PA RENEWALS DUE BEFORE MARCH 31, 2015

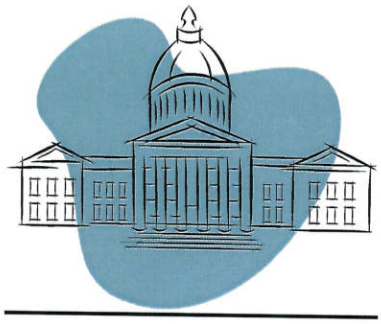
All 2015 license renewals will be done online and will be available for completion after February 1, 2015. If you have an email address on file with the Board Office, we will send an e-blast e-mail to all licensees due for renewal. When completing your 2015 license renewal just follow the following steps:

1) From www.wvbdosteo.org click on "PA Renewals" in left hand column;
2) Log in with either your last name, license number or last 4 digits of SSN;
3) Enter "Submit and Continue"
4) Continue to fill in all fields requesting information and enter "Submit and Continue;"
5) When answering the personal information questions, if you have a "yes" answer it will bring up a screen for you to type in your response;
6) The CME report allows you to link directly with the NCCPA to obtain your CME hours. But you still have to enter them into the application;
7) There is also a place to waive the Pain Prescribing 3 hour CME requirement if you attest to never prescribing a controlled substance during the last two year cycle;
8) Lastly you check a certification box which attests to the accuracy of your information;
9) The next screen is the payment screen for you to enter your credit card information. You will be given only one opportunity to print your receipt at the conclusion of the payment.

NEW THIS RENEWAL CYLCE

With the Emergency PA Rule which went into effect June 6, 2014, Physician Assistants MUST have a Practice Agreement, completed and signed by the PA and the Supervising Physician. This is in place of your Privilege List and Prescriptive Authority, both of which are included in the Practice Agreement.

EVERY PHYSICIAN ASSISTANT RENEWING IN 2015 MUST COMPLETE AND SUBMIT A PRACTICE AGREEMENT. IF NOT, YOUR RENEWAL APPLICATION WILL BE CONSIDERED INCOMPLETE AND YOUR LICENSE WILL NOT BE RENEWED.



LEGISLATIVE RULE CHANGES
2015

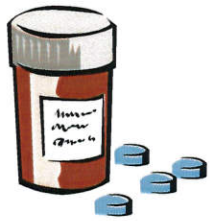
In order to make the licensing of PA's in West Virginia easier and less complicated, the two medical licensing boards have recommended the creation of a new section of the Code, Article 3E. This authorizes both Boards to license and discipline Physician Assistants based on who is named the Primary Supervisor. It will allow for both MD's and DO's to serve as alternate supervising physicians, with the full responsibility of the Physician Assistant assigned only to the primary supervising physician.

This has been a collaborative effort by both medical licensing boards to insure there is no delay or obstacles placed upon Physician Assistants becoming licensed by either Board. It will streamline the administrative application process for PA's practicing in West Virginia and, at the same time, clarify the due process rights and disciplinary sanctions that each licensing board is authorized to administer.

The WV Legislature approved the Code change and the Governor signed the bill on June 6, 2014. Emergency Rules have been implemented and sent to the Legislature for final approval. Please check our website, www.wvbdosteo.org for all legislative updates. The Physician Assistant rule will be identified under Series 2.

Also new in this rule, will be the creation of a Practice Agreement. This will replace the Privilege List and Prescriptive Authority forms found in the old PA Application. A Physician Assistant can obtain a license as soon as they complete their education and pass the NCCPA boards. However, they cannot work until a Practice Agreement has been completed and signed by both the PA and the Supervising Physician.

If you have questions or would like more information about the Code changes, please contact our office, (304) 558-6095.



ALL DO AND PA LICENSEE'S MUST COMPLETE BOARD-APPROVED CME ON PAIN PRESCRIBING BEFORE NEXT LICENSE RENEWAL

All practitioners holding a current WV Osteopathic License are required to complete 3 hours of Board-Approved CME on Pain Prescribing and Drug Diversion Training before their next renewal period. Check the Board's website, www.wvbdosteo.org for all Board-Approved CME offerings. If it is not listed on the Board's website, it has NOT been approved by the Board.

Any practitioner licensed after July 1, 2014, must complete the 3 hour CME on Pain Prescribing and Drug Diversion within the first year of licensure. That includes all Osteopathic Physicians and Physician Assistants whose license issue date is **July 1, 2014** or later.

Regularly check the Board's website, www.wvbdosteo.org for information on upcoming CME events that have been approved by the Board in meeting the 3 hour requirement. No other CME programs will be accepted other than those listed on our website. Pay particular attention to the marketing brochure when registering for a CME program. If it does not say it was approved to meet the 3 hour requirement by the WV Board of Osteopathic Medicine, we will not be able to give you credit for it. The online CME is always available on our website, www.wvbdosteo.org.

UPON COMPLETION OF YOUR REQUIRED 3 HOUR CME, SUBMIT THE FORM BELOW FOR CREDIT WITH THE BOARD OFFICE.

BEST PRACTICE PRESCRIBING OF CONTROLLED SUBSTANCES AND DRUG DIVERSION TRAINING VERIFICATION FORM

Please complete the following information and return to the West Virginia Board of Osteopathic Medicine to receive credit.
405 Capitol Street, Suite 402
Charleston, WV 25301

NAME:____ SUFFIX:____________
D.O. or PA-C

ADDRESS:____
Street or P.O. Box

____
City State Zip Code

LICENSE NUMBER:

____

Declaration: I have completed the board-approved drug diversion and best practice prescribing course on ____________________________________
Date

sponsored by ____
CME Sponsor

for the current license renewal period.

Licensee's Signature:

____

Date Signed:

____

* *

CURRENT BOARD-APPROVED CME PROGRAMS

On-Line CME: www.wvbdosteo.org

SEE WVBDOSTEO.ORG FOR ALL UPCOMING LIVE CME PROGRAMS APPROVED FOR 3 HOUR PAIN PRESCRIBING/DRUG DIVERSION CME

Disciplinary Actions in 2014:

Allen George Saoud, D.O.
License Permanently Revoked
for 22 Felony Convictions.

Mary Elizabeth Coll, D.O.
License Suspended Until
Further Notice of the Board.

Robert Timothy Hogan, II, D.O.
License Suspended Until
Further Notice of the Board.

Roland Chalifoux, Jr., D.O.
License Summarily Suspended
For Lack of Standard of Care. By
Circuit Court Order Dated, 8/28/14,
Summary Suspension Was Stayed.

Charles Edward Merrill, D.O.
License Application Denied.

Joel Adams Smithers, D.O.
Licensed Under Consent Order
Requiring Quarterly Reports
From NCMPHP.

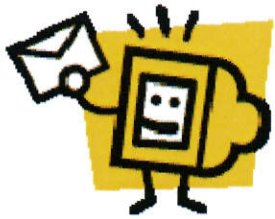
CURRENT BOARD MEMBERS

Ernest Miller, Jr., D.O.	**President**
Robert Whitler	**Vice President**
Arthur Rubin, D.O.	**Secretary**
Elizabeth Blatt, Ph.D.	**Public Member**
Joseph Schreiber, D.O.	**Physician Member**
Michael Muscari, D.O.	**Physician Member**
Heather Jones, PA-C	**PA Member**

CURRENT WV OSTEOPATHIC STATISTICS

As of the printing of this newsletter the following statistics reflect the licensing of osteopaths in the state of West Virginia:

Total Number of Osteopathic Physicians Licensed in West Virginia:	***1,221***
Total Number Practicing in West Virginia:	***902***
Total Number of Osteopathic PA's Licensed in West Virginia:	***211***
Total Number of Residents with Educational Permits	***69***



E-MAIL ADDRESSES

In an attempt to cut the cost of postage, to speed up and to insure better delivery of important notices from the Board and the State to our licensees, the WV Board of Osteopathic Medicine is using E-MAIL as our primary means of communication. An e-mail address is now REQUIRED on all license applications. If you have not yet submitted an email address to the Board Office, you can easily send it to us via the "Contact Us" button on our homepage, www.wvbdosteo.org. Or just send us an email and notify us to use it to contact you. wvbdosteo@wv.gov. REMEMBER: The email address you give us is how we will contact you directly!!

WEST VIRGINIA
Department of
Health & Human Resources
BUREAU FOR
PUBLIC HEALTH

October 1, 2014

Quick Notes for Providers

EBOLA

- All ill patients should be questioned about a travel history. Specifically looking for travel to Liberia, Guinea, Sierra Leone and Nigeria, as well as the Democratic Republic of Congo.
- It would include contact with friends or family that have traveled to these areas as well for the preceding 21 days.
- Ebola incubates for 2 to 21 days; average is 8 to 10 days
- A patient is not contagious until symptomatic
- Symptoms include fever, muscle aches, vomiting, diarrhea, abdominal pain and unexplained hemorrhage
- Ebola is spread through direct contact with blood or bodily fluids of a contagious patient. It is not spread through the air, in water or in food
- Ebola is killed with hospital grade disinfectants
- Ebola virus dried on surfaces such as doorknobs and countertops can survive for several hours. Ebola in bodily fluids can survive days at room temperature
- Treatment is supportive. Basic interventions tremendously improve survival. They include IV fluids, balancing electrolytes, maintain oxygen levels and blood pressure and treating other infections.
- Report all suspected cases to your local health department and the Bureau for Public Health at 1(800) 642-8244.

Dear Colleague:

This is my third letter to update you on Ebola. I appreciate your time and attention to this letter. The world we live in is getting smaller and nothing brings that home more than two cases of Ebola being diagnosed in the United States. As I am sure you are aware, the second case involves a nurse who was helping take care of the first patient diagnosed with Ebola. Health care workers are at high risk for contracting this disease because we take care of the ill, often putting ourselves in harm's way. Here in the United States we frequently pride ourselves on our health care system, but the diagnosis of an American nurse with Ebola contracted while taking care of an Ebola patient in an American Hospital reminds us only too well that we must be ever vigilant in the use of personal protection equipment and in the identification of possible Ebola patients and quickly place them in isolation.

With this in mind, I want to ask each of you – are you prepared? Do you know what to do if a person who has a suspected case of Ebola enters your emergency room or your office? Do you know who to call? And after you isolate the patient, how do you dispose of any contaminated personal protection equipment or other contaminated supplies? What about cleaning the space? What are you going to tell patients who inquire? How are you going to address their fears and concerns? What if they do not want to come back to your office or hospital because you managed an Ebola patient?

First, please familiarize yourself with your preparedness director at the hospital where you have privileges. Hospitals have been working on plans to address what to do if a patient presents with a suspected Ebola infection and you should be familiar with those plans. If you are unaffiliated with a hospital, please prepare yourself and your staff on the appropriate procedures to follow should a patient be identified as potentially having Ebola.

For your reference, I have attached a copy of the correct sequence for the donning of personal protection equipment (PPE) and the correct sequence for removing PPE. Strict adherence to these sequences is absolutely critical for your safety and the safety of everyone in your office or the hospital. Please share this information with others you work with, particularly those in your office.

It is also crucial that potential cases of Ebola be identified early. This is best accomplished by being familiar with the signs and symptoms of Ebola and asking the correct travel history. The signs and symptoms of Ebola include: a fever of 38.6°C or higher and may also include headache, muscle pain, nausea, vomiting, diarrhea, abdominal pain and unexplained bleeding. Travel history would include travel in the last 21 days to Sierra Leone, Guinea, Liberia, Senegal, Nigeria or the Democratic Republic of Congo. Additionally, a nurse who was working in Africa has been diagnosed in Spain with Ebola. Until this current outbreak in Africa is halted, the Ebola virus will likely be identified in other countries. It would also be important to ask if the patient had contact with anyone who had or was suspected of having Ebola or if they attended any funerals or visited any sick relatives in the hospital. Also inquire about any recent deaths in the patient's family. The Ebola virus has an incubation period of 2 to 21 days, though most symptoms occur between days 6-10. As more information becomes available we will update our website to share it with you. (http://www.dhhr.wv.gov/bph)

A patient is not contagious until they start to display symptoms, a fever usually being the presenting symptom. Even then, the patient may not have a viral load large enough to test positive for Ebola until after three days of symptoms. So if you have a strong suspicion and there is a likelihood of the patient having Ebola and the first test comes back negative, repeat the blood test and continue using strict contact and isolation precautions.

If you are suspicious of a patient having Ebola, after you institute isolation precautions and stabilize the patient, a call should be made to the CDC and to the Bureau for Public Health. The CDC number is 1-800-232-4636. Ask for the Emergency Operations Center. The Bureau for Public Health (BPH) can be reached at 1-800-423-1271, ext. 1. Both of these numbers are manned 24/7/365. Do not let anyone who came with the patient leave, even if they are not displaying any symptoms. Place them in a separate room and notify BPH. To prevent the spread of Ebola, it is critical that contact tracing start immediately. BPH will be able to advise you on a number of issues relating to a patient who is suspected of having Ebola. Our website also has many resources from environmental infection control for your office and/or hospital, how to safely draw blood and transport the same, medical waste information and many many others. Please become familiar with this web page and please visit it often as it will be updated as needed.

Additionally, I have attached to this letter a copy of the checklist created by the CDC for practitioners to use when evaluating a patient for a possible Ebola infection.

Please take the time to review the material that is being provided. You are the front line and we will all need to work together if Ebola comes to West Virginia. Preparation is our best defense.

Thank you for your attention to this important matter.

Sincerely,

Letitia Tierney, M.D., J.D.
Commissioner and WV State Health Officer

LT/jr
Enclosure

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Checklist for Patients Being Evaluated for Ebola Virus Disease (EVD) in the United States

Upon arrival to clinical setting/triage

- ❑ Does patient have fever (subjective or ≥101.5°F)?
- ❑ Does patient have compatible EVD symptoms such as headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain or hemorrhage?
- ❑ Has the patient traveled to an Ebola-affected area in the 21 days before illness onset?

Upon initial assessment

- ❑ Isolate patient in single room with a private bathroom and with the door to hallway closed
- ❑ Implement standard, contact, & droplet precautions
- ❑ Notify the hospital Infection Control Program at _____
- ❑ Report to the health department at 1-800-423-1211 Ext 1

Conduct a risk assessment for:

High-risk exposures

- ❑ Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids from an EVD patient
- ❑ Direct skin contact with skin, blood or body fluids from an EVD patient
- ❑ Processing blood or body fluids from an EVD patient without appropriate PPE
- ❑ Direct contact with a dead body in an Ebola-affected area without appropriate PPE

Low-risk exposures

- ❑ Household members of an EVD patient or others who had brief direct contact (e.g., shaking hands) with an EVD patient without appropriate PPE
- ❑ Healthcare personnel in facilities with EVD patients who have been in care areas of EVD patients without recommended PPE

Use of personal protective equipment (PPE)

- ❑ Use a buddy system to ensure that PPE is put on and removed safely

Before entering patient room, wear:

- ❑ Gown (fluid resistant or impermeable)
- ❑ Facemask
- ❑ Eye protection (goggles or face shield)
- ❑ Gloves

If likely to be exposed to blood or body fluids, additional PPE may include but isn't limited to:

- ❑ Double gloving
- ❑ Disposable shoe covers
- ❑ Leg coverings

Upon exiting patient room

- ❑ PPE should be carefully removed without contaminating one's eyes, mucous membranes, or clothing with potentially infectious materials
- ❑ Discard disposable PPE
- ❑ Re-useable PPE should be cleaned and disinfected per the manufacturer's reprocessing instructions
- ❑ Hand hygiene should be performed immediately after removal of PPE

During aerosol-generating procedures

- ❑ Limit number of personnel present
- ❑ Conduct in an airborne infection isolation room
- ❑ Don PPE as described above except use a NIOSH certified fit-tested N95 filtering facepiece respirator for respiratory protection or alternative (e.g., PAPR) instead of a facemask

Patient placement and care considerations

- ❑ Maintain log of all persons entering patient's room
- ❑ Use dedicated disposable medical equipment (if possible)
- ❑ Limit the use of needles and other sharps
- ❑ Limit phlebotomy and laboratory testing to those procedures essential for diagnostics and medical care
- ❑ Carefully dispose of all needles and sharps in puncture-proof sealed containers
- ❑ Avoid aerosol-generating procedures if possible
- ❑ Wear PPE (detailed in center box) during environmental cleaning and use an EPA-registered hospital disinfectant with a label claim for non-enveloped viruses*

Initial patient management

- ❑ Consult with health department about diagnostic EVD RT-PCR testing**
- ❑ Consider, test for, and treat (when appropriate) other possible infectious causes of symptoms (e.g., malaria, bacterial infections)
- ❑ Provide aggressive supportive care including aggressive IV fluid resuscitation if warranted
- ❑ Assess for electrolyte abnormalities and replete
- ❑ Evaluate for evidence of bleeding and assess hematologic and coagulation parameters
- ❑ Symptomatic management of fever, nausea, vomiting, diarrhea, and abdominal pain
- ❑ Consult health department regarding other treatment options

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

*see _____ for more information

**see _____

Facts *about* Ebola in the U.S.

You can't get Ebola through air

You can't get Ebola through water

You can't get Ebola through food

You can only get Ebola from:

- Touching the blood or body fluids of a person who is sick with or has died from Ebola.
- Touching contaminated objects, like needles.
- Touching infected animals, their blood or other body fluids, or their meat.

CS250586

Ebola Virus Disease (EVD)

Algorithm for Evaluation of the Returned Traveler

FEVER (subjective or ≥101.5°F or 38.6°C) or compatible EVD symptoms* in patient who has traveled to an Ebola-affected area** in the 21 days before illness onset

* headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain or hemorrhage

NO

Report asymptomatic patients with high- or low-risk exposures (see below) in the past 21 days to the health department

YES

1. Isolate patient in single room with a private bathroom and with the door to hallway closed
2. Implement standard, contact, and droplet precautions (gown, facemask, eye protection, and gloves)
3. Notify the hospital Infection Control Program and other appropriate staff
4. Evaluate for any risk exposures for EVD
5. IMMEDIATELY report to the health department

HIGH-RISK EXPOSURE

Percutaneous (e.g., needle stick) or mucous membrane contact with blood or body fluids from an EVD patient

OR

Direct skin contact with, or exposure to blood or body fluids of, an EVD patient

OR

Processing blood or body fluids from an EVD patient without appropriate personal protective equipment (PPE) or biosafety precautions

OR

Direct contact with a dead body (including during funeral rites) in an Ebola affected area** without appropriate PPE

LOW-RISK EXPOSURE

Household members of an EVD patient and others who had brief direct contact (e.g., shaking hands) with an EVD patient without appropriate PPE

OR

Healthcare personnel in facilities with confirmed or probable EVD patients who have been in the care area for a prolonged period of time while not wearing recommended PPE

NO KNOWN EXPOSURE

Residence in or travel to affected areas** without HIGH- or LOW-risk exposure

Review Case with Health Department Including:

- Severity of illness
- Laboratory findings (e.g., platelet counts)
- Alternative diagnoses

EVD suspected

TESTING IS INDICATED

The health department will arrange specimen transport and testing at a Public Health Laboratory and CDC

The health department, in consultation with CDC, will provide guidance to the hospital on all aspects of patient care and management

EVD not suspected

TESTING IS NOT INDICATED

If patient requires in-hospital management:

Decisions regarding infection control precautions should be based on the patient's clinical situation and in consultation with hospital infection control and the health department

If patient's symptoms progress or change, re-assess need for testing with the health department

If patient does not require in-hospital management

Alert the health department before discharge to arrange appropriate discharge instructions and to determine if the patient should self-monitor for illness

Self-monitoring includes taking their temperature twice a day for 21 days after their last exposure to an Ebola patient

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

** CDC Website to check current affected areas: www.cdc.gov/vhf/ebola

CS251058-A