# Meeting of the Virginia Board of Medicine

## February 15, 2024
## 8:30 a.m.

Virginia Department of Health Professions

**Board of Medicine**
**Thursday, February 15, 2024 @ 8:30 a.m.**
**Perimeter Center**
**9960 Mayland Drive, Suite 201**
**Board Room 2**
**Henrico, VA 23233**

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

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

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

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

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

## Board Room 4

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

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

**Agenda Item: Approval of Minutes of the October 19, 2023**

**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

October 19, 2023 | Department of Health Professions | Henrico, VA 23233

**CALL TO ORDER:** Dr. Clements called the meeting to order at 8:30 a.m.

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

**MEMBERS PRESENT:**
John R. Clements, DPM – President & Chair
Peter J. Apel, MD – Vice-President
David Archer, MD
Manjit Dhillon, MD
Hazem Elariny, MD
Madge Ellis, MD
William Hutchens, MD
Oliver Kim, JD, LLM
Krishna Madiraju, MD
L. Blanton Marchese
Jacob Miller, DO
Pradeep Pradhan, MD
Jennifer Rathmann, DC
Joel Silverman, MD
Ryan Williams, MD

**MEMBERS ABSENT:**
Jane Hickey, JD
Karen Ransone, MD – Secretary-Treasurer
Alvin Edwards, MDiv, PhD

**STAFF PRESENT:**
William L. Harp, MD - Executive Director
Jennifer Deschenes, JD - Deputy Exec. Director for Discipline
Colanthia Morton Opher - Deputy Exec. Director for Administration
Michael Sobowale, LLM - Deputy Exec. Director for Licensure
Barbara Matusiak, MD - Medical Review Coordinator
Deirdre Brown - Executive Assistant
Arnie Owens – DHP Director
James Jenkins, RN – DHP Chief Deputy Director
Erin Barrett, JD – DHP Director for Legislative and Regulatory Affairs
Matt Novak – DHP Policy Analyst
Brent Saunders, JD – Board Counsel/Senior Asst. Attorney General

**OTHERS PRESENT:** Jennie Wood – Board Staff
Tamika Hines- Board Staff
Roslyn Nickens – Board Staff
Janice Martin – Board Staff
Scott Johnson – Hancock Daniel & Johnson/MSV

## EMERGENCY EGRESS INSTRUCTIONS

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

## APPROVAL OF MINUTES OF JUNE 22, 2023

Ms. Barrett addressed a revision that needed to be made on page 6 of the agenda packet under New Business concerning the current regulatory actions. She recommended the following changes:

"Ms. Barrett noted that since the preparation of the report for this meeting, all the proposed regulations have moved from Department of Planning and Budget to the Secretary's Office. All remaining fast-track actions will go to the Secretary's Office and then a longer public comment period will follow. However, they will not come back to the Board for ~~comments~~ action. Once the comment period closes, the ~~Executive Committee will vote on the regulations~~ regulations will become effective."

**ACTION:** Dr. Miller moved to approve the minutes with the amendment proposed by Ms. Barrett. The motion was properly seconded by Dr. Apel and carried unanimously.

## ADOPTION OF AGENDA

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

## PUBLIC COMMENT

None.

## DHP DIRECTOR'S REPORT

Mr. Owens welcomed everyone and thanked the Board members for their time and their expertise that they bring to the Board. He shared that DHP is beginning a review of board processes throughout DHP with the goal of improving efficiencies. Impact Makers will be performing the study and will start with the Board of Medicine. They will then move to the Board of Counseling and to other boards. Mr. Owens stated that this board process review should improve efficiency, especially in licensing, and get professionals into the workforce

more expeditiously. Mr. Owens advised that the Governor is in the process of finalizing the budget for the fiscal year 2025. He said that DHP does not get general funds but is still required to run its budget through the General Assembly. DHP will have a number of legislative proposals for the 2024 Session. He also shared that the General Assembly has a new building and encouraged everyone to visit it as it is open to the public. Mr. Owens gave an update on the healthcare workforce study conducted by the Virginia Healthcare Workforce Development Authority. The study has focused on shortages in nursing, primary care, and behavioral health workforces and how to retain and recruit more professionals to Virginia. Lastly, Mr. Owens said that the Governor's *Right Help Right Now* Behavioral Health Plan is receiving a lot of support from various faith-based groups.

## REPORTS OF OFFICERS AND EXECUTIVE DIRECTOR

### PRESIDENT

Dr. Clements thanked Mr. Owens for the upgraded software that allows Board members performing probable cause to review medical images more efficiently. He then thanked Michael Sobowale for his service as Commissioner from Virginia to the Occupational Therapy Compact and for chairing the Compact's Rules Committee.

### VICE-PRESIDENT

No report.

### SECRETARY-TREASURER

No report.

### EXECUTIVE DIRECTOR

Dr. Harp reported that on June 30, 2022, the Board's cash balance was $10,703,44. The cash balance on June 30, 2023, was $11,942,161. He said that there were 5 areas in the FY2023 budget that exceeded the budgeted amount by a collective total of $13,708. In contrast to that small figure, FY2023 ended with an excess of $435,970. This put the Board in a good financial posture for FY2024 which began July 1, 2023. During calendar year 2024, doctors and occupational therapists will be renewing, so it will be a big revenue year. Dr. Harp then thanked the Board members who are continuing to serve while awaiting their replacements. Lastly, he mentioned that general dentists will be able to administer cosmetic botulinum toxin injections when Board of Dentistry regulations are in place. He asked Ms. Barrett to comment on this issue. She stated that the Board of Dentistry must consult with the Board of Medicine to establish training and continuing education requirements. Regulations are designated emergency, so they must

be done by the end of the year. She said that Virginia will be one of two states that authorizes dentists to provide this service. The first meeting to draft regulations will be October 27th.

## COMMITTEE AND ADVISORY BOARD REPORTS

Dr. Miller moved to accept all reports since June 22, 2023, en bloc. The motion was properly seconded by Dr. Williams and carried unanimously.

## OTHER REPORTS

### Board Counsel

Brent Saunders, Senior AAG, reported that the Office of the Attorney General was dealing with three pending appeals.

This report was for informational purposes only.

### Board of Health Professions

No report.

### Podiatry Report

No report.

### Chiropractic Report

No report.

### Committee of the Joint Boards of Nursing and Medicine

No report.

## NEW BUSINESS

### 1. Current Legislative and Regulatory Actions/Considerations – Erin Barrett

Ms. Barrett presented the chart of regulatory actions as of September 28, 2023, stating that there are 15 regulatory actions currently in the Secretary's Office.

**2. Consideration of human trafficking CE requirement – Erin Barrett**

After a thorough discussion, Dr. Madiraju moved that the Board consider the requirement for 2 hours of CE on human trafficking in the next biennial renewal cycle. His motion was not seconded.

Dr. Hutchens expressed his concern that multiple states are implementing a variety of mandated CE topics. For those holding licenses in multiple states, it is burdensome to try to keep up with the latest mandated topic(s), while making time to actually keep up to date on the medicine the licensee practices on a daily basis.

After some discussion, Dr. Apel moved to table the issue and form an ad hoc committee to review the matter and present its findings to the Board later for consideration.

Mr. Marchese noted that the law was passed by the General Assembly with input from the Board in part to address the issue of outside groups requesting that the Board require CE in certain subjects. He said the Board should effectively use the tool given it by the General Assembly, preferably in 2024 with human trafficking. Ms. Deschenes added that while she understands the hesitation to add to the CE mandates, this law gives the Board a useful tool that the Board of Pharmacy has had in place for years to address significant CE issues. This new law permits the Board to respond to emerging issues of concern, rather than having outside organizations make such decisions for the Board.

Ms. Barrett noted that the next meeting of the full Board is in February 2024, and an ad hoc would not be able to meet and make recommendations that could be timely communicated to the licensees before the next renewal cycle begins January 2024.

Dr. Apel withdrew his prior motion.

Mr. Marchese moved to implement the 2 hours of CE on human trafficking for the next biennial renewal cycle. A friendly amendment was made to reduce the requirement to 1 hour. The motion was seconded.

Dr. Clements called for a vote. The vote was 12-2.

Ms. Barrett pointed out that 4 of the Board's professions do not have a CE requirement (e.g., physician assistants, licensed midwives et al) and that this would be an added renewal requirement for those 4 professions.

After further discussion, Mr. Marchese amended his motion to exclude the 4 professions identified by Ms. Barrett. Dr. Madiraju and Dr. Ellis noted that the 4 professions engage with the public and could identify potential human trafficking victims (e.g., physician assistants are primary staff in many hospital emergency departments; licensed midwives see pregnant women in the home). A friendly amendment to the motion was made to include all the professions licensed by the Board, with the exception being certified surgical technologists.

Dr. Clements restated the motion on the floor as 1 hour of CE for the next biennial renewal cycle regarding human trafficking for all professions licensed by the Board. The motion passed 13-1.

**3. Consideration of fast-track regulatory changes to 18VAC85-130-80 – Ms. Barrett**

Ms. Barrett reviewed the proposed changes in Project 7683 – Fast-Track for 18VAC85-130-80. This change updates the regulations to comport with the recommendations of the Regulatory Advisory Panel that met to develop the Formulary and Best Practices document for licensed midwives that was approved by the August Executive Committee.

**ACTION:** Mr. Marchese moved to amend 18VAC85-130-80 as presented by fast-track action. The motion was properly seconded by Dr. Clements and carried unanimously.

**4. Initiation of periodic review of public participation guidelines contained in 18VAC85-11 – Ms. Barrett**

Ms. Barrett reviewed with the Board the requirement of agencies to review its regulatory chapters every 4 years.

**ACTION:** Dr. Miller moved to initiate periodic review of 18VAC85-11. The motion was properly seconded by Dr. Clements and carried unanimously.

**5. Consideration of fast-track regulatory changes to 18VAC90-30-240 – Ms. Barrett**

Ms. Barrett explained to the Board that this regulatory action was missed, and that due to statutory deadlines for exempt actions, this now needed to be fast-tracked. She also informed the Board that the action was adopted by the Board of Nursing on September 12, 2023.

**ACTION:** Mr. Marchese moved to amend 18VAC90-30-240 as presented by fast-track action. The motion was properly seconded by Dr. Williams and carried unanimously.

**6. Licensing Report**

Mr. Sobowale stated that the total number of licensees is currently 88,870. He shared that the licensing unit is now fully staffed and introduced a new staff member, Licensing Specialist Janice Martin.

Mr. Sobowale shared with the Board that the number of days from application to issuance of a license is going down. He stated that in 2022 the average processing time was up to 75 days, whereas this year's average is down to 61 days.

Lastly, Mr. Sobowale stated that since March of 2023, the Board has issued 342 licenses through reciprocity to physicians in Maryland and the District of Columbia. The average processing time is 20 days.

**7. Discipline Report**

Ms. Deschenes provided a brief report on the status of cases open as of October 1, 2023. She stated that the Board is catching up on formal hearings that were delayed due to the pandemic.

Ms. Deschenes gave a brief overview of BOX and stated how useful the program is to Discipline and the Board members in the review of cases. Dr. Williams asked if the links to cases sent for probable cause review could have a longer expiration date than the current 2 weeks. Ms. Deschenes stated that could be considered.

**ANNOUNCEMENTS**

Dr. Clements announced that the next Board meeting will be held on February 15-17, 2023 at 8:30 a.m.

**ADJOURNMENT**

With no further business to conduct, the meeting adjourned at 10:04 a.m.

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William L. Harp, MD
Executive Director

**Agenda Item:** **DHP Agency Director's Report**

**Staff Note:** All items for information only

**Action:** None.

**Agenda Item:** **Report of Officers**

**Staff Note:**

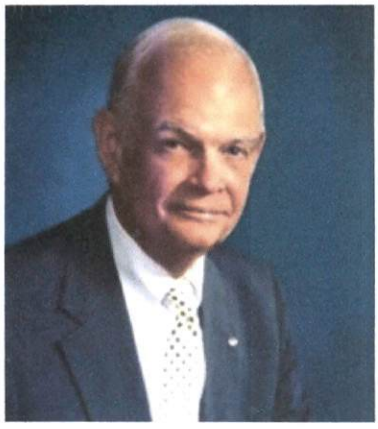
- President
- Vice-President
- Secretary-Treasurer
- Executive Director

**Action:** Informational presentation. No action required.

**Agenda Item:** **Executive Director's Report**

**Staff Note:** All items for information only

**Action:** None.



# Warren W. Koontz, Jr., MD

Class Year

1957

Affiliation

Alumni

Posted on: November 9, 2023

Dr. Warren Woodson Koontz, Jr., died November 1, 2023. Dr. Koontz was born on June 10, 1932, in Lynchburg, Virginia. He was the son of the late Dr. Warren Womack Koontz and Mary Winston Woodson Koontz. He graduated from Virginia Episcopal School in Lynchburg and received a B.S. in Biology from the Virginia Military Institute in 1953, where he was a Distinguished Military Graduate.

Dr. Koontz received his MD degree from the University of Virginia in 1957 and was elected to Alpha Omega Alpha his senior year. He served two years of residency in General Surgery at the New York Hospital-Cornell Medical Center. He was then called to duty and served two years in the United States Air Force as a Captain and Chief of Surgery at the 328 th USAF Hospital at Richards-Gebaur AFB, Missouri. He returned to New York Hospital for a third year of residency in General Surgery, followed by a four-year residency in Urology under another Virginian, Dr. Victor F. Marshall. Following residency, Dr. Koontz joined the faculty of the Medical College of Virginia (MCV) in Richmond as an Assistant Professor. He then moved to Boston as Assistant Urologist at the Massachusetts General Hospital and Assistant Professor at the Harvard Medical School. In 1970 Dr. Koontz returned to Richmond and MCV as Professor and Chairman of the Division of Urology. In 1994 he became Professor Emeritus in Urology and for five and a half years served as the Executive Director of the Virginia Board of Medicine. He then worked part time at MCV and the McGuire VA Hospital until his retirement in 2003. He was a member of many medical organizations and served as a board member and President of the Richmond Academy of Medicine, Virginia Chapter of the American College of Surgeons, the Society of University Urologists, the Mid-Atlantic Section of the American Urological Association, and the American Association of Genito-Urinary Surgeons. He served as Associate Dean for Clinical Affairs and Chief of the Medical Staff at MCV from 1982 to 1988. Dr. Koontz was immensely proud of the many residents that he was associated with during their training. These men and women have practiced in many parts of the U.S. and overseas. In 2014 Dr. Koontz was appointed by Gov. Terence McAuliffe to the Board of Long-Term Care Administrators as a citizen member. He is a former member of the Commonwealth Club, the Country Club of Virginia, the West Richmond Rotary Club, and the Smith Mountain Lake Chapter of the Classic and Antique Boat Club. Warren often said the luckiest day of his life was in September 1953 when he had a blind date with Edwina (Win) Sykes, a freshman at Randolph Macon Woman's College. They dated for four years and married in June, 1957.

Throughout their life together Warren and Win traveled extensively in Europe, Asia, the Middle East, Central and South America, and Antarctica. They also spent a sabbatical in Antwerp, Belgium. Warren loved traveling with his family, spending quality time at Smith Mountain Lake and sailing in the Caribbean. Tennis with friends was also a passion. Fly fishing in Maine was an annual event for many years. Warren is survived by his wife of 66 years, Edwina Sykes Koontz; his son Dr. Warren Sykes Koontz of Richmond; his daughter Mary Koontz Hayes (H. Robert Hayes, Jr.) of Smithfield; his granddaughter Katherine Edwina Hayes (Jackson Bruce Prillaman) of Arlington; and his grandson William Coulbourn Hayes of Virginia Beach. Warren was extremely proud of his son, daughter, son-in-law, and grandchildren and all their accomplishments.

**FY 2024 Budget / Actual through December 2023**
**Virginia Department of Health Professions**
**Includes: (base budget, salary/benefit budget, and other budget accounts)**

**Period Ending:** **12/31/2023**
**% of the Year Completed:** **50%**
**Department ID:** **10200**
**Department Name:** **Board of Medicine**
**Fund** **09223**

| TYPE | Account Number | Description | FY24 Budget | July | August | September | October | November | December | Grand Total | (Over) Under Budget | % of the Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 5011250 | Salaries, Overtime | 8,000.00 | 2,973.27 | 243.64 | 630.67 | - | 26.14 | - | 3,873.72 | 4,126.28 | 52% |
| | 5011340 | Specified Per Diem Payments | 12,000.00 | 950.00 | 250.00 | 150.00 | 300.00 | 350.00 | 450.00 | 2,450.00 | 9,550.00 | 80% |
| | 5012110 | Express Services | - | - | - | - | - | - | - | - | - | 0% |
| | 5012120 | Outbound Freight Services | 12,000.00 | 600.17 | - | 1,007.10 | 694.37 | 881.89 | 833.59 | 4,017.12 | 7,982.88 | 67% |
| | 5012130 | Messenger Services | 500.00 | - | - | 218.66 | - | (163.44) | 27.36 | 82.58 | 417.42 | 83% |
| | 5012140 | Postal Services | 66,802.00 | 9,767.17 | 3,890.03 | 18,918.45 | 14,019.21 | 11,157.48 | - | 57,752.34 | 9,049.66 | 14% |
| | 5012150 | Printing Services | 2,000.00 | - | - | 1,164.29 | - | - | - | 1,164.29 | 835.71 | 42% |
| | 5012190 | Inbound Freight Services | 150.00 | - | - | 102.35 | 19.82 | - | - | 122.17 | 27.83 | 19% |
| | 5012210 | Organization Memberships | 7,228.00 | 305.00 | - | 4,121.00 | - | 2,400.00 | - | 6,826.00 | 402.00 | 6% |
| | 5012220 | Publication Subscriptions | - | - | - | - | - | - | - | - | - | 0% |
| | 5012240 | Employee Training Courses, Workshops, and Conferences: | 7,500.00 | - | - | 160.00 | - | - | 1,620.00 | 1,780.00 | 5,720.00 | 76% |
| | 5012270 | Employee Training - Transportation, Lodging, Meals, and Incidentals: | - | - | - | - | - | - | - | - | - | 0% |
| | 5012440 | Management Services | - | 270.52 | - | - | - | (270.52) | - | - | - | 0% |
| | 5012450 | Personnel Management Services | - | - | - | - | - | - | - | - | - | 0% |
| | 5012460 | Public Informational and Public Relations Services | 400.00 | - | - | 250.00 | - | - | - | 250.00 | 150.00 | 38% |
| | 5012470 | Legal Services | 5,579.00 | 853.50 | - | - | 55.00 | 1,086.00 | 805.00 | 2,799.50 | 2,779.50 | 50% |
| | 5012480 | Media Services | - | - | - | - | - | - | - | - | - | 0% |
| | 5012510 | Custodial Services | - | 129.12 | - | 286.21 | 114.48 | (529.81) | - | (0.00) | 0.00 | 0% |
| | 5012520 | Electrical Repair and Maintenance Services | - | - | - | - | - | - | - | - | - | 0% |
| | 5012530 | Equipment Repair and Maintenance Services | 5,000.00 | - | - | 415.67 | - | 154.96 | - | 570.63 | 4,429.37 | 89% |
| | 5012590 | Vehicle Repair and Maintenance Services | - | - | - | - | - | - | - | - | - | 0% |
| | 5012640 | Food and Dietary Services | 15,000.00 | 1,966.61 | - | 915.20 | 238.19 | 1,484.85 | 532.97 | 5,137.82 | 9,862.18 | 66% |
| | 5012730 | Information Management Design and Development Services (provided by anOther Budget BudgetBudgetState agency (not VITA) or vendor) | - | - | - | - | - | - | - | - | - | 0% |
| | 5012740 | Computer Hardware Maintenance Services | - | - | - | - | - | - | - | - | - | 0% |

Base Budget

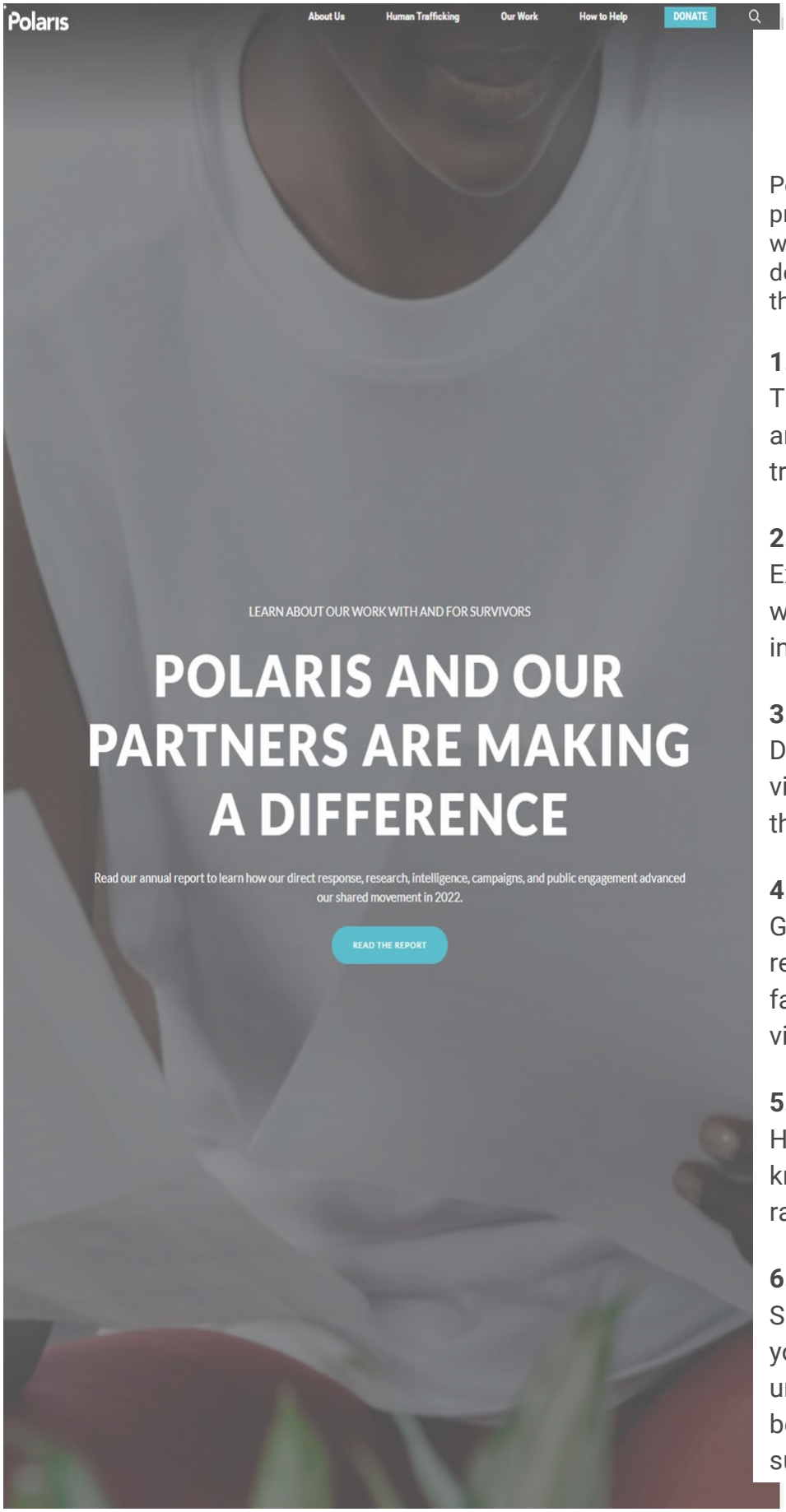
| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 5012750 | Computer Software Maintenance Services | - | - | - | - | - | - | - | - | - | 0% |
| 5012760 | Computer Operating Services (provided by VITA) | - | - | - | - | - | - | - | - | - | 0% |
| 5012770 | Computer Operating Services (provided by anOther Budget BudgetBudgetState agency (not VITA) or vendor) | - | - | - | - | - | - | - | - | - | 0% |
| 5012780 | VITA Information Technology Infrastructure Services (Provided by VITA) | - | - | - | - | - | - | - | - | - | 0% |
| 5012790 | Computer Software Development Services | 58,500.00 | - | - | - | - | 11,700.00 | 11,700.00 | 23,400.00 | 35,100.00 | 60% |
| 5012810 | Moving and Relocation Services | - | - | 115.16 | - | - | (115.16) | - | - | - | 0% |
| 5012820 | Travel, Personal Vehicle | 15,000.00 | 1,905.44 | 365.49 | 771.59 | 751.94 | 677.27 | 1,397.79 | 5,869.52 | 9,130.48 | 61% |
| 5012830 | Travel, Public Carriers | 4,170.00 | - | - | - | - | - | - | - | 4,170.00 | 100% |
| 5012840 | Travel, State Owned or Leased Vehicles | - | - | - | - | - | - | - | - | - | 0% |
| 5012850 | Travel, Subsistence, and Lodging | 13,524.00 | 558.60 | 1,344.56 | 111.72 | 113.95 | 995.36 | 368.38 | 3,492.57 | 10,031.43 | 74% |
| 5012880 | Travel, Meal Reimbursements - Not Reportable to the IRS | 7,407.00 | 643.00 | - | 67.50 | 197.00 | - | 233.50 | 1,141.00 | 6,266.00 | 85% |
| 5013110 | Apparel Supplies | - | - | - | - | - | 138.02 | 22.74 | 160.76 | (160.76) | 0% |
| 5013120 | Office Supplies | 14,609.00 | 1,615.73 | - | 3,310.42 | 1,988.95 | 539.73 | (0.82) | 7,454.01 | 7,154.99 | 49% |
| 5013130 | Stationery and Forms | - | - | - | - | - | - | - | - | - | 0% |
| 5013510 | Building Repair and Maintenance Materials | 60.00 | - | - | - | - | 28.25 | - | 28.25 | 31.75 | 53% |
| 5013530 | Electrical Repair and Maintenance Materials | - | - | - | - | - | - | - | - | - | 0% |
| 5013550 | Vehicle Repair and Maintenance Materials | - | - | - | - | - | - | - | - | - | 0% |
| 5013620 | Food and Dietary Supplies | 528.00 | - | - | - | - | - | - | - | 528.00 | 100% |
| 5013630 | Food Service Supplies | - | - | - | - | - | - | - | - | - | 0% |
| 5013730 | Computer Operating Supplies | 166.00 | - | - | - | - | - | - | - | 166.00 | 100% |
| 5013740 | Educational Supplies | - | - | - | - | - | - | - | - | - | 0% |
| 5014130 | Premiums | - | - | - | - | - | - | - | - | - | 0% |
| 5015410 | Agency Service Charges | 2,000.00 | - | - | - | 724.97 | 270.52 | 229.16 | 1,224.65 | 775.35 | 39% |
| 5022110 | Desktop Client Computers (microcomputers) | - | - | - | - | - | - | - | - | - | 0% |
| 5022120 | Mobile Client Computers (microcomputers) | - | - | - | - | - | - | - | - | - | 0% |
| 5022160 | Network Components | - | - | - | - | - | - | - | - | - | 0% |
| 5022170 | Other Budget BudgetBudgetComputer Equipment | 15,000.00 | 1,553.00 | - | 8,510.00 | - | 655.00 | 443.24 | 11,161.24 | 3,838.76 | 26% |
| 5022180 | Computer Software Purchases | - | - | - | - | - | - | - | - | - | 0% |
| 5022240 | Reference Equipment | - | - | - | - | - | - | - | - | - | 0% |
| 5022310 | Electronic Equipment | - | - | - | - | - | - | - | - | - | 0% |
| 5022620 | Office Furniture | 20,000.00 | 18,924.69 | - | - | - | - | - | 18,924.69 | 1,075.31 | 5% |
| 5022640 | Office Machines | - | - | - | - | - | - | - | - | - | 0% |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 5022710 | Household Equipment | - | - | - | - | - | - | - | - | - | 0% |
| **Base Budget Total** | | | 293,123.00 | 43,015.82 | 6,208.88 | 41,110.83 | 19,217.88 | 31,466.54 | 18,662.91 | 159,682.86 | 133,440.14 | 46% |
| | 5012160 | Telecommunications Services (provided by VITA) | 11,408.00 | 876.04 | 885.22 | 870.77 | 876.42 | 838.45 | 901.19 | 5,248.09 | 6,159.91 | 54% |
| | 5012170 | Telecommunications Services (provided by Non-State vendor) | 1,080.00 | 90.00 | 90.00 | 135.00 | 45.00 | 90.00 | 135.00 | 585.00 | 495.00 | 46% |
| | 5012250 | Employee Tuition Reimbursement: | - | - | - | - | - | - | - | - | - | 0% |
| | 5012260 | Employee Training Consulting Services: | - | - | - | - | - | - | - | - | - | 0% |
| | 5012420 | Fiscal Services | 140,000.00 | 3,413.36 | 3,871.67 | 3,744.07 | - | 6,566.71 | 3,168.81 | 20,764.62 | 119,235.38 | 85% |
| | 5012430 | Attorney Services | - | - | - | - | - | - | - | - | - | 0% |
| | 5012490 | Recruitment Advertising | - | - | - | - | - | - | - | - | - | 0% |
| | 5012630 | Clerical Services | 78,137.00 | 6,427.45 | - | 15,261.37 | 16,971.22 | 1,776.13 | 7,494.76 | 47,930.93 | 30,206.07 | 39% |
| | 5012660 | Manual Labor Services | 14,124.00 | 1,377.88 | 667.92 | 498.14 | 656.54 | 1,030.36 | 966.05 | 5,196.89 | 8,927.11 | 63% |
| | 5012670 | Production Services | 97,412.00 | 15,553.06 | 4,012.12 | 9,728.32 | 6,714.17 | 4,303.58 | 6,482.01 | 46,793.26 | 50,618.74 | 52% |
| | 5012680 | Skilled Services | 450,000.00 | 43,614.89 | 46,585.14 | 31,216.78 | 31,823.62 | 37,864.66 | 35,153.88 | 226,258.97 | 223,741.03 | 50% |
| | 5013230 | Gasoline | - | - | - | - | - | - | - | - | - | 0% |
| | 5013350 | Packaging and Shipping Supplies | - | - | - | - | - | - | - | - | - | 0% |
| | 5013430 | Field Supplies | - | - | - | - | - | - | - | - | - | 0% |
| | 5015160 | Property Insurance | 485.00 | - | - | - | - | - | - | - | 485.00 | 100% |
| | 5015340 | Equipment Rentals | 6,785.00 | 305.35 | - | 1,524.21 | 554.40 | 517.22 | 517.22 | 3,418.40 | 3,366.60 | 50% |
| | 5015350 | Building Rentals | 1,012.00 | - | 289.80 | - | 277.00 | - | - | 566.80 | 445.20 | 44% |
| | 5015390 | Building Rentals – Non-State Owned Facilities - New | 157,062.00 | 12,695.35 | 12,695.35 | 12,695.35 | 12,695.35 | 12,695.35 | 12,695.35 | 76,172.10 | 80,889.90 | 52% |
| | 5015450 | DGS Parking Charges | - | - | - | - | - | - | - | - | - | 0% |
| | 5015470 | Private Vendor Service Charges | - | - | (58.09) | 58.09 | - | - | - | (0.00) | 0.00 | 0% |
| | 5015510 | General Liability Insurance | 4,416.00 | - | - | - | - | - | - | - | 4,416.00 | 100% |
| | 5015540 | Surety Bonds | 75.00 | - | - | - | - | - | - | - | 75.00 | 100% |
| | 5015550 | Workers' Compensation | - | - | - | - | - | - | - | - | - | 0% |
| | 5013760 | Law Enforcement Supplies | - | - | - | 138.02 | 22.74 | (138.02) | (22.74) | 0.00 | (0.00) | 0% |
| **Other Budget Total** | | | 961,996.00 | 84,353.38 | 69,039.13 | 75,870.12 | 70,636.46 | 65,544.44 | 67,491.53 | 432,935.06 | 529,060.94 | 55% |
| | 5011110 | Employer Retirement Contributions – VRS Defined Benefits program | 236,234.00 | 18,742.35 | 19,311.95 | 28,517.33 | 9,875.02 | 19,571.18 | 29,356.77 | 125,374.60 | 110,859.40 | 47% |
| | 5011120 | Federal Old-Age Insurance for Salaried State Employees (Salaried Social Security and Medicare) | 135,296.00 | 11,259.05 | 9,842.67 | 16,187.18 | 5,456.93 | 8,461.63 | 9,097.47 | 60,304.93 | 74,991.07 | 55% |
| | 5011140 | Group Life Insurance | 22,850.00 | 1,811.23 | 1,871.45 | 2,764.41 | 956.27 | 1,904.10 | 2,856.15 | 12,163.61 | 10,686.39 | 47% |
| | 5011150 | Medical/Hospitalization Insurance (Annual Employer Health Insurance Premium) | 267,756.00 | 20,886.00 | 21,944.00 | 32,362.50 | 11,041.41 | 22,313.00 | 33,469.50 | 142,016.41 | 125,739.59 | 47% |
| | 5011160 | Retiree Health (Medical/Hospitalization) Insurance Credit Premium | 19,099.00 | 1,513.91 | 1,564.21 | 2,310.58 | 799.29 | 1,591.52 | 2,387.28 | 10,166.79 | 8,932.21 | 47% |
| | 5011170 | VSDP and Long-term Disability Insurance | 9,816.00 | 749.43 | 789.03 | 1,185.12 | 415.25 | 817.92 | 1,226.88 | 5,183.63 | 4,632.37 | 47% |

Other Budget

fit Budget

| Salary/Wage/Bene | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 5011190 | Employer Retirement Contributions - Defined Contribution program | - | - | - | - | - | - | - | - | - | 0% |
| | 5011220 | Salaries, Appointed Officials | - | - | - | - | - | - | - | - | - | 0% |
| | 5011230 | Salaries, Classified | 1,722,201.00 | 141,263.27 | 139,437.23 | 201,981.41 | 78,568.27 | 139,789.31 | 187,315.18 | 888,354.67 | 833,846.33 | 48% |
| | 5011240 | Salaries, Other Budget Officials | - | - | - | - | - | - | - | - | - | 0% |
| | 5011310 | Bonuses and Incentives | - | - | 1,000.00 | - | - | - | - | 1,000.00 | (1,000.00) | 0% |
| | 5011380 | Deferred Compensation Match Payments | 5,040.00 | 340.00 | 380.00 | 630.00 | 210.00 | 420.00 | 630.00 | 2,610.00 | 2,430.00 | 48% |
| | 5011410 | Wages, General | 88,763.00 | 5,825.52 | 6,387.18 | 4,412.66 | 5,778.55 | 6,787.67 | 8,764.25 | 37,955.83 | 50,807.17 | 57% |
| | 5011430 | Wages, Overtime | - | - | - | - | - | - | - | - | - | 0% |
| | 5011530 | Short-term Disability Benefits | - | - | - | 39,543.44 | 3,264.25 | 1,568.43 | - | 44,376.12 | (44,376.12) | 0% |
| | 5011620 | Salaries, Annual Leave Balances | - | - | - | - | - | - | - | - | - | 0% |
| | 5011630 | Salaries, Sick Leave Balances | - | - | - | - | - | - | - | - | - | 0% |
| | 5011640 | Salaries, Compensatory Leave Balances | - | - | - | - | - | - | - | - | - | 0% |
| | 5011660 | Defined Contribution Match - VRS Hybrid Retirement Plan | 10,332.00 | 802.88 | 860.96 | 1,291.44 | 487.95 | 975.90 | 1,463.85 | 5,882.98 | 4,449.02 | 43% |
| **Salary/Wage/Benefit Budget Total** | | | 2,517,387.00 | 203,193.64 | 203,388.68 | 331,186.07 | 116,853.19 | 204,200.66 | 276,567.33 | 1,335,389.57 | 1,181,997.43 | 47% |
| **Grand Total** | | | 3,772,506.00 | 330,562.84 | 278,636.69 | 448,167.02 | 206,707.53 | 301,211.64 | 362,721.77 | 1,928,007.49 | 1,844,498.51 | 49% |




## Training Modules

Polaris's interactive, online training program includes six short modules, as well as survivor stories, and quizzes designed to deepen your understanding of the issue.

**1. Defining Human Trafficking**
This module provides legal definitions and breaks down what human trafficking is and isn't.

**2. How Human Trafficking Happens**
Explaining some of the most common ways that human trafficking happens in the United States.

**3. Understanding the Victims**
Delving into who human trafficking victims are and the factors that make them vulnerable.

**4. How Traffickers Operate**
Going over how traffickers commonly recruit and control their victims and the factors that make it challenging for victims to leave.

**5. Recognizing Human Trafficking**
Highlighting the importance of knowing the story behind a situation rather than just knowing the signs.

**6. Now What?**
Summarizing some of the ways that you can apply your knowledge and understanding to stop trafficking before it happens and support survivors.

# Virginia NGOs Providing Health and Human Trafficking Training

freedom424

**Human Trafficking in Healthcare Training**

**Length: 1 or 2 hours in person (virtual option coming soon); VA CME and TX HHSC certifications in process**

**Contact: info@freedom424.org or call 434-582-4527**

Freedom 4/24's Human Trafficking in Healthcare Training offers a comprehensive, trauma-informed program that educates healthcare professionals about human trafficking's relevance to their field. Covering both labor and sex trafficking, it delves into trafficker and victim profiles and techniques to identify potential victims seeking medical help. After completing this training, healthcare providers will possess the knowledge and tools to recognize vulnerabilities, assess the impact of trafficking on patients' physical and mental health, and offer the necessary support to identified victims.

Global Centurion offers a 1-hour human trafficking training for healthcare providers, both in-person and online. It covers key topics, including defining human trafficking, understanding survivors' physical and mental health challenges, recognizing trafficking indicators at various stages of care, addressing implicit bias, overcoming barriers, adopting victim-centered approaches, utilizing Multi-disciplinary Teams (MDTs), role-playing warm hand-offs, and more, including legal aspects and reporting obligations.

GLOBAL CENTURION
FIGHTING MODERN SLAVERY BY FOCUSING ON DEMAND

**Health and Human Trafficking Training**

**Length: 1 Hour**
**Contact: jlederer@globalcenturion.org**

SAFE HOUSE PROJECT

**Health and Human Trafficking Training**

**Length: 2.5 Hours CME**
**Contact:**
**training.safehouseproject.org**

The Safe House Project, in partnership with the Academy of Forensic Nursing, introduces H.O.P.E. Human Trafficking Training. Comprising eight digital lessons, it enhances survivor identification in healthcare. This program equips healthcare personnel to recognize and assist trafficked patients, covering trafficking business models, victim profiles, and healthcare intersections. Supplementary materials facilitate integration into healthcare facilities' training programs through healthcare LMS integration, Safe House Project hosting, or individual licenses available for purchase.

Shared Hope's i:CARE Health Care Provider's Guide is a vital training tool for healthcare providers. This guide, reviewed by healthcare leaders, improves identification and response to domestic minor sex trafficking victims. It covers legal aspects, trafficker tactics, and victim vulnerabilities, enhancing awareness in urgent care settings. The package includes the guide, a training video series, and access to supplementary resources. Tailored for healthcare professionals, the guide empowers them to combat domestic minor sex trafficking effectively.

sharedhope INTERNATIONAL

**i:CARE Health Care Provider's Guide to Recognizing and Caring for Domestic Minor Sex Trafficking Victims**

**Available at: https://store.sharedhope.org/product/icare-health-care-providers-guide/**

## Red Flags To Freedom

**Introductory Course on Health and Human Trafficking**

**Length: 1-2 Hours**
**Contact:**
**contact@redflags2freedom.org**

Red Flags to Freedom offers online training for medical students and students in health-related fields, covering human trafficking basics, patient presentations, and trauma-informed care. The majority of the course's instructors are trafficking survivors. The course includes videos, readings, exercises, and clinical scenarios. An optional two-hour in-person workshop, led by CHKD's Child Advocacy Center, is also available. Both the online and in-person trainings are required for students volunteering at the Blue Heart clinic at EVMS, our trauma-informed clinic.

Studies show human trafficking victims often seek medical help. Healthcare providers must identify trafficking signs and provide victim-centered care within multidisciplinary teams, covering broader needs for recovery. TFI's training modules can be tailored for Grand Rounds (45 minutes), 1-hour Continuing Medical Education, or longer in-depth sessions. These cover human trafficking definitions, identifying vulnerable victims and traffickers, prevalent physical and mental health conditions, trafficking indicators, care barriers, effective treatment strategies, and more.

Transformation Freedom Initiative TFI

**Health and Human Trafficking Training**

**Length: 45 Minutes, 1 Hour, or Longer**
**Contact: anna@transformationfreedom.org**

# 2023 FSMB Member Board Survey

## Key Findings

## About the Survey

In fall 2023, FSMB sent survey invitations via email to member board executive directors. These results reflect the 9th annual survey. 76% (53 out of 70) state boards responded to the survey.

## Topics and Services

Importance of various topics to your board (0/not important to 10/extremely important), the highest ranked topics were:

- Physician Sexual Misconduct (8.6)
- Responsible Opioid Prescribing (8.4)
- Physician Impairment (8.4)
- Physician Wellness and Burnout (8.1)
- Board Autonomy (7.7)

## Challenges Facing Boards

Greatest policy challenge facing your board, the following was mentioned:

- Licensing and regulation (57%), including licensing and regulating physicians that is concurrent with legislative changes, ensuring public safety when minimum standards for licensing international medical graduates are changing.

- Being able to adequately regulate telehealth and technology (15%).
- Scope of practice (13%), including practice expansion from PAs and NPs and regulation of medical spas, IV therapy and ketamine clinics.

Greatest operational challenge facing your board, the following was mentioned:

- Limitation of financial and employee resources (60%)
- Keeping up with management systems (15%)

Board's greatest concern regarding the use of artificial intelligence (AI) in clinical practice, responses included:

- Our board has not discussed or decided on an official position (30%)
- Concern of over-reliance of AI (28%)
- Concern on how to regulate AI (24%), (e.g., who would be responsible for a wrong diagnosis and how to regulate international AI providers)
- Concerns that quality of care could diminish (20%)

## Media

Board disciplinary actions (83%), followed by physician sexual misconduct (49%) and access to abortion (47%) were the most frequent topics for media outlets contacting boards.

## Licensing

- It takes boards on average 39 days to issue an initial medical license.
- 47% of boards are considering changing licensing software applications or making significant updates to current systems within the next two years.
- 46% of board's licensing application is publicly available online without a password.
- 57% of boards ask applicants if they are clinically active during the license renewal process.

## Re-Entry

- Most boards (69%) do not collect data on the number of medical professionals who have left and then applied for re-entry.
- 55% of boards directly oversee the re-entry process for physicians.

## Licensing Applications and Physician Health Programs (PHPs)

- 86% of boards allow licensees to independently seek treatment through a PHP without being named or known by the board.
- 55% of boards' licensing applications contain a "safe haven" clause allowing applicants to remain anonymous if they are in good standing under a treatment and monitoring program.

## Sexual Misconduct

- 50% of boards have had members of their staff receive trauma-informed training about investigation complaints relating to sexual misconduct; 25% for members of their board.
- 30% of boards have made changes to how they investigate complaints related to sexual boundary violations during the past three years.
- 52% of boards have the authority to automatically revoke a license for a felony conviction for a sex crime, even in the absence of a complaint being submitted to the board.

# MAIN TAKEAWAYS

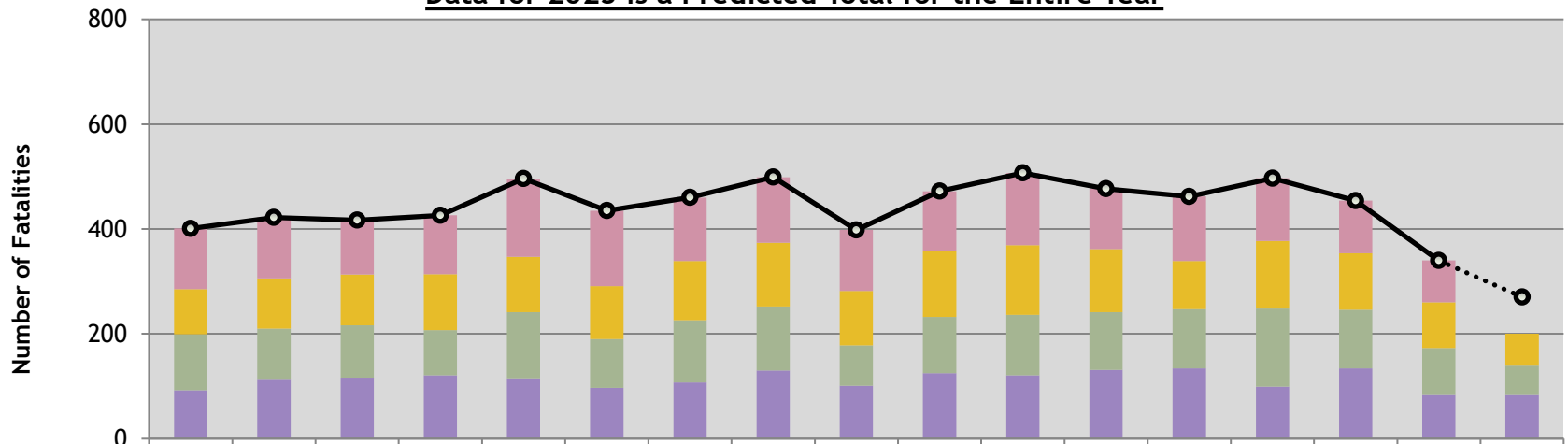
- Fatal drug overdose has been the leading method of unnatural death in Virginia since 2013
- Opioids, specifically illicit fentanyl, have been the driving force behind the large increases in fatal overdoses since 2013
- In 2015 statewide, the number of illicit opioids deaths surpassed prescription (Rx) opioid deaths. This trend continued at a greater magnitude in 2016 to present
- From 2007-2021, there wasn't a substantial increase or decrease in fatal prescription (Rx) opioid overdoses; however, in 2022, there was a large drop in Rx opioid overdoses compared to the past 15-year span
- Fentanyl (prescription, illicit, and/or analogs) caused or contributed to death in 75.9% of all fatal overdoses in 2022
- Fatal non-opioid illicit drug overdoses are on the rise. In 2022, fatal cocaine overdoses increased 22.1% and fatal methamphetamine overdoses increased 5.5% compared to 2021
- In 2022, the most common combination of substances causing fatal overdoses was cocaine and fentanyl, representing 30.6% of all overdose deaths

# PRESCRIPTION OPIOIDS (EXCLUDING FENTANYL)[24]

Since 2007, fatal prescription (Rx) opioid overdoses have been the leading category of drugs causing or contributing to death in the Commonwealth, with historically, oxycodone being the most common drug. Given the transition in fatal fentanyl overdoses from pharmaceutically produced fentanyl (2007-2014) to nearly all illicitly produced fentanyl (2015-present), fentanyl needs to be removed from the Rx opioid category and analyzed separately. This allows one to see the significant impact the drug is having on fatal overdose numbers in Virginia. By removing fentanyl from this Rx category, it is to be expected that Rx opioid fatalities from 2007-2013 to be slightly undercounted because true Rx fentanyl overdoses are excluded and combined with all 'fentanyl' to capture recent trends of illicit fentanyl in Virginia.

**Total Number of Fatal Prescription Opioid Overdoses (Excluding Fentanyl) by Quarter and Year of Death, 2007-2023***

**Data for 2023 is a Predicted Total for the Entire Year**




| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q4 | 116 | 116 | 104 | 112 | 149 | 144 | 121 | 125 | 116 | 113 | 138 | 115 | 123 | 120 | 100 | 80 | |
| Q3 | 86 | 96 | 97 | 107 | 106 | 101 | 113 | 122 | 104 | 127 | 133 | 121 | 92 | 129 | 108 | 87 | 61 |
| Q2 | 107 | 96 | 100 | 86 | 126 | 93 | 119 | 122 | 77 | 107 | 115 | 110 | 113 | 149 | 112 | 90 | 56 |
| Q1 | 92 | 114 | 116 | 121 | 115 | 97 | 107 | 130 | 101 | 125 | 121 | 131 | 134 | 99 | 134 | 83 | 83 |
| Total Fatalities | 401 | 422 | 417 | 426 | 496 | 435 | 460 | 499 | 398 | 472 | 507 | 477 | 462 | 497 | 454 | 340 | 270 |

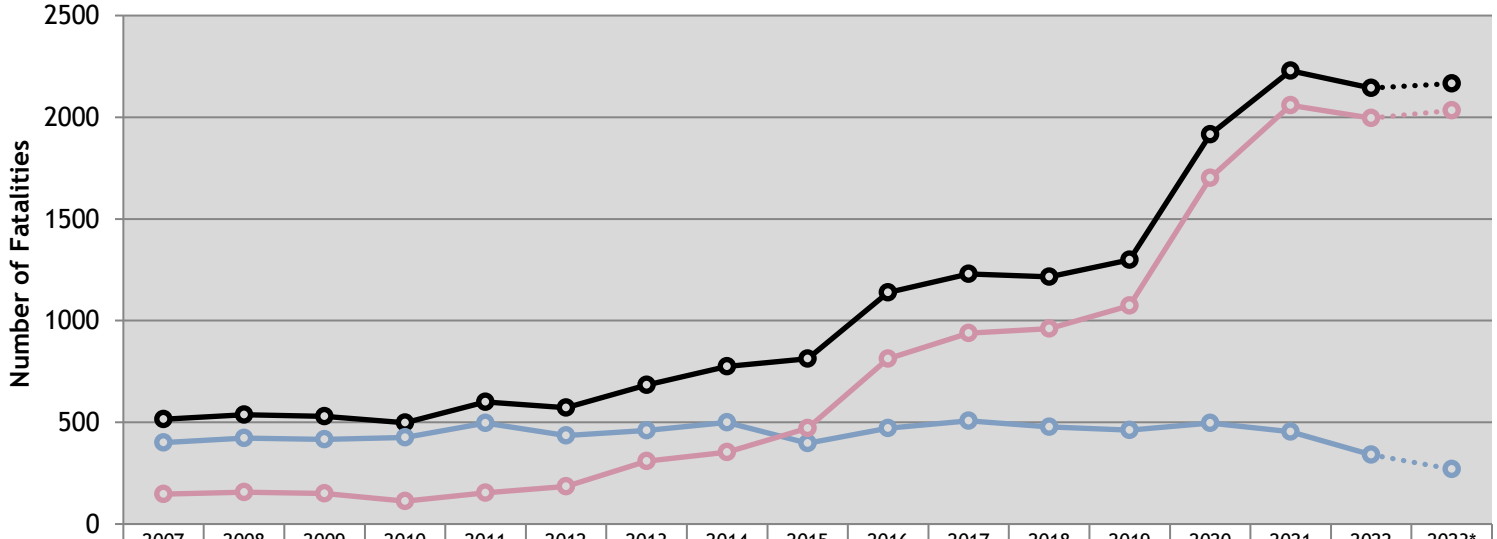
[1] 'Prescription Opioids (excluding fentanyl)' calculates all deaths in which one or more prescription opioids caused or contributed to death, but excludes fentanyl from the **required list** of prescription opioid drugs used to calculate the numbers. However, given that some of these deaths have multiple drugs on board, some deaths may have fentanyl in addition to other prescriptions opioids, and are therefore counted in the total number. Analysis must be done this way because by excluding all deaths in which fentanyl caused or contributed to death, the calculation would also exclude other prescription opioid deaths (oxycodone, methadone, etc.) from the analysis and would thereby undercount the actual number of fatalities due to these true prescription opioids.

# OPIOIDS- A DIFFERENT PERSPECTIVE

Prescription opioids are a group of drugs that are commercially made by pharmaceutical companies in certified laboratories that act upon the opioid receptors in the brain. Historically, fentanyl has been one of these drugs. However, in late 2013, early 2014, illicitly made fentanyl began showing up in Virginia and by 2016, most fatal fentanyl overdoses were of illicit production of the drug. Separating fentanyl from the grouping of prescription opioids for this reason demonstrates a slight decrease in fatal prescription opioid overdoses in 2015 and a dramatic increase in the number of fatal fentanyl and/or heroin overdoses. This has caused the significant rise in all fatal opioid overdoses in the Commonwealth since 2012.

**Total Number of Prescription Opioid (Excluding Fentanyl), Fentanyl and/or Heroin, and All Opioid Overdoses by Year of Death, 2007-2023***

**Data for 2023 is a Predicted Total for the Entire Year**




| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| All Opioids | 516 | 538 | 530 | 498 | 601 | 572 | 684 | 775 | 812 | 1138 | 1229 | 1215 | 1298 | 1915 | 2229 | 2143 | 2165 |
| Prescription Opioids (excluding fentanyl) | 401 | 422 | 417 | 426 | 496 | 435 | 460 | 499 | 398 | 472 | 507 | 477 | 462 | 497 | 454 | 340 | 270 |
| Fentanyl and/or Heroin | 148 | 157 | 150 | 112 | 153 | 185 | 309 | 353 | 471 | 813 | 939 | 961 | 1073 | 1702 | 2058 | 1995 | 2034 |

[1] 'All Opioids' include all versions of fentanyl, heroin, prescription opioids, and opioids unspecified

[2] Illicit and pharmaceutically produced fatal fentanyl overdoses are represented in this analysis. This includes all different types of fentanyl analogs (acetyl fentanyl, furanyl fentanyl, etc.)

[3] 'Prescription Opioids (excluding fentanyl)' calculates all deaths in which one or more prescription opioids caused or contributed to death, but excludes fentanyl from the **required list** of prescription opioid drugs used to calculate the numbers. However, given that some of these deaths have multiple drugs on board, some deaths may have fentanyl in addition to other prescriptions opioids, and are therefore counted in the total number. Analysis must be done this way because by excluding all deaths in which fentanyl caused or contributed to death, the calculation would also exclude other prescription opioid deaths (oxycodone, methadone, etc.) from the analysis and would thereby undercount the actual number of fatalities due to these true prescription opioids.

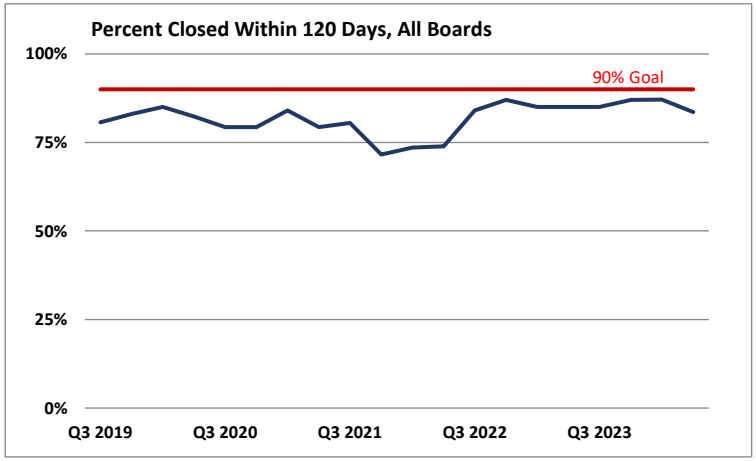
# Virginia Department of Health Professions
## Board Level Patient Care Case Processing Times:
## Quarterly Performance Measurement, Q3 2019 - Q2 2024

Arne Owens,
Agency Director

Data Analytics by
VisualResearch

### All Boards

| Fiscal Quarter | Total Cases Closed | Mean Days | Median Days | Percent closed within 120 Days |
|---|---|---|---|---|
| Q3 2019 | 964 | 86 | 22 | 81% |
| Q4 2019 | 1213 | 80 | 29 | 83% |
| Q1 2020 | 1043 | 78 | 28 | 85% |
| Q2 2020 | 893 | 90 | 37 | 82% |
| Q3 2020 | 1198 | 102 | 60 | 79% |
| Q4 2020 | 1105 | 98 | 44 | 79% |
| Q1 2021 | 1061 | 86 | 38 | 84% |
| Q2 2021 | 897 | 105 | 47 | 79% |
| Q3 2021 | 911 | 97 | 50 | 81% |
| Q4 2021 | 844 | 126 | 53 | 72% |
| Q1 2022 | 1202 | 125 | 74 | 74% |
| Q2 2022 | 1269 | 122 | 82 | 74% |
| Q3 2022 | 1363 | 91 | 48 | 84% |
| Q4 2022 | 910 | 75 | 36 | 87% |
| Q1 2023 | 1156 | 80 | 29 | 85% |
| Q2 2023 | 942 | 79 | 41 | 85% |
| Q3 2023 | 1159 | 78 | 47 | 85% |
| Q4 2023 | 1164 | 84 | 56 | 87% |
| Q1 2024 | 1367 | 79 | 43 | 87% |
| Q2 2024 | 1024 | 85 | 47 | 84% |




Technical Notes: Board Level constitutes the sum of days in Probable Cause, Informal, Formal, and Pending. Percent Closed Within 120 Days (175 calendar days) is calculated using an 8 quarter moving window consisting of patient care cases closed within 120 business days that were received within the preceding eight quarters.

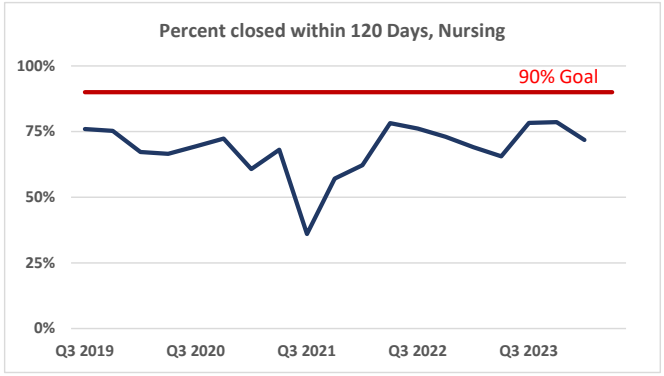
# Virginia Department of Health Professions
## Board Level Patient Care Case Processing Times:
## Quarterly Performance Measurement, Q3 2019 - Q2 2024

Arne Owens,
Agency Director

Data Analytics by
VisualResearch

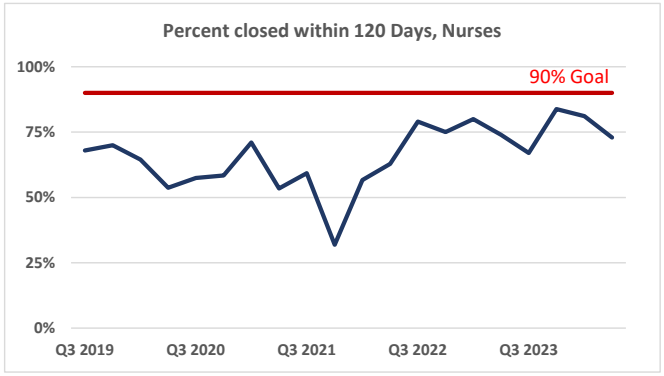
### Board of Nursing

| Fiscal Quarter | Total Cases Closed | Mean Days | Median Days | Percent closed within 120 Days |
|---|---|---|---|---|
| Q3 2019 | 438 | 109 | 64 | 74% |
| Q4 2019 | 517 | 103 | 45 | 76% |
| Q1 2020 | 396 | 116 | 54 | 75% |
| Q2 2020 | 357 | 153 | 123 | 67% |
| Q3 2020 | 478 | 158 | 107 | 67% |
| Q4 2020 | 461 | 141 | 96 | 69% |
| Q1 2021 | 422 | 131 | 69 | 72% |
| Q2 2021 | 321 | 172 | 96 | 61% |
| Q3 2021 | 357 | 148 | 71 | 68% |
| Q4 2021 | 261 | 257 | 249 | 36% |
| Q1 2022 | 483 | 192 | 150 | 57% |
| Q2 2022 | 561 | 167 | 132 | 62% |
| Q3 2022 | 629 | 125 | 87 | 78% |
| Q4 2022 | 293 | 118 | 77 | 76% |
| Q1 2023 | 405 | 119 | 58 | 73% |
| Q2 2023 | 324 | 132 | 88 | 69% |
| Q3 2023 | 352 | 139 | 110 | 66% |
| Q4 2023 | 561 | 124 | 107 | 78% |
| Q1 2024 | 543 | 112 | 81 | 79% |
| Q2 2024 | 373 | 120 | 77 | 72% |




### Nurses

| Fiscal Quarter | Total Cases Closed | Mean Days | Median Days | Percent closed within 120 Days |
|---|---|---|---|---|
| Q3 2019 | 321 | 124 | 82 | 68% |
| Q4 2019 | 381 | 118 | 56 | 70% |
| Q1 2020 | 242 | 144 | 97 | 65% |
| Q2 2020 | 216 | 179 | 149 | 54% |
| Q3 2020 | 324 | 186 | 147 | 57% |
| Q4 2020 | 310 | 171 | 145 | 58% |
| Q1 2021 | 300 | 137 | 72 | 71% |
| Q2 2021 | 234 | 198 | 142 | 53% |
| Q3 2021 | 221 | 167 | 75 | 59% |
| Q4 2021 | 226 | 262 | 258 | 32% |
| Q1 2022 | 427 | 194 | 155 | 57% |
| Q2 2022 | 325 | 161 | 131 | 63% |
| Q3 2022 | 462 | 117 | 89 | 79% |
| Q4 2022 | 216 | 122 | 87 | 75% |
| Q1 2023 | 291 | 97 | 53 | 80% |
| Q2 2023 | 242 | 117 | 82 | 74% |
| Q3 2023 | 285 | 134 | 100 | 67% |
| Q4 2023 | 396 | 108 | 79 | 84% |
| Q1 2024 | 334 | 103 | 74 | 81% |
| Q2 2024 | 310 | 115 | 73 | 73% |



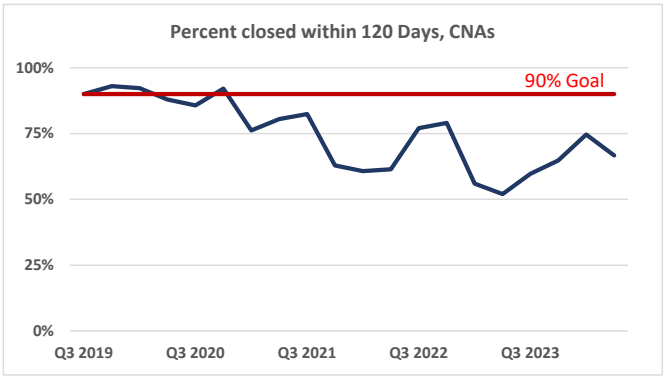
# Virginia Department of Health Professions
## Board Level Patient Care Case Processing Times:
## Quarterly Performance Measurement, Q3 2019 - Q2 2024

Arne Owens,
Agency Director

Data Analytics by
VisualResearch

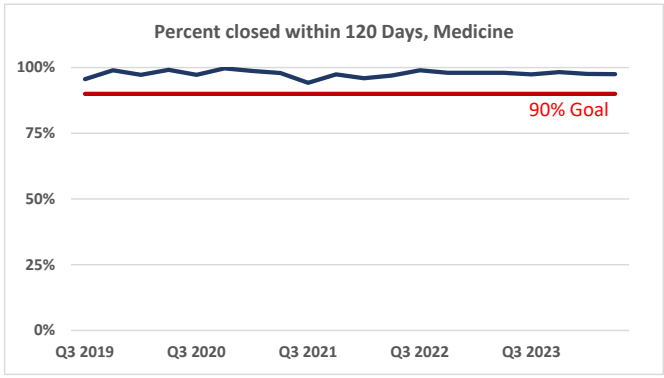
### CNAs

| Fiscal Quarter | Total Cases Closed | Mean Days | Median Days | Percent closed within 120 Days |
|---|---|---|---|---|
| Q3 2019 | 117 | 68 | 17 | 90% |
| Q4 2019 | 136 | 62 | 44 | 93% |
| Q1 2020 | 154 | 72 | 47 | 92% |
| Q2 2020 | 141 | 112 | 112 | 88% |
| Q3 2020 | 154 | 100 | 80 | 86% |
| Q4 2020 | 151 | 80 | 69 | 92% |
| Q1 2021 | 122 | 115 | 63 | 76% |
| Q2 2021 | 87 | 103 | 57 | 81% |
| Q3 2021 | 136 | 116 | 70 | 82% |
| Q4 2021 | 35 | 226 | 147 | 63% |
| Q1 2022 | 56 | 177 | 145 | 61% |
| Q2 2022 | 236 | 174 | 140 | 61% |
| Q3 2022 | 167 | 145 | 82 | 77% |
| Q4 2022 | 77 | 106 | 32 | 79% |
| Q1 2023 | 114 | 177 | 132 | 56% |
| Q2 2023 | 82 | 177 | 173 | 52% |
| Q3 2023 | 67 | 160 | 146 | 60% |
| Q4 2023 | 165 | 162 | 167 | 65% |
| Q1 2024 | 209 | 125 | 91 | 75% |
| Q2 2024 | 63 | 140 | 91 | 67% |




### Medicine

| Fiscal Quarter | Total Cases Closed | Mean Days | Median Days | Percent closed within 120 Days |
|---|---|---|---|---|
| Q3 2019 | 274 | 31 | 6 | 96% |
| Q4 2019 | 388 | 23 | 7 | 99% |
| Q1 2020 | 354 | 26 | 8 | 97% |
| Q2 2020 | 325 | 21 | 9 | 99% |
| Q3 2020 | 434 | 33 | 14 | 97% |
| Q4 2020 | 346 | 18 | 8 | 100% |
| Q1 2021 | 382 | 33 | 11 | 99% |
| Q2 2021 | 283 | 29 | 9 | 98% |
| Q3 2021 | 330 | 42 | 13 | 94% |
| Q4 2021 | 346 | 32 | 12 | 97% |
| Q1 2022 | 369 | 33 | 12 | 96% |
| Q2 2022 | 332 | 35 | 14 | 97% |
| Q3 2022 | 459 | 27 | 9 | 99% |
| Q4 2022 | 334 | 24 | 7 | 98% |
| Q1 2023 | 387 | 22 | 5 | 98% |
| Q2 2023 | 369 | 27 | 7 | 98% |
| Q3 2023 | 423 | 23 | 5 | 97% |
| Q4 2023 | 351 | 21 | 5 | 98% |
| Q1 2024 | 413 | 22 | 6 | 98% |
| Q2 2024 | 321 | 27 | 7 | 98% |



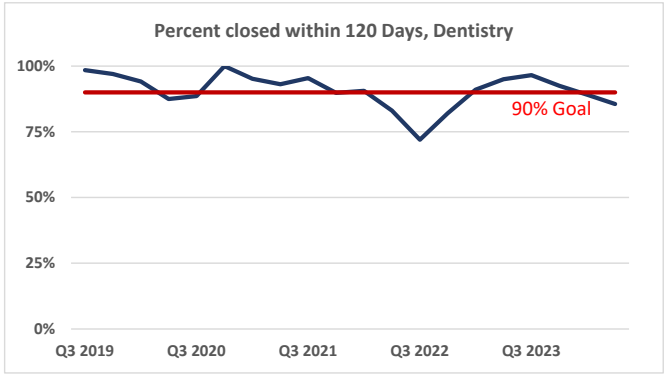
# Virginia Department of Health Professions
## Board Level Patient Care Case Processing Times:
## Quarterly Performance Measurement, Q3 2019 - Q2 2024

Arne Owens,
Agency Director

Data Analytics by
VisualResearch

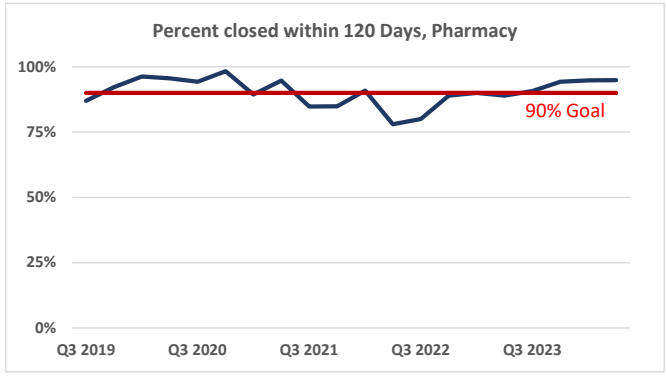
### Dentistry

| Fiscal Quarter | Total Cases Closed | Mean Days | Median Days | Percent closed within 120 Days |
|---|---|---|---|---|
| Q3 2019 | 68 | 30 | 14 | 99% |
| Q4 2019 | 67 | 26 | 14 | 97% |
| Q1 2020 | 68 | 41 | 20 | 94% |
| Q2 2020 | 48 | 58 | 8 | 88% |
| Q3 2020 | 70 | 45 | 13 | 89% |
| Q4 2020 | 54 | 20 | 16 | 100% |
| Q1 2021 | 63 | 37 | 16 | 95% |
| Q2 2021 | 87 | 50 | 21 | 93% |
| Q3 2021 | 65 | 35 | 14 | 95% |
| Q4 2021 | 59 | 52 | 22 | 90% |
| Q1 2022 | 85 | 57 | 17 | 91% |
| Q2 2022 | 77 | 89 | 20 | 83% |
| Q3 2022 | 39 | 105 | 23 | 72% |
| Q4 2022 | 81 | 112 | 70 | 82% |
| Q1 2023 | 65 | 89 | 59 | 91% |
| Q2 2023 | 42 | 70 | 72 | 95% |
| Q3 2023 | 89 | 63 | 73 | 97% |
| Q4 2023 | 53 | 77 | 77 | 93% |
| Q1 2024 | 175 | 104 | 109 | 89% |
| Q2 2024 | 90 | 101 | 87.5 | 86% |




### Pharmacy

| Fiscal Quarter | Total Cases Closed | Mean Days | Median Days | Percent closed within 120 Days |
|---|---|---|---|---|
| Q3 2019 | 38 | 76 | 54 | 87% |
| Q4 2019 | 77 | 82 | 57 | 92% |
| Q1 2020 | 54 | 65 | 46 | 96% |
| Q2 2020 | 45 | 60 | 51 | 96% |
| Q3 2020 | 53 | 64 | 37 | 94% |
| Q4 2020 | 58 | 54 | 40 | 98% |
| Q1 2021 | 66 | 71 | 48 | 89% |
| Q2 2021 | 76 | 95 | 82 | 95% |
| Q3 2021 | 46 | 93 | 61 | 85% |
| Q4 2021 | 53 | 99 | 101 | 85% |
| Q1 2022 | 77 | 76 | 42 | 91% |
| Q2 2022 | 100 | 105 | 86 | 78% |
| Q3 2022 | 54 | 91 | 47 | 80% |
| Q4 2022 | 81 | 86 | 59 | 89% |
| Q1 2023 | 107 | 75 | 52 | 90% |
| Q2 2023 | 74 | 80 | 55 | 89% |
| Q3 2023 | 129 | 68 | 50 | 91% |
| Q4 2023 | 70 | 66 | 49 | 94% |
| Q1 2024 | 116 | 55 | 29 | 95% |
| Q2 2024 | 117 | 55 | 32 | 95% |



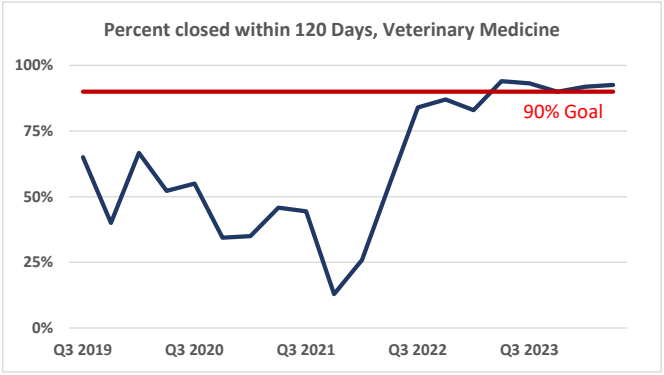
# Virginia Department of Health Professions
## Board Level Patient Care Case Processing Times:
## Quarterly Performance Measurement, Q3 2019 - Q2 2024

Arne Owens,
Agency Director

Data Analytics by
VisualResearch

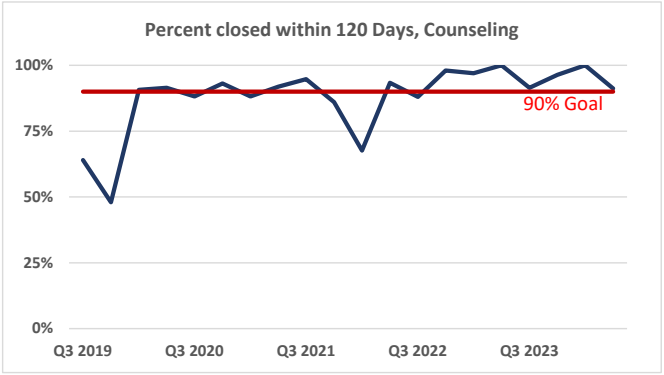
### Veterinary Medicine

| Fiscal Quarter | Total Cases Closed | Mean Days | Median Days | Percent closed within 120 Days |
|---|---|---|---|---|
| Q3 2019 | 17 | 131 | 57 | 65% |
| Q4 2019 | 15 | 241 | 279 | 40% |
| Q1 2020 | 33 | 149 | 126 | 67% |
| Q2 2020 | 23 | 191 | 170 | 52% |
| Q3 2020 | 20 | 150 | 135 | 55% |
| Q4 2020 | 32 | 284 | 299 | 34% |
| Q1 2021 | 20 | 274 | 279 | 35% |
| Q2 2021 | 24 | 221 | 243 | 46% |
| Q3 2021 | 27 | 236 | 251 | 44% |
| Q4 2021 | 31 | 306 | 331 | 13% |
| Q1 2022 | 58 | 309 | 337 | 26% |
| Q2 2022 | 87 | 160 | 165 | 55% |
| Q3 2022 | 43 | 79 | 19 | 84% |
| Q4 2022 | 31 | 65 | 26 | 87% |
| Q1 2023 | 53 | 83 | 37 | 83% |
| Q2 2023 | 31 | 60 | 32 | 94% |
| Q3 2023 | 44 | 75 | 72 | 93% |
| Q4 2023 | 30 | 79 | 68 | 90% |
| Q1 2024 | 37 | 56 | 38 | 92% |
| Q2 2024 | 27 | 70 | 69 | 93% |




### Counseling

| Fiscal Quarter | Total Cases Closed | Mean Days | Median Days | Percent closed within 120 Days |
|---|---|---|---|---|
| Q3 2019 | 22 | 130 | 66 | 64% |
| Q4 2019 | 71 | 185 | 188 | 48% |
| Q1 2020 | 54 | 77 | 53 | 91% |
| Q2 2020 | 47 | 64 | 39 | 92% |
| Q3 2020 | 51 | 94 | 106 | 88% |
| Q4 2020 | 58 | 84 | 93 | 93% |
| Q1 2021 | 51 | 85 | 85 | 88% |
| Q2 2021 | 37 | 75 | 35 | 92% |
| Q3 2021 | 38 | 79 | 62 | 95% |
| Q4 2021 | 43 | 91 | 55 | 86% |
| Q1 2022 | 71 | 134 | 135 | 68% |
| Q2 2022 | 61 | 101 | 104 | 93% |
| Q3 2022 | 59 | 93 | 89 | 88% |
| Q4 2022 | 44 | 55 | 45 | 98% |
| Q1 2023 | 61 | 72 | 80 | 97% |
| Q2 2023 | 51 | 75 | 92 | 100% |
| Q3 2023 | 71 | 78 | 81 | 92% |
| Q4 2023 | 56 | 68 | 79 | 96% |
| Q1 2024 | 74 | 57 | 75 | 100% |
| Q2 2024 | 34 | 87 | 104 | 91% |



# Virginia Department of Health Professions
## Board Level Patient Care Case Processing Times:
## Quarterly Performance Measurement, Q3 2019 - Q2 2024

Arne Owens,
Agency Director

Data Analytics by
VisualResearch

| | Fiscal Quarter | Total Cases Closed | Mean Days | Median Days | Percent closed within 120 Days |
|---|---|---|---|---|---|
| **Social Work** | Q3 2019 | 17 | 192 | 309 | 47% |
| | Q4 2019 | 31 | 143 | 50 | 61% |
| | Q1 2020 | 16 | 152 | 95 | 56% |
| | Q2 2020 | 8 | 192 | 127 | 50% |
| | Q3 2020 | 24 | 255 | 329 | 46% |
| | Q4 2020 | 47 | 205 | 231 | 40% |
| | Q1 2021 | 13 | 17 | 16 | 100% |
| | Q2 2021 | 13 | 90 | 16 | 77% |
| | Q3 2021 | 12 | 39 | 21 | 92% |
| | Q4 2021 | 11 | 19 | 17 | 100% |
| | Q1 2022 | 12 | 37 | 14 | 92% |
| | Q2 2022 | 3 | 2 | 0 | 100% |
| | Q3 2022 | 13 | 103 | 106 | 100% |
| | Q4 2022 | 11 | 77 | 117 | 100% |
| | Q1 2023 | 5 | 103 | 135 | 100% |
| | Q2 2023 | 2 | 2 | 2 | 100% |
| | Q3 2023 | 5 | 160 | 1 | 60% |
| | Q4 2023 | 9 | 61 | 5 | 89% |
| | Q1 2024 | 12 | 122 | 107 | 83% |
| | Q2 2024 | 9 | 39 | 10 | 100% |
| **Psychology** | Q3 2019 | 27 | 148 | 162 | 63% |
| | Q4 2019 | 18 | 90 | 49 | 83% |
| | Q1 2020 | 22 | 25 | 5 | 100% |
| | Q2 2020 | 16 | 49 | 7 | 94% |
| | Q3 2020 | 27 | 134 | 156 | 56% |
| | Q4 2020 | 31 | 198 | 201 | 19% |
| | Q1 2021 | 7 | 180 | 195 | 14% |
| | Q2 2021 | 17 | 138 | 159 | 53% |
| | Q3 2021 | 7 | 81 | 5 | 71% |
| | Q4 2021 | 13 | 161 | 158 | 54% |
| | Q1 2022 | 16 | 161 | 85 | 56% |
| | Q2 2022 | 8 | 258 | 288 | 50% |
| | Q3 2022 | 20 | 296 | 285 | 25% |
| | Q4 2022 | 5 | 16 | 0 | 100% |
| | Q1 2023 | 11 | 79 | 13 | 82% |
| | Q2 2023 | 4 | 102 | 77 | 75% |
| | Q3 2023 | 6 | 100 | 2 | 83% |
| | Q4 2023 | 10 | 211 | 86 | 70% |
| | Q1 2024 | 13 | 313 | 349 | 39% |
| | Q2 2024 | 14 | 333 | 420 | 29% |

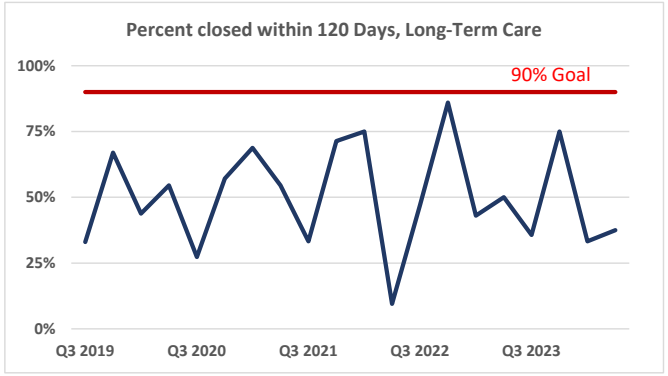

# Virginia Department of Health Professions
## Board Level Patient Care Case Processing Times:
## Quarterly Performance Measurement, Q3 2019 - Q2 2024

Arne Owens,
Agency Director

Data Analytics by
VisualResearch

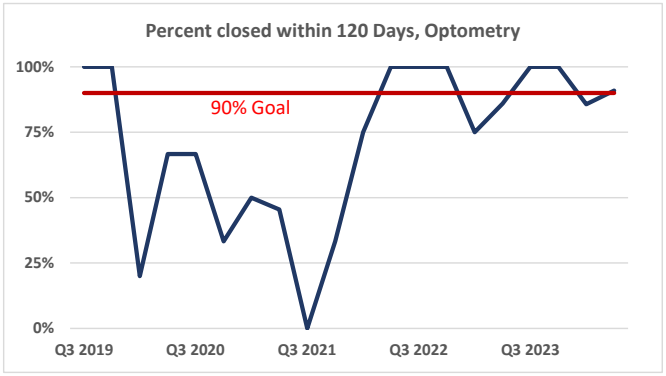
### Long-Term Care

| Fiscal Quarter | Total Cases Closed | Mean Days | Median Days | Percent closed within 120 Days |
|---|---|---|---|---|
| Q3 2019 | 15 | 268 | 351 | 33% |
| Q4 2019 | 6 | 121 | 66 | 67% |
| Q1 2020 | 16 | 226 | 229 | 44% |
| Q2 2020 | 11 | 181 | 139 | 55% |
| Q3 2020 | 11 | 264 | 294 | 27% |
| Q4 2020 | 7 | 182 | 7 | 57% |
| Q1 2021 | 16 | 150 | 11 | 69% |
| Q2 2021 | 11 | 205 | 171 | 55% |
| Q3 2021 | 6 | 158 | 193 | 33% |
| Q4 2021 | 7 | 150 | 3 | 71% |
| Q1 2022 | 4 | 151 | 91 | 75% |
| Q2 2022 | 21 | 340 | 388 | 10% |
| Q3 2022 | 15 | 177 | 216 | 47% |
| Q4 2022 | 7 | 53 | 16 | 86% |
| Q1 2023 | 30 | 215 | 188 | 43% |
| Q2 2023 | 14 | 184 | 142 | 50% |
| Q3 2023 | 14 | 274 | 311 | 36% |
| Q4 2023 | 8 | 117 | 54 | 75% |
| Q1 2024 | 9 | 281 | 347 | 33% |
| Q2 2024 | 16 | 254 | 352 | 38% |




### Optometry

| Fiscal Quarter | Total Cases Closed | Mean Days | Median Days | Percent closed within 120 Days |
|---|---|---|---|---|
| Q3 2019 | 2 | 34 | 34 | 100% |
| Q4 2019 | 4 | 44 | 56 | 100% |
| Q1 2020 | 5 | 273 | 314 | 20% |
| Q2 2020 | 3 | 190 | 110 | 67% |
| Q3 2020 | 3 | 129 | 127 | 67% |
| Q4 2020 | 3 | 234 | 343 | 33% |
| Q1 2021 | 2 | 194 | 194 | 50% |
| Q2 2021 | 11 | 263 | 278 | 46% |
| Q3 2021 | 3 | 313 | 344 | 0% |
| Q4 2021 | 9 | 196 | 215 | 33% |
| Q1 2022 | 8 | 94 | 44 | 75% |
| Q2 2022 | 3 | 62 | 66 | 100% |
| Q3 2022 | 7 | 50 | 36 | 100% |
| Q4 2022 | 3 | 71 | 28 | 100% |
| Q1 2023 | 4 | 163 | 115 | 75% |
| Q2 2023 | 7 | 81 | 49 | 86% |
| Q3 2023 | 10 | 57 | 62 | 100% |
| Q4 2023 | 5 | 27 | 7 | 100% |
| Q1 2024 | 7 | 54 | 23 | 86% |
| Q2 2024 | 11 | 96 | 66 | 91% |



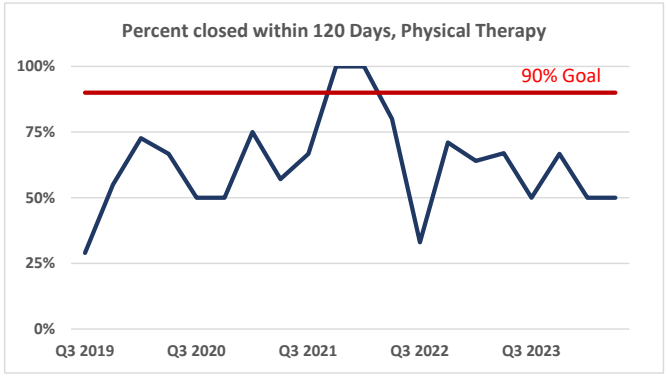
# Virginia Department of Health Professions
## Board Level Patient Care Case Processing Times:
## Quarterly Performance Measurement, Q3 2019 - Q2 2024

Arne Owens,
Agency Director

Data Analytics by
VisualResearch

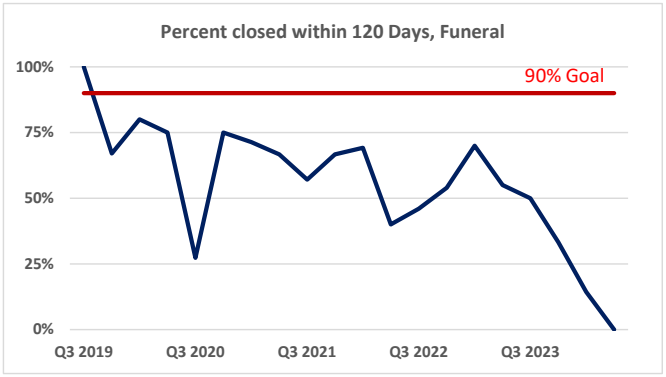
### Physical Therapy

| Fiscal Quarter | Total Cases Closed | Mean Days | Median Days | Percent closed within 120 Days |
|---|---|---|---|---|
| Q3 2019 | 14 | 266 | 284 | 29% |
| Q4 2019 | 11 | 171 | 90 | 55% |
| Q1 2020 | 11 | 103 | 70 | 73% |
| Q2 2020 | 3 | 122 | 98 | 67% |
| Q3 2020 | 14 | 195 | 177 | 50% |
| Q4 2020 | 4 | 148 | 177 | 50% |
| Q1 2021 | 8 | 98 | 47 | 75% |
| Q2 2021 | 7 | 155 | 166 | 57% |
| Q3 2021 | 6 | 125 | 157 | 67% |
| Q4 2021 | 2 | 79 | 79 | 100% |
| Q1 2022 | 4 | 80 | 68 | 100% |
| Q2 2022 | 5 | 108 | 46 | 80% |
| Q3 2022 | 12 | 270 | 286 | 33% |
| Q4 2022 | 7 | 128 | 126 | 71% |
| Q1 2023 | 14 | 141 | 127 | 64% |
| Q2 2023 | 9 | 120 | 47 | 67% |
| Q3 2023 | 4 | 144 | 149 | 50% |
| Q4 2023 | 3 | 123 | 0 | 67% |
| Q1 2024 | 12 | 176 | 169 | 50% |
| Q2 2024 | 2 | 99 | 99 | 50% |




### Funeral

| Fiscal Quarter | Total Cases Closed | Mean Days | Median Days | Percent closed within 120 Days |
|---|---|---|---|---|
| Q3 2019 | 5 | 103 | 92 | 100% |
| Q4 2019 | 3 | 130 | 146 | 67% |
| Q1 2020 | 10 | 89 | 65 | 80% |
| Q2 2020 | 4 | 131 | 167 | 75% |
| Q3 2020 | 11 | 157 | 202 | 27% |
| Q4 2020 | 4 | 160 | 162 | 75% |
| Q1 2021 | 7 | 117 | 157 | 71% |
| Q2 2021 | 6 | 161 | 126 | 67% |
| Q3 2021 | 14 | 173 | 146 | 57% |
| Q4 2021 | 6 | 156 | 139 | 67% |
| Q1 2022 | 13 | 172 | 147 | 69% |
| Q2 2022 | 10 | 160 | 195 | 40% |
| Q3 2022 | 11 | 190 | 198 | 46% |
| Q4 2022 | 13 | 203 | 174 | 54% |
| Q1 2023 | 10 | 167 | 162 | 70% |
| Q2 2023 | 11 | 178 | 159 | 55% |
| Q3 2023 | 8 | 202 | 178 | 50% |
| Q4 2023 | 3 | 276 | 338 | 33% |
| Q1 2024 | 7 | 269 | 272 | 14% |
| Q2 2024 | 8 | 387 | 395 | 0% |



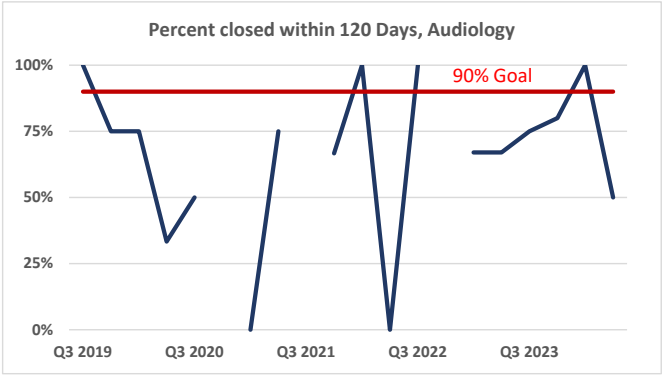
# Virginia Department of Health Professions
## Board Level Patient Care Case Processing Times:
## Quarterly Performance Measurement, Q3 2019 - Q2 2024

Arne Owens,
Agency Director

Data Analytics by
VisualResearch

### Audiology

| Fiscal Quarter | Total Cases Closed | Mean Days | Median Days | Percent closed within 120 Days |
|---|---|---|---|---|
| Q3 2019 | 1 | 106 | 106 | 100% |
| Q4 2019 | 4 | 75 | 34 | 75% |
| Q1 2020 | 4 | 159 | 135 | 75% |
| Q2 2020 | 3 | 251 | 214 | 33% |
| Q3 2020 | 2 | 136 | 136 | 50% |
| Q4 2020 | 0 | | | |
| Q1 2021 | 4 | 275 | 214 | 0% |
| Q2 2021 | 4 | 149 | 162 | 75% |
| Q3 2021 | 0 | | | |
| Q4 2021 | 3 | 190 | 147 | 67% |
| Q1 2022 | 2 | 54 | 54 | 100% |
| Q2 2022 | 1 | 289 | 289 | 0% |
| Q3 2022 | 2 | 28 | 28 | 100% |
| Q4 2022 | 0 | | | |
| Q1 2023 | 3 | 138 | 137 | 67% |
| Q2 2023 | 3 | 128 | 116 | 67% |
| Q3 2023 | 4 | 111 | 61 | 75% |
| Q4 2023 | 5 | 130 | 70 | 80% |
| Q1 2024 | 5 | 42 | 14 | 100% |
| Q2 2024 | 2 | 163 | 163 | 50% |



# Candidate for Board of Directors

**L. Blanton Marchese**

**Virginia**

FEDERATION OF STATE MEDICAL BOARDS

COMMONWEALTH of VIRGINIA

Arne W. Owens
Director

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

www.dhp.virginia.gov
PHONE (804) 367- 4400

Sarvam P. TerKonda, MD
Chair, FSMB Nominating Committee

Dear Dr. TerKonda:

It is with great pleasure that I write on behalf of the Virginia Board of Medicine to nominate Blanton Marchese for the Federation of State Medical Boards Board of Directors. These comments are based on 5.5 years of familiarity with him.

Mr. Marchese was appointed to the Board in June 2018 and immediately began making an impact. Since 2018, he has served as the Board member reviewer for all applications with non-routine information. In his 5+ years, he has reviewed approximately 5,000 applications. He also served on the Credentials Committee which worked to streamline the licensing process for all of the Board's 20 professions and attended hearings with applicants who may not be qualified for licensure. His colleagues on the Board quickly recognized his leadership skills, particularly his emergency medical experience, his years as a death investigator for the Office of the Chief Medical Examiner, and his experience as CEO of a successful emergency medical company. The Board elected him to the Secretary-Treasurer position, then Vice-President, and then 2 years as President of the Board. He has always been a splendid ambassador for the Board of Medicine, is greatly respected and no doubt, elevated respect for the Board.

During his time on the Virginia Board, he has:

- Chaired the Executive Committee
- Chaired the Legislative Committee
- Served on the Committee of the Joint Boards of Nursing and Medicine
- Served on the Ad Hoc Committee on USP 797/800
- Chaired the Regulatory Advisory Panel on Opioids and Buprenorphine
- Chaired the Ad Hoc Committee on Medications and Best Practices for Midwives
- Served on the Board of Pharmacy Work Group on Statewide Protocols for Pharmacists

It should be noted that Mr. Marchese runs excellent, disciplined, agenda-focused meetings all the while allowing for full discussion of an issue prior to bringing it to a vote.

In keeping with his taking broader perspectives on matters and his interest in effective engagement, Mr. Marchese has attended 4 FSMB Annual Meetings and 2 Tri-Regulator Meetings. He has attended meetings on the Physician Assistant Compact and will be in attendance at the January 2024 Symposium on Artificial Intelligence in Health Care and Medical Regulation in Washington, DC.

Enough cannot be said about what an asset he would be on the FSMB Board of Directors. His energy, dedication and creativity would serve any organization well, and the Virginia Board of Medicine recommends him without reservation.

Mr. Marchese is ready, willing and able to serve. He is aware of the time commitment required for the position. His contact information is as follows:

Thanks for your consideration and kindest regards,

William L. Harp, MD
Executive Director
Virginia Board of Medicine

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

**Staff Note:** Please note Committee assignments and minutes of meetings since October 19, 2023.

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

# VIRGINIA BOARD OF MEDICINE

## Committee Appointments

## FY2024

### EXECUTIVE COMMITTEE (8)
**Randy Clements, DPM – President, Chair**
**Peter Apel, MD – Vice-President**
William Hutchens, MD
Oliver Kim
L. Blanton Marchese
Jacob Miller, DO
**Karen Ransone, MD – Secretary-Treasurer**
Jennifer Rathmann, DC

### LEGISLATIVE COMMITTEE (7)
**Peter Apel, MD – Vice-President, Chair**
**Randy Clements, DPM – President**
Thomas Corry
Manjit Dhillon, MD
Krishna Madiraju, MD
Pradeep Pradhan, MD
Jennifer Rathmann, DC

### CREDENTIALS COMMITTEE (9)
**Jacob Miller, DO – Chair**
David Archer, MD
Hazem Elariny, MD
Madge Ellis, MD
Deborah DeMoss Fonseca
William Hutchens, MD
Elliott Lucas, MD
Krishna Madiraju, MD
Patrick McManus, MD

### FINANCE COMMITTEE
**J. Randy Clements, DPM – President**
**Peter Apel, MD – Vice-President**
**Karen Ransone, MD – Secretary-Treasurer**

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

### CHIROPRACTIC COMMITTEE
Jennifer Rathmann, DC

### BOARD OF HEALTH PROFESSIONS
Krishna Madiraju, MD

### COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
**Randy Clements, DPM – President**
Blanton Marchese
Karen Ransone, MD

--- DRAFT UNAPPROVED---

# VIRGINIA BOARD OF MEDICINE

## LEGISLATIVE COMMITTEE MINUTES

Friday, January 5, 2024 | Department of Health Professions | Henrico, VA

**CALL TO ORDER:** Dr. Apel called the meeting of the Legislative Committee to order at 8:31 a.m.

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

**MEMBERS PRESENT:**
Peter Apel, MD - Vice-President, Chair
J. Randy Clements, DPM - President
Thomas Corry
Manjit Dhillon, MD
Pradeep Pradhan, MD
Jennifer Rathmann, DC

**MEMBERS ABSENT:** None

**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
Deirdre Brown - Executive Assistant
Erin Barrett - DHP Policy Analyst
James Jenkins, RN - DHP Senior Deputy Director

**COUNCIL PRESENT:** W. Brent Saunders - Senior AAG

**OTHERS PRESENT:**
Ben Traynham - Hancock Daniel/MSV
Jennie Wood - Discipline Staff
Tamika Hines – Discipline Staff
Krystal Blanton – Discipline Staff
Laura Ellis – Administrative Staff

### EMERGENCY EGRESS INSTRUCTIONS

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

### APPROVAL OF MINUTES OF JANUARY 13, 2023

Dr. Pradhan moved to approve the meeting minutes of January 13, 2023, as presented. The motion was properly seconded and carried unanimously.

## ADOPTION OF AGENDA

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

## PUBLIC COMMENT

There was no public comment.

## DHP DIRECTOR'S REPORT

Jim Jenkins, RN, DHP Senior Deputy Director, addressed the Committee members in Mr. Owens' absence and expressed the agency's continued appreciation for their leadership. Mr. Jenkins stated that they were gearing up for the 2024 General Assembly and anticipates a busy session since this a budget cycle.

## EXECUTIVE DIRECTOR'S REPORT

Dr. William Harp informed the Committee of the appointment of new Board members: Deborah DeMoss Fonseca – citizen replacing Alvin Edwards; Elliot Lucas, MD - replacing Ryan Williams, MD; Patrick McManus, MD replacing Joel Silverman, MD; and Thomas Corry, the newest member on the Committee, replacing Jane Hickey, JD. Mr. Corry introduced himself and provided a brief background of his experience within the medical community and with standards and policies.

Dr. Harp then provided the members with an update on the status of the Business Processes Analysis and Re-Engineering Project led by Impact Makers. This group was recommended by the Governor, and they are focused on streamlining our current licensing process. He said that they are currently assisting with rewriting the MD/DO application instructions and will be working in phases to get through all the professions. It is anticipated that the first phase of their work will be completed by the end of March.

Additionally, Dr. Harp reported that HB1426 to require one hour of continuing education on human trafficking was added to the 2024 renewal notifications in early December. Since, notifying the licensees of this mandatory requirement and providing a link to the free CE at the Polaris Project, the Board has received multiple inquiries including a comment from a Colorado physician who stated this was the most memorable CE a board has mandated him to do. Shortly after, another comment was received that said it was the most worthless. So, there appears to be varying opinions about the mandated CE. Dr. Harp noted that those renewing in January and February will be provided an extension to meet this requirement, and an attestation will be sent out in March to assess their compliance.

Lastly, Dr. Harp mentioned that continuing education audits for all professions under the Board may be going away if the amended regulations are approved. Board staff has never had the capacity to complete audits on all the professions in the past, including those required for MDR.

**NEW BUSINESS**

1. Current Regulatory Actions – Erin Barrett

Ms. Barrett provided an update on the Board's current regulatory actions as of January 4, 2024. For the benefit of the Committee members, Ms. Barrett provided an overview of the stages that regulations move through from the NOIRA stage to final regulations and noted that there was no formula or way of knowing when they would be approved.

2. Legislative Summary – Erin Barrett

Ms. Barrett walked the Committee through the following bills after advising that the Session begins on January 10th. Ms. Barrett said she anticipates there will be more bills of interest to come, and they will be presented at the February 15th Full Board meeting.

- **HB 8 – Medical Ethics Defense Act; established**

Establishes the right of a medical practitioner, health care institution, or health care payer not to participate in or pay for any medical procedure or service that violates such medical practitioner's, health care institution's, or health care payer's conscience, as those terms and conditions are defined in the bill.

- **HB 32 Medicine, Board of; continuing ed. related to implicit bias and cultural competency in health care.**

Requires the Board of Medicine to adopt and implement policies that require each practitioner licensed by the Board who has direct contact with persons who are or may become pregnant to complete two hours of continuing education related to implicit bias, defined in the bill, and cultural competency in health care at least once every other license renewal cycle.

- **HB 42 Dentists and dental hygienists; added to list of providers who are immune from civil liability, etc.**

Adds dentists and dental hygienists to the list of providers who are immune from civil liability for any act done or made in performance of his duties while serving as a member of or consultant to an entity that functions primarily to review, evaluate, or make recommendations on a professional program to address issues related to career fatigue and wellness in health care professionals. The bill also extends civil immunity to certain providers for any act done or made in performance of his duties while serving as a member of or consultant to an entity that functions primarily to arrange for or provide outpatient health care for health care professionals. The bill also revises the Board of Medicine reporting requirements when a health care professional is admitted for mental health treatment. Under the bill, if a health care professional is voluntarily admitted to a health care institution for treatment of a substance abuse or psychiatric illness and is no longer believed to be a danger within 30 days then no report will be made to the Board of Medicine.

- **HB 120 DPOR and DHP; certain suspensions not considered disciplinary action.**

Prohibits any board of the Department of Professional and Occupational Regulation or the Department of Health Professions issuing a suspension upon any regulant of such board pursuant to such regulant's having submitted a check, money draft, or similar instrument for payment of a fee required by statute or regulation that is not honored by the bank or financial institution named from considering or describing such suspension as a disciplinary action.

- **HB 188 Advance Health Care Planning Registry; amendment of regulations.**

Amends the list of documents that may be submitted to the Advance Health Care Directive Registry to include any other document that supports advance health care planning. The bill also changes the name of the Advance Health Care Directive Registry to the Advance Health Care Planning Registry.

- **HB 217 Physicians; informed consent, disclosure of certain info. prior to hysterectomy or oophorectomy.**

Requires physicians to obtain informed consent from a patient prior to performing a hysterectomy or oophorectomy. Prior to obtaining informed consent, physicians must inform the patient of the patient's freedom to withhold or withdraw consent, refer the patient to the Hysterectomy Educational Resources and Services (HERS) Foundation, and provide the patient with anatomical diagrams relevant to the procedure. The bill allows physicians to forego obtaining informed consent when a hysterectomy or oophorectomy is performed in a life-threatening emergency situation.

- **SB 35 Renewal of licensure; Boards of Medicine & of Nursing to require Bd of Nursing etc.,cont. ed. reqd.**

Directs the Board of Medicine and the Board of Nursing to require unconscious bias and cultural competency training as part of the continuing education and continuing competency requirements for renewal of licensure. The bill specifies requirements for the training and requires the Board of Medicine and Board of Nursing to report on the training to the Department of Health and the Neonatal Perinatal Collaborative.

Lastly, Ms. Barrett provided the Committee with the status of a house bill which seeks to remove the requirement for the Executive Director for the Board of Medicine to be eligible for licensure as a physician in Virginia. She said that if the bill passes, it would allow for the position to be filled by an attorney and that opens the bandwidth for recruitment.

Dr. Harp commented that the Executive Director’s role has changed since the early 2000’s from mostly clinical review to mostly administrative tasks today.

**ANNOUNCEMENTS**

None.

**NEXT MEETING**

May 5, 2023

**ADJOURNEMENT**

With no other business to conduct, the meeting adjourned at 9:38 a.m.

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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 Department of Health Professions
Board of Health Professions

# Draft Meeting Minutes

**Call to Order**
The October 27, 2023, Virginia Board of Health Professions meeting was called to order at 10:00 a.m. at the Department of Health Professions (DHP), Perimeter Center, 9960 Mayland Drive, 2nd Floor, Board Room 2, Henrico, Virginia 23233.

**Presiding Officer**
James Wells, RPh

**Members Present**
Margaret Lemaster, RDH, Board of Dentistry
Mitchell Davis, NHA, Board of Long-Term Care Administrators
Krishna P. Madiraju, MD, FAAP, Board of Medicine
A. Tucker Gleason, PhD, Board of Nursing
Steve Karras, DVM, Board of Veterinary Medicine
Sheila E. Battle, MHS, Citizen Member
Carmina Bautista, MSN, FNP-BC, BC-ADM, Citizen Member
Claire Wulf Winiarek, PhD, Citizen Member
Karen E. Kimsey, Citizen Member
Susan Wallace, PhD, Board of Psychology (joined at 10:15 a.m.)

**Staff Present**
Arne W. Owens, Agency Director
Leslie L. Knachel, Executive Director
Kelli Moss, Deputy Executive Director
Erin Barrett, Director of Legislative and Regulatory Affairs
Laura Booberg, Assistant Attorney General, Board Counsel
Laura Paasch, Senior Licensing Specialist

**Public Present**
Mary Ottinot, RN
Stephanie Shawalter
Clark Barrineau, Medical Society of Virginia

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

**Ordering of Agenda**
Mr. Wells opened the floor to any changes to the agenda. Ms. Knachel indicated that the agenda order may change due to multiple meetings that presenters were attending. No

other changes were noted. The agenda was accepted as presented noting the possible order change.

**Public Comment**
Ms. Ottinot provided comments about mental health services.

**Approval of Minutes**
Mr. Wells opened the floor to any additions or corrections regarding the draft minutes from the Full Board Meeting on March 29, 2022. Hearing none, the minutes were approved as presented.

**Agency Director's Report**
Mr. Owens provided an update on the agency's activities.

**Legislative/Regulatory Report**
Ms. Barrett provided information regarding the policy review for the electronic participation amendment.

> Dr. Karras made a motion to revise the electronic participation policy as presented. The motion was seconded by Ms. Wulf Winiarek. The motion carried unanimously.

**Reports**
Staff
Ms. Knachel provided the staff report.

Healthcare Workforce Data
Dr. Yetty Shobo provided her report on the activities of the Healthcare Workforce Data Center.

Enforcement
Ms. Pam Twombly, Acting Director of the Enforcement Division, Josh Goggan, Enforcement Case Intake Manager, and Melody Morton, Enforcement Inspections Manager, provided a report on the activities in the Enforcement Division.

Communications
Ms. Diane Powers, DHP Communications Director, provided a report on the activities in the Communications Division.

Finance
Mr. Chris Moore, Finance Director, provided his report on the activities in the Finance Division.

Administrative Proceedings Division
Ms. Julia Bennett, Deputy Director for the Administrative Proceedings Division, reported for James Banning, Director for the unit. She provided her report on the activities in the Administrative Proceedings Division.

**Board Counsel Report**
Ms. Booberg had no information to report to the Board.

**Board Chair Report**
Mr. Wells had no information to report to the Board.

**New Business**
Elections
Mr. Wells provided information from the bylaws regarding officer elections.

**Chair**
Dr. Madiraju made a motion to self-nominate to serve as Chair. Mr. Wells seconded the motion. No further nominations were received. Voting by roll-call ballot was unanimous and the motion carried for Dr. Madiraju to serve a one-year term as office of the Chair beginning January 1, 2024.

**First Vice-Chair**
Ms. Lemaster made a motion to self-nominate to serve as the First Vice-Chair. The motion was seconded by Dr. Gleason. No other nominations were received. Voting by roll-call ballot was unanimous and the motion carried for Ms. Lemaster to serve a one-year term as First Vice-Chair beginning January 1, 2024.

**Second Vice-Chair**
Dr. Wallace made a motion to nominate Ms. Wulf Winiarek to serve as the Second Vice-Chair. The motion was seconded by Ms. Battle. No other nominations were received. Voting by roll-call ballot was unanimous and the motion carried for Dr. Wulf Winiarek to serve a one-year term as Second Vice-Chair beginning January 1, 2024.

**Reports continued**
Right Help Right Now
Ms. Jamie Hoyle, Executive Director for the Boards of Psychology, Social Work and Counseling provided a report on the Governor's Initiative, Right Help Right Now.

**Next Meeting**
The next full board meeting will be announced at a future time.

**Adjournment**
Hearing no objections, Mr. Wells adjourned the meeting at 1:15 p.m.

**Agenda Item:** **Current Regulatory Actions**

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

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

**Board of Medicine**
**Current Regulatory Actions**
**As of February 6, 2024**

## Recently effective/awaiting publication

| VAC | Stage | Subject Matter | Publication date | Effective date |
|---|---|---|---|---|
| 18VAC85-101 | Fast-track | Implementation of changes following 2022 periodic review of Chapter | 2/12/2024 | 3/28/2024 |
| 18VAC85-120 | Fast-track | Implementation of changes following 2022 periodic review of Chapter | 2/12/2024 | 3/28/2024 |

## In the Governor's Office

None.

## In the Secretary's Office

| VAC | Stage | Subject Matter | Submitted from agency | Time in current location | Notes |
|---|---|---|---|---|---|
| 18VAC85-160 | Final | Changes consistent with a licensed profession | 6/17/2022 | 581 days | Proposed regulations consistent with surgical assistants changing from certification to licensure |
| 18VAC85-160 | Fast-track | Reinstatement as a surgical technologist | 6/17/2022 | 525 days | Action to allow certified surgical technologists to voluntarily request inactive status, and for surgical technologists to reinstate certification from inactive status or from suspension or revocation following disciplinary action. |

| | | | | | |
|---|---|---|---|---|---|
| 18VAC85-130 | Fast-track | Implementation of changes following 2022 periodic review of Chapter | 10/6/2022 | 252 days | Implements changes following 2022 periodic review |
| 18VAC85-140 | Fast-track | Implementation of changes following 2022 periodic review of Chapter | 10/6/2022 | 249 days | Implements changes following 2022 periodic review |
| 18VAC85-150 | Fast-track | Implementation of changes following 2022 periodic review of Chapter | 10/6/2022 | 246 days | Implements changes following 2022 periodic review |
| 18VAC85-170 | Fast-track | Implementation of changes following 2022 periodic review of Chapter | 10/6/2022 | 246 days | Implements changes following 2022 periodic review |
| 18VAC85-15 | Fast-Track | Implementation of Periodic Review | 10/6/2022 | 211 days | Implements changes following 2022 periodic review |
| 18VAC85-40 | Fast-track | Implementation of changes following 2022 periodic review of Chapter | 10/6/2022 | 190 days | Implements changes following 2022 periodic review |
| 18VAC85-80 | Fast-track | Implementation of changes following 2022 periodic review of Chapter | 10/6/2022 | 181 days | Implements changes following 2022 periodic review |
| 18VAC85-50 | NOIRA | Removal of patient care team physician or podiatrist name from prescriptions issued by physician assistants | 8/8/2023 | 179 days | Regulatory action begun in response to a petition for rulemaking |
| 18VAC85-50 | Fast-track | Implementation of changes following 2022 | 8/15/2023 | 175 days | Implements changes following 2022 periodic review |

| | | | | | |
|---|---|---|---|---|---|
| | | periodic review of Chapter | | | |
| 18VAC85-110 | Fast-track | Implementation of changes following 2022 periodic review of Chapter | 10/6/2022 | 172 days | Implements changes following 2022 periodic review |
| 18VAC85-50 | NOIRA | Amendment to requirements for patient care team physician or podiatrist consultation and collaboration | 8/8/2023 | 169 days | Regulatory action begun in response to a petition for rulemaking |
| 18VAC85-80 | Final | Implementation of the OT Compact | 8/23/2023 | 167 days | Replaces emergency regulations for participation in the OT Compact |
| 18VAC85-20 | Fast-track | Implementation of changes following 2022 periodic review of Chapter | 10/6/2022 | 160 days | Implements changes following 2022 periodic review |
| 18VAC85-21 | Fast-track | Amendment of opioid and buprenorphine prescribing regulations | 7/14/2023 | 4 days | Updates opioid and buprenorphine regulations based on updated CDC guidelines |

**At DPB**

None.

**At OAG**

| VAC | Stage | Subject Matter | Submitted from agency | Time in current location | Notes |
|---|---|---|---|---|---|
| 18VAC85-30 | Fast-track | General disclosure requirement consistent with statutory changes | 10/23/2023 | 106 days | Updates requirements for midwife disclosures consistent with 2023 legislative changes |

**Agenda Item:** **2024 General Assembly Report**

**Staff Note:** Ms. Barrett will speak to legislation of interest to the Board of Medicine.

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

**Agenda Item:** FSMB Report on "Reentry to Practice"

**Staff note:** The Federation of State Medical Boards is a private organization that helps state boards of medicine in many ways. One of those is developing model policy documents with assistance from boards and for consideration of implementation by all state boards. The draft report on Reentry to Practice is included for your review.

Note that there are 9 recommendations in the Executive Summary. Here are some preliminary comments from Board and Staff individuals.

1) The Board communicates with its licensees through its Board Briefs newsletter. The regulations regarding reentry can be published in the newsletter.

2&3) The Board currently considers each initial application and reinstatement application on a case-by-case basis, not only what the applicant's plans are, but also what they have done while out of practice to prepare to return.

4) Currently the Board's regulations suggest that an applicant that has been out of practice more than 4 years should take the SPEX. If more is required of an applicant, it can be determined by the Credentials Committee.

5) Board staff sees this as a bridge too far. Years ago, contact was made with specialty societies to identify medical expert reviewers for the Board. 2, maybe 3, physicians responded out of 30,000 or so. Likewise, efforts were made to establish assessment centers for physicians with academic centers. Only those with existing centers were interested, but they were not specialty-specific.

6) Supervisory arrangements are usually set up by the licensee/applicant.

7) DHP's Healthcare Workforce Data Center surveys the Board's professions every 2-4 years.

8) Licensees can choose an "inactive" license which does not authorize them to practice any act of their profession.

9) Coordinating with all other boards of medicine would be a Herculean task.

**Action:** To discuss and formulate comments for FSMB.

# REENTRY TO PRACTICE

*Report of the FSMB Workgroup on Reentry to Practice*
*Draft, January 2024*

## Executive Summary

Physicians may take a leave from practice for a variety of reasons, necessitating reentry. The following document contains guidance for state medical boards when considering potential reentry to practice requirements for physicians seeking to regain licensure following a significant absence from practice. Recommendations offered in the document reflect an appreciation that unique situations exist for physicians (and includes physician assistants) seeking to reenter practice and therefore we encourage flexibility and the need to consider reentry decisions on a case-by-case basis.

Key considerations for state medical boards in reentry decisions include:

- the duration of time out of practice;
- clinical and other relevant activities engaged in by the physician while out of practice;
- the need for assessment of a physician's competence prior to reentry to practice;
- reentry during public health emergencies;
- collection of data about the clinical activity of the licensee population;
- the variety of challenges faced by physicians seeking to reenter practice;
- instances where absence from practice occurs to manage potentially impairing illness;
- differing reentry requirements where absence from practice occurs as a result of state medical board disciplinary proceedings or criminal conviction;
- mentoring and supervision for reentering physicians; and
- differing requirements when retraining is required due to a change in scope of practice or a lack of training or experience in the physician's intended scope of practice.

The following recommendations are included for state medical boards:

1) State medical boards should proactively communicate with and educate licensees/applicants about the issues associated with reentering clinical practice.
2) Reentry to practice decisions should be made on a case-by-case basis.
3) All licensees/applicants returning to clinical practice after a period of inactivity should be required to provide a detailed description of their future scope of practice plans.
4) State medical boards and licensees/applicants who have been clinically inactive should agree upon a reentry to practice plan acceptable to the state medical board. Applicants should provide proof of completion of the plan prior to reentry.
5) State medical boards should foster collaborative relationships with academic institutions, community hospital training centers, state medical societies, and state chapters of specialty societies to develop and ensure the availability of assessment, educational and other interventions and resources for the various types of practices.
6) Supervisory arrangements for reentering physicians should be approved by state medical boards. Where formal supervision is not required, mentorship may be arranged by

reentering physicians. State medical boards should make efforts to ensure a sufficient pool of supervisors and mentors is available to reentering physicians.

7) State medical boards should require licensees to report information about their practice as part of the license renewal process, including type of practice, status, whether they are actively seeing patients, specialty board certification status, and what activities they are engaged in if they are not engaged in clinical practice.
8) Licensees who are clinically inactive should be allowed to maintain their licensure status provided they meet the requirements set forth by the state medical board. Depending on a licensee's engagement in activities designed to maintain clinical competence, should the licensee choose to return to active clinical practice, the board may require participation in a reentry program.
9) State medical boards should be consistent in the creation and execution of reentry programs.

## Introduction

In April 2012, the Federation of State Medical Boards (FSMB) adopted the *Report of the Special Committee on Reentry to Practice (2012).* The following year, the FSMB adopted the *Report of the Special Committee on Reentry for the Ill Physician (2013).* At the time of their adoption, the two reports addressed current regulatory challenges associated with physician reentry to practice, while recognizing that there was a paucity of research surrounding the issue. Despite minimal advance in research, widespread recognition has since developed that physicians may take a temporary absence from clinical practice for a variety of reasons, and physician reentry can be a common part of a physician's continuing practice of medicine.

Jeffrey D. Carter, MD, Chair of the FSMB, appointed the Workgroup on Reentry to Practice in May 2023 to update and bring current FSMB policies related to reentry to practice for state medical and osteopathic boards (hereinafter referred to as "state medical boards" and/or "medical boards"). The Workgroup was charged with conducting a comprehensive review of state medical and osteopathic board rules, regulations and policies related to reentry to practice; conducting a review and evaluation of FSMB policies, including *Reentry to Practice (HOD 2012)* and *Reentry for the Ill Physician (HOD 2013)* and specifically the recommendations regarding out of practice timelines based on current evidence; conducting a literature review of related research, guidelines and other publications and the impact of demographic changes in the physician workforce on licensure and practice; identifying available educational resources and activities for physicians to positively impact their ability to demonstrate their fitness to reenter the workforce; and identifying options for competency assessment tools for state medical boards to evaluate physicians' fitness to reenter the workforce.

In meeting its charge, the Workgroup also surveyed medical boards to better understand the current priorities and procedures related to the departure and reentry to practice. Survey results indicated that reentry to practice is a high priority for medical boards. Results also indicated that 57 percent of responding medical boards ask licensees, whether during license renewal or another mechanism, if they are actively clinically practicing. However, a greater number of medical boards (69 percent of respondents) reported not collecting data on the number of medical professionals who left clinical practice and applied for reentry.

The results of the survey helped guide Workgroup discussions, as did the involvement of a subject matter expert with extensive experience working in assessment and training of physicians reentering practice. These also helped inform the Workgroup's decision that *Reentry to Practice* and *Reentry for the Ill Physician* should be combined into one document, as did FSMB's recent experience working with state medical boards on the issue of physician well-being. This report, and recommendations, are intended to serve as a framework for common reentry standards and processes. These recommendations are also intended to provide flexibility for state medical boards and physician and physician assistant licensees/applicants.

The recommendations provided in this report are organized as follows:

- Education and Communication
- Determining Medical Fitness to Reenter Practice
- Supervision and Mentoring for Practitioners Who Want to Reenter the Workforce

- Improving Regulation of Licensed Practitioners Who are Clinically Inactive

**Section One. Glossary**

The Workgroup presents the following glossary to support a common interpretation of key terms related to reentry to practice.

"Absence from Practice" means any duration of time that a physician voluntarily takes an absence from providing direct, consultative, or supervisory patient care. Some absences from practice may require a medical board-approved reentry process, whereas absences of shorter duration or absences that include activities aimed at maintaining competence may not. Unless otherwise specified, an absence from practice does not include absences that result from medical board disciplinary action.

"Clinically Active Practice" means a physician who, at the time of license renewal, is engaged in direct, consultative, or supervisory patient care, or as further defined by the states.

"Mentoring" means a dynamic, reciprocal relationship in a work environment between two individuals where, often but not always, one is an experienced physician in active practice and the other is a physician reentering practice. The peer-relationship is aimed at providing the physician reentering practice with knowledge and resources to support safe reentry. This relationship is distinct from a supervisory relationship in that the mentor plays a supportive role but does not have a specific reporting responsibility to the medical board beyond that which would exist in any clinical context.

"Physician Reentry" means a return to clinical practice in the discipline in which one has been trained or certified following an extended period of clinical inactivity not resulting from medical board disciplinary action. Physician reentry is distinct from remediation or retraining.

"Physician Reentry Program" means a formal, structured curriculum and clinical experience which prepares a physician to return to clinical practice following an extended period of clinical inactivity.

"Physician Retraining" means the process of learning the necessary skills to move into a new clinical area that is distinct from the area of one's primary medical training. Physician retraining is distinct from physician reentry.

"Supervision" means a medical board-mandated process whereby a supervisor physician, who has been actively practicing for at least the five prior consecutive years, observes a physician reentering practice for a defined period and provides feedback, educational, and clinical support. The support is aimed at ensuring safe reentry to practice. This relationship is distinct from a mentor relationship in that the supervisor has a defined responsibility to the medical board for assessing the reentering physician's fitness to practice independently. For physician assistants, the role of supervisor may be fulfilled by the supervising physician.

**Section Two. Key Issues**

The Workgroup identified several key issues relevant to state medical board decisions about reentry to practice.

Timeframe

More than two years away from practice is commonly accepted as the timeframe for when physicians should go through a reentry process. The two-year timeframe is based on extensive state medical board experience and subject matter expertise in physician assessment and remediation. The Workgroup recognizes the need for flexibility when applying the two-years-absent-from-practice timeframe to an individual physician, as there is great variability in specialty, type of practice, and clinical and educational engagement while absent from practice.

When determining whether a physician requires a reentry to practice program, a medical board may choose to consider the following factors:

- administrative or consultative activity (e.g., chart reviews);
- concordance of prior and intended scopes of practice;
- educational or mentoring responsibilities;
- intention to perform procedures upon reentry;
- length of time in practice prior to departure;
- participation in accredited continuing medical education and/or volunteer activities during the time out of practice;
- participation in continuous certification[1] prior to departure from practice;
- prior disciplinary history;
- time since completion of post-graduate training; and
- whether absence from practice resulted from disciplinary action or criminal conviction

Assessment of Fitness to Reenter Practice

It is the responsibility of state medical boards to determine whether a licensee/applicant who has had an absence from practice should demonstrate whether they are competent to reenter practice. The assessment, as well as the assessment modality or modalities may be tailored to the individual. If it is not immediately clear what needs to be assessed as part of the licensee's fitness to practice, state medical boards are encouraged to seek the expertise of assessment organizations with experience in this area.[2] Boards may recommend that clinically inactive physicians proactively complete a self-assessment prior to reentering practice to identify any clinical deficiencies as this may be valuable in determining board-mandated reentry requirements.

Public Health Emergencies

During public health emergencies, state medical boards may recognize the need to, and choose to, implement temporary licensure modifications and waivers allowing clinically inactive physicians to reenter practice. When doing so, medical boards should utilize mechanisms that can quickly identify and verify credentials of health professionals to ensure patient safety and maintain

[1] The Workgroup recognizes that at the time of drafting, some specialty certifying boards continue to use the term "Maintenance of Certification" to describe this process.

[2] FSMB, Directory of Physician Assessment and Remedial Education Programs. October 2023, available at: https://www.fsmb.org/siteassets/spex/pdfs/remedprog.pdf.

oversight of licensure waivers that fall outside medical board control. If a clinically inactive physician chooses to practice beyond the public health emergency, they must complete the appropriate reentry program determined by the state medical board. Boards are encouraged to make licensees aware of Provider Bridge so they may choose to register as potential volunteers in advance of future public health emergencies.

State Medical Board Data Collection on Clinical Activity

State medical boards should consider means of collecting information from licensees about their clinical activity to understand workforce demographics. While some state medical boards will be limited in their capacity to collect data on licensee clinical activity, they may wish to consider alternative means to collecting this on licensing applications such as optional surveys to licensees. This can be particularly important for understanding the degree to which active licensees are not clinically active, and may inform reentry decisions for this population.

Challenges to Reentry

There are difficulties associated with identifying entities that provide reentry services to physicians. These include cost, geographic considerations, eligibility requirements, licensure, malpractice issues and lack of uniformity among alternatives available to physicians seeking reentry. While some of these challenges are outside the purview of state medical boards, others can be mitigated by boards, including requirements for mentors, rather than supervisors, and the ability to obtain a training license. State medical boards may choose to review their current practices to avoid undue burdens or barriers to reentry, while being mindful of patient safety considerations. Boards may proactively choose to communicate these challenges to licensees so that they can plan accordingly when an absence from practice is anticipated.

- *Cost and duration of reentry programs*: Due to the time and resources required to effectively assess and support a physician through a reentry process, reentry programs are, of necessity, costly. However, they are an essential mechanism to inform state medical board decisions about reentry requirements in the interest of patient safety.
- *Accessibility of reentry programs*: There is a wide range of entities[3] that offer reentry services, ranging in remediation programs to mini residencies. Accessibility may vary depending on the needs of the reentering physician and the geographic location of reentry programs. However, as some services are being offered online, accessibility is improving.
- *Availability of mentors and supervisors*: It may be challenging for medical boards to identify and select mentors and supervisors based on the needs of the reentering physician, due to various reasons, including geographical location or specialty. Boards may develop a roster of mentors and supervisors that would serve in these roles for reentering physicians. Recruitment may occur through questions on renewal applications or through advertising in board publications.
- *Ability to obtain a training license (and engage in clinical activity without a full and unrestricted license)*: As many medical board-approved programs necessitate clinical training which includes direct patient care, a training license is required. However, this license type is not offered in all states. Boards may choose to evaluate whether their existing license types include a license that permits reentering physicians to practice within

[3] *Ibid.*

their reentry program. Possible license types may include a limited or special purpose license, temporary license, or a resident license.

- *Medical Liability Insurance and Hospital Credentialing/Privileging*: In many jurisdictions it is not possible to obtain liability insurance without first obtaining a medical license. As mentioned previously, because of this requirement, medical boards may again choose to evaluate whether their existing license types include a license that permits reentering physicians to practice and subsequently obtain liability insurance. It is also not possible to obtain hospital privileges without first obtaining a license or liability insurance.

Impairment

The terms "illness" and "impairment" are not synonymous. Illness is the term used to describe the existence of a disease state. It can be physical or psychiatric and can include addictive disease, injury, and cognitive change. Impairment, however, is a functional classification that implies the inability of the person affected by illness or injury to provide medical care with reasonable skill and safety.[4]

A physician who is or has been ill is not necessarily impaired and may be able to function effectively and practice safely, especially with participation in relevant treatment programs and ongoing monitoring, where appropriate. Therefore, the same set of reentry requirements and programs should be available to this population of physicians seeking reentry. State medical boards may familiarize themselves with the FSMB's *Policy on Physician Illness and Impairment* (HOD, 2021), as well as resources available in their state, such as the state's Physician Health Program.

Mentoring and Supervision of Reentry Physicians

Academic Medical Centers (AMCs) and Community Hospital Training Centers have a role in physician reentry as they already have the facilities, faculty, and resources to effectively perform assessment and training. AMCs and Community Hospital Training Centers can provide a complete reentry package from initial assessment of the reentry physician to final evaluation of competence and performance in practice. AMCs can provide selected services on an as-needed basis such as assessment testing, focused practice-based learning, procedure labs and identifying and vetting mentors and supervisors. Potential incentives to stimulate AMC involvement in reentry include research opportunities and generation of revenue.

Maintaining Licensure if Not in Active Clinical Practice

Some states consider the work done and decisions made by medical directors of health care programs to be the practice of medicine and therefore they are required to have an active license. Other states issue administrative medicine licenses as a distinct area of practice, which includes consultations and other educational functions that are non-clinical in nature. These types of licenses do not include the authority to practice clinical medicine, examine, care for, or treat patients, prescribe medications including controlled substances, or delegate medical acts or prescriptive authority to others.[5]

[4] FSMB, *Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health*. May 2021, available at: https://www.fsmb.org/siteassets/advocacy/policies/policy-on-physician-impairment.pdf.

[5] Iowa Code Ann. § 148.11A.

Retraining When Practice Differs or is Modified from Area of Primary Training

Some physicians who seek reentry want to practice in a specialty or area that differs from their area of primary training. In such cases, it is considered retraining, not reentry, and would require the physician to complete the necessary educational and training requirements for the new specialty. An obstetrician/gynecologist wishing to practice family medicine would fall into this category and require retraining. A physician seeking to narrow their primary area of practice, however, would not need to complete retraining, such as when an obstetrician/gynecologist wishes to limit their practice to only gynecology.

## Section Three. Recommendations

The following recommendations are intended to provide state medical boards, licensees, health insurers, physician health programs, health care organizations, and state government agencies with a framework for developing common standards and terminology around the reentry process.

Education and Communication

***Recommendation 1: Proactive communications***

To help prepare licensees/applicants who either are thinking about taking a leave of absence or are considering returning to clinical practice, state medical boards should proactively educate licensees/applicants about ways to maintain competence while absent from practice and the issues associated with reentering clinical practice (e.g., continued participation in CME activities while out of practice, unintended consequences of taking a leave of absence such as impact on malpractice costs and future employment). For example, state medical boards could develop written guidance on issues like the importance of engaging in clinical practice, if even on a limited, part-time basis, or seeking counsel from their insurance carriers prior to withdrawal from practice and when they are ready to reenter practice. They might also suggest that the licensee/applicant review the FSMB Roadmap for Those Considering Temporarily Leaving Practice (See Appendix A). State medical boards could include such information with the initial license, with the license renewal application, in the board's newsletter, and on the board's website. This may also help physicians who are contemplating retirement but are unaware that a reentry process may be required by their state medical board if they change their mind.

Determining Medical Fitness to Reenter Practice

***Recommendation 2: Review on a case-by-case basis***

Because competence is maintained in part through continuous engagement in patient care activities, licensees/applicants seeking to return to clinical work after an absence from practice should be considered on a case- by-case basis. Absences from practice of two years or greater are generally accepted as the minimum timeframe for when physicians should be required to engage in a reentry process. However, decisions about whether the licensee/applicant should demonstrate readiness to reenter practice should be based on a global review of the licensee/applicant's situation, including:

- administrative or consultative activity (e.g., chart reviews);
- concordance of prior and intended scopes of practice;
- educational or mentoring responsibilities;
- intention to perform procedures upon reentry;
- length of time in practice prior to departure;

- participation in accredited continuing medical education and/or volunteer activities during the time out of practice;
- participation in continuous certification prior to departure from practice;
- prior disciplinary history;
- time since completion of post-graduate training; and
- whether absence from practice resulted from disciplinary action or criminal conviction

Licensees/applicants who wish to take some time away from clinical practice should be encouraged to remain clinically active in some, even if limited, capacity, and urged to participate in continuing medical education and continuous certification.

***Recommendation 3: Documentation***

All licensees/applicants returning to clinical practice after a period of inactivity should be required to provide a detailed description of their future scope of practice plans. The degree of documentation required may vary depending on the length of time away from clinical practice and whether the licensee/applicant's scope of practice is consistent with their medical education and training. For example, documented evidence might include CME certificates and verification of volunteer activities.

A physician returning to a scope or area of practice in which they previously trained or certified, or in which they previously had an extensive work history may need reentry. A physician returning to clinical work in an area or scope of practice in which they have not previously trained or certified or in which they have not had an extensive work history needs retraining and, for the purposes of this report, is not considered a reentry physician. The reentering licensee/applicant should also be required to provide information regarding the environment within which they will be practicing, the types of patients they anticipate seeing, and the types of clinical activities in which they will be engaged.

***Recommendation 4: Reentry plan after extended time out of practice***

State medical boards and licensees/applicants who have been clinically inactive should agree upon a reentry to practice plan based on various considerations, which may include a self-assessment by the licensee/applicant, assessment of the licensee/applicant's knowledge and skills, and any activities completed during the absence from practice. The state medical board has final approval of the reentry plan and the licensee/applicant should be required to present proof of completion of the plan to the state medical board.

In instances where reentry plans require activities involving direct patient care, state medical boards may consider whether their existing license types allow for the reentering physician to practice. Such licenses permit the licensee/applicant to participate in activities necessary to regain the knowledge and skills needed to provide safe patient care, such as participation in a mini residency.

***Recommendation 5: State medical board collaborative relationships***

State medical boards should foster collaborative relationships with academic institutions, community hospital training centers, state medical societies, and state chapters of specialty societies to develop assessment, educational and other interventions and resources for the various

types of practices. The National Board of Osteopathic Medical Examiners, the National Board of Medical Examiners, the American Board of Medical Specialties, the American Osteopathic Association Bureau of Osteopathic Specialties, and the American Medical Association may likewise serve in a supportive role to state medical boards in this regard. These institutions and organizations may have readily adaptable programs or simulation centers that meet the individual needs of reentering physicians.

Supervision and Mentoring for Practitioners Who Want to Reenter the Workforce

***Recommendation 6: State medical board-approved supervisors and mentors***

Supervisors may be selected by either the state medical board or the licensee/applicant, but in all cases should be approved by the state medical board. At a minimum, the supervisor should be ABMS or AOA board certified, have no prior disciplinary history, and practice in the same clinical area as the licensee/applicant seeking reentry.

The state medical board should set forth in writing its expectations of the supervisor, including what aspects of the reentering licensee/applicant's practice are to be supervised, frequency and content of reports by the supervisor to the state medical board, and how long the practice is to be supervised. The board's expectations should be communicated both to the supervisor and the licensee/applicant being supervised. For physician assistants, the role of supervisor may be fulfilled by the supervising physician.

The supervisor should be required to demonstrate to the medical board's satisfaction that they have the capacity to serve as a supervisor, for example, sufficient time for supervising, lack of disciplinary history, proof of an active, unrestricted medical license, and demonstration of having actively practiced for at least the prior five consecutive years. The supervisor may be permitted to receive financial compensation or incentives for work associated with supervision. Potential sources of bias should be identified, and in some cases may disqualify a potential supervisor from acting in that capacity.

The licensee/applicant reentering practice should establish a peer-mentorship with an actively practicing physician who meets the requirements of a supervising physician, but the mentor does not require medical board approval or reporting beyond that which would typically exist in any clinical context.

State medical boards should work with state medical and osteopathic societies and associations and the medical education community to identify and increase the pool of potential supervisors and mentors. To protect the pool of supervisors, boards may make supervisors agents of the board.

Improving Regulation of Licensed Practitioners Who are Clinically Inactive

***Recommendation 7: Identifying clinically inactive licensees***

State medical boards should require licensees to report information about their practice as part of the license renewal process, including type of practice, status (e.g., full-time, part-time, number of hours worked per week), whether they are actively seeing patients, specialty board certification status, and what activities they are engaged in if they are not engaged in clinical practice (e.g., research, administration, non-medical work, retired, etc.). Such information will enable state medical boards to identify licensees who are not clinically active and to intervene and guide, as

needed, if a licensee chooses to return to patient care duties. State medical boards should advise licensees who are clinically inactive of their responsibility to participate in an individualized, diagnostic reentry plan prior to resuming patient care duties.

***Recommendation 8: Licensure status***

Licensees who are clinically inactive should be allowed to maintain their licensure status if they pay the required fees and complete any required continuing medical education or other requirements as set forth by the medical board. Depending on a licensee's engagement in activities designed to maintain clinical competence, should the licensee choose to return to active clinical practice, the board may require participation in a reentry program.

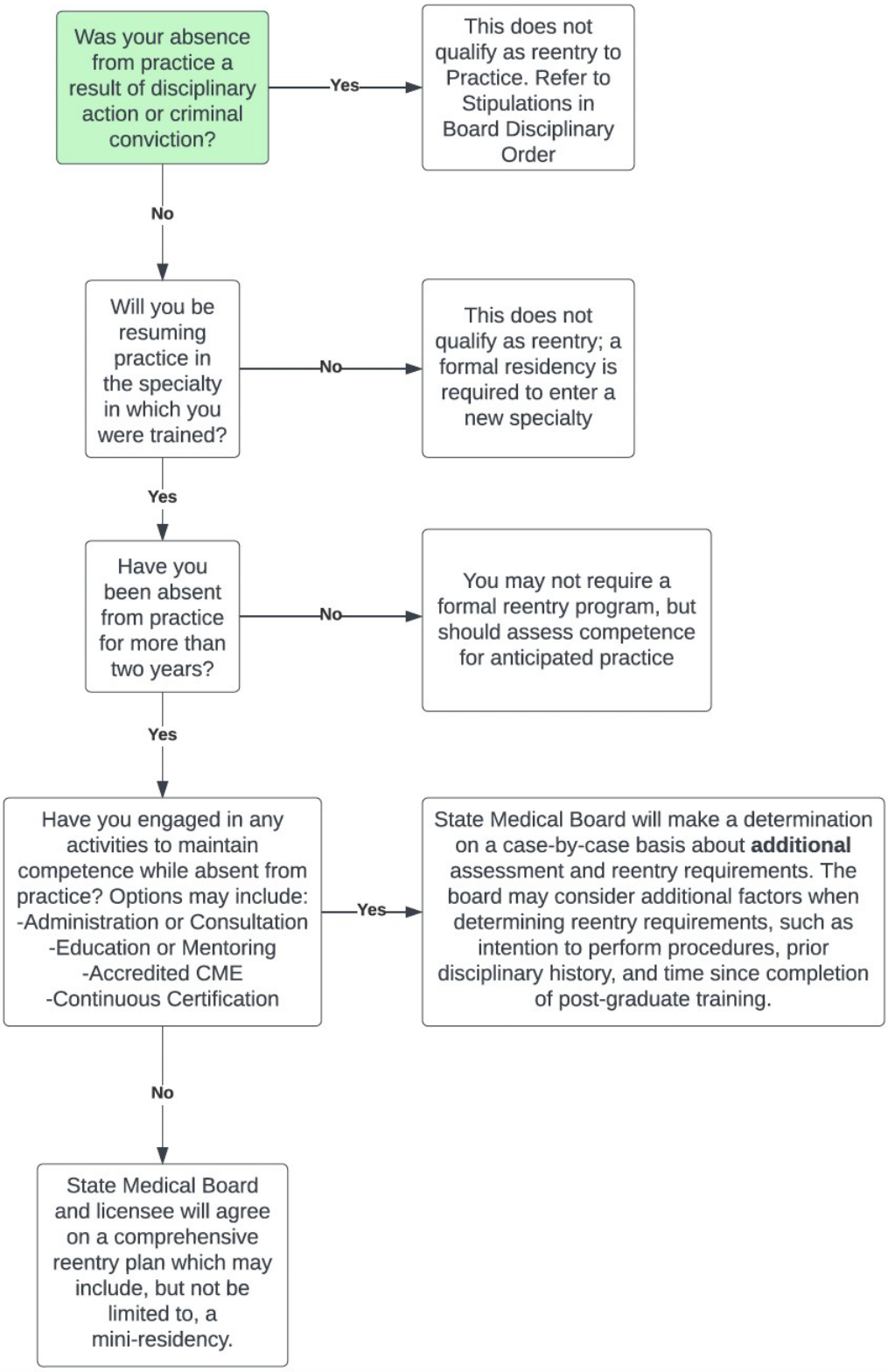
***Recommendation 9: Consistency of reentry across jurisdictions***

State medical boards should be consistent in the creation and execution of reentry programs. In recognition of the differences in resources, statutes, and operations across states, and acknowledging that implementation of physician reentry should be within the discretion and purview of each board, these guidelines are designed to be flexible to meet local considerations. However, physicians may reasonably be concerned about an overly burdensome reentry process where they might have to meet varying criteria to obtain licensure in different states. For purposes of license portability, FSMB will continue to track the implementation of these guidelines to facilitate transparency for licensees and encourage consistency among boards.

**Conclusion**

Since the FSMB's *Reentry to Practice (2012),* there has been widespread recognition that physicians may take a temporary absence from clinical practice for a variety of reasons, and physician reentry can be a normal part of a physician's continuing practice of medicine. State medical boards should create standardized processes for reentry to practice that allow flexibility for the board and for the licensee/applicant, while also ensuring patient safety. In creating reentry programs, state medical boards should rely on, and collaborate with, the broader medical system for education, training, and supervision and mentorship.

## Appendix A. FSMB Roadmap for Those Considering Temporarily Leaving Practice



Appendix B. Additional policy resources related to physician health, illness and impairment, and physician reentry to practice

1. AMA: Resources for physicians returning to clinical practice, definition of physician impairment, Resources for Physician Health
2. AOA: Resources for Physician Wellness
3. CMSS/Specialty Society: CMSS Position on Physician Reentry (11/11)
4. FSPHP: Public Policy Statement : Physician Illness vs. Impairment
5. ACOG: Re-entering the Practice of Obstetrics and Gynecology

**FSMB WORKGROUP ON REENTRY TO PRACTICE**[6]

**Members**

George M. Abraham, MD, MPH, Chair
FSMB Board of Directors
Former Chair, Massachusetts Board of Registration in Medicine

John S. Antalis, MD
Former Chair, Georgia Composite Medical Board

Nathaniel B. Berg, MD
Chair, Guam Board of Medical Examiners

Lawrence J. Epstein, MD
Chair, New York State Board for Medicine

Rebecca Fishman, DO
Vice President and Fellow, American Osteopathic College of Physical Medicine and Rehabilitation
Fellow, American Academy of Physical Medicine and Rehabilitation

Allen Friedland, MD, FAAP, MACP
American Academy of Pediatrics

Maroulla S. Gleaton, MD
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Shawn P. Parker, JD, MPA
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Anuradha Rao-Patel, MD
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Naveed Razzaque, MD
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Sanjay Desai, MD
Chief Academic Officer and Group Vice President of Education, American Medical Association

Geraldine T. O'Shea, DO
Trustee, American Osteopathic Association

[6] State Medical Board or organizational affiliations are presented for purposes of identification and do not imply endorsement of any draft or final version of this report

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John P. Bremer
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Andrew Smith
Legislative Specialist, FSMB

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Vice President, Education, FSMB

**Agenda Item:** Guidelines for the Structure and Function of a State Medical Board

**Staff Comment:** Overall, this 48-page document touches on all aspects of a board of medicine. The Virginia Board of Medicine generally comports with the many recommendations through its current processes. Staff has selected Section IV – State Medical Board Membership – for discussion, specifically Qualifications and Compensation/Reimbursement. Pages 1-5 & 15-17 are included for your review.

**Action:** Discuss and develop comments for FSMB and/or DHP and the Executive Branch.

# Guidelines for the Structure and Function of a State Medical and Osteopathic Board

*Draft – January 2024*

## INTRODUCTION

As early as 1914, the Federation of State Medical Boards (FSMB), which now represents 70 state and territorial medical and osteopathic licensing and disciplinary boards (hereafter referred to as "state medical board(s)" or "board(s)"), recognized the need for a guidance document supporting U.S. states and territories in their development, and updating as needed, of their medical practice acts, and the corresponding structures and functions of their medical boards.

Following extensive consultation with members and staff of state medical boards, and a review of emerging best practices, the FSMB first issued *A Guide to the Essentials of a Modern Medical Practice Act* in 1956. The stated purposes of this guidance document were:

1. To serve as a guide to those states that may adopt new medical practice acts or may amend existing laws; and
2. To encourage the development and use of consistent standards, language, definitions, and tools by boards responsible for physician and physician assistant regulation.

Over the years, dynamic changes in medical education, in the practice of medicine, and in the diverse responsibilities that face medical boards have necessitated frequent revision of a state or territory's medical practice act. *The Essentials* underwent numerous revisions to respond to these changes and assist member boards to be consistent with best practices in the interests of public protection and patient safety.

The guidance document adopted in 2018, *Guidelines for the Structure and Function of a State Medical and Osteopathic Board ("Structure and Function"),* incorporated the contents of prior *Elements* and *Essentials* documents, containing the principles of state medical board responsibility, duty, empowerment, and accountability that the initial documents outlined, as well as detailing the essential components for the structure and function of a state medical board.

*Structure and Function* was reviewed and updated in 2021 and now again in 2024 to reflect relevant characteristics of effective medical boards, incorporating recently adopted FSMB policies, and best practices and innovative concepts. This guidance document is worthy of consideration for adaptation to the requirements of any state or territorial jurisdiction. Although it could hardly be expected that any one jurisdiction would accept every component of these guidelines, it should lead every jurisdiction to assess its present board structure and function. Does the status quo provide maximum potential for protection of the public interest? Though presented for consideration as an integrated whole, the guidelines offer approaches to a variety of issues that concern many boards, including funding and budgeting, confidentiality, board authority, personnel and staffing, administration, emergency powers, training of

board members, immunity and indemnity, standards of evidence, and the transparency.

Recognizing the differences among jurisdictions, this document is designed with the flexibility to accommodate as many of those differences as possible, while maintaining the integrity of the overall concept. Some sections empower boards to adopt alternatives of their choice, provided they are in accordance with other state statutes, while other sections are phrased loosely to allow boards necessary discretionary authority. These guidelines may thus be seen not as one proposal but as various proposals. Each is applicable in one form or another to a diversity of settings, and all are aimed at increasing or refining the ability of state medical boards to better protect the health, safety, and welfare of the public.

The Federation urges member boards to consider including any recommendations contained herein in their respective medical practice acts, rules, or their own guidance documents.

The following guidelines apply equally to boards that govern physicians who have acquired the M.D. or D.O. degree, and the terms used herein should be interpreted throughout with this understanding.

## Table of Contents

44. Employ, direct, reimburse, evaluate, and dismiss when appropriate the Board's executive director, in accordance with the Board's state's procedures; Supervision of staff is the purview of the executive director.
45. Develop, recommend, and adopt rules, standards, policies, and guidelines related to qualifications of physicians and medical practice;
46. Direct the preparation and circulation of educational material, policies, and guidelines the Board determines are helpful and proper for licensees;
47. Develop educational programs to facilitate licensee awareness of provisions contained in the medical practice act and to facilitate public awareness of the role and function of state medical boards;
48. Delegate to the executive director the Board's authority to discharge its duties as appropriate; and
49. Recommend to the Legislature those changes in, or amendments to, the medical practice act that the Board determines would benefit the health, safety, and welfare of the public.

## Section IV. State Medical Board Membership

State medical boards bear primary responsibility for licensing and regulating the medical profession for the protection of the public. Every board should include physician and public members. All board members should act to further the public interest, not their personal or professional interests.

### Composition and Size

The Board should consist of enough members to appropriately discharge its duties, and at least 25% should be public members. The Board should consider several factors when determining the appropriate size and composition, including the size of a state's physician population, the composition and functions of board committees, adequate separation of prosecutorial and judicial powers, and the other work of the board described throughout this document. The Board should be of sufficient size to allow for recusals due to conflicts of interest and occasional member absences to avoid concentrating final decisions in the hands of too few members or loss of a quorum.

### Qualifications

Board membership should be drawn from different regions of the state and diverse specialties, and should reflect the demographics of the state.

Sex, race, national or ethnic origin, creed, religion, disability, gender identity, sexual orientation, marital status, or age above majority should not preclude an individual from serving on the board.

All physician board members should reside in the state and be in active practice[5] at least 20 hours per

[5] FSMB's *Report of the Special Committee on Reentry to Practice (2012)* defines the clinically active physician as one who,

week, hold a full and unrestricted medical license in the jurisdiction, be persons of recognized professional ability and integrity, and resided or practiced in the jurisdiction long enough to be familiar with the laws, policies, and practice in the jurisdiction (e.g., five years). In addition, physician members should not be currently under investigation or have had any public disciplinary action by any licensing board during the past ten years before applying for appointment, no history of felony convictions of any kind, and no misdemeanor convictions related to the practice of medicine.

Public members should reside in the state and be persons of recognized ability and integrity; not be licensed physicians, providers of health care, or retired physicians or health care providers; have no past or current substantial personal or financial interests in the practice of medicine or with any organization regulated by the Board (except as a patient or caregiver of a patient); and have no immediate familial relationships with any licensees or any organization regulated by the Board, unless otherwise required by law. Public members should represent a wide range of careers.

Board members should not be registered as a lobbyist representing any health care interest or association nor be an officer, board member, or employee of a state or national organization established for advocating the interests of individuals involved in the practice of medicine or any organization regulated by the Board.

**Terms**

Appointed board members should serve staggered terms to ensure continuity. Term lengths should be set to permit development of effective skills and experience by members (e.g., three or four years). However, a limit should be set on consecutive terms of service (e.g., two or three consecutive terms).

A board member may be reappointed two years after completion of such service. A person who serves more than half of an un-expired term should be considered to have served a full term.

**Requirements**

Before assuming the duties of office, the following should be required of each board member:

1. Take a constitutional oath or affirmation of office;
2. Swear or affirm that the member is qualified to serve under all applicable statutes;
3. Sign a statement agreeing to disclose any potential conflicts of interest that may arise for that member in the conduct of board business;
4. Sign a confidentiality and ethics statement agreeing to maintain the confidentiality of confidential board business and patient identification and uphold high ethical standards in discharging board duties.

The Board should also conduct, and new members should attend, an annual training program designed to familiarize new members with their duties and the ethics of public service.

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at the time of license renewal, is engaged in direct, consultative, or supervisory patient care, or as further defined by the states.

**Appointment**

Board members should be appointed by the Governor or Legislature, and the appointment should be made at least 30 calendar days prior to the beginning of the board term. The appointing authority should fill an unexpired term within 30 calendar days of the vacancy's occurrence. The incumbent should serve until the appointing authority names a replacement. Any individual, organization or group should be permitted to recommend potential board appointees.

**Removal**

The appointing authority should remove board members from the Board if they:

1. Cease to be qualified;
2. Submit a written resignation to the appointing authority;
3. Are absent from the state for a period of more than six months;
4. Are found guilty of a felony or an unlawful act involving moral turpitude by a court of competent jurisdiction;
5. Are found guilty of malfeasance, misfeasance, or nonfeasance in relation to their Board duties by a court of competent jurisdiction;
6. Are found to be mentally incompetent by a court of competent jurisdiction;
7. Fail to attend three successive board meetings without just cause as determined by the board, or if a new member fails to attend the new members' training program without just cause as determined by the board;
8. Are found to be in violation of the medical practice act; or
9. Are found to be in violation of the conflict of interest/ethics law.

The Board should have the authority to recommend a member's removal to the appointing authority.

**Compensation/Reimbursement**

Board members should receive appropriate compensation for services and reimbursement for expenses.

- Compensation: Service on the Board should not present an undue economic hardship. Board members should therefore receive compensation in an amount sufficient to allow full participation and not preclude qualified individuals from serving.
- Expenses: Each board member's reasonable travel expenses necessarily and properly incurred for active board service should be reimbursed.
- Education/Training: Travel expenses, and daily compensation should also be paid for each board member's attendance, in or out of the board's jurisdiction, at education or training programs approved by the board and directly related to board duties.

**Section V. State Medical Board Structure**

**Officers**

**Agenda Item:** Reciprocal Licensing of Physician Assistants with Maryland and the District of Columbia

**Staff Note:** Since March of 2023, the medical boards of Virginia, Maryland and the District of Columbia have been reciprocally licensing physicians amongst the 3 jurisdictions. Maryland has proposed that the same agreement be reached for physician assistants. The Maryland Board initiated this with the District of Columbia, and the DC Board has approved the concept. Today, it is being presented for approval to at least begin negotiations with DC and Maryland. On the following pages you will find an email string started by Christine Farrelly, Executive Director for the Maryland Board along with a table of minimum requirements for license for the 3 jurisdictions.

**Action:** To discuss and approve or reject the concept.

**From:** Harp, William L. (DHP) <William.Harp@DHP.VIRGINIA.GOV>
**Sent:** Friday, February 2, 2024 12:44 PM
**To:** Chithenga, Sithembile (DOH) <sithembile.chithenga@dc.gov>; Christine Farrelly -MDH- <christine.farrelly@maryland.gov>
**Cc:** Sobowale, Michael (DHP) <Michael.Sobowale@dhp.virginia.gov>; Nixon, Aisha (DOH) <aisha.nixon@dc.gov>; Fenzel, Suzanne (DOH) <suzanne.fenzel3@dc.gov>
**Subject:** Re: PA Reciprocity

Thanks, Thembi. The Virginia Board of Medicine meets on February 15th. This issue will be on the agenda. WLH

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**From:** Chithenga, Sithembile (DOH) <sithembile.chithenga@dc.gov>
**Sent:** Friday, February 2, 2024 12:28 PM
**To:** Christine Farrelly -MDH- <christine.farrelly@maryland.gov>; Harp, William L. (DHP) <William.Harp@dhp.virginia.gov>
**Cc:** Sobowale, Michael (DHP) <Michael.Sobowale@dhp.virginia.gov>; Nixon, Aisha (DOH) <aisha.nixon@dc.gov>; Fenzel, Suzanne (DOH) <suzanne.fenzel3@dc.gov>
**Subject:** Re: PA Reciprocity

Good morning,

Hope all is well. Some good news. At our January meeting, the board voted that our licensing requirements are substantially equivalent, effectively paving the way for the Memorandum of Agreement (MOA). We will keep you updated on the progress of the MOA and the feedback we receive.

Kind regards,

**Sithembile "Thembi" Chithenga, MD, MPH.** (She/Her/Hers)
Executive Director, DC Board of Medicine & DC Board of Chiropractic
Health Regulation and Licensing Administration
Cell: 202 235 3136
Direct: 202 724 8755
Email: chithenga.sithembile1@dc.gov
899 North Capitol Street NE, 2nd Floor, Washington, DC 20002
dchealth.dc.gov

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

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**From:** Chithenga, Sithembile (DOH) <sithembile.chithenga@dc.gov>
**Sent:** Tuesday, November 28, 2023 11:35 AM
**To:** Christine Farrelly -MDH- <christine.farrelly@maryland.gov>; Harp, William L. (DHP)

<William.Harp@dhp.virginia.gov>; Nixon, Aisha (DOH) <aisha.nixon@dc.gov>; Fenzel, Suzanne (DOH) <suzanne.fenzel3@dc.gov>
**Cc:** Sobowale, Michael (DHP) <Michael.Sobowale@dhp.virginia.gov>
**Subject:** Re: PA Reciprocity

Good morning all,

Hope all is well. Planning on discussing with our Board at a meeting in mid December. Will keep you updated.

Kind regards,

**Sithembile "Thembi" Chithenga, MD, MPH.** (She/Her/Hers)
Executive Director, DC Board of Medicine & DC Board of Chiropractic
Health Regulation and Licensing Administration
Cell: 202 235 3136
Direct: 202 724 8755
Email: chithenga.sithembile1@dc.gov
899 North Capitol Street NE, 2nd Floor, Washington, DC 20002
dchealth.dc.gov


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**From:** Christine Farrelly -MDH- <christine.farrelly@maryland.gov>
**Sent:** Tuesday, November 28, 2023 10:05 AM
**To:** Harp, William L. (DHP) <William.Harp@dhp.virginia.gov>; Nixon, Aisha (DOH) <aisha.nixon@dc.gov>; Chithenga, Sithembile (DOH) <sithembile.chithenga@dc.gov>
**Cc:** Sobowale, Michael (DHP) <Michael.Sobowale@dhp.virginia.gov>
**Subject:** Re: PA Reciprocity



Hi Dr. Harp,
No problem. I'm also copying DC, so they can include VA when they discuss it with their Board.

Thanks,
-C

On Mon, Nov 27, 2023 at 1:18 PM Harp, William L. (DHP) <William.Harp@dhp.virginia.gov> wrote:
Hi Christine:

Astraw poll of staff and Board members says we should strongly consider reciprocity for PA's with Maryland and DC.

So if you could include Virginia in the motion as a potential partner in this, it would be much appreciated.

The first time the Virginia Board would be able to vote on this will be FEB 2024.

Thanks for your consideration. Bill

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**From:** Christine Farrelly -MDH- <christine.farrelly@maryland.gov>
**Sent:** Wednesday, November 22, 2023 2:06 PM
**To:** Harp, William L. (DHP) <William.Harp@dhp.virginia.gov>
**Subject:** PA Reciprocity

Hi Dr. Harp,
I hope all is well with you.

DC and I met, and we are going to proceed with establishing PA reciprocity. I'm bringing this to my Board in December and have outlined the requirements for all three jurisdictions (see attached).

I just want to verify that VA is not interested. If you have any interest, I will request that my Board approve it for VA, as well as DC.

Please let me know.

Have a Happy Thanksgiving.

-C

--
Christine A. Farrelly
Executive Director
Maryland Board of Physicians

***The Board of Physicians is committed to customer service. Please click here to take our Customer Satisfaction Survey.***

--
Christine A. Farrelly
Executive Director
Maryland Board of Physicians

***The Board of Physicians is committed to customer service. Please click here to take our Customer Satisfaction Survey.***

DRAFT – Minimum Requirements for Initial Licensure with Maryland and District of Columbia

| **Minimum Requirements for Initial Licensure - (Physician Assistants)** | **Maryland** | **Virginia** | **DC** |
|---|---|---|---|
| 18 + years old | X | X | X |
| Good moral character (from character & fitness questions) - Includes malpractice | X | X | X |
| Graduate of a PA Training Program accredited by CAAHEP or the Accreditation Review Commission on Education for the Physician Assistant, OR, | X | X | X |
| *Alternative: Passed the NCCPA exam prior to 1986 and practiced continuously* | X | | |
| After 10/01/2003, must have 1 of the following:<br>1. A bachelor's degree<br>2. At least 120 credits at the college level | X | | |
| English language competency (oral) | X | Not required | Not required |
| English language competency (written) | X | Not required | Not required |
| Passed the national certifying exam given by the NCCPA (PANCE) | X | X | X |
| Current NCCPA Certification | X | X | X |
| CHRC | X | Not required | X |
| NPDB Self-report | Not required | X | X |
| Character References – 3 | Not required | Not required | X |
| Verification of licensure in other States | X | X | X |

**Agenda Item:** **Licensing Report**

**Staff Note:** Mr. Sobowale will provide information on note-worthy licensing matters.

**Action:** None anticipated.

**Agenda Item:** **Discipline Report**

**Staff Note:** Ms. Deschenes will provide information on discipline matters.

**Action:** Consent orders may be presented for consideration.

**Agenda Item:** **Appointment of a Nominating Committee**

**Staff Note:** The current officer terms will expire at the time of the June 2024 Board meeting. A new slate of officers will be presented by the Nominating Committee at the June Board meeting for approval.

**Action:** Appointment of the Nominating Committee.

Next Meeting Date of the Full Board is

June 13-15, 2024

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

**March 16, 2024**