BOARD OF OPTOMETRY
BOARD MEETING
FEBRUARY 7, 2006

TIME AND PLACE:	The meeting was called to order at 10:08 a.m. on Tuesday, February 7, 2006 at the Department of Health Professions, Conference Room 3, 6603 W. Broad St., Richmond, VA.
PRESIDING OFFICER:	David H. Hettler, O.D, President
MEMBERS PRESENT:	Paula H. Boone, O.D. Gregory P. Jellenek, O.D. W. Ernest Schlabach, Jr., O.D. Jacquelyn S. Thomas, Citizen Member William T. Tillar, O.D.
STAFF PRESENT:	Emily Wingfield, Assistant Attorney General, Board Counsel Elizabeth A. Carter, Ph.D., Executive Director for the Board Elaine Yeatts, Senior Regulatory Analyst Carol Stamey, Administrative Assistant Peggy Call, Intervention Program Manager
MEMBERS ABSENT:	All board members were present.
OTHERS PRESENT:	Betty Graumlich, NAOO Zelda Dugger, Board for Opticians, DPOR Elinore McCance-Katz, M.D., Ph.D., VA HPIP, Medical Director
QUORUM:	With six members of the Board present, a quorum was established.
ADOPTION OF AGENDA:	The agenda was revised to include the following topics: prescription blank requirements, prescription monitoring program and Board of Health Professions Report.
PUBLIC COMMENT:	No public comment was presented.
APPROVAL OF MINUTES:	◈**Action** On properly seconded motion by Dr. Jellenek, the Board voted unanimously to approve the minutes of the December 9, 2005 meeting.
PRESENTATION ON SUBSTANCE ABUSE ISSUES:	Dr. Elinore McCance-Katz presented a slide presentation on the topic of health practitioner impairment and addiction. The presentation is incorporated into the minutes as Attachment 1.
REPORT FROM MS. YEATTS	Ms. Yeatts apprised the Board that the "returned check" fee

had increased from $25 (twenty-five) to $35 (thirty-five) due to a change in statute and required an amendment to the regulations.

Action On properly seconded motion by Dr. Jellenek, the Board voted unanimously to adopt the revised fee and amend the regulations.

DISCUSSION ITEMS:

Regulation of Contact Lens as Medical Devices
Dr. Carter advised that the new federal regulations were now in place which clarified that *all* contact lenses, including cosmetic planos, are considered to be medical devices under the U.S. Drug Control Act. She indicated that complaints concerning unlicensed persons dispensing contact lenses without proper prescriptions are directed to investigators of the Food and Drug Administration. Ms. Dugger reported that the Board for Opticians does the same.

COMMITTEE REPORTS:

TPA Formulary Committee
Dr. Tillar reported that the Committee had no actions to report.

Professional Designation Committee
Dr. Boone requested guidance on sanctioning licensees who are found to be using unregistered professional designations. It was discussed that the need to register professional designations was in articles in the last two Board newsletters. It was also noted that allegations regarding professional designation violations were sometimes mixed with other allegations, such as those involving standards of care. As such, it was deemed that each case continue to be adjudicated on a case-by-case basis.

Continuing Education Committee
The Continuing Education Committee asked that a date be scheduled prior to the next full Board meeting. Scheduling had been an issue. May 10th prior to the full board meeting was determined to be the best time. The agenda will include a review of compliance based upon this year's audit results and discussion of what may be needed to improve monitoring such as through the OE Tracker Program and the need for potential amendments to the statutes and regulations.

The percentage for the 2005 random CE audit will remain at 5% (five percent).

Newsletter Committee
Dr. Hettler requested that newsletter articles be submitted by

May 1st for the June 2006 publication. Dr. Schlabach noted that he had submitted articles on continuing education non-compliance and professional designations. Dr. Hettler reported that he would submit an article on the new changes for prescription pads. Additionally, Dr. Schlabach requested that the Board of Pharmacy's Frequently Asked Questions section relating to the new prescription pad requirements be added the Optometry's website. Dr. Carter will draft an article on the topic of the expanding Prescription Monitoring Program.

Credentials Committee
Dr. Boone reported that 3 (three) applicants had been approved for licensure.

CPT Code Committee
Dr. Hettler reported that there were no actions to report from the Committee.

Legislative/Regulatory Review Committee
Dr. Hettler reported that there were no actions to report from the Committee.

EXECUTIVE DIRECTOR'S REPORT:

Case Agency Standards and Other Statistics
Dr. Carter presented a brief summary of the agency's disciplinary performance standards and a statistical analysis of the licensee and case counts. She noted that there had been a 25% (twenty-five percent) increase in the number of disciplinary cases received.

Board Budget
Dr. Carter reported that the Board had approximately $497,000 cash on hand, a figure higher than last year at this time. It was requested that Ms. Yeatts and the Finance Division review the fees and present an overview at the May meeting.

PRESIDENT'S REPORT:

Expense Voucher
Dr. Hettler informed the Board of the availability of an Excel spreadsheet that automatically calculates expense totals on the travel reimbursement expense voucher.

BHP Report
Dr. Hettler reported that the Board of Health Professions had met on January 17th. He stated that the Regulatory Research Committee had been approved to develop a workplan regarding the issue of expunging minor disciplinary offenses against licensees and hold a public hearing. Further, the BHP

Board will be holding an issues forum and a fall retreat to focus on the Board's mission and exchange various Boards' perspectives. Dr. Carter updated the Board regarding the Sanction Reference Study, noting that some of the smaller Boards would begin their reviews within the year.

NEW BUSINESS:

Dr. Schlabach informed the Board that he would be attending the annual Association of Regulatory Boards of Optometry (ARBO) House of Delegates meeting in June as well as the upcoming regional ARBO meeting in February. Dr. Boone noted that she would also like to attend the annual ARBO meeting. Dr. Schlabach was requested to be the voting member at the ARBO meeting.

Dr. Schlabach reported that a National Optometric Continuing Education Conference will be held May 13-14, 2006 to discuss the current status of optometric continuing education and future trends. His plans for attending the meeting will be announced shortly.

Dr. Schlabach requested that staff explore the feasibility of obtaining laptops for Board members for Board business.

Action On properly seconded motion by Dr. Schlabach, the Board voted unanimously that Dr. Carter submit a request to the Data Division to obtain computer laptops to conduct Board business for each Board member.

ADJOURNMENT:

The Board concluded its meeting at 11:55 a.m.

David H. Hettler, O.D.
President

Elizabeth A. Carter, Ph.D.
Executive Director

Virginia Health Practitioners' Intervention Program Overview

Elinore McCance-Katz, M.D., Ph.D.
Medical Director

February 7, 2006

Health Practitioner Impairment
■Refers to situations in which health practitioners are unable to perform their professional responsibilities adequately because of a variety of health problems:
■Medical disease
■Mental Illness
■Substance abuse

Substance Abuse
■Principal cause of practitioner impairment
■Points of Discussion:
–Identification of addictive disease in health care practitioners
–Medicolegal issues
–Reporting requirements in Virginia
–Identification, intervention, treatment and aftercare
–Re-entry into practice
–Virginia Health Practitioners' Intervention Program

Substance Abuse
■Chronic disease with exacerbations responsive to treatment
■Characteristics of addiction:
–Behavioral dysfunction
–Medical complications
–Mental illness
■Loss of control over substance use, overuse, intoxication, withdrawal:
–Poor occupational functioning and poor clinical outcomes
–Inability to practice safely
–Potential harm to patients
■Neurobiological changes underlie addiction

Medicolegal Issues
■Legal aspects of practitioner impairment handled primarily at state level
■State licensing organizations can withdraw a license from a practitioner deemed to be impaired/incompetent
■Primary goal of licensing boards is to protect public from unqualified health care practitioners

Virginia Reporting Requirements

▪**Virginia Code (54.1-2906-2909) requires :**

–Hospitals and health care institutions Chiefs of Staff/CEOs, practitioners treating other practitioners (except for substance disorders) are required to report within 30 days to the appropriate board on:

▪Information that a health professional is in need of treatment or admitted for treatment for a substance use or psychiatric illness that may render the health professional a danger to himself, the public, or his patients

▪Reasonable probability of unethical, fraudulent or unprofessional behavior

▪Any disciplinary action (including but not limited to denial or restriction of privileges or employment)

▪Voluntary resignation or restriction or expiration of privileges while under investigation or while subject of disciplinary proceedings related to negligence, medical incompetence, unprofessional conduct, moral turpitude, mental or physical impairment, or substance abuse

–State Professional Society Presidents must report any disciplinary action taken by the professional organization related to professional ethics violations, incompetence, moral turpitude, drug addiction or alcohol abuse

–Any person making such reports shall be immune from civil liability

–Failure to report may result in fines of up to $25,000

Medicolegal Issues

■History of substance abuse is queried on staff applications and renewals

■Employer based drug testing increasing

■For physicians: National Practitioner Data Bank (NPDB): actions of state licensing boards, hospital medical staff office action, state medical societies and malpractice claims (note: voluntary entrance to substance abuse treatment is not reportable)

Identification of the Impaired Practitioner

■High risk conditions

–Family history

–Access

–Domestic breakdown

–Unusual stress at work

■Behaviors of Addiction

–Large quantities, frequent intoxication

–Self prescribing

–Neglect of responsibilities

–Angry outbursts

–Staff concerns about behavior

–Frequent medical complaints without specific diagnoses evident (fatigue, insomnia, depression)

–Sexual promiscuity

–DUI

Identification of the Impaired Practitioner

- Signs of Addiction
  - Smell of alcohol on breath
  - Ataxic gait
  - Slurred speech
  - Unexplained tremor
  - Disheveled appearance
  - Somnolence
  - Unexplained weight changes
  - Depressed mood

Intervention

- Impaired health care providers obtain treatment
- Intervention should occur to assist with getting practitioner to treatment

Treatment

- Once practitioner agrees to treatment, a comprehensive assessment is necessary:
  - Substance disorders
  - Psychiatric disorders
  - Medical illness
  - Type of treatment setting
  - Inpatient
  - Continued Outpatient
    - **Group therapy usually weekly for 2-3 years**
    - **Continued AA/NA**
    - **Family therapy as needed**
    - **Identification of support system for practitioner**
    - **Urine toxicology screening**

Re-Entry to Practice

- Once the initial rehabilitation process has been completed and enrollment in continuing treatment is ongoing, the practitioner may re-enter practice under contract and monitoring
- Contract stipulates treatment, urine toxicology screening, self-help groups, monitors

Factors that may Contribute to Relapse

- **Failure to understand/accept disease concept**
- **Continued denial**
- **Dishonesty**
- **Dysfunctional family**
- **Lack of spiritual program**
- **Inability to cope with stress**

- **Unresolved anger**
- **Isolation**
- **Cross addiction to more than one chemical**
- **Untreated secondary addictions (food, work, sex)**
- **Holiday syndrome**
- **Severe withdrawal**
- **Overconfidence**
- **Return to old friends/habits**
- **Guilt/shame**
- **Medical problems**
- **Multiple relapses**
- **Incomplete treatment**
- **Poor monitoring**
- **Failure to treat comorbid mental illness**
- **Lack of total abstinence**
- **IV drug use**
- **Poor relationship skills**
- **Legal or work problems**

What about prescribed narcotics in those with addiction?

- Recommend use of non-narcotic interventions
- Can't monitor safety in health care setting as UDS will be positive
- UDS does not differentiate impairment from use-only tells us a client is using
- IPC has made policy that mood-altering substances cannot be used by clients being monitored when they are practicing

Virginia HPIP Mission

To help ensure the safety of the citizens of Virginia by providing monitoring services to impaired health care practitioners and assisting practitioners in the recovery process

Eligibility for the Program

- Licensed or certified by a DHP Board
- Must maintain license OR have active application on file
- Suspended or revoked licenses

Referral Mechanisms

- Investigation by Enforcement Division of DHP
- Self Referral
- Employer Referral

Investigation
■Enforcement Division Investigator collects information, interviews respondent
■May inform practitioner of HPIP for self-referral
■Investigation continues to conclusion
■Possible Board hearing
■Board may order individual into HPIP and impose other sanctions

Self-referral
■Self-referrals are eligible for HPIP
■Confidentiality is maintained, though law or contract violation must be reported to Program Manager at DHP

■If there is a violation of the law discovered at program entry, practitioner must be reported
Employer Referral
■Employer may report practitioner
–Encouraged to advise self-referral
■Employers must report activity to Enforcement Division if:
–a) consistent with infraction of law
–b) termination is warranted
–c) positive test for cause

HPIP Process for Participants
Participation Contract and Releases
■Participation Contract allows HPIP to:
–gather information
–speak with DHP officials
–remove from practice if necessary

■Releases allow contact with relevant individuals and organizations
■Participation voluntary; consent can be withdrawn at any time

Stay of Disciplinary Action
■HPIP determines qualification for Stay and requests Stay from IPC through Program Manager

■IPC Reports on Qualification for Stay to a Board

■Program Noncompliance can result in a request to vacate stay
–Board may re-open investigation

–Board may open new investigation
–Increase monitoring
–Increase clinical care
Requirements for Stay of Disciplinary Action
•No report of possible violation of law or regulation, other than impairment or the diversion of controlled substances for personal use so long as the personal use does not constitute a danger to patients or clients

•The practitioner must enter the program by written contract with the Program Intervention Committee

•Disciplinary action against the practitioner has not previously been stayed in accordance with this section

•The practitioner remains in compliance with such terms, testing, treatment and other conditions as may be specified in the contract with the Intervention Program Committee

•The Intervention Program Committee has consulted with a designated representative of the relevant health regulatory board to determine whether disciplinary action should be stayed
Participant Orientation
■Case Manager is assigned to each participant and is primary program contact
■Case Manager presents Recovery Monitoring Contract, obtains practitioner's consent to abide by provisions in contract
■Participant attends Orientation after giving consent for Recovery Monitoring Contract
■After Orientation, participant enters full monitoring program

Monitoring
■Individualized
■Based on Recovery Monitoring Contract
■Reports
–Participant, treatment provider(s), work site monitor, peer monitor, urine toxicology
–Self-help meetings (AA, NA, CA, Caduceus, Rational Recovery, etc.)
–Report submission is participant's responsibility

Monitoring
■Urine Toxicology Testing (for those with substance disorders)
–Frequency varies over time with progress in recovery
–Participants call Monday through Friday for testing date
–Case Manager follows for compliance status/relapse
Monitoring
■Return to practice requires:
▪active license
▪no board order stating must refrain from practice
▪completed initial treatment
▪compliant with contract

Monitoring
■Return to Practice (con't)
▪May recommend witnessed naltrexone (Revia) or disulfiram (Antabuse)
–HPIP recommendation only
–MUST obtain prescription through physician

Participant Contact with VA HPIP
■Monthly telephone contact initiated by client
■In-person meetings; GOAL: once or twice yearly
■Educational activities/assessments in Richmond

VAHPIP Assistance to Clients
■Multi-panel screens reduce UDS costs
■Free screens for those with severe financial problems
■Scholarship and reduced rates at preferred providers
■CSB referral for indigent
Representation at Hearings
■Board Conferences/Hearings may be required of participants
■Case Managers
–testify to status and progress
–will discuss with participant what will be presented to the Board

Other Virginia HPIP Branches
■Credentialing
–review of staff CVs & resumes
–review of program services & certifications
■Education
■Evaluation

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Questions