COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
Department of Health Professions
Henrico, Virginia 23233

BUSINESS MEETING AGENDA
Wednesday, February 26, 2025, at 9:30 A.M.- **Board Room 2**

DHP Mission *– the mission of the Department of Health Professions is to ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public.*

Call To Order – Helen M. Parke, DNP, FNP; Board of Nursing; **Chair**

Establishment of Quorum

Public Comment

- Dissolution of the Advisory Committee to the Committee of the Joint Boards of Nursing and Medicine (see **B1** for information)

Dialogue with DHP Director – Mr. Owens

Announcements

- Many thanks to: Stuart Mackler, MD; David Ellington, MD; Kevin Brigle, PhD, NP; and Mark Coles, RN, BA, MSN, NP-C for their two terms of service on the CJB Advisory Committee.

A. Staff Report – Dr. Hills

A1 Advanced Practice Licensure & Discipline Update (distributed day of meeting)

DHP Healthcare Workforce Data Center

A2 APRN Workforce Report: 2024
A3 APRN Specialties Comparison Report: 2024

Joint Commission on Health Care

A4 Final Report - Strategies to Strengthen the Anesthesia Workforce in Virginia 2024
A5 In Brief - Strategies to Strengthen the Anesthesia Workforce in Virginia 2024

B. Discussion/Action Item

B1 Dissolution of Advisory Committee to the Committee of the Joint Boards of Nursing and Medicine

C. Legislation/Regulations - Ms. Barrett

- Chart of Regulatory Actions (distributed day of meeting)
- Report of the 2025 General Assembly (distributed day of meeting)

D. Discipline Minutes (information only)

- **D1** February 28, 2024 minutes
- **D2** April 24, 2024 minutes
- **D3** June 26, 2024 minutes
- **D4** October 23, 2024 minutes

E. New Business

Discipline Meeting today at 11:00am – see Agenda

Next Scheduled Meeting Date/Location:

Wednesday, April 23, 2025, at 9:00 A.M in Board Room 2

Adjourn

DRAFT

A2

Virginia's Licensed Advanced Practice Registered Nurse Workforce: 2024

Healthcare Workforce Data Center

October 2024

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233
804-597-4213, 804-527-4434 (fax)
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Follow us on Tumblr: www.vahwdc.tumblr.com
Get a copy of this report from:
http://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/

Nearly 8,000 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
Director

Barbara Hodgdon, PhD
Deputy Director

Rajana Siva, MBA
Data Analyst

Christopher Coyle, BA
Research Assistant

The Committee of the Joint Boards of Nursing and Medicine

Members

Delia Acuna, FNP-C
Quinton

Blanton L. Marchese
North Chesterfield

Helen M. Parke, DNP, FNP-BC
Concord

Shelly Smith, PhD, DNP, ANP-BC
Powhatan

Bo Vaughan, Jr., MD
Richmond

Ryan Williams, MD
Suffolk

Executive Director of Board of Medicine

William L. Harp, MD

Executive Director of Board of Nursing

Claire Morris, RN, LNHA

Contents

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

The Workforce

Licensees:	22,528
Virginia's Workforce:	15,790
FTEs:	13,446

Survey Response Rate

All Licensees:	35%
Renewing Practitioners:	91%

Demographics

Female:	90%
Diversity Index:	47%
Median Age:	44

Background

Rural Childhood:	33%
HS Degree in VA:	43%
Prof. Degree in VA:	50%

Education

Master's Degree:	74%
Post-Masters Cert.:	8%

Finances

Median Inc.:	$120k or More
Health Benefits:	64%
Under 40 w/ Ed. Debt:	63%

Current Employment

Employed in Prof.:	96%
Hold 1 Full-Time Job:	63%
Satisfied?:	95%

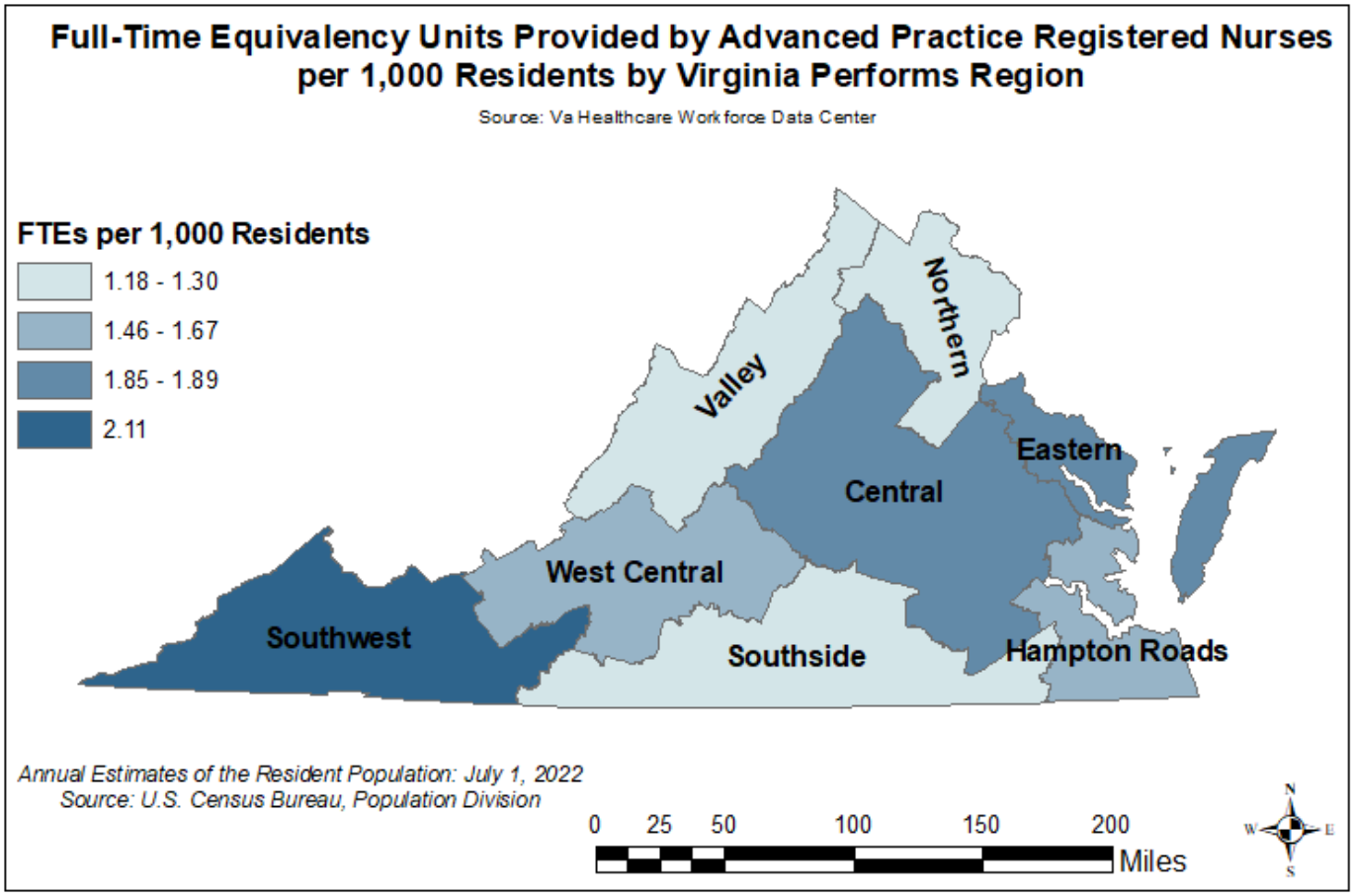
Job Turnover

Switched Jobs:	8%
Employed Over 2 Yrs.:	53%

Time Allocation

Patient Care:	90%-99%
Patient Care Role:	86%
Admin. Role:	3%

Source: Va. Healthcare Workforce Data Center



Results in Brief

This report contains the results of the 2024 Advanced Practice Registered Nurse (APRN) survey. In total, 7,934 APRNs voluntarily participated in this survey. 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 APRNs have access to the survey in a given year. These survey respondents represent 35% of the 22,528 APRNs who are licensed in the state and 91% of renewing practitioners.

The HWDC estimates that 15,790 APRNs participated in Virginia's workforce during the survey period, which is defined as those APRNs 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. Virginia's APRN workforce provided 13,446 "full-time equivalency units," which the HWDC defines simply as working 2,000 hours per year (or 40 hours per week for 50 weeks with 2 weeks of vacation).

Nine out of every ten APRNs are female, and the median age of this workforce is 44. In a random encounter between two APRNs, there is a 47% chance that they would be of different races or ethnicities, a measure known as the diversity index. This diversity index increases to 48% for APRNs who are under the age of 40. For Virginia's overall population, the comparable diversity index is 60%. One-third of all APRNs grew up in a rural area, and 23% of APRNs who grew up in a rural area currently work in a non-metro area of Virginia. In total, 11% of all APRNs work in a non-metro area of the state. More than half of Virginia's APRN workforce have some educational background in the state.

Among all APRNs, 96% are employed in the profession, 63% hold one full-time job, and 49% work between 40 and 49 hours per week. More than half of all APRNs work in the for-profit sector, while another 34% work in the non-profit sector. The median annual income of Virginia's APRN workforce is greater than $120,000 per year, and 88% receive this income as either a salary or an hourly wage. In addition, 83% of wage or salaried APRNs receive at least one employer-sponsored benefit, including 64% who have access to health insurance. Among all APRNs, 95% indicated that they are satisfied with their current work situation, including 64% who indicated that they are "very satisfied".

Summary of Trends

In this section, all statistics for the current year are compared to the 2014 APRN workforce.[1] The number of licensed APRNs in Virginia has increased by 191% (22,528 vs. 7,741). At the same time, the size of Virginia's APRN workforce has increased by 151% (15,790 vs. 6,302), and the number of FTEs provided by this workforce has increased by 133% (13,446 vs. 5,777). Virginia's renewing APRNs are more likely to respond to this survey (91% vs. 79%).

While there has been no change in the percentage of all APRNs who are female (90%), the median age of this workforce has fallen (44 vs. 48). The diversity index of this workforce has increased (47% vs. 28%), and this is also the case among those APRNs who are under the age of 40 (48% vs. 34%). APRNs are more likely to have grown up in a rural area (33% vs. 31%), and APRNs who grew up in a rural area are more likely to currently work in a non-metro area of Virginia (23% vs. 20%). The percentage of all APRNs who work in a non-metro area of the state has risen as well (11% vs. 10%). APRNs are more likely to carry education debt (51% vs. 40%), and the median outstanding balance among APRNs who carry education debt has increased ($60k-$70k vs. $40k-$50k).

The median annual income of Virginia's APRN workforce has increased ($120k or more vs. $90k-$100k), and APRNs are more likely to receive this income as a salary (66% vs. 61%) than as an hourly wage (23% vs. 32%). However, wage and salaried APRNs are slightly less likely to receive at least one employer-sponsored benefit (83% vs. 84%), including those APRNs who have access to health insurance (64% vs. 66%). While there has been no change in the percentage of all APRNs who indicated that they are satisfied with their current work situation (95%), the percentage who indicated that they are "very satisfied" has fallen (64% vs. 66%).

[1] See the "Results in Brief" and "Summary of Trends" sections of the 2023 APRN report for details of the policy changes in the APRN workforce over the past seven years.

A Closer Look:

Licensees		
License Status	**#**	**%**
Renewing Practitioners	8,183	36%
New Licensees	3,028	13%
Non-Renewals	1,095	5%
Renewal Date Not in Survey Period	9,999	44%
All Licensees	**22,528**	**100%**

Source: Va. Healthcare Workforce Data Center

Our surveys tend to achieve very high response rates. Among all renewing APRNs, 91% voluntarily submitted a survey. These represent 35% of the 22,528 APRNs who held a license at some point during the licensing period.

Response Rates			
Statistic	**Non Respondents**	**Respondents**	**Response Rate**
By Age			
Under 30	443	90	17%
30 to 34	1,735	913	35%
35 to 39	2,956	1,205	29%
40 to 44	2,323	1,552	40%
45 to 49	2,169	996	32%
50 to 54	1,620	1,134	41%
55 to 59	1,264	671	35%
60 and Over	2,084	1,373	40%
Total	**14,594**	**7,934**	**35%**
New Licenses			
Issued in Past Year	2,871	157	5%
Metro Status			
Non-Metro	1,003	670	40%
Metro	7,260	5,017	41%
Not in Virginia	6,330	2,247	26%

Source: Va. Healthcare Workforce Data Center

Definitions

1. **The Survey Period:** The survey was conducted between October 2023 and September 2024 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 some APRNs newly licensed during the survey time frame.

Response Rates	
Completed Surveys	**7,934**
Response Rate, All Licensees	**35%**
Response Rate, Renewals	**91%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed APRNs

Number:	22,528
New:	13%
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:	15,790
FTEs:	13,446

Utilization Ratios

Licensees in VA Workforce:	70%
Licensees per FTE:	1.68
Workers per FTE:	1.17

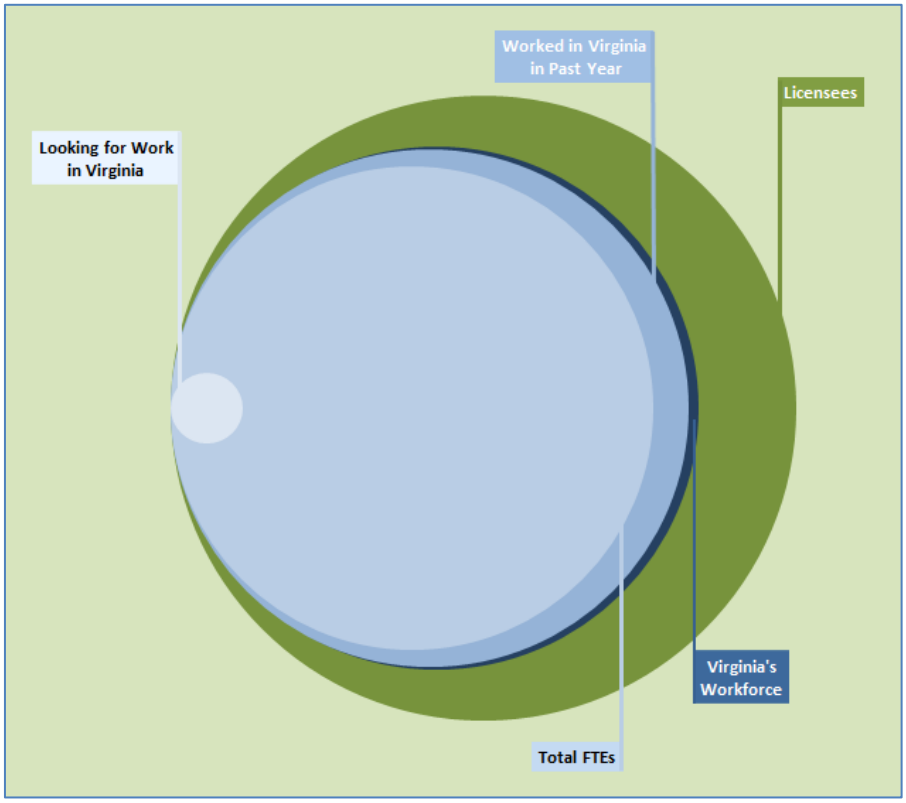
Source: Va. Healthcare Workforce Data Center

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	15,492	98%
Looking for Work in Virginia	298	2%
Virginia's Workforce	**15,790**	**100%**
Total FTEs	**13,446**	
Licensees	**22,528**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Weighting is used to estimate the figures in this report. Unless otherwise noted, figures refer to the Virginia Workforce only. For more information on the HWDC's methodology, visit: https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 30	32	8%	380	92%	412	3%
30 to 34	136	8%	1,532	92%	1,668	13%
35 to 39	204	9%	2,181	92%	2,385	18%
40 to 44	247	12%	1,863	88%	2,111	16%
45 to 49	190	11%	1,562	89%	1,751	14%
50 to 54	190	12%	1,348	88%	1,539	12%
55 to 59	129	12%	953	88%	1,082	8%
60 and Over	214	11%	1,749	89%	1,964	15%
Total	**1,342**	**10%**	**11,569**	**90%**	**12,911**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

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

Age

Median Age:	44
% Under 40:	35%
% 55 and Over:	24%

Diversity

Diversity Index:	47%
Under 40 Div. Index:	48%

Source: Va. Healthcare Workforce Data Center

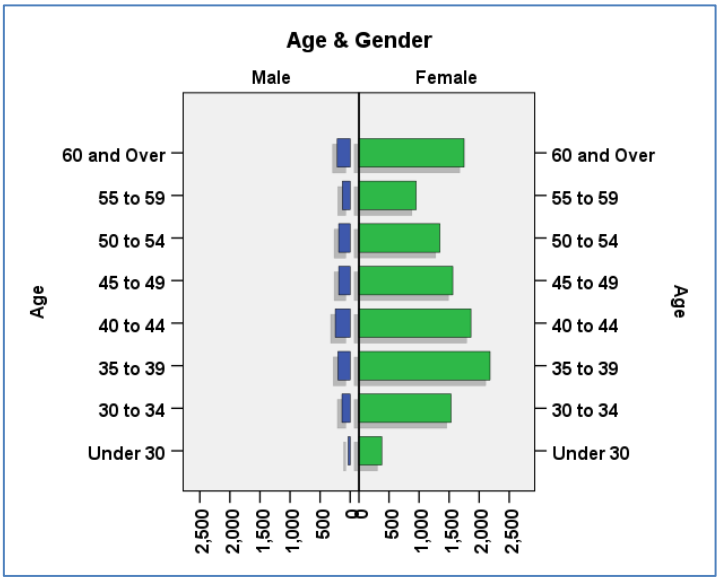
Race & Ethnicity					
Race/ Ethnicity	Virginia*	APRNs		APRNs Under 40	
	%	#	%	#	%
White	59%	9,151	70%	3,155	70%
Black	18%	2,068	16%	596	13%
Asian	7%	827	6%	340	8%
Other Race	1%	111	1%	32	1%
Two or More Races	5%	312	2%	116	3%
Hispanic	10%	512	4%	239	5%
Total	**100%**	**12,981**	**100%**	**4,478**	**100%**

*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

In a chance encounter between two APRNs, there is a 47% chance that they would be of different races or ethnicities (a measure known as the Diversity Index), compared to a 60% chance for Virginia's population as a whole.

More than one-third of all APRNs are under the age of 40. Among APRNs who are under the age of 40, 92% are female. In addition, the diversity index among APRNs who are under the age of 40 is 48%.



Source: Va. Healthcare Workforce Data Center

At a Glance:

Childhood

Urban Childhood:	14%
Rural Childhood:	33%

Virginia Background

HS in Virginia:	43%
Prof. Ed. in VA:	50%
HS or Prof. Ed. in VA:	55%
Initial APRN Degree in VA:	50%

Location Choice

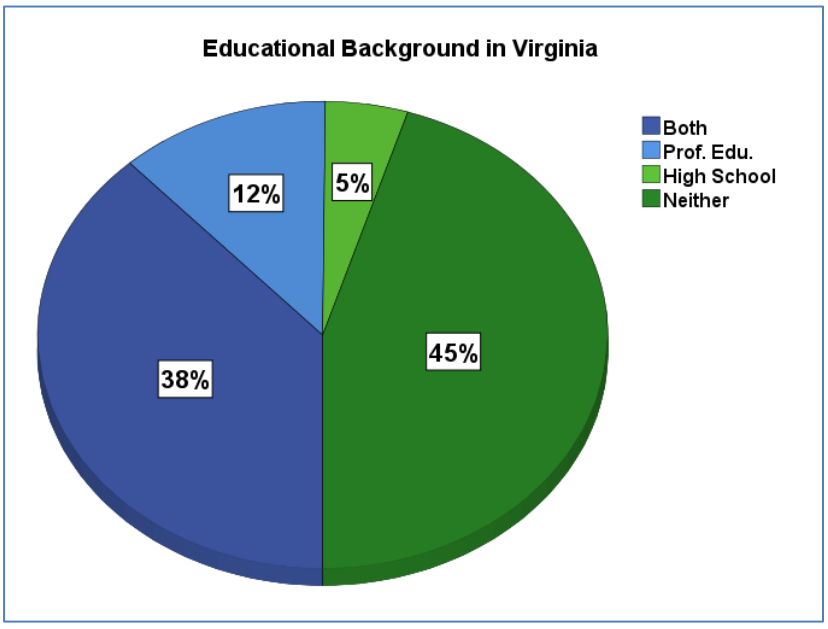
% Rural to Non-Metro:	23%
% Urban/Suburban to Non-Metro:	5%

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+	22%	61%	17%
2	Metro, 250,000 to 1 Million	50%	42%	8%
3	Metro, 250,000 or Less	43%	48%	9%
	Non-Metro Counties			
4	Urban, Pop. 20,000+, Metro Adjacent	67%	22%	10%
6	Urban, Pop. 2,500-19,999, Metro Adjacent	66%	29%	6%
7	Urban, Pop. 2,500-19,999, Non-Adjacent	83%	12%	5%
8	Rural, Metro Adjacent	57%	31%	12%
9	Rural, Non-Adjacent	49%	37%	15%
	Overall	**33%**	**53%**	**14%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

One-third of all APRNs grew up in self-described rural areas, and 23% 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 Advanced Practical Registered Nurse Recruitment

Rank	All APRNs					
	High School	#	Init. Prof Degree	#	Init. APRN Degree	#
1	Virginia	5,501	Virginia	6,379	Virginia	6,318
2	Outside U.S./Canada	1,141	Pennsylvania	497	Washington, D.C.	764
3	New York	547	New York	496	Tennessee	616
4	Pennsylvania	518	Maryland	469	Pennsylvania	467
5	Maryland	481	Tennessee	467	North Carolina	453
6	North Carolina	433	North Carolina	456	Maryland	373
7	Florida	393	Florida	414	Minnesota	329
8	Tennessee	294	West Virginia	277	Illinois	308
9	Ohio	274	Washington, D.C.	265	Florida	297
10	West Virginia	259	Ohio	264	New York	273

Source: Va. Healthcare Workforce Data Center

Rank	Licensed in the Past Five Years					
	High School	#	Init. Prof Degree	#	Init. APRN Degree	#
1	Virginia	2,534	Virginia	3,037	Virginia	2,841
2	Outside U.S./Canada	740	Maryland	307	Washington, D.C.	317
3	Maryland	254	Florida	271	Tennessee	313
4	Florida	246	North Carolina	252	Pennsylvania	241
5	North Carolina	239	Tennessee	211	Minnesota	240
6	New York	222	Pennsylvania	204	Illinois	237
7	Pennsylvania	217	New York	198	North Carolina	233
8	Tennessee	171	Texas	168	Florida	200
9	Texas	156	Ohio	166	Maryland	188
10	Ohio	145	Outside U.S./Canada	155	Texas	139

Source: Va. Healthcare Workforce Data Center

Among all licensees, 30% did not participate in Virginia's APRN workforce during the past year. Among licensees who did not participate in Virginia's APRN workforce, 96% worked at some point in the past year, including 94% who worked in a nursing-related capacity.

At a Glance:

Not in VA Workforce

Total:	6,725
% of Licensees:	30%
Federal/Military:	8%
Va. Border State/DC:	18%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Degree		
Degree	**#**	**%**
NP Certificate	182	1%
Master's Degree	9,335	74%
Post-Masters Cert.	994	8%
Doctorate of NP	1,632	13%
Other Doctorate	551	4%
Post-PhD Cert.	4	<1%
Total	**12,698**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

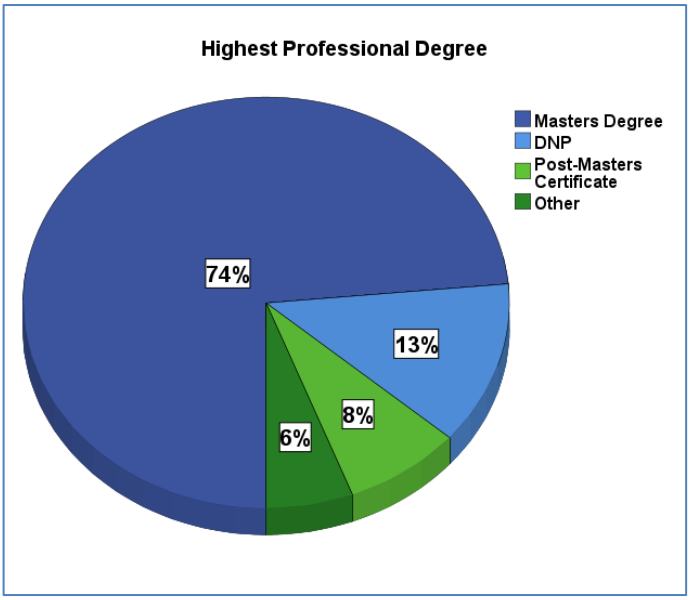
Education

Master's Degree: 74%
Post-Masters Cert.: 8%

Education Debt

Carry Debt: 51%
Under Age 40 w/ Debt: 63%
Median Debt: $60k-$70k

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Among all APRNs, 74% have a Master's degree as their highest professional degree. More than half of all APRNs carry education debt, including 63% of those APRNs who are under the age of 40. The median outstanding balance among those APRNs with education debt is between $60,000 and $70,000.

Education Debt				
Amount Carried	**All APRNs**		**APRNs Under 40**	
	#	**%**	**#**	**%**
None	5,609	49%	1,452	37%
Less than $30,000	1,071	9%	480	12%
$30,000-$39,999	385	3%	190	5%
$40,000-$49,999	492	4%	223	6%
$50,000-$59,999	536	5%	242	6%
$60,000-$69,999	445	4%	199	5%
$70,000-$79,999	349	3%	161	4%
$80,000-$89,999	368	3%	179	5%
$90,000-$99,999	260	2%	84	2%
$100,000-$109,999	449	4%	170	4%
$110,000-$119,999	194	2%	61	2%
$120,000 or More	1,204	11%	480	12%
Total	**11,362**	**100%**	**3,921**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Primary Specialty

Family Health: 26%
RN Anesthetist: 13%
Psychiatric/ Mental Health: 11%

Credentials

AANPCP – Family NP: 22%
ANCC – Family NP: 18%
ANCC – Family Psychiatric-Mental Health NP: 5%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Primary Specialties		
Specialty	**#**	**%**
Family Health	3,278	26%
Certified Registered Nurse Anesthetist	1,609	13%
Psychiatric/Mental Health	1,328	11%
Acute Care/Emergency Room	1,077	9%
Adult Health	832	7%
Pediatrics	742	6%
OB/GYN - Women's Health	486	4%
Geriatrics/Gerontology	408	3%
Surgical	406	3%
Certified Nurse Midwife	208	2%
Certified Nurse Specialist	109	1%
Other Specialty Area	1,668	13%
Medical Specialties (Not Listed)	315	3%
Total	**12,464**	**100%**

Source: Va. Healthcare Workforce Data Center

Credentials		
Credential	**#**	**% of Workforce**
AANPCP: Family NP (FNP-C)	3,444	22%
ANCC: Family NP (FNP-BC)	2,914	18%
ANCC: Family Psychiatric-Mental Health NP (PMHNP-BC)	744	5%
ANCC: Adult-Gerontology Acute Care NP (AGACNP-BC)	714	5%
ANCC: Adult Psychiatric-Mental Health NP (PMHNP-BC)	668	4%
NCC: Women's Health Care NP (WHNP-BC)	349	2%
ANCC: Acute Care NP (ACNP-BC)	344	2%
AANPCP: Adult-Gerontology Primary Care NP (A-GNP-C)	342	2%
ANCC: Adult NP (ANP-BC)	331	2%
ANCC: Adult-Gerontology Primary Care NP (AGPCNP-BC)	275	2%
ANCC: Pediatric NP (PNP-BC)	229	1%
NCC: Neonatal NP (NNP-BC)	165	1%
All Other Credentials	174	1%
At Least One Credential	**9,827**	**62%**

Source: Va. Healthcare Workforce Data Center

Among all APRNs, 26% have a primary specialty in family health, while another 13% have a primary specialty as a Certified RN Anesthetist. In addition, 62% of APRNs hold at least one credential, including 22% who are credentialed as an AANPCP: Family NP (FNP-C).

At a Glance:

Employment

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

Positions Held

1 Full-Time: 63%
2 or More Positions: 20%

Weekly Hours:

40 to 49: 49%
60 or More: 6%
Less than 30: 10%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Current Work Status		
Status	**#**	**%**
Employed, Capacity Unknown	5	<1%
Employed in a Nursing-Related Capacity	12,197	96%
Employed, NOT in a Nursing-Related Capacity	93	1%
Not Working, Reason Unknown	0	0%
Involuntarily Unemployed	24	<1%
Voluntarily Unemployed	309	2%
Retired	142	1%
Total	**12,769**	**100%**

Source: Va. Healthcare Workforce Data Center

Among all APRNs, 96% are currently employed in the profession, 63% hold one full-time job, and 49% work between 40 and 49 hours per week.

Current Weekly Hours		
Hours	**#**	**%**
0 Hours	475	4%
1 to 9 Hours	150	1%
10 to 19 Hours	310	2%
20 to 29 Hours	812	7%
30 to 39 Hours	2,654	21%
40 to 49 Hours	6,161	49%
50 to 59 Hours	1,174	9%
60 to 69 Hours	450	4%
70 to 79 Hours	120	1%
80 or More Hours	161	1%
Total	**12,467**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Positions		
Positions	**#**	**%**
No Positions	475	4%
One Part-Time Position	1,627	13%
Two Part-Time Positions	461	4%
One Full-Time Position	7,966	63%
One Full-Time Position & One Part-Time Position	1,684	13%
Two Full-Time Positions	56	<1%
More than Two Positions	302	2%
Total	**12,571**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Annual Income		
Income Level	**#**	**%**
Volunteer Work Only	66	1%
Less than $80,000	1,113	11%
$80,000-$89,999	533	5%
$90,000-$99,999	603	6%
$100,000-$109,999	1,129	12%
$110,000-$119,999	1,181	12%
$120,000 or More	5,161	53%
Total	**9,786**	**100%**

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	**#**	**%**
Very Satisfied	8,003	64%
Somewhat Satisfied	3,816	31%
Somewhat Dissatisfied	533	4%
Very Dissatisfied	113	1%
Total	**12,465**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Earnings

Median Income: > $120k

Benefits

(Wage/Salary Employees)

Retirement: 73%

Health Insurance: 64%

Satisfaction

Satisfied: 95%

Very Satisfied: 64%

Source: Va. Healthcare Workforce Data Center

The typical APRN has an annual income of more than $120,000. Among APRNs who receive either an hourly wage or a salary as compensation at their primary work location, 73% have access to a retirement plan and 64% receive health insurance.

Employer-Sponsored Benefits*			
Benefit	**#**	**%**	**% of Wage/Salary Employees**
Retirement	8,086	66%	73%
Paid Leave	7,820	64%	70%
Health Insurance	7,105	58%	64%
Dental Insurance	6,941	57%	63%
Group Life Insurance	5,506	45%	50%
Signing/Retention Bonus	2,316	19%	22%
At Least One Benefit	**9,265**	**76%**	**83%**

*From any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Employment Instability in the Past Year		
In the Past Year, Did You . . .?	**#**	**%**
Experience Involuntary Unemployment?	114	1%
Experience Voluntary Unemployment?	707	4%
Work Part-Time or Temporary Positions, but Would Have Preferred a Full-Time/Permanent Position?	322	2%
Work Two or More Positions at the Same Time?	2,885	18%
Switch Employers or Practices?	1,200	8%
Experience at Least One?	**4,489**	**28%**

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.[2]

At a Glance:

Unemployment Experience

Involuntarily Unemployed: 1%
Underemployed: 2%

Turnover & Tenure

Switched Jobs: 8%
New Location: 29%
Over 2 Years: 53%
Over 2 Yrs., 2nd Location: 40%

Employment Type

Salary: 66%
Hourly Wage: 23%

Source: Va. Healthcare Workforce Data Center

Location Tenure				
Tenure	**Primary**		**Secondary**	
	#	**%**	**#**	**%**
Not Currently Working at This Location	233	2%	188	6%
Less than 6 Months	1,071	9%	476	15%
6 Months to 1 Year	1,492	12%	495	15%
1 to 2 Years	2,944	24%	746	23%
3 to 5 Years	2,824	23%	683	21%
6 to 10 Years	1,766	15%	310	10%
More than 10 Years	1,801	15%	300	9%
Subtotal	**12,131**	**100%**	**3,197**	**100%**
Did Not Have Location	330		12,553	
Item Missing	3,328		39	
Total	**15,790**		**15,790**	

Source: Va. Healthcare Workforce Data Center

More than half of all APRNs have worked at their primary work location for more than two years.

Two-thirds of all APRNs receive a salary at their primary work location, while 23% receive an hourly wage.

Employment Type		
Primary Work Site	**#**	**%**
Salary/Commission	6,132	66%
Hourly Wage	2,104	23%
By Contract	667	7%
Business/Practice Income	366	4%
Unpaid	50	1%
Subtotal	**9,318**	**100%**
Missing Location	330	
Item Missing	6,141	

Source: Va. Healthcare Workforce Data Center

[2] 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 2.3% and a high of 3.5%. At the time of publication, the unemployment rate for August 2024 was still preliminary, and the unemployment rate for September 2024 had not yet been released.

At a Glance:

Concentration

Top Region:	28%
Top 3 Regions:	70%
Lowest Region:	2%

Locations

2 or More (Past Year):	26%
2 or More (Now*):	24%

Source: Va. Healthcare Workforce Data Center

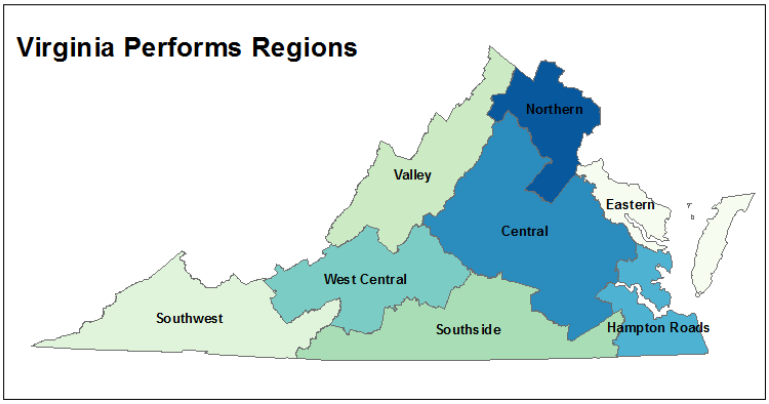
Seven out of every ten APRNs work in Northern Virginia, Central Virginia, or Hampton Roads.

A Closer Look:

Regional Distribution of Work Locations

Virginia Performs Region	Primary Location		Secondary Location	
	#	%	#	%
Central	2,925	24%	601	19%
Eastern	244	2%	66	2%
Hampton Roads	2,228	18%	520	16%
Northern	3,350	28%	828	26%
Southside	431	4%	94	3%
Southwest	759	6%	187	6%
Valley	638	5%	167	5%
West Central	1,124	9%	263	8%
Virginia Border State/D.C.	147	1%	124	4%
Other U.S. State	243	2%	332	10%
Outside of the U.S.	7	<1%	11	<1%
Total	**12,096**	**100%**	**3,193**	**100%**
Item Missing	3,362		43	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Number of Work Locations

Locations	Work Locations in Past Year		Work Locations Now*	
	#	%	#	%
0	298	2%	464	4%
1	8,871	72%	8,892	72%
2	1,907	15%	1,918	16%
3	973	8%	869	7%
4	150	1%	111	1%
5	63	1%	47	<1%
6 or More	126	1%	87	1%
Total	**12,388**	**100%**	**12,388**	**100%**

*At the time of survey completion (Oct. 2023 - Sept. 2024, birth month of respondent).

Source: Va. Healthcare Workforce Data Center

Among all APRNs, 24% currently have multiple work locations, while 26% have had multiple work locations over the past year.

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	6,071	53%	1,994	66%
Non-Profit	3,926	34%	758	25%
State/Local Government	811	7%	178	6%
Veterans Administration	281	2%	26	1%
U.S. Military	217	2%	35	1%
Other Federal Government	132	1%	32	1%
Total	**11,438**	**100%**	**3,023**	**100%**
Did Not Have Location	330		12,553	
Item Missing	4,020		212	

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Sector

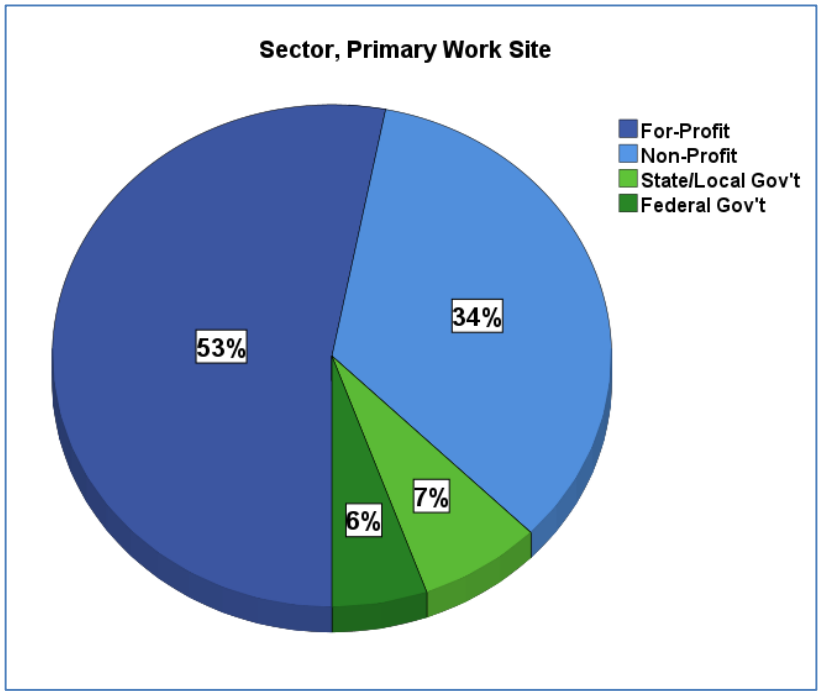
For Profit: 53%
Federal: 6%

Top Establishments

Clinic, Primary Care: 19%
Hospital, Inpatient: 19%
Academic Institution: 7%

Source: Va. Healthcare Workforce Data Center

Nearly nine out of every ten APRNs work in the private sector, including 53% who work in for-profit establishments. Meanwhile, 7% of APRNs work for state or local governments, and 6% work for the federal government.



Source: Va. Healthcare Workforce Data Center

Electronic Health Records (EHRs) and Telehealth		
Activity	#	% of Workforce
Meaningful Use of EHRs	4,175	26%
Remote Health, Caring for Patients in Virginia	3,946	25%
Remote Health, Caring for Patients Outside of Virginia	1,047	7%
Use at Least One	**6,228**	**39%**

Source: Va. Healthcare Workforce Data Center

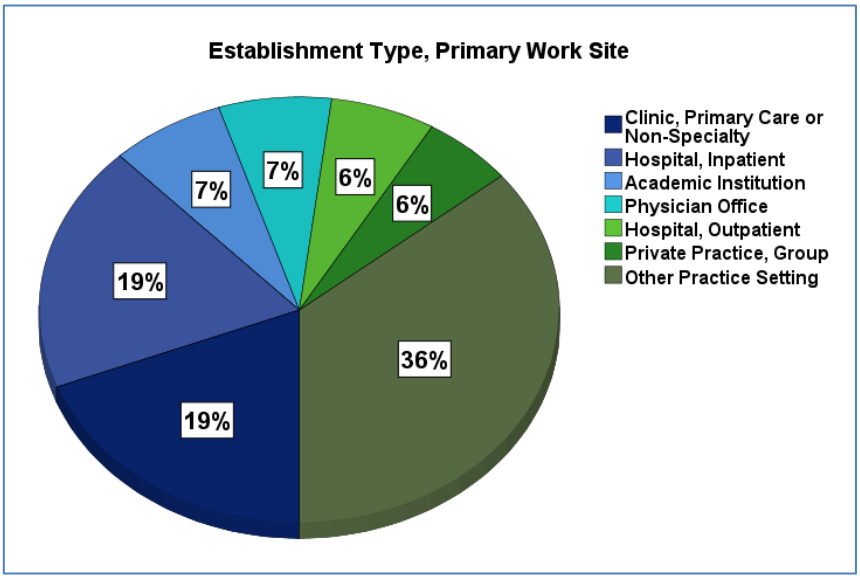
More than one-quarter of the state's APRN workforce use EHRs. One out of every four APRNs also provide remote health care for Virginia patients.

Location Type				
Establishment Type	Primary Location		Secondary Location	
	#	%	#	%
Clinic, Primary Care or Non-Specialty (e.g., FQHC, Retail or Free Clinic)	2,127	19%	443	15%
Hospital, Inpatient Department	2,124	19%	462	16%
Academic Institution (Teaching or Research)	786	7%	172	6%
Physician Office	761	7%	119	4%
Hospital, Outpatient Department	719	6%	132	5%
Private Practice, Group	646	6%	127	4%
Mental Health, or Substance Abuse, Outpatient Center	562	5%	154	5%
Clinic, Non-Surgical Specialty (e.g., Dialysis, Diagnostic, Infusion, Blood)	515	5%	98	3%
Ambulatory/Outpatient Surgical Unit	501	4%	183	6%
Other Practice Setting	2,529	22%	1,040	35%
Total	**11,270**	**100%**	**2,930**	**100%**
Did Not Have Location	330		12,553	

Source: Va. Healthcare Workforce Data Center

Nearly two out of every five APRNs work in either a primary care/non-specialty clinic or the inpatient department of a hospital.

Among those APRNs who also have a secondary work location, nearly one-third work in either the inpatient department of a hospital or a primary care/non-specialty clinic.



Source: Va. Healthcare Workforce Data Center

Accepted Forms of Payment		
Payment	#	% of Workforce
Private Insurance	8,972	57%
Medicaid	8,331	53%
Medicare	8,214	52%
Cash/Self-Pay	7,850	50%

Source: Va. Healthcare Workforce Data Center

Private insurance is the most commonly accepted form of payment among Virginia's APRNs.

At a Glance:
(Primary Locations)

Languages Offered

Spanish:	30%
French:	17%
Chinese:	17%

Means of Communication

Virtual Translation:	71%
Onsite Translation:	28%
Other Staff Member:	26%

Source: Va. Healthcare Workforce Data Center

Among all APRNs, 30% are employed at a primary work location that offers Spanish language services for patients.

A Closer Look:

Languages Offered		
Language	**#**	**% of Workforce**
Spanish	4,804	30%
French	2,755	17%
Chinese	2,725	17%
Arabic	2,717	17%
Korean	2,639	17%
Vietnamese	2,543	16%
Hindi	2,472	16%
Tagalog/Filipino	2,413	15%
Persian	2,236	14%
Urdu	2,159	14%
Amharic, Somali, or Other Afro-Asiatic Languages	2,070	13%
Pashto	2,013	13%
Others	1,133	7%
At Least One Language	**5,725**	**36%**

Source: Va. Healthcare Workforce Data Center

Means of Language Communication		
Provision	**#**	**% of Workforce with Language Services**
Virtual Translation Services	4,073	71%
Onsite Translation Service	1,615	28%
Other Staff Member is Proficient	1,515	26%
Respondent is Proficient	989	17%
Other	141	2%

Source: Va. Healthcare Workforce Data Center

Among APRNs who are employed at a primary work location that offers language services for patients, 71% offer these services by means of a virtual translation service.

At a Glance:
(Primary Locations)

Typical Time Allocation

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

Roles

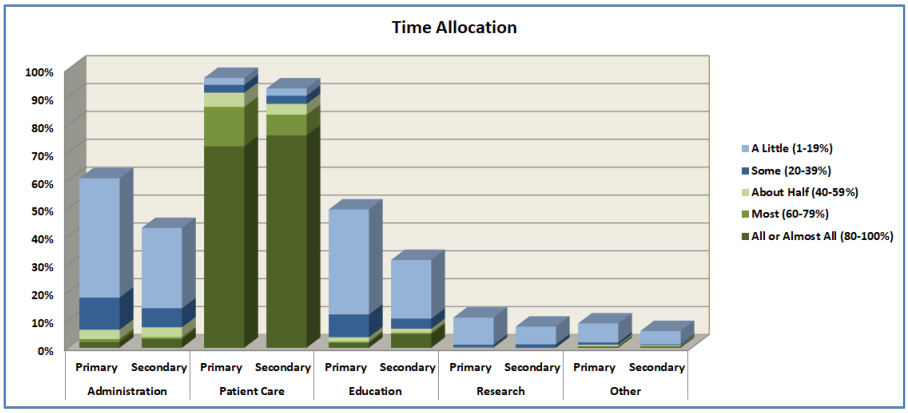
Patient Care:	86%
Administration:	3%
Education:	2%

Patient Care APRNs

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

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

APRNs typically spend most of their time on patient care activities. In fact, 86% 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	
	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site
All or Almost All (80-100%)	2%	3%	72%	76%	2%	5%	0%	0%	0%	0%
Most (60-79%)	1%	1%	14%	7%	0%	1%	0%	0%	0%	0%
About Half (40-59%)	3%	4%	5%	4%	2%	1%	0%	0%	1%	0%
Some (20-39%)	12%	7%	3%	3%	8%	4%	1%	1%	1%	0%
A Little (1-19%)	43%	29%	2%	3%	38%	21%	10%	6%	7%	5%
None (0%)	39%	57%	3%	7%	50%	68%	89%	92%	91%	94%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All APRNs		APRNs 50 and Over	
	#	%	#	%
Under Age 50	160	2%	0	0%
50 to 54	402	4%	20	1%
55 to 59	1,052	10%	181	5%
60 to 64	2,638	25%	730	19%
65 to 69	3,915	37%	1,555	42%
70 to 74	1,475	14%	771	21%
75 to 79	323	3%	193	5%
80 or Over	135	1%	77	2%
I Do Not Intend to Retire	562	5%	218	6%
Total	10,662	100%	3,745	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All APRNs

Under 65: 40%
Under 60: 15%

APRNs 50 and Over

Under 65: 25%
Under 60: 5%

Time Until Retirement

Within 2 Years: 5%
Within 10 Years: 19%
Half the Workforce: By 2049

Source: Va. Healthcare Workforce Data Center

Among all APRNs, 40% expect to retire by the age of 65. Among APRNs who are age 50 and over, 25% expect to retire by the age of 65.

Within the next two years, 11% of APRNs expect to increase patient care hours, and 10% expect to pursue additional educational opportunities.

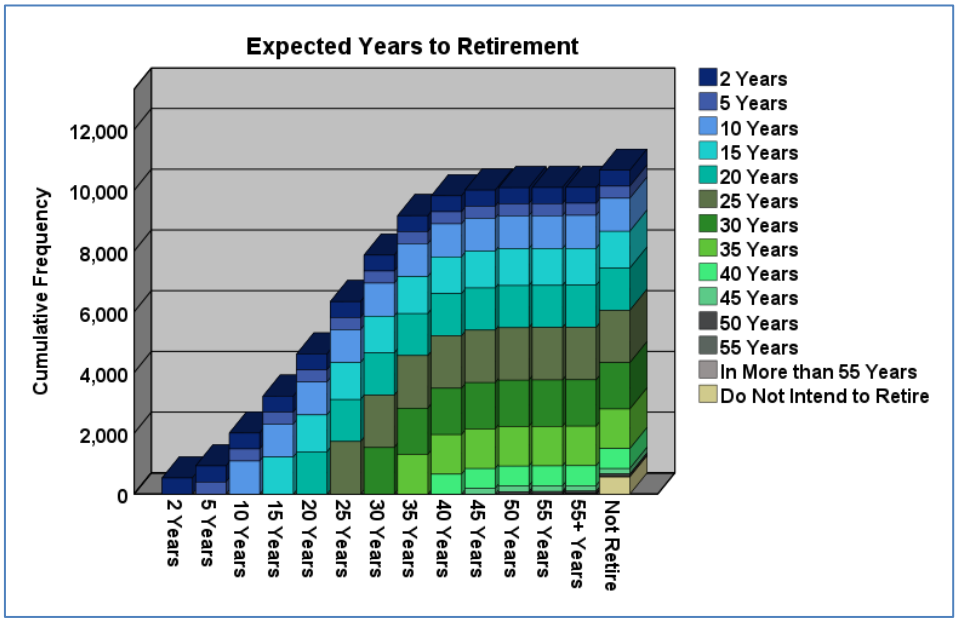
Future Plans		
Two-Year Plans:	#	%
Decrease Participation		
Leave Profession	97	1%
Leave Virginia	387	2%
Decrease Patient Care Hours	1,314	8%
Decrease Teaching Hours	106	1%
Increase Participation		
Increase Patient Care Hours	1,675	11%
Increase Teaching Hours	1,447	9%
Pursue Additional Education	1,559	10%
Return to Virginia's Workforce	152	1%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for APRNs. While 5% of APRNs expect to retire in the next two years, 19% expect to retire in the next ten years. More than half of the current APRN workforce expect to retire by 2049.

Time to Retirement			
Expect to Retire Within. . .	#	%	Cumulative %
2 Years	525	5%	5%
5 Years	398	4%	9%
10 Years	1,085	10%	19%
15 Years	1,216	11%	30%
20 Years	1,388	13%	43%
25 Years	1,726	16%	59%
30 Years	1,527	14%	74%
35 Years	1,303	12%	86%
40 Years	652	6%	92%
45 Years	186	2%	94%
50 Years	80	1%	95%
55 Years	5	<1%	95%
In More than 55 Years	8	<1%	95%
Do Not Intend to Retire	562	5%	100%
Total	**10,662**	**100%**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Using these estimates, retirement will begin to reach 10% of the current workforce every five years by 2034. Retirement will peak at 16% of the current workforce around 2049 before declining to under 10% of the current workforce again around 2064.

At a Glance:

FTEs

Total: 13,446
FTEs/1,000 Residents[3]: 1.55
Average: 0.87

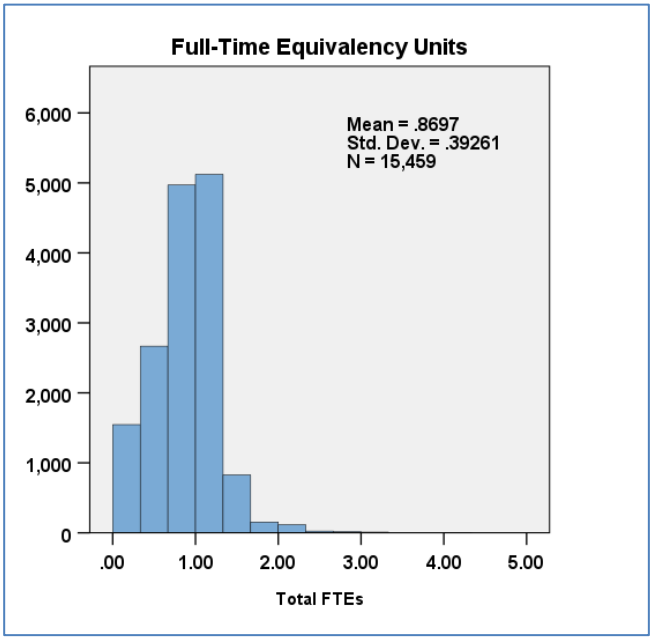
Age & Gender Effect

Age, *Partial Eta*^{2}: Small
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:

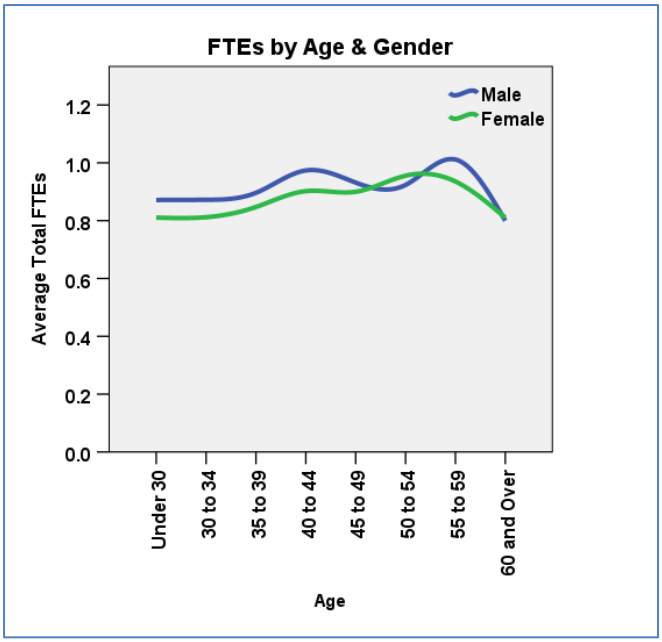


Source: Va. Healthcare Workforce Data Center

The typical (median) APRN provided 0.92 FTEs, or approximately 37 hours per week for 50 weeks. Although FTEs appear to vary by age and gender, statistical tests did not verify a difference exists.[4]

Full-Time Equivalency Units		
Age	**Average**	**Median**
Under 30	0.82	0.86
30 to 34	0.80	0.80
35 to 39	0.89	1.01
40 to 44	0.90	0.88
45 to 49	0.82	0.87
50 to 54	0.99	1.08
55 to 59	0.94	0.92
60 and Over	0.77	0.68
Gender		
Male	0.91	0.96
Female	0.87	0.93

Source: Va. Healthcare Workforce Data Center

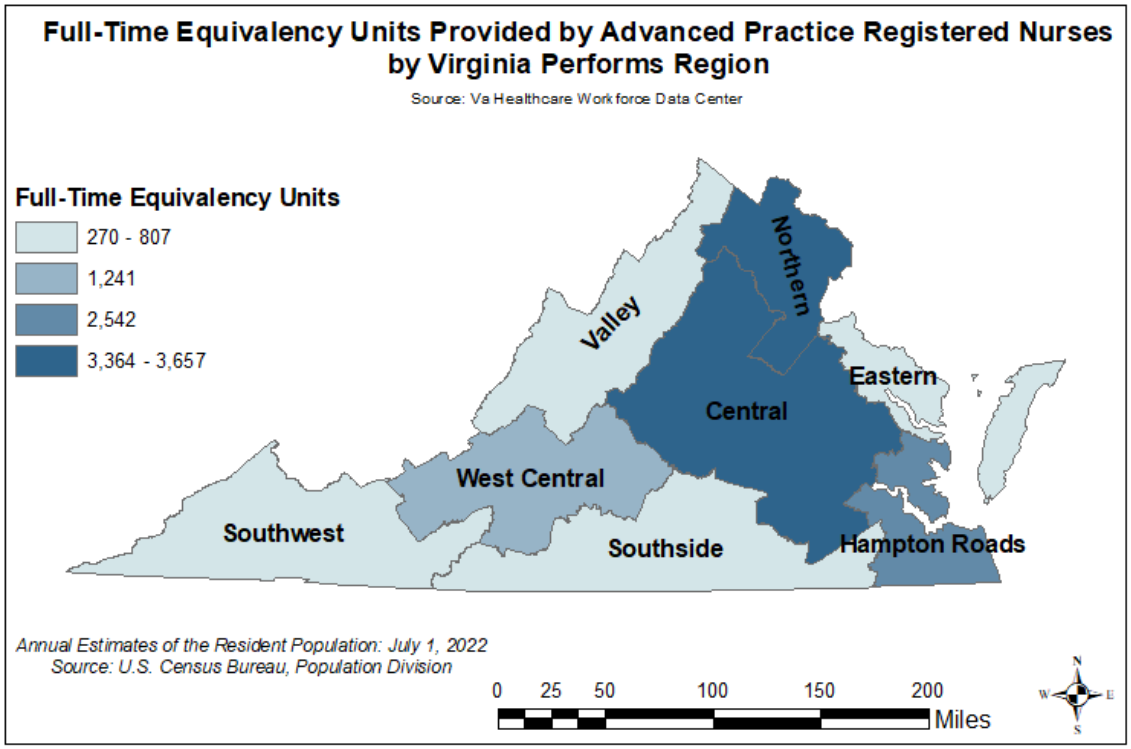


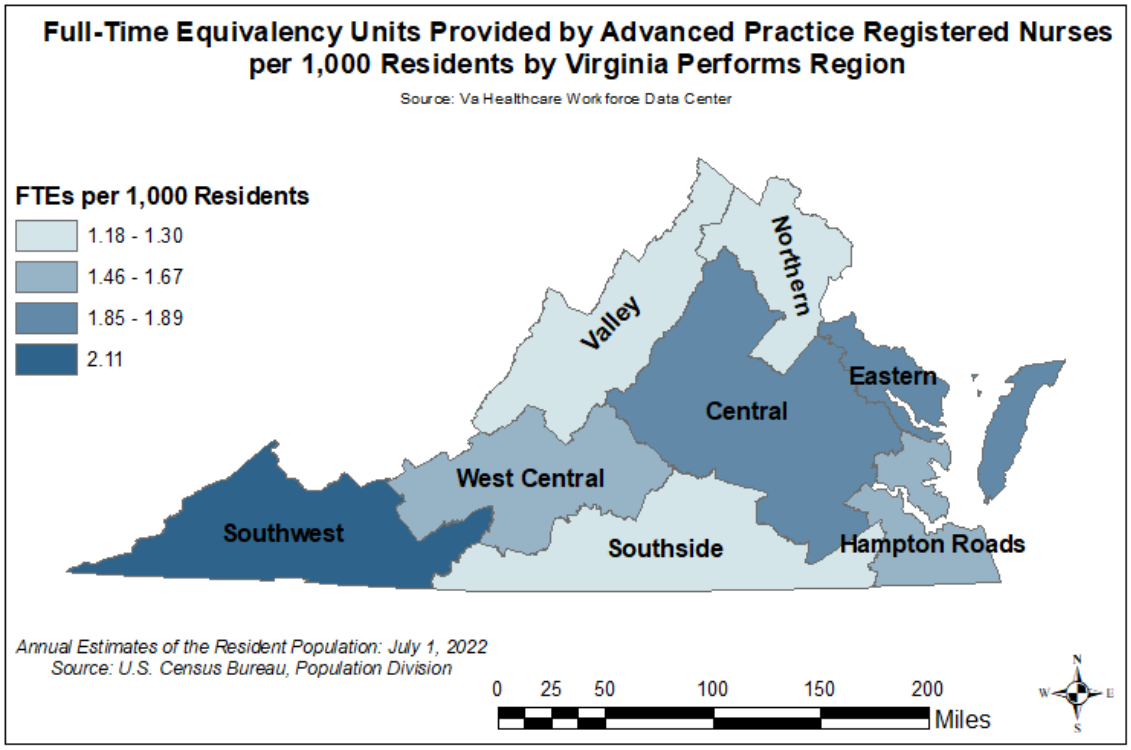
Source: Va. Healthcare Workforce Data Center

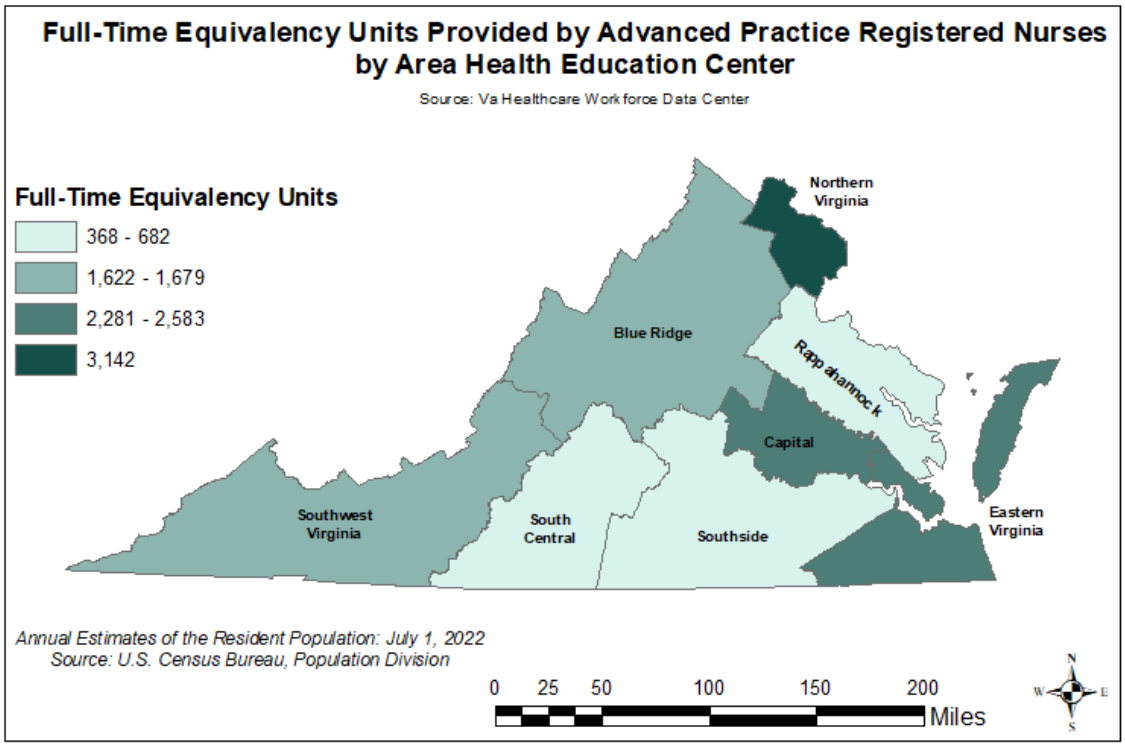
[3] Number of residents in 2022 was used as the denominator.
[4] Due to assumption violations in Mixed between-within ANOVA (Levene's Test was significant).

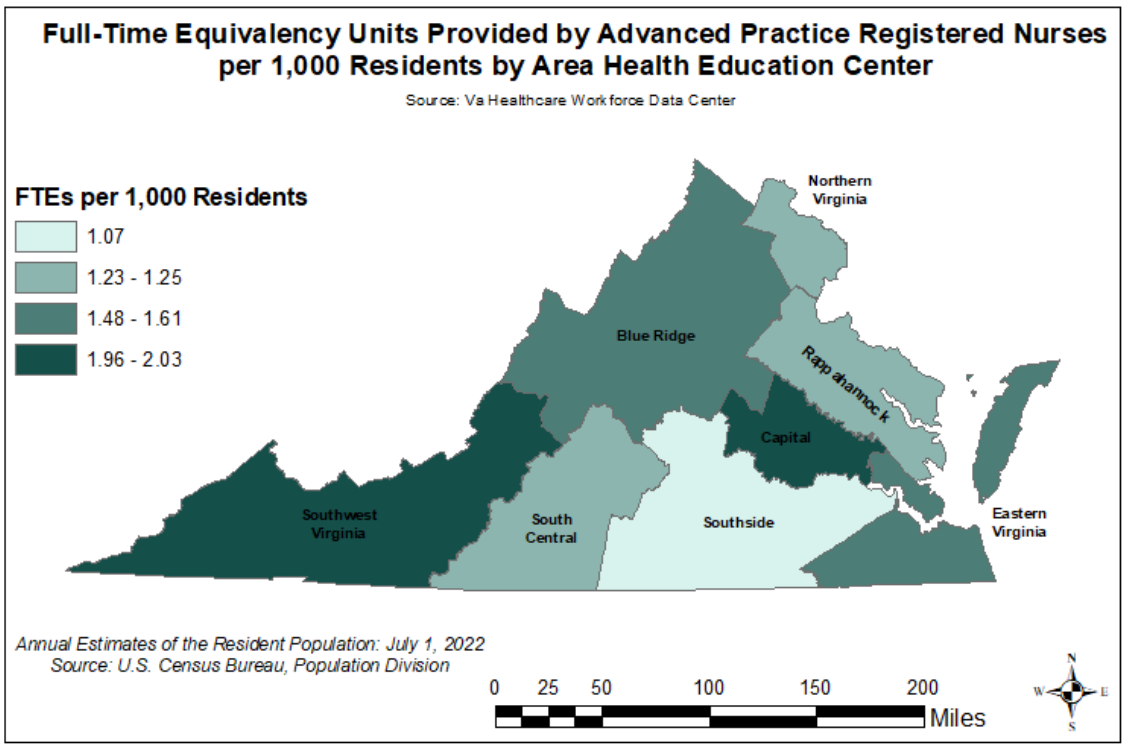
Maps

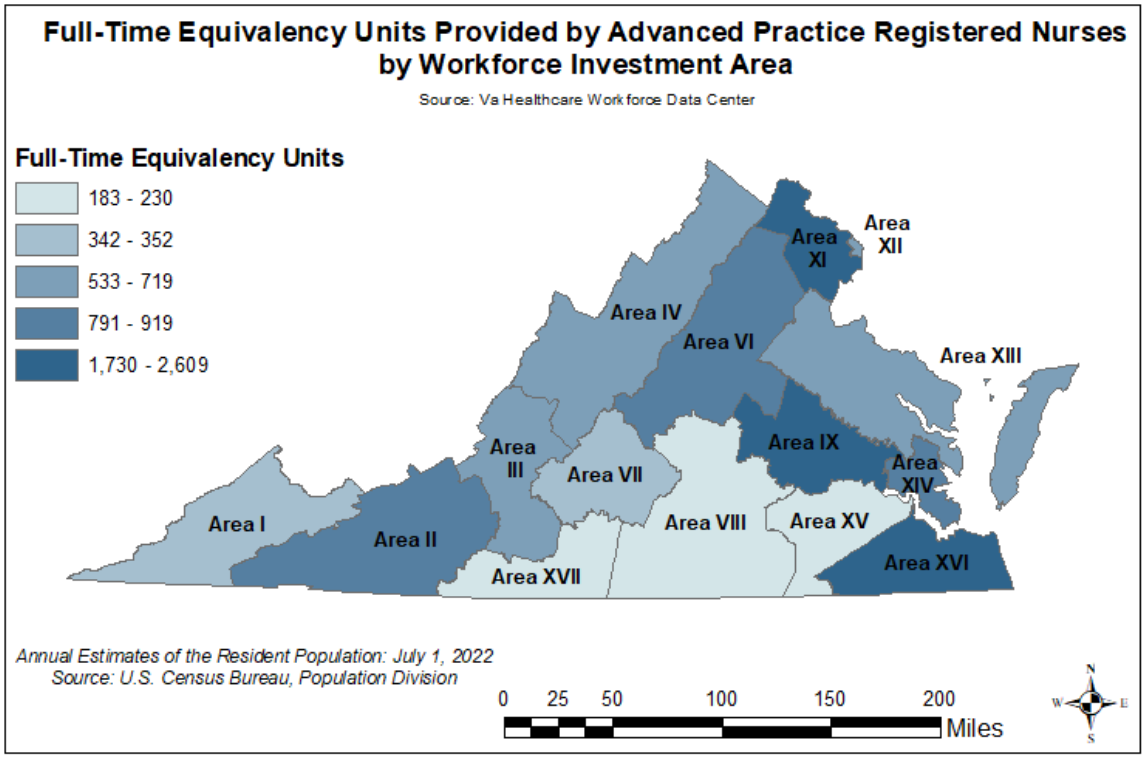
Virginia Performs Regions

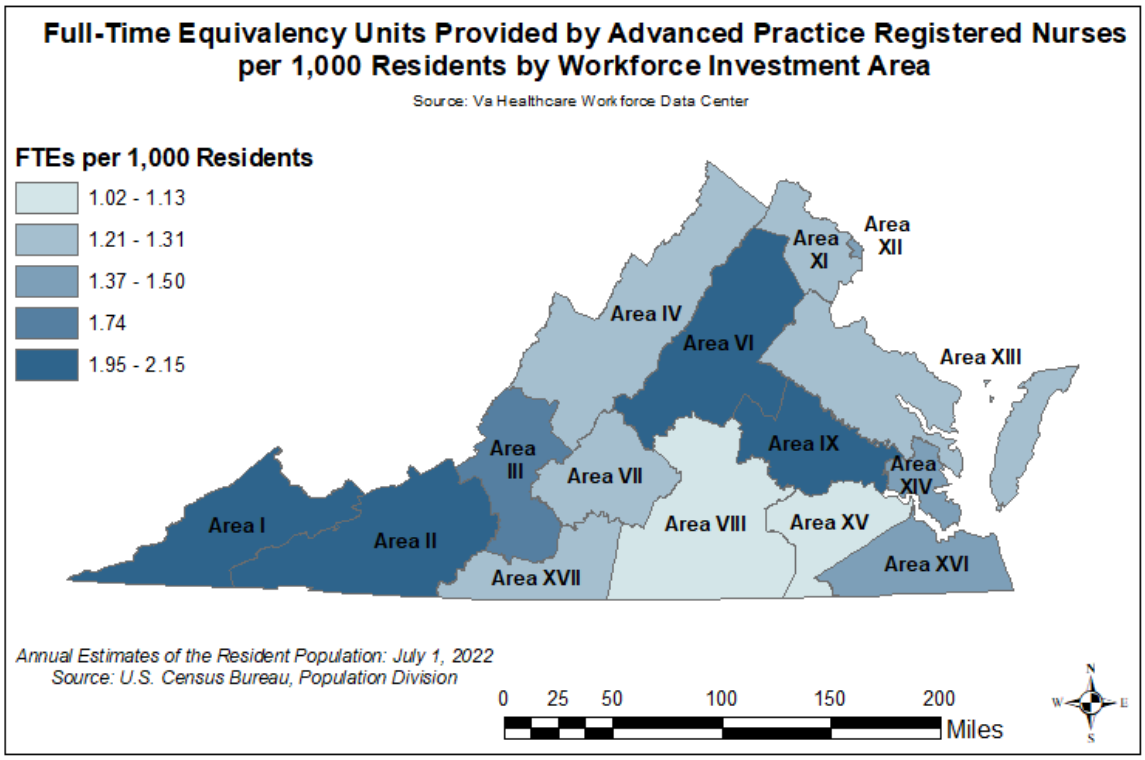


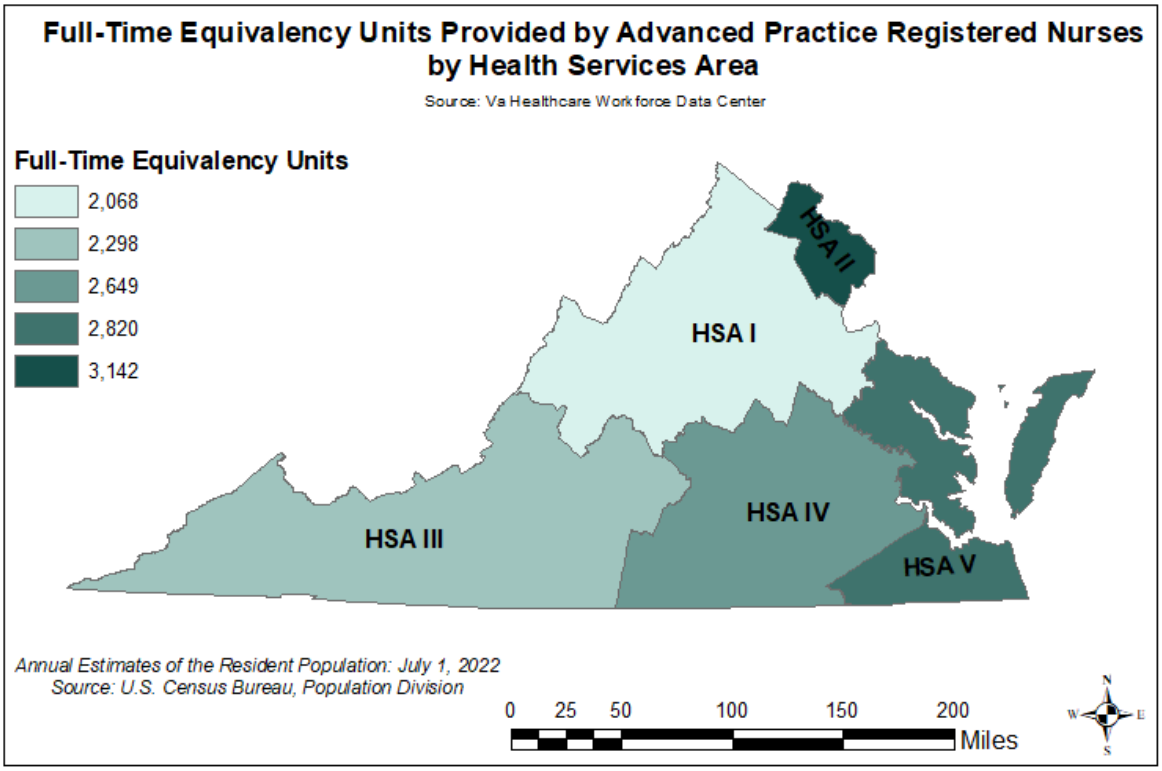


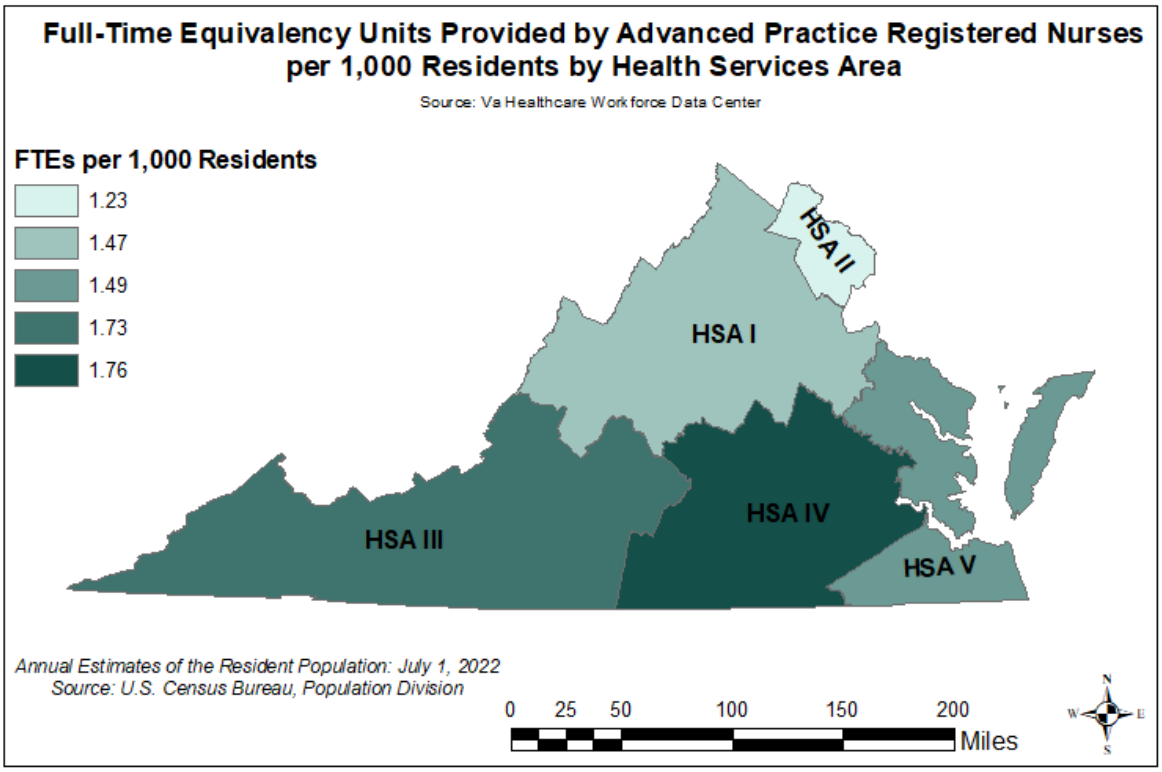

Full-Time Equivalency Units Provided by Advanced Practice Registered Nurses by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
368 - 682
1,622 - 1,679
2,281 - 2,583
3,142
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

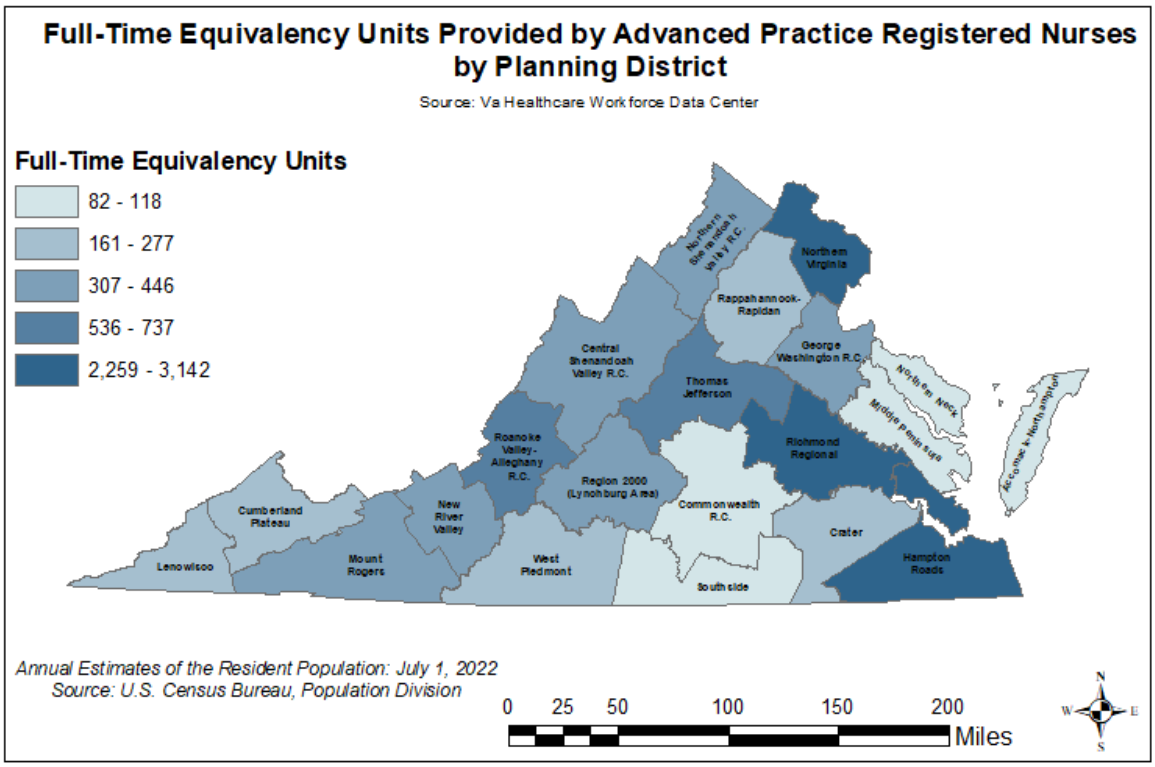

Full-Time Equivalency Units Provided by Advanced Practice Registered Nurses per 1,000 Residents by Area Health Education Center
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
1.07
1.23 - 1.25
1.48 - 1.61
1.96 - 2.03
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Advanced Practice Registered Nurses by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
183 - 230
342 - 352
533 - 719
791 - 919
1,730 - 2,609
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Advanced Practice Registered Nurses per 1,000 Residents by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
1.02 - 1.13
1.21 - 1.31
1.37 - 1.50
1.74
1.95 - 2.15
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Advanced Practice Registered Nurses by Health Services Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
2,068
2,298
2,649
2,820
3,142
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Advanced Practice Registered Nurses per 1,000 Residents by Health Services Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
1.23
1.47
1.49
1.73
1.76
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Advanced Practice Registered Nurses by Planning District
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
82 - 118
161 - 277
307 - 446
536 - 737
2,259 - 3,142
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
Central Shenandoah Valley R.C.
George Washington R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
Richmond Regional
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Crater
Cumberland Plateau
New River Valley
Mount Rogers
West Piedmont
Lenowisco
South side
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
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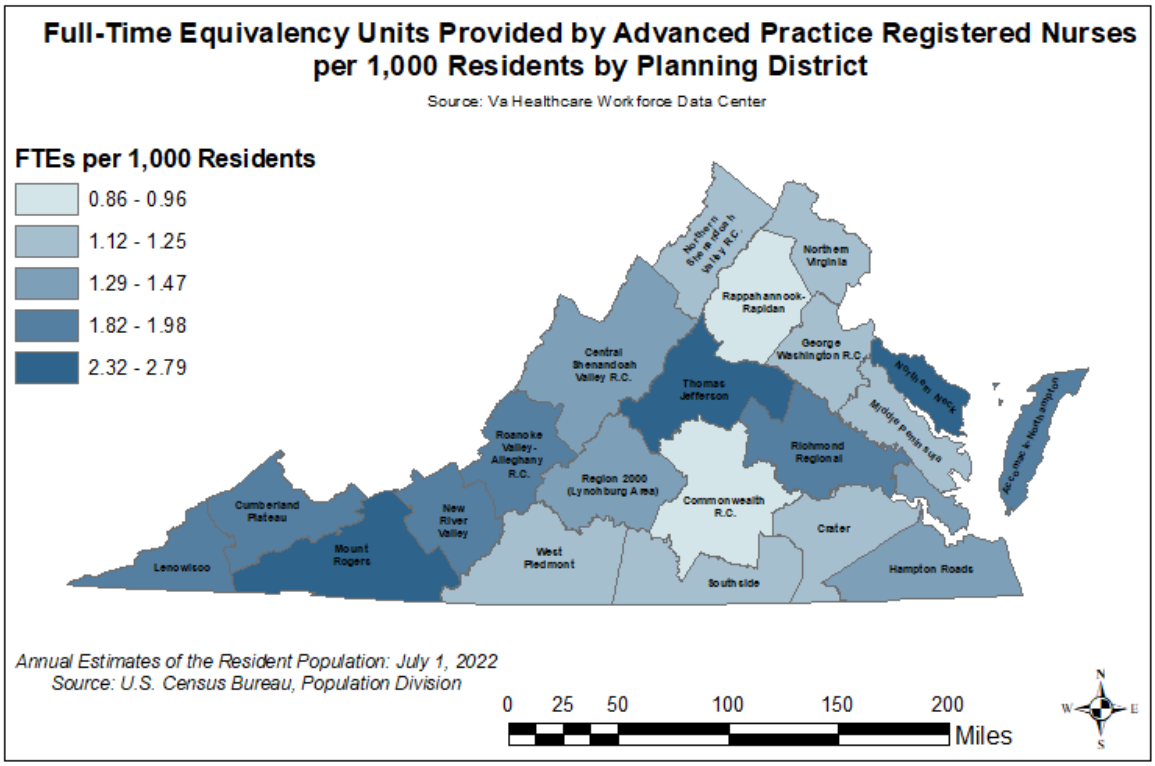
S


Full-Time Equivalency Units Provided by Advanced Practice Registered Nurses per 1,000 Residents by Planning District
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.86 - 0.96
1.12 - 1.25
1.29 - 1.47
1.82 - 1.98
2.32 - 2.79
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
Central Shenandoah Valley R.C.
George Washington R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
Richmond Regional
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Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

Appendices

Appendix A: Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Metro, 1 Million+	9,570	40.92%	2.444	2.090	5.097
Metro, 250,000 to 1 Million	1,220	37.87%	2.641	2.259	5.508
Metro, 250,000 or Less	1,487	42.97%	2.327	1.990	4.854
Urban. Pop. 20,000+, Metro Adj.	230	40.87%	2.447	2.093	5.103
Urban, Pop. 20,000+, Non-Adj.	0	NA	NA	NA	NA
Urban, Pop. 2,500-19,999, Metro Adj.	503	36.18%	2.764	2.364	3.361
Urban, Pop. 2,500-19,999, Non-Adj.	392	46.17%	2.166	1.852	4.517
Rural, Metro Adj.	406	36.21%	2.762	2.362	3.359
Rural, Non-Adj.	142	46.48%	2.152	1.840	2.617
Virginia Border State/D.C.	3,677	27.50%	3.637	3.111	7.586
Other U.S. State	4,900	25.22%	3.964	3.391	8.269

Source: Va. Healthcare Workforce Data Center

Age	Age Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Under 30	533	16.89%	5.922	4.517	8.269
30 to 34	2,648	34.48%	2.900	2.198	4.049
35 to 39	4,161	28.96%	3.453	2.617	4.821
40 to 44	3,875	40.05%	2.497	1.892	3.486
45 to 49	3,165	31.47%	3.178	2.408	4.437
50 to 54	2,754	41.18%	2.429	1.840	3.391
55 to 59	1,935	34.68%	2.884	2.185	4.026
60 and Over	3,457	39.72%	2.518	1.908	3.515

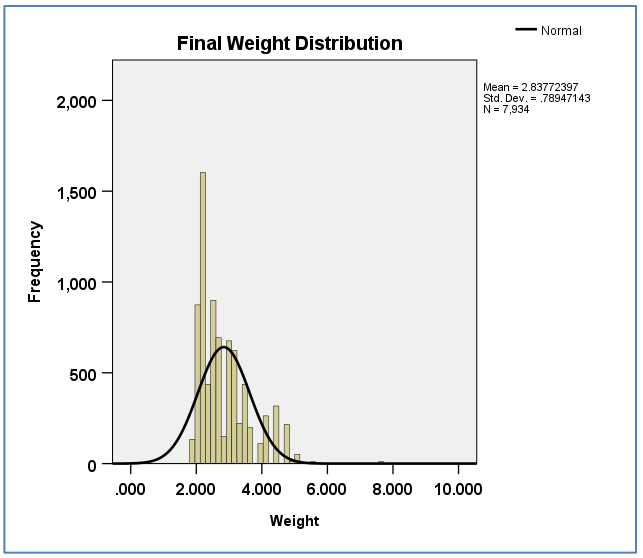
Source: Va. Healthcare Workforce Data Center

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: 0.352184



Source: Va. Healthcare Workforce Data Center

DRAFT

A3

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

Healthcare Workforce Data Center

December 2024

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
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Henrico, VA 23233
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Follow us on Tumblr: ***www.vahwdc.tumblr.com***
Get a copy of this report from:
http://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/

Over 14,900 Licensed Advanced Practice Registered Nurse voluntarily participated in the 2023 and 2024 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

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Executive Director	*Deputy Director*	*Data Analyst*	*Research Assistant*

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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 2023 and 2024 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 2023 survey occurred between October 2022 and September 2023; the 2024 survey occurred between October 2023 and September 2024. 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 (CRNAs), certified nurse midwives (CNMs), clinical nurse specialists (CNSs), and certified nurse practitioners (CNPs). CNPs make up the highest proportion of APRNs. Over 80% of APRNs are CNPs while CNMs and CNSs constitute only 2% of APRNs. The full time equivalency units are also similarly distributed by specialty.

Nine of ten APRNs are female; Almost all CNMs (99%) are female whereas approximately 71% of CRNAs are female; 97% of CNSs are female, and 92% of CNPs are female. The median age of all APRNs is 44. The median age of CRNAs is 46, the median age for CNMs and CNPs is 44, and the CNSs' median age is 61. In a random encounter between two APRNs, there is a 46% chance that they would be of different races or ethnicities, a measure known as the diversity index. CNSs were the least diverse with 30% diversity index, while CNPs had the highest diversity index at 47%. 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%, 7%, and 2% of CRNAs, CNMs, and CNSs respectively.

CRNAs and CNSs had the highest educational attainment with 22% reporting a doctor of nursing practice degree; whereas 19% of CNMs and 11% 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. CNSs had the lowest median at $40k-$50k. CRNAs had $80-$90k in education debt but only 38% of all CRNAs carried education debt.

CRNAs and CNMs reported a median annual income of $120k or more per year, as compared to a median of $110k-120k for all APRNs. Further, 90% of CRNAs reported $120,000 or more in annual income compared to 52% of CNMs, 34% of CNSs and 43% of CNPs. However, only 66% of CRNAs received at least one employer-sponsored benefit compared to 77% of CNMs and CNSs as well as 79% of CNPs. Overall, 93% of APRNs are satisfied with their current employment situation. However, only 90% of CNMs were satisfied compared to 98% of CRNAs, 91% of CNSs and 94% 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.

Most CNRAs (92%) worked in the private sector compared to 89% of CNMs and 86% of CNS and CNPs. Meanwhile, CNSs (53%) were most likely to work in the non-profit sector. CRNAs, CNMs, and CNSs were most likely to be working in inpatient hospital departments whereas CNPs were most likely to work in primary care clinics. Only 14% of CRNAs used at least one form of electronic health record or telehealth compared to 42% of CNMs, 28% of CNSs, and 45% of CNPs. Over half of CNSs plan to retire within the next decade compared to 25% of CNRAS, 20% of CNMs and 17% of CNPs. About 47%, 36%, 25% and 40% of CRNAs, CNMs, CNSs, and CNPs, respectively, plan to retire by the age of 65. Meanwhile, 3%, 4%, 8%, and 6% of CRNAs, CNMs, CNSs, and CNPs, respectively, do not intend to retire.

Closer Look:

At a Glance:

Licensed APRNs

Total:	23,413
CRNA:	3,128
CNM:	548
CNS:	398
CNP:	19,326

Response Rates

All Licensees: (2023 & 2024)	68%

Source: Va. Healthcare Workforce Data Center

This report uses data from the 2023 and 2024 APRN Surveys, and licensure data retrieved in October 2024. 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, 3,128 of APRNs reported their first specialty as CRNA, 548 had a first specialty of CNM, 398 reported a CNS specialty, and 19,326 had other first specialties. However, 12 CRNAs, 106 CNMs, and 27 CNSs reported other APRN specialties. "At a Glance" shows the breakdown by specialty. Over 80% are CNPs, 13% are CRNAs, 2% are CNMs, and 2% are CNSs.

Response Rates

	CRNA	CNM	CNS	CNP	Total
Completed Surveys 2022	951	169	156	5,725	**7,003**
Completed Surveys 2023	1,108	188	151	6,583	**7,934**
Response Rate, all licensees	**67%**	**68%**	**66%**	**68%**	**68%**

Source: Va. Healthcare Workforce Data Center

Our surveys tend to achieve very high response rates. An average of 68% of APRNs submitted a survey in both 2022 and 2023. As shown above, the response rate was highest for CRNAs and lowest for CNSs.

Not in Workforce in Past Year

	CRNA	CNM	CNS	CNP	All 2024
% of Licensees not in VA Workforce	30%	23%	17%	30%	**30%**
% in Federal Employee or Military:	7%	12%	15%	8%	**8%**
% Working in Virginia Border State or DC	16%	18%	14%	20%	**18%**

Source: Va. Healthcare Workforce Data Center

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

Definitions

1. **The Survey Period:** The survey was conducted between October 2022 and September 2023, and between October 2023 and September 2024, 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:

2022 and 2023 Workforce

Virginia's APRN Workforce:	16,436
FTEs:	14,020

Workforce by Specialty

CRNA:	2,187
CNM:	420
CNS:	330
CNP:	13,482

FTE by Specialty

CRNA:	1,819
CNM:	423
CNS:	297
CNP:	11,501

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		CNS		CNP		All (2024)	
Status	#	%	#	%	#	%	#	%	#	%
Worked in Virginia in Past Year	2,187	99%	409	97%	313	95%	13,213	98%	16,128	98%
Looking for Work in Virginia	10	<1%	11	3%	18	5%	269	2%	308	2%
Virginia's Workforce	**2,198**	**100%**	**420**	**100%**	**330**	**100%**	**13,482**	**100%**	**16,436**	**100%**
Total FTEs	**1,819**		**423**		**297**		**11,501**		**14,020**	
Licensees	**3,128**		**548**		**398**		**19,326**		**23,401**	

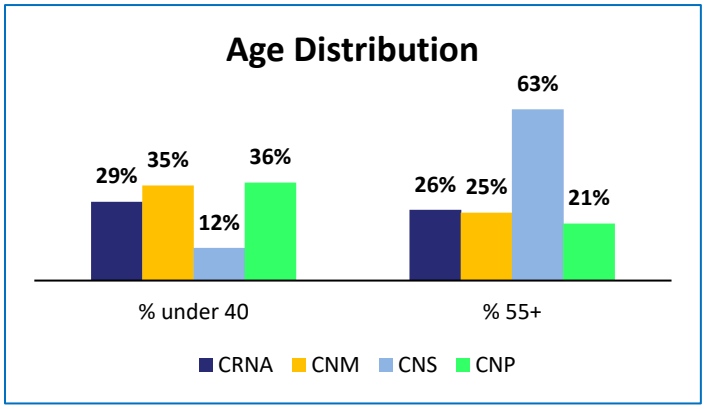
Source: Va. Healthcare Workforce Data Center

CNPs provided 82% of the nurse practitioner FTEs in the state. CRNAs provided 13% whereas CNMs provided 3%, and CNSs provided 2% of the FTEs. 5% of CNSs in the state's workforce were looking for work in the state compared to 3% or less of the other APRNs.

A Closer Look (All Nurse Practitioners in 2024):

Age & Gender						
	Male		Female		Total	
Age	#	% Male	#	% Female	#	% in Age Group
Under 30	31	8%	377	93%	408	3%
30 to 34	161	9%	1,726	92%	1,886	14%
35 to 39	193	8%	2,184	92%	2,376	18%
40 to 44	284	12%	2,131	88%	2,414	18%
45 to 49	190	11%	1,502	89%	1,692	12%
50 to 54	202	12%	1,528	88%	1,730	13%
55 to 59	112	11%	886	89%	997	7%
60 +	235	11%	1,834	89%	2,068	15%
Total	**1,406**	**10%**	**12,166**	**90%**	**13,572**	**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:	99%
CNS:	97%
CNP:	92%

% Female <40 by Specialty

CRNA:	78%
CNM:	100%
CNS:	94%
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, and CNSs' median age is 61.

Age & Gender by Specialty																
	CRNA				CNM				CNS				CNP			
	Female		Total		Female		Total		Female		Total		Female		Total	
Age	#	% Female	#	% in Age Group	#	% Female	#	% in Age Group	#	% Female	#	% in Age Group	#	% Female	#	% in Age Group
Under 30	3	100%	3	0%	10	100%	10	3%	0	0%	0	0%	365	92%	395	4%
30-34	178	78%	229	13%	41	100%	41	12%	13	100%	13	4%	1,493	93%	1,603	14%
35-39	231	78%	297	16%	72	100%	72	20%	19	93%	21	7%	1,862	94%	1,984	18%
40-44	221	69%	322	18%	64	100%	64	18%	30	100%	30	10%	1,814	91%	1,997	18%
45- 49	165	69%	239	13%	45	97%	46	13%	17	100%	17	6%	1,274	92%	1,387	13%
50-54	190	70%	270	15%	31	100%	31	9%	28	96%	30	10%	1,278	91%	1,399	13%
55-59	103	70%	148	8%	22	100%	22	6%	25	96%	27	9%	736	92%	801	7%
60+	203	63%	323	18%	66	98%	68	19%	151	96%	157	54%	1,414	93%	1,521	14%
Total	**1,293**	**71%**	**1,831**	**100%**	**351**	**99%**	**354**	**100%**	**283**	**97%**	**293**	**100%**	**10,236**	**92%**	**11,089**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look (All APRNs in 2024):

Race & Ethnicity (2024)					
Race/ Ethnicity	Virginia*	APRNs		APRNs under 40	
	%	#	%	#	%
White	61%	9,747	72%	3,388	73%
Black	19%	2,070	15%	572	12%
Asian	7%	839	6%	325	7%
Other Race	0%	123	1%	33	1%
Two or more races	3%	315	2%	110	2%
Hispanic	10%	528	4%	238	5%
Total	**100%**	**13,622**	**100%**	**4,666**	**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

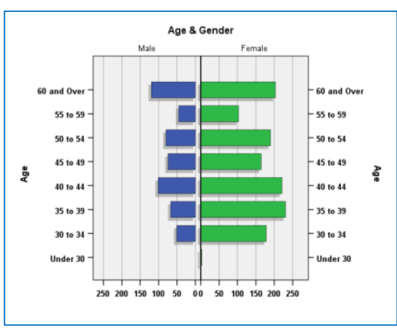
Diversity Index: 46%
Under 40 Div. Index: 45%

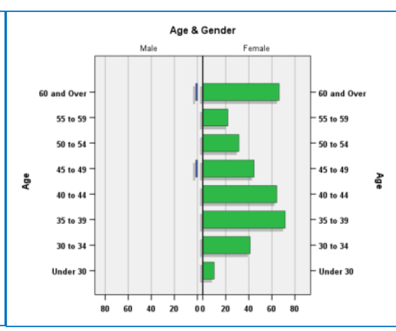
Diversity by Specialty

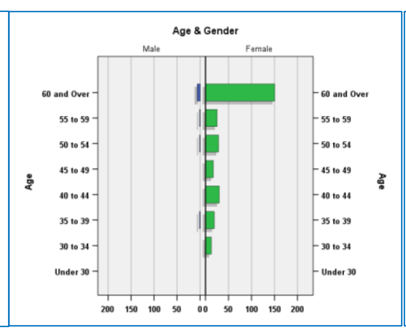
CRNA: 45%
CNM: 33%
CNS: 30%
CNP: 47%

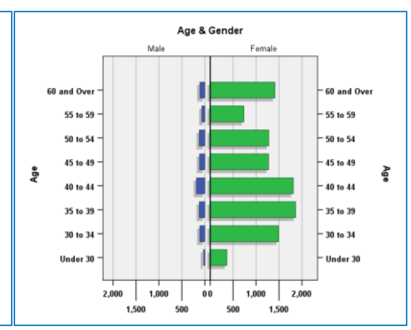
Source: Va. Healthcare Workforce Data Center

Age, Race, Ethnicity & Gender																
	CRNA				CNM				CNS				CNP			
Race/ Ethnicity	APRNs		APRNs under 40		APRNs		APRNs under 40		APRNs		APRNs under 40		APRNs		APRNs under 40	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
White	1,330	73%	366	70%	295	81%	103	82%	244	83%	22	73%	7,872	71%	2,894	73%
Black	186	10%	50	10%	40	11%	14	11%	31	11%	4	13%	1,812	16%	503	13%
Asian	125	7%	39	7%	4	1%	2	2%	4	1%	1	3%	706	6%	282	7%
Other Race	11	1%	2	0%	5	1%	0	0%	3	1%	0	0%	104	1%	32	1%
Two or more races	65	4%	21	4%	7	2%	3	2%	5	2%	0	0%	238	2%	86	2%
Hispanic	101	6%	45	9%	13	4%	4	3%	8	3%	3	10%	407	4%	186	5%
Total	**1,818**	**100%**	**523**	**100%**	**364**	**100%**	**126**	**100%**	**295**	**100%**	**30**	**100%**	**11,139**	**100%**	**3,983**	**100%**









Source: Va. Healthcare Workforce Data Center

A Closer Look:

At a Glance:

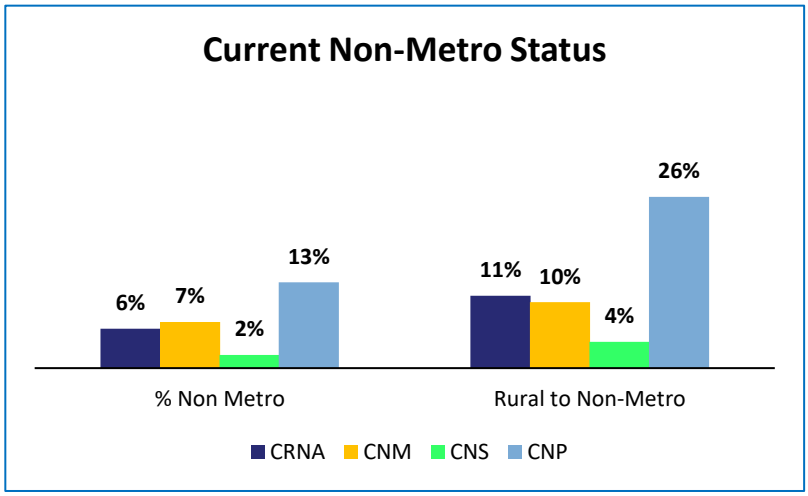
Rural Childhood

CRNA:	27%
CNM:	30%
CNS:	38%
CNP:	35%
All:	33%

Non-Metro Location

CRNA:	6%
CNM:	7%
CNS:	2%
CNP:	13%
All:	11%

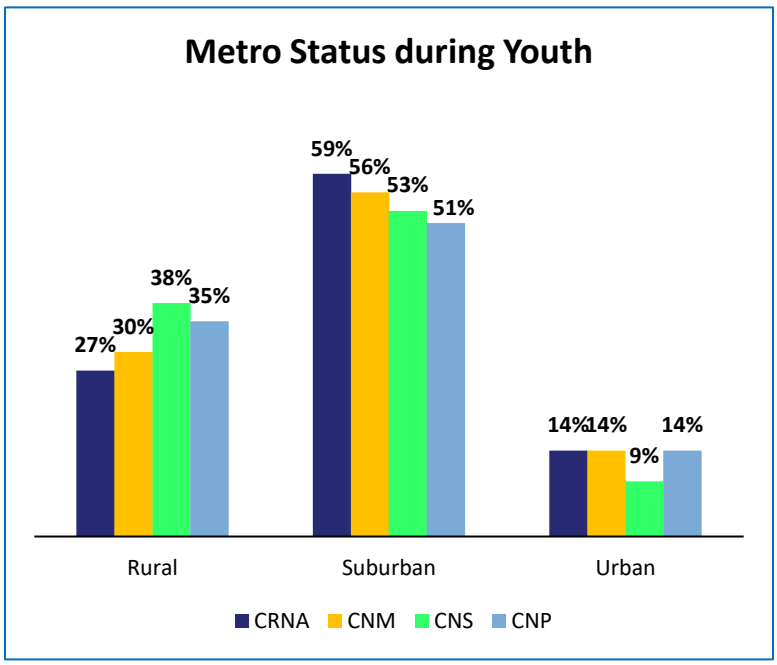
Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

	HS in VA	Prof. Ed. in VA	HS or Prof in VA	APRN Degree in VA
CRNA	27%	29%	34%	36%
CNM	32%	32%	39%	24%
CNS	51%	55%	60%	71%
CNP	46%	54%	58%	52%
All (2024)	**43%**	**50%**	**54%**	**50%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

CNSs 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.

A Closer Look:

At a Glance:

Median Educational Debt

CRNA:	$80k-$90k
CNM:	$90k-$100k
CNS:	$40k-$50k
CNP:	$60k-$70k

Source: Va. Healthcare Workforce Data Center

CNMs were most likely to carry education debt; 57% of all CNMs and 74% of CNMs under age 40 had education debt. CNMs also had the highest median debt at $90k-$100K. CNSs had the lowest median education debt. Finally, 38% of all CRNAs, and 61% of CRNAs under 40 reported education debt.

Highest Degree										
	CRNA		CNM		CNS		CNP		All (2024)	
Degree	#	%	#	%	#	%	#	%	#	%
NP Certificate	99	6%	11	3%	0	0%	101	1%	217	2%
Master's Degree	1,129	63%	269	74%	152	53%	8,401	77%	9,955	75%
Post-Masters Cert.	19	1%	37	9%	46	16%	902	8%	1,004	8%
Doctorate of NP	389	22%	33	19%	62	22%	1,153	11%	1,638	12%
Other Doctorate	148	8%	14	4%	28	10%	329	3%	520	4%
Post-Ph.D. Cert.	0	0%	0	0%	0	0%	4	<1%	4	<1%
Total	**1,784**	**100%**	**364**	**100%**	**288**	**100%**	**10,895**	**100%**	**13,338**	**100%**

Source: Va. Healthcare Workforce Data Center

Educational Debt										
Amount Carried	CRNA		CNM		CNS		CNP		All (2024)	
	All	Under 40	All	Under 40	All	Under 40	All	Under 40	All	Under 40
None	60%	35%	50%	34%	47%	37%	49%	36%	49%	36%
$20,000 or less	6%	4%	4%	3%	7%	8%	7%	7%	7%	7%
$20,000-$29,999	2%	2%	<1%	0%	4%	5%	4%	5%	4%	5%
$30,000-$39,999	2%	3%	3%	3%	4%	5%	4%	5%	4%	5%
$40,000-$49,999	3%	5%	3%	4%	4%	6%	4%	5%	4%	5%
$50,000-$59,999	2%	1%	2%	4%	4%	5%	4%	5%	4%	5%
$60,000-$69,999	2%	4%	2%	1%	4%	6%	4%	6%	4%	6%
$70,000-$79,999	2%	4%	3%	6%	4%	5%	4%	5%	4%	5%
$80,000-$89,999	3%	5%	3%	3%	4%	4%	3%	4%	3%	4%
$90,000-$99,999	1%	2%	3%	3%	3%	4%	3%	3%	3%	3%
$100,000-$109,999	2%	3%	4%	4%	3%	3%	3%	4%	3%	4%
$110,000-$119,999	1%	2%	4%	11%	2%	3%	2%	3%	2%	3%
$120,000 or more	14%	29%	4%	3%	10%	8%	10%	11%	10%	11%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Employed in Profession

CRNA:	98%
CNM:	93%
CNS:	89%
CNP:	96%

Involuntary Unemployment

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

Source: Va. Healthcare Workforce Data Center

A Closer Look:

	Current Weekly Hours				
Hours	CRNA	CNM	CNS	CNP	All (2024)
0 hours	1%	7%	4%	3%	3%
1 to 9 hours	1%	2%	5%	1%	1%
10 to 19 hours	3%	5%	6%	3%	3%
20 to 29 hours	8%	4%	7%	7%	7%
30 to 39 hours	24%	15%	14%	20%	20%
40 to 49 hours	53%	37%	41%	49%	49%
50 to 59 hours	7%	14%	13%	11%	11%
60 to 69 hours	2%	11%	8%	4%	4%
70 to 79 hours	<1%	3%	1%	1%	1%
80 or more hours	<1%	3%	1%	2%	2%
Total	**100%**	**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. Among CNSs, 41% work 40-49 hours and an additional 23% 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		CNS		CNP		All (2024)	
Positions	#	%	#	%	#	%	#	%	#	%
No Positions	16	1%	19	5%	11	4%	297	3%	343	3%
One Part-Time Position	231	13%	43	12%	53	20%	1,411	13%	1,739	13%
Two Part-Time Positions	101	6%	16	4%	12	5%	403	4%	533	4%
One Full-Time Position	1,085	61%	225	63%	148	57%	6,942	65%	8,405	64%
One Full-Time Position & One Part-Time Position	228	13%	41	12%	28	11%	1,384	13%	1,681	13%
Two Full-Time Positions	9	1%	1	<1%	0	0%	45	<1%	55	<1%
More than Two Positions	115	6%	11	3%	8	3%	201	2%	334	3%
Total	**1,785**	**100%**	**359**	**11%**	**260**	**100%**	**10,683**	**100%**	**13,090**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Employer-Sponsored Benefits*					
Benefit	**CRNA**	**CNM**	**CNS**	**CNP**	**All (2024)**
Signing/Retention Bonus	34%	23%	10%	16%	19%
Dental Insurance	50%	58%	60%	58%	57%
Health Insurance	52%	58%	62%	60%	59%
Paid Leave	52%	65%	68%	68%	65%
Group Life Insurance	45%	49%	51%	46%	46%
Retirement	61%	68%	71%	68%	67%
Receive at least one benefit	**66%**	**77%**	**77%**	**79%**	**77%**

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

Source: Va. Healthcare Workforce Data Center

CRNAs and CNMs reported $120k or more in median income. All other NPs, including CNSs, reported $110k-$120k 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, and 2% of CNSs reported being very dissatisfied.

At a Glance:

Median Income

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

Percent Satisfied

CRNA:	98%
CNM:	90%
CNS:	91%
CNP:	94%

Source: Va. Healthcare Workforce Data Center

Income					
Annual Income	**CRNA**	**CNM**	**CNS**	**CNP**	**All (2024)**
Volunteer Work Only	0%	0%	3%	1%	1%
Less than $40,000	1%	2%	5%	2%	2%
$40,000-$49,999	0%	0%	1%	1%	1%
$50,000-$59,999	0%	3%	2%	1%	1%
$60,000-$69,999	0%	0%	2%	1%	1%
$70,000-$79,999	2%	7%	13%	8%	8%
$80,000-$89,999	1%	8%	8%	6%	6%
$90,000-$99,999	1%	6%	6%	8%	7%
$100,000-$109,999	2%	10%	9%	15%	13%
$110,000-$119,999	2%	11%	16%	14%	12%
$120,000 or more	90%	52%	34%	43%	49%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Employment Instability in Past Year					
In the past year did you . . .?	CRNA	CNM	CNS	CNP	All (2024)
Experience Involuntary Unemployment?	<1%	1%	0%	1%	1%
Experience Voluntary Unemployment?	2%	8%	6%	5%	4%
Work Part-time or temporary positions, but would have preferred a full-time/permanent position?	1%	1%	1%	3%	2%
Work two or more positions at the same time?	22%	19%	18%	18%	18%
Switch employers or practices?	5%	9%	4%	9%	8%
Experienced at least 1	**28%**	**31%**	**27%**	**29%**	**29%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Involuntarily Unemployed

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

Underemployed

CRNA:	1%
CNM:	1%
CNS:	1%
CNP:	3%

Over 2 Years Job Tenure

CRNA:	61%
CNM:	52%
CNS:	72%
CNP:	50%

Source: Va. Healthcare Workforce Data Center

Job Tenure at Location								
Tenure	CRNA		CNM		CNS		CNP	
	Primary	Secondary	Primary	Secondary	Primary	Secondary	Primary	Secondary
Not Currently Working at this Location	1%	4%	4%	2%	3%	7%	2%	6%
< 6 Months	7%	11%	8%	15%	6%	10%	10%	16%
6 Months-1 yr	9%	13%	10%	15%	7%	7%	13%	16%
1 to 2 Years	22%	19%	26%	28%	12%	18%	24%	24%
3 to 5 Years	24%	27%	25%	26%	15%	16%	23%	20%
6 to 10 Years	15%	13%	15%	8%	13%	18%	14%	10%
> 10 Years	22%	13%	11%	5%	44%	25%	13%	8%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center

Forms of Payment					
Primary Work Site	CRNA	CNM	CNS	CNP	All (2024)
Salary/ Commission	49%	75%	66%	68%	65%
Hourly Wage	34%	19%	20%	23%	25%
By Contract	17%	5%	13%	8%	9%
Unpaid	<1%	1%	1%	1%	<1%
Total	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center

75% of CNMs were be paid by salary or commission, as compared to 49% of CRNAs, 66% of CNSs, and 68% of CNPs. This makes CNMs the most likely to be paid in this way.

At a Glance:

% in Top 3 Regions

CRNA:	78%
CNM:	67%
CNS:	75%
CNP:	68%

2 or More Locations Now

CRNA:	31%
CNM:	25%
CNS:	20%
CNP:	24%

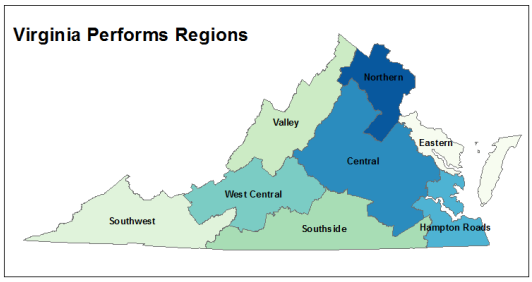
Source: Va. Healthcare Workforce Data Center

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

A Closer Look

	Regional Distribution of Work Locations							
Virginia Performs Region	CRNA		CNM		CNS		CNP	
	Primary	Sec.	Primary	Sec.	Primary	Sec.	Primary	Sec.
Central	25%	19%	19%	28%	36%	34%	24%	16%
Eastern	1%	1%	1%	1%	1%	0%	2%	2%
Hampton Roads	24%	24%	18%	16%	19%	24%	17%	16%
Northern	28%	28%	30%	18%	21%	15%	27%	25%
Southside	2%	3%	4%	3%	2%	2%	4%	4%
Southwest	2%	3%	1%	4%	1%	0%	7%	7%
Valley	5%	3%	11%	15%	5%	8%	6%	5%
West Central	8%	6%	11%	7%	14%	12%	10%	9%
Virginia Border State/DC	1%	4%	1%	1%	2%	2%	1%	4%
Other US State	2%	10%	4%	5%	0%	3%	2%	12%
Outside of the US	0%	0%	0%	1%	0%	0%	0%	0%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Va. Healthcare Workforce Data Center



	Number of Work Locations Now*							
Locations	CRNA		CNM		CNS		CNP	
	#	%	#	%	#	%	#	%
0	20	1%	21	6%	25	9%	398	4%
1	1,195	68%	241	69%	1925	70%	7,632	72%
2	276	16%	62	18%	44	16%	1,703	16%
3	200	11%	18	5%	11	4%	703	7%
4	40	2%	5	2%	1	1%	75	1%
5	16	1%	-	-	-	-	32	0%
6 +	10	1%	2	1%	-	-	82	1%
Total	**1,757**	**100%**	**350**	**100%**	**274**	**100%**	**10,624**	**100%**

Source: Va. Healthcare Workforce Data Center

*At survey completion (birth month of respondents)

A Closer Look:

Sector	Location Sector									
	CRNA		CNM		CNS		CNP		All (2024)	
	Primary	Sec	Primary	Sec	Primary	Sec	Primary	Sec	Primary	Sec
For-Profit	52%	66%	54%	55%	33%	38%	54%	65%	54%	65%
Non-Profit	40%	28%	35%	38%	53%	45%	32%	25%	34%	26%
State/Local Government	3%	2%	4%	2%	11%	11%	8%	7%	7%	6%
Veterans Administration	2%	1%	0%	2%	2%	2%	3%	1%	2%	1%
U.S. Military	3%	3%	3%	2%	2%	4%	2%	1%	2%	2%
Other Federal Government	0%	0%	3%	0%	0%	2%	1%	1%	1%	1%
Total	**100%**	**100%**	**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 89% of CNMs, and 86% of CNSs 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:	52%
CNM:	54%
CNS:	33%
CNP:	54%

Top Establishments

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

Source: Va. Healthcare Workforce Data Center

Electronic Health Records (EHRs) and Telehealth					
	CRNA	CNM	CNS	CNP	All (2024)
Meaningful use of EHRs	12%	25%	17%	30%	27%
Remote Health, Caring for Patients in Virginia	1%	25%	19%	29%	25%
Remote Health, Caring for Patients Outside of Virginia	<1%	6%	5%	8%	7%
Use at least one	**14%**	**42%**	**28%**	**45%**	**40%**

Source: Va. Healthcare Workforce Data Center

Approximately 40% 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 nature of their job.

Establishment Type	Location Type									
	CRNA		CNM		CNS		CNP		All (2024)	
	Primary	Sec.	Primary	Sec.	Primary	Sec.	Primary	Sec.	Primary	Sec.
Clinic, Primary Care or Non-Specialty	1%	2%	11%	16%	3%	0%	23%	17%	19%	15%
Hospital, Inpatient Department	40%	29%	26%	32%	34%	36%	14%	12%	18%	15%
Physician Office	<1%	1%	7%	7%	4%	4%	8%	5%	7%	4%
Academic Institution (Teaching or Research)	11%	6%	10%	5%	17%	24%	6%	7%	7%	7%
Private practice, group	1%	2%	17%	12%	1%	2%	6%	5%	6%	4%
Hospital, Outpatient Department	14%	12%	4%	0%	4%	0%	5%	3%	6%	4%
Clinic, Non-Surgical Specialty	1%	2%	4%	1%	1%	0%	5%	5%	5%	4%
Ambulatory/Outpatient Surgical Unit	19%	34%	1%	5%	<1%	0%	2%	1%	4%	6%
Long Term Care Facility, Nursing Home	0%	0%	<1%	0%	0%	0%	4%	5%	3%	4%
Hospital, Emergency Department	4%	2%	1%	8%	4%	0%	3%	4%	3%	3%
Mental Health, or Substance Abuse, Outpatient Center	0%	0%	1%	0%	11%	9%	5%	7%	5%	6%
Private practice, solo	0%	1%	2%	4%	5%	4%	2%	3%	2%	3%
Hospice	<1%	0%	<1%	0%	<1%	0%	1%	3%	1%	3%
Other Practice Setting	9%	10%	14%	8%	15%	20%	15%	25%	14%	22%
Total	**100%**	**100%**	**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, CNMs, and CNSs. For CNPs, primary care clinic was the most mentioned primary work establishment, followed by the inpatient department.

At a Glance:
(Primary Locations)

Patient Care Role

CRNA:	95%
CNM:	84%
CNS:	51%
CNP:	87%

Education Role

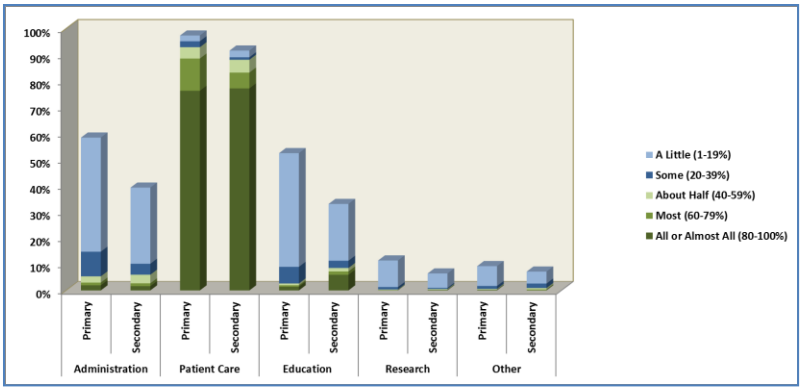
CRNA:	1%
CNM:	3%
CNS:	10%
CNP:	2%

Admin Role

CRNA:	2%
CNM:	1%
CNS:	11%
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 84% of CNMs, 51% of CNSs, and 87% CNPs.

	Patient Care Time Allocation									
Time Spent	**CRNA**		**CNM**		**CNS**		**CNP**		**All (2024)**	
	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%)	88%	92%	67%	82%	39%	36%	72%	73%	73%	76%
Most (60-79%)	7%	2%	16%	5%	11%	2%	15%	10%	14%	8%
About Half (40-59%)	2%	3%	7%	1%	8%	2%	5%	4%	5%	4%
Some (20-39%)	1%	1%	3%	1%	15%	9%	3%	3%	3%	3%
A Little (1-20%)	1%	1%	1%	1%	12%	8%	2%	3%	2%	3%
None (0%)	1%	0%	4%	9%	14%	40%	3%	7%	3%	7%

Source: Va. Healthcare Workforce Data Center

A Closer Look

Future Plans	CRNA		CNM		CNS		CNP	
2 Year Plans:	#	%	#	%	#	%	#	%
Decrease Participation								
Leave Profession	14	1%	9	2%	8	2%	96	1%
Leave Virginia	63	3%	18	4%	7	2%	304	2%
Decrease Patient Care Hours	211	10%	36	9%	38	12%	1,185	9%
Decrease Teaching Hours	6	0%	2	0%	12	4%	91	1%
Increase Patient Care Hours	94	4%	42	10%	24	7%	1,557	12%
Increase Teaching Hours	100	5%	53	13%	29	9%	1,391	10%
Pursue Additional Education	64	3%	49	12%	27	8%	1,577	12%
Return to Virginia's Workforce	3	0%	3	1%	3	1%	109	1%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement within 2 Years

CRNA:	8%
CNM:	7%
CNS:	16%
CNP:	4%

Retirement within 10 Years

CRNA:	25%
CNM:	20%
CNS:	51%
CNP:	17%

Source: Va. Healthcare Workforce Data Center

47%, 36%, 25%, and 40% of CRNAs, CNMs, CNSs, and CNPs, respectively, expect to retire by the age of 65. Further, 33% of CRNAs, 18% of CNMs and CNSs, and 24% of CNPs, respectively, aged 50 or over expect to retire by the same age. Meanwhile, 3%, 4%, 8%, and 6% of CRNAs, CNMs, CNSs, and CNPs, respectively, do not plan to retire at all.

Expected Retirement Age	CRNA		CNM		CNS		CNP		All (2024)	
	All	>50 yrs	All	>50 yrs	All	>50 yrs	All	>50 yrs	All	>50 yrs
Under age 50	1%	-	4%	-	0%	-	2%	-	2%	-
50 to 54	5%	2%	2%	0%	3%	0%	4%	0%	4%	1%
55 to 59	12%	6%	7%	3%	5%	1%	9%	5%	10%	5%
60 to 64	29%	26%	23%	15%	16%	17%	25%	19%	25%	20%
65 to 69	37%	43%	32%	37%	34%	34%	36%	41%	36%	41%
70 to 74	9%	14%	19%	27%	18%	19%	13%	21%	13%	20%
75 to 79	3%	5%	4%	11%	9%	12%	3%	6%	3%	6%
80 or over	1%	0%	4%	5%	6%	7%	1%	2%	1%	2%
I do not intend to retire	3%	4%	4%	2%	8%	11%	6%	7%	5%	6%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

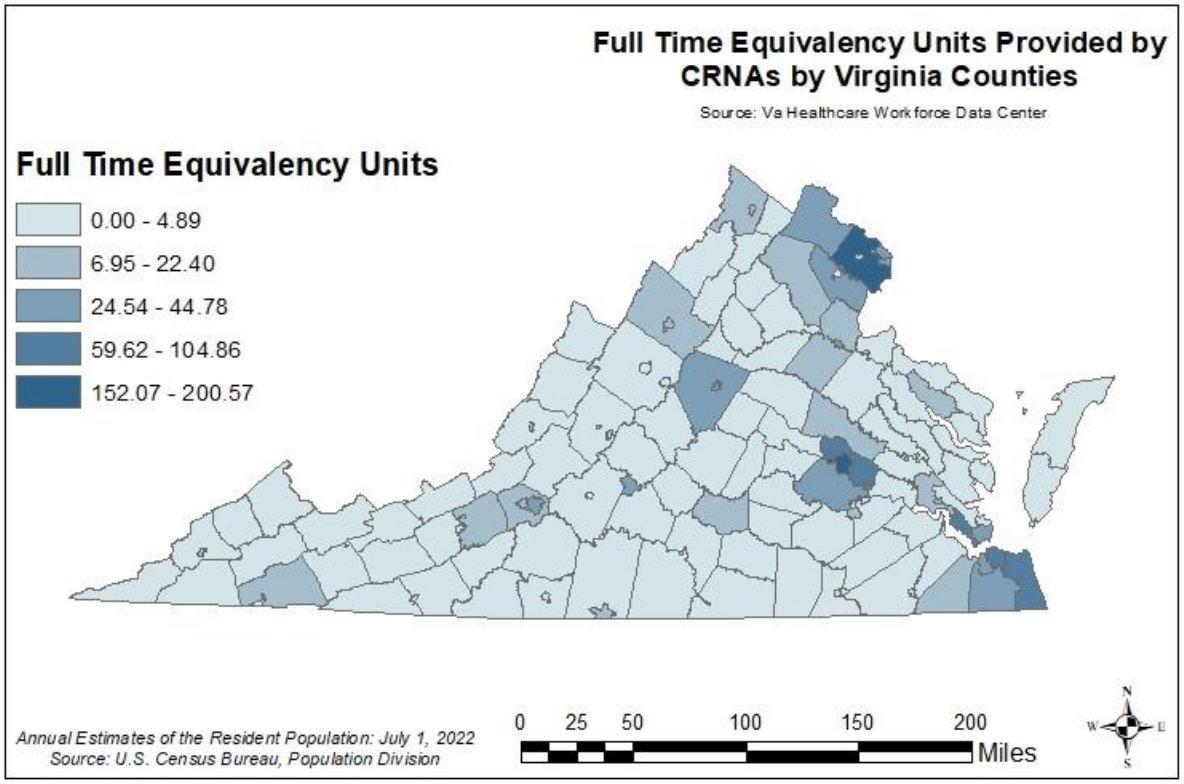
Source: Va. Healthcare Workforce Data Center

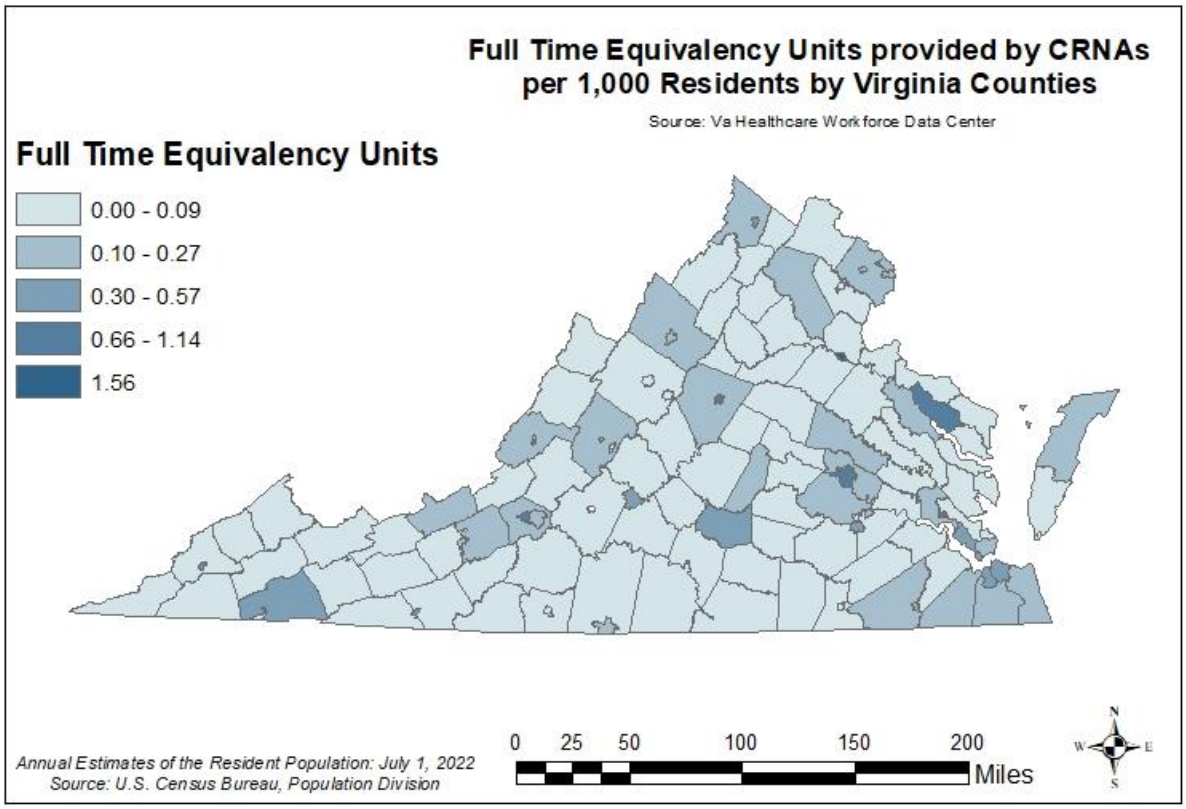
Time to Retirement										
	CRNA		CNM		CNS		CNP		All (2024)	
Expect to retire within:	#	%	#	%	#	%	#	%	#	%
2 years	131	8%	20	7%	38	16%	401	4%	591	5%
5 years	60	4%	9	3%	30	12%	304	3%	402	4%
10 years	213	13%	30	10%	55	23%	832	9%	1,130	10%
15 years	202	13%	33	11%	27	11%	1,051	11%	1,313	12%
20 years	224	14%	37	12%	18	7%	1,183	13%	1,462	13%
25 years	261	16%	34	11%	19	8%	1,478	16%	1,792	16%
30 years	215	14%	53	18%	15	6%	1,370	15%	1,655	15%
35 years	167	11%	45	15%	15	6%	1,198	13%	1,428	13%
40 years	55	3%	13	4%	5	2%	593	6%	667	6%
45 years	9	1%	9	3%	0	0%	183	2%	201	2%
50 years	3	0%	2	1%	0	0%	67	1%	72	1%
55 years	0	0%	0	0%	0	0%	4	0%	4	0%
In more than 55 years	1	0%	4	1%	0	0%	7	0%	13	0%
Do not intend to retire	46	3%	12	4%	20	8%	535	6%	613	5%
Total	**1,587**	**100%**	**300**	**100%**	**243**	**100%**	**9,205**	**100%**	**11,341**	**100%**

Source: Va. Healthcare Workforce Data Center

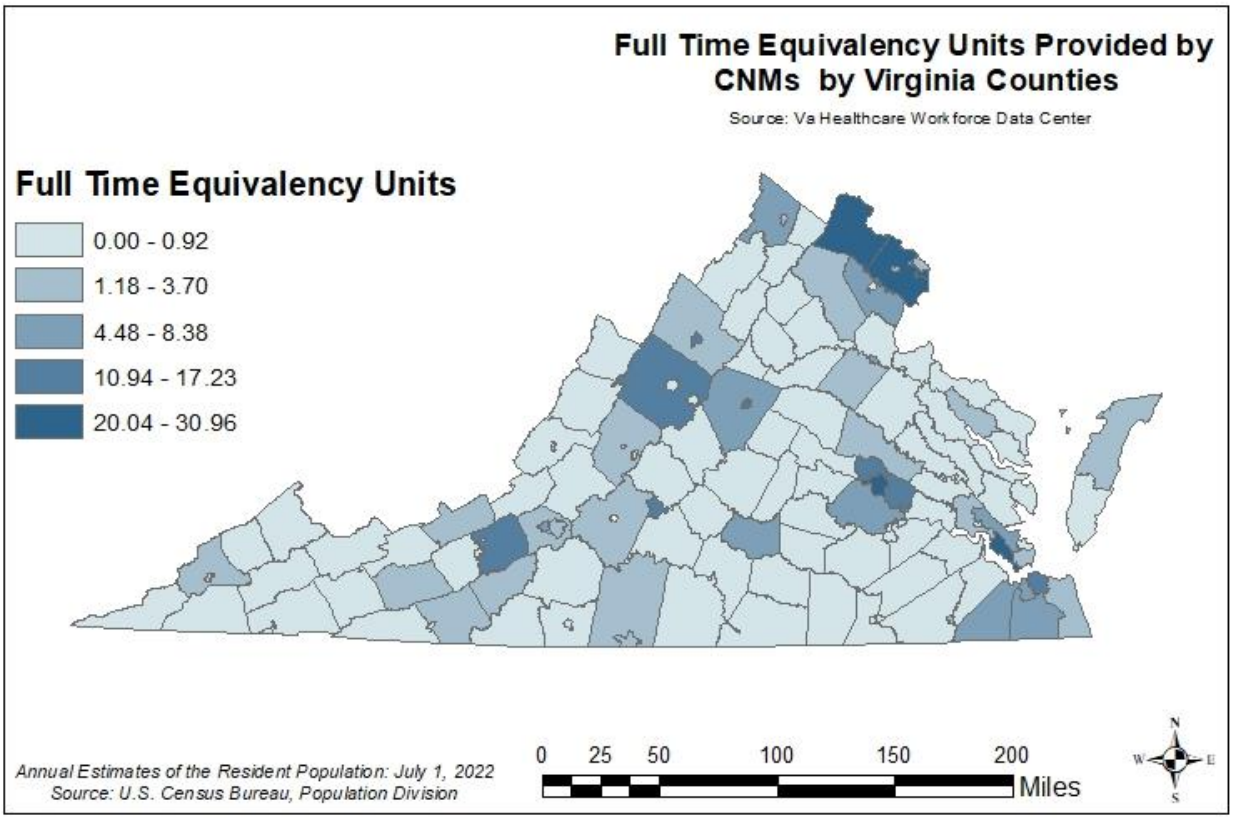
Using these estimates, retirement will begin to reach over 10% of the current workforce every 5 years by 2034. Retirement will peak at 16% of the current workforce around 2049 before declining to under 10% of the current workforce again around 2064.

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%.


Full Time Equivalency Units Provided by CNMs by Virginia Counties
Source: Va Healthcare Workforce Data Center
Full Time Equivalency Units
0.00 - 0.92
1.18 - 3.70
4.48 - 8.38
10.94 - 17.23
20.04 - 30.96
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
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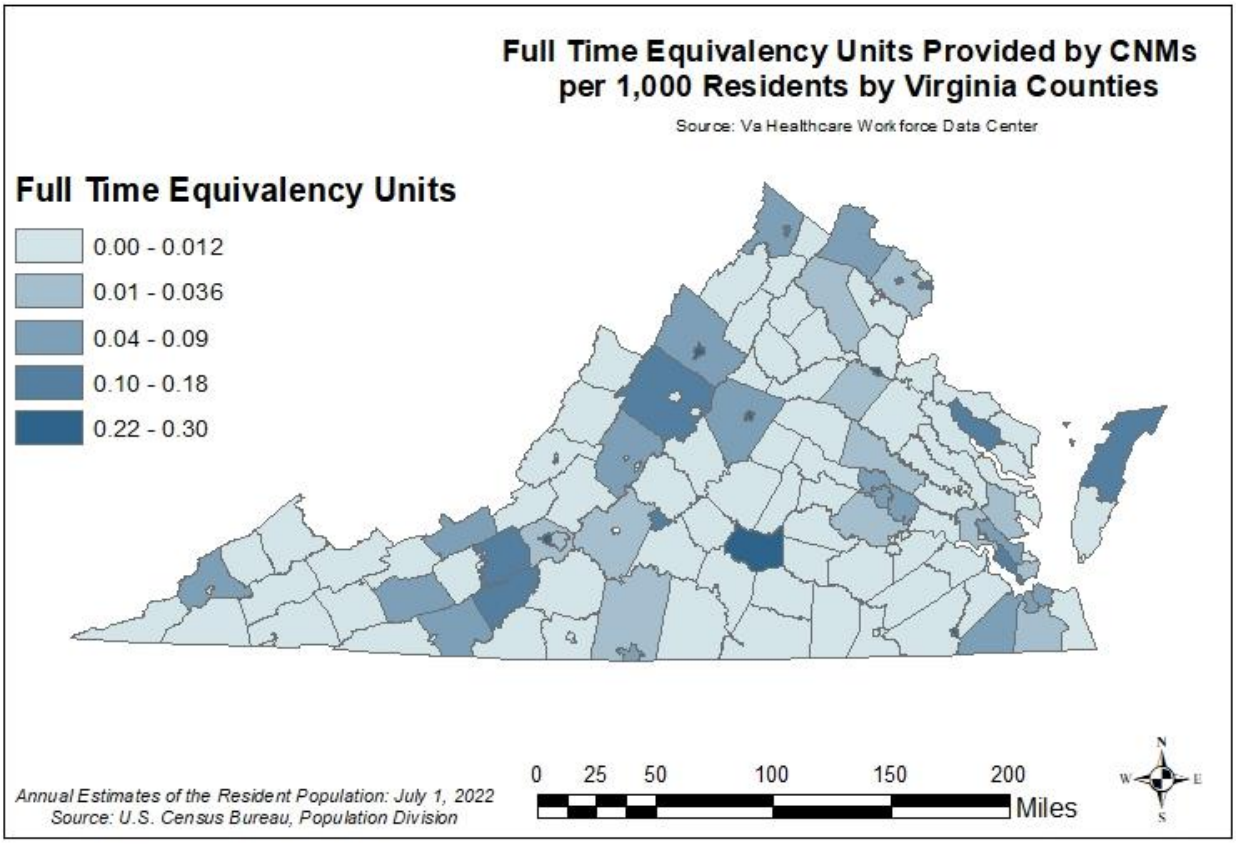
Full Time Equivalency Units Provided by CNMs per 1,000 Residents by Virginia Counties
Source: Va Healthcare Workforce Data Center
Full Time Equivalency Units
0.00 - 0.012
0.01 - 0.036
0.04 - 0.09
0.10 - 0.18
0.22 - 0.30
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
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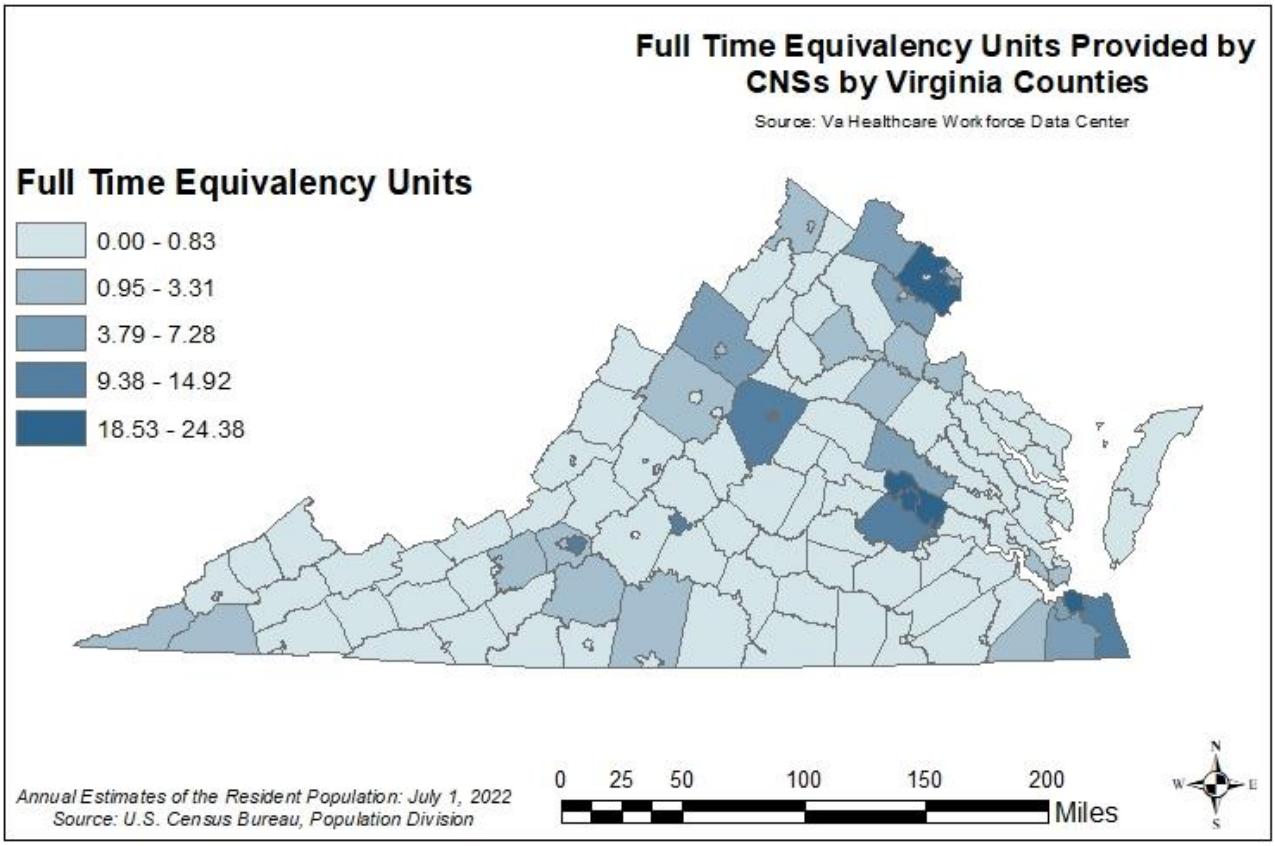
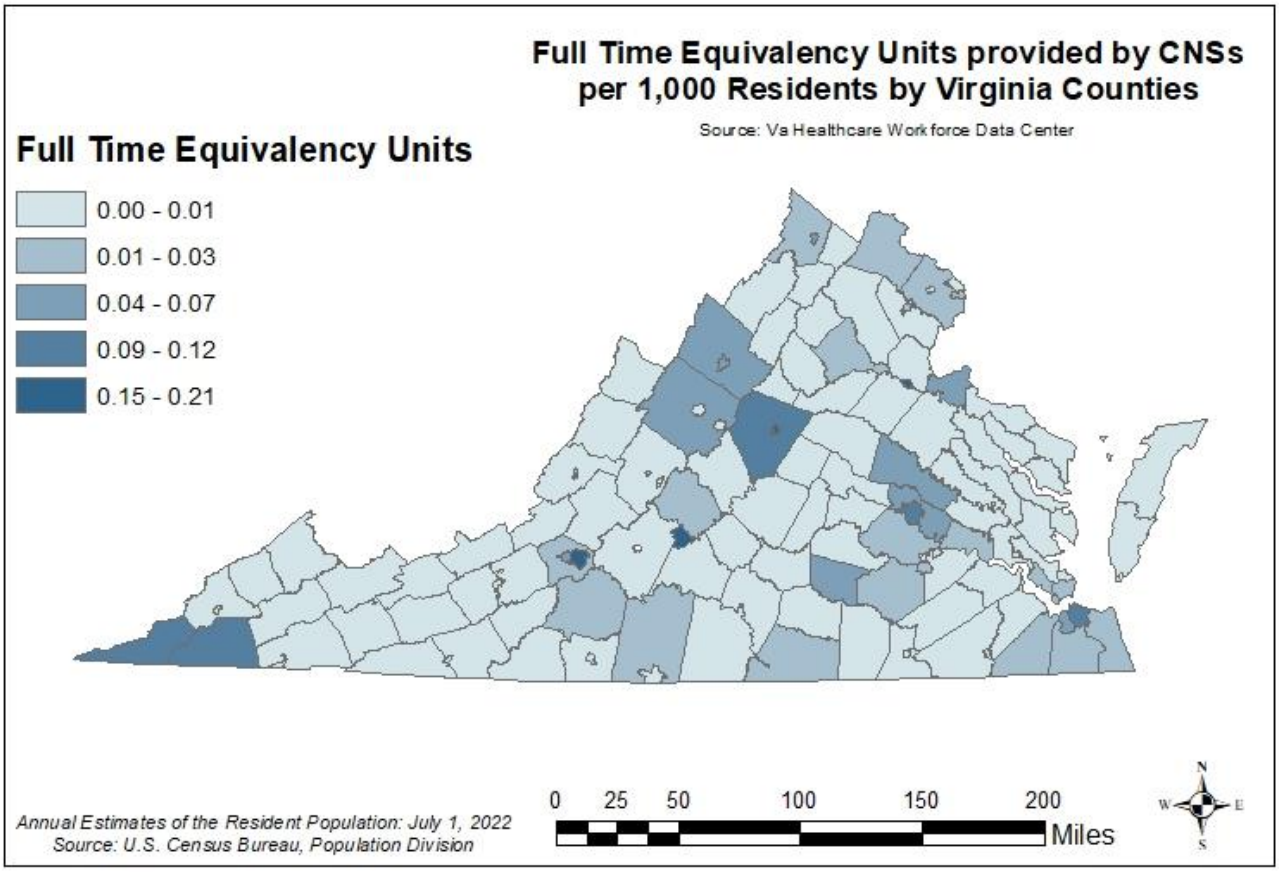
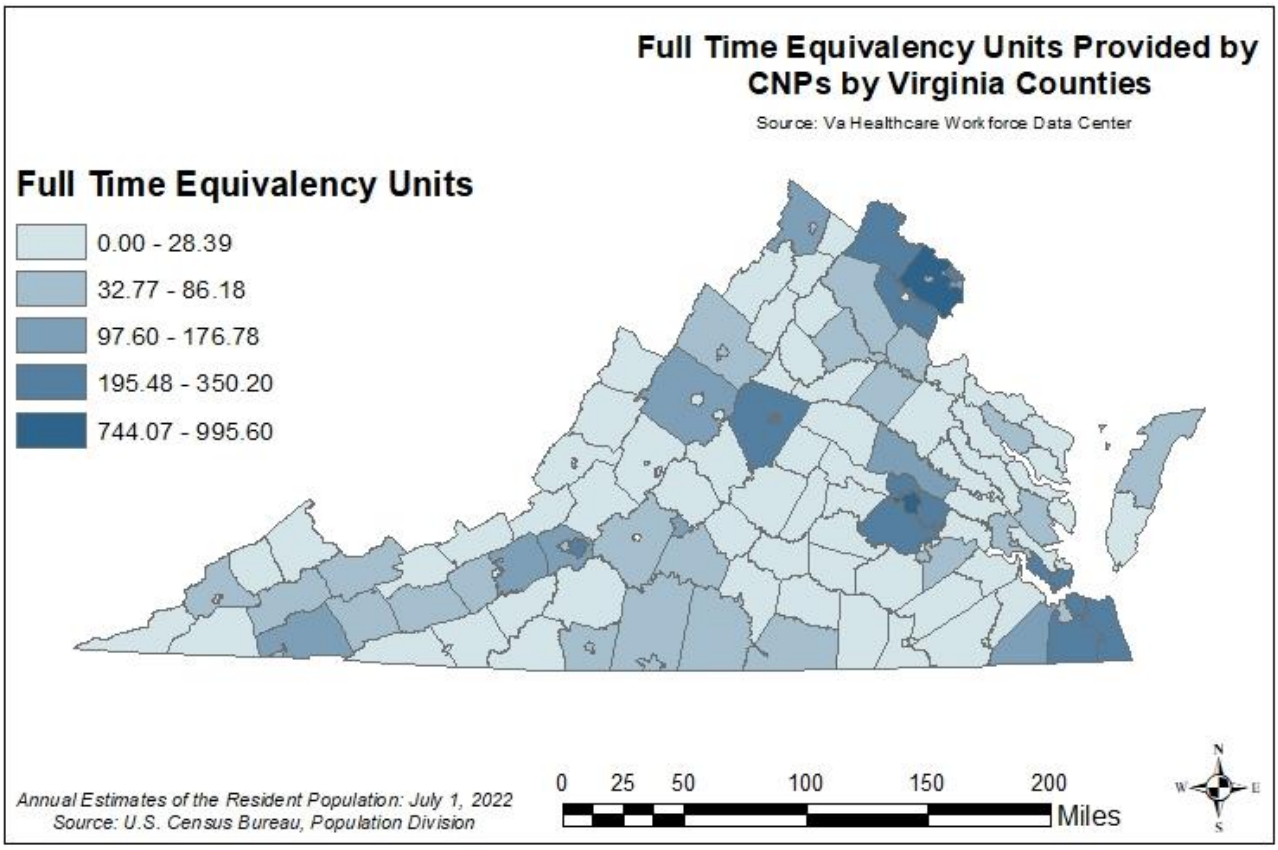
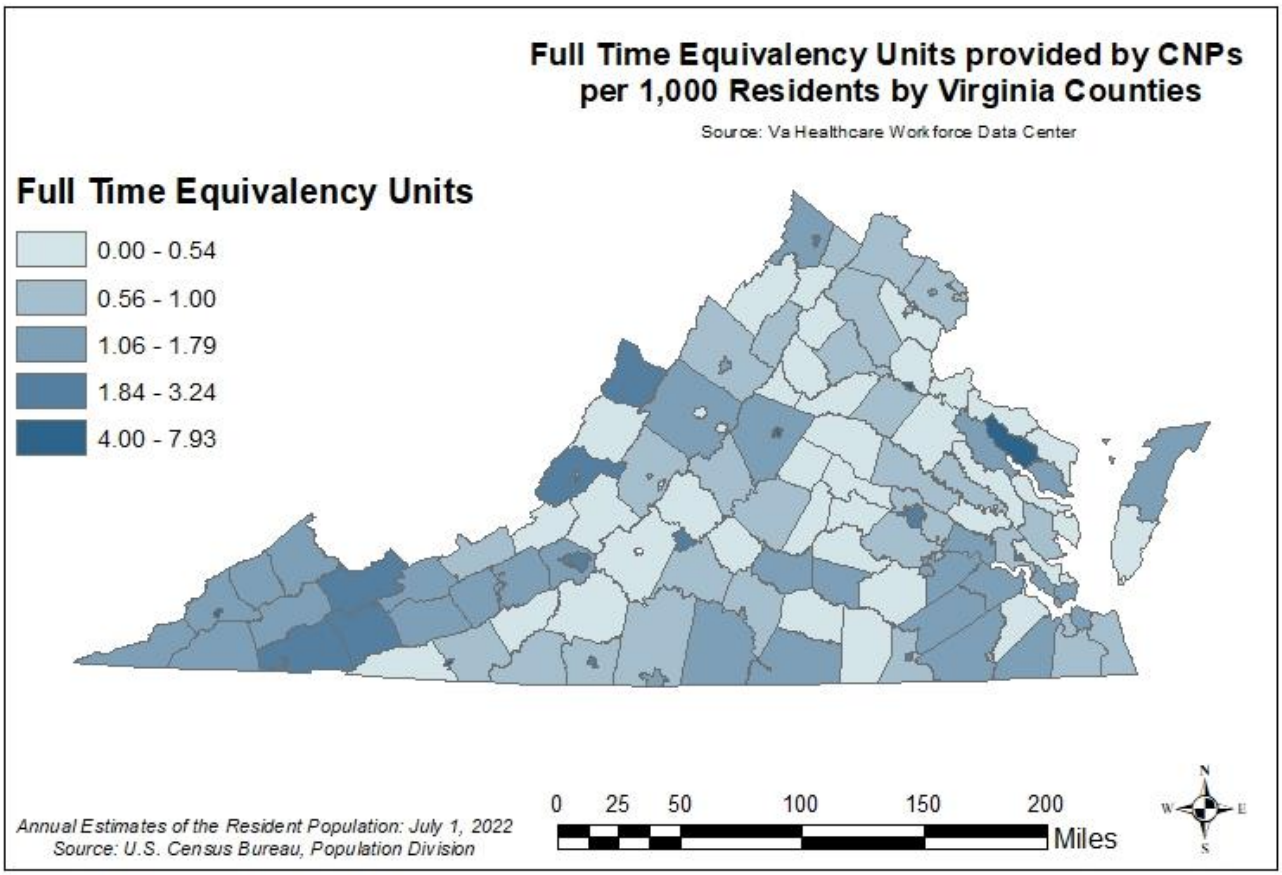
Map of Full Time Equivalency Units – Clinical Nurse Specialists





Map of Full Time Equivalency Units – Certified Nurse Practitioners





A4

JOINT COMMISSION ON HEALTH CARE

STRATEGIES TO STRENGTHEN THE ANESTHESIA WORKFORCE IN VIRGINIA

REPORT TO THE GOVERNOR AND THE
GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT #939

COMMONWEALTH OF VIRGINIA
RICHMOND
2024

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care. For the purposes of this chapter, "health care" shall include behavioral health care.

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Strategies to Strengthen the Anesthesia Workforce in Virginia

Contents

Strategies to Strengthen the Anesthesia Workforce in Virginia

POLICY OPTIONS IN BRIEF

Option 1: Direct BON to update regulations governing practice of CRNAs to remove references to any specific edition of the American Association of Nurse Anesthetists' Standards for Nurse Anesthesia Practice.

Option 2:

Not recommend any policy that would make supervision of certified registered nurse anesthetists more restrictive.

Option 3:

Direct the DHP to develop a plan to transition CRNAs with sufficient training and experience to independent practice.

Option 4:

Require DHP to re-analyze the state of the anesthesia workforce in Virginia.

Option 5:

Provide funding to VHWDA to study the capacity and needs of current anesthesiology residency programs and CRNA training programs in Virginia and make recommendations for further expansion.

FINDINGS IN BRIEF

Multiple authorities are responsible for determining supervision requirements of CRNAs

There are at least three layers of rules that may impact the extent to which CRNAs are supervised, including federal rules, state laws, and hospital or facility bylaws. Due to the interplay between these overlapping authorities, CRNA supervision requirements vary widely in each state. In Virginia, CRNAs are currently subject to the federal rule and Code of Virginia § 54.1-2957.

Stakeholders agree that more restrictive supervision requirements would be detrimental to efforts to address anesthesia workforce shortages

Stakeholders agreed that implementing more restrictive supervision requirements for CRNAs would greatly impact how anesthesia care is delivered in Virginia, particularly for remote or rural facilities in Virginia which use proceduralists as CRNA supervisors and may not have physician anesthesiologists on staff.

Available evidence supports a measured approach to changes in CRNA supervision requirements

Evidence indicates that less restrictive CRNA supervision requirements present a low risk of harm to patients and a possible benefit to the anesthesia workforce. State models that step down from supervision into independent practice could be considered so that possible impacts can be monitored over time.

Strengthening Virginia's anesthesia workforce requires a multifaceted approach

Stakeholders interviewed by the JCHC offered alternative strategies to address anesthesia provider workforce shortages beyond changes to CRNA supervision, including the licensing of CAAs to practice in Virginia and developing additional capacity for physician anesthesiologist residency programs and CRNA training programs.

JCHC Analyst: Emily Atkinson

Strategies to Strengthen the Anesthesia Workforce in Virginia

Concerns about the anesthesia workforce in Virginia received significant debate during the 2024 General Assembly session with the introduction of two bills, HB 1322 and SB 33, pertaining to the supervision of Certified Registered Nurse Anesthetists (CRNA; APPENDIX 1a and 1b). CRNAs are advanced practice nurses who specialize in administering anesthesia and, per Virginia law, are required to be supervised by a licensed doctor of medicine, osteopathy, podiatry, or dentistry (*Code of Virginia* § 54.1-2957).

Lacking stakeholder consensus on the impact changes to CRNA supervision requirements would have on the anesthesia workforce, HB 1322 and SB 33 were both tabled and referred by letter to the Joint Commission on Health Care (JCHC) from the House Committee on Health and Human Services and the Senate Committee on Education and Health. These letters requested that the JCHC study "issues related to the supervision of CRNAs, and an assessment of the anesthesia provider workforce including physician anesthesiologists, CRNAs, and certified anesthesiologist assistants (CAAs)."

During the June 2024 Commission meeting, JCHC members directed staff to conduct a targeted, narrowly scoped study on the anesthesia workforce in Virginia, with a focus on:

- Understanding and describing the anesthesia provider workforce to include the role of anesthesiologists, CRNAs, and CAAs, and
- Assessing the impact of and noting considerations for state strategies to expand the anesthesia provider workforce, including changes to CRNA supervision requirements.

Multiple health care professionals are involved in the delivery of anesthesia care to patients

Anesthesia is an important aspect of patient care and prevents patients from feeling pain during surgery or other medical procedures (SIDEBAR). There are three types of health care professionals who can deliver anesthesia care, two of which practice in Virginia. A physician anesthesiologist is a doctor of medicine or osteopathy who administers anesthesia. A CRNA is an advanced practice registered nurse who specializes in administering anesthesia. CAAs practice as members of care teams who work under the direction of a physician anesthesiologist to carry out the anesthesia care plan. CAAs are

Types of anesthesia serve different purposes and vary in intensity. Local anesthesia numbs a small part of the body while regional anesthesia, such as an epidural, blocks pain in large parts of the body. Sedation puts a patient partially to sleep with the ability to easily wake them and is typically used for colonoscopies. General anesthesia makes a patient completely unconscious and unaware of pain and is typically used for major surgeries.

not permitted to practice in Virginia but do practice in 21 other states/localities. Each provider has differing levels of education, training, and responsibilities as it pertains to a patient's anesthesia care.

Anesthesia providers vary in education, training, certification, and licensing requirements

Anesthesia providers must meet varying educational and training requirements before they can practice (TABLE 1). Anesthesiologists complete four years of pre-med undergraduate education and four years of medical school followed by four years of a residency program in anesthesiology, resulting in a minimum of 12 years of education. It is difficult to quantify the number of clinical hours a physician anesthesiologist receives over the course of their training; however, it is estimated that they receive close to 16,000 hours. This is calculated based on anesthesia residency restrictions which state that residents cannot work more than 80 hours per week. CRNAs pursue a nursing degree through four years of nursing school and then must work for at least one year obtaining hands-on experience in an intensive care unit (ICU). They can then apply to attend a three-year doctoral nurse anesthesia program, during which they complete 2,000 clinical hours. Similar to anesthesiologists, CAAs first complete pre-med training through an undergraduate program. They then pursue a two-year master's level Anesthesia Assistant program during which they complete 2,000 clinical hours, resulting in a minimum of 6 years of educational training.

TABLE 1. Anesthesia providers differ in their educational and training requirements

Education Comparison	Anesthesiologist	CRNA	CAA
Degree Level	MD or DO	Doctor of Nursing	Master's Program
Months of Anesthesia Program	48	36 (Note 1)	24-28
Patient Cases	Unclear	650-700	600
Clinical Hours	~16,640 (4 years at 80 hours per week)	2000	2000
Minimum Total Number of Years of Education	12	7	6
Certification	Board Certification	Exam and national certification	Exam and national certification
Licensing in Virginia	Board of Medicine	Board of Nursing & Medicine	N/A (Note 2)

MD = Doctor of Medicine; DO = Doctor of Osteopathy
NOTE 1: By 2025, all new CRNAs must have a doctorate degree from a nurse anesthesia program that is accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs (COA).
NOTE 2: CAAs are not permitted to practice in Virginia.
SOURCE: JCHC staff analysis of program documentation, 2024.

While the length of the anesthesia programs represents minimum educational requirements, stakeholders reported that in Virginia, many physician anesthesiologists and CRNAs pursue additional years of training. For example, CRNA programs have such competitive applicants that many seek additional years of experience in an ICU setting before applying. In addition, physician anesthesiologists may move into a fellowship for specialty anesthesia following their residency, instead of going directly into practice. Anesthesiologists interviewed by JCHC staff highlighted their advanced skill set, either in terms of the hours of clinical training in certain procedures, or exposure to complex cases during residencies and fellowships, which they felt qualified them to address more difficult cases and specialty cases, such as pediatric or cardiac patients.

In addition to education, all anesthesia providers can receive certification although the processes and certification bodies differ. Anesthesiologists are medical doctors who can obtain board certification; however, board certification is not required to practice. Conversely, CRNAs and CAAs are both mandated to take certification exams through national accrediting bodies. CRNAs receive certification through the National Board Certification and Recertification for Nurse Anesthetists (NBCRNA) and CAAs receive certification through the National Commission of Certification of Anesthesiologist Assistants (NCCAA).

Responsibilities and tasks can vary depending on the type of anesthesia provider

Responsibilities for anesthesia providers can be divided into (1) preoperative, (2) intraoperative, and (3) postoperative responsibilities. Preoperative responsibilities include tasks such as obtaining patient health history, evaluating the patient, ordering tests, prescribing preanesthetic medications, and developing the anesthesia care plan. Intraoperative responsibilities occur during the procedure and include duties such as prescribing anesthetic medications, administering anesthetic agents, establishing airway interventions, monitoring the patient, and recording intraoperative events. Post operative responsibilities include facilitating emergence and recovery from anesthesia, prescribing post-anesthetic agents, conducting post-anesthesia evaluation, and discharging the patient.

Anesthesiologists and CRNAs can perform similar preoperative, intraoperative, and postoperative responsibilities, while CAAs have less scope (APPENDIX 2). For example, physician anesthesiologists and CRNAs are both capable of developing an anesthesia care plan for a patient; however, CAAs must work under the supervision of a physician anesthesiologist to assist in creating the plan. Also, physician anesthesiologists and CRNAs can prescribe anesthetic medications, while CAAs cannot.

Anesthesia providers deliver services via two models of care

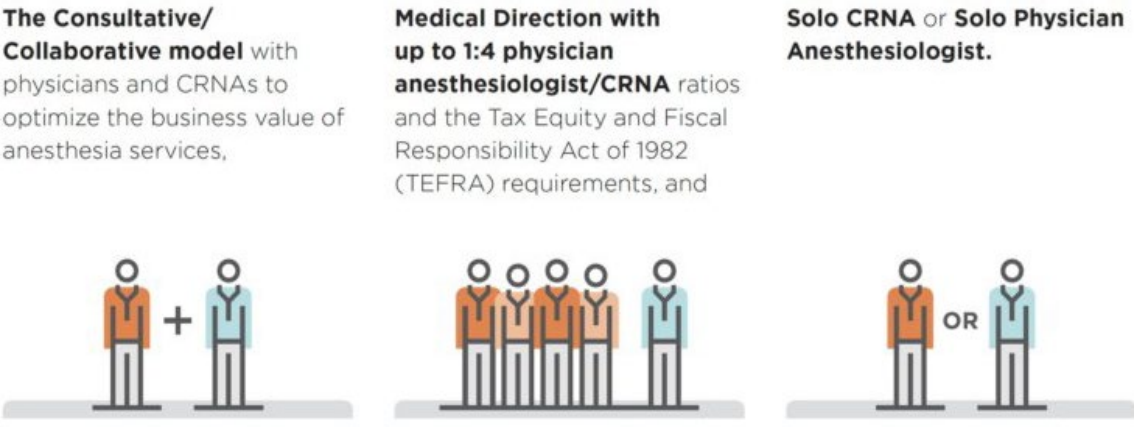
Anesthesia departments may choose to implement services through one of two delivery models: (1) the Anesthesia Care Team (ACT) Model, or (2) the Efficiency Driven Anesthesia Model.

The Anesthesia Care Team Model is directed by a physician anesthesiologist who supervises non-physician anesthesia providers, such as CRNAs or CAAs. There is a clear hierarchy within the model, with the physician anesthesiologist responsible for management of team personnel, patient preanesthetic evaluation, prescription of the anesthetic plan, management of the anesthetic, post anesthesia care, and anesthesia consultation. According to the ACT model, the anesthesiologist may delegate tasks to other team members but should, "participate in critical parts of the anesthetic, and remain immediately available for management of emergencies.[i]"

The Efficiency Driven Anesthesia Model is non-hierarchal and identifies the optimal distribution of anesthesia providers based on factors such as provider availability, provider capabilities, patient acuity, and procedure type while maintaining quality and increasing patient access. The model is flexible to match local demand and financial capacity with three team structures (FIGURE 1):

- The ***consultative/collaboration model*** includes the use of both physician anesthesiologists and CRNAs.
- The ***medical direction model*** uses one physician anesthesiologist who is responsible for overseeing up to four CRNAs, or a 1:4 ratio.
- The ***solo CRNA*** or ***solo physician anesthesiologist model*** involves the selected practitioner delivering anesthesia by themselves.

FIGURE 1. The Efficiency Driven Anesthesia Model offers flexible team structures



SOURCE: American Association of Nurse Anesthesiology. *Efficiency Driven Model Toolkit*, 2022.

[i] American Society of Anesthesiologists. *Statement on the Anesthesia Care Team.* 2023.

Anesthesia providers report multiple factors influence the type of anesthesia delivery models available in Virginia facilities

Based on Virginia Medicare claims from 2022, the most recent year available, 55 percent of anesthesia procedures were performed using the medical direction model. For stakeholders practicing under this model, the most frequently mentioned ratio was 1:4, meaning one anesthesiologist was responsible for supervising four CRNAs. Ratios were even more stringent for specialty and higher acuity cases with providers reporting either a ratio of 1:1 or 1:2 when treating pediatric patients or cardiac cases. Another 23 percent of procedures were performed using the consultative/collaborative model, and 22 percent were performed by a solo anesthesiologist. Stakeholders interviewed for this study indicate that the model used to deliver anesthesia services in Virginia varies based on facility type, geographic location, patient acuity, or the complexity of the surgical procedure.

CRNAs and physician anesthesiologists more often work separately in rural areas than in urban ones. In one national sample of rural hospitals, nearly 55 percent of counties had no anesthesia provider, and for those that did, on average more than 80 percent of anesthesia providers in rural counties were CRNAs. Consistent with national literature, larger hospitals and health systems in Virginia more often reported using the ACT model with a physician anesthesiologist as lead, while smaller rural hospitals and ambulatory surgical centers reported using the solo CRNA model where operating physicians work with CRNAs to provide services. JCHC staff analysis of procedures among Virginia Medicare recipients in rural and remote health districts indicates a smaller proportion of procedures are performed by solo physician anesthesiologists compared to procedures using the medically directed model or the consultative/collaborative model (APPENDIX 3). Given their increased presence in rural areas, studies also indicate that CRNAs were more likely to be the anesthesia providers for vulnerable populations, such as lower-income, uninsured, unemployed, and Medicaid eligible patients, rather than anesthesiologist-provided care.

Specialty cases, such as pediatric or cardiac patients, and higher acuity cases are better suited for anesthesiologists

In Virginia, anesthesiologists, CRNAs, proceduralists (e.g., operating physicians or dentists), and health systems interviewed for this study agree that anesthesiologists are better qualified to take on higher acuity and specialty cases. Interviewees indicated that anesthesiologists were necessary in facilities that served patients with high acuity or complex procedures, and within certain specialty areas, particularly pediatrics and cardiology.

Stakeholders also acknowledged confidence in CRNAs' ability to determine when it is clinically necessary to transfer a case to a higher level of care or determine if a case is not appropriate for the practice setting in which the patient is being treated. CRNAs recognized their role in ensuring patients are being treated in the appropriate setting and described several instances in which high acuity patients were stabilized and transferred to a facility

with an anesthesiologist. As one CRNA interviewed for this study explained, "it's my role as an anesthesia provider to say, hey, this is not a patient that is appropriate for this setting."

Provider shortages are a barrier to timely anesthesia care for patients in Virginia

Nationally, the number of anesthesia providers, including physician anesthesiologists, CRNAs, and CAAs, has increased by 54 percent since 2012. Stakeholders in Virginia however, cite the increasing demand for anesthesia services as the main reason why a shortage of anesthesia providers is still the largest barrier to timely anesthesia care in Virginia.

Supply of anesthesia providers is not keeping pace with demand

Research on the anesthesia workforce points to several factors impacting the demand for anesthesia services, including a growing elderly population, an increasing number of elective and outpatient procedures, and proliferation of non-operating room anesthesia (NORA) sites. Stakeholders in Virginia point to an "explosion" of NORA sites, including imaging centers and ambulatory surgical centers, leading to rationing of the anesthesia provider workforce. At the same time, the supply of physician anesthesiologists is impacted by limits on the number of residency slots, an aging workforce, and burnout. In addition, hospitals expressed increasing financial pressures from rising salaries and competition with private equity groups that offer significant benefits to anesthesiologists and CRNAs not available through private practices or small hospitals.

The number of anesthesiologists practicing in Virginia has increased

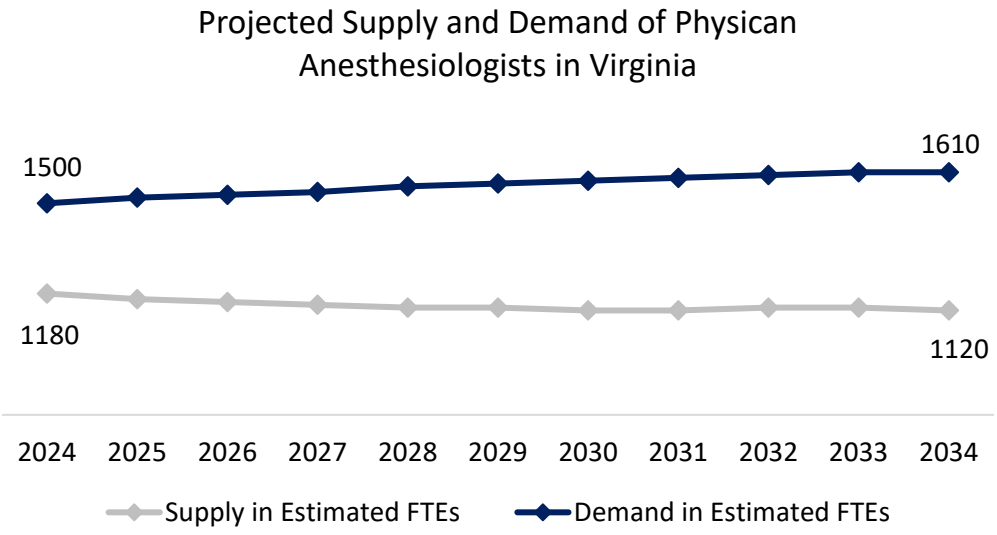
Data from the Virginia Department of Health Professions (DHP) indicate that the number of physicians who are board certified in anesthesiology has increased by 125 providers between 2014 to 2020.[ii] Since the COVID-19 pandemic, stakeholders interviewed for this study report significant shifts in the physician anesthesiologist workforce, including more residents choosing to enter fellowships instead of entering into practice, an increase in retirements, changes in specialties that require less intensive schedules, and a shift towards positions with better work/life balance.

The National Center for Health Workforce Analysis estimates that Virginia's physician anesthesiologists are at 79 percent adequacy in 2024, meaning the current workforce can

[ii] DHP reports a significant decrease in the number of board-certified anesthesiologists practicing in Virginia in 2022, the most recent year of data available. However, DHP staff indicate that the decrease may have resulted from board certifications no longer being a required reporting element.

meet 79 percent of current demand. By 2034, they estimate that adequacy for physician anesthesiologists will drop to 70 percent, attributed to a five percent decrease in the workforce and a seven percent increase in demand (FIGURE 2). This suggests that Virginia will require additional physician anesthesiologists to ensure patients have access to anesthesia services.

FIGURE 2. The demand for anesthesiologists is predicted to increase faster than the supply

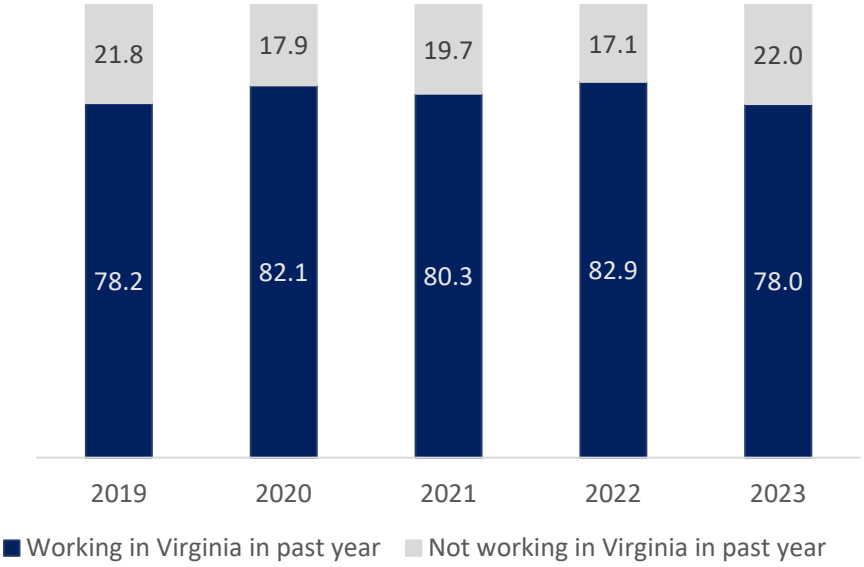


FTE = Full time equivalent
SOURCE: JCHC staff analysis of data from the National Center for Workforce Analysis, 2024.

The number of CRNAs licensed and practicing in Virginia has increased

The total number of CRNAs licensed in Virginia increased by 33 percent in the past five years, from 2,070 in 2019 to 2,771 in 2023. JCHC staff analysis of available DHP data indicates, on average, 80 percent of CRNAs licensed in Virginia also practice in Virginia (FIGURE 3). In 2023, the most recent year available, DHP estimates that 2,162 of 2,771 CRNAs worked in Virginia in the past year. These estimates exclude CRNAs working in Virginia for the federal government, the military, or Veterans Affairs facilities.

FIGURE 3. On average, eighty percent of CRNAs licensed in Virginia also practice in Virginia



SOURCE: JCHC staff analysis of DHP profession report data, 2019-2023.

Between 2024 and 2036, the National Center for Health Workforce Analysis predicts a 24 percent increase in supply of CRNAs in Virginia, but only an 8 percent increase in demand. While Virginia does not currently have enough CRNAs to meet demand, the rapid increase in the number of CRNAs practicing in the state indicates a narrowing, rather than widening, gap between supply and demand.

The Virginia General Assembly considered changing CRNA supervision requirements to strengthen the anesthesia workforce

Currently, Virginia law requires CRNAs to be supervised by a licensed doctor of medicine, osteopathy, podiatry, or dentistry. Some stakeholders suggest that removing supervision requirements would increase access to anesthesia services through the independent practice of CRNAs, while others suggest that CRNAs practicing independently may compromise patient safety and quality of care.

HB 1322 and SB 33 on CRNA Supervision

During Virginia's 2024 legislative session, two bills were introduced regarding CRNA supervision requirements. HB 1322 would have changed the requirement that a CRNA practice *under the supervision of* a doctor of medicine, osteopathy, podiatry, or dentistry to a requirement that a CRNA practice *in consultation with* a doctor of medicine, osteopathy, podiatry, or dentistry. In contrast, SB 33 would have defined supervision as "the licensed doctor of medicine, osteopathy, podiatry, or dentistry is present during an operation or procedure or is immediately available to respond and provide patient care as needed." This sparked a debate within the Virginia General Assembly around the merits of current CRNA supervision requirements. Those in favor of HB 1322 suggested that removing CRNA supervision requirements would increase access to anesthesia care for patients and assist with anesthesia workforce shortages, while those opposed believed removing supervision requirements would be detrimental to the quality and safety of anesthesia care for patients. Those in favor of SB 33 felt that supervision should be further defined to provide clarity around the practice of CRNAs, while those opposed believed SB 33 to define supervision more restrictively than current law requires, therefore potentially exacerbating anesthesia workforce shortages.

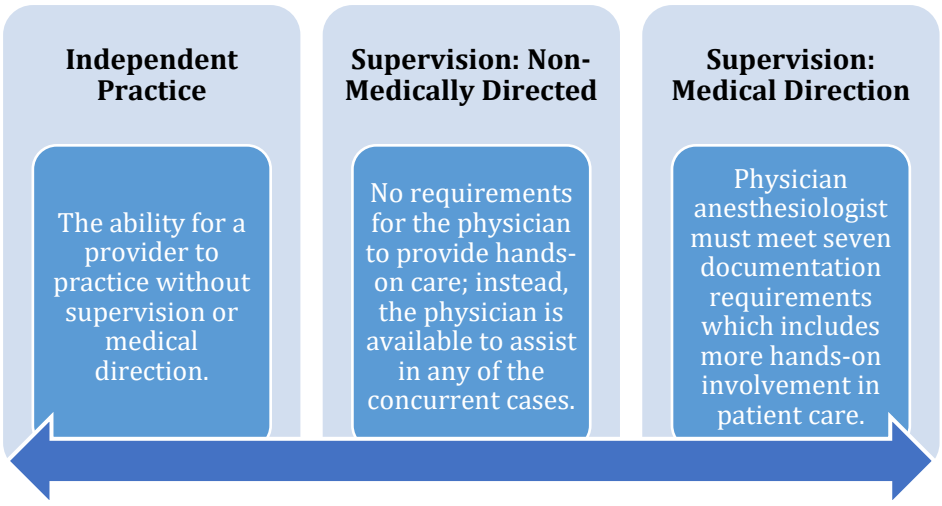
JCHC staff reviewed relevant documents and scientific literature and conducted interviews with more than 50 stakeholders to determine factors influencing CRNA supervision and the potential impacts of proposed changes (see APPENDIX 4 for a full description of methods).

CRNA supervision and scope of practice are separate, distinct concepts

Differing definitions and uses of terms describing CRNA practice, such as supervision and scope of practice, have caused confusion during discussions of key issues on CRNA practice in Virginia. According to the American Medical Association**, scope of practice** "refers to those activities that a person licensed to practice as a health professional is permitted to perform." Scope of practice is best explained as the actual *procedures* a CRNA can perform based on their education and license.

Scope of practice is a distinct and separate concept from **supervision,** which refers to the *type of oversight* with which a CRNA may practice. The type and degree of supervision required for CRNA practice can range from direct, in-person supervision by an anesthesiologist to no supervision (FIGURE 4). The presence of supervision does not innately limit CRNAs' scope of practice. When a CRNA is practicing under supervision, they may still practice the full scope of anesthesia procedures and services they have been trained to perform. Virginia law currently requires CRNAs to practice under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry but does not require the in-person presence of the supervising practitioner. Nothing in Virginia law currently restricts CRNA scope of practice beyond the American Association of Nurse Anesthesiology standards.

FIGURE 4. CRNAs practice under a spectrum of supervision models



SOURCE: JCHC staff analysis of relevant documentation, 2024.

Multiple authorities are responsible for determining supervision requirements of CRNAs

Supervision requirements are not solely determined by state law or regulation. There are at least three layers of rules that may impact the extent to which CRNAs are supervised, including federal rules, state laws, and hospital or facility bylaws. Due to the interplay between these overlapping authorities, CRNA supervision requirements vary widely in each state. This makes interpreting CRNA supervision by state difficult, as it could vary substantially across patient population and facility types.

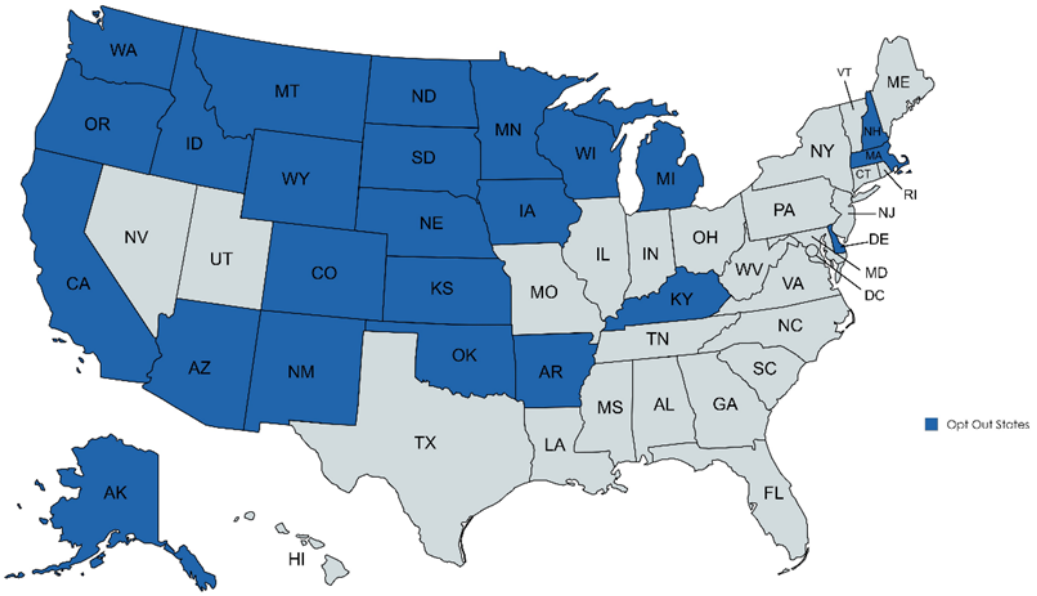
States may choose to opt-out of the federal rule requiring CRNA supervision

Prior to 2001, the federal Centers for Medicare & Medicaid Services (CMS) required, as a Condition of Participation (SIDEBAR) for Medicare and Medicaid reimbursement, that CRNAs in hospitals, critical access hospitals, and ambulatory surgery centers administer anesthesia only under the supervision of an operating practitioner or of an anesthesiologist who is immediately available (42 C.F.R. pts. 416, 482, and 485). Beginning in 2001, CMS permitted states to opt out of this rule if the state's governor sent a letter to CMS attesting consultation with the state's Boards of Medicine and Nursing, affirmed that the opt-out is consistent with state law, and concluded that opting out would be in the best interest of the state.

CMS developed **Conditions of Participation** (CoPs) that health care organizations must meet to begin and continue participating in the Medicare and Medicaid programs. These standards are the foundation for improving quality and protecting the health and safety of beneficiaries.

As of May 2024, 24 states and Guam have opted out of the federal CRNA supervision rule (FIGURE 5). For the remaining 26 states, including Virginia, the federal CRNA supervision rule is still in effect for hospitals and facilities seeking reimbursement from Medicare and Medicaid for CRNA services.

FIGURE 5. Twenty-four states and Guam have opted out of the federal CRNA supervision rule



SOURCE: JCHC staff analysis of documentation provided by CMS, 2024.

Opting out of the federal rule does not guarantee CRNA independent practice. The federal CRNA supervision rule is relevant to reimbursement for CRNA services in hospitals, including critical access hospitals and ambulatory surgical centers. In other scenarios, state law applies, and in some opt out states, the applicable state statute or regulation is more restrictive than the federal rule. In other words, it is possible for a state to opt out of the federal rule and still have state statute or regulations which require CRNAs to practice under supervision or medical direction. For example, Arizona opted out of the federal rule in 2020; however, their state law requires CRNAs to practice under the direction of a physician or surgeon and requires an in-person presence of this supervisor. This language makes Arizona's state law more restrictive than the federal rule. Similarly, Wisconsin opted out of the federal rule in 2005 and has state statute which requires CRNAs to perform anesthesia services "in the presence of a supervising anesthesiologist or performing physician." There are also states that have opted out of the federal rule but still require supervision in particular care settings. For example, New Hampshire opted out of the federal rule in 2002 but only allows CRNAs to deliver anesthesia services without supervision in critical access hospitals. California opted out of the federal rule in 2009 but requires CRNAs to be supervised in trauma centers. So, while these states are typically

counted as "opt-out states," CRNAs are not permitted to practice independently in all settings.

All states describe CRNA supervision in state law or regulation, but language varies considerably

JCHC staff identified state statutes or regulations that describe CRNA supervision in all 50 states and the District of Columbia (see APPENDIX 5 for language from each state). While there are consistencies across states in defining the role of CRNAs, JCHC did not identify a single standard or model policy that multiple states use to describe supervision requirements. In fact, fourteen different terms or phrases are used to describe how CRNAs relate to other health care professionals, such as operating physicians or anesthesiologists, with many states using multiple terms (TABLE 2). States most commonly described the relationship between CRNAs and physicians as collaborative (18 states) or supervisory (11 states, including Virginia). Only 5 states specifically use the term "independent." Fifteen states use language that requires a health care professional other than the CRNA to be immediately available (eight states) or physically present (ten states). Three states require a physician to be immediately available *and* physically present.

TABLE 2. States use 14 terms to describe the relationship between CRNAs and other health care professionals

Term Appearing in Statute or Regulation	Number of States
In collaboration with	18
Under supervision	11
In consultation with	9
Under the direction of	7
Independent	5
Responsible to	2
Refer to	2
Interdependent	2
Without supervision	2
With the consent of	1
Accountable to	1
Delegate to	1
In coordination with	1
Upon request of	1
Total	**63**

NOTE: States can use more than one term.
SOURCE: JCHC staff analysis of state statutes and regulations, 2024.

In Virginia, CRNAs are currently subject to the federal rule and *Code of Virginia* § 54.1-2957. Virginia has not opted out of the federal ruling for CRNA supervision. In addition, *Code of Virginia* § 54.1-2957 requires CRNAs to practice under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry; however, supervision is not further defined. Virginia regulations in *18VAC90-30-121* further state that, "the practice of a certified registered nurse anesthetist shall be based on specialty education preparation as an advanced practice registered nurse in accordance with standards of the applicable certifying organization and with the functions and standards defined by the American Association of Nurse Anesthetists (Standards for Nurse Anesthesia Practice, Revised 2013)." However, the Standards for Nurse Anesthesia Practice were most recently updated in 2019.

➔ **OPTION 1:** The JCHC could introduce a Section 1 bill directing the Board of Nursing to update regulations governing practice of advance practice registered nurses licensed as certified registered nurse anesthetists (CRNAs) to remove references to any specific edition of the American Association of Nurse Anesthetists' Standards for Nurse Anesthesia Practice, so that the practice of a CRNA shall be consistent with the most recent version of the Standards for Nurse Anesthesia Practice available.

Hospital bylaws determine team structure and define roles for anesthesia providers

In addition to the federal rule and state statute, hospitals and health systems implement their own bylaws for CRNA supervision that can be more restrictive than the state law limiting CRNA practice. For example, a facility could choose to use a more restrictive model of practice, such as **medical direction,** which would mean that the procedures and services a CRNA could perform could be limited by the supervisor to an extent that is more limited than the CRNA's scope of practice. Literature reviewed by JCHC staff indicates that anesthesia team structure, supervision requirements, and the type of procedures and tasks a CRNA is allowed to perform are more hospital-driven than federal rule or state statute-driven. Even in states that opt out of the federal rule and have permissive supervision requirements, some health care facilities still choose to engage in the Anesthesia Care Team model. In Virginia, CRNAs interviewed by JCHC staff reported that the application of hospital bylaws limits the type of procedures and tasks they are allowed to perform more than the state supervision law.

Given the authority health systems have to implement their own bylaws, stakeholders interviewed by JCHC staff expressed uncertainty about the impact of changes in the federal rule or state law. Anesthesiologists hypothesized that hospital bylaws requiring CRNA supervision would likely not change if Virginia opted out of the federal rule. However, health systems said they would consider moving to an efficiency-driven model, where CRNAs could practice independently at certain facilities or under certain circumstances. One health system noted, "we would probably still keep [supervision] in place at our

hospitals because in the acute setting, those patients are sicker, and the anesthesia is more complicated. But what we would also do is, in an ambulatory setting, we might loosen [supervision restrictions]."

Stakeholders do not want more restrictive CRNA practice but disagree on the impact of reducing CRNA supervision requirements

While stakeholders interviewed by JCHC for this study had varying opinions on reducing CRNA supervision requirements, they were unanimously opposed to implementing more restrictive supervision requirements.

Stakeholders agree that more restrictive supervision requirements would be detrimental to efforts to address anesthesia workforce shortages

In general, CRNAs and proceduralists indicated that Virginia statute, as currently written, was flexible enough to allow anesthesia providers to practice as they preferred and to allow proceduralists to deliver anesthesia care to their patients as they preferred, with CRNAs under the supervision of an anesthesiologist or a proceduralist. Some anesthesiologists expressed a preference for more restrictive supervision, where CRNAs always practiced under their supervision, but they also recognized that such a structure would be impractical given current workforce shortages. Most anesthesiologists believe that the current state law is working for Virginia. One anesthesiologist stated, "good care is happening under our current system" and another recognized that the current law is flexible enough for hospitals to implement the supervision requirements that fit their situation. Stakeholders universally agreed that implementing more restrictive supervision requirements for CRNAs would greatly impact how anesthesia care is delivered in Virginia, particularly for remote or rural facilities in Virginia which use proceduralists as CRNA supervisors and may not have physician anesthesiologists on staff.

➔ **OPTION 2:** The JCHC should not recommend any policy that would make supervision of certified registered nurse anesthetists more restrictive than current state statute or federal rule require.

There is no consensus among stakeholders regarding the impact of reducing supervision requirements

Stakeholders had varying opinions on the impact that reducing CRNA supervision requirements would have on the anesthesia provider workforce in Virginia. Anesthesiologists generally oppose reducing supervision due to concerns about patient safety. They hypothesized that, if CRNA supervision were removed, anesthesia care would develop into a two-tiered model in Virginia, where certain populations would have access to an anesthesiologist and certain populations would have access to a CRNA depending on

where they live and not the type of care they need. In terms of the impact on the workforce, anesthesiologists typically believed that changing CRNA supervision requirements would create additional workforce concerns as anesthesiologists would seek out practice environments where they are "actually contributing to care rather than just signing pieces of paper" and proceduralists who are uncomfortable in a CRNA-only environment would choose to practice elsewhere.

CRNAs interviewed by JCHC staff supported reducing supervision requirements. CRNAs reported that the current state law does not, in their opinion, reflect current practice with its emphasis on supervision instead of collaboration. Anesthesiologists interviewed for this study often used the word "collaborative" to describe their relationship with CRNAs. One CRNA stated, "it's the anesthesiologist's job to assess the risk of the patient, do the pre-operative, and then be there for that extra set of hands if you ever need them, but then we're performing 95% of the anesthesia that happens." CRNAs felt that changing supervision requirements could eliminate confusion about current practice and address concerns about the relationship between supervision and liability that make some proceduralists hesitant to work with CRNAs.

Many CRNAs expressed that in cases where a proceduralist is providing supervision, they are providing supervision on paper, but not in practice. Proceduralists are not experts in airways or anesthesia and therefore do not truly supervise CRNAs in the way that a physician anesthesiologist would. CRNAs believe that loosening supervision requirements in Virginia would not have a huge impact on how anesthesia care is being delivered but would instead more accurately reflect what is already occurring in practice and possibly reduce the administrative burdens supervision carries, leading to less costly care for patients, and more CRNAs wanting to come to Virginia to practice.

Hospitals and health systems remained neutral in their opinions around the impact of changing CRNA supervision requirements. While they would not oppose additional flexibility around supervision rules and would welcome the opportunity to move to an efficiency driven model, changes to supervision requirements at the state level would likely not have significant impacts on how they operate, particularly for specialty cases and higher acuity cases. One health system indicated that, if state law became less restrictive, they would be willing to reconsider their bylaws to allow CRNAs to practice more independently. In contrast, a specialty hospital indicated that they would not change their bylaws regarding CRNA supervision, even if state law became less restrictive, given the acuity of patients that come to their hospital.

There is little evidence to suggest that CRNAs decrease patient safety, patient outcomes, or quality of care compared to anesthesiologists

Anesthesiologists opposed to changes in CRNA practice believed patient safety would be compromised if supervision requirements were removed as CRNAs would not have back up in the operating room if something went wrong. However, the literature reviewed by JCHC

staff does not support this concern. A number of studies provided quantitative evidence that there is no difference in patient safety or patient outcomes with CRNAs compared to anesthesiologists. Multiple stakeholders interviewed for this study agreed that both anesthesiologists and CRNAs provide safe, effective, and high-quality anesthesia services to patients. Several Virginia-based health systems also expressed that they did not see a difference in care quality between the different anesthesia providers that were employed by their health system.

Evidence is mixed on whether CRNAs increase access to care for patients

Proceduralists interviewed by JCHC staff noted that working with CRNAs had improved access to care for their patients by allowing them to treat patients in an outpatient setting who would otherwise have had to be hospitalized. However, evidence from the scientific literature is mixed on the impact of CRNA supervision on access to anesthesia care. While CRNAs have been shown to assist with workforce shortages and access to anesthesia services more generally, it is unclear if changes in supervision requirements are the reason patients' access to anesthesia services increases. A handful of studies provided evidence that CRNAs are more likely to practice in rural and underserved areas, but multiple studies also showed that reducing supervision requirements had no impact on patient's access to anesthesia services. This suggests that the presence of CRNAs on a care team might increase access to anesthesia services more generally, but changes in supervision requirements do not necessarily equate to increased access for patients.

Available evidence supports a measured approach to changes in CRNA supervision requirements

In summary, evidence reviewed by JCHC staff for this study indicates that less restrictive CRNA supervision requirements present a low risk of harm to patients and a possible benefit to the anesthesia workforce. If repealing or reducing CRNA supervision requirements is of interest to the General Assembly, state models that step down from supervision into independent practice could be considered so that possible impacts can be monitored over time, including any unintended consequences.

Three states allow CRNAs to transition from supervised practice to independent practice based on specific criteria. In Michigan, for example, CRNAs may practice without supervision after 3 years of experience and a minimum of 4,000 hours as a nurse anesthetist. In Vermont, a formal agreement with a collaborating provider is required until CRNAs reach 12 months of experience or 1,600 hours. And in Connecticut, CRNAs must practice under a physician for the first three years after receiving their initial licensure.

➔ **OPTION 3:** JCHC could introduce a Section 1 bill directing the Department of Health Professions, in consultation with the Board of Medicine and the Board of Nursing, to develop a plan to transition CRNAs with sufficient training and experience to independent practice. Development of the plan should include stakeholder engagement, considerations

for opting out of the federal rule, and methods to monitor the effects of implementation. The plan should specify the training and experience necessary for transition to independent practice, including (i) the appropriate number of clinical hours and years of practice required for transition to independent practice and any requirements related to clinical hours dedicated to specialty anesthesia services such as anesthesia services for pediatric, cardiac, or higher acuity patients, if appropriate, and (ii) the process by which a CRNA may apply for and obtain permission to practice without supervision. DHP would submit the plan and suggested language for legislation to the Joint Commission on Health Care by October 1, 2025.

Strengthening Virginia's anesthesia workforce requires a multifaceted approach

Stakeholders interviewed by the JCHC offered alternative strategies to address anesthesia provider workforce shortages beyond changes to CRNA supervision, including the licensing of CAAs to practice in Virginia and developing additional capacity for physician anesthesiologist residency programs and CRNA training programs.

CAAs practice in 21 states and Washington, D.C. but supply is limited

CAAs practice in 21 states and Washington, D.C. Currently, Virginia does not allow CAAs to practice and there are no CAA training programs in the state. Most states that license CAAs have explicit licensure through the state medical board, but four states (Kansas, Michigan, Pennsylvania, Texas) require CAAs to practice under delegatory authority of an anesthesiologist's license, and one state (Kentucky) requires CAAs to also have a physician assistant license to practice. There are 20 CAA training programs across the United States, with the closest to Virginia being in Washington, D.C., and as of 2024, there were approximately 4,000 CAAs in total across the entire country. For CAAs to be a health care extender in Virginia, additional training capacity would be required. As such, CAAs would not necessarily address short-term workforce issues.

CAAs are limited in the tasks they can perform and, unlike CRNAs, must always be under the direction of an anesthesiologist. Although the tasks that CAAs can carry out vary from state to state, most commonly CAAs can administer controlled substances, establish airway interventions, and perform epidurals. Anesthesiologists and health systems who provided perspective on the CAAs felt that even with their limited scope, CAAs could assist with workforce shortages in areas where anesthesiologists are practicing by reducing strain on the current anesthesia workforce and providing hospitals additional staffing flexibility. For example, one health system indicated that they would use CAAs consistent with their skill set, adding, "we can control the safety and make sure we have the same level of care, not because of anything the Commonwealth would do, but because of our own regulations and bylaws."

In 2017, DHP conducted a study on the feasibility of licensing CAAs at the request of the Virginia General Assembly. At that time, the DHP report concluded that licensing CAAs was not recommended due, in part, to a lack of proof of a statewide shortage of anesthesia providers. However, workforce projections used in DHP's analysis have changed significantly since that time given the impacts of the COVID-19 pandemic and the slow pace at which the health care workforce generally, and the anesthesia provider workforce specifically, has been able to recover.

➔ **OPTION 4:** JCHC could submit a Section 1 bill requiring the Department of Health Professions to re-analyze the state of the anesthesia workforce in Virginia with the most current data available to determine whether there is sufficient proof of an anesthesia workforce shortage that would justify licensure of certified anesthesiologist assistants. The Department would submit a report to the Joint Commission on Health Care by October 1, 2025.

Stakeholders support increasing the pipeline of anesthesiologists and CRNAs in Virginia

Stakeholders interviewed for this study nearly unanimously supported increasing the capacity of Virginia's physician anesthesiology residency programs and CRNA doctoral training programs as a strategy to address provider shortages. National research also supports the value of increasing the anesthesia provider pipeline, with one study indicating that an annual increase of two percentage points in the entry rate of anesthesia providers would eliminate nearly all excess demand within seven years.

Virginia's anesthesiology residency programs and CRNA training programs are operating at capacity

Education and training program leaders indicate significant interest in pursuing careers in anesthesia; however, programs lack capacity to accommodate all qualified candidates. Currently, there are three anesthesiology residency programs in Virginia, located at Virginia Commonwealth University (VCU), the University of Virginia (UVA), and Eastern Virginia Medical School (EVMS). Data from the National Residency Matching Program reports the number of residency slots for anesthesiologists in Virginia has increased from 27 residents in 2020 to 33 residents in 2024. Except for 2020, when there was one less resident than slots, residency slots for the three programs in Virginia have been filled. In addition, Mary Baldwin University announced a new anesthesiology residency program to begin in July 2025 with a class of 6 residents.

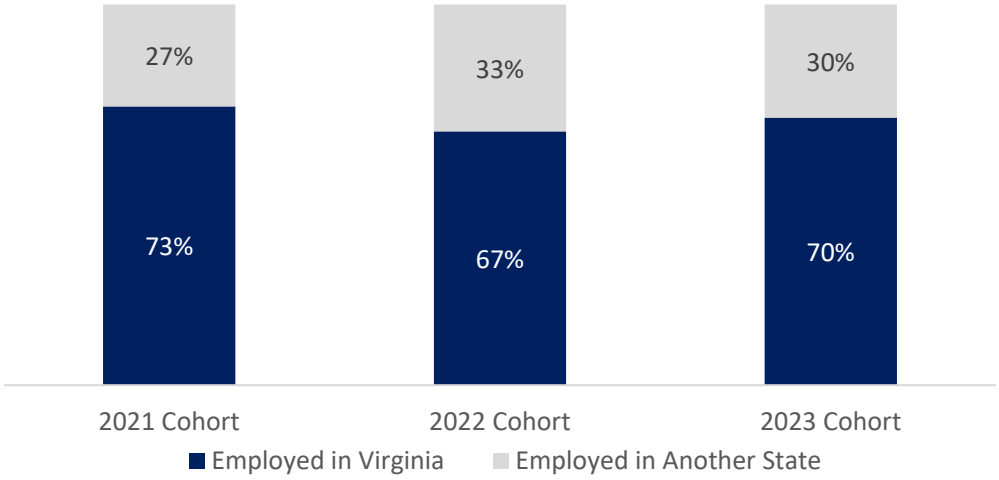
Old Dominion University (ODU), Virginia Commonwealth University (VCU), and Mary Baldwin University operate Virginia's three accredited CRNA training programs. Program capacity varies, with VCU admitting 55 students, ODU admitting 30 students, and Mary Baldwin admitting 25 students into their most recent cohorts. These programs are very

popular and competitive; one program director reported turning away over 500 qualified applicants.

Most anesthesia providers who graduate from Virginia programs gain employment in Virginia

Among physicians with a board certification in anesthesiology currently practicing in Virginia, 34 percent completed graduate school or their post-graduate training in Virginia and an additional 25 percent completed graduate school or their post-graduate training in a state/locality bordering Virginia. Similarly, most graduates from CRNA training programs at VCU and ODU gain employment in Virginia following graduation (FIGURE 6).[iii] In 2023, 70 percent of graduating CRNAs reported employment in Virginia whereas 30 percent reported employment in other states.

FIGURE 6. CRNAs graduating from Virginia programs seek employment in Virginia following graduation



SOURCE: JCHC analysis of CRNA training program data, 2024.

Adding capacity to existing programs or creating new programs requires careful consideration to balance the resources needed for additional faculty and clinical training opportunities within existing workforce needs. Proper planning also avoids workforce saturation and ensures programs are of appropriate educational quality and can provide meaningful clinical training to their students.

[iii] Mary Baldwin expects their first graduating cohort in 2025.

➔ **OPTION 5:** JCHC could submit a budget amendment, providing funding to the Virginia Health Workforce Development Authority (VHWDA) to, in collaboration with the State Council of Higher Education for Virginia, and other relevant stakeholders, study the capacity and needs of current anesthesiology residency programs and CRNA training programs in Virginia and make recommendations for further expansion. VHWDA would submit a report to the Joint Commission on Health Care and to the Chairs of the House Appropriations Committee and Senate Finance and Appropriations Committee by October 1, 2026.

Appendix 1a: House Bill 1322

2024 SESSION

HOUSE SUBSTITUTE

24107103D

HOUSE BILL NO. 1322
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the House Committee on Health and Human Services
on February 8, 2024)
(Patron Prior to Substitute—Delegate Sickles)

A BILL to amend and reenact §§ 54.1-2900 and 54.1-2957 of the Code of Virginia, relating to certified registered nurse anesthetist; elimination of supervision requirement.

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2900 and 54.1-2957 of the Code of Virginia are amended and reenacted as follows:

§ 54.1-2900. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Acupuncturist" means an individual approved by the Board to practice acupuncture. This is limited to "licensed acupuncturist" which means an individual other than a doctor of medicine, osteopathy, chiropractic or podiatry who has successfully completed the requirements for licensure established by the Board (approved titles are limited to: Licensed Acupuncturist, Lic.Ac., and L.Ac.).

"Advanced practice registered nurse" means a certified nurse midwife, certified registered nurse anesthetist, clinical nurse specialist, or nurse practitioner who is jointly licensed by the Boards of Medicine and Nursing pursuant to § 54.1-2957, has completed an advanced graduate-level education program in a specialty category of nursing, and has passed a national certifying examination for that specialty.

"Auricular acupuncture" means the subcutaneous insertion of sterile, disposable acupuncture needles in predetermined, bilateral locations in the outer ear when used exclusively and specifically in the context of a chemical dependency treatment program.

"Birth control" means contraceptive methods that are approved by the U.S. Food and Drug Administration. "Birth control" shall not be considered abortion for the purposes of Title 18.2.

"Board" means the Board of Medicine.

"Certified nurse midwife" means an advanced practice registered nurse who is certified in the specialty of nurse midwifery and who is jointly licensed by the Boards of Medicine and Nursing as an advanced practice registered nurse pursuant to § 54.1-2957.

"Certified registered nurse anesthetist" means an advanced practice registered nurse who is certified in the specialty of nurse anesthesia, who is jointly licensed by the Boards of Medicine and Nursing as an advanced practice registered nurse pursuant to § 54.1-2957, and who practices ~~under the supervision of~~ *in consultation with* a doctor of medicine, osteopathy, podiatry, or dentistry but is not subject to the practice agreement requirement described in § 54.1-2957.

"Clinical nurse specialist" means an advanced practice registered nurse who is certified in the specialty of clinical nurse specialist and who is jointly licensed by the Boards of Medicine and Nursing as an advanced practice registered nurse pursuant to § 54.1-2957.

"Collaboration" means the communication and decision-making process among health care providers who are members of a patient care team related to the treatment of a patient that includes the degree of cooperation necessary to provide treatment and care of the patient and includes (i) communication of data and information about the treatment and care of a patient, including the exchange of clinical observations and assessments, and (ii) development of an appropriate plan of care, including decisions regarding the health care provided, accessing and assessment of appropriate additional resources or expertise, and arrangement of appropriate referrals, testing, or studies.

"Consultation" means communicating data and information, exchanging clinical observations and assessments, accessing and assessing additional resources and expertise, problem-solving, and arranging for referrals, testing, or studies.

"Genetic counselor" means a person licensed by the Board to engage in the practice of genetic counseling.

"Healing arts" means the arts and sciences dealing with the prevention, diagnosis, treatment and cure or alleviation of human physical or mental ailments, conditions, diseases, pain or infirmities.

"Licensed certified midwife" means a person who is licensed as a certified midwife by the Boards of Medicine and Nursing.

"Medical malpractice judgment" means any final order of any court entering judgment against a licensee of the Board that arises out of any tort action or breach of contract action for personal injuries or wrongful death, based on health care or professional services rendered, or that should have been rendered, by a health care provider, to a patient.

"Medical malpractice settlement" means any written agreement and release entered into by or on behalf of a licensee of the Board in response to a written claim for money damages that arises out of

HOUSE SUBSTITUTE

HB1322H1

any personal injuries or wrongful death, based on health care or professional services rendered, or that should have been rendered, by a health care provider, to a patient.

"Nurse practitioner" means an advanced practice registered nurse, other than an advanced practice registered nurse licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife, certified registered nurse anesthetist, or clinical nurse specialist, who is jointly licensed by the Boards of Medicine and Nursing pursuant to § 54.1-2957.

"Occupational therapy assistant" means an individual who has met the requirements of the Board for licensure and who works under the supervision of a licensed occupational therapist to assist in the practice of occupational therapy.

"Patient care team" means a multidisciplinary team of health care providers actively functioning as a unit with the management and leadership of one or more patient care team physicians for the purpose of providing and delivering health care to a patient or group of patients.

"Patient care team physician" means a physician who is actively licensed to practice medicine in the Commonwealth, who regularly practices medicine in the Commonwealth, and who provides management and leadership in the care of patients as part of a patient care team.

"Patient care team podiatrist" means a podiatrist who is actively licensed to practice podiatry in the Commonwealth, who regularly practices podiatry in the Commonwealth, and who provides management and leadership in the care of patients as part of a patient care team.

"Physician assistant" means a health care professional who has met the requirements of the Board for licensure as a physician assistant.

"Practice of acupuncture" means the stimulation of certain points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain ailments or conditions of the body and includes the techniques of electroacupuncture, cupping and moxibustion. The practice of acupuncture does not include the use of physical therapy, chiropractic, or osteopathic manipulative techniques; the use or prescribing of any drugs, medications, serums or vaccines; or the procedure of auricular acupuncture as exempted in § 54.1-2901 when used in the context of a chemical dependency treatment program for patients eligible for federal, state or local public funds by an employee of the program who is trained and approved by the National Acupuncture Detoxification Association or an equivalent certifying body.

"Practice of athletic training" means the prevention, recognition, evaluation, and treatment of injuries or conditions related to athletic or recreational activity that requires physical skill and utilizes strength, power, endurance, speed, flexibility, range of motion or agility or a substantially similar injury or condition resulting from occupational activity immediately upon the onset of such injury or condition; and subsequent treatment and rehabilitation of such injuries or conditions under the direction of the patient's physician or under the direction of any doctor of medicine, osteopathy, chiropractic, podiatry, or dentistry, while using heat, light, sound, cold, electricity, exercise or mechanical or other devices.

"Practice of behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

"Practice of chiropractic" means the adjustment of the 24 movable vertebrae of the spinal column, and assisting nature for the purpose of normalizing the transmission of nerve energy, but does not include the use of surgery, obstetrics, osteopathy, or the administration or prescribing of any drugs, medicines, serums, or vaccines. "Practice of chiropractic" shall include (i) requesting, receiving, and reviewing a patient's medical and physical history, including information related to past surgical and nonsurgical treatment of the patient and controlled substances prescribed to the patient, and (ii) documenting in a patient's record information related to the condition and symptoms of the patient, the examination and evaluation of the patient made by the doctor of chiropractic, and treatment provided to the patient by the doctor of chiropractic. "Practice of chiropractic" shall also include performing the physical examination of an applicant for a commercial driver's license or commercial learner's permit pursuant to § 46.2-341.12 if the practitioner has (i) applied for and received certification as a medical examiner pursuant to 49 C.F.R. Part 390, Subpart D and (ii) registered with the National Registry of Certified Medical Examiners.

"Practice of genetic counseling" means (i) obtaining and evaluating individual and family medical histories to assess the risk of genetic medical conditions and diseases in a patient, his offspring, and other family members; (ii) discussing the features, history, diagnosis, environmental factors, and risk management of genetic medical conditions and diseases; (iii) ordering genetic laboratory tests and other diagnostic studies necessary for genetic assessment; (iv) integrating the results with personal and family medical history to assess and communicate risk factors for genetic medical conditions and diseases; (v) evaluating the patient's and family's responses to the medical condition or risk of recurrence and providing client-centered counseling and anticipatory guidance; (vi) identifying and utilizing community

resources that provide medical, educational, financial, and psychosocial support and advocacy; and (vii) providing written documentation of medical, genetic, and counseling information for families and health care professionals.

"Practice of licensed certified midwifery" means the provision of primary health care for preadolescents, adolescents, and adults within the scope of practice of a certified midwife established in accordance with the Standards for the Practice of Midwifery set by the American College of Nurse-Midwives, including (i) providing sexual and reproductive care and care during pregnancy and childbirth, postpartum care, and care for the newborn for up to 28 days following the birth of the child; (ii) prescribing of pharmacological and non-pharmacological therapies within the scope of the practice of midwifery; (iii) consulting or collaborating with or referring patients to such other health care providers as may be appropriate for the care of the patients; and (iv) serving as an educator in the theory and practice of midwifery.

"Practice of medicine or osteopathic medicine" means the prevention, diagnosis, and treatment of human physical or mental ailments, conditions, diseases, pain, or infirmities by any means or method.

"Practice of occupational therapy" means the therapeutic use of occupations for habilitation and rehabilitation to enhance physical health, mental health, and cognitive functioning and includes the evaluation, analysis, assessment, and delivery of education and training in basic and instrumental activities of daily living; the design, fabrication, and application of orthoses (splints); the design, selection, and use of adaptive equipment and assistive technologies; therapeutic activities to enhance functional performance; vocational evaluation and training; and consultation concerning the adaptation of physical, sensory, and social environments.

"Practice of podiatry" means the prevention, diagnosis, treatment, and cure or alleviation of physical conditions, diseases, pain, or infirmities of the human foot and ankle, including the medical, mechanical and surgical treatment of the ailments of the human foot and ankle, but does not include amputation of the foot proximal to the transmetatarsal level through the metatarsal shafts. Amputations proximal to the metatarsal-phalangeal joints may only be performed in a hospital or ambulatory surgery facility accredited by an organization listed in § 54.1-2939. The practice includes the diagnosis and treatment of lower extremity ulcers; however, the treatment of severe lower extremity ulcers proximal to the foot and ankle may only be performed by appropriately trained, credentialed podiatrists in an approved hospital or ambulatory surgery center at which the podiatrist has privileges, as described in § 54.1-2939. The Board of Medicine shall determine whether a specific type of treatment of the foot and ankle is within the scope of practice of podiatry.

"Practice of radiologic technology" means the application of ionizing radiation to human beings for diagnostic or therapeutic purposes.

"Practice of respiratory care" means the (i) administration of pharmacological, diagnostic, and therapeutic agents related to respiratory care procedures necessary to implement a treatment, disease prevention, pulmonary rehabilitative, or diagnostic regimen prescribed by a practitioner of medicine or osteopathic medicine; (ii) transcription and implementation of the written or verbal orders of a practitioner of medicine or osteopathic medicine pertaining to the practice of respiratory care; (iii) observation and monitoring of signs and symptoms, general behavior, general physical response to respiratory care treatment and diagnostic testing, including determination of whether such signs, symptoms, reactions, behavior or general physical response exhibit abnormal characteristics; and (iv) implementation of respiratory care procedures, based on observed abnormalities, or appropriate reporting, referral, respiratory care protocols or changes in treatment pursuant to the written or verbal orders by a licensed practitioner of medicine or osteopathic medicine or the initiation of emergency procedures, pursuant to the Board's regulations or as otherwise authorized by law. The practice of respiratory care may be performed in any clinic, hospital, skilled nursing facility, private dwelling or other place deemed appropriate by the Board in accordance with the written or verbal order of a practitioner of medicine or osteopathic medicine, and shall be performed under qualified medical direction.

"Practice of surgical assisting" means the performance of significant surgical tasks, including manipulation of organs, suturing of tissue, placement of hemostatic agents, injection of local anesthetic, harvesting of veins, implementation of devices, and other duties as directed by a licensed doctor of medicine, osteopathy, or podiatry under the direct supervision of a licensed doctor of medicine, osteopathy, or podiatry.

"Qualified medical direction" means, in the context of the practice of respiratory care, having readily accessible to the respiratory therapist a licensed practitioner of medicine or osteopathic medicine who has specialty training or experience in the management of acute and chronic respiratory disorders and who is responsible for the quality, safety, and appropriateness of the respiratory services provided by the respiratory therapist.

"Radiologic technologist" means an individual, other than a licensed doctor of medicine, osteopathy, podiatry, or chiropractic or a dentist licensed pursuant to Chapter 27 (§ 54.1-2700 et seq.), who (i)

performs, may be called upon to perform, or is licensed to perform a comprehensive scope of diagnostic or therapeutic radiologic procedures employing ionizing radiation and (ii) is delegated or exercises responsibility for the operation of radiation-generating equipment, the shielding of patient and staff from unnecessary radiation, the appropriate exposure of radiographs, the administration of radioactive chemical compounds under the direction of an authorized user as specified by regulations of the Department of Health, or other procedures that contribute to any significant extent to the site or dosage of ionizing radiation to which a patient is exposed.

"Radiologic technologist, limited" means an individual, other than a licensed radiologic technologist, dental hygienist, or person who is otherwise authorized by the Board of Dentistry under Chapter 27 (§ 54.1-2700 et seq.) and the regulations pursuant thereto, who performs diagnostic radiographic procedures employing equipment that emits ionizing radiation that is limited to specific areas of the human body.

"Radiologist assistant" means an individual who has met the requirements of the Board for licensure as an advanced-level radiologic technologist and who, under the direct supervision of a licensed doctor of medicine or osteopathy specializing in the field of radiology, is authorized to (i) assess and evaluate the physiological and psychological responsiveness of patients undergoing radiologic procedures; (ii) evaluate image quality, make initial observations, and communicate observations to the supervising radiologist; (iii) administer contrast media or other medications prescribed by the supervising radiologist; and (iv) perform, or assist the supervising radiologist to perform, any other procedure consistent with the guidelines adopted by the American College of Radiology, the American Society of Radiologic Technologists, and the American Registry of Radiologic Technologists.

"Respiratory care" means the practice of the allied health profession responsible for the direct and indirect services, including inhalation therapy and respiratory therapy, in the treatment, management, diagnostic testing, control, and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system under qualified medical direction.

"Surgical assistant" means an individual who has met the requirements of the Board for licensure as a surgical assistant and who works under the direct supervision of a licensed doctor of medicine, osteopathy, or podiatry.

§ 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 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~~ *in consultation with* a licensed doctor of medicine, osteopathy, podiatry, or dentistry *and under the regulations jointly promulgated by the Board of Medicine and the Board of Nursing*. 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 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, 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.

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 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 the patient care team physician stating (i) that the patient care team physician has served as a patient care team physician 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) that 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 for which the nurse practitioner was certified and licensed; and (iii) the period of time for which the patient care team physician 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) 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) consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided, and (c) 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.

Appendix 1b: Senate Bill 33

2024 SESSION

SENATE SUBSTITUTE

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SENATE BILL NO. 33
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the Senate Committee on Education and Health
on January 25, 2024)
(Patron Prior to Substitute—Senator Locke)

A BILL to amend and reenact § 54.1-2957 of the Code of Virginia, relating to supervision of certified registered nurse anesthetists; work group; report.

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 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. *"Supervision" for the purpose of this subsection means that the licensed doctor of medicine, osteopathy, podiatry, or dentistry is present during an operation or procedure or is immediately available to respond and provide patient care as needed.* 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 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

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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, 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.

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 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 the patient care team physician stating (i) that the patient care team physician has served as a patient care team physician 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) that 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 for which the nurse practitioner was certified and licensed; and (iii) the period of time for which the patient care team physician 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) 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) consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided, and (c) 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 Secretary of Health and Human Resources, in collaboration with the Board of Medicine, the Board of Nursing, and the Department of Health Professions, shall convene a work group to evaluate and make recommendations to increase the anesthesia provider workforce in the Commonwealth, including an assessment of (i) the factors limiting the current and future numbers of physician anesthesiologists and certified registered nurse anesthetists, (ii) the projected impact of licensing anesthesiology assistants who are currently in the anesthesia provider workforce in the Commonwealth, (iii) how potential changes to the current law regarding the practice of certified registered nurse anesthetists will impact patients in historically economically disadvantaged communities and underserved areas of Virginia, and (iv) whether potential changes to the law will increase or decrease health disparities. The work group shall include representatives from the Virginia Society of Anesthesiologists, the Virginia Association of Nurse Anesthetists, the Virginia Hospital and Healthcare Association, the Virginia Academy of Anesthesiologist Assistants, and other relevant stakeholders. The work group shall report its recommendations to the Chairmen of the Senate Committee on Education and Health and the House Committee on Health and Human Services by November 1, 2024.

Appendix 2: Operative responsibilities by anesthesia provider

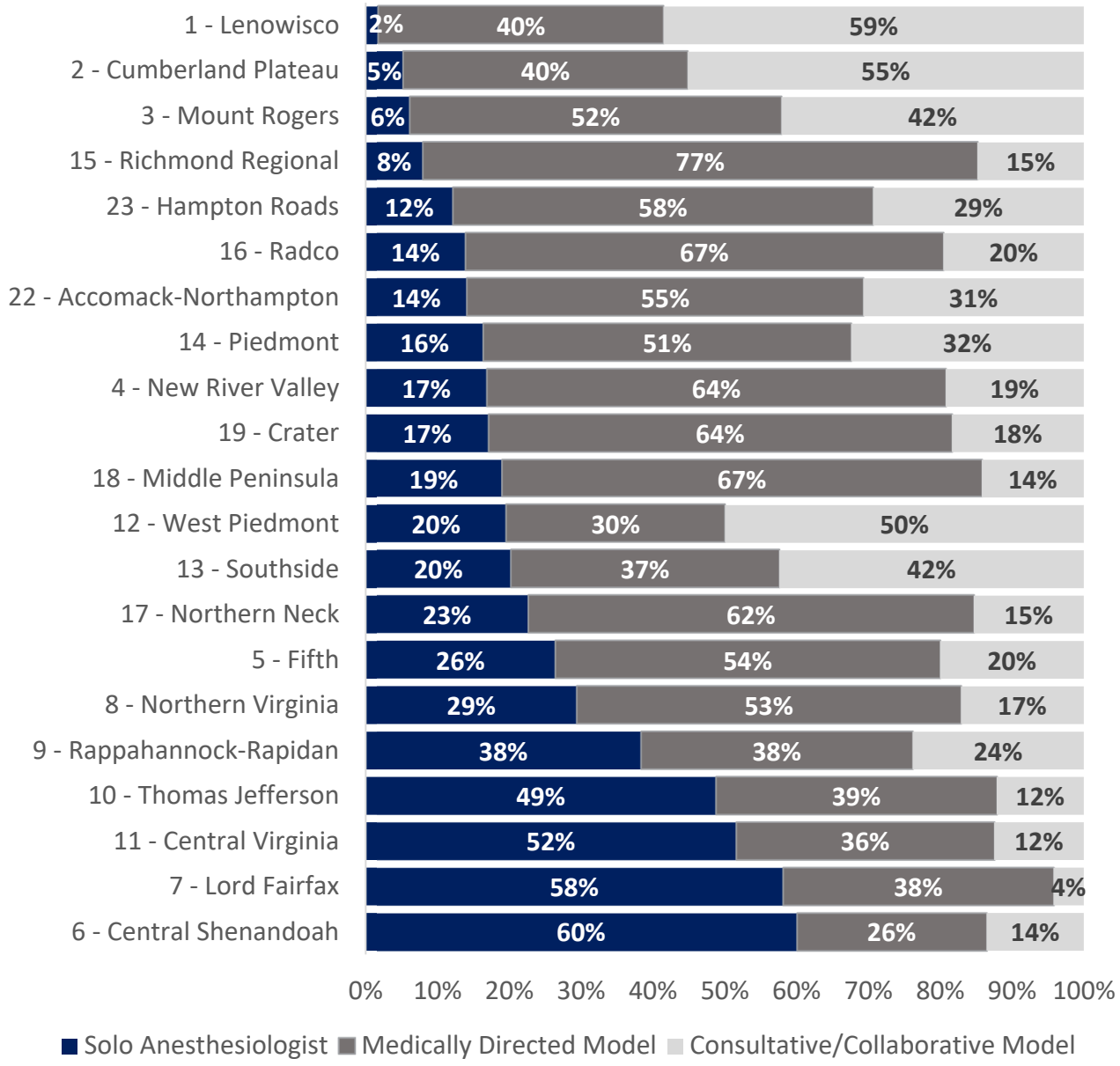
TABLE 3. Anesthesiologists and CRNAs are capable of performing similar preoperative, intraoperative, and postoperative responsibilities

	AN	CRNA	CAA
Preoperative Responsibilities			
Obtain pre-anesthesia health history	X	X	X
Provide patient education and counseling	X	X	
Examine, assess, and evaluate patient	X	X	X
Order tests	X	X	X
Obtain Informed Consent	X	X	X
Select, order and prescribe preanesthetic medications	X	X	
Develop anesthesia plan for anesthesia, analgesia, multimodal pain management, and recovery	X	X	
Intraoperative Responsibilities			
Implement plan of care	X	X	
Administer anesthetic agent and anesthetic techniques, such as general, regional, and local anesthesia, sedation, and multimodal pain management	X	X	
Select, order, and prescribe anesthetic medication	X	X	
Select and insert invasive and noninvasive monitoring modalities	X	X	
Establish airway intervention	X	X	X
Monitor patient	X	X	X
Assist in induction, maintenance, and emergence of patient anesthetic			X
Record intraoperative events	X	X	X
Postoperative Responsibilities			
Facilitate emergence and recovery from anesthesia	X	X	
Select, order, and prescribe post anesthetic medication	X	X	
Conduct post anesthesia evaluation	X	X	
Ensure transfer of care information	X	X	
Remain with patient until receiving provider arrives	X	X	X
Record patient progress	X	X	X
Perform duties delegated by anesthesiologist			X
Perform administrative duties			X
Record patient progress			X
Educate patient on recovery	X	X	
Discharge patient	X	X	

AN = Anesthesiologist; CRNA = Certified Registered Nurse Anesthetist; CAA = Certified Anesthesiologist Assistant
SOURCE: JCHC staff review of documents and literature.

Appendix 3: Anesthesia models by health district

FIGURE 7. Proportion of procedures among Medicare recipients performed by solo anesthesiologists varies by health district



NOTE: Percentages may not equate to 100% due to rounding.
SOURCE: JCHC staff analysis of Medicare claims data, 2022.

Appendix 4: Sources and methods

Narrative Review

JCHC staff conducted a literature review to address three study questions: (1) what is the scope of current and projected shortages for anesthesia providers and do shortages disproportionately impact specific populations; (2) how have historical licensing changes among anesthesia providers impacted the anesthesia provider workforce and do changes in the workforce disproportionately impact specific populations; and (3) how does patients' access, quality, and safety vary by anesthesia provider type and do variations in patient outcomes disproportionately impact specific populations.

Staff identified common words and phrases associated with the anesthesia workforce in existing literature. Using these key terms, a search phrase was created for each study question:

(1) anesthes* AND workforce shortage

(2) "nurse anesthetist AND licens*" OR "nurse anesthetist AND regulat*"

(3) "anesthesiologist AND nurse anesthetist AND patient outcomes" OR "anesthesiologist AND nurse anesthetist AND access" OR "anesthesiologist AND nurse anesthetist AND quality" OR "anesthesiologist AND nurse anesthetist AND safety"

JCHC staff used these phrases to conduct an advanced literature search, identifying articles in which these terms were used in either the title or the abstract. This search was conducted in research databases available through VCU libraries and staff identified 118 articles which fit the search criteria. JCHC staff independently reviewed articles for relevance to the inclusion criteria. The inclusion criteria required that studies be: (1) written in English, (2) published between 2000 and 2024, and (3) published in a credible peer-reviewed journal.

Staff then reviewed articles for applicability to the three study questions of interest. Articles could be relevant to more than one category, which resulted in some article overlap between study questions. 547 articles were removed for lack of relevance to study questions, 15 articles were removed due to article type, and 107 articles were removed because they were not based in the United States, leaving 118 articles for content analysis. JCHC staff reviewed the remaining articles in detail, using content analysis techniques to identify significant themes across studies addressing each study question.

Interviews

JCHC staff conducted stakeholder interviews to address three study questions: (1) what is the current standard of care for administering anesthesia and how are anesthesia services being delivered in Virginia; (2) how have historical licensing changes among anesthesia providers impacted the anesthesia provider workforce and do changes in the workforce disproportionately impact specific populations; and (3) how does patients' access, quality, and safety vary by anesthesia provider type and do variations in patient outcomes disproportionately impact specific populations.

JCHC staff conducted interviews with relevant stakeholders to develop a clearer understanding of the three study questions. These interviews were conducted with numerous types of anesthesia providers, proceduralists and operating physicians, provider associations, and health systems. Detailed notes were taken by a secondary interviewer and JCHC staff transcribed interview notes. JCHC staff performed qualitative analysis to identify overarching categories and themes. Any categories and themes that emerged were used to derive a deeper understanding of anesthesia services in Virginia.

Data Analysis

JCHC staff analyzed data from multiple sources to understand trends in the anesthesia provider education pipeline and workforce in Virginia and nationally, including:

- Health Care Profession reports from the Virginia Department of Health Professions, available for Advanced Practice Registered Nurses, including CRNAs, and MD/DOs that summarize data from the state's licensure database and voluntary surveys completed during licensure renewal;
- Virginia Department of Health Professions Provider Profile that maintains individual-level data on physicians licensed in Virginia;
- Data on enrollment, graduation and employment rates from the three accredited CRNA training programs in Virginia;
- Anesthesia provider billing modifiers from Medicare claims data on anesthesia services, provided in aggregate by Virginia Health Information;
- Anesthesiology residency match data from the National Resident Matching Program;
- Provider-level practice location data on providers with National Provider Identifiers from the National Plan and Provider Enumeration System; and
- State and county-level data on providers with National Provider Identifiers from the US Health Resources and Services Administration Area Health Resources Files.

50-State Scan

JCHC staff used WestLaw, a legal research database, to identify state statute or regulation relevant to the practice of CRNAs in 50 states and the District of Columbia. Staff used the search terms, "nurse anesthetist,", "CRNA", and "anesthesia" to identify relevant sections of state statute that described the nature of the relationship between CRNAs and other health care professionals, including operating physicians, podiatrists, dentists, and anesthesiologists. If such language was not explicit in state statute, staff used the same search terms to review state regulations. Staff were able to capture language in all 50 states and the District of Columbia, current as of September 2024.

Appendix 5: State statutes and regulations

Table 4 summarizes the language in either state statute or regulation relevant to the relationship between CRNAs and other health care professionals, typically operating physicians or anesthesiologists, in hospital settings. Key words to describe the relationship, if applicable, are **bolded**. States that use different standards for other health care settings, such as critical access hospitals, ambulatory surgical centers, or medical offices are noted.

TABLE 4. CRNA supervision language by state, hospital settings

NOTE: * indicates states where CRNA practice varies by health care setting.

State	Citation	Language
Alabama	Ala. Code § 34-21-81	The nurse anesthetist…functions **under the direction of or in coordination with** a physician licensed to practice medicine, a podiatrist, or a dentist, who is **immediately available**. Nothing in this paragraph shall be construed to restrict the authority of a health care facility to adopt policies relating to the provision of anesthesia and analgesia services.
Alaska*	Alaska Admin. Code tit. 7, § 12.130	Anesthesia care may be provided only by a physician or dentist with anesthesia privileges, a registered nurse anesthetist, or an appropriately supervised trainee in an educational program approved by the department.
Arizona	Ariz. Rev. Stat. Ann. § 32-1634.04	A certified registered nurse anesthetist may administer anesthetics **under the direction of and in the presence of** a physician or surgeon in connection with the preoperative, intraoperative or postoperative care of a patient or as part of a procedure performed by a physician or surgeon.
Arkansas	Ark. Code Ann. § 17-87-102	"Practice of certified registered nurse anesthesia" means the performance for compensation of advanced nursing practices by a certified registered nurse anesthetist that are relevant to the administration of anesthetics **in consultation with, but not necessarily in the presence of,** a licensed physician, licensed dentist, or other person lawfully entitled to order anesthesia.
California*	Cal. Code Regs. tit. 22, § 70235	Anesthesia care shall be provided by physicians or dentists with anesthesia privileges, nurse anesthetists, or appropriately supervised trainees in an approved educational program.
Colorado	Colo. Rev. Stat. Ann. § 12-255-111	An advanced practice registered nurse shall practice in accordance with the standards of the appropriate national professional nursing organization and have a safe mechanism for **consultation or collaboration with a physician or, when appropriate, referral to** a physician.

State	Citation	Language
Connecticut	Conn. Gen. Stat. Ann. § 20-87a	An advanced practice registered nurse…shall, for the first three years after having been issued such license, **collaborate** with a physician licensed to practice medicine in this state…except such advanced practice registered nurse licensed pursuant to section 20-94a and maintaining current certification from the American Association of Nurse Anesthetists who is prescribing and administrating medical therapeutics during surgery may only do so if the physician who is medically directing the prescriptive activity is **physically present** in the institution, clinic or other setting where the surgery is being performed.
District of Columbia	D.C. Code Ann. § 3-1206.05a	A certified registered nurse anesthetist may plan and deliver anesthesia, pain management, and related care to patients or clients of all health complexities across the lifespan. This practice incorporates the use of **independent judgement as well as collaborative interaction** with other health care professionals.
Delaware	Del. Code Ann. tit. 24, § 1902	"Advanced practice registered nurse" includes certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, or clinical nurse specialist. Advanced practice nursing is an expanded scope of nursing licensed as an **independent** licensed practitioner in a role and population focus approved by the Board of Nursing, with or without compensation or personal profit, and includes the RN scope of practice.
Florida*	Fla. Stat. Ann. § 464.012	An advanced practice registered nurse shall perform those functions authorized in this section within the framework of an established protocol that must be maintained on site at the location or locations at which an advanced practice registered nurse practices, unless the advanced practice registered nurse is registered and practicing under s. 464.0123. In the case of multiple supervising physicians in the same group, an advanced practice registered nurse must enter into a **supervisory protocol** with at least one physician within the physician group practice.
Georgia*	Ga. Code Ann. § 43-26-11.1	In any case where it is lawful for a duly licensed physician practicing medicine under the laws of this state to administer anesthesia, such anesthesia may be administered by a certified registered nurse anesthetist, provided that such anesthesia is administered **under the direction and responsibility of** a duly licensed physician.
Hawaii	Haw. Rev. Stat. Ann. § 431:10C-103	"Anesthetist" means a registered nurse-anesthetist who performs anesthesia services **under the supervision of** a licensed physician.
Idaho	Idaho Code Ann. § 54-1402	Advanced practice registered nurses shall include the following four (4) roles: certified nurse-midwife; clinical nurse specialist; certified nurse practitioner; and certified registered nurse anesthetist as defined in board rule. An advanced practice registered nurse **collaborates** with other health professionals in providing health care.

State	Citation	Language
Illinois*	225 Ill. Comp. Stat. Ann. 65/65-35	In the case of anesthesia services provided by a certified registered nurse anesthetist, an anesthesiologist, a physician, a dentist, or a podiatric physician must participate through discussion of and agreement with the anesthesia plan and **remain physically present and available** on the premises during the delivery of anesthesia services for diagnosis, **consultation**, and treatment of emergency medical conditions.
Indiana	Ind. Code Ann. § 25-23-1-30	A certified registered nurse anesthetist may administer anesthesia if the certified registered nurse anesthetist acts **under the direction of and in the immediate presence** of a physician.
Iowa	Iowa Admin. Code r. 481-51.19(135B)	Written policies and procedures governing anesthesia services shall be developed and implemented in consultation with and with the approval of the hospital's medical staff and, at a minimum, provide for… anesthesia services **under the direction of** a qualified doctor of medicine or osteopathy.
Kansas	Kan. Stat. Ann. § 65-1158	A registered nurse anesthetist shall perform duties and functions in an **interdependent** role as a member of a physician or dentist directed health care team.
Kentucky	Ky. Rev. Stat. Ann. § 314.042	**Nothing in this chapter shall be construed as requiring an advanced practice registered nurse designated by the board as a certified registered nurse anesthetist to enter into a collaborative agreement** with a physician, pursuant to this chapter or any other provision of law, in order to deliver anesthesia care.
Louisiana	La. Stat. Ann. § 37:930	The registered nurse administers anesthetics and ancillary services **under the direction and supervision of** a physician or dentist who is licensed to practice under the laws of the state of Louisiana.
Maine*	Me. Rev. Stat. Ann. tit. 32, § 2211	A certified registered nurse anesthetist **is responsible and accountable to** a licensed physician or dentist for aspects of anesthesia practice that require execution of the medical regimen as prescribed by that physician or dentist.
Maryland	Md. Code Ann., Health Occ. § 8-513	A nurse anesthetist shall **collaborate** with an anesthesiologist, a licensed physician, or a dentist in the following manner: (1) An anesthesiologist, a licensed physician, or a dentist shall be **physically available** to the nurse anesthetist for **consultation** at all times during the administration of, and recovery from, anesthesia; (2) An anesthesiologist shall be available for **consultation** to the nurse anesthetist for other aspects of the practice of nurse anesthesia; and (3) If an anesthesiologist is not available, a licensed physician or dentist shall be available to provide this type of **consultation**.
Massachusetts	244 Mass. Code Regs. 4.06	A CRNA who does not register for prescriptive authority administers anesthesia pursuant to the signed order of a registered prescriber. Such CRNA may select anesthetic agents based upon protocols that are mutually developed with a registered prescriber responsible for the perioperative care of a patient, as appropriate for the practice setting.

State	Citation	Language
Michigan	Mich. Comp. Laws Ann. § 333.17210	All of the following apply to a registered professional nurse who holds a specialty certification as a nurse anesthetist: B. If he or she meets both of the following requirements, he or she may provide the anesthesia and analgesia services described in subdivision (a) **without supervision:** (i) He or she meets either of the following: (A) He or she has practiced in the health profession specialty field of nurse anesthetist for 3 years or more and has practiced in that health profession specialty field in a health care facility for a minimum of 4,000 hours. (B) He or she has a doctor of nurse anesthesia practice degree or doctor of nursing practice degree. (ii) He or she is **collaboratively** participating in a patient-centered care team. (c) He or she may provide the anesthesia and analgesia services described in subdivision (a) in a health care facility if the health care facility has a policy in place under subsection (4) allowing for the provision of the anesthesia and analgesia services and ensuring that a qualified health care professional **is immediately available** in person or through telemedicine to address any urgent or emergent clinical concerns.
Minnesota	Minn. Stat. Ann. § 148.171	"Registered nurse anesthetist practice" means the provision of anesthesia care and related services including: (1) selecting, obtaining, and administering drugs and therapeutic devices to facilitate diagnostic, therapeutic, and surgical procedures; (2) ordering, performing, supervising, and interpreting diagnostic studies, excluding interpreting computed tomography scans, magnetic resonance imaging scans, positron emission tomography scans, nuclear scans, and mammography; (3) prescribing pharmacologic and nonpharmacologic therapies; and (4) **consulting with, collaborating with, or referring to** other health care providers as warranted by the needs of the patient.
Mississippi	Miss. Code Ann. § 73-15-20	An advanced practice registered nurse shall perform those functions authorized in this section within a **collaborative/consultative relationship** with a dentist or physician with an unrestricted license to practice dentistry or medicine in this state and within an **established protocol or practice guidelines**, as appropriate, that is filed with the board upon license application, license renewal, after entering into a new collaborative/consultative relationship or making changes to the protocol or practice guidelines or practice site. The board shall review and approve the protocol to ensure compliance with applicable regulatory standards.
Missouri	Mo. Ann. Stat. § 334.104	A certified registered nurse anesthetist…shall be permitted to provide anesthesia services **without a collaborative practice arrangement** provided that he or she is **under the supervision** of an anesthesiologist or other physician, dentist, or podiatrist who is **immediately available** if needed.
Montana	Mont. Admin. R. 24.159.1480	Certified Registered Nurse Anesthetist (CRNA) practice is the **independent and/or collaborative** performance of any act involving the determination, preparation, administration, or monitoring of anesthesia care and anesthesia-related services, and the management of acute and chronic pain.

State	Citation	Language
Nebraska	Neb. Rev. Stat. Ann. § 38-711	The determination and administration of total anesthesia care shall be performed by the certified registered nurse anesthetist or a nurse anesthetist temporarily licensed pursuant to section 38-708 in **consultation and collaboration with and with the consent of** the licensed practitioner.
Nevada*	Nev. Admin. Code 449.388	A certified registered nurse anesthetist who is **under the direction of** the operating practitioner or of an anesthesiologist who is **immediately available** if needed.
New Hampshire*	N.H. Code Admin. R. He-P 802.33	The anesthesiologist shall be qualified in anesthesiology in accordance with the medical staff bylaws of the hospital.
New Jersey*	N.J. Admin. Code § 8:43G-6.3	General or major regional anesthesia shall be administered and monitored only by the following… (3) An APN/anesthesia, in accordance with a joint protocol established in accordance with N.J.A.C. 13:37–6.3, which joint protocol shall require sections governing: i. The availability of an anesthesiologist to **consult** with the APN/anesthesia on site, on-call or by electronic means; and ii. The **presence** of an anesthesiologist during induction, emergence and critical change in status.
New Mexico	N.M. Stat. Ann. § 61-3-23.3	Certified registered nurse anesthetists shall function in an **interdependent** role as a member of a health care team in which the medical care of the patient is directed by a licensed physician, osteopathic physician, dentist or podiatrist licensed in New Mexico pursuant to the Dental Health Care Act, the Medical Practice Act or the Podiatry Act. The certified registered nurse anesthetist shall **collaborate** with the licensed physician, osteopathic physician, dentist or podiatrist concerning the anesthesia care of the patient. As used in this subsection, **"collaboration"** means the process in which each health care provider contributes the health care provider's respective expertise. Collaboration includes systematic formal planning and evaluation between the health care professionals involved in the **collaborative practice arrangement**.
New York*	N.Y. Comp. Codes R. & Regs. tit. 10, § 405.13	Anesthesia shall be administered in accordance with their credentials, competencies and privileges by the following…(iv) certified registered nurse anesthetists (CRNA's) **under the supervision of** an anesthesiologist who is **immediately available** as needed or **under the supervision of** the operating physician who has been found qualified by the governing body and the medical staff to supervise the administration of anesthetics and who has accepted responsibility for the supervision of the CRNA.
North Carolina	21 N.C. Admin. Code 36.0226	Only a registered nurse who completes a program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs, is credentialed as a certified registered nurse anesthetist by the Council on Certification of Nurse Anesthetists, and who maintains recertification through the Council on Recertification of Nurse Anesthetists, shall perform nurse anesthesia activities **in collaboration with** a physician, dentist, podiatrist, or other lawfully qualified health care provider.

State	Citation	Language
North Dakota	N.D. Admin. Code 54-05-03.1-03.1	The advanced practice registered nurse has evolved into the roles of certified nurse practitioner, certified registered nurse anesthetist, certified nurse midwife, or certified clinical nurse specialist. The advanced practice registered nurse functions in any setting as a member of the interdisciplinary team and provides care to the fullest extent of the scope of practice which includes…**Collaborate** with the interdisciplinary team.
Ohio	Ohio Rev. Code Ann. § 4723.43 (West)	A nurse authorized to practice as a certified registered nurse anesthetist, consistent with the nurse's education and certification and in accordance with rules adopted by the board, may do the following: (1) With **supervision and in the immediate presence** of a physician, podiatrist, or dentist, administer anesthesia and perform anesthesia induction, maintenance, and emergence.
Oklahoma	Okla. Stat. Ann. tit. 59, § 567.3a (West)	"Certified Registered Nurse Anesthetist" is an Advanced Practice Registered Nurse who…(2) administers anesthesia **in collaboration with** a medical doctor, an osteopathic physician, a podiatric physician or a dentist licensed in this state and under conditions in which timely **onsite consultation** by such doctor, osteopath, podiatric physician or dentist is available.
Oregon	Or. Admin. R. 851-006-0010	"Anesthesia care" means the Certified Registered Nurse Anesthetist (CRNA) **independent or collaborative** performance of any act involving the treatment of a client presenting for a procedure including, but not limited to, sole or concurrent use of sedation, analgesia or anesthesia.
Pennsylvania	63 Pa. Stat. Ann. § 218.9 (West)	A certified registered nurse anesthetist shall have the authority to perform anesthesia services **in cooperation with** a physician, podiatrist or dentist involved in a procedure for which anesthesia care is being provided.
Rhode Island	5 R.I. Gen. Laws Ann. § 5-34.2-2 (West)	"Practice of certified registered nurse anesthesia" means providing certain healthcare services **in collaboration with** anesthesiologists, licensed physicians, or licensed dentists.
South Carolina	S.C. Code Ann. § 40-33-20	A CRNA must practice in accordance with **approved written guidelines** developed **under supervision of** a licensed physician or dentist or approved by the medical staff within the facility where practice privileges have been granted.
South Dakota	S.D. Codified Laws § 36-9-3.1	The certified registered nurse anesthetist shall **collaborate with** a physician, a dentist, a podiatrist, a certified nurse practitioner, a certified nurse midwife, or a physician assistant when providing anesthesia services.
Tennessee*	Tenn. Comp. R. & Regs. 0720-14-.07	Anesthesia must be administered only by: 1. A qualified anesthesiologist; 2. A doctor of medicine or osteopathy (other than an anesthesiologist); 3. A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law; 4. A certified registered nurse anesthetist (CRNA); or 5. A graduate registered nurse anesthetist under the supervision of an anesthesiologist who is immediately available if needed.

State	Citation	Language
Texas	Tex. Occ. Code Ann. § 157.058 (West)	In a licensed hospital or ambulatory surgical center, a physician **may delegate to** a certified registered nurse anesthetist the ordering of drugs and devices necessary for the nurse anesthetist to administer an anesthetic or an anesthesia-related service ordered by the physician.
Utah	Utah Code Ann. § 58-31b-102	Practice of advanced practice registered nursing includes: (a) maintenance and promotion of health and prevention of disease; (b) diagnosis, treatment, correction, consultation, and referral; (c) prescription or administration of prescription drugs or devices including: (i) local anesthesia; (ii) Schedule III-V controlled substances; and (iii) Schedule II controlled substances; or (d) the provision of preoperative, intraoperative, and postoperative anesthesia care and related services **upon the request of** a licensed health care professional by an advanced practice registered nurse specializing as a certified registered nurse anesthetist
Vermont	20-4 Vt. Code R. § 1100	An APRN with fewer than 24 months and 2,400 hours of licensed active advanced nursing practice in an initial role and population focus or fewer than 12 months and 1,600 hours for any additional role and population focus shall have a **formal agreement with a collaborating provider** as required by 26 VSA § 1613.
Virginia	Va. Code Ann. § 54.1-2957	A certified registered nurse anesthetist shall practice **under the supervision of** a licensed doctor of medicine, osteopathy, podiatry, or dentistry.
Washington*	Wash. Admin. Code 246-840-300	ARNP practice is grounded in nursing process and incorporates the use of **independent** judgment. Practice includes interprofessional interaction with other health care professionals in the assessment and management of wellness and health conditions.
West Virginia	W. Va. Code Ann. § 30-7-15	In any case where it is lawful for a duly licensed physician or dentist practicing medicine or dentistry under the laws of this state to administer anesthetics, such anesthetics may lawfully be given and administered by any person (a) who has been licensed to practice registered professional nursing under this article, and (b) who holds a diploma or certificate evidencing his or her successful completion of the educational program of a school of anesthesia duly accredited by the American association of nurse anesthetists: Provided, That such anesthesia is administered by such person **in the presence and under the supervision of** such physician or dentist.
Wisconsin	Wis. Admin. Code HS § 107.065	A nurse anesthetist shall perform services **in the presence of a supervising** anesthesiologist or performing physician.

State	Citation	Language
Wyoming*	Wyo. Admin. Code 048.0061.12 § 10	Policies and procedures for the administration of all anesthetics shall be in place. In hospitals where there is no department of anesthesia, the department of surgery and/or medical staff shall assume the responsibility for establishing general policies regarding the administration of anesthetics. For hospitals with (twenty-five) 25 licensed beds or less, a CRNA may administer anesthetics **without physician supervision** if the CRNA's practice is otherwise consistent with the medical staff bylaws. The medical staff shall designate those individuals qualified to administer anesthetics and shall delineate what each individual is qualified and approved to do.

JOINT COMMISSION ON HEALTH CARE

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Strategies to Strengthen the Anesthesia Workforce in Virginia

POLICY OPTIONS IN BRIEF

Option: Direct BON to update regulations governing practice of CRNAs to remove references to any specific edition of the American Association of Nurse Anesthetists' Standards for Nurse Anesthesia Practice (Option 1, page 13).

Option: Not recommend any policy that would make supervision of certified registered nurse anesthetists more restrictive (Option 2, page 14).

Option: Direct the DHP to develop a plan to transition CRNAs with sufficient training and experience to independent practice (Option 3, page 16).

Option: Require DHP to re-analyze the state of the anesthesia workforce in Virginia (Option 4, page 18).

Option: Provide funding to VHWDA to study the capacity and needs of current anesthesiology residency programs and CRNA training programs in Virginia and make recommendations for further expansion (Option 5,

FINDINGS IN BRIEF

Multiple authorities are responsible for determining supervision requirements of CRNAs

There are at least three layers of rules that may impact the extent to which CRNAs are supervised, including federal rules, state laws, and hospital or facility bylaws. Due to the interplay between these overlapping authorities, CRNA supervision requirements vary widely in each state. In Virginia, CRNAs are currently subject to the federal rule and Code of Virginia § 54.1-2957.

Stakeholders agree that more restrictive supervision requirements would be detrimental to efforts to address anesthesia workforce shortages

Stakeholders agreed that implementing more restrictive supervision requirements for CRNAs would greatly impact how anesthesia care is delivered in Virginia, particularly for remote or rural facilities in Virginia which use proceduralists as CRNA supervisors and may not have physician anesthesiologists on staff.

Available evidence supports a measured approach to changes in CRNA supervision requirements

Evidence indicates that less restrictive CRNA supervision requirements present a low risk of harm to patients and a possible benefit to the anesthesia workforce. State models that step down from supervision into independent practice could be considered so that possible impacts can be monitored over time.

Strengthening Virginia's anesthesia workforce requires a multifaceted approach

Stakeholders interviewed by the JCHC offered alternative strategies to address anesthesia provider workforce shortages beyond changes to CRNA supervision, including the licensing of CAAs to practice in Virginia

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November 2024

and developing additional capacity for physician anesthesiologist residency programs and CRNA training programs.

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Considering the Dissolution of the Advisory Committee to the Committee of the Joint Boards of Nursing and Medicine

Pursuant to section 22 of Virginia Code § 54.1-3005[1], the Boards of Nursing and Medicine promulgated regulations governing APRNs in which the 6-member Committee of the Joint Boards of Nursing and Medicine (CJB) is delegated the regulatory authority to conduct proceedings on behalf of the Boards[2]. In addition, the Boards gave the CJB the ability, in its discretion, to establish an 8-member Advisory Committee (non-Governor appointments)[3].

Historically, the CJB has conducted 5 regularly scheduled business meetings each year inviting the 8-member Advisory Committee primarily to provide an environmental scan to the CJB. In recent years, however, although disciplinary proceedings have been conducted, 4 out of the 5 CJB business meetings have been canceled. These cancellations were in response to the Governor's emphasis on reducing costs (i.e. travel expenditures) and regulatory burden through the elimination of discretionary meetings during which no statutory or regulatory actions occur.

It follows that with the discretion to create the Advisory Committee comes the discretion to dissolve the Advisory Committee once created. With a significant majority of the Advisory Committee members' terms expiring at the end of 2024, the timing for considering the dissolution of the Advisory Committee is optimal.

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1. **§ 54.1-3005 Specific powers and duties of Board**
   In addition to the general powers and duties conferred in this title, the Board shall have the following specific powers and duties:
   22. To promulgate, together with the Board of Medicine, regulations governing the licensure of advanced practice registered nurses pursuant to § 54.1-2957 and the licensure of licensed certified midwives pursuant to § 54.1-2957.04.

2. **18VAC90-30-230. Administrative proceedings.**
   B. Except as provided in 18VAC90-30-240 [delegation to Agency Subordinate section]*, the Committee of the Joint Boards of Nursing and Medicine shall conduct all proceedings prescribed herein and shall take action on behalf of the boards.*

3. **18VAC90-30-30. Committee of the Joint Boards of Nursing and Medicine.**
   B. The committee, in its discretion, may appoint an advisory committee. Such an advisory committee shall be comprised of four licensed physicians and four licensed advanced practice registered nurses, of whom one shall be a certified nurse midwife, one shall be a certified registered nurse anesthetist and two shall be advanced practice registered nurses from other categories. Appointment to the advisory committee shall be for four years; members may be appointed for one additional four-year period.

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

TIME AND PLACE: The discipline meeting of the Committee of the Joint Boards of Nursing and Medicine was convened at 10:42 A.M., February 28, 2024 in Board Room 2, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

MEMBERS PRESENT: Cynthia 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

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 Discipline and Licensing Specialist

OTHERS PRESENT: Laura Booberg, Senior Assistant Attorney General; Board Counsel

INTRODUCTIONS: 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.

CONSIDERATION OF AGENCY SUBORDINATE RECOMMENDATIONS

Dianna White, APRN 0024-166972
Ms. White appeared accompanied by her attorney, Wilfredo Bonilla, Jr.

CLOSED MEETING: Dr. Parke moved that the Committee of the Joint Boards of Nursing and Medicine convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 10:49 A.M., for the purpose of consideration of the agency subordinate recommendations for Dianna White. Additionally, Dr. Parke moved that Ms. Douglas, Dr. Hills, Ms. Claiborne, and Ms. Booberg, Board counsel, attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded by Mr. Marchese and carried unanimously.

RECONVENTION: The Board reconvened in open session at 10:53 A.M.

Dr. Parke moved that the Committee of the Joint Boards of Nursing and Medicine certify that it heard, discussed, or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed

meeting was convened. The motion was seconded by Dr. Ransone and carried unanimously.

Dr. Clements moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to place the license of **Dianna White** on Probation with terms and conditions. The motion was seconded by Dr. Ransone and carried unanimously.

Donna Clark, APRN **0024-171097**
Ms. Clark did not appear.

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to indefinitely suspend the license of **Donna Clark, APRN.** The motion was seconded by **Dr. Parke** and carried unanimously.

Jasseth Taylor-Palmer, APRN **0024-184464**
Ms. Taylor-Palmer did not appear.

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to place the license of **Jasseth Taylor-Palmer, APRN** on indefinite probation with terms and conditions. The motion was seconded by **Dr. Parke** and carried unanimously.

CLOSED MEETING: Dr. Parke moved that the Committee of the Joint Boards of Nursing and Medicine convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 10:59 A.M., for the purpose of consideration of the agency subordinate recommendations for **Ania Ramondo and Courtney Williams**. Additionally, Dr. Parke moved that Ms. Douglas, Dr. Hills, Ms. Claiborne, and Ms. Booberg, Board counsel, attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded by Mr. Marchese and carried unanimously.

RECONVENTION: The Board reconvened in open session at 11:12 A.M.

Dr. Parke moved that the Committee of the Joint Boards of Nursing and Medicine certify that it heard, discussed, or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed

meeting was convened. The motion was seconded by Dr. Ransone and carried unanimously.

Ania Ramondo, APRN **0024-173902**
Ms. Ramondo did not appear.

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine reject the recommended decision of the agency subordinate regarding **Ania Ramondo, APRN** and refer to a formal hearing**.** The motion was seconded by **Dr. Clements** and carried unanimously.

Courtney Williams, APRN **0024-174666**
Ms. Williams did not appear.

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine modify the recommended decision of the agency subordinate Reprimanding **Courtney Williams, APRN** and require her, within 60 days from the date of entry of the Order, to provide written proof satisfactory to the Board of successful completion of Board-approved courses at least 12 contact hours in a Committee-approved course in the subject of Medical Ethics, Boundaries and Professionalism**.** The motion was seconded by **Dr. Ransone** and carried unanimously.

CONSIDERATION OF CONSENT ORDER

CLOSED MEETING: Dr. Parke moved that the Committee of the Joint Boards of Nursing and Medicine convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 11:15 A.M., for the purpose of consideration of the consent orders for **Elizabeth Donald** and **Elisabeth Taurino**. Additionally, Dr. Parke moved that Ms. Douglas, Dr. Hills, Ms. Claiborne, and Ms. Booberg, Board counsel, attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded by Mr. Marchese and carried unanimously.

RECONVENTION: The Board reconvened in open session at 11:23 A.M.

Dr. Parke moved that the Committee of the Joint Boards of Nursing and Medicine certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed

meeting was convened. The motion was seconded by Dr. Ransone and carried unanimously.

Elizabeth Donald, APRN **0024-177449**
Ms. Donald did not appear.

Dr. Parke moved that the Committee of the Joint Boards of Nursing and Medicine accept the consent order to Reprimand **Elizabeth Donald** and indefinitely suspend her APRN license with suspension stayed upon proof of Ms. Donald's continued compliance with all of the terms and conditions of the Virginia Health Practitioners' Monitoring Program (HPMP) for the period specified by the HPMP. The motion was seconded by **Mr. Marchese** and carried unanimously.

Elisabeth Taurino, APRN **0024-172180**
Ms. Taurino did not appear.

Dr. Parke moved that the Committee of the Joint Boards of Nursing and Medicine accept the consent order for voluntary surrender for indefinite suspension the license of **Elisabeth Taurino, APRN** to practice and Advanced Practice Registered Nurse in the Commonwealth of Virginia**.** The motion was seconded by **Mr. Marchese** and carried unanimously.

ADJOURNMENT: The meeting was adjourned at 11:24 A.M.

Robin L. Hills

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

VIRGINIA COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
DISCIPLINE MEETING MINUTES
April 24, 2024

TIME AND PLACE: The discipline meeting of the Committee of the Joint Boards of Nursing and Medicine was convened at 9:02 A.M., April 24, 2024 in Board Room 2, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

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

STAFF PRESENT:
Jay P. Douglas, RN, MSM, CSAC, FRE; Executive Director
Robin L. Hills, DNP, RN, WHNP; Deputy Executive Director for Advanced Practice
Lakisha Goode, Discipline Team Coordinator

OTHERS PRESENT: Laura Booberg, Senior Assistant Attorney General; Board Counsel

INTRODUCTIONS: 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.

CONSIDERATION OF AGENCY SUBORDINATE RECOMMENDATIONS

Parris Diondra Langhorne, APRN **0024-177766**
Ms. Langhorne did not appear.

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to suspend the license of **Parris Diondra Langhorne, APRN** and the suspension shall be stayed upon proof of entry into a contract with the Virginia Health Practitioners' Monitoring Program ("HPMP"). The motion was seconded by Dr. Clements and carried unanimously.

Anna Jean Flowers Holland, APRN **0024-166047**
Ms. Holland did not appear.

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to reprimand the license of **Anna Jean Flowers Holland, APRN** and require Ms. Holland to review the American Association of Nurse

Anesthesiology ("AANA")'s Code of Ethics for the Certified Registered Nurse Anesthetist, Scope of Nurse Anesthesia Practice, and Standards for Nurse Anesthesia Practice, write a summary acceptable to the Committee of the Joint Boards, of how the AANA code of ethics, scope of practice guidelines, and standards of conduct relate to her conduct on March 21, 2022, submit this summary to the Committee of the Joint Boards within 30 days from the date of entry of this Order, and to provide written proof of successful completion of course(s) approved by the Committee of the Joint Boards of at least 3 contact hours in the subject of critical thinking within 90 days from the date of entry of the Order. The motion was seconded by Dr. Clements and carried unanimously.

Amanda Renee Welch, APRN **0024-177677**
Ms. Welch did not appear.

CLOSED MEETING: Dr. Parke moved that the Committee of the Joint Boards of Nursing and Medicine convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 9:06 A.M., for the purpose of consideration of the agency subordinate recommendations for Amanda Renee Welch. Additionally, Dr. Parke moved that Ms. Douglas, Dr. Hills, Ms. Goode, and Ms. Booberg, Board counsel, attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded by Mr. Marchese and carried unanimously.

RECONVENTION: The Board reconvened in open session at 9:10 A.M.

Dr. Parke moved that the Committee of the Joint Boards of Nursing and Medicine certify that it heard, discussed, or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded by Mr. Marchese and carried unanimously.

Dr. Parke moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to place the license of **Amanda Renee Welch, APRN** on Probation with terms and conditions. The motion was seconded by Mr. Marchese and carried unanimously.

ADJOURNMENT: The meeting was adjourned at 9:11 A.M.

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

VIRGINIA COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
DISCIPLINE MEETING MINUTES
June 26, 2024

TIME AND PLACE: The discipline meeting of the Committee of the Joint Boards of Nursing and Medicine was convened at 9:01 A.M., June 26, 2024, in Board Room 2, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

MEMBERS PRESENT: Ann Tucker Gleason, PhD, Citizen Member, Board of Nursing, **Chair**
Helen M. Parke, DNP, FNP; Board of Nursing
Delia Acuna, FNP-C; Board of Nursing
Karen Ransone, MD; Board of Medicine

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 & Discipline Specialist

OTHERS PRESENT: Laura Booberg, Senior Assistant Attorney General; Board Counsel

INTRODUCTIONS: Committee members and staff members introduced themselves.

ESTABLISHMENT OF A QUORUM: Dr. Gleason called the meeting to order and, with 4 members present, established that a quorum was present.

CONSIDERATION OF AGENCY SUBORDINATE RECOMMENDATIONS

Jessica Scalzo, APRN **0024-166203**
Ms. Scalzo appeared.

CLOSED MEETING: Ms. Acuna moved that the Committee of the Joint Boards of Nursing and Medicine convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 9:12 A.M., for the purpose of consideration of the agency subordinate recommendations for Jessica Scalzo. Additionally, Ms. Acuna moved that Ms. Douglas, Dr. Hills, Ms. Claiborne, and Ms. Booberg, Board counsel, attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded by Dr. Parke and carried unanimously.

RECONVENTION: The Board reconvened in open session at 9:14 A.M.

Ms. Acuna moved that the Committee of the Joint Boards of Nursing and Medicine certify that it heard, discussed, or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed

meeting was convened. The motion was seconded by Dr. Parke and carried unanimously.

Dr. Ransone moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to place the license of **Jessica Scalzo, APRN** on Probation with terms and conditions**.** The motion was seconded by Dr. Parke and carried unanimously.

CLOSED MEETING: Ms. Acuna moved that the Committee of the Joint Boards of Nursing and Medicine convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 9:19 A.M., for the purpose of consideration of the agency subordinate recommendations for Charlene Bell, Fawn Avery, and Jessica VanAuken. Additionally, Ms. Acuna moved that Ms. Douglas, Dr. Hills, Ms. Claiborne, and Ms. Booberg, Board counsel, attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded by Dr. Parke and carried unanimously.

RECONVENTION: The Board reconvened in open session at 9:29 A.M.

Ms. Acuna moved that the Committee of the Joint Boards of Nursing and Medicine certify that it heard, discussed, or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded by Dr. Parke and carried unanimously.

Charlene Bell, APRN **0024-173892**
Ms. Bell did not appear.

Ms. Acuna moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to reprimand **Charlene Bell, APRN.** The motion was seconded by Dr. Parke and carried unanimously.

Fawn Avery, APRN **0024-181769**
Ms. Avery did not appear.

Dr. Parke moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to suspend the license of **Fawn Avery, APRN** and the suspension shall be stayed upon proof of entry into a contract with the Virginia Health Practitioners' Monitoring Program ("HPMP"). The motion was seconded by Dr. Ransone and carried unanimously.

Jessica Van Auken, APRN **0024-172972**
Ms. Avery did not appear.

Dr. Ransone moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to suspend the license of **Jessica Van Auken, APRN** and the suspension shall be stayed upon proof of entry into a contract with the Virginia Health Practitioners' Monitoring Program ("HPMP"). The motion was seconded by Dr. Parke and carried unanimously.

ADJOURNMENT: The meeting was adjourned at 9:31 A.M.

Robin L. Hills

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

VIRGINIA COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
DISCIPLINE MEETING MINUTES
October 23, 2024

TIME AND PLACE: The discipline meeting of the Committee of the Joint Boards of Nursing and Medicine was convened at 9:02 A.M., October 23, 2024, in Board Room 2, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

MEMBERS PRESENT: Helen M. Parke, DNP, FNP; Board of Nursing; **Chair**
Shelly Smith PhD, DNP, ANP-BC; Board of Nursing
Blanton Marchese; Board of Medicine
Randy Clements, DPM; Board of Medicine
Bo Vaughan, Jr. MD; Board of Medicine

STAFF PRESENT: Robin L. Hills, DNP, RN, WHNP; Deputy Executive Director for Advanced Practice
Christina Bargdill, Deputy Executive Director
Tamika Claiborne, Senior Licensing Discipline Specialist

OTHERS PRESENT: James Rutkowski, Senior Assistant Attorney General; Board Counsel

INTRODUCTIONS: Committee members and staff members introduced themselves.

ESTABLISHMENT OF A QUORUM: Dr. Parke called the meeting to order and established that a quorum was present.

CONSIDERATION OF AGENCY SUBORDINATE RECOMMENDATIONS

Ruby Anumah, APRN **0024-170024**
Ms. Anumah appeared.

CLOSED MEETING: Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 9:11 A.M., for the purpose of consideration of the agency subordinate recommendation for Ruby Anumah. Additionally, Mr. Marchese moved that Dr. Hills, Ms. Claiborne, Ms. Bargdill and Mr. Rutkowski, Board counsel, attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded by Dr. Clements and carried unanimously.

RECONVENTION: The Board reconvened in open session at 9:21 A.M.

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine certify that it heard, discussed, or considered only public business matters lawfully exempted from open meeting requirements

under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded by Dr. Clements and carried unanimously.

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine modify the recommended decision of the agency subordinate to reprimand **Ruby Anumah, APRN** and require her, within 90 days from the date of entry of the Order, to provide written proof of successful completion of minimum of six (6) contact hours in the subject of proper opioid prescribing**.** The motion was seconded by Dr. Clements and carried unanimously.

Morgan Cardoza, APRN **0024-179711**
Ms. Cardoza did not appear.

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to place the license of **Morgan Cardoza, APRN** on Probation with terms and conditions**.** The motion was seconded by Dr. Vaughan and carried unanimously.

Nidjan Aquino, APRN **0024-170699**
Ms. Aquino did not appear.

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to reprimand **Nidjan Aquino, APRN** and require her, within 60 days from the date of entry of the Order, to submit a written summary acceptable to the Committee of the Joint Boards of the Regulations Governing the Licensure of Advanced Practice Registered Nurse and submit a revised practice agreement that defines the scope of her practice and patient population within the limits of the national competencies of an adult nurse practitioner. The motion was seconded by Dr. Vaughan and carried unanimously.

Curstina Jennings, APRN **0024-178321**
Ms. Jennings did not appear.

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to reprimand **Curstina Jennings, APRN** and require her, within 90 days from the date of entry of the Order, to provide written proof of successful completion of minimum of six (6) contact hours in the subject of medical documentation. The motion was seconded by Dr. Vaughan and carried unanimously.

Olusegun Taiwo, APRN **0024-173892**
Mr. Taiwo did not appear.

Mr. Marchese moved that the Committee of the Joint Boards of Nursing and Medicine accept the recommended decision of the agency subordinate to indefinitely suspend the license of **Olusegun Taiwo, APRN.** The motion was seconded by Dr. Vaughan and carried unanimously.

ADJOURNMENT: The meeting was adjourned at 9:24 A.M.

Robin L. Hills

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Robin L. Hills, DNP, RN, WHNP
Deputy Executive Director for Advanced Practice
Virginia Board of Nursing