Call to Order | Mr. Catron
---|---
Emergency Egress | Dr. Carter
Welcome New Members | Dr. Carter
Public Comment | Mr. Catron
Approval of Minutes - August 18, 2016 – page 2 | Mr. Catron
Director's Report | Dr. Brown
Legislative and Regulatory Report | Ms. Yeatts
Executive Director's Report | Dr. Carter
- Agency Performance – page 7
- Board Budget - page 16
- Healthcare Workforce Data Center – page 19
- Communications – page 22
- Certified Anesthesiologist Assistant Study – page 27
Sanction Reference Point Update – page 36 | Mr. Kauder
Telehealth | Ms. Hoyle
- Behavioral Sciences Boards – page 37
Board Elections – page 58 | Mr. Catron
- Chair
- Vice Chair
Individual Board Reports | Mr. Catron
New Business | Mr. Catron
Next Full Board Meeting | Mr. Catron
- May 9, 2017
Adjournment |
Board of Health Professions
Full Board Meeting

August 18, 2016
11:00 a.m. - Board Room 2
9960 Mayland Dr, Henrico, VA 23233

In Attendance
Barbara Allison-Bryan, MD, Board of Medicine
CHAIRMAN: Robert J. Catron, Citizen Member
Helene D. Clayton-Jeter, OD, Board of Optometry
Kevin Doyle, Ed.D., LPC, LSATP, Board of Counseling
Yvonne Haynes, LCSW, Board of Social Work
Mark Johnson, DVM, Board of Veterinary Medicine
Allen R. Jones, Jr., DPT, PT
Robert H. Logan, III, Ph.D., Citizen Member
Ryan Logan, Board of Pharmacy
Martha S. Perry, MS, Citizen Member
Jacquelyn M. Tyler, RN, Citizen Member
Laura P. Verdun, MA, CCC-SLP, Board of Audiology & Speech-Language Pathology
James D. Watkins, DDS, Board of Dentistry
James Wells, RPH, Citizen Member

Absent
Trula E. Minton, MS, RN, Board of Nursing

DHP Staff
David E. Brown, D.C., Director DHP
Elizabeth A. Carter, Ph.D., Executive Director BHP
Charles Giles, Budget Manager
Elaine Yeatts, Senior Policy Analyst DHP
Laura L. Jackson, Operations Manager BHP

Observers
Dr. William Ward, Virginia Chiropractic Association
Laura McHale, Keeney Group/VCA

Call to Order

Acting Chair     Mr. Catron              Time    11:05 a.m.
Quorum          Established

Public Comment

Comment         Dr. William Ward, Virginia Chiropractic Association
Discussion
Dr. Ward thanked the Board for its work on the Chiropractor review and extended his wishes that the committee agree with the addition of this item to the scope of practice.

Approval of Minutes

Presenter  Mr. Catron

Discussion
The May 5, 2016 10:00 a.m. Full Board meeting minutes were approved with one amendment: remove the DHP logo from the Telehealth Review update report, and properly seconded. All members in favor, none opposed.

Directors Report

Presenter  Dr. Brown

Discussion
Dr. Brown provided an update on the agency’s internal training activities and plans for the fall board member training day. In addition, he mentioned the agency’s continued efforts in activities related to reduction of opiate abuse. DHP will be submitting three (3) bills this year to the General Assembly. DHP Boards are reviewing statutes and making revisions as necessary. The Board of Medicine is hosting a website for the Prescription Drug Task Force which will go live in early September.

Legislative and Regulatory Report

Presenter  Ms. Yeatts

Discussion
Ms. Yeatts advised the Board that 18VAC 75-30-10 et seq., regulations governing standards for dietitians and nutritionists require appeal because the language is now incorporated into statute.

Motion
A motion was made to repeal 18VAC 75-30-10 et seq., regulations governing standards for dietitians and nutritionists. The motion was properly seconded by Dr. Watkins. All members were in favor, none opposed.

Discussion
Ms. Yeatts advised the Board that 18VAC 75-11-10 et seq. needs to be amended to include a requirement for the Board to afford interested persons an opportunity to present their views and be accompanied by and represented by counsel or other representative in the promulgation of any regulatory action. This amendment reflects statutory update.

Motion
A motion was made to amend 18VAC 75-11-10 et seq. The motion was properly seconded by Dr. Logan, III. All members were in favor, none opposed.
**DHP Budget Review**

**Presenter**  Mr. Giles

**Discussion**
Mr. Giles provided an overview of DHPs FY17 budget. He stated that DHP is a non-general fund agency and that revenue is generated by issuing licensees and not tax dollars. 83% of the agency's revenue is budgeted based on then number of renewals forecasted for a given fiscal year. The remaining 17% of revenue is budgeted based on historical data.

**Lunch Break**

**Presenter**  Mr. Catron

Mr. Catron announced a lunch break at 11:55 a.m. The meeting reconvened at 12:14 p.m.

**Executive Directors Report**

**Presenter**  Dr. Carter

**Agency Performance**
Dr. Carter reviewed the agencies performance measures in relation to clearance rate, age of pending caseload and time to disposition.

**Board Budget**
Dr. Carter stated that the Board utilized 95.57% of its yearly budget. Staff turnover in early FY2016 accounted for the 4.43% difference.

**Healthcare Workforce Data Center**
Dr. Carter provided an update on the Data Center. The latest Dentist and Dental Hygienist reports will be presented to the Board of Dentistry in September. She will also be presenting at the Council on Licensure, Enforcement and Regulation annual conference in September. The presentation will focus on Virginia’s minimum data set standard approach as a model for other states’ professional licensing boards.

**Regulatory Research Committee Report**

**Presenter**  Mr. Wells

**Chair**
Mr. Wells updated the Board on the progress that was made regarding the Chiropractor/CLD review at the August 18, 2016 10:00 a.m. Regulatory Research Committee meeting. The Committee concluded the following: (1) It affirms that health care providers should be allowed to practice to the highest level of their education and training. (2) Chiropractors licensed by the Virginia Board of Medicine who successfully complete the Federal Motor Carrier Safety Administration Medical Examiner training and testing do have the requisite education and training. (3) Virginia’s chiropractor scope of practice statutory language is dated and does not reflect current circumstances. The General Assembly may wish to consider a comprehensive scope of practice update to avoid single-issue amendments in the future. Board staff will create a letter in response to Delegate Orrock’s original request by November 1, 2016.
Motion
A motion was made to create a response letter to Delegate Orrock to include the three items as discussed. The motion was properly seconded by Dr. Allison-Bryan. All in favor, none opposed.

Board Reports

Presenter Mr. Catron

Board of Physical Therapy
Dr. Jones stated reported that the new Board of Physical Therapy's Executive Director has been hired and will begin August 25. He thanked Ms. Russell for her service.

Board of Medicine
Dr. Allison-Bryan reported on the Board of Medicine’s Legislative Committee’s recommendation not to participate in the Interstate Medical Licensure Compact in its current form. Dr. Allison-Bryan stated that the purpose of the Compact was three-fold: 1) promote access to underserved states, 2) avoid duplication of the licensing work by boards, and 3) preempt a need for the federal government to issue a national license. She advised there were several factors discussed at length that were not consistent with the Board’s current operations, including language that conflicts with Virginia laws and regulations. She also stated that the Board of Medicine is looking into decreasing the current licensing fee.

Board of Social Work
Ms. Haynes stated that the Board of Social Work completed fast track regulations to lessen the burden for future licensure by endorsement applicants.

Board of Audiology & Speech-Language Pathology
Ms. Verdun reported that regulations are being refined to stream line the language for SLP Assistants.

Board of Counseling
Dr. Doyle reported that the Board has scheduled a Supervisor Summit and Education Summit for September 9, 2016. In a matter of three hours after posting the invitation, 150 people had signed-up to attend. At this time, there will additional summits scheduled, as this is too many people to attend at one time.

Board of Pharmacy
Mr. Logan stated that the Board of Pharmacy’s Regulatory Advisory Panel is reviewing regulations for processors of cannabidiol oil and THC-A oil to treat epilepsy patients who experience seizures. This work is extensive and ongoing at this time.

New Business

Presenter Mr. Catron

There was no new business to discuss.
Adjourned

Adjourned 12:48 p.m.

Acting Chair
Robert Catron
Signature: __________________________________ Date: _____/_____/

Board Executive Director
Elizabeth A. Carter, Ph.D.
Signature: __________________________________ Date: _____/_____/


Virginia Department of Health Professions
Patient Care Disciplinary Case Processing Times:
Quarterly Performance Measurement, Q2 2013 - Q2 2017

"To ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public."
DHP Mission Statement

In order to uphold its mission relating to discipline, DHP continually assesses and reports on performance. Extensive trend information is provided on the DHP website, in biennial reports, and, most recently, on Virginia Performs through Key Performance Measures (KPMs). KPMs offer a concise, balanced, and data-based way to measure disciplinary case processing. These three measures, taken together, enable staff to identify and focus on areas of greatest importance in managing the disciplinary caseload: Clearance Rate, Age of Pending Caseload and Time to Disposition uphold the objectives of the DHP mission statement. The following pages show the KPMs by board, listed in order by caseload volume; volume is defined as the number of cases received during the previous 4 quarters. In addition, readers should be aware that vertical scales on the line charts change, both across boards and measures, in order to accommodate varying degrees of data fluctuation.

Clearance Rate - the number of closed cases as a percentage of the number of received cases. A 100% clearance rate means that the agency is closing the same number of cases as it receives each quarter. DHP's goal is to maintain a 100% clearance rate of allegations of misconduct. The current quarter's clearance rate is 117%, with 514 patient care cases received and 1068 closed.

Age of Pending Caseload - the percent of open patient care cases over 250 business days old. This measure tracks the backlog of patient care cases older than 250 business days to aid management in providing specific closure targets. The goal is to maintain the percentage of open patient care cases older than 250 business days at no more than 20%. The current quarter shows 16% patient care cases pending over 250 business days with 2,504 patient care cases pending and 406 pending over 250 business days.

Time to Disposition - the percent of patient care cases closed within 250 business days for cases received within the preceding eight quarters. This moving eight-quarter window approach captures the vast majority of cases closed in a given quarter and effectively removes any undue influence of the oldest cases on the measure. The goal is to resolve 90% of patient care cases within 250 business days. The current quarter shows 87% percent of patient care cases being resolved within 250 business days with 1032 cases closed and 865 closed within 250 business days.

Submitted: 1/25/2017

Prepared by: Department of Health Professions
Virginia Department of Health Professions - Patient Care Disciplinary Case Processing Times, by Board

**Nursing** - In Q2 2017, the clearance rate was 121%, the Pending Caseload older than 250 business days was 9% and the percent closed within 250 business days was 88%.
Q2 2017 Caseloads:
Received=447, Closed=541
Pending over 250 days=106
Closed within 250 days=478

**Nurses** - In Q2 2017, the clearance rate was 110%, the Pending Caseload older than 250 business days was 8% and the percent closed within 250 business days was 88%.
Q2 2017 Caseloads:
Received=324, Closed=357
Pending over 250 days=66
Closed within 250 days=315

**CNA** - In Q2 2017, the clearance rate was 150%, the Pending Caseload older than 250 business days was 12% and the percent closed within 250 business days was 89%.
Q2 2017 Caseloads:
Received=123, Closed=184
Pending over 250 days=40
Closed within 250 days=163

Note: Vertical scales on line charts change, both across boards and measures, in order to accommodate varying degrees of data fluctuation.

Submitted: 1/25/2017

Prepared by: Department of Health Professions
Virginia Department of Health Professions - Patient Care Disciplinary Case Processing Times, by Board

**Medicine** - In Q2 2017, the clearance rate was 95%, the Pending Caseload older than 250 business days was 14% and the percent closed within 250 business days was 95%.
- **Q2 2017 Caseloads:**
  - Received=305, Closed=290
  - Pending over 250 days=84
  - Closed within 250 days=266

**Dentistry** - In Q2 2017, the clearance rate was 171%, the Pending Caseload older than 250 business days was 28% and the percent closed within 250 business days was 84%.
- **Q2 2017 Caseloads:**
  - Received=34, Closed=58
  - Pending over 250 days=50
  - Closed within 250 days=43

**Pharmacy** - In Q2 2017, the clearance rate was 172%, the Pending Caseload older than 250 business days was 33% and the percent closed within 250 business days was 59%.
- **Q2 2017 Caseloads:**
  - Received=32, Closed=55
  - Pending over 250 days=47
  - Closed within 250 days=26

---

**Percent Closed in 250 Business Days**
- **Medicine:**
  - 100% Goal
  - 90% Goal
- **Dentistry:**
  - 100% Goal
  - 80% Goal
- **Pharmacy:**
  - 100% Goal
  - 60% Goal

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Note: Vertical scales on line charts change, both across boards and measures, in order to accommodate varying degrees of data fluctuation.

Submitted: 1/25/2017

Prepared by: Department of Health Professions
Veterinary Medicine - In Q2 2017, the clearance rate was 138%, the Pending Caseload older than 250 business days was 24% and the percent closed within 250 business days was 61%. Q2 2017 Caseloads:
- Received=21, Closed=39
- Pending over 250 days=28
- Closed within 250 days=23

Counseling - In Q2 2017, the clearance rate was 192%, the Pending Caseload older than 250 business days was 19% and the percent closed within 250 business days was 72%. Q2 2017 Caseloads:
- Received=13, Closed=25
- Pending over 250 days=9
- Closed within 250 days=18

Social Work - In Q2 2017, the clearance rate was 58%, the Pending Caseload older than 250 business days was 32% and the percent closed within 250 business days was 55%. Q2 2017 Caseloads:
- Received=19, Closed=11
- Pending over 250 days=25
- Closed within 250 days=6

Note: Vertical scales on line charts change, both across boards and measures, in order to accommodate varying degrees of data fluctuation.

Submitted: 1/25/2017

Prepared by: Department of Health Professions
Virginia Department of Health Professions - Patient Care Disciplinary Case Processing Times, by Board

**Psychology** - In Q2 2017, the clearance rate was 150%, the Pending Caseload older than 250 business days was 47% and the percent closed within 250 business days was 91%.

- **Q2 2017 Caseloads:**
  - Received=10, Closed=15
  - Pending over 250 days=27
  - Closed within 250 days=10

**Long-Term Care** - In Q2 2017, the clearance rate was 91%, the Pending Caseload older than 250 business days was 23% and the percent closed within 250 business days was 70%.

- **Q2 2017 Caseloads:**
  - Received=11, Closed=10
  - Pending over 250 days=12
  - Closed within 250 days=7

**Optometry** - In Q2 2017, the clearance rate was 175%, the Pending Caseload older than 250 business days was 53% and the percent closed within 250 business days was 83%.

- **Q2 2017 Caseloads:**
  - Received=4, Closed=7
  - Pending over 250 days=8
  - Closed within 250 days=5

Note: Vertical scales on line charts change, both across boards and measures, in order to accommodate varying degrees of data fluctuation.

Submitted: 1/25/2017

Prepared by: Department of Health Professions
Virginia Department of Health Professions - Patient Care Disciplinary Case Processing Times, by Board

**Physical Therapy** - In Q2 2017, the clearance rate was 57%, the Pending Caseload older than 250 business days was 10% and the percent closed within 250 business days was 25%.
- Q2 2017 Caseloads:
  - Received=7, Closed=4
  - Pending over 250 days=2
  - Closed within 250 days=1

**Funeral** - In Q2 2017, the clearance rate was 0%, the Pending Caseload older than 250 business days was 18% and the percent closed within 250 business days was N/A.
- Q2 2017 Caseloads:
  - Received=3, Closed=0
  - Pending over 250 days=2
  - Closed within 250 days=0

**Audiology** - In Q2 2017, the clearance rate was 0% the Pending Caseload older than 250 business days was 0% and the percent closed within 250 business days was N/A.
- Q2 2017 Caseloads:
  - Received=1, Closed=0
  - Pending over 250 days=0
  - Closed within 250 days=0

*Note: Vertical scales on line charts change, both across boards and measures, in order to accommodate varying degrees of data fluctuation.*

Submitted: 1/25/2017

Prepared by: Department of Health Professions
Agency Goals
2017-2018

Our mission is to ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public.

Goal One: Keep the people of Virginia safe through the licensure of competent healthcare professionals throughout the Commonwealth

Objective
- Ensure healthcare practitioners across 13 health regulatory boards meet the requirements for licensure as required by the Code of Virginia (COV)

Goal Two: Enforce standards of practice regarding the delivery of healthcare

Objectives
- Institute and uphold regulations in association with laws enacted by the General Assembly regarding patient care and professional practice
- Provide an alternative to disciplinary action for impaired practitioners through the Health Practitioners’ Monitoring Program (HPMP)
- Take timely and appropriate disciplinary actions where there is evidence of professional misconduct by enforcing state and federal statutes governing the delivery of health care

Strategy
- Make information available regarding changes in laws and regulations that impact patient care and professional practice

Goal Three: Cultivate and provide information to healthcare practitioners and the public

Objectives
- Collect and analyze data pertaining to licensure, regulation, and the disciplinary processes of the 13 health regulatory boards, as well as data regarding Agency programs
- Effectively communicate tolicensees and stakeholders through the Prescription Monitoring Program and Virginia AWARE
- Place information in the public domain for consumer use
Strategies

- Collect healthcare workforce data by DHP’s Healthcare Workforce Data Center through the regular survey of key workforce-related factors including demographics, education, practice and patient characteristics and future plans among the healthcare workforce upon licensure renewal
- Collect data on the use of the Prescription Monitoring Program (PMP) among licensees of health regulatory boards to serve as an early warning system for practitioners in the fight against prescription opioid and heroin abuse among their patients
- Provide to federal bodies statistical data regarding disciplinary action taken against licensees of health regulatory boards
- Provide timely information via the DHP, health regulatory boards, PMP, HPMP, VaAware, and HWDC websites
- Represent DHP at regional and national professional associations

Goal 4: Promote a competent healthcare workforce through the approval of quality education programs

Objectives

- Approve professional and practical nursing education programs preparing individuals for licensure
- Approve nurse aide and medication aide education programs
- Jointly administer with VDH and provide funds for the Mary Marshall Scholarship Fund
- Approve qualifying pharmacy technician training programs

Goal 5: Strengthen DHP’s internal systems, operations, and culture of preparedness to better meet the needs of licensees, the public and decision makers

Objectives

- Integrate technology with business processes to support an effective workflow and a reduction of errors and delays
- Maintain an effective Continuity of Operations Plan to safeguard personnel and assets so the agency can continue to function in the event of an emergency
- Streamline the licensure and renewal process for licensees of health regulatory boards
- Encourage a culture of learning
Strategies

- Utilize technology to promote operational efficiency
- Establish a digital library of training materials for board members and employees
- Provide avenues for gaining knowledge

Measures of Performance

Percent of initial licensure applications processed within 30 days of receipt of a completed application

This measure is derived from an electronic check-list tracking system built into the Department of Health Professions' licensure database and defined by date parameters. The calculation is based on the number of completed applications processed within 30 days of receipt divided by the total number of completed application received within that time frame.

Percent of patient care cases pending over one year

Each quarter, disciplinary case data is downloaded from the Department's MLo data system to determine the number of cases that have been open more than 250 days as a percentage of all patient care cases open.

The cost to issue a new registered nurse license

Each year the budget analyst calculates the cost to issue registered nurse licenses. This is determined by taking the percentage of the total Board of Nursing fiscal year budget used for licensing staff salaries, wages & fringe benefits, and multiply by the total fiscal year direct Board of Nursing expenditures. Then divide that number by the total number of initial registered nurse licenses issued in the fiscal year to determine the cost to issue a new Registered Nurse license.

The number of queries by prescribers to the Prescription Monitoring Program as a percent of prescriptions added

The Prescription Monitoring Program collects the number of queries for prescription history by prescribers and the number of prescriptions added by date. This measure is calculated by dividing the number of prescriber queries per quarter by the number of prescriptions added per quarter.
<table>
<thead>
<tr>
<th>Account Number</th>
<th>Account Description</th>
<th>Amount</th>
<th>Budget</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>5011110</td>
<td>Employer Retirement Contrib.</td>
<td>15,773.12</td>
<td>41,465.00</td>
<td>38.04%</td>
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<tr>
<td>5011120</td>
<td>Fed Old Age Ins - Sal St Emp</td>
<td>9,786.09</td>
<td>23,615.00</td>
<td>41.62%</td>
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<tr>
<td>5011130</td>
<td>Fed Old Age Ins - Wage Earners</td>
<td>892.75</td>
<td>3,094.00</td>
<td>28.85%</td>
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<tr>
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<td>Group Insurance</td>
<td>1,658.47</td>
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<tr>
<td>5011150</td>
<td>Medical/Hospitalization Ins.</td>
<td>3,841.50</td>
<td>25,896.00</td>
<td>14.83%</td>
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<tr>
<td>5011160</td>
<td>Retiree Medical/Hospitalization</td>
<td>1,491.62</td>
<td>3,628.00</td>
<td>41.11%</td>
</tr>
<tr>
<td>5011170</td>
<td>Long term Disability Ins</td>
<td>841.62</td>
<td>2,029.00</td>
<td>41.48%</td>
</tr>
</tbody>
</table>

Total Employee Benefits: 34,285.17 103,655.00 69,369.83 33.08%

5011200 Salaries

5011230 Salaries, Classified: 127,495.42 307,376.00 179,880.58 41.48%

5011250 Salaries, Overtime: 222.91

Total Salaries: 127,718.33 307,376.00 179,657.67 41.55%

5011300 Special Payments

5011380 Deferred Compnstrn Match Prnts: 650.00 1,920.00 1,270.00 33.85%

Total Special Payments: 650.00 1,920.00 1,270.00 33.85%

5011400 Wages

5011410 Wages, General: 11,670.00 82,042.00 70,372.00 14.22%

Total Wages: 11,670.00 82,042.00 70,372.00 14.22%

5011600 Terminatn Personal Svce Costs

5011660 Defined Contribution Match - Hy: 1,497.73

Total Terminatn Personal Svce Costs: 1,497.73

5011930 Turnover/Vacancy Benefits

Total Personal Services: 175,821.23 494,093.00 319,171.77 35.52%

5012000 Contractual Svcs

5012100 Communication Services

5012110 Express Services: - 50.00 50.00 0.00%

5012140 Postal Services: 264.16 500.00 235.84 52.83%

5012160 Telecommunications Svcs (VITA): 1,140.38 2,800.00 1,659.62 40.73%

5012170 Telecomm. Svcs (Non-State): 292.50

5012190 Inbound Freight Services: 3.96 20.00 16.04 19.80%

Total Communication Services: 1,701.00 3,370.00 1,659.00 50.47%

5012200 Employee Development Services

5012210 Organization Memberships: 26.00 200.00 174.00 13.00%

5012220 Publication Subscriptions: - 50.00 50.00 0.00%

5012240 Employee Training/Workshop/Conf: 747.50 3,500.00 2,752.50 21.36%

Total Employee Development Services: 773.50 3,750.00 2,976.50 20.63%

5012400 Mgmt and Informational Svcs

5012470 Legal Services: 357.80 1,200.00 842.20 29.82%

5012480 Media Services: - 200.00 200.00 0.00%

Total Mgmt and Informational Svcs: 357.80 1,400.00 1,042.20 25.56%

5012600 Support Services

5012630 Clerical Services: - 600.00 600.00 0.00%
Virginia Department of Health Professions  
Revenue and Expenditures Summary  
Department 30900 - Board of Health Professions  
For the Period Beginning July 1, 2016 and Ending December 31, 2016

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<tr>
<th>Account Number</th>
<th>Account Description</th>
<th>Amount</th>
<th>Budget</th>
<th>Under/Over</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>5012640</td>
<td>Food &amp; Dietary Services</td>
<td>239.80</td>
<td>750.00</td>
<td>510.20</td>
<td>31.97%</td>
</tr>
<tr>
<td>5012660</td>
<td>Manual Labor Services</td>
<td>-</td>
<td>50.00</td>
<td>50.00</td>
<td>0.00%</td>
</tr>
<tr>
<td>5012670</td>
<td>Production Services</td>
<td>150.00</td>
<td>20.00</td>
<td>(130.00)</td>
<td>75.00%</td>
</tr>
<tr>
<td>5012680</td>
<td>Skilled Services</td>
<td>10,067.50</td>
<td>94,993.00</td>
<td>84,025.50</td>
<td>11.55%</td>
</tr>
<tr>
<td></td>
<td>Total Support Services</td>
<td>11,357.30</td>
<td>96,413.00</td>
<td>85,055.70</td>
<td>11.78%</td>
</tr>
<tr>
<td>5012700</td>
<td>Technical Services</td>
<td>2,375.22</td>
<td>-</td>
<td>(2,375.22)</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>Total Technical Services</td>
<td>2,375.22</td>
<td>-</td>
<td>(2,375.22)</td>
<td>0.00%</td>
</tr>
<tr>
<td>5012800</td>
<td>Transportation Services</td>
<td>2,221.27</td>
<td>3,845.00</td>
<td>1,623.73</td>
<td>57.77%</td>
</tr>
<tr>
<td>5012820</td>
<td>Travel, Personal Vehicle</td>
<td>1,131.33</td>
<td>670.00</td>
<td>(461.33)</td>
<td>168.86%</td>
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<tr>
<td>5012830</td>
<td>Travel, Public Carriers</td>
<td>1,013.79</td>
<td>1,100.00</td>
<td>86.21</td>
<td>92.16%</td>
</tr>
<tr>
<td>5012850</td>
<td>Travel, Subsistence &amp; Lodging</td>
<td>371.75</td>
<td>550.00</td>
<td>178.25</td>
<td>67.59%</td>
</tr>
<tr>
<td>5012880</td>
<td>Trvl, Meal Reimb- Not Rprtble</td>
<td>4,738.14</td>
<td>6,165.00</td>
<td>1,426.86</td>
<td>76.86%</td>
</tr>
<tr>
<td></td>
<td>Total Transportation Services</td>
<td>21,302.96</td>
<td>111,098.00</td>
<td>89,795.04</td>
<td>19.17%</td>
</tr>
<tr>
<td>5013000</td>
<td>Supplies And Materials</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5013100</td>
<td>Administrative Supplies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5013120</td>
<td>Office Supplies</td>
<td>136.55</td>
<td>30.00</td>
<td>(106.55)</td>
<td>461.63%</td>
</tr>
<tr>
<td>5013130</td>
<td>Stationery and Forms</td>
<td>-</td>
<td>50.00</td>
<td>50.00</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>Total Administrative Supplies</td>
<td>136.55</td>
<td>80.00</td>
<td>(58.55)</td>
<td>173.19%</td>
</tr>
<tr>
<td>5013300</td>
<td>Manufacturing and Merch Supplies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5013350</td>
<td>Packaging &amp; Shipping Supplies</td>
<td>-</td>
<td>25.00</td>
<td>25.00</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>Total Manufacturing and Merch Supplies</td>
<td>-</td>
<td>25.00</td>
<td>25.00</td>
<td>0.00%</td>
</tr>
<tr>
<td>5013600</td>
<td>Residential Supplies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5013620</td>
<td>Food and Dietary Supplies</td>
<td>111.22</td>
<td>-</td>
<td>(111.22)</td>
<td>0.00%</td>
</tr>
<tr>
<td>5013630</td>
<td>Food Service Supplies</td>
<td>-</td>
<td>50.00</td>
<td>50.00</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>Total Residential Supplies</td>
<td>111.22</td>
<td>50.00</td>
<td>(61.22)</td>
<td>222.44%</td>
</tr>
<tr>
<td>5013700</td>
<td>Specific Use Supplies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5013740</td>
<td>Educational Supplies</td>
<td>-</td>
<td>50.00</td>
<td>50.00</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>Total Specific Use Supplies</td>
<td>-</td>
<td>50.00</td>
<td>50.00</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>Total Supplies And Materials</td>
<td>249.77</td>
<td>205.00</td>
<td>(44.77)</td>
<td>121.84%</td>
</tr>
<tr>
<td>5015000</td>
<td>Continuous Charges</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5015300</td>
<td>Operating Lease Payments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5015340</td>
<td>Equipment Rentals</td>
<td>220.40</td>
<td>900.00</td>
<td>679.60</td>
<td>24.49%</td>
</tr>
<tr>
<td>5015350</td>
<td>Building Rentals</td>
<td>12.96</td>
<td>-</td>
<td>(12.96)</td>
<td>0.00%</td>
</tr>
<tr>
<td>5015360</td>
<td>Land Rentals</td>
<td>-</td>
<td>40.00</td>
<td>40.00</td>
<td>0.00%</td>
</tr>
<tr>
<td>5015390</td>
<td>Building Rentals - Non State</td>
<td>11,761.23</td>
<td>22,630.00</td>
<td>10,848.77</td>
<td>52.06%</td>
</tr>
<tr>
<td></td>
<td>Total Operating Lease Payments</td>
<td>12,014.59</td>
<td>23,570.00</td>
<td>11,555.41</td>
<td>50.97%</td>
</tr>
<tr>
<td></td>
<td>Total Continuous Charges</td>
<td>12,014.59</td>
<td>23,570.00</td>
<td>11,555.41</td>
<td>50.97%</td>
</tr>
<tr>
<td>5022000</td>
<td>Equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5022100</td>
<td>Computer Hardware &amp; Software</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Page 2 of 3
Virginia Department of Health Professions  
Revenue and Expenditures Summary  
Department 30900 - Board of Health Professions  
For the Period Beginning July 1, 2016 and Ending December 31, 2016

<table>
<thead>
<tr>
<th>Account Number</th>
<th>Account Description</th>
<th>Amount</th>
<th>Budget</th>
<th>Under/(Over)</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>5022180</td>
<td>Computer Software Purchases</td>
<td>8,976.00</td>
<td>-</td>
<td>(8,976.00)</td>
<td>0.00%</td>
</tr>
<tr>
<td>5022180</td>
<td>Total Computer Hrdware &amp; Sftware</td>
<td>8,976.00</td>
<td>-</td>
<td>(8,976.00)</td>
<td>0.00%</td>
</tr>
<tr>
<td>5022200</td>
<td>Educational &amp; Cultural Equip</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5022240</td>
<td>Reference Equipment</td>
<td>76.95</td>
<td>500.00</td>
<td>423.05</td>
<td>15.39%</td>
</tr>
<tr>
<td>5022240</td>
<td>Total Educational &amp; Cultural Equip</td>
<td>76.95</td>
<td>500.00</td>
<td>423.05</td>
<td>15.39%</td>
</tr>
<tr>
<td>5022300</td>
<td>Electnc &amp; Photographic Equip</td>
<td>-</td>
<td>108.00</td>
<td>108.00</td>
<td>0.00%</td>
</tr>
<tr>
<td>5022320</td>
<td>Photographic Equipment</td>
<td>-</td>
<td>100.00</td>
<td>100.00</td>
<td>0.00%</td>
</tr>
<tr>
<td>5022330</td>
<td>Voice &amp; Data Transmission Equip</td>
<td>-</td>
<td>208.00</td>
<td>208.00</td>
<td>0.00%</td>
</tr>
<tr>
<td>5022600</td>
<td>Office Equipment</td>
<td>-</td>
<td>30.00</td>
<td>30.00</td>
<td>0.00%</td>
</tr>
<tr>
<td>5022630</td>
<td>Office Incidentals</td>
<td>-</td>
<td>30.00</td>
<td>30.00</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>Total Office Equipment</td>
<td>-</td>
<td>30.00</td>
<td>30.00</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>Total Equipment</td>
<td>9,052.95</td>
<td>738.00</td>
<td>(8,314.95)</td>
<td>1226.69%</td>
</tr>
<tr>
<td></td>
<td>Total Expenditures</td>
<td>218,441.50</td>
<td>630,604.00</td>
<td>412,162.50</td>
<td>34.64%</td>
</tr>
</tbody>
</table>
Department of Health Professions
Healthcare Workforce Data Center

www.dhp.virginia.gov/hwdc/
Tumbler: www.yahwdc.tumblr.com
YouTube: https://www.youtube.com/watch?v=0ha5o8w8mXE

Data Products

Profession Reports (www.dhp.virginia.gov/hwdc/findings.htm)
The HWDC Profession Reports are the mainstay of the HWDC’s data products. They provide a
statewide look at the healthcare workforce on a profession-by-profession basis. Profession reports are
published following the end of the data collection period. Profession reports include HWDC CareForce
Indicators as well as more detailed information pertaining to the professions.

Virginia CareForce Snapshots (yahwdc.tumblr.com/VACareForceSnapshot)
The Virginia CareForce Snapshot is a compilation of the CareForce indicators for all professions,
statewide, in a given HWDC survey year. The Careforce Snapshot, updated annually in spring, provide
an interactive guide to compare CareForce Indicators across professions.

Regional CareForce Snapshot (yahwdc.tumblr.com/RegionalCareforce)
Produced in collaboration with the Virginia Healthcare Workforce Development Authority, (VHWDA)
our Regional CareForce Products provide an interactive guide to the CareForce in each of Virginia’s eight
AHEC regions. Regional Reports are updated each spring.

Trends in Healthcare Workforce Full Time Equivalency (FTE) Units
(http://yahwdc.tumblr.com/Full%20Time%20Equivalency)
Starting in June 2016, the Trends in Healthcare Workforce Full Time Equivalency (FTE) Units feature
enables FTE trend comparisons of the original surveyed professions from 2012 to 2015. It also compares
2015 results for 20 professions by county, as well as AHEC, Council on Virginia’s Future, Workforce
Investment Area, and Health Planning Districts.

Student Choice (yahwdc.tumblr.com/StudentChoice)
Our interactive Student Choice page uses HWDC data and data from the Bureau of Labor Statistics
to help students begin thinking about health careers and education. This tool highlights the
interoperability of HWDC data and how it can be used in analysis and decision making.

Virginia Health Workforce Briefs (www.dhp.virginia.gov/hwdc/briefs.htm)
The Healthcare Workforce Data Center’s Virginia Healthcare Workforce Briefs provide timely
indicators of the strength of Virginia’s healthcare labor market in an accessible format. Information in these briefs is based on data provided by the US Department of Labor, Bureau of Labor Statistics and the US Department of Commerce, Bureau of Economic
Analysis. The briefs consist of three series:
  • Series 1: State & National Employment (Monthly)
  • Series 2: Virginia Regional & Sectoral Employment (Monthly)
  • Series 3: Income & Compensation (Quarterly)

February 2017
# Workforce Survey Reports - Release Dates
- Department of Health Professions -
Healthcare Workforce Data Center

<table>
<thead>
<tr>
<th>Year</th>
<th>Month</th>
<th>Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>January</td>
<td></td>
</tr>
<tr>
<td></td>
<td>February</td>
<td></td>
</tr>
<tr>
<td></td>
<td>March</td>
<td>~Assisted Living Facility Administrator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Dentist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Dental Hygienist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Funeral Home Providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Nursing Home Administrator</td>
</tr>
<tr>
<td></td>
<td>April</td>
<td></td>
</tr>
<tr>
<td></td>
<td>May</td>
<td></td>
</tr>
<tr>
<td></td>
<td>June</td>
<td>~Licensed Clinical Psychologist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Licensed Clinical Social Worker</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Licensed Professional Counselor</td>
</tr>
<tr>
<td></td>
<td>July</td>
<td></td>
</tr>
<tr>
<td></td>
<td>August</td>
<td></td>
</tr>
<tr>
<td></td>
<td>September</td>
<td></td>
</tr>
<tr>
<td></td>
<td>October</td>
<td>~Certified Nurse Aide (CNA)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Licensed Nurse Practitioner</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Licensed Practical Nurse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Registered Nurse</td>
</tr>
<tr>
<td></td>
<td>November</td>
<td>~Audiologist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Optometrist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Pharmacist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Pharmacy Technician</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Physician Assistant (odd years)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Radiologic Technician (odd years)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Respiratory Therapist (odd years)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Speech-Language Pathologist</td>
</tr>
<tr>
<td></td>
<td>December</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>January</td>
<td></td>
</tr>
<tr>
<td></td>
<td>February</td>
<td></td>
</tr>
<tr>
<td></td>
<td>March</td>
<td>~Assisted Living Facility Administrator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Dentist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Dental Hygienist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Funeral Home Providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Nursing Home Administrator</td>
</tr>
<tr>
<td></td>
<td>April</td>
<td></td>
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<tr>
<td></td>
<td>May</td>
<td></td>
</tr>
<tr>
<td></td>
<td>June</td>
<td>~Licensed Clinical Psychologist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Licensed Clinical Social Worker</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Licensed Professional Counselor</td>
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<tr>
<td></td>
<td>July</td>
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<td></td>
<td>August</td>
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<tr>
<td></td>
<td>September</td>
<td></td>
</tr>
<tr>
<td></td>
<td>October</td>
<td>~Certified Nurse Aide (CNA)</td>
</tr>
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<td>~Licensed Nurse Practitioner</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Licensed Practical Nurse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Registered Nurse</td>
</tr>
<tr>
<td></td>
<td>November</td>
<td>~Audiologist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Occupational Therapist (even years)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Occupational Therapist Assistant (even years)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Optometrist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Pharmacist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Pharmacy Technician</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Physical Therapist (even years)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Physical Therapist Assistant (even years)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Physician DO &amp; MD (even years)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>~Speech-Language Pathologist</td>
</tr>
</tbody>
</table>
The Virginia Longitudinal Data System is a powerful tool for Virginia's future, giving the Commonwealth an unprecedented and cost-effective tool for extracting and analyzing insightful education and workforce development data within a secure environment.
PMP Education Toolkit

Contents

Introduction
Benefits of the PMP
Article from the Program Director
PMP Testimonials
PMP Brochure
Program Video
Graphs & Trends
Prescriber Delegates
CDC Opioid Guidelines
Sample Press Clippings

Introduction

More people die from prescription drug abuse than from car accidents. That puts prescribers and pharmacists on the front lines of the nation’s fight to keep people safe from drug overdose and death. In Virginia, the Prescription Monitoring Program (PMP), a secure digital database and risk management tool for prescribers and pharmacists, centralizes the dispensing history of patients prescribed Schedule II – IV controlled substances.

Use the links in the table of contents of this PMP education toolkit to learn more about the mission of Virginia’s PMP to promote the appropriate use of controlled substances for legitimate medical purposes while deterring the misuse, abuse and diversion of controlled substances.

Find fast PMP facts on topics including—

- New developments such as work flow integration and delegation making it easier to use PMP
- Interoperability with other state Prescription Monitoring Programs
- Legislative updates

PMP’s regularly updated education toolkit also includes statistical data including charts and graphs, changes in regulation for registered users of the system, feature articles for patients and quotes for news organizations that are just a click away.

^Back to top^
Governor McAuliffe Announces Website to Help Combat Prescription Drug and Heroin Addiction in Virginia

~VaAware.com provides resources for prevention, treatment and recovery from opioid addiction~

RICHMOND – Governor Terry McAuliffe announced today the launch of www.VaAware.com (http://www.VaAware.com), a new website developed as an informational tool for Virginia’s fight against prescription drug and heroin abuse in Virginia. As a recommendation of the Governor’s Task Force on Prescription Drug and Heroin Abuse in Virginia, VaAware.com features specific pages for parents, health-care providers, law enforcement members and those seeking help with addiction. Virginia is actively working to combat this epidemic, as more than half of the recommendations made by the Governor’s opioid task force have already been or are currently being implemented.

“This website is an important tool to help those struggling with addiction and their family members find resources available in Virginia, and to provide a resource to health care and public safety professionals seeking the latest information in our efforts to end this epidemic,” said Governor McAuliffe. “Deaths from prescription drug overdoses doubled in Virginia over the past 15 years, while heroin-related deaths tripled from 2011 to 2015. We must all do our part to bring positive change to the lives of Virginians battling substance abuse, and I am proud of our state agencies for their teamwork and dedication to this important initiative.”

“As we continue to fight the epidemic of heroin and prescription opioid addiction, it is important to have a central web presence where people can find resources and information to get help for themselves or loved ones, and where health and law enforcement professionals can find guidance as well,” said Secretary of Health and Human Resources Dr. Bill Hazel. “It is hard enough to take the first step to find help, but by providing information online in an easily-accessible format, we can make it easier for people to take that step any hour of the day or night.”

“Our duty as public officials is to bring all the key stakeholders to the table and develop effective solutions,” said Secretary of Public Safety and Homeland Security Brian Moran. “This website will prove to be a useful tool for the law enforcement community as we collectively and
cohesively combat the heroin and prescription opioid epidemic."

The website is the result of collaboration between four Virginia agencies: the Department of Health Professions, the Virginia Department of Health, the Department of Criminal Justice Services, and the Department of Behavioral Health and Development Services. The site is hosted and maintained by the Department of Health Professions.

"We are happy to support this important resource as Virginia fights the opioid epidemic," said Department of Health Professions Director David Brown. "The website will also be useful for health professionals, with best practices, guidelines and continuing education links on pain management, addiction and proper prescribing of opioids."

Resources and informational materials found on the site are aimed at addressing the opioid and heroin crisis throughout the Commonwealth, and are available for download here (http://vaaware.com/learn/additionalresources/).

###

GOVERNOR TERRY MCAULIFFE

About The Governor (/about-the-governor/)
The Administration (/the-administration/)
Constituent Services (/constituent-services/)
Policy Priorities (/policy-priorities/)
Newsroom (/newsroom/)
Executive Actions (/executive-actions/)
Integrity Commission (/integrity-commission/)

AT YOUR SERVICE

ConnectVA (https://www.connectva.org)
Expenditures (http://datapoint.apa.virginia.gov/exp/exp_checkbook_agency.cfm?AGYCODE=121)
Cities & Counties (http://www.virginia.org/cities/towns/counties/related-links/)
Elected Officials (http://www.virginia.gov/government)
For Immediate Release: January 26, 2017
Contacts: Office of the Governor: Brian Coy, (804) 225-4260, Brian.Coy@governor.virginia.gov
Department of Health Professions, Diane Powers, 804-367-4524, Diane.Powers@dhp.virginia.gov

Governor McAuliffe Announces Grant to Help Doctors Identify Potential Opioid Abuse

~Prescription Monitoring Program receives $3 million grant from PurduePharma~

RICHMOND - Governor Terry McAuliffe today announced that the Prescription Monitoring Program has been awarded a grant to help integrate use of its data in doctors' and pharmacists' regular workflow. The $3.1 million grant from PurduePharma will allow the Department of Health Professions to connect the state PMP with electronic health records (EHR) used by Virginia doctors and pharmacies. This is an additional step in Virginia's fight against the epidemic of opioid addiction and overdose.

"The epidemic of opioid addiction is a public health emergency in Virginia, and combating it is a top priority for my administration," said Governor McAuliffe. "The Prescription Monitoring Program is a critical prevention tool that helps curb abuse of prescription medications, and I applaud this enhancement that makes the PMP easier and more likely for physicians to use."

The Virginia PMP allows physicians and pharmacists to check a patient's prescription history, through the PMP database, for certain prescriptions as reported by in-state and out-of-state pharmacies. Doctors and pharmacists already check the PMP database when prescribing or dispensing controlled substances both to enhance patient care and to help prevent "doctor shopping," abuse, or diversion of prescription medications.

Integrating the PMP with EHR - through "NarxCare" technology developed by Kentucky-based Appriss - will make the step of checking the PMP easier for prescribers and pharmacists by integrating the PMP query into the existing workflow. The goal is to improve the performance, access and usability of the PMP program data for 18,000 prescribers and 400 pharmacies in the Commonwealth of Virginia by the end of 2017. Appriss is the vendor the Department of Health Professionals uses to operate the PMP.

"The Prescription Monitoring Program is an important resource to help us track prescription data and spot potential abuse," said Virginia Secretary of Health and Human Resources Dr. Bill Hazel. "Integrating this data with electronic health records strengthens the PMP and is an important step in our ongoing battle against the epidemic of opioid abuse."
"This upgrade of Virginia's prescription drug monitoring program will allow health providers and pharmacists to more effectively flag at-risk patients and curb prescription drug abuse as we fight against our commonwealth's opioid abuse epidemic," said David Brown, Director of the Department of Health Professions.

"Purdue Pharma has supported prescription drug monitoring programs to help reduce the overprescribing of opioids for more than a decade, through funding, and by working with state governments, regulatory agencies and healthcare organizations," said Mark Timney, President and Chief Executive Officer, Purdue Pharma L.P. "We recognize the immediate need for technology innovations, such as this, to improve access to the PMP data through workflow integration."

###

GOVERNOR TERRY MCAULIFFE

About The Governor (/about-the-governor/)
The Administration (/the-administration/)
Constituent Services (/constituent-services/)
Policy Priorities (/policy-priorities/)
Newsroom (/newsroom/)
Executive Actions (/executive-actions/)
Integrity Commission (/integrity-commission/)

AT YOUR SERVICE

ConnectVA (https://www.connectva.org)
Expenditures (http://datapoint.apa.virginia.gov/exp/exp_checkbook_agency.cfm?AGYCODE=121)
Cities & Counties (http://www.virginia.org/citiescountiesrelatedlinks/)
Elected Officials (http://www.virginia.gov/government)

SITE RESOURCES

Website Feedback (https://governor.virginia.gov/email-the-webmaster/)
Background & Authority:

By virtue of its statutory authority in §54.1-2510 of the Code of Virginia to advise the Governor, the General Assembly, and the Department Director on matters related to the regulation and level of regulation of health care occupations and professions in the Commonwealth, the Virginia Board of Health Professions is conducting a review into the feasibility of state licensure for certified anesthesiologist assistants. This study is pursuant to the attached requests from Senator Stephen Newman and Delegate Robert Orrock dated November 16, 2016 and response from Dr. David Brown, Director of the Department of Health Professions dated November 29, 2016.

Scope & Methodology:

The purpose of this study is to evaluate the need to regulate anesthesia assistants in the Commonwealth of Virginia. The Board has adopted a formal evaluative criteria and methodology to guide all such reviews as set forth in its published Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions, 1998. (Guidance Document 75-2 accessible at http://www.dhp.virginia.gov/bhp/guidelines/75-2.doc). Referred to hereinafter as “the Criteria,” these policies and procedures provide a standard conceptual framework with proscribed questions and research methods that have been employed for over two decades to objectively inform key policy issues related to health professional regulation. This standard is in keeping with regulatory principles established in Virginia law and is accepted in the national community of regulators. The approach is designed to lead consideration of the least governmental restrictions possible that is consistent with the public’s protection. The Criteria address: (1) Risk of Harm to the Consumer, (2) Specialized Skills and Training, (3) Autonomous Practice, (4) Scope of Practice, (5) Economic Costs, (5) Alternatives to Regulation, and (6) Least Restrictive Regulation.

The Regulatory Research Committee (Committee) will prepare the report for consideration by the full Board and transmission to Senator Newman and Delegate Orrock through the Department Director.

The following steps are recommended for this review:

1. Conduct a comprehensive review of the pertinent policy and professional literature.
2. Review and summarize available relevant empirical data as may be available from pertinent research studies, malpractice insurance carriers, and other sources.

3. Review relevant federal and state laws, regulations and governmental policies.

4. Review other states’ relevant experiences with scope and practice.

5. Develop a report of research findings, to date, and solicit public comment on reports and other insights through hearing and written comment period.

6. Publish second draft of the report with summary of public comments.

7. Develop final report with recommendations, including proposed legislative language as deemed appropriate by the Committee.

8. Present final report and recommendations to the full Board for review and approval.

9. Forward to the Director and Secretary for review and comment.

10. Submit final report to Senator Newman and Delegate Orrock and post.

**Timetable and Resources:**

This study will be conducted with existing staff and within the budget for FY2017-18 and according to the following tentative timetable:

**DATES:**

- **02/23/2017**  
  Full Board Meeting - Draft workplan reviewed and project assigned to the Regulatory Research Committee

- **04/10/2017**  
  Committee Meeting - Review 1st draft report  
  Public Hearing and Written Comment Period

- **05/09/2017**  
  Committee Meeting - Review 2nd draft report

- June–July (TBD)  
  Committee Meeting (tentative only)

- **08/31/2017**  
  Committee Meeting – Final review and recommendations  
  Full Board Meeting – Committee report for Board consideration

- September (TBD)  
  Board Report to the Director and Secretary for review and comment

- **11/01/2017**  
  Final Report due to Delegate Orrock and Senator
November 16, 2016

David E. Brown, D.C., Director
Virginia Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

Dear Director Brown,

I am writing to request that the Department of Health Professions, with assistance from the Board of Medicine, undertake a study considering licensing a new class of anesthesia providers in the Commonwealth: Certified Anesthesiology Assistants (CAAs). As you know, there is a national shortage of anesthesia providers, including nurse anesthetists. Being able to employ a growing pool of CAAs would help address the present and future shortage of anesthesia providers. For this reason, I believe it would be prudent for the Department to study whether it would be beneficial to license CAAs in Virginia.

It is my understanding that seventeen jurisdictions as well as the District of Columbia currently allow CAAs to practice. Virginia is surrounded by other states that have already adopted the CAA approach (North Carolina, Washington, D.C., Kentucky and Ohio). Although some states have permitted CAAs to practice through delegatory authority, the Board of Medicine has advised that licensure would be required in Virginia.

CAAs work under the direction of licensed physician anesthesiologists to implement anesthesia care plans. CAAs work exclusively within the anesthesia care team environment and, unlike nurse anesthetists; they must be supervised by a physician anesthesiologist.

All CAAs possess a premedical background, a baccalaureate degree and also complete a comprehensive didactic and clinical program at the graduate school level. There are 10 accredited CAA educational programs in the U.S. There is interest in launching a CAA program in Virginia, as well.
There are nearly 2,000 CAAs already practicing throughout the nation. CAA students currently rotate through Virginia hospitals, but must go elsewhere to work when they finish training (i.e. there are currently 10 CAAs who are Virginia residents who have to travel to other states to work).

Because members of the Legislature are considering whether to introduce legislation on this topic, I kindly request that you let us know whether you are willing to undertake this study by December 15, 2016. If you do agree to undertake it, we would further request that you make the results of your study available no later than November 15, 2017.

With kind regards, I remain,

Sincerely yours,

[Signature]

Senator Stephen D. Newman

cc: William L. Harp, M.D., Executive Director of the Board of Medicine
November 16, 2016

David E. Brown, D.C., Director
Virginia Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

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Because members of the Legislature are considering whether to introduce legislation on this topic, I am requesting that you let me know by December 15, 2016 whether you are willing to undertake this study. If you agree to do it, I would also ask that you make the results of your study available no later than November 15, 2017.

Sincerely,

Delegate Robert D. Orrock

cc: William L. Harp, M.D., Executive Director, Board of Medicine
The Honorable Stephen D. Newman  
P. O. Box 480  
Forest, VA  24551

The Honorable Robert D. Orrock, Sr.  
P. O. Box 458  
Thornburg, Virginia 22565

Dear Senator Newman and Delegate Orrock,

We are in receipt of your letters requesting that the Department of Health Professions undertake a study of the feasibility of licensure for certified anesthesiology assistants (CAAs). As you may know, the Code of Virginia authorizes the Board of Health Professions to conduct such studies in § 54.1-2510:

§ 54.1-2510. Powers and duties of Board of Health Professions.

2. To evaluate all health care professions and occupations in the Commonwealth, including those regulated and those not regulated by other provisions of this title, to consider whether each such profession or occupation should be regulated and the degree of regulation to be imposed. Whenever the Board determines that the public interest requires that a health care profession or occupation which is not regulated by law should be regulated, the Board shall recommend to the General Assembly a regulatory system to establish the appropriate degree of regulation:

To fulfill its statutory duty, the Board has applied seven criteria to any study of the feasibility of regulating a new profession: its criteria are: 1) risk of harm to the consumer, 2) specialized skills and training, 3) autonomous practice, 4) scope of practice, 5) economic impact, 6) alternatives to regulation, and 7) least restrictive regulation. For further explanation and description of the criteria, the Board has published Guidance Document 75-2, which is available on its website at: http://www.dhp.virginia.gov/bhp/bhp_guidelines.htm. The President of the Board of Medicine is also a member of the Board of Health Professions.

The Board will assume responsibility for a feasibility study but will not have the opportunity to adopt a workplan and timeline for its completion until its next scheduled meeting.
which is February 23, 2017. As soon as the Dr. Elizabeth Carter, Executive Director of the Board and her research staff have reviewed the scope of the work, we will share a preliminary schedule for a report of the study results, which will be provided by November 15, 2017. We have also received a copy of a letter sent to you from the Virginia Association of Nurse Anesthetists; it will be provided to the Board along with your letter of request for the study.

We hope that this information is helpful and appreciate the opportunity to respond to your request. Please let us know if there is anything further we can do to assist your office either between or during the upcoming Session of the General Assembly.

Sincerely,

[Signature]

David E. Brown, D.C.

cc: The Honorable William A. Hazel, M.D.
    Elizabeth Carter, Ph.D.
November 22, 2016

The Honorable Steve Newman  
Virginia Senate  
P.O. Box 480  
Forest, VA 24551

The Honorable Bobby Orrock  
Virginia House of Delegates  
P.O. Box 458  
Thornburg, VA 22565

Dear Senator Newman and Delegate Orrock,

I am writing on behalf of the Virginia Association of Nurse Anesthetists regarding your possible request to the Department of Health Professions ("DHP") to undertake a study regarding the licensing of Certified Anesthesiology Assistants ("CAA") in Virginia.

VANA represents the more than 1200 certified registered nurse anesthetists ("CRNA") who are licensed in Virginia and who serve as the primary providers of anesthesia care services in Virginia’s rural surgical facilities.

As the numbers of people needing critical anesthesia care continues to grow in Virginia, it is important that we ensure a robust pipeline of anesthesia providers to meet current and future anesthesia needs. As such, we support the request for a CAA feasibility study, provided the study is comprehensive and provides clear guidance on whether the licensing of a third anesthesia provider will provide greater access to anesthesia care in Virginia.

To this end, we would kindly ask that, in the event a request for a study moves forward, you would consider the following as part of the request:

1. That DHP consider whether an anesthesia provider shortage currently exists in Virginia and if so, whether there are any immediate steps that can be taken (in terms of CRNA or anesthesiologist practice) to mitigate the shortage.
2. That DHP consider whether the current and future numbers of CRNA and anesthesiologist students and graduates will meet the projected demand for anesthesia care services in the coming years.

3. That DHP include, as part of any licensing feasibility study, an assessment of the anesthesia delivery costs of CRNAs, anesthesiologist and CAAs.

4. That, given the limited number of clinical sites currently available to health care provider students and new graduates, DHP consider the impact a third anesthesia provider may have on site availability and how this will impact the ability of Virginia’s CRNA and anesthesiologist students and new graduates to obtain required clinical experience.

5. The impact, if any, a third anesthesia provider may have on current anesthesia jobs in Virginia.

6. The impact, if any, the licensing of a third anesthesia provider will have in terms of access to anesthesia care, particularly in Virginia’s rural regions.

7. That the Virginia Board of Nursing, which licenses CRNAs, assist in the study.

We applaud your interest in ensuring Virginia’s citizens have access to anesthesia care and we appreciate your consideration of this request.

Sincerely,

[Signature]
Peter Deforest
President
Virginia Association of Nurse Anesthetists

✓cc: Dr. David Brown, Director, Department of Health Professions
     Jay Douglas, Executive Director, Board of Nursing
     Dr. William Harp, Executive Director, Board of Medicine
     Michele Satterlund, McGuireWoods Consulting
Sanction Reference Point Program

Background

In the spring of 2001, the Virginia Department of Health Professions approved a workplan to study sanctioning disciplinary cases for Virginia’s 13 health regulatory boards. The purpose of the study was to “... provide an empirical, systematic analysis of board sanctions for offenses and based on this analysis, to derive reference points for board members...” The purposes and goals of the study were consistent with state statutes which specify that the Board of Health Professions (BHP) periodically review the investigatory and disciplinary processes to ensure the protection of the public and fair and equitable treatment of health professionals.

After interviewing members and staff of respective boards, a committee of board members, staff and research consultants assembled a research agenda involving the most exhaustive statistical study of sanctioned professionals ever conducted in the United States. The analysis included collecting over 100 factors on all respective boards sanctioned cases over four to six year periods. The factors measured case seriousness, respondent characteristics, and prior disciplinary history. After identifying the factors that were consistently associated with sanctioning, it was decided that the results provided a solid foundation for the creation of sanctioning reference points (SRPs). Using both the data and collective input from the respective boards, analysts developed a usable set of sanction worksheets as a way to implement the reference system. Because the laws, regulations, and disciplinary histories of the respective boards are different, respective boards were analyzed separately to produce respective worksheets and manuals.

The Board of Medicine launched the first SRP system in 2004, and by 2010, all 13 boards had SRP systems in place. SRPs are based upon ongoing empirical analyses that guide boards to maintain or adjust their systems to reflect current circumstances.

Neal Kauder’s presentation will provide an overview of the program and latest findings.
PSYPACT Advancing the Interjurisdictional Practice of Psychology

Created by the Association of State and Provincial Psychology Boards (ASPPB), the Psychology Interjurisdictional Compact (PSYPACT) is an interstate compact that facilitates the practice of psychology using telecommunications technologies (telepsychology) and/or temporary in-person, face-to-face psychological practice.

About PSYPACT

- **PSYPACT** is a cooperative agreement enacted into law by participating states
- Addresses increased demand to provide/receive psychological services via electronic means (telepsychology)
- Authorizes both telepsychology and temporary in-person, face-to-face practice of psychology across state lines in PSYPACT states
- PSYPACT states have the ability to regulate telepsychology and temporary in-person, face-to-face practice

How PSYPACT Works

- PSYPACT becomes operational when seven states enact PSYPACT into law
- Psychologists who wish to practice under PSYPACT obtain:
  - E-Passport Certificate for telepsychology
  - Interjurisdictional Practice Certificate (IPC) for temporary in-person, face-to-face practice
- PSYPACT states communicate and exchange information including verification of licensure and disciplinary sanctions

Benefits of PSYPACT

- Increases client/patient access to care
- Facilitates continuity of care when client/patient relocates, travels, etc.
- Certifies that psychologists have met acceptable standards of practice
- Promotes cooperation between PSYPACT states in the areas of licensure and regulation
- Offers a higher degree of consumer protection across state lines

How PSYPACT Impacts Psychologists

- Allows licensed psychologists to practice telepsychology and/or conduct temporary in-person, face-to-face practice across state lines without having to become licensed in additional PSYPACT states
- Permits psychologists to provide services to populations currently underserved or geographically isolated
- Standardizes time allowances for temporary practice regulations in PSYPACT states

EMAIL: info@psypact.org  WEBSITE: www.psypact.org  SOCIAL: @PSYPACT
ARTICLE I
PURPOSE

Whereas, states license psychologists, in order to protect the public through verification of education, training and experience and ensure accountability for professional practice; and

Whereas, this Compact is intended to regulate the day-to-day practice of telepsychology (i.e., the provision of psychological services using telecommunication technologies) by psychologists across state boundaries in the performance of their psychological practice as assigned by an appropriate authority; and

Whereas, this Compact is intended to regulate temporary in-person, face-to-face practice of psychology by psychologists across state boundaries for 30 days within a calendar year in the performance of their psychological practice as assigned by an appropriate authority;

Whereas, this Compact is intended to authorize State Psychology Regulatory Authorities to afford legal recognition, in a manner consistent with the terms of the Compact, to psychologists licensed in another state;

Whereas, this Compact recognizes that states have a vested interest in protecting the public's health and safety through their licensing and regulation of psychologists and that such state regulation will best protect public health and safety;

Whereas, this Compact does not apply when a psychologist is licensed in both the Home and Receiving States; and

Whereas, this Compact does not apply to temporary in-person, face-to-face practice, it does allow for authorization of temporary psychological practice.

Consistent with these principles, this Compact is designed to achieve the following purposes and objectives:

1. Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services into a state which the psychologist is not licensed to practice psychology;

2. Enhance the states' ability to protect the public's health and safety, especially client/patient safety;

3. Encourage the cooperation of Compact States in the areas of psychology licensure and regulation;

4. Facilitate the exchange of information between Compact States regarding psychologist licensure, adverse actions, and disciplinary history;

5. Promote compliance with the laws governing psychological practice in each Compact State; and

6. Invest all Compact States with the authority to hold licensed psychologists accountable through the mutual recognition of Compact State licenses.
ARTICLE II
DEFINITIONS

A. "Adverse Action" means: Any action taken by a State Psychology Regulatory Authority which finds a violation of a statute or regulation that is identified by the State Psychology Regulatory Authority as discipline and is a matter of public record.

B. "Association of State and Provincial Psychology Boards (ASPPB)" means: the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities responsible for the licensure and registration of psychologists throughout the United States and Canada.

C. "Authority to Practice Interjurisdictional Telepsychology" means: a licensed psychologist's authority to practice telepsychology, within the limits authorized under this Compact, in another Compact State.

D. "Bylaws" means: those Bylaws established by the Psychology Interjurisdictional Compact Commission pursuant to Section X for its governance, or for directing and controlling its actions and conduct.

E. "Client/Patient" means: the recipient of psychological services, whether psychological services are delivered in the context of healthcare, corporate, supervision, and/or consulting services.

F. "Commissioner" means: the voting representative appointed by each State Psychology Regulatory Authority pursuant to Section X.

G. "Compact State" means: a state, the District of Columbia, or United States territory that has enacted this Compact legislation and which has not withdrawn pursuant to Article XIII, Section C or been terminated pursuant to Article XII, Section B.

H. "Coordinated Licensure Information System" also referred to as "Coordinated Database" means: an integrated process for collecting, storing, and sharing information on psychologists' licensure and enforcement activities related to psychology licensure laws, which is administered by the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

I. "Confidentiality" means: the principle that data or information is not made available or disclosed to unauthorized persons and/or processes.

J. "Day" means: any part of a day in which psychological work is performed.

K. "Distant State" means: the Compact State where a psychologist is physically present (not through the use of telecommunications technologies), to provide temporary in-person, face-to-face psychological services.

L. "EPassport" means: a certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.

M. "Executive Board" means: a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

N. "Home State" means: a Compact State where a psychologist is licensed to practice psychology. If the psychologist is licensed in more than one Compact State and is practicing under the Authorization to Practice Interjurisdictional Telepsychology, the Home State is the Compact State where the psychologist is physically present when the telepsychological services are delivered. If the psychologist is licensed in more than one Compact State and is practicing under the Temporary Authorization to Practice, the Home State is any Compact State where the psychologist is licensed.

O. "Identity History Summary" means: a summary of information retained by the FBI, or other designee with similar authority, in connection with arrests and, in some instances, federal employment, naturalization, or military service.
P. "In-Person, Face-to-Face" means: interactions in which the psychologist and the client/patient are in the same physical space and which does not include interactions that may occur through the use of telecommunication technologies.

Q. "Interjurisdictional Practice Certificate (IPC)" means: a certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that grants temporary authority to practice based on notification to the State Psychology Regulatory Authority of intention to practice temporarily, and verification of one's qualifications for such practice.

R. "License" means: authorization by a State Psychology Regulatory Authority to engage in the independent practice of psychology, which would be unlawful without the authorization.

S. "Non-Compact State" means: any State which is not at the time a Compact State.

T. "Psychologist" means: an individual licensed for the independent practice of psychology.

U. "Psychology Interjurisdictional Compact Commission" also referred to as "Commission" means: the national administration of which all Compact States are members.

V. "Receiving State" means: a Compact State where the client/patient is physically located when the telepsychological services are delivered.

W. "Rule" means: a written statement by the Psychology Interjurisdictional Compact Commission promulgated pursuant to Section XI of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Commission and has the force and effect of statutory law in a Compact State, and includes the amendment, repeal or suspension of an existing rule.

X. "Significant Investigatory Information" means:

1. investigative information that a State Psychology Regulatory Authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proven true, would indicate more than a violation of state statute or ethics code that would be considered more substantial than minor infraction, or

2. investigative information that indicates that the psychologist represents an immediate threat to public health and safety regardless of whether the psychologist has been notified and/or had an opportunity to respond.

Y. "State" means: a state, commonwealth, territory, or possession of the United States, the District of Columbia.

Z. "State Psychology Regulatory Authority" means: the Board, office or other agency with the legislative mandate to license and regulate the practice of psychology.

AA. "Telepsychology" means: the provision of psychological services using telecommunication technologies.

BB. "Temporary Authorization to Practice" means: a licensed psychologist's authority to conduct temporary in-person, face-to-face practice, within the limits authorized under this Compact, in another Compact State.

CC. "Temporary In-Person, Face-to-Face Practice" means: where a psychologist is physically present (not through the use of telecommunications technologies), in the Distant State to provide for the practice of psychology for 30 days within a calendar year and based on notification to the Distant State.
ARTICLE III

HOME STATE LICENSURE

A. The Home State shall be a Compact State where a psychologist is licensed to practice psychology.

B. A psychologist may hold one or more Compact State licenses at a time. If the psychologist is licensed in more than one Compact State, the Home State is the Compact State where the psychologist is physically present when the services are delivered as authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

C. Any Compact State may require a psychologist not previously licensed in a Compact State to obtain and retain a license to be authorized to practice in the Compact State under circumstances not authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

D. Any Compact State may require a psychologist to obtain and retain a license to be authorized to practice in a Compact State under circumstances not authorized by Temporary Authorization to Practice under the terms of this Compact.

E. A Home State's license authorizes a psychologist to practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only if the Compact State:
   1. Currently requires the psychologist to hold an active IPC;
   2. Has a mechanism in place for receiving and investigating complaints about licensed individuals;
   3. Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;
   4. Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation FBI, or other designee with similar authority, no later than ten years after activation of the Compact.

F. A Home State's license grants Temporary Authorization to Practice to a psychologist in a Distant State only if the Compact State:
   1. Currently requires the psychologist to hold an active IPC;
   2. Has a mechanism in place for receiving and investigating complaints about licensed individuals;
   3. Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;
   4. Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation FBI, or other designee with similar authority, no later than ten years after activation of the Compact.

5. Complies with the Bylaws and Rules of the Commission.
ARTICLE IV

COMPACT PRIVILEGE TO PRACTICE TELPSYCHOLOGY

A. Compact States shall recognize the right of a psychologist, licensed in a Compact State in conformance with Article III, to practice telepsychology in other Compact States (Receiving States) in which the psychologist is not licensed, under the Authority to Practice Interjurisdictional Telepsychology as provided in the Compact.

B. To exercise the Authority to Practice Interjurisdictional Telepsychology under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

1. Hold a graduate degree in psychology from an institution of higher education that was, at the time the degree was awarded:
   a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, OR authorized by Provincial Statute or Royal Charter to grant doctoral degrees; OR
   b. A foreign college or university deemed to be equivalent to 1 (a) above by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; AND

2. Hold a graduate degree in psychology that meets the following criteria:
   a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;
   b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;
   c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;
   d. The program must consist of an integrated, organized sequence of study;
   e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;
   f. The designated director of the program must be a psychologist and a member of the core faculty;
   g. The program must have an identifiable body of students who are matriculated in that program for a degree;
   h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;
   i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degree and a minimum of one academic year of full-time graduate study for master’s degree;
   j. The program includes an acceptable residency as defined by the Rules of the Commission.

3. Possess a current, full and unrestricted license to practice psychology in a Home State which is a Compact State;

4. Have no history of adverse action that violate the Rules of the Commission;

5. Have no criminal record history reported on an Identity History Summary that violates the Rules of the Commission;

6. Possess a current, active E.Passport;

7. Provide attestations in regard to areas of intended practice, conformity with standards of practice, competence in telepsychology technology, criminal background, and knowledge and adherence to legal requirements in the home and receiving states, and provide a release of information to allow for primary source verification in a manner specified by the Commission; and
8. Meet other criteria as defined by the Rules of the Commission.

C. The Home State maintains authority over the license of any psychologist practicing in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology.

D. A psychologist practicing in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology will be subject to the Receiving State's scope of practice. A Receiving State may, in accordance with that state's due process law, limit or revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology in the Receiving State and may take any other necessary actions under the Receiving State's applicable law to protect the health and safety of the Receiving State's citizens. If a Receiving State takes action, the state shall promptly notify the Home State and the Commission.

E. If a psychologist's license in any Home State, another Compact State, or any Authority to Practice Interjurisdictional Telepsychology in any Receiving State, is restricted, suspended or otherwise limited, the E.Passport shall be revoked and therefore the psychologist shall not be eligible to practice telepsychology in a Compact State under the Authority to Practice Interjurisdictional Telepsychology.

ARTICLE V

COMPACT TEMPORARY AUTHORIZATION TO PRACTICE

A. Compact States shall also recognize the right of a psychologist, licensed in a Compact State in conformance with Article III, to practice temporarily in other Compact States (Distant States) in which the psychologist is not licensed, as provided in the Compact.

B. To exercise the Temporary Authorization to Practice under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

1. Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

   a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, OR authorized by Provincial Statute or Royal Charter to grant doctoral degrees; OR

   b. A foreign college or university deemed to be equivalent to 1 (a) above by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; AND

2. Hold a graduate degree in psychology that meets the following criteria:

   a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

   b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

   c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines.
d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master’s degree;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

3. Possess a current, full and unrestricted license to practice psychology in a Home State which is a Compact State;

4. No history of adverse action that violates the Rules of the Commission;

5. No criminal record history that violates the Rules of the Commission;

6. Possess a current, active IPC;

7. Provide attestations in regard to areas of intended practice and work experience and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

8. Meet other criteria as defined by the Rules of the Commission.

C. A psychologist practicing into a Distant State under the Temporary Authorization to Practice shall practice within the scope of practice authorized by the Distant State.

D. A psychologist practicing into a Distant State under the Temporary Authorization to Practice will be subject to the Distant State's authority and law. A Distant State may, in accordance with that state's due process law, limit or revoke a psychologist's Temporary Authorization to Practice in the Distant State and may take any other necessary actions under the Distant State's applicable law to protect the health and safety of the Distant State's citizens. If a Distant State takes action, the state shall promptly notify the Home State and the Commission.

E. If a psychologist's license in any Home State, another Compact State, or any Temporary Authorization to Practice in any Distant State, is restricted, suspended or otherwise limited, the IPC shall be revoked and therefore the psychologist shall not be eligible to practice in a Compact State under the Temporary Authorization to Practice.
ARTICLE VI
CONDITIONS OF TELEPSYCHOLOGY PRACTICE IN A RECEIVING STATE

A. A psychologist may practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only in the performance of the scope of practice for psychology as assigned by an appropriate State Psychology Regulatory Authority, as defined in the Rules of the Commission, and under the following circumstances:

1. The psychologist initiates a client/patient contact in a Home State via telecommunications technologies with a client/patient in a Receiving State;

2. Other conditions regarding telepsychology as determined by Rules promulgated by the Commission.

ARTICLE VII
ADVERSE ACTIONS

A. A Home State shall have the power to impose adverse action against a psychologist’s license issued by the Home State. A Distant State shall have the power to take adverse action on a psychologist’s Temporary Authorization to Practice within that Distant State.

B. A Receiving State may take adverse action on a psychologist’s Authority to Practice Interjurisdictional Telepsychology within that Receiving State. A Home State may take adverse action against a psychologist based on an adverse action taken by a Distant State regarding temporary in-person, face-to-face practice.

C. If a Home State takes adverse action against a psychologist’s license, that psychologist’s Authority to Practice Interjurisdictional Telepsychology is terminated and the E.PASSport is revoked. Furthermore, that psychologist’s Temporary Authorization to Practice is terminated and the IPC is revoked.

1. All Home State disciplinary orders which impose adverse action shall be reported to the Commission in accordance with the Rules promulgated by the Commission. A Compact State shall report adverse actions in accordance with the Rules of the Commission.

2. In the event discipline is reported on a psychologist, the psychologist will not be eligible for telepsychology or temporary in-person, face-to-face practice in accordance with the Rules of the Commission.

3. Other actions may be imposed as determined by the Rules promulgated by the Commission.

D. A Home State’s Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee which occurred in a Receiving State as it would if such conduct had occurred by a licensee within the Home State. In such cases, the Home State’s law shall control in determining any adverse action against a psychologist’s license.
E. A Distant State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a psychologist practicing under Temporary Authorization Practice which occurred in that Distant State as it would if such conduct had occurred by a licensee within the Home State. In such cases, Distant State's law shall control in determining any adverse action against a psychologist's Temporary Authorization to Practice.

F. Nothing in this Compact shall override a Compact State's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain non-public if required by the Compact State's law. Compact States must require psychologists who enter any alternative programs to not provide telepsychology services under the Authority to Practice Interjurisdictional Telepsychology or provide temporary psychological services under the Temporary Authorization to Practice in any other Compact State during the term of the alternative program.

G. No other judicial or administrative remedies shall be available to a psychologist in the event a Compact State imposes an adverse action pursuant to subsection C, above.
disciplinary matters. The Commission may create additional rules for mandated or discretionary sharing of information by Compact States.

ARTICLE IX

COORDINATED LICENSURE INFORMATION SYSTEM

A. The Commission shall provide for the development and maintenance of a Coordinated Licensure Information System (Coordinated Database) and reporting system containing licensure and disciplinary action information on all psychologists individually to whom this Compact is applicable in all Compact States as defined by the Rules of the Commission.

B. Notwithstanding any other provision of state law to the contrary, a Compact State shall submit a uniform data set to the Coordinated Database on all licensees as required by the Rules of the Commission, including:

1. Identifying information;

2. Licensure data;

3. Significant investigative information;

4. Adverse actions against a psychologist’s license;

5. An indicator that a psychologist’s Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice is revoked;

6. Non-confidential information related to alternative program participation information;

7. Any denial of application for licensure, and the reasons for such denial, and

8. Other information which may facilitate the administration of this Compact, as determined by the Rules of the Commission.

C. The Coordinated Database administrator shall promptly notify all Compact States of any adverse action taken against, or significant investigative information on, any licensee in a Compact State.
D. Compact States reporting information to the Coordinated Database may designate
information that may not be shared with the public without the express permission of the
Compact State reporting the information.

E. Any information submitted to the Coordinated Database that is subsequently required to be
expunged by the law of the Compact State reporting the information shall be removed from
the Coordinated Database.

ARTICLE X

ESTABLISHMENT OF THE PSYCHOLOGY INTERJURISDICTIONAL COMPACT
COMMISSION

A. The Compact States hereby create and establish a joint public agency known as the
Psychology Interjurisdictional Compact Commission.

1. The Commission is a body politic and an instrumentality of the Compact States.

2. Venue in proper and judicial proceedings by or against the Commission shall be
brought solely and exclusively in a court of competent jurisdiction where the
principal office of the Commission is located. The Commission may waive venue and
jurisdictional defenses to the extent it adopts or consents to participate in alternative
dispute resolution proceedings.

3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

B. Membership, Voting, and Meetings

1. The Commission shall consist of one voting representative appointed by each
Compact State who shall serve as that state’s Commissioner. The State Psychology
Regulatory Authority shall appoint its delegate. This delegate shall be empowered to
act on behalf of the Compact State. This delegate shall be limited to:

a. Executive Director, Executive Secretary or similar executive;

b. Current member of the State Psychology Regulatory Authority of a Compact State;

OR

c. Designee empowered with the appropriate delegate authority to act on behalf of the
Compact State.

2. Any Commissioner may be removed or suspended from office as provided by the law
of the state from which the Commissioner is appointed. Any vacancy occurring in
the Commission shall be filled in accordance with the laws of the Compact State in which the vacancy exists.

3. Each Commissioner shall be entitled to one (1) vote with regard to the promulgation of Rules and creation of Bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A Commissioner shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Commissioners' participation in meetings by telephone or other means of communication.

4. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

5. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Article XI.

6. The Commission may convene in a closed, non-public meeting if the Commission must discuss:
   a. Non-compliance of a Compact State with its obligations under the Compact;
   b. The employment, compensation, discipline or other personnel matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;
   c. Current, threatened, or reasonably anticipated litigation against the Commission;
   d. Negotiation of contracts for the purchase or sale of goods, services or real estate;
   e. Accusation against any person of a crime or formally censoring any person;
   f. Disclosure of trade secrets or commercial or financial information which is privileged or confidential;
   g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
   h. Disclosure of investigatory records compiled for law enforcement purposes;
   i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the Compact;
   j. Matters specifically exempted from disclosure by federal and state statute.

7. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes which fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, of any person participating in the meeting, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

C. The Commission shall, by a majority vote of the Commissioners, prescribe Bylaws and/or Rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the Compact, including but not limited to:

1. Establishing the fiscal year of the Commission;

2. Providing reasonable standards and procedures:
   a. for the establishment and meetings of other committees; and
   b. governing any general or specific delegation of any authority or function of the Commission;

3. Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an
opportunity for attendance of such meetings by interested parties, with enumerated
excitement to present the public's interest, the privacy of individuals of such
proceedings, and proprietary information, including trade secrets. The Commission
may meet in close sessions only after a majority of the Commissioners vote to close a
meeting to the public in whole or in part. As soon as practicable, the Commission
must make public a copy of the vote to close the meeting revealing the vote of each
Commissioner, with no proxy votes allowed.

4. Establishing the titles, duties and authority and reasonable procedures for the election
   of the officers of the Commission;

5. Providing reasonable standards and procedures for the establishment of the personnel
   policies and programs of the Commission. Notwithstanding any civil service or other
   similar law of any Compact State, the Bylaws shall exclusively govern the personnel
   policies and programs of the Commission;

6. Promulgating a Code of Ethics to address permissible and prohibited activities of
   Commission members and employees;

7. Providing a mechanism for concluding the operations of the Commission and the
   equitable disposition of any surplus funds that may exist after the termination of the
   Compact after the payment and/or reserving of all of its debts and obligations;

8. The Commission shall publish its Bylaws in a convenient form and file a copy thereof
   and a copy of any amendment thereto, with the appropriate agency or officer in each
   of the Compact States;

9. The Commission shall maintain its financial records in accordance with the Bylaws;

10. The Commission shall meet and take such actions as are consistent with the
    provisions of this Compact and the Bylaws.

D. The Commission shall have the following powers:

1. The authority to promulgate uniform rules to facilitate and coordinate implementation
   and administration of this Compact. The rules shall have the force and effect of law
   and shall be binding in all Compact States;

2. To bring and prosecute legal proceedings or actions in the name of the Commission,
   provided that the standing of any State Psychology Regulatory Authority or other
   regulatory body responsible for psychology licenses to sue or be sued under
   applicable law shall not be affected;

3. To purchase, acquire, and maintain insurance and bonds;

4. To borrow, accept or contract for services of personnel, including, but not limited to,
   employees of a Compact State;

5. To hire employees, elect or appoint officers, fix compensation, define duties, grant
   such individuals appropriate authority to carry out the purposes of the Compact,
   and to establish the Commission’s personnel policies and programs relating to conflicts
   of interest, qualifications of personnel, and other related personnel matters;

6. To accept any and all appropriate donations and grants of money, equipment,
   supplies, materials and services, and to receive, utilize and dispose of the same;
   provided that at all times the Commission shall strive to avoid any appearance of
   impropriety and/or conflict of interest;

7. To lease, purchase, accept appropriate gifts or donations of, or otherwise own,
   hold, improve or use, any property, real, personal or mixed, provided that at all times
   the Commission shall strive to avoid any appearance of impropriety;

8. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of
   any property real, personal or mixed;

9. To establish a budget and make expenditures;

10. To borrow money;
11. To appoint committees, including advisory committees comprised of Members, State regulators, State legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the Bylaws;

12. To provide and receive information from, and to cooperate with, law enforcement agencies;

13. To adopt and use an official seal; and

14. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of psychology licensure, temporary in-person, face-to-face practice and telepsychology practice.

E. The Executive Board

The elected officers shall serve as the Executive Board, which shall have the power to act on behalf of the Commission according to the terms of this Compact.

1. The Executive Board shall be comprised of six members:

   a. Five voting members who are elected from the current membership of the Commission by the Commission;

   b. One ex-officio, nonvoting member from the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

2. The ex-officio member must have served as staff or member on a State Psychology Regulatory Authority and will be selected by its respective organization.

3. The Commission may remove any member of the Executive Board as provided in Bylaws.

4. The Executive Board shall meet at least annually.

5. The Executive Board shall have the following duties and responsibilities:

F. Financing of the Commission

1. The Commission shall pay, or provide for the payment of the reasonable expenses of its establishment, organization and ongoing activities.

2. The Commission may accept any and all appropriate revenue sources, donations and grants of money, equipment, supplies, materials and services.

3. The Commission may levy on and collect an annual assessment from each Compact State or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission which shall promulgate a rule binding upon all Compact States.

4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the Compact States, except by and with the authority of the Compact State.
5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its Bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant and the report of the audit shall be included in and become part of the annual report of the Commission.

G. Qualified Immunity, Defense, and Indemnification

1. The members, officers, Executive Director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, Executive Director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, Executive Director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided that the actual or alleged act, error or omission did not result from the intentional or willful or wanton misconduct of that person.
ARTICLE XI
RULEMAKING

A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this Article and the Rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

B. If a majority of the legislatures of the Compact States rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, then such rule shall have no further force and effect in any Compact State.

C. Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

D. Prior to promulgation and adoption of a final rule or Rules by the Commission, and at least sixty (60) days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rulemaking:
   1. On the website of the Commission; and
   2. On the website of each Compact States' Psychology Regulatory Authority or the publication in which each state would otherwise publish proposed rules.

E. The Notice of Proposed Rulemaking shall include:
   1. The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;
   2. The text of the proposed rule or amendment and the reason for the proposed rule;
   3. A request for comments on the proposed rule from any interested persons; and
   4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

F. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions and arguments, which shall be made available to the public.

G. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:
   1. At least twenty-five (25) persons who submit comments independently of each other;
   2. A governmental subdivision or agency; or
   3. A duly appointed person in an association that has at least twenty-five (25) members.

H. If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing.
   1. All persons wishing to be heard at the hearing shall notify the Executive Director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five (5) business days before the scheduled date of the hearing.
   2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.
   3. No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not preclude the Commission from making a transcript or recording of the hearing if it so chooses.
   4. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.
I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

J. The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

K. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or Compact State funds;

3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule, or

4. Protect public health and safety.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule.
ARTICLE XII

OVERSIGHT, DISPUTE RESOLUTION AND ENFORCEMENT

A. Oversight

1. The Executive, Legislative and Judicial branches of state government in each Compact State shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

2. All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a Compact State pertaining to the subject matter of this Compact which may affect the powers, responsibilities or actions of the Commission.

3. The Commission shall be entitled to receive service of process in any such proceeding, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact or promulgated rules.

B. Default, Technical Assistance, and Termination

1. If the Commission determines that a Compact State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:
   a. Provide written notice to the defaulting state and other Compact States of the nature of the default, the proposed means of remedying the default and/or any other action to be taken by the Commission; and
   b. Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to remedy the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the Compact States, and all rights, privileges and benefits conferred by this Compact shall be terminated on the effective date of termination. A remedy of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

3. Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be submitted by the Commission to the Governor, the majority and minority leaders of the defaulting state's legislature, and each of the Compact States.

4. A Compact State which has been terminated is responsible for all assessments, obligations and liabilities incurred through the effective date of termination, including obligations which extend beyond the effective date of termination.

5. The Commission shall not bear any costs incurred by the state which is found to be in default or which has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the state of Georgia or the federal district where the Compact has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

C. Dispute Resolution

1. Upon request by a Compact State, the Commission shall attempt to resolve disputes related to the Compact which arise among Compact States and between Compact and Non-Compact States.
2. The Commission shall promulgate a rule providing for both mediation and binding
dispute resolution for disputes that arise before the commission.

D. Enforcement

1. The Commission, in the reasonable exercise of its discretion, shall enforce the
provisions and Rules of this Compact.

2. By majority vote, the Commission may initiate legal action in the United States
District Court for the State of Georgia or the federal district where the Compact has
its principal offices against a Compact State in default to enforce compliance with the
provisions of the Compact and its promulgated Rules and Bylaws. The relief sought
may include both injunctive relief and damages. In the event judicial enforcement is
necessary, the prevailing member shall be awarded all costs of such litigation,
including reasonable attorney’s fees.

3. The remedies herein shall not be the exclusive remedies of the Commission. The
Commission may pursue any other remedies available under federal or state law.

ARTICLE XIII

DATE OF IMPLEMENTATION OF THE PSYCHOLOGY INTERJURISDICTIONAL
COMPACT COMMISSION AND ASSOCIATED RULES, WITHDRAWAL, AND
AMENDMENTS

A. The Compact shall come into effect on the date on which the Compact is enacted into law
in the seventh Compact State. The provisions which become effective at that time shall
be limited to the powers granted to the Commission relating to assembly and the
promulgation of rules. Thereafter, the Commission shall meet and exercise rulemaking
powers necessary to the implementation and administration of the Compact.

B. Any state which joins the Compact subsequent to the Commission’s initial adoption of
the rules shall be subject to the rules as they exist on the date on which the Compact
becomes law in that state. Any rule which has been previously adopted by the
Commission shall have the full force and effect of law on the day the Compact becomes
law in that state.

C. Any Compact State may withdraw from this Compact by enacting a statute repealing the
same.

1. A Compact State’s withdrawal shall not take effect until six (6) months after
enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing State’s
Psychology Regulatory Authority to comply with the investigative and adverse
action reporting requirements of this act prior to the effective date of withdrawal.

D. Nothing contained in this Compact shall be construed to invalidate or prevent any
psychology licensure agreement or other cooperative arrangement between a Compact
State and a Non-Compact State which does not conflict with the provisions of this
Compact.
E. This Compact may be amended by the Compact States. No amendment to this Compact shall become effective and binding upon any Compact State until it is enacted into the law of all Compact States.

ARTICLE XIV
CONSTRUCTION AND SEVERABILITY

This Compact shall be liberally construed so as to effectuate the purposes thereof. If this Compact shall be held contrary to the constitution of any state member thereto, the Compact shall remain in full force and effect as to the remaining Compact States.
Board Chair and Vice Chair Election

Nominations from the Floor for Board Chair

Nominations from the floor will be taken for each office just before the election for that office.

Board Chair will open nominations from the floor, "Nominations are now in order for the office of Board Chair/Vice Chair. Are there nominations for Board Chair/Vice Chair?" After each nomination, the chair repeats the name as having been nominated.

The process of making floor nominations is subject to the following rules:

- Recognition by the chair isn't required to make a nomination. A member may call out a nomination while remaining seated.
- It is not in order under any circumstances for a member to nominate more persons than there are seats available.
- A person can be nominated for more than one office and can even serve in more than one office, if elected.
- Nominations don't have to be seconded for endorsement.
- Nominations are taken for successive offices in the order they're listed in the bylaws.

Closing Nominations

Board Chair will ask if there are more nominations, if there are not, he/she will declare nominations closed.

Determining Who Wins

After nominations are closed, the voice vote is taken on each nominee in the order in which they were nominated. Elections are decided by majority vote. A position will not be filled until a candidate receives the majority number of votes required for election.
VIRGINIA BOARD OF HEALTH PROFESSIONS

BYLAWS

ARTICLE I. Name.

This body shall be known as the Virginia Board of Health Professions as set forth in the Code of Virginia Chapter 25, Title 54.1, Subtitle III, hereinafter referred to as the Board.

ARTICLE II. Powers and Duties.

The powers and duties of the Board (§54.1-2510 Code of Virginia) are:

1. To evaluate the need for coordination among the health regulatory boards and their staffs and report its findings and recommendations to the Director (of the Department of Health Professions) and the boards (within the Department of Health Professions);

2. To evaluate all health care professions and occupations in the Commonwealth, including those regulated and those not regulated by other provisions of Title 54.1, Subtitle III, Code of Virginia, to consider whether each such profession or occupation should be regulated and the degree of regulation to be imposed. Whenever the Board determines that the public interest requires that a health care profession or occupation which is not regulated by law should be regulated, the Board shall recommend to the General Assembly a regulatory system to establish the appropriate degree of regulation;

3. To review and comment on the budget for the Department;

4. To provide a means of citizen access to the Department;

5. To provide a means of publicizing the policies and programs of the Department in order to educate the public and elicit public support for Department activities;

6. To monitor the policies and activities of the Department, serve as a forum for resolving conflicts among the health regulatory boards and between the health regulatory boards and the Department and have access to Departmental information;

7. To advise the Governor, the General Assembly and the Director on matters relating to the regulation or deregulation of health care professions and occupations;
8. To make bylaws for the government of the Board of Health Professions and the proper fulfillment of its duties under Chapter 25 of the Code of Virginia;

9. To promote the development of standards to evaluate the competency of the professions and occupations represented on the Board of Health Professions;

10. To review and comment, as it deems appropriate, on all regulations promulgated or proposed for issuance by the health regulatory boards under the auspices of the Department. At least one member of the relevant Board shall be invited to present during any comments by the Board on proposed board regulations;

11. To review periodically the investigatory, disciplinary and enforcement processes of the Department and the individual boards to ensure the protection of the public and the fair and equitable treatment of health professionals;

12. To examine the scope of practice conflicts involving regulated and unregulated professions and advise the health regulatory boards and the General Assembly of the nature and degree of such conflicts;

13. To receive, review, and forward to the appropriate health regulatory board any departmental investigative reports related to complaints of violations by practitioners to Chapter 24.1 (§54.1-2410 et seq.) of the Code of Virginia, entitled “Practitioner Self-Referral Act.”;

14. To determine compliance with and violations of and grant exceptions to the prohibitions set forth in the “Practitioner Self-Referral Act” (Chapter 24.1 §54.1-2410 et seq. of the Code of Virginia); and

15. To take appropriate actions against entities, other than practitioners as defined in §54.1-2410 et seq. of the Code of Virginia, for violations of the “Practitioner Self-Referral Act.”

ARTICLE III. Members.

1. The membership of the Board shall be the persons appointed by the Governor of the Commonwealth as set forth in the Code of Virginia (§54.1-2507).

2. Members of the Board shall attend all regular and special meetings of the Board unless prevented by illness or other unavoidable cause.

ARTICLE IV. Officers and Election.

1. The Officers of the Board shall be the Chairman and Vice Chairman.
2. The Officers shall be elected by the Board members at the Annual Meeting of the Board each fall.

3. The term of office shall be for the next calendar year following the election, or until the successor shall be elected as herein provided.

4. A vacancy occurring in any elected position shall be filled by the Board at the next meeting.

**ARTICLE V. Duties of Officers.**

1. The Chairman shall preside at all meetings of the Board; appoint all committees, except as where specifically provided by law; call special meetings; and perform duties as prescribed by parliamentary authority.

2. The Vice Chairman shall act as Chairman in the absence of the Chairman.

**ARTICLE VI. Executive Committee.**

1. This Committee shall consist of the Officers.

2. The Committee shall review matters of interest to the Board and may make recommendations to the Board.

3. The Chairman of the Board shall be the Chairman of the Committee.

**ARTICLE VII. Committees.**

1. The Chairman may appoint committees as necessary to assist in fulfilling the duties of the Board.

2. The committees shall be advisory to the Board and shall offer recommendations to the Board for final action.

**ARTICLE VIII. Meetings.**

1. The Board shall meet at least one time per year on a date at the discretion of the Board.
2. Special meetings shall be called by the Chairman or by written request to the Chairman of any three members of the board, provided that there is at least seven days’ notice given to Board members.

3. A quorum for any Board meeting shall consist of a majority of the members of the board. A quorum for any committee shall consist of a majority of committee members. No member shall vote by proxy.

4. A majority vote of the members present shall determine all matters at any meeting, regular or special, unless otherwise provided herein.

5. Members shall attend all scheduled meetings of the Board and committees to which they serve. In the event of two consecutive absences at any meeting of the Board or its committees, the Chairman shall make a recommendation to the Director of the Department of Health Professions for referral to the Secretary of Health and Human Resources and Secretary of the Commonwealth.

ARTICLE IX. Parliamentary Authority.

The rules contained in the current edition of Robert’s Rules of Order shall govern the Board in all cases to which they are applicable and in which they are not inconsistent with these bylaws and any special rules the Board may adopt and any statutes applicable to the Board.

ARTICLE X. Amendment of Bylaws.

The bylaws may be amended at any meeting of the Board by an affirmative vote of two-thirds of the members present, provided the proposed amendment was distributed to all members of the Board at least 30 days in advance.

Approved by the Board of Health Professions on May 28, 2015.
<table>
<thead>
<tr>
<th>Profession</th>
<th>Name</th>
<th>Term</th>
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<tr>
<td>ASLP</td>
<td>Laura P. Verdun, MA, CCC-SLP</td>
<td>2019</td>
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<tr>
<td>COUNSELING</td>
<td>Kevin Doyle, Ed.D., LPC, LSATP</td>
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<td>DENTISTRY</td>
<td>James D. Watkins, DDS</td>
<td>2020</td>
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<td>FUNERAL DIRECTORS &amp; EMBALMERS</td>
<td>Junius H. Williams, Jr., MA</td>
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<td>LONG-TERM CARE ADMINISTRATORS</td>
<td>Derrick Kendall, NHA</td>
<td>2017</td>
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<td>MEDICINE</td>
<td>Barbara A. Allison-Bryan, MD</td>
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<td>NURSING</td>
<td>Trula E. Minton, MS, RN</td>
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<td>OPTOMETRY</td>
<td>Helene D. Clayton-Jeter, OD, Vice Chair</td>
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<td>PHARMACY</td>
<td>Ryan Logan</td>
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<td>Allen R. Jones, Jr., DPT, PT</td>
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<td>Herbert L. Stewart, PhD</td>
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<td>VETERINARY MEDICINE</td>
<td>Mark Johnson, DVM</td>
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<td>CITIZEN MEMBER</td>
<td>Robert J. Catron, Chair</td>
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<td>Marvin B. Figueroa, MEd</td>
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<td>Martha S. Perry, MS</td>
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<td>Jacquelyn M. Tyler, RN</td>
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<td>CITIZEN MEMBER</td>
<td>James Wells, RPh</td>
<td>2019</td>
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