considered;
2. Provide a complete record of professional licensure in each state in which he has held a license and a copy of any current license;
3. Provide the name of the nonprofit organization, the dates and location of the voluntary provision of services; and
4. ~~Pay a registration fee of $10; and~~

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

18VAC85-50-60. (Repealed.)

18VAC85-50-61. Restricted volunteer license.

A. A physician assistant who held an unrestricted license issued by the Virginia Board of Medicine or by a board in another state as a licensee in good standing at the time the license expired or

became inactive may be issued a restricted volunteer license to practice without compensation in a clinic that is organized in whole or in part for the delivery of health care services without charge in accordance with § 54.1-106 of the Code of Virginia.

B. To be issued a restricted volunteer license, a physician assistant shall submit an application to the board that documents compliance with requirements of § 54.1-2928.1 of the Code of Virginia and the application fee prescribed in 18VAC85-50-35.

C. The licensee who intends to continue practicing with a restricted volunteer license shall renew biennially during his birth month, meet the continued competency requirements prescribed in subsection D of this section, and pay to the board the renewal fee prescribed in 18VAC85-50-35.

~~D. The holder of a restricted volunteer license shall not be required to attest to hours of continuing education for the first renewal of such a license. For each renewal thereafter, the licensee shall attest to obtaining 50 hours of continuing education during the biennial renewal period with at least 25 hours in Type 1 and no more than 25 hours in Type 2 as acceptable to the NCCPA.~~

Part III. Examination [Repealed]

18VAC85-50-70. (Repealed.)

Part IV. Practice Requirements

18VAC85-50-101. Requirements for a practice agreement.

A. Prior to initiation of practice, a physician assistant and one or more patient care team physicians or podiatrists shall enter into a written or electronic practice agreement that spells out the roles and functions of the physician assistant and is consistent with provisions of § 54.1-2952 of the Code of Virginia.

1. 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 physicians or podiatrists, the nature of the treatment, special procedures, and the nature of the physicians' or podiatrists' availability in ensuring direct physician or podiatrist involvement at an early stage and regularly thereafter.

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 physicians or podiatrists shall review the record of services rendered by the physician assistant.

3. The practice agreement may include requirements for periodic site visits by licensees who supervise and direct the patient care team physicians or podiatrists to collaborate and consult with physician assistants who provide services at a location other than where the physicians or podiatrists regularly practice.

B. The board may require information regarding the degree of collaboration and consultation by the patient care team physicians or podiatrists. The board may also require 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 physicians or 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.

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. 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 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 physicians or podiatrists 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 physicians or podiatrists, 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 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. If, due to illness, vacation, or unexpected absence, a patient care team physician or podiatrist or alternate physician or podiatrist is unable to ~~supervise the activities of~~ collaborate or consult with 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.

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 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.

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.

~~18VAC85-50-116. Volunteer restricted license for certain physician assistants.~~

~~The issuance of a volunteer restricted license and the practice of a physician assistant under such a license shall be in accordance with the provisions of § 54.1-2951.3 of the Code of Virginia.~~

18VAC85-50-117. Authorization to use fluoroscopy.

A physician assistant working under a practice agreement with a licensed doctor of medicine or osteopathy specializing in the field of radiology is authorized to use fluoroscopy for guidance of diagnostic and therapeutic procedures provided such activity is specified in his protocol and he has met the following qualifications:

1. Completion of at least 40 hours of structured didactic educational instruction and at least 40 hours of supervised clinical experience as set forth in the Fluoroscopy Educational Framework for the Physician Assistant created by the American Academy of Physician Assistants (AAPA) and the American Society of Radiologic Technologists (ASRT); and

2. Successful passage of the American Registry of Radiologic Technologists (ARRT) Fluoroscopy Examination.

18VAC85-50-120. (Repealed.)

Part V. Prescriptive Authority.

18VAC85-50-130. Qualifications for approval of prescriptive authority.

An applicant for prescriptive authority shall meet the following requirements:

1. Hold a current, unrestricted license as a physician assistant in the Commonwealth;

2. Maintain a practice agreement acceptable to the board as prescribed in 18VAC85-50-101 and § 54.1-2952.1 of the Code of Virginia; and

3. Submit evidence of successful completion of a minimum of 35 hours of acceptable training to the board in pharmacology.

18VAC85-50-140. Approved drugs and devices.

A. The approved drugs and devices which the physician assistant with prescriptive authority may prescribe, administer, or dispense manufacturer's professional samples shall be in accordance with provisions of § 54.1-2952.1 of the Code of Virginia:

B. The physician assistant may prescribe only those categories of drugs and devices included in the practice agreement. The patient care team physician or podiatrist retains the authority to restrict certain drugs within these approved categories.

C. The physician assistant, pursuant to § 54.1-2952.1 of the Code of Virginia, shall only dispense manufacturer's professional samples or administer controlled substances in good faith for medical or therapeutic purposes within the course of his professional practice.

18VAC85-50-150. (Repealed.)

18VAC85-50-160. Disclosure.

A. Each prescription for a Schedule II through V drug shall bear the name of the patient care team physician or podiatrist and of the physician assistant.

B. The physician assistant shall disclose to the patient that he is a licensed physician assistant, and also the name, address and telephone number of the patient care team physician or podiatrist. Such disclosure shall either be included on the prescription or be given in writing to the patient.

18VAC85-50-170. (Repealed.)

Part VI Standards of Professional Conduct.

18VAC85-50-175. Confidentiality.

A. 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.

B. Unauthorized use or disclosure of confidential information received from the Prescription Monitoring Program shall be grounds for disciplinary action.

18VAC85-50-176. Treating and prescribing for self or family.

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

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

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

18VAC85-50-177. 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 properly manage patient records and shall maintain timely, accurate, legible and complete records.

C. 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.

18VAC85-50-178. Practitioner-patient communication.

A. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately inform a patient or his legally authorized representative of his medical diagnoses, prognosis and prescribed treatments or plans of care in understandable terms to the patient. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure prescribed or directed by the practitioner in the treatment of any disease or condition.

~~B. A practitioner shall present information relating to the patient's care to a patient or his legally authorized representative in understandable terms and encourage participation in the decisions regarding the patient's care and shall refer to or consult with other health care professionals if so indicated.~~

C. Before surgery or any invasive procedure is performed, 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 surgery or invasive procedure that a reasonably prudent practitioner in similar practice in Virginia would tell a patient.

1. 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.

2. An exception to the requirement for consent prior to performance of surgery or an invasive procedure may be made in an emergency situation when a delay in obtaining consent would likely result in imminent harm to the patient.

3. For the purposes of this provision, "invasive 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.

18VAC85-50-179. 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 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.

~~**18VAC85-50-180. Vitamins, minerals and food supplements.**~~

~~A. The recommendation or direction for the use of vitamins, minerals or food supplements and the rationale for that recommendation shall be documented by the practitioner. The recommendation or direction shall be based upon a reasonable expectation that such use will result in a favorable patient outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use.~~

~~B. Vitamins, minerals, or food supplements, or a combination of the three, shall not be sold, dispensed, recommended, prescribed, or suggested in doses that would be contraindicated based on the individual patient's overall medical condition and medications.~~

~~C. The practitioner shall conform to the standards of his particular branch of the healing arts in the therapeutic application of vitamins, minerals or food supplement therapy.~~

~~**18VAC85-50-181. Pharmacotherapy for weight loss.**~~

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

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

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

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

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

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

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

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

~~**18VAC85-50-182. Anabolic steroids.**~~

~~A physician assistant shall not prescribe or administer anabolic steroids to any patient for other than accepted therapeutic purposes.~~

18VAC85-50-183. 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.

18VAC85-50-184. 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.

18VAC85-50-191. Practice and supervision of laser hair removal.

A. A physician assistant, as authorized pursuant to § 54.1-2952 of the Code of Virginia, may perform or supervise the performance of laser hair removal upon completion of training in the following:

1. Skin physiology and histology;
2. Skin type and appropriate patient selection;
3. Laser safety;
4. Operation of laser device to be used;
5. Recognition of potential complications and response to any actual complication resulting from a laser hair removal treatment; and
6. A minimum number of 10 proctored patient cases with demonstrated competency in treating various skin types.

B. Physician assistants who have been performing laser hair removal prior to August 7, 2019, are not required to complete training specified in subsection A of this section.

C. A physician assistant who delegates the practice of laser hair removal and provides supervision for such practice shall ensure the supervised person has completed the training required in subsection A of this section.

D. A physician assistant who performs laser hair removal or who supervises others in the practice shall receive ongoing training as necessary to maintain competency in new techniques and laser devices. The physician assistant shall ensure that persons the physician assistant supervises also receive ongoing training to maintain competency.

E. A physician assistant may delegate laser hair removal to a properly trained person under the physician assistant's direction and supervision. Direction and supervision shall mean that the physician assistant is readily available at the time laser hair removal is being performed. The supervising physician assistant is not required to be physically present but is required to see and evaluate a patient for whom the treatment has resulted in complications prior to the continuance of laser hair removal treatment.

F. Prescribing of medication shall be in accordance with § 54.1-3303 of the Code of Virginia.

DOCUMENTS INCORPORATED BY REFERENCE

Fluoroscopy Educational Framework for the Physician Assistant, December 2009, American Academy of Physician Assistants, 950 North Washington Street, Alexandria, VA 22314 and the American Society of Radiologic Technologists, 15000 Central Avenue, SE, Albuquerque, NM 87123

Agenda Items: Issue periodic review decision and adoption of fast-track regulatory changes recommended by the advisory board

Included in your agenda package are:

- Notice of periodic review
- Recommended revisions to Chapter 80

Staff Note: Advisory board recommended to retain Chapter 80 with amendments.

Action needed:

- Motion to retain Chapter 80 with amendments;

- Motion to adopt changes recommended by advisory board as fast-track regulatory changes.

Agency	**Department of Health Professions**
Board	**Board of Medicine**
Chapter	**Regulations for Licensure of Occupational Therapists [18 VAC 85 - 80]**

Edit Review Review 2150

Periodic Review of this Chapter

Includes a Small Business Impact Review

Date Filed: 6/16/2022

Review Announcement

Pursuant to Executive Order 14 (as amended July 16, 2018) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, this regulation is undergoing a periodic review.

The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018). http://TownHall.Virginia.Gov/EO-14.pdf.

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

In order for you to receive a response to your comment, your contact information (preferably an email address or, alternatively, a U.S. mailing address) must accompany your comment. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

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

Publication Information and Public Comment Period

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Comment Period begins on the publication date and ends on 8/17/2022

Comments Received: 0

Review Result

Pending

Attorney General Certification

Pending

This periodic review was created by Erin Barrett on 06/16/2022 at 12:25pm

Commonwealth of Virginia

REGULATIONS

GOVERNING THE LICENSURE OF OCCUPATIONAL THERAPISTS

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-80-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Revised Date: March 5, 2020

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

(804) 367-4600 (TEL)
(804) 527-4426 (FAX)
email: medbd@dhp.virginia.gov

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Part I. General Provisions.

18VAC85-80-10. 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"

"Occupational therapy assistant"

"Practice of occupational therapy"

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

"ACOTE" means the Accreditation Council for Occupational Therapy Education.

"Active practice" means a minimum of 160 hours of professional practice as an occupational therapist or an occupational therapy assistant within the 24-month period immediately preceding renewal or application for licensure, if previously licensed or certified in another jurisdiction. The active practice of occupational therapy may include supervisory, administrative, educational or consultative activities or responsibilities for the delivery of such services.

~~"Advisory board" means the Advisory Board of Occupational Therapy.~~

"Contact hour" means 60 minutes of time spent in continued learning activity.

"NBCOT" means the National Board for Certification in Occupational Therapy, under which the national examination for certification is developed and implemented.

"National examination" means the examination prescribed by NBCOT for certification as an occupational therapist or an occupational therapy assistant and approved for licensure in Virginia.

"Occupational therapy personnel" means appropriately trained individuals who provide occupational therapy services under the supervision of a licensed occupational therapist.

~~**18VAC85-80-20. Public participation.**~~

~~A separate regulation, 18VAC85-10-10 et seq., Public Participation Guidelines, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine~~

18VAC85-80-25. Current name and address.

Each licensee 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 shall be validly given when sent to the latest address of record provided or served to the licensee. 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.

18VAC85-80-26. Fees.

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

1. The initial fee for the occupational therapist license shall be $130; for the occupational therapy assistant, it shall be $70.

2. The fee for reinstatement of the occupational therapist license that has been lapsed for two years or more shall be $180; for the occupational therapy assistant, it shall be $90.

3. The fee for active license renewal for an occupational therapist shall be $135; for an occupational therapy assistant, it shall be $70. The fees for inactive license renewal shall be $70 for an occupational therapist and $35 for an occupational therapy assistant. Renewals shall be due in the birth month of the licensee in each even-numbered year. ~~For 2020, the fee for renewal of an active license as an occupational therapist shall be $108; for an occupational therapy assistant, it shall be $54. For renewal of an inactive license in 2020, the fees shall be $54 for an occupational therapist and $28 for an occupational therapy assistant.~~

4. The additional fee for processing a late renewal application within one renewal cycle shall be $50 for an occupational therapist and $30 for an occupational therapy assistant.

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

6. The fee for reinstatement of licensure pursuant to §54.1-2408.2 of the Code of Virginia shall be $2,000.

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

8. The fee for a duplicate license shall be $5, and the fee for a duplicate wall certificate shall be $15.

9. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $35, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $15 for each renewal cycle.

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

Part II. Requirements of Licensure as an Occupational Therapist.

18VAC85-80-30. (Repealed)

18VAC85-80-35. Application requirements.

An applicant for licensure shall submit the following on forms provided by the board:

1. A completed application and a fee as prescribed in 18VAC85-80-26.

2. Verification of professional education in occupational therapy as required in 18VAC85-80-40.

3. ~~Verification of practice as required in 18VAC85-80-60 and as specified on the application form.~~

~~4.~~ Documentation of passage of the national examination as required in 18VAC85-80-50.

~~5.~~4. If licensed or certified in any other jurisdiction, verification that there has been no disciplinary action taken or pending in that jurisdiction.

18VAC85-80-40. Educational requirements.

A. An applicant who has received his professional education in the United States, its possessions or territories, shall successfully complete all academic and fieldwork requirements of an accredited educational program as verified by the ACOTE.

B. An applicant who has received his professional education outside the United States, its possessions or territories, shall successfully complete all academic and clinical fieldwork requirements of a program approved by a member association of the World Federation of Occupational Therapists as verified by the candidate's occupational therapy program director and as required by the NBCOT and submit proof of proficiency in the English language by passing the Test of English as a Foreign Language (TOEFL) with a score acceptable to the board. TOEFL may be waived upon evidence of English proficiency.

C. An applicant who does not meet the educational requirements as prescribed in subsection A or B of this section but who has received certification by the NBCOT as an occupational therapist or an occupational therapy assistant shall be eligible for licensure in Virginia and shall provide the board verification of his education, training and work experience acceptable to the board.

18VAC85-80-45. Practice by a graduate awaiting examination results.

A. A graduate of an accredited occupational therapy educational program may practice with the designated title of "Occupational Therapist, License Applicant" or "O.T.L.-Applicant" until he has received a failing score on the licensure examination from NBCOT or for six months from the date of graduation, whichever occurs sooner. The graduate shall use one of the designated titles on any identification or signature in the course of his practice.

B. A graduate of an accredited occupational therapy assistant educational program may practice with the designated title of "Occupational Therapy Assistant-License Applicant" or "O.T.A.-Applicant" until he has received a failing score on the licensure examination from NBCOT or for six months from the date of graduation, whichever occurs sooner. The graduate shall use one of the designated titles on any identification or signature in the course of his practice.

18VAC85-80-50. Examination requirements.

A. An applicant for licensure to practice as an occupational therapist shall submit evidence to the board that he has passed the certification examination for an occupational therapist and any other examination required for initial certification from the NBCOT.

B. An applicant for licensure to practice as an occupational therapy assistant shall submit evidence to the board that he has passed the certification examination for an occupational therapy assistant and any other examination required for initial certification from the NBCOT.

18VAC85-80-60. Practice requirements.

An applicant who has been practicing occupational therapy in another jurisdiction and has met the requirements for licensure in Virginia shall provide evidence that he has engaged in the active practice of occupational therapy as defined in 18VAC85-80-10. If the applicant has not engaged in active practice as defined in 18VAC85-80-10, he shall serve a board-approved practice of 160 hours, which is to be completed within 60 consecutive days, under the supervision of a licensed occupational therapist.

18VAC85-80-61. (Repealed.)

18VAC85-80-65. Registration for voluntary practice by out-of-state licensees.

Any occupational therapist or an occupational therapy assistant who does not hold a license to practice in Virginia and who seeks registration to practice under subdivision 27 of §54.1-2901 of the Code of Virginia on a voluntary basis under the auspices of a publicly supported, all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people shall:
1. File a complete application for registration on a form provided by the board at least five business days prior to engaging in such practice. An incomplete application will not be considered;

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

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

~~4. Pay a registration fee of $10; and~~

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

Part III. Renewal of Licensure; Reinstatement.

18VAC85-80-70. Biennial renewal of licensure.

A. An occupational therapist or an occupational therapy assistant shall renew his license biennially during his birth month in each even-numbered year by:

1. Paying to the board the renewal fee prescribed in 18VAC85-80-26;

2. Indicating that he has been engaged in the active practice of occupational therapy as defined in 18VAC85-80-10; and

3. Attesting to completion of continued competency requirements as prescribed in 18VAC85-80-71.

B. An occupational therapist or an occupational therapy assistant whose license has not been renewed by the first day of the month following the month in which renewal is required shall pay an additional fee as prescribed in 18VAC85-80-26.

18VAC85-80-71. Continued competency requirements for renewal of an active license.

A. In order to renew an active license biennially, a practitioner shall complete at least ~~20~~ 10 contact hours of continuing learning activities ~~as follows:~~

~~1. A minimum of 10 of the 20 hours shall be in Type 1 activities,~~ which shall consist of an organized program of study, classroom experience, or similar educational experience that is related to a licensee's current or anticipated roles and responsibilities in occupational therapy and approved or provided by one of the following organizations or any of its components:

~~a.~~1. Virginia Occupational Therapy Association;

~~b.~~2. American Occupational Therapy Association;

~~c.~~3. National Board for Certification in Occupational Therapy;

~~d.~~4. Local, state, or federal government agency;

~~e.~~5. Regionally accredited college or university;

~~f.~~6. Health care organization accredited by a national accrediting organization granted authority by the Centers for Medicare and Medicaid Services to assure compliance with Medicare conditions of participation; or

~~g.~~7. An American Medical Association Category 1 Continuing Medical Education program.

~~2.~~B. ~~No more than 10 of the 20 hours may be Type 2 activities, which may include consultation with another therapist, independent reading or research, preparation for a presentation, or other such experiences that promote continued learning.~~ Up to two of the ~~Type 2~~ continuing education hours may be satisfied through delivery of occupational therapy services, without compensation, to low-income individuals receiving services through a local health department or a free clinic organized in whole or primarily for the delivery of health services. One hour of continuing education may be credited for three hours of providing such volunteer services as documented by the health department or free clinic.

C. Up to two of the continuing education hours may be satisfied through supervision or experiences that promote the education of students. One hour of continuing education may be credited for eight hours of providing such supervision as documented by the educational institution for which supervision is performed.

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

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

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

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

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

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

18VAC85-80-72. Inactive licensure.

A. A licensed occupational therapist or an occupational therapy 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 18VAC85-80-71 and shall not be entitled to perform any act requiring a license to practice occupational therapy 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. ~~If the license has been inactive for two to six years, documentation of having engaged in the active practice of occupational therapy or having completed a board-approved practice of 160 hours within 60 consecutive days under the supervision of a licensed occupational therapist; and~~

~~4.~~ Documentation of completed continued competency hours equal to the requirement for the number of years, not to exceed ~~four~~ six years, in which the license has been inactive.

C. An occupational therapist or an occupational therapy assistant who has had an inactive license for six years or more and who has not engaged in active practice, as defined in 18VAC85-80-10, shall ~~serve a board-approved practice of 320 hours to be completed in four consecutive months under the supervision of a licensed occupational therapist~~ provide evidence of current certification by NBCOT or retake and pass the national examination.

D. The board reserves the right to deny a request for reactivation 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.

18VAC85-80-73. Restricted volunteer license.

A. An occupational therapist or an occupational therapy assistant who held an unrestricted license issued by the Virginia Board of Medicine or by a board in another state as a licensee in good standing at the time the license expired or became inactive may be issued a restricted volunteer license to practice without compensation in a clinic that is organized in whole or in part for the delivery of health care services without charge in accordance with §54.1-106 of the Code of Virginia.

B. To be issued a restricted volunteer license, an occupational therapist or occupational therapy assistant shall submit an application to the board that documents compliance with requirements of §54.1-2928.1 of the Code of Virginia and the application fee prescribed in 18VAC85-80-26.

C. The licensee who intends to continue practicing with a restricted volunteer license shall renew biennially during his birth month, meet the continued competency requirements prescribed in subsection D of this section, and pay to the board the renewal fee prescribed in 18VAC85-80-26.

D. The holder of a restricted volunteer license shall not be required to attest to hours of continuing education for the first renewal of such a license. For each renewal thereafter, the licensee shall attest to obtaining ~~10~~ 5 hours of continuing education during the biennial renewal period ~~with at least five hours of Type 1 and no more than five hours of Type 2~~ as specified in 18VAC85-80-71.

18VAC85-80-80. Reinstatement.

A. An occupational therapist or an occupational therapy assistant who allows his license to lapse for a period of two years or more and chooses to resume his practice shall submit a reinstatement application to the board and information on any practice and licensure or certification in other jurisdictions during the period in which the license was lapsed, and shall pay the fee for reinstatement of his licensure as prescribed in 18VAC85-80-26.

B. An occupational therapist or an occupational therapy assistant who has allowed his license to lapse for two years or more shall provide evidence of current certification by NBCOT or retake and pass the national examination. ~~but less than six years, and who has not engaged in active practice as defined in 18VAC85-80-10, shall serve a board-approved practice of 160 hours to be completed in two consecutive months under the supervision of a licensed occupational therapist.~~

~~C. An occupational therapist or an occupational therapy assistant who has allowed his license to lapse for six years or more, and who has not engaged in active practice, shall serve a board-approved practice of 320 hours to be completed in four consecutive months under the supervision of a licensed occupational therapist.~~

~~D.~~C. An applicant for reinstatement shall meet the continuing competency requirements of 18VAC85-80-71 for the number of years the license has been lapsed, not to exceed ~~four~~ six years.

E. An occupational therapist or an occupational therapy 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 18VAC85-80-26 pursuant to §54.1-2408.2 of the Code of Virginia.

Part IV. Practice of Occupational Therapy.

18VAC85-80-90. ~~General responsibilities.~~ Repealed.

~~A. An occupational therapist renders services of assessment, program planning, and therapeutic treatment upon request for such service. The practice of occupational therapy includes therapeutic use of occupations for habilitation and rehabilitation to enhance physical health, mental health, and cognitive functioning. The practice of occupational therapy may include supervisory, administrative, educational or consultative activities or responsibilities for the delivery of such services.~~

~~B. An occupational therapy assistant renders services under the supervision of an occupational therapist that do not require the clinical decision or specific knowledge, skills and judgment of a licensed occupational therapist and do not include the discretionary aspects of the initial assessment, evaluation or development of a treatment plan for a patient.~~

18VAC85-80-100. ~~Individual r~~ Responsibilities.

A. An occupational therapist provides assessment by determining the need for, the appropriate areas of, and the estimated extent and time of treatment. His responsibilities include an initial screening of the patient to determine need for services and the collection, evaluation and interpretation of data necessary for treatment.

B. An occupational therapist provides program planning by identifying treatment goals and the methods necessary to achieve those goals for the patient. The therapist analyzes the tasks and activities of the program, documents the progress, and coordinates the plan with other health, community or educational services, the family and the patient. The services may include but are not limited to education and training in basic and instrumental activities of daily living (ADL); the design, fabrication, and application of orthoses (splints); the design, selection, and use of adaptive equipment and assistive technologies; therapeutic activities to enhance functional performance; vocational evaluation and training; and consultation concerning the adaptation of physical, sensory, and social environments.

C. An occupational therapist provides the specific activities or therapeutic methods to improve or restore optimum functioning, to compensate for dysfunction, or to minimize disability of patients impaired by physical illness or injury, emotional, congenital or developmental disorders, or by the aging process.

D. An occupational therapy assistant is responsible for the safe and effective delivery of those services or tasks delegated by and under the direction of the occupational therapist. Individual responsibilities of an occupational therapy assistant may include:

1. Participation in the evaluation or assessment of a patient by gathering data, administering tests, and reporting observations and client capacities to the occupational therapist;

2. Participation in intervention planning, implementation, and review;

3. Implementation of interventions as determined and assigned by the occupational therapist;

4. Documentation of patient responses to interventions and consultation with the occupational therapist about patient functionality;

5. Assistance in the formulation of the discharge summary and follow-up plans; and

6. Implementation of outcome measurements and provision of needed patient discharge resources.

E. The practice of occupational therapy may include supervisory, administrative, educational or consultative activities or responsibilities for the delivery of such services.

18VAC85-80-110. Supervisory responsibilities of an occupational therapist.

A. Delegation to an occupational therapy assistant.

1. An occupational therapist shall be ultimately responsible and accountable for patient care and occupational therapy outcomes under his clinical supervision.

2. An occupational therapist shall not delegate the discretionary aspects of the initial assessment, evaluation or development of a treatment plan for a patient nor shall he delegate any task requiring a clinical decision or the knowledge, skills, and judgment of a licensed occupational therapist.

3. Delegation shall only be made if, in the judgment of the occupational therapist, the task or procedures do not require the exercise of professional judgment, can be properly and safely performed by an appropriately trained occupational therapy assistant, and the delegation does not jeopardize the health or safety of the patient.

4. Delegated tasks or procedures shall be communicated to an occupational therapy assistant on a patient-specific basis with clear, specific instructions for performance of activities, potential complications, and expected results.

B. The frequency, methods, and content of supervision are dependent on the complexity of patient needs, number and diversity of patients, demonstrated competency and experience of the assistant, and the type and requirements of the practice setting. The occupational therapist providing clinical supervision shall meet with the occupational therapy assistant to review and evaluate treatment and progress of the individual patients at least once every tenth treatment session or 30 calendar days, whichever occurs first. For the purposes of this subsection, group treatment sessions shall be counted the same as individual treatment sessions.

C. An occupational therapist may provide clinical supervision for up to six occupational therapy personnel, to include no more than three occupational therapy assistants at any one time.

D. The occupational therapy assistant shall document in the patient record any aspects of the initial evaluation, treatment plan, discharge summary, or other notes on patient care performed by the

assistant. The supervising occupational therapist shall countersign such documentation in the patient record at the time of the review and evaluation required in subsection B of this section.

18VAC85-80-111. Supervision of unlicensed occupational therapy personnel.

A. Unlicensed occupational therapy personnel may be supervised by an occupational therapist or an occupational therapy assistant.

B. Unlicensed occupational therapy personnel may be utilized to perform:

1. Nonclient-related tasks including, but not limited to, clerical and maintenance activities and the preparation of the work area and equipment; and

2. Certain routine patient-related tasks that, in the opinion of and under the supervision of an occupational therapist, have no potential to adversely impact the patient or the patient's treatment plan.

Part V. Standards of Professional Conduct.

18VAC85-80-120. (Repealed.)

18VAC85-80-130. 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.

18VAC85-80-140. Patient records.

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

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

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

D. Practitioners who are employed by a health care institution, school system 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. M~~ maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:

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

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

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

~~2. From October 19, 2005, 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.~~

18VAC85-80-150. Practitioner-patient communication; 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.

18VAC85-80-160. 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 A 3 of this section.

18VAC85-80-170. 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 which:

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.

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 shall mean: 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.

18VAC85-80-180. 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 Items: Issue periodic review decision and adoption of fast-track regulatory changes recommended by the advisory board

Included in your agenda package are:

- Notice of periodic review
- Public comment received
- Recommended revisions to Chapter 101

Staff Note: Advisory board recommended to retain Chapter 101 with amendments.

Action needed:

- Motion to retain Chapter 101 with amendments;
- Motion to adopt changes recommended by advisory board as fast-track regulatory changes.

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Agency	Department of Health Professions
Board	Board of Medicine
Chapter	Regulations Governing the Licensure of Radiologic Technology [18 VAC 85 - 101]

Edit Review

Review 2151

Periodic Review of this Chapter

Includes a Small Business Impact Review

Date Filed: 6/16/2022

Review Announcement

Pursuant to Executive Order 14 (as amended July 16, 2018) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, this regulation is undergoing a periodic review.

The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018). http://TownHall.Virginia.Gov/EO-14.pdf.

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

In order for you to receive a response to your comment, your contact information (preferably an email address or, alternatively, a U.S. mailing address) must accompany your comment. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

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

Publication Information and Public Comment Period

Published in the Virginia Register on 7/18/2022 [Volume: 38 Issue: 24]

Comment Period begins on the publication date and ends on 8/17/2022

Comments Received: 6

Review Result

Pending

Attorney General Certification

Pending

This periodic review was created by Erin Barrett on 06/16/2022 at 12:26pm

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Agency **Department of Health Professions**

Board **Board of Medicine**

Chapter **Regulations Governing the Licensure of Radiologic Technology [18 VAC 85 - 101]**

6 comments

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

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Commenter: Ferell Justice 7/8/22 2:40 pm

Chapter 101 - Radiologic Technology

I am in full support of the continuation of regulations in Virginia related to Chapter 101-Radiologic Technology. I support the retention of this regulation, at this time, as written.

CommentID: **122220**

Commenter: Millard Ferell Justice 7/18/22 9:32 am

Chapter 101 - Radiologic Technology

I am in full support of the continuation of regulations in Virginia related to Chapter 101 - Radiologic Technology. I support the retention of this regulation, at this time, as written.

CommentID: **122696**

Commenter: Ruth Kusterer / Virginia Society of Radiologic Technologists 7/18/22 12:39 pm

Radiologic Technology, Chapter 101

I am in support of the regulations for Radiologic Technologist remaining intact, as written relating to Chapter 101-Radiologic Technology. I fully support no revisions of this chapter at this time.

CommentID: **122720**

Commenter: Nicholas Gimmi, Virginia Society of Radiologic Technologists, Board Chair 7/25/22 1:21 pm

Chapter 101-Radiologic Technology

I am in support of keeping the current regulations as written in Chapter 101-Radiologic Technology. Discontinuing this would water down regulations, placing patients at risk of receiving care from a person or caregiver that has limited or no education in this field. This could certainly lead to undiagnostic imaging and possible misdiagnosis, as well as risk of overexposure.

CommentID: **122952**

Commenter: Travis Prowant, American Registry of Radiologic Technologists 8/7/22 3:18 pm

Chapter 101- Radiologic Technology

I am in full support of the continuation of regulations in Virginia related to Chapter 101- Radiologic Technology. I support retention of this regulation, at this time, as written.

As an American Registry of Radiologic Technologist Board Trustee, I find this even more important to keep in place as we routinely find encroachment issues in almost every state. And, more importantly, people want to use medical imaging and dispense ionizing radiation to the public with very little or NO training or experience in proper use of the equipment. I have genuine concerns over the safety and health of the citizens of the Commonwealth should this regulation be removed.
CommentID: **127143**

Commenter: Jacqueline Stuart / Virginia Society of Radiologic Technologists 8/13/22 1:27 pm

Chapter 101- Radiologic Technology

I am in full support of the continuation of regulations in Virginia related to Chapter 101- Radiologic Technology. I support retention of this regulation, at this time, as written.

As a student of the radiologic imaging sciences at Tidewater Community College and an active student member of the VSRT I am very aware of the issue of professional encroachment. More importantly, I am concerned ultimately about public health and safety if this regulation is removed. In accredited educational programs for these sciences we learn radiation physics and safety practices at length, as well as how to obtain and recognize diagnostic quality images. The practice of imaging without properly regulated training and maintained certification introduces too many variables into patient care related to medical imaging.

CommentID: **127211**

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF Radiologic Technology

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-101-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Revised Date: April 1, 2022

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

(804) 367-4600 (TEL)
(804) 527-4426 (FAX)
email: medbd@dhp.virginia.gov

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Part I. General Provisions.

18VAC85-101-10. Definitions.

In addition to definitions in § 54.1-2900 of the Code of Virginia, the following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

"ACRRT" means the American Chiropractic Registry of Radiologic Technologists.

"ARRT" means the American Registry of Radiologic Technologists.

"Bone densitometry" means a process for measuring bone mineral density by utilization of single x-ray absorptiometry (SXA), dual x-ray absorptiometry (DXA) or other technology that is substantially equivalent as determined by the board.

"Direct supervision" means that a licensed radiologic technologist, doctor of medicine, osteopathy, chiropractic or podiatry is present and is fully responsible for the activities performed by radiologic personnel, with the exception of radiologist assistants.

"Direction" means the delegation of radiologic functions to be performed upon a patient from a licensed doctor of medicine, osteopathy, chiropractic, or podiatry, to a licensed radiologic technologist or a radiologic technologist-limited for a specific purpose and confined to a specific anatomical area, that will be performed under the direction of and in continuing communication with the delegating practitioner.

"ISCD" means the International Society for Clinical Densitometry.

"NMTCB" means Nuclear Medicine Technology Certification Board.

"Radiologist" means a doctor of medicine or osteopathic medicine specialized by training and practice in radiology.

" R.T.(R)" means a person who is currently certified by the ARRT as a radiologic technologist with certification in radiography.

"Traineeship" means a period of activity during which an applicant for licensure as a radiologic technologist works under the direct supervision of a practitioner approved by the board while waiting for the results of the licensure examination or an applicant for licensure as a radiologic technologist-limited working under direct supervision and observation to fulfill the practice requirements in 18VAC85-101-60.

~~**18VAC85-101-20. Public Participation Guidelines.**~~

~~A separate board regulation, 18VAC85-11, entitled Public Participation Guidelines, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.~~

18VAC85-101-25. Fees.

A. Unless otherwise provided, fees listed in this section shall not be refundable.

B. Initial licensure fees.

1. The application fee for radiologic technologist or radiologist assistant licensure shall be $130.

2. The application fee for the radiologic technologist-limited licensure shall be $90.

3. All examination fees shall be determined by and made payable as designated by the board.

C. Licensure renewal and reinstatement for a radiologic technologist or a radiologist assistant.

1. The fee for active license renewal for a radiologic technologist shall be $135, and the fee for inactive license renewal shall be $70. For 2021, the fees for renewal shall be $108 for an active license as a radiologic technologist and $54 for an inactive license. If a radiologist assistant holds a current license as a radiologic technologist, the renewal fee shall be $50. If a radiologist assistant does not hold a current license as a radiologic technologist, the renewal fee shall be $150. For renewal of a radiologist assistant license in 2021, the fee shall be $40 for a radiologist assistant with a current license as a radiologic technologist and $120 for a radiologist assistant without a current license as a radiologic technologist.

2. An additional fee of $50 to cover administrative costs for processing a late renewal application within one renewal cycle shall be imposed by the board.

3. The fee for reinstatement of a radiologic technologist or a radiologist assistant license that has lapsed for a period of two years or more shall be $180 and shall be submitted with an application for licensure reinstatement.

4. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

D. Licensure renewal and reinstatement for a radiologic technologist-limited.

1. The fee for active license renewal shall be $70, and the fee for inactive license renewal shall be $35. For 2021, the fees for renewal shall be $54 for an active license as a radiologic technologist and $28 for an inactive license.

2. An additional fee of $25 to cover administrative costs for processing a late renewal application within one renewal cycle shall be imposed by the board.

3. The fee for reinstatement of a license that has lapsed for a period of two years or more shall be $120 and shall be submitted with an application for licensure reinstatement.

4. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

E. Other fees.

1. The application fee for a traineeship as a radiologic technologist or a radiologic technologist-limited shall be $25.

2. The fee for a letter of good standing or verification to another state for licensure shall be $10; the fee for certification of scores to another jurisdiction shall be $25.

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

4. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

18VAC85-101-26. Current name and address.

Each licensee 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 shall be validly given when sent to the latest address of record provided or served to the licensee. Any change of name or address of record or the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

Part II. Licensure Requirements - Radiologist Assistants.

18VAC85-101-27. Educational requirements for radiologist assistants.

An applicant for licensure as a radiologist assistant shall be a graduate of an educational program that is currently recognized by the ARRT for the purpose of allowing an applicant to sit for the ARRT certification examination leading to the Registered Radiologist Assistant credential.

18VAC85-101-28. Licensure requirements.

A. An applicant for licensure as a radiologist assistant shall:

1. Meet the educational requirements specified in 18VAC85-101-27;

2. Submit the required application, fee, and credentials to the board;

3. Hold certification by the ARRT as an R.T.(R) or be licensed in Virginia as a radiologic technologist;

4. Submit evidence of passage of an examination for radiologist assistants resulting in national certification as an Registered Radiologist Assistant by the ARRT; and

5. Hold current certification in Advanced Cardiac Life Support (ACLS).

B. If an applicant has been licensed or certified in another jurisdiction as a radiologist assistant or a radiologic technologist, the application shall include verification that there has been no disciplinary action taken or pending in that jurisdiction.

C. An applicant who fails the ARRT examination for radiologist assistants shall follow the policies and procedures of the ARRT for successive attempts.

Part III. Licensure Requirements - Radiologic Technologist.

18VAC85-101-30. Educational requirements for radiologic technologists.

An applicant for licensure as a radiologic technologist shall be a graduate of an educational program acceptable to the ARRT for the purpose of sitting for the ARRT certification examination.

18VAC85-101-40. Licensure requirements.

A. An applicant for board licensure shall:

1. Meet the educational requirements specified in 18VAC85-101-30;

2. Submit the required application, fee, and credentials to the board; and

3. Submit evidence of passage of an examination resulting in certification by the ARRT or the NMTCB.

B. If an applicant has been licensed or certified in another jurisdiction, he shall provide information on the status of each license or certificate held and verification from that jurisdiction of any current, unrestricted license.

C. An applicant who fails the ARRT or NMTCB examination shall follow the policies and procedures of the certifying body for successive attempts.

18VAC85-101-50. (Repealed).

Part IV. Licensure Requirements - Radiologic Technologist-Limited.

18VAC85-101-55. Educational requirements for radiologic technologists-limited.

A. An applicant for licensure as a radiologic technologist-limited shall be trained by one of the following:

1. Successful completion of educational coursework that is directed by a radiologic technologist with a bachelor's degree and current ARRT certification, has instructors who are licensed radiologic technologists or doctors of medicine or osteopathic medicine who are board-certified in radiology, and has a minimum of the following coursework:

a. Image production/equipment operation —25 clock hours;

b. Radiation protection —15 clock hours; and

c. Radiographic procedures in the anatomical area of the radiologic technologist-limited's practice —10 clock hours taught by a radiologic technologist with current ARRT certification or a licensed doctor of medicine, osteopathy, podiatry or chiropractic;

2. An ACRRT-approved program;

3. The ISCD certification course for bone densitometry; or

4. Any other program acceptable to the board.

B. A radiologic technologist-limited who has been trained through the ACRRT-approved program or the ISCD certification course and who also wishes to be authorized to perform x-rays in other anatomical areas shall meet the requirements of subdivision A 1 of this section.

18VAC85-101-60. Licensure requirements.

A. An applicant for licensure by examination as a radiologic technologist-limited shall submit:

1. The required application and fee as prescribed by the board;

2. Evidence of successful completion of an examination as required in this section; and

3. Evidence of completion of training as required in 18VAC85-101-55.

B. To qualify for limited licensure to practice under the direction of a doctor of medicine or osteopathic medicine with the exception of practice in bone densitometry, the applicant shall:

1. Provide evidence that he has received a passing score as determined by the board on the core section of the ARRT examination for Limited Scope of Practice in Radiography;

2. Meet one of the following requirements:

a. Provide evidence that he has received a passing score as determined by the board on the section of the ARRT examination on specific radiographic procedures, depending on the anatomical areas in which the applicant intends to practice; or

b. Until the ARRT offers an examination for limited licensure in the radiographic procedures of the abdomen and pelvis, the applicant may qualify for a limited license by submission of a notarized statement from a licensed radiologic technologist or doctor of medicine or osteopathy attesting to the applicant's training and competency to practice in that anatomical area as follows:

(1) To perform radiographic procedures on the abdomen or pelvis, the applicant shall have successfully performed during the traineeship at least 25 radiologic examinations on patients of the abdomen or pelvis under the direct supervision and observation of a licensed radiologic technologist or a doctor of medicine or osteopathy. The notarized statement shall further attest to the applicant's competency in the areas of radiation safety, positioning, patient instruction, anatomy, pathology and technical factors.

(2) When a section is added to the limited license examination by the ARRT that includes the abdomen and pelvis, the applicant shall provide evidence that he has received a passing score on that portion of the examination as determined by the board; and

3. Provide evidence of having successfully performed in a traineeship at least 10 radiologic examinations on patients in the anatomical area for which he is seeking licensure under the direct supervision and observation of a licensed radiologic technologist or a doctor of medicine or osteopathy. A notarized statement from the supervising practitioner shall attest to the applicant's competency in the areas of radiation safety, positioning, patient instruction, anatomy, pathology and technical factors.

C. To qualify for limited licensure to practice in bone densitometry under the direction of a doctor of medicine, osteopathy, or chiropractic, the applicant shall either:

1. Provide evidence that he has received a passing score as determined by the board on the core section of the ARRT examination for Limited Scope of Practice in Radiography; and

a. The applicant shall provide a notarized statement from a licensed radiologic technologist or doctor of medicine, osteopathy, or chiropractic attesting to the applicant's training and competency to practice in that anatomical area. The applicant shall have successfully performed at least 10 examinations on patients for bone density under the direct supervision and observation of a licensed radiologic technologist or a doctor of medicine or osteopathy; or

b. When a section is added to the limited license examination by the ARRT that includes bone densitometry, the applicant shall provide evidence that he has received a passing score on that portion of the examination as determined by the board; or

2. Provide evidence that he has taken and passed an examination resulting in certification in bone densitometry from the ISCD or any other substantially equivalent credential acceptable to the board.

D. To qualify for a limited license in the anatomical areas of the spine or extremities or in bone densitometry to practice under the direction of a doctor of chiropractic, the applicant shall provide evidence that he has met the appropriate requirements of subsection B, taken and passed the appropriate requirements of subsection C for bone densitometry only, or taken and passed an examination by the ACRRT.

E. To qualify for a limited license in the anatomical area of the foot and ankle to practice under the direction of a doctor of podiatry, the applicant shall provide evidence that he has taken and passed an examination acceptable to the board.

F. An applicant who fails the examination shall be allowed two more attempts to pass the examination after which he shall reapply and take additional educational hours which meet the criteria of 18VAC85-101-70.

18VAC85-101-61. (Repealed.)

18VAC85-101-70 to 18VAC85-101-90. (Repealed.)

Part V. Practice of Radiologist Assistants.

18VAC85-101-91. General requirements.

A. A licensed radiologist assistant is authorized to:

1. Assess and evaluate the physiological and psychological responsiveness of patients undergoing radiologic procedures;

2. Perform patient assessment, and assist in patient management and patient education;

3. Evaluate image quality, make initial observations, and communicate observations to the supervising radiologist;

4. Administer contrast media or other medications prescribed by the supervising radiologist; and

5. Perform, or assist the supervising radiologist in performing, imaging procedures consistent with the guidelines adopted by the American College of Radiology, the American Society of Radiologic Technologists, and the American Registry of Radiologic Technologists.

B. A licensed radiologist assistant is not authorized to:

1. Provide official interpretation of imaging studies; or

2. Dispense or prescribe medications.

18VAC85-101-92. Supervision of radiologist assistants.

A radiologist assistant shall practice under the direct supervision of a radiologist. Direct supervision shall mean that the radiologist is present in the facility and immediately available to assist and direct the performance of a procedure by a radiologist assistant. The supervising radiologist may determine that direct supervision requires his physical presence for the performance of certain procedures, based on factors such as the complexity or invasiveness of the procedure and the experience and expertise of the radiologist assistant.

Part VI. Practice of Radiologic Technologists.

18VAC85-101-100. General requirements.

A. All services rendered by a radiologic technologist shall be performed only upon direction of a licensed doctor of medicine, osteopathy, chiropractic, or podiatry.

B. Licensure as a radiologic technologist is not required for persons who are employed by a licensed hospital pursuant to §54.1-2956.8:1 of the Code of Virginia.

18VAC85-101-110. Individual responsibilities to patients and to licensed doctor of medicine, osteopathy, chiropractic, or podiatry.

A. The radiologic technologist's responsibilities are to administer and document procedures consistent with his education and certifying examination and within the limit of his professional knowledge, judgment and skills.

B. A radiologic technologist shall maintain continuing communication with the delegating practitioner.

18VAC85-101-120. Supervisory responsibilities.

A. A radiologic technologist shall supervise no more than four radiologic technologists-limited or three trainees at any one time.

B. A radiologic technologist shall be responsible for any action of persons performing radiologic functions under the radiologic technologist's supervision or direction.

C. A radiologic technologist may not delegate radiologic procedures to any unlicensed personnel except those activities that are available without prescription in the public domain to include but not limited to preparing the patient for radiologic procedures and post radiologic procedures. Such nonlicensed personnel shall not perform those patient care functions that require professional judgment or discretion.

Part VII. Practice of Radiologic Technologist-Limited.

18VAC85-101-130. General requirements.

A. A radiologic technologist-limited is permitted to perform radiologic functions within his capabilities and the anatomical limits of his training and examination. A radiologic technologist-limited is responsible for informing the board of the anatomical area or areas in which he is qualified by training and examination to practice.

B. A radiologic technologist-limited shall not administer contrast media or radiopharmaceuticals or perform mammography, fluoroscopic procedures, computerized tomography, or vascular-interventional procedures. The radiologic technologist-limited is responsible to a licensed radiologic technologist, or doctor of medicine, osteopathy, chiropractic, or podiatry.

18VAC85-101-140. Individual responsibilities to patients and licensed radiologic technologist, doctor of medicine, osteopathy, chiropractic, or podiatry.

A. The radiologic technologist-limited's procedure with the patient shall only be made after verbal or written communication, or both, with the licensed radiologic technologist, doctor of medicine, osteopathy, chiropractic, or podiatry.

B. The radiologic technologist-limited's procedures shall be made under direct supervision.

C. A radiologic technologist-limited, acting within the scope of his practice, may delegate nonradiologic procedures to an unlicensed person, including but not limited to preparing the patient for radiologic procedures and post radiologic procedures. Such nonlicensed personnel shall not perform those patient care functions that require professional judgment or discretion.

18VAC85-101-145. Registration for voluntary practice by out-of-state licensees.

Any radiologist assistant, radiologic technologist or radiologic technologist-limited who does not hold a license to practice in Virginia and who seeks registration to practice under subdivision 27 of §54.1-2901 of the Code of Virginia on a voluntary basis under the auspices of a publicly supported, all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people shall:

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

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

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

4. ~~Pay a registration fee of $10; and~~

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

Part VIII. Renewal of Licensure.

18VAC85-101-150. Biennial renewal of license.

A. A radiologist assistant, radiologic technologist or radiologic technologist-limited who intends to continue practice shall renew his license biennially during his birth month in each odd-numbered year and pay to the board the prescribed renewal fee.

B. A license that has not been renewed by the first day of the month following the month in which renewal is required shall be expired.

C. An additional fee as prescribed in 18VAC85-101-25 shall be imposed by the board.

D. In order to renew an active license as a radiologic technologist, a licensee shall attest to having completed 24 hours of continuing education as acceptable to the ARRT within the last biennium.

E. In order to renew an active license as a radiologic technologist-limited, a licensee shall attest to having completed 12 hours of continuing education within the last biennium that corresponds to the anatomical areas in which the limited licensee practices. Hours shall be acceptable to the ARRT, or by the ACRRT for limited licensees whose scope of practice is chiropractic, or by any other entity approved by the board for limited licensees whose scope of practice is podiatry or bone densitometry.

F. In order to renew an active license as a radiologist assistant, a licensee shall attest to having completed 50 hours of continuing education as acceptable to the ARRT within the last biennium. A minimum of 25 hours of continuing education shall be recognized by the ARRT as intended for

radiologist assistants or radiologists and shall be specific to the radiologist assistant's area of practice. Continuing education hours earned for renewal of a radiologist assistant license shall satisfy the requirements for renewal of a radiologic technologist license.

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

H. Other provisions for continuing education shall be as follows:

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

2. The practitioner shall retain in his records the Continued Competency Activity and Assessment Form available on the board's website with all supporting documentation for a period of four years following the renewal of an active license.

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

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

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

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

18VAC85-101-151. Reinstatement.

A. A licensee who allows his license to lapse for a period of two years or more and chooses to resume his practice shall submit to the board a new application, information on practice and licensure in other jurisdictions during the period in which the license was lapsed, evidence of completion of hours of continuing education equal to those required for a biennial renewal and the fees for reinstatement of his license as prescribed in 18VAC85-101-25.

B. A licensee whose license has been revoked by the board and who wishes to be reinstated shall submit a new application to the board, fulfill additional requirements as specified in the order from the board, and pay the fee for reinstatement of his license as prescribed in 18VAC85-101-25.

18VAC85-101-152. Inactive license.

A. A licensed radiologist assistant, radiologic technologist or radiologic technologist-limited who holds a current, unrestricted license in Virginia may, 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 continuing education hours and shall not be entitled to perform any act requiring a license to practice radiography in Virginia.

B. To reactivate an inactive license, a licensee shall:

1. Submit the required application;

2. Pay a fee equal to the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure; and

3. Verify that he has completed continuing education hours equal to those required for the period in which he held an inactive license in Virginia, not to exceed one biennium.

C. The board reserves the right to deny a request for reactivation 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.

18VAC85-101-153. Restricted volunteer license.

A. A licensed radiologist assistant, radiologic technologist or a radiologic technologist-limited who held an unrestricted license issued by the Virginia Board of Medicine or by a board in another state as a licensee in good standing at the time the license expired or became inactive may be issued a restricted volunteer license to practice without compensation in a clinic that is organized in whole or in part for the delivery of health care services without charge in accordance with §54.1-106 of the Code of Virginia.

B. To be issued a restricted volunteer license, a licensee shall submit an application to the board that documents compliance with requirements of §54.1-2928.1 of the Code of Virginia and the application fee prescribed in 18VAC85-101-25.

C. The licensee who intends to continue practicing with a restricted volunteer license shall renew biennially during his birth month, meet the continued competency requirements prescribed in subsection D of this section, and pay to the board the renewal fee prescribed in 18VAC85-101-25.

D. The holder of a restricted volunteer license shall not be required to attest to hours of continuing education for the first renewal of such a license. For each renewal thereafter, a licensed radiologic technologist shall attest to having completed 12 hours of Category A continuing education as acceptable to and documented by the ARRT within the last biennium. A radiologic technologist-limited shall attest to having completed six hours of Category A continuing education within the last biennium that corresponds to the anatomical areas in which the limited licensee practices. Hours shall be acceptable to and documented by the ARRT or by any other entity approved by the board for limited licensees whose scope of practice is podiatry or bone densitometry.

18VAC85-101-160. [Repealed]

Part IX. Standards of Professional Conduct.

18VAC85-101-161. 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.

18VAC85-101-162. Patient records.

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

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

C. Practitioners shall maintain a patient record in accordance with policies and procedures of the employing institution or entity.

18VAC85-101-163. Practitioner-patient communication.

A. 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.

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

C. A practitioner shall refer to or consult with other health care professionals, if so indicated.

~~D. 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.~~

18VAC85-101-164. Practitioner responsibility.

A practitioner shall not:

1. Perform procedures or techniques or provide interpretations 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 A 3 of this section.

18VAC85-101-165. 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 which:

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.

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 shall mean: spouse or partner, parent or child, guardian, or legal representative of the patient.

E. Sexual contact between a practitioner and 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.

18VAC85-101-166. 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 Items: Issue periodic review decision and adoption of fast-track regulatory changes

Included in your agenda package are:

- Notice of periodic review
- Recommended revisions to Chapter 110

Staff Note: Advisory board did not have a quorum, but reviewed and supported the included amendments.

Action needed:

- Motion to retain Chapter 110 with amendments;

- Motion to adopt changes to Chapter 110 as fast-track regulatory changes.

Agency Department of Health Professions

Board Board of Medicine

Chapter Regulations Governing the Practice of Licensed Acupuncturists [18 VAC 85 - 110]

Edit Review

Review 2152

Periodic Review of this Chapter

Includes a Small Business Impact Review

Date Filed: 6/16/2022

Review Announcement

Pursuant to Executive Order 14 (as amended July 16, 2018) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, this regulation is undergoing a periodic review.

The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018). http://TownHall.Virginia.Gov/EO-14.pdf.

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

In order for you to receive a response to your comment, your contact information (preferably an email address or, alternatively, a U.S. mailing address) must accompany your comment. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

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

Publication Information and Public Comment Period

Published in the Virginia Register on 7/18/2022 [Volume: 38 Issue: 24]

Comment Period begins on the publication date and ends on 8/17/2022

Comments Received: 0

Review Result

Pending

Attorney General Certification

Pending

This periodic review was created by Erin Barrett on 06/16/2022 at 12:26pm

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF LICENSED ACUPUNCTURISTS

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-110-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Revised Date: March 5, 2020

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

(804) 367-4600 (TEL)
(804) 527-4426 (FAX)
email: medbd@dhp.virginia.gov

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Part I. General Provisions.

18VAC85-110-10. 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.

Acupuncturist

Board

Licensed acupuncturist

Practice of acupuncture

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

"ACAHM" means the Accreditation Commission for Acupuncture and Herbal Medicine.

"CCAHM" means the Council of Colleges of Acupuncture and Herbal Medicine.

"CNT course" means a Clean Needle Technique Course as administered by the CCAHM.

"NCCAOM" means the National Certification Commission for Acupuncture and Oriental Medicine.

~~**18VAC85-110-20. Public participation.**~~

~~A separate board regulation, 18VAC85-11, entitled Public Participation Guidelines, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.~~

18VAC85-110-30. [Repealed]

18VAC85-110-35. Fees.

Unless otherwise provided, the following fees shall not be refundable:

1. The application fee for a license to practice as an acupuncturist shall be $130.

2. The fee for biennial active license renewal shall be $135; the fee for biennial inactive license renewal shall be $70. For 2021, the fee for renewal of an active license shall be $108 and the fee for renewal of an inactive license shall be $54.

3. The additional fee for processing a late renewal within one renewal cycle shall be $50.

4. The fee for reinstatement of a license which has expired for two or more years shall be $180.

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

6. The fee for reinstatement of a license pursuant to §54.1-2408.2 of the Code of Virginia shall be $2,000.

7. The fee for a duplicate wall certificate shall be $15.

8. The fee for a duplicate renewal license shall be $5.

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

10. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $35, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $15 for each renewal cycle.

18VAC85-110-36. Current name and address.

Each licensee 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 shall be validly given when sent to the latest address of record provided or served to the licensee. Any change of name or address of record or the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

Part II. Requirements for Licensure.

18VAC85-110-40. [Repealed]

18VAC85-110-50. Educational requirements: graduates of approved institutions or programs in the United States.

A. Requirements for acupuncture education obtained prior to July 1, 1990, shall be as provided in this subsection.

1. An applicant applying for licensure to practice as an acupuncturist on the basis of successful completion of education in a school or college of acupuncture accredited by the ACAHM or other accrediting agencies approved by the Board of Medicine, which confers a degree or certificate in acupuncture in the United States, shall submit evidence of successful completion of an acupuncture course of study in an accredited school or college for acupuncture, providing evidence of not less than 1,000 hours of schooling in not less than a continuous 18-month period.

2. The studies shall include not less than 700 didactic hours and not less than 250 clinical hours. Additional hours may be in either didactic or clinical hours based upon the school or college curriculum.

B. Requirements for acupuncture education obtained after July 1, 1990, shall be as provided in this subsection.

An applicant applying for licensure to practice as a licensed acupuncturist on the basis of successful completion of education in a school or college for acupuncture accredited by ACAHM or any other accrediting agency approved by the Board of Medicine, that confers a degree or certificate in

acupuncture in the United States, shall submit evidence of having a minimum of three academic years in length equivalent to 90 semester credit hours or 135 quarter credit hours.

One academic year means full-time study completed in four quarters, two semesters, or three trimesters. A full-time continuous study program shall be a concentrated educational process in acupuncture which requires individual study with assigned materials in a classroom or clinical setting.

C. Requirements for acupuncture education obtained after July 1, 1999, shall be as provided in this subsection. An applicant applying for licensure to practice as a licensed acupuncturist on the basis of successful completion of education in a school or college for acupuncture accredited by ACAHM or any other accrediting agency approved by the Board of Medicine, which confers a degree or certificate in acupuncture in the United States, shall submit evidence of having a minimum of 1,725 hours of entry-level acupuncture education to include at least 1,000 didactic hours and 500 clinical hours. Clinical hours may include observation, as well as internship or treatment hours; the remaining 225 hours may be earned as either didactic or clinical. Correspondence programs or courses in acupuncture are excluded and may not be used to meet the requirements for acupuncture education.

D. Requirements for acupuncture education obtained after February 1, 2011, shall be as provided in this subsection. An applicant applying for licensure to practice as a licensed acupuncturist on the basis of successful completion of education in a school or college for acupuncture accredited by ACAHM or any other accrediting agency approved by the Board of Medicine, which confers a degree or certificate in acupuncture in the United States, shall submit evidence of having a minimum of 1,905 hours of entry-level acupuncture education to include at least 1,155 didactic hours and 660 clinical hours. Clinical hours may include observation, as well as internship or treatment hours; the remaining 90 hours may be earned as either didactic or clinical hours. Correspondence programs or courses in acupuncture are excluded and may not be used to meet the requirements for acupuncture education.

E. An applicant from an acupuncture program in a school or college that has achieved candidacy status for accreditation by ACAHM shall be eligible for licensure provided the program meets the applicable requirements of subsection A, B, C, or D of this section, with the exception of full ACAHM accreditation.

18VAC85-110-60. Requirements of foreign graduates of nonaccredited educational programs in acupuncture.

A. An applicant who has completed an educational course of study in a school or college outside the United States or Canada that is not accredited by ACAHM or any other board-approved accrediting agency shall:

1. Submit a transcript from his educational course of study in acupuncture to a credential evaluation service approved by the board to determine equivalency in education and training to that required in 18VAC85-110-50.

2. Meet the examination requirements as prescribed in 18VAC85-110-80 and 18VAC85-110-90.

B. All documents submitted to the board which are not in English must be translated into English and certified by the embassy of the issuing government or by a translating service.

18VAC85-110-70. [Repealed]

18VAC85-110-80. Examination requirements for licensure.

The examination requirements for licensure shall consist of:

1. Passing the NCCAOM ~~comprehensive written~~ examination, resulting in current, active certification by the NCCAOM at the time the application is filed with the board;

~~2. Passing the Point Location Examination;~~ and

~~3.~~2. Completing the CNT course as administered by the CCAHM.

18VAC85-110-90. Test of spoken English requirements.

A. An applicant applying for licensure to practice as an acupuncturist whose native language is not English and whose acupuncture education was also not in English shall submit evidence of having achieved a passing score as acceptable to the board on either the Test of Spoken English (TSE) or the Test of English as a Foreign Language (TOEFL) administered by the Educational Testing Services.

B. An applicant applying for licensure to practice as an acupuncturist whose native language is not English and whose acupuncture education was also not in English shall be exempt from the requirement for TSE or TOEFL if the majority of his clients speak the language of the acupuncturist.

Part III. Scope of Practice.

18VAC85-110-100. General requirements.

Prior to performing acupuncture, a licensed acupuncturist shall obtain written documentation that the patient has received a diagnostic examination within the past six months by a licensed doctor of medicine, osteopathy, chiropractic, or podiatry acting within the scope of his practice or shall provide to the patient a written recommendation for such a diagnostic examination on a form specified by the board and signed by the patient. The original of the signed form shall be maintained in the patient's chart and a copy provided to the patient.

18VAC85-110-110. Limitation of titles.

A person practicing as a licensed acupuncturist is restricted to the use of the titles "Lic.Ac." or "L.Ac." and shall not use the terms "physician" or "doctor" in his name or practice unless he simultaneously uses a clarifying title, initials, abbreviation or designation or language.

18VAC85-110-120. [Repealed]

18VAC85-110-130. [Repealed]

18VAC85-110-140. Sterilization practices and infection control.

Acupuncture needles shall be presterilized, prewrapped, disposable needles, for the prevention of infection, to protect the health, safety, and welfare of the patient. Such needles shall be discarded after each patient treatment.

18VAC85-110-145. Registration for voluntary practice by out-of-state licensees.

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

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

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

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

~~4. Pay a registration fee of $10~~; and

~~5.~~4. Provide a notarized statement from a representative of the nonprofit organization attesting to its compliance with provisions of subdivision 27 of §54.1-2901 of the Code of Virginia.

Part IV. Renewal and Reinstatement of Licensure.

18VAC85-110-150. Biennial renewal of licensure.

A. A licensed acupuncturist shall renew his license biennially during his birth month in each odd-numbered year by:

1. Paying to the board the renewal fee as prescribed in subdivision 2 of 18VAC85-110-35; and

2. Attesting to having current, active certification by the NCCAOM.

B. A licensed acupuncturist whose license has not been renewed by the first day of the month following the month in which renewal is required shall not be licensed in Virginia.

C. An additional fee to cover administrative costs for processing a late application renewal shall be imposed by the board as prescribed by subdivision 3 of 18VAC85-110-35.

18VAC85-110-155. Inactive licensure.

A. A licensed acupuncturist 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.

1. The holder of an inactive license shall not be required to maintain current, active certification by the NCCAOM.

2. An inactive licensee shall not be entitled to perform any act requiring a license to practice acupuncture in Virginia.

B. An inactive licensee may reactivate his license by:

1. Submission of the required application;

2. Payment of the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure for the biennium in which the license is being reactivated; and

3. Submission of documentation of having maintained current certification or having been recertified by the NCCAOM.

C. The board reserves the right to deny a request for reactivation 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.

18VAC85-110-160. Reinstatement.

A. A licensed acupuncturist who allows his license to lapse for a period of two years or more and chooses to resume his practice shall submit to the board a reinstatement application, information on practice and licensure in other jurisdictions for the period in which the license was lapsed in Virginia, proof of current, active certification by the NCCAOM, and the fee for reinstatement of his license as prescribed in subdivision 4 of 18VAC85-110-35.

B. A licensed acupuncturist whose license has been revoked by the board and who wishes to be reinstated must make a new application to the board, hold current, active certification by the NCCAOM, and pay the fee for reinstatement of his license as prescribed in subdivision 6 of 18VAC85-110-35.

18VAC85-110-161. Restricted volunteer license.

A. A licensed acupuncturist who held an unrestricted license issued by the Virginia Board of Medicine or by a board in another state as a licensee in good standing at the time the license expired or became inactive may be issued a restricted volunteer license to practice without compensation in a clinic that is organized in whole or in part for the delivery of health care services without charge in accordance with §54.1-106 of the Code of Virginia.

B. To be issued a restricted volunteer license, a licensed acupuncturist shall submit an application to the board that documents compliance with requirements of §54.1-2928.1 of the Code of Virginia and the application fee prescribed in 18VAC85-110-35.

C. The licensee who intends to continue practicing with a restricted volunteer license shall renew biennially during his birth month, meet the continued competency requirements prescribed in subsection D of this section, and pay to the board the renewal fee prescribed in 18VAC85-110-35.

D. The holder of a restricted volunteer license shall not be required to attest to hours of continuing education for the first renewal of such a license. For each renewal thereafter, the licensee shall attest to obtaining 20 hours of continuing education acceptable to the NCCAOM, obtained within the last biennium.

18VAC85-110-170. [Repealed]

Part VI. Standards of Professional Conduct.

18VAC85-110-175. 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.

18VAC85-110-176. Patient records.

A. Practitioners shall comply with provisions of § 32.1-127.1:03 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 patient records and shall maintain timely, accurate, legible and complete patient records.

D. Practitioners shall maintain a patient record in accordance with policies and procedures of the employing entity. In the even the practitioner is a sole proprietor, the practitioner shall develop policies for maintenance of patient records and adhere to those policies. ~~for a minimum of six years following the last patient encounter with the following exceptions:~~

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

~~2. Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative; or~~
~~3. Records that are required by contractual obligation or federal law may need to be maintained for a longer period of time.~~

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

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

18VAC85-110-177. Practitioner-patient communication; 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 inform a patient or his legally authorized representative of his professional assessment and prescribed treatment or plan of care in understandable terms to the patient. 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 prescribed or directed by the practitioner in the treatment of any disease or condition.

2. ~~A practitioner shall present information to a patient or his legally authorized representative in understandable terms and encourage participation in the decisions regarding the patient's care.~~

~~3.~~ Before any acupuncture treatment or procedure is performed, informed consent shall be obtained from the patient. Practitioners shall inform patients of the risks, benefits, and alternatives of the recommended treatment that a reasonably prudent licensed acupuncturist practicing in Virginia would tell a patient. 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. Termination of the practitioner/patient relationship.

1. The practitioner or the patient may terminate the relationship. In either case, the practitioner shall make a copy of 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.

18VAC85-110-178. Practitioner responsibility.

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 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 A 2 of this section.

~~18VAC85-110-179. Advertising ethics.~~

~~A. Any statement specifying a fee, whether standard, discounted or free, for professional services which does not include the cost of all related procedures, services and products which, to a substantial likelihood, will be necessary for the completion of the advertised service as it would be understood by an ordinarily prudent person shall be deemed to be deceptive or misleading, or both. Where reasonable disclosure of all relevant variables and considerations is made, a statement of a range of prices for specifically described services shall not be deemed to be deceptive or misleading.~~

~~B. Advertising a discounted or free service, examination, or treatment and charging for any additional service, examination, or treatment which is performed as a result of and within 72 hours of the initial office visit in response to such advertisement is unprofessional conduct unless such professional services rendered are as a result of a bonafide emergency. This provision may not be waived by agreement of the patient and the practitioner.~~

~~C. Advertisements of discounts shall disclose the full fee that has been discounted. The practitioner shall maintain documented evidence to substantiate the discounted fees and shall make such information available to a consumer upon request.~~

~~D. A licensee shall disclose the complete name of the specialty board which conferred the certification when using or authorizing the use of the term "board certified" or any similar words or phrase calculated to convey the same meaning in any advertising for his practice.~~

~~E. A licensee of the board shall not advertise information which is false, misleading, or deceptive. For an advertisement for a single practitioner, it shall be presumed that the practitioner is responsible and accountable for the validity and truthfulness of its content. For an advertisement for a practice in which there is more than one practitioner, the name of the practitioner or practitioners responsible and accountable for the content of the advertisement shall be documented and maintained by the practice for at least two years.~~

18VAC85-110-180. Dietary supplements.

A. The recommendation or direction for the use of dietary supplements and the rationale for that recommendation shall be documented by the practitioner. The recommendation or direction shall be based upon a reasonable expectation that such use will result in a favorable patient outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use.

B. Dietary supplements, used singly or in combination, shall not be sold, dispensed, recommended, prescribed, or suggested in doses that would be contraindicated based on the individual patient's overall medical condition and medications.

C. The practitioner shall conform to the standards of his particular branch of the healing arts in the therapeutic application of dietary supplement therapy.

~~18VAC85-110-181. Solicitation or remuneration in exchange for referral.~~

~~A practitioner shall not knowingly and willfully solicit or receive any remuneration, directly or indirectly, in return for referring an individual to a facility or institution as defined in §37.2-100 of the Code of Virginia, or hospital as defined in §32.1-123 of the Code of Virginia. Remuneration shall be defined as compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by Title 42, §1320a-7b(b) of the United States Code, as amended, or any regulations promulgated thereto.~~

18VAC85-110-182. 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 which:

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.

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 shall mean: 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.

18VAC85-110-183. 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 Items: Issue periodic review decision and adoption of fast-track regulatory changes recommended by the advisory board

Included in your agenda package are:

- Notice of periodic review
- Public comment received
- Recommended revisions to Chapter 120

Staff Note: Advisory board recommended to retain Chapter 120 with amendments.

Action needed:

- Motion to retain Chapter 120 with amendments;
- Motion to adopt changes recommended by advisory board as fast-track regulatory changes.

Virginia.gov Agencies | Governor

Agency	Department of Health Professions
Board	Board of Medicine
Chapter	Regulations Governing the Licensure of Athletic Trainers [18 VAC 85 - 120]

Edit Review

Review 2153

Periodic Review of this Chapter

Includes a Small Business Impact Review

Date Filed: 6/16/2022

Review Announcement

Pursuant to Executive Order 14 (as amended July 16, 2018) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, this regulation is undergoing a periodic review.

The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018). http://TownHall.Virginia.Gov/EO-14.pdf.

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

In order for you to receive a response to your comment, your contact information (preferably an email address or, alternatively, a U.S. mailing address) must accompany your comment. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

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

Publication Information and Public Comment Period

Published in the Virginia Register on 7/18/2022 [Volume: 38 Issue: 24]

Comment Period begins on the publication date and ends on 8/17/2022

Comments Received: 0

Review Result

Pending

Attorney General Certification

Pending

This periodic review was created by Erin Barrett on 06/16/2022 at 12:26pm

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

Periodic Review Chapter 120 - Athletic Trainers

2 messages

Virginia Athletic Trainers' Association President <vatapresident@gmail.com> Wed, Jul 20, 2022 at 5:50 PM
To: William Harp <william.harp@dhp.virginia.gov>, Erin Barrett <erin.barrett@dhp.virginia.gov>

Good Afternoon!

I have the following items to submit for the periodic review of Chapter 120 - Athletic Trainers.

1. Change NATABOC to Board of Certification, Inc. (BOC) throughout the document. The BOC is now a separate entity as a credentialing agency.

2. Change the term "Student Athletic Trainer" to " Athletic Training Student". This is the accepted terminology put forth by the National Athletic Trainers' Association.

Thank you,

Danny

Daniel Carroll, MEd, LAT, ATC
President, Virginia Athletic Trainers' Association
Athletic Trainer, Mountain View High School
150 Stonewall Ln
Quicksburg, VA 22847

Harp, William <william.harp@dhp.virginia.gov> Thu, Jul 21, 2022 at 7:14 AM
To: Virginia Athletic Trainers' Association President <vatapresident@gmail.com>
Cc: Erin Barrett <erin.barrett@dhp.virginia.gov>

Thank you, Mr. Carroll. WLH
[Quoted text hidden]

Commonwealth of Virginia

REGULATIONS

GOVERNING THE LICENSURE OF ATHLETIC TRAINERS

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-120-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Revised date: March 5, 2020

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

(804) 367-4600 (TEL)
(804) 527-4426 (FAX)
email: medbd@dhp.virginia.gov

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Part I. General Provisions.

18VAC85-120-10. Definitions.

In addition to words and terms defined in §54.1-2900 of the Code of Virginia, the following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

~~"Advisory board" means the Advisory Board on Athletic Training to the board as specified in §54.1-2957.5 of the Code of Virginia.~~

"Athletic trainer" means a person licensed by the Virginia Board of Medicine to engage in the practice of athletic training as defined in §54.1-2900 of the Code of Virginia.

"Board" means the Virginia Board of Medicine.

"Direction" means authorization by a doctor of medicine, osteopathy, chiropractic, podiatry, or dentistry for care and treatment by a verbal order if the doctor or dentist is present or by written order, telecommunication, plans of care, protocols, or standing orders if the doctor or dentist is not present.

"NATABOC" means the National Athletic Trainers' Association Board of Certification.

"Student athletic trainer" means a person enrolled in an accredited bachelor's or master's level educational program in athletic training.

~~**18VAC85-120-20. Public participation.**~~

~~A separate board regulation, 18VAC85-11, entitled Public Participation Guidelines, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.~~

18VAC85-120-30. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by these regulations to be given by the board to any such licensee shall be validly given when sent to the latest address of record given to the board. Any change of name or address of record or the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-120-35. Fees.

A. Unless otherwise provided, fees listed in this section shall not be refundable.

B. The following fees have been adopted by the board:

1. The application fee shall be $130.

2. The fee for renewal of licensure shall be $135 and shall be due in the licensee's birth month, in each odd-numbered year.

3. A fee of $50 for processing a late renewal within one renewal cycle shall be paid in addition to the renewal fee.

4. The fee for reinstatement of a license that has expired for two or more years shall be $180 and shall be submitted with an application for reinstatement.

5. The fee for reinstatement of a license pursuant to §54.1-2408.2 of the Code of Virginia shall be $2,000.

6. The fee for a duplicate renewal license shall be $5, and the fee for a duplicate wall certificate shall be $15.

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

8. The fee for a letter of verification to another jurisdiction shall be $10.

9. The fee for an inactive license shall be $70, and the fee for a late renewal shall be $25.

~~10. For 2021, the fee for renewal of an active license shall be $108, and the fee for renewal of an inactive license shall be $54.~~

Part II. Requirements for Licensure as an athletic trainer.

~~**18VAC85-120-40. General requirements.**~~

~~No person shall practice or hold himself out as practicing as an athletic trainer in the Commonwealth unless licensed by the board except as provided in §54.1-2957.6 of the Code of Virginia.~~

18VAC85-120-50. Requirements for licensure.

An applicant for licensure shall submit evidence of meeting the following requirements for licensure on forms provided by the board:
1. A completed application and fee as prescribed in 18VAC85-130-150;

2. Verification of professional activity as required on the application form;

3. Evidence of current NATABOC certification; and

4. If licensed or certified in any other jurisdiction, documentation of practice as an athletic trainer and verification as to whether there has been any disciplinary action taken or pending in that jurisdiction.

18VAC85-120-60. (Repealed)

18VAC85-120-70. (Repealed)

18VAC85-120-75. Temporary authorization to practice.

Upon written request from an applicant and his employer and for good cause shown, an applicant who provides documentation of current NATABOC certification ~~and, if licensed or certified by another jurisdiction in the United States, documentation that his license or certificate is current and unrestricted,~~ may be granted temporary authorization to practice as an athletic trainer for 45 days pending submission of all other required documentation and issuance of a license. At the discretion of the board, additional time, not to exceed 15 days, may be allowed to complete the application process.

18VAC85-120-80. Provisional licensure.

A. An applicant who has been approved by NATABOC to sit for the certification examination may be granted a provisional license to practice athletic training under the supervision ~~and control~~ of an athletic trainer.

B. The graduate shall submit an application for a provisional license to the board for review and approval by the Chair of the Advisory Board on Athletic Training or his designee.

C. The provisional license shall expire six months from issuance or upon receipt of notification of a failing score on the NATABOC certification examination or upon licensure as an athletic trainer by the board, whichever comes first.

18VAC85-120-85. Registration for voluntary practice by out-of-state athletic trainers.

Any athletic trainer who does not hold a license to practice in Virginia and who seeks registration to practice on a voluntary basis under the auspices of a publicly supported, all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people shall:

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

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

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

4. ~~Pay a registration fee of $10; and~~

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

Part III. Renewal and Reinstatement.

18VAC85-120-90. Renewal of license.

A. Every athletic trainer intending to continue licensure shall biennially in each odd-numbered year in his birth month:

1. Register with the board for renewal of licensure;

2. Pay the prescribed renewal fee at the time he files for renewal; and

3. Attest to current NATABOC certification.

B. An athletic trainer whose license has not been renewed by the first day of the month following the month in which renewal is required shall pay a late fee as prescribed in 18VAC85-120-150.

18VAC85-120-95. Inactive licensure.

A. An athletic trainer 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.

1. The holder of an inactive license shall not be required to maintain NATABOC certification.

2. An inactive licensee shall not be entitled to practice as an athletic trainer in Virginia.

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

1. The required application;

2. Payment of the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure for the biennium in which the license is being reactivated; and

3. Documentation of having maintained certification or having been recertified by the NATABOC.

C. The board reserves the right to deny a request for reactivation 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.

18VAC85-120-100. Reinstatement.

A. In order to reinstate a license that has been lapsed for more than two years, an athletic trainer shall file an application for reinstatement, pay the fee for reinstatement of his license as prescribed in 18VAC85-120-150, and submit to the board evidence of current certification by NATABOC.

B. An athletic trainer whose license has been revoked by the board and who wishes to be reinstated shall file a new application to the board and pay the fee for reinstatement of his license as prescribed in 18VAC85-120-150 pursuant to §54.1-2408.2 of the Code of Virginia.

Part IV. Standards of Practice.

18VAC85-120-110. Individual responsibilities.

A. The athletic trainer's responsibilities are to evaluate the individual being treated, plan the treatment program, and administer and document treatment within the limit of his professional knowledge, judgment, and skills and in accordance with the practice of athletic training as set forth in § 54.1-2900 of the Code of Virginia.

B. An athletic trainer practices under the direction of the individual's physician or under the direction of any doctor of medicine, osteopathy, chiropractic, podiatry, or dentistry.

18VAC85-120-120. General responsibilities.

~~A. An athletic trainer shall be responsible for the actions of persons engaging in the practice of athletic training under his supervision and direction.~~

~~B.~~ An athletic trainer shall ensure that unlicensed persons under his supervision shall not perform those functions that require professional judgment or discretion in the practice of athletic training. An athletic trainer shall be responsible for the actions of persons acting under his supervision and direction.

18VAC85-120-130. Supervisory responsibilities.

A. The athletic trainer supervising the practice of persons holding a provisional license issued by the board shall develop a written protocol with the provisional licensee to include but not be limited to the following:

1. Provisions for daily, on-site review and evaluation of services being provided, including a review of outcomes for individuals being treated; and

2. Guidelines for availability and ongoing communications proportionate to such factors as practice setting, acuity of population being served, and experience of the provisional licensee.

B. The athletic trainer supervising the practice of student athletic trainers shall:

1. Provide daily, on-site supervision and shall plan, direct, advise and evaluate the performance and experience of the student athletic trainer.

2. Delegate only nondiscretionary tasks that are appropriate to the level of competency and experience of the student athletic trainer, practice setting and acuity of population being served.

~~**18VAC85-120-140. Violations.**~~

~~Violations of Chapter 29 (§54.1-2900 et seq.) of Title 54.1 of the Code of Virginia may subject a licensee to sanctions as set forth in §54.1-2915 of the Code of Virginia.~~

Part V. Fees .

18VAC85-120-150. (Repealed)

Part VI. Standards of Professional Conduct.

18VAC85-120-155. 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.

18VAC85-120-156. Patient records.

A. Practitioners shall comply with provisions of § 32.1-127.1:03 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 patient records and keep timely, accurate, legible and complete patient records.

~~D.~~C. Practitioners who are employed by a health care institution, school system 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.~~D. Practitioners who are self-employed or employed by an entity in which the individual practitioner does own and is responsible for patient records shall~~:~~ develop policies regarding retention of records and adhere to those policies.

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

~~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.~~

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

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

18VAC85-120-157. Practitioner-patient communication.

A. 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.

B. A practitioner shall not deliberately 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.

C. 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.

18VAC85-120-158. 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 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 A 3 of this section.

18VAC85-120-159. Vitamins, minerals and food supplements.

A. The recommendation or direction for the use of vitamins, minerals or food supplements and the rationale for that recommendation shall be documented by the practitioner. The recommendation or direction shall be based upon a reasonable expectation that such use will result in a favorable patient outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use.

B. Vitamins, minerals, or food supplements, or a combination of the three, shall not be sold, dispensed, recommended, prescribed, or suggested in doses that would be contraindicated based on the individual patient's overall medical condition and medications.

C. The practitioner shall conform to the standards of his particular branch of the healing arts in the therapeutic application of vitamins, minerals or food supplement therapy.

18VAC85-120-160 Anabolic steroids.

An athletic trainer shall not sell, dispense, or administer anabolic steroids to any patient.

18VAC85-120-161. 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 which:

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.

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 shall mean: spouse or partner, parent or child, guardian, or legal representative of the patient.

D. 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.

18VAC85-120-162. 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 Items: Issue periodic review decision and adoption of fast-track regulatory changes

Included in your agenda package are:

- Notice of periodic review
- Public comment received
- Recommended revisions to Chapter 130

Staff Notes: Advisory board did not have a quorum, but reviewed and supported the included amendments.

All 179 comments received on Regulatory Town Hall in response to this periodic review requested that midwives be permitted to carry and administer medications, many of which incorrectly stated the scope of practice is determined by Board regulations. Virginia Code § 54.1-2957.9 specifically prohibits licensed professional midwives from having prescriptive authority and the possession and administration of controlled substances, which in Virginia includes Schedule VI medications. The Board has no jurisdiction to change the Code. Statutory changes are made by the General Assembly and therefore the public comments cannot be addressed in the periodic review of the regulations governing licensed professional midwives.

Action needed:

- Motion to retain Chapter 130 with amendments;
- Motion to adopt changes to Chapter 130 as fast-track regulatory changes.

Agency	Department of Health Professions
Board	Board of Medicine
Chapter	Regulations Governing the Practice of Licensed Midwives [18 VAC 85 - 130]

Edit Review

Review 2154

Periodic Review of this Chapter

Includes a Small Business Impact Review

Date Filed: 6/16/2022

Review Announcement

Pursuant to Executive Order 14 (as amended July 16, 2018) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, this regulation is undergoing a periodic review.

The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018). http://TownHall.Virginia.Gov/EO-14.pdf.

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

In order for you to receive a response to your comment, your contact information (preferably an email address or, alternatively, a U.S. mailing address) must accompany your comment. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

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

Publication Information and Public Comment Period

Published in the Virginia Register on 7/18/2022 [Volume: 38 Issue: 24]

Comment Period begins on the publication date and ends on 8/17/2022

Comments Received: 179

Review Result

Pending

Attorney General Certification

Pending

This periodic review was created by Erin Barrett on 06/16/2022 at 12:27pm

Export to PDF Export to Excel

Agency **Department of Health Professions**

Board **Board of Medicine**

Chapter **Regulations Governing the Practice of Licensed Midwives [18 VAC 85 - 130]**

179 comments

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

Back to List of Comments

Commenter: Doran Richards, CPM, Grace Midwifery 7/18/22 10:12 am

REVIEW of regulations for CPM's

Written by someone else mostly, but I found it to be "right on" and state it here as my comments:

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often needed or requested during antepartum period, at the time of birth, or postpartum. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of mothers and babies. Unnecessary exposure of infants to the public, and further overburdening of our healthcare systems, means that this inconsistency negatively affects the entire community. However, if the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility.

Prioritizing public safety means allowing trained health professionals to use all of their resources and skills. Strong, self reliant communities are built on skilled individuals like our midwives. To reiterate, our LMs are already trained and certified to administer these medications; only the law prevents their acting on it. Please remove the barrier to a "community standard of care" that we want to be held by. Allow midwives to administer, posses all the tools(medications) they need to offer safe, quality care for women and families in our state of Virignia.

Thank you,
Doran Richards
CommentID: **122700**

Commenter: Briana Watts 7/18/22 11:10 am

License midwives for meds

As a two time client of CPM midwives I must insist you correct the discrepancy in this regulation that prevents Virginia's Licensed Midwives from using the skills for which they are trained. I needed rhogam after my first birth and it was incredibly difficult with how much jumping through hoops I had to do to get this standard medicine for A-negative blood type moms. Not because my care providers aren't trained to, just that the regulation fails to reflect that.

The medicines that midwives are trained to carry prevent emergencies. Subjecting women and care providers to stress and uncertainty surrounding such important resources is senseless. Some of the medicines are even required by the state to be offered. Why overburden our healthcare system with moms and infants who could easily get that care at home?

Virginia should be reaping the full benefits of our licensed midwives.

CommentID: **122706**

Commenter: Mance Miller 7/18/22 11:30 am

Allow midwives to practice to their full ability

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

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CommentID: **122709**

Commenter: Corey Watts 7/18/22 11:36 am

Virginia Midwives

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CommentID: **122711**

Commenter: Sylvia Boudali, CNM 7/18/22 2:07 pm

CPM/LM access to needed medications

I personally agree with the message included below. As a community midwife with the license (Certified Nurse Midwife) to prescribe and administer these medicines, it is evident to me how integral this ability is for the safety and comfort of all families choosing out of hospital birth.

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often needed or requested during antepartum period, at the time of birth, or postpartum. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

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we want to be held by. Allow midwives to administer, posses all the tools(medications) they need to offer safe, quality care for women and families in our state of Virginia.
CommentID: **122725**

Commenter: Rachel Adams 7/18/22 2:39 pm

Midwives To Be Allowed Medication

I am a Birth Doula and I support Certified Professional Midwife/Licensed Midwife. I wanted to make the analysts and reviewers aware of an inconsistency in the regulations that impacts midwifery practice and public health. State law requires that a newborn be administered certain drugs within 24 hours of birth but the midwifery laws prevent us/them from carrying or administering these drugs. Furthermore, there are low risk procedures occasionally required during or after a birth that requires the administration of certain medications that the current law prohibits us/them from carrying and administering. Midwives are trained and competent to administer these drugs but current law is preventing them form administering these drugs creating an unnecessary burden for clients.

Home Birth is safe and our community needs our midwives to have all tools possible to care for low-risk birthers.

CommentID: **122726**

Commenter: Anonymous 7/18/22 7:56 pm

Certified Midwives should have all of their privileges

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

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Prioritizing public safety means allowing trained health professionals to use all of their resources and skills. The demand for midwifery care will increase as uncertainty rises. Strong, self reliant communities are built on skilled individuals like our midwives. To reiterate, our LMs are already trained and certified to administer these medications; only the law prevents their acting on it.

CommentID: **122747**

Commenter: DD 7/18/22 9:22 pm

Allow us the ability to practice our full scope

We should be allowed to utilize the medications recommended by the World Health Organization. Please let us practice to the full extent of our scope. This makes homebirth which already has amazing outcomes, even safer.

CommentID: **122751**

Commenter: Sara Dunn 7/18/22 9:44 pm

License CPMs to carry and administer certain medications

I am a student midwife who seeks to serve on the Northern Neck, an area that currently has no hospital that will deliver babies and very limited access to prenatal or postpartum care. Families on the Neck deserve safe birth options. Continuing to restrict CPMs from practicing the full scope of our training forces these families to birth in a low resource setting. Situations that may arise and be easily managed with certain medications become inconvenient or even dangerous because of these restrictions. Families must endanger newly delivered mothers and their brand new babies by venturing out to a clinic or hospital for medications, such as Rhogam or vitamin K, when they should be at home recovering from pregnancy and birth. Ambulances must be called in to transport birthing parents to a hospital just to administer antihemorrhagics. Travel time is blood lost in these situations and that increases the risk of morbidity and mortality when pitocin or misoprostol could have remedied the situation. Giving CPMs the ability to carry medications will ensure safer births for many families who choose home births for religious reasons, inability to travel long distances while in labor, or personal choice.

CommentID: **122752**

Commenter: Anonymous 7/19/22 8:22 am

Midwifery in Virginia

I am a birth doula, lactation consultant and a breech home birth after cesarean (all a variation of normal and not a high risk emergency) mom myself. It is imperative that midwives be allowed to use the full scope of practice that they are trained including administration of medications. Birth is inherently safe and therefore home birth is inherently safe. CPMs are fully trained in normal physiological birth but they are also fully trained and capable of handling an emergency if it we're to arise much more so than most of the EMS department that would respond in an emergency situation. The health of our community and the health of moms and babies depends on CPMs being able to use all of their skills often times saving lives. It's completely unethical to tie their hands behind their back and disallow them to use skills that they are fully trained in.

CommentID: **122760**

Commenter: Amy Rollogas, RN and CNM student 7/19/22 9:55 am

Practicing to the full extent of training

I am a registered nurse in L&D. I have been doing birth work for 15 years and I have ever understood the absurdity in the regulations on midwifery practice and public health in this state. State law requires that a newborn be administered certain drugs within 24 hours of birth but midwifery laws prevent midwives from carrying or administering these drugs. This is a public health issue. These meds are simple to administer and have a nonexistent potential for abuse. Not

having the legal ability to administer these med puts the burden on the new family to take their baby out in public before most are ready for this.

There are other low risk procedures occasionally required during or after a birth that require the administration of certain (sometimes life saving) medications that the current law prohibits midwives from carrying and administering. Midwives are trained and competent to administer these drugs but current law is preventing them from administering them. A hospital trip for a postpartum perineal repair that could have been done at home in a few minutes is just absurd!

Since midwifery is legal, let's also let it be as safe as possible for Virginians who choose this route for bringing their children to the world!

For more information please feel free to contact the Virginia Midwives' Alliance at info@virginiamidwives.org or by visiting our website at www.virginiamidwives.org.

CommentID: **122765**

Commenter: Savannah Fassero, CPM, Heart of Lynchburg Midwifery 7/19/22 11:08 am

Allowing Full Scope of Practice

I am a Certified Professional Midwife here in Virginia and want to alert the analysts and reviewers of an inconsistency in our regulations that impacts public health. State law requires newborns to be administered certain drugs within 24 hours of birth but current laws prevent us from carrying or administering these drugs. Additionally, optimal midwifery care occasionally requires the administration of certain low-risk medications during or after birth that current legislation prohibits us from carrying and administering. We are trained to administer these drugs but are prevented from doing so, creating an unnecessary burden for our clients and the maternity care system in Virginia as they struggle to find these resources elsewhere. For more information please feel free to contact the Virginia Midwives' Alliance at info@virginiamidwives.org or by visiting our website at www.virginiamidwives.org.

CommentID: **122769**

Commenter: MaryMay Short, BSN, RN 7/19/22 11:19 am

Moms' access and health comes first.

Allowing midwives to be licensed to perform a skill they are already are trained for, improves healthcare for all of Virginia. Virginians deserve the health freedom bestowed on them by God. As a nurse, I support safe standards of care for each citizen this includes providing licensure to trained & qualified midwives to provide any skill improving the health of the mother & child which they are appropriately trained to do.

CommentID: **122771**

Commenter: LeaAnna H Miller, CPM, LM 7/19/22 11:41 am

Midwives allowed full scope of practice

I am a Certified Professional Midwife and wanted to make the analysts and reviewers aware of an inconsistency in our regulations that impacts midwifery practice and public health. State law requires that a newborn be administered certain drugs within 24 hours of birth but the midwifery laws prevent us from carrying or administering these drugs. Furthermore, there are low risk procedures occasionally required during or after a birth that requires the administration of certain

medications that the current law prohibits us from carrying and administering. We are trained and competent to administer these drugs but current law is preventing us form administering these drugs creating an unnecessary burden for our clients. For more information please feel free to contact the Virginia Midwives' Alliance at info@... or by visiting our website at www.virginiamidwives.org.

Our goal is for all women and babies in our care to be safe and healthy and and the current legislation limits our ability to ensure that .

CommentID: **122773**

Commenter: Meredith Nelson 7/19/22 3:35 pm

Nothing to Lose!

Thank you for reviewing the licensing and regulation of certified professional midwives! I have given birth at home twice myself, and am also a doula who has attended births at home, in birth centers, and in twenty different hospitals across the country. With this broad experience I can attest that home birth with CPMs is a safe option, validated by many studies and reviews to-date.

I've worked in Virginia for seven years, but previously worked in California and Utah where CPM midwives can carry and administer standard medications such as anti-hemorrhagic drugs, IV saline, and oxygen. Birth emergencies are extremely rare for women who are healthy when they go into labor, but when an emergency such as hemorrhage occurs, there are mere minutes to treat it for optimal outcomes. CPMs have many non-pharmaceutical tools to prevent and manage hemorrhage, and some studies have shown hemorrhage rates to be lower at home than in hospital due to the lower rates of interventions such as epidural anesthesia and induction/augmentation with Pitocin. But when serious hemorrhage occurs, the Virginia laws currently in the books could cost a woman her life -- when a CPM could have saved it with the right tools (that she is already trained to administer).

Aside from emergencies, it should not be necessary for a woman to transfer mid-birth for dehydration (which IV fluids could easily solve at home) or for antibiotics should she wish to receive them for Group B Strep infection. Similarly, if she wishes to accept Vitamin K or erythromycin ointment for her baby, she should be able to receive them shortly after birth within the standard timeframe, and without having to leave her home. ANY disruption during the first few hours/days after birth can impact breastfeeding, bonding, infant health, and maternal mental health longterm --- hospital transfer is not only disruptive but potentially traumatic. Having these medications available to her chosen home care provider allows the mother-baby dyad to be as undisturbed during birth and postpartum as possible.

There is nothing to lose in expanding the legal scope of Virginia midwifes to match their professional scope and training.

CommentID: **122784**

Commenter: Anne V Monson LM CPM 7/19/22 3:42 pm

Regulations governing the practice of Licensed Midwife

: I am a Certified Professional Midwife and wanted to make the analysts and reviewers aware of an inconsistency in our regulations that impacts midwifery practice and public health. State law requires that a newborn be administered certain drugs within 24 hours of birth but the midwifery laws prevent us from carrying or administering these drugs. Furthermore, there are low risk

procedures occasionally required during or after a birth that requires the administration of certain medications that the current law prohibits us from carrying and administering. We are trained and competent to administer these drugs but current law is preventing us form administering these drugs creating an unnecessary burden for our clients. For more information please feel free to contact the Virginia Midwives' Alliance at info@... or by visiting our website at www.virginiamidwives.org.

CommentID: **122785**

Commenter: Kelly Jenkins 7/19/22 4:08 pm

Regulations Governing the Practice of Licensed Midwives

As a medical provider (CPM), licensed in the state of Virginia, due to the law, I am unable to carry or administer life saving medications including antihemorrhagics, that I am trained to use in community birth (out of hospital birth). This is an inconsistency in our regulations that impacts midwifery care and public health. Move us forward Virginia!

CommentID: **122786**

Commenter: Michael Vernon Voss, Congressional Affairs Lead 7/19/22 6:23 pm

CPM/LM access to needed medications

As the husband of a longtime Doula and aspiring midwife, I personally agree with the message included below, please allow these professionals the tools they need to provide the great care these families deserve.

As a community midwife with the license (Certified Nurse Midwife) to prescribe and administer these medicines, it is evident to me how integral this ability is for the safety and comfort of all families choosing out of hospital birth.

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often needed or requested during antepartum period, at the time of birth, or postpartum. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of mothers and babies. Unnecessary exposure of infants to the public, and further overburdening of our healthcare systems, means that this inconsistency negatively affects the entire community. However, if the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility.

Prioritizing public safety means allowing trained health professionals to use all of their resources and skills. Strong, self reliant communities are built on skilled individuals like our midwives. To reiterate, our CPMs/LMs are already trained and certified to administer these medications; only the law prevents their acting on it. Please remove the barrier to a "community standard of care" that

we want to be held by. Allow midwives to administer, posses all the tools(medications) they need to offer safe, quality care for women and families in our state of Virginia.
CommentID: **122790**

Commenter: Maggie Grevas 7/20/22 2:50 pm

Allow Certified Professional Midwives to Carry and Administer Maternity and Newborn Medicines

I am a birth doula, birth assistant to a CPM, and an aspiring midwife. I have experienced and witnesses many births attended by amazing CPMs and how they are changing the health and well-being of mothers and their families. Please consider the below comment and change the regulation to allow these trained professionals to fully practice in the scope they are trained for. This is especially helpful when many of the mothers we serve are at least an hour drive from the nearest hospital with a labor and delivery unit. I have witnessed a hospital transfer that would have otherwise been unnecessary if the midwife would have been permitted to administer the medications the mother needed in the moment. Due to the transfer, the mother and father needed to worry about what would happen with their baby, the EMS staff was rude to everyone, and their peaceful birth was interrupted with a 30-minute ambulance ride, delaying being with their new family.

The medications these midwives are trained and nationally certified to use includes:

Allowing to administer:

-antihemorrhagics

-local anesthetic

-newborn eye ointment

-rhogam

-IV fluids and antibiotics

-oxygen

-Vitamin K

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communities are built on skilled individuals like our midwives. To reiterate, our LMs are already trained and certified to administer these medications, only the law prevents their acting on it.

CommentID: **122816**

Commenter: Naomi Voss 7/20/22 6:42 pm

Please us the ability to practice our full scope

I personally agree with the message included below; please allow us the tools they need to provide the great care these families deserve.

The medications these midwives are trained and nationally certified to use includes:

Allowing to administer:

-Vitamin K

-antihemorrhagics in case of excessive bleeding

-IV fluids

-local anesthetic for perineal repair

-newborn eye ointment

-Rhogam for our Rh-positive birthing families

-oxygen- for neonatal resuscitation

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CommentID: **122827**

Commenter: Katrina Nakao, Pathways Midwifery 7/20/22 8:38 pm

Allow CPMs to carry medicines

I am a Certified Professional Midwife in Maryland and wanted to make the analysts and reviewers aware of an inconsistency in the regulations that impacts midwifery practice and public health. State law requires that a newborn be administered certain drugs within 24 hours of birth but the midwifery laws prevent Virginia midwives from carrying or administering these drugs. Furthermore, there are low risk procedures occasionally required during or after a birth that require the administration of certain medications that the current law prohibits them from carrying and administering. This is unique to Virginia as other nearby states such as DC, Maryland, Delaware, and Pennsylvania allow midwives to carry these common-sense medications. VA CPMs are trained and competent to administer these drugs but current law is preventing them from administering them, creating an unnecessary burden for clients.

CommentID: **122828**

Commenter: Anonymous

7/20/22 9:09 pm

VA midwives Practice

Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of mothers and babies. Unnecessary exposure of infants to the public, and further overburdening of our healthcare systems, means that this inconsistency negatively affects the entire community. However, if the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility.

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CommentID: **122830**

Commenter: Lorri Carr, LM, CPM, LDM, LDEM - Highland Midwife

7/22/22 10:55 am

Maximum Scope = Maximum Public Safety

The statistics for midwifery care outcomes from Washington state clearly prove that the greater the legal scope of home birth midwives, the better the outcomes for the public, which has prompted WA to continue to expand the list of drugs and devices approved for midwives. Public health and safety is served best by empowering midwives to carry and use everything that may be needed at a birth, not by deliberately restricting the prompt use of anything that could improve care or save a life if needed. I am more than happy to discuss this in person with any legislator who genuinely desires an improvement in maternity care outcomes.

CommentID: **122866**

Commenter: Anonymous

7/22/22 1:17 pm

Va Midwifery

I personally agree with the message included below; please allow us the tools they need to provide the great care these families deserve.

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Allowing to administer:

-Vitamin K

-antihemorrhagics in case of excessive bleeding

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-local anesthetic for perineal repair

-newborn eye ointment

-Rhogam for our Rh-positive birthing families

-oxygen- for neonatal resuscitation

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Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that, at best inconvenience and at the worst endanger the wellbeing of mothers and babies. Unnecessary exposure of infants to the public and further overburdening of our healthcare systems, means that this inconsistency negatively affects the entire community. However, if the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well-stocked medical facility.

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CommentID: **122868**

Commenter: Anonymous 7/22/22 11:45 pm

Let's bring midwifery care up-to-date!

There are various reasons someone might choose to birth at home, one being a pandemic. Having a traumatic birth at a hospital might drive a mother to birth in a calmer setting for the health of both her and the child. These mothers should be able to get the best care possible. Certified nurse midwives should be able to access the medications required to care for the mothers without need to contact the local hospital. They have done the work required to hold their certifications so why hold this back?

CommentID: **122875**

Commenter: Dominique clothiaux 7/25/22 6:22 pm

Let's get out of the stone ages.

I am a Certified Professional Midwife and wanted to make the analysts and reviewers aware of an inconsistency in our regulations that impacts midwifery practice and public health. State law requires that

a newborn be administered certain drugs within 24 hours of birth but the midwifery laws prevent us from carrying or administering these drugs. Furthermore, there are low risk procedures occasionally required during or after a birth that requires the administration of certain medications that the current law prohibits us from carrying and administering. We are trained and competent to administer these drugs but current law is preventing us form administering these drugs creating an unnecessary burden for our clients. For more information please feel free to contact the Virginia Midwives' Alliance at info@virginiamidwives.org or by visiting our website at www.virginiamidwives.org.

CommentID: **122988**

Commenter: Anonymous 7/25/22 7:02 pm

Help keep mamas and babies safe

I am a home birth and birth center supporter and wanted to make the analysts and reviewers aware of an inconsistency in our regulations that impacts midwifery practice and public health. State law requires that a newborn be administered certain drugs within 24 hours of birth but the midwifery laws prevent us from carrying or administering these drugs. Furthermore, there are low risk procedures occasionally required during or after a birth that requires the administration of certain medications that the current law prohibits us from carrying and administering. We are trained and competent to administer these drugs but current law is preventing us from administering them, creating an unnecessary burden for our clients. For more information please feel free to contact the Virginia Midwives' Alliance at info@virginiamidwives.org or by visiting our website at www.virginiamidwives.org.

States across the country are making it so that homebirth and out of hospital midwives can carry and administer these important medications. Statistics prove that out of hospital birth is safe for healthy moms and healthy babies, while midwives are often scrutinized about having unsafe birthing practices that simply is not true. Nobody talks about the horrendous birth statistics in the hospitals throughout our state. As a family who has chosen homebirth, I think that it is absolutely ridiculous to allow out of hospital midwives to practice in our state but not give them the full rights of their training. Or to carry the essential tools that they need to keep women and babies safe.

CommentID: **123988**

Commenter: Anonymous 7/25/22 7:11 pm

Allow CPMs to administer meds needed for mom and baby.

I am a home birth and birth center support and wanted to make the analysts and reviewers aware of an inconsistency in our regulations that impacts midwifery practice and public health. State law requires that a newborn be administered certain drugs within 24 hours of birth but the midwifery laws prevent us from carrying or administering these drugs. Furthermore, there are low risk procedures occasionally required during or after a birth that requires the administration of certain medications that the current law prohibits us from carrying and administering. We are trained and competent to administer these drugs but current law is preventing us form administering these drugs creating an unnecessary burden for our clients. For more information please feel free to contact the Virginia Midwives' Alliance at info@virginiamidwives.org or by visiting our website at www.virginiamidwives.org.

States across the country are making it so that homebirth and out of hospital midwives can carry these important medication's and administer these important mini medication's. Statistics prove that out of hospital birth is safe for healthy moms and healthy babies while midwives are often scrutinized about having unsafe birthing practices that simply is not true. Nobody talks about the

horrendous Birth statistics in the hospitals throughout our state. As a family who has chosen homebirth I think that it is absolutely ridiculous to allow out of hospital midwives to practice in our state but not give them the full rights of their training. Or to carry the essential choose tools that they need to keep women and babies safe. Even though the demand of medication's administering of medication's for the low risk mom and baby are very very low.

CommentID: **123989**

Commenter: Antonia Harris 7/25/22 7:20 pm

regulations that impact midwifery

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CommentID: **123990**

Commenter: Anonymous 7/25/22 7:27 pm

Virginia Midwifery

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CommentID: **123993**

Commenter: Anonymous 7/25/22 8:10 pm

Allowing midwives to practice to their full scope

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CommentID: **123996**

Commenter: Anonymous 7/25/22 8:29 pm

Midwifery Care

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CommentID: **123997**

Commenter: Anonymous 7/25/22 9:05 pm

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CommentID: **124000**

Commenter: Anonymous 7/25/22 9:10 pm

In Support of Virginia Midwives

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CommentID: **124001**

Commenter: Julia Bray 7/26/22 1:06 pm

Policy information

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CommentID: **124040**

Commenter: Jesse Parsons 7/26/22 2:27 pm

Allow midwives to provide care they are certified for

I hope this order will be repealed or amended to allow midwives to carry and administer medications and drugs for mothers and babies. Their training and licensing allows it, and Virginia law reflecting that can only help give parents more options and alleviate strain on the hospital system.

CommentID: **124047**

Commenter: Anonymous 7/26/22 2:44 pm

Medications

My daughter insisted on using midwives & I know I would feel much better if they could legally have the medications that prevent emergencies for her & my new grandchildren!

CommentID: **124050**

Commenter: Anonymous 7/26/22 2:44 pm

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CommentID: **124049**

Commenter: Hannah Johnson 7/26/22 5:49 pm

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CommentID: **124061**

Commenter: Linnea Charisse Anderson 7/26/22 11:23 pm

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CommentID: **124079**

Commenter: Angela Hobbs 7/28/22 8:54 pm

Midwives

As a mother I deserve full access to all the benefits of midwife care. As a client of CPM midwives I must insist you correct the discrepancy in this regulation that prevents Virginia's Licensed Midwives from using the skills for which they are trained. Should a mother need rhogam, pitocen for hemorrhage, or her newborn need oxygen she should have full access, through the care team she has chosen. Midwives should be able to practice as they have been trained.

The medicines that midwives are trained to carry prevent emergencies. Subjecting women and care providers to stress and uncertainty surrounding such important resources is senseless. Some of the medicines are even required by the state to be offered. Why overburden our healthcare system with moms and infants who could easily get that care at home?

Virginia should be reaping the full benefits of our licensed midwives. So let's stop restricting them from the care they can so wonderfully give.

CommentID: **124134**

Commenter: Julie Brierre 7/28/22 9:37 pm

Allow midwives to carry essentials

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CommentID: **124135**

Commenter: Adelaide Myers, RN 7/29/22 7:04 pm

Best Practice Homebirth

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CommentID: **124182**

Commenter: M. D'vorah Honey CPM LM 7/29/22 8:12 pm

In favor of full scope

I stand for expanding the scope of practice for Certified Professional Midwives/Licensed Midwives to include the administration of medications they are trained in. The Virginia Board of Medicine recognizes the North American Registry of Midwives standards of certification which includes requirements for training and education in the use of these interventions.

The World Health Organization states: "All midwives should be educated to high standards *and enabled to practice to their full scope."* (emphasis added)

The WHO also states "It is now almost universally acknowledged that unless the traditional health practitioners (including traditional midwives) are properly recognized and articulated with the national health system, countries will never be able to achieve adequate health coverage for all their populations....The development of a policy favorable to traditional midwifery depends on the enlightened understanding of the nature of such care and the role and resources of its practitioners, many of whom possess a fund of wisdom, knowledge and experience that can only serve to improve the quality of care that countries provide for their populations."

According the the March of Dimes 47% of counties in Virginia are without full access to maternity care. Arming midwives with the tools they need would quickly reduce this number. Midwives as individuals are typically more willing and able to establish themselves in rural communities quickly.

The Virginia Rural Health Plan states "pregnant women living in rural communities face unprecedented barriers to accessing adequate maternity care, often leading to disparate birth outcomes." The VRHP also states "In order to begin to bridge the gaps between rural mothers,

their babies, and adequate care, growing and retaining the maternity care workforce in rural communities should be made a top priority by health policy makers..." Midwives are essential pieces in quickly and efficiently reaching healthcare deserts.

Denying the value of midwives who are able to practice to the full extent of their training is denying mothers across Virginia completely safe birth. Many of these women are hour(s) from a hospital but minutes from a midwife.

Lastly, I would like to acknowledge the skill, knowledge and effectiveness at which midwives in Virginia have already been practicing despite the limited scope. The expansion of scope would only serve to make birth even safer in the state of Virginia. The benefit to families, hospitals, Emergency Medical Personnel and communities across the state would be astronomical.

I ask that these statements be considered in the decision to honor the training CPMs receive and expand the scope of practice.

Sources: https://www.vdh.virginia.gov/content/uploads/sites/76/2022/01/Virginia-Rural-Health-Plan_8-Healthy-Moms.pdf

https://www.who.int/

www.marchofdimes.org

CommentID: **124183**

Commenter: Anonymous 7/30/22 8:47 am

Women need fully practicing midwives.

Allow midwives to practice within the full scope of their expertise. Women in VA deserve to have this option for childbirth support.

CommentID: **124187**

Commenter: Wendy Owens, CPM 7/30/22 6:22 pm

Midwives to carry basic life saving pharmaceuticals

I am a midwife in Tennessee and am also licensed in VA. As a CPM our scope of practice and training is underutilized in VA. We can not even carry an O2 tank or administer Vitamin K to infants under the current guidelines in VA. In most states we have the ability to carry life saving pharmaceuticals in case of postpartum hemorrhaging like Cytotec or Pitocin or administer an IV for shock or even dehydration in the first trimester.

Virginia women should be allowed to have complete care from their midwives unhindered by laws that keep them from doing so.

CommentID: **124205**

Commenter: Anonymous 7/30/22 10:17 pm

Midwives

Get updated with the times. Midwives are essential to the health of mom and baby. Why is America the only country that doesn't have midwives as the standard of care?

CommentID: **124211**

Commenter: Kate Heard, RN 7/31/22 7:38 am

Midwives can do it

As stated in numerous comments previously we have an opportunity to serve our community with midwifery in places where access to healthcare is limited. It is an amazing alternative to birth your baby without all the unnecessary interventions that you would receive if you were to birth in a hospital. Additionally you are not exposed to all the germs that people carry into there from illness. Midwives are medical professionals and carry the skill to make judgement calls when the use of medications is necessary. It's silly to withhold this from them. Open up the doors!

CommentID: **124215**

Commenter: Michaela Skinner 7/31/22 4:16 pm

Midwifery care changed my life

Being able to receive care from and birth at home with a midwifery team changed my life. My first baby was born in a hospital under duress with extreme pressure for unnecessary medical intervention by the staff. I was treated so poorly than many of their actions would be considered malpractice and unfortunately that is the case for too many women. Midwifery is a caring, empathetic and respect based experience. Midwifery care is essential for the ability of mothers to choose their birth and expanding what they are able to offer will make home birth safer and more available for every woman.

CommentID: **124235**

Commenter: Bria 8/1/22 2:45 pm

Just say no to hospital births

I loved both my midwife experiences, during prenatal care and labor and even in the months afterwards. The care and attention midwives provide far surpasses any hospital experience I have ever had. I would never go back to mainstream hospital care, especially for giving birth and every chance I get I recommend home birth. In fact, I'd go so far as to say any environment is better and safer than the hospital for birthing. Does that sound crazy? Maybe, but it is the cold, hard truth.

CommentID: **124385**

Commenter: Anonymous 8/2/22 6:09 am

CPMs are trained professionals!

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at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of mothers and babies. Unnecessary exposure of infants to public spaces, and further overburdening of our healthcare systems, means that this inconsistency negatively affects the entire community. However, if the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility.

Prioritizing public safety means allowing trained health professionals to use all of their resources and skills. The demand for midwifery care will increase as uncertainty rises. Strong, self reliant communities are built on skilled individuals like our midwives. To reiterate, our LMs are already trained and certified to administer these medications; only the law prevents their acting on it.

CommentID: **124497**

Commenter: Barry Wilder O'Keefe 8/2/22 9:34 am

Empower Midwives

I was born at home with a midwife, as were my brothers, my nieces and nephews, and my children.

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CommentID: **124517**

Commenter: Ashley Lyttle 8/2/22 12:50 pm

Midwives are Heroes

Allow VA state certified midwives to administer and carry medicines used for birth and after birth for both child and mother. This is critical to care and a positive experience for life with Americans.

CommentID: **124557**

Commenter: Jade Hillery 8/2/22 1:00 pm

Increase access to care

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CommentID: **124560**

Commenter: Savannah Longest 8/2/22 5:02 pm

Allow midwives to serve their patients

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CommentID: **124623**

Commenter: Hilary Jenish 8/2/22 5:10 pm

Midwife/ Home birth

Midwives are amazing! They provide the best care for thier expecting mothers pre-natal, birth and post-natal! They should be allowed to carry the medication they need for thier patients.

CommentID: **124625**

Commenter: Brittany Inzeo 8/2/22 5:52 pm

Allow midwives to carry life -saving medications!

Please consider allowing our Virginia Certified Professional Midwives to carry and administer basic life saving drugs. This can mean the difference between life and death for our women!

CommentID: **124639**

Commenter: Miranda C 8/2/22 7:54 pm

Midwifery

Midwife's should be able to help their clients with medications that are necessary during pregnancy and birth. They are highly trained and very knowledgeable.

CommentID: **124656**

Commenter: Anonymous 8/3/22 3:06 pm

Expand options for mothers, by giving midwives the freedom to practice

For two of my births, Virginia regulations caused obstacles and traumas for me and my family.

After my first birth at home, my midwives had to transfer me to the hospital to get stitches for a tear, because the regulations in Virginia did not allow them to carry analgesic medication that would make getting the few stitches needed painless to do in my own bed. My midwives were fully trained to perform the procedure, but instead I had to be separated from my newborn, spend 6 hours siting in the ER waiting room, and then have an ER doctor do the procedure after complaining that he had to bring all of his tools from L&D to ER to do it. All of this while my new baby was at home waiting to start learning to breastfeed. It was an unnecessary inconvenience for everyone involved.

For a different pregnancy, I was again planning to give birth in my home in Virginia, but thanks to the regulations, I was risked out of care due to being diagnosed with twins. In hopes of avoiding having to labor and deliver in an OR, I found that my only affordable option was to leave the country. Meanwhile, my friend in Minnesota had no issues having her twins peacefully at home, fully supported by her community.

This is not empowering for women of Virginia, nor their children. A planned home birth is just as safe if not safer than a hospital birth. If midwives were allowed to practice the full spectrum of care they have been trained for, women of Virginia would see better birth outcomes.

CommentID: **124837**

Commenter: Selena 8/3/22 8:27 pm

Midwife support

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CommentID: **126963**

Commenter: Kim Pekin, Premier Birth Center 8/5/22 3:01 pm

Update our outdated law to reflect CPM scope of practice

I have been a Licensed Midwife in Virginia for nearly 13 years. I served on the Midwifery Advisory Board from 2014 to 2021, and I serve as Vice-Chair and Director of Professional Development for the North American Registry of Midwives (NARM), the organization that administers the CPM credential. I own two accredited freestanding birth centers where our Licensed Midwives have served over 2000 families for home and birth center births. Most births go well, but there are times when our training to provide first-line management of common complications is needed. As CPMs, we have the knowledge and skills needed to administer medications that can prevent or help manage life and death emergencies. **It is frustrating for us to essentially have to practice with our hands tied when it comes to the medications we need for managing complications.**

Our law in Virginia does not reflect our scope of practice as defined by the North American Registry of Midwives' Job Analysis (the blueprint for the NARM Exam and the list of skills requiring verification of competency by NARM Registered Preceptors). This law is outdated and adds unnecessary risks for community birth. **There is only one other state (Arkansas) that licenses midwives yet restricts them from accessing these medications. Providers should be able to work within their full scope of practice.**

The March of Dimes states that 47% of Virginia counties are Maternity Care Deserts. Maternity care deserts are areas where there is limited or no access to maternity health care services. **Maternal mortality in the United States is higher than in all other industrialized countries, and postpartum hemorrhage is the leading cause of maternal mortality worldwide.** Postpartum hemorrhage requires quick action to prevent severe maternal morbidity and mortality. **It is unconscionable to withhold access to life-saving antihemorrhagic medications for any maternity care provider, but it is especially important given the maternity care desert situation in Virginia.**

If families want injectable vitamin K or erythromycin eye ointment, they need to go to the hospital to get those within the recommended time parameters. This creates unnecessary strain on already struggling hospital systems. It is unnecessary to burden hospitals with the responsibility of providing basic medications that could safely be administered outside the hospital setting. Families have to jump through unnecessary hoops to access the medications that make birth safer. **Some must self-administer medications while their Licensed Midwife stands by, unable to assist them due to this outdated law. Some women have to endure the pain of being sutured without the use of a local anesthetic or choose to risk permanent damage to their bodies by not having those lacerations repaired properly.**

It is time to support Virginia Licensed Midwives and the people they serve. This outdated law needs to be changed to reflect the current scope of practice of Licensed Midwives, and Virginia families deserve these life-saving medications wherever they choose to give birth.

CommentID: **127134**

Commenter: Melissa Marshall 8/6/22 1:41 pm

Midwives are trained professionals

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state officials recommend that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of mothers and babies. Unnecessary exposure of infants to public spaces, and further overburdening of our healthcare systems, means that this inconsistency negatively affects the entire community. However, if the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility.

Prioritizing public safety means allowing trained health professionals to use all of their resources and skills. The demand for midwifery care will increase as uncertainty rises. Strong, self reliant communities are built on skilled individuals like our midwives. To reiterate, our LMs are already trained and certified to administer these medications; only the law prevents their acting on it.

CommentID: **127139**

Commenter: Stephanie Krautkramer 8/8/22 3:40 pm

Certified Professional Midwives

I am a Virginian, wife and parent of a son and daughter and I agree with the statement below. I have had 1 hospital birth and 1 home birth and I highly support CPM's and LM's as an options versus a hospital birth.

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.
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CommentID: **127151**

Commenter: Beverley L Bouchard 8/8/22 9:31 pm

New Licensed Midwife

I am a newly Licensed Midwife and was required by my examining board to show proficiency in all aspects of women's health in the child bearing years. This included the usage and administration of antihemorrhagics, Vit K medications etc. However, now that I am licensed, I cannot use this knowledge and skill to support my home birth and birth center families. I cannot work to the full extent of my scope. Please allow LMs to serve the families of Virginia to the full extent of their scope and certification. I fully agree with the statement below :-

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state officials recommend that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

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CommentID: **127153**

Commenter: Anonymous 8/9/22 4:18 pm

Supporting safe delivery/ full access

I have been going to out of hospital births since 2015 in a home birth and freestanding birth center setting. Recently i attended the birth of a young woman with her second baby and after a straight forward delivery she had one of the most significant hemorrhages Ive seen in the 7 years i've been attending births. Luckily this client had decided to see a secondary provider and pay out of pocket for the access for anti-hemorrhagics that she fully intended on self administering, which she did. With the use of these medications we were able to minimize bleeding while we transferred to the hospital for a higher level of care. I whole heartedly believe that she was a good candidate for a home birth and that these medications saved her life. It was very much a possibility that even after adequate education that she would have chosen to not seek out those medications and in that case we would have gone without. It is also concerning to have clients/ partners/ grandmother/ friends/ whoever administer IM medications with no training, while the one trained professional in the room is unable to.

CommentID: **127155**

Commenter: Dana Washington-Queen 8/10/22 12:16 am

Allow CPMs and LMs to carry Standard Medications for VA Homebirth Families in their Midwifery Care

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CommentID: **127157**

Commenter: Julia pelly 8/11/22 12:33 am

CPMs must be able to serve families fully

Model comment:
I am a homebirth mom and I agree with the statement below.
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CommentID: **127189**

Commenter: Ray T

8/11/22 2:50 pm

Meds for midwives

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CommentID: **127199**

Commenter: Anonymous

8/12/22 7:11 am

Pleas allow midwives to prescribe basic medication

I am a home birth and birth center support and wanted to make the analysts and reviewers aware of an inconsistency in our regulations that impacts midwifery practice and public health. State law requires that a newborn be administered certain drugs within 24 hours of birth but the midwifery laws prevent us from carrying or administering these drugs. Furthermore, there are low risk procedures occasionally required during or after a birth that requires the administration of certain medications that the current law prohibits us from carrying and administering. We are trained and competent to administer these drugs but current law is preventing us form administering these drugs creating an unnecessary burden for our clients. For more information please feel free to contact the Virginia Midwives' Alliance at info@virginiamidwives.org or by visiting our website at www.virginiamidwives.org.

States across the country are making it so that homebirth and out of hospital midwives can carry these important medication's and administer these important mini medication's. Statistics prove that out of hospital birth is safe for healthy moms and healthy babies while midwives are often scrutinized about having unsafe birthing practices that simply is not true. Nobody talks about the horrendous Birth statistics in the hospitals throughout our state. As a family who has chosen homebirth I think that it is incongruent to allow out of hospital midwives to practice in our state but not give them the full rights of their training, or to carry the essential choose tools that they need to keep women and babies safe. Even though the demand of medication's administering of medication's for the low risk mom and baby are very very low.
CommentID: **127203**

Commenter: Anonymous

8/12/22 4:12 pm

Midwife use of Vitamin K saved my baby's life

I live in rural Virginia, about 1.5 hours from the nearest hospital. After my first child was born before arrival, I opted for a home birth with licensed midwives for my second.

In their precipitous entry into the world, my second baby sustained a minor birth injury - a cephalohematoma. Out of an abundance of caution, my midwife suggested we take him to the pediatrician at two weeks of age and ask the doctor about giving him the injectable, more effective Vitamin K than the oral regime the baby was on. He said no.

Two weeks later, we noticed unexplained bruises on the baby, and I took him back to the pediatrician. When blood work and an x-ray came back normal, he suggested my toddler might be pinching the baby behind my back.

Unsatisfied with this answer, I told my midwife about the bruises and she immediately was concerned about Vitamin K deficiency, a key vitamin for blood clotting in infants.

Again, I asked my pediatrician if he would recommend a Vitamin K shot and again he said no - even as I began making plans with my midwife to deliver the injection, in line with their nationally certified training but against Virginia law.

The baby became increasingly unsettled and started crying inconsolably about 1.5 hours prior to her arrival. When he still didn't calm down after the shot, we raced to the ER where he was diagnosed with a brain bleed and life-flighted to the nearest PICU that could take him, 3.5 hours from our home.

Very fortunately for us, her administration of the Vitamin K likely halted the bleed - it hadn't grown in the hours between ER and PICU admission. After 8 days of testing and monitoring, he was discharged and diagnosed with Vitamin K Deficiency Bleeding, likely due to a failure of the oral dosage.

I can't allow myself to think what would have happened if my midwife had not caught the warning signs my pediatrician missed, prioritized meeting me that day for the vitamin K injection, or administered the shot. If she hadn't - especially with our rural location - I know that my baby could have been permanently brain damaged or died.

The ability for midwives to carry and administer Vitamin K should absolutely be legal in the state or Virginia. By administering Vitamin K to my baby, my midwife saved my baby's life.

CommentID: **127207**

Commenter: Jeni Rector, CPM The Village Midwife and Birth Center 8/13/22 1:06 pm

Outdated midwifery law

I have been a Licensed Midwife in Virginia for nearly 15 years.

I own a freestanding birth center and have served over 700 families at home or in our center.

As a CPM, I have the ability to administer medications that can prevent or help manage life and death emergencies.

The current law is forcing me to practice at less than my full capability.

The law in Virginia does not reflect our scope of practice as defined by the North American Registry of Midwives' Job Analysis (the blueprint for the NARM Exam and the list of skills requiring

verification of competency by NARM Registered Preceptors). This law is outdated and adds unnecessary risks for community birth. There is only one other state (Arkansas) that licenses midwives yet restricts them from accessing these medications. Providers should be able to work within their full scope of practice.

The March of Dimes states that 47% of Virginia counties are Maternity Care Deserts. Maternity care deserts are areas where there is limited or no access to maternity health care services. Maternal mortality in the United States is higher than in all other industrialized countries, and postpartum hemorrhage is the leading cause of maternal mortality worldwide. Postpartum hemorrhage requires quick action to prevent severe maternal morbidity and mortality. It is unconscionable to withhold access to life-saving antihemorrhagic medications for any maternity care provider, but it is especially important given the maternity care desert situation in Virginia.

If families want injectable vitamin K or erythromycin eye ointment, they need to go to the hospital to get those within the recommended time parameters. This creates unnecessary strain on already struggling hospital systems. It is unnecessary to burden hospitals with the responsibility of providing basic medications that could safely be administered outside the hospital setting. Families have to jump through unnecessary hoops to access the medications that make birth safer. Some must self-administer medications while their Licensed Midwife stands by, unable to assist them due to this outdated law. Some women have to endure the pain of being sutured without the use of a local anesthetic or choose to risk permanent damage to their bodies by not having those lacerations repaired properly.

It is time to support Virginia Licensed Midwives and the people they serve. This outdated law needs to be changed to reflect the current scope of practice of Licensed Midwives, and Virginia families deserve these life-saving medications wherever they choose to give birth.

CommentID: **127210**

Commenter: Anonymous 8/14/22 2:17 pm

Midwives should be able to administer and prescribe these meds!!

Model comment:
I am a (occupation, parent, Virginian, etc) and I agree with the statement below. (Add personal statement if desired).
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Prioritizing public safety means allowing trained health professionals to use all of their resources and skills. The demand for midwifery care will increase as uncertainty rises. Strong, self reliant communities are built on skilled individuals like our midwives. To reiterate, our LMs are already trained and certified to administer these medications; only the law prevents their acting on it.

CommentID: **127213**

Commenter: Emma Stevens

8/14/22 2:47 pm

My midwife should have been able to have these available

I am a mother in Virginia and I agree with the statement below. I recently gave birth at a highly reputable birth center facility under the excellent care of fully certified CPMa and Doulas and was prescribed all precautionary medications through a nurse midwife who has an independent practice and partners with my CpM. One of the prescriptions was rhoGAM (not needed unless baby's blood type requires after it is tested after birth and only available in a OB office or hospital unless it's ordered by a specialty pharmacy). My daughter was born 10 days ago at the beginning of a weekend and her blood type came back late on a Friday revealing that I did in fact need the shot. This must be given within 72 hours after birth so it couldn't wait until Monday when any specialty pharmacy would get it in as a special order. Because it was a weekend we were faced with either spending all day in an ER waiting for the shot (backing up actual emergencies and wasting precious hours with my newborn and recovery and risking infection in a hospital) or hoping and praying we found the medication in stock somewhere by some fluke. We spent my daughters first day home calling every pharmacy we and my midwives could think of hoping they might have one dose In stock. Within 200 miles, only ONE place happened to have one available and it was located two and a half hours away. My husband then left me home alone with my 2day old and toddler to pickup and pay CASH price for my shot. We are extremely lucky to have found that but had my birth center been authorized to prescribe and handle this medication (and honestly all other meds we ended up paying cash for just as a precaution) in house as the skilled well trained professionals they are, the whole situation could have been avoided and saved us much strain and expense as a family and for myself in recovery.

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CommentID: **127214**

Commenter: Beth Wehr

8/14/22 2:51 pm

Thank you for reading- this is important to help the lives of mothers and their children

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified

Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state officials recommend that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

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CommentID: **127215**

Commenter: Christina Owens, CPM, LM (VMA VP) EVa Homebirth 8/14/22 3:58 pm

Licensed Midwive's Scope of Practice to administer certain medications

As Certified Professional Midwives, licensed to practice in Virginia, our current laws are outdated and not in line with our Job Description, according to our certifying body, NARM. It is of utmost importance for LM's to practice to their full scope as a matter of public safety and to decrease the burden on already overwhelmed healthcare facilities. During this current pandemic, midwives have helped relieve some of the burden on hospitals by increasing the number of community births attended. We can continue to do so and with an increase in reducing this burden with access to life-saving medications for birthing folks and their newborns, some of which are required by law but yet we cannot have access to them. We are not asking for prescriptive privileges, just the ability to carry and administer the needed medications to help keep families safe and within our Job Description and professional training.

CommentID: **127216**

Commenter: Anonymous 8/14/22 4:56 pm

Safe home birth

Meds for CPMs and their clients!

CommentID: **127217**

Commenter: Anonymous 8/14/22 5:27 pm

Allow midwives to practice fully

In favor of allowing VA midwives to administer medications to their clients and practice to their full ability! More options for safe, out of hospital births.

CommentID: **127218**

Commenter: Kassy Newman 8/14/22 8:39 pm

Please change the current law

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state officials recommend that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

In my birthing situation, everything went exactly how I could have imagined it at the birth center. The midwives were so thorough and detailed in their practice. My baby was welcomed into this world in a peaceful and quiet place. She was healthy. There was only one issue… I started hemorrhaging after my daughter was born and in Virginia, midwives can't administer medication to stop that. I also had a tear and ultimately had to go to the hospital within the hour after my delivery. That trip to the hospital was a traumatic experience for my husband, new born baby, and me that could've been avoided if this archaic law was not in place.

Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of mothers and babies. Unnecessary exposure of infants to public spaces, and further overburdening of our healthcare systems, means that this inconsistency negatively affects the entire community. In our case. It was December when there was a huge COVID 19 spike. One of the main reasons that we opted for the birth center was to avoid the hospital at all costs. When I unfortunately had to be transferred to the hospital after my delivery, my husband and hour old newborn were not allowed to come with me, meaning I wasn't able to feed my daughter in her first few hours of life. We were left to the judgements of the hospital and did not feel supported.

If the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility.

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Please consider changing this law. It could save lives and prevent both physical and emotional traumas for mothers, fathers, and infants.

CommentID: **127220**

Commenter: Nicole Kramer 8/14/22 9:59 pm

Please give VA midwives access to life saving medications!

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CommentID: **127221**

Commenter: Anonymous 8/14/22 10:46 pm

Please allow midwives to act within the full scope of their training

I am a mother of four home-birthed children in Virginia, and I asking that you review the outdated laws regarding what Virginia midwives are allowed/ not allowed to carry and administer.

Because midwives in Virginia are not currently permitted to administer the Vitamin K shot, I had to take each of my babies into the pediatrician same day or earliest next day so they could be given the shot (which I had to get a prescription for and pick up each time at 8 months pregnant because the pediatrician office doesn't carry those.) Interestingly, every time, my actual pediatrician was unsure and nervous about giving the shot and she herself wondered aloud why a CPM wasn't permitted to do so. If it weren't for the Vitamin K shot, the peds office only asked for an appointment within 48 hours, which, in my opinion, is quite different than giving birth and then having to go to the pediatrician several hours later all because my TRAINED birth attendant isn't allowed to administer something she's trained to do.

In addition, after the birth of our first child, I need stitches for a tear. The hospital had an opening for us late in the evening, so just four hours after giving birth, I was going to the hospital with my newborn to get stitches, with a doctor who was none too kind nor thrilled to be having to work at 11:30 PM. Again, had my midwife been allowed to use pain medication, she would have been able to do the stitches at home and relieved the burden on the hospital and the unfortunate doctor on call.

Please allow Virginian midwives to practice within the full scope of their training!!!

CommentID: **127222**

Commenter: Debbie Wong 8/15/22 4:27 am

VA Families seeking a homebirth must be kept safe

I am a Virginia midwife and I agree with the statement below.
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CommentID: **127224**

Commenter: Anonymous 8/15/22 7:11 am

Allow CPMs to administer these essential, safe medications and treatments

I am a mother of three young children, one of whom needed to be born at home due to a history of fast births. I needed to receive stitches after the birth, and could only do so because I had a CNM present. Many Virginians do not have access to a home birth CNM, but many Virginians are safest giving birth in their home. Let's make home birth an accessible, safe option for all Virginians by allowing CNM to administer medications they are trained in providing.

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state officials recommend that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of mothers and babies. Unnecessary exposure of infants to public spaces, and further overburdening of our healthcare systems, means that this inconsistency negatively affects the entire community. However, if the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility.

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CommentID: **127226**

Commenter: Forrest 8/15/22 8:56 am

Midwifery

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are

often required or requested at the time of birth. Furthermore, state officials recommend that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

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CommentID: **127227**

Commenter: Alexandra Loginov 8/15/22 9:12 am

Allow CPMs to administer meds

Allow CPMs to have and administer lifesaving medications during childbirth. Not doing this puts both mothers and babies at risk. It also makes things more complicated for mothers who need to figure out how to obtain these medications on their own and how to pay for them separately.

CommentID: **127228**

Commenter: Jessica Sewell 8/15/22 11:04 am

Allow midwives to carry and administer necessary medications

I am a Virginian and a parent, and I believe that midwives in Virginia need to be able to carry and administer medications that are often required or requested at time of birth. State laws also require that a newborn be administered certain drugs within 24 hours of birth. Every licensed midwife is certified at the national level to carry and administer these medications, but the Virginia midwifery laws currently prevent them from carrying them or administering them. This flaw in the law prevents midwives in Virginia from serving the public health and safety of Virginians to the best of their training, skills, and abilities.

Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of babies and mothers. If the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility.

Licensed midwives are trained and certified to administer these medications; only the law prevents their acting on it.

CommentID: **127229**

Commenter: Anonymous 8/15/22 12:15 pm

Medications Access

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state officials recommend that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

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CommentID: **127231**

Commenter: Anna Whetsel Rucker, Doula, HBCE. MomaRee's Doula Services, LLC

8/15/22 12:34 pm

VA Midwives need to admirer medications

Hello,

I'm voicing my concerns for Birthing Parents in VA. I love that parents have birthing options but for the homebirth option to be safer and more utilized option, Midwives need access and the approval to give life saving medications. All births are complete different. What works for one birthing parent may not work for another. To keep the risks down, as well as emergency expenses, it is imperative that Midwives have the ability and authority to administer life saving medications. The ability to administer the standard medications and vaccines that a Dr can would bridge the healthy access health gap in many families! Virginia needs to approve Midwives carrying and administering medications and vaccines as needed. Thank you for your time.

CommentID: **127232**

Commenter: Anna Whetsel Rucker, Doula, HBCE. MomaRee's Doula Services, LLC

8/15/22 12:35 pm

VA Midwives need to administer medications

Hello,

I'm voicing my concerns for Birthing Parents in VA. I love that parents have birthing options but for the homebirth option to be safer and more utilized option, Midwives need access and the approval to give life saving medications. All births are complete different. What works for one birthing parent may not work for another. To keep the risks down, as well as emergency expenses, it is imperative that Midwives have the ability and authority to administer life saving medications. The ability to administer the standard medications and vaccines that a Dr can would bridge the healthy access health gap in many families! Virginia needs to approve Midwives carrying and administering medications and vaccines as needed. Thank you for your time.

CommentID: **127233**

Commenter: Louise Smith

8/15/22 1:00 pm

Let midwives do their job properly

I support change in the law to allow midwives to carry and administer medications that they are trained to use and that mothers and babies need.

CommentID: **127235**

Commenter: Joanna Berger

8/15/22 1:09 pm

Protect families by allowing midwives to administer the medications they are trained to use

I had a midwife-assisted home-birth. It was by far the best choice for me and my baby. My baby and I had a perfect birth experience. There were many, many reasons why I felt that a home birth was by far a better option for me than a hospital birth. One reason was that the women on my dad's side of my family have always given birth at home with professional midwives because my dad is from England and that is still standard practice in the UK. My great aunt and cousin are both professional midwives in the UK. Virginia needs to allow trained midwives to do their jobs. Midwives need to be allowed to administer medications that can really, really help mothers and babies! It needs to be easier for midwives and their clients to access these medications. There is no reason to restrict midwives from using the medications that they are trained to use. Please stop unnecessarily restricting midwives' access to medications to use during out-of-hospital births.

CommentID: **127236**

Commenter: Mr. Horst

8/15/22 4:54 pm

Repeal This Idiotic Law and Let the Trained Professionals do their Job

I am a concerned Virginia parent and voter. My wife and I had a traumatic birth experience at a hospital prior to covid. We felt more like we were being sent through a General Motors assembly line than receiving care as human beings. Since then, covid has made hospital experiences worse with increased regulations and rules. With our second child we received care from a certified professional midwife both pre and post birth. This last birth experience far surpasses the hospital experience. At our child's birth the midwife had to use an AMBU bag. Her next option was oxygen, which this ridiculous law prevents her from using. Every human being has a right to oxygen which is essential for life. My wife also would need the RhoGam shot if it weren't for my blood type, which of course, this law prevents the midwife from administering. Politics and greed for money and control now governs our healthcare providers and this ridiculous law needs to be abolished immediately for the safety of the citizens of the Commonwealth of Virginia. Not allowing these professionally trained midwives exercise the skills they are trained in is like not allowing an EMT/Firefighter to administer CPR.
Furthermore I also agree with the following statement.
"A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

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CommentID: **127245**

Commenter: Tina Bein 8/15/22 5:04 pm

Midwives

Let Midwives do their job in homebirths. Midwife's should be able to help their clients with medications that are necessary during pregnancy and birth. They are highly trained and very knowledgeable. They know what they are doing.

CommentID: **127246**

Commenter: Anonymous 8/15/22 5:13 pm

Midwives

Please allow them to administer needed medications for women during and after birth!!!

CommentID: **127247**

Commenter: Jessica H. 8/15/22 9:56 pm

Midwives are amazing

Don't limit midwives! They are amazing people with a breadth of knowledge and skills they should be permitted to use. Why take away lidocaine and force a woman who had an otherwise uncomplicated birth to have to go to the hospital for stitches when her midwife could handle it? Why are you wanting to keep them from accessing rhogam which helps a woman not develop rh+ antibodies that would harm her next baby? These proposals make no sense. Let midwives use their skills.

CommentID: **127250**

Commenter: Anonymous 8/15/22 9:57 pm

Midwives and their right to administer life saving medication

As a woman who has had a homebirth, I have seen the outstanding care that certified professional midwives offer to their clients. It is unacceptable that they aren't allowed to carry life-saving medication or offer to administer vitamin K to an infant after birth. They are trained to do all that and should be allowed to carry and administer medication. Let them be able to offer even better care to mothers and families throughout pregnancy, birth and postpartum.

CommentID: **127251**

Commenter: Elizabeth Losh 8/15/22 10:43 pm

Supporting Midwives

I agree that this is a great way to support women's health.

CommentID: **127252**

Commenter: Mel J Horan 8/16/22 12:13 am

Empower Midwives

Midwives should have every tool available to them to ensure the health of newborns and mothers.

CommentID: **127253**

Commenter: Anonymous 8/16/22 7:34 am

Midwives are the answer to maternity care deserts!

Maternity care deserts are areas where there is limited or no access to maternity health care services. According to a 2020 report published by the March of Dimes, 47% of Virginia counties are Maternity Care Deserts (March of Dimes, 2020)

Licensed Midwives in Virginia are restricted from administering medications that are within their scope of practice. Virginia is one of only two states that license midwives, yet restrict them from accessing these medications. Providers should be able to work within their full scope of practice. Virginia Midwives for Safe Community Births is a group of Virginia Licensed Midwives, freestanding Birth Centers, and consumers interested in improving community birth by updating Virginia's outdated midwifery law prohibiting Licensed Midwives from being able to possess and administer medications that make community birth safe.

CommentID: **127254**

Commenter: Anita Barefoot 8/16/22 8:13 am

Save mothers lives, empower midwives!

Give midwives what they need to practice to the full extent! Midwifery care saves womens lives!

CommentID: **127255**

Commenter: Jenny Fox 8/16/22 9:16 am

CPMs are trained to use medications and authorized to do so in other states

I am a Virginia midwife, and have previously held a midwifery license in another state. A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Part of our training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which may be required or requested at the time of birth. Furthermore, state laws require that a newborn be

administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws in Virginia prevent them from carrying or administering them.

Midwives who are licensed in other states have access to these medications because having access to medications is an essential component to provide safe community birth, and a normal part of midwifery. There are many examples from other states who have developed reliable pathways for midwives to have access to the medications we are trained to use so that families can be offered the safest care. It is reasonable and necessary to change this so that midwives can carry and administer appropriate medications in Virginia.

CommentID: **127257**

Commenter: Anonymous 8/16/22 11:04 am

Midwives in VA

I am a parent and I agree with the statement below.
A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.
Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of mothers and babies. Unnecessary exposure of infants to the public, and further overburdening of our healthcare systems, means that this inconsistency negatively affects the entire community. However, if the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility.
Prioritizing public safety means allowing trained health professionals to use all of their resources and skills. The demand for midwifery care will increase as uncertainty rises. Strong, self reliant communities are built on skilled individuals like our midwives. To reiterate, our LMs are already trained and certified to administer these medications; only the law prevents their acting on it."

CommentID: **127261**

Commenter: Anonymous 8/16/22 1:05 pm

Keep Women and Newborns Safe Through CPM Care

Please keep pregnancy and childbirth safe for women who choose Certified Professional Midwife (CPM) care in the State of Virginia.

CPMs need the ability to administer treatments which include but are not limited to State-required Vitamin K shots to newborns, anti-hemmorage shots to mothers after birth if there is excessive bleeding, Rhogam to mothers with negative (-) blood types to prevent immune response against positive (+) blood type babies, Lidocane when stitching is required, IV fluids to laboring moms for dehydration, Antibiotic IVs for moms with Group B strep at risk for passing it to their babies, Oxygen to support desirable heart rates in both mothers and babies, and Erythromycin eye ointment applied to newborns to prevent infection.

Virginia Administrative Code - Title 18. Professional And Occupational Licensing - Agency 85. Board of Medicine - Chapter 130. Regulations Governing the Practice of Licensed Midwives

needs to be amended so that midwives can be licensed to administer basic life-saving treatments & preventatives to newborns and pregnant moms. Amending this regulation (i) is necessary for the protection of public health, safety, and welfare of mothers and their newborns.

CommentID: **127263**

Commenter: Madison Orme 8/16/22 3:48 pm

Protect Women in Virginia

I am an Office Manager at a local birth center and I agree with the statement below. My son, now six years old, was born at home in the company of two qualified, licensed, and experienced midwives. I was so fortunate not to need any medications in the company of my birth, but there are so many women in Virginia who don't have the same fortune. As it stands, pregnant parents are required to jump through a series of hoops in order to receive the medications essential to the safety of their birth.

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

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CommentID: **127268**

Commenter: Lori Murafka Orme CPM 8/16/22 4:07 pm

Full scope practice for midwives

I co-own a free-standing birth center in Virginia and I have been a licensed, practicing midwife in Virginia for 15 years. Our practice serves about 100 clients a year. I could give many examples from the births I have attended as to how a dose of pitocin or IV fluids would have been helpful and perhaps even have avoided an unwanted transfer to a hospital. I can list off countless examples of the "work arounds" my clients have experienced in order to get needed medications such as Rhogam or Vitamin K. But many of those stories have already been told in other comments. The fact of the matter is that licensed midwives in Virginia should be able to practice to the full extent of their scope which includes being able to carry and administer medications as we are trained to do. It is a matter of public safety.

CommentID: **127270**

Commenter: Marinda Shindler CPM LM

8/16/22 4:32 pm

Necessary Changes for the Health and Safety of Women and Babies

I am a Certified Professional Midwife Licensed in Virginia and I agree with the statement below.
A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of our training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws and regulations prevent them from carrying or administering them.
Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of mothers and babies. Unnecessary exposure of infants to the public, and further overburdening of our healthcare systems, means that this inconsistency negatively affects the entire community. However, if the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility.
Prioritizing public safety means allowing trained health professionals to use all of their resources and skills. To reiterate, our LMs are already trained and certified to administer these medications; only the law prevents their acting on it.
CommentID: **127272**

Commenter: Leah Paul

8/16/22 4:48 pm

Midwives and Medications

I'm a licensed midwife who co-owns a freestanding birth center in Virginia. Not being able to practice within my full scope as a Certified Professional Midwife by being prevented from carrying and administering certain medications that I am trained and certified to administer, is at best, inconvenient and extremely frustrating, and at worst, dangerous for the women and babies who might require said medications.

The below comment sums this issue up perfectly:

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state officials recommend that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

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CommentID: **127273**

Commenter: Anonymous 8/16/22 6:44 pm

Is the restrictive law worth a life !

I am a trained doula, certified lactation counselor and a future student midwife. I have been a patient of a CPM. The restrictive Va law could have cost my life! I had a postpartum hemorrhage and had to self-administer my own prescription of pitocin. My children could be motherless if I was unable to do so, because the law prevented my midwife from doing what she was trained nationally to do !

CommentID: **127278**

Commenter: D3 8/16/22 7:20 pm

Responsibility = ability to respond

Midwives in VA are responsible for the care of mother and babies before, during, and immediately after birth. However the law does not allow them the **ability to respond** adequately in all the situations they face. There are several parts of the Commonwealth where a hospital is more than an hour away. Midwives are need to be able to use appropriate pharmaceutical solutions to protect those mothers and babies they are responsible for. Midwives have extensive training in on these solutions but are barred from applying the best solution.

CommentID: **127279**

Commenter: Mary Wese 8/16/22 7:25 pm

Virginia Midwives and life saving medications

Im a mom of 4. Ive had 2 homebirths. My first child was born in 2001. Around 2003, the Virginia Assembly finally repealed the law that had banned homebirth midwives for at least 10 years from practicing (unless you were grandfathered in). So hurray Virginia Assembly and homebirth advocates! We turned it around in 2003. Now allowing midwives their full scope of practice is up for debate. That is wonderful! Though Im not sure why it's a debate, unless it is to protect the OBGYNs business. As a homebirth advocate in 2002, I know that was the issue. The object of delivering a baby is to protect both mother and child, not to protect someone's business. Of course homebirth midwives should be able to carry and administer life saving medicines. Homebirth is a viable option for many women. Homebirth midwives provide excellent one on one care and support to their clients, which can not be said for large OBGYN practices. And that care provides excellent results. So now is the time for Virginia to make medications appropriate for childbirth accessible the our homebirth midwives.

CommentID: **127280**

Commenter: Anonymous 8/16/22 7:42 pm

Midwives should be able to use medications within their scope of practice

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state officials recommend that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

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CommentID: **127281**

Commenter: Anonymous

8/16/22 8:17 pm

Support Midwives in VA

As a student midwife working towards the Certified Professional Midwife certification, I am fortunate to be learning from four incredible Licensed Midwives. As I apprentice with these smart and highly trained women, I am inspired and motivated for my future career as a midwife, serving the expectant mothers of my community. Access to and administration of medications is a huge barrier I see my preceptors face on a daily basis in their busy birth practice.
A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws in Virginia prevent them from carrying or administering them.

Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of mothers and babies. Unnecessary exposure of infants to the public, and further overburdening of our healthcare systems, means that this inconsistency negatively affects the entire community. However, if the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility.

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CommentID: **127282**

Commenter: Ethan P Dunn

8/16/22 8:24 pm

Midwives should have meds

Midwives take care of patients way out in the boondocks where no other medical attention is available, and even when they work in birth centers in a town, a doctor is not wanting in the next room. Also they already have the training to administer drugs. Midwives should be allowed to administer meds. Lives are endangered otherwise.

CommentID: **127283**

Commenter: Rebekah Vansant RN BSN 8/16/22 9:06 pm

Allow CPM to provide life saving medications

As a current practicing Labor and Delivery nurse in a hospital setting, I am in full support of CPMs having the right to carry and administer medications. To improve maternal mortality and morbidity rates, mothers and infants must have access to certain medications. CPMs frequently practice in areas far away from hospitals and need certain medications to treat emergency situations, like a postpartum hemorrhage. CPMs are trained on how to carry, administer, and monitor response to medications. CPMs administering routine and necessary medications will decrease strain on hospitals when homebirth clients have to go into a hospital to receive an injection. America has one of the worst maternal morbidity rate in the developed world. Allowing CPMs to function fully as they have been trained will only improve maternal outcomes. Please give them the right to administer medications.

CommentID: **127284**

Commenter: Pamela H. Pilch, Esq. 8/16/22 9:09 pm

License Emergency Meds for Out of Hospital Midwives

I urge the Virginia Board of Medicine to find a way to permit licensed midwives (Certified Professional Midwives) to possess, carry and administer emergency medications (anti-hemorrhagics, oxygen, IV fluids) and standard maternal and newborn medications. Currently, CPMs are trained and fully certified to administer these medications. Because their use is expressly part of the CPM scope of practice outlined in the current NARM Job Analysis, which is the statutory standard in the Virginia Code, when mothers obtain a precription from their own provider for emergency labor or standard maternal or newborm medications, their CPM/LM should legally be allowed to administer them. Failure to permit midwives to practice to the full scope of their training and certification puts mothers and babies at risk.

CommentID: **127285**

Commenter: Meghan Kelly 8/16/22 9:20 pm

Midwives should have RX rights

Midwives should be able to prescribe basic, appropriate prescriptions. This is really an obvious call. The medications on question are low risk and high benefit. A midwife should have the ability to prescribe within a specified scope of medications.

CommentID: **127286**

Commenter: Benjamin Pilch 8/16/22 9:30 pm

Facilitate safe conditions for homebirth mothers

My name is Benjamin Pilch. I am a 23 year old student at George Mason University and I support women's reproductive choice in birthing in Virginia. My two brothers were born at home with midwives and it is very important to me that midwives in Virginia be allowed to carry and administer ALL emergency and standard maternal and newborn medications which they are trained and certified to use. It prevents women from having full bodily autonomy when they cannot access these meds from their midwives when they have home births or birth center births. I urge that the regulations be changed to permit Certified Professional Midwives to carry and administer these meds. Thank you.

CommentID: **127287**

Commenter: Spencer Thompson 8/16/22 9:30 pm

LET MIDWIVES USE THEIR MEDS

I support women's reproductive choice in birthing in Virginia. It is very important to me that midwives in Virginia be allowed to carry and administer ALL emergency and standard maternal and newborn medications which they are trained and certified to use. It prevents women from having full bodily autonomy when they cannot access these meds from their midwives when they have home births or birth center births. I urge that the regulations be changed to permit Certified Professional Midwives to carry and administer these meds. Thank you.

CommentID: **127288**

Commenter: Daniel Pilch 8/16/22 9:47 pm

Midwives are trained and certified, let them administer medication

I am a 20 year old student at George Mason University and I support women's reproductive choice in birthing in Virginia. My brother and I were both born at home with midwives and it is very important to me that midwives in Virginia be allowed to carry and administer ALL emergency and standard maternal and newborn medications which they are trained and certified to use. It prevents women from having full bodily autonomy when they cannot access these meds from their midwives when they have home births or birth center births. I urge that the regulations be changed to permit Certified Professional Midwives to carry and administer these meds. Thank you. -Daniel

CommentID: **127289**

Commenter: J. Anderson Gould, LCSW 8/16/22 10:07 pm

Support healthy moms and babies - allow midwives to carry medications

Virginia lawmaker,
As the partner of a mother who gave birth at home under the care and guidance of a team of midwives, I can personally attest to the depth of knowledge and wisdom that these practitioners possess. Throughout our prenatal care they were able to quell concerns, prepare us with realistic expectations, and guide us in honing my partner's birth plan so that it reflected her wishes while keeping the realities of child birth in mind.

While my partner was fortunate in her birth process to not require significant medication administration, I am well aware that every birth is unique. In an effort to best equip our midwives for the myriad of possibilities that can present over the course of labor, I urge you to support

legislation that will allow these practitioners to carry and administer the medications that can mean the difference between a successful home birth or birth at a birth center or a potentially traumatic hospital transfer.

Our midwives possess a deep and old wisdom through their training, practice, and their inherent ties to the power of a woman's intuition. By supporting the robust practice of midwifery in all ways, you will be supporting countless mothers and children through healthier and safer labor and child birth.

Thank you in advance for your support and consideration. If I can be of any service in clarifying any of my points please do not hesitate to reach me at (804)586-6345 or Anderson.gould@gmail.com.

Respectfully,
Anderson Gould, LCSW

CommentID: **127290**

Commenter: Sarah Miksa 8/16/22 10:13 pm

Legalize pertinent LM medication administration in VA

Both of my children were home-birthed: my eldest in the State of Washington and my youngest in the Commonwealth of Virginia. Although my VA midwife had three times as many years of experience as my WA midwife, I understood that birthing at home in VA was inherently riskier as my widwife could not legally administer a narrow range of medications pertinent to pre/post-natal care and birthing, for which she was trained and certified. Some of these medications might be a matter of convenience (e.g., not needing to make separate trips to a doctor's office to receive rhogam shots) - but consider that convenience is a matter of privilege and a barrier to access for others.

CommentID: **127291**

Commenter: Meagan Flaherty 8/16/22 10:41 pm

Virginia Midwifery Laws Must Change to Reflect National and Global Midwifery Practice Scope of Care

Honorable Members of the Board,

Certified Professional Midwives (CPM) play an important role within our communities by providing alternative quality perinatal health care options to the families living in Virginia, as well as helping to ease the strain on the already overburdened hospital systems. Community birth in home and birth center settings along with receiving excellent antepartum, intrapartum, and postpartum care with licensed midwives is becoming more and more mainstream both locally and nationally. Virginia saw a clinically significant rise in the number of home deliveries between 2019 and 2020 compared to 2018 to 2019, and will likely continue to trend upwards (Gregory, Osterman, & Valenzuela, 2021). This rise can be attributed to a number of factors including families becoming more aware of the maternal health crisis in the United States, the high rate of interventions even with low-risk pregnancies and births that are utilized in hospital settings, fear of being exposed to COVID in hospital settings, being aware that midwifery care has shown to improve outcomes in low-risk pregnancies, and lack of access to perinatal care providers or hospitals within their local communities.

Current Virginia midwifery laws and regulations restrict Licensed CPMs within our state from prescribing, carrying, or administering controlled substances that are recognized as being within their scope of practice on both nationally and globally (International Confederation of Midwives,

2019; North American Registry of Midwives, 2016). This is problematic because not only does Virginia law mandate that Erythromycin eye ointment be administered to the newborn as soon as possible after delivery yet CPMs are prohibited by law to do so, CPMs are also unable to manage common conditions such as dehydration during labor with IV fluids or administer Rho(D) immune globulin to Rh- clients. In addition certain complications that could be appropriately managed in a home or birth center setting with medications, such as postpartum hemorrhage, require hospital transfers which are disruptive to the important physiologic processes after delivery that ensure appropriate bonding between the mother/infant dyad as well as establishing lactation, they are also a burden on the health system. Lastly, to deny trained perinatal healthcare providers such as CPMs access to live-saving medications for emergency situations is akin to telling birthing families that the Virginia Medical Board views them as just another statistic, and not worthy of access to the full scope and care that the North American Registry of Midwives (NARM) and the International Confederation of Midwives list as part of the essential skills a midwife must possess.

It is imperative that you review the current midwifery regulations restricting controlled substances and make positive change for the mothers, babies, and families within our state by allowing licensed CPMs unrestricted access to the medications and therapies that NARM lists as part of their accepted scope of practice. Please show the families of Virginia that you are committed to ensuring that every pregnant person has access to safe, quality, and comprehensive midwifery care.

Respectfully,

Meagan Flaherty

References

Gregory, E., C., W., Osterman, M., J., K., & Valenzuela, C., P. (2021). Changes in home births by race and hispanic origin and state of residence of mother: United States, 2018–2019 and 2019–2020. National Vital Statistics Reports, 70(15), 1-10. https://www.cdc.gov/nchs/data/nvsr/nvsr70/NVSR70-15.pdf

International Confederation of Midwives. (October, 2019). Essential competencies for midwifery practice [PDF]. https://www.internationalmidwives.org/assets/files/general-files/2019/10/icm-competencies-en-print-october-2019_final_18-oct-5db05248843e8.pdf

March of Dimes. (June, 2021). Maternity care desert. March of Dimes Peristats. https://www.marchofdimes.org/peristats/datareg=99&top=23&stop=641&lev=1&slev=4&obj=9&sreg=51

North American Registry of Midwives. (2016). 2016 NARM job analysis survey comprehensive report [PDF]. Inteleos Psychometric Services. http://narm.org/pdffiles/2016-Job-Analysis.pdf

CommentID: **127293**

Commenter: Anonymous 8/16/22 10:46 pm

Let CPMs administer medications

CPMs are specifically trained to manage out of hospital prenatal care and births, and that training includes the administration of important medications. Virginia law prohibits CPMs to use and administer these medications, which could be life-saving. They need to be allowed to practice as they are trained to do.

CommentID: **127294**

Commenter: John Pilch 8/16/22 11:03 pm

Certified Professional Midwives are excellent and deserve support

My wife and I had our first child in a hospital setting. The experience was awful and the baby nearly died from mistakes by nurses and doctors. We had our second and third children at home with Certified Professional Midwives (CPMs). It was great! The CPMs demonstrated much greater knowledge and competence than did the hospital personnel, and the "bedside manner" was not even close. With that experience in mind, I urge you to change the regulation so that CPMs in Virginia are clearly allowed to carry and administer ALL emergency and standard maternal and newborn medications which they are trained and certified to use. This would put CPMs on the same level as EMTs, which I believe is both appropriate and common in other jurisdictions around the world. CPMs provide a vital service in a well-defined segment of the healthcare market and they deserve the right to do so without having one hand tied behind their back. Thank you.

CommentID: **127295**

Commenter: Gwen Paulson 8/16/22 11:08 pm

Birth access in VA

I'm a homebirth mom, Perinatal Mental Health Therapist, and Birth Doula in Fredericksburg, VA. I wholeheartedly support midwives to practice at their full scope for the health and safety of the families they serve, including access to critical medications for birth and postpartum. As someone who works with a midwifery practice professionally, has experienced midwifery care personally, and offers counseling to persons during the perinatal period, I trust midwives, their training, their practice, their profession, and scope. Additionally, I trust birthing persons to make the best decisions for them regarding their prenatal and birth care. Birthing parents are best able to make these choices when midwives are able to practice at their full scope. So often I meet with parents who have experienced tremendous birth trauma and have desires midwifery care but have been denied largely due to concerns for access to some of these critical medications. The trauma these women experience impacts their mental health significantly as well as their ability to care for their babies and form attachments to their children, which we know has additional long term effects. Supporting midwives is supporting families and family values.

CommentID: **127296**

Commenter: Jerika Smith 8/17/22 12:40 am

Give the autonomy for midwives to practice within their scope and training

As a student midwife, I agree with the statement below!

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often needed or requested during antepartum period, at the time of birth, or postpartum. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of mothers and babies. Unnecessary exposure of infants to the public, and further overburdening of our healthcare

systems, means that this inconsistency negatively affects the entire community. However, if the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility.

Prioritizing public safety means allowing trained health professionals to use all of their resources and skills. Strong, self reliant communities are built on skilled individuals like our midwives. To reiterate, our CPMs/LMs are already trained and certified to administer these medications; only the law prevents their acting on it. Please remove the barrier to a "community standard of care" that we want to be held by. Allow midwives to administer, posses all the tools(medications) they need to offer safe, quality care for women and families in our state of Virginia.

CommentID: **127297**

Commenter: Tara 8/17/22 1:37 am

Midwives are capable

Midwives have to go through extensive training to become a CPM. Since this is the case, CPM's are more than capable of providing medicine to their patients in the event of a need/emergency.

CommentID: **127298**

Commenter: Brittany Monaghan 8/17/22 4:50 am

Midwives MUST be allowed to administer medications!!!!

I am a parent and soon to be student midwife in Virginia and I agree with the statement below. Access to appropriate medications and medical treatment is a basic human right. Certified Professional Midwives are nationally trained to administer the medications used in their practice yet Virginia law prohibits them from performing their jobs properly putting countless mothers and babies at unnecessary risk. The law needs to change immediately.

CommentID: **127299**

Commenter: Lindsay Meredith 8/17/22 8:30 am

Let them do their jobs

I am an educator and I agree with the statement below:

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.
Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of mothers and

babies. Unnecessary exposure of infants to the public, and further overburdening of our healthcare systems, means that this inconsistency negatively affects the entire community. However, if the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility.
Prioritizing public safety means allowing trained health professionals to use all of their resources and skills. The demand for midwifery care will increase as uncertainty rises. Strong, self reliant communities are built on skilled individuals like our midwives. To reiterate, our LMs are already trained and certified to administer these medications; only the law prevents their acting on it.

CommentID: **127301**

Commenter: Anonymous 8/17/22 11:03 am

Let CPMs practice in full scope of care!

I reside in Fredericksburg VA and attempted to give birth under midwifery care, however, due to lack of availability exacerbated by lack of policy support in Virginia, was attended by an OB.

a flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often needed or requested during antepartum period, at the time of birth, or postpartum. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of mothers and babies. Unnecessary exposure of infants to the public, and further overburdening of our healthcare systems, means that this inconsistency negatively affects the entire community. However, if the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility.

Prioritizing public safety means allowing trained health professionals to use all of their resources and skills. Strong, self reliant communities are built on skilled individuals like our midwives. To reiterate, our CPMs/LMs are already trained and certified to administer these medications; only the law prevents their acting on it. Please remove the barrier to a "community standard of care" that we want to be held by. Allow midwives to administer, posses all the tools(medications) they need to offer safe, quality care for women and families in our state of Virginia.

why is our policy limiting practitioners from utilizing the full scope of their professional training, especially in the midst of a national provider shortage?

CommentID: **127303**

Commenter: Helen Avramidis 8/17/22 11:46 am

Comment

I am a doula and I agree with the statement below.
A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified

Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.
Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of mothers and babies. Unnecessary exposure of infants to the public, and further overburdening of our healthcare systems, means that this inconsistency negatively affects the entire community. However, if the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility.
Prioritizing public safety means allowing trained health professionals to use all of their resources and skills. The demand for midwifery care will increase as uncertainty rises. Strong, self reliant communities are built on skilled individuals like our midwives. To reiterate, our LMs are already trained and certified to administer these medications; only the law prevents their acting on it. Mothers deserve the best care possible without having to advocate unnecessary things for themselves, and midwives are the best care for them.
CommentID: **127304**

Commenter: Erin Murphy, CPM, LM 8/17/22 12:09 pm

Laws and regulations should be in place to protect birthing families, not harm them. Change the law!

Laws and regulations should be in place to protect birthing families, not harm them. Having an outdated law that restricts midwive's availability to obtain, administer life-saving, and evidence-based medications is not helping VA families, it is hurting them. Please update this outdated law.

These medications are already within our CPM scope of practice.

I question the motives of anyone opposing access of these medications for midwives. How can anyone oppose mothers' having access to these standard of care, evidence-based medications?

Please update our regulation so that CPMs can practice within our full scope.

CommentID: **127305**

Commenter: Robin Brown 8/17/22 12:31 pm

Women's rights are human rights!

Legalize midwives access and medication to properly treat women in Virginia!

CommentID: **127307**

Commenter: Erika Bennett 8/17/22 1:33 pm

Change the Law!

Allow midwives to practice in their full scope of care. Mothers and babies will be better cared for and protected.

CommentID: **127308**

Commenter: Anonymous 8/17/22 1:34 pm

Give midwives full rights

Midwives should be given full medical license rights. They should be able to administer medicines that could save lives in an emergency.

CommentID: **127309**

Commenter: Misty Ward VA Birth Center Alliance 8/17/22 2:21 pm

Barriers to medication access for LM's is a safety hazard.

Virginia families choosing community birth deserve easy, affordable, and barrier free access to standard medication for pregnancy, childbirth, and their newborn that makes birth and babies safer. The current restrictions to access lead many families to forgo potentially life-saving treatment for themselves and their newborn. We know through research that these medications are safe and effective and that when families have easy access their compliance, satisfaction, and outcomes are improved. Please keep this in mind as you review the Licensed Midwife regulations.

CommentID: **127310**

Commenter: Kamika Brown 8/17/22 2:55 pm

Medication access for CPM!

Clients(birther and Baby) of birth centers and home birth deserve ease of access to the possible life saving medication as well as every medication that is routinely given in hospital. We are trained professionals that should be able to work within our license.Our clients should not have to go to a 3rd party providers to gain access to medications, then be asked after giving birth to push a needle with medication into their baby or their own bodies. This is a rather scary concept to alot of people.

While taking a new look at our regulations please keep in mind that allowing out of Hospital CPM's to carry and administer pitocin & or misoprostal for the purpose of postpartum hemorrhage, lidocane for suturing in the postpartum, Vit-K for newborns to prevent VKDB, erythromycin opthalmic ointment for newborn eye infection should be allowed by the state of Virginia as it is under our licensure

CommentID: **127314**

Commenter: Kat Mcclenahan 8/17/22 3:25 pm

FIX LAWS SURROUNDING CPMS

I am a mom of 2 boys, and have birthed both babies out of hospital, one at a birthing center and one at home.

CPMs deserve to have flexible laws surrounding their care for moms who choose to birth out of hospital. Preventing them from doing so won't stop out of hospital births. So please allow them to provide safe and affective prenatal and postnatal support!

Thanks!

CommentID: **127317**

Commenter: Emily Huffman 8/17/22 3:50 pm

Support FULL practice for licensed midwives

I am a Virginia resident and was a midwifery client for both my pregnancies. The training licensed midwives undergo is rigorous, comprehensive, and ongoing. I felt I was in excellent hands throughout my pregnancies and births. It is upsetting our midwives are restricted from offering a full scope of practice. My first birth I was advised to transfer to hospital after completing 95% of labor at home simply because my midwife was not permitted to administer IV fluids. This was administered to me en route to the hospital and was the ONLY intervention needed to safely and naturally birth my daughter. She was born within 20 minutes of receiving fluids and I had no medical emergency which required hospitalization. Had my midwife been able to practice within the full scope of her training, I likely would have completed my birth at home. Midwives in Virginia are an important asset to birthing women and should be treated as such with supportive legislation. I agree with and support the following statements:

Virginia Licensed Midwives currently are not permitted to possess, prescribe, or administer potentially life-saving medications within their scope of practice. This needs to change! I ask for your support for legislation allowing Licensed Midwives the right to provide the medications within their scope of practice.

Maternity Care Desert

Maternity care deserts are areas where there is limited or no access to maternity health care services. According to a 2020 report published by the March of Dimes, 47% of Virginia counties are Maternity Care Deserts (March of Dimes, 2020)

Safety & Ethic

Maternal mortality in the United States is higher than all other highly industrialized countries. More than 700 people die each year in the United States from childbirth-related causes, and it is estimated that approximately 60% of those deaths are preventable (Maternal Mortality Review Information Application (MMRIA), 2018). Hemorrhage is the leading cause of maternal death worldwide (James, 2022), and there are basic medications Licensed Midwives can administer to prevent or treat postpartum hemorrhage. Access to life-saving medications is a human right and is essential to safe practice in all birth settings

Strain on Hospital System

Families who choose to give birth at home or at a freestanding birth center ease the strain on hospital systems. It is unnecessary to burden hospitals with the responsibility of providing basic medications that could safely be administered outside the hospital setting

Scope of Practic

Licensed Midwives in Virginia are restricted from administering the medications that are within their scope of practice*. Virginia is one of only two states that license midwives yet restrict them from accessing these medications. Providers should be able to work within their full scope of practice

Workaround

Families must jump through numerous hoops to gain access to the medications that make their birth safer. Some must drive over two hours to see a physician who would be willing to prescribe medications. Some must go to the hospital within 2 hours of their baby's birth so that their baby can receive a potentially life-saving vitamin K injection or erythromycin eye ointment that can prevent permanent blindness due to maternal infection. Some people must choose between having to endure the pain of being sutured without the use of local anesthetic or risking permanent damage to their body by not having those lacerations repaired properly. Some must self-administer

prescribed medications, while their Licensed Midwife stands by, unable to assist them due to an outdated law

I urge you to support Virginia Licensed Midwives and the people they serve. This outdated law needs to be changed to reflect the scope of practice of Licensed Midwives, and Virginia families deserve these life-saving medications wherever they choose to give birth.

Sincerely,

Emily Huffman

CommentID: **127319**

Commenter: Caeli Werner 8/17/22 4:38 pm

Supporting safe delivery/ full acesss

I support Licensed CPM in the state of VA getting medications, that are potentially life saving and standard in may other states, in order to offer the best care to their clients

CommentID: **127321**

Commenter: Emily Friar CPM 8/17/22 5:18 pm

Please support all Virginia mothers and babies

Please support all Virginia families, including those that make the decision to deliver at home or in a birth center with the assistance of a CPM, by removing barriers to life saving medications.

CommentID: **127322**

Commenter: Ildiko Baugus, CPM, LM 8/17/22 6:12 pm

Statement on Midwives concerning changes to Midwife laws

On behalf of the Virginian Midwives Alliance, I want to urge the sunset reviewers and analysts to consider advising the legislature, in the sunset report, to address the inconsistency between the midwifery scope of practice and the current legislation. The midwifery scope of practice allows the use of certain medication in their practice and as a result Virginia midwives are trained in the proper use of these medications. However, current Virginia law prohibits midwives from using these medications in their practice. This results in one of several undesirable options; 1) the mother self-medicates, 2) a 911 call, which, according to several local fire department financial supervisors, costs approximately $2,000 each, 3) mother and baby travel to a medical facility and since 47% of Virginia is considered a maternal care desert (March of Dimes Report, October 2020) that creates a significant burden of the new mom and baby. None of these outcomes are desirable or healthy and can easily be addressed by changing the law to be consistent with the midwifery scope of practice.

Sincerely,

Ildiko Baugus, CPM, LM

President, Virginia Midwives Alliance

CommentID: **127325**

Commenter: Karen Kelly, Virginia Affiliate of American College of Nurse-Midwives

8/17/22 6:24 pm

Bring LM Scope in Regs Up to National Standards

On behalf of the Virginia Affiliate of the American College of Nurse-Midwives, I am writing in support of the review and amendment of regulations regarding the inability for Licensed Midwives, to practice to the full extent of their scope and national standards outlined by their certifying body, the National Association of Registered Midwives (NARM). The current regulations in Virginia on Certified Professional Midwives, (CPMs), titled 'Licensed Midwives", are in opposition to evidence based recommendations from the World Health Organization and March of Dimes with regard to ability of CPMs to best utilize pharmaceutical agents that are within their education and scope that will have the biggest impact on reducing maternal, newborn and child morbidity and mortality in the community birth setting.

The midwifery model of care is known to be a key component to improving the health of Virginians during the childbearing years. The purpose of lincensure and regulations are for public and professional safety. Excluding valuable maternal health care providers from prescribing, possessing or administering medications considered life saving, and which would allow them to practice in accordance with national standards, is a barrier to integrating the midwifery model of care into the health system.

For these reasons we recommend amending the law to remove the exception for prescribing, possessing, and administering medication in 54.1-2957.9 and thus amend the regs 18VAC85-130-80.

Sincerely,

Karen Kelly, CM, MS, FACNM

President-Virginia Affiliate of the American College of Nurse-Midwives

CommentID: **127326**

Commenter: Natalie Detrich, FNP

8/17/22 6:28 pm

Autonomous practice

I support midwives to have full autonomous practice, including prescribing power for life saving medications.

CommentID: **127327**

Commenter: Anna Graham, RN, BSN

8/17/22 6:53 pm

Let out of hospital midwives carry emergency medications

Let out of hospital midwives legally carry emergency medications. Change the law.

CommentID: **127329**

Commenter: Lydia Heatwole

8/17/22 7:39 pm

Allow midwives to administer medicines/drugs!!

After complications delivering my placenta in my first 2 births, pitocin was a GAME CHANGER for the 3rd time. The differences with my placenta delivery as well as overall birth recovery was almost night and day. My midwives are completely competent in administering commonly used medicines. This fundamental right goes along with their practice. To an extent, their “hands are tied” when unable to have the full scope of “tools” at their disposal. Allow them to do this!!

CommentID: **127331**

Commenter: Rebecca Amstutz 8/17/22 8:20 pm

Midwives should have access

Cpms are trained to use meds and use them in other states. Restricting their access in VA makes birth less safe not more safe. Let midwives legally use meds to make birth safer in VA.

CommentID: **127332**

Commenter: Melanie 8/17/22 8:42 pm

Midwives

Midwives should have access to necessary medication.

CommentID: **127333**

Commenter: Anonymous 8/17/22 8:48 pm

Support midwives and families in VA

As a birth professional and aspiring midwife I agree with the following statement:

It is time to support Virginia Licensed Midwives and the people they serve. This outdated law needs to be changed to reflect the current scope of practice of Licensed Midwives, and Virginia families deserve these life-saving medications wherever they choose to give birth.

CommentID: **127334**

Commenter: Jill Crossland 8/17/22 8:49 pm

My VA midwife is more qualified to administer my Rhogam than I am!

Midwives should not be restricted from providing basic, life saving care. Medication administration is being put in the hands of individuals themselves instead of medically trained professionals.

CommentID: **127335**

Commenter: Kinsey Johnston 8/17/22 8:49 pm

Midwives should be allowed to carry the life-saving medication they are already qualified to use.

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified

Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state officials recommend that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them. Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of mothers and babies. Unnecessary exposure of infants to public spaces, and further overburdening of our healthcare systems, means that this inconsistency negatively affects the entire community. However, if the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility. Prioritizing public safety means allowing trained health professionals to use all of their resources and skills. The demand for midwifery care will increase as uncertainty rises. Strong, self reliant communities are built on skilled individuals like our midwives. To reiterate, our LMs are already trained and certified to administer these medications; only the law prevents their acting on it.

CommentID: **127336**

Commenter: Anonymous 8/17/22 9:34 pm

It's a yes for me!

Please allow midwives to carry life-saving medication as they assist in home births.

CommentID: **127337**

Commenter: Kaitlyn 8/17/22 9:49 pm

Midwives scope of practice

I am a licensed practical nurse and mother and I agree with the statement below.
A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.
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Prioritizing public safety means allowing trained health professionals to use all of their resources and skills. The demand for midwifery care will increase as uncertainty rises. Strong, self reliant communities are built on skilled individuals like our midwives. To reiterate, our LMs are already trained and certified to administer these medications; only the law prevents their acting on it.

CommentID: **127338**

Commenter: Amanda Hall 8/17/22 9:54 pm

Support our midwives

Support our midwives who put their hearts into their work

CommentID: **127339**

Commenter: Gayle 8/17/22 9:55 pm

Yes

I am a Virginian parent, and I agree with the statement below.

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.
Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of mothers and babies. Unnecessary exposure of infants to the public, and further overburdening of our healthcare systems, means that this inconsistency negatively affects the entire community. However, if the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility.
Prioritizing public safety means allowing trained health professionals to use all of their resources and skills. The demand for midwifery care will increase as uncertainty rises. Strong, self reliant communities are built on skilled individuals like our midwives. To reiterate, our LMs are already trained and certified to administer these medications; only the law prevents their acting on it.

CommentID: **127340**

Commenter: Chris 8/17/22 10:01 pm

Support our midwives

Midwives are Healthcare practitioners that need to be allowed to do their jobs. Please fix your laws so that they can serve our communities properly.

CommentID: **127341**

Commenter: Leslie 8/17/22 10:08 pm

Virgina Midwives and scope of practice

I am a doula, childbirth educator,, parent, and Virginian and I agree with the statement below.

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be

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CommentID: **127342**

Commenter: Terri Hewitt, LM, CPM

8/17/22 10:11 pm

It is time...

As a community midwife and Certified Professional Midwife with a VA Midwifery license I agree and testify to the importance to access, carry and administer these medications. It is evident how integral this ability is for the safety and comfort of all families choosing out of hospital birth. This will also free up resources better used for the overburdened medical care system. When an office visit or emergency room is used for care that could easily have been provided and resolved with the access and administering of a medication it wastes important time and resources for the population at large. This has been never so evident as it was through the pandemic. I agree with the statement below.

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often needed or requested during antepartum period, at the time of birth, or postpartum. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of mothers and babies. Unnecessary exposure of infants to the public, and further overburdening of our healthcare systems, means that this inconsistency negatively affects the entire community. However, if the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility.

Prioritizing public safety means allowing trained health professionals to use all of their resources and skills. Strong, self reliant communities are built on skilled individuals like our midwives. To reiterate, our CPMs/LMs are already trained and certified to administer these medications; only the law prevents their acting on it. Please remove the barrier to a "community standard of care" that we want to be held by. Allow midwives to administer, posses all the tools(medications) they need to offer safe, quality care for women and families in our state of Virginia.

It is more than time to best serve birthing people and their babies.
CommentID: **127343**

Commenter: Desiree Cripps CPM, RN 8/17/22 10:25 pm

Remove barriers to safe maternal care

About 1% of Pregnant mothers choose to give birth out of the hospital, a subculture that deserves equity in their maternity care. Remove the barriers from VA licensed midwives so they may provide routine and emergency medications when indicated, without hardship to the families they serve.

CommentID: **127344**

Commenter: Chelea Shira, CPM, LM 8/17/22 10:27 pm

Families Deserve Access to Safe Options Out Of Hospital!

I am a Midwife and Mother who has had two homebirths of my own. I have experienced first hand through my own births, as well as those I have attended as a midwife, the effects of not having access to medications that would make out of hospital birth a safer environment for mother and baby. I have seen women hemorrhage, retain their placentas, have episiotomies done and repaired in their homes with no pain management medications. I have seen mothers who are actively bleeding praying for their life have to wait for emergency services to arrive just to have IV fluids given to them before being transferred and receiving medications. I have experienced on my own bleeding on my bathroom floor after losing a baby, and not having access to appropriate care before being transferred to a hospital. It is time for families in Virginia to have access to care from ALL providers who are trained to do so!!

I am a Virginia Midwife, and Mother and I agree with the statement below!

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.
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CommentID: **127345**

Commenter: Aili Huber 8/17/22 10:29 pm

People will be safer if midwives can carry meds

I had two safe and uncomplicated home births, in 2010 and 2012, under the care of a CPM. When I became pregnant for the third time, in 2018, I knew there was nobody else that I would trust to care for me and my family during that pregnancy and birth. The birth went well, overall, but shortly afterward, the CPM expressed concern about the amount of blood I was using. I said that I felt fine, but when I stood up, I fainted. The CPM massaged my uterus to try to get it to contract, in order to stop the bleeding. When that wasn't working fast enough, she gave me a shot of pitocin. At that time, she employed a CNM so that she could have access to basic medications necessary for safely managing birth. However, it was the CPM, and not the CNM, who observed that I was in bad shape and needed this intervention. My sister-in-law was present at this birth. She is a physician who trained at the Mayo Clinic. She told me later that she was extremely impressed with the CPM's handling of the situation, and that she didn't think any doctor could have done better. She believes that the CPM's careful observation, fast action, and excellent training saved my life.

I find it frustrating and upsetting that CPMs are not permitted to obtain or administer life-saving medications without the oversight of a doctor or CNM. They are trained and nationally certified to use them. Why can't people giving birth in Virginia have access to the safest options, regardless of whether their care provider is a CPM, a CNM, or an OB/GYN?

CommentID: **127346**

Commenter: Christa Hall 8/17/22 10:41 pm

Midwifery scope of practice

I am a home maker, mother and Virginian and I agree with the statement below.

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CommentID: **127348**

Commenter: Mitchiko Taylor massage therapist 8/17/22 10:48 pm

Midwife's practice

I am a massage therapist,parent, Virginian and I agree with the statement below.
A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified

Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.
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CommentID: **127349**

Commenter: Anonymous 8/17/22 10:49 pm

Support VA Midwives

I am a Virginia parent and I agree with the statement below.

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CommentID: **127350**

Commenter: Jackie Hess, Yorktown Soula 8/17/22 11:02 pm

Midwives need access to the same drugs as midwives have in the hospital.

Please give our VA midwives the resources and access they need to provide the best care possible for their patients. There are several reasons why they need these drugs as options.
Namely, they are the patients first and usually only medical professional at the time, starts the the drugs before other care is needed or would arrive and give Virginia mothers the full benefits at

home. VA moms want their birth out of hospital because trust has been lost.
Allowing access to these important medications will help restore trust between both communities. Our midwives are that critical link.

CommentID: **127351**

Commenter: Kim Graves 8/17/22 11:02 pm

Midwifery safety laws

I am a former childbirth educator and mother who's had two homebirths and I agree with the statement below.

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

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CommentID: **127352**

Commenter: Anonymous 8/17/22 11:04 pm

Allow licensed midwives full scope.

The lack of access to medications causes harm to families. A homebirth plan can be a transfer to a hospital for something as simple as IV fluids . Also it risks the life in cases of hemorrhage that can be stopped but instead waiting on ems response. Lack of medications clearly will not stop families from choosing homebirth. The midwives in this state have an excellent record of care since licensure in 2005. It is beyond time to allow full scope to ensure the safety of mothers in Virginia.

CommentID: **127353**

Commenter: Michael Landry 8/17/22 11:05 pm

Allow Virginia mothers to receive the care certified professional midwives are trained to provide.

I am a Virginian and I agree with the statement below.

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

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CommentID: **127354**

Commenter: Nancy Ang — 8/17/22 11:13 pm

Keep midwives accessible

I am a parent and I agree with the statement below. As a birthing mother in Virginia, finding adequate care with providers that do not brush off symptoms cause you're just another chart is hard enough. Take away our midwives and we lose all personal care that would make sure every symptom is heard and looked at.

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CommentID: **127355**

Commenter: Sara reimold — 8/17/22 11:16 pm

Help midwives save lives

Midwives should be able to use life-saving medication is emergency situations. Does the state care about the health of mothers and babies? Tying the hands of licensed care providers is criminal.

CommentID: **127356**

Commenter: Kerrie

8/17/22 11:18 pm

Midwives rule

I am a Virginian and I agree with the statement below.

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CommentID: **127357**

Commenter: Tiffany Delk

8/17/22 11:20 pm

Midwifery Care Mitigates Poor Outcomes

I am a Student Midwife studying to become a Certified Professional Midwife. I agree with the statement below because, in addition to being a student midwife, I am also a Black Women who sought midwifery care due to the morbidity and mortality epidemic we are seeing surrounding the perinatal care of Black women. I believe that midwifery care mitigates these poor outcomes, and what we are asking for provides an additional resource to combat the epidemic we are facing in the U.S., (not just for Black women, but for ALL women) with poor maternal and fetal outcomes.

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.

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CommentID: **127358**

Commenter: Hadassah Bellot

8/17/22 11:24 pm

All families deserve Midwifery Care

Research shows that midwifery care is a safe option for families giving birth in out of hospital settings. Giving midwives in Virginia the same allowances to utilize life saving medication is the right thing to do. Most of the US recognizes that CPMs should have access to keep families safe at home . Virginia should prioritize families and their safety but listening to midwives about what can help them keep transfer rates low.

CommentID: **127359**

Commenter: Markesha

8/17/22 11:32 pm

Let's move in the direction of progress

I am a therapist and a mother who had the privilege to use midwives for my children and I agree with the statement below.

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CommentID: **127360**

Commenter: Anonymous

8/17/22 11:40 pm

Allow access to life saving medications!

I am a Virginia Parent and I agree with the statement below. I urge Virginia to allow midwives access to medications!

A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.
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CommentID: **127361**

Commenter: Virginia Ferguson

8/17/22 11:42 pm

Let the midwives use their training!

I have had 3 homebirths and have attended many other births. I have seen midwives having to transfer to hospitals for very simple things, such as stitches needed, when they are trained to do it, but not legally allowed to. I have seen women refuse to go to hospitals to get stiches and risk infections and suffer in pain because they are afraid of hospitals, or taking the baby into a place so full of illnesses. In other countries such as England, midwives are allowed to use all their training to help women, including medications and other procedures deemed necessary by the Midwife even in a home setting. Midwives should be free to use all their skills that support women's safety and health.

CommentID: **127362**

Commenter: David

8/17/22 11:42 pm

Support for Midwives

I am a child of a midwife and was born at home and I agree with the statement below.

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CommentID: **127363**

Commenter: Chelsea Bayer 8/17/22 11:48 pm

Midwives

I am a home birth mother of four and I agree with the statement below:

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CommentID: **127364**

Commenter: Anonymous 8/17/22 11:51 pm

Licensed midwife law

I am a Virginia resident and I agree with the statement below. (Add personal statement if desired).

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CommentID: **127365**

Commenter: Kathleen Winters 8/17/22 11:56 pm

Midwife License Law

I am a parent, doula, and Certified Lactation Counselor and I agree with the statement below.
A flaw in our regulations prevents Virginia midwives from serving the public health and safety of Virginians to the best of their training, skills, and abilities. Training at a national level for Certified Professional Midwives includes the carrying and administering of certain medications, which are often required or requested at the time of birth. Furthermore, state laws require that a newborn be administered certain drugs within 24 hours of birth. Every Licensed Midwife is certified at the national level to carry and administer these medications, but the current midwifery laws prevent them from carrying or administering them.
Situations that are low risk and manageable within the home or community are, as a result, made into ordeals that at best inconvenience and at worst endanger the wellbeing of mothers and babies. Unnecessary exposure of infants to the public, and further overburdening of our healthcare systems, means that this inconsistency negatively affects the entire community. However, if the barrier to the resources for which they are trained is removed, midwives could relieve the maternity care desert status affecting nearly half of Virginians, who live outside a reasonable driving distance from a well stocked medical facility.
Prioritizing public safety means allowing trained health professionals to use all of their resources and skills. The demand for midwifery care will increase as uncertainty rises. Strong, self reliant communities are built on skilled individuals like our midwives. To reiterate, our LMs are already trained and certified to administer these medications; only the law prevents their acting on it
CommentID: **127366**

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF LICENSED MIDWIVES

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-130-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Effective Date: March 5, 2020

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

(804) 367-4600 (TEL)
(804) 527-4426 (FAX)
email: medbd@dhp.virginia.gov

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Part I. General Provisions.

18VAC85-130-10. Definitions.

A. The following words and terms when used in this chapter shall have the meanings ascribed to them in § 54.1-2957.7 of the Code of Virginia.
"Midwife"
"Practicing midwifery"

B. The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:
"Board" means the Virginia Board of Medicine.
"Client" means a person receiving midwifery care and shall be considered synonymous with the word "patient."
"Controlled substance" means a drug, substance or immediate precursor in Schedules I through VI as set out in the Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia).
"CPM" means the Certified Professional Midwife credential issued by the North American Registry of Midwives.
"NARM" means the North American Registry of Midwives.

~~**18VAC85-130-20. Public participation.**~~

~~A separate board regulation, 18VAC85-11, entitled Public Participation Guidelines, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.~~

18VAC85-130-30. Fees.

Unless otherwise provided, the following fees shall not be refundable:

1. The application fee for a license to practice as a midwife shall be $277.

2. The fee for biennial active license renewal shall be $312; the additional fee for late renewal of an active license within one renewal cycle shall be $105.

3. The fee for biennial inactive license renewal shall be $168; the additional fee for late renewal of an inactive license within one renewal cycle shall be $55.

4. The fee for reinstatement of a license that has expired for a period of two years or more shall be $367 in addition to the late fee. The fee shall be submitted with an application for licensure reinstatement.

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

6. The fee for an application for reinstatement if a license has been revoked or if an application for reinstatement has been previously denied shall be $2,000.

7. The fee for a duplicate wall certificate shall be $15.

8. The fee for a duplicate renewal license shall be $5.

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

~~10. For 2021, the fee for renewal of an active license shall be $250, and the fee for renewal of an inactive license shall be $125.~~

18VAC85-130-31. Current name and address.

Each licensee 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 shall be validly given when sent to the latest address of record provided or served to the licensee. Any change of name or address of record or the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

Part II.
Requirements for Licensure and Renewal of Licensure.

18VAC85-130-40. Criteria for initial licensure.

A. An applicant for board licensure shall submit:
1. The required application on a form provided by the board and the application fee as prescribed in 18 VAC 85-130-30;
2. Evidence satisfactory to the board of current certification as a CPM; and
3. A report from NARM indicating whether there has ever been any adverse action taken against the applicant.

B. If an applicant has been licensed or certified in another jurisdiction, the applicant shall provide information on the status of each license or certificate held and on any disciplinary action taken or pending in that jurisdiction.

18VAC85-130-45. Practical experience under supervision.

A person may perform tasks related to the practice of midwifery under the direct and immediate supervision of a licensed doctor of medicine or osteopathic medicine, a certified nurse midwife, or a licensed midwife while enrolled in an accredited midwifery education program or during completion of the North American Registry of Midwives' Portfolio Evaluation Process Program without obtaining a license issued by the board until such person has taken and received the results of any examination required for CPM certification or for a period of 10 years, whichever occurs sooner.

18VAC85-130-50. Biennial renewal of licensure.

A. A licensed midwife shall renew licensure biennially during the midwife's birth month in each odd-numbered year by:
1. Paying to the board the renewal fee as prescribed in 18 VAC 85-130-30; and
2. Attesting to having current, active CPM certification by NARM.

B. A licensed midwife whose license has not been renewed by the first day of the month following the month in which renewal is required shall not be considered licensed in Virginia.

C. An additional fee to cover administrative costs for processing a late application renewal shall be imposed by the board as prescribed by 18 VAC 85-130-30.

18VAC85-130-60. Inactive licensure.

A. A licensed midwife 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.
1. The holder of an inactive license shall not be required to maintain current, active certification by NARM.
2. An inactive licensee shall not be entitled to perform any act requiring a license to practice midwifery in Virginia.

B. An inactive licensee may reactivate licensure by:
1. Payment of the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure for the biennium in which the license is being reactivated; and
2. Submission of documentation of having current, active certification by NARM.
C. The board reserves the right to deny a request for reactivation 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 provision of this chapter.

18VAC85-130-70. Reinstatement.

A. A licensed midwife who allows licensure to lapse for a period of two years or more and chooses to resume practice shall submit to the board a reinstatement application, information on practice and licensure in other jurisdictions for the period in which the license was lapsed in Virginia, proof of current, active certification by NARM, and the fee for reinstatement of licensure as prescribed in 18 VAC 85-130-30.

B. A licensed midwife whose license has been revoked by the board and who wishes to be reinstated must make a new application to the board, hold current, active certification by NARM, and pay the fee for reinstatement of a revoked license as prescribed in 18 VAC 85-130-30.

Part III.
Practice Standards.

18VAC85-130-80. General disclosure requirements.

A licensed midwife shall provide written disclosures to any client seeking midwifery care. The licensed midwife shall review each disclosure item and obtain the client's signature as evidence that the disclosures have been received and explained. Such disclosures shall include:
1. A description of the licensed midwife's qualifications, experience, and training;
2. A written protocol for medical emergencies, including hospital transport, particular to each client;
3. A statement as to whether the licensed midwife has hospital privileges;

4. A statement that a licensed midwife is prohibited from prescribing, possessing or administering controlled substances;
5. A description of the midwife's model of care;
6. A copy of the regulations governing the practice of midwifery;
7. A statement as to whether the licensed midwife carries malpractice or liability insurance coverage and, if so, the extent of that coverage;
8. An explanation of the Virginia Birth-Related Neurological Injury Compensation Fund and a statement that licensed midwives are currently not covered by the fund; and
9. A description of the right to file a complaint with the Board of Medicine and with NARM and the procedures and contact information for filing such complaint.

18VAC85-130-81. Disclosures on health risks.

A. 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.

B. If any of the following conditions or risk factors are presented, the midwife shall request and review the client's medical history, including records of the current or previous pregnancies; disclose to the client the risks associated with a birth outside of a hospital or birthing center; and provide options for consultation and referral. If the client is under the care of a physician for any of the following medical conditions or risk factors, the midwife shall consult with or request documentation from the physician as part of the risk assessment for birth outside of a hospital or birthing center.

1. Antepartum risks:

Conditions requiring ongoing medical supervision or ongoing use of medications;
Active cancer;
Cardiac disease;
Severe renal disease -- active or chronic;
Severe liver disease -- active or chronic;
HIV positive status with AIDS;
Uncontrolled hyperthyroidism;
Chronic obstructive pulmonary disease;
Seizure disorder requiring prescriptive medication;
Psychiatric disorders;
Current substance abuse known to cause adverse effects;
Essential chronic hypertension over 140/90;
Significant glucose intolerance;
Genital herpes;
Inappropriate fetal size for gestation;
Significant 2nd or 3rd trimester bleeding;
Incomplete spontaneous abortion;
Abnormal fetal cardiac rate or rhythm;
Uterine anomaly;

Platelet count less than 120,000;
Previous uterine incision and/or myomectomy with review of surgical records and/or subsequent birth history;
Isoimmunization to blood factors;
Body mass index (BMI) equal to or greater than 30;
History of hemoglobinopathies;
Acute or chronic thrombophlebitis;
Anemia (hematocrit less than 30 or hemoglobin less than 10 at term);
Blood coagulation defect;
Pre-eclampsia/eclampsia;
Uterine ablation;
Placental abruption;
Placenta previa at onset of labor;
Persistent severe abnormal quantity of amniotic fluid;
Suspected chorioamnionitis;
Ectopic pregnancy;
Pregnancy lasting longer than 42 completed weeks with an abnormal nonstress test;
Any pregnancy with abnormal fetal surveillance tests;
Rupture of membranes 24 hours before the onset of labor;
Position presentation other than vertex at term or while in labor; or
Multiple gestation.

2. Intrapartum risks:

Current substance abuse;
Documented intrauterine growth retardation (IUGR)/small for gestational age (SGA) at term;
Suspected uterine rupture;
Active herpes lesion in an unprotectable area;
Prolapsed cord or cord presentation;
Suspected complete or partial placental abruption;
Suspected placental previa;
Suspected chorioamnionitis;
Pre-eclampsia/eclampsia;
Thick meconium stained amniotic fluid without reassuring fetal heart tones and birth is not imminent;
Position presentation other than vertex at term or while in labor;
Abnormal auscultated fetal heart rate pattern unresponsive to treatment or inability to auscultate fetal heart tones;
Excessive vomiting, dehydration, or exhaustion unresponsive to treatment;
Blood pressure greater than 140/90 that persists or rises and birth is not imminent;
Maternal fever equal to or greater than 100.4°F; or
Labor or premature rupture of membrane (PROM) less than 37 weeks according to due date.

3. If a risk factor first develops when birth is imminent, the individual midwife must use judgment taking into account the health and condition of the mother and baby in determining whether to proceed with a home birth or arrange transportation to a hospital.

C. If the risks factors or criteria have been identified that may indicate health risks associated with birth of a child outside of a hospital or birthing center, the midwife shall provide evidence-based

information on such risks. Such information shall be specified by the board in guidance documents and shall include evidence-based research and clinical expertise from both the medical and midwifery models of care.

D. The midwife shall 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.

18VAC85-130-90. Confidentiality.

A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a client. 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.

18VAC85-130-100. Client records.

A. Practitioners shall comply with provisions of § 32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of client records.
B. Practitioners shall provide client records to another practitioner or to the client or the client's personal representative in a timely manner in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.

C. Practitioners shall properly manage client records and shall maintain timely, accurate, legible and complete client records. Practitioners shall clearly document objective findings, decisions and professional actions based on continuous assessment for ongoing midwifery care.

D. Practitioners shall document a client's decisions regarding choices for care, including informed consent or refusal of care. Practitioners shall clearly document when a client's decisions or choices are in conflict with the professional judgment and legal scope of practice of the licensed midwife.

E. Practitioners shall maintain a client record for a minimum of six years following the last client encounter with the following exceptions:
1. 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 client encounter regardless of the age of the child;
2. Records that have previously been transferred to another practitioner or health care provider or provided to the client or the client's personal representative do not have to be kept for a minimum of six years following the last client encounter; or
3. Records that are required by contractual obligation or federal law may need to be maintained for a longer period of time.

F. Practitioners shall in some manner inform all clients concerning the time frame for record retention and destruction. Client records shall only be destroyed in a manner that protects client confidentiality, such as by incineration or shredding.

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

18VAC85-130-110. Practitioner-client communication; termination of relationship.

A. Communication with clients.
1. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately inform a client or the client's legally authorized representative of the client's assessment and prescribed plan of care in understandable terms to the patient. 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 directed by the practitioner.
~~2. A practitioner shall present information relating to the client's care to a client or the client's legally authorized representative in understandable terms and encourage participation in the decisions regarding the client's care.~~
3. Before any invasive procedure is performed, informed consent shall be obtained from the client. Practitioners shall inform clients of the risks, benefits, and alternatives of the recommended procedure that a reasonably prudent licensed midwife practicing in Virginia would tell a client. In the instance of a minor or a client who is incapable of making an informed decision on the client's 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. Termination of the practitioner/client relationship.
1. The practitioner or the client may terminate the relationship. In either case, the practitioner shall make a copy of the client record available, except in situations where denial of access is allowed by law.
2. ~~Except as provided in § 54.1-2962.2 of the Code of Virginia, a~~ A practitioner shall not terminate the relationship or make services unavailable without documented notice to the client that allows for a reasonable time to obtain the services of another practitioner.

18VAC85-130-120. Practitioner responsibility.

A. A practitioner shall:
1. Transfer care immediately in critical situations that are deemed to be unsafe to a client or infant and remain with the client until the transfer is complete;
2. Work collaboratively with other health professionals and refer a client or an infant to appropriate health care professionals when either needs care outside the midwife's scope of practice or expertise; and
3. Base choices of interventions on empirical and/or research evidence that would indicate the probable benefits outweigh the risks.

B. A practitioner shall not:
1. Perform procedures or techniques that are outside the scope of the midwife's practice or for which the midwife is not trained and individually competent;
2. Knowingly allow apprentices or subordinates to jeopardize client safety or provide client care outside of the apprentice's or subordinate's scope of practice or area of responsibility. Practitioners shall delegate client care only to those who are properly trained and supervised; and
3. Exploit the practitioner/client relationship for personal gain.

18VAC85-130-130. Advertising ethics.

~~A. Any statement specifying a fee, whether standard, discounted or free, for professional services that does not include the cost of all related procedures, services and products that, to a substantial likelihood, will be necessary for the completion of the advertised service as it would be understood by an ordinarily prudent person shall be deemed to be deceptive or misleading, or both. Where reasonable disclosure of all relevant variables and considerations is made, a statement of a range of prices for specifically described services shall not be deemed to be deceptive or misleading.~~

~~B. Advertising a discounted or free service, examination, or treatment and charging for any additional service, examination, or treatment that is performed as a result of and within 72 hours of the initial office visit in response to such advertisement is unprofessional conduct unless such professional services rendered are as a result of a bona fide emergency. This provision may not be waived by agreement of the client and the practitioner.~~

~~C. Advertisements of discounts shall disclose the full fee that has been discounted. The practitioner shall maintain documented evidence to substantiate the discounted fees and shall make such information available to a consumer upon request.~~

~~D. A licensee shall disclose the complete name of the board that conferred the certification when using or authorizing the use of the term "board certified" or any similar words or phrase calculated to convey the same meaning in any advertising for the licensee's practice.~~

~~E.~~ A licensee of the board shall not advertise information which is false, misleading, or deceptive. For an advertisement for a single practitioner, it shall be presumed that the practitioner is responsible and accountable for the validity and truthfulness of its content. For an advertisement for a practice in which there is more than one practitioner, the name of the practitioner or practitioners responsible and accountable for the content of the advertisement shall be documented and maintained by the practice for at least two years. Documentation, scientific and otherwise, supporting claims made in an advertisement shall be maintained and available for the board's review for at least two years.

~~18VAC85-130-140. Vitamins, minerals and food supplements.~~

~~A. The recommendation or direction for the use of vitamins, minerals or food supplements and the rationale for that recommendation shall be documented by the practitioner. The recommendation or direction shall be based upon a reasonable expectation that such use will result in a favorable client outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use.~~

~~B. Vitamins, minerals, or food supplements, or a combination of the three, shall not be sold, dispensed, recommended, prescribed, or suggested in doses that would be contraindicated based on the individual client's overall medical condition and medications.~~

~~C. The practitioner shall conform to the standards of the practitioner's particular branch of the healing arts in the therapeutic application of vitamins, minerals or food supplement therapy.~~

~~18VAC85-130-150. Solicitation or remuneration in exchange for referral.~~

~~A practitioner shall not knowingly and willfully solicit or receive any remuneration, directly or indirectly, in return for referring an individual to a facility as defined in § 37.2-100 of the Code of Virginia, or hospital as defined in § 32.1-123 of the Code of Virginia.~~
~~Remuneration shall be defined as compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by 42 USC § 1320a-7b(b), as amended, or any regulations promulgated thereto.~~

18VAC85-130-160. 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 client, or both; or
2. May reasonably be interpreted as romantic involvement with a client regardless of whether such involvement occurs in the professional setting or outside of it.

B. Sexual contact with a client.
1. The determination of when a person is a client 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 client until the client-practitioner relationship is terminated.
2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a client does not change the nature of the conduct nor negate the statutory prohibition.

C. Sexual contact between a practitioner and a former client after termination of the practitioner-client 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 client care. For purposes of this section, key third party of a client shall mean: spouse or partner, parent or child, guardian, or legal representative of the client.

E. Sexual contact between a supervisor and a trainee or apprentice 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 client care.

18VAC85-130-170. 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.

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Agenda Items: Issue periodic review decision and adoption of fast-track regulatory changes recommended by the advisory board

Included in your agenda package are:

- Notice of periodic review
- Recommended revisions to Chapter 140

Staff Note: Advisory board recommended to retain Chapter 140 with amendments.

Action needed:

- Motion to retain Chapter 140 with amendments;
- Motion to adopt changes recommended by advisory board as fast-track regulatory changes.

Agency **Department of Health Professions**

Board **Board of Medicine**

Chapter **Regulations Governing the Practice of Polysomnographic Technologists [18 VAC 85 - 140]**

Edit Review Review 2155

Periodic Review of this Chapter

Includes a Small Business Impact Review

Date Filed: 6/16/2022

Review Announcement

Pursuant to Executive Order 14 (as amended July 16, 2018) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, this regulation is undergoing a periodic review.

The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018). http://TownHall.Virginia.Gov/EO-14.pdf.

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

In order for you to receive a response to your comment, your contact information (preferably an email address or, alternatively, a U.S. mailing address) must accompany your comment. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

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

Publication Information and Public Comment Period

Published in the Virginia Register on 7/18/2022 [Volume: 38 Issue: 24]

Comment Period begins on the publication date and ends on 8/17/2022

Comments Received: 0

Review Result

Pending

Attorney General Certification

Pending

This periodic review was created by Erin Barrett on 06/16/2022 at 12:28pm

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF POLYSOMNOGRAPHIC TECHNOLOGISTS

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-140-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Effective Date: March 5, 2020

9960 Mayland Drive, Suite 300
Henrico, VA 23233-2463

(804) 367-4600 (TEL)
(804) 527-4426 (FAX)
email: medbd@dhp.virginia.gov

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Part I General Provisions

18VAC85-140-10. Definitions.

A. The following word and term when used in this chapter shall have the meaning ascribed to it in § 54.1-2900 of the Code of Virginia:

"Board"

B. The following words and terms when used in this chapter shall have the meanings ascribed to them in § 54.1-2957.15 of the Code of Virginia:

"Polysomnographic technology"

"Practice of polysomnographic technology"

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

"Active practice" means a minimum of 160 hours of professional practice as a polysomnographic technologist within the 24-month period immediately preceding application for reinstatement or reactivation of licensure. The active practice of polysomnographic technology may include supervisory, administrative, educational, or consultative activities or responsibilities for the delivery of such services.

~~"Advisory board" means the Advisory Board on Polysomnographic Technology to the Board of Medicine as specified in § 54.1-2957.14 of the Code of Virginia.~~

~~**18VAC85-140-20. Public participation.**~~

~~A separate board regulation, 18VAC85-11, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.~~

18VAC85-140-30. Current name and address.

Each licensee 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 shall be validly given when sent to the latest address of record provided or served to the licensee. Any change of name or change in the 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.

18VAC85-140-40. Fees.

The following fees are required:

1. The application fee, payable at the time the application is filed, shall be $130.

2. The biennial fee for renewal of active licensure shall be $135 and for renewal of inactive licensure shall be $70, payable in each odd-numbered year in the license holder's birth month. For 2021, the renewal fee for an active license shall be $108, and the renewal fee for an inactive license shall be $54.

3. The additional fee for late renewal of licensure within one renewal cycle shall be $50.

4. The fee for reinstatement of a license that has lapsed for a period of two years or more shall be $180 and must be submitted with an application for licensure reinstatement.

5. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

6. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

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

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

Part II
Requirements for Licensure as a Polysomnographic Technologist

18VAC85-140-45. Practice as a student or trainee.

A student enrolled in an educational program in polysomnographic technology or a person engaged in a traineeship is not required to hold a license to practice polysomnographic technology, provided that such student or trainee is under the direct supervision of a licensed polysomnographic technologist or a licensed doctor of medicine or osteopathic medicine.

1. Any such student or trainee shall be identified to patients as a student or trainee in polysomnographic technology.

2. Such student or trainee is required to have a license to practice after 18 months from the start of the educational program or traineeship or six months from the conclusion of such program or traineeship, whichever is earlier.

18VAC85-140-50. Application requirements.

An applicant for licensure shall submit the following on forms provided by the board:

1. A completed application and a fee as prescribed in 18VAC85-140-40.

2. Verification of a professional credential in polysomnographic technology as required in 18VAC85-140-60.

3. Verification of practice as required on the application form.

4. If licensed or certified in any other jurisdiction, documentation of any disciplinary action taken or pending in that jurisdiction.

18VAC85-140-60. Licensure requirements.

A. An applicant for a license to practice as a polysomnographic technologist shall provide documentation of one of the following:

1. Current certification as a Registered Polysomnographic Technologist (RPSGT) by the Board of Registered Polysomnographic Technologists;

2. Documentation of the Sleep Disorders Specialist credential from the National Board of Respiratory Care (NBRC-SDS); or

3. A professional certification or credential approved by the board from an organization or entity that meets the accreditation standards of the Institute for Credentialing Excellence.

B. An applicant for licensure shall provide documentation of current certification in Basic Life Support for Health Care Providers with a hands-on practice training evaluation segment.

Part III
Renewal and Reinstatement

18VAC85-140-70. Renewal of license.

A. Every licensed polysomnographic technologist who intends to maintain an active license shall biennially renew his license each odd-numbered year during his birth month and shall:

1. Submit the prescribed renewal fee;

2. Attest to having current certification in Basic Life Support for Health Care Providers with a hands-on practice training evaluation segment; and

3. Attest to having met the continuing education requirements of 18VAC85-140-100.

B. The license of a polysomnographic technologist is lapsed if the license has not been renewed by the first day of the month following the month in which renewal is required. Practice with a lapsed license may be grounds for disciplinary action. A license that is lapsed for two years or less may be renewed by payment of the renewal fee and a late fee as prescribed in 18VAC85-140-40 and attestation of compliance with continuing education requirements and current Basic Life Support for Health Care Providers with a hands-on practice training evaluation segment certification.

18VAC85-140-80. Inactive license.

A licensed polysomnographic technologist who holds a current, unrestricted license in Virginia shall, upon a request at the time of renewal and submission of the required fee, be issued an inactive license. The holder of an inactive license shall not be entitled to perform any act requiring a license to practice polysomnographic technology in Virginia.

18VAC85-140-90. Reactivation or reinstatement.

A. To reactivate an inactive license or to reinstate a license that has been lapsed for more than two years, a polysomnographic technologist shall submit an attestation of current certification in Basic Life Support for Health Care Providers with a hands-on practice training evaluation segment and evidence of competency to return to active practice to include one of the following:

1. Information on continued active practice in another jurisdiction during the period in which the license has been inactive or lapsed;

2. Attestation of at least 10 hours of continuing education for each year in which the license has been inactive or lapsed, not to exceed three years; or

3. Recertification by passage of an examination for the Registered Polysomnographic Technologist (RPSGT), the Sleep Disorders Specialist credential from the National Board of Respiratory Care (NBRC-SDS), or other credential approved by the board for initial licensure.

B. To reactivate an inactive license, a polysomnographic technologist shall pay a fee equal to the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure.

C. To reinstate a license that has been lapsed for more than two years, a polysomnographic technologist shall file an application for reinstatement and pay the fee for reinstatement of his licensure as prescribed in 18VAC85-140-40. The board may specify additional requirements for reinstatement of a license so lapsed to include education, experience, or reexamination.

D. A polysomnographic technologist whose licensure has been revoked by the board and who wishes to be reinstated shall make a new application to the board, fulfill additional requirements as specified in the order from the board, and make payment of the fee for reinstatement of his licensure as prescribed in 18VAC85-140-40 pursuant to § 54.1-2408.2 of the Code of Virginia.

E. 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.

18VAC85-140-100. Continuing education requirements.

A. In order to renew an active license as a polysomnographic technologist, a licensee shall attest to having successfully completed 20 hours of continuing education in courses directly related to the practice of polysomnographic technology as approved and documented by a provider recognized by one of the following:

1. The Board of Registered Polysomnographic Technologists Education Advisory Board (BRPT-EAC);

2. The American Academy of Sleep Medicine (AASM);

3. The American Medical Association for Category 1 continuing medical education credit;

4. The American Association of Sleep Technologists (AAST);

5. The American Society of Electroneurodiagnostic Technologists, Inc. (ASET);

6. The American Association for Respiratory Care (AARC);

7. The American Nurses Association (ANA); or

8. The American College of Chest Physicians (ACCP).

B. Up to two continuing education hours may be satisfied through delivery of polysomnographic technology services, without compensation, to low-income individuals receiving services through a local health department or a free clinic organized in whole or primarily for the delivery of health services. One hour of continuing education may be credited for three hours of providing such volunteer services. For the purpose of continuing education credit for voluntary service, the hours shall be approved and documented by the health department or free clinic.

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

D. The practitioner shall retain the completed form with all supporting documentation in his records for a period of four years following the renewal of an active license.

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

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

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

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

Part IV
Scope of Practice

~~18VAC85-140-110. General responsibility.~~

~~A polysomnographic technologist shall engage in the practice of polysomnographic technology, as defined in § 54.1-2957.15 of the Code of Virginia, upon receipt of written or verbal orders from a qualified practitioner and under qualified medical direction. The practice of polysomnographic technology may include supervisory, administrative, educational, or consultative activities or responsibilities for the delivery of such services.~~

18VAC85-140-120. Supervisory responsibilities.

A. A polysomnographic technologist shall be responsible for supervision of unlicensed polysomnographic personnel who work under his direction and shall be ultimately responsible and accountable for patient care and outcomes under his clinical supervision.

B. Delegation to unlicensed polysomnographic personnel shall:

1. Not include delegation of the discretionary aspects of the initial assessment, evaluation, or development of a treatment plan for a patient nor shall it include any task requiring a clinical decision or the knowledge, skills, and judgment of a licensed polysomnographic technologist.

2. Only be made if, in the judgment of the polysomnographic technologist, the task or procedures do not require the exercise of professional judgment, can be properly and safely performed by appropriately trained unlicensed personnel, and the delegation does not jeopardize the health or safety of the patient.

3. Be communicated on a patient-specific basis with clear, specific instructions for performance of activities, potential complications, and expected results.

C. The frequency, methods, and content of supervision are dependent on the complexity of patient needs, number and diversity of patients, demonstrated competency and experience of the unlicensed personnel, and the type and requirements of the practice setting.

D. The polysomnographic technologist providing clinical supervision shall routinely meet with any unlicensed personnel to review and evaluate patient care and treatment.

E. The polysomnographic technologist shall review notes on patient care entered by unlicensed personnel prior to reporting study results to the supervising physician and shall, by some method, document in a patient record that such a review has occurred.

Part V
Standards of Professional Conduct

18VAC85-140-130. 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.

18VAC85-140-140. Patient records.

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

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

D. A practitioner who is 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. A practitioner who is self-employed or employed by an entity in which the individual practitioner owns 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, including immunizations, shall be maintained until the child reaches the age of 18 years 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.

~~3. When closing, selling, or relocating his practice, 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.~~

18VAC85-140-150. Practitioner-patient communication~~; 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 medication, treatment, or procedure provided or directed by the practitioner in the treatment of any disease or condition.~~

~~3. Before an invasive procedure is performed, 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 polysomnographic technology 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 an invasive 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, "invasive 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. 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.~~

18VAC85-140-160. 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 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.

~~**18VAC85-140-170. Solicitation or remuneration in exchange for referral.**~~

~~A practitioner shall not knowingly and willfully solicit or receive any remuneration, directly or indirectly, in return for referring an individual to a facility or institution as defined in § 37.2-100 of the Code of Virginia or hospital as defined in § 32.1-123 of the Code of Virginia.~~

~~"Remuneration" means compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by 42 USC § 1320 a-7b(b), as amended, or any regulations promulgated thereto.~~

18VAC85-140-180. 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 within 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 practitioner-patient relationship is terminated.

2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient neither changes the nature of the conduct nor negates 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.

18VAC85-140-190. 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 Items: Issue periodic review decision and adoption of fast-track regulatory changes recommended by advisory board

Included in your agenda package are:

- Notice of periodic review
- Public comment received
- Revisions to Chapter 150 recommended by advisory board

Staff note: Advisory board recommended retain Chapter 150 with amendments.

Action needed:

- Motion to retain Chapter 150 with amendments;

- Motion to adopt changes recommended by advisory board as fast-track regulatory changes.

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Agency **Department of Health Professions**

Board **Board of Medicine**

Chapter **Regulations Governing the Practice of Behavior Analysis [18 VAC 85 - 150]**

Edit Review

Review 2156

Periodic Review of this Chapter

Includes a Small Business Impact Review

Date Filed: 6/16/2022

Review Announcement

Pursuant to Executive Order 14 (as amended July 16, 2018) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, this regulation is undergoing a periodic review.

The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018). http://TownHall.Virginia.Gov/EO-14.pdf.

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

In order for you to receive a response to your comment, your contact information (preferably an email address or, alternatively, a U.S. mailing address) must accompany your comment. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

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

Publication Information and Public Comment Period

Published in the Virginia Register on 7/18/2022 [Volume: 38 Issue: 24]

Comment Period begins on the publication date and ends on 8/17/2022

Comments Received: 2

Review Result

Pending

Attorney General Certification

Pending

This periodic review was created by Erin Barrett on 06/16/2022 at 12:28pm

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Agency **Department of Health Professions**

Board **Board of Medicine**

Chapter **Regulations Governing the Practice of Behavior Analysis [18 VAC 85 - 150]**

2 comments

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

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Commenter: Prof. Michael Moates, MA, LP, LBA, LMHC, LADAC 7/30/22 1:04 am

Comment

The Advisory Board admitted the current text does not comply with the statute. It should be amended to comply with the law or it would be unlawful.

CommentID: **124186**

Commenter: Christy Evanko, Virginia Association for Behavior Analysis 8/17/22 2:51 pm

Comments on Behavior Analysis Regulations

We, the Public Policy Committee of the Virginia Association for Behavior Analysis, are of the opinion that the Regulations Governing the Practice of Behavior Analysis should be amended. First, they should more similarly conform to other professions under the Board of Medicine. Second, to protect consumer safety, they should clarify the qualifications of organizations who can nationally certify someone who is to become licensed as follows. This is to best protect the consumer of these services.

Certifications and other credentials should be accepted as evidence of qualification for licensure to practice behavior analysis in this state only if they are issued by a non-profit credentialing organization that has all of the following features and safeguards:

- A mission to protect consumers of behavior analysis services by establishing professional standards of practice
- Published, publicly available bylaws, standards, and procedures
- A governing body (typically a Board of Directors) whose voting members are
  - Unpaid
  - Credentialed (certified and/or licensed) behavior analysts representing the range of practitioners in the field and 1-2 consumers of behavior analytic services
  - Selected or elected in accordance with procedures specified in the bylaws
  - Independent of any other organizations or entities in making decisions about the organization's credentialing programs
- Key leadership personnel who are credentialed professional behavior analysts
- A well-established track record in managing credentialing programs for practitioners of behavior analysis

- Credentialing programs that are accredited by the National Commission for Certifying Agencies (NCCA) of the Institute for Credentialing Excellence or American National Standards Institute. Accreditation by the NCCA is preferred because that organization
    - Was the first to develop standards for professional certification programs
    - From its inception in 1977, designed its standards to (a) ensure the health, welfare, and safety of the public; (b) to be consistent with the Standards for Educational and Psychological Testing; and (c) to be applicable to all professions and industries
    - Requires certifying bodies to demonstrate that they are free of undue influence from any other body and are autonomous in making decisions about certification activities
    - has been accrediting professional credentialing programs in behavior analysis and similar professions for many years.
- Requirements and standards for each credential that have been derived from job (or occupational) analysis studies that
    - Involved subject matter experts in behavior analysis and psychometrics (test construction) and large numbers of practitioners of behavior analysis
    - Were designed to identify the knowledge, skills, and abilities (KSAs) required to practice behavior analysis generally, not with any specific client or service recipient population(s) or in any specific settings
    - Were conducted in accordance with standards and procedures that are widely accepted and followed by other similar professions
    - Resulted in a comprehensive list of KSAs (often called a task list) that is publicly available
    - Are published and available to the public
- Credentialing requirements set by the organization's governing body that include
    - Completion of a degree or degrees
    - Successful completion of specified coursework in behavior analysis
    - Successful completion of specified experiential training in delivering behavior analytic services to clients under the supervision of credentialed professional behavior analysts
    - Passage of an objective, valid, and reliable professional examination in behavior analysis that is derived from the applicable job analysis study and managed in ways that assure the security of exam items, administrations, and results
    - Continuing education in behavior analysis to maintain the credential
    - Adherence to ethical and disciplinary standards that have been developed by professional behavior analysts, are publicly available, and are enforced by the organization in accordance with publicly available procedures

Third, the regulations must address the time gap between certification and licensure and allow for practice under supervision while certificants are waiting for the paperwork to be completed. Finally, it is necessary to add that licensees must maintain certification in order to renew their license, similar to other professions.

We thank you for your time and dedication to the safety of consumers who receive services provided by licensed behavior analysts and licensed assistant behavior analysts.

CommentID: **127313**

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF BEHAVIOR ANALYSIS

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18VAC85-150-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Effective Date: March 5, 2020

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

(804) 367-4600 (TEL)
(804) 527-4426 (FAX)
email: medbd@dhp.virginia.gov

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Part I
General Provisions

18VAC85-150-10. 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

Practice of behavior analysis

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

"BACB" means the Behavior Analyst Certification Board, Inc.

"BCBA®" means a Board Certified Behavior Analyst®.

"BCaBA®" means a Board Certified Assistant Behavior Analyst®.

~~**18VAC85-150-20. Public participation.**~~

~~A separate board regulation, 18VAC85-11, entitled Public Participation Guidelines, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.~~

18VAC85-150-30. Current name and address.

Each licensee 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 shall be validly given when sent to the latest address of record provided or served to the licensee. Any change of name or change in the 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.

18VAC85-150-40. Fees.

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

1. The initial fee for the behavior analyst license shall be $130; for the assistant behavior analyst license, it shall be $70.

2. The fee for reinstatement of the behavior analyst license that has been lapsed for two years or more shall be $180; for the assistant behavior analyst license, it shall be $90.

3. The fee for active license renewal for a behavior analyst shall be $135; for any assistant behavior analyst, it shall be $70. The fees for inactive license renewal shall be $70 for a

behavior analyst and $35 for an assistant behavior analyst. Renewals shall be due in the birth month of the licensee in each odd-numbered year. For 2021, the renewal of an active license as a behavior analyst shall be $108, and the renewal fee for an inactive license shall be $54; the renewal fee for an active license as an assistant behavior analyst shall be $54, and the renewal fee for an inactive license shall be $28.

4. The additional fee for processing a late renewal application within one renewal cycle shall be $50 for a behavior analyst and $30 for an assistant behavior analyst.

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

6. The fee for reinstatement of licensure pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

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

8. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

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

Part II
Requirements for Licensure as a Behavior Analyst or an Assistant Behavior Analyst

18VAC85-150-50. Application requirements.

An applicant for licensure shall submit the following on forms provided by the board:

1. A completed application and a fee as prescribed in 18VAC85-150-40.

2. Verification of certification as required in 18VAC85-150-60.

3. Verification of practice as required on the application form.

4. If licensed or certified in any other jurisdiction, verification that there has been no disciplinary action taken or pending in that jurisdiction.

5. Verification from the BACB on disciplinary action taken or pending by that body.

18VAC85-150-60. Licensure requirement.

An applicant for a license to practice as a behavior analyst or an assistant behavior analyst shall hold current certification as a BCBA® or a BCaBA® obtained by meeting qualifications and passage of the examination required for certification as a BCBA® or a BCaBA® by the BACB.

Part III
Renewal and Reinstatement

18VAC85-150-70. Renewal of licensure.

A. Every behavior analyst or assistant behavior analyst who intends to maintain an active license shall biennially renew his license each odd-numbered year during his birth month and shall:

1. Submit the prescribed renewal fee; and

2. Attest to having met the continuing education requirements of 18VAC85-150-100.

B. The license of a behavior analyst or assistant behavior analyst that has not been renewed by the first day of the month following the month in which renewal is required is lapsed. Practice with a lapsed license may be grounds for disciplinary action. A license that is lapsed for two years or less may be renewed by payment of the renewal fee, a late fee as prescribed in 18VAC85-150-40, and documentation of compliance with continuing education requirements.

18VAC85-150-80. Inactive licensure.

A behavior analyst or assistant behavior analyst 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 entitled to perform any act requiring a license to practice as a behavior analyst or assistant behavior analyst in Virginia.

18VAC85-150-90. Reactivation or reinstatement.

A. To reactivate an inactive license or to reinstate a license that has been lapsed for more than two years, a behavior analyst or assistant behavior analyst shall submit evidence of competency to return to active practice to include one of the following:

1. Information on continued practice in another jurisdiction as a licensed behavior analyst or a licensed assistant behavior analyst or with certification as a BCBA® or BCaBA® during the period in which the license has been inactive or lapsed;

2. Sixteen hours of continuing education for each year in which the license as a behavior analyst or 10 hours for each year in which the license as an assistant behavior analyst has been inactive or lapsed, not to exceed three years; or

3. Recertification by passage of the BCBA® or the BCaBA® certification examination from the BACB.

B. To reactivate an inactive license, a behavior analyst or assistant behavior analyst shall pay a fee equal to the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure.

C. To reinstate a license that has been lapsed for more than two years, a behavior analyst or assistant behavior analyst shall file an application for reinstatement and pay the fee for reinstatement of his license as prescribed in 18VAC85-150-40. The board may specify additional requirements for reinstatement of a license so lapsed to include education, experience, or reexamination.

D. A behavior analyst or assistant behavior analyst whose licensure has been revoked by the board and who wishes to be reinstated shall make a new application to the board, fulfill additional requirements as specified in the order from the board, and make payment of the fee for reinstatement of his licensure as prescribed in 18VAC85-150-40 pursuant to § 54.1-2408.2 of the Code of Virginia.

E. 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.

18VAC85-150-100. Continuing education requirements.

A. In order to renew an active license, a behavior analyst shall attest to having completed 32 hours of continuing education and an assistant behavior analyst shall attest to having completed 20 hours of continuing education as approved and documented by a sponsor recognized by the BACB within the last biennium. Four of the required hours shall be related to ethics in the practice of behavior analysis. Up to two continuing education hours may be satisfied through delivery of behavioral analysis services, without compensation, to low-income individuals receiving services through a local health department or a free clinic organized in whole or primarily for the delivery of health services. One hour of continuing education may be credited for three hours of providing such volunteer services. For the purpose of continuing education credit for voluntary service, the hours shall be approved and documented by the health department or free clinic.

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

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

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

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

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

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

Part IV
Scope of Practice

~~**18VAC85-150-110. Scope of practice.**~~

Commented [VP1]: Advisory board recommended deletion. The first part is in statute, and the second is unnecessary because it's in the next regulation

~~The practice of a behavior analyst includes:~~

~~1. Design, implementation, and evaluation of environmental modifications using the principles and methods of behavior analysis to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior; and~~

~~2. Supervision of licensed assistant behavior analysts and unlicensed personnel.~~

18VAC85-150-120. Supervisory responsibilities.

A. The licensed behavior analyst is ultimately responsible and accountable for client care and outcomes under his clinical supervision.

B. There shall be a written supervisory agreement between the licensed behavior analyst and the licensed assistant behavior analyst that shall address:

1. The domains of competency within which services may be provided by the licensed assistant behavior analyst; and

2. The nature and frequency of the supervision of the practice of the licensed assistant behavior analyst by the licensed behavior analyst.

A copy of the written supervisory agreement shall be maintained by the licensed behavior analyst and the licensed assistant behavior analyst and made available to the board upon request.

C. Delegation shall only be made if, in the judgment of the licensed behavior analyst, the task or procedures can be properly and safely performed by an appropriately trained assistant behavior analyst or other person, and the delegation does not jeopardize the health or safety of the client.

D. Supervision activities by the licensed behavior analyst include:

1. Direct, real-time observation of the supervisee implementing behavior analytic assessment and intervention procedures with clients in natural environments and/or training others to implement them, with feedback from the supervisor.

2. One-to-one, real-time interactions between supervisor and supervisee to review and discuss assessment and treatment plans and procedures, client assessment and progress data and reports, published research, ethical and professional standards and guidelines, professional development needs and opportunities, and relevant laws, regulations, and policies.

3. Real-time interactions between a supervisor and a group of supervisees to review and discuss assessment and treatment plans and procedures, client assessment and progress data and reports, published research, ethical and professional standards and guidelines, professional development needs and opportunities, and relevant laws, regulations, and policies.

4. Informal interactions between supervisors and supervisees via telephone, electronic mail, and other written communication are encouraged but may not be considered formal supervision.

For the purposes of this subsection, "real-time" shall mean live and person-to-person.

E. The frequency and nature of supervision interactions are determined by the individualized assessment or treatment plans of the clients served by the licensed behavior analyst and the assistant behavior analyst but shall occur not less than once every four weeks with each supervision session lasting no less than one hour.

18VAC85-150-130. Supervision of unlicensed personnel.

A. Unlicensed personnel may be supervised by a licensed behavior analyst or a licensed assistant behavior analyst.

B. Unlicensed personnel may be utilized to perform:

1. Nonclient-related tasks, including but not limited to clerical and maintenance activities and the preparation of the work area and equipment; and

2. Certain routine client-related tasks that, in the opinion of and under the supervision of a licensed behavior analyst or a licensed assistant behavior analyst, have no potential to adversely impact the client or the client's treatment plan and do not constitute the practice of behavior analysis.

Part V
Standards of Professional Conduct

18VAC85-150-140. Confidentiality.

A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a client. 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.

18VAC85-150-150. Client 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 client records.

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

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

D. Practitioners who are employed by a health care institution, educational institution, school system, or other entity in which the individual practitioner does not own or maintain his own records shall maintain client 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 owns and is responsible for client records shall:

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

   a. Records of a minor child shall be maintained until the child reaches the age of 18 years or becomes emancipated, with a minimum time for record retention of six years from the last client 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 client or his legally authorized 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 clients concerning the time frame for record retention and destruction. Client records shall only be destroyed in a manner that protects client confidentiality, such as by incineration or shredding.

~~3. When closing, selling, or relocating his practice, 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 client's choice or provided to the client or legally authorized representative.~~

18VAC85-150-160. Practitioner-client communication; termination of relationship.

A. Communication with clients.

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

3. Before an initial assessment or intervention is performed, informed consent shall be obtained from the client or his legally authorized representative. Practitioners shall inform clients or their legally authorized representative of the risks, benefits, and alternatives of the recommended procedure that a reasonably prudent practitioner would tell a client.

a. Informed consent shall also be obtained if there is a significant change to a therapeutic procedure or intervention performed on a client that is not part of routine, general care and that is more restrictive on the continuum of care.

b. In the instance of a minor or a client 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.

c. An exception to the requirement for consent prior to performance of a procedure or intervention may be made in an emergency situation when a delay in obtaining consent would likely result in imminent harm to the client.

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

B. Termination of the practitioner-client relationship.

1. The practitioner or the client may terminate the relationship. In either case, the practitioner shall make the client 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 client that allows for a reasonable time to obtain the services of another practitioner.

18VAC85-150-170. 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 a subordinate to jeopardize client safety or provide client care outside of the subordinate's scope of practice or area of responsibility. Practitioners shall delegate client 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 client care or could reasonably be expected to adversely impact the quality of care rendered to a client; or

4. Exploit the practitioner-client relationship for personal gain.

B. Advocating for client safety or improvement in client 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.

~~18VAC85-150-180. Solicitation or remuneration in exchange for referral.~~

~~A practitioner shall not knowingly and willfully solicit or receive any remuneration, directly or indirectly, in return for referring an individual to a facility or institution as defined in § 37.2-100 of the Code of Virginia or hospital as defined in § 32.1-123 of the Code of Virginia.~~

~~Remuneration shall be defined as compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by 42 USC § 1320 a-7b(b), as amended, or any regulations promulgated thereto.~~

18VAC85-150-190. 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 client, or both; or

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

B. Sexual contact with a client.

1. The determination of when a person is a client 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 client until the practitioner-client relationship is terminated.

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

C. Sexual contact between a practitioner and a former client after termination of the practitioner-client 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 client care. For purposes of this section, key third party of a client means spouse or partner, parent or child, guardian, or legal representative of the client.

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 client care.

18VAC85-150-200. 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 Items: Issue periodic review decision and adoption of fast-track regulatory changes recommended by advisory board

Included in your agenda package are:

- Notice of periodic review
- Revisions to Chapter 170 recommended by advisory board

Staff note: Advisory board recommended retain Chapter 170 with amendments.

Action needed:

- Motion to retain Chapter 170 with amendments;
- Motion to adopt changes recommended by advisory board as fast-track regulatory changes.

Agency Department of Health Professions

Board Board of Medicine

Chapter Regulations Governing the Practice of Genetic Counselors [18 VAC 85 - 170]

Edit Review Review 2158

Periodic Review of this Chapter

Includes a Small Business Impact Review

Date Filed: 6/16/2022

Review Announcement

Pursuant to Executive Order 14 (as amended July 16, 2018) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, this regulation is undergoing a periodic review.

The review of this regulation will be guided by the principles in Executive Order 14 (as amended July 16, 2018). http://TownHall.Virginia.Gov/EO-14.pdf.

The purpose of this review is to determine whether this regulation should be repealed, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

In order for you to receive a response to your comment, your contact information (preferably an email address or, alternatively, a U.S. mailing address) must accompany your comment. Following the close of the public comment period, a report of both reviews will be posted on the Town Hall and a report of the small business impact review will be published in the Virginia Register of Regulations.

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

Publication Information and Public Comment Period

Published in the Virginia Register on 7/18/2022 [Volume: 38 Issue: 24]

Comment Period begins on the publication date and ends on 8/17/2022

Comments Received: 0

Review Result

Pending

Attorney General Certification

Pending

This periodic review was created by Erin Barrett on 06/16/2022 at 12:29pm

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF GENETIC COUNSELORS

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-170-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Effective Date: September 1, 2021

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

(804) 367-4600 (TEL)
(804) 527-4426 (FAX)
email: medbd@dhp.virginia.gov

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Part I. General Provisions.

18VAC85-170-10. 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"

"Genetic counselor"

"Practice of genetic counseling"

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

"ABGC" means the American Board of Genetic Counseling.

"ABMG" means the American Board of Medical Genetics.

"Active practice" means a minimum of 160 hours of professional practice as a genetic counselor within the 24-month period immediately preceding application for reinstatement or reactivation of licensure. The active practice of genetic counseling may include supervisory, administrative, educational, or consultative activities or responsibilities for the delivery of such services.

~~"Conscience clause" means the provision of § 54.1-2957.21 of the Code of Virginia.~~

"NSGC" means the National Society of Genetic Counselors.

~~**18VAC85-170-20. Public participation guidelines.**~~

~~A separate board regulation, 18VAC85-11, entitled Public Participation Guidelines, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.~~

18VAC85-170-30. Current name and address.

Each licensee 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 shall be validly given when sent to the latest address of record provided or served to the licensee. Any change of name or change in the 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.

18VAC85-170-40. Fees.

The following fees are required:

1. The application fee for licensure, payable at the time the application is filed, shall be $130.

2. The application fee for a temporary license, payable at the time the application is filed, shall be $50.

3. The biennial fee for renewal of active licensure shall be $135 and for renewal of inactive licensure shall be $70, payable in each odd-numbered year in the license holder's birth month. For 2021, the renewal fee for an active license shall be $108, and the renewal fee for an inactive license shall be $54.

4. The additional fee for late renewal of licensure within one renewal cycle shall be $50.

5. The fee for reinstatement of a license that has lapsed for a period of two years or more shall be $180 and shall be submitted with an application for licensure reinstatement.

6. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

7. The fee for a duplicate license shall be $5, and the fee for a duplicate wall certificate shall be $15.

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

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

Part II. Requirements for Licensure as a Genetic Counselor.

18VAC85-170-50. Application requirements.

An applicant for licensure shall submit the following on forms provided by the board:

1. A completed application and a fee as prescribed in 18VAC85-170-40.

2. Verification of a professional credential in genetic counseling as required in 18VAC85-170-60.

3. Verification of practice as required on the application form.

4. If licensed or certified in any other jurisdiction, documentation of any disciplinary action taken or pending in that jurisdiction.

18VAC85-170-60. Licensure requirements.

A. An applicant for a license to practice as a genetic counselor shall provide documentation of (i) a master's degree from a genetic counseling training program that is accredited by the Accreditation Council of Genetic Counseling and (ii) a current, valid certificate issued by the ABGC or ABMG to practice genetic counseling.

B. Pursuant to § 54.1-2957.19 D of the Code of Virginia, applicants for licensure who do not meet the requirements of subsection A of this section may be issued a license provided they (i) apply for licensure before December 31, 2018; (ii) comply with the board's regulations relating to the NSGC

Code of Ethics; (iii) have at least 20 years of documented work experience practicing genetic counseling; (iv) submit two letters of recommendation, one from a genetic counselor and another from a physician; and (v) have completed, within the last five years, 25 hours of continuing education approved by the NSGC or the ABGC. For the purpose of this subsection, the board deems the provisions of Part IV (18VAC85-170-110 et seq.) of this chapter to be consistent with the NSGC Code of Ethics.

C. An applicant for a temporary license shall provide documentation of having been granted the active candidate status by the ABGC. Such license shall expire 12 months from issuance or upon failure of the ABGC certification examination, whichever comes first.

Part III. Renewal and Reinstatement.

18VAC85-170-70. Renewal of license.

A. Every licensed genetic counselor who intends to maintain an active license shall biennially renew his license each odd-numbered year during his birth month and shall:

1. Submit the prescribed renewal fee; and

2. Attest to having met the continuing education requirements of 18VAC85-170-100.

B. The license of a genetic counselor that has not been renewed by the first day of the month following the month in which renewal is required is lapsed. Practice with a lapsed license may be grounds for disciplinary action. A license that is lapsed for two years or less may be renewed by payment of the renewal fee, a late fee as prescribed in 18VAC85-170-40, and attestation of compliance with continuing education requirements.

18VAC85-170-80. Inactive license.

A licensed genetic counselor who holds a current, unrestricted license in Virginia shall, upon a request at the time of renewal and submission of the required fee, be issued an inactive license. The holder of an inactive license shall not be entitled to perform any act requiring a license to practice genetic counseling in Virginia.

18VAC85-170-90. Reactivation or reinstatement.

A. To reactivate an inactive license or to reinstate a license that has been lapsed for more than two years, a genetic counselor shall submit evidence of competency to return to active practice to include one of the following:

1. Information on continued active practice in another jurisdiction during the period in which the license has been inactive or lapsed;

2. Attestation of meeting requirements for continuing education as specified in 18VAC85-170-100 for each biennium in which the license has been inactive or lapsed, not to exceed four years; or

3. Current certification by ABGC or ABMG.

B. To reactivate an inactive license, a genetic counselor shall pay a fee equal to the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure.

C. To reinstate a license that has been lapsed for more than two years a genetic counselor shall file an application for reinstatement and pay the fee for reinstatement of his licensure as prescribed in 18VAC85-170-40. The board may specify additional requirements for reinstatement of a license so lapsed to include education, experience, or reexamination.

D. A genetic counselor whose licensure has been revoked by the board and who wishes to be reinstated shall make a new application to the board, fulfill additional requirements as specified in the order from the board, and make payment of the fee for reinstatement of his licensure as prescribed in 18VAC85-170-40 pursuant to § 54.1-2408.2 of the Code of Virginia.

E. 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.

18VAC85-170-100. Continuing education requirements.

A. In order to renew an active license biennially, a licensee shall complete the Continued Competency Activity and Assessment Form that is provided by the board indicating completion of at least 50 contact hours of continuing learning activities as follows:

1. A minimum of 30 of the 50 hours shall be in Category 1 activities approved by the ABGC, the ABMG, or the NSGC and may include in-service training, self-study courses, continuing education courses, or professional workshops.

2. No more than 20 of the 50 hours may be Category 2 activities or professional activity credits, which may include consultation with another counselor or a physician, independent reading or research, authorship, clinical supervision, volunteer leadership in the profession, preparation for a presentation, or other such experiences that promote continued learning.

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

C. The licensee shall retain in his records the completed form with all supporting documentation for a period of four years following the renewal of an active license.

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

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

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

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

Part IV. Scope of Practice.

18VAC85-170-110. General responsibility.

~~A genetic counselor shall engage in the practice of genetic counseling, as defined in § 54.1-2900 of the Code of Virginia.~~ The practice of genetic counseling may include supervisory, administrative, educational, or consultative activities or responsibilities for the delivery of such services.

18VAC85-170-120. Supervisory responsibilities.

A. A genetic counselor shall be responsible for supervision of unlicensed personnel who work under his direction and ultimately responsible and accountable for patient care and outcomes under his clinical supervision.

B. Delegation to unlicensed personnel shall:

1. Not include delegation of the discretionary aspects of the initial assessment, evaluation, or development of recommendations for a patient, or any task requiring a clinical decision or the knowledge, skills, and judgment of a licensed genetic counselor;

2. Only be made if, in the judgment of the genetic counselor, the task or procedures do not require the exercise of professional judgment and can be properly and safely performed by appropriately trained unlicensed personnel, and the delegation does not jeopardize the health or safety of the patient; and

3. Be communicated on a patient-specific basis with clear, specific instructions for performance of activities, potential complications, and expected results.

18VAC85-170-125. Responsibilities of a temporary licensee.

A. A person holding a temporary license as a genetic counselor shall practice under the clinical supervision of a genetic counselor or a physician licensed in the Commonwealth.

B. Clinical supervision shall require that:

1. The supervisor and temporary licensee routinely meet to review and evaluate patient care and treatment; and

2. The supervisor reviews notes on patient care entered by the temporary licensee prior to reporting study results and making recommendations to a patient. Such review shall be documented by some method in a patient record.

Part V. Standards of Professional Conduct.

18VAC85-170-130. 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.

18VAC85-170-140. 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 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 owns 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 years 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 timeframe for record retention and destruction. Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.

~~3. When closing, selling, or relocating his practice, 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.~~

18VAC85-170-150. Practitioner-patient communication; 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~~ or diagnostic test is recommended, documented informed consent shall be obtained from the patient in accordance with the policies of the health care entity and consistent with the standard of care. ~~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 decisionmaker 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. 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.

18VAC85-170-160. 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 area of responsibility. Practitioners shall delegate patient care only to subordinates who are properly trained and supervised;

~~3.~~2. 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.~~3. Exploit the practitioner-patient relationship for personal gain.

B. Advocating for patient safety or improvement in patient care within a health care entity shall not constitute disruptive behavior provided the practitioner does not engage in behavior prohibited in subdivision A 3 of this section.

~~**18VAC85-170-170. Solicitation or remuneration in exchange for referral.**~~

~~A practitioner shall not knowingly and willfully solicit or receive any remuneration, directly or indirectly, in return for referring an individual to a facility as defined in § 37.2-100 of the Code of Virginia or hospital as defined in § 32.1-123 of the Code of Virginia.~~

~~"Remuneration" means compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by 42 USC § 1320a-7b(b), as amended, or any regulations promulgated thereto.~~

18VAC85-170-180. Sexual contact.

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

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

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

B. Sexual contact with a patient.

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

2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient neither changes the nature of the conduct nor negates 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.

18VAC85-170-190. 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: Reaffirmation of Guidance Documents 85-2, 85-20, and 85-21

Included in your agenda package are:

- Guidance Document 85-2, a 1986 opinion of the Virginia Attorney General regarding school physicals;
- Guidance Document 85-20, a 1992 opinion of the Virginia Attorney General regarding employment by nonprofit corporations; and
- Guidance Document 85-21, a 1995 opinion of the Virginia Attorney General regarding employment by for-profit corporations.

Staff Note: Legislative Committee recommended reaffirmation of Guidance Documents 85-2, 85-20, and 85-21.

Action needed:

- Motion to adopt the recommendation of the Legislative Committee to reaffirm Guidance Documents 85-2, 85-20, and 85-21.

COMMONWEALTH of VIRGINIA

Office of the Attorney General

Mary Sue Terry
Attorney General

H. Lane Kneedler
Chief Deputy Attorney General

R. Claire Guthrie
Deputy Attorney General
Human & Natural Resources Division

Gail Starling Marshall
Deputy Attorney General
Judicial Affairs Division

Walter A. McFarlane
Deputy Attorney General
Finance & Transportation Division

Stephen D. Rosenthal
Deputy Attorney General
Criminal Law Enforcement Division

Deborah Love-Bryant
Executive Assistant

October 25, 1986

The Honorable Thomas W. Athey
County Attorney for York County
P. O. Box 532
Yorktown, Virginia 23690

My dear Mr. Athey:

You ask three questions regarding the meaning of the physical examination and immunization requirements for admission of students to public schools as set forth in §§ 22.1-270 and 22.1-271.2 of the Code of Virginia. More specifically, you ask:

(1) whether an individual licensed to practice chiropractic by the Virginia State Board of Medicine is a "qualified licensed physician" for purposes of performing a physical examination within the meaning of § 22.1-270(A)(i);

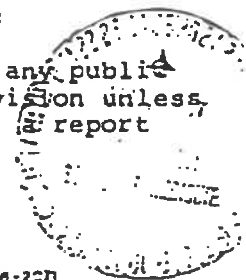
(2) whether such an individual is a "licensed physician" who may give a written certification that "one or more of the required immunizations may be detrimental to the student's health" as contemplated by § 22.1-271.2(C)(ii); and

(3) whether a general statement to the effect that the vaccines used for preschool immunization are contraindicated because each of the vaccines is accompanied by a listing of certain potentially harmful side effects, where the statement does not relate the general potential for harmful side effects to specific medical conditions or circumstances of the child, satisfies the requirements for an exemption from immunization which are set forth in § 22.1-271.2(C)(ii).

I. Chiropractor Is Not "Qualified Licensed Physician" for Purposes of § 22.1-270(A)(i)

Section 22.1-270(A) provides, in pertinent part:

"No pupil shall be admitted for the first time to any public kindergarten or elementary school in a school division unless such pupil shall furnish, prior to admission, (i) a report



> from a qualified licensed physician of a comprehensive physical examination of a scope prescribed by the State Health Commissioner performed no earlier than twelve months prior to the date such pupil first enters such public kindergarten or elementary school or (ii) records establishing that such pupil furnished such report upon prior admission to another school or school division and providing the information contained in such report." (Emphasis added.)

No definition of the term "physician" is found in Title 22.1; however, the term is defined in § 4-2(19) as "any person duly authorized to practice medicine pursuant to the laws of Virginia," and in § 8.01-581.1 as "a person licensed to practice medicine or osteopathy in this Commonwealth pursuant to Chapter 12 (§ 54-273 et seq.) of Title 54." Section 54-273(3) defines the "practice of medicine or osteopathy" as "the prevention, diagnosis and treatment of human physical or mental ailments, conditions, diseases, pain or infirmities by any means or method."

The "practice of chiropractic" is distinguished from the practice of medicine or osteopathy in § 54-273(6) and is therein defined to mean "the adjustment of the twenty-four movable vertebrae of the spinal column, and assisting nature for the purpose of normalizing the transmission of nerve energy. It does not include the use of surgery, obstetrics, osteopathy, nor the administration nor prescribing of any drugs, medicines, serums or vaccines."

A prior Opinion holds that diagnosis is contemplated as an element of the healing arts, including chiropractic. See 1981-1982 Report of the Attorney General at 193. The extent of the examination necessary to make a diagnosis, however, was not addressed. The physical examination required by § 22.1-270 is "comprehensive" and is to be of a scope prescribed by the State Health Commissioner. The standard School Entrance Physical Examination and Immunization Certification Form MCH 213B prescribes the scope of that examination to include laboratory testing, such as urinalysis, hemoglobin and tuberculin tests, as well as the certification of the immunizations about which you inquire.

I am not aware whether the training the chiropractor in question has received would enable him to interpret the required laboratory tests. I note, however, that the second portion of the form requires the examiner to certify that the child has received a proper immunization. Because chiropractors are specifically forbidden to prescribe or administer serums or vaccines

under § 54-273(6), it is my opinion that it would be contrary to the intent of the General Assembly to allow chiropractors to certify to the administration of immunizations which they themselves are not authorized to administer.[1]

In summary, because the scope of the preschool physical examination, including the certification of immunization, exceeds those areas to which a chiropractor's scope of practice is limited by § 54-273(6), I am of the opinion that a chiropractor is not a "qualified licensed physician" as contemplated by § 22.1-270.

II. Chiropractor Is Not "Licensed Physician" as Contemplated by § 22.1-271.2(C)(ii)

Section 22.1-271.2(C)(ii) provides an exception to the immunization requirements of Art. II of Ch. 14 of Title 22.1, if "the school has written certification from a *licensed physician* or a local health department that one or more of the required immunizations may be detrimental to the student's health, indicating the specific nature and probable duration of the medical condition or circumstance that contraindicates immunization." (Emphasis added.)

Because, as noted above, the administration or prescription of any drugs, medicines, serums or vaccines is specifically excluded from the definition of the practice of chiropractic in § 54-273(6), it is my opinion that a chiropractor may not render a professional opinion on the possible effects of such drugs, medicines, vaccines or serums. Furthermore, because a chiropractor may testify as an expert witness in a court of law only with respect to matters within the scope of practice of chiropractic as defined in § 54-273,[2] I am also of the opinion that a chiro-

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[1] This interpretation is consistent with the language of § 8.01-401.2, which authorizes chiropractors to testify as expert witnesses in a court of law as to "etiology, diagnosis, prognosis, and disability, including anatomical, physiological, and pathological considerations within the scope of the practice of chiropractic as defined in § 54-273," but not as to other subjects of medicine. Reading §§ 8.01-401.2 and 54-273 together, the General Assembly has specifically limited the authority of chiropractors to render opinions in a court of law to matters involving the spinal column and the transmission of nerve energy.

[2] *See supra* note 1.

practor may not render an opinion to the State Health Department on a subject about which he may not render an opinion in a court of law. As a result, it is my opinion that the certification required by § 22.1-271.2(C)(ii) is outside the scope of the practice of chiropractic and that the "licensed physician" to which the statute refers does not include a doctor of chiropractic.

III. Statement that Specific Vaccines Are Contraindicated Because of Potential Side Effects Does Not Satisfy Requirements of § 22.1-271.2(C)(ii)

Your third question asks whether a statement by a "licensed physician" that "[t]he vaccines are specifically contraindicated because of potential allergic reactions including fever, convulsion, brain damage, encephalopathy, ataxia, hyperactivity, seizure, retardation, aseptic meningitis, hemiparesis, and death and the condition is permanent" (emphasis in original) satisfies the requirement of § 22.1-271.2(C)(ii). Because § 22.1-271(C)(ii) requires that the statement indicate "the specific nature and probable duration of the medical condition or circumstance that contraindicates immunization" (emphasis added), a statement of potential side effects, without more, is, in my opinion, insufficient to satisfy the statutory requirement.

The obvious purpose of § 22.1-271.2(C)(ii) is to exempt children from the immunization requirement when it has been demonstrated that immunization poses a higher risk to the student's health than the risk of contracting one of the diseases against which the immunization is directed. The statement proffered above is a generalization not meeting the purpose or intent of the certification requirement set forth in the statute. Accordingly, I am of the opinion that the statement is not legally sufficient.

With kindest regards, I am

Sincerely,

Mary Sue Terry
Attorney General

6:14/54-077

Reviewed and reaffirmed: October 6, 2022

Office of the Attorney General

COMMONWEALTH of VIRGINIA
Office of the Attorney General

Mary Sue Terry
Attorney General

H. Lane Kneedler
Chief Deputy Attorney General

Deborah Love-Bryant
Chief-of-Staff

K. Marshall Cook
Deputy Attorney General
Finance & Transportation Division

R. Claire Guthrie
Deputy Attorney General
Human & Natural Resources Division

Gail Starling Marshall
Deputy Attorney General
Judicial Affairs Division

Stephen D. Rosenthal
Deputy Attorney General
Public Safety & Economic Development Div.

December 7, 1992

The Honorable Robert S. Bloxom
Member, House of Delegates
Box 27
Mappsville, Virginia 23407

My dear Delegate Bloxom:

You ask whether a proposed agreement between a hospital and an orthopedic surgeon, under which the surgeon would be employed directly by the hospital as a full-time member of its medical staff, would violate any of the provisions of Title 54.1 of the *Code of Virginia* pertaining to the practice of medicine. You also ask whether the proposed employment is prohibited by statutes pertaining to professional corporations.

I. Facts

A nonstock, nonprofit corporation operates Northampton-Accomack Memorial Hospital (the "Hospital") in Nassawaddox, Virginia. The Hospital services two Eastern Shore counties, both of which have widely dispersed populations and a relatively high percentage of patients who are indigent or whose medical services are paid for by government programs. The closest other hospitals are 75 miles to the north, in Maryland, and 55 miles to the south, across the Chesapeake Bay. You state that the Hospital's rural location has hampered its efforts to recruit physicians, particularly specialists.

Under the proposed agreement, the Hospital would employ an orthopedic surgeon, licensed by the Commonwealth to practice medicine, as a full-time member of its medical staff. This physician would be paid a salary by the Hospital. The Hospital would bill patients for the physician's services and would retain all amounts collected. The physician would be permitted to exercise independent professional judgment and would be solely responsible both for the medical care of patients and for the supervision of any "technical" employees of the Hospital who assist the physician in rendering medical services. I assume that these "technical" employees could include unlicensed individuals who administer various diagnostic tests and treatments ordered by physicians in accordance with Hospital protocols.

II. Applicable Statutes

A. Practice of Medicine

Articles 1 through 6, Chapter 29 of Title 54.1, containing §§ 54.1-2900 through 54.1-2973, define the practice of medicine and other specialties regulated by the Board of Medicine (the "Board"), establish eligibility requirements for licensure in the Commonwealth and detail the unprofessional conduct

that may subject a licensee of the Board to professional discipline. Generally, the "'[p]ractice of *medicine or osteopathic medicine*' means the prevention, diagnosis and treatment of human physical or mental ailments, conditions, diseases, pain or infirmities by any means or method." Section 54.1-2900. Section 54.1-2901(6) provides that personnel employed by a physician, to whom the physician delegates nondiscretionary duties for which the physician assumes responsibility, are expressly excluded from the definition of the practice of medicine and thus from the licensing requirements in Chapter 29. Sections 54.1-2902 and 54.1-2929 make it unlawful to practice medicine without a license.

Section 54.1-2903 defines the practice of medicine as follows:

> Any person shall be regarded as practicing the healing arts who actually engages in such practice as defined in this chapter, or who opens an office for such purpose, or who advertises or announces to the public in any manner a readiness to practice or who uses in connection with his name the words or letters "Doctor," "Dr.," "M.D.," "D.O.," "D.P.M.," "D.C.," "Healer," "Physical Therapist," "R.P.T.," "P.T.," "L.P.T.A.," "Clinical Psychologist," or any other title, word, letter or designation intending to designate or imply that he is a practitioner of the healing arts or that he is able to heal, cure or relieve those suffering from any injury, deformity or disease.

Section 54.1-2964 defines certain standards of medical practice:

> A. Any practitioner of the healing arts shall, prior to referral of a patient to any facility or entity engaged in the provision of health-related services, appliances or devices, including but not limited to physical therapy, hearing testing, or sale or fitting of hearing aids or eyeglasses provide the patient with a notice in bold print that discloses any known material financial interest of or ownership by the practitioner in such facility or entity and states that the services, appliances or devices may be available from other suppliers in the community. In making any such referral, the practitioner of the healing arts may render such recommendations as he considers appropriate, but shall advise the patient of his freedom of choice in the selection of such facility or entity. This section shall not be construed to permit any of the practices prohibited in § 54.1-2914.

Section 54.1-2914 details the grounds on which a physician may be considered guilty of unprofessional conduct. The division of fees between surgeons and other physicians is prohibited by § 54.1-2962. Section 54.1-2962.1 provides:

> No practitioner of the healing arts shall knowingly and willfully solicit or receive any remuneration directly or indirectly, in cases or in kind, in return for referring an individual or individuals to a facility or institution as defined in § 37.1-179 or a hospital as defined in § 32.1-123. The Board shall adopt regulations as necessary to carry out the provisions of this section. Such regulations shall exclude from the definition of "remuneration" any payments, business arrangements, or payment practices not prohibited by Title 42, Section 1320a-7b (b) of the United States Code, as amended, or any regulations promulgated pursuant thereto.

The federal statute to which § 54.1-2962.1 refers provides that the prohibition against receiving remuneration for patient referrals shall not apply to "any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services." 42 U.S.C. § 1320a-7b(b)(3)(B).

B. Professional Corporations

Professional corporations are organized under Chapter 7 of Title 13.1, §§ 13.1-542 through 13.1-556.

A "professional corporation" is defined in § 13.1-543(B) as

> (i) a corporation which is organized under this chapter for the sole and specific purpose of rendering professional service and which has as its shareholders only individuals who themselves are duly licensed or otherwise legally authorized within this Commonwealth to render the same professional service as the corporation; or ... (iii) a corporation which is organized under this chapter or under Chapter 10 [pertaining to nonstock corporations] of this title for the sole and specific purpose of rendering the professional services of one or more practitioners of the healing arts, licensed under the provisions of Chapter 29 of Title 54.1 ... and all of whose shares are held by or all of whose members are persons duly licensed or otherwise legally authorized to perform the services of a practitioner of the healing arts ....

Licensed professionals may organize and become shareholders in a professional corporation for pecuniary profit and may become members of a nonstock corporation for the "sole and specific purpose of rendering the same and specific professional service, subject to any laws, not inconsistent with the provisions of this chapter, which are applicable to the practice of that profession in the corporate form." Section 13.1-544.

Section 13.1-546 provides:

> No corporation organized and incorporated under this chapter may render professional services except through its officers, employees and agents who are duly licensed or otherwise legally authorized to render such professional services within this Commonwealth ....

III. "Corporate Practice of Medicine" Doctrine Precluding Hospital Corporation's Employment of Physician Not Adopted in Virginia Statute or Court Decision

The courts in a number of other states have developed what is known as the "corporate practice of medicine" doctrine, holding that, since a corporation may not lawfully practice medicine, a corporation may not employ a doctor as an agent to practice medicine for it. Under the doctrine, a physician hired by the corporation would also be unlawfully practicing medicine. *See, e.g., Dr. Allison, Dentist, Inc. v. Allison*, 360 Ill. 638, 196 N.E. 799 (1935); *Parker v. Board of Dental Examiners*, 216 Cal. 285, 14 P.2d 67 (1932); *see also Rockett v. Texas State Board of Medical Examiners*, 287 S.W.2d 190 (Tex. Civ. App. 1956). Those decisions were influenced primarily by statutory and public policy concerns that the medical community could be subject to commercial exploitation that would result in divided loyalties,

motivated by profit and improper lay control over professional decisions. These concerns generally were allayed by structuring contractual relationships in which the physician maintains an "independent contractor" status with the hospital and sole control over diagnosis and treatment of the patient. Although there is no court decision or statute in Virginia adopting the "corporate practice of medicine" doctrine,[1]

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[1]The fact that Virginia does not adhere strictly to the "corporate practice of medicine" doctrine has been recognized by the *Report of the Department of Health and the Department of Health Professions on Commercial Walk-In Medical Clinics in the Commonwealth*: "The [American Medical Association] encourages states to consider prohibitions on the 'corporate practice of medicine,' but in the view of the Task Force the use of the state's regulatory authority to restrict physicians from affiliating with commercial corporations may invite federal scrutiny under antitrust provisions of the Sherman and Federal Trade Commission Acts. In Virginia, statutes prohibiting physician practice in connection with commercial or mercantile establishments were repealed in 1986." 2 H. & S. DOCS., H. DOC. NO. 45, at 18 (1990 Sess.). Under one such repealed statute, § 54-278.1, it was unlawful for a physician to practice "as a lessee of any commercial or mercantile establishment." VA. CODE ANN. *id.* (Michie Repl. Vol. 1982).

Arguments favoring the existence of the "corporate practice of medicine" doctrine in Virginia are predicated only on inference. First, proponents of the doctrine infer its existence from the fact that only an individual, and not a corporation, may be licensed to practice medicine. That fact, however, does not preclude a corporation from employing a licensed individual. *See* §§ 54.1-2901, 54.1-2902.

Second, proponents of the doctrine note that § 38.2-4319(C) states: "A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law." There is, however, another explanation for this statutory language. Health maintenance organizations ("HMOs") arrange, pay for or reimburse costs of health care services for its members or enrollees. *See* § 38.2-4303. Without the exception in § 38.2-4319(C), HMO enrollees or their physicians might argue that a refusal of an HMO's agent, presumably unlicensed, to authorize reimbursement for certain medical services, such as extra days of hospitalization for a routine operation, constitutes the unlawful practice of medicine by an unlicensed person.

Third, proponents of the "corporate practice of medicine" doctrine cite § 54.1-2941, which provides express authority for state-owned medical care institutions to employ licensed practitioners, and infer from this language that other institutions may not do so. However, § 54.1-2941 was enacted before the repeal of other statutes prohibiting physician practice in commercial or mercantile establishments that might have been construed to prohibit corporate employment of physicians. Moreover, the Commonwealth may have a different relationship with patients at state institutions than private hospitals have with their patients. Without the express authority for state employment of physicians in § 54.1-2941, patients treated in state facilities might claim their physicians had a conflict of interests. This concern underscores the importance of all licensees' maintaining their independent professional judgment, whether employed in state or private institutions, but § 54.1-2941 does not preclude private hospitals from employing licensed physicians under appropriate circumstances.

Further, Virginia's professional corporation statutes, §§ 13.1-542 through 13.1-556, apply to professions in addition to those practicing the healing arts, and the availability of this corporate form has multiple purposes. It would be overreaching to conclude that the statutory framework for professional corporations precludes nonprofessional corporations from employing physicians. Indeed, other statutes illustrate the General Assembly's willingness to prohibit employment relationships for other health care professionals. *See, e.g.*, §§ 54.1-3205, 54.1-3205.1, 54.1-2716 to 54.1-2718 (expressly prohibiting commercial or mercantile employment of optometrists and dentists). If the General Assembly had intended to impose a similar prohibition on corporate employment of physicians, it could have done so in the same express manner.

many Virginia hospitals desiring to retain physicians' services have contracted with physicians as independent contractors. *See, e.g., Stuart Circle Hosp. Corp. v. Curry*, 173 Va. 136, 3 S.E.2d 153 (1939); 1954-1955 ATT'Y GEN. ANN. REP. 146.

IV. Professional Corporation Statutes Permit Properly Licensed Employee to Practice Medicine

In Virginia, a licensed professional, such as a physician, may become a member of a nonstock corporation organized to render professional services. Section 13.1-544. Such a professional corporation likewise has specific statutory authority to employ other persons licensed in the same profession to provide professional services. *See* § 13.1-546.

From the facts you provide, it is not clear whether the nonstock corporation operating the Hospital is a "professional corporation" as defined in § 13.1-543(B) or, if so, whether the physician will be a member of such a professional corporation. If those are the circumstances, the Hospital clearly has authority to employ the physician. According to a recent opinion of the Supreme Court of Virginia, however, § 13.1-546 "does not allow a professional corporation to render professional services through an independent contractor." *Palumbo v. Bennett*, 242 Va. 248, 251, 409 S.E.2d 152, 153 (1991).[2]

V. Physician May Perform Professional Services for Nonprofessional Corporation as Employee if Professional Independence Guaranteed

A prior Opinion of this Office concludes that a foundation organized as a nonstock, nonprofit corporation that has no members may employ physicians to provide medical care, and not be deemed to be practicing medicine unlawfully, as long as the physicians' exercise of professional judgment is not controlled or influenced in any way by the corporation. 1989 ATT'Y GEN. ANN. REP. 283, 285.[3]

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[2]In *Palumbo*, the Court held that, although a contract defining a physician as an independent contractor violated the statute, the contract might not be unenforceable. Although the Court recognized that "certain professionals [may] render professional services as officers, employees, or agents of a professional corporation," 242 Va. at 252, 409 S.E. 2d at 154, the Court apparently did not consider an independent contractor to be an "agent" of the professional corporation for purposes of § 13.1-546 under the facts of that case.

[3]An earlier Opinion of the Attorney General concludes that, under the medical licensure statutes in effect in 1955, a hospital which employed a physician might be engaging in the practice of medicine if there was a direct patient-physician relationship, but the hospital billed the patient for the physician's services. That Opinion further concludes that a physician having direct access to the patient should have billed that patient directly. Conversely, the hospital could bill for the services of a radiologist who provided support services for a patient, but did not have direct patient contact. That Opinion also concludes that a determination of what constitutes the practice of medicine must be made on a case-by-case basis. 1954-1955 ATT'Y GEN. ANN. REP. 146, 147. Under the current statutes, with more complex corporate structures now in use, sophisticated professional specialties, and more complicated liability issues, it is my opinion that this determination is more properly based on the physician's retention of professional judgment, rather than on the extent of his patient access or billing.

You indicate that the proposed employment agreement between the physician and the Hospital will give the physician exclusive control over decisions requiring professional medical judgment. Even though the physician is an employee of the Hospital, therefore, it is my opinion that the Hospital will not be engaging in the unlawful practice of medicine merely by paying a salary to the physician.

You also state that the proposed agreement would give the physician supervisory responsibility for unlicensed technical employees of the Hospital. Under § 54.1-2901(6), unlicensed individuals in the personal employ of a physician to whom the physician delegates nondiscretionary duties are expressly excluded from the definition of the practice of medicine. In the facts you present, however, the technical personnel would be employees of the Hospital, although supervised by the physician. Because the activities of these employees would not automatically be excluded from the definition of the practice of medicine, these unlicensed individuals must not engage in practices for which licensure is required. *See also* § 54.1-111.

VI. Conclusion

Based on the above, it is my opinion that Virginia statutes and court decisions allow the Hospital to retain the physician as an employee, as long as the agreement authorizes the physician to exercise control over the diagnosis and treatment of the patient, the physician's professional judgment is not improperly influenced by commercial or lay concerns and the physician-patient relationship is not altered.

With kindest regards, I am

Sincerely,

Mary Sue Terry
Attorney General

6:32/54-214

PROFESSIONS AND OCCUPATIONS: MEDICINE AND OTHER HEALING ARTS — PHARMACY — DRUG CONTROL ACT - PERMITTING OF PHARMACIES.

For-profit subsidiary corporations, wholly owned by general hospital operated by nonprofit tax-exempt hospital corporation, will not be engaging in unlawful practice of medicine or in unlawful practice of pharmacy by paying salaries of licensed physicians and pharmacists employed by them, as long as physicians exercise exclusive control over decisions requiring professional medical judgment, and pharmacists exercise independent professional judgment in dispensing drugs.

May 22, 1995

The Honorable Jackie T. Stump
Member, House of Delegates

You ask whether the formation by a nonprofit, tax-exempt hospital corporation of two for-profit subsidiary corporations for the purposes of employing physicians and operating a retail pharmacy would violate any of the provisions of Title 54.1 of the *Code of Virginia* pertaining to the practice of either medicine or pharmacy.

You relate that a nonstock, nonprofit corporation operates a general hospital in Southwest Virginia. The hospital serves counties with widely dispersed populations, and a relatively high percentage of the patients in these counties are indigent or their medical services are paid by government programs. You state that efforts to recruit physicians—in particular, specialists—have been hindered due to the hospital's rural location.

Under the proposed arrangement, the hospital would form a wholly owned for-profit subsidiary corporation ("physician subsidiary") to employ one or more physicians, licensed by the Commonwealth to practice medicine, as full-time members of its medical staff. You state that the physicians would be employees of the physician subsidiary, which would be controlled by a board of directors that may consist of one or more members of the board of directors of the hospital, as well as members from the community at large. The physician subsidiary would bill patients for the physicians' services and would pay the physicians' salaries. If so directed by the board of the physician subsidiary, the hospital would receive dividends from the physician subsidiary should its revenues exceed operating costs.

Physicians employed by the physician subsidiary would exercise their independent professional judgment, and would be solely responsible for the medical care of patients and for the supervision of unlicensed technical employees administering diagnostic treatments and tests ordered by the physicians in accordance with hospital or subsidiary protocols.

You also relate that a separate for-profit subsidiary corporation ("pharmacy subsidiary") would be established to own and operate a retail pharmacy to meet the needs of

both the hospital's patients and the general public. The pharmacy subsidiary would employ a pharmacist or pharmacists, licensed by the Commonwealth, to practice pharmacy. An independent board of directors would be appointed to direct the activities of the pharmacy subsidiary, although one or more of the members also may be members of the hospital's board of directors. I assume the pharmacy subsidiary would bill patients for pharmacy services and would retain all sums collected. If so directed by the board of the pharmacy subsidiary, the hospital would receive dividends from the pharmacy subsidiary should its revenues exceed operating costs.[1]

Articles 1 through 6, Chapter 29 of Title 54.1, §§ 54.1-2900 through 54.1-2973, define the practice of medicine and other specialties regulated by the Board of Medicine, and establish eligibility requirements for licensure in the Commonwealth. Generally, "'*practice of medicine or osteopathic medicine*' means the prevention, diagnosis and treatment of human physical or mental ailments, conditions, diseases, pain or infirmities by any means or method."[2] Sections 54.1-2902 and 54.1-2929 make it unlawful to practice medicine without a license. Section 54.1-111(A)(1) also provides that it is "unlawful for any person, partnership, corporation or other entity" to practice "a profession or occupation without holding a valid license as required by statute or regulation."[3]

Prior opinions of the Attorney General conclude that a nonprofit hospital corporation and a foundation organized as a nonstock, nonprofit corporation that has no members may employ physicians to provide medical care and not be deemed to be practicing medicine unlawfully, as long as the physicians' exercise of professional judgment is not controlled or influenced in any way by the corporations.[4]

You indicate that the proposed employment arrangement between licensed physicians and the physician subsidiary will give the physicians exclusive control over decisions requiring professional medical judgment. Therefore, even though licensed physicians would be employees of the physician subsidiary, it is my opinion that the subsidiary would not be engaging in the unlawful practice of medicine merely by paying the salaries of those physicians.

Chapter 33 of Title 54.1, §§ 54.1-3300 through 54.1-3319, defines the practice of pharmacy, establishes eligibility requirements for licensure in the Commonwealth, and details unprofessional conduct that may subject a licensee of the Board of Pharmacy to discipline. Section 54.1-3300 includes the following definition:

> "*Practice of pharmacy*" means the personal health service that is concerned with the art and science of selecting, procuring, recommending, administering, preparing, compounding, packaging and dispensing of drugs, medicines and devices used in the diagnosis, treatment, or prevention of disease, whether compounded or dispensed on a prescription or otherwise legally dispensed or distributed, and shall include the proper and safe storage and distribution of drugs, the maintenance of proper records and the

responsibility of providing information concerning drugs and medicines and their therapeutic values and uses in the treatment and prevention of disease.

Section 54.1-3310 makes it unlawful to practice pharmacy without a license.

Section 54.1-3432 states that "[e]very pharmacy shall be under the personal supervision of a pharmacist on the premises of the pharmacy." In § 54.1-3434, the General Assembly expressly anticipates that a pharmacist-in-charge may be employed by a pharmacy owned by a legal corporation or partnership.[6] That section permits such an arrangement, as long as the pharmacist-in-charge applies for a permit, provides requested information and retains authority to exercise professional judgment in the dispensing of drugs.

I assume that the proposed employment arrangement between licensed pharmacists and the pharmacy subsidiary will give the pharmacists exclusive control over decisions regarding the dispensing of drugs. As long as licensed pharmacists exercise independent professional judgment in the dispensing of drugs, it is my opinion that the pharmacy subsidiary will not be engaging in the unlawful practice of pharmacy merely by paying the salaries of those pharmacists.

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[1]I assume that the factual details are such that the proposed arrangement would not violate the Practitioner Self-Referral Act, §§ 54.1-2410 through 54.1-2414, or applicable provisions of § 54.1-2962.1 (prohibiting solicitation or receipt of remuneration in return for patient referral) and § 54.1-2964 (disclosing interest or ownership in referral facilities and clinical laboratories). For the purposes of this opinion, I also assume that the facts are such that the proposed arrangement would be consistent with the physicians' obligations under § 1877 of the Social Security Act, which became effective for most purposes on January 1, 1995. *See* 42 U.S.C.A. § 1395nn (West Supp. 1995). This federal statute prohibits a physician who has a financial relationship with an entity from referring Medicare patients to the entity to receive any designated health services. *See id.* § 1395nn(a)(1)(A). A financial relationship may exist as an ownership or investment relationship or in a compensation arrangement with an entity. *See id.* § 1395nn(a)(2). Compensation arrangements exist when there is any arrangement in which payment of any kind, including a salary or consulting fee, passes between a physician or a member of the physician's immediate family and an entity, such as a hospital. *See id.* § 1395nn(h)(1).

[2]Section 54.1-2900; *see also* § 54.1-2903.

[3]Prior opinions of the Attorney General discuss in detail the statutes and court decisions pertaining to the practice of medicine. *See* Op. Va. Att'y Gen.: 1992 at 147; 1989 at 283.

[4]*See* Op. Va. Att'y Gen.: 1992, *supra*, at 150; 1989, *supra*, at 285. In Virginia, each health regulatory board has its own basic law and has developed regulations applicable to the professions it regulates. Judicial decisions that pertain to a particular health profession are appropriately based on statutes and regulations pertinent to the profession at issue. Because there are significant differences among the statutes and regulations pertaining to each health profession, judicial decisions based on a particular profession's basic law and regulations are not generalizable across professions. For example, in the case of *Virginia Beach S.P.C.A., Inc. v. South Hampton Roads Veterinary Association, et al.*, the Supreme Court of Virginia relied on specific regulations of the Virginia Board of Veterinary Medicine to conclude that an S.P.C.A.'s operation of a full-service veterinary clinic, despite employment of a fully licensed veterinarian, constituted the unlawful

practice of veterinary medicine. 229 Va. 349, 329 S.E.2d 10 (1985). These regulations prohibited the registration of any animal facility unless the owner, partner or officer of the facility was a licensed veterinarian and, further, characterized as "unprofessional conduct" the forming, entering or being employed by a partnership or corporation to practice veterinary medicine in which any other partner or corporation officer is not a licensed veterinarian. *Id.* at 352-53, 329 S.E.2d at 12. Since there are no similar statutory or regulatory provisions pertaining to the Board of Medicine or the Board of Pharmacy, the Supreme Court decision affects only the Board of Veterinary Medicine. Further, as discussed in detail in a prior opinion, statutes prohibiting physician practice in connection with commercial or mercantile establishments were repealed in 1986. *See* 1992 Op. Va. Att'y Gen., *supra* note 3, at 151 n.1; *see also* Ch. 87, 1986 Va. Acts Reg. Sess. 114.

Similarly, the Virginia Supreme Court's decision in *Ritholz v. Commonwealth* was based on statutes pertinent to the practice of optometry, and did not involve the practice of medicine or pharmacy. 184 Va. 339, 35 S.E.2d 210 (1945).

[5]Section 54.1-3434 requires that "[n]o person shall conduct a pharmacy without first obtaining a permit from the Board [of Pharmacy]." This statute requires that the application for the permit be "signed by a pharmacist who will be in full and actual charge of the pharmacy and who will be fully engaged in the practice of pharmacy at the location designated on the application." Further, § 54.1-3434 expressly anticipates that the pharmacy may have a corporate owner and requires that the pharmacist-in-charge be permitted to exercise independent professional judgment, by providing:

"The application shall show the corporate name and trade name and shall list any pharmacist in addition to the pharmacist-in-charge practicing at the location indicated on the application.

"If the owner is other than the pharmacist making the application, the type of ownership shall be indicated and shall list any partner or partners, and, if a corporation, then the corporate officers and directors. Further, if the owner is not a pharmacist, he shall not abridge the authority of the pharmacist-in-charge to exercise professional judgment relating to the dispensing of drugs in accordance with this act and Board regulations.

"The permit shall be issued only to the pharmacist who signs the application as the pharmacist-in-charge and as such assumes the full responsibilities for the legal operation of the pharmacy. This permit and responsibilities shall not be construed to negate any responsibility of any pharmacist or other person.

"Upon termination of practice by the pharmacist-in-charge, or upon any change in partnership composition, or upon the acquisition of the existing corporation by another person, the permit previously issued shall be immediately surrendered to the Board by the pharmacist-in-charge to whom it was issued, or by his legal representative, and an application for a new permit may be made ...."

Agenda Items: Adopt revisions to Guidance Document 85-1

Included in your agenda package are:

- Proposed revisions to Guidance Document 85-1 as recommended by the Legislative Committee in both redline and clean version

Action needed:

- Motion to accept recommendation of Legislative Committee regarding revisions to Guidance Document 85-1

VIRGINIA BOARD OF MEDICINE

BYLAWS

PART I: THE BOARD

Article I – Members

The appointment and limitations of service of the members shall be in accordance with §~~Section~~ 54.1-2911 of the Code of Virginia.

Article II - Officers of the Board

Section 1. Offices and Titles – Officers of the Board shall consist of a president, vice-president and secretary/treasurer. All shall be elected by the Board for a term of one year. The term of each office shall begin at the conclusion of the June Board meeting and end at the conclusion of the subsequent June Board meeting.

A. President: The president shall preserve order and preside at all meetings according to parliamentary rules, the Virginia Administrative Process Act, and the Virginia Freedom of Information Act. The president shall appoint the members of the Executive Committee, Credentials Committee, Finance Committee, Committee of the Joint Boards of Medicine and Nursing, and ad hoc committees of the Board. He shall sign his name as president to the certificates authorized to be signed by the president.

B. Vice President: The vice president shall act as president in the absence of the president. The vice president shall preserve order and preside at all meetings of the Legislative Committee according to parliamentary rules, the Virginia Administrative Process Act, and the Virginia Freedom of Information Act. He shall, in consultation with the president, appoint the members of the Legislative Committee and shall sign his name as vice-president to the certificates authorized to be signed by the vice-president.

C. Secretary/Treasurer: The secretary/treasurer shall be knowledgeable of budgetary and financial matters of the Board. The secretary/treasurer shall preserve order and preside at all meetings of the Finance Committee according to parliamentary rules, the Virginia Administrative Process and the Virginia Freedom of Information Act. He shall sign his name as secretary/treasurer to the certificates authorized to be signed by the secretary/treasurer.

D. The officers of the Board shall faithfully perform the duties of their offices and shall coordinate with staff regularly on matters pertaining to their offices.

E. Order of succession: In the event of a vacancy in the office of president, the vice president shall assume the office of president for the remainder of the term. In the event of a vacancy in the office of vice president, the secretary/treasurer shall assume the office of vice president for the remainder of the term. In the event of a vacancy of the

office of secretary/treasurer, the president shall appoint a ~~b~~Board member to fill the vacancy for the remainder of the term.

F. The Executive Director shall keep true records of all general and special acts of the Board and all ~~papers~~ documents of value. When a committee is appointed for any purpose, he shall notify each member of his appointment and furnish any essential document or information at his command. He shall conduct the correspondence of the Board when requested and shall sign certificates authorized to be issued by the Board and perform all such other duties as naturally pertain to his position.

Article III - Meetings

Section 1. Frequency of meetings: The Board shall meet at least three times a year.

Section 2. Order of Business Meetings - The order of business shall be as follows:

Call to order

Roll call

Approval of minutes of preceding regular Board meeting and any called meeting since the last regular meeting of the Board

Adoption of Agenda

Public Comment Period

Report of Officers and Executive Director:
- President
- Vice President
- Secretary/Treasurer
- Executive Director

Report of Committees:
- Executive Committee
- Legislative Committee
- Credentials Committee
- Finance Committee
- Other Standing Committees
- Ad Hoc Committees

Report of Advisory Boards
- Acupuncture
- Athletic Training
- Midwifery
- Occupational Therapy
- Physician Assistant
- Radiological Technology

Respiratory Care
Behavior Analysis
Polysomnographic Technology
Genetic Counseling

Old Business

New Business

Election of Officers

Article IV – Committees

Section 1. Standing committees. The standing committees of the Board shall consist of the following:

Executive Committee
Legislative Committee
Credentials Committee
Finance Committee
Committee of the Joint Boards of Medicine and Nursing
Other Standing Committees

A. **Executive Committee**. The Executive Committee shall consist of the president, vice-president, the secretary-treasurer and five other members of the board appointed by the president. The Executive Committee shall include at least two citizen members. The president shall serve as chairman of the Executive Committee. In the absence of the Board, the executive committee shall have full powers to take any action and conduct any business as authorized by § 54.1-2911 of the Code of Virginia. Five members of the executive committee shall constitute a quorum.

B. **Legislative Committee**. The Legislative Committee shall consist of seven Board members appointed by the vice-president of the Board in consultation with the President. The vice president of the Board or his designee will serve as chair. The committee shall consider all questions bearing upon state and federal legislation, and regulations. The Legislative Committee shall recommend changes in the law and regulations as it may deem advisable and, at the direction of the Board, shall take such steps as may further the desire of the Board in matters of legislation and regulations. The committee shall submit proposed changes in the rules and regulations of the Board in writing to all Board members prior to any scheduled meeting of the Board.

C. **Credentials Committee**. The Credentials Committee shall consist of nine members of the Board appointed by the President and shall satisfy itself that applicants for licensure by endorsement or by examination fulfill the requirements of the Board. The Committee shall review the credentials of the applicants who may fail to meet the requirements of the Board as specified in statute or regulation. The Committee may hear credentialing issues in accordance with §2.2-4019~~, §2.2-4020~~ and §2.2-4021 of the Code of Virginia and guidelines adopted by the Board.

D. **Finance Committee**. The Finance Committee shall consist of the secretary/treasurer, two other members appointed by the president and the Executive Director shall act ex officio to the committee. This committee shall be responsible for making recommendations to the Board regarding all financial matters. The committee shall meet as necessary.

E. **Committee of the Joint Boards of Medicine and Nursing.** The Committee shall be appointed in accordance with § 54.1-2957 of the Code of Virginia and shall function as provided in 18VAC90-30-30 of the Regulations Governing the Licensure of Nurse Practitioners~~ (18VAC 90-30-30)~~.

F. Members appointed to a committee shall faithfully perform the duties assigned to the committee. Committee chairs shall regularly communicate with staff on matters pertaining to the committee.

Section 2. Ad Hoc Committees.

A. The Board or any of its standing committees may establish such ad hoc committees as are deemed necessary to assist the Board or committee in its work.

B. The members of an ad hoc committee shall be appointed by the ~~chair~~ president of the B~~b~~oard or the chair of the committee creating the ad hoc committee. The chair may appoint members to an ad hoc committee who are not members of the B~~b~~oard when it serves the purpose of the committee.

C. All members of an ad hoc committee shall have full and equal voting rights.

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Article V – Elections

The Board shall appoint a Nominating Committee at its February meeting. The Nominating ~~c~~Committee shall present the names of candidates for office to the Board for election at its June meeting. In the event that the offices are vacated and succession is not possible, the Board shall appoint ~~the~~ a Nominating Committee which will develop a slate of candidates for the Board's consideration at its next meeting.

Amendments to Bylaws

Amendments to these bylaws may be proposed by presenting the amendments in writing to all ~~b~~Board members seven calendar days prior to any scheduled ~~b~~Board meeting.

VIRGINIA BOARD OF MEDICINE

BYLAWS

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F. The Executive Director shall keep true records of all general and special acts of the Board and all documents of value. When a committee is appointed for any purpose, he shall notify each member of his appointment and furnish any essential document or information at his command. He shall conduct the correspondence of the Board when requested and shall sign certificates authorized to be issued by the Board and perform all such other duties as naturally pertain to his position.

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- Vice President
- Secretary/Treasurer
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- Credentials Committee
- Finance Committee
- Other Standing Committees
- Ad Hoc Committees

Report of Advisory Boards
- Acupuncture
- Athletic Training
- Midwifery

Occupational Therapy
Physician Assistant
Radiological Technology
Respiratory Care
Behavior Analysis
Polysomnographic Technology
Genetic Counseling

Old Business

New Business

Election of Officers

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by endorsement or by examination fulfill the requirements of the Board. The Committee shall review the credentials of the applicants who may fail to meet the requirements of the Board as specified in statute or regulation. The Committee may hear credentialing issues in accordance with §2.2-4019 and §2.2-4021 of the Code of Virginia and guidelines adopted by the Board.

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B. The members of an ad hoc committee shall be appointed by the president of the Board or the chair of the committee creating the ad hoc committee. The chair may appoint members to an ad hoc committee who are not members of the Board when it serves the purpose of the committee.

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Article V – Elections

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Amendments to Bylaws

Amendments to these bylaws may be proposed by presenting the amendments in writing to all Board members seven calendar days prior to any scheduled Board meeting.

Agenda Items: Adopt revisions to Guidance Document 85-4

Included in your agenda package are:

- Proposed revisions to Guidance Document 85-4 as recommended by the Legislative Committee in both redline and clean version

Action needed:

- Motion to accept recommendation of Legislative Committee regarding revisions to Guidance Document 85-4

Guidance document: 85-4 Adopted: October 18, 2018Revised: October 6, 2022

Effective: December 8, 2022

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Virginia Board of Medicine

Approved Continuing Education Providers for Chiropractors

18VAC85-20-235(A)(1)(a) states that Type 1 continuing education hours in chiropractic shall be clinical hours that are approved by a college or university accredited by the Council on Chiropractic Education or any other organization approved by the Board.

The Board has approved the following organizations for Type 1 continuing education hours in chiropractic pursuant to 18VAC85-20-235(A)(1)(a):

1. Providers of Approved Continuing Education (PACE), a program of the Federation of Chiropractic Licensing Boards (FCLB), which was approved upon motion and vote of the Board at its February 19, 2015 meeting; and
2. The Virginia Chiropractic Association, which was approved upon motion and vote of the Board at its October 18, 2018 meeting.

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At its February 19, 2015 meeting, the Board of Medicine addressed the question of whether the new program of the Federation of Chiropractic Licensing Boards (FCLB) for continuing education, entitled Providers of Approved Continuing Education (PACE), could be considered as approved for Type 1 continuing competency hours for chiropractic for renewal and reinstatement. Regulations of the Board on continuing competency requirements specify that "Type 1 hours in chiropractic shall be clinical hours that are approved by a college or university accredited by the Council on Chiropractic Education or any other organization approved by the board."

The Board of Medicine FCLB's PACE program could be accepted as "any other organization approved by the board" in accordance with its regulations. Therefore, it voted unanimously to approve such continuing education submitted by chiropractors in satisfaction of their renewal or reinstatement requirements in Virginia.

At its October 18, 2018 meeting, the Board addressed the request by the Virginia Chiropractic Association to have continuing education offered by its group to be accepted as "any other organization approved by the board" in accordance with its regulations. Therefore, it voted unanimously to approve such continuing education submitted by chiropractors in satisfaction of their renewal or reinstatement requirements in Virginia.

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Board of Medicine

Approved Continuing Education Providers for Chiropractors

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2. The Virginia Chiropractic Association, which was approved upon motion and vote of the Board at its October 18, 2018 meeting.

Agenda Items: Adopt revisions to Guidance Document 85-6

Included in your agenda package are:

- Proposed revisions to Guidance Document 85-6 as recommended by the Legislative Committee
- Existing Guidance Document 85-6

Staff Note: Formatting issues in the existing guidance document prevented making changes via redline.

Action needed:

- Motion to accept recommendation of Legislative Committee regarding revisions to Guidance Document 85-6

Board of Medicine
Competency Assessments for Three Paid Claims

Virginia Code § 54.1-2912.3 states that the Board shall require a competency assessment of any person with an active license on whose behalf three separate medical malpractice judgments or settlements of more than $75,000 each are paid within the most recent 10-year period. The statute requires that the assessment be completed within 18 months or less by a program acceptable to the Board. The Board must review the assessment and determine a plan of corrective action or appropriate resolution based on the assessment.

Identification of Licensees Subject to Competency Assessments.

The Department of Health Professions will identify licensees that appear to have three medical malpractice judgments or settlements of more than $75,000 each within the most recent 10-year period by searching practitioner profiles on the Board's Practitioner Information site on a quarterly basis. Identification of individuals subject to a competency assessment may also occur through a review of other data held by the Board.

Notification of Licensees Identified.

Licensees that appear to require a competency assessment pursuant to Virginia Code § 54.1-2912.3 will be sent a letter by certified mail stating the practitioner's responsibility to obtain a competency assessment. If a licensee believes that he or she has received the letter in error or needs further clarification regarding the assessment, the licensee should call the Board.

Obtaining a Competency Assessment.

The licensee is required to make arrangements for the assessment, and may do so from one of the national programs that conduct such assessments. The approved list of programs includes, but is not limited to the Federation of State Medical Boards Post-Licensure Assessment Program and the Center for Personalized Education for Physicians.

The licensee may also obtain the competency assessment from a medical school faculty member practicing in the same specialty as the licensee. If the licensee chooses this option, the following steps should be followed:

1. Contact the appropriate department of the medical school where the assessment will be sought;

2. Identify a faculty member of the same specialty as the licensee who will serve as the evaluator and who is willing to perform the assessment;

3. With the evaluator, the licensee prepares an outline of the proposed approach to the assessment. The evaluator has the latitude to determine the format of the assessment. At a minimum, the paid claims that triggered the assessment should be discussed, as well as

matters pertinent to an assessment of global competency to practice. This would include the licensee's fund of knowledge, medical judgment, and skills in a procedural specialty. The assessment can include more elements if the parties deem it necessary;

4. Send the outline of the proposed assessment to the Executive Director for approval prior to proceeding with the assessment;

5. After receiving approval, proceed with the assessment;

6. Provide the evaluator with a written release of liability for the assessment and subsequent report to the Board;

7. Ensure that the evaluator sends the report of the competency assessment to the Board; and

8. Compensate the evaluator for his or her time.

Completion of Assessment and Report to the Board.

1. The assessment must be completed within 18 months of the Board's notification to the licensee.

2. The Board will review the report of the assessment and communicate its recommendations to the licensee. The Board may choose to close the matter or require further assessment. While the competency assessment is not, in and of itself, a disciplinary matter for the licensee, it is possible that the assessment could lead to the initiation of a disciplinary proceeding.

3. The competency assessment and the process are confidential pursuant to Virginia Code § 54.1-2400.2. If a matter becomes disciplinary, however, any notices or orders associated with the process will be public.

Suggested Competency Assessment Form

Please ask the evaluator to print or type the requested information.

Doctor to be evaluated: ______________________________

Virginia License Number: ______________________________

Evaluator: ______________________________

Evaluator's Address: ______________________________

Evaluator's Telephone Number: ______________________________

Evaluator's Email Address: ______________________________

Date(s) of face-to-face meeting(s): ______________________________

(Attach additional sheets to review of any section as necessary.)

1. Review of the facts regarding paid claim cases.

The evaluator may request that the doctor provide the evaluator with any documentation necessary to assist in the competency assessment. That documentation may include:

- Complaints or motions for judgement;
- Answers or grounds of defense;
- Medical records, including any relevant radiology images;
- Expert witness designations;
- Deposition transcripts of parties and expert witnesses;
- Court orders;
- Settlement agreements; and
- Lessons learned, risk management, and resulting practice changes.

2. Describe doctor's fund of knowledge, medical judgment, and decision-making, and, in the case of procedural specialties, skills.

The evaluator may request:

- Board certification information;
- CME records; and
- Other educational information.

3. Doctor's strengths:

4. Doctor's weaknesses:

5. Is there a need for remediation?

6. Is this doctor safe and competent to practice?

______________________________ ______________

Evaluator Signature Date

Please return to:

William L. Harp, M.D.,
Executive Director, Virginia Board of Medicine
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

GUIDANCE DOCUMENT OF THE VIRGINIA BOARD OF MEDICINE

COMPETENCY ASSESSMENTS FOR THREE PAID CLAIMS

In 2005 the General Assembly passed law to require competency assessments for licensees with three medical malpractice claims (judgments or settlements) paid in the most recent ten-year period. The original law was amended in 2007 and again in 2011. It is found in Section 54.1-2912.3 of the Code of Virginia and now reads as follows:

§ 54.1-2912.3. Competency assessments of certain practitioners.

The Board shall require an assessment of the competency of any person holding an active license under this chapter on whose behalf three separate medical malpractice judgments or medical malpractice settlements of more than $75,000 each are paid within the most recent JO-year period. The assessment shall be accomplished in 18 months or less by a program acceptable to the Board. The licensee shall bear all costs of the assessment. The results of the assessment shall be reviewed by the Board and the Board shall determine a plan of corrective action or appropriate resolution pursuant to the assessment. The assessment, related documents and the processes shall be governed by the confidentiality provisions of§ 54.1-2400.2 and shall not be admissible into evidence in any medical malpractice action involving the licensee. The Board shall annually post the number of competency assessments undertaken on its website.

(2005, cc. 649 692; 2007, c. 861; 20/ J, c. 808.)

In the implementation of the initial law, it was determined that at least one of the paid claims must have occurred on or after July I, 2005.

Identification of Licensees Subject to the Law

The Data Division of the Depal lment of Health Professions will proactively identify the licensees that appear to have three medical malpractice judgments or settlements of more than $75,000 in the most recent ten-year period by searching the Board of Medicine's Physician Profiles on a quarterly basis. Identification of individuals subject to this law may also occur through the review of other data held by the Board.

Notification of Subject Licensees

Licensees that appear to be subject to this law will be sent a letter by cetlified mail apprising them of their responsibility to obtain a competency assessment. If a licensee believes that he/she has received the letter in error, or needs further clarification regarding the assessment, he/she is instructed to call the Board.

Process of Obtaining a Competency Assessment

It is the responsibility of the subject licensee to make the arrangements for the assessment. The Board has determined that a licensee may obtain a competency assessment from one of the national programs that conduct such assessments. The list includes, but is not limited to, the Federation of State Medical Boards Post-Licensure Assessment Program and the Center for Personalized Education for Physicians.

The Board has also determined that a subject licensee may obtain the competency assessment with a medical school faculty member of the same specialty. Should the licensee choose this approach, the following steps should be followed.

1) Contact the appropriate department of the medical school where the assessment will be sought.
2) Identify a faculty member (evaluator) of the same specialty that is willing to perform the assessment.
3) With the evaluator, prepare an outline of the proposed approach to the assessment. The evaluator has the latitude to determine the format of the assessment. At a minimum, the paid claims that triggered the assessment should be discussed, as well as matters pertinent to an assessment of global competency to practice. This would include a subject licensee's fund of knowledge, medical judgment and in a procedural specialty, skills. The assessment can include more elements if deemed necessary by the parties.
4) Send the outline of the proposed assessment to the Executive Director for approval prior to proceeding.
5) After receiving approval, proceed with the assessment.
6) Provide the evaluator with all documents required by the approved outline. The Board will not provide info1mation to the evaluator.
7) Provide the evaluator with a written release of liability for the assessment and report to the Board.
8) Ensure that the evaluator sends the report of the competency assessment to the Board.
9) Compensate the evaluator for his/her time.

Completion of Assessment and Report to the Board

1) The assessment must be completed within 18 months of the Board's notification to the licensee.

2) The Board will review the report of the assessment and communicate its recommendations to the subject licensee. The Board may choose to close the matter or require further assessment. While the competency assessment is, in and of itself, not a disciplinary matter for the licensee, it is possible that the assessment could lead to the initiation of a disciplinary process.

3) The competency assessment and the process are confidential pursuant to § 54.1-2400.2 of the Code of Virginia. However, if matter becomes disciplinary, Notices and Orders associated with the process will be public.

Virginia Board of Medicine
Competency Assessment Form

Please ask the evaluator to print/type the requested information.

Doctor to be evaluated: ....

Virginia License Number: ____

Evaluator: ....

Evaluator's Address: ....

____

Evaluator's Telephone Number: ____

Evaluator's Email Address: ....

Date(s) of face to face meeting(s): ____

1. **Review of the facts regarding the paid claim cases:**

   The evaluator may request the doctor provide him with any documentation necessary to assist in the competency assessment which may include:

   - Complaint or motion for the Judgment
   - Answer or Grounds of Defense
   - Medical Records, including relevant radiology images
   - Expert Witness Designations
   - Deposition Transcripts of all Patties and expert Witnesses
   - Court Orders
   - Settlement Agreements
   - Lessons learned, risk management and practice changes

     (attach additional sheets as necessary)

2. **Describe this doctor's fund of knowledge, medical judgment or decision-making and in the case of procedural specialties, skills.**

   The evaluator may request:

   - Board certification information
   - CME records
   - Other educational information. *(attach additional sheets as necessary)*

3. **Doctor's strengths:**

4. **Doctor's weaknesses:**

S. **Is there a need for remediation?**

6. **Is this doctor safe to practice?**

Evaluator Signature   Date:

Please return to the attention of Dr. Harp at
Virginia Board of Medicine
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Agenda Items: Adopt revisions to Guidance Document 85-8

Included in your agenda package are:

- Proposed revisions to Guidance Document 85-8 as recommended by the Legislative Committee in both redline and clean version

Action needed:

- Motion to accept recommendation of Legislative Committee regarding revisions to Guidance Document 85-8

Guidance Document: 85-8 ~~Adopted: 2/23/12~~
~~Reaffirmed: 10/18/18~~Revised: October 6, 2022
Effective: December 8, 2022

Board of Medicine

Authority of Physician Assistants to ~~w~~ Write Do Not Resuscitate Orders ~~(DNR Orders)~~

Section 54.1-2987.1 of~~In~~ the Health Care Decisions Act, ~~(~~Va. Code § 54.1-2981 *et seq.*~~, of the Code of Virginia), § 54.1-2987.1~~ provides that a Durable Do Not Resuscitate ("DNR") Order may be issued by a physician. Virginia Code § 54.1-2952.2 provides that, "[~~W~~w]henever any law or regulation requires a signature…by a physician, it shall be deemed to include a signature…by a physician assistant."

T~~herefore, t~~he Board of Medicine interprets these two statutory provisions~~concurs~~ to mean that licensed physician assistants have the statutory and regulatory authority to write ~~Do Not Resuscitate~~ DNR Orders~~, in accordance with §§ 54.1-2952.2 and 54.1-2987.1 of the Code of Virginia and 18VAC85-50-101 of the Virginia Administrative Code.~~

The authority for a physician assistant to write DNR orders must be included in the written ~~protocol~~ practice agreement as a delegated act by the supervising physician and must be performed in consultation with the physician.

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Board of Medicine

Authority of Physician Assistants to Write Do Not Resuscitate Orders

Section 54.1-2987.1 of the Health Care Decisions Act, Va. Code § 54.1-2981 *et seq.*, provides that a Durable Do Not Resuscitate ("DNR") Order may be issued by a physician. Virginia Code § 54.1-2952.2 provides that, "[w]henever any law or regulation requires a signature…by a physician, it shall be deemed to include a signature…by a physician assistant."

The Board of Medicine interprets these two statutory provisions to mean that licensed physician assistants have the statutory and regulatory authority to write DNR Orders.

The authority for a physician assistant to write DNR orders must be included in the written practice agreement as a delegated act by the supervising physician and must be performed in consultation with the physician.

Agenda Items: Adopt revisions to Guidance Document 85-13

Included in your agenda package are:

- Proposed revisions to Guidance Document 85-13 as recommended by the Legislative Committee in both redline and clean version

Action needed:

- Motion to accept recommendation of Legislative Committee regarding revisions to Guidance Document 85-13

Guidance Document 85-13

~~Adopted: January 22, 2004~~
Revised: October 6, 2022~~18, 2018~~
Effective: December 8, 2022

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Virginia Board of Medicine

Guidelines on Performing Procedures on the Newly Deceased for Training Purposes

Section 54.1-2961 of the Code of Virginia requires the Board of Medicine to adopt guidelines concerning the ethical practice of physicians, interns, and residents. The Board is required to consider "the nonbinding ban developed by the American Medical Association in 2000 on using newly dead patients as training subjects without the consent of the next of kin or other legal representative to the extent practical under the circumstances in which medical care is being rendered." Va. Code § 54.1-2961(E). ~~provides:~~

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~~*E. The Board of Medicine shall adopt guidelines concerning the ethical practice of physicians practicing in emergency rooms, surgeons, and interns and residents practicing in hospitals, particularly hospital emergency rooms, or other organizations operating graduate medical education programs. These guidelines shall not be construed to be or to establish standards of care or to be regulations and shall be exempt from the requirements of the Administrative Process Act (§ 2.2-4000 et seq.). The Medical College of Virginia of Virginia Commonwealth University, the University of Virginia School of Medicine, the Eastern Virginia Medical School, the Medical Society of Virginia, and the Virginia Hospital and Health Care Association shall cooperate with the Board in the development of these guidelines.*~~

~~*The guidelines shall include, but need not be limited to (i) the obtaining of informed consent from all patients or from the next of kin or legally authorized representative, to the extent practical under the circumstances in which medical care is being rendered, when the patient is incapable of making an informed decision, after such patients or other persons have been informed as to which physicians, residents, or interns will perform the surgery or other invasive procedure; (ii) except in emergencies and other unavoidable situations, the need, consistent with the informed consent, for an attending physician to be present during the surgery or other invasive procedure; (iii) policies to avoid situations, unless the circumstances fall within an exception in the Board's guidelines or the policies of the relevant hospital, medical school or other organization operating the graduate medical education program, in which a surgeon, intern or resident represents that he will perform a surgery or other invasive procedure that he then fails to perform; and (iv) policies addressing informed consent and the ethics of appropriate care of patients in emergency rooms. Such policies shall take into consideration the nonbinding ban developed by the American Medical Association in 2000 on using newly dead patients as training subjects without the consent of the next of kin or other legal representative to extent practical under the circumstances in which medical care is being rendered.*~~

Therefore, as guidance to its licensees, the ~~Virginia~~ Board ~~of Medicine has~~ endorse~~d~~s the ethical guideline on performing procedures on the newly deceased for training purposes adopted by the American Medical Association in June, 2001~~, as follows~~:

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> ~~"~~Physicians should work to develop institutional policies that address the practice of performing procedures on the newly deceased for purposes of training. Any such policy should ensure that the interests of all the parties involved are respected under established and clear ethical guidelines. Such policies

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should consider rights of patients and their families, benefits to trainees and society, as well as potential harm to the ethical sensitivities of trainees, and risks to staff, the institution and the profession associated with performing procedures on the newly deceased without consent. The following considerations should be addressed before medical trainees perform procedures on the newly deceased:

(1) The teaching of life-saving skills should be the culmination of a structured training sequence, rather than relying on random opportunities. Training should be performed under close supervision, in a manner and environment that takes into account the wishes and values of all involved parties.

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(2) Physicians should inquire whether the deceased individual had expressed preferences regarding handling of the body or procedures performed after death. In the absence of previously expressed preferences, physicians should obtain permission from the family before performing such procedures. When reasonable efforts to discover previously expressed preferences of the deceased or to find someone with authority to grant permission for the procedure have failed, physicians must not perform procedures for training purposes on the newly deceased patient.

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In the event post-mortem procedures are undertaken on the newly deceased, they must be recorded in the medical record."[1]

American Medical Association, Council on Ethical and Judicial Affairs, Code of Medical Ethics, Opinion 8.181, "Performing Procedures on the Newly Deceased for Training Purposes," adopted June 2001.

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[1] American Medical Association, Council on Ethical and Judicial Affairs, Code of Medical Ethics, Opinion 8.181, "Performing Procedures on the Newly Deceased for Training Purposes," adopted June 2001.

Virginia Board of Medicine

Guidelines on Performing Procedures on the Newly Deceased for Training Purposes

Section 54.1-2961 of the Code of Virginia requires the Board of Medicine to adopt guidelines concerning the ethical practice of physicians, interns, and residents. The Board is required to consider "the nonbinding ban developed by the American Medical Association in 2000 on using newly dead patients as training subjects without the consent of the next of kin or other legal representative to the extent practical under the circumstances in which medical care is being rendered." Va. Code § 54.1-2961(E).

Therefore, as guidance to its licensees, the Board endorses the ethical guideline on performing procedures on the newly deceased for training purposes adopted by the American Medical Association in June, 2001:

> Physicians should work to develop institutional policies that address the practice of performing procedures on the newly deceased for purposes of training. Any such policy should ensure that the interests of all the parties involved are respected under established and clear ethical guidelines. Such policies should consider rights of patients and their families, benefits to trainees and society, as well as potential harm to the ethical sensitivities of trainees, and risks to staff, the institution and the profession associated with performing procedures on the newly deceased without consent. The following considerations should be addressed before medical trainees perform procedures on the newly deceased:
>
> (1) The teaching of life-saving skills should be the culmination of a structured training sequence, rather than relying on random opportunities. Training should be performed under close supervision, in a manner and environment that takes into account the wishes and values of all involved parties.
>
> (2) Physicians should inquire whether the deceased individual had expressed preferences regarding handling of the body or procedures performed after death. In the absence of previously expressed preferences, physicians should obtain permission from the family before performing such procedures. When reasonable efforts to discover previously expressed preferences of the deceased or to find someone with authority to grant permission for the procedure have failed, physicians must

> not perform procedures for training purposes on the newly deceased patient.
>
> In the event post-mortem procedures are undertaken on the newly deceased, they must be recorded in the medical record.

American Medical Association, Council on Ethical and Judicial Affairs, Code of Medical Ethics, Opinion 8.181, "Performing Procedures on the Newly Deceased for Training Purposes," adopted June 2001.

Agenda Items: Adopt revisions to Guidance Document 85-15

Included in your agenda package are:

- Proposed revisions to Guidance Document 85-15 as recommended by the Legislative Committee in both redline and clean version

Action needed:

- Motion to accept recommendation of Legislative Committee regarding revisions to Guidance Document 85-15

Virginia Board of Medicine
Guidance document: 85-15

~~Adopted: January 22, 2004~~
Revised: October ~~18, 2018~~6, 2022
Effective: December 8, 2022

Guidelines Concerning the Ethical Practice of Attending Physicians, ~~and~~ Fellows, Residents, and Interns

Section 54.1-2961 of the Code of Virginia requires the Board of Medicine to adopt guidelines concerning the ethical practice of physicians, interns, and residents. Pursuant to that requirement, the Board issues the following guidelines concerning ethical practice.

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Explanation of the nature and risk of an operation to the patient or to the patient's representative is essential.

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Commented [VP1]: To what?

Before surgery or an invasive procedure is performed, informed consent should be obtained from the patient in accordance with the policies of the health care entity. Patients should understand the indications for the surgery or invasive procedure, the risk involved, and the result that is hoped to be attained. 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 legally authorized ~~available~~ to give consent should be informed and the consent of the person documented. An exception to the requirement for consent prior to or during the performance of surgery or an invasive procedure may be made if a delay in obtaining consent would likely result in imminent harm to the patient.

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Under the usual and customary arrangement with patients, and with reference to the usual form of consent to surgery or an invasive procedure, it is the attending physician to whom the patient grants consent and who is obligated to perform the surgery or invasive procedure. With the consent of the patient or another legally authorized person available to give consent, it is ethical for the attending physician to delegate the performance of some or all aspects of the surgery or invasive procedure to the fellow, resident, intern or assistant, provided that this is done under the physician's supervision as described in the supervising policy of the Accreditation Council for Graduate Medical Education (ACGME). If some or all of the surgery or procedure is to be delegated to another health care provider, or if care of the patient is to be turned over to another attending physician, the patient or the ~~legally authorized~~ person legally authorized ~~available~~ to give consent is entitled to be so informed and to give documented consent.

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It is unethical to mislead a patient as to the identity of the doctor who performs the surgery or invasive procedure. If the identified attending physician cannot perform the surgery or invasive procedure due to any unusual or emergency reasons, the patient or another ~~legally authorized~~ person legally authorized ~~available~~ to give consent must be fully informed and given another opportunity to accept or reject the replacement physician.

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Supervision of trainees (fellows, residents and interns) by attending physicians

Virginia Board of Medicine
Guidance document: 85-15

Adopted: January 22, 2004
Revised: October 18, 20186, 2022
Effective: December 8, 2022

The attending physician has both an ethical and a professional responsibility for the overall care of the individual patient and for the supervision of any trainee involved in the care of the patient. Although senior trainees require less direction than their junior counterparts, even the most senior should be supervised. A chain of command that emphasizes graded authority and increasing responsibility as experience is gained should be established. Judgments on this delegation of responsibility should be made by the attending physician who is ultimately responsible for the patient's care; such judgments should be based on the attending physician's direct observation and knowledge of each trainee's skills and ability.

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To ensure the fulfillment of these responsibilities, the following principles of supervision should be operative within a training program:.

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1. Supervision of trainees should be specified in the bylaws, policies, procedures, rules and/or regulations of the department, which should not be less demanding that those of the institution.
2. Evidence that adequate supervision exists within a program should be provided in the form of signed notes in the patient charts and/or other such records.
3. Proper supervision should not conflict with progressively more independent decision-making on the part of the trainee; thus, the degree of supervision may vary with the clinical circumstances and the training level of the trainee. However, tTo exercise their responsibilities properly, however, members of the teaching staff always should be immediately available for consultation and support.

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Commented [VP2]: What department do we mean here?

For the purposes of this guidance document, "invasive procedure" shall mean 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 institution is to document specific informed consent from the patient or surrogate decision-maker prior to proceeding.

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Guidelines Concerning the Ethical Practice of Attending Physicians, Fellows, Residents, and Interns

Section 54.1-2961 of the Code of Virginia requires the Board of Medicine to adopt guidelines concerning the ethical practice of physicians, interns, and residents. Pursuant to that requirement, the Board issues the following guidelines concerning ethical practice.

Explanation of the nature and risk of an operation to the patient or to the patient's representative is essential.

Before surgery or an invasive procedure is performed, informed consent should be obtained from the patient in accordance with the policies of the health care entity. Patients should understand the indications for the surgery or invasive procedure, the risk involved, and the result that is hoped to be attained. 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 person legally authorized to give consent should be informed and the consent of the person documented. An exception to the requirement for consent prior to or during the performance of surgery or an invasive procedure may be made if a delay in obtaining consent would likely result in imminent harm to the patient.

Under the usual and customary arrangement with patients, and with reference to the usual form of consent to surgery or an invasive procedure, it is the attending physician to whom the patient grants consent and who is obligated to perform the surgery or invasive procedure. With the consent of the patient or another legally authorized person available to give consent, it is ethical for the attending physician to delegate the performance of some or all aspects of the surgery or invasive procedure to the fellow, resident, intern or assistant, provided that this is done under the physician's supervision as described in the supervising policy of the Accreditation Council for Graduate Medical Education (ACGME). If some or all of the surgery or procedure is to be delegated to another health care provider, or if care of the patient is to be turned over to another attending physician, the patient or the person legally authorized to give consent is entitled to be so informed and to give documented consent.

It is unethical to mislead a patient as to the identity of the doctor who performs the surgery or invasive procedure. If the identified attending physician cannot perform the surgery or invasive procedure due to any unusual or emergency reasons, the patient or another person legally authorized to give consent must be fully informed and given another opportunity to accept or reject the replacement physician.

Supervision of trainees (fellows, residents and interns) by attending physicians

The attending physician has both an ethical and a professional responsibility for the overall care of the individual patient and for the supervision of any trainee involved in the care of the patient. Although senior trainees require less direction than their junior counterparts, even the most senior should be supervised. A chain of command that emphasizes graded authority and increasing responsibility as experience is gained should be established. Judgments on this delegation of responsibility should be made by the attending physician who is ultimately responsible for the patient's care; such judgments should be based on the attending physician's direct observation and knowledge of each trainee's skills and ability.

To ensure the fulfillment of these responsibilities, the following principles of supervision should be operative within a training program:

1. Supervision of trainees should be specified in the bylaws, policies, procedures, rules or regulations of the department, which should not be less demanding that those of the institution.
2. Evidence that adequate supervision exists within a program should be provided in the form of signed notes in the patient charts or other such records.
3. Proper supervision should not conflict with progressively more independent decision-making on the part of the trainee; thus, the degree of supervision may vary with the clinical circumstances and the training level of the trainee. To exercise their responsibilities properly, however, members of the teaching staff should be immediately available for consultation and support.

For the purposes of this guidance document, "invasive procedure" shall mean 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 institution is to document specific informed consent from the patient or surrogate decision-maker prior to proceeding.

Agenda Items: Adopt revisions to Guidance Document 85-16

Included in your agenda package are:

- Proposed revisions to Guidance Document 85-16 as recommended by the Legislative Committee in both redline and clean version

Action needed:

- Motion to accept recommendation of Legislative Committee regarding revisions to Guidance Document 85-16

Guidance Document 85-16

Revised: October 6, 2022
Effective: December 8, 2022

Board of Medicine
Questions and Answers on Continuing Competency Requirements
~~for the Virginia Board of Medicine~~

1. **When must I have the required number of continuing competency hours completed in order to renew my license?**

   In your birth month in even years. You will be required to sign a certification on your renewal form that you have met the continuing competency requirements. Falsification on the renewal form is a violation of law and may subject you to disciplinary action. *See* 18VAC85-20-230.

2. **Am I required to send in evidence of my continuing competency hours at the time I renew?**

   No. The Board will randomly select licensees for a post-renewal audit. If selected, you would be notified by mail that documentation is required and given a time frame within which to comply. *See* 18VAC85-20-235(D).

3. **When do the continuing competency requirements begin?**

   Hours must be obtained within the two years immediately preceding renewal. You may not count any hours obtained prior to 24 months preceding renewal nor may you carry over excess hours to the following biennium. *See* 18VAC85-20-235.

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

   It is the practitioner's responsibility to maintain the certificates and any other continuing competency forms or records for six years following renewal. Do not send any forms or documents to the Board of Medicine unless requested to do so. *See* 18VAC85-20-235(C).

5. **What are "Type 1" hours?**

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

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6. **What are "Type 2" hours?**

   Type 2 hours (no more than 30 each biennium) are those earned in self-study, attending professionally related meetings, research and writing for a journal, learning a new procedure, sitting with the hospital ethics panel, etc. They are activities chosen by the practitioner based on assessment of his/her practice. They do not have to be sponsored by an accrediting organization, but must be recorded by the practitioner on the form provided by the Board.

7. **Where do I obtain the instructions and forms for continuing competency requirements?**

Forms and instructions can be downloaded from the Board's website at: www.dhp.virginia.gov/medicine/medicine_forms.htm. Records may be maintained electronically, but copies of documentation and forms will be necessary if a practitioner is audited following a renewal cycle. Forms may also be copied.

8. Is it possible for a practitioner to earn accredited hours that are sanctioned by the profession but are outside the specialty area in which he/she practices?

Yes. For example, a pediatrician or a surgeon could receive credit for documented hours sponsored by the American Academy of Family Practice.

9. What if I have earned the AMA Physician Recognition Award or have been recertified by my specialty board? Would that count for my continuing competency hours?

Yes. Provided the Board has documented proof that the requirements to obtain the AMA award (or other similar awards) or specialty board certification are equal to or exceed those required for renewal of licensure. It would only be necessary to submit evidence of ~~having~~ receiving such an award or certification.

10. What if I am newly licensed? Do I still have to obtain the full 60 hours of continued competency?

No. There is an exemption for those persons newly licensed under 18VAC85-20-235(B). Additionally, there is an exemption ~~and~~ for anyone practicing solely without pay in a practice (free clinic, rescue squad, etc.) that is under the direction of a fully licensed physician under 18VAC85-20-235(H).

11. What if I become ill or incapacitated and unable to complete my continuing competency requirements prior to renewal?

Upon written request from the practitioner explaining the circumstances, the Board may grant an extension or exemption for all or part of the required hours. *See* 18VAC85-20-235(G).

12. What if I am now retired and ~~don't~~ do not want to obtain continuing competency hours but ~~don't~~ do not want to give up my license?

You may request an inactive license from the Board, beginning with your next renewal. It is important to note that **holding an inactive license does not authorize anyone to engage in the practice of medicine, osteopathy, podiatry or chiropractic in Virginia.** If you intend to practice at all in Virginia, even on a part-time or non-compensatory basis, you must retain your active license. *See* 18VAC85-20-236.

13. What happens if I take inactive licensure status and later decide to reactivate?

A practitioner seeking to reactivate a license must pay the active renewal fee and obtain the number of hours which would have be required for the years in which the license was inactive (not to exceed four years). If the practitioner has not been engaged in active practice for more than four years, he/she must pass a special purpose examination in his area of licensure. *See* 18VAC85-20-240.

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

If you perform or supervise anesthesia in your practice, you must obtain four hours of Type 1 CE in anesthesia topics each biennium. *See* 18VAC85-20-330(C)(2).

Guidance Document 85-16

Revised: October 6, 2022
Effective: December 8, 2022

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

Board of Medicine
Questions and Answers on Continuing Competency Requirements

1. **When must I have the required number of continuing competency hours completed in order to renew my license?**

   In your birth month in even years. You will be required to sign a certification on your renewal form that you have met the continuing competency requirements. Falsification on the renewal form is a violation of law and may subject you to disciplinary action. *See* 18VAC85-20-230.

2. **Am I required to send in evidence of my continuing competency hours at the time I renew?**

   No. The Board will randomly select licensees for a post-renewal audit. If selected, you would be notified by mail that documentation is required and given a time frame within which to comply. *See* 18VAC85-20-235(D).

3. **When do the continuing competency requirements begin?**

   Hours must be obtained within the two years immediately preceding renewal. You may not count any hours obtained prior to 24 months preceding renewal nor may you carry over excess hours to the following biennium. *See* 18VAC85-20-235.

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

   It is the practitioner's responsibility to maintain the certificates and any other continuing competency forms or records for six years following renewal. Do not send any forms or documents to the Board of Medicine unless requested to do so. *See* 18VAC85-20-235(C).

5. **What are "Type 1" hours?**

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

6. **What are "Type 2" hours?**

   Type 2 hours (no more than 30 each biennium) are those earned in self-study, attending professionally related meetings, research and writing for a journal, learning a new procedure, sitting with the hospital ethics panel, etc. They are activities chosen by the practitioner based on assessment of his/her practice. They do not have to be sponsored by an accrediting organization, but must be recorded by the practitioner on the form provided by the Board.

7. **Where do I obtain the instructions and forms for continuing competency requirements?**

   Forms and instructions can be downloaded from the Board's website at: www.dhp.virginia.gov/medicine/medicine_forms.htm. Records may be maintained electronically, but

copies of documentation and forms will be necessary if a practitioner is audited following a renewal cycle. Forms may also be copied.

8. Is it possible for a practitioner to earn accredited hours that are sanctioned by the profession but are outside the specialty area in which he/she practices?

Yes. For example, a pediatrician or a surgeon could receive credit for documented hours sponsored by the American Academy of Family Practice.

9. What if I have earned the AMA Physician Recognition Award or have been recertified by my specialty board? Would that count for my continuing competency hours?

Yes. Provided the Board has documented proof that the requirements to obtain the AMA award (or other similar awards) or specialty board certification are equal to or exceed those required for renewal of licensure. It would only be necessary to submit evidence of receiving such an award or certification.

10. What if I am newly licensed? Do I still have to obtain the full 60 hours of continued competency?

No. There is an exemption for those persons newly licensed under 18VAC85-20-235(B). Additionally, there is an exemption for anyone practicing solely without pay in a practice (free clinic, rescue squad, etc.) that is under the direction of a fully licensed physician under 18VAC85-20-235(H).

11. What if I become ill or incapacitated and unable to complete my continuing competency requirements prior to renewal?

Upon written request from the practitioner explaining the circumstances, the Board may grant an extension or exemption for all or part of the required hours. *See* 18VAC85-20-235(G).

12. What if I am now retired and do not want to obtain continuing competency hours but do not want to give up my license?

You may request an inactive license from the Board, beginning with your next renewal. It is important to note that **holding an inactive license does not authorize anyone to engage in the practice of medicine, osteopathy, podiatry or chiropractic in Virginia**. If you intend to practice at all in Virginia, even on a part-time or non-compensatory basis, you must retain your active license. *See* 18VAC85-20-236.

13. What happens if I take inactive licensure status and later decide to reactivate?

A practitioner seeking to reactivate a license must pay the active renewal fee and obtain the number of hours which would have be required for the years in which the license was inactive (not to exceed four years). If the practitioner has not been engaged in active practice for more than four years, he/she must pass a special purpose examination in his area of licensure. *See* 18VAC85-20-240.

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

If you perform or supervise anesthesia in your practice, you must obtain four hours of Type 1 CE in anesthesia topics each biennium. *See* 18VAC85-20-330(C)(2).

Agenda Item: Consideration of repeal of 85-19

Included in your agenda package are:

- Guidance Document 85-19
- Glossary on practitioner profile site

Staff note: This document does not interpret statute or regulation, and is not appropriate as a guidance document. All information contained in this document is provided on the Board's practitioner profile site. Legislative Committee recommended repeal.

Action needed:

- Motion to adopt Legislative Committee's recommendation to repeal Guidance Document 85-19.

Glossary of Terms

A

Active License: Licensee may practice medicine, osteopathic medicine, or podiatry in Virginia.

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Admitting Privileges: The level of privilege that allows the licensee to admit patients under his or her care at that particular hospital.

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Judgment: In the context of a malpractice claim, a judgment is an award by a court, with or without a jury, to the plaintiff, in response to a lawsuit.

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Law: Laws for the Physician Profile System are found in the *Code of Virginia* as follows:

§54.1-2910.1. Certain data required.

A. The Board of Medicine shall require all doctors of medicine, osteopathy and podiatry to report and shall make available the following information:

1. The names of the schools of medicine, osteopathy, or podiatry and the years of graduation;

2. Any graduate medical, osteopathic, or podiatric education at any institution approved by the Accreditation Council for Graduation Medical Education, the American Osteopathic Association or the Council on Podiatric Medical Education;

3. Any specialty board certification as approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of the American Osteopathic Association, the American Board of Multiple Specialties in Podiatry, or the Council on Podiatric Medical Education of the American Podiatric Medical Association;

4. The number of years in active, clinical practice as specified by regulations of the Board;

5. Any hospital affiliations;

6. Any appointments, within the most recent 10-year period, of the doctor to the faculty of a school of medicine, osteopathy or podiatry and any publications in peer-reviewed literature within the most recent five-year period and as specified by regulations of the Board;

7. The location and telephone number of any primary and secondary practice settings and the approximate percentage of the doctor's time spent practicing in each setting. For the sole purpose of expedited dissemination of information about a public health emergency, the doctor shall also provide to the Board any e-mail address or facsimile number; however, such e-mail address or

facsimile number shall not be published on the profile database and shall not be released or made available for any other purpose;

8. The access to any translating service provided to the primary and secondary practice settings of the doctor;

9. The status of the doctor's participation in the Virginia Medicaid Program;

10. Any final disciplinary or other action required to be reported to the Board by health care institutions, other practitioners, insurance companies, health maintenance organizations, and professional organizations pursuant to §§ 54.1-2400.6, 54.1-2908, and 54.1-2909 that results in a suspension or revocation of privileges or the termination of employment or a final order of the Board relating to disciplinary action;

11. Conviction of any felony; and

12. Other information related to the competency of doctors of medicine, osteopathy, and podiatry, as specified in the regulations of the Board.

B. In addition, the Board shall provide for voluntary reporting of insurance plans accepted and managed care plans in which the doctor participates.

C. The Board shall promulgate regulations to implement the provisions of this section, including, but not limited to, the release, upon request from a consumer, of such information relating to a specific doctor. The Board's regulations shall provide for reports to include all medical malpractice judgments and medical malpractice settlements of more than $10,000 within the most recent 10-year period in categories indicating the level of significance of each award or settlement; however, the specific numeric values of reported paid claims shall not be released in any individually identifiable manner under any circumstances. Notwithstanding this subsection, a licensee shall report a medical malpractice judgment or medical malpractice settlement of less than $10,000 if any other medical malpractice judgment or medical malpractice settlement has been paid by or for the licensee within the preceding 12 months.

D. This section shall not apply to any person licensed pursuant to §§ 54.1-2928.1, 54.1-2933.1, 54.1-2936, and 54.1-2937 or to any person holding an inactive license to practice medicine, osteopathy, or podiatry.

(1998, c. 744; 1999, c. 573; 2000, c. 199; 2001, c. 199; 2001, Sp. Sess. I, c. 5; 2002, c. 38; 2004, cc. 64, 703; 2007, c. 861; 2008, c. 479.)

Licensee: A person who meets the requirements to have a license in the State of Virginia

M

Medicare Participating Provider: A licensee who contractually accepts the participating provider fee schedule.

N

Notices or Statement of Particulars: A "Notice and/or "Statement of Particulars" contains a statement of charges that have not been proven. The Board will meet with the named practitioner to discuss these charges and make a decision, or settle the charges with a consent order. After the meeting, the Board may decide to exonerate the practitioner or dismiss the charges. Or, the Board may decide that some or all of the charges are proven and a violation of law or regulation occurred. If the evidence supports a violation, the Board may take appropriate action against the license of the practitioner. Until the Board issues a decision (by letter, order or consent order) that contains findings about these charges, they are not proven.

O

Optional Data Elements: Not required by law or regulations however, the physician has the option of including these elements in his profile. These elements include:
Continuing Education
Days of Week at Practice Locations
Email Address
Fax number at Practice Locations
Honors and Awards
Maiden name
Medicare participation
Website Address

Order: The document issued by the Board of Medicine indicating the Board's decision that the practitioner, as a matter of past or present fact, is or is not in violation of law or regulation. Typically, an order resolves the allegations in the Notice, and contains findings of fact and conclusions of law. It may impose a sanction or require some action by the practitioner. In some cases, the Board's decision is to dismiss the allegations in the Notice and such a decision is usually stated in a letter. "Order" also applies to "Consent Orders" which are agreed to by the practitioner, often without a meeting with the Board. Orders and letters containing the Board's resolution of allegations are public documents and copies are available.

P

Paid Claim: In the context of malpractice, a paid claim is a payment made to a person in response to a claim. It may be in the form of a "judgment" or "settlement."

Peer-Reviewed Literature: A journal or publication whose articles are reviewed and selected by an editorial board comprised of individuals having attained similar certification, education, training, and experience.

Practice Address: A location where the licensee engages in practice of medicine, osteopathic medicine, or podiatry regardless if patients are seen. Practitioners may designate a primary practice address and additional practice addresses.

Practitioner Has Not Provided Information: This message appears when a doctor has not yet completed his profile. By regulation, doctors have thirty days from the date of request from the Board to provide the requested information.

Probation: A status whereby a practitioner maintains his license but must comply with the terms and conditions required by the Board. The conditions may restrict the practice.

R

Regulation: Rules adopted by the Board to implement the Law. Regulations pertaining to the Physician Profile are:

18VAC85-20-280. Required information.

A. In compliance with requirements of §54.1-2910.1 of the Code of Virginia, a doctor of medicine, osteopathic medicine, or podiatry licensed by the board shall provide, upon initial request or whenever there is a change in the information that has been entered on the profile, the following information within 30 days:

1. The address and telephone number of the primary practice setting and all secondary practice settings with the percentage of time spent at each location;

2. Names of medical, osteopathic or podiatry schools and graduate medical or podiatric education programs attended with dates of graduation or completion of training;

3. Names and dates of specialty board certification, if any, as approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of the American Osteopathic Association or the Council on Podiatric Medical Education of the American Podiatric Medical Association;

4. Number of years in active, clinical practice in the United States or Canada following completion of medical or podiatric training and the number of years, if any, in active, clinical practice outside the United States or Canada;

5. The specialty, if any, in which the physician or podiatrist practices;

6. Names of hospitals with which the physician or podiatrist is affiliated;

7. Appointments within the past 10 years to medical or podiatry school faculties with the years of service and academic rank;

8. Publications, not to exceed 10 in number, in peer-reviewed literature within the most recent five-year period;

9. Whether there is access to translating services for non-English speaking patients at the primary and secondary practice settings and which, if any, foreign languages are spoken in the practice;

10. Whether the physician or podiatrist participates in the Virginia Medicaid Program and whether he is accepting new Medicaid patients;

11. A report on felony convictions including the date of the conviction, the nature of the conviction, the jurisdiction in which the conviction occurred, and the sentence imposed, if any;

12. Final orders of any regulatory board of another jurisdiction that result in the denial, probation, revocation, suspension, or restriction of any license or that results in the reprimand or censure of any license or the voluntary surrender of a license while under investigation in a state other than Virginia while under investigation, as well as any disciplinary action taken by a federal health institution or federal agency; and

13. Any final disciplinary or other action required to be reported to the board by health care institutions, other practitioners, insurance companies, health maintenance organizations, and professional organizations pursuant to §§54.1-2400.6, 54.1-2908, and 54.1-2909 that results in a suspension or revocation of privileges or the termination of employment.

B. Adjudicated notices and final orders or decision documents, subject to s 54.1-2400.2 F of the Code of Virginia, shall be made available on the profile. Information shall be posted indicating the availability of unadjudicated notices and of orders that have not yet become final.
C. For the sole purpose of expediting dissemination of information about a public health emergency, an email address or facsimile number shall be provided, if available. Such addresses or numbers shall not be published on the profile and shall not be released or made available for any other purpose.

18VAC85-20-285. Voluntary information.

A. The doctor may provide names of insurance plans accepted or managed care plans in which he participates.

B. The doctor may provide additional information on hours of continuing education earned, subspecialities obtained, honors or awards received.

18VAC85-20-290. Reporting of malpractice paid claims.

A. In compliance with requirements of §54.1-2910.1 of the Code of Virginia, a doctor of medicine, osteopathic medicine, or podiatry licensed by the board shall report all medical malpractice judgments and settlements of $10,000 or more in the most recent 10-year period within 30 days of the initial payment. A doctor shall report a medical malpractice judgment or settlement of less than $10,000 if any other medical malpractice judgment or settlement has been paid by or for the licensee within the preceding 12 months. Each report of a settlement or judgment shall indicate:

1. The year the judgment or settlement was paid.
2. The specialty in which the doctor was practicing at the time the incident occurred that resulted in the judgment or settlement.
3. The total amount of the judgment or settlement in United States dollars.
4. The city, state, and country in which the judgment or settlement occurred.

B. The board shall not release individually identifiable numeric values of reported judgments or settlements but shall use the information provided to determine the relative frequency of judgments or settlements described in terms of the number of doctors in each specialty and the percentage with malpractice judgments and settlements within the most recent 10-year period. The statistical methodology used will include any specialty with more than 10 judgments or settlements. For each specialty with more than 10 judgments or settlements, the top 16% of the judgments or settlements will be displayed as above average payments, the next 68% of the

judgments or settlements will be displayed as average payments, and the last 16% of the judgments or settlements will be displayed as below average payments.

C. For purposes of reporting required under this section, medical malpractice judgment and medical malpractice settlement shall have the meanings ascribed in § 54.1-2900 of the Code of Virginia. A medical malpractice judgment or settlement shall include:

1. A lump sum payment or the first payment of multiple payments;

2. A payment made from personal funds;

3. A payment on behalf of a doctor of medicine, osteopathic medicine, or podiatry by a corporation or entity comprised solely of that doctor of medicine, osteopathic medicine, or podiatry; or

4. A payment on behalf of a doctor of medicine, osteopathic medicine or podiatry named in the claim where that doctor is dismissed as a condition of, or in consideration of the settlement, judgment or release. If a doctor is dismissed independently of the settlement, judgment or release, then the payment is not reportable.

18VAC85-20-300. Non-compliance or falsification of profile.

A. The failure to provide the information required by 18 VAC 85-20-280 and by 18 VAC 85-20-290 within 30 days of the request for information by the board or within 30 days of a change in the information on the profile may constitute unprofessional conduct and may subject the licensee to disciplinary action by the board.

B. Intentionally providing false information to the board for the practitioner profile system shall constitute unprofessional conduct and shall subject the licensee to disciplinary action by the board.

Residency: Extended postgraduate training usually in relation to establishing a specialty field of medical practice.

Revocation: The loss of licensure. A practitioner's license is revoked for a minimum of one year before he is eligible to petition for reinstatement (except in the case of a mandatory revocation. See § 54.1-2917 of the Code of Virginia). The practitioner cannot practice during the period of revocation.

S

Self-designated practice area: The practice area in which the licensee declares a special interest; i.e., family practice, pediatrics, urology, etc. Board Certification is not a requirement for selecting a self-designated practice area.

Self-reported: The licensee has reported this information and assumes responsibility for its accuracy and completeness. It has not been verified or confirmed by the Board of Medicine; however the Board reserves the right to audit or investigate.

Settlement: In the context of a paid malpractice claim, a settlement is an agreement between the

parties in which payment is made to the plaintiff to resolve the claim without proceeding to court. A court may approve the settlement, but it is not an award of the court. A settlement does not necessarily mean that the practitioner admits liability for damages sustained by the plaintiff.

Surrendered: By consent order, a practitioner agrees to surrender the license and the Board accepts the surrender in lieu of further proceedings. The practitioner can then no longer lawfully practice. "Surrendered" can also mean the surrender of the privilege to renew the license. This privilege is available to a practitioner whose license has expired for less than two years. Upon acceptance by the Board, the practitioner cannot renew the license without approval of the Board. Permanent surrender of the license or the privilege to renew means the practitioner agrees never to seek to regain the license and the ability to practice in Virginia.

Suspension: A practitioner's license is suspended for a specified period of time. A practitioner cannot practice until the suspension has been stayed, lifted or terminated by the Board.

Virginia Board of Medicine
Practitioner Information

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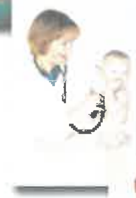
Thank you for visiting the Virginia Board of Medicine's Practitioner Information Website. This site contains information on over 30,000 Doctors of Medicine, Osteopathic Medicine, and Podiatry licensed in the Commonwealth of Virginia.



About this site

The following information contained in this database is provided from the records of the Board of Medicine.

- Licensee name
- License number
- Date of issue
- Date of expiration
- Any Virginia Board of Medicine Notice or Order

The Department and the Board have taken measures to assure that the above information reflects information contained in records that it maintains consistent with its statutory responsibility to doctors of medicine, osteopathy, and podiatry.

The following information is required to be self-reported by licensees under penalty of law. This information is not verified by the Board. The Department and the Board have the authority to investigate reported inaccuracies in the displayed information and if warranted, seek correction and effect licensee compliance with the law and regulations governing the practitioner information system.

Required information provided by doctors:

- Practice information (location(s), telephone number(s), translating services, percentage of time spent at location(s)
- Education
- Years in active clinical practice
- Board Certifications
- Hospital affiliations
- Academic appointments
- Publications
- Medicaid participation
- Actions
- Felony convictions
- Paid claims in the most recent ten years

Optional information doctors may choose to include:

- Insurance plans accepted or managed care plans in which they participate
- Self-Designated practice area
- Honors and awards received
- Medicare information
- Hours of continuing education
- Practice name
- Days of the week at practice location
- Maiden name
- Web site address
- Non-emergency email address

The Board does not comprehensively verify the information required to be self-reported by doctors, and therefore does not accept responsibility for the accuracy of self-reported information. The Board conducts periodic random audits of profiles as an effort to improve the accuracy and timeliness of the information.

Please note that if a practitioner's license is not active, they are under no obligation to update their profile so the information contained in that profile may not be up-to-date.

Begin a search

Perimeter Center, 9960 Mayland Drive, Suite 300, Henrico, VA, 23233-1463
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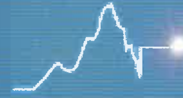
Virginia.gov Agencies | Governor Search Virginia.Gov



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6. Any appointments, within the most recent 10-year period, of the doctor to the faculty of a school of medicine, osteopathy or podiatry and any publications in peer-reviewed literature within the most recent five-year period and as specified by regulations of the Board;
7. The location and telephone number of any primary and secondary practice settings and the approximate percentage of the doctor's time spent practicing in each setting. For the sole purpose of expedited dissemination of information about a public health emergency, the doctor shall also provide to the Board any e-mail address or facsimile number; however, such e-mail address or facsimile number shall not be published on the profile database and shall not be released or made available for any other purpose;
8. The access to any translating service provided to the primary and secondary practice settings of the doctor;
9. The status of the doctor's participation in the Virginia Medicaid Program;
10. Any final disciplinary or other action required to be reported to the Board by health care institutions, other practitioners, insurance companies, health maintenance organizations, and professional organizations pursuant to §§ 54.1-2400.6, 54.1-2908, and 54.1-2909 that results in a suspension or revocation of privileges or the termination of employment or a final order of the Board relating to disciplinary action;
11. Conviction of any felony; and
12. Other information related to the competency of doctors of medicine, osteopathy, and podiatry, as specified in the regulations of the Board.

B. In addition, the Board shall provide for voluntary reporting of insurance plans accepted and managed care plans in which the doctor participates.

C. The Board shall promulgate regulations to implement the provisions of this section, including, but not limited to, the release, upon request from a consumer, of such information relating to a specific doctor. The Board's regulations shall provide for reports to include all medical malpractice judgments and medical malpractice settlements of more than $10,000 within the most recent 10-year period in categories indicating the level of significance of each award or settlement; however, the specific numeric values of reported paid claims shall not be released in any individually identifiable manner under any circumstances. Notwithstanding this subsection, a licensee shall report a medical malpractice judgment or medical malpractice settlement of less than $10,000 if any other medical malpractice judgment or medical malpractice settlement has been paid by or for the licensee within the preceding 12 months

D. This section shall not apply to any person licensed pursuant to §§ 54.1-2928.1, 54.1-2933.1, 54.1-2936, and 54.1-2937 or to any person holding an inactive license to practice medicine, osteopathy, or podiatry.

(1998, c. 744; 1999, c. 573; 2000, c. 199; 2001, c. 199; 2001, Sp. Sess. I, c. 5; 2002, c. 38; 2004, cc. 64, 703; 2007, c. 861; 2008, c. 479.)

Licensee: A person who meet the requirements to have a license in the State of Virginia

M

Medicare Participating Provider: A licensee who contractually accepts the participating provider fee schedule.

N

Notices or Statement of Particulars:A "Notice and/or "Statement of Particulars" contains a statement of charges that have not been proven. The Board will meet with the named practitioner to discuss these charges and make a decision, or settle the charges with a consent order. After the meeting, the Board may decide to exonerate the practitioner or dismiss the charges. Or, the Board may decide that some or all of the charges are proven and a violation of law or regulation occurred. If the evidence supports a violation, the Board may take appropriate action against the license of the practitioner. Until the Board issues a decision (by letter, order or consent order) that contains findings about these charges, they are not proven.

O

Optional Data Elements: Not required by law or regulations however, the physician has the option of including these elements in their profile. These elements include:
Continuing Education
Days of Week at Practice Locations
Email Address
Fax number at Practice Locations
Honors and Awards
Maiden name
Medicare participation
Website Address

Order: The document issued by the Board of Medicine indicating the Board's decision that the practitioner, as a matter of past or present fact, is or is not in violation of law or regulation. Typically, an order resolves the allegations in the Notice, and contains findings of fact and conclusions of law. It may impose a sanction or require some action by the practitioner. In some cases, the Board's decision is to dismiss the allegations in the Notice and such a decision is usually stated in a letter. "Order" also applies to "Consent Orders" which are agreed to by the practitioner, often without a meeting with the Board.

Orders and letters containing the Board's resolution of allegations are public documents and copies are available.

P

Paid Claim: In the context of malpractice, a paid claim is a payment made to a person in response to a claim. It may be in the form of a "judgment" or "settlement."

Peer-Reviewed Literature: A journal or publication whose articles are reviewed and selected by an editorial board comprised of individuals having attained similar certification, education, training, and experience.

Practice Address: A location where the licensee engages in practice of medicine, osteopathy, or podiatry regardless if patients are seen. Practitioners may designate a primary practice address and additional practice addresses.

Practitioner Has Not Provided Information: This message appears when a doctor has not yet completed their profile. By regulation, doctors have thirty days from the date of request from the Board to provide the requested information.

Probation: A status whereby a practitioner maintains their license but must comply with the terms and conditions required by the Board. The conditions may restrict the practice.

R

Regulations: Rules adopted by the Board to implement the Law. Regulations pertaining to the Physician Profile are:

18VAC85-20-280. Required information.

A. In compliance with requirements of §54.1-2910.1 of the Code of Virginia, a doctor of medicine, osteopathic medicine, or podiatry licensed by the board shall provide, upon initial request or whenever there is a change in the information that has been entered on the profile, the following information within 30 days:

1. The address and telephone number of the primary practice setting and all secondary practice settings with the percentage of time spent at each location;
2. Names of medical, osteopathic or podiatry schools and graduate medical or podiatric education programs attended with dates of graduation or completion of training;
3. Names and dates of specialty board certification, if any, as approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of the American Osteopathic Association or the Council on Podiatric Medical Education of the American Podiatric Medical Association;
4. Number of years in active, clinical practice in the United States or Canada following completion of medical or podiatric training and the number of years, if any, in active, clinical practice outside the United States or Canada;
5. The specialty, if any, in which the physician or podiatrist practices;
6. Names of hospitals with which the physician or podiatrist is affiliated;
7. Appointments within the past 10 years to medical or podiatry school faculties with the years of service and academic rank;
8. Publications, not to exceed 10 in number, in peer-reviewed literature within the most recent five-year period;
9. Whether there is access to translating services for non-English speaking patients at the primary and secondary practice settings and which, if any, foreign languages are spoken in the practice;
10. Whether the physician or podiatrist participates in the Virginia Medicaid Program and whether he is accepting new Medicaid patients;

11. A report on felony convictions including the date of the conviction, the nature of the conviction, the jurisdiction in which the conviction occurred, and the sentence imposed, if any;
12. Final orders of any regulatory board of another jurisdiction that result in the denial, probation, revocation, suspension, or restriction of any license or that results in the reprimand or censure of any license or the voluntary surrender of a license while under investigation in a state other than Virginia while under investigation, as well as any disciplinary action taken by a federal health institution or federal agency; and
13. Any final disciplinary or other action required to be reported to the board by health care institutions, other practitioners, insurance companies, health maintenance organizations, and professional organizations pursuant to §§54.1-2400.6, 54.1-2908, and 54.1-2909 that results in a suspension or revocation of privileges or the termination of employment.

B. Adjudicated notices and final orders or decision documents, subject to §54.1-2400.2 F of the Code of Virginia, shall be made available on the profile. Information shall be posted indicating the availability of unadjudicated notices and of orders that have not yet become final.

C. For the sole purpose of expediting dissemination of information about a public health emergency, an email address or facsimile number shall be provided, if available. Such addresses or numbers shall not be published on the profile and shall not be released or made available for any other purpose.

18VAC85-20-285. Voluntary information.

A. The doctor may provide names of insurance plans accepted or managed care plans in which he participates.

B. The doctor may provide additional information on hours of continuing education earned, subspecialities obtained, honors or awards received.

18VAC85-20-290. Reporting of medical malpractice judgments and settlements.

A. In compliance with requirements of § 54.1-2910.1 of the Code of Virginia, a doctor of medicine, osteopathic medicine, or podiatry licensed by the board shall report all medical malpractice judgments and settlements of $10,000 or more in the most recent 10-year period within 30 days of the initial payment. A doctor shall report a medical malpractice judgment or settlement of less than $10,000 if any other medical malpractice judgment or settlement has been paid by or for the licensee within the preceding 12 months. Each report of a settlement or judgment shall indicate:

1. The year the judgment or settlement was paid.
2. The specialty in which the doctor was practicing at the time the incident occurred that resulted in the judgment or settlement.
3. The total amount of the judgment or settlement in United States dollars.
4. The city, state, and country in which the judgment or settlement occurred.

B. The board shall not release individually identifiable numeric values of reported judgments or settlements but shall use the information provided to determine the relative frequency of judgments or settlements described in terms of the number of doctors in each specialty and the percentage with malpractice judgments and settlements within the most recent 10-year period. The statistical methodology used will include any specialty with more than 10 judgments or settlements. For each specialty with more than 10 judgments or settlements, the top 16% of the judgments or settlements will be displayed as above average payments, the next 68% of the judgments or settlements will be displayed as average payments, and the last 16% of the judgments or settlements will be displayed as below average payments.

C. For purposes of reporting required under this section, medical malpractice judgment and medical malpractice settlement shall have the meanings ascribed in § 54.1-2900 of the Code of Virginia. A medical malpractice judgment or settlement shall include:

1. A lump sum payment or the first payment of multiple payments;
2. A payment made from personal funds;
3. A payment on behalf of a doctor of medicine, osteopathic medicine, or podiatry by a corporation or entity comprised solely of that doctor of medicine, osteopathic medicine, or podiatry; or
4. A payment on behalf of a doctor of medicine, osteopathic medicine or podiatry named in the claim where that doctor is dismissed as a condition of, or in consideration of the settlement, judgment or release. If a doctor is dismissed independently of the settlement, judgment or release, then the payment is not reportable.

18VAC85-20-300. Non-compliance or falsification of profile.

A. The failure to provide the information required by 18 VAC 85-20-280 and by 18 VAC 85-20-290 within 30 days of the request for information by the board or within 30 days of a change in the information on the profile may constitute unprofessional conduct and may subject the licensee to disciplinary action by the board.

B. Intentionally providing false information to the board for the practitioner profile system shall constitute unprofessional conduct and shall subject the licensee to disciplinary action by the board.

Residency: Extended postgraduate training usually in relation to establishing a specialty field of medical practice.

Revocation: The loss of licensure. A practitioner's license is revoked for a minimum of three years (five years for violations pursuant to 54.1-2915(A)(19) of the Code of Virginia) before he is eligible to petition for reinstatement (see 54.1-2408.2 of the Code of Virginia for text of the full law). The practitioner cannot practice during the period of revocation.

S

Self-designated practice area: The practice area that the licensee declares a special interest in i.e., family practice, pediatrics, urology, etc. Board Certification is not a requirement for selecting a self-designated practice area.

Self-reported: The licensee has reported this information and assumes responsibility for its accuracy and completeness. It has not been verified or confirmed by the Board of Medicine however the Board reserves the right to audit or investigate.

Settlement: In the context of a paid malpractice claim, a settlement is an agreement between the parties in which payment is made to the plaintiff to resolve the claim without proceeding to court. A court may approve the settlement, but it is not an award of the court. A settlement does not necessarily mean that the practitioner admits liability for damages sustained by the plaintiff.

Surrendered: By consent order, a practitioner agrees to surrender the license and the Board accepts the surrender in lieu of further proceedings. The practitioner can then no longer lawfully practice. "Surrendered" can also mean the surrender of the privilege to renew the license. This privilege is available to a practitioner whose license has expired for less than two years. Upon acceptance by the Board, the practitioner cannot renew the license without approval of the Board. Permanent surrender of the license or the privilege to renew means the practitioner agrees never to seek to regain the license and the ability to practice in Virginia.

Suspension: A practitioner's license is suspended for a specified period of time. A practitioner cannot practice until the suspension has been stayed, lifted or terminated by the Board.

T

Telephone interpretation: Over the telephone interpretation service available. Translating services for many languages and dialects available. Please call the doctor's office for further details.

Perimeter Center, 9960 Mayland Drive, Suite 300, Henrico, VA, 23233-1463
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Agenda Items: Adopt revisions to Guidance Document 85-23

Included in your agenda package are:

- Proposed revisions to Guidance Document 85-23 as recommended by the Legislative Committee in both redline and clean version

Action needed:

- Motion to accept recommendation of Legislative Committee regarding revisions to Guidance Document 85-23

Guidance Document 85-23

Revised: October ~~18, 2018~~6, 2022
Effective: December 8, 2022

Formatted: Right

~~Virginia~~ Board of Medicine ~~on~~

Use of Confidential Consent Agreements

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

The determination as to the appropriateness of a confidential consent agreement shall be made by the Board and/or Board staff at the probable cause stage through a review and recommendation by the Executive Director or Medical Review Coordinator. The types of cases that may be subject to the use of a confidential consent agreement ~~will~~ include, but are not limited to, the following:

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

Board of Medicine

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

Agenda Item: Statewide Pharmacy Protocols

Staff Note: The 2022 General Assembly passed HB1323 which further expanded the authorization of pharmacists to initiate treatment for certain conditions. On August 8, 2022, a Work Group comprised of 3 Board of Medicine members, 3 Board of Pharmacy members, and a physician and a pharmacist from the Virginia Department of Health met to derive protocols for COIVD vaccines, Tobacco Cessation therapies, and COVID testing. In the following pages you will find a Vaccine Statewide Protocol, a Pharmacist Statewide Protocol for Tobacco Cessation, and a Pharmacist Statewide Protocol for Coronavirus Testing.

Action: These protocols are required by law. They have been carefully crafted by the Work Group to meet the requirements in the Code. The Board can discuss the protocols with anticipation of their adoption.

VIRGINIA BOARD OF PHARMACY

Vaccine Statewide Protocol

(Effective upon the expiration of the provisions of the federal Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19 related to the vaccination and COVID-19 testing of minors.)

Consistent with the Immunization Schedule published by the Centers for Disease Control and Prevention ("CDC") or current emergency use authorization from the U.S. Food and Drug Administration, a pharmacist may issue a prescription to initiate treatment with, dispense, or administer, or may direct a pharmacy technician or pharmacy intern under the supervision of the pharmacist to administer vaccines to persons 3 years of age or older.

PHARMACIST EDUCATION AND TRAINING
Prior to issuing a prescription to initiate treatment with a patient, dispensing, or administering vaccines under this protocol, the pharmacist shall be knowledgable of the manufacturer's instructions for use or instructions indicated in the emergency use authorization, the current Immunization Schedule published by the CDC, how to properly identify which vaccines a patient may require, storage and handling requirements, and how to counsel the patient on possible adverse reactions.

PHARMACY TECHNICIAN AND PHARMACY INTERN TRAINING
Prior to administering a vaccine, a pharmacy technician or pharmacy intern shall have completed a practical training program of at least 20 hours that is approved by the Accreditation Council for Pharmacy Education ("ACPE"). This training program must include hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines.

PATIENT INCLUSION CRITERIA
The pharmacist shall review applicable medical history prior to administering a vaccine to ensure the vaccine administration is appropriate for the patient's medical condition(s) (e.g., pregnancy or immunocompromised state). The following patients are eligible for vaccines under this protocol:

- An individual 3 years of age or older whose immunization history is incomplete or unknown and for whom a vaccine is recommended at his or her age in accordance with the most current Child and Adolescent Immunization Schedule or the Adult Immunization Schedule published by the CDC inclusive of additional information for COVID-19 vaccination.
- An individual 3 years of age or older whose immunization history is incomplete or unknown and for whom a vaccine with current emergency use authorization from the U.S. Food and Drug Administration is recommended by the CDC; and,
- An individual 3 years of age or older preparing to travel to a destination for which immunization history is incomplete or unknown and for whom a vaccine is recommended by the CDC prior to traveling to the specific destination.

PATIENT EXCLUSION CRITERIA
The following patients are NOT eligible for vaccines under this protocol:

- An individual less than 3 years of age;
- An individual for whom a vaccine is not recommended by the CDC for reasons such as based on the patient's medical condition(s); or
- An individual who has received all CDC recommended doses for their age, medical condition or other indicators.

COUNSELING
The pharmacist shall ensure the patient or patient's agent is provided with written information regarding the vaccine and possible adverse reactions.

RECORDKEEPING
The pharmacist shall maintain records in accordance with Regulation 18VAC110-21-46 and report such administration to the Virginia Immunization Information System in accordance with the requirements of§ 32.1-46.01.

NOTIFICATION OF PRIMARY CARE PROVIDER
In accordance with 54.1-3303.1 of the Code of Virginia, the pharmacist shall notify the patient's primary care provider. If the patient does not have a primary care provider, the pharmacist shall counsel the patient regarding the benefits of establishing a relationship with a primary health care provider and provide information regarding primary health care providers, including federally qualified health centers, free clinics, or local health departments serving the area in which the patient is located. A pharmacist who administers a vaccination to a minor shall provide written notice to the minor's parent or guardian that the minor should visit a pediatrician annually.

Adopted: _______
Effective: _________

VIRGINIA BOARD OF PHARMACY

Pharmacist Statewide Protocol for Tobacco Cessation

Consistent with Virginia Code § 54.1-3303.1, a pharmacist may initiate treatment with U.S Food and Drug Administration-approved Nicotine Replacement Therapy ("NRT") and other tobacco cessation therapies ("Non-NRT"), including controlled substances as defined in the Drug Control Act (Va. Code § 54.1-3400 et seq.), together with providing appropriate patient counseling.

PHARMACIST INITIATION OF TREATMENT

A licensed pharmacist may prescribe an individual 18 years of age or older NRT and Non-NRT for tobacco cessation.

PHARMACIST EDUCATION AND TRAINING

Pharmacists initiating treatment for tobacco cessation shall receive appropriate training to conduct the activity in a safe and effective manner. This includes a minimum of two hours of documented continuing education provided by the Accreditation Council for Pharmacy Education ("ACPE") related to pharmacists prescribing tobacco cessation products.

OBTAINING HISTORY

The pharmacist shall obtain a history from the patient, including questioning the patient for any known allergies, adverse reactions, contraindications, or health diagnoses or conditions that would be adverse to the initiation of tobacco cessation therapy.

RECORDKEEPING

The pharmacist shall maintain records in accordance with 18VAC110-21-46.

NOTIFICATION OF PRIMARY CARE PROVIDER

In accordance with 54.1-3303.1 of the Code of Virginia, the pharmacist shall notify the patient's primary care provider, provided that the patient consents to such notification. If the patient does not have a primary care provider, the pharmacist shall counsel the patient regarding the benefits of establishing a relationship with a primary health care provider and provide information regarding primary health care providers, including federally qualified health centers, free clinics, or local health departments serving the area in which the patient is located.

DRAFT - Tobacco Cessation Self-Screening Patient Intake Form

CONFIDENTIAL- Protected Health Information

Date of Birth_______/____/______ Age_____

Date_______/____/_____

Legal Name______________________________ Preferred Name ______________________

Sex Assigned at Birth (circle) M / F Gender Identification (circle) M / F / Other

Preferred Pronouns (circle) She/Her/Hers, He/Him/His, They/Them/Their, Ze/Hir/Hirs, Other__________

Street Address____

Phone ( ) ______________________ Email Address ______________________

Primary Care Provider ________________ Phone ( ) ___________ Fax ( ) ____________

Do you have health insurance? Yes/ No Insurance Provider Name ____________________

Any allergies to medications? Yes/ No If yes, please list ______________________

Any allergies to foods (ex. menthol/soy)? Yes/ No If yes, please list ______________________

List of medicine(s) you take:

____

____

Do you consent to the pharmacy notifying your primary care provider should medication be initiated? Yes/ No

Do you have a preferred tobacco cessation product you would like to use?________________

Have you tried quitting smoking in the past? If so, please describe ____________________

What best describes how you have tried to stop smoking in the past?

- ☐ "Cold turkey"
- ☐ Tapering or slowly reducing the number of cigarettes you smoke a day
- ☐ Medicine
  - o Nicotine replacement (like patches, gum, inhalers, lozenges, etc.)
  - o Prescription medications (ex. bupropion [Zyban®, Wellbutrin®], varenicline [Chantix®])
- ☐ Other ________________________________

Health and History Screen - Background Information:

1.	Are you under 18 years old?	☐Yes☐ No
2.	Are you pregnant, nursing, or planning on getting pregnant or nursing in the next 6 months?	☐Yes☐ No☐ Not sure
3.	Are you currently using and trying to quit non-cigarette products (ex. Chewing tobacco, vaping, e-cigarettes, Juul)?	☐Yes☐ No

Medical History:

4.	Have you ever had a heart attack, irregular heartbeat or angina, or chest pains in the past two weeks?	☐ Yes ☐ No ☐ Not sure
5.	Do you have stomach ulcers?	☐ Yes ☐ No ☐ Not sure
6.	Do you wear dentures or have TMJ (temporomandibular joint disease)?	☐ Yes ☐ No ☐ Not sure
7.	Do you have a chronic nasal disorder (ex. nasal polyps, sinusitis, rhinitis)?	☐ Yes ☐ No ☐ Not sure
8.	Do you have asthma or another chronic lung disorder (ex. COPD, emphysema, chronic bronchitis)?	☐ Yes ☐ No ☐ Not sure

Tobacco History:

9.	Do you smoke between 0-4 cigarettes per day OR less than 1 can or pouch per week of snuff or chew?	☐Yes☐ No
10	Do you smoke between 5-10 cigarettes per day OR 1-2 cans or pouches per week of snuff or chew OR 3-6mg/ml e-liquid?	☐Yes☐ No
11	Do you smoke 11+ cigarettes per day OR 2 cans or pouches per week of snuff or chew OR 6-12+mg/ml e-liquid?	☐Yes☐ No

Tobacco Cessation Self-Screening Patient Intake Form
CONFIDENTIAL- Protected Health Information

Blood Pressure Reading _______/_______ mmHg *(Note: Must be taken by a pharmacist)*

Stop here if patient and pharmacist are considering nicotine replacement therapy or blood pressure is ≥ 160/100 mmHg.

If patient and pharmacist are considering non-nicotine replacement therapy (ex. varenicline or bupropion) and blood pressure is < 160/100mmHg continue to answer the questions below.

Medical History Continued:

12.	Have you ever had an eating disorder such as anorexia or bulimia?	☐Yes☐ No☐ Not sure
13.	Have you ever had a seizure, convulsion, significant head trauma, brain surgery, history of stroke, or a diagnosis of epilepsy?	☐Yes☐ No☐ Not sure
14.	Have you ever been diagnosed with chronic kidney disease?	☐Yes☐ No☐ Not sure
15.	Have you ever been diagnosed with liver disease?	☐Yes☐ No☐ Not sure
16.	Have you been diagnosed with or treated for a mental health illness in the past 2 years? (ex. depression, anxiety, bipolar disorder, schizophrenia)?	☐Yes☐ No☐ Not sure

Medication History:

17.	Do you take a monoamine oxidase inhibitor (MAOI) antidepressant? (ex. selegiline [Emsam®, Zelapar®], Phenelzine [Nardil®], Isocarboxazid [Marplan®], Tranylcypromine [Parnate®], Rasagiline [Azilect®])	☐ Yes ☐ No ☐ Not sure
18.	Do you take linezolid?	☐ Yes ☐ No ☐ Not sure
19.	Do you use alcohol or have you recently stopped taking sedatives? (ex. Benzodiazepines)	☐ Yes ☐ No ☐ Not sure

The Patient Health Questionnaire 2 (PHQ 2):

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

Suicide Screening:

Over the last 2 weeks, how often have you had thoughts that you would be better off dead, or have you hurt yourself or had thoughts of hurting yourself in some way?	0	1	2	3

Patient Signature____ Date______________

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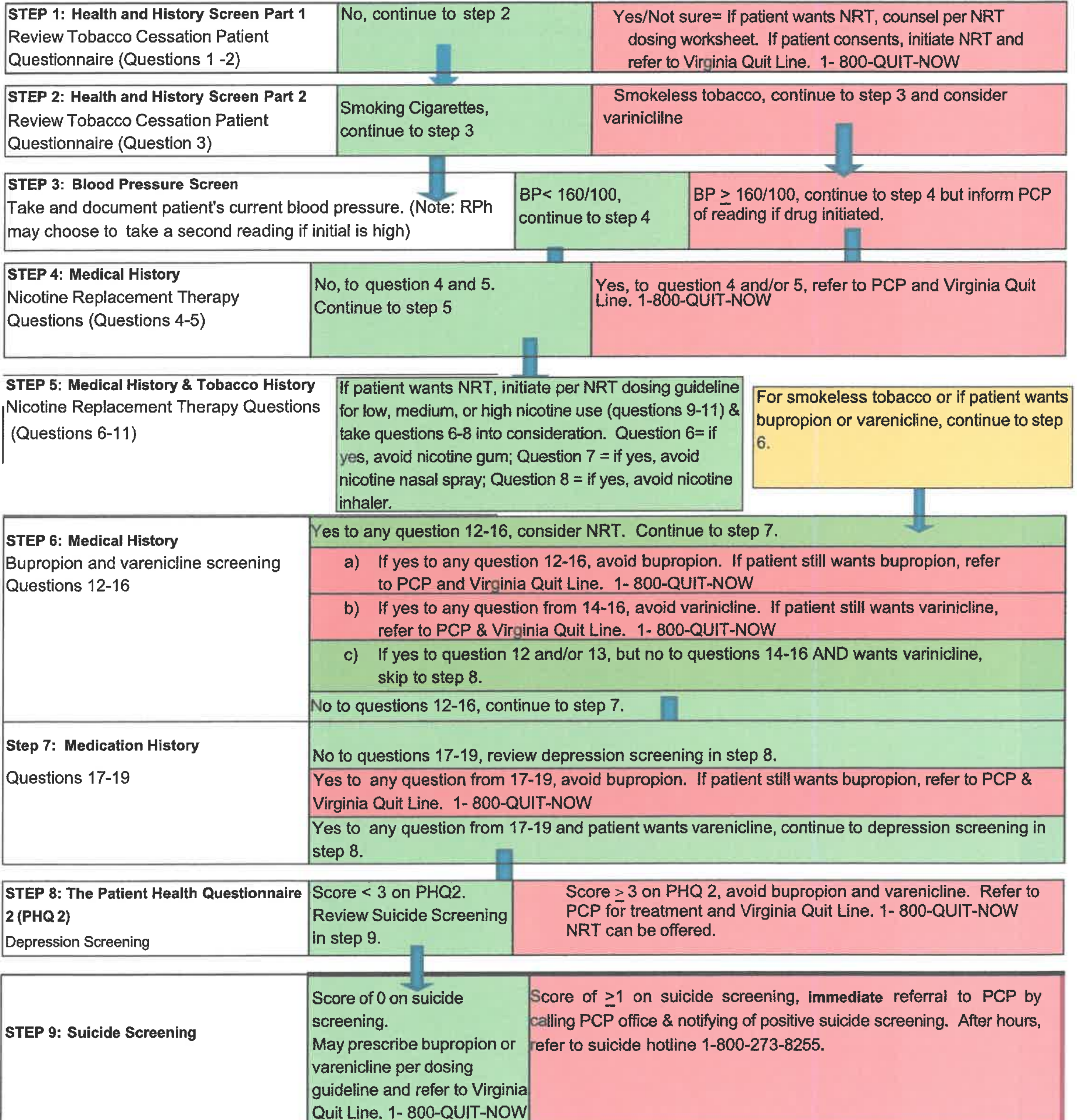
Tobacco Cessation Assessment and Treatment Care Pathway

(DRAFT)



Step			
STEP 1: Health and History Screen Part 1 Review Tobacco Cessation Patient Questionnaire (Questions 1 -2)	No, continue to step 2	Yes/Not sure= If patient wants NRT, counsel per NRT dosing worksheet. If patient consents, initiate NRT and refer to Virginia Quit Line. 1- 800-QUIT-NOW	
STEP 2: Health and History Screen Part 2 Review Tobacco Cessation Patient Questionnaire (Question 3)	Smoking Cigarettes, continue to step 3	Smokeless tobacco, continue to step 3 and consider varinicline	
STEP 3: Blood Pressure Screen Take and document patient's current blood pressure. (Note: RPh may choose to take a second reading if initial is high)	BP< 160/100, continue to step 4	BP $\geq$ 160/100, continue to step 4 but inform PCP of reading if drug initiated.	
STEP 4: Medical History Nicotine Replacement Therapy Questions (Questions 4-5)	No, to question 4 and 5. Continue to step 5	Yes, to question 4 and/or 5, refer to PCP and Virginia Quit Line. 1-800-QUIT-NOW	
STEP 5: Medical History & Tobacco History Nicotine Replacement Therapy Questions (Questions 6-11)	If patient wants NRT, initiate per NRT dosing guideline for low, medium, or high nicotine use (questions 9-11) & take questions 6-8 into consideration. Question 6= if yes, avoid nicotine gum; Question 7 = if yes, avoid nicotine nasal spray; Question 8 = if yes, avoid nicotine inhaler.	For smokeless tobacco or if patient wants bupropion or varenicline, continue to step 6.	
STEP 6: Medical History Bupropion and varenicline screening Questions 12-16	Yes to any question 12-16, consider NRT. Continue to step 7.		
	a) If yes to any question 12-16, avoid bupropion. If patient still wants bupropion, refer to PCP and Virginia Quit Line. 1- 800-QUIT-NOW		
	b) If yes to any question from 14-16, avoid varinicline. If patient still wants varinicline, refer to PCP & Virginia Quit Line. 1- 800-QUIT-NOW		
	c) If yes to question 12 and/or 13, but no to questions 14-16 AND wants varinicline, skip to step 8.		
	No to questions 12-16, continue to step 7.		
Step 7: Medication History Questions 17-19	No to questions 17-19, review depression screening in step 8.		
	Yes to any question from 17-19, avoid bupropion. If patient still wants bupropion, refer to PCP & Virginia Quit Line. 1- 800-QUIT-NOW		
	Yes to any question from 17-19 and patient wants varenicline, continue to depression screening in step 8.		
STEP 8: The Patient Health Questionnaire 2 (PHQ 2) Depression Screening	Score < 3 on PHQ2. Review Suicide Screening in step 9.	Score $\geq$ 3 on PHQ 2, avoid bupropion and varenicline. Refer to PCP for treatment and Virginia Quit Line. 1- 800-QUIT-NOW NRT can be offered.	
STEP 9: Suicide Screening	Score of 0 on suicide screening. May prescribe bupropion or varenicline per dosing guideline and refer to Virginia Quit Line. 1- 800-QUIT-NOW	Score of $\geq$1 on suicide screening, **immediate** referral to PCP by calling PCP office & notifying of positive suicide screening. After hours, refer to suicide hotline 1-800-273-8255.	

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Dosing Guidelines

Nicotine Replacement Therapy (NRT) Dosing:

	High Nicotine Use	Medium Nicotine Use	Low Nicotine Use
•Initiate therapy based on maximum use of nicotine/day at therapy initiation. •Combination Nicotine Replacement Therapy is strongly recommended. Monotherapy may also be appropriate. •Therapy choice should be based on time to first use, quantity, patient preference and comorbidities, data from past attempts, and desired quit date. **•NRT use in women who are pregnant or breastfeeding**: the patient should be educated on the risks or smoking or vaping versus the unknown risks of NRT. If the patient consents to NRT, then intermittent delivery formulations (gum, lozenge or inhaler) are believed to be safer than continuous delivery (avoid use of Transdermal Dermal patch). If the patient is pregnant, educate on importance of PCP/OBGyn for further prenatal care.	11+ cigarettes per day OR ≥ 2 cans or pouches per week of snuff or chew OR 6-12+mg/ml e-liquid	5-10 cigarettes per day OR 1 to 2 cans or pouches per week of snuff or chew OR 3-6mg/mL e-liquid	0-4 cigarettes per day OR less than 1 can or pouch per week of snuff or chew
	Per Product Label: •Nicotine Patch 21mg/24hrs for 8 weeks. Then, •Nicotine Patch 14mg/24hrs for 2 weeks. Then, •Nicotine Patch 7mg/24hrs for 2 weeks. **AND/OR any of the following as needed** NRT products •Nicotine Gum 4mg every hour as needed for cravings. (Max 20 pieces/day) x 12 weeks. OR •Nicotine lozenge 4mg every hour as needed for cravings. (Max 15/day) x 12 weeks. OR •Nicotine Oral Inhaler Puff 6-16 cartridges per day as needed for cravings x12 weeks. OR •Nicotine Nasal Inhaler 1-2 doses/hour; 8-40 doses per day as needed for cravings x 12 weeks.	Per Product Label: •Nicotine Patch 14mg/24hrs for 8 **weeks.** Then, •Nicotine Patch 7mg/24hrs for 4 Weeks. **AND/OR any of the following as needed** NRT products •Nicotine Gum 2mg every hour as needed for cravings. (Max 20 pieces/day) x 12 weeks. OR •Nicotine lozenge 2mg every hour as needed for cravings. (Max 15/day) x 12 weeks. OR •Nicotine Oral Inhaler Puff 6-16 cartridges per day as needed for cravings x12 weeks. OR •Nicotine Nasal Inhaler 1-2 doses/hour; 8-40 doses per day as needed for cravings x 12 weeks.	Per Product Label: •Nicotine Gum 2mg every hour as needed for cravings. (Max 20 pieces/day) x 12 weeks. **OR** •Nicotine lozenge 2mg every hour as needed for cravings. (Max 15/day) x 12 weeks. OR •Nicotine Oral Inhaler Puff 6-8 cartridges per day as needed for cravings x 12 weeks. OR •Nicotine Nasal Inhaler 1-2 doses/hour; 8-20 doses per day as needed for cravings x 12 weeks.
Additional Pearls	• **Nicotine Patches:** Adjustment may be required during initial treatment (move to higher dose if experiencing withdrawal symptoms; lower dose if side effects are experienced). • **Nicotine Inhaler**: If patient is unable to stop smoking by the fourth week of therapy, consider discontinuation. *Discontinuation of therapy:* After initial treatment, gradually reduce daily dose over 6 to 12 weeks. Some patients may not require gradual reduction of dosage and may stop treatment abruptly. • **Nasal Spray**: Adjust dose as needed based on patient response; do not exceed more than 5 doses (10 sprays) per hour [maximum: 40 mg/day (80 sprays)] or 3 months of treatment. If using nicotine nasal spray alone without nicotine patches, for best results, use at least the recommended minimum of 8 doses per day (less is likely to be effective). Use beyond 6 months is not recommended (has not been studied). If patient is unable to stop smoking by the fourth week of therapy, consider discontinuation. *Discontinuation of therapy:* Discontinue over 4 to 6 weeks. Some patients may not require gradual reduction of dosage and may stop treatment abruptly.		

Dosing Guidelines

Non-Nicotine Replacement Therapy Dosing:

Prescribing Bupropion

- 150mg SR daily for 3 days then 150mg SR twice daily for 8 weeks or longer. Quit day after day 7.
- Consider combining with Nicotine patch or Nicotine lozenge or Nicotine gum for increased efficacy.
- For patients who do not tolerate titration to the full dose, consider continuing 150mg once daily as the lower dose has shown efficacy.

Prescribing Varenicline

- 0.5mg daily for 3 days then 0.5mg twice daily for 4 days then 1mg twice daily for 12 to 24 weeks. Quit day after day 7 or alternatively quit date up to 35 days after initiation of varenicline.
- Generally not used in combination with other smoking cessation medications as first line therapy.
- Advise patient to limit alcohol use while taking varenicline until known if it affects patient's ability to tolerate alcohol.

DRAFT

VIRGINIA BOARD OF PHARMACY

Pharmacist Statewide Protocol for Coronavirus Testing

Consistent with Virginia Code § 54.1-3303.1 and CLIA requirements administered by the U.S. Food and Drug Administration, a pharmacist may initiate ~~treatment with, dispense, or~~ and administer tests for COVID-19 and other coronaviruses to persons ~~18~~ 3 years of age or older.

PHARMACIST EDUCATION AND TRAINING
Pharmacists collecting specimen samples and performing tests for COVID-19 or other coronaviruses shall receive appropriate training to conduct the activity in a safe and effective manner. This includes adherence to the testing device manufacturer's instructions. Completion of training must be documented. For additional information, refer to the "General Guidelines" section on CDC's website and information from the Virginia Department of Health COVID-19 Viral Testing Information for Pharmacists.

PATIENT INCLUSION CRITERIA
Any patient 18 years or older may receive or be administered a test for COVID-19 or other coronav1ruses.

OBTAINING HISTORY
The pharmacist shall obtain a history from the patient, including questioning the patient for any known allergies, adverse reactions, contraindications, or health diagnoses or conditions that would be adverse to the initiation of the test.

RECORDKEEPING
The pharmacist shall maintain records in accordance with 18VAC110-21-46 and ~~report such administration to the Virginia Immunization Information System in accordance with the requirements of§ 32.1-46.01.~~ shall report all positives to the local or state health department in accordance with 32.1-36 and 12VAC5-90.

NOTIFICATION OF PRIMARY CARE PROVIDER
In accordance with 54.1-3303.1 of the Code of Virginia, the pharmacist shall notify the patient's primary care provider. If the patient does not have a primary care provider, the pharmacist shall counsel the patient regarding the benefits of establishing a relationship with a primary health care provider and provide information regarding primary health care providers, including federally qualified health centers, free clinics, or local health departments serving the area in which the patient is located.

EFFECTIVENESS OF PROTOCOL
This protocol authorizes a pharmacist to initiate treatment with, dispense, or administer tests for COVID-19 and other coronaviruses to persons 3 years of age or older upon the expiration of the provisions of the federal Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19 related to the vaccination and COVID-19 testing of minors.

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EXCLUSIONS

Nothing shall preclude a pharmacist, pharmacy technician, or pharmacy intern under the supervision of a pharmacist, meaning that the pharmacist is at the same physical location as the pharmacy technician or pharmacy intern, from performing CLIA-waived tests in accordance with the Food and Drug Administration's CLIA requirements.

Agenda Item: **Licensing Report**

Staff Note: Mr. Sobowale will provide information on note-worthy licensing matters.

Action: None anticipated.

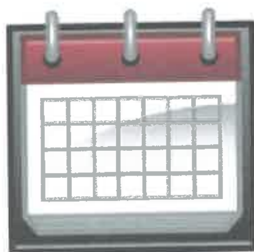
Agenda Item: **Discipline Report**

Staff Note: Ms. Deschenes will provide information on discipline matters.

Action: Consent orders may be presented for consideration.

Next Meeting Date of the Full Board is

February 23-25, 2023



Please check your calendars and advise staff of any known conflicts that may affect your attendance.

The travel regulations require that "travelers must submit the Travel Expense Reimbursement Voucher **within 30 days after completion of their trip"**. (CAPP Topic 20335, State Travel Regulations, p.7). If you submit your reimbursement after the 30-day deadline, please provide a justification for the late submission and be aware that it may not be approved.

In order for the agency to be in compliance with the travel regulations, please submit your request for today's meeting no later than

November 3, 2022