

DRAFT UNAPPROVED
AGENDA

1

VIRGINIA BOARD OF HEALTH PROFESSIONS
FULL BOARD MEETING
May 5, 2016
Board Room #2 10:00 a.m.

Call to Order	<i>Mr. Catron</i>
Public Comment	<i>Mr. Catron</i>
Approval of Minutes – Page 2 <ul style="list-style-type: none">• February 11, 2016	<i>Mr. Catron</i>
Director’s Report	<i>Dr. Brown</i>
Legislative and Regulatory Report	<i>Ms. Yeatts</i>
DHP Budget	<i>Mr. Giles</i>
Communications Report – Page 7	<i>Ms. Powers</i>
Executive Director’s Report <ul style="list-style-type: none">• Agency Performance – Page 26• Board Budget• Healthcare Workforce Data Center Update – Page 32• Sanction Reference Article – Page 33• Telehealth Update – Page 39• 2016 Workplan – Page 97• HRSA Supply and Demand Model	<i>Dr. Carter</i>
Chiropractor Review – Page 100	<i>Dr. Carter</i>
Board Reports	<i>Mr. Catron</i>
New Business	<i>Mr. Catron</i>
Adjournment – Retreat to Follow	



Full Board Meeting

February 11, 2016
10:00 a.m. - Board Room 2
9960 Mayland Dr, Henrico, VA 23233

In Attendance

- Barbara Allison-Bryan, MD, Board of Medicine
- 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
- Allen R. Jones, Jr., DPT, PT
- Robert H. Logan, III, Ph.D., Citizen Member
- Martha S. Perry, MS, Citizen Member
- Robert Logan III, Citizen Member
- Ryan Logan, Board of Pharmacy
- Laura P. Verdun, MA, CCC-SLP, Board of Audiology & Speech-Language Pathology
- J. Paul Welch, II, Board of Funeral Directors and Embalmers

Absent

- Jacquelyn M. Tyler, RN, Citizen Member
- Trula E. Minton, MS, RN, Board of Nursing
- James D. Watkins, DDS, Board of Dentistry

DHP Staff

- David E. Brown, D.C., Director DHP
- Lisa R. Hahn, MPA, Chief Deputy Director DHP
- Elizabeth A. Carter, Ph.D., Executive Director BHP
- Elaine Yeatts, Senior Policy Analyst DHP
- Yetty Shobo, Ph.D., Deputy Executive Director BHP
- Laura L. Jackson, Operations Manager BHP
- Sandy Reen, Executive Director Board of Dentistry
- Leslie Knachel, Executive Director Boards of Optometry, Audiology and Speech-Language Pathology, Veterinary Medicine

Emergency Egress

Dr. Carter

Observers

No observers signed-in



Call to Order

Acting Chair Mr. Catron **Time** 10:00 a.m.
Quorum Established

The Board has three newly appointed members, Barbara Allison-Bryan, MD with the Board of Medicine, Ryan Logan with the Board of Pharmacy and Mark Johnson, DVM with the Board of Veterinary Medicine. Board member introductions were made.

Public Comment

Comment No public comment was provided

Approval of Minutes

Presenter Mr. Catron

Discussion

The August 6, 2015 11:00 a.m. Full Board meeting minutes were approved and properly seconded. All members in favor, none opposed.

Directors Report

Presenter Dr. Brown

Discussion

Dr. Brown stated that Ms. Yeatts would provide the majority of his report. He added that concerns have been expressed to the Board of Pharmacy regarding the lack of oversight of Pharmacy Benefit Managers (PBMs) and that a workgroup has been formed to make recommendations regarding the need for additional oversight of PBMs. A report has been prepared addressing these concerns and is in the review process at this time.

This year’s General Assembly has several bills that are focused on nurse practitioners, dental hygienists and the Practitioner Monitoring Program.

Legislative and Regulatory Report

Presenter Ms. Yeatts

Discussion

Ms. Yeatts provided an overview of recent legislation and regulation. She stated that SB212 Health Regulatory Boards provides that members appointed by the Governor to serve on the Board of Health Professions for four-year terms under current law shall serve such term or terms concurrent with their terms as members of health regulatory boards, whichever is less. Also, HB574 Dietitians and



nutritionists clarify the situations under which they may practice. It is possible that dietitians and nutritionist may be repealed from BHP. Ms. Yeatts will provide updates at the May 5, 2016 meeting.

There are currently 59 House bills, 27 Senate bills, with 15 primarily associated with DHP.

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/Recruitment

Dr. Carter stated that the Board has utilized 51% of its budget as of December 31, 2015.

Healthcare Workforce Data Center

Dr. Carter provided a PowerPoint presentation overview on the Department's Healthcare Workforce Data Center.

Practitioner Self-Referral

A practitioner self-referral request was submitted by Alliance Xpress Care, LLC. July 9, 2015. It was reviewed and accepted by an agency subordinate September 24, 2015 and presented to the Full Board for consideration and ratification today.

Motion

A motion was made to consider and ratify the Practitioner Self-Referral request presented by Alliance Xpress Care, LLC. The motion was properly seconded by Mr. Wells. All members were in favor, none opposed.

Sanction Reference

Dr. Carter presented the December 31, 2015 Sanctioning Reference Points (SRP) Agreement Analysis report with the Board.

Funeral Multi-Licensure Update

Dr. Carter reviewed the letter that was sent to Senator Alexander in response to his request for a study on the options for separate funeral director-only and embalmer licenses. The letter stated the Board's findings and advised on the availability of the Board's standard policies and procedures for evaluating the need to regulate any new profession.

Retreat

The Board will be holding a retreat May 5, 2016 here at the Perimeter Center that will run concurrent with the Full Board meeting scheduled for 10:00 a.m. A committee will be established to review the Boards duties and determine items that need to be reviewed, such as statutes and regulations and guidance documents, along with guidance concerning views on the chief issues for the Board moving



forward. It was requested that materials be disseminated at least one month prior to the retreat for the Board members to review.

Telehealth Review

Dr. Shobo provided a PowerPoint presentation elaborating on the report that was submitted by Andrew Feagans and Andrea Peaks, VCU Capstone students. It was determined that the report needs to be reviewed by DHP boards that participate in telehealth, to ensure that the information contained is accurate.

Motion

A motion was made to have the each Board Executive Director, and/or relevant staff, review the report and return with a determination of the Board’s actual telehealth findings. The motion was properly seconded by Mr. Catron. All members were in favor, none opposed.

Election - Chair and Vice Chair

Presenter Dr. Carter

Chair

Dr. Carter called for nominations for the position of Board Chair. Mr. Logan, III moved to nominate Mr. Catron as Chair.

Motion

With no other nominations made, the motion was seconded by Dr. Jones and carried Mr. Catron would be Chair.

Vice Chair

Dr. Carter called for nominations for the position of Vice chair. Mr. Wells, Mr. Logan, III and Dr. Clayton-Jeter each voiced their interest in the position. Mr. Wells rescinded his bid and it was determined by a vote of 6 to 4 that Dr. Clayton Jeter would be the Vice Chair.

Motion

With no other motions made, the motion was seconded and carried that Dr. Clayton-Jeter would be Vice Chair.

Board Reports

Presenter Mr. Catron

Board of Physical Therapy

Dr. Jones stated that the Board of Physical Therapy has established telehealth guidelines. They are in the process of gathering additional information regarding dry needling.



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Board of Medicine

Dr. Allison-Bryan stated the Board has telemedicine guidelines but not with regard to practice crossing state lines.

Board of Funeral Directors and Embalmers

Mr. Welch reported that according to the Maryland Board of Morticians and Funeral Directors, only a registered mortuary transport service may remove or transport human remains in Maryland and to hold such a permit, you must agree to use a vehicle that has been inspected by an inspector designated by the Maryland Board.

Board of Social Work

Ms. Haynes stated that the Board of Social Work is reviewing multi-level licensure. The Board has also been looking into telehealth but refers to it in different terms.

Board of Pharmacy

Mr. Logan stated that the Board of Pharmacy is conducting a full review of their regulations which they are hoping to have finalized in September 2016.

New Business

Presenter Mr. Catron

There was no new business to discuss.

Adjourned

Adjourned 1:28 p.m.

Acting Chair Robert Catron

Signature: _____ Date: ____/____/____

Board Executive Director Elizabeth A. Carter, Ph.D.

Signature: _____ Date: ____/____/____

Department of Health Professions Standard Operating Procedures for Media Relations

The Virginia Department of Health Professions (DHP) is a non general fund agency in the Health and Human Resources Secretariat of the Executive Branch of government. DHP is composed of: 13 health regulatory boards; the Board of Health Professions; the Prescription Monitoring Program (PMP); the DHP Healthcare Workforce Data Center (HWDC); and, the Healthcare Practitioner Monitoring Program (HPMP).

This document addresses the third part of DHP's mission "to provide information to (health care practitioners) and the public." Most often information is conveyed to the public through the press.

To ensure consistent messages across boards and programs, DHP media relations are centralized in communications as part of the Office of the Director. Local, state, regional and national news organizations including traditional print and broadcast media and new media such as online publications and blogs are considered members of the third estate and qualify as working members of the press corps.

Press requests for public information are protected by the Freedom of Information Act (FOIA) and are recognized as verbal FOIA's under §2.2-3704 of the Code of Virginia. As such, DHP is required to be both transparent and timely in response to requests for information not protected under law. FOIA requests must be answered verbally or in writing within five (5) working days though news media often have hourly or daily deadlines.

Communications is staffed by one full time director and a part time associate and serves as the initial point of contact between the news media, health regulatory boards and DHP programs. Queries are then routed by communications to the appropriate board(s) or program(s). Similarly, media calls and email messages received over the transom by boards and programs are directed to communications.

This management strategy serves a number of purposes.

- As liaison between news organizations and DHP content experts, communications staff can ask questions about the news coverage sought that may be awkward for gatekeepers of information.
- Centralized receipt of press requests for information provides content experts with time to prepare for interviews.
- An agency spokesperson may be in a better position should it be necessary to decline a request for an interview than a representative of a board or program.
- As a central conduit for information communications staff can alert content experts when a news item becomes a trend story and alternate methods of information management become necessary such as posting facts online.
- Centralization of media requests for information reduces the risk that a member of the press is "shopping" for an answer by contacting different boards and programs to ask the same question.

- Communications assists DHP spokespersons with the packaging of media responses and media-related FOIA requests.
- Communications maintains an open rapport with other governmental agencies and stakeholder groups likely to be cited in a news report or provided as a referral to members of the working press and will contact them as appropriate to keep them informed of fast breaking news reports they may wish to address.
- Communications prepares Media Alerts for hand off to the Office of the Director.

Step By Step Action Items

- All media requests for health regulatory boards and DHP programs are routed to communications.
- Communications determines which content experts are appropriate to respond to the request and collaborates with or convenes board(s) and program(s) for input as needed.
- In the event neither the agency communications director nor the part-time communications associate are available, the appropriate DHP spokesperson should determine whether to defer the request or provide a response. If a response is provided it will be the responsibility of the content expert to complete and submit an electronic copy of the Media Alert to communications and a hard copy to the agency chief deputy director before close of business.
- Communications will gather additional details from the reporter to inform the board and programmatic decision making process regarding the request. This includes --
 - a. Determining whether the reporter is on deadline
 - b. Seeking additional details about the information requested and whether it available on a board, program or the DHP website
 - c. Identifying the story angle
 - d. Referring a reporter to another source
 - e. Researching communications records in the event the reporter has contacted other boards or programs at DHP regarding the same story
 - f. Reviewing background information on both the reporter making the request and their news organization
 - g. Informing other state agency communications staff when a news story is likely to impact them
- Communications collaborates with board executive directors, deputy executive directors, program directors, the Office of the Director and on occasion with DHP's chief counsel at the Office of the Attorney General when necessary.
- Communications will make recommendations regarding how best to manage media requests and may develop a draft written response for review by agency content experts before it is release.
- Once there is agreement on an electronic response, it is sent by communications to the reporter with a blind carbon copy to the staff leadership of the board or program engaged.

- Communications completes an internal document called a “DHP Media Alert” for review by content experts and submits at the conclusion of a press interview to the Director and Chief Deputy before the close of business that day or as soon as possible
- DHP’s Media Alert serves as a final record of information provided to the press and may be advanced by the Office of the Director to the Office of the Secretary and/or Governor
- When on-camera, live tape sync or other onsite interview is sought, communications will manage the following aspects of preparation--
 - Identify and reserve a room for the interview, preferably on the second floor in the Conference Center
 - Alert first floor guard station and DHP’s third floor receptionist that a member of the press will be in the building
 - Meet the reporter and camera crew downstairs in the first floor lobby to escort them to the interview
 - Confirm with the reporter the topic to be discussed, parameters for the interview and manage press expectations
 - Assist DHP’s content expert with preparations for the interview such as defining key message points to convey
 - Support DHP’s content expert throughout the interview process and take notes
 - A member of the communications staff must accompany the reporter and camera crew at all times
 - At the conclusion of the interview communications staff will escort the news team to the lobby
- Camera crews that elect to tape or broadcast in the Perimeter Center Building parking lot will be encouraged to coordinate with the Office of Communications

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Board	Publication	Reporter/Author	Date
Nursing	WTVR	Melissa Hipolit	16-Mar-16
Nursing	Fairfax County Times	Marta Wallace	16-Mar-16
Medicine	<i>State Journal-Register</i>	Dean Olsen	23-Feb-16
Medicine	<i>News 5 WCYB</i>	Kristi O'Connor	22-Feb-16
Medicine	Richmond Times Dispatch	Tammie Smith	18-Feb-16
Medicine	Scripps News	Aaron Kessler	11-Feb-16
Medicine	Richmond Times Dispatch	Tammie Smith	11-Feb-16
Medicine	News and Advance	Amy Trent	11-Feb-16
Medicine	WCPO digital	Dnaiel Monk	10-Feb-16
Medicine	<i>Newport News Daily Press</i>	Sarah Ketchum	30-Mar-16
Medicine	<i>Daily News Record</i>	Pete Delea	30-Mar-16
Medicine	<i>WHSV TV</i>	Channing Frampton	24-Mar-16
Medicine	<i>Boston Globe</i>	Rebecca Robins	11-Mar-16
Medicine	<i>Daily Press</i>	Sarah J. Ketchum	1-Mar-16
Medicine	Richmond Times Dispatch	Katie Evans	4-Feb-16
Medicine	WCPO	Daniel Monk	10-Feb-16
Medicine	8News TV	Kerri O'Brien	12-Jan-16
Medicine	News 5 WCYB	Kristi O'Connor	14-Jan-16
Medicine	Richmond Times Dispatch	Katie Evans	4-Feb-16
Medicine	Washington Post	Laura Vozelle	13-Apr-16
Pharmacy	Fairfax Times	Angela Woolsey	7-Apr-16
Pharmacy	Washington Post	Justin Jouvenal	30-Mar-16
Pharmacy	WTVR CBS 6	Melissa Hipolit	16-Mar-16
Pharmacy	Scripps national Investigative Producer	Aaron Kessler	10-Feb-16
Pharmacy	Richmond Times Dispatch	Tammie Smith	21-Jan-16
Dentistry	<i>Smithfield Times</i>	Matt Leonard	21-Mar-16
Dentistry	<i>Smithfield Times</i>	Matthew Leonard	16-Mar-16

**Department of Health Professions
Media Contact**

1. Date and time of contact: 9 a.m. and 1 p.m., Wednesday, February 10, 2016

2. Media who contacted us: Aaron Kessler, *Scripps National Investigative Producer*, Scripps Washington Bureau, 202-408-2724 (work), 202-688-5320 (softphone) 609-214-6542 (cell), aaron.kessler@scripps.com

3. What is [the story](#) or the requested information?

[First Inquiry/9 a.m.]

“I’m a reporter with the Scripps News Washington Bureau, and it was suggested I write to you for assistance. We’re trying to determine if a certain doctor has, or has ever had, a Virginia license to dispense/prescribe medication, and specifically if she also has a Va.-based license to prescribe controlled substances.

After spending some time on the phone yesterday with one of the Board of Pharmacy’s staff, who was very helpful, she was unable to find any records in their initial database search. However, to err on the side of being extra cautious, given the gravity of an accusation that someone is writing controlled substance prescriptions without a valid license, it was suggested that we contact the Board of Medicine as well to see if there may be any records or searches on your end that could be done to help determine this doctor’s status for Rx dispensing..

If it’s possible to search your records as well, that would be greatly appreciated, so we can determine what the doctor’s status is in this regard.

The doctor’s name and Virginia medical license number/info is below, to help this process along. We’d greatly appreciate your help to make sure we can accurately determine Dr. Temeck’s status.”

License Information

License Number	0101037123
Occupation	Medicine & Surgery
Specialization	Surgery (Board Certified) Surgery: Thoracic Cardiovascular Surgery (Self Proclaimed) Thoracic Surgery (Board Certified)
Name	Barbara K Temeck
Address of Record	Cincinnati, OH 45220
Initial License Date	08/09/1984
Expire Date	06/30/2016
License Status	Current Active
Additional Public Information*	No

[Second Inquiry/1 p.m.]

Thanks for the quick response, and it’s good to hear from you.

I want to make sure I understand: neither the Virginia Board of Pharmacy, nor the Board of Medicine, issue licenses anymore for controlled substances? If that's the case, does your office track whether Virginia doctors do indeed have a DEA number tied to Virginia? We'd like you to look in those records to see if the department has a record of a current or former DEA number.

Also just to be clear – Virginia doctors also do not need a separate license to dispense non-controlled medication. Instead, when they get their medical license that automatically grants them the ability to dispense and write such prescriptions?

Finally, since Dr. Temeck was originally licensed in Virginia back in the 1980s, would it be safe to assume that this would date back to the time when Virginia indeed issued its own controlled substances certificates? If this is the case, we'd ask that you also pull the records on Dr. Temeck regarding the older Virginia-issued certificates and find out if she was ever given such a certificate and if so when the most recent time that such a certificate was was valid.

Is that something that you can help us determine this afternoon? Would be much appreciated.

4. What information was provided?

[First Inquiry/9 a.m.]

Thank you for your request for information regarding whether or not a Virginia Licensee has a Virginia DEA number. It appears you are asking if Virginia issues a controlled substances certificate.

Virginia used to issue a controlled substances certificate, but ceased doing so many years ago.

A license from the Virginia Board of Medicine authorizes a physician to write for Schedule VI drugs. If a physician wishes to write controlled substances (Schedules I-V), he/she must become registered with the DEA (Drug Enforcement Administration). You can learn more about registration with the DEA at www.deadiversion.usdoj.gov/

I hope this is helpful.

[Second Inquiry/ 1 p.m.]

Hi, Aaron--

The Virginia Board of Medicine issues a license to practice Medicine and Surgery that authorizes a physician to prescribe Schedule VI drugs.

To write controlled substances, the physician must hold a DEA registration.

The Virginia Board of Pharmacy used to issue a controlled substances certificate/license, which was removed from the law probably in 1996 or 1998.

According to Board of Medicine records, Dr. Temeck was issued a license to practice Medicine and Surgery on August 9, 1984.

The records also indicate that Dr. Temeck held a controlled substance license as well.

5. When will the story appear? (TBD)

6. What do you expect the report to describe? (See above)

7. Comments (optional): N/A

Name: Diane Powers

Title: Director of Communications

Seven Digit telephone number: 804/367-4524

Exclusive: Whistleblowers cite disorder at VA hospital

Special investigation: Dereliction of Duty

MARK GREENBLATT (MAILTO:MARK.GREENBLATT@SHNS.COM), DAN MONK
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Feb 16, 2016

Nearly three dozen whistleblowers have come forward saying the VA Medical Center in Cincinnati is in a state of disorder. They say veterans are not getting the care they need in the backyard of Secretary of Veterans Affairs Bob McDonald, the former chief executive of Cincinnati-based Procter & Gamble Co.

Since October, a team of Scripps reporters has been talking to a group of 34 current and former medical center staff members. The group, including 18 doctors from several departments, sent an unsigned letter to McDonald in September describing "urgent concerns about quality of care" at the facility, which serves more than 40,000 area veterans. They allege a pattern of cost cutting that forced out experienced surgeons, reduced access to care and put patients in harm's way.

At the center of the controversy are Dr. Barbara Temeck, acting chief of staff for the Cincinnati VA Medical Center, and Jack Hetrick, the Department of Veterans Affairs' regional director.

Whistleblowers describe poor care at the VA hospital in Cincinnati, OH

The VA has launched one investigation and requested the Office of Inspector General open an additional independent investigation. The VA also temporarily removed oversight authority of the Cincinnati hospital from Hetrick, the highest-ranking VA official in Ohio, Michigan and Indiana. The agency did this "to ensure no conflict of interest." The Cincinnati VA is reporting to a Pittsburgh-based regional director while the investigations proceed.

The findings of a joint investigation by the Scripps News Washington Bureau and WCPO triggered the federal probes.

[READ MORE: 'Dereliction of Duty' exclusive investigation] (<http://www.wcpo.com/va>)

Several local veterans described long delays and substandard care during Dr. Temeck's tenure. Ted Dickey, a 72-year-old Vietnam veteran, had depended on the Cincinnati VA for care for some 30 years. When the VA told Dickey he needed a hip replacement last May, instead of treating him, they gave him a referral and showed him the door. He was told there were no longer hip surgeons on staff.

Dr. Barbara K. Temeck assumed the role of acting chief of staff at the Cincinnati VA Medical Center in July 2013. (Scripps Photo by Matt Anzur)

"They don't know how to run a hospital," Dickey said. "Their way of running a hospital is not doing surgery and farming it out."

Dr. Temeck declined to comment for this story. Mr. Hetrick walked out of an interview after praising the Cincinnati hospital for overcoming "resource challenges" and improving quality.

"I've worked very closely with them to make sure we get them back on track," he said. "I wanted to make sure that this organization was set solid for the future. I think we're there." The hospital has consistently received four or five stars, which are the highest ratings by the VA.

Here are some of the Scripps-WCPO findings, all based on interviews and documents:

- | Services to veterans have been reduced, including spine and orthopedic surgeries, along with customized prosthetic services for artificial limbs.
- | Dr. Temeck prescribed controlled substances, including hydrocodone and a generic form of Valium, to Mrs. Hetrick, the wife of her regional boss, Jack Hetrick. State and federal authorities confirm Dr. Temeck does not have a valid controlled

substances license that would allow her to write prescriptions privately for Mrs. Hetrick.

- | Dr. Temeck cut around-the-clock staffing by emergency airway specialists to save money, resulting in at least one close call involving a patient who could not breathe.
- | Dr. Temeck told operating-room staff they were being "too picky" when they reported surgical instruments delivered to operating rooms with blood and bone chips from previous surgeries.
- | Dr. Temeck is paid separately as a VA administrator and cardiothoracic surgeon. But whistleblowers say she has never served as the operating surgeon since coming to Cincinnati.

The nearly three dozen whistleblowers have been voicing their concerns for the better part of a year, including meeting in person with regional director Hetrick and reaching out to members of Congress and Secretary McDonald. They say little has been done to remedy the problems.

The chairman of the House Committee on Veterans Affairs, Florida Republican Jeff Miller, said his staff has been talking to Cincinnati whistleblowers, but he wanted to give McDonald some time to address the issues they raised. "If in fact this is true, I would hope the secretary will take it seriously because if he doesn't, we'll examine it from the committee standpoint," Miller said.

Local VA 'just not up to standard'

Three longtime employees of the Cincinnati VA agreed to go public with their concerns because they believe hospital leaders are no longer acting in the best interest of veterans.

Their public comments reflect the private concerns of dozens of doctors and nurses who also agreed to be interviewed and provided documents but asked not to be named for fear of retaliation.

"This was a model hospital," said Dr. Richard Freiberg, former chief of orthopedics for the Cincinnati VA.

'We were serving veterans with almost every imaginable problem and doing state-of-the-art care. Now, we're unable to care for almost all of them'

"We were serving veterans with almost every imaginable problem and doing state-of-the-art care. Now, we're unable to care for almost all of them." He recounted that shortly after Dr. Temeck came to Cincinnati, she called a sudden meeting of the hospital's full-time total joint surgeons: "We were told that we were going to be reduced to one full time between the three of us."

Dr. Freiberg ended his VA employment in October, frustrated by cuts that rendered the hospital unable to do complex joint replacements for hips, knees and shoulders.

He continues to volunteer for the facility.

"Things I've observed at the Cincinnati VA are just not up to standard," said Mike Brooks, a certified registered nurse anesthetist who joined the VA after a 24-year Navy career that began when he was 17. Brooks is a shop steward for the national nurses union and began working in Cincinnati in 2008. "It bothers me because I know the veterans who deserve the best care we can give them are being put at risk."

Susan Ware is a nurse practitioner who decided to speak publicly because of the dismantling of a neurosurgery practice that treated 686 patients in 2013 and now refers all brain and nervous-system procedures elsewhere. Ware worked in neurosurgery for 16 years.

"What's happening at the Cincinnati VA is sad," she said. "There is a reason why the VA exists and there's a reason veterans want to come to the VA. And it's being ignored."

Ware said she and other employees started complaining about Dr. Temeck's management decisions more than a year ago, but the regional director Jack Hetrick took no action.

"It seems that Mr. Hetrick supports her," Ware said, "despite the knowledge that he has about how unhappy the staff is."

The boss' wife

Mr. Hetrick and Dr. Temeck have a work relationship that dates back to at least 2002. He was the director of the Edward Hines Jr. VA near Chicago and Dr. Temeck was the hospital's chief of staff, records show. Both moved on to jobs outside of Illinois, but stayed with the VA.

Jack G. Hetrick is Network Director of the VA's regional office that oversees hospitals in Ohio, Indiana and Michigan. (U.S. Air Force photo by Wesley Farnsworth/Released)

According to documents obtained by Scripps, on Dec. 26, 2012, more than two years after Dr. Temeck left her position in Illinois, she prescribed pain medication for Mr. Hetrick's wife — 50 pills of a generic form of Valium. On May 17, 2013, Dr. Temeck prescribed 100 pills of hydrocodone. This was eight weeks before Dr. Temeck was named Cincinnati's acting chief of staff. Both drugs are labeled controlled substances by the U.S. Drug Enforcement Administration.

During an interview, Mr. Hetrick walked out of the room when asked about the prescriptions.

"You're not going to engage me," he said.

At the time of publication, Mrs. Hetrick's attorney had not responded to requests for comment.

These prescriptions raise several issues:

- | Dr. Temeck was working at a VA hospital in South Carolina when the 2013 prescription was written, but she used an Illinois address tied to the VA hospital she had left in 2010 to issue the prescription.
- | Dr. Temeck's Illinois license does not allow her to write prescriptions for controlled substances outside the VA.
- | Dr. Temeck's authority to prescribe controlled substances in Illinois expired in 2011.
- | State and federal officials told Scripps that Dr. Temeck did not have in 2011, nor does she have now, a valid controlled substance license that would allow her to write prescriptions privately for Mrs. Hetrick.
- | According to medical ethics experts interviewed by Scripps, it poses a conflict of interest for a doctor to provide treatment, particularly controlled substances, for his or her work superior, or their family members.

(<http://timemapper.okfnlabs.org/scrippsnews/timeline1?embed=1>)

Click to view the interactive timeline in a new window.

According to a statement from Derek Atkinson, spokesperson for the VA regional network headed by Mr. Hetrick, Dr. Temeck has "an active state medical license in Virginia that includes prescribing controlled substances." An official with the Virginia Department of Health Professions, which regulates the state's doctors and pharmacists, told Scripps that Virginia medical licenses do not include the ability to write prescriptions for controlled substances.

"To write controlled substances, the physician must hold a DEA registration," department spokeswoman Diane Powers said. Dr. Temeck has not held a Drug Enforcement Administration controlled substances registration outside the VA system for nearly two decades, the DEA told Scripps. Instead, in recent years she's held what's known as a "limited registration," which allows her to write prescriptions only within VA facilities she's working in.

When asked about the prescription matter, Rep. Miller said rules appear to have been broken. "Was the person allowed to receive the prescription? From what I can gather they were not." He added, "I believe that it needs to be fully investigated."

The boss' pay

As acting chief of staff, Dr. Temeck earns \$137,191. According to the VA, Temeck earns an additional \$194,343 for her role as a cardiothoracic surgeon, for a total of \$331,534.

Multiple sources, including those who have been inside the operating room with Dr. Temeck, say she only serves as an assistant and has never worked as the operating surgeon since arriving in Cincinnati. "It's certainly common knowledge in the hospital that she's gaming the system," Dr. Freiberg said.

Brooks said it's an "open secret" in the hospital that Dr. Temeck earns the additional salary as a cardiothoracic surgeon for work he has never seen her perform.

VA rules allow physicians to receive a "market pay augmentation" in specialties where it's competing with private-sector hospitals for labor talent. The VA handbook says the amount of market pay depends on several factors, including the doctor's level of experience, credentials and accomplishments along with analysis of the local health care labor market.

Mike Brooks, a certified registered nurse anesthetist, began working at the Cincinnati VA in 2008. (Scripps News photo by Matt Anzur)

"It's certainly not right by the taxpayer," said Brooks, a certified nurse anesthetist who participated in several surgeries in which he says Dr. Temeck scrubbed in, then assisted in surgery.

Sometimes, she holds a retractor, Brooks said, but she never took the lead. A retractor is a medical instrument used for drawing back the edges of an incision.

"She's in the room when surgeries happen," he added, "but I can't say I've ever seen her pick up a scalpel and do a surgery."

The Cincinnati VA declined to say how many times Dr. Temeck has led a thoracic surgery since joining the hospital staff, but stated her "workload is consistent with other provider(s) in Cincinnati and other facilities of similar complexities."

The VA also said Dr. Temeck is "privileged and in good standing" at the Cincinnati VA "and works within the scope of privileges."

Bryan Snyder, a supervisory human resources specialist at the hospital, made the case for awarding the permanent chief of staff job to Dr. Temeck, along with a substantial pay raise. According to an internal memo, Snyder sought an exception to let Dr. Temeck exceed the federal salary cap of \$385,000 for her role as a cardiothoracic surgeon if she gets the permanent job.

"Dr. Temeck has already proved invaluable in the short time she has been detailed to this facility," Snyder wrote. "Her input and assistance have assisted with decision-making and planning and facilitated a 'fresh eyes' approach to the clinical operations of the facility that is transforming several patient services and processes."

Cost-cutting close call

When Dr. Temeck arrived in 2013, the hospital was paying overtime to nurse anesthetists so they would be available 24 hours a day, seven days a week to handle emergency breathing problems. As a cost-cutting measure, sources say Dr. Temeck replaced that system with a requirement that on-call surgeons perform intubation during off hours. Intubation is the insertion of a plastic tube into a patient's windpipe to assist in breathing.

On May 9, 2014, Dr. Temeck was the on-call surgeon when a patient stopped breathing. "She had trouble," said Brooks, referring to Dr. Temeck. "She had to call for backup." Others who were involved in the incident confirmed his account.

Sources told us the VA's Office of Medical Inspector recently interviewed employees about the incident.

Days after the incident, sources say Dr. Temeck reversed the policy. The Cincinnati VA says it now provides "Certified Registered Nurse Anesthetists coverage 24/7."

Bones on blades

Brooks and other operating-room staff said one of the most disturbing problems involved contaminated surgical instruments. "I've seen surgical instruments that once we open the sterile pack, they will have pieces of debris, possibly bone or other debris from previous surgeries still on the instrumentation," Brooks said.

Instead of committing to better training or spending to hire more certified technicians, Brooks said Dr. Temeck told operating-room staff to stop complaining.

She also required them to notify her when they spotted problems so she could inspect the tools before they could be replaced with clean ones. Brooks said surgeries were halted, sometimes with patients cut open, waiting for Dr. Temeck to arrive for an inspection.

"She felt that these were all fabrications, that we were making up stories about the instruments not being clean, so she wanted to see for herself," he said. "If she was in another meeting, it could be 20 minutes, half an hour, with the patient under anesthesia."

CLICK TO ENLARGE - Source: U.S. Department of Veterans Affairs

Under Dr. Temeck's tenure at the Cincinnati VA the rate of MRSA infections has increased substantially. The highly contagious, drug-resistant infection is commonly associated with surgeries. According to the most recent publicly available data, Cincinnati now has one of the highest rates of MRSA infections for VA hospitals nationally.

Brooks said he and many of the other whistleblowers filed complaints with the U.S. Office of Special Counsel, a federal agency that reviews whistleblower complaints, but does not have independent investigative authority. The agency notified him in May that no action would be taken. Brooks shared the written response he received.

"You were unable to provide our office with detailed information regarding the gravity and frequency of the problem," said Olare Nelson, an attorney in the OSC's disclosure unit.

Brooks is undeterred.

"I'm ringing the bell," he said. "I'm letting people know there's an issue here. They continue to say that everything's fine, but we know on the inside that we have an institutional culture that is not promoting safe patient care."

Scripps News Washington Bureau and WCPO will continue to report on conditions and factors in the Cincinnati VA and nationwide in the coming days and weeks. If you have a tip for us to investigate or if you're a veteran who wants to share your experience seeking care at any VA hospital in the nation, drop us a line.

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(SiuTan Wong contributed to this report)

**Department of Health Professions
Media Contact**

1. Date and time of contact: 3:30 p.m., Tuesday, January 5, 2016

2. Media who contacted us: *Richmond Times Dispatch* Reporter, Tammie Smith, Reporter, News Department t. 804.649.6572 m. 804.212.8165
TLSmith@timesdispatch.com

3. What is the story or the requested information?

Ms. Smith inquires, "I am planning to come to the Prescription Monitoring Program Advisory Committee Board Meeting tomorrow. It is listed as from 10 to 2 . Is it likely to last that long?"

4. What information was provided?



PMP Agenda Packet
1-6-16.pdf

Attached is the agenda for tomorrow's PMP Advisory Committee Meeting.

We anticipate the meeting will not go beyond two p.m. and that it is likely to conclude earlier.

If you will have the guard at the front entrance give me a call, I will take you to the meeting room.

5. When will the story appear? (TBD)

6. What do you expect the report to describe? There is a public comment period during which a healthcare group seeking legislative access to PMP may seek to address. See the attached program agenda.

7. Comments (optional): N/A

Name: Diane Powers

Title: Director of Communications

Seven Digit telephone number: 804/367-4524

Va. opioid overdose deaths spur action on tracking who gets painkiller prescriptions

By TAMMIE SMITH Richmond Times-Dispatch | Posted: Friday, March 11, 2016 9:57 am

Doctors and other prescribers will have to check the state's Prescription Monitoring Program database before writing an opioid prescription for longer than 14 consecutive days, under legislation passed by the General Assembly this session.

The prescription monitoring legislation and a flurry of others bills were passed by legislators in an attempt to address Virginia's recent epidemic of opioid overdose hospitalizations and deaths.

Deaths from prescription narcotic and heroin overdoses have been on the rise and in recent years have reached epidemic proportions. The death last Friday of a Chesterfield County man from a heroin overdose and the hospitalization of his half-sister from an overdose have put a face on the extent of the problem.

Virginia legislators considered at least a half-dozen bills that would have affected the Prescription Monitoring Program, a state database that captures information on every prescription written and dispensed for narcotic painkillers and other controlled substances.

The database includes information on the drug prescribed, the patient, the prescriber and where the prescription was filled. The program is designed to identify people going from doctor to doctor to get narcotics prescriptions and then from pharmacy to pharmacy to fill those prescriptions to avoid being detected.

Some people who "doctor-shop" are addicted and getting the drugs for their own use. But there's also the issue of narcotics diversion, where individuals sell their narcotics to others, which is also believed to be a factor in the rising epidemic of opioid and heroin overdoses.



opoids

-Pharmacist Tim Lucas, owner of DownHome Pharmacy in Roanoke, Va., and also the president of the Roanoke Valley Pharmacists Association, works at his pharmacy in 2014. Lucas uses a monitoring system that allows doctors and pharmacists to check patient's records to see if they are "doctor shopping," or have multiple prescriptions filled at different places by different doctors.

“This is a session that really saw the enormity of the problem and worked hard on it,” said Dr. David Brown, director of the Virginia Department of Health Professions. “Last year, we got the ability to mandatorily register all prescribers and dispensers. This year, we have genuine mandatory use of the PMP.”

“For the first time, there is mandatory continuing education,” Brown added, referring to House Bill 829, which requires prescribers who write a lot of prescriptions for narcotic painkillers to take classes on safe and responsible prescribing.

Elaine Yeatts, senior regulatory analyst with the Virginia Department of Health Professions, said the PMP bill “was a compromise from what was originally introduced.”

“We think one of the benefits of this bill will be that it will cause some prescribers to deliberately write (prescriptions) for 13 days rather than 30 days simply so they don’t have to fall under the requirements to check the PMP, which ultimately may be a good thing because that means there’s less opiate medication sitting in people’s medicine cabinets,” she said.

The bills requiring that the PMP be checked, House Bill 293 and Senate Bill 513, allow prescribers to delegate a staff person in their offices who is licensed, certified or registered with the Department of Health Professions and subject to patient confidentiality requirements, to check the PMP. In addition, the bills exempt some situations, including patients in hospice or palliative care and hospitalized patients.

“We felt like everything that was within those bills our physicians could get behind ... and also help the current problem that the Medical Society of Virginia feels is a very important issue,” said Mike Jurgensen of the Medical Society of Virginia.

Other PMP bills that passed include:

- House Bill 657, which requires the Department of Health Professions, in consultation with an advisory committee, to come up with criteria to identify unusual patterns of prescribing and dispensing of certain covered substances. That information can then be provided to the Department’s enforcement division for investigation and action.
- Senate Bill 287, which shortened the time allowed for pharmacies and other dispensers to report to the PMP from seven days to 24 hours or the next business day, whichever comes later. It also allows consulting physicians to access the database and clarifies that the PMP report can be part of a patient’s medical record.
- House Bill 1044 and Senate Bill 491, which allow physicians and pharmacists employed by Virginia Medicaid managed care organizations to request information about specific patients from the PMP under certain circumstances.

VIRGINIA'S PRESCRIPTION MONITORING MONITORING PROGRAM

VISIT PMP ONLINE

RX DRUG AND HEROIN DEATHS
OUTNUMBER
AUTOMOBILE DEATHS IN VIRGINIA

THOUSANDS
OF FAMILIES
ARE IMPACTED EACH YEAR

PRESCRIPTION DRUG DEATHS
HAVE BEEN

ON THE RISE
IN VIRGINIA

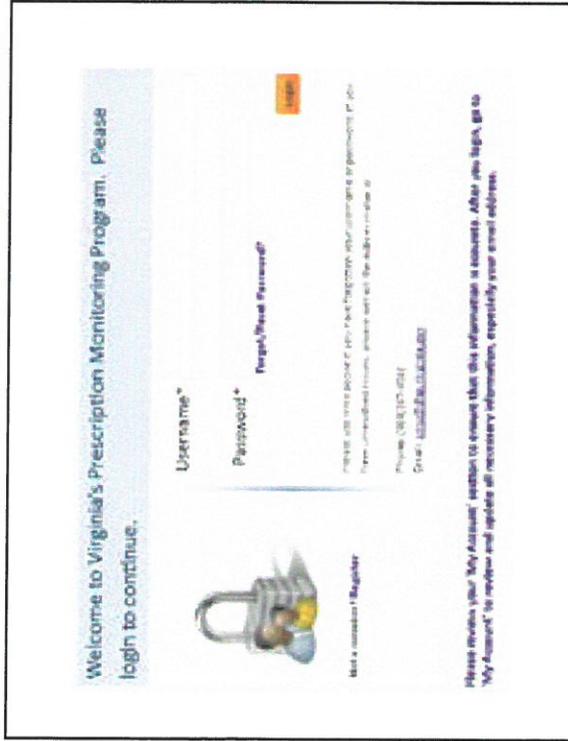
SINCE 1996



THE SOLUTION FOR SAFE PRESCRIBING IN VIRGINIA

A DIGITAL DATABASE OF
PRESCRIPTION AND PATIENT HISTORIES

DIGITALLY CONNECTED WITH 19 OTHER STATES



- Arizona
- Connecticut
- Delaware
- Illinois
- Indiana
- Kansas
- Kentucky
- Maryland
- Michigan
- Minnesota
- New Jersey
- New Mexico
- North Dakota
- Ohio
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Virginia
- West Virginia

As of 2016 there are more than **55,000** prescribers and **13,000** pharmacists registered to use PMP

WHAT DOES PMP DO?

PMP is authorized with specific powers and duties by the code of Virginia. PMP's mission is to promote the appropriate use of controlled substances for legitimate medical purposes while deterring the misuse, abuse and diversion of controlled substances.

The prescription monitoring program collects prescription data for Schedule II-IV drugs into a central database which can then be used by authorized users to assist in deterring the illegitimate use of prescription drugs.

NEW DEVELOPMENTS

AUTOMATIC REGISTRATION



As of January 2016, all newly licensed practitioners are automatically registered for the PMP Program.

NEW LEGISLATION



New legislation passed by the 2016 General Assembly requires doctors and other prescribers to check the PMP database before writing an opioid prescription for longer than 14 days.

NEW DEVELOPMENT 3



2016 CDC guidelines for opioid prescribing include: use of non-opioid therapies for chronic pain; and use of the lowest possible effective opioid dose.

KEEP UP WITH THE PROGRAM

Visit Virginia's PMP Online

View the CDC Guidelines for Prescribing Pain Medication

Virginia Department of Health Professions

David E. Brown, D.C.

Patient Care Disciplinary Case Processing Times: Quarterly Performance Measurement, Q3 2012 - Q3 2016

Director

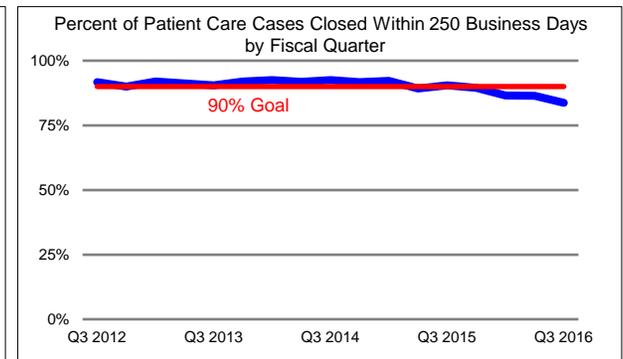
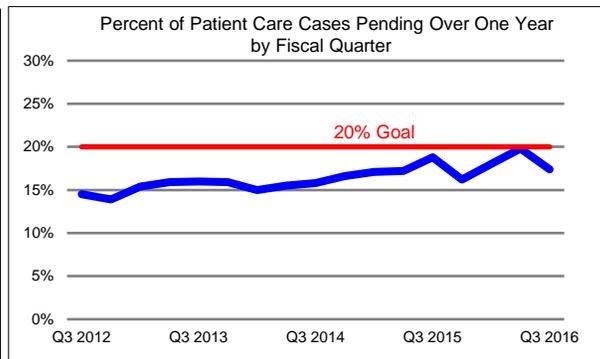
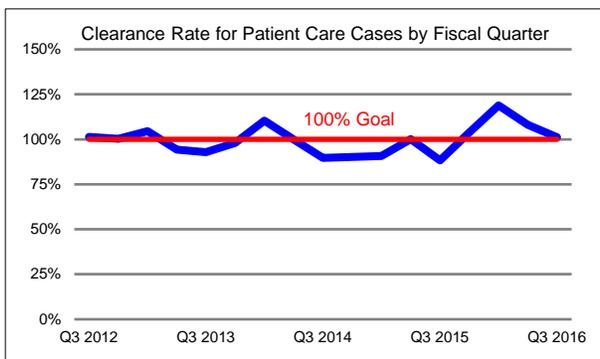
"To ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public."
DHP Mission Statement

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 through the end of FY 2016. The current quarter's clearance rate is 101%, with 1,003 patient care cases received and 1,014 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% through the end of FY 2016. The current quarter shows 17% patient care cases pending over 250 business days with 2,382 patient care cases pending and 415 pending over 250 business days.

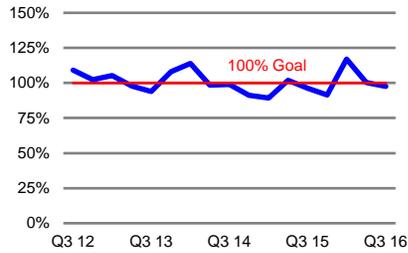
Time to Disposition - the percent of patient care cases closed within 250 business days for cases received within the preceding eight quarters. This moving eight-quarter window approach captures the vast majority of cases closed in a given quarter and effectively removes any undue influence of the oldest cases on the measure. The goal is to resolve 90% of patient care cases within 250 business days through the end of FY 2016. The current quarter shows 84% percent of patient care cases being resolved within 250 business days with 992 cases closed and 830 closed within 250 business days.



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

Nursing - In Q3 2016, the clearance rate was 98%, the Pending Caseload older than 250 business days was 6% and the percent closed within 250 business days was 85%.
Q3 2016 Caseloads:
 Received=497, Closed=485
 Pending over 250 days=68
 Closed within 250 days=412

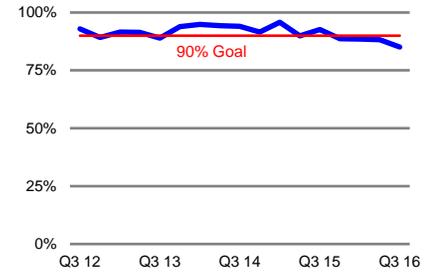
Clearance Rate



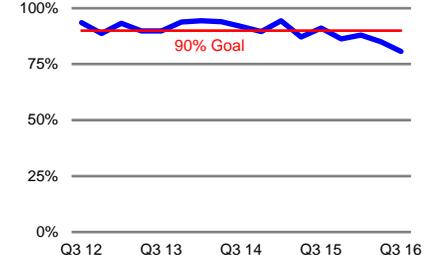
Age of Pending Caseload
 (percent of cases pending over one year)



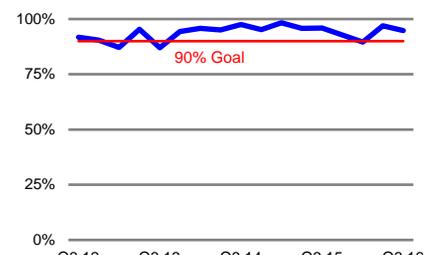
Percent Closed in 250 Business Days



Nurses - In Q3 2016, the clearance rate was 95%, the Pending Caseload older than 250 business days was 8% and the percent closed within 250 business days was 81%.
Q3 2016 Caseloads:
 Received=348, Closed=331
 Pending over 250 days=62
 Closed within 250 days=267



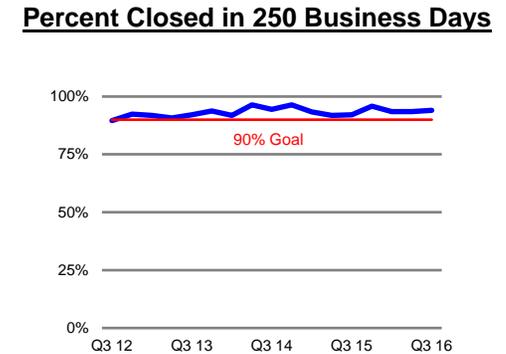
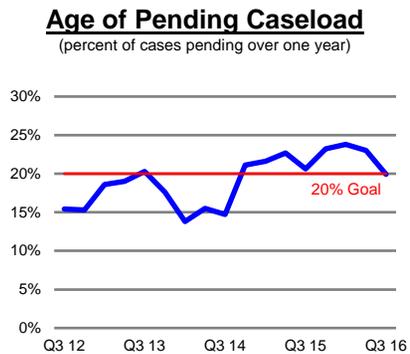
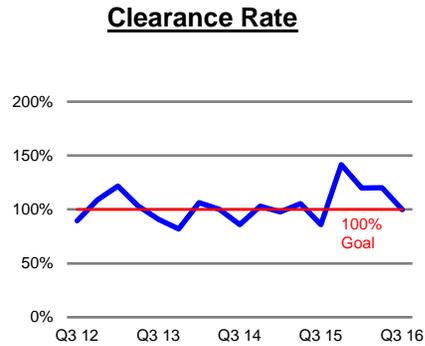
CNA - In Q3 2016, the clearance rate was 103%, the Pending Caseload older than 250 business days was 2% and the percent closed within 250 business days was 95%.
Q3 2016 Caseloads:
 Received=149, Closed=154
 Pending over 250 days=6
 Closed within 250 days=145



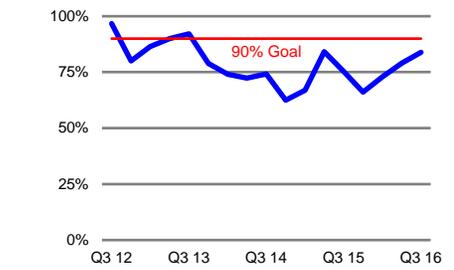
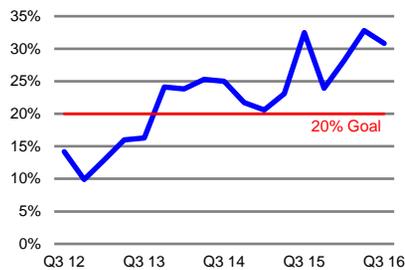
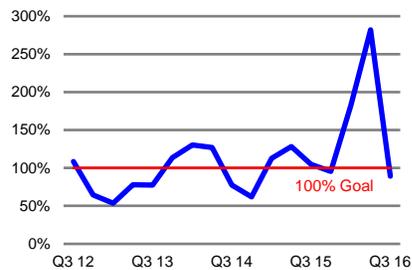
Note: Vertical scales on line charts change, both across boards and measures, in order to accommodate varying degrees of data fluctuation.

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

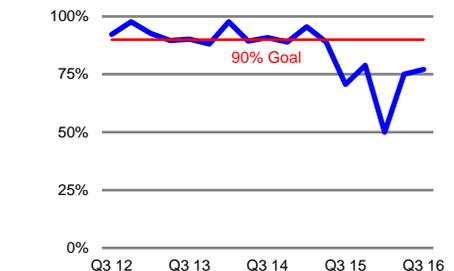
Medicine - In Q3 2016, the clearance rate was 100%, the Pending Caseload older than 250 business days was 20% and the percent closed within 250 business days was 94%.
Q3 2016 Caseloads:
 Received=298, Closed=297
 Pending over 250 days=99
 Closed within 250 days=270



Dentistry - In Q3 2016, the clearance rate was 89%, the Pending Caseload older than 250 business days was 31% and the percent closed within 250 business days was 84%.
Q3 2016 Caseloads:
 Received=74, Closed=66
 Pending over 250 days=60
 Closed within 250 days=52



Pharmacy - In Q3 2016, the clearance rate was 117%, the Pending Caseload older than 250 business days was 38% and the percent closed within 250 business days was 77%.
Q3 2016 Caseloads:
 Received=30, Closed=35
 Pending over 250 days=58
 Closed within 250 days=27

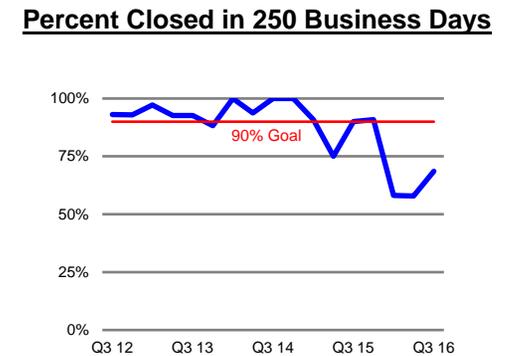
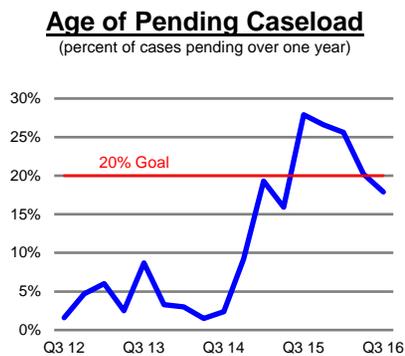
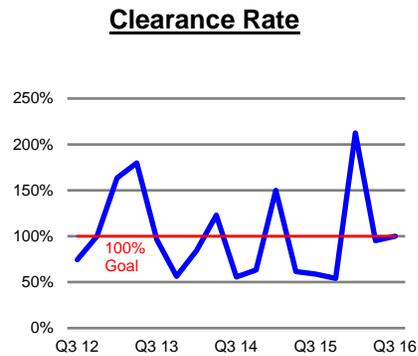


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Virginia Department of Health Professions - Patient Care Disciplinary Case Processing Times, by Board

Veterinary Medicine - In Q3 2016, the clearance rate was 100%, the Pending Caseload older than 250 business days was 18% and the percent closed within 250 business days was 69%.

Q3 2016 Caseloads:
 Received=37, Closed=37
 Pending over 250 days=24
 Closed within 250 days=24



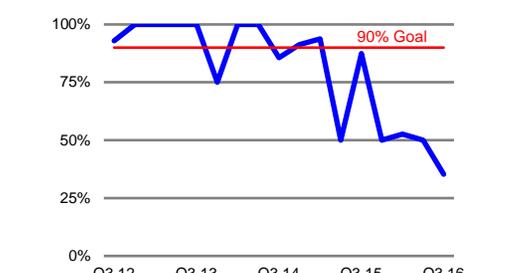
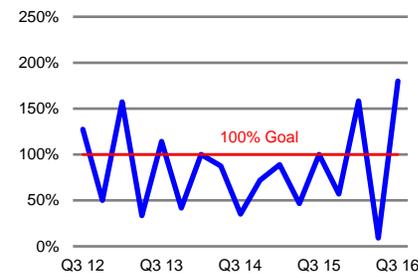
Counseling - In Q3 2016, the clearance rate was 129%, the Pending Caseload older than 250 business days was 32% and the percent closed within 250 business days was 31%.

Q3 2016 Caseloads:
 Received=14, Closed=18
 Pending over 250 days=22
 Closed within 250 days=5



Social Work - In Q3 2016, the clearance rate was 180%, the Pending Caseload older than 250 business days was 47% and the percent closed within 250 business days was 35%.

Q3 2016 Caseloads:
 Received=10, Closed=18
 Pending over 250 days=43
 Closed within 250 days=6

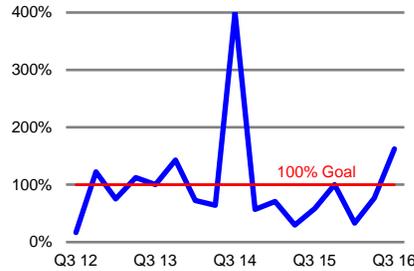


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Virginia Department of Health Professions - Patient Care Disciplinary Case Processing Times, by Board

Psychology - In Q3 2016, the clearance rate was 163%, the Pending Caseload older than 250 business days was 37% and the percent closed within 250 business days was 29%.
Q3 2016 Caseloads:
 Received=16, Closed=26
 Pending over 250 days=22
 Closed within 250 days=7

Clearance Rate

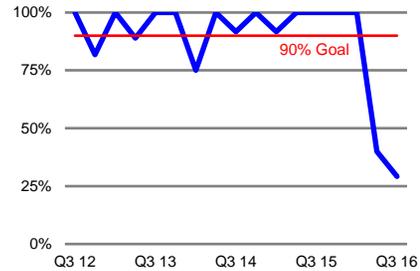


Age of Pending Caseload

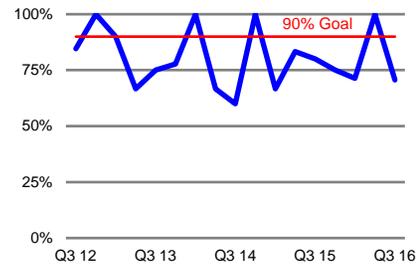
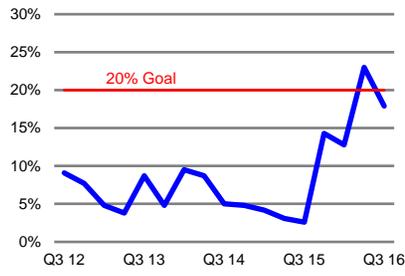
(percent of cases pending over one year)



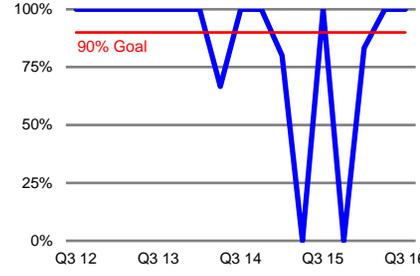
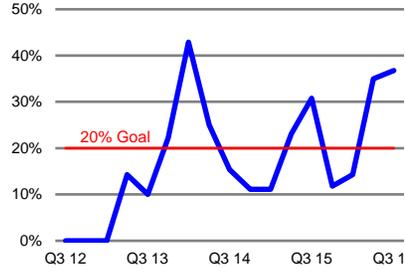
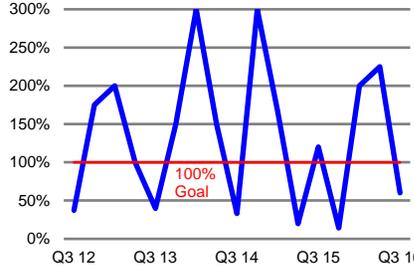
Percent Closed in 250 Business Days



Long-Term Care - In Q3 2016, the clearance rate was 170%, the Pending Caseload older than 250 business days was 18% and the percent closed within 250 business days was 71%.
Q3 2016 Caseloads:
 Received=10, Closed=17
 Pending over 250 days=7
 Closed within 250 days=12



Optometry - In Q3 2016, the clearance rate was 60%, the Pending Caseload older than 250 business days was 37% and the percent closed within 250 business days was 100%.
Q3 2016 Caseloads:
 Received=5, Closed=3
 Pending over 250 days=7
 Closed within 250 days=3

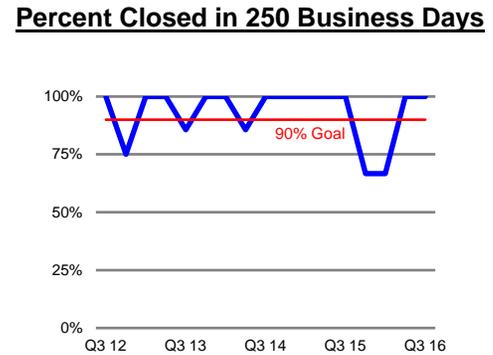
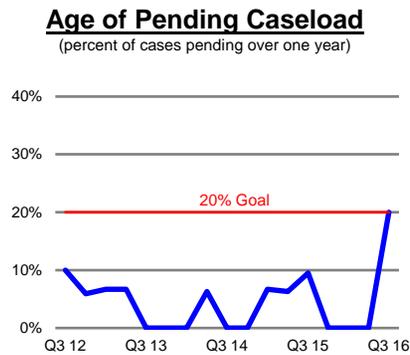


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Virginia Department of Health Professions - Patient Care Disciplinary Case Processing Times, by Board

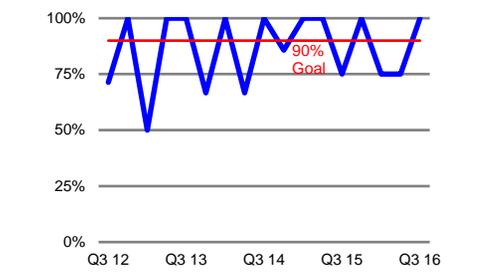
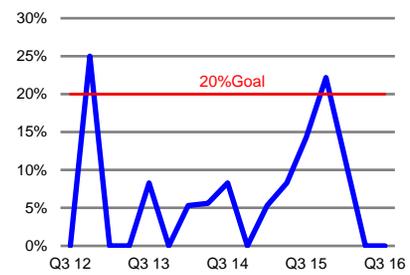
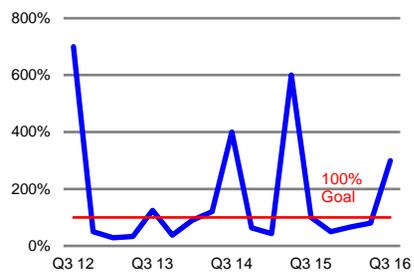
Physical Therapy - In Q3 2016, the clearance rate was 56%, the Pending Caseload older than 250 business days was 20% and the percent closed within 250 business days was 100%.

Q3 2016 Caseloads:
 Received=9, Closed=5
 Pending over 250 days=5
 Closed within 250 days=5



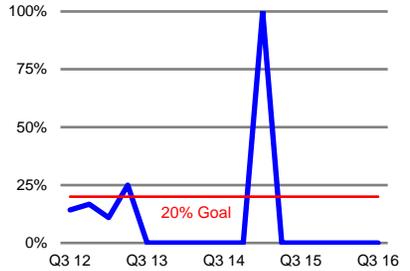
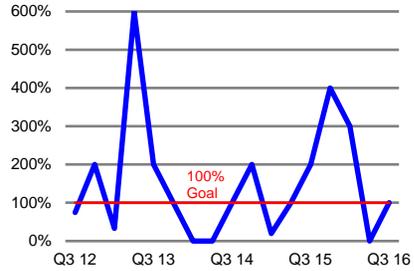
Funeral - In Q3 2016, the clearance rate was 300%, the Pending Caseload older than 250 business days was 0% and the percent closed within 250 business days was 100%.

Q3 2016 Caseloads:
 Received=2, Closed=6
 Pending over 250 days=0
 Closed within 250 days=6



Audiology - In Q3 2016, the clearance rate was 100% the Pending Caseload older than 250 business days was 0% and the percent closed within 250 business days was 100%.

Q3 2016 Caseloads:
 Received=1, Closed=1
 Pending over 250 days=0
 Closed within 250 days=1



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

Department of Health Professions Healthcare Workforce Data Center

www.dhp.virginia.gov/hwdc/

Tumblr: www.vahwdc.tumblr.com

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 (vahwdc.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 (www.vahwdc.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.

Student Choice (www.vahwdc.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)*

Implementing a Sanctioning Reference System for the Virginia Board of Nursing

Elizabeth A. Carter, PhD, and Neal B. Kauder, MS

In response to criticism regarding the objectivity and consistency of disciplinary sanctions, the Virginia Board of Health Professions decided to analyze sanctioning decisions and consider developing sanctioning reference points for boards to use in disciplinary cases. As a result, Virginia's Department of Health Professions and the independent consulting firm VisualResearch, Inc., jointly developed a sanctioning reference point system for and with each of the state's 13 professional boards, including the board of nursing. This article describes the system's development, implementation, and effectiveness.

Keywords: Discipline, nursing regulation, sanctioning, sanctioning reference point system

The Virginia Board of Nursing (BON) is housed within the Department of Health Professions, along with the state's 12 other health professional licensing boards and the advisory Board of Health Professions (BHP). Their collective mission is to ensure safe and competent patient care by licensing competent health professionals, enforcing standards of practice, and providing information to health care practitioners and the public (Code of Virginia §54.1-100 et seq; Virginia Department of Health Professions, n.d.).

The licensing boards accomplish this mission through the licensure, regulation, and discipline of over 370,000 health care practitioners across more than 60 professions. BHP does not license professions. Its role is to research and advise on issues regarding the regulation of health professions and agency operations. BHP conducts periodic reviews of agency and board investigatory, disciplinary, and enforcement processes "to ensure public protection and the fair and equitable treatment of health professionals" (Code of Virginia § 54.1-2510 (11)). Appointed by the governor, members of the licensing board and BHP are volunteers who are practitioners licensed by the board and citizen members.

In April 2001, BHP approved a plan to analyze health regulatory board sanctioning and to consider the appropriateness of developing historically based sanctioning reference points for boards to use in disciplinary cases (VisualResearch, Inc., 2001). Respondents, attorneys, public officials, and the media had suggested that sanctioning was too harsh, too lenient, or inconsistent over time. Some critics indicated that the variability in sanctioning could be attributed to extralegal factors, such as the composition of the boards, the geographic location of the hearing, a respondent's representation by an attorney, a respondent's race or ethnicity, and a respondent's gender. The BHP decided that an analysis should be conducted to determine if these assertions were true and what measures should be taken to rectify them.

Following this decision, Virginia's Department of Health Professions and an independent consulting firm, VisualResearch, Inc., jointly developed, implemented, and launched a sanctioning reference point (SRP) system for the state's professional boards, including the BON, for use in disciplinary proceedings. (See Table 1.)

Goals

Recognizing the complexity of sanction decision making, board and staff members indicated that a successful sanctioning system must be "developed with complete board oversight, be value neutral, be grounded in sound data analysis, and be totally voluntary" (VisualResearch, Inc., 2001). With this in mind, the following purposes and goals were established for the SRP system:

- To make sanctioning decisions more predictable
- To provide an education tool for new board members
- To add an empirical element to an inherently subjective process
- To provide a resource for board staff members and attorneys
- To neutralize sanctioning inconsistencies
- To validate board members' or staff members' recall of past cases
- To constrain undesirable influences
- To help predict future caseloads and the need for probation services.

BHP acknowledged that board members are asked to serve in a quasi-judicial role in determining whether misconduct has occurred and the appropriate sanctioning. Although knowledgeable about their profession's regulation and practice standards, board members lack systematized case histories and sentencing guidelines that are both readily available in the criminal justice system to assist justices.

Methodology

The SRP system borrows heavily from Virginia's criminal justice sentencing guidelines research methods because of a lack of any

TABLE 1

Sanctioning Reference Point System Timeline for Virginia

Timeline	
2001	Board of Health Professions work order/directive
2002–2004	Board of Medicine (pilot board) sanctioning reference point (SRP) system kick-off, development, implementation, adoption
2004	Board of nursing (BON) SRP system kick-off
2005	BON SRP development
2006	BON SRP implementation and adoption
2004–2009	Boards of Dentistry, Pharmacy, Optometry, Veterinary Medicine, Social Work, Psychology, Funeral Directors, Counseling, and Physical Therapy SRP development, implementation, adoption
2011	Effectiveness study, including revising worksheets with new data
2013	Revised nursing SRP worksheets adopted

comparable research in the regulatory realm. Virginia's criminal sentencing guidelines were developed in the late 1980s as an empirically based, systematic reference tool to help ensure neutrality, proportionality, and consistency. Essentially, the sentencing system uses multivariate statistical models to determine the relative influence of the offender and the offense factors that judges consider when sentencing convicted offenders. Significant factors are reviewed for their appropriateness, and any "extralegal" factors, such as race and gender, are eliminated from the models.

Following this analytic process, factors are selected and given a score using weights derived from a revised set of statistical models and matrix-based algorithms. Scores are then totaled and used in tables that contain thresholds for different sentencing severity levels—ranging from probation to terms of incarceration. The system is continually monitored, and staff update the sentencing guidelines as needed.

Virginia's regulatory SRP system was developed using similar analytical methods as used in the state's criminal justice sentencing guidelines, but it also uses normative adjustments; this approach combines information from past practice with policy adjustments to achieve the most up-to-date, consistent, and practical sanctioning outcomes (Carter & Kauder, 2004).

For each of the regulatory boards, following the SRP program timeline, researchers conducted in-depth personal interviews with board and staff members to gain insight into the factors that contribute to sanctioning decisions. The purposes of the interviews were to ensure that the factors members consider would be included in the SRP system worksheets and to identify any other factors that may come into play.

From 2004 to 2006, researchers collected detailed information on all BON disciplinary cases ending in a violation. The sample size for nursing licensees was approximately 350 cases, a statisti-

cally significant sample. Researchers used data available through the Department of Health Professions case management system and primary data collected from hard copy files. The hard copy files contained investigative reports, board notices, board orders, and all other documentation made available to board members when deciding a case sanction.

More than 100 different factors were collected on each case to describe the attributes that board members identified as potentially influencing sanction decisions. Among the factors that could influence sanctioning decisions were board history, substance abuse, patient injury, and corrective action taken. A comprehensive database was created to analyze the offense and respondent factors that were identified as potentially influencing sanctioning decisions. As was done with the criminal sentencing guidelines, staff used statistical analysis to construct a historic portrait of sanctioning decisions; the factors deemed to be consistently important were identified, and their relative weights (translated into worksheet scores) were then derived to create the SRP system. Over the course of the 15-year project, various multivariate and other statistical methods have been used to test the influence of case and respondent factors on sanctioning decisions for all 13 licensing boards. The details go beyond the scope of the current article, but can be found in Carter and Kauder (2004).

According to SRP system manual instructions (Virginia Department of Health Professions, 2013), the worksheets are completed regardless of whether the board's sanctioning agrees with the SRP in the case. The worksheets are collected to enable BHP's ongoing quarterly monitoring of agreement rates and examination of stated reasons for mitigating or aggravating departure. (See Figure 1.) To keep SRPs current in the face of new laws and regulations, professions, and evolving disciplinary issues, BHP consults the respective licensing boards to evaluate the need for updates.

Implementation Steps

The SRP system was implemented for each of the state's 13 boards following these 10 steps:

1. Conduct interviews with current and past board members, counsel, staff and members of the attorney general's office to glean information about the boards' past sanctioning, future goals, and expectations regarding uses for the SRP system.
2. Analyze the results of the interviews and obtain board feedback and approval on factors to be collected and the approach for scoring subjective factors.
3. Finalize data from the collection instrument for obtaining sanctioning information from case files, minutes, and notices. Collect data and enter the data into a database.
4. Compile, merge, and clean the database.
5. Determine statistically significant factors through multivariate analyses, report the results of the analysis showing the relative importance of each factor, and determine which factors the board wishes to retain as appropriate and exclude as inappropriate.

FIGURE 1

Sanctioning Reference Points Agreement Analysis

Virginia Department of Health Professions. Data through December 31, 2015. David E. Brown, D.C. Director

Board	Start Date	Completed Worksheets	Agreement		Departures				Agreement by Board
			#	%	Aggravating #	Aggravating %	Mitigating #	Mitigating %	
Medicine	Aug-04	230	165	72%	10	4%	55	24%	Medicine  72%
Nursing	Jul-05	1554	1220	79%	283	18%	51	3%	Nursing  79%
CNA	Jul-05	907	873	96%	19	2%	15	2%	CNA  96%
RMA	Jun-13	43	32	74%	10	23%	1	2%	RMA  74%
Dentistry	Jun-06	214	165	77%	20	9%	29	14%	Dentistry  77%
Funeral	May-07	38	31	82%	1	3%	6	16%	Funeral  82%
Veterinary Medicine	May-07	96	79	82%	13	14%	4	4%	Veterinary Medicine  82%
Pharmacy	Nov-07	107	77	72%	5	5%	25	23%	Pharmacy  72%
Pharmacy Technicians	Jun-13	4	2	50%			2	50%	Pharmacy Technicians  50%
Optometry	Dec-08	14	11	79%	2	14%	1	7%	Optometry  79%
Social Work	Jun-09	14	7	50%	2	14%	5	36%	Social Work  50%
Psychology	Jun-09	10	8	80%	2	20%			Psychology  80%
Counseling	Jun-09	17	15	88%	1	6%	1	6%	Counseling  88%
Physical Therapy	Nov-09	6	4	67%	2	33%			Physical Therapy  67%
Long-Term Care	Mar-10	12	8	67%			4	33%	Long-Term Care  67%
Audiology	Jun-10	2	2	100%					Audiology  100%
DHP Total		3268	2699	83%	368	11%	201	6%	DHP Total  83%

Note. CNA = certified nurse aide; RMA = registered medication aide; DHP = Department of Health Professions. Prepared by VisualResearch, Inc.

- Introduce board feedback into the statistical model and revise it. Use analysis to predict sanctioning outcomes.
- Begin developing the SRP worksheet.
- Finalize the sanctioning worksheet with sanction decision grids that provide for simultaneous consideration of the offense, the respondent, and prior record factors deemed appropriate by the board, making normative adjustments, if any, as the board deems needed.
- Conduct training sessions for board members, staff, enforcement and adjudicative staff, the press, the attorney general's office, and interested private lawyers. Post the SRP system manual on the board's website.
- Begin using the SRP system and begin ongoing monitoring of sanctioning worksheets for proper use, including a formal effectiveness study.

System Framework

The SRP system is grounded in a case type–based conceptual framework (VisualResearch, Inc., 2005). The SRP system worksheets for the BON are grouped into three offense types:

- Inability to practice safely
- Standard of care

- Unlicensed activity and fraud.

This organization is based on the most recent historic analysis of board sanctioning. The SRP system factors on each worksheet proved important in determining sanctioning outcomes.

The system uses a two-dimensional sanctioning grid for nursing cases. Analysis supports the idea that both the offense and respondent factors impacted sanction outcomes, so the SRP system makes use of a two-dimensional scoring grid. One dimension scores factors related to the current violation, and the other dimension scores factors related to the respondent. The first dimension assigns points for circumstances related to the violation. For example, the respondent may receive points for an inability to practice safely because of impairment at the time of the offense or because multiple patients were involved. The second dimension assigns points for factors related to the respondent. For example, a respondent before the board for an unlicensed activity may also receive points for having a history of disciplinary violations for other types of cases. That same respondent would receive more points if the prior violation were similar to the current one.

The system uses one of three worksheets depending on the case type. Detailed instructions are provided for each factor on a worksheet and should be referenced to ensure accurate scoring. (See Figure 2). The scoring weights assigned to a factor cannot be

FIGURE 2

Board of Nursing Standard of Care Worksheet

Below is the Standard of Care Worksheet that the board of nursing uses to determine sanctions.

Standard of Care Worksheet
Board of Nursing
Adopted 3/22/11

Offense Score	Points	Score
a. Sexual Abuse/Inappropriate Relationship	55	_____
b. Patient injury	20	_____
c. Patient especially vulnerable	20	_____
d. Concurrent sanction by employer	20	_____
e. Act of commission	10	_____
f. Any patient involvement	10	_____
Total Offense Score		_____

Respondent Score	Points	Score
a. Concurrent criminal conviction	30	_____
b. Significant and substantial danger to the public	30	_____
c. Any prior Board violations	20	_____
d. License ever taken away	20	_____
e. Been sanctioned by another state/entity	20	_____
f. Past difficulties (substances, mental/physical)	10	_____
g. Three or more employers in past 5 years	10	_____
Total Respondent Score		_____

Offense Score

0-40 41-70 71 or more

	0-40	41-70	71 or more
0-20	No Sanction ... to > Reprimand/CE/ Monetary Penalty	Reprimand/CE/ Monetary Penalty	Reprimand/CE/ Monetary Penalty ... to > Treatment/Monitoring
30 or more	Reprimand/CE/ Monetary Penalty	Treatment/Monitoring ... to > Recommend Formal/ Suspension or Revocation	Treatment/Monitoring ... to > Recommend Formal/ Suspension or Revocation

Grid cells give a single recommendation or a range of recommendations for imposing sanctions.

Confidential pursuant to § 54.1-2400.2 of the Code of Virginia. 17

Unlicensed Activity/Fraud Worksheet Instructions

Offense Score	Respondent Score
<p>Step 1: Use Circumstances (score all that apply)</p> <p>a. Enter "20" if the respondent received a sanction from his/her employer in response to the current incident. A sanction from an employer may include, but is not limited to: suspension, termination, or disciplinary counseling notice.</p> <p>b. Enter "20" if a patient was intentionally or unintentionally injured. Injury includes any physical injury, physical or sexual abuse, and death.</p> <p>c. Enter "20" if the patient is especially vulnerable. Patients in this category must be at least one of the following: under age 18, over age 65, or mentally/physically handicapped.</p> <p>d. Enter "15" if the offense involves a patient. Patient involvement is direct contact with a patient, patient neglect, boundary issues, or drug diversion with patient deprivation.</p> <p>e. Enter "10" if the respondent's motivation for the violation included financial or material gain.</p> <p>f. Enter "10" if this was an act of commission. An act of commission is interpreted as purposeful or with knowledge.</p>	<p>Step 3: (score all that apply)</p> <p>a. Enter "30" if the respondent received a criminal conviction related to this offense. This factor includes respondents pleading guilty with first offender status.</p> <p>b. Enter "20" if the respondent has any prior order(s) issued by the Virginia Board of Nursing finding them in violation.</p> <p>c. Enter "20" if the Virginia Board of Nursing previously revoked, suspended, or summarily suspended the respondent's license.</p> <p>d. Enter "20" if the respondent has previously been sanctioned by any other state or jurisdiction. Sanctioning by an employer is not scored here.</p> <p>e. Enter "10" if the respondent has had any past difficulties in the following areas: drugs, alcohol, mental capabilities or physical capabilities. Scored here would be prior convictions for DUI/DWI, inpatient/outpatient treatment, and bona fide mental health care for a condition affecting his/her abilities to function safely or properly.</p> <p>f. Enter "10" if the respondent has had three or more employers in the past five years.</p>
<p>Step 2: Combine all for Total Offense Score</p>	<p>Step 4: Combine all for Total Respondent Score</p>

Sanctioning Grid

Step 5: Identify SRP Recommendation. Locate the Offense and Respondent scores within the correct ranges on the top and left sides of the grid. The cell where row and column scores intersect displays the sanctioning recommendation.

Example: If the Offense Score is 30 and the Respondent Score is 0, the recommended sanction is shown on the top left grid cell - "No Sanction is Recommended/CE/Monetary Penalty."

Step 6: Coversheet. Complete the coversheet, including the grid sanction, the imposed sanction and the reasons for departure if applicable.

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adjusted. The SRP system is not applied in any of the following circumstances: action by another board, compliance and reinstatement, confidential consent agreements, and mandatory suspensions.

The system ensures wide sanctioning ranges. The SRP system considers and weighs the circumstances of an offense and the relevant characteristics of the respondent, providing the board with a sanctioning model that encompasses approximately 75% of historic practice. In approximately 25% of past cases, respondents received stricter or milder sanctions than the SRP system indicated. In these cases, aggravating or mitigating factors play a legitimate role in sanctions. The wide sanctioning ranges allow the board to customize a particular sanction within the broader SRP system recommended range.

Complying with the SRP recommendations is voluntary. The SRP system should be viewed as a decision aid for the BON. Sanctioning within the SRP system ranges is voluntary, meaning that the system is viewed strictly as a tool and the board may choose any sanction outside of the recommendation. The board maintains complete discretion in determining the sanction. However, worksheets still must be completed and presented in every eligible case.

Effectiveness Study

The purpose of the effectiveness study was to evaluate the SRP system against its own objectives. Although all 13 licensing boards participated in the effectiveness study, which examined each board in turn from 2011 to 2013, this article focuses on the BON's use of the SRP system. The goals of the effectiveness study included the following:

- Examining sanctioning agreement rates and board feedback practices
- Reexamining and modifying the SRP system worksheet factors and scoring weights
- Reexamining and modifying the SRP system sanction recommendation thresholds
- Assessing consistency, proportionality, and neutrality in sanctions
- Determining how board policies fit within the SRP system
- Examining whether or not the SRP system training was adequate
- Identifying unintended consequences and outcomes of the SRP system.

SRP System Coversheets and Worksheets

Completed SRP system coversheets and worksheets were assessed for accuracy and integrity. This assessment entailed comparing the data on the actual, completed coversheets and worksheets against the facts found in the case files, hearing minutes, notices, and reports. Accuracy and completeness were also assessed by evaluating form completeness, checking for mathematical errors, and verifying proper sanction grid cross-referencing. Although the worksheets were found to be very reliable, an ongoing maintenance-training program will mitigate any issues found in this assessment.

SRP System Sanctioning Agreement

Completed SRP system coversheets and worksheets were analyzed to determine what percentage of sanctions handed down by the BON were within the recommended sanction ranges determined by the SRP system. The effectiveness study revealed an agreement rate of approximately 77%, which is nearly the same as the percentage targeted during SRP system development. Sanctioning reference point agreement rates are produced quarterly and reported to BHP (January 2007 to present). These documents are used as working papers, and can be obtained from the Board of Health Professions, as seen in Figure 1.

Sanctioning Departure Reasons

The SRP system is voluntary and is used as a guideline. The BON can choose to sanction respondents outside the recommended sanction range. When the BON departs from the recommended range, the SRP system coversheet captures the departure reason in a free-form field. The departure reasons support the BON's decision to impose sanctions that are harsher or milder than the recommended range. Analysis of the departure reasons led to a number of minor changes to the grid sanction recommendations and worksheet definitions.

Consistency, Proportionality, and Neutrality

Using the goals of Virginia's criminal sentencing guidelines of ensuring consistency, proportionality, and neutrality, the BON's SRP tool was evaluated as to whether it upheld the same three objectives.

Consistency in sanctioning addresses the following question: To what extent do similar respondents and offenses receive similar sanctions? One of the goals of the SRP system is to make concepts such as "similarly situated" measurable. For example, given a combination of offense and respondent factors on the BON's standard of care worksheet, a respondent falls into a certain grid cell. Other respondents in the same grid cell should be comparable in terms of factors deemed relevant in sanctioning and should receive similar outcomes. The primary method for evaluating consistency relies on examining SRP system agreement rates and, as noted above, the agreement rate of 77% coincides with the 75% predicted rate for nursing.

Proportionality in sanctioning addresses the following question: Are the most serious cases getting the most serious sanctions

and are less serious cases getting less serious sanctions? The SRP system provides an empirical point system that links offense and respondent characteristics to appropriate sanctions. For rational sanctioning, the proportionality of offense to sanction must be accurately represented by the point system. Inaccurate or unproven numeric proportions could lead to more serious offenders receiving less serious sanctions and vice versa. The analysis resulted in changes to several sanctioning grids, leading to higher agreement rates and thus more proportional sanctioning outcomes.

Neutrality addresses the issue that sanctions could differ based on extralegal characteristics of the respondent or case. For example, older respondents or respondents with attorneys could receive milder sanctions even when other worksheet factors remain constant. Neutrality is traditionally the most difficult criterion to measure when differentiating among sanctioning decisions. The effectiveness study analyzed closed cases using SRP system worksheets and collecting data on extralegal factors. The extralegal factors available for analysis (gender, age, attorney involvement) were not found to be significant factors in determining departures.

SRP System Training

During the implementation phase of the SRP system, formal training was provided to various constituencies, including BON members, the executive director and administrative staff of the BON, attorneys from the attorney general's office, and private attorneys. As a result of normal turnover among personnel from these various groups, many of the people currently using the SRP system have not been formally trained. Ad hoc training has occurred over time but periodic, formal training is required to maintain the integrity of the SRP system. As part of the effectiveness study, training was reviewed and a long-term maintenance training plan was created, and it is currently being implemented.

Conclusion

After using the SRP worksheets on more than 2,200 disciplinary cases, the BON continues to find the system to be a useful and accurate representation of historic sanctioning practice. Not only do Virginia's health regulatory boards feel that the system is beneficial, but the program has been recognized for innovation and excellence by several national health professions associations and organizations. As the analytic knowledge base continues to expand, the BHP has brought a more empirically based structure to the difficult task of sanctioning. With this expansion also comes the measurable benefit of increasing equity and accountability during the health care provider disciplinary process.

The SRP approach has been replicated among the 13 health regulatory boards in Virginia. But SRP worksheets and manuals from these boards cannot be applied interchangeably or "off the shelf" by another state's licensing board for the same profession. The degree to which it may be replicated outside of the state will depend upon the desire and means to replicate the empirical pro-

cesses involved in developing, evaluating, and maintaining a working model.

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Jackson, Laura (DHP)

From: Juran, Caroline (DHP)
Sent: Tuesday, April 05, 2016 4:52 PM
To: Carter, Elizabeth A. (DHP); Jackson, Laura (DHP)
Cc: Cindy Warriner
Subject: Comments from BOP Chair and ED on the BHP/VCU Telehealth Report

Liz,

Thanks for allowing the executive directors and chairmen to review the Telehealth report. Cindy Warriner, Board of Pharmacy Chairman, and I submit the comments below for the BHP's consideration.

- The report does not mention the implication that telehealth may have on a prescriber's ability to issue prescriptions for drugs in Schedules II-V
 - While there is no federal license to practice, the rules for defining a valid prescription for a drug in Schedules II-V based on the establishment of a bona fide practitioner-patient relationship are addressed both federally and in state law. In most instances, state law mirrors the federal rules on this subject and prescribers must maintain both a state practice license and a DEA registration in order to prescribe such drugs.
 - There is confusion as to whether and under what circumstances, if any, a prescriber treating a patient via telemedicine may issue a prescription in Schedules II-V. I am hoping to speak with the DEA policy section chief today on this issue.
 - §54.1-3303 specifically addresses the use of telehealth to prescribe drugs in Schedules VI, but it is not clear to me whether the law supports the use of telehealth to prescribe drugs in Schedules II-V.
- In the last paragraph on page 6, it states the definition of telemedicine services/telehealth "appear to have applications across the spectrum of health care professions". Then throughout the report, certain boards within DHP are highlighted for having not yet addressed telehealth or multi-state licensure issues. However, the report does not address the fact that the state definition of telehealth does not cleanly incorporate certain professional practices, e.g., pharmacy, and therefore, the report may not accurately represent the Board of Pharmacy's actions on this related subject. The practice of pharmacy is continuously inundated with an increased use of technology to review prescription orders and dispense drugs to patients. However, the use of technology in the examples listed below may not necessarily meet the current definition of "telemedicine services". The current definition appears to contemplate the use of technology for communicating with the patient or consulting with another practitioner. The examples below don't generally involve communication with the patient and the purpose of the communication isn't necessarily for consult, but they do demonstrate Board of Pharmacy action to embrace the use of technology in providing patients with pharmaceutical services. These examples include:
 - Rules that address the processing and dispensing of drugs from a remote location. This involves the use of technology for transmitting prescription orders to a remote location, the performance of a prospective drug review or verification of the accuracy of a data entry by pharmacists located remotely within the state or in another state. This process is often used to spread workload among multiple pharmacies and improve efficiencies in dispensing drugs to patients, thereby improving access to timely medications. Additionally, it is often used by small hospitals or nursing homes that do not have a pharmacist on-site and therefore, rely on a pharmacist located elsewhere to remotely review prescription orders prior to the nurses pulling the drugs for administration.

- The majority of pharmacies having embraced technology to facilitate e-prescribing of drugs in Schedules II-VI.
- The use of robotics, bar-code scanning, and RFID technology in the distribution and dispensing processes.
- The board's adoption of a legislative proposal which was introduced as HB 528 in the 2016 General Assembly Session which conform state pedigree requirements to the recently enacted federal law for track and trace technology to be used throughout the drug supply chain.
- Several innovative pilot programs currently approved by the board which allow for enhanced use of technology in the dispensing process that are otherwise not currently addressed in law or regulation.
- The report appears to emphasize the importance for considering a multi-state licensure compact and references the supporting positions of several national organizations. However, the National Association of Boards of Pharmacy has reviewed this issue in the past and does not appear to believe this is necessary for pharmacy based on the efficient electronic licensure transfer process in place with NABP acting as the clearinghouse. On page 25, it states licensure in separate states can be onerous and time-consuming and includes a quote regarding the process taking 3-6 months for physicians to obtain licensure in separate states. That is not the case with pharmacists. Assuming the pharmacist successfully passes the jurisprudence exam on his or her first attempt and does not have reasons for possible denial, he or she can obtain licensure in a separate state often within 3-4 weeks. I'll forward you a separate email from NABP on this subject.
- The report states on page 11 that "state licensing of health professionals serves to not only insulate the health care market among individual professions within a state, but also insulates a state's health care market from competition posed by providers in other states." I recommend "may" being inserted into this sentence as this statement is inaccurate with respect to pharmacy. Boards of Pharmacy routinely license out-of-state pharmacies to provide services to patients within the state. Virginia currently has approximately 800 nonresident pharmacies registered with the board compared to approximately 1800 in-state pharmacies. The nonresident pharmacy is required to have a VA-licensed pharmacist-in-charge. Our current state licensing process does not appear to insulate the pharmacy industry from competition by providers in other states. We have a similar concern on page 24 in the last sentence of the first paragraph. We recommend inserting the word "may" prior to "limit the state's ability to utilize telehealth..." since this does not appear to be true for pharmacy.
- In general, we recommend that the report acknowledge the issues above and the reasons for why certain boards have not directly addressed telehealth as it is defined in statute. Specifically, we also recommend:
 - Page 1 – first paragraph, last sentence – insert "may" before "hamper efforts to improve access to care."
 - Page 17- the description of §54.1-3303 appears incorrect. The description should reference the use of telemedicine to prescribe Schedule VI drugs, not the longstanding ability to accept prescriptions from out-of-state prescribers.
 - Page 18- first paragraph, last sentence – seems inaccurate to state that Pharmacy has no specific activity regarding telehealth based on the allowance for a pharmacist to dispense a prescription in §54.1-3303 based on a bona fide practitioner-patient relationship which now includes certain allowances for telemedicine.
 - Page 21- under Telehealth Efforts Underway – what are the national efforts underway with reference to Pharmacy?
 - Page 22- under Establishing a consistent definition of telehealth and ensuring standards of care – A reference to the confusion and possible limitations for prescribing drugs in Schedules II-V via telemedicine based on federal and state rules should be inserted into the sentence, "In addition, practitioners debate how the definition of telehealth should establish a sufficient physician-patient relationship..." A similar reference should be included on page 23 with the "Practitioners:" section.

Please let me know if you have any questions.

Caroline

Caroline D. Juran, RPh

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Knachel, Leslie (DHP)

From: Knachel, Leslie (DHP)
Sent: Thursday, March 03, 2016 10:33 AM
To: 'jmiller@rvshc.org'
Cc: Stamey, Carol S. (DHP)
Subject: FW: Telehealth

Dear Ms. Miller,

I am not permitted to provide legal advice or interpret the laws and regulations related to the practice of speech-language pathology in Virginia. However, the information below appears to be applicable to your question.

Question: *What is the Board's stand on the practice of telehealth at present?*

Response: The following excerpts from the Board of Audiology and Speech-Language Pathology address telepractice:

May 26, 2011

Research Needed to Address Issues Related to Telepractice

Ms. Knachel informed the Board of an inquiry received in reference to telepractice guidelines for Virginia. She stated that there is consensus among the boards within the agency that telepractice is emerging with the advancements in technology. Additionally, there is consensus among the boards that if the patient or client receiving services resides in Virginia, then the health professional providing the services must be licensed in Virginia. Ms. Knachel expressed that before guidelines can be determined, more information must be gathered regarding the functions that can be carried out by audiologists and SLP's via telepractice. Dr. Gleason reported that ASHA recently formed a special interest group with the goal of developing guidelines for telepractice. In addition, Scott Rankins, SHAV, commented that he recently attended two conferences that provided highlights regarding the growth of telepractice and provided some resources that would assist in gaining a better understanding of the movement and growth of telepractice in Virginia. The Board requested that staff continue to gather information from the professional speech and hearing associations and how other states are addressing telepractice.

November 3, 2011

Frequently Asked Questions(FAQ's)

Ms. Knachel presented an overview of the amendments to the current FAQ's posted on the board website. Ms. Knachel noted that the amendments provided updated information on commonly asked questions. The Board requested that the FAQ related to telepractice be revised to encompass advancements that may occur in telepractice technology. Further, that Ms. Knachel forward the proposed draft language of the amended FAQ to the Board for review prior to it being posted to the Board's webpage. [Note: The FAQ's are no longer posted on the Board's website.]

May 24, 2012

Telepractice and Licensure Portability Update

Dr. Gleason referred the Board to the telepractice information contained in the agenda packet. She noted that the regulations are silent with regards to the issue of telepractice. She mentioned that the Board had previously discussed that a Virginia license is required if treating a patient located in Virginia. Dr. Gleason expressed that telepractice will be an on-going issue for further discussion.

To review the laws and regulations applicable to the practice of speech-language pathology, please go to http://www.dhp.virginia.gov/aud/aud_laws_regs.htm.

Sincerely,
Leslie Knachel

Leslie L. Knachel, M.P.H.

Executive Director

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**Virginia Department of
Health Professions**

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Under no circumstances shall the Boards, their members, officers, agents, or employees be liable for any actions taken or omissions made in reliance on any information contained in this e mail.

From: Janet Miller [<mailto:jmiller@rvshc.org>]
Sent: Monday, February 29, 2016 1:51 PM
To: Board of Audiology and Speech
Subject: Telehealth

What is the Board's stand on the practice of telehealth at present? Thank you.
Janet Miller

Janet Miller, MA, CCC-SLP
Speech/Language Pathologist
Roanoke Valley Speech & Hearing Center
2030 Colonial Ave. SW



AN ANALYSIS OF TELEHEALTH IN VIRGINIA



Andrew Feagans and Andrea Peeks
MPA CAPSTONE REPORT
DECEMBER 2015

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EXECUTIVE SUMMARY

The Board of Health Professions (BHP), part of the Virginia Department of Health Professions (DHP), engaged with MPA graduate students in the L. Douglas Wilder School of Government and Public Affairs at Virginia Commonwealth University (VCU) to conduct an “environmental scan” of existing evidence pertaining to the use and provisions of telehealth in Virginia. Accordingly, this report examines which entities within Virginia are effectuating the use of telehealth—defined simply as the use of technology to provide health care over long distances—and provides a general synopsis of the opportunities and risks posed by its implementation.

The results of this study are intended to assist DHP and its health regulatory boards with their ongoing consideration of whether to support efforts to expand the use of telehealth in Virginia. With respect to the multitude of resources and references that already exist regarding telehealth, this report is unique in its objective review of the current status of telehealth use, of commonly-cited benefits and challenges to its implementation, and of how Virginia compares to other states in regards to its openness and use of telehealth in its provision of health care.

The study approaches the process of an environmental scan by utilizing a four lens approach that starts at the national level, and progressively focuses on the specific activities of the 13 health regulatory boards. The results of this research provide a succinct yet comprehensive evaluation of the matter of telehealth- a brief overview of its history, a synopsis of its most common definitions and features, a balanced look at current commentary regarding its use, nationally published references for telehealth standards of care, and current legal and regulatory frameworks guiding its use.

Findings of the report reveal Virginia is a national leader in telehealth efforts, with the Boards of Medicine and Nursing having the most involvement at the state level. Virginia’s membership in a multi-state licensing compact is currently limited to the Nurse Licensure Compact, but research shows that others of the health regulatory boards—namely Medicine, Psychology, and possibly Physical Therapy—are actively considering compacts for their respective professions. Overall, the Virginia health regulatory boards are at varying stages of telehealth utilization.

The report concludes by providing recommendations regarding the use of telehealth within Virginia: (1) balance the inherent values conflict between the desire to use telehealth to expand access to care while simultaneously ensuring that the care provided comports with board-approved standards of care; (2) be aware that the rapid advancement of telehealth poses a significant challenge to the standard business models of health care; specifically, health providers and their licensing boards may have to re-think how they deliver and regulate health care to keep up with changing customer expectations; (3) consider ways to streamline deliberate processes for obtaining state licensure as a way to enable wider use of telehealth between states; and (4) recognize that Virginia has, within its borders, substantial resources at its disposal for use in advancing the use of telehealth.

INTRODUCTION

Changes in telecommunications technology have created new methods of delivering health care services to patients and make it easier than ever before to connect health care providers with patients in remote and underserved areas (Darkins & Cary, 2000). However, the new ability to project expertise and provide health care services over vast distances is circumscribed by the licensing regulations which exist to ensure health care providers are well-trained and qualified to practice in their field. In the U.S., the licensing of health care providers is a responsibility of state governments. As such, a license to practice medicine in one state is bound for use only in that state, unless there is some other agreement, such as a multi-state compact, that will allow a provider to practice across state lines. Ironically, the regulatory structure built to ensure the quality of healthcare hampers efforts to improve access to care.

This report provides a review of the regulatory environment as it relates to telehealth and the role that multi-state licensing could play in augmenting its adoption. The report describes the problem and the current regulatory environment. It explores how telehealth is defined in statute across the Mid-Atlantic region, discusses the evolution of the current licensing regulatory structure, and considers the impact of historical developments on the health care provider population in Virginia. The report then explores how states have responded to the issue, with particular focus on Virginia and the specific references to telehealth that exist as of the publication of this report. An examination of states' responses to telehealth, as often guided by the national organization representing each individual profession, generates practical models that DHP and its constituent health regulatory boards might consider. The report concludes with the range of commentary surrounding the matter of telehealth, observations on trends in telehealth for Virginia, and recommendations for how Virginia might respond to the current situation.

Statement of Problem

The Department of Health Professions (DHP) ensures safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing relevant information to health care practitioners and the public. Under the purview of the department are 13 health regulatory boards that together govern the standards of practice for over 370,000 Virginia healthcare providers from 80 professions. In addition to the 13 boards, DHP also oversees the Board of Health Professions (BHP) which, in accordance with its statutory authority granted by § 54.1-2507 through § 54.1-2510, Code of Virginia, advises the Governor, General Assembly, Secretary of Health and Human Resources and DHP Director on key issues pertaining to the regulation of health professions.

In accordance with its statutory responsibilities, BHP produced a study in 1998 at the request of the then-Virginia Secretary of Health and Human Resources intended to promote the use of new technology to benefit consumers and create opportunities for health care providers to extend their practice (DHP, "Report on Practice," 1998, p.1). The resulting publication, *Report on Practice of Telehealth Across State Lines and State Regulation*, provides an overview of

telehealth, a discussion regarding the locus of practice for its use (as cited in the report to be where the patient is located), a listing of the benefits and risks of telehealth, and alternatives for the implementation of telehealth care (p. 1-10).

With respect to the passage of time and significant advancements in technology since the publication of the 1998 report, BHP announced at its August 6, 2015 Board Meeting an effort to undergo a “comprehensive review of the literature and insights into current best practices in the regulation of telehealth” (DHP, “Draft Minutes,” 2015, p. 3). Specifically, BHP announced that the research effort would be initiated as a capstone project by graduate students with Virginia Commonwealth University’s L. Douglas Wilder School of Government and Public Affairs (VCU). BHP requested that the VCU students conduct an “environmental scan” of telehealth practice and oversight and detail relevant recommended policies, model legislation, and other formal guidance developed to date.

To direct the VCU team, BHP identified the following three questions to guide the research:

1. How is telehealth practice defined and governed by federal and state statutes, regulations, or state professional licensing guidance?
2. Which professions provide telehealth care?
3. What conflicting commentary exists on this topic?

Accordingly, this report serves as a reference for BHP and the 13 health regulatory boards under the authority of DHP.

Connection to Public Sector Values

In 2009, the Network of Schools of Public Policy, Affairs, and Administration (NASPAA) adopted a set of accreditation standards that emphasize public service values (Molina, 2012). Amongst the public service values identified by NASPAA are several that relate directly to the mission of DHP and BHP. Those values include: accountability, incorruptibility, innovativeness, responsiveness, social justice, and transparency. This report supports those values by providing a high-level review of the topic of telehealth practice in Virginia.

The development of telehealth provides the health professions opportunities to innovate and to respond to patient needs and concerns about access to health care in underserved areas. As BHP supports telehealth, it demonstrates the public service values of innovation, responsiveness, and social justice. However, telehealth technologies also bring change to the industry of health care. Since the health profession board members are practicing professionals within the health care industry, the persistent concern that board members may act in their personal interest in opposition to the wider public interest (Gross, 1984) has taken on a new urgency. An example of this is as evidenced by a recent Supreme Court ruling against the North Carolina Board of Dental Examiners for violation of anti-trust laws by preventing the provision

of teeth whitening services by non-dentists (Fraser, 2015). This means that in this era, maintaining the values of accountability, incorruptibility, and transparency is particularly important.

In his influential book, *Administrative Behavior*, the Nobel Prize winning economist Herbert Simon described the concept of bounded rationality. Simon acknowledged that decision-makers act with incomplete knowledge of all of the variables that may influence the outcome of their decisions. Since decision-makers cannot have perfect knowledge of all variables, they cannot make fully rational decisions. Instead, they accept conscious and unconscious premises which serve to limit the choices that must be considered. These premises may be formal such as laws or organizational structures or they may be informal like an assessment of political possibilities or unconscious biases. The public service values identified by NASPAA are examples of premises that may assist in decision making. The acceptance of premises allows the decision-maker to make a rational choice within a manageable framework.

Simon's theory also highlights the power and influence that those accepted premises have over the decision-making process. The people who set the premises that guide the decisions of others hold the power to determine the decisions that are made. That idea is why it is important for BHP to consider recommendations derived from public service values as premises in their decision-making related to telehealth practice.

BACKGROUND

Overview of the Department of Health Professions (DHP)

DHP is the state agency responsible for supporting Virginia's 13 health regulatory boards. It shares with those Boards the mission "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" (COV § 54.1-100).

Chapter 25 of Title 54.1, Code of Virginia, establishes the powers and duties of DHP to include licensing health professionals, receiving complaints against health professionals, investigating those complaints and reporting violations of criminal law, and monitoring the Commonwealth's population of health professionals. DHP and its constituent boards are funded through the collection of licensing fees. Chapter 25 also creates the Board of Health Professions (BHP), as comprised of members from each of the 13 health regulatory boards and five board members appointed by the Governor from the Commonwealth at large (§ 54.1-2507). BHP is tasked with evaluating the need for coordination amongst the 13 health regulatory boards and assisting with the resolution of conflicts between the various boards (§ 54.1-2510). In particular, BHP is asked to promote the development of standards of competency for the various health professions, review discipline and enforcement decisions, determine which professions should be regulated, and consider issues related to the scope of practice.

Table 1 provides a detailed list of the health regulatory boards overseen and supported by DHP. As this table shows, there are a vast number of medical professions organized into boards of varying size. Because all 13 boards fall under the single umbrella agency of DHP, fees charged to licensees are lower due to efficiencies realized by centralized administrative tasks.

TABLE 1 : COMMONWEALTH OF VIRGINIA HEALTH REGULATORY BOARDS

Name of Board	Component Professions	
AUDIOLOGY AND SPEECH - LANGUAGE PATHOLOGY	Audiologists Speech-Language Pathologists	School Speech-Language Pathologists
COUNSELING	Professional Counselors Substance Abuse Counselors Rehabilitation Counselors	Marriage and Family Therapists Substance Abuse Treatment Practitioners
DENTISTRY	Dentists (DDS, DMD) Dental Hygienists (RDH)	Dental Assistants II Oral/Maxillofacial Surgeons
FUNERAL DIRECTORS & EMBALMERS	Funeral Service Licensees Embalmers	Funeral Directors Surface transportation & removal services
MEDICINE	Medical Doctors (MDs) Osteopathic Physicians (ODs) Podiatrists (DPMs) Chiropractors (DCs) Physician Assistants Acupuncturists Radiological Technologists	Radiological Technologists-Limited Respiratory Therapists Occupational Therapists Athletic Trainers Midwives Polysomnographic Technologists
NURSING	Registered Nurses (RNs) Licensed Practical Nurses (LPNs) Licensed Nurse Practitioners Clinical Nurse Specialists	Certified Nurse Aides Massage Therapists Medication Aides (Assisted living facilities)
LONG-TERM CARE ADMINISTRATORS	Nursing Home Administrators Assisted Living Facility Administrators	
OPTOMETRY	Optometrists	
PHARMACY	Pharmacists	Pharmacy Technicians
PHYSICAL THERAPY	Physical Therapists	Physical Therapists Assistants
PSYCHOLOGY	Clinical Psychologists School Psychologists Applied Psychologists	Sex Offender Treatment Providers School Psychologists –Limited
SOCIAL WORK	Social Workers	Clinical Social Workers
VETERINARY MEDICINE	Veterinarians Veterinary technicians	Equine dental technicians
DHP COMPOSITE BOARD	Board of Health Professions	

Source: Virginia Department of Health Professions (“Agency Brochure” 2015)

Table 2 shows the total number of licensees for each board as of the first quarter of state fiscal year 2016 (July 1, 2015 to September 30, 2015). As shown, the Board of Nursing oversees the highest number of licensees at 57 percent of the total number of licensees, while the Boards of Optometry and Long Term Care Administrators have the fewest, at approximately one-half of one percent of the total, each.

TABLE 2: TOTAL NUMBER OF LICENSEES BY BOARD

Board	Total Licensees¹	Percentage of Licensees out of Total
Audiology/Speech Pathology	4,944	1.3%
Counseling	7,249	1.9%
Dentistry	13,999	3.7%
Funeral Directing	2,540	0.7%
Long Term Care Administrators	2,115	0.6%
Medicine	65,337	17.1%
Nursing/Nurse Aid	218,696	57.3%
Optometry	1,931	0.5%
Pharmacy	36,365	9.5%
Physical Therapy	10,908	2.9%
Psychology	4,028	1.1%
Social Work	6,544	1.7%
Veterinary Medicine	7,304	1.9%
TOTALS	381,960	100%

¹ Total Licensees registered by the Department of Health Professions for the first quarter of FY16 (DHP, "Count of Licenses," 2015)

Development of Telehealth

Telehealth seems as though it is a recent and revolutionary development in the health care field; however, people have been communicating health information over distance for a long time. In fact, some commentators cite early forms of telehealth as medieval lepers wearing bells to warn others of their approach and ships during the era of the bubonic plague flying flags to indicate that the crew was infected and under quarantine (Darkins & Cary, 2000). Even though communicating health information over distance is not a new development, recent advancements in telecommunication technologies allow for a much richer experience.

The telephone changed the health care landscape by allowing people to communicate in real time with their medical providers across much further distances than previously possible. The telephone is limited, however, as it can only provide verbal information along with audible clues of a patient's health, such as if the patient coughs or sounds to be in emotional distress. New technologies allow for a more dimensional media experience which now permits the patient and provider to exchange nearly as much information as they could if they met in

person. Providers may now interact in real-time with patients both audibly and visually through such advances as teleconferencing.

This development means that for many services, the patient and provider may no longer need to be within physical proximity of one another. This new ability was first exploited by organizations and industries to provide medical services to remote populations; for instance, employees on an oil platform in the Gulf of Mexico used telecommunications technology provided by their company to speak with physicians located back on land (Darkins & Cary, 2000).

From the earliest adoption of the technology, telehealth held a clear potential to provide health care services to remote areas. This was seen as a potential panacea for the existing access to care issues that were experienced by people in remote and/or underserved areas. However, the full promise of telehealth to correct access to care issues has yet to be realized because the new technologies raise intractable questions regarding the licensing of providers across state borders and a host of legal and liability issues (Darkins & Cary, 2000).

In Virginia, telehealth has seen strong use in two areas: rural health and in the provision of services to inmates with the Virginia Department of Corrections (DOC). Both the University of Virginia (UVA) and Virginia Commonwealth University (VCU) act as leaders in these efforts with UVA focusing on rural health efforts, and VCU facilitating services for inmates in partnership with DOC (Virginia Board of Dentistry Meeting Minutes, 2015). Later sections of this report will provide a profession-by-profession account of activities related to telehealth in Virginia.

Definition of Telehealth

The terms telehealth and telemedicine are often used interchangeably to refer to the provision of health care services through the use of advanced telecommunications technologies (Lustig, 2012). However, this does cause some semantic confusion. While the two terms are interchangeable in most contexts, when considered profession-by-profession, there is a clear difference in use of the two words. For instance, when pharmacists discuss their telehealth efforts, they may refer to telepharmacy, or dentists may refer to teledentistry. Applying the term telemedicine to the efforts of other health professions may be misleading since there appears to be a professional preference to specify the area of health care by adding the prefix “tele-“ to the name of the profession. Since this report provides a high-level review of all such activities in Virginia, the term “telehealth” is used throughout.

However, statutory definitions of telehealth frequently use the word telemedicine in the interchangeable sense. When used in that context, it does appear to have applications across the spectrum of health care professions. For example, the definition of telehealth adopted by the Virginia General Assembly in accordance with § 38.2-3418.16 B., Code of Virginia, refers to it as telemedicine:

As used in this section, "telemedicine services," as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.

The statutory definition of telemedicine used in Virginia reflects common elements found in other definitions of telehealth:

- Communication is facilitated electronically using telecommunications technology
- Information exchange is assumed to be interactive and immediate
- Purpose of the communication is to treat a patient or consult with a colleague regarding a patient
- Earlier and less interactive technologies may be excluded

The definition provided by the Code of Virginia focuses on interactive technologies. However, definitions of telehealth may also include language to encompass "store and forward" technologies that allow providers to share patient information electronically in an asynchronous format.

Table 3 lists the statutory definitions for telehealth in each of the states served by the Mid-Atlantic Telehealth Research Center (MATRC). The states served by MATRC provide a convenient regional lens for comparing Virginia's definition of telehealth with those used by other states. As Table 3 shows, statutory definitions of telehealth/telemedicine can be interpreted as interchangeable at times, but can also mean something very different at others. For example, Kentucky's definition of telehealth consultation closely matches Virginia's definition of telemedicine. Meanwhile, Delaware's recent telemedicine parity legislation designates telemedicine as a "form of telehealth:"

The Mid-Atlantic Telehealth Resource Center (MATRC)

MATRC is funded by the U.S. Department of Health and Human Service's Health Resources and Services Administration (HRSA) Office for the Advancement of Telehealth, part of the Office of Rural Health Policy. MATRC provides technical assistance and other resources to the following states:

- Delaware
- District of Columbia
- Kentucky
- Maryland
- New Jersey (Central & South)
- North Carolina
- Pennsylvania
- Virginia
- West Virginia

MATRC is one of 14 national federally-funded telehealth resource centers. Its mission is "to advance the adoption and utilization of telehealth within the MATRC region; and to work collaboratively with the other federally funded Telehealth Resource Centers to accomplish the same nationally."

For more information, please visit: www.matrc.org

Source: MATRC, 2015

Title 18, Chapter 33, Section 3370, Delaware Code:

(5) "Telemedicine" means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in the state, while such patient is at an originating site and the health care provider is at a distant site.

Identifying the correct definition of telehealth or telemedicine may seem to be a purely academic pursuit, but it has important implications in the regulatory world. Comparing Delaware's definition of telemedicine with Virginia's definition helps to draw out those implications.

For example, by asserting that telemedicine is a form of telehealth in their definition, Delaware may be creating the opportunity to address the unique needs of other professions in statute as separate additional forms of telehealth. They may craft separate definitions for teledentistry or telenursing. Virginia appears to use telemedicine as a catch-all term with applications across the health professions. For instance, § 54.1-2957, Code of Virginia, discusses telehealth and nurse practitioners this way: "Collaboration and consultation among nurse practitioners and patient care team physicians may be provided through telemedicine as described in § 38.2-3418.16." It refers to the telemedicine definition from § 38.2-3418.16 rather than crafting a separate definition for telenursing.

Another important difference relates to the types of technologies used that make a practice more likely to be considered telemedicine. The definition provided by the Code of Virginia focuses on interactive technologies. However, Delaware's definition of telemedicine also includes language to encompass "store and forward" technologies that allow providers to share patient information electronically in an asynchronous format. Virginia's definition excludes audio-only technologies. Delaware's definition embraces two-way audio as a form of telehealth.

Virginia and Delaware are using their statutory definitions of "telemedicine" to designate which technologies fall under their telehealth regulations. This means that forms of telehealth practice may develop in one state that cannot develop in the other state due to the statutory limitations written into the state's definition.

TABLE 3: STATUTORY DEFINITIONS OF TELEHEALTH: A REVIEW OF THE NINE STATES SERVED BY THE MID-ATLANTIC TELEHEALTH RESOURCE CENTER

State	Telehealth/Telemedicine Definition	Code Citation
Delaware	"Telemedicine" means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in the state, while such patient is at an originating site and the health care provider is at a distant site.	<i>Delaware Code: Title 18, Chapter 33, Section 3370</i>
Kentucky	(15) "Telehealth consultation" means a medical or health consultation, for purposes of patient diagnosis or treatment, that requires the use of advanced telecommunications technology, including, but not limited to: (a) Compressed digital interactive video, audio, or data transmission; (b) Clinical data transmission via computer imaging for teleradiology or telepathology; and (c) Other technology that facilitates access to health care services or medical specialty expertise.	<i>Kentucky Code: 205.510 Definitions for medical assistance law</i>
Maryland	(8) "Telemedicine" means the practice of medicine from a distance in which intervention and treatment decisions and recommendations are based on clinical data, documents, and information transmitted through telecommunications systems.	<i>Maryland Code (10.32.05.02)</i>
New Jersey	None found	<i>n/a</i>
North Carolina	As used in this subsection, "telemedicine" is the use of two-way real-time interactive audio and video between places of lesser and greater medical capability or expertise to provide and support health care when distance separates participants who are in different geographical locations. A recipient is referred by one provider to receive the services of another provider via telemedicine.	<i>North Carolina General Statutes: § 122C-263</i>
Pennsylvania	"Telemedicine." The use of telecommunication and information technology in order to provide clinical health care at a distance.	<i>Pennsylvania Unconsolidated Statutes: 2014 Act 198, Section 2</i>

State	Telehealth/Telemedicine Definition	Code Citation
Virginia	B. As used in this section, "telemedicine services," as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.	<i>Code of Virginia § 38.2-3418.16. Coverage for telemedicine services.</i>
Washington, D.C.	None found	n/a
West Virginia	As used in this section, the term "practice of telemedicine" means the use of electronic information and communication technologies to provide health care when distance separates participants and includes one or both of the following: (1) The diagnosis of a patient within this state by a physician located outside this state as a result of the transmission of individual patient data, specimens or other material by electronic or other means from within this state to the physician or his or her agent; or (2) the rendering of treatment to a patient within this state by a physician located outside this state as a result of transmission of individual patient data, specimens or other material by electronic or other means from within this state to the physician or his or her agent.	<i>West Virginia Code §30-3-13. Unauthorized practice of medicine and surgery or podiatry; criminal penalties; limitations.</i>

Historical Perspectives

Health Profession Licenses Issued on a State-by-State Basis

The structure of DHP and its component health regulatory boards has evolved over the course of more than a century to accommodate the unique health professional licensing practices of the United States. In America, the ability to set the scope of practice, establish professional occupational standards, and provide licenses to health professionals falls under the purview of state governments, rather than the federal government. State licensing authorities may only issue licenses to health practitioners within the geographical borders of the state and may not provide practicing privileges in another state (Wakefield, 2010).

This state-by-state issuance of licenses appears to have several purposes. Of most import is the purpose of licensure to ensure that providers are well trained, competent, and capable of providing health care services. This protects patients and the public from impaired or incompetent practitioners. Health profession licensing is also concerned with defining the scope of practice of the various health professions. As noted earlier, the Code of Virginia tasks BHP with considering issues related to scope of practice, as this is what defines the services that

may be provided by each licensed profession. For instance, a psychologist is able to prescribe medications based on their scope of practice while the scope of practice for a social worker may not allow them to authorize prescriptions. The ability to set scope of practice has a direct economic impact on practitioners because it sets out what service they may or may not offer to patients.

For example, even if licensing standards and requirements for a specific profession were identical between Virginia and Pennsylvania, a provider licensed in Virginia would not be able to practice in Pennsylvania. The authority of the Virginia license does not extend beyond the Virginia state line, so the provider would need to acquire a Pennsylvania license to practice their profession in that state. As such, state licensing of health professions serves to not only insulate the health care market among individual professions within a state, but also insulates a state's health care market from competition posed by providers in other states.

The proliferation of telehealth has challenged the traditional model of state-issued licensure. The historical model worked well when the only setting in which health services could be provided required the patient and the health care provider to be in physical proximity to one another. As such, a provider who wished to practice in more than one state needed only to maintain a handful of licenses—one for each state in close proximity to their main practice. However, now that telecommunications technology makes it possible for patients and providers to interact across vast distances, that same provider may wish to use the new technology to offer services to patients at a much further distance. Providers have new incentives to seek licenses in multiple states. To do so, the provider must go through the process of obtaining individual licensure in each of the states they wish to offer telehealth services in, or forego offering those telehealth services in those states.

The Internet Changes the Relationship between Patients and Providers

The telecommunications advances that facilitate telehealth have also resulted in changes in the relationship between patients and providers. Traditionally, there was an information asymmetry between the patient and the provider in which the patient had limited access to health information and treatment outcomes. This led to the traditional model in which patients accepted their providers recommendation with little question. The internet gives patients the ability to research their diagnoses and treatment. That patient access to information quickly altered the relationship between patients and providers (Ford, 2000). Patients now approach their health care with more of a consumer attitude in which they weigh costs and options and choose their treatment with the assistance of their provider rather than adhere to previous, more paternalistic models (Darkins & Cary, 2000).

METHODOLOGY

The primary methodological approach of this report is that of an environmental scan of the current information and legal provisions pertaining to telehealth. An environmental scan is a broad analysis of the current business environment with the purpose of identifying information

and interconnections between that information that will be useful for future planning and decision-making (Morrison, 1992). This report represents an attempt to recognize and define premises that may influence future decisions. To produce this environmental scan, the research team focused on reviewing the existing literature, resources, best practices, and models available to health professional boards related to telehealth, and such closely-related topics as licensure portability, multi-state licensing, and licensure compacts.

The intent of this report is to support the decision-making process of Virginia's health regulatory boards as they consider how to use telehealth to improve access to healthcare in the Commonwealth. Specifically, by providing an environmental scan of the policies and practices related to telehealth in Virginia, this report reveals premises that may influence the Boards' decisions. It considers the purposes and history of health professional licensing, the evolution of and definition of telehealth practices, best practices and model legislation proposed by several national organizations to ease licensing restrictions, and surveys the efforts of Virginia's health regulatory boards to facilitate access through telehealth. Finally, it identifies several recommendations that support the public service values identified above.

There is a vast amount of literature and commentary on telehealth and its uses. The topic has been considered from many different perspectives. Some sources consider telehealth from a practical perspective – does this improve access and health outcomes? Other sources may consider the economics of telehealth, the policy ramifications, or the legal implications. Telehealth has also been examined on a profession-by-profession basis with distinct bodies of literature for different fields of health care. Given the breadth of existing research and commentary on the topic and the broad mandate of the environmental scan method, the chief research challenge was the question of how to limit the research task so that it would be useful to BHP.

Four Research Lenses: Federal, Mid-Atlantic Region, Virginia, and Board-by-Board

The research team chose to employ four lenses to help direct the research; first starting from a wide-angle, national-level perspective, narrowing in gradually to a local Virginia-specific lens:

- The first lens is a high level review of the commentary and best practices suggested by national-level organizations. For this lens, the research team focused on model legislation and policy recommendations published by organizations with a national agenda. Since questions of multi-state licensing seem to be a prominent feature of the national level commentary, the research focused on that issue. The national-level commentary reflects a comprehensive scan of state level activities and serves to capture trends and activities for the country as a whole.
- The second lens is a regional scan that focuses on the states served by the Mid-Atlantic Telehealth Resource Center. This research concentrates on how the different states define telehealth and treat it in statute. For this lens, the research team searched the statutes of

each state included in the Mid-Atlantic Telehealth Research Center's catchment area for definitions of telehealth or telemedicine. Those definitions were then compared to analyze for trends, similarities, and differences.

- The third lens considers Virginia specifically and looks at information pertaining to how Virginia considers telehealth in statute. For this lens, the research reviews provisions in the Code of Virginia regarding telehealth/telemedicine and details the impact of those provisions on the use of telehealth within the Commonwealth.
- The fourth lens is a board-by-board approach. For this lens, the researchers catalogued the telehealth efforts of each of the 13 health regulatory boards in Virginia. The findings for this lens were collected by: (1) reviewing all published guidance documents for each board to discern their applicability to the matter of telehealth; (2) reviewing the publically-available meeting minutes for each of the 13 health regulatory boards for any references to "telehealth" or "telemedicine" occurring between January 1, 2015 and November 15, 2015; (3) researching the existence and/or development of multi-state compacts involving the profession(s) served by each board; and (4) reviewing publically-available information published by each board's national affiliate professional organization for references to telehealth efforts. This comprehensive review was intended to capture all telehealth efforts already undertaken, underway, or potentially on the horizon for each of the 13 boards.

Research Limitations

Each lens provides focus for the research but has inherent limitations that exclude information. For instance:

- At the national level, the Affordable Care Act (ACA) was not considered in depth in the national-level guides to telehealth that were considered in the research, therefore it is not discussed in detail in this report.
- By selecting the regional lens, the researchers excluded looking in detail at the practices of states outside of the region. This means that the practices of any states seen as leaders on the matter of telehealth that are not within the Mid-Atlantic regions are not considered in this report.
- The Virginia-level lens focuses strictly on how telehealth is treated in statute and does not consider broader topics. For example, another approach to reviewing telehealth in Virginia could provide an account of the specific telehealth technologies currently being employed in the state.
- The board-by-board lens is useful for comparing activity amongst the boards in Virginia, but it fails to provide insights on how the board activity in Virginia compares with that of other

states. As an example, this report does not consider how the telehealth activities pursued by Virginia's Board of Nursing compare with Maryland's Board of Nursing.

Given the breadth of the research topic and the limitations of the selected lenses, the findings of this report should be viewed as an informative general analysis on a broad and complex topic.

FINDINGS

How Telehealth Practice is Defined and Governed

Research Question 1: How is telehealth practice defined and governed by federal and state statutes, regulations, or state professional licensing guidance?

At the Federal Level

No Federal Authority Regarding Licensure

As stated previously, the federal government plays no role in the licensing of health professionals as this responsibility falls to the states. The state authority to regulate these industries is granted under the police powers established by the Tenth Amendment to the U.S. Constitution, while the ability of each state to administer licenses is limited by the Commerce Clause of the Constitution which prohibits the states from erecting barriers against interstate trade (Wakefield 2010). However, while the federal government cannot directly impact the licensure process, Congress did create the National Practitioner Data Bank (NPDB) to track state-specific enforcement actions. The NPDB is an electronic information repository of medical malpractice payments and "certain adverse actions related to health care practitioners, entities, providers, and suppliers" (National Practitioner Data Bank, 2015). The NPDB tracks actions as specified by federal law, and requires the organizations authorized to access the data to use it to make decisions regarding licensing, credentialing, privileging, or employment.

The fact that the federal government does not currently have the legal authority to issue a national license could be construed as a barrier as this creates the need for providers to hold multiple licenses in order to practice across state lines. Both the United States Department of Health and Human Services' Health Resources and Services Administration (HRSA) and the Federal Communications Commission identify national licensure as a potential solution to the difficulties of multi-state licensing (Wakefield, 2010). As such, until national licensure becomes a valid option, if ever, the challenge is to continue to find methods of facilitating the provision of telehealth services across state lines.

How the Federal Government Can Affect the Use of Telehealth

Despite the federal government's limited role in the licensing of the health professions, it can still support state-level efforts to advance the use of telehealth. For instance, HRSA provides grants, guidance documents, and operational assistance to states for the expansion of telehealth programs. In Virginia, examples of this support are seen in several recent grants (HRSA Data Warehouse, 2015):

- 2014-2015: \$400,000 grant to City of Charlottesville for Evidence-Based Tele-emergency Network Grant Program
- 2012-2015: grant to Essex County for \$249,771 for Rural Health: Telehealth Network Grant Program (H2A)
- 2014-2015 \$325,000 grant: 2013 \$27,048 to the City of Charlottesville for Telehealth Resource Center Grant Program (G22)

See Appendix A for a listing of Virginia-specific telehealth resources

Another Virginia-specific example of federal efforts to facilitate the use of telehealth is the Memorandum of Understanding between the Center for Medicare & Medicaid Services (CMS) and the Commonwealth of Virginia (Department of Medical Assistance Services, DMAS) (Commonwealth Coordinated Care, 2014). These two governmental agencies have forged a federal-state partnership

to implement the "Commonwealth Coordinated Care program," a three-way contract with participating plans to provide integrated benefits in targeted geographic areas. This memorandum identifies telehealth services as an "innovative, cost effective means to decrease hospital admissions, reduce emergency department visits, address disparities in care, increase access, and increase timely interventions...[in order] to promote community living and improve access to behavioral health services" (p. 72). This effort specifically encourages the use of telehealth "to promote community living and improve access to behavioral health services" (p. 72). The program also establishes that participating plans are allowed to use and reimburse for telehealth services, serving as an example of how the federal government can assist states with their efforts to advance telehealth use.

HRSA also provides guidance regarding nationwide efforts and recommendations for implementing telehealth. As an example, HRSA provides nationally-suggested model legislation and policy efforts that states should consider regarding the use of telehealth; highlights of this list are as follows (Wakefield, 2010), see Table 8 for additional detail:

- *American Telemedicine Association (ATA)*: Suggested model legislation that amends states' professional licensing requirements to make those for telehealth-provided practices the same as for in-person practice, as well as the allowance for out-of-state consultations without the need for additional state licensure.

- *American Bar Association (ABA)*: Suggested policy of mutual licensure recognition between states; specifically the adoption by states of uniform definition of telemedical practice, requisite procedures for telemedical licensure, requirement for the practitioner to agree to the jurisdiction of the patient's home state for malpractice actions, and continued role of state medical boards in physician licensure and discipline.
- *Federal Communications Commission (FCC)*: Suggested national collaboration on an interstate agreement regarding "e-care" licensing policies (as facilitated by such entities as the National Governors Association, the National Conference on State Legislatures or the Federation of State Medical Boards).
- *Federation of State Medical Boards (FSMB)*: Promotion of its Interstate Medical Licensure Compact as "another pathway for licensure that does not otherwise change a state's existing Medical Practice Act."
- *National Council of State Boards of Nursing (NCSBN)*: Promotion of the Nurse Licensure Compact (NLC), through which registered nurses (RNs) and licensed practical/vocational nurses (LPN/VN) have a multistate licensure privilege in each of NLC member state.
- *National Governors Association (NGA)*: Recommendation for states to "consider ways to accommodate e-health...while still maintaining state-based jurisdiction and authorities; specifically look for ways that states can streamline their licensure application processes."

At the State Level

The licensing of health professionals is administered at the state level; thus the state provisions governing licensure and the use of telehealth have a greater impact than those at the federal level because they form the functional regulatory structure in which these programs operate. Within Virginia, legal provisions regarding telehealth can be found within the Code of Virginia.

Code of Virginia

Table 4 provides a listing of the references within the Code of Virginia that pertain to telehealth/telemedicine and a brief description of the section's impact on the use of these services within the Commonwealth. The law to which is attributed the greatest enhancement of the use of telehealth services in Virginia is that which amended § 38.2-3418.16 to mandate reimbursement of expenses for the use of telehealth. The amendments, sponsored by then-Senator Wampler and signed by Governor McDonnell as Chapter 222 of the 2010 Acts of Assembly, are attributed with causing "an exponential increase in the utilization of telemedicine across the state" (Desai & Rheuban). Another Code section of note is the enabling statute for the Office of Telework Promotion and Broadband Assistance, within the Office of the Virginia Secretary of Technology, whose invested interest in the advancement of telecommunications makes them a unique partner in the telehealth effort.

TABLE 4: CODE OF VIRGINIA SECTIONS PERTAINING TO TELEMEDICINE OR TELEHEALTH

Code Section	Title	Description
§ 2.2-225.1	Office of Telework Promotion & Broadband Assistance	Establishes the office within the office of the Secretary of Technology to increase the use of telework, broadband access—to include advocating for and facilitating the development and deployment of telemedicine in order to “bolster the usage and demand for broadband level telecommunications” (COV, B.5.)
§ 38.2-3418.16	Coverage for telemedicine services	Considered by the American Telemedicine Association as “telemedicine parity law;” with full parity defined as “classified as comparable coverage and reimbursement for telemedicine-provided services to that of in-person services.” (ATA, “2015 State Telemedicine Legislation Tracking” 2015, p. 6)
§ 54.1-2901	Provider-to-Provider consultations	“Any legally qualified out-of-state or foreign practitioner from meeting in consultation with legally licensed practitioners in this Commonwealth; The rendering of medical advice or information through telecommunications from a physician licensed to practice medicine in Virginia or an adjoining state, or from a licensed nurse practitioner, to emergency medical personnel acting in an emergency situation” (Thomas & Capistrant, 2015, p. 78)
§ 54.1-2957	Licensure and practice of nurse practitioners	Authorizes the use of telemedicine for providing collaboration/consultation among nurse practitioners and patient care team physicians (in accordance with 38.2-3418.16)
§ 54.1-3303	State Internet Prescribing Policies	Permits a pharmacy in Virginia to dispense a controlled substance pursuant to a prescription issued by an out-of-state prescriber provided the prescription complies with Virginia’s requirements (COV)

Source: Code of Virginia, various citations

Professions that Provide Telehealth Care

Research Question 2: Which professions provide telehealth care?

The 13 health regulatory boards under the purview of DHP are at varied stages of involvement with telehealth initiatives. The Boards of Medicine and Nursing are the most advanced in terms of their efforts to promote and engage with telehealth, followed by burgeoning efforts evidenced by the Boards of Counseling, Dentistry, Optometry, Physical Therapy, Psychology, and Social Work. As of the publish date of this report, no specific activity regarding telehealth was found for the Boards of Audiology and Speech-Language Pathology, Funeral Directors and Embalmers, Long-Term Care Administrators, Pharmacy, and Veterinary Medicine.

When considering the advancement of telehealth efforts by particular boards, it is important to note that some represent professions that lend themselves more easily to telehealth usage than others. For example, the large number of constituencies licensed by the Boards of Nursing and Medicine increase the likelihood that practitioners in those fields will express interest in telehealth initiatives; these fields also contain health care specialties that adapt well to distance application. Conversely, the Boards of Funeral Directors and Embalmers and Long-Term Care Administrators, the two boards with the least amount of telehealth involvement—even at the national level—represent practitioners whose trade does not often involve distance application, and therefore may not benefit from telehealth involvement.

The Boards of Medicine and Nursing are the most advanced in terms of their efforts to promote telehealth, followed by burgeoning efforts by the Boards of Counseling, Dentistry, Optometry, Physical Therapy, Psychology, and Social Work

As indicated by Table 5, this report examined four factors of “telehealth effort” to gauge each Boards’ progress on the matter of advancing the use of telehealth. The first two factors, issuance of guidance documents and membership in a multi-state licensing compact, reveal concrete actions taken by a Board that have a marked impact on the ability of their licensees to practice telehealth. The last two factors, mention of telehealth/telemedicine in 2015 board meeting minutes and telehealth efforts underway by associated professional organizations, reflect board telehealth efforts currently under development, or board efforts that have the potential to develop in the near future.

TABLE 5: STATUS OF TELEHEALTH-EFFORTS BY VIRGINIA HEALTH REGULATORY BOARDS*

	Board-Issued Guidance Document Regarding Telehealth	Membership in Multi-State Licensing Compact	Telehealth References in 2015 Board Meeting Minutes	Telehealth Efforts Underway by Associated Professional Organizations
Audiology and Speech-Language Pathology	X	X	X	✓
Counseling	○	○	X	✓
Dentistry	○	X	✓	✓
Funeral Directors and Embalmers	X	X	X	X
Long-Term Care Administrators	X	X	X	X
Medicine	✓	○	✓	✓
Nursing	✓	✓	✓	✓
Optometry	X	X	✓	○
Pharmacy	X	X	X	✓
Physical Therapy	✓	○	✓	✓
Psychology	X	○	✓	✓
Social Work	○	X	X	○
Veterinary Medicine	X	X	X	○

*See Appendices B-N for Board-specific telehealth efforts

X = None found

○ = Related Effort/Under Development

✓ = Verified

The most specific telehealth-related action taken by any of Virginia health regulatory boards is the issuance of a telehealth-specific guidance document

- *Guidance Documents:* The most specific telehealth-related action taken by any of 13 health regulatory boards is the issuance of a telehealth-specific guidance document. To date, three Virginia boards have issued such documents: Medicine (adopted in February 2015), Nursing (based on the Board of Medicine’s guidance document and adopted July 2015), and Physical Therapy (also based on the Board of Medicine’s guidance document and adopted November 2015). The Boards of Counseling and Social Work have issued related guidance documents, respectively titled *Guidance on Technology-Assisted Counseling and Technology-Assisted Supervision*, adopted in 2008, and *Guidance on Technology-Assisted Therapy and the Use of Social Media*, adopted in 2013. Given the increasing use of telehealth, the potential it has to alter how each profession operates, and that many of these efforts are recent, it is anticipated that the number of official Board documents regarding telehealth will continue to grow.
- *Membership in a Multi-State Licensing Compact:* On the issue of multi-state licensing, most boards address licensure portability, however only four have considered participating in a multi-state licensing compact. The Board of Nursing is the first and only of the Virginia health regulatory boards to participate in a multi-state licensing compact; the Commonwealth’s membership in the Nurse Licensure Compact (NLC) dates back to January 2005. The Board of Medicine is deliberating on whether to participate in the emerging Federation of State Medical Boards’ (FSMB) Interstate Medical Licensure Compact; the dialogue is ongoing and has yet to reach a resolution (Opher, 2015, p.3). The Board of Psychology is considering participating in the Psychology Interjurisdictional Compact (“PSYPACT”); a new national initiative awaiting adoption by at least seven states during their 2016 legislature sessions to become effective. Finally, the Board of Physical Therapy is tracking the progress of the Physical Therapy Licensure Compact under development by the Federation of State Boards of Physical Therapy (FSBPT); according to the FSBPT, a proposed compact will be released to states for their consideration within the next 18 months (FSBPT, 2015). For each of the multi-state licensing compacts referenced, stipulations regarding locale of care specify that the legal provisions regarding a patient’s care are those of the state within which they are located at the time the care is given.
- *Telehealth references in 2015 Board Meeting Minutes:* Any references to “telehealth” and/or “telemedicine” were documented for 2015 meeting minutes of the regulatory health boards (January 1, 2015 through November 15, 2015). Of note are mentions by the Boards of Dentistry, Optometry, and Psychology, boards that have not issued telehealth-specific guidance documents nor are considering memberships in multi-state licensing compacts, but are in the process developing positions on the matter of telehealth. These efforts appear to be quickly materializing and merit continued monitoring over the next several months to stay abreast of their development.

- *Telehealth efforts underway by associated professional organizations:* Virginia health regulatory boards engaged in telehealth efforts, or undergoing consideration of engagement, are aligned with their affiliated national organization with similar efforts underway. However, there are three boards for which national efforts are underway and no actions appear to have been initiated within Virginia: Audiology and Speech-Language Pathology, Pharmacy, and Veterinary Medicine. As the national efforts taken by these boards' affiliated organizations are relatively new, similar efforts at the Virginia level may be forthcoming.

There is significant variation in telehealth efforts within Virginia health regulatory boards

There are two Boards for which there appears to be no telehealth efforts either on the national or state level: Funeral Directors and Embalmers and Long-Term Care Administrators. Again, this may be due to the nature of these professions that makes telehealth an ineffectual practice.

Assessing the activity in Virginia, it is clear that certain professions are very engaged in the development of and adaptation to telehealth, while other boards appear to have a less proactive engagement of telehealth. A key finding is that there is significant variation in telehealth efforts within Virginia health regulatory boards.

Conflicting Commentary on Telehealth

Research Question 3: What conflicting commentary exists on this topic?

The literature regarding telehealth is comprised mostly of articles that applaud the benefits of its use. However, the threads of concern that do exist regarding the use of telehealth revolve around the following issues:

- *Fair compensation for health care providers:* Definitions and billing/reimbursement processes for telehealth care vary widely, making practitioners wary to take-on telehealth practice out of fear that they will not be fairly compensated (Laff, 2014). According to a member of the American Academy of Family Practitioners' Board of Directors, "one of the biggest issues [regarding telehealth care] is payment because of the constrained rules that exist in the current payment systems" (Hinkle, 2014).

A June 2014 survey found that 55 percent of health care personnel do not bill for [telehealth] services

A June 2014 survey of health care personnel found that 55 percent of those responding, representing 46 of the 50 states, do not bill for telehealth services (Antioniotti, Drude & Rowe, 2014, p. 540). The top two reasons given were "major payers do not pay," and "no Medicaid reimbursement." Respondents also cited significant uncertainty on the processes for billing for telehealth services, selecting such topics as "Review of

Medicare/Medicaid/private payers,” and “Billing and Coding” as areas in which they wanted additional information (Antioniotti, et al., 2014, p. 542). Overall, the survey provided the following observation regarding a current barrier to the expansion and use of telehealth:

There are significant learning needs for the telemedicine community to better understand the billing and coding processes for telehealth services, how to approach legislators and influence public policy, how to approach and talk with private payers, and how to effect change in secular, specific reimbursement arenas such as certain health professions, certain services, and certain service delivery sites. (Antioniotti, et al., 2014, p. 543)

Providing telehealth care requires practitioners to purchase and maintain the necessary technology, as well as to hire, train, and retain skilled staff

- *Capital expenses for telehealth technology and staff:*

Practitioners who wish to engage or expand telehealth care provision need to have the resources to purchase and maintain the necessary technology, as well as to hire, train, and retain staff able to use it. The availability of staff may be of a concern going forward, as the current Virginia licensed workforce has a median age around 50, with more than one-third physicians and Registered Nurses age 55 or older (Healthcare Workforce Data Center, “Virginia’s Physician Workforce: 2014,” 2015; and “Virginia’s Registered Nurse Workforce: 2014,” 2015). The need for new and skilled staff could be a particularly significant barrier for smaller practices, as they may not

be able to produce the volume of practice required to realize efficiencies provided by telehealth (Laff, 2014).

A significant barrier also remains in the continued unequal access to broadband internet. This inequality makes it difficult to reach one of the prime target recipient groups for telehealth: those living in rural areas (Hinkle, 2014). According to the Virginia Office of Telework Promotion and Broadband Assistance, nearly one-third of Virginia cities and counties still have more than a quarter of their residents without coverage (Virginia Office of Telework, 2014). Without the technological backbone to support the provision of telehealth care, the rules and regulations pertaining to its use are futile.

- *Establishing a consistent definition of telehealth/telemedicine and ensuring standards of care:* As detailed in Table 3 of this report, even states within the same Mid-Atlantic region have a wide variation in statutory definitions of telehealth/telemedicine. Without a consistent understanding of the term, the ability to ensure adequate reimbursement for services provided becomes even more uncertain. In addition, practitioners debate how the definition of telehealth should establish a sufficient physician-patient relationship; a key component of ensuring compliance with standards of care. While some practitioners feel that the necessary relationship can be adequately established via technology, others feel that “nothing can take place of the physical exam in an exam room” (Porter, 2015).

- *Patient receptivity*: While advocates of telehealth are quick to tout its benefits and cite its ability to expand access to care, very little is said about whether the patient population is open and eager to receive electronic means of care. A 2015 study of Montana residents found that 43 percent of respondents were “unequivocally averse” to telemedicine, even though it would negate the inconvenience of in-person health care visits (Call, Erickson, Daily, Hicken, Rupper, Yorgason & Bair, 2015). Some of the reasons given for patients’ reluctance to use telehealth care include perceived vulnerability in confidentiality, security, and privacy, and a general discomfort with being treated by a practitioner hundreds of miles away (Menachemi, Burke, & Ayers, 2004). The study indicates that significant advocacy is needed for those promoting the use of telehealth to overcome its questionable perception and reception by the general public (Call, et al., 2015, p. 649).

Is there sufficient patient demand for telehealth care?

Overall, conflicting commentary on the matter of telehealth can be pared into concerns by the three main stakeholder groups involved in its use (Menachemi, et al., 2004):

- *Patients*: concerns over security and privacy, unfamiliarity with technology, and needing to adapt to a new way of interacting with healthcare providers;
- *Practitioners*: legal concerns regarding telehealth practice—specifically related to licensure requirements and varying definitions of telehealth, concerns regarding quality of care and service, uncertainty over billing processes; and
- *Administrators/insurers*: uncertainties over cost effectiveness, reimbursement, and legal matters.

To address these concerns sufficiently to enable greater use of telehealth, all parties involved—to include legislators and regulators—must work together to better define “telehealth” and the necessary standards of care and processes for its use. Otherwise, its growth will be hampered by resistance from one or more of these integral stakeholders (McConnochie, 2015).

Virginia is one of only five states receiving an “A” rating for its “accommodation of telemedicine adoption”
-*The American Telemedicine Association*

RECOMMENDATIONS

The American Telemedicine Association ranks Virginia as one of only five states receiving an “A” rating for its “accommodation of telemedicine adoption” (Thomas & Capistrant, 2015, p. 1). This fact should be on the forefront of any discussions to expand telehealth usage considered by DHP and its 13 health regulatory boards, and kept in mind when reviewing the below recommendations. These four recommendations represent the themes evident in both the environmental scan and the literature review.

1. Seek the Right Balance: Access to Care vs. Standards of Care

There is a values conflict between the motivation to improve access to care by facilitating multi-state licensing and the equally powerful motivation to ensure that patients continue to be protected by the standards of care set by the health regulatory boards. The more open a state is to multi-state licensing, the less control its boards are able to exert because they do not have authority to set the standards of care adopted by other states. For example, under the Nurse Licensure Compact, while participants must meet the licensure requirements of their home state, Article III, Section e. of the Compact states that they are held accountable to the Nurse Practice Act of the state where the patient is located or where practice occurs. The Interstate Medical Licensure Compact and the "PSYPACT" have similar requirements (Nurse Licensure Compact, 2015). However, a state's unwillingness to participate in efforts to facilitate multi-state licensing to preserve control over the standards of care serves limits that state's ability to utilize telehealth as a way to expand access to care.

2. Consider Telehealth's Role in the Increasing Perception of Health Care as a Commodity

The rapid advances in telecommunications technology and the solutions it provides for delivering health care are radically altering the health professions (Darkins & Cary, 2000). Since telecommunications easily overcome the geographical distance between the provider and the patient, they call into question the continued relevance and validity of state-based licensing (Wakefield 2010).

The literature reveals that national licensing is being touted as a possible alternative to the current state-based licensing structure (Wakefield, 2010). In their report, the Federal Communications Commission suggested giving states 18 months to develop policies on the issue and if that did not occur, they suggested federal intervention. That sentiment is echoed in HRSA's report to Congress which included two methods of national licensure in its list of best practices (Wakefield, 2010). However, this appears to be a suggestion designed as a negative incentive to promote coordination amongst the states on the issue.

Health regulatory boards should heed the warning implicit in the suggestions of national licensure as an alternative. The prevalence of commentary on national licensure in the literature suggests that political, market, and sociological forces could align to make national licensure a reality before the states are able to provide an adequate alternative based on the current licensing structure.

There also appears to be a significant movement underway that challenges the traditional autonomous authority of state medical boards. Due to health care becoming an increasingly large share of the market, greater attention is being paid to the professions' scopes of practice and their impact on restricting what services can be provided by non-licensed professionals. Such weakening of health boards' traditional autonomy to enforce scope of practice regulations is evidenced by a recent court case regarding teeth whitening in North Carolina.

In the case, *the North Carolina Board of Dental Examiners v. Federal Trade Commission (FTC)*, the Supreme Court found the Board in violation of anti-trust laws due to its actions to try and exclude non-dentists from providing teeth whitening services (Fraser, 2015). This case has a direct impact on how all state health regulatory boards define their scopes of practice. As such, the Virginia Office of the Attorney General has formed a taskforce to determine future guidance for Virginia's health regulatory boards in light of the Supreme Court's ruling. Going forward, it is conceivable that the FTC's response to this situation in North Carolina will set a precedent where health regulatory boards may encounter similar federal resistance if they use scope of practice arguments too aggressively. Since easing restrictions on multi-state licensing may bring additional providers into the health care marketplace, boards may be tempted to use scope of practice regulations to protect their profession from the increased market competition. As is evidenced by this case, the delineations of scopes of practice and their limitations on what services non-licensed persons can provide is drawing criticism for restricting trade without appreciable benefits.

3. Streamline State Licensing Processes

Providers in those professions without the option of a multi-state licensing compact must go through a separate licensure application and maintenance process for each state in which they wish to provide care. For most states, these processes can be onerous and time-consuming. As cited by a member of the Board of Directors of the American Academy of Family Practitioners, "Under the current system, physicians who wish to practice in more than one state have to navigate a fairly burdensome process that involves paperwork, fees and three to six months of waiting" (Lee, 2014). Even the National Governor's Association recommends that states look for ways to streamline their licensure application processes (Wakefield, 2010).

Virginia could facilitate greater multistate licensing by improving the experience of applying for a license. The various boards' websites can be confusing to navigate with instructions that refer applicants to dense policy documents and require submission of paper rather than electronic forms. This appears to be the case in other states as well. For instance, Maryland's Board of Examiners for Psychologists suggests copying and pasting information from one form to another rather than designing an application that only requires entering the information once (Maryland Application for Licensure, 2015). For Virginia's advancement, DHP should consider an effort to improve and simplify its licensing processes. However, it is noted that such enhancements require resources that are often in short-supply for state health boards. Budgetary constraints, political realities, and technological barriers may be to blame for less-than-optimal licensing processes. Due to these understandable constraints, multi-state licensing compacts become an even more appealing option.

4. Utilize Inter-Board Collaboration and Nationally-Recognized Best Practices to Guide Telehealth Efforts in Virginia

One of Virginia's best resources may in fact be itself. Within the state's boundaries, resources abound that provide tips, guidance, legal insight, recommendations, and templates for the

Virginia is its own best
telehealth resource

boards' consideration. In addition, health regulatory boards interested in exploring ways to augment their professions' use of telehealth may benefit from reviewing the actions taken by other

Boards; such as those that have utilized the Boards of Medicine's telehealth guidance document as a reference.

Of note, while there are only three multi-state licensure compacts in existence for Virginia practitioners to consider (including PSYPACT, awaiting enactment during states' 2016 legislative sessions; does not consider the Physical Therapy Licensure Compact still under development), as of September 30, 2015, more than 60 percent of current licensees under the purview of DHP fall within the professions that are, or may soon be, eligible for membership in one of these three compacts. As set-out in Table 6 and depicted in Chart 1, nearly 180,000 of the 382,000 current licensees within DHP are in professions that qualify for membership in accordance with the stipulations of the three compacts.

TABLE 6: CURRENT DHP LICENSEES ELIGIBLE OR POTENTIALLY ELIGIBLE FOR MEMBERSHIP IN A MULTI-STATE LICENSING COMPACT

Board	Total Licensees¹ Through Q1 FY 2016 July 1, 2015- Sept 30, 2015	Licensees Eligible or Potentially Eligible for Compact Membership
Medicine ²	65,337	39,888
Nursing ³	164,128	135,720
Psychology ⁴	4,028	3,232
Not Eligible	148,467	-
TOTALS	381,960	178,840

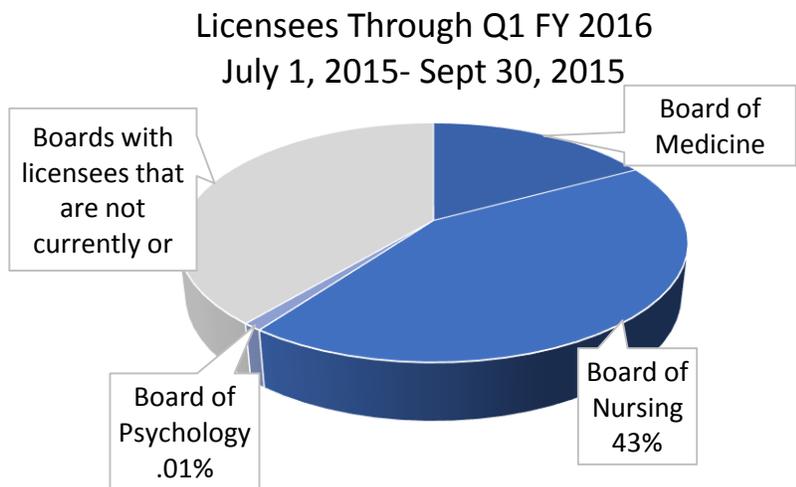
¹ Source: Virginia Department of Health Professions ("Count of Current Licenses," 2015)

² Eligible physicians as defined in accordance with the Model Language for the Interstate Medical Licensure Compact proposed by the Federation of State Medical Boards (Interstate Medical Licensure Compact, 2015).

³ Eligible nurses as defined in accordance with Article II j. of the Nurse Licensure Compact Model Language, approved May 4, 2015 (NLC, 2015).

⁴ Eligible psychologists as defined in accordance with the proposed Model Language for the Psychology Interjurisdictional Compact (PSYPACT), Updated August 2015 (Psychology Interjurisdictional Compact, 2015).

CHART 1: CURRENT DHP LICENSEES ELIGIBLE OR POTENTIALLY ELIGIBLE FOR MEMBERSHIP IN A MULTI-STATE LICENSING COMPACT



Source: Virginia Department of Health Professions (“Count of Current Licenses,” 2015)

Outside of Virginia, there are a variety of alternative licensure models of state cooperation that would allow a health professional to practice across state lines electronically. The most prominent models are summarized in Table 7 below:

TABLE 7: ALTERNATIVE LICENSURE MODELS

Model	Explanation
Consulting Exceptions	Physicians can practice medicine in another state at the request of and in consultation with a referring physician in that state. The scope of these exceptions varies from state-to-state; some states only permit a specific number of consulting exceptions per year.
Endorsement	When state boards grant licenses to health professionals in other states with equivalent standards (note: some states may require additional qualifications or documentation). Health professionals must apply for a license by endorsement from each state in which they seek to practice. Endorsements allow states to retain their traditional power to set and enforce standards.
Reciprocity	Requires the authorities of each state to negotiate and enter into agreements to recognize licenses issued by the other state(s) without a further review of individual credentials. A license valid in one state would give privileges to practice in all other states with which the home state has agreements.
Mutual Recognition	A system in which the licensing authorities voluntarily enter into an agreement to legally accept the policies and processes (licensure) of a licensee’s home state; requires a harmonization of standards for licensure and professional conduct among all participant states. The Nurse Licensure Compact is based on this model.

Model	Explanation
Registration	A health professional licensed in one state registers to practice part-time in another state, agreeing to operate under the legal authority and jurisdiction of the other state. They do not need to meet entrance requirements imposed upon those licensed in the host state but they are held accountable for breaches in professional conduct in any state in which they are registered.
Limited Licensure	A health professional with a full and unrestricted license in at least one state can obtain a limited license in another state for the delivery of specific health services under particular circumstances. This model limits the scope rather than the time period of practice. The Federation of State Medical Boards' "Model Act to Regulate the Practice of Medicine Across State Lines" follows this model.
National Licensure	A license would be issued based on a universal standard for the practice of healthcare in the U.S. If administered at the national level, questions might be raised about states' revenue loss, the legal authority of states, logistics about how data would be collected and processed, and how enforcement of licensure standards and discipline would be administered. If administered at the state level, these questions might be alleviated. States would have to agree on a common set of standards and criteria ranging from qualifications to discipline.
Federal Licensure	Health professionals would be issued one license by the federal government, valid throughout the U.S. Licensure would be based on federally-established and administered standards that would preempt state licensure laws. However, given the difficulties associated with central administration and enforcement, the states might play a role in implementation.

Source: Health Licensing Board Report to Congress Requested by Senate Report 111-66 (Wakefield, 2010)

In addition, there are multiple templates and model policy documents available for states' use in considering furthering implementation of telehealth. Some of the most widely-accepted are listed in Table 8, below:

TABLE 8: MODEL LEGISLATION AND POLICY SUGGESTIONS FROM NATIONAL ORGANIZATIONS

Organization	Suggested Model Legislation or Policy Suggestion
American Telemedicine Association	The state's health professional licensing boards shall modify, as necessary, requirements for telemedicine-provided practices to be the same as for in-person practices. A professional should be able to consult with an out-of-state peer professional, such as a sub-specialist, without the need for an additional state license.

Organization	Suggested Model Legislation or Policy Suggestion
American Bar Association	Institute a system of mutual licensure recognition whereby a physician with a current, valid and unencumbered license in any state could file a single application which would permit the physician to practice telemedicine in some or all other states subject to continuing compliance with those states' licensure fees, discipline, and other applicable laws and regulations, and adherence to professional standards of medical care. Such legislation should specify a uniform definition of telemedical practice (e.g., that the physician does not set up an office, appoint a place for meeting patients, or routinely receive calls within the state), the requisite procedures for telemedical licensure, a requirement that the telemedicine provider must agree to the jurisdiction of the patient's home state for malpractice actions, and the continuing role of state medical boards in physician licensure and discipline.
Federal Communications Commission	The nation's governors and state legislatures could collaborate through such groups as the National Governors Association, the National Conference of State Legislatures and the Federation of State Medical Boards to craft an interstate agreement. If states fail to develop reasonable e-care licensing policies, Congress should consider intervening to ensure that Medicare and Medicaid beneficiaries are not denied the benefits of e-care.
Federation of State Medical Boards- Interstate Medical Licensure Compact	To strengthen access to health care, and in recognition of the advances in the delivery of health care, the member states of the Interstate Medical Licensure Compact have allied in common purpose to develop a comprehensive process that complements the existing licensing and regulatory authority of state medical boards, provides a streamlined process that allows physicians to become licensed in multiple states, thereby enhancing the portability of a medical license and ensuring the safety of patients. The Compact creates another pathway for licensure and does not otherwise change a state's existing Medical Practice Act. The Compact also adopts the prevailing standard for licensure and affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located. State medical boards that participate in the Compact retain the jurisdiction to impose an adverse action against a license to practice medicine in that state issued to a physician through the procedures in the Compact.
National Council of State Boards of Nursing	A multistate license to practice registered or licensed practical/vocational nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a nurse to practice as a registered nurse (RN) or as a LPN/VN, under a multistate licensure privilege, in each party state.
National Governor's Association	States should streamline the licensure application and credentials verification processes to allow providers to more easily apply for a license in multiple states. The current system for most health professionals is burdensome and time consuming, thereby discouraging practitioners from seeking the multiple licenses required to deliver e-health services, including in times of emergency. As a second and more long-term effort, the State Alliance is encouraging states to consider ways to accommodate e-health (including telemedicine and telepharmacy) practice while still maintaining state-based jurisdiction and authorities

Source: Health Licensing Board Report to Congress Requested by Senate Report 111-66 (Wakefield, 2010)

CONCLUSION

Telehealth has ushered in an era of change in the health professions. The ability to quickly connect a health care provider with a distant patient in another building, town, state, country or continent presents a challenge to the regulations and business practices that have sufficed to provide health care services for generations. One of the core premises that guided the evolution of the current state of the profession was that the patient and the provider needed to be in physical proximity to one another, but now, the capabilities of telehealth invalidate that premise. These technological changes call into question the relevance of many of the regulations that govern the health professions.

While an era of change is certainly challenging to navigate, change also provides opportunities to reconsider old practices and beliefs. Change allows for innovation and improvement. There is evidence that Virginia's health professions are embracing the opportunities provided by this era of change. Most of the health regulatory boards in the Commonwealth are working to adapt to telehealth. Virginia participates in one multi-state compact, has numerous projects across several disciplines dedicated to telehealth, and is recognized as a national leader in its efforts to embrace and adapt to telehealth.

However, this remains an unsettled time. The state-by-state licensing structure is threatened by suggestions that a national license would make more sense in this era. New business models built around telehealth technologies challenge traditional models. There is a race to see whether local and state-based organizations will develop adequate policies and practices to facilitate the use of telehealth before political and market pressures lead to a national solution.

The evidence shows that Virginia is adapting well thus far, but there is a great deal of work left to do. This report provides a brief survey of the current environment. There is important work that should be done to consider the economic impact of telehealth. There are also demographic and sociological changes that should be considered as a generation of children that have been connected to the internet from infancy come of age. Legal issues persist as well. To navigate these changes, this report suggests considering public service values such as accountability, incorruptibility, innovativeness, responsiveness, social justice, and transparency as decision making premises for the health professional boards.

Even though there is a community of people diligently working on this issue in Virginia, many health professional boards have only started to think about how telehealth impacts their profession. If Virginia intends to remain a leader and continue to adapt well to the changes that telehealth brings to the health professions, there need to be sustained efforts to continue to research the topic. The ability of the health professional boards to anticipate how telehealth will alter their practice will determine whether they are able to facilitate change, or have cause to fear it.

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APPENDICES

APPENDIX A

Entities Specific to Virginia with Government Ties Supporting Telehealth

Entity	Contribution to Telehealth in Virginia
Mid-Atlantic Telehealth Resource Center (MATRC)	Provides technical assistance and other resources to advance the adoption and utilization of telehealth within the MATRC region; works collaboratively with the other federally funded Telehealth Resource Centers to accomplish the same nationally. http://www.matrc.org/
Star Telehealth / Southside Telehealth Training Academy and Resource Center	A training program for health care providers and students seeking to use advanced telemedicine and telehealth systems to improve access to quality healthcare for rural and medically-underserved populations. Operated by the New College Institute in partnership with the University of Virginia Center for Telehealth at UVA Health System. Partially-funded by the Virginia Health Workforce Development Authority (VHWDA) by grant T55HP20285 from the Health Resources and Services Administration, HRSA (Siegle 2014).
University of Virginia Center for Telehealth	An HRSA-designated and funded Telehealth Resource Center (TRC) that provides assistance, education and information to those actively providing or interested in providing medical care at a distance. Assists in expanding the availability of health care to underserved populations; generally free of charge. Funded by the HRSA Office for the Advancement of Telehealth, part of the Office of Rural Health Policy.
Virginia Commonwealth University (VCU) Telemedicine Center	“Offers long-distance clinical health care, as well as patient and professional health-related education. Patients unable to receive treatment at our Richmond hospitals can access our medical care in a cost-efficient manner through telemedicine technology.” Partners with the Virginia Department of Corrections (DOC) to provide telehealth services to 30 DOC facilities and services an additional seven public health centers and systems (“Telemedicine Center” 2015).
VDH, Office of Minority Health and Health Equity, Division of Primary Care and Rural Health, State Office of Rural Health	Stated position in support of telehealth initiatives (VDH, 2015): Virginia's State Office of Rural Health has actively sought and received grant funding to implement and expand telehealth; views telehealth as part of a model of care that has far reaching implications. (https://www.vdh.virginia.gov/omhhe/primarycare/ruralhealth/telehealth.htm)
Virginia Rural Health Association	A 501(c)3 nonprofit organization working to improve the health of rural Virginians through education, advocacy, and fostering cooperative partnerships. Promotes the use of telehealth as a cost efficiency and tool to provide better health care to rural populations (Virginia Rural Health Association, 2015).
Virginia Telehealth Network (VTN)	A 501(c)(3) nonprofit public charity whose mission is to devote “its resources to advancing the adoption, implementation and integration of telehealth and related technologies into models of healthcare statewide, and promotes the integration of health systems to support the delivery of care for all Virginians” (“About VTN,” 2015). Currently operates under the auspices of VDH and strives for seamless interoperability between telehealth providers, their services and remote sites.

APPENDIX B
Virginia Board of Audiology and Speech-Language Pathology
Involvement with Telehealth

as of November 15, 2015

Effort	X O ✓	Explanation	Information Source
Board-Issued Guidance Document Regarding Telehealth		None found	n/a
Membership in Multi-State Licensing Compact		Nothing found regarding the existence or development of a multi-state licensing compact for professionals licensed by this Board	n/a
Telehealth References in 2015 Board Meeting Minutes		None found	n/a
Telehealth Efforts Underway by Associated Professional Organizations		<ul style="list-style-type: none"> • National Council of State Boards (NCSB) of Examiners for Speech-Language Pathology and Audiology: <ul style="list-style-type: none"> ○ Listing of states with Telepractice Regulations ○ NCSB Position Statement on Telepractice (revised March 2015) • American Academy of Audiology: October 15, 2015: <ul style="list-style-type: none"> ○ Current Practices in Tele-audiology ○ Tele-audiology Toolkit 	<ul style="list-style-type: none"> • http://www.ncsb.info/telepractice • http://www.ncsb.info/position-statements#ncsbpsot • http://www.audiology.org/practice_management/resources/current-practices-tele-audiology • http://www.audiology.org/practice_management/resources/tele-audiology-toolkit

X = None found

O = Related Effort/Under Development

✓ = Verified

APPENDIX C

Virginia Board of Counseling Involvement with Telehealth

as of November 15, 2015

Effort	X O ✓	Explanation	Information Source
Board-Issued Guidance Document Regarding Telehealth	O	<p>Related Guidance Document: 115-1.4 Adopted 8/8/08: Guidance on Technology-Assisted Counseling and Technology-Assisted Supervision; excerpts:</p> <ul style="list-style-type: none"> • Counseling may be continued using technology-assisted means after it is initiated in a traditional setting (p.1) • When working with a client who is not in Virginia, counselors are advised to check the regulations of the state board in which the client is located (p.1) • The Board of Counseling governs the practice of counseling in Virginia. Counselors who are working with a client who is not in Virginia are advised to check the regulations of the state board in which a supervisee is located. It is important to be mindful that certain states may regulate or prohibit supervision by an individual who is unlicensed by that state. (p.3) 	http://www.dhp.virginia.gov/counseling/counseling_guidelines.htm
Membership in Multi-State Licensing Compact	O	<p>Possible national effort developing: On 8/17/15, the American Association of State Counseling Boards (AASCB) proposed a five-year effort to increase portability of counseling licensure across state lines.</p> <p>No mention of the Virginia Board of Counseling pursuing involvement in this potential compact effort.</p>	http://www.aascb.org/aws/AASCB/pt/sd/news_article/110786/PARENT/layout_details/false
Telehealth References in 2015 Board Meeting Minutes	X	None found	n/a
Telehealth Efforts Underway by Associated Professional Organizations	✓	<ul style="list-style-type: none"> • American Counseling Association: Code of Ethics: (2014): Section H: "Distance Counseling, Technology, and Social Media " (p. 17-18) • National Board for Certified Counselors: Policy Regarding the Provision of Distance Professional Services 	http://www.counseling.org/Resources/aca-code-of-ethics.pdf http://www.nbcc.org/Assets/Ethics/NBCCPolicyRegardingPracticeofDistanceCounselingBoard.pdf

X = None found

O = Related Effort/Under Development

✓ = Verified

APPENDIX D

Virginia Board of Dentistry Involvement with Telehealth

as of November 15, 2015

Effort	X O ✓	Explanation	Information Source
Board-Issued Guidance Document Regarding Telehealth	O	<ul style="list-style-type: none"> 10/16/15: Regulatory-Legislative Committee Draft Meeting Minutes: Discussion of “the need for a policy which requires licensure in Virginia establishes the doctor-patient relationship and addresses the security of patient information.” Board voted to consider a revised version of the Board of Medicine’s Guidance Document 85-12 at its December 2015 meeting (p.5) 	<ul style="list-style-type: none"> http://www.dhp.virginia.gov/dentistry/minutes/2015/RegLeg10162015_Draft.pdf
Membership in Multi-State Licensing Compact	X	<ul style="list-style-type: none"> Nothing found regarding the existence or development of a multi-state licensing compact for professionals licensed by this Board 	n/a
Telehealth References in 2015 Board Meeting Minutes	✓	<ul style="list-style-type: none"> 8/14/15: Open Forum on Policy Strategies to Address Teledentistry Meeting Minutes: Received input from stakeholders regarding views on the need for policies on the use of teledentistry in Virginia 9/18/15: Board Business Meeting Draft Meeting Minutes: Discussion regarding the Open Forum on Teledentistry held on 8/14/15, noted considerations for any potential teledentistry provisions in Virginia: (1) Consideration of the hands-on nature of dentistry; (2) requiring state licensure; (3) cyber security and the use of smart phones; and (4) using teledentistry to address the supervision of dental hygienists. Matter referred to the Board’s Regulatory-Legislative Committee. (p. 4) 10/16/15: (see first row, above) 	<ul style="list-style-type: none"> http://www.dhp.virginia.gov/dentistry/minutes/2015/OpenForum08142015.pdf http://www.dhp.virginia.gov/dentistry/minutes/2015/BusMtg09182015_DRAFT.pdf http://www.dhp.virginia.gov/dentistry/minutes/2015/RegLeg10162015_Draft.pdf
Telehealth Efforts Underway by Associated Professional Organizations	✓	<ul style="list-style-type: none"> Recent legislative effort: SB647; 2014 General Assembly Session (left in the House Appropriations Committee); defined teledentistry (“the delivery of dental services through the use of interactive audio, video or other electronic media used for the purpose of diagnosis, consultation or treatment”) and directed the Department of Medical Assistance Services (DMAS) to enter into a Memorandum of Agreement with the Virginia Dental Association for a two-year teledentistry pilot program. Other stakeholders responsible for developing metrics for the plan included the Virginia Dental Hygienists’ Association and the Virginia Oral Health Coalition. “Teledentistry: A Systematic Review of Clinical Outcomes, Utilization and Costs,” course offered by the American Dental Hygienists’ Association through 4/30/17 	<ul style="list-style-type: none"> https://lis.virginia.gov/cgi-bin/legp604.exe?151+ful+SB647ES1 https://adha.cdeworld.com/courses/20099-Teledentistry:A_Systematic_Review_of_Clinical_Outcomes-Utilization_and_Costs

X = None found

O = Related Effort/Under Development

✓ = Verified

APPENDIX E

Virginia Board of Funeral Directors and Embalmers Involvement with Telehealth

as of November 15, 2015

Effort	X O ✓	Explanation
Board-Issued Guidance Document Regarding Telehealth	X	None found
Membership in Multi-State Licensing Compact	X	Nothing found regarding the existence or development of a multi-state licensing compact for professionals licensed by this Board
Telehealth References in 2015 Board Meeting Minutes	X	None found
Telehealth Efforts Underway by Associated Professional Organizations	X	<p>None found</p> <p>Note: Searched for references to telehealth on the following organizations' websites:</p> <ul style="list-style-type: none"> • National Funeral Directors Association • International Cemetery, Cremation and Funeral Association

X = None found

O = Related Effort/Under Development

✓ = Verified

APPENDIX F

Virginia Board of Long-Term Care Administrators Involvement with Telehealth

as of November 15, 2015

Effort	X O ✓	Explanation
Board-Issued Guidance Document Regarding Telehealth	X	None found
Membership in Multi-State Licensing Compact	X	Nothing found regarding the existence or development of a multi-state licensing compact for professionals licensed by this Board
Telehealth References in 2015 Board Meeting Minutes	X	None found
Telehealth Efforts Underway by Associated Professional Organizations	X	<p>None found</p> <p>Note: Searched for references to telehealth on the following organizations' websites:</p> <ul style="list-style-type: none"> • National Association of Long-Term Care Administrator • American College of Health Care Administrators

X = None found

O = Related Effort/Under Development

✓ = Verified

APPENDIX G

Virginia Board of Medicine Involvement with Telehealth

as of November 15, 2015

Effort	X O ✓	Explanation	Information Source
Board-Issued Guidance Document Regarding Telehealth	✓	Guidance Document 85-12, adopted 2/19/15	https://www.dhp.virginia.gov/medicine/
Membership in Multi-State Licensing Compact	O	<p>Interstate Medical Licensure Compact under development by the Federation of State Medical Boards (FSMB):</p> <p>2/19/15: Full Board Meeting Minutes: adopted motion to consider the Compact; issue referred to the Legislative Committee</p> <p>5/15/15: Legislative Committee Minutes: concerns with the Compact: 1) requirements regarding complaints that conflict with Virginia's existing law, 2) the creation of a new license, 3) impact on the rulemaking process, and 4) the timing of the request. Matter tabled until the next meeting (1/15/16) to consider a roadmap for participation in the Compact, "including model legislation and implications of participation" (p. 3).</p>	http://www.dhp.virginia.gov/medicine/medicine_calendar.htm
Telehealth References in 2015 Board Meeting Minutes	✓	<p>1/28/15: Work Group of the Ad Hoc Committee on Telemedicine: passed recommended guidance for the full Board's consideration</p> <p>2/19/15: Full Board Meeting: Formally adopted the Telemedicine Guidance document</p> <p>No other references found in the meeting minutes for Board of Medicine Advisory Boards</p>	http://www.dhp.virginia.gov/medicine/medicine_calendar.htm
Telehealth Efforts Underway by Associated Professional Organizations	✓	<p>American Medical Association (AMA) guiding principles on the provision of telemedicine services</p> <p>Federation of State Medical Boards (FSMB): Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine</p> <p>Medical Society of Virginia: Guidance document: "Telemedicine: How to get started"</p>	<p>http://www.ama-assn.org/ama/pub/news/news/2014/2014-06-11-policy-coverage-reimbursement-for-telemedicine.page</p> <p>http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB_Telemedicine_Policy.pdf</p> <p>http://www.msv.org/MainMenuCategories/MemberCenter/MSVPublications/VirginiaMedicalNews/2015/June-2015/Telemedicine-How-to-get-started--.aspx</p>

X = None found

O = Related Effort/Under Development

✓ = Verified

APPENDIX H

Virginia Board of Nursing Involvement with Telehealth

as of November 15, 2015

Effort	X O ✓	Explanation	Information Source
Board-Issued Guidance Document Regarding Telehealth	✓	<ul style="list-style-type: none"> • Guidance Document 90-64: Virginia Board of Medicine & Virginia Board of Nursing Telemedicine for Nurse Practitioners; Adopted by the Board of Medicine 2/19/15; adopted by the Board of Nursing 7/14/15 • Note: Related Guidance Document: Guidance on the Use of Social Media: Adopted 5/15/12 	<ul style="list-style-type: none"> • https://www.dhp.virginia.gov/nursing/nursing_guidelines.htm
Membership in Multi-State Licensing Compact	✓	<ul style="list-style-type: none"> • Nurse Licensure Compact (NLC): <ul style="list-style-type: none"> ○ Virginia became a participating state on 1/1/05 pursuant to §54.1-3030, et. seq., Code of Virginia ○ The NLC authorizes Licensed Practical Nurses and Registered Nurses to practice in other compact states without the necessity of obtaining an additional license; license in his/her primary state of residence grants “multi-state privilege” to practice in other compact states ○ Other states currently participating in the NLC: Arizona, Arkansas, Colorado, Delaware, Idaho, Iowa, Kentucky, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, and Wisconsin 	<ul style="list-style-type: none"> • https://www.dhp.virginia.gov/nursing/nursing_compact.htm • https://www.ncsbn.org/nurse-licensure-compact.htm • https://www.ncsbn.org/NLC_Implementation_2015.pdf
Telehealth References in 2015 Board Meeting Minutes	✓	<ul style="list-style-type: none"> • 6/10/15: Committee of the Joint Boards of Nursing and Medicine Meeting Minutes: Adopted Board of Medicine Telehealth Guidance Document 85-12 (p.2) 	<ul style="list-style-type: none"> • http://www.dhp.virginia.gov/nursing/nursing_calendar.htm
Telehealth Efforts Underway by Associated Professional Organizations	✓	<ul style="list-style-type: none"> • Report on State-based Licensure and Telehealth (2014) • National Council of State Boards of Nursing Position Paper on Telehealth Nursing Practice 	<ul style="list-style-type: none"> • https://www.ncsbn.org/6568.htm • https://www.ncsbn.org/3847.htm

X = None found

O = Related Effort/Under Development

✓ = Verified

APPENDIX I

Virginia Board of Optometry Involvement with Telehealth

as of November 15, 2015

Effort	X O ✓	Explanation	Information Source
Board-Issued Guidance Document Regarding Telehealth	X	None found Note: Potential future action indicated by Draft Board Meeting Minutes from 7/17/15: "Board Chair Dr. Droter requested that the topic of telemedicine....be addressed as [a] future issu[e]. Ms. Yeatts [Staff Sr Policy Analyst] reported that the Board of Medicine has a guidance document on telemedicine. Ms. Knachel [Board Executive Director] stated that the guidance document will be forwarded to the board members" (p. 2)	http://www.dhp.virginia.gov/Optometry/minutes/2015/FB07172015_draft.pdf
Membership in Multi-State Licensing Compact	X	Nothing found regarding the existence or development of a multi-state licensing compact for professionals licensed by this Board	n/a
Telehealth References in 2015 Board Meeting Minutes	✓	Draft Board Meeting Minutes from 7/17/15: <ul style="list-style-type: none">• Board Chair Dr. Droter requested that the topic of telemedicine....be addressed as [a] future issu[e]. Ms. Yeatts [Staff Sr Policy Analyst] reported that the Board of Medicine has a guidance document on telemedicine. Ms. Knachel [Board ED] stated that the guidance document will be forwarded to the board members" (p. 2)• In reference to the Supreme Court decision involving the North Carolina Board of Dentistry and its ensuing potential impact on scope of practice determinations by Virginia Medical Boards: "Virginia Office of the Attorney General has created a task force and is looking into what advice to provide to the agencies across the Commonwealth. The guidance for DHP is not yet developed and legal advice related to this issue from any other entity is not applicable to the Board at this time." (p.4)	http://www.dhp.virginia.gov/Optometry/minutes/2015/FB07172015_draft.pdf
Telehealth Efforts Underway by Associated Professional Organizations	O	Association of Regulation of Boards of Optometry: "developing guidance around social media and telehealth" -Letter from the President, Summer 2015 Greensheet	http://www.arbo.org/greensheets/Greensheet_Summer2015.pdf

X = None found

O = Related Effort/Under Development

✓ = Verified

APPENDIX J

Virginia Board of Pharmacy Involvement with Telehealth

as of November 15, 2015

Effort	X O ✓	Explanation	Information Source
Board-Issued Guidance Document Regarding Telehealth	X	None found Note: Reference § 54.1-3303, Code of Virginia regarding conditions for prescribing a Schedule VI controlled substance to a patient via telemedicine services as defined in § 38.2-3418.16	http://law.lis.virginia.gov/vacode/title54.1/chapter33/section54.1-3303/
Membership in Multi-State Licensing Compact	X	Nothing found regarding the existence or development of a multi-state licensing compact for professionals licensed by this Board	n/a
Telehealth References in 2015 Board Meeting Minutes	X	None found	n/a
Telehealth Efforts Underway by Associated Professional Organizations	✓	National Association of Boards of Pharmacy (NABP): Model State Pharmacy Act and Model Rules: August 2015. Includes guidance on the practice of Telepharmacy within and between state lines Note: Searched for references to telehealth on the following organizations' websites: <ul style="list-style-type: none"> • American Society for Pharmacology and Experimental Therapeutics (ASPET) • American Society for Clinical Pharmacology and Therapeutics 	http://www.nabp.net/publications/model-act/

X = None found

O = Related Effort/Under Development

✓ = Verified

APPENDIX K

Virginia Board of Physical Therapy Involvement with Telehealth

as of November 20, 2015

Effort	X O ✓	Explanation	Information Source
Board-Issued Guidance Document Regarding Telehealth		<ul style="list-style-type: none"> Guidance on Telehealth, Guidance Document 112-21: adopted 11/20/15 	<ul style="list-style-type: none"> http://www.dhp.virginia.gov/PhysicalTherapy/physther_guidelines.htm
Membership in Multi-State Licensing Compact		<ul style="list-style-type: none"> Physical Therapy Licensure Compact under development by the Federation of State Boards of Physical Therapy (FSBPT). Status: the effort is in the final stage of the Drafting Phase and within the next 18 months, a proposed compact will be released to states for consideration. 	<ul style="list-style-type: none"> https://www.fsbpt.org/FreeResources/PhysicalTherapyLicensureCompact.aspx
Telehealth References in 2015 Board Meeting Minutes		<ul style="list-style-type: none"> 9/24/15: Draft Meeting Minutes for the Ad Hoc Committee- Telehealth: proposed guidance document to be presented at next full Board meeting (document since adopted; see first row, above) 	<ul style="list-style-type: none"> http://www.dhp.virginia.gov/PhysicalTherapy/physther_calendar.htm
Telehealth Efforts Underway by Associated Professional Organizations		<ul style="list-style-type: none"> FSBPT: Telehealth in Physical Therapy: Policy Recommendations for Appropriate Regulation (dated 11/12/14) American Physical Therapy Association (APTA): Telehealth- Definitions and Guidelines BOD G03-06-09-19 [Retitled: Telehealth; Amended BOD G03-03-07-12; Initial BOD 11-01-28-70] [Guideline] 	<ul style="list-style-type: none"> https://www.fsbpt.org/Portals/0/documents/news-events/TelehealthInPhysicalTherapy.pdf http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/TelehealthDefinitionsGuidelines.pdf

X = None found

O = Related Effort/Under Development

✓ = Verified

APPENDIX L

Virginia Board of Psychology Involvement with Telehealth

as of November 15, 2015

Effort	X O ✓	Explanation	Information Source
Board-Issued Guidance Document Regarding Telehealth	X	<ul style="list-style-type: none"> None found 	n/a
Membership in Multi-State Licensing Compact	O	<ul style="list-style-type: none"> In February 2015, the Association of State and Provincial Psychology Boards (ASPPB) created the Psychology Interjurisdictional Compact ("PSYPACT"). The purpose of the PSYPACT is to "facilitate telehealth and temporary in-person, face-to-face practice of psychology across jurisdictional boundaries. At the 6/16/15 Regulatory Committee Meeting, the PSYPACT was discussed; group consensus was to conduct additional research and report back to the Committee 	<ul style="list-style-type: none"> https://asppb.site-ym.com/page/micrositehp http://www.dhp.virginia.gov/Psychology/psychology_calendar.htm
Telehealth References in 2015 Board Meeting Minutes	✓	<ul style="list-style-type: none"> 6/16/15: Regulatory Committee Meeting Draft Meeting Minutes: Discussion regarding the PSYPACT, its risks and benefits, and whether the Virginia Board of Psychology should become involved; decision made for members and staff to gather information and report back to the Board on the stance of other boards and associations regarding social media, texting and telepsychology (p. 2.) 8/25/15: Board meeting Draft Meeting Minutes: <ul style="list-style-type: none"> Report on the above-referenced discussion from the 6/16/15 Regulatory Committee Meeting Discussion of provision by psychologists working with Telemental Health through the VA Health Administration and their licensing purview under the Federal Supremacy Clause; no specific action taken 	<ul style="list-style-type: none"> http://www.dhp.virginia.gov/Psychology/psychology_calendar.htm
Telehealth Efforts Underway by Associated Professional Organizations	✓	<ul style="list-style-type: none"> American Psychological Association (APA): Guidelines for the Practice of Telepsychology Association of State and Provincial Psychology Boards (ASPPB): Telepsychology Task Force Principles/Standards American Psychologists Association: Code of Ethics: applies to activities across a variety of contexts, such as in person, postal, telephone, Internet, and other electronic transmissions (p. 2) 	<ul style="list-style-type: none"> http://www.apa.org/practice/guidelines/telepsychology.aspx http://c.ymcdn.com/sites/www.asppb.net/resource/resmgr/PSYPACT_Docs/ASPPB_TELEPSYCH_PRINCIPLES.pdf http://www.apa.org/ethics/code/

X = None found

O = Related Effort/Under Development

✓ = Verified

APPENDIX M

Virginia Board of Social Work Involvement with Telehealth

as of November 15, 2015

Effort	X O ✓	Explanation	Information Source
Board-Issued Guidance Document Regarding Telehealth	O	None found Note: Related Guidance Document: 140-3 (issued 10/23/13): Guidance on Technology-Assisted Therapy and the Use of Social Media	https://www.dhp.virginia.gov/social/social_guidelines.htm
Membership in Multi-State Licensing Compact	X	Nothing found regarding the existence or development of a multi-state licensing compact for professionals licensed by this Board	n/a
Telehealth References in 2015 Board Meeting Minutes	X	None found	n/a
Telehealth Efforts Underway by Associated Professional Organizations	O	Association of Social Work Boards (ASWB): Model Regulatory Standards for Technology and Social Work Practice	https://www.aswb.org/wp-content/uploads/2015/03/ASWB-Model-Regulatory-Standards-for-Technology-and-Social-Work-Practice.pdf

X = None found

O = Related Effort/Under Development

✓ = Verified

APPENDIX N

Virginia Board of Veterinary Medicine Involvement with Telehealth

as of November 15, 2015

Effort	X O ✓	Explanation	Information Source
Board-Issued Guidance Document Regarding Telehealth	X	None found	n/a
Membership in Multi-State Licensing Compact	X	Nothing found regarding the existence or development of a multi-state licensing compact for professionals licensed by this Board	n/a
Telehealth References in 2015 Board Meeting Minutes	X	None found	n/a
Telehealth Efforts Underway by Associated Professional Organizations	O	<ul style="list-style-type: none"> American Association of Veterinary State Boards (AAVSB): Veterinary Medicine Practice Act Model with Comments created 2001, Latest revisions in 2014; excerpt follows: "Rather than attempting to define "telepractice" or create a limited license to address sporadic practice, it is recommended that legislatures address these technologically driven practice issues through a temporary practice approach. This temporary practice language is intended to address sporadic practice within the state irrespective of whether it is electronically rendered or rendered in Person" (p.43) American Veterinary Medical Association (AVMA): While the AMVA does not have an official stance on telehealth, see article posted 10/14/15: "AMVA panel to scrutinize telemedicine," excerpt follows: "The practice of telemedicine remains an unresolved issue in veterinary medicine. In fact, the practice of exchanging medical information via electronic communications to improve patients' health status will only become more prevalent" 	<ul style="list-style-type: none"> file:///C:/Users/Andrea/Downloads/PAM%20Final%20%202014%20Revisions%20(1).pdf https://www.avma.org/News/JAVMANews/Pages/151101c.aspx

X = None found

O = Related Effort/Under Development

✓ = Verified

VIRGINIA BOARD OF HEALTH PROFESSIONS
CY2016 WORKPLAN

I. **CHAIR— (Also serves as Ex Officio Member of All Committees)**

- A. Set agenda - (30 days in advance of meeting)
- B. Appoint Members to Committees - (as new members are oriented to the Board and for ad hoc committees)

II. **EXECUTIVE COMMITTEE—Chair, Vice-Chair, Chairs of Standing Committees**

Mission: To review matters of interest to the Board and make recommendations to the Board. To evaluate the need for coordination among the boards and their staffs and report findings and recommendations to the Director and the boards. To monitor policies and activities of the Department, to serve as a forum for resolving conflicts among the boards and Between the boards and the Department. To review and comment on the budget for the Department.

- A. Orient new appointees – Orient new members within 30 days of appointment, individually and at Board Member Training conducted annually.
- B. Review and comment on budgetary proposal for the agency.
- C. Develop a committed membership by working with current and future board members for a clearer understanding of the role of BHP . Review minutes of health regulatory boards after each meeting for their use in respective health regulatory board's meetings and discussions of the citizen members as they deem appropriate (Draft now available on Townhall within ten (10) days after board meeting and final minutes within three (3) days of approval).

III. **REGULATORY RESEARCH COMMITTEE**

Mission: To evaluate regulated and unregulated health care professions to consider whether the professions should be regulated and the degree of regulation to be imposed. To examine scope of practice conflicts involving regulated and unregulated professions and advise the boards and the General Assembly regarding the nature and extent of these conflicts.

- A. Monitor the introduction of all legislation substantially affecting regulation of health providers and provide comment to the Secretary, Governor, and relevant General Assembly Members through the Director.

- B. Remain abreast of emerging health occupations and professions and the need for required regulation.
- C. Support research projects as requested by the Director pertaining to health reform issues

IV. EDUCATION COMMITTEE

Mission: To provide a means of citizen access to the Department. To provide a means of publicizing the policies and programs of the Department to educate the public and elicit public support. To promote the development of standards to evaluate the competency of professions represented on the Board.

- A. Enhance public access to policy, licensure, discipline, and workforce information
 - Review the agency's websites and consider ways to better leverage electronic communications
 - Continue to partner with other organizations
- B. Support Board Member educational efforts
 - New Board Member Training
 - Continuing education credit opportunities

V. ENFORCEMENT COMMITTEE

Mission: To review periodically the investigatory, disciplinary, and enforcement processes of the Department and the boards to ensure the protection of the public and the fair and equitable treatment of health professions.

- A. Continue work on Sanction Reference Points Study.
 - All Boards have a SRPs
 - Formal evaluation underway with monograph for professional publication anticipated.
 - Consider requests for assistance by other agencies within the Commonwealth and elsewhere.
- B. Monitor agency DHP enforcement processes and performance.
 - Continue to remain abreast of agency performance in meeting investigative and case resolution standards through periodic reports at Board meetings.
 - Receive reports on strategies being used by the individual boards as well as the agency staff to more effectively address discipline caseloads.

- C. Consider Ongoing Board Member Training in Disciplinary Process.
- D. Respond to Legislative Requests by General Assembly relating to discipline.

VI. NOMINATING COMMITTEE

Mission: To develop a slate of officers for annual elections of offices and a listing of members for consideration as acting officer, should the need arise.

- A. Chair
- B. Vice-Chair

**VIRGINIA BOARD OF HEALTH PROFESSIONS
VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS**

DRAFT STUDY WORKPLAN

**Evaluation of Chiropractor Competencies to Conduct Physical Examinations for
Commercial Driver Licensure and Learner's Permit Applicants**

May 5, 2016

Background and Authority

The Board of Health Professions has been requested by the Director of the Department to conduct a review to determine whether chiropractors' education and training enables performance of commercial driver's license and learner's permit physical examinations as provided in federal regulation. The request is pursuant to a letter to the Director from Delegate Robert and a result the introduction of House Bill 1098 in 2016 and similar proposal in 2015 (see Attachment).

The Board of Health Professions is authorized by the General Assembly with a variety of powers and duties specified in §§54.1-2500, 54.1-2409.2, 54.1-2410 *et seq.*, 54.1-2729 and 54.1-2730 *et seq.* of the *Code of Virginia*. Of greatest relevance here is §54.1-2510 (1), (7), and (12) enable the Board to evaluate the need for coordination among health regulatory boards, to advise on matters relating to the regulation or deregulation of health care professions and occupations, and to examine scope of practice conflicts involving professions and advise on the nature and degree of such conflicts.

Methods

In keeping with constitutional principles, Virginia statutes, and nationally recognized research standards, the Board has developed a standard methodology to address key issues of relevance in gauging the need for regulation of individual health professions. The specifics are fully described in the Board's *Policies and Procedures for the Evaluation of the Need to Regulate Health Occupations and Professions*, available from the Board's website: http://www.dhp.virginia.gov/bhp/bhp_guidelines.htm) under Guidance Document **75-2 Appropriate Criteria in Determining the Need for Regulation of Any Health Care Occupation or Professions, revised February 1998.** The Policies and Procedures' seven evaluative criteria apply most directly to determining *whether* a profession should be regulated and to what degree. But, they also provide a standard conceptual framework with proscribed questions and research methods that have been employed for over two decades to objectively address key policy issues related to health professional regulation. The seven Criteria typically used in sunrise review studies are, (1) Risk of Harm to the Consumer, (2) Specialized Skills and Training, (3) Autonomous Practice, (4) Scope of Practice, (4) Economic Costs, (5) Alternatives to Regulation, and (6) Lease Restrictive Regulation.

Chiropractors are already licensed by the Virginia Board of Medicine. Thus, only the criteria directly relevant to determinations of competency to perform physical examinations as proscribed by the U.S. Department of Transportation's Federal Motor Carrier Administration (FMCSA) apply in the current review. The following questions are recommended to guide the study:

Risk of Harm to the Consumer and Specialized Skills and Training

- ❖ What are the competencies required of medical examiners certified through the U.S. Department of Transportation's Federal Motor Carrier Safety Administration (FMCSA)?
 - Which health professions are currently eligible for this national certification in Virginia and elsewhere?
 - Which training programs are acceptable? How are they accredited?
 - What are the competencies (knowledge, skills, and abilities) assessed by the national FMCSA Medical Examiner Certification Test?
 - What are the continuing competency requirements for maintaining a listing on the National Registry of Certified Medical Examiners?
 - What constitutes grounds for removal from the Registry list?
- ❖ What specifically constitutes physical examinations pursuant to FMCSA requirements?
- ❖ Is there evidence of harm to the consumer related to FMCSA qualifying physical examinations performed by Chiropractors? If any,
 - How is the evidence documented (e.g., FMCSA action, Board discipline, malpractice cases, criminal cases, other administrative disciplinary actions)?
 - Characterize the type of harm (physical, emotional, mental, social, or financial).
 - How does this compare with other health professions, generally?
- ❖ Does a potential for fraud exist because of the inability of the public to make informed choice in selecting a competent practitioner?
- ❖ Do Virginia's Chiropractor licensure requirements differ substantively from other states¹ that allow Chiropractors to perform FMCSA commercial driver license physical examinations? If so, what are the differences attributed to?
 - Requisite education, training or educational program acceptance?
 - Examination(s)?
 - Continuing competency requirements to maintain licensure?
 - Grounds for Board disciplinary action?

¹ D.C., Kentucky, Maryland, North Carolina, Pennsylvania, and West Virginia are examples of surrounding jurisdictions that permit Chiropractors to perform CDL physicals.

Scope of Practice

- ❖ Do Chiropractors who are on the FMCSA National Registry of Medical Examiners from other states perform commercial driver physical examinations differently than the other professions so authorized?
 - Doctors of Medicine
 - Doctors of Osteopathy
 - Physician Assistants
 - Advanced Practice Nurses

Economic Costs

- ❖ If the data are available, what are the typical fees for performing FMCSA physical examinations in Virginia? In adjoining states? Nationally?
- ❖ Is there evidence that expanding the scope of practice of Chiropractors to include these examinations?
 - Increase the cost for services?
 - Increase salaries for those employed by health delivery organizations?
 - Restrict other professions in providing care?
 - Other deleterious economic effects?
- ❖ If data are available, address issues related to supply and demand and distribution of resources including discussion of insurance reimbursement.

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. Prepare the final report for reply to Delegate Orrock as well as publication and electronic posting and dissemination to interested parties.

Timetable and Resources

This study will be conducted with existing staff and within the budget for FY2016-17 and according to the following tentative timetable:

DATES

May 5, 2016	Draft Workplan reviewed by Regulatory Research Committee
June 6, 2016	Staff update and 1 st draft of Report reviewed by Committee
June 28, 2016	Public Hearing
August 16, 2016	Review of Comments by Committee and Recommendation Determination for consideration by the full Board.
September 30, 2016	Board Report to the Director and Secretary for review and comment
November 1, 2016	Final Report to Delegate Orrock

Appendices

- **Letter from Delegate Orrock**
- **HB 1098**



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HOUSE OF DELEGATES
RICHMOND



COMMITTEE ASSIGNMENTS:
HEALTH, WELFARE AND INSTITUTIONS (CHAIRMAN)
FINANCE
AGRICULTURE, CHESAPEAKE AND
NATURAL RESOURCES
RULES

February 4, 2016

David Brown, DC Director
Department of Health Professions
9960 Mayland Drive, STE 300
Henrico, VA 23233-1463

Re: House Bill 1098 – Chiropractors and CDL Physicals

Dear Dr. Brown:

As chairman of the Health Welfare and Institutions Committee, I am writing to you regarding House Bill 1098 which has been introduced by Delegate Ron Villanueva. The legislation seeks to include within the scope of practice of chiropractors the ability to perform commercial driver's license "CDL" physicals. Senator Newman had virtually the same bill in the 2015 session which did not pass the House of Delegates.

Since this issue has been raised for two consecutive years, I am requesting that you have the Virginia Board of Health Professions determine if chiropractors do or do not have the requisite education and training to perform CDL physicals as set forth in federal regulations. In doing so it would be most helpful if you could address how the education and training does or does not exist for each element of the CDL physical according to the physical form that is required for use in the federal regulations.

I would appreciate receiving a report back from you by November 1, 2016 so that I may evaluate it with Delegate Villanueva and the stakeholders.

Thank you in advance for your assistance.

Sincerely,

Robert D. "Bobby" Orrock, Sr.

CC: The Honorable Ron A. Villanueva

2016 SESSION

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HOUSE BILL NO. 1098
Offered January 13, 2016
Prefiled January 13, 2016

A BILL to amend and reenact § 54.1-2900 of the Code of Virginia, relating to practice of chiropractic; scope.

Patrons—Villanueva and Hugo

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:
1. That § 54.1-2900 of the Code of Virginia is amended and reenacted as follows:

- § 54.1-2900. Definitions.
 - As used in this chapter, unless the context requires a different meaning:
 - "Acupuncturist" means an individual approved by the Board to practice acupuncture. This is limited to "licensed acupuncturist" which means an individual other than a doctor of medicine, osteopathy, chiropractic or podiatry who has successfully completed the requirements for licensure established by the Board (approved titles are limited to: Licensed Acupuncturist, Lic.Ac., and L.Ac.).
 - "Auricular acupuncture" means the subcutaneous insertion of sterile, disposable acupuncture needles in predetermined, bilateral locations in the outer ear when used exclusively and specifically in the context of a chemical dependency treatment program.
 - "Board" means the Board of Medicine.
 - "Genetic counselor" means a person licensed by the Board to engage in the practice of genetic counseling.
 - "Healing arts" means the arts and sciences dealing with the prevention, diagnosis, treatment and cure or alleviation of human physical or mental ailments, conditions, diseases, pain or infirmities.
 - "Medical malpractice judgment" means any final order of any court entering judgment against a licensee of the Board that arises out of any tort action or breach of contract action for personal injuries or wrongful death, based on health care or professional services rendered, or that should have been rendered, by a health care provider, to a patient.
 - "Medical malpractice settlement" means any written agreement and release entered into by or on behalf of a licensee of the Board in response to a written claim for money damages that arises out of any personal injuries or wrongful death, based on health care or professional services rendered, or that should have been rendered, by a health care provider, to a patient.
 - "Nurse practitioner" means an advanced practice registered nurse who is jointly licensed by the Boards of Medicine and Nursing pursuant to § 54.1-2957.
 - "Occupational therapy assistant" means an individual who has met the requirements of the Board for licensure and who works under the supervision of a licensed occupational therapist to assist in the practice of occupational therapy.
 - "Patient care team" means a multidisciplinary team of health care providers actively functioning as a unit with the management and leadership of one or more patient care team physicians for the purpose of providing and delivering health care to a patient or group of patients.
 - "Patient care team physician" means a physician who is actively licensed to practice medicine in the Commonwealth, who regularly practices medicine in the Commonwealth, and who provides management and leadership in the care of patients as part of a patient care team.
 - "Physician assistant" means an individual who has met the requirements of the Board for licensure and who works under the supervision of a licensed doctor of medicine, osteopathy, or podiatry.
 - "Practice of acupuncture" means the stimulation of certain points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain ailments or conditions of the body and includes the techniques of electroacupuncture, cupping and moxibustion. The practice of acupuncture does not include the use of physical therapy, chiropractic, or osteopathic manipulative techniques; the use or prescribing of any drugs, medications, serums or vaccines; or the procedure of auricular acupuncture as exempted in § 54.1-2901 when used in the context of a chemical dependency treatment program for patients eligible for federal, state or local public funds by an employee of the program who is trained and approved by the National Acupuncture Detoxification Association or an equivalent certifying body.
 - "Practice of athletic training" means the prevention, recognition, evaluation, and treatment of injuries or conditions related to athletic or recreational activity that requires physical skill and utilizes strength,

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59 power, endurance, speed, flexibility, range of motion or agility or a substantially similar injury or
60 condition resulting from occupational activity immediately upon the onset of such injury or condition;
61 and subsequent treatment and rehabilitation of such injuries or conditions under the direction of the
62 patient's physician or under the direction of any doctor of medicine, osteopathy, chiropractic, podiatry, or
63 dentistry, while using heat, light, sound, cold, electricity, exercise or mechanical or other devices.

64 "Practice of behavior analysis" means the design, implementation, and evaluation of environmental
65 modifications, using behavioral stimuli and consequences, to produce socially significant improvement in
66 human behavior, including the use of direct observation, measurement, and functional analysis of the
67 relationship between environment and behavior.

68 "Practice of chiropractic" means the adjustment of the 24 movable vertebrae of the spinal column,
69 and assisting nature for the purpose of normalizing the transmission of nerve energy, but does not
70 include the use of surgery, obstetrics, osteopathy or the administration or prescribing of any drugs,
71 medicines, serums or vaccines. *The practice includes performing the physical examinations of applicants*
72 *for a commercial driver's license or commercial learner's permit pursuant to § 46.2-341.12.*

73 "Practice of genetic counseling" means (i) obtaining and evaluating individual and family medical
74 histories to assess the risk of genetic medical conditions and diseases in a patient, his offspring, and
75 other family members; (ii) discussing the features, history, diagnosis, environmental factors, and risk
76 management of genetic medical conditions and diseases; (iii) ordering genetic laboratory tests and other
77 diagnostic studies necessary for genetic assessment; (iv) integrating the results with personal and family
78 medical history to assess and communicate risk factors for genetic medical conditions and diseases; (v)
79 evaluating the patient's and family's responses to the medical condition or risk of recurrence and
80 providing client-centered counseling and anticipatory guidance; (vi) identifying and utilizing community
81 resources that provide medical, educational, financial, and psychosocial support and advocacy; and (vii)
82 providing written documentation of medical, genetic, and counseling information for families and health
83 care professionals.

84 "Practice of medicine or osteopathic medicine" means the prevention, diagnosis and treatment of
85 human physical or mental ailments, conditions, diseases, pain or infirmities by any means or method.

86 "Practice of occupational therapy" means the therapeutic use of occupations for habilitation and
87 rehabilitation to enhance physical health, mental health, and cognitive functioning and includes the
88 evaluation, analysis, assessment, and delivery of education and training in basic and instrumental
89 activities of daily living; the design, fabrication, and application of orthoses (splints); the design,
90 selection, and use of adaptive equipment and assistive technologies; therapeutic activities to enhance
91 functional performance; vocational evaluation and training; and consultation concerning the adaptation of
92 physical, sensory, and social environments.

93 "Practice of podiatry" means the prevention, diagnosis, treatment, and cure or alleviation of physical
94 conditions, diseases, pain, or infirmities of the human foot and ankle, including the medical, mechanical
95 and surgical treatment of the ailments of the human foot and ankle, but does not include amputation of
96 the foot proximal to the transmetatarsal level through the metatarsal shafts. Amputations proximal to the
97 metatarsal-phalangeal joints may only be performed in a hospital or ambulatory surgery facility
98 accredited by an organization listed in § 54.1-2939. The practice includes the diagnosis and treatment of
99 lower extremity ulcers; however, the treatment of severe lower extremity ulcers proximal to the foot and
100 ankle may only be performed by appropriately trained, credentialed podiatrists in an approved hospital
101 or ambulatory surgery center at which the podiatrist has privileges, as described in § 54.1-2939. The
102 Board of Medicine shall determine whether a specific type of treatment of the foot and ankle is within
103 the scope of practice of podiatry.

104 "Practice of radiologic technology" means the application of ionizing radiation to human beings for
105 diagnostic or therapeutic purposes.

106 "Practice of respiratory care" means the (i) administration of pharmacological, diagnostic, and
107 therapeutic agents related to respiratory care procedures necessary to implement a treatment, disease
108 prevention, pulmonary rehabilitative, or diagnostic regimen prescribed by a practitioner of medicine or
109 osteopathic medicine; (ii) transcription and implementation of the written or verbal orders of a
110 practitioner of medicine or osteopathic medicine pertaining to the practice of respiratory care; (iii)
111 observation and monitoring of signs and symptoms, general behavior, general physical response to
112 respiratory care treatment and diagnostic testing, including determination of whether such signs,
113 symptoms, reactions, behavior or general physical response exhibit abnormal characteristics; and (iv)
114 implementation of respiratory care procedures, based on observed abnormalities, or appropriate reporting,
115 referral, respiratory care protocols or changes in treatment pursuant to the written or verbal orders by a
116 licensed practitioner of medicine or osteopathic medicine or the initiation of emergency procedures,
117 pursuant to the Board's regulations or as otherwise authorized by law. The practice of respiratory care
118 may be performed in any clinic, hospital, skilled nursing facility, private dwelling or other place deemed
119 appropriate by the Board in accordance with the written or verbal order of a practitioner of medicine or
120 osteopathic medicine, and shall be performed under qualified medical direction.

2015 SESSION

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SENATE BILL NO. 1244

Senate Amendments in [] — February 9, 2015

A BILL to amend and reenact § 54.1-2900 of the Code of Virginia, relating to practice of chiropractic; scope; certain physical examinations.

Patrons Prior to Engrossment—Senator Newman; Delegate: Filler-Corn

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2900 of the Code of Virginia is amended and reenacted as follows:

§ 54.1-2900. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Acupuncturist" means individuals approved by the Board to practice acupuncture. This is limited to "licensed acupuncturist" which means an individual other than a doctor of medicine, osteopathy, chiropractic or podiatry who has successfully completed the requirements for licensure established by the Board (approved titles are limited to: Licensed Acupuncturist, Lic.Ac., and L.Ac.).

"Auricular acupuncture" means the subcutaneous insertion of sterile, disposable acupuncture needles in predetermined, bilateral locations in the outer ear when used exclusively and specifically in the context of a chemical dependency treatment program.

"Board" means the Board of Medicine.

"Genetic counselor" means a person licensed by the Board to engage in the practice of genetic counseling.

"Healing arts" means the arts and sciences dealing with the prevention, diagnosis, treatment and cure or alleviation of human physical or mental ailments, conditions, diseases, pain or infirmities.

"Medical malpractice judgment" means any final order of any court entering judgment against a licensee of the Board that arises out of any tort action or breach of contract action for personal injuries or wrongful death, based on health care or professional services rendered, or that should have been rendered, by a health care provider, to a patient.

"Medical malpractice settlement" means any written agreement and release entered into by or on behalf of a licensee of the Board in response to a written claim for money damages that arises out of any personal injuries or wrongful death, based on health care or professional services rendered, or that should have been rendered, by a health care provider, to a patient.

"Nurse practitioner" means an advanced practice registered nurse who is jointly licensed by the Boards of Medicine and Nursing pursuant to § 54.1-2957.

"Occupational therapy assistant" means an individual who has met the requirements of the Board for licensure and who works under the supervision of a licensed occupational therapist to assist in the practice of occupational therapy.

"Patient care team" means a multidisciplinary team of health care providers actively functioning as a unit with the management and leadership of one or more patient care team physicians for the purpose of providing and delivering health care to a patient or group of patients.

"Patient care team physician" means a physician who is actively licensed to practice medicine in the Commonwealth, who regularly practices medicine in the Commonwealth, and who provides management and leadership in the care of patients as part of a patient care team.

"Physician assistant" means an individual who has met the requirements of the Board for licensure and who works under the supervision of a licensed doctor of medicine, osteopathy, or podiatry.

"Practice of acupuncture" means the stimulation of certain points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain ailments or conditions of the body and includes the techniques of electroacupuncture, cupping and moxibustion. The practice of acupuncture does not include the use of physical therapy, chiropractic, or osteopathic manipulative techniques; the use or prescribing of any drugs, medications, serums or vaccines; or the procedure of auricular acupuncture as exempted in § 54.1-2901 when used in the context of a chemical dependency treatment program for patients eligible for federal, state or local public funds by an employee of the program who is trained and approved by the National Acupuncture Detoxification Association or an equivalent certifying body.

"Practice of athletic training" means the prevention, recognition, evaluation, and treatment of injuries or conditions related to athletic or recreational activity that requires physical skill and utilizes strength, power, endurance, speed, flexibility, range of motion or agility or a substantially similar injury or

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60 condition resulting from occupational activity immediately upon the onset of such injury or condition;
61 and subsequent treatment and rehabilitation of such injuries or conditions under the direction of the
62 patient's physician or under the direction of any doctor of medicine, osteopathy, chiropractic, podiatry, or
63 dentistry, while using heat, light, sound, cold, electricity, exercise or mechanical or other devices.

64 "Practice of behavior analysis" means the design, implementation, and evaluation of environmental
65 modifications, using behavioral stimuli and consequences, to produce socially significant improvement in
66 human behavior, including the use of direct observation, measurement, and functional analysis of the
67 relationship between environment and behavior.

68 "Practice of chiropractic" means the adjustment of the 24 movable vertebrae of the spinal column,
69 and assisting nature for the purpose of normalizing the transmission of nerve energy, but does not
70 include the use of surgery, obstetrics, osteopathy or the administration or prescribing of any drugs,
71 medicines, serums or vaccines. [*The practice includes performing the physical examinations of*
72 *applicants for a new commercial driver's license or commercial driver's instruction permit or a renewal*
73 *of such license or permit required pursuant to § 46.2-341.12. Upon meeting the requirements of*
74 *§ 390.103 of the Federal Motor Carrier Safety Regulations, the practice shall include performing the*
75 *physical examinations for a commercial driver's license or commercial learner's permit pursuant to*
76 *§ 46.2-341.12.]*

77 "Practice of genetic counseling" means (i) obtaining and evaluating individual and family medical
78 histories to assess the risk of genetic medical conditions and diseases in a patient, his offspring, and
79 other family members; (ii) discussing the features, history, diagnosis, environmental factors, and risk
80 management of genetic medical conditions and diseases; (iii) ordering genetic laboratory tests and other
81 diagnostic studies necessary for genetic assessment; (iv) integrating the results with personal and family
82 medical history to assess and communicate risk factors for genetic medical conditions and diseases; (v)
83 evaluating the patient's and family's responses to the medical condition or risk of recurrence and
84 providing client-centered counseling and anticipatory guidance; (vi) identifying and utilizing community
85 resources that provide medical, educational, financial, and psychosocial support and advocacy; and (vii)
86 providing written documentation of medical, genetic, and counseling information for families and health
87 care professionals.

88 "Practice of medicine or osteopathic medicine" means the prevention, diagnosis and treatment of
89 human physical or mental ailments, conditions, diseases, pain or infirmities by any means or method.

90 "Practice of occupational therapy" means the therapeutic use of occupations for habilitation and
91 rehabilitation to enhance physical health, mental health, and cognitive functioning and includes the
92 evaluation, analysis, assessment, and delivery of education and training in basic and instrumental
93 activities of daily living; the design, fabrication, and application of orthoses (splints); the design,
94 selection, and use of adaptive equipment and assistive technologies; therapeutic activities to enhance
95 functional performance; vocational evaluation and training; and consultation concerning the adaptation of
96 physical, sensory, and social environments.

97 "Practice of podiatry" means the prevention, diagnosis, treatment, and cure or alleviation of physical
98 conditions, diseases, pain, or infirmities of the human foot and ankle, including the medical, mechanical
99 and surgical treatment of the ailments of the human foot and ankle, but does not include amputation of
100 the foot proximal to the transmetatarsal level through the metatarsal shafts. Amputations proximal to the
101 metatarsal-phalangeal joints may only be performed in a hospital or ambulatory surgery facility
102 accredited by an organization listed in § 54.1-2939. The practice includes the diagnosis and treatment of
103 lower extremity ulcers; however, the treatment of severe lower extremity ulcers proximal to the foot and
104 ankle may only be performed by appropriately trained, credentialed podiatrists in an approved hospital
105 or ambulatory surgery center at which the podiatrist has privileges, as described in § 54.1-2939. The
106 Board of Medicine shall determine whether a specific type of treatment of the foot and ankle is within
107 the scope of practice of podiatry.

108 "Practice of radiologic technology" means the application of x-rays to human beings for diagnostic or
109 therapeutic purposes.

110 "Practice of respiratory care" means the (i) administration of pharmacological, diagnostic, and
111 therapeutic agents related to respiratory care procedures necessary to implement a treatment, disease
112 prevention, pulmonary rehabilitative, or diagnostic regimen prescribed by a practitioner of medicine or
113 osteopathic medicine; (ii) transcription and implementation of the written or verbal orders of a
114 practitioner of medicine or osteopathic medicine pertaining to the practice of respiratory care; (iii)
115 observation and monitoring of signs and symptoms, general behavior, general physical response to
116 respiratory care treatment and diagnostic testing, including determination of whether such signs,
117 symptoms, reactions, behavior or general physical response exhibit abnormal characteristics; and (iv)
118 implementation of respiratory care procedures, based on observed abnormalities, or appropriate reporting,
119 referral, respiratory care protocols or changes in treatment pursuant to the written or verbal orders by a
120 licensed practitioner of medicine or osteopathic medicine or the initiation of emergency procedures,
121 pursuant to the Board's regulations or as otherwise authorized by law. The practice of respiratory care

122 may be performed in any clinic, hospital, skilled nursing facility, private dwelling or other place deemed
123 appropriate by the Board in accordance with the written or verbal order of a practitioner of medicine or
124 osteopathic medicine, and shall be performed under qualified medical direction.

125 "Qualified medical direction" means, in the context of the practice of respiratory care, having readily
126 accessible to the respiratory care practitioner a licensed practitioner of medicine or osteopathic medicine
127 who has specialty training or experience in the management of acute and chronic respiratory disorders
128 and who is responsible for the quality, safety, and appropriateness of the respiratory services provided
129 by the respiratory care practitioner.

130 "Radiologic technologist" means an individual, other than a licensed doctor of medicine, osteopathy,
131 podiatry, or chiropractic, or a dentist licensed pursuant to Chapter 27 (§ 54.1-2700 et seq.), who (i)
132 performs, may be called upon to perform, or who is licensed to perform a comprehensive scope of
133 diagnostic radiologic procedures employing equipment which emits ionizing radiation and (ii) is
134 delegated or exercises responsibility for the operation of radiation-generating equipment, the shielding of
135 patient and staff from unnecessary radiation, the appropriate exposure of radiographs or other procedures
136 which contribute to any significant extent to the site or dosage of ionizing radiation to which a patient is
137 exposed.

138 "Radiologic technologist, limited" means an individual, other than a licensed radiologic technologist,
139 dental hygienist or person who is otherwise authorized by the Board of Dentistry under Chapter 27
140 (§ 54.1-2700 et seq.) and the regulations pursuant thereto, who performs diagnostic radiographic
141 procedures employing equipment which emits ionizing radiation which is limited to specific areas of the
142 human body.

143 "Radiologist assistant" means an individual who has met the requirements of the Board for licensure
144 as an advanced-level radiologic technologist and who, under the direct supervision of a licensed doctor
145 of medicine or osteopathy specializing in the field of radiology, is authorized to (i) assess and evaluate
146 the physiological and psychological responsiveness of patients undergoing radiologic procedures; (ii)
147 evaluate image quality, make initial observations, and communicate observations to the supervising
148 radiologist; (iii) administer contrast media or other medications prescribed by the supervising radiologist;
149 and (iv) perform, or assist the supervising radiologist to perform, any other procedure consistent with the
150 guidelines adopted by the American College of Radiology, the American Society of Radiologic
151 Technologists, and the American Registry of Radiologic Technologists.

152 "Respiratory care" means the practice of the allied health profession responsible for the direct and
153 indirect services, including inhalation therapy and respiratory therapy, in the treatment, management,
154 diagnostic testing, control and care of patients with deficiencies and abnormalities associated with the
155 cardiopulmonary system under qualified medical direction.

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