MINUTES

NORTH CAROLINA MEDICAL BOARD

November 18-20, 2015

1203 Front Street
Raleigh, North Carolina

General Session Minutes of the North Carolina Medical Board Meeting held November 18-20, 2015.

The November 2015 meeting of the North Carolina Medical Board was held at the Board's Office, 1203 Front Street, Raleigh, NC 27609. Pascal O. Udekwu, MD, President called the meeting to order. Board members in attendance were: Eleanor E. Greene, MD, President-Elect; Timothy E. Lietz, MD, Secretary/Treasurer; Cheryl L. Walker-McGill, MD, Immediate Past-President; Mr. Michael Arnold; Ms. H. Diane Meelheim, FNP-BC; Mr. A. Wayne Holloman; Bryant A. Murphy, MD; Debra Bolick, MD; Judge Ralph A. Walker and Barbara E. Walker, DO. Board Members absent: Subhash C. Gumber, MD.

Instillation Ceremony and New Officers Oath

Dr. Walker-McGill administered the Oath of Office for President of the NC Medical Board to Dr. Pascal O. Udekwu.

Dr. Udekwu administered the Oath of Office for President-Elect to Dr. Eleanor E. Greene and for Secretary/Treasurer to Dr. Timothy Lietz.

Presidential Remarks

Dr. Udekwu commenced the meeting by sharing his first words as President. He also reminded the Board members of their duty to avoid conflicts of interest with respect to any matters coming before the Board as required by the State Government Ethics Act. No conflicts were reported.

Minute Approval

Motion: A motion passed to approve the September 16-18, 2015 Board Minutes. There was not a Board Hearing in October; therefore there were no minutes for that month.

Announcements

Dr. Murphy gave an update on the Appalachian Summit that was held on September 23, 2015 in Wise, Virginia. The Summit covered many subjects such as: drug courts, physician education, more pharmacy involvement, engaging the recovery community, treatment best practices and regulators of pain clinics. North Carolina was well represented by stakeholder organizations.

Dr. Walker-McGill gave an update on the Tri-Regulator Symposium that was held on October 6-7, 2015 in Arlington, Virginia. The Symposium covered the following topics: utilization of swarm technology, successful team building and challenges that are faced, new practice models and regulatory strategies, ensuring fair and respectful stakeholder communication, federal trade commission v dental board and reaction to the dental board case.

Dr. Udekwu gave an update on the on the CTel Executive Telehealth Fall Summit 2015, held November 12-13, 2015 at Arlington, Virginia. The summit was well attended by regulators and those interested in entering the market.

North Carolina Physician Health Program Reports (NCPHP)

Dr. Bolick gave a report regarding the November 18, 2015 NCPHP Board of Directors meeting.

NCPHP COMPLIANCE COMMITTEE REPORT

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

Dr. Warren Pendergast, CEO, NC Physicians Health Program (PHP), gave the PHP Compliance Committee report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

NCMB Attorney's Report

Mr. Thom Mansfield, Chief Legal Officer, gave the Attorney's Report.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

The Board's attorneys gave an update on pending litigation and provided legal advice regarding one non-public attorney-client privileged matter.

A motion passed to return to open session.

NCMB Committee Reports

EXECUTIVE COMMITTEE REPORT

Members present were: Pascal O. Udekwu, MD, Chairperson; Cheryl L. Walker-McGill, MD; Eleanor E. Greene, MD; Timothy E. Lietz, MD; and Mr. Michael J. Arnold.

Strategic Plan

a. Strategic Goals Update

   The Committee reviewed the updated Strategic Goals Task Tracker. Updates on the 2015 strategic goal outcomes will be reviewed in January. Also in January, staff will present the Committee with suggested metrics for the 2016 strategic goals.

   Committee Recommendation: Accept as information.

   Board Action: Accept committee recommendation. Accept as information.

Financial Statements

a. Monthly Accounting

The Committee reviewed the compiled financial statements for August 2015 and September 2015. September is the eleventh month of fiscal year 2015.

Committee Recommendation: Accept the financial statements as reported.

Board Action: Accept Committee Recommendation. Accept the financial statements as reported.

b. Investment Account Statements

The Committee reviewed the investment statements for September and October 2015.

Committee Recommendation: Accept as information.

Board Action: Accept Committee Recommendation. Accept as information.

Old Business

a. Proposed Travel Policy

The Committee reviewed an updated proposed Travel Policy for Board members and staff. One section in the travel policy (rental cars) required modifications in order to allow the Travel Policy to accommodate both Board members and staff in one policy. The proposed policy memorializes current NCMB policies (written and unwritten) and incorporates other customary expense reimbursement practices.

Staff updated the Travel Policy to include all changes specified by the Executive Committee and presented the revised policy to the full Board.

Committee Recommendation: Approve the Travel Policy with changes specifying that the 14-day deadline for the submission of reimbursement forms applies only to staff.

Board Action: Approve the revised Travel Policy.

b. Cumberland County Medical Society (CCMS) Concerns

Earlier this year, CCMS expressed various concerns regarding the Federation of State Medical Boards (FSMB) and its CEO, Dr. Humayun Chaudhry, and asked the NCMB to withdraw its membership in the FSMB. In July, the Board voted to forward these concerns to the FSMB Board of Directors and request an official response. A response was received from the FSMB on August 26, 2015. By letter dated October 27, 2015, CCMS replied to the FSMB response.

Committee Recommendation:

1. Retain membership with the FSMB and thereby continue to benefit from educational programs that disseminate regulatory best practices and provide a forum for discussions with other state medical boards.

2. Continue to carefully consider whether FSMB policy recommendations promote the Board's public protection mission.
3. Continue gathering information regarding the improper financial relationships alleged by CCMS.

Board Action: Accept Committee Recommendation. Take the following actions:

1. Retain membership with the FSMB and thereby continue to benefit from educational programs that disseminate regulatory best practices and provide a forum for discussions with other state medical boards.
2. Continue to carefully consider whether FSMB policy recommendations promote the Board's public protection mission.
3. Continue gathering information regarding the improper financial relationships alleged by CCMS.

c. Longevity in Practice Roundtable

Staff provided an update on the October 21st Switching Gears: Longevity in Practice Roundtable. The Longevity in Practice workgroup will be meeting Thursday afternoon to make recommendations to the Board.

Committee Recommendation: Accept as information.

Board Action: Accept Committee Recommendation. Accept as information

New Business

a. Call for FSMB Resolutions

Executive Committee members discussed any potential resolutions for submission to the 2016 FSMB House of Delegates. The Board will not be submitting any resolutions at this time.

Committee Recommendation: Do not submit any draft resolutions to FSMB in 2016.

Board Action: Accept Committee Recommendation. Do not submit any draft resolutions to FSMB in 2016.

b. Appointment of PHP Compliance Committee

The Executive Committee is responsible for nominating a former Board member to the NC PHP Compliance Committee for service from January 1, 2016 until December 31, 2018. Dr. Saunders is not available to serve a second term. The Committee discussed appointing former Board member Dr. Karen Gerancher to the NC PHP Compliance Committee.

Committee Recommendation: Appoint Dr. Karen Gerancher for service on the NC PHP Compliance Committee.

Board Action: Accept Committee Recommendation. Appoint Dr. Karen Gerancher for service on the NC PHP Compliance Committee.

c. Request to Add Voluntary Information to the Renewal Form

In 2016, NCMB will be launching a public awareness campaign to highlight information found in the licensee information directory. The Committee discussed the best way to increase the quality and quantity of the information provided on the licensee information pages – i.e. increasing the information reported in the voluntary fields. The Committee discussed concerns about adding additional questions to the license renewal application and that it must be communicated clearly that providing this information is voluntary. It is important to be transparent to the licensees and the public regarding this voluntary information.

Committee Recommendation:

1. Add a page to the license renewal application with questions for the voluntary fields.
2. Put at the top of the form information that makes it clear to licensees that completion of this portion of the renewal application is voluntary.
3. Explore adding additional information to the licensee page to alert licensees and the public that the information is audited but that it is a limited audit.
4. Proactively communicate with licensees and the public the intent behind the voluntary information found on the website.

Board Action: Accept Committee Recommendation. Take the following actions:

1. Add a page to the license renewal application with questions for the voluntary fields.
2. Put at the top of the form information that makes it clear to licensees that completion of this portion of the renewal application is voluntary.
3. Explore adding additional information to the licensee page to alert licensees and the public that the information is audited but that it is a limited audit.
4. Proactively communicate with licensees and the public the intent behind the voluntary information found on the website.

d. Modifications to Renewals

A request has been made to require licensees to either (1) provide information on the renewal form that is required by G.S. 90-5.2 or (2) declare that that field does not apply to them. The Committee discussed this request and the differences between incomplete forms and inaccurate forms. The Committee suggested modifying the statement at the end of the renewal application indicating that if a mandatory field is left blank the Board will assume the reason is that the field does not apply.

Committee Recommendation: Modify the statement at the end of the renewal application to ensure the requirements of the Medical Practice Act (MPA) are met.

Board Action: Accept Committee Recommendation. Modify the statement at the end of the renewal application to ensure the requirements of the Medical Practice Act (MPA) are met.

e. Draft Controlled Substances CME Requirement Rule

On September 18, 2015, Governor McCrory signed Session Law 2015-241; House Bill 97 into law (State Budget). One provision relates to mandated NCMB CME regarding controlled substance prescribing. The provision will require rule-making to make updates to the CME requirements for applicable licensees. The Committee discussed this provision and the next steps in the process of rule development.

Committee Recommendation: Staff to draft proposed changes to the CME rule for consideration by the Board in January as follows: For physicians who prescribe controlled substances, at least three hours of the Category 1 CME required in a three-year cycle shall be controlled substances CME. For physician assistants who prescribe controlled substances, at least two hours of the Category 1 CME required in a two-year cycle shall be controlled substances CME.

Board Action: Accept Committee Recommendation. Staff to draft proposed changes to the CME rule for consideration by the Board in January as follows: For physicians who prescribe controlled substances, at least three hours of the Category 1 CME required in a three-year cycle shall be controlled substances CME. For physician assistants who prescribe controlled substances, at least two hours of the Category 1 CME required in a two-year cycle shall be controlled substances CME.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

The Board discussed a confidential personnel matter.

A motion passed to return to open session.

POLICY COMMITTEE REPORT

Members Present: Cheryl L. Walker-McGill, Chairperson; Michael Arnold; H. Diane Meelheim, FNP-BC and Wayne Holloman.

Old Business

a. Office Based Procedures **(Appendix A)**

At the May 2015 Policy Committee meeting, the Committee discussed potential review of the Office-Based Procedures position statement to conform to current standards. The Committee recommended referring the position statement to the Executive Committee for further discussion regarding the type and costs of such a review. The full Board accepted the Committee's recommendation and the matter is being considered by the Executive Committee at its September 2015 meeting.

Staff updated the Committee on the steps he has taken thus far to secure an outside entity to review the position statement and advised that he has been unable to find a private entity; however, he has spoken with the Department of Health and Human Services. The Committee suggested additional avenues for staff to pursue.

Committee Recommendation: Continue to pursue securing an entity or entities to review the policy statement, including the Medical Society, the Old North State, and the Centers for Medicare and Medicaid Services. Report back to Committee in January 2016.

Board Action: Accept Committee recommendation. Continue to pursue securing an entity or entities to review the policy statement, including the Medical Society, the Old North State, and the Centers for Medicare and Medicaid Services. Report back to Committee in January 2016.

b. Physician supervision of other licensed health care providers **(Appendix B)**

At the July 2015 Policy Committee meeting, the Committee members discussed concerns about: (1) the potential for boundary violations between supervising physicians and their health care supervisees; and (2) the need to clarify the prohibition on supervisees owning a practice and employing their supervising physician. The Committee recommended, and the Board approved, bringing the position statement back to the Committee in September 2015 with proposed language to address both concerns. The current position statement and a proposed statement are attached as appendix B.

The Committee discussed the proposed language as previously submitted to the Committee. The Committee also asked the guests in the audience for their input and Ms. Cathy Fields, Executive Director at NC Academy of Physician Assistants indicated that they had no further concerns.

Committee Recommendation: Accept proposed language.

Board Action: Accept Committee recommendation. Accept proposed language.

c. Self-Treatment and Treatment of Family Members

At the September 2015 Board meeting, the Policy Committee directed staff to draft language that would allow licensees to treat minor, chronic illnesses.

The Committee discussed at length the pros and cons revolving around changing any language in this position statement.

Committee Recommendation: Do not make any changes to position statement.

Board Acton: Accept Committee Recommendation. Do not make any changes to position statement.

New Business

a. Involuntary departure from hospital-owned practice

The Board received an inquiry from one of its licensees regarding a recent termination from a hospital-owned physician network. The licensee felt that the termination was

handled in a way that prevented her from following guidelines for patient notification and for safe continuity of care.

The Committee recognized that this particular scenario is likely to increase moving forward. The Committee discussed the best way to hold hospital-owned practices accountable for continuity of care. Staff mentioned that the AMA has an ethics opinion related to this particular topic and pointed out the proliferation of hospital-owned practices. The Committee also discussed how this issue is intertwined with the corporate practice of medicine.

Committee Recommendation:

1. Organize roundtable to discuss this particular issue with various stakeholders.
2. Develop corporate practice of medicine position statement with a section addressing hospital-owned practices.
3. Refer complaint to the appropriate department.

Board Action: Accept Committee Recommendation.

1. Organize roundtable to discuss this particular issue with various stakeholders.
2. Develop corporate practice of medicine position statement with a section addressing hospital-owned practices.
3. Refer complaint to the appropriate department.

Position Statement Review Tracking Chart

The Policy Committee reviewed the Position Statement Review Tracking Chart and confirmed that all position statements are on track to be reviewed at least once every four years as required by the January 2010 Board Action.

Committee Recommendation: Accept as information.

Board Action: None necessary. Accept as information.

LICENSE COMMITTEE REPORT

Members present were: Bryant Murphy, MD, Chairperson, Debra Bolick, MD, Eleanor Greene, MD, Mr. A. Wayne Holloman, Mr. R. Walker

Old Business

a. USMLE/COMLEX - Three attempt limit

At the September Board meeting, the Board voted to table the discussion regarding the 3 attempt limit until additional information was received from the NBOME regarding the percentage pass rate for initial and multiple attempts for COMLEX components 1, 2 and 3. Additional data from NBOME has been received.

The committee discussed the rationale for retaining the current USMLE 3 attempt rule. The rationale is as follows:

1. A plurality of other state medical boards use the 3 attempt rule.

2. The multistate compact has chosen to use the 3 attempt rule.
3. A previous Board considered this matter with deliberation and care and instituted the 3 attempt rule.
4. The current rule was instituted to alleviate multiple problems with a time-based rule.
5. Increasing the number of USMLE passing attempts does not assure that this would improve the flow of well-qualified physicians to North Carolina.
6. While it is acknowledged the current 3 attempt rule is not based on hard outcome data, attempts to obtain this information have not proven conclusive. Additionally, other entities, who do have resources to analyze the information available, have not been able to come to a firm conclusion on what is best practice.
7. With very minimal exception the current rule has worked well since it was implemented, and there is no compelling reason to change the current rule.

Committee Recommendation: Retain the current USMLE 3 attempt rule

Board Action: Accept committee recommendation. Retain the current USMLE 3 attempt rule.

b. Rules for Approval **(Appendix C)**
The proposed rule changes for 21 NCAC 32b. 1370 and 21 NCAC 32b. 1402 have been published in the NC register and the Board's website. To date, no comments have been received. Public hearing was scheduled for November 16, 2015. No comments were received prior to November 16th, therefore, the proposed rules will be sent to Rules Review with an expected effective date of January 1, 2016.

Committee Recommendation: Approve rules.

Board Action: Accept committee recommendation. Approve rules.

c. Interstate Licensure Compact

The Committee reviewed an update from FSMB regarding current progress of the Interstate Licensure Compact.

Committee Recommendation: Accept as information. Staff will continue to monitor.

Board Action: Accept committee recommendation. Accept as information. Staff will continue to monitor.

New Business

a. Key Performance Indicators

The Committee reviewed performance data from April – September, 2015.

Committee Recommendation: Accept as information.

Board Action: Accept committee recommendation. Accept as information.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to

Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

The License Committee reviewed nine cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

LICENSE INTERVIEW REPORT

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

Four licensure interviews were conducted. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

ALLIED HEALTH COMMITTEE REPORT

Committee Members present were: H. Diane Meelheim, FNP-BC, Chairperson, Barbara E. Walker, DO

Old Business

1. PHYSICIAN ASSISTANTS

   Rules for Approval **(Appendix D)**

The Committee considered proposed rule changes for 21 NCAC 32S .0202 that would change the required letters of recommendation for PA applicants from three to two. The proposed rule has been published in the NC register and on the Board's website. To date, no comments have been received. A public hearing was held on November 16, 2015. No comments regarding the proposed rule were made from the public.

Committee Recommendation: Approve rule.

Board Action: Accept committee recommendation. Approve rule.

2. PERFUSIONISTS

   The Committee reviewed minutes of the September, 2015 Perfusionist Advisory Committee ("PAC") meeting.

Committee Recommendation: Accept as information.

Board Action: Accept committee recommendation. Accept as information.

3. CLINICAL PHARMACIST PRACTITIONERS

The Committee reviewed minutes of the September, 2015 Clinical Pharmacist Practitioners ("CPP") Sub-committee meeting.

Committee Recommendation: Accept the minutes of the September, 2015 CPP meeting.

Board Action: Accept committee recommendation. Accept the minutes of the September, 2015 CPP meeting.

4. NC EMERGENCY MEDICAL SERVICES

No items for discussion.

5. ANESTHESIOLOGIST ASSISTANTS

No items for discussion.

6. NURSE PRACTITIONERS

No items for discussion.

7. POLYSOMNOGRAPHIC TECHNOLOGISTS

No items for discussion.

MIDWIFERY JOINT COMMITTEE

The Midwifery Joint Committee (MJC) was called to order at 5:00 p.m. November 17, 2015 at the office of the NC Board of Nursing. Committee Members present were: H. Diane Meelheim, FNP-BC, Vice-Chair, Barbara E. Walker, Do, Vernon Stringer, M.D., and Keith Nelson, M.D.

The Committee elected new officers, Ami Goldstein, CNM, Chair, and H. Diane Meelheim, FNP-BC, Vice Chair. The Committee adopted a proposed new rule regarding DHHS reporting information to the Committee regarding the prescribing practices of midwives prescribing controlled substances. The Committee also discussed the complaint investigatory process and asked that staff report complaint statistics to the Committee at its next meeting.

Committee Recommendation: Accept as Information.

NURSE PRACTITIONER JOINT SUBCOMMITTEE REPORT

The Nurse Practitioner Joint Subcommittee (NPJS) was called to order at 6:00 p.m. November 17, 2015 at the office of the NC Board of Nursing. Committee Members present were: H. Diane Meelheim, FNP-BC, Chairperson, Barbara E. Walker, DO

The subcommittee approved the minutes of the May 12, 2015 meeting; elected a new chair, Cheryl Duke, PhD, NP (NCBON); received the NP compliance report from Bobby Lowery, PhD, NP (NCBON); and accepted as information reports of public disciplinary actions taken by both boards since May 2015.

Committee Recommendation: Accept as information.

DISCIPLINARY (COMPLAINTS) COMMITTEE REPORT

Members present were: Barbara E. Walker, DO (chairperson), Mr. Michael J. Arnold, Eleanor E. Greene, MD, Timothy E. Lietz, MD, H. Diane Meelheim, FNP and Bryant A. Murphy, MD

The committee reviewed the Key Performance Indicators (KPI) and Quality Assurance (QA) measures for the Complaint Dept. and Office of Medical Director.

Committee Recommendation: Accept as information.

Board Action: Accept committee recommendation. Accept as information.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

The Disciplinary (Complaints) Committee reported on forty-four complaint cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

DISCIPLINARY (MALPRACTICE) COMMITTEE REPORT

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

The Disciplinary (Malpractice) Committee reported on thirty-nine cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

DISCIPLINARY (MEDICAL EXAMINER) COMMITTEE REPORT

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

The Disciplinary (Medical Examiner) Committee reported on three cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

INVESTIGATIVE INTERVIEW REPORT

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

Seven investigative interviews were conducted. A written report was presented for the Board's review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

DISCIPLINARY (INVESTIGATIVE) COMMITTEE REPORT

Members present were: Timothy E. Lietz, MD (chairperson), Mr. Michael J. Arnold, Debra A. Bolick, MD, Eleanor E. Greene, MD, H. Diane Meelheim, FNP, Bryant A. Murphy, MD, and Barbara E. Walker, DO

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

Forty-four investigative cases were reviewed. A written report was presented for the Board's review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

OUTREACH COMMITTEE

Members present were: Timothy E. Lietz, MD, Chairperson, Debra A. Bolick, MD, Bryant A. Murphy, MD, and Ralph A. Walker, JD, LLB.

Old Business

a. NCMB Social Media plan and position on distribution of public disciplinary actions

NCMB's Communications Department has developed a social media plan that discusses the Board's goals and objectives. As directed, the Communications Department has offered the Board several options for handling information about disciplinary actions on social media. Committee members did not feel they have enough information to make a decision regarding inclusion of information about public actions in posts.

Committee Recommendation: Defer Board decision regarding role of public actions in social media content to allow staff more time to conduct research.

Board action: Accept committee recommendation. Defer Board decision regarding role of public actions in social media content to allow staff more time to conduct research.

b. Update on Licensee Information Compliance program

NCMB's Licensee Information (LI) Coordinator began conducting compliance reviews in November, selecting candidates for review from among licensees renewing in August 2015. The LI Coordinator reviewed information required under NCGS 90-5.2 and also looked at whether licensees have provided content in optional categories. Results were emailed to the first batch of licensees reviewed this month.

Committee recommendation: Accept as information. Staff should review all Board Member LI pages to ensure that all have provided applicable optional content and are in full compliance with required information.

Board action: Accept committee recommendation. Direct staff to review all Board member LI pages to ensure that all have provided applicable optional content and are in full compliance with required information.

c. Update on ongoing Outreach activities

Communications staff are continuing to actively solicit opportunities for Board Members and staff to present. Staff are working to increase talks to hospital and health system audiences and are working with a major professional liability carrier to provide talks to groups of their insureds. Board Member input and suggestions for consumer/community groups that might be interested in inviting NCMB to speak would be appreciated.

Committee recommendation: Accept as information

Board discussion: The Board President noted that he is starting a new initiative to provide medical students and other early career professionals with a “mini-internship” program that will help them learn more about the Board and its responsibilities. The possibility of having Outreach Committee manage implementation of this program was discussed.

Board action: Accept as information. The Board directed staff to schedule presentations several months out to ensure that Board Members are free to accept speaking opportunities.

d. Receipt of spatial analysis of public disciplinary actions per capita

Outreach Committee previously requested assistance from the Cecil G. Sheps Center for Health Services Research at UNC-Chapel Hill to analyze NCMB disciplinary actions data per licensee per capita. The Sheps Center has completed this report.

Committee recommendation: Accept as information

Board action: Accept committee recommendation. Accept as information.

New Business:

a. Implementation of POWER Workgroup recommendations

The POWER Workgroup, which addressed burnout and physician wellness make three recommendations. The Committee reviewed these recommendations:

i. Amend Outreach presentations to include slides on wellness and resiliency
ii. Identify resources and links to be offered on the Board’s website.
iii. Staff to a draft a position statement to send to roundtable participants for review, eventual submission to the Policy Committee

Committee recommendation: Staff should implement the following recommendations of the POWER Workgroup:
1. Begin including slides on wellness and resiliency in NCMB presentations.
2. Assemble and post on NCMB’s website select resources and links on the subject of physician wellness and resiliency.
3. Proceed with a draft position statement, to be presented for consideration by the Outreach Committee at its January 2016 meeting, for eventual distribution to stakeholders and submission for consideration by the Policy Committee.

Board action: Accept Committee recommendation. Staff should implement the following recommendations of the POWER Workgroup.

1. Begin including slides on wellness and resiliency in NCMB presentations.
2. Assemble and post on NCMB's website select resources and links on the subject of physician wellness and resiliency.
3. Proceed with a draft position statement, to be presented for consideration by the Outreach Committee at its January 2016 meeting, for eventual distribution to stakeholders and submission for consideration by the Policy Committee.

b. Develop strategies for improving the Board's image with licensees

Communications Department staff presented an idea to feature mini profiles of Board Members in the *Forum* newsletter, starting with the Board President. The goal of these profiles would be to "put a human face" on members of the Board by discussing what motivates each Board Member to serve, what aspects of their service on the Board is most rewarding, etc.

Committee recommendation: Staff to proceed with featuring mini profiles of Board Members in the *Forum* newsletter, starting with the Board President.

Board action: Accept committee recommendation. Staff to proceed with featuring mini profiles of Board Members in the *Forum* newsletter, starting with the Board President.

LONGEVITY IN PRACTICE WORKGROUP

Members present were: Cheryl L. Walker-McGill, MD, Chair; Bryant Murphy, MD; and Barbara Walker, DO.

a. Debrief October Roundtable.

The Workgroup discussed the Roundtable. Board members and staff received positive feedback. A diverse array of stakeholders presented very thoughtful feedback.

b. Discussion of summarized key points.

The following key points were summarized by moderator Dr. Cheryl Walker-McGill at the Roundtable:

- The NCMB has a role.
- The NCMB is not considering any type of testing.
- Longevity in practice is not an age issue.
- There is a need to increase awareness of issues surrounding longevity.
- The Board could provide resources and direction.
- It is important to consider that with regards to performance on tests, the one's attitude effects on performance, including the threat of stereotypes creating an

expectation, and therefore result, of failure.

- The Board should consider “Is there a role for real world evaluations?”

The Workgroup agreed this was representative of the Roundtable discussion.

c. Next Steps.

The Workgroup discussed a variety of undertakings to begin to address the issue of longevity in practice. At this time, the Workgroup will make four recommendations. First, the Workgroup believes all licensees, as well as the public, may benefit from access to the minutes from the Roundtable. The Workgroup also discussed the need for a Position Statement and noted that the Position Statement should make it clear that the Board will not be pursuing any type of age-related mandatory testing. The Workgroup recommends collaborating with stakeholders to develop resources for its licensees surrounding longevity in practice issues. The Workgroup also sees a benefit in making sure Outreach presentations are tailored for appropriate audiences so that the cases presented are relevant to that stage in the audience’s career.

Workgroup Recommendation:

1) Direct the Policy committee to develop a Position Statement related to longevity in practice for consideration at the January meeting.
2) Direct staff to place Roundtable minutes/discussion notes on the website.
3) Direct staff to collaborate with stakeholders to determine what resources may be available to licensees pertaining to longevity in practice.
4) Encourage the Outreach Committee to review presentation slide decks and revise according to the audience. Cases discussed within the slide presentation should be relevant to the phase of the career of the audience members.

Board Action: Accept Workgroup Recommendation. Take the following actions:

1) Direct the Policy committee to develop a Position Statement related to longevity in practice for consideration at the January meeting.
2) Direct staff to place Roundtable minutes/discussion notes on the website.
3) Direct staff to collaborate with stakeholders to determine what resources may be available to licensees pertaining to longevity in practice.
4) Encourage the Outreach Committee to review presentation slide decks and revise according to the audience. Cases discussed within the slide presentation should be relevant to the phase of the career of the audience members.

DIVERSITY WORKGROUP

Members present were: Debra Bolick MD, Chairperson, Barbara Walker DO, and Diane Meelheim, FNP-BC.

New Business

a. Update on Staffing

Recent hires: Chief Communications Officer (07/13/15) and Credentialing Coordinator (11/30/15)

Current open positions: none.

b. EEOC Census presented a snapshot of Board staff breakdown by race and age. The Workgroup discussed the practice of filling open positions by recruiting from racially diverse candidate pools. This was practiced in the recruiting of the aforementioned positions filled. With the aging staff population, succession planning needs to be continued. The Workgroup discussed orally recording knowledge of Board history from retiring staff members, and possibly Board members.

   Workgroup Recommendation: Approve opportunities to fill open positions by recruiting from racially diverse candidate pools.

c. Recently attended presentations: Staff recently attended two Diversity Trainings, specifically regarding Multigenerational workforce and employing the Disabled.

d. Upcoming events: Staff will attend Diversity training on Inclusion Readiness sponsored by the Society for Human Resources Management.

ADJOURNMENT
This meeting was adjourned at 12:00 p.m., November 20, 2015.

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Timothy E. Lietz, MD
Secretary/Treasurer

CURRENT POSITION STATEMENT:

Office-based procedures

Preface

This Position Statement on Office-Based Procedures is an interpretive statement that attempts to identify and explain the standards of practice for Office-Based Procedures in North Carolina. The Board's intention is to articulate existing professional standards and not to promulgate a new standard.

This Position Statement is in the form of guidelines designed to assure patient safety and identify the criteria by which the Board will assess the conduct of its licensees in considering disciplinary action arising out of the performance of office-based procedures. Thus, it is expected that the licensee who follows the guidelines set forth below will avoid disciplinary action by the Board. However, this Position Statement is not intended to be comprehensive or to set out exhaustively every standard that might apply in every circumstance. The silence of the Position Statement on any particular matter should not be construed as the lack of an enforceable standard.

General Guidelines

The Physician's Professional and Legal Obligation

The North Carolina Medical Board has adopted the guidelines contained in this Position Statement in order to assure patients have access to safe, high quality office-based surgical and special procedures. The guidelines further assure that a licensed physician with appropriate qualifications takes responsibility for the supervision of all aspects of the perioperative surgical, procedural and anesthesia care delivered in the office setting, including compliance with all aspects of these guidelines.

These obligations are to be understood (as explained in the Preface) as existing standards identified by the Board in an effort to assure patient safety and provide licensees guidance to avoid practicing below the standards of practice in such a manner that the licensee would be exposed to possible disciplinary action for unprofessional conduct as contemplated in N.C. Gen. Stat. § 90-14(a)(6).

Exemptions

These guidelines do not apply to Level I procedures.

Written Policies and Procedures

Written policies and procedures should be maintained to assist office-based practices in providing safe and quality surgical or special procedure care, assure consistent personnel performance, and promote an awareness and understanding of the inherent rights of patients.

Emergency Procedure and Transfer Protocol

The physician who performs the surgical or special procedure should assure that a transfer protocol is in place, preferably with a hospital that is licensed in the jurisdiction in which it is located and that is within reasonable proximity of the office where the procedure is performed.

All office personnel should be familiar with and capable of carrying out written emergency instructions. The instructions should be followed in the event of an emergency, any untoward

anesthetic, medical or surgical complications, or other conditions making hospitalization of a patient necessary. The instructions should include arrangements for immediate contact of emergency medical services when indicated and when advanced cardiac life support is needed. When emergency medical services are not indicated, the instructions should include procedures for timely escort of the patient to the hospital or to an appropriate practitioner.

Infection Control
The practice should comply with state and federal regulations regarding infection control. For all surgical and special procedures, the level of sterilization should meet applicable industry and occupational safety requirements. There should be a procedure and schedule for cleaning, disinfecting and sterilizing equipment and patient care items. Personnel should be trained in infection control practices, implementation of universal precautions, and disposal of hazardous waste products. Protective clothing and equipment should be readily available.

Performance Improvement
A performance improvement program should be implemented to provide a mechanism to review yearly the current practice activities and quality of care provided to patients.

Performance improvement activities should include, but are not limited to, review of mortalities; the appropriateness and necessity of procedures performed; emergency transfers; reportable complications, and resultant outcomes (including all postoperative infections); analysis of patient satisfaction surveys and complaints; and identification of undesirable trends (such as diagnostic errors, unacceptable results, follow-up of abnormal test results, medication errors, and system problems). Findings of the performance improvement program should be incorporated into the practice's educational activity.

Medical Records and Informed Consent
The practice should have a procedure for initiating and maintaining a health record for every patient evaluated or treated. The record should include a procedure code or suitable narrative description of the procedure and should have sufficient information to identify the patient, support the diagnosis, justify the treatment, and document the outcome and required follow-up care.
Medical history, physical examination, lab studies obtained within 30 days of the scheduled procedure, and pre-anesthesia examination and evaluation information and data should be adequately documented in the medical record.
The medical records also should contain documentation of the intraoperative and postoperative monitoring required by these guidelines.
Written documentation of informed consent should be included in the medical record.

Credentialing of Physicians
A physician who performs surgical or special procedures in an office requiring the administration of anesthesia services should be credentialed to perform that surgical or special procedure by a hospital, an ambulatory surgical facility, or substantially comply with criteria established by the Board.

Criteria to be considered by the Board in assessing a physician's competence to perform a surgical or special procedure include, without limitation:

1. state licensure;
2. procedure specific education, training, experience and successful evaluation appropriate for the patient population being treated (*i.e.*, pediatrics);

3. for physicians, board certification, board eligibility or completion of a training program in a field of specialization recognized by the ACGME or AOA or by a national medical specialty board that is recognized by the ABMS or AOA for expertise and proficiency in that field. For purposes of this requirement, board eligibility or certification is relevant only if the board in question is recognized by the ABMS, AOA, or equivalent board certification as determined by the Board;
4. professional misconduct and malpractice history;
5. participation in peer and quality review;
6. participation in continuing education consistent with the statutory requirements and requirements of the physician's professional organization;
7. to the extent such coverage is reasonably available in North Carolina, malpractice insurance coverage for the surgical or special procedures being performed in the office;
8. procedure-specific competence (and competence in the use of new procedures and technology), which should encompass education, training, experience and evaluation, and which may include the following:
    a. adherence to professional society standards;
    b. credentials approved by a nationally recognized accrediting or credentialing entity; or
    c. didactic course complemented by hands-on, observed experience; training is to be followed by a specified number of cases supervised by a practitioner already competent in the respective procedure, in accordance with professional society standards.

If the physician administers the anesthetic as part of a surgical or special procedure (Level II only), he or she also should have documented competence to deliver the level of anesthesia administered.

Accreditation

After one year of operation following the adoption of these guidelines, any physician who performs Level II or Level III procedures in an office should be able to demonstrate, upon request by the Board, substantial compliance with these guidelines, or should obtain accreditation of the office setting by an approved accreditation agency or organization. The approved accreditation agency or organization should submit, upon request by the Board, a summary report for the office accredited by that agency.

All expenses related to accreditation or compliance with these guidelines shall be paid by the physician who performs the surgical or special procedures.

Patient Selection

The physician who performs the surgical or special procedure should evaluate the condition of the patient and the potential risks associated with the proposed treatment plan. The physician also is responsible for determining that the patient has an adequate support system to provide for necessary follow-up care. Patients with pre-existing medical problems or other conditions, who are at undue risk for complications, should be referred to an appropriate specialist for preoperative consultation.

ASA Physical Status Classifications

Patients that are considered high risk or are ASA physical status classification III, IV, or V and require a general anesthetic for the surgical procedure, should not have the surgical or special procedure performed in a physician office setting.

Candidates for Level II Procedures
Patients with an ASA physical status classification I, II, or III may be acceptable candidates for office-based surgical or special procedures requiring conscious sedation/ analgesia. ASA physical status classification III patients should be specifically addressed in the operating manual for the office. They may be acceptable candidates if deemed so by a physician qualified to assess the specific disability and its impact on anesthesia and surgical or procedural risks.

Candidates for Level III Procedures
Only patients with an ASA physical status classification I or II, who have no airway abnormality, and possess an unremarkable anesthetic history are acceptable candidates for Level III procedures.

Surgical or Special Procedure Guidelines

Patient Preparation
A medical history and physical examination to evaluate the risk of anesthesia and of the proposed surgical or special procedure should be performed by a physician qualified to assess the impact of co-existing disease processes on surgery and anesthesia. Appropriate laboratory studies should be obtained within 30 days of the planned surgical procedure.
A pre-procedure examination and evaluation should be conducted prior to the surgical or special procedure by the physician. The information and data obtained during the course of this evaluation should be documented in the medical record
The physician performing the surgical or special procedure also should:

1. ensure that an appropriate pre-anesthetic examination and evaluation is performed proximate to the procedure;
2. prescribe the anesthetic, unless the anesthesia is administered by an anesthesiologist in which case the anesthesiologist may prescribe the anesthetic;
3. ensure that qualified health care professionals participate;
4. remain physically present during the intraoperative period and be immediately available for diagnosis, treatment, and management of anesthesia-related complications or emergencies; and
5. ensure the provision of indicated post-anesthesia care.

Discharge Criteria
Criteria for discharge for all patients who have received anesthesia should include the following:

1. confirmation of stable vital signs;
2. stable oxygen saturation levels;
3. return to pre-procedure mental status;
4. adequate pain control;
5. minimal bleeding, nausea and vomiting;
6. resolving neural blockade, resolution of the neuraxial blockade; and
7. eligible to be discharged in the company of a competent adult.

Information to the Patient
The patient should receive verbal instruction understandable to the patient or guardian, confirmed by written post-operative instructions and emergency contact numbers. The instructions should include:

1. the procedure performed;
2. information about potential complications;
3. telephone numbers to be used by the patient to discuss complications or should questions arise;

4. instructions for medications prescribed and pain management;
5. information regarding the follow-up visit date, time and location; and
6. designated treatment hospital in the event of emergency.

Reportable Complications

Physicians performing surgical or special procedures in the office should maintain timely records, which should be provided to the Board within three business days of receipt of a Board inquiry. Records of reportable complications should be in writing and should include:

1. physician's name and license number;
2. date and time of the occurrence;
3. office where the occurrence took place;
4. name and address of the patient;
5. surgical or special procedure involved;
6. type and dosage of sedation or anesthesia utilized in the procedure; and
7. circumstances involved in the occurrence.

Equipment Maintenance

All anesthesia-related equipment and monitors should be maintained to current operating room standards. All devices should have regular service/maintenance checks at least annually or per manufacturer recommendations. Service/maintenance checks should be performed by appropriately qualified biomedical personnel. Prior to the administration of anesthesia, all equipment/monitors should be checked using the current FDA recommendations as a guideline. Records of equipment checks should be maintained in a separate, dedicated log which must be made available to the Board upon request. Documentation of any criteria deemed to be substandard should include a clear description of the problem and the intervention. If equipment is utilized despite the problem, documentation should clearly indicate that patient safety is not in jeopardy.

The emergency supplies should be maintained and inspected by qualified personnel for presence and function of all appropriate equipment and drugs at intervals established by protocol to ensure that equipment is functional and present, drugs are not expired, and office personnel are familiar with equipment and supplies. Records of emergency supply checks should be maintained in a separate, dedicated log and made available to the Board upon request.

A physician should not permit anyone to tamper with a safety system or any monitoring device or disconnect an alarm system.

Compliance with Relevant Health Laws

Federal and state laws and regulations that affect the practice should be identified and procedures developed to comply with those requirements.

Nothing in this position statement affects the scope of activities subject to or exempted from the North Carolina health care facility licensure laws. (1)

Patient Rights

Office personnel should be informed about the basic rights of patients and understand the importance of maintaining patients' rights. A patients' rights document should be readily available upon request.

Enforcement

In that the Board believes that these guidelines constitute the accepted and prevailing standards of practice for office-based procedures in North Carolina, failure to substantially comply with these guidelines creates the risk of disciplinary action by the Board.

Level II Guidelines

Personnel

The physician who performs the surgical or special procedure or a health care professional who is present during the intraoperative and postoperative periods should be ACLS certified, and at least one other health care professional should be BCLS certified. In an office where anesthesia services are provided to infants and children, personnel should be appropriately trained to handle pediatric emergencies (*i.e.*, APLS or PALS certified).

Recovery should be monitored by a registered nurse or other health care professional practicing within the scope of his or her license or certification who is BCLS certified and has the capability of administering medications as required for analgesia, nausea/vomiting, or other indications.

Surgical or Special Procedure Guidelines

Intraoperative Care and Monitoring

The physician who performs Level II procedures that require conscious sedation in an office should ensure that monitoring is provided by a separate health care professional not otherwise involved in the surgical or special procedure. Monitoring should include, when clinically indicated for the patient:

- direct observation of the patient and, to the extent practicable, observation of the patient's responses to verbal commands;
- pulse oximetry should be performed continuously (an alternative method of measuring oxygen saturation may be substituted for pulse oximetry if the method has been demonstrated to have at least equivalent clinical effectiveness);
- an electrocardiogram monitor should be used continuously on the patient;
- the patient's blood pressure, pulse rate, and respirations should be measured and recorded at least every five minutes; and
- the body temperature of a pediatric patient should be measured continuously.

Clinically relevant findings during intraoperative monitoring should be documented in the patient’s medical record.

Postoperative Care and Monitoring

The physician who performs the surgical or special procedure should evaluate the patient immediately upon completion of the surgery or special procedure and the anesthesia.
Care of the patient may then be transferred to the care of a qualified health care professional in the recovery area. A registered nurse or other health care professional practicing within the scope of his or her license or certification and who is BCLS certified and has the capability of administering medications as required for analgesia, nausea/vomiting, or other indications should monitor the patient postoperatively.
At least one health care professional who is ACLS certified should be immediately available until all patients have met discharge criteria. Prior to leaving the operating room or recovery area, each patient should meet discharge criteria.
Monitoring in the recovery area should include pulse oximetry and non-invasive blood pressure measurement. The patient should be assessed periodically for level of consciousness, pain relief, or any untoward complication. Clinically relevant findings during post-operative monitoring should be documented in the patient’s medical record.

Equipment and Supplies
Unless another availability standard is clearly stated, the following equipment and supplies should be present in all offices where Level II procedures are performed:

1. Full and current crash cart at the location where the anesthetizing is being carried out. (the crash cart inventory should include appropriate resuscitative equipment and medications for surgical, procedural or anesthetic complications);
2. age-appropriate sized monitors, resuscitative equipment, supplies, and medication in accordance with the scope of the surgical or special procedures and the anesthesia services provided;
3. emergency power source able to produce adequate power to run required equipment for a minimum of two (2) hours;
4. electrocardiographic monitor;
5. noninvasive blood pressure monitor;
6. pulse oximeter;
7. continuous suction device;
8. endotracheal tubes, laryngoscopes;
9. positive pressure ventilation device (e.g., Ambu);
10. reliable source of oxygen;
11. emergency intubation equipment;
12. adequate operating room lighting;
13. appropriate sterilization equipment; and
14. IV solution and IV equipment.

Level III Guidelines

Personnel
Anesthesia should be administered by an anesthesiologist or a CRNA supervised by a physician. The physician who performs the surgical or special procedure should not administer the anesthesia. The anesthesia provider should not be otherwise involved in the surgical or special procedure.
The physician or the anesthesia provider should be ACLS certified, and at least one other health care professional should be BCLS certified. In an office where anesthesia services are provided to infants and children, personnel should be appropriately trained to handle pediatric emergencies (*i.e.*, APLS or PALS certified).

Surgical or Special Procedure Guidelines

Intraoperative Monitoring
The physician who performs procedures in an office that require major conduction blockade, deep sedation/analgesia, or general anesthesia should ensure that monitoring is provided as follows when clinically indicated for the patient:

- direct observation of the patient and, to the extent practicable, observation of the patient's responses to verbal commands;
- pulse oximetry should be performed continuously. Any alternative method of measuring oxygen saturation may be substituted for pulse oximetry if the method has been demonstrated to have at least equivalent clinical effectiveness;
- an electrocardiogram monitor should be used continuously on the patient;
- the patient's blood pressure, pulse rate, and respirations should be measured and recorded at least every five minutes;

- monitoring should be provided by a separate health care professional not otherwise involved in the surgical or special procedure;
- end-tidal carbon dioxide monitoring should be performed on the patient continuously during endotracheal anesthesia;
- an in-circuit oxygen analyzer should be used to monitor the oxygen concentration within the breathing circuit, displaying the oxygen percent of the total inspiratory mixture;
- a respirometer (volumeter) should be used to measure exhaled tidal volume whenever the breathing circuit of a patient allows;
- the body temperature of each patient should be measured continuously; and
- an esophageal or precordial stethoscope should be utilized on the patient.

Clinically relevant findings during intraoperative monitoring should be documented in the patient's medical record.

Postoperative Care and Monitoring

The physician who performs the surgical or special procedure should evaluate the patient immediately upon completion of the surgery or special procedure and the anesthesia.
Care of the patient may then be transferred to the care of a qualified health care professional in the recovery area. Qualified health care professionals capable of administering medications as required for analgesia, nausea/vomiting, or other indications should monitor the patient postoperatively.

Recovery from a Level III procedure should be monitored by an ACLS certified (PALS or APLS certified when appropriate) health care professional using appropriate criteria for the level of anesthesia. At least one health care professional who is ACLS certified should be immediately available during postoperative monitoring and until the patient meets discharge criteria. Each patient should meet discharge criteria prior to leaving the operating or recovery area.
Monitoring in the recovery area should include pulse oximetry and non-invasive blood pressure measurement. The patient should be assessed periodically for level of consciousness, pain relief, or any untoward complication. Clinically relevant findings during postoperative monitoring should be documented in the patient's medical record.

Equipment and Supplies

Unless another availability standard is clearly stated, the following equipment and supplies should be present in all offices where Level III procedures are performed:

1. full and current crash cart at the location where the anesthetizing is being carried out (the crash cart inventory should include appropriate resuscitative equipment and medications for surgical, procedural or anesthetic complications);
2. age-appropriate sized monitors, resuscitative equipment, supplies, and medication in accordance with the scope of the surgical or special procedures and the anesthesia services provided;
3. emergency power source able to produce adequate power to run required equipment for a minimum of two (2) hours;
4. electrocardiographic monitor;
5. noninvasive blood pressure monitor;
6. pulse oximeter;
7. continuous suction device;
8. endotracheal tubes, and laryngoscopes;
9. positive pressure ventilation device (*e.g.*, Ambu);
10. reliable source of oxygen;
11. emergency intubation equipment;

12. adequate operating room lighting;
13. appropriate sterilization equipment;
14. IV solution and IV equipment;
15. sufficient ampules of dantrolene sodium should be emergently available;
16. esophageal or precordial stethoscope;
17. emergency resuscitation equipment;
18. temperature monitoring device;
19. end tidal CO2 monitor (for endotracheal anesthesia); and
20. appropriate operating or procedure table.

definitions

AAAASF – the American Association for the Accreditation of Ambulatory Surgery Facilities.
AAAHC – the Accreditation Association for Ambulatory Health Care
ABMS – the American Board of Medical Specialties
ACGME – the Accreditation Council for Graduate Medical Education
ACLS certified – a person who holds a current "ACLS Provider" credential certifying that they have successfully completed the national cognitive and skills evaluations in accordance with the curriculum of the American Heart Association for the Advanced Cardiovascular Life Support Program.
Advanced cardiac life support certified – a licensee that has successfully completed and recertified periodically an advanced cardiac life support course offered by a recognized accrediting organization appropriate to the licensee's field of practice. For example, for those licensees treating adult patients, training in ACLS is appropriate; for those treating children, training in PALS or APLS is appropriate.
Ambulatory surgical facility – a facility licensed under Article 6, Part D of Chapter 131E of the North Carolina General Statutes or if the facility is located outside North Carolina, under that jurisdiction's relevant facility licensure laws.
Anesthesia provider – an anesthesiologist or CRNA.
Anesthesiologist – a physician who has successfully completed a residency program in anesthesiology approved by the ACGME or AOA, or who is currently a diplomate of either the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology, or who was made a Fellow of the American College of Anesthesiology before 1982.
AOA – the American Osteopathic Association
APLS certified – a person who holds a current certification in advanced pediatric life support from a program approved by the American Heart Association.
Approved accrediting agency or organization – a nationally recognized accrediting agency (*e.g.*, AAAASF; AAAHC, JCAHO, and HFAP) including any agency approved by the Board.
ASA – the American Society of Anesthesiologists
BCLS certified – a person who holds a current certification in basic cardiac life support from a program approved by the American Heart Association.
Board – the North Carolina Medical Board.
Conscious sedation – the administration of a drug or drugs in order to induce that state of consciousness in a patient which allows the patient to tolerate unpleasant medical procedures without losing defensive reflexes, adequate cardio-respiratory function and the ability to respond purposefully to verbal command or to tactile stimulation if verbal response is not possible as, for example, in the case of a small child or deaf person. Conscious sedation does not include an oral dose of pain medication or minimal pre-procedure tranquilization such as the administration of a pre-procedure oral dose of a benzodiazepine designed to calm the patient. "Conscious sedation" should be synonymous with the term "sedation/analgesia" as used by the American Society of Anesthesiologists.

Credentialed – a physician that has been granted, and continues to maintain, the privilege by a hospital or ambulatory surgical facility licensed in the jurisdiction in which it is located to provide specified services, such as surgical or special procedures or the administration of one or more types of anesthetic agents or procedures, or can show documentation of adequate training and experience.
CRNA – a registered nurse who is authorized by the North Carolina Board of Nursing to perform nurse anesthesia activities.
Deep sedation/analgesia – the administration of a drug or drugs which produces depression of consciousness during which patients cannot be easily aroused but can respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

FDA – the Food and Drug Administration.
General anesthesia – a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
Health care professional – any office staff member who is licensed or certified by a recognized professional or health care organization.
HFAP – the Health Facilities Accreditation Program, a division of the AOA.
Hospital – a facility licensed under Article 5, Part A of Chapter 131E of the North Carolina General Statutes or if the facility is located outside North Carolina, under that jurisdiction's relevant facility licensure laws.
Immediately available – within the office.
JCAHO – the Joint Commission for the Accreditation of Health Organizations
Level I procedures – any surgical or special procedures:

a. that do not involve drug-induced alteration of consciousness;
b. where preoperative medications are not required or used other than minimal preoperative tranquilization of the patient (anxiolysis of the patient) ;
c. where the anesthesia required or used is local, topical, digital block, or none; and
d. where the probability of complications requiring hospitalization is remote.

Level II procedures – any surgical or special procedures:

a. that require the administration of local or peripheral nerve block, minor conduction blockade, Bier block, minimal sedation, or conscious sedation; and
b. where there is only a moderate risk of surgical and/or anesthetic complications and the need for hospitalization as a result of these complications is unlikely.

Level III procedures – any surgical or special procedures:

a. that require, or reasonably should require, the use of major conduction blockade, deep sedation/analgesia, or general anesthesia; and
b. where there is only a moderate risk of surgical and/or anesthetic complications and the need for hospitalization as a result of these complications is unlikely.

Local anesthesia – the administration of an agent which produces a transient and reversible loss of sensation in a circumscribed portion of the body.
Major conduction blockade – the injection of local anesthesia to stop or prevent a painful sensation in a region of the body. Major conduction blocks include, but are not limited to, axillary, interscalene, and supraclavicular block of the brachial plexus; spinal (subarachnoid), epidural and caudal blocks.
Minimal sedation (anxiolysis) – the administration of a drug or drugs which produces a state of consciousness that allows the patient to tolerate unpleasant medical procedures while

responding normally to verbal commands. Cardiovascular or respiratory function should remain unaffected and defensive airway reflexes should remain intact.
Minor conduction blockade – the injection of local anesthesia to stop or prevent a painful sensation in a circumscribed area of the body (*i.e.*, infiltration or local nerve block), or the block of a nerve by direct pressure and refrigeration. Minor conduction blocks include, but are not limited to, intercostal, retrobulbar, paravertebral, peribulbar, pudendal, sciatic nerve, and ankle blocks.
Monitoring – continuous, visual observation of a patient and regular observation of the patient as deemed appropriate by the level of sedation or recovery using instruments to measure, display, and record physiologic values such as heart rate, blood pressure, respiration and oxygen saturation.
Office – a location at which incidental, limited ambulatory surgical procedures are performed and which is not a licensed ambulatory surgical facility pursuant to Article 6, Part D of Chapter 131E of the North Carolina General Statutes.
Operating room – that location in the office dedicated to the performance of surgery or special procedures.
OSHA – the Occupational Safety and Health Administration.
PALS certified – a person who holds a current certification in pediatric advanced life support from a program approved by the American Heart Association.
Physical status classification – a description of a patient used in determining if an office surgery or procedure is appropriate. For purposes of these guidelines, ASA classifications will be used. The ASA enumerates classification: I-normal, healthy patient; II-a patient with mild systemic disease; III a patient with severe systemic disease limiting activity but not incapacitating; IV-a patient with incapacitating systemic disease that is a constant threat to life; and V-moribund, patients not expected to live 24 hours with or without operation.
Physician – an individual holding an MD or DO degree licensed pursuant to the NC Medical Practice Act and who performs surgical or special procedures covered by these guidelines.
Reasonable Proximity**-**The Board recognizes that reasonable proximity is a somewhat ambiguous standard. The Board believes that the standard often used by hospitals of thirty (30) minutes travel time is a useful benchmark.
Recovery area – a room or limited access area of an office dedicated to providing medical services to patients recovering from surgical or special procedures or anesthesia.
Reportable complications – untoward events occurring at any time within forty-eight (48) hours of any surgical or special procedure or the administration of anesthesia in an office setting including, but not limited to, any of the following: paralysis, nerve injury, malignant hyperthermia, seizures, myocardial infarction, pulmonary embolism, renal failure, significant cardiac events, respiratory arrest, aspiration of gastric contents, cerebral vascular accident, transfusion reaction, pneumothorax, allergic reaction to anesthesia, unintended hospitalization for more than twenty-four (24) hours, or death.
Special procedure – patient care that requires entering the body with instruments in a potentially painful manner, or that requires the patient to be immobile, for a diagnostic or therapeutic procedure requiring anesthesia services; for example, diagnostic or therapeutic endoscopy; invasive radiologic procedures, pediatric magnetic resonance imaging; manipulation under anesthesia or endoscopic examination with the use of general anesthesia.

Surgical procedure – the revision, destruction, incision, or structural alteration of human tissue performed using a variety of methods and instruments and includes the operative and non-operative care of individuals in need of such intervention, and demands pre-operative assessment, judgment, technical skill, post-operative management, and follow-up.

Topical anesthesia – an anesthetic agent applied directly or by spray to the skin or mucous membranes, intended to produce a transient and reversible loss of sensation to a circumscribed area.

[A Position Statement on Office-Based Surgery was adopted by the Board on September 2000. The statement above (Adopted January 2003) replaces that statement.]

(Adopted September 2011) (Amended January 2003, May 2011) (Reviewed May 2015)

APPENDIX B

PROPOSED POSITION STATEMENT:

Physician supervision of other licensed health care practitioners

The physician who provides medical supervision of other licensed healthcare practitioners is expected to provide adequate oversight. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise the appropriate amount of supervision over a licensed healthcare practitioner which will ensure the maintenance of quality medical care and patient safety in accord with existing state and federal law and the rules and regulations of the North Carolina Medical Board. What constitutes an "appropriate amount of supervision" will depend on a variety of factors. Those factors include, but are not limited to:

- The number of supervisees under a physician's supervision
- The geographical distance between the supervising physician and the supervisee
- The supervisee's practice setting
- The medical specialty of the supervising physician and the supervisee
- The level of training of the supervisee
- The experience of the supervisee
- The frequency, quality, and type of ongoing education of the supervisee
- The amount of time the supervising physician and the supervisee have worked together
- The quality of the written collaborative practice agreement, supervisory arrangement, protocol or other written guidelines intended for the guidance of the supervisee
- The supervisee's scope of practice consistent with the supervisee's education, national certification and/or collaborative practice agreement

Physicians should also be cognizant of maintaining appropriate boundaries with their supervisees, including refraining from requesting medical treatment by the physician's supervisee.[1] Physician assistants and nurse practitioners are specifically prohibited from prescribing controlled substances for the use of their supervising physicians.

Practices owned solely by physician assistants or nurse practitioners may not hire or contract with physicians to practice medicine on behalf of the physician assistant or nurse practitioner owned practice. The physician assistant or nurse practitioner may contract with a physician to provide the legally required supervision of the physician assistant or nurse practitioner.

[1] See also the Board's position statement on "Self-treatment and Treatment of Family Members."

(Adopted July 2007)(Reviewed September 2012)(Revised November 2015)

21 NCAC 32B .1370 is proposed to be amended as follows:

21 NCAC 32B .1370 REENTRY TO ACTIVE PRACTICE

(a) ~~A~~ An applicant for licensure ~~physician or physician assistant applicant ("applicant" or "licensee")~~ who has not actively practiced or who has not maintained continued competency, as determined by the Board, for the two-year period immediately preceding the filing of an application for a license ~~from the Board~~ shall complete a reentry agreement as a condition of licensure.

(b) ~~The applicant shall identify a mentoring physician.~~ The first component of a reentry agreement involves formulating a reentry plan that assesses the applicant's current strengths and weaknesses in the intended area(s) of practice. The process may include testing and evaluation by colleagues, educators or others.

(c) ~~The applicant shall propose a reentry plan containing the components outlined in Paragraphs (g) and (h) of this Rule to the Board. The Board shall review the proposed reenter plan and interview the applicant.~~ The second component of the reentry plan is education. Education shall address the applicant's area(s) of needed improvement and consist of a reentry period of retraining and education upon terms as the Board may decide.

(d) Factors that may affect the length and scope of the reentry plan include:

(1) The applicant's amount of time out of practice;

(2) The applicant's prior intensity of practice;

(3) The reason for the interruption in practice;

(4) The applicant's activities during the interruption in practice, including the amount of practice-relevant continuing medical education;

(5) The applicant's previous and intended area(s) of practice;

(6) The skills required of the intended area(s) of practice;

(7) The amount of change in the intended area(s) of practice over the time the applicant has been out of continuous practice;

(8) The applicant's number of years of graduate medical education;

(9) The number of years since completion of graduate medical education; and

(10) As applicable, the date of the most recent ABMS, AOA or equivalent specialty board, or National Commission on Certification of Physician Assistant certification or recertification.

(e) If the Board approves an applicant's reentry plan, it shall be incorporated by reference into a reentry agreement and executed by the applicant, the Board and ~~the mentoring physician.~~ And any applicable Board agents assisting with the reentry plan.

(f) After the reentry agreement has been executed, and the applicant has completed all other requirements for licensure, the applicant shall receive a ~~restricted~~ License. The licensee may not practice outside of the scope of the reentry agreement and its referenced reentry plan during the reentry period.

~~(g) The first component of a reentry plan is an assessment of the applicant's current strengths and weaknesses in his or her intended area of practice. The process used to perform the assessment shall be described by the applicant and confirmed by the mentoring physician. The process may include self-reflection, self-assessment, and testing and evaluation by colleagues, educators or others. The applicant and mentoring physician shall evaluate and describe applicant's strengths and areas of needed improvement in regard to the core competencies. The assessment shall continue throughout the reentry period as the licensee and the mentoring physician practice together.~~

~~(h) The second component of the reentry plan is education. Education shall address the licensee's areas of needed improvement. Education shall consist of:~~

~~(1) a reentry period of retraining and education under the guidance of a mentoring physician, upon terms as the Board may decide, or~~

~~(2) a reentry period of retraining and education under the guidance of a mentoring physician consisting of the following:~~

~~(A) Phase I – The observation phase. During the observation phase, the licensee will not practice, but will observe the mentoring physician in practice.~~

~~(B) Phase II – Direct supervision phase. During the direct supervision phase, the licensee shall practice under the direct supervision of the mentoring physician. Guided by the core competencies, the mentoring physician shall reassess the licensee's progress in addressing identified areas of needed improvement.~~

~~(C) Phase III – Indirect supervision phase. During the indirect supervision phase, the licensee shall continue to practice with supervision of the mentoring physician. Guided by the core competencies, and using review of patient charts and regular meetings, the mentoring physician shall reassess the licensee's progress in addressing the areas of needed improvement.~~

~~(D) No later than 30 days after the end of phase I and II, the mentoring physician shall send a report to the Board regarding the licensee's level of achievement in each of the core competencies. At the completion of phase III the mentoring physician shall submit a summary report to the Board regarding the licensee's level of achievement in each of the core competencies and affirm the licensee's suitability to resume practice as a physician or to resume practice as a physician assistant.~~

~~(E) If the mentoring physician reassesses the licensee and concludes that the licensee requires an extended reentry period or if additional areas of needed improvement are identified during Phases II or III, the Board, the licensee and the mentoring physician shall amend the reentry agreement.~~

~~(i) Under the terms of either reentry periods Subparagraph (h)(1) or (h)(2) of this Rule, the mentoring physician may terminate his role as the mentoring physician upon written notice to the Board. Such written notice shall state the reasons for termination. The licensee's approval is not required for the mentoring physician to terminate his role as mentoring physician. Upon receipt of the notice of termination, the Board shall place the licensee's license on~~

~~inactive status. Within six months from the effective date of the mentoring physician's termination, the licensee shall provide a substitute mentoring physician, who must be approved by the Board in writing, and resume the reentry plan upon such terms as are acceptable to the Board. In such event, an amended reentry agreement must be executed prior to resumption of the reentry plan. If licensee does not resume the reentry plan as required herein within six months from the effective date of the mentoring physician's termination, then the Board shall not return the licensee to active status unless and until licensee applies and is approved for reactivation of the license with a new reentry agreement and reentry plan, which must be in place before licensee may resume practice as a physician or physician assistant.~~

~~(j) Under the terms of either reentry periods Subparagraph (h)(1) or (h)(2) of this Rule, the licensee may terminate the relationship with the mentoring physician upon written notice to the Board. Such written notice shall state the reasons for termination. The mentoring physician's approval is not required for the licensee to terminate this relationship. Upon receipt of the notice of termination, the Board shall place the licensee's license on inactive status. Within six months from the effective date of the mentoring physician's termination, the licensee shall provide a substitute mentoring physician, who must be approved by the Board in writing, and resume the reentry plan upon such terms as are acceptable to the Board. In such event, an amended reentry agreement must be executed prior to resumption of the reentry plan. If licensee does not resume the reentry plan as required herein within six months from the effective date of the mentoring physician's termination, then the Board shall not return the licensee to active status unless and until licensee applies and is approved for reactivation of the license with a new reentry agreement and reentry plan, which must be in place before licensee may resume practice as a physician or physician assistant.~~

~~(k) The licensee shall meet with members of the Board at such dates, times and places as directed by the Board to discuss the licensee's transition back into practice and any other practice related matters.~~

~~(l)~~(g) Unsatisfactory completion of the reentry plan or practicing outside the scope of the reentry agreement, as determined by the Board, shall result in the automatic inactivation of the licensee's license, unless the licensee requests a hearing within 30 days of receiving notice from the Board.

~~(m)~~(h) ~~If the Board determines the licensee has successfully completed~~ Upon successful completion of the reentry plan, the Board shall terminate the reentry agreement and notify the licensee that the license is no longer restricted.

History Note: *Authority G.S. 90-8.1; 90-14(a)(11a);*
Eff. March 1, 2011.
Amended Eff. January 1, 2016.

21 NCAC 32B .1402 is proposed to be amended as follows:

21 NCAC 32B .1402 APPLICATION FOR RESIDENT'S TRAINING LICENSE

(a) In order to obtain a Resident's Training License, an applicant shall:

(1) submit a completed application which can be found on the Board's website in the application section at http://www.ncmedboard.org/licensing, attesting under oath or affirmation that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;

(2) submit documentation of a legal name change, if applicable;

(3) submit a photograph, two inches by two inches, affixed to the oath or affirmation which has been attested to by a notary public;

(4) submit proof on the Board's Medical Education Certification form that the applicant has completed at least 130 weeks of medical education.

(5) furnish an original ECFMG certification status report of a currently valid ECFMG certification ~~of the ECFMG~~ if the applicant is a graduate of a medical school other than those approved by LCME, AOA, COCA, or CACMS. The ECFMG certification status report requirement shall be waived if:

(A) the applicant has passed the ECFMG examination and successfully completed an approved Fifth Pathway program (original ECFMG score transcript from the ECFMG required); or

(B) the applicant has been licensed in another state on the basis of a written examination before the establishment of the ECFMG in 1958;

(6) submit an appointment letter from the program director of the GME program or his or her appointed agent verifying the applicant's appointment and commencement date;

(7) submit two completed fingerprint record cards supplied by the Board;

(8) submit a signed consent form allowing a search of local, state, and national files for any criminal record;

(9) pay a non-refundable fee pursuant to G.S. 90-13.1(b), plus the cost of a criminal background check;

(10) provide proof that the applicant has taken and passed within three attempts:

(A) ~~the~~ COMLEX Level 1, ~~and~~ each component of COMLEX Level 2 (cognitive evaluation and performance evaluation) ~~and~~ and, if taken, COMLEX Level 3; or

(B) ~~the~~ USMLE ~~Step 1~~ Step 1, ~~and~~ each component of ~~the~~ USMLE Step 2 (Clinical Knowledge and Clinical ~~Skills); and~~ Skills) and, if taken USMLE Step 3; ~~and~~ or

(C) MCCQE Part 1 and, if taken, MCCQE Pat 2;

(11) upon request, supply any additional information the Board deems necessary to evaluate the applicant's competence and character.

(b) An applicant shall be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character, if the Board needs more information to complete the application.

(c) If the applicant previously held a North Carolina residency training license, the licensure requirements established by rule at the time the applicant first received his or her North Carolina residency training license shall apply. Information about these Rules is available from the Board.

History Note: Authority G.S. 90-8.1; 90-12.01; 90-13.1;
Eff. August 1, 2010;
Amended Eff. January 1, 2016; September 1, 2014; November 1, 2013; August 1, 2012; November 1, 2011.

21 NCAC 32S .0202 is proposed to be amended as follows:

21 NCAC 32S .0202 QUALIFICATIONS AND REQUIREMENTS FOR LICENSE

(a) Except as otherwise provided in this Subchapter, an individual shall obtain a license from the Board before practicing as a physician assistant. An applicant for a physician assistant license shall:

(1) submit a completed application, available at www.ncmedboard.org, to the Board;

(2) meet the requirements set forth in G.S. 90-9.3 and has not committed any of the acts listed in G.S. 90-14;

(3) supply a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired U.S. passport. If the applicant does not possess proof of U.S. citizenship, the applicant shall provide information about the applicant's immigration and work status that the Board shall use to verify applicant's ability to work lawfully in the United States;

(4) submit to the Board proof that the applicant completed a Physician Assistant Educational Program. He or she shall also show successful completion of the Physician Assistant National Certifying Examination;

(5) pay to the Board a non-refundable fee of two hundred dollars ($200.00) plus the cost of a criminal background check. There is no fee to apply for a physician assistant limited volunteer license;

(6) submit National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB) reports. These reports shall be requested by the applicant and submitted to the Board within 60 days of the request;

(7) submit a Board Action Data Bank Inquiry from the Federation of State Medical Boards (FSMB). This report shall be requested by the applicant and submitted to the Board within 60 days of the request;

(8) submit to the Board two complete original fingerprint record cards, on fingerprint record cards supplied by the Board upon request;

(9) submit to the Board a signed consent form allowing a search of local, state, and national files to disclose any criminal record;

(10) disclose whether he or she has ever been suspended from, placed on academic probation, expelled, or required to resign from any school, including a PA educational program;

(11) attest that he or she has no license, certificate, or registration as a physician assistant currently under discipline, revocation, suspension, or probation or any other adverse action resulting from a health care licensing board;

(12) certify that he or she is mentally and physically able to safely practice as a physician assistant and is of good moral character;

(13) provide the Board with ~~three~~ two original recommendation forms dated within six months of the application. These recommendations shall come from persons under whom the applicant has worked or trained who are familiar with the applicant's academic competence, clinical skills, and character. At least one reference form shall be from a physician and two reference forms must be from peers under whom the applicant has worked or trained. References shall not be from any family member or in the case of

applicants who have not been licensed anywhere, references shall not be from fellow students of the applicant's Educational Program;

(14) if two years or more have passed since graduation from a Physician Assistant Educational Program, document that he or she has completed at least 100 hours of continuing medical education (CME) during the preceding two years, at least 50 hours of which must be recognized by the National Commission on Certification of Physician Assistants as Category I ~~CME; and~~ CME. An applicant who is currently certified with the NCCPA will be deemed in compliance with this Rule; and

(15) supply any other information the Board deems necessary to evaluate the applicant's qualifications, including explanation or documentation of the information required in this Rule.

(b) An applicant may be required to appear in person for an interview with the Board, if the Board determines in its discretion that more information is needed to evaluate the application.

History Note: *Authority G.S. 90-9.3; 90-11; 90-18(c)(13); 90-18.1;*
Eff. September 1, 2009;
Amended Eff. January 1, 2016; May 1, 2015; March 1, 2011.