Meeting of the Virginia Board of Medicine

June 13, 2024
8:30 a.m.

Virginia Department of Health Professions

Board of Medicine
Thursday, June 13, 2024 @ 8:30 a.m.
Perimeter Center
9960 Mayland Drive, Suite 201
Board Room 4
Henrico, VA 23233

Call to Order and Roll Call for Full Board Meeting

PERIMETER CENTER CONFERENCE CENTER
EMERGENCY EVACUATION OF BOARD AND TRAINING ROOMS
(Script to be read at the beginning of each meeting.)

PLEASE LISTEN TO THE FOLLOWING INSTRUCTIONS ABOUT EXITING THESE PREMISES IN THE EVENT OF AN EMERGENCY.

In the event of a fire or other emergency requiring the evacuation of the building, alarms will sound.

When the alarms sound, leave the room immediately. Follow any instructions given by Security staff

Board Room 4

Exit the room using one of the doors at the back of the room. (**Point**) Upon exiting the room, turn **RIGHT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

Agenda Item: Approval of Minutes of the February 15, 2024

Staff Note: Draft minutes that have been posted on Regulatory Townhall and the Board's website are presented. Review and revise if necessary.

Action: Motion to approve minutes.

---DRAFT - UNAPPROVED---

VIRGINIA BOARD OF MEDICINE
FULL BOARD MINUTES

February 15, 2024 Department of Health Professions Henrico, VA 23233

CALL TO ORDER: Dr. Clements called the meeting to order at 8:35 a.m.

ROLL CALL: Ms. Brown called the roll; a quorum was established.

MEMBERS PRESENT:
John R. Clements, DPM – President, Chair
Peter J. Apel, MD – Vice-President
Karen Ransone, MD – Secretary-Treasurer
David Archer, MD
Hazem Elariny, MD
L. Blanton Marchese
Pradeep Pradhan, MD
Jennifer Rathmann, DC
Patrick McManus, MD
Elliott Lucas, MD
Thomas Corry
Deborah DeMoss Fonseca

MEMBERS ABSENT:
Manjit Dhillon, MD
Madge Ellis, MD
William Hutchens, MD
Oliver Kim, JD, LLM
Krishna Madiraju, MD
Jacob Miller, DO

STAFF PRESENT:
William L. Harp, MD - Executive Director
Jennifer Deschenes, JD - Deputy Exec. Director for Discipline
Colanthia Morton Opher - Deputy Exec. Director for Administration
Michael Sobowale, LLM - Deputy Exec. Director for Licensure
Barbara Matusiak, MD, Medical Review Coordinator
Deirdre Brown - Executive Assistant
Arne Owens – DHP Director
M. Brent Saunders, JD – Senior Assistant Attorney General

OTHERS PRESENT:
Jennie Wood – Board Staff
Tamika Hines- Board Staff
Roslyn Nickens – Board Staff
Krystal Blanton – Board Staff
Laura Wozneak, MD – VCU PGY-4

Hena Yakoob, MD – VCU PGY-4
Scott Castro – Medical Society of Virginia

ANNOUCEMENT OF NEW BOARD MEMBERS

Dr. Clements welcomed new Board members Elliot Lucas, MD, Patrick McManus, MD, Ms. Deborah DeMoss Fonseca, and Mr. Thomas Corry to the Board of Medicine. Each introduced themselves to their fellow Board members. Thereafter, Dr. Clements expressed thanks and well wishes to those who had recently left the Board - Joel Silverman, MD, Ryan Williams, MD, Ms. Jane Hickey, JD and Reverend Alvin Edwards, PhD.

EMERGENCY EGRESS INSTRUCTIONS

Dr. Apel provided the emergency egress instructions for Board Room 2.

DHP DIRECTOR'S REPORT

Mr. Owens welcomed the new Board members and gave an update on the General Assembly. He said DHP is tracking 102 bills. He shared that Erin Barrett, DHP's Director of Legislative and Regulatory Affairs, was currently downtown attending meetings at the General Assembly.

Mr. Owens said there are 2 bills that are being closely followed, SB403 and HB 449. SB403 is about Behavioral Health Aides, and HB1449 impacts a number of mental health professions. If these 2 bills become law, more staff will be required at the Behavioral Boards to implement the initiatives.

Next, Mr. Owens updated the Board on the process of reengineering licensing processes in DHP with the assistance of a consulting firm, ImpactMakers. They are offering guidance on streamlining processes to be more efficient for the applicants and Board staff. ImpactMakers has started with the Board of Medicine and will move to other boards throughout the agency.

He informed the Board about staff changes at DHP, starting with the new Enforcement Division Director, Dr. Sarah Rogers. He also mentioned that the Director of Communications, Diane Powers, will be retiring in April. The Chief Operating Officer, Lisa Hahn, will be retiring in July.

Mr. Owens then shared with the Board that DHP's finances are in solid shape. He reminded the Board members that DHP is entirely funded by licensing fees.

Lastly, Mr. Owens announced a couple of upcoming events. New Board Member Training will be held at DHP on March 26, 2024. All-Staff Training Day will again be held at the Science Museum of Virginia's Dewey Gottwald Center on April 30, 2024. He said that approximately 350 staff attended the training last year.

DISCILPLINARY MATTERS FOR THE BOARD'S CONSIDERATION

The Board received information from Sean Murphy, JD, Assistant Attorney General, regarding Patrick A. Oliver, MD, license number 0101247379, to determine whether Dr. Oliver's continued practice of medicine constituted a danger to public health and safety. Mr. Murphy provided details of the case to the Board for its consideration.

On a motion by Dr. Apel and duly seconded by Dr. Ransone, the Board voted unanimously to summarily suspend Dr. Oliver's license simultaneous with the institution of proceedings for a formal administrative hearing pursuant to Section 54.1-2408.1 of the Code of Virginia.

Next, the Board received information from Sean Murphy, JD, Assistant Attorney General, regarding Kristina M. Collins, DC, license number 0104001985, to determine whether Dr. Collins' continued practice of chiropractic constituted a danger to public health and safety. Mr. Murphy provided details of the case to the Board for its consideration.

On a motion by Mr. Marchese and duly seconded by Dr. Ransone, the Board voted unanimously to summarily suspend Dr. Collins' license simultaneous with the institution of proceedings for a formal administrative hearing pursuant to Section 54.1-2408.1 of the Code of Virginia.

Lastly, the Board received information from Amanda Padula-Wilson, JD, Assistant Attorney General, regarding Gregory A. Alouf, MD, license number 0101230957, to determine whether Dr. Alouf's continued practice of medicine constituted a danger to public health and safety. Mr. Murphy provided details of the case to the Board for its consideration.

On a motion by Ms. DeMoss Fonseca and duly seconded by Dr. Elariny, the Board voted unanimously to summarily suspend Dr. Alouf's license simultaneous with the institution of proceedings for a formal administrative hearing pursuant to Section 54.1-2408.1 of the Code of Virginia.

APPROVAL OF MINUTES OF OCTOBER 19, 2023

ACTION: Dr. Ransone moved to approve the minutes from October 19, 2023. The motion was properly seconded by Dr. Pradhan and carried unanimously.

ADOPTION OF AGENDA

Dr. Ransone moved to approve the agenda as presented. The motion was properly seconded by Dr. Elariny and carried unanimously.

PUBLIC COMMENT

None.

REPORTS OF OFFICERS AND EXECUTIVE DIRECTOR

PRESIDENT

Dr. Clements commented on DHP's ongoing dedication to fix BOX so imaging studies in cases can be properly viewed. Ms. Deschenes said that TBS in getting an estimate on AmberViewer, a plug-in to BOX, which hopefully can be implemented in the next month or two.

VICE-PRESIDENT

No report.

SECRETARY-TREASURER

No report.

EXECUTIVE DIRECTOR

Dr. Harp began with honoring two men who were important to the Board, Warren W. Koontz, Jr., MD and N. Ray Tuck, Jr., DC, who recently passed.

Dr. Harp shared that Dr. Koontz served as Executive Director for the Board of Medicine from 1994-2000. He was an exceptional physician, a great teacher, and a kind and generous man who skillfully led the Board of Medicine. Dr. Clements then shared that Dr. Tuck had been President of the Board of Medicine and the American Chiropractic Association. Dr. Clements acknowledged that Dr. Rathmann had worked with Ray for years at the Tuck Clinic. A moment of silence was held in honor of Dr. Koontz and Dr. Tuck.

Budget

Dr. Harp then directed the Board members to the FY24 Budget which began on July 1, 2023. He focused on the FY24 Base Budget column and the Over/Under Budget column. He highlighted that 6 months into FY24, 49% of the budgeted dollars remain – which is right on target thanks to the precision budgeting of the financial office. He reminded the Board that this is an even calendar year, which is a higher income year. He said the Board was in good fiscal shape, given that the early income from January and February renewals have added to its bottom line.

Human Trafficking CE

Dr. Harp updated the Board on the 1 hour of Human Trafficking CE that is required for renewal for all professions. He shared that a notice was sent out to all licensees on December 8, 2023, regarding the updated CE requirement along with a link to The Polaris Project which provides high quality, online training at no cost to the licensee. The Board is now aware of 6 additional options for CE that will be provided in the Board Briefs to all licensees. They include the following:

- Freedom 4/24 Human Trafficking in Healthcare Training
- Global Centurion
- The Safe House Project
- Shared Hope International
- Red Flags to Freedom
- Transformation Freedom Initiative

FSMB Member Board Survey Results

Dr. Harp reviewed the FSMB 2023 Member Board Survey Results with the Board which reflected responses from 53 of 70 state boards in the fall of 2023. Top ranked topics for the boards were rated on a scale of 1 to 10. The highest ranked issue was Physician Sexual Misconduct at 8.6. Second was Responsible Opioid Prescribing at 8.4. Third was Physician Impairment also at 8.4. Other results from the survey included licensing stats with boards declaring an average of 39 days to issuance; Virginia is at 52 days. The Virginia Board is measured on the number of days from the receipt of an application to the date the license is issued, which may not be the case for all boards.

Quarterly Fatal Drug Overdose Death Report

Dr. Harp reviewed the 2023 Q2 Quarterly Fatal Drug Overdose Report from the Office of the Chief Medical Examiner. It showed that in 2022, there was a substantial drop in Rx opioid overdoses compared to 2007-2021. The projected total at the end of 2023 is 270. Unfortunately, there has been an increase in non-opioid fatal overdoses in 2021 and 2022. Cocaine overdoses have increased by 22.1%, and fatal methamphetamine overdoses have increased by 5.5%. The combination of cocaine and fentanyl represented 30.6% of all overdose deaths in 2022.

Disciplinary Processing Times

Dr. Harp reviewed DHP's Patient Care Case Processing Times report with the Board members. He explained that the Department of Health Professions has a goal of closing 90% of patient care cases in 120 days. In the 2nd quarter of FY2024, DHP closed 84% of the cases within 120 days. The Board of Medicine's goal is also 90%. Medicine has not dropped under 94% since the 3rd quarter of FY2021. The latest statistic from the 2nd quarter of FY2024 indicated a 98% closure rate. Dr. Harp thanked Dr. Matusiak, Ms. Deschenes and all the Board members for their efforts in timely case processing in support of the protection of the public.

Dr. Harp then asked Michael Sobowale to give the Board an update on the processing times for licensure. Mr. Sobowale shared that the current processing time averages 52 days across all 20 professions. This number is down from a year ago when the average was 76 days. Mr. Sobowale attributed the decrease to having a full staff and the implementation of streamlined licensing processes. Suggestions from ImpactMakers should further decrease processing times.

Blanton Marchese's FSMB Nomination

Dr. Harp said that on behalf of the Board, he had written a letter to the FSMB Nominating Committee for consideration of Blanton Marchese as a nominee for the FSMB Board of Directors. Mr. Marchese has been approved as a nominee. Mr. Marchese then shared his interest in Artificial Intelligence in healthcare and reported on his attendance at the January 2024 FSMB Symposium on AI in Health Care and Medical Regulation in Washington, DC.

COMMITTEE AND ADVISORY BOARD REPORTS

Dr. Ransone moved to accept all reports since October 19, 2023, en bloc. The motion was properly seconded by Dr. Archer and carried unanimously.

Break

Dr. Clements called for a recess at 10:28 a.m.; the meeting reconvened at 10:38 a.m.

OTHER REPORTS

Board Counsel – Brent Saunders, JD – Senior Assistant Attorney General

Mr. Saunders, SAAG, provided an update on 5 pending legal cases. He stated that 4 are appeals that all have been filed by physicians. He indicated that the filing in Zackrison v. Board of Medicine is pending.

Board of Health Professions

Draft meeting minutes from the meeting held October 27, 2023 were provided to the Board. Dr. Clements pointed out that Dr. Madiraju has been elected Chair of BHP.

Podiatry Report

No report.

Chiropractic Report

No report.

Committee of the Joint Boards of Nursing and Medicine

No report.

NEW BUSINESS

1. Current Regulatory Actions

   Dr. Harp presented the chart of regulatory actions as of February 6, 2024, stating that that there are currently 16 regulatory actions in the Secretary's Office.

   This report was for informational purposes only and did not require any action.

2. 2024 General Assembly Report

   Mr. Owens expanded on his previous review of bills in the General Assembly.

3. Comments on FSMB Draft Policies

   - FSMB Report on "Reentry to Practice"

     Dr. Harp said that FSMB develops policy documents to help all boards. During the development of a policy, FSMB asks all boards of medicine to review and make comments on the draft. The report from the FSMB Workgroup on Reentry to Practice provides a list of key considerations that the processes of the Virginia Board of Medicine currently incorporates. After consideration and concerns from various Board members on how the Virginia Board of Medicine should respond to FSMB, it settled upon a response.

     MOTION: Dr. Apel moved to thank FSMB for the document and to let them know that the Board will have its Credentials Committee convene to review its processes and identify any changes that should be made. The motion was properly seconded by Dr. Ransone and carried unanimously.

   - Guidelines for the Structure and Function of a State Medical Board

     Dr. Harp reviewed the FSMB draft policy, "Guidelines for the Structure and Function of a State Medical Board and Osteopathic Board." He pointed out the qualifications of a Board member and the compensation/reimbursement suggested. As for qualifications, all Board members are appointed by the Governor. Dr. Harp did offer to write a letter to Mr. Owens on behalf of the Board members with any requests concerning compensation/reimbursement, if needed.

     MOTION: Dr. Apel moved that a letter be sent to FSMB thanking them for the document and to let them know that Virginia Board of Medicine members serve without compensation other than reimbursement for expenses. DR. Ransone seconded, and the motion passed unanimously.

4. Reciprocal Licensing of Physician Assistants with Maryland and the District of Columbia.

   Dr. Harp reviewed the proposal from Maryland and the District of Columbia to establish a reciprocal licensing agreement for physician assistants. The 3 jurisdictions have had such

an agreement in place for physicians since March of 2023. Dr. Harp noted the table of application requirements prepared by Christine Farrelly, Executive Director for the Maryland Board. Maryland and DC have approved this proposal and are now seeking Virginia to be a part of a reciprocity agreement.

MOTION: Mr. Marchese moved that Board staff be authorized to pursue reciprocity for PA's with Maryland and the District of Columbia. The motion was properly seconded by Dr. Clements and carried unanimously.

5. Licensing Report

Mr. Sobowale stated that the total number of licensees is currently 90,220. He shared that the Board received a total of 11,088 applications last year of which 10,874 were completed and licensed. This gives the Board a 98% clearance rate.

Mr. Sobowale shared that the Licensing staff is currently working with ImpactMakers to further streamline the licensing process to make it more efficient and user friendly for the applicant. Inquiries about pending applications from applicants, legislators, and the Executive Branch have already dropped considerably.

Lastly, Mr. Sobowale updated the Board on reciprocal licensing with Maryland and the District of Columbia. From March 2023 to present, the Board has issued 566 MD/DO licenses by reciprocity. 126 Virginia physicians have applied for licensure in the District of Columbia, and 175 have applied in Maryland.

6. Discipline Report

Ms. Deschenes provided a brief report on the status of open cases as of February 1, 2024, stating that there are total of 979 cases at all stages. Referring to the 2nd Quarter FY2024 discipline numbers, Ms. Deschenes pointed out that the Board has received 546 cases and closed 514. She also noted that there were 11 Summary Suspensions in 2023 up from 4 in 2022.

Ms. Deschenes then presented a Consent Order for Julie Yia-Pei Chao, MD, an applicant for reinstatement.

MOTION: Mr. Marchese moved to accept the Consent Order. The motion was properly seconded by Dr. Ransone with a vote of 11-0-1.

7. Appointment of a Nominating Committee

Dr. Clements stated that current officers' terms will be expiring at the June 2024 Board meeting. A Nominating Committee needs to be constituted to consider a slate of officers for 2024-2025. Board members were reminded that if they are considering running for office,

they will not be on the Nominating Committee. The Committee was not constituted at the meeting.

ANNOUNCEMENTS

Dr. Clements announced that the next Board meeting will be held on June 13, 2024, at 8:30 a.m.

ADJOURNMENT

With no additional business, the meeting adjourned at 11:36 a.m.

_____
William L. Harp, MD
Executive Director

DRAFT

Virginia's Licensed Advanced Practice Registered Nurse Workforce: 2023

Healthcare Workforce Data Center

November 2023

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233
804-597-4213, 804-527-4466(fax)
E-mail: ***HWDC@dhp.virginia.gov***

Follow us on Tumblr: ***www.vahwdc.tumblr.com***
Get a copy of this report from:
http://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/

7,102 Licensed Advanced Practice Registered Nurses voluntarily participated in this survey. *Without their efforts the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Nursing express our sincerest appreciation for their ongoing cooperation.*

Thank You!

Virginia Department of Health Professions

Arne E. Owens, MS
Director

James L. Jenkins, Jr., RN
Chief Deputy Director

Healthcare Workforce Data Center Staff:

Yetty Shobo, PhD	Barbara Hodgdon, PhD	Rajana Siva, MBA	Christopher Coyle, BA
Director	*Deputy Director*	*Data Analyst*	*Research Assistant*

The Committee of the Joint Boards of Nursing and Medicine

Members

Laurie Buchwald, MSN, WHNP, NCMP, FNP
Radford

Blanton L. Marchese
North Chesterfield

Helen M. Parke, DNP, FNP-BC
Concord

Joel Silverman, MD
Richmond

Ryan Williams, MD
Suffolk

Executive Director of Board of Medicine

William L. Harp, MD

Executive Director of Board of Nursing

Jay P. Douglas, MSM, RN, CSAC, FRE

Contents

The Licensed Advanced Practice Registered Nurse Workforce: At a Glance:

The Workforce	
Licensees:	20,485
Virginia's Workforce:	14,837
FTEs:	12,313

Survey Response Rate	
All Licensees:	35%
Renewing Practitioners:	91%

Demographics	
Female:	90%
Diversity Index:	45%
Median Age:	44

Background	
Rural Childhood:	34%
HS Degree in VA:	44%
Prof. Degree in VA:	50%

Education	
Master's Degree:	76%
Post-Masters Cert.:	7%

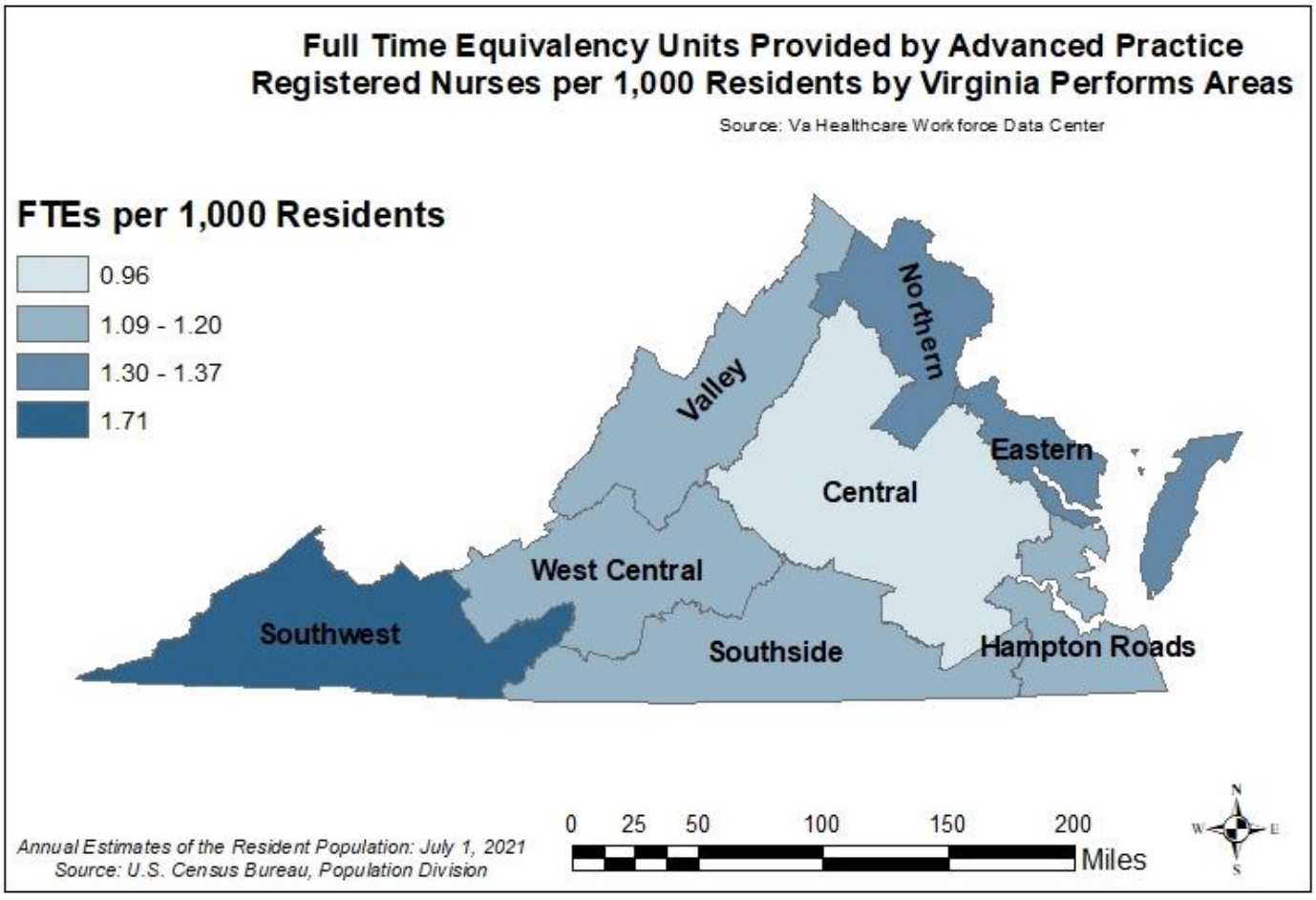
Finances	
Median Income:	$110k-$120k
Health Benefits:	61%
Under 40 w/ Ed debt:	64%

Current Employment	
Employed in Prof.:	96%
Hold 1 Full-time Job:	64%
Satisfied?:	94%

Job Turnover	
Switched Jobs:	9%
Employed over 2 yrs:	53%

Time Allocation	
Patient Care:	90%-99%
Patient Care Role:	88%
Admin. Role:	3%

Source: Va. Healthcare Workforce Data Center



Results in Brief

Over 7,000 Licensed Advanced Practice Registered Nurse (APRNs) voluntarily took part in the 2023 Licensed Nurse Practitioner Workforce Survey[1]. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during license renewal, which takes place during a two-year renewal cycle in the birth month of each respondent. About half of all APRNs have access to the survey every year. The 2023 survey respondents represent 35% of the 20,485 APRNs who are licensed in the state and 91% of renewing practitioners. This report includes any advanced practice registered nurse. Detailed information on APRNs, nurse anesthetists, and/or certified nurse midwives is available as a separate report.

The HWDC estimates that 14,837 APRNs participated in Virginia's workforce during the survey period, which is defined as those who worked at least a portion of the year in the state or who live in the state and intend to return to work as an APRN at some point in the future. Between October 2022 and September 2023, Virginia's APRN workforce provided 12,313"full-time equivalency units" (FTEs), which the HWDC defines simply as working 2,000 hours a year.

Nine out of 10 APRNs are female, and the median age of all APRNs is 44. In a random encounter between two APRNs, there is a 45% chance that they would be of different races or ethnicities; this measure is known as the diversity index. This makes Virginia's APRN workforce less diverse than the state's overall population which has a diversity index of 60%. The diversity index is 45% among APRNs under age 40. Over one-third of APRNs grew up in a rural area, and 24% of these professionals currently work in non-Metro areas of the state. Overall, 11% of APRNs work in rural areas. Meanwhile, 44% of Virginia's APRNs graduated from high school in Virginia, and 50% of APRNs earned their initial professional degree in the state. In total, 55% of Virginia's APRN workforce have some educational background in the state.

Over three quarters of all APRNs hold a Master's degree as their highest professional degree and over 20% have additional education or certifications beyond a Master's degree. Over half of all APRNs currently carry educational debt, including 64% of those under the age of 40. The median debt for those APRNs with educational debt is between $70,000 and $80,000.

Summary of Trends

Several significant changes have occurred in the APRN workforce in the past six years. In 2018, a policy change authorized the Committee of the Joint Boards of Nursing and Medicine (the Joint Boards) to promulgate regulations that permit qualified nurse practitioners to practice autonomously after the completion of five years of clinical experience as a nurse practitioner. In 2020, the General Assembly reduced the required clinical experience to two years before autonomous practice. This change sunset July 1, 2022; the prerequisite years of clinical experience is 5 years, again. The number of licensed APRNs in the state has more than doubled since 2014; the number in the state's workforce also has more than doubled, and the FTEs provided increased by 113%. Compared to 2020, the response rate of renewing APRNs increased from 77% to 91%. The percent of APRNs working in non-metro areas decreased from a high of 14% in 2022 to compared to 11% in 2023.

The percent female has stayed consistently around 90%. The diversity index continues to increase from 28% in 2014 to a high of 45% in 2023, though the diversity index is still lower than the statewide diversity index (60%). Median age declined from 48 years in 2014 to 44 years in 2020 and has stayed at 44 through 2023. In 2023, the percent of APRNs with a doctorate APRN is 11%, which is higher than the 2014 level of 4%. The percent carrying debt also has increased across the years; 52% of all APRNs carry debt compared to 40% in 2014. Median debt increased from $40,000-$50,000 in 2014 to $70,000-$80,000. Median income also increased to $110,000-$120,000 since 2022. Retirement expectations have declined over time; and 19% of APRNs intend to retire within a decade of the survey, as compared to 24% in 2014.

[1] To reduce respondents' burden, HWDC changed its procedure in 2019 so that nurses now complete a survey for the highest profession in which they are practicing. This may have resulted in more APRNs responding. This distinction should be kept in mind when comparing this year's survey to previous years.

A Closer Look:

Licensees		
License Status	#	%
Renewing Practitioners	6,720	33%
New Licensees	2,912	14%
Non-Renewals	978	5%
Renewal date not in survey period	9,578	47%
All Licensees	**20,485**	**100%**

Source: Va. Healthcare Workforce Data Center

Our surveys tend to achieve very high response rates. More than nine of every ten renewing APRNs submitted a survey. These represent 35% of APRNs who held a license at some point during the licensing period.

Definitions

1. **The Survey Period:** The survey was conducted between October 2022 and September 2023 in the birth month of each renewing practitioner.
2. **Target Population:** All APRNs who held a Virginia license at some point during the survey period.
3. **Survey Population:** The survey was available to APRNs who renewed their licenses online. It was not available to those who did not renew, including APRNs newly licensed during the

Response Rates			
Statistic	**Non Respondents**	**Respondent**	**Response Rate**
By Age			
Under 30	462	84	15%
30 to 34	1,692	873	34%
35 to 39	2,706	1,082	29%
40 to 44	2,048	1,346	40%
45 to 49	1,883	870	32%
50 to 54	1,486	995	40%
55 to 59	1,163	577	33%
60 and Over	1,943	1,275	40%
Total	**13,383**	**7,102**	**35%**
New Licenses			
Issued After Sept. 2021	2,746	166	6%
Metro Status			
Non-Metro	961	603	39%
Metro	6,881	4,685	41%
Not in Virginia	5,541	1,813	25%

Source: Va. Healthcare Workforce Data Center

Response Rates	
Completed Surveys	7,102
Response Rate, all licensees	35%
Response Rate, Renewals	91%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed APRNs

Number: 20,485
New: 14%
Not Renewed: 5%

Response Rates

All Licensees: 35%
Renewing Practitioners: 91%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Workforce

Virginia's APRN Workforce:	14,837
FTEs:	12,313

Utilization Ratios

Licensees in VA Workforce:	72%
Licensees per FTE:	1.66
Workers per FTE:	1.20

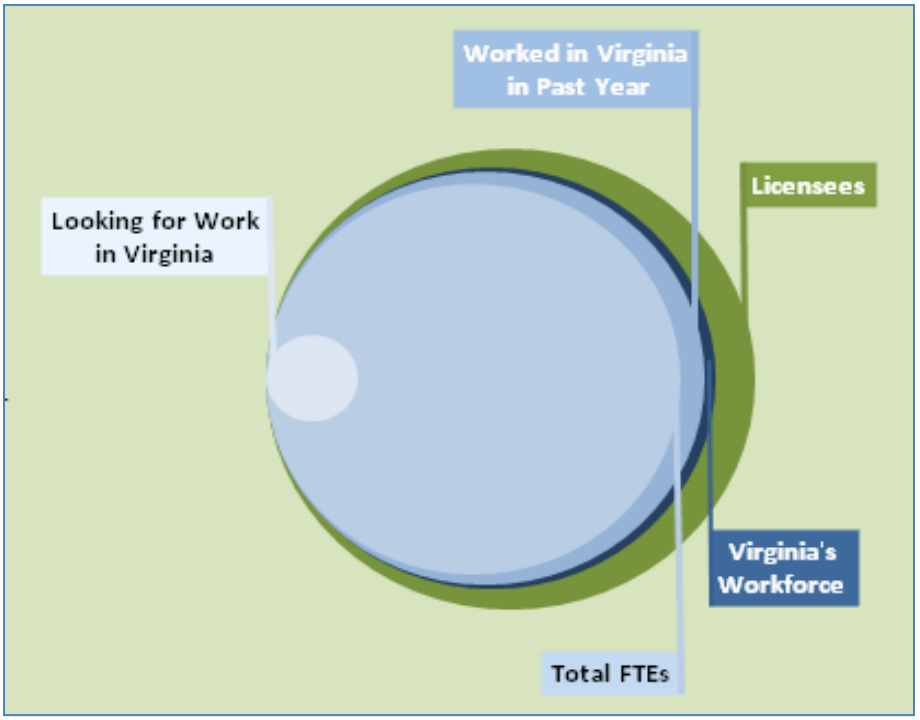
Source: Va. Healthcare Workforce Data Center

Definitions

1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time during the survey timeframe or who indicated intent to return to Virginia's workforce at any point in the future.
2. **Full Time Equivalency Unit (FTE):** The HWDC uses 2,000 (40 hours for 50 weeks) as its baseline measure for FTEs.
3. **Licensees in VA Workforce:** The proportion of licensees in Virginia's Workforce.
4. **Licensees per FTE:** An indication of the number of licensees needed to create 1 FTE. Higher numbers indicate lower licensee participation.
5. **Workers per FTE:** An indication of the number of workers in Virginia's workforce needed to create 1 FTE. Higher numbers indicate lower utilization of available workers.

Virginia's APRN Workforce		
Status	#	%
Worked in Virginia in Past Year	14,561	98%
Looking for Work in Virginia	275	2%
Virginia's Workforce	**14,837**	**100%**
Total FTEs	**12,313**	
Licensees	**20,485**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

This report uses weighting to estimate the figures in this report. Unless otherwise noted, figures refer to the Virginia Workforce only. For more information on HWDC's methodology visit: www.dhp.virginia.gov/hwdc

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 30	26	7%	358	93%	384	3%
30 to 34	144	9%	1,445	91%	1,589	13%
35 to 39	174	8%	2,115	92%	2,289	19%
40 to 44	234	11%	1,817	89%	2,052	17%
45 to 49	188	11%	1,467	89%	1,655	13%
50 to 54	159	11%	1,305	89%	1,464	12%
55 to 59	108	11%	877	89%	986	8%
60 +	212	11%	1,656	89%	1,868	15%
Total	**1,245**	**10%**	**11,041**	**90%**	**12,286**	**100%**

Source: Va. Healthcare Workforce Data Center

Race & Ethnicity					
Race/ Ethnicity	Virginia*	APRNs		APRNs under 40	
	%	#	%	#	%
White	59%	8,952	73%	3,174	75%
Black	18%	1,762	14%	476	11%
Asian	7%	735	6%	269	6%
Other Race	1%	120	1%	32	1%
Two or more races	5%	280	2%	91	2%
Hispanic	10%	460	4%	200	5%
Total	**100%**	**12,309**	**100%**	**4,242**	**100%**

*Population data in this chart is from the U.S. Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2022.

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

% Female:	90%
% Under 40 Female:	92%

Age

Median Age:	44
% Under 40:	35%
% 55+:	23%

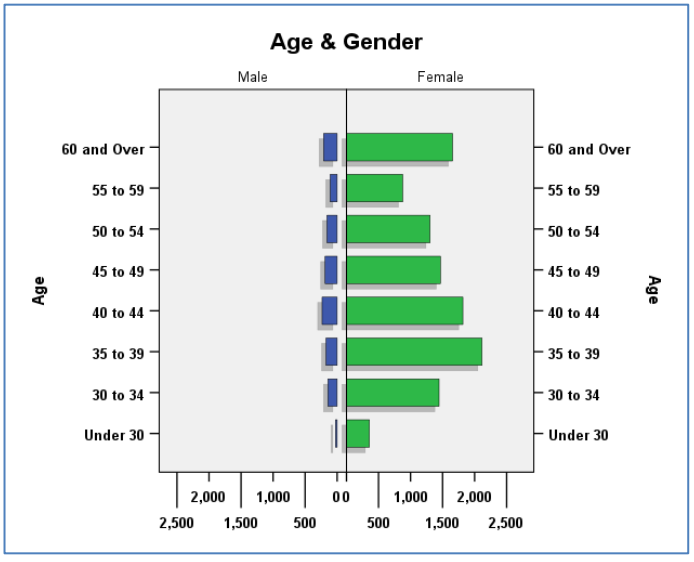
Diversity

Diversity Index:	45%
Under 40 Div. Index:	42%

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two APRNs, there is a 45% chance they would be of a different race/ethnicity (a measure known as the Diversity Index), compared to a 60% chance for Virginia's population as a whole.

35% of APRNs are under the age of 40. 92% of these professionals are female. In addition, the diversity index among APRNs under the age of 40 is 42%, which is slightly lower than the diversity index among Virginia's overall APRN workforce.



Source: Va. Healthcare Workforce Data Center

At a Glance:

Childhood

Urban Childhood:	13%
Rural Childhood:	34%

Virginia Background

HS in Virginia:	44%
Prof. Ed. in VA:	50%
HS or Prof. Ed. in VA:	55%
Initial NP Degree in VA:	51%

Location Choice

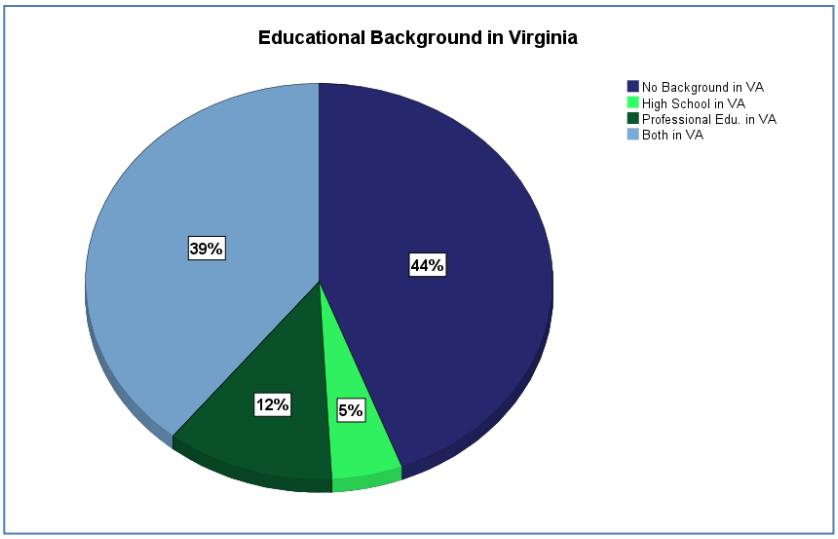
% Rural to Non-Metro:	24%
% Urban/Suburban to Non-Metro:	5%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Primary Location: USDA Rural Urban Continuum		Rural Status of Childhood Location		
Code	Description	Rural	Suburban	Urban
	Metro Counties			
1	Metro, 1 million+	23.4%	61.2%	15.4%
2	Metro, 250,000 to 1 million	53.6%	38.4%	8.0%
3	Metro, 250,000 or less	44.1%	45.4%	10.6%
	Non-Metro Counties			
4	Urban pop 20,000+, Metro adjacent	65.2%	25.9%	9.0%
6	Urban pop, 2,500-19,999, Metro adjacent	66.3%	29.2%	4.4%
7	Urban pop, 2,500-19,999, non adjacent	87.5%	9.3%	3.2%
8	Rural, Metro adjacent	72.5%	22.2%	5.2%
9	Rural, non adjacent	52.0%	34.7%	13.3%
	Overall	**34%**	**53%**	**13%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

34% of all APRNs grew up in self-described rural areas, and 24% of these professionals currently work in non-metro counties. Overall, 11% of all APRNs currently work in non-metro counties.

Top Ten States for Licensed Nurse Practitioner Recruitment

Rank	All APRNs					
	High School	#	Init. Prof Degree	#	Init. NP Degree	#
1	Virginia	5,334	Virginia	6,088	Virginia	6,147
2	Outside of U.S./Canada	1,026	Pennsylvania	522	Washington, D.C.	627
3	New York	586	New York	508	Tennessee	597
4	Maryland	474	Tennessee	456	Pennsylvania	439
5	Pennsylvania	471	Maryland	455	North Carolina	434
6	North Carolina	458	North Carolina	449	Maryland	315
7	Florida	325	Florida	341	New York	298
8	Tennessee	276	Outside of U.S./Canada	311	Florida	276
9	West Virginia	255	West Virginia	266	Illinois	261
10	Ohio	248	Ohio	233	Minnesota	258

Source: Va. Healthcare Workforce Data Center

Rank	Licensed in the Past 5 Years					
	High School	#	Init. Prof Degree	#	Init. NP Degree	#
1	Virginia	2,381	Virginia	3,028	Virginia	2,876
2	Outside of U.S./Canada	558	Maryland	301	Tennessee	329
3	Maryland	233	Pennsylvania	252	Washington, D.C.	286
4	New York	232	North Carolina	245	North Carolina	225
5	Pennsylvania	206	Tennessee	219	Pennsylvania	202
6	North Carolina	198	New York	193	Illinois	202
7	Florida	197	Florida	179	Maryland	198
8	Tennessee	149	Outside of U.S./Canada	168	Minnesota	191
9	New Jersey	131	West Virginia	129	Florida	155
10	Minnesota	120	Ohio	117	Massachusetts	145

Source: Va. Healthcare Workforce Data Center

28% of Virginia's licensees did not participate in Virginia's APRN workforce during the past year. Ninety-five percent of these licensees worked at some point in the past year, including 91% who worked in a nursing-related capacity.

At a Glance:

Not in VA Workforce

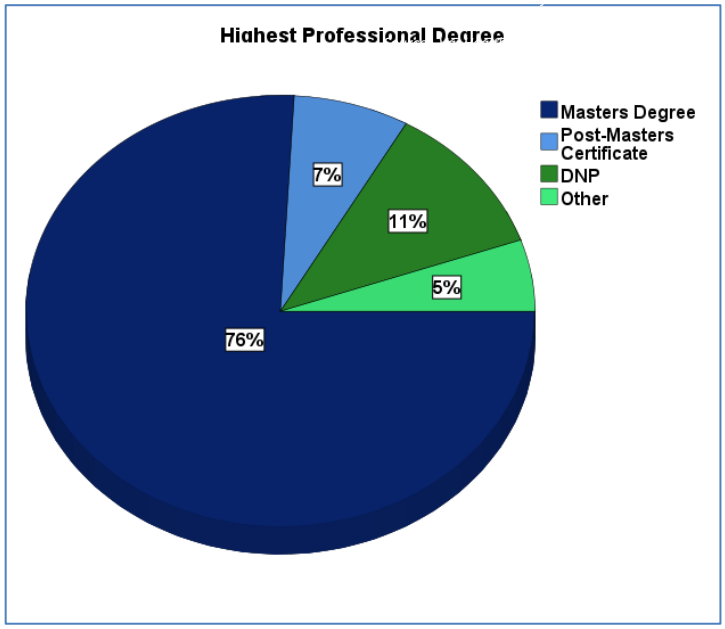
Total:	5,651
% of Licensees:	28%
Federal/Military:	9%
Va. Border State/DC:	19%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Degree		
Degree	#	%
NP Certificate	220	2%
Master's Degree	9,146	76%
Post-Masters Cert.	887	7%
Doctorate of NP	1,377	11%
Other Doctorate	423	4%
Post-Ph.D. Cert.	2	0%
Total	**12,055**	**100%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

At a Glance:

Education

Master's Degree: 76%
Post-Masters Cert.: 7%

Educational Debt

Carry debt: 52%
Under age 40 w/ debt: 64%
Median debt: $70k-$80k

Source: Va. Healthcare Workforce Data

Educational Debt				
Amount Carried	All APRNs		APRNs under 40	
	#	%	#	%
None	5,240	48%	1,343	36%
$10,000 or less	380	3%	151	4%
$10,000-$19,999	379	3%	134	4%
$20,000-$29,999	403	4%	186	5%
$30,000-$39,999	442	4%	200	5%
$40,000-$49,999	415	4%	193	5%
$50,000-$59,999	397	4%	190	5%
$60,000-$69,999	423	4%	219	6%
$70,000-$79,999	411	4%	179	5%
$80,000-$89,999	357	3%	161	4%
$90,000-$99,999	322	3%	144	4%
$100,000-$109,999	320	3%	128	3%
$110,000-$119,999	235	2%	92	2%
$120,000 or more	1,210	11%	451	12%
Total	**10,934**	**100%**	**3,771**	**100%**

Source: Va. Healthcare Workforce Data Center

More than three-quarters of all APRNs hold a Master's degree as their highest professional degree. Half of APRNs carry education debt, including 64% of those under the age of 40. The median debt burden among APRNs with educational debt is between $70,000 and $80,000.

Specialties & Certifications

At a Glance:

Primary Specialty

Family Health: 29%
RN Anesthetist: 14%
Psychiatric/ Mental Health: 9%

Credentials

AANPCP – Family NP: 22%
ANCC – Family NP: 19%
ANCC – Family Psychiatric-Mental Health NP: 4%

Source: Va. Healthcare Workforce Data Center

Specialty	Primary	
	#	%
Family Health	3,504	29%
Certified Registered Nurse Anesthetist	1,606	14%
Psychiatric/Mental Health	1,055	9%
Acute Care/Emergency Room	957	8%
Pediatrics	778	7%
Adult Health	726	6%
OB/GYN - Women's Health	378	3%
Geriatrics/Gerontology	358	3%
Surgical	343	3%
Medical Specialties (Not Listed)	270	2%
Certified Nurse Midwife	230	2%
Neonatal Care	166	1%
Clinical Nurse Specialist	129	1%
Gastroenterology	117	1%
Other	1,278	11%
Total	**11,895**	**100%**

Source: Va. Healthcare Workforce Data Center

Credentials		
Credential	#	%
AANPCP: Family NP	3,320	22%
ANCC: Family NP	2,766	19%
ANCC: Family Psychiatric-Mental Health NP	566	4%
ANCC: Adult-Gerontology Acute Care NP	497	3%
ANCC: Adult Psychiatric-Mental Health NP	453	3%
ANCC: Adult NP	334	2%
ANCC: Acute Care NP	332	2%
NCC: Women's Health Care NP	316	2%
ANCC: Adult-Gerontology Primary Care NP	294	2%
ANCC: Pediatric NP	261	2%
AANPCP: Adult-Gerontology Primary Care NP (A-GNP-C)	227	2%
NCC: Neonatal NP	157	1%
AANPCP: Adult NP	120	1%
All Other Credentials	111	1%
At Least One Credential	**9,106**	**61%**

Source: Va. Healthcare Workforce Data Center

Approximately 30% of all APRNs had a primary specialty in family health, while another 14% had a primary specialty as a Certified RN Anesthetist. 61% of all APRNs also held at least one credential. AANPCP: Family NP was the most reported credential held by Virginia's APRN workforce.

At a Glance:

Employment

Employed in Profession: 96%
Involuntarily Unemployed: <1%

Positions Held

1 Full-time: 64%
2 or More Positions: 19%

Weekly Hours:

40 to 49: 50%
60 or more: 6%
Less than 30: 12%

Source: Va. Healthcare Workforce Data

A Closer Look:

Current Work Status		
Status	#	%
Employed, capacity unknown	9	<1%
Employed in a nursing- related capacity	11,111	96%
Employed, NOT in a nursing-related capacity	62	1%
Not working, reason unknown	0	0%
Involuntarily unemployed	15	<1%
Voluntarily unemployed	288	3%
Retired	112	1%
Total	**11,596**	**100%**

Source: Va. Healthcare Workforce Data Center

96% of APRNs are currently employed in their profession. 64% of APRNs hold one full-time job, while 19% currently have multiple jobs. Half of all APRNs work between 40 and 49 hours per week, while 6% work at least 60 hours per week.

Current Weekly Hours		
Hours	#	%
0 hours	2	<1%
1 to 9 hours	166	1%
10 to 19 hours	313	3%
20 to 29 hours	858	7%
30 to 39 hours	2,464	21%
40 to 49 hours	5,756	50%
50 to 59 hours	1,178	10%
60 to 69 hours	500	4%
70 to 79 hours	98	1%
80 or more hours	137	1%
Total	**11,472**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Positions		
Positions	#	%
No Positions	303	3%
One Part-Time Position	1,618	14%
Two Part-Time Positions	518	4%
One Full-Time Position	7,629	64%
One Full-Time Position & One Part-Time Position	1,427	12%
Two Full-Time Positions	45	<1%
More than Two Positions	311	3%
Total	**11,851**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Income		
Hourly Wage	#	%
Volunteer Work Only	57	1%
Less than $40,000	352	4%
$40,000-$49,999	157	2%
$50,000-$59,999	206	2%
$60,000-$69,999	232	3%
$70,000-$79,999	335	4%
$80,000-$89,999	574	6%
$90,000-$99,999	804	9%
$100,000-$109,999	1,334	14%
$110,000-$119,999	1,151	12%
$120,000 or more	4,196	45%
Total	**9,398**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Earnings

Median Income: $110k-$120k

Benefits

Retirement: 71%

Health Insurance: 61%

Satisfaction

Satisfied: 94%

Very Satisfied: 62%

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	#	%
Very Satisfied	7,336	62%
Somewhat Satisfied	3,877	33%
Somewhat Dissatisfied	535	5%
Very Dissatisfied	137	1%
Total	**11,884**	**100%**

Source: Va. Healthcare Workforce Data Center

The typical APRN had an annual income of between $110,000 and $120,000. Among APRNs who received either a wage or salary as compensation at their primary work location, 71% also had access to a retirement plan and 61% received health insurance.

Employer-Sponsored Benefits*			
Benefit	#	%	% of Wage/Salary Employees
Paid Leave	7,431	85%	71%
Retirement	7,525	86%	71%
Health Insurance	6,607	75%	61%
Dental Insurance	6,357	72%	59%
Group Life Insurance	5,193	59%	49%
Signing/Retention Bonus	2,002	23%	18%
Receive at least one benefit	**8,799**	**79%**	**82%**

*From any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Employment Instability in Past Year		
In the past year did you . . .?	#	%
Experience Involuntary Unemployment?	102	1%
Experience Voluntary Unemployment?	647	4%
Work Part-time or temporary positions, but would have preferred a full-time/permanent position?	386	3%
Work two or more positions at the same time?	2,717	18%
Switch employers or practices?	1,338	9%
Experienced at least 1	**4,329**	**29%**

Source: Va. Healthcare Workforce Data Center

Only 1% of Virginia's APRNs experienced involuntary unemployment at some point in the prior year. By comparison, Virginia's average monthly unemployment rate was 2.9% during the same period.[1]

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at this Location	235	2%	183	6%
Less than 6 Months	1,132	10%	474	15%
6 Months to 1 Year	1,455	13%	459	14%
1 to 2 Years	2,645	23%	741	23%
3 to 5 Years	2,655	23%	687	22%
6 to 10 Years	1,626	14%	345	11%
More than 10 Years	1,798	16%	280	9%
Subtotal	**11,546**	**100%**	**3,169**	**100%**
Did not have location	299		11,587	
Item Missing	2,992		81	
Total	**14,837**		**14,837**	

Source: Va. Healthcare Workforce Data Center

65% of APRNs receive a salary at their primary work location, while 27% receive an hourly wage.

At a Glance:

Unemployment Experience
Involuntarily Unemployed: 1%
Underemployed: 4%

Turnover & Tenure
Switched Jobs: 9%
New Location: 30%
Over 2 years: 53%
Over 2 yrs, 2nd location: 41%

Employment Type
Salary: 65%
Hourly Wage: 27%

Source: Va. Healthcare Workforce Data Center

53% of APRNs have worked at their primary location for more than 2 years—the job tenure normally required to get a conventional mortgage loan.

Employment Type		
Primary Work Site	#	%
Salary/ Commission	5,621	65%
Hourly Wage	2,353	27%
By Contract	618	7%
Business/ Practice Income	0	0%
Unpaid	37	<1%
Subtotal	**8,629**	
Missing location	299	
Item missing	5,546	

Source: Va. Healthcare Workforce Data Center

[1] As reported by the U.S. Bureau of Labor Statistics. Over the past year, the non-seasonally adjusted monthly unemployment rate has fluctuated between a low of 2.5% and a high of 3.3%. At the time of publication, the unemployment rate for September 2023 was still preliminary.

Work Site Distribution

At a Glance:

Concentration

Top Region:	27%
Top 3 Regions:	70%
Lowest Region:	2%

Locations

2 or more (Past Year):	28%
2 or more (Now*):	26%

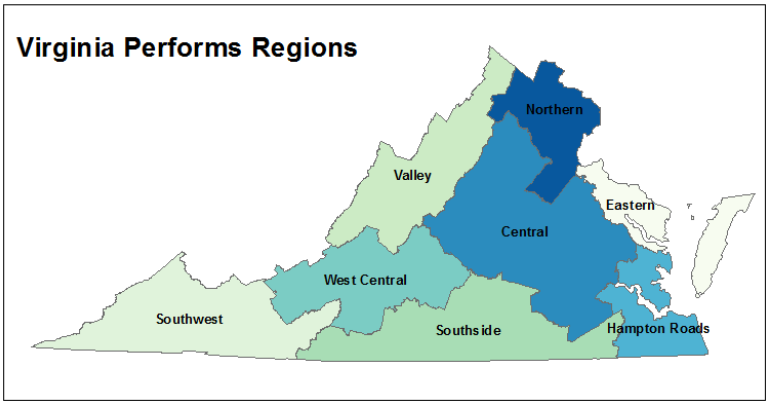
Source: Va. Healthcare Workforce Data Center

Northern Virginia has the highest number of APRNs in the state, while Eastern Virginia has the fewest number of APRNs in Virginia.

A Closer Look:

Regional Distribution of Work Locations				
Virginia Performs Region	Primary Location		Secondary Location	
	#	%	#	%
Central	2,787	24%	513	16%
Eastern	178	2%	33	1%
Hampton Roads	2,100	18%	631	20%
Northern	3,143	27%	788	24%
Southside	426	4%	131	4%
Southwest	684	6%	215	7%
Valley	748	6%	162	5%
West Central	1,113	10%	282	9%
Virginia Border State/DC	117	1%	112	3%
Other US State	250	2%	345	11%
Outside of the US	3	0%	11	0%
Total	**11,549**	**100%**	**3,223**	**100%**
Item Missing	2,989		28	

Source: Va. Healthcare Workforce Data Center



Number of Work Locations				
Locations	Work Locations in Past Year		Work Locations Now*	
	#	%	#	%
0	273	2%	401	3%
1	8,249	70%	8,348	71%
2	1,928	16%	1,927	16%
3	957	8%	851	7%
4	180	2%	110	1%
5	65	1%	42	<1%
6 or More	108	1%	81	1%
Total	**11,761**	**100%**	**11,761**	**100%**

*At the time of survey completion (Oct. 2022 - Sept. 2023, birth month of respondent).

Source: Va. Healthcare Workforce Data Center

26% of all APRNs had just one work location during the past year, while 28% of APRNs had multiple work locations.

Establishment Type

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	5,925	54%	1,941	64%
Non-Profit	3,641	33%	807	26%
State/Local Government	770	7%	183	6%
Veterans Administration	279	3%	34	1%
U.S. Military	211	2%	65	2%
Other Federal Government	109	1%	16	1%
Total	**10,935**	**100%**	**3,046**	**100%**
Did not have location	299		11,587	
Item Missing	3,603		204	

Source: Va. Healthcare Workforce Data Center

More than 85% of all APRNs work in the private sector, including 54% in for-profit establishments. Meanwhile, 7% of APRNs work for state or local governments, and 5% work for the federal government.

Electronic Health Records (EHRs) and Telehealth		
	#	%
Meaningful use of EHRs	4,164	28%
Remote Health, Caring for Patients in Virginia	3,717	25%
Remote Health, Caring for Patients Outside of Virginia	938	6%
Use at least one	**5,946**	**40%**

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

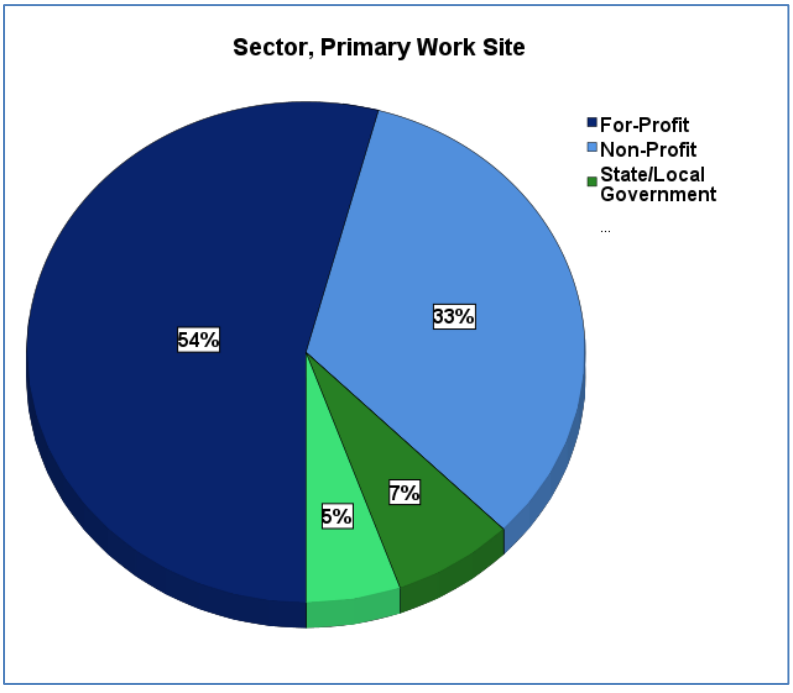
Sector

For Profit:	54%
Federal:	5%

Top Establishments

Hospital, Inpatient:	20%
Clinic, Primary Care:	17%
Academic Institution:	7%

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

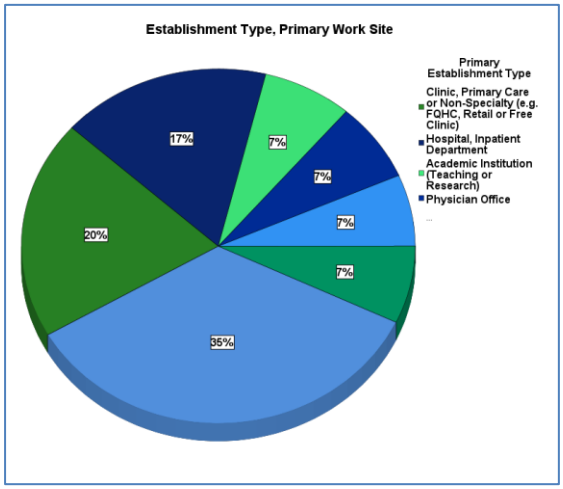
Over a quarter of the state's APRN workforce use EHRs. 25% also provide remote health care for Virginia patients.

Location Type				
Establishment Type	Primary Location		Secondary Location	
	#	%	#	%
Clinic, Primary Care or Non-Specialty	2,126	20%	407	14%
Hospital, Inpatient Department	1,834	17%	428	15%
Academic Institution (Teaching or Research)	786	7%	222	8%
Physician Office	765	7%	116	4%
Hospital, Outpatient Department	693	7%	106	4%
Private practice, group	600	6%	118	4%
Clinic, Non-Surgical Specialty	506	5%	132	5%
Mental Health, or Substance Abuse, Outpatient Center	488	5%	177	6%
Ambulatory/Outpatient Surgical Unit	368	3%	189	7%
Long Term Care Facility, Nursing Home	347	3%	119	4%
Hospital, Emergency Department	272	3%	117	4%
Private practice, solo	233	2%	85	3%
Home Health Care	172	2%	77	3%
Other Practice Setting	1,452	14%	612	21%
Total	**10,642**	**100%**	**2,905**	**100%**
Did Not Have a Location	299		11,587	

Source: Va. Healthcare Workforce Data Center

The single largest employer of Virginia's APRNs is primary care or non-specialty clinics of hospitals, where 20% of all APRNs have their primary work location. Inpatient hospital departments, academic institutions, physicians' offices, and outpatient hospital departments were also common primary establishment types for Virginia's APRN workforce.

Among those APRNs who also have a secondary work location, 15% work at the inpatient department of a hospital and 14% work in a primary care/non-specialty clinic.



Source: Va. Healthcare Workforce Data Center

92% of APRNs who responded to the question about forms of payment reported accepting private insurance as a form of payment for services rendered.

Accepted Forms of Payment		
Payment	#	% of Workforce
Private Insurance	8,553	92%
Medicaid	7,912	85%
Medicare	7,885	85%
Cash/Self-Pay	7,513	81%

Source: Va. Healthcare Workforce Data Center

Time Allocation

At a Glance:
(Primary Locations)

Typical Time Allocation

Patient Care:	90%-99%
Administration:	1%-9%
Education:	1%-9%

Roles

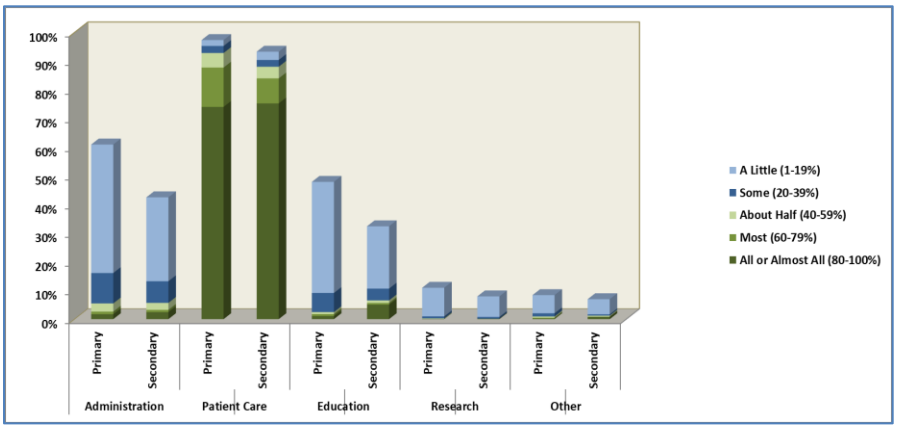
Patient Care:	88%
Administration:	3%
Education:	2%

Patient Care APRNs

Median Admin Time:	1%-9%
Ave. Admin Time:	1%-9%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

A typical APRN spends most of her time on patient care activities, with most of the remaining time split between administrative and educational tasks. 88% of all APRNs fill a patient care role, defined as spending 60% or more of their time on patient care activities.

Time Allocation										
Time Spent	**Admin.**		**Patient Care**		**Education**		**Research**		**Other**	
	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site
All or Almost All (80-100%)	2%	2%	74%	75%	1%	5%	0%	0%	0%	1%
Most (60-79%)	1%	1%	14%	9%	1%	1%	0%	0%	0%	0%
About Half (40-59%)	3%	2%	5%	4%	1%	1%	0%	0%	0%	0%
Some (20-39%)	11%	8%	2%	2%	7%	4%	1%	1%	1%	0%
A Little (1-20%)	45%	29%	2%	3%	39%	22%	10%	7%	6%	5%
None (0%)	39%	58%	3%	7%	52%	68%	89%	92%	92%	93%

Source: Va. Healthcare Workforce Data

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All APRNs		APRNs over 50	
	#	%	#	%
Under age 50	198	2%	0	0%
50 to 54	372	4%	20	1%
55 to 59	967	9%	148	4%
60 to 64	2,715	26%	760	21%
65 to 69	3,732	36%	1,496	41%
70 to 74	1,283	12%	676	19%
75 to 79	406	4%	242	7%
80 or over	130	1%	70	2%
I do not intend to retire	583	6%	240	7%
Total	**10,386**	**100%**	**3,652**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All APRNs

Under 65: 41%
Under 60: 15%

APRNs 50 and over

Under 65: 25%
Under 60: 5%

Time until Retirement

Within 2 years: 6%
Within 10 years: 19%
Half the workforce: By 2048

Source: Va. Healthcare Workforce Data Center

41% of APRNs expect to retire by the age of 65, while 25% of APRNs who are age 50 or over expect to retire by the same age. Meanwhile, 36% of all APRNs expect to retire in their late 60s, and 23% of all APRNs expect to work until at least age 70, including 6% who do not expect to retire at all.

Within the next two years, only 2% of Virginia's APRNs plan on leaving either the profession or the state. Meanwhile, 10% of APRNs plan on increasing patient care hours, and 11% plan on pursuing additional educational opportunities.

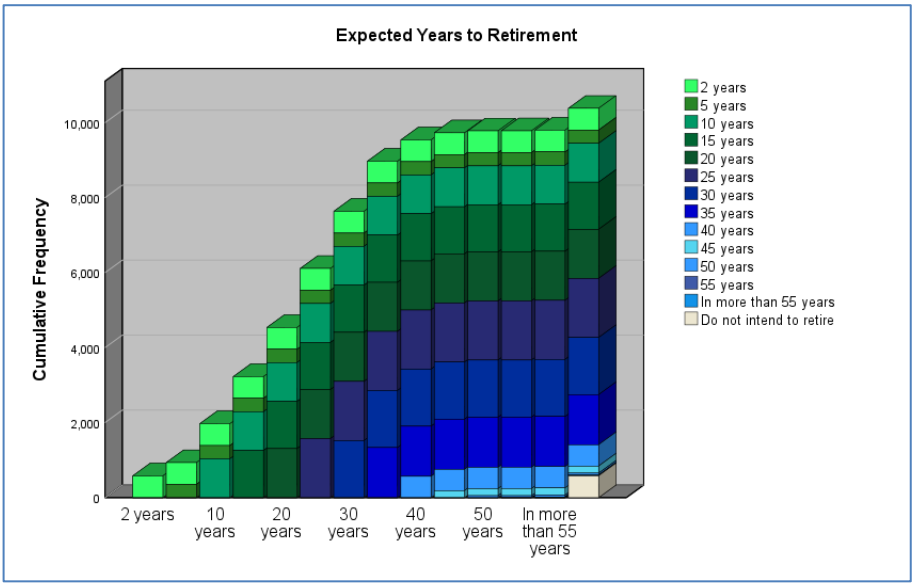
Future Plans		
2 Year Plans:	#	%
Decrease Participation		
Leave Profession	146	1%
Leave Virginia	319	2%
Decrease Patient Care Hours	1,439	10%
Decrease Teaching Hours	98	1%
Increase Participation		
Increase Patient Care Hours	1,508	10%
Increase Teaching Hours	1,464	10%
Pursue Additional Education	1,638	11%
Return to Virginia's Workforce	106	1%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for APRNs. 6% of APRNs expect to retire in the next two years, while 19% expect to retire in the next 10 years. More than half of the current APRN workforce expect to retire by 2048.

Time to Retirement			
Expect to retire within. . .	#	%	Cumulative %
2 years	581	6%	6%
5 years	355	3%	9%
10 years	1,037	10%	19%
15 years	1,257	12%	31%
20 years	1,309	13%	44%
25 years	1,577	15%	59%
30 years	1,524	15%	74%
35 years	1,335	13%	86%
40 years	569	5%	92%
45 years	190	2%	94%
50 years	52	1%	94%
55 years	2	0%	94%
In more than 55 years	16	0%	94%
Do not intend to retire	583	6%	100%
Total	**10,386**	**100%**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Using these estimates, retirement will begin to reach over 10% of the current workforce every 5 years by 2033. Retirement will peak at 15% of the current workforce around 2048 before declining to under 10% of the current workforce again around 2063.

Full-Time Equivalency Units

At a Glance:

FTEs

Total:	12,313
FTEs/1,000 Residents:	1.42
Average:	0.85

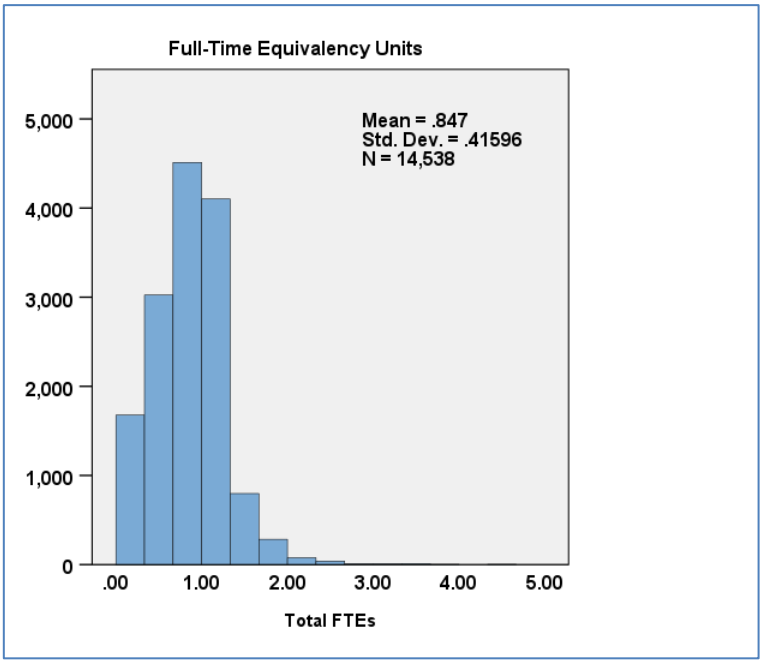
Age & Gender Effect

Age, Partial Eta^2:	Negligible
Gender, Partial Eta^2:	Negligible

Partial Eta^2 Explained:
Partial Eta^2 is a statistical measure of effect size.

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

The typical (median) APRN provided 0.85 FTEs, or approximately 34 hours per week for 52 weeks. Although FTEs appear to vary by age and gender, statistical tests did not verify a difference exists[2].

Full-Time Equivalency Units		
Age	**Average**	**Median**
Under 30	0.76	0.74
30 to 34	0.79	0.79
35 to 39	0.77	0.79
40 to 44	0.89	0.83
45 to 49	0.93	0.86
50 to 54	0.96	0.90
55 to 59	0.79	0.89
60 and Over	0.82	0.81
Gender		
Male	0.94	1.03
Female	0.88	0.91

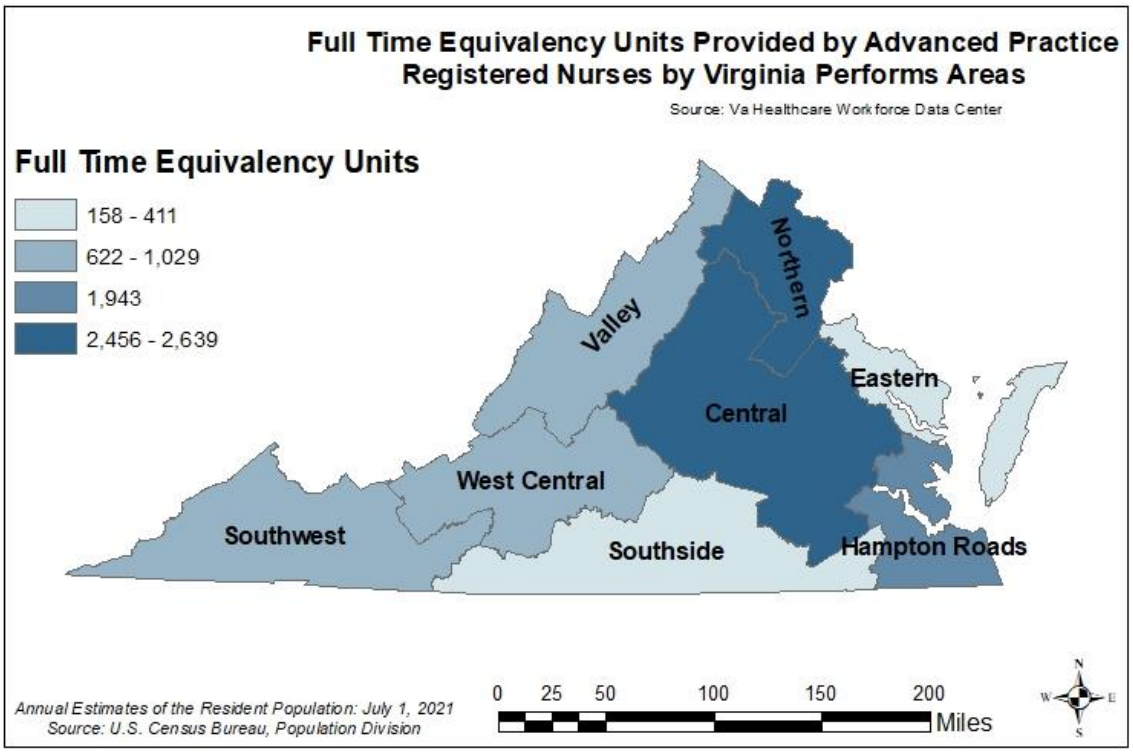
Source: Va. Healthcare Workforce Data Center

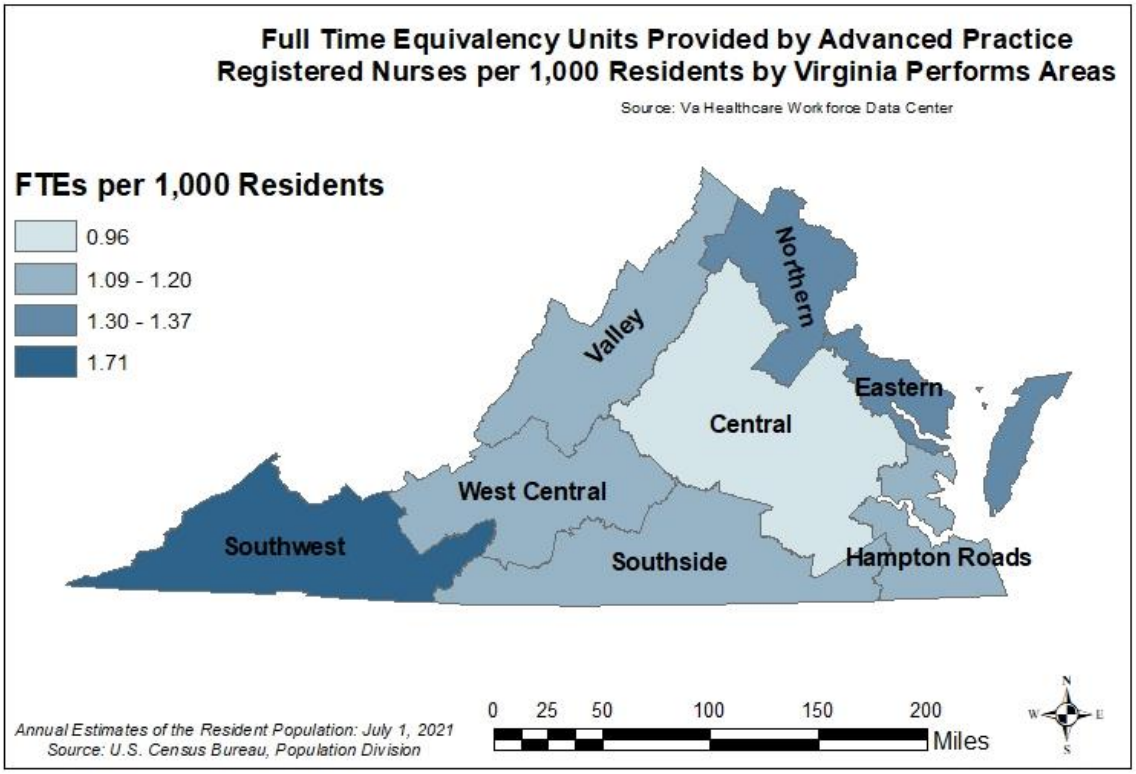
Source: Va. Healthcare Workforce Data Center

[2] Due to assumption violations in Mixed between-within ANOVA (Levene's Test and Interaction effect are significant)

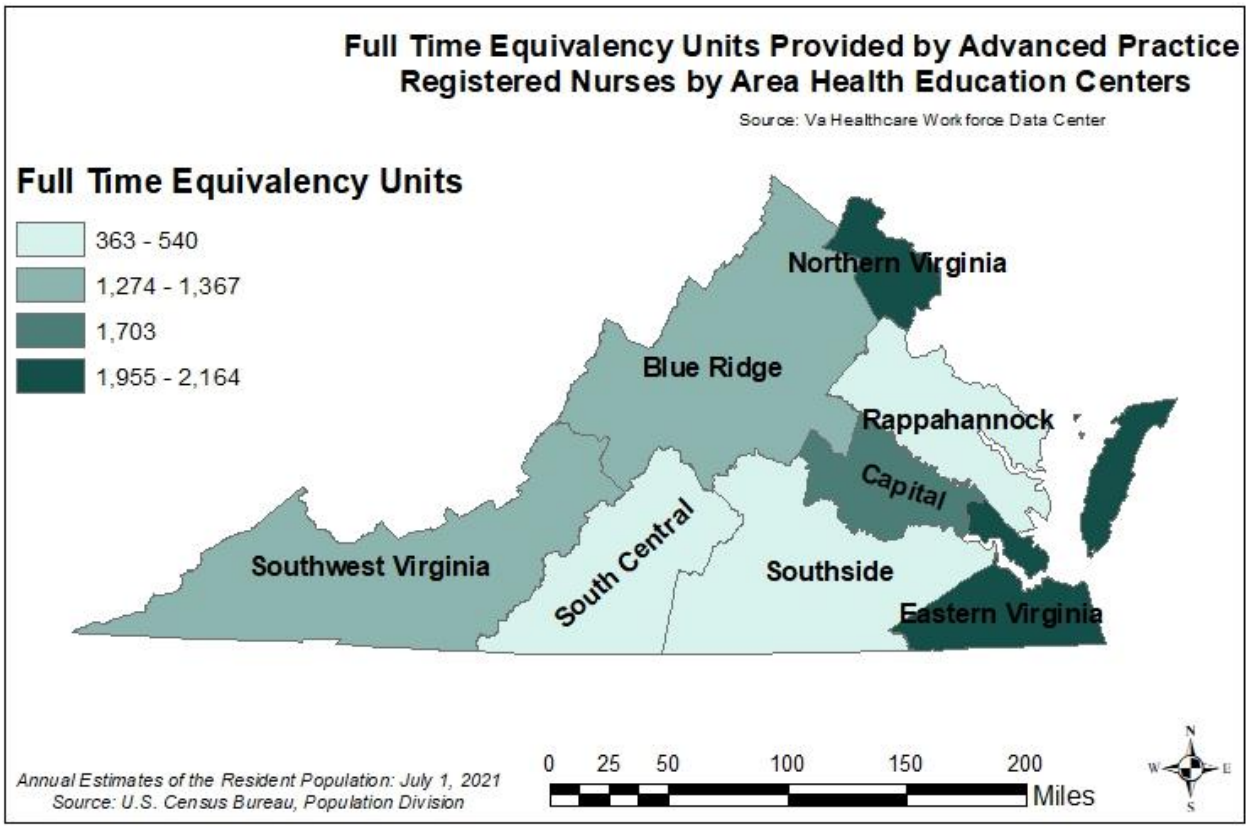
Maps

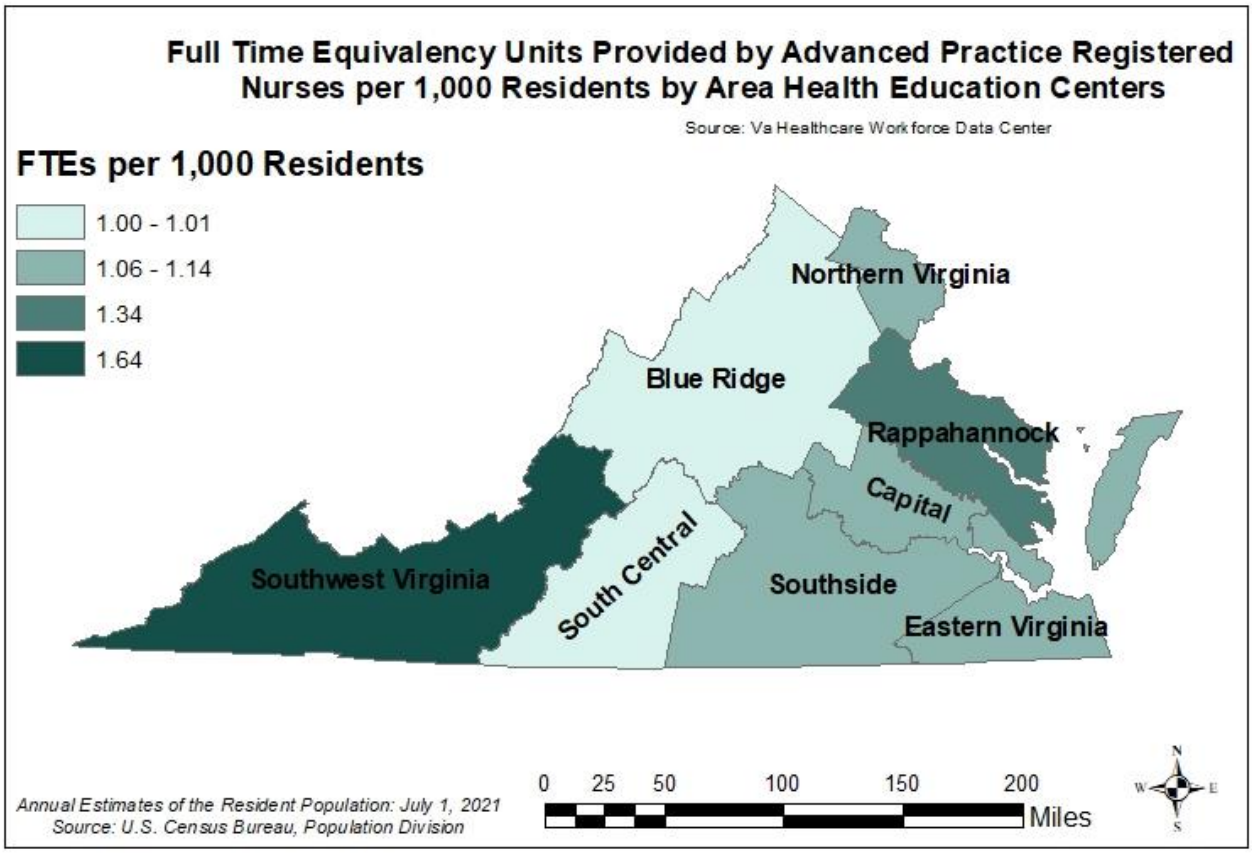
Virginia Performs Regions



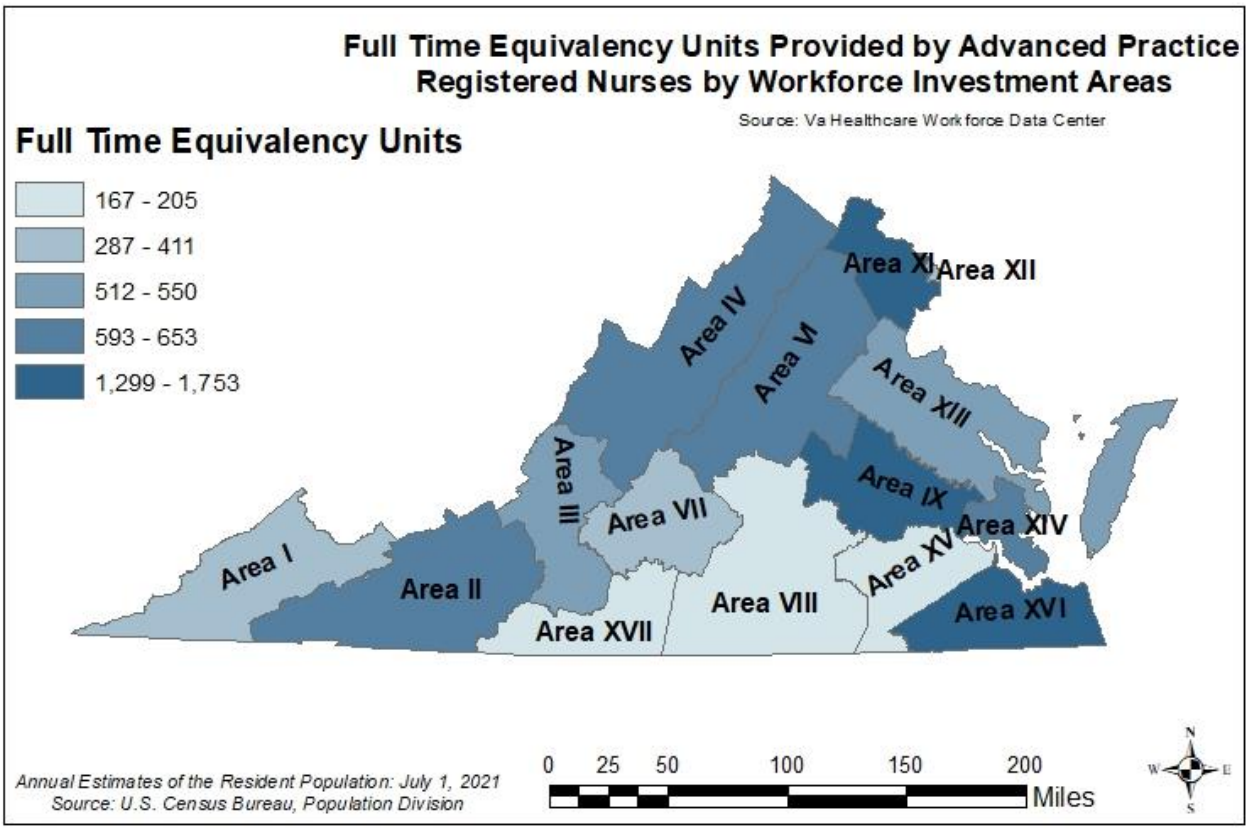


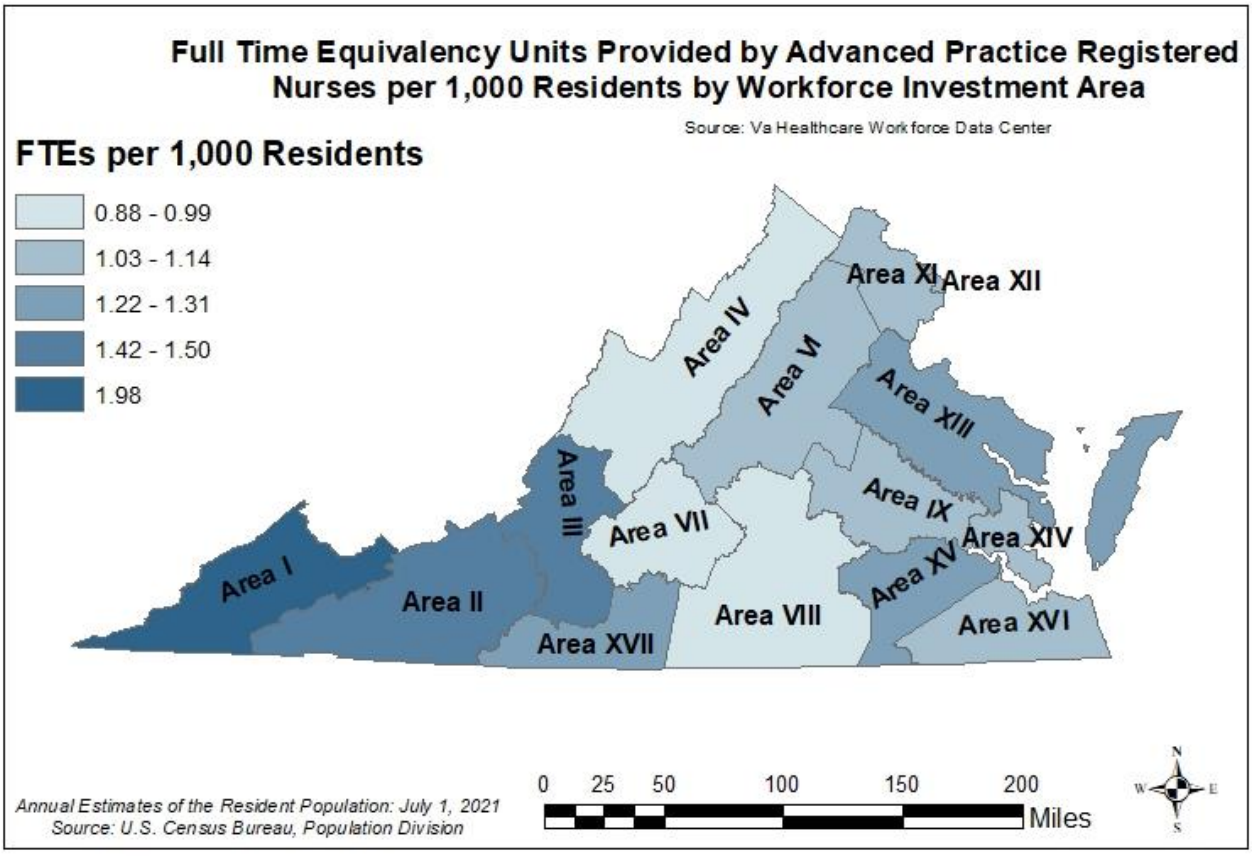
Area Health Education Center Regions



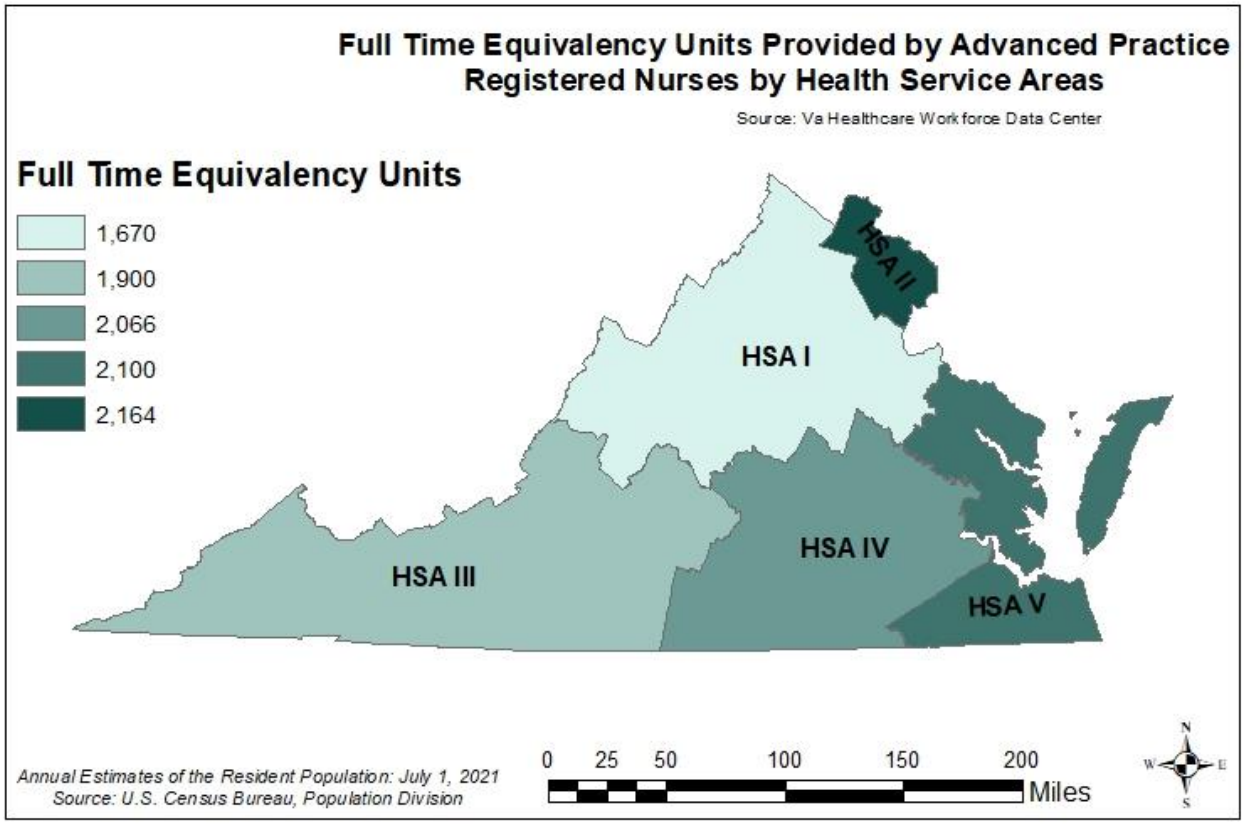


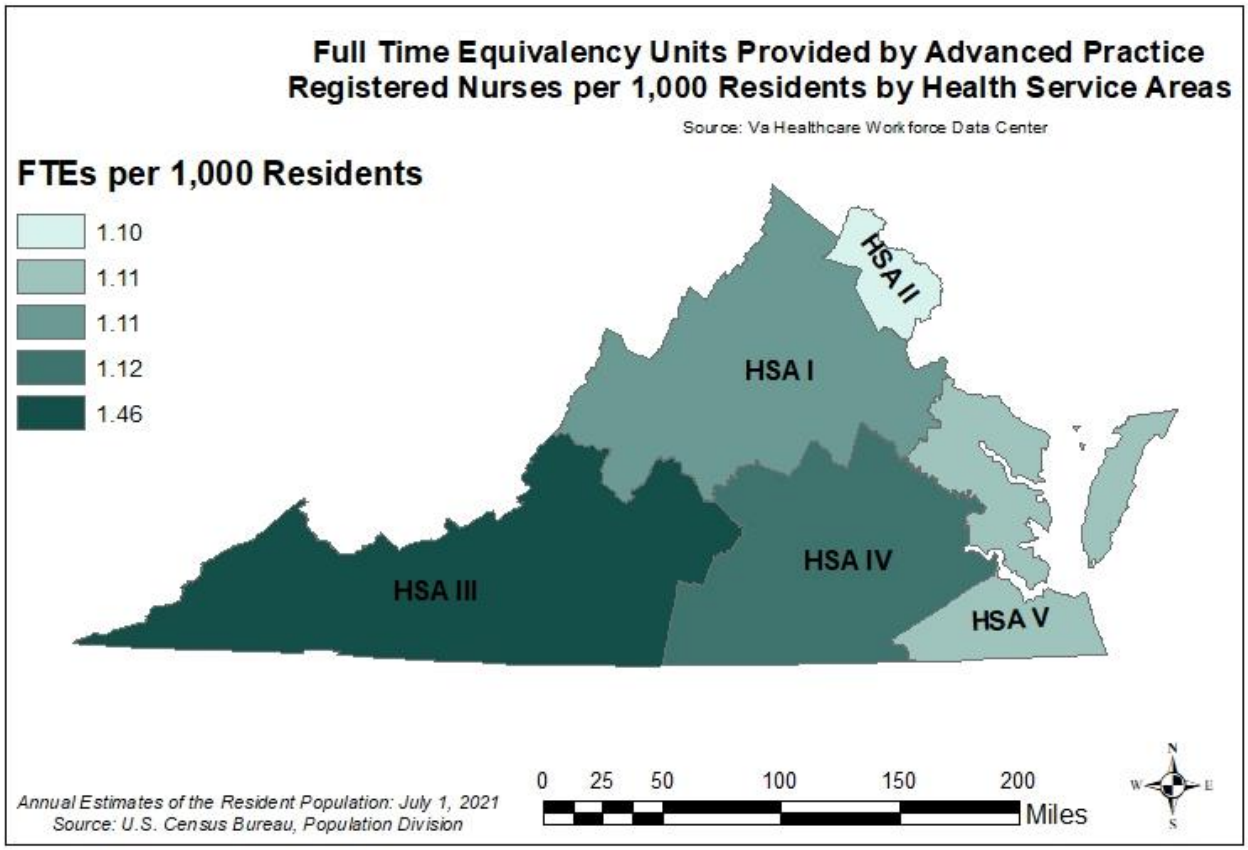
Workforce Investment Areas



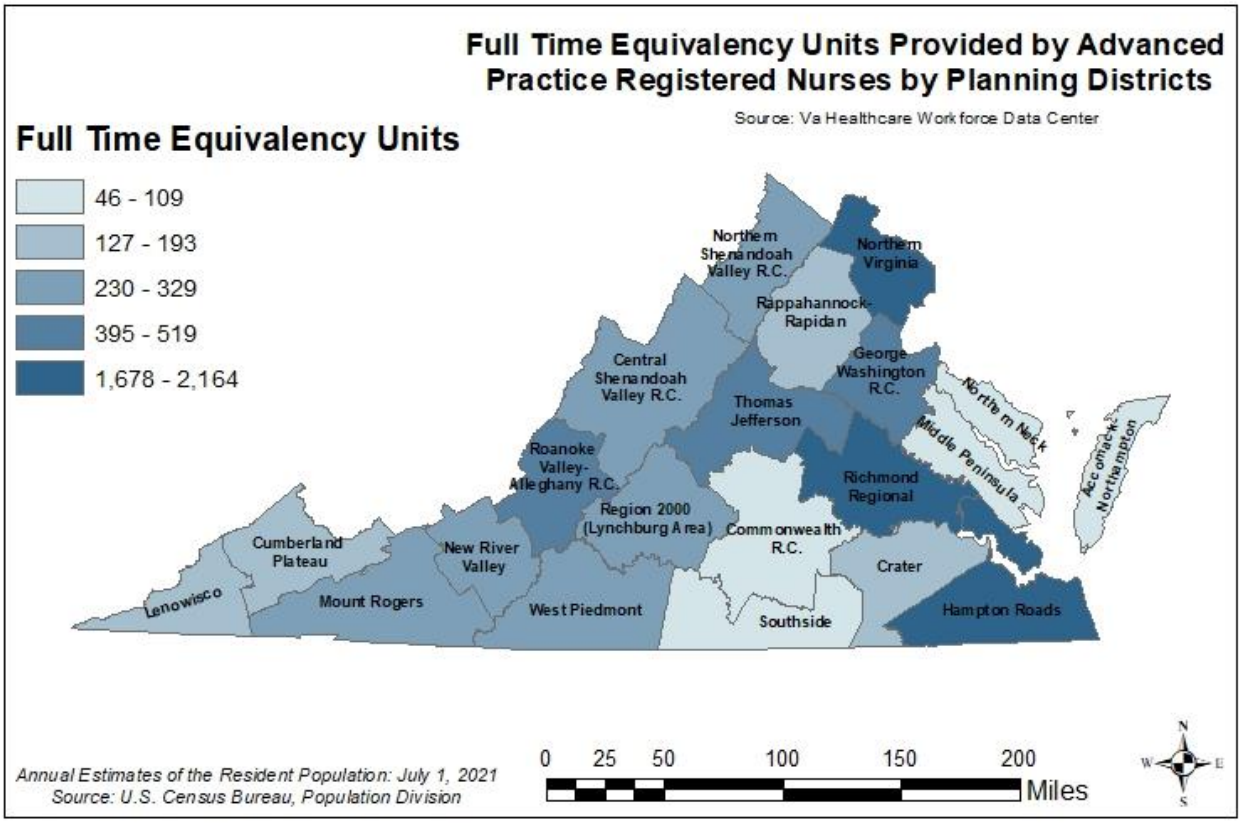


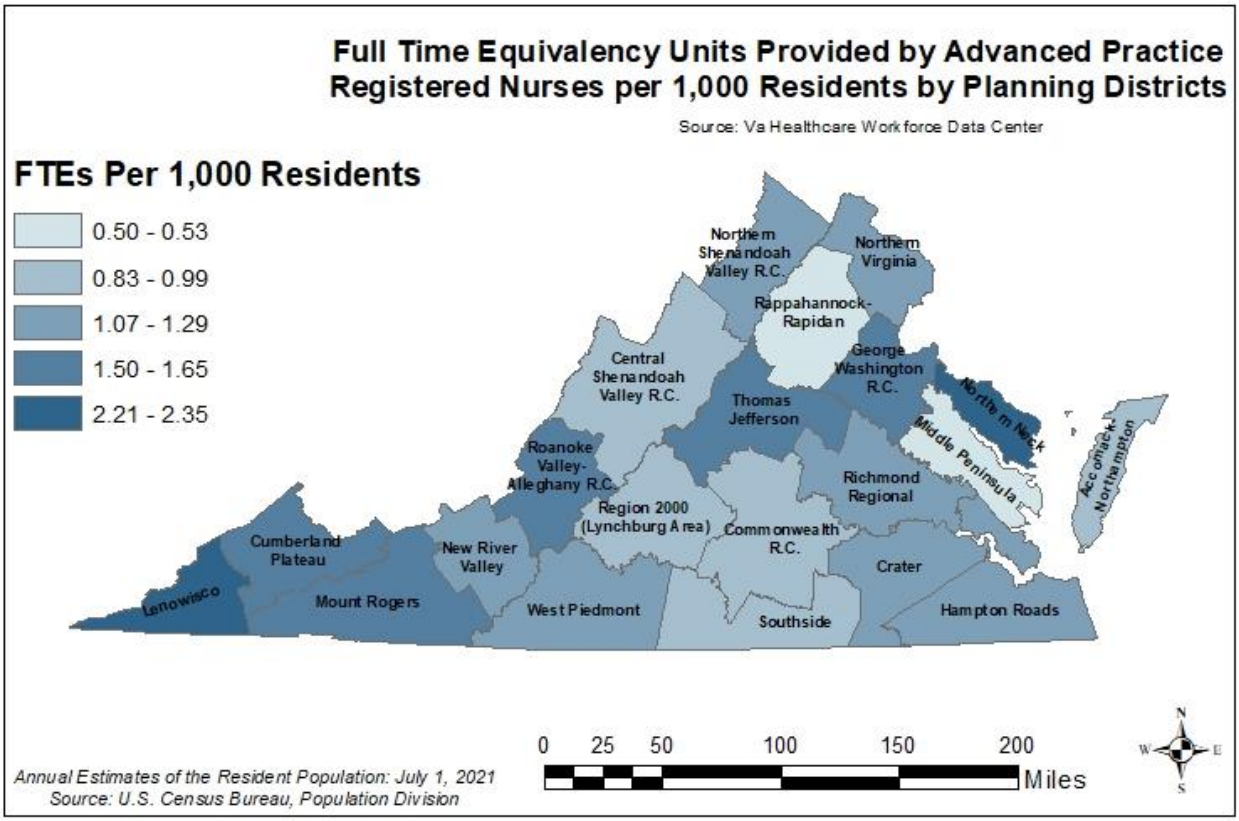
Health Services Areas





Planning Districts





Appendices

Appendix A: Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min	Max
Metro, 1 million+	7,930	38.90%	2.5705	2.1289	5.2792
Metro, 250,000 to 1 million	1,008	36.31%	2.7541	2.2810	5.6562
Metro, 250,000 or less	1,273	40.22%	2.4863	2.0592	5.1063
Urban pop 20,000+, Metro adj	201	38.31%	2.6104	2.1620	3.2035
Urban pop 20,000+, nonadj	0	NA	NA	NA	NA
Urban pop, 2,500-19,999, Metro adj	398	32.66%	3.0615	2.5356	6.2876
Urban pop, 2,500-19,999, nonadj	355	40.85%	2.4483	2.0277	5.0282
Rural, Metro adj	310	35.48%	2.8182	2.3341	5.7879
Rural, nonadj	117	48.72%	2.0526	1.7000	4.2156
Virginia border state/DC	2,494	24.82%	4.0291	3.3369	8.2747
Other US State	2,970	23.16%	4.3169	3.5753	8.8658

Source: Va. Healthcare Workforce Data Center

Age	Age Weight			Total Weight	
	#	Rate	Weight	Min	Max
Under 30	472	16.53%	6.0513	4.2156	8.8658
30 to 34	2,229	35.53%	2.8144	1.9606	4.1234
35 to 39	3,088	27.66%	3.6159	2.5190	5.2977
40 to 44	2,667	37.65%	2.6564	1.8506	3.8919
45 to 49	2,243	30.32%	3.2985	2.2979	4.8327
50 to 54	2,023	40.98%	2.4403	1.7000	3.5753
55 to 59	1,488	31.65%	3.1592	2.2009	4.6286
60 and Over	2,847	37.97%	2.6337	1.8347	3.8586

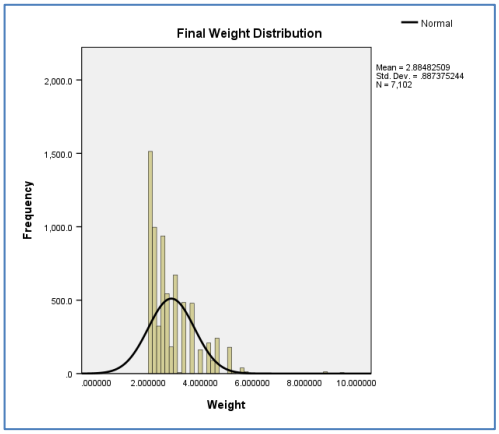
Source: Va. Healthcare Workforce Data Center

See the Methods section on the HWDC website for details on HWDC Methods: https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/

Final weights are calculated by multiplying the two weights and the overall response rate:

Age Weight x Rural Weight x Response Rate
= Final Weight.

Overall Response Rate: **0.34669**



Source: Va. Healthcare Workforce Data Center

DRAFT

Virginia's Licensed Advanced Practice Registered Nurse Workforce: Comparison by Specialty

Healthcare Workforce Data Center

December 2023

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233
804-597-4213, 804-527-4466(fax)
E-mail: ***HWDC@dhp.virginia.gov***

Follow us on Tumblr: ***www.vahwdc.tumblr.com***
Get a copy of this report from:
http://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/

Over 12,000 Licensed Advanced Practice Registered Nurse voluntarily participated in the 2021 and 2022 surveys. *Without their efforts the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Joint Boards of Nursing and Medicine express our sincerest appreciation for their ongoing cooperation.*

Thank You!

Virginia Department of Health Professions

Arne Owens, MS
Director

James Jenkins, BS/N, RN, SCRN
Chief Deputy Director

Healthcare Workforce Data Center Staff:

Yetty Shobo, PhD	Barbara Hodgdon, PhD	Rajana Siva, MBA	Christopher Coyle, BA
Executive Director	*Deputy Director*	*Data Analyst*	*Research Assistant*

Joint Boards of Nursing and Medicine

Members

Laurie Buchwald, MSN, WHNP, NCMP, FNP
Radford

Blanton L. Marchese
North Chesterfield

Helen M. Parke, DNP, FNP-BC
Concord

Joel Silverman, MD
Richmond

Ryan Williams, MD
Suffolk

Executive Director, Board of Medicine

William Harp, MD

Executive Director, Board of Nursing

Jay P. Douglas, MSM, RN, CSAC, FRE

Contents

Results in Brief

This is a special report created for the Committee of the Joint Boards of Nursing and Medicine. The report uses data from the 2022 and 2023 Advanced Practice Registered Nurse Surveys. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place during a two-year renewal cycle on the birth month of each respondent. Therefore, approximately half of all APRNs have access to the survey in any given year. Two years' worth of data, therefore, will allow all eligible Advanced Practice Registered Nurses (APRNs) the opportunity to complete the survey. The 2022 survey occurred between October 2021 and September 2022; the 2023 survey occurred between October 2022 and September 2023. The survey was available to all renewing APRNs who held a Virginia license during the survey period and who renewed their licenses online. It was not available to those who did not renew, including APRNs who were newly licensed during the survey period.

This report breaks down survey findings for certified registered nurse anesthetists (CRNA), certified nurse midwives (CNM), and certified nurse practitioners (CNPs). CNPs make up the highest proportion of APRNs. Over 80% of APRNs are CNPs and CNMs constitute only 3% of APRNs. The full time equivalency units are also similarly distributed by specialty.

Nine of ten APRNs are female; CNMs are all female whereas approximately 71% of CRNAs are female; 92% of CNPs are female. The median age of all APRNs is 44. The median age of CRNAs is 46 and the median age for CNMs and CNPs is 44. In a random encounter between two APRNs, there is a 44% chance that they would be of different races or ethnicities, a measure known as the diversity index. CNMs were the least diverse with 36% diversity index; CRNAs and CNPs had 41% and 45% diversity indices, respectively. Overall, 11% of APRNs work in rural areas. CNPs had the highest rural workforce participation; 13% of CNPs work in rural areas compared to 6% and 7% of CRNAs and CNMs, respectively.

CRNAs had the highest educational attainment with 19% reporting a doctor of nursing practice degree; only 10% of CNMs and 10% of CNPs did. However, CNMs reported the highest median education debt of $95k and half of CNMs had education debt. Over half of CNPs also reported education debt although they had the lowest median at $60k-$70k. CRNAs had $80-$90k in education debt but only 40% of all CRNAs carried education debt.

CRNAs reported the highest median annual income, $120k or more per year, which reflected the median for all APRNs. Further, 87% of CRNAs reported $120,000 or more in annual income compared to 38% of CNMs and 24% of CNPs. However, only 68% of CRNAs received at least one employer-sponsored benefit compared to 81% of CNMs and 80% of CNPs. Overall, 93% of APRNs are satisfied with their current employment situation. However, only 89% of CNMs were satisfied compared to 97% of CRNAs and 93% of CNPs. Almost a third of all APRNs reported employment instability in the year prior to the survey, with CNMs being most likely to report employment instability.

CRNAs had the highest participation in the private sector, 92% of them worked in the sector compared to 87% of CNMs and CNPs. Meanwhile, CRNAs had the lowest percent working in federal, state, or local government. CRNAs and CNMs were most likely to be working in the inpatient department of hospitals whereas CNPs were most likely to work in primary care clinics. Only 13% of CRNAs used at least one form of electronic health record or telehealth compared to 42% of CNMs and 45% of CNPs. More than one in four CRNAs plan to retire within the next decade compared to 21% of CNMs and 18% of CNPs. About 50%, 36% and 40% of CRNAs, CNMs, and CNPs, respectively, plan to retire by the age of 65. Meanwhile, 3%, 4%, and 6% of CRNAs, CNMs, and CNPs, respectively, do not intend to retire.

Survey Response Rates

A Closer Look:

At a Glance:

Licensed APRNs

Total:	21,235
CRNA:	2,771
CNM:	531
CNP:	17,933

Response Rates

All Licensees: (2022 & 2023)	61%

Source: Va. Healthcare Workforce Data Center

This report uses data from the 2022 and 2023 APRN Surveys, and licensure data retrieved in October 2023. Two years of survey data were used to get a complete portrait of the APRN workforce since APRNs are surveyed every two years in their birth month. Thus, every APRN would have been eligible to complete a survey in only one of the two years. Newly licensed APRNs do not complete the survey, so they are excluded from the survey. From the licensure data, 2,771 of APRNs reported their first specialty as CRNA; 531 had a first specialty of CNM, and 17,933 had other first specialties. However, 86 CNMs reported one additional specialty. 28 CRNAs also reported one other specialty. "At a Glance" shows the break down by specialty. Over 80% are CNPs, 13% are CRNAs, and about 3% are CNMs.

Response Rates				
	CRNA	**CNM**	**CNP**	**Total**
Completed Surveys 2022	830	160	4,780	**5,770**
Completed Surveys 2023	965	170	5,965	**7,100**
Response Rate, all licensees	**65%**	**62%**	**60%**	**61%**

Source: Va. Healthcare Workforce Data Center

Our surveys tend to achieve very high response rates. An average of 61% of APRNs submitted a survey in both 2022 and 2023. As shown above, the response rate was highest for CRNAs and lowest for CNPs.

Not in Workforce in Past Year				
	CRNA	**CNM**	**CNP**	**All 2022**
% of Licensees not in VA Workforce	31%	19%	26%	**19%**
% in Federal Employee or Military:	7%	21%	11%	**13%**
% Working in Virginia Border State or DC	15%	15%	22%	**20%**

Source: Va. Healthcare Workforce Data Center

CRNAs were most likely to not be working in the state workforce whereas CNPs were most likely to be working in border states.

Definitions

1. **The Survey Period:** The survey was conducted between October 2021 and September 2022, and between October 2022 and September 2023, on the birth month of each renewing practitioner.
2. **Target Population:** All APRNs who held a Virginia license at some point during the survey period.
3. **Survey Population:** The survey was available to APRNs who renewed their licenses online. It was not available to those who did not renew, including APRNs newly licensed during the survey time frame.

A Closer Look:

At a Glance:

2021 and 2022 Workforce

Virginia's APRN Workforce:	15,591
FTEs:	13,435

Workforce by Specialty

CRNA:	2,173
CNM:	427
CNP:	12,991

FTE by Specialty

CRNA:	1,869
CNM:	409
CNP:	11,176

Source: Va. Healthcare Workforce Data Center

Definitions

1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time during the survey timeframe or who indicated intent to return to Virginia's workforce at any point in the future.
2. **Full Time Equivalency Unit (FTE):** The HWDC uses 2,000 (40 hours for 50 weeks) as its baseline measure for FTEs.
3. **Licensees in VA Workforce:** The proportion of licensees in Virginia's Workforce.
4. **Licensees per FTE:** An indication of the number of licensees needed to create 1 FTE. Higher numbers indicate lower licensee participation.
5. **Workers per FTE:** An indication of the number of workers in Virginia's workforce needed to create 1 FTE. Higher numbers indicate lower utilization of available workers.

Virginia's APRN Workforce								
	CRNA		CNM		CNP		All (2023)	
Status	#	%	#	%	#	%	#	%
Worked in Virginia in Past Year	2,162	99%	409	96%	12,737	98%	15,308	98%
Looking for Work in Virginia	11	1%	18	4%	254	2%	283	2%
Virginia's Workforce	**2,173**	**100%**	**427**	**100%**	**12,991**	**100%**	**15,591**	**100%**
Total FTEs	**1,869**		**409**		**11,176**		**13,435**	
Licensees	**2,771**		**531**		**17,933**		**21,235**	

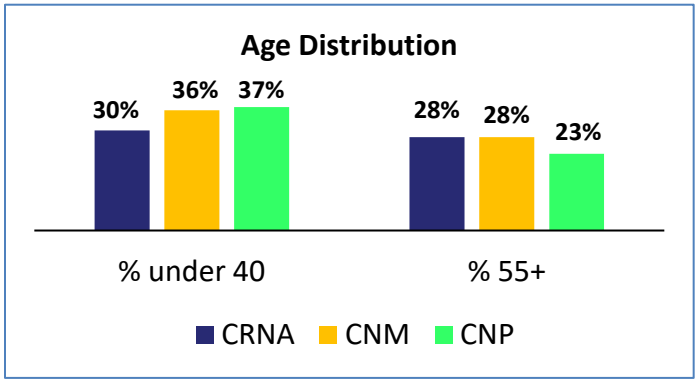
Source: Va. Healthcare Workforce Data Center

CNPs provided 83% of the nurse practitioner FTEs in the state. CRNAs provided 14% whereas CNMs provided 3% of the FTEs. 4% of CNMs in the state's workforce were looking for work compared to 2% or less of the other APRNs.

A Closer Look (All Nurse Practitioners in 2023):

Age & Gender						
	Male		Female		Total	
Age	#	% Male	#	% Female	#	% in Age Group
Under 30	33	8%	381	92%	414	3%
30 to 34	163	9%	1,766	92%	1,929	16%
35 to 39	187	9%	1,939	91%	2,125	17%
40 to 44	216	11%	1,816	89%	2,032	16%
45 to 49	181	13%	1,269	88%	1,450	12%
50 to 54	161	11%	1,326	89%	1,486	12%
55 to 59	107	11%	879	89%	986	8%
60 +	220	11%	1,767	89%	1,987	16%
Total	**1,269**	**10%**	**11,142**	**90%**	**12,411**	**100%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

% Female:	90%
% Under 40 Female:	92%

% Female by Specialty

CRNA:	71%
CNM:	100%
CNP:	93%

% Female <40 by Specialty

CRNA:	77%
CNM:	100%
CNP:	93%

Source: Va. Healthcare Workforce Data Center

CNMs have and CNPs have a median age of 44. The median age of CRNAs is 46.

Age & Gender by Specialty												
	CRNA				CNM				CNP			
	Female		Total		Female		Total		Female		Total	
Age	#	% Female	#	% in Age Group	#	% Female	#	% in Age Group	#	% Female	#	% in Age Group
Under 30	5	100%	5	0%	11	100%	11	3%	361	90%	401	4%
30 to 34	195	78%	250	14%	44	100%	44	12%	1,545	93%	1,661	15%
35 to 39	205	77%	269	15%	69	100%	69	19%	1,840	95%	1,947	18%
40 to 44	228	73%	314	17%	71	98%	73	20%	1,734	91%	1,907	17%
45 to 49	177	69%	257	14%	34	100%	34	9%	1,213	91%	1,329	12%
50 to 54	181	71%	256	14%	41	100%	41	11%	1,240	92%	1,342	12%
55 to 59	117	68%	173	9%	19	100%	19	5%	732	93%	791	7%
60 +	204	63%	322	17%	79	100%	79	21%	1,516	93%	1,631	15%
Total	**1,313**	**71%**	**1,847**	**100%**	**369**	**100%**	**370**	**100%**	**10,181**	**93%**	**11,010**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look (All APRNs in 2023):

Race & Ethnicity (2023)					
Race/ Ethnicity	Virginia*	APRNs		APRNs under 40	
	%	#	%	#	%
White	59%	9,662	73%	3,385	73%
Black	18%	1,866	14%	560	12%
Asian	7%	794	6%	326	7%
Other Race	1%	137	1%	35	1%
Two or more races	5%	297	2%	106	2%
Hispanic	10%	468	4%	209	5%
Total	**100%**	**13,224**	**100%**	**4,621**	**100%**

* Population data in this chart is from the US Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2022.

Source: Va. Healthcare Workforce Data Center

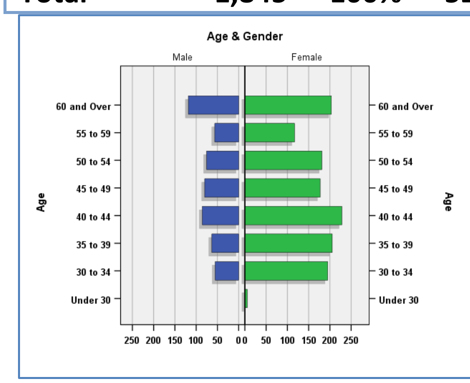
At a Glance:

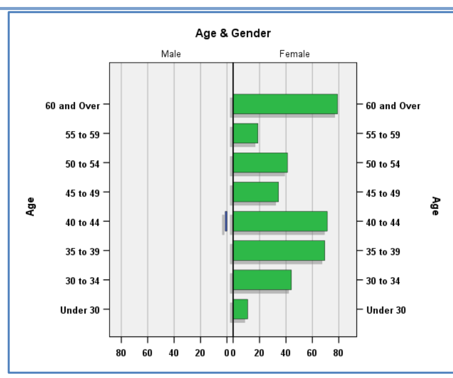
2023 Diversity
Diversity Index: 44%
Under 40 Div. Index: 44%

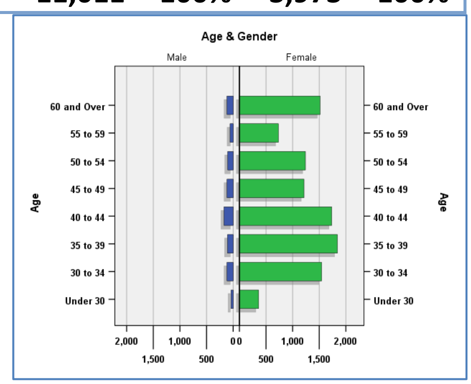
Diversity by Specialty
CRNA: 41%
CNM: 36%
CNP: 45%

Source: Va. Healthcare Workforce Data Center

Age, Race, Ethnicity & Gender												
	CRNA				CNM				CNP			
Race/ Ethnicity	APRNs		APRNs under 40		APRNs		APRNs under 40		APRNs		APRNs under 40	
	#	%	#	%	#	%	#	%	#	%	#	%
White	1,393	76%	380	73%	290	79%	104	81%	7,979	72%	2,902	73%
Black	162	9%	44	8%	46	13%	18	14%	1,658	15%	498	13%
Asian	119	6%	40	8%	1	0%	0	0%	674	6%	286	7%
Other Race	19	1%	2	0%	4	1%	0	0%	115	1%	33	1%
Two or more races	63	3%	24	5%	8	2%	2	2%	225	2%	80	2%
Hispanic	89	5%	31	6%	19	5%	5	4%	360	3%	174	4%
Total	**1,845**	**100%**	**521**	**100%**	**368**	**100%**	**129**	**100%**	**11,011**	**100%**	**3,973**	**100%**







Source: Va. Healthcare Workforce Data Center

A Closer Look:

At a Glance:

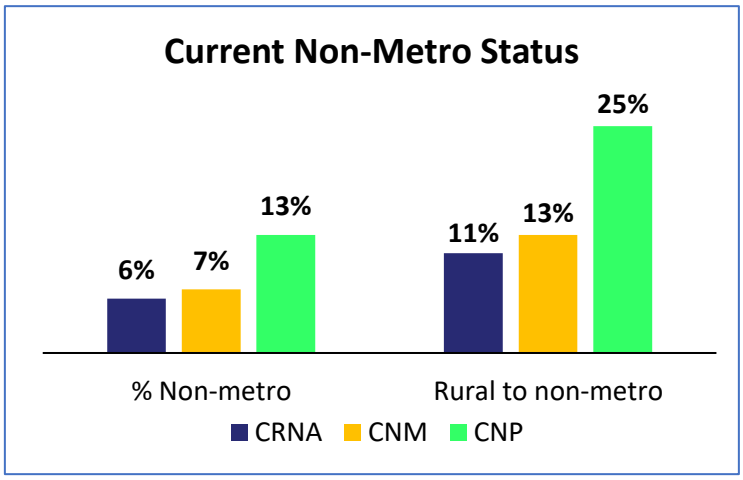
Rural Childhood

CRNA:	28%
CNM:	27%
CNP:	36%
All:	34%

Non-Metro Location

CRNA:	6%
CNM:	7%
CNP:	13%
All:	11%

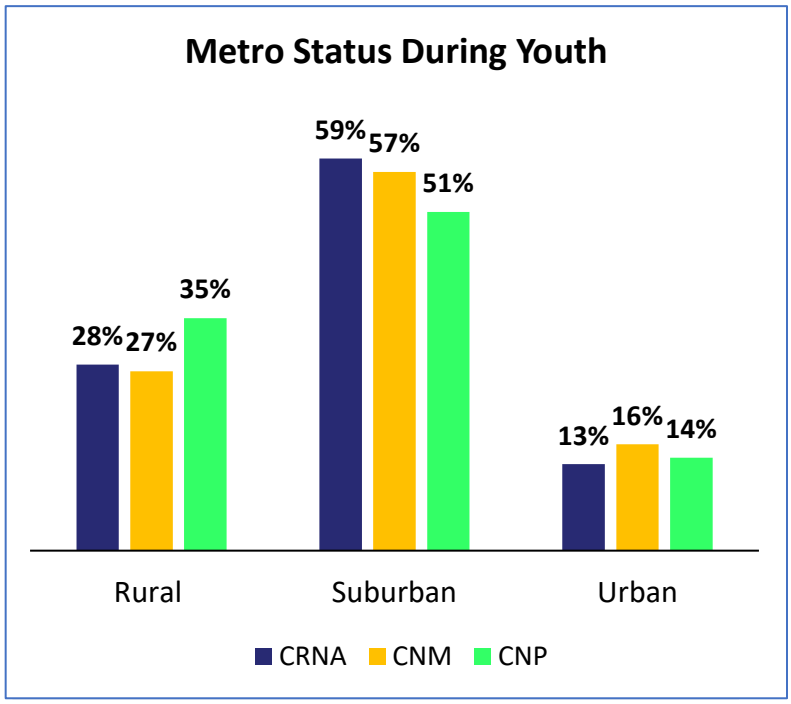
Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

	HS in VA	Prof. Ed. in VA	HS or Prof in VA	APRN Degree in VA
CRNA	29%	30%	35%	36%
CNM	31%	32%	39%	24%
CNP	47%	54%	59%	53%
All (2022)	**43%**	**50%**	**55%**	**49%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

CNPs were most likely to have been educated in the state. CNMs were least likely to have obtained their APRN education in the state. Also, CNPs had the highest percent reporting a non-metro work location.

Education

A Closer Look:

At a Glance:

Median Educational Debt

CRNA:	$80k-$90k
CNM:	$90k-$100k
CNP:	$60k-$70k

Source: Va. Healthcare Workforce Data Center

CNPs were most likely to carry education debt; 53% of all CNPs and 63% of CNPs under age 40 had education debt. However, CNPs had the lowest median education debt. CNMs had the highest median debt at $90k-$100K, Additionally, 50% of all CNMs, and 66% of CNMs under 40 reported education debt.

	Highest Degree							
	CRNA		CNM		CNP		All (2023)	
Degree	#	%	#	%	#	%	#	%
NP Certificate	111	6%	13	4%	112	1%	236	2%
Master's Degree	1,187	66%	275	74%	8,388	78%	9,850	76%
Post-Masters Cert.	18	1%	34	9%	907	8%	960	7%
Doctorate of NP	351	19%	38	10%	1,094	10%	1,484	11%
Other Doctorate	134	7%	10	3%	296	3%	441	3%
Post-Ph.D. Cert.	0	0%	0	0%	3	0%	3	0%
Total	**1,801**	**100%**	**370**	**100%**	**10,800**	**100%**	**12,974**	**100%**

Source: Va. Healthcare Workforce Data Center

	Educational Debt							
Amount Carried	CRNA		CNM		CNP		All (2023)	
	All	Under 40	All	Under 40	All	Under 40	All	Under 40
None	60%	35%	50%	34%	47%	37%	49%	36%
$20,000 or less	6%	4%	4%	3%	7%	8%	7%	7%
$20,000-$29,999	2%	2%	<1%	0%	4%	5%	4%	5%
$30,000-$39,999	2%	3%	3%	3%	4%	5%	4%	5%
$40,000-$49,999	3%	5%	3%	4%	4%	6%	4%	5%
$50,000-$59,999	2%	1%	2%	4%	4%	5%	4%	5%
$60,000-$69,999	2%	4%	2%	1%	4%	6%	4%	6%
$70,000-$79,999	2%	4%	3%	6%	4%	5%	4%	5%
$80,000-$89,999	3%	5%	3%	3%	4%	4%	3%	4%
$90,000-$99,999	1%	2%	3%	3%	3%	4%	3%	3%
$100,000-$109,999	2%	3%	4%	4%	3%	3%	3%	4%
$110,000-$119,999	1%	2%	4%	11%	2%	3%	2%	3%
$120,000 or more	14%	29%	4%	3%	10%	8%	10%	11%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Employed in Profession

CRNA:	98%
CNM:	91%
CNP:	96%

Involuntary Unemployment

CRNA:	0%
CNM:	1%
CNP:	0%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

	Current Weekly Hours			
Hours	CRNA	CNM	CNP	All (2023)
0 hours	1%	7%	3%	3%
1 to 9 hours	1%	2%	1%	1%
10 to 19 hours	3%	5%	3%	3%
20 to 29 hours	8%	4%	7%	7%
30 to 39 hours	24%	15%	20%	20%
40 to 49 hours	53%	37%	49%	49%
50 to 59 hours	7%	14%	11%	11%
60 to 69 hours	2%	11%	4%	4%
70 to 79 hours	<1%	3%	1%	1%
80 or more hours	<1%	3%	2%	2%
Total	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center

Over half of CRNAs work 40-49 hours and approximately 10% work more than 50 hours whereas about 37% of CNMs work 40-49 hours and 31% work more than 50 hours. Close to half of CNPs work 40-49 hours and 18% work more than 50 hours.

	Current Positions							
	CRNA		CNM		CNP		All (2023)	
Positions	#	%	#	%	#	%	#	%
No Positions	19	1%	25	7%	289	3%	333	3%
One Part-Time Position	254	14%	6	2%	1,383	13%	1,679	13%
Two Part-Time Positions	101	6%	17	5%	429	4%	550	4%
One Full-Time Position	1,056	59%	14	4%	6,925	65%	8,203	64%
One Full-Time Position & One Part-Time Position	244	14%	54	15%	1,293	12%	1,578	12%
Two Full-Time Positions	10	1%	132	37%	43	0%	53	<1%
More than Two Positions	117	6%	49	14%	211	2%	338	3%
Total	**1,801**	**100%**	**41**	**11%**	**10,573**	**100%**	**12,734**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

	Employer-Sponsored Benefits*			
Benefit	**CRNA**	**CNM**	**CNP**	**All (2023)**
Signing/Retention Bonus	30%	20%	15%	17%
Dental Insurance	50%	59%	58%	57%
Health Insurance	51%	61%	60%	59%
Paid Leave	53%	70%	68%	66%
Group Life Insurance	45%	47%	46%	46%
Retirement	62%	72%	67%	66%
Receive at least one benefit	**68%**	**81%**	**80%**	**78%**

*Wage and salaried employees receiving from any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

At a Glance:

Median Income

CRNA:	$120k or more
CNM:	$100k-$110k
CNP:	$90k-$100K
All (2022):	$120k or More

Percent Satisfied

CRNA:	97%
CNM:	89%
CNP:	93%

Source: Va. Healthcare Workforce Data Center

CRNAs reported $120k or more in median income. All other NPs, including CNMs, reported $90k-$110k in median income. CNMs were the least satisfied with their current employment situation whereas CRNAs were the most satisfied. Approximately 1% of CRNAs, CNMs, and CNPs reported being very dissatisfied.

	Income			
Annual Income	**CRNA**	**CNM**	**CNP**	**All (2023)**
Volunteer Work Only	0%	1%	1%	1%
Less than $40,000	1%	6%	4%	4%
$40,000-$49,999	0%	2%	2%	2%
$50,000-$59,999	1%	5%	2%	2%
$60,000-$69,999	0%	1%	3%	3%
$70,000-$79,999	1%	3%	5%	4%
$80,000-$89,999	2%	8%	7%	6%
$90,000-$99,999	2%	10%	10%	9%
$100,000-$109,999	3%	16%	17%	15%
$110,000-$119,999	2%	11%	15%	13%
$120,000 or more	87%	38%	34%	41%
Total	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center

Labor Market

A Closer Look:

Employment Instability in Past Year				
In the past year did you . . .?	CRNA	CNM	CNP	All (2023)
Experience Involuntary Unemployment?	1%	1%	1%	1%
Experience Voluntary Unemployment?	3%	11%	5%	5%
Work Part-time or temporary positions, but would have preferred a full-time/permanent position?	1%	4%	3%	3%
Work two or more positions at the same time?	23%	20%	18%	19%
Switch employers or practices?	6%	10%	10%	9%
Experienced at least 1	**30%**	**35%**	**30%**	**30%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Involuntarily Unemployed

CRNA: 1%
CNM: 1%
CNP: 1%

Underemployed

CRNA: 3%
CNM: 11%
CNP: 5%

Over 2 Years Job Tenure

CRNA: 64%
CNM: 46%
CNP: 53%

Source: Va. Healthcare Workforce Data Center

Job Tenure at Location						
Tenure	CRNA		CNM		CNP	
	Primary	Secondary	Primary	Secondary	Primary	Secondary
Not Currently Working at this Location	2%	5%	5%	6%	2%	6%
< 6 Months	6%	11%	8%	15%	11%	16%
6 Months-1 yr	9%	11%	14%	11%	13%	15%
1 to 2 Years	23%	20%	27%	30%	23%	22%
3 to 5 Years	22%	24%	21%	20%	24%	22%
6 to 10 Years	15%	15%	14%	10%	14%	10%
> 10 Years	23%	14%	11%	9%	14%	8%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center

80% of CNMs were be paid by salary or commission, as compared to 49% of CRNAs and 68% of CNPs. This makes CNMs the most likely to be paid in this way.

Forms of Payment				
Primary Work Site	CRNA	CNM	CNP	All (2023)
Salary/ Commission	49%	80%	68%	66%
Hourly Wage	36%	16%	25%	27%
By Contract	14%	3%	6%	7%
Unpaid	<1%	1%	1%	<1%
Total	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center

Work Site Distribution

At a Glance:

% in Top 3 Regions

CRNA:	77%
CNM:	68%
CNP:	68%

2 or More Locations Now

CRNA:	32%
CNM:	23%
CNP:	24%

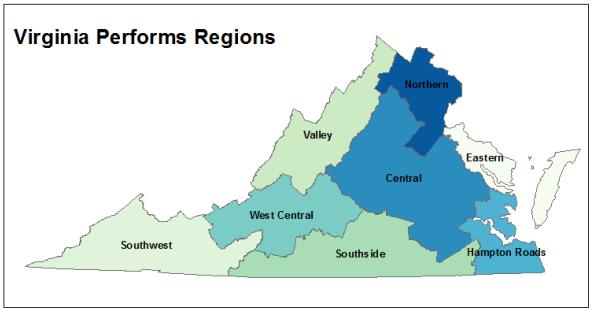
Source: Va. Healthcare Workforce Data Center

For primary work locations, Northern Virginia has the highest proportion of CNMs whereas CRNAs and CNPs were most concentrated in both the Central and Northern Virginia regions.

A Closer Look

Regional Distribution of Work Locations						
Virginia Performs Region	CRNA		CNM		CNP	
	Primary	Secondary	Primary	Secondary	Primary	Secondary
Central	26%	17%	18%	31%	25%	17%
Eastern	1%	0%	1%	1%	2%	1%
Hampton Roads	24%	26%	17%	19%	17%	17%
Northern	27%	30%	33%	14%	27%	24%
Southside	2%	2%	4%	1%	4%	3%
Southwest	2%	3%	1%	1%	7%	7%
Valley	4%	3%	10%	16%	6%	5%
West Central	9%	6%	11%	10%	10%	9%
Virginia Border State/DC	1%	2%	2%	1%	1%	4%
Other US State	3%	9%	4%	7%	2%	12%
Outside of the US	0%	0%	0%	0%	0%	0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center



Number of Work Locations Now*						
Locations	CRNA		CNM		CNP	
	#	%	#	%	#	%
0	27	2%	2	8%	383	4%
1	1,180	66%	356	66%	7,596	72%
2	306	17%	29	17%	1,687	16%
3	194	11%	235	6%	692	7%
4	41	2%	60	2%	66	1%
5	18	1%	23	0%	39	0%
6 +	16	1%	7	1%	66	1%
Total	**1,782**	**100%**	**356**	**100%**	**10,529**	**100%**

Source: Va. Healthcare Workforce Data Center

*At survey completion (birth month of respondents)

Establishment Type

A Closer Look:

Sector	Location Sector							
	CRNA		CNM		CNP		All (2023)	
	Primary	Sec	Primary	Sec	Primary	Sec	Primary	Sec
For-Profit	54%	68%	55%	50%	54%	63%	54%	63%
Non-Profit	38%	28%	32%	40%	33%	27%	34%	27%
State/Local Government	4%	2%	7%	7%	8%	7%	7%	6%
Veterans Administration	2%	1%	0%	0%	3%	1%	2%	1%
U.S. Military	3%	2%	3%	3%	2%	1%	2%	1%
Other Federal Government	<1%	0%	2%	0%	1%	1%	1%	1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center

CRNAs had the highest participation in the private sector, 92% of them worked in the sector compared to 87% of CNMs and CNPs. Meanwhile, CRNAs had the lowest percent working in state, local or federal government.

At a Glance:
(Primary Locations)

For-Profit Primary Sector

CRNA: 54%
CNM: 55%
CNP: 54%

Top Establishments

CRNA: Inpatient Department
CNM: Inpatient Department
CNP: Clinic, Primary Care

Source: Va. Healthcare Workforce Data Center

Electronic Health Records (EHRs) and Telehealth				
	CRNA	CNM	CNP	All (2023)
Meaningful use of EHRs	12%	30%	31%	28%
Remote Health, Caring for Patients in Virginia	1%	22%	29%	25%
Remote Health, Caring for Patients Outside of Virginia	<1%	7%	7%	6%
Use at least one	**13%**	**42%**	**45%**	**40%**

Source: Va. Healthcare Workforce Data Center

More than a quarter of the state APRN workforce used at least one EHR. 25% also provided remote health care for Virginia patients. CNPs were most likely to report using at least one EHR or telehealth whereas CRNAs were least likely to report doing so, likely because of the

Establishment Type	Location Type							
	CRNA		CNM		CNP		All (2023)	
	Primary	Sec	Primary	Sec	Primary	Sec	Primary	Sec
Clinic, Primary Care or Non-Specialty	1%	3%	13%	23%	23%	16%	19%	14%
Hospital, Inpatient Department	39%	29%	19%	23%	14%	13%	18%	16%
Physician Office	1%	3%	6%	2%	8%	4%	7%	4%
Academic Institution (Teaching or Research)	11%	6%	9%	5%	6%	8%	7%	7%
Private practice, group	2%	3%	17%	11%	7%	5%	6%	5%
Hospital, Outpatient Department	14%	11%	4%	0%	6%	3%	7%	4%
Clinic, Non-Surgical Specialty	1%	1%	5%	1%	5%	5%	4%	4%
Ambulatory/Outpatient Surgical Unit	19%	33%	3%	5%	1%	1%	4%	6%
Long Term Care Facility, Nursing Home	0%	0%	0%	0%	4%	5%	3%	4%
Hospital, Emergency Department	3%	2%	1%	2%	3%	4%	3%	4%
Mental Health, or Substance Abuse, Outpatient Center	0%	0%	0%	0%	5%	6%	4%	5%
Private practice, solo	0%	1%	3%	6%	2%	3%	2%	3%
Hospice	0%	0%	0%	0%	1%	3%	1%	3%
Other Practice Setting	9%	8%	18%	21%	15%	24%	14%	21%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center

The inpatient department of a hospital was the most mentioned primary work establishment for CRNAs and CNMs. For CNPs, primary care clinic was the most mentioned primary work establishment, followed by the inpatient department.

Time Allocation

At a Glance:
(Primary Locations)

Patient Care Role

CRNA:	95%
CNM:	80%
CNP:	87%

Education Role

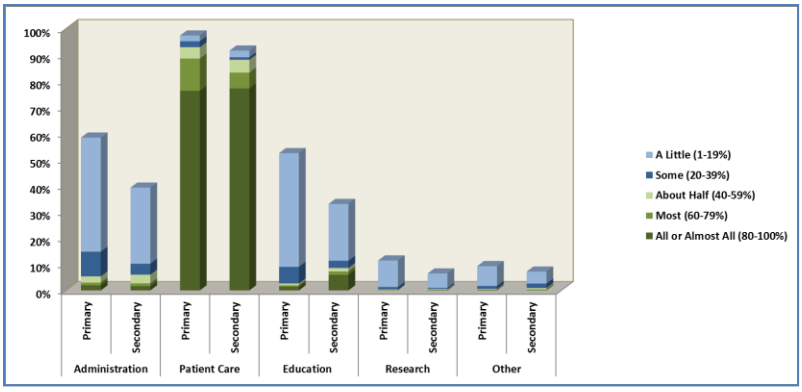
CRNA:	<1%
CNM:	3%
CNP:	2%

Admin Role

CRNA:	2%
CNM:	4%
CNP:	3%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

On average, 87% of all APRNs fill a patient care role, defined as spending 60% or more of their time on patient care activities. CRNAs were most likely to fill a patient care role; 95% of CRNAs filled such role compared to 80% of CNMs and 87% CNPs.

Patient Care Time Allocation								
Time Spent	**CRNA**		**CNM**		**CNP**		**All (2023)**	
	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site
All or Almost All (80-100%)	89%	93%	62%	79%	71%	72%	74%	76%
Most (60-79%)	6%	2%	19%	7%	15%	9%	14%	8%
About Half (40-59%)	2%	1%	10%	3%	5%	5%	5%	4%
Some (20-39%)	1%	0%	5%	2%	3%	2%	3%	2%
A Little (1-20%)	1%	1%	2%	2%	3%	3%	2%	3%
None (0%)	2%	1%	3%	5%	3%	8%	3%	7%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Future Plans						
	CRNA		CNM		CNP	
2 Year Plans:	#	%	#	%	#	%
Decrease Participation						
Leave Profession	19	1%	13	3%	119	1%
Leave Virginia	56	3%	12	3%	298	2%
Decrease Patient Care Hours	249	11%	61	14%	1,262	10%
Decrease Teaching Hours	6	0%	1	0%	106	1%
Increase Patient Care Hours	112	5%	47	11%	1,461	11%
Increase Teaching Hours	99	5%	56	13%	1,440	11%
Pursue Additional Education	77	4%	52	12%	1,660	13%
Return to Virginia's Workforce	4	0%	8	2%	91	1%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement within 2 Years

CRNA:	8%
CNM:	8%
CNP:	5%

Retirement within 10 Years

CRNA:	26%
CNM:	21%
CNP:	18%

Source: Va. Healthcare Workforce Data Center

50%, 36% and 40% of CRNAs, CNMs, and CNPs, respectively, expect to retire by the age of 65. Further, 35%, 24%, and 24% of CRNAs, CNMs, and CNPs, respectively, aged 50 or over expect to retire by the same age. Meanwhile, 3%, 4%, and 6% of CRNAs, CNMs, and CNPs, respectively, do not plan to retire at all.

Expected Retirement Age	CRNA		CNM		CNP		All (2023)	
	All	>50 yrs	All	>50 yrs	All	>50 yrs	All	>50 yrs
Under age 50	1%	-	5%	-	2%	-	2%	-
50 to 54	4%	1%	4%	0%	4%	0%	4%	1%
55 to 59	12%	6%	7%	6%	9%	4%	9%	4%
60 to 64	33%	28%	20%	18%	25%	20%	26%	21%
65 to 69	34%	40%	36%	39%	37%	40%	36%	40%
70 to 74	10%	16%	16%	24%	13%	19%	12%	19%
75 to 79	3%	5%	5%	12%	4%	7%	4%	6%
80 or over	0%	0%	2%	0%	1%	2%	1%	1%
I do not intend to retire	3%	4%	4%	1%	6%	8%	6%	7%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

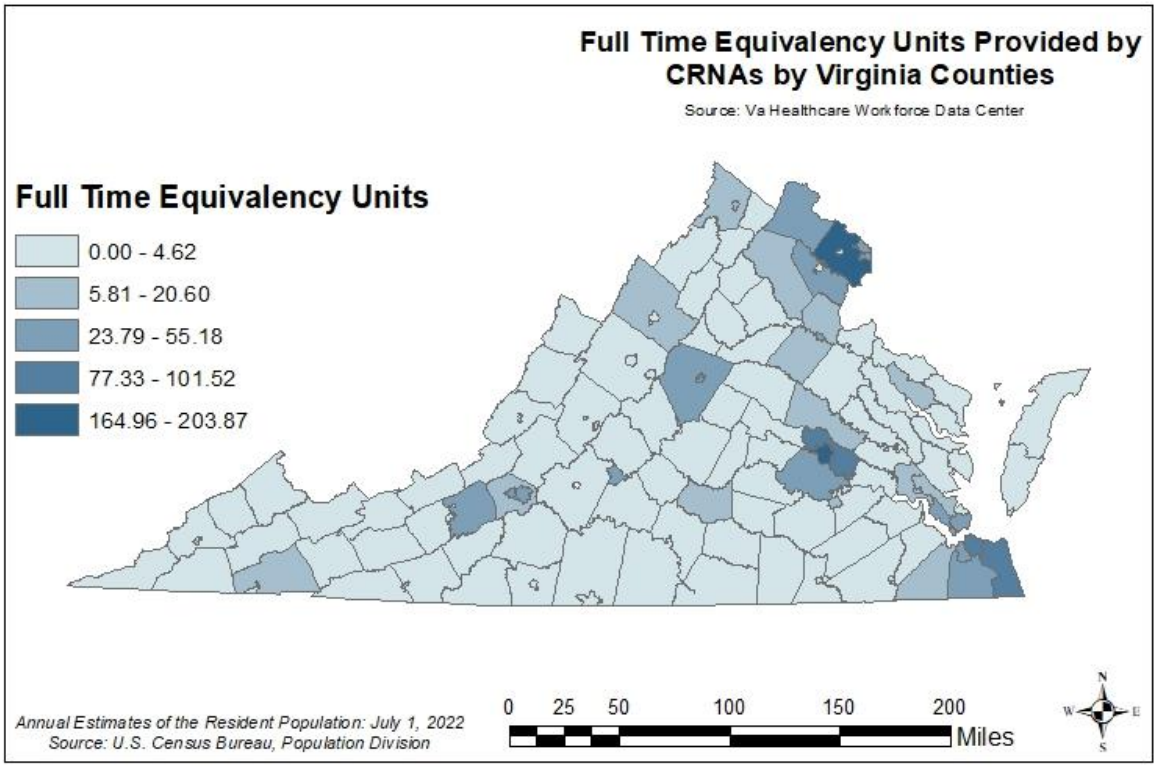
Source: Va. Healthcare Workforce Data Center

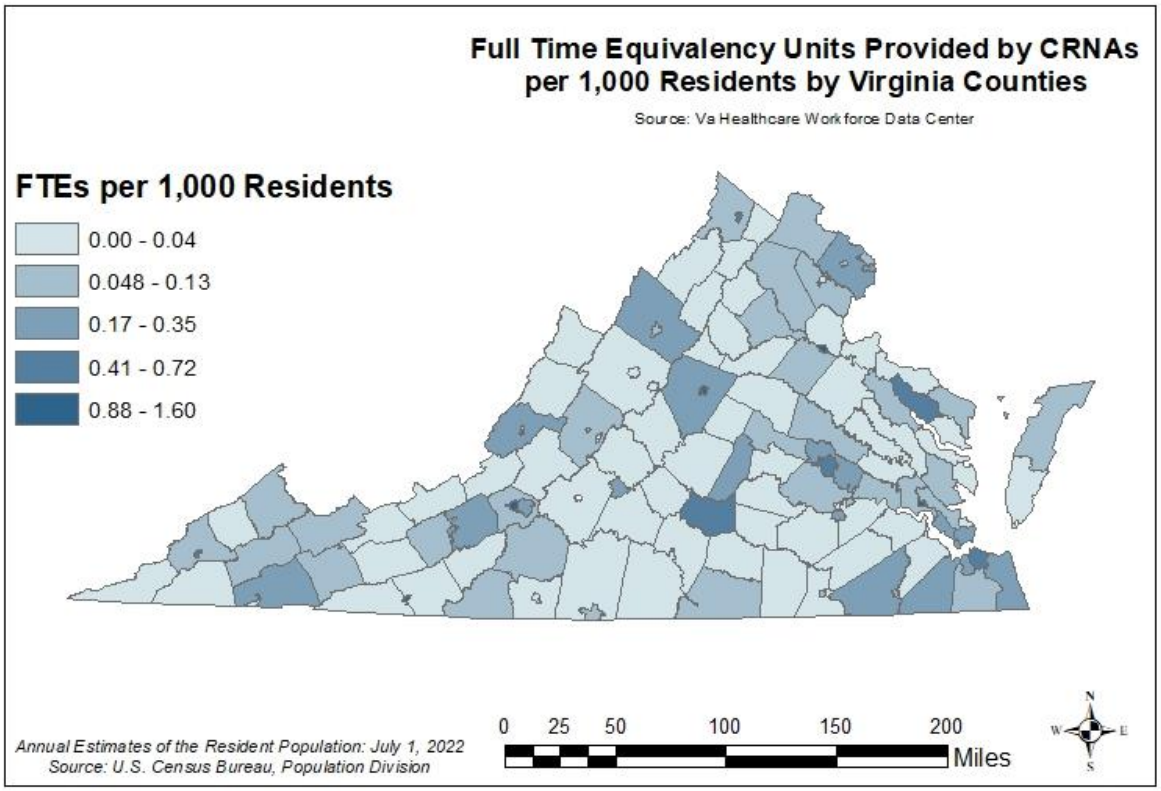
	Time to Retirement							
	CRNA		CNM		CNP		All (2023)	
Expect to retire within. . .	#	%	#	%	#	%	#	%
2 years	130	8%	25	8%	431	5%	586	5%
5 years	56	4%	13	4%	299	3%	369	3%
10 years	220	14%	29	9%	894	10%	1,144	10%
15 years	201	13%	37	12%	1,079	12%	1,316	12%
20 years	234	15%	41	13%	1,076	12%	1,352	12%
25 years	261	16%	35	11%	1,395	15%	1,691	15%
30 years	203	13%	47	15%	1,354	15%	1,604	14%
35 years	184	12%	50	16%	1,172	13%	1,405	13%
40 years	53	3%	7	2%	575	6%	635	6%
45 years	6	0%	9	3%	207	2%	221	2%
50 years	0	0%	2	1%	66	1%	67	1%
55 years	0	0%	0	0%	9	0%	9	0%
In more than 55 years	0	0%	6	2%	14	0%	20	0%
Do not intend to retire	40	3%	14	4%	593	6%	647	6%
Total	**1,588**	**100%**	**316**	**100%**	**9,162**	**100%**	**11,066**	**100%**

Source: Va. Healthcare Workforce Data Center

Using these estimates, retirement will begin to reach over 10% of the current workforce every 5 years by 2033. Retirement will peak at 15% of the current workforce around 2048 before declining to under 10% of the current workforce again around 2063.

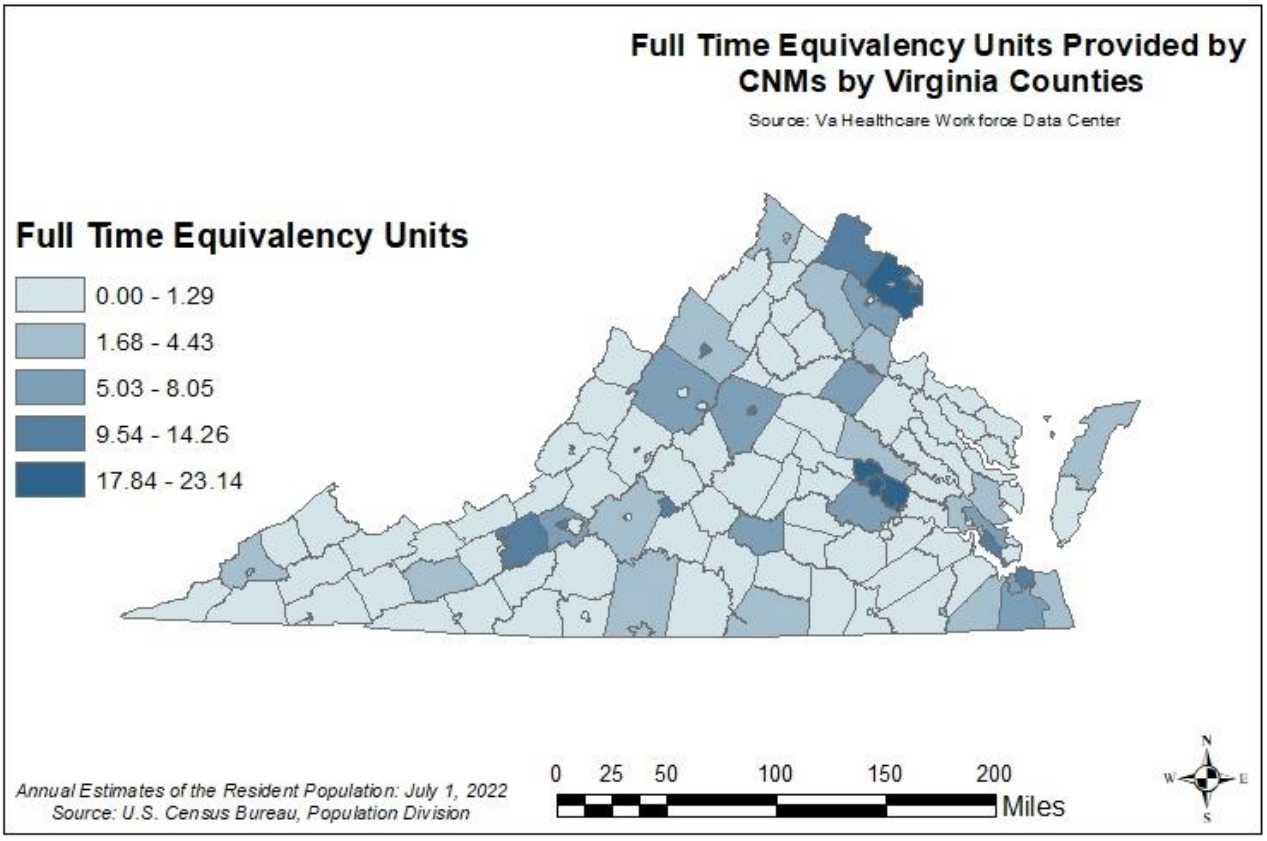
Map of Full Time Equivalency Units – Certified Registered Nurse Anesthetists

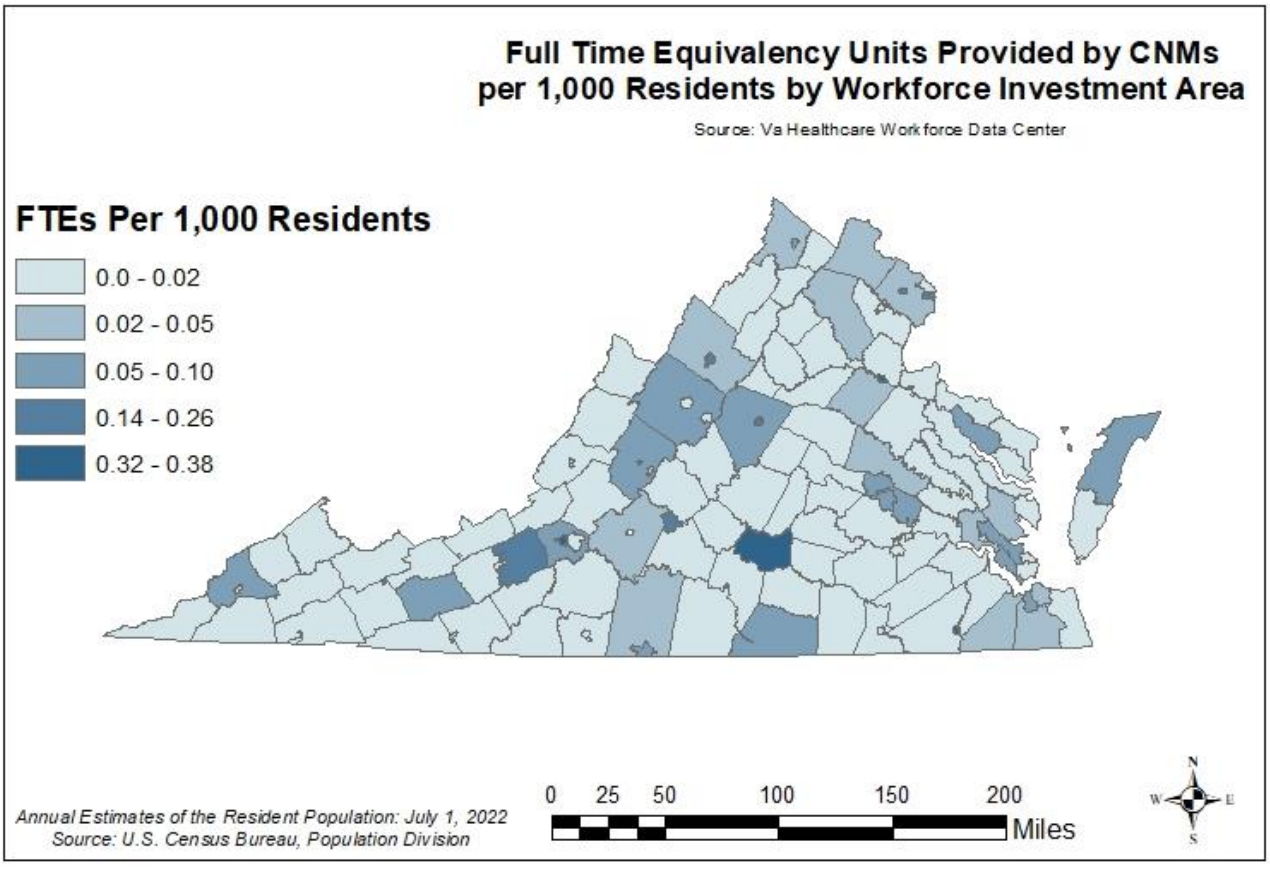




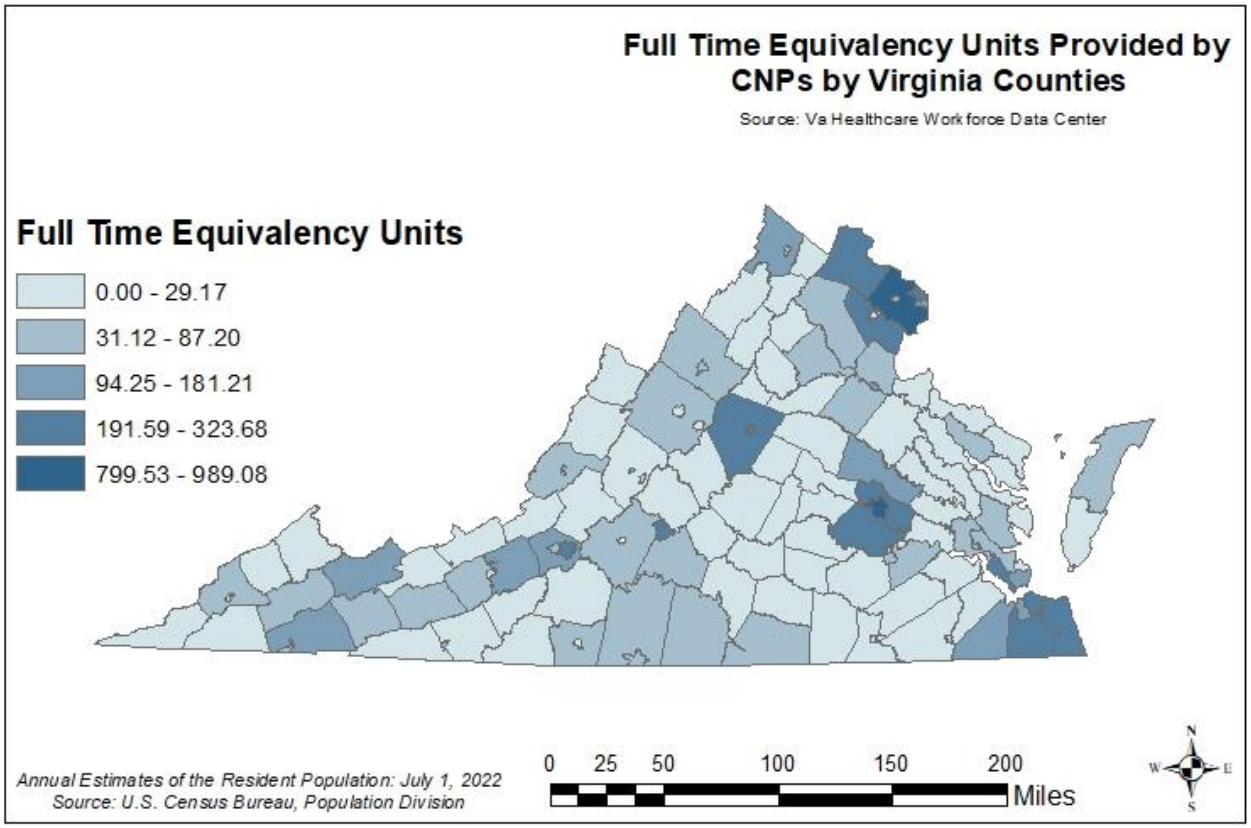
Note: Maps show reported work hours in primary and secondary locations of respondents who provided a response to the relevant question. Map may not reflect hours worked by all nurse practitioners licensed in the state since response rate was less than 100%.

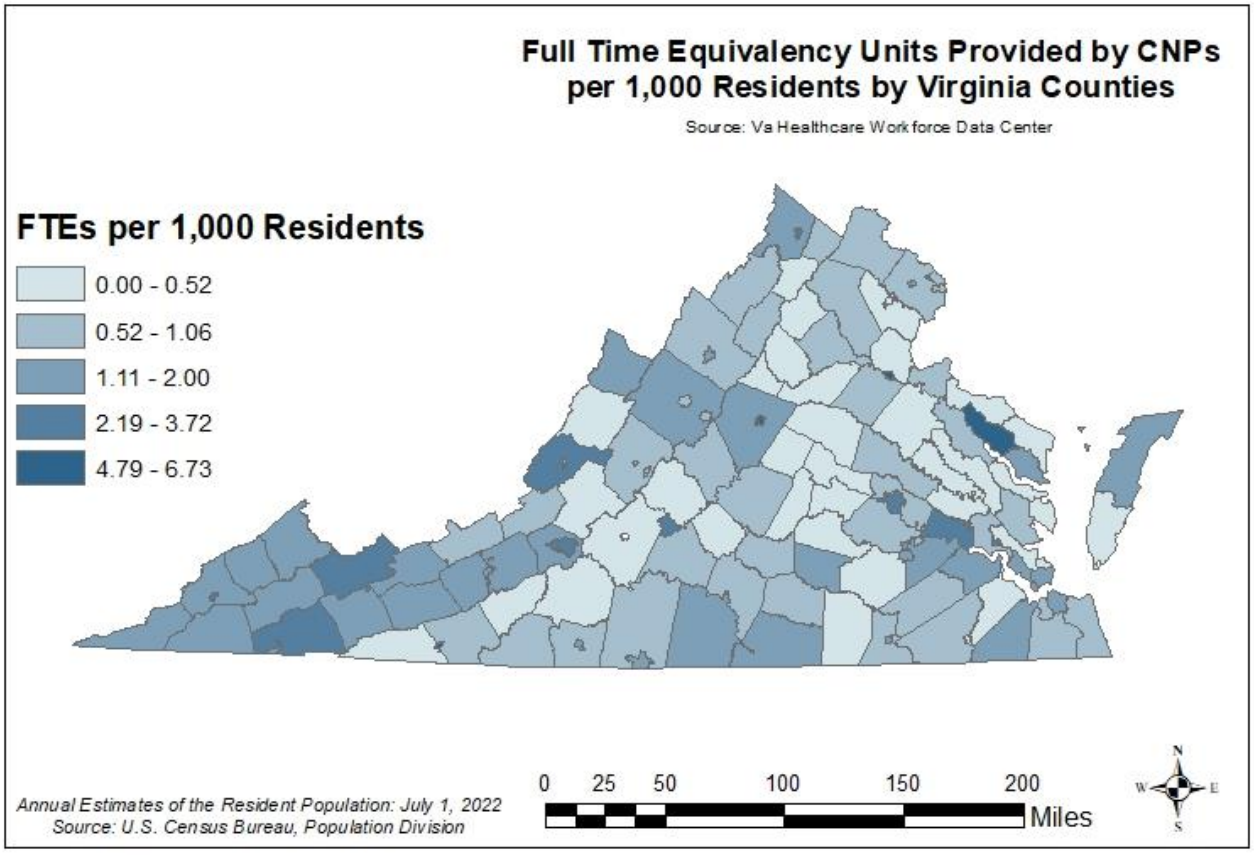
Map of Full Time Equivalency Units – Certified Nurse Midwives





Map of Full Time Equivalency Units – Certified Nurse Practitioners





Agenda Item: **DHP Agency Director's Report**

Staff Note: All items for information only

Action: None.

Agenda Item: **Report of Officers**

Staff Note:

- President
- Vice-President
- Secretary-Treasurer
- Executive Director

Action: Informational presentation. No action required.

Agenda Item: **Executive Director's Report**

Staff Note: All items for information only

Action: None.

EXECUTIVE DIRECTOR'S REPORT

- **FY2024 Budget** – 4/30/24
  - 3.8 million - almost 3 million spent
  - 16.7% of FY2024 remaining - 22% of budget remaining

- **Licensing Statistics** –
  - Customer Satisfaction for FY2024 Q3 – 100%
  - Time from receipt of application to issuance of license - 45 days

- **OCCUPATIONAL THERAPY COMPACT** –
  - Regulations became effective 5/22/24

- **PHYSICIAN ASSISTANT RECIPROCAL LICENSING WITH MARYLAND AND THE DISTRICT OF COLUMBIA**

- **DISCIPLINE STATISTICS** –
  - FY2024 Q3 Clearance Rate 119%
  - Average time to close a case – 166.7 days
  - Percent of cases closed in 1 year - 92.4%
  - Disposition within 415 days - 99%

- **BUSINESS PROJECT WITH IMPACTMAKERS** - Still ongoing

- **VDH OCME 2023 Q3 OVERDOSE DEATH STATISTICS**
  - "From 2007-2021, there wasn't a substantial increase or decrease in fatal prescription (Rx) opioid overdoses; however, in 2022, there was a large drop in Rx opioid overdoses compared to the past 15-year span." **THE ESTIMATED NUMBER OF DEATHS FROM PRESCRIPTION OPIOIDS FOR 2023 IS 266, DOWN FROM A HIGH OF 507 IN 2017 AND DOWN FROM 340 IN 2022.**

- **PERSONNEL CHANGES**

Agenda Item: **Committee and Advisory Board Reports**

Staff Note: Please note Committee assignments and minutes of meetings.

Action: Motion to accept minutes as reports to the Board.

EXECUTIVE COMMITTEE (8)
Randy Clements, DPM – President, Chair
Peter Apel, MD – Vice-President
William Hutchens, MD
Oliver Kim
L. Blanton Marchese
Jacob Miller, DO
Karen Ransone, MD – Secretary-Treasurer
Jennifer Rathmann, DC

LEGISLATIVE COMMITTEE (7)
Peter Apel, MD – Vice-President, Chair
Randy Clements, DPM – President
Thomas Corry
Manjit Dhillon, MD
Krishna Madiraju, MD
Pradeep Pradhan, MD
Jennifer Rathmann, DC

CREDENTIALS COMMITTEE (9)
Jacob Miller, DO – Chair
David Archer, MD
Hazem Elariny, MD
Madge Ellis, MD
Deborah DeMoss Fonseca
William Hutchens, MD
Elliott Lucas, MD
Krishna Madiraju, MD
Patrick McManus, MD

FINANCE COMMITTEE
J. Randy Clements, DPM – President
Peter Apel, MD – Vice-President
Karen Ransone, MD – Secretary-Treasurer

BOARD BRIEFS COMMITTEE
William L. Harp, M.D., Ex Officio

CHIROPRACTIC COMMITTEE
Jennifer Rathmann, DC

BOARD OF HEALTH PROFESSIONS
Krishna Madiraju, MD

COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
Randy Clements, DPM – President
Blanton Marchese
Karen Ransone, MD

VIRGINIA BOARD OF MEDICINE

EXECUTIVE COMMITTEE MINUTES

Friday, April 5, 2024 Department of Health Professions Henrico, VA

CALL TO ORDER: Dr. Clements called the Executive Committee to order at 8:32 a.m.

ROLL CALL: Ms. Brown called the roll; a quorum was established.

MEMBERS PRESENT:
John R. Clements, DPM – President, Chair
Peter Apel, MD – Vice President
William Hutchens, MD
Oliver Kim
L. Blanton Marchese
Jacob Miller, DO
Karen Ransone, MD
Jennifer Rathmann, DC

STAFF PRESENT:
Jennifer Deschenes, JD – Acting Exec. Director
Colanthia Morton Opher - Deputy Exec. Director for Administration
Michael Sobowale, LLM - Deputy Exec. Director for Licensure
Erin Barrett - DHP Director of Legislative and Regulatory Affairs
Arnie Owens - DHP Director
Jim Jenkins – DHP Deputy Director
Barbara Matusiak, MD - Medical Review Coordinator
Deirdre Brown - Executive Assistant

OTHERS PRESENT:
W. Scott Johnson – MSV
Christopher Fleury – MSV
Bo Keeney – VA Chiropractic Association
Mary Ottinot, RN, BSN

EMERGENCY EGRESS INSTRUCTIONS

Dr. Clements provided the emergency egress instructions for those in the building.

APPROVAL OF MINUTES FROM AUGUST 5, 2023

Dr. Miller moved to approve the meeting minutes from August 5, 2023, as presented. The motion was seconded by Dr. Ransone and carried unanimously.

ADOPTION OF AGENDA

Dr. Miller moved to adopt the agenda as presented. The motion was seconded by Dr. Ransone and carried unanimously.

PUBLIC COMMENT

Mary Ottinot, RN, BSN, emphasized the need to include the public in public participation. Ms. Ottinot also encouraged practitioners to use resources regarding human trafficking and report any activity to the proper authorities.

DHP DIRECTOR'S REPORT

Mr. Owens shared with the Board that the General Assembly wrapped up in March, and that the challenge now is the follow-up action with DHP's various Boards. Next, he stated that Impact Makers completed an overview of the licensing process for the Board of Medicine and will soon give a status report that will identify problem areas and suggested methods to improve efficiency.

Mr. Owens stated that DHP is undergoing several internal changes in leadership. First being the new Director of Enforcement, Sarah Rogers, followed by the departure of Diane Powers who retired as the agency's Communications Director. Mr. Owens stated that on July 1st, Lisa Hahn, Chief Operating Officer, will be retiring as well. Jay Douglas, Executive Director of Nursing, will also be retiring from DHP. He stated that DHP is in great hands and mentioned that currently Jennifer Deschenes has been standing in as Acting Executive Director for the Board of Medicine during Dr. Harp's absence.

PRESIDENT'S REPORT

Dr. Clements reminded the Board that Mr. Marchese will be in Nashville in mid-April seeking election to the FSMB Board of Directors. Dr. Clements continued to pledge his support to fix BOX so imaging studies in cases can be viewed properly, and asked that representatives from the IT department be invited to attend the June Board meeting to hear board member concerns.

ACTING EXECUTIVE DIRECTOR'S REPORT

Ms. Deschenes stated that Enforcement is sending cases pre-merged through BOX which should help with the imaging results. She stated that at the upcoming Full Board meeting in June staff will request that someone from IT attend to hear board member concerns. Ms. Deschenes stated that other Boards were having similar issues and the Discipline Workgroup is meeting monthly to troubleshoot and find solutions.

Lastly, Ms. Deschenes stated that Dr. Harp is doing well and should be back at DHP at the end of April. Then she shared that Jennie Wood, Regulatory Boards Administrator for Medicine, is retiring in June, and that she will be greatly missed.

NEW BUSINESS

1. Regulatory Actions as of March 18, 2024

Ms. Barrett presented the chart for review only.

2. Current Regulatory Actions

Ms. Barrett reviewed the Current Regulatory Actions with the Board and gave updates to House Bills as some statuses have changed. She also shared that if the Governor takes no action on a bill by April 8, 2024, it becomes law.

This report was for informational purposes only and did not require any action.

3. Completion of Periodic Review of Public Participation Guidelines – 18VAC85-11

Ms. Barrett shared with the Board that a periodic review of regulatory chapters is required to be conducted by agencies every four years. Changes are made to public participation guideline regulations only when the Department of Planning and Budget provides new language, but the Board is still required to issue a periodic review. Ms. Barrett recommended that the Board retain the Chapter as is because the Department of Planning and Budget has not provided recommended changes.

MOTION: Dr. Miller moved to retain 18VAC85-11 as is. The motion was seconded by Dr. Hutchens and carried unanimously.

4. Previously Posted Guidance Documents that do not meet the definition of "guidance document" Under Va. Code § 2-2-4101

Ms. Barrett reviewed with the Board the following documents that do not meet the definition of "guidance documents" as defined in Virginia Code § 2.2-4101.

- Guidance Document 85-1: Bylaws of the Board of Medicine
- Guidance Document 85-2: Attorney General opinion on school physical exams (1986)
- Guidance Document 85-3: Bylaws for advisory boards of the Board of Medicine
- Guidance Document 85-9: Policy on USMLE step attempts
- Guidance Document 85-11: Sanction Reference Points manual
- Guidance Document 85-20: Attorney General opinion on employment of surgeon by nonprofit corporation (1992)
- Guidance Document 85-21: Attorney General opinion on employment of physician by for-profit corporation (1995)
- Guidance Document 85-26: Compliance with law for licensed midwives (list of statutory references and VDH contact)

Therefore, Ms. Barrett informed the Board that they will be removed from Town Hall as guidance documents and placed on the Board's website as policy documents or informational documents. Ms. Deschenes stated that the OAG has completed its review of the above documents and agreed that they do not qualify as "guidance documents", so the changes can be made to the BOM website.

ANNOUNCEMENTS

Dr. Clements informed the Board of the updated guideline for travel reimbursement. Effective immediately, board members need to submit their request for reimbursement within 30 days for reimbursement approval. No exceptions after the 30-day deadline will be accepted.

The next meeting of the Executive Committee will be August 2, 2024, at 8:30 a.m.

ADJOURNMENT

With no additional business, the meeting adjourned at 9:25 a.m.

_____
Jennifer Deschenes, JD
Acting Executive Director

Agenda Item: Other Reports

- Assistant Attorney General*
- Board of Health Professions
- Podiatry Report*
- Chiropractic Report*
- Committee of the Joint Boards of Nursing and Medicine

Staff Note: *Reports will be given orally at the meeting

Action: These reports are for information only. No action needed unless requested by presenter.

VIRGINIA COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
BUSINESS MEETING MINUTES
February 28, 2024

TIME AND PLACE: The meeting of the Committee of the Joint Boards of Nursing and Medicine was convened at 9:01 A.M., February 28, 2024 in Board Room 2, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

MEMBERS PRESENT:
Cindy M. Swineford, RN, MSN, CNE; Board of Nursing - **Chair**
Helen M. Parke, DNP, FNP; Board of Nursing
Blanton Marchese; Board of Medicine
Randy Clements, DPM; Board of Medicine
Karen Ransone, MD; Board of Medicine

ADVISORY COMMITTEE MEMBERS PRESENT:
Kevin E. Brigle, PhD, RN, ANP
David A. Ellington, MD
Jean Snyder DNaP, CRNA
Adam T. Kaul, MD
Mark Coles, RN, BA, MSN, NP-C
Komkwuan P. Paruchabutr, DNP, FNP-BC,WHNP-BC, CNM- **joined at 9:03 A.M.**

STAFF PRESENT:
Jay P. Douglas, RN, MSM, CSAC, FRE; Executive Director
Robin L. Hills, DNP, RN, WHNP; Deputy Executive Director for Advanced Practice
Tamika Claiborne, Senior Licensing and Discipline Specialist

OTHERS PRESENT:
Laura Booberg, Assistant Attorney General; Board Counsel
Arne Owens, DHP Director
James Jenkins, Jr., RN, DHP Chief Deputy
Erin Barrett, DHP Director of Legislative Affairs and Policy
William L. Harp, MD, Executive Director; Board of Medicine – **joined at 9:33 A.M.**

IN THE AUDIENCE:
Christopher Fleury, Medical Society of Virginia (MSV)
Matthew Novak, Assistant to the DHP Director of Legislative Affairs and Policy
Jen Deschenes, Deputy Executive Director; Board of Medicine

INTRODUCTIONS: Committee members, Advisory Committee members, and staff members introduced themselves.

ESTABLISHMENT OF

A QUORUM: Ms. Swineford called the meeting to order and established that a quorum was present.

WELCOME NEW MEMBERS: Ms. Swineford acknowledged new Committee and Advisory Members.

DIALOGUE WITH AGENCY DIRECTOR: Mr. Owens reported the following:

- **General Assembly –** will wrap up soon; APRN bills went to Senate/House became Dead Bill to consolidate Nursing and Medicine Joint Boards into Board of Nursing only. Bill to Transition down from 5 years to 3 years will likely sign into law. Governor supports both bills.

STAFF REPORTS: Dr. Hills provided update on new profession-Licensed Certified Midwife and the APRN tab on the Board of Nursing website and APRN Licensure and Discipline update.

Blanton Marchese asked if we know where the new licensees will be working.

PUBLIC COMMENT: No public comments were received.

LEGISLATION/ REGULATIONS:

Chart of Regulatory Actions:
Ms. Barrett reviewed the Chart of Regulatory Actions.

Report of the 2024 General Assembly (GA):
Ms. Barrett reviewed the 2024 GA report and noted that the report included dead bills also.

Mr. Owens and Ms. Barrett reiterated that the administration supported all APRN bills.

RECESS: The Committee recessed at 9:38 A.M.

RECONVENTION: The Committee reconvened at 9:50 A.M.

NEW BUSINESS: **Healthcare Workforce Data Center (HWDC) Reports**:

- ❖ APRN Workforce Report: 2023
- ❖ APRN Specialties Comparison Report: 2023

Dr. Hodgdon presented the key findings of the 2023 reports:
Advanced Practice Registered Nurse (APRN) Workforce: 2023

Advanced Practice Registered Nurses Workforce: Comparison by Specialty – 2023

ENVIRONMENTAL SCAN – ADVISORY COMMITTEE MEMBERS

Ms. Swineford asked for updates from the Advisory Committee Members.

Dr. Snyder discussed consultation and not collaboration

Mr. Coles reported on FDP especially military struggles and the 50th anniversary of VCNP is upcoming.

Dr. Kaul reported on advocacy crisis services and the shortage of ED APRNs and ECO/TDO processes uphill.

Dr. Brigle discussed the APRNs retention is a problem.

Ms. Paruchabutr discussed issues with autonomous practice.

Dr. Ellington reported that APRN were well represented at VA Family Physicians.

Ms. Swineford thanked Advisory Committee Members for their participation.

Members of the Advisory Committee, Dr. Harp, and the public left the meeting at 10.55 A.M.

ADJOURNMENT: As there was no additional business, the meeting was adjourned at 10:27 A.M.

_____
Robin L. Hills, DNP, RN, WHNP
Deputy Executive Director for Advanced Practice

Board of Medicine
Current Regulatory Actions
As of May 22, 2024

In the Governor's Office

None.

In the Secretary's Office

VAC	Stage	Subject Matter	Submitted from agency	Time in current location	Notes
18VAC85-160	Final	Changes consistent with a licensed profession	6/17/2022	687 days (1.9 years)	Proposed regulations consistent with surgical assistants changing from certification to licensure
18VAC85-160	Fast-track	Reinstatement as a surgical technologist	6/17/2022	631 days (1.7 years)	Action to allow certified surgical technologists to voluntarily request inactive status, and for surgical technologists to reinstate certification from inactive status or from suspension or revocation following disciplinary action.
18VAC85-130	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	358 days	Implements changes following 2022 periodic review
18VAC85-140	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	355 days	Implements changes following 2022 periodic review
18VAC85-150	Fast-track	Implementation of changes following 2022	10/6/2022	352 days	Implements changes following 2022 periodic review

		periodic review of Chapter			
18VAC85-170	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	352 days	Implements changes following 2022 periodic review
18VAC85-15	Fast-Track	Implementation of Periodic Review	10/6/2022	317 days	Implements changes following 2022 periodic review
18VAC85-40	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	296 days	Implements changes following 2022 periodic review
18VAC85-80	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	287 days	Implements changes following 2022 periodic review
18VAC85-50	NOIRA	Removal of patient care team physician or podiatrist name from prescriptions issued by physician assistants	8/8/2023	285 days	Regulatory action begun in response to a petition for rulemaking
18VAC85-50	Fast-track	Implementation of changes following 2022 periodic review of Chapter	8/15/2023	281 days	Implements changes following 2022 periodic review
18VAC85-110	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	278 days	Implements changes following 2022 periodic review
18VAC85-50	NOIRA	Amendment to requirements for patient care team physician or podiatrist consultation and collaboration	8/8/2023	275 days	Regulatory action begun in response to a petition for rulemaking

18VAC85-20	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	266 days	Implements changes following 2022 periodic review
18VAC85-21	Fast-track	Amendment of opioid and buprenorphine prescribing regulations	7/14/2023	110 days	Updates opioid and buprenorphine regulations based on updated CDC guidelines
18VAC85-130	Fast-Track	General disclosure requirement consistent with statutory changes	10/23/2023	26 days	Updates requirements for midwife disclosures consistent with 2023 legislative changes

At the Department of Planning and Budget

None.

At the Office of the Attorney General

None.

Recently effective/awaiting publication

VAC	Stage	Subject Matter	Publication date	Effective date
18VAC85-80	Final	Implementation of the OT Compact	4/22/2024	5/22/2024

Agenda Item: Current Regulatory Actions

Staff Note: Ms. Barrett will speak to the Board of Medicine actions underway.

Action: If any action is required, guidance will be provided.

Agenda Item: Adoption of exempt regulatory action pursuant to SB133

Included in your agenda package:

- Draft changes to 18VAC85-50-101 providing exemption to the requirement to maintain a separate practice agreement in certain employment situations, consistent with changes in the 2024 GA; and

- SB133, which created exemptions to the requirement to maintain a separate practice agreement in certain employment situations.

Action needed:

- Adoption of exempt regulatory change to amend 18VAC85-50-101 as presented.

Project 7925 - Exempt Final

Board of Medicine

Amendment to allow physician assistants working for defined employers to practice without a separate practice agreement if certain statutory requirements are met

18VAC85-50-101. Requirements for a practice agreement.

A. Prior to initiation of practice, a physician assistant and one or more patient care team physicians or podiatrists shall enter into a written or electronic practice agreement that spells out the roles and functions of the assistant and is consistent with provisions of § 54.1-2952 of the Code of Virginia.

1. Any such practice agreement shall take into account such factors as the physician assistant's level of competence, the number of patients, the types of illness treated by the physicians or podiatrists, the nature of the treatment, special procedures, and the nature of the physicians' or podiatrists' availability in ensuring direct physician or podiatrist involvement at an early stage and regularly thereafter.

2. The practice agreement shall also provide an evaluation process for the physician assistant's performance, including a requirement specifying the time period, proportionate to the acuity of care and practice setting, within which the physicians or podiatrists shall review the record of services rendered by the physician assistant.

3. The practice agreement may include requirements for periodic site visits by licensees who supervise and direct the patient care team physicians or podiatrists to collaborate and consult with physician assistants who provide services at a location other than where the physicians or podiatrists regularly practice.

B. The board may require information regarding the degree of collaboration and consultation by the patient care team physicians or podiatrists. The board may also require a patient care team physician or podiatrist to document the physician assistant's competence in performing such tasks.

C. If the role of the physician assistant includes prescribing drugs and devices, the written practice agreement shall include those schedules and categories of drugs and devices that are within the scope of practice and proficiency of the patient care team physicians or podiatrists.

D. If the initial practice agreement did not include prescriptive authority, there shall be an addendum to the practice agreement for prescriptive authority.

E. If there are any changes in consultation and collaboration, authorization, or scope of practice, a revised practice agreement shall be entered into at the time of the change.

F. Physician assistants appointed as medical examiners pursuant to § 32.1-282 of the Code of Virginia may practice without a written or electronic practice agreement.

G. Physician assistants employed by (i) a hospital as defined by § 32.1-123 of the Code of Virginia, (ii) a state facility as defined by § 37.2-100 of the Code of Virginia, or (iii) a federally qualified health center designated by the Centers for Medicare and Medicaid Services may practice without a written or electronic practice agreement consistent with the requirements contained in § 54.1-2951.1 E of the Code of Virginia.

CHAPTER 116

An Act to amend and reenact §§ 54.1-2951.1, 54.1-2952, 54.1-2952.1, and 54.1-2953 of the Code of Virginia, relating to physician assistants; practice agreement exemption.

[S 133]

Approved March 20, 2024

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2951.1, 54.1-2952, 54.1-2952.1, and 54.1-2953 of the Code of Virginia are amended and reenacted as follows:

§ 54.1-2951.1. Requirements for licensure and practice as a physician assistant; licensure by endorsement.

A. The Board shall promulgate regulations establishing requirements for licensure as a physician assistant that shall include the following:

1. Successful completion of a physician assistant program or surgical physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant;

2. Passage of the certifying examination administered by the National Commission on Certification of Physician Assistants; and

3. Documentation that the applicant for licensure has not had his license or certification as a physician assistant suspended or revoked and is not the subject of any disciplinary proceedings in another jurisdiction.

B. The Board may issue a license by endorsement to an applicant for licensure as a physician assistant if the applicant (i) is the spouse of an active duty member of the Armed Forces of the United States or the Commonwealth, (ii) holds current certification from the National Commission on Certification of Physician Assistants, and (iii) holds a license as a physician assistant that is in good standing, or that is eligible for reinstatement if lapsed, under the laws of another state.

C. ~~Every~~ *Except as provided in subsection E, every* physician assistant shall practice as part of a patient care team and shall provide care in accordance with a written or electronic practice agreement with one or more patient care team physicians or patient care team podiatrists.

A practice agreement shall include acts pursuant to § 54.1-2952, provisions for the periodic review of patient charts or electronic health records, guidelines for collaboration and consultation among the parties to the agreement and the patient, periodic joint evaluation of the services delivered, and provisions for appropriate physician input in complex clinical cases, in patient emergencies, and for referrals.

A practice agreement may include provisions for periodic site visits by a patient care team physician or patient care team podiatrist who is part of the patient care team at a location other than where the licensee regularly practices. Such visits shall be in the manner and at the frequency as determined by the patient care team physician or patient care team podiatrist who is part of the patient care team.

D. ~~Evidence~~ *Except as provided in subsection E, evidence* of a practice agreement shall be maintained by the physician assistant and provided to the Board upon request. The practice agreement may be maintained in writing or electronically and may be a part of credentialing documents, practice protocols, or procedures.

E. Physician assistants employed by a hospital as defined in § 32.1-123 or employed in (i) a state facility as defined in § 37.2-100 operated by the Department of Behavioral Health and Developmental Services or (ii) a federally qualified health center designated by the Centers for Medicare and Medicaid Services may practice without a separate practice agreement if the credentialing and privileging requirements of the applicable facility include a practice arrangement that incorporates the components of a practice agreement set forth in the provisions of subsection C, including requiring and designating a patient care team physician or podiatrist, and the patient care team requirements of § 54.1-2952. Such physician assistants shall continue to practice as part of a patient care team in collaboration and consultation with patient care team physicians or patient care team podiatrists.

§ 54.1-2952. Role of patient care team physician or patient care team podiatrist on patient care teams; services that may be performed by physician assistants; responsibility of licensee; employment of physician assistants.

A. A patient care team physician or patient care team podiatrist licensed under this chapter may serve on a patient care team with physician assistants and shall provide collaboration and consultation to such physician assistants. No patient care team physician or patient care team podiatrist shall be allowed to collaborate or consult with more than six physician assistants on a patient care team at any one time.

Service as part of a patient care team by a patient care team physician or patient care team podiatrist shall not, by the existence of such service alone, establish or create vicarious liability for the actions or

inactions of other team members.

B. Physician assistants may practice medicine to the extent and in the manner authorized by the Board. A patient care team physician or patient care team podiatrist shall be available at all times to collaborate and consult with physician assistants. Each patient care team shall identify the relevant physician assistant's scope of practice and an evaluation process for the physician assistant's performance.

C. Physician assistants appointed as medical examiners pursuant to § 32.1-282 may practice without a written or electronic practice agreement.

D. Any professional corporation or partnership of any licensee, any hospital and any commercial enterprise having medical facilities for its employees that are supervised by one or more physicians or podiatrists may employ one or more physician assistants in accordance with the provisions of this section.

Activities shall be performed in a manner consistent with sound medical practice and the protection of the health and safety of the patient. Such activities shall be set forth in a practice agreement *or by the credentialing and privileging practice arrangement requirements of a facility described in subsection E of § 54.1-2951.1* and may include health care services that are educational, diagnostic, therapeutic, or preventive, including establishing a diagnosis, providing treatment, and performing procedures. Prescribing or dispensing of drugs may be permitted as provided in § 54.1-2952.1. In addition, a physician assistant may perform initial and ongoing evaluation and treatment of any patient in a hospital, including its emergency department, in accordance with the practice agreement *or the credentialing and privileging practice arrangement requirements of a facility described in subsection E of § 54.1-2951.1*, including tasks performed, relating to the provision of medical care in an emergency department.

A patient care team physician or the on-duty emergency department physician shall be available at all times for collaboration and consultation with both the physician assistant and the emergency department physician. No person shall have responsibility for any physician assistant who is not employed by the person or the person's business entity.

E. No physician assistant shall perform any acts beyond those set forth in the practice agreement or authorized as part of the patient care team. No physician assistant practicing in a hospital shall render care to a patient unless the physician responsible for that patient is available for collaboration or consultation, pursuant to regulations of the Board.

F. Notwithstanding the provisions of § 54.1-2956.8:1, a licensed physician assistant who (i) is working in the field of radiology or orthopedics as part of a patient care team, (ii) has been trained in the proper use of equipment for the purpose of performing radiologic technology procedures consistent with Board regulations, and (iii) has successfully completed the exam administered by the American Registry of Radiologic Technologists for physician assistants for the purpose of performing radiologic technology procedures may use fluoroscopy for guidance of diagnostic and therapeutic procedures.

§ 54.1-2952.1. Prescription of certain controlled substances and devices by licensed physician assistants.

A. In accordance with the provisions of this section and pursuant to the requirements of Chapter 33 (§ 54.1-3300 et seq.), a licensed physician assistant shall have the authority to prescribe controlled substances and devices as set forth in Chapter 34 (§ 54.1-3400 et seq.) and as provided in a practice agreement *or by the credentialing and privileging practice arrangement requirements of a facility described in subsection E of § 54.1-2951.1*. Such practice agreements shall include a statement of the controlled substances the physician assistant is or is not authorized to prescribe and may restrict such prescriptive authority as deemed appropriate by the patient care team physician or patient care team podiatrist.

B. It ~~shall be~~ *is* unlawful for the physician assistant to prescribe controlled substances or devices pursuant to this section unless such prescription is authorized by the practice agreement *or by the credentialing and privileging practice arrangement requirements of a facility described in subsection E of § 54.1-2951.1* and the requirements in this section.

C. The Board of Medicine, in consultation with the Board of Pharmacy, shall promulgate such regulations governing the prescriptive authority of physician assistants as are deemed reasonable and necessary to ensure an appropriate standard of care for patients.

The regulations promulgated pursuant to this section shall include, at a minimum, (i) such requirements as may be necessary to ensure continued physician assistant competency, which may include continuing education, testing, and any other requirement and shall address the need to promote ethical practice, an appropriate standard of care, patient safety, the use of new pharmaceuticals, and appropriate communication with patients, and (ii) a requirement that the physician assistant disclose to his patients his name, address, and telephone number and that he is a physician assistant. If a patient or his representative requests to speak with the patient care team physician or patient care team podiatrist, the physician assistant shall arrange for communication between the parties or provide the necessary information.

D. This section shall not prohibit a licensed physician assistant from administering controlled substances in compliance with the definition of "administer" in § 54.1-3401 or from receiving and

dispensing manufacturers' professional samples of controlled substances in compliance with the provisions of this section.

§ 54.1-2953. Renewal, revocation, suspension, and refusal.

The Board may revoke, suspend, or refuse to renew a license to practice as a physician assistant for any of the following:

1. Any action by a physician assistant constituting unprofessional conduct pursuant to § 54.1-2915;

2. Practice by a physician assistant other than as part of a patient care team, including practice without entering into a practice agreement with one or more patient care team physicians or patient care team podiatrists, *except as provided in subsection E of § 54.1-2951.1*;

3. Failure of the physician assistant to practice in accordance with the requirements of his practice agreement;

4. Negligence or incompetence on the part of the physician assistant or other member of the patient care team;

5. Violation of or cooperation in the violation of any provision of this chapter or the regulations of the Board; or

6. Failure to comply with any regulation of the Board required for licensure of a physician assistant.

Agenda Item: Adoption of exempt regulatory actions pursuant to HB699

Included in your agenda package:

- Draft changes to 18VAC85-21-22 setting forth certain patient counseling and recordkeeping requirements related to opioid prescriptions, consistent with changes in the 2024 GA;

- Draft changes to 18VAC90-40-21, which are identical to changes in 18VAC85-21-22; and

- HB699, which requires these changes.

Staff Note: Changes regarding APRN prescribing will be voted on by the Board of Nursing at its July 2024 meeting.

Action needed:

- Adoption of exempt regulatory change to amend 18VAC85-21-22 as presented.

- Adoption of exempt regulatory change to amend 18VAC90-40-21 as presented.

Project 7888 - Exempt Final

Board of Medicine

Changes to patient counseling regarding opioid prescriptions pursuant to HB699

18VAC85-21-22. Patient counseling.

A. Prior to issuing a prescription for an opioid to treat acute or chronic pain, practitioners must provide patient counseling on the following:

1. The risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines, and other central nervous system depressants;

2. The reasons why the prescription is necessary;

3. Alternative treatments that may be available; and

4. Risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, that there is a risk of developing a physical or psychological dependence on the controlled dangerous substance, and that the risks of taking more opioids than prescribed, or mixing sedatives, benzodiazepines, or alcohol with opioids can result in fatal respiratory depression.

Such patient counseling shall be documented in the patient's medical record.

B. Patient counseling as described in subsection A shall not be a requirement for patients who are (i) in active treatment for cancer, (ii) receiving hospice care from a licensed hospice or palliative care, (iii) residents of a long-term care facility, (iv) being prescribed an opioid in the course of treatment for substance abuse or opioid dependence, or (v) receiving treatment for sickle cell disease.

Project 7889 - Exempt Final

Board of Nursing

Changes to patient counseling regarding opioid prescriptions pursuant to HB699

18VAC90-40-21. Patient counseling for opioids.

A. Prior to issuing a prescription for an opioid to treat acute or chronic pain, practitioners must provide patient counseling on the following:

1. The risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines, and other central nervous system depressants;

2. The reasons why the prescription is necessary;

3. Alternative treatments that may be available; and

4. Risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, that there is a risk of developing a physical or psychological dependence on the controlled dangerous substance, and that the risks of taking more opioids than prescribed, or mixing sedatives, benzodiazepines, or alcohol with opioids can result in fatal respiratory depression.

Such patient counseling shall be documented in the patient's medical record.

B. Patient counseling as described in subsection A shall not be a requirement for patients who are (i) in active treatment for cancer, (ii) receiving hospice care from a licensed hospice or palliative care, (iii) residents of a long-term care facility, (iv) being prescribed an opioid in the course of treatment for substance abuse or opioid dependence, or (v) receiving treatment for sickle cell disease.

REPRINT

CHAPTER 448

An Act to direct the Board of Medicine, the Board of Dentistry, the Board of Optometry, and the Boards of Medicine and Nursing to amend their regulations related to patient counseling for the prescription of opioids to treat acute or chronic pain.

[H 699]

Approved April 4, 2024

Be it enacted by the General Assembly of Virginia:

1. *§ 1. That the Board of Medicine, the Board of Dentistry, the Board of Optometry, and the Boards of Medicine and Nursing shall amend their regulations to require that, prior to issuing a prescription for any opioid to treat acute or chronic pain, practitioners provide patient counseling. Such patient counseling shall include providing the patient with information regarding (i) the risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines, and other central nervous system depressants; (ii) the reasons why the prescription is necessary; (iii) alternative treatments that may be available; and (iv) risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, that there is a risk of developing a physical or psychological dependence on the controlled dangerous substance, and that the risks of taking more opioids than prescribed, or mixing sedatives, benzodiazepines, or alcohol with opioids, can result in fatal respiratory depression. The regulations shall require that the practitioner document in the patient's medical record that the patient has discussed with the practitioner the risks of developing a physical or psychological dependence on the controlled dangerous substance and alternative treatments that may be available. The regulations shall include an exception to the patient counseling requirement for patients who are (a) in active treatment for cancer, (b) receiving hospice care from a licensed hospice or palliative care, (c) residents of a long-term care facility, (d) being prescribed an opioid in the course of treatment for substance abuse or opioid dependence, or (e) receiving treatment for sickle cell disease.*

2. That the Board of Medicine, the Board of Dentistry, the Board of Optometry, and the Boards of Medicine and Nursing shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment.

Agenda Item: Adoption of exempt regulatory action pursuant to HB971

Included in your agenda package:

- Draft changes to 18VAC90-30-86 reducing required practice prior to autonomous practice designation for APRNs from five years to three years, consistent with changes in the 2024 GA; and

- HB971, which changed required practice from five years to three prior to autonomous practice designation for APRNs.

Staff Note: This exempt action will be voted on by the Board of Nursing at its July 2024 meeting.

Action needed:

- Adoption of exempt regulatory change to amend 18VAC90-30-86 as presented.

Project 7924 - Exempt Final

Board of Nursing

Reduction of required practice for APRNs prior to practice without a practice agreement consistent with statutory change.

18VAC90-30-86. Autonomous practice for advanced practice registered nurses other than nurse midwives, certified registered nurse anesthetists, or clinical nurse specialists.

A. An advanced practice registered nurse with a current, unrestricted license, other than someone licensed in the category of certified nurse midwife, certified registered nurse anesthetist, or clinical nurse specialist, may qualify for autonomous practice by completion of the equivalent of ~~two years of full-time clinical experience as an advanced practice registered nurse until July 1, 2022. Thereafter, the requirement shall be the equivalent of five~~ three years of full-time ~~clinical~~ experience to qualify for autonomous practice.

1. Full-time ~~clinical~~ experience shall be defined as 1,800 hours per year.

2. ~~Clinical experience~~ Experience shall be defined as the postgraduate delivery of health care directly to patients pursuant to a practice agreement with a patient care team physician.

B. Qualification for authorization for autonomous practice shall be determined upon submission of a fee as specified in 18VAC90-30-50 and an attestation acceptable to the boards. The attestation shall be signed by the advanced practice registered nurse and the advanced practice registered nurse's patient care team physician stating that:

1. The patient care team physician served as a patient care team physician on a patient care team with the advanced practice registered nurse pursuant to a practice agreement

meeting the requirements of this chapter and §§ 54.1-2957 and 54.1-2957.01 of the Code of Virginia;

2. While a party to such practice agreement, the patient care team physician routinely practiced with a patient population and in a practice area included within the category, as specified in 18VAC90-30-70, for which the advanced practice registered nurse was certified and licensed; and

3. The period of time and hours of practice during which the patient care team physician practiced with the advanced practice registered nurse under such a practice agreement.

C. The advanced practice registered nurse may submit attestations from more than one patient care team physician with whom the advanced practice registered nurse practiced during the equivalent of ~~five~~ three years of practice, but all attestations shall be submitted to the boards at the same time.

D. If an advanced practice registered nurse is licensed and certified in more than one category as specified in 18VAC90-30-70, a separate fee and attestation that meets the requirements of subsection B of this section shall be submitted for each category. If the hours of practice are applicable to the patient population and in practice areas included within each of the categories of licensure and certification, those hours may be counted toward a second attestation.

E. In the event a patient care team physician has died, become disabled, retired, or relocated to another state, or in the event of any other circumstance that inhibits the ability of the advanced practice registered nurse from obtaining an attestation as specified in subsection B of this section, the advanced practice registered nurse may submit other evidence of meeting the qualifications for autonomous practice along with an attestation signed by the advanced practice registered nurse. Other evidence may include employment records, military service,

Medicare or Medicaid reimbursement records, or other similar records that verify full-time clinical practice in the role of an advanced practice registered nurse in the category for which the advanced practice registered nurse is licensed and certified. The burden shall be on the advanced practice registered nurse to provide sufficient evidence to support the advanced practice registered nurse's inability to obtain an attestation from a patient care team physician.

F. An advanced practice registered nurse to whom a license is issued by endorsement may engage in autonomous practice if such application includes an attestation acceptable to the boards that the advanced practice registered nurse has completed the equivalent of ~~five~~ three years of full-time ~~clinical~~ experience as specified in subsection A of this section and in accordance with the laws of the state in which the advanced practice registered nurse was previously licensed.

G. An advanced practice registered nurse authorized to practice autonomously shall:

1. Only practice within the scope of the advanced practice registered nurse's clinical and professional training and limits of the advanced practice registered nurse's knowledge and experience and consistent with the applicable standards of care;

2. Consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided; and

3. Establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers.

CHAPTER 404

An Act to amend and reenact § 54.1-2957 of the Code of Virginia, relating to nurse practitioners; patient care team provider; autonomous practice.

[H 971]

Approved April 4, 2024

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2957 of the Code of Virginia is amended and reenacted as follows:

§ 54.1-2957. Licensure and practice of advanced practice registered nurses.

A. As used in this section, "clinical experience" means the postgraduate delivery of health care directly to patients pursuant to a practice agreement with a patient care team physician.

B. The Board of Medicine and the Board of Nursing shall jointly prescribe the regulations governing the licensure of advanced practice registered nurses. It is unlawful for a person to practice as an advanced practice registered nurse in the Commonwealth unless he holds such a joint license.

C. Every nurse practitioner who ~~meets~~ *does not meet* the requirements of subsection I shall maintain appropriate collaboration and consultation, as evidenced in a written or electronic practice agreement, with at least one patient care team physician. A nurse practitioner who meets the requirements of subsection I may practice without a written or electronic practice agreement. A certified nurse midwife shall practice pursuant to subsection H. A clinical nurse specialist shall practice pursuant to subsection J. A certified registered nurse anesthetist shall practice under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry. An advanced practice registered nurse who is appointed as a medical examiner pursuant to § 32.1-282 shall practice in collaboration with a licensed doctor of medicine or osteopathic medicine who has been appointed to serve as a medical examiner pursuant to § 32.1-282. Collaboration and consultation among advanced practice registered nurses and patient care team physicians may be provided through telemedicine as described in § 38.2-3418.16.

Physicians on patient care teams may require that an advanced practice registered nurse be covered by a professional liability insurance policy with limits equal to the current limitation on damages set forth in § 8.01-581.15.

Service on a patient care team by a patient care team member shall not, by the existence of such service alone, establish or create liability for the actions or inactions of other team members.

D. The Boards of Medicine and Nursing shall jointly promulgate regulations specifying collaboration and consultation among physicians and advanced practice registered nurses working as part of patient care teams that shall include the development of, and periodic review and revision of, a written or electronic practice agreement; guidelines for availability and ongoing communications that define consultation among the collaborating parties and the patient; and periodic joint evaluation of the services delivered. Practice agreements shall include provisions for (i) periodic review of health records, which may include visits to the site where health care is delivered, in the manner and at the frequency determined by the advanced practice registered nurse and the patient care team physician and (ii) input from appropriate health care providers in complex clinical cases and patient emergencies and for referrals. Evidence of a practice agreement shall be maintained by an advanced practice registered nurse and provided to the Boards upon request. For advanced practice registered nurses providing care to patients within a hospital or health care system, the practice agreement may be included as part of documents delineating the advanced practice registered nurse's clinical privileges or the electronic or written delineation of duties and responsibilities in collaboration and consultation with a patient care team physician.

E. The Boards of Medicine and Nursing may issue a license by endorsement to an applicant to practice as an advanced practice registered nurse if the applicant has been licensed as an advanced practice registered nurse under the laws of another state and, pursuant to regulations of the Boards, the applicant meets the qualifications for licensure required of advanced practice registered nurses in the Commonwealth. An advanced practice registered nurse to whom a license is issued by endorsement may practice without a practice agreement with a patient care team physician pursuant to subsection I if such application provides an attestation to the Boards that the applicant has completed the equivalent of at least ~~five~~ *three* years of full-time ~~clinical~~ experience, as determined by the Boards, in accordance with the laws of the state in which the nurse practitioner was licensed.

F. Pending the outcome of the next National Specialty Examination, the Boards may jointly grant temporary licensure to advanced practice registered nurses.

G. In the event a physician who is serving as a patient care team physician dies, becomes disabled, retires from active practice, surrenders his license or has it suspended or revoked by the Board, or relocates his practice such that he is no longer able to serve, *or for other good cause,* and an advanced

practice registered nurse is unable to enter into a new practice agreement with another patient care team physician, the advanced practice registered nurse may continue to practice upon notification to the designee or his alternate of the Boards and receipt of such notification. Such advanced practice registered nurse may continue to treat patients without a patient care team physician for an initial period not to exceed 60 days, provided that the advanced practice registered nurse continues to prescribe only those drugs previously authorized by the practice agreement with such physician and to have access to appropriate input from appropriate health care providers in complex clinical cases and patient emergencies and for referrals. The designee or his alternate of the Boards shall grant permission for the advanced practice registered nurse to continue practice under this subsection for another 60 days, provided that the advanced practice registered nurse provides evidence of efforts made to secure another patient care team physician and of access to physician input. *At the conclusion of the second 60-day period, provided that the advanced practice registered nurse provides evidence of the continued efforts to secure another patient care team physician and of access to physician input, the designee or his alternate of the Boards may grant permission for the advanced practice registered nurse to continue practicing under the management and leadership of a nurse practitioner licensed by the Boards of Medicine and Nursing who (i) meets the requirements of subsection I, (ii) routinely practiced with a patient population and in a practice area within the category for which the advanced practice registered nurse was certified and licensed, and (iii) has been authorized to practice without a written or electronic practice agreement for at least three years.*

H. Every certified nurse midwife shall practice in accordance with regulations adopted by the Boards and consistent with the Standards for the Practice of Midwifery set by the American College of Nurse-Midwives governing such practice. A certified nurse midwife who has practiced fewer than 1,000 hours shall practice in consultation with a certified nurse midwife who has practiced for at least two years prior to entering into the practice agreement or a licensed physician, in accordance with a practice agreement. Such practice agreement shall address the availability of the certified nurse midwife who has practiced for at least two years prior to entering into the practice agreement or the licensed physician for routine and urgent consultation on patient care. Evidence of the practice agreement shall be maintained by the certified nurse midwife and provided to the Boards upon request. A certified nurse midwife who has completed 1,000 hours of practice as a certified nurse midwife may practice without a practice agreement upon receipt by the certified nurse midwife of an attestation from the certified nurse midwife who has practiced for at least two years prior to entering into the practice agreement or the licensed physician with whom the certified nurse midwife has entered into a practice agreement stating (i) that such certified nurse midwife or licensed physician has provided consultation to the certified nurse midwife pursuant to a practice agreement meeting the requirements of this section and (ii) the period of time for which such certified nurse midwife or licensed physician practiced in collaboration and consultation with the certified nurse midwife pursuant to the practice agreement. A certified nurse midwife authorized to practice without a practice agreement shall consult and collaborate with and refer patients to such other health care providers as may be appropriate for the care of the patient.

I. A nurse practitioner who has completed the equivalent of at least ~~five~~ *three* years of full-time clinical experience, as determined by the Boards, may practice in the practice category in which he is certified and licensed without a written or electronic practice agreement upon receipt by the nurse practitioner of an attestation from *either (i)* the patient care team physician *or (ii) an attesting nurse practitioner who assumed management and leadership of a nurse practitioner pursuant to subsection G and has met the requirements of this subsection for at least three years* stating ~~(i)~~ *(a)* that the patient care team physician *or attesting nurse practitioner* has served as a patient care team physician *or attesting nurse practitioner, respectively,* on a patient care team with the nurse practitioner pursuant to a practice agreement meeting the requirements of this section and § 54.1-2957.01; ~~(ii)~~ *(b)* that while a party to such practice agreement, the patient care team physician *or attesting nurse practitioner* routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed; and ~~(iii)~~ *(c)* the period of time for which the patient care team physician *or attesting nurse practitioner* practiced with the nurse practitioner under such a practice agreement. A copy of such attestation shall be submitted to the Boards together with a fee established by the Boards. Upon receipt of such attestation and verification that a nurse practitioner satisfies the requirements of this subsection, the Boards shall issue to the nurse practitioner a new license that includes a designation indicating that the nurse practitioner is authorized to practice without a practice agreement. In the event that a nurse practitioner is unable to obtain the attestation required by this subsection, the Boards may accept other evidence demonstrating that the applicant has met the requirements of this subsection in accordance with regulations adopted by the Boards.

A nurse practitioner authorized to practice without a practice agreement pursuant to this subsection shall ~~(a)~~ *(1)* only practice within the scope of his clinical and professional training and limits of his knowledge and experience and consistent with the applicable standards of care, ~~(b)~~ *(2)* consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided, and ~~(c)~~ *(3)* establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers.

J. A clinical nurse specialist licensed by the Boards of Medicine and Nursing who does not prescribe controlled substances or devices may practice in the practice category in which he is certified and licensed without a written or electronic practice agreement. Such clinical nurse specialist shall (i) only practice within the scope of his clinical and professional training and limits of his knowledge and experience and consistent with the applicable standards of care, (ii) consult and collaborate with other health care providers based on the clinical condition of the patient to whom health care is provided, and (iii) establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers.

A clinical nurse specialist licensed by the Boards who prescribes controlled substances or devices shall practice in consultation with a licensed physician in accordance with a practice agreement between the clinical nurse specialist and the licensed physician. Such practice agreement shall address the availability of the physician for routine and urgent consultation on patient care. Evidence of a practice agreement shall be maintained by a clinical nurse specialist and provided to the Boards upon request. The practice of clinical nurse specialists shall be consistent with the standards of care for the profession and with applicable laws and regulations.

2. That the Department of Health Professions (the Department) shall collect data on the implementation of this act, including the total number of applicants, the year of their initial advanced practice registered nurse licensure, the geographic area, the practice setting and patient population, and the total number of disciplinary actions of those persons licensed to practice pursuant to subsection I of § 54.1-2957 of the Code of Virginia, as amended by this act. The Department shall make this data and other pertinent data publicly available on its website.

Agenda Item: Consideration of fast-track regulatory action to remove active practice requirement for renewal of licensure

Included in your agenda package:

- Draft changes to 18VAC85-80-10 and 18VAC85-85-80-70 to remove active practice requirement for renewal of licensure

Staff Note: This requirement is unique to OT and a significant barrier to licensure. This may keep individuals coming back from medical leave, caring for family, childbirth, or other paid work from participating in the healthcare workforce. Staff recommends adopting this as a fast-track regulatory action.

Action needed:

- Motion to adopt fast-track regulatory amendments to 18VAC85-80-10 and 18VAC85-80-70 to remove the active practice requirement for renewal as an occupational therapist or occupational therapist assistant.

Draft potential changes to eliminate active practice for renewal

18VAC85-80-10. Definitions.

A. The following words and terms when used in this chapter shall have the meanings ascribed to them in § 54.1-2900 of the Code of Virginia:

"Board"

"Occupational therapy assistant"

"Practice of occupational therapy"

B. The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

"ACOTE" means the Accreditation Council for Occupational Therapy Education.

"Active practice" means a minimum of 160 hours of professional practice as an occupational therapist or an occupational therapy assistant within the 24-month period immediately preceding ~~renewal or~~ application for licensure, if previously licensed or certified in another jurisdiction. The active practice of occupational therapy may include supervisory, administrative, educational or consultative activities or responsibilities for the delivery of such services.

"Advisory board" means the Advisory Board of Occupational Therapy.

"Contact hour" means 60 minutes of time spent in continued learning activity.

"NBCOT" means the National Board for Certification in Occupational Therapy, under which the national examination for certification is developed and implemented.

"National examination" means the examination prescribed by NBCOT for certification as an occupational therapist or an occupational therapy assistant and approved for licensure in Virginia.

"Occupational therapy personnel" means appropriately trained individuals who provide occupational therapy services under the supervision of a licensed occupational therapist.

18VAC85-80-70. Biennial renewal of licensure.

A. An occupational therapist or an occupational therapy assistant shall renew his license biennially during his birth month in each even-numbered year by:

1. Paying to the board the renewal fee prescribed in 18VAC85-80-26; and

2. ~~Indicating that he has been engaged in the active practice of occupational therapy as defined in 18VAC85-80-10; and~~

~~3.~~ Attesting to completion of continued competency requirements as prescribed in 18VAC85-80-71.

B. An occupational therapist or an occupational therapy assistant whose license has not been renewed by the first day of the month following the month in which renewal is required shall pay an additional fee as prescribed in 18VAC85-80-26.

Agenda Item: **Licensing Report**

Staff Note: Mr. Sobowale will provide information on note-worthy licensing matters.

Action: None anticipated.

Agenda Item: **Discipline Report**

Staff Note: Ms. Deschenes will provide information on discipline matters.

Action: None anticipated.

Agenda Item: **Approval of the DRAFT 2025 Meeting Calendar**

Staff Note: For your review.

Action: Motion to accept or recommend alternate dates.

Agenda Item: **Report of the Nominating Committee**

Staff Note: The Committee met at 7:45 a.m. to develop a slate of officers for next year.

Action: Approve the slate as presented or develop an alternate slate.

Agenda Item: **Board Member Terms**

Staff Note: Dr. Harp will acknowledge.

Action: None anticipated.

Next Meeting Date of the Full Board is

October 24-26, 2024

Please check your calendars and advise staff of any known conflicts that may affect your attendance.

The travel regulations require that "travelers must submit the Travel Expense Reimbursement Voucher **within 30 days after completion of their trip"**. (CAPP Topic 20335, State Travel Regulations, p.7). Vouchers submitted after the 30-day deadline can not be approved.

In order for the agency to be in compliance with the travel regulations, please submit your request for today's meeting on or before

July 13, 2024