Virginia Regulatory Town Hall

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Final Regulation
Agency Background Document

Agency name	Board of Physical Therapy, Department of Health Professions
Virginia Administrative Code (VAC) citation	18VAC112-20
Regulation title	Regulations Governing the Practice of Physical Therapy
Action title	Direct access certification
Date this document prepared	11/18/08

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 36 (2006) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

Please provide a brief summary (no more than 2 short paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation. Also, please include a brief description of changes to the regulation from publication of the proposed regulation to the final regulation.

Following a thorough review of regulations in Chapter 20, the Board has made revisions to clarify certain definitions and requirements for practice by physical therapists, simplify regulations for trainees, specify the additional training or course work required to retake the examination after three failures, add evidence of competency for licensure by endorsement, clarify the responsibilities of physical therapist in the evaluation and discharge of a patient, modify the requirements for renewal or reinstatement of licensure, and add provisions on standards of professional practice and grounds for unprofessional conduct.

Statement of final agency action

Please provide a statement of the final action taken by the agency including (1) the date the action was taken, (2) the name of the agency taking the action, and (3) the title of the regulation.

On November 7, 2008, the Board of Physical Therapy adopted final amendments to 18VAC112-20-10 et seq., Regulations Governing the Practice of Physical Therapy, in order to implement recommendations from its periodic review of regulations and to respond to public comment on proposed regulations.

Legal basis

Please identify the state and/or federal legal authority to promulgate this proposed regulation, including (1) the most relevant law and/or regulation, including Code of Virginia citation and General Assembly chapter numbers, if applicable, and (2) promulgating entity, i.e., agency, board, or person. Describe the legal authority and the extent to which the authority is mandatory or discretionary.

Chapter 24 of Title 54.1 establishes the general powers and duties of health regulatory boards including the responsibility of the Board of Physical Therapy to promulgate regulations, levy fees, and administer a licensure and renewal program.

§ 54.1-2400. General powers and duties of health regulatory boards.--The general powers and duties of health regulatory boards shall be:

1. *To establish the qualifications for registration, certification or licensure in accordance with the applicable law which are necessary to ensure competence and integrity to engage in the regulated professions.*

2. *To examine or cause to be examined applicants for certification or licensure. Unless otherwise required by law, examinations shall be administered in writing or shall be a demonstration of manual skills.*

3. *To register, certify or license qualified applicants as practitioners of the particular profession or professions regulated by such board.*

4. *To establish schedules for renewals of registration, certification and licensure.*

5. *To levy and collect fees for application processing, examination, registration, certification or licensure and renewal that are sufficient to cover all expenses for the administration and operation of the Department of Health Professions, the Board of Health Professions and the health regulatory boards.*

6. *To promulgate regulations in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) which are reasonable and necessary to administer effectively the regulatory system. Such regulations shall not conflict with the purposes and intent of this chapter or of Chapter 1 and Chapter 25 of this title.*

Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Detail the specific reasons it is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.

The Board's purpose is to update and clarify its regulations pursuant to recommendations from the Regulatory/Legislative Committee, which conducted a periodic review of regulations in accordance with Executive Order 36 (2006).

Questions from practitioners about the responsibility of physical therapists in discharge of a patient, in the role of patient evaluations, in medical recordkeeping and other issues relating to practice have been further specified in order to ensure that patients receive competent care. Additional requirements for persons applying for PT licensure by endorsement will help assure minimal competency in current knowledge and skills and will ensure that the Virginia board is fully informed about any disciplinary problems or malpractice payments.

The inclusion of standards of practice will further protect patient health and safety by setting rules for professional behavior in the protection of patient confidentiality, disclosure of records, patient communication, sexual contact and other issues that may impede patient care or result in patient harm. Standards set in regulations supplement those in the law and will provide the Board with further grounds to discipline practitioners who violate such provisions.

Substance

Please identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. A more detailed discussion is required under the "All changes made in this regulatory action" section.

Following its review of all provisions of Chapter 20, the Board has proposed revisions to the following sections:

Section 10 – Definitions

The Board has added a definition for "discharge" and modified the definitions of "evaluation," "trainee," and "traineeship."

Section 40 - Education requirements: graduates of approved programs

Amendments are proposed to add acceptance of TOEFL iBT, the Internet Based tests of listening, reading, speaking and writing and to specify what evidence of English proficiency is acceptable in lieu of the required tests.

Section 50 - Education requirements: graduates of schools not approved by an accrediting agency approved by the board.

Amendments are recommended to add acceptance of TOEFL iBT, the Internet Based tests of listening, reading, speaking and writing and to specify what evidence of English proficiency is acceptable in lieu of the required tests. Amendments will also be considered to eliminate the specific requirements for a "foreign-trained trainee" and refer to general requirements for a traineeship in section 140.

Section 60 - Requirements for licensure by examination.

The Board intends to clarify the "additional clinical training or course work in the deficiency areas of the examination" required for applicants who have failed the licensure examination three times. The language currently found in a guidance document will be incorporated into regulation.

Section 65 – Requirements for licensure by endorsement.
The Board is concerned that it may not have sufficient documentation to ensure the competency of applicants coming from other states, especially since the requirements for endorsement were changed to allow evidence of clinical practice for five years to replace the educational qualifications of applicants for licensure by examination. The Board will require submission of reports on malpractice payments and actions taken by other boards or healthcare organizations and evidence of continuing education equivalent to that required in Virginia to ensure that the applicant has practiced safely and has maintained current knowledge and skills.
Section 70 – Traineeship for unlicensed graduate scheduled to sit for the national examination.
The requirements for an unlicensed graduate trainee will be amended in accordance with general traineeship requirements and to specify a limitation on the amount of time someone who has not passed the national examination can serve in a traineeship.
Part III. Practice Requirements.
Provisions of sections 90, 100, and 120 are amended to clarify practice questions and issues that have come to the attention of the Board. The Board has clarified the role of the physical therapist in evaluations and discharges.
Section 131. Continued competency requirements for renewal of an active license.
The Board has added documentation of completion of a transitional doctoral program as evidence of satisfying continued competency requirements and has clarified that the exemption for persons in their first renewal following initial licensure is for licensure by examination.
Section 136. Reinstatement requirements.
This section needs to be amended to distinguish between a licensee whose license has lapsed for less than two years, who may reinstate by meeting the renewal requirements and payment of a late fee, and the licensee whose license is lapsed for more than two years who must reinstate by completion of a traineeship or evidence of practice in another jurisdiction.
Section 140. Traineeship requirements.
Section 140 is amended to make it applicable to all references to traineeship; other sections of the regulation will be amended accordingly.
Section 150. Fees.
The Board has added a fee for reinstatement of a suspended license.
Part IV on Standards of conduct. (Section 160 – 200)
The Board has added regulations specifying standards of practice and grounds for unprofessional conduct. § 54.1-3483 of the Code of Virginia provides grounds for unprofessional conduct by a physical therapist or a physical therapist assistant, including conducting one's practice in such a manner as to be a danger to the health and welfare of his patients or to the public. The Board has determined that it needs to establish in regulation requirements for practice that may provide greater protection for the health and welfare of patients, relating to confidentiality and maintenance of patient records, informed consent, termination of care, and responsibility for performance of procedures within one's skill and scope of practice. Sections 160 through 200 are taken from the standards of conduct regulations under the Board of Medicine, as applicable to occupational therapists, physician assistants, radiologic technologists and other professionals.

Issues

Please identify the issues associated with the proposed regulatory action, including:

1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;
2) the primary advantages and disadvantages to the agency or the Commonwealth; and
3) other pertinent matters of interest to the regulated community, government officials, and the public.
If there are no disadvantages to the public or the Commonwealth, please indicate.

1) The primary advantage to the public would be to provide greater specificity about the responsibility of the physical therapist in the evaluation and discharge of a patient and in the standards by which a practitioner should guide his practice and interactions with patients.

2) There are no advantages or disadvantages to the agency or the Commonwealth.

3) There is no other pertinent matter of interest related to this action.

Changes made since the proposed stage

Please describe all changes made to the text of the proposed regulation since the publication of the proposed stage. For the Registrar's office, please put an asterisk next to any substantive changes.

The following changes were made to the text of the proposed regulation since publication:

Section 10. Definitions.
The definitions of "discharge" and "evaluation" were amended for clarity, consistent with recommendations from the Virginia Physical Therapy Association (VPTA).

Section 40. Education requirements: graduates of approved programs.
Subsection B was amended to assure that the waiver provision for proof of English proficiency could apply to applicants for the PT and PTA license.

Section 90. General provisions.
Subsection A was amended to clarify the documentation that is necessary at the time of discharge, consistent with a recommendation from the VPTA.

Section 140. Traineeships.
The sentence was restructured to clarify its meaning.

Public comment

Please summarize all comments received during the public comment period following the publication of the proposed stage, and provide the agency response. If no comment was received, please so indicate.

Proposed regulations were published in the Virginia Register of Regulations on August 4, 2008. Public comment was requested for a 60-day period ending October 3, 2008. A Public Hearing

before the Board of Physical Therapy was held on August 22, 2008. ***In reviewing the comments, the Board agreed that there were issued raised that had not been noticed or considered during the periodic review of regulations. Those issues are starred (*) on the following summary and have been referred to the Regulatory/Legislative Committee for future consideration and possible action.***

The following comment was received at the public hearing:

*Shawne Soper asked that the Board consider, when amending traineeship requirements, the work force shortage issues that may worsen if traineeships are eliminated altogether.

The following comment was received in writing or electronically:

Laurie Daigle, PT – The amendment requiring the PT to see a patient every 30 days *from initial evaluation"* seems to penalize the PT who maintains direct patient contact early in the treatment cycle.

Board response: The proposed amendment requires the PT to see a patient once every 30 days from the *last evaluation*, so the Board believes the proposed language addresses the commenter's concern.

*Jane R. Hill, PT – Recommends the repeal of section 70 on traineeships, as the graduate may now sit for the examination without delay and the traineeship no longer serves a purpose. If traineeships are retained, the following are recommended:

1. The number of supervisors of the unlicensed graduate trainee be limited to one.
2. The designation of the unlicensed graduate trainee be "PT Trainee" for the physical therapist graduate and "PTA Trainee" for the unlicensed PTA graduate. This designation as a "trainee" is needed to clearly identify the qualification of the treating practitioner. The designation as "trainee" has significant billing/insurance implications.
3. State that all patient progress notes must be countersigned by the trainee's supervisor. This includes computerized/electronic patient care notes. There must be documentation that the trainee is being supervised.

The currently stated regulation 18VAC112-20-70 leaves much room for broad interpretation and implementation. Also recommend that at the time of approval of the application for traineeship status, information regarding the requirements and limitations of the traineeship be sent to the trainee, the trainee's supervisor, and the employer.

Virginia Physical Therapy Association –

1) In reference to section 18VAC112-20-10 the proposed change related to discharge VPTA would propose the following language:

"Discharge" means the discontinuation of interventions in an episode of care which has been provided in an unbroken sequence in a single practice setting and related to the physical therapy interventions for a given condition or problem.

The rationale for this change is that the term 'episode of care' as used in the Guide to Physical Therapy Practice from the APTA actually crosses care settings – i.e. a hip fracture episode of care includes acute, inpatient rehab and outpatient. The Board either needs to define 'episode of care' differently in this document or clarify that the discharge is related to a given practice setting.

Board response: The Board concurred with the comment and amended the definition accordingly.

2) In reference to this section 10 the term "Evaluation" we would propose to include "or screening" after "an examination".

Board response: The Board concurred with the comment and amended the definition accordingly.

3) In reference to 18VAC112-20-40, the requirement for tests of English proficiency, VPTA comments that it should read "physical therapy education or program" to encompass both PT and PTA programs. This same language that reference PTA education is used again in section 18VAC112-20-50 item C -1.

Board response: The Board concurred with the comment and amended section 40 accordingly.

*4) 18VAC112-20-50 item D requires a 1,000-hour *full-time* traineeship; VPTA requests deletion of the words "full time" as many individuals may not have the option or opportunity to work full time in a traineeship – the individuals should be able to complete the required number of hours in a part time format if needed.

*5) VPTA also recommends a 480-hour traineeship with an option for an extension to a greater number of hours, or an additional traineeship for 480 hours, if deemed necessary by the supervising physical therapist.

*6) Also, consider allowing the PTA traineeship to be a fewer number of hours than the PT traineeship, since PTA education programs are shorter than PT education programs, and the scope of services provided by the PTA is less than that provided by a PT.

*7) VPTA recommends deletion of 18VAC 112-20-70, which entitled traineeship for unlicensed graduate scheduled to sit for the national examination

This option was available to graduates who in the past had to wait several months to find out the results of their scores on the national examination. This is no longer the case – the graduate gets results in 3-5 business days upon sitting for the exam. In addition, the national examination is now more difficult requiring more new graduate preparation before sitting for the exam. This becomes difficult to do once the new graduate has started working and has expectations from his/her new employer. The current new graduate trainee is not considered licensed in Virginia making them unable to provide care to individuals under Medicare and other providers due to

this status. Also, VPTA is aware that there have been challenges with graduates who have had difficulty passing the exam on multiple attempts and have extended traineeships for long periods of time, often making it difficult for the PT Board to track them over time. Given all of this rationale, and if one believes that the national examination is the gatekeeper for competence to practice, it would seem prudent at this time to eliminate the new graduate traineeship and require that new graduates study for and pass the national exam before being granted a license to practice in Virginia.

8) VPTA proposes that A-3 in section 90 be changed for documented "discharge" to documented "status" because the proposed language would make it virtually impossible for PT's in the acute care setting to comply. In cases where the patient is unexpectedly discharged, the final treatment note needs to serve as the documented discharge status.

Board response: The Board concurred with the comment and amended the definition accordingly.

*9) Requests the elimination of "face-to-face" home study courses, online or audio courses offered by the approving organizations be counted for Type I courses in requirements for CE.

10) Requirements to reinstate for a license lapsed less than two years seem to be less restrictive than those who have chosen to make their license inactive. VPTA encourages a review of this language to ensure that those two categories are equitable in what would be required for reinstatement.

Board response: Renewal of a license that is lapsed less than 2 years is a "late" renewal and does not require reinstatement. It does require payment of the renewal fee and late fee and completion of all required continuing education. The Board believes the categories of reinstatement and reactivation are equitable.

*11) Related to section 140, VPTA is supportive of pursuing further the recent discussion at the PT Board meeting about utilizing the new FSBPT competency testing as a mechanism for determining competence of the inactive licensee who wishes to return to practice in lieu of a traineeship. This would support the concern from a recent survey of those previously licensed who wished to return to practice but found the requirement for the traineeship to be a barrier. If this is not possible at this time we also provide the following to eliminate the hour-requirement and allow the supervisor to determine successful completion.

This would provide an assessment mechanism for the supervising PT to provide input to the Board about the performance of the trainee in the clinical setting. The current APTA CPI performance instrument could be utilized for this purpose. This could also be utilized to determine if an additional traineeship was necessary if you chose to reduce the hours noted in the previous section from 1,000 to 480 for graduates of unapproved programs.

All changes made in this regulatory action

*Please detail all changes that are being proposed and the consequences of the proposed changes. Detail new provisions and/or all changes to existing sections. The changes to the proposed amendments in the final adoption are noted in **BOLD.***

Current section number	Current requirement	Proposed change and rationale
10	Sets out definitions for words and terms used in this chapter	*A new definition for "Discharge" is added to clarify the Board's interpretation of the word as used in regulation.* It means the discontinuation of interventions in an episode of care which has been provided in an unbroken sequence in a single practice setting and related to the physical therapy interventions for a given condition or problem. ***The definition was amended from the proposed because an episode of care might cross varied practice settings (acute care, rehab and home health). As the patient is discharged from each of those, the PT should put a summary of his status at that point in the patient record.*** The word "evaluation" is redefined as a process in which the physical therapist makes clinical judgments based on data gathered during an examination **or screening** in order to plan and implement a treatment intervention, provide preventive care, reduce risks of injury and impairment, or provide for consultation. *The amended definition clarifies the role of the physical therapist in the evaluation of a patient. There are aspects of screening and assessment in the current definition that may be performing by a PTA, so the meaning is confusing.* The term "trainee" is defined to include all types of person seeking licensure as a PT or PTA who are undergoing a traineeship for the purpose of meeting certain qualifications. *The terms for the various categories of trainee are eliminated consistent with amended regulations.*
40 B	Provides the requirements for graduates of an approved physical therapy program that is located outside the U.S.	*The amendments allow the Board to except either TOEFL and TSE or the newer version of the tests that is internet-based and combined into a 4-part test called TOEFL iBT. Equivalency of the tests was accepted by the Board in a guidance document adopted in 2005, which will be rescinded with the promulgation of this amendment. The Board has accepted other evidence of English proficiency in lieu of the exams but has not had criteria by which to judge that evidence; the amendments will establish such criteria.* ***The amendment to the proposed regulation will clarify that the waiver provision may apply to physical therapist or physical therapist assistant applicants.***
50 B 3	Provides the requirements for graduates of an	*The amendments allow the Board to except either TOEFL and TSE or the newer version of the tests that is internet-*

	unapproved PT or PTA program that is located outside the U.S.	*based and combined into a 4-part test called TOEFL iBT. Equivalency of the tests was accepted by the Board in a guidance document adopted in 2005, which will be rescinded with the promulgation of this amendment. The Board has accepted other evidence of English proficiency in lieu of the exams but has not had criteria by which to judge that evidence; the amendments will establish such criteria.*
50 D	Sets out requirements for a traineeship for persons who are not graduates of approved programs	*The traineeship requirements are consolidated into one section (140) so there is greater clarity and consistency.*
60	Sets out the requirements for licensure by examination	Guidance document 112-13 currently sets out the board's guidance on remediation for a person who has failed the licensure examination three times. The purpose of remediation is to give the candidate a greater opportunity for passage but also to provide greater assurance that he/she is competent and has sufficient knowledge and skills to safely practice. Current regulations state that candidates applying for approval to sit for the examination after 3 failures must provide *"evidence satisfactory to the board of having successfully completed additional clinical training or coursework in the deficiency areas of the examination."* Amended regulations will offer specificity on how to provide such evidence: *1. Provide the board with a copy of the deficiency report from the examination; 2. Review areas of deficiency with the applicant's physical therapy educational program and develop a plan, which may include additional clinical training or coursework, to address deficiency areas; and 3. Take an examination review course and the practice examination.* There is sufficient flexibility in the requirement to allow a candidate to choose additional clinical training or coursework, depending on the area of deficiency.
65	Sets out the requirements for licensure by endorsement	The Board is concerned that self-reporting of disciplinary problems in other states or malpractice claims against a person applying for licensure in Virginia may not always be accurate or provide complete information. It is proposing to adopt the policy of other boards and require a HIPDB and a NPDB report for an applicant for endorsement; all boards and malpractice carriers are required to report actions to these two databanks. Additionally, there is currently a requirement for evidence of continuing education to renew a license in Virginia and for reinstatement of a lapsed license or reactivation of an inactive license, but there is no such requirement for endorsement of a license from another state. Therefore, it is easier for someone who has never had a Virginia license than for a PT who was licensed in Virginia but moved to another state and now

		wants to return. For consistency and for greater assurance of current knowledge and competency to practice, the Board proposed that an applicant provide evidence of completion of 15 hours of continuing education for each year in which the applicant held a license in another U. S. jurisdiction, or 60 hours obtained within the past four years. If an applicant has been licensed in another state and has met its requirements for renewal, it is likely that the requirement will not necessitate any additional CE hours be taken. Other states in our area, Maryland, Kentucky, Tennessee, NJ all require 30 per biennium (NC is in the promulgation stage for CE)
70	Sets out the traineeship requirements for an unlicensed graduate	The Board allows an unlicensed graduate to apply for a new traineeship while waiting to take the next examination; this allows a person to obtain additional clinical experience under the supervision of a licensed PT. However, the Board does not want persons becoming "permanent trainees" without ever achieving a passing score and becoming licensed, so it is adding a limitation of one year following receipt of the first examination results.
90	Sets out the general responsibilities for a physical therapist	The Board has received inquiries about whether it is the responsibility of the PT to discharge a patient. While there may be circumstances in which the PT may not see a patient for final discharge or in which the PTA has recorded the patient's response to treatment, it is the responsibility of the PT to document the discharge, including the patient's response to therapeutic intervention at the time of discharge. ***In response to comment from VPTA, the Board changed the language to documented "status" of the patient at the time of discharge to make it clear that, while the PT is not always able to "discharge" his patient, he is responsible for documenting the patient's status at the time of discharge. In cases where the patient is unexpectedly discharged, the final treatment note may serve as the documented discharge status.***
120	Sets out the responsibilities of the PT and the PTA to the patient	The amendment to subsection D clarifies that the PT is responsible for reevaluating the patient at least once every 30 days *from the last evaluation.*
131	Sets out the continuing competency requirements for renewal of licensure	There are two changes in this section: 1) The Board will accept documentation of graduation from a transitional doctor of physical therapy program as evidence of completion of continuing competency requirements for the biennium in which the physical therapist was awarded the degree. *A licensee who has completed all the coursework required for a transitional DPT has fulfilled an excess of 30 clock hours of educational courses.* 2) Subsection C is clarified that the exemption from CE

		requirements is for initial licensure *by examination* for newly graduated licensees who have obtained their first professional license. It was not intended to include those who have been licensed by endorsement.
135	Sets out the requirements for inactive licensees to reactivate.	In subsection B, the hourly requirement currently stated in section 140 is added to the section.
136	Sets out the requirements for persons to reinstate a lapsed license.	Subsection A is added to clarify that a PT or PTA can renew a lapsed license within two years of expiration by payment of fees and completion of continuing competency requirements; thereafter, a person must reinstate the license. The regulation is consistent with current policy of this board and all other boards at DHP.
140	Sets out the provisions for a traineeship	All references to traineeships in this chapter are linked to section 140. The specific hourly requirements are stated within the section that sets out a traineeship, so section 140 is the generic regulation for all types of traineeships. ***The amendments to section 140 are clarifying. The correct sentence structure indicates that the traineeship facility is approved by the board and is under supervision; it is the traineeship itself that is approved and under supervision.***
150	Sets out the fee structure for licensure	A new fee of $500 is added for an application for reinstatement of a license that has been suspended. Currently, there is a fee of $1,000 for reinstatement of a revoked license, but the investigative process and administrative proceeding for consideration of reinstating a suspended license is similar, though somewhat less in cost.
	New sections 160-200 Set out standards for professional practice 2. Knowingly and willfully commits any act which is a felony under the laws of this Commonwealth or the United States, or any act which is a misdemeanor under such laws and involves moral turpitude; 3. Aids or abets, has professional contact with, or lends his name to any person known to him to be practicing physical	§ 54.1-3483 of the Code of Virginia provides grounds for unprofessional conduct by a physical therapist or a physical therapist assistant, including conducting one's practice in such a manner as to be a danger to the health and welfare of his patients or to the public. The Board has determined that it needs to establish in regulation requirements for practice that may provide greater protection for the health and welfare of patients, relating to confidentiality and maintenance of patient records, informed consent, termination of care, and responsibility for performance of procedures within one's skill and scope of practice. Sections 160 through 200 are taken from the standards of conduct regulations under the Board of Medicine, as applicable to occupational therapists, physician assistants, radiologic technologists and other professionals. **Section 160 sets out requirements for patient records.** *A. Practitioners shall comply with provisions of § 32.1-127.1:03*

	therapy illegally; 4. 5. Is unable to practice with reasonable skill or safety because of illness or substance abuse; 6. Publishes in any manner an advertisement that violates Board regulations governing advertising; 7. Performs any act likely to deceive, defraud or harm the public; 8. Violates any provision of statute or regulation, state or federal, relating to controlled substances; 9. Violates or cooperates with others in violating any of the provisions of this chapter or regulations of the Board; or 10. Engages in sexual contact with a patient concurrent with and by virtue of the practitioner/patient relationship or otherwise engages at any time during the course of the practitioner/patient relationship in conduct of a sexual nature that a reasonable patient would consider lewd and offensive. (2000, c. 688; 2001, c. 858.)	*related to the confidentiality and disclosure of patient records.* *B. Practitioners shall provide patient records to another practitioner or to the patient or his personal representative in a timely manner in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.* Both state and federal laws specifically set out the requirements for disclosure of records and providing a record upon request. The regulation requires a practitioner to comply with such laws. *C. Practitioners shall properly manage and keep timely, accurate, legible and complete patient records;* Subsection C requires practitioners to properly manage patient records and maintain timely, accurate, legible and complete patient records. (*In disciplinary cases, the Board has seen evidence of records that were poorly maintained, illegible or inaccurate so that they were effectively useless and provided little or no record of the patient's care.)* *D. Practitioners who are employed by a health care institution, school system or other entity, in which the individual practitioner does not own or maintain his own records, shall maintain patient records in accordance with the policies and procedures of the employing entity.* Subsection D applies to the PT's and PTA's who are employees of a health care institution or other entity, such as a hospital and do not have ownership of patient records. It requires the licensee to adhere to the policies and procedures of the employing entity in the maintenance of records. *E. Practitioners who are self-employed or employed by an entity in which the individual practitioner does own and is responsible for patient records shall:* *1. Maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:* *a. Records of a minor child shall be maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child;* *b. Records that have previously been transferred to another practitioner or health care provider or provided*

		to the patient or his personal representative; or *c. Records that are required by contractual obligation or federal law may need to be maintained for a longer period of time.* *2. From (six months from the effective date of the regulation), post information or in some manner inform all patients concerning the time frame for record retention and destruction. Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.* Subsection E applies to PT's who are self-employed or do have ownership of patient records. It sets the time limit for maintenance of a patient record. *(Practitioners have requested some rule on the maintenance of records. The rules established provide a minimal standard for record-keeping; practitioners may choose to maintain patient records for longer periods of time, if so required by a malpractice carrier or other contractual obligation.)* Subsection E also requires a practitioner (six months from the effective date of regulations) to post information or in some manner inform all patients concerning the time frame for record retention and destruction and requires patient records to be destroyed in a manner that protects patient confidentiality. *(In order for patients to know the record retention policy, practitioners will be required to post that information in their offices or include it in some informed consent document given to patients. The purpose of such a requirement is to make patients aware that a record might be destroyed and no longer available after a period of time, so if the patient has a need to refer to earlier treatment, the record may no longer exist. This will give patients the opportunity to request a copy of their records before they are destroyed. The rule also requires destruction of records in a manner that protects confidentiality.)* *F. When a practitioner is closing, selling or relocating his practice, he shall meet the requirements of § 54.1-2405 of the Code of Virginia for giving notice that copies of records can be sent to any like-regulated provider of the patient's choice or provided to the patient.* Subsection F would apply provisions of the Code to a practitioner selling, closing or relocating his practice.
		Section 170 sets out requirements for confidentiality and practitioner-patient communication. *A. A practitioner shall not willfully or negligently breach the*

		confidentiality between a practitioner and a patient. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the practitioner shall not be considered negligent or willful. Subsection A prohibits a willful or negligent breach of patient confidentiality but relieves the practitioner of responsibility if the breach is required or permitted by law or beyond his control. *B. Communication with patients.* *1. Except as provided in § 32.1-127.1:03F of the Code of Virginia, a practitioner shall accurately present information to a patient or his legally authorized representative in understandable terms and encourage participation in decisions regarding the patient's care.* *2. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a treatment or procedure provided or directed by the practitioner in the treatment of any disease or condition.* *3. Before any invasive procedure is performed, informed consent shall be obtained from the patient and documented in accordance with the policies of the health care entity. Practitioners shall inform patients of the risks, benefits, and alternatives of the recommended invasive procedure that a reasonably prudent practitioner in similar practice in Virginia would tell a patient. In the instance of a minor or a patient who is incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent shall be informed and the consent documented.* *4. Practitioners shall adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from patients prior to involving them as subjects in human research with the exception of retrospective chart reviews.* Subsection B provides rules for communication with patients. If information is not provided in a manner and in terms that a patient should reasonably be expected to understand, the practitioner is not accurately informing patients or giving them an opportunity to make decisions regarding their care and treatment. The proposed rule also protects patients by requiring practitioners to accurately inform patients and to not deliberately mislead them about their care. Rules on informed consent prior to performance of an invasive procedure are consistent with those set out in guidance adopted by the Board of Medicine and with the policies and procedures of most hospitals. It is not intended that informed consent must be obtained before any routine

		PT procedure is performed, but a procedure such a sharp debridement would require consent. There are specific requirements already in the Code for informed consent for patients in research, so that provision of law is referred. *C. Termination of the practitioner/patient relationship.* *1. The practitioner or the patient may terminate the relationship. In either case, the practitioner shall make the patient record available, except in situations where denial of access is allowed by law.* *2. A practitioner shall not terminate the relationship or make his services unavailable without documented notice to the patient that allows for a reasonable time to obtain the services of another practitioner.* Subsection C sets out the requirements for termination of the practitioner/patient relationship, consistent with the law, and with practices that protect the patient.
		Section 180 includes rules for practitioner responsibility. *A. A practitioner shall not:* *1. Perform procedures or techniques that are outside the scope of his practice or for which he is not trained and individually competent;* *2. Knowingly allow persons under his supervision to jeopardize patient safety or provide patient care outside of such person's scope of practice or area of responsibility. Practitioners shall delegate patient care only to persons who are properly trained and supervised;* *3. Engage in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient; or* *4. Exploit the practitioner/patient relationship for personal gain.* All of the behaviors or conducts listed under subsection A have been relevant to disciplinary cases before this Board and/or other health regulatory boards. The practitioner's ultimate responsibility is to the health and safety of his patients, and behaviors that interfere with care may be unprofessional. *B. A practitioner shall not knowingly and willfully solicit or receive*

		any remuneration, directly or indirectly, in return for referring an individual to a facility or institution as defined in §37.2-100 of the Code of Virginia, or hospital as defined in §32.1-123 of the Code of Virginia. *Remuneration shall be defined as compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by Title 42, §1320a-7b(b) of the United States Code, as amended, or any regulations promulgated thereto.* Subsection B prohibits a practitioner from willfully received kickbacks or other payments for his referrals to a facility or hospital. The same prohibition currently exists in the Board of Medicine regulations. *C. A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation.* This language is identical to the current rule in all of the Board of Medicine regulations. It is necessary to ensure that a practitioner's refusal to provide records or information to an investigator can before grounds for disciplinary action. *D. A practitioner shall report any disciplinary action taken by a physical therapy regulatory board in another jurisdiction within 30 days of final action.* The Board recently encountered a situation in which a licensee had been disciplined by another board but there was a long period of time before the Virginia board was notified. Meanwhile, the person held an active, unrestricted license to practice. At the very least, this provision will give the Board additional grounds on which to impose disciplinary action.
		18VAC112-20-190. Sexual contact. *A. For purposes of § 54.1-3483 (10) of the Code of Virginia and this section, sexual contact includes, but is not limited to, sexual behavior or verbal or physical behavior which:* *1. May reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the patient, or both; or* *2. May reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it.* Subsection A defines, for the purposes of unprofessional conduct set forth in the Code of Virginia, what is meant by

		"sexual contact." *B. Sexual contact with a patient.* *1. The determination of when a person is a patient for purposes of § 54.1-3483 (10) of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the patient-practitioner relationship is terminated.* *2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient does not change the nature of the conduct nor negate the statutory prohibition.* Subsection B sets out the rules prohibiting sexual contact with a current patient. The fact that a patient is not actively seeing the practitioner or that there was consent to the contact does not negate the prohibition. *C. Sexual contact between a practitioner and a former patient.* *Sexual contact between a practitioner and a former patient after termination of the practitioner-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence of emotions derived from the professional relationship.* Subsection C sets out the rules regarding sexual contact between a practitioner and a former patient, which may still constitute unprofessional conduct if the contact is based on exploitation of the patient in some way. The Board examined the possibility of a prohibition for such contact – as with current patients – but decided that would be too restrictive and unreasonable. The key to determining whether such contact constitutes unprofessional conduct is the effect of patient care and the way in which the practitioner has used his or her position of power and superiority to initiate the sexual contact. *D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care. For purposes of this section, key third party of a patient shall mean: spouse or partner, parent or child, guardian, or legal representative of the patient.*

		Subsection D addresses sexual contact between a practitioner and a key third party. It provides that such contact shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care. For purposes of this section, key third party of a patient shall mean: spouse or partner, parent or child, guardian, or legal representative of the patient. *E. Sexual contact between a supervisor and a trainee shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care.* Subsection E addresses sexual contact between a supervisor and a trainee. It provides that such contact shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care. The rules on sexual contact are identical to those for professions under the Board of Medicine, such as occupational therapists and medical doctors.
		Section 200 establishes rules for ethics practices in advertising by physical therapists. *A. Any statement specifying a fee, whether standard, discounted or free, for professional services which does not include the cost of all related procedures, services and products which, to a substantial likelihood, will be necessary for the completion of the advertised service as it would be understood by an ordinarily prudent person shall be deemed to be deceptive or misleading, or both. Where reasonable disclosure of all relevant variables and considerations is made, a statement of a range of prices for specifically described services shall not be deemed to be deceptive or misleading.* Subsection A requires any statement specifying a fee to be inclusive of the cost necessary to complete the advertised service. If there are reasonable variances, the advertisement must state a range of prices. *B. Advertising a discounted or free service, examination, or treatment and charging for any additional service, examination, or treatment which is performed as a result of and within 72 hours of the initial office visit in response to such advertisement is unprofessional conduct unless such professional services rendered are as a result of a bona fide emergency. This provision may not be*

		waived by agreement of the patient and the practitioner. Subsection B prohibits charging for a service within 72 hours of the time a patient has responded to an advertised free service. *C. Advertisements of discounts shall disclose the full fee that has been discounted. The practitioner shall maintain documented evidence to substantiate the discounted fees and shall make such information available to a consumer upon request.* Subsection C requires the advertisement to state the full fee that has been discounted and maintain documented evidence to substantiate the fee. *D. A licensee shall not use the term "board certified" or any similar words or phrase calculated to convey the same meaning in any advertising for his practice unless he holds certification in a clinical specialty issued by the American Board of Physical Therapy Specialties.* Subsection D requires a licensee to disclose the full name of a specialty board that is advertised. *E. A licensee of the board shall not advertise information which is false, misleading, or deceptive. For an advertisement for a single practitioner, it shall be presumed that the practitioner is responsible and accountable for the validity and truthfulness of its content. For an advertisement for a practice in which there is more than one practitioner, the name of the practitioner or practitioners responsible and accountable for the content of the advertisement shall be documented and maintained by the practice for at least two years.* Subsection E prohibits advertising information that is false, misleading or deceptive and holds the practitioner responsible for the content. *F. Documentation, scientific and otherwise, supporting claims made in an advertisement shall be maintained and available for the board's review for at least two years.* Provisions of section 200 are identical to the advertising rules for chiropractors, physicians and podiatrists and other licensees of the Board of Medicine.

Regulatory flexibility analysis

Please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or

simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

In order to determine the minimum education, training, and experience required for certification, the Board was required to consult with an advisory committee, as set forth in subsection C of § 54.1-3482.1. The law requires that the advisory committee be comprised of three members selected by the Medical Society of Virginia and three members selected by the Virginia Physical Therapy Association. All members of the advisory committee must be licensed by the Board of Physical Therapy or the Board of Medicine and must engage in clinical practice.

The Committee met on Friday, May 11, 2007, from 4:00pm - 6:00pm at the Department of Health Professions in Richmond, Virginia. All members were in attendance.

The Committee began its discussions with consideration of the minimum criteria set out in subsection B of 54.1-3482.1, as follows: *The minimum education, training, and experience requirements for certification shall include evidence that the applicant has successfully completed (i) a doctor of physical therapy program approved by the American Physical Therapy Association; (ii) a transitional program in physical therapy as recognized by the Board; or (iii) at least three years of active practice with evidence of continuing education relating to carrying out direct access duties under § 54.1-3482.*

The physical therapists on the Committee described the scope of the doctoral program and the transitional program in physical therapy, including the preparation for practice in a direct access environment. Students graduating from accredited physical therapy programs currently receive the DPT or Doctor of Physical Therapy degree. Physical therapists who graduated before schools adopted doctoral programs may enter a transitional program that leads to a doctoral degree. Virginia physical therapy schools have been graduating doctoral students for at least three years. The physical therapists also provided information about courses available for continuing education in medical screening and differential diagnosis.

There was discussion about the educational and practice preparation in medical screening and differential diagnosis in the DPT and transitional programs and about the need for some period of time in independent practice of physical therapy to ensure experience with patient presentation, treatment options and indicators for referral. Based on the information provided and its responsibility to recommend the education, training and experience criteria necessary to promote patient safety, the Committee recommends the following qualifications for certification:

1) Evidence of completion of a doctor of physical therapy program approved by the American Physical Therapy Association and completion of at least one year of post-licensure, full-time, clinical practice;

2) Evidence of completion of a transitional program in physical therapy as recognized by the Board of Physical Therapy and completion of at least one year of post-licensure, full-time, clinical practice; or

3) Evidence of completion of at least 15 contact hours of continuing education (to include face-to-face or on-line courses with a post-course examination) in patient assessment or differential diagnosis, offered by a provider approved by the Board and at least three years of post-licensure, full-time, clinical practice.

The 2007 legislation required the advisory committee to provide a written report of its recommendations and submit it to the Board of Physical Therapy. Prior to the Board's adoption of regulations, the recommendations were also be submitted to the Board of Medicine for such comments as may be deemed appropriate. Therefore, the advisory committee submitted its report to the Board of Medicine for its review and comment at its meeting on June 21, 2007. The Board of Medicine accepted the report without further recommendation. The Board of Physical Therapy is required to promulgate regulations, including continuing education requirements relating to carrying out direct access duties, to be effective within 280 days of its enactment or by November 26, 2007. The provisions of the act amending § 54.1-3482 do not become effective for 180 days after the effective date of the regulations. Finally, the law provides that the Committee may meet periodically to advise the Board on the regulation of such procedures.

The Board of Physical Therapy accepted the report of the Advisory Committee but did not follow its recommendation for one year of post-licensure, full-time clinical practice as qualification for certification in direct access. It is the position of the Board that graduates from a DPT program have been taught to practice in a direct access environment since most states already permit PT's to evaluate and treat patients without referral. In addition, physical therapy programs are now doctoral-level with extensive hours of clinical experience in seeing patients, making differential diagnoses. They have knowledge and training in knowing when to refer patients who present with conditions or diseases that require medical care. Therefore, there was no compelling reason to require graduates to have an additional year of experience to be qualified for direct access.

Family impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

There is no impact on the family.