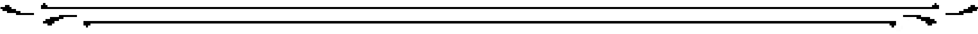
Meeting of the Virginia Board of Medicine

October 25, 2024
8:30 a.m.

Virginia Department of Health Professions



Board of Medicine
Friday, October 25, 2024 @ 8:30 a.m.
Perimeter Center
9960 Mayland Drive, Suite 201
Board Room 2
Henrico, VA 23233

Call to Order and Roll Call for Full Board Meeting

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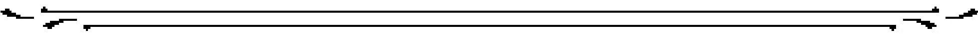

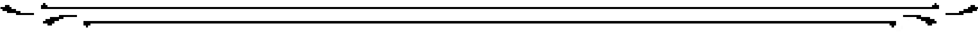

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New Business:

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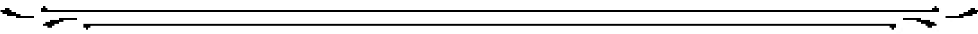

PERIMETER CENTER CONFERENCE CENTER
EMERGENCY EVACUATION OF BOARD AND TRAINING ROOMS
(Script to be read at the beginning of each meeting.)

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

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

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

Board Room 2

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

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

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

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

Agenda Item: Presentation of Cases for Possible Summary Suspension

Staff Note: The Office of the Attorney General and the Administrative Proceedings Division will present several cases for the Board's consideration to summarily suspend the license of the practitioners.

Action: The Board will vote to suspend the licenses or determine an alternative approach.

** 2 **

Agenda Item: **Approval of Minutes of the June 13, 2024**

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

Action: Motion to approve minutes.

---DRAFT - UNAPPROVED---

VIRGINIA BOARD OF MEDICINE
FULL BOARD MINUTES

June 13, 2024	Department of Health Professions	Henrico, VA 23233

CALL TO ORDER:	Dr. Clements called the meeting to order at 8:40 a.m.
ROLL CALL:	Ms. Brown called the roll; a quorum was established.
MEMBERS PRESENT:	John R. Clements, DPM – President & Chair Peter J. Apel, MD – Vice-President Karen Ransone, MD – Secretary-Treasurer Jacob W. Miller, DO David Archer, MD Hazem A. Elariny, MD L. Blanton Marchese Pradeep Pradhan, MD Jennifer Rathmann, DC Manjit Dhillon, MD Madge Ellis, MD William Hutchens, MD Oliver Kim, JD, LLM Elliott Lucas, MD Thomas Corry Deborah DeMoss Fonseca
MEMBERS ABSENT:	Patrick McManus, MD Krishna P. Madiraju, MD
STAFF PRESENT:	William L. Harp, MD - Executive Director Jennifer Deschenes, JD – Dep. Exec. Dir. for Discipline Colanthia Morton Opher – Dep. Exec Dir. for Board Administration Michael Sobowale, LLM – Dep. Exec. Dir. for Licensure Barbara Matusiak, MD, Medical Review Coordinator Deirdre Brown - Executive Assistant Arne Owens – DHP Director M. Brent Saunders, JD – Sr. Asst. Attorney General/Board Counsel
OTHERS PRESENT:	Jennie Wood – Discipline Case Manager Tamika Hines – Discipline Case Manager Roslyn Nickens – Licensing Supervisor Krystal Blanton - Discipline Compliance Matt Novak – DHP Policy Analyst Yetty Shobo – Director, Healthcare Workforce Data Center

Barbara Hodgdon – Dep. Dir., Healthcare Workforce Data Center
Robert Jenkins – Director of DHP IT
Neil Kauder – Visual Research, Inc.
Kim Small – Visual Research, Inc.
Scott Castro – Medical Society of Virginia
W. Scott Johnson – Hancock Daniel & Johnson
Elizabeth Lunn – Hancock Daniel & Johnson
Raza Glasgow, PA-C
Michele Satterlund – Macaulay Jamerson Satterlund & Sessa, PC
Jonathan Williams – Virginia Academy of Physician Assistants

EMERGENCY EGRESS INSTRUCTIONS

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

APPROVAL OF MINUTES OF FEBRUARY 15, 2024

ACTION: Dr. Miller moved to approve the minutes from February 15, 2024. The motion was properly seconded by Dr. Apel and carried unanimously.

ADOPTION OF AGENDA

Dr. Harp requested that the agenda be amended to include the meeting minutes of the Advisory Board of Surgical Assistants from June 10, 2024.

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

PUBLIC COMMENT

None.

PRESIDENTIAL COMMENT

Dr. Clements introduced and welcomed the Governor's Fellow, Max Suskin, to the Board; Mr. Suskin thanked everyone for the warm welcome.

PRESENTATIONS:

"UPDATED SANCTIONING REFERENCE POINTS" – Kim Small – Visual Research

Ms. Small gave a presentation on the "Updated Sanctioning Reference Points". She asked the Board to consider implementing the revised worksheets. Ms. Deschenes suggested, with this being a policy document, that the Board members could start using the new worksheets as a

trial run. Dr. Clements suggested to first pilot it with certain Board members. Dr. Clements then said that the adoption of the updated documents could occur at the next Executive Meeting.

DHP BOX SYSTEM – Rob Jenkins – DHP IT

Mr. Jenkins presented an update on procuring the Imaging Tools for the Box system. This was for informational purposes only.

ADVANCED PRACTICE REGISTERED NURSES – Barbara Hodgdon, PhD - HWDC

Dr. Hodgdon presented two PowerPoints. The first was on "Virginia's Licensed Advanced Practice Registered Nurse Workforce: 2023", and the second was "Virginia's Licensed Advanced Practice Nurse Workforce: Comparison by Specialty." These presentations were for informational purposes only.

DHP DIRECTOR'S REPORT

Mr. Owens welcomed all members of the Board. He said that the state budget has been agreed upon and will be effective July 1, 2024, the beginning of FY2025. The new budget allots DHP 12 new full-time positions. Mr. Owens reminded the Board that DHP does not get its funding from the General Fund through the General Assembly. However, the General Assembly does have to approve the DHP budget, even though it is funded by licensing fees.

Mr. Owens shared that ImpactMakers, the business practice analysts who are trying to improve the online experience of applying for a license at the Board of Medicine, is still working diligently with Board staff.

Mr. Owens stated that a salary structure study by Gallagher is now being conducted on Pay Grade 5 positions and for 6 different executive directors covering 13 boards. These studies are instrumental in ensuring that DHP salaries are comparable to other state agencies, which is important to attracting and retaining top quality staff.

Break

Dr. Clements called for a recess at 9:50 a.m.; the meeting reconvened at 10:01 a.m.

REPORTS OF OFFICERS AND EXECUTIVE DIRECTOR

PRESIDENT

Dr. Clements shared his experience of attending the April 2024 Federation of State Medical Boards Annual Meeting in Nashville. He then called upon others who attended the meeting to share their experiences.

Mr. Marchese said that he was not successful in his run for a seat on the FSMB Board of Directors. He stated that Denise Pines, MBA, a very qualified Board member from California, was re-elected as a public member. He thanked everyone for all their support.

Dr. Pradhan shared that this was his first time attending the meeting. He found it interesting hearing the different ways other states use to address common regulatory issues. He stated that it was a good experience and thanked the Board for supporting his attendance.

Mr. Corry, also a first-time attendee, agreed that it was a great experience that allowed him to get better acquainted with his fellow Board members. In the meetings, he got to hear about challenges other states face and how they are handling them. He thanked Dr. Harp and the Board for allowing him to attend.

VICE-PRESIDENT

No report.

SECRETARY-TREASURER

No report.

EXECUTIVE DIRECTOR

Budget Numbers as of April 30, 2024

Dr. Harp shared an update on the budget as of April 30, 2024, reflecting the 10-month mark of FY2024. He said that almost $3,000,000 has been spent of the $3,800,000 budgeted. He pointed out that 16.7% of FY2024 remains, and 22% of the funds budgeted for FY2024 remain. The Board is again succeeding in its frugality. The cash balance as of 4/30/24 was $12,676,148, further underscoring the Board's favorable financial position.

Licensing Achievements

Dr. Harp gave a nod to Michael Sobowale and his licensing staff for their 100% Customer Satisfaction score for FY2024 Q3. In the last 2 years, the average time from receipt of application to the issuance of a license for all the Board's professions has dropped from 88 days to 45 days. Mr. Sobowale would like to see it at 30 days.

Occupational Therapy Compact

Dr. Harp stated that the Occupational Therapy Compact regulations became effective on May 22, 2024. The Board will be ready to issue authorizations to practice once the Compact Commission says all is ready for implementation.

Physician Assistant Reciprocity with Maryland and DC

Dr. Harp said that in March of 2023 the Virginia Board of Medicine began the reciprocity pathway with DC and Maryland for both MDs and DOs. The Maryland Board of Physicians has asked DC and Virginia if they would be interested in reciprocity for Physician's Assistants as well. Board staff has agreed. The Memorandum of Agreement for this effort is being reviewed by board counsels. Sometime in the month of August, the three jurisdictions should be ready to implement the reciprocity process for PA's.

Disciplinary Statistics

Dr. Harp reviewed some statistics of the Discipline Section, pointing out that during the 3rd quarter of the 2024 fiscal year, it had a case clearance rate of 119%. The average time for closing a case was 166.7 days. 92.4% of the cases received were being closed within one year, and 99% were closed within 415 days. Dr. Harp thanked the Discipline Section and all the Board members for their efforts in probable cause review and administrative proceedings.

Business Practices Project with ImpactMakers

Dr. Harp stated that the project with ImpactMakers is still ongoing for the development of streamlined applications and instructions across all professions at the Board of Medicine.

VDH Office of the Chief Medical Examiner 2023 3rd Quarter Overdose Death Statistics

Dr. Harp shared that overdose deaths from prescribed opioids did not substantially increase or decrease from 2007-2021. However, in 2022 there was a significant drop in prescription opioid deaths. The zenith was 507 overdose deaths in 2017. In 2022, they dropped to 340. The 2023 estimate stands at 266.

Personnel Changes

Dr. Harp announced that Jennie Wood, Case Manager for the Board of Medicine, will be retiring soon. He thanked Ms. Wood for her time with the Board and her great work. Ms. Wood will be succeeded by Tamika Hines. Dr. Harp then deferred to Jennifer Deschenes.

Ms. Deschenes shared that Ms. Wood has been with the Board of Medicine since 2006. Ms. Wood has been on the front lines taking calls and making people feel heard. She is a true treasure to the Board. Ms. Deschenes stated that Ms. Hines does great work, and the Board is very fortunate to have her stepping into the position of Case Manager.

Her colleagues on the Board staff presented Ms. Wood with a bouquet of flowers. Everyone applauded and thanked her for her time and service to the Board and the Commonwealth.

COMMITTEE AND ADVISORY BOARD REPORTS

Dr. Ransone moved to accept all reports and minutes since April 5, 2024, including those in the agenda packet and handouts, en bloc. The motion was properly seconded by Dr. Miller and carried unanimously.

OTHER REPORTS

Board Counsel – Brent Saunders, JD – Senior Assistant Attorney General

Mr. Saunders, SAAG, provided an update on 6 pending legal cases.

Board of Health Professions

No report.

Podiatry Report

No report.

Chiropractic Report

No report.

Committee of the Joint Boards of Nursing and Medicine

Dr. Clements reported that the Joint Boards of Nursing and Medicine had a business meeting on February 28, 2024, at which Dr. Ransone, Mr. Marchese and he were present.

NEW BUSINESS

1. Current Regulatory Actions

   Ms. Barrett presented the chart of regulatory actions as of May 22, 2024, stating that that there are currently 16 regulatory actions in the Secretary's Office.

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

2. Adoption of Exempt Regulatory Action Pursuant to SB113

   Ms. Barrett reviewed the draft changes to 18VAC85-50-101 required by SB133 which was approved by the General Assembly on March 20, 2024.

   MOTION: Mr. Marchese moved to adopt exempt regulatory changes to amend 18VAC85-50-101 as presented. Dr. Apel seconded, and the motion passed unanimously.

3. Adoption of Exempt Regulatory Action Pursuant to HB699

Ms. Barrett reviewed the draft changes to 18VAC85-21-22 and 18VAC90-40-21 required by HB699 which was approved by the General Assembly on April 4, 2024. Ms. Barrett said that the Board of Nursing will be voting on these changes regarding APRN prescribing at its next meeting.

MOTION: Mr. Marchese moved to adopt exempt regulatory changes to amend 18VAC85-21-22 as presented. Dr. Apel seconded, and the motion passed unanimously.

MOTION: Mr. Marchese moved to adopt exempt regulatory changes to amend 18VAC90-40-21 as presented. Dr. Apel seconded, and the motion passed unanimously.

4. Adoption of Exempt Regulatory Action Pursuant to HB971

Ms. Barrett presented the draft changes to 18VAC90-30-86, which are to implement the new law from the 2024 General Assembly that reduces the required time for autonomous practice 5 years to 3 years. HB971 also changed the requirement for the 3 years to be "experience", dropping the descriptor "clinical." Ms. Barrett pointed out that the Board of Nursing will vote on this action at its meeting in July.

MOTION: Dr. Apel moved to adopt exempt regulatory changes to amend 18VAC90-30-86 as presented. Mr. Marchese seconded, and the motion passed unanimously.

5. Consideration of Fast-Track Regulatory Action to Remove the "Active Practice" Requirement for Renewal of Licensure in Occupational Therapy

Ms. Barrett shared that the draft changes to 18VAC85-80-10 and 18VAC85-85-80-70 remove the attestation for having practiced at least 160 hours during the biennium prior to renewal. She said that this requirement is for Occupational Therapy and Occupational Therapy Assistants, but it is not required of many other professions for renewal. Ms. Barrett pointed out that removing this requirement will help retain OT's and OTA's in Virginia's healthcare workforce.

MOTION: Dr. Miller moved to adopt the fast-track regulatory amendments to 18VAC85-80-10 and 18VAC85-80-70 to remove the active practice requirement for renewal as an occupational therapist or occupational therapist assistant. Dr. Ransone seconded, and the motion passed unanimously.

6. Licensing Report

Mr. Sobowale shared with the Board that during FY2024, the Licensing Unit has maintained a 97% rolling clearance rate for incoming applications.

Mr. Sobowale said he shared at the February Board meeting that the average timeframe for processing an application was 52 days. In the time since, the Licensing Section has reduced the average to 45 days with the goal of a 30-day processing time.

Mr. Sobowale said that applications through the reciprocity pathway have increased since June 2023, at which time there were 158 physicians. There are now 345.

Mr. Sobowale stated that August 15, 2024 is the target date for having reciprocal licensing of physician assistants in place with Maryland and the District.

Dr. Apel asked how is it that the number of processing days for licensure have come down? Mr. Sobowale responded that a full complement of licensing specialists and the streamlining of application requirements have reduced the processing time while still being able to ensure public safety. An example Mr. Sobowale gave was that instead of requiring applicants to submit license verifications from all the states in which they have been licensed, the Board now requires listing all states on the application and the submission of one state verification. Dr. Clements extended his thanks to the licensing staff for issuing all of the training licenses this year, since the July 1 start date for residencies is rapidly approaching.

7. Discipline Report

Ms. Deschenes clarified for the Board members what information can and cannot be included in advisory letters. The "advice" in the letter needs to be tied to the Board's law and regulations. She directed Board members to the Disciplinary Case Report handout at their desks.

8. Approval of Draft 2025 Meeting Calendar

Dr. Clements asked the Board members to review the draft of the 2025 Meeting Calendar.

MOTION: Dr. Ransone moved to accept the 2025 Meeting Calendar. Dr. Miller seconded, and the motion passed unanimously.

9. Nominating Committee Report

Dr. Miller stated that the Nominating Committee met this morning at 7:45 a.m. and arrived at the following slate of officers for the Board's consideration:

- J. Randy Clements, DPM – President
- Karen Ransone, MD & Peter J. Apel, MD – Vice-President
- Thomas Corry – Secretary-Treasurer

MOTION: Ms. DeMoss Fonseca moved to approve the nomination for President as presented. Dr. Pradhan seconded, and the motion passed unanimously.

MOTION: Ms. DeMoss Fonseca moved to approve the nomination for Secretary-Treasurer as presented. Mr. Kim seconded, and the motion was passed unanimously.

MOTION: Ms. DeMoss Fonseca moved to vote on the two candidates presented for Vice-President. Dr. Miller seconded, and the motion was passed unanimously.

Dr. Ransone and Dr. Apel spoke about their experience and their goals as Vice-President. Ms. Deschenes instructed the Board that the vote on the two candidates is required to be done openly. Ms. Opher conducted the vote by a raising of hands which resulted in Dr. Apel getting 9 votes and Dr. Ransone 7 votes. Dr. Apel was declared Vice-President for the coming year.

10. Acknowledgement of Members with Expiring Terms

Dr. Harp announced that the following Board members terms would expire on June 30, 2024.

- Dr. Archer – finishing 2nd term
- Dr. Dhillon – finishing 1st term
- Dr. Ellis – finishing 1st term
- Dr. Miller – finishing 1st term
- Dr. Ransone – finishing 1st term

Dr. Harp reminded the Board members that it is customary that they remain on the Board until their successor is appointed. He thanked all for their dedication to the Board and the citizens of the Commonwealth. Each received a small token of the Board's appreciation.

ANNOUNCEMENTS

Dr. Clements announced that the next Board meeting will be held on October 24, 2024, at 8:30 a.m.

ADJOURNMENT

With no additional business, the meeting adjourned at 11:01 a.m.

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William L. Harp, MD
Executive Director

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

Staff Note: All items for information only

Action: None.

Agenda Item: **Report of Officers**

Staff Note:

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

Action: Informational presentation. No action required.

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

Staff Note: All items for information only.

Action: None.

FY 2024 Budget / Actual through June Final 2024
Virginia Department of Health Professions
Cash Balance

Period Ending:	**6/30/2024**
% of the Year Completed:	**100%**
Department ID:	**10200**
Department Name:	**Board of Medicine**
Fund	**09223**

Cash Balance as of June 30, 2023	11,942,161
YTD FY 2024 Revenue	12,015,743
Less: YTD FY 2024 Direct & Allocated Expenditures	9,982,691
Cash Balance as of June 30, 2024	**$ 13,975,213**

FY 2024 Budget / Actual through June Final 2024
Virginia Department of Health Professions
Allocated Expenses

Period Ending:	**6/30/2024**
% of the Year Completed:	**100%**
Department ID:	**10200**
Department Name:	**Board of Medicine**
Fund	**09223**

Code	Description	Amount
20100	Behavioral Science Executive Director	-
20200	Opt\Vet-Med\ASLP Executive Director	-
20400	Nursing / Nurse Aide	-
20600	Funeral\LTCA\PT Executive Director	-
30100	Technology and Business Services	1,202,155.13
30200	Human Resources	169,437.74
30300	Finance	558,534.19
30400	Director's Office	215,206.38
30500	Enforcement	2,669,787.10
30600	Administrative Proceedings	767,233.32
30700	Health Practitioners' Monitoring Program	36,702.70
30800	Attorney General	389,199.93
30900	Board of Health Professions	19,046.50
31000	SRTA	-
31100	Maintenance and Repairs	360.37
31300	Employee Recognition Program	7,334.99
31400	Conference Center	10,299.91
31500	Program Development and Implementation	70,390.70
31600	Healthcare Workforce	111,289.74
31800	CBC (Criminal Background Check Unit)	
		6,226,978.70

YTD Direct and Allocated Expenditures	
Direct Expenditures	**3,755,711.92**
Allocated Expenditures	**6,226,978.70**
Total Expenditures	**9,982,690.62**

Agenda Item:	**Committee and Advisory Board Reports**
Staff Note:	Please note Committee assignments and minutes of meetings.
Action:	Motion to accept minutes as reports to the Board.

VIRGINIA BOARD OF MEDICINE

Committee Appointments

FY2025

EXECUTIVE COMMITTEE (8)
Randy Clements, DPM – President, Chair
Peter Apel, MD – Vice-President
William Hutchens, MD
Oliver Kim
L. Blanton Marchese
Deborah DeMoss Fonseca
Thomas Corry – Secretary-Treasurer
Jennifer Rathmann, DC

LEGISLATIVE COMMITTEE (7)
Peter Apel, MD – Vice-President, Chair
Randy Clements, DPM – President
Thomas Corry – Secretary-Treasurer
Krishna Madiraju, MD
Pradeep Pradhan, MD
Jennifer Rathmann, DC
Leroy Vaughan, Jr., MD

CREDENTIALS COMMITTEE (9)
William Hutchens, MD – Chair
Kamlesh Dave, MD
Hazem Elariny, MD
Elliott Lucas, MD
Krishna Madiraju, MD
Ken McDowell, DO
Patrick McManus, MD
Michele Nedelka, MD
Mark Simcox, MD

FINANCE COMMITTEE
J. Randy Clements, DPM – President
Peter Apel, MD – Vice-President
Thomas Corry – Secretary-Treasurer

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

CHIROPRACTIC COMMITTEE
Jennifer Rathmann, DC

BOARD OF HEALTH PROFESSIONS
Krishna Madiraju, MD

COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
Randy Clements, DPM – President
Blanton Marchese
Leroy Vaughan, Jr, MD

VIRGINIA BOARD OF MEDICINE
LEGISLATIVE COMMITTEE MINUTES

Friday, September 13, 2024 | Department of Health Professions | Henrico, VA

CALL TO ORDER: Dr. Apel called the meeting of the Legislative Committee to order at 8:39 a.m.

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

MEMBERS PRESENT:
Peter Apel, MD, Vice-President, Chair
J. Randy Clements, DPM, President
Jennifer Rathmann, DC
Leroy Vaughan, Jr., MD

MEMBERS ABSENT:
Thomas Corry, Secretary-Treasurer
Krishna Madiraju, MD
Pradeep Pradhan, MD

STAFF PRESENT:
William L. Harp, MD - Executive Director
Jennifer Deschenes, JD - Deputy Director, Discipline
Colanthia Morton Opher - Deputy Director, Administration
Michael Sobowale, LLM - Deputy Director, Licensing
Barbara Matusiak, MD - Medical Review Coordinator
Erin Barrett, JD – DHP Director for Legislative and Regulatory Affairs
Deirdre Brown - Executive Assistant
Danielle Sangiuliano – Administrative Assistant

COUNCIL PRESENT: W. Brent Saunders, JD - Senior Assistant Attorney General

OTHERS PRESENT:
Tamika Hines - Discipline Case Manager
Sean Nolan – Discipline Reinstatement Case Manager
Roslyn Nickens – Licensing Supervisor
Nathaniel Tuck – Guest of Dr. Rathmann
Tyler Cox – Hancock, Daniel & Johnson, PC
Clark Barrineau – Medical Society of Virginia
Brandi Kilmer – Refugee Physicians Advocacy Coalition
Lily Cameron – Refugee Physicians Advocacy Coalition
Benjamin Hermerding – Chief of Staff for Del. Kathy Tran

EMERGENCY EGRESS INSTRUCTIONS

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

APPROVAL OF MINUTES OF January 5, 2024

Dr. Harp noted that the date for next meeting needed to be changed from May 5, 2023 to May 5, 2024. Ms. Deschenes also corrected the title of James Jenkins from DHP Senior Deputy Director to DHP Chief Deputy Director.

Dr. Clements moved to approve the meeting minutes of January 5, 2024 with the changes noted above. The motion was seconded by Dr. Rathmann and carried unanimously.

ADOPTION OF AGENDA

The agenda was adopted by unanimous consent.

PUBLIC COMMENT

Brandi Kilmer of the Refugee Physicians Advocacy Coalition addressed the Committee concerning HB995 referring to a handout that indicated the Coalition has a network of 80 international physicians. She asked that the Board's regulations provide clarification of the requirements in HB995.

NEW BUSINESS

1. HB995 - Temporary Licensure of Physicians Licensed in a Foreign Country

Ms. Barrett gave a brief PowerPoint presentation on HB995.

After the presentation, the Committee engaged in discussion and posed questions to Ms. Barrett concerning licensure eligibility for foreign physicians and implementation of the licensing process. Dr. Harp shared that the training requirements would be in a general format that would cover all the assessment program milestones but would not address specialty milestones. Ms. Barrett added that the Board has the authority to add specialty requirements when developing the regulations. Consideration can also be given to what the applicant has done during training in their home country. The Board could also require specific clinical assessments.

Ms. Barrett and Ms. Deschenes clarified the two licenses defined in HB995 and how they were connected.

MOTION: Dr. Clements moved to recommend to the full Board the adoption of a notice of intended regulatory action (NOIRA) to implement the provisions of HB995. The motion was seconded by Dr. Vaughan and carried unanimously.

2. Budget Item Regarding Prescribers for Behavioral Health

Ms. Barrett reviewed the requirements of Item 285 of the Budget Bill - HB 6001.

During discussion, a few key points were addressed. Ms. Deschenes stated that Item 285 covers anyone who prescribes behavioral health medications to children and adolescents. Dr. Harp agreed with Ms. Deschenes and added that with the Board's current process, new licensees cannot be identified as being subject to Item 285. All newly licensed MD's, DO's and DPM's are notified that they are required to populate their Practitioner Profile within 30 days of licensure. The statutory obligations of Item 285 could be included with that notification.

Dr. Apel noted that the vague language in B(ii) appeared to require licensees to always be on call.

Ms. Deschenes commented that a law is already in place, §54.1-2405, which requires practitioners who are closing their practices to provide records within 30 days. HB6001 requires the records to be produced in one week which is much less time, especially for behavioral health records.

Ms. Barrett asked the Committee if this would add another audit. Dr. Apel replied that it would require auditing every licensee. In response, Ms. Barrett said that with this requirement being in the biennial budget, implementation would have to be accomplished in a short period of time to cover the remainder of the biennium.

Mr. Sobowale asked Ms. Barrett if HB6001 - Item 285 has been reviewed by the Board of Nursing, to which she replied, not at this time. Mr. Saunders asked for an opportunity to do some research into the issue and provide legal guidance on how this should be approached before moving forward.

In conclusion, Ms. Barrett stated that there were no recommendations for an action at this time.

ANNOUNCEMENTS

None.

NEXT MEETING

January 10, 2025

ADJOURNMENT

With no other business to conduct, the meeting adjourned at 9:31 a.m.

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William L. Harp, MD
Executive Director

==DRAFT UNAPPROVED==

NOMINATING COMMITTEE
JUNE 13, 2024 @7:45 AM
PERIMETER CENTER - HEARING ROOM 3

Thursday, June 13, 2024, at 7:45 AM Perimeter Center 9960 Mayland Drive, Henrico

Committee Members

- Jacob Miller, DO - Chair
- Deborah DeMoss Fonseca
- Pradeep Pradhan, MD
- Jennifer Rathmann, DC

The Committee interviewed the candidates in the following order.

- Randy Clements, DPM - seeking the Presidency
- Peter Apel, MD - seeking the Presidency
- Karen Ransone, MD - seeking the Vice-Presidency
- Tom Corry - seeking Secretary-Treasurer

The Committee discussed the candidates and arrived at the following slate.

- Randy Clements, DPM - President
- Peter Apel, MD or Karen Ransone, MD - Vice-President (Full Board to vote)
- Tom Corry - Secretary-Treasurer

The meeting was adjourned at 8:25 AM.

William L. Harp, MD
Executive Director

DRAFT

VIRGINIA BOARD OF MEDICINE

CREDENTIALS COMMITTEE BUSINESS MEETING

Friday, September 20, 2024 Department of Health Professions Henrico, VA

CALL TO ORDER: Dr. Hutchens called the meeting to order at 9:03 a.m.

MEMBERS PRESENT: William Hutchens, MD, Chair
Hazem Elariny, MD
Patrick McManus, MD
Ken McDowell, DO
Michele Nedelka, MD
Elliott Lucas, MD
Kamlesh Dave, MD

STAFF PRESENT: William L. Harp, MD, Executive Director
Michael Sobowale, LLM, Deputy Executive Director, Licensing
Colanthia M. Opher, Deputy Executive Director, Administration
Jennifer Deschenes, JD, Deputy Executive Director, Discipline
Roslyn Nickens, Licensing Supervisor

GUESTS PRESENT: W. Scott Johnson, Esq. – Medical Society of Virginia

Emergency Egress Instructions

Dr. Harp read the emergency egress instructions.

Dr. Hutchens asked Committee members to introduce themselves.

Roll Call

Mr. Sobowale called the roll; a quorum was declared.

Approval of the Agenda

Dr. Nedelka moved approval of the agenda as presented. Dr. Dave seconded. Motion approved.

Public Comment

Mr. Johnson spoke in favor of the agenda item regarding licensure by endorsement for all

professions. The Medical Society of Virginia is in favor of the move by the Board to start discussion of this issue. Mr. Johnson informed members that there is proposed legislation in the Governor's office for licensing applicants by endorsement from other states. He applauded the work of the Board and Board staff for taking the initiative to present this issue for discussion.

New Business:

1. **Expiration of Applications**

   Dr. Harp provided a brief overview of why this topic was being discussed. He reminded members of the work that the Committee had done after the COVID-19 pandemic to streamline the licensing process for all professions. The Board eliminated some documents and for others, copies would be accepted. The streamlining yielded the desired results in terms of decreasing application processing times. Still, a significant number of applicants in the traditional pathway do not complete their applications a year after they are submitted. This causes the Board's licensing times to be inflated when looking at the number of days from receipt of an application to issuance of a license. He suggested the Committee consider recommending a 90 – 120-day policy for an applicant to complete the application prior to its expiration. He informed members that Maryland keeps their applications open for 90 days, whereas the Board currently keeps an application open for 13 months. Members reviewed a chart showing the number of applications completed and those that expired in 2022, 2023, and 2024. After extensive discussion, Dr. Elariny moved that a recommendation be made to the full Board to adopt a policy to keep applications open for 6 months. Dr. Nedelka seconded. The motion passed unanimously.

2. **Limited Radiologic Technologist Licensing Process**

   Mr. Sobowale provided an overview of the current licensing process for limited radiologic technologists. Currently, the application is submitted after the student has completed the didactic portion of training. The Board then notifies ARRT that the individual has finished their didactics and is authorized to sit for the Radiologic Technologist- Limited examination. Additionally, the Board requires license applicants to provide evidence of having successfully performed at least 10 radiological examinations in the anatomical area for which they are seeking licensure. X-rays must be performed under the direct supervision of a licensed radiologic technologist or a Doctor of Medicine or Osteopathy. Some applicants wait months after submitting their application to let Board staff know who the clinical training supervisor will be so they can be approved to start taking x-rays. Some do not take the ARRT exam, perform their x-rays, or finish the application process. A high percentage of limited radiologic technologist applications submitted expire after 13 months. The suggestion to the Committee was to streamline this multi-step process by having the aspiring limited radiologic technologist submit an application after their didactics and required x-rays have been completed. Committee members reviewed the amended 10 radiographic procedures/ clinical training form to be completed by the license applicant and the trainer and submitted along with the license application. Members discussed whether to recommend this amendment to the process. Upon a motion by Dr. McManus, seconded

by Dr. Elariny, the Committee voted unanimously to recommend this revision of the process to the full Board.

3. **Licensure by Endorsement Process for All Professions**

Dr. Harp introduced this topic. The Board is anticipating that licensure by endorsement will be introduced for all 20 of the Board's professions in the 2025 General Assembly. Currently, through existing regulations, a Medical Doctor, Doctor of Osteopathic Medicine, Doctor of Podiatric Medicine, and a Physician Assistant spouse of an active-duty military member can apply by endorsement. It was suggested that the Committee consider having the Board create an endorsement application pathway for the allied professions akin to the licensure by reciprocity pathway for physicians and physician assistants that Virgina enjoys with Maryland and the District of Columbia. This would only require the applicant to submit 2 documents in the licensing process - 1 state license verification and a National Practitioner Data Bank (NPDB) report. The 1 state license verification would recognize that the applicant had submitted "static documents" to the other state. "Static documents" include evidence of graduation from an educational program and passage of a national certification exam. The NPDB report would yield actions taken by other state boards. Members noted that it is possible not all states require a national certification/examination process for licensure. Various states and U.S. territories have different requirements for licensure, certification, permission, and regulatory standards, or none at all, to allow someone to practice a profession regulated by the Virginia Board. Given the limited information available to the Committee regarding a list of states that do not have a national certification requirement in their licensing process, the Board's mission to protect the public may be impacted by licensing an applicant from another state with limited documentation. The Committee decided to table further discussion until more information is available.

4. **Re-Entry to Practice Process for Physicians and Other Professions**

Dr. Hutchens led the discussion. The Board discussed the Federation of State Medical Boards' report on "Reentry to Practice" at its February 2024 meeting and suggested that the Credentials Committee review the matter to see if any changes were warranted. Members discussed the challenges and feasibility of implementing the steps recommended in the FSMB report. Some of the recommendations would impose a huge burden on the licensee and the Board. Committee members determined that the current process the Board has in place to ensure competence and safety to practice in both the discipline and licensing tracks serves the public well. The Committee decided to take no further action.

5. **Continuing Education Requirements for License Reinstatement**

Dr. Harp led the discussion. Currently, the Board's regulations for license renewal and reactivation of an inactive license require the licensee to attest to having obtained the required number of continuing education (CE) hours. For renewals, the CE must have been obtained in the 2 years since the license was last renewed. For reactivation, up to 4 years of CE may be required. For those applying for reinstate a license which has been expired for 2 years or more, the regulations require submission of documentation of the

required number of CE hours for up to 4 years. The decision before the Committee was whether to accept attestation of CE for reinstatement as in renewing and reactivating a license. Dr. Harp said that such a recommendation from the Committee would most likely be seen as non-controversial and decreasing the burden on licensees. This amendment could be submitted as a fast-track action by the Board. After discussion, Dr. Elariny moved that the Committee recommend to the full Board adoption of a fast-track action to allow CE for reinstatement of licensure be by attestation, excluding disciplinary reinstatements. Dr. Nedelka seconded. The Committee vote was unanimous.

6. Announcements

Dr. Harp reminded members to submit their travel expense reimbursement vouchers within 30 days in order to remain in compliance with State Travel Regulations.

With no additional business, the meeting adjourned 10:34 a.m.

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William Hutchens, MD
Chair

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William L. Harp, MD
Executive Director

---DRAFT UNAPPROVED--

ADVISORY BOARD ON PHYSICIAN ASSISTANTS
Minutes
October 10, 2024

The Advisory Board on Physician Assistants met on Thursday, October 10, 2024, at 1:00 p.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Justin Hepner, PA-C – Chair
Tracey Dunn - Citizen Member
Lucy Treene, PA-C

MEMBERS ABSENT: Brian Hanharan, MD
Erin Myers, PA-C – Vice Chair

STAFF PRESENT: William L. Harp, MD, Executive Director
Arne Owens, DHP Director
Michael Sobowale, LLM - Deputy Executive Director, Licensure
Jennifer Deschenes, JD – Deputy Executive Director, Discipline
Erin Barrett, JD – Director of DHP Legislative and Regulatory Affairs
Matt Novak – DHP Policy and Economic Analyst
Roslyn Nickens - Licensing Supervisor
Jamie Culp - Licensing Specialist

GUESTS PRESENT: Robert Glasson, VAPA
Jonathan Williams - VAPA

Call to Order

Justin Hepner called the meeting to order at 1:06 p.m.

Emergency Egress Procedures

Dr. Harp provided the emergency egress instructions.

Roll Call

Jamie Culp called the roll; a quorum was established.

---DRAFT UNAPPROVED--

Approval of Minutes

Dr. Harp suggested an amendment to the minutes of June 6, 2024, by striking the statement, "Erin Myers moved to approve the minutes of the September 22, 2022, meeting." Tracey Dunn moved to accept the minutes with the amendment. Lucy Treene seconded. By unanimous vote, the minutes were approved as amended.

Adoption of Agenda

Justin Hepner moved to adopt the meeting agenda as presented; it was adopted by acclamation.

Public Comments:

None

New Business

1. **Report of Regulatory Actions**

   Erin Barrett gave a report of the Advisory Board's regulatory actions. The exempt regulatory action to allow physician assistants working for certain employers to practice without a separate practice agreement will become effective on November 6, 2024.

2. **Consideration of Language for PA Reinstatement Process**

   Erin Barrett discussed draft language to authorize the reinstatement of PA licenses. She stated that, if draft language is recommended to the Full Board, the regulatory action will be presented as a fast-track regulatory action. After discussion, Lucy Treene made a motion to accept the draft regulatory language for physician assistant reinstatement of licensure. Tracey Dunn seconded. Motion passed.

3. **Update on Implementation of the Physician Assistant Licensure Compact**

   Justin Hepner gave a brief overview of the PA Licensure Compact. Thirteen states have so far agreed to participate in the Compact. Legislation has become effective in ten states, and five other states have started the process of introducing legislation in their states. For the inaugural meeting of the PA Compact Commission on September 24-25, 2024, in Washington, DC, Justin Hepner was appointed by the Board of Medicine President to serve as Virginia's primary delegate to the Compact Commission. Mr. Hepner answered questions from members and staff pertaining to the Compact.

---DRAFT UNAPPROVED--

4. **Approve Appointment of Primary Delegate to the PA Compact Commission**

   Upon a motion by Tracey Dunn and seconded by Lucy Treene, Justin Hepner was selected to continue to serve as Virginia's primary delegate to the Compact Commission.

5. **Election of Alternate Delegate to the PA Compact Commission**

   Upon a motion by Tracey Dunn, seconded by Justin Hepner, Lucy Treene was selected to serve as the alternate delegate to the Compact Commission.

6. **Approval of 2025 Meeting Calendar**

   Lucy Treene moved to approve the 2025 meeting calendar. Tracey Dunn seconded. The motion passed.

7. **Election of Officers**

   Lucy Treene nominated Justin Hepner to continue as Chair. Tracey Dunn seconded. The motion passed. Tracey Dunn nominated Erin Myers to continue as Vice-Chair. Lucy Treene seconded. The motion passed.

ANNOUNCEMENTS:

<u>License Statistics</u>

Jamie Culp provided the licensing report. The Board has a total of 6, 813 physician assistants. 705 licenses have been issued so far this year.

<u>Next Scheduled Meeting</u>

The next scheduled meeting is February 13, 2025 at 1:00 p.m.

Adjournment

With no other business to conduct, the meeting was adjourned at 1:38 p.m.

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William L. Harp, MD - Executive Director

==DRAFT UNAPPROVED==

ADVISORY BOARD ON MIDWIFERY
Minutes
October 11, 2024

The Advisory Board on Midwifery met on Friday, October 11, 2024, at 10:00 AM in the Department of Health Professions, 9960 Mayland Drive, Henrico, Virginia, 23233.

MEMBERS PRESENT:	Rebecca Banks, CPM – Vice Chair Ildiko Baugus, CPM Ami Keatts, MD
MEMBERS ABSENT:	None
STAFF PRESENT:	William L. Harp, M.D. Executive Director Michael Sobowale, LLM - Deputy Executive Director, Licensure Jennifer Deschenes, JD - Deputy Executive Director, Discipline Matthew Novak – DHP Policy and Economic Analyst Erin Barrett, JD - Director of DHP Legislative and Regulatory Affairs Kelly Smith - Director of Communications Colanthia Morton Opher - Deputy Executive Director, Administration Roslyn P. Nickens - Licensing Supervisor Shannon DeCriscio - Licensing Specialist Coralyn Powell - Executive Assistant, Discipline
GUESTS PRESENT:	Marinda Schindler, Virginia Midwives Alliance

CALL TO ORDER

Rebecca Banks called the meeting to order at 10:00 AM.

EMERGENCY EGRESS PROCEDURES

Dr. Harp announced the emergency egress instructions.

ROLL CALL

Roll was called; a quorum was established.

APPROVAL OF MINUTES

Ami Keatts moved to approve the minutes of the June 16, 2023, meeting. Ildiko Baugus seconded. The motion passed.

ADOPTION OF AGENDA

Rebecca Banks moved to adopt the agenda. Ami Keatts seconded. The motion passed.

PUBLIC COMMENTS

None

NEW BUSINESS

1. Report on Status of Regulatory / Policy Actions

Matt Novak presented the status of the regulatory actions that were of interest to the Advisory.

2. Discussion on Medication Access for Midwives

Ami Keatts kicked off the discussion about midwives' access to necessary medications. Rhogam was specifically mentioned. An Advisory member noted that hospitals could place larger orders than individual practitioners which may have some impact on this issue. It was also noted that this appears to be an issue for practitioners across the board.

3. Discussion on the Board's Disciplinary System Pertaining to Midwifery

Jennifer Deschenes provided an overview of the discipline process that applies to all Board licensees, explaining that anyone may file a complaint and all complaints within the Board's jurisdiction are investigated as required by law. She also reviewed the mandatory report obligations of Board of Medicine licensees and Virginia hospitals to report any alleged unprofessional conduct by a licensee that includes an alleged failure to meet the standard of care. Ms. Deschenes noted that complaints and investigations are confidential pursuant to Virginia law, only notices and orders of discipline are made public. If a case is closed after investigation, no information about that case is available to the public.

4. Approval of 2025 Meeting Calendar

Rebecca Banks moved to approve the 2025 Meeting Calendar. The motion was seconded followed by a unanimous vote.

5. Election of Officers

Rebecca Banks "volunteered" to nominate herself as Chair of the Advisory, and Ami Keatts seconded. The motion passed.

Rebecca Banks moved to nominate Ildiko Baugus as Vice-Chair for the Advisory. Ami Keatts seconded, and the motion passed.

Announcements

Michael Sobowale reported to the Advisory that as of October,11, 2024, there were 128 current active midwives licensed by the Board.

==DRAFT UNAPPROVED==

Next Scheduled Meeting

February 14, 2025, at 10:00 a.m.

Adjournment

With no other business to conduct, Rebecca Banks adjourned the meeting at 10:41 a.m.

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William L. Harp, MD, Executive Director

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ADVISORY BOARD ON SURGICAL ASSISTING
Minutes
October 15, 2024

The Advisory Board on Surgical Assisting met on Tuesday, October 15, 2024, at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Jessica Wilhelm, LSA - Chair
Thomas Gochenour, LSA – Vice Chair
Deborah Redmond, LSA
Nicole Meredith, RN (arrived at 10:25 am)

MEMBERS ABSENT: Srikanth Mahavadi, MD

STAFF PRESENT: William L. Harp, M.D., Executive Director
Michael Sobowale, LLM, Deputy Executive Director - Licensure
Colanthia M. Opher, Deputy Executive Director – Administration
Erin Barret, JD - Director of DHP Legislative and Regulatory Affairs
Matthew Novak - DHP Policy and Economic Analyst
Arne Owens - DHP Director
Roslyn Nickens - Licensing Supervisor
Joshlynn Jones - Licensing Specialist

GUESTS PRESENT: None

Call to Order

Jessica Wilhelm called the meeting to order at 10:00 a.m.

Emergency Egress Procedures

Dr. Harp announced the emergency egress instructions.

Roll Call

Joshlynn Jones called the roll; a quorum was declared.

Approval of Minutes

Thomas Gochenour moved to approve the minutes from the June 10, 2024, meeting. Deborah Redmond seconded the motion. The motion was approved.

Adoption of Agenda

Deborah Redmond moved to adopt the agenda. Thomas Gochenour seconded. The motion was approved.

Public Comment

None

New Business

1. **Report on Status of Regulatory /Policy Actions**

   Erin Barrett reviewed the status of the Advisory Board's regulatory actions. Approval for the fast-track action for reinstatement of certification as a surgical technologist cleared the Secretary's office and has been sent to the Governor's Office.

2. **Consideration of American Allied Health Surgical Technician Training Program**

   During discussion, members shared their concerns. The name difference and skill set between "Surgical Technician" and "Surgical Technologist" are different and may confuse the public. The testing and recertification requirements that American Allied Health (AAH) presented are less rigorous compared to what already approved entities such as NBSTSA and NCCT require. Following testing, AAH requires only 5 CEU hours for maintenance of AAH certification. The NBSTSA requires 30 hours and NCCT requires 14 hours per year. The program requirements listed for training and eligibility to sit for the certifying exam are general, not specific, and does not list a hands-on, clinical training as part of the student's education and experience prior to sitting for the examination.

   After discussion, Deborah Redmond moved to recommend to the full board to deny AAH's request at this time. Thomas Gochenour seconded. The motion passed.

3. **Approval of 2025 Meeting Calendar**

   Mr. Gochenour moved to approve the 2025 meeting calendar. Jessica Wilhelm seconded. The motion passed.

4. **Election of Officers**

Deborah Redmond nominated Jessica Wilhelm to continue as Chair. Thomas Gochenour seconded. The motion passed. Ms. Redmond nominated Thomas Gochenour to continue as Vice-Chair. Jessica Wilhelm seconded. The motion passed.

Announcements:

Licensing Statistics

Joshlynn Jones provided the licensing and certification statistics. From January 1, 2024, to October 15, 2024, the Board has licensed a total of 100 surgical assistants and 473 surgical technologist certificates from January 1, 2024, to date. The Board's total number of surgical assistants is 832, and the number of certified surgical technologists is 2,617. There are 207 out-of-state surgical assistants and 1,034 surgical technologists.

Next Scheduled Meeting

The next scheduled meeting is Tuesday, February 18, 2025, at 10:00 a.m.

Adjournment

With no other business to conduct, Jessica Wilhem adjourned the meeting at 10:30 a.m.

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William L. Harp, MD, Executive Director

Agenda Item: Other Reports

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

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

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

Agenda Item: Current Regulatory Actions

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

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

Board of Medicine
Current Regulatory Actions
As of October 1, 2024

In the Governor's Office

VAC	Stage	Subject Matter	Submitted from agency	Time in current location	Notes
18VAC85-20	Fast-Track	Implementation of 2022 Periodic Review of Chapter 20	10/6/2022	41 days	Implements changes following 2022 periodic review

In the Secretary's Office

VAC	Stage	Subject Matter	Submitted from agency	Time in current location	Notes
18VAC85-160	Final	Changes consistent with a licensed profession	6/17/2022	819 days (2.3 years)	Proposed regulations consistent with surgical assistants changing from certification to licensure
18VAC85-130	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	490 days	Implements changes following 2022 periodic review
18VAC85-140	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	487 days	Implements changes following 2022 periodic review
18VAC85-150	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	484 days	Implements changes following 2022 periodic review
18VAC85-170	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	484 days	Implements changes following 2022 periodic review

18VAC85-15	Fast-Track	Implementation of Periodic Review	10/6/2022	317 days	Implements changes following 2022 periodic review
18VAC85-40	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	428 days	Implements changes following 2022 periodic review
18VAC85-80	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	419 days	Implements changes following 2022 periodic review
18VAC85-50	NOIRA	Removal of patient care team physician or podiatrist name from prescriptions issued by physician assistants	8/8/2023	417 days	Regulatory action begun in response to a petition for rulemaking
18VAC85-50	Fast-track	Implementation of changes following 2022 periodic review of Chapter	8/15/2023	413 days	Implements changes following 2022 periodic review
18VAC85-110	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	410 days	Implements changes following 2022 periodic review
18VAC85-50	NOIRA	Amendment to requirements for patient care team physician or podiatrist consultation and collaboration	8/8/2023	407 days	Regulatory action begun in response to a petition for rulemaking
18VAC85-21	Fast-track	Amendment of opioid and buprenorphine prescribing regulations	7/14/2023	242 days	Updates opioid and buprenorphine regulations based on updated CDC guidelines
18VAC85-130	Fast-Track	General disclosure	10/23/2023	158 days	Updates requirements for

		requirement consistent with statutory changes			midwife disclosures consistent with 2023 legislative changes
18VAC85-80	Fast-Track	Elimination of active practice for renewal	6/18/2024	11 days	Eliminates requirement of active practice for renewal of OT license

<u>At the Department of Planning and Budget</u>

None.

<u>At the Office of the Attorney General</u>

None.

<u>Recently effective/awaiting publication</u>

VAC	Stage	Subject Matter	Publication date	Effective date
18VAC85-80	Fast-Track	Changes to patient counseling regarding opioid prescriptions pursuant to HB699	10/7/2024	11/6/2024
18VAC85-50	Fast-Track	Amendment to allow physician assistants working for defined employers to practice without a separate practice agreement if certain statutory requirements are met	10/7/2024	11/6/2024
18VAC85-160	Fast-Track	Reinstatement of certification as a surgical technologist	Pending	Pending

Agenda Item: Consideration of Fast-Track amendment regarding attestation of CE compliance on licensure applications

Included in your agenda package:

- 18VAC85-20-240 with recommended changes

Staff Note: This topic was discussed by the credentialing committee at their meeting on September 20th, where the committee unanimously recommended to the full board the included change. Currently, reinstatement and reactivation from active practice requires an applicant to provide documentation of having completed the required CE, whereas for renewal the Board simply requires an attestation of having completed the required CE.

Action Needed:

- Motion to amend 18VAC85-20-240 by Fast-Track action as presented

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

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

1. File a completed application for reinstatement;
2. Pay the reinstatement fee prescribed in 18VAC85-20-22; and
3. ~~Provide documentation of~~ Attest to having completed continued competency hours equal to the requirement for the number of years, not to exceed four years, in which the license has been lapsed.

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

C. If a practitioner has not engaged in active practice in his profession for more than four years and wishes to reinstate or reactivate his license, the board may require the practitioner to pass one of the following examinations. For the purpose of determining active practice, the practitioner shall provide evidence of at least 640 hours of clinical practice within the four years immediately preceding his application for reinstatement or reactivation.

1. The Special Purpose Examination (SPEX) given by the Federation of State Medical Boards.
2. The Comprehensive Osteopathic Medical Variable Purpose Examination—USA (COMVEX-USA) given by the National Board of Osteopathic Examiners.
3. The Special Purposes Examination for Chiropractic (SPEC) given by the National Board of Chiropractic Examiners.

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

D. The board reserves the right to deny a request for reinstatement or reactivation to any licensee who has been determined to have committed an act in violation of § 54.1-2915 of the Code of Virginia or any provisions of this chapter.

Agenda Item: Consideration of language for physician assistant reinstatement

Included in your agenda package:

- Draft changes to 18VAC85-50 to accommodate reinstatement of physician assistant licenses

Staff Note: At their October 10th meeting, the advisory board on Physician Assistants voted to recommend the included draft changes that accommodate reinstatement for physician assistant licenses to the full Board. Currently, physician assistants that let their license lapse by two years or more must file a new application for licensure. This is unusual and procedurally problematic. The attached draft language is consistent with other licensing boards' handling of this issue.

Action Needed:

- Motion to adopt fast-track regulatory changes regarding physician assistant reinstatement as presented

Project 8085 - Fast-Track

Board of Medicine

Reinstatement of licensure for physician assistants

18VAC85-50-35. Fees.

Unless otherwise provided, the following fees shall not be refundable:

1. The initial application fee for a license, payable at the time application is filed, shall be $130.

2. The biennial fee for renewal of an active license shall be $135 and for renewal of an inactive license shall be $70, payable in each odd-numbered year in the birth month of the licensee. For 2021, the fee for renewal of an active license shall be $108, and the fee for renewal of an inactive license shall be $54.

3. The additional fee for late renewal of licensure within one renewal cycle shall be $50.

4. A restricted volunteer license shall expire 12 months from the date of issuance and may be renewed without charge by receipt of a renewal application that verifies that the physician assistant continues to comply with provisions of § 54.1-2951.3 of the Code of Virginia.

5. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

6. The fee for reinstatement of a license that has expired for a period of two years or more shall be $180.

~~6.~~ 7. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

Draft

~~7.~~ 8. The handling fee for a returned check or a dishonored credit card or debit card shall be $50.

~~8.~~ 9. The fee for a letter of good standing or verification to another jurisdiction shall be $10.

~~9.~~ 10. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $35, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $15 for each renewal cycle.

18VAC85-50-56. Renewal of license.

A. Every licensed physician assistant intending to continue to practice shall biennially renew the license in each odd numbered year in the licensee's birth month by:

1. Returning the renewal form and fee as prescribed by the board; and

2. Verifying compliance with continuing medical education standards established by the NCCPA.

B. Any physician assistant who allows his NCCPA certification to lapse shall be considered not licensed by the board. Any such assistant who proposes to resume his practice ~~shall make a new application for licensure.~~ within two years or less shall apply for renewal and pay the late fee specified in 18VAC85-50-35. A physician assistant shall apply for reinstatement and pay the associated fee specified in 18VAC85-50-35 if the license has lapsed for more than two years.

18VAC85-50-62. Reinstatement.

A. A physician assistant whose license is lapsed for a period of two years or less may reinstate the license by payment of the renewal and late fees as set forth in 18VAC85-50-35.

B. A physician assistant whose license is lapsed for a period of more than two years may apply for reinstatement and shall submit:

Draft

1. A completed application package;

2. The fee specified in 18VAC85-50-35; and

3. Evidence of current certification by NCCPA.

Draft

Agenda Item: Notice of Intended Regulatory Action to implement HB995

Included in your agenda package:

- HB995 from the 2024 General Assembly

Staff Note: This issue was discussed by the legislative committee at their September 13th meeting at which the committee recommended the Board issue a Notice of Intended Regulatory Action to implement the provisions of HB995, including:

- Fees associated with initial applications for renewals of provisional and restricted licenses;
- Application requirements for provisional and restricted licenses;
- Renewal requirements for provisional and restricted licenses;
- Criteria for assessment and evaluation programs of provisional licensees;
- Additional criteria required by the Board to obtain a provisional license;
- Amendments to disciplinary provisions of any regulations to include provisional and restricted licensees; and
- Amendments to regulations related to reinstatement to include provisional and restricted licensees.

Action Needed:

- Motion to adopt a notice of intended regulatory action (NOIRA) to implement the provisions of HB995 as recommended by the Legislative Committee.

VIRGINIA ACTS OF ASSEMBLY -- 2024 SESSION

CHAPTER 464

An Act to amend and reenact § 54.1-2933.1 of the Code of Virginia, relating to the Board of Medicine; temporary licensure of physicians licensed in a foreign country.

[H 995]

Approved April 4, 2024

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2933.1 of the Code of Virginia is amended and reenacted as follows:

§ 54.1-2933.1. Temporary licensure of certain foreign graduates.

A. The Board may issue~~,~~ to a physician licensed in a foreign country~~,~~ a nonrenewable license valid for a period not to exceed two years to practice medicine while such physician is attending advanced training in an institute for postgraduate health science operated collaboratively by a health care system having hospitals and health care facilities with residency and training ~~program(s)~~ *programs* approved by an accrediting agency recognized by the Board and a public institution of higher education. This temporary license shall only authorize the holder to practice medicine in the hospitals and outpatient clinics of the collaborating health care system while he is receiving training in the institute for postgraduate health science.

B. The Board may issue to a physician previously licensed or otherwise authorized to practice in a foreign country a provisional license to practice medicine valid for a period not to exceed two years to an applicant if the applicant submits evidence acceptable to the Board that the applicant:

1. Has received a degree of doctor of medicine or its equivalent from a legally chartered medical school outside of the United States recognized by the World Health Organization, has been licensed or otherwise authorized to practice medicine in a country other than the United States, and has practiced medicine for at least five years;

2. Has a valid certificate issued by the Educational Commission for Foreign Medical Graduates or other credential evaluation service approved by the Board, provided, however, that the Board may waive such certification at its discretion where the applicant is unable to obtain the required documentation from a noncooperative country;

3. Has achieved a passing score on both Step 1 and Step 2 (Clinical Knowledge) of the United States Medical Licensing Examination;

4. Has entered into an agreement with a medical care facility as defined in § 32.1-3 that provides an assessment and evaluation program designed to develop, assess, and evaluate the physician's nonclinical skills and familiarity with standards appropriate for medical practice in the Commonwealth according to criteria developed or approved by the Board;

5. Will enter a full-time employment relationship with such medical care facility after the Board issues a license pursuant to this subsection; and

6. Has satisfied any other criteria that the Board may require for issuance of a provisional license pursuant to this subsection.

C. An individual who successfully obtains a license pursuant to subsection B and practices under such license until its expiration shall be eligible to apply for a renewable two-year restricted license to practice medicine in a medically underserved area in Virginia as defined in § 32.1-122.5 or a health professional shortage area designated in accordance with the criteria established in 42 C.F.R. Part 5. The Board may issue such renewable license to an applicant if the applicant submits evidence acceptable to the Board that the applicant:

1. Has successfully completed the participating medical care facility's assessment and evaluation program required pursuant to subsection B;

2. Has achieved a passing score on Step 3 of the United States Medical Licensing Examination; and

3. Will enter a full-time employment relationship with a medical care facility.

D. After at least two years of practice under a renewable two-year restricted license issued pursuant to subsection C, an internationally trained physician shall be eligible to apply for a full, unrestricted license to practice medicine.

E. The Board may promulgate regulations for ~~such license~~ *licenses issued pursuant to this section.*

Agenda Item: Consideration of American Allied Health as an approved provider for surgical technician certification

Included in your agenda package:

- Topical study guide provided by American Allied Health;

- Virginia Code § 54.1-2956.12.

Staff note: The Advisory Board for Surgical Assistants met on October 15th and discussed whether the American Allied Health certification met the requirements of § 54.1-2956.12. The certification concerned the advisory board members for the following reasons:

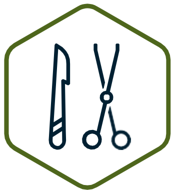
- No clinical training is offered, as everything appears to be online.
- This is a certification program for surgical technicians, which are generally a lower level than surgical technologists. Use of the different term alone may be confusing to the public.
- No indication in program materials what educational programs are acceptable to sit for exam (this is different than previously-approved NCCT).
- Recertification for American Allied Health requires only 5 CEUs per calendar year (NCCT requires 15).

The Advisory Board recommends that the Board of Medicine deny approval to the certification provided by American Allied Health.

Action needed:

- Motion to either:
    - Accept the recommendation of the Advisory Board; or

    - Approve American Allied Health as an approved provider for surgical technologist certification.



TOPICAL STUDY GUIDE

Surgical Technician, NRST

American Allied Health

NATIONAL CERTIFICATION & REGISTRATION

American Allied Health (AAH), for nearly two decades, has been featured in health science textbooks as a leading allied health certification & credentialing agency.

AAH partners with U.S. State Departments of Education to provide certification and continuing education courses for over ten different health career vocational pathways; our 10,000+ members work in all 50 states and over 30 countries overseas.

For more information, visit: www.AmericanAlliedHealth.com

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Eligibility to Sit for the Exam

To sit for any AAH national certification exam, you must first demonstrate your eligibility by submitting "Proof of Eligibility." You will be asked to upload documentation directly to your AAH account (.PDF, .doc, docx, .JPEG or .PNG). Your paperwork will be reviewed and approved by AAH within 24-48 hours. You may complete this step before or after registration, and if your application is denied, your registration fee will be fully refunded.

Eligibility Requirements

To sit for the exam, you must satisfy at least **one** of the following requirements.

- **a.** Completion of a related course or training program, or
- **b.** One year's work experience in the field, or
- **c.** Relevant military training, or
- **d.** Previously have been certified by another agency

Approved Documentation

To demonstrate your eligibility, you must upload to your AAH account at least **one** of the following forms of documentation.

Copy of either school transcript, diploma, or certificate	**Letter** from employer indicating job title and length of employment	**Check stub** indicating job title and hire date
DD Form 214 (for military personnel)	**Member ID or Certification # from previous certification agency**	**Enter an Exam Registration Code or School Code***

***Note:** If you have been instructed to enter a Registration Code or School Code by one of our AAH-Affiliated testing partners, you won't be required to submit any documentation.

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How to Earn National Certification Online

The Certification Process

STEP 1

Register Online

Register for the exam at:
www.AmericanAlliedHealth.com

STEP 2

Confirm your Eligibility

Show AAH you're qualified to sit for the exam, by submitting proof of eligibility documentation (see page 1).

STEP 3

Take the Exam Online

Get instant results and access to your certification documents.

Examination Format

ALL EXAMS

150 questions
Multiple choice & true/false

120 mins
Exams are timed; the test must be taken in one sitting

75%
Passing score

Free Study Materials

What's included in the registration fee?

- Free Practice Exams
- Free Topical Study Guide
- Free Retake Examination

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NRST Exam Content

Certification Type	Credentials	Pricing	
Surgical Technician	**NRST**	**$130**	Register

Competency-Based Testing

AAH certification exams evaluate key competency areas expected of entry-level allied health professionals. These "competencies" are demonstrated by the applicant's ability to apply — in a testing environment — their understanding of the relevant knowledge, skills, and abilities (KSAs) that are determined by the American Allied Health Board of Examiners.

Core Competency Areas

The exam tests for “Knowledge, Skills, and Abilities” (KSAs) in the following core competency areas:

5%	The Profession and the Professional
10%	Communication and Teamwork
12%	Medicolegal Aspects of Surgical Technology
10%	Diagnostic and Assessment Procedures
5%	Environmental Hazards
20%	Microbes and the Process of Infection
5%	Moving, Handling, and Positioning the Surgical Patient
10%	Surgical Instruments
5%	Perioperative Pharmacology
5%	Anesthesia, Physiological Monitoring, and Post Anesthesia Recovery
8%	General Surgery and Specialty Surgery
5%	Disaster Preparedness

Examination Format & Criterion

- Online Computer-Based Testing (CBT)
- 150 multiple choice & true/false questions
- 120 mins
- The passing score is 75%

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Topical Breakdown

Use the following topical guide to help you prepare for the exam:

I. The Profession and the Professional (5%)

- Short History of the Profession
- Surgical Technology Education and Certification
- Required Skills
- Becoming a Health Care Professional

II. Communication and Teamwork (10%)

- Elements of Communication
- Verbal and Nonverbal Communication
- Supporting the Psychosocial Needs of the Patient

III. Medicolegal Aspects of Surgical Technology (12%)

- Types of Law
- Facilities Standards and Policies
- Patients' Rights
- Proper Documentation

IV. Diagnostic and Assessment Procedures (10%)

- Concepts Related to Pathology
- Vital Signs
- Microbiological Studies

V. Environmental Hazards (5%)

- Risk and Safety
- Electrical Hazards
- Fire Safety
- Standard Precautions

VI. Microbes and the Process of Infection (20%)

- Microorganisms and the Diseases They Cause
- Sterile Technique and Infection Control
- Principles of Decontamination, Sterilization, and Disinfection
- Instrument Cleaning and Decontamination

VII. Moving, Handling, and Positioning the Surgical Patient (5%)

- Patient Identification
- Transport and Transfers
- Preoperative Skin Marking

VIII. Surgical Instruments (10%)

- Equipment Operation
- Use of Instruments by Tissue Type
- Passing Surgical Instruments in Surgery

IX. Perioperative Pharmacology (5%)

- Regulation of Drugs, Substances, and Delivery
- Unit Systems of Measurement
- Prescription and Drug Orders
- Drug Preparation and Transfer to the Sterile Field

X. Anesthesia, Physiological Monitoring, and Post Anesthesia Recovery (5%)

- General, Regional, and Procedural Sedation
- States of Anesthesia

XI. General Surgery and Specialty Surgery (8%)

- Gastrointestinal Surgery
- Gynecological and Obstetrical Surgery
- ENT Surgery
- Plastic and Reconstructive Surgery
- Orthopedic Surgery
- Thoracic and Pulmonary Surgery
- Cardiac Surgery
- Neurosurgery
- Emergency Trauma Surgery

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XII. Disaster Preparedness (5%)

- Training
- Classification and Definition of Disasters
- Disaster Management and Government Structures

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Sample Test Questions

Next page contains Answer Key

1. ____________ demonstrates that a surgical technologist from an accredited program has achieved a minimum level of knowledge and skills.

    a. An Associate's degree
    b. Licensure
    c. Certification
    d. Graduation

2. The surgical consent is signed by the ____________ , ____________ , and a(n) ____________ .

    a. Surgeon, nurse, family member
    b. Nurse, surgeon, anethesiologist
    c. Patient, surgeon, nurse
    d. Patient, surgeon, witness

3. ____________ measures hemoglobin, hematocrit, platelet and leukocytes.

    a. CBC
    b. Metabolic panel
    c. Imaging study
    d. ABO

4. A drug applied to the skin or mucous membranes is ____________ .

    a. Parenteral
    b. Subcutaneous
    c. Topical
    d. Instill

5. The balloon of a Foley catheter must be filled with sterile ____________ .

    a. Water
    b. Air
    c. Saline
    d. Lubricant

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Sample Test Questions: Answer Key

1. _____________ demonstrates that a surgical technologist from an accredited program has achieved a minimum level of knowledge and skills.

   a. An Associate's degree
   b. Licensure
   c. Certification CORRECT
   d. Graduation

2. The surgical consent is signed by the _____________ , _____________ , and a(n) _____________ .

   a. Surgeon, nurse, family member
   b. Nurse, surgeon, anethesiologist
   c. Patient, surgeon, nurse
   d. Patient, surgeon, witness CORRECT

3. _____________ measures hemoglobin, hematocrit, platelet and leukocytes.

   a. CBC CORRECT
   b. Metabolic panel
   c. Imaging study
   d. ABO

4. A drug applied to the skin or mucous membranes is _____________ .

   a. Parenteral
   b. Subcutaneous
   c. Topical CORRECT
   d. Instill

5. The balloon of a Foley catheter must be filled with sterile _____________ .

   a. Water CORRECT
   b. Air
   c. Saline
   d. Lubricant

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About Online Testing

Computer Based Testing (CBT)

All examinations are taken via AAH's secure online Computer-Based Testing (CBT) Portal. The exam is taken while logged into your AAH account, at www.AmericanAlliedHealth.com, either from your own home computer or onsite, if directed by one of our 300+ AAH-Affiliated Testing Partners.

Test Results

All scoring is determined via the CBT portal's computer calculations and test results are shown immediately. Upon passing the exam, you immediately gain access to documentation of a passing grade, as well as your official certification documents themselves.

Retake Examinations

The first retake examination is included in the initial registration fee. There is no mandatory cool off period between retake exams; you may initiate a retake exam from within your AAH account whenever you are ready. And if you need additional test attempts, further examinations may be purchased for a small retake fee.

Appeal Policy

Candidates who receive a non-passing score have the ability to appeal their test results up to 30 days after an examination attempt. Appeals must include the candidate name, date of testing, and description of the reason for appeal.

Send requests directly to appeals@americanalliedhealth.com —the Appeals Review Committee will respond within 15 days of submission.

System Requirements

The online exam is compatible with all modern web browsers and both Apple and/or PC systems.

The testing portal may be accessed the device of your choosing:

- Desktop computer
- Laptop
- Chromebook
- Tablet
- Mobile device

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General Information

What is National Certification?

Certification provides standardized, third-party evaluation of the competencies of allied health professionals — according to national standards of care. This is why is it often required by employers. Certification has become standard practice for joining allied healthcare careers.

National Certification vs State Licensure

Certification is not the same thing as a state licensure program. This can be confusing because some states require active AAH certification as a pre-requisite to applying for licensure in that state — but earning the certification itself is a non-governmental process. Most states do not have a licensure requirement beyond AAH certification. Use our searchable Regulations Map to verify there are no additional requirements beyond AAH certification to work in your state.

Competency-Based Testing

AAH certification exams are designed to evaluate key competency areas expected of entry-level allied health professionals. These "competencies" are demonstrated by the applicant's ability to apply — in a testing environment — their understanding of the relevant knowledge, skills, and abilities (KSAs) that are determined by the American Allied Health Board of Examiners.

AAH Board of Examiners

AAH's question pool is developed, maintained, and systematically peer-reviewed by a panel of subject matter experts, medical doctors, pharmacists, and educators, who are collectively referred to as the

"Board of Examiners." The Board is responsible for ensuring AAH's standardized exams test for key competency areas which are in line with national standards of care.

Membership in the American Allied Health Association

Those who pass the national exam are automatically placed on AAH's national registry and receive free membership in the American Allied Health Association. Benefits include gaining access to AAH's library of continuing education courses, employee verification and documentation services, digital record keeping, professional networking, and more.

Code of Conduct and Disciplinary Process

To create an AAH account and register for an exam, all users must first read and agree to AAH's Code of Conduct and the website's Terms and Conditions. If any member is found to be in violation of these standards, then, in accordance with our written Disciplinary Policy and Bylaws, that member's certification may be revoked.

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Renewal Process: How to Keep Your Certification

After you pass a national exam, your certification remains active for one year; afterward it must be renewed annually to keep your credentials current. As long as you maintain your certification, you will not need to retake the exam.

Keeping your certification current is simple: everything is done online, once a year, directly within your AAH account. There are only two renewal requirements: paying renewal membership dues and completing online continuing education (CE) courses (or upload your own external documentation of completed CE courses).

Renewal Requirements

1. Pay annual renewal dues: **$32.00**
2. Complete Continuing Education: **5 CEs**

How often do I renew? How much does it cost?

To keep your certification current you must renew once a year by logging back into your AAH account. The annual membership renewal dues are $32.00 per year.

Late Renewals

In most cases renewal is still possible after paying a small late fee. But depending on your last expiration date, you may have to re-register and retake the exam.

Renewal by Reciprocity

If you were previously certified with another agency, and your certification has not been expired longer than 3 years, then you may renew your certification with AAH without retesting. You may apply for renewal by reciprocity within your AAH account by uploading a copy of your previous certification card, or official documentation showing your previous MemberID/Certification# and latest expiration date.

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Continuing Education

What is the Continuing Education (CE) Requirement?

To keep your certification current you must complete at least 5 CE credits before your next expiration date. You can get these credits anytime throughout the year by taking a short, online CE course provided by AAH — or by uploading documentation of your own external CEs (CEUs, CECs, or CEHs) you have earned that year.

Two ways to apply CEs towards your certification

- **A** Get AAH CE Credits
- **B** Import non-AAH CEs

Online CE Courses Provided by AAH

AAH provides a library of online CE courses; you may self-study the material and take a small quiz over the content. Upon course completion, CE credits are automatically applied towards your account for renewal.

How to Import External CE Credits

If you have completed any external CE courses within the last year, you may upload documentation of your training directly into your AAH account. Your documents will be reviewed, and if approved, your CE credits will be imported into your AAH account. There is, however, a small processing fee when applying external CEs towards renewal.

Health Education Courses

student David Smith

Healthcare Education Course	5 credits	6/24/2021

Documentation of non-AAH continuing education must include:

- Name of continuing education provider
- Student's name
- Name of the training or course
- Date of training or issue date
- Number of CE/CEU/CECs/Hours earned

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American Allied Health

NATIONAL CERTIFICATION & REGISTRATION

Contact Information

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Code of Virginia
Title 54.1. Professions and Occupations
Subtitle III. Professions and Occupations Regulated by Boards within the Department of Health Professions
Chapter 29. Medicine and Other Healing Arts
Article 4. Licensure and Certification of Other Practitioners of the Healing Arts

§ 54.1-2956.12. Registered surgical technologist; use of title; registration

A. No person shall hold himself out to be a surgical technologist or use or assume the title of "surgical technologist" or "certified surgical technologist," or use the designation "S.T." or any variation thereof, unless such person is certified by the Board. No person shall use the designation "C.S.T." or any variation thereof unless such person (i) is certified by the Board and (ii) has successfully completed an accredited surgical technologist training program and holds a current credential as a certified surgical technologist from the National Board of Surgical Technology and Surgical Assisting or its successor.

B. The Board shall certify as a surgical technologist any applicant who presents satisfactory evidence that he (i) has successfully completed an accredited surgical technologist training program and holds a current credential as a certified surgical technologist from the National Board of Surgical Technology and Surgical Assisting or its successor, (ii) has successfully completed a training program for surgical technology during the person's service as a member of any branch of the armed forces of the United States, (iii) has successfully completed a surgical technologist apprenticeship program registered with the U.S. Department of Labor, (iv) has successfully completed a hospital-based surgical technologist training program approved by the Board, (v) has successfully completed a surgical technologist training program through an institution or program accredited by a nationally recognized accreditation organization and holds a current credential as a surgical technologist from an entity approved by the Board, or (vi) has practiced as a surgical technologist or attended a surgical technologist training program at any time prior to October 1, 2022, provided he registers with the Board by December 31, 2023.

2014, c. 531;2016, c. 99;2021, Sp. Sess. I, c. 230;2022, c. 71;2023, c. 792.

The chapters of the acts of assembly referenced in the historical citation at the end of this section(s) may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

Agenda Item: Re-Entry to Practice

Staff Note: The Board discussed the FSMB report on “Reentry to Practice at its February 2024 meeting. The suggestion by the Board was for the Credentials Committee to review this matter to see if any changes were warranted.

On September 20, 2024, the Credentials Committee discussed the FSMB report and the Board’s current process for re-entry. The Committee determined that the Board’s current approach is individualized and appears to meet its mission of protecting the public. Therefore, no change was recommended.

Action: Approve the recommendation of the Credentials Committee or amend it.

Virginia Administrative Code
Title 18. Professional And Occupational Licensing
Agency 85. Board of Medicine
Chapter 20. Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry, and Chiropractic

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

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

1. File a completed application for reinstatement;

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

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

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

C. If a practitioner has not engaged in active practice in his profession for more than four years and wishes to reinstate or reactivate his license, the board may require the practitioner to pass one of the following examinations. For the purpose of determining active practice, the practitioner shall provide evidence of at least 640 hours of clinical practice within the four years immediately preceding his application for reinstatement or reactivation.

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

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

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

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

D. The board reserves the right to deny a request for reinstatement or reactivation to any licensee who has been determined to have committed an act in violation of § 54.1-2915 of the Code of Virginia or any provisions of this chapter.

Statutory Authority

§ 54.1-2400 and Chapter 29 of Title 54.1 of the Code of Virginia.

Historical Notes

Derived from VR465-02-1 § 6.1, eff. January 18, 1989; amended, Virginia Register Volume 6, Issue 4, eff. December 20, 1989; Volume 6, Issue 8, eff. February 14, 1990; Volume 6, Issue 26, eff. October 24, 1990;

Volume 7, Issue 26, eff. October 23, 1991; Volume 10, Issue 9, eff. February 23, 1994; Volume 10, Issue 24, eff. September 21, 1994; Volume 11, Issue 25, eff. October 4, 1995; Volume 14, Issue 21, eff. August 5, 1998; Volume 16, Issue 4, eff. December 8, 1999; Errata, 16:8 VA.R. 997 January 3, 2000; amended, Volume 16, Issue 13, eff. April 12, 2000; Volume 20, Issue 10, eff. February 25, 2004.

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

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

REENTRY TO PRACTICE

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

Executive Summary

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

Key considerations for state medical boards in reentry decisions include:

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

The following recommendations are included for state medical boards:

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

DRAFT

46 reentering physicians. State medical boards should make efforts to ensure a sufficient pool
47 of supervisors and mentors is available to reentering physicians.
48 7) State medical boards should require licensees to report information about their practice as
49 part of the license renewal process, including type of practice, status, whether they are
50 actively seeing patients, specialty board certification status, and what activities they are
51 engaged in if they are not engaged in clinical practice.
52 8) Licensees who are clinically inactive should be allowed to maintain their licensure status
53 provided they meet the requirements set forth by the state medical board. Depending on a
54 licensee's engagement in activities designed to maintain clinical competence, should the
55 licensee choose to return to active clinical practice, the board may require participation in
56 a reentry program.
57 9) State medical boards should be consistent in the creation and execution of reentry
58 programs.
59

DRAFT

Introduction

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

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

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

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

The recommendations provided in this report are organized as follows:

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

- Improving Regulation of Licensed Practitioners Who are Clinically Inactive

Section One. Glossary

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

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

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

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

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

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

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

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

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152 **Section Two. Key Issues**
153
154 The Workgroup identified several key issues relevant to state medical board decisions about
155 reentry to practice.
156
157 Timeframe
158 More than two years away from practice is commonly accepted as the timeframe for when
159 physicians should go through a reentry process. The two-year timeframe is based on extensive
160 state medical board experience and subject matter expertise in physician assessment and
161 remediation. The Workgroup recognizes the need for flexibility when applying the two-years-
162 absent-from-practice timeframe to an individual physician, as there is great variability in specialty,
163 type of practice, and clinical and educational engagement while absent from practice.
164
165 When determining whether a physician requires a reentry to practice program, a medical board
166 may choose to consider the following factors:
167 • administrative or consultative activity (e.g., chart reviews);
168 • concordance of prior and intended scopes of practice;
169 • educational or mentoring responsibilities;
170 • intention to perform procedures upon reentry;
171 • length of time in practice prior to departure;
172 • participation in accredited continuing medical education and/or volunteer activities during
173 the time out of practice;
174 • participation in continuous certification[1] prior to departure from practice;
175 • prior disciplinary history;
176 • time since completion of post-graduate training; and
177 • whether absence from practice resulted from disciplinary action or criminal conviction
178
179 Assessment of Fitness to Reenter Practice
180 It is the responsibility of state medical boards to determine whether a licensee/applicant who has
181 had an absence from practice should demonstrate whether they are competent to reenter practice.
182 The assessment, as well as the assessment modality or modalities may be tailored to the individual.
183 If it is not immediately clear what needs to be assessed as part of the licensee's fitness to practice,
184 state medical boards are encouraged to seek the expertise of assessment organizations with
185 experience in this area.[2] Boards may recommend that clinically inactive physicians proactively
186 complete a self-assessment prior to reentering practice to identify any clinical deficiencies as this
187 may be valuable in determining board-mandated reentry requirements.
188
189 Public Health Emergencies
190 During public health emergencies, state medical boards may recognize the need to, and choose to,
191 implement temporary licensure modifications and waivers allowing clinically inactive physicians
192 to reenter practice. When doing so, medical boards should utilize mechanisms that can quickly
193 identify and verify credentials of health professionals to ensure patient safety and maintain

[1] The Workgroup recognizes that at the time of drafting, some specialty certifying boards continue to use the term "Maintenance of Certification" to describe this process.
[2] FSMB, Directory of Physician Assessment and Remedial Education Programs. October 2023, available at: https://www.fsmb.org/siteassets/spex/pdfs/remedprog.pdf.

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194 oversight of licensure waivers that fall outside medical board control. If a clinically inactive
195 physician chooses to practice beyond the public health emergency, they must complete the
196 appropriate reentry program determined by the state medical board. Boards are encouraged to
197 make licensees aware of Provider Bridge so they may choose to register as potential volunteers in
198 advance of future public health emergencies.
199
200 State Medical Board Data Collection on Clinical Activity
201 State medical boards should consider means of collecting information from licensees about their
202 clinical activity to understand workforce demographics. While some state medical boards will be
203 limited in their capacity to collect data on licensee clinical activity, they may wish to consider
204 alternative means to collecting this on licensing applications such as optional surveys to licensees.
205 This can be particularly important for understanding the degree to which active licensees are not
206 clinically active, and may inform reentry decisions for this population.
207
208 Challenges to Reentry
209 There are difficulties associated with identifying entities that provide reentry services to
210 physicians. These include cost, geographic considerations, eligibility requirements, licensure,
211 malpractice issues and lack of uniformity among alternatives available to physicians seeking
212 reentry. While some of these challenges are outside the purview of state medical boards, others
213 can be mitigated by boards, including requirements for mentors, rather than supervisors, and the
214 ability to obtain a training license. State medical boards may choose to review their current
215 practices to avoid undue burdens or barriers to reentry, while being mindful of patient safety
216 considerations. Boards may proactively choose to communicate these challenges to licensees so
217 that they can plan accordingly when an absence from practice is anticipated.

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

[3] *Ibid.*

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

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

Impairment

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

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

Mentoring and Supervision of Reentry Physicians

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

Maintaining Licensure if Not in Active Clinical Practice

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

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

[5] Iowa Code Ann. § 148.11A.

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

Section Three. Recommendations

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

<u>Education and Communication</u>
Recommendation 1: Proactive communications
To help prepare licensees/applicants who either are thinking about taking a leave of absence or are considering returning to clinical practice, state medical boards should proactively educate licensees/applicants about ways to maintain competence while absent from practice and the issues associated with reentering clinical practice (e.g., continued participation in CME activities while out of practice, unintended consequences of taking a leave of absence such as impact on malpractice costs and future employment). For example, state medical boards could develop written guidance on issues like the importance of engaging in clinical practice, if even on a limited, part-time basis, or seeking counsel from their insurance carriers prior to withdrawal from practice and when they are ready to reenter practice. They might also suggest that the licensee/applicant review the FSMB Roadmap for Those Considering Temporarily Leaving Practice (See Appendix A). State medical boards could include such information with the initial license, with the license renewal application, in the board's newsletter, and on the board's website. This may also help physicians who are contemplating retirement but are unaware that a reentry process may be required by their state medical board if they change their mind.

<u>Determining Medical Fitness to Reenter Practice</u>
Recommendation 2: Review on a case-by-case basis
Because competence is maintained in part through continuous engagement in patient care activities, licensees/applicants seeking to return to clinical work after an absence from practice should be considered on a case- by-case basis. Absences from practice of two years or greater are generally accepted as the minimum timeframe for when physicians should be required to engage in a reentry process. However, decisions about whether the licensee/applicant should demonstrate readiness to reenter practice should be based on a global review of the licensee/applicant's situation, including:

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

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

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

Recommendation 3: Documentation

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

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

Recommendation 4: Reentry plan after extended time out of practice

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

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

Recommendation 5: State medical board collaborative relationships

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

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371 types of practices. The National Board of Osteopathic Medical Examiners, the National Board of
372 Medical Examiners, the American Board of Medical Specialties, the American Osteopathic
373 Association Bureau of Osteopathic Specialties, and the American Medical Association may
374 likewise serve in a supportive role to state medical boards in this regard. These institutions and
375 organizations may have readily adaptable programs or simulation centers that meet the individual
376 needs of reentering physicians.
377
378 Supervision and Mentoring for Practitioners Who Want to Reenter the Workforce
379 ***Recommendation 6: State medical board-approved supervisors and mentors***
380 Supervisors may be selected by either the state medical board or the licensee/applicant, but in all
381 cases should be approved by the state medical board. At a minimum, the supervisor should be
382 ABMS or AOA board certified, have no prior disciplinary history, and practice in the same clinical
383 area as the licensee/applicant seeking reentry.
384
385 The state medical board should set forth in writing its expectations of the supervisor, including
386 what aspects of the reentering licensee/applicant's practice are to be supervised, frequency and
387 content of reports by the supervisor to the state medical board, and how long the practice is to be
388 supervised. The board's expectations should be communicated both to the supervisor and the
389 licensee/applicant being supervised. For physician assistants, the role of supervisor may be
390 fulfilled by the supervising physician.
391
392 The supervisor should be required to demonstrate to the medical board's satisfaction that they have
393 the capacity to serve as a supervisor, for example, sufficient time for supervising, lack of
394 disciplinary history, proof of an active, unrestricted medical license, and demonstration of having
395 actively practiced for at least the prior five consecutive years. The supervisor may be permitted to
396 receive financial compensation or incentives for work associated with supervision. Potential
397 sources of bias should be identified, and in some cases may disqualify a potential supervisor from
398 acting in that capacity.
399
400 The licensee/applicant reentering practice should establish a peer-mentorship with an actively
401 practicing physician who meets the requirements of a supervising physician, but the mentor does
402 not require medical board approval or reporting beyond that which would typically exist in any
403 clinical context.
404
405 State medical boards should work with state medical and osteopathic societies and associations
406 and the medical education community to identify and increase the pool of potential supervisors
407 and mentors. To protect the pool of supervisors, boards may make supervisors agents of the board.
408
409 Improving Regulation of Licensed Practitioners Who are Clinically Inactive
410 ***Recommendation 7: Identifying clinically inactive licensees***
411 State medical boards should require licensees to report information about their practice as part of
412 the license renewal process, including type of practice, status (e.g., full-time, part-time, number of
413 hours worked per week), whether they are actively seeing patients, specialty board certification
414 status, and what activities they are engaged in if they are not engaged in clinical practice (e.g.,
415 research, administration, non-medical work, retired, etc.). Such information will enable state
416 medical boards to identify licensees who are not clinically active and to intervene and guide, as

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

Recommendation 8: Licensure status

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

Recommendation 9: Consistency of reentry across jurisdictions

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

Conclusion

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

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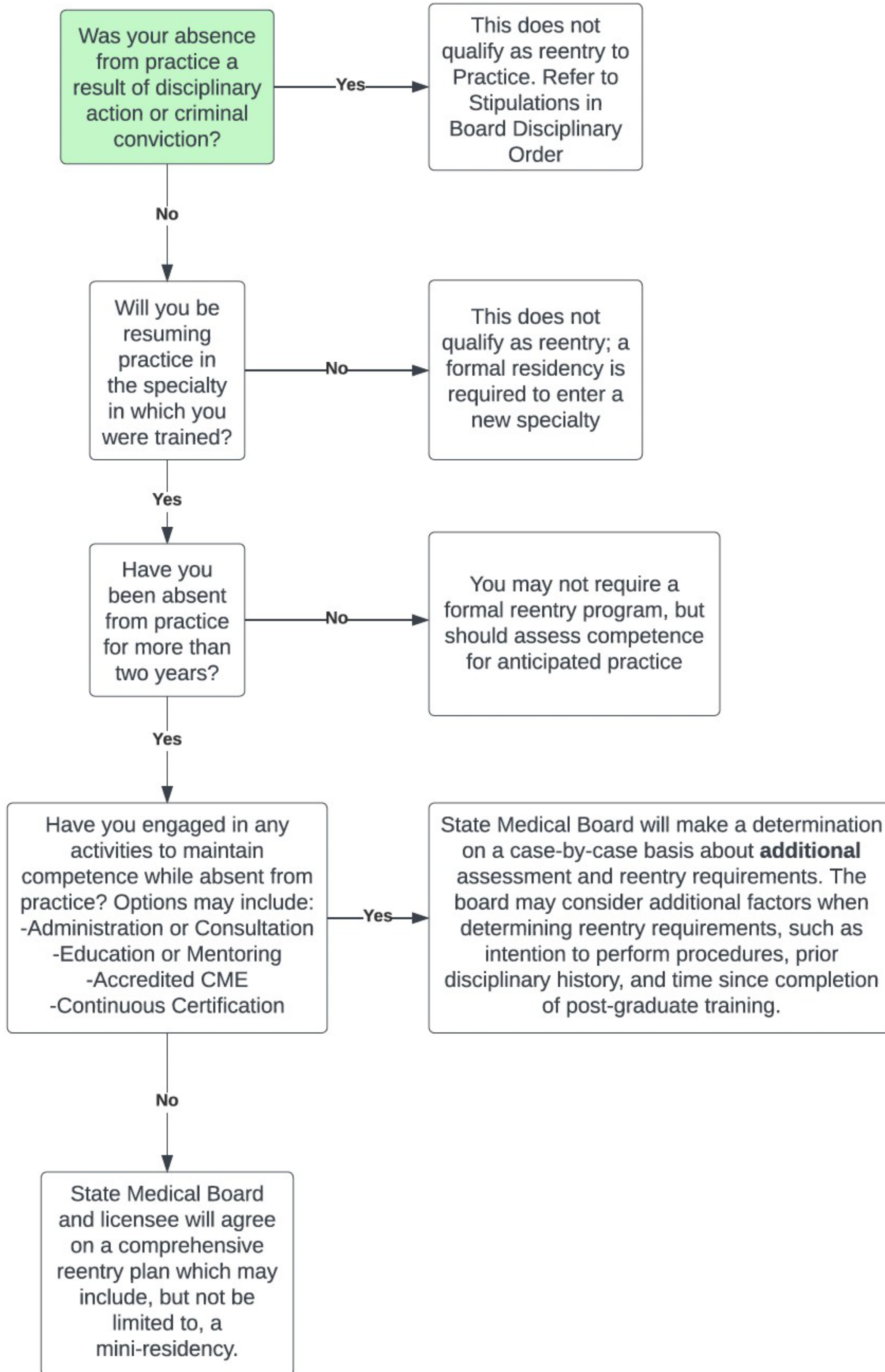
447 **Appendix A. FSMB Roadmap for Those Considering Temporarily Leaving Practice**



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449 Appendix B. Additional policy resources related to physician health, illness and impairment, and
450 physician reentry to practice
451 1. AMA: Resources for physicians returning to clinical practice, definition of physician
452 impairment, Resources for Physician Health
453 2. AOA: Resources for Physician Wellness
454 3. CMSS/Specialty Society: CMSS Position on Physician Reentry (11/11)
455 4. FSPHP: Public Policy Statement : Physician Illness vs. Impairment
456 5. ACOG: Re-entering the Practice of Obstetrics and Gynecology

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

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Agenda Item: Expiration of Applications

Staff Note: The Board's current policy is to keep an application open for 1 year plus an extra month of grace. An application can be open for 395 days. Maryland keeps its applications open for 90 days. As you know, our system requires the applicant to make sure the necessary documents get to the Board. We now have 3 pathways for physicians, traditional endorsement, and reciprocity with Maryland and DC. 100% of the endorsement and reciprocity applicants are licensed quickly. They have the incentive to work their application. We have licensed a physician by endorsement in 1 day. In contrast, a number of applicants that choose the traditional pathway may not work their application, so it languishes for months. Some may never finish their application because they decided to go to another state. It is the group that is slow to work their applications that inflate the Licensing Section's number of days from receipt of an applications to the issuance of the license. Have a 90-day expiration on an application – for all processions – would incentivize applicants to timely submit the required documentation and get their license. Once an app is complete, it is usually reviewed, and the license issued in 1-2 days.

On September 20, 2024, the Credentials Committee this matter and determined that applications should remain open for 180 days.

Action: To approve or amend the recommendation of 180 days.

Pending Applications Completed and Expired
2022-2024 (Ending 8/31/24)

BOARD OF MEDICINE	2022	2023	2024
Total Number of Applications Received	11,188	11,506	8,619
Total Number Completed (License Issued) Between 91-120 Days	1,024	689	315
Total Number Completed (License Issued) over 120 Days	1,866	1,297	519
Total Number of Application Expired After 13 months	720	1,880	1,283

Agenda Item: **Licensing Report**

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

Action: None anticipated.

Agenda Item: **Discipline Report**

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

Action: None anticipated.

- Next Meeting Date of the Full Board is February 20-22, 2025. Please check your calendars and advise staff of any known conflicts that may affect your attendance.

- The travel regulations require that "travelers must submit the Travel Expense Reimbursement Voucher within 30 days after completion of their trip". (CAPP Topic 20335, State Travel Regulations, p.7). If you submit your reimbursement after the 30-day deadline, please provide a justification for the late submission and be aware that it may not be approved.

- In order for the agency to be in compliance with the travel regulations, please submit your request for today's meeting no later than **November 24, 2024.**