VIRGINIA BOARD OF HEALTH PROFESSIONS
DEPARTMENT OF HEALTH PROFESSIONS
FULL BOARD MEETING
SEPTEMBER 4, 2003

TIME AND PLACE:	The meeting was called to order at 12:55 p.m. on Thursday, September 4, 2003, Department of Health Professions, 6603 W. Broad St., 5th Floor, Room 2, Richmond, VA.
PRESIDING OFFICER:	Alan Mayer, Acting Chair
MEMBERS PRESENT:	Lynne M. Cooper, Citizen Member Michelle R. Easton, R.PH Joe Gieck, P.T. Terone B. Green, Citizen Member David H. Hettler, O.D. Joseph Jenkins, Jr., F.S.L. Nadia B. Kuley, Ph.D. Michael W. Ridenhour, AU.D. Harry S. Seigle, D.D.S. Mary M. Smith, L.N.H.A. Demis L. Stewart, Citizen Member Joanne Taylor, Citizen Member Lucia Anna Trigiani, Citizen Member
MEMBERS NOT PRESENT:	David R. Boehm, L.C.S.W. Jerry A. Hinn, D.V.M. Diane Reynolds-Cane, M.D. Natale A. Ward, LPC
STAFF PRESENT:	Robert A. Nebiker, Agency Director Gail Jaspen, Chief Deputy Director Elizabeth A. Carter, Ph.D., Executive Director for the Board Elaine Yeatts, Senior Regulatory Analyst Carol Stamey, Administrative Assistant
OTHERS PRESENT:	Neal Kauder, Visual Research Debbie Cote, R.N., Nephrology Nursing Certification Commission Francine Sandidge, Amhurst Dialysis Facility
QUORUM:	With fourteen (14) members present, a quorum was established.
INTRODUCTION OF NEW MEMBERS:	Mr. Mayer welcomed all the new board members and introduction was made by each.
PUBLIC COMMENT:	No public comment was presented.
AGENDA AMENDMENT:	Because the New Board Member Orientation ran long, the Sanction Reference Study orientation was presented at 12:15 p.m. with the update of the activities since the Board's last meeting provided immediately thereafter. The entire Sanction Reference Study slide presentation is incorporated into the minutes as Attachment #1.

APPROVAL OF MINUTES: On properly seconded motion by Mr. Green, the Board voted unanimously to approve the minutes of the May 2, 2003 meeting.

COMMENTS OF AGENCY DIRECTOR, WORKPLAN: Due to the significant amount of board member turnover, Mr. Nebiker requested a workplan of agenda items that the Board wished to pursue.

With regard to the workplan, Mr. Gieck requested a listing of relevant issues from staff.

Mr. Mayer requested that the Board explore the current status of the Department's response to the JLARC recommendations from the 1999 study. Dr. Carter will forward copies of the JLARC study to all board members.

COMMENTS OF EXECUTIVE DIRECTOR, BOARD CALENDAR: Dr. Carter reported that the next full Board meeting had been scheduled for October 22, 2003 as well as the Executive Committee meeting. Given the turnover of board members, she asked the members if this date presented a problem. There was no objection to the scheduled date. Dr. Carter also reported that the FY 2003 budget for the Board closed out with a 6% surplus.

The chief topic for the Executive Committee is discussion of the Department budget. The Committee anticipates reporting its findings and recommendations to the full Board at the October 22, 2003 meeting.

OVERVIEW OF A NATIONAL CREDENTIALING PROGRAM FOR DIALYSIS TECHNICIANS - NEPHROLOGY NURSING CERTIFICATION COMMISSION: Ms. Cote's presentation is incorporated into the minutes at Attachment #2. Ms. Cote reported that she will try to obtain statistical data with regard to patient harm or bad outcomes for the Board's consideration in its review of regulations pursuant to credentialing dialysis care technicians.

REGULATORY REVIEW – PROPOSAL REGARDING DIALYSIS TECHNICIANS CREDENTIALING: Ms. Yeatts presented an overview of the passage of HB2605 that became law on July 1, 2003 requiring action by the Board. Staff had presented proposed language for the Board's review which essentially endorsed as "approving organizations" the three national credentialing bodies, the Nephrology Nursing Certification Commission, the Board of Nephrology Examiners, Inc. Nursing and Technology, and National Nephrology Certification Organization. The Board deferred action so that the Regulatory Review Committee could further review the matter and make recommendations to the full Board at the October 22, 2003 meeting.

LEGISLATION HOUSE BILL 1441 (2003) PROPOSALS FOR 2004: Ms. Jaspen presented a review of HB1441, with emphasis on Confidential Consent Agreements (CCA's). The presentation documents are incorporated into the minutes at Attachment #3.

Ms. Yeatts presented an overview of the 2004 draft legislation (see Attachment #4).

COMPOSITION OF THE NOMINATING COMMITTEE: ELECTION OF CHAIR:

Due to illness, the Chair of the Nominating Committee and the only existing member of that committee could not attend. Given the pressing need for the Board to select a Chair and Vice-Chair, nominations for these offices were accepted from the floor.

Election of Chair
On properly seconded motion by Ms. Trigiani, the Board voted unanimously to elect Mr. Mayer to serve as Chair.

Election of Vice-Chair
On properly seconded motion by Ms. Trigiani, the Board voted unanimously to elect Dr. Ridenhour to serve as Vice-Chair.

BOARD REPORTS:

Board of Audiology and Speech-Language Pathology
Dr. Ridenhour's Board report is incorporated into the minutes as Attachment #5.

Board of Nursing
Ms. Cooper presented the Board's report and it is incorporated into the minutes as Attachment #6.

Board of Nursing Home Administrators
Ms. Smith presented the Board's report and it is incorporated into the minutes as Attachment #7. Ms. Smith reported that the Board of Nursing Home Administrators had been discussing the fact that complaints are being received regarding directors for assisted living facilities who are not currently regulated by any of the health regulatory boards.

On properly seconded motion by Ms. Smith, the Board voted unanimously to study the feasibility of licensing directors of assisted living facilities in order to provide a basic level of oversight comparability of the directors, given the vulnerable nature of the clients they serve. The study was assigned to the Regulatory Review Committee for review and recommendations to the full Board.

Board of Optometry
Dr. Hettler presented the Board's report and it is incorporated into the minutes as Attachment #8.

Board of Pharmacy
Dr. Easton presented the Board's report and it is incorporated into the minutes as Attachment #9.

Board of Funeral Directors and Embalmers
Mr. Jenkins presented the Board's report and it is incorporated into the minutes as Attachment #10.

Board of Physical Therapy
Mr. Gieck presented the Board's report is incorporated into the minutes as Attachment #11.

NEW BUSINESS: No new business was introduced.

ADJOURNMENT: On properly seconded motion by Dr. Seigel, the meeting adjourned at 3:00 p.m.

_____
Alan E. Mayer, Chair

_____
Elizabeth A. Carter, Ph.D., Executive Director for the Board

ATTACHMENT 1

Slide 1

Sanction Reference Study

Board of Health Professions
September 2003

Neal B. Kauder, President
VisualResearch, Inc.

Sanctioning Study

Virginia Department of Health Professions

Need for study

- Questions raised relating to consistency, neutrality, and appropriateness of Health Regulatory Board sanctions
- Concerns not supported by a comprehensive empirical analysis
- Empirical information unavailable on factors that effect sanction decisions – aggravating or mitigating factors, etc.

Virginia Board of Health Professions, Work plan, Spring 2001

Sanctioning Study

Virginia Department of Health Professions

Purpose

"…to provide an empirical, systematic analysis of board sanctions for offenses and, based upon this systematic analysis, to derive reference points for board members and an educational tool for respondents and the public"

Virginia Board of Health Professions, Work plan, Spring 2001

Sanctioning Study

Virginia Department of Health Professions

Guiding principle

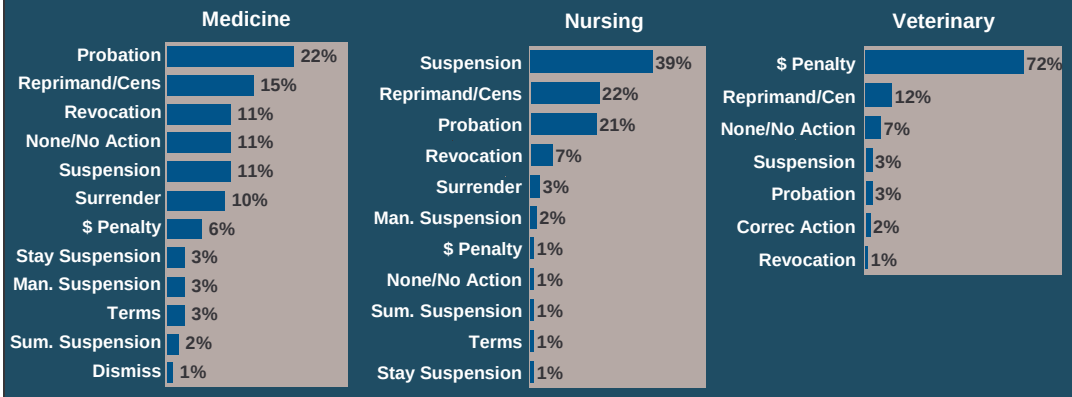
" … for any sanction reference system to be successful, it must be developed with complete board oversight (representatives from various boards), be value-neutral and grounded in sound data analysis, and be totally voluntary…"

DHP Internal Committee & Staff, Fall 2001

Sanctioning Study

Virginia Department of Health Professions

Medicine had high rates of probation (22%), Veterinary high rate of monetary penalties (72%) & Nursing had highest rate of suspensions (39%).



Sanctioning Study

Virginia Department of Health Professions

13 Boards, each with different case types and sanctioning process -- How to get started?

Medicine (Selected as first board)

- Large number of cases
- Good variation in case type
- Eagerness to serve as pilot

Sanctioning Study

Virginia Department of Health Professions

Theoretical Framework

32 personal interviews and various committee meetings--- Medicine develops "Blueprint"

- Overall sanctioning goals
- Purpose of reference points
- Analytical approach
- Measuring case complexity & factors to collect
- Key features of reference system

Sanctioning Study

Virginia Department of Health Professions

Extracted from Blueprint:

Overall sanctioning goals

- **Protect the public**
- **Deterrence**
- **Punishment**
- **Rehabilitation**
- **Treatment**

Sanctioning Study

Virginia Department of Health Professions

From Blueprint:

Purposes of sanctioning reference points

- Make sanctioning more predictable
- Education tool for new board members
- Add empirical element to a process
- A resource for staff and attorneys
- “Neutralize” unwarranted inconsistencies
- Validate board member recall of past cases
- Help ‘predict’ future caseloads (need for services, terms)

Sanctioning Study

Virginia Department of Health Professions

From Blueprint:

Analytical approach

Descriptive model --- Answers “What is” ?

- Historical data analysis of relevant factors

Descriptive model/normative adjustment-- Answers “What ought to be” ?

- Historical data serves as baseline, boards modify to serve goals

Sanctioning Study

Virginia Department of Health Professions

From Blueprint:

Case complexity

- Case seriousness - priority levels & patient harm
- Prior history – what type and how much?
- Subjective factors - remorse, cooperation, etc.
  - Should continue to play role--as aggravating and mitigating circumstances

Sanctioning Study

Virginia Department of Health Professions

From Blueprint:

Factors mentioned by BOM (partial list)

- Risk of future or repeated incidents
- Type of case
- Chronic or single incident in nature
- Drug or alcohol impairment
- Degree of Patient Harm
- Effect on health and welfare of public
- What sanction will "help" respondent
- What sanction will "stop" any harm to public
- Egregious nature
- Financial, or willful intent
- Monetary gain was purpose of offense
- Settlement method (IFC, FH, CO)
- Actions by other boards or entities
- Time of day of hearing
- Length of hearing (time)
- Complainant present at hearing
- Witness testimony
- Practice type, years in practice
- Respondent credentials
- Area of specialty
- International Medical Graduate
- Respondent attorney presence
- Honesty or credibility of respondent
- "Willingness" of respondent to admit wrong doing

Sanctioning Study

Virginia Department of Health Professions

From Blueprint:

Key features

- Voluntary - maintain complete discretion
- Accommodate full array of mitigating and aggravating factors
- Operate within existing statutes and regulations
- Not too specific or narrow
- Allow multiple sanctioning goals to be considered

Sanctioning Study

Virginia Department of Health Professions

Method - Steps

- Conduct personal interviews
- Review literature/profile states
- Build consensus for theoretical framework & methods
- Identify sample
- Collect data
- Merge all information/conduct analysis
- Identify “historically relevant factors”
- Translate factors into usable reference system
- Pilot test, get board feedback, evaluate usefulness 

Sanctioning Study

Virginia Department of Health Professions

Study sample

- All violations 1996-2001 -- 6 year “window”
- 6 year period captures 447 “cases”
- Event based analysis -- “cases” vs. “orders”

Sanctioning Study

Virginia Department of Health Professions

Data collection sources:

- Case file presented to board
- Practitioner Information website
- Microfiche
- Minutes of hearings
- Freedom of Information Act (FOIA) files
- Staff
- Ad hoc data reports

Sanctioning Study

Virginia Department of Health Professions

BOM I

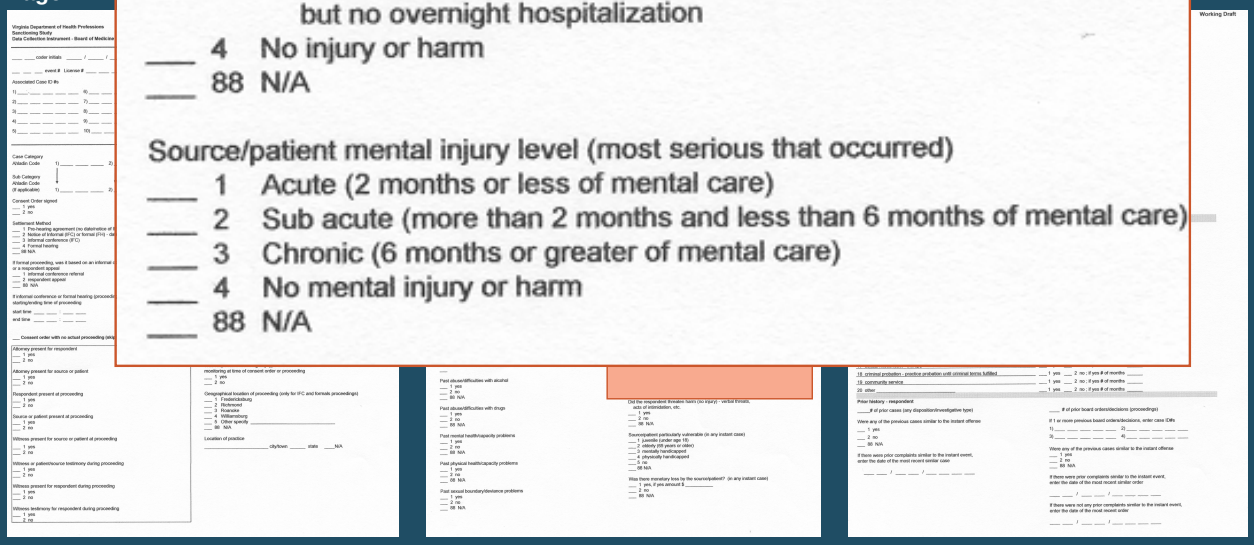
Page 1

Source/patient physical injury level (most serious that occurred)

___ 1 Death
___ 2 Serious physical injury - requiring overnight or prolonged hospitalization
___ 3 Physical injury - requiring medical care including first aide but no overnight hospitalization
___ 4 No injury or harm
___ 88 N/A

Source/patient mental injury level (most serious that occurred)

___ 1 Acute (2 months or less of mental care)
___ 2 Sub acute (more than 2 months and less than 6 months of mental care)
___ 3 Chronic (6 months or greater of mental care)
___ 4 No mental injury or harm
___ 88 N/A



Sanctioning Study

Virginia Department of Health Professions

Descriptive & Multivariate analysis

Descriptive – describes cases in a basic way

- What sanctions do respondents receive (by offense)
- How may respondents have prior record?
- How many respondents have ongoing substance problems?
- How long do hearings take?
- What injury levels occur?

Sanctioning Study

Virginia Department of Health Professions

Descriptive & Multivariate analysis

Multivariate – tests the influence of factors simultaneously

- Statistical models help explain how similarly situated cases have been handled in the past
- How much weight have boards assigned to factors ?
  - How influential is prior history, injury level, etc
- What respondent or offense factors lead to suspension?

Sanctioning Study

Virginia Department of Health Professions

What are we trying to predict ?

Sanction Groupings

	Loss of license	Reprimand	Treatment/ Monitoring	No Sanction
Revocation	X			
Surrender license or privilege to renew	X			
Suspension	X			
Stayed suspension - immediate			X	
Continue on terms			X	
Mental or physical evaluation			X	
Monetary Penalty		X		
No sanction				X
Probation			X	
Reprimand		X		
Terms				
Competency - continuing education			X	
Competency - audit of practice			X	
Competency - special examine (SPEX)			X	
Prescribing - log			X	
Practice probation/fulfill criminal probation			X	
Impairment - evaluation			X	
Impairment - HPIP			X	
Practice restriction - chart/record review			X	
Practice restriction - oversight by monitor			X	
Practice restriction - specific		X		
Prescribing - restrictions		X		
Sexual misconduct - chaperone			X	
Sexual misconduct - evaluation			X	
Sexual misconduct - supervised practice			X	
Sexual misconduct - therapy			X	

Sanctioning Study

Virginia Department of Health Professions

Loss of License - Significant factors & influence

(suspension, revocation, surrender)

	Direction of influence (+) more (-) less	Degree of Influence
Patient death	+	High
Impaired/Obtain by Fraud	+	High
Consent order signed	+	High
Standards of Care	+	High
Past mental health/capacity problems	+	High
Past sexual boundaries/deviance problems	+	Med
Past difficulties with drugs/alcohol	+	Med
One or more prior board orders/decisions	+	Med
Attorney present	-	Med
Respondent impaired during incident	+	Med
Respondent receiving treatment	-	Low
Respondent female	+	Low
Past treatment -- alcohol related	-	Low
Years practicing	+	Low
Days in Board Stage	-	Low

Sanctioning Study

Virginia Department of Health Professions

What factors should continue to play a role in sanctioning ?

- **Patient injury vs. attorney representation**
- **Past substance abuse/mental illness vs. respondent gender**

What other factors (if any) should be <u>normatively</u> added ?

- **Multiple patients involved**
- **Prior violations** (not prior cases or orders)

Sanctioning Study

Virginia Department of Health Professions

Creating Sanction Reference Points

- Translate statistics into useable reference points
- Place historically important factors on 5 offense worksheets
- Add other factors board feels should play a role
- Score all persons in database on worksheets
  - 70% accuracy average on 5 worksheets
  - 30% of sanctions fall above or below recommendations
- Develop *Sanctioning Reference Points* instruction manual

Sanctioning Study

Virginia Department of Health Professions

5 worksheets/grids

- **Impairment**
- **Patient Care**
- **Inappropriate Relationship/Sexual Abuse**
- **Fraud/Deception/Misrepresentation**
- **Unlicensed Activity**

Impairment Worksheet

OFFENSE SCORE	POINTS	SCORE
Circumstances (score all that apply)		
a. Impaired - Inability to practice	25	
b. Patient especially vulnerable	20	
c. Financial or material gain from offense	20	
d. Multiple patients involved	30	
Injury level (score only if applicable)		
a. Physical Injury - death	100	
b. Physical Injury - medical care	50	
c. Mental Injury	50	
Priority level (must score one)		
a. Danger (priority 1 & 2)	75	
b. Harmful/threaten harm (priority 3 & 4)	30	
c. Harm without risk (priority 5 & 6)	20	
	Total Offense Score	

RESPONDENT SCORE		
Circumstances (score all that apply)		
a. Concurrent action	60	
b. Past mental health problems	50	
c. Past inappropriate relationship/sexual problems	50	
d. Past alcohol problems	25	
e. Past drug problems	25	
Prior orders/notices with violation (score all that apply)		
a. One or more prior board violations	60	
b. Any prior "similar" board violations	50	
	Total Respondent Score	

OFFENSE SCORE

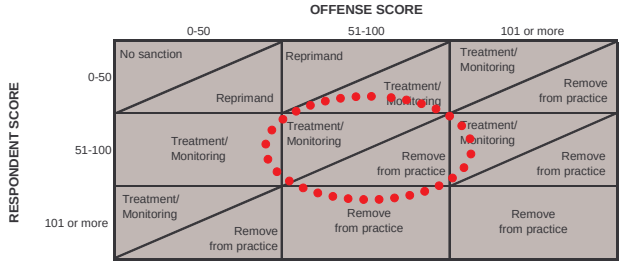
RESPONDENT SCORE	0-50	51-100	101 or more
0-50	No sanction / Reprimand	Reprimand / Treatment/ Monitoring	Treatment/ Monitoring / Remove from practice
51-100	Treatment/ Monitoring	Treatment/ Monitoring / Remove from practice	Treatment/ Monitoring / Remove from practice
101 or more	Treatment/ Monitoring / Remove from practice	Remove from practice	Remove from practice

Respondent: _____ License Number: _____

Impairment Worksheet

OFFENSE SCORE	POINTS	SCORE
Circumstances (score all that apply)		
a. Impaired - Inability to practice	25	25
b. Patient especially vulnerable	20	
c. Financial or material gain from offense	20	
d. Multiple patients involved	30	
Injury level (score only if applicable)		
a. Physical Injury - death	100	
b. Physical Injury - medical care	50	
c. Mental Injury	50	
Priority level (must score one)		
a. Danger (priority 1 & 2)	75	
b. Harmful/threaten harm (priority 3 & 4)	30	30
c. Harm without risk (priority 5 & 6)	20	
	Total Offense Score	55

RESPONDENT SCORE		
Circumstances (score all that apply)		
a. Concurrent action	60	
b. Past mental health problems	50	
c. Past inappropriate relationship/sexual problems	50	
d. Past alcohol problems	25	
e. Past drug problems	25	
Prior orders/notices with violation (score all that apply)		
a. One or more prior board violations	60	60
b. Any prior "similar" board violations	50	
	Total Respondent Score	60



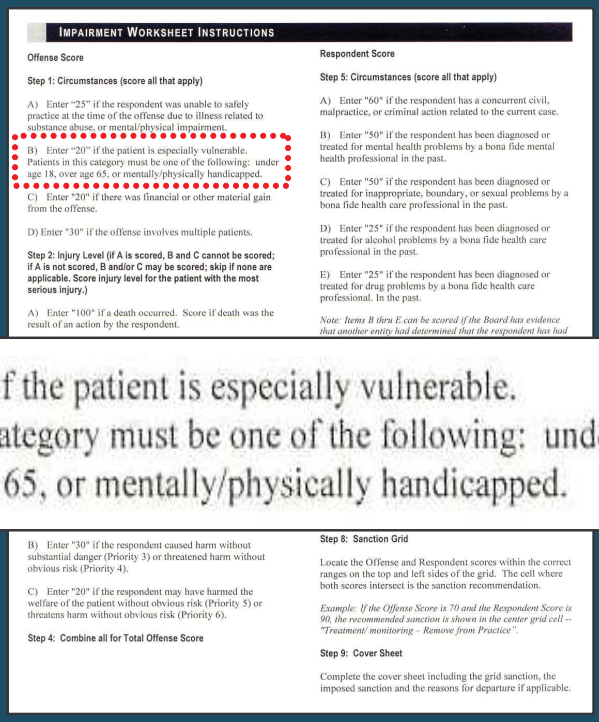
Respondent: _____ License Number: _____

Sanctioning Study

Virginia Department of Health Professions

5 sets of instructions

- **Impairment**
- **Patient Care**
- **Inappropriate Relationship/Sexual Abuse**
- **Fraud/Deception/Mis**
- **Unlicensed Activity**



IMPAIRMENT WORKSHEET INSTRUCTIONS

Offense Score

Step 1: Circumstances (score all that apply)

A) Enter "25" if the respondent was unable to safely practice at the time of the offense due to illness related to substance abuse, or mental/physical impairment.

B) Enter "20" if the patient is especially vulnerable. Patients in this category must be one of the following: under age 18, over age 65, or mentally/physically handicapped.

C) Enter "20" if there was financial or other material gain from the offense.

D) Enter "30" if the offense involves multiple patients.

Step 2: Injury Level (if A is scored, B and C cannot be scored; if A is not scored, B and/or C may be scored; skip if none are applicable. Score injury level for the patient with the most serious injury.)

A) Enter "100" if a death occurred. Score if death was the result of an action by the respondent.

B) Enter "30" if the respondent caused harm without substantial danger (Priority 3) or threatened harm without obvious risk (Priority 4).

C) Enter "20" if the respondent may have harmed the welfare of the patient without obvious risk (Priority 5) or threatens harm without obvious risk (Priority 6).

Step 4: Combine all for Total Offense Score

Respondent Score

Step 5: Circumstances (score all that apply)

A) Enter "60" if the respondent has a concurrent civil, malpractice, or criminal action related to the current case.

B) Enter "50" if the respondent has been diagnosed or treated for mental health problems by a bona fide mental health professional in the past.

C) Enter "50" if the respondent has been diagnosed or treated for inappropriate, boundary, or sexual problems by a bona fide health care professional in the past.

D) Enter "25" if the respondent has been diagnosed or treated for alcohol problems by a bona fide health care professional in the past.

E) Enter "25" if the respondent has been diagnosed or treated for drug problems by a bona fide health care professional. In the past.

Note: Items B thru E can be scored if the Board has evidence that another entity had determined that the respondent has had

Step 8: Sanction Grid

Locate the Offense and Respondent scores within the correct ranges on the top and left sides of the grid. The cell where both scores intersect is the sanction recommendation.

Example: If the Offense Score is 70 and the Respondent Score is 90, the recommended sanction is shown in the center grid cell -- "Treatment/ monitoring – Remove from Practice".

Step 9: Cover Sheet

Complete the cover sheet including the grid sanction, the imposed sanction and the reasons for departure if applicable.

B) Enter "20" if the patient is especially vulnerable. Patients in this category must be one of the following: under age 18, over age 65, or mentally/physically handicapped.

Sanctioning Study

Virginia Department of Health Professions

Offense types covered by the sanction reference points

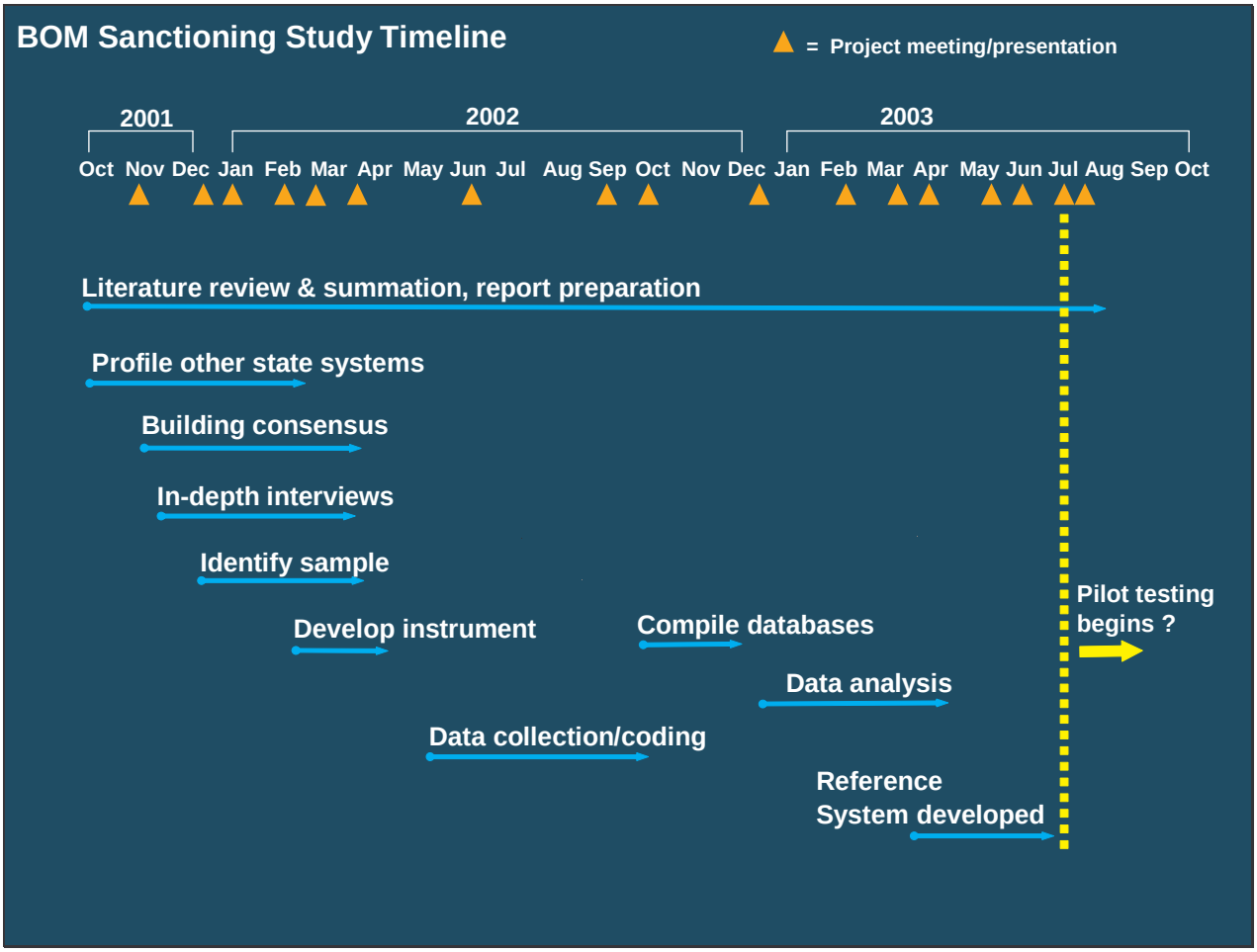
Offense Group	Case Categories (Aladdin Codes)
Impairment	Drug Related-Obtaining Drugs by Fraud Impairment Drug Related-Personal Use Inability Safely Practice - Incapacitated Inability Safely Practice – Impairment
Patient Care	Delay in Treatment Inappropriate or Excessive Prescribing/Dispensing Alternative Treatment Treatment Related-Other Improper Performance of Surgery Inspection Deficiencies/Facility Violation Records release Supervision - neglect Unnecessary Surgery
Inappropriate Relationship/Sexual Abuse	Relationship - inappropriate Abuse (including sexual)
Fraud/Deception/Misrepresentation	Advertising-deceptive/misleading Claim of Superiority Inappropriate Use of Specialty or Board Certification Financial Fraud Student loan default Fail to provide tax plan or estimate Improper Use of Trade Name Advertising-Other Fail to Disclose Full Fee when Advertising Discounts Omission of Required Wording/Ad Element
Unlicensed Activity	Misdemeanor conviction No valid license-qualified to practice Practice beyond the scope of license Aiding/abetting unlicensed activity

Sanctioning Study

Virginia Department of Health Professions

Existing sanctions fit into 4 sanction groups

Sanction Grid	Available Sanctions
Remove from Practice	Revocation Surrender License or Privilege to Renew Suspension
Reprimand	Monetary Penalty Reprimand Censure
Treatment/Monitoring	Stayed Suspension Continue on Terms Mental or Physical Evaluation- § 2915 (b) Probation Examples of Terms: Continuing education Audit of practice or chart/record review Special examine (SPEX) Prescribing log Evaluation HPIP Chaperone Oversight by monitor/ supervisor Therapy Other
No Sanction	No Sanction


BOM Sanctioning Study Timeline
= Project meeting/presentation
2001
2002
2003
Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun Jul Aug Sep Oct
Literature review & summation, report preparation
Profile other state systems
Building consensus
In-depth interviews
Identify sample
Develop instrument
Compile databases
Pilot testing begins ?
Data analysis
Data collection/coding
Reference System developed

Sanctioning Study

Virginia Department of Health Professions

What's next?

- Medicine (BOM)
  - Waiting on DHP approval of manual
  - Questions regarding eligible cases? (Formals vs. Informals)
- Pharmacy
  - Interviews & data collection complete
  - Descriptive results being drafted for review/approval
  - Can system be similar to BOM pilot ?
  - Awaiting for BOM resolution
- Dentistry
  - Interviews complete
  - Data collection after Dentistry meeting (Sept/Oct, 2003)
  - Awaiting for BOM resolution
- Nursing – next board for review

ATTACHMENT 2

Nephrology Nursing Certification Commission

Clinical Hemodialysis Technician Certification Examination

Purpose: The examination was designed to measure essential knowledge needed to provide safe, competent care, with minimal supervision, to hemodialysis patients following completion of a training program. The intent of the exam is to protect the public from incompetent caregivers.

Content:	**Dialysis Practice Area**	**% of Test**
	I. Clinical	50%
	II. Technical	23%
	III. Environment	15%
	IV. Role	12%

Test questions are also categorized by cognitive level, with at least 50% at application level, the remainder at knowledge and comprehension levels. (See Test Blueprint grid on page 4.)

The specific activities performed by technicians in each content area were identified by a joint Task Force consisting of the American Nephrology Nurses Association (ANNA) and the National Association of Nephrology Technicians/Technologists (NANT). The activities were used as the basis for the job analysis survey, as well as for writing test questions.

Specific Content Areas -- Activities Performed:

I. Clinical

1. Use aseptic technique for dialysis procedures.
2. Perform cardiopulmonary resuscitation (CPR).
3. Assess vital signs, i.e., blood pressure, temperature, pulse, respirations.
4. Measure patient's weight.
5. Provide basic comfort measures.
6. Report potential or actual adverse patient occurrences.
7. Reinforce patient education.
8. Recognize signs and symptoms of infection.
9. Provide patients with diversional activities.
10. Check patient's pre-dialysis fluid status.
11. Evaluate patient's access pre-dialysis.
12. Administer intradermal lidocaine (prohibited in some states by law).
13. Administer topical anesthetic (EMLA).
14. Question patient regarding problems since last treatment.
15. Identify changes in patient's general physical state pre-dialysis.
16. Identify changes in patient's general psychological state pre-dialysis.
17. Set the dialysis machine according to the patient's prescription.
18. Insert dialysis needles into patient's access.
19. Prepare patient's hemodialysis catheter.*
20. Obtain patient's blood samples.

21. Obtain culture specimens from patient.*
22. Initiate hemodialysis treatment with arteriovenous graft/fistula.
23. Initiate hemodialysis treatment with hemodialysis catheter.*
24. Monitor patient during dialysis treatment.
25. Identify significant patient changes during treatment.
26. Follow protocol for treating hypotension.
27. Follow protocol for treating muscle cramps.
28. Determine patient's clotting time.*
29. Follow protocol for administering heparin.
30. Discontinue patient's dialysis treatment with arteriovenous graft/fistula.
31. Discontinue patient's dialysis treatment with hemodialysis catheter.*
32. Apply pressure to access site after removing dialysis access needles.
33. Perform post-dialysis access care.
34. Check patient's post-dialysis fluid status.

II. Technical

35. Maintain safe usage of equipment.
36. Participate in quality control (QC) activities.
37. Use syringes and needles to draw up and administer solutions.
38. Verify effectiveness of the water treatment system.
39. Prepare dialysate solution.
40. Check conductivity, pH, and temperature of dialysate solution.
41. Set equipment alarms.
42. Test equipment alarms.
43. Set up hemodialysis extracorporeal circuit.
44. Set up reprocessed dialyzer.
45. Prepare equipment for dialysis.
46. Monitor dialysis equipment during treatment.
47. Prepare dialyzer for reprocessing per protocol.
48. Reprocess dialyzers.

III. Environment

49. Disinfect dialysis equipment.
50. Use standard precautions.
51. Use proper body mechanics.
52. Maintain safety of environment.
53. Follow infection control precautions.
54. Use chemicals to disinfect environmental surfaces.
55. Discard disposable supplies post-dialysis.

IV. Role

56. Document findings.
57. Maintain appropriate caregiver/client relationships.
58. Participate in quality improvement initiatives, e.g., continuous quality improvement (CQI), DOQI) .
59. Differentiate roles and responsibilities of care team members.
60. Participate in client rehabilitation activities/initiatives.

61. Use interpersonal communication techniques with clients and significant others.
62. Provide age-appropriate care.
63. Maintain patient's dignity.
64. Maintain patient's privacy.
65. Maintain patient confidentiality.
66. Communicate client's hemodialysis post-treatment outcomes to appropriate personnel.

**Activities with asterisks may not be part of the hemodialysis technician's role in some states or some facilities.*
Areas of knowledge needed to perform the listed activities safely and effectively in the hemodialysis setting were identified for inclusion in the exam.

Knowledge Areas Included in Exam

1. Basic renal anatomy and physiology
2. Scientific principles used in hemodialysis, e.g., osmosis, diffusion, ultrafiltration, fluid dynamics
3. Bloodborne pathogens
4. Hazardous materials precautions
5. Water treatment
6. Composition of dialysate solution
7. Components of dialysis machine, e.g., blood pump, air detector, alarms, etc.
8. Dialyzer characteristics
9. Basic renal diet and fluid restrictions
10. Types of vascular access
11. Treatment modalities for ESRD (i.e., what they are)
12. Response to environmental emergencies, e.g., power failure, fire
13. Hemodialysis procedure complications, e.g., bloodline disconnection, clotting, needle dislodgement
14. Glucose, hematocrit/hemoglobin monitoring
15. Scope of role and responsibilities of dialysis technician
16. Complications of dialysis, e.g., hypotension, allergic reactions, etc.
17. Management of access complications
18. Complications of ESRD, e.g., anemia, renal osteodystrophy
19. Effectiveness of hemodialysis treatment, e.g., adequacy
20. Major causes of renal failure, e.g., hypertension, diabetes mellitus
21. Metric system
22. Medical terminology (in hemodialysis)
23. Basic fluids and electrolytes (related to hemodialysis)
24. Patient's rights and responsibilities

Other Essential Knowledge Already Included via Activity Statements

1. Aseptic technique
2. Standard precautions
3. Infection control
4. Anticoagulation
5. Anesthetics commonly used for fistula needle placement
6. Basic communication skills
7. Roles of health team members
8. Signs and symptoms of infection
9. Venipuncture technique
10. Dialyzer reuse process
11. Basic principles of patient teaching/reinforcement of teaching
12. Normal range for vital signs and general patient condition

13. Documentation of procedures
14. Sampling techniques
15. Specimen collection
16. Clinical practice guidelines, e.g., DOQI (i.e., that they exist & why)
17. Usage of syringes and needles.

Test Blueprint for the Clinical Hemodialysis Technician Certification Examination

Ψ Cognitive Level Dialysis Practice Area ∴	Knowledge	Comprehension	Application	Total
Clinical	6 - 8	18 - 20	48 - 50	**72 - 78 (48 - 52%)**
Technical	4 - 5	8 - 10	20 - 23	**32 - 38 (21 - 25%)**
Environment	1 - 3	6 - 8	12 - 14	**19 - 25 (13% - 17%)**
Role	1 - 3	3 - 4	10 - 14	**15 - 20 (10 - 14%)**
Total	**12 - 19 (8 - 13%)**	**35 - 42 (23% - 28%)**	**90 - 101 (60 - 67%)**	**150**

Hemodialysis Technician Job Analysis

A job analysis was performed by the Center for Nursing Education and Testing (C-NET) to define and validate the initial knowledge, skills, and abilities (KSA=s) needed for competent performance of hemodialysis technicians. That is, after the group of experts listed the KSA=s, a survey was performed to determine the actual practice of hemodialysis technicians. This job analysis provided the basis for the validity of the Clinical Hemodialysis Technician Certification Examination.

There were three survey forms: an Agency Form, a Preceptor/Supervisor Form, and a Technician Form.

C-NET received 87 usable Agency Forms from agencies in 31 states. The Agency Form asked for information about the agency only; no activity statements were included. Of the Agency Forms received, 41 were from private non-profit, 41 from private for-profit, and 4 from governmental agencies.

The Preceptors and Technician Forms included the same list of activity statements, but they were asked different questions. **C-NET received 80 usable Preceptor Forms from 77 facilities in 28 states**. The Preceptors were asked two questions:

1. After completion of training how much experience, on average, does a technician need before being assigned to perform this activity with a minimum of direct supervision in your facility?

   " Less than 1 month
   " 1 B 6 months
   " More than 6 months
   " Technician needs further training before performing the activity
   " Technician is <u>not allowed</u> to perform this activity.

2. How important is it to carry out each activity? Will the particular activity positively influence client outcomes by decreasing complications, lessening client distress, or improving functioning and health status? If it has an extremely positive influence, then it should receive the Ahighest@ priority rating. If the technician is not allowed to perform the activity, leave the priority rating blank.

   " Lowest
   " Low
   " High
   " Highest

C-NET received 118 Technician Forms from 72 facilities in 28 states. The Technicians were asked only one question about the activity statements:

> This section contains a list of activities that patient-care technicians in hemodialysis do in their work. The activities might not apply to your job. If the activity is one you do not perform, mark the circle in the column that says, ADo not perform.@
>
> For each activity, think about what you did during a typical day in the facility during the past week. For each activity, how often did you do the activity on the typical day? Fill in the circle that corresponds to the number of times you did the activity.
>
> " Do not perform
> " Less than 1 per day
> " 1-5 per day
> " 6-10 per day

" Over 10 per day

Summary of Preceptor Responses

The preceptors were asked: (1) the length of posttraining experience needed before a technician could perform each activity with minimal supervision, and (2) the priority of each activity. The technicians were not asked these questions because the technician survey asked for participants who were at the entry level, and entry-level technicians could not reasonably be expected to respond to these questions. (Despite our request, the technicians who actually responded had experience ranging from three months to more than ten years, which turned out to be helpful.)

The activities on the list were those required for safe performance with minimal supervision of ***new*** technicians. However, only **22** of the 66 activities were rated as safely performed less than one month following training. On the other hand, almost all of the activities were rated as safely performed within six months following training. (See the pages of graphics comparing the preceptor and technician ratings of the activities.)

The activities that could be safely performed after one month of training are listed below. While many of these activities are specific to a dialysis setting, others are characteristic of nursing assistants in any setting.

Clinical

14. Use aseptic technique for dialysis procedures. (51%)*
15. Assess vital signs, i.e., blood pressure, temperature, pulse, respirations. (65%)
16. Measure patient's weight. (77%)
17. Provide basic comfort measures. (71%)
18. Provide patients with diversional activities. (53%)
19. Perform post-dialysis access care. (50%)
20. Apply pressure to access site after removing dialysis access needles. (54%)

Technical

21. Test equipment alarms. (51%)
22. Set up reprocessed dialyzer. (50%)
23. Prepare equipment for dialysis. (56%)
24. Set up hemodialysis extracorporeal circuit. (58%)

Environmental safety

25. Disinfect dialysis equipment. (52%)
26. Use proper body mechanics. (73%)
27. Maintain safety of environment. (66%)
28. Follow infection control precautions. (76%)
29. Use chemicals to disinfect environmental surfaces. (77%)
30. Discard disposable supplies post-dialysis. (78%)
18. Use standard precautions. (68%)

Role responsibilities

19. Maintain patient=s dignity. (73%)
20. Maintain patient=s privacy. (75%)
21. Maintain patient=s confidentiality. (76%)
22. Communicate patient=s hemodialysis post-treatment outcomes to appropriate personnel. (57%)

Note: Numbers in parentheses indicate the percent of preceptors who indicated the activity could be expected within one month of completing training.

The preceptors rated the importance of each activity on a scale that ranged from 1 (lowest) to 4 (highest).
The ten activities given the ***highest*** priority by preceptors and their mean priority ratings were :

1. Report potential or actual adverse patient occurrences. (M = 3.83)
2. Use aseptic technique for dialysis procedures. (M = 3.78)
3. Follow infection control precautions. (M = 3.76)
4. Maintain patient=s confidentiality. (M = 3.75)
5. Set the dialysis machine according to the patient=s prescription. (M = 3.69)
6. Insert dialysis needles into patient=s access. (M = 3.68) [tie]
6. Maintain patient=s dignity. (M = 3.68) [tie]
6. Communicate patient=s post-treatment outcomes to appropriate personnel. (M = 3.68) [tie]
9. Follow protocol for treating hypotension. (M = 3.65) [tie]
9. Use standard precautions. (M = 3.65) [tie]

The ten activities given the ***lowest*** priority by preceptors were:

57. Provide basic comfort measures. (M = 3.01)
58. Identify changes in patient=s general psychological state pre-dialysis. (M = 2.99)
59. Participate in quality control (QC) activities. (M = 2.91)
60. Differentiate roles and responsibilities of care-team members. (M = 2.84)
61. Administer intradermal lidocaine. (M = 2.82)
62. Participate in quality improvement initiatives. (M = 2.81)
63. Determine patient=s clotting time. (M = 2.64)
64. Participate in client rehabilitation activities. (M = 2.59)
65. Administer topical anesthetic (EMLA). (M = 2.23)
66. Provide patient with diversional activities. (M = 2.17)

It should be noted that several of the activities with the lowest priority rankings were near 3.00, which was described as AHigh@ priority. None of the activity rankings fell below 2.00, which indicates that all activities were appropriate for technicians in some settings. As anticipated, activities related to hemodialysis catheters were not permitted by technicians in some states. In some facilities, technicians did not administer heparin or other medications. In others, technicians were not permitted to obtain culture specimens or perform reprocessing of dialyzers or prepare dialysate solution.

Despite these differences in practice, it was felt that all the activities should be included in the technician examination. In states that prohibit a particular activity (e.g., Texas prohibits activities related to catheters), test questions related to the particular activity would be reviewed by the state agency responsible for technicians; if the state wishes, those questions would be replaced or not scored.

Summary of Technician Responses

A wide range of hours of clinically supervised training was reported by both preceptors and technicians. For both groups, the average length of clinical training reported was about six weeks, although it ranged from less than 40 hours to more than 340 hours of training.

The experience reported by technicians varied widely, from less than three months to more than ten years, with a mean of 3.7 years (estimated standard deviation = 4.5). The respondents= experience is given below:

Less than 3 months - 5
3 - 6 months - 26
7 - 11 months - 11
1 - 2 years - 33
3 - 4 years - 12
5 - 10 years - 19
More than 10 years - 12

The technicians reported how often they performed each of the 66 activities on a scale ranging from 1 (do not perform) to 5 (more than 10 times per day). The activities were then ranked, from those performed most often to those performed least often. The activities with the ***highest*** rankings and their mean ratings were:

1. Follow infection control precautions. (M = 4.71)
2. Use standard precautions. (M = 4.69)
3. Assess vital signs (blood pressure, TPR). (M = 4.68)
4. Discard disposable supplies post-dialysis. (M = 4.66) [tie]
4. Maintain patient=s privacy. (M = 4.66) [tie]
6. Maintain patient=s confidentiality. (M = 4.64)
7. Maintain patient=s dignity. (M = 4.61)
8. Use chemicals to disinfect environmental surfaces. (M = 4.59)
9. Monitor patient during dialysis treatment. (M = 4.58) [tie]
9. Maintain safety of environment. (M = 4.58) [tie]

The activities with the ***lowest*** rankings and their mean ratings were:

58. Prepare patient=s hemodialysis catheter. (M = 2.53) [tie]
58. Prepare dialysate solution. (M = 2.53) [tie]
59. Initiate hemodialysis treatment with hemodialysis catheter. (M = 2.50)
60. Determine patient=s clotting time. (M = 2.49)
61. Discontinue patient=s dialysis treatment with hemodialysis catheter. (M = 2.44)
62. Administer intradermal lidocaine. (M = 2.37)
63. Obtain culture specimens from patient. (M = 2.06)
64. Reprocess dialyzers. (M = 1.78)
65. Perform cardiopulmonary resuscitation (CPR). (M = 1.68)
66. Administer topical anesthetic (EMLA). (M = 1.51)

Many of the activities with the lowest rankings are activities that technicians are not permitted to perform in some states or some facilities, such as those related to catheters.

Separate rankings were compiled for each of the seven subgroups by experience (listed at bottom of page 7). When the subgroup rankings were compared, they were found to be remarkably similar, with the same activities appearing at the top (and bottom) of the list for each subgroup. Those persons with more experience tended to perform the activities more frequently than those with less experience. However, on analysis of variance, the only activities that were

performed significantly more often by experienced technicians were: (1) AInitiate hemodialysis treatment with arteriovenous graft/fistula,@ and (2) ADiscontinue patient=s dialysis treatment with arteriovenous graft/fistula.@

Therefore, it appears that the list of activities was comprehensive in describing the activities of hemodialysis patient care technicians, regardless of how much experience they have. This finding is not surprising, since the scope of practice of technicians is defined and limited. (In a similar job analysis of nursing assistants performed by the National Council of State Boards of Nursing in 1998, it was found that new and very experienced nursing assistants also did not differ in the activities they performed.)

Pilot Testing

Test questions were written by three teams of item writers. Each team included one technician, two registered nurses with experience working with technicians, and a C-NET staff member who was a nurse with item-writing expertise. Two hundred items were written and documented by checking the correct and incorrect answers in references used for technician training, primarily the Amgen *Core Curriculum for the Dialysis Technician.*

The test questions were edited and assembled into three Amini-tests@ of sixty questions. The mini-tests were administered to a total of 167 technicians at 41 facilities in 17 states. Each facility administered only one form of the exam in order to limit the exposure of test items.

Item analysis statistics were computed for each form of the test to identify the difficulty of each question (i.e., the percent of technicians that answered the question correctly) and other item characteristics (e.g., discrimination index, quality of distractors). The average percent correct for each of the three mini-tests was 80% for Form A, 75% for Form B, and 73% for Form C.

Information concerning experience was available for a subset of 52 techniciansBmany of whom had completed the Technician Form survey instrument. Several facility educators also provided information about years of experience. The technicians who took the pilot test had experience ranging from less than six months to more than ten years. Interestingly, with the exception of the technicians with ten or more years of experience, there were no differences in the scores by length of experience. The technicians with ten or more years of experience clearly earned the highest scores.

The questions that performed best were chosen for the assembly of the final, 150-item certification test. The mean difficulty level of the items in the final test was 76%. The Nephrology Nursing Certification Commission assumed responsibility for the review of the job analysis results, final test development, and test administration. In August 2000, the final test was reviewed by NNCC representatives and the ANNA/NANT Task Force (which is now the Hemodialysis Technician Certification Board under NNCC), and final item revisions were made.

Applications: Application materials are now available through the Nephrology Nursing Certification Commission (NNCC), East Holly Avenue, Box 56, Pitman, NJ 08071-0056. Phone: 856-256-2321 or
888-561-6622. Fax: 856-589-7463. E-mail: giovet@mail.ajj.com

ATTACHMENT 3

Reporting Disciplinary Actions, Impairment and Misconduct of Certain Health Care Practitioners Pursuant to House Bill No. 1441 (2003 Session)

Gail D. Jaspen
Chief Deputy Director
Virginia Department of Health Professions
August 2003

1

Objective of HB 1441 (2003)

- ***To enhance DHP's ability to perform prompt, efficient, and effective investigations,***
  - ***aided by timely and meaningful information,***
  - ***from sources most likely to have knowledge of the practitioner's conduct and ability.***

2

Means Chosen by General Assembly to Accomplish the Objective

- Articulation of circumstances under which hospital officials and others must report to DHP
- Establishment of timetable for required reports
- Requirement to provide specific information calculated to help DHP focus its investigation
- Imposition of enhanced penalties for noncompliance with reporting requirements

3

Reporting Laws

- Va. Code § 54.1-2906
- Va. Code § 54.1-2907
- Va. Code § 54.1-2908
- Va. Code § 54.1-2909

4

Reporting Laws

Va. Code § 54.1-2906

- **Hospitals and other health care institutions** to report:
  - **impairment,**
  - **misconduct,**
  - **disciplinary action, and**
  - **resignation while under investigation**

  of any person licensed by a health regulatory board.

- **State Health Commissioner** to report
  - **information of which VDH may become aware indicating misconduct**

  by any person licensed by a health regulatory board.

5

Persons *Licensed* by Health Regulatory Boards

- Audiology/Speech/Language Pathology:
  - ***Audiologists***
  - ***Speech Pathologists***
- Counseling
  - ***Marriage and Family Therapists***
  - ***Professional counselors***
  - ***Licensed Substance Abuse Treatment Practitioners***
- Dentistry:
  - ***Dentists***
  - ***Oral and Maxillofacial Surgeons***
  - ***Dental Hygienists***

6

Persons *Licensed* by Health Regulatory Boards *(cont.)*

- Medicine:
  - ***Doctors of Medicine, including interns and residents***
  - ***Doctors of Osteopathic Medicine***
  - ***Chiropractors***
  - ***Nurse Practitioners***
  - ***Podiatrists***
  - ***Physician Assistants***
  - ***Radiologic Technologists***
  - ***Radiologic Technologists, Limited***
  - ***Respiratory Care Providers***
  - ***Occupational Therapists***
  - ***Acupuncturists***

7

Persons *Licensed* by Health Regulatory Boards *(cont.)*

- Nursing:
  - ***Registered Nurses***
  - ***Licensed Practical Nurses***
  - ***Nurse Practitioners***
  - ***Clinical Nurse Specialists***
- Nursing Home Administrators:
  - ***Nursing Home Administrators***
- Optometry:
  - ***Optometrists***
- Pharmacy:
  - ***Pharmacists***
- Physical Therapy:
  - ***Physical Therapists***
  - ***Physical Therapist Assistants***

8

Persons *Licensed* by Health Regulatory Boards *(cont.)*

- Psychology:
  - ***Applied Psychologists***
  - ***Clinical Psychologists***
  - ***School Psychologists***
- Social Work:
  - ***Clinical Social Workers***
  - ***Social Workers***

Licensees of the Board of Funeral Directors and Embalmers and the Board of Veterinary Medicine should be reported under the subsection of § 54.1-2906 requiring report if in need of treatment for or admitted for treatment of substance abuse or psychiatric illness.

9

Reporting Laws *(cont.)*

Va. Code § 54.1-2907

(Not amended by HB 1441)

- **Every practitioner licensed or certified by a health regulatory board, who treats professionally *any other person licensed or certified by a health regulatory board,*** to report, *except as prohibited by federal law*, **when such health professional is treated for**
  - **a mental disorder,**
  - **chemical dependency or**
  - **alcoholism**

  unless the treating practitioner determines there is a reasonable probability that the professional being treated is competent to continue practice or would not constitute a danger to himself, his patients, or the public.

10

Persons *Certified* by Health Regulatory Boards

Athletic trainers

Massage Therapists

Certified Nurse Aides

Certified Rehabilitation Providers

Certified Sex Offender Treatment Providers

Certified Substance Abuse Treatment Providers

11

Reporting Laws *(cont.)*

Va. Code § 54.1-2908

- The **presidents of professional organizations** to report **disciplinary action** ***taken against any member licensed by the BOM*** resulting from:
  - intentional or negligent conduct that causes or is likely to cause injury to a patient,
  - breach of professional ethics,
  - incompetence,
  - moral turpitude,
  - drug addiction, or
  - alcohol abuse

12

Reporting Laws *(cont.)*
Va. Code § 54.1-2909

- **Persons licensed by the BOM, presidents of professional organizations, state-licensed health care institutions, malpractice carriers, and HMOs** to report, ***with regard to persons licensed by the BOM:***
  - **disciplinary actions,**
  - **malpractice judgments,**
  - **voluntary surrenders of license,**
  - **settlements of malpractice claims, and**
  - **any other evidence indicating that such person**
    - **may be professionally incompetent,**
    - **has engaged in misconduct that causes or is likely to cause injury,**
    - **has engaged in unprofessional conduct, or**
    - **may be mentally or physically unable to practice safely.**

13

Persons *Licensed* by the Board of Medicine

- ***Doctors of Medicine, including interns and residents***
- ***Doctors of Osteopathic Medicine***
- ***Chiropractors***
- ***Nurse Practitioners***
- ***Podiatrists***
- ***Physician Assistants***
- ***Radiologic Technologists***
- ***Radiologic Technologists, Limited***
- ***Respiratory Care Providers***
- ***Occupational Therapists***
- ***Acupuncturists***

14

A closer look at …

Va. Code § 54.1-2906 as amended by HB 1441

15

A closer look. . . Va. Code § 54.1-2906

- Who reports:

  CEO and Chief of Staff of every hospital or other health care institution in the Commonwealth.

  "**Health care institution**" *includes:*
  - *general hospitals,*
  - *outpatient surgical hospitals,*
  - *nursing homes and certified nursing facilities,*
  - *licensed mental or psychiatric hospitals, and*
  - *hospitals operated by UVa and VCU.*

  State Health Commissioner

- Who is reported:

  Any person licensed by a health regulatory board

16

A closer look. . . Va. Code § 54.1-2906

- What is reported / when:
  - **When a CEO/COS becomes aware *in his official capacity*:**
    - that a **licensed practitioner is in need of treatment for or has been admitted or committed to treatment for substance abuse or psychiatric illness which may render practitioner a danger to himself or others**.
      - *Report admission or commitment **within 5 days**.*
      - *Report other circumstances **within 30 days**.*
    - that a ***reasonable probability* exists that a licensed practitioner engaged in *unethical, fraudulent or unprofessional conduct*.**
      - *Report **within 30 days** of determining reasonable probability exists.*

17

A closer look. . . Va. Code § 54.1-2906

"*In his official capacity*" = when information is imparted to or received by the CEO/COS while engaged in official duties or by virtue of his position.

***"Reasonable Probability"* =** a likelihood greater than a mere possibility.

To determine "reasonable probability," a CEO/COS may undertake reasonable investigation or consultation, as needed, with internal boards or committees. If information received is of sufficient credibility and is sufficiently complete, no investigation by CEO/COS may be needed.

"Unethical, fraudulent or unprofessional conduct" – as defined by the laws and regulations governing the profession.

18

A closer look. . . Va. Code § *54.1-2906 (cont.)*

- What is reported / when (cont.)
  - Any **disciplinary action** taken or begun against a licensed practitioner as a result of intentional or negligent conduct that causes or is likely to cause injury, a breach of professional ethics, professional incompetence, moral turpitude, or substance abuse.
    - *Report **within 30 days** of notifying practitioner in writing of disciplinary action.*
  - Any **voluntary resignation, restriction, or expiration of privileges of any health professional while under investigation or subject to disciplinary proceedings** related to possible intentional or negligent conduct that causes or is likely to cause injury, medical incompetence, unprofessional conduct, moral turpitude, mental or physical impairment, or substance abuse.
    - *Report **within 30 days**.*

19

A closer look. . . Va. Code § *54.1-2906 (cont.)*

- To whom / Content / Penalty:

Report in writing to Director of DHP. Include:

- Name and address of subject
- Full description of the circumstances
- Names and contact information of persons with knowledge of the facts
- Names and contact information of persons from whom the institution sought information
- All relevant medical records if patient care or practitioner health is at issue.

Give professional who is the subject of the report to DHP an opportunity to review the report. Practitioner may submit a separate report.

20

A closer look. . . Va. Code § *54.1-2906 (cont.)*

If report is sent to National Practitioner Data Bank, provide notice of such to relevant board.

No requirement to submit any proceedings, minutes, records, or reports that are privileged under peer review statute (§ 8.01-581.17), except that there is **no bar to making the required report or to submitting medical records that are necessary to investigate professional conduct**.

No obligation to report if CEO/COS has actual knowledge that matter has been reported.

Certain records and information in connection with treatment for drug or alcohol abuse are subject to confidentiality under federal law and are exempt from these reporting requirements.

21

A closer look. . . Va. Code § *54.1-2906 (cont.)*

Persons making report or providing information in good faith shall be immune from civil liability.

A civil penalty up to $ 25,000 may be assessed by Director of DHP for a failure to report. Loss of Medicare / Medicaid certification and denial of issuance or renewal of licensure until penalty is paid.

22

A closer look at …

Va. Code § 54.1-2908
as amended by HB 1441

23

A closer look. . . Va. Code § 54.1-2908

- Who reports:

  Presidents of:
  Medical Society of Va
  Osteopathic Medical Assn
  Va Chiropractors Assn
  Va Podiatric Medical Assn

- **Presidents of any association, society, academy, or organization whose members are licensed by the Board of Medicine**

- Who is reported:

  Any member of respective organization who is licensed by the Board of Medicine.

24

A closer look. . . Va. Code § 54.1-2908

- What is reported / when:
  - **Presidents of named organizations** to report *any* ***disciplinary action taken by the organization*** against a **member licensed by the BOM** as result of intentional or negligent conduct that causes or is likely to cause injury to a patient, professional ethics, professional incompetence, moral turpitude, drug addiction or alcohol abuse.
  - **Presidents of any organization, society, etc.** to report ***any disciplinary action taken*** against a **member licensed by the BOM** as result of intentional or negligent conduct that causes or is likely to cause injury to a patient, professional ethics, professional incompetence, moral turpitude, drug addiction or alcohol abuse.

  Reports are to be made ***within 30 days***.

25

A closer look. . . Va. Code § 54.1-2908

- To Whom / Content / Penalty:

Report in writing to the Board of Medicine. Include:

- Name and address of subject of the report
- Full description of the circumstances surrounding facts required to be reported
- Names and contact information of persons with knowledge of the facts reported
- Names and contact information of persons from whom the organization sought information to substantiate the facts
- All relevant medical records if patient care or practitioner health is at issue

Give professional who is the subject of the report to DHP an opportunity to review the report. Practitioner may submit a separate report.

If report has been sent to National Practitioner Data Bank, provide notice of such to relevant board.

26

A closer look. . . Va. Code § 54.1-2908

No person obligated to report as required if such person has actual knowledge that matter has been reported to the BOM.

If one of the named organizations receives complaint against a member, the organization, in lieu of disciplinary action, may request that the BOM investigate. Immunity from civil liability for such report in good faith.

Person making report or providing information in good faith shall be immune from civil liability.

Any person who fails to make report as required shall be subject to civil penalty not to exceed $5,000. Denial of issuance or renewal of licensure until penalty is paid.

27

A closer look at …

Va. Code § 54.1-2909 as amended by HB 1441

28

A closer look. . . Va. Code § 54.1-2909

- Who reports:
  - **Persons licensed by the BOM**
  - **Presidents of professional organizations whose members are regulated by the BOM**
  - **Health care institutions licensed by the Commonwealth**
  - **Malpractice insurance carriers of persons who are subjects of a judgment or settlement**
  - **HMOs**
- Who is reported:
  - **Any person licensed by the BOM:**
    - **Doctors of Medicine, including interns and residents**
    - **Doctors of Osteopathy**
    - **Chiropractors**
    - **Podiatrists**
    - **Physician Assistants**
    - **Radiologic Technologists**
    - **Radiologic Technologists. Limited**
    - **Respiratory care providers**
    - **Occupational Therapists**
    - **Acupuncturists**
    - **Nurse Practitioners**

29

A closer look. . . Va. Code § 54.1-2909

- What is reported / when:
  - **Disciplinary action** taken against **person licensed by BOM** (including oneself) **in another state or a federal health institution, or the voluntary surrender of a license in another state while under investigation**
  - Any **malpractice judgment or settlement** against such a practitioner
  - Any evidence indicating a **reasonable probability that a person licensed by the BOM is or may be professionally incompetent; has engaged in intentional or negligent conduct that causes or is likely to cause injury to a patient; has engaged in unprofessional conduct; or may be mentally or physically unable to practice safely**

Reports are to be made within 30 days.

30

A closer look. . . Va. Code § 54.1-2909

- To Whom / Content / Penalty:

Report in writing to the Board of Medicine. Include:

- Name and address of subject of the report
- Full description of the circumstances surrounding facts required to be reported

The reporting requirements **shall be deemed met** with regard to any matter **if reported to the National Practitioner Data Bank and notice** of such report is **provided to the BOM**.

No person is obligated to report as required if person has actual knowledge that matter has been reported to the BOM.

31

A closer look. . . Va. Code § 54.1-2909

Person making report or providing information in good faith shall be immune from civil liability or criminal prosecution resulting therefrom.

Clerks of state circuit and district courts are also obligated to report to the BOM convictions of known licensees for *any misdemeanor involving a controlled substance, marijuana, substance abuse or moral turpitude* or for *any felony*.

Any person who fails to make report as required shall be subject to civil penalty not to exceed $5,000. Denial of issuance or renewal of licensure until penalty is paid.

Disciplinary action against any person licensed, registered, or certified by the BOM shall be based upon the underlying conduct of the person and not upon the report of a settlement or judgment submitted under this section.

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If in doubt . . .

Contact:

- Executive Director of relevant health regulatory board;
- Enforcement Division of DHP;
- DHP Director, Robert Nebiker;
- DHP Chief Deputy Director, Gail Jaspen; or
- Your personal or your institution's legal counsel.

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ATTACHMENT 4

Department of Health Professions

2004 Session of the General Assembly

Draft Legislation

A bill to amend and reenact § 54.1-2400 of the Code of Virginia and to repeal §§54.1-2919, 54.1-3009 and 54.1-3010 relating to disciplinary proceedings by health regulatory boards.

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2400 of the Code of Virginia is amended as follows:

§ 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 (§ 2.2-4000 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 (§ 54.1-100 et seq.) and Chapter 25 (§ 54.1-2500 et seq.) of this title.
7. To revoke, suspend, restrict, or refuse to issue or renew a registration, certificate or license which such board has authority to issue for causes enumerated in applicable law and regulations.
8. To appoint designees from their membership or immediate staff to coordinate with the Intervention Program Committee and to implement, as is necessary, the provisions of Chapter 25.1 (§ 54.1-2515 et seq.) of this title. Each health regulatory board shall appoint one such designee.
9. To take appropriate disciplinary action for violations of applicable law and regulations.
10. To appoint a special conference committee, composed of not less than two members of a health regulatory board or, when required for special conference committees of the Board of Medicine, not less than two members of the Board and one member of the relevant advisory board, to act in accordance with § 2.2-4019 upon receipt of information that a practitioner of the appropriate board may be subject to disciplinary action. The special conference committee may (i) exonerate the practitioner; (ii) reinstate the practitioner; (iii) place the practitioner on probation with such terms as it may deem appropriate; (iv) reprimand the practitioner; (v) modify a previous order; and (vi) impose a monetary penalty pursuant to § 54.1-2401. The order of the special conference committee shall become final 30 days after service of the order unless a

written request to the board for a hearing is received within such time. If service of the decision to a party is accomplished by mail, three days shall be added to the 30-day period. Upon receiving a timely written request for a hearing, the board or a panel of the board shall then proceed with a hearing as provided in § 2.2-4020, and the action of the committee shall be vacated. This subdivision shall not be construed to ~~affect the authority or procedures of the Boards of Medicine and Nursing pursuant to §§ 54.1-2919 and 54.1-3010~~ limit the authority of a board to delegate to an agency subordinate the authority to conduct informal fact-finding proceedings in accordance with § 2.2-4019, upon receipt of information that a practitioner may be subject to a disciplinary action.

11. To convene, at their discretion, a panel consisting of at least five board members or, if a quorum of the board is less than five members, consisting of a quorum of the members to conduct formal proceedings pursuant to § 2.2-4020, decide the case, and issue a final agency case decision. Any decision rendered by majority vote of such panel shall have the same effect as if made by the full board and shall be subject to court review in accordance with the Administrative Process Act. No member who participates in an informal proceeding conducted in accordance with § 2.2-4019 shall serve on a panel conducting formal proceedings pursuant to § 2.2-4020 to consider the same matter.

12. To issue inactive licenses or certificates and promulgate regulations to carry out such purpose. Such regulations shall include, but not be limited to, the qualifications, renewal fees, and conditions for reactivation of licenses or certificates.

13. To meet by telephone conference call to consider settlement proposals in matters pending before special conference committees convened pursuant to this section, § 54.1-2919 or § 54.1-3010 or matters referred for formal proceedings pursuant to § 2.2-4020 to a health regulatory board or a panel of the board or to consider modifications of previously issued board orders when such considerations have been requested by either of the parties.

14. To request and accept from a certified, registered or licensed practitioner, in lieu of disciplinary action, a confidential consent agreement. A confidential consent agreement shall be subject to the confidentiality provisions of § 54.1-2400.2 and shall not be disclosed by a practitioner. A confidential consent agreement shall include findings of fact and may include an admission or a finding of a violation. A confidential consent agreement shall not be considered either a notice or order of any health regulatory board, but it may be considered by a board in future disciplinary proceedings. A confidential consent agreement shall be entered into only in cases involving minor misconduct where there is little or no injury to a patient or the public and little likelihood of repetition by the practitioner. A board shall not enter into a confidential consent agreement if there is probable cause to believe the practitioner has (i) demonstrated gross negligence or intentional misconduct in the care of patients or (ii) conducted his practice in such a manner as to be a danger to the health and welfare of his patients or the public. A certified, registered or licensed practitioner who has entered into two confidential consent agreements involving a standard of care violation, within the 10-year period immediately preceding a board's receipt of the most recent report or complaint being considered, shall receive public discipline for any subsequent violation within the 10-year period unless the board finds there are sufficient facts and circumstances to rebut the presumption that the disciplinary action be made public.

15. When a board has probable cause to believe a practitioner is unable to practice with reasonable skill and safety to patients because of excessive use of alcohol or drugs or physical or mental illness, the board, after preliminary investigation by either an informal fact-finding proceeding, in accordance with § 2.2-4019 or a special conference committee in accordance with § 54.1-2400 (10), may direct that the practitioner submit to a mental or physical examination. Failure to submit to the examination shall constitute grounds for disciplinary action. Any

practitioner affected by this subsection shall be afforded reasonable opportunity to demonstrate that he is competent to practice with reasonable skill and safety to patients.

2. That §§ 54.1-2919, 54.1-3009 and 54.1-3010 are repealed.

Department of Health Professions

2004 Session of the General Assembly

Draft Legislation

A bill to amend the Code of Virginia by adding §§54.1-2000.6, 54.1-2400.7, and 54.1-2400.8 and to repeal §§54.1-2906 and 54.1-2707 relating to reporting of misconduct by practitioners regulated by health regulatory boards.

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding §§ 54.1-2400. 6, 54.1-2400.7 and 54.1-2400.8 as follows:

§ 54.1-2400.6. Hospitals and other health care institutions required to report disciplinary actions against and certain disorders of health professionals; immunity from liability; failure to report.
A. The chief executive officer and the chief of staff of every hospital or other health care institution in the Commonwealth shall report within 30 days, except as provided in subsection B, to the Director of the Department of Health Professions the following information regarding any person licensed, certified, or registered by a health regulatory board or holding a multistate licensure privilege to practice nursinig unless exempted under subsection E :
1. Any information of which he may become aware in his official capacity indicating that such a health professional is in need of treatment or has been committed or admitted as a patient, either at his institution or at any other health care institution, for treatment of substance abuse or a psychiatric illness which may render the health professional a danger to himself, the public or his patients.
2. Any information of which he may become aware in his official capacity indicating, after reasonable investigation and consultation as needed with the appropriate internal boards or committees authorized to impose disciplinary action on a health professional, that there is a reasonable probability that such health professional may have engaged in unethical, fraudulent or unprofessional conduct as defined by the pertinent licensing statutes and regulations. The report required under this section shall be submitted within 30 days of the date that the chief executive officer or chief of staff determines that a reasonable probability exists.
3. Any disciplinary action, including but not limited to denial or termination of employment, denial or termination of privileges or restriction of privileges, while under investigation or during disciplinary proceedings, taken or begun by the institution as a result of conduct involving intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, professional ethics, professional incompetence, moral turpitude, or substance abuse. The report required under this section shall be submitted within 30 days of the date of written communication to the health professional notifying him of any disciplinary action.
4. The voluntary resignation from the staff of the health care institution or voluntary restriction or expiration of privileges at the institution of any health professional while such health professional is under investigation or is the subject of disciplinary proceedings taken or begun by the institution or a committee thereof for any reason related to possible intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, medical incompetence, unprofessional conduct, moral turpitude, mental or physical impairment, or substance abuse.
Any report required by this section shall be in writing directed to the Director of the Department of Health Professions, shall give the name and address of the person who is the subject of the report and shall fully describe the circumstances surrounding the facts required to be reported.

The report shall include the names and contact information of individuals with knowledge about the facts required to be reported and the names and contact information of individuals from whom the hospital or health care institution sought information to substantiate the facts required to be reported. All relevant medical records shall be attached to the report if patient care or the health professional's health status is at issue. The reporting hospital or health care institution shall also provide notice to the Department that it has submitted a report to the National Practitioner Data Bank under the Health Care Quality Improvement Act, 42 U.S.C. § 11101, et seq. The reporting hospital or health care institution shall give the health professional who is the subject of the report an opportunity to review the report. The health professional may submit a separate report if he disagrees with the substance of the report.

This section shall not be construed to require the hospital or health care institution to submit any proceedings, minutes, records or reports that are privileged under § 8.01-581.17, except that the provisions of § 8.01-581.17 shall not bar (i) any report required by this section or (ii) any requested medical records which are necessary to investigate unprofessional conduct reported pursuant to this subtitle or unprofessional conduct that should have been reported pursuant to this subtitle. Under no circumstances shall compliance with this section be construed to waive or limit the privilege provided in § 8.01-581.17. No person or entity shall be obligated to report any matter to the Department if the person or entity has actual notice that the same matter has already been reported to the Department.

B. Any report required by this section concerning the commitment or admission of such health professional as a patient shall be made within five days of when the chief administrative officer learns of such commitment or admission.

C. The State Health Commissioner shall report to the Department any information of which the Department of Health may become aware in the course of its duties indicating that such a health professional may be guilty of fraudulent, unethical or unprofessional conduct as defined by the pertinent licensing statutes and regulations.

D. Any person making a report required by this section, providing information pursuant to an investigation or testifying in a judicial or administrative proceeding as a result of such report shall be immune from any civil liability alleged to have resulted therefrom unless such person acted in bad faith or with malicious intent.

E. Medical records or information learned or maintained in connection with an alcohol or drug prevention function which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall be exempt from the reporting requirements of this section to the extent that such reporting is in violation of 42 U.S.C. § 290dd-2 or regulations promulgated thereunder.

F. Any person who fails to make a report to the Department as required by this section shall be subject to a civil penalty not to exceed $25,000 assessed by the Director. The Director shall report the assessment of such civil penalty to the Commissioner of the Department of Health. Any person assessed a civil penalty pursuant to this section shall not receive a license or certification or renewal of such unless such penalty has been paid pursuant to § 32.1-125.01. The Medical College of Virginia Hospitals and the University of Virginia Hospitals shall not receive certification pursuant to § 32.1-137 or Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1 unless such penalty has been paid.

§ 54.1-2400.7. Practitioners treating other practitioners for certain disorders to make reports; immunity from liability.

A. Every practitioner in the Commonwealth licensed or certified by a health regulatory board or who holds a multistate licensure privilege to practice nursing who treats professionally any person licensed or certified by a health regulatory board or who holds a multistate licensure

privilege shall, unless exempted by subsection C hereof, report to the appropriate board whenever any such health professional is treated for mental disorders, chemical dependency or alcoholism, unless the attending practitioner has determined that there is a reasonable probability that the person being treated is competent to continue in practice or would not constitute a danger to himself or to the health and welfare of his patients or the public.

B. Any person making a report required by this section or testifying in a judicial or administrative proceeding as a result of such report shall be immune from any civil liability alleged to have resulted therefrom unless such person acted in bad faith or with malicious intent.

C. Medical records or information learned or maintained in connection with an alcohol or drug abuse prevention function which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall be exempt from the reporting requirements of this section to the extent that such reporting is in violation of 42 U.S.C. § 290dd-2 or regulations promulgated thereunder.

§ 54.1-2400.8. Immunity for reporting

Any person making a report as required by law or regulation, that a practitioner may be professionally incompetent; has engaged in intentional or negligent conduct that causes or it likely to cause injury to a patient or patients; has engaged in unprofessional conduct; or may be mentally or physically unable to engage safely in the practice of his profession, or any person providing information pursuant to an investigation or testifying in a judicial or administrative proceeding as a result of such report shall be immune from any civil liability or criminal prosecution resulting therefrom unless such person acted in bad faith or with malicious intent.

2. That §§ 54.1-2906 and 54.1-2907 are repealed.

ATTACHMENT 5

TALKING POINTS
AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

- The current officers of the Board are Michael Ridenhour, Audiology, Chair and Dr. Charles Johnson, Otolaryngologist, as Vice –Chair.

- The Governor appointed two new citizen members effective July 1, 2003: Robin Duke, attorney from Portsmouth and Holly Meadow from Alexandria. Ms. Meadow is hearing impaired and will definitely add a wealth of knowledge of the clients served in that realm.

ATTACHMENT 6

BOARD OF HEALTH PROFESSIONS REPORT

Board of Nursing Activities for the past Year
July 2002- June 2003

- The Board of Nursing celebrated 100 Years since the passage of legislation to regulate Nursing in the Commonwealth on May 14, 1903.

- Jay P. Douglas, RN was named Executive Director December 2002 following the retirement of Nancy K. Durrett.

- A period review of Nursing Regulations was completed. The Regulations have not been approved for publication as of yet. A public comment period will be set upon approval.

- The Board President has represented the Board on the Governor's Advisory Council on the future of Nursing. This group has primarily focused on Nursing Education, recruitment, retention and nursing shortage issues.

- Final Regulations were adopted regarding Advanced Certification for Nurse Aides.

- The Board adopted final Regulations governing licensure of Nurse Practitioners which include continued Competency Requirements.

- The Discipline Committee has continued to look at alternative ways to handle the disciplinary caseload within APA guidelines. The Board authorized staff to offer pre-hearing consent orders in certain circumstances. The Board adopted guidelines to assist staff in identifying cases appropriate for confidential consent agreements.

- Legislation was passed authorizing Virginia's membership in a multi-state Nursing Compact that provides the structure for reciprocal recognition of other states' licenses to practice as a Registered Nurse or Licensed Practical Nurse. The Compact also provides for each states' autonomy in setting licensure standards for person's licensed in their home state as well as in disciplinary proceedings. The Nurse Licensure Compact will be effective January 1, 2005.

ATTACHMENT 7

Board of Health Professions Meeting 9/4/2003
Report from the Board of Nursing Home Administrators

The Board of Nursing Home Administrators has completed the revision of the regulations.

The Board of Nursing Home Administrators would like the ~~Department~~ Board of Health Professions to study the feasibility of licensing Assisted Living Administrators in order to provide a basic level of accountability given the nature of the clients served.

Submitted by
Mary M. Smith

ATTACHMENT 8

BOARD OF OPTOMETRY

BHP September 4, 2003

2003 Update

New Members

The Board has two new members, William Tillar, OD of Emporia and Catherine Burk of Purcellville filling the vacancies of Dr. Samuel Smart of Fredericksburg and Jeff Smith of Richmond.

Amendments to the Board's general and therapeutic pharmaceutical agents' certification regulations became effective on January 15 and provide for the following:

- **The Board moved its annual renewal to coincide with the calendar year.**
- **An optometrist may now practice under his own personal name or only under a single professional designation.**
- **Continuing education requirements have increased from 14 to 16 hours annually, with 14 directly pertaining to patient care. Therapeutic Pharmaceutical Agents certified optometrists must have at least two of the 16 hours pertaining to TPA prescribing and administration.**
- **CE Courses are approved now only by board-approved sponsors/approving bodies and must be approved in advance of being offered.**
- **For courses with post-test requirements, credit will only be recognized if the optometrist passes the test(s).**

CPT Codes

From time to time, the Board of Optometry clarifies what activities fall within the scope of practice of optometrists by referring to the Current Procedural Terminology manual. The Board provides on its website a listing of specific Board Approved CPT Codes. The latest addition in January and added "multiple punctures of anterior cornea," "scanning ophthalmic diagnostic imaging" and "pachymetry."

Voluntary Practice Regulations

On July 7, 2003 the board finalized regulations regarding voluntary practice by out-of-state optometrists to volunteer their services to a non-profit organization that has no paid employees and offers health care to underprivileged populations throughout the world. to comply with legislation passed in 2002. These regulations were identical to those adopted as emergency regulations last year. So far, we have had one applicant.

Proposed Legislation

The Board is proposing three pieces of legislation:

1. To amend the Therapeutic Pharmaceutical Agents Formulary to include the Diagnostic Pharmaceutical Agents formulary.

2. To expand TPA certified optometrist's prescriptive authority to include oral antibiotics.

3. To require TPA certification for all new licensees.

ATTACHMENT 9

BOARD OF PHARMACY
Summary of Activities
2003

The registration of pharmacy technicians in Virginia began in February as required by legislation passed in 2001. Pharmacy technicians have until February 25, 2004 to become registered if they are to continue performing technician tasks. To be eligible for registration a person must either hold current certification from the Pharmacy Technician Certification Board or complete a board approved training program and pass a board approved examination. As of August 15, 2003, there are approximately 800 technicians registered with the total number expected to be over 4000.

Legislation passed in 2002 required the Director of the Department of Health Professions to implement a prescription monitoring program (PMP) in southwest Virginia. The purpose of this PMP as currently authorized is to collect prescribing and dispensing data for controlled substances in a central database to improve the accuracy and efficiency of investigations of alleged diversion by prescription fraud, and also to provide prescribers with the ability to check on patients seeking controlled substances to determine if they are "doctor shopping." The current reporting requirement for the PMP is limited to Schedule II controlled substances dispensed in State Health Planning Region III (Southwest Virginia), comprised of 29 counties and 12 cities with a total of 362 pharmacies. The information collected in this program is maintained by DHP and strict security and confidentiality measures will be enforced. Only those persons authorized by law can be provided information from the database, and the list of authorized persons is very limited. Any information provided in connection with an ongoing investigation is limited to the scope of the particular investigation. Any information provided to a prescriber is limited to that relating to a particular patient who has given written consent. At the current time, pharmacies are not authorized to obtain information from the system. There has been concern expressed that the PMP may suppress the legitimate prescribing and dispensing of controlled substances, particularly for cancer pain or other chronic pain patients. Under the current law, the data in the PMP cannot be analyzed or "mined" for possible cases of doctor shopping or indiscriminate prescribing or dispensing. There should be no concern that patients, prescribers, or pharmacists will be targeted for investigation because of this program.

The board will be publishing proposed regulations based on the biennial review process. The proposed regulations will correct problems with current language and encompass new technology and changes or advances in pharmacy practice. It is the first comprehensive review and update of the regulation in many years.

The board is proposing 2 legislative proposals for the 2004 General Assembly.
PHA1: Current code (54.1-3434.02) allows the pharmacist to delegate the filling and stocking of automated dispensing devices to persons who hold current certification from the National Pharmacy Technician Certification Board (PTCB). The bill will conform this section of the code to section 54.1-3321 which requires the registration of pharmacy technicians in Virginia and allows registered pharmacy technicians to stock or load

automated dispensing devices used in the dispensing process. PHA2: Each pharmacist is required to obtain a minimum of fifteen continuing education hours through an approved program during the year immediately preceding the license renewal date. The goal of this proposal is to allow the Board of Pharmacy to require up to two hours of continuing pharmacy education in a specific subject area. This will allow the board to require training in critical areas at a given time. Examples of critical areas where training is needed now are prevention of dispensing errors, pharmacy's role in emergency preparedness, and smallpox administration. Any requirements for a particular year will be published by January 1 of that year.

ATTACHMENT 10

TALKING POINTS
FUNERAL DIRECTORS AND EMBALMERS

- During the 2003 Virginia General Assembly, a bill was which clarified the law regarding the importability of irrevocable preneed trusts. Another bill during the session grants the Board the authority to inspect crematories.

- The current officers of the Board are Bobby Gardner, Sr., FSL, President, Michael Williams, FSL, Vice-President and Jack Miller, FSL, Secretary-Treasurer.

- The Governor appointed three funeral service licensee members effective July 1, 2003: Billie Hughes, FSL from Alexandria, Barry Murphy, FSL from Arlington, and Skip Tharp, FSL from Bedford.

ATTACHMENT 11

TALKING POINTS
PHYSICAL THERAPY

- During the 2003 Virginia General Assembly, a bill was passed which allows physical therapists to administer Schedule 6 topical drugs.

- The current officers of the Board are Lisa Shoaf, PT, President and Gayle Garnett as Vice-President.

- The Governor appointed two new members effective July 1, 2003: Damien Howell, PT from Richmond and Maureen Lyons, Pt from Roanoke.

- The Board recently completed its first major regulatory review with amendments in licensure by endorsement and licensure of foreign educated graduates.