



Department of Health Professions

## Virginia Board of Health Professions Historic Overview

Board Retreat  
Perimeter Conference Center  
Henrico, VA  
May 5, 2016



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- What is the Board of Health Professions?
- What is its authority and duty?
- Who are its members and what is their role?
- What comprises its history, major policy reviews and other activities?
- How is its work accomplished?
- Where is the future work best focused?



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### What is the Board of Health Professions?

The Board of Health Professions is a largely advisory body within the Department of Health Professions authorized by the General Assembly with specific powers and duties listed 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*.



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### What is BHP's authority and duty?

Its statutory responsibilities are several. For ease of understanding, the following listing collapses similar duties.



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**What is BHP's authority and duty?**

**I. To evaluate, advise, and assist in promoting coordination and resolving conflicts**

More specifically, to evaluate the need for coordination among the health regulatory boards, to serve as a forum for resolving conflicts among health regulatory boards, to examine scope of practice conflicts among professions, and to advise the boards and General Assembly of the nature and degree of such conflicts.



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**What is BHP's authority and duty?**

**II. To study matters relating to the regulation or deregulation of health care professions,**

including whether or to what degree a particular profession should be regulated and to advise the Department Director, General Assembly, and Governor accordingly.



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**What is BHP's authority and duty?**

**III. To facilitate communication with the public**

To provide a means for citizen access to the Department, a means for publicizing the policies and programs of the Department, and to generally educate the public and elicit support for Department activities.



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**What is BHP's authority and duty?**

**IV. Review agency activities**

Have access to Departmental information so that it may monitor the policies and activities of the Department. And, as part of this, to periodically review the investigatory, disciplinary, and enforcement processes of the Department and the individual boards to ensure public protection and the fair and equitable treatment of health professionals.



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**What is BHP's authority and duty?**

**V. Practitioner Self-Referral Act (1994)**

To receive, review, and forward to the appropriate health regulatory board any investigative reports relating to complaints of *Practitioner Self-Referral Act* (PSR) violation, and

To determine compliance with, violations of, and grant exemptions to PSR and take appropriate action against entities, other than practitioners, for violations.



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**What is BHP's authority and duty?**

**VI. Other**

To promote the development of standards to evaluate the competency of the professions and occupations represented, and

To make bylaws for its own governance.



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**Bylaws**

Provide guidance by formally addressing:

- Powers and Duties of the Board
- Duties of its Officers
- Duties of the Executive Committee
- Elections and Terms
- Appointments
- Defining Quorums for Full Board and Committees
- Attendance Requirements
- Adoption of Parliamentary Authority
- Amendment



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**Regulations**

- Governing Standards for Dietitians and Nutritionists - §18 VAC 75-30-10 *et seq.* (1996)\*
- Governing Certification of Dialysis Technicians - §18 VAC 75-40-10 *et seq.* (2005)
- Governing Practitioner Self-Referral - §18VAC 75-20-10 *et seq.* (2007)



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**Guidance Documents**

- **75-2** Appropriate Criteria in Determining the Need for Regulation of Any Health Care Occupations or Professions, revised February 1998 – “The Criteria”
- **75-3** Mission and Vision of the Board, adopted April 1998 – Did not change in 2006’s Retreat
- **75-4** Bylaws adopted May 28, 2015



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**Who are BHP’s members?**

The Board is comprised of 18 members appointed by the Governor. Five are citizen members, and one member is selected by the Governor from each of DHP’s 13 health regulatory boards



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**and their primary roles?**

The chief role of the members from the health regulatory boards is to bring their subject-matter expertise and perspectives as health care providers to the Board to assist in conducting policy reviews. The five citizen members offer their unique perspectives to this effort as health care consumers and as informed members of the general public.



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**History**

The Board of Health Professions was created by the General Assembly in 1977 at the same time as the Department to provide a means for objective policy recommendations regarding issues related to the regulation of health professions and occupations.



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**History**

When the Board (originally Council on Health Regulatory Boards) was created, only seven health regulatory boards were in the Department: **Dentistry, Funeral Directors & Embalmers, Medicine, Nursing, Optometry, Pharmacy, and Veterinary Medicine.** Since 1977, six regulatory boards have been added, bringing the total to 13.



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**History**

During the 1980's, several were transferred from the Dept. of Professional and Occupational Regulation:

- **Counseling, Psychology, & Social Work** (1983)
- **Audiology & Speech-Language Pathology and Nursing Home Administrators\*** (1986).

In 2000, a separate **Physical Therapy** board was created.

\*In 2005, Home Administrators reorganized and renamed as Long-Term Care Administrators comprised of Nursing Home Administrators, Assisted Living Administrators and Citizen members.



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**Policy Reviews/Activities**

**1984-86** Respiratory Therapy, Occupational Therapy, Athletic Trainers (1984)

**1986-88** Definition of Nursing; Allied Health Professions; Dietitians and Nutritionists; X-Ray Technicians; and Hypnosis and Hypnotherapy, Athletic Trainers (1986)

**1988-90** Anabolic Steroids; Enforcement & Discipline; X-Ray Technicians; Practice of Acupuncture; Cytotechnologists and Cytotechnicians; and Athletic Trainers (1990).



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**Policy Reviews/Activities**

**1990-91** Nurse Practitioners – Barriers to Practice; Walk-in Medical Centers; Pharmaceutical Drug Diversion; Effects of the Use of Methylphenidate on ADHD Children; Medication Technicians (Nursing Homes); and Recreational Therapists

**1991-92** Practice of Nurse Midwives; Sunrise Review Policies and Procedures ("The Criteria"); Managed Care; HIV/HBV Continuing Education; and Sexual Assault Victims and Offenders



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**Policy Reviews/Activities**

**1993-1994** Physician Demographics; Reciprocity/Endorsement; Need for Board of Chiropractic; Marriage and Family Therapists; Tattooists and Tattoo Parlors; Certification of Sex Offender Treatment Providers; and Certification of Private Rehabilitation Providers

**1994-95** Dietitians and Nutritionists and Outpatient Cardiovascular Pulmonary Clinics



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**Policy Reviews/Activities**

**1995-96** Alternative/Complementary Medicine; Pharmacy Technicians; Massage Therapy; Art Therapy, Respiratory Therapy; Levels of Current Regulation

**1996-97** Compliance and Disciplinary Performance; Disclosure of Disciplinary Information; Counseling-related Professions; and Appropriate Criteria in Determining the Need for Regulation (pursuant to §54.1-2409.2)



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**Policy Reviews/Activities**

**1997-98** Sunrise Policies and Procedures (update to 1992)\* and Competition in the Funeral Industry in Virginia

**1998-99** Athletic Trainers (3 previous studies), Telehealth; and Criminal Background Checks. Also sponsored:

- *President's Roundtable Discussion on Major Issues Confronting the Health Regulatory Boards &*
- *Issues Forum and Roundtable Discussion on Managed Care*

\* Policies and Procedures for Evaluating the Need to Regulate Health Occupations and Professions



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**Policy Reviews/Activities**

**1999-2000** Clinical Laboratory Professions; Reporting of Infectious Disease Status of the Deceased; Speech-Language Pathology Assistants; Merit of an Independent Board of Physical Therapy; Merit of an Independent Board of Chiropractic; Enforcement & Disciplinary Activity Update; Evaluation of the Agency's Disciplinary Database in Support of Appropriate Resource Management Methods.



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**Policy Reviews/Activities**

**2000-2001** Clinical Laboratory Professions (cont'd);  
Certified Occupational Therapy Assistants;  
Enforcement & Disciplinary Activity Update (cont'd).  
Also sponsored an Issues Forum, entitled: *Role of Health Regulatory Boards in the Reduction of Medical Errors*

**2001-2002** Sanction Reference Points Project (SRP);  
Aided Dept. of Professional and Occupational Regulation in their studies of Electrologists, Estheticians, and Roller Skating Rinks; and Policy Review on Release of Complaint Intake Form Information to Respondent



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**Policy Reviews/Activities**

**2002 - present** SRP Project continued \*

**2003-2005** Assisted Living Administrator; Agency Performance Review; Priority System Review; Dialysis Patient Care Technician regulations and revised legislation;

**2005:** Naturopath; Telehealth Update; Dialysis Patient Care Technician legislation

\* By 2004, the first SRP system was instituted by the Board of Medicine. All 13 boards had their own SRPs by 2011, with periodic updates. Recognized for innovation by the Council of State Governments in 2006 and, in 2011, received CLEAR's Innovation Award for Regulatory Excellence.



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**SRP Peer Reviewed Publications**

Carter, E.A. & Kauder, N.B. (2016). Implementing a sanctioning reference system for the Virginia Board of Nursing. *Journal of Nursing Regulation*, 7(1), 21-26.

Carter, E., Kauder, N., & Ostrom, B. (2007, May). *Sanctioning reference: An empirically based approach for licensing board disciplinary decision-making*. Poster session presented at the annual meeting of the Association for Psychological Science, Washington, D.C.

Kauder, N. & Carter, E. (2004). An empirically-based structured sanctioning system. *Journal of Medical Licensure and Discipline*, 90(4), 8-17.



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**Policy Reviews/Activities**

**2006 - 2007** Issues Forum with Citizens Advocacy Center, *Accountability through Transparency*; Telehealth Update; and Ayurvedic Medicine

**2007 – 2008** Continuing Competency Assurance (AARP) and Criminal Background Checks

**2008 – current** "Emerging Professions" focus



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**“Emerging Professions” Reviews since 2008**

- Central Services/Sterile Processing Technicians
- Community Health Workers/“Grand Aides”
- Genetic Counselors
- Kinesiotherapists
- Medical Interpreters
- Medical Laboratory Scientists & Technicians
- Orthopedic Technologists
- Orthopedic Physicians Assistants
- Orthotists
- Perfusionists
- Polysomnographers
- Prosthetists
- Podiatrists
- ✓ Surgical Assistants
- ✓ Surgical Technologists

• Recommended against regulation  
✓ Recommended in favor of regulation



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**“Other” Policy Reviews/Activities**

**2010** Medication Aides Practice in Nursing Homes;  
Review of the Need for an Allied Health Board--results referred to the Board of Medicine)

**2010 – 2015** Scope of Practice Barriers  
(Secretary’s request relating to health reform)

- Nurse Practitioners
- Pharmacy Technicians
- Dental Hygienists/Dental Assistants

NOTE: In 2008, DHP Healthcare Workforce Data Center was launched, with BHP shared staffing since 2010.



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**“Other” Policy Reviews/Activities**

**2012** Military Credentialing Review

**2013-2015** National Governors’ Association Veterans’ Licensure and Certification Demonstration Policy Academy and ongoing assistance

**2015** Board of Funeral Directors and Embalmers Multiple Licensure Review

**2016** Current request: Competency of Chiropractors to Perform CDL Physical Examinations



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**Practitioner Self-Referral**

- Virginia’s *Practitioner Self-Referral Act (PSR)* is designed to ensure that the business relationship between a practitioner and referral entity is easily discerned by the patient.
- Exceptions – none approved, to date.
- Advisory Opinion Requests, list follows.



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**Practitioner Self-Referral**

- Advisory Opinion Regarding Excimer Laser Center, L.L.C. (1996)
- Advisory Opinion Regarding Medserve, Inc. (1996)
- Advisory Opinion Regarding Eye Doctors of Richmond, L.L.C. (1997)
- Advisory Opinion Regarding Virginia Fertility Center, L.L.C. (1997)
- Advisory Opinion Regarding Vistar Eye Center, Inc. (2000)
- Advisory Opinion Regarding InVision Healthcare, Inc. (2004)
- Advisory Opinion Regarding Vascular Access, Ltd. (2005)
- Advisory Opinion Regarding Tuckahoe MRI, L.L.C. (2006)
- Advisory Opinion Regarding Joint Application of Winchester Neurological Consultants, Inc. and Winchester Orthopaedic Associates, Ltd. and Medical Circle, L.L.C. (2008)
- Advisory Opinion Regarding The Therapy Network L.C. (TTN) (2011)
- Advisory Opinion Regarding Tidewater Kidney Specialists, Inc. (2012)
- Advisory Opinion Regarding Center For Weight Loss Success (2014)
- Advisory Opinion Regarding Alliance Xpress Care, L.L.C. (2015)



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**How is BHP's work accomplished?**

- Board Members (largely through Committees)
- Executive Director, Deputy Executive Director, Operations Manager, and Research
- Contractors and Graduate Research Assistants and Summer Interns
- Multiple DHP Units: *Director's Office, Administration, Administrative Proceedings, the Boards, Enforcement, Health Practitioner Monitoring Program, Health Workforce Data Center, and Prescription Monitoring Program*



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**How is BHP's work accomplished?**

Standing Committees:

- Executive
- Regulatory Research
- Education
- Enforcement
- Nominating
- Practitioner Self-Referral matters handled through ad hoc committee
- Other ad hoc committees have been formed at the direction of the respective standing committee (Example: Committee to Evaluate the Merit of a Board of Physical Therapy)



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**BHP's Workplan**

The BHP Workplan communicates overall goals and direction and is broken down by Committee. It is prepared annually and revised according to the Board's changing needs. Also, any member of the Board may ask for amendments to include new projects. Requests for projects from the Governor, Director, the General Assembly, and the public are included.



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**Executive Committee's Mission**

- Review matters of interest
- Evaluate the need for coordination among boards
- Monitor policies and activities of the Department
- Serve as a forum for resolving conflicts between boards and the Department
- Review and comment on the budget

NOTE: Members consist of the Officers (includes committee officers). The Chair of the Executive Committee is the Chair of the Board.



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**Regulatory Research Mission**

- Evaluate the need and required degree for regulation of health care professions
- Examine scope of practice conflicts
- Advise the boards and the General Assembly concerning the nature and extent of such conflicts



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**Education Committee's Mission**

- Provide a means for citizen access to the Department
- Provide a means of publicizing the policies and programs of the Department to educate the public and elicit public support
- Promote the development of standards to evaluate the competencies of professions represented on the Board.



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**Enforcement Committee's Mission**

- Review periodically the investigatory, disciplinary, and enforcement processes of the Department and boards
- Ensure the protection of the public and the fair and equitable treatment of health professions.

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**Nominating Committee's Mission**

- To develop a slate of officers for annual elections at the Board's fall meeting.

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**Questions**



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**Future Directions**



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- Requests from the Governor, Secretary, Director, General Assembly, Board Members, the Public will vary considerably from year to year
- Trending topics for Board focus:
  - Telehealth, new care delivery modes and models
  - Health care workforce issues and implications for access to care, concern over professional licensure's barrier to employment and practice, for veterans and general public

**Announcement**  
**Board of Health Professions Issues Forum**  
**November 13, 1998**  
**9:00am to Noon**  
**Richmond Marriott**

The Board of Health Professions will host an Issues Forum on professional regulation in a changing health care climate. The forum will feature a presentation by Dr. Robert E. Hurley Associate Professor, at the Medical College of Virginia's Department of Health Administration.

Emerging systems and methods of payment have changed the relationship between individual health care providers and their patients or clients. For example, no longer is care a matter settled between a practitioner and a patient but is influenced by a variety of non-medical, contractual and financial determinants which could restrict practice and access for consumers. Nevertheless, patients, government policy makers, providers, and health care institutions expect professional licensing boards to hold providers accountable for the quality for health care services.

How can health regulatory boards determine initial and continued competency of practitioners and hold them accountable for their actions in a system which divides the delivery of health care and masks the responsibility for such care? To whom does the patient turn with his individual problem and who is ultimately accountable for the care needed?

The Board of Health Professions, a seventeen-member body appointed by the Governor and comprised of practitioners and consumers, will host the forum entitled "Professional Regulation in a Changed Health Care System" to address such issues. It is scheduled for November 13, 1998 from 9:00 a.m. to noon at the Richmond Marriott.

Individuals invited to participate in the forum will include policy makers in the executive branch, members of the General Assembly, administrators of hospitals and health care organizations, practitioners, consumers of health care services, medical directors of managed care plans, state officials responsible for the regulation of health care delivery and members of Virginia health regulatory boards. Following a presentation by Dr. Hurley, the participants will divide into discussion groups to consider issues related to the theme of the forum and will report their findings and recommendations to the body.

For additional information, interested parties may call Bob Nebiker at (804) 662-9966 or Elaine Yeatts at (804) 662-9918 at the Department of Health Professions.

## Past Board of Health Professions Issues Forums

**Date:** November 13, 1998

**Topic:** Professional Regulation in a Changing Health Care Climate

**Speaker:** Dr. Robert E. Hurley, professor at MCV, Department of Health Administration, author of "*Approaching the Slippery Slope: Managed Care as Industrial Rationalization of Medical Practice*"

**Date:** November 9, 1999

**Topic:** Utilization of Unlicensed Personnel in Healthcare

**Speaker:** Panel – Dr. Lissa Power-DeFur (Dept. of Education); Mary Ann Bergeron (Va. Assn. of Community Service Boards); B. J. Bartleson (VP for Nursing, Winchester Medical Center); Scott Burnette (CEO, Community Memorial Hospital) – moderated by Senator Jane Woods

**Date:** November 15, 2000

**Topic:** Role of Health Regulatory Boards in Reduction of Medical Errors – responding to the IOM Report

**Speaker:** Panel – Dr. Lois Kercher (VP & Nurse Exec. at Va. Beach General); Dr. Richard Hamrick (President of Richmond Academy of Medicine; co-chair of Statewide Coalition of Virginias Improving Patient Care and Safety); Dr. Craig Kirkwood (Manager of Pharmacy Services at MCV); and Mr. Robert Nebiker (DHP) – moderated by Senator Bill Bolling

## Group questions for Issues Forum

November 13, 1998

### Group 1:

- How do we allow competent individuals to deliver care where they are now restricted by rigid scopes of practice?
- How can professional regulation aimed at individuals be reconciled with the increasing likelihood that most professional work will be rendered in the context of complex organizations which often foster team approaches?

### Group 2:

- What will be the role of professional regulatory bodies in the oversight of new product-like developments such as disease management programs?
- If professional boundaries and self-interest can be an impediment to innovations in care delivery and management, how can they be minimized?

### Group 3:

- How will economic pressures to substitute less costly personnel to perform clinical work be reconciled with current scope and domain of practice laws?
- What information should regulatory bodies make available about providers to consumers, employers, insurers and organizations with which they participate?

### Group 4:

- Can professional regulatory bodies be asked to mediate and arbitrate growing disputes between professions over control over new technologies and likely efforts to expand scopes of practice to deal with declining revenue; if so, how?
- What are the limits of the consumer-driven health care systems, e.g. is "caveat emptor" reasonable and responsible in a world where care comes packaged by organizations?

### Group 5:

- How are patient/consumer interests to be protected by professional licensure bodies when more responsibility for care delivery and management shifts to organizations and away from individual practitioners?
- How can consumers be educated in order to maintain control of their health and make choices for health care?

## **Questions for Small Group Discussions**

### **Board of Health Professions Issues Forum – November 13, 1998**

#### **How do we allow competent individuals to deliver care where they are now restricted by rigid scopes of practice?**

- Question of how we define competency. Do those who want to expand boundaries have the competence to do so? Setting minimal competency becomes more important with the increase of practitioners moving into new areas of practice.
- There are multiple measurements for competency – whose is correct? Managed care organizations setting their own guidelines for competency; sometimes those standards are more rigid than those of the licensing boards.
- There could be a problem if the choice is for the least expensive provider versus the most competent provider.
- Question of how rigid are the scopes of practice. There are overlapping scopes, but the rigidity often occurs when parties with a vested interest interpret the practice rigidly.
- Need for definition of scope of practice, but again who makes that determination and doesn't that evolve over time?
- The Board of Health Professions can play an important role in sorting out competencies and scopes of practice in order to make health care affordable and available without sacrificing the protection of the public health, safety and welfare. Does it have, or should it have the necessary authority?

#### **How can professional regulation aimed at individuals be reconciled with the increasing likelihood that most professional work will be rendered in the context of complex organizations which often foster team approaches?**

- Question of accountability when practice occurs as a team. Where does the patient turn for accountability or redress?
- It is the individual who provides discreet care; there must be oversight of the individuals in a system.
- There are gaps in how we regulate the entities where the practice occurs. Increasingly, practice occurs in that atmosphere. For example, services of a hospital may be provided by contract employees or physicians may call-forward their patients to triage by nurses who work out-of-state.
- Boundaries between governmental agencies are sometimes fuzzy; i.e. between Department of Health and Department of Health Professions; there is a need for greater collaboration.
- How do we regulate those who control the apportionment of health care? To whom are they accountable? May be a need to change the statutes to address that liability.
- May also need to examine a change in the Department of Health Professions boundaries to address these evolving practices and problems.

#### **What will be the role of professional regulatory bodies in the oversight of new product-like developments such as disease management programs?**

- Challenge is in the changing scopes of practice; regulatory system set up to support old division of labor rather than on competencies, regulatory role should be to establish criteria that establishes standards to be met in order to carry out a scope of practice.

- Streams of reimbursement & traditional scopes of practice are impediment to change; not necessarily directed to the right scope of practice by the right provider at the right place.
- Need to look at continuum of care and multi-functioning; the problem is how to achieve a balance among quality, access and accountability. With multi-functioning and expanding scopes of practice, who determines quality and competency?
- Need:
  - New models of collaborative practice
  - Pilot programs for disease management teams or to explore expanding/changing scopes of practice
  - All parties at the table with the best interest of the patient

**If professional boundaries and self-interest can be an impediment to innovations in care delivery and management, how can they be minimized?**

- Current professional training and credentialing and the regulatory system is set up to support traditional roles.
- Need to address attitudes toward alternative therapies and work to ensure access through the necessary referrals and insurance for such therapies. More outcomes research is needed.
- Problem is to deliver the highest level of care with the least cost; a team of health care providers working together to provide a continuum of care may be best solution.
- Problem with outcome-based research is that the current system of credentialing is cumbersome and sometimes inaccurate. It can deter providers from caring for high-risk patients because the outcome numbers would be detrimental.
- Demand for access to innovative treatments and newer technology/pharmacology will increase as consumers become more aggressive in their own research and more knowledgeable about options. Consumers are often not in a trusting relationship with their provider.
- Boundaries and self-interest can be partially mitigated by more collaborative training with a team approach to disease management.
- Pilot programs and clinical trials can minimize the boundaries by providing data on competencies and outcomes for treatment by non-traditional providers or by a collaborative team of providers.

**How will economic pressures to substitute less costly personnel to perform clinical work be reconciled with current scope and domain of practice laws?**

- The use of less costly personnel to provide care does not necessarily protect the patient, which is the mandate of health regulatory boards. As various factions fight for a piece of the same pie, the boards are caught in the dilemma of competing interests. The determination of appropriate is often based on political or economic rather than on sound outcomes data or measurements of competency.
- As professional practices increasingly overlap, there needs to be a process or a mechanism to determine appropriate scopes of practice in a more scientific, less politicized environment.
- Economic pressures have increased the use of unlicensed personnel, over whom there is no disciplinary authority and for whom there is no credentialing by regulatory boards.
- To address the practice of unlicensed persons, the Board of Nursing has adopted regulations on the delegation of tasks by a registered nurse in which the nurse has a responsibility for which acts may be delegated and for the competency of any unlicensed person to whom an act is delegated.
- Where there is institutional licensing, the institution has some responsibility for the actions of unlicensed persons. Some state agencies that license institutions have rules for who can do what tasks; those rules don't always concur with the rules of the Department of Health Professions which licenses and regulates the individuals.

**What information should regulatory bodies make available about providers to consumers, employers, insurers, and organizations with which they participate?**

- Any information that is disclosed must be accurate, current and consistent.
- Question of consumers right to know compared with practitioners right to privacy. Question of whether the consumer should be given information such as unfounded complaints, education, specialties, malpractice claims and awards.
- Public needs confidence in the process and in the outcome of the process. Need to have any disciplinary complaint handled in a timely manner.
- Providers also need information on patients, may want to know how many providers a patient has sued before deciding to provide care to that patient.
- Patients need to have access to information on licensure qualifications and any disciplinary actions. The amount of disciplinary information to be released needs more study.

**Can professional regulatory bodies be asked to mediate and arbitrate growing disputes between professions over control of new technologies and likely efforts to expand scopes of practice to deal with declining revenue; if so, how?**

- Role of the health regulatory boards must be to protect the health and safety of the public and to establish those skills and credentials necessary to engage in practice.
- Boards should try to be a neutral body that does not have a vested interest in “turf battles” and does not become involved in a political process.
- Regulatory boards should serve as dispassionate body with the knowledge, expertise, and technical background to judge whether a change is in the best interest of the public. If expertise is not available within the board, it should draw on contacts with academic institutions or others not involved in a potential dispute.
- Ideally, economics should be removed from issues of quality of care and competency.
- More communication is needed among all interested parties and among the boards and their licensees. Narrow representation on boards may not result in an understanding of issues and expertise in other health professions.
- Boards tend to be reactive rather than proactive.
- Would need additional statutory authority to mediate scope of practice disputes.

**What are the limits of the consumer-driven health care systems, e.g. is “caveat emptor” reasonable and responsible in a world where care comes packaged by organizations?**

- “Buyer beware” places the consumer at a disadvantage because the consumer never has the level of knowledge and expertise as the provider, who has a responsibility for providing the safe and effective care.
- Consumer must be a participant in his health care and also have some accountability for his choices.
- Patient should be better informed about treatment options and about the avenues available for appealing HMO decisions.

**How are patient/consumer interests to be protected by professional licensure bodies when more responsibility for care delivery and management shifts to organizations and away from individual practitioners?**

- Who is the “consumer?” was addressed first. It was deemed to be the patient.
- There is a clear demand for improvements in the efficiency of the databases used by the respective health regulatory boards which should be partially addressed by a new computer system for DHP (AHLADIN) and for physicians, by the provisions of SB 660, which requires the Board of Medicine to establish a profile of information which is then available to consumers. Appropriate and up-to-date disciplinary and credentialing data should be readily available to all health care decision-makers, including managed care planners and consumers. These data should be tied to identifiers other than license number and should model after Massachusetts. There is marked frustration by insurers over the length of time taken to adjudicate substandard care cases.
- Related to the first response, information needs to be flowing in both directions. Specifically, when managed care plans are aware of substandard care and other disciplinary issues, they should be reporting their findings to the respective health regulatory boards.
- Regarding accountability of managed care employees, SB 712 and NCQA standards are a first step. It was also noted that there needs to be some way to have jurisdiction over companies outside of the state doing business in Virginia.
- Along the lines of the above, it was noted that there needs to be a place for the patient, practitioner, or managed care employee to come for guidance on standard of care issues – perhaps the Board of Health Professions or some other agency’s role could be expanded to accommodate this need.

**How can consumers be educated in order to maintain control of their health and make choices for health care?**

- It was noted that the majority of consumers have an extensive variety of sources of information, particularly the Internet. However, there is an appetite to know more about the boards’ licensure and disciplinary functions. There should be better dissemination of information about the boards’ efforts, being careful to balance the public’s right to know with the licensee’s right to due process.
- There is concern that the functionally illiterate and those who are uninsured do not have information readily available which may be fundamentally important for their health care decisions. There should be every effort made to include consumers and consumer groups in future forums and to find ways to reach the “disenfranchised” consumers.