Virginia Department of Health Professions
Board of Medicine

Welcome to the Advisory Board on Occupational Therapy

The Virginia Board of Medicine will hold an electronic meeting of the Advisory Board on Occupational Therapy on **May 25, 2021 at 10:00 A.M.** This meeting will be supported by Cisco WebEx Meetings application.

For the best WebEx experience, you may wish to download the Cisco WebEx Meeting application on your mobile device, tablet or laptop in advance of the meeting. Please note that WebEx will make an audio recording of the meeting for posting

This electronic meeting is deemed warranted under Amendment 28 to HB29 based on that requiring in-person attendance by the Advisory Board members is impracticable or unsafe to assemble in a single location.

Comments will be received from those persons who have submitted an email to william.harp@dhp.virginia.gov no later than 8:00 a.m. on May 24, 2021 indicating that they wish to offer comment. Comment may be offered by these individuals when their names are announced by the chairman.

Whether you are a member of the Advisory Board or a member of the public, you can join the meeting in the following ways.

- **JOIN by WEBEX**

https://covaconf.webex.com/covaconf/j.php?MTID=mda895e4f961fee1da0e5c4d9ef69b494

Meeting number (access code): 161 708 4868
Meeting password: Us65taRZeH6

- **JOIN BY PHONE**

+1-517-466-2023 US Toll
+1-866-692-4530 US Toll Free
Meeting number (access code): 161 708 4868

TECHNICAL DIFFICULTIES: Should you experience technical difficulties, you may call the following number: (804) 339-0627 for assistance. Any interruption in the telephonic or video broadcast of the meeting shall result in the suspension of action at the meeting until repairs are made and public access is restored.

The Board of Medicine and the Freedom of Information Act Council are interested in your evaluation of the electronic experience of this meeting. You can provide comment via the following form **HERE**.

Advisory Board on Occupational Therapy

Virginia Board of Medicine

May 25, 2021

10:00 am

Advisory Board on Occupational Therapy

Board of Medicine

Tuesday, May 25, 2021 @ 10:00 a.m.

9960 Mayland Drive, Suite 300, Henrico, VA

Electronic Meeting

<<<DRAFT UNAPPROVED>>>

ADVISORY BOARD ON OCCUPATIONAL THERAPY

Minutes

January 26, 2021

Electronic Meeting

The Advisory Board on Occupational Therapy held a virtual meeting on Tuesday, January 26, 2021 hosted at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT:	Breshae Bedward, Chair Dwayne Pitre OT, Vice-Chair Kathryn Skibek, OT
MEMBERS ABSENT:	Raziuddin Ali, MD Karen Lebo, JD, Citizen Member
STAFF PRESENT:	William L. Harp, MD, Executive Director Michael Sobowale, LLM, Deputy Director, Licensing Elaine Yeatts, DHP Senior Policy Analyst Jennifer Deschenes, Deputy Director, Discipline ShaRon Clanton, Licensing Specialist
GUESTS PRESENT:	Chris McCormick, Public Lindsay Sessa, Public

CALL TO ORDER

Breshae Breward, Chair, called the meeting to order at 10:15a.m.

EMERGENCY EGRESS PROCEDURES

Breshae Breward announced the emergency egress instructions for those that may be attending the virtual meeting in the Perimeter Center.

ROLL CALL

Roll was called, and a quorum declared.

APPROVAL OF MINUTES of OCTOBER 6, 2020

Ms. Skibek moved to approve the minutes of the October 6, 2020 meeting. Mr. Pitre seconded the motion. By roll call vote, the minutes were approved as presented.

ADOPTION OF AGENDA

Ms. Skibek moved to approve the adoption of the agenda. The motion was seconded by Mr. Pitre. By a roll call vote, the meeting agenda was adopted as presented.

PUBLIC COMMENTS ON AGENDA ITEMS (15 minutes)

None

NEW BUSINESS

1. **Report of the 2021 General Assembly**

   Elaine Yeatts provided a report from the 2021 General Assembly. She discussed bills that were of interest to the Advisory Board.

2. **AOTA Proposed Revision to the Definition of Occupational Therapy Practice**

   Breshae Beward provided a review of the proposed revision from the American Occupational Therapy Association (AOTA).

ANNOUNCEMENTS:

ShaRon Clanton provided the licensing report. The Board has a total of 3,549 current active occupational therapists and 1,448 occupational therapy assistants.

Next Meeting Date

Next scheduled meeting date: May 25, 2021 at 10:00 a.m.

ADJOURNMENT

With no other business to conduct, Breshae Bedward adjourned the meeting at 11:08 a.m.

Breshae Breward, Chair

William L. Harp, M.D., Executive Director

ShaRon Clanton, Licensing Specialist

2020 Occupational Therapy and Occupational Therapy Assistant Workforce Reports

DRAFT

Virginia's Occupational Therapy Workforce: 2020

Healthcare Workforce Data Center

March 2021

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

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

More than 3,800 Occupational 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 Medicine express our sincerest appreciation for your ongoing cooperation.*

Thank You!

Virginia Department of Health Professions

David E. Brown, DC
Director

Barbara Allison-Bryan, MD
Chief Deputy Director

Healthcare Workforce Data Center Staff:

Elizabeth Carter, PhD	Yetty Shobo, PhD	Laura Jackson, MSHSA	Rajana Siva, MBA	Christopher Coyle
Director	*Deputy Director*	*Operations Manager*	Data Analyst	*Research Assistant*

Virginia Occupational Therapy Advisory Board

Chair

Breshae Bedward, OT
Charles City

Vice-Chair

Dwayne Pitre, OT
Charlottesville

Members

Raziuddin Ali, MD
Midlothian

Karen Lebo
Richmond

Kathryn Skibek, OT
Woodbridge

Executive Director

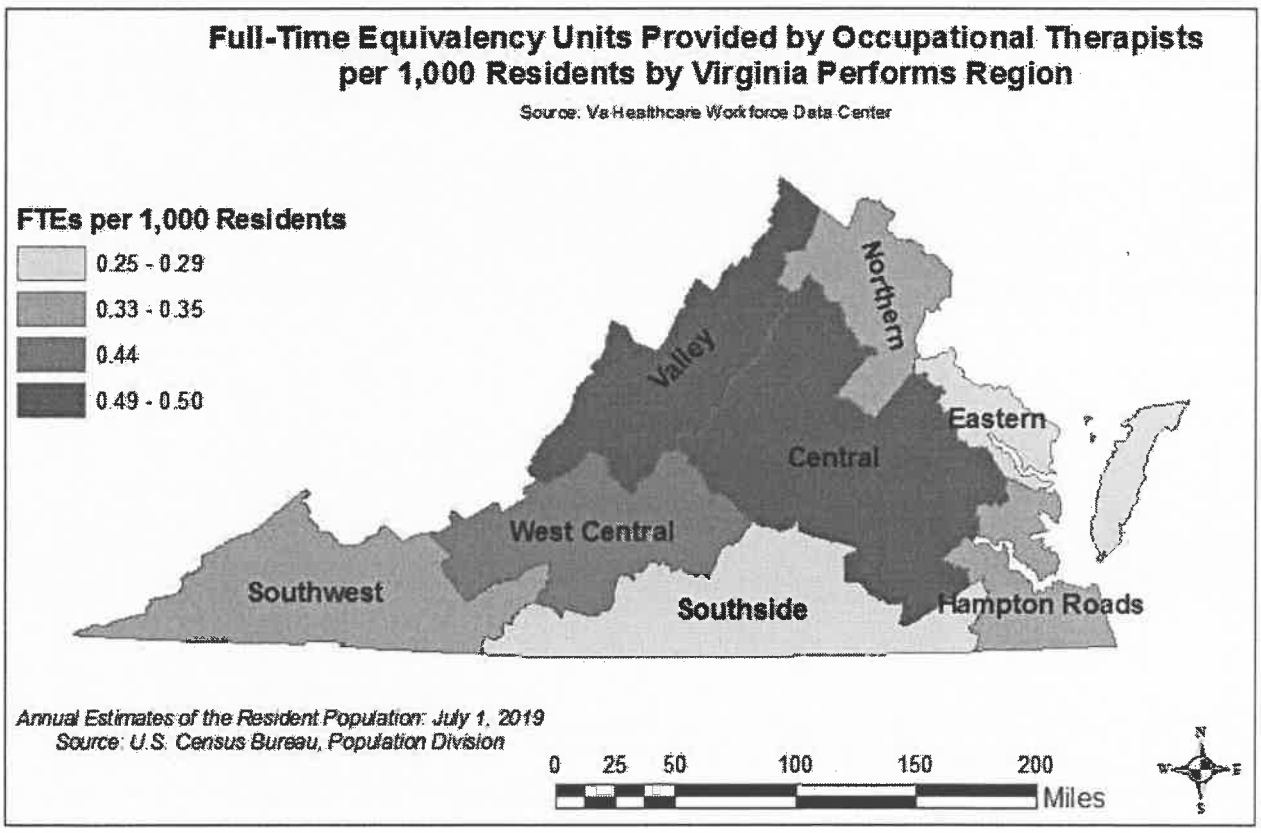
William L. Harp, MD

Contents

The Occupational Therapy Workforce At a Glance:

The Workforce		Background		Current Employment	
Licensees:	5,075	Rural Childhood:	29%	Employed in Prof.:	95%
Virginia's Workforce:	4,317	HS Degree in VA:	42%	Hold 1 Full-Time Job:	61%
FTEs:	3,365	Prof. Degree in VA:	42%	Satisfied?:	95%
Survey Response Rate		**Education**		**Job Turnover**	
All Licensees:	75%	Masters:	68%	Switched Jobs:	8%
Renewing Practitioners:	93%	Baccalaureate:	26%	Employed Over 2 Yrs.:	57%
Demographics		**Finances**		**Primary Roles**	
% Female:	92%	Median Income:	$70k-$80k	Patient Care:	83%
Diversity Index:	26%	Health Benefits:	65%	Administration:	5%
Median Age:	38	Under 40 w/ Ed. Debt:	63%	Education:	1%

Source: Va. Healthcare Workforce Data Center



Results in Brief

This report contains the results of the 2020 Occupational Therapy (OT) Workforce survey. More than 3,800 OTs voluntarily participated in this survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place on even-numbered years during the birth month of each OT. These survey respondents represent 75% of the 5,075 OTs who are licensed in the state and 93% of renewing practitioners.

The HWDC estimates that 4,317 OTs participated in Virginia's workforce during the survey period, which is defined as those OTs who worked at least a portion of the year in the state or who live in the state and intend to return to work as an OT at some point in the future. This workforce provided 3,365 "full-time equivalency units", which the HWDC defines simply as working 2,000 hours per year.

More than 90% of all OTs are female, including 93% of those OTs who are under the age of 40. Overall, the median age of this workforce is 38. In a random encounter between two OTs, there is a 26% chance that they would be of different races or ethnicities, a measure known as the diversity index. For those OTs who are under the age of 40, this diversity index increases to 27%. However, these values are considerably below the comparable diversity index of 57% for Virginia's population as a whole. Nearly 30% of all OTs grew up in rural areas, and 19% of these professionals currently work in non-metro areas of the state. In total, 10% of all OTs currently work in non-metro areas of Virginia.

Among all OTs, 95% are currently employed in the profession, 61% hold one full-time job, and 45% work between 40 and 49 hours per week. Meanwhile, 9% of OTs have experienced involuntary unemployment at some point in the past year, and 6% have experienced underemployment. More than 80% of all OTs work in the private sector, including 52% who are employed in for-profit establishments. The median annual income for OTs is between $70,000 and $80,000. In addition, nearly 80% of all OTs receive at least one employer-sponsored benefit, including 65% who have access to health insurance. Overall, 95% of OTs indicated that they are satisfied with their current employment situation, including 61% who indicated that they are "very satisfied".

Summary of Trends

In this section, all statistics for the current year are compared to the 2014 Occupational Therapy workforce. The number of licensed OTs has increased by 33% (5,075 vs. 3,826). In addition, the size of Virginia's OT workforce has increased by 34% (4,317 vs. 3,231), and the number of FTEs provided by this workforce has increased by 29% (3,365 vs. 2,602). Virginia's renewing OTs are more likely to respond to this survey (93% vs. 80%).

The percentage of Virginia's OT workforce that is female has fallen slightly (92% vs. 93%), and the median age of this workforce has also declined (38 vs. 41). Meanwhile, the diversity index of Virginia's OTs has increased (26% vs. 23%) at a time when the state's overall population is also becoming more diverse (57% vs. 54%). OTs are less likely to have grown up in rural areas (29% vs. 31%), but this group of professionals is slightly more likely to be employed in non-metro areas of Virginia (19% vs. 18%). Overall, Virginia's OTs are more likely to work in non-metro areas of the state (10% vs. 9%).

Although Virginia's OTs are less likely to work between 40 and 49 hours per week (45% vs. 49%), they are more likely to hold one full-time job (61% vs. 58%). At the same time, the rates of involuntary unemployment (9% vs. 1%) and underemployment (6% vs. 3%) in the past year have both increased significantly. Virginia's OT workforce is more likely to be employed in the private sector (82% vs. 77%), including those who work in the for-profit sector (52% vs. 50%).

Virginia's OTs are considerably more likely to receive a Master's degree as their highest professional degree (68% vs. 56%) instead of a baccalaureate degree (26% vs. 41%). In addition, OTs are more likely to carry education debt (45% vs. 43%), and the median debt amount among those OTs with education debt has increased ($60k-$70k vs. $40k-$50k). Meanwhile, the median annual income of Virginia's OT workforce has also increased ($70k-$80k vs. $60k-$70k). However, the percentage of OTs who indicated that they are satisfied with their current work situation has fallen (95% vs. 97%), and this decline was even larger among OTs who indicated that they are "very satisfied" (61% vs. 68%).

A Closer Look:

Licensees		
License Status	#	%
Renewing Practitioners	4,112	81%
New Licensees	432	9%
Non-Renewals	531	10%
All Licensees	5,075	100%

Source: Va. Healthcare Workforce Data Center

HWDC surveys tend to achieve very high response rates. More than 90% of all renewing OTs submitted a survey. These represent 75% of OTs who held a license at some point in 2020.

Definitions

1. **The Survey Period:** The survey was conducted throughout 2020.
2. **Target Population:** All OTs who held a Virginia license at some point in 2020.
3. **Survey Population:** The survey was available to OTs who renewed their licenses online. It was not available to those who did not renew, including all OTs newly licensed in 2020.

Response Rates	
Completed Surveys	3,804
Response Rate, All Licensees	75%
Response Rate, Renewals	93%

Source: Va. Healthcare Workforce Data Center

Response Rates			
Statistic	Non Respondents	Respondents	Response Rate
By Age			
Under 30	556	461	45%
30 to 34	230	667	74%
35 to 39	128	562	81%
40 to 44	79	491	86%
45 to 49	49	456	90%
50 to 54	48	429	90%
55 to 59	46	333	88%
60 and Over	135	405	75%
Total	**1,271**	**3,804**	**75%**
New Licenses			
Issued in Past Year	432	0	0%
Metro Status			
Non-Metro	80	235	75%
Metro	580	2,838	83%
Not in Virginia	611	731	54%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed OTs

Number:	5,075
New:	9%
Not Renewed:	10%

Response Rates

All Licensees:	75%
Renewing Practitioners:	93%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Workforce

2020 OT Workforce:	4,317
FTEs:	3,365

Utilization Ratios

Licensees in VA Workforce:	85%
Licensees per FTE:	1.51
Workers per FTE:	1.28

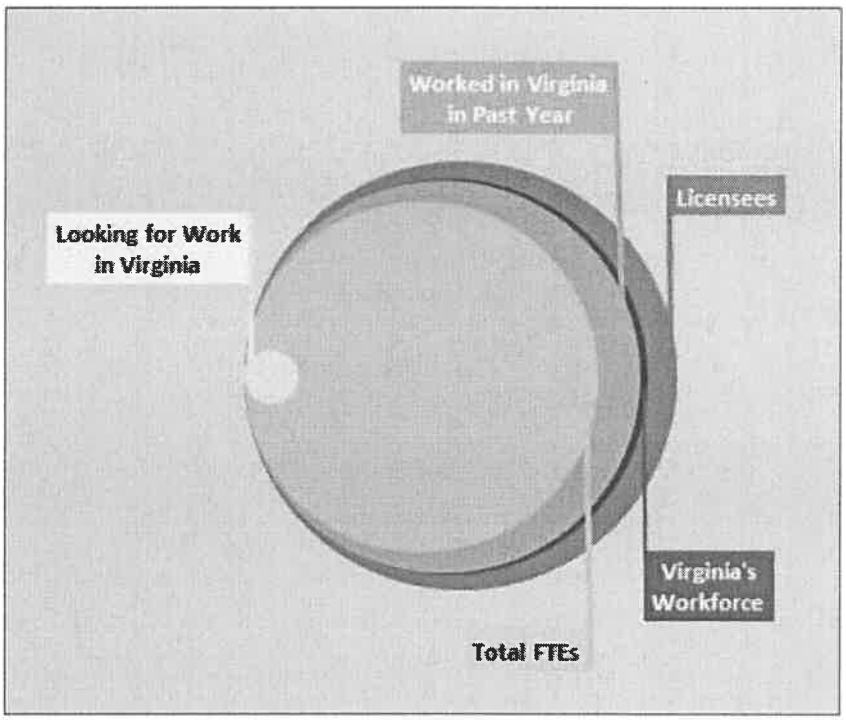
Source: Va. Healthcare Workforce Data Center

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 hours (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 OT Workforce		
Status	**#**	**%**
Worked in Virginia in Past Year	4,236	98%
Looking for Work in Virginia	81	2%
Virginia's Workforce	**4,317**	**100%**
Total FTEs	**3,365**	
Licensees	**5,075**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

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

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 30	38	4%	860	96%	898	22%
30 to 34	57	8%	680	92%	737	18%
35 to 39	45	9%	477	91%	523	13%
40 to 44	34	8%	405	92%	439	11%
45 to 49	33	9%	344	91%	377	9%
50 to 54	46	13%	316	87%	361	9%
55 to 59	31	11%	260	89%	291	7%
60 and Over	26	7%	353	93%	379	9%
Total	**310**	**8%**	**3,694**	**92%**	**4,005**	**100%**

Source: Va. Healthcare Workforce Data Center

Race & Ethnicity					
Race/ Ethnicity	Virginia*	OTs		OTs Under 40	
	%	#	%	#	%
White	61%	3,495	85%	1,868	85%
Black	19%	208	5%	105	5%
Hispanic	10%	95	2%	56	3%
Asian	7%	181	4%	102	5%
Two or More Races	3%	73	2%	51	2%
Other Race	0%	37	1%	10	0%
Total	**100%**	**4,089**	**100%**	**2,192**	**100%**

*Population data in this chart is from the U.S. Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2019.

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

% Female:	92%
% Under 40 Female:	93%

Age

Median Age:	38
% Under 40:	54%
% 55 and Over:	17%

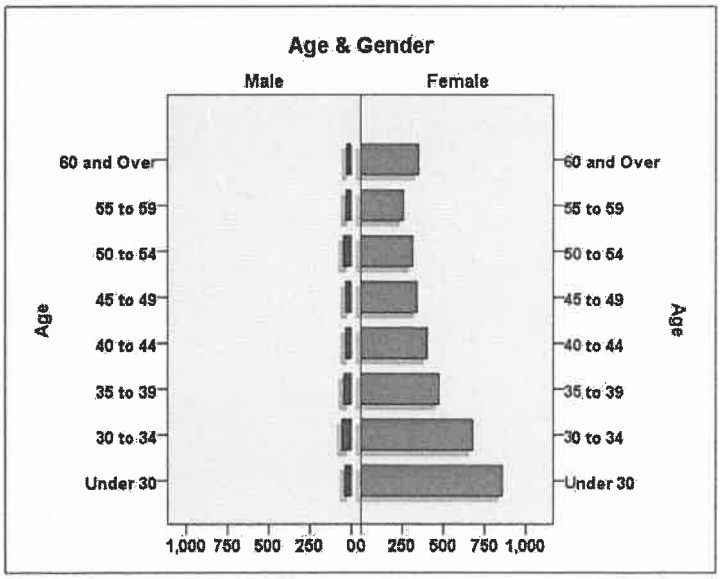
Diversity

Diversity Index:	26%
Under 40 Div. Index:	27%

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two OTs, there is a 26% chance that they would be of different races or ethnicities (a measure known as the diversity index). For Virginia's population as a whole, the comparable number is 57%.

More than half of all OTs are under the age of 40, and 93% of these professionals are female. In addition, there is a 27% chance that two randomly chosen OTs from this group would be of different races or ethnicities.



Source: Va. Healthcare Workforce Data Center

At a Glance:

Childhood

Urban Childhood:	9%
Rural Childhood:	29%

Virginia Background

HS in Virginia:	42%
Professional Edu. in VA:	42%
HS/Prof. Edu. in VA:	52%

Location Choice

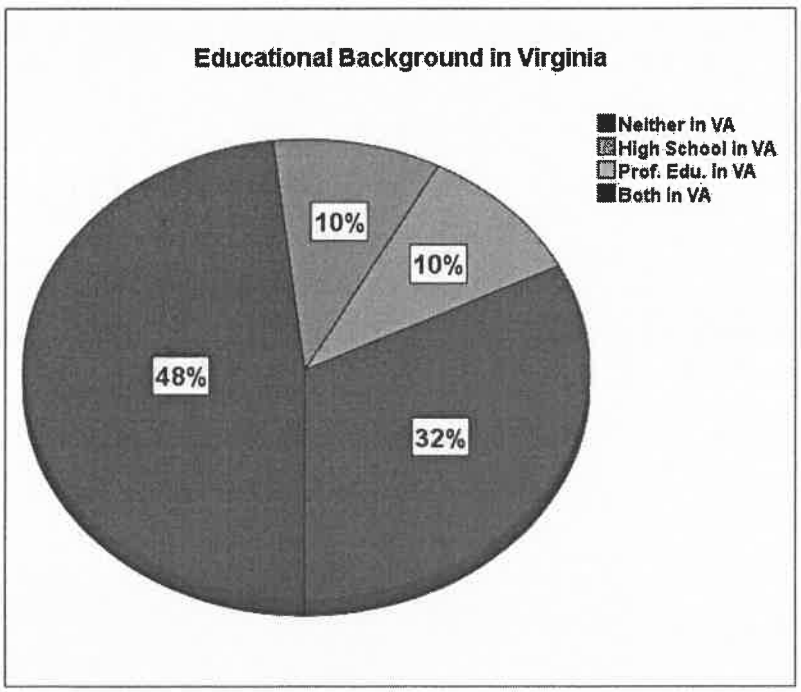
% Rural to Non-Metro:	19%
% Urban/Suburban to Non-Metro:	6%

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+	22%	69%	9%
2	Metro, 250,000 to 1 Million	35%	58%	7%
3	Metro, 250,000 or Less	42%	51%	7%
	Non-Metro Counties			
4	Urban, Pop. 20,000+, Metro Adjacent	61%	32%	7%
6	Urban, Pop. 2,500-19,999, Metro Adjacent	59%	32%	10%
7	Urban, Pop. 2,500-19,999, Non-Adjacent	73%	20%	7%
8	Rural, Metro Adjacent	50%	43%	7%
9	Rural, Non-Adjacent	32%	52%	16%
	Overall	**29%**	**62%**	**9%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Nearly 30% of OTs grew up in self-described rural areas, and 19% of these professionals currently work in non-metro counties. In total, 10% of all OTs work in non-metro counties of Virginia.

Top Ten States for Occupational Therapist Recruitment

Rank	All Occupational Therapists			
	High School	#	Professional School	#
1	Virginia	1,717	Virginia	1,716
2	Pennsylvania	350	Pennsylvania	415
3	New York	290	New York	272
4	Maryland	192	North Carolina	157
5	Outside U.S./Canada	178	Massachusetts	140
6	New Jersey	139	Florida	125
7	North Carolina	117	Outside U.S./Canada	105
8	Ohio	92	Washington, D.C.	104
9	West Virginia	90	Tennessee	88
10	Florida	76	Maryland	85

Source: Va. Healthcare Workforce Data Center

Among all OTs, 42% received their high school degree in Virginia, and 42% also received their initial professional degree in the state.

Among OTs who were licensed in the past five years, 42% received their high school degree in Virginia, and 42% also received their initial professional degree in the state.

Rank	Licensed in the Past Five Years			
	High School	#	Professional School	#
1	Virginia	600	Virginia	603
2	Pennsylvania	111	Pennsylvania	153
3	New York	94	New York	92
4	Maryland	70	North Carolina	62
5	North Carolina	66	Massachusetts	53
6	New Jersey	59	Florida	52
7	Ohio	47	Washington, D.C.	44
8	Florida	35	Tennessee	39
9	West Virginia	31	Ohio	30
10	Outside U.S./Canada	30	Missouri	29

Source: Va. Healthcare Workforce Data Center

In total, 16% of licensed OTs did not participate in Virginia's workforce in 2020. Among these licensees, 94% worked at some point in the past year, including 88% who currently work as OTs.

At a Glance:

Not in VA Workforce

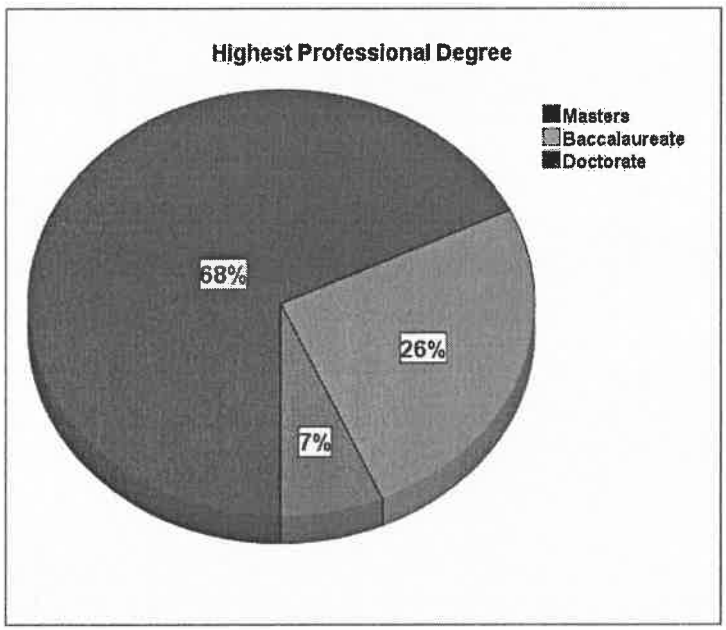
Total:	792
% of Licensees:	16%
Federal/Military:	6%
VA Border State/DC:	24%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Professional Degree		
Degree	#	%
Baccalaureate	1,035	26%
Masters	2,739	68%
Doctorate	265	7%
Total	**4,038**	**100%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

At a Glance:

Education

Masters: 68%
Baccalaureate: 26%

Education Debt

With Debt: 45%
Under Age 40 w/ Debt: 63%
Median Debt: $60k-$70k

Source: Va. Healthcare Workforce Data Center

More than two-thirds of all OTs hold a Master's degree as their highest professional degree.

Nearly half of all OTs carry education debt, including 63% of those who are under the age of 40. For those with education debt, the median debt amount is between $60,000 and $70,000.

Education Debt				
Amount Carried	All OTs		OTs Under 40	
	#	%	#	%
None	2,039	55%	736	37%
$20,000 or Less	282	8%	157	8%
$20,001-$40,000	299	8%	209	10%
$40,001-$60,000	251	7%	189	9%
$60,001-$80,000	206	6%	167	8%
$80,001-$100,000	196	5%	166	8%
$100,001-$120,000	178	5%	154	8%
More than $120,000	253	7%	218	11%
Total	**3,702**	**100%**	**1,994**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Top Specializations

Physical Rehabilitation: 25%
Pediatrics: 23%
Gerontology: 22%

Top Certifications:

Cert. Hand Therapist: 3%
Lympthedema Therapist: 2%
Dementia Care: 1%

Source: Va. Healthcare Workforce Data Center

Three-quarters of all OTs have at least one specialization, including 25% who have a specialization in Physical Rehabilitation.

A Closer Look:

Specializations		
Area	#	% of Workforce
Physical Rehabilitation	1,095	25%
Pediatrics	999	23%
Gerontology	930	22%
Neurorehabilitation	721	17%
Sensory Processing	661	15%
Home Health	639	15%
School Systems	635	15%
Acute Care	564	13%
Developmental Disabilities	545	13%
Early Intervention	394	9%
Environmental Modification	300	7%
Hand Therapy	297	7%
Feeding, Eating, Swallowing	271	6%
Mental Health	266	6%
Low Vision	122	3%
Driving and Community Mobility	57	1%
Industrial/Workplace	48	1%
Other	210	5%
At Least One Specialization	3,254	75%

Source: Va. Healthcare Workforce Data Center

Certifications		
Proficiency Area	#	% of Workforce
Certified Hand Therapist (CHT)	128	3%
Certified Lympthedema Therapist	100	2%
Dementia Care Specialist	59	1%
School Systems	51	1%
Pediatrics (BCP)	26	1%
Other	340	8%
At Least One Certification	638	15%

Source: Va. Healthcare Workforce Data Center

Among all OTs, 15% hold at least one certification, including 3% who have a certification as a Certified Hand Therapist (CHT).

At a Glance:

Employment

Employed in Profession:	95%
Involuntarily Unemployed:	1%

Positions Held

1 Full-Time:	61%
2 or More Positions:	18%

Weekly Hours:

40 to 49:	45%
60 or More:	1%
Less than 30:	18%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Current Work Status		
Status	**#**	**%**
Employed, Capacity Unknown	0	0%
Employed in an Occupational Therapy-Related Capacity	3,865	95%
Employed, NOT in an Occupational Therapy-Related Capacity	45	1%
Not Working, Reason Unknown	0	0%
Involuntarily Unemployed	45	1%
Voluntarily Unemployed	103	3%
Retired	25	1%
Total	**4,084**	**100%**

Source: Va. Healthcare Workforce Data Center

More than nine out of every ten OTs are currently employed in the profession, 61% hold one full-time job, and 45% work between 40 and 49 hours per week.

Current Positions		
Positions	**#**	**%**
No Positions	173	4%
One Part-Time Position	674	17%
Two Part-Time Positions	200	5%
One Full-Time Position	2,438	61%
One Full-Time Position & One Part-Time Position	435	11%
Two Full-Time Positions	1	0%
More than Two Positions	99	2%
Total	**4,020**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Weekly Hours		
Hours	**#**	**%**
0 Hours	173	4%
1 to 9 Hours	127	3%
10 to 19 Hours	219	6%
20 to 29 Hours	353	9%
30 to 39 Hours	1,043	26%
40 to 49 Hours	1,801	45%
50 to 59 Hours	199	5%
60 to 69 Hours	35	1%
70 to 79 Hours	7	0%
80 or More Hours	17	0%
Total	**3,974**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Income		
Annual Income	#	%
Volunteer Work Only	10	0%
$30,000 or Less	221	7%
$30,001-$40,000	153	5%
$40,001-$50,000	202	6%
$50,001-$60,000	361	11%
$60,001-$70,000	574	17%
$70,001-$80,000	713	22%
$80,001-$90,000	545	16%
$90,001-$100,000	306	9%
$100,001-$110,000	144	4%
$110,001-$120,000	43	1%
More than $120,000	49	2%
Total	3,320	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Earnings
Median Income: $70k-$80k

Benefits
Health Insurance: 65%
Retirement: 64%

Satisfaction
Satisfied 95%
Very Satisfied: 61%

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	#	%
Very Satisfied	2,424	61%
Somewhat Satisfied	1,347	34%
Somewhat Dissatisfied	148	4%
Very Dissatisfied	51	1%
Total	3,971	100%

Source: Va. Healthcare Workforce Data Center

The typical OT earns between $70,000 and $80,000 per year. In addition, nearly 80% of OTs receive at least one employer-sponsored benefit, including 65% who have access to health insurance.

Employer-Sponsored Benefits			
Benefit	#	%	% of Wage/Salary Employees
Paid Vacation	2,588	67%	73%
Retirement	2,485	64%	69%
Health Insurance	2,327	65%	65%
Dental Insurance	2,225	58%	63%
Paid Sick Leave	1,965	51%	55%
Group Life Insurance	1,453	38%	41%
Signing/Retention Bonus	278	7%	8%
Total	3,042	79%	84%

*From any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Employment Instability in the Past Year		
In the Past Year, Did You . . .?	**#**	**%**
Work Two or More Positions at the Same Time?	900	21%
Experience Involuntary Unemployment?	396	9%
Switch Employers or Practices?	350	8%
Work Part-Time or Temporary Positions, but Would Have Preferred a Full-Time/Permanent Position?	271	6%
Experience Voluntary Unemployment?	264	6%
Experienced At Least One	**1,634**	**38%**

Source: Va. Healthcare Workforce Data Center

Nearly 10% of OTs experienced involuntary unemployment in the past year. By comparison, Virginia's average monthly unemployment rate was 6.0% during the same time period.[1]

Location Tenure				
Tenure	**Primary**		**Secondary**	
	#	**%**	**#**	**%**
Not Currently Working at This Location	120	3%	123	11%
Less than 6 Months	179	5%	128	12%
6 Months to 1 Year	365	9%	151	14%
1 to 2 Years	1,048	27%	236	22%
3 to 5 Years	913	23%	231	21%
6 to 10 Years	528	13%	113	10%
More than 10 Years	788	20%	107	10%
Subtotal	**3,941**	**100%**	**1,089**	**100%**
Did Not Have Location	88		3,191	
Item Missing	287		37	
Total	**4,317**		**4,317**	

Source: Va. Healthcare Workforce Data Center

Nearly nine out of every ten OTs receive either a salary or an hourly wage at their primary work location.

At a Glance:

Unemployment Experience

Involuntarily Unemployed:	9%
Underemployed:	6%

Turnover & Tenure

Switched Jobs:	8%
New Location:	21%
Over 2 Years:	57%
Over 2 Yrs., 2nd Location:	41%

Employment Type

Salary/Commission:	47%
Hourly Wage:	43%

Source: Va. Healthcare Workforce Data Center

Among all OTs, 57% have worked at their primary work location for more than two years.

Employment Type		
Primary Work Site	**#**	**%**
Salary/Commission	1,492	47%
Hourly Wage	1,362	43%
By Contract	300	9%
Business/Practice Income	44	1%
Unpaid	6	0%
Subtotal	**3,204**	**100%**

Source: Va. Healthcare Workforce Data Center

[1] As reported by the U.S. Bureau of Labor Statistics. The non-seasonally adjusted monthly unemployment rate fluctuated between a low of 2.8% and a high of 10.8%. The unemployment rate from December 2020 was still preliminary at the time of publication.

At a Glance:

Concentration

Top Region:	30%
Top 3 Regions:	73%
Lowest Region:	1%

Locations

2 or More (Past Year):	28%
2 or More (Now*):	24%

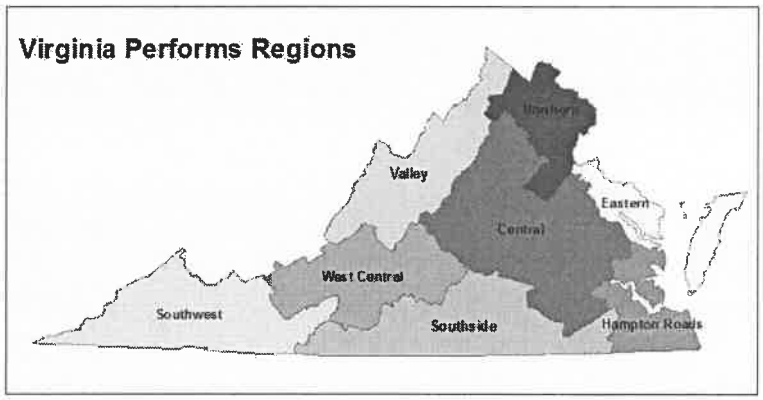
Source: Va. Healthcare Workforce Data Center

Nearly three-quarters of all OTs work in Northern Virginia, Central Virginia, and Hampton Roads.

A Closer Look:

Regional Distribution of Work Locations				
Virginia Performs Region	Primary Location		Secondary Location	
	#	%	#	%
Northern	1,196	30%	292	26%
Central	1,016	26%	256	23%
Hampton Roads	651	17%	164	15%
West Central	379	10%	97	9%
Valley	272	7%	78	7%
Southwest	163	4%	52	5%
Southside	136	3%	27	2%
Eastern	51	1%	19	2%
Virginia Border State/D.C.	25	1%	50	4%
Other U.S. State	46	1%	76	7%
Outside of the U.S.	3	0%	1	0%
Total	**3,938**	**100%**	**1,112**	**100%**
Item Missing	289		15	

Source: Va. Healthcare Workforce Data Center



Number of Work Locations				
Locations	Work Locations in Past Year		Work Locations Now*	
	#	%	#	%
0	81	2%	171	4%
1	2,811	70%	2,869	72%
2	643	16%	581	15%
3	352	9%	325	8%
4	54	1%	34	1%
5	39	1%	14	0%
6 or More	33	1%	17	0%
Total	**4,011**	**100%**	**4,011**	**100%**

*At the time of survey completion: 2020 (continual renewal cycle).

Source: Va. Healthcare Workforce Data Center

While nearly one-quarter of OTs currently have multiple work locations, 28% have had multiple work locations over the past year.

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	1,958	52%	679	64%
Non-Profit	1,140	30%	265	25%
State/Local Government	612	16%	97	9%
Veterans Administration	51	1%	2	0%
U.S. Military	13	0%	4	0%
Other Federal Government	10	0%	7	1%
Total	**3,784**	**100%**	**1,054**	**100%**
Did Not Have Location	88		3,191	
Item Missing	445		73	

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Sector

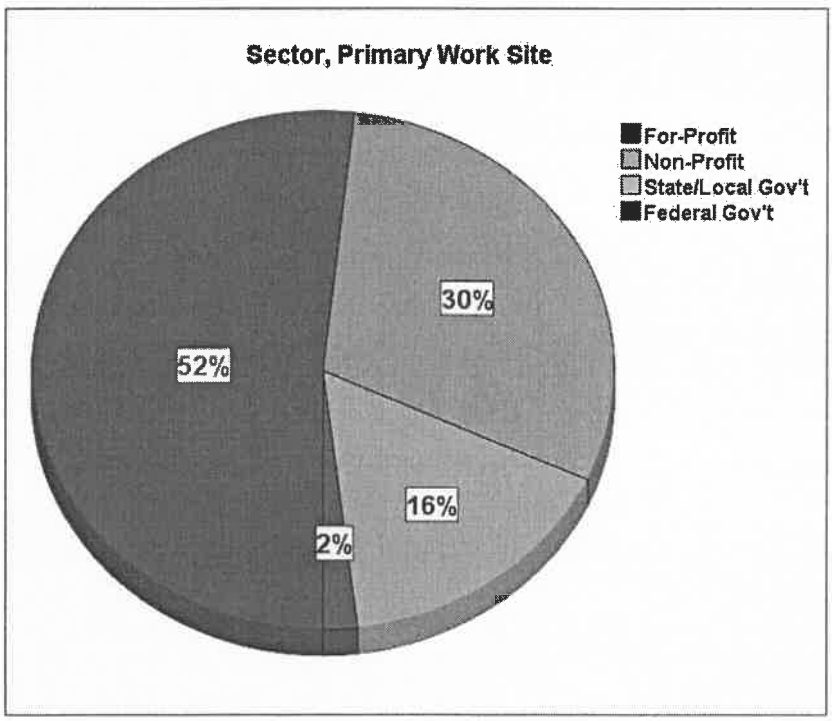
For-Profit:	52%
Federal:	2%

Top Establishments

Hospital, Inpatient:	15%
Skilled Nursing Facility:	14%
K-12 School System:	13%

Source: Va. Healthcare Workforce Data Center

More than four out of every five OTs work in the private sector, including 52% who work at for-profit establishments.



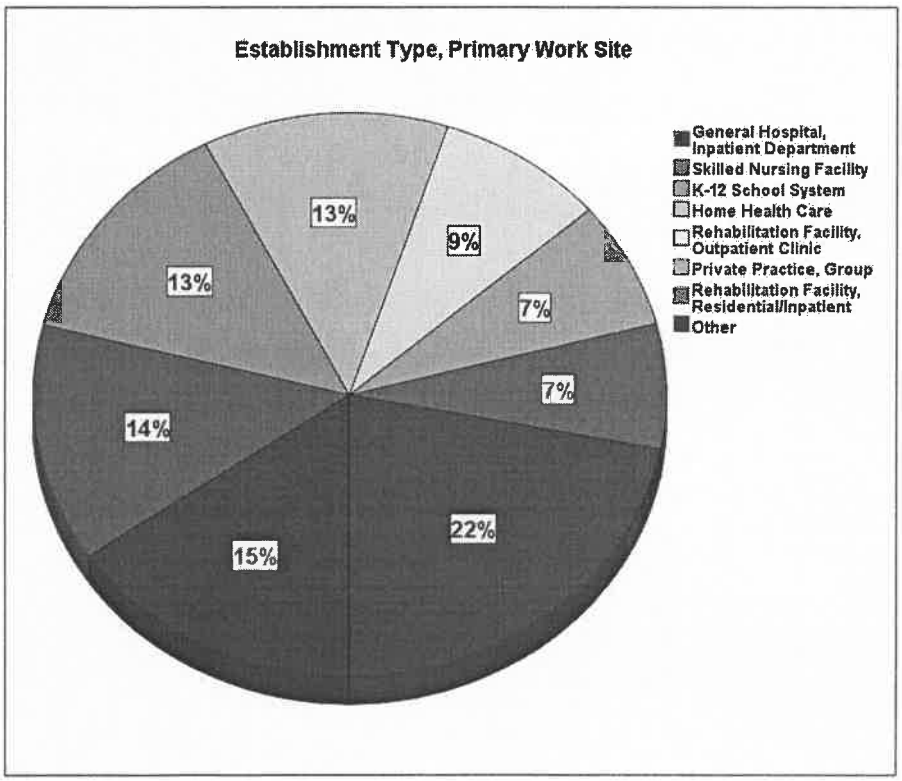
Source: Va. Healthcare Workforce Data Center

Location Type				
Establishment Type	Primary Location		Secondary Location	
	#	%	#	%
General Hospital, Inpatient Department	564	15%	160	16%
Skilled Nursing Facility	501	14%	190	19%
K-12 School System	494	13%	53	5%
Home Health Care	461	13%	164	16%
Rehabilitation Facility, Outpatient Clinic	315	9%	51	5%
Private Practice, Group	268	7%	55	5%
Rehabilitation Facility, Residential/Inpatient	263	7%	99	10%
General Hospital, Outpatient Department	170	5%	28	3%
Assisted Living or Continuing Care Facility	131	4%	50	5%
Academic Institution	112	3%	56	5%
Private Practice, Solo	98	3%	39	4%
Mental Health, Inpatient	52	1%	5	0%
Other	241	7%	75	7%
Total	**3,670**	**100%**	**1,025**	**100%**
Did Not Have a Location	88		3,191	

Source: Va. Healthcare Workforce Data Center

Nearly 30% of all OTs work at either the inpatient department of general hospitals or skilled nursing facilities.

Among those OTs who also have a secondary work location, 35% work in either skilled nursing facilities or home health care establishments.



Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

A Typical OTs Time

Patient Care:	80%-89%
Administration:	1%-9%
Education:	1%-9%

Roles

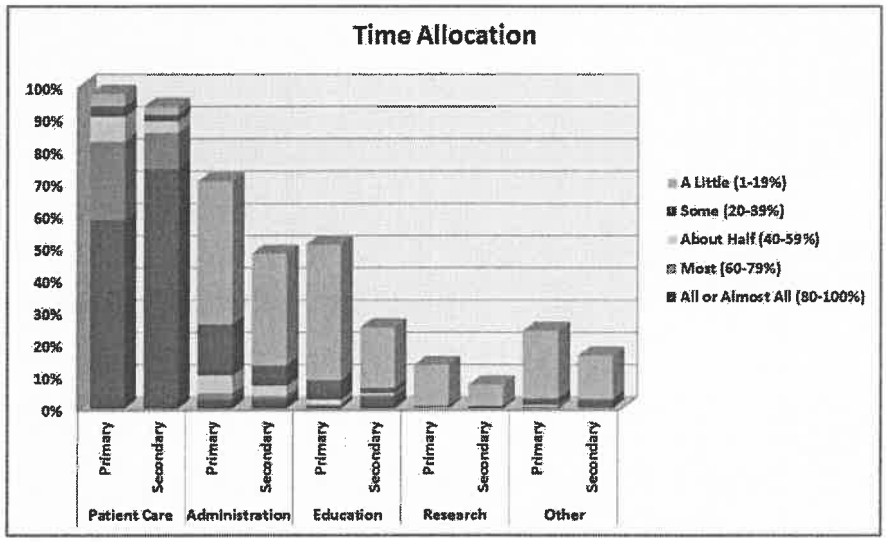
Patient Care:	83%
Administrative:	5%
Education:	1%

Patient Care OTs

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

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

OTs spend most of their time performing patient care activities. In fact, 83% of all OTs fill a patient care role, defined as spending at least 60% of their time in that activity.

Time Allocation										
Time Spent	Patient Care		Admin.		Education		Research		Other	
	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site
All or Almost All (80-100%)	59%	74%	3%	3%	1%	4%	0%	0%	0%	0%
Most (60-79%)	24%	11%	2%	1%	0%	0%	0%	0%	0%	0%
About Half (40-59%)	8%	3%	5%	3%	1%	1%	0%	0%	0%	0%
Some (20-39%)	3%	2%	16%	6%	6%	2%	0%	1%	2%	3%
A Little (1-19%)	4%	2%	44%	35%	42%	19%	13%	7%	21%	13%
None (0%)	2%	6%	30%	52%	49%	75%	86%	93%	76%	83%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All OTs		OTs 50 and Over	
	#	%	#	%
Under Age 50	113	3%	-	-
50 to 54	162	5%	5	1%
55 to 59	369	11%	46	5%
60 to 64	993	28%	206	23%
65 to 69	1,357	39%	420	47%
70 to 74	308	9%	142	16%
75 to 79	63	2%	24	3%
80 or Over	19	1%	7	1%
I Do Not Intend to Retire	128	4%	43	5%
Total	3,512	100%	893	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All OTs
- Under 65: 47%
- Under 60: 18%

OTs 50 and Over
- Under 65: 29%
- Under 60: 6%

Time Until Retirement
- Within 2 Years: 3%
- Within 10 Years: 14%
- Half the Workforce: By 2050

Source: Va. Healthcare Workforce Data Center

Nearly half of all OTs expect to retire by the age of 65. For those OTs who are age 50 and over, 29% still expect to retire by the age of 65.

Within the next two years, 19% of OTs expect to pursue additional educational opportunities, and 13% expect to increase their patient care hours.

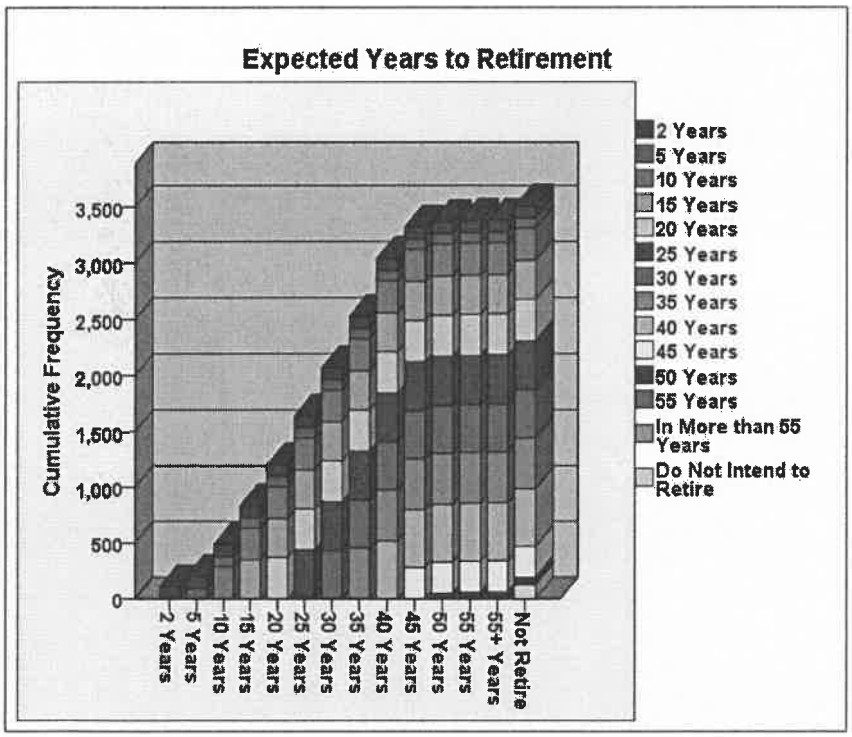
Future Plans		
Two-Year Plans:	#	%
Decrease Participation		
Decrease Patient Care Hours	370	9%
Leave Virginia	186	4%
Leave Profession	56	1%
Decrease Teaching Hours	19	0%
Increase Participation		
Pursue Additional Education	825	19%
Increase Patient Care Hours	571	13%
Increase Teaching Hours	394	9%
Return to Virginia's Workforce	50	1%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectations to age, we can estimate the maximum years to retirement for OTs. While only 3% of OTs expect to retire in the next two years, 14% expect to retire within the next decade. More than half of the current workforce expect to retire by 2050.

Time to Retirement			
Expect to Retire Within. . .	#	%	Cumulative %
2 Years	106	3%	3%
5 Years	93	3%	6%
10 Years	285	8%	14%
15 Years	349	10%	24%
20 Years	369	11%	34%
25 Years	438	12%	47%
30 Years	430	12%	59%
35 Years	456	13%	72%
40 Years	518	15%	87%
45 Years	279	8%	95%
50 Years	48	1%	96%
55 Years	9	0%	96%
In More than 55 Years	4	0%	96%
Do Not Intend to Retire	128	4%	100%
Total	**3,512**	**100%**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Using these estimates, retirement will begin to reach 10% of the current workforce every five years by 2035. Retirement will peak at 15% of the current workforce in 2060 before declining to under 10% of the current workforce again around 2065.

At a Glance:

FTEs

Total:	3,365
FTEs/1,000 Residents[2]:	0.394
Average:	0.80

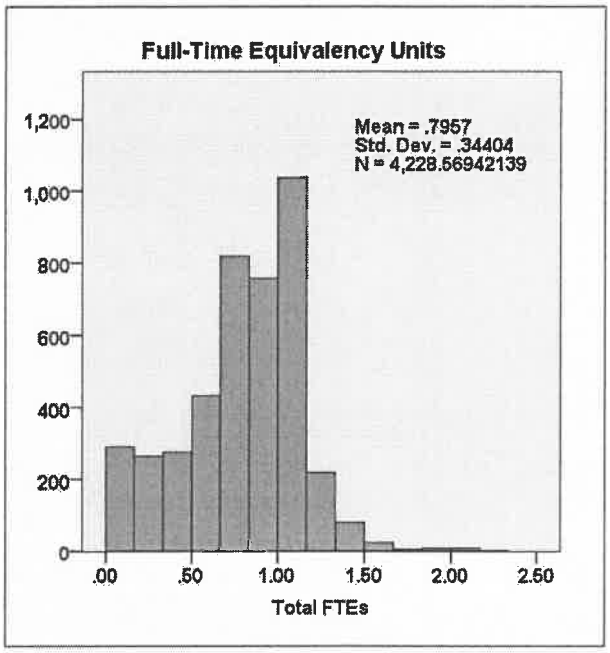
Age & Gender Effect

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

Partial Eta² Explained:
Partial Eta² is a statistical measure of effect size.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

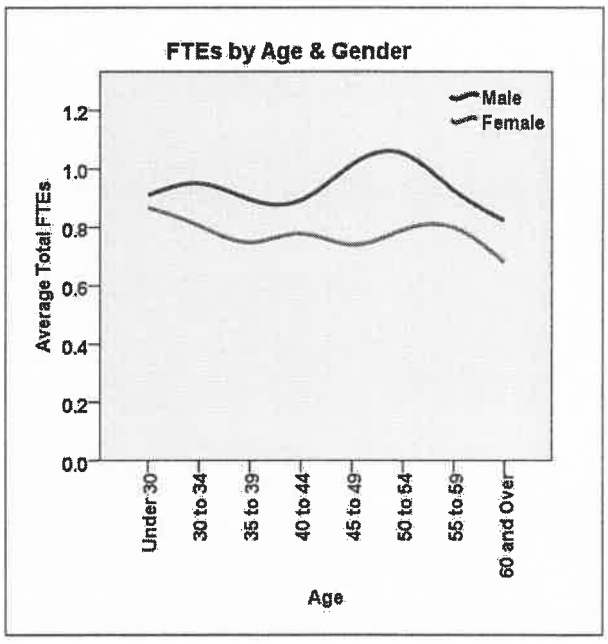


Source: Va. Healthcare Workforce Data Center

The typical OT provided 0.84 FTEs in 2020, or approximately 34 hours per week for 50 weeks. Although FTEs appear to vary by age and gender, statistical tests did not verify that a difference exists.[3]

Full-Time Equivalency Units		
Age	Average	Median
Age		
Under 30	0.87	0.96
30 to 34	0.82	0.88
35 to 39	0.73	0.80
40 to 44	0.79	0.81
45 to 49	0.76	0.78
50 to 54	0.81	0.83
55 to 59	0.80	0.80
60 and Over	0.70	0.78
Gender		
Male	0.94	1.01
Female	0.79	0.84

Source: Va. Healthcare Workforce Data Center

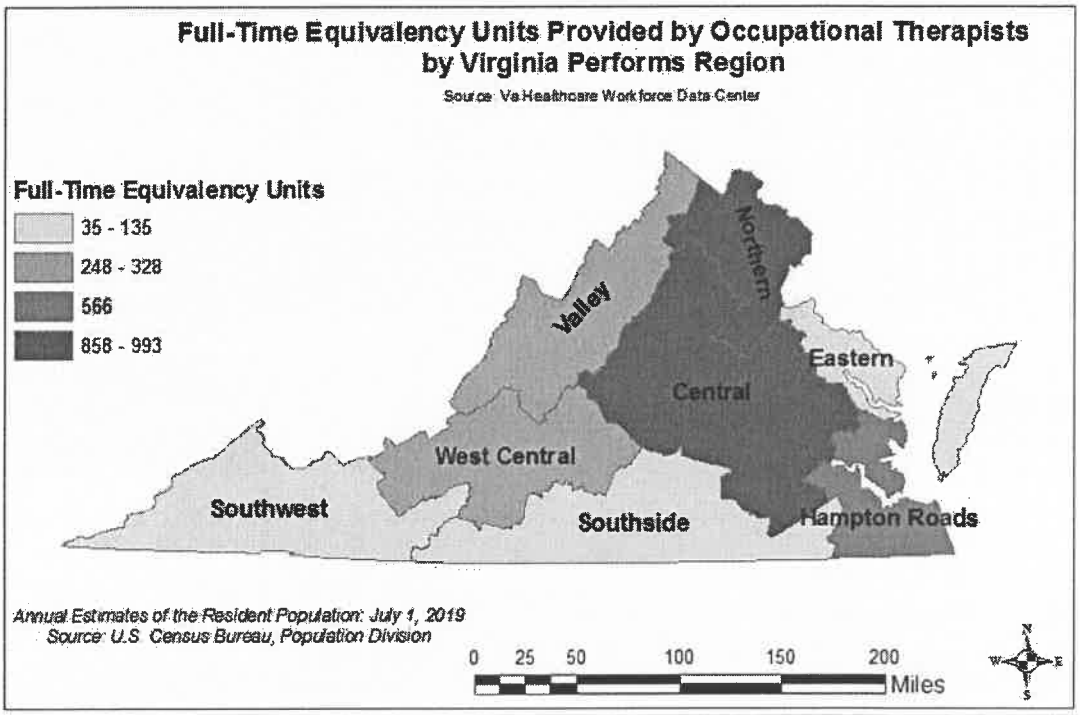


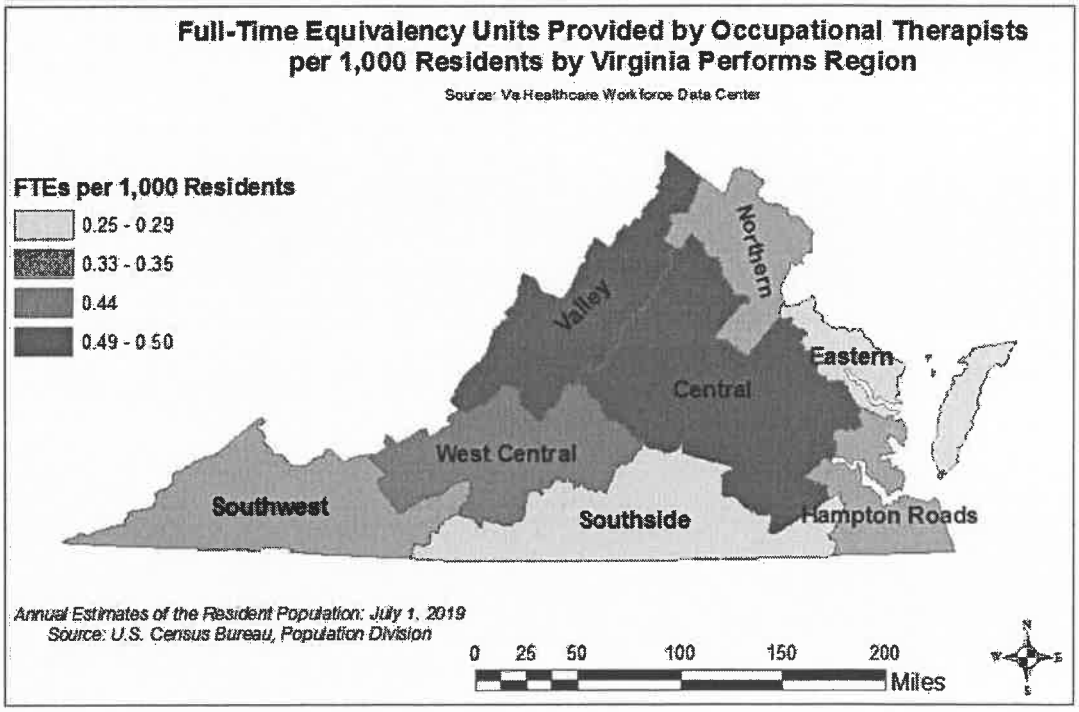
Source: Va. Healthcare Workforce Data Center

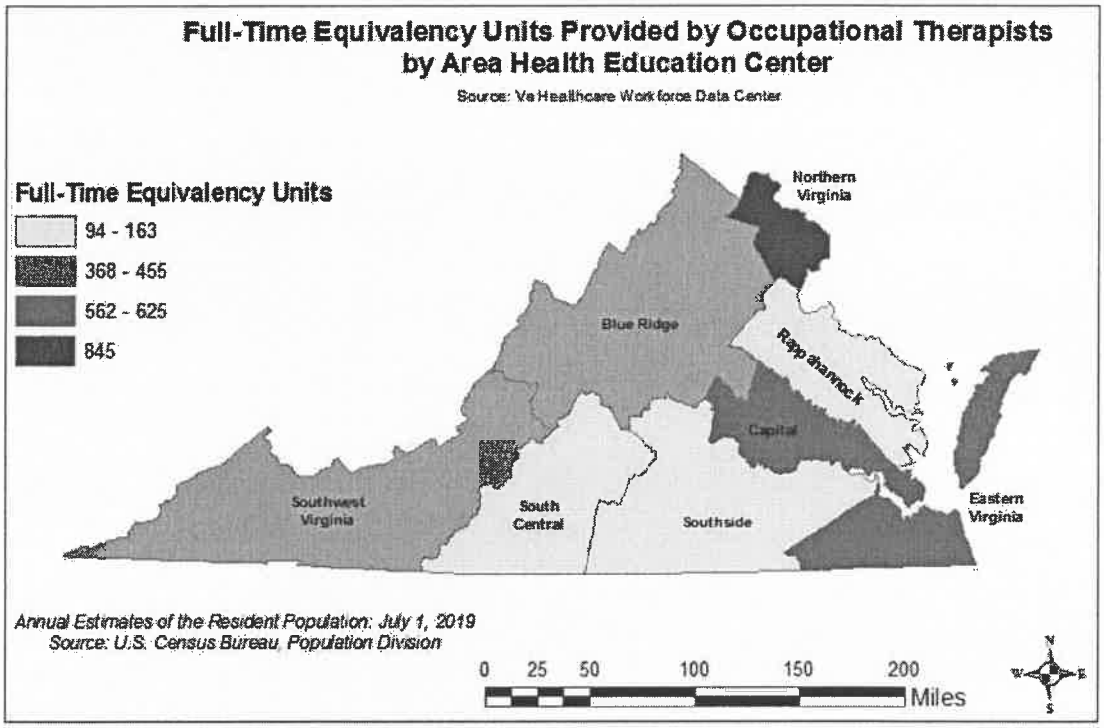
[2] Number of residents in 2019 was used as the denominator.
[3] Due to assumption violations in Mixed between-within ANOVA (Levene's Test was significant).

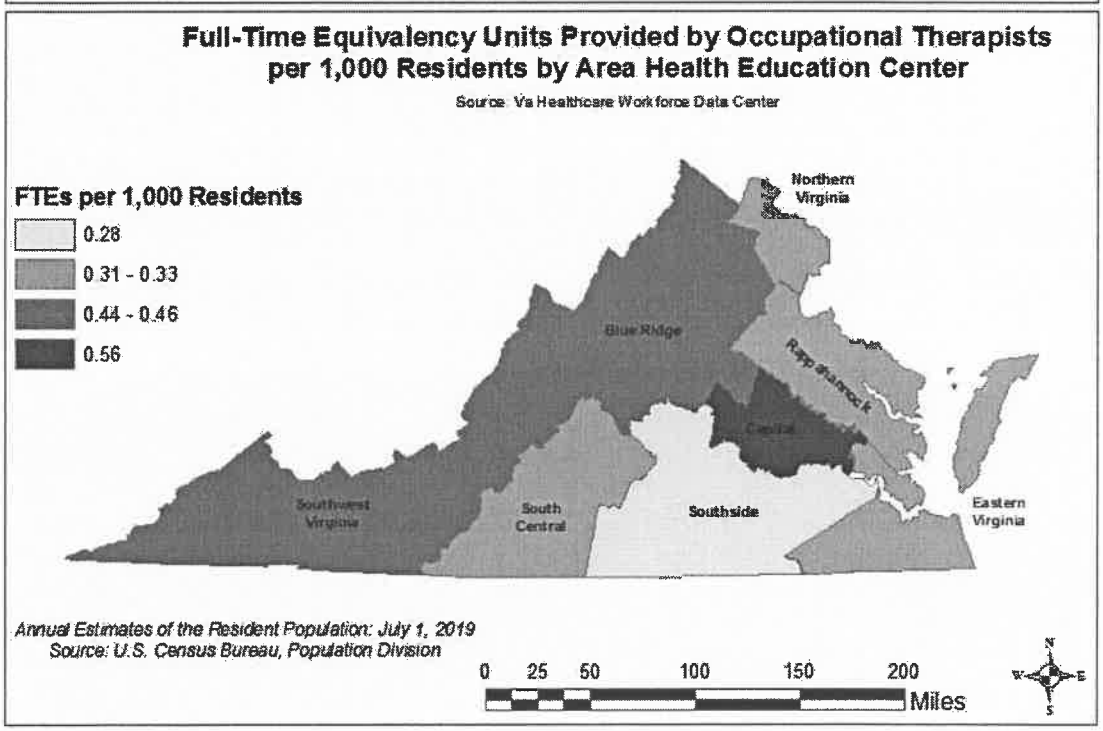
Maps

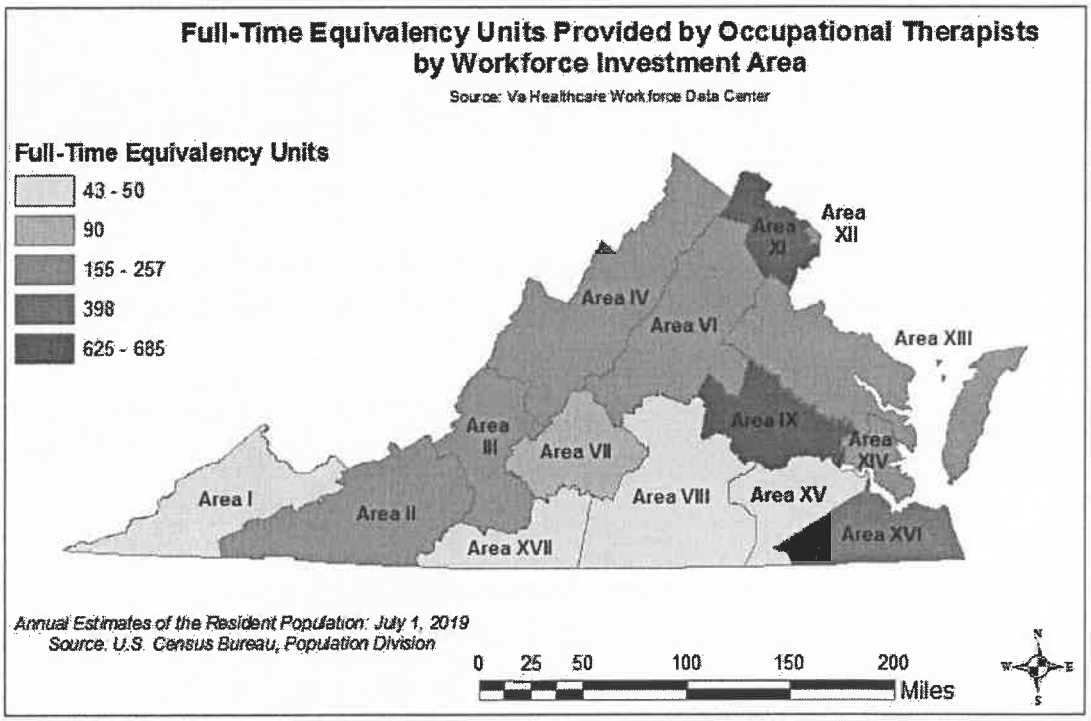
Virginia Performs Regions

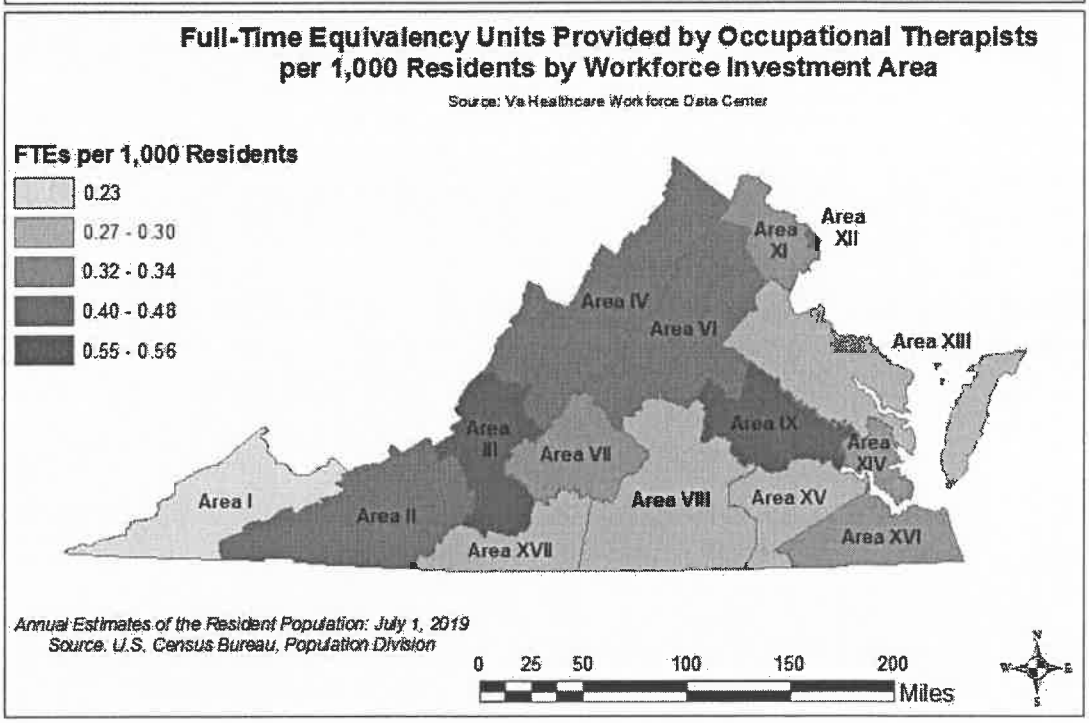


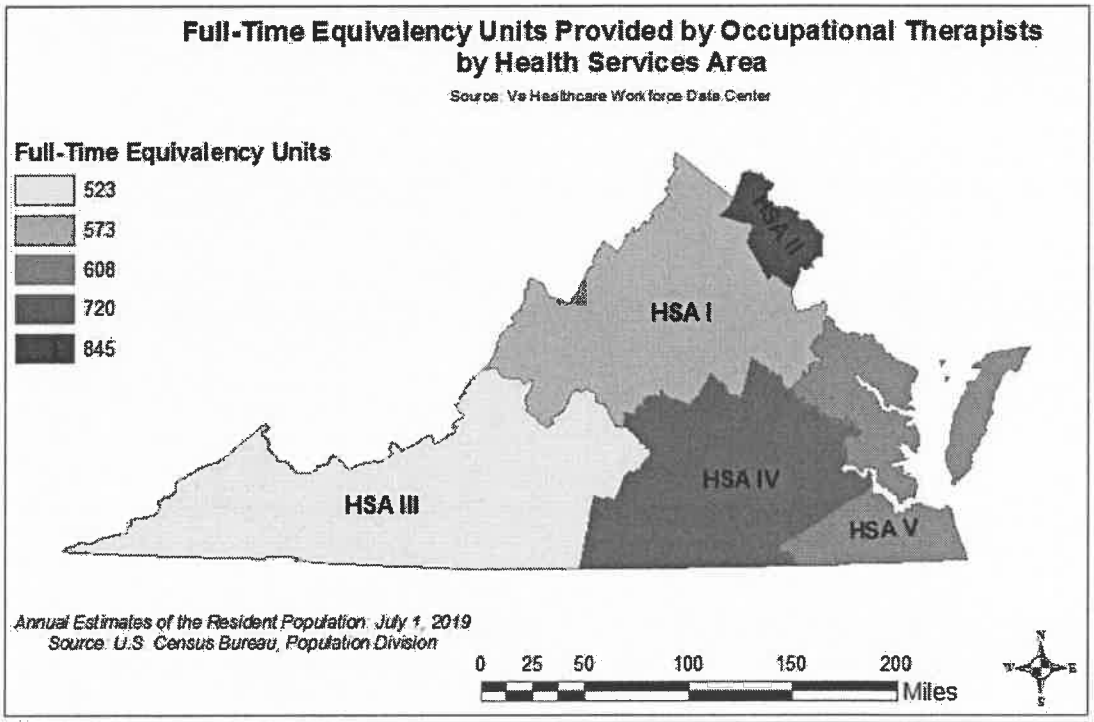


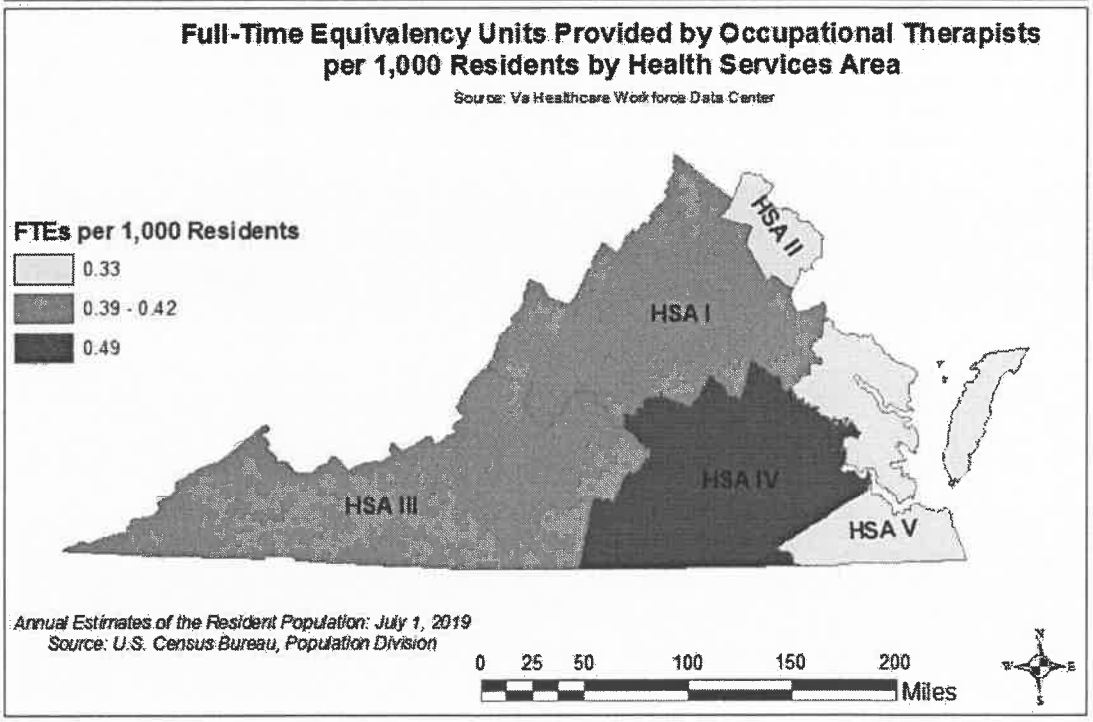

Full-Time Equivalency Units Provided by Occupational Therapists by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
94 - 163
368 - 455
562 - 625
845
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
Annual Estimates of the Resident Population: July 1, 2019
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

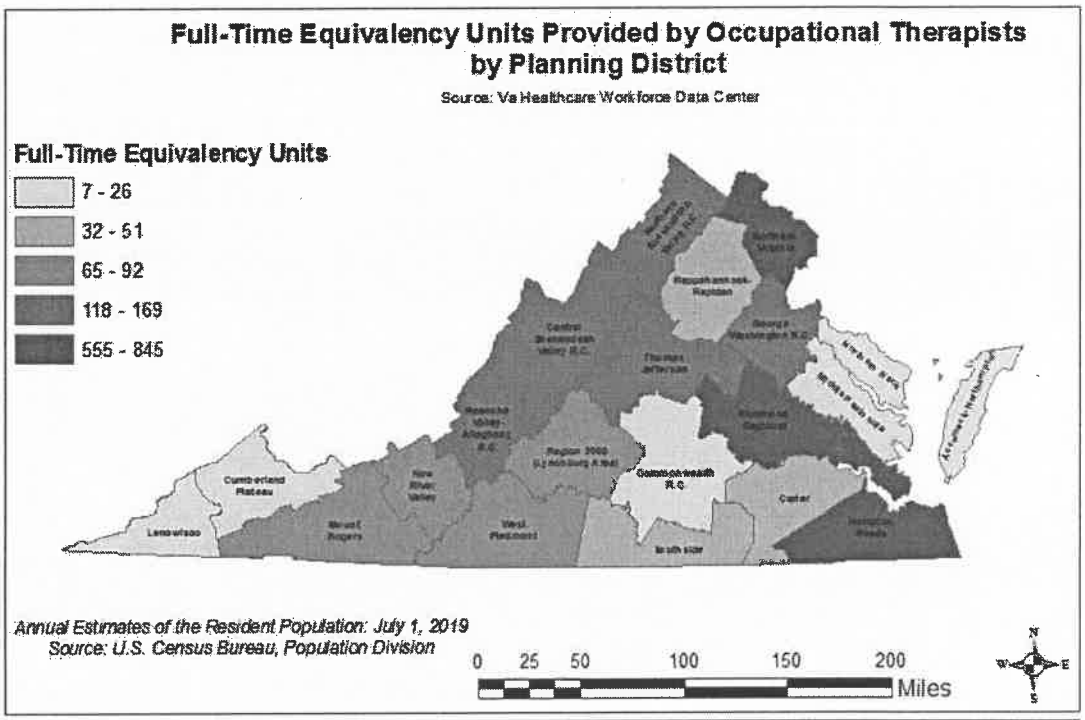

Full-Time Equivalency Units Provided by Occupational Therapists per 1,000 Residents by Area Health Education Center
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.28
0.31 - 0.33
0.44 - 0.46
0.56
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
Annual Estimates of the Resident Population: July 1, 2019
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

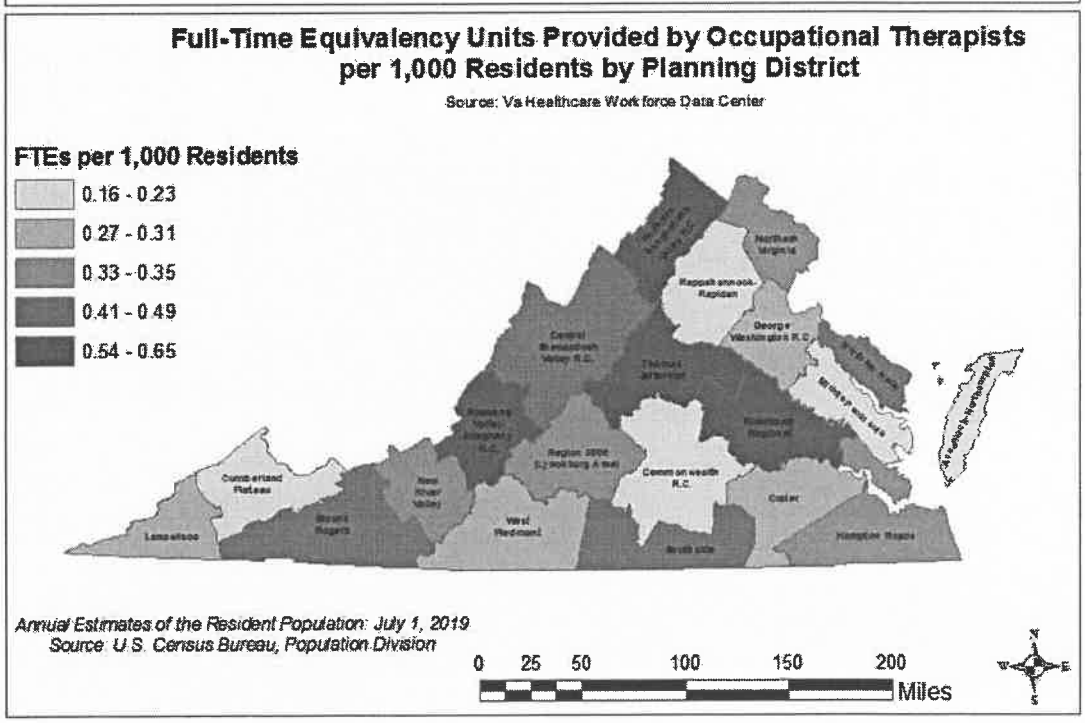

Full-Time Equivalency Units Provided by Occupational Therapists by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
43 - 50
90
155 - 257
398
625 - 685
Area XI
Area XII
Area IV
Area VI
Area XIII
Area IX
Area III
Area VII
Area XIV
Area I
Area II
Area VIII
Area XV
Area XVII
Area XVI
Annual Estimates of the Resident Population: July 1, 2019
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Occupational Therapists per 1,000 Residents by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.23
0.27 - 0.30
0.32 - 0.34
0.40 - 0.48
0.55 - 0.56
Area XI
Area XII
Area IV
Area VI
Area XIII
Area IX
Area III
Area VII
Area XIV
Area I
Area II
Area VIII
Area XV
Area XVII
Area XVI
Annual Estimates of the Resident Population: July 1, 2019
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Occupational Therapists by Health Services Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
523
573
608
720
845
HSA II
HSA I
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2019
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles


Full-Time Equivalency Units Provided by Occupational Therapists per 1,000 Residents by Health Services Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.33
0.39 - 0.42
0.49
HSA II
HSA I
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2019
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles


Full-Time Equivalency Units Provided by Occupational Therapists by Planning District
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
7 - 26
32 - 51
65 - 92
118 - 169
555 - 845
Annual Estimates of the Resident Population: July 1, 2019
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Occupational Therapists per 1,000 Residents by Planning District
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.16 - 0.23
0.27 - 0.31
0.33 - 0.35
0.41 - 0.49
0.54 - 0.65
Annual Estimates of the Resident Population: July 1, 2019
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+	2,583	82.15%	1.217	1.010	2.013
Metro, 250,000 to 1 Million	351	85.75%	1.166	0.968	1.928
Metro, 250,000 or Less	484	85.74%	1.166	0.968	1.929
Urban, Pop. 20,000+, Metro Adj.	40	85.00%	1.176	0.977	1.945
Urban, Pop. 20,000+, Non-Adj.	0	NA	NA	NA	NA
Urban, Pop. 2,500-19,999, Metro Adj.	120	73.33%	1.364	1.132	2.255
Urban, Pop. 2,500-19,999, Non-Adj.	55	74.55%	1.341	1.114	2.218
Rural, Metro Adj.	72	70.83%	1.412	1.172	2.334
Rural, Non-Adj.	28	75.00%	1.333	1.107	2.205
Virginia Border State/D.C.	554	60.83%	1.644	1.365	2.718
Other U.S. State	788	50.00%	2.000	1.660	3.307

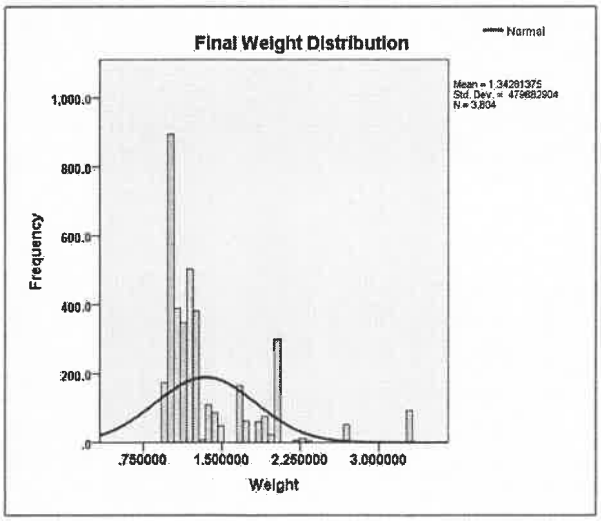
Source: Va. Healthcare Workforce Data Center

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

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

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

Overall Response Rate: 0.749557



Source: Va. Healthcare Workforce Data Center

Age	Age Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Under 30	1,017	45.33%	2.206	1.928	3.307
30 to 34	897	74.36%	1.345	1.175	2.016
35 to 39	690	81.45%	1.228	1.073	1.841
40 to 44	570	86.14%	1.161	1.015	1.740
45 to 49	505	90.30%	1.107	0.968	1.660
50 to 54	477	89.94%	1.112	0.972	1.667
55 to 59	379	87.86%	1.138	0.995	1.706
60 and Over	540	75.00%	1.333	1.165	1.999

Source: Va. Healthcare Workforce Data Center

DRAFT

Virginia's Occupational Therapy Assistant Workforce: 2020

Healthcare Workforce Data Center

March 2020

Virginia Department of Health Professions
Healthcare Workforce Data Center
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Get a copy of this report from:
https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/

More than 1,400 Occupational Therapy 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 Medicine express our sincerest appreciation for your ongoing cooperation.*

Thank You!

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Virginia's Workforce:	1,710
FTEs:	1,212

Survey Response Rate	
All Registrants:	75%
Renewing Practitioners:	92%

Demographics	
% Female:	90%
Diversity Index:	34%
Median Age:	38

Background	
Rural Childhood:	49%
HS Degree in VA:	60%
Prof. Degree in VA:	69%

Education	
Associate:	95%
Baccalaureate:	4%

Finances	
Median Income:	$45k-$50k
Health Insurance:	56%
Under 40 w/ Ed. Debt:	55%

Current Employment	
Employed in Prof.:	91%
Hold 1 Full-Time Job:	60%
Satisfied?:	92%

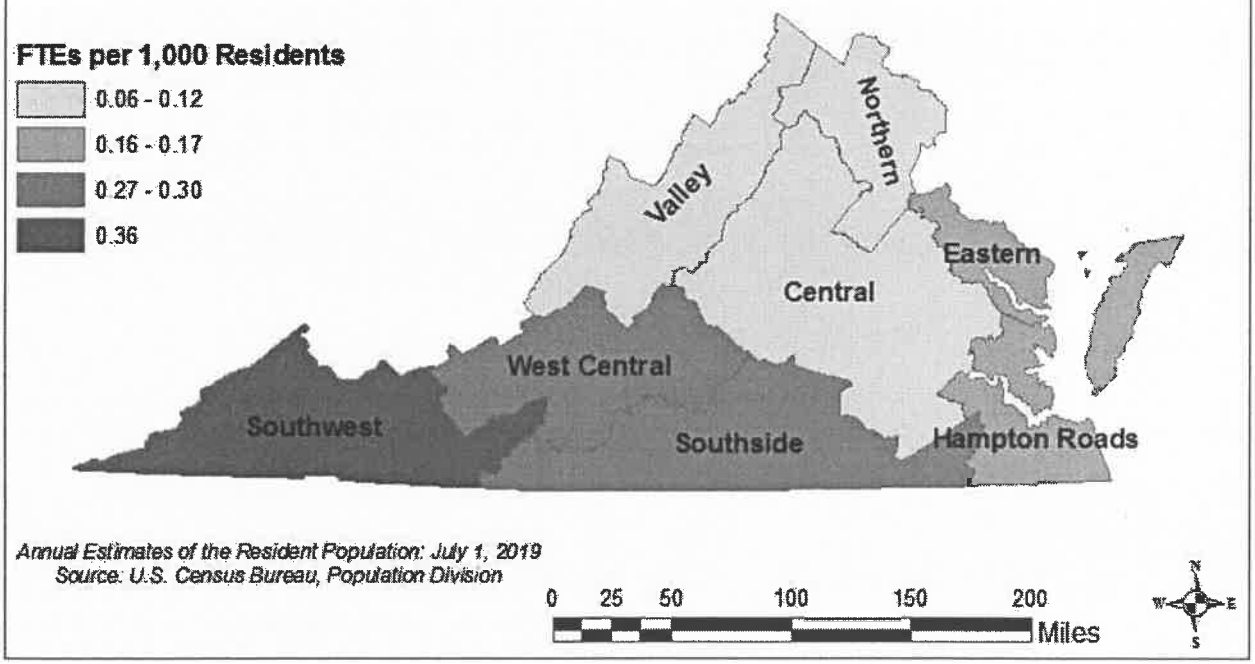
Job Turnover	
Switched Jobs:	9%
Employed Over 2 Yrs.:	55%

Primary Roles	
Patient Care:	86%
Administration:	4%
Education:	1%

Source: Va. Healthcare Workforce Data Center

Full-Time Equivalency Units Provided by Occupational Therapy Assistants per 1,000 Residents by Virginia Performs Region

Source: Va Healthcare Workforce Data Center



Results in Brief

This report contains the results of the 2020 Occupational Therapy Assistant (OTA) workforce survey. More than 1,400 OTAs voluntarily participated in this survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the registration renewal process, which takes place on even-numbered years during the birth month of each OTA. These survey respondents represent 75% of the 1,888 OTAs who are registered in the state and 92% of renewing practitioners.

The HWDC estimates that 1,710 OTAs participated in Virginia's workforce during the survey period, which is defined as those OTAs who worked at least a portion of the year in the state or who live in the state and intend to return to work as an OTA at some point in the future. This workforce provided 1,212 "full-time equivalency units", which the HWDC defines simply as working 2,000 hours per year.

Nine out of every ten OTAs are female, including 93% of those OTAs who are under the age of 40. Overall, the median age of this workforce is 38. In a random encounter between two OTAs, there is a 34% chance that they would be of different races or ethnicities, a measure known as the diversity index. For those OTs who are under the age of 40, this diversity index increases to 36%. However, both of these values are well below the comparable diversity index of 57% for Virginia's population as a whole. Nearly half of all OTAs grew up in rural areas, and one-third of these professionals currently work in non-metro areas of the state. In total, 22% of all OTAs currently work in non-metro areas of Virginia.

More than 90% of all OTAs are currently employed in the profession, 60% hold one full-time job, and 31% work between 40 and 49 hours per week. Meanwhile, 12% of OTAs have experienced involuntary unemployment at some point in the past year, and 12% have also experienced underemployment. Nearly 90% of all OTAs work in the private sector, including 70% who are employed in for-profit establishments. The median annual income for Virginia's OTAs is between $45,000 and $50,000. In addition, more than three-fourths of all OTAs receive at least one employer-sponsored benefit, including 56% who have access to health insurance. More than 90% of all OTAs indicated that they are satisfied with their current work situation, including 60% who indicated that they are "very satisfied".

Summary of Trends

In this section, all statistics for the current year are compared to the 2014 Occupational Therapy Assistant workforce. The number of registered OTAs has increased by 49% (1,888 vs. 1,270). In addition, the size of Virginia's OTA workforce has increased by 52% (1,710 vs. 1,125), and the number of FTEs provided by this workforce has increased by 35% (1,212 vs. 898). Virginia's renewing OTAs are more likely to respond to this survey (92% vs. 83%).

The percentage of OTAs who are female has increased slightly (90% vs. 89%). At the same time, the median age of this workforce has fallen considerably (38 vs. 42). The diversity index of Virginia's OTAs has increased (34% vs. 29%), and this increase in the diversity index is even greater among OTAs who are under the age of 40 (36% vs. 29%). Meanwhile, Virginia's OTAs are slightly less likely to have grown up in rural areas (49% vs. 50%), and this group of professionals is less likely to be employed in non-metro areas of the state (33% vs. 38%). In total, the percentage of all OTAs who work in non-metro areas of Virginia has declined (22% vs. 26%).

OTAs are less likely to be employed in the profession (91% vs. 97%), hold one full-time job (60% vs. 63%), or work between 40 and 49 hours per week (31% vs. 40%). Meanwhile, the rates of involuntary unemployment (12% vs. 3%) and underemployment (12% vs. 7%) in the past year have both increased. OTAs are more likely to be employed in the private sector (88% vs. 85%), and this increase comes from those OTAs who work in the non-profit sector (18% vs. 15%).

Virginia's OTAs are relatively more likely to obtain a baccalaureate degree as their highest professional degree (4% vs. 1%) instead of an associate degree (95% vs. 98%). At the same time, Virginia's OTAs are more likely to carry education debt (45% vs. 42%), and the median debt amount among these professionals has increased ($20k-$25k vs. $12k-$15k). OTAs indicated that they are satisfied with their current work situation (92% vs. 97%), including those who indicated that they are "very satisfied" (60% vs. 73%).

A Closer Look:

Registrants		
Status	**#**	**%**
Renewing Practitioners	1,531	81%
New Registrants	121	6%
Non-Renewals	236	13%
All Registrations	**1,888**	**100%**

Source: Va. Healthcare Workforce Data Center

HWDC surveys tend to achieve very high response rates. More than 90% of renewing OTAs submitted a survey. These represent 75% of all OTAs who held a registration at some point in 2020.

Definitions

1. **The Survey Period:** The survey was conducted throughout 2020.
2. **Target Population:** All OTAs who held a Virginia registration at some point in 2020.
3. **Survey Population:** The survey was available to OTAs who renewed their registrations online. It was not available to those who did not renew, including all OTAs newly registered in 2020.

Response Rates			
Statistic	**Non Respondents**	**Respondents**	**Response Rate**
By Age			
Under 30	155	250	62%
30 to 34	85	245	74%
35 to 39	52	180	78%
40 to 44	45	156	78%
45 to 49	37	166	82%
50 to 54	29	163	85%
55 to 59	28	116	81%
60 and Over	48	133	74%
Total	**479**	**1,409**	**75%**
New Registrants			
Registered in Past Year	121	0	0%
Metro Status			
Non-Metro	66	292	82%
Metro	262	940	78%
Not in Virginia	151	177	54%

Source: Va. Healthcare Workforce Data Center

Response Rates	
Completed Surveys	**1,409**
Response Rate, All Registrants	**75%**
Response Rate, Renewals	**92%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Registered OTAs

Number:	1,888
New:	6%
Not Renewed:	13%

Response Rates

All Registrants:	75%
Renewing Practitioners:	92%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Workforce

2020 OTA Workforce:	1,710
FTEs:	1,212

Utilization Ratios

Registrants in VA Workforce:	91%
Registrants per FTE:	1.56
Workers per FTE:	1.41

Source: Va. Healthcare Workforce Data Center

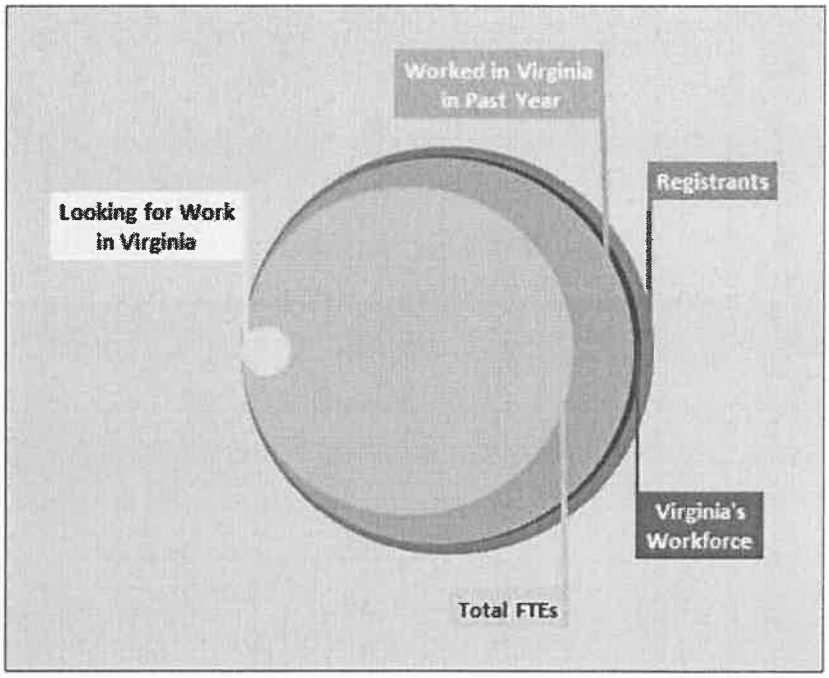
Definitions

1. **Virginia's Workforce:** A registrant 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. **Registrants in VA Workforce:** The proportion of registrants in Virginia's Workforce.
4. **Registrants per FTE:** An indication of the number of registrants needed to create 1 FTE. Higher numbers indicate lower registrant 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 OTA Workforce		
Status	**#**	**%**
Worked in Virginia in Past Year	1,683	98%
Looking for Work in Virginia	28	2%
Virginia's Workforce	**1,710**	**100%**
Total FTEs	**1,212**	
Registrants	**1,888**	

Source: Va. Healthcare Workforce Data Center

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



Source: Va. Healthcare Workforce Data Center

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 30	18	5%	334	95%	352	22%
30 to 34	16	5%	282	95%	298	19%
35 to 39	26	13%	180	87%	206	13%
40 to 44	23	13%	153	87%	176	11%
45 to 49	14	9%	147	91%	162	10%
50 to 54	30	19%	128	81%	157	10%
55 to 59	14	12%	96	88%	110	7%
60 and Over	13	11%	105	89%	118	7%
Total	154	10%	1,425	90%	1,579	100%

Source: Va. Healthcare Workforce Data Center

Race & Ethnicity					
Race/ Ethnicity	Virginia*	OTAs		OTAs Under 40	
	%	#	%	#	%
White	61%	1,292	80%	693	79%
Black	19%	166	10%	75	9%
Hispanic	10%	56	3%	40	5%
Asian	7%	39	2%	30	3%
Two or More Races	3%	44	3%	31	4%
Other Race	0%	16	1%	3	0%
Total	100%	1,612	100%	873	100%

*Population data in this chart is from the U.S. Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2019.

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

% Female:	90%
% Under 40 Female:	93%

Age

Median Age:	38
% Under 40:	54%
% 55 and Over:	14%

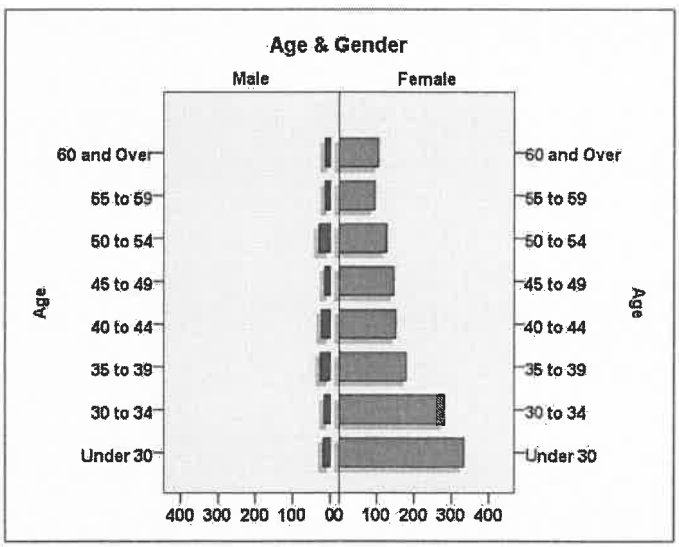
Diversity

Diversity Index:	34%
Under 40 Div. Index:	36%

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two OTAs, there is a 34% chance that they would be of different races or ethnicities (a measure known as the diversity index). For Virginia's population as a whole, the comparable number is 57%.

More than half of all OTAs are under the age of 40, and 93% of these professionals are female. In addition, there is a 36% chance that two randomly chosen OTAs from this age group would be of different races or ethnicities.



Source: Va. Healthcare Workforce Data Center

At a Glance:

Childhood

Urban Childhood:	11%
Rural Childhood:	49%

Virginia Background

HS in Virginia:	60%
Professional Edu. in VA:	69%
HS/Prof. Edu. in VA:	72%

Location Choice

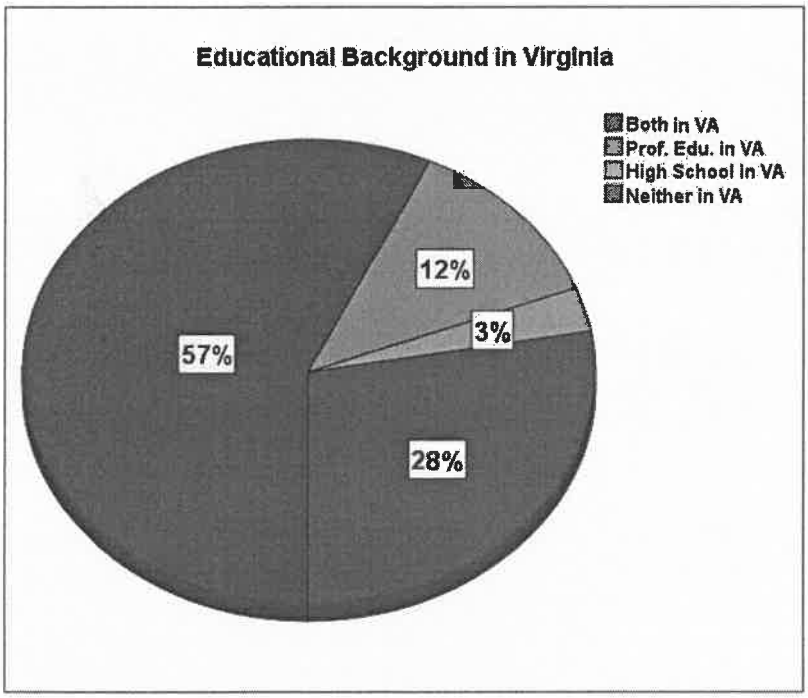
% Rural to Non-Metro:	33%
% Urban/Suburban to Non-Metro:	12%

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+	32%	55%	13%
2	Metro, 250,000 to 1 Million	59%	30%	10%
3	Metro, 250,000 or Less	67%	25%	8%
	Non-Metro Counties			
4	Urban, Pop. 20,000+, Metro Adjacent	69%	18%	13%
6	Urban, Pop. 2,500-19,999, Metro Adjacent	57%	29%	14%
7	Urban, Pop. 2,500-19,999, Non-Adjacent	85%	12%	3%
8	Rural, Metro Adjacent	90%	10%	0%
9	Rural, Non-Adjacent	60%	23%	17%
	Overall	**49%**	**40%**	**11%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Nearly half of OTAs grew up in self-described rural areas, and one-third of these professionals currently work in non-metro counties. Overall, 22% of Virginia's OTAs work in non-metro counties of the state.

Top Ten States for Occupational Therapy Assistant Recruitment

Rank	All Occupational Therapy Assistants			
	High School	#	Professional School	#
1	Virginia	968	Virginia	1,112
2	Pennsylvania	81	Pennsylvania	60
3	New York	75	New York	51
4	West Virginia	56	West Virginia	46
5	Florida	41	Florida	37
6	Ohio	38	North Carolina	34
7	North Carolina	34	Minnesota	32
8	Outside U.S./Canada	34	Maryland	28
9	Maryland	26	Texas	26
10	New Jersey	23	Ohio	20

Source: Va. Healthcare Workforce Data Center

Among all OTAs, 60% received their high school degree in Virginia, and 69% received their initial professional degree in the state.

Among OTAs who were registered in the past five years, 61% received their high school degree in Virginia, and 70% received their initial professional degree in the state.

Rank	Registered in the Past Five Years			
	High School	#	Professional School	#
1	Virginia	389	Virginia	448
2	Pennsylvania	25	Minnesota	26
3	New York	22	Pennsylvania	23
4	Florida	21	Florida	23
5	Outside U.S./Canada	21	West Virginia	19
6	West Virginia	20	New York	11
7	California	13	Texas	10
8	Illinois	12	California	9
9	Maryland	12	Maryland	8
10	Ohio	10	North Carolina	6

Source: Va. Healthcare Workforce Data Center

Nearly 10% of registered OTAs did not participate in Virginia's workforce in the past year. Nearly 90% of these professionals worked at some point in the past year, including 74% who currently work as OTAs.

At a Glance:

Not in VA Workforce

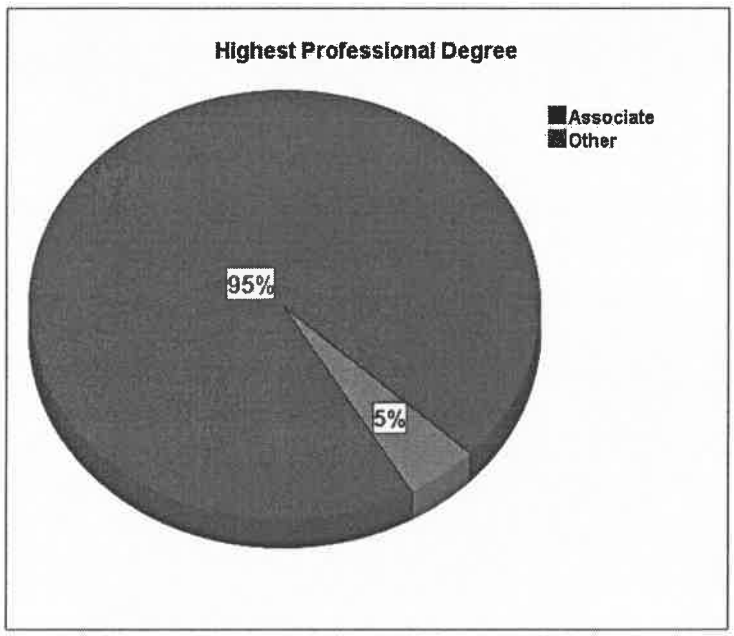
Total:	178
% of Registrants:	9%
Federal/Military:	3%
VA Border State/DC:	16%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Professional Degree		
Degree	#	%
Associate Degree	1,509	95%
Baccalaureate Degree	63	4%
Master's Degree	6	0%
Doctoral Degree	4	0%
Total	1,582	100%

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

At a Glance:

Education

Associate: 95%

Baccalaureate: 4%

Education Debt

With Debt: 45%

Under Age 40 w/ Debt: 55%

Median Debt: $20k-$25k

Source: Va. Healthcare Workforce Data Center

More than nine out of every ten OTAs hold an associate degree as their highest professional degree.

Nearly half of all OTAs carry education debt, including 55% of those who are under the age of 40. For those with education debt, the median debt amount is between $20,000 and $25,000.

Education Debt				
Amount Carried	All OTAs		OTAs Under 40	
	#	%	#	%
None	777	55%	342	45%
$2,000 or Less	23	2%	21	3%
$2,001-$4,000	22	2%	8	1%
$4,001-$6,000	46	3%	28	4%
$6,001-$8,000	44	3%	29	4%
$8,001-$10,000	32	2%	22	3%
$10,001-$12,000	27	2%	16	2%
$12,001-$15,000	24	2%	15	2%
$15,001-$20,000	67	5%	41	5%
$20,001-$25,000	78	5%	48	6%
More than $25,000	280	20%	195	25%
Total	1,421	100%	765	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Top Specialties

Gerontology:	27%
Physical Rehabilitation:	24%
Home Health:	21%

Top Certifications

Dementia Care:	3%
School Systems:	2%
Lymphedema Therapist:	1%

Source: Va. Healthcare Workforce Data Center

Two-thirds of all OTAs have at least one specialization, including 27% who have a specialization in Gerontology.

A Closer Look:

Specializations		
Area	#	% of Workforce
Gerontology	460	27%
Physical Rehabilitation	405	24%
Home Health	362	21%
Pediatrics	210	12%
Neurorehabilitation	198	12%
School Systems	184	11%
Acute Care	172	10%
Environmental Modification	150	9%
Developmental Disabilities	139	8%
Sensory Processing	136	8%
Feeding, Eating, Swallowing	117	7%
Mental Health	110	6%
Hand Therapy	102	6%
Early Intervention	78	5%
Low Vision	76	4%
Driving and Community Mobility	6	0%
Industrial/Workplace	6	0%
Other	95	6%
At Least One Specialization	1,128	66%

Source: Va. Healthcare Workforce Data Center

Certifications		
Proficiency Area	#	% of Workforce
Dementia Care Specialist	47	3%
School Systems	35	2%
Certified Lymphedema Therapist	25	1%
Low Vision (SCALV)	7	0%
Feeding, Eating, Swallowing (SCAFES)	5	0%
Environmental Modification (SCAEM)	4	0%
Other	99	6%
At Least One Certification	195	11%

Source: Va. Healthcare Workforce Data Center

More than 10% of all OTAs hold at least one certification, including 3% who have been certified as Dementia Care Specialists.

At a Glance:

Employment

Employed in Profession:	91%
Involuntarily Unemployed:	3%

Positions Held

1 Full-Time:	60%
2 or More Positions:	18%

Weekly Hours:

40 to 49:	31%
60 or More:	2%
Less than 30:	20%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Current Work Status		
Status	**#**	**%**
Employed, Capacity Unknown	0	0%
Employed in an Occupational Therapy-Related Capacity	1,471	91%
Employed, NOT in an Occupational Therapy-Related Capacity	55	3%
Not Working, Reason Unknown	0	0%
Involuntarily Unemployed	43	3%
Voluntarily Unemployed	39	2%
Retired	4	0%
Total	**1,612**	**100%**

Source: Va. Healthcare Workforce Data Center

More than 90% of all OTAs are currently employed in the profession, 60% hold one full-time job, and 31% work between 40 and 49 hours per week.

Current Positions		
Positions	**#**	**%**
No Positions	86	5%
One Part-Time Position	263	17%
Two Part-Time Positions	84	5%
One Full-Time Position	955	60%
One Full-Time Position & One Part-Time Position	149	9%
Two Full-Time Positions	1	0%
More than Two Positions	49	3%
Total	**1,587**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Weekly Hours		
Hours	**#**	**%**
0 Hours	86	6%
1 to 9 Hours	68	4%
10 to 19 Hours	90	6%
20 to 29 Hours	158	10%
30 to 39 Hours	621	40%
40 to 49 Hours	473	31%
50 to 59 Hours	29	2%
60 to 69 Hours	7	0%
70 to 79 Hours	4	0%
80 or More Hours	14	1%
Total	**1,550**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Annual Income		
Income Level	**#**	**%**
Volunteer Work Only	5	0%
$30,000 or Less	179	15%
$30,001-$35,000	55	5%
$35,001-$40,000	113	9%
$40,001-$45,000	128	11%
$45,001-$50,000	142	12%
$50,001-$55,000	159	13%
$55,001-$60,000	161	13%
$60,001-$65,000	101	8%
$65,001-$70,000	69	6%
$70,001-$75,000	49	4%
$75,001-$80,000	17	1%
More than $80,000	36	3%
Total	**1,214**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Earnings
Median Income: $45k-$50k

Benefits
Health Insurance: 56%
Retirement: 53%

Satisfaction
Satisfied 92%
Very Satisfied: 60%

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	**#**	**%**
Very Satisfied	945	60%
Somewhat Satisfied	499	32%
Somewhat Dissatisfied	86	6%
Very Dissatisfied	47	3%
Total	**1,577**	**100%**

Source: Va. Healthcare Workforce Data Center

The typical OTA earns between $45,000 and $50,000 per year. In addition, more than three-quarters of all OTAs receive at least one employer-sponsored benefit, including 56% who have access to health insurance.

Employer-Sponsored Benefits			
Benefit	**#**	**%**	**% of Wage/Salary Employees**
Paid Vacation	983	67%	69%
Health Insurance	823	56%	57%
Dental Insurance	795	54%	56%
Retirement	774	53%	53%
Paid Sick Leave	676	46%	46%
Group Life Insurance	480	33%	34%
Signing/Retention Bonus	32	2%	2%
At Least One Benefit	**1,127**	**77%**	**77%**

*From any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Employment Instability in the Past Year		
In the Past Year, Did You . . .?	#	%
Work Two or More Positions at the Same Time?	347	20%
Work Part-Time or Temporary Positions, but Would Have Preferred a Full-Time/Permanent Position?	204	12%
Experience Involuntary Unemployment?	202	12%
Switch Employers or Practices?	147	9%
Experience Voluntary Unemployment?	113	7%
Experienced At Least One	**714**	**42%**

Source: Va. Healthcare Workforce Data Center

More than 10% of OTAs experienced involuntary unemployment in the past year. By comparison, Virginia's average monthly unemployment rate was 6.0% during the same time period.[1]

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at This Location	68	4%	67	13%
Less than 6 Months	81	5%	68	14%
6 Months to 1 Year	152	10%	63	13%
1 to 2 Years	397	26%	128	25%
3 to 5 Years	437	28%	117	23%
6 to 10 Years	222	14%	44	9%
More than 10 Years	197	13%	15	3%
Subtotal	**1,555**	**100%**	**502**	**100%**
Did Not Have Location	38		1,189	
Item Missing	117		20	
Total	**1,710**		**1,710**	

Source: Va. Healthcare Workforce Data Center

More than three-quarters of Virginia's OTAs received an hourly wage at their primary work location, while another 15% either received a salary or worked on commission.

At a Glance:

Unemployment Experience

Involuntarily Unemployed:	12%
Underemployed:	12%

Turnover & Tenure

Switched Jobs:	9%
New Location:	23%
Over 2 Years:	55%
Over 2 Yrs., 2nd Location:	35%

Employment Type

Hourly Wage:	76%
Salary/Commission:	15%

Source: Va. Healthcare Workforce Data Center

Among all OTAs, 55% have worked at their primary work location for more than two years.

Employment Type		
Primary Work Site	#	%
Hourly Wage	923	76%
Salary/Commission	182	15%
By Contract	110	9%
Unpaid	5	0%
Business/Practice Income	0	0%
Subtotal	**1,220**	**100%**

Source: Va. Healthcare Workforce Data Center

[1] As reported by the U.S. Bureau of Labor Statistics. The non-seasonally adjusted monthly unemployment rate fluctuated between a low of 2.8% and a high of 10.8%. The unemployment rate from December 2020 was still preliminary at the time of publication.

At a Glance:

Concentration

Top Region:	24%
Top 3 Regions:	55%
Lowest Region:	2%

Locations

2 or More (Past Year):	33%
2 or More (Now*):	29%

Source: Va. Healthcare Workforce Data Center

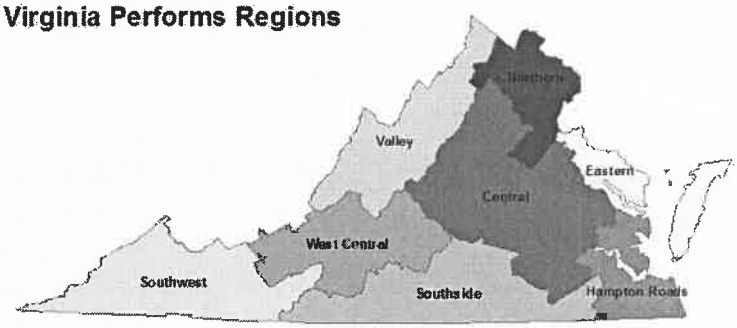
More than half of all OTAs work in Hampton Roads, West Central Virginia, and Northern Virginia.

A Closer Look:

Regional Distribution of Work Locations				
Virginia Performs Region	Primary Location		Secondary Location	
	#	%	#	%
Hampton Roads	365	24%	108	21%
West Central	244	16%	79	16%
Northern	238	15%	65	13%
Central	231	15%	92	18%
Southwest	198	13%	61	12%
Southside	136	9%	35	7%
Valley	81	5%	28	6%
Eastern	34	2%	8	2%
Virginia Border State/D.C.	4	0%	3	1%
Other U.S. State	16	1%	28	6%
Outside of the U.S.	0	0%	2	0%
Total	**1,547**	**100%**	**509**	**100%**
Item Missing	124		14	

Source: Va. Healthcare Workforce Data Center

Virginia Performs Regions



Nearly 30% of OTAs currently have multiple work locations, while one-third of all OTAs have had multiple work locations over the past year.

Number of Work Locations				
Locations	Work Locations in Past Year		Work Locations Now*	
	#	%	#	%
0	28	2%	86	6%
1	1,030	65%	1,041	66%
2	308	20%	277	18%
3	151	10%	143	9%
4	37	2%	23	1%
5	12	1%	3	0%
6 or More	12	1%	5	0%
Total	**1,577**	**100%**	**1,577**	**100%**

*At the time of survey completion: 2020 (on the birth month of each respondent).

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	1,030	70%	371	79%
Non-Profit	258	18%	72	15%
State/Local Government	149	10%	24	5%
Veterans Administration	4	0%	1	0%
U.S. Military	13	1%	0	0%
Other Federal Gov't	7	0%	0	0%
Total	1,461	100%	468	100%
Did Not Have Location	38		1,189	
Item Missing	213		53	

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Sector

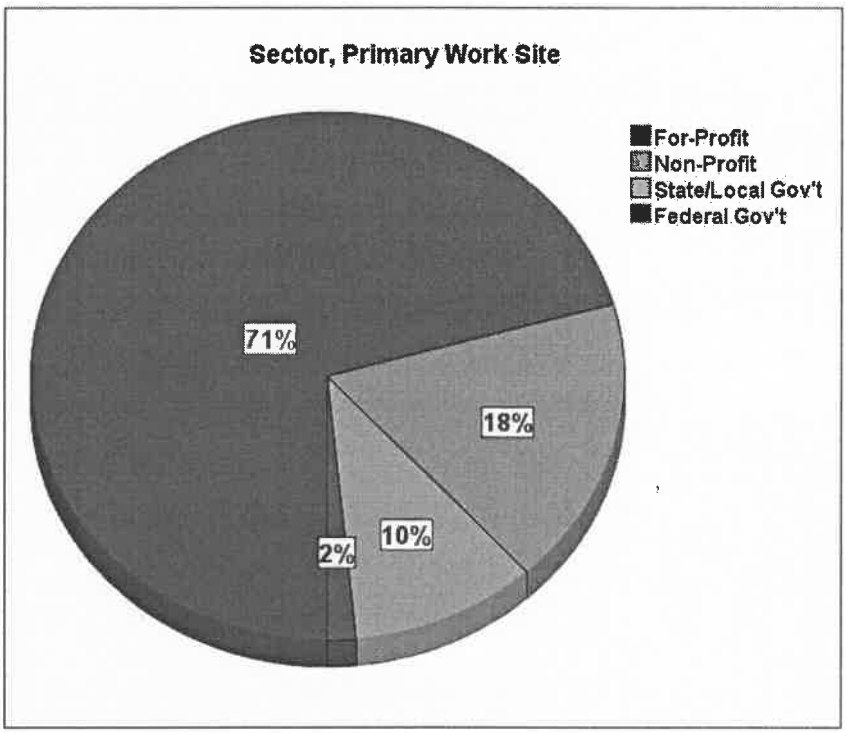
For-Profit: 70%
Federal: 2%

Top Establishments

Skilled Nursing Facility: 40%
Home Health Care: 15%
Assisted Living/
Continuing Care Facility: 9%

Source: Va. Healthcare Workforce Data Center

Nearly 90% of all OTAs work in the private sector, including 70% who work at for-profit establishments.



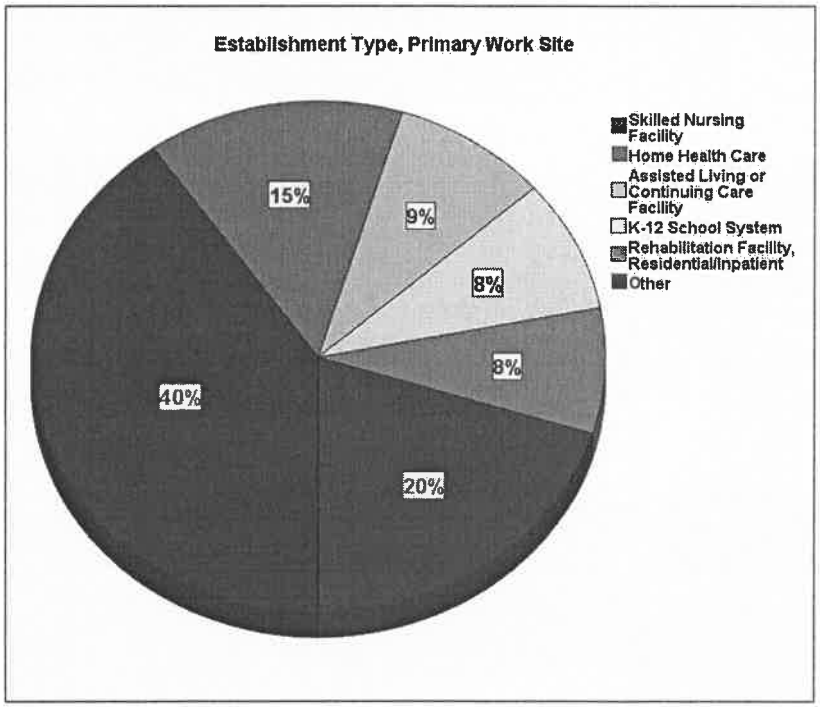
Source: Va. Healthcare Workforce Data Center

Location Type				
Establishment Type	Primary Location		Secondary Location	
	#	%	#	%
Skilled Nursing Facility	568	40%	199	42%
Home Health Care	205	15%	89	19%
Assisted Living or Continuing Care Facility	124	9%	45	10%
K-12 School System	118	8%	15	3%
Rehabilitation Facility, Residential/Inpatient	112	8%	43	9%
General Hospital, Inpatient Department	68	5%	14	3%
Rehabilitation Facility, Outpatient Clinic	58	4%	10	2%
Private Practice, Group	46	3%	12	3%
Private Practice, Solo	19	1%	6	1%
Academic Institution	16	1%	2	0%
General Hospital, Outpatient Department	10	1%	4	1%
Mental Health, Inpatient	9	1%	0	0%
Other	58	4%	30	6%
Total	1,411	100%	469	100%
Did Not Have a Location	38		1,189	

Source: Va. Healthcare Workforce Data Center

More than half of all OTAs work in either skilled nursing facilities or home health care establishments as their primary work location.

Among those OTAs who also have a secondary work location, more than 60% work in either skilled nursing facilities or home health care establishments.



Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

A Typical OTA's Time

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

Roles

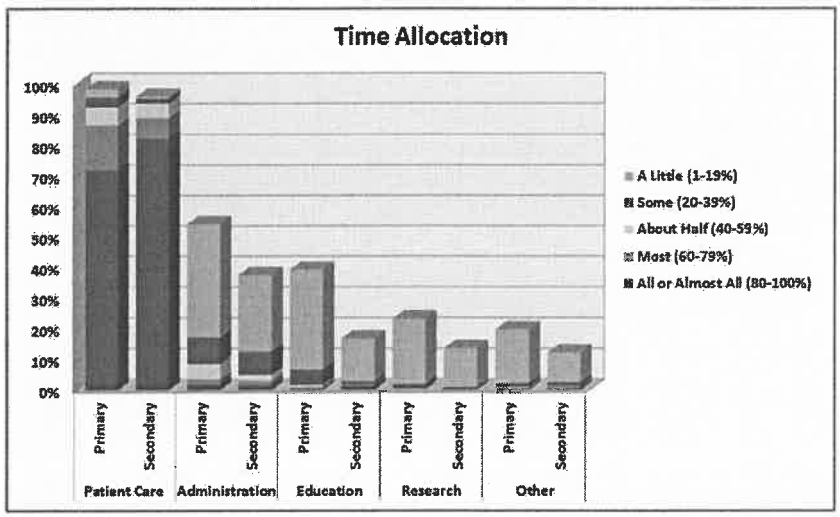
Patient Care:	86%
Administrative:	4%
Education:	1%

Patient Care OTAs

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

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

OTAs spend most of their time performing patient care activities. In fact, 86% of all OTAs fill a patient care role, defined as spending at least 60% of their time in that activity.

Time Allocation										
Time Spent	Patient Care		Admin.		Education		Research		Other	
	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site
All or Almost All (80-100%)	72%	82%	2%	2%	1%	1%	0%	0%	0%	0%
Most (60-79%)	15%	7%	2%	2%	0%	0%	0%	0%	0%	1%
About Half (40-59%)	6%	5%	5%	2%	1%	0%	0%	0%	0%	0%
Some (20-39%)	3%	2%	9%	8%	5%	1%	2%	1%	1%	1%
A Little (1-19%)	3%	1%	37%	25%	32%	14%	21%	13%	17%	10%
None (0%)	2%	4%	46%	63%	61%	83%	77%	86%	80%	87%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All OTAs		OTAs 50 and Over	
	#	%	#	%
Under Age 50	78	6%	-	-
50 to 54	92	7%	4	1%
55 to 59	145	11%	17	5%
60 to 64	345	25%	81	24%
65 to 69	447	33%	156	46%
70 to 74	132	10%	52	15%
75 to 79	32	2%	7	2%
80 or Over	7	1%	2	1%
I Do Not Intend to Retire	95	7%	21	6%
Total	1,373	100%	340	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All OTAs

Under 65:	48%
Under 60:	23%

OTAs 50 and Over

Under 65:	30%
Under 60:	6%

Time Until Retirement

Within 2 Years:	3%
Within 10 Years:	13%
Half the Workforce:	By 2050

Source: Va. Healthcare Workforce Data Center

Nearly half of all OTAs expect to retire by the age of 65. Among those OTAs who are age 50 and over, 30% still expect to retire by the age of 65.

Within the next two years, 18% of OTAs expect to pursue additional OT-related educational opportunities, and 17% expect to increase their patient care hours.

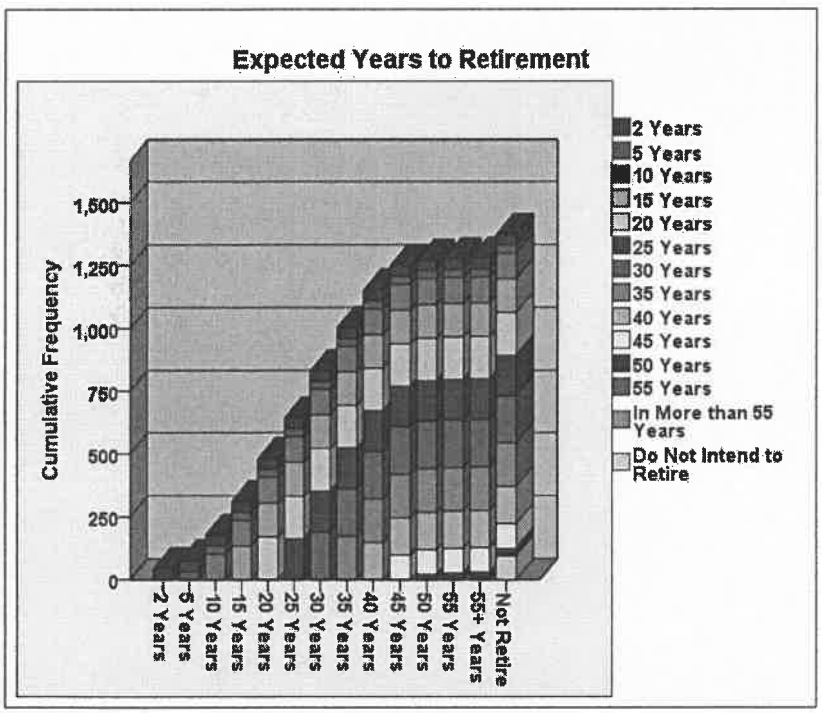
Future Plans		
Two-Year Plans:	#	%
Decrease Participation		
Decrease Patient Care Hours	101	6%
Leave Profession	58	3%
Leave Virginia	55	3%
Decrease Teaching Hours	2	0%
Increase Participation		
Pursue Other OT-Related Education	311	18%
Increase Patient Care Hours	288	17%
Pursue Education to Become an OT	194	11%
Increase Teaching Hours	79	5%
Return to Virginia's Workforce	13	1%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectations to age, we can estimate the maximum years to retirement for OTAs. While only 3% of OTAs expect to retire in the next two years, 13% expect to retire within the next decade. More than half of the current workforce expect to retire by 2050.

Time to Retirement			
Expect to Retire Within. . .	#	%	Cumulative %
2 Years	43	3%	3%
5 Years	31	2%	5%
10 Years	102	7%	13%
15 Years	134	10%	23%
20 Years	170	12%	35%
25 Years	162	12%	47%
30 Years	189	14%	61%
35 Years	172	13%	73%
40 Years	148	11%	84%
45 Years	98	7%	91%
50 Years	22	2%	93%
55 Years	5	0%	93%
In More than 55 Years	3	0%	93%
Do Not Intend to Retire	95	7%	100%
Total	1,373	100%	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Using these estimates, retirement will begin to reach 10% of the current workforce every five years by 2035. Retirement will peak at 14% of the current workforce in 2050 before declining to under 10% of the current workforce again around 2065.

At a Glance:

FTEs

Total:	1,212
FTEs/1,000 Residents[2]:	0.142
Average:	0.73

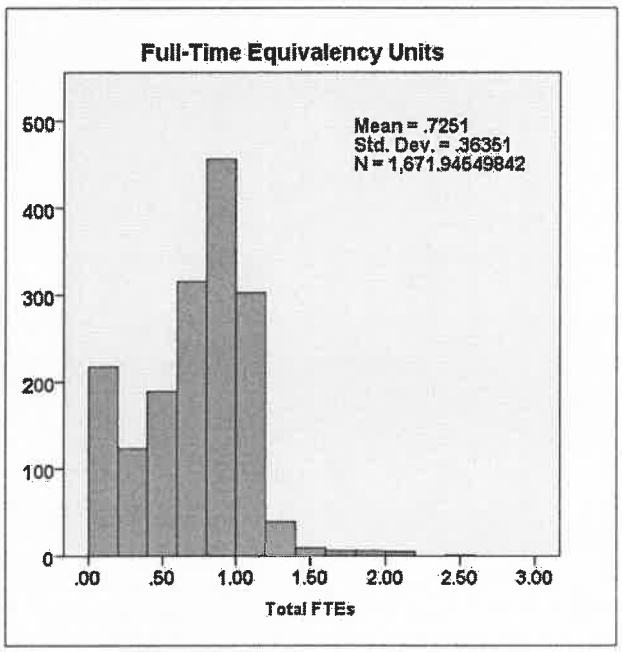
Age & Gender Effect

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

Partial Eta² Explained:
Partial Eta² is a statistical measure of effect size.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

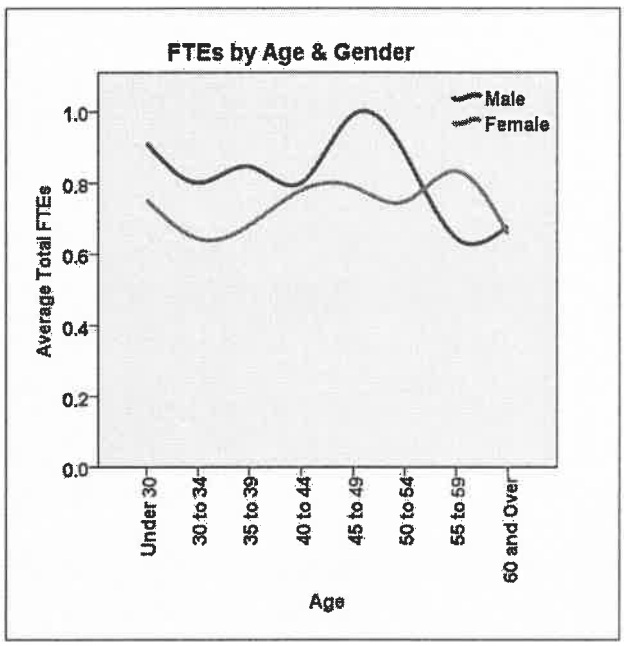


Source: Va. Healthcare Workforce Data Center

The typical OTA provided 0.80 FTEs in 2020, or approximately 32 hours per week for 50 weeks. Although FTEs appear to vary by gender, statistical tests did not verify that a difference exists.[3]

Full-Time Equivalency Units		
Age	Average	Median
Age		
Under 30	0.76	0.80
30 to 34	0.66	0.72
35 to 39	0.68	0.77
40 to 44	0.77	0.83
45 to 49	0.79	0.83
50 to 54	0.77	0.83
55 to 59	0.79	0.87
60 and Over	0.58	0.63
Gender		
Male	0.83	0.93
Female	0.73	0.80

Source: Va. Healthcare Workforce Data Center

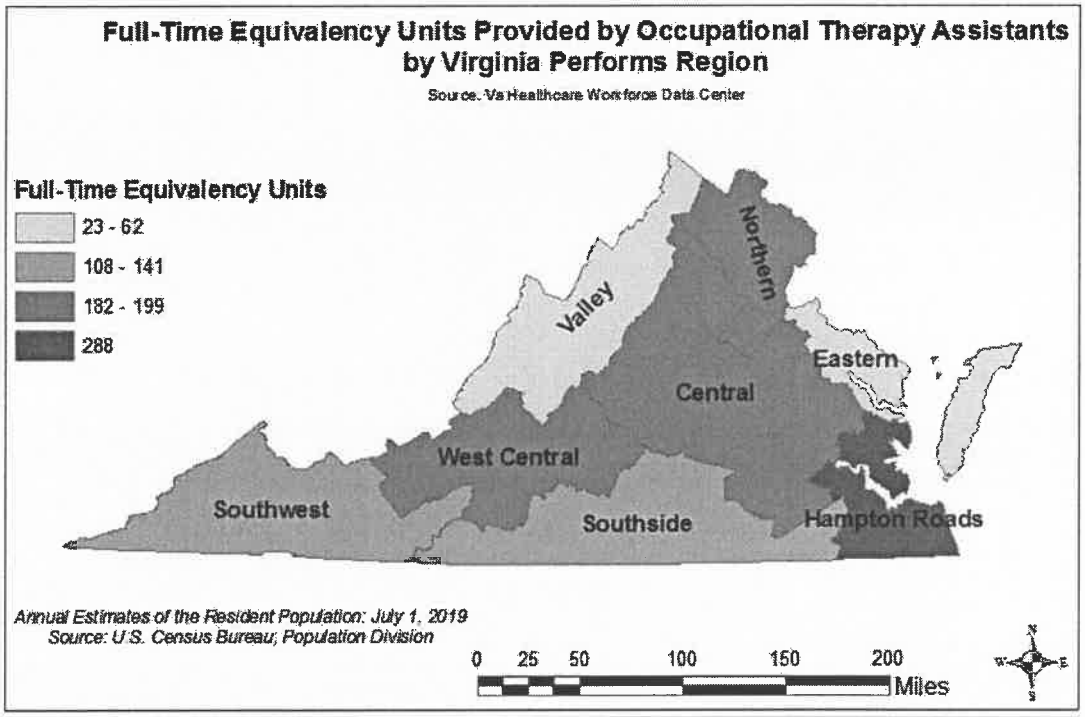


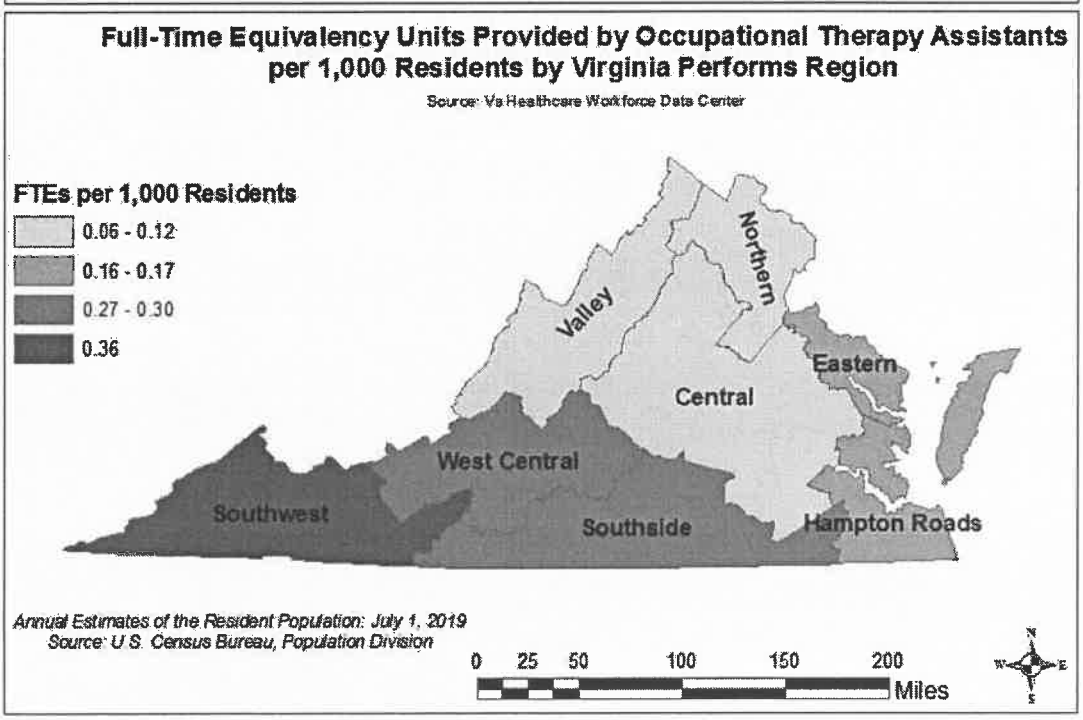
Source: Va. Healthcare Workforce Data Center

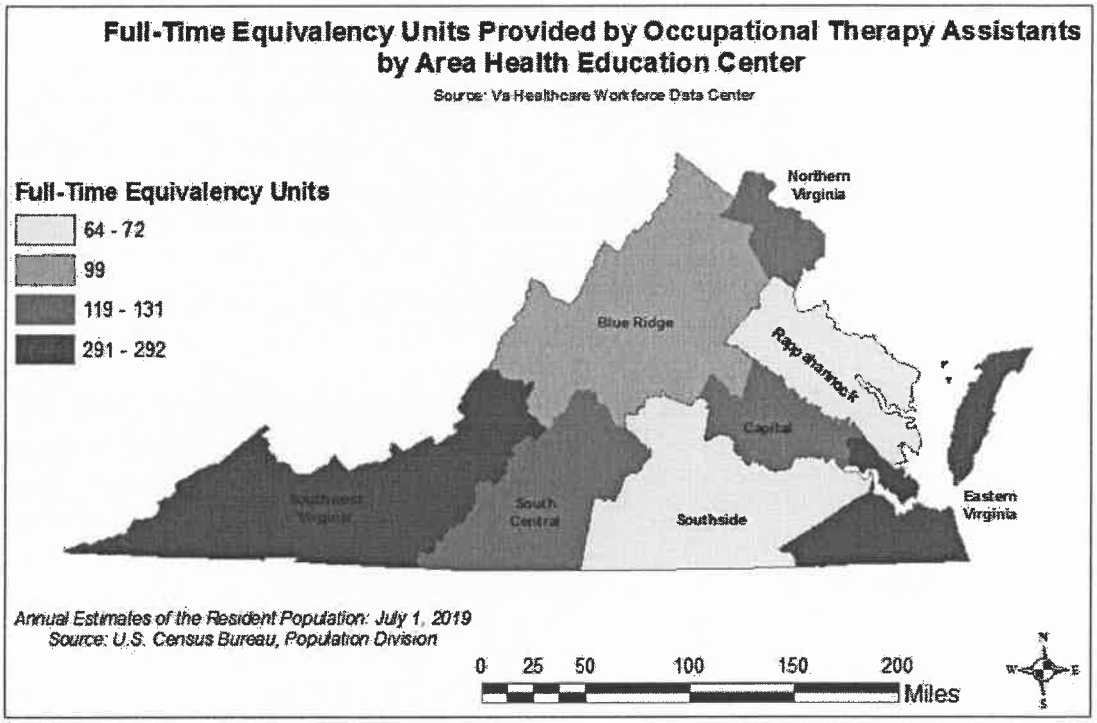
[2] Number of residents in 2019 was used as the denominator.
[3] Due to assumption violations in Mixed between-within ANOVA (Levene's Test was significant).

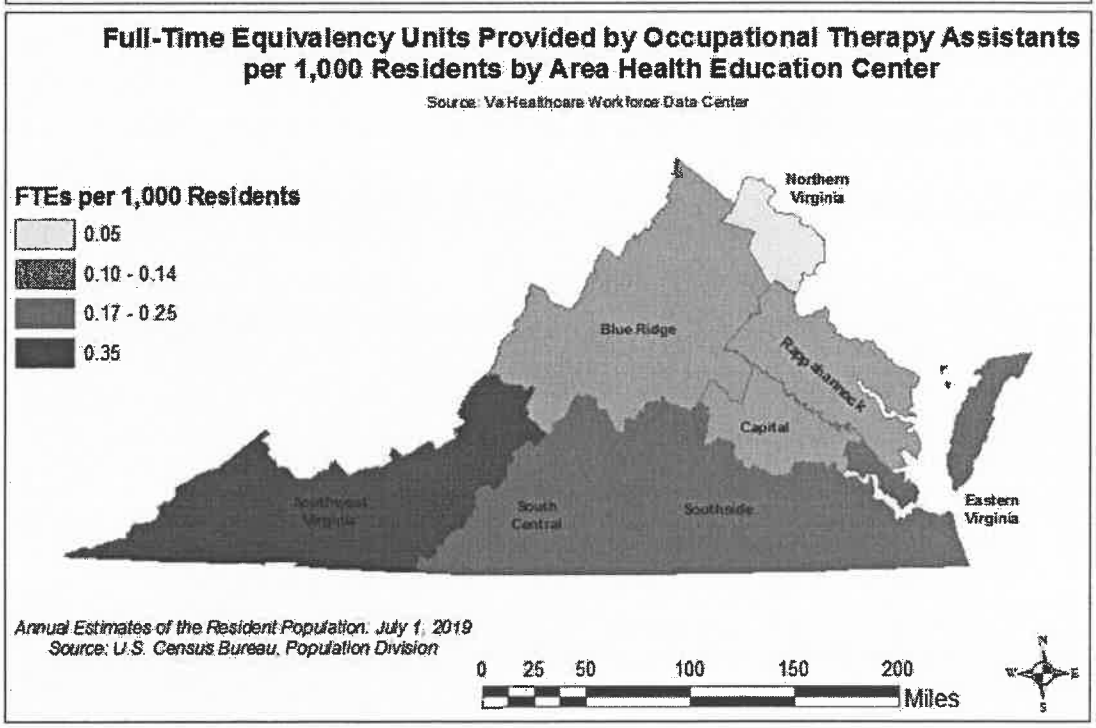
Maps

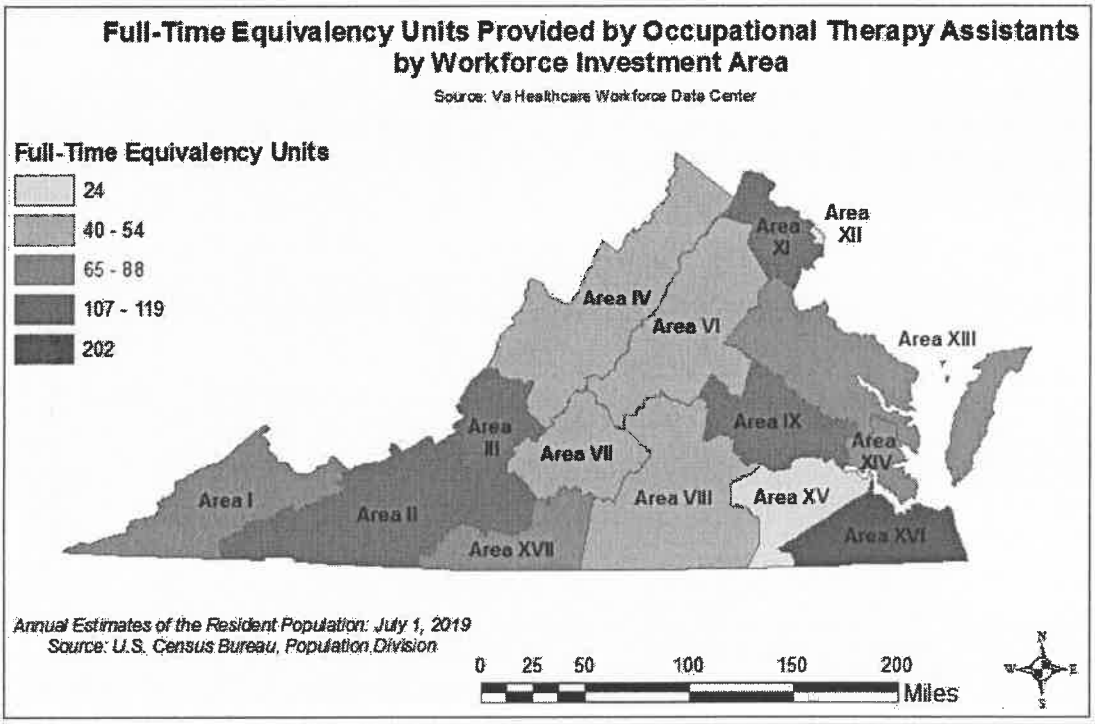
Virginia Performs Regions

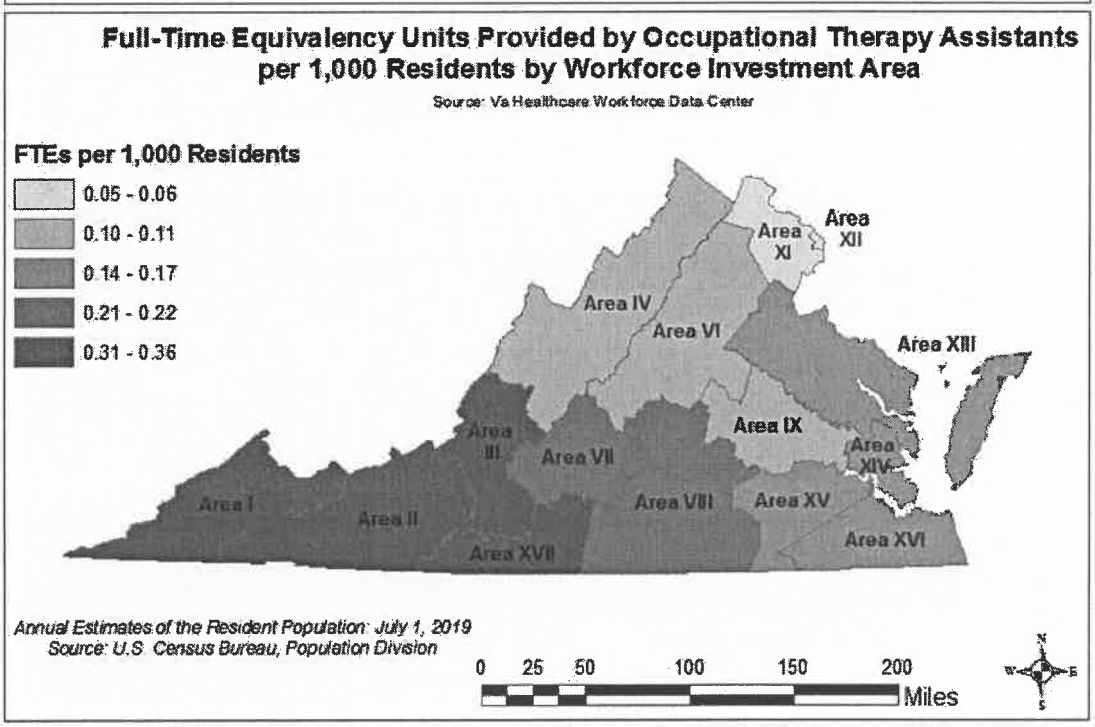


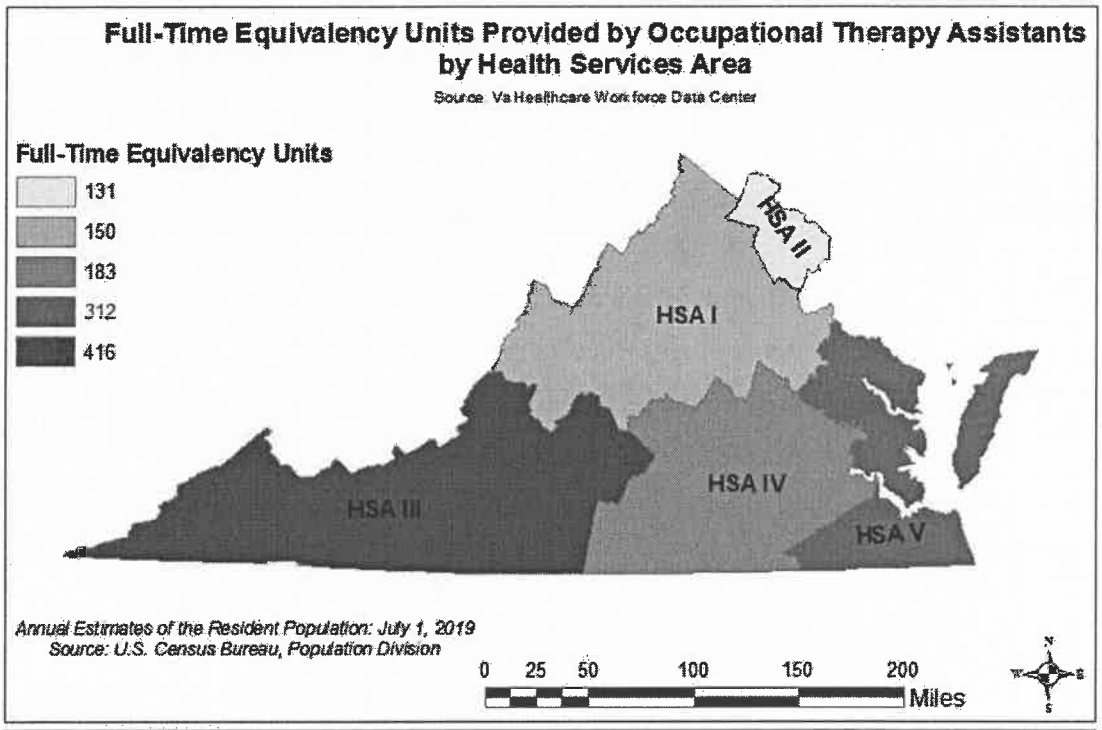


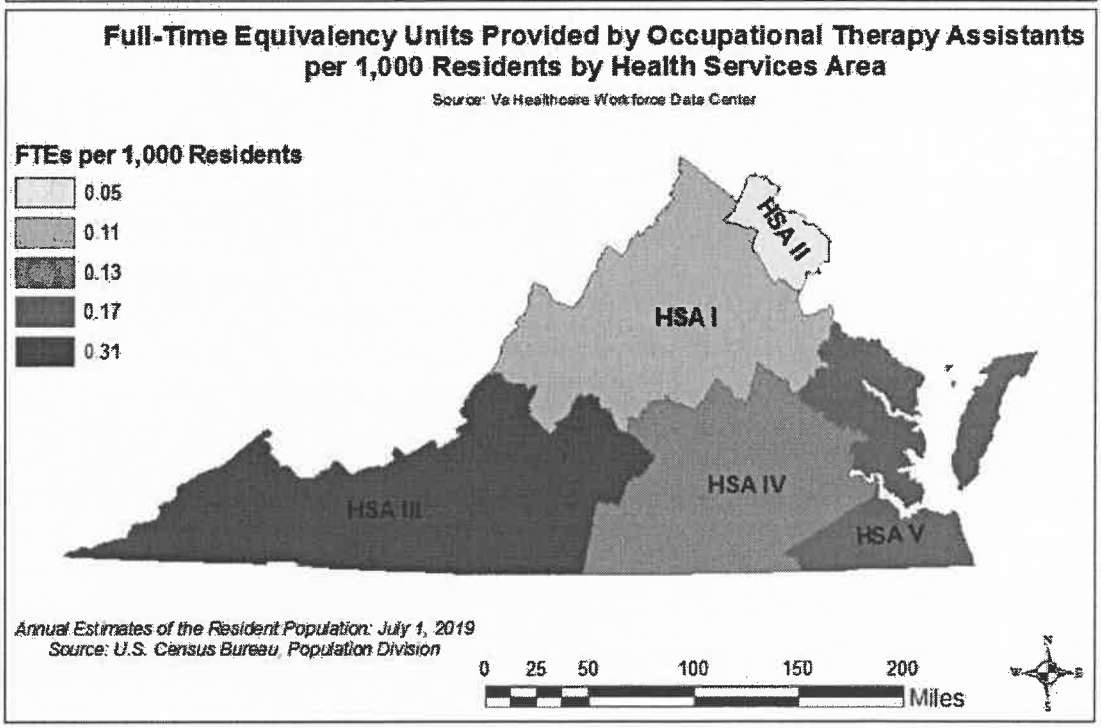

Full-Time Equivalency Units Provided by Occupational Therapy Assistants by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
64 - 72
99
119 - 131
291 - 292
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
Annual Estimates of the Resident Population: July 1, 2019
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

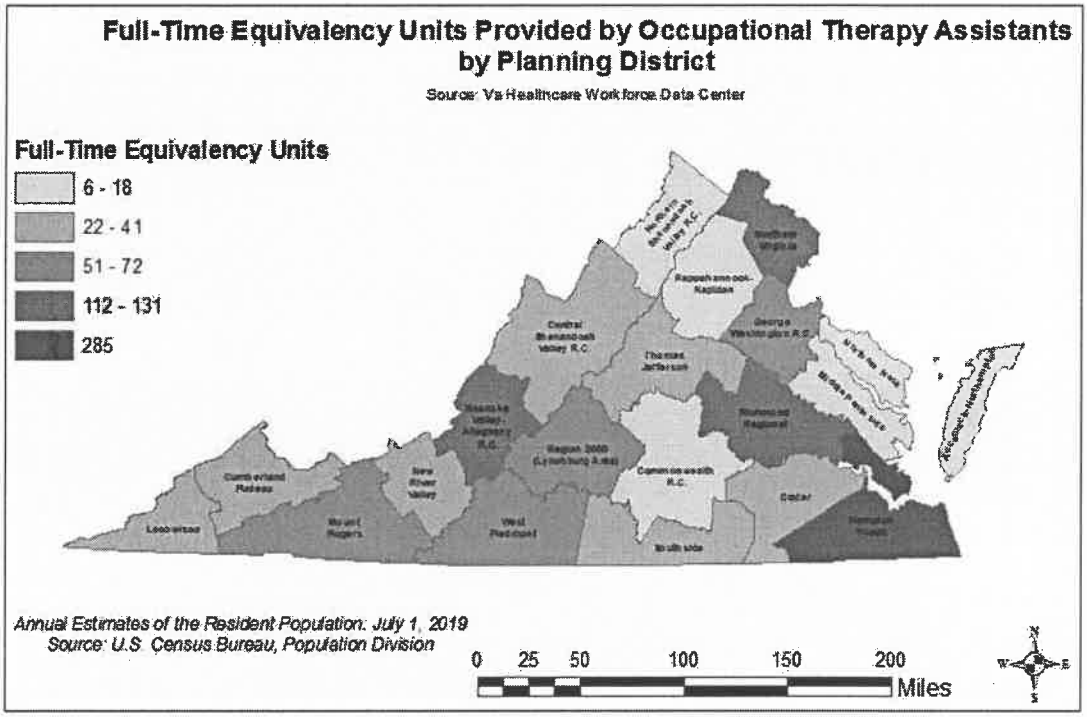

Full-Time Equivalency Units Provided by Occupational Therapy Assistants per 1,000 Residents by Area Health Education Center
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.05
0.10 - 0.14
0.17 - 0.25
0.35
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
Annual Estimates of the Resident Population: July 1, 2019
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

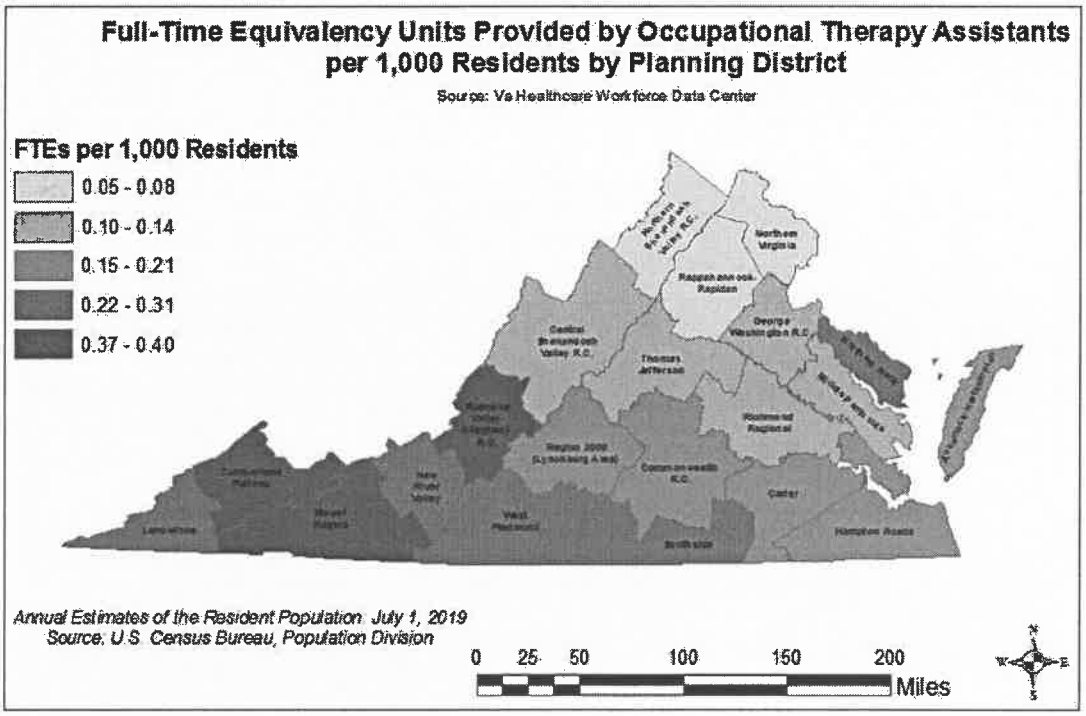

Full-Time Equivalency Units Provided by Occupational Therapy Assistants by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
24
40 - 54
65 - 88
107 - 119
202
Area XII
Area XI
Area IV
Area VI
Area XIII
Area IX
Area III
Area VII
Area XIV
Area I
Area II
Area VIII
Area XV
Area XVII
Area XVI
Annual Estimates of the Resident Population: July 1, 2019
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles


Full-Time Equivalency Units Provided by Occupational Therapy Assistants per 1,000 Residents by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.05 - 0.06
0.10 - 0.11
0.14 - 0.17
0.21 - 0.22
0.31 - 0.36
Area XII
Area XI
Area IV
Area VI
Area XIII
Area IX
Area III
Area VII
Area XIV
Area I
Area II
Area VIII
Area XV
Area XVII
Area XVI
Annual Estimates of the Resident Population: July 1, 2019
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles


Full-Time Equivalency Units Provided by Occupational Therapy Assistants by Health Services Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
131
150
183
312
416
HSA II
HSA I
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2019
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles


Full-Time Equivalency Units Provided by Occupational Therapy Assistants per 1,000 Residents by Health Services Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.05
0.11
0.13
0.17
0.31
HSA II
HSA I
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2019
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles


Full-Time Equivalency Units Provided by Occupational Therapy Assistants by Planning District
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
6 - 18
22 - 41
51 - 72
112 - 131
285
Annual Estimates of the Resident Population: July 1, 2019
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles


Full-Time Equivalency Units Provided by Occupational Therapy Assistants per 1,000 Residents by Planning District
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.05 - 0.08
0.10 - 0.14
0.15 - 0.21
0.22 - 0.31
0.37 - 0.40
Annual Estimates of the Resident Population: July 1, 2019
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles

Appendices

Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Metro, 1 Million+	839	76.64%	1.305	1.147	1.578
Metro, 250,000 to 1 Million	258	83.72%	1.194	1.050	1.444
Metro, 250,000 or Less	105	77.14%	1.296	1.140	1.567
Urban, Pop. 20,000+, Metro Adj.	65	87.69%	1.140	1.002	1.379
Urban, Pop. 20,000+, Non-Adj.	0	NA	NA	NA	NA
Urban, Pop. 2,500-19,999, Metro Adj.	80	82.50%	1.212	1.066	1.465
Urban, Pop. 2,500-19,999, Non-Adj.	115	78.26%	1.278	1.123	1.545
Rural, Metro Adj.	42	76.19%	1.313	1.154	1.587
Rural, Non-Adj.	56	83.93%	1.191	1.047	1.441
Virginia Border State/D.C.	150	58.00%	1.724	1.516	2.084
Other U.S. State	178	50.56%	1.978	1.739	2.391

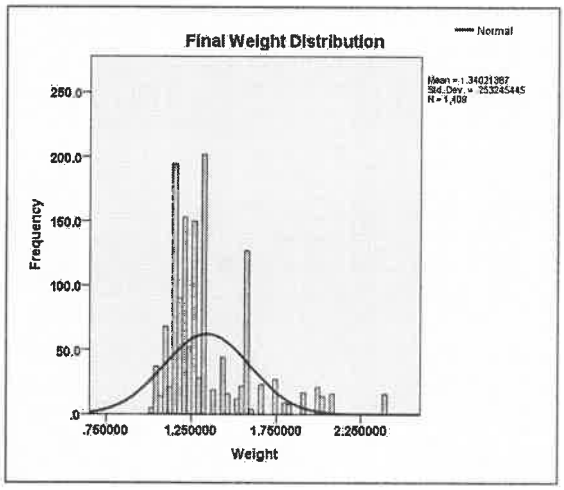
Source: Va. Healthcare Workforce Data Center

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

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

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

Overall Response Rate: 0.746292



Source: Va. Healthcare Workforce Data Center

Age	Age Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Under 30	405	61.73%	1.620	1.379	2.391
30 to 34	330	74.24%	1.347	1.146	1.988
35 to 39	232	77.59%	1.289	1.097	1.902
40 to 44	201	77.61%	1.288	1.097	1.902
45 to 49	203	81.77%	1.223	1.041	1.805
50 to 54	192	84.90%	1.178	1.002	1.739
55 to 59	144	80.56%	1.241	1.056	1.832
60 and Over	181	73.48%	1.361	1.158	2.009

Source: Va. Healthcare Workforce Data Center

New Business Agenda

Item #1. Summary of 2021 General Assembly

Item #2. Chart of Post-2021 General Assembly Regulatory/Policy Actions

Item #3. Consideration of Amendments to Regulations for Implementation of OT Intestate Compact

Legislation from the 2021 General Assembly
Board of Medicine

HB 1737 Nurse practitioners; practice without a practice agreement.

Chief patron: Adams, D.M.

Summary as passed House:

Nurse practitioners; practice without a practice agreement. Reduces from five to two the number of years of full-time clinical experience a nurse practitioner must have to be eligible to practice without a written or electronic practice agreement. The bill has an expiration date of July 1, 2022.

HB 1747 Clinical nurse specialist; licensure of nurse practitioners as specialists, etc.

Chief patron: Adams, D.M.

Summary as passed House:

Clinical nurse specialist; licensure; practice. Changes for clinical nurse specialists the requirement to register with the Board of Nursing as a clinical nurse specialist to licensure by the Boards of Medicine and Nursing to practice as a nurse practitioner in the category of clinical nurse specialist and provides that a nurse practitioner licensed as a clinical nurse specialist shall practice pursuant to a practice agreement between the clinical nurse specialist and a licensed physician and in a manner consistent with the standards of care for the profession and applicable law and regulations. For the transition of registration to licensure, the bill requires the Boards of Medicine and Nursing to jointly issue a license to practice as a nurse practitioner in the category of a clinical nurse specialist to an applicant who is an advance practice registered nurse who has completed an advanced graduate-level education program in the specialty category of clinical nurse specialist and who is registered by the Board of Nursing as a clinical nurse specialist on July 1, 2021.

HB 1817 Certified nurse midwives; practice.

Chief patron: Adams, D.M.

Summary as passed:

Practice of certified nurse midwives. Expands the categories of practitioners with whom a certified nurse midwife may enter into a practice agreement to include other certified nurse midwives who have

practiced for at least two years and allows a certified nurse midwife who has practiced at least 1,000 hours to practice without a practice agreement. The bill also provides that certified nurse midwives shall practice in accordance with regulations of the Boards of Medicine and Nursing and consistent with the Standards for the Practice of Midwifery set by the American College of Nurse-Midwives and shall consult and collaborate with and refer patients to such other health care providers as may be appropriate for the care of the patient.

HB 1913 Career fatigue and wellness in certain health care providers; programs to address, civil immunity.

Chief patron: Hope

Summary as introduced:

Programs to address career fatigue and wellness in certain health care providers; civil immunity; emergency. Expands civil immunity for health care professionals serving as members of or consultants to entities that function primarily to review, evaluate, or make recommendations related to health care services to include health care professionals serving as members of or consultants to entities that function primarily to address issues related to career fatigue and wellness in health care professionals licensed, registered, or certified by the Boards of Medicine, Nursing, or Pharmacy, or in students enrolled in a school of medicine, osteopathic medicine, nursing, or pharmacy located in the Commonwealth. The bill contains an emergency clause and is identical to SB 1205.

EMERGENCY

HB 1953 Licensed certified midwives; clarifies definition, licensure, etc.

Chief patron: Gooditis

Summary as passed:

Licensed certified midwives; licensure; practice. Defines "practice of licensed certified midwifery," directs the Boards of Medicine and Nursing to establish criteria for the licensure and renewal of a license as a certified midwife, and requires licensed certified midwives to practice in consultation with a licensed physician in accordance with a practice agreement. The bill also directs the Department of Health Professions to convene a work group to study the licensure and regulation of certified nurse midwives, certified midwives, and certified professional midwives to determine the appropriate licensing entity for such professionals. The bill requires the Department to report its findings and

conclusions to the Governor and the General Assembly by November 1, 2021. This bill is identical to SB 1320.

HB 1987 Telemedicine; coverage of telehealth services by an insurer, etc.

Chief patron: Adams, D.M.

Summary as passed:

Telemedicine. Requires the Board of Medical Assistance Services to amend the state plan for medical assistance to provide for payment of medical assistance for remote patient monitoring services provided via telemedicine for certain high-risk patients, makes clear that nothing shall preclude health insurance carriers from providing coverage for services delivered through real-time audio-only telephone that are not telemedicine, and clarifies rules around the prescribing of Schedule II through VI drugs via telemedicine, including establishing a practitioner-patient relationship via telemedicine. This bill is identical to SB 1338.

HB 1988 Cannabis oil; processing and dispensing by pharmaceutical processors.

Chief patron: Adams, D.M.

Summary as passed:

Board of Pharmacy; pharmaceutical processors; processing and dispensing cannabis oil. Effects numerous changes to the processing and dispensing of cannabis oil by pharmaceutical processors in the Commonwealth. The bill defines the term "designated caregiver facility" and allows any staff member or employee of a designated caregiver facility to assist with the possession, acquisition, delivery, transfer, transportation, and administration of cannabis oil for any patients residing in the designated caregiver facility. The bill allows written certifications for use of cannabis oil to include an authentic electronic practitioner signature. The bill also eliminates the requirement that a pharmacist have oversight of the cultivation and processing areas of a pharmaceutical processor, instead requiring pharmaceutical processors to designate a person to oversee cultivation and production areas; removes the requirement that a cannabis dispensing facility undergo quarterly inspections, instead requiring that inspections occur no more than once annually; and allows pharmaceutical processors to remediate cannabis oil that fails any quality testing standard. The bill requires pharmaceutical processors to maintain evidence of criminal background checks for all employees and delivery agents of the pharmaceutical processor. The bill directs the Board of Pharmacy to promulgate regulations implementing the provisions of the bill and

regulations creating reasonable restrictions on advertising and promotion by pharmaceutical processors by September 1, 2021.

HB 2039 Physician assistant; eliminates certain requirement for practice.

Chief patron: Rasoul

Summary as passed House:

Practice as a physician assistant. Allows a physician assistant to enter into a practice agreement with more than one patient care team physician or patient care team podiatrist and provides that a patient care team physician or patient care team podiatrist shall not be liable for the actions or inactions of a physician assistant for whom the patient care team physician or patient care team podiatrist provides collaboration and consultation. The bill also makes clear that a student physician assistant shall not be required to be licensed in order to engage in acts that otherwise constitute practice as a physician assistant, provided that the student physician assistant is enrolled in an accredited physician assistant education program.

HB 2061 VIIS; any health care provider in the Commonwealth that administers immunizations to participate.

Chief patron: Willett

Summary as introduced:

Virginia Immunization Information System; health care entities; required participation. Requires any health care provider in the Commonwealth that administers immunizations to participate in the Virginia Immunization Information System (VIIS) and report patient immunization history and information to VIIS. Under current law, participation in VIIS is optional for authorized health care entities. The bill has a delayed effective date of January 1, 2022.

HB 2079 Pharmacists; initiation of treatment with and dispensing and administering of drugs and devices.

Chief patron: Rasoul

Summary as passed House:

Pharmacists; initiation of treatment; certain drugs and devices. Expands provisions governing the initiation of treatment with and dispensing and administering of drugs and devices by pharmacists to

allow the initiation of treatment with and dispensing and administering of drugs, devices, and controlled paraphernalia to persons 18 years of age or older, in accordance with protocols developed by the Board of Pharmacy in collaboration with the Board of Medicine and the Department of Health, and of (i) vaccines included on the Immunization Schedule published by the Centers for Disease Control and Prevention; (ii) tuberculin purified protein derivative for tuberculosis testing; (iii) controlled substances for the prevention of human immunodeficiency virus, including controlled substances prescribed for pre-exposure and post-exposure prophylaxis pursuant to guidelines and recommendations of the Centers for Disease Control and Prevention; and (iv) drugs, devices, controlled paraphernalia, and other supplies and equipment available over-the-counter, covered by the patient's health carrier when the patient's out-of-pocket cost is lower than the out-of-pocket cost to purchase an over-the-counter equivalent of the same drug, device, controlled paraphernalia, or other supplies or equipment. The bill requires any pharmacist who administers a vaccination pursuant to clause (i) to report such administration to the Virginia Immunization Information System. The bill also (a) requires the Board of Pharmacy, in collaboration with the Board of Medicine and the Department of Health, to establish protocols for the initiation of treatment with and dispensing and administering of drugs, devices, and controlled paraphernalia by pharmacists in accordance with the provisions of the bill by November 1, 2021; (b) requires the Board of Pharmacy, in collaboration with the Board of Medicine, to adopt regulations within 280 days of the bill's enactment to implement the provisions of the bill; and (c) requires the Board of Pharmacy to convene a work group composed of an equal number of representatives of the Boards of Pharmacy and Medicine and other stakeholders to provide recommendations regarding the developing of protocols for the initiation of treatment with and dispensing and administering of certain drugs and devices by pharmacists to persons 18 years of age or older.

HB 2220 Surgical technologist; certification, use of title.

Chief patron: Hayes

Summary as introduced:

Surgical technologist; certification; use of title. Provides that no person shall hold himself out to be a surgical technologist or use or assume the title of "surgical technologist" or "certified surgical technologist" unless such person is certified by the Board of Medicine; currently, a person must be registered with the Board of Medicine to use the title "registered surgical technologist." The bill also (i) adds a requirement that an applicant whose certification is based on his holding a current credential as a certified surgical technologist from the National Board of Surgical Technology and Surgical Assisting also demonstrate that he has successfully completed an accredited surgical technologist training program

and (ii) provides that the Board of Medicine may certify a person who has practiced as a surgical technologist at any time in the six months prior to July 1, 2021, provided that he registers with the Board of Medicine by December 31, 2021.

SB 1178 Genetic counseling; repeals conscience clause.

Chief patron: Ebbin

Summary as introduced:

Genetic counseling; conscience clause. Repeals the conscience clause for genetic counselors who forgo participating in counseling that conflicts with their deeply held moral or religious beliefs, provided that they inform the patient and offer to direct the patient to the online directory of licensed genetic counselors maintained by the Board of Medicine. The law being repealed also prohibits the licensing of any genetic counselor from being contingent upon participating in such counseling.

SB 1187 Physical therapy; extends time allowed for a therapist to evaluate and treat patients.

Chief patron: Hashmi

Summary as introduced:

Department of Health Professions; practice of physical therapy. Extends from 30 days to 60 days the time allowed for a physical therapist who has completed a doctor of physical therapy program approved by the Commission on Accreditation of Physical Therapy Education or who has obtained a certificate of authorization to evaluate and treat patients after an initial evaluation without a referral under certain circumstances. The bill also provides that after discharging a patient a physical therapist shall not perform an initial evaluation of a patient without a referral if the physical therapist has performed an initial evaluation of the patient for the same condition within the immediately preceding 60 days.

SB 1189 Occupational therapists; licensure.

Chief patron: Hashmi

Summary as passed Senate:

Licensure of occupational therapists; Occupational Therapy Interjurisdictional Licensure Compact. Authorizes Virginia to become a signatory to the Occupational Therapy Interjurisdictional Licensure Compact. The Compact permits eligible licensed occupational therapists and occupational therapy assistants to practice in Compact member states, provided that they are licensed in at least one member

state. The bill has a delayed effective date of January 1, 2022, and directs the Board of Medicine to adopt emergency regulations to implement the provisions of the bill. The Compact takes effect when it is enacted by a tenth member state.

SB 1406 Marijuana; legalization of simple possession, etc.

Chief patron: Ebbin, Lucas

Summary as enacted with Governor's Recommendations:

Marijuana; legalization; retail sales; penalties. Eliminates criminal penalties for simple possession of up to one ounce of marijuana by persons 21 years of age or older, modifies several other criminal penalties related to marijuana, and imposes limits on dissemination of criminal history record information related to certain marijuana offenses. The bill creates the Virginia Cannabis Control Authority (the Authority), the Cannabis Oversight Commission, the Cannabis Public Health Advisory Council, the Cannabis Equity Reinvestment Board and Fund, and the Virginia Cannabis Equity Business Loan Program and Fund and establishes a regulatory and licensing structure for the cultivation, manufacture, wholesale, and retail sale of retail marijuana and retail marijuana products, to be administered by the Authority. The bill contains social equity provisions that, among other things, provide support and resources to persons and communities that have been historically and disproportionately affected by drug enforcement. The bill has staggered effective dates, and numerous provisions of the bill are subject to reenactment by the 2022 Session of the General Assembly. This bill incorporates SB 1243 and is identical to HB 2312. See S. B. 1406 Chapter PDF text:

Department of Health Professions
Regulatory/Policy Actions – 2021 General Assembly
Board on Medicine

EMERGENCY REGULATIONS:

Legislative source	Mandate	Promulgating agency	Board adoption date	Effective date Within 280 days of enactment
SB1189	Occupational therapy compact	Medicine	8/6/21	**By 12/23/21**

EXEMPT REGULATORY ACTIONS

Legislative source	Mandate	Promulgating agency	Adoption date	Effective date
HB1737	Revise autonomous practice reg consistent with 2 years	Nursing & Medicine	N – 7/20/21 M – 8/6/21	
HB1747	Licensure of CNS as nurse practitioners – Amend Chapters 30 and 40 Delete sections of Chapter 20 with reference to registration of CNS	Nursing & Medicine	N – 7/20/21 M – 8/6/21	
HB1817	Autonomous practice for CNMs with 1,000 hours	Nursing & Medicine	N – 7/20/21 M – 8/6/21	
HB1988	Changes to pharmaceutical processors	Pharmacy	7/6/21	By Sept. 1st
HB2218/SB1333	Sale of cannabis botanical products	Pharmacy	7/6/21	By Sept. 1st
HB2039	Conform PA regs to Code	Medicine	10/14/21	
HB2220	Change registration of surgical technologists to certification	Medicine	10/14/21	
SB1178	Delete reference to conscience clause in regs for genetic counselors	Medicine	10/14/21	

APA REGULATORY ACTIONS

Legislative source	Mandate	Promulgating agency	Adoption date	Effective date
HB1953	Licensure of certified midwives	Nursing & Medicine	NOIRA Nursing – 7/20/21 Medicine – 8/6/21	Unknown

NON-REGULATORY ACTIONS

Legislative source	Affected agency	Action needed	Due date
HB1747	Nursing	Notification to registered certified nurse specialists that they must have a practice agreement with a physician before licensure as a nurse practitioner as of July 1, 2021	After March 31, 2021
HB793 (2018)	Medicine & Nursing	To report data on the number of nurse practitioners who have been authorized to practice without a practice agreement, the	November 1, 2021

		geographic and specialty areas in which nurse practitioners are practicing without a practice agreement, and any complaints or disciplinary actions taken against such nurse practitioners, along with any recommended modifications to the requirements of this act including any modifications to the clinical experience requirements for practicing without a practice agreement.	
SB431	Behavioral health/medicine/legal	Continuance of study of mental health services to minors and access to records *Requested an extension of 2020 study*	November 1, 2021
Budget bill	Department	To study and make recommendations regarding the oversight and regulation of advanced practice registered nurses (APRNs). The department shall review recommendations of the National Council of State Boards of Nursing, analyze the oversight and regulations governing the practice of APRNs in other states, and review research on the impact of statutes and regulations on practice and patient outcomes.	November 1, 2021
HB1953	Department	To convene a work group to study and report on the licensure and regulation of certified nurse midwives, certified midwives, and certified professional midwives to determine the appropriate licensing entity for such professionals.	November 1, 2021
HB1987	Boards with prescriptive authority	Revise guidance documents with references to 54.1-3303	As boards meet after July 1
HB2079	Pharmacy (with Medicine & VDH)	To establish protocols for the initiation of treatment with and dispensing and administering of drugs, devices, controlled paraphernalia, and supplies and equipment available over-the-counter by pharmacists in accordance with § **54.1-3303.1**. Such protocols shall address training and continuing education for pharmacists regarding the initiation of treatment with and dispensing and administering of drugs, devices, controlled paraphernalia, and supplies and equipment.	Concurrent with emergency regulations
HB2079	Pharmacy	To convene a work group to provide recommendations regarding the development of protocols for the initiation of treatment with and dispensing and administering of drugs, devices, controlled paraphernalia, and supplies and equipment by pharmacists to persons 18 years of age or older, including (i) controlled substances, devices, controlled paraphernalia, and supplies and equipment for the treatment of diseases or conditions for which clinical decision-making can be guided by a clinical	November 1, 2021

		test that is classified as waived under the federal Clinical Laboratory Improvement Amendments of 1988, including influenza virus, urinary tract infection, and group A Streptococcus bacteria, and (ii) drugs approved by the U.S. Food and Drug Administration for tobacco cessation therapy, including nicotine replacement therapy. The work group shall focus its work on developing protocols that can improve access to these treatments while maintaining patient safety.	

Future Policy Actions:

HB2559 (2019) - requires the Secretary of Health and Human Resources to convene a work group to identify successes and challenges of the electronic prescription requirement and offer possible recommendations for increasing the electronic prescribing of controlled substances that contain an opioid and to report to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by **November 1, 2022**.

Agenda item: Consideration of amendments to regulations for implementation of OT Interstate Compact

Information from AOTA:

AOTA is working on creating an interstate professional licensing compact for occupational therapy to address licensure portability. The Occupational Therapy Licensure Compact legislation must be passed into law in each state where it will apply. The goal for this multi-year initiative is to begin state participation ***by 2024****.*

Included in agenda package:

Copy of legislation passed in 2021 General Assembly – SB1189

Copy of regulations adopted by the Board of Physical Therapy for implementation of PT Compact

Timeline for regulations:

May 25 – Discussion of compact rules/fees by Advisory Board

August 6 – Adoption of emergency regulations and NOIRA by Board of Medicine

December 23 – Deadline for regulations; effective date no sooner than January 1, 2022

CHAPTER 242

*An Act to amend the Code of Virginia by adding a section numbered **54.1-2956.7:1**, relating to Occupational Therapy Interjurisdictional Licensure Compact.*

[S 1189]
Approved March 18, 2021

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered **54.1-2956.7:1** as follows:

*§ **54.1-2956.7:1**. Occupational Therapy Interjurisdictional Licensure Compact.*

The General Assembly hereby enacts, and the Commonwealth of Virginia hereby enters into, the Occupational Therapy Interjurisdictional Licensure Compact with any and all states legally joining therein according to its terms, in the form substantially as follows:

OCCUPATIONAL THERAPY INTERJURISDICTIONAL LICENSURE COMPACT.
Article I. Purpose.

The purpose of this Compact is to facilitate interstate practice of occupational therapy with the goal of improving public access to occupational therapy services. The practice of occupational therapy occurs in the state where the patient/client is located at the time of the patient/client encounter. The Compact preserves the regulatory authority of states to protect public health and safety through the current system of state licensure.

This Compact is designed to achieve the following objectives:

1. Increase public access to occupational therapy services by providing for the mutual recognition of other member state licenses;

2. Enhance the states' ability to protect the public's health and safety;

3. Encourage the cooperation of member states in regulating multi-state occupational therapy practice;

4. Support spouses of relocating military members;

5. Enhance the exchange of licensure, investigative, and disciplinary information between member states;

6. Allow a remote state to hold a provider of services with a compact privilege in that state accountable to that state's practice standards; and

7. Facilitate the use of telehealth technology in order to increase access to occupational therapy services.

Article II. Definitions.

As used in this Compact, and except as otherwise provided, the following definitions shall apply:

"Active duty military" means full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active duty orders pursuant to 10 U.S.C. Chapter 1209 and Section 1211.

"Adverse action" means any administrative, civil, equitable, or criminal action permitted by a state's laws which is imposed by a licensing board or other authority against an occupational therapist or occupational therapy assistant, including actions against an individual's license or compact privilege such as censure, revocation, suspension, probation, monitoring of the licensee, or restriction on the licensee's practice.

"Alternative program" means a non-disciplinary monitoring process approved by an occupational therapy licensing board.

"Compact" means the Occupational Therapy Interjurisdictional Licensure Compact.

"Compact privilege" means the authorization, which is equivalent to a license, granted by a remote state to allow a licensee from another member state to practice as an occupational therapist or practice as an occupational therapy assistant in the remote state under its laws and rules. The practice of occupational therapy occurs in the member state where the patient/client is located at the time of the patient/client encounter.

"Continuing competence/education" means a requirement, as a condition of license renewal, to provide evidence of participation in, and/or completion of, educational and professional activities relevant to practice or area of work.

"Current significant investigative information" means investigative information that a licensing board, after an inquiry or investigation that includes notification and an opportunity for the occupational therapist or occupational therapy assistant to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction.

"Data system" means a repository of information about licensees, including but not limited to license status, investigative information, compact privileges, and adverse actions.

"Encumbered license" means a license in which an adverse action restricts the practice of occupational therapy by the licensee or said adverse action has been reported to the National Practitioners Data Bank (NPDB).

"Executive committee" means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

"Home state" means the member state that is the licensee's primary state of residence.

"Impaired practitioner" means individuals whose professional practice is adversely affected by substance abuse, addiction, or other health-related conditions.

"Investigative information" means information, records, and/or documents received or generated by an occupational therapy licensing board pursuant to an investigation.

"Jurisprudence requirement" means the assessment of an individual's knowledge of the laws and rules governing the practice of occupational therapy in a state.

"Licensee" means an individual who currently holds an authorization from the state to practice as an occupational therapist or as an occupational therapy assistant.

"Member state" means a state that has enacted the Compact.

"Occupational therapist" means an individual who is licensed by a state to practice occupational therapy.

"Occupational therapy assistant" means an individual who is licensed by a state to assist in the practice of occupational therapy.

"Occupational therapy," "occupational therapy practice," and the "practice of occupational therapy" mean the care and services provided by an occupational therapist or an occupational therapy assistant as set forth in the member state's statutes and regulations.

"Occupational Therapy Compact Commission" or "Commission" means the national administrative body whose membership consists of all states that have enacted the Compact.

"Occupational therapy licensing board" or "licensing board" means the agency of a state that is authorized to license and regulate occupational therapists and occupational therapy assistants.

"Primary state of residence" means the state (also known as the home state) in which an occupational therapist or occupational therapy assistant who is not active duty military declares a primary residence for legal purposes as verified by: driver's license, federal income tax return, lease, deed, mortgage or voter registration or other verifying documentation as further defined by Commission rules.

"Remote state" means a member state other than the home state, where a licensee is exercising or seeking to exercise the compact privilege.

"Rule" means a regulation promulgated by the Commission that has the force of law.

"State" means any state, commonwealth, district, or territory of the United States of America that regulates the practice of occupational therapy.

"Single-state license" means an occupational therapist or occupational therapy assistant license issued by a member state that authorizes practice only within the issuing state and does not include a compact privilege in any other member state.

"Telehealth" means the application of telecommunication technology to deliver occupational therapy services for assessment, intervention, and/or consultation.

Article III. State Participation in the Compact.

A. To participate in the Compact, a member state shall:

1. License occupational therapists and occupational therapy assistants;

2. Participate fully in the Commission's data system, including but not limited to using the Commission's unique identifier as defined in rules of the Commission;

3. Have a mechanism in place for receiving and investigating complaints about licensees;

4. Notify the Commission, in compliance with the terms of the Compact and rules, of any adverse action or the availability of investigative information regarding a licensee;

5. Implement or utilize procedures for considering the criminal history records of applicants for an initial compact privilege. These procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records;

a. A member state shall, within a time frame established by the Commission, require a criminal background check for a licensee seeking/applying for a compact privilege whose primary state of residence is that member state, by receiving the results of the Federal Bureau of Investigation criminal record search, and shall use the results in making licensure decisions.

b. Communication between a member state, the Commission and among member states regarding the verification of eligibility for licensure through the Compact shall not include any information received from the Federal Bureau of Investigation relating to a federal criminal records check performed by a member state under P.L. ***92-544****.*

6. Comply with the rules of the Commission;

7. Utilize only a recognized national examination as a requirement for licensure pursuant to the rules of the Commission; and

8. Have continuing competence/education requirements as a condition for license renewal.

B. A member state shall grant the compact privilege to a licensee holding a valid unencumbered license in another member state in accordance with the terms of the Compact and rules.

C. Member states may charge a fee for granting a compact privilege.

D. A member state shall provide for the state's delegate to attend all Occupational Therapy Compact Commission meetings.

E. Individuals not residing in a member state shall continue to be able to apply for a member state's single-state license as provided under the laws of each member state. However, the single-state license granted to these individuals shall not be recognized as granting the compact privilege in any other member state.

F. Nothing in this Compact shall affect the requirements established by a member state for the issuance of a single-state license.

Article IV. Compact Privilege.

A. To exercise the compact privilege under the terms and provisions of the Compact, the licensee shall:

1. Hold a license in the home state;

2. Have a valid United States social security number or national practitioner identification number;

3. Have no encumbrance on any state license;

4. Be eligible for a compact privilege in any member state in accordance with subsections D, F, G, and H;

5. Have paid all fines and completed all requirements resulting from any adverse action against any license or compact privilege, and two years have elapsed from the date of such completion;

6. Notify the Commission that the licensee is seeking the compact privilege within a remote state(s);

7. Pay any applicable fees, including any state fee, for the compact privilege;

8. Complete a criminal background check in accordance with subdivision A 5 of Article III. The licensee shall be responsible for the payment of any fee associated with the completion of a criminal background check;

9. Meet any jurisprudence requirements established by the remote state(s) in which the licensee is seeking a compact privilege; and

10. Report to the Commission adverse action taken by any non-member state within 30 days from the date the adverse action is taken.

B. The compact privilege is valid until the expiration date of the home state license. The licensee must comply with the requirements of subsection A to maintain the compact privilege in the remote state.

C. a licensee providing occupational therapy in a remote state under the compact privilege shall function within the laws and regulations of the remote state.

D. Occupational therapy assistants practicing in a remote state shall be supervised by an occupational therapist licensed or holding a compact privilege in that remote state.

E. A licensee providing occupational therapy in a remote state is subject to that state's regulatory authority. A remote state may, in accordance with due process and that state's laws, remove a licensee's compact privilege in the remote state for a specific period of time, impose fines, and/or take any other necessary actions to protect the health and safety of its citizens. The licensee may be ineligible for a compact privilege in any state until the specific time for removal has passed and all fines are paid.

F. If a home state license is encumbered, the licensee shall lose the compact privilege in any remote state until the following occur:

1. The home state license is no longer encumbered; and

2. Two years have elapsed from the date on which the home state license is no longer encumbered in accordance with subdivision 1.

G. Once an encumbered license in the home state is restored to good standing, the licensee must meet the requirements of subsection A to obtain a compact privilege in any remote state.

H. If a licensee's compact privilege in any remote state is removed, the individual may lose the compact privilege in any other remote state until the following occur:

1. The specific period of time for which the compact privilege was removed has ended;

2. All fines have been paid and all conditions have been met;

3. Two years have elapsed from the date of completing requirements for subdivisions 1 and 2; and

4. The compact privileges are reinstated by the Commission, and the compact data system is updated to reflect reinstatement.

I. If a licensee's compact privilege in any remote state is removed due to an erroneous charge, privileges shall be restored through the compact data system.

J. Once the requirements of subsection H have been met, the license must meet the requirements in subsection A to obtain a compact privilege in a remote state.

Article V. Obtaining a New Home State License by Virtue of Compact Privilege.

A. An occupational therapist or occupational therapy assistant may hold a home state license, which allows for compact privileges in member states, in only one member state at a time.

B. If an occupational therapist or occupational therapy assistant changes primary state of residence by moving between two member states:

1. The occupational therapist or occupational therapy assistant shall file an application for obtaining a new home state license by virtue of a compact privilege, pay all applicable fees, and notify the current and new home state in accordance with applicable rules adopted by the Commission.

2. Upon receipt of an application for obtaining a new home state license by virtue of compact privilege, the new home state shall verify that the occupational therapist or occupational therapy assistant meets the pertinent criteria outlined in Article IV via the data system, without need for primary source verification except for:

*a. An FBI fingerprint based criminal background check if not previously performed or updated pursuant to applicable rules adopted by the Commission in accordance with P.L. **92-544**;*

b. Other criminal background check as required by the new home state; and

c. Submission of any requisite jurisprudence requirements of the new home state.

3. The former home state shall convert the former home state license into a compact privilege once the new home state has activated the new home state license in accordance with applicable rules adopted by the Commission.

4. Notwithstanding any other provision of this Compact, if the occupational therapist or occupational therapy assistant cannot meet the criteria in Article IV, the new home state shall apply its requirements for issuing a new single-state license.

5. The occupational therapist or the occupational therapy assistant shall pay all applicable fees to the new home state in order to be issued a new home state license.

C. If an occupational therapist or occupational therapy assistant changes primary state of residence by moving from a member state to a non-member state, or from a non-member state to a member state, the state criteria shall apply for issuance of a single-state license in the new state.

D. Nothing in this compact shall interfere with a licensee's ability to hold a single-state license in multiple states; however, for the purposes of this compact, a licensee shall have only one home state license.

E. Nothing in this Compact shall affect the requirements established by a member state for the issuance of a single-state license.

Article VI. Active Duty Military Personnel or their Spouses.

Active duty military personnel, or their spouses, shall designate a home state where the individual has a current license in good standing. The individual may retain the home state designation during the period the service member is on active duty. Subsequent to designating a home state, the individual shall only change their home state through application for licensure in the new state or through the process described in Article V.

Article VII. Adverse Actions.

A. A home state shall have exclusive power to impose adverse action against an occupational therapist's or occupational therapy assistant's license issued by the home state.

B. In addition to the other powers conferred by state law, a remote state shall have the authority, in accordance with existing state due process law, to:

1. Take adverse action against an occupational therapist's or occupational therapy assistant's compact privilege within that member state.

2. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses as well as the production of evidence. Subpoenas issued by a licensing board in a member state for the attendance and testimony of witnesses or the production of evidence from another member state shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage and other fees required by the service statutes of the state in which the witnesses or evidence are located.

C. For purposes of taking adverse action, the home state shall give the same priority and effect to reported conduct received from a member state as it would if the conduct had occurred within the home state. In so doing, the home state shall apply its own state laws to determine appropriate action.

D. The home state shall complete any pending investigations of an occupational therapist or occupational therapy assistant who changes primary state of residence during the course of the investigations. The home state, where the investigations were initiated, shall also have the authority to take appropriate action(s) and shall promptly report the conclusions of the investigations to the OT Compact Commission data system. The occupational therapy compact commission data system administrator shall promptly notify the new home state of any adverse actions.

E. A member state, if otherwise permitted by state law, may recover from the affected occupational therapist or occupational therapy assistant the costs of investigations and disposition of cases resulting from any adverse action taken against that occupational therapist or occupational therapy assistant.

F. A member state may take adverse action based on the factual findings of the remote state, provided that the member state follows its own procedures for taking the adverse action.

G. Joint investigations.

1. In addition to the authority granted to a member state by its respective state occupational therapy laws and regulations or other applicable state law, any member state may participate with other member states in joint investigations of licensees.

2. Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

H. If an adverse action is taken by the home state against an occupational therapist's or occupational therapy assistant's license, the occupational therapist's or occupational therapy assistant's compact privilege in all other member states shall be deactivated until all encumbrances have been removed from the state license. All home state disciplinary orders that impose adverse action against an occupational therapist's or occupational therapy assistant's license shall include a statement that the occupational therapist's or occupational therapy assistant's compact privilege is deactivated in all member states during the pendency of the order.

I. If a member state takes adverse action, it shall promptly notify the administrator of the data system. The administrator of the data system shall promptly notify the home state of any adverse actions by remote states.

J. Nothing in this Compact shall override a member state's decision that participation in an alternative program may be used in lieu of adverse action.

Article VIII. Establishment of the Occupational Therapy Compact Commission.

A. The Compact member states hereby create and establish a joint public agency known as the Occupational Therapy Compact Commission:

1. The Commission is an instrumentality of the compact states.

2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

3. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

B. Membership, voting, and meetings.

1. Each member state shall have and be limited to one delegate selected by that member state's licensing board.

2. The delegate shall be either:

a. A current member of the licensing board, who is an occupational therapist, occupational therapy assistant, or public member; or

b. An administrator of the licensing board.

3. Any delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed.

4. The member state board shall fill any vacancy occurring in the Commission within 90 days.

5. Each delegate shall be entitled to one vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

6. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

7. The Commission shall establish by rule a term of office for delegates.

C. The Commission shall have the following powers and duties:

1. Establish a code of ethics for the Commission;

2. Establish the fiscal year of the Commission;

3. Establish bylaws;

4. Maintain its financial records in accordance with the bylaws;

5. Meet and take such actions as are consistent with the provisions of this Compact and the bylaws;

6. Promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all member states;

7. Bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any state occupational therapy licensing board to sue or be sued under applicable law shall not be affected;

8. Purchase and maintain insurance and bonds;

9. Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state;

10. Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

11. Accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and receive, utilize and dispose of the same; provided that at all times the Commission shall avoid any appearance of impropriety and/or conflict of interest;

12. Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall avoid any appearance of impropriety;

13. Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property real, personal, or mixed;

14. Establish a budget and make expenditures;

15. Borrow money;

16. Appoint committees, including standing committees composed of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the bylaws;

17. Provide and receive information from, and cooperate with, law enforcement agencies;

18. Establish and elect an executive committee; and

19. Perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of occupational therapy licensure and practice.

D. The executive committee.

The executive committee shall have the power to act on behalf of the Commission according to the terms of this Compact.

1. The executive committee shall be composed of nine members:

a. Seven voting members who are elected by the Commission from the current membership of the Commission;

b. One ex-officio, nonvoting member from a recognized national occupational therapy professional association; and

c. One ex officio, nonvoting member from a recognized national occupational therapy certification organization.

2. The ex officio members will be selected by their respective organizations.

3. The Commission may remove any member of the executive committee as provided in bylaws.

4. The executive committee shall meet at least annually.

5. The executive committee shall have the following duties and responsibilities:

a. Recommend to the entire Commission changes to the rules or bylaws, changes to this Compact legislation, fees paid by compact member states such as annual dues, and any commission compact fee charged to licensees for the compact privilege;

b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;

d. Maintain financial records on behalf of the Commission;

e. Monitor Compact compliance of member states and provide compliance reports to the Commission;

f. Establish additional committees as necessary; and

g. Perform other duties as provided in rules or bylaws.

E. Meetings of the Commission.

1. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Article X.

2. The Commission or the executive committee or other committees of the Commission may convene in a closed, non-public meeting if the Commission or executive committee or other committees of the Commission must discuss:

a. Non-compliance of a member state with its obligations under the Compact;

b. The employment, compensation, discipline or other matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation;

d. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;

e. Accusing any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigative records compiled for law enforcement purposes;

i. Disclosure of information related to any investigative reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the Compact; or

j. Matters specifically exempted from disclosure by federal or member state statute.

3. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision.

4. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.

F. Financing of the Commission.

1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

2. The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

3. The Commission may levy on and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved by the Commission each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a rule binding upon all member states.

4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the member states, except by and with the authority of the member state.

5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the Commission.

G. Qualified immunity, defense, and indemnification.

1. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be

construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the grossly negligent, intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, executive director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel, and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

Article IX. Data System.

A. The Commission shall provide for the development, maintenance, and utilization of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensed individuals in member states.

B. A member state shall submit a uniform data set to the data system on all individuals to whom this Compact is applicable (utilizing a unique identifier) as required by the rules of the Commission, including:

1. Identifying information;

2. Licensure data;

3. Adverse actions against a license or compact privilege;

4. Non-confidential information related to alternative program participation;

5. Any denial of application for licensure, and the reason(s) for such denial;

6. Other information that may facilitate the administration of this Compact, as determined by the rules of the Commission; and

7. Current significant investigative information.

C. Current significant investigative information and other investigative information pertaining to a Licensee in any member state will only be available to other member states.

D. The Commission shall promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license. Adverse action information pertaining to a licensee in any member state will be available to any other member state.

E. Member states contributing information to the data system may designate information that may not be shared with the public without the express permission of the contributing state.

F. Any information submitted to the data system that is subsequently required to be expunged by the laws of the member state contributing the information shall be removed from the data system.

Article X. Rulemaking.

A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this article and the rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

B. The Commission shall promulgate reasonable rules in order to effectively and efficiently achieve the purposes of the Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of the Compact, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force and effect.

C. If a majority of the legislatures of the member states rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact within four years of the date of adoption of the rule, then such rule shall have no further force and effect in any member state.

D. Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

E. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least 30 days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a notice of proposed rulemaking:

1. On the website of the Commission or other publicly accessible platform; and

2. On the website of each member state occupational therapy licensing board or other publicly accessible platform or the publication in which each state would otherwise publish proposed rules.

F. The notice of proposed rulemaking shall include:

1. The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

2. The text of the proposed rule or amendment and the reason for the proposed rule;

3. A request for comments on the proposed rule from any interested person; and

4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

G. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

H. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

1. At least 25 persons;

2. A state or federal governmental subdivision or agency; or

3. An association or organization having at least 25 members.

I. If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing. If the hearing is held via electronic means, the Commission shall publish the mechanism for access to the electronic hearing.

1. All persons wishing to be heard at the hearing shall notify the executive director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. All hearings will be recorded. A copy of the recording will be made available on request.

4. Nothing in this article shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this article.

J. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

K. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

L. The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

M. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the Compact and in this article shall be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or member state funds;

3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

4. Protect public health and safety.

N. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

Article XI. Oversight, Dispute Resolution, and Enforcement.

A. Oversight.

1. The executive, legislative, and judicial branches of state government in each member state shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

2. All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of this Compact which may affect the powers, responsibilities, or actions of the Commission.

3. The Commission shall be entitled to receive service of process in any such proceeding, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

B. Default, technical assistance, and termination.

1. If the Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to cure the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the member states, and all rights, privileges and benefits conferred by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

3. Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

4. A state that has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

5. The Commission shall not bear any costs related to a state that is found to be in default or that has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

C. Dispute resolution.

1. Upon request by a member state, the Commission shall attempt to resolve disputes related to the Compact that arise among member states and between member and non-member states.

2. The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

D. Enforcement.

The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this Compact.

By majority vote, the Commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the Commission has its principal offices against a member state in default to enforce compliance with the provisions of the Compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

Article XII. Date of Implementation of the Interstate Commission for Occupational Therapy Practice and Associated Rules, Withdrawal, and Amendment.

A. The Compact shall come into effect on the date on which the Compact statute is enacted into law in the tenth member state. The provisions, which become effective at that time, shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the implementation and administration of the Compact.

B. Any state that joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

C. Any member state may withdraw from this Compact by enacting a statute repealing the same.

1. A member state's withdrawal shall not take effect until six months after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing state's occupational therapy licensing board to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

D. Nothing contained in this Compact shall be construed to invalidate or prevent any occupational therapy licensure agreement or other cooperative arrangement between a member state and a non-member state that does not conflict with the provisions of this Compact.

E. This Compact may be amended by the member states. No amendment to this Compact shall become effective and binding upon any member state until it is enacted into the laws of all member states.

Article XIII. Construction and Severability.

This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any member state or of the United States or the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person, or circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution of any member state, the Compact shall remain in full force and effect as to the remaining member states and in full force and effect as to the member state affected as to all severable matters.

Article XIV. Binding Effect of Compact and Other Laws.

A. A licensee providing occupational therapy in a remote state under the compact privilege shall function within the laws and regulations of the remote state.

B. Nothing herein prevents the enforcement of any other law of a member state that is not inconsistent with the Compact.

C. Any laws in a member state in conflict with the Compact are superseded to the extent of the conflict.

D. Any lawful actions of the Commission, including all rules and bylaws promulgated by the Commission, are binding upon the member states.

E. All agreements between the Commission and the member states are binding in accordance with their terms.

F. In the event any provision of the Compact exceeds the constitutional limits imposed on the legislature of any member state, the provision shall be ineffective to the extent of the conflict with the constitutional provision in question in that member state.

2. That the Board of Medicine shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment.

3. That the provisions of this act shall become effective on January 1, 2022.

Project 6119

BOARD OF PHYSICAL THERAPY

Implementation of the Physical Therapy Compact

Part I

General Provisions

18VAC112-20-10. Definitions.

In addition to the words and terms defined in § §§ 54.1-3473 and 54.1-3486 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.

"Assessment tool" means oPTion or any other self-directed assessment tool approved by FSBPT.

"CLEP" means the College Level Examination Program.

"Compact" means the Physical Therapy Licensure Compact (§ 54.1-3485 of the Code of Virginia).

"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.

"Physical Therapy Compact Commission" or "commission" means the national administrative body whose membership consists of all states that have enacted the compact.

"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.

18VAC112-20-27. Fees.

A. Unless otherwise provided, fees listed in this section shall not be refundable.

B. Licensure by examination.

1. The application fee shall be $140 for a physical therapist and $100 for a physical therapist assistant.

2. The fees for taking all required examinations shall be paid directly to the examination services.

C. Licensure by endorsement. The fee for licensure by endorsement shall be $140 for a physical therapist and $100 for a physical therapist assistant.

D. Licensure renewal and reinstatement.

1. The fee for active license renewal for a physical therapist shall be $135 and for a physical therapist assistant shall be $70 and shall be due by December 31 in each even-numbered year.

2. The fee for an inactive license renewal for a physical therapist shall be $70 and for a physical therapist assistant shall be $35 and shall be due by December 31 in each even-numbered year.

3. A fee of $50 for a physical therapist and $25 for a physical therapist assistant for processing a late renewal within one renewal cycle shall be paid in addition to the renewal fee.

4. The fee for reinstatement of a license that has expired for two or more years shall be $180 for a physical therapist and $120 for a physical therapist assistant and shall be submitted with an application for licensure reinstatement.

E. Other fees.

1. The fee for an application for reinstatement of a license that has been revoked shall be $1,000; the fee for an application for reinstatement of a license that has been suspended shall be $500.

2. The fee for a duplicate license shall be $5, and the fee for a duplicate wall certificate shall be $15.

3. The handling fee for a returned check or a dishonored credit card or debit card shall be $50.

4. The fee for a letter of good ~~standing/verification~~ standing or verification to another jurisdiction shall be $10.

5. The application fee for direct access certification shall be $75 for a physical therapist to obtain certification to provide services without a referral.

6. The state fee for obtaining or renewing a compact privilege to practice in Virginia shall be $50.

18VAC112-20-60. Requirements for licensure by examination.

Every applicant for initial licensure by examination shall submit:

1. Documentation of having met the educational requirements specified in 18VAC112-20-40 or 18VAC112-20-50;

2. The required application, fees, and credentials to the board, including a criminal history background check as required by § 54.1-3484 of the Code of Virginia; and

3. Documentation of passage of the national examination as prescribed by the board.

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.~~ United States jurisdiction;

2. The required application, fees, and credentials to the board, including a criminal history background check as required by § 54.1-3484 of the Code of Virginia;

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.~~ United States 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.~~ United States 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 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.

18VAC112-20-82. Requirements for a compact privilege.

To obtain a compact privilege to practice physical therapy in Virginia, a physical therapist or physical therapist assistant licensed in a remote state shall comply with the rules adopted by the Physical Therapy Compact Commission in effect at the time of application to the commission.

18VAC112-20-90. General responsibilities.

A. The physical therapist shall be responsible for managing all aspects of the physical therapy care of each patient and shall provide:

1. The initial evaluation for each patient and its documentation in the patient record;

2. Periodic reevaluation, including documentation of the patient's response to therapeutic intervention; and

3. The documented status of the patient at the time of discharge, including the response to therapeutic intervention. If a patient is discharged from a health care facility without the opportunity for the physical therapist to reevaluate the patient, the final note in the patient record may document patient status.

B. The physical therapist shall communicate the overall plan of care to the patient or ~~his~~ the patient's legally authorized representative and shall also communicate with a referring doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery~~,~~; nurse practitioner; or physician assistant to the extent required by § 54.1-3482 of the Code of Virginia.

C. A physical therapist assistant may assist the physical therapist in performing selected components of physical therapy intervention to include treatment, measurement, and data collection~~,~~ but not to include the performance of an evaluation as defined in 18VAC112-20-10.

D. A physical therapist assistant's visits to a patient may be made under general supervision.

E. A physical therapist providing services with a direct access certification as specified in § 54.1-3482 of the Code of Virginia shall utilize the Direct Access Patient Attestation and Medical Release Form prescribed by the board or otherwise include in the patient record the information, attestation and written consent required by subsection B of § 54.1-3482 of the Code of Virginia.

F. A physical therapist or physical therapist assistant practicing in Virginia on a compact privilege shall comply with all applicable laws and regulations pertaining to physical therapy practice in Virginia.

18VAC112-20-130. Biennial renewal of license.

A. A physical therapist and physical therapist assistant who intends to continue practice shall renew his license biennially by December 31 in each even-numbered year and pay to the board the renewal fee prescribed in 18VAC112-20-27.

B. A licensee whose licensure has not been renewed by the first day of the month following the month in which renewal is required shall pay a late fee as prescribed in 18VAC112-20-27.

C. In order to renew an active license, a licensee shall be required to:

1. Complete a minimum of 160 hours of active practice in the preceding two years; and

2. Comply with continuing competency requirements set forth in 18VAC112-20-131.

D. In order to renew a compact privilege to practice in Virginia, the holder shall comply with the rules adopted by the Physical Therapy Compact Commission in effect at the time of the renewal.

18VAC112-20-140. Traineeship requirements.

A. The traineeship shall be approved by the board and under the direction and supervision of a licensed physical therapist.

B. Supervision and identification of trainees:

1. There shall be a limit of two physical therapists assigned to provide supervision for each trainee.

2. The supervising physical therapist shall countersign patient documentation (i.e., notes, records, charts) for services provided by a trainee.

3. The trainee shall wear identification designating them as a "physical therapist trainee" or a "physical therapist assistant trainee."

C. Completion of traineeship.

1. The physical therapist supervising the trainee shall submit a report to the board at the end of the required number of hours on forms supplied by the board.

2. If the traineeship is not successfully completed at the end of the required hours, as determined by the supervising physical therapist, the president of the board or his designee shall determine if a new traineeship shall commence. If the president of the board determines that a new traineeship shall not commence, then the application for licensure shall be denied.

3. The second traineeship may be served under a different supervising physical therapist and may be served in a different organization than the initial traineeship. If the second traineeship is not successfully completed, as determined by the supervising physical therapist, then the application for licensure shall be denied.

D. A traineeship shall not be approved for an applicant who has not completed a criminal background check for initial licensure pursuant to § 54.1-3484 of the Code of Virginia.

18VAC112-20-200. Advertising ethics.

A. Any statement specifying a fee, whether standard, discounted, or free, for professional services that does not include the cost of all related procedures, services, and products ~~which~~ that, to a substantial likelihood, will be necessary for the completion of the advertised service as it would be understood by an ordinarily prudent person shall be deemed to be deceptive or misleading, or both. Where reasonable disclosure of all relevant variables and considerations is made, a statement of a range of prices for specifically described services shall not be deemed to be deceptive or misleading.

B. Advertising a discounted or free service, examination, or treatment and charging for any additional service, examination, or treatment that is performed as a result of and within 72 hours of the initial office visit in response to such advertisement is unprofessional conduct unless such professional services rendered are as a result of a bona fide emergency. This provision may not be waived by agreement of the patient and the practitioner.

C. Advertisements of discounts shall disclose the full fee that has been discounted. The practitioner shall maintain documented evidence to substantiate the discounted fees and shall make such information available to a consumer upon request.

D. A licensee or holder of a compact privilege shall not use the term "board certified" or any similar words or phrase calculated to convey the same meaning in any advertising for his practice unless he holds certification in a clinical specialty issued by the American Board of Physical Therapy Specialties.

E. A licensee or holder of a compact privilege of the board shall not advertise information that is false, misleading, or deceptive. For an advertisement for a single practitioner, it shall be presumed that the practitioner is responsible and accountable for the validity and truthfulness of its content. For an advertisement for a practice in which there is more than one practitioner, the name of the practitioner ~~or practitioners~~ responsible and accountable for the content of the advertisement shall be documented and maintained by the practice for at least two years.

F. Documentation, scientific and otherwise, supporting claims made in an advertisement shall be maintained and available for the board's review for at least two years.