Virginia Department of Health Professions

Agenda

Virginia Board of Veterinary Medicine
Full Board Meeting

April 20, 2017
Board Room 2
9:00 a.m.

Call to Order – Ellen G. Hillyer, MPH, DVM, Board President

- Welcome
- Emergency Egress Procedures

Ordering of Agenda – Dr. Hillyer

Public Comment – Dr. Hillyer

The Board will receive all public comment related to agenda items at this time. The Board will not receive comment on any regulatory process for which a public comment period has closed or any pending or closed complaint or disciplinary matter.

Approval of Minutes **Pages 1-16**

- January 18, 2017, Regulatory Advisory Panel – Faculty Licensure
- January 18, 2017, Regulatory Advisory Panel – Opioid Prescribing
- February 9, 2017, Public Hearing
- February 9, 2017, Full Board Meeting
- February 9, 2017, Resolution of Case No. 159438

Agency Director's Report - David Brown, DC

Legislative/Regulatory Report – Elaine Yeatts **Pages 17-106**

- Regulatory Update
- Emergency Regulations for Prescribing Opioids and Buprenorphine
  - Review emergency regulation process
  - Review draft regulations
  - Take Action regarding adoption of emergency regulations
- Regulations for Periodic Review
  - Review Public Comment
  - Respond to Public Comment
  - Take action regarding adoption of final regulations

Discussion Items **Pages 107-121**

- Healthcare Workforce Data Center Survey Questions – **Elizabeth Carter, PhD**
- Expert Admissibility Standards – **Charis Mitchell**
- Drug Loss Investigation Protocol – **Leslie Knachel/Amanda Blount**

President's Report – Dr. Hillyer

Board of Health Professions' Report – Mark A. Johnson, DVM

Staff Reports **Pages 122-124**

- Executive Director's Report – **Leslie Knachel**
- Discipline Report – **Amanda Blount**
- Continuing Education Audit – **Carol Stamey**

New Business – Dr. Hillyer

Next Meeting – June 13, 2017

Meeting Adjournment – Dr. Hillyer

This information is in **DRAFT** form and is subject to change.

BOARD OF VETERINARY MEDICINE
REGULATORY ADVISORY PANEL – FACULTY LICENSURE
MEETING MINUTES
JANUARY 18, 2017

TIME AND PLACE:	The Regulatory Advisory Panel (Panel) meeting was called to order at 10:02 a.m. on Wednesday, January 18, 2017, at the Department of Health Professions (DHP), Perimeter Center, 9960 Mayland Drive, 2nd Floor, Training Room 1, Henrico, Virginia.
PRESIDING OFFICER:	Mary Yancey Spencer, J.D., Board Member
MEMBERS PRESENT:	Terry Swecker, DVM, Ph.D., Diplomat, ACVN, Director of the Veterinary Teaching Hospital VA-MD College of Veterinary Medicine Peggy Rucker, DVM, President Virginia Medical Association of Virginia Kelly Gottschalk, DVM, Previous Board Member and Preceptor Participant
MEMBERS NOT PRESENT:	All members were present.
QUORUM:	With all members of the Panel present, a quorum was established.
STAFF PRESENT:	Leslie L. Knachel, Executive Director Elaine Yeatts - Senior Policy Analyst Carol Stamey, Operations Manager Brandy Latvala, Administrative Assistant
OTHERS PRESENT:	Robin Schmitz, VVMA
ORDERING OF AGENDA:	No changes were made to the agenda.
PUBLIC COMMENT:	No public comment was presented.
CHARGE TO THE PANEL:	Ms. Spencer provided the following charge to the panel: *Pursuant to Chapter 306 of the Virginia Acts of the Assembly (HB1058, 2016 Session), the Board of Veterinary Medicine is to establish requirements for the licensure of persons engaged in the practice of veterinary medicine pursuant to § 54.1-3800, as part of a veterinary medical education program accredited by the American Veterinary Medical Association Council on Education and located in the Commonwealth. The Board appointed a Regulatory Advisory Panel to develop recommended regulations for the Board's consideration at its meeting on February 8, 2017.*

DISCUSSION:

Review of Legislation
Ms. Yeatts provided an overview of the legislation that revised § 54.1-3801 and § 54.1-3804 of the *Code of Virginia*. She reviewed faculty/intern/resident licensure requirements for the Boards of Dentistry and Medicine which could be used as to help in developing regulations for the Board of Veterinary Medicine.

The Panel discussed requirements related to licensure of faculty/interns/residents at the Virginia-Maryland College of Veterinary Medicine which is the only veterinary school in Virginia. Following the discussion the Panel requested that Ms. Yeatts prepare a draft (Attachment 1) that reflected the discussion for presentation to the full board at its next scheduled meeting.

NEW BUSINESS:

No new business was presented.

ADJOURNMENT:

The meeting adjourned at 12:17 p.m.

Mary Yancey Spencer, J.D.
Chair

Date

Leslie L. Knachel, M.P.H
Executive Director

Date

ATTACHMENT 1
DRAFT
Regulations for Faculty and Intern/Resident Licenses

18VAC150-20-100. Fees.

The following fees shall be in effect:

Veterinary application for licensure	$200
Veterinary application for faculty license	$100
Veterinary license renewal (active)	$175
Veterinary license renewal (inactive)	$85
Veterinary faculty license renewal	$75
Veterinary reinstatement of expired license	$255
Veterinary license late renewal	$60
Veterinary faculty license late renewal	$25
Veterinarian reinstatement after disciplinary action	$450
Veterinary intern/resident license – initial or renewal	$25
Veterinary technician application for licensure	$65
Veterinary technician license renewal	$50
Veterinary technician license renewal (inactive)	$25
Veterinary technician license late renewal	$20
Veterinary technician reinstatement of expired license	$95
Veterinary technician reinstatement after disciplinary action	$125
Equine dental technician initial registration	$100
Equine dental technician registration renewal	$70
Equine dental technician late renewal	$25
Equine dental technician reinstatement	$120
Initial veterinary establishment registration	$300
Veterinary establishment renewal	$200
Veterinary establishment late renewal	$75
Veterinary establishment reinstatement	$75

Veterinary establishment reinspection	$300
Veterinary establishment -- change of location	$300
Veterinary establishment -- change of veterinarian-in-charge	$40
Duplicate license	$15
Duplicate wall certificate	$25
Returned check	$35
Licensure verification to another jurisdiction	$25

18VAC150-20-122. Requirements for faculty licensure.

A. Upon payment of the fee prescribed in 18VAC15-20-100 and provided that no grounds exist to deny licensure pursuant to § 54.1-3807 of the Code of Virginia, the Board may grant a faculty license to engage in the practice of veterinary medicine as part of a veterinary medical education program accredited by the American Veterinary Medical Association Council on Education to an applicant who:

1. Is qualified for full licensure pursuant to 18VAC150-20-110 or 18VAC150-20-120;

2. Is a graduate of an accredited veterinary program and has an unrestricted, current license, or if lapsed is eligible for reinstatement, in another U. S. jurisdiction; or

3. Is a graduate of a veterinary program and has advanced training recognized by the American Board of Veterinary Specialties or a specialty training program acceptable to the veterinary medical education program in which he serves on the faculty.

B. The dean of a veterinary medical education program shall verify to the board that the applicant meets one of the qualifications of subsection A of this section and has the clinical competency that qualifies the applicant for a faculty license.

C. The holder of a faculty license shall be entitled to perform all functions that a person licensed to practice veterinary medicine would be entitled to perform as part of his faculty duties, including patient care functions associated with teaching, research, and the delivery of patient care that takes place only within the veterinary establishment or clinics operated by or affiliated with the veterinary program. A faculty license shall not authorize the holder to practice veterinary medicine in nonaffiliated veterinary establishments or in private practice settings.

D. A faculty license shall expire on December 31 of the second year after its issuance and may be renewed annually without a requirement for continuing education, as specified in 18VAC150-20-70, as long as the accredited program certifies to the licensee's continued employment. When such a license holder ceases serving on the faculty, the license shall be null and void upon termination of employment. The dean of the veterinary medical education program shall notify the board within 30 days of such termination of employment.

18VAC150-20-123. Requirements for an intern/resident license.

A. Upon payment of the fee prescribed in 18VAC150-20-100 and provided that no grounds exist to deny licensure pursuant to § 54.1-3807 of the Code of Virginia, the board may issue a temporary license to practice veterinary medicine to an intern or resident. Upon recommendation of the dean or director of graduate education of the veterinary medical education program, such a license may be issued to an applicant who is a graduate of an AVMA-accredited program or who meets requirements of the Educational Commission of Foreign Veterinary Graduates (ECFVG) or the Program for the Assessment of Veterinary Education Equivalence (PAVE) of the AAVSB, as verified by veterinary medical education program. The application shall include the beginning and ending dates of the internship or residency.

B. The intern or resident shall be supervised by a fully licensed veterinarian or a veterinarian who holds a faculty license issued by the board. The intern or resident shall only practice within the veterinary establishment or clinics operated by or affiliated with the veterinary program. A temporary license shall not authorize the holder to practice veterinary medicine in nonaffiliated veterinary establishments or in private practice settings

C. An intern or resident license shall expire on August 1 of the second year after its issuance and may be renewed upon recommendation by the dean of the veterinary medical education program.

BOARD OF VETERINARY MEDICINE
REGULATORY ADVISORY PANEL – OPIOID PRESCRIBING
MEETING MINUTES
JANUARY 18, 2017

TIME AND PLACE: The Regulatory Advisory Panel (Panel) meeting was called to order at 1:04 p.m. on Wednesday, January 18, 2017, at the Department of Health Professions (DHP), Perimeter Center, 9960 Mayland Drive, 2nd Floor, Training Room 1, Henrico, Virginia.

PRESIDING OFFICER: Ellen Hillyer, DVM, Board President

MEMBERS PRESENT:
Bayard Rucker, III, DVM, Board Member
Peggy Rucker, DVM, President Virginia Medical Association of Virginia (VVMA)
Lisa Carter, DVM, VVMA
Noah Pavlisko, DVM, DACVAA, Assistant Professor, Anesthesiology VA-MD College of Veterinary Medicine

MEMBERS NOT PRESENT: All members were present.

QUORUM: With all members of the Panel present, a quorum was established.

STAFF PRESENT:
David E. Brown, D.C., Director
Leslie L. Knachel, Executive Director
Elaine Yeatts - Senior Policy Analyst
Carol Stamey, Operations Manager

OTHERS PRESENT: No others were present.

ORDERING OF AGENDA: No changes were made to the agenda.

PUBLIC COMMENT: No public comment was presented.

DIRECTOR'S COMMENT: Dr. Brown presented comment regarding the opioid crisis in Virginia. He requested that the Panel develop regulations that address conditions for the prescribing of opioids, required documentation, security, and storage.

CHARGE TO THE PANEL: Dr. Hillyer provided the following charge to the panel:
The Commissioner of the Virginia Department of Health has declared a public health crisis related to opioid abuse. The Board of Veterinary Medicine appointed a Regulatory Advisory Panel to develop emergency regulations for veterinarians related to opioid prescribing for the Board's consideration at a future meeting.

DISCUSSION:

Review of Proposed Regulations Related to Drug Security and Storage

Ms. Yeatts reviewed the following with the Panel:

- Excerpt from the Proposed Regulations Related to Drug Security and Storage.

The consensus of the Panel was to include the changes

related to drug security and storage.

The Panel discussed drafting additional guidance information related to drug security and storage.

- Board of Medicine Draft Regulations for Pain Management.

  The Panel discussed and considered the following topics for inclusion in proposed emergency regulations to address acute and chronic pain management:
  - Definition of acute and chronic pain/conditions
  - Prescription limitations based on the classification of the drug to include buprenorphine
  - Re-examination requirement for refills
  - Treatment plan requirements
  - Client education about the usage, storage and disposal of scheduled drugs

The Panel requested that Ms. Yeatts draft the emergency regulations as discussed for presentation to the full board at its next meeting.

NEW BUSINESS: No new business was presented.

ADJOURNMENT: The meeting adjourned at 2:45 p.m.

Ellen G. Hillyer, D.V.M.
Chair

Date

Leslie L. Knachel, M.P.H
Executive Director

Date

BOARD OF VETERINARY MEDICINE
PUBLIC HEARING ON PROPOSED REGULATIONS
DEPARTMENT OF HEALTH PROFESSIONS
FEBRUARY 9, 2017

TIME AND PLACE: The Public Hearing was called to order at 9:00 a.m. The purpose of the hearing was to receive public comment on the proposed amendments to regulations which resulted from a periodic review of the regulations.

PRESIDING OFFICER: Ellen G. Hillyer, DVM, Board President

MEMBERS PRESENT:
Tregel M. Cockburn, DVM
Autumn N. Halsey, LVT
Mark A. Johnson, DVM
Steve Karras, DVM
Bayard A. Rucker, III, DVM
Mary Yancey Spencer, J.D., Citizen Member

QUORUM: With all members present, a quorum was established.

STAFF PRESENT:
Leslie Knachel, Executive Director
Amanda E. M. Blount, Deputy Executive Director
Charis Mitchell, Assistant Attorney General, Board Counsel
Carol Stamey, Operations Manager
Brandy Latvala, Administrative Assistant

OTHERS PRESENT:
Rena Allen, DVM, Alexandria, Virginia
Khalfani Carr, Student, Veterinary Assistant, Alexandria, Virginia
Melanie Crovo, DVM, Roanoke, Virginia
Heather Jenkins, DVM, Southwest Virginia
Taryn Singleton, LVT, Virginia Association of Licensed Veterinary Technicians (VALVT)
Amanda Blankenship, LVT, Alexandria, Virginia
Susan Seward, Virginia Veterinary Medical Association (VVMA)
Toni Pullen, LVT, Alexandria Animal Hospital
Staesha Walker, LVT, VCA, Alexandria, Virginia
Lee Hinkel

PUBLIC COMMENT:

Dr. Allen presented comment regarding *18VAC150-20-172. Delegation of Duties*. She requested that the board consider not removing the language "include but are not limited to the following" in 18VAC150-20-172.C. Dr. Allen noted that she had submitted online written comment.

Mr. Carr provided comment regarding *18VAC150-20-172.Delegation of Duties*. He stated that he supports the inclusion of monitoring anesthesia as a duty for veterinary assistants. He stated that if the task for anesthesia monitoring was taken away from veterinary assistants, it could inhibit the potential of other unlicensed veterinary assistants.

Dr. Crovo, provided comment regarding *18VAC150-20-172. Delegation of Duties*. She stated that she has a small practice and the language regarding sedation and monitoring of anesthesia needed clarification. She interprets the proposed language to mean an assistant cannot monitor an anesthetized

patient just a sedated one as long as a veterinarian is present.

Dr. Jenkins provided comment regarding *18VAC150-20-172. Delegation of Duties.* She stated that there were severe animal welfare issues in Southwest Virginia to include shortage of LVTs. Due to the shortage of LVTs, it would damage her clinic if veterinary assistants could not monitor anesthesia.

Ms. Singleton provided comment regarding *18VAC150-20-172. Delegation of Duties.* She stated that the VALVT was in support of the requirement for a licensed veterinarian to be in the building when a patient was sedated or under anesthesia. She further stated the proposed regulation supported public safety. Ms. Singleton stated that it was the public's perception that a licensed veterinarian is in the building when any procedures are performed.

Ms. Blankenship provided comment regarding *18VAC150-20-172. Delegation of Duties.* She stated that she is a supervisor for 12 locations and supports assistants performing anesthesia monitoring. She further stated that there is a shortage of LVTs and there is a need for veterinary assistants.

Ms. Seward provided comment regarding *18VAC150-20-172. Delegation of Duties.* She stated that the VVMA supports veterinary assistants to monitor a sedated patient provided that a veterinarian is on the premises. She further provided that the VVMA had received comments from its membership regarding the following:

- Delete prohibition against delegating intravenous catheters to an unlicensed assistant in 18VAC150-20-172(B);
- Do not delete "include but not limited to" from 18VAC150-20-172(C); and
- Delete "clipping and scrubbing in preparation for surgery" and add "assisting in surgery" to broaden usage of assistants in 18VAC150-20-172(C).

Ms. Pullen provided comment regarding *18VAC150-20-172. Delegation of Duties.* She stated that the shortage of LVTs continues to rise and supports veterinary assistants performing the tasks of IV catheter placement, anesthesia monitoring and broadening the duties for properly trained assistants.

Ms. Walker provided comment regarding *18VAC150-20-172. Delegation of Duties.* She is very appreciative of the correction made to 18VAC150-20-172(C). She stated that if duties of unlicensed assistants are limited, then patient care will be compromised. She indicated that she has to have the help of assistants.

Dr. Allen requested to speak again to add her support for removing the prohibition against delegating intravenous catheters to an unlicensed assistant in 18VAC150-20-172(B).

ADJOURNMENT: With no further comment received, the hearing adjourned at 9:20 a.m.

Ellen G. Hillyer, DVM
President

Date

Leslie L. Knachel, M.P.H
Executive Director

Date

VIRGINIA BOARD OF VETERINARY MEDICINE
MINUTES OF FULL BOARD
DEPARTMENT OF HEALTH PROFESSIONS
TRAINING ROOM 2
HENRICO, VA
FEBRUARY 9, 2017

TIME AND PLACE: The Board of Veterinary Medicine (Board) was called to order at 9:33 a.m., at the Department of Health Professions (DHP), Perimeter Center, 9960 Mayland Drive, 2nd Floor, Training Room 2, Henrico, Virginia.

PRESIDING OFFICER: Ellen G. Hillyer, D.V.M., President

MEMBERS PRESENT:
Tregel M. Cockburn, D.V.M.
Autumn N. Halsey, L.V.T.
Mark A. Johnson, D.V.M.
Steven B. Karras, D.V.M.
Bayard A. Rucker, III, D.V.M.
Mary Yancey Spencer, J.D., Citizen Member

QUORUM: With seven members of the Board present, a quorum was established.

STAFF PRESENT:
Leslie L. Knachel, Executive Director
Amanda E. M. Blount, Deputy Executive Director
Elaine Yeatts, Senior Policy Analyst
Carol Stamey, Licensing Operations Manager
Charis Mitchell, Assistant Attorney General, Board Counsel

OTHERS PRESENT:
Lee Henkel
Kelly J. Gottschalk, D.V.M.

ORDERING OF AGENDA: No changes were made to the agenda.

PUBLIC COMMENT: Ms. Lee Henkel provided public comment regarding the *Veterinary Establishment Inspection Report*. She expressed concern that certain requirements related to students working in a veterinary establishment are not confirmed through the inspection process. Requirements of concern are the following:

1) Disclosure when a preceptee or extern is practicing in the veterinary establishment;
2) Informed consent for surgery from client if a veterinary student is to perform the surgery; and
3) Presence of the supervising veterinarian in the surgery room when a student is performing the surgery.

DIRECTOR'S REPORT: Dr. Brown was not available to provide a report.

APPROVAL OF MINUTES: Dr. Karras moved to approve the December 16, 2016, meeting minutes. The motion was seconded and carried.

LEGISLATIVE/REGULATORY UPDATE:

2017 Legislative Update
Ms. Knachel reported that there was no 2017 legislation that directly affected veterinary medicine.

Regulatory Update

- **Proposed Regulations in Public Comment Period until**

February 24, 2017
Ms. Knachel informed the Board that the public comment period for the proposed regulations closes on February 24, 2017.

- **Continuing Education (CE) Credit for Volunteer Service**
  Ms. Knachel informed the board that the regulations for CE credit for volunteer practice are under administrative review.

- **Regulatory Advisory Panel – Regulation for Faculty Licensure**
  Ms. Knachel provided a brief summary of the Regulatory Advisory Panel's (RAP) activities from its meeting on January 18, 2017. She reviewed a revised draft of the proposed regulations that replaced the draft in the agenda package for the board's consideration.

  After review and discussion, Ms. Spencer moved to adopt the proposed regulations as presented. The motion was seconded and carried.

- **Regulatory Advisory Panel – Emergency Regulations for Opioid Prescribing**
  Ms. Knachel provided a brief summary of the RAPs activities from its meeting held on January 18, 2017. She reviewed the draft regulations for the board's discussion and recommendations.

  The board reviewed, discussed and determined that minor changes were required for the proposed regulations. The board requested that staff amend the draft regulations to include the following recommendations:
  - 18VAC150-20-174(A)(3) – delete "short acting";
  - 18VAC150-20-174(B) – add "osteoarthritis" to list of chronic conditions;
  - 18VAC150-20-174(C) – add "…shall include a description of signs or presentation of the pain or condition…"
  - 18VAC150-20-174(D) – delete "The veterinarian shall also discuss the exit strategy for discontinuation of opioids in the event they are not effective."
  - 18VAC150-20-174(E) – clarify that the patient needs to be evaluated in the last 12 months for pain or condition and at least annually for the pain or condition.
  - 18VAC150-20-190 – delete this section for inclusion with the opioid prescribing because they are part of the proposed stage already in the promulgation process and include language that is not currently in use.

  The Board requested that a draft with the suggested changes be presented at the next meeting for consideration and adoption.

DISCUSSION ITEMS:

Guidance Document Update

- **76-21.2:1 Veterinary Establishment Inspection Report – addition of disclosure by signage found in 18VAC150-20-130**
  Ms. Knachel stated that the Board needs to consider adding to the Veterinary Establishment Inspection Report the requirement to notify owners that a preceptee/extern is practicing in the veterinary establishment.

Dr. Karras moved to add the proposed language to the Inspection Form as a minor violation and assign one point to a violation. The motion was seconded and carried.

- **150-23: Disposal of Deceased Animals**
  Ms. Knachel provided the Board with a revised draft that replaced the draft in the agenda package. Ms. Knachel reviewed the draft for the Boards consideration.

  Dr. Karras moved to adopt Guidance Document 150-23 as presented. The motion was seconded and carried.

Continuing Education Audit

- **2015 Results**
  Ms. Stamey informed the board that a total of 259 licensees had been audited (172 veterinarians, 85 veterinary technicians, 2 Equine Dental Technicians). She stated that the audit resulted in 18 disciplinary cases.

- **2016 Audit**
  Ms. Knachel reminded the board that due to regulatory changes to the veterinary technician continuing education (CE) requirements mid-year, the audit would be for 6 hours of CE rather than the current requirement of 8 hours as previously decided by the Board.

Attendance at American Association of Veterinary State Board's Annual Meeting

Ms. Knachel reminded the board members of travel reimbursement approval. She reported that the next annual association meeting is scheduled for September 13-15, 2017, in San Antonio, Texas. Ms. Knachel requested responses from board members interested in attending the meeting.

Meeting Schedule

Ms. Knachel reported that the Board will need to schedule an additional board meeting for March or April to review public comments for the proposed regulations and consider the draft emergency regulations for prescribing opioids. Staff will send out alternate board meeting dates for review by the board members.

PRESIDENT'S REPORT:

Dr. Hillyer stated that she did not have a report to present.

Ms. Halsey reported that she will be attending the VVMA meeting and will present a board report at their business meeting.

EXECUTIVE DIRECTOR'S REPORT:

Statistics

Ms. Knachel reported that the statistics data had been included in the agenda packet.

Budget

Ms. Knachel reported that the cash balance reflects the recent revenue from the renewal cycle that just ended.

Outreach

Ms. Knachel reported on the outreach activities disseminated by board staff.

Discipline Update
Ms. Blount provided an overview of the caseload statistics. Additionally, she informed the board that a report on the Board's 250-day case closure statistics will be provided at the next board meeting.

NEW BUSINESS: No new business was identified.

ADJOURNMENT: The meeting adjourned at 11:20 a.m.

Ellen G. Hillyer, D.V.M.
Chair

Date

Leslie L. Knachel, M.P.H
Executive Director

Date

UNAPPROVED DRAFT

VIRGINIA BOARD OF VETERINARY MEDICINE
CONSIDERATION OF POSSIBLE RESOLUTION OF CASE NO. 159438
DEPARTMENT OF HEALTH PROFESSIONS
TRAINING ROOM 2
HENRICO, VA
FEBRUARY 9, 2017
MINUTES

CALL TO ORDER: The meeting of the Virginia Board of Veterinary Medicine was called to order at 9:27 a.m., on February 9, 2017, at the Virginia Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, Training Room 2, 9960 Mayland Drive, Henrico, VA 23233.

PRESIDING: Autumn Halsey, L.V.T., Vice-President

MEMBERS PRESENT:
Tregel Cockburn, D.V.M.
Mark A. Johnson, D.V.M.
Mary Yancey Spencer, J.D.

MEMBERS EXCUSED:
Ellen G. Hillyer, M.P.H., D.V.M.
Steven B. Karras, D.V.M.
Bayard A. Rucker, III, D.V.M.

QUORUM: With four members of the Board participating, a quorum was established.

STAFF PRESENT:
Leslie L. Knachel, Executive Director
Amanda E. M. Blount, Deputy Executive Director
Carol Stamey, Licensing Operations Manager
Brandy Latvala, Administrative Assistant

BOARD COUNSEL: Charis A. Mitchell, Assistant Attorney General

CASE NO. 159438 The Board received information from Ms. Blount regarding a Consent Order for possible resolution of Case No. 159438 in lieu of a formal hearing.

CLOSED SESSION: Dr. Johnson moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia ("Code") for the purpose of deliberation to reach a decision in the matter of Case No. 159438. Additionally, he moved that Ms. Mitchell and Ms. Knachel attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENE: Dr. Johnson moved that the Board certify that it heard,

discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and carried unanimously.

The Board reconvened in open session pursuant to § 2.2-3712(D) of the Code.

DECISION:

Dr. Cockburn moved that the Board accept the Consent Order for Case No. 159438 in lieu of proceeding with a formal hearing. Following a second, a roll call vote was taken. The motion passed unanimously.

ADJOURNMENT:

The meeting was adjourned at 9:34 a.m.

Autumn Halsey, L.V.T., Vice-President

Leslie L. Knachel, M.P.H., Executive Director

Date

Date

Agenda Item: **Regulatory Actions - Chart of Regulatory Actions**
As of April 7, 2017

Board **Board of Veterinary Medicine**

Chapter		Action / Stage Information
[18 VAC 150 - 20]	Regulations Governing the Practice of Veterinary Medicine	Periodic review [Action 4428] Proposed - *Register Date: 12/26/16* Comment period closed: 2/24/17
[18 VAC 150 - 20]	Regulations Governing the Practice of Veterinary Medicine	Faculty and intern/resident license [Action 4616] Proposed - *DPB Review in progress*
[18 VAC 150 - 20]	Regulations Governing the Practice of Veterinary Medicine	CE credit for volunteer practice [Action 4749] Fast-Track - *Register Date: 3/20/17* *Effective: 5/5/17*

Agenda Item: **Adoption of Emergency Regulations Prescribing of Opioids**

Included in agenda package:

Copy of HB2163 with Governor's recommendation
Copy of Draft regulations

Board action:

In your agenda package is copy of the minutes of the Board meeting on February 9, 2017, at which the recommendations of the Regulatory Advisory Panel were discussed and minor changes were made. The Board requested that a draft with the suggested changes be presented at this meeting for consideration and adoption.

In addition to the changes discussed at the last meeting, this draft includes language for prescribing of buprenorphine – as necessary for compliance with HB2163 amended by the Governor.

VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend the Code of Virginia by adding a section numbered 54.1-3408.4, relating to prescription of buprenorphine without naloxone; limitation.

[H 2163]

Approved

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 54.1-3408.4 as follows:

§ 54.1-3408.4. Prescription of buprenorphine without naloxone; limitation.

Prescriptions for products containing buprenorphine without naloxone shall be issued only (i) for patients who are pregnant, (ii) when converting a patient from methadone to buprenorphine containing naloxone for a period not to exceed seven days, or (iii) as permitted by regulations of the Board of Medicine, the Board of Nursing, or the Board of Veterinary Medicine.

2. That the provisions of this act shall expire on July 1, 2022.

18VAC150-20-174. Prescribing of controlled substances for pain or chronic conditions.

A. Evaluation of the patient and need for prescribing a controlled substance for pain.

1. For the purposes of this section, a controlled substance shall be a Schedule II through V drug, as set forth in the Drug Control Act.

2. Non-pharmacologic and non-opioid treatment for pain shall be given consideration prior to treatment with opioids. Prior to initiating treatment with a controlled substance, defined, the prescriber shall perform a history and physical examination appropriate to the complaint and conduct an assessment of the patient's history as part of the initial evaluation.

3. If a controlled substance containing an opioid is necessary for treatment of acute pain, the veterinarian shall give a controlled substance in the lowest effective dose appropriate to the size and species of the animal for the least amount of time. The dose shall not exceed a seven-day supply as determined by the manufacturer's directions, unless extenuating circumstances are clearly documented in the patient's record.

4. The veterinarian may prescribe a controlled substance containing an opioid for an additional seven days, if medically necessary and consistent with an appropriate standard of care and after a re-evaluation of the patient as documented in the patient record.

B. In accordance with the accepted standard of care, a veterinarian may prescribe a controlled substance containing an opioid beyond 14 days for management of certain chronic conditions, such as chronic heart failure, chronic bronchitis, osteoarthritis, collapsing trachea or related

conditions. For treatment of chronic pain or a chronic condition with an opioid beyond 14 days, the treatment plan shall include measures to be used to determine progress in treatment, further diagnostic evaluations or modalities that might be necessary, and the extent to which the pain or condition is associated with physical impairment. For any prescribing of a controlled substance containing an opioid beyond 14 days, the patient shall be seen and re-evaluated at least every six months, and the justification for such prescribing documented in the patient record.

C. Prior to prescribing or dispensing a controlled substance containing an opioid, the veterinarian shall document a discussion with the owner about the known risks and benefits of opioid therapy, the responsibility for the security of the drug, and proper disposal of any unused drug.

D. For pain or a condition that goes beyond the normal course, non-opioid controlled substances may be prescribed for a period greater than 14 days, provided the patient has been seen and evaluated for the pain or condition within the past 12 months and at least annually thereafter. Continuation of treatment with controlled substances shall be supported by documentation of continued benefit from the prescribing. If the patient's progress is unsatisfactory, the veterinarian shall assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

E. Prescribing of buprenorphine for out-patient administration shall only occur in accordance with the following:

1. The dosage, quantity, and formulation shall be appropriate for the patient; and

2. The prescription shall not exceed a seven-day supply. Any prescribing beyond seven days shall be consistent with an appropriate standard of care and only after a re-evaluation of the patient as documented in the patient record.

F. The medical record for prescribing controlled substances shall include signs or presentation of the pain or condition, a presumptive diagnosis for the origin of the pain or condition, an examination appropriate to the complaint, a treatment plan and the medication prescribed to include the date, type, dosage, and quantity prescribed.

Agenda Item: Consideration of Public Comment on Proposed Regulations

Included in the agenda package:

Copy of summary of public comment
Copies of all public comment
Copy of proposed regulations

Staff note:

Included in the copy of proposed regulations are technical changes recommended by staff. They are shown in brackets [ ].

The Board will review the comments and determine whether to:

1) make any changes to the proposed regulations;
2) adopt as final with no changes; or
3) refer back to the Regulation Committee for discussion and recommendation.

Board of Veterinary Medicine
Summary of Comment on Proposed Regulations
Periodic Review

A public comment period on proposed regulations resulting from a periodic review was open between December 26, 2106 and February 24, 2017. There was a public hearing conducted before the Board on February 9, 2017.

On February 1, 2017, the Executive Director of the Board sent an email to all licensees noting that the proposed regulations posted to the Virginia Regulatory Town Hall website included an error in 18VAC150-20-172(B). The email stated that: *As approved by the Board of Veterinary Medicine on February 16, 2016, the section should state the following:*

> *An assistant shall not be delegated the induction of sedation or anesthesia by any means. The monitoring of a sedated patient not fully recovered from anesthesia may be delegated to an assistant if a veterinarian remains on the premises.*

The error occurred inadvertently and will be corrected during the final stage of the promulgation process.

Prior and even after the notice of an error in the proposed regulation in section 172, the vast majority of comments objected to the proposed regulation that would not allow an assistant to monitor a patient that is intubated: *The monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided the patient is no longer intubated and provided a veterinarian or licensed veterinary technician remains on premises until the patient is fully recovered.* The proposed language was an earlier version that was subsequently changed by the Board, but was inadvertently not changed in the system from which the proposed regulation is published.

Commenter	Comment
36 persons	Opposed the restriction on unlicensed assistants monitoring a sedated or anesthetized patient if it is intubated. *Note above about correction to be made in adoption of final regulations.*
	Additional comments
Maureen Perry, RPh	Limitation on access to controlled drugs should include pharmacists and pharmacy technicians
Melaine Gevedon	Clarification about whether regulation does not allow placement of microchips at a public vaccine clinic even when there is a veterinarian present.
Melanie Crovo, DVM	Need regulations requiring notification and provision for records when a veterinary establishment closes
Jerry Hinn, DVM	Assistant should be allowed to remove endotracheal tube; closure of a simple extraction site once cleansed is different from regulatory wording addressing creation of a gingival flap.
Stephen Smith, DVM	Fish should be in the veterinary practice act in Va.

Christina Blevins	Question of whether a head loop with light constitutes emergency lighting in the surgical suite
Yonas Mehari, DVM	Definition of a preceptee should include a graduate who is a ECFVG candidate in process under the AVMA.
Margaret Rucker, DVM for Virginia Veterinary Medical Association	Notes concerns of one of VVMA members: 1) Revise restriction on unlicensed assistants placing IV catheters (*not revised in proposed regulation; restriction is current language)* 2) Do not remove "including but limited to" so the veterinarian can determine which tasks can be delegated to a trained assistant. 3) Replace "clipping and scrubbing in preparation for surgery" with "assisting in surgery" 4) Delete the restriction on access to Schedule II – V drugs so unlicensed persons can access and administer on weekends when no licensed persons are on the premises.
Joe May, DVM	Concerns noted in comment above. Restrictions on surgery and performed surgery only in a surgical suite need to be deleted or modified Vets in an ambulatory/house call practice should be able to see patients at any location
Lee Henkel	Concern by the Board was about postoperative monitoring, not what happens during surgery
Jane Kaye, DVM	Assistants should be able to monitor anesthesia and place IV catheters
Hillary Rader, DVM	Should put back the "include but are not limited to" so assistants can be trained to perform additional tasks
Hiedi Orr, DVM	Assistants should be able to place IV catheters (*note: it is a current restriction, not a proposed change)* Should put back the "include but are not limited to" so assistants can be trained to perform additional tasks
William Swecker, VMCVM	1) Access to drugs should include other medical professionals such as pharmacists and pharmacy technicians 2) Need clarification of requirements in section 130 and 173 on informed consent/written approval for student or preceptee to perform surgery
Kris Keane	Vets should have clients sign a consent for non-licensed assistants to be involved in anesthesia
Kristin Wallace, LVT	Unlicensed assistants should not be able to place a endotracheal tube – patients should have the priority rather than time of the vet
Ellen Carozza, LVT	Agreed that public should know when unlicensed assistants are monitoring anesthesia
Dani Tyree, LVT	Patients deserve trained veterinary technicians
Brittany Kestner, LVT	Unlicensed assistants should be limited in what they can do; LVTs are licensed but are limited in certain tasks.
Anne Norback, LVT	Supports the regulatory change for the safety of patients
Jason Bollenbeck	Should put back the "include but are not limited to" so assistants can be trained to perform additional tasks
Jessica Wootton, DVM	Was an assistant before a DVM; did not have proper training to perform those tasks or troubleshoot problems that arose.
Karleigh Walkosz, LVT	Does not support allowing an unlicensed assistant to monitor sedation; most problems occur within 3 hours following an anesthetic event. Blurring the lines between licensed and unlicensed practice.
Kendall Blackwell, LVT	Concurs with comment above
Micki Armour, DVM	Proposes that only a licensed tech or DVM should intubate and monitor

	anesthesia. If a LVT is unavailable, a DVM should be present during the entire anesthesia.
Nicole Kennedy, LVT	Assistants do not have the knowledge to monitor a patient waking up from anesthesia; too much can go wrong.
Genito Animal Hospital	Differentiation of assistant vs trained veterinary technical is important as the standard of care as expectations and pet care evolve in our society as a whole
Theresa Gray, LVT	Assistants should not be monitoring patients under anesthesia; Lists additional duties in 172 that are not included in NAVTA approved Assistant Certification course – does not include drawing blood; dental polishing and scaling of teeth. Should follow the NAVTA standard for how assistants should be trained.
Taryn Singleton, LVT	Recommends that a licensed person should be on the premises whenever an animal is sedated.

BOARD OF VETERINARY MEDICINE
PUBLIC HEARING ON PROPOSED REGULATIONS
DEPARTMENT OF HEALTH PROFESSIONS
FEBRUARY 9, 2017

TIME AND PLACE: The Public Hearing was called to order at 9:00 a.m. The purpose of the hearing was to receive public comment on the proposed amendments to regulations which resulted from a periodic review of the regulations.

PRESIDING OFFICER: Ellen G. Hillyer, DVM, Board President

MEMBERS PRESENT:
Tregel M. Cockburn, DVM
Autumn N. Halsey, LVT
Mark A. Johnson, DVM
Steve Karras, DVM
Bayard A. Rucker, III, DVM
Mary Yancey Spencer, J.D., Citizen Member

QUORUM: With all members present, a quorum was established.

STAFF PRESENT:
Leslie Knachel, Executive Director
Amanda E. M. Blount, Deputy Executive Director
Charis Mitchell, Assistant Attorney General, Board Counsel
Carol Stamey, Operations Manager
Brandy Latvala, Administrative Assistant

OTHERS PRESENT:
Rena Allen, DVM, Alexandria, Virginia
Khalfani Carr, Student, Veterinary Assistant, Alexandria, Virginia
Melanie Crovo, DVM, Roanoke, Virginia
Heather Jenkins, DVM, Southwest Virginia
Tarya Singleton, LVT, Virginia Association of Licensed Veterinary Technicians (VALVT)
Amanda Blankenship, LVT, Alexandria, Virginia
Susan Seward, Virginia Veterinary Medical Association (VVMA)
Tori Pullen, LVT, Alexandria Animal Hospital
Staesha Walker, LVT, VCA, Alexandria, Virginia
Lee Hinkel

PUBLIC COMMENT: Dr. Allen presented comment regarding *18VAC150-20-172. Delegation of Duties*. She requested that the board consider not removing the language "include but are not limited to the following" in 18VAC150-20-172.C. Dr. Allen noted that she had submitted online written comment.

Mr. Carr provided comment regarding *18VAC150-20-172.Delegation of Duties*. He stated that he supports the inclusion of monitoring anesthesia as a duty for veterinary assistants. He stated that if the task for anesthesia monitoring was taken away from veterinary assistants, it could inhibit the potential of other unlicensed veterinary assistants.

Dr. Crovo, provided comment regarding *18VAC150-20-172. Delegation of Duties.* She stated that she has a small practice and the language regarding sedation and monitoring of anesthesia needed clarification. She interprets the proposed language to mean an assistant cannot monitor an anesthetized

patient just a sedated one as long as a veterinarian is present.

Dr. Jenkins provided comment regarding *18VAC150-20-172. Delegation of Duties.* She stated that there were severe animal welfare issues in Southwest Virginia to include shortage of LVTs. Due to the shortage of LVTs, it would damage her clinic if veterinary assistants could not monitor anesthesia.

Ms. Singleton provided comment regarding *18VAC150-20-172. Delegation of Duties.* She stated that the VALVT was in support of the requirement for a licensed veterinarian to be in the building when a patient was sedated or under anesthesia. She further stated the proposed regulation supported public safety. Ms. Singleton stated that it was the public's perception that a licensed veterinarian is in the building when any procedures are performed.

Ms. Blankenship provided comment regarding *18VAC150-20-172. Delegation of Duties.* She stated that she is a supervisor for 12 locations and supports assistants performing anesthesia monitoring. She further stated that there is a shortage of LVTs and there is a need for veterinary assistants.

Ms. Seward provided comment regarding *18VAC150-20-172. Delegation of Duties.* She stated that the VVMA supports veterinary assistants to monitor a sedated patient provided that a veterinarian is on the premises. She further provided that the VVMA had received comments from its membership regarding the following:

- Delete prohibition against delegating intravenous catheters to an unlicensed assistant in 18VAC150-20-172(B);
- Do not delete "included but not limited to" from 18VAC150-20-172(C); and
- Delete "clipping and scrubbing in preparation for surgery" and add "assisting in surgery" to broaden usage of assistants in 18VAC150-20-172(C).

Ms. Pullen provided comment regarding *18VAC150-20-172. Delegation of Duties.* She stated that the shortage of LVTs continues to rise and supports veterinary assistants performing the tasks of IV catheter placement, anesthesia monitoring and broadening the duties for properly trained assistants.

Ms. Walker provided comment regarding *18VAC150-20-172. Delegation of Duties.* She is very appreciative of the correction made to 18VAC150-20-172(C). She stated that if duties of unlicensed assistants are limited, then patient care will be compromised. She indicated that she has to have the help of assistants.

Dr. Allen requested to speak again to add her support for removing the prohibition against delegating intravenous catheters to an unlicensed assistant in 18VAC150-20-172(B).

ADJOURNMENT: With no further comment received, the hearing adjourned at 9:20 a.m.

From: Perry, Maureen [mailto:maperry1@vt.edu]
Sent: Friday, February 24, 2017 4:42 PM
To: Knachel, Leslie (DHP)
Subject: Public Comment in regards to 18VAC150-190

I would like to comment on 18VAC150-190 (i)

(i) clarification that only the veterinarian or licensed veterinary technician has access to Schedule II through V drugs

This statement appropriately limits access to controlled drugs, but should include RPh (registered pharmacists) RPh T (registered pharmacy technicians) and CPhT (certified pharmacy technicians).
Any of these persons can legally have access to such drugs and might be employed by a veterinary practice to run their dispensary.
There are a number of pharmacy residency programs throughout the country training pharmacist specialists in veterinary pharmacy.

Maureen Perry RPh, FSVHP,DICVP
Pharmacy Supervisor
Veterinary Teaching Hospital
Virginia-Maryland Regional College of Veterinary Medicine
Virginia Tech, Phase III 245 Duck Pond Dr (0443)
Blacksburg, VA 24061 540-231-7260
email: maureen.perry@vt.edu

From: Melanie Crovo [mailto:melcrovo@gmail.com]
Sent: Thursday, February 16, 2017 6:58 AM
To: Board of Veterinary, yy; Knachel, Leslie (DHP)
Subject: veterinary clinic closing regulations

February 16, 2017

Dear Dr. Knachel,

This letter is intended to begin a discussion regarding protocols for the closure of veterinary clinics. In the past couple of years, the Roanoke Valley has had three(one has since reopened) veterinary clinics close. In each of those cases, it has been difficult to impossible for clients and other veterinary clinics to obtain the patients' complete medical records After reading current regulations, it appears that a closing clinic is only required to notify clients if they sell or transfer all of the records to another facility. If they just close, they are not required to notify clients or transfer records.

In the past, this may not have been an issue as veterinary clinics rarely closed and patient records may have been limited to annual exams and vaccines. However, times have changed and economic situations have led to sudden closure of several clinics in our area alone. I am sure this situation is not limited to the Roanoke Valley. In addition, modern medicine and changing relationships with our pets have led medical records to be more complex. Most records include

expensive lab tests and advanced diagnostics. Our patients and clients deserve to have access to these records.

Would it be too late to address this issue in the current regulatory changes that are being discussed? If not how can we begin? If it is too late, can you guide me making this change by petition?

Thank you for your help.

Melanie Crovo, DVM

Furry Friends Veterinary Clinic, LLC

540-890-8500 office

540-529-4468 cell

From: Jahinn [mailto:jahinn@aol.com]
Sent: Tuesday, February 07, 2017 9:57 AM
To: Board of Veterinary, yy
Subject: Re: The role of assistants and the closure of dental extraction sites

Dear Ms. Knachel,

I was glad to take time to provide input and if I may, please let me add 2 additional reflections. The first being that of how the removal of an ET tube was earmarked, but not that of the removal of an intravenous catheter? Not that I want to introduce this area of patient care as overreaching by a properly trained and supervised assistant and not that we always place femoral catheters as in human medicine which have at times placed humans in danger by failing to assure homeostasis once removed. Secondly, I was speaking with one of our staff members yesterday who is about to complete her licensed technician program this spring and she said that she was trained as a beginning assistant by a senior LVT on the removal of endotracheal tubes as a patient was coming out of anesthesia and it was *this* experience exposing her to patient care that encouraged to go to technician school as she was hungry for more knowledge in a formal program.

Again thanks for bringing my thoughts forward.

Sincerely,

Jerry Hinn, DVM

From: Jahinn [mailto:jahinn@aol.com]
Sent: Sunday, February 05, 2017 7:00 AM
To: Knachel, Leslie (DHP)
Cc: Board of Veterinary, yy
Subject: The role of assistants and the closure of dental extraction sites

Dear Members of the Board of Veterinary Medicine,

I would like to address 2 areas:

1) Earlier in the regulatory process after the extraction of a single rooted tooth, closure of the gum of a single rooted tooth was allowed to be performed by a licensed veterinary technician just as skin was authorized. This closure the closure of a simple extraction site once cleansed is far different than the regulatory wording addressing the creation of a gingival flap to close a defect such as an oral-nasal flap opening where a canine tooth has been extracted which indeed should be performed by a licensed veterinarian.

2) During anesthetic recovery of a patient, there is little reason that a properly trained assistant could not be permitted to monitor this stage particularly if monitoring equipment is still in place as well as to remove the endotracheal tube once the jaw tone is increasing as well as the swallow reflex and patient awareness are returning. While the thought of only allowing the monitoring of a recovering by an assistant for a patient that has been extubated is ideologically well intended, there would be concern that the doctor and/or the procedural licensed technician may have demands of their presence in another area of the practice such as the attending of an emergency that has been presented, another patient being prepared for surgery, or a declining critically ill hospitalized patient. Most practices in Virginia are desperate to hire licensed veterinary technicians and to this date as all practitioners are aware, the availability of such employees of this these partners in practice has yet to me met.

Thank you for considering my thoughts during this public comment period. All of us practicing in the Commonwealth appreciate your service as well as that of those in the Department of Health that strive to elevate and maintain the standards of practice of veterinary medicine.

Respectfully,

Jerry A. Hinn, DVM

From: Stephen Smith [mailto:stsmith7@vt.edu]
Sent: Saturday, February 04, 2017 6:41 AM
To: Board of Veterinary, yy
Subject: Inclusion of fish in veterinary medicine

How about including "fish" in your definition of "Companion animal" and Agricultural animal" in your Regulations Governing the Practice of Veterinary Medicine. Fish as agricultural animals are under USDA-APHIS purview and should be included in the practice act of the Commonwealth. Fish as companion or ornamental animals should also be included in the veterinary practice act of the Commonwealth. SAS

Stephen A. Smith, DVM, PhD
Professor of Aquatic, Wildlife and Exotic Animal Medicine Dept. Biomedical Sciences and Pathobiology
VA/MD Regional College of Veterinary Medicine Phase II, 205 Duck Pond Drive Virginia Tech
Blacksburg, VA 24061-0442
Phone (540)-231-7666 (college)
Phone (540)-231-9586 (laboratory)
FAX (540)-231-6033
E-mail stsmith7@vt.edu
Web site: http://www.vetmed.vt.edu/research/aquatic/index.html

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From: smlahospital@aol.com [mailto:smlahospital@aol.com]
Sent: Tuesday, January 24, 2017 3:37 PM
To: Knachel, Leslie (DHP)
Subject: proposed changes

Dear Leslie and board members,

This note is to state my opinions about proposed changes to the regulations that we are required to follow. There is a major concern by myself and local colleagues regarding duties to licensed technicians. The proposed change,18VAC150-20-172 Delegation of duties part B, will put a difficult limitation to many practicing veterinary hospitals in rural areas. While it is necessary to have only appropriately trained individuals monitoring anesthesia, limiting only to LVT's and preventing in-house trained employees from performing this duty will make it impossible to function in under-served areas. There is a severe shortage of LVT's in the southwest Virginia area and there are many hospitals with none or only one LVT on staff. This shortage is purely from a population trend as most hospitals are wanting and actively searching for LVT's that are not living in certain areas of the state.

Even in the best of situations, there are times that lay staff, who are properly trained, need to perform the duty of monitoring anesthetized patients. The proposed change, if ratified, would put us in a position to either risk our license and perform an emergency surgery without an LVT present, or uphold the rules and risk the animal dying. The board needs to realize and understand the rules they plan to enforce are realistic for everyone in the state, not just urban areas with different demographics.

With Respect,
Brian Weitzman
Smith Mountain Lake Animal Hospital
15029 Moneta Rd.
Moneta, Va. 24121

From: Christina Blevins, LVT [mailto:ceblevins@springfieldvetcenter.com]
Sent: Thursday, January 05, 2017 12:34 PM
To: Knachel, Leslie (DHP)
Subject: Proposed **Regulations** Question

Dear Ms. Knachel,

This question is in regards to the emergency lighting in the surgical suite. Does a head loop with light satisfy the requirement proposed for focal emergency lighting? Thank you for your time.

--
Christina Blevins, LVT

From: Melanie Gevedon [mailto:mgevedon@vt.edu]
Sent: Wednesday, January 04, 2017 9:49 AM
To: Board of Veterinary, yy
Subject: Question regarding microchipping

Hello Board,

If I am reading this correctly, public vaccine clinics may not place microchips even with a veterinarian present?

Is chip placement considered like controlled injectable drug administration? Or like vaccines?

Would private owners be able to place on their own animals?

No comments other than I expect I will be asked about these requirements and would like clarification.

Thanks,
Melanie

From: judy johnson [mailto:jldvmd@me.com]
Sent: Wednesday, January 04, 2017 1:45 AM

To: Knachel, Leslie (DHP)
Subject: Board review

Dear Leslie
I am not sure what regulation is up for review. I am looking on my phone and not a computer but what I just read about prescription drugs is vague and nebulous. Could you clarify what this regulation change is? I am not in favor of increasingly restrictive government control of our medical practices and medicines.
Dr Judy Downs

From: Yonas Mehari [mailto:yonastmehari@gmail.com]
Sent: Tuesday, January 03, 2017 9:40 PM
To: Board of Veterinary, yy
Subject: ECFVG candidate in process under AVMA

Good Evening,

AVMA required that foreign veterinary graduate preparing to take the CPE should have clinical experience and basic animal handling/husbandry skills working with the species used in ECFVG exam. Most emphasis is placed on the dog, cat, horse, and cow with a lesser emphasis on goats, sheep, and pigs. Therefore provision under "Preceptee" or "extern" means a student who is enrolled and in good standing in an AVMA accredited college of veterinary medicine or AVMA accredited veterinary technology program and who is receiving practical experience under the supervision of a licensed veterinarian or licensed veterinary technician." The Definition should also include Foreign Veterinary (ECFVG) candidate in process under AVMA. Otherwise, they will be disadvantaged.

--
Yonas Mehari DVM, MS,

From: Joe May [mailto:jmaydoc@hotmail.com]
Sent: Tuesday, January 24, 2017 6:33 PM
To: Knachel, Leslie (DHP); Behr, Terri H. (DHP); Steph at NVA; B. A. Rucker, DVM; Sophia Decker; Dale Sprenkel; Emily Lawrence; Ed Fallin; Kathy George; Hillary Rader; Hiedi Orr; PHIL HOPKINS; Joe May; Larry Cooper; Emily Lawrence; Sharon Lawson at NVA; Heidi Orr; Robin at VVMA; John T. Wise, DVM; Tiffanie Walters; Terry Taylor, DVM; Mark A. Johnson, DVM; Marilyn; Robert Bell, DVM; Cathy DeMott; Brandi Nickelston; Brandy Barker; Al Henry, DVM; Amy Waryas-Coleman; Andy Tripp, DVM; Autumn N. Halsey, LVT; Board of Veterinary, yy
Subject: What happened with Anesthesia Monitoring? New Regulation on Town Hall Web Site from Veterinary Board.

Dear Virginia Veterinarians and those interested or working in Virginia Veterinary Hospitals

Here is language from Town Hall web site concerning an assistant monitoring a sedated or anesthetized patient along with some previous email correspondence below. It has been changed from what was agreed upon at my last Board meeting in July when I left the Board (See text in email below). I do not know who changed it or why it was changed and I also do not understand why things keep getting put on the Town Hall Web Site when they have not been discussed and approved by the board. I would really like answers to these questions and I am encouraging all interested parties to make their disapproval known to the board and post

comments on the town hall site. As it is written, it completely forbids an assistant from monitoring a sedated or anesthetized patient. At our hospital, the tube is not removed until the patient is recovered enough to be transferred to a recovery cage and close monitoring is no longer needed. Very few rural practices have an excess of LVTs employed and could not comply with this proposed regulation. In addition, a licensed DVM's license always remains on the line if he allows someone to do something they are not trained for and the DVM should be allowed to use their professional judgment.

The only logical explanation I can come up with for the reappearance of regulations restricting assistants from being able to do things they have done safely for years is that someone on the board is trying to legislate job security for LVTs. To me this is quite short sighted and is an insult to both DVMs as well as LVTs. It prevents both groups from being able to use their professional judgment and it prevents an LVT from being able to train assistants under them to do things to free up the LVT to do more to take the load off the DVM and give better patient care. It makes absolutely no logical sense to me and I highly recommend that all DVMs, LVTs, and Assistants contact the Virginia Board of Veterinary Medicine and the Town Hall Web site with their comments on this proposed regulation.

Feel free to forward the contents of this email as needed.

Joseph A. May, DVM

Former member of Board of Veterinary medicine

VIRGINIA VETERINARY MEDICAL ASSOCIATION

3801 Westerre Parkway, Suite D | Henrico, Virginia 23233
(P) 804-346-2611 | 800-YES-VVMA | (F) 804-346-2655
(E) info@vvma.org | www.vvma.org

February 9, 2017

Ms. Leslie L. Knachel, Director
Virginia Board of Veterinary Medicine
Virginia Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

RE: Comments on Periodic Review, 18VAC150-20-10, Regulations Governing the Practice of Veterinary Medicine

Dear Ms. Knachel,

The Virginia Veterinary Medical Association ("VVMA") offers the following comments on the Periodic Review of 18VAC150-20-10, Regulations Governing the Practice of Veterinary Medicine. The VVMA appreciates the work of the Board of Veterinary Medicine in updating these regulations.

In developing our comments, the association asked our membership to share their thoughts and concerns regarding the proposed regulations. Although one issue garnered the largest response, it appears that the proposed wording on that particular regulation was put forward for comment in error. The language approved by the Board of Veterinary Medicine in February 2016 stating that the monitoring of a sedated patient not fully recovered from anesthesia may be delegated to an assistant if a veterinarian remains on the premises is overwhelmingly supported by the membership of the VVMA. Therefore, the notice by the Board of Veterinary Medicine acknowledging the error in the language of the proposed regulations on this issue posted to the Virginia Regulatory Town Hall website on 18VAC150-20-172(B), nullifies a number of comments offered by the VVMA membership.

However, there are two specific concerns regarding duties by unlicensed assistants that were brought to VVMA's attention by membership. The first concern regards the prohibition of unlicensed assistants placing IV catheters. Given the shortage of licensed technicians and the high frequency with which IV catheters are placed in clinics, particularly for emergency patients and patients undergoing elective procedures, this restriction on who can place IV catheters is not practical and negatively impacts the ability of our membership to meet the needs of the pet owning public. In response to our members' concerns, we suggest striking through "the placement of IV catheters" as something that cannot be delegated to a non licensed person.

The second issue brought forward to the VVMA was a request that the wording "include but are not limited to the following" remain in 18VAC150-20-172. Our member asserts that removing that language restricts assistants to doing ONLY those tasks listed. In his opinion, there are many more tasks not listed that a trained assistant can perform safely and since the licensed veterinarian remains responsible whenever a task is delegated, the veterinarian will be judicious given the potential liability. He said this is regulation is particularly impactful to rural practitioners, as the supply of LVTs in rural areas of the state is very limited. He also suggested replacing the new proposed language, "Clipping and scrubbing in preparation for surgery" with "Assisting in surgery" in the list of duties that can be delegated to unlicensed assistants in 18VAC150-20-172(C).

The VVMA supports the new language regarding drug storage and disposal, as we acknowledge this issue poses increasing challenges to practitioners. The new language clarifies handling incidences of diversion or theft, recordkeeping requirements, and storage and disposal issues. This new guidance should prove useful to all practices in the Commonwealth.

However, there was one concern brought to our attention with the proposed language in 18VAC150-20-190(D) Sections 3. Section 3 states "Whenever the establishment is closed, all general and working stock of Schedule II through V drugs and any dispensed prescriptions that were not delivered during normal business hours shall be securely stored as required for the general stock." One VVMA member said he is worried that this new language could limit the opportunity of assistants or kennel personnel to administer prescribed controlled drugs such as Phenobarbital to boarders when a DVM or LVT is not on the premises. It is a common practice for these unlicensed assistants to treat animals in the hospital when they come in to feed and clean on weekends or after hours and the regulations should allow for this practice. A clarification of the proposed regulation as it relates to this situation would be appreciated, as it is a common practice in many clinics.

Thank you for the opportunity to comment on these proposed regulations and for the Board's efforts in this process.

Sincerely,

Margaret Rucker, DVM
President

Banfield
PET HOSPITAL

FEB 1 3 2017
DHP

February 8, 2017

Virginia Board of Veterinary Medicine
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

VIA FEDEX and EMAIL: vetbd@dph.virginia.gov

Re: Proposed changes to 18 VAC 150-20-172

Dear Virginia Board of Veterinary Medicine,

I am writing to urge that the Board reconsider implementing the proposed changes to 18 VAC 150-20-172 as currently written. Specifically, I am concerned that limiting anesthesia monitoring of intubated animals to DVMs and LVTs will have the unintended effect of reducing the overall quality of veterinary care in Virginia.

As other commenters have pointed out, Virginia, like many other states, has a shortage of LVTs. Despite our concerted efforts to recruit LVTs, including a tuition reimbursement program, Banfield's ratio of LVTs to DVMs is approximately 1:12. Banfield currently employs 118 DVMs in the state of Virginia and only 16 LVTs. In contrast, Banfield Hospitals employ 291 veterinary assistants in Virginia. In those hospitals which do not currently have an LVT, the proposed changes would drastically limit that hospital's ability to perform surgery and pose an unacceptable compromise to patient care by forcing the DVM to simultaneously perform surgery and monitor anesthesia.

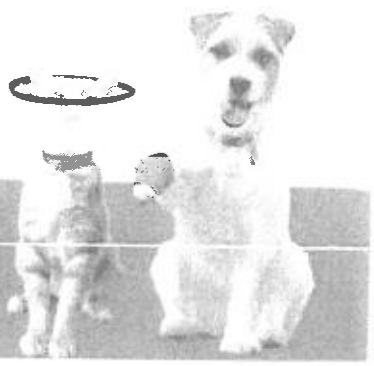
All veterinary assistants at Banfield undergo rigorous training, including training in anesthesia monitoring. Further, all veterinary assistants who assist with anesthesia monitoring at Banfield do so under the direct supervision of an LVT or DVM. Prohibiting veterinary assistants from performing a task which they have been performing safely for years under LVT and DVM supervision is unnecessary and will adversely impact the quality of veterinary care in Virginia. On behalf of Banfield and the veterinary industry I implore the Board to reconsider the proposed changes to 18 VAC 150-20-172.

Sincerely,

Daniel Aja, DVM

Daniel Aja, DVM
Chief Medical Officer
Banfield Pet Hospital
18101 SE 6th Way
Vancouver, Washington 98683
www.banfield.com

cc: Virginia Veterinary Medical Association



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VIRGINIA REGULATORY TOWN HALL

Logged in as
Elaine J. Yeatts

Department of Health Professions

Board

Board of Veterinary Medicine

Chapter

Regulations Governing the Practice of Veterinary Medicine [18 VAC 150 - 20]

Action	Periodic review
Stage	Proposed
Comment Period	Ends 2/24/2017

All good comments for this forum Show Only Flagged

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Commenter: Karen Bates, VCA Alexandria Animal Hospital * 1/11/17 6:07 pm

Proposed changes to 18VCA150-20-172

Dear Sirs,

I would like to comment on the proposed changes to 18VCA150-20-172 Delegation of Duties for the Board of Veterinary Medicine. Specifically: The monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided the patient is **no longer intubated** and provided a veterinarian or licensed veterinary technician remains on premises until the patient is fully recovered.

Unfortunately, if this regulation is implemented, this would place the burden of monitoring an intubated, anesthetized patient on either a veterinarian or a licensed veterinary technician (LVT). We find ourselves unable to hire enough LVTs to perform the tasks now required by regulation.

I fear that the limitation of the staff authorized to assist and monitor during even minor procedures, or common procedures such as dentals and extractions, would tremendously increase the cost to the owners, without increasing patient safety. Thereby decreasing the availability of these procedures to the majority of the pet owning public.

As an alternative I would suggest each hospital submit their veterinary assistant training program for Board review and approval, to ensure that staff involved in any anesthetic procedure are trained to competently ensure patient safety.

Thank you for your consideration,

Karen E. Bates, Hospital Manager

Commenter: Jacqueline Suarez, VCA Alexandria Animal Hospital * 1/13/17 10:12 am

Proposal to disallow assistants from monitoring patients who are intubated

I feel this change will drastically impact our ability to practice veterinary medicine. I have practiced in our hospital for 21 years. We have an excellent training program for veterinary assistants, which allows them to monitor patients who are intubated. A technician or DVM is in the room at all times. Although we strive to hire veterinary technicians, they are in short supply and high demand. This new rule would greatly decrease the number of needed procedures we can provide, decrease the amount of pets who can be cared for, and decrease the amount of jobs we provide for our assistants. If I thought that our assistants were not able to monitor our patients, I would certainly change what we do. Our patient's **lives** are the most important aspect of veterinary medicine. If statistically you proved that an assistant is unable to monitor, I am willing to listen. Our hospital has had a very low mortality since the implementation of an assistant monitoring all of our equipment while the doctor and technician are performing their role. The reality is that veterinary medicine does not have enough licensed technicians for all of the jobs you would like them to perform. I ask you to carefully consider what I believe is a well intentioned change that will have a huge negative impact on our medicine.

Commenter: Khalfani Carr VCA Alexandria Animal Hospital* * 1/15/17 3:53 am

Proposed changes to 18VCA150-20-172

To whom it may concern--?

If you no longer allow unlicensed veterinary assistants to monitor sedate or intubated patients, it would inhibit the potential of younger veterinary generations to come.

When I first started with VCA Alexandria Animal Hospital, I was not equipped with the vetertinary expirience that I have today. Never did I expect to be in this field surrounded by dogs, cats, and other wild life.

Growing up in the busy city of Alexandria my childhood and teenage years were spent on various sport teams and hanging out with friends. Sports are a very important building block in young teenage lives because it teaches self-control, sportsmanship, and most of all team work. All the values that we hold here at VCA Alexandria. Every day is a blessing because of the impact we make on eachothers lives and the animals.

Before working in the veterinary field I had little to no idea what I wanted to be in life. Getting the tour watching my future assistant co-workers in surgery monitoring anesthiesia was the light at the end of the tunnel I wanted to run towards. Ive never felt so important to a team before which made me strive to become as knowlegable as possible to ensure that I am comfortable in surgery and that the patients recovery is smooth as can be on my end.

Our anesthia training here at VCA is thorough and challenging. My trainer, David Buck, is the most knowlegable person in my short 23 years on this earth that I have had the honor to learn from. The information taught to me from not just my trainer, but doctors and also LVT's have been essential to my rapid successes the past 2 years.

Because of the dedication and hard work of our administrative and supervisory team here at VCA, I have had the honor of monitoring for many types of surguries and procedures. If not for anesthesia I would have never have found this passion.

It is hard to believe that myself, a young man who only enjoyed playing basketball and chasing around "the ladies" also graduationg high school with only a 2.0 GPA along with low self esteem would be welcomed with open arms into a family who not only care about themselves but the well-being of the animals that walk through the door.

I look in the mirror with pride now that I can say my life has evolved to being a team player, a B+ student with a 3.5 GPA in college, along with being a mentor to younger generations mentoring telling them the sky is the limit! All because of the love at first sight with anesthesia monitoring.

New hires and a few less expirienced staff whether it was an LVT, assisistant and on occassions doctors began to ask me questions about trouble shooting machines or how to fix a problem when something starts to malfunction. Just simple things like that makes a person feel of value to a team, get more knowlege on basic to critical anesthesia monitoring, knowing there is much more to learn has ignighted a spark in me to become not only to reach for the stars for myself, but to also help others surpass what I have and will do; past and present.

The Veterinary Technician demand is at an all-time high. Without letting assistants learn to monitor anesthesia, it may potentially suppress the desire of other men and women, young and old to pursue an education to become an LVT not knowing their hidden potential to become successful and not feel disposable in the work place.

Although I was awarded an LVT scholarship it still will not stop me from standing up for the next assistant whos eyes light up when a scaple blade is pulled out and the surgery start time begins.

Thank you for your consideration,

Khalfani Carr, Emergency Veterinary Assistant

Commenter: Caroline Pattie, DVM, Aldie Veterinary Hospital * 1/17/17 6:46 pm

Proposed changes to 18VCA150-20-172

I am concerned with the current proposed wording of the amendment, as it is a potentially good use of staff and resources to allow certain established/experienced vet assistants to help with monitoring anesthesia.

We are a progressive and busy 24-hr clinic. We have several highly trained LVTs but within the past year we altered our policies to have a vet assistant (VA) to be on board with every dental prophy procedure because the task of monitoring, along with performing the procedure a patient is anesthetized for, we felt opened up too much liability for a single person. Anesthesia is probably the most liable time that any patient is subjected to, and for a vast majority of that time during the

most important moments (induction & recovery) the veterinarian may not be directly present; rather instructions have been given to an LVT after a pre-sedation exam (at this point the vet is often in the office, on the phone, etc.).

We only delegate this task of helping the LVT to particular assistants who we feel are capable and trustworthy, and at most they are an additional set of hands for the LVT to direct about bagging patient, adjusting the flowmeter or gas, etc., while they record the stats on the surgery flowsheet, allowing ultimately a faster/more efficient procedure.

This is also an excellent opportunity for learning for some of these assistants, many of whom have aspirations for LVT education themselves. I propose that certain assistants, at the judgement of the veterinarian, be allowed to assist with anesthesia monitoring for at least the dental procedures due to the LVT's direct responsibility to perform the prophy. Thank you.

Commenter: Amanda Blankenship, VCA Alexandria Animal Hospital * 1/17/17 6:48 pm

proposed changes to 18VCA150-20-172

Dear Sirs,

I am a licensed veterinary technician working at a 24 hours general practice in the wonderful state of Virginia. I started out working as a veterinary assistant at my current hospital. I graduated from Northern Virginia Community College's AVMA approved program and sat for boards in 2003. I am also regional technician supervisor for 13 other area hospitals. I assist them with training and mentoring of technicians and assistants. I am a VALVT member and NAVTA member.

I am sending this letter in regards to the prosed changes to 18VCA150-20-172 Delegation of Duties for the Board of Veterinary Medicine. Specifically: The monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided the patient is **no longer intubated** and provided a veterinarian or licensed veterinary technician remains on premises until the patient is fully recovered.

I understand the intention of the Board with the proposed law. In a perfect world, licensed technicians would perform all technical skills in a veterinary practice. Unfortunately, we do not live in a perfect world. As I am sure you are aware, there is a great shortage of licensed technicians due to burnout, compassion fatigue and lack of pay. For every veterinarian there is 0.48 licensed techicians vs. human medicine for every doctor there are 2 .8 registered nurses. The Virginia DHP Count of Current Licenses for the FY ending June 30th, 2016 which lists 2032 licensed Veterinary Technicians, 4217 licensed Veterinarians and 772 Full Service Veterinary Facilities which translates to approximately 0.48 LVT per licensed veterinarian and 2.6 LVT's per full service facility. This falls well below most veterinary industry recommendations for a minimum of 1-2 FTE LVTs/ FTE veterinarian in a full-service GP veterinary practice. Workforce data from the same time period in the human medical profession show that 37115 Physicians and 104,873 Registered Nurses were licensed in the state of Virginia which represents 2.8 registered nurses for each licensed physician.

With the proposed law, what I fear most is the limitation it would place on patient care. Taking care of patients is the reason why I became a licensed technician and why I have continued to remain in the field. I fear there will be veterinarian "monitoring" alone while doing surgery in order to follow the law. Patients will not be intubated that really should be so a trained assistant can monitor them. I do strongly believe in the current Virginia laws. Only licensed personal can induce anesthesia. Only licensed personal can place an endotracheal tube. I believe these laws help to protect our patients and protect the veterinary technician profession without crippling licensed technicians and veterinarians.

A side from patient care, I also fear the proposed law would increase the cost to owners because there would be a limited the number of procedures that could be offered to the public due to lack of licensed technicians. It would put more of a strain on the already limited licensed staff.

As an alternative I would suggest each hospital submit their veterinary assistant training program for the Board to review and approve. This would help ensure that all staff involved with any anesthetic procedure is trained properly to increase patient safety. Currently our trained anesthesia veterinary assistants undergo an intense training program. Afterwards a licensed technician or veterinarian helps to overseas the care of these patients.

Thank you for your consideration.

Sincerely,

Amanda Blankenship LVT

Commenter: Rena Allen 1/18/17 8:04 pm

comments on proposed change to 18VAC150-20-172

Dear Board Members,

I am a veterinarian who has practiced small animal medicine for over 25 years, most of those in the state of Virginia. Please consider the following comments regarding proposed changes to Article 18VAC150-20-172, Delegation of Duties, of the Virginia Register of Regulations, Volume 33, Issue 9, pages 952-953:

B. Injections involving ~~anesthetic or~~ chemotherapy drugs, subgingival scaling, or the placement of intravenous catheters shall not be delegated to an assistant. An assistant shall also not be delegated the induction of sedation or anesthesia by any means. The monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided the patient is no longer intubated and provided a veterinarian or licensed veterinary technician remains on premises until the patient is fully recovered.

The new provision in the above regulation that specifically prohibits a veterinarian from delegating anesthetic monitoring of an intubated patient to an unlicensed, trained assistant concerns me. In my experience, the demand for Licensed Veterinary Technicians (LVTs) far outstrips the supply. VCA-Alexandria Animal Hospital currently employs 11 LVTs and needs more. Consistently months and sometimes even years go by with few or no applicants for open LVT positions. This phenomenon is not isolated to our hospital as evidenced by examination of the Virginia DHP Count of Current Licenses. During the preceding Fiscal Year ending June 30th, 2016, there were 2,032 Licensed Veterinary Technicians, 4,217 licensed Veterinarians and 772 Full Service Veterinary Facilities. This equates to approximately 0.48 LVTs per Licensed Veterinarian and a mere 2.6 LVTs per full service facility. Bearing in mind that those numbers assume equal distribution of LVTs by facility, which is almost certainly not the case, the number of LVTs at some practices is likely even fewer. In any event, those numbers fall woefully short of most veterinary industry recommendations for a minimum of 1-2 full time employed LVTs per full time employed veterinarian in a full-service General Practice Veterinary Facility. Workforce data from the same time period in the human medical profession show that there were 37,115 Physicians and 104,873 Registered Nurses licensed in the state of Virginia. This reflects a dramatically different ratio of 2.8 Registered Nurses for each Licensed Physician. A comparison of workforce data from human medicine to veterinary medicine is not perfect, but there are many similarities in the amount and type of labor needed to provide patient care in both fields. Perhaps one of the most striking similarities is that both professions are currently experiencing a shortage of licensed support care staff, with that of veterinary medicine obviously being the more severe.

This well intentioned proposed regulatory change, undoubtedly meant to improve patient safety and promote the LVT profession, will instead have profoundly negative consequences for both the quality and availability of veterinary care in Virginia precisely because it comes during a severe shortage of LVTs in the state. In light of this reality, there are only a handful of options open to practitioners seeking to comply. Consider the following scenarios:

1. A typically understaffed facility necessarily and dramatically reduces the amount and types of services requiring intubation to accommodate the increased demand for man-hours associated with anesthetic monitoring and recovery. There is no option available to the owner to simply go to another facility because the LVT shortage is a state-wide problem. The net result is that the availability of veterinary care suffers in general. Wait times for elective procedures become protracted and, in the emergency environment, diminished capacity can lead to patients being turned away with disastrous consequences.

2. LVTs and/or veterinarians monitoring stable but intubated patients during routine anesthesia and through extubated recovery are unavoidably diverted from providing monitoring and care to patients which may require more or specialized attention but simply do not have an endotracheal tube in place. Both the quality and availability of care to the non-intubated patient is thereby potentially decreased.

3. A veterinary practitioner, doctors and LVTs alike, at any given practice may find themselves tempted to avoid intubating patients that should be. This places them in the position of being forced to choose, between what is best for their patients and clients or abiding by the regulation. A regulation should never interfere with best practices, but this almost certainly will occur with the inevitable resulting reduction in the quality of patient care.

4. A veterinarian or LVT may find themselves trying to simultaneously perform a procedure on an intubated patient while monitoring anesthesia themselves. Alternatively, one LVT may be tasked with monitoring multiple patients at the same time. That kind of divided attention is untenable and, again, the quality of patient care will suffer.

5. Some practices will simply be unable to comply in all circumstances and will instead choose to disregard the regulation on a case by case basis. That is a sad reality, but a reality non-the-less.

All of the aforementioned scenarios are definitely less desirable than the current situation that exists in most practices. Historically, well-trained and yet unlicensed technician assistants have safely provided anesthetic monitoring for intubated patients. From the time of LVT or DVM induction and intubation all the way through extubation and recovery, these routine procedures have always been overseen by either a Licensed Veterinarian or LVT providing immediate, direct supervision and support to the assistant.

There is no escaping the fact that there is a dearth of LVTs in Virginia at the present time. Mandating specific duties to LVTs via this proposed regulation only exacerbates the problem. Until the current crisis is mitigated, I believe that a more efficacious solution exists. Our patients, our clients and the veterinary profession in Virginia as a whole would be better served by a standardized, detailed anesthetic assistant training syllabus. Such best practices standardization could easily be developed by a recognized body such as the American Veterinary Medical Association (AVMA), the American Animal Hospital Association (AAHA), or equivalent as deemed appropriate by the Board, and implemented by individual hospitals and clinics. Following Board approval, such a program would allow unlicensed technician assistants who have successfully completed the training program to monitor intubated anesthetized patients under appropriate supervision of Licensed Veterinarians or LVTs.

Thank you for taking the time to review and consider the above comments.

Very Respectfully,

Rena Allen, DVM

VA License # 0301005796

Medical Director, VCA-Alexandria Animal Hospital

2660 Duke Street

Alexandria, VA 22306

phone: 703-751-2022

e-mail: rena.allen@vca.com

Commenter: Margaret J Rucker, DVM * 1/22/17 9:05 am

18VAC150-20-172.

I am making this comment as a licensed veterinarian in this state, and not as a representative of the VVMA.

I know the intent of this change was to protect the public and their pets..Unfortunately, I suspect the result of this change will be the opposite.

I have been in practice in Southwest Virginia for over 40 years, and we employ three licensed veterinary technicans. However, I know most practices in this region do not employ any licensed technicians...simply because of the lack of availability of licensed technicians., and the reluctance of licensed technician's wanting to live and work in this region.

Thus, as they try to follow the letter of this revised law, veterinarians will use injectable anesthetic agents and be reluctant to intubate, even in cases where intubation would be safer for the pet. I know that forcing veterinarians to make this medical decision based on the law rather than the needs of the patient is not the intent of the change, but will, ultimately, be the result.

Commenter: Donna Krochak DVM, VCA Alexandria Animal Hospital * 1/22/17 10:00 pm

Re 18VCA150-20-172

This letter is in reference to the Board's proposed changes to 18VCA150-20-172 Delegation of Duties for the Board of Veterinary Medicine stopping the ability to use assistants to monitor intubated patients and require LVT's to be the primary responsible personnel to monitor these patients. There are always reasons for the board to consider making these types of changes. Perhaps there have been too many cases reported of compromised care of patients or perhaps the licensed veterinary technicians would like to have their profession recognized for the efforts in attaining their degrees. Changing the regulations might at first appear to be a quick way of fixing these types of situations however, making these types of changes would create a tremendous burden to the practice of veterinary medicine not to mention potentially reduce the quality of care to our patients.

Many veterinary practices are in rural areas where they have trouble attracting licensed veterinary technicians. Even those practices in more urban locations often have less than a 1:3 ratio of technicians to veterinarians. Unlike in human medicine where there are greater than five nurses licensed to number of doctors. Changing the regulations in an attempt to give greater recognition

to the technician field is not going to solve this shortage. It will only cause the current technicians to work harder and perhaps lead to burn out in their profession.

As far as safety issues regarding the use of assistants to monitor intubated patients many hospitals use in house training programs to teach these requirements to their staff. Perhaps the regulations could state that assistants performing these tasks can do so under the direct supervision of a licensed technician and/or veterinarian. I would like to hope this is already the case.

Ultimately, the doctor is fully responsible for a patients care. If limitations to how we can use our staff continues we will be severely limited in our daily duties. Many practices will suffer economically while others may even prosper from the referrals of these patients. Many patients may get compromised care by using injectable anesthestics in place of gas anesthestics if they have no licensed technicians or worse yet doctors might compromise their care by trying to monitor and perform surgery at the same time.

I ask that these regulations not be accepted for these reasons and that the reasons for considering these changes be pursued under a different agenda.

Commenter: Dr. Jenifer Farrell, VCA Alexandria Animal Hospital * 1/24/17 7:28 am

Proposal to Mandate an LVT must monitor anesthetized patients

I have been a small animal practioner for 21 years. The hard facts are that if the regulation is approved as worded (unlicensed assistants would no longer be permitted to monitor an intubated patient during anesthesia and recovery) our ability to provide surgical and dental procedures will be dramatically diminished. There are nowhere near enough LVTs available in the state of Virginia to enable practices to adhere to such a regulation and continue to provide the current number of anesthetic procedures. To have an LVT (or veterinarian) be required to monitor a patient until extubation prevents them from moving on to the next procedure. In a busy practice where each LVT /DVM pair is doing 6 procedures per day, this will add about 1.5-2 hours per day of unproductive time while the LVT waits for the patient to be extubated. This has a negative impact on the economic health of the practice, as well as the ability of the practice to provide the care our patients need. In addition, requiring the LVT that is performing a dental procedure to also be doing the anesthetic monitoring simultaneous would dramatically reduce the standard of care that we currently have and compromise patient safety. To change from our current structure, where the patients are continuously monitored throughout their anesthetic procedure (including temperature, blood pressure, oxygen saturation, ECG and capnograph) to a situation where the technician who is focused on the dental prophy or the veterinarian who is actively doing surgery has to also be monitoring, is a terrible idea that will lead to increased anesthetic risk for the patients. The answer is not and can not be "Hire more LVTs" - since there very few LVTs out there to hire. Until the situation of the LVT shortage is corrected, the best solution is to mandate that every antesthetized patient is monitored by a trained veterinary assistant, that has completed a a specified, regulated anesthetic training program.

I vigorously oppose this provision that would mandate only licensed personnel can monitor intubated patients.

Commenter: Shannon Talbott, DVM VCA Alexandria Animal Hospital * 1/24/17 11:05 am

Comments on proposed regulatory change

Dear Board Members,

I am a veterinarian who has practiced small animal medicine for 15 years, all in the state of Virginia. Please consider the following comments regarding proposed changes to Article 18VAC150-20-172, Delegation of Duties, of the Virginia Register of Regulations, Volume 33, Issue 9, pages 952-953:

B. Injections involving ~~anesthetic or~~ chemotherapy drugs, subgingival scaling, or the placement of intravenous catheters shall not be delegated to an assistant. An assistant shall also not be delegated the induction of sedation or anesthesia by any means. The monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided the patient is no longer intubated and provided a veterinarian or licensed veterinary technician remains on premises until the patient is fully recovered.

The new provision in the above regulation that specifically prohibits a veterinarian from delegating anesthetic monitoring of an intubated patient to an unlicensed, trained assistant concerns me.

The proposed regulatory change, intended to protect patients and promote the LVT profession, will instead have negative consequences on the quality, availability, and cost of veterinary care in Virginia, due to the severe shortage of LVTs in the state.

Other solutions can still protect veterinary patients. Detailed training for anesthetic assistants could be developed, and demonstrated by practices, or a standardized curriculum developed by

the Board or professional organization such as AAHA. Prior to veterinary school, while working as a technician assistant, I received extremely thorough training in anesthetic monitoring, always under the supervision of an LVT and veterinarian. During anesthetic rotations in veterinary school, I found that the training I received as an assistant was more complete than that of certain classmates who had worked as LVTs. A rigorous training program would allow unlicensed technician assistants to responsibly monitor intubated anesthetized patients under appropriate supervision of Licensed Veterinarians or LVTs.

Thank you for taking the time to review and consider the above comments.

Respectfully,

Shannon Talbott, DVM

VA License # 0301200547

Associate Veterinarian, VCA-Alexandria Animal Hospital

2660 Duke Street

Alexandria, VA 22306

703-751-2022

Commenter: Pender Veterinary Centre *

1/24/17 7:20 pm

Regulations Governing the Practice of Veterinary medicine (18 VAC 150-20)

The new provision in the above listed regulation that specifically prohibits a veterinarian from delegating anesthetic monitoring of an intubated patient to an unlicensed, trained assistant concerns me. The proposed change will have a negative consequences on the quality, availability and cost of veterinary car in Virginia, due to gthe severe shortage of LVTs in the state. The LVT program does not grandfather in some very experienced and well trained veterinary nurses working in many and our practice.

Respectifully

Rachel C Coligan, DVM

Commenter: Sarah McKinney *

1/27/17 12:22 am

Delegation of monitoring intubated patients to LVTs

As a concerned member of the veterinary community I am writing in regards to the proposed changes to Article 18VAC150-20-172, Delegation of Duties, of the Virginia Register of Regulations, Volume 33, Issue 9, pages 952-953:

B. Injections involving anesthetic or chemotherapy drugs, subgingival scaling, or the placement of ***intravenous catheters shall not be delegated to an assistant.*** *An assistant shall also not be delegated the induction of sedation or anesthesia by any means. The monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided the patient is no longer intubated and provided a veterinarian or licensed veterinary technician remains on premises until the patient is fully recovered.*

As an LVT working in a busy GP/ER facility my concerns are mainly with the impact on the level of care that I and my fellow technicians will be able to provide to our patients if the board decides to pass this proposal. While there will also undoubtedly be resulting economic effects, my current focus lies in the ability to continue providing the highest standards of care for the patients in our hospitals.

Delegating anesthetic monitoring of intubated patients solely to a veterinarian or licensed technician will place additional levels of burden on teams that are already stretched thin by the lack of available LVT's. The most current statistics indicate that in Virginia there are 0.48 licensed technicians for every veterinarian, not taking into consideration the uneven distribution between urban and rural practices. Given the high rate of burnout resulting in a large number of graduates leaving the field less than 5 years after graduating, the veterinary community is going to be hard pressed to employ enough staff to abide by regulations.

Following the institution of this new regulation there are a few different possible options that

practices will be forced to employ. Hospitals that perform more than one procedure at a time are likely to end up having a single technician monitoring all the patients, or technicians that are required to simultaneously monitor anesthesia while performing dentals. Veterinarians may also be forced to monitor their patient during surgeries which puts patients at risk as one person cannot properly concentrate on both tasks. These solutions all carry higher levels of risk than having a trained assistant monitor each patient individually.

Other hospitals may choose to avoid intubating patients at all and move towards injectable anesthesia in order to comply with the law and utilize their available staff. As an industry, we have spent years educating clients on why proper anesthetic management is a benefit to their pets, only to see the potential for this to slow as practices are being forced to choose whether they break the law to provide proper anesthesia or provide substandard care that could result in increased patient risk.

While I appreciate the effort to emphasize the importance of licensed staff in practices, with a state-wide shortage of technicians I do not see this proposal resulting in the outcome that the board expects. Instead I truly believe it will result in a decline in patient safety and care, and may further result in more LVTs abandoning their careers as more responsibility is placed on their shoulders.

In my experience, there are assistants currently monitoring anesthesia in private practices that are highly trained and I ask the board to consider allowing those who have proven their competency through testing or training programs to continue monitoring intubated patients.

Thank you for your consideration,

Sarah McKinney

Commenter: Heather Jenkins, DVM, CVA Healing Springs Animal Hospital * 1/28/17 6:56 pm

18VAC150-20-172. Delegation of duties

I am against the proposed changes to put further limitations on veterinary assistants. I have had 4 licensed vet tech employed in my 18 years at this clinic. They are difficult to recruit to Southwest Virginia and they don't want to stay. The last Vet Tech I employed started as an assistant. I paid for her to do online Vet tech training. As soon as her contract to pay back her education expired, she moved on. (She is now an RN). My current two assistants have a combined experience of 37 years in this hospital. Neither want to move forward with their education and go to an on-line or brick and mortar tech program. These two assistants have been trained and worked under 4 vet techs. They have been trained to work the mechanical ventilator and the Surgivet monitoring equipment by the respective manufacturers. They are well versed with the workings of the anesthetic equipment. They have attended CE classes sporadically throughout their tenure here. They are competent and always under supervision.

Our day consists of one doctor doing surgery and the other doctor doing appointments. There is never an incident where our assistants are unsupervised monitoring anesthesia. There is always a doctor present. On days when there is only one doctor working, we do not do surgery.

We are located in Galax, VA. The southwestern tip of the state. We have a poor rural demographic. The financial hardship of paying for vet care is a never ending challenge in this area. Forcing my clinic to recruit a veterinary technician to my area will be impossible and expensive. There are not enough vet technician's in the state of Virginia to recruit one to SW VA.

I am willing to invest in my assistants. I can send my assistants to a certification class on anesthesia, if the board of Vet medicine and VMRCVM wants to create one. I encourage my assistants to attend continuing education classes yearly to further their knowledge. They periodically take advantage of the benefit. I can change my policy and make it a requirement of their employment. I would be happy to forward their continuing education opportunities to the board. Logistically for us in South west Va finding and keeping a LVT will be difficult. To comply with the new ruling, we will be unable to offer surgery or increase the cost substantially since two doctors will have to be involved in the surgery. This ruling puts an unnecessary financial burden on my clients with no compensatory gain.

Please consider not implementing this new ruling. Thank you for your consideration.

Heather Jenkins, DVM, CVA

Commenter: Stacy M Riddle, DVM * 1/31/17 7:56 am

delegation of duties

I am writing to express my concern with the proposed changes regarding the delegation of duties to veterinary assistants. I want to echo what other veterinarians have said. By limiting the staff

that are capable of administering and monitoring anesthesia, it will severely limit our ability to give quality care to patients in a timely manner.

Delegating anesthetic monitoring of intubated patients solely to a veterinarian or licensed technician will place additional levels of burden on teams that are already stretched thin by the lack of available LVT's. The most current statistics indicate that in Virginia there are 0.48 licensed technicians for every veterinarian, not taking into consideration the uneven distribution between urban and rural practices. Given the high rate of burnout resulting in a large number of graduates leaving the field less than 5 years after graduating, the veterinary community is going to be hard pressed to employ enough staff to abide by regulations.

Please reconsider the change to these regulations.

Commenter: Len Rice *

1/31/17 4:35 pm

http://townhall.virginia.gov/L/viewcomments.cfm?commentid=56000

I am concerned that the proposed regulatory language unreasonably limits the use of experienced assistants under the direct supervision of a veterinarian. It will also increase costs for clients especially for those who provide low cost spay and neuter services for shelters and rescue groups since often lvts are not available to service these procedures or the cost of providing them would limit access to these services for lower income individuals. The summary in the town hall language is also inaccurate and does not truly reflect the proposed language. I would suggest language which supports the use of assistants to help monitor patients under the supervision of a licensed individual. This recognizes the role of lvts but maintains the ability of veterinarians to provide cost effective and timely services. It also discourages the use of less than ideal anesthetic techniques (injectable only) to meet regulatory guidelines by veterinarians who are unable to hire adequate numbers of lvts.

Commenter: Dr. Jason Bollenbeck *

1/31/17 5:16 pm

18VAC150-20-172, Delegation of duties

I am commenting on proposed regulation change 18VAC150-20-172, Delegation of duties. My specific concern is with section B, second sentence. "An assistant shall also not be delegated the induction of sedation or anesthesia by any means. The monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided the patient is no longer intubated and provided a veterinarian or licensed veterinary technician remains on premises until the patient is fully recovered". My concern is the burden on both the veterinarian and the pet owner requiring all intubated animals to be monitored only by licensed individuals. Currently, there are not enough available licensed technicians in the state of Virginia, especially in rural areas, to accommodate this proposed change. Also, the increased staff costs would increase the cost of care making veterinary medicine unaffordable for many Virginians. Most Veterinarians in the Common Wealth want to provide the best care possible and would agree that unlicensed individuals should not be making medical decisions. But unlicensed assistants monitoring patients under the supervision of licensed DVMs and LVTs is different and necessary for many practices to be able to provide surgical/dental care to their patients. I think the regulation should read something like "An assistant shall also not be delegated the induction of sedation or anesthesia. A sedated or anesthetized patient may be monitored by an assistant under the direct supervision of a licensed veterinarian or licensed veterinary technician and a licensed individual must remain on premises until the patient is fully recovered".

Commenter: Dr. Joe May *

2/1/17 4:19 pm

Comments to Proposed Changes

February 1, 2017

Dear Board of Veterinary Medicine Members,

My name is Dr. Joseph A. May and as most of you know, I just finished serving eight years on the Board of Veterinary Medicine. I have concerns about the following changes to the regulations concerning the practice of Veterinary Medicine posted on the Town Hall Web Site.

5. Advertising in a manner ~~which~~ that is false, deceptive, or misleading or ~~which~~ that makes subjective claims of superiority

Suggest rewriting to make it flow better:

5. Advertising in a manner that is false, deceptive, misleading, or makes subjective claims of superiority

B. Injections involving ~~anesthetic or~~ chemotherapy drugs, subgingival scaling, or the placement of intravenous catheters shall not be delegated to an assistant. An assistant shall also not be delegated the induction of sedation or anesthesia by any means. The monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided the patient is no longer intubated and provided a veterinarian or licensed veterinary technician remains on premises until the patient is fully recovered.

This proposal has caused a great deal of angst among Veterinarians especially in rural practices. It basically prohibits an assistant from monitoring or recovering an anesthetized patient. I have been told that the words "provided the patient is no longer intubated and" was accidently added from wording from a previous document that the Board approved and will be deleted. I do remember the wording above without the added words but do not ever remember ever seeing a document with the added words in it. It is possible that it came from a committee to study revisions but to my knowledge, it was never discussed by the full board or approved. I along with several other board members would never approve of such a proposal as it would create a severe hardship on many practitioners. There seems to be a push by some in the Veterinary community to restrict more things routinely done successfully for years by assistants trained within the hospital to licensed personnel only. To me, this is extremely short sighted and creates an extreme hardship on many practitioners. Currently there is only one licensed LVT for every four practitioners and many rural practices can simply not attract LVTs to come to their area and work in the practice. The Licensed DVM remains responsible for the safety of the patient regardless of who is helping with that patient and regulations should not restrict his ability to use his professional judgement. In addition, regulations such as this also hampers the ability of an LVT to train and delegate staff they are supervising so they can use the skills they were trained for to take over tasks typically done by the DVM to improve overall patient care. They are highly trained and should not be regulated into doing tasks that others can be easily trained to do. Instead of passing regulations to restrict assistants, we should take a cue from our human counterparts and allow LVTs to use their skills and play a greater part in patient care similar to the way Nurse Practitioners assist MDs.

~~B. Additional~~ C. The following tasks ~~that~~ may be delegated by a licensed veterinarian to a properly trained assistant ~~include but are not limited to the following~~:

1. Grooming;
2. Feeding;
3. Cleaning;
4. Restraining;
5. Assisting in radiology;
6. Setting up diagnostic tests;
7. ~~Prepping for surgery~~ Clipping and scrubbing in preparation for surgery;
8. Dental polishing and scaling of teeth above the gum line (supragingival);
9. Drawing blood samples; or
10. Filling of Schedule VI prescriptions under the direction of a veterinarian licensed in Virginia.

In the proposal above, I feel the words "include but are not limited to the following" needs to remain in the regulation and not be deleted. By removing it, it restricts assistants to doing ONLY those tasks listed. There are many more tasks not listed that a trained assistant can safely do and as mentioned previously, the Licensed DVM remains responsible whenever a task is delegated. Again, rural practitioners often do not have the opportunity to have an abundance of LVTs in their practice and must rely on trained assistants to lend a helping hand. If you notice "assist with surgery" is not listed above so with a strict interpretation of the regulation, it would prohibit a trained assistant from donning a pair of sterile gloves and helping with a difficult abdominal surgery which could actually lead to the animal dying on the table. I see no reason to change this wording and I actually made a motion to leave it when it was discussed by the board but my motion failed for a lack of a second. I hope the board will reconsider.

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I would also suggest replacing "Clipping and scrubbing in preparation for surgery" **with "assisting in surgery" to be more comprehensive.**

3. Whenever the establishment is closed, all general and working stock of Schedule II through V drugs and any dispensed prescriptions that were not delivered during normal business hours shall be securely stored as required for the general stock.

4. Prescriptions that have been dispensed and prepared for delivery shall be maintained under lock or in an area that is not readily accessible to the public and may be delivered to an owner by an unlicensed person, as designated by the veterinarian.

While the two proposals above are designed to help prevent diversion of drugs meant for our patients, I am concerned that it would also limit the opportunity of assistants or kennel personnel to administer prescribed controlled drugs such as phenobarbital to boarders when a DVM or LVT is not on the premises. It is a common practice for these folks to treat animals in the hospital when they come in to feed and clean on weekends or after hours and provisions need to be made to allow this.

A. Agricultural or equine ambulatory practice. An agricultural or equine ambulatory establishment is a mobile practice in which health care is performed at the location of the animal. Surgery on large animals may be performed as part of an agricultural or equine ambulatory practice provided the establishment has surgical supplies, instruments, and equipment commensurate with the kind of surgical procedures performed. All agricultural or equine ambulatory establishments shall meet the requirements of a stationary establishment for laboratory, radiology, and minimum equipment, with the exception of equipment for assisted ventilation.

B. House call or proceduralist establishment. A house call or proceduralist establishment is an ambulatory practice in which health care of small animals is performed at the residence of the owner of the small animal or another establishment registered by the board. A veterinarian who has established a veterinarian-owner-patient relationship with an animal at the owner's residence or at another registered veterinary establishment may also provide care for that animal at the location of the patient.

1. Surgery may be performed only in a surgical suite at a registered establishment that has passed inspection.

In the proposed regulations above concerning House Call Practices, there is no provision to attend an animal at a place other than "the owner's home or an establishment registered by the Board". Practitioners need to be able to see a patient at a boarding kennel or wherever it is located and the wording should be more like those concerning Ambulatory practice above. It should also not restrict them to only see patients they have seen before and already have a veterinary-owner-patient relationship. I would suggest clarifying the first sentence to include all locations and delete the second sentence. I do not think the Board is intentionally restricting this but likely has just not thought of the consequences.

The proposal above concerning the restriction on Surgery really needs to be eliminated or modified as well. "Surgery" is a term that can encompass many procedures from lancing an abscess or suturing a small wound under a local to thoracic surgery requiring specialized equipment and numerous personnel. As written above, it prevents a house call practitioner from doing any minor surgical procedures that could easily and safely do in the field. These include lancing of abscesses, draining seromas, or removing small bumps and suturing small wounds under local anesthesia. Again, the practitioner is ultimately responsible for all decisions concerning patient care and he should be allowed to use his professional judgement on how best to treat his patients after discussing it with the owner. I would suggest either eliminating the wording above or modifying it so that it only pertained to surgeries that require general anesthesia.

While I am on the subject of surgery, there are other regulations that restrict surgical procedures to be performed in a room specifically set up for surgery and others that prohibit certain equipment from being in the room. I agree completely that any hospital performing surgery should have a room set up for it but there needs to be a common sense approach to the regulations. As I have said before, the practitioner is ultimately responsible for the results and he should be allowed to use his professional judgement on where and how to perform a specific surgery. There are many surgeries that should only be performed in a sterile room but there are others such as repairing contaminated or infected wounds or lancing abscesses that should not be. Advanced dental extractions are clearly surgical procedures but they should be performed in an area set up specifically for dental procedures where dental equipment and dental x-rays are readily available and not necessarily in an operating room set up for other procedures. Often, more than one type of surgery such as a neuter combined with a dental extraction and teeth cleaning are performed on a single patient. It makes perfect sense to do both procedures at a single location rather than extending anesthesia to move the patient between two locations in the hospital.

I respectfully ask that the Board review regulations and modify them as needed with these points in mind. It is far better to allow the practitioner to use his best judgement than to create restrictive regulations that are not based on common sense.

Thank you for the opportunity to express my opinions and I hope the Board will find it helpful.

Joseph A. May, DVM

Collinsville, Virginia

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Thank you for the opportunity to express my opinions and I hope the Board will find it helpful.

Joseph A. May, DVM

Collinsville, Virginia

Commenter: Stephanie Cooley * 2/2/17 8:45 am

18VAC150-20-172-Delegation of Duties

I am opposed to the proposed changes to put further limitations on veterinary assistants. Currently, there are not enough available licensed technicians in the state of Virginia, especially in rural areas to accommodate this proposed change. I have worked at King's Mountain Animal Clinic for 28 years and we have had only a few of LVT's work for us in that period, they are hard to recruit to come and stay in our area. Also, the increased staff costs would increase the cost of care making veterinary medicine unaffordable for many Virginians, especially in rural areas!

Commenter: Dr. Drew Luce, Dulles South Veterinary Center * 2/2/17 11:52 am

Proposed change in regulation

I feel it is unrealistic to only have LVT's monitor anesthesia. How many LVT's are there in Virginia vs how many are needed? We have had a shortage of LVT's in Virginia as long as I can remember and in our neighboring state of Md, one does not have to be liscensed to even perform these duties. That being said, I believe standard of care would dictate that only a liscensed LVT or DVM should be inducing and should always be on hand during anesthetic episodes. Veterinary Assistants commonly play a role in helping to monitor patients as well as receiving valuable training in this area. Is it safer to have an LVT performing a dental and trying to monitor anesthesia by themselves or to have an assistant monitoring and recording and conveying information to either an LVT or a DVM? I feel closer attention is payed to the patient when multiple people are involved. I would propose the Board does not limit the ability of practices to utilize this important part of staffing.

Commenter: Stuart Morse, DVM, Occoquan Animal Hospital * 2/2/17 4:21 pm

Requirement to disallow assistants monitoring anesthetized patients

I feel this provision would severely restrict our ability to provide necessary surgical services as licensed techs are in short supply and hard to find. Many assistants are well trained and have been at their jobs for years. While we as the veterinarian are ultimately responsible for the patient, having an assistant to monitor allows us to concentrate more on the surgery while still being present should any anesthetic problems arise. Whil monitoring equipment is helpful and important those machines malfunction more often than attending assistants. I believe we provide better service to our clients and patients when we can have trained assistants helping us with anesthesia and patient care before during and after surgery/anesthesia.

Commenter: Dr. Lauren Kloer, Leesburg Veterinary Hospital * 2/2/17 5:01 pm

Proposed changes to veterinary regulations

I am writing to oppose the proposed wording of the veterinary regulation listed below in italics. While I understand the reasoning behind this proposal, implementation is impractical and at times may actually be detrimental to a patient (in times during an emergency when anesthesia is needed and an LVT is not available). I feel the regulation should read: "When possible, a licensed technician should intubate and monitor anesthesia (unless a veterinarian chooses to do so themselves). If an LVT/RVT/CVT are unavailable, a veterinarian should directly oversee (or directly perform when needed) intubation and the monitoring of anesthesia. In cases where a licensed technician is not available, it is very important for a veterinarian to be present during the entire anesthesia process." - Dr Lauren Kloer

> B. Injections involving anesthetic or chemotherapy drugs, subgingival scaling, or the placement of intravenous catheters shall not be delegated to an assistant. An assistant shall also not be delegated the induction of

sedation or anesthesia by any means. The monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided the patient is no longer intubated and provided a veterinarian or licensed veterinary technician remains on premises until the patient is fully recovered."

Commenter: Lesley Esposito, Acredale Animal Hospital *

2/2/17 8:00 pm

Proposed changes

As someone who spent the time and effort to go to tech school I am often comflicted when I see the line between tech and assistant blurred. This is one of those occasions. I read all of the comments and completely understand the problem, with the shortage of techs. I do agree assistants can be trained to do basic anesthetic monitoring though I wish it did not have to be this way. Would you prefer I liscnsed nurse monitor you if you had surgery or just a nurse assistant? But again I understand the shortage resulting in an unfortunate situation. So I agree we should allow only trusted assistants with this task however I would never allow an assistant to induce anesthesia or intubate an animal. Here in Virginia beach we are in the process of developing a tech program locally, I know it won't help in the rural areas much. Hopefully as the profession grows I hope we can find more ways to keep people in the profession longer through better pay, more education opportunities and overall better job satisfaction.

Commenter: Sandra Tall, Seven Hills Animal Hospital *

2/2/17 10:10 pm

Proposed changes

I am writing to oppose the changes in the following paragraph: Injections involving ~~anesthetic or~~ chemotherapy drugs, subgingival scaling, or the placement of intravenous catheters shall not be delegated to an assistant. An assistant shall also not be delegated the induction of sedation or anesthesia by any means. The monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided the patient is no longer intubated and provided a veterinarian or licensed veterinary technician remains on premises until the patient is fully recovered.

It is unrealistic to think all veterinary practices in VA have enough LVT's on staff to have one on the premises at all times. While routine surgeries might be scheduled when a LVT is scheduled to work, emergencies arise at all possible times. Assistants need to be allowed to monitor anesthesia with a veterinarian present in the room. Ultimately the veterinarian is responsible for the anesthesia, but assistants can be adequately trained to monitor anesthesia under direct supervision. Does the board really want to prevent a veterinarian from doing a necessary procedure requiring anesthesia because a LVT is not available? This is compleltey impractical.

Commenter: Les Mulligan, DVM- Peaks View Animal Hospital *

2/5/17 11:08 am

Proposed Changes

I am writing to oppose the changes in the following paragraph: Injections involving ~~anesthetic or~~ chemotherapy drugs, subgingival scaling, or the placement of intravenous catheters shall not be delegated to an assistant. An assistant shall also not be delegated the induction of sedation or anesthesia by any means. The monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided the patient is no longer intubated and provided a veterinarian or licensed veterinary technician remains on premises until the patient is fully recovered.

This change would be impossible to implement in many practices due to the limited number of LVT's in Virginia. In practices with numerous LVT's the regulation would dramatically increase surgical costs to the owner. More importantly the burden of safe anesthetic procedures should remain under the control of the veterinarian. An appropriately trained assistant is capable of monitoring an anesthetized patient throughout a surgical procedure.

Commenter: Lee Henkel *

2/5/17 5:31 pm

Consider a Slight Revision

I was present at the Legislative and Regulatory Committee where the change regarding monitoring of sedated and anesthetized patients was discussed and approved. As I remember it, the discussion was not about what happens during surgery, when licensed staff are present. The

change was proposed in response to complaints regarding deaths which occurred when patients that had not fully recovered from anesthesia were left in the care of an unlicensed individual when the licensed staff left for the day. Perhaps the concerns of the previous commenters could be resolved by rephrasing the section in question to read "*The **postoperative** monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided the patient is no longer intubated and provided a veterinarian or licensed veterinary technician remains on premises until the patient is fully recovered.*"

Commenter: Katy Wilson, DVM * 2/6/17 9:03 am

Proposed change in assistant guidelines

To Whom It May Concern,

The proposed changes would cause increased economic hardship to the veterinary community by mandating LVT to perform all duties when it comes to anesthesia. Properly trained nursing assistants under the direct supervision of a licensed veterinarian allows many clinics to employ more staff and frees more LVTs to perform more important duties and have more supervision over nursing staff. Veterinary practices throughout the state would have a difficult time replacing all their nursing staff with LVT.

Thank you for your consideration,

Katy Wilson, DVM

Commenter: Jeremy Dubin, DVM - USDA-Food Safety Inspection Service * 2/7/17 11:10 am

Proposed regulations

As a concerned Virginia veterinarian, who has spent over a decade involved in private clinical practice both as an assistant and a veterinarian, I wish to add my name to the list of my colleagues requesting the Board reconsider the wording and implementation of the underlined passage in the proposed regulation:

18VAC150-20-172. Delegation of duties.

B. Injections involving anesthetic or chemotherapy drugs, subgingival scaling, or the placement of intravenous catheters shall not be delegated to an assistant. An assistant shall also not be delegated the induction of sedation or anesthesia by any means. The monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided the patient is no longer intubated and provided a veterinarian or licensed veterinary technician remains on premises until the patient is fully recovered.

As has been amply researched and argued by my colleagues, the supply of Licensed Veterinary Technicians (LVTs) in Virginia is currently woefully inadequate to implement the policy as worded, without having a severe deleterious effect on patient care and the economics of practice. I can testify firsthand that assistants properly trained in the monitoring of patients under anesthesia (in this case, specifically referring to intubated patients) only enhance efficiency and quality of care. This is of vital importance in large, busy practices in urban/suburban areas, and can be absolutely essential for practices in rural areas or underserved communities, where LVTs can be few and far between. Again, as my colleagues have pointed out, to deny practitioners this option would be to unnecessarily divide the attention of veterinarians and licensed technicians away from the immediate care of individual patients, and take away their flexibility to intervene with other patients when required.

Furthermore, implementing this policy now would necessarily require practices to make economic decisions about cutting back on the number of patients served, while simultaneously causing them to cut back on the quality of care provided to avoid being in non-compliance with the proposed rule (the classic example would be using more general anesthesia without intubation). It seems to me responsible governance would be about promoting both the economic growth of the industry and the value of high-quality care to the public it serves.

Nothing we are counter-proposing is intended to somehow absolve veterinarians and licensed technicians of ensuring the well-being of their patients under general anesthesia. In fact, we know from experience that well-trained anesthetic assistants only make the quality of medicine and surgery provided better. We are only stating that, while we appreciate the Board's intent to recognize the value of LVTs, we find the proposed rule incredibly impractical at this time, given the shortage of licensed technicians and relatively high burn-out rate.

We would suggest amending the proposed rule to read: "...The monitoring of a sedated or anesthetized patient may be delegated to an assistant, ~~provided the patient is no longer intubated and~~ provided a veterinarian or licensed veterinary technician remains on premises until the patient

is fully recovered...."

While I am no longer in private practice, I feel I have plenty of expertise to offer in this argument, and it is a matter near and dear to my heart. Thank you very much for your consideration.

Jeremy Dubin, DVM

Supervisory Public Health Veterinarian

USDA-Food Safety Inspection Service (Landover, MD Circuit)

Commenter: Dr. Sheryl H. Carls, Owner/VIC @ Lexington Animal Hospital * 2/8/17 1:31 pm

Proposed changes to anesthetic monitoring w

As I read the comments made by my colleagues on the proposed changes to anesthetic monitoring, I would like to make comment on **their** thoughts by just saying 'DITTO'! However, I think Dr. Dubin covers *all* the relevant information on this subject, ***and,*** Lee Henkel makes a brilliant statement on a slight change in the wording of the regulation.

Everyone knows it is impossible, in rural Virginia, to have the recommended 'three LVTs for each Veterinarian'. And, even if it were possible to draw LVTs to rural areas, ***and,*** then, **keep** them, it would/could be cost prohibitive. This, in turn, would result in increased costs to the public and, ultimately, **reduce** the medical care many of our clients provide to their pets.

The Regulatory Board needs to remember that the Veterinarian is ultimately responsible for the care of the patient. And, if that Vet has *properly* trained an assistant in the care and monitoring of an anesthetized patient, the risks to the patient should be ***minimal,*** while a Vet is readily available. That is--'on the premises'. It seems that this would maintain and provide 'the standard of care', and would not blur the line of who is ultimately responsible.

Thank you for your time.

Dr. Sheryl Carls

Commenter: Medical Management International, Inc. (dba Banfield Pet Hospital) * 2/9/17 5:29 pm

Re: Proposed changes to 18 VAC 150-20-172

February 7, 2017

Dear Virginia Board of Veterinary Medicine,

I am writing to urge that the Board reconsider implementing the proposed changes to 18 VAC 150-20-172 as currently written. Specifically, I am concerned that limiting anesthesia monitoring of intubated animals to DVMs and LVTs will have the unintended effect of reducing the overall quality of veterinary care in Virginia.

As other commenters have pointed out, Virginia, like many other states, has a shortage of LVTs. Despite our concerted efforts to recruit LVTs, including a tuition reimbursement program, Banfield's ratio of LVTs to DVMs is approximately 1:12. Banfield currently employs 118 DVMs in the state of Virginia and only 16 LVTs. In contrast, Banfield Hospitals employ 291 veterinary assistants in Virginia. In those hospitals which do not currently have an LVT, the proposed changes would drastically limit that hospital's ability to perform surgery and pose an unacceptable compromise to patient care by forcing the DVM to simultaneously perform surgery and monitor anesthesia.

All veterinary assistants at Banfield undergo rigorous training, including training in anesthesia monitoring. Further, all veterinary assistants who assist with anesthesia monitoring at Banfield do so under the direct supervision of an LVT or DVM. Prohibiting veterinary assistants from performing a task which they have been performing safely for years under LVT and DVM supervision is unnecessary and will adversely impact the quality of veterinary care in Virginia. On behalf of Banfield and the veterinary industry I implore the Board to reconsider the proposed changes to 18 VAC 150-20-172.

Sincerely,

Daniel Aja, DVM

Chief Medical Officer

Banfield Pet Hospital

18101 SE 6th Way

Vancouver, Washington 98683

www.banfield.com

Commenter: Molly Mittens Mom * 2/18/17 11:58 am

These regulations are irrelevant and will not protect our pets

There regulations are completely missing the point.

It does not matter who is monitoring the animal, what matters is that they have the critical thinking skills to understand if the animal is having a problem following anesthesia.

And that VA needs to establish a reasonable standard of care for vets that will protect our pets.

Take Molly Mittens case

Molly had a routine spay procedure with anesthesia and her surgery ended at approx. 1130 AM

At 1:30 PM, I was told the surgery went fine and Molly was waking up well

At 4:40 PM, a licenses that lacked any critical thinking ability notes Molly is unresponsive. This vet does nothing. She does not call the owner to report the change, she does not assess Molly or do any vital signs or notify a vet with some intelligence. Instead, she turns off the lights and leaves a sweet innocent 6 month old kitten alone in the dark. I was never notified or given the opportunity to transfer Molly to a 24 hour vet. It gets worse.

At 9 PM, a tech checks on Molly and notes she is unresponsive. Again the tech does nothing. No call to me, no call to a vet. The tech again leaves Molly alone in the dark.

In the morning, MOLLY IS FOUND DEAD. Then i get all kinds of phone calls, work, home and cell. Too little, too late to save Molly.

Now to add insult to injury. I filed a complaint with this Board. And the Board which has the mandate to ensure vets follow a reasonable standard of care, finds this lack of care to be completely appropriate. The vet and tech did nothing wrong. It is Molly's fault that she is having a reaction to the anesthesia. Of course, that was why she was at the vets so that they could assess her for any problems post anesthesia and then TREAT HER. How do you blame a kitten for her own death, when the vets failed to do anything for her and try to find out what was wrong or at least do a set of vital signs or check her oxygen levels. Maybe consider reintubation until she is more awake. Maybe give a reversal agent. Those are the kinds of efforts that I as an RN would make if my human patient was not waking up well after surgery. If I failed to take those actions, I would be negligent.

So the problem is not who monitors the animal, the problem is that this Board has set the care in Molly's case as ACCEPTABLE veterinary care in VA. There was no wrongdoing. It is fine to leave a kitten that you have documented twice is non responsive after anesthesia all alone to die and not even call the owner until the kitten is dead.

If the board does not hold vets to a higher standard than this, it is completely irrelevant as to who monitors the pet. Bring the janitor in or the groundskeepers, they would have done better than Kristen P, licensed vet in VA. Practicing in Front Royal.

If anyone doubts the above facts, please email me at MollyMittens7@gmail.com. I will be happy to share poor Molly's records and this board's lack of accountability, in my opinion.

Respectfully submitted,

Molly Mittens' Mom, RN, JD

Commenter: Jane Currie Kaye, DVM * 2/21/17 8:36 am

Limiting monitoring duties to LVT only does not serve patients well

I feel that veterinary assistants are an essential part of the team that cares for anesthetized patients in veterinary medicine. They act as another set of eyes while the LVT or DVM is performing the procedure, and allow the LVT or DVM to focus fully on the procedure, resulting in better outome and shorter anesthesia times to the obvious benefit of the patient. These assistants will also gain experience at the side of the licensed personel, so that they gain ability and also inspiration to want to further their own education. When supervised by licensed staff, I feel assitants should be able to monitor anesthesia, and place IV catheters.

Commenter: Hillary Rader, DVM; King's Mountain Animal Clinic * 2/21/17 11:54 am

18VAC150-20-172 Delegation of duties

I am writing in response to '18VAC150-20-172. Delegation of duties' proposed changes on the Virginia Regulatory Town Hall website.

B. Injections involving ~~anesthetic or~~ chemotherapy drugs, subgingival scaling, or the placement of intravenous catheters shall not be delegated to an assistant. An assistant shall also not be delegated the induction of sedation or anesthesia by any means. The monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided the patient is no longer intubated and provided a veterinarian or licensed veterinary technician remains on premises until the patient is fully recovered.

- I do not think that the word anesthetic should be taken out as I do think only LVTs or veterinarians should be giving anesthetic injections. However, assistants should be able to monitor patients that are sedated/anesthetized even if they are still intubated. Not every facility has enough LVTs on hand to monitor each sedated patient that is intubated. By limiting this job to only licensed personnel, then will have to find more LVTs which is hard to do in rural Virginia. The delegation of monitoring sedated/anesthetized patients that are intubated should be given by the veterinarian to either an LVT or assistant that has adequate training to safely monitor an intubated patient.

C. The following tasks ~~that~~ may be delegated by a licensed veterinarian to a properly trained assistant ~~include but are not limited to the following~~:

1. Grooming;

2. Feeding;

3. Cleaning;

4. Restraining;

5. Assisting in radiology;

6. Setting up diagnostic tests;

7. ~~Prepping for surgery~~ Clipping and scrubbing in preparation for surgery;

8. Dental polishing and scaling of teeth above the gum line (supragingival);

9. Drawing blood samples; or

10. Filling of Schedule VI prescriptions under the direction of a veterinarian licensed in Virginia.

- The phrase 'include but are not limited to the following' should not be removed from the regulations as assistants are trained to do several other tasks and have both the talent and ability to do more than what is listed above. With removal of the phrase, it makes it seem like assistants will *only* be able to do 1-10 on the list and nothing more.

Sincerely,

Hillary Rader, DVM

King's Mountain Animal Clinic - Collinsville, VA

Commenter: Melanie Casey Crovo, DVM Furry Friends Veterinary Clinic * 2/22/17 10:46 am

regulation changes/ closing of a veterinary clinic medical record access/ patient monitoring

In the past couple of years, the Roanoke Valley has had three(one has since reopened) veterinary clinics close. In each of those cases, it has been difficult to impossible for clients and other veterinary clinics to obtain the patients' complete medical records After reading current regulations, it appears that a closing clinic is only required to notify clients if they sell or transfer all of the records to another facility. If they just close, they are not required to notify clients or transfer records.

In the past, this may not have been an issue as veterinary clinics rarely closed and patient records may have been limited to annual exams and vaccines. However, times have changed and economic situations have led to sudden closure of several clinics in our area alone. I am sure this situation is not limited to the Roanoke Valley. In addition, modern medicine and changing relationships with our pets have led medical records to be more complex. Most records include expensive lab tests and advanced diagnostics. Our patients and clients deserve to have access to these records.

As we are modifying the current regulations, I would like us to develop a protocol for hospitals to follow that would better facilitate access to complete (not just vaccine) medical records for patients when a client closes but does not sell records to another entity.

In addition, I would like to concur with the numerous other comments regarding delegating monitoring anesthesia to a trained unlicensed assistant. I believe that a trained unlicensed assistant should be able to monitor an ANESTHETIZED patient while under direct supervision of a veterinarian or LVT. The use of the term anesthesia vs just sedation would be an important distinction in a court of law. If needed, hospitals could submit a particular training protocol or

possibly have assistants take a class or test to prove competence.

Thank you.

Please feel free to contact me at my office 540-890-8500 if you would like more information.

Commenter: Emily Lawrence, DVM * 2/22/17 12:34 pm

Proposed changes to anesthetic monitoring

I am writing to express opposition to the terminology used and implications of changing anesthetic monitoring procedures. I do not feel that anesthetic monitoring of intubated patients should be limited to LVT's and DVM's only. Our rural area, yet busy practice, would struggle to practice in line with this type of regulation, as LVT's are very few in number and we have multiple doctors performing surgical procedures at the same time in our practice. I feel very confident in the ability of many of my assistants to adequately monitor and recover patients, and simply do not see a need for this type of regulation.

Commenter: Hiedi Orr, DVM * 2/22/17 1:15 pm

Veterinary board regulations

My name is Dr. Hiedi Orr. I have practiced veterinary medicine in the state of Virginia for sixteen years. I have concerns about the following changes in the regulations concerning the practice of veterinary medicine in Virginia. Thank you for taking the time to address my concerns. Please feel free to contact me via email at wvuproud1996@gmail.com or via phone 276-647-3714 if needed.

1) 18VAC150-20-172

B: Injections involving ~~anesthetic or~~ chemotherapy drugs, subgingival scaling, or the placement of intravenous catheters shall not be delegated to an assistant. An assistant shall also not be delegated the induction of sedation or anesthesia by any means. The monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided the patient is no longer intubated and provided the veterinarian of licensed veterinary technician remains on the premises until the patient is fully recovered.

I am opposed to assistants not being able to place intravenous catheters. If assistants were allowed to place intravenous catheters they would be trained by a LVT or veterinarian. I feel assistants being able to place IV catheters will benefit the licensed veterinary technicians and veterinarians. This will free up the licensed veterinary technicians to help in surgery if needed. My biggest reason for wanting assistants to place intravenous catheters is in case of an emergency (example : if there is only one veterinarian and that veterinarian and the LVT were working on a patient and another patient presented as an emergency and need an intravenous catheter).

I am opposed to the words "provided the patient is no longer intubated." I feel trained assistants should be able to extubate patients if directed to so by a veterinarian. We have trained assistants to perform this task when needed. As veterinarians we are the ones responsible for our patients, thus anything that occurs when they are in our care is our responsibility. We do not delegate tasks to untrained assistants or LVTs.

C. The following tasks that may be delegated by a licensed veterinarian to a properly trained assistant ~~include but are not limited to the following~~:

I am opposed to removing the words "include but are not limited to the following." By removing these words you are putting very specific limitations on what procedures can actually be performed by a trained assistant. Many veterinary clinics, including our own, do not have the luxury of employing several licensed veterinary technicians. We do, however, train our veterinary assistants so they can be of the greatest benefit to us.

Commenter: William Swecker Jr Virginia Maryland College of Veterinary Medicine * 2/23/17 5:27 pm

18VAC150-190: Requirements for drug storage, dispensing,

This comment may only apply to our facility as a teaching hospital. I request that the line

Those amendments include (i) clarification that only the veterinarian or licensed veterinary technician has access to Schedule II through V drugs; could be changed to (i) clarification that only the veterinarian, licensed veterinary technician, or **other licensed medical professionals** has access to Schedule II through V drugs; We employ licensed pharmacists and pharmacy technicians and would appreciate them having access to II through V drugs. If this is already inferred in the proposed change, then the revision is not needed.

Commenter: William Swecker Jr Virginia Maryland College of Veterinary Medicine * 2/23/17 5:49 pm

18VAC150-20-130 B 18VAC150-20-173.

In 18VAC150-20-130 B the requirement is *Prior to allowing a preceptee or extern in veterinary medicine to perform surgery on a patient unassisted by a licensed veterinarian, a licensed veterinarian shall receive written approval from the owner.* In 18VAC150-20-173. the requirement is *If a veterinary student, preceptee, or extern is to perform the surgery, the informed consent shall include that information.* These statements may appear to be in conflict as the first requires informed consent on unassisted surgeries, the second infers any surgeries. A clarification of these two statements may be helpful

Commenter: Jonathan Collins DVM, Halifax County Veterinary Center * 2/23/17 9:15 pm

Delegation of duties

As a practice owner in rural Virginia, I am very concerned about the restrictions on duties that can be delegated to an assistant. Our practice has been actively seeking a liscensed technician for several years but have yet to have one interested in moving to Halifax. By my interpretation of the proposed rules, our practice would no longer be able to offer surgical services due to a lack of availability of someone to monitor anesthesia. Furthermore, none of the 3 other practices in our county would be able to either. Our practice has enjoyed great success utilizing talented, well trained assistants to work along side our doctors. The assistants do not perform their duties without the doctor present and are trained to communicate with the doctor to provide high quality care. I feel that the intent of the new regulations is to improve patient care. However, the end result will be a lack of care provided in rural Virginia. I strongly suggest removing the proposed restrictions on veterinary assistants duties as I truly believe that it will be in the best interest of the profession as well as the patients.

Commenter: Kris Keane * 2/23/17 10:09 pm

pets and their people deserve better

Below is the corrected version of the proposed regulatory change and I am writing in support of this change. I am horrified to read other comments stating that veterinarians and technicians have more important things to do in the course of their busy day than stay on premesis when a patient is recovering from anesthesia. Seriously? We are all taught that recovery is one of the most high risk times in an anesthetic episode and clearly there have been enough cases presented to the Board to prompt this clarification. It seems like common sense, but clearly is not.

For those practitioners who are convinced that their on the job assistants are as well trained as a LVT, perhaps they would be willing to have their cleints sign a consent giving permission for someone who is not licensed/educated specifically in anesthesia monitoring & emergencies to monitor their pet throughout their anesthesia event. The board is requesting a change in current regs that would require a consent from clients when vet students and vet tech students are working on their pets, so why not include unlicensed, unregulated assistants in that as well? I expect that the pet owners of Virginia expect better than that!

Is the problem truly that there are not enough LVTs. There are many options for education for LVTs now but people are leaving the profession faster than new LVTs are entering. Perhaps it is time to stop sticking our heads in the sand and start taking the actions necessary to keep LVTs practicing for more than 4-5 years on average.

An assistant shall not be delegated the induction of sedation or anesthesia by any means. The monitoring of a sedated patient not fully recovered from anesthesia may be delegated to an assistant if a veterinarian remains on the premises.

Commenter: Kristin Wallace, L.V.T. * 2/23/17 10:43 pm

Regards to assistants and anesthesia

I stand with the lisenced technician that taught me, Kris Keane. All her hard work in teaching technicians to become the hard working individual and educated individual she is today should not go unrewarded. As a successful student of hers and a technician in practice for 9 years, if it wasn't for her knowledge that she and the other wonderful D.V.M. at BRCC, I would have not saved as many lives or educated so many people. (Specially my brachycephalic friends) I also have passed on some knowledge in help training two other lisenced technicians that graduated from BRCC and are doing incredible things. Do not allow uneducated people in anatomy to be able to place tracheal tube... as a doctor be more aware of time saving vs. patient priority. Patients should be the right choice.

Commenter: Ellen Carozza LVT * 2/23/17 10:43 pm

In agreement with Kris Keane- With comments

Below is the corrected version of the proposed regulatory change and I am writing in support of this change. I am horrified to read other comments stating that veterinarians and technicians have more important things to do in the course of their busy day than stay on premesis when a patient is recovering from anesthesia. Seriously? We are all taught that recovery is one of the most high risk times in an anesthetic episode and clearly there have been enough cases presented to the Board to prompt this clarification. It seems like common sense, but clearly is not.

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> **An assistant shall not be delegated the induction of sedation or anesthesia by any means. The monitoring of a sedated patient not fully recovered from anesthesia may be delegated to an assistant if a veterinarian remains on the premises.**
>
> **By allowing the non credentialed assistant to perform tasks by a formal trained credentialed technician simply proves that the veterinary industry does not care in the quality of medicine they want to practice. Would you allow a non licensed RN,LPN, anesthesia nurse to work on you or a family member? No, so why do it to someone's pet. Veterinary medicine is going to stay a disrespected industry with this attitude. You hold yourselves down by obtaining cheap labor because "anyone" can be trained. Sure...they sent a chimp into orbit, but it had NO clue what to do other than throwing switches. That's the same for a non credentialed tech working in a practice as a credentialed technician. Support the right personnel so our clients and patients get the quality care they deserve. If your reason is there is not enough Technicians- stop being cheap and send them to school. You only hurt yourself,the industry, the hospital and god forbid your patients in the end.**

Commenter: Dani Tyree LVT * 2/23/17 11:00 pm

Regarding assistants and anesthesia

Our patients deserve skilled, licensed technicians caring for them during all aspects of their anesthetic experience. Recovery is known to be a very dangerous time- who better to monitor them through this period than a LVT? We are fortunate to have multiple Veterinary Technology programs in the state putting out excellent graduates every year. Online programs are easily available as well. I would suggest that veterinarians start paying a competetive wage and utilizing their LVT's to their fullest extent, in order to keep them in the field longer than 4-5 years. If you have assistants that you feel are so capable, maybe you should step up and help them get through an on line program in order to get their license? There are many ways to increase the number of veterinary techincians in your practice if you really want to.

Commenter: Brittany Kestner LVT * 2/23/17 11:25 pm

No assistants in anesthesia. Period.

I support the board 100%. I can't prescribe medicine, diagnose a patient, or perform surgery as a licensed equine veterinary technician so why should an assistant NOT be limited to what they can do as well? Does my education and passed board exam mean nothing? The board is doing this for the safety of the patient and by doing so is preserving the need for LVTs. And that makes me happy. To those of you who have previously commented disagreeing with the board, SHAME ON YOU.

Commenter: Anne Norback * 2/23/17 11:32 pm

Delegation of Duties

I support the proposed delegation of duties regulation changes, for the safety of our patients and the peace of mind of our clients. If I was being admitted to a hospital for an anesthetic procedure I most certainly would not want a nursing assistant to be monitoring my anesthesia, why should our clients expect less from their veterinarian. Highly trained assistants who would like to advance their skills should consider entering a Technician program. There are plenty of quality on-site and on-line programs available in Va.

Anne Norback, LVT

Commenter: Dr. Jason Bollenbeck * 2/23/17 11:42 pm

Delegation of Duties

C. The following tasks ~~that~~ may be delegated by a licensed veterinarian to a properly trained assistant ~~include but are not limited to the following.~~

The phrase 'include but are not limited to the following' should not be removed from the regulations as assistants are trained to do several other tasks and have both the talent and ability to do more than what is listed above. With removal of the phrase, it makes it seem like assistants will *may only* be able to do 1-10 on the list and nothing more.

Commenter: Jessica Wootton, DVM * 2/24/17 9:52 am

18VAC150-20-172. Delegation of duties

I am writing in support of the proposed changes to the regulations. Prior to obtaining my DVM, I worked as one of the "talented, highly-trained assistants" in a practice in Virginia. After completing my veterinary training, I understand that using an unlicensed individual to perform tasks that should be peformed by an LVT placed our patients at risk. I was a conscientious, reliable assitant, but I did not have the proper training and licensing to perform those tasks or troubleshoot any problems that arose. I would suggest that practices currently utilitizing talented assistants to perform these duties should consider supporting those assistants in obtaining their license through an accredited veterinary technology program. Our practice has one assistant enrolled in the part time program at NVCC, and we consider this to be an investment in the future of our practice.

Commenter: Karleigh Walkosz, LVT * 2/24/17 10:12 am

18VAC150-20-172 Delegation of Duties

I do not support section B of 18VAC150-20-172 Delegation of Duties statement saying " The monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided the patient is no longer intubated and provided a veterinarian or licensed veterinary technician remains on premisis until the patient is fully recovered". During the recovery process following any anesthetic event is the very most risky part of anesthesia. Research shows that we lose most of our patents in the recovery process of anesthesia usually within 3 hours following an anesthetic event. Veterinarians and Licensed Veterinary Technicians are trained individuals who know the most common and most uncommon things to look for in a patient post anesthesia. I a Licensed Veterinary Technician do not feel comfortable with an assistant recovering any of my anesthetized patients no matter how routine the surgery or anesthesia may be. Should an assistant be able to recover an anesthetized or be apart of any anesthetic event, they become a trained professional. I

honestly do feel that if of this is allowed it will take Veterinary Medicine in the wrong direction. There does need to be a line drawn between when an assistant is appropriate for certain roles in the veterinary work place. As assistants are vital members of the veterinary community,but they are much more useful in other areas such as animal restraint, blood draws, assisting the Dr in appointments, and many other areas. Please keep trained and educated personnel only in anesthesia.

Commenter: Kendall Blackwell, LVT * 2/24/17 10:15 am

PATIENTS COME FIRST.

Don't get me wrong, I truly value our assistants and many are such strong parts of our team and profession. I began my career as an assistant for nearly 7 years. That being said, these duties should NOT be delegated to an assistant.

Anesthesia is an art- isn't that what we are taught in school? It is more than practical skill. It is more than a set of eyes on a patient. I understand that some practices may think they have the best assistants or training program, but that is not the case for all practices in the state of Virginia- which this regulatory action would govern.

As a technician, we receive the knowledge, anatomy, physiology, pharmacology, and practical skills that allow us to do our jobs. Assistants are not trained as extensively in these subjects. If they are, then they should consider becoming an LVT.

If you were to walk into a hospital and a medical assistant told you they were going to monitor you during anesthesia, I would hope you would have a problem with that.

We just rallied for years to increase our CE requirements to ensure we are up to date with most recent advances and protocols in veterinary medicine, and many technicians complained about that too. How are you going to vouch for your assistants' education when you complain about TWO additional hours of CE for yourself? If you are a practice owner, or technician in a busy practice, and think there is something more important you can attend to than making sure your patient fully recovers from anesthesia, maybe you are the one that should reconsider your profession.

For those complaining about the technician shortage- perhaps we as technicians should value ourselves, education, and abilities more to increase public awareness of the importance of our jobs...

Practice owners- consider treating and paying your technicians so they want to stay in the field.

Commenter: Micki Armour VMD * 2/24/17 11:09 am

proposed changes

In a perfect world, there would only be DVMs and LVTs, and hopefully we can get there soon. Unfortunately, with such a demand for LVTs in the state of Virginia, it is just not a reality at this time. We struggle with this in general and specialty practice alike. I propose the following:

"A licensed technician or DVM should intubate and monitor anesthesia. If an LVT is unavailable, a veterinarian should directly oversee the monitoring of anesthesia performed by an unlicensed assistant and the DVM shall be present during the entire anesthesia."

Commenter: Mary Anderson, lvt * 2/24/17 12:51 pm

Assistants doing tech work

The docs FOR this should reimburse my tuition. Thanks for trying to cheapening my profession.

Commenter: Nicole Kennedy, LVT * 2/24/17 10:52 pm

Tech duties

I do not support section B of 18VAC150-20-172 Delegation of Duties statement saying " The monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided the patient is no longer intubated and provided a veterinarian or licensed veterinary technician remains on premisis until the patient is fully recovered". Assistants do not have the knowledge they need to monitor a patient waking up from anesthesia. I went to school and got my degree and license. I learned all I could learn in Tech school to be able to care for our patients while under anesthesia and recovering from anesthesia. Too much can go wrong in recovery and we can't put an

unlicensed, uneducated assistant in that situation if something goes wrong. If assistants want to do more then please go to school and get the education that is needed to properly care for these patients. They deserve the best care we can give them!

Commenter: Genito Animal Hospital * 2/24/17 11:10 pm

Standard of Care in Anesthesia

Changes in veterinary medicine must be embraced and accepted as the average patient these days in not an outdoor farm dog, and the average client expects a level of care different than that of 20 years ago. Although I know our veterinary assistants are long-term and extremely skilled, I realize that when a client entrusts their animal to our care for a procedure involving anesthesia, there is an expectation in "standard of care" that has evolved and with which we must progress as a profession. The differentiation of assistant vs trained veterinary technician is important not only as a point of progress of our kindred professions, but as a standard of care provided as expectations and pet care evolve in our society as a whole.

Commenter: Theresa Gray, LVT * 2/24/17 11:16 pm

PLEASE MAKE CHANGES TO THE LAW our patients need it!!

To the Board Members,

The majority of the responses are not in favor of making the proposed changes to the law 18 VAC 150-20. I have been in the veterinary profession for 14 years and a LVT for 10 years. I took an oath at the beginning of my career to do no harm and give the best care I can. No disrespect to the doctors who have already posted but I am in favor that assistants **should not** be monitoring patients under anesthesia at any time.

It may be a hardship in the beginning but in the end, we as a profession will have giving a higher standard of care to our patients. Over my time in the field I have met and talked to assistants who feel they are equal to LVT's for they do everything a LVT does so why should they get licensed. Some years ago, I had asked an assistant the name of the vein in the front leg which she draws blood; to which she replied she did not know she just draws the blood from there. A few years later at another practice, I asked another assistant why while manually bagging for anesthesia did she not go over 20MmHg? She answered she didn't know she just does it because that is what she was told. This assistant at the time had been in the field 20 plus years; both situations scare me.

If you look at the Essential Skill List for the NAVTA approved Assistant Certification course it states under **VI Surgical Preparation and Assisting**; subsection A "Assist in performing surgical preparations" item number 8: Aid the veterinarian/ or veterinary technician with physical monitoring of recovering surgical patients. You will notice it **does NOT** state for assistants to monitor under anesthesia but to "aid" the doctor or technician. It also states under **VII Laboratory Procedures;** subsection A "Assistance in the Laboratory" item 3: Assist in the collection of blood samples with restraint and supply preparation. You will also notice it **does NOT** state for assistance to draw blood but to assist. Therefore, under 18VAC150-20-172 Delegation of duties subsection B number 9 "Drawing blood samples" should be removed. The four-page skills list **does not** even list dental polishing and scaling of teeth. Which is list under 18VAC150-20-172 "Delegation of duties" subsection B "Additional duties which may be delegated by a veterinarian to a properly trained assistant" (please remove "but not limited to"); item 8: Dental polishing and scaling of teeth above the gum line (supragingival). The NAVTA Assistant Certification course should be the standard for all assistants to be taught whether they get certified or not. Not every veterinarian or LVT can teach or will follow the law. This is the only way Technicians as a profession will be respected by letting us do our job for what we were schooled trained for and licensed for.

A lot of the responses say it will be a hardship on their practice that there is a shortage of LVTs. But if there is such a large shortage in Virginia then why are the only ads out on the different web sites are for the large hospitals, ER, or overnight shifts or hospitals in Maryland? Where are all the small practices that don't have LVT's? I have been looking since December if hospitals are truly looking for LVTs then where are their ads? Its easier to train none licensed staff then to respect and pay LVTs. This a major problem with our profession and I hope that you board members are brave enough to make the needed changes for the good of the patients. Below is my name and email if any board member or anyone else wants to discuss my views.

Theresa Gray, LVT mgray42437@icloud.com

pe over this text and enter your comments here. You are limited to approximately 3000 words.

Commenter: Keith Richardson *

2/24/17 11:43 pm

In responsed to the proposed regulations by the Vet board

Quoting the proposed text

18VAC150-20-115

Requirements for Licensure by Examination As a Veterinary Technician

The applicant, in order to be licensed by the board to practice veterinary

3. Have passed the Veterinary Technician National Examination approved by the AAVSB or any other board-approved, national board examination for veterinary technology with a score acceptable to the board.

4. Sign a statement attesting that the applicant has read, understands, and will abide by the statutes and regulations governing veterinary practice in Virginia.

5. Have committed no acts that would constitute a violation of § 54.1-3807 of the Code of Virginia.

again this is what 18VAC150-20-115 Requirements for Licensure by Examination As a Veterinary Technician actually proposes?

Why isn't 54.1-3806 put there instead?

Another criticism I have is the text that contains

"veterinarian in charge "

You will be able to figure out why later...

Some more quotes from the proposed text

18VAC150-20-130

Surgery

B.Whenever a veterinary preceptee or extern is performing surgery on a patient, either assisted or unassisted, the supervising veterinarian shall be in the operatory during the procedure. Prior to allowing a preceptee or extern in veterinary medicine to perform surgery on a patient unassisted by a licensed veterinarian, a licensed veterinarian shall receive written approval from the owner.

D. A veterinarian or veterinary technician who supervises a preceptee or extern remains responsible for the care and treatment of the patient

If I were to compare this to

§54.1-3805 and §54.1-3806 say

A supervising veterinary is the responsible party

8.01-581.19 has nothing to do with licensed Veterinary techs and preceptee correct as far as liablility?

Why is it that a preceptee or extern can assit in a procedure

Remember 18VAC150-20-172. Delegation of Duties states as a preceptee can (along with monitoring anesthesia blood pressure cleaning)

What are veterinary assistants defined as?

Anesthesia Technician

Veterinary Associate

While 18VAC150-20-172 also states

E . The veterinarian remains responsible for the duties being delegated and remains responsible for the health and safety of the animal.

Yet again "veterinian techincian" under §54.1-3806 cannot preform surgery?

You all never state what a supervising veterinarian is

Finally in regards to vet technians

18VAC150-20-115

18VAC150-20-121

Those two above have no mention of §54.1-3806

54.1-3805

No references at all

For example
Endorsement of licensure technician

preceding four years;

5. Signs a statement attesting that the applicant has read, understands, and will abide by the statutes and regulations governing veterinary practice in Virginia

Should at least reference and reiterate§ 54.1-3806

18VAC150-20-70. Licensure renewal requirements.

Where are the veterinary tech requirements for annual renewal

Oh let me see there is §54.1-3805.2 for vet technicians

Which should have been some in the proposed language of

18VAC150-20-70

Commenter: Taryn Singleton, LVT * 2/25/17 12:01 am

Regulations pertaining to Delegation of duties

I was a board member when the regulatory review and proposed changes were being discussed. The new wording was added to protect the public so that a veterinarian or Licensed Veterinary Technician remained on premises during **all** phases of an anesthetic procedure, including recovery thru extubation and consciousness of the patient. We are all busy, and juggle many tasks, requiring delegation of duties. Please remember the following from the AAHA anesthesia guidelines, *(Most anesthesia deaths occur during recovery, especially in the first 3 hours)* Previous regulatory language implied veterinarians could delegate the administration of scheduled VI drugs (non controlled) to patients prior to their arrival on premise, or not having a licensee in the clinic while a patient is still recovering from anesthesia. That is the VALVT's concern. This could include expediting patients for surgical procedures, patients requiring sedation for grooming or non complicated dental cleanings. While we believe it is clear that veterinarians understand it is ultimately their responsibility to care for his/her patients, some may feel the need to take that risk, due to case load, or staffing issues. Is it really the best for patients put in their care? We believe it is the perception of the public that while their pet is undergoing a procedure whether it is sedation or general anesthesia that licensed personal will be in the building overseeing the care of their pet until fully recovered.

I along with members of the VALVT, suggest the following wording under the delegation of duties so as not to restrict the veterinary team, and not cause economic hardship

Induction of anesthesia, sedation, or chemotherapy drugs, subgingival scaling, or the placement of intravenous catheters shall not be delegated to an assistant. The monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided a veterinarian or licensed veterinary technician remains on the premises until the patient is conscious.

In closing, as veterinarians and technicians we strive to do the best every day. We should not loose sight of the publics perception, and common sense when they leave their pet in our care. We feel that the above recommendation will satisfy and protect everyone including the public, our patients, and the veterinary community.

Respectfully Submitted

Taryn Singleton, LVT

* Nonregistered public user

Staff Recommended Changes to the Proposed Veterinary Medicine Regulations

Section 10 – Definitions

- "NBVME" has changed its name to "ICVA" which stands for International Council for Veterinary Assessment
- "Veterinarian In Charge" appears later in the document with hyphens "Veterinarian-in-Charge"

Section 110 – Requirements for licensure by examination as a veterinarian

- (A)(2) requires "NBVME" to be changed to "ICVA"

Section115. Requirements for licensure by examination as a veterinary technician

- (A)(2)(a) delete "and notarized" include submission of "fee"

Section 120 – Requirements for licensure by endorsement as a veterinarian

- Add statement about submission of an application and fee

Section 121 – Requirements for licensure by endorsement for veterinary technicians

- Add to first paragraph "…who is licensed, certified or registered to practice as a veterinary technician by ~~in~~ another stated…"
- (3) Add statement about submission of an application and fee
- (4) change "12" hours to "16"

Section 130 – Requirements for practical training in a preceptorship or externship

- (C) Add "veterinary" to clarify that the regulation is for veterinary students and not veterinary technology students.

Section 180 – Requirements to be registered as a veterinary establishment

- (A)(2) Change to singular to read as "An application for registration must be made to the board…" and need to include submit fee requirement.

Section 210 – Revocation or suspension of a veterinary establishment registration

- (3) Add "…beyond the scope of a limited stationary establishment…"

Project 4496 - Proposed

BOARD OF VETERINARY MEDICINE

Periodic review

Part I

General Provisions

18VAC150-20-10. Definitions.

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

"AAVSB" means the American Association of Veterinary State Boards.

~~"Animal shelter" means a facility, other than a private residential dwelling and its surrounding grounds, that is used to house or contain animals and that is owned, operated, or maintained by a nongovernmental entity including, but not limited to, a humane society, animal welfare organization, society for the prevention of cruelty to animals, or any other organization operating for the purpose of finding permanent adoptive homes for animals.~~

"Automatic emergency lighting" is lighting that is powered by battery, generator, or alternate power source other than electrical power, is activated automatically by electrical power failure, and provides sufficient light to complete surgery or to stabilize the animal until surgery can be continued or the animal moved to another establishment.

"AVMA" means the American Veterinary Medical Association.

"Board" means the Virginia Board of Veterinary Medicine.

"Companion animal" means any dog, cat, horse, nonhuman primate, guinea pig, hamster, rabbit not raised for human food or fiber, exotic or native animal, reptile, exotic or native bird, or

any feral animal or animal under the care, custody or ownership of a person or any animal that is bought, sold, traded, or bartered by any person. Agricultural animals, game species, or any animals regulated under federal law as research animals shall not be considered companion animals for the purposes of this chapter.

"CVMA" means the Canadian Veterinary Medical Association.

"DEA" means the U.S. Drug Enforcement Administration.

~~"Full-service establishment" means a stationary or ambulatory facility that provides surgery and encompasses all aspects of health care for small or large animals, or both.~~

["ICVA" means the International Council for Veterinary Assessment.]

"Immediate ~~and direct~~ supervision" means that the licensed veterinarian is immediately available to the licensed veterinary technician or assistant, either electronically or in person, and provides a specific order based on observation and diagnosis of the patient within the last 36 hours.

[~~"NBVME" means the National Board of Veterinary Medical Examiners.~~]

"Owner" means any person who (i) has a right of property in an animal; (ii) keeps or harbors an animal; (iii) has an animal in his care; or (iv) acts as a custodian of an animal.

~~"Pound" means a facility operated by the state or a locality for the purpose of impounding or harboring seized, stray, homeless, abandoned, or unwanted animals; or a facility operated for the same purpose under a contract with a locality or an incorporated society for the prevention of cruelty to animals.~~

"Preceptee" or "extern" means a student who is enrolled and in good standing in an AVMA accredited college of veterinary medicine or AVMA accredited veterinary technology program and

who is receiving practical experience under the supervision of a licensed veterinarian or licensed veterinary technician.

"Preceptorship" or "externship" means a formal arrangement between an AVMA accredited college of veterinary medicine or an AVMA accredited veterinary technology program and a veterinarian who is licensed by the board and responsible for the practice of the preceptee. A preceptorship or externship shall be overseen by faculty of the college or program.

"Private animal shelter" means a facility that is used to house or contain animals and that is owned or operated by an incorporated, nonprofit, and nongovernmental entity, including a humane society, animal welfare organization, society for the prevention of cruelty to animals, or any other organization operating for the purpose of finding permanent adoptive homes for animals.

"Professional judgment" includes any decision or conduct in the practice of veterinary medicine, as defined by § 54.1-3800 of the Code of Virginia.

"Public animal shelter" means a facility operated by the Commonwealth, or any locality, for the purpose of impounding or sheltering seized, stray, homeless, abandoned, unwanted, or surrendered animals, or a facility operated for the same purpose under a contract with any locality.

~~"Restricted service establishment" means a stationary or ambulatory facility which does not meet the requirements of a full-service establishment.~~

"Specialist" means a veterinarian who has been awarded and has maintained the status of diplomate of a specialty organization recognized by the American Board of Veterinary Specialties of the American Veterinary Medical Association, or any other organization approved by the board.

"Surgery" means treatment through revision, destruction, incision or other structural alteration of animal tissue. Surgery does not include dental extractions of single-rooted teeth or skin

closures performed by a licensed veterinary technician upon a diagnosis and pursuant to direct orders from a veterinarian.

["Veterinarian in charge" "Veterinarian-in-charge"] means a veterinarian who holds an active license in Virginia and who is responsible for maintaining a veterinary establishment within the standards set by this chapter, for complying with federal and state laws and regulations, and for notifying the board of the establishment's closure.

"Veterinary establishment" means any ~~fixed~~ stationary or ~~mobile~~ ambulatory practice, veterinary hospital, animal hospital, or premises wherein or out of which veterinary medicine is being conducted.

"Veterinary technician" means a person licensed by the board as required by § 54.1-3805 of the Code of Virginia.

18VAC150-20-30. Posting of licenses; accuracy of address.

A. All licenses~~,~~ and registrations ~~and permits~~ issued by the board shall be posted in a place conspicuous to the public at the establishment where veterinary services are being provided or available for inspection at the location where an equine dental technician is working. Licensees who do relief or temporary work in an establishment shall carry a license with them or post it at the establishment. Ambulatory veterinary practices that do not have an office accessible to the public shall carry their licenses and ~~permits~~ registrations in their vehicles.

B. It shall be the duty and responsibility of each licensee, registrant, and holder of a registration ~~permit~~ to operate a veterinary establishment to keep the board apprised at all times of his current address of record and the public address, if different from the address of record. All notices required by law or by this chapter to be mailed to any veterinarian, veterinary technician, registered equine dental technician, or holder of a ~~permit~~ registration to operate a veterinary establishment~~,~~ shall be validly given when mailed to the address of record furnished to the board

pursuant to this regulation. All address changes shall be furnished to the board within 30 days of such change.

18VAC150-20-70. Licensure renewal requirements.

A. Every person licensed by the board shall, by January 1 of every year, submit to the board a completed renewal application and pay to the board a renewal fee as prescribed in 18VAC150-20-100. Failure to renew shall cause the license to lapse and become invalid, and practice with a lapsed license may subject the ~~licensees~~ licensee to disciplinary action by the board. Failure to receive a renewal notice does not relieve the licensee of his responsibility to renew and maintain a current license.

B. Veterinarians shall be required to have completed a minimum of 15 hours, and veterinary technicians shall be required to have completed a minimum of eight hours, of approved continuing education for each annual renewal of licensure. Continuing education credits or hours may not be transferred or credited to another year.

1. Approved continuing education credit shall be given for courses or programs related to the treatment and care of patients and shall be clinical courses in veterinary medicine or veterinary technology or courses that enhance patient safety, such as medical recordkeeping or compliance with requirements of the Occupational Health and Safety Administration (OSHA).

2. An approved continuing education course or program shall be sponsored by one of the following:

a. The AVMA or its constituent and component/branch associations, specialty organizations, and board certified specialists in good standing within their specialty board;

b. Colleges of veterinary medicine approved by the AVMA Council on Education;

c. International, national, or regional conferences of veterinary medicine;

d. Academies or species-specific interest groups of veterinary medicine;

e. State associations of veterinary technicians;

f. North American Veterinary Technicians Association;

g. Community colleges with an approved program in veterinary technology;

h. State or federal government agencies;

i. American Animal Hospital Association (AAHA) or its constituent and component/branch associations;

j. Journals or veterinary information networks recognized by the board as providing education in veterinary medicine or veterinary technology; or

k. An organization or entity approved by the Registry of Approved Continuing Education of the ~~American Association of Veterinary State Boards~~ AAVSB.

3. A licensee is exempt from completing continuing education requirements and considered in compliance on the first renewal date following his initial licensure by examination.

4. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

5. The board may grant an extension for good cause of up to one year for the completion of continuing education requirements upon written request from the licensee prior to the renewal date. Such an extension shall not relieve the licensee of the continuing education requirement.

6. Licensees are required to attest to compliance with continuing education requirements on their annual license renewal and are required to maintain original documents verifying the date and subject of the program or course, the number of continuing education hours or credits, and certification from an approved sponsor. Original documents must be maintained for a period of two years following renewal. The board shall periodically conduct a random audit to determine compliance. Practitioners selected for the audit shall provide all supporting documentation within ~~10~~ 14 days of receiving notification of the audit unless an extension is granted by the board.

7. Continuing education hours required by disciplinary order shall not be used to satisfy renewal requirements.

8. Falsifying the attestation of compliance with continuing education on a renewal form or failure to comply with continuing education requirements may subject a licensee to disciplinary action by the board, consistent with § 54.1-3807 of the Code of Virginia.

C. A licensee who has requested that his license be placed on inactive status is not authorized to perform acts that are considered the practice of veterinary medicine or veterinary technology and, therefore, shall not be required to have continuing education for annual renewal. To reactivate a license, the licensee is required to submit evidence of completion of continuing education hours as required by § 54.1-3805.2 of the Code of Virginia and this section equal to the number of years in which the license has not been active for a maximum of two years.

18VAC150-20-75. Expired license; reinstatement; practice with an expired or lapsed license not permitted.

A. A license may be renewed up to one year after the expiration date, provided a late fee as prescribed in 18VAC150-20-100 is paid in addition to the required renewal fee. A license shall automatically lapse if the licensee fails to renew by the expiration date. The practice of veterinary

medicine without a current, active license is unlawful and may subject the licensee to disciplinary action by the board.

B. Reinstatement of licenses expired for more than one year shall be at the discretion of the board. To reinstate a license, the licensee shall pay the reinstatement fee as prescribed in 18VAC150-20-100 and submit evidence of completion of continuing education hours as required by § 54.1-3805.2 of the Code of Virginia and 18VAC150-20-70 equal to the number of years in which the license has been expired, for a maximum of two years. The board may require additional documentation of clinical competency and professional activities.

18VAC150-20-100. Fees.

The following fees shall be in effect:

Veterinary application for licensure	$200
Veterinary license renewal (active)	$175
Veterinary license renewal (inactive)	$85
Veterinary reinstatement of expired license	$255
Veterinary license late renewal	$60
Veterinarian reinstatement after disciplinary action	$450
Veterinary technician application for licensure	$65
Veterinary technician license renewal	$50
Veterinary technician license renewal (inactive)	$25
Veterinary technician license late renewal	$20
Veterinary technician reinstatement of expired license	$95
Veterinary technician reinstatement after disciplinary action	$125
Equine dental technician initial registration	$100
Equine dental technician registration renewal	$70
Equine dental technician late renewal	$25
Equine dental technician reinstatement	$120
Initial veterinary establishment ~~permit~~ registration	$300
Veterinary establishment renewal	$200
Veterinary establishment late renewal	$75

Veterinary establishment reinstatement	$75
Veterinary establishment reinspection	$300
Veterinary establishment -- change of location	$300
Veterinary establishment -- change of veterinarian-in-charge	$40
Duplicate license	$15
Duplicate wall certificate	$25
Returned check	$35
Licensure verification to another jurisdiction	$25

Part II

Licensure for Veterinarians and Veterinary Technicians

18VAC150-20-110. Requirements for licensure by examination as a veterinarian.

A. The applicant, in order to be licensed by the board to practice veterinary medicine, shall:

1. Have received a degree in veterinary medicine from a college or school of veterinary medicine accredited by the AVMA ~~or have fulfilled the requirements of the Educational Commission of Foreign Veterinary Graduates (ECFVG) of the AVMA or any other substantially equivalent credentialing body as determined by the board.~~, as verified by an official transcript from the applicant's college or school, indicating completion of the veterinary degree; and

2. Have passed the North American Veterinary License Examination (since the fall of 2000) or the National Board Examination and the Clinical Competency Test (prior to the fall of 2000) of the [~~NBVME~~ ICVA] or any other substantially equivalent national examination as approved by the board with a score acceptable to the board.

3. In lieu of a degree from an accredited college or school, an applicant may submit verification that he has fulfilled the requirements of the Educational Commission of Foreign Veterinary Graduates (ECFVG) of the AVMA or the Program for the Assessment of

Veterinary Education Equivalence (PAVE) of the AAVSB or any other substantially equivalent credentialing body as determined by the board.

~~2. File the following documents with the board:~~ B. All applicants shall also:

~~a. A~~ 1. Submit the application fee specified in 18VAC150-20-100 and a complete ~~and notarized~~ application on a form obtained from the board;

~~b. An official copy, indicating veterinary degree, of the applicant's college or school transcript;~~

~~c. Certification of a full and unrestricted~~ 2. Provide verification that any license to practice veterinary medicine ~~by each board from which the applicant holds a license.~~ issued by a board of veterinary medicine in another state or United States jurisdiction is in good standing;

~~3. Pass the North American Veterinary License Examination or the National Board Examination and the Clinical Competency Test approved by the American Association of Veterinary State Boards or any other substantially equivalent national examination as approved by the board with a score acceptable to the board.~~

~~4.~~ 3. Sign a statement attesting that the applicant has read, understands, and will abide by the statutes and regulations governing veterinary practice in Virginia~~.~~; and

~~5.~~ 4. Have committed no acts ~~which~~ that would constitute a violation of § 54.1-3807 of the Code of Virginia.

~~B.~~ C. If the application for licensure has not been successfully completed within one year from the date of initial submission, a new application and fee shall be required.

18VAC150-20-115. Requirements for licensure by examination as a veterinary technician.

A. The applicant, in order to be licensed by the board as a veterinary technician, shall:

1. Have received a degree in veterinary technology from a college or school accredited by the AVMA or the CVMA.

2. Have filed with the board the following documents:

a. A complete [~~and notarized~~] application on a form obtained from the board;

b. An official copy, indicating a veterinary technology degree, of the applicant's college or school transcript; and

c. ~~Certification~~ Verification that the applicant is in good standing by each board in another state or United States jurisdiction from which the applicant holds a license, certification, or registration to practice veterinary technology.

3. ~~Pass a~~ Have passed the Veterinary Technician National Examination approved by the AAVSB or any other board-approved, national board examination for veterinary technology with a score acceptable to the board.

4. Sign a statement attesting that the applicant has read, understands, and will abide by the statutes and regulations governing veterinary practice in Virginia.

[5. Have submitted the application fee specified in 18VAC150-20-100.

~~5.~~ 6.] Have committed no acts that would constitute a violation of § 54.1-3807 of the Code of Virginia.

B. The application for licensure shall be valid for a period of one year after the date of initial submission, after which time a new application and fee shall be required.

18VAC150-20-120. Requirements for licensure by endorsement as a veterinarian.

~~A.~~ The board may, in its discretion, grant a license by endorsement to an applicant who is licensed to practice veterinary medicine in another state, the District of Columbia, or possessions or territories of the United States, provided that the applicant:

1. ~~All licenses are in good standing.~~ Holds at least one current, unrestricted license in another jurisdiction of the United States and is not a respondent in any pending or unresolved board action in any jurisdiction;

2. ~~The applicant has been~~ Provides documentation of having been regularly engaged in clinical practice for at least two of the past four years immediately preceding application; ~~and~~

3. ~~The applicant has met all applicable requirements of 18VAC150-20-110, except foreign-trained veterinarians who have attained specialty recognition by a board recognized by the AVMA are exempt from the requirements of ECFVG or any other substantially equivalent credentialing body as determined by the board.~~ Provides documentation of completion of at least 30 hours of continuing education requirements during the preceding four years;

[4. Submits the application fee specified in 18VAC150-20-100 and a complete application on a form obtained from the board;

~~4.~~5.] Signs a statement attesting that the applicant has read, understands, and will abide by the statutes and regulations governing veterinary practice in Virginia; and

[~~5.~~6.] Has committed no acts that would constitute a violation of § 54.1-3807 of the Code of Virginia.

~~B. Provided that the applicant has met the requirements of subsection A of this section, the board may, in its discretion, waive the requirement that the applicant pass the national board exam or the clinical competency test, or both.~~

18VAC150-20-121. Requirements for licensure by endorsement for veterinary technicians.

In its discretion, the board may grant a license by endorsement to an applicant who is licensed, certified or registered to practice as a veterinary technician in another state, the District of Columbia, or possessions or territories of the United States, provided that the applicant:

1. ~~All licenses, certificates or registrations are in good standing~~ Holds at least one current and unrestricted license, certification, or registration [~~in~~ issued by the regulatory entity in] another jurisdiction of the United States and that he is not a respondent in any pending or unresolved board action in any jurisdiction;

2. ~~The applicant has been~~ Provides documentation of having been regularly engaged in clinical practice as a licensed, certified, or registered veterinary technician for at least two of the past four years immediately preceding application; ~~and~~

3. ~~The applicant has~~ Has received a degree in veterinary technology from a college or school accredited by the AVMA or the CVMA or has passed a the Veterinary Technician National Examination approved by the AAVSB or any other board-approved national board examination for veterinary technology with a score acceptable to the board~~.~~;

4. Provides documentation of completion of at least [~~12~~ 16] hours of continuing education requirements during the preceding four years;

[5. Submits the application fee specified in 18VAC150-20-100 and a complete application on a form obtained from the board;

~~5.~~6.] Signs a statement attesting that the applicant has read, understands, and will abide by the statutes and regulations governing veterinary practice in Virginia; and

[~~6.~~7.] Has committed no acts that would constitute a violation of § 54.1-3807 of the Code of Virginia.

18VAC150-20-130. Requirements for practical training in a preceptorship or externship.

A. The practical training and employment of qualified students of veterinary medicine or veterinary technology shall be governed and controlled as follows:

1. A veterinary student who is ~~duly~~ enrolled and in good standing in a veterinary college or school accredited or approved by the AVMA may be engaged in a preceptorship or externship. A veterinary preceptee or extern may perform duties that constitute the practice of veterinary medicine for which he has received adequate instruction by the college or school and only under the on-premises supervision of a licensed veterinarian.

2. A veterinary technician student who is ~~duly~~ enrolled and in good standing in a veterinary technology program accredited or approved by the AVMA may be engaged in a preceptorship or externship. A veterinary technician preceptee or extern may perform duties that constitute the practice of veterinary technology for which he has received adequate instruction by the program and only under the on-premises supervision of a licensed veterinarian or licensed veterinary technician.

B. Whenever a veterinary preceptee or extern is performing surgery on a patient, either assisted or unassisted, the supervising veterinarian shall be in the operatory during the procedure. Prior to allowing a preceptee or extern in veterinary medicine to perform surgery on a patient unassisted by a licensed veterinarian, a licensed veterinarian shall receive written approval from the owner.

C. When there is a [veterinary] preceptee or extern practicing in the establishment, the supervising veterinarian shall disclose such practice to owners. The disclosure shall be by signage clearly visible to the public or by inclusion on an informed consent form.

D. A veterinarian or veterinary technician who supervises a preceptee or extern remains responsible for the care and treatment of the patient.

18VAC150-20-135. Voluntary practice by out-of-state practitioners.

Any veterinarian who seeks registration to practice on a voluntary basis under the auspices of a publicly supported all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people shall:

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

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

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

4. Pay a registration fee of $10; and

5. Provide a ~~notarized~~ statement from a representative of the nonprofit organization attesting to its compliance with provisions of subdivision 4 of § 54.1-3801 of the Code of Virginia.

Part III

Unprofessional Conduct

18VAC150-20-140. Unprofessional conduct.

Unprofessional conduct as referenced in subdivision 5 of § 54.1-3807 of the Code of Virginia shall include the following:

1. Representing conflicting interests except by express consent of all concerned given after a full disclosure of the facts. Acceptance of a fee from both the buyer and the seller is prima facie evidence of a conflict of interest.

2. Practicing veterinary medicine or equine dentistry where an unlicensed person has the authority to control the professional judgment of the licensed veterinarian or the equine dental technician.

3. Issuing a certificate of health unless he shall know of his own knowledge by actual inspection and appropriate tests of the animals that the animals meet the requirements for the issuance of such certificate on the day issued.

4. Revealing confidences gained in the course of providing veterinary services to a client, unless required by law or necessary to protect the health, safety, or welfare of other persons or animals.

5. Advertising in a manner ~~which~~ that is false, deceptive, or misleading or ~~which~~ that makes subjective claims of superiority.

6. Violating any state law, federal law, or board regulation pertaining to the practice of veterinary medicine, veterinary technology or equine dentistry.

7. Practicing veterinary medicine or as an equine dental technician in such a manner as to endanger the health and welfare of his patients or the public, or being unable to practice veterinary medicine or as an equine dental technician with reasonable skill and safety.

8. Performing surgery on animals in an unregistered veterinary establishment or not in accordance with the establishment ~~permit~~ registration or with accepted standards of practice.

9. Refusing the board or its agent the right to inspect an establishment at reasonable hours.

10. Allowing unlicensed persons to perform acts restricted to the practice of veterinary medicine, veterinary technology, or an equine dental technician including any invasive

procedure on a patient or delegation of tasks to persons who are not properly trained or authorized to perform such tasks.

11. Failing to provide immediate ~~and direct~~ supervision to a licensed veterinary technician or an assistant in his employ.

12. Refusing to release a copy of a valid prescription upon request from ~~a client~~ an owner, unless there are medical reasons documented in the patient record and the veterinarian would not dispense the medication from his own practice.

13. Misrepresenting or falsifying information on an application or renewal form.

14. Failing to report suspected animal cruelty to the appropriate authorities.

15. Failing to release a copy of patient records when requested by the owner; a law-enforcement entity; or a federal, state, or local health regulatory agency.

16. Committing an act constituting fraud, deceit, or misrepresentation in dealing with the board or in the ~~veterinarian-client-patient~~ veterinarian-owner-patient relationship, or with the public.

17. Representing oneself as a "specialist" without meeting the definition set forth in 18VAC150-20-10 or using the words "specialist" or "specialty" in the name of a veterinary establishment unless there is a veterinarian on staff who meets the definition of a "specialist."

18. Failure to submit evidence of correction resulting from a violation noted in an inspection or reported by another agency within 14 days, unless an extension is granted by the board.

18VAC150-20-172. Delegation of duties.

A. A licensed veterinarian may delegate the administration (including by injection) of Schedule VI drugs to a properly trained assistant under his immediate ~~and direct~~ supervision. The

prescribing veterinarian has a specific duty and responsibility to determine that the assistant has had adequate training to safely administer the drug in a manner prescribed.

B. Injections involving ~~anesthetic or~~ chemotherapy drugs, subgingival scaling, or the placement of intravenous catheters shall not be delegated to an assistant. An assistant shall also not be delegated the induction of sedation or anesthesia by any means. The monitoring of a sedated or anesthetized patient may be delegated to an assistant, provided the patient is no longer intubated and provided a veterinarian or licensed veterinary technician remains on premises until the patient is fully recovered.

~~B. Additional~~ C. The following tasks ~~that~~ may be delegated by a licensed veterinarian to a properly trained assistant ~~include but are not limited to the following~~:

1. Grooming;

2. Feeding;

3. Cleaning;

4. Restraining;

5. Assisting in radiology;

6. Setting up diagnostic tests;

7. ~~Prepping for surgery~~ Clipping and scrubbing in preparation for surgery;

8. Dental polishing and scaling of teeth above the gum line (supragingival);

9. Drawing blood samples; or

10. Filling of Schedule VI prescriptions under the direction of a veterinarian licensed in Virginia.

~~C.~~ D. A licensed veterinarian may delegate duties electronically, verbally, or in writing to appropriate veterinary personnel provided the veterinarian has physically examined the patient within the previous 36 hours.

~~D.~~ E. Massage therapy ~~or~~, physical therapy, or laser therapy may be delegated by a veterinarian to persons qualified by training and experience by an order from the veterinarian.

~~E.~~ F. The veterinarian remains responsible for the duties being delegated and remains responsible for the health and safety of the animal.

18VAC150-20-173. Informed consent for surgery.

A. Before surgery is performed, informed consent shall be obtained from the owner and documented in the patient record. Veterinarians shall inform an owner of the risks, benefits, and alternatives of the recommended surgery that a reasonably prudent practitioner in similar practice in Virginia would tell an owner.

B. An exception to the requirement for consent prior to performance of surgery may be made in an emergency situation when a delay in obtaining consent would likely result in imminent harm to the patient.

C. If a veterinary student, preceptee, or extern is to perform the surgery, the informed consent shall include that information.

Part V

Veterinary Establishments

18VAC150-20-180. Requirements to be registered as a veterinary establishment.

A. Every veterinary establishment shall apply for registration on a form provided by the board [and submit the application fee specified in 18VAC150-20-100. ~~and may be issued~~ The board may issue] a ~~permit~~ registration as a ~~full-service or restricted service~~ stationary or ambulatory

establishment. Every veterinary establishment shall have a veterinarian-in-charge registered with the board in order to operate.

1. Veterinary medicine may only be practiced out of a registered establishment except in emergency situations or in limited specialized practices as provided in 18VAC150-20-171. The injection of a microchip for identification purposes shall only be performed in a veterinary establishment, except personnel of public or private animal shelters ~~or pounds~~ may inject animals while in their possession.

2. [~~Applications~~ An application] for ~~permits~~ registration must be made to the board 45 days in advance of opening or changing the location of the establishment or requesting a change in the establishment category ~~to a full-service establishment~~ listed on the registration.

3. Any addition or renovation of a stationary establishment or an ambulatory establishment that involves changes to the structure or composition of a surgery room shall require reinspection by the board and payment of the required fee prior to use.

B. A veterinary establishment will be registered by the board when:

1. It is inspected by the board and is found to meet the standards set forth by 18VAC150-20-190 and 18VAC150-20-200 or 18VAC150-20-201 where applicable. If, during a new or routine inspection, violations or deficiencies are found necessitating a reinspection, the prescribed reinspection fee will be levied. Failure to pay the fee shall be deemed unprofessional conduct and, until paid, the establishment shall be deemed to be unregistered.

2. A veterinarian currently licensed by and in good standing with the board is registered with the board in writing as veterinarian-in-charge and ~~has paid~~ ensures that the establishment registration fee has been paid.

18VAC150-20-181. Requirements for veterinarian-in-charge.

A. The veterinarian-in-charge of a veterinary establishment is responsible for:

1. Regularly being on site ~~on a schedule of no less than monthly and providing~~ as necessary to provide routine oversight to the veterinary establishment for patient safety and compliance with law and regulation.

2. Maintaining the facility within the standards set forth by this chapter.

3. Performing the biennial controlled substance inventory and ensuring compliance at the facility with any federal or state law relating to controlled substances as defined in § 54.1-3404 of the Code of Virginia. The performance of the biennial inventory may be delegated to another licensee, provided the veterinarian-in-charge signs the inventory and remains responsible for its content and accuracy.

4. Notifying the board in writing of the closure of the ~~permitted~~ registered facility 10 days prior to closure.

5. Notifying the board immediately if no longer acting as the veterinarian-in-charge.

6. Ensuring the establishment maintains a current and valid ~~permit~~ registration issued by the board.

B. Upon any change in veterinarian-in-charge, these procedures shall be followed:

1. The veterinarian-in-charge registered with the board remains responsible for the establishment and the stock of controlled substances until a new veterinarian-in-charge is registered or for five days, whichever occurs sooner.

2. An application for a new ~~permit~~ registration, naming the new veterinarian-in-charge, shall be made five days prior to the change of the veterinarian-in-charge. If no prior notice was given by the previous veterinarian-in-charge, an application for a new ~~permit~~

registration naming a new veterinarian-in-charge shall be filed as soon as possible, but no more than 10 days, after the change.

3. The previous establishment ~~permit~~ registration is void on the date of the change of veterinarian-in-charge and shall be returned by the former veterinarian-in-charge to the board five days following the date of change.

4. Prior to the opening of the business, on the date of the change of veterinarian-in-charge, the new veterinarian-in-charge shall take a complete inventory of all Schedule ~~II-V~~ II through V drugs on hand. He shall date and sign the inventory and maintain it on premises for ~~two~~ three years. That inventory may be designated as the official biennial controlled substance inventory.

C. Prior to the sale or closure of a veterinary establishment involving the transfer of patient records to another location, the veterinarian-in-charge shall:

1. Follow the requirements for transfer of patient records in accordance with § 54.1-2405 of the Code of Virginia; and

2. Provide to the board information about the location of patient records and the disposition of all scheduled drugs.

18VAC150-20-185. Renewal of veterinary establishment ~~permits~~ registrations.

A. Every veterinary establishment shall be required to renew the registration ~~permit~~ by January 1 of each year and pay to the board a registration fee as prescribed in 18VAC150-20-100.

B. Failure to renew the establishment ~~permit~~ registration by January 1 of each year shall cause the ~~permit~~ registration to expire and become invalid. Practicing veterinary medicine in an establishment with an expired registration may subject a licensee or registration holder to disciplinary action by the board. The ~~permit~~ registration may be reinstated without reinspection

within 30 days of expiration, provided the board receives a properly executed renewal application, renewal fee, and a late fee as prescribed in 18VAC150-20-100.

C. Reinstatement of an expired ~~permit~~ registration after 30 days shall be at the discretion of the board and contingent upon a reinspection and payment of the late fee, the reinspection fee, the renewal fee and the veterinary establishment ~~permit~~ registration reinstatement fee.

18VAC150-20-190. Requirements for drug storage, dispensing, destruction, and records for all establishments~~, full service and restricted~~.

A. All drugs shall be maintained, administered, dispensed, prescribed and destroyed in compliance with state and federal laws, which include § 54.1-3303 of the Code of Virginia, the Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia), applicable parts of the federal Food, Drug, and Cosmetic Control Act (21 USC § 301 et seq.), the Prescription Drug Marketing Act (21 USC § 301 et seq.), and the Controlled Substances Act (21 USC § 801 et seq.), as well as applicable portions of Title 21 of the Code of Federal Regulations.

B. All repackaged tablets and capsules dispensed for companion animals shall be in approved safety closure containers, except safety caps shall not be required when any person who requests that the medication not have a safety cap, or in such cases in which the medication is of such form or size that it cannot be reasonably dispensed in such containers (e.g., topical medications, ophthalmic, or otic). ~~A client~~ An owner request for nonsafety packaging shall be documented in the patient record.

C. All drugs dispensed for companion animals shall be labeled with the following:

1. Name and address of the facility;

2. ~~Name~~ First and last name of ~~client~~ owner;

3. Animal identification and species;

4. Date dispensed;

5. Directions for use;

6. Name, strength (if more than one dosage form exists), and quantity of the drug; and

7. Name of the prescribing veterinarian.

D. All ~~drugs shall be maintained~~ veterinary establishments shall maintain drugs in a ~~secured~~ secure manner with precaution taken to prevent theft or diversion. Only the veterinarian or [~~licensed~~] veterinary technician shall have access to Schedule II through V drugs.

1. ~~All Schedule II through V drugs shall be maintained under lock at all times, with access to the veterinarian or veterinary technician only, but not to any unlicensed personnel~~ In a stationary establishment, the general stock of Schedule II through V drugs shall be stored in a securely locked cabinet or safe that is not easily movable.

2. The establishment may also have a working stock of Schedule II through V drugs that shall be kept in (i) a securely locked container, cabinet, or safe when not in use or (ii) direct possession of a veterinarian or veterinary technician. A working stock shall consist of only those drugs that are necessary for use during a normal business day or 24 hours, whichever is less.

3. Whenever the establishment is closed, all general and working stock of Schedule II through V drugs and any dispensed prescriptions that were not delivered during normal business hours shall be securely stored as required for the general stock.

4. Prescriptions that have been dispensed and prepared for delivery shall be maintained under lock or in an area that is not readily accessible to the public and may be delivered to an owner by an unlicensed person, as designated by the veterinarian.

~~2.~~ 5. Whenever ~~a veterinarian discovers~~ a theft or any unusual loss of Schedule II~~, III, IV, or~~ through V drugs is discovered, ~~he~~ the veterinarian-in-charge, or in his absence, his designee, shall immediately report such theft or loss to the Board of Veterinary Medicine and the Board of Pharmacy and to the ~~U.S. Drug Enforcement Administration~~ DEA. The report to the boards shall be in writing and sent electronically or by regular mail. The report to the DEA shall be in accordance with 21 CFR 1301.76(b). If the veterinarian-in-charge is unable to determine the exact kind and quantity of the drug loss, he shall immediately take a complete inventory of all Schedule II through V drugs.

E. Schedule II~~, III, IV and~~ through V drugs shall be destroyed by (i) transferring the drugs to another entity authorized to possess or provide for proper disposal of such drugs or (ii) destroying the drugs ~~by burning in an incinerator that is~~ in compliance with applicable local, state, and federal laws and regulations. If Schedule II through V drugs are to be destroyed, a DEA drug destruction form shall be fully completed and used as the record of all drugs to be destroyed. A copy of the destruction form shall be retained at the veterinarian practice site with other inventory records.

F. The drug storage area shall have appropriate provision for temperature control for all drugs and biologics~~, including~~. If drugs requiring refrigeration are maintained at the facility, they shall be kept in a refrigerator with the interior thermometer maintained between 36°F and 46°F. If a refrigerated drug is in Schedule II through V, the drug shall be kept in a locked container secured to the refrigerator, or the refrigerator shall be locked. Drugs stored at room temperature shall be maintained between 59°F and 86°F.

G. The stock of drugs shall be reviewed frequently, and expired drugs shall be removed from the working stock of drugs at the expiration date and shall not be administered or dispensed.

~~G.~~ H. A distribution record shall be maintained in addition to the patient's record, in chronological order, for the administration and dispensing of all Schedule ~~II-V~~ II through V drugs.

This record is to be maintained for a period of ~~two~~ three years from the date of transaction. This record shall include the following:

1. Date of transaction;

2. Drug name, strength, and the amount dispensed, administered, and wasted;

3. ~~Client~~ Owner and animal identification; and

4. Identification of the veterinarian authorizing the administration or dispensing of the drug.

~~H.~~ I. Original invoices for all Schedule II~~, III, IV and~~ through V drugs received shall be maintained in chronological order on the premises where the stock of drugs is held, and the actual date of receipt ~~is~~ shall be noted. ~~Invoices for Schedule II drugs shall be maintained separately from other records.~~ All drug records shall be maintained for a period of ~~two~~ three years from the date of transaction.

~~I.~~ J. A complete and accurate inventory of all Schedule II~~, III, IV and~~ through V drugs shall be taken, dated, and signed on any date that is within two years of the previous biennial inventory. Drug strength must be specified. This inventory shall indicate if it was made at the opening or closing of business and shall be maintained on the premises where the drugs are held for ~~two~~ three years from the date of taking the inventory.

K. Inventories and records, including original invoices, of Schedule II drugs shall be maintained separately from all other records, and the establishment shall maintain a continuous inventory of all Schedule II drugs received, administered, or dispensed, with reconciliation at least monthly. Reconciliation requires an explanation noted on the inventory for any difference between the actual physical count and the theoretical count indicated by the distribution record. A continuous inventory shall accurately indicate the physical count of each Schedule II drug in the general and working stocks at the time of performing the inventory.

~~J.~~ L. Veterinary establishments in which bulk reconstitution of injectable, bulk compounding, or the prepackaging of drugs is performed shall maintain adequate control records for a period of one year or until the expiration, whichever is greater. The records shall show the name of the ~~drug(s)~~ drugs used; strength, if any; date repackaged; quantity prepared; initials of the veterinarian verifying the process; the assigned lot or control number; the manufacturer's or distributor's name and lot or control number; and an expiration date.

M. If a limited stationary or ambulatory practice uses the facilities of another veterinary establishment, the drug distribution log shall clearly reveal whose Schedule II through V drugs were used. If the establishment's drug stock is used, the distribution record shall show that the procedure was performed by a visiting veterinarian who has the patient record. If the visiting veterinarian uses his own stock of drugs, he shall make entries in his own distribution record and in the patient record and shall leave a copy of the patient record at the other establishment.

18VAC150-20-195. Recordkeeping.

A. A legible, daily record of each patient treated shall be maintained by the veterinarian at the permitted veterinary establishment and shall include ~~pertinent medical data such as drugs administered, dispensed or prescribed, and all relevant medical and surgical procedures performed. Records should contain~~ at a minimum:

1. Name of the patient and the owner;

2. Identification of the treating veterinarian and of the person making the entry (Initials may be used if a master list that identifies the initials is maintained.);

~~1.~~ 3. Presenting complaint/reason for contact;

4. Date of contact;

~~2.~~ 5. Physical examination findings~~, if appropriate~~;

~~3.~~ 6. Tests and diagnostics performed and results;

~~4.~~ 7. Procedures performed/treatment given and results; ~~and~~

~~5.~~ 8. Drugs ~~(and their dosages)~~ administered, dispensed, or prescribed, including quantity, strength and dosage, and route of administration. For vaccines, identification of the lot and manufacturer shall be maintained;

9. Radiographs or digital images clearly labeled with identification of the establishment, the patient name, date taken, and anatomic specificity. If an original radiograph or digital image is transferred to another establishment or released to the owner, a record of this transfer or release shall be maintained on or with the patient's records; and

10. Any specific instructions for discharge or referrals to other practitioners.

B. ~~Individual records~~ An individual record shall be maintained on each patient, except that records for economic animals or litters of companion animals under the age of four months may be maintained on a per ~~client~~ owner basis. ~~Client~~ Patient records, including radiographs or digital images, shall be kept for a period of three years following the last office visit or discharge of such animal from a veterinary establishment.

~~C. An animal identification system must be used by the establishment.~~

~~D. Upon the sale or closure of a veterinary establishment involving the transfer of patient records to another location, the veterinarian shall follow the requirements for transfer of patient records in accordance with § 54.1-2405 of the Code of Virginia.~~

~~E.~~ C. An initial rabies certification for an animal receiving a primary rabies vaccination shall clearly display the following information: "An animal is not considered immunized for at least 28 days after the initial or primary vaccination is administered."

18VAC150-20-200. Standards for stationary veterinary establishments.

A. ~~Full-service~~ Stationary establishments. A ~~full-service~~ stationary establishment shall provide surgery and encompass all aspects of health care for small or large animals, or both. All ~~full-service~~ stationary establishments shall meet the requirements set forth ~~below~~ in this subsection:

1. Buildings and grounds must be maintained to provide sanitary facilities for the care and medical well-being of patients.

a. Temperature, ventilation, and lighting must be consistent with the medical well-being of the patients.

b. ~~Water and waste.~~ There shall be on-premises:

(1) Hot and cold running water of drinking quality, as defined by the Virginia Department of Health;

(2) An acceptable method of disposal of deceased animals, in accordance with any local ordinance or state and federal regulations; and

(3) Refrigeration exclusively for carcasses of companion animals that require storage for 24 hours or more.

c. Sanitary toilet and lavatory shall be available for personnel and ~~clients~~ owners.

2. Areas within building. The areas within the facility shall include the following:

a. A reception area separate from other designated rooms;

b. Examination room or rooms containing a table or tables with nonporous surfaces;

c. ~~Surgery room. There shall be a~~ A room ~~which~~ that is reserved only for surgery and used for no other purpose. ~~The walls of the surgery room must be constructed of nonporous material and extend from the floor to the ceiling.~~ In order that surgery can be performed in a manner compatible with current veterinary medical practice with

regard to anesthesia, asepsis, life support, and monitoring procedures, the surgery room shall:

(1) Have walls constructed of nonporous material and extending from the floor to the ceiling;

(2) Be of a size adequate to accommodate a surgical table, anesthesia support equipment, surgical supplies, ~~the veterinarian, an assistant, and the patient~~ and all personnel necessary for safe performance of the surgery;

~~(2)~~ (3) Be kept so that storage in the surgery room shall be limited to items and equipment normally related to surgery and surgical procedures;

(4) Have a surgical table made of nonporous material;

(5) Have surgical supplies, instruments, and equipment commensurate with the kind of services provided;

(6) Have surgical and automatic emergency lighting to facilitate performance of procedures; and

~~(3)~~ (7) For ~~small animal facilities~~ establishments that perform surgery on small animals, have a door to close off the surgery room from other areas of the practice.

~~d. Laboratory.~~ 3. The veterinary establishment shall have, ~~as~~ at a minimum, proof of use of either in-house laboratory service or outside laboratory services for performing ~~the following~~ lab tests, consistent with appropriate professional care for the species being treated~~:~~.

~~(1) Urinalysis, including microscopic examination of sediment;~~

~~(2) Complete blood count, including differential;~~

~~(3) Flotation test for ova of internal parasites;~~

~~(4) Skin scrapings for diagnosing external parasites;~~

~~(5) Blood chemistries;~~

~~(6) Cultures and sensitivities~~;

~~(7) Biopsy;~~

~~(8) Complete necropses, including histopathology; and~~

~~(9) Serology.~~

~~e. Animal housing areas. These shall be provided with~~ 4. For housing animals, the establishment shall provide:

a. An animal identification system at all times when housing an animal;

b. Accommodations of appropriate size and construction to prevent residual contamination or injury;

~~(1) Separate compartments constructed in such a way as to prevent residual contamination;~~

~~(2)~~ c. Accommodations allowing for the effective separation of contagious and noncontagious patients; and

~~(3)~~ d. Exercise ~~runs which~~ areas that provide and allow effective separation of animals or walking the animals at medically appropriate intervals.

~~3. Radiology.~~ 5. A veterinary establishment shall~~: a. Either~~ either have radiology service in-house or documentation of outside services for obtaining diagnostic-quality radiographs. ~~b.~~ If radiology is in-house~~:~~

~~(1) Each radiograph shall be permanently imprinted with the identity of the facility or veterinarian, patient and the date of exposure. Each radiograph shall also be clearly labeled by permanent imprinting to reflect anatomic specificity.~~

~~(2) Document~~, the establishment shall:

a. Document that radiographic equipment complies with Part VI ~~(12VAC5-481-1580~~ (12VAC5-481-1581 et seq.), Use of Diagnostic X-Rays in the Healing Arts, of the Virginia Radiation Protection Regulations of the Virginia Department of Health, which requirements are adopted by this board and incorporated herewith by reference in this chapter.

~~c. Maintain radiographs as a part of the patient's record. If a radiograph is transferred to another establishment or released to the client, a record of this transfer must be maintained on or with the patient's records.~~

b. Maintain and utilize lead aprons and gloves and individual radiation exposure badges for each employee exposed to radiographs.

~~4. Equipment; minimum requirements.~~ 6. Minimum equipment in the establishment shall include:

~~a. Examination room containing a table with nonporous surface.~~

~~b. Surgery suite.~~

~~(1) Surgical table with nonporous surface;~~

~~(2) Surgical supplies, instruments and equipment commensurate with the kind of surgical services provided;~~

~~(3) Automatic emergency lighting;~~

~~(4) Surgical lighting;~~

~~(5) Instrument table, stand, or tray; and~~

~~(6) Waste receptacle.~~

~~c. Radiology (if in-house).~~

~~(1) Lead aprons and gloves;~~

~~(2) Radiation exposure badges; and~~

~~(3) X-ray machine.~~

~~d. General equipment.~~

~~(1) Steam pressure sterilizer or an~~ a. An appropriate method of sterilizing instruments;

~~(2)~~ b. Internal and external sterilization monitors~~, if steam pressure sterilizers are used~~;

~~(3)~~ c. Stethoscope;

~~(4) Thermometer;~~

~~(5)~~ d. Equipment for delivery of assisted ventilation appropriate to the species being treated, including ~~but not necessarily limited to: (a) A resuscitation bag; and (b) Endotracheal~~ endotracheal tubes~~.~~;

~~(6) Scales~~ e. Adequate means of determining patient's weight; and

~~(7)~~ f. Storage for records.

B. Additional requirements for stationary establishments.

1. A stationary establishment that is open to the public 24 hours a day shall have licensed personnel on premises at all times and shall be equipped to handle emergency critical care and hospitalization. The establishment shall have radiology/imaging and laboratory services available on site.

2. A stationary establishment that is not open to the public 24 hours a day shall have licensed personnel available during its advertised hours of operation and shall disclose to the public that the establishment does not have continuous staffing in compliance with § 54.1-3806.1 of the Code of Virginia.

3. All stationary establishments shall provide for continuity of care when a patient is transferred to another establishment.

~~Restricted~~ C. Limited stationary establishments. When the scope of practice is less than full service, a specifically ~~restricted~~ limited establishment ~~permit~~ registration shall be required. Upon submission of a completed application, satisfactory inspection, and payment of the ~~permit~~ registration fee, a ~~restricted~~ limited establishment ~~permit~~ registration may be issued. Such ~~restricted~~ establishments shall have posted in a conspicuous manner the specific limitations on the scope of practice on a form provided by the board.

~~1. Large animal establishment, ambulatory practice. A large animal ambulatory establishment is a mobile practice in which health care of large animals is performed at the location of the animal. Surgery on large animals may be performed as part of a large animal ambulatory practice provided the facility has surgical supplies, instruments and equipment commensurate with the kind of surgical services provided. All large animal ambulatory establishments shall meet the requirements of a full-service establishment in subsection A of this section with the exception of those set forth below:~~

~~a. All requirements for buildings and grounds.~~

~~b. All requirements for an examination room and surgery suite.~~

~~c. Equipment for assisted ventilation.~~

~~d. Scales.~~

~~2. Small animal establishment, house call practice. A small animal house call establishment is a mobile practice in which health care of small animals is performed at the residence of the owner of the small animal. Surgery may be performed only in a surgical suite that has passed inspection. Small animal house call facilities shall meet the~~

~~requirements of a full-service establishment in subsection A of this section with the exception of those set forth below:~~

~~a. All requirements for buildings and grounds.~~

~~b. All requirements for an examination room or surgery suite.~~

~~c. Steam pressure sterilizer.~~

~~d. Internal or external sterilization monitor.~~

~~3. Small animal establishment, outpatient practice. A small animal outpatient establishment is a stationary facility or ambulatory practice where health care of small animals is performed. This practice may include surgery, provided the facility is equipped with a surgery suite as required by subdivision A 2 c of this section. Overnight hospitalization shall not be required. All other requirements of a full-service establishment shall be met.~~

~~C.~~ D. A separate facility ~~permit~~ registration is required for separate practices that share the same location.

18VAC150-20-201. Standards for ambulatory veterinary establishments.

A. Agricultural or equine ambulatory practice. An agricultural or equine ambulatory establishment is a mobile practice in which health care is performed at the location of the animal. Surgery on large animals may be performed as part of an agricultural or equine ambulatory practice provided the establishment has surgical supplies, instruments, and equipment commensurate with the kind of surgical procedures performed. All agricultural or equine ambulatory establishments shall meet the requirements of a stationary establishment for laboratory, radiology, and minimum equipment, with the exception of equipment for assisted ventilation.

B. House call or proceduralist establishment. A house call or proceduralist establishment is an ambulatory practice in which health care of small animals is performed at the residence of the owner of the small animal or another establishment registered by the board. A veterinarian who has established a veterinarian-owner-patient relationship with an animal at the owner's residence or at another registered veterinary establishment may also provide care for that animal at the location of the patient.

1. Surgery may be performed only in a surgical suite at a registered establishment that has passed inspection.

2. House call or proceduralist establishments shall meet the requirements of a stationary establishment for laboratory, radiology, and minimum equipment, with the exception of equipment for assisted ventilation.

C. Mobile service establishment. A mobile service establishment is a veterinary clinic or hospital that can be moved from one location to another and from which veterinary services are provided. A mobile service establishment shall meet all the requirements of a stationary establishment appropriate for the services provided.

D. A separate establishment registration is required for separate practices that share the same location.

18VAC150-20-210. Revocation or suspension of a veterinary establishment ~~permit~~ registration.

A. The board may revoke or suspend or take other disciplinary action deemed appropriate against the registration ~~permit~~ of a veterinary establishment if it finds the establishment to be in violation of any ~~provisions~~ provision of laws or regulations governing veterinary medicine or if:

1. The board or its agents are denied access to the establishment to conduct an inspection or investigation;

2. The ~~licensee~~ holder of a registration does not pay any and all prescribed fees or monetary penalties;

3. The establishment is performing procedures beyond the scope of a ~~restricted~~ limited [stationary] establishment ~~permit~~ registration; or

4. The establishment has no veterinarian-in-charge registered with the board.

~~B. The Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) shall apply to any determination under this section.~~

Part VI

Equine Dental Technicians

18VAC150-20-220. Requirements for registration as an equine dental technician.

A. A person applying for registration as an equine dental technician shall provide a recommendation from at least two veterinarians licensed in Virginia who attest that at least 50% of their practice is equine, and that they have observed the applicant within the past five years immediately preceding the attestation and can attest to his competency to be registered as an equine dental technician.

B. The qualifications for registration shall include documentation of one of the following:

1. Current certification from the International Association of Equine Dentistry;

2. Completion of a board-approved certification program or training program;

3. Completion of a veterinary technician program that includes equine dentistry in the curriculum; or

4. Evidence of equine dental practice for at least five years and proof of 16 hours of continuing education in equine dentistry completed within the five years immediately preceding application for registration.

C. In order to maintain an equine dental technician registration, a person shall renew such registration by January 1 of each year by payment of the renewal fee specified in 18VAC150-20-100 and attestation of obtaining 16 hours of continuing education relating to equine dentistry within the past three years.

1. Equine dental technicians shall be required to maintain original documents verifying the date and subject of the continuing education program or course, the number of continuing education hours, and certification of completion from a sponsor. Original documents shall be maintained for a period of two years following renewal. The board shall periodically conduct a random audit to determine compliance. Practitioners selected for the audit shall provide all supporting documentation within ~~10~~ 14 days of receiving notification of the audit, unless granted an extension by the board.

a. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the technician, such as temporary disability, mandatory military service, or officially declared disasters.

b. The board may grant an extension for good cause of up to one year for the completion of continuing education requirements upon written request from the technician prior to the renewal date. Such an extension shall not relieve the technician of the continuing education requirement.

2. Registration may be renewed up to one year after the expiration date, provided a late fee as prescribed in 18VAC150-20-100 is paid in addition to the required renewal fee.

3. Reinstatement of registration expired for more than one year shall be at the discretion of the board. To reinstate a registration, the applicant shall pay the reinstatement fee as prescribed in 18VAC150-20-100 and submit evidence of completion of continuing education hours equal to the number of years in which the registration has been expired,

for a maximum of two years. The board may require additional documentation of clinical competency and professional activities.

Veterinarian Survey - DRAFT

Instructions:

The following survey will assist policy makers at the state, federal and local levels assess the adequacy of the current Veterinarian workforce and project future workforce needs in relation to [illegible] Council on Veterinary Medicine and to improve the health of all Virginians. By law, information collected [illegible] survey [illegible] Numbers and other individually identifying information are removed from Healthcare Workforce Data Center datasets. The [illegible] Data Center [illegible] aggregate or de-identified [illegible] organizations who meet our strict confidentiality standards. Participation in this survey is voluntary. You [illegible] by [illegible] the "Submit" button or by clicking on the "Finish" button at the bottom of the [illegible] clicking [illegible].

This survey includes questions [illegible] professions and among [illegible] federal data collection efforts. Some of the questions, particularly the [illegible]

Educational Background		
1)	Year of Birth:	*Dropdown: 2000 to 1920 (reverse order)*
2)	Sex:	*Dropdown: Male/Female*
	Please select the items that best describe your race/ethnicity. Please answer both question 3a about Hispanic origin and 3b about race/ethnicity.	
3a)	Select one:	*Check one*
		Hispanic, Latino or Spanish Origin
		Not Hispanic, Latino or Spanish Origin
3b)	Select all that apply:	*Check all that apply*
		White
		Black or African American
		American Indian or Alaska Native
		Asian
		Native Hawaiian or Pacific Islander
		Some other race
3c)	If some other race, please specify:	*Fill in the blank*
4)	Where did you graduate from high school (Secondary School)?	*Dropdown*
		Outside of the US or Canada
		Canada
		57 US States and Territories
5)	Was your childhood spent mostly in rural, urban or suburban areas?	*Dropdown: urban, rural, suburban*
6)	Where did you obtain your undergraduate degree?	*Dropdown*
		Did not obtain an undergraduate degree
		Outside of the US or Canada
		Canada
		57 US States and Territories
7)	Where did you complete veterinary school?	*Dropdown*
		Outside of the US or Canada
		Canada
		57 US States and Territories
8)	Please indicate any education you have completed as of today (excluding residencies or advanced training programs)? Please check all that apply:	*Check all that apply*
		Bachelor of Science Degree
		Other Bachelor's Degree
		Graduate Certificate
		Masters Degree
		PhD
		DVM/VMD
9)	Do you hold an active license to practice veterinary medicine in any other jurisdiction?	*Check all that apply*
		District of Columbia
		Kentucky
		Maryland
		North Carolina
		Tennessee
		West Virginia
		One or more other US states
10a)	Please indicate any residencies or recognized specialty training certificates you have completed as of today. Please check all that apply:	*Check all that apply*
		Anesthesiology and Anesthesia
		Animal Welfare
		Avian Practice
		Bacteriology/Mycology
		Beef Cattle Practice
		Behavior
		Canine and Feline Practice
		Canine Practice
		Cardiology
		Critical Care
		Dairy Practice
		Dentistry
		Dermatology
		Epidemiology
		Equine Practice
		Exotic Companion Animal
		Feline Practice
		Food Animal Practice

		Immunology
		Internal Medicine
		Laboratory Animal Medicine
		Microbiology
		Neurology
		Nutrition
		Oncology
		Ophthalmology
		Parasitology
		Pathology
		Pharmacology
		Poultry
		Radiation Oncology
		Radiology
		Reproductive Medicine
		Reptile Amphibian
		Shelter Medicine
		Sports Medicine and Rehabilitation
		Surgery
		Swine Health Management
		Toxicology
		Virology
		Zoological Medicine
10b)	Please indicate any other areas in which you have significant education, training or practice experience.	*Check all that apply*
		Preventative Medicine
		Theriogenology
		Others??????
10c)	If you have any other additional training or credentials, please provide a short description:	open ended
11)	Where did you complete your most recent residency or fellowship?	*Dropdown*
		Outside of the US or Canada
		Canada
		57 US States and Territories
		N/A
Current Employment Status		
12	Which choice best describes your *current* employment or work situation?	*Dropdown*
		Employed in a Veterinary-related capacity.
		Employed, NOT in a Veterinary-related capacity.
		I am retired.
		Voluntarily unemployed (including for medical reasons).
		Involuntarily unemployed.
13)	Overall, and taking into account all positions you fill, how satisfied are you with your *current* employment or work situation?	*Dropdown*
		Very satisfied
		Somewhat satisfied
		Somewhat dissatisfied
		Very dissatisfied
14)	If employed, how many positions do you *currently* hold?	*Dropdown*
	Note: There is no legal standard for part-time work, and each employer defines part-time work differently. Part-time work generally refers to workweeks of 35-hours per week or less. Per diem, temporary, contract, self-employed and seasonal workers, and workers subject to annual limits on hours should consider average hours spent working over the term of employment.	One part-time position
		One full-time position
		Two part-time positions
		position
		Two full-time positions
		More than two positions
15)	Considering all postions you *currently* fill, how long is your average workweek?	*Dropdown*
		I am not currently working
		1 to 4 hours
		5 to 9 hours
		10 to 14 hours
		15 to 19 hours
		20 to 24 hours
		25 to 29 hours
		30 to 34 hours
		35 to 39 hours
		40 to 44 hours
		45 to 49 hours
		50 to 54 hours
		55 to 59 hours
		60 to 64 hours
		65 to 69 hours
		70 to 74 hours
		75 to 79 hours
		80 or more hours
Unless otherwise noted, the rest of the questions draw on your experiences over the past 12 months. If you did not work in the past 12 months in a capacity that drew on your veterinary medical background, please skip to question 39.		
Primary Work Location		

Questions 16 to 22 refer to your primary place of employment, work or practice (volunteer or paid) over the past 12 months. This is the location where you spend the most work hours during an average workweek or where you spent the most weeks working in the past 12 months. You do not need to currently work at this location. These questions refer to a location, not an employer. Persons who consistently work in multiple locations (e.g. temporary workers, home health, multi-facility rounds) should choose the location where they are based.

16)	Please select the Virginia County or Independent City, or other location, of your primary place of employment, work or practice:	Dropdown: Outside of US Virginia Border State/DC Other US State List of Virginia's Cities and Counties
17)	How long have you worked at this particular location?	*Dropdown* I do not currently work at this location Less than 6 months 6 months to 1 year 1 to 2 years 3 to 5 years 6 to 10 years More than 10 years
18a)	Approximate number of weeks at which at least some time was spent at this work location within the past twelve months (exclude vacation, medical leave, etc):	*Dropdown: 1 week - 52 weeks*
18b)	How many hours do you (or did you) work in an average workweek at this location?	*Dropdown* 1 to 4 hours 5 to 9 hours 10 to 14 hours 15 to 19 hours 20 to 24 hours 25 to 29 hours 30 to 34 hours 35 to 39 hours 40 to 44 hours 45 to 49 hours 50 to 54 hours 55 to 59 hours 60 to 64 hours 65 to 69 hours 70 to 74 hours 75 to 79 hours 80 or more hours
19)	In the average workweek at this location, roughly what percentage of your working hours were spent in the following roles: **(Answers should roughly equate to 100%).**	*Dropdown: (for each sub-question)*
19a)	Administration or business-related matters	None 1% to 9% 10% to 19% 20% to 29% 30% to 39% 40% to 49% 50% to 59% 60% to 69% 70% to 79% 80% to 89% 90% to 99% 100%
19b)	Direct patient care, including patient education and coordination of care	
19c)	Education of health professions students	
19d)	Formal research	
19e)	Other	
20a)	Average number of patient care visits you conduct(ed) at this location per week?	None 1 to 24 25 to 49 50 to 74 75 to 99 100 to 124 125 to 149 150 to 174 175 to 199 200 to 224 225 to 249 250 to 274 275 to 299 300 or more
21a)	Please select the choice that best describes this location's organizational sector:	*Dropdown* For-profit (e.g. private practice, corporate) Non-profit (including religious affiliated) State/local-government US military Veterans Administration Other federal government
21b)	Please select the choice that best describes this practice setting:	*Dropdown:* Solo practice/Partnership Group practice Public Health Program Veterinary Education Progam Veterinary Technology Education Program Non-veterinary Education Program Supplier Organization Other Practice Setting

21c)	If you selected "other practice setting" please provide a brief description:	*Open-ended*
22)	Please indicate how you are (were) personally compensated for activities at this location:	*Dropdown*
		Salary/Commission (excluding salaries from owners/partners)
		Business/Practice income (including salaries of owners/partners)
		Hourly wage
		By contract, per diem, traveling
		Volunteer, unreimbursed

If you only had one practice location in the past 12 months, please skip to question 33. If you had additional practice locations, please continue.

Secondary Work Location

Questions 23 to 30 refer to your secondary place of employment, work or practice (volunteer or paid) over the past 12 months. This is the location where you spend the second most work hours during an average workweek or where you spent the second most weeks working in the past 12 months. You do not need to currently work at this location. These questions refer to a location, not an employer. Persons who consistently work in multiple locations (e.g. temporary workers, home health, multi-facility rounds) should choose the location where they are based.

23	Is this location with the same employer or practice as your primary location, or a different employer/practice?	*Dropdown*
		Same employer or practice
		Different employer or practice
24)	Please select the Virginia County or Independent City, or other location, of your primary place of employment, work or practice:	Dropdown:
		Outside of US
		Virginia Border State/DC
		Other US State
		List of Virginia's Cities and Counties
25)	How long have you worked at this particular location?	*Dropdown*
		I do not currently work at this location
		Less than 6 months
		6 months to 1 year
		1 to 2 years
		3 to 5 years
		6 to 10 years
		More than 10 years
26a)	Approximate number of weeks at which at least some time was spent at this work location within the past twelve months (exclude vacation, medical leave, etc):	*Dropdown: 1 week - 52 weeks*
26b)	How many hours do you (or did you) work in an average workweek at this location?	*Dropdown*
		1 to 4 hours
		5 to 9 hours
		10 to 14 hours
		15 to 19 hours
		20 to 24 hours
		25 to 29 hours
		30 to 34 hours
		35 to 39 hours
		40 to 44 hours
		45 to 49 hours
		50 to 54 hours
		55 to 59 hours
		60 to 64 hours
		65 to 69 hours
		70 to 74 hours
		75 to 79 hours
		80 or more hours
27)	In the average workweek at this location, roughly what percentage of your working hours were spent in the following roles: **(Answers should roughly equate to 100%).**	*Dropdown: (for each sub-question)*
27a)	Administration or business-related matters	None
27b)	Direct patient care, including patient education and coordination of care	1% to 9%
27c)	Education of health professions students	10% to 19%
27d)	Formal research	20% to 29%
27e)	Other	30% to 39%
		40% to 49%
		50% to 59%
		60% to 69%
		70% to 79%
		80% to 89%
		90% to 99%
		100%
28a)	Average number of patient care visits you conduct(ed) at this location per week?	None
		1 to 24
		25 to 49
		50 to 74
		75 to 99
		100 to 124
		125 to 149
		150 to 174
		175 to 199
		200 to 224
		225 to 249

		250 to 274
		275 to 299
		300 or more
29a)	Please select the choice that best describes this location's organizational sector:	*Dropdown*
		For-profit (e.g. private practice, corporate)
		Non-profit (including religious affiliated)
		State/local-government
		US military
		Veterans Administration
		Other federal government
29b)	Please select the choice that best describes this practice setting:	*Dropdown:*
		Solo practice/Partnership
		Group practice
		Public Health Program
		Veterinary Education Progam
		Veterinary Technology Education Program
		Non-veterinary Education Program
		Supplier Organization
		Other Practice Setting
29c)	If you selected "other practice setting" please provide a brief description:	*Open-ended*
30)	Please indicate how you are (were) personally compensated for activities at this location:	*Dropdown*
		Salary/Commission (excluding salaries from owners/partners)
		Business/Practice income (including salaries of owners/partners)
		Hourly wage
		By contract, per diem, traveling
		Volunteer, unreimbursed

If you had only two locations in the past 12 months, please skip to question 33. If you had additional practice locations, please continue.

31)	How many **total** work locations have you had *over the past 12 months?*	*Dropdown*
		3
		4
		5
		6 or more
32)	How many work locations do you have *currently?*	*Dropdown*
		3
		4
		5
		6 or more

Employment Information

The Healthcare Workforce Data Center collects compensation information to assess the balance of supply and demand in the state and in localities, and to assist students in planning health careers and choosing specialties. Information from these questions will only be presented in the aggregate. The confidentiality of information for these and all questions is protected by law. All questions are voluntary.

33)	Within the past 12 months, have you experienced any of the following:	*Check all that apply*
		Voluntary unemployment (including for medical reasons)?
		Involuntary unemployment?
		Switched employers/practices?
		Worked part-time or temporary positions, but would have preferred a full-time or permanent position?
		Worked two or more positions at the same time?
34)	What is your estimated annual net income from your veterinary medicine related activities?	*Dropdown:*
		Volunteer work only
		Less than $30,000
		$30,000-$39,999
		$40,000-$49,999
		$50,000-$59,999
		$60,000-$69,999
		$70,000-$79,999
		$80,000-$89,999
		$90,000-$99,999
		$100,000-$109,999
		$110,000-$119,999
		$120,000-$129,999
		$130,000-$139,999
		$140,000-$149,999
		$150,000-$159,999
		$160,000-$169,999
		$170,000-$179,999
		$180,000-$189,999
		$190,000-$199,999
		$200,000-$209,999
		$210,000-$219,999
		$220,000-$229,999
		$230,000-$239,999

		$240,000-$249,999
		$250,000-$259,999
		$260,000-$269,999
		$270,000-$279,999
		$280,000-$289,999
		$290,000-$299,999
		$300,000-$309,999
		$310,000-$319,999
		$320,000-$329,999
		$330,000-$339,999
		$340,000-$349,999
		$350,000 or more
316)	Do you receive any of the following benefits from any *current* employer?	
		Check all that apply:
		Paid Vacation
		Paid Sick Leave
		Health Insurance
		Dental Insurance
		Retirement (401k, Pension, etc.)
		Group Life Insurance
		Signing/retention bonus
36)	What is your estimated current educational debt?	
		Dropdown:
		None
		Less than $10,000
		$10,000-$19,999
		$20,000-$29,999
		$30,000-$39,999
		$40,000-$49,999
		$50,000-$59,999
		$60,000-$69,999
		$70,000-$79,999
		$80,000-$89,999
		$90,000-$99,999
		$100,000-$109,999
		$110,000-$119,999
		$120,000-$129,999
		$130,000-$139,999
		$140,000-$149,999
		$150,000-$159,999
		$160,000-$169,999
		$170,000-$179,999
		$180,000-$189,999
		$190,000-$199,999
		$200,000 or more
37)	At what age do you plan to retire from veterinary medicine?	
		Dropdown
		Under age 50
		50 to 54
		55 to 59
		60 to 64
		65 to 69
		70 to 74
		75 to 79
		80 or over
		I do not intend to retire
38)	Within the next two years do you plan to do any of the following:	
		Check all that apply
		Retire
		Cease working in veterinary medicine
		Continue working in veterinary medicine, but cease working in Virginia
		Increase patient care hours
		Decrease patient care hours
		Increase time spent teaching veterinary medicine
		Pursue additional veterinary medical education
End of Questionnaire for active practitioners-Thank you!		
39)	If you did not practice, teach or otherwise work in veterinary medicine within the past twelve months, did/are you. . .?	
		Check all that apply:
		I am retired.
		Work occasionally for charity/consultation/special patients?
		Pursue veterinary medical education or certifications?
		Pursue education not related to veterinary medicine?
		Work in another profession or field?
		Experience temporary **voluntary** unemployment (including for medical reasons)?
		Experience temporary **involuntary** unemployment?
40)	Do you provide any volunteer, mentoring or other services within veterinary medicine in Virginia? If so, approximately how many hours in the past year?	
		Dropdown:
		None
		1-25 hours
		26-50 hours

		51-75 hours
		76-100 hours
		Over 100 hours
41)	Do you expect to begin working in veterinary medicine in Virginia? If so, when?	*Dropdown:*
		Not currently planning to practice/work in Virginia
		Plan to practice/work in a volunteer capacity
		Yes, within the next year
		Yes, within 1-2 years
		Yes, within 3-5 years
		Yes, in more than 5 years
		Yes, do not know when
End of Questionnaire-Thank you!		

Veterinary Technician Survey - DRAFT

Instructions:

The following survey will assist policymakers at the state, federal and local levels assess the adequacy of the current Veterinary Technology workforce and project future workforce trends in relation to Virginia's changing population and health needs. It will help us advance the practice of Veterinary Technology and to improve the health of all Virginians. By law, information collected as part of this survey is confidential. License numbers and other individually identifying information are removed from Healthcare Workforce Data Center data sets. The Healthcare Workforce Data Center only releases information in the aggregate or to qualified research organizations who meet our strict confidentiality standards. Participation in this survey is voluntary. You may exit the survey at any time by scrolling to the bottom and pushing the "Submit" button or by clicking on the "Finish" button at the bottom of the left sidebar. Note: Clicking "Finish" will finalize your renewal application.

The survey questions are designed to allow comparisons across professions, and among state and federal data collection efforts. Some of the questions, particularly the demographic questions, match Federal data collection standards.

Education and Background		
1)	**Year of Birth:**	*Dropdown: 2000 to 1920 (reverse order)*
2)	Sex:	*Dropdown: Male/Female*
	Please select the items that best describe your race/ethnicity. Please answer both question 3a about Hispanic origin and 3b about race/ethnicity.	
3a)	Select one:	*Check one*
		Hispanic, Latino or Spanish Origin
		Not Hispanic, Latino or Spanish Origin
3b)	Select all that apply:	*Check all that apply*
		White
		Black or African American
		American Indian or Alaska Native
		Asian
		Native Hawaiian or Pacific Islander
		Some other race
3c)	If some other race, please specify:	*Fill in the blank*
4)	Where did you graduate from high school (Secondary School)?	*Dropdown*
		Outside of the US or Canada
		Canada
		57 US States and Territories
5)	Was your childhood spent mostly in rural, urban or suburban areas?	*Dropdown: urban, rural, suburban*
6)	Where did you obtain your associate's degree?	*Dropdown*
		Did not obtain an undergraduate degree
		Outside of the US or Canada
		Canada
		57 US States and Territories
7)	Where did you obtain the degree that initially qualified you to practice veterinary technology?	*Dropdown*
		Outside of the US or Canada
		Canada
		57 US States and Territories
8)	Please indicate the highest level of veterinary technologist education you have completed as of today:	*Dropdown*
		Associate Degree
		Bachelor Degree
		Other
9)	Do you hold an active license to practice veterinary technology in any other jurisdiction?	*Check all that apply*
		District of Columbia
		Kentucky
		Maryland
		North Carolina
		Tennessee
		West Virginia
		One or more other US states
Current Employment Status		
10	Which choice best describes your *current* employment or work situation?	*Dropdown*
		Employed in a veterinary technician related capacity.
		Employed, NOT in a veterinary technician related capacity.
		I am retired.
		Voluntarily unemployed (including for medical reasons).

		Involuntarily unemployed.
11)	Overall, and taking into account all positions you fill, how satisfied are you with your *current* employment or work situation?	*Dropdown*
		Very satisfied
		Somewhat satisfied
		Somewhat dissatisfied
		Very dissatisfied
12)	How many positions do you *currently* hold?	*Dropdown*
	Note: There is no legal standard for part-time work, and each employer defines part-time work differently. Part-time work generally refers to workweeks of 35-hours per week or less. Per diem, temporary, contract, self-employed and seasonal workers, and workers subject to annual limits on hours should consider average hours spent working over the term of employment.	Not currently working
		One part-time position
		One full-time position
		Two part-time positions
		One full-time position & one part-time position
		Two full-time positions
		More than two positions
13)	Considering all postions you *currently* fill, how long is your average workweek?	*Dropdown*
		I am not currently working
		1 to 4 hours
		5 to 9 hours
		10 to 14 hours
		15 to 19 hours
		20 to 24 hours
		25 to 29 hours
		30 to 34 hours
		35 to 39 hours
		40 to 44 hours
		45 to 49 hours
		50 to 54 hours
		55 to 59 hours
		60 to 64 hours
		65 to 69 hours
		70 to 74 hours
		75 to 79 hours
		80 or more hours
Unless otherwise noted, the rest of the questions draw on your experiences over the past 12 months. If you did not work in the past 12 months in a capacity that drew on veterinary technology background, please skip to question 37.		
Primary Work Location		
Questions 14 to 20 refer to your primary place of employment, work or practice (volunteer or paid) over the past 12 months. This is the location where you spend the most work hours during an average workweek or where you spent the most weeks working in the past 12 months. You do not need to currently work at this location. These questions refer to a location, not an employer. Persons who consistently work in multiple locations (e.g. temporary workers, home health, multi-facility rounds) should choose the location where they are based.		
14)	Please select the Virginia County or Independent City, or other location, of your primary place of employment, work or practice:	*Dropdown:*
		Outside of US
		Virginia Border State/DC
		Other US State
		List of Virginia's Cities and Counties
15)	How long have you worked at this particular location?	*Dropdown*
		I do not currently work at this location
		Less than 6 months
		6 months to 1 year
		1 to 2 years
		3 to 5 years
		6 to 10 years
		More than 10 years
16a)	Approximate number of weeks at which at least some time was spent at this work location within the past twelve months (exclude vacation, medical leave, etc):	*Dropdown: 1 week - 52 weeks*
16b)	How many hours do you (or did you) work in an average workweek at this location?	*Dropdown*
		1 to 4 hours
		5 to 9 hours
		10 to 14 hours
		15 to 19 hours
		20 to 24 hours
		25 to 29 hours
		30 to 34 hours

		35 to 39 hours
		40 to 44 hours
		45 to 49 hours
		50 to 54 hours
		55 to 59 hours
		60 to 64 hours
		65 to 69 hours
		70 to 74 hours
		75 to 79 hours
		80 or more hours
17)	In the average workweek at this location, roughly what percentage of your working hours were spent in the following roles: **(Answers should roughly equate to 100%).**	*Dropdown: (for each sub-question)*
17a)	Administration or business-related matters	None
17b)	Direct patient care, including client education and coordination of care	1% to 9%
17c)	Education of health professions students	10% to 19%
17d)	Formal research	20% to 29%
17e)	Other	30% to 39%
		40% to 49%
		50% to 59 %
		60% to 69%
		70% to 79%
		80% to 89%
		90% to 99%
		100%
18)	Average number of patient care visits you conduct(ed) at this location per week:	None
		1 to 24
		25 to 49
		50 to 74
		75 to 99
		100 to 124
		125 to 149
		150 to 174
		175 to 199
		200 or more
19a)	Please select the choice that best describes this location's organizational sector:	*Dropdown*
		For-profit (e.g. private practice, corporate)
		Non-profit (including religious affiliated)
		State/local-government
		US military
		Veterans Administration
		Other federal government
19b)	Please select the choice that best describes this practice setting:	*Dropdown:*
		Solo practice/Partnership
		Group practice
		Public health program
		Veterinary Technology program, Community College
		Veterinary Technology program, Technical School
		Supplier organization
		Other
19c)	If you selected "other practice setting" please provide a brief description:	*Open-ended*
20)	Please indicate how you are (were) personally compensated for activities at this location:	*Dropdown*
		Salary/Commission (excluding salaries from owners/partners)
		Business/Practice income (including salaries of owners/partners)
		Hourly wage
		By contract, per diem, traveling
		Volunteer, unreimbursed

If you only had one practice location in the past 12 months, please skip to question 31. If you had additional practice locations, please continue.

Secondary Work Location

Questions 21 to 28 refer to your secondary place of employment, work or practice (volunteer or paid) over the past 12 months. This is the location where you spend the second most work hours during an average workweek or where you spent the second most weeks working in the past 12 months. You do not need to currently work at this location. These questions refer to a location, not an employer. Persons who consistently work in multiple locations (e.g. temporary workers, home health, multi-facility rounds) should choose the location where they are based.

21	Is this location with the same employer or practice as your primary location, or a different employer/practice?	*Dropdown*
		Same employer or practice

		Different employer or practice
22)	Please select the Virginia County or Independent City, or other location, of your primary place of employment, work or practice:	*Dropdown:*
		Outside of US
		Virginia Border State/DC
		Other US State
		List of Virginia's Cities and Counties
23)	How long have you worked at this location?	Dropdown
		I do not currently work here
		Less than 6 months
		6 months to 1 year
		1 to 2 years
		3 to 5 years
		6 to 10 years
		More than 10 years
24a)	Approximate number of weeks at which at least some time was spent at this work location within the past twelve months (exclude vacation, medical leave, etc):	*Dropdown: 1 week - 52 weeks*
24b)	How many hours do you (or did you) work in an average workweek at this location?	*Dropdown*
		1 to 4 hours
		5 to 9 hours
		10 to 14 hours
		15 to 19 hours
		20 to 24 hours
		25 to 29 hours
		30 to 34 hours
		35 to 39 hours
		40 to 44 hours
		45 to 49 hours
		50 to 54 hours
		55 to 59 hours
		60 to 64 hours
		65 to 69 hours
		70 to 74 hours
		75 to 79 hours
		80 or more hours
25)	In the average workweek at this location, roughly what percentage of your working hours were spent in the following roles: **(Answers should roughly equate to 100%)**.	*Dropdown: (for each sub-question)*
25a)	Administration or business-related matters	None
25b)	Direct patient care, including patient education and coordination of care	1% to 9%
25c)	Education of health professions students	10% to 19%
25d)	Formal research	20% to 29%
25e)	Other	30% to 39%
		40% to 49%
		50% to 59 %
		60% to 69%
		70% to 79%
		80% to 89%
		90% to 99%
		100%
26)	Average number of patient care visits you conduct(ed) at this location per week:	None
		1 to 24
		25 to 49
		50 to 74
		75 to 99
		100 to 124
		125 to 149
		150 to 174
		175 to 199
		200 or more
27a)	Please select the choice that best describes this location's organizational sector:	*Dropdown*
		For-profit (e.g. private, corporate)
		Non-profit (including religious affiliated)
		State/local-government
		US military
		Veterans Administration
		Other federal government
27b)	Please select the choice that best describes this practice setting:	*Dropdown:*
		Solo practice/Partnership
		Group practice
		Public health program
		Veterinary Technology program, Community College

		Veterinary Technology program, Technical School
		Supplier organization
		Other
27c)	If you selected "other practice setting" please provide a brief description:	*Open-ended*
28)	Please indicate how you are (were) personally compensated for activities at this location:	*Select all that apply:*
		Salary/Commission (excluding salaries from owners/partners)
		Business/Practice income (including salaries of owners/partners)
		Hourly wage
		By contract, per diem, traveling
		Volunteer, unreimbursed

If you had only two locations in the past 12 months, please skip to question 31. If you had additional practice locations, please continue.

29)	How many **total** work locations have you had *over the past 12 months?*	*Dropdown*
		3
		4
		5
		6 or more
30)	How many work locations do you have *currently?*	*Dropdown*
		3
		4
		5
		6 or more

Employment Information

The Healthcare Workforce Data Center collects compensation information to assess the balance of supply and demand in the state and in localities, and to assist students in planning health careers and choosing specialties. Information from these questions will only be presented in the aggregate. The confidentiality of information for these and all questions is protected by law. All questions are voluntary.

31)	**Within the past 12 months, have you experienced any of the following:**	***Check all that apply***
		Voluntary unemployment (including for medical reasons)?
		Involuntary unemployment?
		Switched employers/practices?
		Worked part-time or temporary positions, but would have preferred a full-time or permanent position?
		Worked two or more positions at the same time?
32)	What is your estimated annual net income from veterinary technology related activities?	*Dropdown:*
		Volunteer work only
		Less than $20,000
		$20,000-$29,999
		$30,000-$39,999
		$40,000-$49,999
		$50,000-$59,999
		$60,000 or more
33)	Do you receive any of the following benefits from any *current* employer?	*Check all that apply:*
		Paid Vacation
		Paid Sick Leave
		Health Insurance
		Dental Insurance
		Retirement (401k, Pension, etc.)
		Group Life Insurance
		Signing/retention bonus
34)	What is your estimated current educational debt?	*Dropdown:*
		None
		Less than $10,000
		$10,000-$19,999
		$20,000-$29,999
		$30,000-$39,999
		$40,000-$49,999
		$50,000-$59,999
		$60,000-$69,999
		$70,000-$79,999
		$80,000-$89,999
		$90,000-$99,999
		$100,000 or more

35)	At what age do you plan to retire from veterinary technology?	*Dropdown*
		Under age 50
		50 to 54
		55 to 59
		60 to 64
		65 to 69
		70 to 74
		75 to 79
		80 or over
		I do not intend to retire
36)	Within the next two years do you plan to do any of the following:	*Check all that apply*
		Retire
		Cease working in the veterinary technology field
		Continue working in the veterinary technology field, but cease working in Virginia
		Increase patient care hours
		Decrease patient care hours
		Increase time spent teaching veterinary technology
		Pursue additional education in the veterinary medicine field
End of Questionnaire for active practitioners-Thank you!		
37)	If you did not practice, teach or otherwise work in veterinary technology within the past twelve months, did/are you. . .?	*Check all that apply:*
		I am retired.
		Work occasionally for charity/consultation/special patients?
		Pursue education or certifications in the field of veterinary technology or veterinary medicine?
		Pursue education outside of the field of veterinary technology or veterinary medicine?
		Work in another profession or field?
		Experience temporary **voluntary** unemployment (including for medical reasons)?
		Experience temporary **involuntary** unemployment?
38)	Do you provide any volunteer, mentoring or other services within veterinary technology in Virginia? If so, approximately how many hours in the past year?	*Dropdown:*
		None
		1-25 hours
		26-50 hours
		51-75 hours
		76-100 hours
		Over 100 hours
39)	Do you expect to begin working in veterinary technology in Virginia? If so, when?	*Dropdown:*
		Not currently planning to practice/work in Virginia
		Plan to practice/work in a volunteer capacity
		Yes, within the next year
		Yes, within 1-2 years
		Yes, within 3-5 years
		Yes, in more than 5 years
		Yes, do not know when
End of Questionnaire-Thank you!		

Expert admissibility standards to consider:

Traditional Virginia Standard:

To qualify to serve as an expert witness, an individual:

> must possess sufficient knowledge, skill, or experience regarding the subject matter of the testimony to assist the trier of fact in the search for the truth. Generally, a witness possesses sufficient expertise when, through experience, study or observation the witness acquires knowledge of a subject beyond that of persons of common intelligence and ordinary experience.

Virginia Medical Malpractice Standard:

To qualify to serve as an expert witness, an individual:

> [a]ny health care provider who is licensed to practice in Virginia shall be presumed to know the statewide standard of care in the specialty or field of practice in which he is qualified and certified....A witness shall be qualified to testify as an expert on the standard of care if he demonstrates expert knowledge of the standards of the defendant's specialty and of what conduct conforms or fails to conform to those standards and if he has had active clinical practice in either the defendant's specialty or a related field of medicine within one year of the date of the alleged act or omission forming the basis of the action.

Discussion Item – Drug Loss Investigation Protocol

18VAC150-20-190. Requirements for drug storage, dispensing, destruction, and records for all establishments, full service and restricted.

D. All drugs shall be maintained in a secured manner with precaution taken to prevent diversion.

2. Whenever a veterinarian discovers a theft or any unusual loss of Schedule II, III, IV, or V drugs, he shall immediately report such theft or loss to the Board of Veterinary Medicine and to the U.S. Drug Enforcement Administration.

Criteria for this report:
License Status = Current Active, Current Inactive, Probation - Current Active, Adverse Findings - Current Active, Current Active-RN Privilege and Expiration Date >= Today or is null.

License Count Report for Veterinary Medicine

Board	Occupation	State	License Status	License Count
Veterinary Medicine				
	Equine Dental Technician			
	Equine Dental Technician	Virginia	Current Active	16
	Equine Dental Technician	Out of state	Current Active	8
	Total for Equine Dental Technician			24
	Veterinarian			
	Veterinarian	Virginia	Current Active	3,023
	Veterinarian	Virginia	Current Inactive	47
	Veterinarian	Virginia	Probation - Curre	1
	Veterinarian	Out of state	Current Active	839
	Veterinarian	Out of state	Current Inactive	238
	Total for Veterinarian			4,148
	Veterinary Establishment - Full Service			
	Veterinary Establishment - Full Service	Virginia	Current Active	759
	Veterinary Establishment - Full Service	Out of state	Current Active	12
	Total for Veterinary Establishment - Full Service			771
	Veterinary Establishment - Restricted			
	Veterinary Establishment - Restricted	Virginia	Current Active	323
	Veterinary Establishment - Restricted	Out of state	Current Active	12
	Total for Veterinary Establishment - Restricted			335
	Veterinary Technician			
	Veterinary Technician	Virginia	Current Active	1,745
	Veterinary Technician	Virginia	Current Inactive	38
	Veterinary Technician	Out of state	Current Active	237
	Veterinary Technician	Out of state	Current Inactive	25
	Total for Veterinary Technician			2,045
Total for Veterinary Medicine				7,323

CURRENT ACTIVE & INACTIVE LICENSES					
License Type	**FY2012**	**FY2013**	**FY2014**	**FY2015**	**4/5/2017**
Veterinarian	3530	3960	4038	4,145	4,148
Veterinary Technician	1579	1689	1788	1,917	2,045
Equine Dental Technician	24	23	23	24	24
Full Service Veterinary Establishment	735	744	750	768	771
Restricted Service Veterinary Establishment	270	287	298	315	335
Total	6138	6703	6897	7,169	7,323

Run Date: 4/5/2017 10:33

Virginia Department of Health Professions
Cash Balance
As of February 28, 2017

	106- Veterinary Medicine
Board Cash Balance as of June 30, 2016	$ 572,256
YTD FY17 Revenue	1,070,722
Less: YTD FY17 Direct and In-Direct Expenditures	713,862
Board Cash Balance as February 28, 2017	$ 929,115

Virginia Department of Health Professions
Cash Balance
As of June 30, 2016

	106- Veterinary Medicine
Board Cash Balance as of June 30, 2015	$ 380,095
YTD FY16 Revenue	1,116,829
Less: YTD FY16 Direct and In-Direct Expenditures	924,668
Board Cash Balance as June 30, 2016	572,256

From: Virginia Board of Veterinary Medicine [mailto:vetbd@dhp.virginia.gov]
Sent: Thursday, March 09, 2017 7:04 PM
Subject: News You Need: Veterinary Establishment Inspection Highlight

Virginia Department of Health Professions

Board of Veterinary Medicine

Board of Veterinary Medicine

Veterinary Establishment Inspection Requirements

Highlight of the Month

The Board of Veterinary Medicine conducted a frequency analysis of deficiencies cited during veterinary establishment inspections. To keep licensees informed about compliance requirements, the most commonly cited deficiencies will be identified in a monthly email during 2017. This month's highlighted requirement is the following:

Regulations Governing the Practice of Veterinary Medicine state the following regarding biennial drug inventories:

18VAC150-20-190. Requirements for drug storage, dispensing, destruction, and records for all establishments, full service and restricted.

I. A complete and accurate inventory of all Schedule II, III, IV and V drugs shall be taken, dated, and signed on any date which is within two years of the previous biennial inventory. Drug strength must be specified. This inventory shall indicate if it was made at the opening or closing of business and shall be maintained on the premises where the drugs are held for two years from the date of taking the inventory.

Guidance Document **76-21.2:1 Veterinary Establishment Inspection Report** states the following regarding the biennial drug inventory requirement found in 18VAC150-20-190(I):

The inventory must be taken on any date which is within two years of the previous inventory, but may be taken more often. The purpose of indicating whether the biennial inventory was taken at the opening or closing of business is to determine whether the drugs received or used on the day of the inventory should be counted, if a drug audit is conducted. The inventory must be signed and dated by the veterinarian-in-charge.

Questions may be directed to the vetbd@dhp.virginia.gov