Advisory Board on Physician Assistants

Virginia Board of Medicine

June 6, 2024
1:00 p.m.

Advisory Board on Physician Assistants

Board of Medicine

Thursday, June 6, 2024 @ 1:00 p.m.

9960 Mayland Drive, Suite 201, Henrico, VA

Training Room 2

Announcements

Next Scheduled Meeting: October 10, 2024 @ 1:00 p.m.

Adjournment

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

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

Training Room 2

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

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

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

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

ADVISORY BOARD ON PHYSICIAN ASSISTANTS
Minutes
September 22, 2022

MEMBERS PRESENT:	Justin Hepner, PA Erin Myers, PA-C Tracy Dunn - Citizen Member Lucy Treene, PA-C
MEMBERS ABSENT:	Frazier W. Frantz, MD
STAFF PRESENT:	William L. Harp, MD - Executive Director Michael Sobowale, LLM - Deputy Director for Licensure Erin Barrett, JD - DHP Senior Policy Analyst Colanthia M. Opher - Deputy Director for Administration ShaRon Clanton - Licensing Specialist
GUESTS PRESENT:	Robert Glasson, VAPA Kathleen Scarbalis, PA-C Clark Barrineau - MSV Jonathan Williams - VAPA Ben Traynham, JD - MSV

Call to Order

Dr. Harp called the meeting to order at 1:03 p.m. He asked members present, 3 of whom were newly-appointed, to introduce themselves.

Emergency Egress Procedures

Dr. Harp provided the emergency egress instructions.

Roll Call

Roll was called; a quorum was established.

Approval of Minutes

Justin Hepner moved to approve the minutes of the May 26, 2022 meeting. Lucy Treene seconded. The motion passed.

Adoption of Agenda

Erin Myer moved to adopt the meeting agenda as presented. Justin Hepner seconded. The motion passed.

Public Comments:

Old Business

1. Update on the Physician Assistant Licensure Compact

Kathleen Scarbalis, immediate past Chair of the Advisory Board, commented on the progress of the physician assistant licensure compact. She explained that the development of the physician assistant compact is being spearheaded by the Council of State Governments (CSG) and currently modeled after the Interstate Medical Licensure Compact. Draft legislation is currently being written that will simultaneously be distributed to all the states when it is ready. The goal is to get Virginia to be one of the first seven (7) states to participate.

2. VAPA Legislative Proposal

Jonathan Williams commented that VAPA hopes to introduce the legislative proposal to eliminate practice agreements in certain institutional settings where credentialing and privileging provide oversight. Also sought will be elimination of the 1:6 ratio of a patient care team physician to physician assistants in the 2023 legislative session.

New Business

1. **Periodic Review of Regulations Governing the Practice of Physician Assistants**

   Mrs. Barrett discussed the mandatory four-year review of Chapter 18 VAC 85-50 to determine whether this regulation should be repealed, amended or retained in its current form, without impacting public safety. The review of the regulations will be guided by the principles in Executive Order 14 as amended July 16, 2018. There was one public comment received seeking to edit and reflect the correct title, "Physician Assistant" in the listing of table of contents on page 4 of the regulations. There was also a request to remove the reference to supervision in Part B of 18VAC85-50-115 to read, "…collaborate or consult with [his] physician assistant…". The changes sought will be

incorporated into the entire changes recommended by the Advisory Board from a review of the entire regulations.

Ms. Barrett then presented her recommendations to amend or delete current language provisions in 18VAC85-50-10(B), 18VAC85-50-30, 18VAC85-50-35(2), 18VAC85-50-40, 18VAC85-50-59(4), 18VAC85-50-61(D), 18VAC85-50-101(A), 18VAC85-50-115(B), 18VAC85-50-116, 18VAC85-50-178, 18VAC85-50-180, 18VAC85-50-181, and 18VAC85-50-182. Some of these provisions are in the law, and it is unnecessary to repeat them in regulation.

Justin Hepner moved that the Advisory Board recommend to the full Board to retain and amend Chapter 50 with suggested changes as discussed. Lucy Treene seconded. The motion passed.

2. Review of Bylaws for Advisory Boards

Erin Barrett presented the uniform Bylaws for all Advisory Boards that the full Board approved at its June meeting. Since the Bylaws are slated to become effective on September 29, 2022, this was for information only.

3. Approval of 2023 Meeting Calendar

Erin Myers moved to approve the 2023 meeting calendar. Lucy Treene seconded. The motion passed.

4. Election of Officers

Tracy Dunn nominated Justin Hepner as Chair. Lucy Treene seconded. The motion passed. Erin Myers self-nominated as Vice-Chair. Lucy Treene seconded. The motion passed.

Announcements

License Statistics

ShaRon Clanton provided the licensing report. The Board has issued a total of 574 physician assistant licenses in 2022. There are currently a total of 5,724 licensees with 4, 049 current active in Virginia and 19 inactive. There are 1, 618 current active out-of-state with 38 are inactive out-of-state.

Next Scheduled Meeting

The next scheduled meeting is February 9, 2023 at 1:00 p.m.

Adjournment

With no other business to conduct, the meeting was adjourned at 2:07 p.m.

_____

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

DRAFT

Virginia's Physician Assistant Workforce: 2023

Healthcare Workforce Data Center

February 2024

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233
804-597-4213, 804-527-4434 (fax)
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 4,600 Physician 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 their ongoing cooperation.*

Thank You!

Virginia Department of Health Professions

Arne W. Owens, MS
Director

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

Healthcare Workforce Data Center Staff:

Yetty Shobo, PhD
Director

Barbara Hodgdon, PhD
Deputy Director

Rajana Siva, MBA
Data Analyst

Christopher Coyle, BA
Research Assistant

Physician Assistant Advisory Board

Chair

Justin Hepner, PA-C
Midlothian

Vice-Chair

Erin Myers, PA-C
Boones Mill

Members

Tracey Dunn
North Chesterfield

Brian Hanrahan, MD
Midlothian

Lucy Treene, PA-C
Arlington

Executive Director

William L. Harp, MD

Contents

The Physician Assistant Workforce At a Glance:

The Workforce	
Licensees	6,692
Virginia's Workforce:	5,174
FTEs:	4,478

Survey Response Rate	
All Licensees:	70%
Renewing Practitioners:	87%

Demographics	
Female:	74%
Diversity Index:	35%
Median Age:	37

Background	
Rural Childhood:	28%
HS Degree in VA:	43%
Prof. Degree in VA:	41%

Education	
Masters:	82%
Baccalaureate:	7%

Finances	
Median Inc.:	$110k-$120k
Health Benefits:	69%
Under 40 w/ Ed. Debt:	66%

Current Employment	
Employed in Prof.:	96%
Hold 1 Full-Time Job:	72%
Satisfied?:	93%

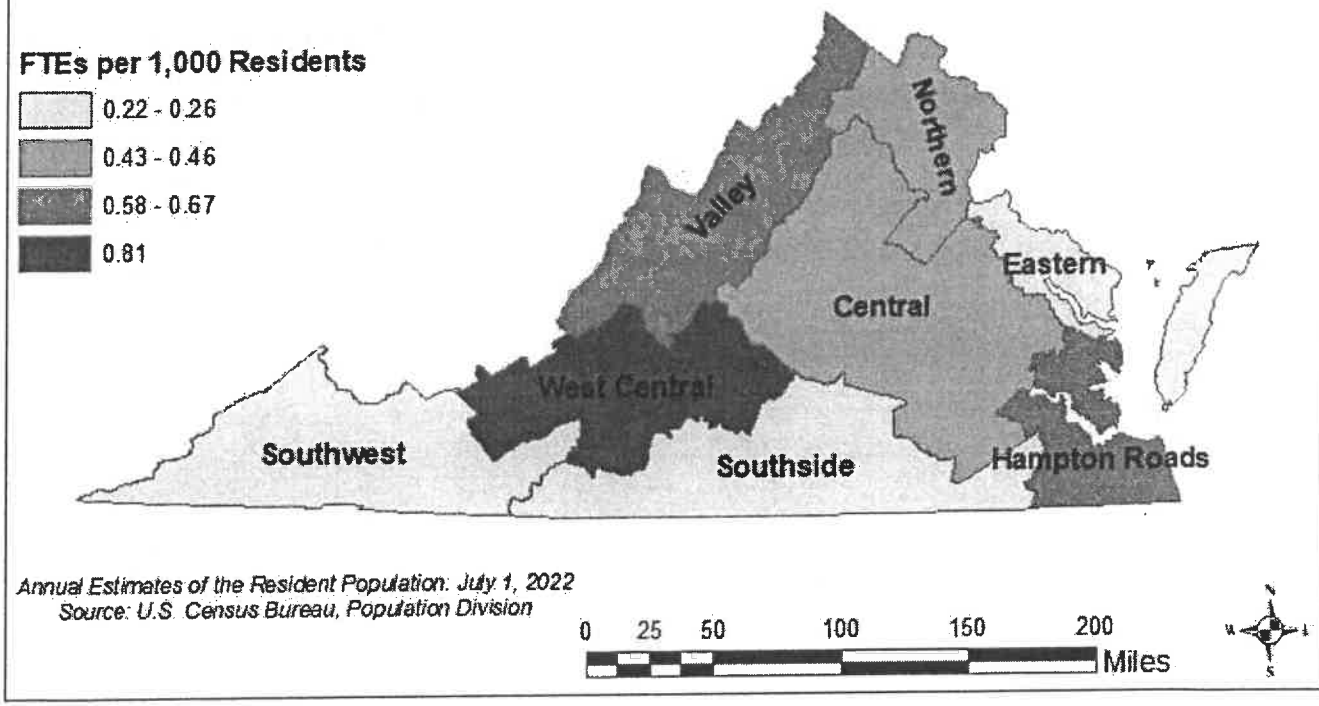
Job Turnover	
Switched Jobs:	11%
Employed Over 2 Yrs.:	50%

Time Allocation	
Patient Care:	90%-99%
Patient Care Role:	89%
Admin. Role:	2%

Source: Va. Healthcare Workforce Data Center

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

Source: Va Healthcare Workforce Data Center



Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division

Results in Brief

This report contains the results of the 2023 Physician Assistant Workforce survey. In total, 4,667 physician assistants voluntarily took part in this survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place during the birth month of each physician assistant on odd-numbered years. These survey respondents represent 70% of the 6,692 physician assistants who are licensed in the state and 87% of renewing practitioners.

The HWDC estimates that 5,174 physician assistants participated in Virginia's workforce during the survey period, which is defined as those professionals who worked at least a portion of the year in the state or who live in the state and intend to return to work in the profession at some point in the future. Virginia's physician assistants provided 4,478 "full-time equivalency units" in the past year, which the HWDC defines simply as working 2,000 hours per year.

Nearly three-fourths of all physician assistants are female, including 82% of those who are under the age of 40. The median age of this workforce is 37. In a random encounter between two physician assistants, there is a 35% chance that they would be of different races or ethnicities, a measure known as the diversity index. This diversity index falls to 33% for those physician assistants who are under the age of 40. For Virginia's overall population, the comparable diversity index is 60%. More than one-quarter of all physician assistants grew up in a rural area, and 14% of those who grew up in a rural area currently work in a non-metro area of the state. In total, 6% of all physician assistants work in a non-metro area of Virginia.

Among all physician assistants, 96% are currently employed in the profession, 72% hold one full-time position, and 49% work between 40 and 49 hours per week. Nearly 60% of physician assistants work in the for-profit sector, while another 33% work in the non-profit sector. The typical physician assistant earns between $110,000 and $120,000 per year, and 74% receive this income in the form of a salary. In addition, 87% of physician assistants receive at least one employer-sponsored benefit, including 69% who have access to health insurance. Among all physician assistants, 93% indicated that they are satisfied with their current work situation, including 56% who indicated that they are "very satisfied."

Summary of Trends

In this section, all statistics for the current year are compared to the 2013 physician assistant workforce. The number of licensed physician assistants in the state has increased by 127% (6,692 vs. 2,953). In addition, the size of Virginia's physician assistant workforce has increased by 117% (5,174 vs. 2,382), and the number of FTEs provided by this workforce has increased by 93% (4,478 vs, 2,321). Virginia's renewing physician assistants are more likely to respond to this survey (87% vs. 81%).

Virginia's physician assistants are more likely to be female (74% vs. 69%). At the same time, the diversity index of this workforce has increased (35% vs. 29%). Physician assistants are less likely to have grown up in a rural area (28% vs. 31%), but physician assistants who grew up in a rural area are more likely to work in a non-metro area of Virginia (14% vs. 13%). However, the percentage of all physician assistants who work in a non-metro area of the state has fallen (6% vs. 7%). Physician assistants are more likely to hold a Master's degree (82% vs. 70%) than a baccalaureate degree (7% vs. 17%) as their highest professional degree. Physician assistants are less likely to carry education debt (54% vs. 63%), but the median outstanding balance among those with education debt has increased ($100k-$110k vs. $60k-$70k).

The median annual income of the physician assistant workforce has increased ($110k-$120k vs. $90k-$100k), and these professionals are more likely to receive this income in the form of a salary (74% vs. 67%) than as an hourly wage (23% vs. 29%). Physician assistants are relatively more likely to work in the non-profit sector (33% vs. 24%) than in the for-profit sector (58% vs. 63%). In addition, physician assistants are relatively more likely to work in either the inpatient department of a hospital (15% vs. 10%) or a multi-specialty group practice (12% vs. 10%) than in either a single-specialty group practice (29% vs. 33%) or the emergency department of a hospital (9% vs. 16%). The percentage of physician assistants who indicated that they are satisfied at their primary work location has fallen (93% vs. 97%), including those physician assistants who indicated that they are "very satisfied" (56% vs. 70%).

Survey Response Rates

A Closer Look:

Licensee Counts		
License Status	#	%
Renewing Practitioners	5,339	80%
New Licensees	715	11%
Non-Renewals	638	10%
All Licensees	6,692	100%

Source: Va. Healthcare Workforce Data Center

HWDC surveys tend to achieve very high response rates. Among all renewing physician assistants, 87% submitted a survey. These represent 70% of the 6,692 physician assistants who held a license at some point in the past year.

Definitions

1. **The Survey Period:** The survey was conducted throughout 2023 on the birth month of each practitioner.
2. **Target Population:** All physician assistants who held a Virginia license at some point in 2023.
3. **Survey Population:** The survey was available to those who renewed their licenses online. It was not available to those who did not renew, including some professionals newly licensed in 2023.

Response Rates			
Statistic	Non Respondents	Respondents	Response Rate
By Age			
Under 30	590	377	39%
30 to 34	531	940	64%
35 to 39	333	969	74%
40 to 44	170	798	82%
45 to 49	122	555	82%
50 to 54	90	429	83%
55 to 59	68	266	80%
60 and Over	121	333	73%
Total	**2,025**	**4,667**	**70%**
New Licenses			
Issued in 2023	715	0	0%
Metro Status			
Non-Metro	86	213	71%
Metro	984	3,088	76%
Not in Virginia	955	1,366	59%

Source: Va. Healthcare Workforce Data Center

Response Rates	
Completed Surveys	4,667
Response Rate, All Licensees	70%
Response Rate, Renewals	87%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed Physician Asst.

Number:	6,692
New:	11%
Not Renewed:	10%

Survey Response Rates

All Licensees:	70%
Renewing Practitioners:	87%

Source: Va. Healthcare Workforce Data Center

The Workforce

At a Glance:

Workforce

Physician Assistant Workforce:	5,174
FTEs:	4,478

Utilization Ratios

Licensees in VA Workforce:	77%
Licensees per FTE:	1.49
Workers per FTE:	1.16

Source: Va. Healthcare Workforce Data Center

Definitions

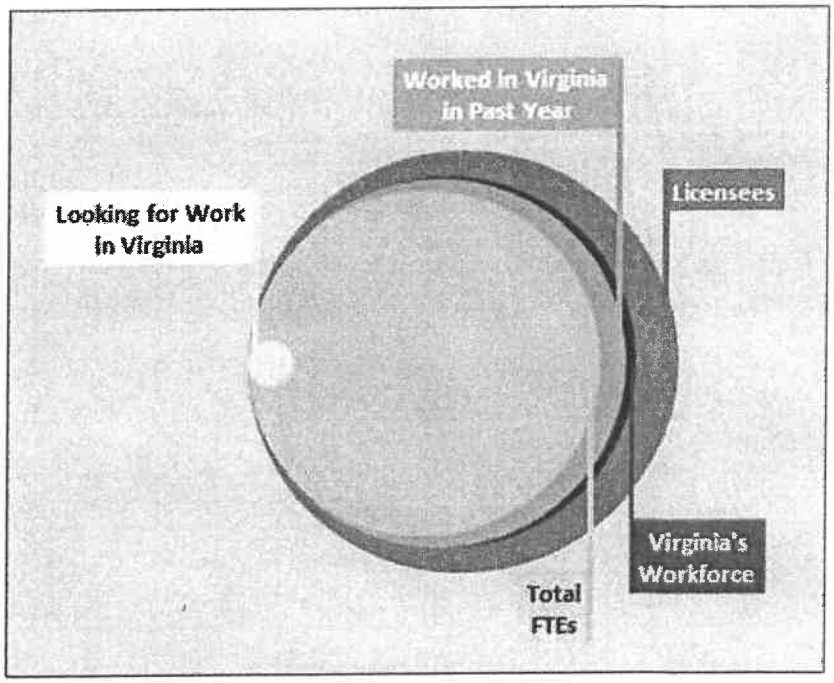
1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time in 2023 or who indicated intent to return to Virginia's workforce at any point in the future.
2. **Full-Time Equivalency Unit (FTE):** The HWDC uses 2,000 (40 hours for 50 weeks) as its baseline measure for FTEs.
3. **Licensees in VA Workforce:** The proportion of licensees in Virginia's Workforce.
4. **Licensees per FTE:** An indication of the number of licensees needed to create 1 FTE. Higher numbers indicate lower licensee participation.
5. **Workers per FTE:** An indication of the number of workers in Virginia's workforce needed to create 1 FTE. Higher numbers indicate lower utilization of available workers.

Virginia's Physician Assistant Workforce

Status	#	%
Worked in Virginia in Past Year	5,095	98%
Looking for Work in Virginia	79	2%
Virginia's Workforce	5,174	100%
Total FTEs	4,478	
Licensees	6,692	

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

Demographics

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 30	142	18%	657	82%	799	17%
30 to 34	177	16%	922	84%	1,099	24%
35 to 39	177	21%	686	80%	863	19%
40 to 44	145	24%	469	76%	614	13%
45 to 49	162	37%	271	63%	433	9%
50 to 54	140	43%	187	57%	328	7%
55 to 59	107	48%	114	52%	221	5%
60 and Over	149	56%	118	44%	267	6%
Total	**1,199**	**26%**	**3,425**	**74%**	**4,625**	**100%**

Source: Va. Healthcare Workforce Data Center

Race & Ethnicity					
Race/ Ethnicity	Virginia*	Physician Asst.		Physician Asst. Under 40	
	%	#	%	#	%
White	59%	3,694	80%	2,246	81%
Black	18%	258	6%	108	4%
Asian	7%	295	6%	192	7%
Other Race	1%	60	1%	30	1%
Two or More Races	5%	109	2%	68	2%
Hispanic	10%	206	4%	117	4%
Total	**100%**	**4,622**	**100%**	**2,761**	**100%**

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

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

% Female:	74%
% Under 40 Female:	82%

Age

Median Age:	37
% Under 40:	60%
% 55 and Over:	11%

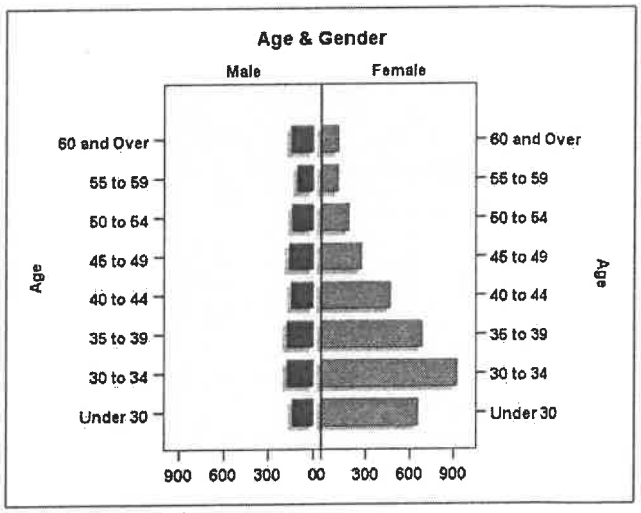
Diversity

Diversity Index:	35%
Under 40 Div. Index:	33%

Source: Va. Healthcare Workforce Data Center

In a random encounter between two physician assistants, there is a 35% 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 diversity index is 60%.

Among the 60% of physician assistants who are under the age of 40, 82% are female. In addition, the diversity index among physician assistants who are under the age of 40 is 33%.



Source: Va. Healthcare Workforce Data Center

Background

At a Glance:

Childhood

Urban Childhood:	9%
Rural Childhood:	28%

Virginia Background

HS in Virginia:	43%
Prof. Education in VA:	41%
HS/Prof. Edu. in VA:	56%

Location Choice

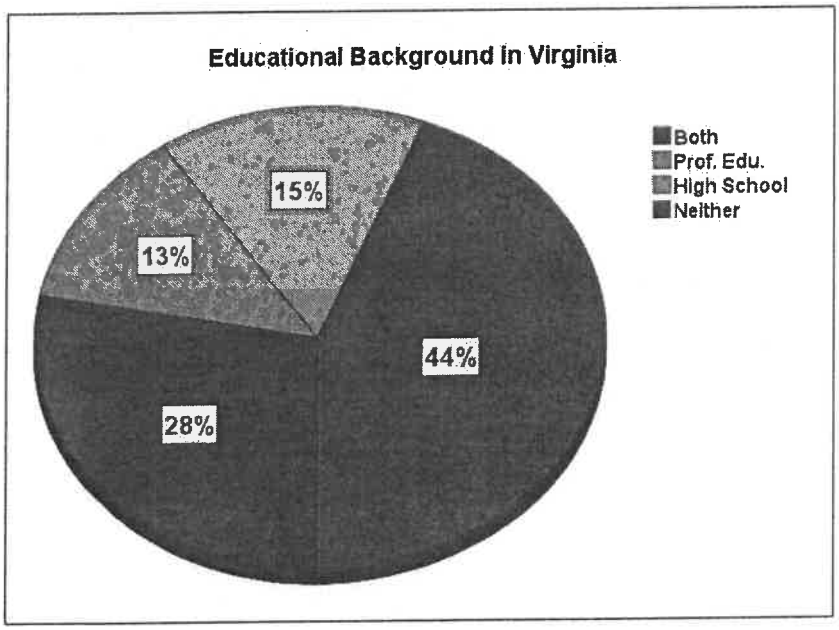
% Rural to Non-Metro:	14%
% Urban/Suburban to Non-Metro:	3%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Primary Location: USDA Rural Urban Continuum		Rural Status of Childhood Location		
Code	Description	Rural	Suburban	Urban
	Metro Counties			
1	Metro, 1 Million+	20%	70%	10%
2	Metro, 250,000 to 1 Million	41%	53%	6%
3	Metro, 250,000 or Less	42%	52%	7%
	Non-Metro Counties			
4	Urban, Pop. 20,000+, Metro Adjacent	50%	47%	3%
6	Urban, Pop. 2,500-19,999, Metro Adjacent	68%	26%	7%
7	Urban, Pop. 2,500-19,999, Non-Adjacent	88%	12%	0%
8	Rural, Metro Adjacent	61%	33%	6%
9	Rural, Non-Adjacent	35%	65%	0%
	Overall	**28%**	**64%**	**9%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

More than one-quarter of all physician assistants grew up in a rural area, and 14% of physician assistants who grew up in a rural area work in a non-metro area of Virginia. In total, 6% of all physician assistants work in a non-metro area of the state.

Top Ten States for Physician Assistant Recruitment

Rank	All Physician Assistants			
	High School	#	Professional School	#
1	Virginia	1,995	Virginia	1,852
2	Pennsylvania	392	Pennsylvania	543
3	Maryland	273	Washington, D.C.	328
4	New York	259	North Carolina	238
5	Florida	145	New York	236
6	North Carolina	138	West Virginia	151
7	Outside U.S./Canada	123	Tennessee	130
8	West Virginia	116	Florida	116
9	New Jersey	111	Maryland	97
10	California	88	Georgia	94

Source: Va. Healthcare Workforce Data Center

Among all physician assistants, 43% received their high school degree in Virginia, while 41% received their initial professional degree in the state.

Among physician assistants who have been licensed in the past five years, 40% received their high school degree in Virginia, while 43% received their initial professional degree in the state.

Rank	Licensed in the Past Five Years			
	High School	#	Professional School	#
1	Virginia	754	Virginia	792
2	Pennsylvania	149	Pennsylvania	201
3	Maryland	141	New York	102
4	New York	86	North Carolina	93
5	Florida	81	Tennessee	69
6	North Carolina	58	Washington, D.C.	67
7	New Jersey	55	Florida	57
8	Outside U.S./Canada	47	Maryland	42
9	California	37	Georgia	39
10	Ohio	35	Nebraska	30

Source: Va. Healthcare Workforce Data Center

Nearly one-quarter of all licensed physician assistants did not participate in Virginia's workforce in 2023. Among physician assistants who did not participate in the state's workforce, 96% worked at some point in the past year, including 93% who currently work as a physician assistant.

At a Glance:

Not in VA Workforce

Total:	1,523
% of Licensees:	23%
Federal/Military:	16%
VA Border State/DC:	23%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Professional Degree		
Degree	#	%
PA Certificate (Undergraduate)	59	1%
Associate	15	0%
Baccalaureate	312	7%
PA Certificate (Postgraduate)	221	5%
Master's	3,702	82%
Doctorate	203	4%
Total	4,512	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

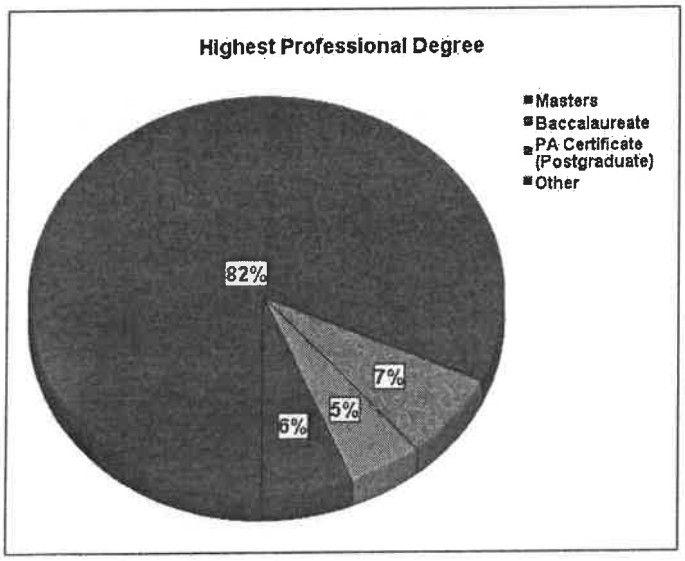
Education

Masters: 82%
Baccalaureate: 7%

Education Debt

Carry Debt: 54%
Under Age 40 w/ Debt: 66%
Median Debt: $100k-$110k

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

More than four out of every five physician assistants hold a Master's degree as their highest professional degree.

More than half of all physician assistants carry education debt, including 66% of those physician assistants who are under the age of 40. For those with education debt, the median outstanding balance is between $100,000 and $110,000.

Education Debt				
Amount Carried	All		Under 40	
	#	%	#	%
None	1,889	46%	841	34%
Less than $10,000	124	3%	59	2%
$10,000-$19,999	125	3%	59	2%
$20,000-$29,999	108	3%	51	2%
$30,000-$39,999	94	2%	49	2%
$40,000-$49,999	130	3%	83	3%
$50,000-$59,999	104	3%	71	3%
$60,000-$69,999	124	3%	91	4%
$70,000-$79,999	86	2%	62	2%
$80,000-$89,999	124	3%	97	4%
$90,000-$99,999	66	2%	54	2%
$100,000-$109,999	144	3%	121	5%
$110,000 or More	996	24%	846	34%
Total	4,115	100%	2,484	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Primary Specialties

Family Medicine:	14%
Emergency Medicine:	14%
Orthopedics:	10%

Secondary Specialties

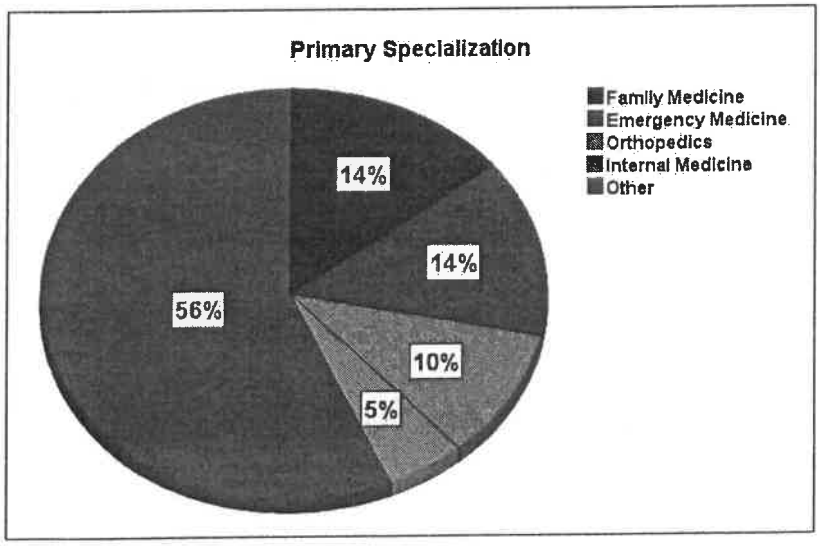
Emergency Medicine:	7%
Family Medicine:	7%
Orthopedics:	4%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Specialties				
Specialty	Primary Specialty		Secondary Specialty	
	#	%	#	%
Family Medicine	653	14%	245	7%
Emergency Medicine	649	14%	254	7%
Orthopedics	471	10%	128	4%
Internal Medicine, General	228	5%	107	3%
Hospital Medicine	197	4%	95	3%
Dermatology	189	4%	40	1%
Cardiology	166	4%	49	1%
Psychiatry	127	3%	34	1%
Cardiovascular Surgery	125	3%	44	1%
General Surgery	108	2%	65	2%
Neurosurgery	107	2%	46	1%
Gastroenterology & Hepatology	107	2%	20	1%
Pediatrics, General	78	2%	35	1%
Plastic Surgery	69	2%	25	1%
Other	1,062	23%	660	18%
No Specialty	247	5%	1,802	49%
Total	4,582	100%	3,650	100%

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Nearly two out of every five physician assistants hold a primary specialty in family medicine, emergency medicine, or orthopedics.

Current Employment Situation

At a Glance:

Employment

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

Positions Held

1 Full-Time:	72%
2 or More Positions:	15%

Weekly Hours:

40 to 49:	49%
60 or More:	4%
Less than 30:	9%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Current Work Status		
Status	**#**	**%**
Employed, Capacity Unknown	3	< 1%
Employed in Profession	4,414	96%
Employed, NOT in Profession	35	1%
Not Working, Reason Unknown	0	0%
Involuntarily Unemployed	8	< 1%
Voluntarily Unemployed	100	2%
Retired	17	< 1%
Total	**4,577**	**100%**

Source: Va. Healthcare Workforce Data Center

Among all physician assistants, 96% are currently employed in the profession, 72% hold one full-time job, and 49% work between 40 and 49 hours per week.

Current Positions		
Positions	**#**	**%**
No Positions	125	3%
One Part-Time Position	488	11%
Two Part-Time Positions	108	2%
One Full-Time Position	3,234	72%
One Full-Time Position & One Part-Time Position	485	11%
Two Full-Time Positions	11	<1%
More than Two Positions	65	1%
Total	**4,516**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Weekly Hours		
Hours	**#**	**%**
0 Hours	125	3%
1 to 9 Hours	57	1%
10 to 19 Hours	125	3%
20 to 29 Hours	223	5%
30 to 39 Hours	1,072	24%
40 to 49 Hours	2,218	49%
50 to 59 Hours	498	11%
60 to 69 Hours	113	3%
70 to 79 Hours	30	1%
80 or More Hours	46	1%
Total	**4,507**	**100%**

Source: Va. Healthcare Workforce Data Center

Employment Quality

A Closer Look:

Annual Income		
Income Level	#	%
Volunteer Work Only	7	0%
Less than $20,000	44	1%
$20,000-$29,999	24	1%
$30,000-$39,999	31	1%
$40,000-$49,999	26	1%
$50,000-$59,999	47	1%
$60,000-$69,999	74	2%
$70,000-$79,999	99	3%
$80,000-$89,999	160	5%
$90,000-$99,999	193	6%
$100,000-$109,999	484	14%
$110,000-$119,999	629	18%
$120,000 or More	1,708	48%
Total	3,527	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Annual Income
Median Income: $110k-$120k

Benefits
Health Insurance: 69%
Retirement: 73%

Satisfaction
Satisfied: 93%
Very Satisfied: 56%

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	#	%
Very Satisfied	2,514	56%
Somewhat Satisfied	1,706	38%
Somewhat Dissatisfied	234	5%
Very Dissatisfied	60	1%
Total	4,515	100%

Source: Va. Healthcare Workforce Data Center

The median annual income for physician assistants is between $110,000 and $120,000. In addition, 87% receive at least one employer-sponsored benefit, including 69% who receive health insurance.

Employer-Sponsored Benefits			
Benefit	#	%	% of Wage/Salary Employees
Paid Vacation	3,346	76%	79%
Retirement	3,243	73%	76%
Health Insurance	3,047	69%	72%
Dental Insurance	2,886	65%	68%
Paid Sick Leave	2,177	49%	51%
Group Life Insurance	1,993	45%	47%
Signing/Retention Bonus	819	19%	19%
At Least One Benefit	3,856	87%	91%

*From any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Employment Instability in Past Year		
In the Past Year, Did You . . .?	#	%
Experience Involuntary Unemployment?	44	1%
Experience Voluntary Unemployment?	253	5%
Work Part-Time or Temporary Positions, but Would Have Preferred a Full-Time/Permanent Position?	85	2%
Work Two or More Positions at the Same Time?	763	15%
Switch Employers or Practices?	568	11%
Experience at Least One?	1,387	27%

Source: Va. Healthcare Workforce Data Center

Among all physician assistants, 1% were involuntarily unemployed at some point in 2023. For comparison, Virginia's average monthly unemployment rate was 2.9%.[1]

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at This Location	121	3%	62	6%
Less than 6 Months	271	6%	136	13%
6 Months to 1 Year	520	12%	133	12%
1 to 2 Years	1,273	29%	295	27%
3 to 5 Years	1,011	23%	231	22%
6 to 10 Years	632	14%	117	11%
More than 10 Years	531	12%	99	9%
Subtotal	4,359	100%	1,073	100%
Did Not Have Location	96		4,058	
Item Missing	719		43	
Total	5,174		5,174	

Source: Va. Healthcare Workforce Data Center

Nearly three out of every four physician assistants receive a salary at their primary work location, while 23% receive an hourly wage.

At a Glance:

Unemployment Experience

Involuntarily Unemployed: 1%
Underemployed: 2%

Turnover & Tenure

Switched: 11%
New Location: 24%
Over 2 Years: 50%
Over 2 Yrs., 2nd Location: 42%

Employment Type

Salary/Commission: 74%
Hourly Wage: 23%

Source: Va. Healthcare Workforce Data Center

One half of all physician assistants have worked at their primary work location for more than two years.

Employment Type		
Primary Work Site	#	%
Salary/Commission	2,633	74%
Hourly Wage	822	23%
By Contract/Per Diem	61	2%
Business/Practice Income	46	1%
Unpaid	15	0%
Subtotal	3,577	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 2.5% and a high of 3.3%. The unemployment rate from December 2023 was still preliminary at the time of publication.

Work Site Distribution

At a Glance:

Concentration

Top Region:	33%
Top 3 Regions:	72%
Lowest Region:	1%

Locations

2 or More (Past Year):	25%
2 or More (Now*):	23%

Source: Va. Healthcare Workforce Data Center

More than 70% of all physician assistants work in Northern Virginia, Hampton Roads, and Central Virginia.

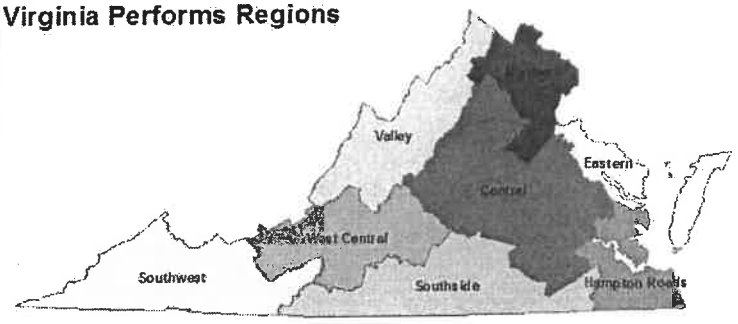
A Closer Look:

Regional Distribution of Work Locations

Virginia Performs Region	Primary Location #	Primary Location %	Secondary Location #	Secondary Location %
Central	820	19%	168	15%
Eastern	33	1%	10	1%
Hampton Roads	912	21%	204	19%
Northern	1,427	33%	325	30%
Southside	81	2%	22	2%
Southwest	107	2%	34	3%
Valley	335	8%	62	6%
West Central	576	13%	127	12%
Virginia Border State/D.C.	31	1%	44	4%
Other U.S. State	42	1%	93	9%
Outside of the U.S.	0	0%	2	0%
Total	**4,364**	**100%**	**1,091**	**100%**
Item Missing	713		25	

Source: Va. Healthcare Workforce Data Center

Virginia Performs Regions



Source: Va. Healthcare Workforce Data Center

Number of Work Locations

Locations	Work Locations in Past Year #	Work Locations in Past Year %	Work Locations Now* #	Work Locations Now* %
0	79	2%	124	3%
1	3,191	73%	3,238	74%
2	512	12%	469	11%
3	395	9%	387	9%
4	81	2%	62	1%
5	56	1%	46	1%
6 or More	68	2%	55	1%
Total	**4,381**	**100%**	**4,381**	**100%**

*At the time of survey completion, January-December 2023.

Source: Va. Healthcare Workforce Data Center

While 23% of all physician assistants currently have multiple work locations, 25% have had multiple work locations in the past year.

Establishment Type

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	2,440	58%	661	63%
Non-Profit	1,391	33%	322	30%
State/Local Government	144	3%	44	4%
Veterans Administration	98	2%	7	1%
U.S. Military	118	3%	16	2%
Other Federal Government	46	1%	7	1%
Total	4,237	100%	1,057	100%
Did Not Have Location	96		4,058	
Item Missing	841		59	

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Sector

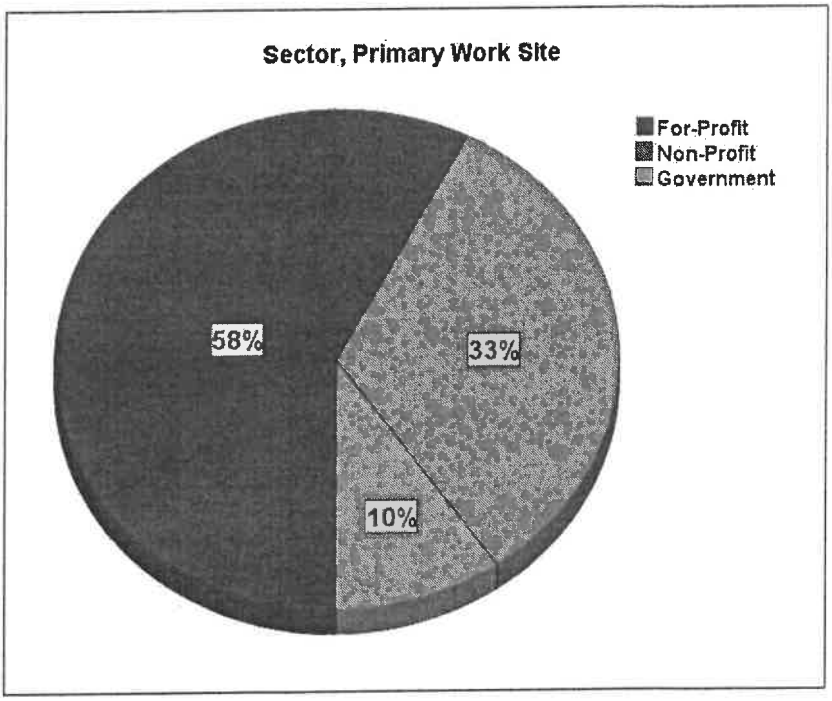
For-Profit: 58%
Federal: 6%

Top Establishments

Group Practice (Single Specialty): 29%
Hospital (Inpatient Dept.): 15%
Group Practice (Multiple Specialties): 12%

Source: Va. Healthcare Workforce Data Center

Among all physician assistants, 58% work in the for-profit sector. Another 33% of physician assistants work in the non-profit sector.



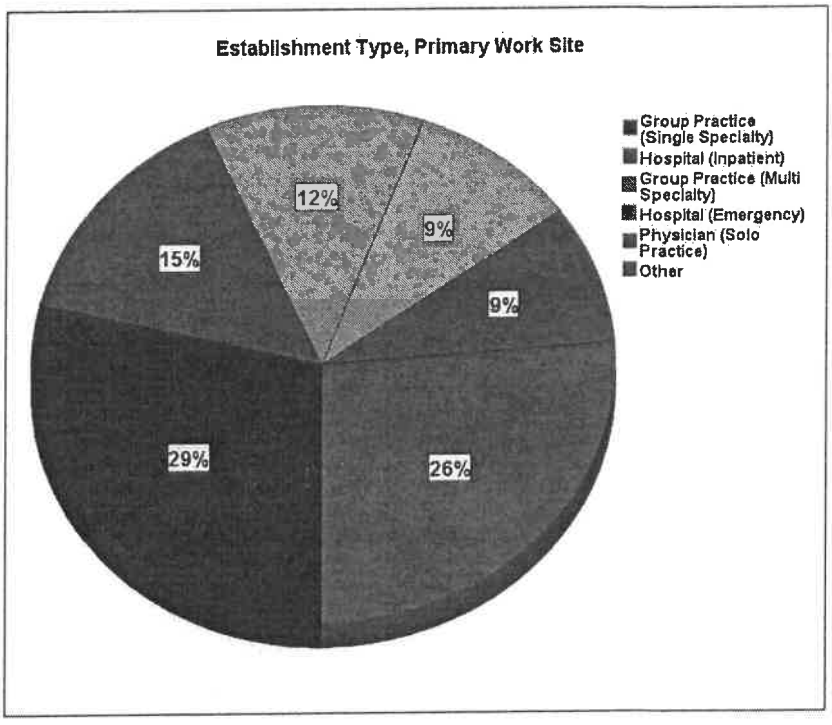
Source: Va. Healthcare Workforce Data Center

Location Type				
Establishment Type	Primary Location		Secondary Location	
	#	%	#	%
Group Practice (Single Specialty)	1,208	29%	224	22%
Hospital (Inpatient Department)	610	15%	169	16%
Group Practice (Multi Specialty)	505	12%	97	9%
Hospital (Emergency Department)	392	9%	145	14%
Physician (Solo Practice)	367	9%	103	10%
Hospital (Outpatient Department)	286	7%	39	4%
Community Clinic/Outpatient Care Center	206	5%	48	5%
Academic Institution (Teaching or Research)	148	4%	28	3%
Academic Institution (Patient Care Role)	130	3%	28	3%
Independent Contractor	28	1%	28	3%
Nursing Home/Long Term Care Facility	24	1%	5	<1%
Other	274	7%	117	11%
Total	**4,178**	**100%**	**1,031**	**100%**
Did Not Have Location	96		4,058	

Source: Va. Healthcare Workforce Data Center

More than half of all physician assistants work in either a group practice (single or multiple specialties) or the inpatient department of a hospital.

For physician assistants who also have a secondary work location, more than half work in either a group practice (single specialty) or a hospital (inpatient or emergency department).



Source: Va. Healthcare Workforce Data Center

Languages

At a Glance:
(Primary Locations)

Languages Offered

Spanish:	27%
Arabic:	15%
Chinese:	15%

Means of Communication

Virtual Translation:	68%
Other Staff Member:	34%
Onsite Translation:	26%

Source: Va. Healthcare Workforce Data Center

More than one-quarter of all physician assistants are employed at a primary work location that offers Spanish language services for patients.

A Closer Look:

Languages Offered		
Language	**#**	**% of Workforce**
Spanish	1,408	27%
Arabic	761	15%
Chinese	752	15%
French	723	14%
Korean	702	14%
Vietnamese	700	14%
Hindi	663	13%
Persian	573	11%
Tagalog/Filipino	567	11%
Urdu	556	11%
Pashto	497	10%
Amharic, Somali, or Other Afro-Asiatic Languages	486	9%
Others	411	8%
At Least One Language	**1,623**	**31%**

Source: Va. Healthcare Workforce Data Center

Means of Language Communication		
Provision	**#**	**% of Workforce with Language Services**
Virtual Translation Services	1,111	68%
Other Staff Member is Proficient	554	34%
Onsite Translation Service	414	26%
Respondent is Proficient	236	15%
Other	40	2%

Source: Va. Healthcare Workforce Data Center

More than two out of every three physician assistants who are employed at a primary work location that offers language services for patients provide it by means of a virtual translation service.

At a Glance:

Top Tasks Performed

Managed Care of Patients (Outpatient): 50%

Minor Surgical Procedures: 34%

# of Hospitals w/ Privileges

None: 44%

One: 33%

Two or More: 24%

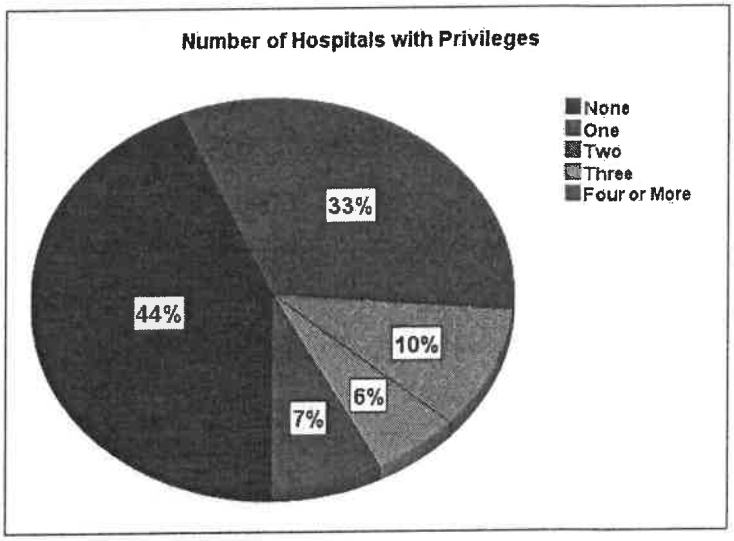
Source: Va. Healthcare Workforce Data Center

A Closer Look:

Tasks Performed		
Task	#	% of Workforce
Manage Care of Patients, Outpatient	2,563	50%
Minor Surgical Procedures	1,766	34%
Manage Care of Patients, Inpatient	1,366	26%
Supervise/Manage Other Clinical Staff	1,035	20%
First Assist at Surgery	781	15%
Supervise/Manage Other PAs	621	12%
At Least One Task Performed	3,645	70%

Source: Va. Healthcare Workforce Data Center

One-half of all physician assistants manage outpatient care, and 34% participate in minor surgical procedures.



Source: Va. Healthcare Workforce Data Center

Hospital Privileges		
# of Hospitals	#	%
None	1,883	44%
1	1,410	33%
2	445	10%
3	252	6%
4 or More	320	7%
Total	4,310	100%

Source: Va. Healthcare Workforce Data Center

Among all physician assistants, 56% have hospital privileges with at least one hospital.

Time Allocation

At a Glance:
(Primary Locations)

Typical Time Allocation

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

Roles

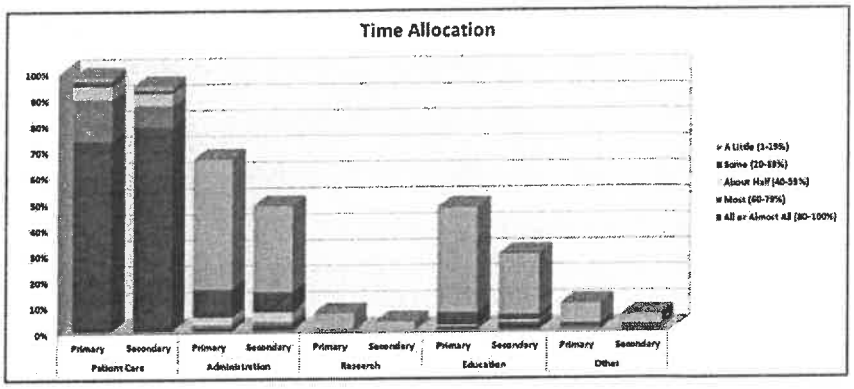
Patient Care:	89%
Administration:	2%
Education:	1%

Patient Care PAs

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

Physician assistants typically spend most of their time in patient care activities. Nearly nine out of every ten physician assistants fill a patient care role, defined as spending 60% or more of their time in that activity.

Time Allocation										
Time Spent	Patient Care		Admin.		Research		Education		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%)	73%	79%	1%	2%	0%	0%	1%	2%	0%	1%
Most (60-79%)	16%	8%	1%	1%	0%	0%	0%	1%	0%	0%
About Half (40-59%)	5%	5%	3%	4%	0%	0%	1%	1%	0%	0%
Some (20-39%)	2%	1%	11%	8%	0%	0%	5%	2%	2%	1%
A Little (1-19%)	1%	2%	50%	33%	6%	3%	40%	24%	8%	4%
None (0%)	2%	5%	34%	52%	93%	97%	53%	71%	90%	94%

Source: Va. Healthcare Workforce Data Center

Patient Visits

At a Glance:
(Primary Locations)

Median Weekly Visits

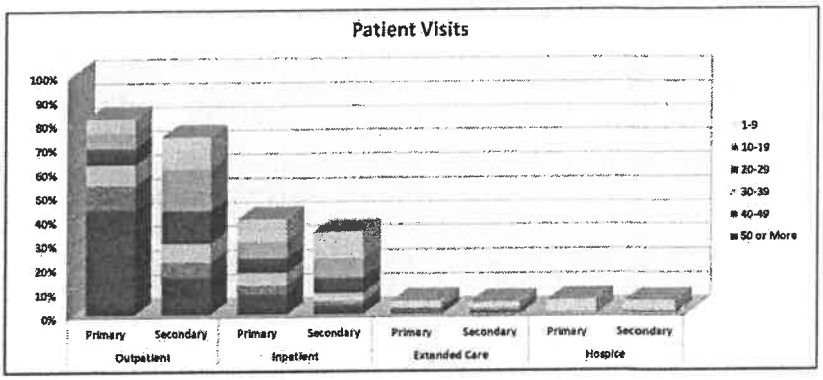
Outpatient:	40-49
Inpatient:	None
Extended Care:	None
Hospice:	None

% With Visits

Outpatient:	82%
Inpatient:	40%
Extended Care:	5%
Hospice:	5%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

Physician assistants typically treat between 40 and 49 patients per week in an outpatient setting. In addition, more than four out of every five physician assistants treat at least one patient per week in an outpatient setting.

Weekly Patient Visits

Visits Per Week	Outpatient		Inpatient		Extended Care		Hospice	
	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site
None	18%	26%	60%	66%	95%	95%	95%	95%
1-9 Visits	6%	13%	9%	11%	2%	2%	5%	4%
10-19 Visits	6%	17%	7%	8%	1%	1%	0%	0%
20-29 Visits	7%	14%	6%	6%	1%	0%	0%	0%
30-39 Visits	9%	8%	5%	4%	0%	0%	0%	0%
40-49 Visits	10%	6%	3%	2%	0%	0%	0%	0%
50 or More Visits	44%	16%	8%	4%	1%	0%	0%	0%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All		50 and Over	
	#	%	#	%
Under Age 50	162	4%	-	-
50 to 54	241	6%	4	1%
55 to 59	548	14%	47	7%
60 to 64	1,248	31%	185	26%
65 to 69	1,335	33%	282	40%
70 to 74	286	7%	102	15%
75 to 79	50	1%	17	2%
80 and Over	31	1%	13	2%
I Do Not Intend to Retire	146	4%	51	7%
Total	4,047	100%	701	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All Professionals
- Under 65: 54%
- Under 60: 23%

50 and Over
- Under 65: 34%
- Under 60: 7%

Time Until Retirement
- Within 2 Years: 2%
- Within 10 Years: 10%
- Half the Workforce: By 2053

Source: Va. Healthcare Workforce Data Center

More than half of all physician assistants expect to retire by the age of 65. Among physician assistants who are age 50 and over, 34% expect to retire by the age of 65.

Within the next two years, 9% of all physician assistants expect to pursue additional educational opportunities, and 8% expect to increase patient care hours.

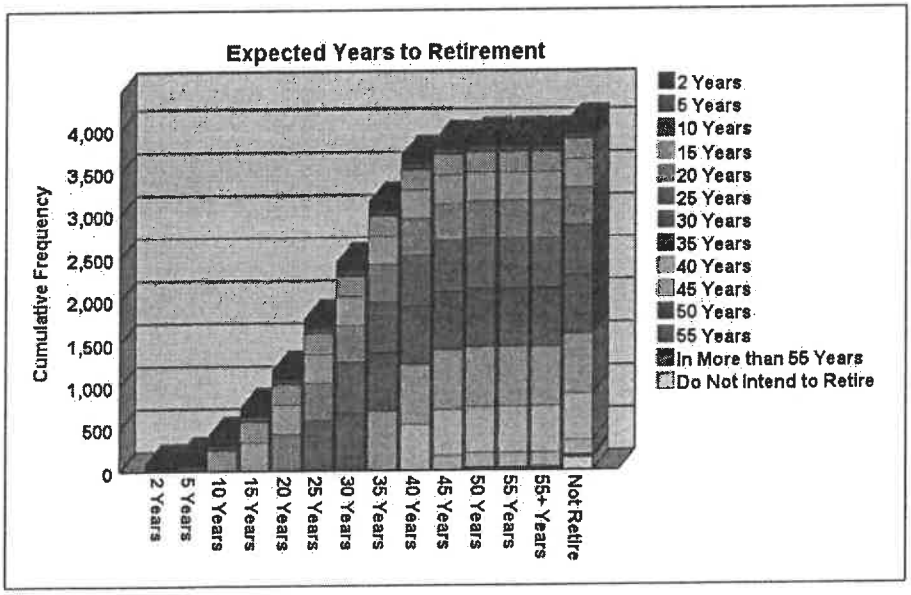
Future Plans		
Two-Year Plans:	#	%
Decrease Participation		
Leave Profession	78	2%
Leave Virginia	162	3%
Decrease Patient Care Hours	531	10%
Decrease Teaching Hours	29	1%
Increase Participation		
Increase Patient Care Hours	409	8%
Increase Teaching Hours	492	10%
Pursue Additional Education	469	9%
Return to the Workforce	34	1%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for physician assistants. While 2% of physician assistants expect to retire in the next two years, 10% expect to retire within the next ten years. Half of the current workforce expect to retire by 2053.

Time to Retirement			
Expect to Retire Within. . .	#	%	Cumulative %
2 Years	93	2%	2%
5 Years	74	2%	4%
10 Years	239	6%	10%
15 Years	338	8%	18%
20 Years	436	11%	29%
25 Years	596	15%	44%
30 Years	673	17%	61%
35 Years	703	17%	78%
40 Years	542	13%	91%
45 Years	172	4%	96%
50 Years	31	1%	96%
55 Years	3	0%	96%
In More than 55 Years	1	0%	96%
Do Not Intend to Retire	146	4%	100%
Total	4,047	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 starting in 2043. Retirement will peak at 17% of the current workforce around 2058 before declining to under 10% of the current workforce again around 2068.

Full-Time Equivalency Units

At a Glance:

FTEs

Total:	4,478
FTEs/1,000 Residents[2]:	0.516
Average:	0.88

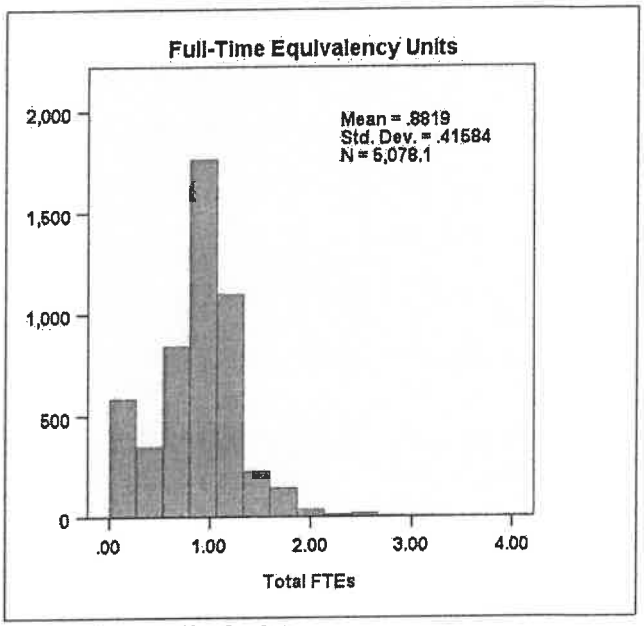
Age & Gender Effect

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

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

Source: Va. Healthcare Workforce Data Center

A Closer Look:

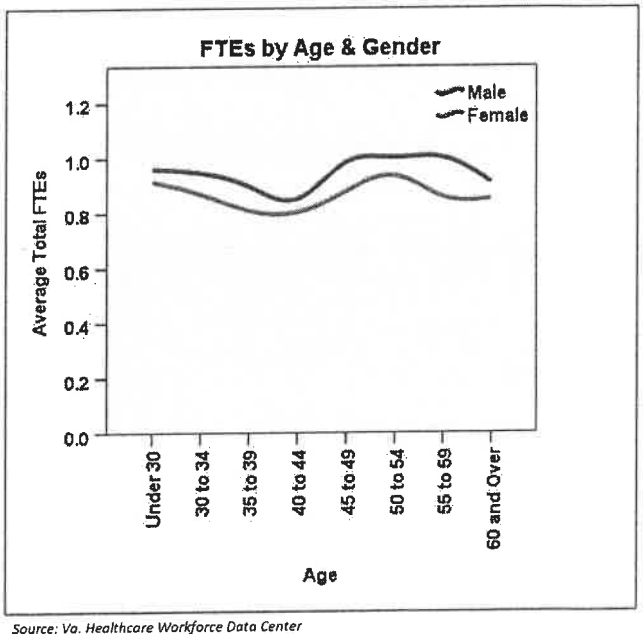


Source: Va. Healthcare Workforce Data Center

The typical physician assistant provided 0.96 FTEs in 2023, or approximately 38 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	Average	Median
Age		
Under 30	0.92	0.96
30 to 34	0.87	0.91
35 to 39	0.85	0.96
40 to 44	0.73	0.83
45 to 49	1.02	1.03
50 to 54	0.97	1.05
55 to 59	0.94	1.05
60 and Over	0.90	0.99
Gender		
Male	0.94	1.01
Female	0.86	0.93

Source: Va. Healthcare Workforce Data Center

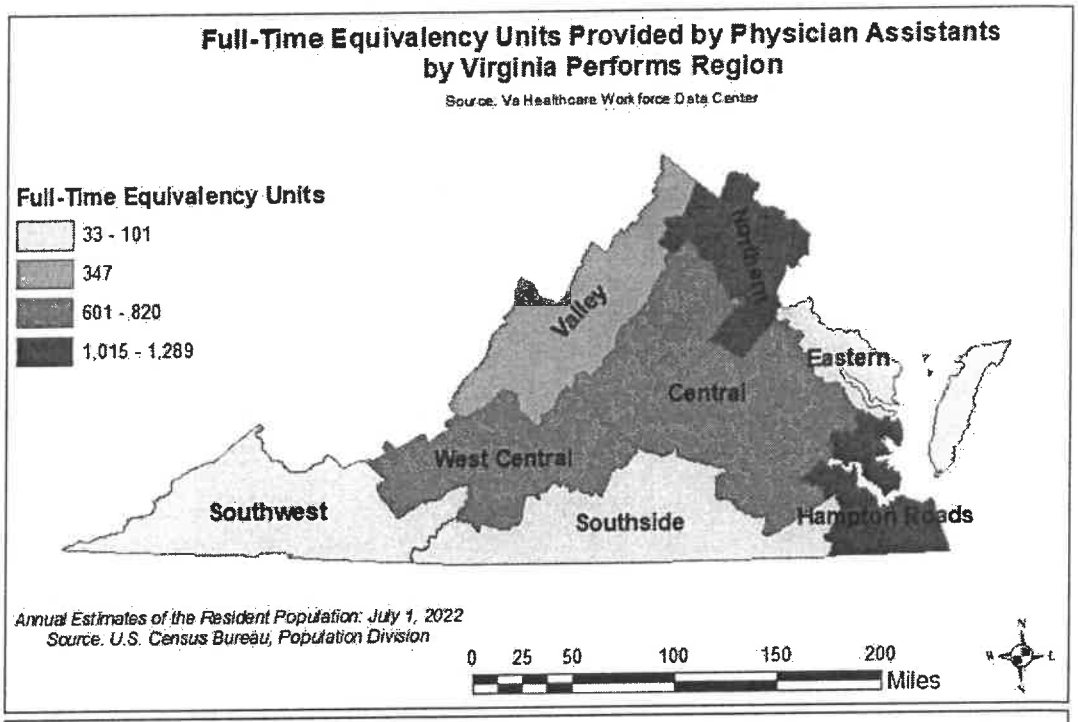


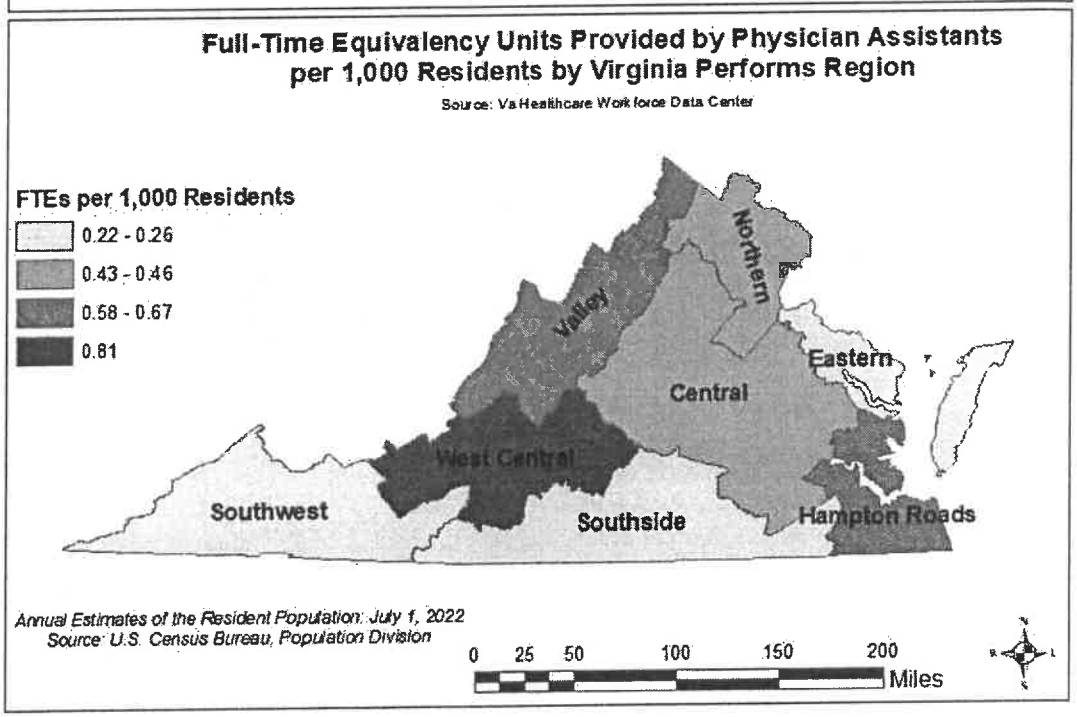
Source: Va. Healthcare Workforce Data Center

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

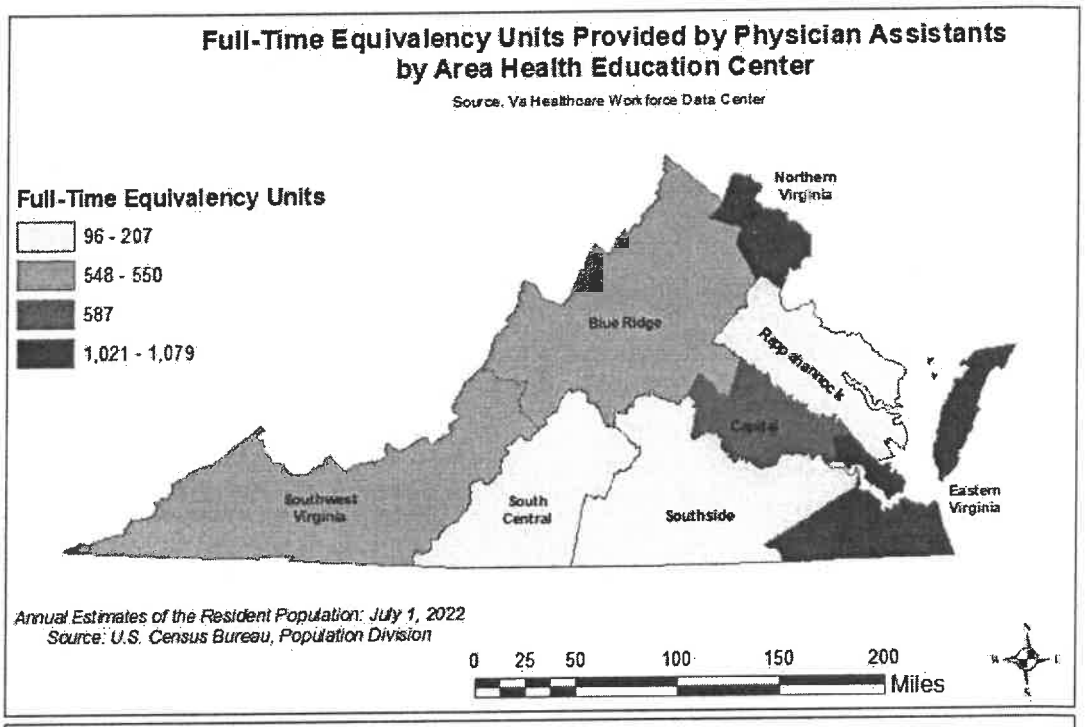
Maps

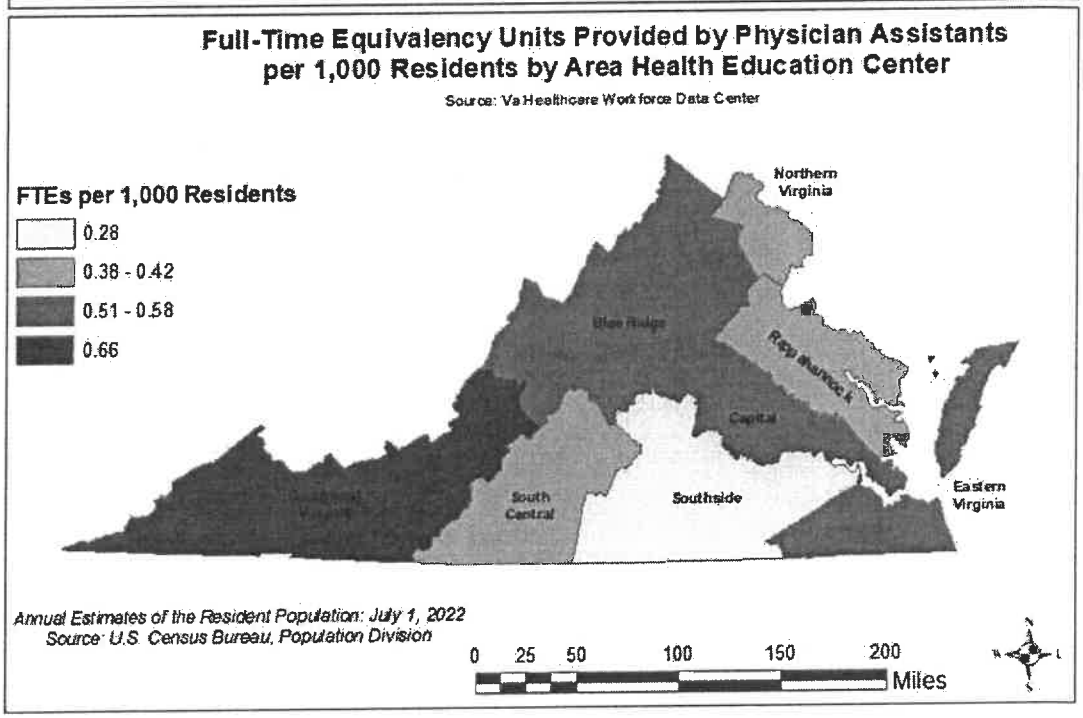
Virginia Performs Regions



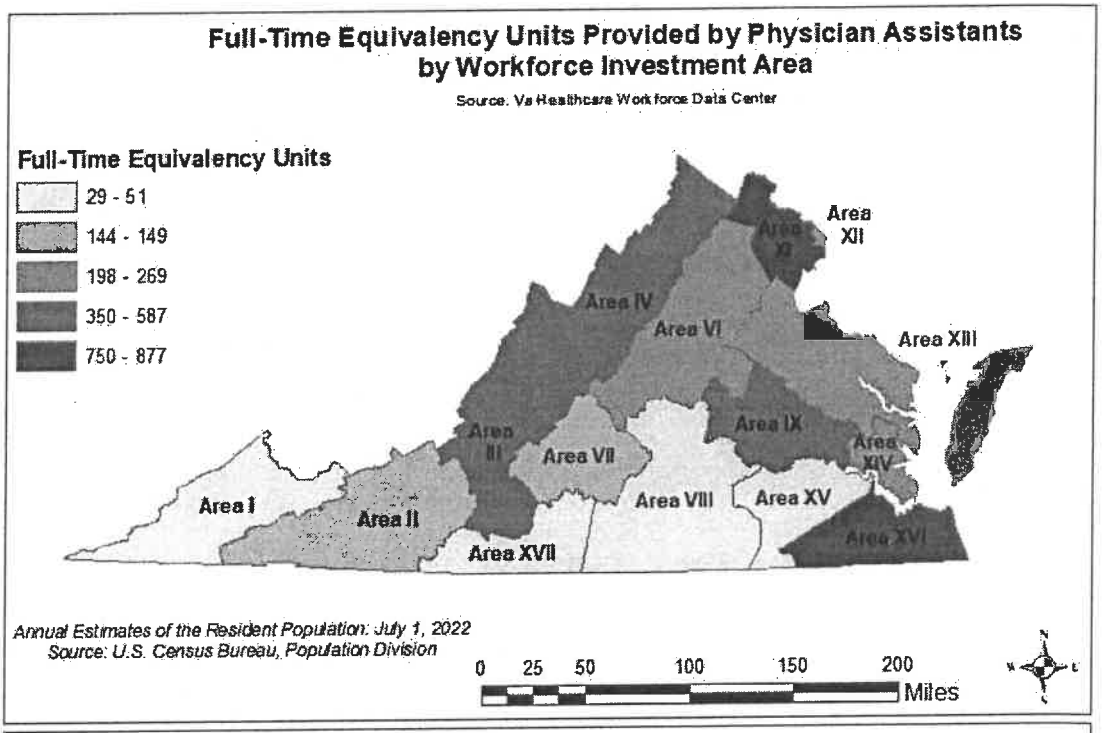


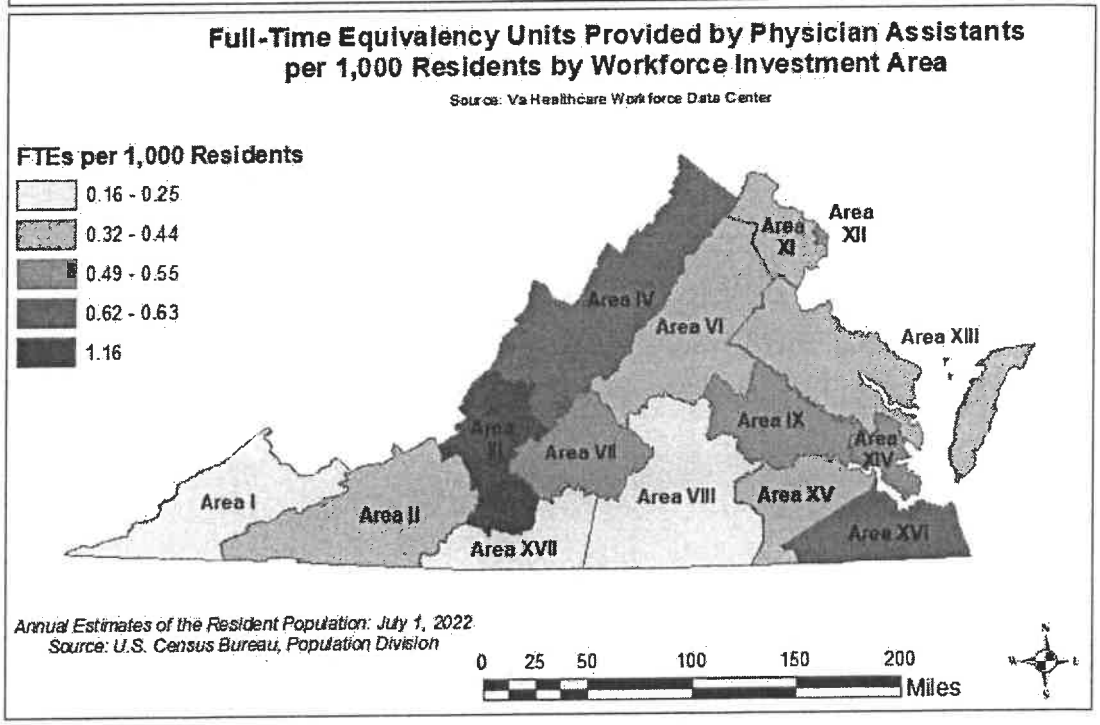
Area Health Education Center Regions



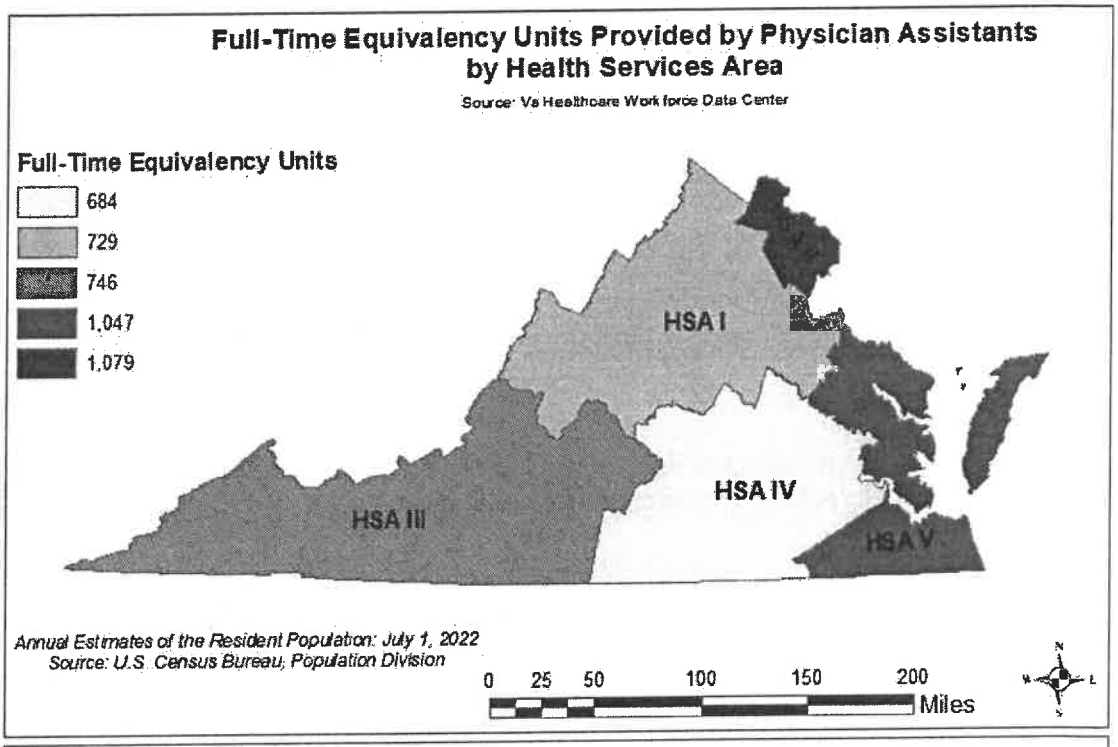


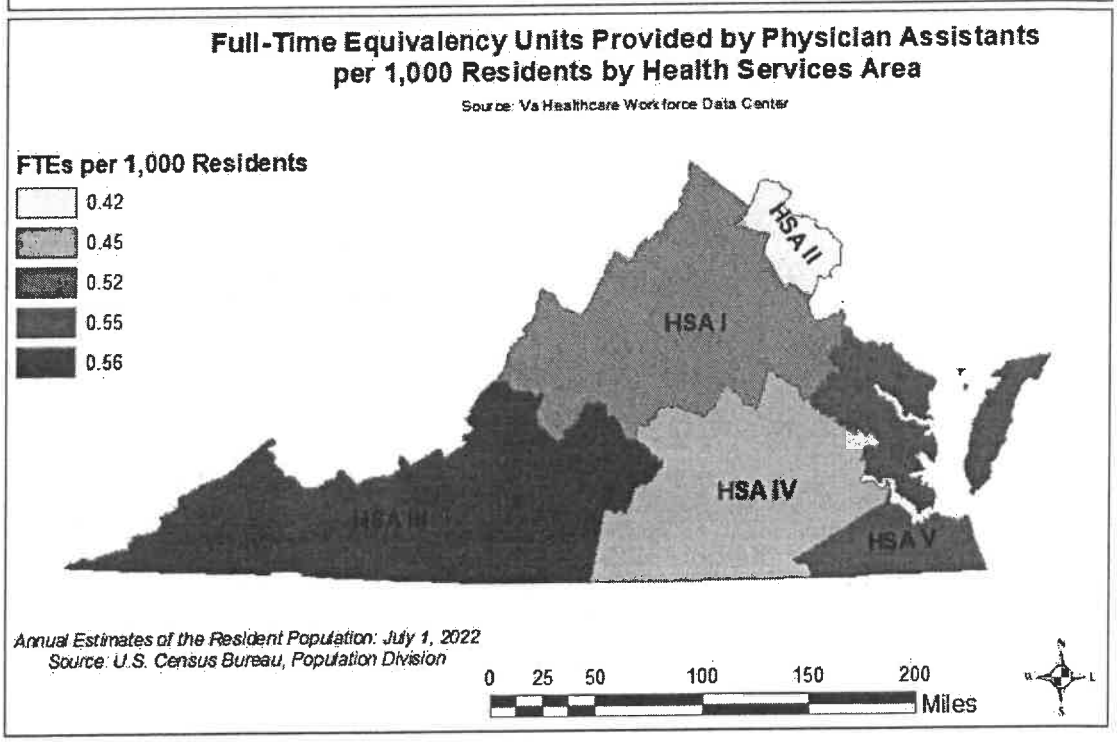
Workforce Investment Areas



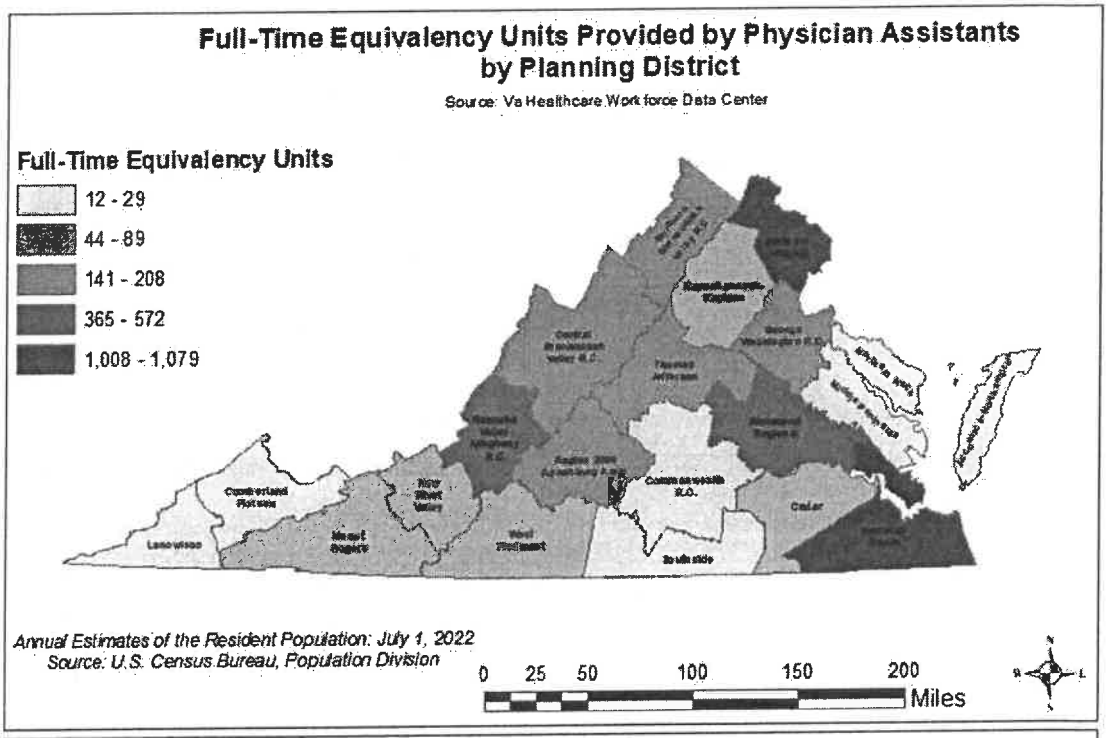


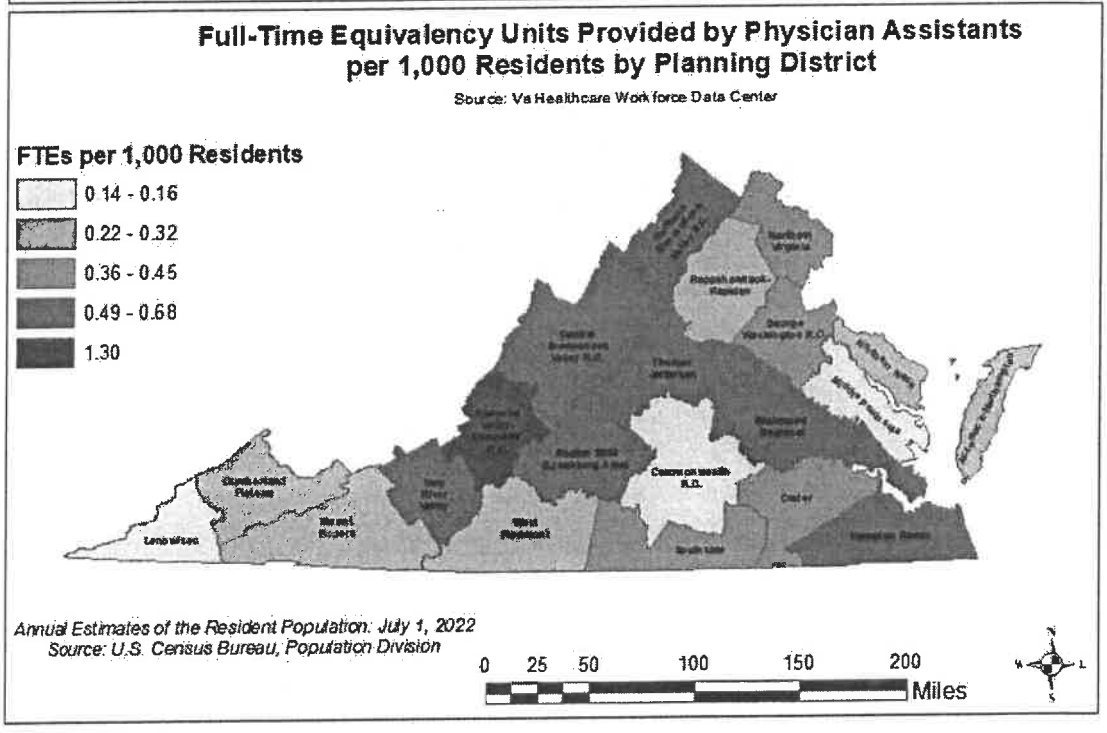
Health Services Areas





Planning Districts





Appendix

Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Metro, 1 Million+	3,071	75.42%	1.326	1.119	2.372
Metro, 250,000 to 1 Million	529	73.91%	1.353	1.141	2.420
Metro, 250,000 or Less	472	80.72%	1.239	1.045	2.216
Urban, Pop. 20,000+, Metro Adj.	27	70.37%	1.421	1.199	2.542
Urban, Pop. 20,000+, Non-Adj.	0	NA	NA	NA	NA
Urban, Pop. 2,500-19,999, Metro Adj.	118	70.34%	1.422	1.199	2.543
Urban, Pop. 2,500-19,999, Non-Adj.	63	79.37%	1.260	1.063	2.254
Rural, Metro Adj.	69	66.67%	1.500	1.266	2.683
Rural, Non-Adj.	22	68.18%	1.467	1.237	2.624
Virginia Border State/D.C.	1,058	59.55%	1.679	1.417	3.004
Other U.S. State	1,263	58.27%	1.716	1.448	3.070

Source: Va. Healthcare Workforce Data Center

Age	Age Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Under 30	967	38.99%	2.565	2.216	3.070
30 to 34	1,471	63.90%	1.565	1.352	1.873
35 to 39	1,302	74.42%	1.344	1.161	1.608
40 to 44	968	82.44%	1.213	1.048	1.452
45 to 49	677	81.98%	1.220	1.054	1.460
50 to 54	519	82.66%	1.210	1.045	1.448
55 to 59	334	79.64%	1.256	1.085	1.503
60 and Over	454	73.35%	1.363	1.178	1.632

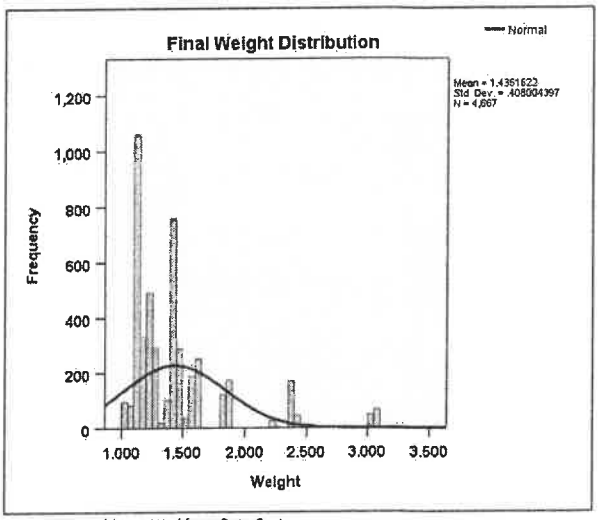
Source: Va. Healthcare Workforce Data Center

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: 0.697400



Source: Va. Healthcare Workforce Data Center

Board of Medicine – Advisory Board on Physician Assistants
Regulatory Actions
February 2024 Update

In the Governor's Office

None.

In the Secretary's Office

VAC	Stage	Subject Matter	Submitted from agency	Time in current location	Notes
18VAC85-50	NOIRA	Amendment to requirements for patient care team physician or podiatrist consultation and collaboration	8/8/2023	270 days	Following a petition for rulemaking, the Board is noticing that it will amend 18VAC85-50-110(1) to reduce requirements for consultation and collaboration
18VAC85-50	NOIRA	Removal of patient care team physician or podiatrist name from prescriptions issued by physician assistants	8/8/2023	280 days	Following a petition for rulemaking, removes the requirement that the patient care team physician or podiatrist name appear on prescriptions issued by physician assistants for Schedule II – V drugs
18VAC85-50	Fast-track	Implementation of changes following 2022 periodic review of Chapter	10/6/2022	276 days	Periodic review changes voted on at 2022 October Board meeting

At DPB or OAG

None.

Recently effective/awaiting publication

None.

Legislative Report
Board of Medicine – Advisory Board on Physician Assistants
June 6, 2024

HB 324 PA Licensure Compact; authorizes Virginia to become a signatory to Compact.

Chief patron: Glass

PA Licensure Compact. Authorizes Virginia to become a signatory to the PA Licensure Compact. The Compact permits eligible physician assistants to practice in Compact-participating states, provided that they are licensed in at least one participating state. The Compact has been passed in three states and takes effect when it is enacted by a seventh participating state or upon the effective date of the bill, whichever is later.

02/07/24 House: Subcommittee recommends reporting with amendments (8-Y 0-N)
02/08/24 House: Reported from Health and Human Services with amendment(s) (22-Y 0-N)
02/13/24 House: VOTE: Block Vote Passage (99-Y 0-N)
02/20/24 Senate: Rereferred from Privileges and Elections (13-Y 1-N)
02/29/24 Senate: Reported from Education and Health (15-Y 0-N)
03/04/24 Senate: Passed Senate (33-Y 7-N)
04/04/24 Governor: Approved by Governor

SB 133 Physician assistants; practice agreement exemption.

Chief patron: Head

Physician assistants; practice agreement exemption. Allows physician assistants employed by a hospital or employed in certain facilities operated by the Department of Behavioral Health and Developmental Services or in federally qualified health centers designated by the Centers for Medicare and Medicaid Services to practice without a separate practice agreement if the credentialing and privileging requirements of the applicable facility include a practice arrangement, as described in the bill.

01/18/24 Senate: Reported from Education and Health (15-Y 0-N)
01/23/24 Senate: Read third time and passed Senate (39-Y 0-N)
02/15/24 House: Subcommittee recommends reporting (8-Y 0-N)
02/20/24 House: Reported from Health and Human Services (21-Y 1-N)

02/23/24 House: VOTE: Passage (97-Y 1-N)

02/28/24 Senate: Enrolled

03/20/24 Governor: Approved by Governor

VIRGINIA ACTS OF ASSEMBLY -- 2024 SESSION

CHAPTER 439

An Act to amend the Code of Virginia by adding a section numbered 54.1-2953.1, relating to PA Licensure Compact.

[H 324]

Approved April 4, 2024

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 54.1-2953.1 as follows:

§ 54.1-2953.1. PA Licensure Compact.

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

PA LICENSURE COMPACT.

Article 1. Purpose.

In order to strengthen access to medical services, and in recognition of the advances in the delivery of medical services, the participating states of the PA Licensure Compact have allied in common purpose to develop a comprehensive process that complements the existing authority of state licensing boards to license and discipline PAs and seeks to enhance the portability of a license to practice as a PA while safeguarding the safety of patients. This Compact allows medical services to be provided by PAs, via the mutual recognition of the licensee's qualifying license by other compact participating states. This Compact also adopts the prevailing standard for PA licensure and affirms that the practice and delivery of medical services by the PA occurs where the patient is located at the time of the patient encounter, and therefore requires the PA to be under the jurisdiction of the state licensing board where the patient is located. State licensing boards that participate in this Compact retain the jurisdiction to impose adverse action against a compact privilege in that state issued to a PA through the procedures of this Compact. The PA Licensure Compact will alleviate burdens for military families by allowing active duty military personnel and their spouses to obtain a compact privilege based on having an unrestricted license in good standing from a participating state.

Article 2. Definitions.

As used in this Compact, unless the context requires otherwise, the following definitions shall apply:

"Adverse action" means any administrative, civil, equitable, or criminal action permitted by a state's laws that is imposed by a licensing board or other authority against a PA license or license application or Compact privilege such as license denial, censure, revocation, suspension, probation, monitoring of the licensee, or restriction on the licensee's practice.

"Compact privilege" means the authorization granted by a remote state to allow a licensee from another participating state to practice as a PA to provide medical services and other licensed activity to a patient located in the remote state under the remote state's laws and regulations.

"Conviction" means a finding by a court that an individual is guilty of a felony or misdemeanor offense through adjudication or entry of a plea of guilt or no contest to the charge by the offender.

"Criminal background check" means the submission of fingerprints or other biometric-based information for a license applicant for the purpose of obtaining that applicant's criminal history record information, as defined in 28 C.F.R. § 20.3(d), from the state's criminal history record repository as defined in 28 C.F.R. § 20.3(f).

"Data system" means the repository of information about licensees, including but not limited to license status and adverse actions, that is created and administered under the terms of this Compact.

"Executive committee" means a group of directors and ex-officio individuals elected or appointed pursuant to subdivision F 2 of Article 7.

"Impaired practitioner" means a PA whose practice is adversely affected by health-related condition(s) that impact their ability to practice.

"Investigative information" means information, records, or documents received or generated by a 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 a PA in a state.

"License" means current authorization by a state, other than authorization pursuant to a Compact privilege, for a PA to provide medical services, which would be unlawful without current authorization.

"Licensee" means an individual who holds a license from a state to provide medical services as a PA.

"Licensing board" means any state entity authorized to license and otherwise regulate PAs.

"Medical services" means health care services provided for the diagnosis, prevention, treatment,

cure, or relief of a health condition, injury, or disease, as defined by a state's laws and regulations.

"Model compact" means the model for the PA Licensure Compact on file with the Council of State Governments or other entity as designated by the Commission.

"Participating state" means a state that has enacted this Compact.

"PA" means an individual who is licensed as a physician assistant in a state. For purposes of this Compact, any other title or status adopted by a state to replace the term "physician assistant" shall be deemed synonymous with "physician assistant" and shall confer the same rights and responsibilities to the licensee under the provisions of this Compact at the time of its enactment.

"PA Licensure Compact Commission," "Compact Commission," or "Commission" mean the national administrative body created pursuant to subsection A of Article 7.

"Qualifying license" means an unrestricted license issued by a participating state to provide medical services as a PA.

"Remote state" means a participating state where a licensee who is not licensed as a PA is exercising or seeking to exercise the compact privilege.

"Rule" means a regulation promulgated by an entity that has the force and effect of law.

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

"State" means any state, commonwealth, district, or territory of the United States.

Article 3. State Participation in This Compact.

A. To participate in this Compact, a participating state shall:

1. License PAs.

2. Participate in the Compact Commission's data system.

3. Have a mechanism in place for receiving and investigating complaints against licensees and license applicants.

4. Notify the Commission, in compliance with the terms of this Compact and Commission rules, of any adverse action against a licensee or license applicant and the existence of significant investigative information regarding a licensee or license applicant.

5. Fully implement a criminal background check requirement, within a time frame established by Commission rule, by its licensing board receiving the results of a criminal background check and reporting to the Commission whether the license applicant has been granted a license.

6. Comply with the rules of the Compact Commission.

7. Utilize passage of a recognized national exam such as the NCCPA PANCE as a requirement for PA licensure.

8. Grant the compact privilege to a holder of a qualifying license in a participating state.

B. Nothing in this Compact prohibits a participating state from charging a fee for granting the compact privilege.

Article 4. Compact Privilege.

A. To exercise the compact privilege, a licensee shall:

1. Have graduated from a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant, Inc., or other programs authorized by Commission rule.

2. Hold current NCCPA certification.

3. Have no felony or misdemeanor conviction.

4. Have never had a controlled substance license, permit, or registration suspended or revoked by a state or by the U.S. Drug Enforcement Administration.

5. Have a unique identifier as determined by Commission rule.

6. Hold a qualifying license.

7. Have had no revocation of a license or limitation or restriction on any license currently held due to an adverse action.

8. If a licensee has had a limitation or restriction on a license or compact privilege due to an adverse action, two years shall have elapsed from the date on which the license or compact privilege is no longer limited or restricted due to the adverse action.

9. If a compact privilege has been revoked or is limited or restricted in a participating state for conduct that would not be a basis for disciplinary action in a participating state in which the licensee is practicing or applying to practice under a compact privilege, that participating state shall have the discretion not to consider such action as an adverse action requiring the denial or removal of a compact privilege in that state.

10. Notify the Compact Commission that the licensee is seeking the compact privilege in a remote state.

11. Meet any jurisprudence requirement of a remote state in which the licensee is seeking to practice under the compact privilege and pay any fees applicable to satisfying the jurisprudence requirement.

12. Report to the Commission any adverse action taken by a nonparticipating state within 30 days after the action is taken.

B. The compact privilege is valid until the expiration or revocation of the qualifying license unless terminated pursuant to an adverse action. The licensee shall also comply with all of the requirements of subsection A to maintain the compact privilege in a remote state. If the participating state takes adverse action against a qualifying license, the licensee shall lose the compact privilege in any remote state in which the licensee has a compact privilege until all of the following occur:

1. The license is no longer limited or restricted; and

2. Two years have elapsed from the date on which the license is no longer limited or restricted due to the adverse action.

C. Once a restricted or limited license satisfies the requirements of subdivisions B 1 and 2, the licensee shall meet the requirements of subsection A to obtain a compact privilege in any remote state.

D. For each remote state in which a PA seeks authority to prescribe controlled substances, the PA shall satisfy all requirements imposed by such state in granting or renewing such authority.

Article 5. Designation of the State from Which Licensee is Applying for a Compact Privilege.

Upon a licensee's application for a compact privilege, the licensee shall identify to the Commission the participating state from which the licensee is applying, in accordance with applicable rules adopted by the Commission, and subject to the following requirements:

1. When applying for a compact privilege, the licensee shall provide the Commission with the address of the licensee's primary residence and thereafter shall immediately report to the Commission any change in the address of the licensee's primary residence.

2. When applying for a compact privilege, the licensee is required to consent to accept service of process by mail at the licensee's primary residence on file with the Commission with respect to any action brought against the licensee by the Commission or a participating state, including a subpoena, with respect to any action brought or investigation conducted by the Commission or a participating state.

Article 6. Adverse Actions.

A. A participating state in which a licensee is licensed shall have exclusive power to impose adverse action against the qualifying license issued by that participating 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 do all of the following:

1. Take adverse action against a PA's compact privilege within that state to remove a licensee's compact privilege or take other action necessary under applicable law to protect the health and safety of its citizens.

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 participating state for the attendance and testimony of witnesses or the production of evidence from another participating 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.

3. Notwithstanding subdivision 2, subpoenas may not be issued by a participating state to gather evidence of conduct in another state that is lawful in that other state for the purpose of taking adverse action against a licensee's compact privilege or application for a compact privilege in that participating state.

4. Nothing in this Compact authorizes a participating state to impose discipline against a PA's compact privilege or to deny an application for a compact privilege in that participating state for the individual's otherwise lawful practice in another state.

C. For purposes of taking adverse action, the participating state that issued the qualifying license shall give the same priority and effect to reported conduct received from any other participating state as it would if the conduct had occurred within the participating state that issued the qualifying license. In so doing, that participating state shall apply its own state laws to determine appropriate action.

D. A participating state, if otherwise permitted by state law, may recover from the affected PA the costs of investigations and disposition of cases resulting from any adverse action taken against that PA.

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

F. Joint investigations.

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

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

G. If an adverse action is taken against a PA's qualifying license, the PA's compact privilege in all remote states shall be deactivated until two years have elapsed after all restrictions have been removed from the state license. All disciplinary orders by the participating state that issued the qualifying license that impose adverse action against a PA's license shall include a statement that the PA's compact

privilege is deactivated in all participating states during the pendency of the order.

H. If any participating state takes adverse action, it promptly shall notify the administrator of the data system.

Article 7. Establishment of the PA Licensure Compact Commission.

A. The participating states hereby create and establish a joint government agency and national administrative body known as the PA Licensure Compact Commission. The Commission is an instrumentality of the compact states acting jointly and not an instrumentality of any one state. The Commission shall come into existence on or after the effective date of the Compact as set forth in subsection A of Article 11.

B. Membership, voting, and meetings.

1. Each participating state shall have and be limited to one delegate selected by that participating state's licensing board or, if the state has more than one licensing board, selected collectively by the participating state's licensing boards.

2. The delegate shall be either:

a. A current PA, physician, or public member of a licensing board or PA council/committee; or

b. An administrator of a licensing board.

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

4. The participating state licensing board shall fill any vacancy occurring in the Commission within 60 days.

5. Each delegate shall be entitled to one vote on all matters voted on by the Commission 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 telecommunications, video conference, 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 this Compact and 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 fees;

4. Establish bylaws;

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

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

7. Promulgate 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 participating states;

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

9. Purchase and maintain insurance and bonds;

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

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

12. 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 or conflict of interest;

13. 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;

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

15. Establish a budget and make expenditures;

16. Borrow money;

17. 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;

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

19. Elect a chair, vice chair, secretary, and treasurer and such other officers of the Commission as provided in the Commission's bylaws;

20. Reserve for itself, in addition to those reserved exclusively to the Commission under the Compact, powers that the executive committee may not exercise;

21. Approve or disapprove a state's participation in the Compact based upon its determination as to whether the state's compact legislation departs in a material manner from the model compact language;

22. Prepare and provide to the participating states an annual report; and

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

D. Meetings of the Commission.

1. All meetings of the Commission that are not closed pursuant to this subsection shall be open to the public. Notice of public meetings shall be posted on the Commission's website at least 30 days prior to the public meeting.

2. Notwithstanding subdivision 1, the Commission may convene a public meeting by providing at least 24 hours' prior notice on the Commission's website, and any other means as provided in the Commission's rules, for any of the reasons it may dispense with notice of proposed rulemaking under subsection L of Article 9.

3. The Commission may convene in a closed, non-public meeting or non-public part of a public meeting to receive legal advice or to discuss:

a. Noncompliance of a participating state with its obligations under this 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 this Compact;

j. Legal advice; or

k. Matters specifically exempted from disclosure by federal or participating states' statutes.

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

5. 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, 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.

E. 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 participating state and may impose compact privilege fees on licensees of participating states to whom a compact privilege is granted to cover the cost of the operations and activities of the Commission and its staff, which shall 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 levied on participating states shall be allocated based upon a formula to be determined by Commission rule.

a. A compact privilege expires when the licensee's qualifying license in the participating state from which the licensee applied for the compact privilege expires.

b. If the licensee terminates the qualifying license through which the licensee applied for the compact privilege before its scheduled expiration, and the licensee has a qualifying license in another participating state, the licensee shall inform the Commission that it is changing to that participating state the participating state through which it applies for a compact privilege and pay to the Commission any compact privilege fee required by Commission rule.

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 participating states, except by and with the authority of the participating 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 financial review and accounting procedures established under its bylaws. All receipts and disbursements of funds handled by the Commission shall

be subject to an annual financial review by a certified or licensed public accountant, and the report of the financial review shall be included in and become part of the annual report of the Commission.

F. The executive committee.

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

2. 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 PA professional association; and

c. One ex-officio, nonvoting member from a recognized national PA certification organization.

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

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

5. The executive committee shall meet at least annually.

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

a. Recommend to the Commission changes to the Commission's rules or bylaws, changes to this Compact legislation, fees to be paid by compact participating 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 participating states and provide compliance reports to the Commission;

f. Establish additional committees as necessary;

g. Exercise the powers and duties of the Commission during the interim between Commission meetings, except for issuing proposed rulemaking or adopting Commission rules or bylaws, or exercising any other powers and duties exclusively reserved to the Commission by the Commission's rules; and

h. Perform other duties as provided in the Commission's rules or bylaws.

7. All meeting of the executive committee at which it votes or plans to vote on matters in exercising the powers and duties of the Commission shall be open to the public and public notice of such meetings shall be given as public meetings of the Commission are given.

8. The executive committee may convene in a closed, non-public meeting for the same reasons that the Commission may convene in a non-public meeting as set forth in subdivision D 3 and shall announce the closed meeting as the Commission is required to under subdivision D 4 and keep minutes of the closed meeting as the Commission is required to under subdivision D 5.

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, both personally and 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 subdivision shall be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person. The procurement of insurance of any type by the Commission shall not in any way compromise or limit the immunity granted hereunder.

2. The Commission shall defend any member, officer, executive director, employee, and 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 as determined by the Commission 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 their own counsel at their own expense; 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, and 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.

4. 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 in any proceedings as authorized by Commission rules.

5. Nothing herein shall be construed as a limitation on the liability of any licensee for professional

malpractice or misconduct, which shall be governed solely by any other applicable state laws.

6. Nothing herein shall be construed to designate the venue or jurisdiction to bring actions for alleged acts of malpractice, professional misconduct, negligence, or other such civil action pertaining to the practice of a PA. All such matters shall be determined exclusively by state law other than this Compact.

7. Nothing in this Compact shall be interpreted to waive or otherwise abrogate a participating state's state action immunity or state action affirmative defense with respect to antitrust claims under the Sherman Act, the Clayton Act, or any other state or federal antitrust or anticompetitive law or regulation.

8. Nothing in this Compact shall be construed to be a waiver of sovereign immunity by the participating states or by the Commission.

Article 8. Data System.

A. The Commission shall provide for the development, maintenance, operation, and utilization of a coordinated data and reporting system containing licensure, adverse action, and the reporting of the existence of significant investigative information on all licensed PAs and applicants denied a license in participating states.

B. Notwithstanding any other state law to the contrary, a participating state shall submit a uniform data set to the data system on all PAs 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. Any denial of application for licensure, and the reason(s) for such denial (excluding the reporting of any criminal history record information where prohibited by law);

5. The existence of significant investigative information; and

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

C. Significant investigative information pertaining to a licensee in any participating state shall only be available to other participating states.

D. The Commission shall promptly notify all participating states of any adverse action taken against a licensee or an individual applying for a license that has been reported to it. This adverse action information shall be available to any other participating state.

E. Participating states contributing information to the data system may, in accordance with state or federal law, designate information that may not be shared with the public without the express permission of the contributing state. Notwithstanding any such designation, such information shall be reported to the Commission through the data system.

F. Any information submitted to the data system that is subsequently expunged pursuant to federal law or the laws of the participating state contributing the information shall be removed from the data system upon reporting of such by the participating state to the Commission.

G. The records and information provided to a participating state pursuant to this Compact or through the data system, when certified by the Commission or an agent thereof, shall constitute the authenticated business records of the Commission, and shall be entitled to any associated hearsay exception in any relevant judicial, quasi-judicial or administrative proceedings in a participating state.

Article 9. Rulemaking.

A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this section and the rules adopted thereunder. Commission rules shall become binding as of the date specified by the Commission for each rule.

B. The Commission shall promulgate reasonable rules in order to effectively and efficiently implement and administer this Compact and achieve its purposes. A Commission rule shall be invalid and have not force or effect only if a court of competent jurisdiction holds that the rule is invalid because the Commission exercised its rulemaking authority in a manner that is beyond the scope of the purposes of this Compact, or the powers granted hereunder, or based upon another applicable standard of review.

C. The rules of the Commission shall have the force of law in each participating state, provided however that where the rules of the Commission conflict with the laws of the participating state that establish the medical services a PA may perform in the participating state, as held by a court of competent jurisdiction, the rules of the Commission shall be ineffective in that state to the extent of the conflict.

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

E. Commission rules shall be adopted at a regular or special meeting of the Commission.

F. 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. To persons who have requested notice of the Commission's notices of proposed rulemaking; and

3. In such other way(s) as the Commission may by rule specify.

G. The notice of proposed rulemaking shall include:

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

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

3. A request for comments on the proposed rule from any interested person and the date by which written comments must be received; and

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

H. 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.

I. If the hearing is to be 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 as directed in the notice of proposed rulemaking, not less than five business days before the scheduled date of the hearing, notify the Commission of their desire to appear and testify at 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 shall be recorded. A copy of the recording and the written comments, data, facts, opinions, and arguments received in response to the proposed rulemaking shall be made available to a person upon request.

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

J. Following the public hearing, the Commission shall consider all written and oral comments timely received.

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

1. If adopted, the rule shall be posted on the Commission's website.

2. The Commission may adopt changes to the proposed rule provided the changes do not enlarge the original purpose of the proposed rule.

3. The Commission shall provide on its website an explanation of the reasons for substantive changes made to the proposed rule as well as reasons for substantive changes not made that were recommended by commenters.

4. The Commission shall determine a reasonable effective date for the rule. Except for an emergency as provided in subsection L, the effective date of the rule shall be no sooner than 30 days after the Commission issued the notice that it adopted the rule.

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule with 24 hours prior notice, without the opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in this Compact and in this section 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 by the Commission in order to:

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

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

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

4. Protect public health and safety.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted Commission rule 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 as set forth in the notice of revisions and delivered to 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.

N. No participating state's rulemaking requirements shall apply under this Compact.

Article 10. Oversight, Dispute Resolution, and Enforcement.

A. Oversight.

1. The executive and judicial branches of state government in each participating state shall enforce this Compact and take all actions necessary and appropriate to implement the Compact.

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. Nothing herein shall affect or limit the selection or propriety of venue in any action against a licensee for professional malpractice, misconduct, or any such similar matter.

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

B. Default, technical assistance, and termination.

1. If the Commission determines that a participating state has defaulted in the performance of its obligations or responsibilities under this Compact or the Commission rules, the Commission shall provide written notice to the defaulting state and other participating states. The notice shall describe the default, the proposed means of curing the default, and any other action that the Commission may take and shall offer 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 this Compact upon an affirmative vote of a majority of the delegates of the participating states, and all rights, privileges, and benefits conferred by this Compact upon such state 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 participation in this 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 to the licensing board(s) of each of the participating 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 this Compact, unless agreed upon in writing between the Commission and the defaulting state.

6. The defaulting state may appeal its termination from the Compact by the Commission by petitioning the United States 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.

7. Upon the termination of a state's participation in the Compact, the State shall immediately provide notice to all licensees within that state of such termination:

a. Licensees who have been granted a compact privilege in that state shall retain the compact privilege for 180 days following the effective date of such termination.

b. Licensees who are licensed in that state who have been granted a compact privilege in a participating state shall retain the compact privilege for 180 days unless the licensee also has a qualifying license in a participating state or obtains a qualifying license in a participating state before the 180-day period ends, in which case the compact privilege shall continue.

C. Dispute resolution.

1. Upon request by a participating state, the Commission shall attempt to resolve disputes related to this Compact that arise among participating states and between participating and nonparticipating states.

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

D. Enforcement.

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

2. If compliance is not secured after all means to secure compliance have been exhausted, 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 participating state in default to enforce compliance with the provisions of this Compact and the Commission's promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party 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.

E. Legal action against the Commission.

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

2. No person other than a participating state shall enforce this Compact against the Commission.

Article 11. Date of Implementation of the PA Licensure Compact Commission.

A. This Compact shall come into effect on the date on which this Compact statute is enacted into law in the seventh participating state.

1. On or after the effective date of the Compact, the Commission shall convene and review the enactment of each of the states that enacted the Compact prior to the Commission convening ("charter participating states") to determine if the statute enacted by each such charter participating state is materially different than the model compact.

a. A charter participating state whose enactment is found to be materially different from the model compact shall be entitled to the default process set forth in subsection B of Article 10.

b. If any participating state later withdraws from the Compact or its participation is terminated, the Commission shall remain in existence and the Compact shall remain in effect even if the number of participating states should be less than seven. Participating states enacting the Compact subsequent to the Commission convening shall be subject to the process set forth in subdivision C 21 of Article 7 to determine if their enactments are materially different from the model compact and whether they qualify for participation in the Compact.

2. Participating states enacting the Compact subsequent to the seven initial charter participating states shall be subject to the process set forth in subdivision C 21 of Article 7 to determine if their enactments are materially different from the model compact and whether they qualify for participation in the Compact.

3. All actions taken for the benefit of the Commission or in furtherance of the purposes of the administration of the Compact prior to the effective date of the Compact or the Commission coming into existence shall be considered to be actions of the Commission unless specifically repudiated by the Commission.

B. Any state that joins this Compact shall be subject to the Commission's rules and bylaws as they exist on the date on which this 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 this Compact becomes law in that state.

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

1. A participating state's withdrawal shall not take effect until 180 days after enactment of the repealing statute. During this 180-day period, all compact privileges that were in effect in the withdrawing state and were granted to licensees licensed in the withdrawing state shall remain in effect. If any licensee licensed in the withdrawing state is also licensed in another participating state or obtains a license in another participating state within the 180 days, the licensee's compact privileges in other participating states shall not be affected by the passage of the 180 days.

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

3. Upon the enactment of a statute withdrawing a state from this Compact, the state shall immediately provide notice of such withdrawal to all licensees within that state. Such withdrawing state shall continue to recognize all licenses granted pursuant to this Compact for a minimum of 180 days after the date of such notice of withdrawal.

D. Nothing contained in this Compact shall be construed to invalidate or prevent any PA licensure agreement or other cooperative arrangement between participating states and between a participating state and nonparticipating state that does not conflict with the provisions of this Compact.

E. This Compact may be amended by the participating states. No amendment to this Compact shall become effective and binding upon any participating state until it is enacted materially in the same manner into the laws of all participating states as determined by the Commission.

Article 12. Construction and Severability.

A. This Compact and the Commission's rulemaking authority shall be liberally construed so as to effectuate the purposes and the implementation and administration of the Compact. Provisions of the Compact expressly authorizing or requiring the promulgation of rules shall not be construed to limit the Commission's rulemaking authority solely for those purposes.

B. The provisions of this Compact shall be severable and if any phrase, clause, sentence, or provision of this Compact is held by a court of competent jurisdiction to be contrary to the constitution of any participating state, a state seeking participation in the Compact, or of the United States, or the applicability thereof to any government, agency, person, or circumstance is held to be unconstitutional

by a court of competent jurisdiction, the validity of the remainder of this Compact and the applicability thereof to any other government, agency, person, or circumstance shall not be affected thereby.

C. Notwithstanding subsection B or this subsection, the Commission may deny a state's participation in the Compact or, in accordance with the requirements of subsection B of Article 10, terminate a participating state's participation in the Compact, if it determines that a constitutional requirement of a participating state is, or would be with respect to a state seeking to participate in the Compact, a material departure from the Compact. Otherwise, if this Compact shall be held to be contrary to the constitution of any participating state, the Compact shall remain in full force and effect as to the remaining participating states and in full force and effect as to the participating state affected as to all severable matters.

Article 13. Binding Effect of Compact.

A. Nothing herein prevents the enforcement of any other law of a participating state that is not inconsistent with this Compact.

B. Any laws in a participating state in conflict with this Compact are superseded to the extent of the conflict.

C. All agreements between the Commission and the participating states are binding in accordance with their terms.

2. That any applicant for a multistate license shall pay the costs of performing any background check required by the PA Licensure Compact, as entered into by this act.

VIRGINIA ACTS OF ASSEMBLY -- 2024 SESSION

CHAPTER 116

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

[S 133]

Approved March 20, 2024

Be it enacted by the General Assembly of Virginia:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

inactions of other team members.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

From: Jessica Thomas <jthomas@csg.org>
Sent: Thursday, May 9, 2024 10:19 AM
Cc: Carl Sims <csims@csg.org>
Subject: PA Compact Activation

Good morning,

The PA Compact has been enacted in at least seven states which triggers its activation. You are receiving this email because your state recently enacted the PA Compact. The states that have enacted the compact at this time include Delaware, Maine, Nebraska, Oklahoma, Virginia, Washington, West Virginia, Wisconsin, and Utah.
CSG is providing interim administrative services for the compact commission as part of a partnership between FSMB, AAPA, and NCCPA. The first order of business will be for your state to appoint a delegate to serve on the compact commission. In the coming weeks, I will send you more information about this process.
Each state appoints one delegate who will have one vote on the commission. If your state has two boards that regulate and license PAs, your state still only has one vote. You will receive more information about this specific scenario in the coming weeks as well.
As stated in Section 7(B) of the PA Compact legislation, these representatives shall be empowered to act on behalf of the compact state and shall be limited to:

1. A current PA, physician or public member of a Licensing Board or PA Council/Committee (only if that council or committee has actual regulatory authority over PAs); or
2. An administrator of a Licensing Board.

If you are not the correct contact for this, please let me know who to contact in your state
CSG is available to answer questions should they arise. Please feel free to respond to this email with any questions or check out https://www.pacompact.org/ for resources and FAQS.

Jessica Thomas
Senior Policy Analyst | The Center of Innovation
The Council of State Governments
1776 Avenue of the States, Lexington, KY 40511

Center of Innovation
THE COUNCIL OF STATE GOVERNMENTS

Agenda Item: License Reinstatement Process for Physician Assistants

Staff Note: There has been no application fee nor reinstatement of licensure process established when a physician assistant license has expired fortwo (2) years or more. Currently, the only provision in the advisory board regulations that addresses a lapsed license is found under renewal of license in 18VAC85-50-56. (B.) which requires a licensee with a lapsed license to file a new, initial application with the Board and pay the initial application fee. This is confusing for most applicants whose license has expired for two years or more ,trying to reactivate/reinstate their license as the system would not allow them to submit another initial application online. They would need to take the extra step of writing or calling to the office to request a paper application and mailing the completed application back to the office with the fee, prior to their submitted application being able to be correctly processed for reinstatement of licensure. This also places an extra administrative burden on board staff whereby, for each physician assistant application submitted, staff is placed in the position of first deciphering whether the application and fee submitted is to be processed as an initial application or reinstatement, as the same application and fee applies to both category of applicants. Most other allied professions at the Board of Medicine have a separate reinstatement process established in regulations that quickly allows staff to correctly identify which applicant with an expired license needs to be processed for renewal or reinstatement of licensure. This needs to be corrected, so that Physician Assistants with an expired license do not have to file another initial application, if their license requires reinstatement.

Action: To vote approval of a license reinstatement process and requirements in regulations for physician assistants.

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF PHYSICIAN ASSISTANTS

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-50-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Revised Date: November 9, 2022

9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

(804) 367-4600 (TEL)
(804) 527-4426 (FAX)
email: medbd@dhp.virginia.gov

TABLE OF CONTENTS

Part I. General Provisions.

18VAC85-50-10. Definitions.

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

"Board."

"Collaboration."

"Consultation."

"Patient care team physician."

"Patient care team podiatrist."

"Physician assistant."

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

"Group practice" means the practice of a group of two or more doctors of medicine, osteopathy, or podiatry licensed by the board who practice as a partnership or professional corporation.

"Institution" means a hospital, nursing home or other health care facility, community health center, public health center, industrial medicine or corporation clinic, a medical service facility, student health center, or other setting approved by the board.

"NCCPA" means the National Commission on Certification of Physician Assistants.

"Practice agreement" means a written or electronic agreement developed by one or more patient care team physicians or podiatrists and the physician assistant that defines the relationship between the physician assistant and the physicians or podiatrists, the prescriptive authority of the physician assistant, and the circumstances under which a physician or podiatrist will see and evaluate the patient.

18VAC85-50-20. (Repealed.)

18VAC85-50-21. Current name and address.

Each licensee shall furnish the board his current name and address of record. All notices required by law or by this chapter to be given by the board to any such licensee shall be validly given when sent to the latest address of record provided or served to the licensee. Any change of name or address of record or the public address, if different from the address of record, shall be furnished to the board within 30 days of such change.

18VAC85-50-30. Public participation guidelines.

A separate board regulation, 18VAC85-11, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.

18VAC85-50-35. Fees.

Unless otherwise provided, the following fees shall not be refundable:

1. The initial application fee for a license, payable at the time application is filed, shall be $130.

2. The biennial fee for renewal of an active license shall be $135 and for renewal of an inactive license shall be $70, payable in each odd-numbered year in the birth month of the licensee. For 2021, the fee for renewal of an active license shall be $108, and the fee for renewal of an inactive license shall be $54.

3. The additional fee for late renewal of licensure within one renewal cycle shall be $50.

4. A restricted volunteer license shall expire 12 months from the date of issuance and may be renewed without charge by receipt of a renewal application that verifies that the physician assistant continues to comply with provisions of § 54.1-2951.3 of the Code of Virginia.

5. The fee for reinstatement of a license pursuant to § 54.1-2408.2 of the Code of Virginia shall be $2,000.

6. The fee for a duplicate license shall be $5.00, and the fee for a duplicate wall certificate shall be $15.

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

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

9. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $35, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $15 for each renewal cycle.

Part II. Requirements for Practice As a Physician's Assistant.

18VAC85-50-40. General requirements.

A. No person shall practice as a physician assistant in the Commonwealth of Virginia except as provided in this chapter.

B. Except as provided in § 54.1-2952 C of the Code of Virginia, all services rendered by a physician assistant shall be performed only in accordance with a practice agreement with one or more doctors of medicine, osteopathy, or podiatry licensed by this board to practice in the Commonwealth.

18VAC85-50-50. Licensure: entry requirements and application.

A. The applicant seeking licensure as a physician assistant shall submit:

1. A completed application and fee as prescribed by the board.

2. Documentation of successful completion of an educational program as prescribed in § 54.1-2951.1 of the Code of Virginia.

3. Documentation of passage of the certifying examination administered by the National Commission on Certification of Physician Assistants.

4. If licensed or certified in any other jurisdiction, verification that there has been no disciplinary action taken or pending in that jurisdiction.

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

18VAC85-50-55. Provisional licensure.

Pending the outcome of the next examination administered by the NCCPA, an applicant who has met all other requirements of 18VAC85-50-50 at the time his initial application is submitted may be granted provisional licensure by the board. The provisional licensure shall be valid until the applicant takes the next subsequent NCCPA examination and its results are reported, but this period of validity shall not exceed 30 days following the reporting of the examination scores, after which the provisional license shall be invalid.

18VAC85-50-56. Renewal of license.

A. Every licensed physician assistant intending to continue to practice shall biennially renew the license in each odd numbered year in the licensee's birth month by:

1. Returning the renewal form and fee as prescribed by the board; and

2. Verifying compliance with continuing medical education standards established by the NCCPA.

B. Any physician assistant who allows his NCCPA certification to lapse shall be considered not licensed by the board. Any such assistant who proposes to resume his practice shall make a new application for licensure.

18VAC85-50-57. Discontinuation of employment.

If for any reason the physician assistant discontinues working with a patient care team physician or podiatrist, a new practice agreement shall be entered into in order for the physician assistant either to be reemployed by the same practitioner or to accept new employment with another patient care team physician or podiatrist.

18VAC85-50-58. Inactive licensure.

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

1. The holder of an inactive license shall not be required to maintain certification by the NCCPA.

2. An inactive licensee shall not be entitled to practice as a physician assistant in Virginia.

B. An inactive licensee may reactivate his license upon submission of:

1. The required application;

2. Payment of the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure for the biennium in which the license is being reactivated; and

3. Documentation of having maintained certification or having been recertified by the NCCPA.

C. The board reserves the right to deny a request for reactivation to any licensee who has been determined to have committed an act in violation of § 54.1-2915 of the Code of Virginia or any provisions of this chapter.

18VAC85-50-59. Registration for voluntary practice by out-of-state licensees.

Any physician assistant who does not hold a license to practice in Virginia and who seeks registration to practice under subdivision 27 of § 54.1-2901 of the Code of Virginia on a voluntary basis under the auspices of a publicly supported, all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people shall:

1. File a complete application for registration on a form provided by the board at least five business days prior to engaging in such practice. An incomplete application will not be considered;

2. Provide a complete record of professional licensure in each state in which he has held a license and a copy of any current license;

3. Provide the name of the nonprofit organization, the dates and location of the voluntary provision of services;

4. Pay a registration fee of $10; and

5. Provide a notarized statement from a representative of the nonprofit organization attesting to its compliance with provisions of subdivision 27 of § 54.1-2901 of the Code of Virginia.

18VAC85-50-60. (Repealed.)

18VAC85-50-61. Restricted volunteer license.

A. A physician assistant who held an unrestricted license issued by the Virginia Board of Medicine or by a board in another state as a licensee in good standing at the time the license expired or

became inactive may be issued a restricted volunteer license to practice without compensation in a clinic that is organized in whole or in part for the delivery of health care services without charge in accordance with § 54.1-106 of the Code of Virginia.

B. To be issued a restricted volunteer license, a physician assistant shall submit an application to the board that documents compliance with requirements of § 54.1-2928.1 of the Code of Virginia and the application fee prescribed in 18VAC85-50-35.

C. The licensee who intends to continue practicing with a restricted volunteer license shall renew biennially during his birth month, meet the continued competency requirements prescribed in subsection D of this section, and pay to the board the renewal fee prescribed in 18VAC85-50-35.

D. The holder of a restricted volunteer license shall not be required to attest to hours of continuing education for the first renewal of such a license. For each renewal thereafter, the licensee shall attest to obtaining 50 hours of continuing education during the biennial renewal period with at least 25 hours in Type 1 and no more than 25 hours in Type 2 as acceptable to the NCCPA.

Part III. Examination [Repealed]

18VAC85-50-70. (Repealed.)

Part IV. Practice Requirements

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

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

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

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

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

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

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

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

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

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

18VAC85-50-110. Responsibilities of the patient care team physician or podiatrist.

A patient care team physician or podiatrist shall:

1. Review the clinical course and treatment plan for any patient who presents for the same acute complaint twice in a single episode of care and has failed to improve as expected. A physician or podiatrist shall be involved with any patient with a continuing illness as noted in the written or electronic practice agreement for the evaluation process.

2. Be available at all times to collaborate and consult with the physician assistant.

18VAC85-50-115. Responsibilities of the physician assistant.

A. The physician assistant shall not render independent health care and shall:

1. Perform only those medical care services that are within the scope of the practice and proficiency of the patient care team physicians or podiatrists as prescribed in the physician assistant's practice agreement. When a physician assistant is working outside the scope of specialty of the patient care team physicians or podiatrists, then the physician assistant's functions shall be limited to those areas not requiring specialized clinical judgment, unless a separate practice agreement has been executed for an alternate patient care team physician or podiatrist.

2. Prescribe only those drugs and devices as allowed in Part V (18VAC85-50-130 et seq.) of this chapter.

3. Wear during the course of performing his duties identification showing clearly that he is a physician assistant.

B. If, due to illness, vacation, or unexpected absence, a patient care team physician or podiatrist or alternate physician or podiatrist is unable to supervise the activities of his physician assistant, such patient care team physician or podiatrist may temporarily delegate the responsibility to another doctor of medicine, osteopathic medicine, or podiatry.

Temporary coverage may not exceed four weeks unless special permission is granted by the board.

C. With respect to physician assistants employed by institutions, the following additional regulations shall apply:

1. No physician assistant may render care to a patient unless the physician or podiatrist responsible for that patient is available for collaboration and consultation with that physician assistant.

2. Any such practice agreement as described in subdivision 1 of this subsection shall delineate the duties which said patient care team physician or podiatrist authorizes the physician assistant to perform.

D. Practice by a physician assistant in a hospital, including an emergency department, shall be in accordance with § 54.1-2952 of the Code of Virginia.

18VAC85-50-116. Volunteer restricted license for certain physician assistants.

The issuance of a volunteer restricted license and the practice of a physician assistant under such a license shall be in accordance with the provisions of § 54.1-2951.3 of the Code of Virginia.

18VAC85-50-117. Authorization to use fluoroscopy.

A physician assistant working under a practice agreement with a licensed doctor of medicine or osteopathy specializing in the field of radiology or orthopedics is authorized to use fluoroscopy for guidance of diagnostic and therapeutic procedures provided such activity is specified in his protocol and he has met the following qualifications:

1. Completion of at least 40 hours of structured didactic educational instruction and at least 40 hours of supervised clinical experience as set forth in the Fluoroscopy Educational Framework for the Physician Assistant created by the American Academy of Physician Assistants (AAPA) and the American Society of Radiologic Technologists (ASRT); and

2. Successful passage of the American Registry of Radiologic Technologists (ARRT) Fluoroscopy Examination.

18VAC85-50-120. (Repealed.)

Part V. Prescriptive Authority.

18VAC85-50-130. Qualifications for approval of prescriptive authority.

An applicant for prescriptive authority shall meet the following requirements:

1. Hold a current, unrestricted license as a physician assistant in the Commonwealth;

2. Maintain a practice agreement acceptable to the board as prescribed in 18VAC85-50-101 and § 54.1-2952.1 of the Code of Virginia; and

3. Submit evidence of successful completion of a minimum of 35 hours of acceptable training to the board in pharmacology.

18VAC85-50-140. Approved drugs and devices.

A. The approved drugs and devices which the physician assistant with prescriptive authority may prescribe, administer, or dispense manufacturer's professional samples shall be in accordance with provisions of § 54.1-2952.1 of the Code of Virginia:

B. The physician assistant may prescribe only those categories of drugs and devices included in the practice agreement. The patient care team physician or podiatrist retains the authority to restrict certain drugs within these approved categories.

C. The physician assistant, pursuant to § 54.1-2952.1 of the Code of Virginia, shall only dispense manufacturer's professional samples or administer controlled substances in good faith for medical or therapeutic purposes within the course of his professional practice.

18VAC85-50-150. (Repealed.)

18VAC85-50-160. Disclosure.

A. Each prescription for a Schedule II through V drug shall bear the name of the patient care team physician or podiatrist and of the physician assistant.

B. The physician assistant shall disclose to the patient that he is a licensed physician assistant, and also the name, address and telephone number of the patient care team physician or podiatrist. Such disclosure shall either be included on the prescription or be given in writing to the patient.

18VAC85-50-170. (Repealed.)

Part VI Standards of Professional Conduct.

18VAC85-50-175. Confidentiality.

A. A practitioner shall not willfully or negligently breach the confidentiality between a practitioner and a patient. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the practitioner shall not be considered negligent or willful.

B. Unauthorized use or disclosure of confidential information received from the Prescription Monitoring Program shall be grounds for disciplinary action.

18VAC85-50-176. Treating and prescribing for self or family.

A. Treating or prescribing shall be based on a bona fide practitioner-patient relationship, and prescribing shall meet the criteria set forth in § 54.1-3303 of the Code of Virginia.

B. A practitioner shall not prescribe a controlled substance to himself or a family member, other than Schedule VI as defined in § 54.1-3455 of the Code of Virginia, unless the prescribing occurs in an emergency situation or in isolated settings where there is no other qualified practitioner available to the patient, or it is for a single episode of an acute illness through one prescribed course of medication.

C. When treating or prescribing for self or family, the practitioner shall maintain a patient record documenting compliance with statutory criteria for a bona fide practitioner-patient relationship.

18VAC85-50-177. Patient records.

A. Practitioners shall comply with the provisions of § 32.1-127.1:03 of the Code of Virginia related to the confidentiality and disclosure of patient records.

B. Practitioners shall properly manage patient records and shall maintain timely, accurate, legible and complete records.

C. Practitioners shall provide patient records to another practitioner or to the patient or his personal representative in a timely manner and in accordance with provisions of § 32.1-127.1:03 of the Code of Virginia.

18VAC85-50-178. Practitioner-patient communication.

A. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately inform a patient or his legally authorized representative of his medical diagnoses, prognosis and prescribed treatments or plans of care. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure prescribed or directed by the practitioner in the treatment of any disease or condition.

B. A practitioner shall present information relating to the patient's care to a patient or his legally authorized representative in understandable terms and encourage participation in the decisions regarding the patient's care and shall refer to or consult with other health care professionals if so indicated.

C. Before surgery or any invasive procedure is performed, informed consent shall be obtained from the patient in accordance with the policies of the health care entity. Practitioners shall inform

patients of the risks, benefits, and alternatives of the recommended surgery or invasive procedure that a reasonably prudent practitioner in similar practice in Virginia would tell a patient.

1. In the instance of a minor or a patient who is incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent shall be informed and the consent documented.

2. An exception to the requirement for consent prior to performance of surgery or an invasive procedure may be made in an emergency situation when a delay in obtaining consent would likely result in imminent harm to the patient.

3. For the purposes of this provision, "invasive procedure" means any diagnostic or therapeutic procedure performed on a patient that is not part of routine, general care and for which the usual practice within the health care entity is to document specific informed consent from the patient or surrogate decision maker prior to proceeding.

18VAC85-50-179. Practitioner responsibility.

A. A practitioner shall not:

1. Perform procedures or techniques that are outside the scope of his practice or for which he is not trained and individually competent;

2. Knowingly allow subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility. Practitioners shall delegate patient care only to subordinates who are properly trained and supervised;

3. Engage in an egregious pattern of disruptive behavior or interaction in a health care setting that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient; or

4. Exploit the practitioner/patient relationship for personal gain.

B. Advocating for patient safety or improvement in patient care within a health care entity shall not constitute disruptive behavior provided the practitioner does not engage in behavior prohibited in subdivision A 3 of this section.

18VAC85-50-180. Vitamins, minerals and food supplements.

A. The recommendation or direction for the use of vitamins, minerals or food supplements and the rationale for that recommendation shall be documented by the practitioner. The recommendation or direction shall be based upon a reasonable expectation that such use will result in a favorable patient outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use.

B. Vitamins, minerals, or food supplements, or a combination of the three, shall not be sold, dispensed, recommended, prescribed, or suggested in doses that would be contraindicated based on the individual patient's overall medical condition and medications.

C. The practitioner shall conform to the standards of his particular branch of the healing arts in the therapeutic application of vitamins, minerals or food supplement therapy.

18VAC85-50-181. Pharmacotherapy for weight loss.

A. A practitioner shall not prescribe amphetamine, Schedule II, for the purpose of weight reduction or control.

B. A practitioner shall not prescribe controlled substances, Schedules III through VI, for the purpose of weight reduction or control in the treatment of obesity, unless the following conditions are met:

1. An appropriate history and physical examination are performed and recorded at the time of initiation of pharmacotherapy for obesity by the prescribing physician, and the physician reviews the results of laboratory work, as indicated, including testing for thyroid function;

2. If the drug to be prescribed could adversely affect cardiac function, the physician shall review the results of an electrocardiogram performed and interpreted within 90 days of initial prescribing for treatment of obesity;

3. A diet and exercise program for weight loss is prescribed and recorded;

4. The patient is seen within the first 30 days following initiation of pharmacotherapy for weight loss, by the prescribing physician or a licensed practitioner with prescriptive authority working under the supervision of the prescribing physician, at which time a recording shall be made of blood pressure, pulse, and any other tests as may be necessary for monitoring potential adverse effects of drug therapy; and

5. The treating physician shall direct the follow-up care, including the intervals for patient visits and the continuation of or any subsequent changes in pharmacotherapy. Continuation of prescribing for treatment of obesity shall occur only if the patient has continued progress toward achieving or maintaining a target weight and has no significant adverse effects from the prescribed program.

C. If specifically authorized in his practice agreement with a patient care team physician, a physician assistant may perform the physical examination, review tests, and prescribe Schedules III through VI controlled substances for treatment of obesity as specified in subsection B of this section.

18VAC85-50-182. Anabolic steroids.

A physician assistant shall not prescribe or administer anabolic steroids to any patient for other than accepted therapeutic purposes.

18VAC85-50-183. Sexual contact.

A. For purposes of § 54.1-2915 A 12 and A 19 of the Code of Virginia and this section, sexual contact includes, but is not limited to, sexual behavior or verbal or physical behavior that:

1. May reasonably be interpreted as intended for the sexual arousal or gratification of the practitioner, the patient, or both; or

2. May reasonably be interpreted as romantic involvement with a patient regardless of whether such involvement occurs in the professional setting or outside of it.

B. Sexual contact with a patient.

1. The determination of when a person is a patient for purposes of § 54.1-2915 A 19 of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the patient-practitioner relationship is terminated.

2. The consent to, initiation of, or participation in sexual behavior or involvement with a practitioner by a patient does not change the nature of the conduct nor negate the statutory prohibition.

C. Sexual contact between a practitioner and a former patient after termination of the practitioner-patient relationship may still constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge, or influence of emotions derived from the professional relationship.

D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care. For purposes of this section, key third party of a patient means spouse or partner, parent or child, guardian, or legal representative of the patient.

E. Sexual contact between a supervisor and a trainee shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on patient care.

18VAC85-50-184. Refusal to provide information.

A practitioner shall not willfully refuse to provide information or records as requested or required by the board or its representative pursuant to an investigation or to the enforcement of a statute or regulation.

18VAC85-50-191. Practice and supervision of laser hair removal.

A. A physician assistant, as authorized pursuant to § 54.1-2952 of the Code of Virginia, may perform or supervise the performance of laser hair removal upon completion of training in the following:

1. Skin physiology and histology;

2. Skin type and appropriate patient selection;

3. Laser safety;

4. Operation of laser device to be used;

5. Recognition of potential complications and response to any actual complication resulting from a laser hair removal treatment; and

6. A minimum number of 10 proctored patient cases with demonstrated competency in treating various skin types.

B. Physician assistants who have been performing laser hair removal prior to August 7, 2019, are not required to complete training specified in subsection A of this section.

C. A physician assistant who delegates the practice of laser hair removal and provides supervision for such practice shall ensure the supervised person has completed the training required in subsection A of this section.

D. A physician assistant who performs laser hair removal or who supervises others in the practice shall receive ongoing training as necessary to maintain competency in new techniques and laser devices. The physician assistant shall ensure that persons the physician assistant supervises also receive ongoing training to maintain competency.

E. A physician assistant may delegate laser hair removal to a properly trained person under the physician assistant's direction and supervision. Direction and supervision shall mean that the physician assistant is readily available at the time laser hair removal is being performed. The supervising physician assistant is not required to be physically present but is required to see and evaluate a patient for whom the treatment has resulted in complications prior to the continuance of laser hair removal treatment.

F. Prescribing of medication shall be in accordance with § 54.1-3303 of the Code of Virginia.

DOCUMENTS INCORPORATED BY REFERENCE

Fluoroscopy Educational Framework for the Physician Assistant, December 2009, American Academy of Physician Assistants, 950 North Washington Street, Alexandria, VA 22314 and the American Society of Radiologic Technologists, 15000 Central Avenue, SE, Albuquerque, NM 87123

Orientation to the Board of Medicine & Your Advisory Board

June 2024

Executive Branch

- Governor Glenn Youngkin
- Secretary of Health and Human Resources – John Littel
- DHP Director – Arne Owens
- Board of Medicine President – Randy Clements, DPM
- Board members cannot speak for the Board or anyone in the Executive Branch.

Department of Health Professions

- Umbrella Agency for 13 Health Regulatory Boards
- Director Owens and Deputy Director Jenkins appointed by the Governor
- Administration, Communications, Finance, Enforcement, Administrative Proceedings, Prescription Monitoring, Health Practitioners' Monitoring, Healthcare Workforce Data Center, IT
- Medicine joined the Department in 1977

Today's Board of Medicine

18 members appointed by the Governor

1 MD from each Congressional District

1 DO

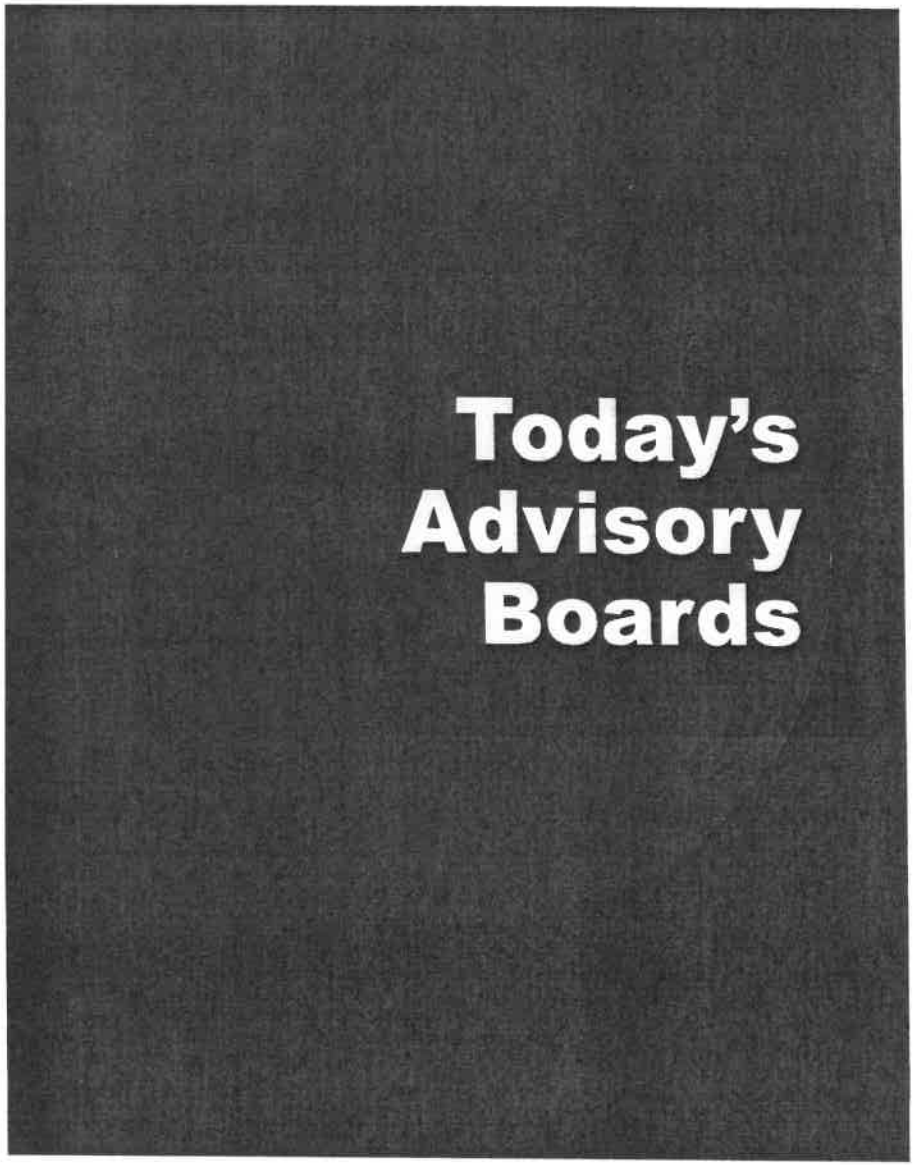
1 DPM

1 DC

4 citizen members

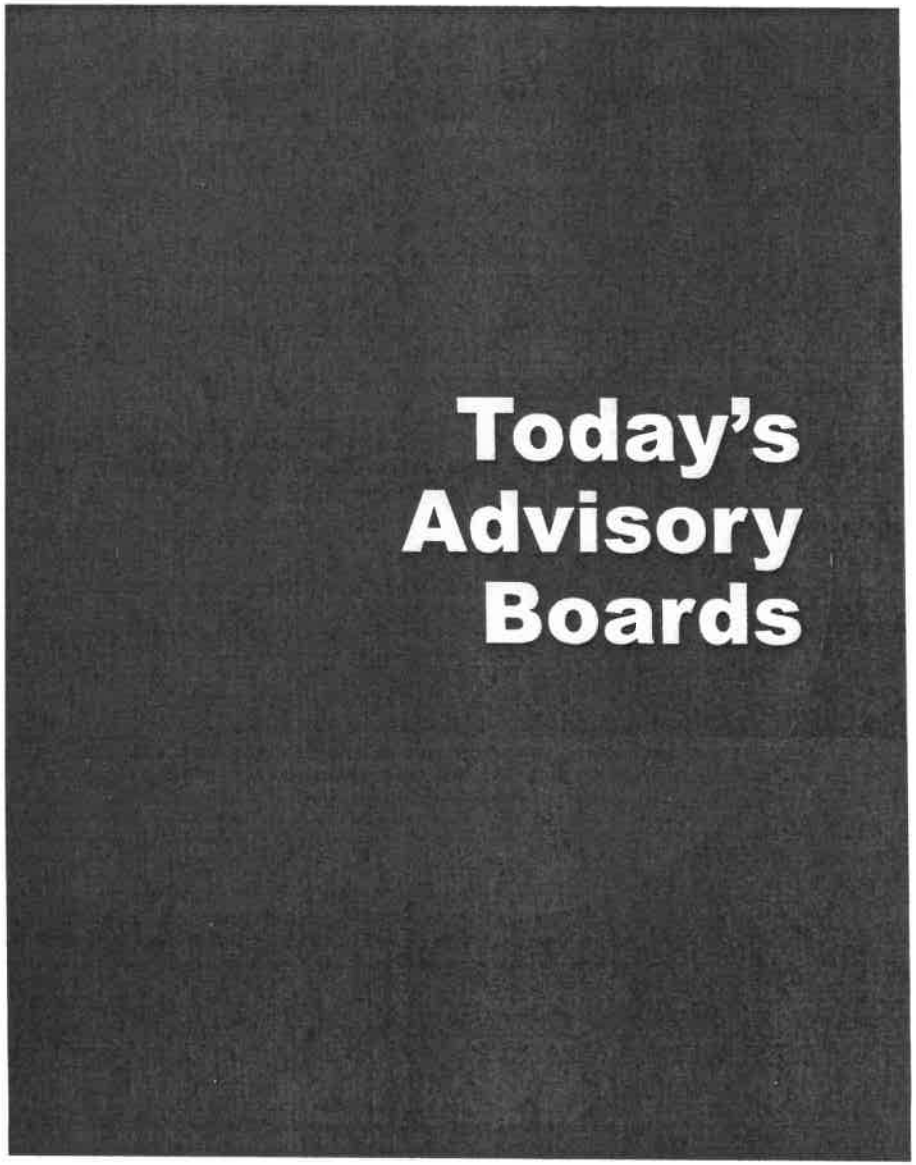
Today's Board

- Pure Board of Medicine
- Composite Board
- Doctors of Medicine, Osteopathy, Podiatry & Chiropractic
- Physician Assistants, Acupuncturists, Athletic Trainers, Licensed Midwives, Licensed Certified Midwives, Occupational Therapists, Occupational Therapy Assistants, Radiologic Technologists, Radiologic Technologists-Limited, Radiologist Assistants, Respiratory Therapists, Polysomnographic Technologists, Behavior Analysts, Assistant Behavior Analysts, Genetic Counselors, Licensed Surgical Assistants, Certified Surgical Technologists & Advanced Practice Registered Nurses



Today's Advisory Boards

- 11 Advisory Boards
- Similar structure & function
- 5 members
    - 3 of the profession
    - 1 physician
    - 1 citizen member



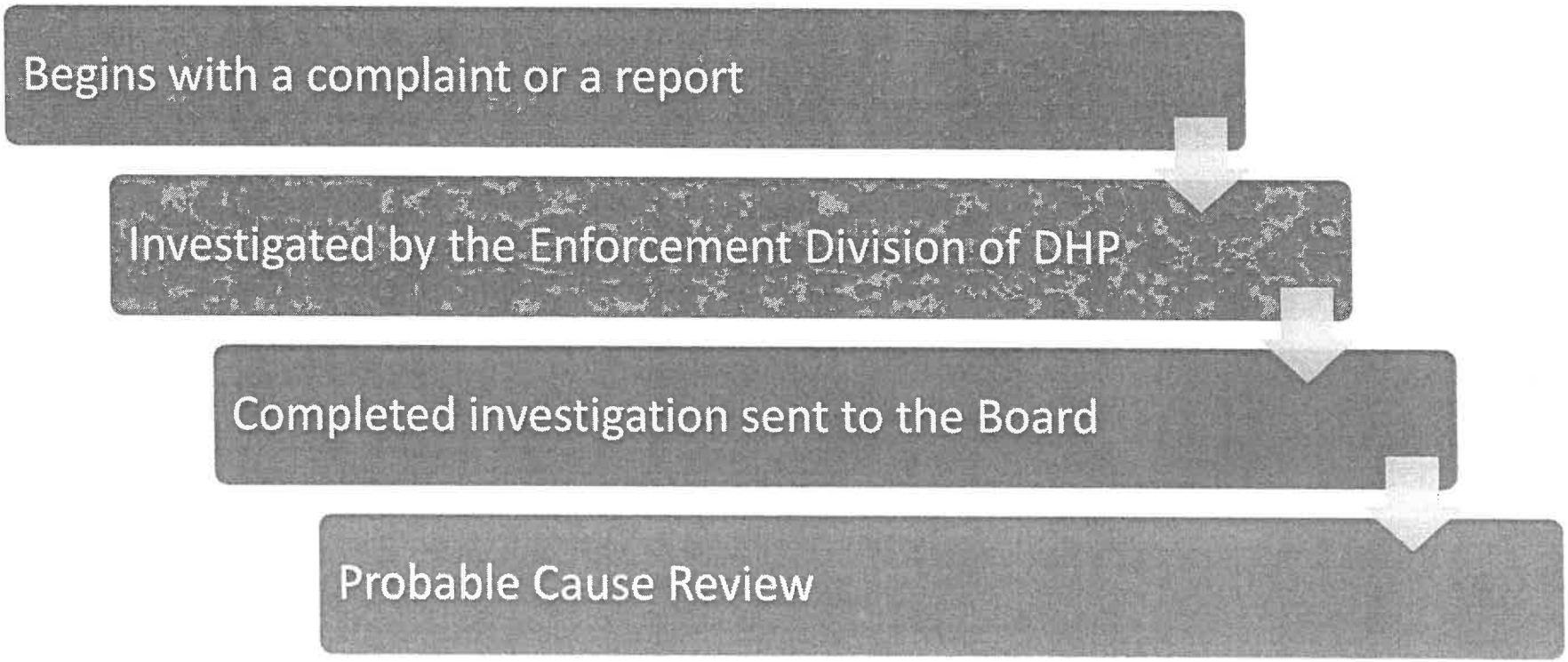
Today's Advisory Boards (cont.)

- Chair & Vice-Chair
- Meets at least once a year
- May attend 1 meeting a year virtually for good cause
- Advise the Board of Medicine on:
    - Licensing
    - Discipline
    - Regulations

THE BOARD'S MISSION

- The protection of the public
- License only qualified applicants
- Discipline for unprofessional conduct
- Promulgate regulations to implement law

THE BOARD'S DISCIPLINARY PROCESS



PROBABLE CAUSE REVIEW

- Board staff and Board members
- Review to understand what happened in the case
- Apply the law and the regulations to determine if a violation has occurred
- Two Board members must agree on standard of care
- If specialized review is required, retain an expert reviewer for the standard of care

OPTIONS FOR RESOLVING THE MATTER

- 85% are closed administratively
- Other options
  - Advisory letters
  - Confidential Consent Agreements
  - Pre-Hearing Consent Orders
  - Informal Conferences
  - Formal Hearings
  - Summary Suspensions

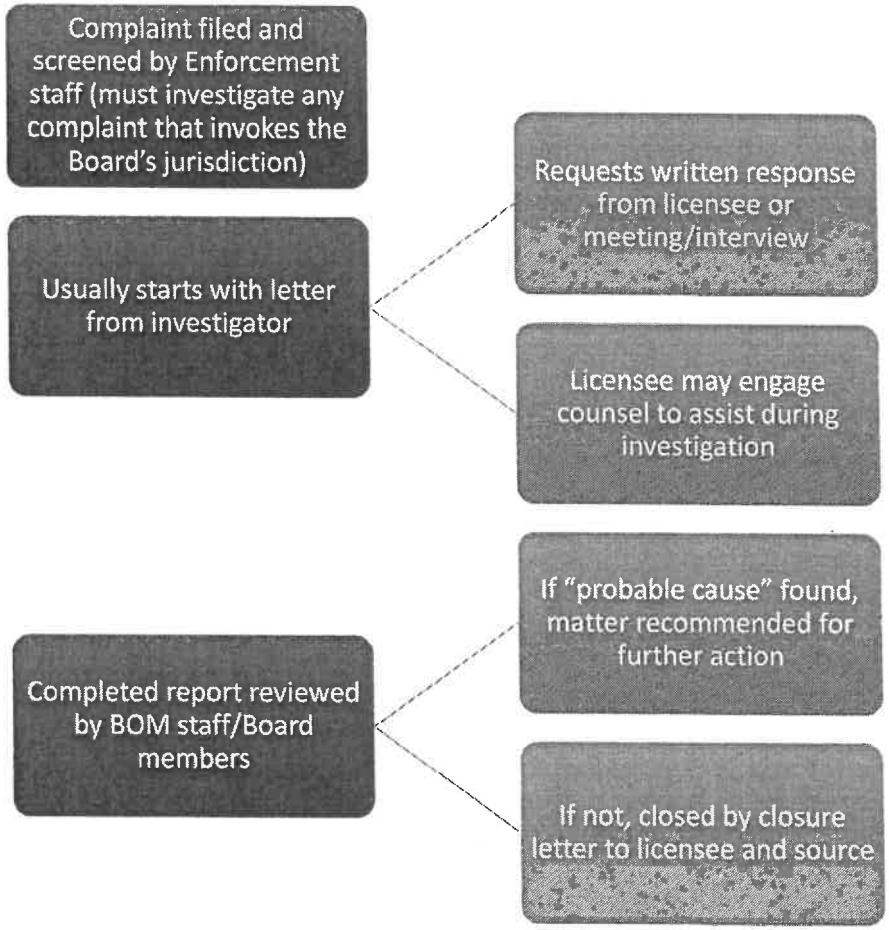
PRINCIPLES OF THE DISCIPLINARY PROCESS

- Confidentiality
- Protection of the public
- Due process
- Proportionate sanctions
- Strive to be fair to all parties

INVESTIGATIONS

- **Who Complains?**
  - The Public (e.g., patients, family members, anonymous, media)
  - Other licensees of the BOM (mandated reporters)
  - Employers
  - Healthcare institutions (e.g., hospital CEO = mandated reporter)
  - Medical malpractice insurance carriers

COMPLAINT PROCESS



ADVICE FOR RESPONDING TO COMPLAINTS

- Take the complaint seriously (even if you believe it to be frivolous)
- Fully cooperate w/the investigator (DHP/BOM is "health oversight agency" under HIPAA)
- You are responsible for ensuring a response and complete records are provided (not your office manager)
- Do NOT contact Board members to discuss your complaint
- Consult with an attorney (familiar with DHP/regulatory boards)

LAWS AND REGULATIONS TO KNOW

- Fraud or Dishonesty
- Substance abuse
- Negligence in practice – standard of care
- Mental or Physical Incapacity
- Aiding and Abetting Unlicensed Practice
- Ethical lapses – standards of professional conduct

LAWS AND REGULATIONS TO KNOW

- Felony convictions or misdemeanors of moral turpitude
- Any provision of the drug law
- Failure to timely sign a death certificate
- Opioid prescriptions submitted electronically
- Surprise billing
- Treating self and family
- Patient records

LAWS AND REGULATIONS TO KNOW

- Confidentiality
- Communication/Termination
- Subordinates and Disruptive Behavior
- Sexual Boundary Violations
- Reporting requirements
- Continuing Medical Education

LAWS AND REGULATIONS TO KNOW

- Office-Based Anesthesia
- Mixing, Diluting or Reconstituting
- Prescription Monitoring Program
- Health Practitioners' Monitoring Program
- Renew License every 2 years

Hearing Protocol

Virginia Board of Medicine

June 14, 2018

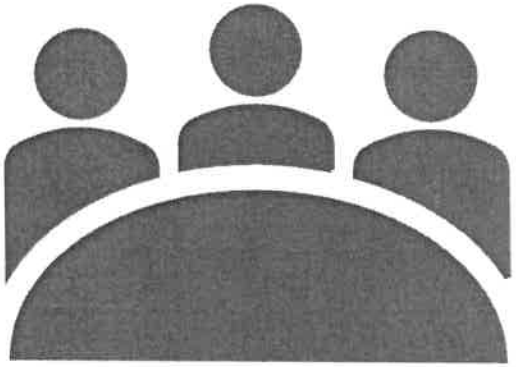
Panel Members at Hearings

- Purpose of disciplinary proceedings is to protect the public by regulating professional conduct and provide fair and impartial consideration of the matter before the Board
- Panel members should avoid actual conflicts and the appearance of impropriety—if you receive case material and think you have a conflict, call staff! (procedure for potential conflict at hearing)
- Strive to be fair and impartial—goal is fairness to *respondent* and *also to the public*

June 2018

Open vs. Closed Sessions

- Board business takes place in open, public forums to foster public accessibility and confidence of the public in the integrity of the regulatory process
- Any meeting of three or more members of the Board at which the members discuss *anything* related to the Board should be considered an open meeting for FOIA purposes (includes group emails).
- Closed meetings: for the Board to deliberate or receive legal advice
- Disciplinary proceedings may also close to deliberate and to protect health information of a respondent



June 2018

Formal Hearings – You are on the record!

A court reporter attends formal hearings

Your words are recorded

The transcript will be reviewed by the Circuit Court if the respondent appeals for evidence of violations of a respondent's constitutional rights, failure of the Board to observe required procedure, indications that the Board may not have had substantial evidence (Erin ex.)

June 2018

Hearings (IFC or formal)

- Cannot deviate earlier from noticed start time
- Choose your questions carefully (avoid answering questions from R)
- Hearings can be emotional; avoid engaging on emotional level (try not to be swayed by tears or manipulative behavior)
- Avoid texting board members (e.g., Loudoun meeting; FOIA Council)
- Do not state you have more knowledge than others-- or less-- based on specialty or non-MD status. All board members are experts in the matters before the board. This has been clearly stated by CAV.
- Do not give practice advice—do not want to bind the Board (especially if you are wrong)

June 2018

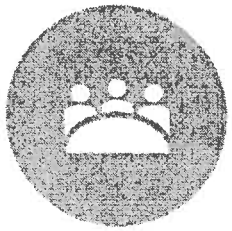
Hearings (IFC or formal)

- Questions should relate to facts of the case and the allegations contained in the Statement of Particulars
- Do not sermonize, do not inject personal, religious, or political beliefs
- Do not express your personal opinion (i.e.," Well, I think your record-keeping was fine.")
- Do not argue with other panel members during hearings, or make statements disparaging other members' statements or questions
- Do not argue with witnesses, respondents, or counsel for respondents – we understand it can be hard with some!

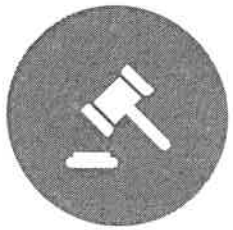
Hearings (IFC or formal)

PANEL CHAIR WILL RULE ON ISSUES RELATED TO RELEVANCE OR THE ADMISSION OF EVIDENCE (WITH BOARD COUNSEL GUIDANCE)

AVOID "ATTORNEY TESTIMONY", THIS IS YOUR OPPORTUNITY TO HEAR FROM THE LICENSEE



DELIBERATION HAPPENS IN CLOSED SESSION



DO NOT ENGAGE, INFORM, INSTRUCT ONCE PROCEEDINGS ARE OVER (STAFF WILL HANDLE; E.G. FRIENDLY ATTORNEY AND PATIENT FAMILY IN AUDIENCE)

June 2018

Procedural mysteries

Board counsel records and enters evidence

Evidence must be formally admitted even though Board members received evidence prior to hearing

Must initial and date evidence to provide record on appeal.

Procedural mysteries, cont.

- Some cases appear old when they reach the formal hearing stage
- Can be for any number of reasons (continuances prior to IFC or formal, length of investigation, etc.)
- Staff and counsel will answer procedural questions in closed session – NOT open session!

What happens in closed session?

Decision on sanction

Craft order, including findings of fact (refer to helpful notes you made during proceeding)

Review conclusions of law alleged; determine what stays

- (1) Violation of a Constitutional right, power, or privilege;
- (2) Failure to comply with statutory authority;
- (3) Failure to observe required procedure where the failure did not result in harmless error; and
- (4) Substantial evidence did not support Board decision.

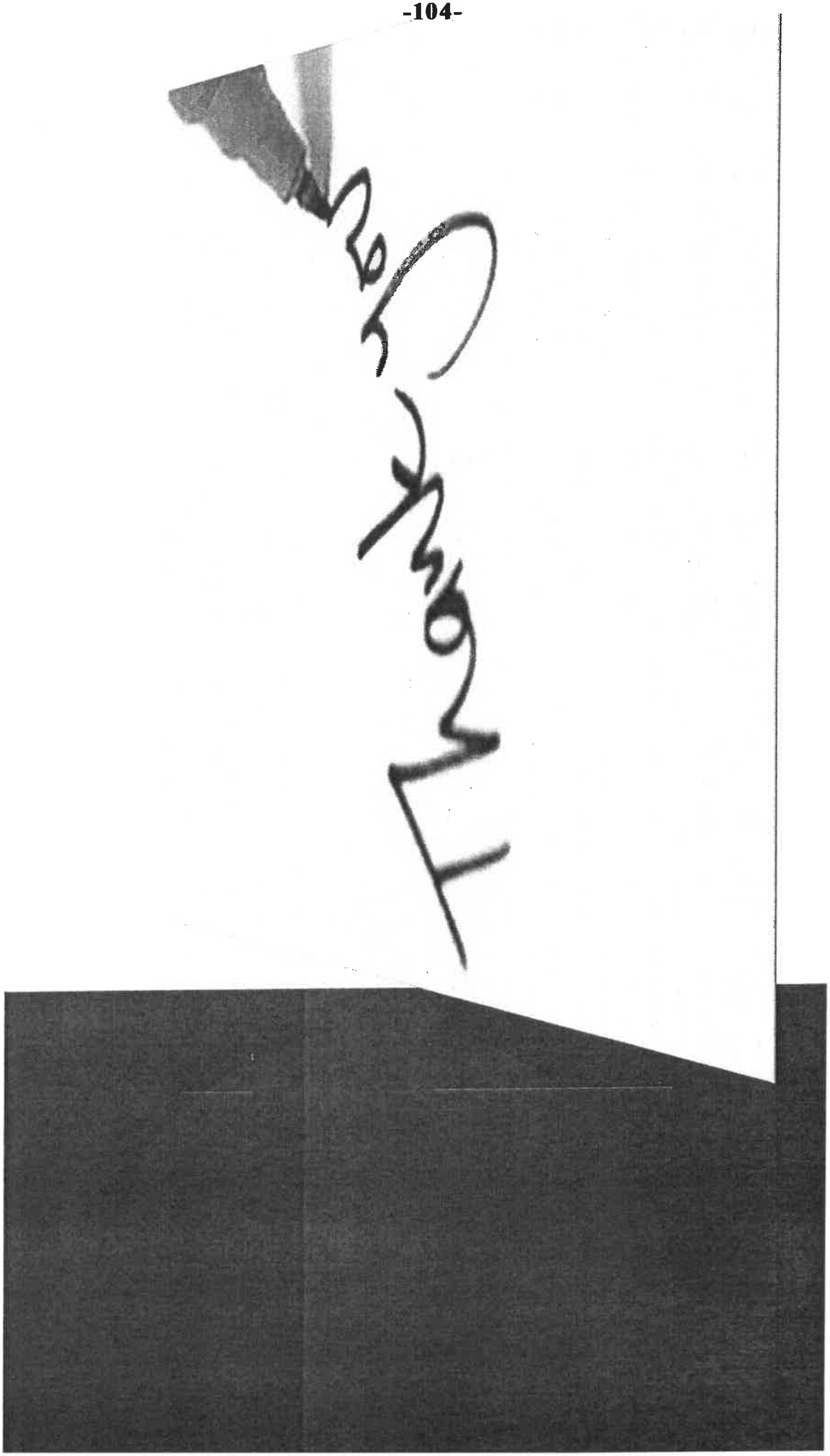
(Va. Code § 2.2-4027.)

June 2018

Helping to ensure that the Board's decisions do not get overturned

- Follow staff guidelines, procedures, and scripts for hearings.
- Ask legal questions in *closed session*. Do not state specific legal questions for board counsel on the record. This raises privilege issues.
- Only the chair of a panel may rule on motions made at a hearing.
- Avoid stating opinions on the record (i.e., "That does not sound like a standard of care issue to me.")
- Work with your fellow panel members, board counsel, and staff to craft well thought out orders.
- Be aware that any respondent can appeal.

June 2018


Thank you

2024 Board Meeting Dates

Advisory Board on:

Behavioral Analysts			**10:00 a.m.**
February 5	June 3	October 7	
Genetic Counseling			**1:00 p.m.**
February 5	June 3	October 7	
Occupational Therapy			**10:00 a.m.**
February 6	June 4	October 8	
Respiratory Care			**1:00 p.m.**
February 6	June 4	October 8	
Acupuncture			**10:00 a.m.**
February 7	June 5	October 9	
Radiological Technology			**1:00 p.m.**
February 7	June 5	October 9	
Athletic Training			**10:00 a.m.**
February 8	June 6	October 10	
Physician Assistants			**1:00 p.m.**
February 8	June 6	October 10	
Midwifery			**10:00 a.m.**
February 9	June 7	October 11	
Polysomnographic Technology			**1:00 p.m.**
February 9	June 7	October 11	
Surgical Assisting			
February 12	June 10	October 15	