Vermont Board of Medical Practice

February 1, 2023

Remote Via Microsoft Teams

Dial: (802) 828-7667 Conference ID: 867 106 939 #

10:30 AM Licensing Committee

12:00 PM Vermont Board of Medical Practice

- **Call to Order; Roll Call; Acknowledge Guests:**
- **Public Comment:**
- **Approval of Minutes of the January 4, 2023, and January 18, 2023, Board Meetings**
- **Board Issues (Dr. Hildebrant):**
- **Administrative Update (David Herlihy):**
- **Presentation of Applications**
- **Convene hearing to discuss any stipulations or disciplinary matters that are before the Board (12:45 PM – 1:15 PM)**
    - **In re: David Bourgeois, MD – Stipulation and Consent Order – MPS 045-0520**
    - **In re: Kasey Shelton – Licensing Matter– (Tentative subject to prior approval of Licensing Committee)**
- **Other Business: (1:15 PM)**
    - **Executive Session for the Purpose of Confidential Attorney/Client Communications Regarding Pending Litigation**
    - **FSMB Annual Meeting**

      The FSMB 2023 Annual Meeting will be held May 4-6 in Minneapolis, Minnesota. Routinely FSMB provides “scholarships” to a voting delegate and a senior staff person. Generally, for this Board (and most boards) the Chair and Executive Director attend. This year FSMB is offering a scholarship to a third representative from each member board to attend. Scholarships may be used for transportation, meal, and hotel expenses, limited to $2,000 per person. The purpose of this discussion will be to identify members who are interested in attending and, if there are multiple members who are interested, deciding on how to select who will attend. Anyone interested in finding out more about the meeting may find information on the FSMB website at: https://www.fsmb.org/education/. Recordings of some 2022 sessions are

available and by the time you read this there may be more details about 2023 offerings.

- **Radiology Assistant Issues**

  UVMMC has asked to address the Board to propose changes with regard to certain practices associated with Radiologist Assistants (RA). The two changes proposed are:

  1. RAs should be able to receive the required, appropriate level of direct supervision through synchronous audio and/or visual means.

  2. RAs should be able to communicate physician findings directly to patients as well as their own observations - not clinical findings - in real time during or immediately after a procedure.

  UVMMC representatives will make a presentation to the Board and there will be discussion of the legal and regulatory standards that bear on the proposal, along with changes to law or rules that would have to be made to accommodate the proposal, before the Board has an opportunity consider whether the proposals should be supported.

  Appendix A with referenced materials is attached.

- **Telehealth Issues**

  Telehealth is on the agenda for two reasons. First, the ad hoc committee formed to review the Board's 2015 policy on *The Appropriate Use of Telemedicine Technologies in the Practice of Medicine* and will present its recommended revision. In arriving at the proposed update to the Board Policy, the ad hoc committee considered the 2022 *FSMB Model Guidelines for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine.*

  The second reason telehealth is on the agenda is that a telehealth business that offers online healthcare services, including prescriptions written by licensed healthcare professionals, approached the Board to announce their intention to seek legislative action in the current session to amend Vermont law allowing them to use their practice model, which does not currently comply with Vermont law. The change that the telehealth company proposes reflects one of the decision points considered by the ad hoc committee in reviewing revisions to the Board's Policy. A decision by the Board on that issue will be both part of the review of the draft update to the Board Policy and establish the position the Board will take should the proposal to change the law is discussed in the Legislature this session.

  The change described by the telehealth company would eliminate or revise current language in a section addressing prescribing via telehealth that

provides: *(B) for the purposes of this subdivision (33), an electronic, on-line, or telephonic evaluation by questionnaire is inadequate for the initial evaluation of the patient.* 26 V.S.A. § 1354(a)(33). More specifically, their desired practice model is to use what is referred to as an "adaptive" or "dynamic" questionnaire that takes a customer through a series of questions that changes depending on the answers given. They believe they can elicit the information from the customer that provides the prescriber with the information necessary to make a decision about prescribing that meets the standard of care without any direct, synchronous communication between the patient and the physician.

- **Licensing Process**

  The is to make the Board aware of a meeting with representatives of VMS, VAHHS, and nursing facilities, during which they raised concerns about our licensing process. One or more of those representatives will join the meeting and present their concerns.

- **Reconvene meeting; Executive Session to discuss:**
  - **Investigative cases recommended for closure**
  - **Other matters that are confidential by law; if any**
- **Return to Open Session; Board Actions on matters discussed in Executive Session:**
- **Board Actions on Committee recommendations regarding any non-confidential matters:**
- **Upcoming Board meetings, Committee meetings, hearings, etc.: Locations are subject to change. A notification will be provided if a change takes place.**
  - **February 9, 2023, North Investigative Committee Meeting, 9:00 AM. Remote via Teams.**
  - **February 10, 2023, Central Investigative Committee Meeting, 9:00 AM. Remote via Teams.**
  - **February 15, 2023, Board Meeting mid-month on pending applications, 12:10 PM. Remote via Teams.**
  - **February 15, 2023, South Investigative Committee Meeting, 12:15 PM. 4th Floor Conference Room, Bloomer State Office Building, Rutland, VT and remote via Teams.**
  - **March 1, 2023, Licensing Committee Meeting, 11:00 AM. Remote via Teams.**
  - **March 1, 2023, Board Meeting, 12:00 PM. Remote via Teams.**

- **Open Forum:**
- **Adjourn:**

Non-Board Members / General Public
Remote via Microsoft Teams
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If you join the meeting during the time the Board is in Executive Session, the line will be open and monitored by staff. You are welcome to remain on the line until the Board returns to Open Session.

If you have any questions about this meeting, contact phone: (802) 657-4220 or email: AHS.VDHMedicalBoard@vermont.gov

Appendix A

RA References for Board Discussion off RA Issues on February 1, 2023

I. Vermont Law

From 26 V.S.A. § 2851, Definitions:

(8) "Supervision" means the direction and review by a supervising radiologist, as determined to be appropriate by the Board, of the medical services provided by the radiologist assistant. At a minimum, supervision shall mean that a radiologist is readily available for consultation and intervention.

From 26 V.S.A. § 2857, Supervision and scope of practice:

a) The number of radiologist assistants permitted to practice under the direction and supervision of a radiologist shall be determined by the Board after review of the system of care delivery in which the supervising radiologist and radiologist assistants propose to practice. Scope of practice and levels of supervision shall be consistent with guidelines adopted by the American College of Radiology, the American Society of Radiologic Technologists, and the ARRT. The authority of a radiologist assistant to practice shall terminate immediately upon termination of the radiologist assistant's employment, and the primary supervising radiologist shall immediately notify the Board and the Commissioner of the Department of Health of the termination. The radiologist assistant's authority to practice shall not resume until he or she provides proof of other employment and a protocol as required under this chapter.

(b) Subject to the limitations set forth in subsection (a) of this section, the radiologist assistant's scope of practice shall be limited to that delegated to the radiologist assistant by the primary supervising radiologist and for which the radiologist assistant is qualified by education, training, and experience. At no time shall the practice of the radiologist assistant exceed the normal scope of the supervising radiologist's practice. A radiologist assistant may not interpret images, make diagnoses, or prescribe medications or therapies.

II. Board Rules

63.0 More Than One Supervising Radiologist

> 63.1 Each application for initial certification, temporary certification, renewal of certification or change of certification shall identify the primary supervising radiologist who shall be responsible for the radiologist assistant's professional activities and sign the protocol required under 26 V.S.A. § 2853.
>
> 63.2 Subject to the scope of practice restrictions in this rule and Chapter 52 of Title 26, the radiologist assistant may also perform services under the supervision of additional board-certified radiologists working in the same office or hospital as the primary supervising radiologist ("secondary supervising radiologist[s]"), but must file a protocol regarding that supervisory relationship and a statement from the secondary supervising radiologist of the responsibility for the professional activities of the radiologist assistant performed under supervision.

66.0 Supervision

66.2 Supervision does not, necessarily, require the constant physical presence of the supervising radiologist; however, the radiologist must remain readily available in the facility for immediate diagnosis and treatment of emergencies.

66.4 Nothing in this section shall prohibit the supervising radiologist from addressing an emergency in another location in the facility.

67.0 Protocol and Scope of Practice

67.1 A radiologist assistant's scope of practice is limited to procedures and treatments that the supervising radiologist performs in the practice.
67.2 A radiologist assistant may not interpret images, make diagnoses, or prescribe medications or therapies.

67.3 The radiologist assistant may assist the radiologist in developing and implementing a radiologic care plan for a patient. In so doing, the radiologist assistant may, in the discretion of the radiologist, perform patient assessment, patient management and selected examinations as outlined below:

67.3.1 Obtaining consent for and injecting agents that facilitate and/or enable diagnostic imaging;

67.3.2 Obtaining clinical history from the patient or medical record;

67.3.3 Performing pre-procedure and post-procedure evaluation of patients undergoing invasive procedures;

67.3.4 Assisting radiologists with invasive procedures;

67.3.5 Performing fluoroscopy for non-invasive procedures with the radiologist providing direct supervision of the service;

67.3.6 Monitoring and tailoring selected examinations under direct supervision (i.e., IVU, CT program, GI studies, VCUG, and retrograde urethrograms);

67.3.7 Communicating the reports of radiologist's findings to the referring physician or an appropriate representative with appropriate documentation;

67.3.8 Providing naso-enteric and oro-enteric feeding tube placement in uncomplicated patients;

67.3.9 Performing selected peripheral venous diagnostic procedures; and

67.3.10 Any other activity that the Board approves in a protocol to allow for changing technology or practices in radiology.

68.0 Places of Practice

A radiologist assistant shall work only in the office of the primary supervising radiologist or in the hospital in which the primary supervising radiologist practices.

III. American College of Radiology

1 ACR Practice Parameters

ACR Practice Parameter For Communication Of Diagnostic Imaging Findings (full document at https://www.acr.org/-/media/ACR/Files/Practice-Parameters/CommunicationDiag.pdf)

Excerpt from 8-page document:

A. Nonphysicians and Interpretation

Rendering interpretations of medical imaging studies (preliminary, final, or otherwise) is beyond the scope of practice and is not the intended role of nonphysician members of the healthcare team, including NPRPs, radiologic technologists, nurses, and others, but excluding physicians in training. Nonphysicians should not be permitted to render interpretations of medical imaging studies, whether under physician supervision or as an independent nonphysician healthcare provider. (ACR Resolution 16, adopted 2021)

An interpretation of an imaging procedure is the action of an individual and not defined by the location of their contributions in the report. Interpretations may appear anywhere in a radiology report or elsewhere in the medical record (eg, findings, impression, or otherwise). Nonphysician members of the healthcare team, including radiologic technologists, nurses and others, should not be involved in the interpretation of an imaging examination regardless of where their observations are located in the report or medical record.

An interpretation is not defined by the availability of a report to other healthcare providers, but rather by its content and the nature of intellectual activity which produced it. Specifically, reports and/or notes in the medical record in any stage of completion by a nonphysician when that nonphysician was not directly involved in the acquisition of the medical images being interpreted or procedure which was performed, may all be considered interpretations, depending on their content. Such a report or note is considered an interpretation whether it is a draft (available only to a radiologist), a preliminary report, a final report, or any other written form.

Nonphysicians such as NPRPs and radiologic technologists may provide observations to the radiologist regarding targeted real-time image acquisitions or invasive procedures in which they were involved. Examples include a technologist providing observations from real-time targeted ultrasound or fluoroscopic image acquisitions and an NPRP describing a needle procedure they performed. Observations from a nonphysician who acquired medical images should be provided to the radiologist in a draft form only and should be limited to observations made during the acquisition of images (such as a sonographer worksheet). Observations from a nonphysician who performed or assisted in an invasive procedure may be provided to the radiologist in any portion of the radiology report and/ or medical record, and may be in any stage of completion as permitted by local institutional policy. It is not appropriate for nonphysicians to routinely provide observations on imaging studies and/ or procedures

when they were not directly involved in the performance of the procedure or acquisition of the images (eg, radiographs, mammography, CT scans, MRI scans, and nuclear imaging). (ACR Resolution 17, Adopted 2021) (underscore added to highlight relevant text)

2 ACR Media Releases

Announcement of Change to Supervision in Practice Parameters

August 29, 2022
ACR Changes CT and MRI Accreditation Contrast Media Supervision Requirements

The American College of Radiology® (ACR®) Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) Accreditation Committees have announced that a radiologist (MD/DO) will now provide direct or general supervision of intravenous contrast material administration and ensure compliance with guidance provided in the ACR Manual on Contrast Media.

Also, in line with the ACR-SPR Practice Parameter for the Use of IV Contrast Media, and recognizing a range of responsible providers trained in and capable of managing an acute hypersensitivity reaction under general supervision of a radiologist, the following providers may provide direct supervision of intravenous contrast administration:

1. Non-radiologist physicians (MD/DO).
2. Advanced practice providers (nurse practitioner, physician assistant).
3. Registered nurses following a symptom- and sign-driven treatment algorithm.

The provider of direct supervision must be immediately available to furnish assistance and direction throughout the performance of the procedure. This does not mean that the supervising provider or radiologist must be present in the room where and when the procedure is performed.

However, there should be at least one person who can recognize adverse events related to contrast media administration in attendance (in the room or in an adjacent control room) to observe the patient during and immediately after the injection and summon medical assistance as needed.

All local and state regulations regarding supervision of contrast media administration must be followed.

For more information, consult the ACR Manual on Contrast Media and the ACR-SPR Practice Parameter for the Use of IV Contrast Media.

(https://www.acr.org/Media-Center/ACR-News-Releases/2022/ACR-Changes-CT-and-MRI-Accreditation-Contrast-Media-Supervision-Requirements)

IV. American Society of Radiologic Technologists

ASRT Practice Standards for Medical Imaging and Radiation Therapy – Radiologist Assistant

Excerpt from Definitions at page PS 23:
initial observation – Assessment of technical image quality with pathophysiology correlation

communicated to a radiologist.
interpretation – The process of

Excerpt from page PS28 of the Practice Standards (full document at: https://www.asrt.org/docs/default-source/practice-standards/ps_raa.pdf?sfvrsn=1ae076d0_22) (underscoring added to highlight relevant material)

Guidance for the Communication of Clinical and Imaging Observations and Procedure Details by Radiologist Assistants to Supervising Radiologists

Advisory Opinion

It is the opinion of the ASRT that based upon current literature, curricula set forth by the ASRT, entry-level clinical activities by the ARRT, regulatory requirements and where federal or state law and/or institutional policy permits that:

1. Communication of clinical and imaging observations and procedure details by the radiologist assistant to the supervising radiologist is an integral part of radiologist assistant practice. Without clear, consistent, appropriate and ascribed communication between members of the radiology team, there is a possibility of inadequate patient care, incomplete reports and diminished departmental productivity. To create a safe and productive radiology environment, communication between the radiologist assistant and supervising radiologist must be free-flowing, consistent and relevant to the patient examination or procedure. This communication can take many forms, including verbal, written and electronic correspondence. These communications may be included and taken into consideration by the radiologist in creating a final report. However, initial clinical and imaging observations and procedure details communicated from the radiologist assistant to the radiologist are only intended for the radiologist's use and do not substitute for the final report created by the radiologist. These communications should be considered and documented as "initial clinical and imaging observations or procedure details."
2. While assisting radiologists in the performance of imaging procedures or during the performance of procedures under radiologist supervision, the radiologist assistant must be able to communicate and document procedure notes, observations, patient responses and other types of information relevant to the radiologist's interpretation and creation of the final report. Radiologist assistants do not independently "report findings" or "interpret" by dictation or by any other means; and to avoid any confusion, these terms should not be used to refer to the activities of the radiologist assistant. However, radiologist assistants may add to the patient record (following the policies and procedures of the facility) in a manner similar to any other dependent nonphysician practitioner. Radiologist assistants who are authorized to communicate initial observations to the supervising radiologist using a voice recognition dictation system or other electronic means must adhere to institutional protocols ensuring that initial observations can be viewed or accessed only by the supervising radiologist. Initial clinical or imaging observations or procedure details created by the radiologist assistant resulting from the radiologist assistant's involvement in the performance of the procedure that are included in the final report should be carefully reviewed by the supervising radiologist and should be incorporated at the supervising radiologist's discretion.

With proper education and proven competence, the communication of clinical and imaging observations and procedure details by radiologist assistants to supervising radiologists provides quality patient services in a safe environment.

V. CMS Regulations

42 CFR § 410.32

Excerpt from regulation

(3) Levels of supervision. Except where otherwise indicated, all diagnostic x-ray and other diagnostic tests subject to this provision and payable under the physician fee schedule must be furnished under at least a general level of supervision as defined in paragraph (b)(3)(i) of this section. In addition, some of these tests also require either direct or personal supervision as defined in paragraph (b)(3)(ii) or (iii) of this section, respectively. When direct or personal supervision is required, supervision at the specified level is required throughout the performance of the test.

(i) General supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

(ii) Direct supervision in the office setting means the physician (or other supervising practitioner) must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician (or other supervising practitioner) must be present in the room when the procedure is performed. Until the later of the end of the calendar year in which the PHE as defined in § 400.200 of this chapter ends or, December 31, 2021, the presence of the physician (or other practitioner) includes virtual presence through audio/video real-time communications technology (excluding audio-only).

(iii) Personal supervision means a physician must be in attendance in the room during the performance of the procedure.

(4) Supervision requirement for RRA or RPA. Diagnostic tests that are performed by a registered radiologist assistant (RRA) who is certified and registered by the American Registry of Radiologic Technologists or a radiology practitioner assistant (RPA) who is certified by the Certification Board for Radiology Practitioner Assistants, and that would otherwise require a personal level of supervision as specified in paragraph (b)(3) of this section, may be furnished under a direct level of physician supervision to the extent permitted by state law and state scope of practice regulations.

THE
University of Vermont
MEDICAL CENTER

Friday, December 9, 2022

Mr. David Herlihy, Executive Director
Vermont Board of Medical Practice
108 Cherry Street
Burlington, VT 05402

Re: *Request for Rule Modification for Radiologist Assistants Licensed and Practicing in Vermont*

Dear Executive Director Herlihy:

Thank you for meeting with me and my colleagues at the UVM Health Network this week to discuss our request for the rule governing the practice of Radiologist Assistants (RAs) be modified. We look forward to attending the January 4th meeting of the Vermont Board of Medical Practice (VBMP or the Board) to discuss this request and appreciate you sending the meeting information and link when they are available.

There are a myriad of reasons we could cite for our request: the pressing need for access to necessary and timely health care services; the national workforce challenge facing all levels of recruitment and retention – of which our state and our Network are most certainly not immune; the cost of relying on the most expensive resource to deliver care, highly specialized physicians, and more. Our request of the VBMP is grounded in something more fundamental, though. We have a decade's worth of excellent results with the practice of RAs in our state, and must now recognize that the rules governing their practice need a modest level of modernization. We do not see this request as radical or as an expansion of scope, but rather a recognition of the modern clinical environment and the reasonable expectation that our rules adapt to these changes while remaining firmly grounded in our unwavering commitment to safe patient care.

Our ask of the VBMP, which is detailed below, is straightforward:

- RAs should be able to receive the required, appropriate level of direct supervision through synchronous audio and/or visual means, and
- RAs should be able to communicate physician findings directly to patients as well as their own observations – not clinical findings – in real time during or immediately after a procedure.

As you will see in the rationale detailed below, we see these changes as adding a level of specificity one could argue is either already permissible and/or required by the rule or other laws.

Rationale

Direct supervision. Vermont law defines an RA as "a person … who is qualified by education, training, experience, and personal character to provide medical services *under the direction and supervision of a radiologist*." 26 VSA §2851(8). Supervision is defined as "direction and review by a supervising radiologist, as determined to be appropriate by the Board…" 26 VSA §2851(7). The law does not define more specifically what "direct supervision" is and instead leaves it up to the Board to define by Rule.

Board Rule 66.1 provides that supervision of an RA by the supervising radiologist "shall be set forth in the written practice protocol filed with the Board." And the rule further requires "a direct, continuing and close supervisory relationship between a radiologist assistant and the supervising radiologist." However, Rule 66.2 clarifies that supervision *does not, necessarily* "require the constant physical presence of the supervising radiologist; however, the radiologist must remain readily available in the facility for immediate diagnosis and treatment of emergencies." Therefore, while some limited remote supervision may be allowed as specified in the written practice protocol, the direct supervision of RAs should be allowed to include remote supervision through synchronous audio and/or visual means.

Communicating to patients on preliminary observations and reports of the radiologists' findings. The law is silent regarding the ability of RAs to both communicate the results of physician reports, as well as their own observations during or immediately following a procedure. The rules (67.3.7) do allow RAs to communicate the reports of radiologist's findings to a referring physician. However, it is not clear whether RAs can communicate reports to the patient. Additionally, procedural observations are made at the time of the exam but not communicated to the patient. RAs would like to communicate preliminary observations to the patient and referring provider prior to the final interpretation and report made by the radiologist. On this latter point, it is our opinion that RA observations will be required to be disclosed to patients through their electronic medical records under the requirements of the federal 21st Century Cures Act. By allowing RAs to provide their observations real time and in-person, patients will be able to engage in a better-informed direct conversation with their trusted clinician who will be operating within their defined scope of practice.

In summary, the changes we are requesting of the VBMP are permissible under Vermont law and, while not currently prohibited, are not clearly permissible under the Rule. We look forward to discussing this in detail with the VBMP and stand ready to answer questions and partner with you and the Board to effectuate these changes.

Sincerely,

Kristen DeStigter

Kristen DeStigter, MD
John P and Kathryn H Tampas Green and Gold Professor
Chair of the Department of Radiology
Larner College of Medicine at the University of Vermont
Health Care Service Chief
Network Department of Radiology

Cc: Mary Streeter, Radiologist Assistant, UVM Health Network
Jason W. Williams, Vice President of Government & Community Relations, UVM Health Network