

**JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION
OF THE VIRGINIA GENERAL ASSEMBLY**

**INTERIM REPORT:
Review of the Health
Regulatory Boards**

House Document No. 31

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Philip A. Leone

Preface

House Joint Resolution 139 and the Appropriation Act, approved by the 1998 General Assembly, directed the Joint Legislative Audit and Review Commission (JLARC) to study the effectiveness of Virginia's health regulatory boards and the Department of Health Professions (DHP). DHP, and the 12 health regulatory boards for which the department provides staff support, have the responsibility for ensuring the safe and competent delivery of health care services through the regulation of health professions.

This review is being conducted in two phases. The first phase includes an assessment of the licensing and rule-making functions of the boards, the composition and structure of the boards, the financial responsibilities of the boards and DHP, and the role of the Board of Health Professions. The second phase of the review, which will be completed in 1999, will focus on the disciplinary system used by the boards and department.

This study found that the composition of the health regulatory boards is generally appropriate, and the boards and DHP appear to perform their licensure function effectively. However, the role of citizen members needs to be enhanced in some instances, and their eligibility requirements need to be clarified. Further, the boards need the authority to conduct criminal background checks. In addition, current law may unreasonably restrict out-of-state dentists from gaining licensure in Virginia.

The report identifies several concerns regarding funding and staffing. Some boards have accumulated large surpluses over the last eight years but have failed to adjust fees to reduce these surpluses, which appears to violate the *Code of Virginia*. In addition, the Certified Nurse Aid program has a growing deficit, and efforts to eliminate the deficit have been unsuccessful. The review also found that due to DHP's difficulty in obtaining approval to hire additional full-time staff, the department is employing part-time workers in a manner that appears to be inconsistent with State personnel policy. The report contains recommendations to address these concerns.

The study also found that the work of the health regulatory boards is slowed by a lengthy rule-making process that frustrates board members and DHP staff. In addition, the Board of Health Professions does not appear to be effectively fulfilling its role as defined by the *Code of Virginia*. The report recommends a review of the rule-making process. Recommendations are also provided to improve the effectiveness of the Board of Health Professions in meeting its statutory responsibilities.

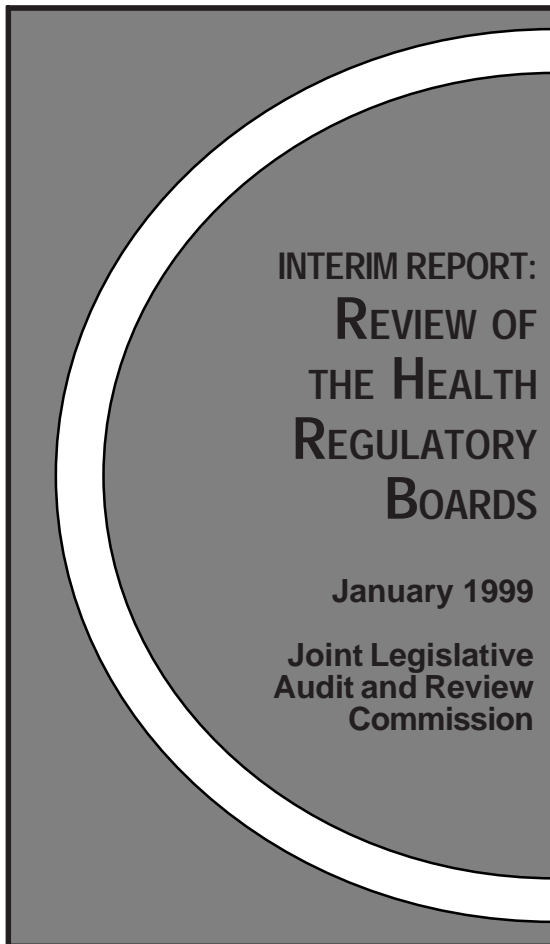
On behalf of the Commission staff, I would like to express our appreciation for the cooperation and assistance provided during the first phase of this review by the health regulatory boards and the Department of Health Professions.



Philip A. Leone
Director

January 12, 1999

JLARC Report Summary



HJR 139 and the Appropriation Act, approved by the 1998 General Assembly, direct JLARC to study the effectiveness of Virginia's health regulatory boards and the Department of Health Professions (DHP). DHP, and the 12 health regulatory boards for which the department provides staff support, have responsibility for ensuring the safe and competent delivery of health care services through the regulation of the health professions.

JLARC staff are conducting this review of DHP and the health regulatory boards in two phases. The first phase review includes a review of the licensure and rule-making functions of the boards. This report also

includes a review of the composition and structure of the boards, the financial responsibilities of the boards and DHP, and the role of the Board of Health Professions (BHP). The second phase review will focus on the disciplinary system used by the boards and department to address cases in which health care practitioners have been alleged to have violated standards of conduct or practice. The second phase report will be completed in 1999.

Based on this first phase of the review, it appears that the composition of the health regulatory boards is generally appropriate, and the boards and DHP appear to perform their licensure function effectively. However, there are some problems that need to be addressed, including the management of board finances, the minimal role currently played by the Board of Health Professions, and the use of some part-time (P-14) employees in a manner that appears inappropriate. The primary findings of the report include:

- The composition of the health regulatory boards appears to be appropriate in most instances, but the role of citizen members should be enhanced in some instances, and their eligibility requirements need to be clarified.
- The licensure process used by the health regulatory boards appears to work relatively well, but the boards need the authority to conduct criminal background checks. Also, current law may unreasonably restrict out-of-state dentists from gaining licensure in Virginia.
- The work of the health regulatory boards is slowed by a lengthy rule-

making process which frustrates board members and DHP staff.

- Most boards are not complying with the statutory requirement that they adjust fees so that their revenues and expenditures match within ten percent.
- The Certified Nurse Aide Program has a growing deficit, and efforts to eliminate the deficit have been unsuccessful.
- Due to the department's difficulty in obtaining approval to hire additional full-time staff, DHP is employing part-time workers (P-14s) in a manner that appears inconsistent with State personnel policy.
- The Board of Health Professions does not appear to be effectively fulfilling its role as defined by the *Code of Virginia*.

Role of Citizen Members Should Be Enhanced and Eligibility Requirements Should Be Better Defined

While the composition of the health regulatory boards appears to generally be appropriate, the number of citizens on some boards may need to be increased, and the role of citizens needs to be strengthened. One of the boards has no citizen members, and several boards have minimal citizen representation. Further, some of the boards, including the Board of Medicine, do not provide for citizen member participation in all of the activities of the board. In addition, the definition of citizen member in the *Code of Virginia* may need to be revised to ensure that individuals who can represent the public interest are appointed as citizen members. A "citizen" member of one of the boards was employed for many years by the association for the health professionals regulated by the board. Such a practice seems to circumvent

the intent of the statute. Recommendations to improve citizen participation include: requiring the appointment of a citizen member to the Board of Medicine's executive committee, increasing citizen membership and participation on some boards, and clarifying the definition of "citizen member."

Licensure Process Appears to Generally Work Well, But Improvements Are Needed

The licensure process, which is used to ensure the initial minimum competence of prospective licensees, appears to generally work well. However, the boards do not currently have the ability to fully check the backgrounds of applicants when information brought to the attention of the boards raises concerns about their ability to competently practice. The boards need to have access to the national criminal records maintained by the National Crime Information Center. In addition, the licensure process in Virginia for dentists appears to unreasonably restrict practitioners in other states from gaining licensure in Virginia. Recommendations in the report to address these concerns include: providing the Department of Health Professions with access to national criminal records and requiring the Board of Dentistry to establish a licensure by endorsement process.

Process for Promulgating Regulations Is Slow

One of the primary responsibilities of the health regulatory boards is to develop the regulations necessary to govern the practice of health professions in the State. At least in the experience of the health regulatory boards, the regulatory process has slowed significantly in recent years with the additional steps and approvals added by governors' executive orders. Since 1994, the average time to promulgate a regulation of the health regulatory boards has been 22 months. This average time is substantially longer than the average time it took the health

regulatory boards to promulgate regulations prior to the establishment of these additional procedures. This slowdown in the regulatory development process has resulted in considerable frustration on the part of many health regulatory board members as well as DHP staff.

In Virginia, an Administrative Law Advisory Committee, created by the General Assembly to examine administrative process issues on an on-going basis, is currently reviewing the length of time that is spent on the rule-making process across various agencies of State government. There is a need to determine if the time frames and the concerns that were found during this review pertaining to the health regulatory boards are unique, or if those time frames and concerns are typical of the experience of other agencies as well. Recommendations in the report provide that if the health regulatory boards' regulations proceed more slowly through the review process than is typical of other regulations, then the Secretary of Health and Human Resources should consider how the executive review process for these regulations might be expedited. If the time frames for executive review that are encountered for health regulatory board regulations are typical, then it appears that there is a critical need to reassess the executive branch review process.

Most Boards Fail to Meet Statutory Budgeting Requirement

The *Code of Virginia* requires each of the 12 health regulatory boards to generate the revenue necessary to carry out their functions. The boards generate the revenue for their operations through the assessment of licensure and renewal fees. JLARC staff's review of DHP and health regulatory boards' financial data indicates that some boards have accumulated large surpluses over the last eight years, while other boards have accumulated large deficits. For example, at the end of each of the last four biennia, the Board

of Medicine has maintained a surplus of 33 percent or more, with balances at the end of each of the biennia between \$1.73 and \$2.25 million.

The failure of the boards to adjust fees to reduce these surpluses and deficits appears to violate the *Code of Virginia*, which requires that fees be adjusted at the end of each biennium so that revenues match expenditures within ten percent. In addition to the boards' failure to appropriately adjust fees, inaccurate projections of fees and revenues and an inefficient process for increasing fees may have increased the size and duration of the surpluses and deficits experienced by many of the health regulatory boards. Recommendations to address this issue include: directing the health regulatory boards to comply with the ten percent requirement in statute, establishing a process to improve accountability for deviations from the ten percent requirement, improving the accuracy of revenue and expenditure projections, and establishing a more efficient process for increasing fees.

Certified Nurse Aide Program Has A Growing Deficit

The Certified Nurse Aide program, which regulates certified nurse aides (CNAs), has accumulated a deficit of more than \$300,000 during the past three years. The CNA program is federally mandated and initially relied on federal funds to cover most expenses. However, the federal government has significantly reduced its funding for the program in recent years. DHP and the Board of Nursing have tried unsuccessfully to eliminate the program's deficit, and currently have to borrow funds from other health regulatory boards to fund it. The lack of an alternative plan to address this problem at DHP raises a fund integrity concern that funds gained through fees paid by health professionals are being used on more than a temporary basis to address the cost of regulating individuals that are outside of their profession. The

Secretary of Health and Human Resources, in consultation with DHP and the Department of Planning and Budget, needs to develop a plan to meet these costs to be presented at the 1999 General Assembly session.

DHP's Use of P-14 Staff Does Not Appear to Meet State Rules and Is Inefficient

DHP appears to generally have sufficient staff to perform its non-disciplinary functions effectively, but it may be using P-14 staff inappropriately in some instances to fill staffing needs for which it cannot obtain approval to hire full-time staff. In some instances, P-14 employees are being used to perform duties which are critical to the operation of DHP and the boards and which are full-time in nature. The use of P-14 employees in these positions appears to be contrary to State personnel policy, and may not be the most efficient and effective way of meeting DHP's staffing needs. The Secretary of Health and Human Resources, with the assistance of the Department of Health Professions, needs to evaluate each P-14 position for the purpose of determining whether it should be converted into a full-time position and present its findings at the 1999 General Assembly session.

Board of Health Professions Does Not Effectively Fulfill Its Role

The Board of Health Professions (BHP) was created to serve as an advisory and policy board to: help coordinate the work of the regulatory boards; provide some oversight of the Department of Health Professions and the regulatory process; and advise the governor, the General Assembly, and DHP director on matters related to the regulation of health professionals. However, in recent years the Board has not been effective in performing its statutory responsibilities. The Board's effectiveness has been limited by, among other things, its lack of authority, limited staff support, weak communication, and some inexperienced and uncommitted members. The current Board has begun to take some steps to address its shortcomings, but additional action is needed for the Board to fulfill its statutory responsibilities. These actions include: taking a much stronger role in the resolution of scope of practice disputes, conducting periodic reviews of the health regulatory boards' regulations, taking a more active role in advising the General Assembly, and communicating more effectively with the health regulatory boards. In addition, the Board of Health Professions needs a full-time executive director, and the process for selection of members to the Board needs to be modified.

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I. Introduction

The Department of Health Professions (DHP) and Virginia's 12 health regulatory boards, along with the Board of Health Professions (BHP), have the responsibility for ensuring the safe and competent delivery of health care services through the regulation of the health professions. DHP provides coordination and staff support for the health regulatory boards and BHP.

House Joint Resolution 139 and Item 16H of the Appropriation Act, approved by the 1998 General Assembly, direct the Joint Legislative Audit and Review Commission to study the effectiveness of Virginia's health regulatory boards and DHP. HJR 139 specifically directs staff to evaluate:

- the appropriateness of the composition of each board,
- the appropriateness of the boards' role in ensuring the qualifications of health care professionals in Virginia, and
- the board's authority and involvement in establishing standards for high quality health care delivery by health care professionals.

In addition, the Appropriation Act directs that the JLARC review must include the following:

- a follow-up to JLARC's 1982 and 1983 study recommendations related to the health regulatory boards;
- an assessment of the working and organizational relationships between the boards, the department staff, and the Board of Health Professions in the licensing and regulation of the health professions;
- an examination of the efficacy, fairness and propriety with which the various statutes, duties, functions, and activities involved in the licensing and regulation of health professions are being performed and discharged; and
- an assessment of the adequacy of the department's staffing and automated systems to meet its current and future operations needs.

A copy of HJR 139 as well as the relevant Appropriation Act language are attached as Appendixes A and B.

This is the first of two reports that are planned in order to meet the study mandate. This interim report primarily addresses issues related to the boards' composition, licensing and rule-making functions as well as budgeting and staffing issues. Also, the role of the Board of Health Professions is reviewed. The final report, which will be completed in 1999, will focus on issues related to the boards' disciplinary function.

HEALTH REGULATORY BOARDS

Virginia's 12 health regulatory boards are responsible for licensing and disciplining health practitioners, and promulgating the regulations that govern regulated health professionals. Some boards also have additional responsibilities. For instance, the Board of Nursing accredits nursing schools. The Department of Health Professions' employees support the boards in their activities, but the members of these boards have the ultimate decision-making authority.

Currently, the 12 boards regulate nearly 240,000 health professionals, facilities, and other entities (see Table 1, bottom of next page). The number of professionals regulated by these boards has increased by about 62 percent in the last ten years. The boards also adjudicate approximately 2,000 disciplinary cases a year and promulgate dozens of regulations. A brief description of each of these boards and the professionals they regulate is provided in Appendix C.

Board Composition

All board members are appointed by the Governor and most are health professionals licensed by the boards for which they are members. In addition, most boards have one to three citizen members. The Board of Nursing Home Administrators is the only health regulatory board that is not required to include a citizen representative. The number of members on each board ranges from six on the Board of Optometry to 17 on the Board of Medicine. Board members serve four year terms and cannot serve more than two successive full terms.

Licensure, Certification, and Registration Authority

Each of the 12 health regulatory boards is responsible for determining which applicants meet the necessary requirements for licensure, certification, and registration. However, this function is conducted primarily by DHP staff and contractors such as testing services retained by DHP.

Licensure or certification typically requires the completion of a board-approved professional education program and the passage of an approved exam in the professional field for which the applicant wants to be licensed or certified. In order to be registered for a profession, an applicant must only provide the appropriate board with his or her name and place of business.

In addition to differences in the requirements for licensure, certification, and registration, there are also different levels of restriction placed on those practicing a profession in each category. In order to practice a licensed profession, one must hold a

license. However, individuals may practice a certified profession without receiving certification, but they may not represent themselves to be certified. Practitioners of a registered profession are only required to register with the appropriate board.

Table 1

**Number of Licensees, Certified Professionals,
and Registrants Regulated by Each
Health Regulatory Board in 1988 and 1998**

Board	Number Regulated in 1988	Number Regulated in 1998
Board of Audiology and Speech-Language Pathology	**	2,226
Board of Dentistry	6,815	8,297
Board of Funeral Directors and Embalmers	2,159	2,405
Board of Medicine	25,261	44,390
Board of Nursing	79,843	149,184
Board of Nursing Home Administrators	**	910
Board of Optometry	997	1,386
Board of Pharmacy	24,285	11,135*
Board of Licensed Professional Counselors, Marriage and Family Therapists, and Substance Abuse Professionals	1,768	6,304
Board of Psychology	476	1,914
Board of Social Work	1,722	3,915
Board of Veterinary Medicine	2,789	4,150
Total	146,115	236,216

*The number regulated by the Board of Pharmacy has decreased because the Board no longer registers approximately 21,000 health care practitioners who prescribe controlled substances.
The federal government does register these individuals.

**These boards were not under the purview of DHP in 1988.

Source: Department of Health Professions 1988 and 1998 Biennial Reports.

Disciplinary Authority

Members of the health regulatory boards adjudicate all of the disciplinary cases brought before the boards. DHP staff investigate and prosecute most of these cases, but board members hear the facts and render the final decisions. The Administrative Process Act allows these cases to be adjudicated by a hearing officer, but the health regulatory boards have exercised their authority to hear the cases themselves.

Regulatory Authority

The health regulatory boards are also responsible for promulgating the regulations which are necessary to govern the professionals they regulate. These regulations establish initial licensure requirements, set fee rates and renewal requirements, and establish standards and scopes of practice.

Board Budgets

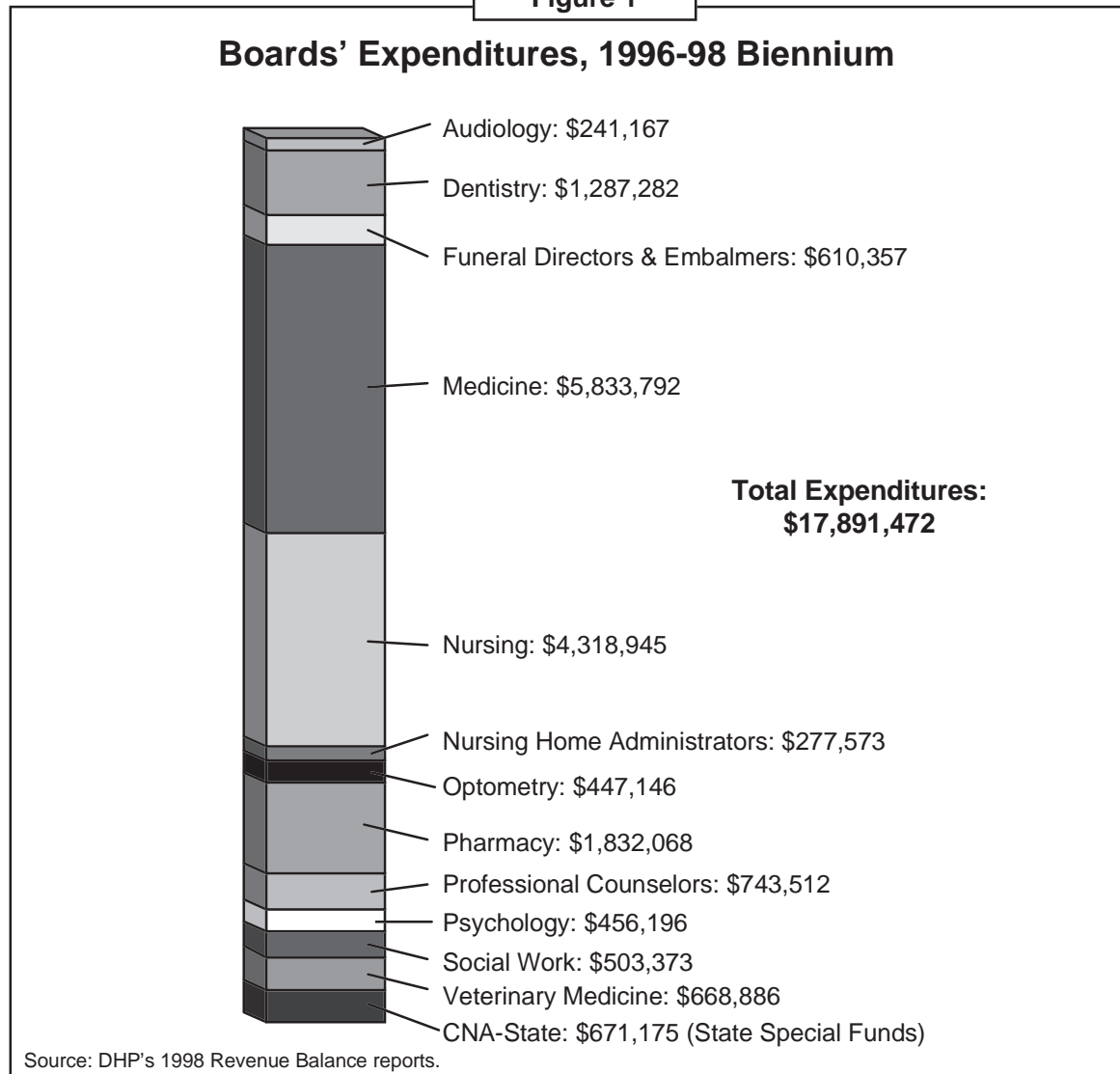
DHP is a special fund agency which receives the money necessary to operate the department, the 12 health regulatory boards, and the Board of Health Professions through fees charged to those regulated by the health regulatory boards. The *Code of Virginia* requires, with one exception, that each of the 12 health regulatory boards collect fees from its licensees which are sufficient to cover the operating expenses of the board. The only regulated health occupation whose costs are not paid for entirely by licensure fees are certified nurse aides (CNAs). Nurse aides are regulated pursuant to a federal mandate, and the federal government provides some funding for their regulation.

During the biennium ending June 30, 1998, the 12 health regulatory boards expended approximately \$18 million (Figure 1). Expenses incurred by DHP and BHP are charged to the boards based on a weighted average calculated using the number of professionals regulated by each board and the number of staff employed by each board. These charges are included in the boards' biennial expenditures. The Board of Medicine spent approximately \$5.8 million in the last biennium which was the most spent by any of the 12 health regulatory boards and represented more than 30 percent of the total department expenditures. The combined spending of the Boards of Medicine, Nursing, and Pharmacy represents 67 percent of the total spending of all the health regulatory boards.

BOARD OF HEALTH PROFESSIONS

The Board of Health Professions (BHP) is a policy board which was created in 1977 primarily to help the health regulatory boards coordinate the development of the policies governing health care professionals in Virginia. BHP is comprised of one rep-

Figure 1



representative from each of the 12 health regulatory boards and five citizens from the Commonwealth at large. Each member is appointed by the Governor.

BHP is primarily responsible for the following: coordinating the work of the regulatory boards; providing some oversight of the Department of Health Professions and the regulatory process; and advising the governor, General Assembly, and DHP director on matters related to the regulation of health professionals.

DEPARTMENT OF HEALTH PROFESSIONS

The Department of Health Professions is the State agency that supports the 12 individual regulatory boards and the Board of Health Professions. The department

supports the boards through several means. Some of the agency staff serve as staff to the individual boards. In addition, the agency provides central staff to support the disciplinary function. The agency also provides the automated systems, budgetary and financial staff support, and human resource management support for the boards. Figure 2 provides an organizational chart of the agency.

Board Staff

Eight DHP staff serve as executive directors to the individual boards. The Boards of Medicine, Nursing, Pharmacy, and Dentistry each have an executive director whose sole responsibility is to serve that board. Another DHP employee serves as the executive director for the Boards of Psychology, Social Work, and Licensed Professional Counselors, Marriage and Family Therapists, and Substance Abuse Professionals (Board of Professional Counselors). An additional staff person serves as the executive director for the Boards of Optometry and Veterinary Medicine. Another DHP employee serves as the executive director for the Boards of Audiology and Speech-Language Pathology, Nursing Home Administrators, and Funeral Directors and Embalmers. Finally, the deputy director of the agency serves as the executive director of the Board of Health Professions. Several of the boards also have one or two deputy executive directors as well as other full-time and P-14 staff who support the boards' functions. The executive directors report both to the director of DHP and to the boards that they serve.

Enforcement Division

The enforcement division is comprised of DHP staff who support the disciplinary function. This division includes: investigators, inspectors, and legal assistants. DHP currently employs 23 full-time investigators to investigate complaints regarding health care professionals. DHP has seven inspectors who conduct routine inspections of pharmacies, veterinary facilities, and funeral homes. Within the enforcement division, there is an Administrative Proceedings Division which employs ten legal assistants. These legal assistants prepare, process, and prosecute disciplinary cases. In addition to the full-time staff who work in the enforcement division, there are also a number of part-time (P-14) staff employed as inspectors, investigators, and legal assistants.

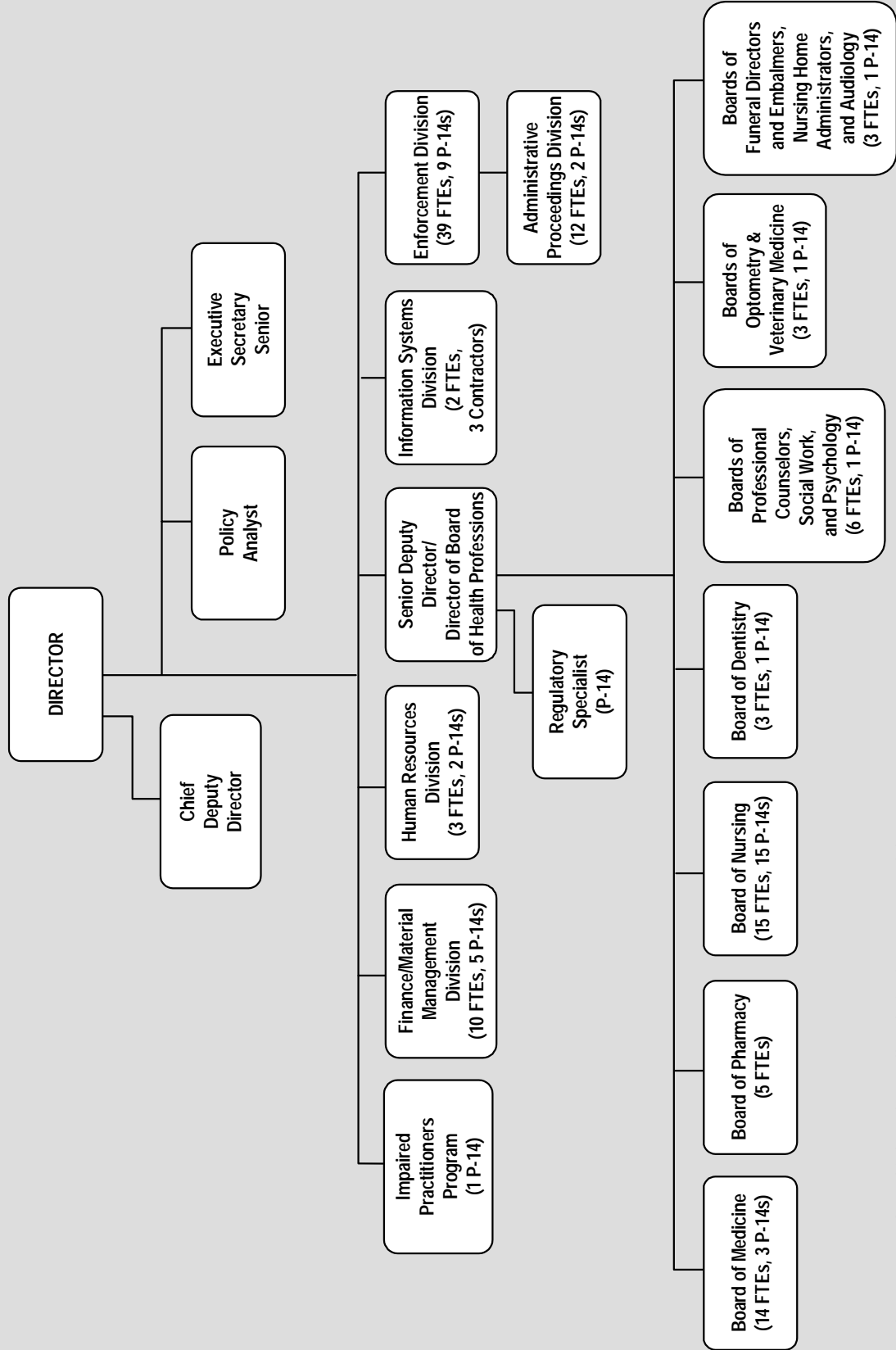
Division of Automated Systems

The Department of Health Professions has a division of automated systems that is responsible for providing computer support for the agency and all of the boards. The division is currently staffed by a division director, program analyst, data base analyst, and three full-time contract employees.

Presently, the two main databases of the department, the licensing and disciplinary databases, are on a mainframe computer at the Department of Information

Figure 2

Department of Health Professions 1998 Organizational Structure



Source: JLARC graphic based on staff analysis of DHP personnel data.

Technology. However, DHP has contracted with a vendor to develop a client-server software system that will be operated by DHP and house all of the databases of the department and the boards.

Finance/Material Management

DHP's Finance/Material Management division handles all of the financial matters related to the department and the individual boards. This division is managed by a finance director and is sub-divided into a finance unit and a material management unit. This division employs 10 full-time staff and five P-14 employees.

The Finance/Material Management division is responsible for developing the budgets for the department and the boards. This includes projecting each board's budget for the biennium and determining if projected fee revenue will cover the anticipated expenses of the board within ten percent as the *Code of Virginia* requires. This division also purchases supplies for DHP, and helps oversee and develop the contracts with vendors that provide services for DHP and the boards.

Human Resources Division

The Human Resource division helps recruit and process the applications for prospective employees, and it assists in managing employee benefits. This division also works with agency management to apportion DHP's positions within the agency and to obtain outside approval to fill vacant and new positions. The Human Resource division is comprised of a director, a personnel analyst, a receptionist, and two P-14 employees who provide clerical support.

JLARC REVIEW

This review provides: an assessment of the composition and structure of the 12 health regulatory boards, an analysis of the boards' licensure and rule-making functions, an assessment of DHP's performance in managing the boards' financial and staffing responsibilities, and a review of the appropriate role of the Board of Health Professions. A number of research activities were undertaken as part of this study in order to obtain a comprehensive understanding of the operations of the health regulatory boards and the Department of Health Professions.

Structured Interviews

One of the primary means of collecting information during this first phase of the study was conducting interviews. In total, JLARC staff conducted approximately 70 interviews. These interviews included the following: current and former presidents or chairs of each health regulatory board, current and former board members, the cur-

rent and former directors of DHP, executive directors to the boards, DHP division managers, and other selected department staff. JLARC staff also interviewed staff from the following State agencies: Department of Medical Assistance Services, Department of Health, Department of Accounts, Department of Planning and Budget, Office of the Attorney General, and the Department of Treasury.

Interviews were conducted with several professional organizations that represent professionals regulated by the boards. In addition, interviews were conducted with experts in the health care field.

Surveys

As part of the review, JLARC staff conducted two mail surveys. One survey was sent to all 153 current members of the health regulatory boards, Board of Health Professions, and advisory boards and committees. This survey was also sent to 107 former board members who had served at least one year during the last five fiscal years. A second survey was conducted of 62 organizations that represent professionals regulated by the health regulatory boards. Both surveys asked the respondents for input on a wide range of issues related to the duties and responsibilities of DHP and the health regulatory boards. The response rate for the board member survey was 72 percent, and the response rate for the organization survey was 53 percent.

Attendance of Meetings and Hearings

Along with interviews and surveys, JLARC staff attended approximately 50 meetings and hearings of the various boards. The purpose of attending the meetings and hearings was to observe the meeting process, develop a stronger understanding of the major issues facing the boards, and assess how effective the boards are in fulfilling their responsibilities.

Document and Data Review

In addition to the interviews, surveys, and attendance of meetings, JLARC staff have reviewed various department documents and data as part of the study. This has included a review of regulation development records, financial data, personnel records, and Board of Health Profession studies.

Regulation Time Frame Review. As part of the study, JLARC staff reviewed all of the regulations proposed by the boards over the last five years. The purpose of this review was to determine how much time is being spent to develop regulations.

Financial Data. JLARC staff also reviewed financial records and budget data. This review was conducted to assess whether the agency has been appropriately handling the revenue collected from the various boards and whether the department has been able to comply with the applicable statutory requirements.

Personnel Records. In addition, JLARC staff reviewed personnel records to evaluate how long it takes to fill vacant positions. The records were also reviewed to determine the extent to which the agency is using P-14s to perform agency functions. DHP records of staff overtime were also analyzed.

Board of Health Professions Studies. JLARC staff also reviewed the BHP studies conducted over the last five years. The purpose of this review was to assess the process used to conduct the studies as well as the quality of the studies produced.

Information on Other States

Finally, in order to obtain another perspective from which to evaluate the performance of Virginia's health regulatory boards, JLARC staff reviewed information regarding other states. This review included studies conducted by legislative agencies in other states. In addition, JLARC staff reviewed other state information available in national association publications, and conducted a telephone survey of boards of medicine directors in the mid-atlantic and southeast regions.

REPORT ORGANIZATION

The report is organized into five chapters. Chapter II discusses issues related to the composition and structure of the health regulatory boards. This chapter includes an evaluation of the role of citizen members and the advisory committees used by the Board of Medicine. Chapter III provides an assessment of the licensure and rule-making functions of the boards. It includes a discussion of the minimum standards set for regulated health professionals in the Commonwealth as well as a review of the regulatory process used by the boards to establish the policies that regulate health care professionals. Chapter IV provides an evaluation of financial and non-disciplinary staffing issues. It addresses DHP's budgeting practices as well as the department's use of P-14 staff. Finally, Chapter V reviews the role of the Board of Health Professions. This chapter evaluates the Board's effectiveness in meeting its statutory responsibilities.

II. Composition and Structure of Boards

The *Code of Virginia* establishes certain requirements regarding the composition of the regulatory boards. The factors that are addressed in the *Code* include: number of licensed professional members, number of citizen members, and geographical location of the members. These factors were examined as part of this study in assessing the composition of the boards. In addition, other composition issues that were considered as part of this review include the need for specialty representation as well as representation of other segments of the health care industry.

The review found that overall, the current composition of the 12 health regulatory boards generally appears appropriate to carry out the responsibilities of the boards regarding licensure and the promulgation of regulations. Current and former board members and Department of Health Professions' staff are generally satisfied with the current composition requirements. However, some modifications may be needed to ensure continuity and balance on the boards, and to ensure that the public is adequately represented on each board through citizen membership.

Also, in contrast to the other health regulatory boards, the Board of Medicine regulates nine licensed professions not represented on the Board through the use of an advisory board/committee structure. Given the number of physical therapists and the dissatisfaction expressed by some of the members of the Advisory Board on Physical Therapy with the current regulatory process, the Board of Health Professions should study the merit of establishing an independent regulatory board to regulate physical therapists and physical therapist assistants. In addition, the Boards of Health Professions and the Board of Medicine, with the assistance of the Department of Health Professions, need to examine whether the current advisory structure used by the Board of Medicine to regulate other allied health professions is the most effective means by which to regulate these professions.

COMPOSITION OF THE BOARDS IS GENERALLY APPROPRIATE

Board members as well as DHP staff are generally satisfied with the current composition of the Boards. However, concern has been expressed that the board member terms for some boards are not evenly staggered, which has resulted in high turnover for some boards in certain years. In addition, the composition requirements for the Board of Medicine need to be changed to reflect the recent statutory change regarding the regulation of psychologists.

Board Members and DHP Staff Are Satisfied with Current Composition

Based on interview and survey responses, board members as well as DHP staff are generally satisfied with the current composition requirements for the health

regulatory boards that they serve. Approximately four-fifths of Board members surveyed indicated that they did not believe additional specialties or health professions should be represented on their boards (Table 2). Table 2 also indicates that a similar percentage of respondents do not believe that their boards need to include representatives from any other area of the health care industry.

Table 2

Board Member Views on Board Composition

Question	Yes	No	No Opinion
In your opinion, are there additional specialties or health professions that should be represented on your Board? (n=152)	13%	79%	8%
In your opinion, are there other segments of the healthcare industry which should be represented on your Board (for example, managed care organizations, hospitals, etc.)? (n=153)	9%	84%	7%

Source: JLARC survey of members of the health regulatory boards, summer 1998.

In interviews with JLARC staff, the executive directors for the 12 health regulatory boards also indicated general satisfaction with the current composition of the boards that they serve. The only concern regarding composition raised by any of them involved the size of two of the boards. The executive director of the Board of Optometry expressed interest in obtaining an additional board member to assist in handling the disciplinary caseload. In addition, the executive director of the Board of Professional Counselors raised the concern that the Board may be too large. Five new members were added to the board last July, and this has apparently resulted in some disruption of the Board's operations.

Terms of Board Members Need to Be More Evenly Staggered

In establishing citizen boards, the General Assembly has historically staggered the terms of board appointees in an effort to ensure continuity in the work of the boards. With the expansion of some of the health regulatory boards over time and the change in the length of terms of at least two boards, several of the boards no longer have evenly staggered terms, which threatens the continuity of the work of some boards.

For example, the Board of Professional Counselors could lose nearly half its members in one year. When the Board was first created in 1976, the *Code* specified that of the initial board, one member be appointed for one year, two members for two years each, two members for three years each, and two members for four years each.

Thereafter, members were appointed to four year terms. However, in 1986, two citizen members were added to the Board with terms that coincided with two existing positions. Eleven years later, five more positions were added as the professions licensed by the Board increased. As a result, the terms are no longer evenly staggered, and the Board has the potential to lose six of its fourteen members in the same year.

As shown in Figure 3, eight of the 12 health regulatory boards have a relatively uneven turnover in positions. Four of the boards have the potential to lose greater than 50 percent of their membership during one year of the four-year appointment cycle, and four other boards have the potential to lose more than 40 percent of their membership during one of the four years.

The executive director of the Board of Medicine believes that this could be a significant problem for the Board of Medicine, because the Board could lose as many as eight individuals in 2000. He is concerned that losing eight of 17 members in one year could pose a hardship for the Board in terms of the loss of experienced members to guide the Board.

The continuity of the work of the health regulatory boards would be further ensured by more evenly staggering the terms of all of the health regulatory boards. With the current situation, a majority of the boards face the potential of losing a significant amount of total years of board experience at one time. This problem could be addressed by a modification of some of the board terms so that no board will lose more than a third of its members in a single year.

***Recommendation (1).* The General Assembly may wish to consider amending the *Code of Virginia* to ensure that no more than one-third of the members of any health regulatory board serve concurrent terms.**

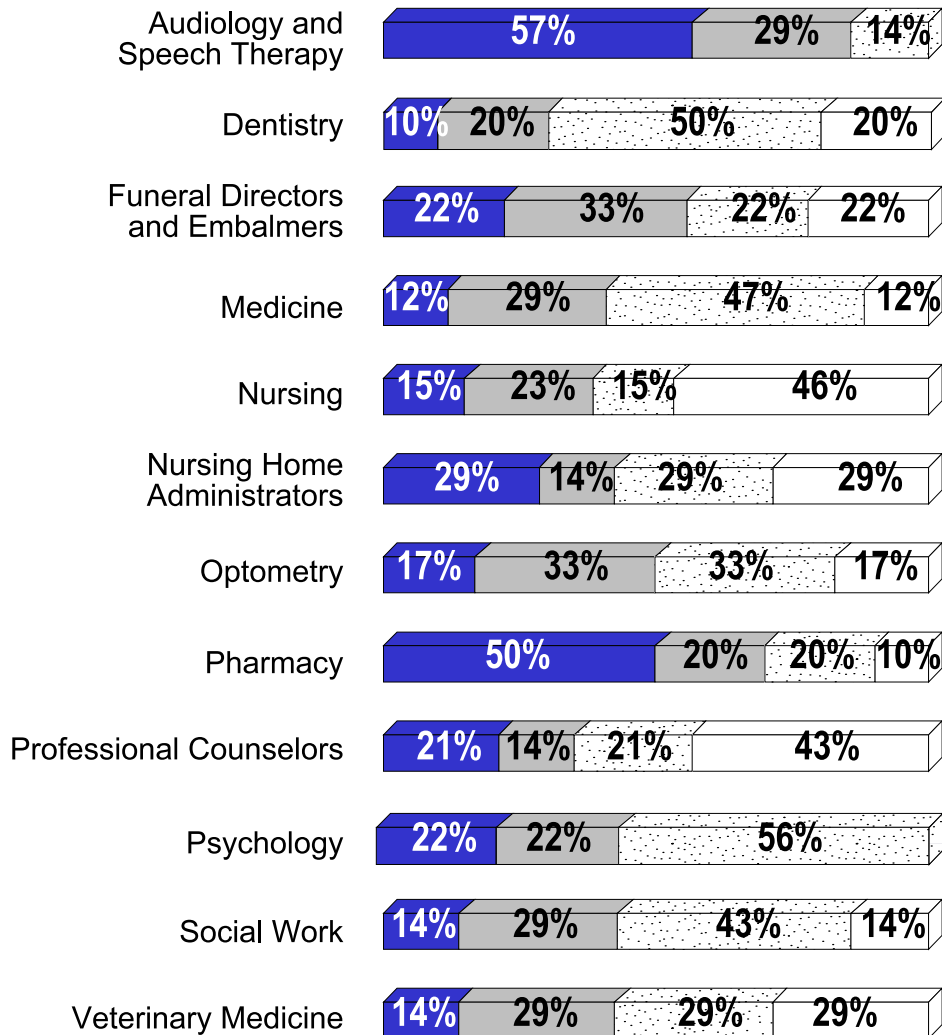
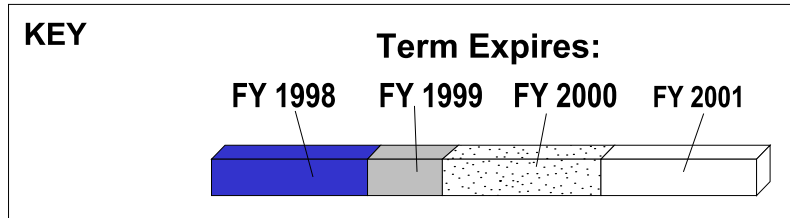
Clinical Psychologist Requirement Should Be Removed

The requirement in the *Code of Virginia* that a clinical psychologist serve on the Board of Medicine is no longer necessary with a recent change in the law regarding the regulation of clinical psychologists. Legislation enacted in 1966 gave the Board of Medicine primary responsibility for the regulation of clinical psychologists. This change also required that the Board of Medicine membership include a psychologist. However, in 1996 the General Assembly enacted legislation that gave the Board of Psychology responsibility for the regulation of psychologists. Despite this change, the *Code* continues to require that the Board of Medicine include a clinical psychologist.

Because the Board of Medicine is no longer responsible for regulating psychologists, it no longer appears necessary to have a psychologist serve on the Board. The executive director has noted that the current clinical psychologist has provided a valuable perspective in disciplinary cases involving issues related to the mental health of physicians or other professionals before the Board. However, the Board has the

Figure 3

Terms of Members of Health Regulatory Boards



Source: Department of Health Professions.

authority and ability to obtain expert advice from psychologists to the extent it is necessary in disciplinary cases without requiring that one serve on the Board.

***Recommendation (2).* The General Assembly may wish to consider amending § 54.1- 2911 of the *Code of Virginia* to remove the requirement that the Board of Medicine include a clinical psychologist.**

CITIZEN MEMBERS' ROLE SHOULD BE STRENGTHENED

While the number of citizen members on the health regulatory boards has increased substantially over the last 15 years, there are areas in which the role of citizens needs to be strengthened. Some boards may need additional citizen members. Other boards need to expand the role of their citizen members. Finally, the definition of citizen member may need to be revised to clarify which individuals are eligible to represent the public perspective.

Background on the Role of Citizen Membership

The 1982 JLARC study of professional regulation recommended that the General Assembly consider requiring that each health regulatory board include at least one citizen member. The Joint Subcommittee Studying Citizen Members on Regulatory Boards recommended adding citizen members to the Boards of Medicine, Nursing Home Administrators, and Social Work in 1984. At the time of the study, only the Boards of Audiology and Speech-Language Pathology and Funeral Directors and Embalmers had requirements for citizen membership. By 1988, all but one of the health regulatory boards were required by statute to have at least one citizen member. Currently, the Board of Nursing Home Administrators has no statutory requirement for citizen membership.

Citizen Members Should Have the Opportunity to Participate Fully on All Committee Structures

Citizen members currently do not fully participate in all functions of the boards on which they sit. Much of the work of the boards is conducted through the use of standing and ad hoc committees. However, it appears that in some instances, citizen members are purposely not placed on certain committees. In addition, there are currently no citizen members on the executive committee of the Board of Medicine, which has significant responsibilities. These limitations to citizen participation may reduce citizen influence on the boards and appear to be inconsistent with the intent of the *Code of Virginia*.

Two executive directors indicated that citizen members are generally excluded from serving on some of the more important committees. For example, one executive

director told JLARC staff that citizen members are generally assigned to the “less important” committees because of their lack of expertise. Another executive director stated that committee assignments are typically based on the knowledge and expertise of committee members, which tends to lead to the selection of professional members.

Of particular concern is the lack of a citizen member on the Board of Medicine’s executive committee. The *Code of Virginia* expressly gives the executive committee of the Board “full powers to take any action and conduct any business” on behalf of the Board in the absence of the full Board. Pursuant to this statutory authority, the Board of Medicine has given the executive committee a prominent role in the business of the Board. The full Board of Medicine only meets three times a year, and the executive committee meets three times a year between meetings of the full Board to conduct the Board’s business.

Despite the major role played by the executive committee, the Board of Medicine does not have a citizen member assigned to it. The *Code* requires that the executive committee be composed of the president, vice-president, and secretary of the Board as well as four other members of the Board but does not explicitly require the appointment of a citizen member to the executive committee. The absence of a citizen member on the executive committee clearly reduces the role of the citizen members in the work of the Board.

Limitations on the participation of citizen members in the boards’ committees appears to be inconsistent with § 54.1-2402 of the *Code of Virginia*, which states that “citizen members appointed to boards within the Department of Health Professions after July 1, 1986 shall participate in all board matters.” All of the boards need to provide opportunities for citizen members to participate in all of the committees of the boards. In addition, the executive committee of the Board of Medicine should be required to include a citizen member given the major role of that committee.

***Recommendation (3).* The General Assembly may wish to consider amending § 54.1-2911 to require that the executive committee of the Board of Medicine be required to include at least one citizen member.**

The Board of Nursing Home Administrators Should Be Required to Have at Least One Citizen Member

The Board of Nursing Home Administrators does not have a statutory requirement that the Board have at least one citizen member. It is the only health regulatory board without such a requirement. Although there is no requirement that the Governor appoint a citizen member, the Board currently has a member that the Board chair, as well as the executive director of the board, consider to be a citizen member. Given the importance that the General Assembly has placed on the inclusion of citizen members on the other health regulatory boards, the General Assembly may wish to consider making the appointment of a citizen member to the Board of Nursing Home Administrators mandatory.

Recommendation (4). The General Assembly may wish to consider amending § 54.1-3101 of the *Code of Virginia* to require that the Board of Nursing Home Administrators include at least one citizen member.

Some Health Regulatory Boards May Need More Citizen Members

Many of the health regulatory boards appear to have a relatively low percentage of citizen members. There is a wide disparity across boards as to the level of citizen membership that is required in statute. Those boards with a lower proportion of citizen members are less able to involve them fully in the work of the boards' committees.

The Boards of Audiology and Speech-Language Pathology and Social Work, each with two required citizen members, have the highest percentage of citizen membership at 29 percent (Table 3). Boards with a relatively low percentage of citizen members are the Board of Dentistry with only one citizen member out of ten (ten percent), and the Board of Medicine with only two citizen members out of a total membership of 17 (12 percent). As previously discussed, the Board of Nursing Home Administrators is not required by law to have any citizen members.

There does not appear to be any public policy rationale for why there is such a variance in the proportion of citizen members across boards. However, definitive guidelines on what the appropriate level of citizen membership on a health regulatory board appear to be lacking in the health professions regulation field. A report recently published by the Pew Health Professions Commission recommends that citizen members comprise at least one-third of the membership of health professional boards. Two reports conducted by other states have recommended that a relatively high percentage of citizen members be included on professional regulatory boards. A 1997 report, prepared for the use of Maine's governor and legislature, recommended that membership on all of the regulatory boards in Maine include at least 30 percent citizen members to provide significant public representation. The Auditor General for Arizona concluded in a 1995 report that the public could be better protected by increasing public membership on the health regulatory boards in Arizona to 50 percent.

Virginia appears to have similar levels of citizen members on its four largest boards as compared to other states in the southeast and mid-Atlantic regions. As Table 4 on page 19 demonstrates, the Board of Medicine and the Board of Dentistry have fewer citizen members than the mean percentage across the boards of the other states, but the Virginia Boards of Nursing and Pharmacy both have a percentage of citizen members that is slightly higher than the mean. Although there is no definitive guideline indicating the ideal proportional representation of citizens members on a board, it appears that boards with a low percentage of citizen members may not be able to fully involve citizen members in the work of their boards. With much of the boards' work conducted through committees, boards with only one citizen member are not able to involve citizen members in all of the committees of the boards.

Table 3

Percentage of Citizen Members Required by Statute

Regulatory Board	Total Members	Number of Citizen Members	Percentage
Board of Audiology and Speech-Language Pathology	7	2	29%
Board of Social Work	7	2	29%
Board of Nursing	13	3	23%
Board of Funeral Directors and Embalmers	9	2	22%
Board of Psychology	9	2	22%
Board of Pharmacy	10	2	20%
Board of Optometry	6	1	17%
Board of Licensed Professional Counselors, Marriage and Family Therapists, and Substance Abuse Professionals	14	2	14%
Board of Veterinary Medicine	7	1	14%
Board of Medicine	17	2	12%
Board of Dentistry	10	1	10%
Board of Nursing Home Administrators	7	0	0%

Source: The Code of Virginia.

In addition, it appears that boards with large disciplinary caseloads are unable to involve citizen members in many of the disciplinary proceedings. The level of involvement of citizen members in disciplinary panels will be discussed in more detail in JLARC staff's phase two report on the boards' disciplinary function.

Recommendation (5). The General Assembly may wish to consider amending the *Code of Virginia* to increase the number of citizens required to be appointed to the health regulatory boards that have a citizen membership of less than 20 percent.

Table 4

Percentage of Citizen Members on Health Regulatory Boards in Southeast and Mid-Atlantic States

State	Percentage of Citizen Members on Board of Medicine	Percentage of Citizen Members on Board of Nursing	Percentage of Citizen Members on Board of Dentistry	Percentage of Citizen Members on Board of Pharmacy
Alabama	0	0	0	0
Delaware	31	36	33	44
Florida	23*	23	18	22
Georgia	8	13**	9	13
Kentucky	15	13	11	17
Maryland	27	18	14	20
Mississippi	0	8	0	0
New Jersey	19	23	17	33
New York	21	20	14	20
North Carolina	25	13	13	17
Pennsylvania	21*	27	15	29
South Carolina	10	11	11	13
Tennessee	7*	11	13	14
Virginia	12	23	10	20
West Virginia	25*	29	14	29
Mean	16	18	13	19

*State regulates Medical Doctors and Osteopaths through two different boards. The percentages above represent the combined totals.

**State regulates registered nurses and licensed practical nurses through two different boards. The percentages above represent the combined totals.

Source: Federation of Medical Boards 1995, National Council of State Boards of Nursing 1996, American Association of Dental Examiners 1997, National Association of Boards of Pharmacy 1997-1998.

Definition of Citizen Member May Need to Be Clarified

The Board of Dentistry's current citizen member may technically qualify as a citizen member under the definition of the term in the *Code*, but this member does not appear to meet the general intent of the definition. Section 54.1-107 of the *Code* defines a citizen member of a regulatory board:

As a person who (i) is not by training or experience a practitioner of the profession or occupation regulated by the board, (ii) is not the spouse, parent, child, or sibling of such a practitioner, and (iii) has no direct or indirect financial interest, except as a consumer, in the practice of the profession or occupation regulated by the board.

The current citizen member of the Board of Dentistry was employed as the executive director of the Virginia Dental Association (VDA) for 24 years prior to her appointment. The VDA works on behalf of a majority of licensed dentists in the State to represent their interests. While she was not appointed to the Board of Dentistry until after she retired from the VDA, she received retirement payments from the VDA during her first three years of service on the Board.

The appointment of such an individual to a health regulatory board as a “citizen” member clearly violates the spirit of the statute. At a minimum, such an appointment is likely to create the perception that the member does not represent the public interest. Moreover, an individual with lengthy experience representing the interests of those licensees regulated by the Board is unlikely to have a true consumer perspective. As a result, the General Assembly may wish to revise the *Code of Virginia* to expressly exclude from those eligible to serve as a citizen member any individual who has been employed by a professional association comprised of members who are licensed or certified by the regulatory board to which the individual would be appointed.

Recommendation (6). **The General Assembly may wish to consider amending § 54.1-107 of the *Code of Virginia* to clarify the definition of a citizen member. The General Assembly may wish to expressly exclude from the definition of “citizen member” any person formerly employed by any organization that represents health professionals who are regulated by the board to which the individual would be appointed.**

ADVISORY BOARD STRUCTURE MAY NEED TO BE MODIFIED

The Board of Medicine currently regulates four professions without the use of advisory boards or committees: physicians, osteopaths, chiropractors, and podiatrists. With the assistance of advisory boards or committees, it regulates nine more licensed professions. Overall, advisory board and Board of Medicine members appear to be generally satisfied with the current regulatory structure. However, concerns have been raised that the current structure may not allow professionals who are regulated through the advisory structure sufficient participation in the regulation of their professions. In addition, some board members and staff believe that the Board of Medicine needs to focus on the regulation of its core licensees. Some physical therapists as well as several DHP staff believe that the system needs to be modified to address these concerns.

Given the large number of physical therapists and the dissatisfaction with the current regulatory structure expressed by members of the Advisory Board on Physical Therapy, the Board of Health Professions should assess whether a separate physical therapy board should be created to regulate physical therapists and physical therapist assistants. In addition, options for modifying the current system of regulating other allied health professions should be considered. Possible alternatives include: (1) establishing a separate board of allied health professions, (2) giving some of these profes-

sions membership on the Board of Medicine, or (3) giving these professions an increased role in the credentialing and disciplinary processes.

Background on Advisory Structure

The Board of Medicine currently regulates nine licensed professions through six advisory boards or committees. Table 5 lists the six boards or committees and the professions that are represented by each one. All three of the advisory boards as well as the Advisory Committee on Physician Assistants are appointed by the Governor. The other two advisory committees are appointed by the Board of Medicine.

Table 5

Professions Licensed by Advisory Boards/Committees

Name of Board	Licensees	Number of Licensees
Advisory Board on Physical Therapy	Physical Therapists Physical Therapist Assistants	3,427 1,171
Advisory Board on Respiratory Therapy	Respiratory Therapists	2,419
Advisory Committee on Radiological Technology	Radiological Tech Practitioner Radiologic Technologists - LTD	1,658 980
Advisory Board of Occupational Therapy	Occupational Therapists	1,725
Advisory Committee on Physician Assistants	Physician Assistants	461
Advisory Committee on Acupuncture	Acupuncturists Licensed Acupuncturists	193 38

Source: Virginia Board of Medicine, July 1998.

All of the advisory boards or committees advise and assist the Board of Medicine in regulating the various professions. However, none of these boards or committees have separate decision-making authority. They serve only in an advisory capacity.

Most Advisory Board, Committee, and Board of Medicine Members Are Satisfied with the Current Structure

Based on the JLARC staff survey of Board of Medicine and advisory board members, members are generally satisfied with the current advisory board structure. As Table 6 shows, all of the Board of Medicine members who responded to the survey

Table 6

Survey Responses on Issue of Advisory Board Structure

Survey Question	Board Responding	Agree	Disagree	No Opinion
The advisory board/ committee structure allows the professions represented adequate input into the Board of Medicine's decisions.	All Advisory Boards/Committees (n = 24)	50%	50%	0%
	Board of Medicine (n = 21)	100%	0%	0%
The advisory board/ committee structure allows the professions represented to play an adequate role in their regulation.	All Advisory Boards/Committees (n = 24)	75%	25%	0%
	Board of Medicine (n = 21)	100%	0%	0%

Source: JLARC survey of health regulatory board members, Summer 1998.

believe that the current advisory board structure allows the professions represented by advisory boards and committees adequate input into Board of Medicine decisions and that the current structure allows the professions represented to play an adequate role in their regulation. Only 50 percent of advisory board or committee members responding to the survey agreed that the current structure allows the professions represented adequate input into the Board of Medicine's decisions. However, 75 percent of those advisory board members responding agreed that the current structure allows the professions represented by advisory boards and committees to play an adequate role in their regulation.

Some members of the Advisory Board on Physical Therapy appear to be dissatisfied with the current regulatory structure. All five of the board members responded that they disagreed that the current structure allows the professions represented adequate input into the Board of Medicine's decisions. In addition, two of the five members disagreed that the current structure allows the professions to play an adequate role in their regulation.

The past president of the Advisory Board on Physical Therapy has expressed frustration with their limited role in the regulatory process. Most recently, she expressed concern with a decision made by the Board of Medicine to reject the advice of a task force comprised of physicians and physical therapists that had developed recommendations regarding how to address a scope of practice dispute between physical therapists and physicians. In addition, she expressed displeasure with a recent decision of a Board of Medicine panel in a disciplinary case involving a physical therapist

assistant as well as displeasure with the advisory board's lack of authority to participate directly in deciding the case.

DHP Staff Are Concerned with the Current Advisory Board/Committee Structure

Several Department of Health Professions staff have expressed concern with the advisory board/committee structure and would like to see most of the professions now regulated by the Board of Medicine moved to a new board. The professions represented by the advisory boards are often referred to as allied health professions. Board of Medicine staff told JLARC staff that the Board spends a considerable amount of time dealing with regulations governing the professions regulated through the advisory boards and committees. A senior staff member of DHP stated that the current system does not work effectively because the Board of Medicine members do not give adequate attention to the matters involving many of the allied health professions that the Board is responsible for regulating. He further stated that the Board has such a large workload regulating its core group of professions that it does not need to have the additional responsibility of regulating professions through the advisory board and committee structure. This staff member also expressed concern with the current structure and noted that there likely will be other allied health professions that the Board of Medicine will be asked to regulate in the future.

Board of Physical Therapy Should Be Considered

With the relatively large number of physical therapists regulated and the dissatisfaction expressed by some physical therapists, the Board of Health Professions should study the possible establishment of an independent board to regulate physical therapists and physical therapist assistants. According to a 1995 survey conducted by the Federation of State Medical Boards, 31 states across the country have independent boards of physical therapy.

The physical therapists have enough licensees (4,598) to justify an independent board. The total number of physical therapists and physical therapist assistants licensed in Virginia outnumber the number of licensees regulated by all of the health regulatory boards except the Boards of Medicine, Nursing, Dentistry, and Pharmacy. Furthermore, as Table 5 demonstrates, the number of licensees regulated by the Board of Medicine through the Advisory Board on Physical Therapy is almost twice as many as the number of licensees regulated through any of the other advisory boards or committees, and more than one-third of the total number of licensees regulated through the advisory structure.

Establishment of a separate board would appear to have several advantages. It would reduce the workload of the Board of Medicine. In addition, it would enable the physical therapists to regulate their own profession. Finally, it would give physical

therapists a stronger role in resolving scope of practice disputes between physical therapists and physicians.

Recommendation (7). The General Assembly may wish to consider directing the Board of Health Professions to evaluate the merit of establishing an independent board of physical therapy for the purpose of regulating physical therapists and physical therapist assistants and present its findings to the General Assembly prior to the 2000 General Assembly session.

Possible Alternatives to the Current System

Due to DHP staff's concerns with the current advisory board/committee structure, the issue of regulating the remaining allied health professions should be evaluated further. The Boards of Medicine and Health Professions, with the assistance of the Department of Health Professions, should evaluate the current advisory board structure and determine whether an alternative method of regulating the allied health professions would be preferable. Several alternative options exist. A new allied health board could be created to regulate the allied health professions that are currently regulated by the Board of Medicine. A second option would be to give the professions with advisory boards or committees a position on the Board of Medicine. A third option would be to retain the current advisory boards and committees but to give them an increased role in credentials and disciplinary cases involving their professions.

Establishment of a Board of Allied Health Professions. One option to be considered is the establishment of a separate board of allied health professions. Three states have boards that regulate more than one allied health profession. As mentioned earlier, a senior Department of Health Professions manager believes that establishment of a board of allied health professions is necessary to allow the Board of Medicine to focus on the regulation of its core licensees. The director of DHP has also told JLARC staff that an additional board will become more necessary given the likelihood that other allied health professions such as athletic trainers will be required to be regulated in the future. He believes that at some point, it will become virtually impossible for the Board of Medicine to regulate all of the allied health professions if it continues to be assigned the regulation of new professions. Another advantage of creating a new board of allied health professions is that it would allow those professions currently regulated through the advisory board structure to have a more active role in the regulation of their professions.

Creation of a separate board of allied health professions would also have some drawbacks. An additional board would require additional staff. In addition, it would be a board comprised of a diverse group of professionals with sometimes diverging interests whose members might have some difficulty working together in the interest of public protection. Also, consensus on the appropriate composition of the board may be difficult to achieve. Finally, there does not appear to be much interest on the part of most of the professions currently regulated through the advisory board system in having a separate regulatory board to regulate their professions.

Establishment of Board Positions for Allied Health Professions. Another option for modification of the current advisory board structure would be to give one or more of the professions currently regulated through the advisory board structure positions on the Board of Medicine. One advantage of this approach would be that the allied health professions would have a representative from their profession with the authority to participate in the work of the Board of Medicine in more than an advisory capacity.

Creating additional positions on the Board of Medicine could also pose problems. The establishment of positions on the Board of Medicine for all allied health professions could make the Board too large and unwieldy. Moreover, the physician members of the Board would likely oppose the establishment of positions for each allied health profession on the Board because that would dilute the voting strength of the physicians currently on the Board unless more physicians were also added. Therefore, difficult decisions would have to be made regarding which professions would be entitled to representation on the Board.

DHP staff also state that historically any profession that receives a position on the Board no longer has an advisory board or committee. It is not apparent that being given one position on a board of 17 while simultaneously losing their existing advisory board would enhance the role of the allied health professions in the regulation of their professions.

Maintain Existing Advisory Board Structure But Increase Regulatory Role. If the Boards of Medicine and Health Professions decide to retain the existing structure, they should consider increasing the role of the allied health professions in the credentialing and disciplinary processes. As mentioned previously, the past president of the Advisory Board on Physical Therapy recently raised concerns about her inability to participate in a disciplinary proceeding involving a physical therapist assistant. Likewise, the past president requested the opportunity to participate in any future credentialing proceedings involving physical therapists or physical therapist assistants.

Currently, the advisory boards have the authority to engage in fact finding and advise the Board of Medicine on credentialing and disciplinary cases involving licensees from their profession. However, they do not have the authority to participate in executive session deliberations or in the decision-making of credentials or informal conference committees.

If the current advisory board structure is maintained, the Board of Medicine should consider giving the advisory boards a more active role in both credentials and disciplinary proceedings involving professionals represented by an advisory board or committee. The president of the applicable advisory board or committee could be given the statutory authority to select one or more members of the board or committee to participate as full voting members in credentials or disciplinary proceedings involving an allied health professional. This would allow the advisory boards to have a greater

role in the regulation of their professions without significantly reducing the authority of the Board of Medicine.

Statutory Powers and Duties Should Be Made Consistent

According to the executive director of the Board of Medicine, all of the advisory boards and committees are viewed by staff as having the same regulatory authority. However, the *Code* provisions establishing the duties and responsibilities for the various boards and committees vary substantially (Table 7). For example, the Advisory Board of Occupational Therapy is the only advisory board given the express authority to take part in the disciplinary system through receiving investigative reports and recommending sanctions. However, all six of the advisory entities are viewed by Board of Medicine staff as having this authority. Another example is the statutory powers expressly given to the Advisory Boards of Occupational Therapy and Respiratory Therapy to recommend criteria for licensure or certification and standards of practice for their licensees. The other advisory boards and committees are not expressly given this power but are viewed by the staff and the Board of Medicine as having this authority. Table 7 demonstrates the inconsistencies in the statutory powers assigned to the various advisory boards and committees.

The Board of Medicine, with the assistance of Department of Health Professions staff and the advisory boards, needs to assess what role the boards and committees play in the regulation of the licensees represented on their boards or committees. The Board then needs to recommend any modifications to the powers and duties of the various advisory boards and committees necessary to ensure that they will have the statutory authority to effectively perform their roles and that the statutory powers and duties for each board or committee are consistent across advisory entities if their roles are generally considered to be the same.

***Recommendation (8).* The Board of Medicine, with the assistance of the Department of Health Professions, should evaluate whether the *Code of Virginia* establishes the powers and duties necessary for the advisory boards and committees to effectively perform their responsibilities and whether the differences in the powers and duties of the various advisory boards and committees reflect real differences in their roles. The Board should then make appropriate recommendations to the General Assembly regarding any needed statutory changes to establish appropriate and consistent powers and duties.**

**Table 7
Powers and Duties of Advisory Boards/Committees**

Advisory Board/Committee	Date created	Appointed by Governor (G) or (BOM)	DUTIES					
			Recommend criteria for certification and standards of professional conduct	Assess and recommend qualified applicants	Receive investigative reports of misconduct & recommend sanctions	Provide, administer, & grade exams	Assist BOM in evaluation of applicants through reciprocity or endorsement	Advise and assist BOM
Occupational Therapy	1989	G	✓	✓	✓			✓
Physical Therapy	1958	G				✓		✓
Respiratory Therapy	1985	G	✓					✓
Radiologic Technology*	1990	BOM						✓
Acupuncture*	1991	BOM						✓
Physicians Assistants*	1989 (via regulations) ----- 1998 (via Code)	BOM (president) ----- G						✓

* Advisory Committees
Sources: Code of Virginia, Virginia Administrative Code.

III. Licensure and Rule-Making

The mission of the health regulatory boards and the Department of Health Professions is to regulate the practice of health professions through three primary functions: licensure, rule-making, and the disciplinary system. The licensure process is used to ensure that those practicing a profession have a minimum level of competence. The boards develop the regulations applicable to the health professions. The disciplinary system then serves to address those circumstances in which health professionals are acting unprofessionally or are not meeting the accepted standards of care in their practice. This chapter focuses on issues related to licensure and rule-making. The disciplinary system will be addressed in a subsequent report to be completed in 1999.

The licensure process appears to work effectively and serves as a useful tool for establishing initial competence. However, the boards need to be able to conduct national criminal background checks. Also, the Board of Dentistry appears to be inappropriately using the licensure process to restrict practitioners in other states from gaining licensure in Virginia. With regard to rule-making, the primary issue appears to be the time frame that is spent on the rule-making process. The slowness of the current regulatory process has hindered the ability of the boards to efficiently promulgate needed regulations.

LICENSURE PROCESS APPEARS TO BE EFFECTIVE

In Virginia, the licensure process appears to work relatively well. The health regulatory boards primarily have responsibility for processing applications. With a few exceptions, most of the examinations given as part of the licensure process are developed nationally. Board members as well as license applicants appear to be satisfied with the process. Furthermore, licensure and renewal fees appear to be relatively low compared to other states in the mid-atlantic and southeast regions.

Background on Licensure and Certification

In Virginia, most health professionals who are regulated are either licensed or certified. The purpose of the licensure process is to ensure that persons desiring to practice a profession have certain minimal qualifications that demonstrate their potential to practice a profession competently. The major qualifications usually include educational and testing requirements.

Most of the professions with licensure requirements have similar types of requirements. Most professions have minimum educational requirements that must be met. In addition, virtually all health professions require an applicant to pass one or more examinations as part of the initial licensure process. These examinations may

test the applicant's substantive knowledge about the profession or knowledge of the laws governing the practice of the profession. Most professions also have a general requirement that the applicant be of good moral character.

Boards and Department Primarily Process Licenses

In recent years, the regulatory boards and the Department of Health Professions have had a steadily decreasing role in the initial licensure of health professionals. One of the reasons for this reduced role has been the increased development and use of national licensure examinations. Moreover, with the exception of the Board of Nursing, the boards do not play any role in the assessment of educational programs that train health professionals. As a result, the primary function of the boards with regard to licensure is to ensure that applications are processed and that candidates have met the minimal requirements for licensure or certification.

The primary situation in which the boards play a substantive role is in cases in which a question is raised about the moral character or the competence of an applicant for licensure. With those cases, most boards convene a panel pursuant to the Administrative Process Act to consider whether the applicant should be licensed. Some boards, including the Board of Medicine, have a standing credentialing committee to consider these cases.

Licensure Process Appears to Work Well

The current licensure process appears to generally work well. Based on surveys, candidates for licensure and professional associations representing licensees appear to be satisfied with the licensure process. Moreover, the boards appear to effectively handle those candidates for whom there is a concern raised and who have to appear before a credentialing committee.

General Satisfaction with the Licensure Process. Based on interviews and surveys, there appears to be general satisfaction with the licensure process. Staff indicated in interviews that they believe the licensure process works well. In addition, those board members surveyed are also satisfied with the current process.

Results of a DHP customer satisfaction survey indicate that applicants who have been through the licensure process are satisfied with it. DHP has been surveying candidates for licensure since the first quarter of 1997. As shown in Table 8, more than 90 percent of those surveyed by the department indicated satisfaction with the licensure process.

Professional associations representing the health professionals regulated in Virginia have also expressed satisfaction with the licensure process. As part of the study, JLARC staff conducted a survey of these organizations and asked them for their opinions of the process. Seventy percent stated that the licensure process was an effec-

Table 8

Results from DHP's Customer Satisfaction Survey

Customer Satisfaction Survey Questions	Strongly Agree	Agree	Disagree	Strongly Disagree	N
Instructions for making application were clear and easy to understand	45%	49%	5%	1%	8,105
Application was processed promptly	54	39	5	2	8,103
Forms were easy to complete	45	49	5	1	8,107
Call was promptly answered or returned	56	39	4	1	6,298
Provided courteous service	64	34	2	1	6,311
Provided accurate information	62	34	3	1	6,222

Note: All figures may not equal 100 percent due to rounding.

Source: Department of Health Professions' customer satisfaction survey results, 1997-98.

tive means to test the initial competence of applicants for licensure. The same percentage of respondents also expressed satisfaction with the timeliness of the process.

Boards Appear to Handle Questionable Candidates Effectively. Based on interviews with DHP staff and observation of credentials committee proceedings, the credentialing process currently used appears to be an effective means for addressing those cases in which an applicant has something in their background that raises questions about their competence to practice the profession in which they are seeking licensure. Department staff believe that the committees effectively address those cases in which an applicant has something in their past that raises concern. Based on observation of credentialing committee meetings, JLARC staff found that committees appear to carefully consider each case, and committee decisions whether to grant licensure appear to be supported by the facts in the cases.

Licensure Fees Are Relatively Low in Virginia

Overall, licensure and renewal fees in Virginia appear to be comparable to those fees assessed in other states (Table 9). There are some Virginia boards' which have initial licensure fees that are significantly lower than the average. For example, the Boards of Nursing and Pharmacy have substantially lower initial licensure fees than the average of other states. The health regulatory boards generally have comparable renewal fees to other states with lower fees than the average in most cases.

Table 9

A Comparison of the Annual Fees Charged by Virginia's and Other States' Health Regulatory Boards

Health Regulatory Board	Fee Type	Other States' Average Charge	Virginia's Charge
Board of Funeral Directors and Embalmers ¹	Licensure	\$114	\$100
	Renewal	84	100
Board of Medicine	Licensure	282	200
	Renewal	96	62
Board of Nursing ²	Licensure	54	25
	Renewal	30	20
Board of Pharmacy	Licensure	70	50
	Renewal	62	50
Board of Psychology ³	Licensure	140	150
	Renewal	158	62
Board of Speech-Language Pathology and Audiology	Licensure	110	100
	Renewal	41	30

Notes: Other states included Alabama, Delaware, Florida, Georgia, Kentucky, Maryland, Mississippi, North Carolina, Pennsylvania, South Carolina, Tennessee, and West Virginia.

¹Data was not available on funeral director license fees for the states of Georgia and Pennsylvania.

²Data was not available on nursing license fees for the states of Florida, Maryland, and Pennsylvania.

³The analysis of other states' licensing fees for psychologists includes only the fees charged for licensing psychologists and does not include the fees charged to ancillary professions.

Source: The Conference of Funeral Service Examining Boards, the Federation of State Medical Boards, the National Council of State Boards of Nursing, the National Association of Boards of Pharmacy, the Association of State and Provincial Psychology Boards, and the American Speech-Language-Hearing Association.

DHP Should Be Provided Access to National Criminal Records in Certain Cases

Under the current licensure system, the health regulatory boards rely primarily on information that is self-reported by applicants with regard to their backgrounds. While the staff to the boards do not believe that it is necessary to conduct criminal background checks of all applicants, there are circumstances in which they would like to be able to conduct a further inquiry into the background of applicants based on the information that is available. However, the health regulatory boards currently are not provided access by the Virginia State Police to national criminal records.

Applicants Are Requested to Provide Information on Licensure Applications. Applications for licensure as a health professional generally include two background questions not related to the applicants' professional training. The first question asks applicants to indicate any previous criminal convictions or professional disciplin-

ary actions taken against the applicant. The second question asks an applicant to provide any history of substance abuse that they might have.

Staff Would Like to Be Able to Conduct Comprehensive Background Checks in Certain Circumstances. While DHP staff generally do not believe that it is necessary to conduct criminal background checks on every applicant for licensure, they would like to have the ability to conduct such checks in those instances in which the boards have information regarding an applicant's background that raises questions about their ability to practice competently. This information could include information self-reported by the applicant on their application, or it could include information provided to the boards through some other source. One executive director told JLARC staff that there have been instances in which the board has discovered after the application process that applicants with extensive criminal histories disclosed only selected parts of their past on their applications.

DHP Access to Criminal Records Is Currently Limited. Eight years ago the Department of Health Professions purchased the equipment necessary to obtain access to the National Crime Information Center in order to conduct national criminal background checks. However, the State Police advised DHP that it should only use this access for "criminal justice purposes." According to the director of enforcement, DHP only used the system in a few instances. Most of the inquiries involved candidates for licensure reinstatement. In January of 1998, the State Police advised DHP that their access to the database would be terminated completely because access is limited to "law enforcement agencies," and the Department of Health Professions is not such an agency under Virginia law. According to the State Police, federal regulations require them to limit access to the National Crime Information Center's database to law enforcement agencies unless directed to provide access to an agency by State statute.

The Department of Health Professions currently has access to the State's criminal record data base. However, this access is of limited value because many of the applicants are from out-of-state. For example, the executive director of the Board of Optometry estimates that more than half of the optometrist applicants are from out-of-state because there are no optometry schools in Virginia.

DHP Should Be Provided Access to National Criminal Records. While criminal background checks do not appear to be necessary for every applicant for licensure, DHP staff need to have the ability to conduct national criminal background checks in those instances in which the department or board members have some reason to be concerned about the background of an applicant. Therefore, DHP needs to have its access to the national database restored. DHP's access should be extended to include use for inquiries during the licensure process and not be limited to use for "criminal justice" purposes.

Recommendation (9). The General Assembly may wish to consider amending the *Code of Virginia* to provide the Department of Health Professions with the authority to access the National Crime Information Center to conduct national criminal background checks on candidates for licensure by

the health regulatory boards. This authority should be provided to the department to enable it to perform checks in those instances in which concerns have been raised about an applicant's background that relate to the candidate's competency to practice the profession for which they are requesting licensure.

BARRIER TO ENTRY FOR OUT-OF-STATE DENTISTS IS NOT BASED ON PUBLIC INTEREST

The *Code of Virginia* does not provide any procedure for licensed dentists in other states to gain Virginia licenses other than completion of Virginia's entire licensure process. Other health regulatory boards license out-of-state practitioners using the less restrictive process of licensure by endorsement. The concept of licensure by endorsement is based on the assumption that professionals licensed in other states have already demonstrated their competency to practice the profession and should not be subject to all of the requirements imposed on a new licensee. The Board of Dentistry has not articulated a clear rationale for not providing licensure by endorsement. Most other states have established a process through statute or regulation for out-of-state licensees to receive a license with minimal requirements. In addition, there is some form of licensure by endorsement for all other categories of health professionals licensed in Virginia.

Current Dentist Licensure Situation in Virginia

Under current Virginia law, licensed dentists in other states who wish to become licensed in Virginia are required to fulfill the requirements for licensure imposed on applicants who are applying for a license for the first time. There is no mechanism for exempting them from the examination requirements even if they are an experienced dentist.

Clinical Examination Is the Major Requirement for Licensure. In Virginia, the primary examination for licensure as a dentist is the clinical examination. The test requires a live patient for the applicant to demonstrate their practical expertise, and it costs \$700. Some applicants also have to pay the patient for their time. The clinical exam is given exclusively by the Southern Regional Testing Agency (SRTA), which develops the test but then contracts with current and former members of Virginia's Board of Dentistry to administer it. Five other states are members of SRTA. They are: Arkansas, Georgia, Kentucky, South Carolina, and Tennessee. Most other states are members of similar regional testing agencies that have developed and use similar clinical examinations.

Licensure by Endorsement or Credentials Is Not Available. Under current State law, any dentist, even if licensed in another state, is required to take the SRTA examination before they can become licensed in Virginia. There is no mecha-

nism such as licensure by endorsement or licensure by credentials which would exempt dentists licensed in other states from the testing requirements imposed on applicants applying for initial licensure unless they are licensed in one of the SRTA states and have taken the SRTA examination.

Need for Change in Licensure of Out-of-State Dentists

The lack of a licensure by endorsement process does not appear to be related to protection of the public and appears to create a barrier to entry for out-of-state dentists. Most other states across the country and all other health professions within Virginia grant recognition to licensees from other states. As a result, the General Assembly should consider amending the *Code of Virginia* to require the Board of Dentistry to establish a process for licensure by endorsement for out-of-state dentists.

Barrier to Entry Not Based on Public Protection. Based on interviews with members of the Board of Dentistry, there does not appear to be any public interest rationale for the establishment of this barrier to entry on dentists licensed in other states who desire to be licensed in Virginia. In interviews, members of the Board of Dentistry as well as the executive director of the Virginia Dental Association acknowledged that the clinical examinations given to persons seeking licensure are very similar throughout the country. Furthermore, none of those interviewed could articulate any public purpose for the restriction. One former member of the Board of Dentistry stated in his survey response that there is no reason that “practitioners from other states should not be licensed by credentials as are all other professions in the state.” Another former member of the Board of Dentistry referred to the lack of licensure by endorsement as “a negative for the population of Virginia.”

Licensure by Endorsement Was Proposed Three Years Ago. Evidence of the effect of this barrier to entry was demonstrated by the large number of applications the State received for licensure from out-of-state licensees during a three month window in 1995 when licensure by endorsement was made available. In 1995, the Board of Dentistry promulgated regulations establishing licensure by endorsement in regulation beginning April 1, 1995. The General Assembly subsequently enacted legislation which became effective July 1, 1995 that effectively eliminated licensure by endorsement by requiring any dentist seeking a license to pass the SRTA examination. During the three-month period in which licensure by endorsement was available, the Board of Dentistry received 533 applications for licensure through this process from dentists practicing in other states.

Most Other States Grant Recognition to Licensees from Other States. According to the American Dental Association, dental boards in 34 states plus the District of Columbia grant licenses to dentists currently licensed and practicing for a period of time in another jurisdiction without further theoretical and clinical examination. Two of the 34 states which grant license recognition to licensees from other states, Arkansas and Kentucky, are members of SRTA and require the same clinical test of individuals who are not licensed by any state that is given to all Virginia applicants. In

addition, Georgia and South Carolina, who are both members of SRTA, have legislative authority to implement licensure by endorsement but have chosen not to at the dental board level.

Dentists Are the Only Licensed Health Professionals in Virginia Without Licensure by Endorsement. The Board of Dentistry is the only health regulatory board in Virginia that does not provide some procedure for professionals who have been licensed and are practicing in another state to obtain a Virginia license without having to fulfill all of the requirements for initial licensure. Based on interviews with board members and staff, there do not appear to be any factors related to public protection that would justify this difference in treatment for dentists.

Recommendation (10). The General Assembly may wish to consider amending § 54.1-2710 of the *Code of Virginia* to require the Board of Dentistry to establish a process for dentists licensed in other states to apply for and receive a Virginia license without being required to pass the clinical examination currently required, as long as they can demonstrate that they have passed a comparable clinical examination in another jurisdiction.

REGULATORY PROCESS IS SLOW

One of the primary responsibilities of the health regulatory boards is to develop the regulations necessary to govern the practice of health professions in the State. The process appears to have slowed significantly in recent years with additional steps that have been added to the process as well as additional approvals that are required. This slowdown in the process has resulted in considerable frustration on the part of many health regulatory board members as well as DHP staff.

Executive Order 13 Added Requirements to the Regulatory Process

Executive Order 13, which was signed in June 1994, required several new procedures to promulgate regulations in addition to those already required by the Administrative Process Act (APA). The executive order added an additional pre-approval phase to the beginning of the process and added some approvals to later steps in the process.

The Regulatory Process Already Had Major Statutory Requirements. The Administrative Process Act establishes certain basic requirements for the promulgation of regulations. The first major step in the process is the preparation of a Notice of Intended Regulatory Action (NOIRA) which must be submitted to and published in the *Virginia Register*. The agency desiring to promulgate regulations must provide for at least 30 days of public comment on the published notice. The next major step in the process is the preparation of the proposed regulation and economic impact analysis of it. The agency that intends to adopt the regulation has responsibility for preparing the

regulatory package, and the Department of Planning and Budget has responsibility for preparing the economic impact statement.

The proposed regulation and economic impact analysis are required to be submitted to the Registrar for publication in the *Virginia Register*. The APA requires that members of the public be given 60 days to comment on a proposed regulation after it is published in the *Register*. The *Code* also requires the Governor to review all proposed regulations and gives him 15 days after the completion of the public comment period to comment on the proposed regulations. The final major statutory step in the process is the adoption of the final regulation, which is published in the *Register* and becomes effective 30 days from the date of publication.

Additional Requirements Established by Executive Order 13. Executive Order 13 established several additional steps in the regulatory process not required by law. These included an additional approval process prior to the publication of a Notice of Intended Regulatory Action as well as an additional approval process prior to the publication of proposed regulations.

Executive Order 13 refers to this additional approval required prior to the development and publication of the NOIRA as the pre-NOIRA process. Under this executive order, each agency is required to submit to the appropriate cabinet secretary and to the Department of Planning and Budget (DPB) a proposal outlining the reasons the agency wishes to promulgate a new or revised regulation.

DPB is required to review each pre-NOIRA package to “determine whether [the proposed regulation] complies with all requirements of [Executive Order 13] and applicable statutes and whether the contemplated regulatory action comports with the policy of the Commonwealth.” The agency must then advise the Governor and appropriate cabinet secretary of its determination. The secretary then is responsible for determining whether to authorize the agency to proceed with the NOIRA.

Executive Order 13 also added an additional approval process prior to the submission and publication of proposed regulations. It required DPB to conduct the same type of review of proposed regulations after they have been developed as it conducts of the pre-NOIRA package and advise the secretary and Governor of its determination. The secretary must then determine whether to authorize the submission of the proposed regulation to the Registrar for publication. According to Executive Order 13, the governor’s approval for publication is required only if the secretary’s determination is contrary to DPB’s determination.

On June 30, 1998, Executive Order 25 was signed by the new Governor and replaced Executive Order 13. This order retains the pre-NOIRA approval process as well as the approval required prior to the publication of proposed regulations. The primary difference between Executive Order 25 and Executive Order 13 is that the new executive order does place time limitations on DPB’s review of the pre-NOIRA (14 days) and proposed regulation packages (45 days) that were not present in the previous executive order. However, it is not clear whether DPB will be able to meet these

time requirements. Moreover, the Governor and his cabinet secretaries are involved in the review and approval process as well.

Regulatory Process Is Slower with Additional Procedures

One of the results of the additional steps in the regulatory process is that the process for the development of regulations by the health regulatory boards has slowed considerably. Based on an analysis of regulations promulgated by the regulatory boards since the new process was established through executive order, the process appears to be significantly slower. The health regulatory boards have promulgated 17 sets of regulations since the new procedures were established by Executive Order 13. The average time spent to promulgate a regulation under the new procedures has been 22 months (Figure 4), and the median time has been 21 months. An additional thirteen sets of regulations have been published in proposed form, and it appears that these regulations will take at least 22 months on average to complete the process. This average time is substantially longer than the average time taken to promulgate regulations by the health regulatory boards prior to the addition of the new procedures. As Figure 4 indicates, the time spent to develop regulations by the health regulatory boards was 13 months in 1990-1991 and 16 months in 1993-1994.

Based on an analysis of the time that was spent to complete each stage of the process, there appear to be two major points in the process which have increased the time typically needed to promulgate regulations (Figure 5). One of the primary factors which appears to be lengthening the process is the added requirement that the health regulatory boards and the Department of Health Professions submit a pre-Notice of Intended Regulatory Action package and receive approval prior to publication of the

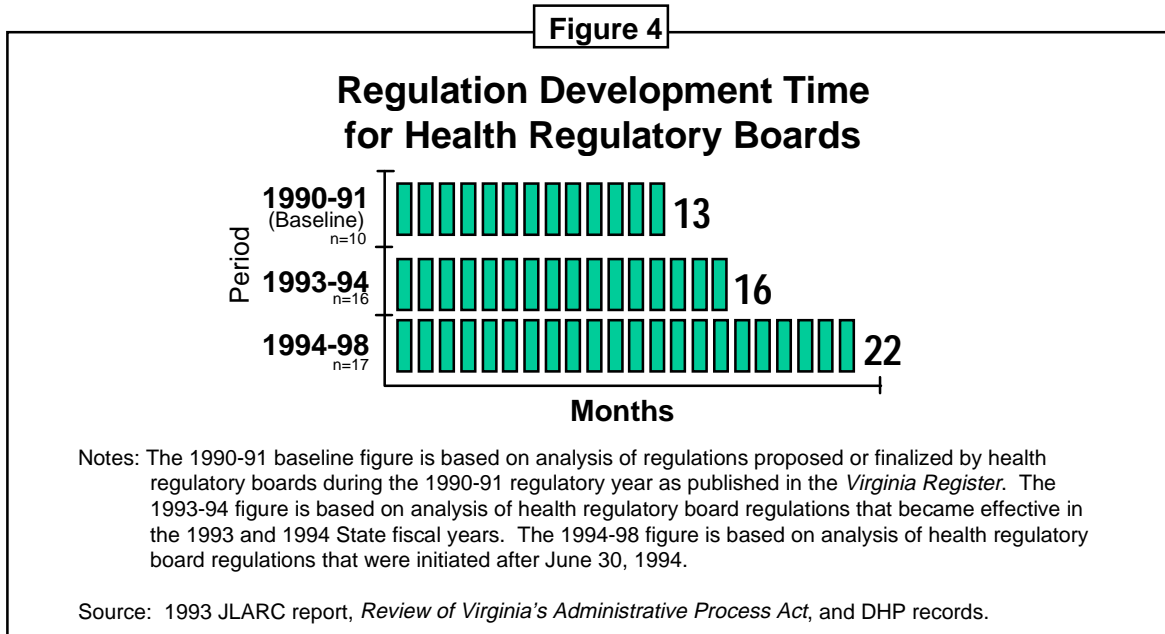
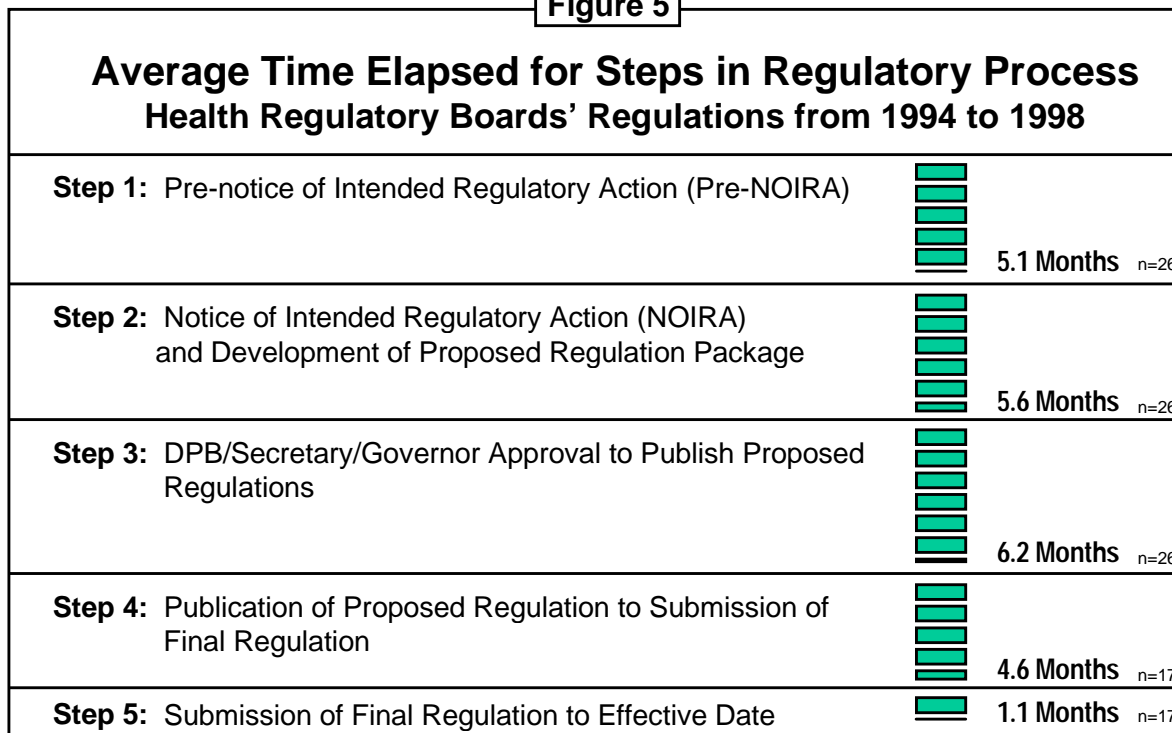


Figure 5



Source: JLARC staff analysis of DHP records.

Notice of Intended Regulatory Action. Based on a review of the regulations promulgated by the boards since the establishment of the pre-NOIRA requirement, this phase in the process adds on average five months to the regulatory process.

Another point in the process which appears to have added some time is the review and approval process now required prior to the publication of proposed regulations. Based on an analysis of the regulations promulgated since the establishment of the new procedures, the longest phase in the process for board regulations is the executive branch review of the regulatory package prior to publication. Based on the JLARC review, this step in the process has taken an average of six months over the last four years.

DHP Staff and Regulatory Board Members Are Frustrated with the Process

DHP staff and board members have expressed frustration with the slowness of the current regulatory process. Most of the executive directors of the boards as well as the current director of the agency expressed frustration to JLARC staff with the process. One executive director stated that the process is “very frustrating for my boards who need to provide needed regulatory changes for licensees.” Another executive director described the current process as “cumbersome and ridiculous.”

Many of the board members interviewed by JLARC staff expressed frustration with the slowness of the regulatory process. One current board member and former board chair described the process as “atrocious.” Another current board chair described the regulatory process as “horrible” and stated that it “tends to take longer to get a regulation than to get a law.” Another board chair stated that he thought the regulatory process time needed to be reduced by half.

Slowness Has Contributed to Board Deficits

One of the most serious concerns expressed by DHP staff with the slowness of the process is the inability of boards to implement timely fee increases to address budget deficits. As discussed in more detail in Chapter IV, the boards may only increase fees through regulation. As a result, several boards have been forced to run deficits for extended periods of time because of the slowness of the regulatory process. For example, the Board of Psychology, which had a deficit in 1995, initiated a fee increase through the regulatory process in February of 1995. The regulation did not become effective until April 1998. During that three year period, the Board continued to run a deficit.

Slowness of Regulatory Process May Lead to Circumvention

Another concern expressed about the slowness of the regulatory process is that it may lead to circumvention of the process. This process has been circumvented in three ways. First, there has been an increased use of the emergency regulation process. Second, in at least one context, the regulated community appears to be simply ignoring the regulatory process. Third, the mindset appears to be developing that the legislative process is the most efficient means of seeking needed changes regarding the regulation of health professionals that could be addressed using the regulatory process.

Boards Are Increasingly Required to Develop Emergency Regulations.

A consequence of the slowness of the regulatory process is that the General Assembly has been increasingly directing the regulatory boards to develop emergency regulations to implement new legislation. During the last three legislative sessions, the General Assembly has directed the health regulatory boards to develop a number of emergency regulations to implement statutes. During the 1998 session, seven statutes were enacted that direct the health regulatory boards to develop emergency regulations. The statutory direction to enact so many emergency regulations appears to result from the recognition by the General Assembly that the normal regulatory process is so slow.

While the emergency process does enable the regulatory boards to enact regulations in a relatively short time-frame, they can only be effective for a year. Boards are then required to develop the same regulations through the full regulatory process. Therefore, the emergency regulation is a very inefficient process to use on a regular

basis. Another significant drawback of emergency regulations is that they are developed without any opportunity for input from the public.

Use of New Technologies without Regulatory Approval. Another issue relating to the slowness of the regulatory process has been a willingness on the part of businesses to proceed with the use of technologies that are not authorized by regulation. The primary area in which this appears to be occurring is the pharmacy profession. According to the executive director of the Board of Pharmacy, there are constant changes in drug dispensing technology. Pharmacies apparently are implementing these new technologies without waiting for regulations. According to the executive director, inspections of pharmacies by DHP inspectors often reveal pharmacists implementing technologies either contrary to or not addressed by the regulations.

Seeking Statutory Instead of Regulatory Changes. Based on interviews with DHP staff and board members, another consequence of the slowdown in the regulatory process has been a developing perception that the legislative process is a preferable means in which to seek changes to the regulation of health care professionals that would ordinarily be made through the regulatory process. According to one executive director, provisions are now being introduced as legislation that clearly belong in regulation because the legislative process is more efficient. The current chair of the Board of Medicine stated that he believes interests seeking a legal change will now try to have that change passed into law instead of regulation even though the change could be made through regulation.

Administrative Law Advisory Committee (ALAC) Should Examine Delays in Rulemaking That Are Due to New Executive Branch Review Processes

JLARC staff's review of the regulatory process indicates that for the Department of Health Professions and the health regulatory boards (which are major regulatory actors), implementation of the current process has been too cumbersome and time-consuming. A review of the health regulatory boards' regulatory time frames indicates that the pre-NOIRA stage and the executive branch review of proposed regulatory packages (in advance of their publication in proposed form) have contributed substantially to lengthening the process for these particular regulations.

While a consistent pattern of delay in the promulgation of the regulations of the health regulatory boards is evident from this review, it was beyond the scope of this review to examine the process for all agencies. However, the concerns identified in this review need to be fully examined by ALAC, which is currently conducting a two-year study of the regulatory process pursuant to Senate Joint Resolution 285. The ALAC review is focusing on time frame issues and rule-making process exemptions.

Recommendation (11). As part of its review, the Administrative Law Advisory Committee needs to scrutinize how much time is utilized in the regulatory process that is not specifically required by the Administrative Process Act and does not contribute to public participation, such as the Pre-Notice of

Intended Regulatory Action, and the executive branch review and approval process for proposed regulation packages. If ALAC's data indicate that the health professions regulatory boards experience of substantial delays in the pre-NOIRA and other executive branch review processes is unique, then ALAC and the Secretary of Health and Human Resources need to examine how delays in the executive branch review of these particular regulations can be avoided. If the experience of the health regulatory boards is not unique, then: (1) ALAC and the Governor should consider elimination of the formal pre-NOIRA process, and (2) ALAC and the Governor should consider ways to substantially streamline the executive branch review of proposed regulatory packages to make that review more timely and efficient.

IV. Financial and Non-Disciplinary Staffing Issues Within the Department of Health Professions

The *Code of Virginia* requires each of the 12 health regulatory boards to generate the revenue necessary to carry out their functions. The boards generate the revenue for their operations through the assessment of licensure and renewal fees. With one exception, the boards do not receive any State General Fund money or federal funds. The financial division within the Department of Health Professions handles most of the financial responsibilities of the boards, including budgeting as well as projecting their revenues and expenditures.

JLARC staff's review of DHP and health regulatory board financial data indicates that over the last eight years some boards have accumulated large surpluses while other boards have accumulated large deficits. These long-term excessive surpluses and deficits are not consistent with legislative intent. Furthermore, it appears that the interest earnings from these surpluses may have been improperly transferred to the State's General Fund by the Department of Treasury.

Several modifications are needed to better ensure compliance with the *Code of Virginia*. They include: increasing the accountability of boards for their surpluses, improving the accuracy of revenue and expenditure projections, and streamlining the process for increasing fees.

Another financial concern is the Certified Nurse Aide (CNA) program. Due to the lengthy process for increasing fees, as well as other factors, the CNA program has incurred a prolonged deficit. The Board of Nursing has taken steps to eliminate the deficit, but has not been able to do so.

JLARC staff's review of non-disciplinary staffing found that while DHP staff appear to provide adequate support to the boards, restrictions on the establishment of additional full-time positions has resulted in the use of part-time staff (P-14s) in a manner that sometimes conflicts with State personnel policy. In addition, this use of P-14 staff in some instances appears to be inefficient. JLARC staff will review disciplinary staffing as part of the second phase of its review of DHP and the health regulatory boards.

SOME HEALTH REGULATORY BOARDS ARE MAINTAINING EXCESSIVE SURPLUSES

The health regulatory boards are required by statute to raise all of the funds necessary for their operations through fees collected from the practitioners they regulate. In addition, the boards are required by statute to adjust fees when revenues and expenditures do not match within ten percent. DHP's financial data demonstrates that the health regulatory boards routinely fail to meet this statutory requirement

partially because the boards do not appropriately adjust fees. In addition, the excessive surplus revenues collected by many of the boards are earning considerable interest for which the boards are not credited. This may conflict with statutory intent.

DHP Is Not Complying with the Statutory Requirement that Fees Be Adjusted So that Revenue and Expenditures Match within Ten Percent

The health regulatory boards are charged with regulating approximately 240,000 healthcare professionals and other entities, and the expense of this regulatory work is supposed to be paid by the licensure fees charged to these professionals. Section 54.1-113 of the *Code of Virginia* directs that if at the end of a biennium, revenues and expenditures for a board do not match within ten percent, then the board should adjust the fees that it imposes accordingly.

Most health regulatory boards have not been meeting this statutory requirement. For the biennium ending June 30, 1998, only two of the twelve boards (the Boards of Nursing Home Administrators and Professional Counselors) have revenues that match expenditures within ten percent. (Table 10). The Boards of Dentistry, Funeral Directors and Embalmers, and Psychology, which currently show deficits, have or are in the process of instituting fee increases to address their deficits. However, the boards with surpluses have not taken sufficient action to reduce fees. DHP's data shows that during the past eight years, most boards have incurred surpluses greater than ten percent, and that they have failed to adequately adjust their fees to reduce these surpluses (Table 11). This data indicates a pattern of non-compliance with statute.

The degree to which revenues and expenditures do not match varies widely by board. For instance, during the biennium ending June 30, 1998, three boards incurred deficits greater than ten percent. The largest percentage deficit was incurred by the Board of Psychology at 19 percent. For that same biennium, seven boards had surpluses in excess of ten percent, ranging from 13 percent (Board of Optometry) to nearly 58 percent (Board of Pharmacy).

When Notified of Projected Deficits or Surpluses Greater than 10 Percent, Boards Often Do Not Adjust Fees Accordingly

The health regulatory boards are kept informed of any discrepancies between their expenditures and revenues, but it is infrequent that boards adequately adjust their fees to ensure that these variables match within ten percent as required by statute. Despite the information boards receive regarding surpluses and deficits, there are boards that have had significant surpluses for all of the last four biennia but which have not taken action substantial enough to bring themselves into compliance with the *Code of Virginia*.

For instance, the Board of Medicine has maintained a surplus between 33 and 48 percent for the past eight years, but it has promulgated only minor changes to its

Table 10

Health Regulatory Boards' Expenditures and Revenues (July 1996 to June 1998)

Board	Revenues*	Expenditures	Surplus/ Deficit \$	Surplus/ Deficit %
Audiology & Speech Pathology	\$372,698	\$241,167	\$131,531	55%
Dentistry	1,113,582	1,287,282	(173,700)	-13
Funeral Director & Embalmers	527,528	610,357	(82,829)	-14
Medicine	8,080,209	5,833,792	2,246,417	39
Nursing**	4,932,168	4,318,945	613,223	14
Nursing Home Administrators	296,216	277,573	18,643	7
Optometry	508,579	447,146	61,433	14
Pharmacy	2,891,603	1,832,068	1,059,535	58
Professional Counselors	785,511	743,512	41,999	6
Psychology	369,722	456,196	(86,474)	-19
Social Work	638,481	503,373	135,108	27
Veterinary Medicine	957,307	668,886	288,421	43
Overall Total/ Average:	\$21,473,604	\$17,220,297	\$4,253,307	25%

*The revenues for each board include the carried forward balance from the preceding biennium.

**The CNA program is not included.

Source: DHP's 1998 Revenue Balance report.

fees once during that same period. These changes decreased some fees but increased others. Another example is the Board of Pharmacy, which has had budget surpluses ranging from 32 to 58 percent during this same time period, yet the Board only voted for a one-time fee reduction for 1994 license renewals. After this one-time fee reduction, the Board's surplus continued to grow.

Recommendation (12). The health regulatory boards should take prompt action at the end of each biennium to adjust fees when revenues and expenditures are not within ten percent so as to comply with § 54.1-113 of the Code of Virginia.

Table 11

**Percentage Boards' Biennial Revenues
are Over or Under Expenditures**

Board	7/90-6/92	7/92-6/94	7/94-6/96	7/96-6/98
Audiology & Speech Pathology	-29	96	119	55
Dentistry	10	-3	6	-13
Funeral Directors & Embalmers	24	25	-1	-14
Medicine	48	33	37	39
Nursing*	10	-6	1	14
Nursing Home Administrators	-58	-24	8	7
Optometry	64	75	16	14
Pharmacy	39	32	51	58
Professional Counselors	38	47	42	6
Psychology	5	-11	11	-19
Social Work	35	53	42	27
Veterinary Medicine	93	100	57	43

*The CNA program is not included.
Source: DHP's Revenue Balance reports.

The Health Regulatory Boards Are Not Credited with All the Interest Earned from Their Surplus Revenue

For each of the past eight years, the total surplus of the health regulatory boards has continuously been between \$3.3 and nearly \$4 million (Table 12). The Department of Treasury invests this surplus, along with the other surplus funds they manage, on behalf of the Commonwealth. The Department deposits interest earned from the investment of the surplus into the General Fund. As a result, neither DHP nor the health regulatory boards are notified of, or directly credited with, this interest.

Some of this interest revenue is credited towards the indirect costs associated with the State agencies which provide services to DHP. Part of the interest is also used

Table 12**Boards' Biennial Surpluses and Deficits**

Board	7/90-6/92	7/92-6/94	7/94-6/96	7/96-6/98
Audiology & Speech Pathology	(\$29,336)	\$100,878	\$203,865	\$131,531
Dentistry	87,107	(33,415)	65,926	(173,700)
Funeral Directors & Embalmers	109,964	124,633	(3,876)	(82,829)
Medicine	1,923,686	1,733,850	1,945,944	2,246,417
Nursing*	303,804	(230,863)	34,422	613,223
Nursing Home Administrators	(106,942)	(47,307)	16,940	18,643
Optometry	188,498	257,344	73,306	61,433
Pharmacy	572,240	542,770	871,762	1,059,535
Professional Counselors	127,443	200,707	244,321	41,999
Psychology	11,703	(30,113)	42,599	(86,474)
Social Work	101,609	177,095	200,539	135,108
Veterinary Medicine	411,457	569,396	394,483	288,421
Total	\$3,701,233	\$3,364,975	\$4,090,231	\$4,253,307

Note: The balances for each board include the carried forward balance from the preceding biennium.

*The CNA program is not included.

Source: DHP's Revenue Balance reports.

to pay a private bank to accept, account for, and deposit various fees DHP is responsible for collecting. However, even after these payments are deducted, there remains a substantial amount of interest revenue that is transferred to the General Fund.

This practice may not be consistent with the intent of § 54.1-2400 of the *Code of Virginia*, which specifies the boards' powers. Among other items, the statute authorizes the health regulatory boards:

To levy and collect fees for application processing, examination, registration, certification or licensure and renewal that are sufficient to cover all expenses for the administration and operation of the De-

partment of Health Professions, the Board of Health Professions and the health regulatory boards.

The language of this provision implies that the funds collected through fees are to be used to pay for expenses related to regulation of the professions. There is no indication that the General Assembly intended for the fees collected from health professionals to be used for any other purpose. The interest generated from the fees would appear by extension to also be funds that should only be used to pay expenses associated with regulating those licensees who paid them. Therefore, it does not appear to be appropriate to transfer this interest to the General Fund.

***Recommendation (13).* The General Assembly may wish to clarify its intent regarding the use of interest accrued from revenue generated by health profession licensure fees.**

MODIFICATIONS ARE NECESSARY TO ENSURE THAT BOARDS MEET THE STATUTORY REQUIREMENT

JLARC staff have identified three changes that are necessary to better ensure that the boards comply with the ten percent requirement. The *Code* needs to be amended to expressly allow for exceptions to the ten percent requirement but to require that boards justify the need for such exceptions and that they be held accountable for deviations from the ten percent requirement. In addition, DHP needs to evaluate the process it uses to develop revenue and expenditure projections in order to improve the accuracy of these projections. Finally, the process for increasing fees charged to those regulated by the health regulatory boards should be streamlined.

Statutory Changes May Be Necessary to Make Boards Accountable for Deviations from the Ten Percent Rule

DHP staff are inappropriately relying on informal advice from the Office of the Attorney General (OAG) which suggests that fees do not necessarily have to be automatically adjusted at the end of a biennium when deficits or surpluses exceed ten percent. DHP staff stated that they have been told by the Office of the Attorney General that if DHP's projections indicate that financial conditions in the next biennium will eliminate the excessive deficit or surplus, fees do not have to be automatically adjusted. However, the OAG has not provided any written interpretation of this statutory requirement, and the language of the statutory provision does not appear to support such an interpretation.

Furthermore, even this loose interpretation of the *Code* does not appear to justify the surpluses maintained for the past four biennia. For instance, seven of the

boards have experienced surpluses in excess of ten percent for three or four of the past four biennia. In many instances, the finance division uses general projections of increased spending for future biennia to justify these continued surpluses. However, the *Code* does not recognize future projections as a ground for not adjusting fees to address excess surpluses.

While the language of § 54.1-113 of the *Code* does not indicate that there are exceptions to this ten percent requirement, there would appear to be instances in which it would not be sensible to adjust fees to eliminate excessive surpluses or deficits. There may be situations in which a board has incurred an excessive surplus or deficit during a biennium, but knows based on expenditure and revenue projections for the next biennium that the surplus or deficit will be eliminated without a fee adjustment. For example, the Board of Medicine has inappropriately accrued a large surplus over the past eight years, but it is now facing additional expenditures in the next biennium to develop a physician profile databank that is mandated under State law. Although these funds have been accumulated in violation of statutory intent over the years, it now seems to make sense to set aside these funds, with legislative approval, for the new databank rather than initiate a fee reduction.

Recognizing that there may occasionally be the need to retain surpluses in excess of ten percent, § 54.1-113 needs to be amended to reflect this. However, along with this authority to request exceptions to the ten percent rule, safeguards need to be established to ensure that exceptions are only granted when clearly justified. In instances in which DHP or a board believes that an exception to § 54.1-113 should be granted, the board should be required to prepare a formal written request, approved by the Secretary of Health and Human Resources, which sets forth in detail the reasons that an exception to the requirement is being requested. This request should be submitted to either the House Appropriations and Senate Finance committees or the Department of Planning and Budget for final review and consideration. If a board's request is denied, it should be required to immediately take action to adjust fees appropriately.

***Recommendation (14).* The General Assembly may wish to consider amending § 54.1-113 of the *Code of Virginia* to allow for an exception to the ten percent requirement when projections for the upcoming biennium indicate that the excess surplus or deficit of a board will be eliminated during the biennium. The General Assembly may wish to further consider requiring in the *Code of Virginia* that a board seeking an exception to the ten percent rule set forth the reasons for such a request in writing and that the request be subject to external review and approval by either: (1) the House Appropriations and Senate Finance committees, or (2) the director of the Department of Planning and Budget. The health regulatory boards should take prompt action to adjust fees appropriately when a request for an exception is denied.**

DHP Needs to Improve Its Revenue and Expenditure Projections

The substantial difference between DHP's revenue and expenditure projections and actual figures has contributed to the boards' failure to comply with the statutory requirement that expenditures and revenues match within ten percent. On average, there was an 11 percent difference between DHP's revenue projections and the actual revenue received in the last biennium, and DHP's expenditure projections were on average 17 percent higher than actual expenditures during that same period (Figure 6). Imprecise projections make it more difficult for boards to plan for the future and meet the ten percent requirement. Moreover, the inaccuracy of the projections raises questions about the process used by DHP to develop them.

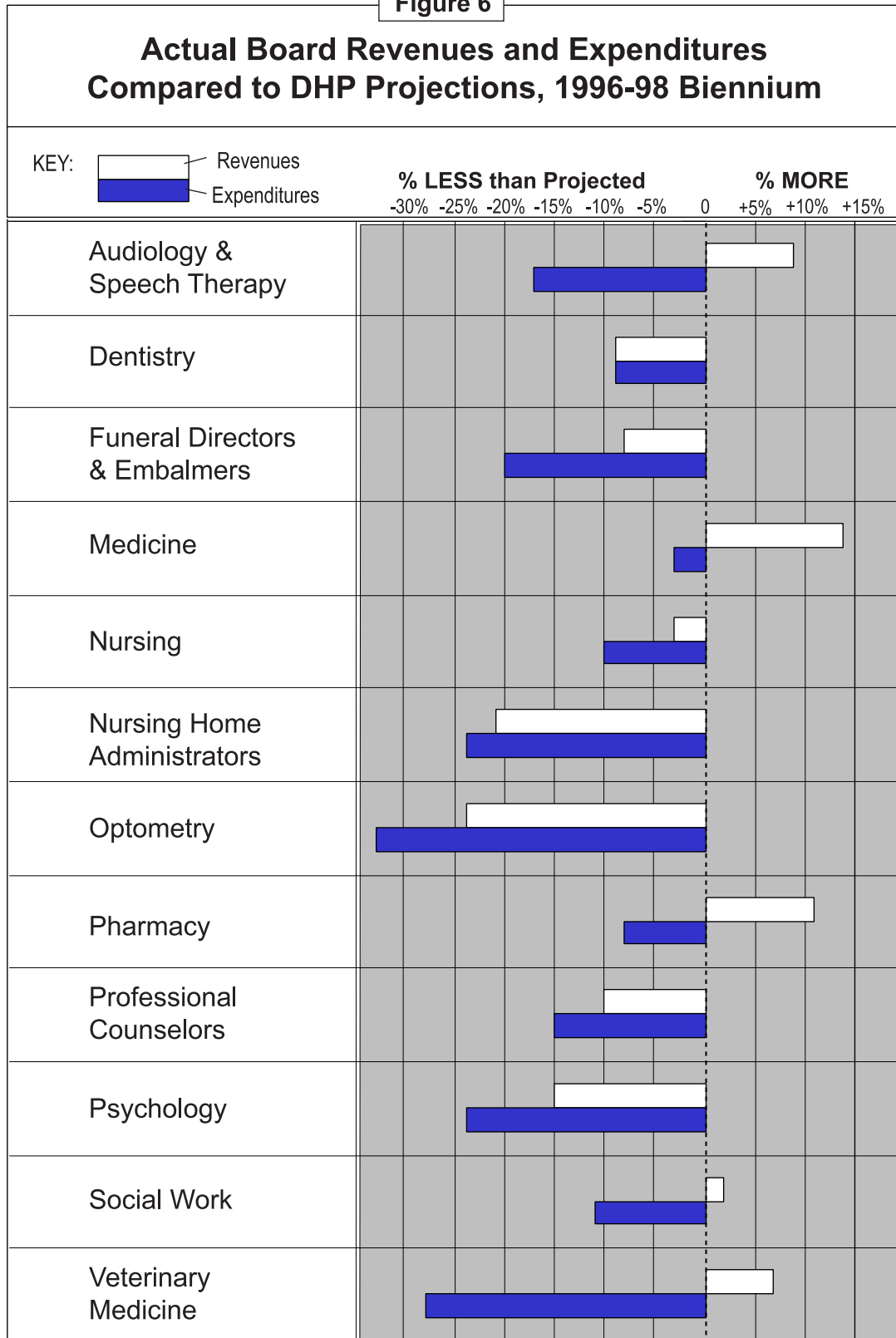
Inaccurate Projections Sometimes Make It Difficult for Boards to Adjust Fees Proactively. Due to the frequent discrepancies between projected and actual expenditures and revenue, it may be difficult for boards to know whether or not to raise, lower, or maintain fees in order to meet the statutory requirements. For instance, the Board of Veterinary Medicine was advised in August 1997 that they would be running a deficit by June 30, 1998. However, by June 30, 1998 the board was actually running a substantial surplus (Table 13). Therefore, if the Board of Veterinary Medicine had increased its fees based on the projections completed only ten months earlier, the Board's surplus would have been even more excessive.

DHP Needs to Re-Evaluate the Process Used to Project Revenues and Expenditures. DHP finance division staff have stated that their projections are sometimes inaccurate because of factors outside of their control, such as across-the-board statewide agency cuts and restrictions on hiring full-time employees. However, these factors do not explain the frequent and substantial variance between projected and actual revenues. DHP finance staff project revenues by using the previous biennium's revenues as a base and asking the boards and their staff to make changes as necessary. These changes may be due to anticipated fee increases or decreases which each board is planning or projected changes in the number of individuals regulated by each board. DHP's consideration of these factors produced revenue projections which ranged from 24 percent below to 14 percent above the actual revenues for the biennium ending June 30, 1998 (Figure 6).

Though projections cannot predict with certainty what future revenues and expenditures will be, it appears that DHP should be able to make more accurate projections than it currently does. DHP's deputy director stated that he believes the department can improve the way it makes projections. DHP finance staff also indicated that they had not recently evaluated the accuracy of their projections, or the effectiveness of the indicators they use to project revenues and expenditures.

Recommendation (15). Department of Health Professions' management should re-evaluate the method used to project the health regulatory boards' revenues and expenditures in order to improve the accuracy of these projections.

Figure 6



Source: JLARC staff analysis of DHP financial data.

Table 13

Percentage Boards' Actual and Projected Biennial Revenues Are Over or Under Expenditures

Board	Projection 7/94-6/96*	Actual 7/94-6/96	Projection 7/96-6/98**	Actual 7/96-6/98
Audiology & Speech Pathology	109%	118.68%	16.19%	54.54%
Dentistry	-18	5.53	-12.99	-13.49
Funeral Directors & Embalmers	7.46	-.59	-24.67	-13.57
Medicine	9.35	37.3	15.82	38.5
Nursing	-.18	.82	6.57	14.2
Nursing Home Administrators	22	7.62	2.10	6.72
Optometry	25.73	15.97	-.53	13.74
Pharmacy	17	50.67	30.06	57.83
Professional Counselors	21.24	41.83	-.29	5.65
Psychology	-26.57	10.7	-27.69	-18.96
Social Work	21.26	42.43	10.5	26.84
Veterinary Medicine	27.84	57.02	-4.16	43.12

*Projections tabulated November 1994.

**Projections tabulated August 1997.

Source: DHP's Revenue and Expenditure Analysis Memos to the boards.

Process to Increase Fees Needs to Be Streamlined

The difference in the efficiency of the process for increasing fees and the process for decreasing fees may exacerbate the excess surplus and deficit problem. In order to increase fees, boards must process fee changes through the full regulatory process, which can be very lengthy. In contrast, the process for decreasing fees is very efficient. The inability to raise fees efficiently when needed may place boards in difficult financial situations. In addition, the knowledge that the process to increase fees is so lengthy may make boards more reluctant to reduce fees when they incur surpluses.

Inefficient Process to Increase Fees Causes Some Boards to Prolong Deficit Situations. Some boards have run deficits for years partly due to the length of time it takes to process fee increases. Fees are established within each board's regulations. As a result, fee increases must be promulgated pursuant to the Administrative Process Act. Based on JLARC analysis of the regulatory process, it takes the health regulatory boards 22 months on average to promulgate a regulation. In one instance, it took a board three years to promulgate a fee increase. The Board of Psychology proposed a fee increase to alleviate a deficit in February 1995 that did not become effective until April 1998. During this three-year period, the board continued to run a deficit.

DHP's director and other agency managers have expressed concern that the length of time it takes to increase fees not only extends the length of time in which a board may run a deficit, but it may cause the accumulation of such a high deficit that a fee increase initially proposed is no longer adequate to meet a board's financial needs. The indefinite period of time it takes to promulgate fee increases, therefore makes it difficult to assess exactly how much the fee increase should be. This uncertainty further contributes to the DHP finance division's difficulty in projecting revenue.

Boards Can Efficiently Reduce Fees. In contrast, the process for decreasing board fees is relatively simple and efficient. In 1997, the General Assembly passed legislation which exempts fee decreases proposed by the health regulatory boards from the Administrative Process Act. If a board wishes to decrease a fee, it can do so merely by a board vote. The efficiency of this process should allow boards to more easily comply with the statutory requirement that revenues match expenditures within ten percent.

Different Processes to Increase and Decrease Fees May Reduce Compliance with Ten Percent Requirement. One of the concerns with the current disparity in the processes for increasing and decreasing fees is that the inability to efficiently increase fees makes the boards more reluctant to use their authority to decrease fees when they have excess revenue. According to the DHP director and other DHP managers, boards appear to be reluctant to decrease fees out of concern that it may take years to obtain a fee increase if they subsequently need additional revenue. As a result, there may be less willingness to adjust fees downward to comply with the ten percent requirement as long as the process for increasing fees remains lengthy.

Given the length of the regulatory process, the health regulatory boards need additional authority to more efficiently increase fees when necessary. Two options are available to achieve this. One option would be to expressly exempt fee increases from the Administrative Process Act (APA) as fee reductions currently are. The other option would be to give the health regulatory boards authority to establish fee caps through the APA and to raise fees without having to use the APA process as long as the increased fee remained under the cap. If a board determined that it needed to raise fees beyond the cap, then it would be required to first raise the cap through the APA process.

Recommendation (16). The General Assembly may wish to either amend § 9-6.14:4:1 of the *Code of Virginia* to exempt requests for fee increases by the health regulatory boards from the Administrative Process Act, or amend the *Code of Virginia* to give the health regulatory boards the authority to establish fee maximum levels through regulation so that the boards will have the discretion to increase fees up to the cap without having to use the Administrative Process Act.

THE CERTIFIED NURSE AIDE PROGRAM HAS A GROWING DEFICIT

Virginia has nearly 40,000 Certified Nurse Aides (CNAs). These professionals are employed primarily by nursing homes and home healthcare providers, and work under the supervision of nurses to assist with patient care. The Certified Nurse Aide program which regulates CNAs has accumulated a deficit of more than \$300,000 during the past three years. The CNA program is federally mandated and initially relied on federal funds to cover most expenses. However, the federal government has significantly reduced its funding for the program in recent years. DHP has made attempts to eliminate the CNA program's deficit, but these initiatives have not been successful. The CNA program is currently borrowing money from other health regulatory boards, which appears to violate the intent of the *Code of Virginia*.

The CNA Program Is Federally Mandated

The federal government, as part of the Omnibus Budget Reconciliation Act of 1987, required the states to establish a certification process and registry for CNAs. Federal requirements mandate that allegations of patient abuse and neglect and misappropriation of patient property made against CNAs be investigated and appropriately processed. Findings against CNAs for abuse or neglect of patients or misappropriation of patient property must be noted on the registry. Federal law further states that nursing homes which receive Medicare and Medicaid funds cannot employ CNAs who have been found culpable of such charges.

CNA Program Is Funded Primarily by Medicaid and Medicare

Unlike other regulatory programs for health care professionals in the State, the CNA program receives most of its funding from sources other than licensee fees. The CNA Registry and the other costs associated with regulating nurse aids are largely funded through Medicaid and Medicare. A small percentage of the program's funding also comes from the State's General Fund. The remainder is funded through certification renewal fees charged to CNAs. Federal law prohibits charging CNAs a fee for their initial certification, but it does allow the Board of Nursing to assess a renewal fee. Table 14 shows that in FY 1993, Medicaid and Medicare covered 95 percent of the costs

Table 14

**Percentage of CNA Program Funding
from Each Revenue Stream
(Fiscal Years 1993 to 1998)**

Fiscal Year	Medicare	Medicaid	General Fund	Renewal Fees	Loans from Other Boards
1993	30%	65%	5%	<1%	0%
1994	29	65	6	<1	0
1995	34	60	6	<1	0
1996	20	34	4	19	23
1997	21	43	3	33	<1
1998	20	43	4	22	11

Source: JLARC analysis of DHP and Department of Health financial data.

of the CNA program, but that by FY 1998, Medicaid and Medicare funded only 63 percent of the program's costs.

**Medicare and Medicaid Funding for the CNA Program
Was Significantly Reduced, Creating a Deficit**

The CNA program began incurring a deficit in FY 1996, when the Medicare funding for the CNA program was decreased by approximately 40 percent, and Medicaid funding was cut by 42 percent. Medicare and Medicaid funding has increased since the 1996 budget cuts, but the funding is still substantially below the program's funding level prior to those cuts. Moreover, the number of CNAs has increased, as have the expenditures associated with their regulation. As a result, the CNA program deficit is growing.

As an explanation for the decrease in funding to the program, the federal Health Care Financing Administration (HCFA) stated that Virginia's CNA program costs more than that of other states and that federal requirements could be met without some of the more costly components of Virginia's program. The federal government did not require changes to the program, but said that it would not continue to provide funding to pay for what were seen as unnecessary aspects of it.

Virginia's program does appear to be more extensive than required by federal law. This is largely due to written advice from the Office of the Attorney General, which states that CNA disciplinary cases must be handled through the Administrative Process Act (APA) like disciplinary cases for other regulated health professionals. Pursuant to the APA, Virginia's Board of Nursing provides some due process protections for the CNAs against whom allegations have been made which federal law does not guarantee.

In Virginia, all allegations against CNAs are investigated, prepared by legal staff, and heard by at least a portion of the Board with legal staff present. In contrast, federal law only requires that CNAs be notified of allegations against them. If the CNA does not respond, a finding of patient abuse, neglect, or misappropriation of patient property is automatically issued against the certificate holder. If the CNA disputes the allegation, a hearing must be held, but the federal requirements for these hearings are not as involved as those required for such proceedings in Virginia.

Board of Nursing Has Not Been Able to Eliminate the Program Deficit

In order to compensate for funding cuts to the CNA program, Virginia has taken several actions. The State has: decreased the number of investigations conducted in response to complaints against CNAs, minimized suspensions and revocations of nurse aides' certificates because more severe sanctions generally involve more costly proceedings, requested and received additional Medicaid funding for the program, and requested a renewal fee and a renewal fee increase for CNAs. Despite these efforts to decrease costs and increase revenue, CNA program funding has not kept pace with the growing demands on the program and the overall decline in federal funding.

Board of Nursing Needs to Take Action to Address the Deficit

It appears that the Board of Nursing's current plan for handling the CNA program's deficit is to continue borrowing from the surpluses of other health regulatory boards. However, the *Code of Virginia* clearly stipulates that the Board of Nursing is responsible for regulating CNAs. Therefore, it does not appear that the *Code* allows the Board of Nursing to use funds from other health regulatory boards on an indefinite basis to pay for the expenses incurred in regulating CNAs.

The Secretary of Health and Human Resources, with the assistance of the Department of Health Professions and the Department of Planning and Budget, needs to further explore available options and develop a plan to eliminate the deficit and adequately fund the program in the future. Options that should be pursued include seeking additional Medicare and Medicaid funding, increasing the renewal fee charged to certified nurse aides, and obtaining funding from nursing home owners.

***Recommendation (17).* The Secretary of Health and Human Resources, with the assistance of the Department of Health Professions and the Department of Planning and Budget, should: (1) examine possible funding options, including additional Medicare and Medicaid funding, for fully funding the Certified Nurse Aide program; and (2) develop a plan for funding the program. This plan should be presented to the House Appropriations and Senate Finance committees by February 1, 1999.**

RESTRICTIONS ON HIRING NEW STAFF HAVE RESULTED IN THE INAPPROPRIATE USE OF P-14 EMPLOYEES

With its current agency-wide staffing level of 120 FTE salaried positions and 16 FTE wage positions, DHP appears to generally have sufficient staff resources to perform its non-disciplinary functions effectively. However, the department may be using P-14 staff inappropriately in some instances to fill staffing needs for which it cannot obtain approval to hire full-time staff. In some instances, P-14 employees are being used to perform duties which are critical to the operation of DHP and the boards, and which are full-time in nature. The use of P-14 employees in these positions appears to be contrary to State personnel policy, and may not be the most efficient and effective way of meeting DHP's staffing needs. (As mentioned previously, JLARC staff will review staffing issues in the disciplinary area as part of its phase two report which will be completed in 1999).

DHP Staff Appear to Provide Adequate Support to the Boards

Based on interviews, observation of meetings, and surveys, DHP staff appear to provide effective support to the boards that they serve in the areas not directly related to discipline. In the JLARC survey of board members, 81 percent of members responded that the executive director serving their board provided adequate support to their board. Furthermore, in interviews with current and former chairs of the health regulatory boards, all of those chairs expressed satisfaction with the support provided by department staff. However, many of the board chairs did raise concerns that the staff appeared to be overworked, and that they appeared to need some assistance.

DHP Uses P-14s in Place of Full-Time Employees Because of Staffing Restrictions

In addition to DHP's full-time staff of 120, it currently employs 42 part-time employees who are classified as P-14 staff. The total hours worked by these P-14s in FY 1998 equated to approximately 16 full-time-equivalents (FTEs), or 12 percent of the agency's workforce. It appears that one of the major reasons why DHP makes extensive use of P-14 positions relates to the difficulty the agency has had in obtaining approval to hire full-time employees. Despite a steady increase in the agency's workload, the agency's maximum employment level (MEL) has declined from 132 in 1994 to 119 presently. During the period from 1994 to 1998, the DHP director requested additional full-time positions, but these requests were denied. As a result, the agency was forced to hire P-14s when the workload demanded additional employees.

Several DHP managers told JLARC staff that they had requested additional full-time staff on numerous occasions over the last four years. In some instances, the requests were specifically to convert P-14 positions into full-time positions. However, such requests generally were denied. As a result, managers began to request P-14s

instead of full-time positions because they recognized that requests for full-time positions would be denied.

DHP's Use of P-14s Sometimes Violates the Intent of Personnel Policy and Is Inefficient

According to the Department of Personnel and Training's *Policies and Procedures Manual*, P-14 (or wage) employees are supposed to "supplement the work force during seasonal or temporary workloads, to provide interim replacements, or to perform short-term projects or other jobs that do not require full-time classified employees." However, it appears that DHP is currently using some P-14 employees to meet agency employment needs which do not match this definition. In addition, the use of temporary part-time staff to meet full-time agency needs appears to be inefficient.

The Use of Some P-14s Violates the Intent of Personnel Policy. Many P-14 staff are used by DHP on a regular basis to perform the duties and responsibilities of DHP and the boards. Although DHP appropriately uses P-14s in some instances, many P-14s are being used to perform responsibilities that should be handled by full-time staff.

DHP uses a number of practices which appear to be outside the intended use of P-14s as defined by DPT's *Policies and Procedures Manual* to ensure that the work of the agency is completed. For example, DHP will sometimes hire multiple P-14s to split a full-time job. In other instances, DHP has employed a P-14 to work the maximum 1,500 hours permitted under State personnel policy for the year, and then has hired an employee from a temporary agency to fill the position for the remainder of the year. There have also been instances in which DHP and the cabinet secretary have approved requests for a P-14 to work in excess of 1,500 hours during a year for several consecutive years. In other situations, P-14s have been hired to perform what are in essence full-time jobs, and then classified staff are required to work overtime to perform the duties the part-time worker does not have time to complete. DHP must compensate many of these employees who work over-time with either time-and-one-half wages or compensatory time.

Many executive directors and division managers have stated that the work performed by P-14s is critical to the operation of DHP and the boards, and they would like many of these P-14 positions to be converted to full-time classified positions. In some instances, managers have hired P-14 staff to perform duties that had once been assigned to full-time classified workers. In other instances, they have hired P-14 staff after being denied requests for additional full-time positions.

Following are two examples of P-14 employees who are charged with responsibilities at DHP which appear to be both important to the agency's operation and full-time in nature.

One P-14 employed by DHP is a regulatory specialist who reports directly to the deputy director. This individual prepares the regulatory

packages for the agency's regulations, conducts and coordinates policy studies, and coordinates legislative packages and tracking. Many of these duties were performed by the deputy director of policy until 1994, when this position was eliminated. Many managers within the agency, as well as board members, have stated that this individual has very specialized knowledge without which the agency would not operate as smoothly.

Supplemental budget requests have been submitted by the department director for at least the last two biennia requesting to convert this P-14 position into a full-time classified position. These requests have been denied. However, the cabinet secretary has approved multiple requests to allow this individual to work more than 1,500 hours in a year. In FY 1998, this employee worked 1,691 hours and earned \$34,017.

* * *

Another P-14 employed by DHP provides the bulk of clerical support for three boards. Her duties include answering phone calls, reviewing and recording continuing education credits, and processing mail. For the past two years, this individual has worked 1,500 hours prior to the end of the fiscal year. Due to this limit on hours, she was effectively unemployed for approximately one month each year, and she applied for and received unemployment benefits.

During the time this individual was collecting unemployment, the three boards continued to need clerical support. Therefore, one year the agency hired a temporary worker from an employment agency to perform these tasks. The following year the agency paid other staff additional time-and-a-half overtime to complete the duties of the P-14 while she was collecting unemployment. When the new fiscal year began, the same P-14 was re-hired by the agency. This employee earned \$17,526 in FY 1998.

These case examples reveal that DHP currently has P-14s fulfilling full-time job responsibilities. The examples also demonstrate that failure to hire full-time staff in such positions has resulted in some inefficient employment practices which also appear to be at odds with State personnel policy.

DHP's Use of P-14s Creates Additional Inefficiencies. DHP managers have also stated that there is a higher turnover rate among P-14 employees than full-time workers, because many P-14 staff are only willing to work part-time until they can find a full-time permanent job. Higher turnover means the agency has to invest more time and money in recruiting and training new employees. Managers also stated that the applicant pool is usually better for full-time classified positions than for temporary part-time positions.

Recommendation (18). The Secretary for Health and Human Resources, with the assistance of the Department of Health Professions, should re-evaluate each P-14 position and determine if it should be converted into a full-time position and report the findings of its evaluation to the House Appropriations and Senate Finance committees by February 1, 1999.

Appendixes

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Appendix A
House Joint Resolution No. 139
1998 Session

Requesting the Joint Legislative Audit and Review Commission to study the effectiveness of Virginia's health regulatory boards.

WHEREAS, Virginia's health regulatory boards regulate a number of professions, including medicine, osteopathy, chiropractic, podiatry, physical therapy, occupational therapy, respiratory therapy, pharmacy, nursing, dentistry, the practice of physician assistants, and other health professions; and

WHEREAS, the activities of the health regulatory boards are intense, requiring significant disciplinary investigations and hearings, as well as the processing of applications for licensure; and

WHEREAS, the advent and growth of the managed care industry has resulted and will continue to result in significant changes in the paradigm of health care; and

WHEREAS, the health regulatory boards' authority to regulate remains more administrative and quasi-judicial than focused on quality assurance; and

WHEREAS, the time and resources of the health regulatory boards may be becoming stretched to meet their extensive disciplinary case load; and

WHEREAS, because of the limits on time and resources, the health regulatory boards' ability to provide careful and in-depth evaluation of their disciplinary cases, while providing a licensure program designed to ensure that Virginia has high quality practitioners, may be taxed; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Legislative Audit and Review Commission be requested to study the effectiveness of Virginia's health regulatory boards. In its study, the Commission shall include: (i) an evaluation of the composition of the respective boards to determine their appropriateness vis—vis the evolving duties and responsibilities for health profession regulation; (ii) an assessment of the respective boards' appropriate roles in ensuring the qualifications of physicians and other health care professionals in this Commonwealth; and (iii) an evaluation of the respective boards' authority and activities to establish standards for high quality health care delivery by physicians and other health professionals in Virginia.

All agencies of the Commonwealth shall provide assistance to the Commission, upon request.

The Joint Legislative Audit and Review Commission shall complete its work in time to submit an interim report of its findings and recommendations to the Governor and the General Assembly no later than January 1, 1999, and shall submit a final report to the Governor and General Assembly no later than January 1, 2000 as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix B

Item 16H - 1998 Appropriation Act

Health Regulatory Boards

The Joint Legislative Audit and Review Commission shall conduct an evaluation of the Department of Health Professions, the Board of Health Professions, and the health regulatory boards. The evaluation shall include, but not be limited to, (i) follow-up of the Commission's 1982 and 1983 study recommendations related to the health regulatory boards, (ii) an assessment of the working and organizational relationships between the boards, the department staff, and the Board of Health Professions in the licensing and regulation of health professions, (iii) an examination of the efficacy, fairness and propriety with which the various statutes, duties, functions, and activities involved in the licensing and regulation of health professions are being performed and discharged, and (iv) an assessment of the Department's staffing and automated systems needed for current and future operations. The Department of Health Professions and the health regulatory boards shall cooperate fully with the Commission and shall provide all information requested by the Commission and its staff. The boards shall also provide the Commissioner's staff with full access to all disciplinary or other proceedings of the boards, including executive sessions, and to all disciplinary files and records of the boards or the Department of Health Professions. The Commission shall make an interim report to the Governor and the General Assembly no later than January 1, 1999, and a final report no later than January 1, 2000.

Appendix C

Overview of the Health Regulatory Boards and the Professions that are Regulated

This appendix provides a description of the various health regulatory boards and the professions they regulate. The discussion addresses the composition of each board, the types and numbers of professionals that each board regulates, and each board's requirements for licensure, certification, or registration as a health professional.

BOARD OF AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

The Board of Audiology and Speech-Language Pathology is responsible for regulating audiologists and speech pathologists. It has responsibility both for licensing and disciplining these professions.

Board Composition

The Board has seven members who are appointed by the Governor. The *Code of Virginia* specifies that the Board must be comprised of two licensed audiologists, two licensed speech-language pathologists, one otolaryngologist, and two citizen members. The Board is required to elect annually a chairman and a vice-chairman. The Director of the Department of Health Professions is required to act as the secretary-treasurer of the Board.

Licensees Regulated by the Board

The two health professions regulated by the Board of Audiologists and Speech-Language Pathologists are each defined in the *Code of Virginia*.

- Audiology - the practice of conducting measurement, testing and evaluation relating to hearing and vestibular systems, including audiologic and electrophysiological measures and conducting programs of identification, hearing conservation, habilitation, and rehabilitation for the purpose of identifying disorders of the hearing and vestibular systems.
- Speech-Language Pathology - facilitating the development and maintenance of human communication through programs of screening, identifying, assessing and interpreting, diagnosing, habilitating and rehabilitating speech-language disorders.

At the end of FY 1998, the Board regulated 2,226 professionals. This total included 363 audiologists and 1,863 speech-language pathologists.

Requirements for Licensure

The educational and testing requirements for licensure in each profession are similar. A prospective licensee must pass a qualifying examination approved by the Board and hold a master's degree or its equivalent from a college or university accredited by the American Speech-Language and Hearing Association. The applicant must also have had 375 hours of clinical experience.

A person may also qualify for licensure who holds a Certificate of Clinical Competence issued by the American Speech-Language Hearing Association and either: (1) has been employed in the area for which he seeks licensure for one of the past three years or two of the last five years, or (2) has passed a qualifying examination approved by the board.

A person may also obtain licensure by endorsement by meeting certain criteria. No mandatory continuing education requirements have been established for either profession.

BOARD OF DENTISTRY

The Board of Dentistry is responsible for regulating the practice of dentistry and dental hygiene. It is also responsible for the licensure of full-time faculty members of schools of dentistry in the Commonwealth.

Board Composition

The Board of Dentistry has ten members that are appointed by the Governor. The *Code of Virginia* specifies that the Board must be comprised of seven dentists, two dental hygienists, and one citizen member. The professional members of the board shall be licensed practitioners of dentistry and dental hygiene, or acknowledge ability in the profession, and must have practiced dentistry or dental hygiene in the Commonwealth for at least three years.

Licensees Regulated by the Board

The Board of Dentistry regulates dentists, dental hygienists, dental and dental hygienist teachers, and dental faculty. The practices of dentistry and dental hygiene are defined in statute as follows.

- Dentistry is the branch of the healing arts concerned with the prevention, diagnosis, and treatment of diseases and restoration to health of the structure of the oral cavity, including teeth and surrounding and supporting structures.

- Dental hygiene is the practice of cleaning and polishing teeth. The practice also assists members of the dental profession in providing oral health care and oral health education to the public.

At the end of FY 1998, the Board regulated 8,297 professionals. Table C-1 presents the number of licensees by profession regulated by the Board as of July 1998.

Table C-1

Board of Dentistry Licensees

Profession	Number of Licensees
Dentists	5,177
Dental Hygienists	3,102
Dental Teachers	5
Dental Hygienists - Teachers	3
Dental Faculty	10
Total	8,297

Source: Department of Health Professions, Current Licensee Quarterly Report, July 1998.

Requirements for Licensure, Certification, and Registration

Requirements for licensure or certification of the health professions regulated by the Board of Dentistry generally include educational and testing requirements. Regulations require continuing competency requirements for both dentists and dental hygienists. Applicants for dental or dental hygiene licensure must pass an examination on the Virginia dental hygiene laws and regulations.

Educational and Testing Requirements. An applicant for dental licensure shall be a graduate and a holder of a diploma from an accredited or approved dental school recognized by the Commission on Dental Accreditation of the American Dental Association. The applicant must also successfully complete Parts I and II of the examination of the Joint Commission on National Dental Examinations prior to making application to this board, and satisfactorily pass the complete board-approved examinations in dentistry.

An applicant for dental hygiene licensure shall have graduated from or be issued a certificate by an accredited school or program of dental hygiene recognized by the Commission on Dental Accreditation of the American Dental Association, have successfully completed the dental hygiene examination of the Joint Commission on National Dental Examinations, and have successfully completed the board-approved examinations in dental hygiene. Dental hygienists who are licensed in other states are eligible to be licensed by endorsement if they meet the educational and testing requirements and pass an examination on the laws and regulations governing the practice of dentistry in Virginia.

Continuing Competency Requirements. The Board promulgates regulations governing continuing requirements for dentists and dental hygienists. The regulations require the completion of fifteen hours annually of continuing education courses for any license renewal or reinstatement. The Board approves continuing education courses that are directly related to the practice of dentistry and dental hygiene and the treatment and care of patients. A licensee is exempt from completing continuing education requirements and considered in compliance on the first renewal date following initial licensure.

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

The Board of Funeral Directors and Embalmers is responsible for regulating the activities of funeral directors, embalmers, their apprentices, and their places of business. These functions are generally described as “funeral services.” The *Code of Virginia* defines funeral services as “engaging in the care and disposition of the human dead, the preparation of the human dead for the funeral service, burial or cremation, the making of arrangements for the funeral service or for the financing of the funeral service and the selling or making of financial arrangements for the sale of funeral supplies to the public.” These services are regulated by the Board through entry standards for those seeking to perform them, and by disciplining licensees in response to public complaints.

Board Composition

The Board of Funeral Directors and Embalmers (Board) is composed of nine members. Seven of the Board’s members are funeral services licensees of the Board with at least five years experience in the field, and two members are appointed from the public. The Board’s members serve four year terms, and are to be as representative of the entire Commonwealth as possible. The *Code of Virginia* states that the Board is required to select a president, vice-president, and secretary-treasurer from among its members.

Licensees Regulated by the Board

The Board of Funeral Directors and Embalmers regulates the practices of funeral services licensees. As mentioned previously, these licensees include funeral directors, embalmers, their apprentices, and their places of business. Also regulated are those engaged in the transportation of the human dead. The following is a list of these groups and the statutory definitions of each group.

- Funeral directors are engaged in the for-profit profession of directing or supervising funerals, or preparing human dead for burial by means other than embalming. Services provided by funeral directors include conducting the arrangements conference, planning the funeral, obtaining the necessary permits, and placing obituary notices.

- Embalmers preserve and disinfect the human dead by external or internal application of chemicals.
- Trainees are persons preparing to be licensed for the practice of funeral services under the direct supervision of a practitioner licensed by the Board. Trainees are not licensed by the Board, but must be registered with it.
- Funeral services establishments are any main establishment, branch, or chapel where any part of the profession of funeral directing or the act of embalming is performed.
- Surface transportation and removal service is defined as any person, private business, or funeral service establishment, except a common carrier engaged in interstate commerce, the Commonwealth and its agencies, engaged in the business of surface transportation or removal of dead human bodies in the Commonwealth.

At the end of FY 1998, the Board had issued a total of 2,405 licenses. Table C-2 displays the various funeral services regulated by the Board and the number of licenses issued to practitioners of each service at the end of FY 1998.

Requirements for Licensure, Certification, and Registration

Those seeking to perform funeral services must be licensed by the Board. Funeral services establishments also must be licensed by the Board. Persons either training to become licensed by the Board, or engaged in transporting the human dead, are required to register with the Board. No continuing education requirements have been established for practitioners to renew their licenses.

Table C-2

Board of Funeral Directors and Embalmers Licensees

Profession	Number of Licenses
Funeral Directors	199
Funeral Embalmers	9
Funeral Service Professionals	1,359
Funeral Trainees	201
Funeral Directors – courtesy cards	106
Surface Transportation and Removal	36
Funeral Service Establishments	495
Total	2,405

Note: Courtesy cards are issued by the Board to out-of-state funeral services licensees and provide limited and restricted funeral services privileges to those licensees in the Commonwealth.

Source: Department of Health Professions, Current Licensee Quarterly Report, July 1998.

Requirements for Licensure. The requirements for a license to conduct funeral services include that the applicant should: (1) be a minimum of 18 years old, (2) be without felony convictions, (3) have graduated high school or its equivalent, (4) have graduated from an approved school of mortuary science or funeral service, and (5) have passed the examination for licensure. The examination for licensure includes the National Board Examination of the Conference of Funeral Service Examining Boards of the United States and the Virginia State Board examination. The Virginia State Board examination tests an applicant's knowledge of the restorative arts as well as funeral service administration and funeral law. A practitioner's license must be renewed with the Board annually.

In addition to practitioners, funeral services establishments are also licensed by the Board. To obtain a license, funeral services establishments must have a full-time, licensed funeral services practitioner on staff who is designated by the facility's owner as its manager. An establishment's license must be renewed each year.

Requirements for Registration. The requirements necessary to obtain a certificate of resident traineeship are similar to the basic requirements for a license to perform funeral services. The applicant must be at least 18 years of age, must be a high school graduate, and cannot have been found guilty of a felony. In addition, the applicant must submit a request to the Board to enter into training which identifies an approved licensee to supervise the applicant. The Board's training program is designed to last at least 18 months. Every six months, a report must be filed by the applicant, signed by his supervisor, detailing the work which the applicant has completed during the previous six months. A trainee cannot sit for examination by the Board for a license until he or she has assisted in embalming 25 bodies and assisted in conducting 25 funerals.

There are no requirements for registration as a provider of surface transportation services, except that an application be filed with the Board. A provider's registration must be renewed with the Board each year.

BOARD OF MEDICINE

The Board of Medicine is responsible for regulating several health professions. Its primary responsibility is the regulation of physicians of medicine and surgery through licensure and disciplinary action. However, it also has responsibility for regulating osteopaths, podiatrists and chiropractors along with physical, respiratory, and occupational therapists.

Board Composition

The Board of Medicine (Board) has 17 members that are appointed by the Governor. The *Code of Virginia* specifies that the Board must be comprised of one medical physician from each Congressional district, one osteopathic physician, one podiatrist, one chiropractor, one clinical psychologist, and two citizen members from the State at

large. The board is required to select from among its board members a president, vice-president, and secretary/treasurer.

The *Code of Virginia* also establishes seven advisory boards/committees that are appointed by the Governor or the Board and are designated to advise the Board. The advisory boards/committees established by statute are the Psychiatric Advisory Committee, the Advisory Board on Physical Therapy, the Advisory Board on Respiratory Therapy, the Advisory Board on Occupational Therapy, and the Advisory Committee on Radiological Technology, the Advisory Committee on Physician Assistants, and the Advisory Committee on Acupuncture. All but the Psychiatric Advisory Committee are active at this time.

Licensees Regulated by the Board

The Board of Medicine regulates several categories of healthcare practices. The following is a list of the professional practices that are regulated by the Board of Medicine along with the statutory or regulatory definition of the practice.

- Medicine or osteopathic medicine (medical doctors and osteopaths) - prevention, diagnosis and treatment of human physical or mental ailments, conditions, pain or infirmities by any means.
- Podiatry (podiatrists) - the medical, mechanical and surgical treatment of the ailments of the human foot and ankle.
- Chiropractic (chiropractors) - the adjustment of the 24 movable vertebrae in the spinal column.
- Physical therapy (physical therapists) - the evaluation, testing, treatment, reeducation and rehabilitation by physical, mechanical or electronic measures and procedures of persons with physical or emotional disorders.
- Acupuncture (acupuncturists) - 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.
- Respiratory therapy (respiratory therapy practitioners) - evaluation, care and treatment of patients with deficiencies and abnormalities associated with the cardiopulmonary system.
- Occupational therapy (occupational therapists) - provision of specific activities or therapeutic methods to improve or restore optimum functioning, to compensate for dysfunction, or to minimize disability of patients impaired by physical illness or injury, emotional, congenital or developmental disorders, or by the aging process.
- Radiologic technology (radiologic technologist) - the application of x-rays to human beings for diagnostic or therapeutic purposes.

For several of these practice areas, assistants are also licensed and regulated by the Board. The following assistants are regulated: physician's assistants, physical therapist assistants, and radiological technologist assistants. Two other categories of professionals regulated by the Board that have specific regulations applicable to them are interns and residents.

At the end of FY 1998, the Board regulated 43,677 health professionals. Table C-3 presents the number of licensees by profession regulated by the Board of Medicine as of July 1998.

Table C-3

Board of Medicine Licensees

Profession	Number of Licensees
Physicians of Medicine and Surgery	26,924
Osteopaths	727
Podiatrists	493
Chiropractors	1,431
Physician Acupuncturists*	193
Licensed Acupuncturists	38
Interns and Residents	2,004
Physical Therapists	3,427
Physician Assistants	461
Physical Therapist Assistants	1,171
Respiratory Therapists	2,419
Occupational Therapists	1,725
Radiological Technician Practitioner	1,658
Radiological Technologist - LTD	980
Other	26
Total	43,667

*Additional license for physicians practicing acupuncture.

Source: Department of Health Professions, Current Licensee Quarterly Report, July 1998.

REQUIREMENTS FOR LICENSURE, CERTIFICATION, AND REGISTRATION

Requirements for licensure or certification of the health professions regulated by the Board of Medicine generally include educational and testing requirements. However, only one of the professions regulated by the Board of Medicine appears to have continuing competency requirements established by law or regulation.

Educational and Testing Requirements. Educational and examination requirements vary across professional categories. The following lists the educational and testing requirements for professions that require licensure by the Board of Medicine.

- Medical doctors and osteopaths must be a graduate of a medical school approved by the Board of Medicine and complete a one year internship or residency. In addition, they are required to pass either components I and II of the Federation Licensing Examination or steps one and two of the United States Medical Licensing Examination. They must then pass step three of the United States Medical Licensing Examination.
- Podiatrists must be a graduate of a school of podiatry approved by the Board of Medicine and complete a one year internship or residency. In addition, they are required to pass an examination prepared by the National Board of Podiatric Medical Examiners as well as Virginia's Podiatric Medical Licensing Examination.
- Chiropractors must graduate from a chiropractor college approved by the Board of Medicine. They must also pass the National Board of Chiropractic Examiners examination and Virginia's chiropractic licensure examination.
- Acupuncturists must have completed the equivalent of two full academic years of undergraduate education, including at least 18 hours of biological sciences in a school recognized by the Board of Medicine, and graduated from a school or college of acupuncture approved by the Board. In addition, they must pass the following tests: the National Commission for the Certification of Acupuncturist written examination, the Practical Examination of Point Location Skills test, and the Clean Needle Technique Course.
- Physical therapists must graduate from a school of physical therapy approved by the American Physical Therapy Association.
- Physician's assistants must complete a prescribed curriculum of academic study for physician's assistants in a school or institution accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association and accredited by the American Academy of Physician Assistants, and must pass the examination administered by the National Commission for Certification of Physician Assistants.
- Physical therapist assistants must graduate from a two-year college-level program for physical therapist assistants approved by the Board of Medicine.
- Occupational therapists must complete all academic and fieldwork requirements of an accredited program and pass the National Board for Licensure in Occupational Therapy examination.
- Radiologic technologists must graduate from an educational program acceptable to the American Registry of Radiologic Technologists (ARRT) and pass the ARRT certification examination.

The regulations governing the Board of Medicine establish the following requirements for the certification of respiratory therapists.

- Respiratory therapists must pass the National Board of Respiratory Care entry level examination for physical therapy.

Continuing Competency Requirements. The only profession regulated by the Board of Medicine that currently has continuing competency requirements established by statute or by regulation are physician's assistants. They are required to comply with continuing medical education requirements established by the National Commission on Certification of Physician Assistants. The Board of Medicine is currently in the process of promulgating continuing education requirements for physicians.

BOARD OF NURSING

The Board of Nursing is entrusted with a number of responsibilities, but its primary responsibility is regulating registered and practical nurses, certified nurse aides, clinical nurse specialists, and massage therapists. The Joint Board of Nursing and Medicine, which is composed of three members from both the Board of Nursing and the Board of Medicine, regulates nurse practitioners. The Board of Nursing also develops minimum standards and approves curricula for nursing education programs, and it approves nursing education programs.

Board Composition

The *Code of Virginia* stipulates that the Board of Nursing consist of 13 members who are appointed by the Governor. Seven members are required to be registered nurses, three members must be licensed practical nurses, and the Board must include three citizen members. Board members serve four year terms. All members should be residents of Virginia and the professional nurse members must have graduated from an approved nursing program, be licensed to practice in the State, and have had at least five years nursing experience with at least three years experience directly preceding their appointment to the Board. The Board of Nursing is required by statute to meet each January and elect a president, vice-president, and secretary.

Licensees Regulated by the Board

As mentioned, the Board of Nursing regulates several categories of nurses as well as massage therapists. The following is a list of the professionals regulated by this Board as well as a brief description of the profession.

- Registered nurses provide patient care, including the administration of medication under the direction of a physician, and they may supervise or teach other nurses.
- Licensed practical nurses also provide patient care but work under the supervision of either a physician or a registered nurse.

- Certified nurse aides provide patient care under the supervision of a nurse.
- Clinical nurse specialists are registered nurses who can also provide advanced services after completion of a specialized nursing program approved by the Board of Nursing.
- Nurse practitioners are licensed registered nurses who have completed a program designed to prepare nurses for advanced clinical practice in a specialty area. They may assume additional responsibility for medical activities, including the prescription of some drugs under the direction of a physician.
- Certified massage therapists treat soft tissues for therapeutic purposes with massage and bodywork techniques.

From June 1988 to June 1998, the number of nurses regulated by the Board of Nursing has increased from nearly 80,000 to approximately 150,000. The current Board also regulates clinical nurse specialists and massage therapists. The profession with the largest growth is the certified nurse aide. As of June 1990, the Board of Nursing certified 15,511 nurse aides; by July 1998 the number certified increased to 39,197. Table C-4 provides a list of the number of professionals regulated by the Board of Nursing as of July 1998.

Table C-4

Board of Nursing Licensees

Profession	Number of Licensees
Nurse Practitioners*	3,344
Registered Nurses	76,781
Licensed Practical Nurses	26,553
Clinical Nurse Specialists	439
Prescriptive Authority	1,393
Massage Therapists	1,477
Certified Nurse Aides	39,197
Total	149,184

*Nurse Practitioners are regulated by the Joint Board of Nursing and Medicine.
Source: Department of Health Professions, Current Licensee Quarterly Report, July 1998.

Requirements for Licensure, Certification, and Registration

The professionals regulated by the Board of Nursing are required to meet basic educational, testing, and training requirements before they are eligible for licensure, certification, or registration. There are no continuing competency requirements for the professions regulated by the Board of Nursing.

The following is a summary of the educational, testing, and training requirements for each applicant's respective profession.

- Registered nurses must have a high school diploma, a degree from an approved professional nursing education program, and pass a written exam approved by the Board.
- Licensed practical nurses must complete two years of high school or its equivalent, hold a diploma from an approved practical nursing program, and pass a written exam approved by the Board.
- Certified nurse aides must successfully complete a nurse aide education program approved by the Board, or the applicant must be enrolled in a nursing education program preparing for licensure to be a registered or practical nurse. In case of the latter, the applicant must also complete at least one nursing course which includes clinical experience involving client care, or complete a nursing education program preparing for registered nurse license or practical nurse license, and have passed a competency evaluation.
- Clinical nurse specialists must register with the Board of Nursing. This requires that applicants have a registered nurse license in Virginia, hold a degree from an approved nursing program, and receive specialty certification from a national certifying organization.
- Certified massage therapists must be 18 years or older, complete at least 500 hours of training from an approved massage therapy program, pass the National Certification Exam for Therapeutic Massage and Bodywork or an exam deemed acceptable by the Board of Nursing; or the Board may certify an applicant who has been practicing massage therapy for up to ten years prior to July 1, 1997 and completes at least 200 hours of training in an education program, or passed the National Certification Exam for Therapeutic Massage and Bodywork prior to 1994.
- Nurse practitioners are licensed by the Joint Board of Nursing and Medicine. Nurse Practitioner applicants must be licensed as a registered nurse in Virginia, and complete an educational program for nurse anesthetists, nurse midwives or nurse practitioners which is approved by the Joint Board or accredited by a professional organization deemed acceptable. The applicant must also be certified by a professional organization accepted by the Joint Board.

BOARD OF NURSING HOME ADMINISTRATORS

The Board of Nursing Home Administrators is responsible for regulating nursing home administrators through licensure. The Department of Health has responsibility for licensing nursing homes, but all homes must be under the supervision of a licensed nursing home administrator.

Board Composition

The Board of Nursing Home Administrators has seven members that are all appointed by the Governor. Three of the members must be licensed nursing home administrators and four must be from institutions or professions concerned with the care and treatment of the chronically ill and elderly patients. Two of the members must be administrators of proprietary nursing homes.

Licensees Regulated by the Board

The only category of licensee regulated by the board is a nursing home administrator. A nursing home administrator is defined by statute as “any individual charged with the general administration of a nursing home.” As of July 1998, there were 751 licensed nursing home administrators in Virginia. In addition, the Board regulates 159 preceptors.

Requirements for Licensure

The regulations provide several means to qualify for licensure. Applicants must pass the State and national examination. In addition, an applicant must possess a baccalaureate or higher degree in one of several programs, including a 400 hour practicum, or complete a 2,080 hour administrator-in-training program. A person licensed in another state may also apply for licensure by endorsement. All licensees must take 20 classroom hours of continuing education each year.

BOARD OF OPTOMETRY

The Board of Optometry is charged with regulating the professional practices of optometrists. Optometry defines the practice of examining the human eye for defects or abnormalities correctable through the use of lenses or visual training. The Board of Optometry meets its regulatory responsibilities by setting standards for applicants seeking entry into the profession, and by disciplining its licensed practitioners.

Board Composition

The Board of Optometry (Board) is composed of six members, five of which are licensed optometrists. The remaining position is designated for a citizen member. Members of the Board serve four year terms, and are appointed by the Governor. Prior to any optometrist's appointment, the individual must have been in practice for at least five years.

Licensees Regulated by the Board

As of July 1998, the Board had issued 1,278 licenses to practice optometry. Optometrists, however, are one of three groups of professionals engaged in the care of the human eye. The other two groups are ophthalmologists and opticians. Ophthalmologists are doctors which specialize in the treatment of diseases or other abnormalities of the eye through medication, surgery or the prescription of lenses. This group of professionals is regulated by the Board of Medicine. Opticians are licensed professionals engaged in the business of filling eye care prescriptions for corrective glasses or contact lenses. This group of professionals is regulated by the Board of Opticians, which is not associated with the Department of Health Professions or the Board of Health Professions.

Like ophthalmologists, optometrists examine the eye for defects or other abnormal conditions. In addition, they may prescribe lenses to correct these defects or abnormalities. *Certified* optometrists may even use medications under limitations to treat defects or abnormalities of the human eye, but optometrists cannot perform eye surgery or utilize other invasive medical techniques.

Requirements for Licensure and Certification

As mentioned previously, the applicants for licenses have to meet certain requirements prior to obtaining their licenses. In addition, many optometrists have met additional requirements necessary to become certified optometrists. The requirements for licensure, certification, and renewal of licenses are outlined in this section.

Requirements for Licensure. In order to obtain a license to practice optometry, an applicant must meet four conditions. The applicant must: (1) be a graduate of a school of optometry approved by the Council on Optometric Education, (2) have passed the examination administered by the National Board of Examiners in Optometry, (3) have passed a practical examination administered or accepted by the Board, and (4) have passed an examination concerned with Virginia's laws about the practice of optometry.

Requirements for Certification. Licensed optometrists may also obtain a certification which permits them to administer medications for the treatment of certain afflictions of the human eye under limited conditions. The requirements for this certification were established by the Board of Medicine, and include classroom instruction in pharmacology and laboratory work. In addition, optometrists who apply for the certification must pass an examination which is administered by the Board of Medicine. As mentioned previously, this certification does not permit optometrists to perform surgery or other invasive medical techniques to correct abnormalities of the eye.

Continuing Competency Requirements. Optometrists are required to renew their licenses by October 31 of each year. Renewal of the license, however, is conditioned upon the optometrist's submission of proof that he or she attended 12 hours of

continuing education during the previous license period. All continuing education courses must pertain directly to the care of patients.

BOARD OF PHARMACY

The Board of Pharmacy is charged with the responsibility of regulating the manufacturing, dispensing, selling, distributing, processing, compounding, and disposal of drugs, cosmetics, and devices used to diagnose, treat, or prevent disease. Regulation of these activities involves: the licensure and discipline of pharmacists; the investigation of complaints about the quality and strength of drugs, cosmetics, and devices sold in the State; and the inspection of pharmacies or any other place in Virginia where drugs, cosmetics, and devices are manufactured, stored or dispensed. Much of the Board's authority is derived from Virginia's Drug Control Act.

Board Composition

The Board of Pharmacy (Board) consists of ten members, eight of whom are licensed pharmacists. Two members of the Board are appointed from the public at large. Board members serve four year terms, and are appointed by the Governor. According to the *Code of Virginia*, the Board is to annually select a chairman from among its members, and a majority of the Board's members represents a quorum.

Licensees Regulated by the Board

A number of individuals and businesses are regulated by the Board. These individuals and businesses must either obtain a license, permit, or registration certificate from the Board before they engage in the manufacturing, selling, distribution, or dispensing of drugs, cosmetics, and devices used to diagnose, treat, or prevent disease. The following list provides a statutory definition for each of the individuals or businesses licensed, permitted, or registered under the authority of the Board of Pharmacy.

- Pharmacists – Professionals practicing the art and science of selecting, procuring, recommending, administering, preparing, compounding, packaging, and dispensing of drugs, medicines, and devices used in the diagnosis, treatment, or prevention of disease. This includes the proper and safe storage and distribution of drugs, the maintenance of proper records and the responsibility of providing information concerning drugs and medicines and their therapeutic values and uses.
- Pharmacies – An establishment or institution in which the practice of pharmacy is conducted.
- Permitted physicians – Physicians licensed by the Board to dispense drugs to persons to whom a pharmaceutical service is not reasonably available. The

physician, when dispensing drugs, is governed by the regulations of the Board of Pharmacy.

- Medical equipment suppliers – Individuals or businesses which deliver to the ultimate consumer, pursuant to a lawful order of a practitioner, hypodermic syringes and needles, medicinal oxygen, controlled devices, and those controlled substances with no medicinal properties which are used for the operation and cleaning of medical equipment.
- Wholesale distributors – Any person engaged in distributing prescription drugs to persons other than consumers and patients.
- Warehouseurs – Any person, other than a wholesale distributor, engaged in the business of selling or otherwise distributing prescription drugs or devices to any person who is not the ultimate user or consumer.
- Restricted manufacturers – Any person who desires to manufacture a proprietary medicine or cosmetic in Virginia must obtain a permit from the Board.
- Non-restricted manufacturers – Any person who desires to manufacture any drug, proprietary medicines, cosmetic, or device shall annually apply to the Board for a permit to do so.
- Humane societies – Humane societies are permitted by the Board to buy, possess, and use drugs approved by the State Veterinarian for the purpose of euthanizing injured, sick, homeless, and unwanted domestic pets and animals.
- Controlled substances registration – Every person who manufactures, distributes, or dispenses any highly controlled substance or who proposes to engage in the manufacture, distribution, or dispensing of a highly controlled substance, with the exception of licensed pharmacies and pharmacists, shall obtain a controlled substances registration certificate.

Table C-5 displays the various individuals and businesses which the Board regulates through its licenses, permits, or registration and the total number of licenses, permits, or registrations which were issued to those groups as of July 1998.

Requirements for Licensure, Certification, and Registration

Although many individuals and businesses must be licensed, permitted, or registered with the Board of Pharmacy, the *Code of Virginia* only specifies licensure requirements for pharmacists. For all other professions involved in the manufacturing, selling, or dispensing of drugs, cosmetics, and devices, the Board routinely issues licenses, permits, and registration certificates upon application, unless the Board has reason to believe that issuance of the license may endanger the public health.

Table C-5

Board of Pharmacy Licensees and Registrants

Profession	Number of Licensees and Registrants
Pharmacists	7,638
Pharmacies	1,613
Non-resident pharmacies	226
Permitted physicians	22
Physicians selling drugs	235
Medical equipment suppliers	178
Wholesale distributors	137
Non-resident wholesale distributors	226
Warehouses	19
Restricted manufacturers	72
Non-restricted manufacturers	22
Humane societies	89
Controlled substance registration	3
Business controlled substance registration	231
Optometrist controlled substance registration	423
Continuing education provider	1
Total	11,135

Source: Department of Health Professions, Current Licensee Quarterly Report, July 1998.

Requirements for Licensure. In order to become licensed to practice as a pharmacist, an applicant must meet five criteria. The criteria are: (1) he or she must be at least 18 years of age, (2) the applicant must be of good moral character, (3) the applicant must be a graduate of an approved school of pharmacy, (4) he or she must have had a period of practical experience in excess of six months under the supervision of a licensed pharmacist, and (5) the applicant must have passed the examination prescribed by the Board of Pharmacy.

Continuing Education Requirements. Pharmacists must renew their licenses to practice by December 31 of each year. That renewal, however, is contingent upon their completion of a minimum of 15 hours continuing pharmacy education. Educational programs accepted by the Board include any educational program sponsored by the American Council on Pharmaceutical Education and those pre-approved by the Board.

**BOARD OF LICENSED PROFESSIONAL COUNSELORS,
MARRIAGE AND FAMILY THERAPISTS, AND SUBSTANCE ABUSE PROFESSIONALS**

The Board of Professional Counselors, Marriage and Family Therapists, and Substance Abuse Professionals (Board of Professional Counselors) is responsible for pro-

mulgating regulations governing the practice of professional counseling, marriage and family therapy, substance abuse treatment, and regulations governing the certification of substance abuse counselors and rehabilitation providers.

Board Composition

House Bill 2721 passed in the 1997 General Assembly Session redefined and expanded the list of professionals regulated by this board. As a result, board membership was increased from nine to fourteen to increase the representation of professional counselors and marriage and family therapists, and include representation by licensed substance abuse practitioners. Two board members are citizen members and the remaining twelve are licensed professionals who represent the various specialties recognized in the profession. Of these, eight are professional counselors, two are marriage and family therapists, and two are licensed substance abuse treatment practitioners. State law requires that the professional members of the board include two full-time faculty members engaged in teaching counseling, substance abuse treatment or marriage and family therapy in an accredited college or university in the Commonwealth, and two counselors engaged in full-time private practice.

Licensees Regulated by the Board

The Board of Professional Counselors is responsible for the licensure of professional counselors, marriage and family therapists, and those engaged in the independent practice of substance abuse treatment. In addition, the board certifies substance abuse counselors and rehabilitation providers. The board also promulgates regulations for the voluntary certification of its licensees as sex offender treatment providers. The following is the statutory or regulatory definition of the regulated professions.

- Professional counselor - a person trained in counseling interventions designed to facilitate an individual's achievement of human development goals and remediating mental, emotional, or behavioral disorders and associated distresses which interfere with mental health and development.
- Marriage and family therapist - a person trained in assessment and treatment of cognitive, affective, or behavioral mental and emotional disorders within the context of marriage and family systems through the application of therapeutic and family systems theories and techniques.
- Licensed substance abuse treatment practitioner - a person who: (1) is trained in and engages in the practice of substance abuse treatment with individuals or groups of individuals suffering from the effects of substance abuse or dependence, and in the prevention of substance abuse or dependency; and (2) is licensed to provide advanced substance abuse treatment and independent, direct and unsupervised treatment to such individuals or groups of individuals, and to plan, evaluate, supervise, and direct substance abuse treatment provided by others.

- Certified substance abuse counselor - a person certified to provide substance abuse counseling in a state-approved public or private substance abuse program or facility.
- Certified rehabilitation provider - a person who is certified by the Board as possessing the training, the skills and the experience as a rehabilitation provider to form an opinion by discerning and evaluating, thereby allowing for a sound and reasonable determination or recommendation as to the appropriate employment for a rehabilitation client and who may provide vocational rehabilitation services that involve the exercise of professional judgment.

Table C-6 lists the total number of licensees for the Board as of July 1998.

Table C-6

Board of Professional Counselors Licensees

Profession	Number of Licenses
Professional Counselors	2,156
Professional Counselor Supervisors	144
Post Graduate Trainees	374
Certified Substance Abuse Counselors	1,067
Marriage and Family Therapist	511
Rehabilitation Providers	2,052
Total	6,304

Source: Department of Health Professions, Current Licensee Quarterly Report, July 1998.

Requirements for Licensure, Certification, and Registration

Every applicant for initial licensure by the board must pass a written examination as prescribed by the board. In addition, every applicant must meet education and experience requirements that vary slightly by profession. In some instances, licensure by endorsement is permitted.

Educational and Supervision Requirements. Educational and supervision requirements are somewhat similar among the professions. The following lists the educational and supervision requirements for professions that require licensure by the Board of Professional Counselors.

- Professional counselors must have a graduate degree in counseling or a related discipline, from a college or university accredited by a regional accrediting agency. The applicant must also have completed 4,000 hours of post-graduate degree experience in counseling practice under supervision by a licensed professional trained in supervision.

- Marriage and family therapists must have a graduate degree in marriage and family therapy or a related discipline from a regionally accredited college or university, or a post-degree training institute accredited by the Commission on Accreditation for Marriage and Family Therapy Education. The applicant must also have completed at least two years of supervised post-graduate degree experience representing no fewer than 4,000 hours of supervised work experience by a licensed professional.
- Certified substance abuse counselors must have an official high school diploma or a general educational development (GED) certificate, and complete 400 clock hours of substance abuse education from an accredited university or college or programs, seminars or workshops approved by the board. The applicant must have completed 2,000 hours of supervised experience in the delivery of clinical substance abuse counseling services by a board approved licensed professional.
- Certified rehabilitation providers must be a graduate of a regionally accredited college or university with a degree in an education, health or human services field or a diploma in nursing or 2,000 hours of training or experience in performing those services that will be offered to a workers' compensation claimant.

Regulations have not yet been developed for licensed substance abuse practitioners so education and experience requirements are not available.

BOARD OF PSYCHOLOGY

The Board of Psychology regulates the practice of psychology in Virginia. This includes setting the standards for and licensing applied and clinical psychologists, school psychologists, and sex offender treatment providers. The Board also has responsibility for regulating these professionals through disciplinary action.

Board Composition

The Board of Psychology is composed of nine members who are appointed to four year terms and appointed by the Governor. The *Code of Virginia* requires that the Board include: five licensed clinical psychologists, one licensed school psychologist, one licensed applied psychologist, and two citizen members. The *Code* also specifies that at least one of the seven psychologist members of the Board shall be a member of the teaching faculty at an accredited college or university in Virginia.

Licensees Regulated by the Board

As mentioned, the Board of Psychology licenses clinical and applied psychologists, and school psychologists. The Board did not begin licensing clinical psychologists

until July 1, 1996; before this time clinical psychologists were regulated by the Board of Medicine. Beginning in July 1999, the Board will also be required to certify sex offender treatment providers. The following is a summary of the statutory definition of the practices regulated by the Board of Psychology.

- Clinical psychology (clinical psychologist) - psychological evaluation or assessment of personal characteristics, diagnosis and treatment of mental and emotional disorders, and psychological consulting.
- Applied psychology (applied psychologist) - use of methods of psychology to improve “organizational function, personnel selection and evaluation, program planning and implementation, individual motivation, development and behavioral adjustment, as well as consultation on teaching and research”.
- School psychology (school psychologist) - psychological assessments related to learning or behavioral problems that impact education, provide counseling for individuals concerning issues that impact the patient’s education, provide consultation related to learning problems, and develop programs to provide more psychologically sound classroom environments.
- Sex offender treatment (sex offender treatment provider) - treatment for sex offenders in accordance with provisions in the *Code of Virginia*.

The Board of Psychology licensed 1,914 professionals at the end of FY 1998. In FY 2000, the Board will also begin to regulate sex offender treatment providers. Table C-7 provides a listing of the professions licensed by the Board of Psychology.

Table C-7

Board of Psychology Licensees

Profession	Number of Licensees
School Psychologist	106
Clinical Psychologist	1,743
Applied Psychologist	65
Sex Offender Treatment Provider*	N/A
Total	1,914

*Sex offender treatment providers will require mandatory certification from the Board of Psychology starting July 1, 1999.

Source: Department of Health Professions, Current Licensee Quarterly Report, July 1998.

Requirements for Licensure and Certification

The *Code of Virginia* and State regulations mandate that educational, testing, and, in some cases, practical experience requirements be met before licensure or certifi-

cation can be granted by the Board of Psychology. The Board has not established any continuing competency requirements for any of the professions that it regulates.

The requirements for the different practitioners regulated by the Board vary some, but all candidates for licensure must pass a national standardized examination in the practice of psychology and the Board of Psychology's written examination. The following is a list of the specific requirements for professionals licensed by the Board of Psychology.

- Clinical psychologists must hold a doctorate in psychology from an accredited school which includes clinical psychology course work prescribed in regulation. They must also complete a one-year, full-time internship approved by the American Psychological Association and possess post-doctoral experience.
- Non-clinical psychologists must hold a doctorate in psychology from an accredited university which includes the course work prescribed in Virginia regulation.
- School psychologists must hold at least a master's degree in school psychology from an accredited college which includes the course requirements stipulated in regulation. They must also complete post-master's degree experience.
- Sex offender treatment providers must hold: a master's or doctoral degree in social work, psychology, counseling, or nursing from an accredited university; or a degree of Doctor of Medicine or Doctor of Osteopathic Medicine; or a comparable degree acceptable to the board. They must also complete 50 hours of training in the areas stipulated in 18 VAC 125-30-50. Sex offender treatment providers must have 2,000 hours of post-degree clinical experience in clinical assessment/treatment services.

BOARD OF SOCIAL WORK

The Board of Social Work formerly functioned under the auspices of the Board of Behavioral Sciences. It regulates the practice of social work.

Board Composition

The Board of Social Work is comprised of two citizen members and five licensed social workers who have been in active practice for not less than five years prior to appointment.

Licensees Regulated by the Board

The Board of Social Work is responsible for the licensure of social work and clinical social work and the registration of every associate social worker and registered

social worker with the former Virginia Board of Registration of Social Workers. The board also promulgates regulations for the voluntary certification of its licensees as sex offender treatment providers. Table C-8 lists the total number of professionals licensed or registered by the Board of Social Work as of July 1998.

Table C-8

Board of Social Work Licensees

Profession	Number of Licensees
Licensed Clinical Social Workers	3,484
Licensed Social Workers	297
Registered Social Workers	125
Associate Social Workers	9
Total	3,915

Source: Department of Health Professions, Current Licensee Quarterly Report, July 1998.

Requirements for Licensure, Certification, and Registration

An applicant for licensure as a social worker or clinical social worker is required to pass a written exam in addition to meeting education and experience requirements. For registration, associate social workers and registered social workers are required to submit a completed application and the appropriate fee to the Board.

Educational and Experience Requirements. Educational and experience requirements vary across professional categories. The following lists the requirements for professions that require licensure by the Board of Social Work.

- The applicant for licensed clinical social worker must hold a minimum of a master’s degree from an accredited school of social work. The degree program must have included a graduate clinical course of study or the applicant must provide documentation of having completed specialized experience, course work or training acceptable to the board as equivalent to a clinical course of study. In addition, the applicant must have had a minimum of 3,000 hours of supervised full-time post-master’s degree experience in the delivery of clinical services or the equivalent in part-time experience.
- The applicant for licensed social worker must hold a bachelor’s or a master’s degree from an accredited school of social work. Master’s degree applicants are not required to have professional experience in the field. Bachelor’s degree applicants must have a minimum of 3,000 hours of supervised full-time post-bachelor’s degree experience or the equivalent in part-time experience in casework management and supportive services under supervision satisfactory to the board.

BOARD OF VETERINARY MEDICINE

The Board of Veterinary Medicine is charged with several responsibilities. Its primary responsibility is the regulation of veterinarians, veterinary technicians, and animal facilities where veterinary medicine is practiced. However, the Board also establishes the requirements and standards necessary for approval of veterinary programs; and establishes and monitors programs for the training of students in veterinary medicine.

Board Composition

The Board of Veterinary Medicine has seven members who are appointed by the Governor for terms of four years. The *Code of Virginia* stipulates that the Board be comprised of five licensed veterinarians, one licensed veterinary technician, and one citizen member. The Board is required to meet at least one time a year and elect a president, vice-president, and secretary.

Licensees Regulated by the Board

As mentioned, the Board licenses veterinarians and veterinary technicians, and registers animal facilities where veterinary medicine is practiced. The following is a summary of the statutory and regulatory definitions regarding the Board's licensees.

- Veterinarian - individual licensed to diagnose, treat, correct, change, relieve or prevent animal disease, deformity, defect, injury, or other physical or mental conditions.
- Veterinary technician - individual licensed to work under the immediate supervision of a licensed veterinarian relating to maintenance of the health or treatment of animals. Veterinarian technicians may not perform surgery, diagnose or prescribe medication for animals.
- Animal facility - registered facility where veterinary medicine may be practiced.

As of the end of FY 1998, the Board of Veterinary Medicine was regulating more than 4,000 licensees. Table C-9 lists the number and type of licenses issued by the Board as of July 1998.

Requirements for Licensure and Registration

Multiple requirements exist for the licensure of veterinarians and veterinary technicians as well as for the registration of animal facilities. Licensed veterinary professionals have primarily educational and testing requirements which include continuing education. State regulations also contain many requirements detailing the manage-

Table C-9

Board of Veterinary Medicine Licensees

Profession	Number of Licensees
Veterinarians	2,787
Animal Technicians	632
Animal Hospitals	731
Total	4,150

Source: Department of Health Professions, Current Licensee Quarterly Report, July 1998.

ment standards necessary to maintain registered animal facilities. The following descriptions summarize the statutory and regulatory requirements of the professions and facilities regulated by the Board of Veterinary Medicine.

- Veterinarians are required to hold a degree in veterinary medicine from a college of veterinary medicine approved by the Board. They must also pass the national board examination, the national clinical competency test, and a written examination administered by the Board.
- Veterinary technicians must hold a degree in veterinary technology from a school approved by the American Veterinary Medical Association. They must also pass the national board examination for veterinary technicians and a written examination administered by the Board.
- Animal facilities where veterinary medicine is practiced must be inspected by Board staff. Staff must determine that the facilities meet all the standards established in 18 VAC 150-20-190 and 18 VAC 150-20-200 to be registered. These regulations govern drug disbursement and storage, records retention, and various facilities standards. Registered animal facilities must also employ a veterinarian licensed and in good standing with the board who must be listed with the board as the veterinarian-in-charge.

Continuing Competency Requirements

Veterinarians and veterinary technicians are required to meet continuing education requirements each year in order to renew their licenses. Veterinarians must also complete a minimum of 15 hours of Board-approved continuing education, and veterinary technicians are required to complete a minimum of six hours of Board-approved continuing education.

Appendix D

Board Member and Health Care Organization Survey Questions

Copies of the survey questions that were asked of the following board members and organization representatives are available at JLARC, Suite 1100, General Assembly Building, Capitol Square, Richmond, Virginia.

- Survey of the Health Regulatory Boards' Members
- Survey of the Board of Medicine Members
- Survey of the Health Regulatory Advisory Board and Committee Members
- Survey of the Citizen Members of the Board of Health Professions
- Survey of Organizations Representing Health Professionals

Appendix E

Agency Response

As part of an extensive data validation process, State agencies involved in a JLARC assessment effort are given the opportunity to comment on an exposure draft of the report. Appropriate technical corrections resulting from written comments have been made in this version of the report. Page references in the agency responses relate to an earlier exposure draft and may not correspond to page numbers in this version.

This appendix contains the response from the Department of Health Professions.



JLARC Staff

DIRECTOR: PHILIP A. LEONE
DEPUTY DIRECTOR: R. KIRK JONAS

DIVISION I CHIEF: GLEN S. TITTERMARY
● *DIVISION II CHIEF:* ROBERT B. ROTZ

SECTION MANAGERS:

PATRICIA S. BISHOP, FISCAL AND ADMINISTRATIVE SERVICES

JOHN W. LONG, PUBLICATIONS AND GRAPHICS

GREGORY J. REST, RESEARCH METHODS

PROJECT TEAM LEADERS:

CRAIG M. BURNS

LINDA BACON FORD

● HAROLD E. GREER, III

WAYNE M. TURNAGE

PROJECT TEAM STAFF:

CYNTHIA A. BOWLING

BETH SILVERMAN CROSS

STEVEN E. FORD

WAYNE A. JONES

APRIL R. KEES

● MELISSA L. KING

ERIC H. MESSICK

SUZANNE R. PRITZKER

LAWRENCE L. SCHACK

E. KIM SNEAD

● PAUL VAN LENTEN

CHRISTINE D. WOLFE

ADMINISTRATIVE AND RESEARCH SUPPORT STAFF:

JOAN M. IRBY

BETSY M. JACKSON

BECKY C. TORRENCE

STEVE MYRON, INTERN

DON MOONEY, INTERN

● *Indicates staff with primary assignment to this project*

FORMER JLARC STAFF WHO CONTRIBUTED TO THIS REPORT:

DEBORAH MOORE GARDNER

JLARC
Suite 1100
General Assembly Building
Capitol Square
Richmond, Virginia 23219
(804) 786-1258 Fax: 371-0101
<http://jlarc.state.va.us>

