Virginia Department of Health Professions

March 29, 2017
Board Room 2
9:30 a.m.

Agenda
Virginia Board of Physical Therapy
Full Board Meeting

Call to Order - Allen R. Jones, Jr., PT, DPT, Board President

- Welcome and Introductions
- Emergency Egress Procedures
- Recognition of Service – Lisa R. Hahn

Approval of Minutes Pages 4-30

- Board Meeting - November 15, 2016
- Legislative/Regulatory Committee - February 7, 2017
- Physical Therapy Compact Committee – February 7, 2017
- Public Hearing – Proposed Dry Needling Regulations – February 7, 2017
- Telephone Conference – February 21, 2017

Ordering of Agenda

Public Comment

Agency Director's Report - David Brown, DC

Staff Reports Pages 32-36

- Executive Director's Report – **Corie E. Tillman Wolf**
- Discipline Report – **Lynne Helmick**

Board of Health Professions Report - Allen R. Jones, Jr., PT, DPT

Workforce Data Center Report - Yetty Shobo, PhD Pages 38-97

Committee Reports

- Legislative/Regulatory Committee - **Melissa Wolff-Burke, PT, EdD, Chair** Pages 99-100
- Physical Therapy Compact Committee - **Dixie Bowman, PT, DPT, EdD, Chair**

Legislation and Regulatory Actions – Elaine Yeatts Pages 102-135

- Status of Regulatory Actions
- Consideration of Draft Regulations for the Recognition of the oPTion Assessment Tool
- Consideration of/Response to Public Comments – Proposed Regulations on the Practice of Dry Needling
- Consideration of Petition for Rulemaking (Continuing Education)
- Guidance Documents
  - Consideration of Revisions to GD 112-2 – Confidential Consent Agreements
  - Consideration of Revisions to GD 112-22 – Procedures for Auditing Continued Competency Requirements

Overview - Sanctioning Reference Points – Neal Kauder, Kim Small	**Pages 137-153**
Health Practitioners' Monitoring Program (HPMP) – Peggy Wood	**Pages 155-156**

Next Meeting – May 11, 2017

Meeting Adjournment

This information is in **DRAFT** form and is subject to change. The official agenda and packet will be approved by the public body at the meeting and will be available to the public pursuant to Virginia Code Section 2.2-3708(D).

Board Minutes

UNAPPROVED
BOARD OF PHYSICAL THERAPY
MEETING MINUTES

The Virginia Board of Physical Therapy convened for a board meeting on Tuesday, November 15, 2016 at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Board Room #1, Henrico, Virginia.

BOARD MEMBERS PRESENT:
Sarah Schmidt, PTA, President
Allen R. Jones, Jr., PT, DPT, Vice-President
Melissa Wolff-Burke, PT, EdD
Dixie Bowman, PT, DPT, EdD
Tracey Adler, PT, DPT
Arkena Dailey, PT, DPT
Steve Lam, Citizen Member

DHP STAFF PRESENT FOR ALL OR PART OF THE MEETING:
Corie Tillman Wolf, J.D., Executive Director
Lynne Helmick, Deputy Executive Director, Discipline
Missy Currier, Deputy Executive Director, Licensure
David Brown, D.C., Agency Director
Elaine Yeatts, Senior Policy Analyst

BOARD COUNSEL PRESENT:
Erin Barrett, Assistant Attorney General

QUORUM:
With 7 members present, a quorum was established.

GUESTS PRESENT
Patrick Deleonibus, Student
Richard Grossman, VPTA
Matthew Stanley, Acupuncture Society of Virginia (ASVA)
Arthur Fan, Ph.D. L.A.C
Fam Yan, L.A.C
Janet L. Borges, L.A.C
Diane Lowry, L.A.C.
Jennifer Yeh, L.A.C., ASVA

CALLED TO ORDER
Sarah Schmidt, President, called the meeting to order at 9:40 a.m. and asked the Board members and staff to introduce themselves.

Ms. Schmidt then stated the following before the first order of business:

1) Laptops were provided to the Board members for the purpose of the meeting only and have no connection to the internet. The material that they are able to review on the computer is the same material that has been made available to the public.
2) Please be sure to speak directly into the microphone so that everyone can hear you.

Ms. Tillman Wolf then read the Emergency Egress Procedures.

Ms. Schmidt stated that sign in sheets were available at the door for guests and public comment.

ORDERING OF THE AGENDA

Upon a motion by Dr. Allen R. Jones, Jr. and properly seconded by Dr. Arkena Dailey, the agenda was accepted as presented. The motion carried unanimously.

ACCEPTANCE OF MINUTES

Upon a motion by Dr. Allen R. Jones, Jr. and properly seconded by Dr. Dixie Bowman, the Board voted to accept the following minutes of the meetings with the addition of Erin Barrett, Board Counsel to the attendance during the May 10, 2016 Board Meeting.

- Board Meeting – May 10, 2016
- Formal Hearing – May 10, 2016
- Physical Therapy Compact Subcommittee Meeting – September 27, 2016
- Physical Therapy Compact Subcommittee Meeting – October 25, 2016

The motion carried unanimously.

PUBLIC COMMENT

There was no public comment.

EXECUTIVE DIRECTOR'S REPORT – Corie Tillman Wolf, J.D.

Ms. Tillman Wolf expressed how pleased she was to serve as Executive Director for the Board and her eagerness to work with the Board members. She then provided the following brief bio:

- She began in her position as Executive Director on August 25, 2016
  - She previously served 8 ½ years at Office of the Attorney General prosecuting cases for the Health Professions Unit
  - Additionally, she was the Assistant Attorney General for Domestic Violence issues; and the Statewide Facilitator for Victims of Domestic Violence

Expenditure and Revenue Summary

FY16 Budget

Cash Balance as of June 30, 2016	$ 712,466
YTD FY16 Revenue	36,125
Less direct and allocated expenditures	< 144,199>
Cash Balance as of 09/30/16	**$ 604,392**

FSBPT UPDATES

Ms. Tillman Wolf provided the following updates from the Federation of State Boards of Physical Therapy (FSBPT):

- The FSBPT Annual Meeting was held November 3-5, 2016, in Columbus Ohio.

- Exam, Licensure and Disciplinary Database (ELDD) - Virginia has an overall rating of 5 stars: 5 stars in licensure reporting, 5 stars in score reporting, 3 stars in discipline reporting. The information for disciplinary reporting is up to date; hopefully this will increase that rating during the next rating cycle.

- The Virginia Board continues to be a leader in workforce data collection and in competence requirements/traineeship requirements.

- NPTE Exam
  - There is a new registration process through PT schools. The new registration process and the Alternate Pathway will be covered more in depth by Deputy Executive Director Missy Currier in her Licensure Report.
  - FSBPT in process of conducting practice analysis for NPTE.
  - There is a proposed exam fee increase in 2018.
  - FSBPT is looking at the eligibility requirements for non-CAPTE graduates.
    - Course Work Tool (CWT) #6 for PT's will be available in January 2017.
    - FSBPT is currently developing a CWT for PTA's.
    - TOEFL standards (Test of English as a Foreign Language) will be reviewed with data collection in 2018, and revised standards in 2019.
  - The lifetime exam limit was put in place on January 1, 2016: the lifetime limit of 6 attempts or 2 scores of 400 or below. As reported during the last meeting, Virginia received 6 appeal requests and 4 were approved. Of the 4 approved, two have taken and passed the exam following the appeal.

- The Practice Review Tool (PRT) ends November 2016 (General and Ortho). The PRT is being replaced by oPTion as the online self-assessment tool. oPTion provides a comparison to entry-level requirements and an opportunity to review PT fundamentals. The change will impact on current regulations with references to "PRT," which will be discussed later in the agenda.

- aPTitude is the FSBPT program for tracking continuing competency. As of this meeting, 858 VA Licensees registered. Of those registered, 678 (79.02%) share information with VA; 180 (20.98%) choose not to share.

- Response to NC Board of Dental Examiners case – As reported at the FSBPT Annual Meeting, a coalition of organizations is looking at proposing a response at federal level, the "State Action Anti-trust Act." This act would be modeled after the Local Government Antitrust Act of 1984 and would create a limitation on treble damages for state licensing bodies.

- The FSBPT 2017 Regulatory Training for Members and Board Staff is scheduled for June 9 - 11, 2017 - Alexandria, VA. Current (new and seasoned) regulatory board members and administrators can request to attend. Attendance is funded by FSBPT.

PT Licensure Compact

- So far, 4 states have passed the Compact - Oregon, Tennessee, Arizona, Missouri. Since the last meeting, the PT Compact Subcommittee held two meetings on September 27th and October 25, 2016. Dr. Bowman will provide a report from the Subcommittee later in the agenda. Since those meetings, some follow up information has been requested and received. On November 1, 2016, Ms. Tillman Wolf and Board counsel had a telephone conference with legal counsel for the FSBPT regarding the compact language. In addition, Ms. Tillman Wolf has obtained templates for use in putting together a fiscal impact analysis for the Board's/Subcommittee's review.

Foreign-Educated PTs and FCCPT

- In September, the FCCPT (Foreign Credentialing Commission on Physical Therapy) released information that the USCIS (U.S. Citizenship and Immigration Services) intended to deny FCCPT's authorization to issue foreign PT healthcare worker certifications. The FCCPT evaluates the education received by foreign-educated PTs to determine whether it is comparable to education required in the US. The FCCPT responded to the USCIS's intent to deny, but as of FSBPT Annual meeting, the FCCPT had not received a response from the USCIS.
- What could this mean for Virginia Board? The Board uses FCCPT as one basis for credentialing non-CAPTE grads (18VAC112-20-50). Applicants would have to go through another Board-approved credentialing agency that meets the regulation requirements (18VAC112-20-50(B)). If denial stands for the FCCPT, it may make the credentialing process harder for some applicants.
- Ms. Tillman Wolf will keep the board informed of any changes

Staff Presentations

Ms. Tillman Wolf shared that the following presentations had been conducted since the last meeting:

- School-Based OT/PTs, Charlottesville, October 19, 2016 – Board staff provided an overview of the function of Board, current Board issues of interest, resources.

- Shenandoah University – Webinar for PT students; October 26, 2016 – Board staff provided an overview of the Board role; licensing and discipline information; new exam registration process; available resources.

Staff Notes

- If you have a change of address, email address, cell phone number, please remember to contact us so that we have the most current information.
- Please try to respond to email requests within a timely manner especially when the email requests a reply for availability or a response to a licensure or disciplinary question.
- Never "Reply All"

Thank you for all you hard work & dedication!

With no further questions, Ms. Tillman Wolf concluded her report.

AGENCY DIRECTORS REPORT – Dr. David Brown, D.C.

Dr. Brown provided the following report:

- The Board Member Training held October 24th was very well received and provided valuable tools and information to Board members. This year's training benefited not only new members but seasoned members as well with topics including; FOIA, Investigative Procedures & Experiences, and the agency and its responsibilities.
- He provided his support for members to attend national meetings and trainings.
- Dr. Brown spoke about the Prescription drug and heroin abuse crisis throughout the Commonwealth and requested that everyone consider alternatives to prescribing pain medications. He also shared the website VaAware.com, which is an online resource and informational tool for all citizens of Virginia.

LICENSURE REPORT – Missy Currier, Deputy Executive Director, Licensure

Virginia Performs – Customer Service Satisfaction

- FY16 – 95.4% overall
- FY17 (1st Qtr.) – 97.5%

Laura Mueller is the front line for the physical therapy board and she is extremely knowledgeable and helpful. Vicki Saxby and Heather Wright are cross trained and able to step in whenever necessary!

Licensee Statistics	**Nov. 2016**	**Nov. 2015**	
PT	8,337	7,462	**+875**
PTA	3,336	3,028	**+308**
Total	**11,673**	**10,490**	**+1,183**
DAccess Certifications	1,124		

We have processed **1,115** new licenses and 81 Direct Access Certifications since last meeting.

July 19 & 20, 2016 PT Exam Results:

88.1% VA pass rate / 11.89% VA failure rate

	# who took exam	# Passed	1st time test takers	Repeat test takers	# Failed	1st time testers	Repeat Test Takers
US Applicants	**239**	**212**	**202**	**10**	**27**	**23**	**4**
Foreign Trained Applicants	**5**	**3**	**1**	**2**	**2**	**1**	**1**
Total	**244**	**215**	**203**	**12**	**29**	**24**	**5**

October 27, 2016 PT Exam Results:

75.3% VA pass rate / 24.72% VA failure rate

	# who took exam	# Passed	1st time test takers	Repeat test takers	# Failed	1st time testers	Repeat Test Takers
US Applicants	**83**	**65**	**57**	**8**	**18**	**7**	**11**
Foreign Trained Applicants	**6**	**2**	**1**	**1**	**4**	**0**	**4**
Total	**89**	**67**	**58**	**9**	**22**	**7**	**15**

2016 YTD PT Exam Stats:

- 639 VA Applicants have taken exam
  - ❑ 569/passed – 70/failed

- ❑ 89.04% pass rate

- 15 Foreign Trained Applicants took exam
  - ❑ 6/passed – 9/failed
  - ❑ 40.0% pass rate

July 6, 2016 PTA Exam Results:

81.4% pass rate / 18.56% failure rate

	# who took exam	# Passed	1st time test takers	Repeat test takers	# Failed	1st time testers	Repeat Test Takers
US Applicants	**97**	**79**	**71**	**8**	**18**	**9**	**9**
Total	**97**	**79**	**71**	**8**	**18**	**9**	**9**

October 6, 2016 PTA Exam Results:

60.3% pass rate / 39.68% failure rate

	# who took exam	# Passed	1st time test takers	Repeat test takers	# Failed	1st time testers	Repeat Test Takers
US Applicants	**63**	**33**	**71**	**5**	**25**	**11**	**14**
Total	**63**	**38**	**33**	**5**	**25**	**11**	**14**

2016 YTD PTA Exam Stats:

- 285 VA Applicants have taken exam
  - ❑ 205/passed – 80/failed
  - ❑ 184 first time test takers
  - ❑ 71.93% pass rate
  - ❑ 28.07% fail rate

Virginia School Pass Rates*

	Virginia	U.S. Accredited
PT	97.80%	95.47%
PTA	87.59%	88.82%

***Based on 2016 Graduation Year**

2017 NPTE Exam Dates

- PT Exams:
  - January 26
  - April 26
  - July 18 & 19
  - October 25
- PTA Exams:
  - January 12
  - April 5
  - July 6
  - October 23

Ms. Currier made special mention that the free score report for students' remains viewable for 30 days following the release of scores. After 30 days, reports may be purchased at the standard fee for an Individual Score Report.

New Enhanced Registration Process for the NPTE

- **Became effective October 2, 2016**
  - The process has NOT changed for states
  - The process HAS changed for candidates. Any first time test taker must set up a profile before they can register for the exam
  - That profile must be initiated by the school
  - The process HAS changed for schools
    1) Schools must enter students so that the student can create a profile
    2) Schools must validate the student is on track to graduate prior to the student registering for the NPTE.

Alternate Approval Pathway

- We viewed a webinar during our May 2016 meeting
- Effective in January 2017, Boards may elect to have FSBPT submit eligibility for an applicant to test prior to jurisdiction approval
- Jurisdiction would still have final decision on licensure but applicant will have already taken exam.
- This is not a requirement by FSBPT so the Virginia Board can discuss the option at anytime

Licensure Renewals

- Renewal notices were emailed on October 18th
- A follow up email with FAQ's regarding the process was sent a week later to include:
  - The Board does not consider postmarked mail
  - First time renewal exemptions & instructions
  - Inactive to Active and Active to Inactive Instructions
  - Reminder about CE and "Active Practice" requirements

Ms. Currier reported that hard copy renewals will be mailed out on November 20th to anybody that had not already renewed or whose email got kicked back.

CEU Audit

- Board Staff will begin the audit process during late January – early February 2017
- Select a random sample of licensees to ensure compliance with CE requirements
- Procedures for Auditing Continuing Education can be found in Guidance Document 95-2

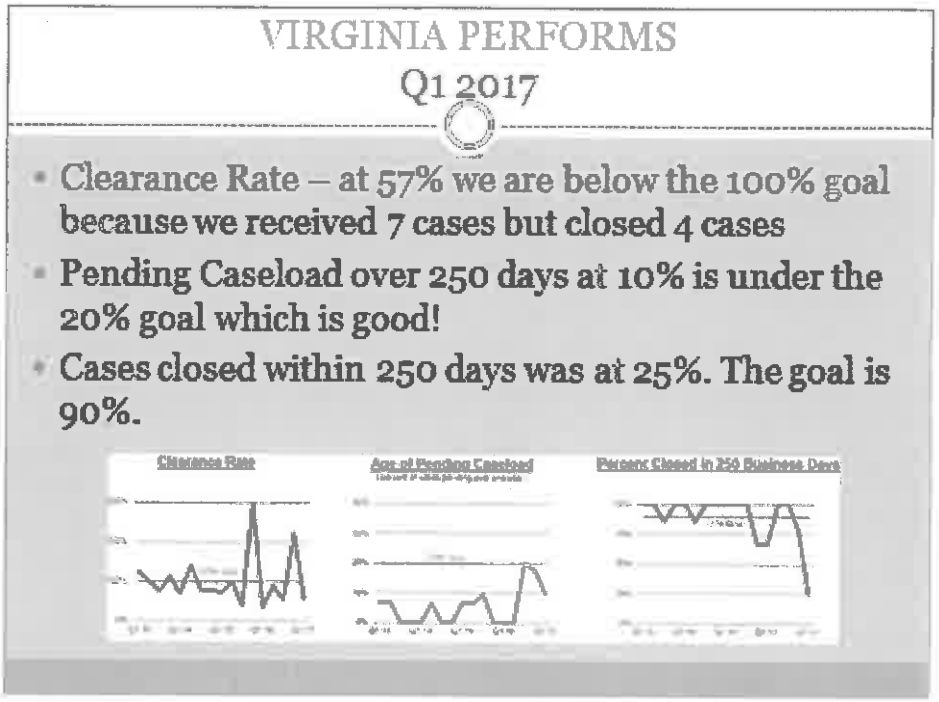
With no further questions, Ms. Currier concluded her report.

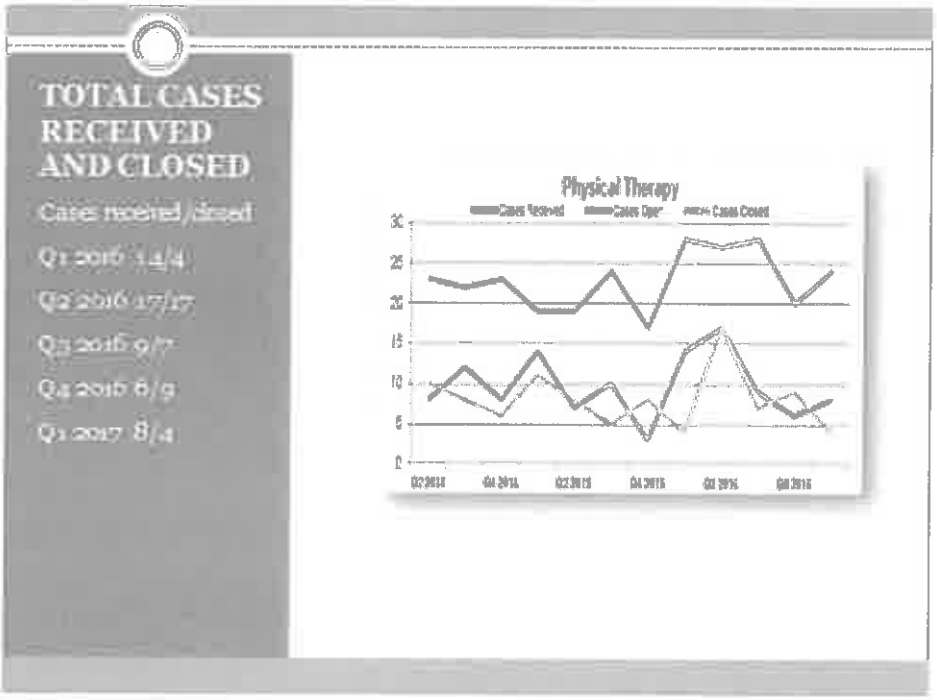
DISCIPLINE REPORT – Lynne Helmick – Deputy Executive Director, Discipline

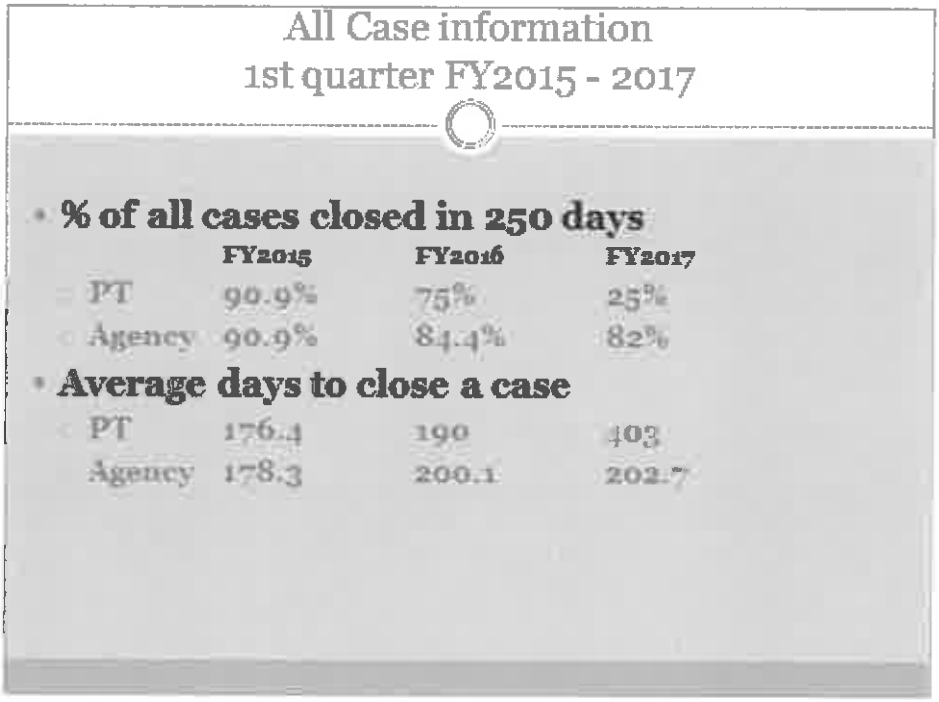
Discipline Statistics

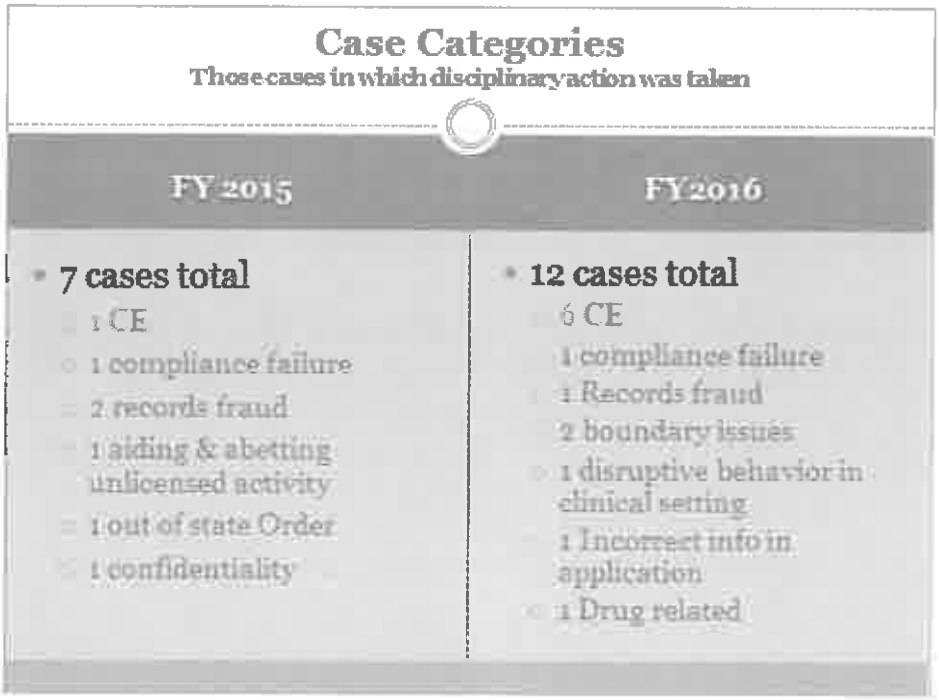
4/28/16	11/10/2016
30 Total Cases	19 Total Cases
▸ 12 in Investigation	9 in Investigation
▸ 15 in Probable Cause	8 in Probable Cause
▸ 0 at APD	2 at APD
▸ 0 at IFC	0 at IFC
▸ 2 at Formal Stage	0 at Formal Stage
▸ 7 licensees in Compliance Monitoring	8 licensees in Compliance Monitoring

Virginia Performs









Ms. Helmick reported that since the May 10, 2016 meeting, two Informal Conferences were held. Additionally, no hearings were on the docket or anticipated to be scheduled in the immediate future.

Dr. Allen R. Jones, Jr. reminded Ms. Helmick to include a footnote in future reports to substantiate why we may have not met the goals.

Ms. Tillman Wolf added that she was working with a few Executive Directors to formulate more realistic statistics for the smaller boards whose numbers can appear skewed when comparing to the larger boards.

Dr. Brown added many factors can affect number of days it takes to close a case that are often outside of the boards' control including the complexity of the case, the granting of continuances, and requesting additional information from investigators. He shared that DHP will be putting together a training video for Probable Cause Review which may assist members when reviewing cases. Finally, Dr. Brown assured the members that he closely watches the numbers and the Board of Physical Therapy and case processing was not a concern for him.

With no additional questions, Ms. Helmick concluded her report.

Board of Health Professions Report – Allen R. Jones, Jr., PT, DPT

Dr. Jones provided the following highlights of the BHP August 18, 2016 meeting and provided a more detailed handout:

- Bruce Keeney spoke in favor of Chiropractors ability to conduct physical exams on commercial driver's license and learners permit applicants.
- Ms. Yeatts presented an exempt regulatory action HB574 which addressed changes in specifications of who can be considered as a dietician or nutritionist. The other document included a list of emergency regulations, emergency regulatory actions by APA, and non – regulatory actions related to DHP from the 2016 General Assembly.
- Ms. Powers and Mr. Treacy presented a video highlighting the DHP Healthcare Data Center.
- Dr. Carter discussed the development of an internal staff committee to explore causes for a recent decrease in meeting the time to disposition 90 day goal.
- Dr. Carter also provided an overview of the Department's Healthcare Workforce Data Center and the research remains in its infancy. Dr. Carter and Neal Kauder submitted and published an article to the Journal of Nursing Regulation titled "Implementing a Sanctioning Reference System for the Virginia Board of Nursing.
- Approval was made to include a cover letter that provides a framing overview report by Andrew Feagans and Andrea Peeks regarding Telehealth; its purpose, and source, and directs readers to an addendum containing comments from the Executive Directors of the various boards.

With no further questions, this concluded Dr. Jones report.

Licensure Compact Subcommittee Report – Dixie H. Bowman, PT, DPT, Ed.D

Dr. Bowman provided an overview of the two meetings held regarding Licensure Compact.

First Meeting - September 27, 2016

Subcommittee members determined that additional discussion was necessary to address a number of questions related to the Compact. Subcommittee members recommended having representatives

from the Federation of State Physical Therapy Boards (FSBPT) and the Virginia Board of Nursing, as well as Board counsel, present at the second meeting to facilitate discussion.

Second Meeting – October 25, 2016

Leslie Adrian, Professional Standards Director from the FSBPT, Jay Douglas, Executive Director of the Board of Nursing, and Erin Barrett, Board Counsel, participated in the discussion. Many questions were answered and the Subcommittee had a better understanding of the Licensure Compact and recommended the following next steps:

1. Obtain information about travelling PT's (workforce data)
2. Ms. Tillman Wolf and Board Counsel to talk to Rick Masters re: legal drafting questions in the compact
3. Obtain more information on cost projections
4. Provide a Subcommittee Report at full Board meeting

Following discussion, a motion was made by Melissa Wolff-Burke and properly seconded by Tracey Adler in favor of the Subcommittee to continue working on the Licensure Compact. The motion carried unanimously.

BREAK

The Board took a recess at 11:20 a.m. and reconvened at 11:33 a.m.

NEW BUSINESS

Legislative Report – Elaine Yeatts, Senior Policy Analyst

Ms. Yeatts pointed out that the Proposed Regulations regarding the Practice of Dry Needling are now at the Office of the Governor. Although there is not a time frame indicating when the Governor will approve, there will be a 60 day public comment period as soon as they are published in the Virginia Register of Regulations, as well as a Public Hearing.

Ms. Yeatts then stated that there were three regulatory actions that the Board needed to consider during the meeting.

1) Public Participation Guidelines (PPG) - Regulatory Change – Fast Track (Attachment A)

Ms. Yeatts explained the revisions in 18VAC112-11-50 the Board needed to consider for the adoption of an amendment by a Fast-track action to the regulations for the Public Participation Guidelines (PPG) regarding Public comment.

Upon a motion by Dr. Allen R. Jones, Jr., and properly seconded by Dr. Arkena Dailey, the Board accepted the draft language as presented in order to conform to the Code of Virginia, Title §2.2-4007.02, Chapter 40, of the Administrative Process Act. The motion carried unanimously.

2) Consideration of CE Credit for Voluntary Work (Attachment B)

Ms. Yeatts explained that the Board would need to promulgate regulations that would allow some volunteer service time to count towards meeting CE requirements. Following discussion and review of the draft verbiage in 18VAC 112-20-131, Continuing Education Requirements, the Board agreed that up to two hours of the Type 2 continuing education hours may be fulfilled by volunteer services.

Upon a motion by Dr. Arkena Dailey and properly seconded by Dr. Tracey Adler, the Board voted to proceed with a Fast-track action for CE credit for voluntary work with the removal of the last sentence in the proposed language. The motion carried unanimously.

3) Consideration of Change in References (PRT & oPTion)

Ms. Yeatts referred the members to the email sent from FSBPT notifying the Board that effective on November 30, 2016 the Practice Review Tools (PRTs) would be retired and that oPTion would be the new self-assessment tool. She explained in detail that the Board's current regulations reference PRT in several sections. Ms. Yeatts suggested that the Board consider issuing a NOIRA recognizing that references to PRT in the regulations have to be addressed and the time frame would allow the Board more time to consider the options.

Following much discussion, a motion was made by Dr. Melissa Wolff-Burke and properly seconded by Dr. Tracey Adler to adopt a NOIRA to consider oPTion as a replacement of PRT in the regulations. The motion carried unanimously.

A second motion was made by Dr. Arkena Dailey and properly seconded by Dr. Allen R. Jones, Jr., to have the Legislative/Regulatory Committee work on reviewing oPTion, the 4 levels of performance a licensee can achieve, and whether or not the Board should consider it as credit for continuing competence. The motion carried unanimously.

FSBPT Fall Conference – Sarah Schmidt, Dixie Bowman, Arkena Dailey, Tracey Adler

Each of the attendees provided a brief overview of their experiences and takeaways during the meeting.

Dr. Tracey Adler reported on the presentation on dry needling that she gave during the meeting.

LIF Meeting – Sarah Schmidt

Ms. Schmidt gave a brief overview of the FSBPT Leadership Conference she attending during August and explained how beneficial it is for the Delegate to attend as it provides preparatory information for the Annual Conference.

Consideration of Board Selection of Delegates for FSBT Meetings – Sarah Schmidt

Ms. Schmidt stated that it has been customary for the Board President to serve as the Delegate during the Annual Meetings. She requested that if anyone was interested in serving as the Alternate Delegate to let Ms. Tillman Wolf know so that the Board can make a decision during the next meeting in 2017.

Election of New Officers

Ms. Schmidt stated that Dr. Allen R. Jones, Jr. submitted his written nomination for President and polled the members if anybody else would like to be considered for nomination. With no other nominations for consideration, the Board voted unanimously in favor of the election of Dr. Allen R. Jones, Jr. as the newly elected Board President.

Ms. Schmidt stated that Dr. Arkena Dailey submitted her written nomination for Vice-President and polled the members if anybody else would like to be considered for nomination. With no other nominations for consideration, the Board voted unanimously in favor of the election of Dr. Arkena Dailey as the newly elected Board Vice-President.

2017 Calendar

- February 14th
- May 11th
- August 22nd
- November 17th

Dr. Allen R. Jones, Jr. thanked Sarah Schmidt for her hard work and dedication while serving as President of the Board and stated he was looking forward to serving the Board during the next term.

ADJOURNMENT

With all business concluded, the meeting adjourned at 12:40 p.m.

Sarah Schmidt, PTA, MPA, President	Corie Tillman Wolf, J.D., Executive Director
Date	Date

Attachment A

18VAC112-11-50. Public comment.

A. In considering any nonemergency, nonexempt regulatory action, the agency shall afford interested persons an opportunity to (i) submit data, views, and arguments, either orally or in writing, to the agency; and (ii) be accompanied by and represented by counsel or other representative. Such opportunity to comment shall include an online public comment forum on the Town Hall.

1. To any requesting person, the agency shall provide copies of the statement of basis, purpose, substance, and issues; the economic impact analysis of the proposed or fast-track regulatory action; and the agency's response to public comments received.

2. The agency may begin crafting a regulatory action prior to or during any opportunities it provides to the public to submit comments.

B. The agency shall accept public comments in writing after the publication of a regulatory action in the Virginia Register as follows:

1. For a minimum of 30 calendar days following the publication of the notice of intended regulatory action (NOIRA).

2. For a minimum of 60 calendar days following the publication of a proposed regulation.

3. For a minimum of 30 calendar days following the publication of a re-proposed regulation.

4. For a minimum of 30 calendar days following the publication of a final adopted regulation.

5. For a minimum of 30 calendar days following the publication of a fast-track regulation.

6. For a minimum of 21 calendar days following the publication of a notice of periodic review.

7. Not later than 21 calendar days following the publication of a petition for rulemaking.

C. The agency may determine if any of the comment periods listed in subsection B of this section shall be extended.

D. If the Governor finds that one or more changes with substantial impact have been made to a proposed regulation, he may require the agency to provide an additional 30 calendar days to solicit additional public comment on the changes in accordance with § 2.2-4013 C of the Code of Virginia.

E. The agency shall send a draft of the agency's summary description of public comment to all public commenters on the proposed regulation at least five days before final adoption of the regulation pursuant to § 2.2-4012 E of the Code of Virginia.

Attachment B

BOARD OF PHYSICAL THERAPY
CE credit for volunteer practice

18VAC112-20-131. Continued competency requirements for renewal of an active license.

A In order to renew an active license biennially, a physical therapist or a physical therapist assistant shall complete at least 30 contact hours of continuing learning activities within the two years immediately preceding renewal. In choosing continuing learning activities or courses, the licensee shall consider the following: (i) the need to promote ethical practice, (ii) an appropriate standard of care, (iii) patient safety, (iv) application of new medical technology, (v) appropriate communication with patients, and (vi) knowledge of the changing health care system.

B. To document the required hours, the licensee shall maintain the Continued Competency Activity and Assessment Form that is provided by the board and that shall indicate completion of the following:

1. A minimum of 20 of the contact hours required for physical therapists and 15 of the contact hours required for physical therapist assistants shall be in Type 1 courses. For the purpose of this section, "course" means an organized program of study, classroom experience or similar educational experience that is directly related to the clinical practice of physical therapy and approved or provided by one of the following organizations or any of its components:

a. The Virginia Physical Therapy Association;
b. The American Physical Therapy Association;
c. Local, state or federal government agencies;
d. Regionally accredited colleges and universities;
e. Health care organizations accredited by a national accrediting organization granted authority by the Centers for Medicare and Medicaid Services to assure compliance with Medicare conditions of participation;
f. The American Medical Association - Category I Continuing Medical Education Course; and
g. The National Athletic Trainers' Association

2. No more than 10 of the contact hours required for physical therapists and 15 of the contact hours required for physical therapist assistants may be Type 2 activities or courses, which may or may not be offered by an approved organization but which shall be related to the clinical practice of physical therapy. Type 2 activities may include but not be limited to consultation with colleagues, independent study, and research or writing on subjects related to practice. Up to two of the Type 2 continuing education hours may be satisfied through delivery of occupational therapy services, without compensation. to low-income individuals receiving services through a local health department or a free clinic organized in whole or primarily for the delivery of health services. One hour of continuing education may be credited for three hours of providing such volunteer services as documented by the health department or free clinic.

3. Documentation of specialty certification by the American Physical Therapy Association may be provided as evidence of completion of continuing competency requirements for the biennium in which initial certification or recertification occurs.

4. Documentation of graduation from a transitional doctor of physical therapy program may be provided as evidence of completion of continuing competency requirements for the biennium in which the physical therapist was awarded the degree.

5. A physical therapist who can document that he has taken the PRT may receive 10 hours of Type 1 credit for the biennium in which the assessment tool was taken. A physical therapist who can document that he has met the standard of the PRT may receive 20 hours of Type 1 credit for the biennium in which the assessment tool was taken.

C. A licensee shall be exempt from the continuing competency requirements for the first biennial renewal following the date of initial licensure by examination in Virginia.

D. The licensee shall retain his records on the completed form with all supporting documentation for a period of four years following the renewal of an active license.

E. The licensees selected in a random audit conducted by the board shall provide the completed Continued Competency Activity and Assessment Form and all supporting documentation within 30 days of receiving notification of the audit.

F. Failure to comply with these requirements may subject the licensee to disciplinary action by the board.

G. The board may grant an extension of the deadline for continuing competency requirements for up to one year for good cause shown upon a written request from the licensee prior to the renewal date.

H. The board may grant an exemption for all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

UNAPPROVED
BOARD OF PHYSICAL THERAPY
PUBLIC HEARING

MEETING MINUTES

The Virginia Board of Physical Therapy Committee met on Tuesday, February 7, 2017 at 9:30 p.m. at the Department of Health Professions, 9960 Mayland Drive, 2nd Floor, Board Room #4, Henrico, Virginia.

COMMITTEE MEMBERS PRESENT:

Melissa Wolff-Burke, PT, EdD, Chair
Sarah Schmidt, PTA, MPA
Tracey Adler, PT, DPT
Steve Lam, Citizen Member

DHP STAFF PRESENT:

Missy Currier, Deputy Executive Director
Lynne Helmick, Deputy Executive Director
Elaine Yeatts, Senior Policy Analyst

QUORUM:

With 3 Committee members present, a quorum was established.

GUESTS PRESENT

Susan Old
Yon Fan
Tom Bohanon
Blaise Williams
Erik Wijtmans
Dorothee Martin
Judith Vaughan
Amy Kasdorf Gonzalez
Juanita Puffinbarger
Ian Scott
Susan Seward
Bruce Lonell
Rebecca Reynolds
Arthur Fan
Aubry Fisher
Sarah Steed
Stephanie Pinco

Brigitte Fox
Sarah Hung
Diane Lowry
Janet Borges
Ian Peuterbaugh
Pamela Howard
Kelly Sherman
Matthew Stanley

CALLED TO ORDER

The Public Hearing was called to order at 9:33 a.m. in order for the Board of Physical Therapy to receive comment on the proposed regulations regarding the practice of Dry Needling.

COMMENTS:

Eleven (11) comments were received in favor of the proposed regulations.

Twelve (12) comments were received in opposition to the proposed regulations.

One (1) person abstained from providing a comment in opposition.

ADJOURNMENT

With no further business, the meeting was adjourned at 10:35 a.m.

Melissa Wolff-Burke, PT, EdD, Chair	Corie Tillman Wolf, J.D., Executive Director
Date	Date

UNAPPROVED
BOARD OF PHYSICAL THERAPY
LEGISLATIVE/REGULATORY COMMITTEE MEETING
MEETING MINUTES

The Virginia Board of Physical Therapy Legislative/Regulatory Committee met on Tuesday, February 7, 2017 at the Department of Health Professions, 9960 Mayland Drive, 2nd Floor, Board Room #4, Henrico, Virginia.

COMMITTEE MEMBERS PRESENT:

Melissa Wolff-Burke, PT, EdD, Chair
Sarah Schmidt, PTA, MPA
Tracey Adler, PT, DPT
Steve Lam, Citizen Member

DHP STAFF PRESENT:

Missy Currier, Deputy Executive Director
Lynne Helmick, Deputy Executive Director
Elaine Yeatts, Senior Policy Analyst

QUORUM:

With 4 Committee members present, a quorum was established.

GUEST PRESENT VIA TELEPHONE

Heidi Herbst Paakkonen, MPA, Continuing Competence Product Manager, Federation of State Boards of Physical Therapy (FSBPT)

CALLED TO ORDER

The committee meeting was called to order at 10:53 a.m. to discuss replacement of the Practice Review Tool (PRT) with oPTion in regulations.

DISCUSSION

Melissa Wolf-Burke, Chair reminded the Committee that during the November 15, 2016 Board meeting, it was announced that PRT was being retired and being replaced by oPTion. Therefore, since PRT was referenced in several sections of the regulations, the decision was made to have the Legislative/Regulatory Committee conduct a more thorough review of oPTion to include assessing the four (4) different levels of performance that at licensee can achieve, and whether or not the Board should consider it as credit for continuing competence.

Ms. Currier stated that the NOIRA to consider oPTion as a replacement for PRT had received no comments as of the date of this meeting and that the comment period would end on February 22, 2017.

The Committee carefully considered the 4 levels of performance and sought clarification to several questions from Ms. Herbst Paakkonen from FSBPT.

RECOMMENDATION

Upon a motion by Tracey Adler, and properly seconded by Sarah Schmidt, the Committee agreed to recommend oPTion for continuing competence and drafted suggested language to share with the full Board during the next meeting.

ADJOURNMENT

With no further business, the meeting was adjourned at 11:45 a.m.

Melissa Wolff-Burke, PT, EdD, Chair	Corie Tillman Wolf, J.D., Executive Director
Date	Date

UNAPPROVED
BOARD OF PHYSICAL THERAPY
SPECIAL COMMITTEE MEETING
ON
LICENSURE COMPACT

MEETING MINUTES

The Virginia Board of Physical Therapy Special Committee on Licensure Compact met on Tuesday, February 7, 2017 at 1:00 p.m. at the Department of Health Professions, 9960 Mayland Drive, 2nd Floor, Board Room #4, Henrico, Virginia.

COMMITTEE MEMBERS PRESENT:

Dixie H. Bowman, PT, DPT, EdD, Chair
Allen R. Jones, Jr., PT, DPT
Sarah Schmidt, PTA, MPA

DHP STAFF PRESENT:

Missy Currier, Deputy Executive Director
Lynne Helmick, Deputy Executive Director
Elaine Yeatts, Senior Policy Analyst

QUORUM:

With 3 members present, a quorum was established.

GUEST PRESENT

Tom Bohanon, PT, DPT, OCS, In Motion Physical Therapy, VPTA

GUEST PRESENT VIA TELEPHONE

Leslie Adrian, PT, DPT, MPA, Director of Professional Standards, FSBPT

CALLED TO ORDER

The committee meeting was called to order at 1:03 p.m.

REVIEW

Dr. Bowman, Chair provided a summary of the October 25, 2016 Committee meeting. She stated that they had consulted telephonically with Leslie Adrien of the Federation of State Boards of Physical Therapy (FSBPT) regarding the Compact's structure and language and in person with Jay Douglas, Executive Director of the Board of Nursing on their experience with the Nurse

Licensure Compact.

Dr. Bowman stated that Board Staff prepared updates and responses to the recommendations made during the October meeting.

UPDATES:

- Conference call held between Erin Barrett, Board Counsel, Corie Tillman Wolf, Executive Director and Rick Masters, Counsel to PT Compact, to clarify certain legal verbiage in the Compact.
- Cost projections on the potential financial impact on the Board.
- Staff process for implementation.
- Implementation of Background Checks

The Committee discussed at length the information provided and formulated pertinent questions to ask Leslie Adrien during their conference call. After reviewing all the information provided and agreeing that all questions were clearly answered by Leslie Adrien, the Special Committee members recommended that further discussion of the Compact be put on hold for one year in an effort to observe what other states do, to get a better handle on what the exact financial impact could be for Virginia, and to further discuss whether or not the Compact will benefit licensees.

RECOMMENDATION

Upon a motion by Dr. Allen R. Jones, Jr. and properly seconded by Sarah Schmidt, the Licensure Compact Committee members decided against recommending pursuit of the Compact during the 2018 legislative session to the full board.

ADJOURNMENT

With no further business, the meeting was adjourned at 2:23 p.m.

Dixie H. Bowman, PT, DPT, EdD, Chair	Corie Tillman Wolf, J.D., Executive Director
Date	Date

VIRGINIA BOARD OF PHYSICAL THERAPY
MINUTES
Tuesday, February 21, 2017
12:00 P.M.

Department of Health Professions
9960 Mayland Drive, Suite #300
Henrico, Virginia 23233

DATE, TIME & PLACE:	On February 21, 2017, at 12:00 p.m., the Board of Physical Therapy convened by telephone conference call with a quorum of the Board present. The Board President presided as Chair, in order to consider whether a practitioner's ability to practice physical therapy constituted a substantial danger to public health and safety pursuant to Va. Code §54.1-2408.1.
MEMBERS PRESENT:	Allen Jones, Jr., PT, PhD., Chair Dixie Bowman, PT, EdD Sarah Schmidt, P.T.A. Melissa Wolff-Burke, PT, EdD Steve Lam, Citizen Member Arkena Dailey, PT, DPT
MEMBERS ABSENT:	Tracey Adler, PT, DPT
BOARD COUNSEL:	Erin Barrett, Assistant Attorney General
DHP STAFF PRESENT:	Corie Tillman Wolf, Executive Director Lynne Helmick, Deputy Executive Director Missy Currier, Deputy Executive Director Kathy Petersen, Discipline Operations Manager
PARTIES ON BEHALF OF COMMONWEALTH:	Wayne Halbleib, Senior Assistant Attorney General Carla Boyd, Adjudication Specialist
MATTER CONSIDERED:	**ANGELA DAWN ANDREWS, P.T.A.** **License No.: 2306-602110** **Case No.: 172531 & 176330** The Board received information from Sr. AAG Wayne Halbleib in order to determine whether Ms. Andrews' ability to practice as a physical therapist assistant constituted a substantial danger to public health and safety. Mr. Halbleib provided details of the case to the Board for its consideration.

CLOSED SESSION:	Upon a motion by Dixie Bowman, and duly seconded by Arkena Dailey, the Board voted to convene a closed meeting at 12:30 p.m., pursuant to §2.2-3711.A(27) of the Code of Virginia, for the purpose of deliberation to reach a decision in the matter of Angela D. Andrews, PTA. Additionally, he moved that Ms. Tillman Wolf, Ms. Helmick, Ms. Petersen, Ms. Currier and Ms. Barrett attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations.
RECONVENE:	Upon a motion by Dr. Bowman, and duly seconded by Dr. Dailey, the Board voted to re-convene at 12:35 p.m.
CERTIFICATION:	Dr. Bowman certified that the matters discussed in the preceding closed session met the requirements of §2.2-3712 of the Code of Virginia, the Board reconvened in open session.
DECISION:	Upon a motion by Sarah Schmidt, and duly seconded by Dr. Dailey, the Board determined that Ms. Andrews' ability to practice constituted a substantial danger to the public health and safety and voted to summarily suspend her license simultaneous with the institution of proceedings for a formal administrative hearing pursuant to §54.1-2408.1 of the Code of Virginia.
VOTE:	The vote was unanimous.
DECISION:	Upon a motion by Sarah Schmidt, and duly seconded by Dr. Dailey, the Board voted to offer Ms. Andrews a Consent Order for Indefinite Suspension for no less than two years.
VOTE:	The vote was unanimous.
ADJOURNMENT:	The Board adjourned at 12:40 p.m.

Allen Jones, Jr., PT, PhD., Chair

Corie Tillman Wolf, Executive Director

Date

Date

Executive Director's Report

Virginia Department of Health Professions
Cash Balance
As of January 31, 2017

	116- Physical Therapy
Board Cash Balance as of June 30, 2016	$ 712,466
YTD FY17 Revenue	1,179,430
Less: YTD FY17 Direct and In-Direct Expenditures	355,784
Board Cash Balance as of January 31, 2017	1,536,112

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 11600 - Physical Therapy

For the Period Beginning July 1, 2016 and Ending January 31, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
4002400	Fee Revenue				
4002401	Application Fee	60,050.00	126,000.00	65,950.00	47.66%
4002406	License & Renewal Fee	1,110,020.00	1,124,390.00	14,370.00	98.72%
4002407	Dup. License Certificate Fee	735.00	550.00	(185.00)	133.64%
4002409	Board Endorsement - Out	6,430.00	5,900.00	(530.00)	108.98%
4002421	Monetary Penalty & Late Fees	2,100.00	5,235.00	3,135.00	40.11%
4002432	Misc. Fee (Bad Check Fee)	35.00	35.00	-	100.00%
	Total Fee Revenue	1,179,370.00	1,262,110.00	82,740.00	93.44%
4003000	Sales of Prop. & Commodities				
4003007	Sales of Goods/Svces to State	5.00	-	(5.00)	0.00%
4003020	Misc. Sales-Dishonored Payments	55.00	-	(55.00)	0.00%
	Total Sales of Prop. & Commodities	60.00	-	(60.00)	0.00%
	Total Revenue	1,179,430.00	1,262,110.00	82,680.00	93.45%
5011110	Employer Retirement Contrib.	7,147.54	11,395.00	4,247.46	62.73%
5011120	Fed Old-Age Ins- Sal St Emp	3,688.50	6,552.00	2,863.50	56.30%
5011130	Fed Old-Age Ins- Wage Earners	64.46	561.00	496.54	11.49%
5011140	Group Insurance	687.42	1,107.00	419.58	62.10%
5011150	Medical/Hospitalization Ins.	15,150.70	24,383.00	9,232.30	62.14%
5011160	Retiree Medical/Hospitalizatn	618.51	997.00	378.49	62.04%
5011170	Long term Disability Ins	348.60	558.00	209.40	62.47%
	Total Employee Benefits	27,705.73	45,553.00	17,847.27	60.82%
5011200	Salaries				
5011230	Salaries, Classified	52,794.60	84,471.00	31,676.40	62.50%
5011250	Salaries, Overtime	64.33	-	(64.33)	0.00%
	Total Salaries	52,858.93	84,471.00	31,612.07	62.58%
5011300	Special Payments				
5011310	Bonuses and Incentives	225.00	-	(225.00)	0.00%
5011380	Deferred Compnstn Match Pmts	180.00	768.00	588.00	23.44%
	Total Special Payments	405.00	768.00	363.00	52.73%
5011400	Wages				
5011410	Wages, General	842.52	7,339.00	6,496.48	11.48%
	Total Wages	842.52	7,339.00	6,496.48	11.48%
5011930	Turnover/Vacancy Benefits	-	-	-	0.00%
	Total Personal Services	81,812.18	138,131.00	56,318.82	59.23%
5012000	Contractual Svs				
5012100	Communication Services				
5012110	Express Services	105.45	5.00	(100.45)	2109.00%
5012140	Postal Services	7,337.90	10,000.00	2,662.10	73.38%
5012150	Printing Services	-	600.00	600.00	0.00%
5012160	Telecommunications Svcs (VITA)	543.14	1,000.00	456.86	54.31%
5012170	Telecomm. Svcs (Non-State)	202.20	-	(202.20)	0.00%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 11600 - Physical Therapy

For the Period Beginning July 1, 2016 and Ending January 31, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
5012190	Inbound Freight Services	1.50	-	(1.50)	0.00%
	Total Communication Services	8,190.19	11,605.00	3,414.81	70.57%
5012200	Employee Development Services				
5012210	Organization Memberships	2,500.00	2,500.00	-	100.00%
5012240	Employee Trainng/Workshop/Conf	121.67	1,000.00	878.33	12.17%
	Total Employee Development Services	2,621.67	3,500.00	878.33	74.90%
5012300	Health Services				
5012360	X-ray and Laboratory Services	-	300.00	300.00	0.00%
	Total Health Services	-	300.00	300.00	0.00%
5012400	Mgmnt and Informational Svcs	-			
5012420	Fiscal Services	19,510.90	18,000.00	(1,510.90)	108.39%
5012440	Management Services	83.80	4,000.00	3,916.20	2.10%
5012470	Legal Services	165.00	300.00	135.00	55.00%
5012490	Recruitment Services	86.00	-	(86.00)	0.00%
	Total Mgmnt and Informational Svcs	19,845.70	22,300.00	2,454.30	88.99%
5012500	Repair and Maintenance Svcs				
5012520	Electrical Repair & Maint Srvc	-	25.00	25.00	0.00%
	Total Repair and Maintenance Svcs	-	25.00	25.00	0.00%
5012600	Support Services				
5012630	Clerical Services	-	19.00	19.00	0.00%
5012640	Food & Dietary Services	12.32	750.00	737.68	1.64%
5012660	Manual Labor Services	58.39	700.00	641.61	8.34%
5012670	Production Services	488.72	2,245.00	1,756.28	21.77%
5012680	Skilled Services	8,850.24	13,000.00	4,149.76	68.08%
	Total Support Services	9,409.67	16,714.00	7,304.33	56.30%
5012800	Transportation Services				
5012820	Travel, Personal Vehicle	1,287.90	3,000.00	1,712.10	42.93%
5012840	Travel, State Vehicles	-	1,500.00	1,500.00	0.00%
5012850	Travel, Subsistence & Lodging	120.88	1,500.00	1,379.12	8.06%
5012880	Trvl, Meal Reimb- Not Rprtble	-	300.00	300.00	0.00%
	Total Transportation Services	1,408.78	6,300.00	4,891.22	22.36%
	Total Contractual Svs	41,476.01	60,744.00	19,267.99	68.28%
5013000	Supplies And Materials				
5013100	Administrative Supplies				
5013120	Office Supplies	446.89	1,000.00	553.11	44.69%
5013130	Stationery and Forms	23.73	-	(23.73)	0.00%
	Total Administrative Supplies	470.62	1,000.00	529.38	47.06%
5013300	Manufctrng and Merch Supplies				
5013350	Packaging & Shipping Supplies	-	50.00	50.00	0.00%
	Total Manufctrng and Merch Supplies	-	50.00	50.00	0.00%
5013500	Repair and Maint. Supplies				
5013530	Electrcal Repair & Maint Matrl	-	15.00	15.00	0.00%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 11600 - Physical Therapy

For the Period Beginning July 1, 2016 and Ending January 31, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
	Total Repair and Maint. Supplies	-	15.00	15.00	0.00%
5013600	Residential Supplies				
5013620	Food and Dietary Supplies	-	200.00	200.00	0.00%
	Total Residential Supplies	-	200.00	200.00	0.00%
5013700	Specific Use Supplies				
5013730	Computer Operating Supplies	-	10.00	10.00	0.00%
	Total Specific Use Supplies	-	10.00	10.00	0.00%
	Total Supplies And Materials	470.62	1,275.00	804.38	36.91%
5015000	Continuous Charges				
5015100	Insurance-Fixed Assets				
5015160	Property Insurance	-	29.00	29.00	0.00%
	Total Insurance-Fixed Assets	-	29.00	29.00	0.00%
5015300	Operating Lease Payments				
5015340	Equipment Rentals	3.20	-	(3.20)	0.00%
5015350	Building Rentals	1.62	-	(1.62)	0.00%
5015390	Building Rentals - Non State	4,423.59	7,332.00	2,908.41	60.33%
	Total Operating Lease Payments	4,428.41	7,332.00	2,903.59	60.40%
5015500	Insurance-Operations				
5015510	General Liability Insurance	-	107.00	107.00	0.00%
5015540	Surety Bonds	-	7.00	7.00	0.00%
	Total Insurance-Operations	-	114.00	114.00	0.00%
	Total Continuous Charges	4,428.41	7,475.00	3,046.59	59.24%
5022000	Equipment				
5022100	Computer Hrdware & Sftware				
5022180	Computer Software Purchases	256.62	-	(256.62)	0.00%
	Total Computer Hrdware & Sftware	256.62	-	(256.62)	0.00%
5022200	Educational & Cultural Equip				
5022240	Reference Equipment	-	60.00	60.00	0.00%
	Total Educational & Cultural Equip	-	60.00	60.00	0.00%
5022600	Office Equipment				
5022610	Office Appurtenances	-	35.00	35.00	0.00%
	Total Office Equipment	-	35.00	35.00	0.00%
	Total Equipment	256.62	95.00	(161.62)	270.13%
	Total Expenditures	128,443.84	207,720.00	79,276.16	61.84%
	Net Revenue In Excess (Shortfall) of Expenditures Before Allocated Expenditures	$ 1,050,986.16	$ 1,054,390.00	$ 3,403.84	99.68%
	Allocated Expenditures				
20600	Funeral\LTCA\PT	54,061.51	103,604.90	49,543.39	52.18%
30100	Data Center	39,785.42	88,523.33	48,737.92	44.94%
30200	Human Resources	7,923.90	25,155.88	17,231.99	31.50%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 11600 - Physical Therapy

For the Period Beginning July 1, 2016 and Ending January 31, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
30300	Finance	38,140.25	45,751.94	7,611.69	83.36%
30400	Director's Office	15,707.14	26,909.81	11,202.67	58.37%
30500	Enforcement	34,764.37	63,543.61	28,779.24	54.71%
30600	Administrative Proceedings	2,940.72	18,570.22	15,629.50	15.84%
30700	Impaired Practitioners	762.96	1,038.40	275.45	73.47%
30800	Attorney General	17,386.28	22,879.75	5,493.47	75.99%
30900	Board of Health Professions	7,227.66	17,743.96	10,516.30	40.73%
31100	Maintenance and Repairs	-	434.88	434.88	0.00%
31300	Emp. Recognition Program	214.32	321.93	107.61	66.57%
31400	Conference Center	192.94	228.66	35.71	84.38%
31500	Pgm Devlpmnt & Implmentn	8,232.51	13,729.48	5,496.96	59.96%
	Total Allocated Expenditures	227,339.99	428,436.77	201,096.78	53.06%
	Net Revenue in Excess (Shortfall) of Expenditures	$ 823,646.17	$ 625,953.23	$ (197,692.94)	131.58%

Workforce Data Center Reports

Virginia's Physical Therapist Workforce: 2016

Healthcare Workforce Data Center

February 2017

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
9960 Mayland Drive, Suite 300
Richmond, VA 23233
804-367-2115, 804-527-4466(fax)
E-mail: ***HWDC@dhp.virginia.gov***

Follow us on Tumblr: ***www.vahwdc.tumblr.com***

6,457 Physical Therapists 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 Physical Therapy express our sincerest appreciation for your ongoing cooperation.*

Thank You!

Virginia Department of Health Professions

David E. Brown, D.C.
Director

Lisa Hahn, MPA
Chief Deputy Director

Healthcare Workforce Data Center Staff:

Dr. Elizabeth Carter, Ph.D.	Yetty Shobo, Ph.D.	Laura Jackson	Christopher Coyle
Executive Director	*Deputy Executive Director*	*Operations Manager*	*Research Assistant*

Virginia Board of Physical Therapy

President

Allen R. Jones, Jr., PT, DPT.
Newport News

Vice-President

Arkena Dailey, PT, DPT
Hampton

Members

Tracey Adler, PT, DPT
Richmond

Dixie Bowman, PT, EdD
Chesterfield

Melissa Wolff-Burke, PT, EdD
Winchester

Steve Lam
Burke

Sarah Schmidt, PTA, MPA
Palmyra

Executive Director

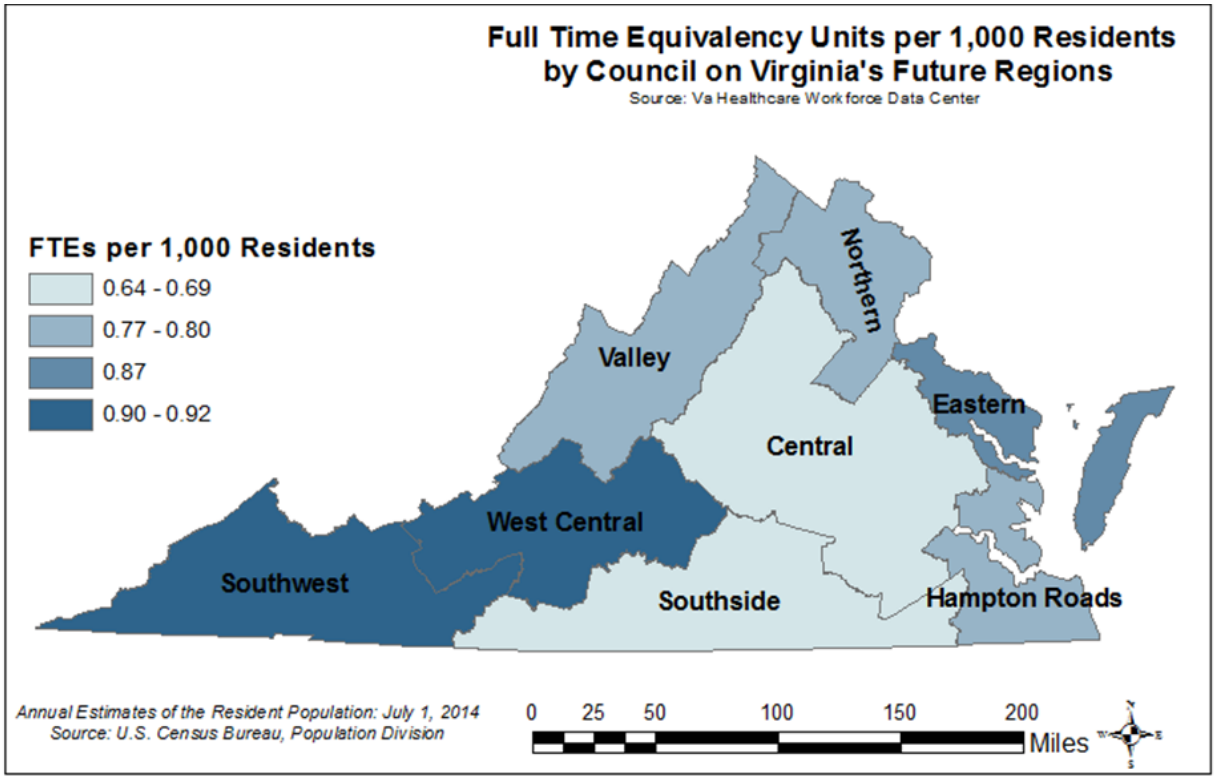
Corie E. Tillman Wolf, J.D.

Contents

The Physical Therapy Workforce: At a Glance:

The Workforce		Background		Current Employment	
Licensees:	8,454	Rural Childhood:	27%	Employed in Prof.:	98%
Virginia's Workforce:	6,726	HS Degree in VA:	39%	Hold 1 Full-time Job:	63%
FTEs:	5,649	Prof. Degree in VA:	38%	Satisfied?:	97%
Survey Response Rate		**Education**		**Job Turnover**	
All Licensees:	76%	Doctorate:	58%	Switched Jobs in 2014:	10%
Renewing Practitioners:	94%	Masters:	21%	Employed over 2 yrs:	57%
Demographics		**Finances**		**Primary Roles**	
% Female:	75%	Median Inc.:	$70k-$80k	Patient Care:	87%
Diversity Index:	32%	Health Benefits:	65%	Administration:	5%
Median Age:	40	Under 40 w/ Ed debt:	70%	Education:	1%

Source: Va. Healthcare Workforce Data Center



Results in Brief

6,457 physical therapists (PTs) voluntarily took part in the 2016 Physical Therapist Workforce Survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place in December during even-numbered years for PTs. These survey respondents represent 76% of the 8,454 PTs who are licensed in the state and 94% of renewing practitioners.

The HWDC estimates that 6,726 PTs participated in Virginia's workforce during the survey period, which is defined as those who worked at least a portion of the year in the state or who live in the state and intend to return to work in the profession at some point in the future. Virginia's PT workforce provided 5,649 "full-time equivalency units" during the survey time period, which the HWDC defines simply as working 2,000 hours a year (or 40 hours per week for 50 weeks with 2 weeks off).

Three-quarter of all PTs are female, and the median age of the PT workforce is 40. In a random encounter between two PTs, there is a 32% chance that they would be of different races or ethnicities, a measure known as the diversity index. For the Virginia population as a whole, the probability is 55%.

27% of PTs grew up in a rural area, and 17% of these professionals currently work in non-Metro areas of the state. Overall, just 9% of Virginia's PTs work in non-Metro areas of the state. Meanwhile, 39% of PTs went to high school in Virginia, and 38% also received their professional degree in the state. In total, nearly half of all PTs received some form of education in the state.

More than half of all PTs earned a Doctorate as their highest professional degree, while nearly one-quarter of the PT workforce earned a Master's degree. 45% of all PTs currently have educational debt, including 70% of those professionals who are under the age of 40. For those PTs with education debt, the median debt load is between $60,000 and $70,000.

In 2016, 98% of PTs are currently employed in the profession, and involuntarily unemployment is nearly nonexistent. 63% of Virginia's PTs hold one full-time position, while 18% have multiple positions. 57% of PTs have been at their primary work location for at least two years, while 26% of all PTs worked at a new location at some point in 2016.

Half of all PTs receive a salary at their primary work location, while 36% receive an hourly wage. The median annual income for Virginia's PT workforce is between $70,000 and $80,000. Among professionals who receive either a salary or an hourly wage at their primary work location, 85% receive at least one employer-sponsored benefit, including 65% who receive health insurance. 97% of PTs indicate they are satisfied with their current employment situation, including 70% who indicate they are "very satisfied".

Sixty-one percent of all PTs work at a for-profit establishment, while just 2% work for the federal government. Group Private Practices currently employ 16% of all PTs in Virginia, the most of any establishment type in the state. Outpatient Rehabilitation Facilities and Home Health Care Companies are also common establishment types for Virginia's PT workforce.

A typical PT spends nearly all of her time caring for patients. In fact, 87% of all PTs serve a patient care role, meaning that at least 60% of their time is spent in that activity. In addition, the typical PT also spends a small amount of time in administrative and educational tasks. In fact, 5% of all PTs serve an administrative role at their job.

Forty-eight percent of all PTs expect to retire by the age of 65. Although only 3% of the current workforce expects to retire in the next two years, half of the current workforce does expect to retire by 2046. Meanwhile, over the next two years, just 1% of all PTs expect to leave the profession, and 4% expect to leave the state. However, 30% of Virginia's PT workforce expects to pursue additional educational opportunities within the next two years, and 11% expect to increase their patient care activities.

Summary of Trends

Few significant changes have occurred in the Physical Therapist (PT) Workforce since 2014 when last surveyed. Most notably the percent of the workforce with a doctorate increased from 51% to 58%, and resulted in declines in the percent with Master's and baccalaureate degrees. The percent with APTA certifications and credentials also increased slightly. In 2016, 15% reported having at least one American Physical Therapy Association's certification compared to 14% in 2014. Similarly, 25% reported at least one credential in 2016 compared to 23% in 2014. The areas in which they held certification of credentialing were relatively the same. Another area of change worth reporting is in regards to workforce participation. Twenty-one percent of PTs did not participate in the workforce in 2016 whereas 19% did not participate in 2014.

The percent with debt also showed a 2% decline for those under age 40 but increased 1% in the overall population of PTs. The median educational debt, however, stayed the same at $60,000 to $70,000. Median income also stayed the same at $70,000 to $80,000. The percent of PTs employed in the profession increased slightly from 97% in 2014 to 98% in 2016; and those involuntary unemployed, though 0%, increased from 10 to 17 respondents between 2014 and 2016.

PTs who receive either a salary or an hourly wage at their primary work location and receive at least one employer-sponsored benefit increased slightly from 84% in 2014 to 85% in 2016. There were also slight changes in the work sector as 31% of PTs now work in the non-profit sector compared to 29% who did in 2014. At the same time, the percent working for the for-profit sector declined from 63% in 2014 to 61% in 2016.

The PT workforce also became slightly more diverse. The percent female went from 76% to 75% and the diversity index increased from 31% in 2014 to 32% in 2016. The percent under age 40 also increased from 49% in 2014 to 51% in 2016. However, the effect of this higher composition of younger workers was likely reversed by the increase in the percent above age 55 from 16% to 17%. Consequently, the median age did not change from 40.

Retirement intention is another area that witnessed some change in 2016. Compared to 2014 when half of the workforce planned to retire in 25 years, half of the workforce population in 2016 intends to retire in 30 years' time. Not surprisingly, the percent who intend to retire at age 65 also declined from 51% to 48%, a positive sign for having the PT workforce needed for the near future.

A Closer Look:

Licensees		
License Status	#	%
Renewing Practitioners	6,475	77%
New Licensees	847	10%
Non-Renewals	1,132	13%
All Licensees	**8,454**	**100%**

Source: Va. Healthcare Workforce Data Center

HWDC surveys tend to achieve very high response rates. 94% of renewing PTs submitted a survey. These represent 76% of PTs who held a license at some point in 2016.

Response Rates	
Statistic	**Non Respondents**	**Respondent**	**Response Rate**
By Age			
Under 30	703	628	47%
30 to 34	421	1,132	73%
35 to 39	221	1,008	82%
40 to 44	139	945	87%
45 to 49	129	842	87%
50 to 54	85	698	89%
55 to 59	92	554	86%
60 and Over	207	650	76%
Total	**1,997**	**6,457**	**76%**
New Licenses			
Issued in 2016	594	253	30%
Metro Status			
Non-Metro	115	417	78%
Metro	832	5,136	86%
Not in Virginia	1,049	903	46%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed PTs

Number:	8,454
New:	10%
Not Renewed:	13%

Response Rates

All Licensees:	76%
Renewing Practitioners:	94%

Source: Va. Healthcare Workforce Data Center

Response Rates	
Completed Surveys	6,457
Response Rate, all licensees	76%
Response Rate, Renewals	94%

Source: Va. Healthcare Workforce Data Center

Definitions

1. **The Survey Period:** The survey was conducted in December 2016.
2. **Target Population:** All PTs who held a Virginia license at some point in 2016.
3. **Survey Population:** The survey was available to PTs who renewed their licenses online. It was not available to those who did not renew, including some PTs newly licensed in 2016.

At a Glance:

Workforce

2016 PT Workforce:	6,726
FTEs:	5,649

Utilization Ratios

Licensees in VA Workforce:	80%
Licensees per FTE:	1.50
Workers per FTE:	1.19

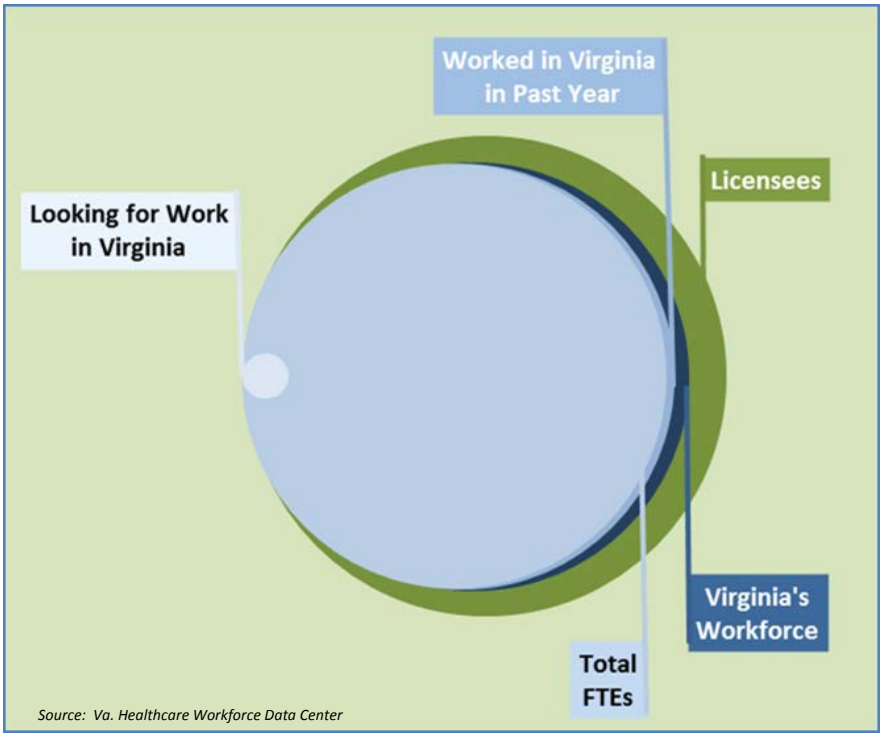
Source: Va. Healthcare Workforce Data Center

Definitions

1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time in the past year 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 PT Workforce		
Status	#	%
Worked in Virginia in Past Year	6,672	99%
Looking for Work in Virginia	54	1%
Virginia's Workforce	**6,726**	**100%**
Total FTEs	**5,649**	
Licensees	**8,454**	

Source: Va. Healthcare Workforce Data Center



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

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 30	268	25%	814	75%	1,082	17%
30 to 34	296	25%	907	75%	1,203	19%
35 to 39	198	22%	702	78%	900	14%
40 to 44	215	28%	551	72%	766	12%
45 to 49	178	27%	488	73%	667	11%
50 to 54	131	24%	425	76%	557	9%
55 to 59	93	20%	371	80%	464	7%
60 +	177	29%	423	71%	600	10%
Total	**1,556**	**25%**	**4,682**	**75%**	**6,237**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

% Female:	75%
% Under 40 Female:	76%

Age

Median Age:	40
% Under 40:	51%
% 55+:	17%

Diversity

Diversity Index:	32%
Under 40 Div. Index:	35%

Source: Va. Healthcare Workforce Data Center

Race & Ethnicity					
Race/ Ethnicity	Virginia*	PTs		PTs under 40	
	%	#	%	#	%
White	63%	5,115	82%	2,537	80%
Black	19%	254	4%	142	4%
Asian	6%	521	8%	300	9%
Other Race	0%	87	1%	51	2%
Two or more races	2%	119	2%	70	2%
Hispanic	9%	139	2%	75	2%
Total	**100%**	**6,235**	**100%**	**3,175**	**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, 2014.**

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two PTs, there is a 32% chance that they would be of a different race/ethnicity (a measure known as the diversity index). For Virginia's population as a whole, the comparable number is 55%.

Half of all PTs are under the age of 40, and 76% of these professionals are female. In addition, there is a 35% chance that two randomly chosen PTs from this group would be of a different race or ethnicity.

Source: Va. Healthcare Workforce Data Center

At a Glance:

Childhood

Urban Childhood:	12%
Rural Childhood:	27%

Native Sons

HS in Virginia:	39%
Prof. Education in VA:	38%
HS/Prof. Edu. in VA:	48%

Location Choice

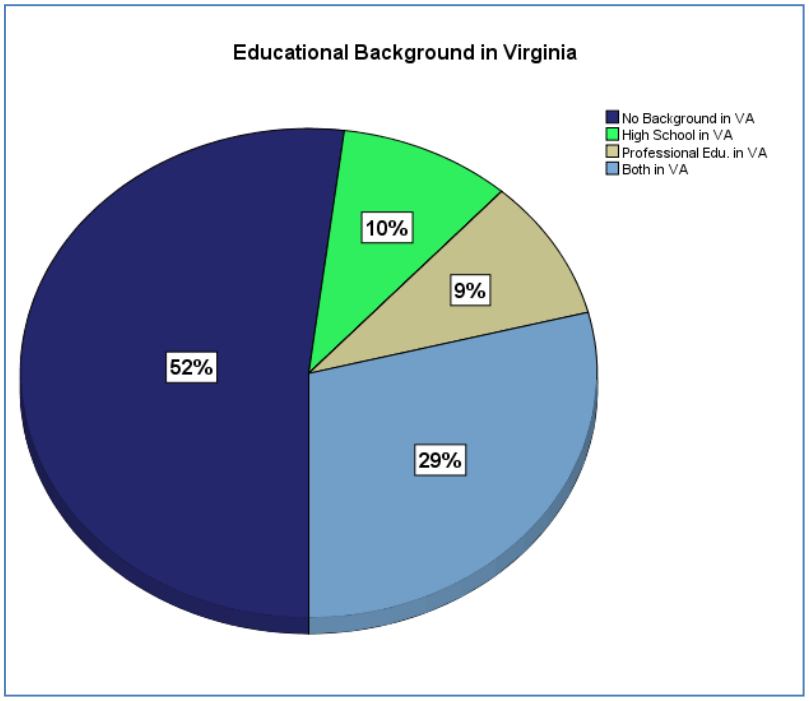
% Rural to Non-Metro:	17%
% Urban/Suburban to Non-Metro:	6%

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+	20%	67%	13%
2	Metro, 250,000 to 1 million	40%	50%	11%
3	Metro, 250,000 or less	39%	51%	11%
	Non-Metro Counties			
4	Urban pop 20,000+, Metro adj	47%	33%	20%
6	Urban pop, 2,500-19,999, Metro adj	50%	36%	14%
7	Urban pop, 2,500-19,999, nonadj	61%	28%	11%
8	Rural, Metro adj	51%	41%	7%
9	Rural, nonadj	46%	48%	6%
	Overall	**27%**	**61%**	**12%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

27% of PTs grew up in self-described rural areas, and 17% of these professionals currently work in non-metro counties. Overall, 9% of Virginia's PT workforce works in non-metro counties of the state.

Top Ten States for PT Recruitment

Rank	All PTs			
	High School	#	PT School	#
1	Virginia	2,401	Virginia	2,353
2	Outside U.S./Canada	544	New York	497
3	New York	543	Pennsylvania	458
4	Pennsylvania	450	Outside U.S./Canada	416
5	Maryland	376	North Carolina	291
6	New Jersey	175	Florida	241
7	North Carolina	158	Washington, D.C.	191
8	Ohio	135	Massachusetts	189
9	Florida	113	Maryland	158
10	Massachusetts	107	California	99

Source: Va. Healthcare Workforce Data Center

39% of PTs received their high school degree in Virginia, while 38% received their initial professional degree in the state.

Among PTs who have been licensed in the past five years, 40% received their high school degree in Virginia, while 39% received their initial professional degree in the state.

Rank	Licensed in the Past 5 Years			
	High School	#	PT School	#
1	Virginia	898	Virginia	870
2	Outside U.S./Canada	184	Pennsylvania	176
3	New York	184	New York	169
4	Pennsylvania	175	Outside U.S./Canada	140
5	Maryland	141	Florida	114
6	North Carolina	77	North Carolina	95
7	Ohio	49	Washington, D.C.	95
8	Mississippi	44	Tennessee	49
9	West Virginia	34	Maryland	45
10	New Jersey	33	West Virginia	38

Source: Va. Healthcare Workforce Data Center

21% of licensed PTs did not participate in Virginia's workforce in 2016. 96% of these PTs worked at some point in the past year, including 92% who currently work as PTs.

At a Glance:

Not in VA Workforce

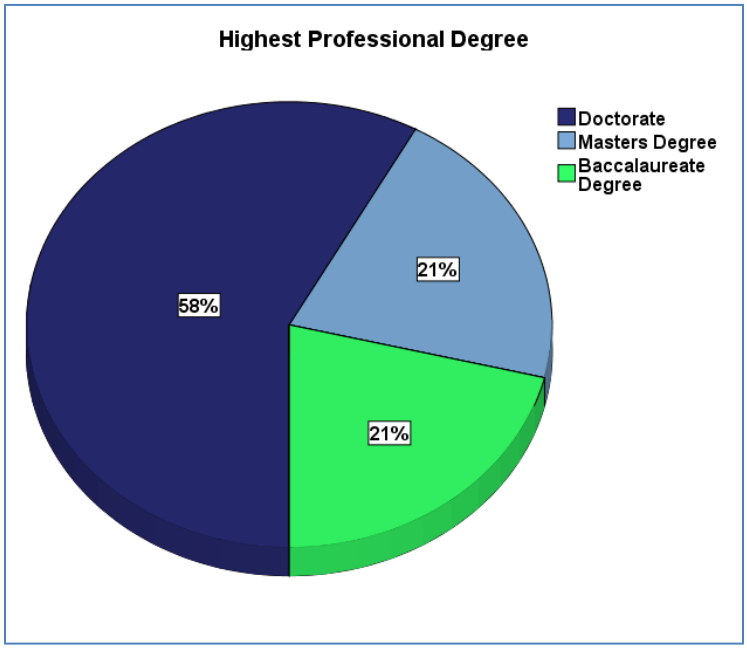
Total:	1,744
% of Licensees:	21%
Federal/Military:	9%
VA Border State/DC:	17%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Professional Degree		
Degree	#	%
Baccalaureate Degree	1,315	21%
Master's Degree	1,294	21%
Doctorate	3,600	58%
Total	**6,210**	**100%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

At a Glance:

Education

Doctorate: 58%
Master's: 21%

Educational Debt

With debt: 45%
Under age 40 with debt: 70%
Median debt: $60k-$70k

Source: Va. Healthcare Workforce Data Center

Nearly one-quarter of all PTs hold a Master's degree as their highest professional degree, while more than half have earned a Doctorate.

45% of PTs currently have educational debt, including 70% of those under the age of 40. For those PTs with educational debt, the median debt burden is between $60,000 and $70,000.

Educational Debt				
Amount Carried	All PTs		PTs under 40	
	#	%	#	%
None	3,170	55%	879	30%
Less than $20,000	372	6%	218	7%
$20,000-$39,999	362	6%	237	8%
$40,000-$59,999	403	7%	298	10%
$60,000-$79,999	322	6%	284	10%
$80,000-$99,999	291	5%	261	9%
$100,000-$119,999	253	4%	238	8%
$120,000 or More	565	10%	529	18%
Total	**5,738**	**100%**	**2,944**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Top Certifications

Othopaedics: 5%
Clinical Instructor (APTA): 5%
At Least One Cert.: 15%

Top Credentials:

Dry Needling: 9%
Exercise/Physical Ther.: 4%
At Least One Cred.: 25%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

APTA Recognition of Advanced Proficiency		
Proficiency Area	#	%
Orthopaedics	366	5%
Clinical Instructor (APTA)	344	5%
Sports	63	1%
Geriatrics	60	1%
Neurology	55	1%
Pediatrics	35	1%
Cardiovascular & Pulmonary	18	0%
Women's Health	6	0%
Clinical Electrophysiology	4	0%
Other	181	3%
At Least 1 Certification	1,038	15%

Source: Va. Healthcare Workforce Data Center

Credentials		
Area	#	%
Dry Needling	616	9%
Exercise/Physical Therapy	237	4%
Athletic Training	194	3%
Lymphedema Therapy	173	3%
Early Intervention	143	2%
Massage Therapy	50	1%
Wound Care	42	1%
Orthotics	21	0%
Assistive Technology	18	0%
Art/Dance Therapy	9	0%
Occupational Therapy	6	0%
Credentials, Nursing	4	0%
Prosthetics	4	0%
Chiropractry	4	0%
Other	520	8%
At Least 1 Credential	1,689	25%

Source: Va. Healthcare Workforce Data Center

15% of all PTs hold at least one APTA certification, while one-quarter of Virginia's PT workforce holds at least one credential. Clinical Instructor (APTA) was the most common certification proficiency area, while Dry Needling was the most common credentialed proficiency area.

At a Glance:

Employment
Employed in Profession: 98%
Involuntarily Unemployed: 0%

Positions Held
1 Full-Time: 63%
2 or more Positions: 18%

Weekly Hours:
40 to 49: 53%
60 or more: 3%
Less than 30: 17%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Current Work Status		
Status	#	%
Employed, capacity unknown	1	0%
Employed in a physical therapy related capacity	6,064	98%
Employed, NOT in a physical therapy related capacity	33	1%
Not working, reason unknown	0	0%
Involuntarily unemployed	10	0%
Voluntarily unemployed	79	1%
Retired	24	0%
Total	**6,211**	**100%**

Source: Va. Healthcare Workforce Data Center

98% of licensed PTs are currently employed in the profession, and involuntarily unemployed is nearly nonexistent at the moment. 63% of all PTs currently hold one full-time job, while 18% have multiple positions. 53% of PTs work between 40 and 49 hours per week, while just 3% of PTs work at least 60 hours per week.

Current Positions		
Positions	#	%
No Positions	113	2%
One Part-Time Position	1,074	17%
Two Part-Time Positions	318	5%
One Full-Time Position	3,903	63%
One Full-Time Position & One Part-Time Position	632	10%
Two Full-Time Positions	3	0%
More than Two Positions	115	2%
Total	**6,159**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Weekly Hours		
Hours	#	%
0 hours	113	2%
1 to 9 hours	153	3%
10 to 19 hours	359	6%
20 to 29 hours	523	9%
30 to 39 hours	1,014	17%
40 to 49 hours	3,230	53%
50 to 59 hours	557	9%
60 to 69 hours	113	2%
70 to 79 hours	32	1%
80 or more hours	19	0%
Total	**6,113**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Income		
Hourly Wage	#	%
Volunteer Work Only	15	0%
Less than $30,000	317	6%
$30,000-$39,999	214	4%
$40,000-$49,999	259	5%
$50,000-$59,999	442	8%
$60,000-$69,999	914	17%
$70,000-$79,999	1,060	20%
$80,000-$89,999	801	15%
$90,000-$99,999	574	11%
$100,000-$109,999	357	7%
$110,000-$119,999	139	3%
$120,000 or more	194	4%
Total	**5,285**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Earnings
Median Income: $70k-$80k

Benefits
Employer Health Ins.: 65%
Employer Retirement: 66%

Satisfaction
Satisfied 97%
Very Satisfied: 70%

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	#	%
Very Satisfied	4,280	70%
Somewhat Satisfied	1,610	26%
Somewhat Dissatisfied	157	3%
Very Dissatisfied	31	1%
Total	**6,078**	**100%**

Source: Va. Healthcare Workforce Data Center

The typical PT earned between $70,000 and $80,000 in 2016. In addition, among PTs who received either an hourly wage or a salary at their primary work location, 65% received health insurance and 66% had access to a retirement plan.

Employer-Sponsored Benefits			
Benefit	#	%	% of Wage/Salary Employees
Paid Vacation	4,238	70%	77%
Retirement	3,697	61%	66%
Health Insurance	3,693	61%	65%
Dental Insurance	3,364	55%	60%
Paid Sick Leave	3,070	51%	57%
Group Life Insurance	2,459	41%	45%
Signing/Retention Bonus	750	12%	14%
Total	**4,813**	**79%**	**85%**

*From any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Underemployment in Past Year		
In the past year did you . . .?	**#**	**%**
Experience Involuntary Unemployment?	68	1%
Experience Voluntary Unemployment?	296	4%
Work Part-time or temporary positions, but would have preferred a full-time/permanent position?	101	2%
Work two or more positions at the same time?	1,272	19%
Switch employers or practices?	665	10%
Experienced at least 1	**1,978**	**29%**

Source: Va. Healthcare Workforce Data Center

Only 1% of Virginia's PTs experienced involuntary unemployment at some point in 2016. By comparison, Virginia's average monthly unemployment rate was 4.0%.[1]

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at this Location	108	2%	120	7%
Less than 6 Months	533	9%	268	16%
6 Months to 1 Year	553	9%	230	14%
1 to 2 Years	1,417	23%	338	21%
3 to 5 Years	1,337	22%	355	22%
6 to 10 Years	911	15%	169	10%
More than 10 Years	1,204	20%	158	10%
Subtotal	**6,063**	**100%**	**1,638**	**100%**
Did not have location	63		5,069	
Item Missing	599		19	
Total	**6,726**		**6,726**	

Source: Va. Healthcare Workforce Data Center

51% of all PTs received a salary at their primary work location, while 36% received an hourly wage.

At a Glance:

Unemployment Experience 2014

Involuntarily Unemployed: 1%
Underemployed: 2%

Turnover & Tenure

Switched Jobs: 10%
New Location: 26%
Over 2 years: 57%
Over 2 yrs, 2nd location: 42%

Employment Type

Salary/Commission: 36%
Hourly Wage: 51%

Source: Va. Healthcare Workforce Data Center

57% of PTs have worked at their primary location for more than 2 years—the job tenure normally required to get a conventional mortgage loan.

Employment Type		
Primary Work Site	**#**	**%**
Salary/ Commission	2,638	51%
Hourly Wage	1,846	36%
By Contract	433	8%
Business/ Practice Income	227	4%
Unpaid	20	0%
Subtotal	**5,163**	**100%**

Source: Va. Healthcare Workforce Data Center

[1] As reported by the US Bureau of Labor Statistics. The not seasonally adjusted monthly unemployment rate ranged from 3.9% in December 2015 to 4.0% in November 2016. November's rate is from preliminary data.

At a Glance:

Concentration

Top Region:	33%
Top 3 Regions:	75%
Lowest Region:	2%

Locations

2 or more (2016):	27%
2 or more (Now*):	25%

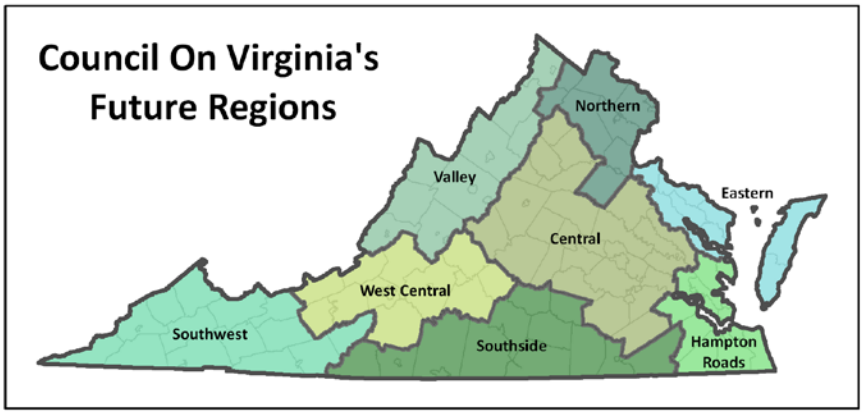
Source: Va. Healthcare Workforce Data Center

Nearly three-quarters of all PTs work in one of three regions of the state: Northern Virginia, Central Virginia, and Hampton Roads.

A Closer Look:

Regional Distribution of Work Locations				
COVF Region	Primary Location		Secondary Location	
	#	%	#	%
Central	1,404	23%	320	19%
Eastern	81	1%	20	1%
Hampton Roads	1,124	19%	269	16%
Northern	1,980	33%	474	29%
Southside	181	3%	60	4%
Southwest	193	3%	54	3%
Valley	409	7%	113	7%
West Central	568	9%	149	9%
Virginia Border State/DC	32	1%	69	4%
Other US State	76	1%	114	7%
Outside of the US	2	0%	4	0%
Total	**6,050**	**100%**	**1,646**	**100%**
Item Missing	612		11	

Source: Va. Healthcare Workforce Data Center



Number of Work Locations				
Locations	Work Locations in 2016		Work Locations Now*	
	#	%	#	%
0	54	1%	110	2%
1	4,395	72%	4,478	73%
2	1,039	17%	998	16%
3	420	7%	407	7%
4	80	1%	39	1%
5	40	1%	32	1%
6 or More	70	1%	34	1%
Total	**6,098**	**100%**	**6,098**	**100%**

*At the time of survey completion, December 2016.

Source: Va. Healthcare Workforce Data Center

25% of all PTs currently have multiple work locations, while 27% of PTs have had at least two work locations over the past year.

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	3,622	61%	1,130	71%
Non-Profit	1,840	31%	374	24%
State/Local Government	297	5%	70	4%
Veterans Administration	62	1%	2	0%
U.S. Military	61	1%	6	0%
Other Federal Government	10	0%	9	1%
Total	5,892	100%	1,592	100%
Did not have location	63		5,069	
Item Missing	770		64.4735	

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Sector

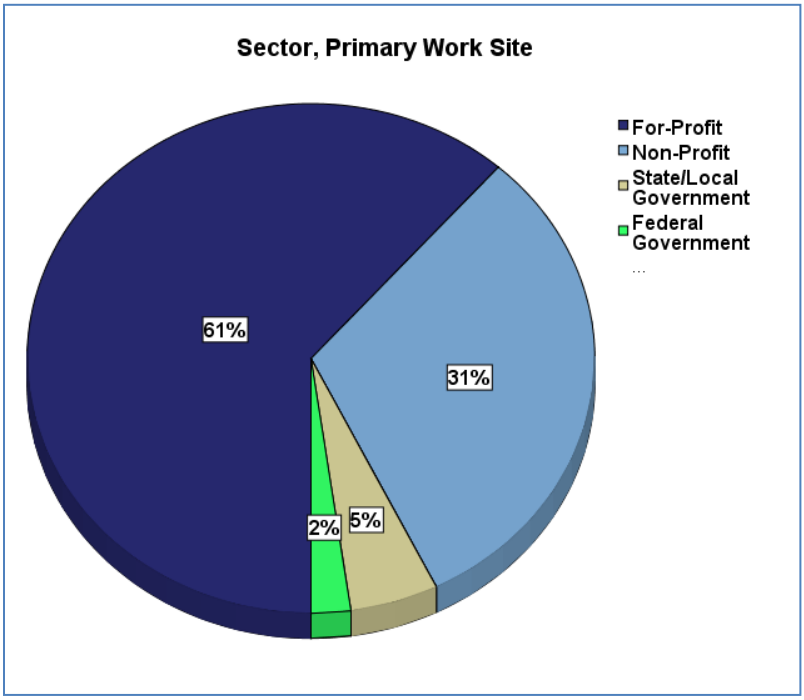
For Profit:	61%
Federal:	2%

Top Establishments

Group Private Practice:	16%
Outpatient Rehab.:	15%
Home Health Care:	14%

Source: Va. Healthcare Workforce Data Center

More than 90% of all PTs work in the private sector, including 61% who work at for-profit establishments. Another 5% of Virginia's PT workforce worked for either state or local governments.



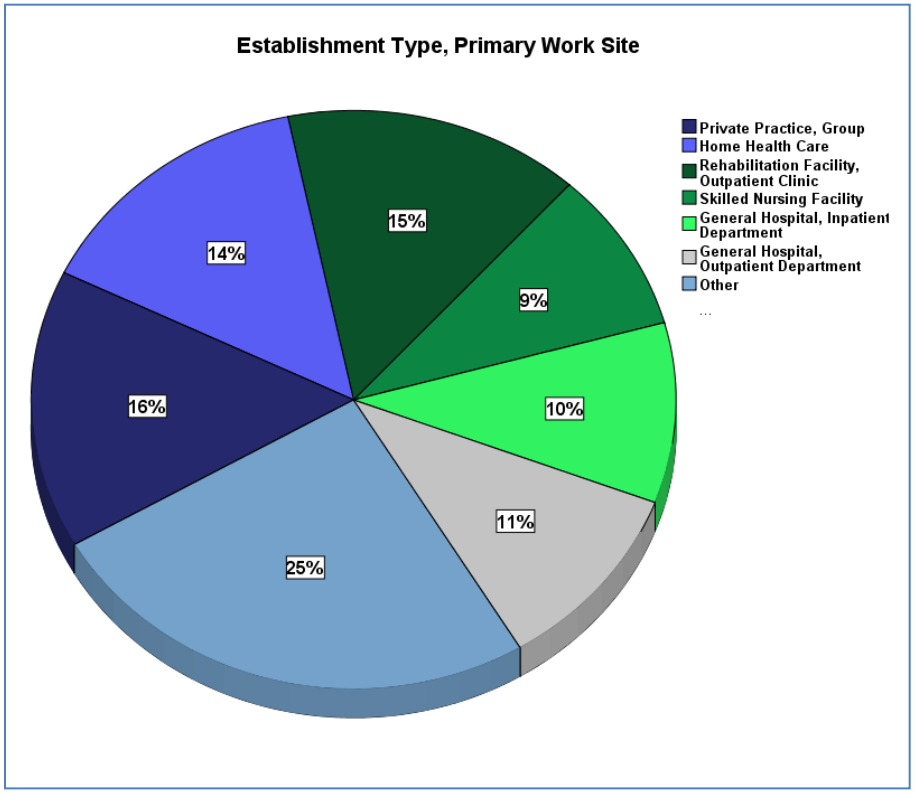
Source: Va. Healthcare Workforce Data Center

Location Type				
Establishment Type	Primary Location		Secondary Location	
	#	%	#	%
Private Practice, Group	895	16%	144	9%
Rehabilitation Facility, Outpatient Clinic	858	15%	135	9%
Home Health Care	832	14%	271	18%
General Hospital, Outpatient Department	608	11%	78	5%
General Hospital, Inpatient Department	579	10%	180	12%
Skilled Nursing Facility	519	9%	264	17%
Private Practice, Solo	420	7%	92	6%
Rehabilitation Facility, Residential/Inpatient	231	4%	89	6%
K-12 School System	140	2%	28	2%
Academic Institution	139	2%	94	6%
Physician Office	133	2%	19	1%
Assisted Living or Continuing Care Facility	123	2%	43	3%
Other	267	5%	107	7%
Total	**5,744**	**100%**	**1,547**	**100%**
Did Not Have a Location	63		5,069	

Source: Va. Healthcare Workforce Data Center

Group Private Practices are the most common establishment type among Virginia's PTs with a primary work location. Home Health Care and Outpatient Rehabilitation Facilities were also typical primary establishment types.

Home Health Care was the most common establishment type among PTs who also had a secondary work location. Skilled Nursing Facilities and the Inpatient Department of Hospitals were also common secondary establishment types.



Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

A Typical PT's Time

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

Roles

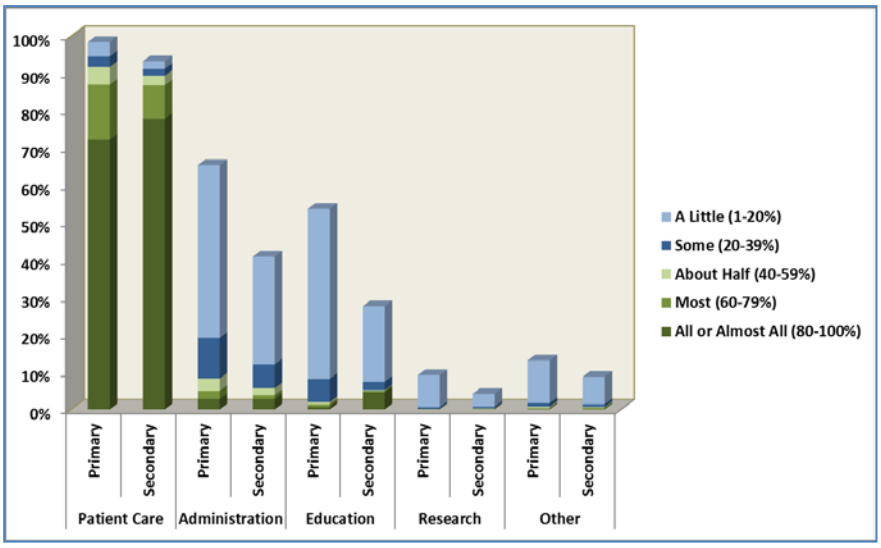
Patient Care:	87%
Administrative:	5%
Education:	1%

Patient Care PTs

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

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

The typical PTA spends most of her time in patient care activities. In fact, 87% of all PTs fill a patient care role, defined as spending at least 60% of her time in that activity. A small number of PTs also fill either an administrative or an educational role at their primary work location.

Time Allocation										
Time Spent	Patient Care		Admin.		Education		Research		Other	
	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site
All or Almost All (80-100%)	72%	78%	3%	3%	1%	5%	0%	0%	0%	0%
Most (60-79%)	15%	9%	2%	1%	1%	0%	0%	0%	0%	0%
About Half (40-59%)	5%	3%	3%	2%	1%	0%	0%	0%	0%	0%
Some (20-39%)	3%	2%	11%	6%	6%	2%	0%	0%	1%	1%
A Little (1-20%)	4%	2%	46%	29%	46%	20%	9%	3%	11%	7%
None (0%)	2%	7%	35%	59%	46%	72%	91%	96%	87%	91%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All PTs		PTs over 50	
	#	%	#	%
Under age 50	144	3%	-	-
50 to 54	287	5%	7	0%
55 to 59	694	12%	90	6%
60 to 64	1,576	28%	390	27%
65 to 69	1,973	35%	611	42%
70 to 74	514	9%	219	15%
75 to 79	78	1%	37	3%
80 or over	39	1%	5	0%
I do not intend to retire	281	5%	94	6%
Total	**5,587**	**100%**	**1,454**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All PTAs

Under 65:	48%
Under 60:	20%

PTAs 50 and over

Under 65:	34%
Under 60:	7%

Time until Retirement

Within 2 years:	3%
Within 10 years:	15%
Half the workforce:	By 2046

Source: Va. Healthcare Workforce Data Center

48% of all PTs expect to retire before the age of 65, while 16% plan on working until at least age 70. Among PTs who are age 50 and over, 35% still expect to retire by age 65, while 24% plan on working until at least age 70.

Within the next two years, just 1% of Virginia's PTs expect to leave the profession and 4% plan on leaving the state. Meanwhile, 30% of PTs plan on pursing additional educational opportunities, and 11% also plan to increase patient care hours. In addition, 12% of PTs plan to certify/recertify for direct access.

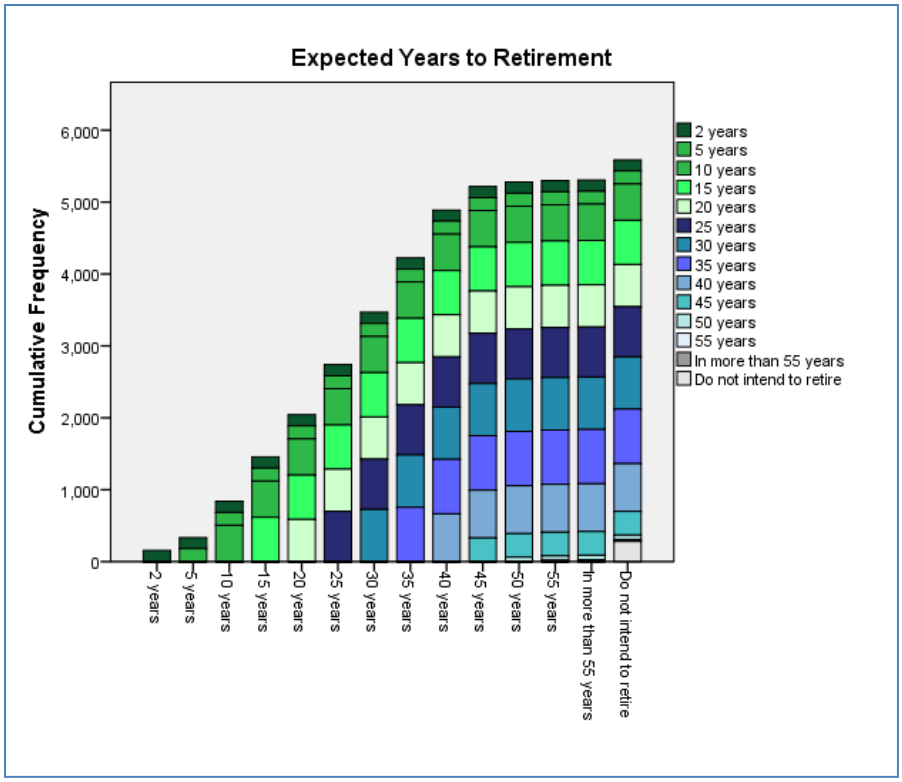
Future Plans		
1 Year Plans:	#	%
Decrease Participation		
Leave Profession	69	1%
Leave Virginia	280	4%
Decrease Patient Care Hours	694	10%
Decrease Teaching Hours	20	0%
Increase Participation		
Increase Patient Care Hours	722	11%
Increase Teaching Hours	703	10%
Pursue Additional Education	2,008	30%
Return to Virginia's Workforce	37	1%
Certify for Direct Access	810	12%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for PTs. Only 3% of PTs expect to retire within the next two years, while 15% plan on retiring in the next ten years. Half of the current PT workforce expects to be retired by 2046.

Time to Retirement			
Expect to retire within. . .	#	%	Cumulative %
2 years	156	3%	3%
5 years	180	3%	6%
10 years	504	9%	15%
15 years	616	11%	26%
20 years	587	11%	37%
25 years	697	12%	49%
30 years	727	13%	62%
35 years	756	14%	61%
40 years	665	12%	87%
45 years	329	6%	93%
50 years	61	1%	94%
55 years	20	0%	95%
In more than 55 years	8	0%	95%
Do not intend to retire	281	5%	100%
Total	**5,587**	**100%**	

Source: Va. Healthcare Workforce Data Center



Using these estimates, retirements will begin to reach 10% of the current workforce starting in 2031. Retirements will peak at 14% of the current workforce around 2051 before declining to under 10% of the current workforce again around 2061.

Source: Va. Healthcare Workforce Data Center

At a Glance:

FTEs

Total:	5,649
FTEs/1,000 Residents:	0.678
Average:	0.85

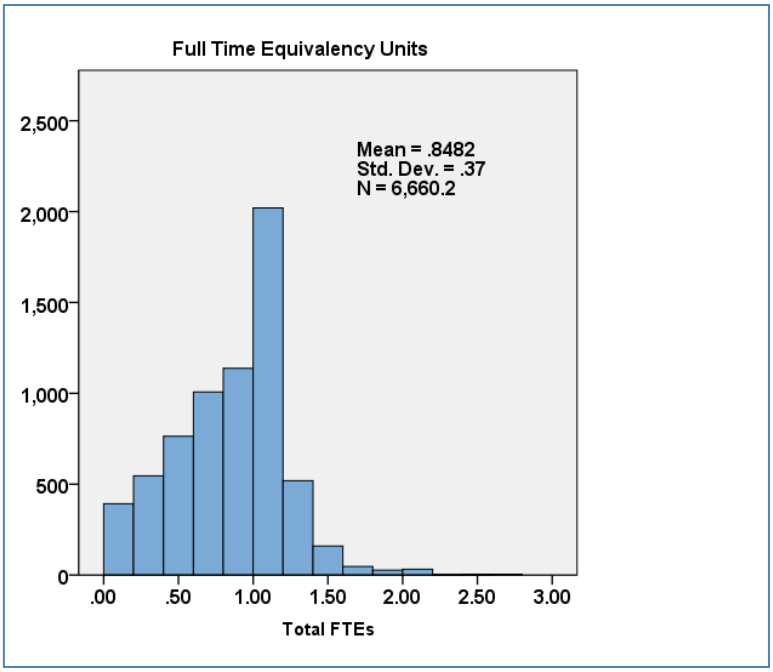
Age & Gender Effect

Age, Partial Eta^2:	Small
Gender, Partial Eta^2:	Medium

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

Source: Va. Healthcare Workforce Data Center

A Closer Look:

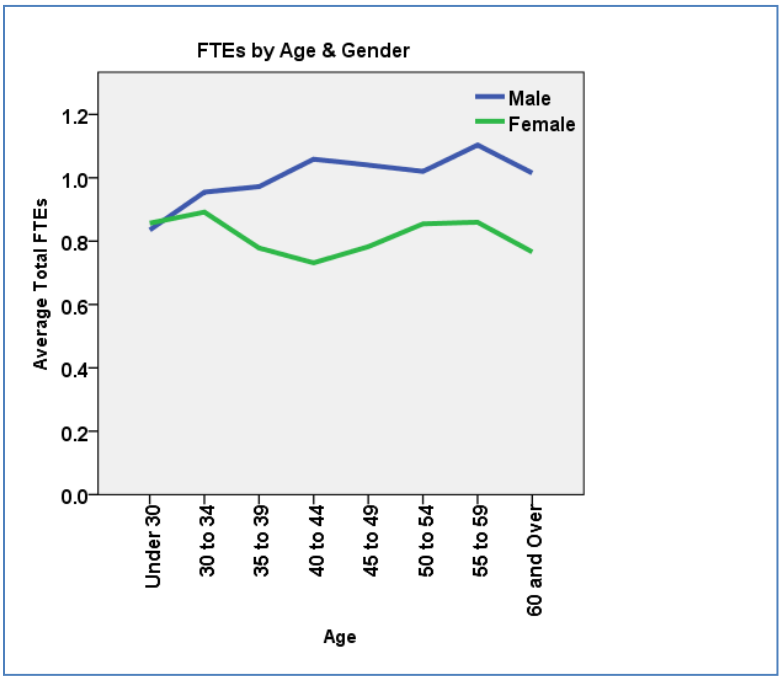


Source: Va. Healthcare Workforce Data Center

The average PT provided 0.92 FTEs in 2016, or approximately 37hours per week for 52 weeks. Although FTEs appear to vary by age and gender, statistical tests did not verify that a difference exists.[2]

Full-Time Equivalency Units		
Age	**Average**	**Median**
Age		
Under 30	0.85	0.99
30 to 34	0.90	1.01
35 to 39	0.80	0.85
40 to 44	0.78	0.84
45 to 49	0.84	0.84
50 to 54	0.88	0.89
55 to 59	0.89	0.91
60 and Over	0.84	0.80
Gender		
Male	0.98	1.05
Female	0.82	0.90

Source: Va. Healthcare Workforce Data Center

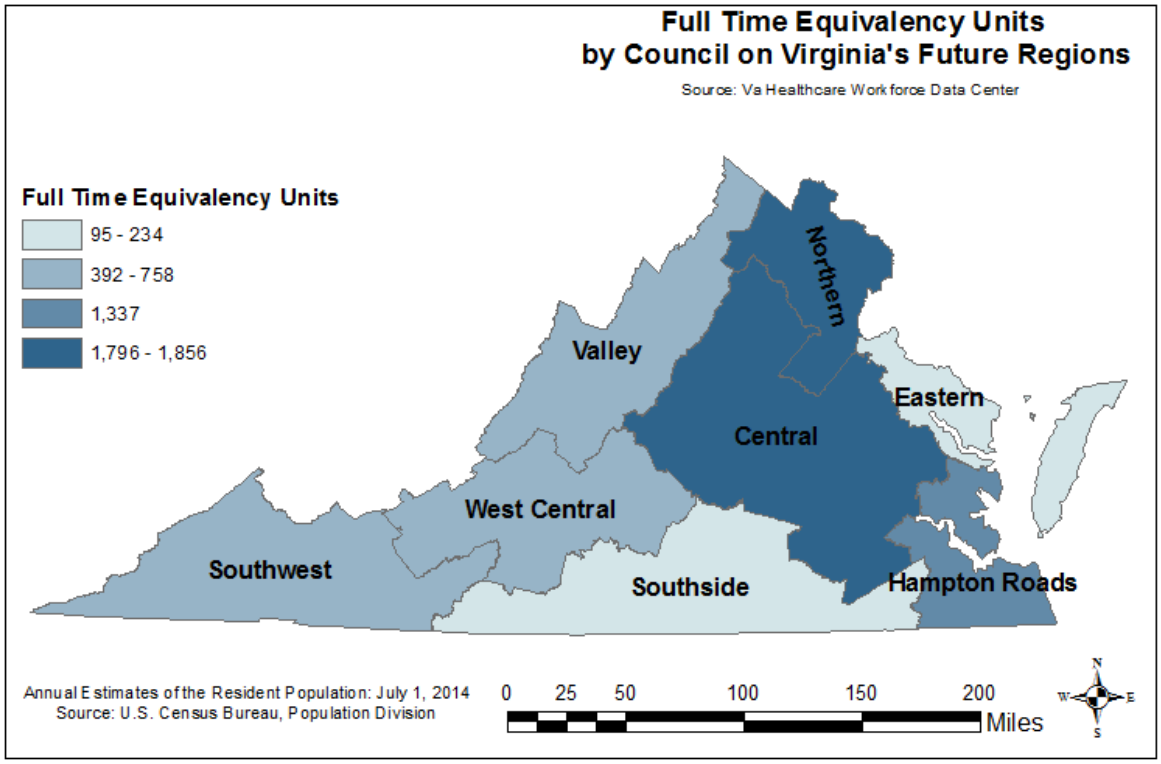


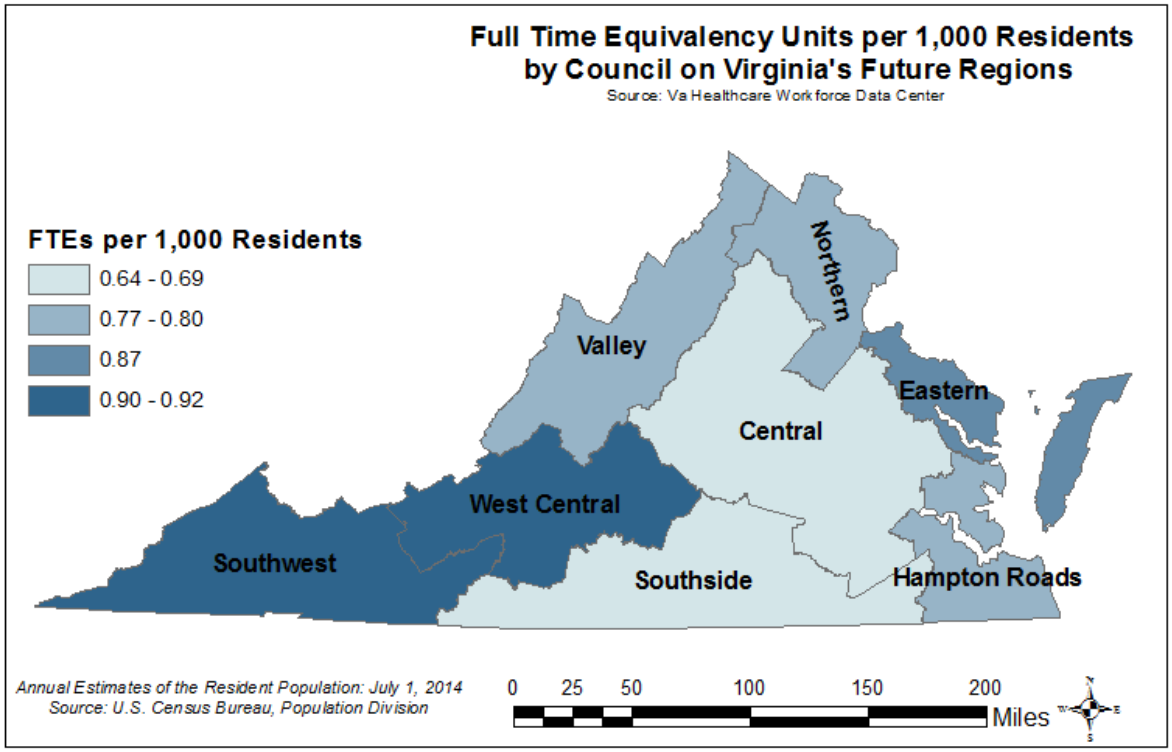
Source:

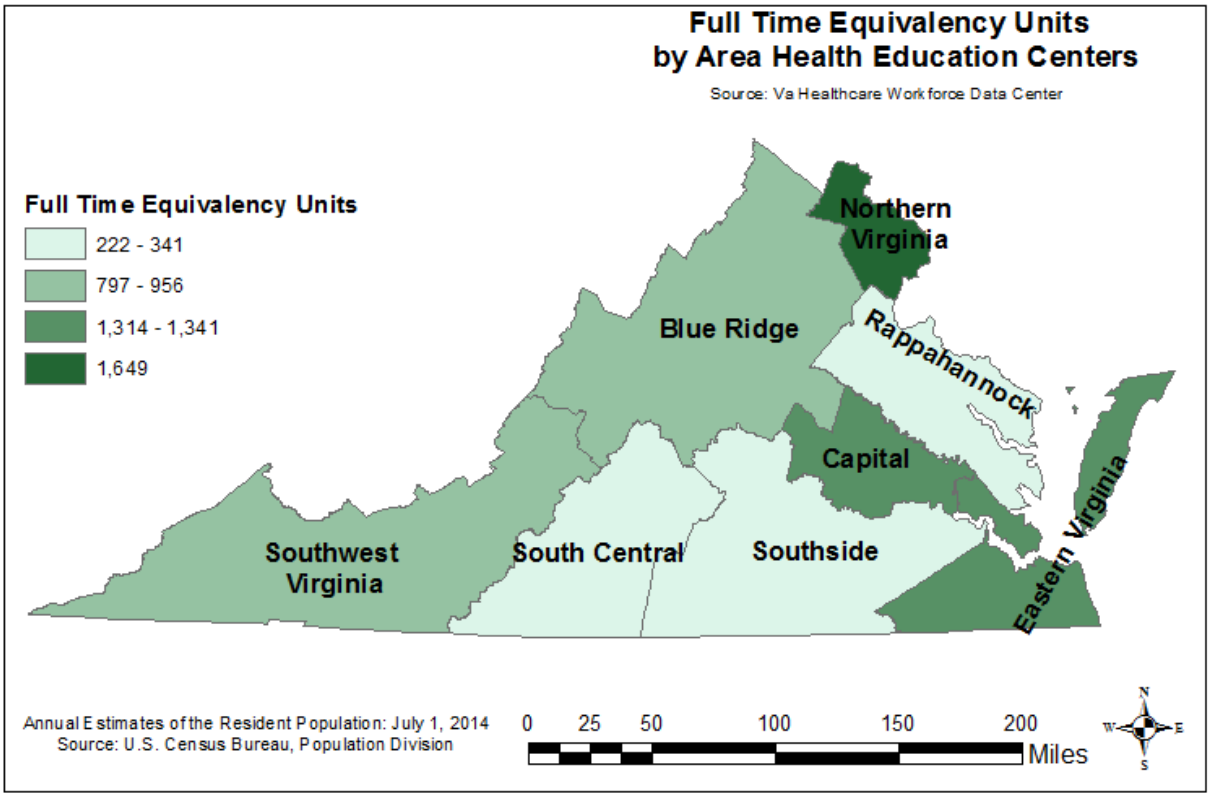
[2] Due to assumption violations in Mixed between-within ANOVA (Levene's Test and Interaction effect were significant).

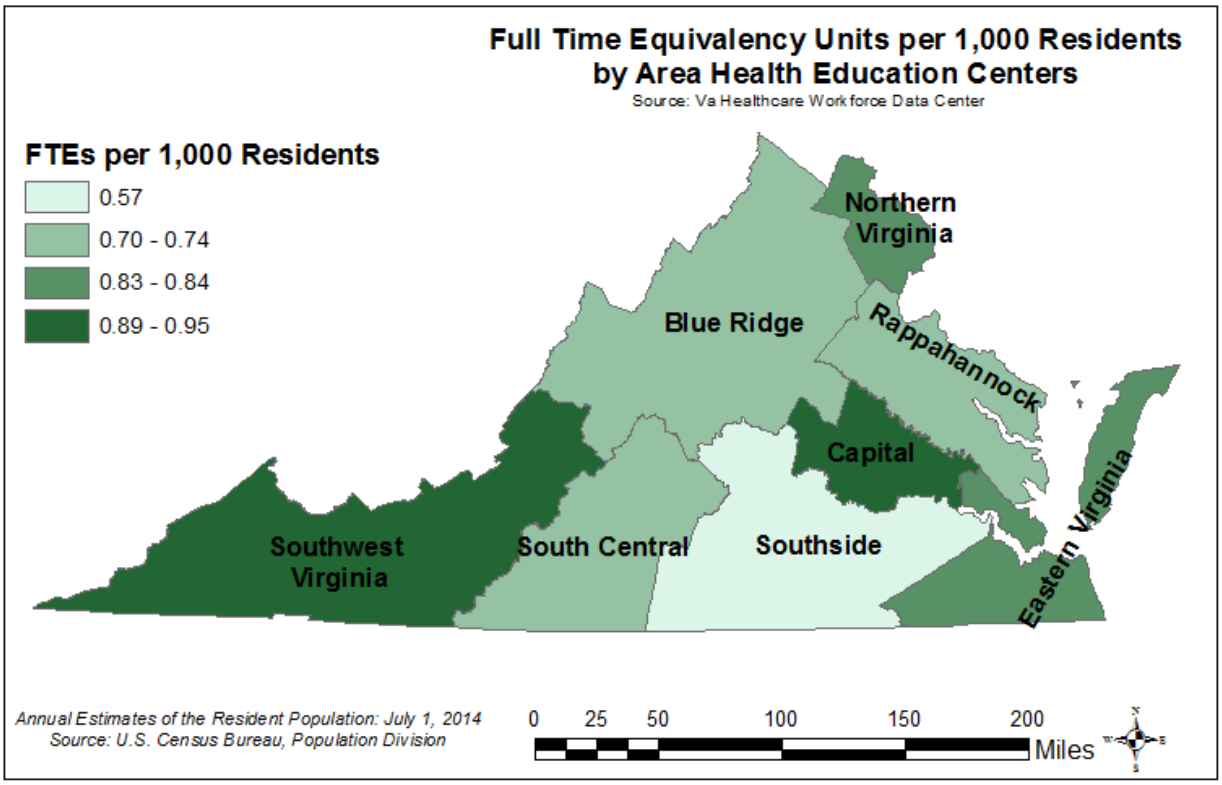
Maps

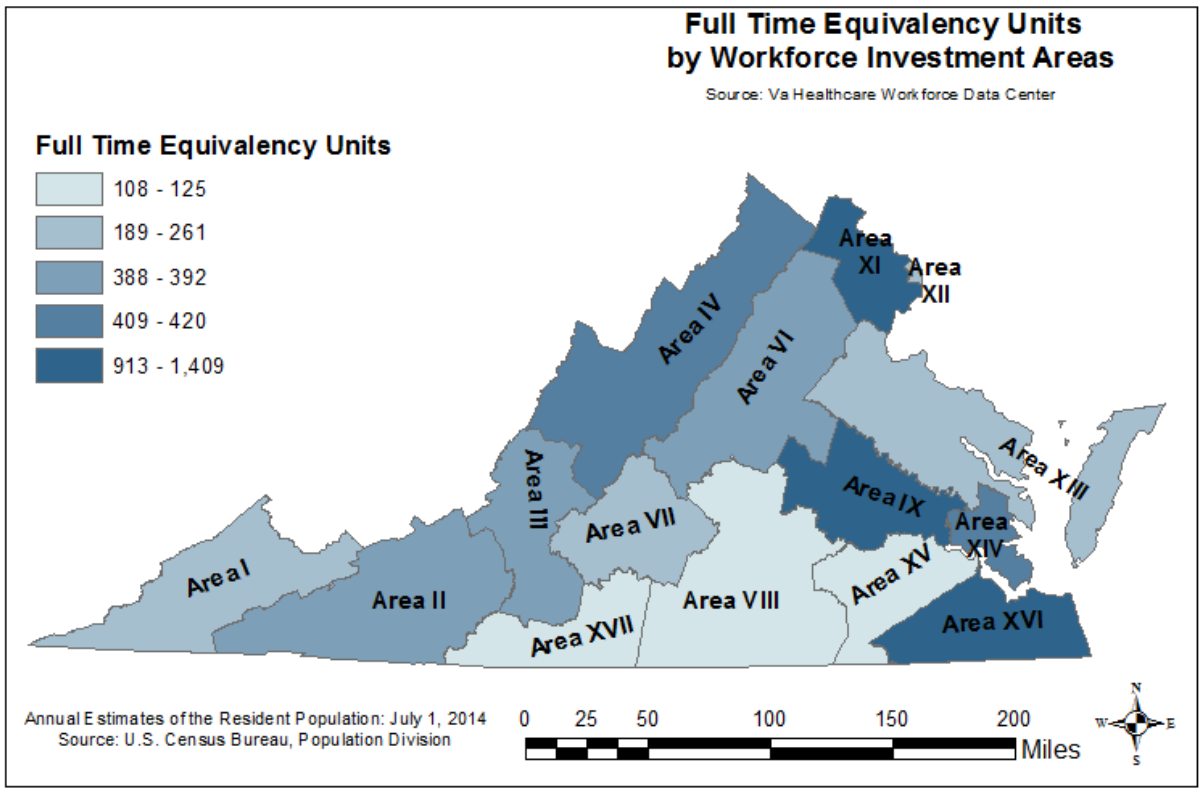
Council on Virginia's Future Regions

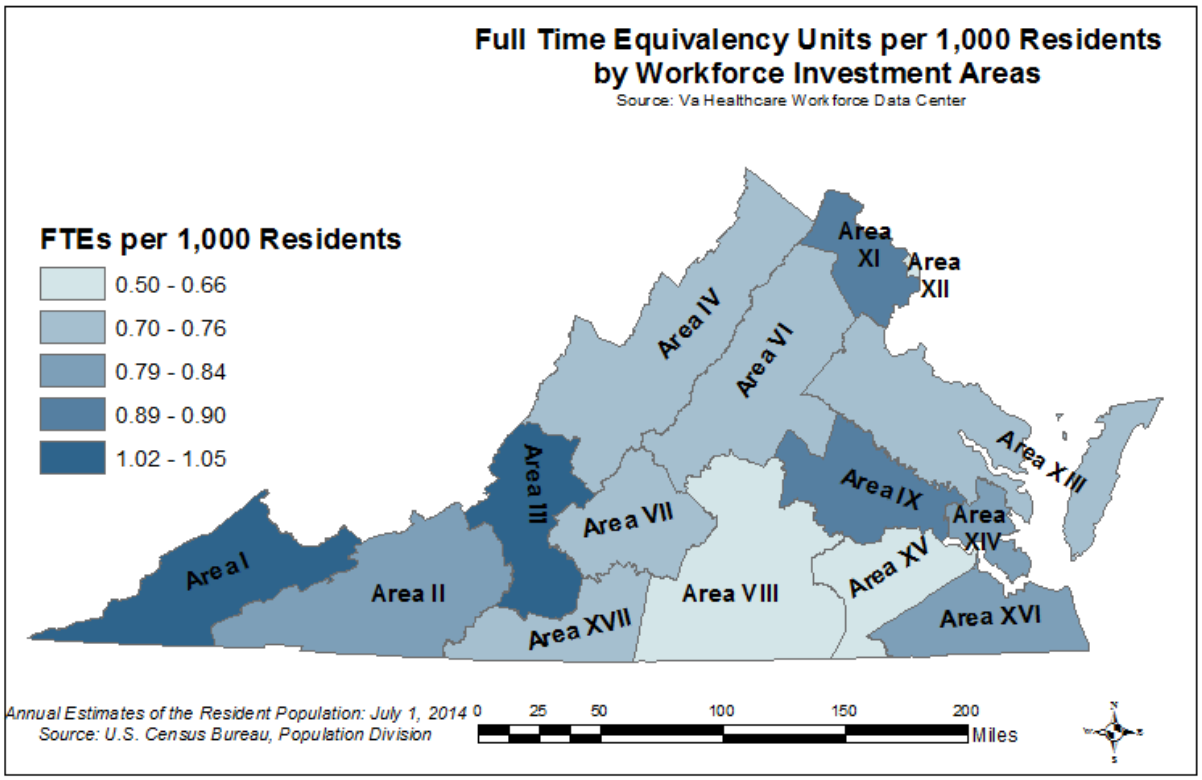


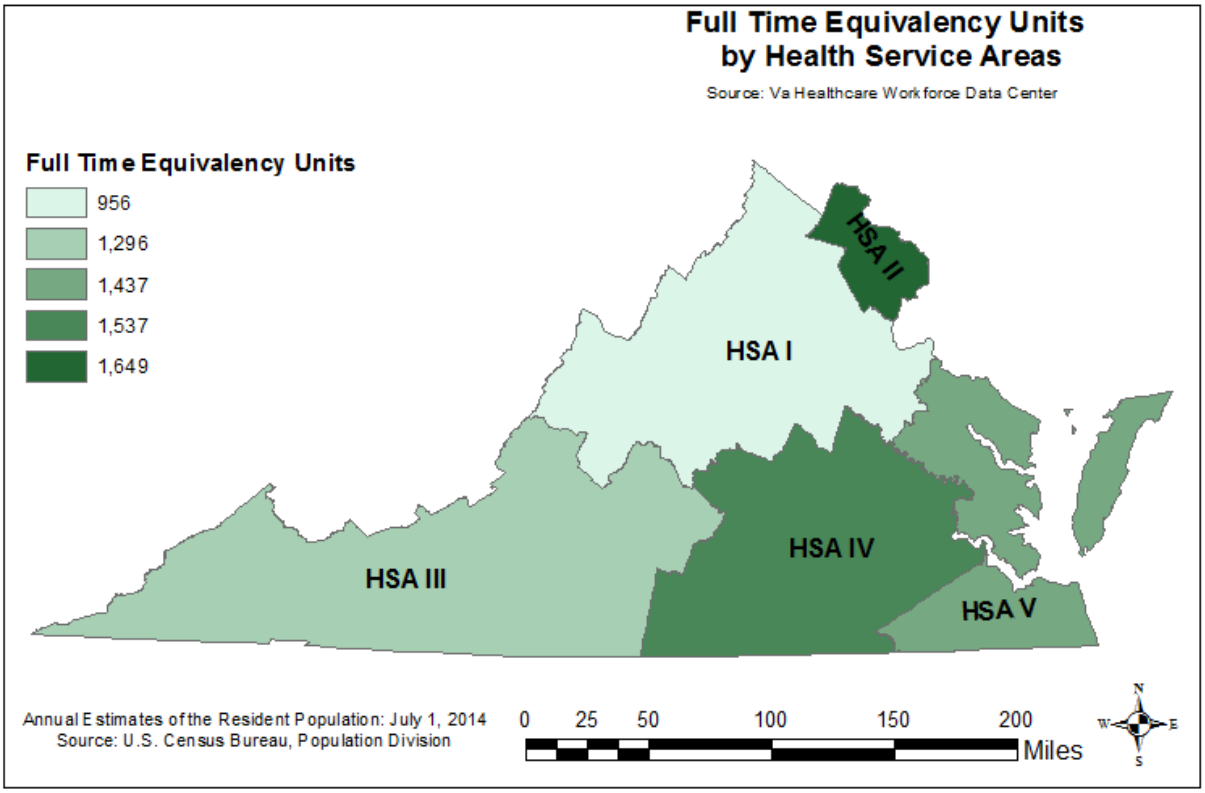


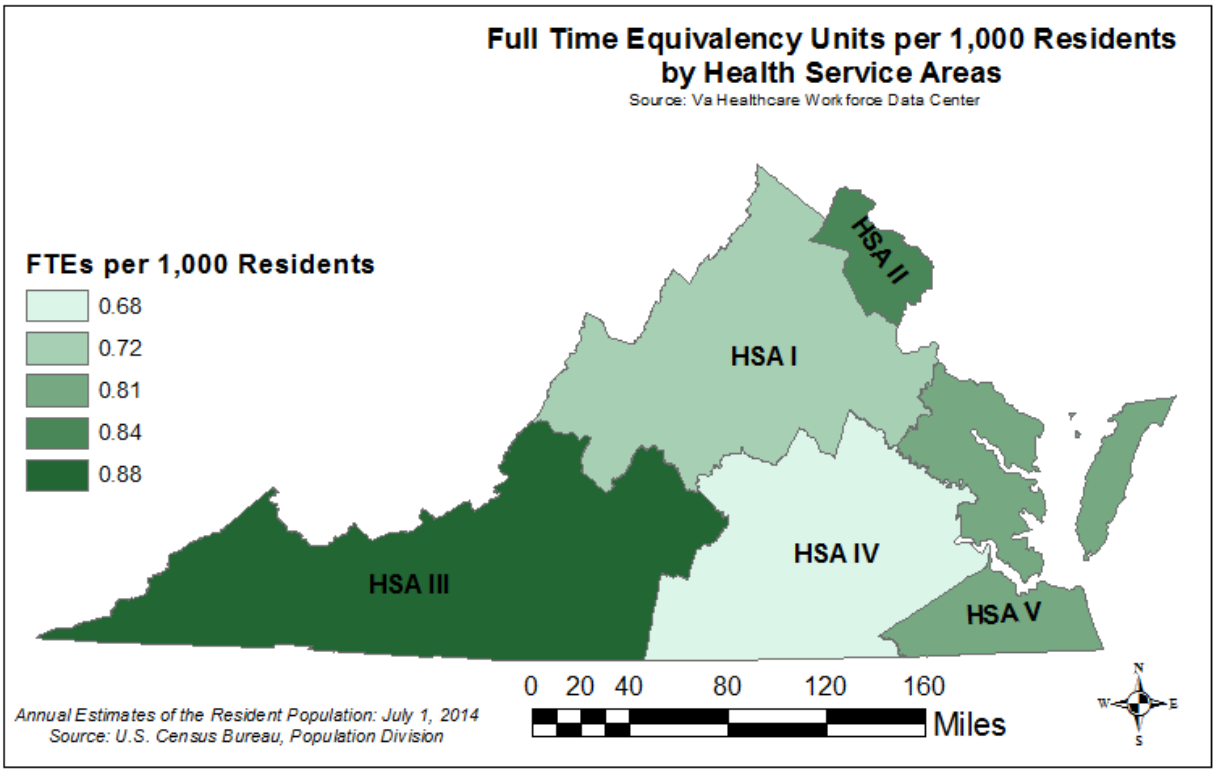

Full Time Equivalency Units
by Area Health Education Centers
Source: Va Healthcare Workforce Data Center
Full Time Equivalency Units
222 - 341
797 - 956
1,314 - 1,341
1,649
Northern Virginia
Blue Ridge
Rappahannock
Capital
Eastern Virginia
Southwest Virginia
South Central
Southside
Annual Estimates of the Resident Population: July 1, 2014
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

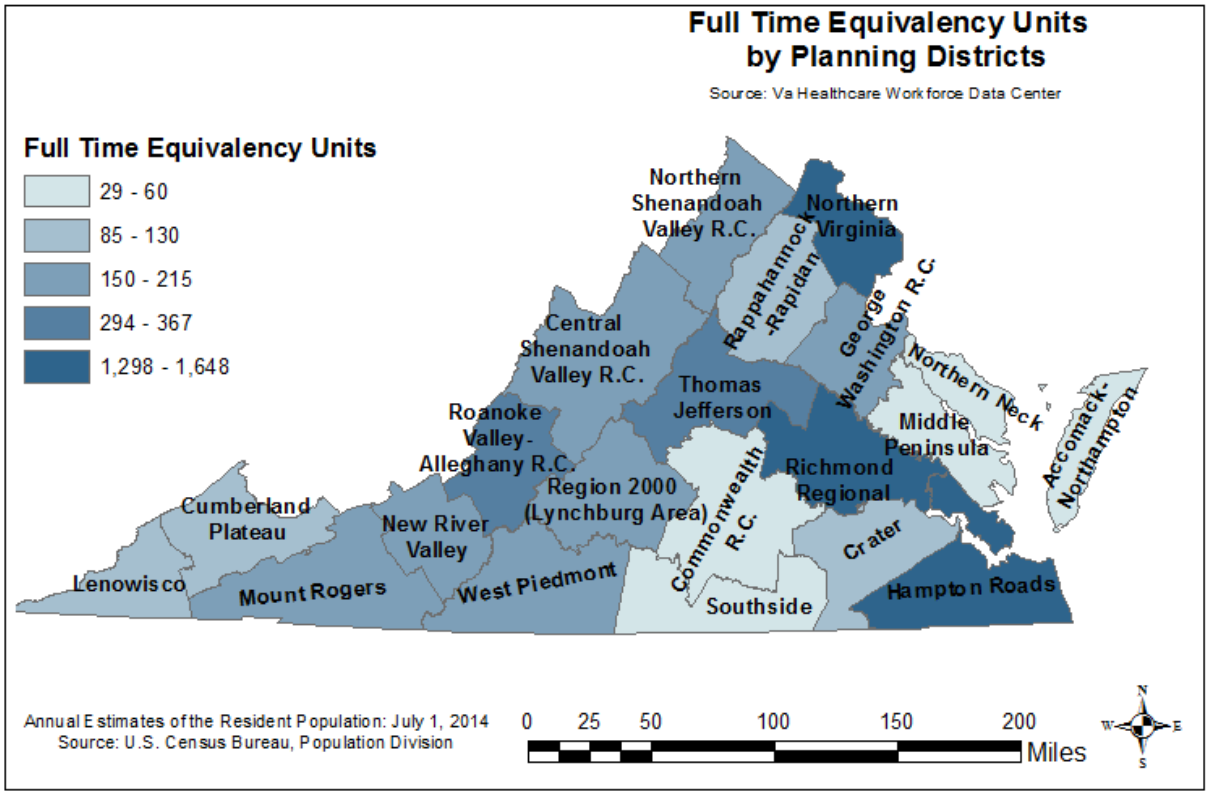

Full Time Equivalency Units per 1,000 Residents
by Area Health Education Centers
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.57
0.70 - 0.74
0.83 - 0.84
0.89 - 0.95
Northern Virginia
Blue Ridge
Rappahannock
Capital
Eastern Virginia
Southwest Virginia
South Central
Southside
Annual Estimates of the Resident Population: July 1, 2014
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

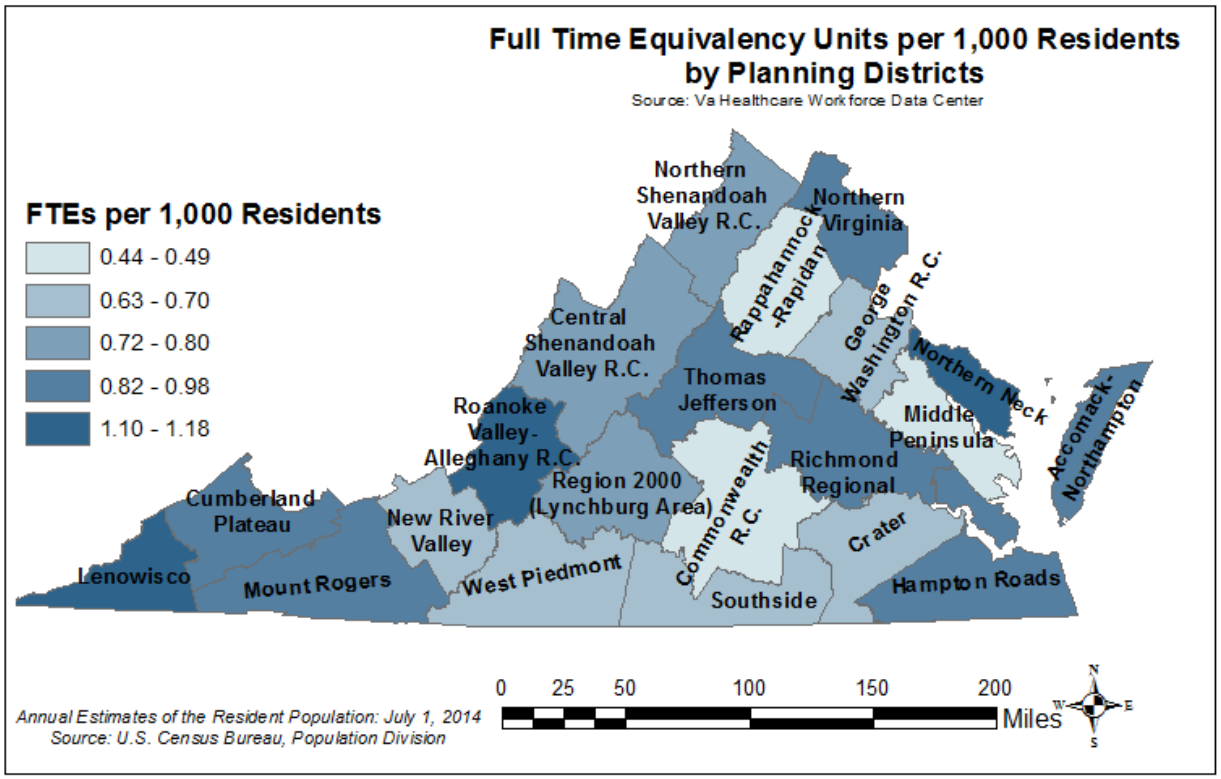

Full Time Equivalency Units
by Workforce Investment Areas
Source: Va Healthcare Workforce Data Center
Full Time Equivalency Units
108 - 125
189 - 261
388 - 392
409 - 420
913 - 1,409
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2014
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full Time Equivalency Units per 1,000 Residents
by Workforce Investment Areas
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.50 - 0.66
0.70 - 0.76
0.79 - 0.84
0.89 - 0.90
1.02 - 1.05
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, 2014
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full Time Equivalency Units
by Health Service Areas
Source: Va Healthcare Workforce Data Center
Full Time Equivalency Units
956
1,296
1,437
1,537
1,649
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2014
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full Time Equivalency Units per 1,000 Residents
by Health Service Areas
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.68
0.72
0.81
0.84
0.88
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2014
Source: U.S. Census Bureau, Population Division
0 20 40 80 120 160
Miles
N
W
E
S


Full Time Equivalency Units
by Planning Districts
Source: Va Healthcare Workforce Data Center
Full Time Equivalency Units
29 - 60
85 - 130
150 - 215
294 - 367
1,298 - 1,648
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock -Rapidan
George Washington R.C.
Central Shenandoah Valley R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
Region 2000 (Lynchburg Area)
Richmond Regional
Commonwealth R.C.
Crater
Cumberland Plateau
New River Valley
Lenowisco
Mount Rogers
West Piedmont
Southside
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2014
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full Time Equivalency Units per 1,000 Residents
by Planning Districts
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.44 - 0.49
0.63 - 0.70
0.72 - 0.80
0.82 - 0.98
1.10 - 1.18
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock -Rapidan
George Washington R.C.
Central Shenandoah Valley R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
Region 2000 (Lynchburg Area)
Richmond Regional
Commonwealth R.C.
Crater
Cumberland Plateau
New River Valley
Lenowisco
Mount Rogers
West Piedmont
Southside
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2014
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

Appendices

Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min	Max
Metro, 1 million+	4,653	86.07%	1.161797753	0.995418	1.880691
Metro, 250,000 to 1 million	537	84.36%	1.185430464	1.015666	1.918947
Metro, 250,000 or less	778	87.15%	1.147492625	0.983161	1.857534
Urban pop 20,000+, Metro adj	76	90.79%	1.101449275	0.943712	1.783
Urban pop 20,000+, nonadj	0	NA	NA	NA	NA
Urban pop, 2,500-19,999, Metro adj	187	77.01%	1.298611111	1.112638	2.102161
Urban pop, 2,500-19,999, nonadj	99	80.81%	1.2375	1.060279	2.003236
Rural, Metro adj	111	71.17%	1.405063291	1.203846	2.274484
Rural, nonadj	59	76.27%	1.311111111	1.123348	2.122396
Virginia border state/DC	744	60.48%	1.653333333	1.416561	2.676378
Other US State	1,208	37.50%	2.666666667	2.284776	4.316738

Age	Age Weight			Total Weight	
	#	Rate	Weight	Min	Max
Under 30	1,331	47.18%	2.119426752	1.783	4.316738
30 to 34	1,553	72.89%	1.371908127	1.154139	2.794231
35 to 39	1,229	82.02%	1.219246032	1.02571	2.483297
40 to 44	1,084	87.18%	1.147089947	0.965007	2.336333
45 to 49	971	86.71%	1.153206651	0.970153	2.348791
50 to 54	783	89.14%	1.121776504	0.943712	2.284776
55 to 59	646	85.76%	1.166064982	0.98097	2.37498
60 and Over	857	75.85%	1.318461538	1.109176	2.685374

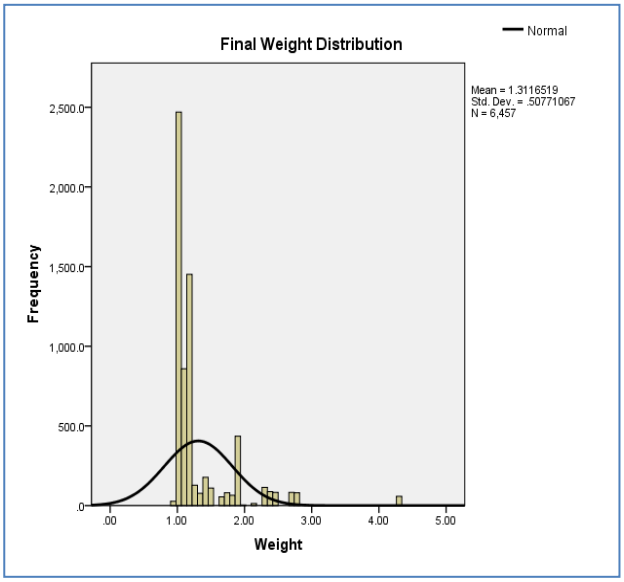
Source: Va. Healthcare Workforce Data Center

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

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: **0.76378**



Virginia's Physical Therapist Assistant Workforce: 2016

Healthcare Workforce Data Center

February 2017

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
9960 Mayland Drive, Suite 300
Richmond, VA 23233
804-367-2115, 804-527-4466(fax)
E-mail: ***HWDC@dhp.virginia.gov***

Follow us on Tumblr: ***www.vahwdc.tumblr.com***

2,726 Physical Therapist Assistants 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 Physical Therapy express our sincerest appreciation for your ongoing cooperation.*

Thank You!

Virginia Department of Health Professions

David E. Brown, D.C.
Director

Lisa Hahn, MPA
Chief Deputy Director

Healthcare Workforce Data Center Staff:

Dr. Elizabeth Carter, Ph.D.	Yetty Shobo, Ph.D.	Laura Jackson	Christopher Coyle
Executive Director	*Deputy Executive Director*	*Operations Manager*	*Research Assistant*

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Contents

The PTA Workforce: At a Glance:

The Workforce

Licensees:	3,385
Virginia's Workforce:	3,040
FTEs:	2,028

Survey Response Rate

All Licensees:	81%
Renewing Practitioners:	94%

Demographics

% Female:	77%
Diversity Index:	30%
Median Age:	41

Background

Rural Childhood:	45%
HS Degree in VA:	62%
Prof. Degree in VA:	75%

Education

Associate or Higher:	98%
Bachelors:	1%

Finances

Median Inc.:	$50k-$60k
Health Benefits:	60%
Under 40 w/ Ed debt:	57%

Current Employment

Employed in Prof.:	96%
Hold 1 Full-time Job:	65%
Satisfied?:	97%

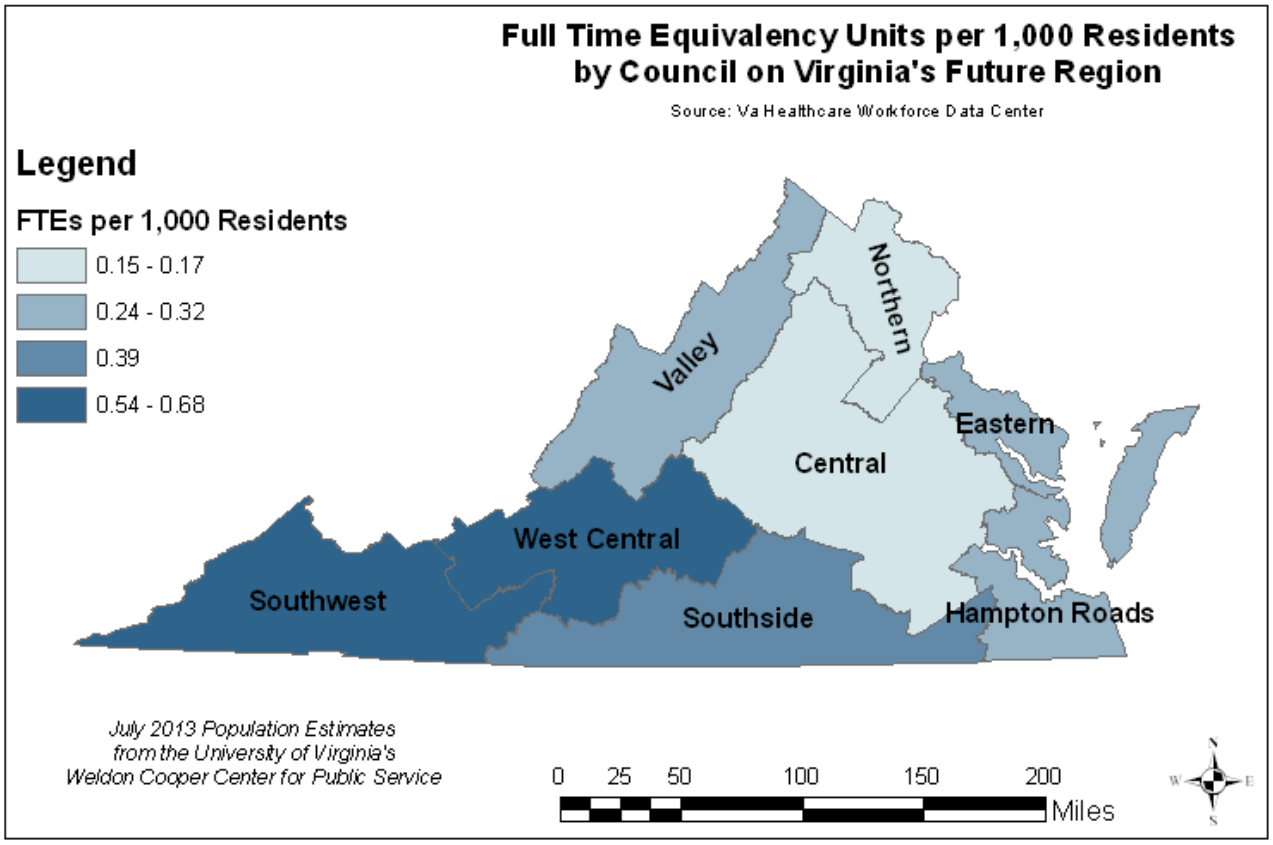
Job Turnover

Switched Jobs in 2016:	10%
Employed over 2 yrs:	56%

Primary Roles

Patient Care:	89%
Administration:	3%
Other:	1%

Source: Va. Healthcare Workforce Data Center



Results in Brief

2,726 physical therapist assistants (PTAs) voluntarily took part in the 2016 Physical Therapist Assistant Workforce Survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place every December on even-numbered years for PTAs. These survey respondents represent 81% of the 3,385 PTAs who are licensed in the state and 94% of renewing practitioners.

The HWDC estimates that 3,040 PTAs participated in Virginia's workforce during the survey period, which is defined as those who worked at least a portion of the year in the state or who live in the state and intend to return to work in the profession at some point in the future. Virginia's PTA workforce provided 2,028 "full-time equivalency units" during the survey time period, which the HWDC defines simply as working 2,000 hours a year (or 40 hours per week for 50 weeks with 2 weeks off).

Nearly 80% of PTAs are female, and the median age of all PTAs is 41. In a random encounter between two PTAs, there is a 30% chance that they would be of different races or ethnicities, a measure known as the diversity index. For the Virginia population as a whole, this same probability is 55%.

Nearly half of all PTAs grew up in a rural area, and approximately one-third of these professionals currently work in non-Metro areas of the state. Overall, 19% of PTAs work in non-Metro areas of the state. Meanwhile, 62% of PTAs went to high school in Virginia, and 75% also received their professional degree in the state.

Eighty-two percent of all PTAs in the state earned an Associate of Applied Science degree as their highest professional degree. 37% of all PTAs currently have educational debt, including 57% of those PTAs who are under the age of 40. For those PTAs with education debt, the median debt load is between $18,000 and $20,000.

Ninety-six percent of PTAs are currently employed in the profession, and less than 1% are involuntarily unemployed at the moment. About two-thirds of Virginia's PTAs hold one full-time position, while 18% have multiple positions. 56% of PTAs have been at their primary work location for at least two years, while more than one-quarter of all PTAs began work at a new location in 2016.

Three-quarters of Virginia's PTAs receive an hourly wage at their primary work location, while 15% receive a salary. The median annual income for PTAs is between $50,000 and $60,000. Among professionals who receive an hourly wage or salary at their primary work location, 82% receive at least one employer-sponsored benefit, including 60% who receive employer-sponsored health insurance. 97% of PTAs indicate they are satisfied with their current employment situation, including 71% who indicate they are "very satisfied".

More than 90% of all PTAs work in the private sector, including 71% who work at a for-profit establishment. About 60% of all PTAs worked at one of three establishment types during the past year: Skilled Nursing Facilities, Home Health Care Organizations, and Outpatient Rehabilitation Facilities.

A typical PTA spends nearly all of her time in caring for patients. In fact, 89% of all PTAs serve a patient care role, meaning that at least 60% of their time is spent in that activity. However, the typical PTA also spends a limited amount of time in administrative tasks, and 3% of all PTAs also serve an administration role at their jobs.

Less than half of all PTAs expect to retire by the age of 65. Although only 3% of the current workforce expects to retire in the next two years, half of the current workforce expects to retire by 2041. Over the next two years, just 2% of all PTAs expect to leave the profession, while 4% expect to move outside Virginia. However, 27% of Virginia's PTA workforce expects to pursue additional educational opportunities within the next two years, and 14% expect to increase their patient care activities.

Summary of Trends

There are few trends worth noting when comparing the 2014 Physical Therapist Assistant Survey to the 2016 survey. First, the survey response rate increased significantly between the two surveys. 76% of all and 90% of renewing licensees responded in the 2014 survey whereas 81% and 94%, respectively, responded in 2016. Although there were more licensees in 2016 and 90% of all licensees in 2016 work in the state compared to 89% in 2014, lower full time equivalency units were provided by the workforce. PTAs provided 2,264 FTEs in 2014 whereas they only provided 2,028 FTEs in 2016. This is likely due to PTAs working for fewer hours. For example, 1% (20) worked 80 or more hours in 2014 whereas 0% (12) did in 2016.

The PTA workforce has become a little bit more diverse. The diversity index was 29% in 2014 whereas it was 30% in 2016. The workforce also witnessed a 2% increase in its male composition. In 2014, female constituted 79% of the workforce compared to 77% in 2016. This is even more the case for PTAs under age 40 as the percent female declined from 77% to 74% for those under age 40. The percent under age 40 also increased from 45% to 47%. Consequently, the average age is now 41 instead of 42 in 2014. PTAs, however, seem less spread out in metro versus non-metro counties. Twenty-one percent of PTAs worked in non-metro areas of the state in 2014 compared to 19% now.

Although both the median education debt and the median education income did not increase, the percent of PTAs with education debt increased. In 2014, 35% of all PTAs had education debt compared to 37% in 2016. The same increase was recorded for PTAs under age 40; 54% had education debt in 2014 and 57% did in 2016.

There were no significant changes in the future plans of PTAs. Half still plan to retire 25 years from the year of the survey. However, those retiring two years from the survey increased from 2% to 3%. Additionally, 1% planned to leave the profession within two years of 2014 whereas 2% plan to leave the profession within two years of 2016.

A Closer Look:

Licensees		
License Status	**#**	**%**
Renewing Practitioners	2,799	83%
New Licensees	284	8%
Non-Renewals	302	9%
All Licensees	**3,385**	**100%**

Source: Va. Healthcare Workforce Data Center

HWDC surveys tend to achieve very high response rates. 94% of renewing PTAs submitted a survey. These represent 81% of PTAs who held a license at some point in 2016.

At a Glance:

Licensed PTAs

Number:	3,385
New:	8%
Not Renewed:	9%

Response Rates

All Licensees:	81%
Renewing Practitioners:	94%

Source: Va. Healthcare Workforce Data Center

Response Rates	
Completed Surveys	2,726
Response Rate, all licensees	81%
Response Rate, Renewals	94%

Source: Va. Healthcare Workforce Data Center

Response Rates			
Statistic	**Non Respondents**	**Respondent**	**Response Rate**
By Age			
Under 30	167	351	68%
30 to 34	123	435	78%
35 to 39	68	376	85%
40 to 44	70	356	84%
45 to 49	58	424	88%
50 to 54	43	295	87%
55 to 59	56	259	82%
60 and Over	74	230	76%
Total	**659**	**2,726**	**81%**
New Licenses			
Issued in 2016	185	99	35%
Metro Status			
Non-Metro	76	446	85%
Metro	355	2,011	85%
Not in Virginia	228	269	54%

Source: Va. Healthcare Workforce Data Center

Definitions

1. **The Survey Period:** The survey was conducted in December 2016.
2. **Target Population:** All PTAs who held a Virginia license at some point in 2016.
3. **Survey Population:** The survey was available to PTAs who renewed their licenses online. It was not available to those who did not renew, including some PTAs newly licensed in 2016.

At a Glance:

Workforce

2016 PTA Workforce:	3,040
FTEs:	2,028

Utilization Ratios

Licensees in VA Workforce:	90%
Licensees per FTE:	1.35
Workers per FTE:	1.21

Source: Va. Healthcare Workforce Data Center

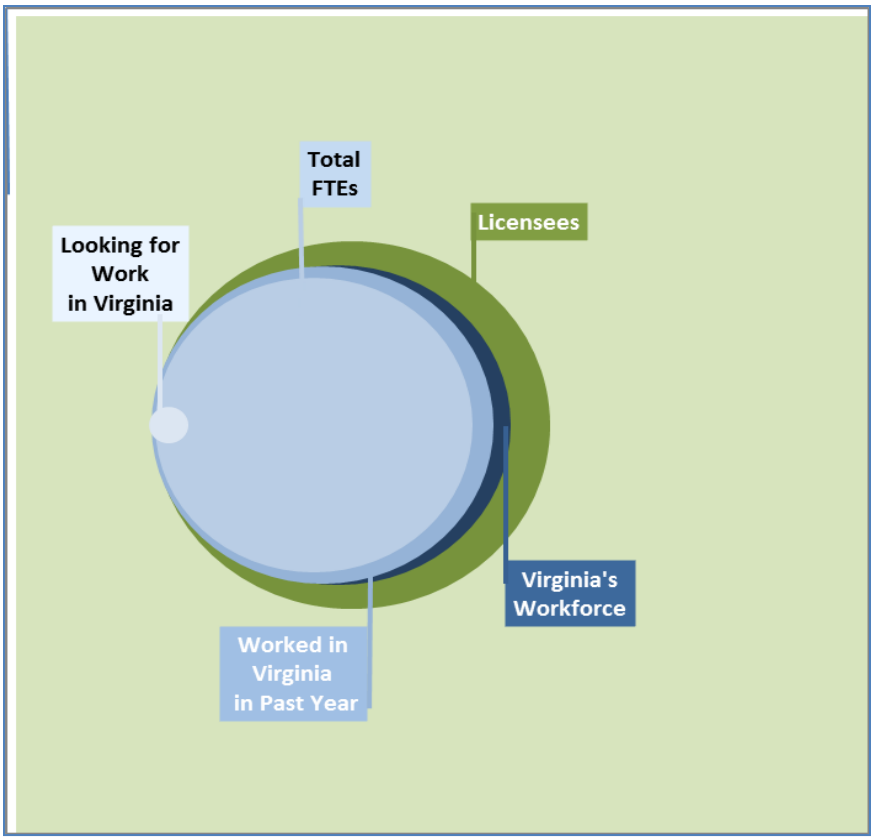
Definitions

1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time in the past year 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 PTA Workforce		
Status	#	%
Worked in Virginia in Past Year	3,014	99%
Looking for Work in Virginia	26	1%
Virginia's Workforce	**3,040**	**100%**
Total FTEs	**2,508**	
Licensees	**3,385**	

Source: Va. Healthcare Workforce Data Center

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



Source: Va. Healthcare Workforce Data Center

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 30	115	25%	344	75%	459	16%
30 to 34	132	26%	367	74%	498	17%
35 to 39	100	26%	284	74%	384	13%
40 to 44	85	23%	284	77%	369	13%
45 to 49	92	23%	300	77%	392	14%
50 to 54	51	18%	230	82%	281	10%
55 to 59	45	17%	214	83%	259	9%
60 +	56	24%	181	76%	237	8%
Total	**676**	**23%**	**2,204**	**77%**	**2,880**	**100%**

Source: Va. Healthcare Workforce Data Center

Race & Ethnicity					
Race/ Ethnicity	Virginia*	PTAs		PTAs under 40	
	%	#	%	#	%
White	63%	2,404	83%	1,075	80%
Black	19%	190	7%	102	8%
Asian	6%	89	3%	52	4%
Other Race	0%	26	1%	11	1%
Two or more races	2%	74	3%	44	3%
Hispanic	9%	103	4%	58	4%
Total	**100%**	**2,887**	**100%**	**1,343**	**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, 2014. *Source: Va. Healthcare Workforce Data Center*

At a Glance:

Gender

% Female:	77%
% Under 40 Female:	74%

Age

Median Age:	41
% Under 40:	47%
% 55+:	17%

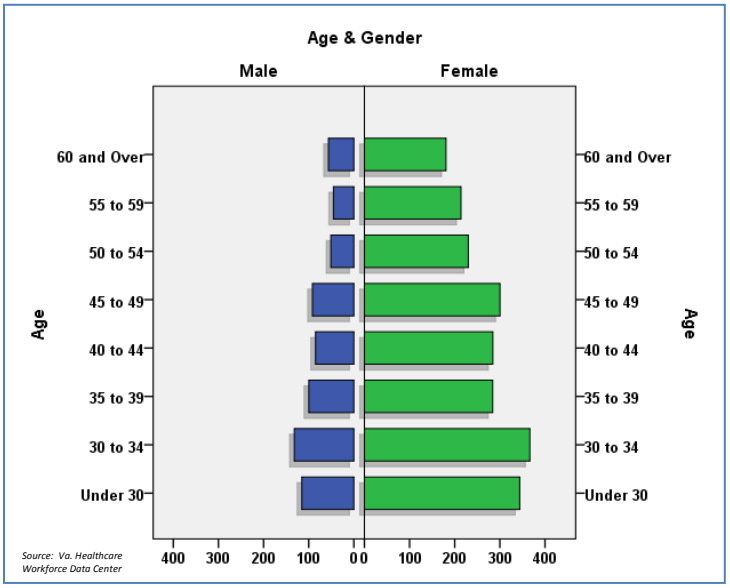
Diversity

Diversity Index:	30%
Under 40 Div. Index:	35%

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two PTAs, there is a 30% chance that they would be of a different race/ethnicity (a measure known as the diversity index). For Virginia's population as a whole, the comparable number is 55%.

47% of all PTAs are under the age of 40, and 74% of these professionals are female. In addition, there is a 35% chance that two randomly chosen PTAs from this group would be of a different race or ethnicity.



At a Glance:

Childhood

Urban Childhood:	11%
Rural Childhood:	45%

Native Sons

HS in Virginia:	62%
Prof. Education in VA:	75%
HS/Prof. Edu. in VA:	78%

Location Choice

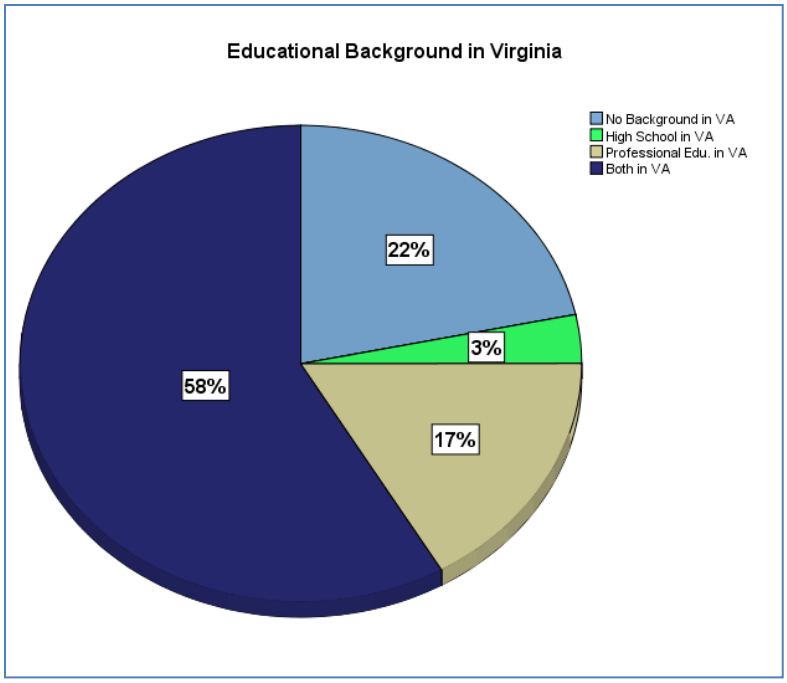
% Rural to Non-Metro:	34%
% Urban/Suburban to Non-Metro:	7%

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+	27%	59%	14%
2	Metro, 250,000 to 1 million	57%	35%	9%
3	Metro, 250,000 or less	61%	30%	10%
	Non-Metro Counties			
4	Urban pop 20,000+, Metro adj	74%	15%	11%
6	Urban pop, 2,500-19,999, Metro adj	78%	18%	4%
7	Urban pop, 2,500-19,999, nonadj	88%	7%	5%
8	Rural, Metro adj	72%	27%	2%
9	Rural, nonadj	71%	22%	7%
	Overall	**45%**	**44%**	**11%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

45% of PTAs grew up in self-described rural areas, and 34% of these professionals currently work in Non-Metro counties. Overall, 19% of Virginia's PTA workforce works in non-Metro counties of the state.

Top Ten States for PTA Recruitment

Rank	All PTAs			
	High School	#	PTA School	#
1	Virginia	1,768	Virginia	2,098
2	Pennsylvania	142	Pennsylvania	83
3	New York	121	New York	71
4	Outside U.S./Canada	106	North Carolina	64
5	West Virginia	70	West Virginia	57
6	North Carolina	68	Florida	50
7	Ohio	57	Ohio	48
8	Maryland	48	Maryland	45
9	Florida	43	Massachusetts	31
10	New Jersey	39	Tennessee	26

Source: Va. Healthcare Workforce Data Center

62% of PTAs received their high school degree in Virginia, while 75% received their initial professional degree in the state.

Among PTAs who have been licensed in the past five years, 61% received their high school degree in Virginia, while 72% received their initial professional degree in the state.

Rank	Licensed in the Past 5 Years			
	High School	#	PTA School	#
1	Virginia	632	Virginia	733
2	Pennsylvania	47	West Virginia	34
3	Outside U.S./Canada	47	Pennsylvania	28
4	New York	28	North Carolina	27
5	West Virginia	26	Ohio	23
6	North Carolina	23	Florida	22
7	Ohio	23	Maryland	20
8	Florida	18	New York	18
9	Maryland	17	Tennessee	11
10	Mississippi	15	Massachusetts	11

Source: Va. Healthcare Workforce Data Center

10% of licensed PTAs did not participate in Virginia's workforce in 2016. 93% of these PTAs worked at some point in the past year, including 85% who currently work as PTAs.

At a Glance:

Not in VA Workforce

Total:	345
% of Licensees:	10%
Federal/Military:	8%
VA Border State/DC:	12%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Education

Associate of Applied Sci.: 82%
Associate of Science: 16%

Educational Debt

With debt: 37%
Under age 40 with debt: 57%
Median debt: $18k-$20k

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Professional Degree		
Degree	#	%
Certificate	11	0%
Associate of Applied Science	2,346	82%
Associate of Science	460	16%
Baccalaureate	34	1%
Other	25	1%
Total	**2,876**	**100%**

Source: Va. Healthcare Workforce Data Center

Highest Non-Professional Degree		
Degree	#	%
Certificate	234	10%
Associate of Applied Science	576	24%
Associate of Science	246	10%
Baccalaureate	935	39%
Masters	107	4%
Doctorate/Professional	11	0%
Other	293	12%
Total	**2,402**	**100%**

Source: Va. Healthcare Workforce Data Center

82% of PTAs have an Associate of Applied Science as their highest professional degree, while 39% have earned a Baccalaureate as their highest non-professional degree.

37% of PTAs currently have educational debt, including 57% of those under the age of 40. For those PTAs with educational debt, the median debt burden is between $18,000 and $20,000.

Educational Debt				
Amount Carried	All PTAs		PTA's under 40	
	#	%	#	%
None	1,646	63%	524	43%
Less than $4,000	91	3%	40	3%
$4,000-$7,999	106	4%	79	6%
$8,000-$11,999	130	5%	92	7%
$12,000-$15,999	62	2%	41	3%
$16,000-$19,999	55	2%	40	3%
$20,000-$23,999	101	4%	74	6%
$24,000-$27,999	89	3%	67	5%
$28,000 or more	348	13%	273	22%
Total	**2,628**	**100%**	**1,230**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Top Certifications

Geriatrics:	4%
Women's Health:	2%
At Least One Cert.:	7%

Top Credentials:

Massage Therapy:	4%
Athletic Training:	2%
At Least One Cred.:	16%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

APTA Recognition of Advanced Proficiency		
Proficiency Area	**#**	**%**
Geriatrics	101	3%
Women's Health	72	2%
Neuromuscular	41	1%
Education	36	1%
Acute Care	30	1%
Aquatic	29	1%
Cardiovascular & Pulmonary	25	1%
Pediatric	15	0%
Sports	12	0%
Oncology	8	0%
At least 1 Certification	**197**	**6%**

Source: Va. Healthcare Workforce Data Center

Credentials		
Area	**#**	**%**
Massage Therapy	94	3%
Exercise Physiology	45	1%
Athletic Training	44	1%
Nursing	19	1%
Kinesiotherapy	16	1%
Medical Assistant	9	0%
Occupational Therapy	6	0%
Orthopedic Technician	4	0%
Orthotic/Prosthetic Fitter	2	0%
Art/Dance Therapy	1	0%
Orthotic/Prosthetic Technician	1	0%
Other	281	9%
At least 1 Credential	**490**	**16%**

Source: Va. Healthcare Workforce Data Center

Only 6% of Virginia's PTAs currently hold at least one APTA certification, while 16% hold at least one credential. Geriatrics is the most common APTA certification, and Message Therapy is the most common credential.

At a Glance:

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

Positions Held
1 Full-Time: 65%
2 or more Positions: 18%

Weekly Hours:
40 to 49: 47%
60 or more: 1%
Less than 30: 15%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Current Work Status		
Status	#	%
Employed, capacity unknown	1	0%
Employed in a physical therapy related capacity	2,766	96%
Employed, NOT in a physical therapy related capacity	43	1%
Not working, reason unknown	0	0%
Involuntarily unemployed	12	0%
Voluntarily unemployed	42	1%
Retired	6	0%
Total	**2,869**	**100%**

Source: Va. Healthcare Workforce Data Center

96% of licensed PTAs are currently employed in the profession, and involuntary unemployment is nearly non-existent at the moment. Nearly two-thirds of all PTAs currently hold one full-time job, while 18% have multiple positions. Nearly half of PTAs work between 40 and 49 hours per week, while just 1% of PTAs work at least 60 hours per week.

Current Positions		
Positions	#	%
No Positions	60	2%
One Part-Time Position	430	15%
Two Part-Time Positions	142	5%
One Full-Time Position	1,843	65%
One Full-Time Position & One Part-Time Position	312	11%
Two Full-Time Positions	1	0%
More than Two Positions	58	2%
Total	**2,846**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Weekly Hours		
Hours	#	%
0 hours	60	2%
1 to 9 hours	67	2%
10 to 19 hours	135	5%
20 to 29 hours	223	8%
30 to 39 hours	865	31%
40 to 49 hours	1,314	47%
50 to 59 hours	104	4%
60 to 69 hours	21	1%
70 to 79 hours	9	0%
80 or more hours	12	0%
Total	**2,809**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Income		
Hourly Wage	#	%
Volunteer Work Only	5	0%
Less than $10,000	69	3%
$10,000-$19,999	53	2%
$20,000-$29,999	134	6%
$30,000-$39,999	250	10%
$40,000-$49,999	567	23%
$50,000-$59,999	654	27%
$60,000-$69,999	429	18%
$70,000-$79,999	170	7%
$80,000-$89,999	68	3%
$90,000-$99,999	22	1%
$100,000 or more	12	1%
Total	**2,433**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Earnings
Median Income: $50k-$60k

Benefits
Employer Health Ins.: 60%
Employer Retirement: 60%

Satisfaction
Satisfied 97%
Very Satisfied: 71%

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	#	%
Very Satisfied	1,989	71%
Somewhat Satisfied	735	26%
Somewhat Dissatisfied	66	2%
Very Dissatisfied	18	1%
Total	**2,808**	**100%**

Source: Va. Healthcare Workforce Data Center

The typical PTA earned between $50,000 and $60,000 in 2016. In addition, among PTAs who received either a wage or a salary at their primary work location, 60% received health insurance and 60% had access to a retirement plan.

Employer-Sponsored Benefits			
Benefit	#	%	% of Wage/Salary Employees
Paid Vacation	2,016	73%	76%
Retirement	1,610	58%	60%
Health Insurance	1,587	57%	60%
Dental Insurance	1,510	55%	57%
Paid Sick Leave	1,467	53%	55%
Group Life Insurance	1,094	40%	41%
Signing/Retention Bonus	180	7%	7%
Receive At Least One Benefit	**2,192**	**79%**	82%

*From any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Underemployment in Past Year		
In the past year did you . . .?	#	%
Experience Involuntary Unemployment?	51	2%
Experience Voluntary Unemployment?	119	4%
Work Part-time or temporary positions, but would have preferred a full-time/permanent position?	154	5%
Work two or more positions at the same time?	606	20%
Switch employers or practices?	300	10%
Experienced at least 1	**967**	**32%**

Source: Va. Healthcare Workforce Data Center

Only 2% of Virginia's PTAs experienced involuntary unemployment at some point in 2016. By comparison, Virginia's average monthly unemployment rate was 4.0%.[1]

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at this Location	56	2%	61	8%
Less than 6 Months	199	7%	123	15%
6 Months to 1 Year	335	12%	134	17%
1 to 2 Years	652	23%	177	22%
3 to 5 Years	656	23%	145	18%
6 to 10 Years	443	16%	84	11%
More than 10 Years	464	17%	78	10%
Subtotal	**2,804**	**100%**	**803**	**100%**
Did not have location	36		2,211	
Item Missing	199		26	
Total	**3,040**		**3,040**	

Source: Va. Healthcare Workforce Data Center

Three-quarters of all PTAs receive an hourly wage at their primary work location, while 15% receive a salary or commission.

At a Glance:

Unemployment Experience 2016

Involuntarily Unemployed: 2%
Underemployed: 5%

Turnover & Tenure

Switched Jobs: 10%
New Location: 28%
Over 2 years: 56%
Over 2 yrs, 2nd location: 38%

Employment Type

Hourly Wage: 75%
Salary/Commission: 15%

Source: Va. Healthcare Workforce Data Center

56% of PTAs have worked at their primary location for more than 2 years—the job tenure normally required to get a conventional mortgage loan.

Employment Type		
Primary Work Site	#	%
Salary/ Commission	361	15%
Hourly Wage	1,759	75%
By Contract	195	8%
Business/ Practice Income	13	1%
Unpaid	3	0%
Subtotal	**2,332**	**100%**

Source: Va. Healthcare Workforce Data Center

[1] As reported by the US Bureau of Labor Statistics. The not seasonally adjusted monthly unemployment rate ranged from 3.9% in December 2015 to 4.0% in November 2016. November's rate is from preliminary data.

At a Glance:

Concentration

Top Region:	25%
Top 3 Regions:	59%
Lowest Region:	2%

Locations

2 or more (2014):	29%
2 or more (Now*):	27%

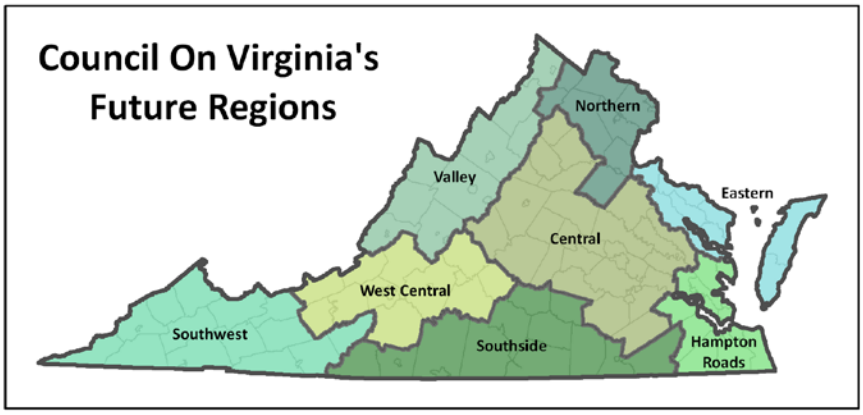
Source: Va. Healthcare Workforce Data Center

59% of all PTAs work in one of three regions of the state: Hampton Roads, Northern Virginia, and West Central Virginia.

A Closer Look:

Regional Distribution of Work Locations				
COVF Region	Primary Location		Secondary Location	
	#	%	#	%
Central	400	14%	119	15%
Eastern	44	2%	21	3%
Hampton Roads	700	25%	189	23%
Northern	514	18%	138	17%
Southside	178	6%	43	5%
Southwest	316	11%	96	12%
Valley	167	6%	44	5%
West Central	447	16%	128	16%
Virginia Border State/DC	4	0%	10	1%
Other US State	23	1%	33	4%
Outside of the US	0	0%	1	0%
Total	**2,792**	**100%**	**822**	**100%**
Item Missing	211		7	

Source: Va. Healthcare Workforce Data Center



Number of Work Locations				
Locations	Work Locations in 2016		Work Locations Now*	
	#	%	#	%
0	26	1%	60	2%
1	1,966	70%	1,997	71%
2	408	15%	409	15%
3	299	11%	290	10%
4	49	2%	23	1%
5	18	1%	12	0%
6 or More	49	2%	23	1%
Total	**2,814**	**100%**	**2,814**	**100%**

*At the time of survey completion, December 2016.

Source: Va. Healthcare Workforce Data Center

27% of all PTAs currently have multiple work locations, while 29% of PTAs have had at least two work locations over the past year.

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	1,915	71%	641	81%
Non-Profit	607	23%	116	15%
State/Local Government	98	4%	27	3%
Veterans Administration	16	1%	0	0%
U.S. Military	40	1%	0	0%
Other Federal Government	7	0%	3	0%
Total	**2,683**	**100%**	**787**	**100%**
Did not have location	36		2,211	
Item Missing	320		43	

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Sector

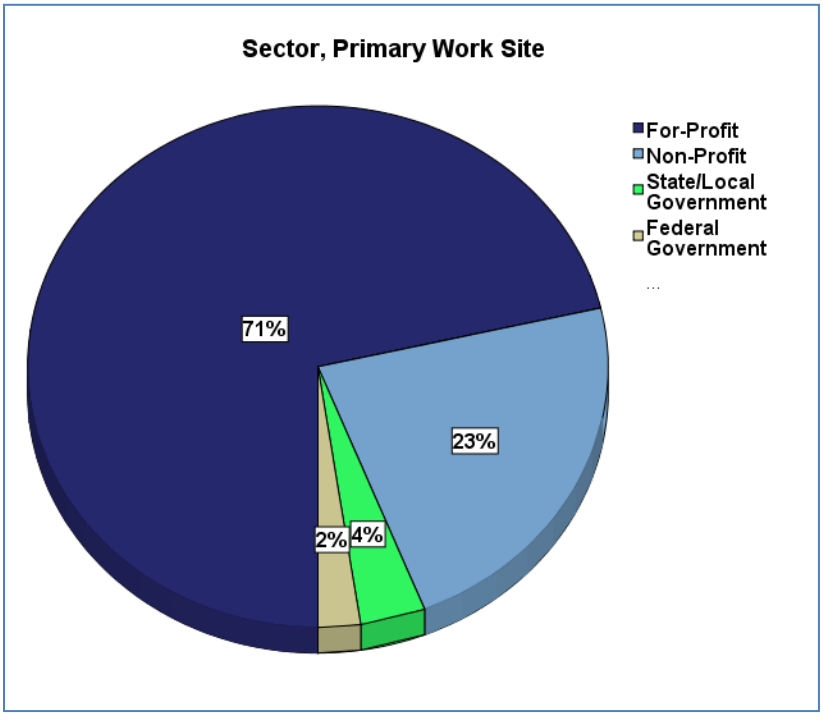
For Profit:	71%
Federal:	2%

Top Establishments

Skilled Nursing Facility:	24%
Home Health Care:	21%
Outpatient Rehab.:	15%

Source: Va. Healthcare Workforce Data Center

More than 90% of all PTAs work in the private sector, including 71% who work at for-profit establishments. Another 4% of Virginia's PTA workforce also worked for either state or local governments.



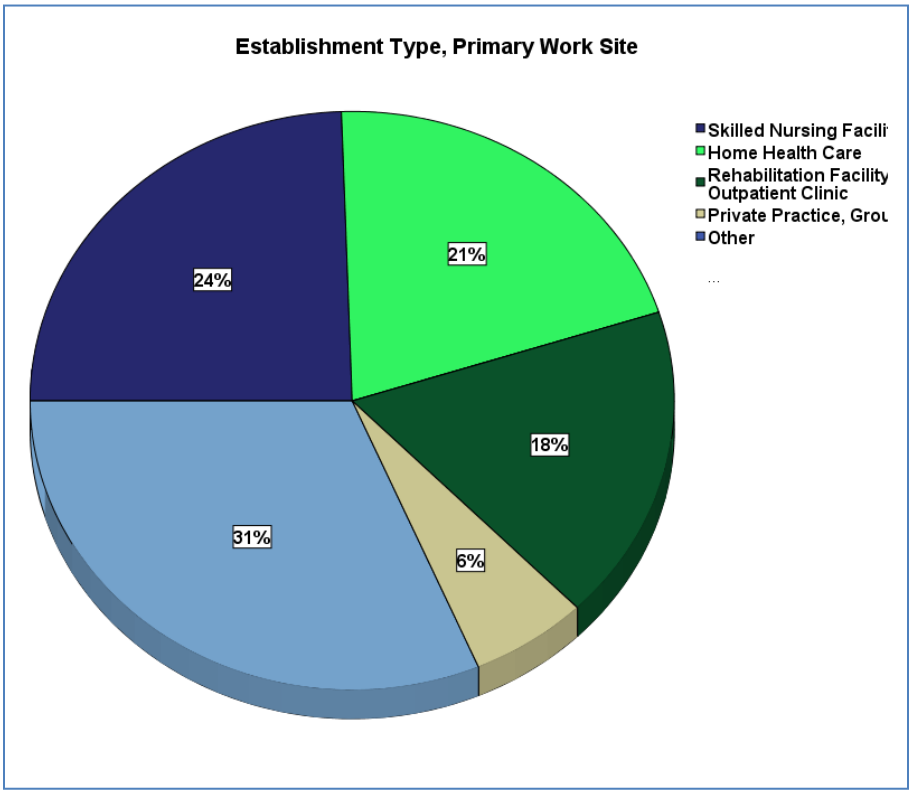
Source: Va. Healthcare Workforce Data Center

Location Type				
Establishment Type	Primary Location		Secondary Location	
	#	%	#	%
Skilled Nursing Facility	642	24%	244	32%
Home Health Care	540	21%	190	25%
Rehabilitation Facility, Outpatient Clinic	463	15%	63	8%
Private Practice, Group	155	7%	34	4%
Rehabilitation Facility, Residential/Inpatient	151	6%	69	9%
Assisted Living or Continuing Care Facility	143	6%	48	6%
General Hospital, Inpatient Department	143	6%	46	6%
General Hospital, Outpatient Department	133	5%	11	1%
Private Practice, Solo	85	3%	14	2%
Physician Office	34	2%	4	1%
K-12 School System	34	1%	6	1%
Academic Institution	15	1%	5	1%
Other	86	3%	30	4%
Total	**2,624**	**100%**	**764**	**100%**
Did Not Have a Location	36		2,211	

Source: Va. Healthcare Workforce Data Center

Skilled Nursing Facilities are the most common establishment type among Virginia's PTAs with a primary work location. Home Health Care and Rehabilitation Facilities were also typical primary establishment types.

About one-third of all PTAs with a secondary work location were employed at a Skilled Nursing Facility, while one-quarter worked at a Home Health Care establishment.



Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

A Typical PTA's Time

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

Roles

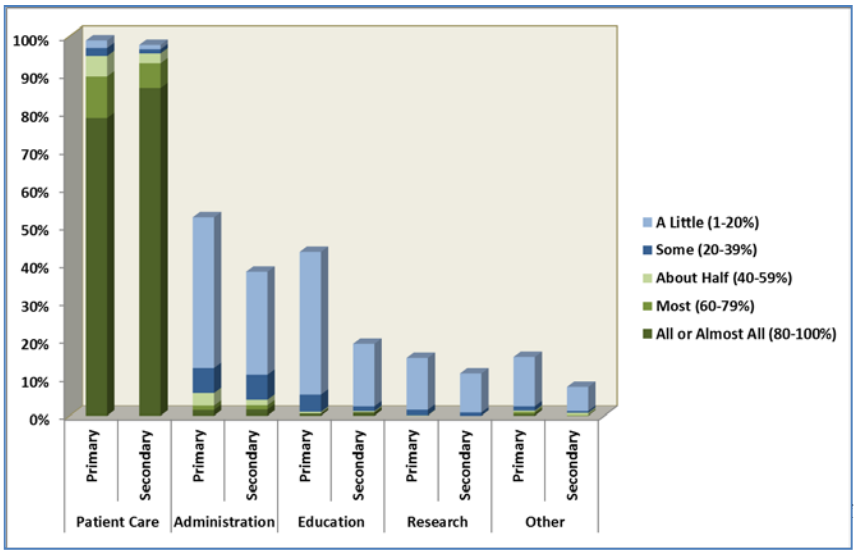
Patient Care:	89%
Administrative:	3%
Other:	1%

Patient Care PTAs

Median Admin Time:	0%
Ave. Admin Time:	1%-9%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

The typical PTA spends nearly all of her time in patient care activities. In fact, 89% of all PTAs fill a patient care role, defined as spending at least 60% of her time in that activity. The typical PTA also spends a small amount of time performing administrative duties during the course of her day.

Time Allocation										
Time Spent	**Patient Care**		**Admin.**		**Education**		**Research**		**Other**	
	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site
All or Almost All (80-100%)	78%	86%	2%	2%	1%	1%	0%	0%	0%	0%
Most (60-79%)	11%	6%	1%	1%	0%	0%	0%	0%	0%	0%
About Half (40-59%)	5%	3%	3%	1%	0%	0%	0%	0%	0%	1%
Some (20-39%)	2%	1%	7%	7%	5%	1%	1%	1%	1%	0%
A Little (1-20%)	2%	1%	40%	27%	38%	17%	14%	10%	13%	6%
None (0%)	1%	2%	48%	62%	57%	81%	85%	89%	85%	92%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All PTAs		PTAs over 50	
	#	%	#	%
Under age 50	90	4%	-	-
50 to 54	121	5%	8	1%
55 to 59	270	11%	47	7%
60 to 64	730	29%	203	30%
65 to 69	881	35%	265	40%
70 to 74	200	8%	88	13%
75 to 79	35	1%	11	2%
80 or over	23	1%	8	1%
I do not intend to retire	165	7%	38	6%
Total	**2,516**	**100%**	**667**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All PTAs

Under 65:	48%
Under 60:	19%

PTAs 50 and over

Under 65:	39%
Under 60:	8%

Time until Retirement

Within 2 years:	3%
Within 10 years:	15%
Half the workforce:	By 2041

Source: Va. Healthcare Workforce Data Center

Slightly less than half of all PTAs expect to retire before the age of 65, while 17% plan on working until at least age 70. Among PTAs who are age 50 and over, 39% still expect to retire by age 65, while 22% plan on working until at least age 70.

Within the next two years, just 2% of Virginia's PTAs expect to leave the profession and 4% plan on leaving the state. Meanwhile, 27% of PTAs plan on pursing additional educational opportunities, and 14% also plan to increase patient care hours.

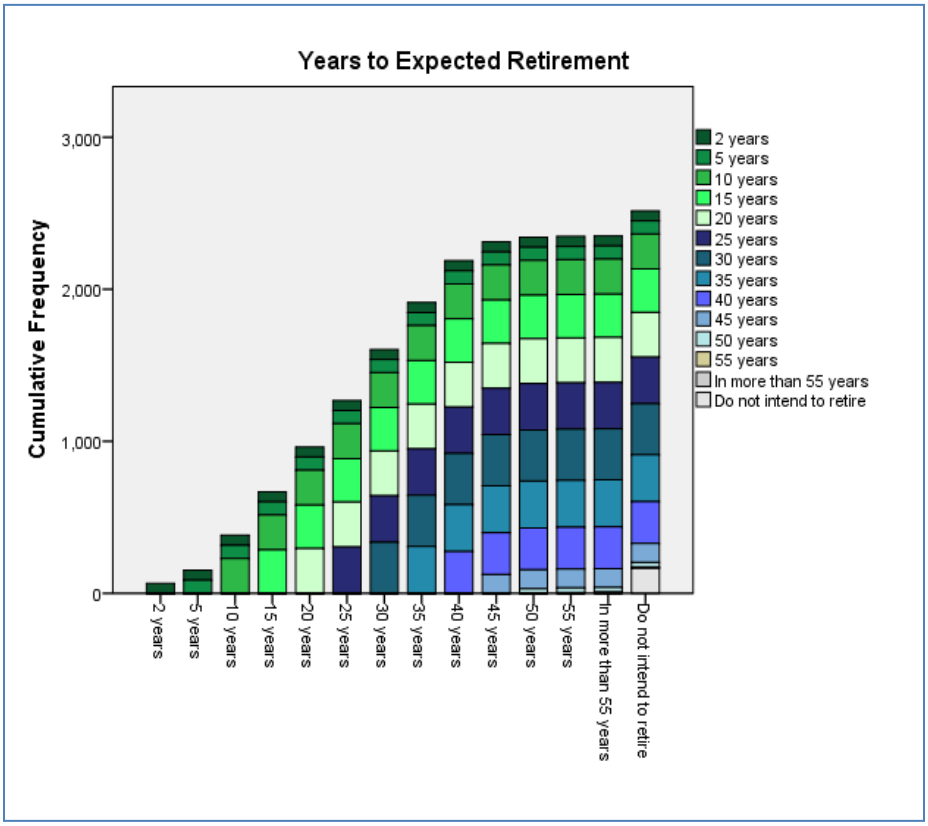
Future Plans		
1 Year Plans:	#	%
Decrease Participation		
Leave Profession	47	2%
Leave Virginia	125	4%
Decrease Patient Care Hours	184	6%
Decrease Teaching Hours	8	0%
Increase Participation		
Increase Patient Care Hours	435	14%
Increase Teaching Hours	265	9%
Pursue Additional Education	830	27%
Return to Virginia's Workforce	17	1%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for PTAs. Only 3% of PTAs expect to retire within the next two years, while 15% plan on retiring in the next ten years. Half of the current PTA workforce expects to be retired by 2041.

Time to Retirement			
Expect to retire within. . .	#	%	Cumulative %
2 years	66	3%	3%
5 years	86	3%	6%
10 years	230	9%	15%
15 years	286	11%	27%
20 years	295	12%	38%
25 years	305	12%	50%
30 years	336	13%	64%
35 years	309	12%	61%
40 years	275	11%	87%
45 years	124	5%	92%
50 years	30	1%	93%
55 years	5	0%	93%
In more than 55 years	3	0%	93%
Do not intend to retire	165	7%	100%
Total	**2,516**	**100%**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Using these estimates, retirements will begin to reach 10% of the current workforce starting in 2031. Retirements will peak at 13% of the current workforce around 2046 before declining to under 10% of the current workforce again around 2061.

At a Glance:

FTEs

Total: 2,508
FTEs/1,000 Residents: 0.30
Average: 0.83

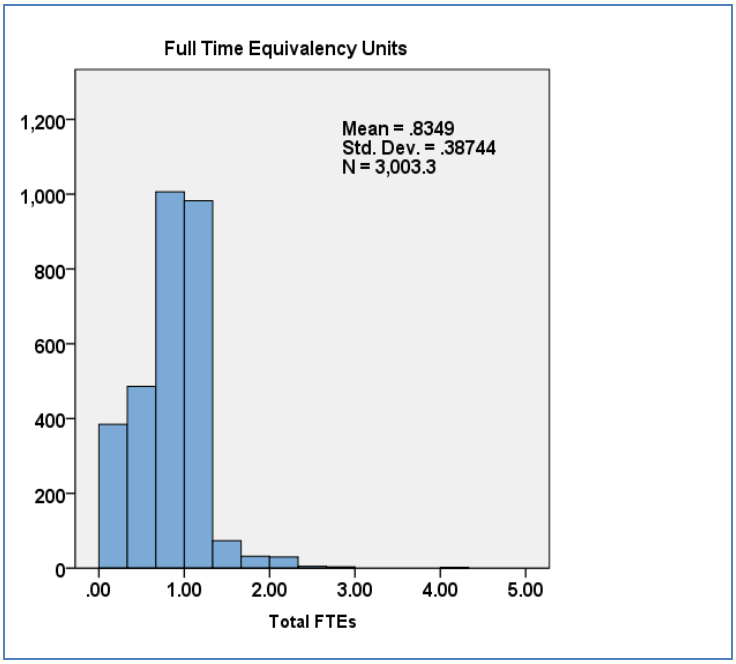
Age & Gender Effect

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

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

Source: Va. Healthcare Workforce Data Center

A Closer Look:

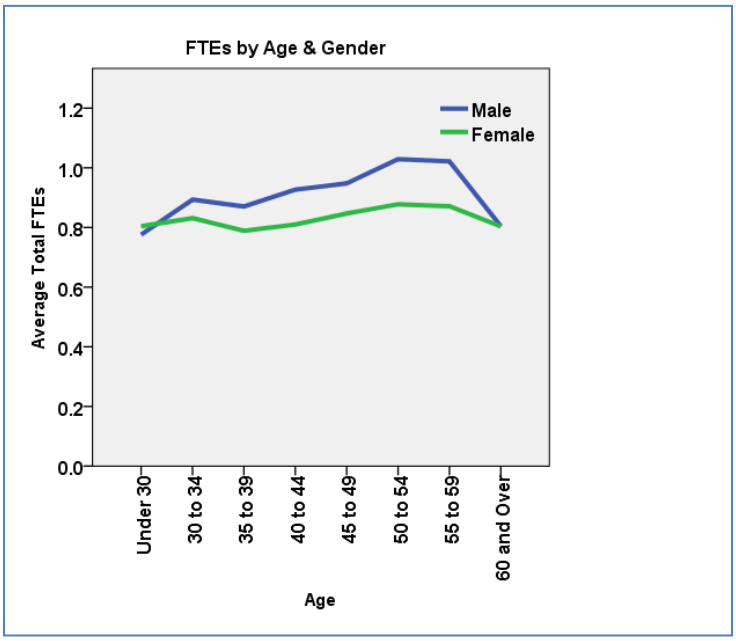


Source: Va. Healthcare Workforce Data Center

The typical PTA provided 0.924 FTEs in 2016, or approximately 33 hours per week for 52 weeks. Although FTEs appear to vary by gender, statistical tests did not verify that a difference exists.[2]

Full-Time Equivalency Units		
Age	**Average**	**Median**
Age		
Under 30	0.79	0.89
30 to 34	0.86	0.94
35 to 39	0.81	0.87
40 to 44	0.83	0.92
45 to 49	0.86	0.92
50 to 54	0.92	0.96
55 to 59	0.87	0.93
60 and Over	0.75	0.80
Gender		
Male	0.89	0.96
Female	0.83	0.91

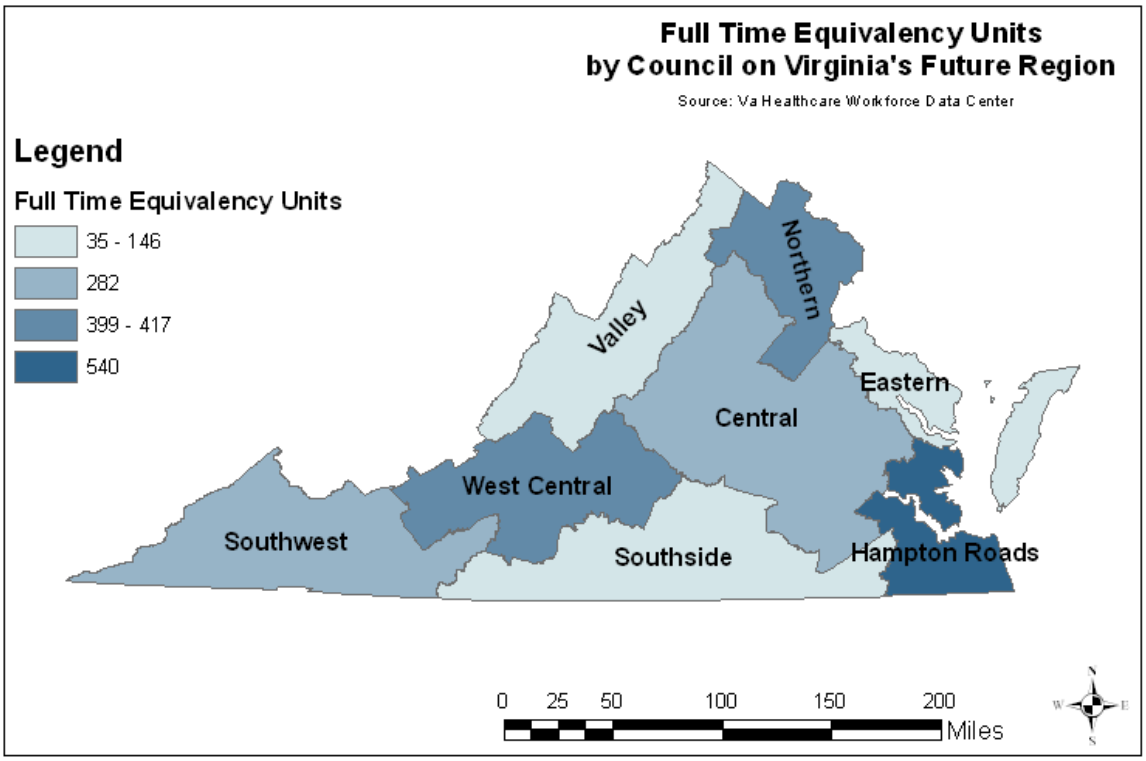
Source: Va. Healthcare Workforce Data Center

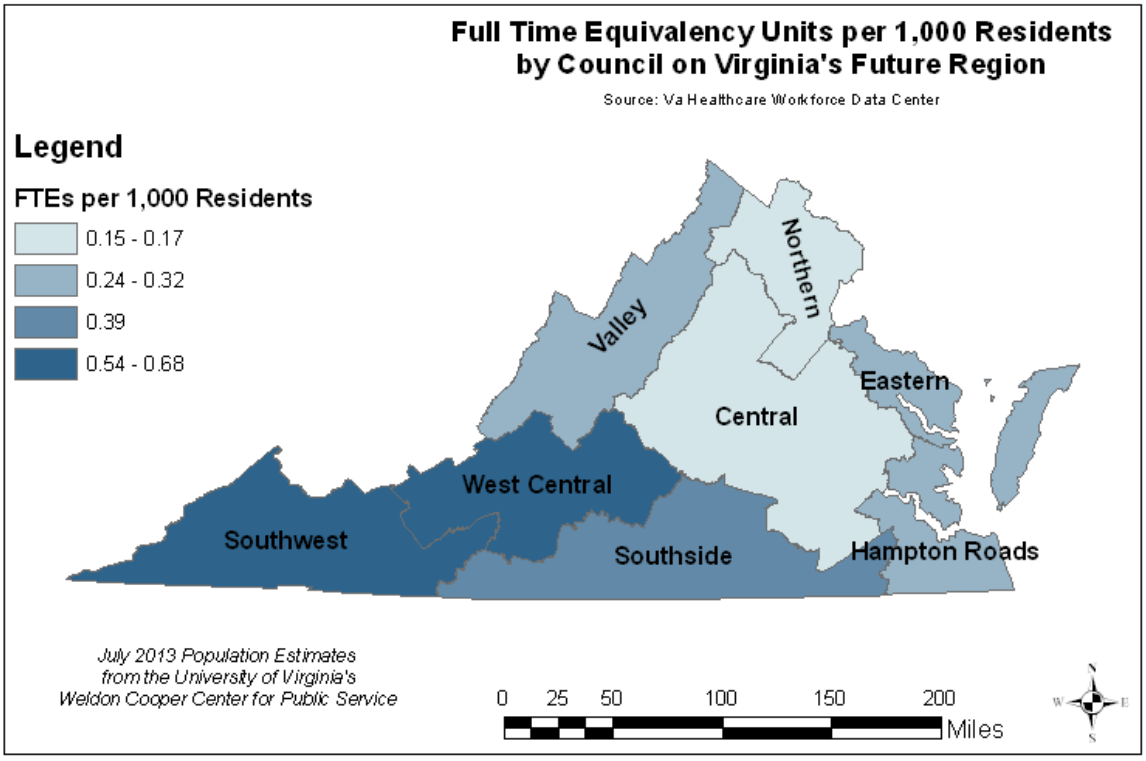


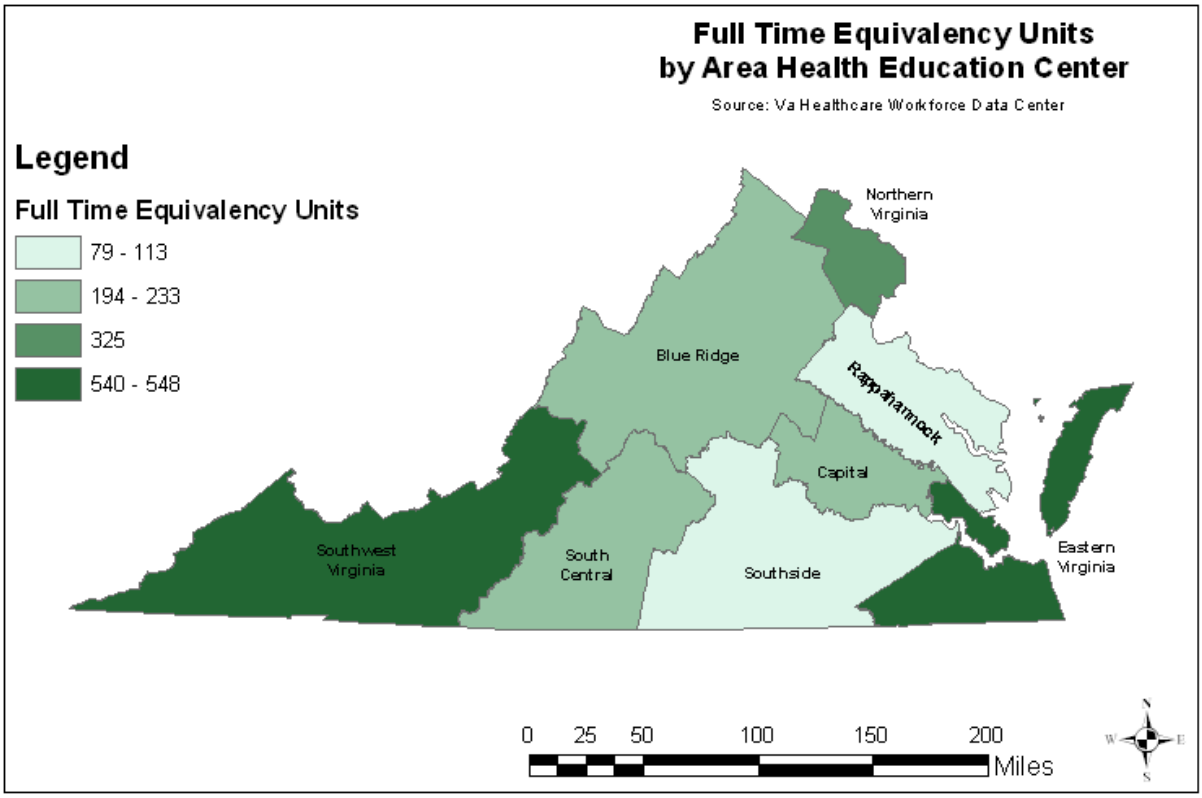
Source: Va. Healthcare Workforce Data Center

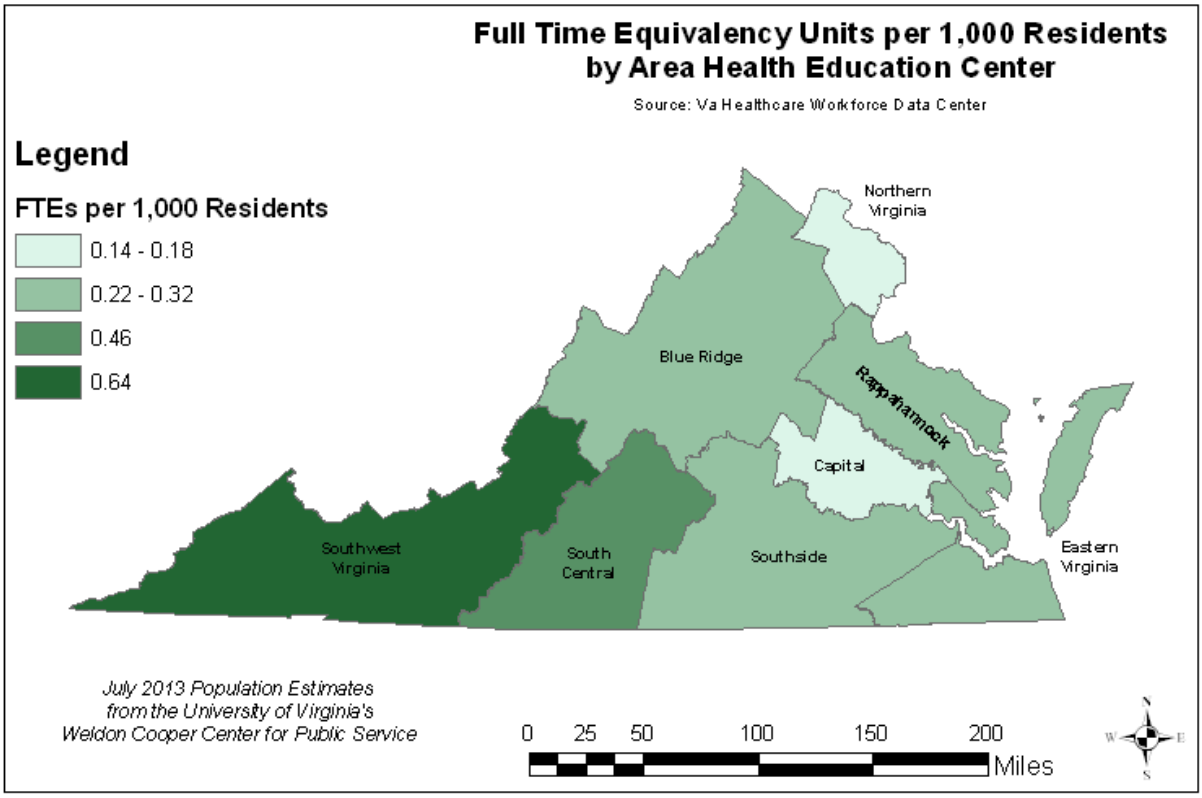
[2] Due to assumption violations in Mixed between-within ANOVA (Levene's Test was significant).

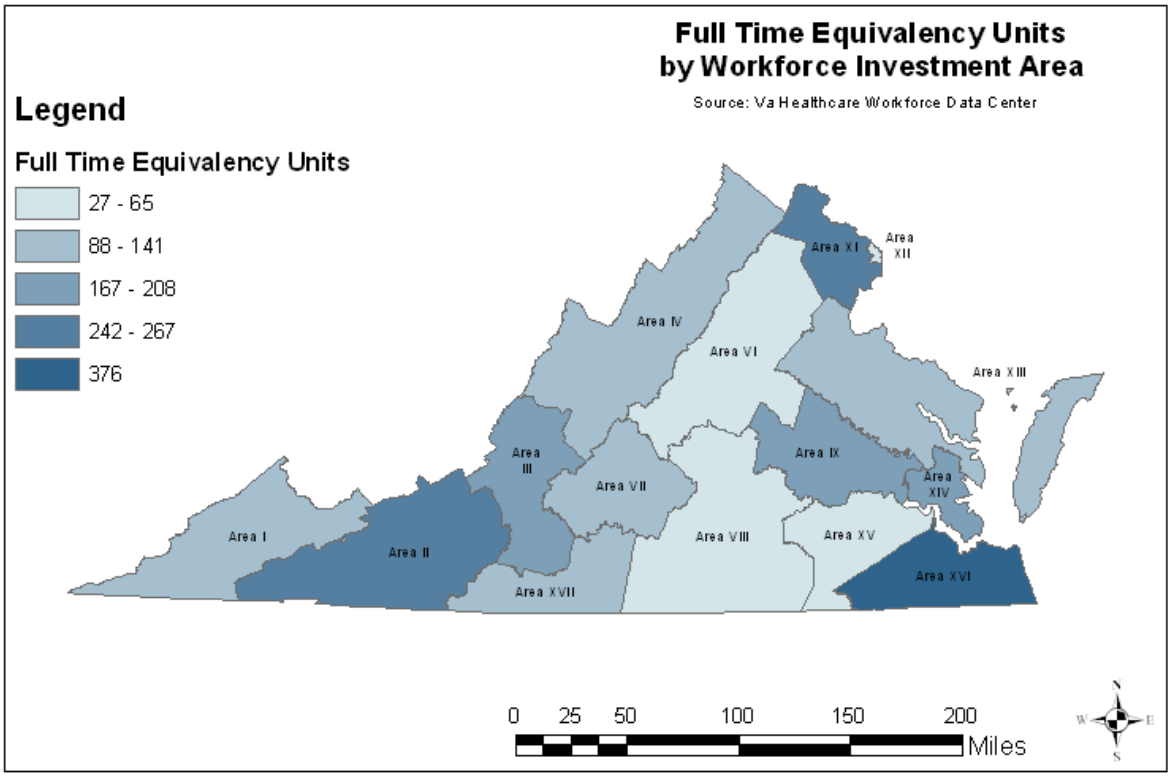
Council on Virginia's Future Regions

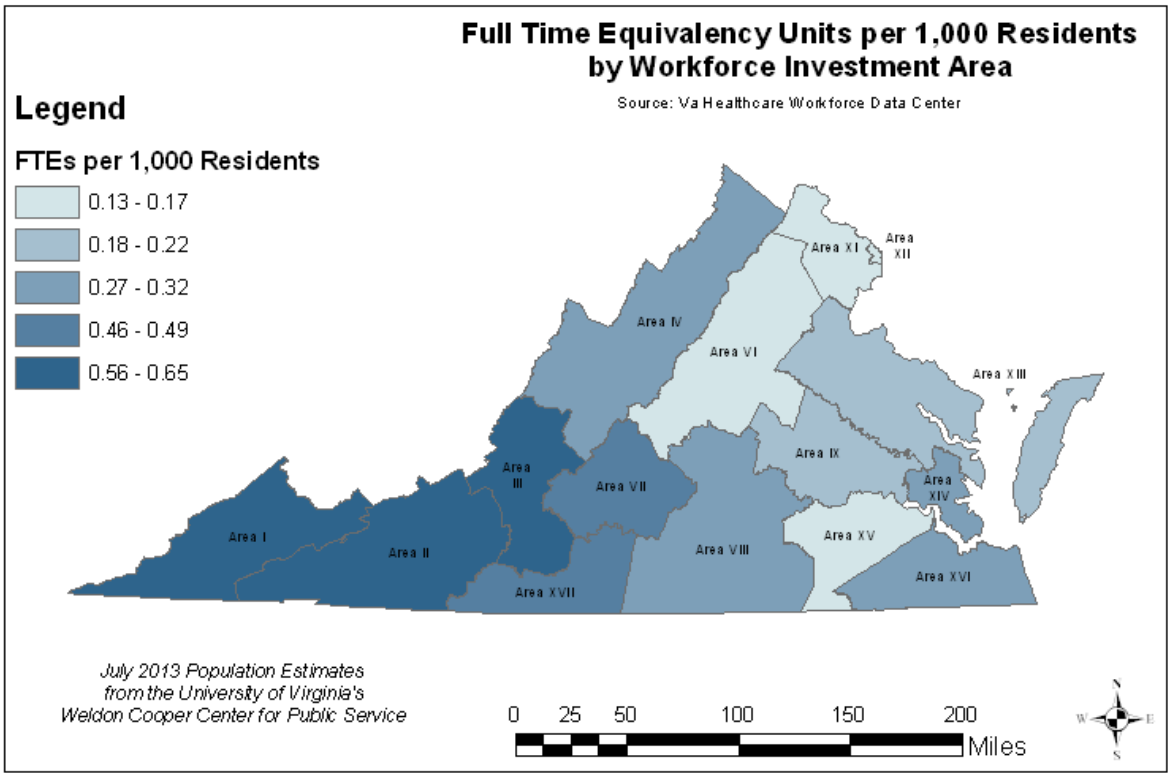


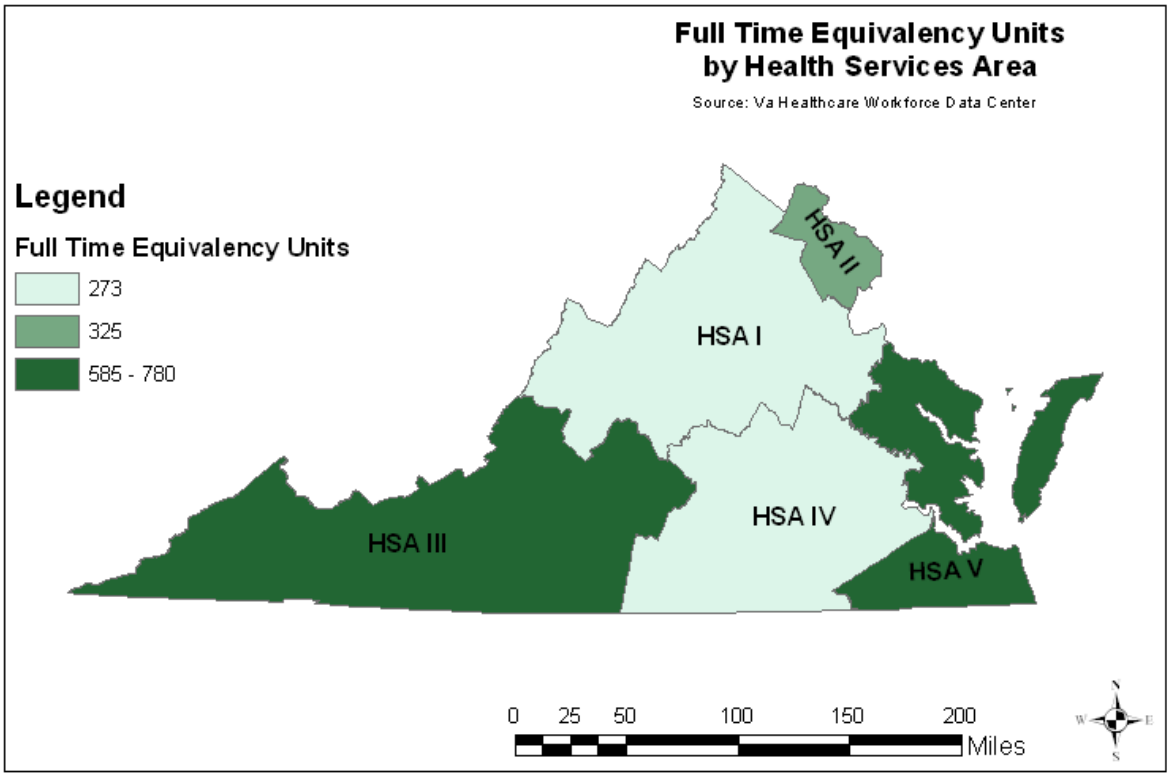


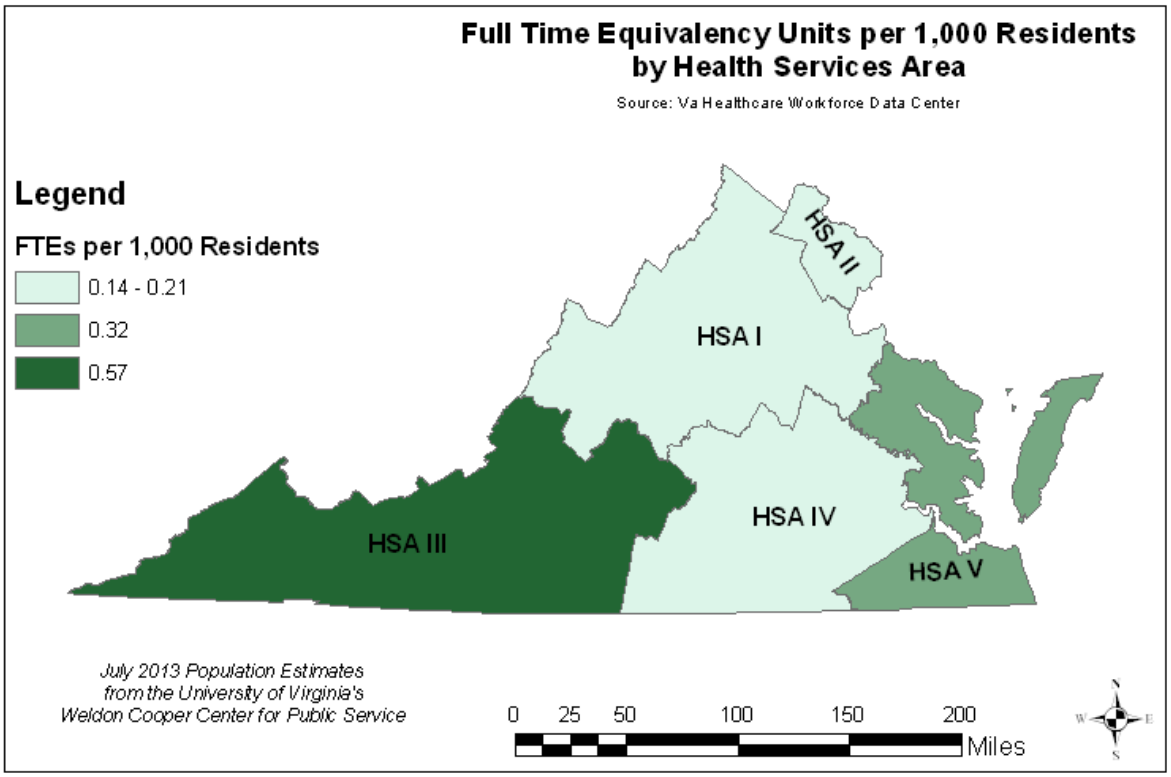

Full Time Equivalency Units
by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
79 - 113
194 - 233
325
540 - 548
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
0 25 50 100 150 200
Miles

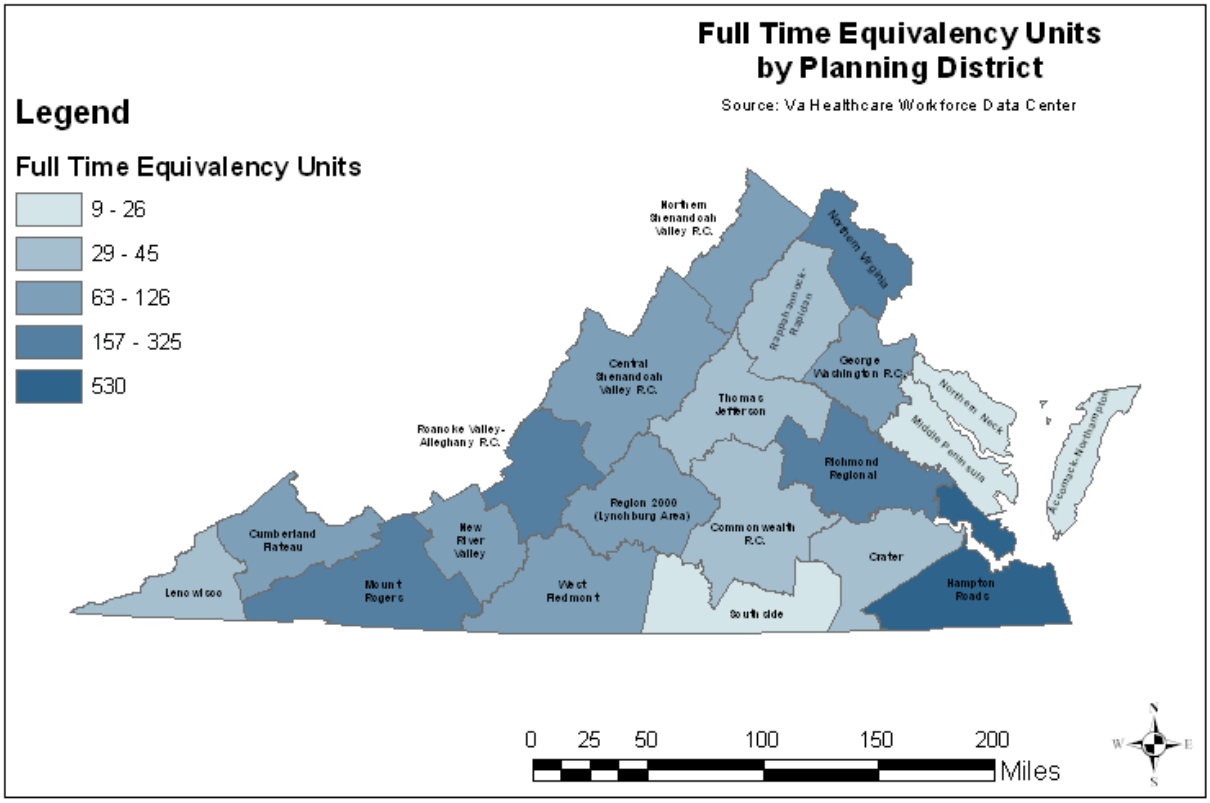

Full Time Equivalency Units per 1,000 Residents
by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.14 - 0.18
0.22 - 0.32
0.46
0.64
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
July 2013 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200
Miles

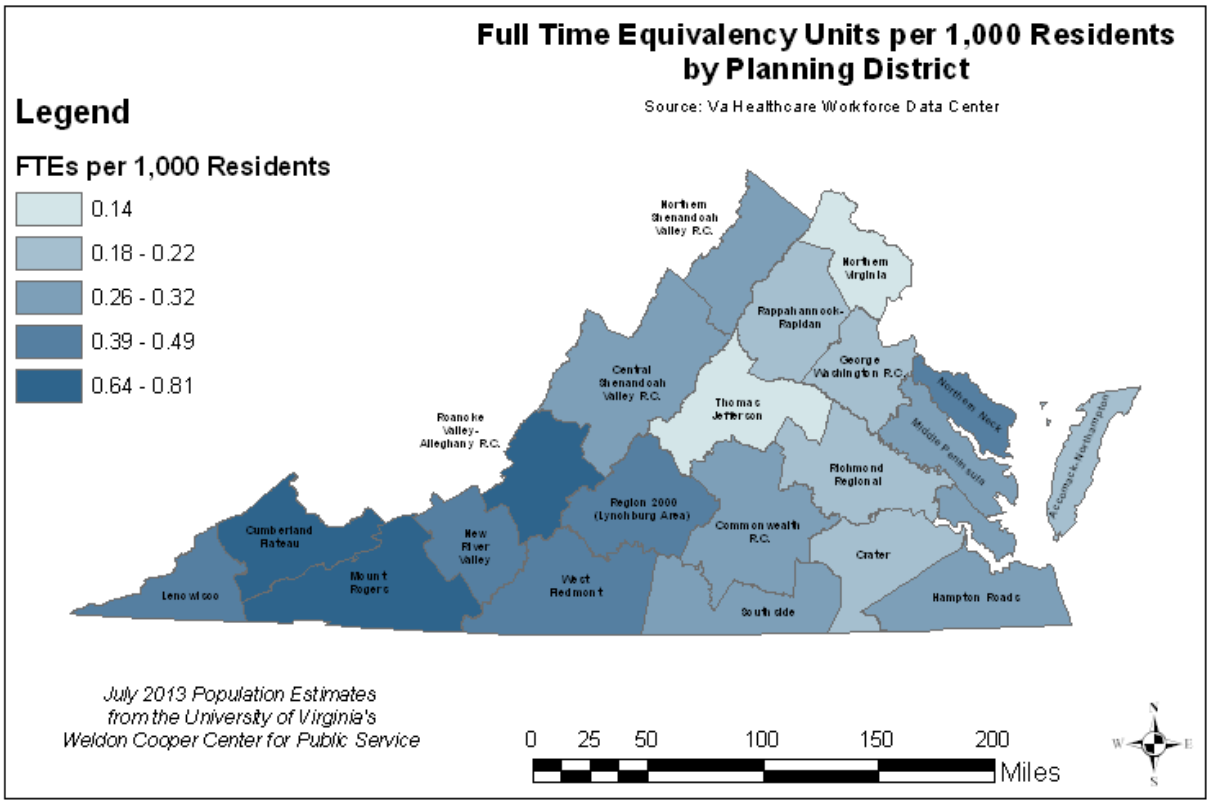

Full Time Equivalency Units
by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
27 - 65
88 - 141
167 - 208
242 - 267
376
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
0 25 50 100 150 200
Miles


Full Time Equivalency Units per 1,000 Residents
by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.13 - 0.17
0.18 - 0.22
0.27 - 0.32
0.46 - 0.49
0.56 - 0.65
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
July 2013 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200
Miles


Full Time Equivalency Units
by Health Services Area
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
273
325
585 - 780
HSA II
HSA I
HSA III
HSA IV
HSA V
0 25 50 100 150 200
Miles


Full Time Equivalency Units per 1,000 Residents
by Health Services Area
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.14 - 0.21
0.32
0.57
HSA II
HSA I
HSA III
HSA IV
HSA V
July 2013 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200
Miles


Full Time Equivalency Units
by Planning District
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
9 - 26
29 - 45
63 - 126
157 - 325
530
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
George Washington R.C.
Central Shenandoah Valley R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
Richmond Regional
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Cumberland Plateau
New River Valley
Crater
Lenowisco
Mount Rogers
West Piedmont
South side
Hampton Roads
0 25 50 100 150 200
Miles
N
W
E
S


Full Time Equivalency Units per 1,000 Residents
by Planning District
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.14
0.18 - 0.22
0.26 - 0.32
0.39 - 0.49
0.64 - 0.81
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
George Washington R.C.
Central Shenandoah Valley R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
Richmond Regional
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Cumberland Plateau
New River Valley
Crater
Lenowisco
Mount Rogers
West Piedmont
South side
Hampton Roads
July 2013 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200
Miles
N
W
E
S

Appendix A: Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min	Max
Metro, 1 million+	1691	83.91%	1.191684285	1.090962	1.416286
Metro, 250,000 to 1 million	442	88.69%	1.12755102	1.032249	1.340065
Metro, 250,000 or less	233	85.84%	1.165	1.066533	1.384573
Urban pop 20,000+, Metro adj	82	89.02%	1.123287671	1.028346	1.334999
Urban pop 20,000+, nonadj	0	NA	NA	NA	NA
Urban pop, 2,500-19,999, Metro adj	161	87.58%	1.141843972	1.045334	1.357052
Urban pop, 2,500-19,999, nonadj	160	81.25%	1.230769231	1.126743	1.462738
Rural, Metro adj	79	86.08%	1.161764706	1.063571	1.380728
Rural, nonadj	40	85.00%	1.176470588	1.077034	1.398205
Virginia border state/DC	293	60.75%	1.646067416	1.50694	1.956309
Other US State	204	44.61%	2.241758242	2.052282	2.664272

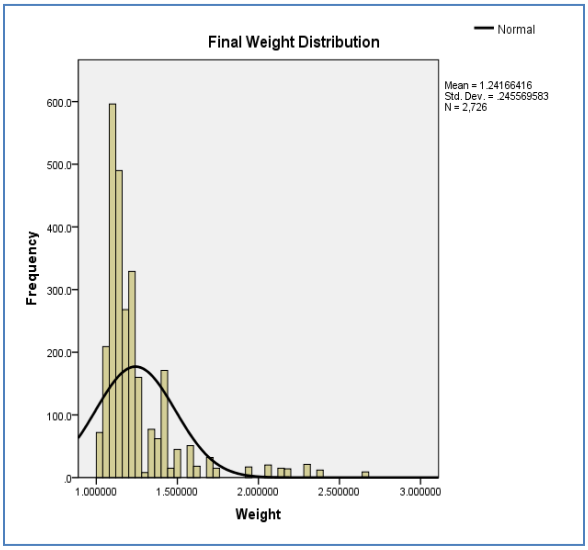
Age	Age Weight			Total Weight	
	#	Rate	Weight	Min	Max
Under 30	518	67.76%	1.475783476	1.334999	2.664272
30 to 34	558	77.96%	1.282758621	1.160388	2.315799
35 to 39	444	84.68%	1.180851064	1.068202	2.131823
40 to 44	426	83.57%	1.196629213	1.082475	2.160307
45 to 49	482	87.97%	1.136792453	1.028346	2.052282
50 to 54	338	87.28%	1.145762712	1.036461	2.068477
55 to 59	315	82.22%	1.216216216	1.100193	2.195668
60 and Over	304	75.66%	1.32173913	1.19565	2.386172

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

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: 0.80532



Committee Reports

Licensure Compact Committee Meeting February 7, 2017

1. Legal Drafting Concerns

   Corie Tillman Wolf and Erin Barrett spoke with Rick Masters (Attorney for FSBPT) on November 1st to discuss some of the drafting concerns identified by the committee. Mr. Masters indicated that slight changes could be made to the compact language as long as they are not substantive changes, for example: deletion of the "dangling" reference to 3.B.4 which does not exist. He also clarified the reference to "litigation materials" as meaning materials from the administrative process, rather than possible materials related to court litigation against the Board, including appeals.

   Another possibly significant issue that may need to be addressed with Mr. Masters is related to the process for issuing the compact privilege and renewals (state issuance of the privilege vs. commission issuance of the privilege). Ms. Tillman Wolf and Ms. Barrett plan to schedule a call with Mr. Masters to discuss this further if the committee decides to meet an additional time.

2. Potential Fiscal Impact

   Missy Currier gave a report on the potential fiscal impact based on Virginia Licensure Stats and fees as well as the Staff process for implementation and the Implementation of Background Checks.

   The positive aspect to belonging to a compact is that it's easier to work across state lines, most impacting SWVA and NOVA.

   There is an anticipated fee of $60 to the Commission for each compact state that you apply for a compact privilege. When that expires, the Licensee has to pay again to renew. It is anticipated that Licensees will have to pay $60 for each compact privilege.

   There are a total of 495 PTs and 201 PTAs, for a total of 696 who are licensed in VA but live in a neighboring state (DC, MD, NC, KY, TN, & WV)

After much discussion, the Committee decided to postpone further discussion for one year in an effort to observe what other states do, to get a better handle on what the exact financial impact could be for Virginia, and to further discuss whether or not the Compact will benefit licensees.

Update on current status of the Licensure Compact:

In March, 2016, the **Oregon** Governor signed the Physical Therapy Licensure Compact (PTLC) into law making Oregon the first state to be a member of the PTLC. In April, 2016, the **Tennessee** Governor signed the PTLC into law. In May, 2016 the **Arizona** Governor signed the PTLC into law; in July 2016, the **Missouri** Governor signed the

PTLC into law. From the February, 2017 FSBPT News Briefs: **Montana** became the first state to join the PTLC in 2017. **Washington, North Dakota, Mississippi**, and **New Hampshire** have passed the bill in one chamber. Additionally, **Colorado, Kentucky, New Jersey, North Carolina**, and **Utah** have introduced bills this session.

Legislative and Regulatory Actions

Agenda Item: **Regulatory Actions - Chart of Regulatory Actions**
(As of March 15, 2017)

Chapter		Action / Stage Information
[18 VAC 112 - 11]	Public participation guidelines	Conformity to Code [Action 4720] Fast-Track - *Register Date: 2/6/17* *Effective: 3/23/17*
[18 VAC 112 - 20]	Regulations Governing the Practice of Physical Therapy	Recognition of oPTion assessment tool [Action 4722] NOIRA - *Register Date: 1/23/17* *Comment closed: 2/22/17* *Board to adopt proposed: 3/29/17*
[18 VAC 112 - 20]	Regulations Governing the Practice of Physical Therapy	Practice of dry needling [Action 4375] Proposed - *Register Date: 12/26/16* *Comment closed: 2/24/17*
[18 VAC 112 - 20]	Regulations Governing the Practice of Physical Therapy	CE credit for volunteer service [Action 4721] Fast-Track - *Register Date: 3/20/17* *Effective: 5/5/17*

Agenda Item: Board Action on Regulations for recognition of the oPTion assessment tool

Included in your agenda package are:

A copy of the Notice of Intended Regulatory Action
(There were no comments on the NOIRA)

A copy of DRAFT regulations as recommended by the Legislative/Regulatory Committee at its meeting on February 7, 2017

Board action:

Adoption of proposed regulations as presented in the attached draft or as amended.

Adoption of draft guidance document.

townhall.virginia.gov

Notice of Intended Regulatory Action (NOIRA)
Agency Background Document

Agency name	Board of Physical Therapy, Department of Health Professions
Virginia Administrative Code (VAC) citation(s)	18VAC112-20
Regulation title(s)	Regulations Governing the Practice of Physical Therapy
Action title	Use of assessment tool oPTion
Date this document prepared	11/17/16

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 17 (2014) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Subject matter and intent

Please describe briefly the subject matter, intent, and goals of the planned regulatory action.

The Board currently recognizes PRT, the Practice Review Tool for competency assessment developed and administered by the Federation of State Boards of Physical Therapy (FSBPT). Physical therapists who take the assessment and those who meet the standard, as set by FSBPT, can receive continuing education credits. Meeting the standard on the PRT also allows an applicant for licensure by endorsement or for reinstatement, who has not been actively practicing, to reduce the required number of hours in a traineeship.

FSBPT has informed member boards that, as of November 30, 2016, it will no longer offer the PRT and has replaced it with a different assessment tool called oPTion. With the shift to oPTion, the FSBPT has also eliminated the "standard" and replaced it with an assessment report that categorizes the therapist's performance into level 1-4.

The Board will decide whether to replace the PRT with oPTion and, if so, it will need to determine if a specific level of performance will be required for the purpose of licensing therapists who have not been engaged in active practice or for granting credit to licensees for continuing education.

Legal basis

Please identify the (1) the agency (includes any type of promulgating entity) and(2) the state and/or federal legal authority for the proposed regulatory action, including the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable. Your citation should include a specific provision, if any, authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

Regulations are promulgated under the general authority of Chapter 24 of Title 54.1 of the Code of Virginia. Section 54.1-2400, which provides the Board of Physical Therapy the authority to promulgate regulations to administer the regulatory system:

§ 54.1-2400 -General powers and duties of health regulatory boards
The general powers and duties of health regulatory boards shall be:
6. (Effective until January 1, 2017) To promulgate regulations in accordance with the Administrative Process Act (§ *2.2-4000* et seq.) which are reasonable and necessary to administer effectively the regulatory system. Such regulations shall not conflict with the purposes and intent of this chapter or of Chapter 1 (§ *54.1-100* et seq.) and Chapter 25 (§ *54.1-2500* et seq.) of this title.

The Board has specific authority to require professional activity or to serve in a traineeship as evidence of competency to practice:

§ 54.1-3479. Licensure by examination or endorsement; traineeships.

D. In granting licenses to out-of-state applicants, the Board may require physical therapists or physical therapist assistants to meet the professional activity requirements or serve traineeships according to regulations promulgated by the Board.

Additionally, the Board has a statutory mandate to require continuing education for renewal:

§ 54.1-3480.1. Continuing education.
As a prerequisite to renewal of a license or reinstatement of a license, each physical therapist shall be required to take biennial courses relating to physical therapy as approved by the Board. The Board shall prescribe criteria for approval of courses of study and credit hour requirements. The Board may approve alternative courses upon timely application of any licensee. Fulfillment of education requirements shall be certified to the Board upon a form provided by the Board and shall be submitted by each licensed physical therapist at the time he applies to the Board for the renewal or reinstatement of his license. The Board may waive individual requirements in cases of certified illness or undue hardship.

Purpose

Please describe the specific reasons why the agency has determined that the proposed regulatory action is essential to protect the health, safety, or welfare of citizens. In addition, please explain any potential issues that may need to be addressed as the regulation is developed.

The purpose of the proposed action is determine whether to utilize a self-assessment tool which allows physical therapists to compare their knowledge, skills, and abilities to entry-level general physical therapy practice. A physical therapist cannot fail oPTion, and the results do not demonstrate minimal competence. Therefore, the Board must balance its responsibility to adopt regulations that protect the public health and safety with an opportunity for applicants to reduce the number of traineeship hours or receive continuing education credits by taking the assessment tool oPTion.

Substance

Please briefly identify and explain the new substantive provisions that are being considered, the substantive changes to existing sections that are being considered, or both.

At its meeting on November 15, 2016, the Board decided to issue a Notice of Intended Regulatory Action (NOIRA) in order to initiate rulemaking. In order to recognize the oPTion assessment tool, the Board would need to amend the sections on definitions, requirements for licensure by endorsement, continuing education, inactive license, and reinstatement. Since meeting the "standard" on the PRT has been replaced with four levels of competency, the Board will have to determine what level is appropriate for the purpose oPTion as used in regulation.

According to FSBPT, the levels are described as: 1) Level 1 indicates the ability to apply entry-level knowledge, concepts, and principles across a limited range of patient conditions; 2) Level 2 indicates the ability to apply entry-level knowledge, concepts, and principles across a moderate range of patient conditions; 3) Level 3 demonstrates ability in a broad range of patient conditions; and 4) Level 4 demonstrates ability across an extensive range of patient conditions.

Alternatives

Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.

Since the PRT will not be available after November 30, 2016, the Board must revise its regulations to recognize oPTion if it wants to continue utilization of an FSBPT assessment tool. An assessment tool is an option for applicants or licensees; there is currently no regulation requiring someone to take the PRT. Therefore, applicants for endorsement, reinstatement, or reactivation who do not have active practice hours will not have the option of taking as

assessment tool to reduce traineeship hours but will be able to be licensed based on completion of a required traineeship.

Public participation

Please indicate whether the agency is seeking comments on the intended regulatory action, including ideas to assist the agency in the development of the proposal and the costs and benefits of the alternatives stated in this notice or other alternatives. Also, indicate whether a public hearing is to be held to receive comments. Please include one of the following choices: 1) a panel will be appointed and the agency's contact if you're interested in serving on the panel is _____; 2) a panel will not be used; or 3) public comment is invited as to whether to use a panel to assist in the development of this regulatory proposal.

The agency is seeking comments on this regulatory action, including but not limited to: ideas to be considered in the development of this proposal, the costs and benefits of the alternatives stated in this background document or other alternatives, and the potential impacts of the regulation.

The agency is also seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include: projected reporting, recordkeeping, and other administrative costs; the probable effect of the regulation on affected small businesses; and the description of less intrusive or costly alternatives for achieving the purpose of the regulation.

Anyone wishing to submit comments may do so via the Regulatory Town Hall website (**http://www.townhall.virginia.gov**) or by mail to Elaine Yeatts, 9960 Mayland Drive, Suite 300, Henrico, VA 23233; by email to elaine.yeatts@dhp.virginia.gov; by fax to (804) 527-4434. Written comments must include the name and address of the commenter. In order to be considered, comments must be received by midnight on the last day of the public comment period.

A public hearing will be held following the publication of the proposed stage of this regulatory action and notice of the hearing will be posted on the Virginia Regulatory Town Hall website (**http://www.townhall.virginia.gov**) and on the Commonwealth Calendar website (https://www.virginia.gov/connect/commonwealth-calendar). Both oral and written comments may be submitted at that time.

Project 4983 - NOIRA

BOARD OF PHYSICAL THERAPY

Recognition of oPTion assessment tool

Part I

General Provisions

18VAC112-20-10. Definitions.

In addition to the words and terms defined in § 54.1-3473 of the Code of Virginia, the following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Active practice" means a minimum of 160 hours of professional practice as a physical therapist or physical therapist assistant within the 24-month period immediately preceding renewal. Active practice may include supervisory, administrative, educational or consultative activities or responsibilities for the delivery of such services.

"Approved program" means an educational program accredited by the Commission on Accreditation in Physical Therapy Education of the American Physical Therapy Association.

"CLEP" means the College Level Examination Program.

"Contact hour" means 60 minutes of time spent in continuing learning activity exclusive of breaks, meals or vendor exhibits.

"Direct supervision" means a physical therapist or a physical therapist assistant is physically present and immediately available and is fully responsible for the physical therapy tasks or activities being performed.

"Discharge" means the discontinuation of interventions in an episode of care that have been provided in an unbroken sequence in a single practice setting and related to the physical therapy interventions for a given condition or problem.

"Evaluation" means a process in which the physical therapist makes clinical judgments based on data gathered during an examination or screening in order to plan and implement a treatment intervention, provide preventive care, reduce risks of injury and impairment, or provide for consultation.

"FCCPT" means the Foreign Credentialing Commission on Physical Therapy.

"FSBPT" means the Federation of State Boards of Physical Therapy.

"General supervision" means a physical therapist shall be available for consultation.

"National examination" means the examinations developed and administered by the Federation of State Boards of Physical Therapy and approved by the board for licensure as a physical therapist or physical therapist assistant.

"Assessment tool" means oPTion or any other competency assessment tool developed or approved by FSBPT.

~~"PRT" means the Practice Review Tool for competency assessment developed and administered by FSBPT.~~

"Reevaluation" means a process in which the physical therapist makes clinical judgments based on data gathered during an examination or screening in order to determine a patient's response to the treatment plan and care provided.

"Support personnel" means a person who is performing designated routine tasks related to physical therapy under the direction and supervision of a physical therapist or physical therapist assistant within the scope of this chapter.

"TOEFL" means the Test of English as a Foreign Language.

"Trainee" means a person seeking licensure as a physical therapist or physical therapist assistant who is undergoing a traineeship.

"Traineeship" means a period of active clinical practice during which an applicant for licensure as a physical therapist or physical therapist assistant works under the direct supervision of a physical therapist approved by the board.

"TSE" means the Test of Spoken English.

"Type 1" means continuing learning activities offered by an approved organization as specified in 18VAC112-20-131.

"Type 2" means continuing learning activities which may or may not be offered by an approved organization but shall be activities considered by the learner to be beneficial to practice or to continuing learning.

18VAC112-20-65. Requirements for licensure by endorsement.

A. A physical therapist or physical therapist assistant who holds a current, unrestricted license in the United States, its territories, the District of Columbia, or Canada may be licensed in Virginia by endorsement.

B. An applicant for licensure by endorsement shall submit:

1. Documentation of having met the educational requirements prescribed in 18VAC112-20-40 or 18VAC112-20-50. In lieu of meeting such requirements, an applicant may provide evidence of clinical practice consisting of at least 2,500 hours of patient care during the five years immediately preceding application for licensure in Virginia with a current, unrestricted license issued by another U.S. jurisdiction;

2. The required application, fees, and credentials to the board;

3. A current report from the Healthcare Integrity and Protection Data Bank (HIPDB);

4. Evidence of completion of 15 hours of continuing education for each year in which the applicant held a license in another U.S. jurisdiction, or 60 hours obtained within the past four years;

5. Documentation of passage of an examination equivalent to the Virginia examination at the time of initial licensure or documentation of passage of an examination required by another state at the time of initial licensure in that state; and

6. Documentation of active practice in physical therapy in another U.S. jurisdiction for at least 320 hours within the four years immediately preceding his application for licensure. A physical therapist who does not meet the active practice requirement shall:

a. Successfully complete 320 hours in a traineeship in accordance with requirements in 18VAC112-20-140; or

b. Document that he ~~meets the standard of the PRT~~ attained at least Level 2 on the FSBPT assessment tool within the two years preceding application for licensure in Virginia and successfully complete 160 hours in a traineeship in accordance with the requirements in 18VAC112-20-140.

C. A physical therapist assistant seeking licensure by endorsement who has not actively practiced physical therapy for at least 320 hours within the four years immediately preceding his application for licensure shall successfully complete 320 hours in a traineeship in accordance with the requirements in 18VAC112-20-140.

18VAC112-20-131. Continued competency requirements for renewal of an active license.

A. In order to renew an active license biennially, a physical therapist or a physical therapist assistant shall complete at least 30 contact hours of continuing learning activities within the two years immediately preceding renewal. In choosing continuing learning activities or courses, the

licensee shall consider the following: (i) the need to promote ethical practice, (ii) an appropriate standard of care, (iii) patient safety, (iv) application of new medical technology, (v) appropriate communication with patients, and (vi) knowledge of the changing health care system.

B. To document the required hours, the licensee shall maintain the Continued Competency Activity and Assessment Form that is provided by the board and that shall indicate completion of the following:

1. A minimum of 20 of the contact hours required for physical therapists and 15 of the contact hours required for physical therapist assistants shall be in Type 1 courses. For the purpose of this section, "course" means an organized program of study, classroom experience or similar educational experience that is directly related to the clinical practice of physical therapy and approved or provided by one of the following organizations or any of its components:

a. The Virginia Physical Therapy Association;

b. The American Physical Therapy Association;

c. Local, state or federal government agencies;

d. Regionally accredited colleges and universities;

e. Health care organizations accredited by a national accrediting organization granted authority by the Centers for Medicare and Medicaid Services to assure compliance with Medicare conditions of participation;

f. The American Medical Association - Category I Continuing Medical Education course; and

g. The National Athletic Trainers' Association.

2. No more than 10 of the contact hours required for physical therapists and 15 of the contact hours required for physical therapist assistants may be Type 2 activities or courses, which may or may not be offered by an approved organization but which shall be related to the clinical practice of physical therapy. Type 2 activities may include but not be limited to consultation with colleagues, independent study, and research or writing on subjects related to practice.

3. Documentation of specialty certification by the American Physical Therapy Association may be provided as evidence of completion of continuing competency requirements for the biennium in which initial certification or recertification occurs.

4. Documentation of graduation from a transitional doctor of physical therapy program may be provided as evidence of completion of continuing competency requirements for the biennium in which the physical therapist was awarded the degree.

5. A physical therapist who can document that he ~~has taken the PRT~~ attained at least Level 2 on the FSBPT assessment tool may receive ~~10~~ 5 hours of Type 1 credit for the biennium in which the assessment tool was taken. A physical therapist who can document that he ~~has met the standard of the PRT~~ attained at least Level 3 or 4 on the FSBPT assessment tool may receive ~~20~~ 10 hours of Type 1 credit for the biennium in which the assessment tool was taken. Continuing competency credit shall only be granted for the FSBPT assessment tool once every four years.

C. A licensee shall be exempt from the continuing competency requirements for the first biennial renewal following the date of initial licensure by examination in Virginia.

D. The licensee shall retain his records on the completed form with all supporting documentation for a period of four years following the renewal of an active license.

E. The licensees selected in a random audit conducted by the board shall provide the completed Continued Competency Activity and Assessment Form and all supporting documentation within 30 days of receiving notification of the audit.

F. Failure to comply with these requirements may subject the licensee to disciplinary action by the board.

G. The board may grant an extension of the deadline for continuing competency requirements for up to one year for good cause shown upon a written request from the licensee prior to the renewal date.

H. The board may grant an exemption for all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

18VAC112-20-135. Inactive license.

A. A physical therapist or physical therapist assistant who holds a current, unrestricted license in Virginia shall, upon a request on the renewal application and submission of the required renewal fee, be issued an inactive license.

1. The holder of an inactive license shall not be required to meet active practice requirements.

2. An inactive licensee shall not be entitled to perform any act requiring a license to practice physical therapy in Virginia.

B. A physical therapist or physical therapist assistant who holds an inactive license may reactivate his license by:

1. Paying the difference between the renewal fee for an inactive license and that of an active license for the biennium in which the license is being reactivated;

2. Providing proof of 320 active practice hours in another jurisdiction within the four years immediately preceding application for reactivation.

a. If the inactive physical therapist licensee does not meet the requirement for active practice, the license may be reactivated by completing 320 hours in a traineeship that meets the requirements prescribed in 18VAC112-20-140 or documenting that he has ~~met the standard of the PRT~~ attained at least Level 2 on the FSBPT assessment tool within the two years preceding application for reactivation of licensure in Virginia and successfully completing 160 hours in a traineeship in accordance with requirements in 18VAC112-20-140.

b. If the inactive physical therapist assistant licensee does not meet the requirement for active practice, the license may be reactivated by completing 320 hours in a traineeship that meets the requirements prescribed in 18VAC112-20-140; and

3. Completing the number of continuing competency hours required for the period in which the license has been inactive, not to exceed four years.

18VAC112-20-136. Reinstatement requirements.

A. A physical therapist or physical therapist assistant whose Virginia license is lapsed for two years or less may reinstate his license by payment of the renewal and late fees as set forth in 18VAC112-20-27 and completion of continued competency requirements as set forth in 18VAC112-20-131.

B. A physical therapist or physical therapist assistant whose Virginia license is lapsed for more than two years and who is seeking reinstatement shall:

1. Apply for reinstatement and pay the fee specified in 18VAC112-20-27;

2. Complete the number of continuing competency hours required for the period in which the license has been lapsed, not to exceed four years; and

3. Have actively practiced physical therapy in another jurisdiction for at least 320 hours within the four years immediately preceding applying for reinstatement.

a. If a physical therapist licensee does not meet the requirement for active practice, the license may be reinstated by completing 320 hours in a traineeship that meets the requirements prescribed in 18VAC112-20-140 or documenting that he has ~~met the standard of the PRT~~ attained at least Level 2 on the FSBPT assessment tool within the two years preceding application for licensure in Virginia and successfully completing 160 hours in a traineeship in accordance with requirements in 18VAC112-20-140.

b. If a physical therapist assistant licensee does not meet the requirement for active practice, the license may be reinstated by completing 320 hours in a traineeship that meets the requirements prescribed in 18VAC112-20-140.

Agenda Item: Board Consideration of Public Comment on Dry Needling Proposed Regulations

Included in your agenda package are:

A copy of the proposed amendments

A copy of the summary of public comment

A copy Public Participation Guidelines – 18VAC112-11-70 on appointment of a RAP

Staff Note:

Board members were sent the following electronically:

Link to all public comment posted on the Regulatory Townhall

Copy of the transcript from the Public Hearing

Copies of hard copy comment

Copy of email comments merged into one document

FSBPT has published a revised Resource Paper Regarding Dry Needling (Dec. 2016)

Maryland and Tennessee have published draft regulations in Fall of 2016

Possible Board action:

Refer dry needling to Regulatory Advisory Panel for consideration of comment and additional information

18VAC112-11-10:
"Regulatory advisory panel" or "RAP" means a standing or ad hoc advisory panel of interested parties established by the agency for the purpose of assisting in regulatory actions.

Project 4433 - Proposed

BOARD OF PHYSICAL THERAPY

Practice of dry needling

18VAC112-20-121. Practice of dry needling.

A. Dry needling is an invasive procedure which requires referral and direction in accordance with § 54.1-3482 of the Code of Virginia. Referral should be in writing; if the initial referral is received orally, it shall be followed up with a written referral.

B. Dry needling is not an entry level skill but an advanced procedure that requires additional training. The training shall be specific to dry needling and shall include emergency preparedness and response, contraindications and precautions, secondary effects or complications, palpation and needle techniques, and physiological responses.

C. Prior to the performance of dry needling, the physical therapist shall obtain informed consent form from the patient or his representative. The informed consent shall include the risks and benefits of the technique and shall clearly state that the patient is not receiving an acupuncture treatment. The informed consent form shall be maintained in the patient record.

Attached is a summary of comment received by the Virginia Board of Physical Therapy on proposed amendments relating to the practice of dry needling. At its meeting on March 29, 2017, the Board will review the comment and consider its response. Final regulations will be adopted at a later meeting after the Board formulates its response and determines what, if any, changes it wants to propose.

No public comment on dry needling can be received on March 29th as the public comment period is closed. Thank you for your participation in the public comment period.

Board of Physical Therapy

Public Comment on Proposed Regulations

Dry Needling

Comments received by Regular Mail

Commenter	Comment
American Medical Society for Sports Medicine	AMSSM is in favor of proposed regulation; fully-trained PTs should be allowed to perform dry needling. Dry needling is proven to be a safe and effective treatment for neuromusculoskeletal conditions, pain, movement impairments, and disability. Agrees with written referral and informed consent. Concern about lack of specificity for additional training; more clarity is needed as well as requirement for some portion of CE in dry needling.
Council of Colleges of Acupuncture & Oriental Medicine	CCAOM opposes the proposed regulations for the following reasons: 1) dry needling is acupuncture; is an invasive procedure that uses acupuncture needles & is part of the armamentarium of acupuncture; 2) acupuncture uses biomedical terminology so use of such language cannot be basis for defining dry needling as distinct from acupuncture; 3) physical therapists are prohibited from performing surgery and dry needling is an incisive procedure; 4) no national standard in PT for education and training in dry needling, so risk of public harm; 5) Attendance in dry needling courses not restricted to PTs who have a doctoral level degree; 6) PT regulators must specify training; 7) PT regulators must conduct adverse event monitoring through appropriate reporting; 8) PT in states where dry needling is allowed have exceeded the intended scope of practice
American Academy of Medical Acupuncture	AAMA submitted its policy statement on dry needling. It is an invasive procedure using acupuncture needles that has medical risk. It should only be performed by practitioners with extensive training and licensure to perform these procedures, such as licensed medical physicians or licensed acupuncturists.
American Academy of Physical Medicine and Rehabilitation	AAPM&R submitted its 2012 position paper which is basically identical to the policy statement of the AAMA.
Geller Law Group on behalf of the Acupuncture Society of Virginia (ASVA)	ASVA opposes the proposed regulation and the practice of dry needling by physical therapists for the following reasons: 1) It is an invasive procedure outside the scope of practice for PT; presents

	a public health and safety risk; and is an overstep of the regulatory authority of the Board. The practice of acupuncture is carved out of the practice of medicine and defined in statute. The AMA position is that the practice should be "performed by practitioner with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists." 2) Nothing in the statutory definition of the practice of PT extends the scope to include insertion of acupuncture needles; 3) the Board has overstep its authority by attempting to add the practice of acupuncture to the practice of PT. Included exhibits on AMA statement and claim report update from CNA on physical therapy liability.
Brigitte Fox, L.Ac. AcuWorks	Opposes the proposed regulations. States that: 1) dry needling is the practice of acupuncture; 2) requirements for licensure to perform acupuncture necessary to protect the public; and 3) proposed regulations lack any minimum training requirement. Practitioners should treat patients in accordance with their expertise and scope of practice.

Comments received by Email

Commenter	Comment
Michelle Wright, L.Ac. Naples, NY	Opposes dry needling by physical therapists, who are not legally and safely qualified to perform acupuncture. Dry needling is one style and technique in acupuncture. Standard for a physician to practice acupuncture is 300 hours of post-doctoral training, and PTs do not have same preparation for invasive procedures. No standard for training practitioner in dry needling and no means of assessment of competency for instructors, so the public is at risk. Dry needling by PT is an intentional misrepresentation to the public. Cites recent reports of serious injuries associated with non-acupuncturists practicing dry needling; lack of education and supervised clinical training could be a direct correlation to such injuries.
Joan Choi, L.Ac.	Acupuncture is a unique profession; dry needing by PT will injure acupuncturists. They need to get acupuncture license; need to protect acupuncture profession.
David S. Groopman, M.D.	Opposes dry needling by physical therapists. It is acupuncture, and extensive training & practice necessary to minimize incidence of adverse events. Weekend courses are no substitute for lengthy and comprehensive training. References the position of the American Academy of Medical Acupuncture (noted above)
Jun Xu, M.D. Greenwich, CT	Dangerous to patient safety to expand PT practice. Reviewed training and education for medical and acupuncture profession and licensure. Unsafe and inadequate training puts patients at risk.
Arthur Yin Fan, PhD L.Ac.	Practice of dry needling just a rebranding of acupuncture. Weekend training is inadequate; education should match requirement for licensed acupuncturists.
Dianna Paulsen	Have gone to a licensed acupuncturist for procedures; would not want a PT without extensive training to practice dry needling.

Comments received at the Public Hearing on February 7, 2017

Commenter	Comment

Susan Ole (in favor)	Had trouble breathing, voice, swallowing, and range of motion in shoulders, arms and neck after cervical surgery. Two months of therapy had no success, but dry needling worked "like a miracle". Voice returned, breathing relieved, neck had range of motion because of dry needling. Therapist was well qualified and did much more than muscle relaxers could. Most outstanding difference between dry needling and acupuncture was the way that acupuncture relates to energies, with no mention of muscles. Physical Therapist works with muscles and bones only.
Tom Bohanon (in favor)	Clinician and past president of the Virginia Physical Therapy Association. Physical therapists are highly educated and get trained at the doctoral level. Based on FSBPT study, 86% of clinical training for dry needling occurs at entry level program (clean and sterile techniques, anatomy with cadaver). Dry needling is a different modality than acupuncture. Physical therapists trained on treatment techniques to the neuromuscular and neuromusculoskeletal system, which trigger point dry needling is.
Blaze Williams (in favor)	Faculty at VCU and current vice president of the sports section of the American Physical Therapy Association. Echo comments of Tom Bohanon. As a physical therapy educator, physical therapists educated in anatomy through gross anatomy, physiology, neuroanatomy, neurophysiology, kinesiology, and functional anatomy. More than ample education to receive additional training in dry needling
Erik Wijtmans (in favor)	30 years as licensed physical therapist, on teaching faculty at ODU, clinical instructor certified by APTA. Teaches dry needling courses to dentists, nurses, nurse practitioners, physicians, physician assistants, chiropractors and acupuncturists. Physical therapy education is at least 8900 hours (5400 in undergraduate, 3400 in graduate school). Dry needling not an entry level skill, taught in post graduate curriculum. Needles being used are solid filiform, specifically made for physical therapists to use in dry needling. Safety and accuracy paramount. Informally surveyed acupuncturists in his classes, they say ashi points are not the same as myofascial trigger points, same for chi response being different from needling response. Dry needling is a tool in the physical therapist tool box. Regulations state that therapist shall obtain full consent from patient; including disclosure that patient is not receiving acupuncture.
Dorthea Martin (in favor)	Agree with previous gentlemen regarding education and continuing education. Previous physical therapists did exercises and manipulation, with no effect. Current one does dry needling, which has been life-changing. Aside from needles, completely different than acupuncture (trigger points, experience).
Judith Vaughn (in favor)	After rectal surgery was in tremendous pain, unaided by physician or specialists. Manipulation also ineffective, but dry needling "literally saved my life". Dry needling has also helped her plantar fasciitis in both feet, frozen shoulder and rotator cuff.
Amy Casdor-Gonzales (in favor)	Pursued numerous modalities for physical pain, but nothing helped until myofascial release physical therapy enhanced by dry needling. Physical therapists who practice this are well trained, studied hard, and know what they are doing
Juanita Puffinbarger (in favor)	My recovery would not be possible without dry needling. When dry needling began she understood it was not acupuncture. What is in place is more than adequate. Patient care should be primary purpose, regulations should keep them informed and covered.

Ian Scott (in favor)	Been all around the world and experienced numerous remedies and solutions, including acupuncture. Used dry needling as alternative to surgery and now pain free, with complete function.
Susan Stuart (in favor)	Quality of life was poor, scared of needles, multiple pain management doctors. Directed to dry needles instead of opioids. Physical therapists explained procedures, showed exactly what they were doing and how muscles linked. Feels like physical therapists taught her more about her own body than Richmond's top neurosurgeon. Has gone in with level 10 pain and left after needling to go shopping, "miraculous".
Bruce Allen (in favor)	Chronic pain in right hip, traditional physical therapy offered no relief. Two session of dry needling did more than all previous therapy combined.
Yun Fan (opposed)	Acupuncture and dry needling is the same as a person changing clothes, they look different, but underneath are the same thing. There is no difference
Rebecca Reynolds (opposed)	Nurse practitioner, also acupuncturist and certified in dry needling. Dry needling acupuncture effective modality. Regulation as they stand now are not adequate to become proficient in dry needling (don't discuss pneumothorax, forbidden points in pregnancy).Orthopedic acupuncture is close to dry needling, which covers item B in proposed changes. Proposing that dry needling is not acupuncture (item C) is an alternative fact, a majority of dry needling points are classis acupuncture points or ashi points. Saying dry needling is not acupuncture is like saying kinesiology is not physical therapy. Dry needling is trigger point localized acupuncture.
Arthur Fan (opposed)	MD, PhD, RAC. Dry needling another name/form for acupuncture, according to WHO. Dry needling brought to Us by acupuncture researcher (Dr. Janet Travell) who used another name to attract more students. Indication and needling activity/techniques are the same as acupuncture. Education requirements are too low, allowing many other people to do it as well (nurse, MD, exercise trainer)
Aubrey Fisher (opposed)	Licensed acupuncturist. Commonwealth of Virginia defines acupuncture as "stimulation of certain points on or near the surface of the body by insertion of needles to prevent or modify the perception of pain or to normalize physiological functions..." Board of Physical Therapy defines dry needling as, "filiform needles to penetrate the skin and/or underlying tissues to affect changes in body structure and function for evaluation and management of neuromuscular conditions, pain, movement, impairments, and disabilities. This is a definition of acupuncture. Language used by Physical Therapists is same as what is already in acupuncture statutes. Acupuncture therapy includes treatment strategy of dry needling, including reactive points also known as hyperirritable loci or trigger points, to relieve musculoskeletal and connective tissue disorders. Acupuncture is more than energy flow and meridians, our channel systems are based on fascial, neurological, circulatory and muscular maps as they relate to body's anatomy and physiology,
Stephanie Penum (opposed)	Licensed acupuncturist in VA and AZ. Dry needling and trigger point dry needling is a term practiced by acupuncturists because it is a treatment strategy, not just a treatment modality. The North Carolina case, which was dismissed without prevalence, only occurred because the NC Board of Acupuncture did not exhaust all of their administrative processes; it was not a ruling in favor of dry needling for physical therapists. There is now another lawsuit pending against the North Carolina Board of Physical Therapy, as the Acupuncture Board has exhausted their methods. When the Texas Attorney General said it would most likely rule

	in favor of the Physical Therapy Board making trigger point dry needling within the scope of practice, which was an opinion not a ruling. These statements are misleading to the public and those reading the proposal. Adverse action reports have been sent out in other states, just not Virginia (Colorado- skier lung was punctured; Maryland- teachers nerve in leg was punctured; Arizona- needles were inserted through patients clothing and needles were disposed in public recycling bin; Georgia-dry needling was performed on a minor without consent from a parent/guardian).
Sarah Steed (opposed)	National Board Certified Acupuncturist. Had patients come to her practice that were injured by dry needling done by a physical therapist, which needed several treatments to recover. Had other patients who were not helped by pain medication, physical therapy, dry needling or chiropractic. There are side effects to dry needling, we just never hear about them.
Bridget Fox (opposed)	Registered Nurse turned acupuncturist. Specialization has occurred throughout human history, including subspecialties within professions. This is to benefit the patient. Physical therapy was borne out of this specialization, as an alternative to surgery. Good physical therapist should not have to do dry needling, rehab should not include needles. This regulation is grasping at another treatment option, "let me stick needles in him". Four years of acupuncture school only covers the tip of the iceberg, any less training is sad and will do more harm than good.
Sarah Hung (opposed)	Licensed acupuncturist. Dry needling is acupuncture, specifically a form of orthopedic acupuncture (taught in schools and has continuing education classes about). No minimum training standards in the regulations is a public safety concern, even though the American Medical Association recommends a minimum level for physical therapists similar to those for acupuncturists. Proposed courses also don't include clinical supervision. Medical doctors need 100 hours of clinical supervision to do acupuncture; it cannot just be a weekend course. I also support what everyone else on the opposed side has said.
Diane Lowry (opposed)	Licensed acupuncturist. The insertion of FDA regulated acupuncture needles into trigger points for providing therapeutic relief falls under the purview of acupuncture, dry needling is not distinct. Dry needling presents a threat to public safety without adequate education, supervised clinical training and independent competency examination. Dry needling is not safe, and injuries range from pneumothorax to nerve damage. This has caused insurance companies to call it an emerging area of risk. Additionally the draft regulation has no minimum training standard, which is against the American Medical Association policy.
Janet Borgess (opposed)	Licensed Acupuncturist. Modality of dry needling is physical intervention that uses filiform acupuncture needles to stimulate points on the body. Where and how to insert the needle is supposedly based only on Western medical concepts, which was the original intent of Janet Travell. Valuable modality; we all want to help our patients. However, dry needling, motor point needling, myofascial needling, trigger point needling, and integrated dry needling are all styles of acupuncture. The only difference is the training and intent of practitioner inserting needle. Licensed acupuncturists practice all of these styles. Regulations as they stand risk intentionally putting public in danger by allowing physical therapists to independently decide if they have advanced procedural skill. Physical therapists have reportedly been doing dry needling since 2003, without a 100% safety record. Current draft may make it more convenient for Board of Physical Therapy to protect itself from public

	complaint, but it does not protect public safety. Further, to have a patient sign a disclosure that says they are not receiving acupuncture and then treating with acupuncture is confusing and deceptive.
Ian Hurdibaugh (opposed)	Abstained from comment
Pamela Howard (opposed)	Licensed and board certified acupuncturist. In the last 4 years delivered over 10,000 treatments to over 1,000 patients. As a patient had great success with acupuncture to treat lateral epicondylitis. Continuing education classes for orthopedic acupuncture addresses motor points of the muscles of the body (class based on Dr. Janet Travell and Matt Calveston- an acupuncturist).
Kelly Sherman (opposed)	Board certified acupuncturist. Respect physical therapists scope of practice and the care they give their patients. Patient centered care to me is integrative care. That means I can refer patients to physical therapists for care and they can refer patients to me, to help in the form of trigger point therapy.
Matthew Stanley (opposed)	Representing Acupuncture Society of Virginia. The Society is opposed to physical therapists practicing procedure called dry needling, as it falls under scope of practice of acupuncture, defined by Virginia Statute pursuant to section 54.12-900. Not been demonstrated how dry needling does not fit under such definition. No statute that provides legal authority for physical therapists or any other health practitioners to expand scope of practice via regulation to include dry needling. We believe Board of Physical Therapy is in violation of state law. Proposed regulation identifies it as an advanced procedure that requires advanced training but does not recommend or require any specific post graduate training hours (can be completed in as little as a weekend with no prior experience in the safe use of needles). Number of serious injuries from dry needling, which cause the American Medical Association to become critical of the lax regulation and nonexistent standards around this invasive procedure (need to meet standards required for acupuncturists and physicians to keep patients safe). Largest company insuring physical therapists called it an emerging area of risk. No provision of these regulations provides protections for patient safety. Acupuncturists in Virginia need at least 1,365 hours of acupuncture specific training, including 775 hours of didactic material specific to acupuncture and 660 hours of supervised clinical training. Even medical doctors with training in use of invasive medical devices need 300 hours of training in acupuncture (more than a weekend). No difference in training requirements for physical therapists without doctorate level degree and entry level physical therapists with less than two years of training. Virginia Department of Planning and Budget Economic Impact Analysis of the regulation state that "54 hours of professional training is required under the existing guidance, while the proposed regulation does not state a specific number of training hours".

Comments posted on the Virginia Regulatory Townhall

Of the 2051 comments posted on the Townhall, there were 1786 unique comments (not duplicated by multiple entries).

There were 610 in support of the proposed regulation. Comments in support included:

- Great clinical utility (important tool in "toolbox")
    - Should be adjunct modality offered with additional continuing education and certification
        - More specific and effective than ultrasound in releasing chronic contracted muscles
        - Mandate reporting of any patient injuries to track whether training is sufficient
    - Recognition of "open access" to a physical therapist's treatment must be maintained
    - Insurance will usually cover dry needling but not acupuncture
- Physical Therapists help people move better- dry needling provides relief of musculoskeletal/ nervous system deficits
- Not the same as acupuncture
    - Inactivate muscular trigger points; useful in pain control, muscle length/stretching, and neuromuscular re-education
        - Can be done without pain medication
        - Targeting only skeletal muscles
        - Helpful with fibromyalgia, myofascial pain,
            - Trigger points and myofascial dysfunction are muscle disorders. The experts in muscle anatomy, physiology, function, and pathology are physical therapists
    - Focus on hyperirritable loci in muscle tissue
        - Dry needling is an extension of manual stimulation of trigger points
        - Differs from acupuncture in clinical reasoning, technique and goal of treatment
        - Only similarity is needle being used
    - Trigger point dry needling focuses on targeting specific muscles that can lead to pain and looks to minimize the presents of active trigger points which have been associated with various types of pain. Acupuncture focuses on meridians and energy flow to restore balance within the body's system.
- Education requirement for certificate (50ish hours)
    - PTs know anatomy, physiology, neuromuscular re-education, soft tissue dysfunction
    - FSMB study shows 86% of KSA required for dry needling is obtained when graduating from accredited program
- Don't let doctors dictate PT practices
    - Physician referral only adds to bureaucratic issues/red tape

There were 1176 comments opposed to the proposed regulations. Comments in opposition included:

- Educational requirements not strict enough
    - Not as strict educational requirements (20-30 hours vs MD education and 300 hours in acupuncture)
        - Outside scope of practice for physical therapist
            - Could damage internal organs (lungs, liver) along with nerves that PTs don't have training in
            - Invasive procedure
        - Need certification of clean needle techniques
        - Mixture of Eastern and Western Medicine (PTs have no eastern training)
            - Regulations have no minimum for training
        - Follow California's example
    - No independent, agency-accredited training programs for "dry needling," no standardized curriculum, no means of assessing the competence of instructors in the field, and no independently administered competency examinations
    - Give acupuncturist PT designation if dry needling is to fall under that scope of practice
- Comparison to acupuncture
    - Existence of trigger points as primary sources of pain has never been confirmed
        - Does not work beyond contextual effects (neurophysical phenomenon)
        - No animal model to study trigger points, can't confirm existence as local pathophysiology
    - Simplified acupuncture- same techniques, tools, indications, same points (just different names)
        - Trigger points are acupoints or ASHI points
    - WHO, AMA and AAPMR has clear definition that dry needling is acupuncture (non physicians should have 1500 hours training)
        - Constitutes acupuncture under VA and FDA law currently
        - medicalacupuncture.org/Portals/2/PDFs/AAMADryNeedlingPolicyOct15.pdf
        - https://www.aapmr.org/practice/resources/positionpapers/AAPMR%20Documents/AAPMR-Position-on-Dry-Needling.pdf
- Public safety risk having PT's do it (public confusion, lower quality of treatment)
    - Minimizes therapeutic value of acupuncture
- PTs trying to capture market share
- American Society of Acupuncturist position
    - Dry needling pseudonym for acupuncture that has been adopted by health providers who lack legal ability to practice acupuncture within scope of practice
    - American Academy of Medical Acupuncture set industry standard of 300 hours of postdoctoral training with examination at end by independent testing board

18VAC112-11-70. Appointment of Regulatory Advisory Panel.

A. The agency may appoint a regulatory advisory panel (RAP) to provide professional specialization or technical assistance when the agency determines that such expertise is necessary to address a specific regulatory issue or action or when individuals indicate an interest in working with the agency on a specific regulatory issue or action.

B. Any person may request the appointment of a RAP and request to participate in its activities. The agency shall determine when a RAP shall be appointed and the composition of the RAP.

C. A RAP may be dissolved by the agency if:

1. The proposed text of the regulation is posted on the Town Hall, published in the Virginia Register, or such other time as the agency determines is appropriate; or

2. The agency determines that the regulatory action is either exempt or excluded from the requirements of the Administrative Process Act.

Statutory Authority

§§ 2.2-4007.02 and 54.1-2400 of the Code of Virginia.

Historical Notes

Derived from Volume 25, Issue 01, eff. October 15, 2008.

Agenda Item: Board action on Petition for Rulemaking

Included in your agenda package are:

Copy of petition

A copy of the applicable sections of regulations

A copy of comment from the Virginia Physical Therapy Association

Board action:

To accept Ms. Belmont's petition and initiate rulemaking with adoption of a NOIRA; or to take no action to amend regulations (the reasons for declining to initiate rulemaking must be stated by the Board).

COMMONWEALTH OF VIRGINIA
Board of Physical Therapy

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4674 (Tel)
(804) 527-4413 (Fax)

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix,)

Belmont Peggy H, P.T. for Virginia Physical Therapy Association Pediatric Special Interest Group (PSIG)

Street Address	Area Code and Telephone Number	
9909 Shady Slope Court	703-455-5644	
City	**State**	**Zip Code**
Fairfax Station	Virginia	22039
Email Address (optional)	**Fax (optional)**	
pbelmont@cox.net		

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

   118 VAC 112-20-131 B-1; Continued Competency Requirements for Renewal of an Active License

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule

   Under B-1, add: "(i) The Virginia Occupational Therapy Association, and, (j) The American Occupational Therapy Association".

   The proposed change would expand the list of authorized Type I Continued Competency coursework providers for PTs/PTAs providing early intervention and special education services to children under the IDEA Law. The VOTA/ AOTA Coursework is uniquely relevant to the special education and early intervention regulations and environment in which PTs/PTAs work. None of the providers currently listed offer coursework specific to this setting.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

   Section 54.1-2400

Signature: **Date:**

18VAC112-20-131. Continued Competency Requirements for Renewal of an Active License.

A. In order to renew an active license biennially, a physical therapist or a physical therapist assistant shall complete at least 30 contact hours of continuing learning activities within the two years immediately preceding renewal. In choosing continuing learning activities or courses, the licensee shall consider the following: (i) the need to promote ethical practice, (ii) an appropriate standard of care, (iii) patient safety, (iv) application of new medical technology, (v) appropriate communication with patients, and (vi) knowledge of the changing health care system.

B. To document the required hours, the licensee shall maintain the Continued Competency Activity and Assessment Form that is provided by the board and that shall indicate completion of the following:

1. A minimum of 20 of the contact hours required for physical therapists and 15 of the contact hours required for physical therapist assistants shall be in Type 1 courses. For the purpose of this section, "course" means an organized program of study, classroom experience or similar educational experience that is directly related to the clinical practice of physical therapy and approved or provided by one of the following organizations or any of its components:

a. The Virginia Physical Therapy Association;

b. The American Physical Therapy Association;

c. Local, state or federal government agencies;

d. Regionally accredited colleges and universities;

e. Health care organizations accredited by a national accrediting organization granted authority by the Centers for Medicare and Medicaid Services to assure compliance with Medicare conditions of participation;

f. The American Medical Association - Category I Continuing Medical Education course; and

g. The National Athletic Trainers' Association.

2. No more than 10 of the contact hours required for physical therapists and 15 of the contact hours required for physical therapist assistants may be Type 2 activities or courses, which may or may not be offered by an approved organization but which shall be related to the clinical practice of physical therapy. Type 2 activities may include but not be limited to consultation with colleagues, independent study, and research or writing on subjects related to practice.

3. Documentation of specialty certification by the American Physical Therapy Association may be provided as evidence of completion of continuing competency requirements for the biennium in which initial certification or recertification occurs.

4. Documentation of graduation from a transitional doctor of physical therapy program may be provided as evidence of completion of continuing competency requirements for the biennium in which the physical therapist was awarded the degree.

5. A physical therapist who can document that he has taken the PRT may receive 10 hours of Type 1 credit for the biennium in which the assessment tool was taken. A physical therapist who can document that he has met the standard of the PRT may receive 20 hours of Type 1 credit for the biennium in which the assessment tool was taken.

C. A licensee shall be exempt from the continuing competency requirements for the first biennial renewal following the date of initial licensure by examination in Virginia.

D. The licensee shall retain his records on the completed form with all supporting documentation for a period of four years following the renewal of an active license.

E. The licensees selected in a random audit conducted by the board shall provide the completed Continued Competency Activity and Assessment Form and all supporting documentation within 30 days of receiving notification of the audit.

F. Failure to comply with these requirements may subject the licensee to disciplinary action by the board.

G. The board may grant an extension of the deadline for continuing competency requirements for up to one year for good cause shown upon a written request from the licensee prior to the renewal date.

H. The board may grant an exemption for all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

Statutory Authority

§ 54.1-2400 of the Code of Virginia.

Historical Notes

Derived from Volume 19, Issue 01, eff. October 23, 2002; amended, Virginia Register Volume 25, Issue 18, eff. June 10, 2009; Volume 25, Issue 26, eff. September 30, 2009; Volume 29, Issue 21, eff. July 17, 2013; Volume 29, Issue 25, eff. September 26, 2013; Volume 32, Issue 03, eff. November 4, 2015.

Virginia.gov Agencies | Governor

Logged in as
Elaine J. Yeatts

Agency **Department of Health Professions**

Board **Board of Physical Therapy**

Chapter **Regulations Governing the Practice of Physical Therapy [18 VAC 112 - 20]**

Back to List of Comments

Commenter: Joshua Bailey, VPTA President * 1/20/17 3:25 pm

VPTA and VOTA are opposed to AOTA or VOTA as being type I CEU approved providers

After consultation with the VOTA President, Erin Clements, the VPTA would oppose having the AOTA or VOTA as approved providers of type I CEUs. Ms. Clements, of the VOTA, advises that the AOTA and VOTA are currently employing a lobbyist to assist in legislation to align the AOTA and NCBOT for type I CEU requirements (volume and quality). These credentialing bodies are currently not in sync and subsequently the quality of the CEU requirements could and likely will be altered. Allowing the AOTA or VOTA to approve course at this time would not be in the best interests of Physical Therapists at this time.

I have spoken to Peggy Belmont and she is in agreement and will request to withdraw her petition.

Thank you for your time and consideration.

Josh Bailey, PT, DPT, OCS, CSCS, CPed

President, Virginia Physical Therapy Association.

* Nonregistered public user

~~**Guidance Document 112-2**~~

Board of Physical Therapy

CONFIDENTIAL CONSENT AGREEMENTS

Virginia Code §54.1-2400(14) authorizes the health regulatory boards to resolve certain allegations of practitioner misconduct by means of a Confidential Consent Agreement ("CCA"). This agreement may be used by a board in lieu of public discipline, but only in cases involving minor misconduct and non-practice related infractions, where there is little or no injury to a patient or the public, and little likelihood of repetition by the practitioner.

A CCA shall not be used if the board determines there is probable cause to believe the practitioner has (i) demonstrated gross negligence or intentional misconduct in the care of patients or (ii) conducted his/her practice in such a manner as to be a danger to the health and welfare of patients or the public.

A CCA shall be considered neither a notice nor an order of a health regulatory board, both of which are public documents. The acceptance and content of a CCA shall not be disclosed by either the board or the practitioner who is the subject of the agreement.

A CCA may be offered and accepted at any time prior to the issuance of a notice of informal conference by the board. By law, the agreement document must include findings of fact and may include an admission or a finding of a violation. A CCA may be considered by the board in future disciplinary proceedings. A practitioner may only enter into two confidential consent agreements involving a standard of care violation within a 10-year period. The practitioner shall receive public discipline for any subsequent violation within the 10-year period following the entry of two CCAs unless the board finds that there are sufficient facts and circumstances to rebut the presumption that such further disciplinary action should be made public.

Violations of regulation or statute that may qualify for resolution by a Confidential Consent Agreement include, but are not limited to:

~~On October 24, 2003, the Board of Physical Therapy adopted the following recommendations for use of CCA's with alleged violations in:~~

- ~~Supervision of PTA by PT does not meet requirements in regulations~~
- ~~PTA treats beyond supervisory period as defined in regulations~~
- ~~Treating from official prescription pad without original MD signature~~
- ~~Documentation not completed in a timely manner~~
- *Inadvertent* HIPPAA/confidentiality violation
- ~~Exceeding script (i.e. number of treatments)~~
- ~~Exceeding 14 days before referring back to MD~~
- ~~Not following script exactly (i.e. using ice instead of heat)~~
- *Exceeding scope of referral (i.e. number of treatments)*
- ~~Failure to provide proof of clinical competency hours for re-licensure~~
- *First violation regarding continued competency (see Guidance Document 112-22)*
- *First violation of advertising regulations*

Virginia Board of Physical Therapy

Procedures for Auditing Continued Competency Requirements

1. The Board of Physical Therapy ~~within the Department of Health Professions~~ *may* audits~~:~~ a random sample of licensees to investigate compliance with the Board's continuing competency requirements and active practice requirements. ~~and reports the results of the audits to the Board.~~ *The Board may also audit active licensees, who by terms of a Confidential Consent Agreement (CCA) or Pre-Hearing Consent Order (PHCO), are required to take continuing education (CE) courses in addition to the continued competency requirements for renewal of a license.*

2. Board staff reviews each audit report and either:
   a. Sends an acknowledgement letter of fulfillment of the continuing competency requirements and active practice requirements, or
   b. Opens a case for probable cause.

3. Once a case is opened for probable cause, *Board* staff may:

   a. Issue a CCA if the licensee was truthful in responding to the renewal attestation and the licensee has not previously been found in violation of CE or active practice requirements.

   For those licensees who fail to meet the CE requirements, the CCA shall require the licensee to submit proof of completion of the missing contact hours(s) within 90 days of the effective date of the CCA. Such contact hours cannot be used toward fulfillment of the next biennial CE requirement for renewal.

   For those licensees who fail to meet the active practice requirements, the CCA shall require the licensee to submit proof that they meet the Board-approved standard on the current assessment and continuing competency tool as developed and administered by the FSBPT within 90 days of CCA entry.

   b. Issue a ~~Pre-Hearing Consent Order (~~PHCO~~)~~ ~~specifying the sanctions if applicable~~ *if the licensee was not truthful in responding to the renewal attestation or the licensee has previously been found in violation of CE or active practice requirements. The following sanctions shall apply:*
      i) Monetary Penalty of $100 per missing contact hour, *up to a maximum of $1,000;*
      ii) Monetary Penalty of $300 for a fraudulent renewal certification; and
         a) For those licensees who fail to meet the CE requirements, require submission of proof of completion of the missing contact hour(s) within 90 days of Order entry. These contact

hours cannot be used toward the next ~~annual~~ *biennial* requirement for renewal.

b) For those licensees who fail to meet the active practice requirements, ~~they must take the FSBPT Practice Review Tool (PRT)~~ *require documentation that they meet the Board-approved standard on the current assessment and continuing competency tool as developed and administered by the FSBPT* within 90 days of Order entry. ~~If they are also found deficient in meeting the continuing competency requirements, they may also earn credit by taking and passing the PRT.~~

4. The case will be referred to an informal fact-finding conference if the licensee:

1. Fails to respond to the audit or does not wish to sign the CCA or PHCO that is offered; or
2. Has previously been disciplined pursuant to a Board Order for not meeting the CE requirements.

~~c. If the licensee fails to respond to the audit or does not wish to sign the offered PHCO, the case will be referred to an informal fact-finding conference (IFC).~~

~~d. If the licensee has been previously disciplined for not meeting the continuing competency requirements, the matter will be referred directly to an IFC.~~

Sanctioning Reference Points

SANCTIONING REFERENCE POINTS

INSTRUCTION MANUAL

Board of Physical Therapy

Prepared for
Virginia Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Richmond, Virginia 23233
804-367-4400 tel

Prepared by
VisualResearch, Inc.
Post Office Box 1025
Midlothian, Virginia 23113
804-794-3144 tel
www.vis-res.com

November 2009
(Revised May 2012)

Guidance Document 112-17

COMMONWEALTH OF VIRGINIA

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Director

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November 2009

Dear Interested Parties:

In the spring of 2001, the Virginia Department of Health Professions approved a workplan to study sanctioning in disciplinary cases for Virginia's 13 health regulatory boards. The purpose of the study was to *"...provide an empirical, systematic analysis of board sanctions for offenses and, based on this analysis, to derive reference points for board members..."* The purposes and goals of this study are consistent with state statutes which specify that the Board of Health Professions periodically review the investigatory and disciplinary processes to ensure the protection of the public and the fair and equitable treatment of health professionals.

Each health regulatory board hears different types of cases, and as a result, considers different factors when determining an appropriate sanction. After interviewing selected Board of Physical Therapy members and staff, a committee of Board members, staff, and research consultants assembled a research agenda involving one of the most exhaustive statistical studies of sanctioned Physical Therapists in the United States. The analysis included collecting over 50 factors on all Board of Physical Therapy sanctioned cases in Virginia over a 10-year period. These factors measured case seriousness, respondent characteristics, and prior disciplinary history. After identifying the factors that were consistently associated with sanctioning, it was decided that the results provided a solid foundation for the creation of sanction reference points. Using both the data and collective input from the Board of Physical Therapy and staff, analysts spent several months developing a usable sanction worksheet as a way to implement the reference system.

One of the most important features of this system is its voluntary nature; that is, the Board is encouraged to depart from the reference point recommendation when aggravating or mitigating circumstances exist. The Sanctioning Reference Points system attempts to model the *typical* Board of Physical Therapy case. Some respondents will be handed down sanctions either above or below the SRP recommended sanction. This flexibility accommodates cases that are particularly egregious or less serious in nature.

Equally important to recommending a sanction, the system allows each respondent to be evaluated against a common set of factors—making sanctioning more predictable, providing an educational tool for new Board members, and neutralizing the possible influence of "inappropriate" factors (e.g., race, sex, attorney presence, identity of Board members). As a result, the following reference instrument should greatly benefit Board members, health professionals and the general public.

Sincerely yours,

Sandra Whitley Ryals
Director

Cordially,

Elizabeth A. Carter, Ph.D.
Executive Director
Virginia Board of Health Professions

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Sanctioning Reference Points Forms

General Instructions

Overview

The Virginia Board of Health Professions has spent the last 7 years studying sanctioning in disciplinary cases. The study is examining all 13 health regulatory boards, with the greatest focus most recently on the Board of Physical Therapy. The Board of Physical Therapy is now in a position to implement the results of the research by using a set of voluntary *Sanctioning Reference Points*. This manual contains some background on the project, the goals and purposes of the system, and the offense-based sanction worksheet that will be used to help Board members determine how a similarly situated respondent has been treated in the past. This sanctioning system is based on a specific sample of cases, and thus only applies to those persons sanctioned by the Virginia Board of Physical Therapy. Moreover, the worksheet has not been tested or validated on any other groups of persons. Therefore, they should not be used at this point to sanction respondents coming before other health regulatory boards, other states, or other disciplinary bodies.

The Sanctioning Reference system is comprised of a single worksheet which scores case type, offense and respondent factors identified using statistical analysis. These factors have been isolated and tested in order to determine their influence on sanctioning outcomes. Sanctioning thresholds found on the worksheet recommend a range of sanctions from which the Board may select in a particular case.

In addition to this instruction booklet, separate coversheets and worksheets are available to record Board specific information, the recommended sanction, the actual sanction and any reasons for departure (if applicable). The completed coversheets and worksheets will be evaluated as part of an on-going effort to monitor and refine the SRPs. These instructions and the use of the SRP system fall within current Department of Health Professions and Board of Physical Therapy policies and procedures. Furthermore, all sanctioning recommendations are those currently available to and used by the Board and are specified within existing Virginia statutes.

Background

In April of 2001, the Virginia Board of Health Professions (BHP) approved a work plan to conduct an analysis of health regulatory board sanctioning and to consider the appropriateness of developing historically-based SRPs for health regulatory boards, including the Board of Physical Therapy. The Board of Health Professions and project staff recognize the complexity and difficulty in sanction decision-making and have indicated that for any sanction reference system to be successful, it must be ***"developed with complete Board oversight, be value-neutral, be grounded in sound data analysis, and be totally voluntary"***—that is, the system is viewed strictly as a Board decision tool.

Goals

The Board of Health Professions and the Board of Physical Therapy cite the following purposes and goals for establishing Sanctioning Reference Points:

- Making sanctioning decisions more predictable
- Providing an education tool for new Board members
- Adding an empirical element to a process/system that is inherently subjective
- Providing a resource for the Board and those involved in proceedings.
- "Neutralizing" sanctioning inconsistencies
- Validating Board member or staff recall of past cases
- Constraining the influence of undesirable factors—e.g., Board member ID, overall Board makeup, race or ethnic origin, etc.
- Helping predict future caseloads and need for probation services and terms

Methodology

The fundamental question when developing a sanctioning reference system is deciding whether the supporting analysis should be grounded in historical data (*a descriptive approach*) or whether it should be developed normatively (*a prescriptive approach*). A normative approach reflects what policymakers feel sanction recommendations *should be*, as opposed to what they *have been*. SRPs can also be developed using historical data analysis with normative adjustments to follow. This approach combines information from past practice with policy adjustments, in order to achieve some desired outcome. The Board of Physical Therapy chose a descriptive approach with normative adjustments.

Methodology, continued

■ Qualitative Analysis

Researchers conducted in-depth personal interviews with past and present Board members, Board staff, and representatives from the Attorney General's office. The interview results were used to build consensus regarding the purpose and utility of SRPs and to further frame the analysis. Additionally, interviews helped ensure the factors considered when sanctioning were included during the quantitative phase of the study. A literature review of sanctioning practice across the United States was also conducted.

■ Quantitative Analysis

Researchers analyzed detailed information on Physical Therapy disciplinary cases ending in a violation between 1999 and 2009; approximately 21 sanctioning "events." Over 50 different factors were collected on each case in order to describe the case attributes Board members identified as potentially impacting sanction decisions. Researchers used data available through the DHP case management system combined with primary data collected from hard copy files. The hard copy files contained investigative reports, Board notices, Board orders, and all other documentation that is made available to Board members when deciding a case sanction.

A comprehensive database was created to analyze the offense and respondent factors which were identified as potentially influencing sanctioning decisions. Using statistical analysis to construct a "historical portrait" of past sanctioning decisions, the significant factors along with their relative weights were derived. These factors and weights were formulated into a sanctioning worksheet with four thresholds, which are the basis of the SRPs.

Offense factors such as financial gain and case severity (priority level) were analyzed as well as prior history factors such as substance abuse, and previous Board orders. Some factors were deemed inappropriate for use in a structured sanctioning reference system. For example, respondent gender was considered an "extra-legal" factor, and was explicitly excluded from the SRPs. Although many factors, both "legal" and "extra-legal" can help explain sanction variation, only those "legal" factors the Board felt should consistently play a role in a sanction decision were included in the final product. By using this method, the hope is to achieve more neutrality in sanctioning, by making sure the Board considers the same set of "legal" factors in every case.

Wide Sanctioning Ranges

The SRPs consider and weigh the circumstances of an offense and the relevant characteristics of the respondent, providing the Board with a sanction range that encompasses roughly 85% of historical practice. This means that 15% of past cases had received sanctions either higher or lower than what the reference points indicate, acknowledging that aggravating and mitigating factors play a role in sanctioning. The wide sanctioning ranges recognize that the Board will sometimes reasonably disagree on a particular sanction outcome, but that a broad selection of sanctions falls within the recommended range.

Any sanction recommendation the Board derives from the SRP worksheets must fall within Virginia law and regulations. If a Sanctioning Reference Point worksheet recommendation is more or less severe than a Virginia statute or DHP regulation, the existing laws or policies supercede any worksheet recommendation.

The Sanctioning Factors

The Board indicated early in the study that sanctioning is influenced by a variety of circumstances. The empirical analysis supported the notion that not only do case types affect sanctioning outcomes, but certain offense, respondent and prior record factors do as well. To this end, the Physical Therapy SRP system scores two groups of factors in order to arrive at a sanctioning recommendation. The first set of factors relates to the case type. The second group relates to elements of the offense, the respondent, and his or her prior record.

Therefore, a respondent before the Board for a fraud case will receive points for the type of case and can potentially receive points for act of commission, multiple patient involvement, and/or for having a history of disciplinary violations.

Four Sanctioning Thresholds

The SRP worksheet uses four thresholds for recommending a sanction. Once all factors are scored, the corresponding points are then added for a total worksheet score. The total is used to locate the sanctioning threshold recommendation found at the bottom of the worksheet. For instance, a respondent having a total worksheet score of 40 would be recommended for a Reprimand/ Monetary Penalty.

Voluntary Nature

The SRP system is a tool to be utilized by the Board of Physical Therapy. Compliance with the SRPs is voluntary. The Board will use the system as a reference tool and may choose to sanction outside the recommendation. The Board maintains complete discretion in determining the sanction handed down. However, a structured sanctioning system is of little value if the Board is not provided with the appropriate coversheet and worksheet in every case eligible for scoring. A coversheet and worksheet should be completed in cases resolved by Informal Conferences and Pre-Hearing Consent Orders. The SRPs can also be referenced and used by agency subordinates where the Board deems appropriate. The coversheet and worksheet will be referenced by Board members during Closed Session.

Worksheets Not Used in Certain Cases

The SRPs will not be applied in any of the following circumstances:

- Formal Hearings — SRPs will not be used in cases that reach a Formal Hearing level.
- Mandatory Suspensions – Virginia law requires that under certain circumstances (conviction of a felony, declaration of legal incompetence or incapacitation, license revocation in another jurisdiction) the licensee must be suspended. The sanction is defined by law and is therefore excluded from the SRPs system.
- Compliance/Reinstatements – The SRPs should be applied to new cases only.
- Action by another Board – When a case which has already been adjudicated by a Board from another state appears before the Virginia Board of Physical Therapy, the Board often attempts to mirror the sanction handed down by the other Board. The Virginia Board of Physical Therapy usually requires that all conditions set by the other Board are completed or complied with in Virginia. The SRPs do not apply as the case has already been heard and adjudicated by another Board.
- Confidential Consent Agreements (CCA) – SRPs will not be used in cases settled by CCA.

Case Selection When Multiple Cases Exist

When multiple cases have been combined into one "event" (one order) for disposition by the Board, only one coversheet and worksheet should be completed and it should encompass the entire event. If a case (or set of cases) has more than one case type only one is selected for scoring according to the case type that appears highest on the following table and receives the highest point value. For example, a respondent found in violation for an inspection deficiency and falsification/alteration of patient records would receive twenty points, since Fraud is above Business Practice Issues/Other on the list and receives the most points. If a case type is not listed, find the most analogous one and use the appropriate score.

Sanctioning Reference Points Case Type Table

Case Type	Included Case Categories	Applicable Points
Abuse/Impairment/ Inappropriate Relationship	• Any sexual assault or mistreatment of a patient • Impairment due to use of alcohol, illegal substances, or prescription drugs • Incapacitation due to mental, physical or medical conditions • Dual, sexual, or other boundary issue. Includes inappropriate touching and written or oral communications	40
Fraud	• Performing unwarranted/unjust services • Falsification/alteration of patient records • Improper patient billing • Falsification of licensing/renewal documents	20
Standard of Care	• Instances in which the diagnosis/treatment was improper, delayed, or unsatisfactory. Also includes failure to diagnose/treat & other diagnosis/treatment issues. • Practicing a profession or occupation without holding a valid license as required by statute or regulation to include: practicing on a revoked, suspended, lapsed, non-existent or expired license, as well as aiding and abetting the practice of unlicensed activity • Failure to obtain or document CE requirements	15
Business Practice Issues/Other	• Records, inspections, audits • Required report not filed	10

Completing the Coversheet and Worksheet

Ultimately, it is the responsibility of the Board to complete the SRP coversheet and worksheet in all applicable cases.

The information relied upon to complete a coversheet and worksheet is derived from the case packet provided to the Board and respondent. It is also possible that information discovered at the time of the informal conference may impact worksheet scoring. The SRP coversheet and worksheet, once completed, are confidential under the Code of Virginia. However, copies of the SRP Manual, including blank coversheets and worksheets, can be found on the Department of Health Professions web site: www.dhp.virginia.gov (paper copy also available on request).

Scoring Factor Instructions

To ensure accurate scoring, instructions are provided for scoring each factor on the SRP worksheet. When scoring a worksheet, the numeric values assigned to a factor on the worksheet ***cannot be adjusted***. The scoring weights can only be applied as 'yes or no'- with all or none of the points applied. In instances where a scoring factor is difficult to interpret, the Board has final say in how a case is scored.

Coversheet

The coversheet is completed to ensure a uniform record of each case and to facilitate recordation of other pertinent information critical for system monitoring and evaluation.

If the Board feels the sanctioning threshold does not recommend an appropriate sanction, the Board is encouraged to depart either high or low when handing down a sanction. If the Board disagrees with the sanction recommendation and imposes a sanction greater or less than the recommended sanction, a short explanation should be recorded on the coversheet to explain the factors or reasons for departure. This process will ensure worksheets are revised appropriately to reflect current Board practice. If a particular reason is continually cited, the Board can examine the issue more closely to determine if the worksheets should be modified to better reflect Board practice.

Coversheet, continued

Aggravating and mitigating circumstances that may influence Board decisions can include, but should not be limited to, such things as:

- Prior record
- Dishonesty/Obstruction
- Motivation
- Remorse
- Restitution/Self-corrective action
- Multiple offenses/Isolated incident

A space is provided on the coversheet to record the reason(s) for departure. Due to the uniqueness of each case, the reason(s) for departure may be wide-ranging. Sample scenarios are provided on the adjacent page:

Departure Example #1
Sanction Threshold Recommendation: Recommend Formal or Accept Surrender
Imposed Sanction: Probation
Reason(s) for Departure: Respondent was particularly remorseful and had already begun corrective action.

Departure Example #2
Sanction Threshold Recommendation: Reprimand/ Monetary Penalty
Imposed Sanction: Probation, Terms – CE, Audit
Reason(s) for Departure: Respondent displayed a lack of knowledge that could be corrected with further education.

Determining a Specific Sanction

The bottom of the SRP worksheet lists four sanction thresholds that encompass a variety of specific sanction types. The table below lists the sanctions most often used by the Board that fall under each threshold. After considering the sanction recommendation, the Board should fashion a more detailed sanction(s) based on the individual case circumstances.

Sanctioning Reference Points Threshold Table

Worksheet Score	Available Sanctions
0-40	Reprimand Monetary Penalty Stayed Monetary Penalty
45-60	Reprimand Monetary Penalty Stayed Monetary Penalty Corrective Action Stayed Suspension Probation Terms: Continuing Education (CE) CE Audit Continue in therapy Employer quarterly reports HPIP Psychological evaluation Supervision Shall not seek/accept employment allowing contact with patients Shall not supervise
65-110	Corrective Action Stayed Suspension Probation Terms: Continuing Education (CE) CE Audit Continue in therapy Employer quarterly reports HPIP Psychological evaluation Supervision Shall not seek/accept employment allowing contact with patients Shall not supervise
115 or more	Suspension Revocation Accept Surrender Recommend Formal

Sanctioning Reference Points - Coversheet for Board of Physical Therapy

- Choose a *Case Type*.
- Complete the *Offense and Respondent Factor* section.
- Determine the *Recommended Sanction* using the scoring results and the *Sanction Thresholds*.
- Complete this Coversheet.

Case Number(s) ☐☐☐☐☐☐ ☐☐☐☐☐☐ ☐☐☐☐☐☐

Respondent Name _____
Last First

License Number _____

Case Type
- ☐ Abuse/Impairment/Inappropriate Relationship
- ☐ Fraud
- ☐ Standard of Care
- ☐ Business Practice Issues/Other

Sanction Threshold Result
- ☐ 0 - 40
- ☐ 45-60
- ☐ 65-110
- ☐ 115 or more

Imposed Sanction
- ☐ Reprimand
- ☐ Monetary Penalty - enter amount $_____
- ☐ Stayed Monetary Penalty - enter amount $_____
- ☐ Probation _____ months
- ☐ CE _____ hours
- ☐ CE Audit
- ☐ HPIP
- ☐ Stayed Suspension
- ☐ Suspension
- ☐ Revocation
- ☐ Accept Surrender
- ☐ Recommend Formal
- ☐ Other Sanction: _____

- ☐ Terms: _____

Reasons for Departure from Sanction Threshold Result _____

Worksheet prepared by: _____ Date completed: _____

Confidential pursuant to §54.1-2400.2 of the Code of Virginia.

Board of Physical Therapy - Sanctioning Reference Points Worksheet Instructions

Case Type

Step 1:
Case Type
(score only one)

Select the case type from the list and score accordingly. When multiple cases have been combined into one "event" (one order) for disposition by the Board, only one case type can be selected. If a case (or set of cases) has more than one case type only one is selected for scoring according to the case type that receives the highest point value.

Abuse/Impairment/Inappropriate Relationship – 40 Points
- Any sexual assault or mistreatment of a patient
- Impairment due to use of alcohol, illegal substances, or prescription drugs
- Incapacitation due to mental, physical or medical conditions
- Dual, sexual or other boundary issue. Includes inappropriate touching and written or oral communications.

Fraud – 20 Points
- Performing unwarranted/unjust services
- Falsification/alteration of patient records
- Improper patient billing
- Falsification of licensing/renewal documents

Standard of Care – 15 Points
- Instances in which the diagnosis/ treatment was improper, delayed, or unsatisfactory. Also includes failure to diagnose/treat & other diagnosis/ treatment issues.
- Practicing a profession or occupation without holding a valid license as required by statute or regulation to include: practicing on a revoked, suspended, lapsed, non-existent or expired license, as well as aiding and abetting the practice of unlicensed activity.
- Failure to obtain or document CE requirements.

Business Practice Issues/Other – 10 Points
- Records, inspections, audits
- Required report not filed

Offense & Respondent Factors

Step 2:
Offense and Respondent Factors
(score all that apply)

Score all factors relative to the totality of the case presented.

Enter "30" if a patient was intentionally or unintentionally injured.

Enter "30" if the respondent was impaired at the time of the offense due to substance abuse (alcohol or drugs) or mental/physical incapacitation.

Enter "30" if the case involved inappropriate physical contact. Inappropriate contact is indicated by the unwanted/unsolicited physical contact of a patient by the respondent. If this factor is scored, case category should be "Abuse/Impairment/Inappropriate Relationship."

Enter "30" if the respondent's license has been previously revoked, suspended, or summarily suspended by any state including Virginia. Sanctions other than those resulting in loss of license are not scored here.

Enter "20" if there was financial or material gain by the respondent.

Enter "20" if this was an act of commission. An act of commission is interpreted as purposeful or with knowledge.

Enter "20" if there was a concurrent civil or criminal action related to this case.

Enter "20" if the respondent has previously been sanctioned by any *other* state or entity. Sanctioning by an employer is not scored here. Sanctions resulting in loss of license are not scored here.

Enter "20" if the respondent has had any past difficulties in the following areas: drugs, alcohol, mental capabilities or physical capabilities. Scored here would be: prior convictions for DUI/DWI, inpatient/ outpatient treatment, and bona fide mental health care for a condition affecting his/her abilities to function safely or properly.

Enter "10" if the offense involves two or more patients. Patient involvement does not require direct contact with a patient. For instance, Fraud can occur with multiple patients.

Enter "10" if the respondent received a sanction from his/her employer in response to the current violation. A sanction from an employer may include: suspension, review, or termination.

Enter "10" if the respondent has any prior violations decided by the Virginia Board of Physical Therapy.

Enter "10" the respondent has any prior similar Virginia Board of Physical Therapy violations. Similar violations would be those listed under the same case type heading in Step 1.

Step 3:
Total Worksheet Score

Add Case Type and Offense and Respondent Factor Scores for a Total Worksheet Score

Step 4:
Determining the Sanction Recommendation

The Total Worksheet Score corresponds to the Sanctioning Reference Points recommended sanction located at the bottom of the worksheet. To determine the appropriate recommended sanction, find the range on the left that contains the Total Worksheet Score for the current worksheet. That range has a corresponding range of recommended sanctions. For instance, a Total Worksheet Score of 40 is recommended for "Reprimand/Monetary Penalty."

Step 5: Coversheet

Complete the coversheet including the SRP sanction result, the imposed sanction and the reasons for departure if applicable.

Board of Physical Therapy - Sanctioning Reference Points Worksheet

Case Type (score only **one**)	Points	Score
Abuse/Impairment/Inappropriate Relationship	40	
Fraud	20	
Standard of Care	15	
Business Practice Issues/Other	10	

score only one

Subtotal ____

Offense and Respondent Factors (score all that apply)

Patient injury	30	
Respondent impaired during incident	30	
Inappropriate physical contact	30	
License taken away by any state	30	
Financial gain or motivation	20	
Act of commission	20	
Concurrent civil or criminal action	20	
Sanctioned by another state or entity	20	
Past difficulties (drugs, alcohol, mental/cognitive, physical)	20	
Two or more patients involved	10	
Sanctioned by employer due to incident	10	
One or more prior VA Board of Physical Therapy violation	10	
Previous violation similar to current offense	10	

score all that apply

Subtotal ____

Total Worksheet Score (add all subtotals) ____

SCORE	Sanctioning Recommendations
0-40	Reprimand/Monetary Penalty
45-60	Reprimand/Monetary Penalty to Corrective Action
65-110	Corrective Action
115 or more	Recommend Formal or Accept Surrender

Respondent Name: _____ Date: _____

Confidential pursuant to § 54.1-2400.2 of the Code of Virginia

Health Practitioner's Monitoring Program

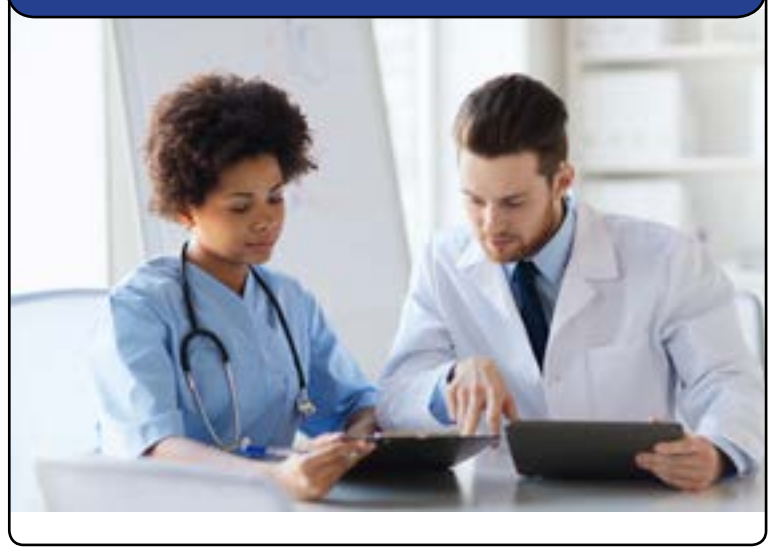
"Ensuring a Safe Return to Practice"

HEALTH PRACTITIONERS MONITORING PROGRAM

What is the HPMP?

The Health Practitioners Monitoring Program (HPMP) monitors the recovery of practitioners who may be impaired by chemical dependencies or who suffer from physical or mental disabilities. The Department of Health Professions (DHP) contracts with the Department of Psychiatry at the Virginia Commonwealth University Health System to provide confidential services for health practitioners enrolled in the HPMP. This voluntary program refers impaired practitioners to appropriate treatment and offers continuous monitoring of progress for participants. The HPMP Orientation Handbook provides further details about the HPMP program and monitoring process.

Am I Eligible?



In order to be eligible for participation in the program, you must hold one of the following documents issued by the Department of Health Professions:

- a current active license;
- a current Virginia certification;
- a current Virginia registration.

You may also be eligible for up to one year if you:

- are applying for licensure, certification or registration for the first time;
- are applying for a reinstatement of your license, certification or registration.

How do I contact HPMP?

Virginia HPMP
701 E Franklin St.
Suite 1407
Richmond, VA 23219

Email vahpmp@vcuhealth.org
Telephone: 1-866-206-4747
Hours: Mon-Fri 8:30 to 5:00 except Holidays

The mission of the Health Practitioners Monitoring Program (HPMP) is to provide an alternative to disciplinary action for impaired practitioners by providing comprehensive and effective monitoring services toward the goal of each participant's return to safe, productive practice.

What is the program?

The HPMP is designed to monitor healthcare professionals who are diagnosed with chemical dependency, mental impairment, or physical impairment. Participation in the program provides individualized referrals to assist a practitioner with their progress toward recovery, health and a safe return to practice.

How do I get started?

To enter the HPMP, a practitioner must contact **Virginia HPMP toll free at 1-866-206-4747**.

The HPMP website lists helpful resources and includes important information about the program. For additional information email HPMP at vahpmp@vcuhealth.org

Who can participate?

Participants include healthcare practitioners who may suffer from chemical dependency or who are impaired physically or mentally. Requirements are listed on the front of this publication.

What can I expect?

Interested practitioners must contact the intake representative at VA HPMP, and must sign a participation contract before entering the HPMP. If represented by an attorney, participants will be asked to sign a release of information form allowing the attorney access to their program information.

What is the cost?

Enrollment in the monitoring program is free. However, any costs associated with treatment and/or screening are the responsibility of the participant.

Will this result in disciplinary action?

In many cases, voluntary participation may avoid disciplinary action and, in the absence of criminal behavior or Board action, public records may not be generated.