State of West Virginia
**Board of Medicine**

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MARK A. SPANGLER, MA
EXECUTIVE DIRECTOR

**SUMMARY OF COMMENTS RECEIVED REGARDING PROPOSED AMENDMENTS TO 11 CSR 1B AND RESPONSES OF THE WEST VIRGINIA BOARD OF MEDICINE**

On June 29, 2021, the West Virginia Board of Medicine filed a Notice of Comment Period on a Proposed Rule, 11 CSR 1B. The Notice established a thirty day comment period on the proposed rule, which concluded at 4:30 pm on July 29, 2021. During the comment period, the Board received four comments directly referencing 11 CSR 1B. In addition, the Board received a comment on a separate rule, 11 CSR 6, which relates to the definition of "drug diversion training and best practice prescribing of controlled substances training." Inasmuch as that definition is also included in 11 CSR 1B, the Board evaluated this comment with respect to both 11 CSR 6 and 11 CSR 1B.[1] The Board has reviewed the comments received, and on July 29, 2021, the following responses were authorized by the Board. A copy of this summary is being provided to the commenter.

| **Commenter** | **Date Received** |
|---|---|
| 1. Frederic D'Alauro, MD | July 12, 2021 |

Dr. D'Alauro commented upon proposed amendments to subsections 9.2 of the 11 CSR 1B. The proposed amendments provide:

> 9.2. In addition to core duties, a physician assistant may perform ~~properly delegated~~ medical acts ~~within a medical specialty that he or she, by education, training and/or experience has the knowledge and competency to perform~~ commensurate with his or her education, training, and experience, which the physician assistant is competent to perform, and consistent with the rules of the Board. The physician assistant may only perform medical acts consistent with sound medical practice and that will protect the health and safety of the patient.

[1] Copies of the comment received by the Board and the Board's individual responses thereto are attached to this summary.

Dr. D-Alauro opines:

> This law would exclude physician assistants from working in subspecialty medical settings in which they do not have experience and training. For example physician assistants should not be permitted to evaluate and treat emergency room patients, cardiology clinic patients and patients in intensive care without having education training and experience commensurate to treat such patients. Just graduating from a physician assistant program would not qualify them to practice in these subspecialty settings. I think the Board's responsibility is to protect the health and welfare of West Virginia citizens. The law is clear in requiring Physician assistants who want to work in subspecialty areas to obtain additional formal training before being permitted to practice subspecialty medicine.

Dr. D-Alauro also submitted an accompanying letter which further expresses his concerns over the expanding role of nurse practitioners and physician assistants in subspecialty practices, particularly without appropriate specialty education and training. A copy of the incorporated letter accompanies attached comment.

**Response:** The proposed amendments to 11 CSR 1B, including the amendments to subsections 9.2. are consistent with Senate Bill 714, and do not modify the scope of practice for physician assistants. The Board has not modified the proposed rule amendments as a result of this comment.

| **Commenter** | **Date Received** |
|---|---|
| 2. Sherri P. Ferrell<br>Chief Executive Officer<br>WV Primary Care Association | July 29, 2021 |

WV Primary Care Association provided a consolidated comment on four of the Board's proposed rules and/or proposed rule amendments. With respect to this rule, WV Primary Care Association indicated its support of the proposed amendments:

> Given the rural areas that our members serve and the associated challenge of recruiting qualified physicians and physician assistants, we are especially excited about the revisions to proposed rule 11 CSR 1B.
>
> The proposed revisions to rule 11 CSR 1B, among other things, allow physician assistants to register with the WVBOM via a practice notification instead of a practice agreement. We thank the WVBOM for extending this practice notification eligibility, which has been available to hospital-based physician assistants since 2019, to community-based providers such as health centers. This change promotes regulatory simplicity and equity. Moreover, we appreciate the

> WVBOM developing a simple, streamlined form for submission of practice notifications. These proposed rules revisions will reduce costs to our health centers from a compliance/legal standpoint and decrease the time needed to onboard new physician assistants.

The organization did not recommend any changes to the proposed rule.

**Response:** The Board appreciates WV Primary Care Association's thoughtful comments. No changes were made to the proposed rule in response thereto.

| **Commenter** | **Date Received** |
|---|---|
| 3. Nicholas Vance, MS, PA-C<br>WVAPA Legislative Committee, Chair | July 29, 2021 |

The West Virginia Association of Physician Assistants indicated that the organization agrees with many aspects of the proposed amendments (and the associated emergency rule) but has recommended three modifications:

> With regards to 11CSR1b-14.2, we feel a fee of $100 to file a practice notification places an undue financial burden on physician assistants and facilities. Neither physicians nor nurse practitioners in West Virginia have to provide a fee (other than for their licenses) to practice. Physician Assistants in Minnesota, where the basis of SB714 originated, have a notification with no fee. Many other states that do not require the practice agreement to be sent in, do not require a fee to practice such as Virginia, Minnesota, Massachusetts, Tennessee, Nebraska, Florida to name a few. We would like consider lower or no fee to file a practice notification. While we understand financial implications, raising the licensing fee would help offset these.
>
> With regards to 11CSR1B-14.3, written notification of practice notification filed to start practice. Part of the purpose for practice notification and scope determined at the practice level is to allow physician assistants to begin practice without extra administrative burdens. Having to delay waiting for board approval can make hiring a provider that is needed rapidly, to look at other professions to fill their need. Offering a grace period to start working while the practice notification is filed and approved would help solve this issue. Both New Jersey and Florida do similar while receiving what they require from the physician assistant.
>
> With regards to 11CSR1B-17, since the CME requirements for renewal is similar to what the NCCPA requires to maintain certification. Would like to suggest that the CME requirements be met if valid NCCPA certification is maintained. Physician assistants that were required to complete the 3 hour drug diversion CME would still have to provide proof it is completed. Any physician assistant not NCCPA certified would still need to follow the current CME requirements and timeline. This would hopefully cut down on the Board's administrative burden since NCCPA status is required with license renewal.

**Response:** The Board appreciates WVAPA's thoughtful comments. With respect to subsection 14.2, the Board did not alter or amend the fee which has been in place for Practice Notifications or (the predecessor Practice Agreements). This fee has not been amended since Practice Agreements were implemented more than five years ago. Notably, physician assistant licensure fees have likewise not been modified in over a decade and the Bord has no current plans to do so. The Board carefully considered this comment and determined not to further modify subsection 14.2.

Second, WVAPA commented on subsection 14.3. The only modification to this subsection in the Board's proposed rule is to substitute "health care facility" for "hospital":

> 14.3. A physician assistant may not commence practice pursuant to a practice notification until the Board provides written notification to the physician assistant and ~~the hospital~~ health care facility that a complete practice notification has been filed with the Board. The Board's written notification activates the practice notification and provides the physician assistant with authorization to practice in the identified ~~hospital(s)~~ health care facility or facilities.

The commenter proposes that the Board implement a grace period for physician assistant practice prior to the Board notification that the Practice Notice has been activated. The Board does not have the discretion to implement this recommendation. Pursuant to SB 714:

> Before a licensed physician assistant may practice in collaboration with physicians, the physician assistant and a health care facility shall:
>
> (1) File a practice notification with the appropriate licensing board;
>
> (2) Pay the applicable fee; and
>
> (3) **Receive written notice from the appropriate licensing board that the practice notification is complete and active.**

W. Va. Code §30-3E-10a(a) (emphasis added). The statute requires notice of activation from the Board prior to the PA commencing practice. The Board has not made any modifications to the rule in response to this portion of the WVAPA's comment.

Third, the WVAPA has requested that the Board accept proof of continuing NCCPA certification to satisfy the Board's continuing education requirements for physician assistants. Of note, the Board did not propose any amendments to section 17 which would alter current CME requirements for physician assistants. Consequently, this comment relates to a portion of the rule for which substantive amendments have not been proposed by the Board.

The Board has carefully considered the WVAPA's request to subordinate its continuing education requirements and schedule[2] to that of the NCCPA, particularly in light of the recent legislative trend to develop clear separations between physician assistant licensure and professional certification. The Board also considered that the overlap of the Board's CME requirements and the NCCPA's certification requirements do not appear to create any additional burden to certified physician assistants. Finally, the Board noted that its rule currently permits physician assistants to utilize NCCPA recertification examination results to satisfy CME requirements (This is an option that is also available to physicians, and the Board is currently engaged in rulemaking to extend the same option to podiatric physicians.) For all of these reasons, the Board is not inclined to accept NCCPA certification in substitution for the currently established CME requirements. Consequently, the Board did not make any modifications section 17 in response to this comment.

| **Commenter** | **Date Received** |
|---|---|
| 4. K. Dean Wright, MPAS, PA-C, DFAAPA<br>Clinical Coordinator, Principal Faculty, Assistant Professor<br>Marshall University Physician Assistant Program | July 29, 2021 |

Mr. Wright opined:

> As a practicing PA for over 40 years in our great State of West Virginia under the licensure of the West Virginia Board of Medicine, I just want to publicly applaud the Board, its staff, and its members for all the work that the Board has done through the licensing, disciplinary and regulatory process to protect the public. As I reviewed the proposed rules over the last month, I appreciate all the effort that has been put into making sure the rules comply with the legislation that was passed and signed by the Governor. I have nothing else to add other than to say excellent job and you are all very much appreciated!

In an effort to provide full public disclosure, Mr. Wright is a former member of the West Virginia Board of Medicine, however his tenure on the Board, and therefore his affiliation with this agency, concluded in July 2020.

**Response:** The Board appreciates Mr. Wright's comments. No modifications were made to the rule based thereupon.

| **Commenter** | **Date Received** |
|---|---|
| 5. Matthew Q. Christiansen, MD, MPH | July 2, 2021 |

[2] The Board requires its licensees to complete continuing education during the interval between license renewals. For physician assistants, the current two-year interval is April 1, 2021, through March 31, 2023.

Director, Office of Drug Control Policy
WV Department of Health and Human Resources

Dr. Christianson submitted a comment with respect to another rule for which the Board has proposed amendments, 11 CSR 6. Series 6 is the Board's rule with regard to continuing education for physicians and podiatric physicians. Dr. Christiansen's comment with respect to 11 CSR 6 related to language which is also included in 11 CSR 1B, as continuing education for PAs is covered by this rule. Accordingly, the Board considered Dr. Christiansen's comment with respect to both proposed rule amendments.

Specifically, Dr. Christiansen proposes further expanding the scope of the 3-hour Board approved course on drug diversion training and best practice prescribing of controlled substances training to include "some education on stigma and the evidence of effectiveness of MOUD and referral to treatment." The term "drug diversion training and best practice prescribing training" is defined in the definition section of 11 CSR 1B at subdivision 2.1.n. In the Board's proposed amendments, the definition of this training was amended to include:

> 2.1.n.12. Information related to substance use disorder treatment referral, including but not limited to programs and initiatives developed through the Governor's Council on Substance Abuse Prevention and Treatment, the Governor's Committee on Crime, Delinquency, and Correction, and/or W. Va. Code § 15-9-7;

Dr. Christiansen proposes changing the name of the training to "drug diversion training, stigma education including addiction as a chronic disease, the basics of substance use disorder treatment and outcomes of MOUD, and best practice prescribing of controlled substances training." He also suggests adding two additional components to the definition which, in this rule, would be inserted as follows:[3]

> 2.1.n. "Drug diversion training and best practice prescribing of controlled substances training" means training which includes all of the following:
>
> 2.1.n.1. Drug diversion, including West Virginia statistics on prescription drug abuse and resulting deaths;
>
> 2.1.n.2. Epidemiology of chronic pain and misuse of opioids;
>
> 2.1.n.3. Indication for opioids in chronic pain treatment including general characteristics, toxicities and drug interactions;

[3] The Board has proposed an amendment to this subdivision. In order to differentiate between Dr. Christiansen's comment and the Board's initial proposed amendment, Dr. Christiansen's proposed comment is in underscore and italics text.

2.1.n.4. Examination of patient evaluation and risk assessment and tools to assess risk and monitor benefits;

2.1.n.5. Initiation and ongoing management of chronic pain patient treated with opioid based therapies, including treatment objectives; monitoring and periodic review; referrals and consultations; informed consent; prescription of controlled substance agreements, urine screens and pill counts; patient education on safe use, storage and disposal of opioids; discontinuation of opioids for pain due to lack of benefits or increased risks; documentation and medical records;

2.1.n.6. Case study of a patient with chronic pain;

2.1.n.7. Identification of diversion and drug seeking tactics and behaviors;

2.1.n.8. Best practice methods for working with patients suspected of drug seeking behavior and diversion;

2.1.n.9. Compliance with controlled substances laws and rules;

2.1.n.10. Training on prescribing and administration of an opioid antagonist;

*2.1.n.11. Training on the impacts of stigma on treatment effectiveness including the concept of addiction as a chronic disease;*

*2.1.n.12. Introduction to MOUD and training on the effectiveness of MOUD treatment including the use of full opioid agonist, partial opioid agonist, and opioid antagonists;*

2.1.n.11. Registration with and use of the West Virginia Controlled Substances Monitoring Program established in ~~West Virginia~~ W. Va. Code Chapter 60A, Article 9; ~~and~~

2.1.n.12. Information related to substance use disorder treatment referral, including but not limited to programs and initiatives developed through the Governor's Council on Substance Abuse Prevention and Treatment, the Governor's Committee on Crime, Delinquency, and Correction, and/or W. Va. Code § 15-9-7; and

2.1.n.1~~2~~3. Maintenance of a record of attendance of each individual who successfully completes the drug diversion training and best practice prescribing of controlled substances training.

**Response:** The Board appreciates Dr. Christiansen's comment and acknowledges the benefit of incorporating modifications to this required training to address the issues he raises. However,

the Board would like to avoid confusion which may arise by a change to the name of this mandatory continuing education course. While the Board has declined to modify the name of the course, the agency approved version of 11 CSR 1B does incorporate the two specific additions to the course proposed by Dr. Christiansen with one modification. The Board has substituted "Medication for Opioid Use Disorder (MOUD)" for the first use of the acronym 'MOUD" for clarity. These two new definition components have been inserted after subdivision 2.1.n.10, and the remaining portions of the definition have been renumbered accordingly.

**Conclusion**

In conclusion, based upon the comments received, the Board's agency approved filing contains the modifications identified hereinabove. The Board again expresses its appreciation to all who submitted comments. These comments assisted the Board's review of its proposed rule and resulted in modifications which the Board believes improve the rule.

35 Mayapple Lane
Shepherdstown, WV 25443
Email fsdasd@gmail.com
July 5, 2021

**Mark A. Spangler, Executive Director**
**West Virginia Board of Medicine**
**101 Dee Drive, Suite 103**
**Charleston, West Virginia 25311**
**Mark.A.Spangler@wv.gov**

Dear Mr. Spangler:

This letter is in comment to the proposed new amendments and new rules for Physician Assistants 11CSR1B. Specifically I am referring to section 9.2 "... a physician assistant may perform medical acts commensurate with his or her education, training and experience which the physician assistant is competent to perform". This law would then exclude physician assistants from working in subspecialty medical settings in which they do not have experience and training. For example physician assistants should not be permitted to evaluate and treat emergency room patients, cardiology clinic patients and patients in intensive care without having education training and experience commensurate to treat such patients. Just graduating from a physician assistant program would not qualify them to practice in these subspecialty settings. I think the Board's responsibility is to protect the health and welfare of West Virginia citizens. The law is clear in requiring Physician assistants who want to work in subspecialty areas to obtain additional formal training before being permitted to practice subspecialty medicine.
See my accompanying letter.

Sincerely,

Frederic D'Alauro, M.D.

I am writing to express my concern about the expanding role of nurse practitioners and physician assistants (advanced practice providers) in subspecialty practices without appropriate education and experience in those areas. Recently, several examples where this is happening have come to my attention. At my local community hospital, the hospital-employed gastroenterologist told me that the hospital hired a nurse practitioner (NP) to work in his practice; the NP would be seeing and evaluating newly-referred patients in spite of having no experience in gastroenterology. The tertiary-care state university hospital in my state has hired recently graduating NPs with no additional training to do inpatient rounds. A medical school colleague who is a developmental pediatrician at an internationally known tertiary-care hospital told me the hospital hired a NP to do follow up visits on his patients. Again, this NP has no special training in developmental pediatrics. This MD told me he felt his patients were not getting optimal care but his administrator told him he had no choice.

In the past NPs worked mostly in primary care practices under the supervision of a physician. In that setting, studies show similar patient outcomes for diabetes care, treatment of hypertension, and patient satisfaction compared to that provided by a physician. Also,at one time, medics who had years of military experience had the opportunity to become advanced level practitioners and to assist with inpatient rounds. Now advanced level providers are permitted to work right out of training evaluating and treating inpatients and ICU patients. Some of these NP training programs are mostly online. Many states have given advanced level providers permission to work independently. However, where is the data showing outcomes for advanced subspecialty practitioners in subspecialty practices? My search of the internet showed little in the way of good studies showing outcome results.

Common sense suggests if you put an advanced level practitioner with little training or experience in a subspecialty position, you will have inferior outcomes. Yes, eventually these practitioners will get on-the-job training and reach some level of competency, but at what cost to the patients? Learning on the job is not sufficient training for an advanced level practitioner because, although they may learn the routine of practicing in a subspecialty, they never get the underlying knowledge you would learn in a formal training program. More importantly, it is bad for the patients because diagnoses will be missed and mistakes made as a result of that lack of experience and training. It would be like an airline hiring a pilot who just obtained his private pilots license and making him the captain of a jumbo jet.. Yes, the airline would save money on this inexperienced pilot's salary and yes most of his flights would land safely but is this the person you would want to be piloting the flight you are taking?

I am Board Certified in Internal Medicine and Anesthesiology. Most hospitals would require that I be Board Certified in Emergency Medicine to be hired as an emergency room physician. Yet an advanced level practitioner can finish their two year program and see patients on their own. The hospital's credentialing system appropriately limits my scope of practice of medicine but it gives advanced level practitioners with no specialized training and minimal experience the ability to evaluate and treat patients with no direct physician supervision.

When you make an appointment to see a specialist don't you have the right and expectation to be seen by an individual who has subspecialty training? If you are admitted to the intensive care unit with complex and multiple medical problems don't you have the expectation that you are being cared for by a medical professional who has specialized training in intensive care? One of the basic functions of the government is safeguarding the lives of its citizens. The state legislatures, the medical regulatory board in your state and the credentialing committee at your hospital should be there to ensure that qualified individuals are practicing medicine. Are they providing this basic function? I would say no.

Hospitals are happy to hire advanced level practitioners because they are much less expensive to hire than physicians and the hospital's reimbursement from private insurers and medicare is only slightly less than if a physician sees the patient. ( Medicare pays 85% of the physician fee if an advanced level practitioner sees you.) So it is a win win for the hospital -lower salary, and similar reimbursement per patient visit . The only loser in this scenario is the patient.

At the present time there is a shortage of physicians in part because the federal government has not provided any increased funding for residency spots for medical school graduates in decades. We have students graduating from medical school who can not find a residency spot. The obvious answer to the physician shortage problem is to provide more funding for physicians' postgraduate training. The wrong answer is to put advanced level practitioners in positions they are not adequately trained for.

So what can you do now? If state and hospital licensing agencies are doing a poor job adequately credentialing medical professionals, patients should take more control of their medical care. This is the advice I give to my friends and family. When you go to any medical facility, request that you be seen by a physician not an advanced level practitioner. You will greatly increase the chances you will be cared for by someone well trained and competent. Hopefully in the future state legislatures and licensing boards will wake up their responsibilities, and the federal government will better fund

postgraduate medical education . Until then be a sophisticated patient and when you need medical care ask for a physician.

Frederic D'Alauro, MD Shepherdstown, WV

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MARK A. SPANGLER, MA
EXECUTIVE DIRECTOR

July 30, 2021

**VIA ELECTRONIC MAIL ONLY**
Frederic D'Alauro, MD
fdalauro@gmail.com

**Re: Proposed Amendments to West Virginia Board of Medicine Rule 11 CSR 1B**

Dear Dr. D'Alauro:

Thank you for taking the time to review and comment on the Board's proposed amendments to 11 CSR 1B, *Licensure, Disciplinary and Complaint Procedures, Continuing Education, Physician Assistants.*

The Legislative Committee of the Board met yesterday, July 29, 2021, to review and consider all of the comments that were received. Discussion occurred, and the Board approved some modifications to the proposed rule in response to the comments it received. Enclosed please find the Board's *Summary of Comments Received Regarding 11 CSR 1B and Responses of the West Virginia Board of Medicine* (without attachments).

The agency-approved version of 11 CSR 1B will be filed with the West Virginia Secretary of State's Office today and will be available for review on their website at https://apps.sos.wv.gov/adlaw/csr/. The enclosed summary along with all comments will also be available on the Secretary of State's website.

Thank you again for your participation in the rulemaking process and for your comments.

Sincerely,

Mark A. Spangler

MAS/jcf
Enclosure

WV
Primary Care Association
*One Mission. One Vision. One Voice.*

Mark Spangler
Executive Director
West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, WV 25311

July 29, 2021

**RE: Comments on West Virginia Board of Medicine Proposed Rules 11 CSR 1A, 11 CSR 1B, 11 CSR 5 and 11 CSR 15**

Dear Mr. Spangler:

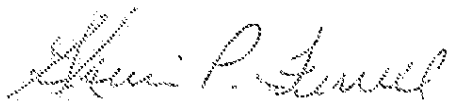
The West Virginia Primary Care Association ("WVPCA") is grateful for the opportunity to offer feedback on the West Virginia Board of Medicine's ("WVBOM") various proposed rules currently out for public comment. The WVPCA represents the state's 32 community health centers and one rural health clinic, which constitute the largest independent primary care network in the state. Health centers and rural health clinics provide primary care, and many offer specialty care, such as dental, behavioral health and school-based health services, and fill prescriptions at affiliated pharmacies. Services and prescriptions are provided to health center patients regardless of their insurance status or ability to pay. Nearly 480,000 West Virginians receive health care services from a health center—more than one out of every four citizens.

The WVPCA is encouraged by the WVBOM's progressive changes to physician and physician assistant licensing and telehealth regulation while still holding true to the legislative intent of relevant legislation. We believe the proposed rule revisions to 11 CSR 1A, 11 CSR 1B and 11 CSR 5, as well as new proposed rule 11 CSR 15, will allow providers under the purview of the WVBOM to practice at the top of their training without unnecessary red tape. Given the rural areas that our members serve and the associated challenge of recruiting qualified physicians and physician assistants, we are especially excited about the revisions to proposed rule 11 CSR 1B .

The proposed revisions to rule 11 CSR 1B, among other things, allow physician assistants to register with the WVBOM via a practice notification instead of a practice agreement. We thank the WVBOM for extending this practice notification eligibility, which has been available to hospital-based physician assistants since 2019, to community-based providers such as health centers. This change promotes regulatory simplicity and equity. Moreover, we appreciate the WVBOM developing a simple, streamlined form for submission of practice notifications. These proposed rules revisions will reduce costs to our health centers from a compliance/legal standpoint and decrease the time needed to onboard new physician assistants.

Again, we thank you for your time and consideration of our comments. Should you or other WVBOM staff wish to discuss our comments on these proposed rules, please do not hesitate to contact Joshua Austin, Policy and Communications Director at the WVPCA, at Joshua.Austin@wvpca.org or at 304.400.8300.

Sincerely,



Sherri P. Ferrell,
Chief Executive Officer

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July 30, 2021

**VIA ELECTRONIC MAIL ONLY**
Ms. Sherri P. Ferrell
Chief Executive Officer
West Virginia Primary Care Association
Sherri@wvpca.org

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Thank you again for your participation in the rulemaking process and for your comments.

Sincerely,

Mark A. Spangler

MAS/jcf
Enclosure

WVAPA

July 29, 2021

Mark Spangler, Executive Director
West Virginia Board of Medicine
101 Dee Dr., Suite 103
Charleston, WV 25311

RE: Comments for proposed rule 11-01B

We would like to thank the West Virginia Board of Medicine (Board) for your work following the passage of SB714 in this past legislative session. We appreciate the due diligence by the Board putting together the emergency rules, and the ability to comment with our thoughts to try and improve the landscape in West Virginia for Physician Assistants. While we agree with many of the aspects to the emergency rules, there are a few we would like make suggestions for change now or for future discussion.

With regards to 11CSR1b-14.2, we feel a fee of $100 to file a practice notification places an undue financial burden on physician assistants and facilities. Neither physicians nor nurse practitioners in West Virginia have to provide a fee (other than for their licenses) to practice. Physician Assistants in Minnesota, where the basis of SB714 originated, have a notification with no fee. Many other states that do not require the practice agreement to be sent in, do not require a fee to practice such as Virginia, Minnesota, Massachusetts, Tennessee, Nebraska, Florida to name a few. We would like consider lower or no fee to file a practice notification. While we understand financial implications, raising the licensing fee would help offset these.

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Thank you for your time and allowing our comments for the patients of West Virginia and Physician Assistant practice environment of our state. We look forward to hearing back and working with you in the future!

Sincerely yours,

Nicholas Vance, MS, PA-C

WVAPA Legislative Committee, Chair

nvancepa@gmail.com

304.688.5100

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July 30, 2021

**VIA ELECTRONIC MAIL ONLY**
Nicholas Vance, MS, PA-C
WVAPA Legislative Committee, Chair
nvancepa@gmail.com

**Re: Proposed Amendments to West Virginia Board of Medicine Rule 11 CSR 1B**

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Thank you again for your participation in the rulemaking process and for your comments.

Sincerely,

Mark A. Spangler

MAS/jcf
Enclosure

Frame, Jamie C <jamie.c.frame@wv.gov>

# Fwd: Comment on Rule Named Licensure, Disciplinary and Complaint Procedures

1 message

**Spangler, Mark A** <mark.a.spangler@wv.gov> Thu, Jul 29, 2021 at 4:21 PM
To: Jamie Alley <jamie.s.alley@wv.gov>, "Frame, Jamie C" <jamie.c.frame@wv.gov>

*Mark A. Spangler*

*Executive Director*

West Virginia Board of Medicine

101 Dee Drive, Suite 103

Charleston, West Virginia 25311

Telephone: (304) 558-2921 Ext. 49862

Facsimile: (304) 558-2084



---------- Forwarded message ---------
From: **Wright, Kenneth** <wrightk@marshall.edu>
Date: Thu, Jul 29, 2021 at 4:21 PM
Subject: Comment on Rule Named Licensure, Disciplinary and Complaint Procedures
To: Spangler, Mark A <Mark.A.Spangler@wv.gov>

Dear Mr. Spangler,

As a practicing PA for over 40 years in our great State of West Virginia under the licensure of the West Virginia Board of Medicine, I just want to publicly applaud the Board, its staff, and its members for all the work that the Board has done through the licensing, disciplinary and regulatory process to protect the public. As I reviewed the proposed rules over the last month, I appreciate all the effort that has been put into making sure the rules comply with the legislation that was

passed and signed by the Governor. I have nothing else to add other than to say excellent job and you are all very much appreciated!

With my utmost respect.

Dean

K. Dean Wright, MPAS, PA-C, DFAAPA

Clinical Coordinator, Principal Faculty, Assistant Professor

Marshall University Physician Assistant Program

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# State of West Virginia
## *Board of Medicine*

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PRESIDENT

QUARTEL-AYNE AMJAD, MD, MPH
SECRETARY

ASHISH P. SHETH, MD
VICE PRESIDENT

MARK A. SPANGLER, MA
EXECUTIVE DIRECTOR


July 30, 2021

**VIA ELECTRONIC MAIL ONLY**
K. Dean Wright, MPAS, PA-C, DFAAPA
Clinical Coordinator, Principal Faculty, Assistant Professor
Marshall University Physician Assistant Program
wright@marshall.edu

**Re: Proposed Amendments to West Virginia Board of Medicine Rule 11 CSR 1B**

Dear Mr. Wright:

Thank you for taking the time to review and comment on the Board's proposed amendments to 11 CSR 1B, *Licensure, Disciplinary and Complaint Procedures, Continuing Education, Physician Assistants.*

The Legislative Committee of the Board met yesterday, July 29, 2021, to review and consider all of the comments that were received. Discussion occurred, and the Board approved some modifications to the proposed rule in response to the comments it received. Enclosed please find the Board's *Summary of Comments Received Regarding 11 CSR 1B and Responses of the West Virginia Board of Medicine* (without attachments).

The agency-approved version of 11 CSR 1B will be filed with the West Virginia Secretary of State's Office today and will be available for review on their website at https://apps.sos.wv.gov/adlaw/csr/. The enclosed summary, along with all comments will also be available on the Secretary of State's website.

Thank you again for your participation in the rulemaking process and for your comments.

Sincerely,

Mark A. Spangler

MAS/jcf
Enclosure

**Frame, Jamie C**

| | |
|---|---|
| **From:** | Christiansen, Matthew Q |
| **Sent:** | Friday, July 2, 2021 2:46 PM |
| **To:** | Spangler, Mark A |
| **Cc:** | Stuchell, Nicholas R; Frame, Jamie C |
| **Subject:** | RE: [External] Fwd: Comment Period Underway for Board of Medicine Rules |
| **Attachments:** | 11CSR6 ODCP comments 06-30-21.docx |
| **Follow Up Flag:** | Follow up |
| **Flag Status:** | Flagged |

Mark,
Attached are my comments on the rule. The main gist is that we need to expand the scope of this training to include some education on stigma and the evidence of effectiveness of MOUD and referral to treatment.

Happy to discuss further with the board or review any feedback.
Matt

Matthew Q Christiansen, MD, MPH
Director, Office of Drug Control Policy
WV Department of Health and Human Resources
One Davis Square, Suite 100, East
Charleston, WV 25301
P: (304) 962-3981
Matthew.Q.Christiansen@wv.gov

**From:** Spangler, Mark A <Mark.A.Spangler@wv.gov>
**Sent:** Wednesday, June 30, 2021 1:49 PM
**To:** Christiansen, Matthew Q <Matthew.Q.Christiansen@wv.gov>
**Cc:** Stuchell, Nicholas R <Nicholas.R.Stuchell@wv.gov>; Frame, Jamie C <Jamie.C.Frame@wv.gov>
**Subject:** RE: [External] Fwd: Comment Period Underway for Board of Medicine Rules

Dear Dr. Christiansen,

Thank you for your comment on the proposed rule. Written comments will be accepted through July 29, 2021 and the Board will review and consider your comment(s) accordingly. It is not uncommon for a proposed rule to be modified as a result of public comment. I am certain the Board will be interested in your informed thoughts on the matter. I encourage you to submit your comments as soon as practical. We look forward to hearing from you.

Kind regards,

*Mark A. Spangler*
*Executive Director*
West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, West Virginia 25311
Telephone: (304) 558-2921 Ext. 49862

Facsimile: (304) 558-2084



**From:** Christiansen, Matthew Q <Matthew.Q.Christiansen@wv.gov>
**Sent:** Wednesday, June 30, 2021 1:35 PM
**To:** Spangler, Mark A <Mark.A.Spangler@wv.gov>
**Cc:** Stuchell, Nicholas R <Nicholas.R.Stuchell@wv.gov>
**Subject:** FW: [External] Fwd: Comment Period Underway for Board of Medicine Rules

Is there still a window that changes can be made to these rules if we submit a formal comment?

Specifically regarding 11CSR6, diversion of prescription drugs is no longer the primary concern for intervention re: SUD, and we need to be sure we are emphasizing education around screening, stigma reduction, and linkage to treatment/MOUD. Thank you,
Matt

Matthew Q Christiansen, MD, MPH
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WV Department of Health and Human Resources
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Matthew.Q.Christiansen@wv.gov

**From:** Matthew Christiansen <matthewchristiansen@email.com>
**Sent:** Tuesday, June 29, 2021 3:57 PM
**To:** Christiansen, Matthew Q <Matthew.Q.Christiansen@wv.gov>
**Subject:** [External] Fwd: Comment Period Underway for Board of Medicine Rules

CAUTION: External email. Do not click links or open attachments unless you verify sender.

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From: <wvbom@wv.gov>
Date: Tue, Jun 29, 2021, 3:39 PM
Subject: Comment Period Underway for Board of Medicine Rules
To: <matthewchristiansen@email.com>

**Comment Period Underway for Proposed Amendments to Seven Existing Board of Medicine Rules and a Proposed New Rule**

Due, in part, to legislation enacted during the 2021 regular session of the West Virginia Legislature, the West Virginia Board of Medicine is accepting written comments on proposed amendments to seven existing rules and a proposed new rule. To view the proposed amendments and the proposed new rule, click on the appropriate link below.

**PROPOSED AMENDMENTS TO EXISTING RULES**

11 CSR 1A, Licensing and Disciplinary Procedures: Physicians, Podiatric Physicians and Surgeons

11 CSR 1B, Licensure, Disciplinary and Complaint Procedures, Continuing Education, Physician Assistants

11 CSR 5, Board of Medicine rules for Dispensing of Prescription Drugs by Practitioners

11 CSR 6, Continuing Education for Physician and Podiatric Physicians

11 CSR 10, Practitioner Requirements for Accessing the West Virginia Controlled Substances Monitoring Program Database

11 CSR 11, Establishment and Regulation of Limited License to Practice Medicine and Surgery at Certain State Veterans Nursing Home Facilities

11 CSR 14, Restoration to Practice During Declared State of Emergency

**PROPOSED NEW RULE**

11 CSR 15, Telehealth and Interstate Telehealth Registration for Physicians, Podiatric Physicians and Physician Assistants

Written comments on the proposed amendments and the proposed new rule are being accepted through 4:30 pm on July 29, 2021, and should be submitted to:

**Mark A. Spangler, Executive Director**
**West Virginia Board of Medicine**
**101 Dee Drive, Suite 103**
**Charleston, West Virginia 25311**
Mark.A.Spangler@wv.gov

# TITLE 11
# LEGISLATIVE RULE
# BOARD OF MEDICINE

## SERIES 6
## CONTINUING EDUCATION FOR PHYSICIANS AND PODIATRIC PHYSICIANS

**~~§11-6-1. General.~~**

1.1. Scope. -- These legislative rules address minimum requirements for continuing education satisfactory to the Board for physicians and podiatric physicians.

1.2. Authority. -- W. Va. Code §30-3-7.

1.3. Filing Date. -- ~~April 23, 2018~~

1.4. Effective Date. -- ~~July 1, 2018~~

1.5. Sunset Provision -- This rule shall terminate and have no further force or effect ~~on July 1, 2023~~ upon August 1, 2027.

**~~§11-6-2. Definitions.~~**

Definitions set forth in 11 CSR 1A are hereby incorporated by reference.

2.1. "ABMS" means American Board of Medical Specialties.

2.2. "Board" means the West Virginia Board of Medicine.

2.3. "Chronic pain" means pain that has persisted after reasonable medical efforts have been made to relieve the pain or cure its cause and that has continued, either continuously or episodically, for longer than three (3) continuous months. For purposes of this rule, "chronic pain" does not include pain associated with a terminal condition or illness or with a progressive disease that, in the normal course of progression, may reasonably be expected to result in a terminal condition or illness.

2.4. "Controlled substances" means drugs that are classified by federal or state law in Schedules I, II, III, IV or V, as defined in W. Va. Code § 60A-2-204 through 212.

2.5. "Drug diversion training, stigma education including addiction as a chronic disease, the basics of substance use disorder treatment and outcomes of MOUD, and best practice prescribing of controlled substances training" means training which includes all of the following:

2.5.a. Drug diversion, including West Virginia statistics on prescription drug abuse and resulting deaths.

2.5.b. Epidemiology of chronic pain and misuse of opioids.

2.5.c. Indication for opioids in chronic pain treatment including general characteristics, toxicities and drug interactions.

2.5.d. Examination of patient evaluation and risk assessment and tools to assess risk and monitor benefits.

2.5.e. Initiation and ongoing management of chronic pain patients treated with opioid based therapies, including treatment objectives; monitoring and periodic review; referrals and consultations; informed consent; prescription of controlled substance agreements, urine screens and pill counts; patient education on safe use, storage and disposal of opioids; discontinuation of opioids for pain due to lack of benefits or increased risks; documentation and medical records.

2.5.f. Case study of a patient with chronic pain.

2.5.g. Identification of diversion and drug seeking tactics and behaviors.

2.5.h. Best practice methods for working with patients suspected of drug seeking behavior and diversion.

2.5.i. Compliance with controlled substances laws and rules.

2.5.j. Training on prescribing and administration of an opioid antagonist.

2.5.k. Training on the impacts of stigma on treatment effectiveness including the concept of addiction as a chronic disease.

2.5.l. Introduction to MOUD and training on the effectiveness of MOUD treatment including the use of full opioid agonist, partial opioid agonist, and opioid antagonists.

2.5.km. Registration with and use of the West Virginia Controlled Substances Monitoring Program established in West Virginia Code Chapter 60A, Article 9.

2.5.n. Information related to substance use disorder treatment referral, including but not limited to programs and initiatives developed through the Governor's Council on Substance Abuse Prevention and Treatment, the Governor's Committee on Crime, Delinquency, and Correction, and/or W. Va. Code § 15-9-7.

2.5.lo. Maintenance of a record of attendance of each individual who successfully completes the drug diversion training and best practice prescribing of controlled substances training.

2.6. "Licensee" means a physician or podiatric physician licensed pursuant to the provisions of W. Va. Code § 30 -3-1 et seq. and the provisions of 11 CSR 1A.

2.7. "Maintenance of certification" means an ongoing process of education and assessment for the twenty four member boards of the ABMS board certified physicians to improve practice performance in six core competencies: professionalism, patient care and professional skills, medical knowledge, practice based learning and improvement, interpersonal and communication skills, and systems based practice.

2.8. "Opioid" means natural and semi-synthetic derivatives of the opium poppy, as well as similar synthetic compounds that have analgesic or pain relieving properties because of their effects in the central nervous system. These include, but are not limited to, codeine, morphine, hydromorphone, hydrocodone, oxycodone, methadone, and fentanyl.

2.9. "Reactivation" means re-licensure of an eligible former licensee who has not held a license issued by the Board for more than one year immediately preceding the request for reactivation.

2.10. "Reinstatement" means re-licensure of an eligible former licensee whose license automatically expired or was subject to a non-disciplinary voluntary surrender less than one year prior to the request for reinstatement.

2.11. "Renewal applicant" means a licensee who is seeking to renew a license issued by the Board.

2.12. "Reporting period" means the two-year period preceding the renewal deadline for a license issued by the Board. Continuing education satisfactory to the Board must be obtained in each reporting period.

2.13. "Website" or "Board's website" means the set of related web pages operated by or on behalf of the West Virginia Board of Medicine located at the domain name [illegible], or at any successor domain name published by the Board.

**§11-6-3. Continuing Education Satisfactory to the Board.**

3.1. Physicians. -- Successful completion of a minimum of fifty hours of continuing medical education satisfactory to the Board during the preceding two-year period is required for the biennial renewal of a medical license. At least thirty hours of the required fifty hours must be related to the physician's area or areas of specialty.

Types and categories of continuing medical education satisfactory to the Board for physicians are:

3.1.a Continuing medical education designated as Category I by the AMA or the American Academy of Family Physicians.

3.1.b. Teaching medical education courses or lecturing to medical students, residents, or licensed physicians, or serving as a preceptor to medical students or residents. A physician may obtain a maximum of twenty hours of continuing medical education credit for this category of activity.

3.1.c. Passing a certification or recertification examination of one of the ABMS member boards, and receiving certification or recertification from said board during the reporting period, or successful involvement in maintenance of certification from said ABMS member board during the reporting period. Certification, recertification, or current successful involvement in maintenance of certification from any board other than one of the ABMS member boards does not qualify the recipient for any credit hours of continuing medical education. A maximum of fifty hours of continuing medical education credit may be awarded for this category of activity, but a physician shall only be awarded forty-seven hours of credit if the physician is a mandatory participant in the continuing education activity described in subsection 3.3 of this rule.

3.1.d. Successful completion during the reporting period of a minimum of twelve months of an ACGME approved post-graduate training program or fellowship. A maximum of fifty hours of continuing medical education credit may be awarded for this category of activity, but a physician shall only be awarded forty-seven hours of credit if the physician is a mandatory participant in the continuing education activity described in subsection 3.3 of this rule.

There are no other types or categories of continuing medical education satisfactory to the Board for physicians.

3.2. Podiatric physicians. -- Successful completion of a minimum of fifty hours of continuing podiatric education satisfactory to the Board during the preceding two-year period is required for the biennial renewal of a podiatric license. At least thirty hours of the hours must be related to the podiatric physician's area or areas of specialty. Types and categories of continuing podiatric education activity satisfactory to the Board for podiatric physicians are:

3.2.a. Continuing podiatric education:

3.2.a.1. Approved by the APMA or Council on Podiatric Medical Education;

3.2.a.2. Presented or sponsored by any of the podiatry colleges in the United States;

3.2.a.3. Designated as Category I by the AMA or the American Academy of Family Physicians; or

3.2.a.4. Presented or sponsored by the West Virginia Podiatric Medical Association.

3.2.b. Teaching podiatric education courses or lecturing to medical students, podiatric students, residents, or licensed physicians or podiatric physicians on podiatric medicine, or serving as a preceptor to podiatric students or residents. Provided, that a podiatric physician may obtain a maximum of twenty hours of continuing podiatric education credit for this category of activity.

3.2.c. Passing a certification or recertification examination of the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery, and receiving certification or recertification from said board during the reporting period. A maximum of fifty hours of continuing medical education credit may be awarded for this category of activity, but a physician shall only be awarded forty-seven hours of credit if the physician is a mandatory participant in the continuing education activity described in subsection 3.3 of this rule.

3.2.~~c~~d. Successful completion during the reporting period of a minimum of twelve months of graduate clinical training in a program approved by the Council on Podiatric Medical Education or the Colleges of Podiatric Medicine. A maximum of fifty hours of continuing podiatric education credit may be awarded for this category of activity, but a podiatric physician shall only be awarded forty-seven hours of credit if the licensee is a mandatory participant in the continuing education activity described in subsection 3.3 of this rule.

There are no other types or categories of continuing podiatric education activity satisfactory to the Board.

3.3. Mandatory Continuing Education Activity for Physicians and Podiatric Physicians. -- As a prerequisite to license renewal, a licensee who has prescribed, administered, or dispensed any controlled substance pursuant to a West Virginia license during the reporting period shall complete a Board-approved continuing education activity for a minimum of three hours of drug diversion training and best practice prescribing of controlled substances training.

3.3.a. The Board-approved drug diversion training and best practice prescribing of controlled substances training shall satisfy three of the fifty required hours of continuing education for the reporting period.

3.3.b. A renewal applicant who has not prescribed, administered, or dispensed any controlled substances pursuant to a West Virginia license during the reporting period may seek a waiver of this continuing education requirement by completing the required attestation and waiver request on the renewal application.

3.4. Other than as specifically set forth herein, in calculating continuing education activities, one hour equals sixty minutes of activity or instruction.

**§11-6-4. Certification of Successful Completion of Continuing Education Requirements.**

4.1. Certification. -- A renewal applicant shall, as a condition of licensure renewal, certify his or her successful completion of all required continuing education during the reporting period.

4.2. Form of Certification. -- The Board shall include a certification of successful completion of required continuing education on its biennial renewal application. The certification shall require the renewal applicant to:

4.2.a. Certify successful completion of all required continuing education;

4.2.b. Attest to the truthfulness and accuracy of the renewal applicant's statements regarding continuing education activities;

4.2.c. Acknowledge that any license issued based upon the renewal application is based upon the truth and accuracy of the applicant's statements and that if false information is submitted in the application, such act constitutes good cause for the revocation of the renewal applicant's license to practice in the State of West Virginia; and

4.2.d. Sign and date the certification.

4.3. Timely Submission of Certification. -- At the beginning of each renewal application period, the Board shall publish the renewal deadline on its website. A continuing education certification is timely if it is received by the Board prior to the renewal deadline.

4.4. A license shall automatically expire if the certification required by this section is not submitted to the Board by the renewal deadline. An automatically expired license shall remain expired until a licensee successfully seeks reinstatement or reactivation of license.

**§11-6-5. Recordkeeping, Audits and Written Documentation of Successful Completion of Continuing Education Requirements.**

5.1. Records. A licensee shall maintain accurate records of all continuing education he or she has completed. Continuing education records shall be maintained for a period of six years.

5.2. Audits. -- The Board may conduct such audits and investigations as it considers necessary to assure compliance with continuing education requirements and to verify the accuracy of a renewal applicant's certification of continuing education.

5.3. Production of Written Documentation. -- Upon written request of the Board to a licensee's preferred mailing address or e-mail address of record with the Board, a licensee shall, within thirty days, submit written documentation satisfactory to the Board corroborating the licensee's renewal application certification of continuing education compliance.

5.4. Failure or Refusal to Provide Written Documentation. -- Failure or refusal of a licensee to provide written documentation requested by the Board as set forth in subsection 5.3. of this rule is prima facie evidence of renewing a license to practice medicine or podiatry by fraudulent misrepresentation and the licensee is subject to disciplinary proceedings under W. Va. Code §30-3-14.

5.5. Inactive License. -- A licensee who holds an inactive license and who makes a written request to the Board for an active license shall submit written documentation of successful completion of a minimum of fifty hours of continuing education as required in section 3 of this rule. The Board shall not consider a change of status request from an inactive to an active license until all written documentation accompanied by a certification in accordance with section 4 of this rule is submitted to and approved by the Board.

5.6. Reinstatement Applicants. - As a part of a reinstatement application, an eligible applicant shall certify his or her completion of all required continuing education for the previous reporting period, and shall submit written documentation satisfactory to the Board corroborating applicant's certification of continuing education compliance.

5.7. Reactivation applicants. – An eligible applicant seeking reactivation of licensure shall submit a reactivation application packet, which includes an initial licensure application accompanied by any corroborating documentation or verifications required by the Board for reactivation applicants, the reactivation application fee, and one of the following:

5.7.a. Certification and written documentation of successful completion of continuing education for the reporting period associated with the applicant's last period of licensure with the Board;

5.7.b. Certification and written documentation of successful completion of fifty hours of continuing education satisfactory to the Board within two-year period preceding the application submission date; or

5.7.c. An attestation by the applicant that he or she holds an active status license in another state which requires the periodic completion of a minimum number of continuing education hours as a condition of continued licensure, and that the applicant is currently compliant with all such continuing education requirements.

**§11-6-6. Board Approval of Drug Diversion Training and Best Practice Prescribing of Controlled Substances Training Courses.**

6.1. The biennial requirement to complete a minimum of three hours of drug diversion training, stigma education, overview of opioid use disorder treatment, and best practice prescribing of controlled substances training requires successful completion of a Board-approved course.

6.2. The Board shall maintain and publish on its website a current list of all educational activities which have been approved by the Board to satisfy the drug diversion training, stigma education, overview of opioid use disorder treatment, and best practice prescribing of controlled substances training continuing education requirement.

6.3. To obtain Board approval that an educational activity satisfies the drug diversion training, stigma education, overview of opioid use disorder treatment, and best practice prescribing of controlled substances training requirement, a provider or sponsor shall submit a written request to the Board at least thirty days in advance of the educational activity:

6.3.a. Identifying the provider, sponsor, all presenters and the full name of the educational activity for which Board approval is sought;

6.3.b. Identifying all dates and locations that the educational activity will be offered;

6.3.c. Confirming that the educational activity includes all required training components which are set forth in subsection 2.5; and

6.3.d. Providing sufficient documentation of the course content and objectives to permit the Board to evaluate whether approval should be granted.

6.4. Board-approval for a proposed continuing education activity is valid for a period of one year. If additional dates or locations of a Board-approved training are offered within the approval period, the course sponsor or presenter shall notify the Board of the date and location of all such additional course offerings.

6.5. To obtain approval in a subsequent year for an updated educational activity which was previously approved pursuant to this section, a provider or sponsor shall submit a written request to the Board at least thirty days in advance of the educational activity:

6.5.a. Identifying full name of the educational activity which was previously approved and any changes to the name for the updated course;

6.5.b. Identifying all dates and locations that the updated educational activity will be offered;

6.5.c. Confirming that the updated educational activity includes all required training components which are set forth in subsection 2.5; and

6.5.d. Providing sufficient information regarding the updated information incorporated into the course content to permit the Board to evaluate whether approval should be granted.

6.6. Board staff shall respond to all requests submitted pursuant to this section, in writing, within twenty days of receipt of the request.

# State of West Virginia
# *Board of Medicine*

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Charleston, WV 25311
Telephone (304) 558-2921
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July 30, 2021

**VIA ELECTRONIC MAIL ONLY**
Matthew Q. Christiansen, MD, MPH
Director, Office of Drug Control Policy
Matthew.Q.Christiansen@wv.gov

**Re: Proposed Amendments to West Virginia Board of Medicine Rule 11 CSR 1B**

Dear Dr. Christiansen:

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Thank you again for your participation in the rulemaking process and for your comments.

Sincerely,

Mark A. Spangler

MAS/jcf
Enclosure