VIRGINIA BOARD OF NURSING
Final Agenda

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

Tuesday, January 30, 2018

9:00 A.M. - Business Meeting of the Board of Nursing – Quorum of the Board - Conference Center Suite 201 – Board room 2

Call to Order: Joyce A. Hahn, PhD. RN, NEA-BC, FNAP; President

Establishment of a Quorum.

Announcements:

- Kendra Lancaster accepted the full- time Licensing Receptionist position and started on December 10, 2017
- Francine Battle, accepted the P-14 position of CNA/RMA/LMT discipline and started on January 8, 2018

Upcoming Meetings:

- eNLC Commission Executive Committee Meeting is scheduled for March 4, 2018 in Chicago – Ms. Douglas will attend.
- NCSBN Midyear Meeting is scheduled for March 5-7, 2018 in Chicago – Ms. Hershkowitz, Dr. McQueen-Gibson, Ms. Douglas and Dr. Hills will attend

Dialogue with DHP Director – Dr. Brown

Review of the Agenda: (Except where times are stated, items not completed on January 30, 2018 will be completed on January 31, 2018.)

1. Additions, Modifications
2. Adoption of a Consent Agenda

Disposition of Minutes:

C November 13, 2017 Panel – Ms. Hershkowitz *
C November 14, 2017 Quorum – Ms. Hershkowitz *
C November 15, 2017 Panel – Ms. Gerardo*
C November 16, 2017 Panel – Ms. Gerardo *
C November 16, 2017 Telephone Conference Call*
C January 17, 2018 Telephone Conference Call**

Reports:

C Agency Subordinate Tracking Log*
C Finance Report*
C Board of Nursing Monthly Tracking Log*
C Health Practitioners Monitoring Program Report*

- Annual Executive Director Report – Ms. Douglas
  - BON January 1 – December 31, 2017 Licensure & Discipline Statistics
  - BON January 1 – December 31, 2017 Criminal Background Checks Report
  - eNLC Implementation Progress Report
- Massage Therapy Advisory Board November 7, 2017 Meeting Minutes – Ms. Krohn*
- Massage Therapy Advisory Board Recommendation – Ms. Krohn*
  1. Current and Revised version of the ***Guidance Document 90-38*** *– Disposition of Disciplinary Cases against Nurses Practicing on Expired Licenses**

2. Current and Revised version of the ***Guidance Document 90-61*** *– Disposition of Disciplinary Cases against Certified Nurse Aides and Registered Medication Aides Practicing on Expired Certificates or Registrations**

- Nominating Committee November 14, 2017 Meeting Minutes – Ms. Douglas*
- 2016 CORE Discipline Report Summary – Ms. Minton*
- eNLC Legal Forum January 4, 2018 Meeting report – Ms. Douglas/Ms. Willinger
  - Written report from Ms. Willinger**
- Enhanced version of the Nurse Licensure Compact effective January 19, 2018 – Ms. Douglas*
  - Map of the eNLC States in effect January 19, 2018
- Nurse Aide Curriculum Committee November 14, 2017 Meeting Minutes –Dr. Saxby**
- The Committee of the Joint Boards of Nursing and Medicine December 6, 2017 Informal Conference minutes – Ms. Hershkowitz*

Other Matters:

- Board Counsel Update – Charis Mitchell (oral report)
- Simulation Guidance Document 90-24 Discussion – Dr. Hahn and Ms. Mitchell**
- Appointments of Board Members to Committees – Dr. Hahn
- DHP Performance Measure Report Q2 FY2018 (No Continuances) – Ms. Douglas**
- Presentation of Dr. Hahn's Research Project "*Perceptions and Experience of National Regulatory Nurse Leaders in advancing the APRN Compact Policy Agenda*"
- Election of Officers – Dr. Hahn
  - Memo from the BON Nominating Committee regarding Final Slate*
  - BON By Laws, Guidance Document 90-57**

Education:

- Education Informal Conference Committee January 17, 2018 Minutes and Recommendation – Dr. Saxby
- Member Board Feedback Draft 2019 NCLEX-RN Test Plan (**CONFIDENTIAL INFORMATION – CLOSED MEETING**) – Dr. Saxby and Ms. Ridout**
- 2018 National Nurse Aide Assessment Program (NNAAP) Exam (**CONFIDENTIAL INFORMATION – CLOSED MEETING**) – Dr. Saxby and Ms. Ridout
- Education Staff Report – Ms. Ridout (oral report)

10:00 A.M. - Public Comment

10:30 A.M. – Policy Forum - Dr. Carter, Healthcare Workforce Data Center (HWDC) Executive Director, and Yetty Shobo, PhD, HWDC Deputy Director

- Virginia's Registered Nurse Workforce: 2017*
- Virginia's Practical Nurse Workforce: 2017*

Legislation/Regulations:

- Status of Regulatory Actions – Ms. Yeatts*
- Report on 2018 General Assembly – Ms. Yeatts
- Regulations Governing the Practice of Nursing revised December 28, 2017 – Ms. Yeatts*
- Possible Regulatory Change to 18VAC19-80, Issuing of License with Multistate Privilege – Ms. Yeatts

Consent Orders: (Closed Session)

- Patricia Elouise Bostic, LPN*
- Jennifer Anne Sargent, RN*
- Tabatha Rose Martin, LPN
- Tracy Lynn Lombardo, LPN
- Mark Anthony Mayberry, RN
- Anne Heaton Stevens, RN
- Brett Lars Crawford, Jr., RN
- Melissa Thompson Woods, RN
- Jessica Mayo, RN
- Chung Hyun Choi Kim, RN
- Jamie Nicole Garrett, RN

12:00 P.M. – Lunch – Service Recognition for Past Board Members

Guia Caliwagan, RN, MAN, EdS
Jeanne E. Holmes, Citizen Member
Kelly S. McDonough, DNP, RN
Rebecca Poston, PhD, RN, CPCP
William Traynham, LPN, CSAC

ADJOURNMENT

1:00 PM **Possible Summary Suspension (case # 184240)**

Committees' Meetings

2:00 PM CORE Committee Meeting**
Board Members – Ms. Minton*, Dr. Ross, and Dr. McQueen-Gibson
Board Staff – Ms. Krohn

3:00 PM Nurse Aide Curriculum Committee Meeting**
Board Members – Dr. Hahn*, Ms. Phelps, and Mr. Monson
Board Staff – Dr. Saxby and Ms. Krohn

(* mailed 10/25) (** mailed 11/1)

VIRGINIA BOARD OF NURSING
FORMAL HEARINGS
November 13, 2017

TIME AND PLACE: The meeting of the Virginia Board of Nursing was called to order at 9:03 A.M. on November 13, 2017 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico Virginia.

BOARD MEMBERS PRESENT:

Louise Hershkowitz, CRNA, MSHA; Vice President
Margaret J. Friedenberg, Citizen Member
Michelle D. Hereford, MSHA, RN, RACHE
Mark Monson, Citizen Member
Jennifer Phelps, LPN, QMHPA
Dustin S. Ross, DNP, MBA, RN, NE-BC

STAFF PRESENT: Brenda Krohn, RN, MS; Deputy Executive Director
Robin L. Hills, DNP, RN, WHNP; Deputy Executive Director for Advanced Practices
Darlene Graham, Senior Discipline Specialist
Jay P. Douglas, MSN, RN, CSAC, FRE; Executive Director – **joined at 1:35 P.M.**

OTHERS PRESENT: Charis Mitchell, Assistant Attorney General, Board Counsel
PN students from Germanna Community College

ESTABLISHMENT OF A PANEL:

With six members of the Board present, a panel was established

FORMAL HEARINGS: **Nicole Janice Lyons Porter 0001-244805**

Ms. Porter appeared and was represented by Nathan Mortier, Esq. and Elizabeth Dahl, Esq. Ms. Porter was accompanied by John and Alicia Lyons, her parents, and Susan Reynolds, MS, RN.

Anne Joseph, Deputy Director for the Administrative Proceedings Division, represented the Commonwealth. Ms. Mitchell was legal counsel for the Board. Medford Howard, court reporter with Crane-Snead & Associates, recorded the proceedings.

Anna Badgley, Senior Investigator, Department of Health Professions, Susan Reynolds, MS, RN, Nursing Faculty, and Rebecca Britt, Case Manager, Virginia Health Practitioners' Monitoring Program (HPMP), were present and testified.

RECESS: The Board recessed at 10:22 A.M.

RECONVENTION: The Board reconvened at 10:27 A.M.

CLOSED MEETING: Dr. Ross moved that the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 10:57 A.M., for the purpose of

deliberation to reach a decision in the matter of Ms. Porter. Additionally, Dr. Ross moved that Ms. Krohn, Dr. Hills, Ms. Graham, and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 11:41 A.M.

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

Mr. Monson moved that the Board of Nursing accept the findings of fact and conclusions of law as presented by Ms. Joseph and amended by the Board. The motion was seconded and carried unanimously.

ACTION: Ms. Phelps moved the Board of Nursing reprimand Nicole Janice Lyons Porter, deny Ms. Porter's application for reinstatement of her registered nurse license, continue her license on indefinite suspension with suspension stayed contingent upon her continued compliance with the Virginia Health Practitioners' Monitoring Program (HPMP), and require her to successfully complete a Board approved refresher course with clinical component before her re-entry into practice. The motion was seconded and carried unanimously.

This decision shall be effective upon the entry by the Board of a written Order stating the findings, conclusions, and decision of this formal hearing panel.

FORMAL HEARINGS: **Kellie Bell Garnes, RN 0001-187028**
Ms. Garnes appeared.

Steve Bulger, Adjudication Specialist represented the Commonwealth. Ms. Mitchell was legal counsel for the Board. Medford Howard, court reporter with Crane-Snead & Associates, recorded the proceedings.

Christopher Moore, Senior Investigator, Department of Health Professions, and Dawn France, Case Manager, Virginia Health Practitioners' Monitoring Program (HPMP) testified via telephone.

CLOSED MEETING: Dr. Ross moved that the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 12:45 P.M., for the purpose of deliberation to reach a decision in the matter of Ms. Garnes. Additionally, Dr. Ross moved that Ms. Krohn, Dr. Hills, Ms. Graham, and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary

and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 1:03 P.M.

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

Mr. Monson moved that the Board of Nursing accept the findings of fact and conclusions of law as presented by Mr. Bulger, and amended by the Board. The motion was seconded and carried unanimously.

ACTION: Dr. Ross moved that the Board of Nursing reprimand Kellie Bell Garnes and indefinitely suspend her license to practice professional nursing in the Commonwealth of Virginia for a period of not less than two (2) years. The motion was seconded and passed unanimously.

This decision shall be effective upon the entry by the Board of a written Order stating the findings, conclusions, and decision of this formal hearing panel.

RECESS: The Board recessed at 1:05 P.M.

RECONVENTION: The Board reconvened at 1:35 P.M.

Ms. Douglas joined the meeting at 1:35 P.M.

FORMAL HEARINGS: **Oumie Sabally, CNA 1401-124968**

Ms. Sabally appeared and was represented by Michael Goodman, Esq., and Eileen Talamante, Esq. Ms. Sabally was accompanied by Marie Umar-Kamara, FNP, DNP, and YaYa Sambou, CNA

Tammie Jones, Adjudication Specialist represented the Commonwealth. Ms. Mitchell was legal counsel for the Board. Medford Howard, court reporter with Crane-Snead & Associates, recorded the proceedings.

Kimberly Lynch, Senior Investigator, Department of Health Professions, Gale Knox, Executive Director at The Hermitage, Colleen Cobb, RN, Director of Health Services at The Hermitage, Marie Umar-Kamara, FNP, DNP, and YaYa Sambou, CNA, were present and testified.

CLOSED MEETING: Ms. Phelps moved that the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 3:53 P.M., for the purpose of deliberation to reach a decision in the matter of Ms. Sabally. Additionally, Ms.

Phelps moved that Ms. Douglas, Dr. Hills, Ms. Graham, and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 5:25 P.M.

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

Ms. Hereford moved that the Board of Nursing accept the findings of fact and conclusions of law as presented by Ms. Jones, and amended by the Board. The motion was seconded and carried unanimously.

ACTION: Mr. Monson moved that the Board of Nursing indefinitely suspend the certificate of Oumie Sabally to practice as a nurse aide in the Commonwealth of Virginia for a period of not less than one (1) year. The motion was seconded and passed with five votes in favor. Dr. Ross opposed the motion.

This decision shall be effective upon the entry by the Board of a written Order stating the findings, conclusions, and decision of this formal hearing panel.

Ms. Douglas left the meeting at 5:36 P.M.

FORMAL HEARINGS: **Tiffany L. Hicks, RN 0001-219148**
Ms. Hicks did not appear.

David Kazzie, Adjudication Specialist represented the Commonwealth. Ms. Mitchell was legal counsel for the Board. Medford Howard, court reporter with Crane-Snead & Associates, recorded the proceedings.

Jennifer Baker, Senior Investigator, Department of Health Professions, and Joan Naff, RN, Director of Nursing at Rocky Mount Rehab and Healthcare Center, were present and testified.

CLOSED MEETING: Ms. Phelps moved that the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 6:15 P.M., for the purpose of deliberation to reach a decision in the matter of Ms. Hicks. Additionally, Ms. Phelps moved that Ms. Krohn, Dr. Hills, Ms. Graham, and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 6:25 P.M.

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

Ms. Hereford moved that the Board of Nursing accept the findings of fact and conclusions of law as presented by Mr. Kazzie, and amended by the Board. The motion was seconded and carried unanimously.

ACTION: Mr. Monson moved that the Board of Nursing indefinitely suspend the license of Tiffany L. Hicks to practice professional nursing in the Commonwealth of Virginia for a period of not less than two (2) years. The motion was seconded and passed unanimously.

This decision shall be effective upon the entry by the Board of a written Order stating the findings, conclusions, and decision of this formal hearing panel.

ADJOURNMENT: The Board adjourned at 6:26 P.M.

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Brenda Krohn, RN, MS
Deputy Executive Director

VIRGINIA BOARD OF NURSING
MINUTES
November 14, 2017

TIME AND PLACE: The meeting of the Board of Nursing was called to order at 9:00 A.M. on November 14, 2017 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Louise Hershkowitz, CRNA, MSHA; Vice President

BOARD MEMBERS PRESENT:
Marie Gerardo, MS, RN, ANP-BC; Secretary
Laura Freeman Cei BS, LPN, CCRP
Alice Clark, Citizen Member
Margaret J. Friedenberg, Citizen Member
Michelle D. Hereford, MSHA, RN, FACHE
Mark D. Monson, Citizen Member
Jennifer Phelps, LPN, QMHPA
Dustin Ross, DNP, MBA, RN, NE-BC

BOARD MEMBERS ABSENT:
Joyce A. Hahn, PhD, RN, NEA-BC, FNAP; President
Regina Gilliam, LPN
Ethlyn McQueen-Gibson, DNP, MSN, RN, BC
Trula Minton, MS, RN
Rebecca Poston, PhD, RN, CPNP-PC

STAFF PRESENT: Jay P. Douglas, MSM, RN, CSAC, FRE; Executive Director
Brenda Krohn, RN, MS; Deputy Executive Director
Jodi P. Power, RN, JD; Senior Deputy Executive Director
Robin Hills, DNP, RN, WHNP; Deputy Executive Director for Advanced Practice
Stephanie Willinger; Deputy Executive Director
Linda Kleiner, RN, Discipline Case Manager
Paula B. Saxby, RN, PhD; Deputy Executive Director
Charlette Ridout, RN, MS, CNE; Senior Nursing Education Consultant
Ann Tiller, Compliance Manager
Huong Vu, Executive Assistant

OTHERS PRESENT: Charis Mitchell, Assistant Attorney General, Board Counsel
David E. Brown, DO, Department of Health Professions Director

IN THE AUDIENCE: W. Scott Johnson, Medical Society of Virginia (MSV)
Sara Heisler, Virginia Hospital and Healthcare Association (VHHA)
Richard Grossman, Virginia Council of Nurse Practitioners (VCNP)
Diana Gaston, Administrative Proceedings Division (APD) Staff
Holly Woodcock, Administrative Proceedings Division (APD) Staff

ESTABLISHMENT OF A QUORUM:
With 9 members present, a quorum was established.

ANNOUNCEMENTS: Ms. Hershkowitz welcomed Ms. Gaston and Ms. Woodcock as APD Staff to DHP.

Ms. Hershkowitz highlighted the announcements on the agenda and added that Grace Thapa, BSN, RN, PCCN, from Centreville, VA was appointed to the Board to serve an unexpired term beginning October 11, 2017, and ending June 30, 2019, to succeed Dr. Poston.

Ms. Douglas added that she has communicated with Ms. Thapa regarding attending this Board Business meeting and was told that Ms. Thapa already had prior commitment. Ms. Douglas noted that Ms. Thapa works at George Washington University with NP students and will be with the Board at its January 2018 meetings.

Ms. Douglas commented that due to personal and professional obligations, Dr. Poston decided to step back on commitments with Board work. Ms. Hershkowitz honored Dr. Poston for her invaluable service to the Board and hopes that Dr. Poston will return to the Board work at some point in the future.

UPCOMING MEETINGS: Ms. Hershkowitz noted the upcoming meetings on the agenda and added that if anyone is interested in attending the 2018 NCSBN Midyear meeting to let Ms. Douglas or Dr. Hahn know.

DIAGLOGUE WITH DHP DIRECTOR: Dr. Brown thanked Board members for active participation and service to the Board. He reminded Board members that they are here to represent the public and not here to represent their profession. He then provided the following information:

- ePrescribing Workgroup – 2017 legislation requires all opioid prescribing be done electronically by 2020. A wide range of groups came together to discuss implementation. The Workgroup looked at technological issues, software requirements, and exceptions.
- Secretary Hazel's Opioid Curriculum for healthcare providers Workgroup – tasked with developing a set of competencies for inclusion in curriculums for training health care providers in the safe prescribing, appropriate use of opioids and pain management. The Workgroup includes representatives from VCU, UVA, Germanna Community College, Hampton University, and Ms. Ridout from the Board. The curriculum is now at the Secretary Office and will be forwarded to the Governor.

Dr. Brown stated that the next step is to convene small group after Thanksgiving to look at funding for an online training tool. Additionally, another group will convene in December 2017 to look at competencies for non-prescribers such as nurses, PT's, OT's, and Social Workers.

Ms. Hershkowitz thanked Dr. Brown and Ms. Ridout for their participation.

Ms. Phelps added that Community Services Board (CSB) is implementing REVIVE training to people to recognize opioid overdose.

Mr. Monson inquired about resources for long term recovery. Dr. Brown stated that currently Virginia is trying to decrease opioid prescribing, expanding treatment, and expanding coverage for Peer Recovery Specialists.

Ms. Phelps commented that she sees more collaboration in which Peer Recovery Navigators come to Detox centers to talk to clients.

Ms. Hershkowitz thanked Ms. Phelps for her work and insights shared with the Board. Ms. Hershkowitz thanked Dr. Brown for the update.

ORDERING OF AGENDA: Ms. Hershkowitz asked staff to provide additions and/or modifications to the Agenda.

Ms. Douglas indicated the following items have been added and/or modified to the agenda for Board consideration:

- First Half of 2018 Informal Conference Schedule has been added
- Education Informal Conference Committee November 8, 2017 Minutes and Recommendations has been added
- Two additional Consent Orders have been added

Ms. Krohn added the following:

- On Wednesday, November 15, Formal Hearings for Panel A have been cancelled due to lack of Board Members' participation.
- On Wednesday, November 15, Panel B – Pamela Jane Sharp, CNS (#15) plans to appear for consideration of the Agency Subordinate recommendation. Written responses have been received from Lorraine Mulcahy Oliver, RN (#1) and Marianne Phelan Stewart (#9) for consideration of the Agency Subordinate recommendations.
- Tamara Cunningham, RN has signed Consent Order (CO), if the Board accepts her CO, then her Formal Hearing scheduled for 9:30 am on Thursday, November 16, will be cancelled. Ms. Friedenberg replaces Ms. Hereford.

Ms. Power added that Stratford University Falls Church Baccalaureate Degree Registered Nursing Education Program plans to appear and address the Board regarding the Education Special Committee recommendations.

CONSENT AGENDA: The Board did not remove any items from the consent agenda.

Mr. Monson moved to accept the consent agenda as presented. The motion was seconded and carried unanimously.

Minutes:
July 17, 2017 Panel – Dr. Hahn
July 18, 2017 Quorum – Dr. Hahn
July 19, 2017 Panel – Dr. Hahn
July 19, 2017 Panel – Ms. Hershkowitz
July 20, 2017 Panel – Ms. Hershkowitz

Reports:
Agency Subordinate Tracking Log
Finance Report as of June 30, 2017
Board of Nursing Monthly Tracking Log
Health Practitioners Monitoring Program Reports

REPORTS:

Executive Director Report:

Ms. Douglas noted that Board staff have been busy with presentations, internally and externally, and with the Enhanced Nurse Licensure Compact (eNLC) implementation. She provided the following:

- Ms. Douglas will be presenting the eNLC training to Board Members in January 2018 meeting.
- The eNLC currently is in a six-month transition of implementing governance and policy issues. Ms. Douglas noted that Ms. Willinger, Ms. Baskins, Ms. Tiller and Mr. Gallini are primarily staff who have been involved in the preparation for implementation. She thanked them for their hard work.
- NCSBN has communicated to licensees, employers, and educators about the eNLC implementation through letters/flyers.
- Ms. Douglas encouraged everyone to go to the Board website for updated information.
- Four States (Colorado, Rhode Island, New Mexico, and Wisconsin), current NLC States, have no legislation in place to join the new version of the NLC. However, New Mexico and Wisconsin are working on legislation to join the new version.
- Licenses issued during the six-month transition period (7/20/17 – 1/19/18) will be reviewed come January 2018 to make sure they meet the new uniform licensure requirements. Board staff are tracking these licenses.
- Nurses issued a license with multistate privilege prior to July 20, 2017 will be grandfathered.

Ms. Hereford asked the rationale for states not joining the Compact. Ms. Douglas responded that the reasons varied for states not being supportive of the legislation.

NCSBN Leadership and Public Policy October 11-12, 2017 Conference report:

Ms. Hershkowitz noted that written report was submitted by Dr. Hahn and reiterated the three "take aways" from the report.

Guidance Document 90-57 (Bylaws) Committee September 20, 2017 Meeting Minutes and Proposed Changes to GD 90-57:

Ms. Hershkowitz reviewed the minutes and proposed changes to GD 90-57. She noted that Board Counsel has also reviewed the changes.

Ms. Douglas added that Section B in Article XII will be move to GD 90-12 and the Code in Section A in Article XIII will need to be changed once the eNLC is implemented on January 19, 2018.

Ms. Gerardo move to accept the minutes, approve the amendments of the GD 90-57 as proposed by the Committee, and authorize Board Staff to revise Article XIII of the GD 90-57 when needed. The motion was seconded and carried unanimously.

Appointment of Nominating Committee:

Ms. Hershkowitz asked for volunteers to serve on the Nominating Committee. Dr. Ross, Mr. Monson, and Ms. Hereford volunteered. Ms. Douglas noted that the Committee will meet after the Board Business meeting.

Guidance Document 90-6 (PICC Line Insertion and Removal) Committee July 18, 2017 Meeting Minutes and Proposed Amendments to GD 90-6:

Ms. Hershkowitz reported that the Committee reviewed the GD 90-6 as well as Board Counsel and all feedback has been included in the draft for Board consideration.

Mr. Monson moved to accept the minutes and to adopt the amendments to GD 90-6 as presented. The motion was seconded and carried unanimously.

RECESS: The Board recessed at 10:06 AM

RECONVENTION: The Board reconvened at 10:15 AM

PRESENTATION FROM GILES COUNTY PN STUDENTS:

Ms. Ridout introduced students Tiler Smith, Samantha Stanley and faculty member Heidi Sizemore Students from Giles County Practical Nursing Program. Ms. Ridout noted that Mr. Smith and Ms. Stanley competed at the state and international HOSA Leadership Conference and took first place at each for their community awareness project. Students and faculty member Heidi Sizemore completed a community awareness project on the dual

diagnosis of mental illness and substance abuse and are here to present to the Board. Written handout was provided also.

Ms. Hershkowitz thanked students and faculty member for their work and encouraged students to be involved in the work of the Board.

REPORTS (Cont.):

Nurse Aide Curriculum Committee September 21, 2017 Meeting Minutes:
Dr. Saxby reported that the Committee continues to meet to review curriculum chapter by chapter. The Committee will meet again today after the Board Business meeting.

Dr. Ross moved to accept the Nurse Aide Curriculum Committee September 21, 2017 Meeting minutes. The motion was seconded and carried unanimously.

The Committee of the Joint Boards of Nursing and Medicine October 11 Business Meeting, Formal Hearing, and Informal Conference Minutes:
Ms. Hershkowitz stated the minutes are presented for Board consideration.

Mr. Monson moved to accept the Committee of the Joint Boards of Nursing and Medicine October 11, 2017 minutes. The motion was seconded and carried unanimously.

OTHER MATTERS:

Board Counsel Update:
Ms. Mitchell stated that the Board has no appeals pending and she has nothing to report.

She commented that she serves on the Healthcare Task Force who put together an article regarding opioids in the VA Lawyers which was published in October 2017. Mr. Monson thanked Ms. Mitchell for all the work that she does.

Appointments of new Board Member to CORE Committee, Discipline Committee, and the Committee of the Joint Boards of Nursing and Medicine:
Ms. Douglas provided background information regarding CORE Committee noting that Ms. Minton is the only member left on this Committee. She added that Dr. Hahn will appoint additional members at the January meeting.

Ms. Douglas said that the Discipline Committee will be changed to a Ad Hoc Committee starting 2018 and will meet as needed. She asked Board members to consider volunteering for this Committee and Dr. Hahn will appoint members at the January meeting also.

Ms. Hershkowitz reported that Dr. Hahn asked her to share that Dr. Hahn will replace Dr. Poston on the Committee of the Joint Boards with Ms. Hershkowitz and Ms. Gerardo.

Ms. Douglas noted that staff try to scheduled committee meetings after the Board Business meetings on Tuesday so that Board Members do not have to come to the Board on additional days.

2018 Board Meeting Dates:
Ms. Douglas said that 2018 Board Meeting Dates are provided and noted unusual dates as some not always on the third week of the month, due to room availability and Holidays. She added that Ms. Vu will continue to check on room availability and notify her for possible date changes for the November 2018 meetings.

First Half of 2018 Informal Conference Schedule:
Ms. Krohn stated that staff have put together the Informal Conference schedule based on the Board Members' first choice. She noted that the Education Special Committee Conferences and the Committee of the Joint Boards of Nursing and Medicine meetings are also included on the list.

Ms. Douglas noted that Dr. Ross is the only member on the Special Conference Committee E (SCC-E) since Dr. Poston resigned. She added that Dr. Hahn will appoint another member for SCC-E.

EDUCATION:

Education Special Conference Committee November 8, 2017 Recommendation regarding Stratford University Falls Church Baccalaureate Degree Registered Nursing Education Program:
Ms. Gerardo chaired the meeting.

Representatives from Stratford University Falls Church BSN accompanied by Stephen Chema, legal counsel, appeared and addressed the recommendations of the Education Special Conference Committee to the Board.

Ms. Hershkowitz, Mr. Monson, Dr. Saxby, Ms. Ridout, and Ms. Power left the meeting at 11:02 A.M.

CLOSED MEETING:

Mr. Phelps moved that the Board of Nursing convene a closed meeting pursuant to Section 2.2-3711(A)(27) of the *Code of Virginia* at 11:02 A.M. for the purpose of deliberation to consider the recommendations of the Education Special Conference Committee regarding Stratford University Falls Church BSN. Additionally, Ms. Phelps moved that Ms. Douglas, Dr. Hills, Ms. Krohn, Ms. Willinger, Ms. Kleiner, Ms. Tiller, Ms. Vu, and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 11:13 A.M.

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

Dr. Ross moved to accept the November 8, 2017 recommended Order of the Education Special Conference Committee to withdraw the approval of Stratford University Falls Church BSN to operate a baccalaureate registered nursing education program. The motion was seconded and passed unanimously.

RECESS: The Board recessed at 11:15 AM

RECONVENTION: The Board reconvened at 11:25 AM

Ms. Hershkowitz, Mr. Monson, Dr. Saxby, Ms. Ridout, and Ms. Power re-joined the meeting at 11:25 A.M.

Mr. Hershkowitz resumed as Chair.

PUBLIC HEARING: The Board received no comment.

EDUCATION (Cont.): **Education Special Conference Committee November 8, 2017 Minutes and Recommendations:**

Ms. Gerardo moved to accept the Education Special Conference Committee November 8, 2017 minutes and recommendations as presented. The motion was seconded and carried unanimously.

Education Staff Report:

Dr. Saxby reported issues of National Nurse Aide Assessment Program (NNAAP) exam for Virginia noting turnover of the Program Director at PearsonVUE, three times already, and exams are not always scheduled within 30 days as stated in the contract. Dr. Saxby noted that PeasrsonVUE has had long good track record until this transition.

Ms. Hershkowitz asked if there is alternate other than PearsonVUE. Dr. Saxby said that NCSBN owns NNAAP exam and has a sole contract with PearsonVUE. She added that if the Board goes with another contractor then it would be a different exam. Dr. Saxby commented that she is not sure if Red Cross has nurse aide exam.

Ms. Douglas asked Dr. Saxby to contact DHP Procurement regarding the matter.

Ms. Ridout reported that Avery University and Rappahannock Community College Programs recently participated in community outreach regarding issues such as opioid crisis and immunization.

LEGISLATION/ REGULATION:

Ms. Douglas reported the following on behalf of Ms. Yeatts:

Status of Regulatory Action:

Ms. Douglas reviewed the chart of regulatory actions, as provided in written handout, noting Board of Medicine will convene a Regulatory Advisory Panel on the laser hair removal on November 20, 2017 and Dr. Selig, former Board President, was asked to be on the Panel.

NOIRA for Eliminating of a Separate Prescriptive Authority License:

Ms. Douglas stated that the Boards of Nursing (BON) and Medicine have discussed the elimination of separate license for prescriptive authority for nurse practitioners. She noted that there is no provision in the Code to require a separate license. She added that the recommendation of the Committee of the Joints Boards for the adoption of a NOIRA to begin the regulatory process for elimination of a separate prescriptive authority license is presented for Board consideration. Mr. Monson moved to adopt the recommendation as present. The motion was seconded and passed unanimously.

Adoption of Final Regulations – Accreditation of RN Education Programs:

Ms. Douglas stated that the final amendments identical to the proposed regulations are presented for Board consideration, noting that no public comment received. Mr. Monson moved to adopt the final amendments identical to the proposed regulations as presented. The motion was seconded and passed unanimously.

Adoption of Final Regulations – Name Tag Requirement:

Ms. Douglas stated that the final regulations identical to amendments to 18VAC90-9-50 are presented for Board consideration. Mr. Monson moved to adopt the final regulations identical to amendments to 18VAC90-9-50 as presented. The motion was seconded and passed unanimously.

Report on Legislative Proposal for 2018:

Ms. Douglas reported that seven legislative proposals from DHP will be presented, only one will directly impact Board of Nursing which is clarification to allow for electronic renewal notice. She shared the legislative process and noted that Ms. Yeatts will have more detail report at the January Board meeting.

CONSIDERATION OF CONSENT ORDERS:

CLOSED MEETING: Ms. Gerardo moved that the Board of Nursing convene a closed meeting pursuant to Section 2.2-3711(A)(27) of the *Code of Virginia* at 11:57 A.M. for the purpose of deliberation to consider consent orders. Additionally, Ms. Gerardo moved that Ms. Douglas, Ms. Power, Dr. Hills, Ms. Krohn, Ms. Willinger, Dr. Saxby, Ms. Ridout, Ms. Kleiner, Ms. Tiller, Ms. Vu, and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 12:00 P.M.

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

Virginia Burcham Miilu, RN 0001-138014

Mr. Monson moved to accept the consent order to accept the voluntary surrender for indefinite suspension of Virginia Burcham Miilu's license to practice professional nursing in the Commonwealth of Virginia. The suspension applies to any multistate privilege. The motion was seconded and carried unanimously.

Lubov Andrea Smith, RMA 0031-008651

Mr. Monson moved to accept the consent order to accept the voluntary surrender for indefinite suspension of Lubov Andrea Smith's registration to practice as medication aide in the Commonwealth of Virginia. The motion was seconded and carried unanimously.

Norfolk State University Accelerated Baccalaureate Degree Registered Nursing Education Program – Program Code: US28500100

Mr. Monson moved to accept the consent order to withdraw the approval of Norfolk State ABSN to operate a registered nursing education program. Said withdrawal is stayed, and Norfolk State ABSN is continued on Conditional Approval for not less than two years, subject to terms and conditions. The motion was seconded and carried unanimously.

Felicia Eloise Hall, LPN 0002-091453

Mr. Monson moved to accept the consent order to accept the voluntary surrender for indefinite suspension of Felicia Eloise Hall's license to practice

practical nursing in the Commonwealth of Virginia. The suspension applies to any multistate privilege. The motion was seconded and carried unanimously.

Deborah Brody, RN 0001-263553

Mr. Monson moved to accept the consent order to reinstate the license of Deborah Brody to practice professional nursing in the Commonwealth of Virginia without restriction. The motion was seconded and carried unanimously.

Beverly Sue Jacks, RN 0001-204498

Mr. Monson moved to accept the consent order to accept the voluntary surrender for indefinite suspension of Beverly Sue Jacks' license to practice professional nursing in the Commonwealth of Virginia. The suspension applies to any multistate privilege. The motion was seconded and carried unanimously.

Tamara Joi Cunningham, RN 0001-189185

Mr. Monson moved to accept the consent to indefinitely suspend the right of Tamara Joi Cunningham to renew her multistate privilege to practice professional nursing in the Commonwealth of Virginia for a period of not less than two years from date of entry of the Order. The motion was seconded and carried unanimously.

ADJOURNMENT: The Board adjourned at 12:05 P.M.

Joyce Hahn, PhD, RN, NEA-BC, FNAP
President

VIRGINIA BOARD OF NURSING
MINUTES
November 15, 2017

TIME AND PLACE: The meeting of the Virginia Board of Nursing was called to order at 9:04 A.M. on November 15, 2017 in Board Room 2, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico Virginia.

BOARD MEMBERS PRESENT:

Louise Hershkowitz, CRNA, MSHA, Vice President
Marie Gerardo, MS, RN, ANP-BC, Secretary
Laura F. Cei, BS, LPN, CCRP
Alice Clark, Citizen Member
Margaret J. Friedenberg, Citizen Member
Ethlyn McQueen-Gibson, DNP, MSN, RN, BC
Mark Monson, Citizen Member
Jennifer Phelps, LPN, QMHPA
Dustin Ross, DNP, MBA, RN, NE-BC

STAFF PRESENT: Jay P. Douglas, MSM, RN, CSAC, FRE; Executive Director
Brenda Krohn, RN, MS; Deputy Executive Director
Huong Vu, Executive Assistant

OTHERS PRESENT: Charis Mitchell, Assistant Attorney General, Board Counsel

ESTABLISHMENT OF A QUORUM:

With nine members of the Board present, a quorum was established.

CONSIDERATION OF CONSENT ORDER:

CLOSED MEETING: Ms. Phelps moved that the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 9:04 A.M., for the purpose of deliberation to consider the consent order. Additionally, Ms. Phelps moved that Ms. Douglas, Ms. Krohn, Ms. Vu and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 9:05 A.M.

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

Bridget Rae Hill, RN 0001-227660

Mr. Monson moved to accept the consent order to reprimand Bridget Rae Hill, and to indefinitely suspend her license to practice professional nursing in the

Commonwealth. This suspension applies to any multistate privilege. The suspension is stayed contingent upon proof of Ms. Hill's re-entry into a Contract with the Virginia Health Practitioners' Monitoring Program (HPMP) and complying with all terms and conditions of the HPMP for the period specified by the HPMP. The motion was and carried unanimously.

Ms. Hershkowitz, Ms. Cei, Ms. Clark, Dr. McQueen-Gibson, and Ms. Douglas left the meeting at 9:11 A.M.

Ms. Gerardo chaired.

CONSIDERATION OF AGENCY SUBORDINATE RECOMMENDATIONS:

Pamela Jane Sharp, CNS Applicant
Ms. Sharp appeared.

CLOSED MEETING: Ms. Phelps moved that the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 9:19 A.M., for the purpose of consideration of the agency subordinate recommendation regarding Ms. Sharp. Additionally, Ms. Phelps moved that Ms. Krohn, Ms. Vu and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 9:24 A.M.

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

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to deny Pamela Jane Sharp's application for registration to practice as a clinical nurse specialist in the Commonwealth of Virginia. The motion was seconded and carried unanimously.

Ms. Douglas and Dr. McQueen-Gibson re-joined the meeting at 9:26 A.M.

CLOSED MEETING: Ms. Phelps moved that the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 9:27 A.M., for the purpose of consideration of the remaining agency subordinate recommendations. Additionally, Ms. Phelps moved that Ms. Douglas, Ms. Krohn, Ms. Vu and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is

deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 9:47 A.M.
Ms. Phelps moved that the Board of Nursing certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and carried unanimously.

Lorraine Mulcahy Oliver, RN 0001-087320
Ms. Oliver did not appear but submitted written response.

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to indefinitely suspend the license of Lorraine Mulcahy Oliver to practice professional nursing in the Commonwealth of Virginia, said suspension applies to any multistate privilege. The suspension is stayed contingent upon Ms. Oliver's continued compliance with all terms and conditions of the Virginia Health Practitioners' Monitoring Program (HPMP) for the period specified by HPMP. The motion was seconded and carried unanimously.

Teresa A. Gorman, RN 0001-240171
Ms. Gorman did not appear.

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to reprimand Teresa A. Gorman and to indefinitely suspend her license to practice professional nursing in the Commonwealth of Virginia for a period of not less than one (1) year from the date of entry of the Order. This suspension applies to any multistate privilege. The motion was seconded and carried unanimously.

Lillie Nicole Dubois, RN 0001-190376
Ms. Dubois did not appear.

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to reprimand Lillie Nicole Dubois and to indefinitely suspend her right to renew her license to practice professional nursing in the Commonwealth of Virginia. This suspension applies to any multistate privilege. The motion was seconded and carried unanimously.

Melinda Faye Brown, RN 0001-243295
Ms. Brown did not appear.

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to indefinitely suspend the license of Melinda Faye

Brown to practice professional nursing in the Commonwealth of Virginia. This suspension applies to any multistate privilege. The motion was seconded and carried unanimously.

Patsy Ann Triplett, LPN 0002-073792
Ms. Triplett did not appear.

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to indefinitely suspend the right of Patsy Ann Triplett to renew her license to practice practical nursing in the Commonwealth of Virginia. This suspension applies to any multistate privilege. The motion was seconded and carried unanimously.

Logan Trout, LPN 0002-088340
Ms. Trout did not appear.

Mr. Monson moved that the Board of Nursing modify the recommended decision of the agency subordinate to indefinitely suspend the license of Logan Trout to practice practical nursing in the Commonwealth of Virginia. This suspension applies to any multistate privilege. The suspension is stayed contingent upon Ms. Trout's entry into a Contract with the Virginia Health Practitioners' Monitoring Program (HPMP) within 60 days of entry of the Order and comply with all terms and conditions of the HPMP for the period specified by the HPMP. The motion was seconded and carried with five votes in favor. Ms. Phelps opposed the motion.

Tia Kay McBribe, LPN 0002-077168
Ms. McBribe did not appear.

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to reprimand Tia Kay McBribe and to indefinitely suspend her license to practice practical nursing in the Commonwealth of Virginia. This suspension applies to any multistate privilege. The motion was seconded and carried unanimously.

Maria Ana Correa, LPN 0002-085970
Ms. Correa did not appear.

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to reprimand Maria Ana Correa and to indefinitely suspend the right to renew her license to practice practical nursing in the Commonwealth of Virginia. This suspension applies to any multistate privilege. The motion was seconded and carried unanimously.

Marianne Phelan Stewart, RN 0001-107442

Ms. Stewart did not appear but submitted written response.

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to indefinitely suspend the license of Marianne Phelan Stewart to practice professional nursing in the Commonwealth of Virginia. This suspension applies to any multistate privilege. The motion was seconded and carried unanimously.

Heather Winters, LPN 0002-086103
Ms. Winters did not appear.

Mr. Monson moved that the Board of Nursing modify the recommended decision of the agency subordinate to require Heather Winters to provide written proof satisfactory to the Board of successful completion of the following NCSBN courses within 60 days from entry of the Order:

- *Virginia Nurse Practice Act; and*
- *Professional Accountability & Legal Liability for Nurses*

The motion was seconded and carried unanimously.

Wendy Rice, CNA 1401-124756
Ms. Rice did not appear.

Dr. McQueen-Gibson moved that the Board of Nursing modify the recommended decision of the agency subordinate to revoke the certification of Wendy Rice to practice as a nurse aide in the Commonwealth of Virginia and to enter Findings of Abuse and Neglect against her in the Virginia Nurse Aide Registry. The motion was seconded and carried unanimously.

Brittney Logan, CNA 1401-165499
Ms. Logan did not appear.

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to reprimand Brittaney Logan. The motion was seconded and carried unanimously.

Joshua R. Bentley, CNA 1401-167515
Mr. Bentley did not appear.

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to revoke the certification of Joshua R. Bentley to practice as a nurse aide in the Commonwealth of Virginia and to enter a Finding of Abuse against him in the Virginia Nurse Aide Registry. The motion was seconded and carried unanimously.

Denise Michelle Smith Baxter, CNA 1401-112459
Ms. Baxter did not appear.

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to reprimand Denise Michelle Smith Baxter and to indefinitely suspend her certificate to practice as a nurse aide in the Commonwealth of Virginia. The motion was seconded and carried unanimously.

Penny S. Jarvis, CNA 1401-156516
Ms. Javis did not appear.

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to revoke the certification of Penny S. Jarvis to practice as a nurse aide in the Commonwealth of Virginia and to enter a Finding of Neglect against her in the Virginia Nurse Aide Registry. The motion was seconded and carried unanimously.

Roxanna Marie Calix, CNA 1401-126112
Ms. Calix did not appear.

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to reprimand Roxanna Marie Calix and to indefinitely suspend the right to renew her certificate to practice as a nurse aide in the Commonwealth of Virginia. The suspension applies to any multistate privilege. The motion was seconded and carried unanimously.

Alex Jordan Samaniego, CAN 1401-130819
Mr. Samaniego did not appear.

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to revoke the certification of Alex Jordan Samaniego to practice as a nurse aide in the Commonwealth of Virginia and to enter a Finding of Abuse against him in the Virginia Nurse Aide Registry. The motion was seconded and carried unanimously.

Brandi Sue Coffey, RMA 0031-000826
Ms. Coffey did not appear.

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to imposed Brandi Sue Coffey a monetary penalty of $150.00 to be paid to the Board within 90 days from entry of the Order. The motion was seconded and carried unanimously.

Kelly Elaine Martin, CNA 1401-040447
Ms. Martin did not appear.

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to indefinitely suspend the right of Kelly Elaine Martin to renew her certification to practice as a nurse aide in the Commonwealth of Virginia. The suspension is stayed contingent upon proof of Ms. Martin's entry into a Contract with the Virginia Health Practitioners' Monitoring Program (HPMP) and complying with all terms and conditions of the HPMP for the period specified by the HPMP. The motion was seconded and carried unanimously.

Patricia D. Johnson, CNA 1401-175852
Ms. Johnson did not appear.

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to reprimand Patricia D. Johnson. The motion was seconded and carried unanimously.

Martha Magdalena Alonso Hernandez Camden, CNA 1401-115847
Ms. Camden did not appear.

Mr. Monson moved that the Board of Nursing accept the recommended decision of the agency subordinate to indefinitely suspend the certificate of Martha Magdalena Alonso Hernandez Camden to practice as a nurse aide in the Commonwealth of Virginia and to enter a Finding of Neglect against her in the Virginia Nurse Aide Registry. The motion was seconded and carried unanimously.

ADJOURNMENT: The Board adjourned at 9:50 A.M.

_____
Brenda Krohn, RN, MS
Deputy Executive Director

VIRGINIA BOARD OF NURSING
FORMAL HEARINGS
November 15, 2017

TIME AND PLACE: The meeting of the Virginia Board of Nursing was called to order at 10:00 A.M. on November 15, 2017 in Board Room 2, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico Virginia.

BOARD MEMBERS PRESENT:

Marie Gerardo, MS, RN. ANP-BC; Secretary, Chair
Margaret J. Friedenberg, Citizen Member
Ethlyn McQueen-Gibson, DNP, MSN, RN, BC
Mark Monson, Citizen Member
Jennifer Phelps, LPN, QMHPA
Dustin Ross, DNP, MBA, RN, NE-BC

STAFF PRESENT: Jay P. Douglas, MSM, RN, CSAC, FRE; Executive Director – **joined at 11:53 A.M.**
Brenda Krohn, RN, MS; Deputy Executive Director
Robin Hills, DNP, RN, WHNP; Deputy Executive Director for Advanced Practice
Huong Vu, Executive Assistant

OTHERS PRESENT: Charis Mitchell, Assistant Attorney General, Board Counsel
CNA Students from Louisa County Public School
Senior Nursing Students from George Washington University (GWU)
Senior Nursing Students from Hampton University

ESTABLISHMENT OF A PANEL:

With six members of the Board present, a panel was established.

FORMAL HEARINGS: **Megan Coles, CNA 1401-178300**
Ms. Coles did not appear.

Tammie Jones, Adjudication Specialist, represented the Commonwealth. Ms. Mitchell was legal counsel for the Board. Medford Howard, court reporter with Crane-Snead & Associates, recorded the proceedings.

Jessica Wilkerson, Senior Investigators, Department of Health Professions, testified via telephone.

CLOSED MEETING: Ms. Phelps moved that the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 10:20 A.M., for the purpose of deliberation to reach a decision in the matter of Ms. Coles. Additionally, Ms. Phelps moved that Ms. Krohn, Dr. Hills, Ms. Vu and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 10:28 A.M.

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

Mr. Monson moved that the Board of Nursing accept the findings of fact and conclusions of law as presented by Ms. Jones. The motion was seconded and carried unanimously.

ACTION: Dr. Ross moved that the Board of Nursing indefinitely suspend the certificate of Megan Coles to practice as a nurse aide in the Commonwealth of Virginia until she can come to the Board and prove that she is safe and competent to practice as a nurse aide. The motion was seconded and carried unanimously.

This decision shall be effective upon the entry by the Board of a written Order stating the findings, conclusions, and decision of this formal hearing panel.

RECESS: The Board recessed at 10:30 A.M.

RECONVENTION: The Board reconvened at 11:00 A.M.

FORMAL HEARINGS: **Tammy Kay Allen, RN Reinstatement 0001-172962**
Ms. Allen appeared.

Cynthia Gaines, Adjudication Specialist, represented the Commonwealth. Ms. Mitchell was legal counsel for the Board. Medford Howard, court reporter with Crane-Snead & Associates, recorded the proceedings.

Kimberly B. Lynch, RN, MS, and Joyce M. Shelton-Jones, Senior Investigators, Department of Health Professions, were present and testified.

CLOSED MEETING: Ms. Phelps moved that the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 11:23 A.M., for the purpose of deliberation to reach a decision in the matter of Ms. Allen. Additionally, Ms. Phelps moved that Ms. Krohn, Dr. Hills, Ms. Vu and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 11:42 A.M.

Ms. Phelps moved that the Board of Nursing certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public

business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and carried unanimously.

Dr. Ross moved that the Board of Nursing accept the findings of fact and conclusions of law as presented by Ms. Gaines, and amended by the Board. The motion was seconded and carried unanimously.

ACTION: Mr. Monson moved that the Board of Nursing reprimand Tammy Kay Allen and approve her application for reinstatement of her license to practice professional nursing in the Commonwealth of Virginia contingent upon her completion of Board-approved refresher course and two NCSBN course called "*Documentation: A Critical Aspect and Professional Accountability & Legal Liability for Nurses*". The motion was seconded and carried unanimously.

This decision shall be effective upon the entry by the Board of a written Order stating the findings, conclusions, and decision of this formal hearing panel.

RECESS: The Board recessed at 11:45 A.M.

RECONVENTION: The Board reconvened at 11:53 A.M.

Ms. Douglas joined the meeting at 11:53 A.M.

FORMAL HEARINGS: **Cynthia Gale Bowman McGrady, CNA 1401-122805**
Ms. McGrady did not appear.

Tammie Jones, Adjudication Specialist, represented the Commonwealth. Ms. Mitchell was legal counsel for the Board. Medford Howard, court reporter with Crane-Snead & Associates, recorded the proceedings.

Amy Tanner, Senior Investigator, Department of Health Professions, was present and testified.

CLOSED MEETING: Ms. Phelps moved that the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 12:08 P.M., for the purpose of deliberation to reach a decision in the matter of Ms. McGrady. Additionally, Ms. Phelps moved that Ms. Douglas, Ms. Krohn, Dr. Hills, Ms. Vu and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 12:16 P.M.

Ms. Phelps moved that the Board of Nursing certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public

business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and carried unanimously.

Dr. Ross moved that the Board of Nursing accept the findings of fact and conclusions of law as presented by Ms. Jones. The motion was seconded and carried unanimously.

ACTION: Mr. Monson moved that the Board of Nursing indefinitely suspend the certificate of Cynthia Gale Bowman McGrady to practice as a nurse aide in the Commonwealth of Virginia for not less than one year until she can prove that she is safe and competent to practice as a nurse aide. The motion was seconded and carried unanimously.

This decision shall be effective upon the entry by the Board of a written Order stating the findings, conclusions, and decision of this formal hearing panel.

RECESS: The Board recessed at 12:08 P.M.

RECONVENTION: The Board reconvened at 1:04 P.M.

FORMAL HEARINGS: **Bethany Mills, CNA Reinstatement 1401-145540**
Ms. Mills appeared.

David Kazzie, Adjudication Specialist, represented the Commonwealth. Ms. Mitchell was legal counsel for the Board. Medford Howard, court reporter with Crane-Snead & Associates, recorded the proceedings.

Stephanie Fried, Senior Investigator, Department of Health Professions, was present and testified.

CLOSED MEETING: Ms. Phelps moved that the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 1:30 P.M., for the purpose of deliberation to reach a decision in the matter of Ms. Mills. Additionally, Ms. Phelps moved that Ms. Douglas, Ms. Krohn, Dr. Hills, Ms. Vu and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 1:59 P.M.

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

Ms. Monson moved that the Board of Nursing accept the findings of fact and conclusions of law as presented by Mr. Kazzie and amended by the Board. The motion was seconded and carried unanimously.

ACTION: Dr. McQueen-Gibson moved that the Board of Nursing deny the application of Bethany Mills for reinstatement of her certificate to practice as a nurse aide in the Commonwealth of Virginia. The motion was seconded and carried unanimously.

This decision shall be effective upon the entry by the Board of a written Order stating the findings, conclusions, and decision of this formal hearing panel.

CONSIDERATION OF CONSENT ORDER:

CLOSED MEETING: Ms. Phelps moved that the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 2:05 P.M., for the purpose of deliberation to consider the consent order. Additionally, Ms. Phelps moved that Ms. Krohn, Dr. Hills and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 2:10 P.M.

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

Cynthia Jearman Nash, RN 0001-164503
Mr. Monson moved to accept the consent order to indefinitely suspend the license of Cynthia Jearman Nash to practice professional nursing in the Commonwealth of Virginia. This suspension applies to any multistate privilege. The motion was seconded and carried unanimously.

FORMAL HEARINGS: **Jody Lynn Martin Hall, RN 0001-155540**
Ms. Hall did not appear.

Tammie Jones, Adjudication Specialist, represented the Commonwealth. Ms. Mitchell was legal counsel for the Board. Medford Howard, court reporter with Crane-Snead & Associates, recorded the proceedings.

Margaret Starks, Senior Investigator, Department of Health Professions, testified via telephone.

CLOSED MEETING: Ms. Phelps moved that the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 2:27 P.M., for the purpose of

deliberation to reach a decision in the matter of Ms. Hall. Additionally, Ms. Phelps moved that Ms. Douglas, Ms. Krohn, Dr. Hills, Ms. Vu and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 2:35 P.M.

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

Dr. Ross moved that the Board of Nursing accept the findings of fact and conclusions of law as presented by Ms. Jones. The motion was seconded and carried unanimously.

ACTION: Mr. Monson moved that the Board of Nursing indefinitely suspend the license of Jody Lynn Martin Hall to practice professional nursing in the Commonwealth of Virginia for a period of not less than two years. The motion was seconded and carried unanimously.

This decision shall be effective upon the entry by the Board of a written Order stating the findings, conclusions, and decision of this formal hearing panel.

FORMAL HEARINGS: **Martina V. Holloway Grigg, LPN 0002-088202**
Ms. Grigg did not appear.

Tammie Jones, Adjudication Specialist, represented the Commonwealth. Ms. Mitchell was legal counsel for the Board. Medford Howard, court reporter with Crane-Snead & Associates, recorded the proceedings.

Andria Christian, Senior Investigator, Department of Health Professions, testified via telephone. Chandra Samlall, LPN, Golden Living – Fredericksburg, Sharon Calloway, LPN, former employee at Golden Living – Fredericksburg, Ashley Hesler, Senior Investigator, Department of Health Professions, James Chrisman III, LCSW, CEO, Owner of River City Comprehensive Counseling Services, and Mary Culp, HR Generalist at River City, were present and testified.

CLOSED MEETING: Ms. Phelps moved that the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 3:41 P.M., for the purpose of deliberation to reach a decision in the matter of Ms. Grigg. Additionally, Ms. Phelps moved that Ms. Douglas, Ms. Krohn, Dr. Hills, Ms. Vu and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed

necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 3:53 P.M.

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

Dr. Ross moved that the Board of Nursing accept the findings of fact and conclusions of law as presented by Ms. Jones. The motion was seconded and carried unanimously.

ACTION: Mr. Monson moved that the Board of Nursing indefinitely suspend the license of Martina V. Holloway Grigg to practice practical nursing in the Commonwealth of Virginia for a period of not less than two years. The motion was seconded and carried unanimously.

This decision shall be effective upon the entry by the Board of a written Order stating the findings, conclusions, and decision of this formal hearing panel.

ADJOURNMENT: The Board adjourned at 3:54 P.M.

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Brenda Krohn, RN, MS
Deputy Executive Director

VIRGINIA BOARD OF NURSING
POSSIBLE SUMMARY SUSPENSION TELEPHONE CONFERENCE CALL
November 16, 2017

A possible summary suspension telephone conference call of the Virginia Board of Nursing was held November 16, 2017 at 8:35 A.M.

The Board of Nursing members participating in the meeting were:

Louise Hershkowitz, CRNA, MSHA; Chair
Marie Gerardo, MS, RN, ANP-BC
Laura F. Cei, BS, LPN, CCRP
Margaret Friedenberg, Citizen Member
Michelle D. Hereford, MSHA, RN, FACHE
Ethlyn McQueen-Gibson, DNP, MSN, RN, BC
Mark Monson, Citizen Member
Dustin S. Ross, DNP, MBA, RN, NE-BC

Others participating in the meeting were:

Charis Mitchell, Assistant Attorney General, Board Counsel
Wayne Halbleib, Assistant Attorney General
David Kazzie, Adjudication Specialist
Jay P. Douglas, MSM, RN, CSAC, FRE; Executive Director
Brenda Krohn, RN, MS; Deputy Executive Director
Robin Hills, RN, DNP, WHNP; Deputy Executive Director for Advanced Practice

The meeting was called to order by Ms. Hershkowitz. With eight members of the Board of Nursing participating, a quorum was established.

J Wayne Halbleib, Assistant Attorney General presented evidence that the continued practice of nursing by Frederick Kofi Wiaboo Yeboah, RN 0001- 165353 may present a substantial danger to the health and safety of the public.

Mr. Monson moved to summarily suspend the nursing license of Frederick Kofi Wiaboo Yeboah for a period of not less than two years pending a formal administrative hearing and to offer a consent order for indefinite suspension of his license in lieu of a formal hearing. The motion was seconded and carried unanimously.

The meeting was adjourned at 8:55 A.M.

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Brenda Krohn, RN, MS
Deputy Executive Director

VIRGINIA BOARD OF NURSING
FORMAL HEARINGS
November 16, 2017

TIME AND PLACE: The meeting of the Virginia Board of Nursing was called to order at 10:00 A.M. on November 16, 2017 in Board Room 2, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico Virginia.

BOARD MEMBERS PRESENT:

Marie Gerardo, MS, RN. ANP-BC; Secretary, Chair
Laura F. Cei, BS, LPN, CCRP
Alice Clark, Citizen Member
Margaret J. Friedenberg, Citizen Member
Ethlyn McQueen-Gibson, DNP, MSN, RN, BC

STAFF PRESENT: Brenda Krohn, RN, MS; Deputy Executive Director
Robin Hills, DNP, RN, WHNP; Deputy Executive Director for Advanced Practice
Huong Vu, Executive Assistant

OTHERS PRESENT: Charis Mitchell, Assistant Attorney General, Board Counsel
Senior Nursing Students from Bon Secours Memorial College
Senior Nursing Students from Riverside College of Health Careers

ESTABLISHMENT OF A PANEL:

With five members of the Board present, a panel was established.

FORMAL HEARINGS: **Charlene Valencia Green, RN 0001-230454**
Ms. Green appeared.

David Kazzie, Adjudication Specialist, represented the Commonwealth. Ms. Mitchell was legal counsel for the Board. Denise Holt, court reporter with Crane-Snead & Associates, recorded the proceedings.

Kelly Ashley, Senior Investigators, Department of Health Professions, and Clariza Hernandez, LPN at Regency Healthcare & Rehabilitation Center, testified via telephone.

CLOSED MEETING: Ms. Cei moved that the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 11:24 A.M., for the purpose of deliberation to reach a decision in the matter of Ms. Green. Additionally, Ms. Cei moved that Ms. Krohn, Dr. Hills, Ms. Vu and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 11:58 A.M.

Ms. Cei moved that the Board of Nursing certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting

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

Ms. Clark moved that the Board of Nursing accept the findings of fact and conclusions of law as presented by Mr. Kazzie and amended by the Board. The motion was seconded and carried unanimously.

ACTION: Dr. McQueen-Gibson moved that the Board of Nursing reprimand Charlene Valencia Green and require her to complete the following NCSBN courses within 90 days from entry of the Order:

- *Documentation: A Critical Aspect;*
- *Medication Errors: Causes & Prevention; and*
- *Professional Accountability & Legal Liability for Nurses*

The motion was seconded and carried unanimously.

This decision shall be effective upon the entry by the Board of a written Order stating the findings, conclusions, and decision of this formal hearing panel.

RECESS: The Board recessed at 12:00 P.M.

RECONVENTION: The Board reconvened at 12:14 P.M.

FORMAL HEARINGS: **Sheila Marie Stokes, RN 0001-152552**
Ms. Stokes appeared.

David Kazzie, Adjudication Specialist, represented the Commonwealth. Ms. Mitchell was legal counsel for the Board. Denise Holt, court reporter with Crane-Snead & Associates, recorded the proceedings.

Kelly D. Ashley, Senior Investigator, Department of Health Professions, was present and testified.

CLOSED MEETING: Ms. Cei moved that the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 12:52 P.M., for the purpose of deliberation to reach a decision in the matter of Ms. Stokes. Additionally, Ms. Cei moved that Ms. Krohn, Dr. Hills, Ms. Vu and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 1:17 P.M.

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

Ms. Clark moved that the Board of Nursing accept the findings of fact and conclusions of law as presented by Mr. Kazzie and amended by the Board. The motion was seconded and carried unanimously.

ACTION: Dr. McQueen-Gibson moved that the Board of Nursing place the license of Sheila Marie Stokes to practice professional nursing in the Commonwealth of Virginia on probation for a period of not less than two years of active practice with terms. The motion was seconded and carried unanimously.

This decision shall be effective upon the entry by the Board of a written Order stating the findings, conclusions, and decision of this formal hearing panel.

RECESS: The Board recessed at 1:20 P.M.

RECONVENTION: The Board reconvened at 1:54 P.M.

FORMAL HEARINGS: **Debra Robinson Swingle, RN 0001-111701**
Ms. Swingle appeared and was accompanied by Linda Rhoads, her sister.

Steve Bulger, Adjudication Specialist, represented the Commonwealth. Ms. Mitchell was legal counsel for the Board. Denise Holt, court reporter with Crane-Snead & Associates, recorded the proceedings.

Gayle Miller, Senior Investigator, Department of Health Professions, was present and testified.

CLOSED MEETING: Ms. Cei moved that the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 3:02 P.M., for the purpose of deliberation to reach a decision in the matter of Ms. Swingle. Additionally, Ms. Cei moved that Ms. Krohn, Dr. Hills, Ms. Vu and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 3:25 P.M.

Ms. Cei moved that the Board of Nursing certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public

business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and carried unanimously.

Ms. Clark moved that the Board of Nursing accept the findings of fact and conclusions of law as presented by Mr. Bulger and amended by the Board. The motion was seconded and carried unanimously.

ACTION: Dr. McQueen-Gibson moved that the Board of Nursing deny the application of Debra Robinson Swingle for reinstatement of her license to practice professional nursing in the Commonwealth of Virginia. The motion was seconded and carried unanimously.

This decision shall be effective upon the entry by the Board of a written Order stating the findings, conclusions, and decision of this formal hearing panel.

ADJOURNMENT: The Board adjourned at 3:29 P.M.

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Brenda Krohn, RN, MS
Deputy Executive Director

VIRGINIA BOARD OF NURSING
POSSIBLE SUMMARY SUSPENSION TELEPHONE CONFERENCE CALL
November 16, 2017

A possible summary suspension telephone conference call of the Virginia Board of Nursing was held November 16, 2017 at 8:35 A.M.

The Board of Nursing members participating in the meeting were:

Louise Hershkowitz, CRNA, MSHA; Chair
Marie Gerardo, MS, RN, ANP-BC
Laura F. Cei, BS, LPN, CCRP
Margaret Friedenberg, Citizen Member
Michelle D. Hereford, MSHA, RN, FACHE
Ethlyn McQueen-Gibson, DNP, MSN, RN, BC
Mark Monson, Citizen Member
Dustin S. Ross, DNP, MBA, RN, NE-BC

Others participating in the meeting were:

Charis Mitchell, Assistant Attorney General, Board Counsel
Wayne Halbleib, Assistant Attorney General
David Kazzie, Adjudication Specialist
Jay P. Douglas, MSM, RN, CSAC, FRE; Executive Director
Brenda Krohn, RN, MS; Deputy Executive Director
Robin Hills, RN, DNP, WHNP; Deputy Executive Director for Advanced Practice

The meeting was called to order by Ms. Hershkowitz. With eight members of the Board of Nursing participating, a quorum was established.

J Wayne Halbleib, Assistant Attorney General presented evidence that the continued practice of nursing by Frederick Kofi Wiaboo Yeboah, RN 0001- 165353 may present a substantial danger to the health and safety of the public.

Mr. Monson moved to summarily suspend the nursing license of Frederick Kofi Wiaboo Yeboah for a period of not less than two years pending a formal administrative hearing and to offer a consent order for indefinite suspension of his license in lieu of a formal hearing. The motion was seconded and carried unanimously.

The meeting was adjourned at 8:55 A.M.

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Brenda Krohn, RN, MS
Deputy Executive Director

VIRGINIA BOARD OF NURSING
POSSIBLE SUMMARY SUSPENSION TELEPHONE CONFERENCE CALL
January 17, 2018

A possible summary suspension telephone conference call of the Virginia Board of Nursing was held January 17, 2018 at 10:31 A.M.

The Board of Nursing members participating in the meeting were:

Joyce A. Hahn, PhD, RN, NEA-BC, FNAP; Chair
Louise Hershkowitz, CRNA, MSHA
Laura F. Cei, BS, LPN, CCRP
Alice Clark, Citizen Member
Michelle D. Hereford, MSHA, RN, FACHE
Ethlyn McQueen-Gibson, DNP, MSN, RN, BC
Mark Monson, Citizen Member
Grace Thapa, BSN, RN

Others participating in the meeting were:

Charis Mitchell, Assistant Attorney General, Board Counsel
James Schilessmann, Assistant Attorney General
Holly Woodcock, Adjudication Specialist
Jay P. Douglas, MSM, RN, CSAC, FRE; Executive Director
Robin Hills, RN, DNP, WHNP; Deputy Executive Director for Advanced Practice
Huong Vu, Executive Assistant

The meeting was called to order by Dr. Hahn. With eight members of the Board of Nursing participating, a quorum was established.

James Schilessmann, Assistant Attorney General presented evidence that the continued practice of nursing by Ashley Rose O'Sullivan, RN 0001- 251696 may present a substantial danger to the health and safety of the public.

CLOSE MEETING: Ms. Monson moved that the Board of Nursing convene a closed meeting pursuant to §2.2-3711(A)(27) of the *Code of Virginia* at 10:51 A.M., for the purpose of deliberation to reach a decision in the matter of Ms. O'Sullivan. Additionally, Mr. Monson moved that Ms. Douglas, Dr. Hills, Ms. Vu and Ms. Mitchell attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Board reconvened in open session at 11:05 A.M.

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

Mr. Monson moved to summarily suspend the nursing license of Ashley Rose O'Sullivan pending a formal administrative hearing and to offer a consent order for indefinite suspension of her license for a period of not less than two years in lieu of a formal hearing. The motion was seconded and carried unanimously.

The meeting was adjourned at 11:08 A.M.

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

Agency Subordinate Recommendation Tracking Trend Log - May 2006 to Present – Board of Nursing

Considered		Accepted		Modified*					Rejected					Final Outcome:** Difference from Recommendation				
Date	Total	Total	Total %	Total	Total %	# present	# ↑	# ↓	Total	Total %	# present	# Ref to FH	# Dis-missed	↑	↓	Same	Pend-ing	N/A
Total to Date:	*2754*	*2437*	*88.5%*	*220*	*8.0%*				*92*	*3.3%*				*68*	*69*	*87*	*5*	
CY2017 to Date:	*230*	*218*	*94.8%*	*10*	*4.3%*	*0*	*5*	*4*	*2*	*0.9%*	*0*	*2*	*0*	*2*	*4*	*6*	*N/A*	
Nov-17	22	21	95.5%	1	4.5%	0	1	0	0		0	0	0	1	1	0		
Sep-17	45	42	93.3%	3	6.7%	0	2	1	0		0	0	0	0	1	0		
Jul-17	40	40	100.0%	0		0	0	0	0		0	0	0	1	0	1		
May-17	40	38	95.0%	1	2.5%	0	0	1	1	2.5%	0	1	0	0	0	2		
Mar-17	35	31	88.6%	4	11.4%	0	2	1	0	0.0%	0	0	0	0	0	2		
Jan-17	48	46	95.8%	1	2.1%	0	0	1	1	2.1%	0	1	0	0	2	1		
Annual Totals:																		
Total 2016	*241*	*227*	*94.2%*	*9*	*3.7%*	*0*	*8*	*0*	*5*	*2.1%*	*2*	*4*	*0*	*4*	*8*	*2*	N/A	
Total 2015	240	218	90.8%	14	5.8%	2	12	2	8	3.3%	3	6	1	9	6	5	N/A	
Total 2014	257	235	91.4%	17	6.6%	2	8	9	5	1.9%	1	3	2	3	3	7	N/A	
Total 2013	248	236	95.2%	10	4.0%				2	0.8%				3	6	2	N/A	
Total 2012	229	211	92.1%	15	6.6%				3	1.3%				4	6	9	N/A	
Total 2011	208	200	96.2%	6	2.9%				2	1.0%				4	1	12	N/A	
Total 2010	194	166	85.6%	21	10.8%				7	3.6%				7	9	9	N/A	
Total 2009	268	217	81.0%	40	14.9%				11	4.1%				11	6	20	N/A	
Total 2008	217	163	75.1%	29	13.4%				22	10.1%				11	11	3	N/A	
Total 2007	174	130	74.7%	30	17.2%				12	6.9%				8	7	4	N/A	
Total 2006	76	62	81.6%	6	7.9%				8	10.5%				2	2		N/A	

***** *Modified = Sanction changed in some way (does not include editorial changes to Findings of Fact or Conclusions of Law. ↑ = additional terms or more severe sanction. ↓ = lesser sanction or impose no sanction.*

****** *Final Outcome Difference = Final Board action/ sanction after FH compared to original Agency Subordinate Recommendation that was modified (then appealed by respondent to FH) or was Rejected by Board (& referred to FH).*

Virginia Department of Health Professions
Cash Balance
As of November 30, 2017

	Nursing	
Board Cash Balance as June 30, 2017	$ 11,626,594	
YTD FY18 Revenue	4,599,874	
Less: YTD FY18 Direct and Allocated Expenditures	5,392,345	*
Board Cash Balance as November 30, 2017	10,834,123	

*** Includes $25,812 deduction for Nurse Scholarship Fund**

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10100 - Nursing

For the Period Beginning July 1, 2017 and Ending November 30, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
4002400	Fee Revenue				
4002401	Application Fee	833,684.00	1,518,220.00	684,536.00	54.91%
4002406	License & Renewal Fee	2,962,000.00	6,526,255.00	3,564,255.00	45.39%
4002407	Dup. License Certificate Fee	10,405.00	23,750.00	13,345.00	43.81%
4002408	Board Endorsement - In	32,980.00	676,000.00	643,020.00	4.88%
4002409	Board Endorsement - Out	10,400.00	14,805.00	4,405.00	70.25%
4002421	Monetary Penalty & Late Fees	120,068.00	188,750.00	68,682.00	63.61%
4002432	Misc. Fee (Bad Check Fee)	245.00	1,750.00	1,505.00	14.00%
	Total Fee Revenue	3,969,782.00	8,949,530.00	4,979,748.00	44.36%
4003000	Sales of Prop. & Commodities				
4003020	Misc. Sales-Dishonored Payments	385.00	-	(385.00)	0.00%
	Total Sales of Prop. & Commodities	385.00	-	(385.00)	0.00%
4009000	Other Revenue				
4009060	Miscellaneous Revenue	15,400.00	34,000.00	18,600.00	45.29%
	Total Other Revenue	15,400.00	34,000.00	18,600.00	45.29%
	Total Revenue	3,985,567.00	8,983,530.00	4,997,963.00	44.37%
5011110	Employer Retirement Contrib.	91,112.04	230,008.00	138,895.96	39.61%
5011120	Fed Old-Age Ins- Sal St Emp	53,311.61	130,683.00	77,371.39	40.79%
5011130	Fed Old-Age Ins- Wage Earners	5,308.57	31,899.00	26,590.43	16.64%
5011140	Group Insurance	9,144.79	22,336.00	13,191.21	40.94%
5011150	Medical/Hospitalization Ins.	129,354.50	393,948.00	264,593.50	32.84%
5011160	Retiree Medical/Hospitalizatn	8,237.42	20,120.00	11,882.58	40.94%
5011170	Long term Disability Ins	4,607.49	11,254.00	6,646.51	40.94%
	Total Employee Benefits	301,076.42	840,248.00	539,171.58	35.83%
5011200	Salaries				
5011230	Salaries, Classified	700,660.89	1,705,020.00	1,004,359.11	41.09%
5011250	Salaries, Overtime	16,895.71	3,254.00	(13,641.71)	519.23%
	Total Salaries	717,556.60	1,708,274.00	990,717.40	42.00%
5011300	Special Payments				
5011380	Deferred Compnstn Match Pmts	2,530.00	14,880.00	12,350.00	17.00%
	Total Special Payments	2,530.00	14,880.00	12,350.00	17.00%
5011400	Wages				
5011410	Wages, General	69,005.00	416,971.00	347,966.00	16.55%
5011430	Wages, Overtime	388.04	-	(388.04)	0.00%
	Total Wages	69,393.04	416,971.00	347,577.96	16.64%
5011530	Short-trm Disability Benefits	5,168.08	-	(5,168.08)	0.00%
	Total Disability Benefits	5,168.08	-	(5,168.08)	0.00%
5011600	Terminatn Personal Svce Costs				
5011620	Salaries, Annual Leave Balanc	145.98	-	(145.98)	0.00%
5011640	Salaries, Cmp Leave Balances	64.88	-	(64.88)	0.00%
5011660	Defined Contribution Match - Hy	3,059.22	-	(3,059.22)	0.00%
	Total Terminatn Personal Svce Costs	3,270.08	-	(3,270.08)	0.00%
5011930	Turnover/Vacancy Benefits		-	-	0.00%
	Total Personal Services	1,098,994.22	2,980,373.00	1,881,378.78	36.87%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10100 - Nursing

For the Period Beginning July 1, 2017 and Ending November 30, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
5012000	Contractual Svs				
5012100	Communication Services				
5012110	Express Services	1,870.75	4,395.00	2,524.25	42.57%
5012120	Outbound Freight Services	-	10.00	10.00	0.00%
5012140	Postal Services	53,709.28	85,633.00	31,923.72	62.72%
5012150	Printing Services	2,001.45	1,322.00	(679.45)	151.40%
5012160	Telecommunications Svcs (VITA)	2,953.92	21,910.00	18,956.08	13.48%
5012170	Telecomm. Svcs (Non-State)	247.50	-	(247.50)	0.00%
5012190	Inbound Freight Services	44.24	17.00	(27.24)	260.24%
	Total Communication Services	60,827.14	113,287.00	52,459.86	53.69%
5012200	Employee Development Services				
5012210	Organization Memberships	-	8,764.00	8,764.00	0.00%
5012220	Publication Subscriptions	-	120.00	120.00	0.00%
5012240	Employee Trainng/Workshop/Conf	1,950.00	482.00	(1,468.00)	404.56%
5012250	Employee Tuition Reimbursement	-	1,000.00	1,000.00	0.00%
	Total Employee Development Services	1,950.00	10,366.00	8,416.00	18.81%
5012300	Health Services				
5012360	X-ray and Laboratory Services	-	4,232.00	4,232.00	0.00%
	Total Health Services	-	4,232.00	4,232.00	0.00%
5012400	Mgmnt and Informational Svcs	-			
5012420	Fiscal Services	70,677.50	197,340.00	126,662.50	35.82%
5012430	Attorney Services	8,209.50	-	(8,209.50)	0.00%
5012440	Management Services	1,218.82	370.00	(848.82)	329.41%
5012460	Public Infrmtnl & Relatn Svcs	-	49.00	49.00	0.00%
5012470	Legal Services	3,055.00	5,616.00	2,561.00	54.40%
	Total Mgmnt and Informational Svcs	83,160.82	203,375.00	120,214.18	40.89%
5012500	Repair and Maintenance Svcs				
5012530	Equipment Repair & Maint Srvc	660.00	3,001.00	2,341.00	21.99%
5012560	Mechanical Repair & Maint Srvc	-	369.00	369.00	0.00%
	Total Repair and Maintenance Svcs	660.00	3,370.00	2,710.00	19.58%
5012600	Support Services				
5012630	Clerical Services	99,465.91	292,088.00	192,622.09	34.05%
5012640	Food & Dietary Services	3,975.76	-	(3,975.76)	0.00%
5012660	Manual Labor Services	13,522.20	38,508.00	24,985.80	35.12%
5012670	Production Services	79,680.16	158,515.00	78,834.84	50.27%
5012680	Skilled Services	367,973.10	1,119,774.00	751,800.90	32.86%
	Total Support Services	564,617.13	1,608,885.00	1,044,267.87	35.09%
5012700	Technical Services				
5012780	VITA InT Int Cost Goods&Svs	1,154.53	-	(1,154.53)	0.00%
5012790	Computer Software Dvp Svs	-	62,000.00	62,000.00	0.00%
	Total Technical Services	1,154.53	62,000.00	60,845.47	1.86%
5012800	Transportation Services				
5012820	Travel, Personal Vehicle	913.76	5,260.00	4,346.24	17.37%
5012830	Travel, Public Carriers	332.40	1.00	(331.40)	33240.00%
5012840	Travel, State Vehicles	-	2,454.00	2,454.00	0.00%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10100 - Nursing

For the Period Beginning July 1, 2017 and Ending November 30, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
5012850	Travel, Subsistence & Lodging	529.63	6,635.00	6,105.37	7.98%
5012880	Trvl, Meal Reimb- Not Rprtble	485.25	3,597.00	3,111.75	13.49%
	Total Transportation Services	2,261.04	17,947.00	15,685.96	12.60%
	Total Contractual Svs	714,630.66	2,023,462.00	1,308,831.34	35.32%
5013000	Supplies And Materials				
5013100	Administrative Supplies				
5013120	Office Supplies	5,789.28	11,696.00	5,906.72	49.50%
5013130	Stationery and Forms	-	3,790.00	3,790.00	0.00%
	Total Administrative Supplies	5,789.28	15,486.00	9,696.72	37.38%
5013200	Energy Supplies				
5013230	Gasoline	14.59	-	(14.59)	0.00%
	Total Energy Supplies	14.59	-	(14.59)	0.00%
5013300	Manufctrng and Merch Supplies				
5013350	Packaging & Shipping Supplies	-	99.00	99.00	0.00%
	Total Manufctrng and Merch Supplies	-	99.00	99.00	0.00%
5013500	Repair and Maint. Supplies				
5013520	Custodial Repair & Maint Matrl	-	29.00	29.00	0.00%
	Total Repair and Maint. Supplies	-	29.00	29.00	0.00%
5013600	Residential Supplies				
5013620	Food and Dietary Supplies	335.91	408.00	72.09	82.33%
5013630	Food Service Supplies	-	1,108.00	1,108.00	0.00%
5013640	Laundry and Linen Supplies	-	22.00	22.00	0.00%
5013650	Personal Care Supplies	155.76	-	(155.76)	0.00%
	Total Residential Supplies	491.67	1,538.00	1,046.33	31.97%
5013700	Specific Use Supplies				
5013730	Computer Operating Supplies	273.88	182.00	(91.88)	150.48%
	Total Specific Use Supplies	273.88	182.00	(91.88)	150.48%
	Total Supplies And Materials	6,569.42	17,334.00	10,764.58	37.90%
5015000	Continuous Charges				
5015100	Insurance-Fixed Assets				
5015120	Automobile Liability	-	163.00	163.00	0.00%
5015160	Property Insurance	-	504.00	504.00	0.00%
	Total Insurance-Fixed Assets	-	667.00	667.00	0.00%
5015300	Operating Lease Payments				
5015340	Equipment Rentals	2,353.85	9,014.00	6,660.15	26.11%
5015350	Building Rentals	248.40	-	(248.40)	0.00%
5015360	Land Rentals	-	275.00	275.00	0.00%
5015390	Building Rentals - Non State	53,034.55	149,154.00	96,119.45	35.56%
	Total Operating Lease Payments	55,636.80	158,443.00	102,806.20	35.11%
5015400	Service Charges				
5015460	SPCC And EEI Check Fees	-	5.00	5.00	0.00%
	Total Service Charges	-	5.00	5.00	0.00%
5015500	Insurance-Operations				
5015510	General Liability Insurance	-	1,897.00	1,897.00	0.00%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10100 - Nursing

For the Period Beginning July 1, 2017 and Ending November 30, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
5015540	Surety Bonds	-	112.00	112.00	0.00%
	Total Insurance-Operations	-	2,009.00	2,009.00	0.00%
	Total Continuous Charges	55,636.80	161,124.00	105,487.20	34.53%
5022000	Equipment				
5022100	Computer Hrdware & Sftware				
5022170	Other Computer Equipment	2,197.98	-	(2,197.98)	0.00%
	Total Computer Hrdware & Sftware	2,197.98	-	(2,197.98)	0.00%
5022200	Educational & Cultural Equip				
5022240	Reference Equipment	384.00	1,123.00	739.00	34.19%
	Total Educational & Cultural Equip	384.00	1,123.00	739.00	34.19%
5022300	Electrnc & Photographic Equip				
5022380	Electronic & Photo Equip Impr	-	1,666.00	1,666.00	0.00%
	Total Electrnc & Photographic Equip	-	1,666.00	1,666.00	0.00%
5022600	Office Equipment				
5022610	Office Appurtenances	-	202.00	202.00	0.00%
5022620	Office Furniture	3,534.40	1,097.00	(2,437.40)	322.19%
5022630	Office Incidentals	-	75.00	75.00	0.00%
	Total Office Equipment	3,534.40	1,374.00	(2,160.40)	257.23%
5022700	Specific Use Equipment				
5022710	Household Equipment	-	133.00	133.00	0.00%
	Total Specific Use Equipment	-	133.00	133.00	0.00%
	Total Equipment	6,116.38	4,296.00	(1,820.38)	142.37%
	Total Expenditures	1,881,947.48	5,186,589.00	3,304,641.52	36.28%
	Allocated Expenditures				
20400	Nursing / Nurse Aid	26,152.29	99,619.71	73,467.42	26.25%
30100	Data Center	544,105.20	1,740,659.93	1,196,554.73	31.26%
30200	Human Resources	96,625.68	249,596.83	152,971.15	38.71%
30300	Finance	347,646.68	737,086.68	389,439.99	47.16%
30400	Director's Office	152,337.75	372,291.49	219,953.74	40.92%
30500	Enforcement	955,640.14	2,550,842.98	1,595,202.85	37.46%
30600	Administrative Proceedings	214,380.61	683,045.26	468,664.65	31.39%
30700	Impaired Practitioners	31,162.90	73,226.77	42,063.87	42.56%
30800	Attorney General	86,917.61	234,618.45	147,700.84	37.05%
30900	Board of Health Professions	83,219.17	211,599.80	128,380.63	39.33%
31100	Maintenance and Repairs	-	3,344.48	3,344.48	0.00%
31300	Emp. Recognition Program	-	4,013.24	4,013.24	0.00%
31400	Conference Center	45,146.36	46,633.20	1,486.84	96.81%
31500	Pgm Devlpmnt & Implmentn	77,301.73	207,711.93	130,410.20	37.22%
	Total Allocated Expenditures	2,660,636.13	7,214,290.76	4,553,654.63	36.88%
	Net Revenue in Excess (Shortfall) of Expenditures	$ (557,016.61)	$ (3,417,349.76)	$ (2,860,333.15)	16.30%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10100 - Nursing

For the Period Beginning July 1, 2017 and Ending November 30, 2017

Account Number	Account Description	July	August	September	October	November	Total
4002400	Fee Revenue						
4002401	Application Fee	166,685.00	156,660.00	143,604.00	191,605.00	175,130.00	833,684.00
4002406	License & Renewal Fee	606,379.00	604,896.00	596,413.00	679,172.00	475,140.00	2,962,000.00
4002407	Dup. License Certificate Fee	2,175.00	2,025.00	2,015.00	2,190.00	2,000.00	10,405.00
4002408	Board Endorsement - In	5,610.00	7,460.00	7,840.00	7,310.00	4,760.00	32,980.00
4002409	Board Endorsement - Out	1,445.00	2,140.00	1,760.00	2,660.00	2,395.00	10,400.00
4002421	Monetary Penalty & Late Fees	23,065.00	25,570.00	23,950.00	24,678.00	22,805.00	120,068.00
4002432	Misc. Fee (Bad Check Fee)	-	35.00	-	105.00	105.00	245.00
	Total Fee Revenue	805,359.00	798,786.00	775,582.00	907,720.00	682,335.00	3,969,782.00
4003000	Sales of Prop. & Commodities						
4003020	Misc. Sales-Dishonored Payments	-	50.00	-	210.00	125.00	385.00
	Total Sales of Prop. & Commodities	-	50.00	-	210.00	125.00	385.00
4009000	Other Revenue						
4009060	Miscellaneous Revenue	4,400.00	2,200.00	2,200.00	6,600.00	-	15,400.00
	Total Other Revenue	4,400.00	2,200.00	2,200.00	6,600.00	-	15,400.00
	Total Revenue	809,759.00	801,036.00	777,782.00	914,530.00	682,460.00	3,985,567.00
5011000	Personal Services						
5011100	Employee Benefits						
5011110	Employer Retirement Contrib.	23,412.17	16,297.24	16,408.24	17,345.43	17,648.96	91,112.04
5011120	Fed Old-Age Ins- Sal St Emp	13,592.59	9,632.19	9,820.77	10,103.57	10,162.49	53,311.61
5011130	Fed Old-Age Ins- Wage Earners	1,464.58	849.21	836.04	1,144.48	1,014.26	5,308.57
5011140	Group Insurance	2,346.28	1,635.24	1,646.02	1,743.69	1,773.56	9,144.79
5011150	Medical/Hospitalization Ins.	33,904.00	23,428.00	23,428.00	24,007.50	24,587.00	129,354.50
5011160	Retiree Medical/Hospitalizatn	2,113.43	1,473.00	1,482.72	1,570.69	1,597.58	8,237.42
5011170	Long term Disability Ins	1,182.13	823.90	829.34	878.54	893.58	4,607.49
	Total Employee Benefits	78,015.18	54,138.78	54,451.13	56,793.90	57,677.43	301,076.42
5011200	Salaries						
5011230	Salaries, Classified	176,371.04	125,760.55	129,430.98	133,595.27	135,503.05	700,660.89
5011250	Salaries, Overtime	3,407.00	4,847.37	3,574.44	2,993.39	2,073.51	16,895.71

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10100 - Nursing

For the Period Beginning July 1, 2017 and Ending November 30, 2017

Account Number	Account Description	July	August	September	October	November	Total
	Total Salaries	179,778.04	130,607.92	133,005.42	136,588.66	137,576.56	717,556.60
5011380	Deferred Compnstn Match Pmts	690.00	435.00	435.00	475.00	495.00	2,530.00
	Total Special Payments	690.00	435.00	435.00	475.00	495.00	2,530.00
5011400	Wages						-
5011410	Wages, General	19,144.72	11,100.78	10,928.73	14,572.35	13,258.42	69,005.00
5011430	Wages, Overtime	-	-	-	388.04	-	388.04
	Total Wages	19,144.72	11,100.78	10,928.73	14,960.39	13,258.42	69,393.04
5011500	Disability Benefits						
5011530	Short-trm Disability Benefits	5,168.08	-	-	-	-	5,168.08
	Total Disability Benefits	5,168.08	-	-	-	-	5,168.08
5011600	Terminatn Personal Svce Costs						
5011620	Salaries, Annual Leave Balanc	-	-	-	145.98	-	145.98
5011640	Salaries, Cmp Leave Balances	-	-	-	64.88	-	64.88
5011660	Defined Contribution Match - Hy	748.70	542.38	542.38	610.88	614.88	3,059.22
	Total Terminatn Personal Svce Costs	748.70	542.38	542.38	821.74	614.88	3,270.08
	Total Personal Services	283,544.72	196,824.86	199,362.66	209,639.69	209,622.29	1,098,994.22
5012000	Contractual Svs						-
5012100	Communication Services						-
5012110	Express Services	-	205.43	325.56	1,090.36	249.40	1,870.75
5012140	Postal Services	8,021.15	14,448.95	7,897.20	14,383.63	8,958.35	53,709.28
5012150	Printing Services	-	-	2,001.45	-	-	2,001.45
5012160	Telecommunications Svcs (VITA)	1,080.57	1,123.79	-	-	749.56	2,953.92
5012170	Telecomm. Svcs (Non-State)	67.50	45.00	45.00	45.00	45.00	247.50
5012190	Inbound Freight Services	-	-	10.00	34.24	-	44.24
	Total Communication Services	9,169.22	15,823.17	10,279.21	15,553.23	10,002.31	60,827.14
5012200	Employee Development Services						
5012240	Employee Trainng/Workshop/Conf	1,950.00	-	-	-	-	1,950.00
	Total Employee Development Services	1,950.00	-	-	-	-	1,950.00
5012400	Mgmnt and Informational Svcs						
5012420	Fiscal Services	13,002.82	10,224.03	12,052.46	23,061.46	12,336.73	70,677.50

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10100 - Nursing

For the Period Beginning July 1, 2017 and Ending November 30, 2017

Account Number	Account Description	July	August	September	October	November	Total
5012430	Attorney Services	-	8,209.50	-	-	-	8,209.50
5012440	Management Services	-	1,240.63	-	(21.81)	-	1,218.82
5012470	Legal Services	-	-	-	1,820.00	1,235.00	3,055.00
	Total Mgmnt and Informational Svcs	13,002.82	19,674.16	12,052.46	24,859.65	13,571.73	83,160.82
5012500	Repair and Maintenance Svcs						
5012530	Equipment Repair & Maint Srvc	-	-	-	-	660.00	660.00
	Total Repair and Maintenance Svcs	-	-	-	-	660.00	660.00
5012600	Support Services						
5012630	Clerical Services	-	21,892.50	26,707.16	32,806.25	18,060.00	99,465.91
5012640	Food & Dietary Services	-	319.83	1,318.30	689.41	1,648.22	3,975.76
5012660	Manual Labor Services	3,065.98	2,567.29	3,460.12	2,005.46	2,423.35	13,522.20
5012670	Production Services	17,963.37	12,478.99	22,534.60	10,328.84	16,374.36	79,680.16
5012680	Skilled Services	72,534.53	74,341.44	72,561.81	76,517.05	72,018.27	367,973.10
	Total Support Services	93,563.88	111,600.05	126,581.99	122,347.01	110,524.20	564,617.13
5012700	Technical Services						
5012780	VITA InT Int Cost Goods&Svs	-	-	1,154.53	-	-	1,154.53
	Total Technical Services	-	-	1,154.53	-	-	1,154.53
5012800	Transportation Services						
5012820	Travel, Personal Vehicle	-	317.80	31.57	67.90	496.49	913.76
5012830	Travel, Public Carriers	-	-	-	332.40	-	332.40
5012850	Travel, Subsistence & Lodging	-	100.37	-	204.38	224.88	529.63
5012880	Trvl, Meal Reimb- Not Rprtble	-	50.25	-	127.50	307.50	485.25
	Total Transportation Services	-	468.42	31.57	732.18	1,028.87	2,261.04
	Total Contractual Svs	117,685.92	147,565.80	150,099.76	163,492.07	135,787.11	714,630.66
5013000	Supplies And Materials						
5013100	Administrative Supplies						-
5013120	Office Supplies	-	761.12	1,116.65	1,292.91	2,618.60	5,789.28
	Total Administrative Supplies	-	761.12	1,116.65	1,292.91	2,618.60	5,789.28
5013200	Energy Supplies						

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10100 - Nursing

For the Period Beginning July 1, 2017 and Ending November 30, 2017

Account Number	Account Description	July	August	September	October	November	Total
5013230	Gasoline	14.59	-	-	-	-	14.59
	Total Energy Supplies	14.59	-	-	-	-	14.59
5013600	Residential Supplies						
5013620	Food and Dietary Supplies	46.26	-	210.14	-	79.51	335.91
5013650	Personal Care Supplies	155.76	-	-	-	-	155.76
	Total Residential Supplies	202.02	-	210.14	-	79.51	491.67
5013700	Specific Use Supplies						
5013730	Computer Operating Supplies	-	62.00	-	211.88	-	273.88
	Total Specific Use Supplies	-	62.00	-	211.88	-	273.88
	Total Supplies And Materials	216.61	823.12	1,326.79	1,504.79	2,698.11	6,569.42
5015000	Continuous Charges						
5015300	Operating Lease Payments						
5015340	Equipment Rentals	-	734.12	259.80	660.71	699.22	2,353.85
5015350	Building Rentals	-	115.20	-	-	133.20	248.40
5015390	Building Rentals - Non State	9,989.96	11,693.95	10,226.17	9,989.96	11,134.51	53,034.55
	Total Operating Lease Payments	9,989.96	12,543.27	10,485.97	10,650.67	11,966.93	55,636.80
	Total Continuous Charges	9,989.96	12,543.27	10,485.97	10,650.67	11,966.93	55,636.80
5022000	Equipment						
5022170	Other Computer Equipment	-	-	-	1,202.98	995.00	2,197.98
	Total Computer Hrdware & Sftware	-	-	-	1,202.98	995.00	2,197.98
5022200	Educational & Cultural Equip						
5022240	Reference Equipment	-	-	-	384.00	-	384.00
	Total Educational & Cultural Equip	-	-	-	384.00	-	384.00
5022620	Office Furniture	-	-	-	2,109.40	1,425.00	3,534.40
	Total Office Equipment	-	-	-	2,109.40	1,425.00	3,534.40
	Total Equipment	-	-	-	3,696.38	2,420.00	6,116.38
	Total Expenditures	411,437.21	357,757.05	361,275.18	388,983.60	362,494.44	1,881,947.48

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 10100 - Nursing

For the Period Beginning July 1, 2017 and Ending November 30, 2017

Account Number	Account Description	July	August	September	October	November	Total
	Allocated Expenditures						
20400	Nursing / Nurse Aid	5,823.27	4,446.03	1,647.00	7,625.78	6,610.21	26,152.29
30100	Data Center	153,994.04	57,546.31	146,250.63	133,335.90	52,978.31	544,105.20
30200	Human Resources	528.50	706.83	588.75	693.94	94,107.64	96,625.68
30300	Finance	115,892.23	61,037.58	60,505.71	32,709.77	77,501.39	347,646.68
30400	Director's Office	37,468.25	30,084.57	28,148.74	29,016.32	27,619.87	152,337.75
30500	Enforcement	244,671.07	180,029.50	173,314.38	178,511.96	179,113.23	955,640.14
30600	Administrative Proceedings	65,307.24	42,043.39	33,040.69	32,920.32	41,068.97	214,380.61
30700	Impaired Practitioners	8,335.06	6,057.80	5,643.09	5,566.36	5,560.60	31,162.90
30800	Attorney General	-	-	43,458.80	43,458.80	-	86,917.61
30900	Board of Health Professions	21,731.89	15,630.88	14,246.29	15,745.23	15,864.88	83,219.17
31400	Conference Center	57.31	108.75	84,260.06	(9,951.36)	(29,328.40)	45,146.36
31500	Pgm Devlpmnt & Implmentn	16,955.97	15,094.42	14,126.28	14,647.01	16,478.05	77,301.73
	Total Allocated Expenditures	670,764.83	412,786.07	605,230.43	484,280.04	487,574.76	2,660,636.13
	Net Revenue in Excess (Shortfall) of Expenditures	$ (272,443.04)	$ 30,492.88	$ (188,723.61)	$ 41,266.36	$ (167,609.20)	$ (557,016.61)

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 11200 - Certified Nurse Aides

For the Period Beginning July 1, 2017 and Ending November 30, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
4002400	Fee Revenue				
4002401	Application Fee	1,150.00	300.00	(850.00)	383.33%
4002406	License & Renewal Fee	470,015.00	1,165,275.00	695,260.00	40.34%
4002421	Monetary Penalty & Late Fees	-	330.00	330.00	0.00%
4002432	Misc. Fee (Bad Check Fee)	180.00	700.00	520.00	25.71%
	Total Fee Revenue	471,345.00	1,166,605.00	695,260.00	40.40%
4003000	Sales of Prop. & Commodities				
4003007	Sales of Goods/Svces to State	142,812.43	545,764.00	402,951.57	26.17%
4003020	Misc. Sales-Dishonored Payments	150.00	-	(150.00)	0.00%
	Total Sales of Prop. & Commodities	142,962.43	545,764.00	402,801.57	26.19%
4009000	Other Revenue				
	Total Revenue	614,307.43	1,712,369.00	1,098,061.57	35.87%
5011110	Employer Retirement Contrib.	6,296.43	15,717.00	9,420.57	40.06%
5011120	Fed Old-Age Ins- Sal St Emp	3,959.52	8,913.00	4,953.48	44.42%
5011130	Fed Old-Age Ins- Wage Earners	3,158.23	5,223.00	2,064.77	60.47%
5011140	Group Insurance	626.22	1,527.00	900.78	41.01%
5011150	Medical/Hospitalization Ins.	14,450.00	36,144.00	21,694.00	39.98%
5011160	Retiree Medical/Hospitalizatn	564.03	1,375.00	810.97	41.02%
5011170	Long term Disability Ins	315.52	769.00	453.48	41.03%
	Total Employee Benefits	29,369.95	69,668.00	40,298.05	42.16%
5011200	Salaries				
5011230	Salaries, Classified	47,943.79	116,505.00	68,561.21	41.15%
5011250	Salaries, Overtime	3,228.54	-	(3,228.54)	0.00%
	Total Salaries	51,172.33	116,505.00	65,332.67	43.92%
5011300	Special Payments				
5011380	Deferred Compnstn Match Pmts	220.00	1,440.00	1,220.00	15.28%
	Total Special Payments	220.00	1,440.00	1,220.00	15.28%
5011400	Wages				
5011410	Wages, General	40,862.30	68,269.00	27,406.70	59.85%
5011430	Wages, Overtime	421.94	-	(421.94)	0.00%
	Total Wages	41,284.24	68,269.00	26,984.76	60.47%
5011600	Terminatn Personal Svce Costs				
5011620	Salaries, Annual Leave Balanc	4,065.07	-	(4,065.07)	0.00%
5011640	Salaries, Cmp Leave Balances	74.52	-	(74.52)	0.00%
5011660	Defined Contribution Match - Hy	152.03	-	(152.03)	0.00%
	Total Terminatn Personal Svce Costs	4,291.62	-	(4,291.62)	0.00%
5011930	Turnover/Vacancy Benefits		-	-	0.00%
	Total Personal Services	126,338.14	255,882.00	129,543.86	49.37%
5012000	Contractual Svs				
5012100	Communication Services				
5012110	Express Services	5.71	-	(5.71)	0.00%
5012140	Postal Services	22,563.08	32,117.00	9,553.92	70.25%
5012150	Printing Services	273.27	276.00	2.73	99.01%
5012160	Telecommunications Svcs (VITA)	69.36	2,500.00	2,430.64	2.77%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 11200 - Certified Nurse Aides

For the Period Beginning July 1, 2017 and Ending November 30, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
	Total Communication Services	22,911.42	34,893.00	11,981.58	65.66%
5012300	**Health Services**				
5012360	**X-ray and Laboratory Services**	-	125.00	125.00	0.00%
	Total Health Services	-	125.00	125.00	0.00%
5012400	**Mgmnt and Informational Svcs**	-			
5012420	**Fiscal Services**	11,093.96	24,920.00	13,826.04	44.52%
5012440	**Management Services**	167.39	530.00	362.61	31.58%
5012460	**Public Infrmtnl & Relatn Svcs**	-	10.00	10.00	0.00%
	Total Mgmnt and Informational Svcs	11,261.35	25,460.00	14,198.65	44.23%
5012500	**Repair and Maintenance Svcs**				
5012560	**Mechanical Repair & Maint Srvc**	-	72.00	72.00	0.00%
	Total Repair and Maintenance Svcs	-	72.00	72.00	0.00%
5012600	**Support Services**				
5012660	**Manual Labor Services**	1,418.29	2,454.00	1,035.71	57.80%
5012670	**Production Services**	8,439.00	10,300.00	1,861.00	81.93%
5012680	**Skilled Services**	5,936.99	48,303.00	42,366.01	12.29%
	Total Support Services	15,794.28	61,057.00	45,262.72	25.87%
5012800	**Transportation Services**				
5012820	**Travel, Personal Vehicle**	2,843.58	6,893.00	4,049.42	41.25%
5012830	**Travel, Public Carriers**	116.60	-	(116.60)	0.00%
5012840	**Travel, State Vehicles**	468.70	310.00	(158.70)	151.19%
5012850	**Travel, Subsistence & Lodging**	1,526.02	912.00	(614.02)	167.33%
5012880	**Trvl, Meal Reimb- Not Rprtble**	1,010.75	528.00	(482.75)	191.43%
	Total Transportation Services	5,965.65	8,643.00	2,677.35	69.02%
	Total Contractual Svs	55,932.70	130,250.00	74,317.30	42.94%
5013000	**Supplies And Materials**				
5013100	**Administrative Supplies**				
5013120	**Office Supplies**	389.88	1,092.00	702.12	35.70%
5013130	**Stationery and Forms**	-	1,203.00	1,203.00	0.00%
	Total Administrative Supplies	389.88	2,295.00	1,905.12	16.99%
5013200	**Energy Supplies**				
5013230	**Gasoline**	7.29	-	(7.29)	0.00%
	Total Energy Supplies	7.29	-	(7.29)	0.00%
5013300	**Manufctrng and Merch Supplies**				
5013350	**Packaging & Shipping Supplies**	-	20.00	20.00	0.00%
	Total Manufctrng and Merch Supplies	-	20.00	20.00	0.00%
5013600	**Residential Supplies**				
5013620	**Food and Dietary Supplies**	-	80.00	80.00	0.00%
5013630	**Food Service Supplies**	-	226.00	226.00	0.00%
	Total Residential Supplies	-	306.00	306.00	0.00%
	Total Supplies And Materials	397.17	2,621.00	2,223.83	15.15%
5015000	**Continuous Charges**				
5015100	**Insurance-Fixed Assets**				
5015160	**Property Insurance**	-	106.00	106.00	0.00%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 11200 - Certified Nurse Aides

For the Period Beginning July 1, 2017 and Ending November 30, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
	Total Insurance-Fixed Assets	-	106.00	106.00	0.00%
5015300	**Operating Lease Payments**				
5015340	**Equipment Rentals**	5.29	-	(5.29)	0.00%
5015350	**Building Rentals**	28.02	-	(28.02)	0.00%
5015360	**Land Rentals**	-	50.00	50.00	0.00%
5015390	**Building Rentals - Non State**	12,591.79	35,414.00	22,822.21	35.56%
	Total Operating Lease Payments	12,625.10	35,464.00	22,838.90	35.60%
5015500	**Insurance-Operations**				
5015510	**General Liability Insurance**	-	399.00	399.00	0.00%
5015540	**Surety Bonds**	-	24.00	24.00	0.00%
	Total Insurance-Operations	-	423.00	423.00	0.00%
	Total Continuous Charges	12,625.10	35,993.00	23,367.90	35.08%
5022000	**Equipment**				
5022200	**Educational & Cultural Equip**				
5022240	**Reference Equipment**	-	162.00	162.00	0.00%
	Total Educational & Cultural Equip	-	162.00	162.00	0.00%
5022600	**Office Equipment**				
5022680	**Office Equipment Improvements**	-	4.00	4.00	0.00%
	Total Office Equipment	-	4.00	4.00	0.00%
	Total Equipment	-	166.00	166.00	0.00%
	Total Expenditures	195,293.11	424,912.00	229,618.89	45.96%
	Allocated Expenditures				
20400	**Nursing / Nurse Aid**	12,650.75	32,465.29	19,814.54	38.97%
30100	**Data Center**	75,041.17	237,970.23	162,929.06	31.53%
30200	**Human Resources**	13,220.63	25,394.11	12,173.49	52.06%
30300	**Finance**	85,701.28	185,137.69	99,436.41	46.29%
30400	**Director's Office**	37,408.55	93,510.29	56,101.73	40.00%
30500	**Enforcement**	276,460.44	735,238.05	458,777.61	37.60%
30600	**Administrative Proceedings**	76,900.59	175,422.13	98,521.54	43.84%
30700	**Impaired Practitioners**	597.55	1,873.59	1,276.04	31.89%
30800	**Attorney General**	516.67	1,837.61	1,320.94	28.12%
30900	**Board of Health Professions**	20,459.62	53,148.56	32,688.95	38.50%
31100	**Maintenance and Repairs**	-	794.07	794.07	0.00%
31300	**Emp. Recognition Program**	-	408.31	408.31	0.00%
31400	**Conference Center**	10,718.92	11,071.94	353.01	96.81%
31500	**Pgm Devlpmnt & Implmentn**	18,979.90	52,172.03	33,192.13	36.38%
	Total Allocated Expenditures	628,656.06	1,606,443.89	977,787.84	39.13%
	Net Revenue in Excess (Shortfall) of Expenditures	$ (209,641.74)	$ (318,986.89)	$ (109,345.16)	65.72%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 11200 - Certified Nurse Aides

For the Period Beginning July 1, 2017 and Ending November 30, 2017

Account Number	Account Description	July	August	September	October	November	Total
4002400	Fee Revenue						
4002401	Application Fee	275.00	25.00	275.00	225.00	350.00	1,150.00
4002406	License & Renewal Fee	103,845.00	96,160.00	99,540.00	95,750.00	74,720.00	470,015.00
4002432	Misc. Fee (Bad Check Fee)	35.00	40.00	35.00	35.00	35.00	180.00
	Total Fee Revenue	104,155.00	96,225.00	99,850.00	96,010.00	75,105.00	471,345.00
4003000	Sales of Prop. & Commodities						
4003007	Sales of Goods/Svces to State	-	-	90,750.55	-	52,061.88	142,812.43
4003020	Misc. Sales-Dishonored Payments	30.00	60.00	-	-	60.00	150.00
	Total Sales of Prop. & Commodities	30.00	60.00	90,750.55	-	52,121.88	142,962.43
	Total Revenue	104,185.00	96,285.00	190,600.55	96,010.00	127,226.88	614,307.43
5011000	Personal Services						
5011100	Employee Benefits						
5011110	Employer Retirement Contrib.	1,871.40	1,285.02	1,285.02	1,046.67	808.32	6,296.43
5011120	Fed Old-Age Ins- Sal St Emp	1,330.08	722.56	760.99	653.56	492.33	3,959.52
5011130	Fed Old-Age Ins- Wage Earners	889.48	358.68	323.82	706.73	879.52	3,158.23
5011140	Group Insurance	185.67	127.50	127.50	104.35	81.20	626.22
5011150	Medical/Hospitalization Ins.	4,328.50	2,965.00	2,965.00	2,385.50	1,806.00	14,450.00
5011160	Retiree Medical/Hospitalizatn	167.22	114.84	114.84	93.99	73.14	564.03
5011170	Long term Disability Ins	93.54	64.24	64.24	52.58	40.92	315.52
	Total Employee Benefits	8,865.89	5,637.84	5,641.41	5,043.38	4,181.43	29,369.95
5011200	Salaries						
5011230	Salaries, Classified	14,315.07	9,732.34	9,732.34	7,965.46	6,198.58	47,943.79
5011250	Salaries, Overtime	-	442.84	944.73	1,161.95	679.02	3,228.54
	Total Salaries	14,315.07	10,175.18	10,677.07	9,127.41	6,877.60	51,172.33
5011380	Deferred Compnstn Match Pmts	60.00	40.00	40.00	40.00	40.00	220.00
	Total Special Payments	60.00	40.00	40.00	40.00	40.00	220.00
5011400	Wages						-
5011410	Wages, General	11,627.27	4,688.40	4,233.19	8,816.44	11,497.00	40,862.30
5011430	Wages, Overtime	-	-	-	421.94	-	421.94

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 11200 - Certified Nurse Aides

For the Period Beginning July 1, 2017 and Ending November 30, 2017

Account Number	Account Description	July	August	September	October	November	Total
	Total Wages	11,627.27	4,688.40	4,233.19	9,238.38	11,497.00	41,284.24
5011600	Terminatn Personal Svce Costs						
5011620	Salaries, Annual Leave Balanc	4,065.07	-	-	-	-	4,065.07
5011640	Salaries, Cmp Leave Balances	74.52	-	-	-	-	74.52
5011660	Defined Contribution Match - Hy	40.59	27.86	27.86	27.86	27.86	152.03
	Total Terminatn Personal Svce Costs	4,180.18	27.86	27.86	27.86	27.86	4,291.62
	Total Personal Services	39,048.41	20,569.28	20,619.53	23,477.03	22,623.89	126,338.14
5012000	Contractual Svs						-
5012100	Communication Services						-
5012110	Express Services	-	-	-	5.71	-	5.71
5012140	Postal Services	3,316.70	5,322.67	4,018.19	4,857.97	5,047.55	22,563.08
5012150	Printing Services	-	-	273.27	-	-	273.27
5012160	Telecommunications Svcs (VITA)	34.00	35.36	-	-	-	69.36
	Total Communication Services	3,350.70	5,358.03	4,291.46	4,863.68	5,047.55	22,911.42
5012400	Mgmnt and Informational Svcs						
5012420	Fiscal Services	2,212.19	1,953.32	1,930.37	3,442.48	1,555.60	11,093.96
5012440	Management Services	-	170.39	-	(3.00)	-	167.39
	Total Mgmnt and Informational Svcs	2,212.19	2,123.71	1,930.37	3,439.48	1,555.60	11,261.35
5012600	Support Services						
5012660	Manual Labor Services	254.37	419.83	148.65	303.29	292.15	1,418.29
5012670	Production Services	1,627.17	2,071.45	1,059.51	1,534.11	2,146.76	8,439.00
5012680	Skilled Services	1,806.91	-	1,290.65	1,548.78	1,290.65	5,936.99
	Total Support Services	3,688.45	2,491.28	2,498.81	3,386.18	3,729.56	15,794.28
5012800	Transportation Services						
5012820	Travel, Personal Vehicle	548.66	241.47	69.55	579.96	1,403.94	2,843.58
5012830	Travel, Public Carriers	-	-	-	-	116.60	116.60
5012840	Travel, State Vehicles	50.66	127.32	-	127.32	163.40	468.70
5012850	Travel, Subsistence & Lodging	490.56	-	-	309.12	726.34	1,526.02
5012880	Trvl, Meal Reimb- Not Rprtble	144.50	-	-	296.50	569.75	1,010.75
	Total Transportation Services	1,234.38	368.79	69.55	1,312.90	2,980.03	5,965.65

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 11200 - Certified Nurse Aides

For the Period Beginning July 1, 2017 and Ending November 30, 2017

Account Number	Account Description	July	August	September	October	November	Total
	Total Contractual Svs	10,485.72	10,341.81	8,790.19	13,002.24	13,312.74	55,932.70
5013000	Supplies And Materials						
5013100	Administrative Supplies						-
5013120	Office Supplies	-	45.99	60.73	44.43	238.73	389.88
	Total Administrative Supplies	-	45.99	60.73	44.43	238.73	389.88
5013200	Energy Supplies						
5013230	Gasoline	-	-	-	-	7.29	7.29
	Total Energy Supplies	-	-	-	-	7.29	7.29
	Total Supplies And Materials	-	45.99	60.73	44.43	246.02	397.17
5015000	Continuous Charges						
5015300	Operating Lease Payments						
5015340	Equipment Rentals	-	-	-	-	5.29	5.29
5015350	Building Rentals	-	13.62	-	-	14.40	28.02
5015390	Building Rentals - Non State	2,371.88	2,776.45	2,427.96	2,371.88	2,643.62	12,591.79
	Total Operating Lease Payments	2,371.88	2,790.07	2,427.96	2,371.88	2,663.31	12,625.10
	Total Continuous Charges	2,371.88	2,790.07	2,427.96	2,371.88	2,663.31	12,625.10
	Total Expenditures	51,906.01	33,747.15	31,898.41	38,895.58	38,845.96	195,293.11
	Allocated Expenditures						
20400	Nursing / Nurse Aid	2,007.92	1,438.07	1,352.45	2,067.60	5,784.71	12,650.75
30100	Data Center	22,293.19	7,500.99	19,761.85	18,382.20	7,102.94	75,041.17
30200	Human Resources	69.93	75.91	63.01	85.41	12,926.36	13,220.63
30300	Finance	29,246.36	14,731.13	14,372.19	8,024.29	19,327.31	85,701.28
30400	Director's Office	9,455.42	7,260.77	6,686.29	7,118.22	6,887.85	37,408.55
30500	Enforcement	87,807.80	52,289.22	45,269.69	45,345.15	45,748.59	276,460.44
30600	Administrative Proceedings	22,350.10	12,528.19	14,149.43	12,351.42	15,521.44	76,900.59

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 11200 - Certified Nurse Aides

For the Period Beginning July 1, 2017 and Ending November 30, 2017

Account Number	Account Description	July	August	September	October	November	Total
30700	Impaired Practitioners	173.65	107.79	118.80	99.76	97.55	597.55
30800	Attorney General	-	-	258.33	258.33	-	516.67
30900	Board of Health Professions	5,484.22	3,772.44	3,383.98	3,862.59	3,956.39	20,459.62
31400	Conference Center	13.61	25.82	20,005.53	(2,362.71)	(6,963.33)	10,718.92
31500	Pgm Devlpmnt & Implmentn	4,278.98	3,642.97	3,355.48	3,593.17	4,109.30	18,979.90
	Total Allocated Expenditures	183,181.17	103,373.29	128,777.05	98,825.44	114,499.12	628,656.06
	Net Revenue in Excess (Shortfall) of Expenditures	$ (130,902.18)	$ (40,835.44)	$ 29,925.09	$ (41,711.02)	$ (26,118.20)	$ (209,641.74)

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 20400 - Nursing / Nurse Aide

For the Period Beginning July 1, 2017 and Ending November 30, 2017

Account Number	Account Description	Amount	Budget	Amount Under/(Over) Budget	% of Budget
5011130	Fed Old-Age Ins- Wage Earners	1,090.40	3,095.00	2,004.60	35.23%
	Total Employee Benefits	1,090.40	3,095.00	2,004.60	35.23%
5011300	Special Payments				
5011340	Specified Per Diem Payment	5,400.00	24,550.00	19,150.00	22.00%
	Total Special Payments	5,400.00	24,550.00	19,150.00	22.00%
5011400	Wages				
5011410	Wages, General	14,253.61	40,448.00	26,194.39	35.24%
	Total Wages	14,253.61	40,448.00	26,194.39	35.24%
5011930	Turnover/Vacancy Benefits		-	-	0.00%
	Total Personal Services	20,744.01	68,093.00	47,348.99	30.46%
5012000	Contractual Svs				
5012400	Mgmnt and Informational Svcs				
5012470	Legal Services	-	4,110.00	4,110.00	0.00%
	Total Mgmnt and Informational Svcs	-	4,110.00	4,110.00	0.00%
5012600	Support Services				
5012640	Food & Dietary Services	-	10,598.00	10,598.00	0.00%
5012680	Skilled Services	-	10,000.00	10,000.00	0.00%
	Total Support Services	-	20,598.00	20,598.00	0.00%
5012800	Transportation Services				
5012820	Travel, Personal Vehicle	7,345.61	16,757.00	9,411.39	43.84%
5012830	Travel, Public Carriers	108.69	39.00	(69.69)	278.69%
5012850	Travel, Subsistence & Lodging	6,922.23	13,828.00	6,905.77	50.06%
5012880	Trvl, Meal Reimb- Not Rprtble	3,682.50	6,546.00	2,863.50	56.26%
	Total Transportation Services	18,059.03	37,170.00	19,110.97	48.58%
	Total Contractual Svs	18,059.03	61,878.00	43,818.97	29.18%
5013000	Supplies And Materials				
5013600	Residential Supplies				
5013620	Food and Dietary Supplies	-	14.00	14.00	0.00%
	Total Residential Supplies	-	14.00	14.00	0.00%
	Total Supplies And Materials	-	14.00	14.00	0.00%
5022000	Equipment				
5022600	Office Equipment				
5022620	Office Furniture	-	2,100.00	2,100.00	0.00%
	Total Office Equipment	-	2,100.00	2,100.00	0.00%
	Total Equipment	-	2,100.00	2,100.00	0.00%
	Total Expenditures	38,803.04	132,085.00	93,281.96	29.38%

Virginia Department of Health Professions

Revenue and Expenditures Summary

Department 20400 - Nursing / Nurse Aide

For the Period Beginning July 1, 2017 and Ending November 30, 2017

Account Number	Account Description	July	August	September	October	November	Total
5011000	Personal Services						
5011100	Employee Benefits						
5011130	Fed Old-Age Ins- Wage Earners	183.62	166.28	96.44	188.36	455.70	1,090.40
	Total Employee Benefits	183.62	166.28	96.44	188.36	455.70	1,090.40
5011300	Special Payments						
5011340	Specified Per Diem Payment	1,550.00	600.00	250.00	1,700.00	1,300.00	5,400.00
	Total Special Payments	1,550.00	600.00	250.00	1,700.00	1,300.00	5,400.00
5011400	Wages						-
5011410	Wages, General	2,400.49	2,173.36	1,260.81	2,462.19	5,956.76	14,253.61
	Total Wages	2,400.49	2,173.36	1,260.81	2,462.19	5,956.76	14,253.61
	Total Personal Services	4,134.11	2,939.64	1,607.25	4,350.55	7,712.46	20,744.01
5012000	Contractual Svs						-
5012800	Transportation Services						
5012820	Travel, Personal Vehicle	1,529.04	1,211.26	361.66	2,557.85	1,685.80	7,345.61
5012830	Travel, Public Carriers	108.69	-	-	-	-	108.69
5012850	Travel, Subsistence & Lodging	1,134.10	1,237.20	912.04	1,478.48	2,160.41	6,922.23
5012880	Trvl, Meal Reimb- Not Rprtble	925.25	496.00	118.50	1,306.50	836.25	3,682.50
	Total Transportation Services	3,697.08	2,944.46	1,392.20	5,342.83	4,682.46	18,059.03
	Total Contractual Svs	3,697.08	2,944.46	1,392.20	5,342.83	4,682.46	18,059.03
	Total Expenditures	7,831.19	5,884.10	2,999.45	9,693.38	12,394.92	38,803.04

2017 Monthly Tracking Log

License Count

Nursing	Dec-16	Jan-17	Feb - 17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Total
Pres Auth	6,366	6,417	6,468	6,572	6,605	6,650	6,724	6,840	6,921	7,026	7,070	7,123	7,141	
Massage Therapy	8,097	8,175	8,219	8,253	8,258	8,282	8,312	8,341	8,392	8,449	8,489	8,525	8,521	
Medication Aide	5,909	5,967	5,885	6,014	6,046	6,083	6,082	6,095	6,139	6,259	6,236	6,233	6,226	
Clinical Nurse Spec	440	439	440	441	441	440	440	437	435	436	435	434	431	
Nurse Practitioner	9,290	9,384	9,469	9,556	9,585	9,633	9,716	9,897	9,970	10,095	10,116	10,154	10,159	
Practical Nurse	29,379	29,319	29,259	29,276	29,199	29,137	29,103	29,116	29,129	29,193	29,151	29,105	29,014	
Registered Nurse	105,254	105,598	105,633	105,989	105,830	105,942	106,402	107,114	107,631	107,851	107,721	107,730	107,676	
Total for Nursing	164,735	165,299	165,373	166,101	165,964	166,167	166,779	167,840	168,617	169,309	169,218	169,304	169,168	
Nurse Aide	52,376	52,842	52,564	52,884	52,530	52,350	51,663	51,511	51,660	52,136	51,996	52,078	52,151	
Advanced Nurse Aide	71	70	68	66	67	65	64	62	62	61	60	60	60	
Total for Nurse Aide	52,447	52,912	52,632	52,950	52,597	52,415	51,727	51,573	51,722	52,197	52,056	52,138	52,211	
Total	217,182	218,211	218,005	219,051	218,561	218,582	218,506	219,413	220,339	221,506	221,274	221,442	221,379	

Open Cases Count

Nursing	1033	995	1004	1061	1072	1081	1100	1033	1082	1173	1123	1118	1133	
Nurse Aide	358	343	341	350	343	349	370	389	411	438	452	446	450	
Total	1,391	1,338	1,345	1,411	1,415	1,430	1,470	1,422	1,493	1,611	1,575	1,564	1,583	

Rec'd RN	66	53	74	86	90	64	86	69	71	85	84	66	59	887
Rec'd PN	44	32	46	46	42	49	42	33	30	41	55	29	34	479
Rec'd NP, AP, CNS	9	20	12	36	16	15	17	20	27	26	20	32	27	268
Rec'd LMT	2	7	2	5	6	1	3	2	2	6	5	4	6	49
Rec'd RMA	11	6	6	6	9	10	10	7	15	16	10	4	4	103
Rec'd Edu Program	3	2	2	5	2	0	4	0	2	1	1	1	1	21
Total Rec'd Nursing	135	120	142	184	165	139	162	131	147	175	175	136	131	1,807
Closed RN	90	57	95	73	61	78	61	84	46	52	90	79	75	851
Closed PN	58	22	71	35	47	54	26	72	28	19	43	35	38	490
Closed NP, AP, CNS	52	14	10	18	19	21	21	10	11	0	31	22	20	197
Closed LMT	3	5	6	7	1	7	4	3	4	3	3	2	1	46
Closed RMA	8	10	10	10	5	6	8	3	11	9	9	6	8	95
Closed Edu Program	0	4	2	2	0	1	3	2	0	1	0	5	6	26
Total Closed Nursing	211	112	194	145	133	167	123	174	100	84	176	149	148	1,705
Nurse Aide														
Received	55	45	59	69	56	52	50	39	55	51	43	33	31	583
Rec'd Edu Program	0	0	0	0	0	0	1	1	0	0	2	0	0	4
Total Rec'd CNA	55	45	59	69	56	52	51	40	55	51	45	33	31	587
Closed	79	60	65	64	72	63	26	27	35	34	29	38	33	546
Closed Edu Program	0	0	0	1	0	0	0	1	0	0	0	0	0	2
Total Closed CNA	79	60	65	65	72	63	26	28	35	34	29	38	33	548

HPMP Monthly Census Report
Active Cases December 31, 2017

Board	Board Participants	License	Count of ID	% with this license
Nursing	279	LPN	35	7.9
Nursing	279	RN	226	50.8
Nursing	279	LNP	17	3.8
Nursing	279	Massage Ther	1	0.2
			279	**62.7**
Nursing	5	CNA	5	1.1
			5	**1.1**
Medicine	112	DO	9	2.0
Medicine	112	Intern/Resident	6	1.3
Medicine	112	MD	76	17.1
Medicine	112	PA	7	1.6
Medicine	112	Lic Rad Tech	2	0.4
Medicine	112	DC	3	0.7
Medicine	112	OT	3	0.7
Medicine	112	RT	4	0.9
Medicine	112	DPM	1	0.2
Medicine	112	LBA	1	0.2
			112	**25.2**
Pharmacy	16	Pharmacist	16	3.6
			16	**3.6**
Dentistry	15	DDS	10	2.2
Dentistry	15	DMD	1	0.2
Dentistry	15	RDH	4	0.9
			15	**3.4**
Social Work	5	LCSW	**5**	**1.1**
Psychology	3	LCP	2	0.4
	3	SOTP	1	0.2
			3	**0.7**
Counseling	1	LPC	**1**	**0.2**
Funeral Directors and Embalmers	1	FSL	**1**	**0.2**
Optometry	2	OD	**2**	**0.4**
Veterinary Medicine	1	DVM	**1**	**0.2**
Audiology & Speech-Language Path	1	SLP	**1**	**0.2**
Physical Therapy	4	PT	1	0.2
Physical Therapy	4	PTA	3	0.7
			4	**0.9**
TOTALS			**445.00**	**100.0**

Virginia Board of Nursing

Executive Director Report

January 30, 2018

Meetings/Speaking Engagements

- **Nurse Aide Education Train-the-trainer presentation -** Dr. Paula Saxby, Deputy Executive Director for the Board of Nursing, presented information at a train-the-trainer course for nurse aide educators on November 28, 2017 in Richmond. Topics of the presentation included nurse aide testing, nurse aide education program curriculum, principles of delegation, application and review process for approved nurse aide education programs, new NNAAP testing process, and history of the nurse aide registry in Virginia. There were 12 nurse aide educators in attendance.

- **University of Virginia (UVA), Clinical Nurse Leader (CNL) program presentation** - Dr. Paula Saxby, Deputy Executive Director for the VA Board of Nursing was invited to present information to the senior nursing students in the CNL program at UVA on November 30, 2017 in Charlottesville. Dr. Saxby presented information on the Board of Nursing, Board Members, Laws and Regulations, Licensure by Exam, and the NCLEX exam. There were approximately 40 nursing students in attendance.

- Jay P. Douglas, Executive Director for Board of Nursing, met with Melissa Hunt, Nursing Director for Hospital Pain Management at VCU Health System, and Kathy Sheehy, Clinical Program Director for Hospital Pain Management at VCU Health System, on November 29, 2017. The focus of the meeting was to discuss the roles in RN's and scope of practice related to VCU's Pain Management Program.

- Jay P. Douglas, Executive Director for Board of Nursing, met with Marjorie Lyne, Associate Director for Patient Care Services at Hunter Holmes McGuire, on November 30, 2017. The focus of the meeting was for the VAMC to gain better understanding of the nursing standards and scope of practice.

- Jay P. Douglas, Executive Director for Board of Nursing, provided training to the Virginia Health Practitioners' Monitoring Program (HPMP) staff on December 1, 2017 regarding the Enhanced Nurse Licensure Compact (eNLC).

- **Virginia Nurses Association (VNA) Board of Directors (BOD) Meeting on Monday, December 4, 2017** – Jay P. Douglas, Executive Director for Board of Nursing, provided and updated on the Board of Nursing.

- On Monday, December 4, 2017, Brenda Krohn, Deputy Executive Director for Board of Nursing, and Beoncia Johnson, RMA Licensing Staff for Board of Nursing, participated in a webinar with PSI and the SMEs (Subject Matter Experts) that have volunteered to participate in a review of the RMA Exam.

- **The DHP/HHR Opioid Curricula Workgroup - Non-Prescribers Meeting On Tuesday, December 5, 2017** - Jay P. Douglas, Executive Director for Board of Nursing, and Charlette Ridout, Senior Nursing Education Consultant, participated in meeting. The workgroup focused on development of core competency topics in addiction, opioids and pain management for the educational programs who prepare non-prescribing healthcare professionals.

- On Wednesday, December 6, 2017, Charlette Ridout, Senior Nursing Education Consultant presented at the Bon Secours Medical Group LPN Continuing Education Summit held in Williamsburg. Ms. Ridout presented information on the Board of Nursing, Board Members, Laws, Regulations, Guidance Documents and the LPN scope of practice. There were approximately 25 LPN's in attendance for both the morning and afternoon presentations.

- **Meeting with VHHA, Thursday, December 7, 2017** - Jay P. Douglas, Board Executive Director, Dr. Paula Saxby, Board Deputy Executive Director, and Stephanie Willinger, Board Deputy Executive Director for Licensure, met with Barbara Brown from VHHA to review the analysis of licensure data that VHHA had requested.

- **eNLC Commission Executive Committee Meeting in GA on December 12 – 14, 2017** - Jay P. Douglas, Board Executive Director, attended a meeting regarding implementation of the Enhanced Nurse Licensure Compact (eNLC).

- **eNLC Legal Forum on January 4, 2018** – Jay P. Douglas, Executive Director, and Stephanie Willinger, Deputy Executive Director for Licensing, for the Virginia Board of Nursing attended the NCSBN Enhanced Nurse Licensure Compact (eNLC) Legal Forum in Chicago. The focus was on The Legal Authority of Rulemaking for The Commission in preparation for the new version of the Compact. Board Counsel was unable to attend this meeting.

- Brenda Krohn, Deputy Executive Director for the Board of Nursing, and Lisa Spellar-Davis, Policy Assistant for the Board of Nursing, attended the Assisted Living Facility (ALF) Stakeholder's Meeting on January 24, 2018. Discussions were about Department of Ageing and Rehabilitative Services (DARS)Auxiliary Grant Program, Department of Social Services (DSS) Comprehensive Revision of Standard for Licensed ALFs, specially looking at medication management and restraint training for staff, and update from the Board of Long Term Care Administrators. The next meeting is scheduled for April 25, 2018 at 2 pm.

Presentations provided by Board Staff in 2017 → 20 total:

12/6/2017 – Charlette Ridout @ Bon Secours Medical Group LPN Continuing Education Summit

11/30/2017 – Paula Saxby @ UVA Clinical Nurse Leader (CNL) Program

11/29/2017 – Jay Douglas @ Hunter Holmes McGuire

11/28/2017 – Paula Saxby @ Richmond Nurse Aide Education Train-the-Trainer

11/17/2017 - Jay Douglas @ Virginia Organization of Executives and Leaders (VONEL)

11/13/2017 – Charlette Ridout @ J. Sargent Reynolds Community College

10/26/2017 – Jodi Power @ Virginia Association of Healthcare Quality's 40th Annual Education Conference in Richmond

10/26/2017 – Charlette Ridout @ Piedmont Community College

9/26/2017 – Paula Saxby @ Charlottesville Nurse Aide Education Train-the-Trainer

9/14/2017 – Jay Douglas, Paula Saxby, and Stephanie Willinger @ Virginia Hospital and Health Care Association (VHHA)

8/21/2017 – Stephanie Willinger @ Sentara Health System

8/1/2017 – Paula Saxby @ Virginia State Simulation Alliance (VASSA)

7/11/2017 - Paula Saxby @ Richmond Nurse Aide Education Train-the-Trainer

7/10/2017 – Jay Douglas @ The Summer School Nurse Institute, Longwood University

6/30/2017 – Jay Douglas @ Medical Society of Virginia (MSV), Virginia Counsel Nurse Practitioner (VCNP), and Delegate Robinson

5/11/2017 – Jay Douglas @ Southside Regional Medical Center in Colonial Height

4/29/2017 – Paula Saxby @ Virginia League for Nursing (VLN) in Charlottesville

4/28/2017 – Jay Douglas @ VCU Students Nurse Practitioners

3/9/2017 - Paula Saxby @ Richmond Nurse Aide Education Train-the-Trainer

2/16/2017 – Paula Saxby and Charlette Ridout @ Averett University Education Presentation in Danville

Board of Nursing January 1 - December 31, 2017 Licensure & Discipline Statistics

License/Certification/Registration Application Count

Nurse Practitioner	1,349
Authorization to Prescribe	1,030
Clinical Nurse Spec	20
Registered Nurse	7,327
Repeat Registered Nurse	249
Practical Nurse	1,605
Repeat Practical Nurse	60
Licensed Massage Therapy	1,050
Medication Aide	1,537
Total for Nursing	**14,227**

Nurse Aide	8383
Advanced Certified Nurse Aide	98
Total for Nurse Aide	**8,481**

Grand Total - 22,708

Issued License Count

Nursing	
Nurse Practitioner	1,364
Authorization to Prescribe	1,042
Clinical Nurse Spec	15
Registered Nurse	8,204
Practical Nurse	1,451
Lisensed Massage Therapy	994
Medication Aide	864
Total for Nursing	**13,934**

Nurse Aide	7,372
Total for Nurse Aide	**7,372**

Grand Total - 21,306

Informal Conference and Formal Hearing Count

Nurse Aide IFC	281
Nursing IFC	463
Total IFC	**744**
Nurse Aide FH	22
Nursing FH	128
Total FH	**150**

Case Received and Closed Counts

Rec'd RN	920
Rec'd PN	495
Rec'd NP, AP, CNS	288
Rec'd LMT	51
Rec'd RMA	115
Rec'd Edu Program	25
Total Rec'd Nursing	**1894**
Closed RN	882
Closed PN	502
Closed NP, AP, CNS	240
Closed LMT	47
Closed RMA	101
Closed Edu Program	24
Total Closed Nursing	**1796**

Nurse Aide	
Received	627
Rec'd Edu Program	4
Total Rec'd CNA	**631**
Closed	554
Closed Edu Program	2
Total Closed CNA	**724**

Items Accomplished by eNLC Implementation Team and Other Key Staff

- Communication with stakeholders
  - Mailings to licensees, employers and education programs by NCSBN
  - Website updates
  - Notified those approved by written authorization to practice outside home state on SS license of legal cessation of process
  - Provide FAQs to DHP call center for use by staff to field questions from public / website
  - Maintain BON/DHP website links to eNLC official websites
- Training
  - Face-to-face training for BON staff, (2x) + mandatory online NCSBN course (also made available to Board members online)
  - Endorsement and exam staff, face-to-face
  - APD staff, and various agency staff
  - HPMP staff, face-to-face
  - DHP Reception training related to instructions on applications
  - NCSBN webinars for employers
- MLO
  - IT communications b/n NCSBN & DHP staff
  - Adjustments to MLO fields
  - Creation of upload configurations to data submission file
  - Test file submitted; final file submitted 1/19
  - Report of anticipated # of licenses that will change from MSP to SS
- Licensure
  - Verified data on MLO re single-state reason codes for applicants after 7/20/2017 – 8/15/2017; working on 8/15 to current; exam and endorsement staff given spread sheets
  - Bullet point checklists for staff
  - Q&A's for use by staff to field questions
  - Changes to applications: regarding meeting of all ULR's before MSP is issued
- Applications
  - Changes to online and paper applications (exam and endorsement, initial, reinstatement and renewal): regarding meeting of all ULR's before MSP is issued – 1/19/18
  - Renewal question changes re: attestation of meeting all ULR's
- Discipline
  - Ensure non-routine application reviewers make determination on SS vs. MSP license
  - Determine a process for how to change SS to MSP for people successfully completing HPMP (ordered and volunteer) and/or probation
- New *The Interstate Commission of Nurse Licensure Compact Administrators* Final Rules adopted 12/12/17; effective 1/19/2018
- HPMP:
  - No more out of state practice agreements
  - Licenses must be issued on other states to practice in other states while under contracts; impact on secondary monitoring
  - Changes needed to HPMP contracts: "must disclose whether they're in alternative program" … will be covered by renewal/application questions.

In process:

- *The Interstate Commission of Nurse Licensure Compact Administrators* Final Rules adopted 12/12/17; effective 1/19/2018
  - Update(s) on website
  - Amendment to current VA MSP regulations after 1/19 – *Board action 1/30/2018*
- NLC Team: Meet intermittently to compare finalized rules with draft changes to all processes
- Letters
  - Template letters -- Ensure temporary license letters specifies only SS license
  - Write-back letters if applicant is found to not be qualified for MSP – "If there's additional info you wish us to review in order to obtain a MSP, please provide us with this information"
- Discipline
  - Change boilerplate on orders / terms in templates
- Changes needed to HPMP contracts: HPMP contracts will require participants to request of specific Virginia BON staff, unquestioned, a SS license. – TBD – Boar*d Counsel advice*

VIRGINIA BOARD OF NURSING
MASSAGE THERAPY ADVISORY BOARD
MINUTES

Tuesday, November 7, 2017

TIME AND PLACE: The meeting of the of the Massage Therapy Advisory Board convened at 10:30 a.m. in Board Room 3, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Joseph L. Schibner, IV, L.M.T., L.Ac., D.O.M., Chair

MEMBERS PRESENT:
Joseph L. Schibner, IV, L.M.T., L.Ac., D.O.M., Chair
Stephanie Quinby, L.M.T., Co-Chair
Dawn Hogue, L.M.T.
Kristina Page, L.M.T.
Jermaine Mincey, Citizen Member

STAFF PRESENT:
Jay P. Douglas, R.N., M.S.M., C.S.A.C., F.R.E., Executive Director
Brenda Krohn, R.N., M.S., Deputy Executive Director
Latasha Austin, Administrative Specialist
Robin L. Hills, R.N., D.N.P., W.H.N.P.

IN THE AUDIENCE:
Becky Bowers-Lanier, American Massage Therapy Association-VA Chapter
Jennifer Kupiec, President, American Massage Therapy Association-VA Chapter

ESTABLISHMENT OF A QUORUM: With 5 members of the Massage Therapy Advisory Board present, a quorum was established.

CALL TO ORDER: Dr. Schibner called the business meeting to order at 10:32 a.m.

OLD BUSINESS: An overview was done of the minutes from the last Massage Therapy Advisory Board meeting held on December 1, 2016. Ms. Hogue moved that the minutes from the December 1, 2016 meeting be approved. The motion was seconded by Ms. Quinby and carried unanimously.

PUBLIC COMMENT: Ms. Bowers-Lanier introduced Ms. Kupiec and announced that she was the new president for the Virginia Chapter of the American Massage Therapy Association.

NEW BUSINESS: Dr. Schibner announced and congratulated Mr. Mincey on his re-appointment to the Massage Advisory Board to serve a 2nd term.

Ms. Krohn reviewed and discussed the 2018 Informal Conference Schedule for the months of January -June & the Formal Hearing dates for 2018 to determine the Massage Therapy Advisory Board Members availability.

The Massage Therapy Advisory Board reviewed and discussed Guidance Documents 90-61 and Guidance Document 90-38. The Advisory Board discussed the following proposed changes to the Guidance Documents:

- **Guidance Document 90-61**
  Proposed to remove:
  - ❖ all language in the document related to Licensed Massage Therapist, LMTs or references to a license

- **Guidance Document 90-38**
  Proposed to add:
  - ❖ Massage Therapist

Ms. Hogue made a motion that the Massage Therapy Advisory Board recommend to the Board of Nursing to accept to propose recommended changes to remove Licensed Massage Therapist from Guidance Document 90-61 and to add Licensed Massage Therapist to Guidance Document 90-38. The motion was seconded by Ms. Quinby and carried unanimously.

REPORTS:

Ms. Douglas gave a report on the criminal background check (CBC) requirement for massage therapist applicants by initial licensure, endorsement and reinstatement that was effective as of January 1, 2017. The report covered statistics from January 1, 2017- October 1, 2017.

- A total of 802 LMT applicants initiated the CBC process for this reporting period
- A total of 352 LMT applicants had convictions (disclosed and non-disclosed)
- A total of 220 LMT applicants self-disclosed their criminal convictions on their applications
- A total of 132 LMT applicants non-disclosed their criminal convictions on their applications

Ms. Krohn reviewed with the Advisory Board the current number of disciplinary cases for all licensees regulated by the Board of Nursing.

Ms. Austin gave a report on the number of massage therapist licensed by the Board of Nursing. The report covered statistics from January 1, 2017-October 1, 2017.

- As of October 1, 2017 there were 8,449 massage therapist currently active in Virginia
- A total of 754 new massage therapist licenses were issued for this reporting period
- A total of 796 new applications (for initial licensure & by endorsement-paper & online) has been received
  - ❖ *of the 796, 763 were online applications*
- A total of 109 duplicate license request has been received for this reporting period
- A total of 20 duplicate wall certificate request

- A total of 214 verification request had been received and processed
- A total of 1 reinstatement application after discipline had been received
- A total of 42 reinstatement applications for licensure as a massage therapist
- A total of 2,574 renewals had been completed for this reporting period

Ms. Austin gave an oral report re-capping the Federation of State Massage Therapy Boards (FSMTB) Annual Meeting that was held in Tampa, FL, September 28-30, 2017.

Ms. Hogue gave an oral report on the Federation of State Massage Therapy Boards Human Trafficking Task Force and the release of the Human Trafficking Task Force Report. The report is available on the FSMTB website at www.fsmtb.org

Ms. Douglas gave a report on the current regulatory action- period review related to regulations governing the licensure of massage therapist. At the time of this report the regulatory actions were at the secretary's office pending approval. Notification will be made and posted on the Board of Nursing website when the regulatory actions have passed.

DISCUSSION OF FUTURE MEETINGS:

Board staff will coordinate with the Massage Therapy Advisory Board members on availability and confirm exact date when possible.

ADJOURNMENT:

Mr. Schibner made a motion to conclude the meeting. The motion was seconded by Ms. Page and carried unanimously. The meeting was adjourned at 11:36 a.m.

Brenda Krohn, R.N., M.S
Deputy Executive Director

TO: BOARD OF NURSING

FROM: BRENDA KROHN RN, MS
DEPUTY EXECUTIVE DIRECTOR

DATE: JANUARY 30, 2018

RE: LMT ADVISORY BOARD RECOMMENDATION

Please find attached copies of the current Guidance Document 90-38, *Disposition of Disciplinary Cases against Nurses Practicing on Expired Licenses* and Guidance Document 90-61, *Disposition of Disciplinary Cases against Certified Nurse Aides, Registered Medication Aides, and Licensed Massage Therapist Practicing on Expired Certification/Registration/Licenses.*

The advisory board reviewed these two guidance documents in light of the recent change from "Certified" Massage Therapist to "Licensed" Massage Therapist. The recommendation is that with licensure comes more accountability and therefore LMTs should be moved to the guidance document with "licensed" RNs and LPNs and the respective penalties for practicing on an expired license.

Attached you will find the revised guidance documents to reflect this recommendation.

Please advise if you would like to approve these revisions to these two guidance document.
Thank you for your consideration.

VIRGINIA BOARD OF NURSING

Disposition of Disciplinary Cases against Nurses Practicing on Expired Licenses

The Board of Nursing delegates to Board discipline staff the authority to offer a prehearing consent order in cases of nurses practicing on expired licenses.

The staff shall use the following when preparing prehearing consent orders:

Practice on an expired license for 30 days or less would result in a $100 monetary penalty.

Practice on an expired license for 31 – 90 days would result in a $200 monetary penalty.

Practice on an expired license for 91 – 180 days would results in a $300 monetary penalty.

Practice on an expired license 6 months – 12 months would results in a $500 monetary penalty.

Practice on an expired license greater than one year would result in a Reprimand and a $500 monetary penalty.

In cases where there is suspicion of a willful act, the licensee will be scheduled for an informal conference.

Adopted: May 11, 1999
Revised: November 18, 2003; March 21, 2007; May 15, 2012; January 29, 2013

VIRGINIA BOARD OF NURSING

Disposition of Disciplinary Cases against Nurses and Massage Therapist Practicing on Expired Licenses

The Board of Nursing delegates to Board discipline staff the authority to offer a prehearing consent order in cases of nurses or massage therapist practicing on expired licenses.

The staff shall use the following when preparing prehearing consent orders:

Practice on an expired license for 30 days or less would result in a $100 monetary penalty.

Practice on an expired license for 31 – 90 days would result in a $200 monetary penalty.

Practice on an expired license for 91 – 180 days would results in a $300 monetary penalty.

Practice on an expired license 6 months – 12 months would results in a $500 monetary penalty.

Practice on an expired license greater than one year would result in a Reprimand and a $500 monetary penalty.

In cases where there is suspicion of a willful act, the licensee will be scheduled for an informal conference.

Adopted: May 11, 1999
Revised: November 18, 2003; March 21, 2007; May 15, 2012; January 29, 2013; January 30, 2018

VIRGINIA BOARD OF NURSING

Disposition of Disciplinary Cases against Certified Nurse Aides, Registered Medication Aides and Licensed Massage Therapists Practicing on Expired Certificates/Registrations/ Licenses

The Board of Nursing delegates to Board discipline staff the authority to offer a prehearing consent order in cases of CNAs, RMAs or LMTs practicing on expired certificates, registrations or licenses.

The staff shall use the following when preparing prehearing consent orders:

Practice on an expired certificate, registration or license for 30 days or less would result in an advisory letter.

Practice on an expired certificate, registration or license for 31 – 90 days would result in a $50 monetary penalty.

Practice on an expired certificate, registration or license for 91 – 180 days would result in a $100 monetary penalty.

Practice on an expired certificate, registration or license for 6 months – 12 months would result in a $150 monetary penalty.

Practice on an expired certificate, registration or license for greater than one year would result in a Reprimand and a $150 monetary penalty.

In cases where there is suspicion of a willful act, the certificate holder, registrant or licensee will be scheduled for an informal conference.

Adopted: May 15, 2012
Revised: October 4, 2017

VIRGINIA BOARD OF NURSING

Disposition of Disciplinary Cases against Certified Nurse Aides and Registered Medication Aides Practicing on Expired Certificates or Registrations

The Board of Nursing delegates to Board discipline staff the authority to offer a prehearing consent order in cases of CNAs or RMAs practicing on expired certificates or registrations.

The staff shall use the following when preparing prehearing consent orders:

Practice on an expired certificate or registration for 30 days or less would result in an advisory letter.

Practice on an expired certificate or registration for 31 – 90 days would result in a $50 monetary penalty.

Practice on an expired certificate or registration for 91 – 180 days would result in a $100 monetary penalty.

Practice on an expired certificate or registration for 6 months – 12 months would result in a $150 monetary penalty.

Practice on an expired certificate or registration for greater than one year would result in a Reprimand and a $150 monetary penalty.

In cases where there is suspicion of a willful act, the certificate holder, or registrant will be scheduled for an informal conference.

Adopted: May 15, 2012
Revised: October 4, 2017; January 30, 2018

VIRGINIA BOARD OF NURSING
Nominating Committee
November 14, 2017
Minutes

TIME AND PLACE: The meeting of the Nominating Committee was called to order at 1:15 pm on November 14, 2017, at Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 4, Henrico, Virginia.

MEMBERS PRESENT: Mark Monson, Citizen Member, Chair
Dustin Ross, DNP, MBA, RN, NE-BC
Michelle Hereford, MSHA, RN, FACHE

STAFF PRESENT: Jay P. Douglas, MSM, RN, CSAC, FRE; Executive Director

DISCUSSION: The Committee appointed Mr. Monson as Chair. Committee members reviewed their discussion with individual Board members, polling them regarding their interest in certain positions. The Committee agreed to the following slate of Board Members who are interested in running for office for 2018:

President: Louise Hershkowitz, CRNA, MSHA
(2nd term expires 2021)

First Vice President: Marie Gerardo, MS, RN, ANP-BC
(1st term expires 2018)
Jennifer Phelps, LPN, QMHPA
(2nd term expires 2021)
Ethlyn McQueen-Gibson, DNP, MSN, RN, BC
(1st term expires 2021)

Second Vice President: Mark Monson, Citizen Member
(1st term expires 2018)
Dustin Ross, DNP, MBA, RN, NE-BC
(1st term expires 2020)

Mr. Monson will follow up with Dr. Hahn about her interest in running for office when she returns from vacation. Mr. Monson will notify Ms. Douglas.

The Executive Director was directed by the Committee to prepare the written slate and provide the slate to all Board Members in the first mailing scheduled for January 10, 2018.

The Committee asked that Board members be reminded that nominations can be made from the floor at the annual meeting in January 2018.

ADJOURNMENT: The meeting adjourned at 2:00 P.M.

_____
Jay P. Douglas, MSM, RN, CSAC, FRE
Executive Director

Commitment to Ongoing Regulatory Excellent (CORE)

Discipline Report Summary 2016

Virginia Board of Nursing CORE Committee:

Trula Minton	Chair
Kelly McDonough	Board Member
Rebecca Poston	Board Member
Brenda Krohn	Board Staff

Introduction

The NCSBN CORE report is the result of a *'comparative performance measurement and benchmarking process'* based on collated survey data from key stakeholders in nursing regulation to include Boards of Nursing, Nurses, Employers and Educators. The CORE report aims to provide a snapshot of results related to performance measures in 4 key areas of nursing regulation: nursing practice, nursing education, nursing licensure and discipline. Evaluating effectiveness and efficiency in nursing regulation overall, both at the national level and at the individual Board of Nursing level, is the focus of CORE survey. Survey data allows individual Boards of Nursing to monitor their performance on key measures over time as well compare their performance to the national average and to like sized Boards of Nursing included in the survey. *(Source: NCSBN CORE Aggregate Report FY 2014 & 2016)*

VA State BON VOL. 2: Discipline

I. Data Collection and Processing

a. Survey was conducted between July and September of 2016 to the following groups:

   i. *RNs with Active License*: In Virginia, a random sample of 1,500 RNs were sent a hard copy of the survey and 157 responded.

   ii. *Boards of Nursing*: Nationally, 54 BONs were sent hard copies and 38 responded. Virginia responded.

   iii. *Employers*: In Virginia, 300 employers were sent hard copies and 18 responded.

   iv. *Educators*: In Virginia, 151 educators were sent hard copies and 22 responded.

b. Note that while hard copies were sent, a reminder letter was sent out to complete survey then the survey was also available electronically.

c. Outside data sources used were: NCLEX-RN/PN examination data, Nursys disciplinary data, and Member Board Profiles data.

II. Limitations

a. Includes missing or incomplete data

b. Uncertainty on how data is reported among BONs due inconsistencies which include but not limited to the following;

i. Maintain own information system,
ii. Do not track data same way,
iii. Interpretation of definitions of the measures, and
iv. Computation of the data.

c. Sampling error as there were low response rates for individual states.
d. Results in the report are descriptive data only. The data are indicators only and subject to possible problems with the validity and reliability.
e. The report should be reviewed considering low number of responses.

Points of Pride: Virginia Board of Nursing Discipline

- Employers commented that there is great communication with the Executive Director in understanding the role of BON in VA
- Educators commented that VBON is an excellent partner, resource and advocate for nursing education
- Educators commented that VBON keeps them informed of important information and offers educational updates to Program Directors
- 95% of nurses in VA indicated the BON's disciplinary process deters nurses from violating regulations
- Nurses, employers and educators in VA report that regarding the nurse practice act is current and reflects state of the art in disciplinary actions are above all board in the survey
- Nurses, employers and educators in VA report that VBON emphasize a culture of safety and promotes the reporting of errors above those of all Boards

Section X. Program Components & Resources

Budget Allocation

- Virginia BON average budget allocated for discipline was $4,082,770 in FY2016 which is considerably higher than the average budget for all umbrella boards which was $3,488,917. When considering the discipline budget allocation in context related to the size of the board as defined by number of licensees, Virginia is an outlier and falls outside of the expected range in terms of spending per complaint when compared to similar size boards.
- Budget allocation related to discipline accounts for 51% of the total budget for the Virginia BON which is comparable to the national average of 48.7% for umbrella boards.
- The average cost per investigation in FY2016 for Virginia BON was $2,700 which is comparable to the national average for umbrella boards at $2,578.

- The national average for number of FTE BON employees involved in the investigative process was 10.3 overall and 5.7 in states with an umbrella board. This measure is not reported by the Virginia BON.

Delegated Authority

- Virginia BON has delegated authority to close cases in all areas measured in the survey. The highest number of boards who indicated their BON staff has delegated authority was for expediting the closure of cases where a violation was not established (30 BONs overall).

Discipline Tools/Practices

- The Virginia BON utilizes the following practices related to discipline: online complaint submission (17 umbrella boards report they use this practice), case assignment to particular investigators (11 umbrella boards report they use this practice), interview templates (8 umbrella boards report they use this practice), report templates (12 umbrella boards report they use this practice), expedited process for admitted allegations (7 umbrella boards report they use this practice), approved guidelines, policies, or matrix for discipline (9 umbrella boards report they use this practice), delegation to subcommittee for resolution of cases (7 umbrella boards report they use this practice), and automatic suspension for noncompliance order (8 umbrella boards report they use this practice).

Qualitative Comments from Respondents

I. **More information needed to more fully understand BON role in their state**

a. *Nurses' comments:*

i. Better clarification of CEU requirements for RNs
ii. Board Member roles/responsibilities
iii. Copies of Nurse Practice Act Available
iv. Easier website
v. Utilize e-mail communication more to provide updates, current news in the field/related information
vi. Need more prominent role in supporting nurses professional judgement, dealing with unsafe work environments

b. *Employers Comments:*

i. Publications/magazines for updates
ii. Great direct communication with the Executive Director – presentations were timely and effective

c. *Educators Comments:*

i. Communicate more effectively
ii. More clarity regarding specifics of nurse practice regulations and scope of practice

iii. BON in Virginia is TOP NOTCH! Excellent partner, resource and advocate for nursing education

iv. Virginia BON keeps us well aware of important information and offers educational updates to Program Directors to keep us informed of any changes and updates. The VBON are always helpful and very responsive to my needs.

II. Activities to improve the protection of the public

a. Nurses Comments:

i. Have podcasts related to different subjects monthly, travel to hospital to provide presentations and updates, email updates on changes in laws, educational opportunities for nurses to protect themselves legally

ii. More publications

iii. Be more visible to the public

iv. Extend presence in the workplace

v. Improve timely turn around on discipline cases with updates to website – seems to take too long (i.e. 6 months)

vi. More organized service during busy times

vii. More roles/opportunities to volunteer with the BON

viii. Improve rules about nurse to patient rations in nursing homes/address safe staffing in nursing homes

ix. Entry to nursing practice must be BSN

x. BON should have role in working with challenges related to clinical placements for nursing students – particularly BSN students

d. Employers' comments:

i. APRNs should be permitted to practice to the full extent of their licensure

ii. More stringent sanctions for repeat offenders

iii. Improve School of Nursing curricula content related to professional behaviors, etc.

e. Educators' comments:

i. Allow teaching at all levels to count as credit towards continuing education

ii. Be more pro-active and guide new programs better

iii. Closer monitoring of impaired nurses & strong discipline measures

Summary of Status/Opportunities

LONGER TERM OUTCOMES

Consumers receive safe and competent care from nurses:

- In Virginia, 83.1% of nurses indicated that over 90% of the nurses they work with provide safe and competent care which was higher than the national aggregate (79%).
- Frequency that Nurses, Employers, and Educators worked with or received reports about nurses committing near misses or patient harm in 2016:
    - Nurses: VA 73.1%; All Boards 70.8%
    - Employers: VA 83.3%; All Boards 58.7%
    - Educators: VA 86.4%; All Boards 87.4%

INTERMEDIATE OUTCOMES

Nurses are deterred from violating regulations:

- In Virginia 94.8% of nurses indicated the board of nursing's disciplinary process deters nurses from violating regulations which is slightly higher than the aggregate. The percentage of employers in agreement with this state was 77.8% in VA which was slightly lower than the aggregate.
- Percent of Nurses and Employers in Agreement with the statement that the Board of Nursing's disciplinary process deters nurse from violating regulations.
    - Nurses: VA 95% strongly agree/somewhat agree; All Boards 93%
    - Employers: VA 78% strongly agree/somewhat agree; All Boards 80%
- Average number of nurses who successfully completed discipline for the same case per 1,000 nurses as reported in NURSYS
    - VA 0.77;
    - All Boards 0.64
- Average number of nurses who successfully completed discipline for the same case peer 1,000 nurses as reported in NURSYS since 2009.
    - 2009: VA 0.25; All Boards 0.47
    - 2012: VA 0.35; All Boards 0.63
    - 2014: VA 0.78; All Boards 0.71
    - 2016: VA0.77; All Boards 0.64
- In VA, the number of nurses who successfully completed discipline increased in both 2012 and 2014 while remaining steady between 2014 and 2016.
- Percent of active nurses without action against license in NURSYS in 2016
    - 2009: VA 98.8%; All Boards 96.2%
    - 2012: VA 98.5%; All Boards 98.6%
    - 2014: VA 98.5%; All Boards 98.8%

- 2016: VA 98.5%; All Boards 98.7%

- Overall, among all boards, the percent of nurses without action against their license increased in 2012 and remained steady throughout 2014 and 2016. In VA, the percent of nurses without action against their license remained steady throughout 2009, 2012, 2014 and 2016.

IMMEDIATE OUTCOMES

Unsafe or incompetent practitioners are removed from practice:

- Average number of nurses removed from practice per 1,000 nurses in NURSYS in 2016
  - VA 1.7;
  - All Boards 1.4
- In VA the average number of nurses removed from practice was slightly higher than the aggregate at 1.7
- Average number of nurses removed from practice per 1,000 nurses in NURSYS 2009-2016
  - 2009: VA 1.5; All Boards 1.3
  - 2012: VA 1.8; All Boards 1.6
  - 2014: VA 1.5; All Boards 1.4
  - 2016: VA 1.7; All Boards 1.4
- While all board removal of nurses in practice remained steady 2009-2016, VA's removal increased in 2012, decreased slightly in 2014 and increased in 2016.

Unsafe or incompetent practitioners are denied licensure:

- Average number of denial for licensure per 1,000 nurses recorded in NURSYS 2009-2016
  - 2009: VA 0.16; All Boards 0.08
  - 2012: VA 0.13; All Boards 0.06
  - 2014: VA 0.10; All Boards 0.13
  - 2016: VA 0.16; All Boards 0.10
- In VA the number of denials for licensure decreased steadily from 2009 to 2014 and then increased in 2016.

Nurses are remediated.

- Average number of nurses with an initial discipline per 1,000 nurses in NURSYS 2009-2016
  - 2009: VA 4.3; All Boards 2.9
  - 2012: VA 3.4; All Boards 3.0
  - 2014: VA 2.6; All Boards 2.5

- 2016: VA 2.6; All Boards 2.5

Overall, the average number of nurses with an initial discipline from all boards was steady 2009-2016. In VA, the number of nurses with an initial discipline decreased 2009-2014 and remained steady 2014-2016,

OUTPUTS

- Board actions taken; cases dismissed; nurses disciplined; nurses remediated without discipline.
  - Average percentage of investigative cases resolved in reportable action, non-reportable action and no action in 2016:
    - Reportable action: VA 38%; All Boards 31%
    - Non-Reportable action: VA 15%; All Boards 22%
    - No Action: VA 45%; All Boards 45%
  - Average number of calendar month from receipt of complaints to resolution of cases 2009-2016
    - 2009: VA 8.7; All Boards 7.1
    - 2012: VA 5.7; All Boards 6.5
    - 2014: VA 5.8; All Boards 5.9
    - 2016: VA 6.7; All Boards 6.4
- Percent of cases resolved by Boards within 6 months, 7-12 months, 13 months-2 years and over 2 years
  - This measure not reported by VABON
  - All Boards:
    - 6 months 67.2%
    - 7-12 months 14.8%
    - 13 months-2 years 13.6%
    - Over 2 years 4.4%
- Average number of calendar months from receipt of complaints to the final action date of formal hearing cases conducted in 2016
  - This measure was not reported by VABON
  - All Boards 14.3 months
- Average number of calendar months from receipt of complaints to the final action date of formal hearing cases conducted 2012-2016
  - This measure was not reported by VABON
  - All Boards:
    - 2012: 12

- 2014: 12.3
- 2016: 14.3

- Percent agreement and disagreement by nurses, employers and educators with the statement that the Board of Nursing acted in a timely manner with the disciplinary process in 2016
  - Nurses: VA 100%; All Boards 63%
  - Employers: VA 80%; All Boards 62%
  - Educators: VA 80%; All Boards 90%
- Percent agreement and disagreement by nurses, employers and educators with the statement that the board of nursing's process used to investigate and resolve the problem regarding the complaint/discipline process was fair in 2016
  - Nurses: VA 100%; All Boards 78%
  - Employers: VA 100%; All Boards 87%
  - Educators: VA 80%; All Boards 88%

PROCESSES AND ACTIVITIES

Establish philosophy, policy, standards, etc.

- Nurses, Employers, and Educators rations regarding their state's nurse practice act in terms of being current and reflecting state-of-the-art in the area of discipline in 2016
  - Nurses (excellent and good): VA 76%; All Boards %75%
  - Employers (excellent and good): VA 89%; All Boards 74%
  - Educators: VA 76%; All Boards 85%
- Percent of Nurses', Employers', and Educators' nursing organizations or nursing program that emphasizes a culture of safety that promotes the report of errors without the fear of retribution in 2016
  - Nurses: VA 73%; All Boards 73%
  - Employers: VA 89%; All Boards 84%
  - Educators: VA 91%; All Boards 88%

Triaging cases to determine risk and course of action; conducting investigations; reviewing complaints with subjects and complainants

- Percent of nurses', employers', and educators' nursing organizations or programs that emphasizes the culture of safety that promotes the report of errors without the fear of retribution in 2016
  - Nurses: VA 73%; All Boards 73%
  - Employers: VA 89%; All Boards 84%
  - Educators:

- Average number of cases assigned to investigations 2009-2016
  - 2009: VA 1,264; All Boards 1,216
  - 2012: VA 1,188; All Boards 1,501
  - 2014: VA 1,346; All Boards 1,586
  - 2016: VA 1,435; All Boards 1,261
- Average number of formal hearing conducted by the board of nursing or by the administrative law judge 2012-2016
  - 2012: VA 107; All Boards 81
  - 2014: VA 70; All Boards 57
  - 2016: VA 85; All Boards 66
- Percent agreement and disagreement by nurses, employers and educators with the statement that the board of nursing kept them informed throughout the disciplinary process in 2016
  - Nurses: VA 75%; All Boards 54%
  - Employers: VA 60%; All Boards 53%
  - Educators: VA 80%; All Boards 95%

PROGRAM COMPONENTS AND RESOURCES

Staff and Dollars

- Average budget allocated to discipline in 2016
  - VA $4,082.770;
  - All Boards $1,883,100
- Average percent of total budget allocated to discipline 2012-2016
  - 2012: VA 29%; All Boards 40%
  - 2014: VA 56%; All Boards 31%
  - 2016: VA 51%; All Boards 40%
- Average cost per investigation 2016
  - VA $2,700;
  - All Boards $1,580
- Average FTE's involved in the investigative process that are board of nursing employees and contracted personnel in 2016
  - VA Not Reported;
  - All Boards 10

Delegated authority for the following tasks in 2015:

- Closure of complaints through approved guidelines and policies for allegations that fall below threshold to investigate (VA and 26 all boards).
- Expediting the closure of cases where a violation has not been established (VA 30 all boards).
- Determine priority or risk level at time of assignment (VA and 26 all boards)
- Offer consent agreements in particular instances (VA and 26 all boards)

Number of BON's who indicated that they provide or utilize the following practices in 2015

- Online complaint submissions (VA and 30 all boards)
- Case assignment to particular investigators (VA and 26 all boards)
- Interview templates (VA and 23 all boards)
- Report templates (VA and 30 all boards)
- Expedited process for admitted allegations (VA and 18 all boards)
- Approved guidelines, policies or matrix for discipline (VA and 26 all boards)
- Delegation to subcommittee for resolution of cases (VA and 16 all boards)
- Automatic suspension for noncompliance with order (VA and 25 all boards)

COMMONWEALTH of VIRGINIA

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TO: Board Members

FROM: Stephanie H. Willinger
Deputy Executive Director

DATE: January 16, 2018

RE: Take Aways from the January 4th 2018 Enhanced Nurse Licensure Compact Legal Forum (NCSBN)

I appreciated the opportunity to attend, with Jay Douglas, the January 4th Legal Forum sponsored by the National Council of State Boards of Nursing (NCSBN). The primary focus of the meeting was to present condensed information to Nursing Executives and their legal representatives regarding the Enhanced Nurse Licensure Compact (eNLC). The agenda covered topics including: an overview of inter-state compacts, other emerging health care compacts, ENLC rule making, rule updates and public comments, etc.

We also heard about some of the challenges being navigated by some of the 'new' states to the Compact regarding rule application. Some of the challenges presented appeared more operational in nature than legal, such as allowing nurses to 'choose' a single-state license over a multi-state (MSP) license even though they may be eligible for a MSP license. An example dilemma was presented: if a nurse believes she will never leave her 'home' state why would a MSP license be necessary. Additionally, some states that are allowing a license status choice also indicated that they are requiring a higher fee to obtain a MSP license. It is important to note that Virginia is not implementing a 'choice' for license status, as the underlying intent of the NLC or ENLC is to promote issuance of more 'portable' or MSP licenses to eligible nurses so they can safely practice across states in a variety of settings/circumstances.

One of the most impactful presentations was the *overview of the 'evolution' of inter-state compacts* presented by Rick Masters, JD, Special Counsel, Interstate Commission of Nurse Licensure Compact Administrators, which put all of the work and challenges under NLC and ENLC in better context. This condensed presentation allowed attendees to see how the framework of the NLC evolved from Articles and authority derived under the US Constitution. More importantly, how 'compacts' allow for states to "create a state-based solution to regional or national problems and effectively retain policy control over certain interstate matters for the **future**" (Emphasis added; excerpt from *The Evolving Law and Use of Interstate Compacts 2nd edition* 2016).

The **future** of the delivery of safe and quality health care services through our licensees should be a collective (state) mission of utmost importance. Nursing proactively led this mission in 2000 by enacting the NLC. While the NLC has existed for over sixteen (16) years, impressive from all of the presentations was the extensive legal, administrative and operational work driving the ENLC to support the **future** delivery of health care benefiting licensees and the public. Moreover, the ENLC has laid a solid foundation for 'state based solutions' under which we will be able to more accurately assess the quality and services provided by our nurses.

Overall, the presentations and discussions brought home that the example dilemma provided should be viewed in the above context related to our collective mission under the ENLC, positively impacting the **future** of healthcare delivery. If a nurse had an opportunity to obtain a MSP license and that nurse could make critical difference assisting in an emergent or unanticipated circumstance outside her home state why would she not avail herself of this opportunity. While the ENLC adds more uniform requirements for nurses that may seem cumbersome, even more opportunities and protections have been created within the ENLC for nurses to continue to practice and flourish in the ever advancing health care environment. There have been too many critical events in the present and there will be more in the foreseeable future that require immediate action by health care providers without barriers negatively impacting patients or consumers. No matter which party state a nurse resides, having a license with multi-state privilege provides opportunities outside of their home state to make an immediate difference for those in need of services.

NURSE LICENSURE COMPACT

The Interstate Commission of Nurse Licensure Compact Administrators

Final Rules

Adopted Dec 12, 2017

Effective Jan 19, 2018

Table of Contents

SECTION 100. DEFINITIONS

(1) "Commission" means the Interstate Commission of Nurse Licensure Compact Administrators.

(2) "Compact" means the Nurse Licensure Compact that became effective on July 20, 2017 and implemented on January 19, 2018.

(3) "Convert" means to change a multistate license to a single-state license if a nurse changes primary state of residence by moving from a party state to a non-party state; or to change a single-state license to a multistate license once any disqualifying events are eliminated.

(4) "Deactivate" means to change the status of a multistate license or privilege to practice.

(5) "Director" means the individual referred to in Article IV of the Interstate Commission of Nurse Licensure Compact Administrators Bylaws.

(6) "Disqualifying Event" means an incident, which results in a person becoming disqualified or ineligible to retain or renew a multistate license. These include but are not limited to the following: any adverse action resulting in an encumbrance, current participation in an alternative program, a misdemeanor offense related to the practice of nursing (which includes, but is not limited to, an agreed disposition), or a felony offense (which includes, but is not limited to, an agreed disposition).

(7) "Independent credentials review agency" means a non-governmental evaluation agency that verifies and certifies that foreign nurse graduates have graduated from nursing programs that are academically equivalent to nursing programs in the United States.

(8) "Licensure" includes the authority to practice nursing granted through the process of examination, endorsement, renewal, reinstatement and/or reactivation.

(9) "Prior Compact" means the Nurse Licensure Compact that was in effect until January 19, 2018.

(10) "Unencumbered license" means a license that authorizes a nurse to engage in the full and unrestricted practice of nursing.

SECTION 200. COORDINATED LICENSURE INFORMATION SYSTEM

201. UNIFORM DATA SET AND LEVELS OF ACCESS

(1) The Compact Administrator of each party state shall furnish uniform data to the Coordinated Licensure Information System, which shall consist of the following:

(a) the nurse's name;

(b) jurisdiction of licensure;

(c) license expiration date;

(d) licensure classification, license number and status;

(e) public emergency and final disciplinary actions, as defined by the contributing state authority;

(f) a change in the status of a disciplinary action or licensure encumbrance;

(g) status of multistate licensure privileges;

(h) current participation by the nurse in an alternative program;

(i) information that is required to be expunged by the laws of a party state;

(j) the applicant or nurse's United States social security number;

(k) current significant investigative information; and

(l) a correction to a licensee's data.

(2) The public shall have access to items (1)(a) through (g) and information about a licensee's participation in an alternative program to the extent allowed by state law.

(3) In the event a nurse asserts that any Coordinated Licensure Information System data is inaccurate, the burden of proof shall be upon the nurse to provide evidence in a manner determined by the party state that substantiates such claim.

(4) A party state shall report the items in the uniform data set to the Coordinated Licensure Information System within fifteen (15) calendar days of the date on which the action is taken.

202. QUERYING THE COORDINATED LICENSURE INFORMATION SYSTEM

(1) Upon application for multistate licensure, with the exception of renewal by a nurse, a party state shall query the Coordinated Licensure Information System to determine the applicant's current licensure status, previous disciplinary action(s), current participation in an alternative program, and any current significant investigative information.

(2) Upon discovery that an applicant is under investigation in another party state, the party state in receipt of the nurse licensure application shall contact the investigating party state and may request investigative documents and information.

SECTION 300. IMPLEMENTATION

301. IMPLEMENTATION DATE

The Compact shall be implemented on January 19, 2018.

302. TRANSITION

(1) (a) A nurse who holds a multistate license on the Compact effective date of July 20, 2017, and whose multistate license remains unencumbered on the January 19, 2018 implementation date and who maintains and renews a multistate license is not required to meet the new requirements for a multistate license under the Compact.

(b) A nurse who retained a multistate license pursuant to subsection (a) of this section and subsequently incurs a disqualifying event shall have the multistate license revoked or deactivated pursuant to the laws of the home state.

(c) A nurse whose multistate license is revoked or deactivated may be eligible for a single state license in accordance with the laws of the party state.

(2) A nurse who applies for a multistate license after July 20, 2017, shall be required to meet the requirements of Article III (c) of the Compact.

(3) During the transition period, a licensee who holds a single state license in a Compact state that was not a member of the prior Compact and who also holds a multistate license in a party state, may retain the single state license until it lapses, expires or becomes inactive."

(4) After the implementation date, party states shall not renew or reinstate a single state license if the nurse has a multistate license in another party state.

303. RECOGNITION OF NEW PARTY STATES AFTER JANUARY 19, 2018

(1) All party states shall be notified by the Commission within fifteen (15) calendar days when a new party state enacts the Compact.

(2) The new party state shall establish an implementation date six (6) months from enactment or as specified in the enabling language and shall notify the Director of the date.

(3) Upon implementation, a new state licensee who holds a single state license in a Compact state that was not a member of the prior Compact and holds a multistate license in a party state, may retain the single state license until it lapses, expires or becomes inactive.

(4) At least ninety (90) calendar days prior to the implementation date, all other party states shall notify any active single state licensee with an address in the new party state that the licensee may only hold one multistate license in the primary state of residence. The licensee shall be advised to obtain or maintain a multistate license only from the primary state of residence.

(5) Each party state shall deactivate a multistate license when a new home state issues a multistate license.

SECTION 400. LICENSURE

401. PARTY STATE RESPONSIBILITIES

(1) On all application forms for multistate licensure, a party state shall require, at a minimum:

(a) A declaration of a primary state of residence and

(b) Whether the applicant is a current participant in an alternative program.

(2) (a) An applicant for licensure who is determined to be ineligible for a multistate license shall be notified by the home state of the qualifications not met.

(b) The home state may issue a single state license pursuant to its laws.

(3) A party state shall not issue a single state license to a nurse who holds a multistate license in another party state.

402. APPLICANT RESPONSIBILITIES

(1) On all application forms for multistate licensure in a party state, an applicant shall declare a primary state of residence.

(2) A nurse who changes primary state of residence to another party state shall apply for a license in the new party state when the nurse declares to be a resident of the state and obtains privileges not ordinarily extended to nonresidents of the state, including but not limited to, those listed in 402 (4) (a) – (e).

(3) A nurse shall not apply for a single state license in a party state while the nurse holds a multistate license in another party state.

(4) A party state may require an applicant to provide evidence of residence in the declared primary state of residence. This evidence may include, but is not limited to, a current:

(a) driver's license with a home address;

(b) voter registration card with a home address;

(c) federal income tax return with a primary state of residence declaration;

(d) military form no. 2058 (state of legal residence certificate); or

(e) W2 form from the United States government or any bureau, division, or agency thereof, indicating residence.

(5) An applicant who is a citizen of a foreign country, and who is lawfully present in the United States and is applying for multistate licensure in a party state may declare either the applicant's country of origin or the party state where they are living as the primary state of residence. If the applicant declares the foreign country as the primary state of residence, the party state shall not issue a multistate license, but may issue a single state license if the applicant meets the party state's licensure requirements.

(6) An applicant shall disclose current participation in an alternative program to any party state, whether upon initial application or within ten (10) calendar days of enrollment in the program.

403. CHANGE IN PRIMARY STATE OF RESIDENCE

(1) A nurse who changes his or her primary state of residence from one party state to another party state may continue to practice under the existing multistate license while the nurse's application is processed and a multistate license is issued in the new primary state of residence.

(2) Upon issuance of a new multistate license, the former primary state of residence shall deactivate its multistate license held by the nurse and provide notice to the nurse.

(3) If a party state verifies that a licensee who holds a multistate license changes primary state of residence to a non-party state, the party state shall convert the multistate license to a single state license within fifteen (15) calendar days, and report this conversion to the Coordinated Licensure Information System.

404. TEMPORARY PERMITS AND LICENSES

A temporary permit, license, or similar temporary authorization to practice issued by a party state to an applicant for licensure shall not grant multistate licensure privileges.

405. IDENTIFICATION OF LICENSES

A license issued by a party state shall be clearly identified as either a single state license or a multistate license.

406. CREDENTIALING AND ENGLISH PROFICIENCY FOR FOREIGN NURSE GRADUATES

(1) A party state shall verify that an independent credentials review agency evaluated the credentials of graduates as set forth in Article III (c)(2)ii.

(2) The party state shall verify successful completion of an English proficiency examination for graduates as set forth in Article III (c)(3).

407. DEACTIVATION, DISCIPLINE AND REVOCATION

A party state shall determine whether a disqualifying event will result in adverse action or deactivation of a multistate license or privilege. Upon deactivation due to a disqualifying event, the home state may issue a single state license.

SECTION 500. ADMINISTRATION

501. DUES ASSESSMENT

(1) The Commission shall determine the annual assessment to be paid by party states. The assessment formula is a flat fee per party state. The Commission shall provide public notice of any proposed revision to the annual assessment fee at least ninety (90) calendar days prior to the Commission meeting to consider the proposed revision.

(2) The annual assessment shall be due within the Commission's first fiscal year after the implementation date and annually thereafter.

Code of Virginia

The Effective Date is January 19, 2018

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 30. Nursing

§ 54.1-3040.1. (Contingent effective date -- see note) Findings and declaration of purpose.

A. The party states find that:

1. The health and safety of the public are affected by the degree of compliance with and the effectiveness of enforcement activities related to state nurse licensure laws;

2. Violations of nurse licensure and other laws regulating the practice of nursing may result in injury or harm to the public;

3. The expanded mobility of nurses and the use of advanced communication technologies as part of our nation's health care delivery system require greater coordination and cooperation among states in the areas of nurse licensure and regulation;

4. New practice modalities and technology make compliance with individual state nurse licensure laws difficult and complex;

5. The current system of duplicative licensure for nurses practicing in multiple states is cumbersome and redundant for both nurses and states; and

6. Uniformity of nurse licensure requirements throughout the states promotes public safety and public health benefits.

B. The general purposes of this Compact are to:

1. Facilitate the states' responsibility to protect the public's health and safety;

2. Ensure and encourage the cooperation of party states in the areas of nurse licensure and regulation;

3. Facilitate the exchange of information between party states in the areas of nurse regulation, investigation, and adverse actions;

4. Promote compliance with the laws governing the practice of nursing in each jurisdiction;

5. Invest all party states with the authority to hold a nurse accountable for meeting all state practice laws in the state in which the patient is located at the time care is rendered through the mutual recognition of party state licenses;

6. Decrease redundancies in the consideration and issuance of nurse licenses; and

7. Provide opportunities for interstate practice by nurses who meet uniform licensure requirements.

2016, c. 108.

Code of Virginia
Title 54.1. Professions and Occupations
Chapter 30. Nursing

§ 54.1-3040.2. (Contingent effective date -- see note) Definitions.

As used in the Nurse Licensure Compact, unless the context requires a different meaning:

"Adverse action" means any administrative, civil, equitable or criminal action permitted by a state's laws which is imposed by a licensing board or other authority against a nurse, including actions against an individual's license or multistate licensure privilege such as revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, or any other encumbrance on licensure affecting a nurse's authorization to practice, including issuance of a cease and desist action.

"Alternative program" means a nondisciplinary monitoring program approved by a licensing board.

"Coordinated licensure information system" means an integrated process for collecting, storing, and sharing information on nurse licensure and enforcement activities related to nurse licensure laws that is administered by a nonprofit organization composed of and controlled by licensing boards.

"Current significant investigative information" means:

1. Investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or

2. Investigative information that indicates that the nurse represents an immediate threat to public health and safety regardless of whether the nurse has been notified and had an opportunity to respond.

"Encumbrance" means a revocation or suspension of, or any limitation on, the full and unrestricted practice of nursing imposed by a licensing board.

"Home state" means the party state which is the nurse's primary state of residence.

"Licensing board" means a party state's regulatory body responsible for issuing nurse licenses.

"Multistate license" means a license to practice as a registered or a licensed practical/vocational nurse (LPN/VN) issued by a home state licensing board that authorizes the licensed nurse to practice in all party states under a multistate licensure privilege.

"Multistate licensure privilege" means a legal authorization associated with a multistate license permitting the practice of nursing as either a registered nurse (RN) or LPN/VN in a remote state.

"Nurse" means RN or LPN/VN, as those terms are defined by each party state's practice laws.

"Party state" means any state that has adopted this Compact.

"Remote state" means a party state, other than the home state.

"Single-state license" means a nurse license issued by a party state that authorizes practice only within the issuing state and does not include a multistate licensure privilege to practice in any other party state.

"State" means a state, territory, or possession of the United States and the District of Columbia.

"State practice laws" means a party state's laws, rules, and regulations that govern the practice of nursing, define the scope of nursing practice, and create the methods and grounds for imposing discipline. "State practice laws" does not include requirements necessary to obtain and retain a license, except for qualifications or requirements of the home state.

2016, c. 108.

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§ 54.1-3040.3. (Contingent effective date -- see note) General provisions and jurisdiction.

A. A multistate license to practice registered or licensed practical/vocational nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a nurse to practice as a registered nurse (RN) or as a licensed practical/vocational nurse (LPN/VN), under a multistate licensure privilege, in each party state.

B. A state must implement procedures for considering the criminal history records of applicants for initial multistate license or licensure by endorsement. Such procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records.

C. Each party state shall require the following for an applicant to obtain or retain a multistate license in the home state:

1. Meets the home state's qualifications for licensure or renewal of licensure, as well as all other applicable state laws;

2. Has (a) graduated or is eligible to graduate from a licensing board-approved RN or LPN/VN prelicensure education program or (b) graduated from a foreign RN or LPN/VN prelicensure education program that has been approved by the authorized accrediting body in the applicable country and has been verified by an independent credentials review agency to be comparable to a licensing board-approved prelicensure education program;

3. Has, if a graduate of a foreign prelicensure education program not taught in English or if English is not the individual's native language, successfully passed an English proficiency examination that includes the components of reading, speaking, writing, and listening;

4. Has successfully passed an NCLEX-RN(R) or NCLEX-PN(R) Examination or recognized predecessor, as applicable;

5. Is eligible for or holds an active, unencumbered license;

6. Has submitted, in connection with an application for initial licensure or licensure by endorsement, fingerprints or other biometric data for the purpose of obtaining criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records;

7. Has not been convicted or found guilty, or has entered into an agreed disposition, of a felony offense under applicable state or federal criminal law;

8. Has not been convicted or found guilty, or has entered into an agreed disposition, of a misdemeanor offense related to the practice of nursing as determined on a case-by-case basis;

9. Is not currently enrolled in an alternative program;

10. Is subject to self-disclosure requirements regarding current participation in an alternative program; and

11. Has a valid United States social security number.

D. All party states shall be authorized, in accordance with existing state due process law, to take adverse action against a nurse's multistate licensure privilege, such as revocation, suspension, probation, or any other action that affects a nurse's authorization to practice under a multistate licensure privilege, including cease and desist actions. If a party state takes such action, it shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.

E. A nurse practicing in a party state must comply with the state practice laws of the state in which the client is located at the time service is provided. The practice of nursing is not limited to patient care, but shall include all nursing practice as defined by the state practice laws of the party state in which the client is located. The practice of nursing in a party state under a multistate licensure privilege will subject a nurse to the jurisdiction of the licensing board, the courts, and the laws of the party state in which the client is located at the time service is provided.

F. Individuals not residing in a party state shall continue to be able to apply for a party state's single-state license as provided under the laws of each party state. However, the single-state license granted to these individuals will not be recognized as granting the privilege to practice nursing in any other party state. Nothing in this Compact shall affect the requirements established by a party state for the issuance of a single-state license.

G. Any nurse holding a home state multistate license, on the effective date of this Compact, may retain and renew the multistate license issued by the nurse's then-current home state, provided that:

1. A nurse who changes primary state of residence after this Compact's effective date must meet all applicable requirements of subsection C to obtain a multistate license from a new home state.

2. A nurse who fails to satisfy the multistate licensure requirements in subsection C due to a disqualifying event occurring after this Compact's effective date shall be ineligible to retain or renew a multistate license, and the nurse's multistate license shall be revoked or deactivated in accordance with applicable rules adopted by the Interstate Commission of Nurse Licensure Compact Administrators (Commission).

2016, c. 108.

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§ 54.1-3040.4. (Contingent effective date -- see note) Applications for licensure in a party state.

A. Upon application for a multistate license, the licensing board in the issuing party state shall ascertain, through the coordinated licensure information system, whether the applicant has ever held, or is the holder of, a license issued by any other state, whether there are any encumbrances on any license or multistate licensure privilege held by the applicant, whether anyadverse action has been taken against any license or multistate licensure privilege held by the applicant, and whether the applicant is currently participating in an alternative program.

B. A nurse may hold a multistate license issued by the home state in only one party state at a time.

C. If a nurse changes primary state of residence by moving between two party states, the nurse must apply for licensure in the new home state, and the multistate license issued by the prior home state will be deactivated in accordance with applicable rules adopted by the Commission.

1. The nurse may apply for licensure in advance of a change in primary state of residence.

2. A multistate license shall not be issued by the new home state until the nurse provides satisfactory evidence of a change in primary state of residence to the new home state and satisfies all applicable requirements to obtain a multistate license from the new home state.

D. If a nurse changes primary state of residence by moving from a party state to a non-party state, the multistate license issued by the prior home state will convert to a single-state license, valid only in the former home state.

2016, c. 108.

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§ 54.1-3040.5. (Contingent effective date -- see note) Additional authorities invested in party state licensing boards.

A. In addition to the other powers conferred by state law, a licensing board shall have the authority to:

1. Take adverse action against a nurse's multistate licensure privilege to practice within that party state.

a. Only the home state shall have the power to take adverse action against a nurse's license issued by the home state.

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

2. Issue cease and desist orders or impose an encumbrance on a nurse's authority to practice within that party state.

3. Complete any pending investigations of a nurse who changes primary state of residence during the course of such investigations. The licensing board shall also have the authority to take appropriate action(s) and shall promptly report the conclusions of such investigations to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any such actions.

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

5. Obtain and submit, for each nurse licensure applicant, fingerprint or other biometric-based information to the Federal Bureau of Investigation for criminal background checks, receive the results of the Federal Bureau of Investigation record search on criminal background checks,and use the results in making licensure decisions.

6. If otherwise permitted by state law, recover from the affected nurse the costs of investigations and disposition of cases resulting from any adverse action taken against that nurse.

7. Take adverse action based on the factual findings of the remote state, provided that the licensing board follows its own procedures for taking such adverse action.

B. If adverse action is taken by the home state against a nurse's multistate license, the nurse's multistate licensure privilege to practice in all other party states shall be deactivated until all encumbrances have been removed from the multistate license. All home state disciplinary orders that impose adverse action against a nurse's multistate license shall include a statement that the nurse's multistate licensure privilege is deactivated in all party states during the pendency of the order.

C. Nothing in this Compact shall override a party state's decision that participation in an alternative program may be used in lieu of adverse action. The home state licensing board shall deactivate the multistate licensure privilege under the multistate license of any nurse for the duration of the nurse's participation in an alternative program.

2016, c. 108.

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§ 54.1-3040.6. (Contingent effective date -- see note) Coordinated licensure information system and exchange of information.

A. All party states shall participate in a coordinated licensure information system of all licensed registered nurses (RNs) and licensed practical/vocational nurses (LPNs/VNs). This system will include information on the licensure and disciplinary history of each nurse, as submitted by party states, to assist in the coordination of nurse licensure and enforcement efforts.

B. The Commission, in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection, and exchange of information under this Compact.

C. All licensing boards shall promptly report to the coordinated licensure information system any adverse action, any current significant investigative information, denials of applications (with the reasons for such denials), and nurse participation in alternative programs known to the licensing board regardless of whether such participation is deemed nonpublic or confidential under state law.

D. Current significant investigative information and participation in nonpublic or confidential alternative programs shall be transmitted through the coordinated licensure information system only to party state licensing boards.

E. Notwithstanding any other provision of law, all party state licensing boards contributing information to the coordinated licensure information system may designate information that may not be shared with non-party states or disclosed to other entities or individuals without the express permission of the contributing state.

F. Any personally identifiable information obtained from the coordinated licensure information system by a party state licensing board shall not be shared with non-party states or disclosed to other entities or individuals except to the extent permitted by the laws of the party state contributing the information.

G. Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing that information shall also be expunged from the coordinated licensure information system.

H. The Compact administrator of each party state shall furnish a uniform data set to the Compact administrator of each other party state, which shall include, at a minimum:

1. Identifying information;

2. Licensure data;

3. Information related to alternative program participation; and

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

I. The Compact administrator of a party state shall provide all investigative documents and information requested by another party state.

2016, c. 108.

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§ 54.1-3040.7. (Contingent effective date -- see note) Establishment of the Interstate Commission of Nurse Licensure Compact Administrators.

A. The party states hereby create and establish a joint public entity known as the Interstate Commission of Nurse Licensure Compact Administrators (Commission).

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

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

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

B. Membership, voting, and meetings.

1. Each party state shall have and be limited to one administrator. The head of the state licensing board or designee shall be the administrator of this Compact for each party state. Any administrator may be removed or suspended from office as provided by the law of the state from which the Administrator is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the party state in which the vacancy exists.

2. Each administrator shall be entitled to one (1) vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. An administrator shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for an administrator's participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws or rules of the commission.

4. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in § 54.1-3040.8.

5. The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:

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

b. The employment, compensation, discipline, or other personnel 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 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 investigatory records compiled for law-enforcement purposes;

i. Disclosure of information related to any reports prepared by or on behalf of the Commission for the purpose of investigation of compliance with this Compact; or

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

6. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefor, 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.

C. The Commission shall, by a majority vote of the administrators, prescribe bylaws or rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of this Compact, including but not limited to:

1. Establishing the fiscal year of the Commission;

2. Providing reasonable standards and procedures:

a. For the establishment and meetings of other committees; and

b. Governing any general or specific delegation of any authority or function of the Commission;

3. Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings, and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the administrators vote to close a meeting in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each administrator, with no proxy votes allowed;

4. Establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the Commission;

5. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any party state, the bylaws shall exclusively govern the personnel policies and programs of the Commission; and

6. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of this Compact after the payment or reserving of all of its debts and obligations.

D. The Commission shall publish its bylaws and rules, and any amendments thereto, in a convenient form on the website of the Commission.

E. The Commission shall maintain its financial records in accordance with the bylaws.

F. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the bylaws.

G. The Commission shall have the following powers:

1. To promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all party states;

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

3. To purchase and maintain insurance and bonds;

4. To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a party state or nonprofit organizations;

5. To cooperate with other organizations that administer state compacts related to the regulation of nursing, including but not limited to sharing administrative or staff expenses, office space, or other resources;

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

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

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

9. To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, whether real, personal, or mixed;

10. To establish a budget and make expenditures;

11. To borrow money;

12. To appoint committees, including advisory committees comprised of administrators, state nursing regulators, state legislators or their representatives, and consumer representatives and other such interested persons;

13. To provide and receive information from, and to cooperate with, law-enforcement agencies;

14. To adopt and use an official seal; and

15. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of nurse licensure and practice.

H. 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 also levy on and collect an annual assessment from each party state to cover the cost of its operations, activities, and staff in its annual budget as approved each year. The aggregate annual assessment amount, if any, shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a rule that is binding upon all party states.

3. 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 party states, except by, and with the authority of, such party state.

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

I. Qualified immunity, defense, and indemnification.

1. The administrators, officers, executive director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person

against whom the claim is made had a reasonable basis for believing occurred, within the scope of Commission employment, duties or responsibilities, provided that nothing in this subdivision shall be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional, willful, or wanton misconduct of that person.

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

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

2016, c. 108.

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§ 54.1-3040.8. (Contingent effective date -- see note) Rulemaking.

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

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

C. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least sixty (60) 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; and

2. On the website of each licensing board or the publication in which each state would otherwise publish proposed rules.

D. The notice of proposed rulemaking shall include:

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

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

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

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

E. 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.

F. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment.

G. The Commission shall publish the place, time, and date of the scheduled public hearing.

1. 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. All hearings will be recorded, and a copy will be made available upon request.

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

H. If no one appears at the public hearing, the Commission may proceed with promulgation of the proposed rule.

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

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

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

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

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

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

L. The Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the 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.

2016, c. 108.

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§ 54.1-3040.9. (Contingent effective date -- see note) Oversight, dispute resolution, and enforcement.

A. Oversight.

1. Each party state shall enforce this Compact and take all actions necessary and appropriate to effectuate this Compact's purposes and intent.

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

B. Default, technical assistance and termination.

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

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

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

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

3. Termination of membership in 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 of the defaulting state and to the executive officer of the defaulting state's licensing board and to each of the party states.

4. A state whose membership in this Compact 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 whose membership in this Compact has been terminated unless agreed upon in writing between the Commission and the defaulting state.

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

C. Dispute resolution.

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

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

3. In the event the Commission cannot resolve disputes among party states arising under this Compact:

a. The party states may submit the issues in dispute to an arbitration panel, which will be comprised of individuals appointed by the Compact administrator in each of the affected party states and an individual mutually agreed upon by the Compact administrators of all the party states involved in the dispute.

b. The decision of a majority of the arbitrators shall be final and binding.

D. Enforcement.

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

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

3. 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.

2016, c. 108.

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§ 54.1-3040.10. (Contingent effective date -- see note) Effective date, withdrawal, and amendment.

A. This Compact shall become effective and binding on the earlier of the date of legislative enactment of this Compact into law by no less than twenty-six (26) states or December 31, 2018. All party states to this Compact that also were parties to the prior Nurse Licensure Compact (Prior Compact) superseded by this Compact shall be deemed to have withdrawn from said Prior Compact within six (6) months after the effective date of this Compact.

B. Each party state to this Compact shall continue to recognize a nurse's multistate licensure privilege to practice in that party state issued under the Prior Compact until such party state has withdrawn from the Prior Compact.

C. Any party state may withdraw from this Compact by enacting a statute repealing the same. A party state's withdrawal shall not take effect until six (6) months after enactment of the repealing statute.

D. A party state's withdrawal or termination shall not affect the continuing requirement of the withdrawing or terminated state's licensing board to report adverse actions and significant investigations occurring prior to the effective date of such withdrawal or termination.

E. Nothing contained in this Compact shall be construed to invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a non-party state that is made in accordance with the other provisions of this Compact.

F. This Compact may be amended by the party states. No amendment to this Compact shall become effective and binding upon the party states unless and until it is enacted into the laws of all party states.

G. Representatives of non-party states to this Compact shall be invited to participate in the activities of the Commission, on a nonvoting basis, prior to the adoption of this Compact by all states.

2016, c. 108.

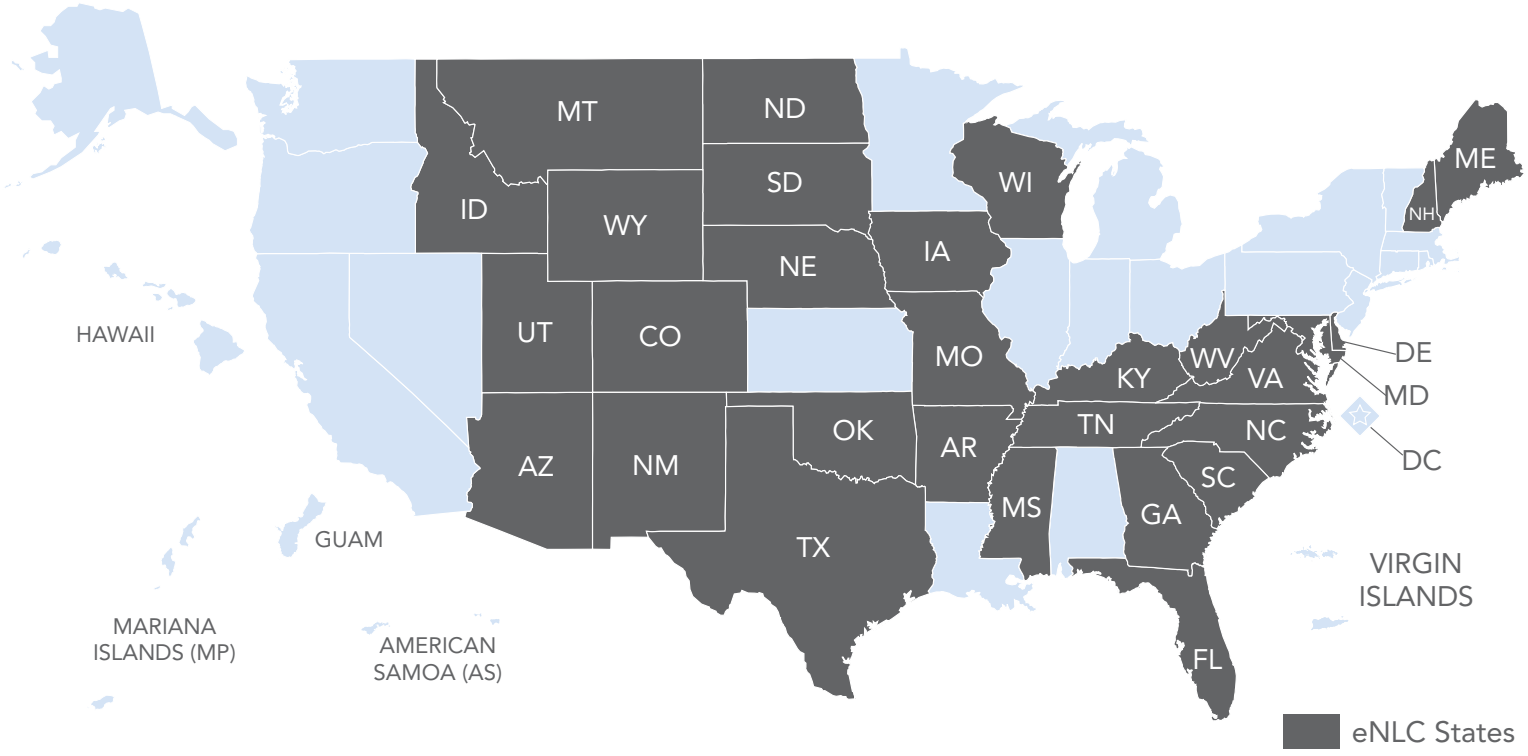
Code of Virginia
Title 54.1. Professions and Occupations
Chapter 30. Nursing

§ 54.1-3040.11. (Contingent effective date -- see note) Construction and severability.

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

2016, c. 108.

The State of the Compact



Map in effect Jan. 19, 2018

NLC
NURSE LICENSURE COMPACT

For up-to-date information, visit ncsbn.org/eNLC.

Virginia Board of Nursing
Nurse Aide Curriculum Committee Sub-group
9960 Mayland Drive - Conference Center Suite 201 – Board Room 4 - Henrico, Virginia 23233
November 14, 2017 – 3:00 p.m.

Minutes

TIME AND PLACE:	A subgroup meeting of the stakeholders regarding the Nurse Aide Curriculum of the Virginia Board of Nursing was called to order by Jennifer Phelps, LPN Board member at 3:08 p.m. on November 14, 2017 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 300, Henrico, Virginia.
BOARD MEMBERS PRESENT	Jennifer Phelps, LPN Board Member (presiding in the absence of the Chair) Mark Monson, Citizen Member Laura Cei, LPN Board Member
STAKEHOLDERS PRESENT	Tina Thomas, Alzheimer's Association Paige McCleary, DARS – Adult Protective Services (DARS) Judy Hackler, Virginia Assisted Living Association (VALA) Deborah Lloyd, Department of Social Services (VDSS)
DHP STAFF PRESENT:	Paula B. Saxby, RN, PhD, Deputy Executive Director, Virginia Board of Nursing Brenda Krohn, RN, MS, Deputy Executive Director, Virginia Board of Nursing
DISCUSSION:	This is the fifth meeting of the subgroup as a recommendation from the full stakeholders group from their meeting on July 14, 2016. The focus of the meeting was to continue to discuss possible changes to the Curriculum pertaining to Nurse Aide Education Programs in Virginia. The group continued to discuss possible changes to the curriculum unit by unit recapping Units 1 to 6, and discussed changes to Unit 7. There were some editorial changes and additions in the content for social isolation, unauthorized receipt of gifts or gratuity, changes in mental status to include confusion, new standards for Blood Pressure (BP), NNAAP exam requirements for taking BP, additional age related changes to skin and hair, and educate client/resident on the use of the call bell. In addition, Tina Thomas will work on language for bedmaking for dementia patients.
PLAN FOR FOLLOWUP:	Christine Smith and Temika Younger will send information from their nurse aide curriculum to assist with revisions. Dr. Saxby will make changes to the curriculum and distribute to the committee members prior to the next meeting. Ms. McDaniel (DNP student) will prepare information for discussion at the next meeting. We will continue discussion of possible changes to the curriculum starting with Unit VIII. The next meeting is scheduled for Tuesday, January 30, 2018 starting at 3:00 p.m. in Board Room 2.
ADJOURNMENT:	The committee adjourned at 5:10 p.m. Paula B. Saxby, R.N., Ph.D. Paula B. Saxby, R.N., Ph.D., Deputy Executive Director

VIRGINIA BOARD OF NURSING
SPECIAL CONFERENCE COMMITTEE OF THE BOARD OF NURSING AND THE COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
MINUTES
December 6, 2017

TIME AND PLACE: The meeting of the Special Conference Committee of the Board of Nursing and the Committee of the Joint Boards of Nursing and Medicine was convened at 10:32 A.M., in Board Room 2, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

MEMBERS PRESENT: Louise Hershkowitz, CRNA, MSHA, Chairperson
Marie Gerardo, MS, RN, ANP-BC
Dr. Kenneth Walker, MD

STAFF PRESENT: Jay P. Douglas, Executive Director, Board of Nursing
Robin Hills, DNP, RN, WHNP, Deputy Director, Board of Nursing
Anne Joseph, Deputy Director, Administrative Proceedings Division

CONFERENCES SCHEDULED: Adrienne Goodknight, **RN, LNP, 0001-139237; 0024-166680**

Ms. Goodknight appeared, accompanied by Douglas Coleman, Esquire, legal counsel.

CLOSED MEETING: Ms. Gerardo moved that the Special Conference Committee of the Board of Nursing and the Committee of the Joint Boards of Nursing and Medicine convene a closed meeting pursuant to Section 2.2-3711(A)(27) of the *Code of Virginia* at 1:22 P.M. for the purpose of deliberation to reach a decision in the matter of Ms. Rosado. Additionally, Ms. Gerardo moved that Ms. Douglas, Dr. Hills, and Ms. Joseph attend the closed meeting because their presence in the closed meeting is deemed necessary, and their presence will aid the Committee in its deliberations.

The motion was seconded and carried unanimously.

RECONVENTION: The Committee reconvened in open session at 2:33 P.M.

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

The motion was seconded and carried unanimously.

ACTION: Ms. Gerardo moved to issue an Order to reprimand the license of Ms. Goodknight to practice as a nurse practitioner in Virginia and place Ms. Goodknight on probation with terms.

The motion was seconded and carried unanimously.

request to the Board for a formal hearing on the allegations made against her is received from Ms. Goodknight within such time. If service of the order is made by mail, 3 additional days shall be added to that period. Upon such timely request for a formal hearing, the Order shall be vacated.

ADJOURNMENT: The meeting was adjourned at 2:40 P.M.

Robin L. Hills, D.N.P., R.N., W.H.N.P.
Deputy Executive Director

Virginia Board of Nursing
Guidance Document # 90-24

TITLE: The Use of Simulation in Nursing Education In Lieu of Direct Client Care

Introduction

This document provides information and guidance to pre-licensure registered nursing (RN) and practical nursing (PN) education programs in Virginia on the use of simulation in lieu of direct client care hours in the fulfillment of the clinical hour requirements for nursing education programs. As of April 2008, all RN nursing education programs approved in Virginia shall provide a minimum of 500 hours of direct client care supervised by qualified faculty, and all PN nursing education programs approved in Virginia shall provide a minimum of 400 hours of direct client care supervised by qualified faculty [18 VAC 90-27-60.A.B.]. This document will outline the essential components and major concepts that are necessary when using simulation in lieu of direct client care.

Background in Simulation

Technological innovations continue to advance practice across all domains of education and industry, and the same is true in nursing education. Research has shown that simulation provides opportunities for innovative learning experiences, fosters a richer understanding of didactic content and assists with developing clinical judgment. Evidence based research concludes that high-quality simulation experiences can be used in lieu of direct client care as an effective means for teaching knowledge and skills (Alexander et al, 2015). As nursing programs prepare to integrate simulation into nursing education, the Virginia Board of Nursing has prepared this outline of major concepts that need to be addressed when developing, implementing and integrating simulation into nursing curricula.

Simulated experiences provide the student with the opportunity to participate autonomously in complex nursing patient care situations in a safe learning environment. These experiences may be ones they may otherwise not experience in actual clinical settings (e.g., no laboring patients, no post-partum mothers, limited pediatric experiences, no patients with cardiac issues, no patients with complex med-surg issues, no home health patients or limited mental health patients). Simulation offers an avenue to assess clinical judgment and critical thinking in a safe environment. A simulated experience allows students to critically analyze their own actions (or failure to act), reflect on their own skill sets and clinical reasoning, and critique the clinical decisions of others (Jefferies 2007; Alexander et al, 2015). Simulation promotes active learning and participation, to enhance students' critical thinking skills (Billings & Halstead 2005). Simulation incorporates the concepts of active, learner-centered experiences that promote deeper understanding of didactic content and prepare students for low frequency, high risk situations. Educators can apply well-founded simulation approaches not only to help students in clinical rotations to attain educational goals, but also to evaluate teaching methods, as well as to investigate alternatives to the goals and methods themselves (Kyle & Murray 2008). Simulation provides an avenue for educators and researchers to improve nursing education and practice as well as advance the science and practice of nursing as a whole.

As a teaching methodology, "a clinical simulation experience is an active event in which students are immersed into a realistic clinical environment or situation. During this authentic clinical experience, learners are required to integrate and synthesize core concepts and knowledge and apply appropriate interpersonal and psychomotor skills. Students must incorporate critical thinking and decision making skills using a process (e.g., nursing process) involving assessment, diagnosis, planning, implementation or intervention and evaluation" (Virginia State Simulation Alliance, 2008 & 2017).

As cited in the Journal of Nursing Regulation October 2015 *NCSBN Simulation Guidelines for Prelicensure Nursing Programs*, concerns have emerged regarding substituting simulation for traditional clinical experiences without the appropriate environment, administrative support or faculty preparation. The NCSBN National Simulation Study: A Longitudinal, Randomized, Controlled Study Replacing Clinical Hours with Simulation in Prelicensure Nursing Education published in the Journal of Nursing Regulation August 2014 concluded that "simulation can be effectively substituted for traditional clinical experience in all prelicensure core nursing courses under conditions comparable to those described in the study. These conditions include faculty members who are formally trained in simulation pedagogy, an adequate number of faculty members to support the student learners, subject matter experts who conduct theory-based debriefing, and equipment and supplies to create a realistic environment". Nursing programs are advised to slowly and steadily increase the amount of simulation as they acquire expertise in this pedagogy (Alexander, M., et al, 2015).

Key Components in Simulation

Integral components of a simulated learning experience include: the educator/facilitator or preceptor, the student(s), key educational practices, and the simulated environment. The educator guides the student in the learning process. Qualified faculty, as defined by NCSBN, and who have additional education and professional development in simulation assume the role of facilitator during the simulated learning experience. Students participating in the simulated learning experience must come into the simulated clinical environment prepared for the simulation with a basic knowledge of the material and dressed appropriately for the clinical experience. The learning environment provides the foundation for effective simulated patient experiences. Simulation experiences must have objectives and identified learning outcomes. Learning occurs when the environment is realistic and students are engaged in the simulation experience by performing a specific role. Simulated experiences offer the opportunity for diverse styles of learning not offered in the class room environment and can result in an increase in student confidence (Jeffries & Rizzolo 2006 & 2015).

Evidence shows that highly effective simulated patient experiences must include:

- Simulation experiences comprised of pre-briefing, actual simulation experience, debriefing, and evaluation processes.
- Each simulated experience must have clearly stated objectives that are presented to the student prior to engaging in the simulation experience.

- Students may be required to prepare for a clinical simulation experience in the same manner as they would prepare for an actual patient care experience.
- An orientation to both the simulation technology and the environment is required.
- The simulation must challenge the student to use problem solving and critical reasoning skills to assess the situation and determine the correct interventions.
- The educator assumes the role of facilitator, providing cues when necessary but maintaining the fidelity of the simulation encounter.
- The educator and the student should participate in a theory based debriefing. Facilitated by the educator, the debriefing should challenge the student to think critically about his/her practice and clinical judgment. Development in debriefing of the educator and engaging students in this pedagogy directly contributes to the efficacy of the debriefing. The educator should utilize best practices in simulation and have an advanced knowledge of the situation to be covered in each simulation that they facilitate. Observing other students performing in a simulation experience, either in real time or videotaped, enhances learning and affects both the participant and the observers' self efficacy (Hoffmann et al. 2007). The debriefing session should occur immediately after the simulation and is completed so the thoughts and feelings of the learner are not forgotten and do not get distorted over time (Jeffries 2007). Video recording of the simulation can be utilized as a tool to provide objective data for review.
- Level of the simulation is congruent with the level of experience of the student and correlates with identified learning outcomes and course objectives.
- Faculty will be experientially prepared to facilitate simulation and debriefing through participation in a structured educational program or by a mentorship with an experienced simulation educator. Faculty will complete professional development in the area of teaching in simulation (to include, but not limited to: simulation conferences attended, coursework on simulation instruction, certification in simulation instruction, education/training by a consultant or targeted work with an experienced mentor)

There needs to be an introduction to both the simulation and the environment by the educator. The environment in which the simulated patient experience is to be performed must reflect reality as much as possible. Pre-briefing and an introduction to the environment are important because it allows students to become familiar with the simulated clinical environment. Poor introduction may lead to students questioning what can be done "for real", which may lead to a decrease in realism and undue stress. The simulation must challenge the student to use problem solving skills and critical thinking to develop clinical judgment. The educator should act as a facilitator in the learning process but maintaining fidelity within the simulation encounter as much as possible.

Definition of Terms:

Briefing:

Pre-briefing: The time before a simulation experience when students are provided information regarding objectives, expectations, roles, specific scenario and the simulated client is provided. Orientation to the simulation environment and equipment should be purposeful, intentional, and strategic. The pre-briefing sets the stage for a successful learning experience, focused on reducing the learner's anxiety and increasing confidence.

Debriefing: A theory based framework; An organized review that is purposeful, intentional, and strategic of an incident or event after it occurs that utilizes guided, reflective questioning for the purpose of discerning learning points, improving care, and quality improvement. Patient simulation requires objective, thorough evaluation of the learners' experience in the simulation.

Clinical Judgment: Obtaining the necessary experience to begin recognizing patterns as well as a familiarity with what needs to be done. An interpretation or conclusion regarding a patient's needs, concerns, or health problems, and/or the decision to take action (or not), use or modify standard approaches, or improvise new ones as deemed appropriate by the patient's response (Tanner, 2006).

Clinical Simulation Experiences: As a teaching methodology, "a clinical simulation experience is an active event in which students are immersed into a realistic clinical environment or situation. During these authentic clinical experience, learners are required to integrate and synthesize core concepts and knowledge and apply appropriate interpersonal and psychomotor skills. Students must incorporate critical thinking and decision making skills using a process (e.g., nursing process) involving assessment, diagnosis, planning, implementation or intervention and evaluation" (Virginia State Simulation Alliance, 2008 & 2017).

Critical Thinking (Clinical Reasoning)A mental process that requires assessment and evaluation of information in order to form a judgment that combines scientific evidence with common sense. An ability to solve problems by making sense of information using creative, intuitive, logical, and analytical mental processes that are continually evaluated (Snyder, 1993).

Cues: Interventions or assistance given by the educator to facilitate learning and problem solving without interfering or taking over a situation.

Direct client care: Nursing care provided to patients/clients in a clinical setting supervised by qualified faculty or a designated preceptor.

Fidelity/Digital clinical experience: The degree to which a simulation and/or a simulation device accurately reproduces clinical and/or human parameters; realism.

> **High-Fidelity Technologies** – A device with lifelike features, either whole body or partial body, that is able to respond to a learner's actions or interventions.
>
> **Low-Fidelity Technologies** – A device that does not respond to interventions or is unable to be altered in real time to create a response.

Hybrid Simulation: The use of two or more modalities of simulation modalities to enhance the fidelity of a scenario by integrating the environment, physiology, emotions, and dialog of a real patient encounter. For example, the use of a manikin to represent the patient, while the embedded participant assumes the role of the patient's voice or takes on the role of a distraught family member. (INACSL Standards of Best Practice: Simulation, Simulation Glossary, 2016)

Objectives: A learning tool designed to focus an educational experience on desired goals. The objectives of the simulation must reflect the intended outcome of the experience, specify expected learner behavior, and include sufficient detail to allow the learner to participate in the simulation effectively (Jeffries, 2007).

Part-task trainer: A device designed to teach students to perform a particular task such as urinary catheter insertion or venipuncture.

Simulated Direct Client/Patient Care: Clinical simulation that is realistic and reflective of care provided to clients in the health care environment. It must build students' clinical judgment and critical thinking and meet the requirements set forth by the Board and supervised by qualified faculty.

Simulation: A technique, not a technology, to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner (Gaba, 2004).

Skills Acquisition/Task Training: Education that is focused on psychomotor skills necessary to complete specific tasks that are integral to patient care. Skills acquisition/task training alone does not qualify as simulated direct client care.

Standardized patient: A person trained to consistently portray a patient or other individual in a scripted scenario for the purposes of instruction, practice, or evaluation (INACSL Standards of Best Practice: Simulation, Simulation Glossary, 2016).

Virtual computer based simulation: A computer-generated reality, which allows a learner or group of learners to experience various auditory and visual stimuli. This reality can be experienced through the use of specialized ear and eyewear (INACSL Standards of Best Practice: Simulation, Simulation Glossary, 2016).

Expectations for Using Simulation in Nursing Education Programs

Nursing program faculty and administrators are responsible for assessing their programs readiness to use simulation experiences in lieu of traditional clinical experiences. The program shall have an organizing framework that provides adequate fiscal, human, and material resources to support the simulation activities. The key components identified in this document must be included in the simulation plan. Faculty and administrators are encouraged to refer to the NCSBN Simulation Guidelines for Prelicensure Nursing Education Programs to determine readiness to implement simulation in lieu of direct client care. VASSA may also be a resource for determining a program's readiness to use simulation.

Faculty teaching in simulation must demonstrate simulation knowledge and skills in this area and are encouraged to have certification in the area of simulation. Minimally, faculty teaching in simulation must have participated in formal simulation related professional development. Faculty shall engage in ongoing professional development in the use of simulation.

Subject matter experts must be present for each simulation experience. If the faculty member conducting the simulation does not have knowledge in the subject area, then you would need faculty present with expertise in the subject area.

One hour of simulated client care, including the pre-briefing and debriefing time, is equal to one hour of direct client care. The faculty to student ratio must be a 1:10 ratio as required with all direct client care clinical learning experiences. Group size is to be determined by the scenario objectives. Each learner must have a defined and active role during the simulation (see INACSL best practices).

No more than 25% of direct patient contact hours may be completed through simulation. For pre-licensure registered nursing programs, the total of simulated patient care hours cannot exceed 125 hours (25% of the required 500 hours). For pre-licensure practical nursing programs, the total of simulated patient care hours cannot exceed 100 hours (25% of the required 400 hours). No more than 50% of the total clinical hours for any course may be used as simulation. If courses are integrated, it is important to make sure clinical hours are obtained as required in 18VAC90-27-90 (B)(1) across the life span...to include adult medical/surgical nursing, geriatric nursing, maternal/infant (obstetrics, gynecology, neonatal) nursing, mental health/psychiatric nursing, nursing fundamentals, and pediatric nursing.

Skills acquisition and task training alone, as in the traditional use of a skills lab, do not qualify as simulated client care, and therefore do not meet the requirements for direct client care hours. Clinical Simulation must be led by qualified faculty as required in regulation 18 VAC 90-27-60.

The following documentation must be available for all simulated experiences:

- course description,
- objectives of simulation experience, and learner outcomes,
- type of simulation,
- location of simulated experience,
- number of simulated hours,

- faculty qualifications,
- methods of pre-briefing and debriefing,
- evaluation of simulated experience, and
- method to communicate student performance to clinical faculty.

Resources

The International Nursing Association for Clinical Simulation and Learning (INACSL)
https://www.inacsl.org/i4a/pages/index.cfm?pageID=1

INACSL Standards of Best Practice

INACSL & Society for Simulation in Healthcare's 2016 Dictionary

National Council of State Boards of Nursing
https://www.ncsbn.org/685.htm
https://www.ncsbn.org/education.htm
https://www.ncsbn.org/16_Simulation_Guidelines.pdf

National League for Nursing
http://www.nln.org/centers-for-nursing-education/nln-center-for-innovation-in-simulation-and-technology
http://sirc.nln.org/

Quality Safety Education in Nursing
http://qsen.org/simulation/

Society for Simulation in Healthcare
http://www.ssih.org/

University of Washington (free modules)
https://collaborate.uw.edu/teaching-with-technology/simulation/

Virginia State Simulation Alliance (VASSA)
http://www.virginiasimulationallianceinc.org/wordpress/#

This recommendation in this document are intended to be merely advisory.

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*The Virginia Board of Nursing wishes to acknowledge the contributions and expertise of representatives from VASSA, without whom this document would not be complete. They were instrumental in the preparation of the original document, as well as the revised document.

*The Virginia Board of Nursing wishes to acknowledge the review, edits, and expertise of Dr. Pamela R. Jeffries, Dean and Professor, The George Washington University School of Nursing. She graciously offered her feedback for the revised version in 2017.

Accepted: July 21, 2009
Revised: _____, 2017

Virginia Department of Health Professions

David E. Brown, D.C.
Director

Patient Care Disciplinary Case Processing Times:
Quarterly Performance Measurement, Q2 2014 - Q2 2018

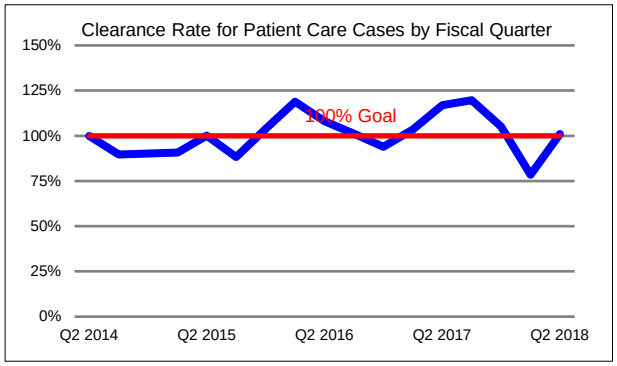
"To ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public."
DHP Mission Statement

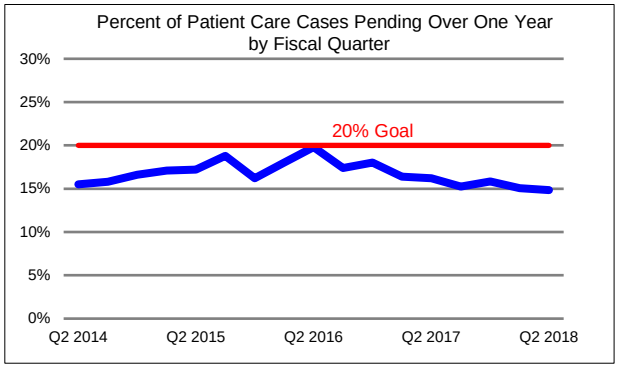
In order to uphold its mission relating to discipline, DHP continually assesses and reports on performance. Extensive trend information is provided on the DHP website, in biennial reports, and, most recently, on Virginia Performs through Key Performance Measures (KPMs). KPMs offer a concise, balanced, and data-based way to measure disciplinary case processing. These three measures, taken together, enable staff to identify and focus on areas of greatest importance in managing the disciplinary caseload; Clearance Rate, Age of Pending Caseload and Time to Disposition uphold the objectives of the DHP mission statement. The following pages show the KPMs by board, listed in order by caseload volume; volume is defined as the number of cases received during the previous 4 quarters. In addition, readers should be aware that vertical scales on the line charts change, both across boards and measures, in order to accommodate varying degrees of data fluctuation. This report does not include the number of days the case was in the continuance activity.

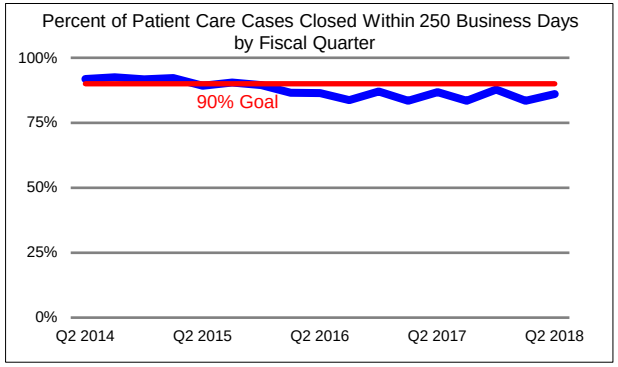
Clearance Rate - the number of closed cases as a percentage of the number of received cases. A 100% clearance rate means that the agency is closing the same number of cases as it receives each quarter. DHP's goal is to maintain a 100% clearance rate of allegations of misconduct. The current quarter's clearance rate is **101%**, with **955** patient care cases received and **965** closed.

Age of Pending Caseload - the percent of open patient care cases over 250 business days old. This measure tracks the backlog of patient care cases older than 250 business days to aid management in providing specific closure targets. The goal is to maintain the percentage of open patient care cases older than 250 business days at no more than 20%. The current quarter shows **15%** patient care cases pending over 250 business days with **2689** patient care cases pending and **399** pending over 250 business days.

Time to Disposition - the percent of patient care cases closed within 250 business days for cases received within the preceding eight quarters. This moving eight-quarter window approach captures the vast majority of cases closed in a given quarter and effectively removes any undue influence of the oldest cases on the measure. The goal is to resolve 90% of patient care cases within 250 business days. The current quarter shows **86%** percent of patient care cases being resolved within 250 business days with **965** cases closed and **830** closed within 250 business days.







Virginia Department of Health Professions - Patient Care Disciplinary Case Processing Times, by Board

Clearance Rate

Age of Pending Caseload
(percent of cases pending over one year)

Percent Closed in 250 Business Days

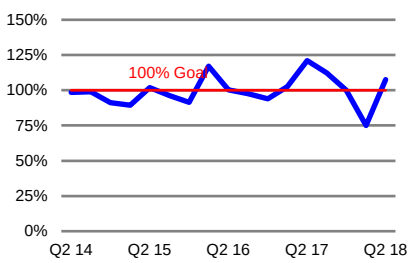
Nursing - In Q2 2018, the clearance rate was **108%**, the Pending Caseload older than 250 business days was **11%** and the percent closed within 250 business days was **80%**

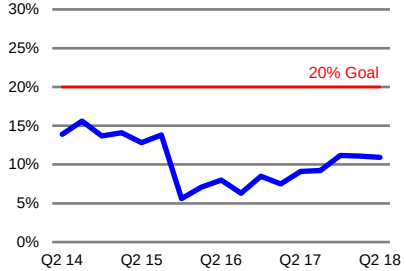
Q1 2018 Caseloads:

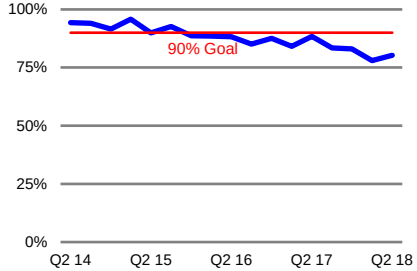
Received = **382** , Closed = **411**

Pending over 250 days = **143**

Closed within 250 days = **330**







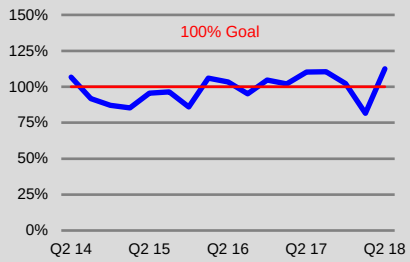
Nurses - In Q2 2018, the clearance rate was **113%**, the Pending Caseload older than 250 business days was **13%** and the percent closed within 250 business days was **81%**.

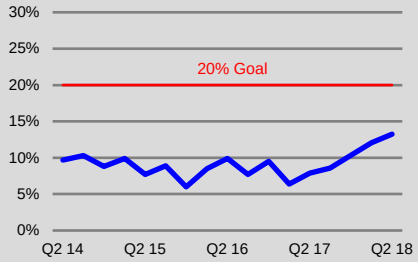
Q1 2018 Caseloads:

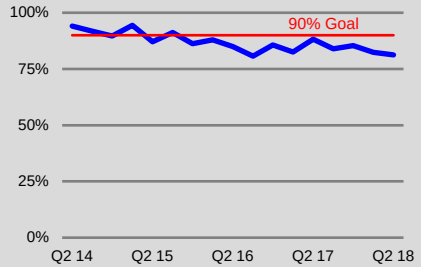
Received = **280** , Closed = **315**

Pending over 250 days = **120**

Closed within 250 days = **256**







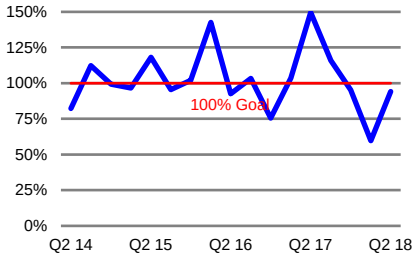
CNA - In Q2 2018, the clearance rate was **94%**, the Pending Caseload older than 250 business days was **6%** and the percent closed within 250 business days was **77%**.

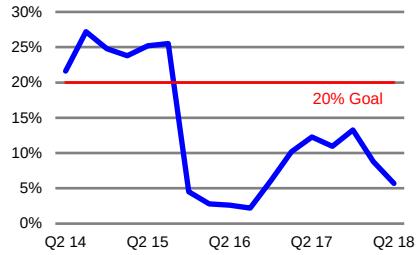
Q1 2018 Caseloads:

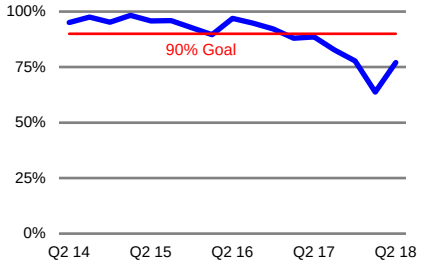
Received= **102** , Closed = **96**

Pending over 250 days = **23**

Closed within 250 days = **74**







Note: Vertical scales on line charts change, both across boards and measures, in order to accommodate varying degrees of data fluctuation.

COMMONWEALTH of VIRGINIA

David E. Brown, D.C.
Director

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

Board of Nursing (804) 367-4515
Nurse Aide Registry (804) 367-4569
FAX (804) 527-4455

Memo

To: Board Members

From: BON Nominating Committee

Re: Election of Officers – Final Slate

Date: January 8, 2018

The Final Slate for Election of Officers is presented for your consideration at the Annual Meeting:

President: Louise Hershkowitz, CRNA, MSHA
(2nd term expires 2021)

First Vice President: Marie Gerardo, MS, RN, ANP-BC
(1st term expires 2018)
Jennifer Phelps, LPN, QMHPA
(2nd term expires 2021)
Ethlyn McQueen-Gibson, DNP, MSN, RN, BC
(1st term expires 2021)

Second Vice President: Mark Monson, Citizen Member
(1st term expires 2018)
Dustin Ross, DNP, MBA, RN, NE-BC
(1st term expires 2020)

VIRGINIA BOARD OF NURSING

BY LAWS

Adopted: May 23, 1988
Revised to Incorporate Changes in *Code of Virginia*: April 1989
Last amended: November 14, 2017

Guidance Document: 90-57

BYLAWS
OF THE
VIRGINIA BOARD OF NURSING

Article I – Name.

This body shall be known as the Virginia Board of Nursing as set forth in § 54.1-3002 of the *Code of Virginia* and hereinafter referred to as the Board.

Article II – Powers and Duties.

The general powers and duties of the Board shall be those set forth in § 54.1-2400 of the *Code of Virginia* and the specific powers and duties shall be those set forth in § 54.1-3005 of the *Code of Virginia.*

Article III - Mission Statement.

To assure safe and competent practice of nursing to protect the health, safety and welfare of the citizens of the Commonwealth.

Article IV – Membership.

A. The Board shall be comprised of fourteen members. Seven members shall be registered nurses, two of whom shall be licensed nurse practitioners, three members shall be licensed practical nurses and three members shall be citizen members.

B. All members shall be appointed by the Governor for terms of four years. No member shall be eligible to serve more than two successive terms in addition to the portion of any unexpired term for which he may have been appointed.

C. Each member shall participate in all matters before the Board.

D. Members shall attend all regular, discipline and special meetings of the Board unless prevented from doing so by unavoidable cause.

E. The Governor may remove any Board member for cause, and the Governor shall be sole judge of the sufficiency of the cause for removal pursuant to § 2.2-108.

Article V – Nominations and Elections.

A. The officers of the Board shall be a President, First Vice-President and Second Vice-President elected by the members.

B. The Nominating Committee shall:

1. Be comprised of three members of the Board to be elected at the meeting immediately preceding the annual meeting held in January;

2. Elect its chair;

3. Prepare a slate of at least one candidate for each office to be filled;

4. Distribute the slate of candidates to all members in advance of the annual meeting;

5. Present the slate of nominees to the Board for election at the annual meeting; and

6. Be governed by *Robert's Rules of Order* (current edition) on nominations by a committee in all cases not provided for in this section.

C. Election

1. The President shall ask for nominations from the floor by office.

2. The election shall be by voice vote with the results recorded in the minutes. In the event of only one nominee for an office, election may be by acclamation.

3. The election shall occur in the following order: President, First Vice President, Second Vice President.

4. The election shall be final when the President announces the official results.

D. Terms of office

1. All terms will commence March 1.

2. The term of office shall be for the succeeding twelve months or until the successor shall be elected. No officer shall serve more than two consecutive twelve-month terms in the same office unless serving an unexpired term.

3. A vacancy in the office of President shall be filled by the First Vice-President. The Board shall fill a vacancy in the office of First Vice-President or Second Vice-President by election at the next meeting after which the vacancy occurred.

Article VI – Duties of Officers.

A. The President shall:

1. Preserve order and conduct of Board meetings according to these bylaws, Robert's Rules, the Administrative Process Act and other applicable laws and regulations;

2. Call special meetings;

3. Appoint all committees, except the nominating committee;

4. Appoint annually three members to the Committee of the Joint Boards of Nursing and Medicine; and

5. Review and approve non-routine applications for licensure, certification or registration as referred by Board staff.

B. The First Vice-President shall:

1. Preside in the absence of the President;

2. Succeed to the office of President for the unexpired term in the event of a vacancy in the office of President; and

3. Assume such functions or responsibilities as may be delegated by the President or the Board.

C. The Second Vice-President shall:

1. Certify minutes of all Board proceedings;

2. Perform all other duties pertaining to this office and not otherwise delegated to staff; and

3. Assume such functions or responsibilities as may be delegated by the President or the Board.

Article VII – Committees.

A. Executive Committee:

The Officers of the Board shall constitute the Executive Committee, which shall represent the interests of the Board in meetings within the Department of Health Professions, with other agencies of the Commonwealth or other organizations as directed

by the Board. The Executive Committee may review matters pending before the Board and make recommendations to the Board for action.

B. Standing Committees

1. Members of the standing committees shall be appointed by the President following the election of the officers for a term of twelve months.

2. Standing Committees shall include:
Committee of the Joint Boards of Nursing and Medicine
Education Committee

C. Special Conference Committees shall be comprised of at least two members of the Board and shall:

1. Review investigative reports resulting from complaints against licensees.

2. Recommend appropriate proceedings for complaint resolution.

3. Conduct informal proceedings pursuant to §§ 2.2-4019, 2.2-4021, and 54.1-2400 of the *Code of Virginia*.

D. Advisory Committees

1. Advisory Committees shall consist of three or more persons appointed by the Board who are knowledgeable in a particular area of practice or education under consideration by the Board.

2. Such committees shall review matters as requested by the Board and advise the Board relative to the matters or make recommendations for consideration by the Board.

E. Ad-Hoc Committees

1. Ad-Hoc Committees comprised of Board members and/or staff may be appointed by the President to assist in fulfilling the powers and duties of the Board.

2. Such committees shall be advisory to the Board and shall make recommendations to the Board for action.

3. A Committee shall be appointed by the Board every three years to review Board of Nursing guidance documents and make recommendations for revisions and/or deletions.

Article VIII – Meetings.

A. The Board shall meet in regular session at least in January of each year for its annual meeting and at such other times as the Board may determine.

B. Special meetings shall be called by the president or by written request to the President from any three members, provided there is at least seven days' notice given to all members.

C. A telephone conference call meeting may be held to consider suspension of a license pursuant to § 54.1-2408.1 pending a hearing when the danger to the public health or safety warrants such action and when a good faith effort to convene a regular meeting has failed.

D. An affirmative vote of a majority of those serving on the Board who are qualified to vote or those serving on a panel of the Board convened pursuant to § 54.1-2400 shall be required for any action to suspend or revoke a license, certificate, or registration or to impose a sanction, except an affirmative vote of a majority of a quorum of the Board shall be sufficient for the summary suspension of a license. An affirmative vote of three-fourths of the members of the Board at the hearing shall be required to reinstate an applicant's license or certificate suspended by the Director of the Department of Health Professions pursuant to § 54.1-2409. An affirmative vote of a quorum of the Board shall determine all other matters at any regular or special meeting.

Article IX – Quorum.

A. A quorum for any Board or committee meeting shall consist of a majority of the members.

B. No member shall vote by proxy.

Article X – Parliamentary Authority.

Roberts' Rules of Order (current edition) shall govern the proceedings of the Board in all cases not provided for in these bylaws, the *Code of Virginia* and the Regulations of the Board.

Article XI – Amendment of Bylaws.

These bylaws may be amended at any meeting of the Board by a two-thirds vote of the members present and voting provided copies of the proposed amendments shall have been presented in writing to all members at least 30 days prior to the meeting at which time such amendments are considered.

Article XII –Discipline.

When the Board of Nursing receives an investigative report from the Enforcement Division, a preliminary review of the case is made to determine whether probable cause exists to proceed with an administrative proceeding on charges that one or more of the Board's statutes or regulations may have been violated. The Board of Nursing staff, for certain disciplinary activities pursuant to Guidance Document # 90-12.

Article XIII – Nurse Licensure Compact.

A. Pursuant to § 54.1-3037 of the *Code of Virginia* the Executive Director of the Board of Nursing shall be the Administrator of the Compact for Virginia and shall perform the duties of the Administrator according to the requirements of the Nurse Licensure Compact.

B. The Board of Nursing shall comply with the Policies and Procedures of the Nurse Licensure Compact Administrators as outlined in the current manual.

VIRGINIA BOARD OF NURSING
EDUCATION INFORMAL CONFERENCE COMMITTEE
MINUTES
January 17, 2018

Note: Due to weather conditions the State Agencies opened at 10:15 a.m. on January 17, 2018

TIME AND PLACE:	The meeting of the Education Informal Conference Committee was convened at 11:17 a.m. in Suite 201, Department of Health Professions 9960 Mayland Drive, Second Floor, Board Room 2, Henrico, Virginia.
MEMBERS PRESENT:	Joyce A. Hahn, PhD, RN, NEA-BC, FNAP, Chair Mark D. Monson, Citizen Member
STAFF PRESENT:	Jay P. Douglas, MSM, RN, CSAC, FRE, Executive Director Paula B. Saxby, RN, Ph.D., Deputy Executive Director Charlette Ridout, RN, MS, CNE, Senior Nursing Education Consultant, Beth Yates, Administrative Assistant

CONFERENCES SCHEDULED:

REGISTERED NURSING, PRACTICAL NURSING, AND NURSE AIDE EDUCATION PROGRAMS

Continued Faculty Exceptions
Liberty University, Lynchburg, BSN Program, US28500000

Shanna Akers, EdD, MSN/MBA-HC, RN, CNE, Dean and Tracey Turner, EDS, MSN, RN, COB, Chair BSN Program were in attendance.

Ms. Douglas left the meeting at 11:30 a.m.

Ms. Douglas returned to the meeting at 11:56 a.m.

At 11:56 a.m. Mr. Monson moved that the Education Informal Conference Committee convene a closed meeting pursuant to §2.2-3711 (A) (27) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter Liberty University, Lynchburg, BSN program. Additionally, he moved that, Ms. Douglas, Dr. Saxby, Ms. Ridout, and Ms. Yates attend the closed meeting because their presence in the closed meeting was deemed necessary.

The motion was seconded and carried unanimously. The Committee reconvened in open session at 12:11 p.m.

Mr. Monson moved that the Education Informal Conference Committee heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened.
Action: Recommend to grant continued exception for 12 faculty members with the exception of Kelly Carmody until such time as she can present

evidence to the Board that she has met the requirements of the regulation for the continued exception. Subsequent to the meeting, we received the necessary information on Ms. Carmody, therefore the recommendation is to grant continued faculty exception for 13 faculty members.

12:30 Public Comment

There was no public comment

Program Status Update

Ms. Ridout, Senior Nursing Education Consultant presented the report regarding the status of several nursing education programs, including continued approval for one RN program and two PN programs; Russell County Public School's intent to not admit any students to their PN program for the 2017-2018 academic year; and the closure of the LPN to RN Bridge Program at Fortis College, Norfolk.

Action: Recommend to accept as information.

Next Generation NCLEX Project

Ms. Ridout presented information from NCSBN on their Next Generation NCLEX project.

Action: Recommend to accept the report as information.

Approved Program Information Posted on the Website

Ms. Ridout presented the new format for listing the approved nursing education programs on the Board of Nursing website.

Action: Recommend to accept the report as information.

Meeting adjourned at 12:47 p.m.

Paula B. Saxby, R.N., Ph.D.
Deputy Executive Director

Charlette Ridout, R.N., M.S.
Senior Nursing Education Consultant

Virginia's Licensed Practical Nurse Workforce: 2017

Healthcare Workforce Data Center

October 2017

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

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

10,591 Licensed Practical Nurses voluntarily participated in this survey. *Without their efforts the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Nursing express our sincerest appreciation for your ongoing cooperation.*

Thank You!

Virginia Department of Health Professions

David E. Brown, D.C.
Director

Lisa R. Hahn, MPA
Chief Deputy Director

Healthcare Workforce Data Center Staff:

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

Virginia Board of Nursing

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Joyce A. Hahn, PhD, RN, NEA-BC, FNAP
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Rebecca Poston, PhD, RN, CPNP
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Dustin S. Ross, DNP, MBA, RN, NE-BC
Chesapeake

Executive Director

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

Contents

The Licensed Practical Nurse Workforce: At a Glance:

The Workforce

Licensees:	30,444
Virginia's Workforce:	27,578
FTEs:	24,286

Survey Response Rate

All Licensees:	35%
Renewing Practitioners:	82%

Demographics

Female:	95%
Diversity Index:	54%
Median Age:	46

Background

Rural Childhood:	49%
HS Degree in VA:	71%
Prof. Degree in VA:	86%

Education

LPN Diploma/Cert.:	96%
Associate:	4%

Finances

Median Income:	$30k-$40k
Health Benefits:	59%
Under 40 w/ Ed debt:	60%

Current Employment

Employed in Prof.:	88%
Hold 1 Full-time Job:	69%
Satisfied?:	94%

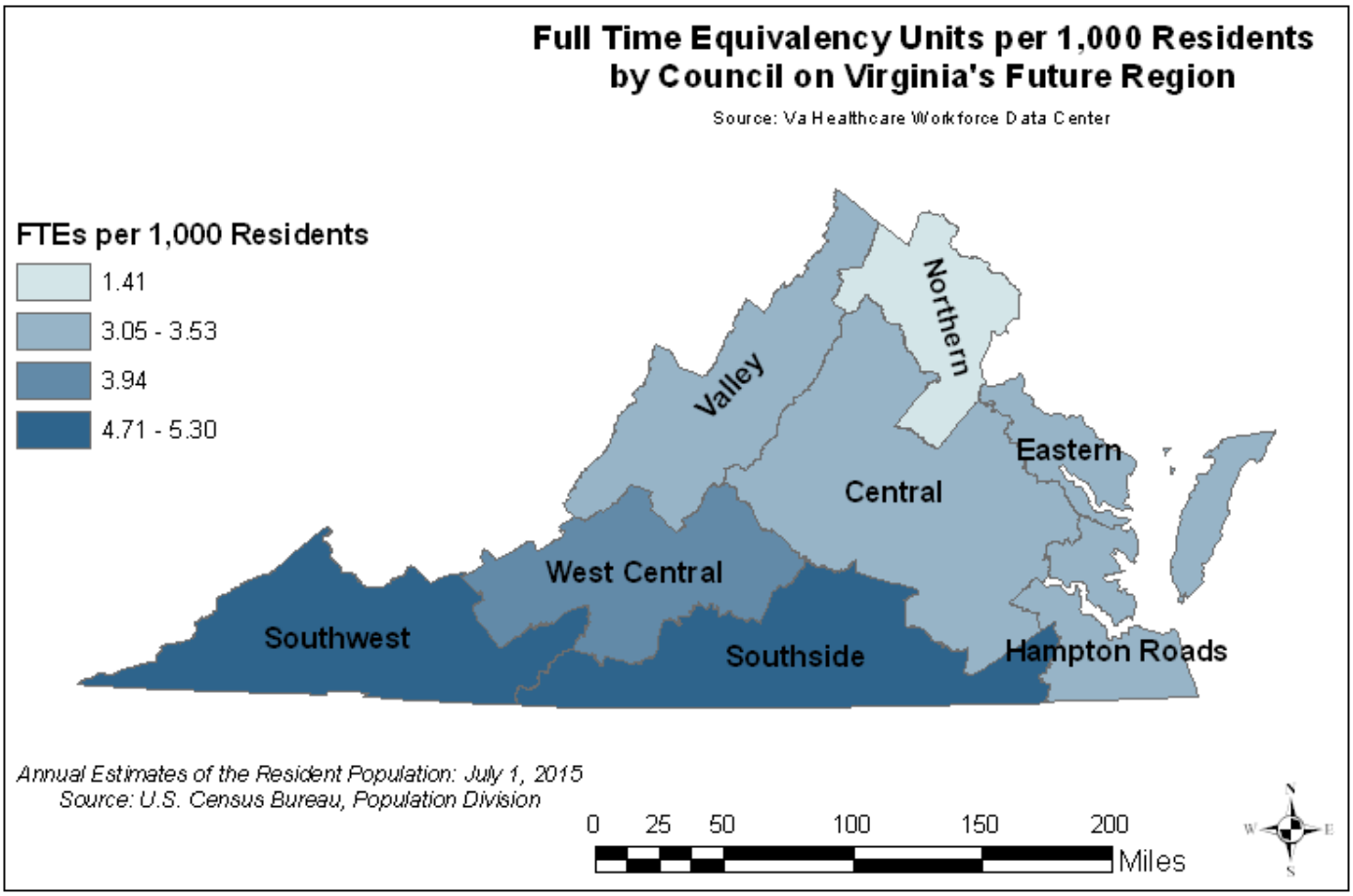
Job Turnover

Switched Jobs:	9%
Employed over 2 yrs:	55%

Time Allocation

Patient Care:	80%-89%
Patient Care Role:	67%
Admin. Role:	7%

Source: Va. Healthcare Workforce Data Center



Results in Brief

10,591 Licensed Practical Nurses (LPNs) voluntarily took part in the 2017 Licensed Practical Nurse Workforce Survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place during a two-year renewal cycle on the birth month of each respondent. Therefore, only approximately half of all LPNs have access to the survey in any given year. Thus, these survey respondents represent only 35% of the 30,444 LPNs who are licensed in the state but 82% of renewing practitioners.

The HWDC estimates that 27,578 LPNs participated in Virginia's workforce during the survey period, which is defined as those who worked at least a portion of the year in the state or who live in the state and intend to return to work as an LPN at some point in the future. Between October 2016 and September 2017, Virginia's LPN workforce provided 24,286 "full-time equivalency units", which the HWDC defines simply as working 2,000 hours a year (or 40 hours per week for 50 weeks with 2 weeks off).

95% of all LPNs are female, and this percentage does not change for those LPNs who are under the age of 40. In a random encounter between two LPNs, there is a 54% chance that they would be of different races or ethnicities, a measure known as the diversity index. Among those LPNs who are under the age of 40, this diversity index increases to 58%. Thus, while the LPN workforce as a whole is slightly less diverse than Virginia's overall population, whose diversity index currently rests at 56%, it is actually more diverse than the general statewide population with respect to those LPNs who are under the age of 40.

49% of all LPNs grew up in a rural area, and 32% of these professionals currently work in non-Metro areas of the state. Overall, 19% of all LPNs work in a non-Metro area of the state. Meanwhile, 71% of Virginia's LPNs graduated from high school in Virginia, and 86% earned their initial professional degree in the state. In total, 88% of Virginia's LPN workforce has some educational background in the state.

96% of all LPNs hold a LPN/LVN diploma or certificate as their highest professional degree. Among those LPNs who have pursued additional education, the vast majority have earned an Associate degree in Nursing. 42% of Virginia's LPN workforce currently has education debt, including 60% of those under the age of 40. The median debt burden for those LPNs with educational debt is between $20,000 and $30,000.

88% of LPNs are currently employed in the profession. 69% of all LPNs hold one full-time position at the moment, while another 12% currently hold two or more positions at the same time. 55% of Virginia's LPNs work between 40 and 49 hours per week, while just 5% of LPNs work at least 60 hours per week. Although 9% of LPNs have switched jobs at some point in the past year, another 55% of LPNs have remained at their current position for at least two years.

The median annual income for LPNs is between $30,000 and $40,000. In addition, 75% of wage or salaried LPNs receive at least one employer-sponsored benefit, including 59% who receive health insurance. 94% of LPNs are satisfied with their current employment situation, including 64% who indicate they are "very satisfied".

25% of Virginia's LPNs have worked at two or more locations in the past year, while 22% of LPNs currently do so. 83% of LPNs work in the private sector, including 63% who work at a for-profit institution. 26% of all LPNs currently work at a long-term care facility or nursing home, while 13% are employed at a physician's office.

A typical LPN spends between 80% and 90% of her time treating patients. In fact, 67% of LPNs serve a patient care role, meaning that at least 60% of their time is spent in patient care activities. Meanwhile, a typical LPN spends approximately 45% of her time treating elderly patients and 35% of her time treating adult patients.

34% of LPNs expect to retire by the age of 65. 6% of the current workforce expects to retire in the next two years, while half the current workforce plans to retire by 2042. Over the next two years, 34% of all LPNs expect to pursue additional educational opportunities, while 9% plan on increasing their patient care hours.

Summary of Trends

Over the past four years, the number of licensed LPNs in the state of Virginia actually fell slightly from 30,752 to 30,444. At the same time, the Healthcare Workforce Data Center experienced an increase in the response rates from these professionals. In 2013, only 33% of all licensees responded to the HWDC survey, but this percentage increased to 35% in 2017. Among renewing practitioners, the increase was even more dramatic. Since 2013, the response rate among renewing practitioners has increased from 74% to 82%.

In addition to the decline in the number of licensed LPNs in Virginia, there was also a decrease in the size of the state's LPN workforce. In 2013, there were 28,391 LPNs in the state's workforce, but this number fell to 27,578 in 2017. At the same time, this workforce has provided considerably fewer FTEs. Virginia's LPN workforce provided 26,573 FTEs in 2013, but the 2017 LPN workforce only provided 24,286 FTEs.

Although there was not much change in the demographic breakdown of Virginia's LPN workforce with respect to its age, the workforce has become somewhat more diverse. The diversity index of the 2013 LPN workforce was 51%, but this percentage increased to 54% in 2017. In addition, the diversity index for those LPNs who are under the age of 40 increased slightly over the past four years from 57% to 58%.

In 2013, half of all LPNs in the state came from a rural background. Over the course of the past four years, this percentage has experienced a modest decline to 49%. At the same time, however, the percentage of those LPNs who grew up in rural areas and chose to work in a non-Metro area of the state increased from 30% in 2013 to 32% in 2017. Overall, there was no change in the percentage of LPNs who work in non-Metro areas of the state. This percentage has remained at 19% over the course of the past four years.

97% of all LPNs held a LPN/LVN diploma or certificate as their highest professional degree in 2013. However, this was only true of 96% of LPNs in 2017. Instead, LPNs have been more likely to pursue additional forms of education. In particular, the percentage of LPNs who hold an Associate degree in Nursing has doubled over the past four years from 2% to 4%. This pursuit of additional education has been accompanied by a rise in education debt among Virginia's LPN workforce. While 37% of all LPNs held education debt in 2013, 42% carry such debt today. In addition, the median debt level has increased since 2013. Four years ago, the median debt burden among those LPNs with education debt was $10,000-$20,000, but this median level has risen to $20,000-$30,000 in 2017.

There has been no change in the median annual income of Virginia's LPN workforce since 2013, which remains at $30,000-$40,000. However, there have been some changes in access to various forms of employer-sponsored benefits. For instance, 63% of all LPNs received health insurance through their employer in 2013, but only 60% have access to employer-sponsored health insurance in 2017. On the other hand, the percentage of LPNs who have access to an employer-sponsored retirement plan has increased from 51% to 53%. These changes may have resulted in a marked increase in the percentage of LPNs who declare themselves to be "very satisfied" with their current work situation from 59% in 2013 to 64% in 2017.

Although there was no change in the median income of the LPN workforce, there was a change in how LPNs received this income. In particular, more LPNs are receiving an hourly wage at their primary work location. In 2013, 81% of all LPNs received an hourly wage, but this percentage increased to 84% in 2017. Meanwhile, the percentage of LPNs who receive a salary at their primary work location has seen a concomitant decrease from 16% to 13%.

22% of all LPNs began work in a new location at either their primary or secondary work locations in 2013, but this percentage increased to 27% in 2017. In addition, the percentage of LPNs who work at multiple locations has increased over the past four years from 20% to 25%. At the same time, there has also been a marked increase in the percentage of LPNs who work in the for-profit sector from 56% in 2013 to 63% in 2017. Meanwhile, LPNs have experienced changes in their time allocation roles over the past four years. For instance, 79% of all LPNs served a patient care role in 2013, but this percentage has fallen to just 67% in 2017. Regardless, the typical LPN still spends 80%-90% of her time treating patients on any given day.

A Closer Look:

Licensees		
License Status	#	%
Renewing Practitioners	13,170	43%
New Licensees	1,069	4%
Non-Renewals	2,174	7%
Renewal date not in survey period	14,031	46%
All Licensees	**30,444**	**100%**

Source: Va. Healthcare Workforce Data Center

HWDC surveys tend to achieve very high response rates. 82% of renewing LPNs submitted a survey. These represent 35% of LPNs who held a license at some point during the survey period.

Response Rates			
Statistic	**Non Respondents**	**Respondent**	**Response Rate**
By Age			
Under 30	2,611	1,010	28%
30 to 34	2,116	1,388	40%
35 to 39	2,489	1,191	32%
40 to 44	2,093	1,441	41%
45 to 49	2,386	1,268	35%
50 to 54	1,967	1,386	41%
55 to 59	2,242	1,061	32%
60 and Over	3,949	1,846	32%
Total	**19,853**	**10,591**	**35%**
New Licenses			
Issued After Sept. 2016	1,069	0	0%
Metro Status			
Non-Metro	4,182	2,391	36%
Metro	14,479	7,788	35%
Not in Virginia	1,192	412	26%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed LPNs

Number:	30,444
New:	4%
Not Renewed:	7%

Response Rates

All Licensees:	35%
Renewing Practitioners:	82%

Source: Va. Healthcare Workforce Data Center

Response Rates	
Completed Surveys	10,591
Response Rate, all licensees	35%
Response Rate, Renewals	82%

Source: Va. Healthcare Workforce Data Center

Definitions

1. **The Survey Period:** The survey was conducted between October 2016 and September 2017 on the birth month of each renewing practitioner.
2. **Target Population:** All LPNs who held a Virginia license at some point during the survey time period.
3. **Survey Population:** The survey was available to LPNs who renewed their licenses online. It was not available to those who did not renew, including LPNs newly licensed during the survey time frame.

At a Glance:

Workforce

Virginia's LPN Workforce:	27,578
FTEs:	24,286

Utilization Ratios

Licensees in VA Workforce:	91%
Licensees per FTE:	1.25
Workers per FTE:	1.14

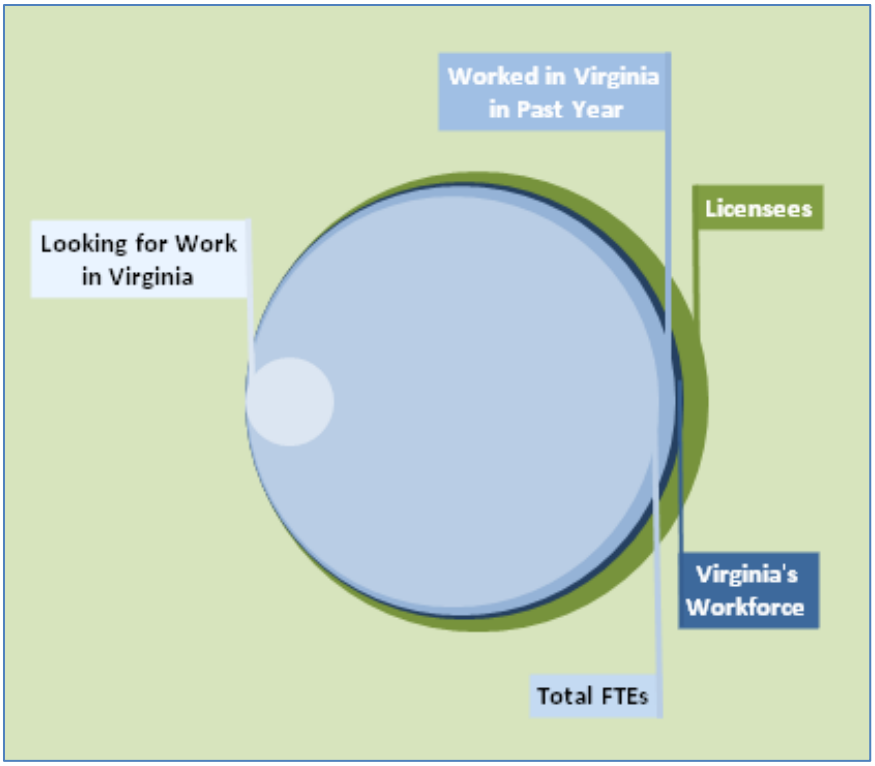
Source: Va. Healthcare Workforce Data Center

Definitions

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

Virginia's LPN Workforce		
Status	#	%
Worked in Virginia in Past Year	26,449	96%
Looking for Work in Virginia	1,129	4%
Virginia's Workforce	**27,578**	**100%**
Total FTEs	**24,286**	
Licensees	**30,444**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

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

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 30	172	5%	3,064	95%	3,236	13%
30 to 34	135	4%	2,920	96%	3,055	12%
35 to 39	149	5%	2,966	95%	3,115	13%
40 to 44	129	4%	2,879	96%	3,008	12%
45 to 49	177	6%	2,790	94%	2,967	12%
50 to 54	123	5%	2,597	96%	2,720	11%
55 to 59	157	6%	2,416	94%	2,573	10%
60 +	215	5%	3,990	95%	4,205	17%
Total	**1,257**	**5%**	**23,622**	**95%**	**24,878**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

% Female:	95%
% Under 40 Female:	95%

Age

Median Age:	46
% Under 40:	38%
% 55+:	27%

Diversity

Diversity Index:	54%
Under 40 Div. Index:	58%

Source: Va. Healthcare Workforce Data Center

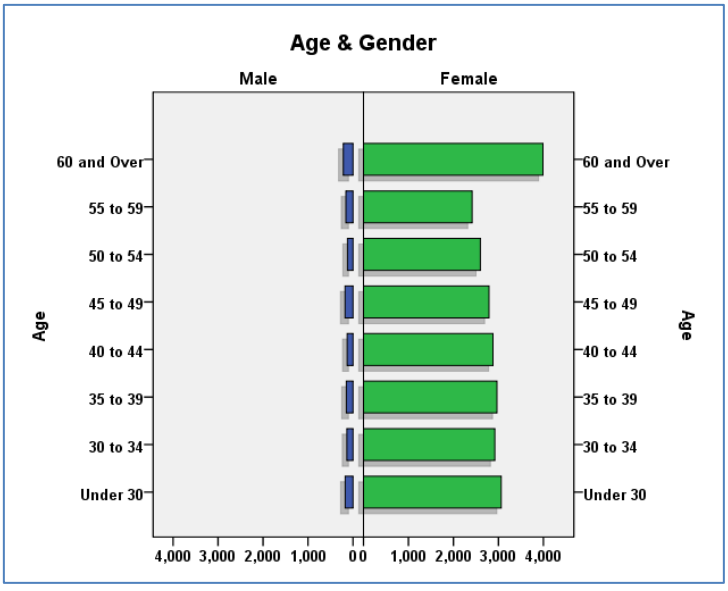
Race & Ethnicity					
Race/ Ethnicity	Virginia*	LPNs		LPNs under 40	
	%	#	%	#	%
White	63%	15,073	60%	5,292	56%
Black	19%	7,744	31%	3,025	32%
Asian	6%	464	2%	236	2%
Other Race	0%	278	1%	97	1%
Two or more races	3%	575	2%	271	3%
Hispanic	9%	828	3%	531	6%
Total	**100%**	**24,962**	**100%**	**9,452**	**100%**

*Population data in this chart is from the US Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2015.

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two LPNs, there is a 54% chance they would be of a different race/ethnicity (a measure known as the Diversity Index), compared to a 56% chance for Virginia's population as a whole.

38% of LPNs are under the age of 40. 95% of these professionals are female. In addition, the diversity index among LPNs under the age of 40 is 58%, which is higher than the diversity index for Virginia's overall population.



Source: Va. Healthcare Workforce Data Center

At a Glance:

Childhood

Urban Childhood:	19%
Rural Childhood:	49%

Virginia Background

HS in Virginia:	71%
Prof. Ed. in VA:	86%
HS or Prof. Ed. in VA:	88%

Location Choice

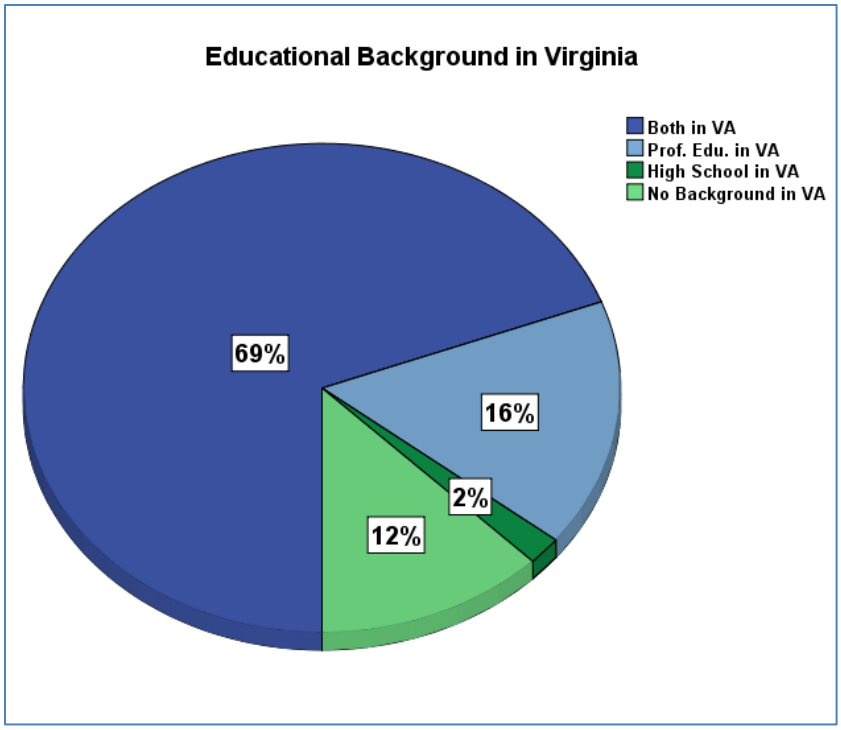
% Rural to Non-Metro:	32%
% Urban/Suburban to Non-Metro:	6%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Primary Location: USDA Rural Urban Continuum		Rural Status of Childhood Location		
Code	Description	Rural	Suburban	Urban
	Metro Counties			
1	Metro, 1 million+	31%	42%	27%
2	Metro, 250,000 to 1 million	62%	26%	13%
3	Metro, 250,000 or less	71%	21%	8%
	Non-Metro Counties			
4	Urban pop 20,000+, Metro adj	67%	20%	13%
6	Urban pop, 2,500-19,999, Metro adj	84%	11%	5%
7	Urban pop, 2,500-19,999, nonadj	91%	6%	3%
8	Rural, Metro adj	79%	18%	3%
9	Rural, nonadj	82%	11%	7%
	Overall	**49%**	**32%**	**19%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

49% of LPNs grew up in self-described rural areas, and 32% of these professionals currently work in non-Metro counties. Overall, 19% of all LPNs currently work in non-Metro counties.

Top Ten States for Licensed Practical Nurse Recruitment

Rank	All LPNs			
	High School	#	Init. Prof Degree	#
1	Virginia	17,656	Virginia	21,215
2	Outside U.S./Canada	1,470	New York	442
3	New York	848	West Virginia	326
4	Pennsylvania	507	Pennsylvania	283
5	West Virginia	461	Texas	220
6	North Carolina	358	Florida	209
7	New Jersey	336	New Jersey	206
8	Florida	288	Washington, D.C.	197
9	Maryland	283	North Carolina	181
10	Ohio	278	California	172

Source: Va. Healthcare Workforce Data Center

71% of licensed LPNs received their high school degree in Virginia, and 86% received their initial professional degree in the state.

Among LPNs who received their license in the past five years, 68% received their high school degree in Virginia, while 83% received their initial professional degree in the state.

Rank	Licensed in the Past 5 Years			
	High School	#	Init. Prof Degree	#
1	Virginia	4,346	Virginia	5,287
2	Outside U.S./Canada	410	West Virginia	112
3	New York	195	Texas	112
4	Pennsylvania	126	New York	98
5	Ohio	107	Florida	83
6	Florida	105	Pennsylvania	76
7	West Virginia	101	California	74
8	California	93	North Carolina	56
9	North Carolina	90	Ohio	56
10	Maryland	77	New Jersey	46

Source: Va. Healthcare Workforce Data Center

9% of Virginia's licensees did not participate in Virginia's LPN workforce during the past year. 64% of these licensees worked at some point in the past year, including 55% who worked in a nursing-related capacity.

At a Glance:

Not in VA Workforce

Total:	2,858
% of Licensees:	9%
Federal/Military:	8%
Va. Border State/DC:	18%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Degree		
Degree	#	%
LPN Diploma or Cert.	23,677	96%
Hospital RN Diploma	27	0%
Associate Degree	891	4%
Baccalaureate Degree	93	0%
Master's Degree	4	0%
Doctorate Degree	3	0%
Total	**24,695**	**100%**

Source: Va. Healthcare Workforce Data Center

96% of all LPNs hold a LPN/LVN Diploma or Certificate as their highest professional degree. 42% of LPNs carry education debt, including 60% of those under the age of 40. The median debt burden among LPNs with educational debt is between $20,000 and $30,000.

At a Glance:

Education

LPN Diploma/Cert.: 96%
Associate: 4%

Educational Debt

Carry debt: 42%
Under age 40 w/ debt: 60%
Median debt: $20k-$30k

Source: Va. Healthcare Workforce Data Center

Current Educational Attainment		
Currently Enrolled?	#	%
Yes	3,580	15%
No	21,032	85%
Total	**24,612**	**100%**
Degree Pursued	#	%
Associate	2,197	64%
Bachelor	1,123	33%
Masters	99	3%
Doctorate	14	0%
Total	**3,434**	**100%**

Source: Va. Healthcare Workforce Data Center

Educational Debt				
Amount Carried	All LPNs		LPNs under 40	
	#	%	#	%
None	12,261	58%	3,304	40%
$10,000 or less	2,228	11%	1,196	15%
$10,000-$19,999	1,892	9%	1,093	13%
$20,000-$29,999	1,712	8%	1,066	13%
$30,000-$39,999	1,041	5%	624	8%
$40,000-$49,999	597	3%	324	4%
$50,000-$59,999	493	2%	284	3%
$60,000-$69,999	308	1%	157	2%
$70,000-$79,999	163	1%	76	1%
$80,000-$89,999	94	0%	48	1%
$90,000-$99,999	57	0%	36	0%
$100,000-$109,999	45	0%	14	0%
$110,000-$119,999	24	0%	16	0%
$120,000 or more	51	0%	7	0%
Total	**20,966**	**100%**	**8,245**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Primary Specialty

LTC/Assisted Living:	14%
Geriatrics/Gerontology:	13%
Pediatrics:	8%

Secondary Specialty

LTC/Assisted Living:	13%
Geriatrics/Gerontology:	11%
Pediatrics:	5%

Licenses

Registered Nurse:	1%

Source: Va. Healthcare Workforce Data Center

14% of all LPNs have specialty in long-term care. Another 13% and 8% have specialties in geriatrics and pediatrics, respectively.

A Closer Look:

Specialties				
Specialty	Primary		Secondary	
	#	%	#	%
Long-Term Care/Assisted Living/Nursing Home	3,243	14%	2,558	13%
Geriatrics/Gerontology	3,084	13%	2,034	11%
Pediatrics	1,968	8%	994	5%
Family Health	1,370	6%	727	4%
Psychiatric/Mental Health	760	3%	520	3%
Acute/Critical Care/Emergency/Trauma	576	2%	605	3%
Rehabilitation	423	2%	600	3%
Adult Health	395	2%	567	3%
Surgery/OR/Pre-, Peri- or Post-Operative	382	2%	273	1%
Cardiology	352	1%	258	1%
Women's Health/Gynecology	344	1%	235	1%
Community Health/Public Health	279	1%	328	2%
Administration/Management	272	1%	436	2%
Orthopedics	238	1%	181	1%
Obstetrics/Nurse Midwifery	229	1%	189	1%
Student Health	218	1%	89	0%
Hospital/Float	187	1%	243	1%
Renal Health/Dialysis	183	1%	109	1%
Palliative/Hospice Care	163	1%	197	1%
General Nursing/No Specialty	6,507	27%	5,765	30%
Medical Specialties (Not Listed)	322	1%	208	1%
Other Specialty Area	2,359	10%	1,951	10%
Total	**23,856**	**100%**	**19,068**	**100%**

Source: Va. Healthcare Workforce Data Center

Other Certifications		
Certification	#	% of Workforce
Registered Nurse	299	1%
Licensed Nurse Practitioner	49	0%
Certified Message Therapist	37	0%
Respiratory Therapist	34	0%
Clinical Nurse Specialist	3	0%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Military Service		
Service?	#	%
Yes	1,581	7%
No	21,949	93%
Total	**23,530**	**100%**

Source: Va. Healthcare Workforce Data Center

Branch of Service		
Branch	#	%
Army	766	53%
Navy/Marine	506	35%
Air Force	154	11%
Other	25	2%
Total	**1,451**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Military Service
% Served: 7%

Branch of Service
Army: 53%
Navy/Marine: 35%
Air Force: 11%

Occupation
Army Health Care Spec.: 14%
Navy Basic Med. Tech.: 7%
Air Force Basic Med. Tech.: 2%

Source: Va. Healthcare Workforce Data Center

7% of Virginia's LPN workforce has served in the military. 53% of these LPNs served in the Army, including 14% who worked as an Army Health Care Specialist (68W Army Medic).

Military Occupation		
Occupation	#	%
Army Health Care Specialist (68W Army Medic)	196	14%
Navy Basic Medical Technician (Navy HM0000)	100	7%
Air Force Basic Medical Technician (Air Force BMTCP 4NOX1)	21	2%
Air Force Independent Duty Medical Technician (IDMT 4NOX1C)	3	0%
Other	1,073	77%
Total	**1,392**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Employment
Employed in Profession: 88%
Involuntarily Unemployed: 1%

Positions Held
1 Full-time: 69%
2 or More Positions: 12%

Weekly Hours:
40 to 49: 55%
60 or more: 5%
Less than 30: 11%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Current Work Status		
Status	#	%
Employed, capacity unknown	24	0%
Employed in a nursing- related capacity	21,609	88%
Employed, NOT in a nursing-related capacity	1,067	4%
Not working, reason unknown	8	0%
Involuntarily unemployed	140	1%
Voluntarily unemployed	1,179	5%
Retired	416	2%
Total	**24,443**	**100%**

Source: Va. Healthcare Workforce Data Center

88% of LPNs are currently employed in their profession. 69% of LPNs hold one full-time job, while 12% currently have multiple jobs. 55% of all LPNs work between 40 and 49 hours per week, while just 5% work at least 60 hours per week.

Current Weekly Hours		
Hours	#	%
0 hours	1,327	6%
1 to 9 hours	398	2%
10 to 19 hours	744	3%
20 to 29 hours	1,353	6%
30 to 39 hours	4,065	17%
40 to 49 hours	12,758	55%
50 to 59 hours	1,408	6%
60 to 69 hours	571	2%
70 to 79 hours	231	1%
80 or more hours	386	2%
Total	**23,241**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Positions		
Positions	#	%
No Positions	1,327	6%
One Part-Time Position	3,000	13%
Two Part-Time Positions	520	2%
One Full-Time Position	16,341	69%
One Full-Time Position & One Part-Time Position	2,041	9%
Two Full-Time Positions	133	1%
More than Two Positions	158	1%
Total	**23,520**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Income		
Hourly Wage	#	%
Volunteer Work Only	296	2%
Less than $20,000	1,248	7%
$20,000-$29,999	2,244	12%
$30,000-$39,999	5,719	30%
$40,000-$49,999	5,292	28%
$50,000-$59,999	2,437	13%
$60,000-$69,999	891	5%
$70,000-$79,999	382	2%
$80,000-$89,999	144	1%
$90,000-$99,999	54	0%
$100,000 or more	90	0%
Total	**18,797**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Earnings
Median Income: $30k-$40k

Benefits
Health Insurance: 59%
Retirement: 52%

Satisfaction
Satisfied: 94%
Very Satisfied: 64%

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	#	%
Very Satisfied	14,889	64%
Somewhat Satisfied	7,159	31%
Somewhat Dissatisfied	950	4%
Very Dissatisfied	398	2%
Total	**23,397**	**100%**

Source: Va. Healthcare Workforce Data Center

The typical LPN earned between $30,000 and $40,000 in the past year. Among LPNs who received either a wage or salary as compensation at their primary work location, 75% received at least one employer-sponsored benefit.

Employer-Sponsored Benefits			
Benefit	#	%	% of Wage/Salary Employees
Paid Leave	13,155	61%	60%
Health Insurance	13,003	60%	59%
Dental Insurance	12,318	57%	55%
Retirement	11,468	53%	52%
Group Life Insurance	8,856	41%	40%
Signing/Retention Bonus	812	4%	4%
Receive at least one benefit	**16,753**	**78%**	**75%**

*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?	409	1%
Experience Voluntary Unemployment?	1,801	7%
Work Part-time or temporary positions, but would have preferred a full-time/permanent position?	1,154	4%
Work two or more positions at the same time?	4,165	15%
Switch employers or practices?	2,468	9%
Experienced at least one	**8,389**	**30%**

Source: Va. Healthcare Workforce Data Center

1% of Virginia's LPNs experienced involuntary unemployment at some point during the renewal cycle. By comparison, Virginia's average monthly unemployment rate was 3.8% during the same time period.[1]

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at this Location	719	3%	482	9%
Less than 6 Months	1,949	9%	866	15%
6 Months to 1 Year	2,492	11%	878	16%
1 to 2 Years	5,110	23%	1,220	22%
3 to 5 Years	4,696	21%	1,027	18%
6 to 10 Years	3,082	14%	547	10%
More than 10 Years	4,530	20%	599	11%
Subtotal	**22,579**	**100%**	**5,619**	**100%**
Did not have location	1,430		21,532	
Item Missing	3,569		427	
Total	**27,578**		**27,578**	

Source: Va. Healthcare Workforce Data Center

84% of LPNs receive an hourly wage at their primary work location, while 13% are salaried employees.

At a Glance:

Unemployment Experience

Involuntarily Unemployed: 1%
Underemployed: 7%

Turnover & Tenure

Switched Jobs: 9%
New Location: 27%
Over 2 years: 55%
Over 2 yrs, 2nd location: 39%

Employment Type

Hourly Wage: 84%
Salary: 13%

Source: Va. Healthcare Workforce Data Center

55% of LPNs have worked at their primary location for more than 2 years—the job tenure normally required to attain a conventional mortgage loan.

Employment Type		
Primary Work Site	**#**	**%**
Hourly Wage	13,832	84%
Salary	2,118	13%
By Contract/Per Diem	337	2%
Unpaid	132	1%
Business/Contractor Income	87	1%
Subtotal	**16,506**	**100%**
Did not have location	1,430	
Item Missing	9,641	

Source: Va. Healthcare Workforce Data Center

[1] As reported by the US Bureau of Labor Statistics. The non-seasonally adjusted monthly unemployment rate ranged from 4.0% in October 2016 to 3.6% in September 2017, the period of the survey. At the time of publication, the unemployment rate for September 2017 was still preliminary.

At a Glance:

Concentration

Top Region:	25%
Top 3 Regions:	62%
Lowest Region:	2%

Locations

2 or more (Past Year):	25%
2 or more (Now*):	22%

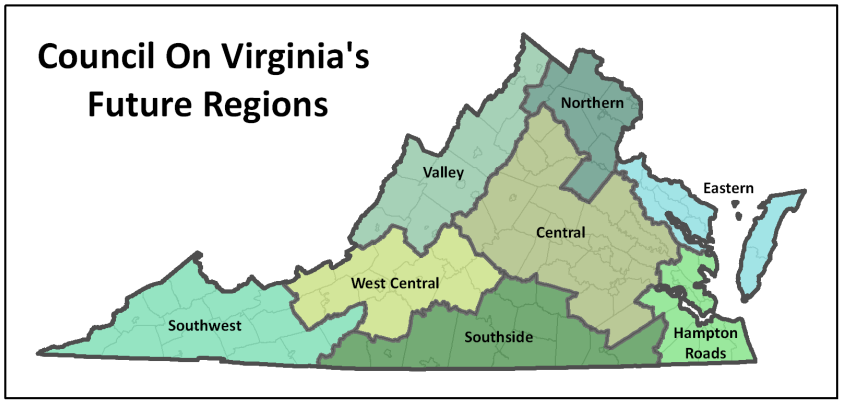
Source: Va. Healthcare Workforce Data Center

25% of all LPNs in Virginia work in Hampton Roads, the most of any region in the state. Another 21% of LPNs work in Central Virginia.

A Closer Look:

Regional Distribution of Work Locations				
COVF Region[2]	Primary Location		Secondary Location	
	#	%	#	%
Central	4,686	21%	1,275	22%
Eastern	467	2%	137	2%
Hampton Roads	5,633	25%	1,370	24%
Northern	3,525	16%	1,014	18%
Southside	1,534	7%	392	7%
Southwest	1,940	9%	385	7%
Valley	1,567	7%	324	6%
West Central	2,686	12%	607	11%
Virginia Border State/DC	51	0%	77	1%
Other US State	65	0%	143	2%
Outside of the US	0	0%	6	0%
Total	**22,154**	**100%**	**5,730**	**100%**
Item Missing	3,993		317	

Source: Va. Healthcare Workforce Data Center



Number of Work Locations				
Locations	Work Locations in Past Year		Work Locations Now*	
	#	%	#	%
0	1,120	5%	1,700	7%
1	16,554	70%	16,750	71%
2	3,521	15%	3,330	14%
3	2,100	9%	1,701	7%
4	153	1%	76	0%
5	47	0%	24	0%
6 or More	173	1%	86	0%
Total	**23,668**	**100%**	**23,668**	**100%**

*At the time of survey completion (Oct. 2016-Sept. 2017, birth month of respondent).

Source: Va. Healthcare Workforce Data Center

25% of all LPNs held two or more positions over the past year, while 22% currently hold multiple positions.

[2] These are now referred to as VA Perform's regions: http://vaperforms.virginia.gov/Regions/regionalScorecards.php

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	13,202	63%	3,691	70%
Non-Profit	4,334	21%	864	16%
State/Local Government	2,488	12%	585	11%
Veterans Administration	460	2%	36	1%
U.S. Military	374	2%	56	1%
Other Federal Government	247	1%	72	1%
Total	**21,105**	**100%**	**5,304**	**100%**
Did not have location	1,430		21532	
Item Missing	5,043		742	

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Sector

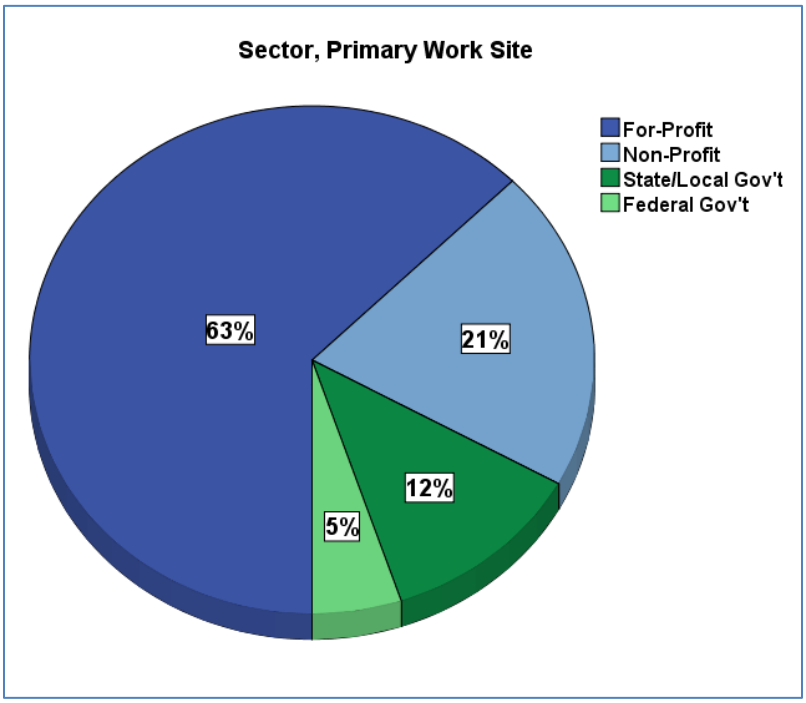
For Profit:	63%
Federal:	5%

Top Establishments

LTC/Nursing Home:	26%
Physician Office:	13%
Home Health Care:	11%

Source: Va. Healthcare Workforce Data Center

83% of all LPNs work in the private sector, including 63% in for-profit establishments. Another 12% of LPNs work for state or local governments, while 5% work for the federal government.



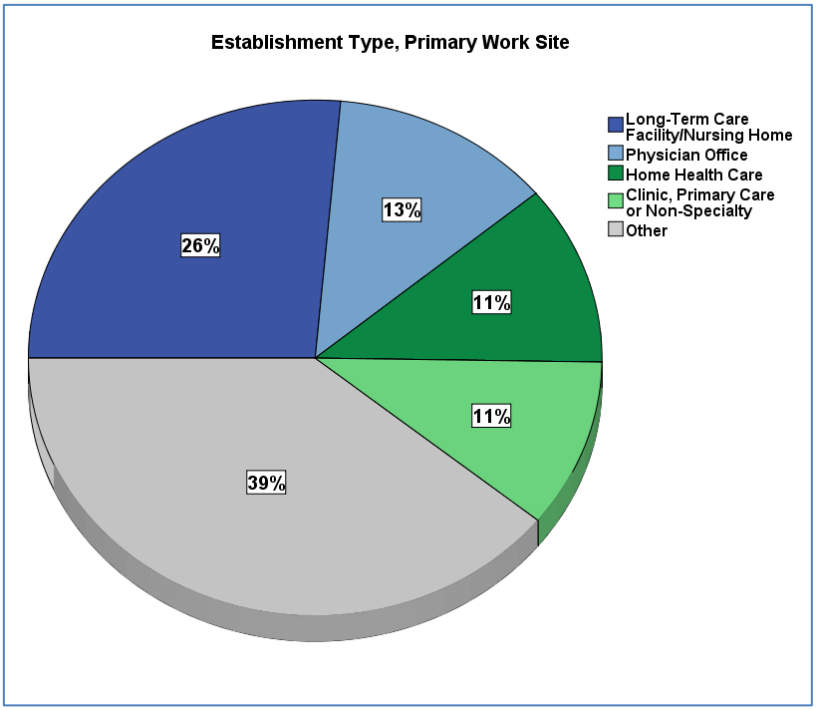
Source: Va. Healthcare Workforce Data Center

Location Type				
Establishment Type	Primary Location		Secondary Location	
	#	%	#	%
Long Term Care Facility, Nursing Home	5,356	26%	1,609	31%
Physician Office	2,544	13%	409	8%
Home Health Care	2,285	11%	828	16%
Clinic, Primary Care or Non-Specialty	2,145	11%	377	7%
Hospital, Inpatient Department	1,011	5%	163	3%
Rehabilitation Facility	885	4%	267	5%
Clinic, Non-Surgical Specialty	761	4%	158	3%
Corrections/Jail	735	4%	232	5%
Mental Health, Development or Substance Abuse, Residential/Group Home	491	2%	153	3%
Hospital, Outpatient Department	486	2%	72	1%
School (Providing Care to Students)	459	2%	64	1%
Other Practice Setting	3,110	15%	776	15%
Total	**20,268**	**100%**	**5,108**	**100%**
Did Not Have a Location	1,430		21,532	

Source: Va. Healthcare Workforce Data Center

26% of all LPNs in the state work at either a long-term care facility or a nursing home as their primary work location. Physician offices and home health care are also common primary establishment types among Virginia's LPN workforce.

Among those LPNs who also have a secondary work location, 31% work at a long-term care facility or a nursing home. Another 16% work for a home health care establishment.



Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Typical Time Allocation

Patient Care:	80%-89%

Roles

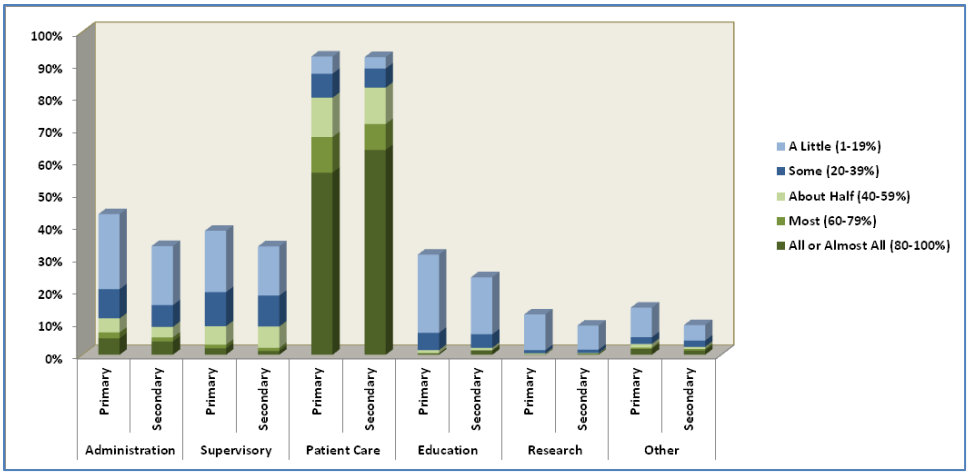
Patient Care:	67%
Administrative:	7%
Supervisory:	3%
Education:	1%

Patient Care LPNs

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

Source: Va. Healthcare Workforce Data Center

A Closer Look:



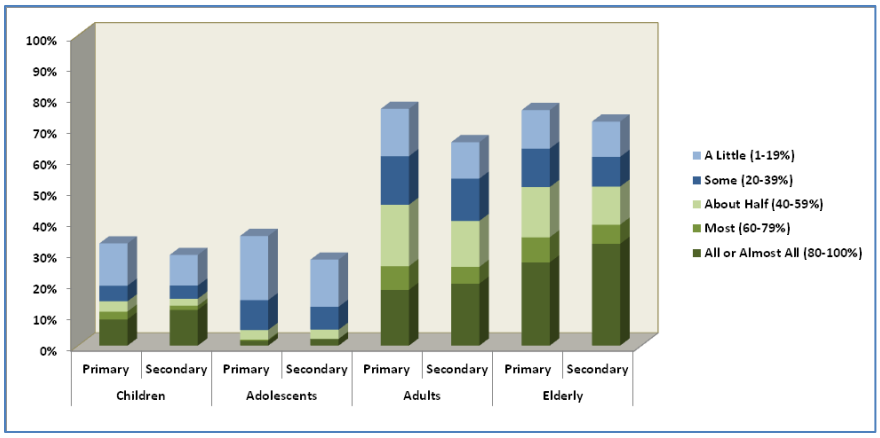
Source: Va. Healthcare Workforce Data Center

A typical LPN spends most of her time on patient care activities. 67% of all LPNs fill a patient care role, defined as spending 60% or more of their time on patient care activities. Another 7% of LPNs serve an administrative role.

Time Allocation												
Time Spent	**Admin.**		**Supervisory**		**Patient Care**		**Education**		**Research**		**Other**	
	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site
All or Almost All (80-100%)	5%	4%	2%	1%	56%	63%	0%	1%	0%	0%	2%	1%
Most (60-79%)	2%	1%	1%	1%	11%	8%	0%	0%	0%	0%	0%	0%
About Half (40-59%)	4%	3%	6%	7%	12%	11%	1%	1%	0%	0%	1%	1%
Some (20-39%)	9%	7%	11%	10%	7%	6%	5%	4%	1%	1%	2%	2%
A Little (1-19%)	23%	18%	19%	15%	5%	4%	24%	18%	11%	7%	9%	5%
None (0%)	56%	66%	62%	66%	8%	8%	69%	76%	87%	91%	85%	91%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

The typical LPN devotes most of her time to treating adults and the elderly. 35% of all LPNs serve an elderly patient care role, meaning that at least 60% of their patients are the elderly. In addition, 26% of all LPNs serve an adult patient care role.

At a Glance:
(Primary Locations)

Typical Patient Allocation

Children:	0%
Adolescents:	0%
Adults:	30%-39%
Elderly:	40%-49%

Roles

Children:	11%
Adolescents:	2%
Adults:	26%
Elderly:	35%

Source: Va. Healthcare Workforce Data Center

Patient Allocation								
Time Spent	Children		Adolescents		Adults		Elderly	
	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site
All or Almost All (80-100%)	8%	12%	2%	2%	18%	20%	27%	33%
Most (60-79%)	3%	1%	0%	0%	8%	5%	8%	6%
About Half (40-59%)	3%	2%	3%	3%	20%	15%	16%	12%
Some (20-39%)	5%	4%	10%	7%	16%	14%	12%	10%
A Little (1-19%)	14%	10%	21%	15%	15%	12%	12%	11%
None (0%)	67%	71%	65%	72%	24%	34%	24%	28%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All LPNs		LPNs over 50	
	#	%	#	%
Under age 50	368	2%	-	-
50 to 54	519	3%	42	1%
55 to 59	1,222	6%	289	4%
60 to 64	4,686	23%	1,656	23%
65 to 69	7,949	39%	3,237	44%
70 to 74	2,863	14%	1,197	16%
75 to 79	652	3%	245	3%
80 or over	309	2%	105	1%
I do not intend to retire	1,595	8%	543	7%
Total	**20,163**	**100%**	**7,314**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All LPNs

Under 65: 34%

Under 60: 10%

LPNs 50 and over

Under 65: 27%

Under 60: 5%

Time until Retirement

Within 2 years: 6%

Within 10 years: 19%

Half the workforce: By 2042

Source: Va. Healthcare Workforce Data Center

34% of LPNs expect to retire by the age of 65, while 27% of LPNs who are age 50 or over expect to retire by the same age. Meanwhile, 27% of all LPNs expect to work until at least age 70, including 8% who do not expect to retire at all.

Within the next two years, 34% of LPNs plan on pursuing additional educational opportunities, and 9% expect to increase their patient care hours.

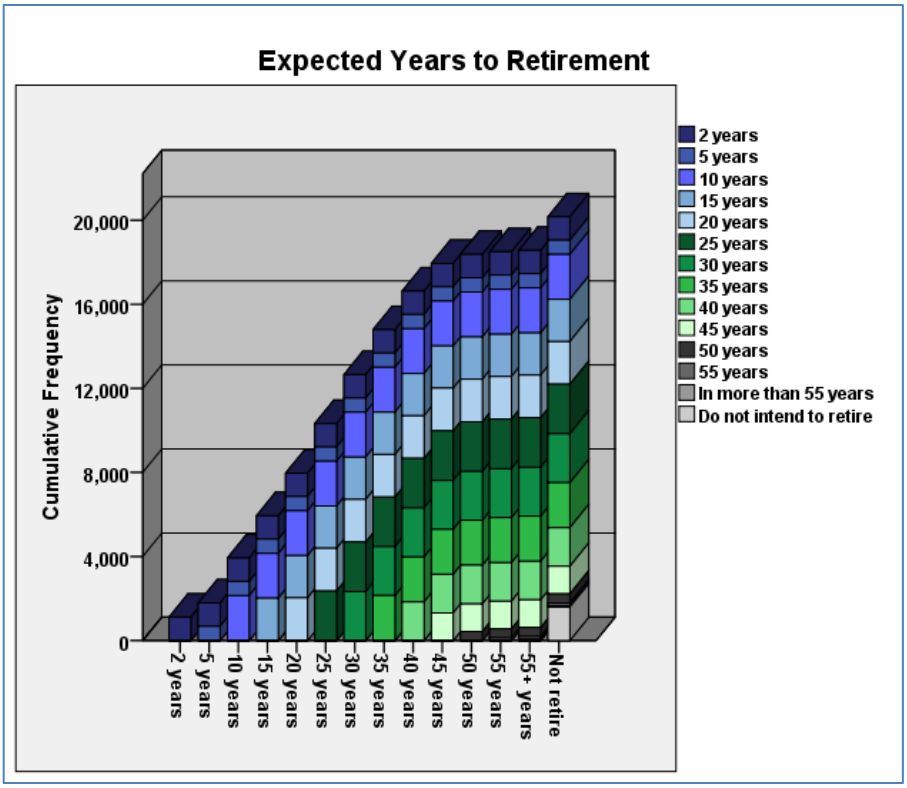
Future Plans		
2 Year Plans:	#	%
Decrease Participation		
Leave Profession	436	2%
Leave Virginia	713	3%
Decrease Patient Care Hours	1,501	5%
Decrease Teaching Hours	21	0%
Increase Participation		
Increase Patient Care Hours	2,566	9%
Increase Teaching Hours	533	2%
Pursue Additional Education	9,326	34%
Return to Virginia's Workforce	510	2%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for LPNs. 6% of LPNs expect to retire in the next two years, while 19% expect to retire in the next 10 years. More than half of the current LPN workforce expects to retire by 2042.

Time to Retirement			
Expect to retire within. . .	#	%	Cumulative %
2 years	1,113	6%	6%
5 years	677	3%	9%
10 years	2,135	11%	19%
15 years	2,012	10%	29%
20 years	2,030	10%	40%
25 years	2,358	12%	51%
30 years	2,328	12%	63%
35 years	2,142	11%	73%
40 years	1,837	9%	82%
45 years	1,313	7%	89%
50 years	431	2%	91%
55 years	126	1%	92%
In more than 55 years	65	0%	92%
Do not intend to retire	1,595	8%	100%
Total	**20,164**	**100%**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Using these estimates, retirements will begin to reach over 10% of the current workforce every 5 years by 2027. Retirements will peak at 12% of the current workforce around 2042 before declining to under 10% of the current workforce again around 2057.

At a Glance:

FTEs

Total:	24,286
FTEs/1,000 Residents:	2.90
Average:	0.93

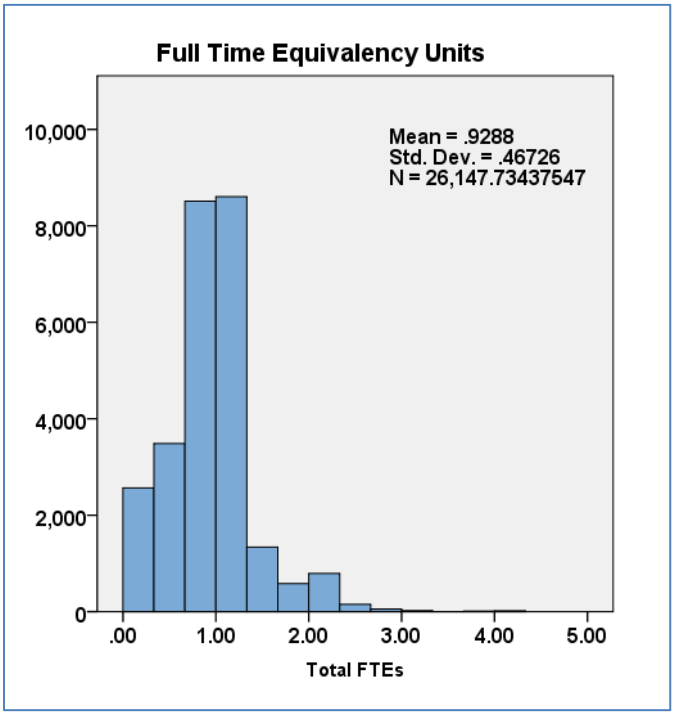
Age & Gender Effect

Age, Partial Eta^2:	Negligible
Gender, Partial Eta^2:	None

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

Source: Va. Healthcare Workforce Data Center

A Closer Look:

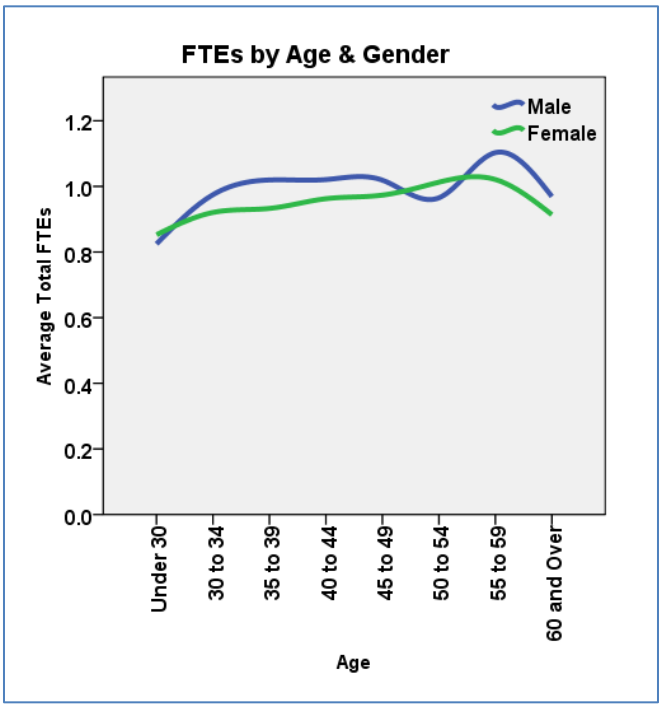


Source: Va. Healthcare Workforce Data Center

The typical (median) LPN provided 0.94 FTEs, 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		
Age	**Average**	**Median**
Age		
Under 30	0.86	0.90
30 to 34	0.90	0.95
35 to 39	0.90	0.93
40 to 44	0.94	0.96
45 to 49	0.97	0.96
50 to 54	0.99	0.97
55 to 59	1.01	0.97
60 and Over	0.89	0.85
Gender		
Male	0.98	1.01
Female	0.94	0.97

Source: Va. Healthcare Workforce Data Center

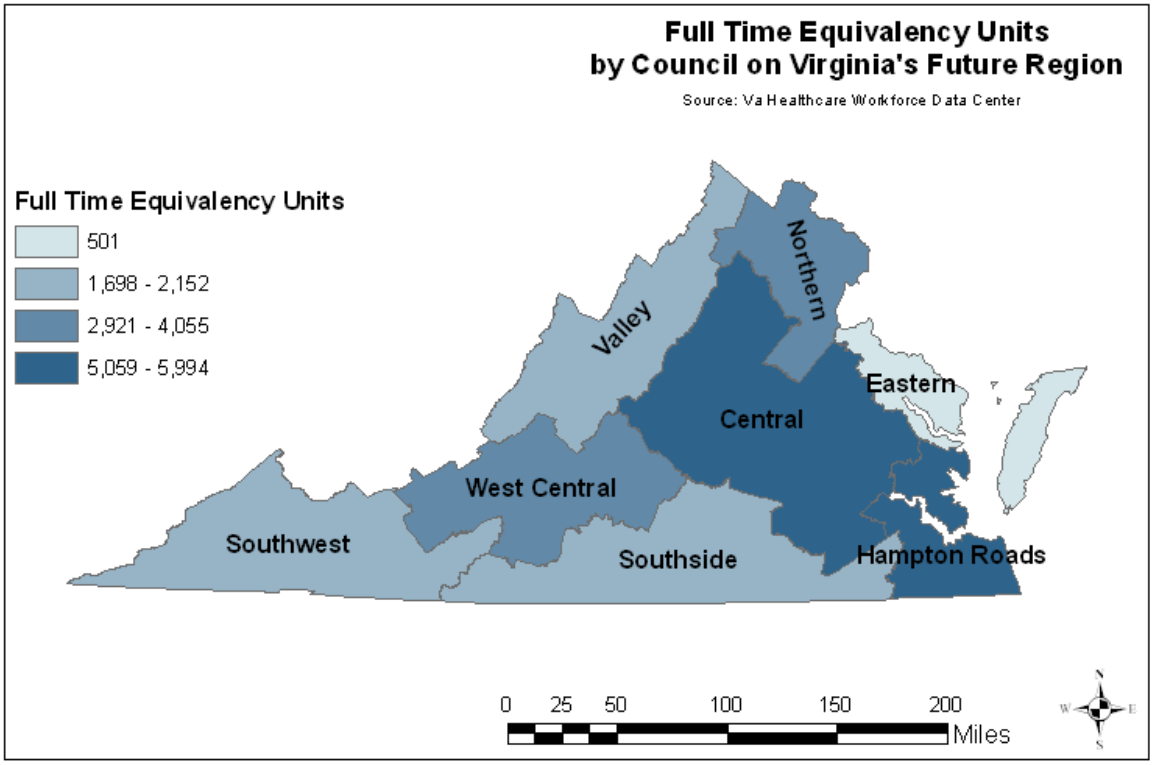


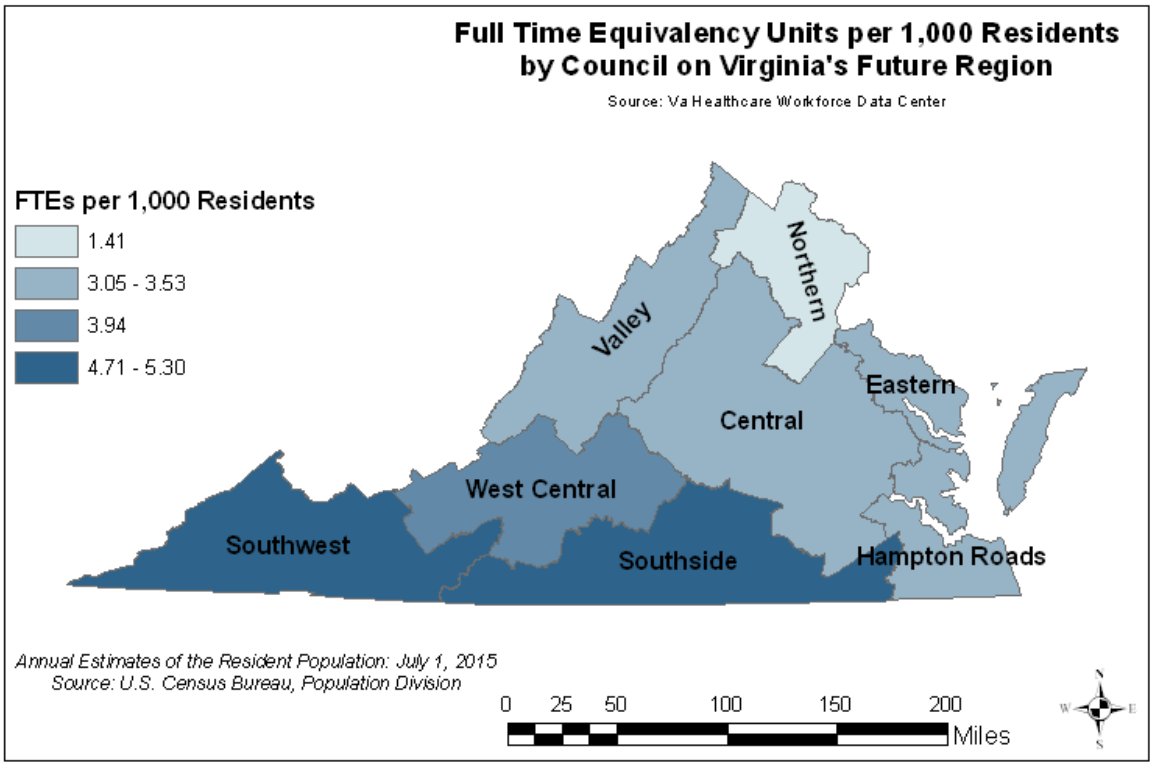
Source: Va. Healthcare Workforce Data Center

[3] Due to assumption violations in Mixed between-within ANOVA (Levene's Test is significant)

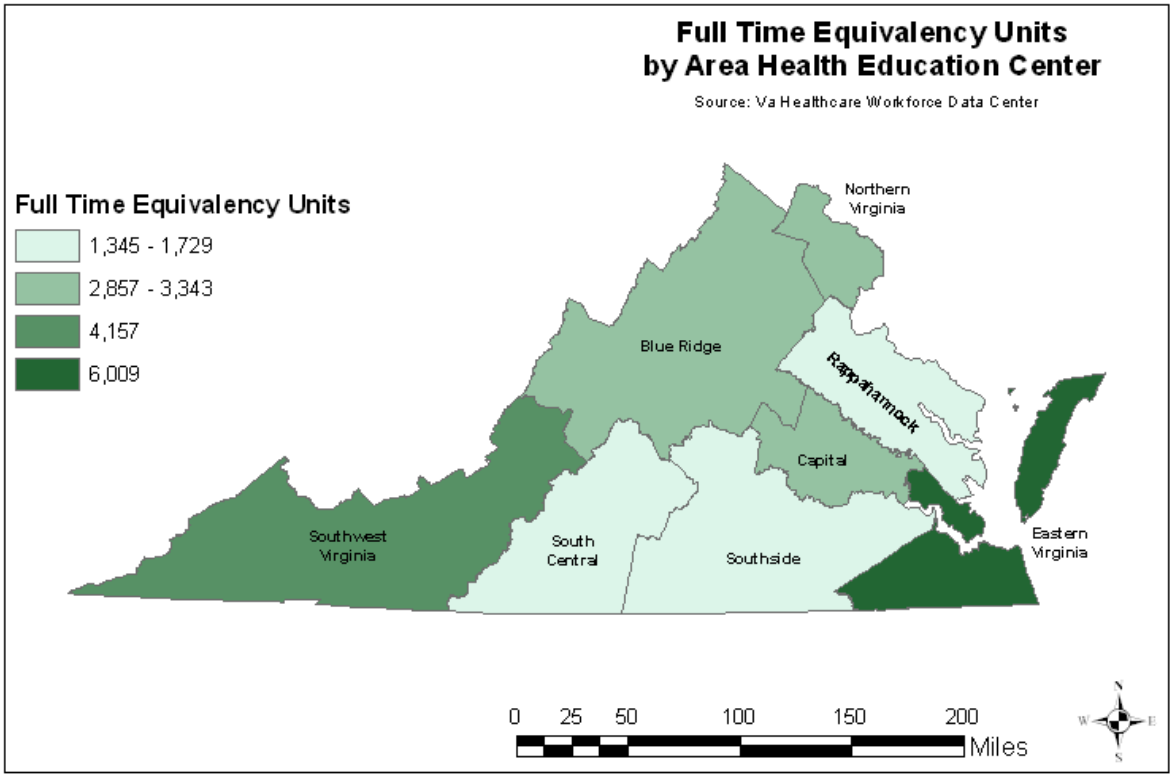
Maps

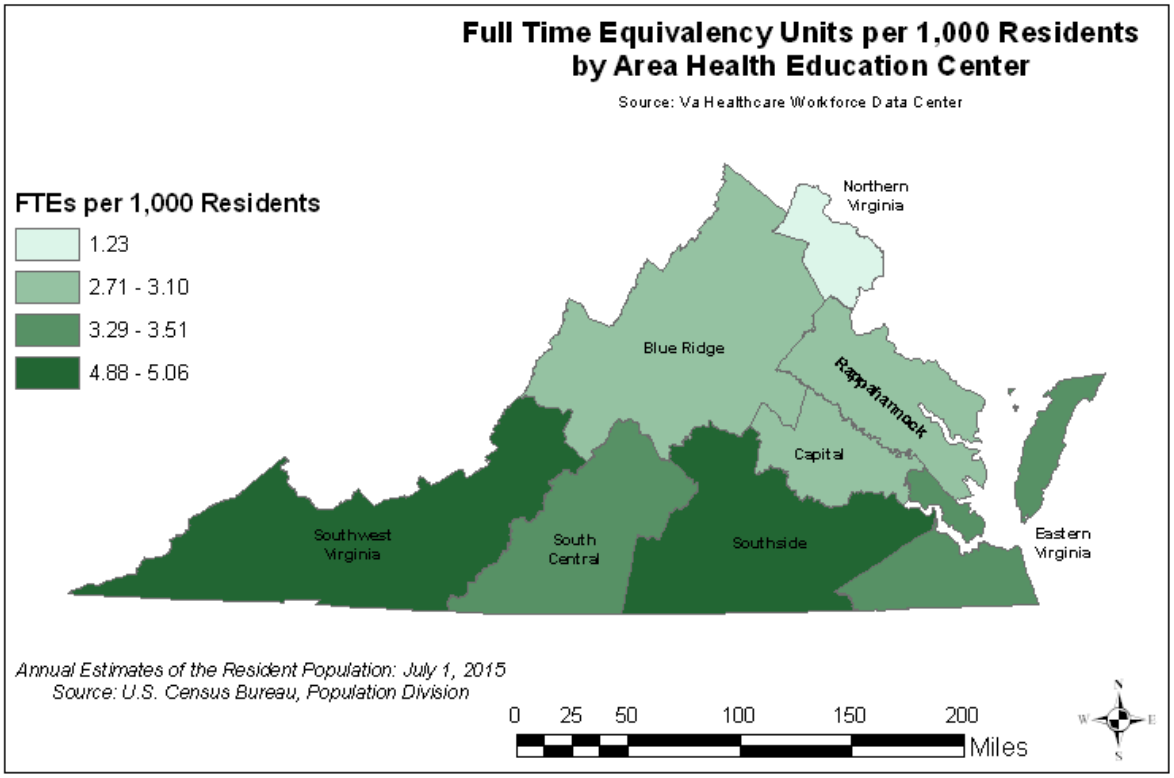
Council on Virginia's Future Regions[3]



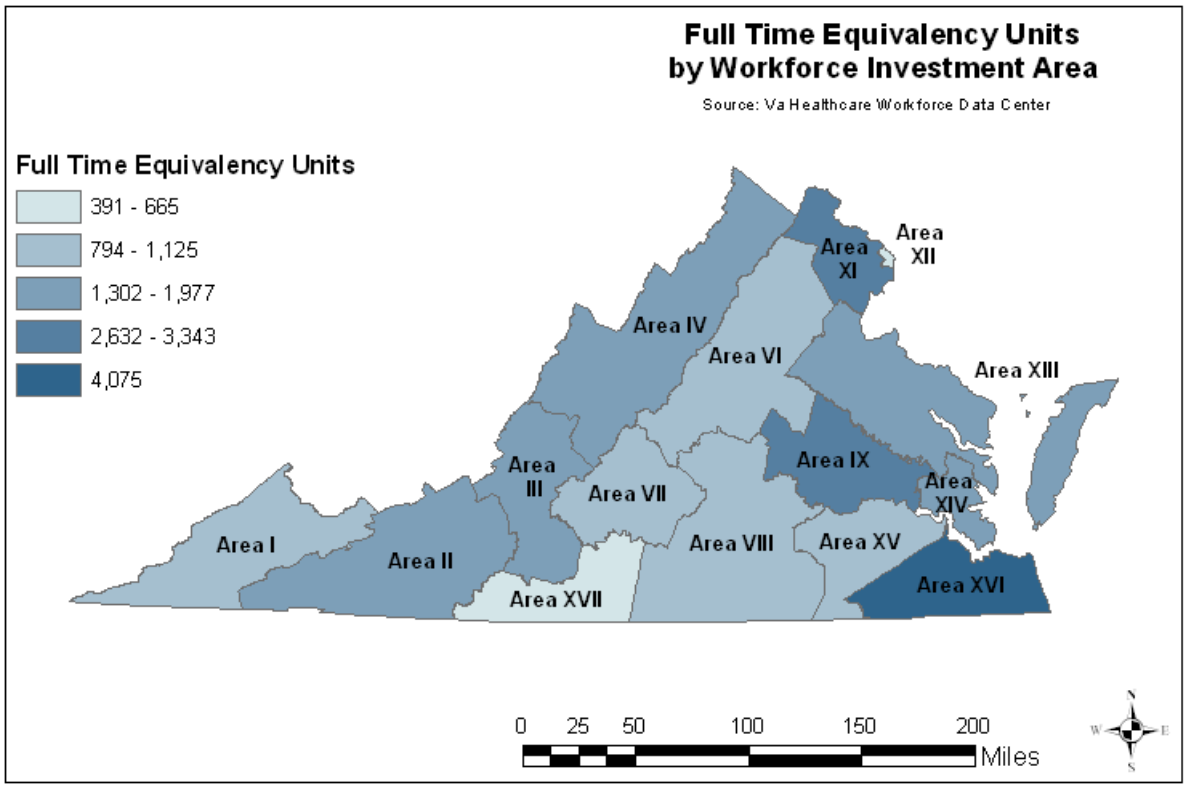


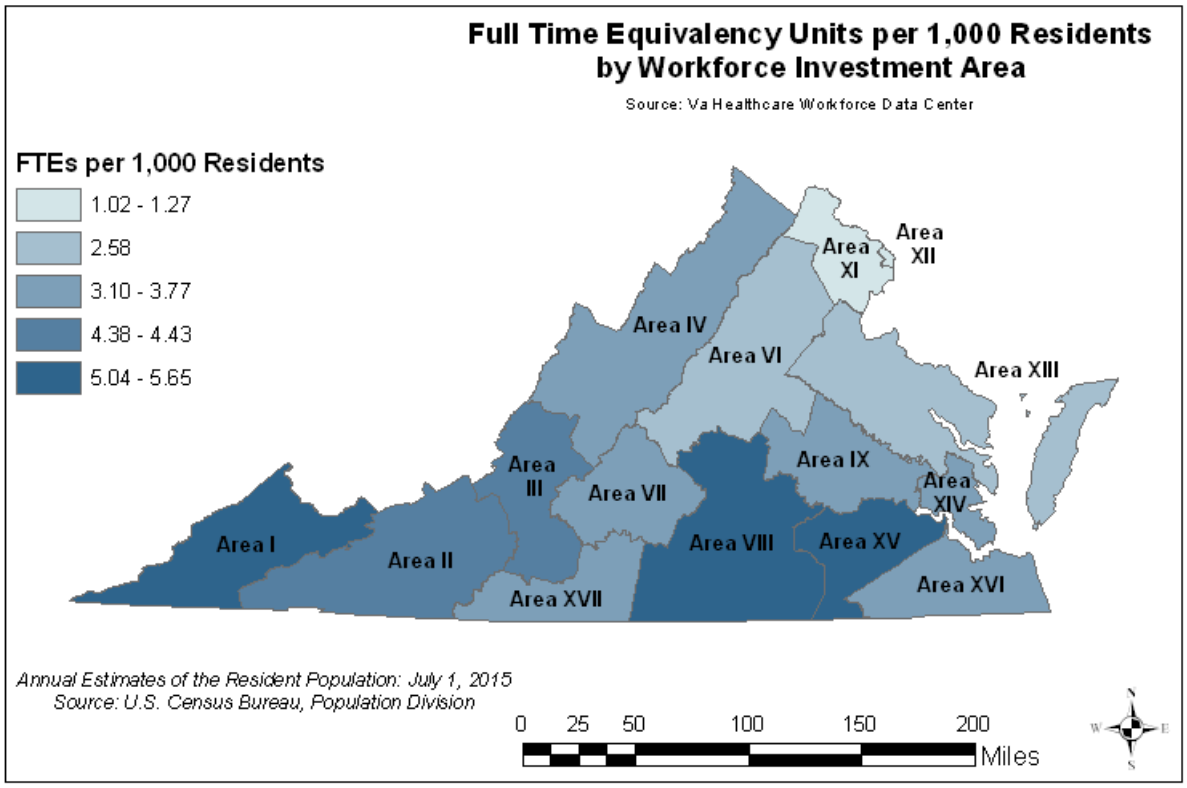
Area Health Education Center Regions



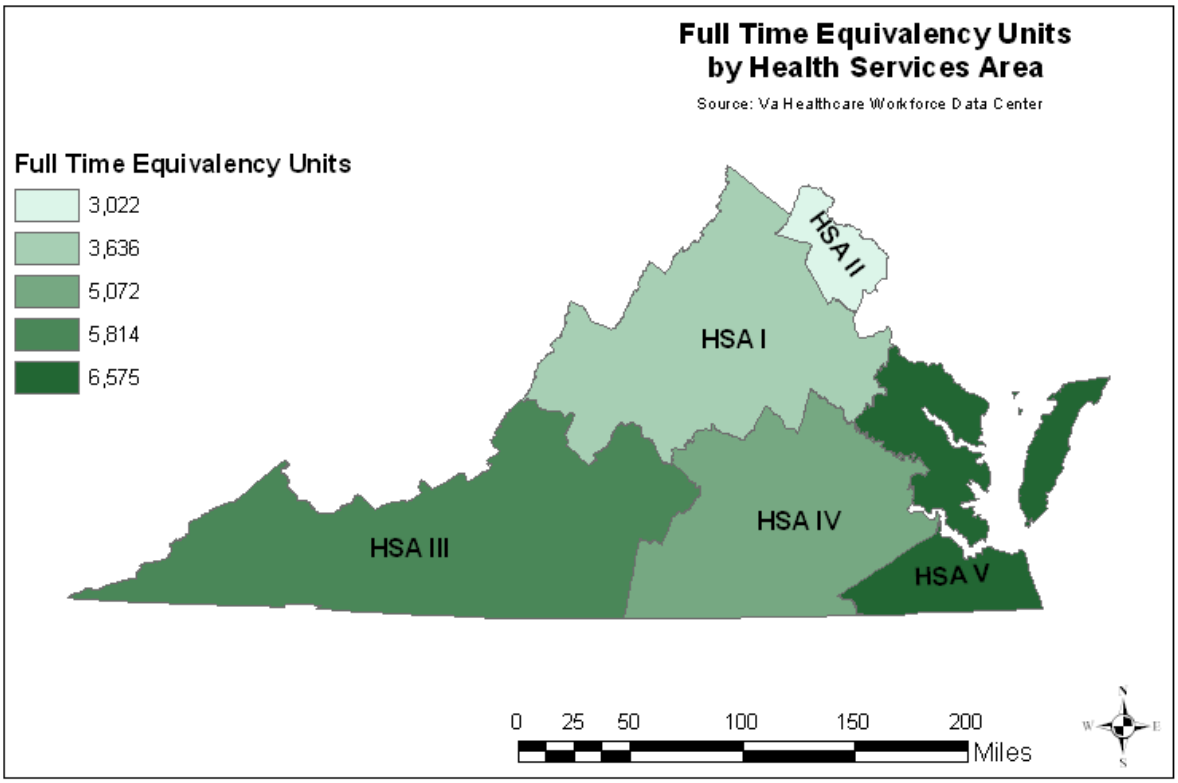


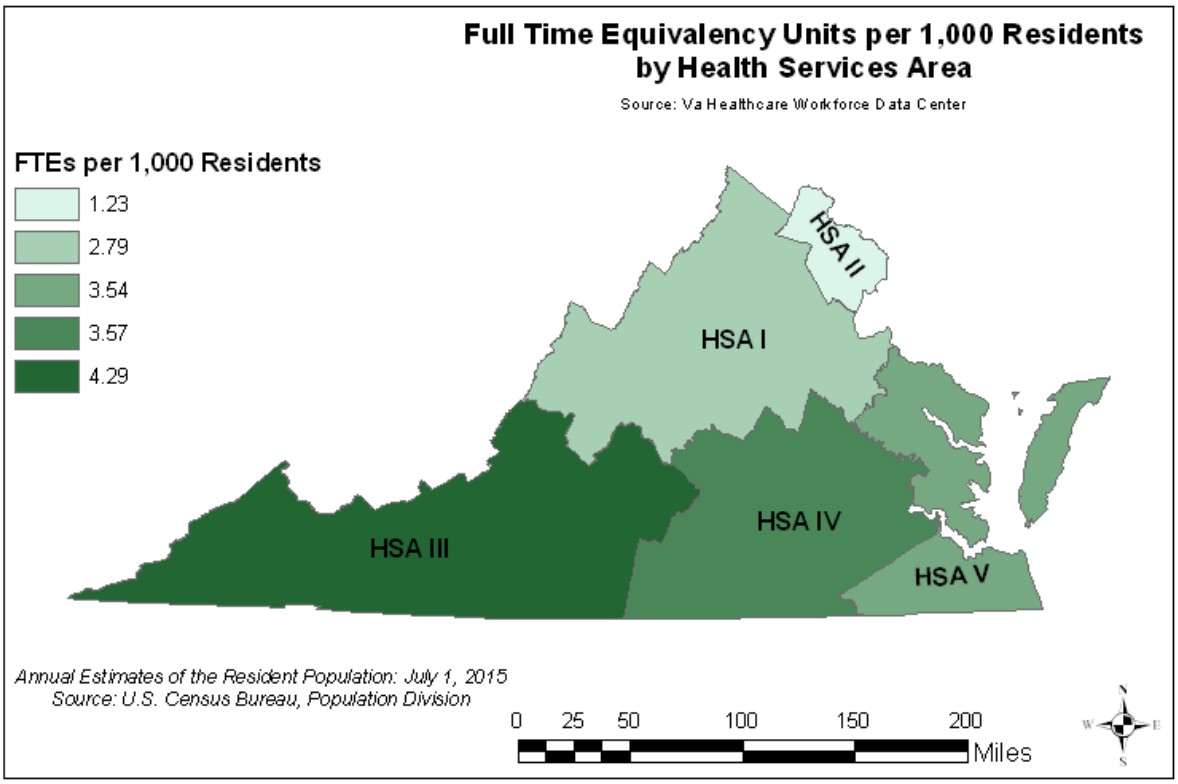
Workforce Investment Areas

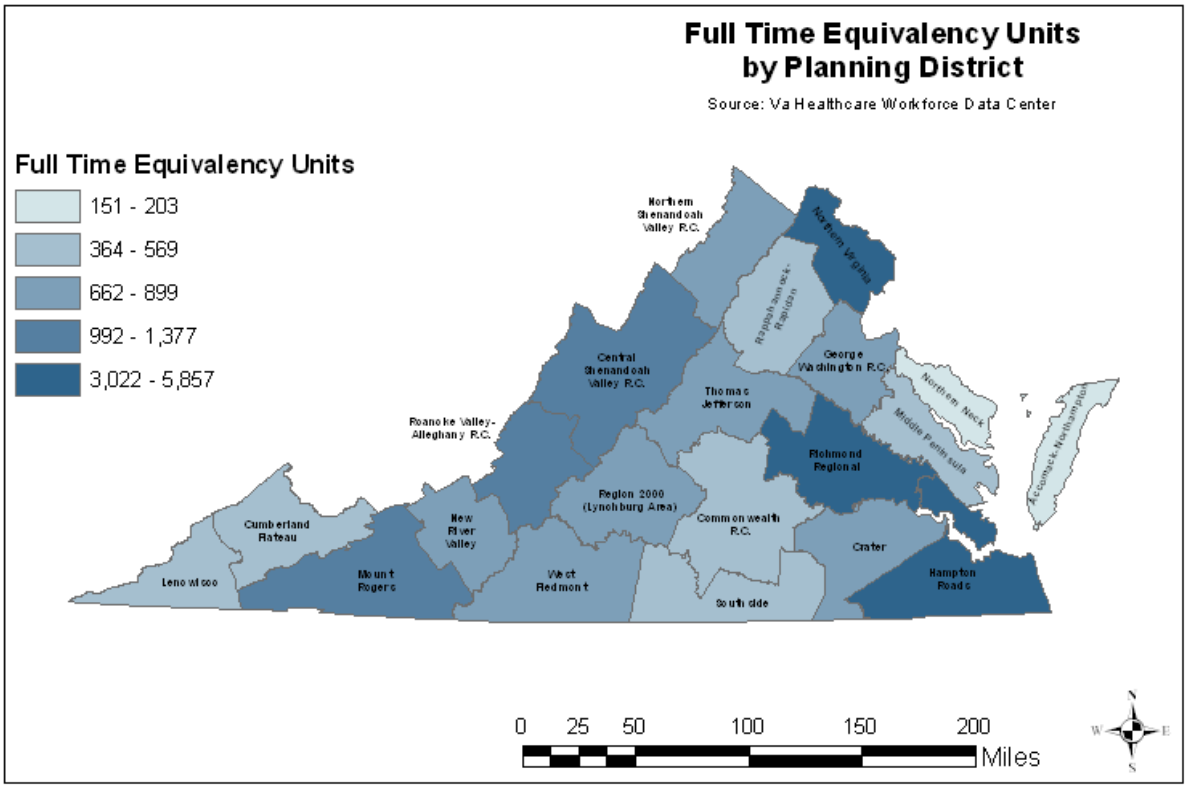


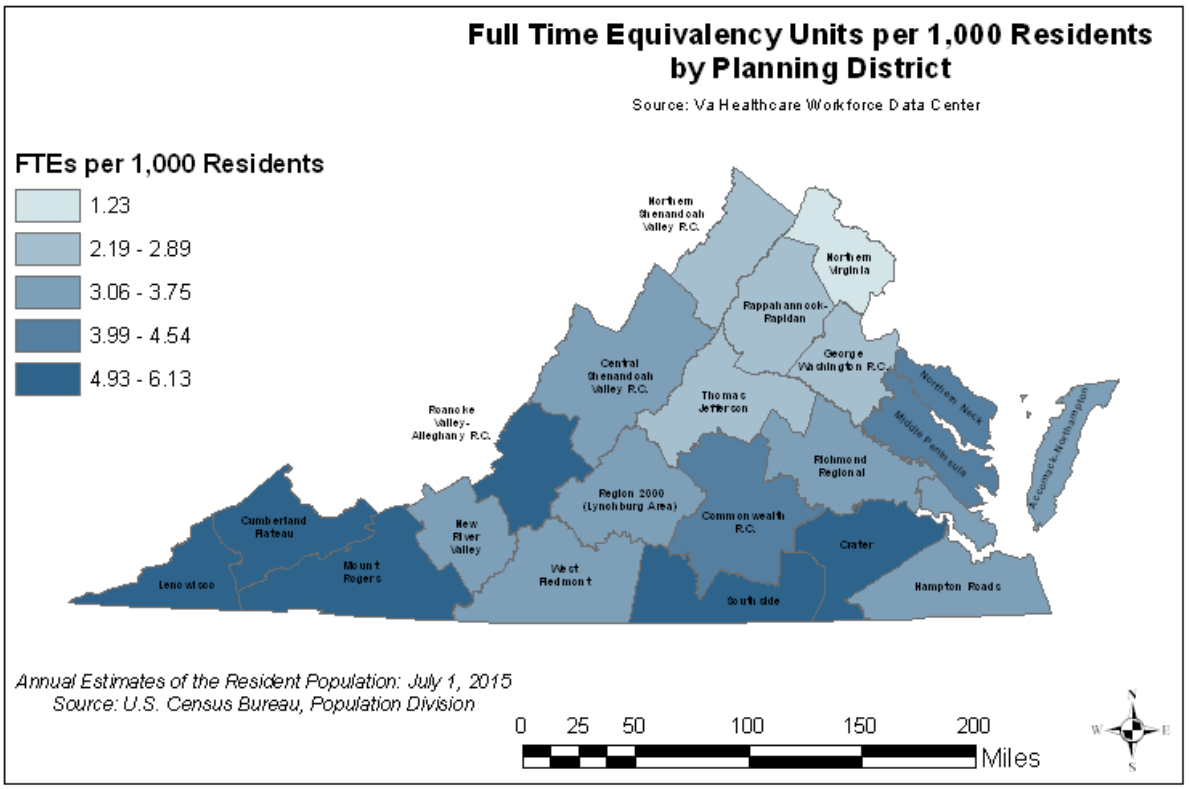


Health Services Areas






Full Time Equivalency Units
by Planning District
Source: Va Healthcare Workforce Data Center
Full Time Equivalency Units
151 - 203
364 - 569
662 - 899
992 - 1,377
3,022 - 5,857
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
George Washington R.C.
Northern Neck
Middle Peninsula
Accomack-Northampton
Central Shenandoah Valley R.C.
Thomas Jefferson
Roanoke Valley-Alleghany R.C.
Richmond Regional
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Crater
Cumberland Plateau
New River Valley
Lenowisco
Mount Rogers
West Piedmont
South side
Hampton Roads
0 25 50 100 150 200
Miles
N
W
E
S


Full Time Equivalency Units per 1,000 Residents
by Planning District
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
1.23
2.19 - 2.89
3.06 - 3.75
3.99 - 4.54
4.93 - 6.13
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
George Washington R.C.
Northern Neck
Middle Peninsula
Accomack-Northampton
Central Shenandoah Valley R.C.
Thomas Jefferson
Roanoke Valley-Alleghany R.C.
Richmond Regional
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Crater
Cumberland Plateau
New River Valley
Lenowisco
Mount Rogers
West Piedmont
South side
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2015
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

Appendices

Appendix A: Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min	Max
Metro, 1 million+	16,856	33.96%	2.944279	2.477905	3.672159
Metro, 250,000 to 1 million	2,811	37.64%	2.6569	2.236046	3.313734
Metro, 250,000 or less	2,600	38.65%	2.587065	2.177273	3.226634
Urban pop 20,000+, Metro adj	833	39.50%	2.531915	2.130859	3.15785
Urban pop 20,000+, nonadj	0	NA	NA	NA	NA
Urban pop, 2,500-19,999, Metro adj	2,178	35.63%	2.806701	2.362119	3.500568
Urban pop, 2,500-19,999, nonadj	1,739	35.94%	2.7824	2.341667	3.47026
Rural, Metro adj	1,179	37.07%	2.697941	2.270586	3.36492
Rural, nonadj	644	34.78%	2.875	2.419599	3.585752
Virginia border state/DC	764	27.09%	3.690821	3.106194	4.603259
Other US State	840	24.40%	4.097561	3.448506	5.110552

Source: Va. Healthcare Workforce Data Center

Age	Age Weight			Total Weight	
	#	Rate	Weight	Min	Max
Under 30	3,621	27.89%	3.585149	3.15785	5.110552
30 to 34	3,504	39.61%	2.524496	2.223612	3.598614
35 to 39	3,680	32.36%	3.08984	2.721576	4.404501
40 to 44	3,534	40.78%	2.452464	2.160165	3.495934
45 to 49	3,654	34.70%	2.881703	2.538246	4.107806
50 to 54	3,353	41.34%	2.419192	2.130859	3.448506
55 to 59	3,303	32.12%	3.113101	2.742064	4.437658
60 and Over	5,795	31.86%	3.13922	2.76507	4.474891

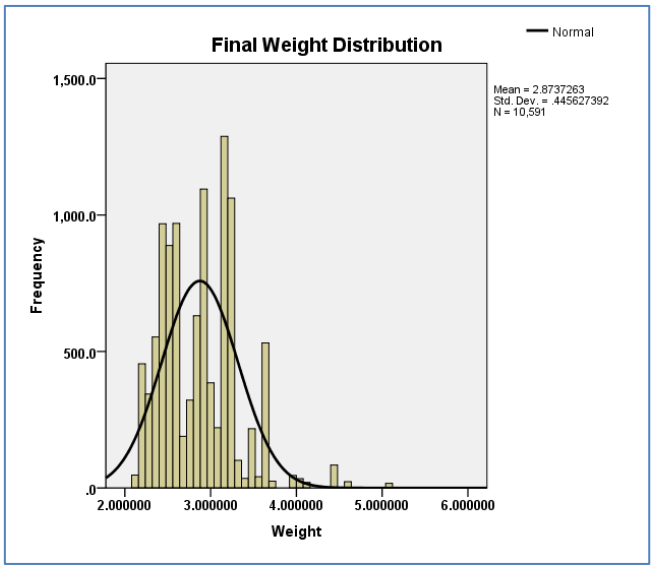
Source: Va. Healthcare Workforce Data Center

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

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

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

Overall Response Rate: 0.347885



Source: Va. Healthcare Workforce Data Center

Virginia's Registered Nurse Workforce: 2017

Healthcare Workforce Data Center

October 2017

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

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

39,780 Registered Nurses voluntarily participated in this survey. *Without their efforts the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Nursing express our sincerest appreciation for your ongoing cooperation.*

Thank You!

Virginia Department of Health Professions

David E. Brown, D.C.
Director

Lisa R. Hahn, MPA
Chief Deputy Director

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Contents

The Registered Nurse Workforce: At a Glance:

The Workforce

Licensees:	108,857
Virginia's Workforce:	90,574
FTEs:	77,979

Survey Response Rate

All Licensees:	37%
Renewing Practitioners:	86%

Demographics

Female:	93%
Diversity Index:	37%
Median Age:	46

Background

Rural Childhood:	37%
HS Degree in VA:	56%
Prof. Degree in VA:	67%

Education

Baccalaureate:	45%
Associate:	31%

Finances

Median Income:	$60k-$70k
Health Benefits:	66%
Under 40 w/ Ed debt:	61%

Current Employment

Employed in Prof.:	90%
Hold 1 Full-time Job:	69%
Satisfied?:	93%

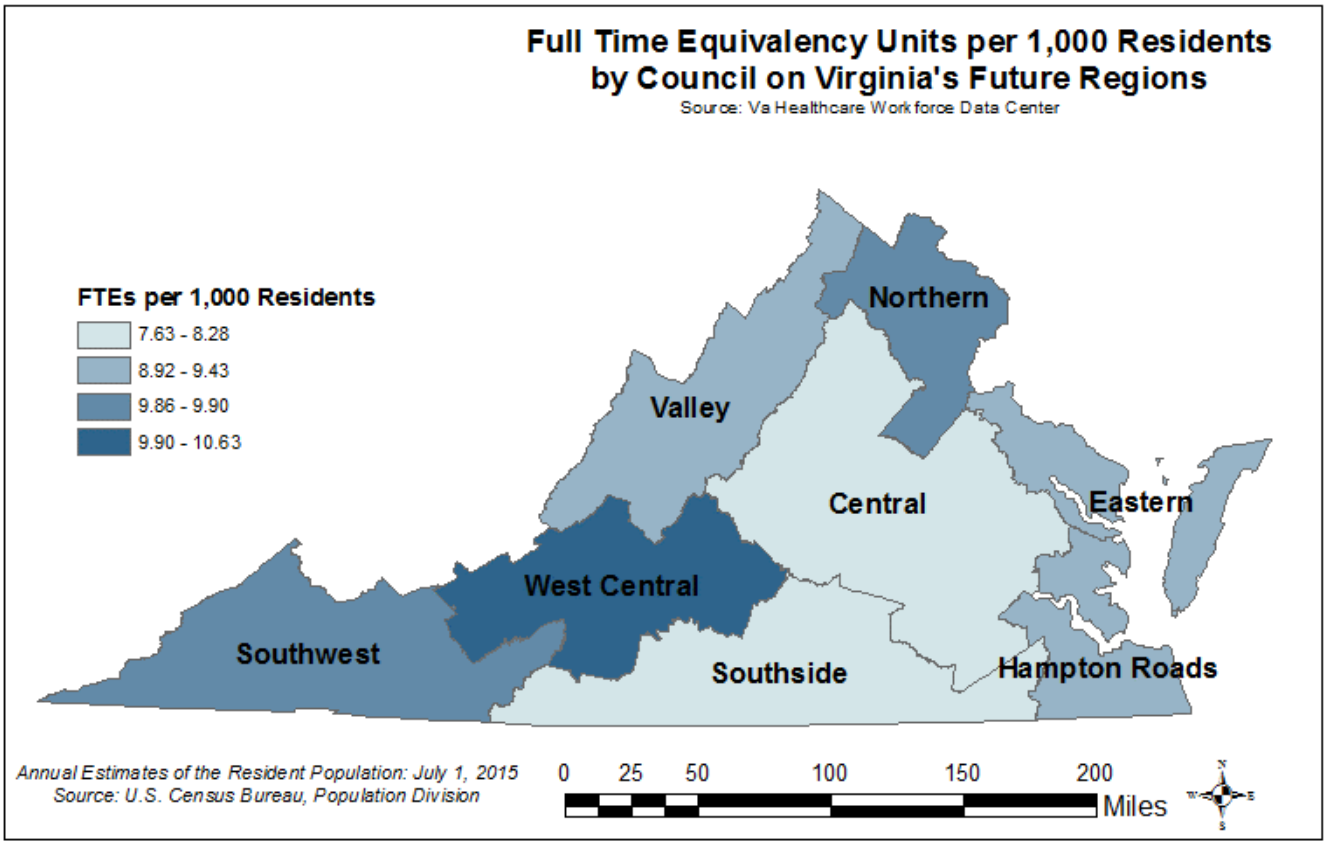
Job Turnover

Switched Jobs:	7%
Employed over 2 yrs:	63%

Time Allocation

Patient Care:	80%-89%
Patient Care Role:	66%
Admin. Role:	7%

Source: Va. Healthcare Workforce Data Center



Results in Brief

39,780 Registered Nurses (RNs) voluntarily took part in the 2017 Registered Nurse Workforce Survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place during a two-year renewal cycle on the birth month of each respondent. Therefore, only approximately half of all RNs have access to the survey in any given year. Thus, these survey respondents represent only 37% of the 108,857 RNs who are licensed in the state but 86% of renewing practitioners.

The HWDC estimates that 90,574 RNs participated in Virginia's workforce during the survey period, which is defined as those who worked at least a portion of the year in the state or who live in the state and intend to return to work as an RN at some point in the future. Between October 2016 and September 2017, Virginia's RN workforce provided 77,979 "full-time equivalency units", which the HWDC defines simply as working 2,000 hours a year (or 40 hours per week for 50 weeks with 2 weeks off).

93% of all RNs are female, while the median age of the RN workforce is 46. In a random encounter between two RNs, there is a 37% chance that they would be of different races or ethnicities, a measure known as the diversity index. This makes Virginia's RN workforce considerably less diverse than the state's overall population, where there is a 56% chance that two randomly chosen people would be of different races or ethnicities. Among RNs who are under the age of 40, there is slightly more diversity, with an index of 40%.

37% of all RNs grew up in a rural area, and 19% of these professionals currently work in non-Metro areas of the state. Overall, just 9% of all RNs work in a non-Metro area of the state. Meanwhile, 56% of Virginia's RNs graduated from high school in Virginia, and 67% earned their initial professional degree in the state. In total, 70% of Virginia's RN workforce has some educational background in the state.

45% of all RNs hold a bachelor's degree as their highest professional degree, while 31% have earned an associate degree in Nursing. 40% of Virginia's RN workforce currently has education debt, including 61% of those under the age of 40. The median debt burden for those RNs with educational debt is between $20,000 and $30,000.

90% of RNs are currently employed in the profession. 69% of all RNs hold one full-time position at the moment, while 10% currently hold two or more positions. 41% of Virginia's RNs work between 40 and 49 hours per week, while 14% of RNs work less than 30 hours per week. Although 7% of RNs have switched jobs at some point in the past year, another 63% of RNs have remained at their primary work location for more than two years.

The median annual income for RNs is between $60,000 and $70,000. In addition, 84% of wage or salaried RNs receive at least one employer-sponsored benefit, including 66% who receive health insurance. 93% of RNs are satisfied with their current employment situation, including 58% who indicate they are "very satisfied".

19% of Virginia's RNs have worked at two or more locations in the past year, and 17% of RNs currently do the same. 84% of RNs work in the private sector, including 42% who work at a for-profit institution. In fact, 39% of all RNs work in the inpatient department of a hospital, which is by far the most of any establishment type in the state.

A typical RN spends nearly all of her time treating patients. In fact, 66% of RNs serve a patient care role, meaning that at least 60% of their time is spent in patient care activities. Meanwhile, a typical RN spends approximately half of her time treating adults and one-quarter of her time treating elderly patients.

39% of RNs expect to retire by the age of 65. 8% of the current workforce expects to retire in the next two years, while half the current workforce expects to retire by 2042. Over the next two years, 29% of all RNs expected to pursue additional educational opportunities, while 7% plan on increasing their patient care hours.

Summary of Trends

Examining data from the past five Virginia Registered Nurse (RN) Surveys reveals some interesting trends. The number of licensed RNs has increased gradually and consistently over the past half-decade. The number of licensed RNs has increased by 9% from 99,901 in 2013 to 108,857 in 2017. Similar increases were recorded in the number of RNs who are in the state's workforce and the number of full time equivalency units provided by those in the workforce; both measures increased by 6% and 5%, respectively, between 2013 and 2017.

However, there has been very minimal change in diversity within the RN workforce. Females still constitute 93% of the workforce, down from 94% in the 2013 survey. The median age is now 46, down from 48 in 2013. The percent under 40 has increased from 32% to 36% and the percent over age 55 has declined from 33% to 31% in the period. The diversity index increased from 33% in 2013 to 37% in the current report. The diversity index for those under 40 years has, however, only increased from 39% to 40% in the same period.

The presence of RNs in rural areas has not increased over the five years of survey. In 2013, 10% of all RNs work in non-metro counties. In the present survey, only 9% do. However, a higher proportion of RNs now have an educational background in the state. In 2013, 67% completed high school or college in the state whereas, in 2017, 70% did.

Educational attainment has improved in the RN workforce. Those holding a baccalaureate degree have increased from 38% in 2013 to 45% in 2017; conversely, the percent reporting an associate degree as their highest degree has declined from 34% to 31% in the same period. The percent holding at most a RN diploma as their highest degree has also declined from 14% in 2013 to 10% in 2017. A slightly higher proportion now hold a Master's or doctoral degree.

The increase in educational attainment, however, comes at a cost. The percent holding education debt was 32% in 2013 but is now 40%. For those under age 40, the increase is from 57% in 2013 to 61% in the current report. The distribution of education debt also changed during the period, particularly for those under age 40. Those under 40 reporting education debt of less than $20,000 were 26% in 2013. Now, they are just 22%. A higher proportion are now at the upper tail of the distribution. In 2013, 3.5% and 3.4% of all RNs with debt and RNs under age 40 with education debt, respectively, reported above $100,000 in education debt. In 2017, the corresponding prevalence was 6.3% and 5.4%, respectively. It is important to keep an eye on the debt burden of RNs as close to a third report wanting to pursue additional education in the past five surveys.

Income has not changed much in the period. Although the median income in 2013 was $50,000-$60,000 and the median income now is $60,000-$70,000, the increase occurred in 2015 and has not changed subsequently. However, there has been some change in the distribution of income. In 2017, 9% earned more than $100,000 whereas 6% did in 2013. Additionally, 33% earned less than $50,000 in 2013 whereas 26% did in 2017.

There are some changes in the specialties of RNs although acute/critical care still ranked the most reported specialty in both 2013 and 2017. However, 16% reported they had specialty in acute/critical care in 2013 whereas 20% did in 2017. Furthermore, 11% reported surgical specialty in 2013 whereas 8% did in 2017. Specialties like women's health and obstetrics declined from 7% in 2013 to 6% in 2017. However, the percent holding a nurse practitioner license remains the same, at 6%.

In both 2013 and 2017, 84% of RNs worked in the private sector. However, 42% now report working for for-profit organizations compared to 38% in 2013. Most of the shift appears to be RNs moving from non-profit to for-profit organizations as the percent reporting working for non-profit declined from 46% to 42% in the same period.

Retirement is becoming a more critical issue in the RN workforce. A higher proportion of RNs expect to retire under 60 and 65 years of age. In 2013, 10% expected to retire by age 60 and 32% by age 65. In 2017, 12% and 39%, respectively, reported the same. Adequate preparation is needed for the anticipated exodus from the workforce.

A Closer Look:

Licensees		
License Status	#	%
Renewing Practitioners	47,274	43%
New Licensees	5,910	5%
Non-Renewals	6,450	6%
Renewal date not in survey period	49,223	45%
All Licensees	**108,857**	**100%**

Source: Va. Healthcare Workforce Data Center

HWDC surveys tend to achieve very high response rates. 86% of renewing RNs submitted a survey. These represent 37% of RNs who held a license at some point during the survey period.

Response Rates			
Statistic	**Non Respondents**	**Respondent**	**Response Rate**
By Age			
Under 30	9,455	3,213	25%
30 to 34	7,643	4,918	39%
35 to 39	7,788	3,820	33%
40 to 44	5,972	4,885	45%
45 to 49	7,598	4,137	35%
50 to 54	6,375	5,231	45%
55 to 59	8,230	4,363	35%
60 and Over	16,016	9,213	37%
Total	**69,077**	**39,780**	**37%**
New Licenses			
Issued After Sept. 2016	5,909	1	0%
Metro Status			
Non-Metro	7,753	4,855	39%
Metro	51,518	32,000	38%
Not in Virginia	9,801	2,923	23%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed RNs

Number: 108,857
New: 5%
Not Renewed: 6%

Response Rates

All Licensees: 37%
Renewing Practitioners: 86%

Source: Va. Healthcare Workforce Data Center

Response Rates	
Completed Surveys	39,780
Response Rate, all licensees	37%
Response Rate, Renewals	86%

Source: Va. Healthcare Workforce Data Center

Definitions

1. **The Survey Period:** The survey was conducted between October 2016 and September 2017 on the birth month of each renewing practitioner.
2. **Target Population:** All RNs who held a Virginia license at some point during the survey time period.
3. **Survey Population:** The survey was available to RNs who renewed their licenses online. It was not available to those who did not renew, including RNs newly licensed during the survey time frame.

At a Glance:

Workforce

Virginia's RN Workforce:	90,574
FTEs:	77,979

Utilization Ratios

Licensees in VA Workforce:	83%
Licensees per FTE:	1.40
Workers per FTE:	1.16

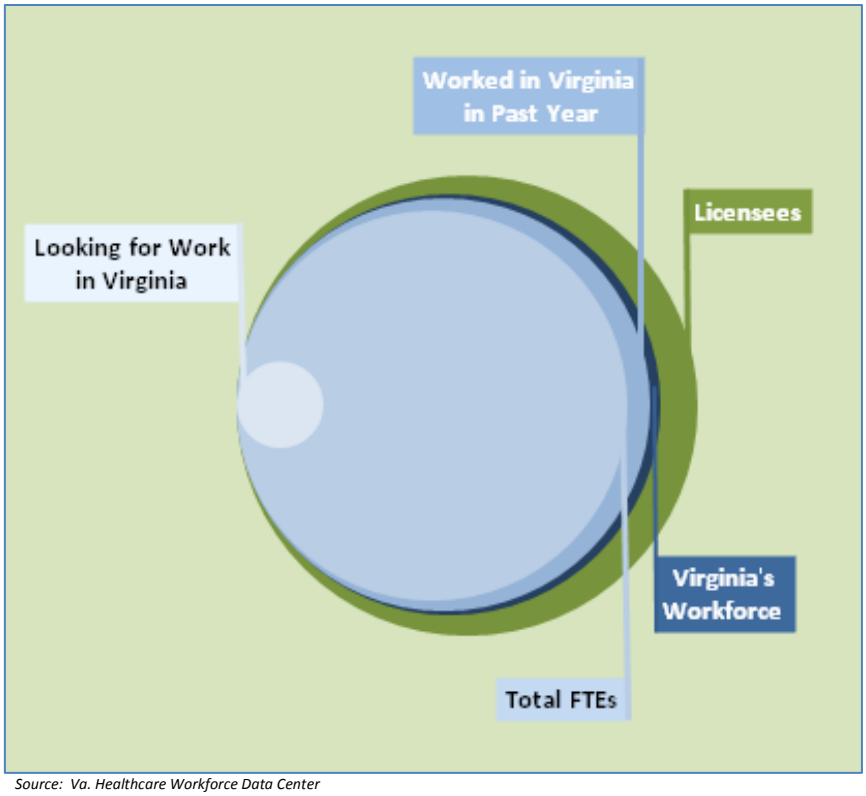
Source: Va. Healthcare Workforce Data Center

Definitions

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

Virginia's RN Workforce		
Status	#	%
Worked in Virginia in Past Year	86,724	96%
Looking for Work in Virginia	3,850	4%
Virginia's Workforce	**90,574**	**100%**
Total FTEs	**77,979**	
Licensees	**108,857**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

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

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 30	647	6%	10,092	94%	10,739	13%
30 to 34	710	7%	9,482	93%	10,193	12%
35 to 39	663	7%	8,741	93%	9,403	11%
40 to 44	654	8%	7,947	92%	8,600	10%
45 to 49	760	8%	8,487	92%	9,247	11%
50 to 54	630	7%	8,339	93%	8,969	11%
55 to 59	620	7%	8,913	93%	9,533	11%
60 +	904	5%	15,569	95%	16,472	20%
Total	**5,587**	**7%**	**77,570**	**93%**	**83,157**	**100%**

Source: Va. Healthcare Workforce Data Center

Race & Ethnicity					
Race/ Ethnicity	Virginia*	RNs		RNs under 40	
	%	#	%	#	%
White	63%	65,548	78%	23,148	76%
Black	19%	9,106	11%	3,292	11%
Asian	6%	4,105	5%	1,654	5%
Other Race	<1%	859	1%	282	1%
Two or more races	3%	1,769	2%	880	3%
Hispanic	9%	2,131	3%	1,116	4%
Total	**100%**	**83,517**	**100%**	**30,371**	**100%**

*Population data in this chart is from the US Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2015.

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

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

Age

Median Age:	46
% Under 40:	36%
% 55+:	31%

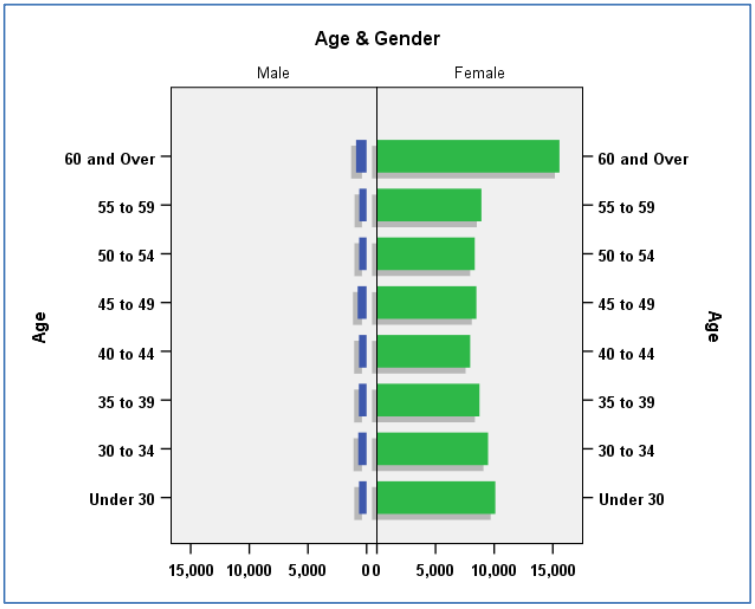
Diversity

Diversity Index:	37%
Under 40 Div. Index:	40%

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two RNs, there is a 37% chance they would be of a different race/ethnicity (a measure known as the Diversity Index), compared to a 56% chance for Virginia's population as a whole.

36% of RNs are under the age of 40. 93% of these professionals are female. In addition, the diversity index among RNs under the age of 40 is 40%, which is higher than the diversity index for Virginia's overall RN workforce.



Source: Va. Healthcare Workforce Data Center

At a Glance:

Childhood

Urban Childhood:	14%
Rural Childhood:	37%

Virginia Background

HS in Virginia:	56%
Prof. Ed. in VA:	67%
HS or Prof. Ed. in VA:	70%

Location Choice

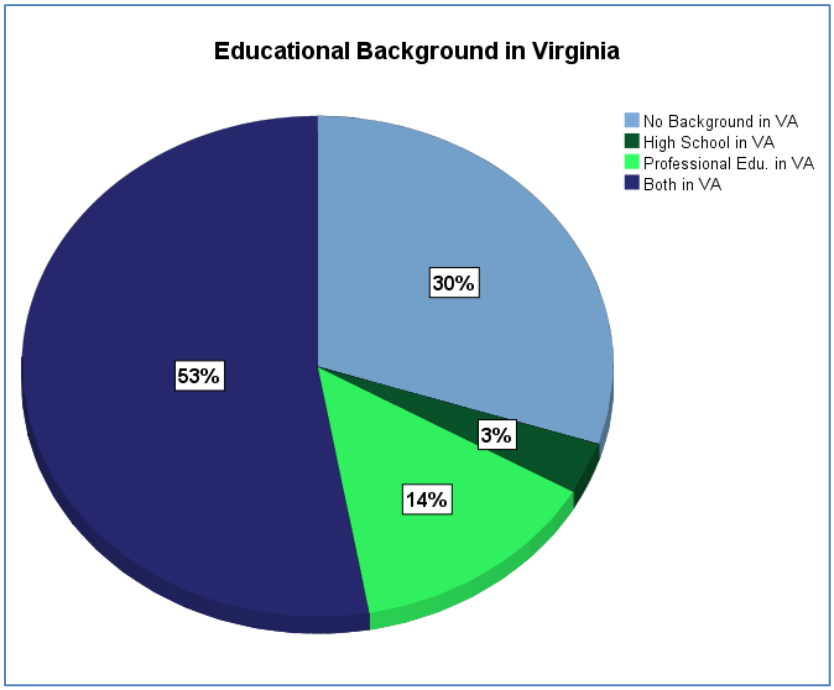
% Rural to Non-Metro:	19%
% Urban/Suburban to Non-Metro:	3%

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+	26%	58%	17%
2	Metro, 250,000 to 1 million	54%	37%	10%
3	Metro, 250,000 or less	54%	37%	9%
	Non-Metro Counties			
4	Urban pop 20,000+, Metro adj	71%	19%	10%
6	Urban pop, 2,500-19,999, Metro adj	74%	20%	6%
7	Urban pop, 2,500-19,999, nonadj	88%	8%	4%
8	Rural, Metro adj	73%	20%	7%
9	Rural, nonadj	72%	22%	6%
	Overall	**37%**	**49%**	**14%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

37% of RNs grew up in self-described rural areas, and 19% of these professionals currently work in non-Metro counties. Overall, 9% of all RNs currently work in non-Metro counties.

Top Ten States for Registered Nurse Recruitment

Rank	All RNs			
	High School	#	Init. Prof Degree	#
1	Virginia	46,728	Virginia	55,256
2	Outside U.S./Canada	5,086	New York	3,043
3	New York	3,904	Pennsylvania	2,916
4	Pennsylvania	3,693	Outside U.S./Canada	2,388
5	Maryland	2,167	West Virginia	1,702
6	New Jersey	1,974	North Carolina	1,617
7	West Virginia	1,918	Maryland	1,559
8	North Carolina	1,724	Florida	1,207
9	Ohio	1,551	Ohio	1,193
10	Florida	1,404	New Jersey	924

Source: Va. Healthcare Workforce Data Center

56% of licensed RNs received their high school degree in Virginia, and 67% received their initial professional degree in the state.

Among RNs who received their license in the past five years, 55% received their high school degree in Virginia, while 68% received their initial professional degree in the state.

Rank	Licensed in the Past 5 Years			
	High School	#	Init. Prof Degree	#
1	Virginia	12,527	Virginia	15,355
2	Outside U.S./Canada	1,428	Pennsylvania	720
3	Pennsylvania	886	New York	509
4	New York	770	West Virginia	508
5	North Carolina	547	Outside U.S./Canada	481
6	Maryland	510	North Carolina	481
7	New Jersey	502	Florida	421
8	West Virginia	483	Maryland	373
9	Florida	473	Ohio	347
10	California	427	Washington, D.C.	231

Source: Va. Healthcare Workforce Data Center

17% of Virginia's licensees did not participate in Virginia's RN workforce during the past year. 73% of these licensees worked at some point in the past year, including 67% who worked in a nursing-related capacity.

At a Glance:

Not in VA Workforce

Total:	18,255
% of Licensees:	17%
Federal/Military:	11%
Va. Border State/DC:	16%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Degree		
Degree	#	%
Hospital RN Diploma[1]	7,968	10%
Associate Degree	25,733	31%
Baccalaureate Degree	37,177	45%
Master's Degree	10,903	13%
Doctorate Degree	1,089	1%
Total	**82,870**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Education

Baccalaureate: 45%
Associate: 31%

Educational Debt

Carry debt: 40%
Under age 40 w/ debt: 61%
Median debt: $20k-$30k

Source: Va. Healthcare Workforce Data Center

45% of RNs have a baccalaureate as their highest professional degree. Forty percent of RNs have education debt, including 61% of those under the age of 40. The median debt burden among RNs with educational debt is between $20,000 and $30,000.

Current Educational Attainment		
Currently Enrolled?	#	%
Yes	12,433	15%
No	70,133	85%
Total	**82,566**	**100%**
Degree Pursued	#	%
Associate	47	0%
Bachelor	6018	50%
Masters	5013	41%
Doctorate	1025	8%
Total	**12,103**	**100%**

Source: Va. Healthcare Workforce Data Center

Educational Debt				
Amount Carried	All RNs		RNs under 40	
	#	%	#	%
None	43,494	60%	10,465	39%
$10,000 or less	5,643	8%	2,926	11%
$10,000-$19,999	4,980	7%	3,001	11%
$20,000-$29,999	4,319	6%	2,486	9%
$30,000-$39,999	3,253	5%	1,914	7%
$40,000-$49,999	2,566	4%	1,645	6%
$50,000-$59,999	2,013	3%	1,269	5%
$60,000-$69,999	1,654	2%	1,053	4%
$70,000-$79,999	1,074	1%	573	2%
$80,000-$89,999	851	1%	488	2%
$90,000-$99,999	531	1%	292	1%
$100,000-$109,999	634	1%	315	1%
$110,000-$119,999	252	0%	130	0%
$120,000 or more	908	1%	452	2%
Total	**72,174**	**100%**	**27,009**	**100%**

Source: Va. Healthcare Workforce Data Center

[1] Includes those who reported they have LPN/LVN diploma or certificates

At a Glance:

Primary Specialty

Acute/Critical Care:	20%
Surgery/OR:	8%
Cardiology:	4%

Secondary Specialty

Acute/Critical Care:	16%
Cardiology:	5%
Surgery/OR:	5%

Licenses

Licensed NP:	5%
LPN:	1%

Source: Va. Healthcare Workforce Data Center

20% of all RNs work at an acute/critical care/emergency/trauma center as their primary work location, the most of any establishment type in the state.

A Closer Look:

Specialties				
Specialty	Primary		Secondary	
	#	%	#	%
Acute/Critical Care/Emergency/Trauma	15,877	20%	9,224	16%
Surgery/OR/Pre-, Peri- or Post-Operative	6,265	8%	2,779	5%
Cardiology	3,625	4%	2,873	5%
Obstetrics/Nurse Midwifery	3,569	4%	1,520	3%
Pediatrics	3,514	4%	2,266	4%
Psychiatric/Mental Health	3,169	4%	1,476	3%
Neonatal Care	2,653	3%	1,509	3%
Administration/Management	2,571	3%	2,523	4%
Oncology	2,329	3%	1,427	2%
Case Management	2,274	3%	1,843	3%
Family Health	2,163	3%	934	2%
Community Health/Public Health	1,959	2%	1,502	3%
Geriatrics/Gerontology	1,801	2%	2,011	3%
Hospital/Float	1,511	2%	1,447	2%
Long-Term Care/Assisted Living/Nursing Home	1,357	2%	1,457	2%
Other Specialty Area	17,565	22%	14,082	24%
General Nursing/No Specialty	7,604	9%	8,620	15%
Medical Specialties (Not Listed)	1,303	2%	1,061	2%
Total	**81,109**	**100%**	**58,554**	**100%**

Source: Va. Healthcare Workforce Data Center

Other Certifications		
Certification	#	%
Licensed Nurse Practitioner	5,207	6%
Licensed Practical Nurse	652	1%
Clinical Nurse Specialist	494	1%

Source: Va. Healthcare Workforce Data Center

6% of RNs are also Licensed Nurse Practitioners. Another 1% of RNs are also Licensed Practical Nurses and Clinical Nurse Specialists.

A Closer Look:

Military Service		
Service?	#	%
Yes	6,179	8%
No	73,335	92%
Total	**79,514**	**100%**

Source: Va. Healthcare Workforce Data Center

Branch of Service		
Branch	#	%
Army	2,222	38%
Navy/Marine	2,173	37%
Air Force	1,307	23%
Other	103	2%
Total	**5,806**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Military Service
% Served: 8%

Branch of Service
Army: 38%
Navy/Marine: 37%
Air Force: 23%

Occupation
Army Health Care Spec.: 7%
Navy Basic Med. Tech.: 6%
Air Force Basic Med. Tech.: 2%

Source: Va. Healthcare Workforce Data Center

8% of Virginia's RN workforce has served in the military. 38% of these RNs served in the Army, including 7% who worked as an Army Health Care Specialist (68W Army Medic).

Military Occupation		
Occupation	#	%
Army Health Care Specialist (68W Army Medic)	411	7%
Navy Basic Medical Technician (Navy HM0000)	328	6%
Air Force Basic Medical Technician (Air Force BMTCP 4NOX1)	145	3%
Air Force Independent Duty Medical Technician (IDMT 4NOX1C)	15	0%
Other	4,706	84%
Total	**5,604**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Employment
Employed in Profession: 90%
Involuntarily Unemployed: 0%

Positions Held
1 Full-time: 69%
2 or More Positions: 10%

Weekly Hours:
40 to 49: 41%
60 or more: 3%
Less than 30: 14%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Current Work Status		
Status	#	%
Employed, capacity unknown	72	<1%
Employed in a nursing- related capacity	74,012	90%
Employed, NOT in a nursing-related capacity	2,368	3%
Not working, reason unknown	12	0%
Involuntarily unemployed	287	<1%
Voluntarily unemployed	3,608	4%
Retired	1,945	2%
Total	**82,305**	**100%**

Source: Va. Healthcare Workforce Data Center

90% of RNs are currently employed in their profession. 69% of RNs hold one full-time job, while 10% currently have multiple jobs. 41% of all RNs work between 40 and 49 hours per week, while 14% work less than 30 hours per week.

Current Weekly Hours		
Hours	#	%
0 hours	3,907	5%
1 to 9 hours	1,411	2%
10 to 19 hours	2,809	4%
20 to 29 hours	6,751	9%
30 to 39 hours	23,550	30%
40 to 49 hours	31,856	41%
50 to 59 hours	5,560	7%
60 to 69 hours	1,673	2%
70 to 79 hours	590	1%
80 or more hours	481	1%
Total	**78,588**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Positions		
Positions	#	%
No Positions	3,907	5%
One Part-Time Position	12,695	16%
Two Part-Time Positions	1,819	2%
One Full-Time Position	54,381	69%
One Full-Time Position & One Part-Time Position	5,606	7%
Two Full-Time Positions	180	0%
More than Two Positions	426	1%
Total	**79,014**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Income		
Hourly Wage	#	%
Volunteer Work Only	966	2%
Less than $20,000	2,584	4%
$20,000-$29,999	1,889	3%
$30,000-$39,999	3,963	6%
$40,000-$49,999	8,147	13%
$50,000-$59,999	11,496	18%
$60,000-$69,999	10,866	17%
$70,000-$79,999	8,212	13%
$80,000-$89,999	5,965	9%
$90,000-$99,999	3,526	6%
$100,000 or more	6,408	9%
Total	**64,022**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Earnings

Median Income: $60k-$70k

Benefits

Health Insurance: 66%

Retirement: 73%

Satisfaction

Satisfied: 93%

Very Satisfied: 58%

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	#	%
Very Satisfied	45,183	58%
Somewhat Satisfied	28,129	36%
Somewhat Dissatisfied	4,039	5%
Very Dissatisfied	1,227	2%
Total	**78,578**	**100%**

Source: Va. Healthcare Workforce Data Center

The typical RN earned between $60,000 and $70,000 in the past year. Among RNs who received either a salary or an hourly wage as compensation at their primary work location, 84% had access to at least one employer-sponsored benefit, including 66% who received health insurance.

Employer-Sponsored Benefits			
Benefit	#	%	% of Wage/Salary Employees
Retirement	53,239	72%	73%
Paid Leave	51,669	70%	71%
Health Insurance	48,560	66%	66%
Dental Insurance	47,724	64%	65%
Group Life Insurance	36,448	49%	50%
Signing/Retention Bonus	5,584	8%	8%
Received at Least One Benefit	**62,415**	**84%**	**84%**

*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?	855	1%
Experience Voluntary Unemployment?	5,564	6%
Work Part-time or temporary positions, but would have preferred a full-time/permanent position?	1,961	2%
Work two or more positions at the same time?	10,864	12%
Switch employers or practices?	6,680	7%
Experienced at least One	**22,349**	**25%**

Source: Va. Healthcare Workforce Data Center

1% of Virginia's RNs experienced involuntary unemployment at some point during the renewal cycle. By comparison, Virginia's average monthly unemployment rate was 3.9% during the same time period.[2]

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at this Location	2,281	3%	1,134	8%
Less than 6 Months	4,544	6%	1,859	13%
6 Months to 1 Year	6,120	8%	1,647	11%
1 to 2 Years	15,717	21%	2,921	20%
3 to 5 Years	16,182	21%	2,877	20%
6 to 10 Years	11,424	15%	1,744	12%
More than 10 Years	20,217	26%	2,270	16%
Subtotal	**76,486**	**100%**	**14,453**	**100%**
Did not have location	4,494		75,285	
Item Missing	9,594		836	
Total	**90,574**		**90,574**	

Source: Va. Healthcare Workforce Data Center

66% of RNs receive an hourly wage at their primary work location, while 29% are salaried employees.

At a Glance:

Unemployment Experience

Involuntarily Unemployed: 1%
Underemployed: 6%

Turnover & Tenure

Switched Jobs: 7%
New Location: 19%
Over 2 years: 63%
Over 2 yrs, 2nd location: 48%

Employment Type

Hourly Wage: 66%
Salary: 29%

Source: Va. Healthcare Workforce Data Center

63% of RNs have worked at their primary location for more than 2 years—the job tenure normally required to attain a conventional mortgage loan.

Employment Type		
Primary Work Site	**#**	**%**
Hourly Wage	17,153	29%
Salary	38,700	66%
By Contract/Per Diem	1,779	3%
Unpaid	486	1%
Business/Contractor Income	523	1%
Subtotal	**58,641**	**100%**
Did not have location	4,494	
Item Missing	27,439	

Source: Va. Healthcare Workforce Data Center

[2] As reported by the US Bureau of Labor Statistics. The average non-seasonally adjusted monthly unemployment rate was 3.9% in October 2016 to September 2017, the period of the survey. The low of the period was 3.6% in September 2017 and the high was 4.2% in January 2017. The data for September 2017 was preliminary.

At a Glance:

Concentration

Top Region:	28%
Top 3 Regions:	72%
Lowest Region:	1%

Locations

2 or more (Past Year):	19%
2 or more (Now*):	17%

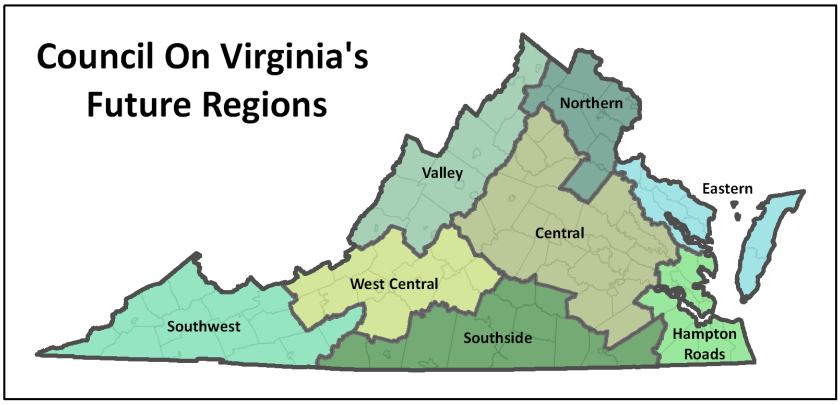
Source: Va. Healthcare Workforce Data Center

28% of all RNs work in Central Virginia, the most of any region in the state. Another 23% of RNs work in Northern Virginia, while 21% work in Hampton Roads.

A Closer Look:

Regional Distribution of Work Locations				
COVF Region[3]	Primary Location		Secondary Location	
	#	%	#	%
Central	20,841	28%	3,397	23%
Eastern	959	1%	269	2%
Hampton Roads	15,861	21%	3,017	21%
Northern	17,504	23%	3,324	23%
Southside	2,522	3%	539	4%
Southwest	3,087	4%	689	5%
Valley	5,143	7%	776	5%
West Central	8,992	12%	1,718	12%
Virginia Border State/DC	335	0%	265	2%
Other US State	467	1%	669	5%
Outside of the US	12	0%	29	0%
Total	**75,723**	**100%**	**14,692**	**100%**
Item Missing	11,050		591	

Source: Va. Healthcare Workforce Data Center



Number of Work Locations				
Locations	Work Locations in Past Year		Work Locations Now*	
	#	%	#	%
0	3,825	5%	5,645	7%
1	61,115	76%	61,131	76%
2	10,071	13%	9,347	12%
3	4,102	5%	3,395	4%
4	360	0%	173	0%
5	209	0%	134	0%
6 or More	427	1%	285	0%
Total	**80,109**	**100%**	**80,109**	**100%**

19% of all RNs held two or more positions over the past year, while 17% currently hold multiple positions.

*At the time of survey completion (Oct. 2016-Sept. 2017, birth month of respondent).

[3] These are now referred to as VA Perform's regions: http://vaperforms.virginia.gov/Regions/regionalScorecards.php

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	30,198	42%	6,976	52%
Non-Profit	30,379	42%	4,824	36%
State/Local Government	7,683	11%	1,114	8%
Veterans Administration	1,692	2%	158	1%
U.S. Military	1,436	2%	197	1%
Other Federal Government	565	1%	123	1%
Total	**71,953**	**100%**	**13,392**	**100%**
Did not have location	4,494		75,285	
Item Missing	14,127		1,897	

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Sector

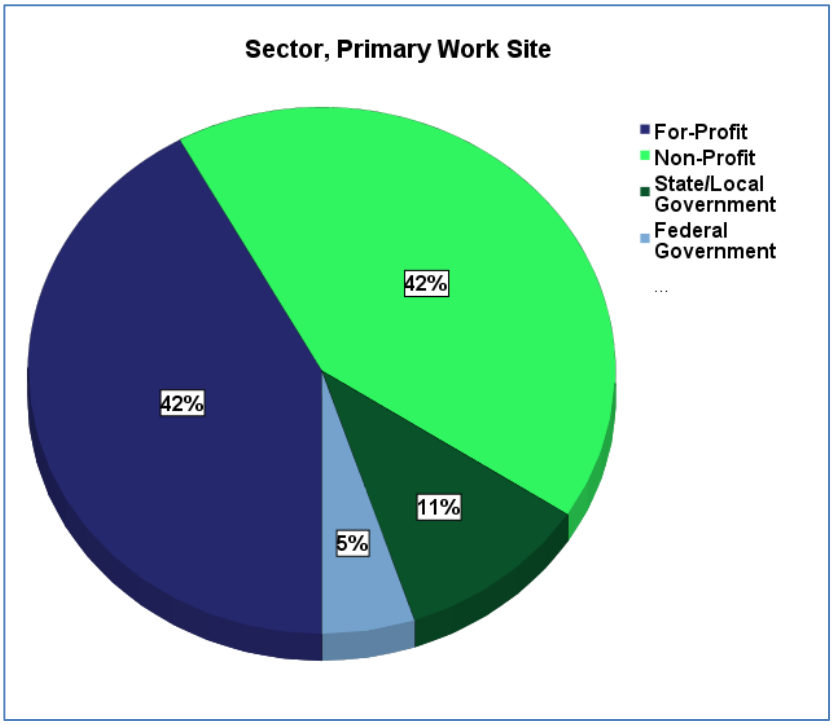
For Profit:	42%
Federal:	5%

Top Establishments

Hospital, Inpatient:	39%
Hospital, Emergency:	7%
Academic Institution:	6%

Source: Va. Healthcare Workforce Data Center

84% of all RNs work in the private sector, including 42% in for-profit establishments. Another 11% of RNs work for state or local governments, while 5% work for the federal government.



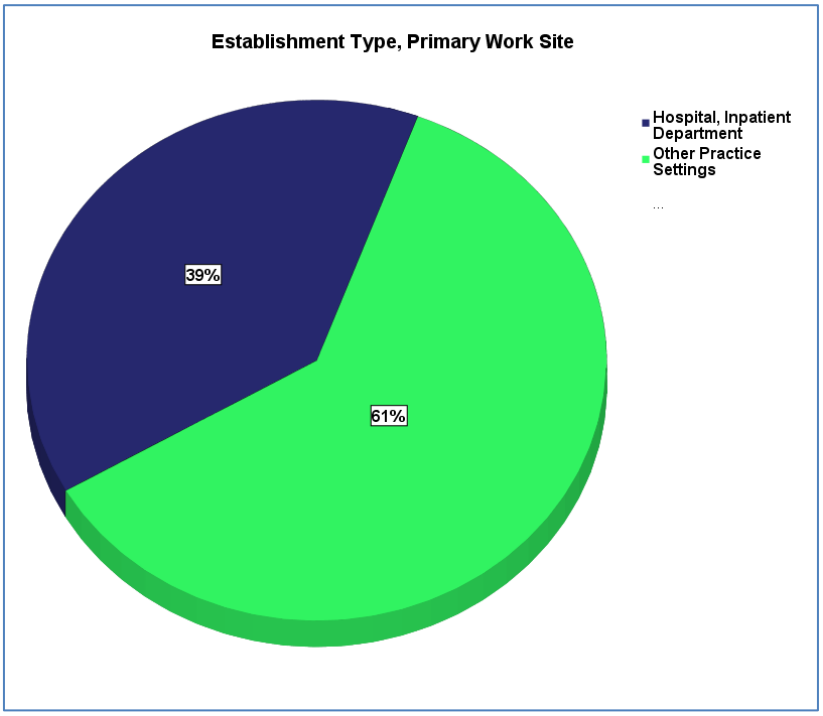
Source: Va. Healthcare Workforce Data Center

Location Type				
Establishment Type	Primary Location		Secondary Location	
	#	%	#	%
Hospital, Inpatient Department	26,830	39%	4,004	31%
Hospital, Emergency Department	4,783	7%	829	6%
Academic Institution (Teaching or Research)	4,260	6%	773	6%
Hospital, Outpatient Department	3,970	6%	512	4%
Home Health Care	3,109	5%	1,067	8%
Clinic, Primary Care or Non-Specialty	2,772	4%	581	4%
Ambulatory/Outpatient Surgical Unit	2,524	4%	820	6%
Long Term Care Facility, Nursing Home	2,524	4%	475	4%
Physician Office	2,409	4%	388	3%
School (Providing Care to Students)	1,937	3%	302	2%
Clinic, Non-Surgical Specialty	1,768	3%	342	3%
Insurance Company, Health Plan	1,448	2%	218	2%
Hospice	1,117	2%	358	3%
Other Practice Setting	9,333	14%	2,288	18%
Total	**68,784**	**100%**	**12,957**	**100%**
Did Not Have a Location	4,494		75,285	

Source: Va. Healthcare Workforce Data Center

39% of all RNs in the state work in the inpatient department of a hospital as the primary work location. Hospital emergency departments and academic institutions are also common primary establishment types among Virginia's RN workforce.

Among those RNs who also have a secondary work location, 31% work at the inpatient department of a hospital. Another 8% work for a home health care establishment.



Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Typical Time Allocation

Patient Care:	80%-89%

Roles

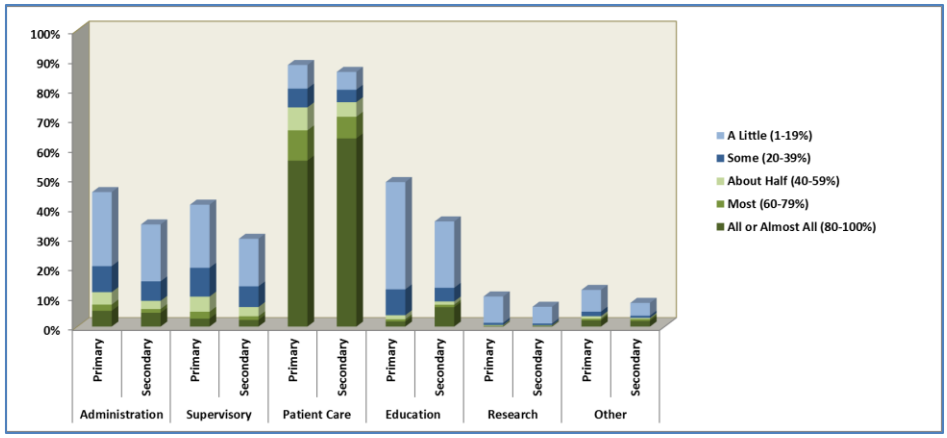
Patient Care:	66%
Administrative:	7%
Supervisory:	5%
Education:	2%

Patient Care RNs

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

Source: Va. Healthcare Workforce Data Center

A Closer Look:



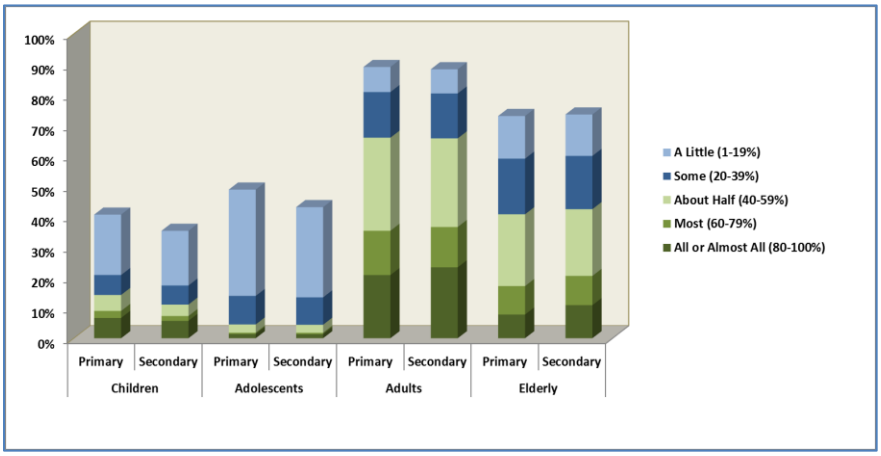
Source: Va. Healthcare Workforce Data Center

A typical RN spends nearly all of her time on patient care activities. 66% of all RNs fill a patient care role, defined as spending 60% or more of their time on patient care activities. Another 7% of RNs serve an administrative role, while 5% serve a supervisory role.

Time Allocation												
Time Spent	**Admin.**		**Supervisory**		**Patient Care**		**Education**		**Research**		**Other**	
	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site
All or Almost All (80-100%)	5%	5%	3%	2%	56%	63%	2%	7%	0%	0%	2%	2%
Most (60-79%)	2%	1%	2%	1%	10%	7%	1%	1%	0%	0%	1%	1%
About Half (40-59%)	4%	3%	5%	3%	8%	5%	1%	1%	0%	0%	1%	0%
Some (20-39%)	9%	7%	10%	7%	6%	4%	9%	5%	1%	1%	2%	1%
A Little (1-20%)	25%	19%	21%	16%	8%	6%	36%	22%	9%	6%	7%	4%
None (0%)	55%	66%	59%	70%	12%	14%	51%	65%	90%	93%	88%	92%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

The typical RN devotes most of her time to treating adults and the elderly. 35% of all RNs serve an adult patient care role, meaning that at least 60% of their patients are adults. In addition, 17% of all RNs serve an elderly patient care role.

At a Glance:
(Primary Locations)

Typical Patient Allocation

Children:	0%
Adolescents:	0%
Adults:	50%-59%
Elderly:	20%-29%

Roles

Children:	9%
Adolescents:	2%
Adults:	35%
Elderly:	17%

Source: Va. Healthcare Workforce Data Center

Patient Allocation								
Time Spent	Children		Adolescents		Adults		Elderly	
	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site
All or Almost All (80-100%)	7%	6%	1%	1%	21%	23%	8%	11%
Most (60-79%)	2%	2%	0%	0%	15%	13%	9%	10%
About Half (40-59%)	5%	4%	3%	3%	31%	29%	24%	22%
Some (20-39%)	7%	6%	9%	9%	15%	15%	18%	17%
A Little (1-20%)	20%	18%	35%	30%	8%	8%	14%	14%
None (0%)	59%	65%	51%	57%	11%	12%	27%	27%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All RNs		RNs over 50	
	#	%	#	%
Under age 50	1,478	2%	-	-
50 to 54	1,839	3%	163	1%
55 to 59	5,290	8%	1,321	5%
60 to 64	18,160	26%	6,998	24%
65 to 69	27,990	40%	12,906	45%
70 to 74	8,669	12%	4,330	15%
75 to 79	2,049	3%	1,044	4%
80 or over	818	1%	380	1%
I do not intend to retire	3,111	4%	1,448	5%
Total	**69,404**	**100%**	**28,590**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All RNs

Under 65:	39%
Under 60:	12%

RNs 50 and over

Under 65:	30%
Under 60:	5%

Time until Retirement

Within 2 years:	8%
Within 10 years:	24%
Half the workforce:	By 2042

Source: Va. Healthcare Workforce Data Center

39% of RNs expect to retire by the age of 65, while 30% of RNs who are age 50 or over expect to retire by the same age. Meanwhile, 20% of all RNs expect to work until at least age 70, including 4% who do not expect to retire at all.

Within the next two years, only 2% of RNs expect to the leave the profession, while 4% plan on leaving the state to practice elsewhere. Meanwhile, 29% of RNs plan on pursuing additional educational opportunities, and 7% expect to increase their patient care hours.

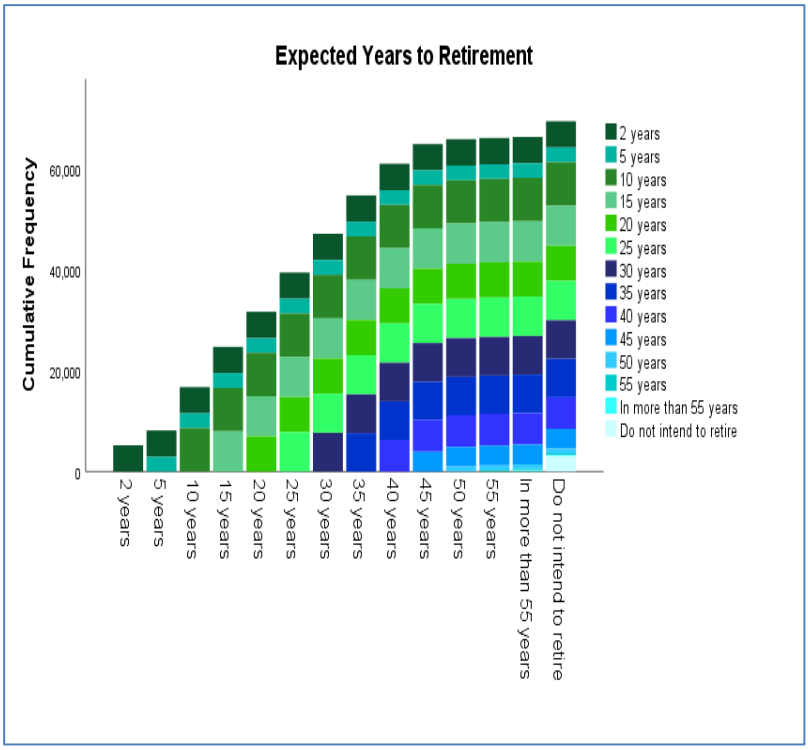
Future Plans		
2 Year Plans:	#	%
Decrease Participation		
Leave Profession	1,576	2%
Leave Virginia	3,203	4%
Decrease Patient Care Hours	7,461	8%
Decrease Teaching Hours	413	0%
Increase Participation		
Increase Patient Care Hours	6,742	7%
Increase Teaching Hours	4,729	5%
Pursue Additional Education	26,338	29%
Return to Virginia's Workforce	1,551	2%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for RNs. 8% of RNs expect to retire in the next two years, while 24% expect to retire in the next 10 years. More than half of the current RN workforce expects to retire by 2042.

Time to Retirement			
Expect to retire within. . .	#	%	Cumulative %
2 years	5,210	8%	8%
5 years	2,916	4%	12%
10 years	8,583	12%	24%
15 years	7,978	11%	36%
20 years	6,954	10%	46%
25 years	7,789	11%	57%
30 years	7,656	11%	68%
35 years	7,609	11%	79%
40 years	6,274	9%	88%
45 years	3,910	6%	93%
50 years	957	1%	95%
55 years	258	0%	95%
In more than 55 years	198	0%	96%
Do not intend to retire	3,111	4%	100%
Total	**69,403**	**100%**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Using these estimates, retirements will begin to reach over 10% of the current workforce every 5 years by 2027. Retirements will peak at 12% of the current workforce around the same time before declining to under 10% of the current workforce again around 2057.

At a Glance:

FTEs

Total:	77,979
FTEs/1,000 Residents:	9.37
Average:	0.91

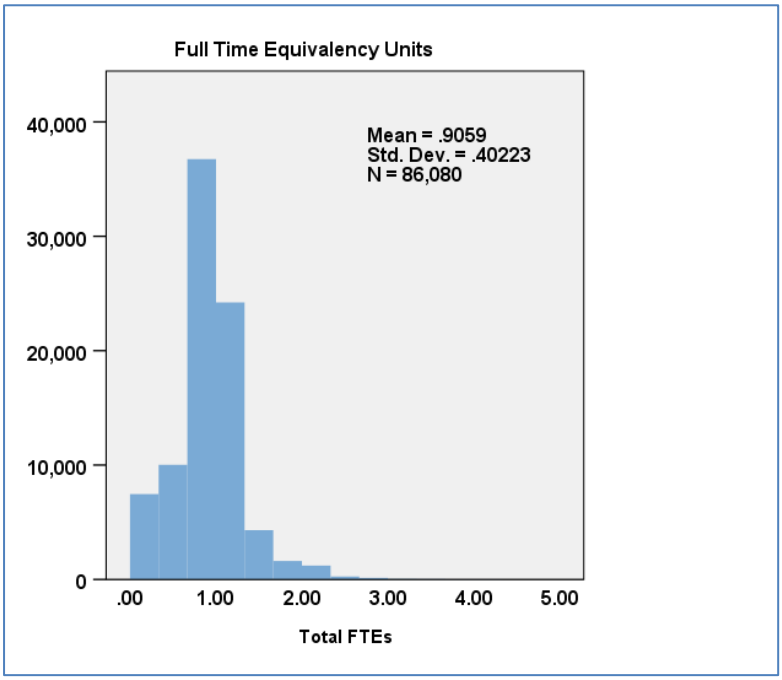
Age & Gender Effect

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

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

Source: Va. Healthcare Workforce Data Center

A Closer Look:

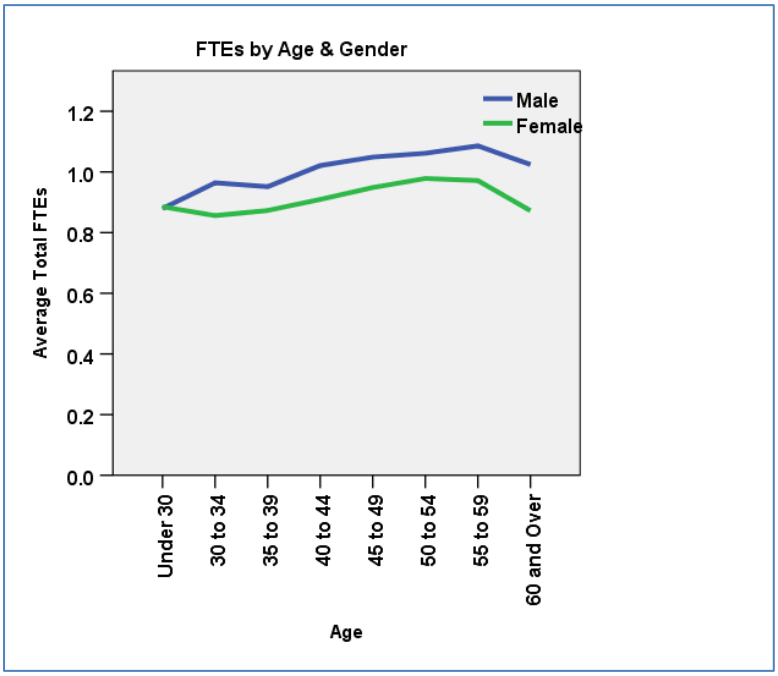


Source: Va. Healthcare Workforce Data Center

The typical (median) RN provided 0.91 FTEs, or approximately 37 hours per week for 50 weeks. Although FTEs appear to vary by age and gender, statistical tests did not verify that a difference exists.[4]

Full-Time Equivalency Units		
Age	**Average**	**Median**
Age		
Under 30	0.88	0.93
30 to 34	0.86	0.91
35 to 39	0.87	0.91
40 to 44	0.91	0.93
45 to 49	0.95	0.94
50 to 54	0.99	0.99
55 to 59	0.96	0.96
60 and Over	0.86	0.84
Gender		
Male	1.00	1.01
Female	0.91	0.94

Source: Va. Healthcare Workforce Data Center

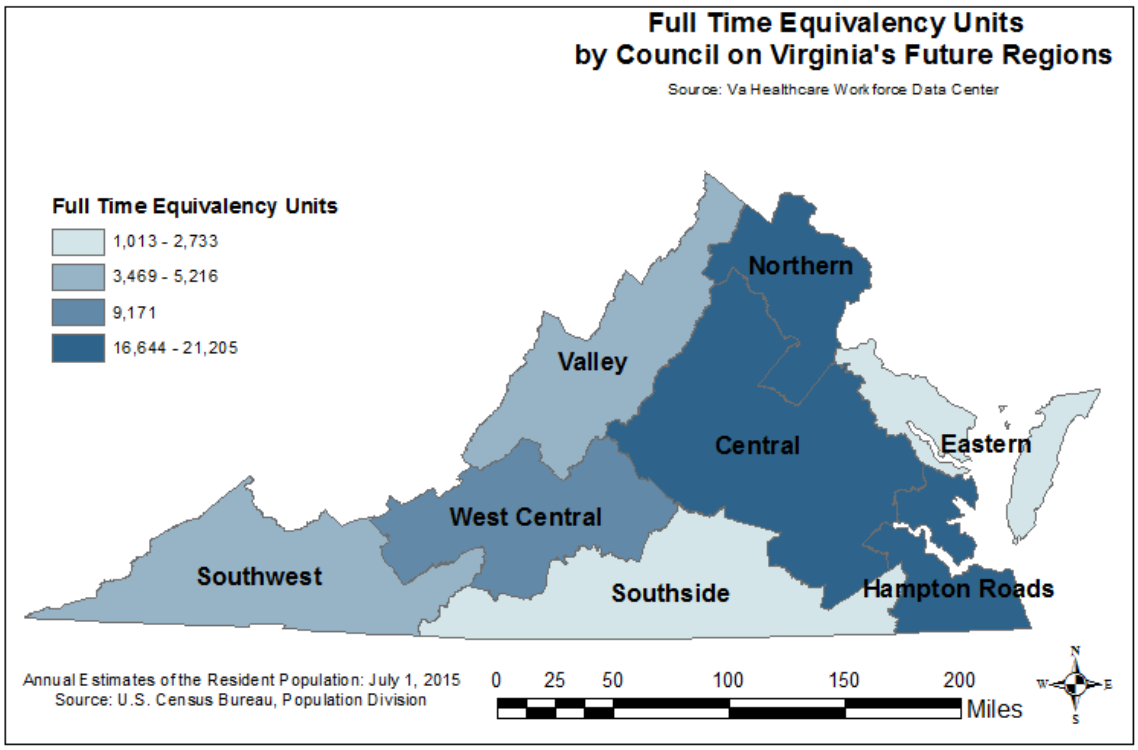


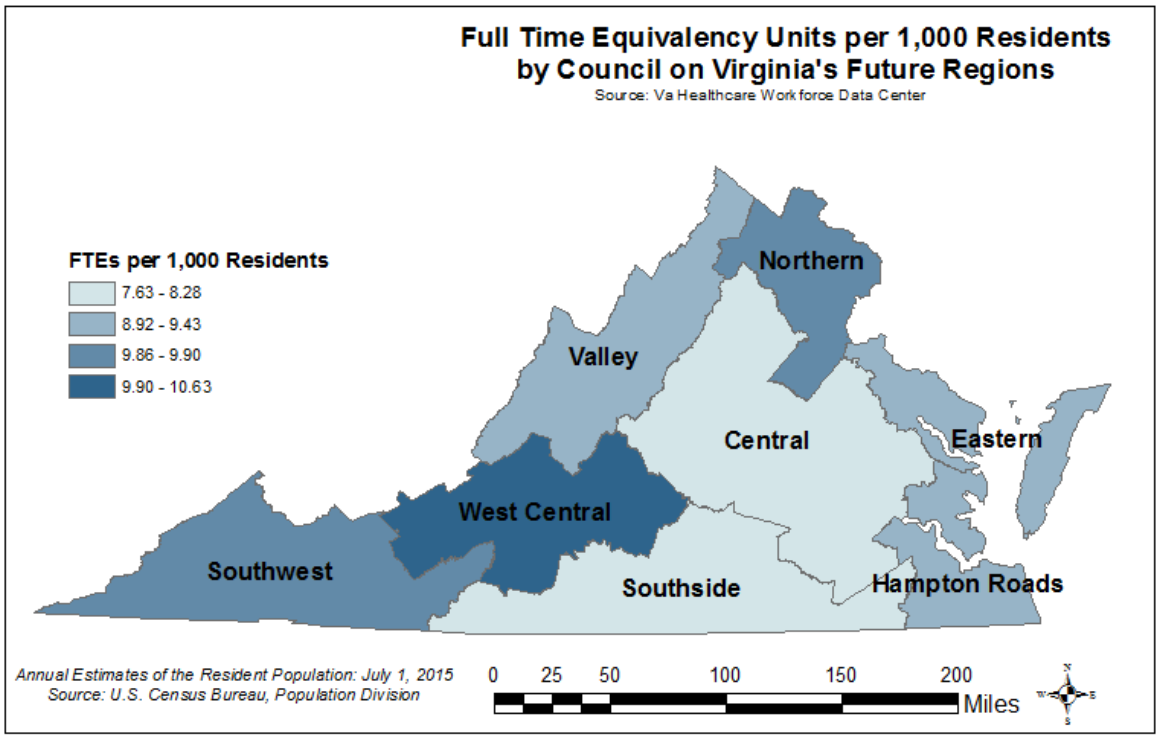
Source: Va. Healthcare Workforce Data Center

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

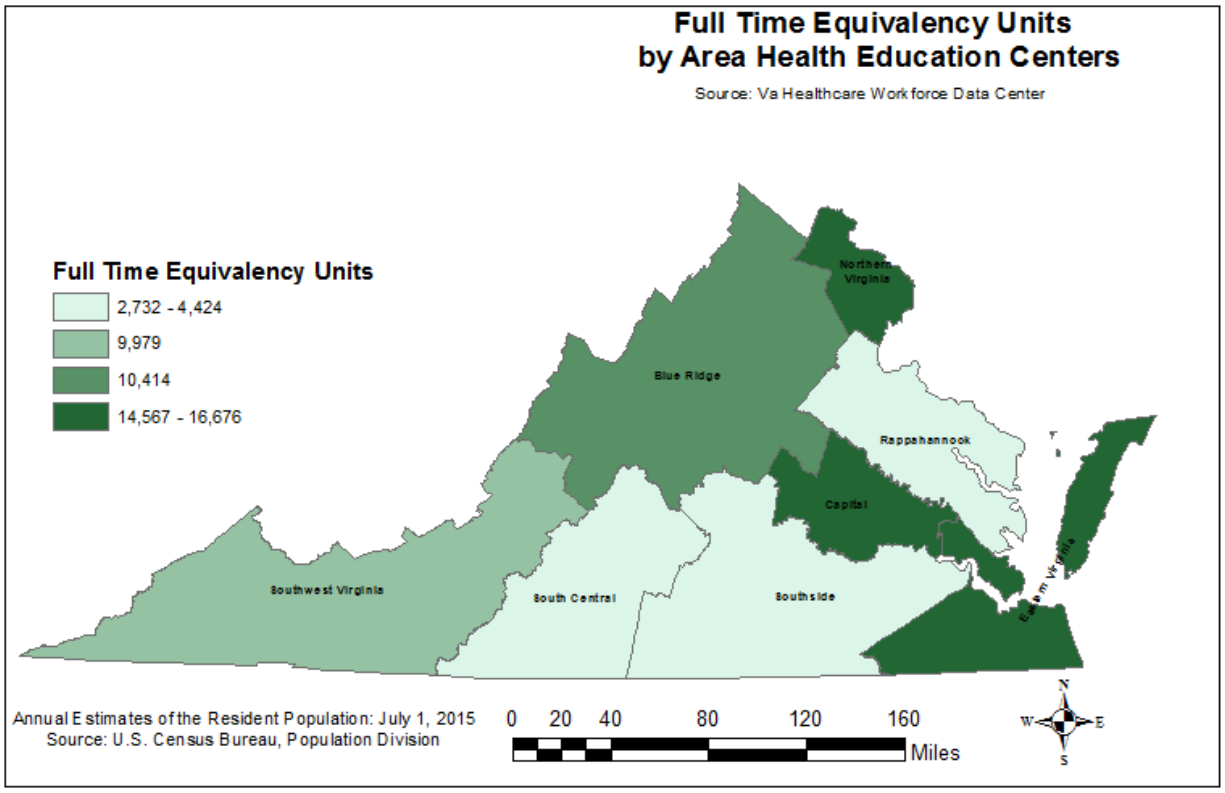
Maps

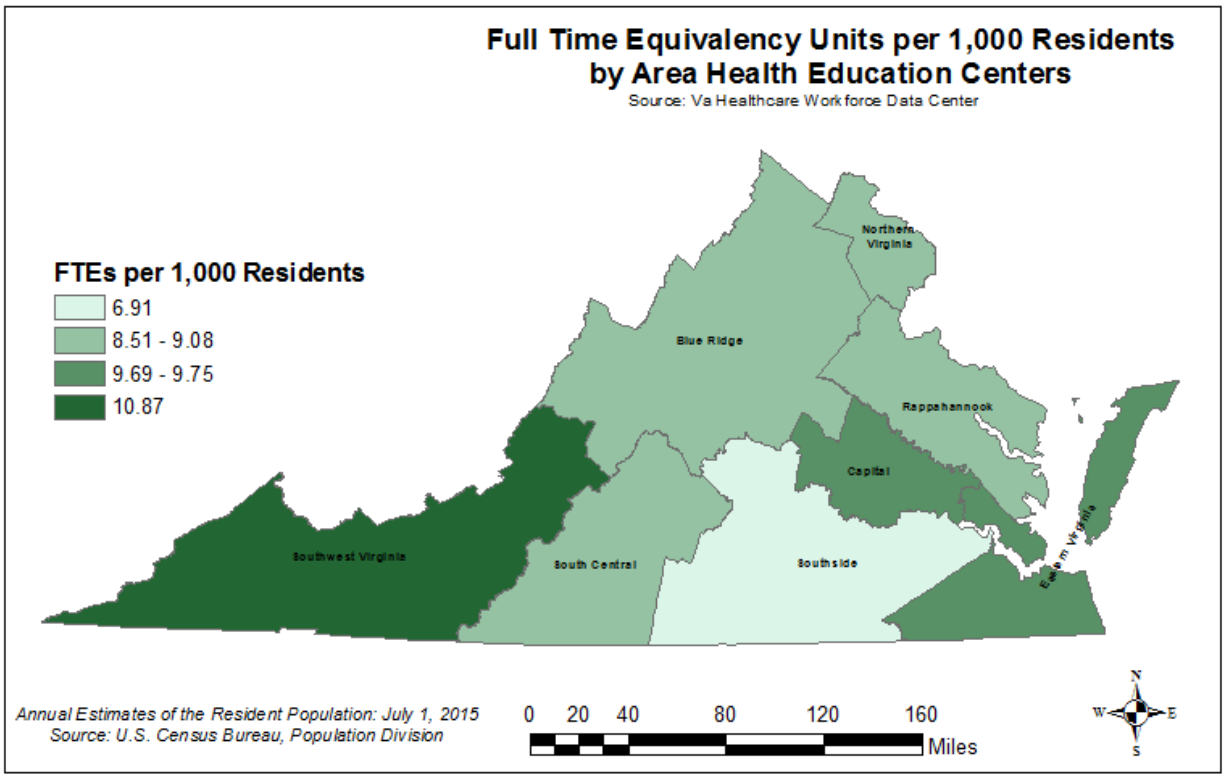
Council on Virginia's Future Regions[3]

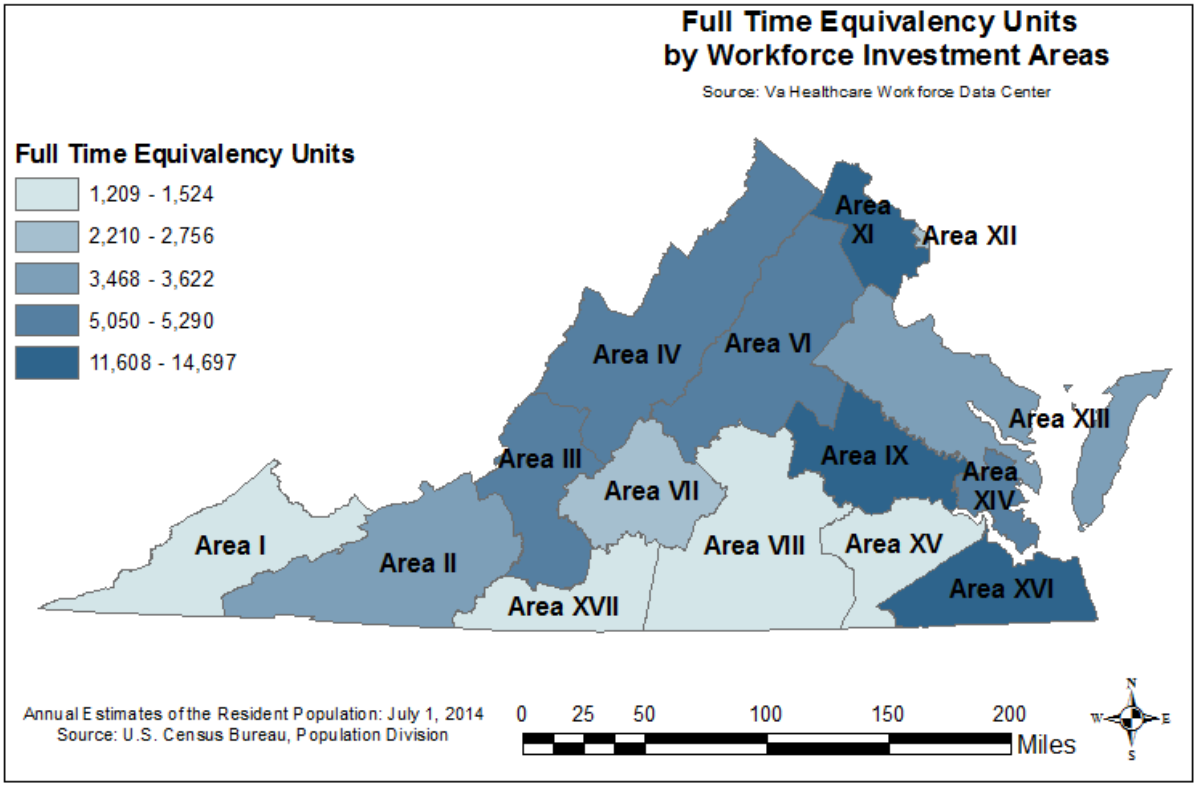


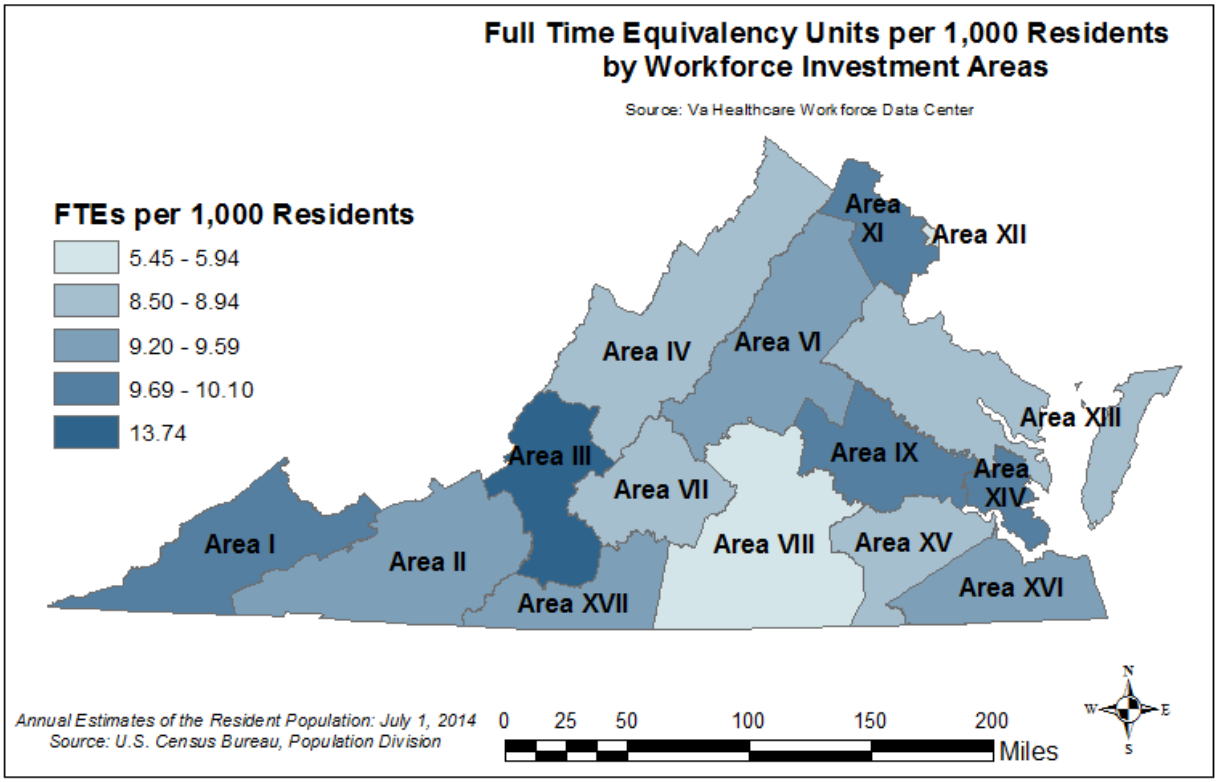


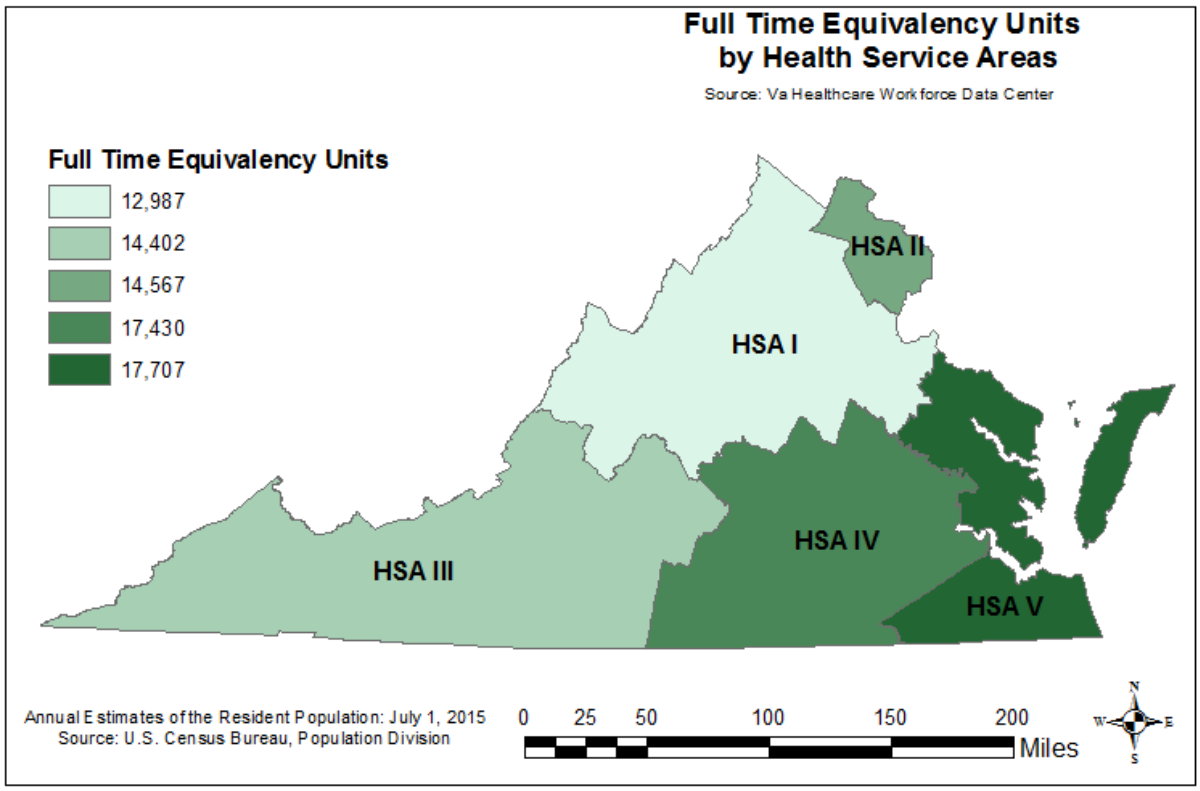
Area Health Education Center Regions

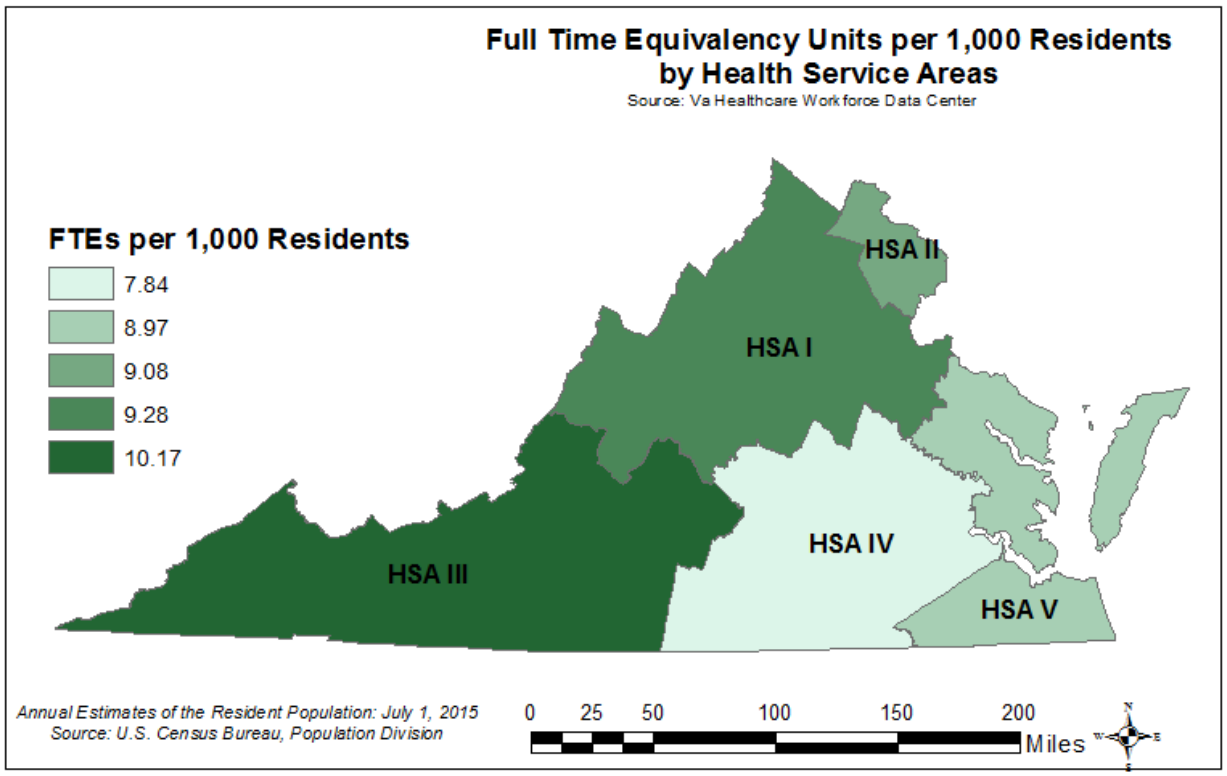


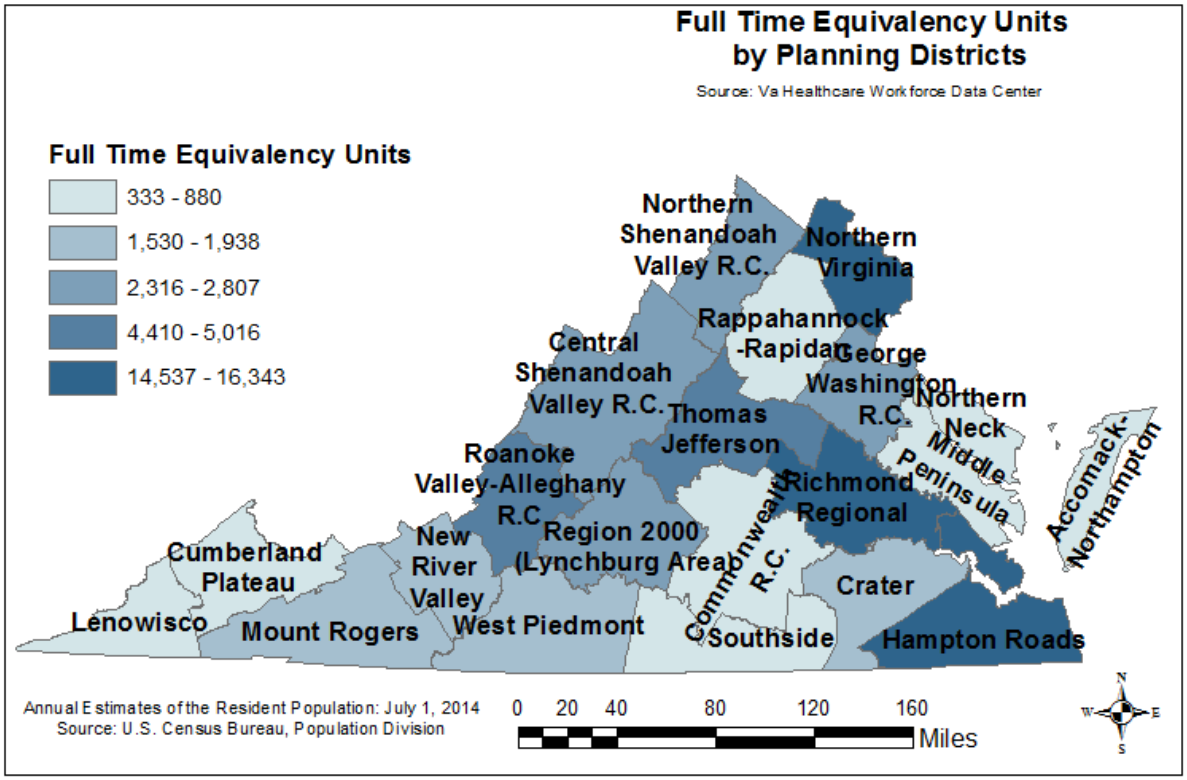


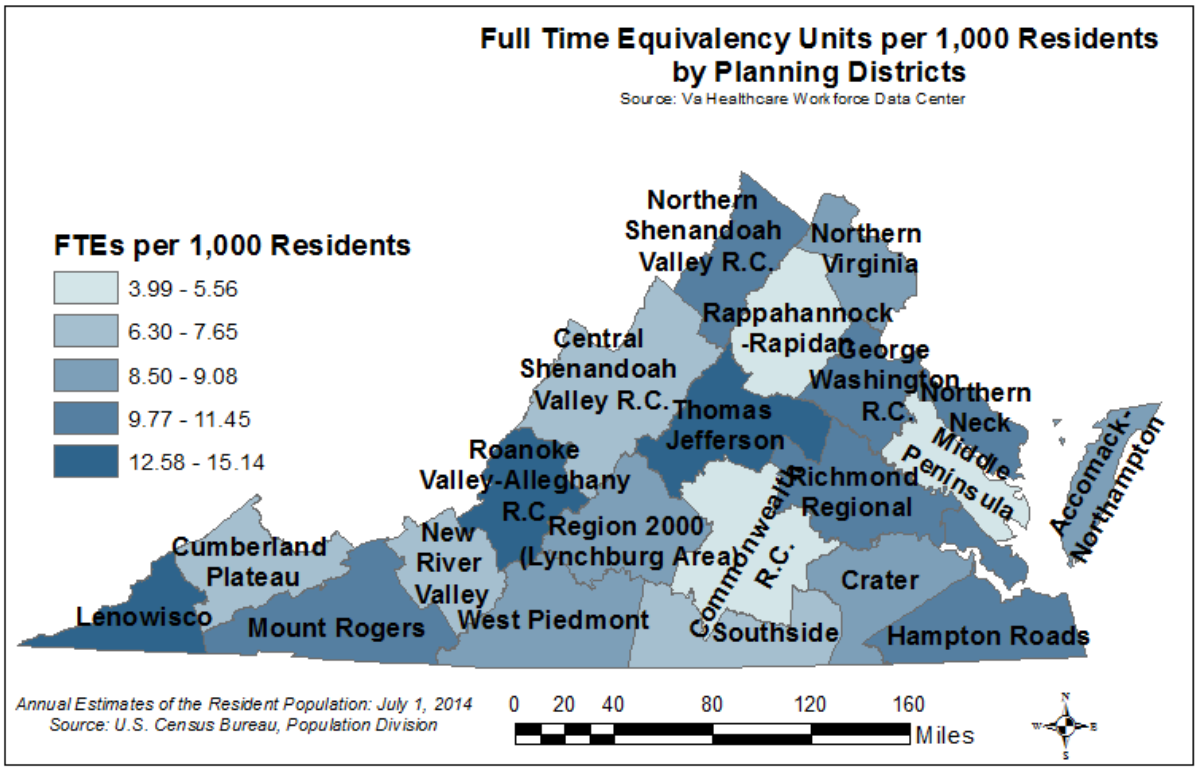

Full Time Equivalency Units
by Workforce Investment Areas
Source: Va Healthcare Workforce Data Center
Full Time Equivalency Units
1,209 - 1,524
2,210 - 2,756
3,468 - 3,622
5,050 - 5,290
11,608 - 14,697
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2014
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full Time Equivalency Units per 1,000 Residents
by Workforce Investment Areas
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
5.45 - 5.94
8.50 - 8.94
9.20 - 9.59
9.69 - 10.10
13.74
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2014
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full Time Equivalency Units
by Health Service Areas
Source: Va Healthcare Workforce Data Center
Full Time Equivalency Units
12,987
14,402
14,567
17,430
17,707
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2015
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full Time Equivalency Units per 1,000 Residents
by Health Service Areas
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
7.84
8.97
9.08
9.28
10.17
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2015
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full Time Equivalency Units
by Planning Districts
Source: Va Healthcare Workforce Data Center
Full Time Equivalency Units
333 - 880
1,530 - 1,938
2,316 - 2,807
4,410 - 5,016
14,537 - 16,343
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock -Rapidan
George Washington R.C.
Central Shenandoah Valley R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C
Richmond Regional
Commonwealth R.C.
New River Valley
Region 2000 (Lynchburg Area)
Cumberland Plateau
Crater
Lenowisco
Mount Rogers
West Piedmont
Southside
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2014
Source: U.S. Census Bureau, Population Division
0 20 40 80 120 160
Miles
N
W
E
S


Full Time Equivalency Units per 1,000 Residents
by Planning Districts
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
3.99 - 5.56
6.30 - 7.65
8.50 - 9.08
9.77 - 11.45
12.58 - 15.14
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock -Rapidan
George Washington R.C.
Central Shenandoah Valley R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C
Richmond Regional
Commonwealth R.C.
New River Valley
Region 2000 (Lynchburg Area)
Cumberland Plateau
Crater
Lenowisco
Mount Rogers
West Piedmont
Southside
Hampton Roads
Annual Estimates of the Resident Population: July 1, 2014
Source: U.S. Census Bureau, Population Division
0 20 40 80 120 160
Miles
N
W
E
S

Appendix A: Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min	Max
Metro, 1 million+	62,889	33.96%	2.945069	2.304241	3.862506
Metro, 250,000 to 1 million	9,852	34.64%	2.88661	2.258502	3.785836
Metro, 250,000 or less	10,673	34.79%	2.874495	2.249023	3.769947
Urban pop 20,000+, Metro adj	1,904	35.45%	2.820741	2.206966	3.699447
Urban pop 20,000+, nonadj	0	NA	NA	NA	NA
Urban pop, 2,500-19,999, Metro adj	4,293	33.92%	2.948489	2.306917	3.866991
Urban pop, 2,500-19,999, nonadj	2,807	34.95%	2.861366	2.238751	3.752728
Rural, Metro adj	2,473	32.03%	3.122475	2.443044	4.095176
Rural, nonadj	1,124	33.72%	2.965699	2.320382	3.889563
Virginia border state/DC	3,359	23.97%	4.172671	3.264725	5.472526
Other US State	8,752	18.40%	5.436025	4.253181	7.129435

Source: Va. Healthcare Workforce Data Center

Age	Age Weight			Total Weight	
	#	Rate	Weight	Min	Max
Under 30	12,368	24.81%	4.031291	3.699447	7.129435
30 to 34	12,073	37.99%	2.632003	2.415345	4.654762
35 to 39	10,900	28.17%	3.550489	3.258223	6.279125
40 to 44	11,024	40.74%	2.454687	2.252625	4.341173
45 to 49	11,539	30.08%	3.324402	3.050748	5.879285
50 to 54	12,092	41.58%	2.404932	2.206966	4.253181
55 to 59	13,077	29.63%	3.37471	3.096914	5.968255
60 and Over	25,062	30.28%	3.301976	3.030168	5.839625

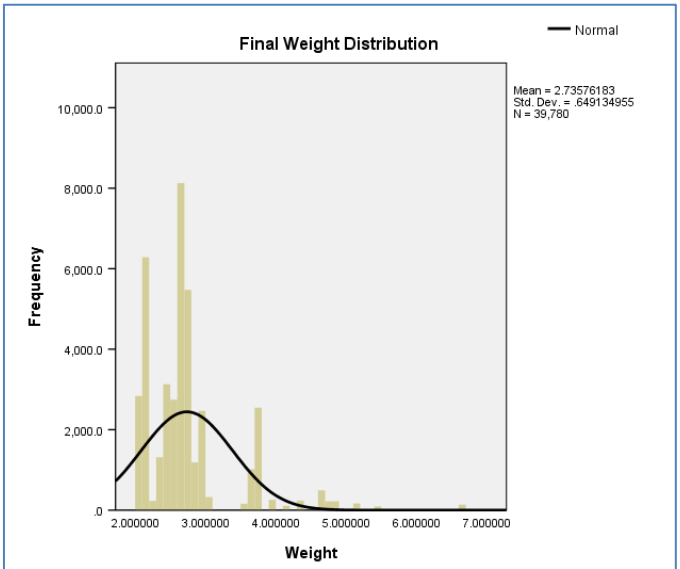
Source: Va. Healthcare Workforce Data Center

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

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

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

Overall Response Rate: **0.365433**



Source: Va. Healthcare Workforce Data Center

Agenda Item: Regulatory Actions - Chart of Regulatory Actions
As of January 8, 2018

Chapter		Action / Stage Information
[18 VAC 90 - 19]	Regulations Governing the Practice of Nursing	Waiver of CGFNS and TOEFL [Action 4871] Fast-Track - *Register Date: 11/13/17* *Effective: 12/28/18*
[18 VAC 90 - 20]	Regulations of the Board of Nursing [Repealed]	Amendment to name tag requirement [Action 4725] Final - *At Secretary's Office for 33 days*
[18 VAC 90 - 27]	Regulations Governing Nursing Education Programs	Definition of full approval and timing of criminal background checks for nursing education programs [Action 4926] Fast-Track - *At Governor's Office for 33 days*
[18 VAC 90 - 27]	Regulations Governing Nursing Education Programs	Accreditation of RN Education programs [Action 4570] Final - *Register Date: 1/8/18* *Effective: 2/7/18*
[18 VAC 90 - 30]	Regulations Governing the Licensure of Nurse Practitioners	Supervision and direction of laser hair removal [Action 4863] NOIRA - *Register Date: 10/2/17* *Proposed to Jt. Boards – 2/7/18*
[18 VAC 90 - 40]	Regulations for Prescriptive Authority for Nurse Practitioners	Elimination of separate license for prescriptive authority [Action 4958] NOIRA - *At Governor's Office for 28 days*
[18 VAC 90 - 40]	Regulations for Prescriptive Authority for Nurse Practitioners	Prescribing of opioids [Action 4797] Proposed - *At Governor's Office for 28 days*
[18 VAC 90 - 40]	Regulations for Prescriptive Authority for Nurse Practitioners	Correction of section relating to practice agreements [Action 4883] Fast-Track - *Register Date: 12/25/17* *Effective: 2/8/18*
[18 VAC 90 - 50]	Regulations Governing the Licensure of Massage Therapists	Periodic review [Action 4559] Final - *Register Date: 12/25/17* *Effective: 1/24/18*

Report of the 2018 General Assembly
Board of Nursing

HB 184 Drug Control Act; dispensing drugs without a prescription.
Chief patron: Hayes

Summary as introduced:

Dispensing drugs without a prescription. Authorizes a pharmacist to dispense up to a five-day supply of a Schedule VI drug to an individual who has been displaced from his residence by a natural or man-made disaster; has had his supply of the drug lost, destroyed, or otherwise rendered unusable as a consequence of the disaster; and is unable to tell the pharmacist the identity of the prescriber or his regular pharmacist or pharmacy. The bill also requires the individual to present evidence sufficient to establish, among other things, that the individual had been in lawful possession of the drug pursuant to a prescription provided to another pharmacist and that his health would be in danger without the benefits of the drug. Before prescribing the drug, the pharmacist is required to determine with a reasonable degree of certainty that the requested drug and dosage level are consistent with the drug and its dosage level that had been prescribed to the individual at the time of his displacement from his residence. During the period for which the drug has been dispensed, the pharmacist is required to diligently attempt to ascertain the identity of the prescriber and the identity of the pharmacist or pharmacy in possession of the prescriber's prescription. Upon obtaining such information, the pharmacist is required to take such additional reasonable action as will permit the individual to obtain a new or renewal prescription and resume obtaining the drug pursuant to his prescription.

12/26/17 House: Prefiled and ordered printed; offered 01/10/18 18103616D
12/26/17 House: Referred to Committee on Health, Welfare and Institutions
12/28/17 House: Introduced bill reprinted 18103616D
01/10/18 House: Impact statement from VDH (HB184)
01/17/18 House: Assigned HWI sub: Subcommittee #1

HB 226 Patients; medically or ethically inappropriate care not required.
Chief patron: Stolle

Summary as introduced:
Medically or ethically inappropriate care not required. Establishes a process whereby a physician may cease to provide health care that has been determined to be medically or ethically inappropriate for a patient.

12/29/17 House: Prefiled and ordered printed; offered 01/10/18 18101693D
12/29/17 House: Referred to Committee on Health, Welfare and Institutions
01/10/18 House: Impact statement from VDH (HB226)
01/22/18 House: Assigned HWI sub: Subcommittee #3

HB 298 Birth control; definition.
Chief patron: Watts

Summary as introduced:

Definition of birth control. Defines "birth control" as contraceptive methods that are approved by the U.S. Food and Drug Administration and provides that birth control shall not be considered abortion for the purposes of Title 18.2.

01/03/18 House: Prefiled and ordered printed; offered 01/10/18 18102477D
01/03/18 House: Referred to Committee for Courts of Justice
01/10/18 House: Impact statement from VDH (HB298)
01/25/18 House: Assigned Courts sub: Subcommittee #1

HB 313 Prescription Monitoring Program; notification of top prescribers by quantity covered substances. Chief patron: Head

Summary as introduced:
Prescription Monitoring Program; notification of top prescribers. Provides that the Director of the Department of Health Professions shall annually review data collected by the Prescription Monitoring Program to identify those prescribers who, based on such data, fall within the top 10 percent of prescribers by quantity of covered substances prescribed and shall notify such prescribers thereof.

01/04/18 House: Referred to Committee on Health, Welfare and Institutions
01/15/18 House: Assigned HWI sub: Subcommittee #2
01/23/18 House: Subcommittee recommends reporting with substitute (10-Y 0-N)
01/25/18 House: Reported from Health, Welfare and Institutions with substitute (22-Y 0-N)
01/25/18 House: Committee substitute printed 18105795D-H1

HB 363 Sexual orientation change efforts; prohibited as training for certain health care providers, etc. Chief patron: Hope

Summary as introduced:

Sexual orientation change efforts prohibited. Prohibits any health care provider or person who performs counseling as part of his training for any profession licensed by a regulatory board of the Department of Health Professions from engaging in sexual orientation change efforts with any person under 18 years of age. The bill defines "sexual orientation change efforts" as any practice or treatment that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender. "Sexual orientation change efforts" does not include counseling that provides assistance to a person undergoing gender transition or counseling that provides acceptance, support, and understanding of a person or facilitates a person's coping, social support, and identity exploration and development, including sexual-orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as such counseling does not seek to change an individual's sexual orientation or gender identity. The bill provides that no state funds shall be expended for the purpose of conducting sexual orientation change efforts, referring a person for sexual orientation change efforts, extending health benefits coverage for sexual orientation change efforts, or awarding a grant or contract to any entity that conducts sexual orientation change efforts or refers individuals for sexual orientation change efforts.

01/05/18 House: Prefiled and ordered printed; offered 01/10/18 18100457D
01/05/18 House: Referred to Committee on Health, Welfare and Institutions
01/25/18 House: Assigned HWI sub: Subcommittee #3
01/25/18 House: Impact statement from VDH (HB363)

HB 450 Abortion; informed written consent.
Chief patron: Rodman

Summary as introduced:
Abortion; informed written consent. Repeals the statutory requirements that a physician obtain a pregnant woman's informed written consent and perform fetal transabdominal ultrasound imaging before performing an abortion.

01/06/18 House: Prefiled and ordered printed; offered 01/10/18 18102742D
01/06/18 House: Referred to Committee for Courts of Justice
01/10/18 House: Impact statement from VDH (HB450)
01/25/18 House: Assigned Courts sub: Subcommittee #1

HB 456 Health Professions, Department of; suspension of license, nonpayment of student loans.
Chief patron: Filler-Corn

Summary as introduced:
Department of Health Professions; suspension of license; nonpayment of student loans. Repeals provisions authorizing an obligee to petition for and a circuit court to order the suspension of any state-issued license to engage in a health care profession or occupation when an obligor is delinquent or in default in the payment of a federally guaranteed or state-guaranteed educational loan or work-conditional scholarship.

01/07/18 House: Prefiled and ordered printed; offered 01/10/18 18101926D
01/07/18 House: Referred to Committee on Health, Welfare and Institutions
01/22/18 House: Assigned HWI sub: Subcommittee #1
01/25/18 House: Impact statement from VDH (HB456)

HB 499 Nursing, Board of; regulations governing identification badges.
Chief patron: Bell, Robert B.

Summary as introduced:
Board of Nursing; regulations governing identification badges. Requires the Board of Nursing to adopt regulations governing identification badges of health professionals licensed, registered, or certified by the Board who practice in hospital emergency departments, psychiatric and mental health units and programs, or health care facility units offering treatment of patients in custody of state or local law-enforcement agencies that provide for display of only the first name and first letter of the last name, as well as the title, of such health professional.

01/08/18 House: Prefiled and ordered printed; offered 01/10/18 18102543D
01/08/18 House: Referred to Committee on Health, Welfare and Institutions
01/17/18 House: Impact statement from VDH (HB499)

HB 501 Home hospice programs; disposal of drugs.
Chief patron: Hodges

Summary as introduced:
Home hospice programs; disposal of drugs. Provides that the Board of Health, in consultation with the Board of Pharmacy, shall promulgate regulations requiring a hospice program to establish a process for mitigating the risk of diversion of drugs dispensed to a hospice patient residing at home and for disposition of any unneeded dispensed drugs by an employee of the hospice program in a manner that is witnessed by the patient, patient's family member, or another employee of the hospice program and documented.

01/25/18 House: Read first time
01/25/18 House: Impact statement from VDH (HB501H1)
01/26/18 House: Read second time
01/26/18 House: Committee substitute agreed to 18105770D-H1
01/26/18 House: Engrossed by House - committee substitute HB501H1

HB 533 Medicine and Dentistry, Boards of; acceptance of substantially equivalent military training, etc.
Chief patron: Freitas

Summary as introduced:
Professions and occupations; qualifications for licensure; acceptance of substantially equivalent military training, education, and experience. Requires the Board of Medicine and the Board of Dentistry to accept the military training, education, or experience of a service member honorably discharged from active military service in the Armed Forces of the United States, to the extent that such training, education, or experience is substantially equivalent to the requirements established by law and regulations of the respective board for the issuance of any license, permit, certificate, or other document, however styled or denominated, required for the practice of any business, profession, or occupation in the Commonwealth. Current law exempts the Board of Medicine and the Board of Dentistry from this requirement and provides that they may accept the military training, education, or experience of a service member under certain circumstances. The bill also directs the Department of Veterans Services to take steps to promote awareness among veterans of the acceptance of such substantially equivalent military training, education, or experience by the Department of Professional and Occupational Regulation, the Department of Health Professions, or any other board named in Title 54.1 (Professions and Occupations).

01/08/18 House: Prefiled and ordered printed; offered 01/10/18 18100132D
01/08/18 House: Referred to Committee on Health, Welfare and Institutions
01/17/18 House: Assigned HWI sub: Subcommittee #1
01/25/18 House: Impact statement from VDH (HB533)

HB 641 Prescription Monitoring Program; recipients of dispensed Schedule II drugs.
Chief patron: Mullin

Summary as introduced:
Prescription Monitoring Program; recipients of dispensed Schedule II drugs. Requires pharmacists who dispense Schedule II drugs pursuant to a valid prescription to include the name, address, and government-issued identification number of the person to whom the covered substance was actually delivered in the report submitted to the Prescription Monitoring Program.

01/09/18 House: Prefiled and ordered printed; offered 01/10/18 18103187D
01/09/18 House: Referred to Committee on Health, Welfare and Institutions
01/12/18 House: Impact statement from VDH (HB641)

01/15/18 House: Assigned HWI sub: Subcommittee #2

HB 793 Nurse practitioners; practice agreements.
Chief patron: Robinson

Summary as introduced:
Nurse practitioners; practice agreements. Eliminates the requirement for a practice agreement with a patient care team physician for nurse practitioners who are licensed by the Boards of Medicine and Nursing and have completed at least 1,040 hours of clinical experience as a licensed, certified nurse practitioner. The bill replaces the term "patient care team physician" with the term "collaborating provider" and allows a nurse practitioner who is exempt from the requirement for a practice agreement to enter into a practice agreement to provide collaboration and consultation to a nurse practitioner who is not exempt from the requirement for a practice agreement. The bill establishes title protection for advanced practice registered nurses, nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists. The bill contains technical amendments.

01/09/18 House: Prefiled and ordered printed; offered 01/10/18 18104186D
01/09/18 House: Referred to Committee on Health, Welfare and Institutions
01/17/18 House: Assigned HWI sub: Subcommittee #1

HB 842 Controlled paraphernalia; possession or distribution, hypodermic needles and syringes, naloxone.
Chief patron: LaRock

Summary as introduced:
Possession or distribution of controlled paraphernalia; hypodermic needles and syringes; naloxone. Provides that a person who is authorized by the Department of Behavioral Health and Developmental Services to train individuals on the administration of naloxone for use in opioid overdose reversal and who is acting on behalf of an organization that provides services to individuals at risk of experiencing an opioid overdose or training in the administration of naloxone for overdose reversal and that has obtained a controlled substances registration from the Board of Pharmacy may dispense or distribute hypodermic needles and syringes in conjunction with such dispensing of naloxone and that a person to whom naloxone has been distributed by such individual may possess hypodermic needles and syringes in conjunction with such possession of naloxone.

01/09/18 House: Referred to Committee on Health, Welfare and Institutions
01/17/18 House: Assigned HWI sub: Subcommittee #2
01/17/18 House: Impact statement from DPB (HB842)
01/23/18 House: Subcommittee recommends reporting with amendments (10-Y 0-N)
01/25/18 House: Reported from Health, Welfare and Institutions with amendments (22-Y 0-N)

HB 860 Prescription drugs; delivery of orders.
Chief patron: Peace

Summary as introduced:
Delivery of prescription drug orders. Provides that whenever any pharmacy delivers a prescription drug order for which refrigeration is required by mail, common carrier, or delivery service, when the drug order is not personally hand delivered directly, to the patient or his agent at the person's residence or other

designated location, the shipment shall include a means for the (i) detection of temperature variations that may cause chemical degradation of the drugs and (ii) notification of the patient of the variation.

01/09/18 House: Prefiled and ordered printed; offered 01/10/18 18104457D
01/09/18 House: Referred to Committee on Health, Welfare and Institutions
01/12/18 House: Impact statement from VDH (HB860)
01/17/18 House: Assigned HWI sub: Subcommittee #3

HB 915 Military medical personnel program; supervision of personnel by chief medical officer.
Chief patron: Stolle

Summary as introduced:
Military medical personnel program; supervision. Provides that military medical personnel in a program, established by the Department of Veterans Services, who may perform certain delegated acts that constitute the practice of medicine while under the supervision of a physician or podiatrist may also perform such acts under the supervision of the chief medical officer, or his designee, of an organization participating in the program. In addition, the bill removes the designation of this program as a pilot program.

01/09/18 House: Prefiled and ordered printed; offered 01/10/18 18101551D
01/09/18 House: Referred to Committee on Health, Welfare and Institutions
01/22/18 House: Impact statement from VDH (HB915)
01/25/18 House: Reported from Health, Welfare and Institutions with substitute (22-Y 0-N)
01/25/18 House: Committee substitute printed 18105896D-H1

HB 974 Medical marijuana; written certification by physician for treatment.
Chief patron: Guzman

Summary as introduced:
Medical marijuana; written certification. Allows a person to possess marijuana or tetrahydrocannabinol pursuant to a valid written certification issued by a physician for the treatment of any medical condition deemed terminal or debilitating by a licensed health care professional, pain management, cancer, glaucoma, intractable epilepsy, human immunodeficiency virus, osteoporosis, or arthritis. The bill allows a physician or pharmacist to distribute such substances without being subject to prosecution. Under current law, a person has an affirmative defense to prosecution for possession of marijuana if the marijuana is in the form of cannabidiol oil or THC-A oil and the person has been issued a written certification by a physician that such marijuana is for the purposes of treating or alleviating the person's symptoms of intractable epilepsy. The bill expands the authority for a pharmaceutical processor, after obtaining a permit from the Board of Pharmacy and under the supervision of a licensed pharmacist, to manufacture and provide marijuana in any form to be used for the treatment of any medical condition deemed terminal or debilitating by a licensed health care professional, pain management, cancer, glaucoma, intractable epilepsy, human immunodeficiency virus, osteoporosis, or arthritis, not just marijuana in the form of cannabidiol oil and THC-A oil to be used for the treatment of intractable epilepsy. Finally, the bill clarifies that the penalties for forging or altering a written certification for medical marijuana or for making or uttering a false or forged written certification are the same as the penalties for committing the same acts with regard to prescriptions.

01/09/18 House: Prefiled and ordered printed; offered 01/10/18 18103676D
01/09/18 House: Referred to Committee for Courts of Justice

01/11/18 House: Impact statement from VCSC (HB974)

HB 1037 Abortions; performance, eliminates certain requirement.
Chief patron: Convirs-Fowler

Summary as introduced:
Performance of abortions. Eliminates the requirement that two other physicians certify that a third trimester abortion is necessary to prevent the woman's death or impairment of her mental or physical health.

01/09/18 House: Prefiled and ordered printed; offered 01/10/18 18103635D
01/09/18 House: Referred to Committee for Courts of Justice
01/25/18 House: Assigned Courts sub: Subcommittee #1

HB 1064 Medical marijuana; written certification issued by physician.
Chief patron: Heretick

Summary as introduced:
Medical marijuana; written certification. Allows a person to possess marijuana or tetrahydrocannabinol pursuant to a valid written certification issued by a physician for the treatment of any medical condition and allows a physician or pharmacist to distribute such substances without being subject to prosecution. Under current law, a person has an affirmative defense to prosecution for possession of marijuana if the marijuana is in the form of cannabidiol oil or THC-A oil and the person has been issued a written certification by a physician that such marijuana is for the purposes of treating or alleviating the person's symptoms of intractable epilepsy. The bill expands the authority for a pharmaceutical processor, after obtaining a permit from the Board of Pharmacy and under the supervision of a licensed pharmacist, to manufacture and provide marijuana in any form to be used for the treatment of any medical condition, not just marijuana in the form of cannabidiol oil and THC-A oil to be used for the treatment of intractable epilepsy. Finally, the bill clarifies that the penalties for forging or altering a written certification for medical marijuana or for making or uttering a false or forged written certification are the same as the penalties for committing the same acts with regard to prescriptions.

01/10/18 House: Prefiled and ordered printed; offered 01/10/18 18102811D
01/10/18 House: Referred to Committee for Courts of Justice
01/11/18 House: Impact statement from VCSC (HB1064)
01/12/18 House: Impact statement from VDH (HB1064)

HB 1071 Health regulatory boards; electronic notice of license renewal.
Chief patron: Heretick

Summary as introduced:
Health regulatory boards; license renewal; electronic notice. Provides that the Board of Funeral Directors and Embalmers, the Board of Medicine, and the Board of Nursing may send notices for license renewal electronically.

01/10/18 House: Prefiled and ordered printed; offered 01/10/18 18101584D
01/10/18 House: Referred to Committee on Health, Welfare and Institutions
01/25/18 House: Reported from Health, Welfare and Institutions with amendment (22-Y 0-N)

01/25/18 House: Impact statement from VDH (HB1071)

HB 1114 Professional and occupational regulation; authority to suspend or revoke licenses, certificates.
Chief patron: VanValkenburg

Summary as introduced:
Professional and occupational regulation; authority to suspend or revoke licenses, certificates, registrations, or permits; default or delinquency of education loan or scholarship. Provides that the Department of Professional and Occupational Regulation, the Department of Health Professions, the Board of Accountancy, and the Board of Education shall not be authorized to suspend or revoke the license, certificate, registration, permit, or authority it has issued any person who is in default or delinquent in the payment of a federal-guaranteed or state-guaranteed educational loan or work-conditional scholarship solely on the basis of such default or delinquency.

01/10/18 House: Prefiled and ordered printed; offered 01/10/18 18104241D
01/10/18 House: Referred to Committee on General Laws
01/19/18 House: Assigned GL sub: Subcommittee #1
01/25/18 House: Subcommittee recommends reporting (7-Y 1-N)

HB 1173 Controlled substances; limits on prescriptions containing opioids.
Chief patron: Pillion

Summary as introduced:
Limits on prescription of controlled substances containing opioids. Eliminates the surgical or invasive procedure treatment exception to the requirement that a prescriber request certain information from the Prescription Monitoring Program (PMP) when initiating a new course of treatment that includes prescribing opioids for a human patient to last more than seven days. Under current law, a prescriber is not required to request certain information from the PMP for opioid prescriptions of up to 14 days to a patient as part of treatment for a surgical or invasive procedure. The provisions of the bill will expire on July 1, 2022.

01/10/18 House: Referred to Committee on Health, Welfare and Institutions
01/12/18 House: Impact statement from VDH (HB1173)
01/18/18 House: Assigned HWI sub: Subcommittee #2
01/23/18 House: Subcommittee recommends reporting (10-Y 0-N)
01/25/18 House: Reported from Health, Welfare and Institutions (22-Y 0-N)

HB 1231 Abortion; a pregnant person has a fundamental right to obtain.
Chief patron: Boysko

Summary as introduced:

Whole Woman's Health Act; right to abortion; provision of abortion. Provides that a pregnant person has a fundamental right to obtain a lawful abortion and that no statute or regulation shall be construed to prohibit the performance of an abortion prior to viability or if necessary to protect the life or health of the pregnant person. The bill also provides that any statute that places a burden on a pregnant person's access to abortion without conferring any legitimate health benefit is unenforceable. The bill expands who can

perform first trimester abortions to include, in addition to physicians, physician's assistants and midwives licensed by the Board of Medicine acting within their scope of practice, nurse practitioners or certified nurse midwives jointly licensed by the Board of Medicine and the Board of Nursing acting within their scope of practice, and persons acting pursuant to orders and under the appropriate supervision of a physician who is acting within the physician's scope of practice. The bill also expands who can perform second trimester abortions to include persons acting pursuant to orders and under the appropriate supervision of a physician. The bill eliminates the requirement that second trimester abortions be performed in a licensed hospital. The bill eliminates the requirement that two other physicians certify that a third trimester abortion is necessary to prevent the pregnant person's death or impairment of her mental or physical health as well as the need to find that the pregnant person's health would be substantially and irremediably impaired. The bill permits a third trimester abortion if the pregnancy is not viable. The bill eliminates all the procedures and processes, including the performance of an ultrasound, required to effect a pregnant person's informed written consent to the performance of an abortion; however, the bill does not change the requirement that a pregnant person's informed written consent first be obtained. The bill removes language classifying facilities that perform five or more first trimester abortions per month as hospitals for the purpose of complying with regulations establishing minimum standards for hospitals. The bill also removes the prohibition on the sale of health insurance policies that provide coverage for abortions through an exchange established or operating in the Commonwealth pursuant to the federal Patient Protection and Affordable Care Act. The bill eliminates the crime, punishable as a Class 4 felony, of administering a drug or other thing to a pregnant person or using other means with the intent to destroy such person's unborn child or to produce an abortion or miscarriage.

01/10/18 House: Prefiled and ordered printed; offered 01/10/18 18104638D
01/10/18 House: Referred to Committee for Courts of Justice
01/25/18 House: Assigned Courts sub: Subcommittee #1

HB 1251 CBD oil and THC-A oil; certification for use, dispensing.
Chief patron: Cline

Summary as introduced:
CBD oil and THC-A oil; certification for use; dispensing. Provides that a practitioner may issue a written certification for the use of cannabidiol oil or THC-A oil for the treatment or to alleviate the symptoms of any diagnosed condition or disease determined by the practitioner to benefit from such use. Under current law, a practitioner may only issue such certification for the treatment or to alleviate the symptoms of intractable epilepsy. This bill is a recommendation of the Joint Commission on Health Care.

01/10/18 House: Referred to Committee on Health, Welfare and Institutions
01/18/18 House: Referred from Health, Welfare and Institutions
01/18/18 House: Referred to Committee for Courts of Justice
01/23/18 House: Assigned Courts sub: Subcommittee #1
01/24/18 House: Subcommittee recommends reporting with amendments (8-Y 0-N)

HB 1377 Epinephrine; possession and administration at outdoor educational programs.
Chief patron: Torian

Summary as introduced:
Possession and administration of epinephrine; outdoor educational programs. Provides that an employee of an organization that provides outdoor educational experiences or programs for youth who is authorized by a prescriber and trained in the administration of epinephrine may possess and administer epinephrine.

01/12/18 House: Presented and ordered printed 18104300D
01/12/18 House: Referred to Committee on Health, Welfare and Institutions
01/19/18 House: Assigned HWI sub: Subcommittee #2

HB 1440 Schedule I and Schedule II drugs; adds various drugs to lists.
Chief patron: Garrett

Summary as introduced:

Schedule I and Schedule II drugs. Adds MT-45 (1-cyclohexyl-4-(1,2-diphenylethyl)piperazine) to Schedule I of the Drug Control Act and Dronabinol [(-)-delta-9-trans tetrahydrocannabinol] in an oral solution in a drug product approved for marketing by the U.S. Food and Drug Administration to Schedule II of the Drug Control Act and removes naldemedine from Schedule II of the Drug Control Act.

01/16/18 House: Referred to Committee on Health, Welfare and Institutions
01/17/18 House: Impact statement from VCSC (HB1440)
01/23/18 House: Impact statement from VDH (HB1440)
01/25/18 House: Reported from Health, Welfare and Institutions (22-Y 0-N)
01/25/18 House: Referred to Committee on Appropriations

HB 1510 Professions & occupations; recognizing licenses/certificates issued by Commonwealth of Puerto Rico.
Chief patron: Simon

Summary as introduced:
Professions and occupations; reciprocity. Directs the Department of Professional and Occupational Regulation and the Department of Health Professions to promulgate regulations recognizing licenses or certificates issued by the Commonwealth of Puerto Rico as full fulfillment of qualifications for licensure or certification in the Commonwealth. The provisions of the bill expire on July 1, 2021.

01/18/18 House: Presented and ordered printed 18104667D
01/18/18 House: Referred to Committee on General Laws
01/22/18 House: Assigned GL sub: Subcommittee #1

SB 258 Subpoenas; issuance by Director of Department of Health Professions or his designee.
Chief patron: Petersen

Summary as introduced:
Department of Health Professions; subpoenas. Provides that a subpoena issued by the Director of the Department of Health Professions or his designee may be delivered by (i) any person authorized to serve process under § 8.01-293, (ii) investigative personnel appointed by the Director, (iii) registered or certified mail or by equivalent commercial parcel delivery service, or (iv) email or facsimile if requested to do so by the recipient. The bill provides that upon failure of any person to comply with a subpoena, the Director may request that the Attorney General or the attorney for the Commonwealth for the jurisdiction in which the recipient of the subpoena resides, is found, or transacts business seek enforcement of the subpoena.

01/22/18 Senate: Committee amendments agreed to
01/22/18 Senate: Engrossed by Senate as amended SB258E
01/22/18 Senate: Printed as engrossed 18104375D-E
01/23/18 Senate: Read third time and passed Senate (39-Y 0-N)
01/23/18 Senate: Impact statement from VDH (SB258E)

SB 330 THC-A oil; dispensing, tetrahydrocannabinol levels.
Chief patron: Dunnavant

Summary as introduced:
THC-A oil; dispensing. Requires the Board of Pharmacy to promulgate regulations that (i) ensure the percentage of tetrahydrocannabinol in dispensed THC-A oil is within 10 percent of the level of tetrahydrocannabinol measured for labeling and (ii) require stability testing of any pharmaceutical processor producing THC-A oil.

01/17/18 Senate: Read third time and passed Senate (40-Y 0-N)
01/23/18 House: Placed on Calendar
01/23/18 House: Read first time
01/23/18 House: Referred to Committee on Health, Welfare and Institutions
01/23/18 Senate: Impact statement from VDH (SB330S1)

SB 357 Death certificates; electronic filing required.
Chief patron: McClellan

Summary as introduced:
Death certificates; electronic filing required. Requires a death certificate, for each death that occurs in the Commonwealth, to be electronically filed with the State Registrar. Under current law, death certificates may be filed electronically or nonelectronically.

01/08/18 Senate: Prefiled and ordered printed; offered 01/10/18 18102472D
01/08/18 Senate: Referred to Committee on Education and Health
01/16/18 Senate: Assigned Education sub: Health
01/19/18 Senate: Impact statement from VDH (SB357)

SB 370 Prescription drugs; delivery of orders.
Chief patron: Newman

Summary as introduced:
Delivery of prescription drug orders. Provides that whenever any pharmacy delivers a prescription drug order for which refrigeration is required by mail, common carrier, or delivery service, when the drug order is not personally hand delivered directly, to the patient or his agent at the person's residence or other designated location, the shipment shall include a means for the (i) detection of temperature variations that may cause chemical degradation of the drugs and (ii) notification of the patient of the variation.

01/09/18 Senate: Prefiled and ordered printed; offered 01/10/18 18104456D
01/09/18 Senate: Referred to Committee on Education and Health
01/12/18 Senate: Impact statement from VDH (SB370)

01/16/18 Senate: Assigned Education sub: Health Professions

SB 417 Community health worker; VDH to approve one or more entities to certify workers in the Commonwealth.
Chief patron: Barker

Summary as introduced:
Community health workers; certification. Requires the Department of Health to approve one or more entities to certify community health workers in the Commonwealth and prohibits a person from using or assuming the title of community health worker unless he is certified by an entity approved by the Department.

01/16/18 Senate: Impact statement from VDH (SB417)
01/22/18 Senate: Assigned Education sub: Health
01/25/18 Senate: Reported from Education and Health with substitute (14-Y 0-N)
01/25/18 Senate: Committee substitute printed 18105859D-S1
01/26/18 Senate: Constitutional reading dispensed (35-Y 0-N)

SB 436 Schedule I drugs; classification for fentanyl derivatives.
Chief patron: Wexton

Summary as introduced:
Schedule I drugs; classification for fentanyl derivatives. Adds to Schedule I of the Drug Control Act a classification for fentanyl derivatives.

01/09/18 Senate: Prefiled and ordered printed; offered 01/10/18 18101586D
01/09/18 Senate: Referred to Committee on Education and Health
01/11/18 Senate: Impact statement from VCSC (SB436)
01/25/18 Senate: Reported from Education and Health (15-Y 0-N)
01/25/18 Senate: Rereferred to Finance

SB 505 Doctorate of medical science; establishes requirements for licensure and practice.
Chief patron: Carrico

Summary as introduced:

Doctorate of medical science; licensure and practice. Establishes requirements for licensure and practice as a doctorate of medical science. The bill provides that it is unlawful to practice as a doctorate of medical science unless licensed by the Board of Medicine (Board) and requires that an applicant for licensure, among other requirements, (i) hold an active unrestricted license to practice as a physician assistant in the Commonwealth or another jurisdiction and be able to demonstrate engagement in active clinical practice as a physician assistant under physician supervision for at least three years and (ii) be a graduate of at least a two-year doctor of medical science program or an equivalent program that is accredited by a regional body under the U.S Department of Education and an accrediting body approved by the Board. The bill provides that doctorates of medical science can practice only as part of a patient care team at a hospital or group medical practice engaged in primary care and are required to maintain appropriate collaboration and consultation, as evidenced in a written or electronic practice agreement, with at least one patient care team physician. The bill requires the Board to establish the scope of practice for

doctorates of medical science and to promulgate regulations regarding collaboration and consultation among a patient care team and requirements for the practice agreement. The bill outlines the prescriptive authority of doctorates of medical science. The bill also authorizes various powers and requires various duties of a doctorate of medical science where such powers and duties are, under current law, given to and required of physician assistants and nurse practitioners.

01/09/18 Senate: Prefiled and ordered printed; offered 01/10/18 18103047D
01/09/18 Senate: Referred to Committee on Education and Health

SB 597 Marijuana; possession or distribution for medical purposes.
Chief patron: Vogel

Summary as introduced:
Possession or distribution of marijuana for medical purposes; affirmative defense for treatment of certain conditions. Provides an affirmative defense to prosecution for possession of marijuana if a person has a valid written certification issued by a practitioner for cannabidiol oil or THC-A oil for treatment of, or to alleviate the symptoms of, cancer, glaucoma, human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, Alzheimer's disease, nail patella, cachexia or wasting syndrome, multiple sclerosis, or complex regional pain syndrome. Under current law, only the treatment of intractable epilepsy is covered by the affirmative defense.

01/09/18 Senate: Prefiled and ordered printed; offered 01/10/18 18103328D
01/09/18 Senate: Referred to Committee for Courts of Justice

SB 632 Controlled substances; limits on prescriptions containing opioids.
Chief patron: Dunnavant

Summary as introduced:

Limits on prescription of controlled substances containing opioids. Eliminates the surgical or invasive procedure treatment exception to the requirement that a prescriber request certain information from the Prescription Monitoring Program (PMP) when initiating a new course of treatment that includes prescribing opioids for a human patient to last more than seven days. Under current law, a prescriber is not required to request certain information from the PMP for opioid prescriptions of up to 14 days to a patient as part of treatment for a surgical or invasive procedure. The provisions of the bill will expire on July 1, 2022.

01/10/18 Senate: Prefiled and ordered printed; offered 01/10/18 18101945D
01/10/18 Senate: Referred to Committee on Education and Health
01/22/18 Senate: Assigned Education sub: Health Professions
01/25/18 Senate: Reported from Education and Health (15-Y 0-N)
01/26/18 Senate: Constitutional reading dispensed (35-Y 0-N)

SB 726 CBD oil and THC-A oil; certification for use, dispensing.
Chief patron: Dunnavant

Summary as introduced:

CBD oil and THC-A oil; certification for use; dispensing. Provides that a practitioner may issue a written certification for the use of cannabidiol oil or THC-A oil for the treatment or to alleviate the symptoms of any diagnosed condition or disease determined by the practitioner to benefit from such use. Under current law, a practitioner may only issue such certification for the treatment or to alleviate the symptoms of intractable epilepsy. This bill is a recommendation of the Joint Commission on Health Care.

01/10/18 Senate: Referred to Committee on Education and Health
01/22/18 Senate: Assigned Education sub: Health Professions
01/23/18 Senate: Impact statement from VDH (SB726)
01/25/18 Senate: Reported from Education and Health with substitute (13-Y 2-N)
01/25/18 Senate: Rereferred to Courts of Justice

SB 728 Prescription Monitoring Program; prescriber and dispenser patterns.
Chief patron: Dunnavant

Summary as introduced:
Prescription Monitoring Program; prescriber and dispenser patterns. Requires the Director of the Department of Health Professions to annually review controlled substance prescribing and dispensing patterns. The bill requires the Director to conduct such review in consultation with an advisory panel consisting of representatives from the relevant health regulatory boards, the Department of Health, the Department of Medical Assistance Services, and the Department of Behavioral Health and Developmental Services. The bill requires the Director to make any necessary changes to the criteria for unusual patterns of prescribing and dispensing and report any findings and recommendations for best practices to the Joint Commission on Health Care by November 1 of each year.

01/10/18 Senate: Referred to Committee on Education and Health
01/22/18 Senate: Assigned Education sub: Health Professions
01/25/18 Senate: Reported from Education and Health with substitute (15-Y 0-N)
01/25/18 Senate: Committee substitute printed 18105239D-S1
01/26/18 Senate: Constitutional reading dispensed (35-Y 0-N)

SB 788 CBD oil and THC-A oil; certification for use, dispensing.
Chief patron: Marsden

Summary as introduced:
CBD oil and THC-A oil; certification for use; dispensing. Provides that a practitioner may issue a written certification for the use of cannabidiol oil or THC-A oil for the treatment or to alleviate the symptoms of any diagnosed condition or disease. Under current law, a practitioner may only issue such certification for the treatment or to alleviate the symptoms of intractable epilepsy. The bill increases the supply of CBD oil or THC-A oil a pharmaceutical processor may dispense from a 30-day supply to a 90-day supply. The bill reduces the minimum amount of cannabidiol or tetrahydrocannabinol acid per milliliter for a dilution of the Cannabis plant to fall under the definition of CBD oil or THC-A oil, respectively. The bill provides that any agent or employee of a pharmaceutical processor is authorized to deliver CBD oil or THC-A oil. Finally, the bill provides that no agent or employee of a pharmaceutical processor can be prosecuted for the possession or manufacture of marijuana or the possession, manufacture, or distribution of CBD oil or THC-A oil if such agent or employee is acting in accordance with certain statutes and regulations. Under current law, such agents and employees may be prosecuted but it is considered an affirmative defense if such agents or employees act in accordance with such statutes and regulations.

01/10/18 Senate: Presented and ordered printed 18100568D
01/10/18 Senate: Referred to Committee for Courts of Justice

SB 795 Cannabidiol oil and THC-A oil; certification for use, dispensing.
Chief patron: Dunnavant

Summary as introduced:
CBD oil and THC-A oil; certification for use; dispensing. Provides that a practitioner may issue a written certification for the use of cannabidiol oil or THC-A oil for the treatment or to alleviate the symptoms of any diagnosed condition or disease determined by the practitioner to benefit from such use. Under current law, a practitioner may only issue such certification for the treatment or to alleviate the symptoms of intractable epilepsy. The bill also reduces the minimum amount of cannabidiol or tetrahydrocannabinol acid per milliliter for a dilution of the Cannabis plant to fall under the definition of CBD oil or THC-A oil, respectively.

01/10/18 Senate: Presented and ordered printed 18103225D
01/10/18 Senate: Referred to Committee on Education and Health
01/22/18 Senate: Assigned Education sub: Health Professions

SB 832 Prescription Monitoring Program; adds controlled substances included in Schedule Vaud naloxone.
Chief patron: Carrico

Summary as introduced:
Prescription Monitoring Program; covered substances. Adds controlled substances included in Schedule V for which a prescription is required and naloxone to the list of covered substances the dispensing of which must be reported to the Prescription Monitoring Program.

01/15/18 Senate: Presented and ordered printed 18101582D
01/15/18 Senate: Referred to Committee on Education and Health

SB 882 Prescription refill; protocol.
Chief patron: DeSteph

Summary as introduced:
Prescription refill; protocol. Provides that a prescriber may authorize a registered nurse or licensed practical nurse to initiate a protocol for a prescription refill for Schedule VI controlled substances, provided that (i) the practitioner has established a bona-fide practitioner-patient relationship with the individual to receive the refill provided; (ii) there is a standing protocol written and maintained by the prescriber; (iii) there is a written order by the prescriber for the registered nurse or licensed practical nurse to initiate the protocol; (iv) the prescription refill is for a maintenance medication prescribed for chronic, long-term conditions and the medication is taken on a regular, recurring basis; (v) the prescription refill is for no more than 90 consecutive days; (vi) documentation sufficient to the Board of Pharmacy is maintained; and (vii) other requirements established by the Board of Pharmacy are met.

01/18/18 Senate: Referred to Committee on Education and Health
01/26/18 Senate: Assigned Education sub: Health Professions

INTRODUCED

18104186D

HOUSE BILL NO. 793

Offered January 10, 2018

Prefiled January 9, 2018

A BILL to amend and reenact §§ 22.1-271.7, 32.1-263, 32.1-282, 54.1-2900, 54.1-2901, 54.1-2957, 54.1-2957.01, 54.1-3016, 54.1-3018.1, 54.1-3300, 54.1-3300.1, 54.1-3301, 54.1-3482, and 54.1-3482.1 of the Code of Virginia, relating to nurse practitioners; practice agreements.

Patrons—Robinson, Bell, John J., Bulova, Fariss, Ransone and Sullivan

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 22.1-271.7, 32.1-263, 32.1-282, 54.1-2900, 54.1-2901, 54.1-2957, 54.1-2957.01, 54.1-3016, 54.1-3018.1, 54.1-3300, 54.1-3300.1, 54.1-3301, 54.1-3482, and 54.1-3482.1 of the Code of Virginia are amended and reenacted as follows:

§ 22.1-271.7. Public middle school student-athletes; pre-participation physical examination.

No public middle school student shall be a participant on or try out for any school athletic team or squad with a predetermined roster, regular practices, and scheduled competitions with other middle schools unless such student has submitted to the school principal a signed report from a licensed physician, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician attesting that such student has been examined, within the preceding 12 months, and found to be physically fit for athletic competition.

§ 32.1-263. Filing death certificates; medical certification; investigation by Office of the Chief Medical Examiner.

A. A death certificate, including, if known, the social security number or control number issued by the Department of Motor Vehicles pursuant to § 46.2-342 of the deceased, shall be filed for each death that occurs in the Commonwealth. Non-electronically filed death certificates shall be filed with the registrar of any district in the Commonwealth within three days after such death and prior to final disposition or removal of the body from the Commonwealth. Electronically filed death certificates shall be filed with the State Registrar of Vital Records within three days after such death and prior to final disposition or removal of the body from the Commonwealth. Any death certificate shall be registered by such registrar if it has been completed and filed in accordance with the following requirements:

1. If the place of death is unknown, but the dead body is found in the Commonwealth, the death shall be registered in the Commonwealth and the place where the dead body is found shall be shown as the place of death. If the date of death is unknown, it shall be determined by approximation, taking into consideration all relevant information, including information provided by the immediate family regarding the date and time that the deceased was last seen alive, if the individual died in his home; and

2. When death occurs in a moving conveyance, in the United States of America and the body is first removed from the conveyance in the Commonwealth, the death shall be registered in the Commonwealth and the place where it is first removed shall be considered the place of death. When a death occurs on a moving conveyance while in international waters or air space or in a foreign country or its air space and the body is first removed from the conveyance in the Commonwealth, the death shall be registered in the Commonwealth but the certificate shall show the actual place of death insofar as can be determined.

B. The licensed funeral director, funeral service licensee, office of the state anatomical program, or next of kin as defined in § 54.1-2800 who first assumes custody of a dead body shall file the certificate of death with the registrar. He shall obtain the personal data, including the social security number of the deceased or control number issued to the deceased by the Department of Motor Vehicles pursuant to § 46.2-342, from the next of kin or the best qualified person or source available and obtain the medical certification from the person responsible therefor.

C. The medical certification shall be completed, signed in black or dark blue ink, and returned to the funeral director within 24 hours after death by the physician in charge of the patient's care for the illness or condition which resulted in death except when inquiry or investigation by the Office of the Chief Medical Examiner is required by § 32.1-283 or 32.1-285.1, or by the physician that pronounces death pursuant to § 54.1-2972.

In the absence of such physician or with his approval, the certificate may be completed and signed by the following: (i) another physician employed or engaged by the same professional practice; (ii) a physician assistant supervised by such physician; (iii) a nurse practitioner practicing ~~as part of a patient care team as defined in § 54.1-2900~~ *in accordance with the provisions of § 54.1-2957*; (iv) the chief

medical officer or medical director, or his designee, of the institution, hospice, or nursing home in which death occurred; (v) a physician specializing in the delivery of health care to hospitalized or emergency department patients who is employed by or engaged by the facility where the death occurred; (vi) the physician who performed an autopsy upon the decedent; or (vii) an individual to whom the physician has delegated authority to complete and sign the certificate, if such individual has access to the medical history of the case and death is due to natural causes.

D. When inquiry or investigation by the Office of the Chief Medical Examiner is required by § 32.1-283 or 32.1-285.1, the Chief Medical Examiner shall cause an investigation of the cause of death to be made and the medical certification portion of the death certificate to be completed and signed within 24 hours after being notified of the death. If the Office of the Chief Medical Examiner refuses jurisdiction, the physician last furnishing medical care to the deceased shall prepare and sign the medical certification portion of the death certificate.

E. If the death is a natural death and a death certificate is being prepared pursuant to § 54.1-2972 and the physician, nurse practitioner, or physician assistant is uncertain about the cause of death, he shall use his best medical judgment to certify a reasonable cause of death or contact the health district physician director in the district where the death occurred to obtain guidance in reaching a determination as to a cause of death and document the same.

If the cause of death cannot be determined within 24 hours after death, the medical certification shall be completed as provided by regulations of the Board. The attending physician or the Chief Medical Examiner, an Assistant Chief Medical Examiner, or a medical examiner appointed pursuant to § 32.1-282 shall give the funeral director or person acting as such notice of the reason for the delay, and final disposition of the body shall not be made until authorized by the attending physician, the Chief Medical Examiner, an Assistant Chief Medical Examiner, or a medical examiner appointed pursuant to § 32.1-282.

F. A physician, nurse practitioner, or physician assistant who, in good faith, signs a certificate of death or determines the cause of death shall be immune from civil liability, only for such signature and determination of causes of death on such certificate, absent gross negligence or willful misconduct.

§ 32.1-282. Medical examiners.

A. The Chief Medical Examiner may appoint for each county and city one or more medical examiners, who shall be licensed as a doctor of medicine or osteopathic medicine, a physician assistant, or a nurse practitioner in the Commonwealth and appointed as agents of the Commonwealth, to assist the Office of the Chief Medical Examiner with medicolegal death investigations. A physician assistant appointed as a medical examiner shall have a practice agreement with and be under the continuous supervision of a physician medical examiner in accordance with § 54.1-2952. A nurse practitioner appointed as a medical examiner shall ~~have a practice agreement with and~~ practice ~~in collaboration with a physician medical examiner~~ in accordance with § 54.1-2957.

B. At the request of the Chief Medical Examiner, the Assistant Chief Medical Examiner, or their designees, medical examiners may assist the Office of the Chief Medical Examiner with cases requiring medicolegal death investigations in accordance with § 32.1-283.

C. The term of each medical examiner appointed, other than an appointment to fill a vacancy, shall begin on the first day of October of the year of appointment. The term of each medical examiner shall be three years; however, an appointment to fill a vacancy shall be for the unexpired term.

§ 54.1-2900. Definitions.

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

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

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

"Board" means the Board of Medicine.

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

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

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

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

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

"Medical malpractice settlement" means any written agreement and release entered into by or on behalf of a licensee of the Board in response to a written claim for money damages that arises out of any personal injuries or wrongful death, based on health care or professional services rendered, or that should have been rendered, by a health care provider, to a patient.

"Nurse practitioner" means an advanced practice registered nurse who is jointly licensed by the Boards of Medicine and Nursing pursuant to § 54.1-2957.

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

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

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

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

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

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

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

"Practice of chiropractic" means the adjustment of the 24 movable vertebrae of the spinal column, and assisting nature for the purpose of normalizing the transmission of nerve energy, but does not include the use of surgery, obstetrics, osteopathy or the administration or prescribing of any drugs, medicines, serums or vaccines. "Practice of chiropractic" shall include performing the physical examination of an applicant for a commercial driver's license or commercial learner's permit pursuant to § 46.2-341.12 if the practitioner has (i) applied for and received certification as a medical examiner pursuant to 49 C.F.R. Part 390, Subpart D and (ii) registered with the National Registry of Certified Medical Examiners.

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

providing written documentation of medical, genetic, and counseling information for families and health care professionals.

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

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

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

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

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

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

"Radiologic technologist" means an individual, other than a licensed doctor of medicine, osteopathy, podiatry, or chiropractic or a dentist licensed pursuant to Chapter 27 (§ 54.1-2700 et seq.), who (i) performs, may be called upon to perform, or is licensed to perform a comprehensive scope of diagnostic or therapeutic radiologic procedures employing ionizing radiation and (ii) is delegated or exercises responsibility for the operation of radiation-generating equipment, the shielding of patient and staff from unnecessary radiation, the appropriate exposure of radiographs, the administration of radioactive chemical compounds under the direction of an authorized user as specified by regulations of the Department of Health, or other procedures that contribute to any significant extent to the site or dosage of ionizing radiation to which a patient is exposed.

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

"Radiologist assistant" means an individual who has met the requirements of the Board for licensure as an advanced-level radiologic technologist and who, under the direct supervision of a licensed doctor of medicine or osteopathy specializing in the field of radiology, is authorized to (i) assess and evaluate the physiological and psychological responsiveness of patients undergoing radiologic procedures; (ii)

evaluate image quality, make initial observations, and communicate observations to the supervising radiologist; (iii) administer contrast media or other medications prescribed by the supervising radiologist; and (iv) perform, or assist the supervising radiologist to perform, any other procedure consistent with the guidelines adopted by the American College of Radiology, the American Society of Radiologic Technologists, and the American Registry of Radiologic Technologists.

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

§ 54.1-2901. Exceptions and exemptions generally.

A. The provisions of this chapter shall not prevent or prohibit:

1. Any person entitled to practice his profession under any prior law on June 24, 1944, from continuing such practice within the scope of the definition of his particular school of practice;

2. Any person licensed to practice naturopathy prior to June 30, 1980, from continuing such practice in accordance with regulations promulgated by the Board;

3. Any licensed nurse practitioner from rendering care in ~~collaboration and consultation with a patient care team physician as part of a patient care team pursuant to~~ § *accordance with the provisions of §§* 54.1-2957 *and 54.1-2957.01* or any nurse practitioner licensed by the Boards of ~~Nursing and~~ Medicine *and Nursing* in the category of certified nurse midwife practicing pursuant to subsection H of § 54.1-2957 when such services are authorized by regulations promulgated jointly by the ~~Board~~ *Boards* of Medicine and ~~the Board of~~ Nursing;

4. Any registered professional nurse, licensed nurse practitioner, graduate laboratory technician or other technical personnel who have been properly trained from rendering care or services within the scope of their usual professional activities which shall include the taking of blood, the giving of intravenous infusions and intravenous injections, and the insertion of tubes when performed under the orders of a person licensed to practice medicine or osteopathy, a nurse practitioner, or a physician assistant;

5. Any dentist, pharmacist or optometrist from rendering care or services within the scope of his usual professional activities;

6. Any practitioner licensed or certified by the Board from delegating to personnel supervised by him, such activities or functions as are nondiscretionary and do not require the exercise of professional judgment for their performance and which are usually or customarily delegated to such persons by practitioners of the healing arts, if such activities or functions are authorized by and performed for such practitioners of the healing arts and responsibility for such activities or functions is assumed by such practitioners of the healing arts;

7. The rendering of medical advice or information through telecommunications from a physician licensed to practice medicine in Virginia or an adjoining state, or from a licensed nurse practitioner, to emergency medical personnel acting in an emergency situation;

8. The domestic administration of family remedies;

9. The giving or use of massages, steam baths, dry heat rooms, infrared heat or ultraviolet lamps in public or private health clubs and spas;

10. The manufacture or sale of proprietary medicines in this Commonwealth by licensed pharmacists or druggists;

11. The advertising or sale of commercial appliances or remedies;

12. The fitting by nonitinerant persons or manufacturers of artificial eyes, limbs or other apparatus or appliances or the fitting of plaster cast counterparts of deformed portions of the body by a nonitinerant bracemaker or prosthetist for the purpose of having a three-dimensional record of the deformity, when such bracemaker or prosthetist has received a prescription from a licensed physician, licensed nurse practitioner, or licensed physician assistant directing the fitting of such casts and such activities are conducted in conformity with the laws of Virginia;

13. Any person from the rendering of first aid or medical assistance in an emergency in the absence of a person licensed to practice medicine or osteopathy under the provisions of this chapter;

14. The practice of the religious tenets of any church in the ministration to the sick and suffering by mental or spiritual means without the use of any drug or material remedy, whether gratuitously or for compensation;

15. Any legally qualified out-of-state or foreign practitioner from meeting in consultation with legally licensed practitioners in this Commonwealth;

16. Any practitioner of the healing arts licensed or certified and in good standing with the applicable regulatory agency in another state or Canada when that practitioner of the healing arts is in Virginia temporarily and such practitioner has been issued a temporary authorization by the Board from practicing medicine or the duties of the profession for which he is licensed or certified (i) in a summer

camp or in conjunction with patients who are participating in recreational activities, (ii) while participating in continuing educational programs prescribed by the Board, or (iii) by rendering at any site any health care services within the limits of his license, voluntarily and without compensation, to any patient of any clinic which is organized in whole or in part for the delivery of health care services without charge as provided in § 54.1-106;

17. The performance of the duties of any active duty health care provider in active service in the army, navy, coast guard, marine corps, air force, or public health service of the United States at any public or private health care facility while such individual is so commissioned or serving and in accordance with his official military duties;

18. Any masseur, who publicly represents himself as such, from performing services within the scope of his usual professional activities and in conformance with state law;

19. Any person from performing services in the lawful conduct of his particular profession or business under state law;

20. Any person from rendering emergency care pursuant to the provisions of § 8.01-225;

21. Qualified emergency medical services personnel, when acting within the scope of their certification, and licensed health care practitioners, when acting within their scope of practice, from following Durable Do Not Resuscitate Orders issued in accordance with § 54.1-2987.1 and Board of Health regulations, or licensed health care practitioners from following any other written order of a physician not to resuscitate a patient in the event of cardiac or respiratory arrest;

22. Any commissioned or contract medical officer of the army, navy, coast guard or air force rendering services voluntarily and without compensation while deemed to be licensed pursuant to § 54.1-106;

23. Any provider of a chemical dependency treatment program who is certified as an "acupuncture detoxification specialist" by the National Acupuncture Detoxification Association or an equivalent certifying body, from administering auricular acupuncture treatment under the appropriate supervision of a National Acupuncture Detoxification Association certified licensed physician or licensed acupuncturist;

24. Any employee of any assisted living facility who is certified in cardiopulmonary resuscitation (CPR) acting in compliance with the patient's individualized service plan and with the written order of the attending physician not to resuscitate a patient in the event of cardiac or respiratory arrest;

25. Any person working as a health assistant under the direction of a licensed medical or osteopathic doctor within the Department of Corrections, the Department of Juvenile Justice or local correctional facilities;

26. Any employee of a school board, authorized by a prescriber and trained in the administration of insulin and glucagon, when, upon the authorization of a prescriber and the written request of the parents as defined in § 22.1-1, assisting with the administration of insulin or administrating glucagon to a student diagnosed as having diabetes and who requires insulin injections during the school day or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia;

27. Any practitioner of the healing arts or other profession regulated by the Board from rendering free health care to an underserved population of Virginia who (i) does not regularly practice his profession in Virginia, (ii) holds a current valid license or certificate to practice his profession in another state, territory, district or possession of the United States, (iii) volunteers to provide free health care to an underserved area of the Commonwealth under the auspices of a publicly supported all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people, (iv) files a copy of the license or certification issued in such other jurisdiction with the Board, (v) notifies the Board at least five business days prior to the voluntary provision of services of the dates and location of such service, and (vi) acknowledges, in writing, that such licensure exemption shall only be valid, in compliance with the Board's regulations, during the limited period that such free health care is made available through the volunteer, nonprofit organization on the dates and at the location filed with the Board. The Board may deny the right to practice in Virginia to any practitioner of the healing arts whose license or certificate has been previously suspended or revoked, who has been convicted of a felony or who is otherwise found to be in violation of applicable laws or regulations. However, the Board shall allow a practitioner of the healing arts who meets the above criteria to provide volunteer services without prior notice for a period of up to three days, provided the nonprofit organization verifies that the practitioner has a valid, unrestricted license in another state;

28. Any registered nurse, acting as an agent of the Department of Health, from obtaining specimens of sputum or other bodily fluid from persons in whom the diagnosis of active tuberculosis disease, as defined in § 32.1-49.1, is suspected and submitting orders for testing of such specimens to the Division of Consolidated Laboratories or other public health laboratories, designated by the State Health Commissioner, for the purpose of determining the presence or absence of tubercle bacilli as defined in § 32.1-49.1;

29. Any physician of medicine or osteopathy or nurse practitioner from delegating to a registered nurse under his supervision the screening and testing of children for elevated blood-lead levels when

such testing is conducted (i) in accordance with a written protocol between the physician or nurse practitioner and the registered nurse and (ii) in compliance with the Board of Health's regulations promulgated pursuant to §§ 32.1-46.1 and 32.1-46.2. Any follow-up testing or treatment shall be conducted at the direction of a physician or nurse practitioner;

30. Any practitioner of one of the professions regulated by the Board of Medicine who is in good standing with the applicable regulatory agency in another state or Canada from engaging in the practice of that profession when the practitioner is in Virginia temporarily with an out-of-state athletic team or athlete for the duration of the athletic tournament, game, or event in which the team or athlete is competing;

31. Any person from performing state or federally funded health care tasks directed by the consumer, which are typically self-performed, for an individual who lives in a private residence and who, by reason of disability, is unable to perform such tasks but who is capable of directing the appropriate performance of such tasks; or

32. Any practitioner of one of the professions regulated by the Board of Medicine who is in good standing with the applicable regulatory agency in another state from engaging in the practice of that profession in Virginia with a patient who is being transported to or from a Virginia hospital for care.

B. Notwithstanding any provision of law or regulation to the contrary, military medical personnel, as defined in § 2.2-2001.4, while participating in a pilot program established by the Department of Veterans Services pursuant to § 2.2-2001.4, may practice under the supervision of a licensed physician or podiatrist.

§ 54.1-2957. Licensure and practice of nurse practitioners.

A. As used in this section:

"Collaborating provider" means a physician who is licensed by the Board of Medicine to practice medicine in the Commonwealth or another nurse practitioner who is licensed jointly by the Boards of Medicine and Nursing and who meets the requirements for practice without a written or electronic practice agreement set forth in subsection I.

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

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

B. The Board of Medicine and the Board of Nursing shall jointly prescribe the regulations governing the licensure of nurse practitioners. It ~~shall be~~ *is* unlawful for a person to practice as a nurse practitioner in the Commonwealth unless he holds such a joint license.

C. ~~Except as provided in~~ *A nurse practitioner meeting the requirements of* subsection H~~,~~ ~~a nurse practitioner shall only practice as part of a patient care team. Each member of a patient care team shall have specific responsibilities related to the care of the patient or patients and shall provide health care services within the scope of his usual professional activities. Nurse practitioners practicing as part of a patient care team shall maintain appropriate collaboration and consultation, as evidenced in~~ *or I may practice without* a written or electronic practice agreement~~, with at least one patient care team physician~~. Nurse practitioners who are certified registered nurse anesthetists shall practice under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry. Nurse practitioners appointed as medical examiners pursuant to § 32.1-282 shall practice in collaboration with a licensed doctor of medicine or osteopathic medicine who has been appointed to serve as a medical examiner pursuant to § 32.1-282. *A nurse practitioner, other than a certified nurse midwife or certified registered nurse anesthetist, not meeting the requirements of subsection I shall maintain appropriate collaboration and consultation, as evidenced by a written or electronic practice agreement, with at least one collaborating provider.* Collaboration and consultation among nurse practitioners and ~~patient care team physicians~~ *collaborating providers* may be provided through telemedicine as described in § 38.2-3418.16. ~~Practice of patient care teams in all settings shall include the periodic review of patient charts or electronic health records and may include visits to the site where health care is delivered in the manner and at the frequency determined by the patient care team.~~

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

~~Service on a patient care team by a patient care team member shall not, by the existence of such~~

~~service alone, establish or create liability for the actions or inactions of other team members.~~

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

Service according to a practice agreement shall not, by the existence of such service alone, establish or create liability for the actions or inactions of other participating members.

E. The Boards may issue a license by endorsement to an applicant to practice as a nurse practitioner if the applicant has been licensed as a nurse practitioner under the laws of another state and, ~~in the opinion~~ *pursuant to regulations* of the Boards, the applicant meets the qualifications for licensure required of nurse practitioners in the Commonwealth.

F. Pending the outcome of the next National Specialty Examination, the Boards may jointly grant temporary licensure to nurse practitioners.

G. In the event a ~~physician who is serving as a patient care team physician~~ *collaborating provider* dies, becomes disabled, retires from active practice, surrenders his license or has it suspended or revoked by the Board *or Boards*, or relocates his practice such that he is no longer able to serve, and a nurse practitioner is unable to enter into a new practice agreement with another ~~patient care team physician~~ *collaborating provider*, the nurse practitioner may continue to practice upon notification to the designee or his alternate of the Boards and receipt of such notification. Such nurse practitioner may continue to treat patients without a ~~patient care team physician~~ *collaborating provider* for an initial period not to exceed 60 days, provided the nurse practitioner continues to prescribe only those drugs previously authorized by the practice agreement with such ~~physician~~ *collaborating provider* and to have access to appropriate ~~physician~~ input *from a collaborating provider* in complex clinical cases and patient emergencies and for referrals. The designee or his alternate of the Boards shall grant permission for the nurse practitioner to continue practice under this subsection for another 60 days, provided the nurse practitioner provides evidence of efforts made to secure another ~~patient care team physician~~ *collaborating provider* and of access to ~~physician~~ input *from a collaborating provider*.

H. Nurse practitioners licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife shall practice in consultation with a licensed physician in accordance with a practice agreement between the nurse practitioner and the licensed physician. Such practice agreement shall address the availability of the physician for routine and urgent consultation on patient care. Evidence of a practice agreement shall be maintained by a nurse practitioner and provided to the Boards upon request. The Boards shall jointly promulgate regulations, consistent with the Standards for the Practice of Midwifery set by the American College of Nurse-Midwives, governing such practice.

I. Nurse practitioners, other than a nurse practitioner licensed by the Boards of Medicine and Nursing in the category of certified nurse midwife or certified registered nurse anesthetist, who have (i) been issued a license to practice as a nurse practitioner from the Boards of Medicine and Nursing and (ii) completed at least 1,040 hours of clinical experience as a licensed nurse practitioner may practice without a written or electronic practice agreement with a collaborating provider upon receipt by the nurse practitioner of an attestation from the collaborating provider stating that the nurse practitioner meets such requirements. A copy of the attestation required pursuant to this subsection shall be maintained by a nurse practitioner and provided to the Boards upon request. The Boards shall have the authority to review, revoke, or suspend such written attestation pursuant to regulations promulgated by the Boards.

§ 54.1-2957.01. Prescription of certain controlled substances and devices by licensed nurse practitioners.

A. In accordance with the provisions of this section and pursuant to the requirements of Chapter 33 (§ 54.1-3300 et seq.), a licensed nurse practitioner, other than a certified registered nurse anesthetist, shall have the authority to prescribe Schedule II through Schedule VI controlled substances and devices as set forth in Chapter 34 (§ 54.1-3400 et seq.). ~~Nurse practitioners shall have such prescriptive authority upon the provision~~

B. A nurse practitioner who does not meet the requirements for practice without a written or electronic practice agreement set forth in subsection I of § 54.1-2957 shall prescribe controlled substances or devices only if such prescribing is authorized by a written or electronic practice agreement entered into by the nurse practitioner and a collaborating provider. Such nurse practitioner shall provide to the ~~Board~~ *Boards* of Medicine and ~~the Board of~~ Nursing ~~of~~ such evidence as ~~they~~ *the Boards* may jointly require that the nurse practitioner has entered into and is, at the time of writing a prescription, a party to a written or electronic practice agreement with a ~~patient care team physician~~ *collaborating provider* that clearly states the prescriptive practices of the nurse practitioner. Such written or electronic practice agreements shall include the controlled substances the nurse practitioner is or is not authorized to prescribe and may restrict such prescriptive authority as described in the practice agreement. Evidence of a practice agreement shall be maintained by a nurse practitioner pursuant to § 54.1-2957. Practice agreements authorizing a nurse practitioner to prescribe controlled substances or devices pursuant to this section shall either be signed by the ~~patient care team physician who is practicing as part of a patient care team with the nurse practitioner~~ *collaborating provider* or shall clearly state the name of the ~~patient care team physician~~ *collaborating provider* who has entered into the practice agreement with the nurse practitioner.

~~B. It shall be unlawful for a nurse practitioner to prescribe controlled substances or devices pursuant to this section unless such prescription is authorized by the written or electronic practice agreement.~~

C. The ~~Board of Nursing and the Board~~ *Boards* of Medicine *and Nursing* shall promulgate such regulations governing the prescriptive authority of nurse practitioners as are deemed reasonable and necessary to ensure an appropriate standard of care for patients. ~~Regulations promulgated pursuant to this section~~ *Such regulations* shall include~~, at a minimum,~~ such requirements as may be necessary to ensure continued nurse practitioner competency, which may include continuing education, testing, or 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.

D. This section shall not limit the functions and procedures of certified registered nurse anesthetists or of any nurse practitioners which are otherwise authorized by law or regulation.

E. ~~The following restrictions shall apply to any~~ *A* nurse practitioner authorized to prescribe drugs and devices pursuant to this section~~:~~

~~1. The nurse practitioner~~ shall disclose to the patient at the initial encounter that he is a licensed nurse practitioner. Any ~~member of a patient care team~~ *party to a practice agreement* shall disclose, upon request of a patient or his legal representative, the name of the ~~patient care team physician~~ *collaborating provider* and information regarding how to contact the ~~patient care team physician~~ *collaborating provider*.

~~2. Physicians shall not serve as a patient care team physician on a patient care team at any one time to more than six nurse practitioners.~~

F. This section shall not prohibit a licensed nurse practitioner 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.

G. Notwithstanding any provision of law or regulation to the contrary, a nurse practitioner licensed by the Boards of ~~Nursing and~~ Medicine *and Nursing* in the category of certified nurse midwife and holding a license for prescriptive authority may prescribe (i) Schedules II through V controlled substances in accordance with any prescriptive authority included in a practice agreement with a licensed physician pursuant to subsection H of § 54.1-2957 and (ii) Schedule VI controlled substances without the requirement for inclusion of such prescriptive authority in a practice agreement.

§ 54.1-3016. Use of titles and abbreviations for nurses.

~~Any~~ *A. Only a* person who holds a license or a multistate licensure privilege to practice professional nursing in ~~Virginia~~ *the Commonwealth* shall have the right to use the title "registered nurse" and the abbreviation "R.N." No other person shall assume such title or use such abbreviation or any other words, letters, signs or devices to indicate that the person using the same is a registered nurse.

B. Only a person who holds a license or a multistate licensure privilege to practice professional nursing in the Commonwealth who has completed an advanced graduate-level nursing education program and passed a national certifying examination to be certified as a nurse anesthetist, nurse midwife, nurse practitioner, or clinical nurse specialist shall have the right to use the title "advanced practice registered nurse" and the abbreviation "A.P.R.N." No other person shall assume such title or use such abbreviation or any other words, letters, signs, or devices to indicate that the person using the same is an advanced practice registered nurse.

C. Only a person who is an advanced practice registered nurse, as defined in § 54.1-3000, who is jointly licensed by the Boards of Medicine and Nursing pursuant to § 54.1-2957 shall have the right to use the title "nurse practitioner" and the abbreviation "N.P." No other person shall assume such title or

use such abbreviation or any other words, letters, signs, or devices to indicate that the person using the same is a nurse practitioner.

D. Only a person who is an advanced practice registered nurse, as defined in § 54.1-3000, who has completed an advanced graduate-level education program and passed a national certifying examination to be certified as a nurse anesthetist and is jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner pursuant to § 54.1-2957 shall have the right to use the title "certified registered nurse anesthetist" and the abbreviation "C.R.N.A." No other person shall assume such title or use such abbreviation or any other words, letters, signs, or devices to indicate that the person using the same is a certified registered nurse anesthetist.

E. Only a person who is an advanced practice registered nurse, as defined in § 54.1-3000, who has completed an advanced graduate-level education program and passed a national certifying examination to be certified as a nurse midwife and is jointly licensed by the Boards of Medicine and Nursing as a nurse practitioner pursuant to § 54.1-2957 shall have the right to use the title "certified nurse midwife" and the abbreviation "C.N.M." No other person shall assume such title or use such abbreviation or any other words, letters, signs, or devices to indicate that the person using the same is a certified nurse midwife.

§ 54.1-3018.1. Registration of clinical nurse specialists.

A. The Board may register an applicant as a clinical nurse specialist if the applicant:

1. Holds a valid license to practice professional nursing pursuant to this article; and

2. Has successfully completed a graduate-level clinical nurse specialist program within a regionally accredited college or university that meets all educational qualifications and standards established by national certification guidelines and holds a national clinical nurse specialist certification that prepares the professional nurse to deliver advanced nursing services.

B. Only a person who is registered as a clinical nurse specialist pursuant to subsection A shall have the right to use the title "clinical nurse specialist" and the abbreviation "C.N.S." No other person shall assume such title or use such abbreviation or any other words, letters, signs, or devices to indicate that the person using the same is a registered clinical nurse specialist.

§ 54.1-3300. Definitions.

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

"Board" means the Board of Pharmacy.

"Collaborative agreement" means a voluntary, written, or electronic arrangement between one pharmacist and his designated alternate pharmacists involved directly in patient care at a single physical location where patients receive services and (i) any person licensed to practice medicine, osteopathy, or podiatry together with any person licensed, registered, or certified by a health regulatory board of the Department of Health Professions who provides health care services to patients of such person licensed to practice medicine, osteopathy, or podiatry; (ii) a physician's office as defined in § 32.1-276.3, provided *that* such collaborative agreement is signed by each physician participating in the collaborative practice agreement; (iii) any licensed physician assistant working under the supervision of a person licensed to practice medicine, osteopathy, or podiatry; or (iv) any licensed nurse practitioner working ~~as part of a patient care team as defined in § 54.1-2900~~ *in accordance with the provisions of § 54.1-2957,* involved directly in patient care which authorizes cooperative procedures with respect to patients of such practitioners. Collaborative procedures shall be related to treatment using drug therapy, laboratory tests, or medical devices, under defined conditions or limitations, for the purpose of improving patient outcomes. A collaborative agreement is not required for the management of patients of an inpatient facility.

"Dispense" means to deliver a drug to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the prescribing and administering, packaging, labeling, or compounding necessary to prepare the substance for delivery.

"Pharmacist" means a person holding a license issued by the Board to practice pharmacy.

"Pharmacy" means every establishment or institution in which drugs, medicines, or medicinal chemicals are dispensed or offered for sale, or a sign is displayed bearing the word or words "pharmacist," "pharmacy," "apothecary," "drugstore," "druggist," "drugs," "medicine store," "drug sundries," "prescriptions filled," or any similar words intended to indicate that the practice of pharmacy is being conducted.

"Pharmacy intern" means a student currently enrolled in or a graduate of an approved school of pharmacy who is registered with the Board for the purpose of gaining the practical experience required to apply for licensure as a pharmacist.

"Pharmacy technician" means a person registered with the Board to assist a pharmacist under the pharmacist's supervision.

"Practice of pharmacy" means the personal health service that is concerned with the art and science of selecting, procuring, recommending, administering, preparing, compounding, packaging, and dispensing of drugs, medicines, and devices used in the diagnosis, treatment, or prevention of disease,

whether compounded or dispensed on a prescription or otherwise legally dispensed or distributed, and shall include the proper and safe storage and distribution of drugs; the maintenance of proper records; the responsibility of providing information concerning drugs and medicines and their therapeutic values and uses in the treatment and prevention of disease; and the management of patient care under the terms of a collaborative agreement as defined in this section.

"Supervision" means the direction and control by a pharmacist of the activities of a pharmacy intern or a pharmacy technician whereby the supervising pharmacist is physically present in the pharmacy or in the facility in which the pharmacy is located when the intern or technician is performing duties restricted to a pharmacy intern or technician, respectively, and is available for immediate oral communication.

Other terms used in the context of this chapter shall be defined as provided in Chapter 34 (§ 54.1-3400 et seq.) unless the context requires a different meaning.

§ 54.1-3300.1. Participation in collaborative agreements; regulations to be promulgated by the Boards of Medicine and Pharmacy.

A pharmacist and his designated alternate pharmacists involved directly in patient care may participate with (i) any person licensed to practice medicine, osteopathy, or podiatry together with any person licensed, registered, or certified by a health regulatory board of the Department of Health Professions who provides health care services to patients of such person licensed to practice medicine, osteopathy, or podiatry; (ii) a physician's office as defined in § 32.1-276.3, provided *that* such collaborative agreement is signed by each physician participating in the collaborative practice agreement; (iii) any licensed physician assistant working under the supervision of a person licensed to practice medicine, osteopathy, or podiatry; or (iv) any licensed nurse practitioner working ~~as part of a patient care team as defined in § 54.1-2900~~ *in accordance with the provisions of § 54.1-2957*, involved directly in patient care in collaborative agreements which authorize cooperative procedures related to treatment using drug therapy, laboratory tests, or medical devices, under defined conditions or limitations, for the purpose of improving patient outcomes. However, no person licensed to practice medicine, osteopathy, or podiatry shall be required to participate in a collaborative agreement with a pharmacist and his designated alternate pharmacists, regardless of whether a professional business entity on behalf of which the person is authorized to act enters into a collaborative agreement with a pharmacist and his designated alternate pharmacists.

No patient shall be required to participate in a collaborative procedure without such patient's consent. A patient who chooses to not participate in a collaborative procedure shall notify the prescriber of his refusal to participate in such collaborative procedure. A prescriber may elect to have a patient not participate in a collaborative procedure by contacting the pharmacist or his designated alternative pharmacists or by documenting the same on the patient's prescription.

Collaborative agreements may include the implementation, modification, continuation, or discontinuation of drug therapy pursuant to written or electronic protocols, provided implementation of drug therapy occurs following diagnosis by the prescriber; the ordering of laboratory tests; or other patient care management measures related to monitoring or improving the outcomes of drug or device therapy. No such collaborative agreement shall exceed the scope of practice of the respective parties. Any pharmacist who deviates from or practices in a manner inconsistent with the terms of a collaborative agreement shall be in violation of § 54.1-2902; such violation shall constitute grounds for disciplinary action pursuant to §§ 54.1-2400 and 54.1-3316.

Collaborative agreements may only be used for conditions which have protocols that are clinically accepted as the standard of care, or are approved by the Boards of Medicine and Pharmacy. The Boards of Medicine and Pharmacy shall jointly develop and promulgate regulations to implement the provisions of this section and to facilitate the development and implementation of safe and effective collaborative agreements between the appropriate practitioners and pharmacists. The regulations shall include guidelines concerning the use of protocols, and a procedure to allow for the approval or disapproval of specific protocols by the Boards of Medicine and Pharmacy if review is requested by a practitioner or pharmacist.

Nothing in this section shall be construed to supersede the provisions of § 54.1-3303.

§ 54.1-3301. Exceptions.

This chapter shall not be construed to:

1. Interfere with any legally qualified practitioner of dentistry, or veterinary medicine or any physician acting on behalf of the Virginia Department of Health or local health departments, in the compounding of his prescriptions or the purchase and possession of drugs as he may require;

2. Prevent any legally qualified practitioner of dentistry, or veterinary medicine or any prescriber, as defined in § 54.1-3401, acting on behalf of the Virginia Department of Health or local health departments, from administering or supplying to his patients the medicines that he deems proper under the conditions of § 54.1-3303 or from causing drugs to be administered or dispensed pursuant to

§§ 32.1-42.1 and 54.1-3408, except that a veterinarian shall only be authorized to dispense a compounded drug, distributed from a pharmacy, when (i) the animal is his own patient, (ii) the animal is a companion animal as defined in regulations promulgated by the Board of Veterinary Medicine, (iii) the quantity dispensed is no more than a 72-hour supply, (iv) the compounded drug is for the treatment of an emergency condition, and (v) timely access to a compounding pharmacy is not available, as determined by the prescribing veterinarian;

3. Prohibit the sale by merchants and retail dealers of proprietary medicines as defined in Chapter 34 (§ 54.1-3400 et seq.) of this title;

4. Prevent the operation of automated drug dispensing systems in hospitals pursuant to Chapter 34 (§ 54.1-3400 et seq.) of this title;

5. Prohibit the employment of ancillary personnel to assist a pharmacist as provided in the regulations of the Board;

6. Interfere with any legally qualified practitioner of medicine, osteopathy, or podiatry from purchasing, possessing or administering controlled substances to his own patients or providing controlled substances to his own patients in a bona fide medical emergency or providing manufacturers' professional samples to his own patients;

7. Interfere with any legally qualified practitioner of optometry, certified or licensed to use diagnostic pharmaceutical agents, from purchasing, possessing or administering those controlled substances as specified in § 54.1-3221 or interfere with any legally qualified practitioner of optometry certified to prescribe therapeutic pharmaceutical agents from purchasing, possessing, or administering to his own patients those controlled substances as specified in § 54.1-3222 and the TPA formulary, providing manufacturers' samples of these drugs to his own patients, or dispensing, administering, or selling ophthalmic devices as authorized in § 54.1-3204;

8. Interfere with any physician assistant with prescriptive authority receiving and dispensing to his own patients manufacturers' professional samples of controlled substances and devices that he is authorized, in compliance with the provisions of § 54.1-2952.1, to prescribe according to his practice setting and a written agreement with a physician or podiatrist;

9. Interfere with any licensed nurse practitioner with prescriptive authority receiving and dispensing to his own patients manufacturers' professional samples of controlled substances and devices that he is authorized, in compliance with the provisions of § 54.1-2957.01, to prescribe ~~according to his practice setting and a written or electronic agreement with a physician~~;

10. Interfere with any legally qualified practitioner of medicine or osteopathy participating in an indigent patient program offered by a pharmaceutical manufacturer in which the practitioner sends a prescription for one of his own patients to the manufacturer, and the manufacturer donates a stock bottle of the prescription drug ordered at no cost to the practitioner or patient. The practitioner may dispense such medication at no cost to the patient without holding a license to dispense from the Board of Pharmacy. However, the container in which the drug is dispensed shall be labeled in accordance with the requirements of § 54.1-3410, and, unless directed otherwise by the practitioner or the patient, shall meet standards for special packaging as set forth in § 54.1-3426 and Board of Pharmacy regulations. In lieu of dispensing directly to the patient, a practitioner may transfer the donated drug with a valid prescription to a pharmacy for dispensing to the patient. The practitioner or pharmacy participating in the program shall not use the donated drug for any purpose other than dispensing to the patient for whom it was originally donated, except as authorized by the donating manufacturer for another patient meeting that manufacturer's requirements for the indigent patient program. Neither the practitioner nor the pharmacy shall charge the patient for any medication provided through a manufacturer's indigent patient program pursuant to this subdivision. A participating pharmacy, including a pharmacy participating in bulk donation programs, may charge a reasonable dispensing or administrative fee to offset the cost of dispensing, not to exceed the actual costs of such dispensing. However, if the patient is unable to pay such fee, the dispensing or administrative fee shall be waived;

11. Interfere with any legally qualified practitioner of medicine or osteopathy from providing controlled substances to his own patients in a free clinic without charge when such controlled substances are donated by an entity other than a pharmaceutical manufacturer as authorized by subdivision 10. The practitioner shall first obtain a controlled substances registration from the Board and shall comply with the labeling and packaging requirements of this chapter and the Board's regulations; or

12. Prevent any pharmacist from providing free health care to an underserved population in Virginia who (i) does not regularly practice pharmacy in Virginia, (ii) holds a current valid license or certificate to practice pharmacy in another state, territory, district or possession of the United States, (iii) volunteers to provide free health care to an underserved area of this Commonwealth under the auspices of a publicly supported all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people, (iv) files a copy of the license or certificate issued in such other jurisdiction with the Board, (v) notifies the Board at least five business days prior to the voluntary provision of services of the dates and location of such service, and (vi) acknowledges, in writing, that

such licensure exemption shall only be valid, in compliance with the Board's regulations, during the limited period that such free health care is made available through the volunteer, nonprofit organization on the dates and at the location filed with the Board. The Board may deny the right to practice in Virginia to any pharmacist whose license has been previously suspended or revoked, who has been convicted of a felony or who is otherwise found to be in violation of applicable laws or regulations. However, the Board shall allow a pharmacist who meets the above criteria to provide volunteer services without prior notice for a period of up to three days, provided the nonprofit organization verifies that the practitioner has a valid, unrestricted license in another state.

This section shall not be construed as exempting any person from the licensure, registration, permitting and record keeping requirements of this chapter or Chapter 34 of this title.

§ 54.1-3482. Practice of physical therapy; certain experience and referrals required; physical therapist assistants.

A. It shall be unlawful for a person to engage in the practice of physical therapy except as a licensed physical therapist, upon the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician, except as provided in this section.

B. A physical therapist who has completed a doctor of physical therapy program approved by the Commission on Accreditation of Physical Therapy Education or who has obtained a certificate of authorization pursuant to § 54.1-3482.1 may evaluate and treat a patient for no more than 30 consecutive days after an initial evaluation without a referral under the following conditions: (i) the patient is not receiving care from any licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician for the symptoms giving rise to the presentation at the time of the presentation to the physical therapist for physical therapy services or (ii) the patient is receiving care from a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician at the time of his presentation to the physical therapist for the symptoms giving rise to the presentation for physical therapy services and (a) the patient identifies a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician from whom he is currently receiving care; (b) the patient gives written consent for the physical therapist to release all personal health information and treatment records to the identified practitioner; and (c) the physical therapist notifies the practitioner identified by the patient no later than 14 days after treatment commences and provides the practitioner with a copy of the initial evaluation along with a copy of the patient history obtained by the physical therapist. Treatment for more than 30 consecutive days after evaluation of such patient shall only be upon the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician. A physical therapist may contact the practitioner identified by the patient at the end of the 30-day period to determine if the practitioner will authorize additional physical therapy services until such time as the patient can be seen by the practitioner. A physical therapist shall not perform an initial evaluation of a patient under this subsection if the physical therapist has performed an initial evaluation of the patient under this subsection for the same condition within the immediately preceding 60 days.

C. A physical therapist who has not completed a doctor of physical therapy program approved by the Commission on Accreditation of Physical Therapy Education or who has not obtained a certificate of authorization pursuant to § 54.1-3482.1 may conduct a one-time evaluation that does not include treatment of a patient without the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician; if appropriate, the physical therapist shall immediately refer such patient to the appropriate practitioner.

D. Invasive procedures within the scope of practice of physical therapy shall at all times be performed only under the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician.

E. It shall be unlawful for any licensed physical therapist to fail to immediately refer any patient to a

licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, or a licensed nurse practitioner practicing in accordance with ~~his~~ ~~practice~~ ~~agreement~~ *the provisions of § 54.1-2957* when such patient's medical condition is determined, at the time of evaluation or treatment, to be beyond the physical therapist's scope of practice. Upon determining that the patient's medical condition is beyond the scope of practice of a physical therapist, a physical therapist shall immediately refer such patient to an appropriate practitioner.

F. Any person licensed as a physical therapist assistant shall perform his duties only under the direction and control of a licensed physical therapist.

G. However, a licensed physical therapist may provide, without referral or supervision, physical therapy services to (i) a student athlete participating in a school-sponsored athletic activity while such student is at such activity in a public, private, or religious elementary, middle or high school, or public or private institution of higher education when such services are rendered by a licensed physical therapist who is certified as an athletic trainer by the National Athletic Trainers' Association Board of Certification or as a sports certified specialist by the American Board of Physical Therapy Specialties; (ii) employees solely for the purpose of evaluation and consultation related to workplace ergonomics; (iii) special education students who, by virtue of their individualized education plans (IEPs), need physical therapy services to fulfill the provisions of their IEPs; (iv) the public for the purpose of wellness, fitness, and health screenings; (v) the public for the purpose of health promotion and education; and (vi) the public for the purpose of prevention of impairments, functional limitations, and disabilities.

§ 54.1-3482.1. Certain certification required.

A. The Board shall promulgate regulations establishing criteria for certification of physical therapists to provide certain physical therapy services pursuant to subsection B of § 54.1-3482 without referral from a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his~~ ~~practice~~ ~~agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the supervision of a licensed physician. The regulations shall include but not be limited to provisions for (i) the promotion of patient safety; (ii) an application process for a one-time certification to perform such procedures; and (iii) minimum education, training, and experience requirements for certification to perform such procedures.

B. The minimum education, training, and experience requirements for certification shall include evidence that the applicant has successfully completed (i) a transitional program in physical therapy as recognized by the Board or (ii) at least three years of active practice with evidence of continuing education relating to carrying out direct access duties under § 54.1-3482.

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

3. That the Boards of Medicine and Nursing shall report on the number of nurse practitioners who have been authorized to practice pursuant to the provisions of this act and the locations at which such nurse practitioners are practicing to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health and the Chairman of the Joint Commission on Health Care by November 1, 2023.

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF NURSING

VIRGINIA BOARD OF NURSING

Title of Regulations: 18 VAC 90-19-10 et seq.

Statutory Authority: §§ 54.1-2400 and Chapter 30 of Title 54.1 of the *Code of Virginia*

Revised Date: December 28, 2017

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CHAPTER 19
REGULATIONS GOVERNING THE PRACTICE OF NURSING

Part I
General Provisions

18VAC90-19-10. Definitions.

In addition to words and terms defined in §§ 54.1-3000 and 54.1-3030 of the Code of Virginia, the following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Active practice" means activities performed, whether or not for compensation, for which an active license to practice nursing is required.

"Board" means the Board of Nursing.

"CGFNS" means the Commission on Graduates of Foreign Nursing Schools.

"Contact hour" means 50 minutes of continuing education coursework or activity.

"National certifying organization" means an organization that has as one of its purposes the certification of a specialty in nursing based on an examination attesting to the knowledge of the nurse for practice in the specialty area.

"NCLEX" means the National Council Licensure Examination.

"NCSBN" means the National Council of State Boards of Nursing.

"Primary state of residence" means the state of a person's declared fixed, permanent, and principal home or domicile for legal purposes.

18VAC90-19-20. Delegation of authority.

The executive director shall be delegated the authority to issue licenses and certificates and execute all notices, orders, and official documents of the board unless the board directs otherwise.

18VAC90-19-30. Fees.

A. Fees required by the board are:

1. Application for licensure by examination - RN	$190
2. Application for licensure by endorsement - RN	$190
3. Application for licensure by examination - LPN	$170
4. Application for licensure by endorsement - LPN	$170

5. Reapplication for licensure by examination	$50
6. Biennial licensure renewal - RN	$140
7. Biennial inactive licensure renewal - RN	$70
8. Biennial licensure renewal - LPN	$120
9. Biennial inactive licensure renewal - LPN	$60
10. Late renewal - RN	$50
11. Late renewal - RN inactive	$25
12. Late renewal - LPN	$40
13. Late renewal - LPN inactive	$20
14. Reinstatement of lapsed license - RN	$225
15. Reinstatement of lapsed license - LPN	$200
16. Reinstatement of suspended or revoked license	$300
17. Duplicate license	$15
18. Replacement wall certificate	$25
19. Verification of license	$35
20. Transcript of all or part of applicant or licensee records	$35
21. Returned check charge	$35
22. Application for CNS registration	$130
23. Biennial renewal of CNS registration	$80
24. Reinstatement of lapsed CNS registration	$125
25. Verification of CNS registration to another jurisdiction	$35
26. Late renewal of CNS registration	$35

B. For renewal of licensure or registration from July 1, 2017, through June 30, 2019, the following fees shall be in effect:

1. Biennial licensure renewal - RN	$105
2. Biennial inactive licensure renewal - RN	$52
3. Biennial licensure renewal - LPN	$90
4. Biennial inactive licensure renewal - LPN	$45
5. Biennial renewal of CNS registration	$60

18VAC90-19-40. Duplicate license.

A duplicate license for the current renewal period shall be issued by the board upon receipt of the required information and fee.

18VAC90-19-50. Identification; accuracy of records.

A. Any person regulated by this chapter who provides direct client care shall, while on duty, wear identification that is clearly visible and indicates the person's first and last name and the appropriate title for the license, registration, or student status under which he is practicing in that setting. Any person practicing in hospital emergency departments, psychiatric and mental health units and programs, or in health care facilities units offering treatment for clients in custody of state or local law-enforcement agencies may use identification badges with first name and first letter only of last name and appropriate title.

B. A licensee who has changed his name shall submit as legal proof to the board a copy of the marriage certificate, a certificate of naturalization, or court order evidencing the change. A duplicate license shall be issued by the board upon receipt of such evidence and the required fee.

C. Each licensee shall maintain an address of record with the board. Any change in the address of record or in the public address, if different from the address of record, shall be submitted by a licensee electronically or in writing to the board within 30 days of such change. All notices required by law and by this chapter to be mailed by the board to any licensee shall be validly given when mailed to the latest address of record on file with the board.

18VAC90-19-60. Data collection of nursing workforce information.

A. With such funds as are appropriated for the purpose of data collection and consistent with the provisions of § 54.1-2506.1 of the Code of Virginia, the board shall collect workforce information biennially from a representative sample of registered nurses, licensed practical nurses, and certified nurse aides and shall make such information available to the public. Data collected shall be compiled, stored, and released in compliance with § 54.1-3012.1 of the Code of Virginia.

B. The information to be collected on nurses shall include (i) demographic data to include age, sex, and ethnicity; (ii) level of education; (iii) employment status; (iv) employment setting or settings such as in a hospital, physician's office, or nursing home; (v) geographic location of employment; (vi) type of nursing position or area of specialty; and (vii) number of hours worked per week in each setting. In addition, the board may determine other data to be collected as necessary.

18VAC90-19-70. Supervision of licensed practical nurses.

Licensed practical nursing shall be performed under the direction or supervision of a licensed medical practitioner, a registered nurse, or a licensed dentist.

Part II
Multistate Licensure Privilege

18VAC90-19-80. Issuance of a license with a multistate licensure privilege.

A. To be issued a license with a multistate licensure privilege by the board, a nurse currently licensed in Virginia or a person applying for licensure in Virginia shall submit a declaration stating that his primary residence is in Virginia. Evidence of a primary state of residence may be required to include:

1. A driver's license with a home address;

2. A voter registration card displaying a home address;

3. A federal or state tax return declaring the primary state of residence;

4. A Military Form No. 2058 – state of legal residence; or

5. A W-2 from the United States government or any bureau, division, or agency thereof indicating the declared state of residence.

B. A nurse on a visa from another country applying for licensure in Virginia may declare either the country of origin or Virginia as the primary state of residence. If the foreign country is declared as the primary state of residence, a single state license shall be issued by Virginia.

C. A nurse changing the primary state of residence from another party state to Virginia may continue to practice under the former party state license and multistate licensure privilege during the processing of the nurse's licensure application by the board for a period not to exceed 90 days.

1. If a nurse is under a pending investigation by a former home state, the licensure application in Virginia shall be held in abeyance and the 90-day authorization to practice stayed until resolution of the pending investigation.

2. A license issued by a former party state shall no longer be valid upon issuance of a license by the board.

3. If the board denies licensure to an applicant from another party state, it shall notify the former home state within 10 business days, and the former home state may take action in accordance with the laws and regulations of that state.

D. A license issued by a party state is valid for practice in all other party states, unless clearly designated as valid only in the state that issued the license. When a party state issues a license

authorizing practice only in that state and not authorizing practice in other party states, the license shall be clearly marked with words indicating that it is valid only in the state of issuance.

18VAC90-19-90. Limitations of a multistate licensure privilege.

A. The board shall include in all disciplinary orders that limit practice or require monitoring the requirement that the licensee subject to the order shall agree to limit practice to Virginia during the period in which the order is in effect. A nurse may be allowed to practice in other party states while an order is in effect with prior written authorization from both the board and boards of other party states.

B. An individual who had a license that was surrendered, revoked, or suspended or an application denied for cause in a prior state of primary residence may be issued a single state license in a new primary state of residence until such time as the individual would be eligible for an unrestricted license by the prior state of adverse action. Once eligible for licensure in the prior state, a multistate license may be issued.

18VAC90-19-100. Access to information in the coordinated licensure information system.

A licensee may submit a request in writing to the board to review the public data relating to the licensee maintained in the coordinated licensure information system. In the event a licensee asserts that any related data is inaccurate, the burden of proof shall be upon the licensee to provide evidence that substantiates such claim. The board shall verify and correct inaccurate data in the information system within 10 business days.

Part III
Licensure and Renewal; Reinstatement

18VAC90-19-110. Licensure by examination.

A. The board shall authorize the administration of the NCLEX for registered nurse licensure and practical nurse licensure.

B. A candidate shall be eligible to take the NCLEX examination (i) upon receipt by the board of the completed application, the fee, and an official transcript or attestation of graduation from the nursing education program and (ii) when a determination has been made that no grounds exist upon which the board may deny licensure pursuant to § 54.1-3007 of the Code of Virginia.

C. To establish eligibility for licensure by examination, an applicant for the licensing examination shall:

1. File the required application, any necessary documentation and fee, including a criminal history background check as required by § 54.1-3005.1 of the Code of Virginia.

2. Arrange for the board to receive an official transcript from the nursing education program that shows either:

a. That the degree or diploma has been awarded and the date of graduation or conferral; or

b. That all requirements for awarding the degree or diploma have been met and that specifies the date of conferral.

3. File a new application and reapplication fee if:

a. The examination is not taken within 12 months of the date that the board determines the applicant to be eligible; or

b. Eligibility is not established within 12 months of the original filing date.

D. The minimum passing standard on the examination for registered nurse licensure and practical nurse licensure shall be determined by the board.

E. Any applicant suspected of giving or receiving unauthorized assistance during the examination may be noticed for a hearing pursuant to the provisions of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) to determine eligibility for licensure or reexamination.

F. Practice of nursing pending receipt of examination results.

1. A graduate who has filed a completed application for licensure in Virginia and has received an authorization letter issued by the board may practice nursing in Virginia from the date of the authorization letter. The period of practice shall not exceed 90 days between the date of successful completion of the nursing education program, as documented on the applicant's transcript, and the publication of the results of the candidate's first licensing examination.

2. Candidates who practice nursing as provided in subdivision 1 of this subsection shall use the designation "R.N. Applicant" or "L.P.N. Applicant" on a nametag or when signing official records.

3. The designations "R.N. Applicant" and "L.P.N. Applicant" shall not be used by applicants who either do not take the examination within 90 days following receipt of the authorization letter from the board or who have failed the examination.

G. Applicants who fail the examination.

1. An applicant who fails the licensing examination shall not be licensed or be authorized to practice nursing in Virginia.

2. An applicant for licensure by reexamination shall file the required board application and reapplication fee in order to establish eligibility for reexamination.

3. Applicants who have failed the examination for licensure in another United States jurisdiction but satisfy the qualifications for licensure in this jurisdiction may apply for licensure by examination in Virginia. Such applicants shall submit the required application and fee. Such applicants shall not, however, be permitted to practice nursing in Virginia until the requisite license has been issued.

18VAC90-19-120. Licensure by endorsement.

A. A graduate of an approved nursing education program who has been licensed by examination in another United States jurisdiction and whose license is in good standing, or is eligible for reinstatement if lapsed, shall be eligible for licensure by endorsement in Virginia provided the applicant satisfies the same requirements for registered nurse or practical nurse licensure as those seeking initial licensure in Virginia.

1. Applicants who have graduated from approved nursing education programs that did not require a sufficient number of clinical hours as specified in 18VAC90-27-100 may qualify for licensure if they can provide evidence of at least 960 hours of clinical practice with an active, unencumbered license in another United States jurisdiction.

2. Applicants whose basic nursing education was received in another country shall meet the requirements of 18VAC90-19-130 for a CGFNS credentials review and examination of English proficiency. However, those requirements may be satisfied if the applicant can provide evidence from another United States jurisdiction of:

a. A CGFNS credentials evaluation for educational comparability; and

b. Passage of an English language proficiency examination approved by the CGFNS, unless the applicant met the CGFNS criteria for an exemption from the requirement.

3. A graduate of a nursing school in Canada where English was the primary language shall be eligible for licensure by endorsement provided the applicant has passed the Canadian Registered Nurses Examination and holds an unrestricted license in Canada.

B. An applicant for licensure by endorsement who has submitted a criminal history background check as required by § 54.1-3005.1 of the Code of Virginia and the required application and fee and has submitted the required form to the appropriate credentialing agency for verification of licensure may practice for 30 days upon receipt of an authorization letter from the board. If an applicant has not received a Virginia license within 30 days and wishes to continue practice, he shall seek an extension of authorization to practice by submitting a request and evidence that he has requested verification of licensure.

C. If the application is not completed within one year of the initial filing date, the applicant shall submit a new application and fee.

18VAC90-19-130. Licensure of applicants from other countries.

A. With the exception of applicants from Canada who are eligible to be licensed by endorsement, applicants whose basic nursing education was received in another country shall be scheduled to take the licensing examination provided they meet the statutory qualifications for licensure. Verification of qualification shall be based on documents submitted as required in subsection B or C of this section.

B. Such applicants for registered nurse licensure shall:

1. Submit evidence from the CGFNS that the secondary education and nursing education are comparable to those required for registered nurses in the Commonwealth;

2. Submit evidence of passage of an English language proficiency examination approved by the CGFNS, unless the applicant meets the CGFNS criteria for an exemption from the requirement; and

3. Submit the required application and fee for licensure by examination.

C. Such applicants for practical nurse licensure shall:

1. Submit evidence from the CGFNS that the secondary education and nursing education are comparable to those required for practical nurses in the Commonwealth;

2. Submit evidence of passage of an English language proficiency examination approved by the CGFNS, unless the applicant meets the CGFNS criteria for an exemption from the requirement; and

3. Submit the required application and fee for licensure by examination.

D. An applicant for licensure as a registered nurse who has met the requirements of subsections A and B of this section may practice for a period not to exceed 90 days from the date of approval of an application submitted to the board when he is working as a nonsupervisory staff nurse in a licensed nursing home or certified nursing facility.

1. Applicants who practice nursing as provided in this subsection shall use the designation "foreign nurse graduate" on nametags or when signing official records.

2. During the 90-day period, the applicant shall take and pass the licensing examination in order to remain eligible to practice nursing in Virginia.

3. Any person practicing nursing under this exemption who fails to pass the licensure examination within the 90-day period may not thereafter practice nursing until he passes the licensing examination.

E. In addition to CGFNS, the board may accept credentials from other recognized agencies that review credentials of foreign-educated nurses if such agencies have been approved by the board.

18VAC90-19-140. Provisional licensure of applicants for licensure as registered nurses.

A. Pursuant to § 54.1-3017.1 of the Code of Virginia, the board may issue a provisional license to an applicant for the purpose of meeting the 500 hours of supervised, direct, hands-on client care required of an approved registered nurse education program.

B. Such applicants for provisional licensure shall submit:

1. A completed application for licensure by examination and fee, including a criminal history background check as required by § 54.1-3005.1 of the Code of Virginia;

2. Documentation that the applicant has successfully completed a nursing education program; and

3. Documentation of passage of the NCLEX in accordance with 18VAC90-19-110.

C. Requirements for hours of supervised clinical experience in direct client care with a provisional license.

1. To qualify for licensure as a registered nurse, direct, hands-on hours of supervised clinical experience shall include the areas of adult medical/surgical nursing, geriatric nursing, maternal/infant (obstetrics, gynecology, neonatal) nursing, mental health/psychiatric nursing, nursing fundamentals, and pediatric nursing. Supervised clinical hours may be obtained in employment in the role of a registered nurse or without compensation for the purpose of meeting these requirements.

2. Hours of direct, hands-on clinical experience obtained as part of the applicant's nursing education program and noted on the official transcript shall be counted towards the minimum of 500 hours and in the applicable areas of clinical practice.

3. For applicants with a current, active license as an LPN, 150 hours of credit shall be counted towards the 500-hour requirement.

4. 100 hours of credit may be applied towards the 500-hour requirement for applicants who have successfully completed a nursing education program that:

a. Requires students to pass competency-based assessments of nursing knowledge as well as a summative performance assessment of clinical competency that has been evaluated by the American Council on Education or any other board-approved organization; and

b. Has a passage rate for first-time test takers on the NCLEX that is not less than 80%, calculated on the cumulative results of the past four quarters of all graduates in each calendar year regardless of where the graduate is seeking licensure.

5. An applicant for licensure shall submit verification from a supervisor of the number of hours of direct client care and the areas in which clinical experiences in the role of a registered nurse were obtained.

D. Requirements for supervision of a provisional licensee.

1. The supervisor shall be on site and physically present in the unit where the provisional licensee is providing clinical care of clients.

2. In the supervision of provisional licensees in the clinical setting, the ratio shall not exceed two provisional licensees to one supervisor at any given time.

3. Licensed registered nurses providing supervision for a provisional licensee shall:

a. Notify the board of the intent to provide supervision for a provisional licensee on a form provided by the board;

b. Hold an active, unrestricted license or multistate licensure privilege and have at least two years of active clinical practice as a registered nurse prior to acting as a supervisor;

c. Be responsible and accountable for the assignment of clients and tasks based on their assessment and evaluation of the supervisee's clinical knowledge and skills;

d. Be required to monitor clinical performance and intervene if necessary for the safety and protection of the clients; and

e. Document on a form provided by the board the frequency and nature of the supervision of provisional licensees to verify completion of hours of clinical experience.

E. The provisional status of the licensee shall be disclosed to the client prior to treatment and shall be indicated on identification worn by the provisional licensee.

F. All provisional licenses shall expire six months from the date of issuance and may be renewed for an additional six months. Renewal of a provisional license beyond the limit of 12 months may be granted and shall be for good cause shown. A request for extension of a provisional license beyond 12 months shall be made at least 30 days prior to its expiration.

18VAC90-19-150. Renewal of licenses.

A. Licensees born in even-numbered years shall renew their licenses by the last day of the birth month in even-numbered years. Licensees born in odd-numbered years shall renew their licenses by the last day of the birth month in odd-numbered years.

B. A nurse shall be required to meet the requirements for continued competency set forth in 18VAC90-19-160 to renew an active license.

C. A notice for renewal of license shall be sent by the board to the last known address of the licensee. The licensee shall complete the renewal form and submit it with the required fee.

D. Failure to receive the renewal form shall not relieve the licensee of the responsibility for renewing the license by the expiration date.

E. The license shall automatically lapse if the licensee fails to renew by the expiration date.

F. Any person practicing nursing during the time a license has lapsed shall be considered an illegal practitioner and shall be subject to prosecution under the provisions of § 54.1-3008 of the Code of Virginia.

G. Upon renewal, all licensees shall declare their primary state of residence. If the declared state of residence is another compact state, the licensee is not eligible for renewal.

18VAC90-19-160. Continued competency requirements for renewal of an active license.

A. To renew an active nursing license, a licensee shall complete at least one of the following learning activities or courses:

1. Current specialty certification by a national certifying organization, as defined in 18VAC90-19-10;

2. Completion of a minimum of three credit hours of post-licensure academic education relevant to nursing practice, offered by a regionally accredited college or university;

3. A board-approved refresher course in nursing;

4. Completion of nursing-related, evidence-based practice project or research study;

5. Completion of publication as the author or co-author during a renewal cycle;

6. Teaching or developing a nursing-related course resulting in no less than three semester hours of college credit, a 15-week course, or specialty certification;

7. Teaching or developing nursing-related continuing education courses for up to 30 contact hours;

8. Fifteen contact hours of workshops, seminars, conferences, or courses relevant to the practice of nursing and 640 hours of active practice as a nurse; or

9. Thirty contact hours of workshops, seminars, conferences, or courses relevant to the practice of nursing.

B. To meet requirements of subdivision A 8 or A 9 of this section, workshops, seminars, conferences, or courses shall be offered by a provider recognized or approved by one of the following:

1. American Nurses Credentialing Center American Nurses Association;

2. National Council of State Boards of Nursing;

3. Area Health Education Centers (AHEC) in any state in which the AHEC is a member of the National AHEC Organization;

4. Any state nurses association;

5. National League for Nursing;

6. National Association for Practical Nurse Education and Service;

7. National Federation of Licensed Practical Nurses;

8. A licensed health care facility, agency, or hospital;

9. A health care provider association;

10. Regionally or nationally accredited colleges or universities;

11. A state or federal government agency;

12. The American Heart Association, the American Health and Safety Institute, or the American Red Cross for courses in advanced resuscitation; or

13. The Virginia Board of Nursing or any state board of nursing.

C. Dual licensed persons.

1. Those persons dually licensed by this board as a registered nurse and a licensed practical nurse shall only meet one of the continued competency requirements as set forth in subsection A of this section.

2. Registered nurses who also hold an active license as a nurse practitioner shall only meet the requirements of 18VAC90-30-105 and, for those with prescriptive authority, 18VAC90-40-55.

D. A licensee is exempt from the continued competency requirement for the first renewal following initial licensure by examination or endorsement.

E. The board may grant an extension for good cause of up to one year for the completion of continuing competency requirements upon written request from the licensee 60 days prior to the renewal date. Such extension shall not relieve the licensee of the continuing competency requirement.

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

G. Continued competency activities or courses required by board order in a disciplinary proceeding shall not be counted as meeting the requirements for licensure renewal.

18VAC90-19-170. Documenting compliance with continued competency requirements.

A. All licensees are required to maintain original documentation of completion for a period of two years following renewal and to provide such documentation within 30 days of a request from the board for proof of compliance.

B. Documentation of compliance shall be as follows:

1. Evidence of national certification shall include a copy of a certificate that includes name of licensee, name of certifying body, date of certification, and date of certification expiration. Certification shall be initially attained during the licensure period, have been in effect during the entire licensure period, or have been recertified during the licensure period.

2. Evidence of post-licensure academic education shall include a copy of transcript with the name of the licensee, name of educational institution, date of attendance, name of course with grade, and number of credit hours received.

3. Evidence of completion of a board-approved refresher course shall include written correspondence from the provider with the name of the licensee, name of the provider, and verification of successful completion of the course.

4. Evidence of completion of a nursing research study or project shall include an abstract or summary, the name of the licensee, role of the licensee as principal or coprincipal investigator, date of completion, statement of the problem, research or project objectives, methods used, and summary of findings.

5. Evidence of authoring or co-authoring a published nursing-related article, paper, book, or book chapter shall include a copy of the publication that includes the name of the licensee and publication date.

6. Evidence of teaching a course for college credit shall include documentation of the course offering, indicating instructor, course title, course syllabus, and the number of credit hours. Teaching a particular course may only be used once to satisfy the continued competency requirement unless the course offering and syllabus has changed.

7. Evidence of teaching a course for continuing education credit shall include a written attestation from the director of the program or authorizing entity including the date or dates of the course or courses and the number of contact hours awarded. If the total number of contact hours totals less than 30, the licensee shall obtain additional hours in continuing learning activities or courses.

8. Evidence of contact hours of continuing learning activities or courses shall include the name of the licensee, title of educational activity, name of the provider, number of contact hours, and date of activity.

9. Evidence of 640 hours of active practice in nursing shall include documentation satisfactory to the board of the name of the licensee, number of hours worked in calendar or fiscal year, name and address of employer, and signature of supervisor. If self-employed, hours worked may be validated through other methods such as tax records or other business records. If active practice is of a volunteer or gratuitous nature, hours worked may be validated by the recipient agency.

18VAC90-19-180. Inactive licensure.

A. A registered nurse or licensed practical nurse who holds a current, unrestricted license in Virginia may, upon a request on the renewal application and submission of the required fee, be issued an inactive license. The holder of an inactive license shall not be entitled to practice nursing in Virginia or practice on a multistate licensure privilege but may use the title "registered nurse" or "licensed practical nurse."

B. Reactivation of an inactive license.

1. A nurse whose license is inactive may reactivate within one renewal period by:

a. Payment of the difference between the inactive renewal and the active renewal fee; and

b. Providing attestation of completion of at least one of the learning activities or courses specified in 18VAC90-19-160 during the two years immediately preceding reactivation.

2. A nurse whose license has been inactive for more than one renewal period may reactivate by:

a. Submitting an application;

b. Paying the difference between the inactive renewal and the active renewal fee; and

c. Providing evidence of completion of at least one of the learning activities or courses specified in 18VAC90-19-160 during the two years immediately preceding application for reactivation.

3. The board may waive all or part of the continuing education requirement for a nurse who holds a current, unrestricted license in another state and who has engaged in active practice during the period the Virginia license was inactive.

4. The board may request additional evidence that the nurse is prepared to resume practice in a competent manner.

5. The board may deny a request for reactivation to any licensee who has been determined to have committed an act in violation of § 54.1-3007 of the Code of Virginia or any provision of this chapter.

18VAC90-19-190. Reinstatement of lapsed licenses or license suspended or revoked.

A. A nurse whose license has lapsed may be reinstated within one renewal period by:

1. Payment of the current renewal fee and the late renewal fee; and

2. Providing attestation of completion of at least one of the learning activities or courses specified in 18VAC90-19-160 during the two years immediately preceding reinstatement.

B. A nurse whose license has lapsed for more than one renewal period shall:

1. File a reinstatement application and pay the reinstatement fee;

2. Provide evidence of completing at least one of the learning activities or courses specified in 18VAC90-19-160 during the two years immediately preceding application for reinstatement; and

3. Submit a criminal history background check as required by § 54.1-3005.1 of the Code of Virginia.

C. The board may waive all or part of the continuing education requirement for a nurse who holds a current, unrestricted license in another state and who has engaged in active practice during the period the Virginia license was lapsed.

D. A nurse whose license has been suspended or revoked by the board may apply for reinstatement by filing a reinstatement application, fulfilling requirements for continuing competency as required

in subsection B of this section, and paying the fee for reinstatement after suspension or revocation. A nurse whose license has been revoked may not apply for reinstatement sooner than three years from entry of the order of revocation.

E. The board may request additional evidence that the nurse is prepared to resume practice in a competent manner.

18VAC90-19-200. Restricted volunteer license and registration for voluntary practice by out-of-state licensees.

A. A registered or practical nurse may be issued a restricted volunteer license and may practice in accordance with provisions of § 54.1-3011.01 of the Code of Virginia.

B. Any licensed nurse who does not hold a license to practice in Virginia and who seeks registration to practice 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 evidence of current, unrestricted licensure in a United States jurisdiction;

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

4. Pay a registration fee of $10; and

5. Provide an attestation from a representative of the nonprofit organization attesting to its compliance with provisions of subdivision 11 of § 54.1-3001 of the Code of Virginia.

Part IV
Clinical Nurse Specialists

18VAC90-19-210. Clinical nurse specialist registration.

A. Initial registration. An applicant for initial registration as a clinical nurse specialist shall:

1. Be currently licensed as a registered nurse in Virginia or hold a current multistate licensure privilege as a registered nurse;

2. Submit evidence of current specialty certification as required by § 54.1-3018.1 of the Code of Virginia or has an exception available from March 1, 1990, to July 1, 1990; and

3. Submit the required application and fee.

B. Renewal of registration.

1. Registration as a clinical nurse specialist shall be renewed biennially at the same time the registered nurse license is renewed. If registered as a clinical nurse specialist with a multistate licensure privilege to practice in Virginia as a registered nurse, a licensee born in even-numbered years shall renew his license by the last day of the birth month in even-numbered years and a licensee born in odd-numbered years shall renew his license by the last day of the birth month in odd-numbered years.

2. The clinical nurse specialist shall complete the renewal form and submit it with the required fee. An attestation of current specialty certification is required unless registered in accordance with an exception.

3. Registration as a clinical nurse specialist shall lapse if the registered nurse license is not renewed or the multistate licensure privilege is lapsed and may be reinstated upon:

a. Reinstatement of RN license or multistate licensure privilege;

b. Payment of reinstatement and current renewal fees; and

c. Submission of evidence of continued specialty certification unless registered in accordance with an exception.

18VAC90-19-220. Clinical nurse specialist practice.

A. The practice of a clinical nurse specialist shall be consistent with the education and experience required for clinical nurse specialist certification.

B. The clinical nurse specialist shall provide those advanced nursing services that are consistent with the standards of specialist practice as established by a national certifying organization for the designated specialty and in accordance with the provisions of Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia.

C. Advanced practice as a clinical nurse specialist shall include performance as an expert clinician to:

1. Provide direct care and counsel to individuals and groups;

2. Plan, evaluate, and direct care given by others; and

3. Improve care by consultation, collaboration, teaching, and the conduct of research.

Part V
Disciplinary and Delegation Provisions

18VAC90-19-230. Disciplinary provisions.

A. The board has the authority to deny, revoke, or suspend a license or multistate licensure privilege issued, or to otherwise discipline a licensee or holder of a multistate licensure privilege upon proof that the licensee or holder of a multistate licensure privilege has violated any of the provisions of §

54.1-3007 of the Code of Virginia. For the purpose of establishing allegations to be included in the notice of hearing, the board has adopted the following definitions:

1. Fraud or deceit in procuring or maintaining a license means, but shall not be limited to:

a. Filing false credentials;

b. Falsely representing facts on an application for initial license, reinstatement, or renewal of a license; or

c. Giving or receiving assistance in the taking of the licensing examination.

2. Unprofessional conduct means, but shall not be limited to:

a. Performing acts beyond the limits of the practice of professional or practical nursing as defined in Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia, or as provided by §§ 54.1-2901 and 54.1-2957 of the Code of Virginia;

b. Assuming duties and responsibilities within the practice of nursing without adequate training or when competency has not been maintained;

c. Obtaining supplies, equipment, or drugs for personal or other unauthorized use;

d. Employing or assigning unqualified persons to perform functions that require a licensed practitioner of nursing;

e. Falsifying or otherwise altering patient, employer, student, or educational program records, including falsely representing facts on a job application or other employment-related documents;

f. Abusing, neglecting, or abandoning patients or clients;

g. Practice of a clinical nurse specialist beyond that defined in 18VAC90-19-220 and § 54.1-3000 of the Code of Virginia;

h. Representing oneself as or performing acts constituting the practice of a clinical nurse specialist unless so registered by the board;

i. Delegating nursing tasks to an unlicensed person in violation of the provisions of Part VI (18VAC90-19-240 et seq.) of this chapter;

j. Giving to or accepting from a patient or client property or money for any reason other than fee for service or a nominal token of appreciation;

k. Obtaining money or property of a patient or client by fraud, misrepresentation, or duress;

l. Entering into a relationship with a patient or client that constitutes a professional boundary violation in which the nurse uses his professional position to take advantage of the vulnerability of a patient, a client, or his family, to include actions that result in personal gain at the expense of the

patient or client, or a nontherapeutic personal involvement or sexual conduct with a patient or client;

m. Violating state laws relating to the privacy of patient information, including § 32.1-127.1:03 the Code of Virginia;

n. Providing false information to staff or board members in the course of an investigation or proceeding;

o. Failing to report evidence of child abuse or neglect as required in § 63.2-1509 of the Code of Virginia or elder abuse or neglect as required in § 63.2-1606 of the Code of Virginia; or

p. Violating any provision of this chapter.

B. Any sanction imposed on the registered nurse license of a clinical nurse specialist shall have the same effect on the clinical nurse specialist registration.

Part VI
Delegation of Nursing Tasks and Procedures

18VAC90-19-240. Definitions for delegation of nursing tasks and procedures.

The following words and terms when used in this part shall have the following meanings unless the content clearly indicates otherwise:

"Delegation" means the authorization by a registered nurse to an unlicensed person to perform selected nursing tasks and procedures in accordance with this part.

"Supervision" means guidance or direction of a delegated nursing task or procedure by a qualified, registered nurse who provides periodic observation and evaluation of the performance of the task and who is accessible to the unlicensed person.

"Unlicensed person" means an appropriately trained individual, regardless of title, who receives compensation, who functions in a complementary or assistive role to the registered nurse in providing direct patient care or carrying out common nursing tasks and procedures, and who is responsible and accountable for the performance of such tasks and procedures. With the exception of certified nurse aides, this shall not include anyone licensed or certified by a health regulatory board who is practicing within his recognized scope of practice.

18VAC90-19-250. Criteria for delegation.

A. Delegation of nursing tasks and procedures shall only occur in accordance with the plan for delegation adopted by the entity responsible for client care. The delegation plan shall comply with provisions of this chapter and shall provide:

1. An assessment of the client population to be served;

2. Analysis and identification of nursing care needs and priorities;

3. Establishment of organizational standards to provide for sufficient supervision that assures safe nursing care to meet the needs of the clients in their specific settings;

4. Communication of the delegation plan to the staff;

5. Identification of the educational and training requirements for unlicensed persons and documentation of their competencies; and

6. Provision of resources for appropriate delegation in accordance with this part.

B. Delegation shall be made only if all of the following criteria are met:

1. In the judgment of the delegating nurse, the task or procedure can be properly and safely performed by the unlicensed person and the delegation does not jeopardize the health, safety, and welfare of the client.

2. The delegating nurse retains responsibility and accountability for nursing care of the client, including nursing assessment, planning, evaluation, documentation, and supervision.

3. Delegated tasks and procedures are within the knowledge, area of responsibility, and skills of the delegating nurse.

4. Delegated tasks and procedures are communicated on a client-specific basis to an unlicensed person with clear, specific instructions for performance of activities, potential complications, and expected results.

5. The person to whom a nursing task has been delegated is clearly identified to the client as an unlicensed person by a name tag worn while giving client care and by personal communication by the delegating nurse when necessary.

C. Delegated tasks and procedures shall not be reassigned by unlicensed personnel.

D. Nursing tasks shall only be delegated after an assessment is performed according to the provisions of 18VAC90-19-260.

18VAC90-19-260. Assessment required prior to delegation.

Prior to delegation of nursing tasks and procedures, the delegating nurse shall make an assessment of the client and unlicensed person as follows:

1. The delegating nurse shall assess the clinical status and stability of the client's condition; determine the type, complexity, and frequency of the nursing care needed; and delegate only those tasks that:

a. Do not require the exercise of independent nursing judgment;

b. Do not require complex observations or critical decisions with respect to the nursing task or procedure;

c. Frequently recur in the routine care of the client or group of clients;

d. Do not require repeated performance of nursing assessments;

e. Utilize a standard procedure in which the tasks or procedures can be performed according to exact, unchanging directions; and

f. Have predictable results and for which the consequences of performing the task or procedures improperly are minimal and not life threatening.

2. The delegating nurse shall also assess the training, skills, and experience of the unlicensed person and shall verify the competency of the unlicensed person to determine which tasks are appropriate for that unlicensed person and the method of supervision required.

18VAC90-19-270. Supervision of delegated tasks.

A. The delegating nurse shall determine the method and frequency of supervision based on factors that include:

1. The stability and condition of the client;

2. The experience and competency of the unlicensed person;

3. The nature of the tasks or procedures being delegated; and

4. The proximity and availability of the registered nurse to the unlicensed person when the nursing tasks will be performed.

B. In the event that the delegating nurse is not available, the delegation shall either be terminated or delegation authority shall be transferred by the delegating nurse to another registered nurse who shall supervise all nursing tasks delegated to the unlicensed person, provided the registered nurse meets the requirements of 18VAC90-19-250 B 3.

C. Supervision shall include:

1. Monitoring the performance of delegated tasks;

2. Evaluating the outcome for the client;

3. Ensuring appropriate documentation; and

4. Being accessible for consultation and intervention.

D. Based on an ongoing assessment as described in 18VAC90-19-260, the delegating nurse may determine that delegation of some or all of the tasks and procedures is no longer appropriate.

18VAC90-19-280. Nursing tasks that shall not be delegated.

A. Nursing tasks that shall not be delegated are those that are inappropriate for a specific, unlicensed person to perform on a specific patient after an assessment is conducted as provided in 18VAC90-19-260.

B. Nursing tasks that shall not be delegated to any unlicensed person are:

1. Activities involving nursing assessment, problem identification, and outcome evaluation that require independent nursing judgment;

2. Counseling or teaching except for activities related to promoting independence in personal care and daily living;

3. Coordination and management of care involving collaboration, consultation, and referral;

4. Emergency and nonemergency triage;

5. Administration of medications except as specifically permitted by the Virginia Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia); and

6. Circulating duties in an operating room.

CORE COMMITTEE AGENDA
January 30, 2018

I. Review of the Educational Reports for 2014 and 2016

II. Plans for future Committee Meeting

III. Any additional business

Virginia Board of Nursing
Nurse Aide Education Curriculum
Meeting Agenda
January 30, 2018

3:00 p.m.	Introductions
3:15 p.m.	Review of Information distributed by Vivienne McDaniel (Background FYI Information, Summary, and PowerPoint)
3:45 p.m.	Suggested additions to the regulations and/or the curriculum by each stakeholder and Board staff. Begin with Unit VIII.
4:45 p.m.	Wrap-up and Next Steps
5:00 p.m.	Adjourn

Informal Summary Brief on Nurse Aide Education

January 2, 2018

Nurse aide training data was reviewed from 2002 to 2017 (15 years) to determine findings and recommendations from various reports and studies. There was a plethora of data, but only four were selected for this brief.

Background:

- Omnibus Budget Reconciliation Act of 1987 (OBRA 87) mandated that nurse aide training consist of no less than 75 hours (OIG, 2002.)
- Longitudinal data suggests that acuity levels and complexity of care for elderly people in long-term care (LTC) settings have increased exponentially since the passage of the OBRA 87 (Hernandez-Medina, Eaton, Hurd, & White, 2006; Office of Inspector General [OIG], 2002; Trinkoff et al., 2017).
- The Institute of Medicine's seminal report "Improving the Quality of Long-Term Care" (2001), identified problem areas, and offered recommendations for strengthening the caregiving workforce.
- Certified nursing assistants (CNAs) make up 60 to 70 percent of the total nursing staff in nursing homes and provide 80 to 90 percent of the direct care for nursing home residents (Hernandez-Medina, Eaton, Hurd, & White, 2006).
- Direct-care workers (nurse aides, home health aides, and personal care aides) are the primary providers of paid hands-on care to older adults, yet they are inadequately trained in geriatric care (IOM, 2008).
-

Findings from a study conducted by the OIG in 2002 (https://oig.hhs.gov/oei/reports/oei-05-01-00030.pdf):

- Training has not kept pace with nursing home practices and new technologies;
- Teaching methods are often ineffective, clinical exposure is too short and unrealistic;
- Nurse aides seek improved clinical experience;
- Nursing home supervisors stressed the importance of early clinical exposure to prepare and screen students
- **Respondents felt that the following teaching methods and formats *impeded* nurse aide training**:
  - poor instructional videotapes and presentations
  - too much medical technology jargon
  - classes "taught over the heads" of students
  - failure to recognize diversity or backgrounds of students, including language barriers
  - emphasis on tasks, rather than interpersonal communication skills
  - teaching skills that will not be used often

- lack of feedback on the quality of the program
- training which lacks geriatric framework
- one-size-fits-all approaches to teaching
- limited time to practice clinical skills

Recommendations from a study conducted by Hernandez-Medina, Eaton, Hurd, and White (2006) for the AARP Public Policy Institute:

- For federal and state policymakers, the study indicates a need to increase clinical training to at least 50 to 60 hours
- Upgrading training programs to screen applicants before enrollment can improve the proportion of students who successfully complete the programs and become CNAs
- Increase clinical skills training
- Address the need for remedial and English as a second language courses

Recommendations from the seminal study, *Retooling for an Aging American*, conducted by the IOM (2008) (http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2008/Retooling-for-an-Aging-America-Building-the-Health-Care-Workforce/ReportBriefRetoolingforanAgingAmericaBuildingtheHealthCareWorkforce.pdf):

- The definition of the health care workforce must be expanded to include everyone involved in a patient's care: health care professionals, direct-care workers, informal caregivers (usually family and friends), and patients themselves
- Enhance the geriatric competence of the entire workforce
- Increase the recruitment and retention of geriatric specialists and caregivers
- Improve the way care is delivered
- Health care professionals should be required to demonstrate their competence in the care of older adults as a criterion of licensure and certification

Findings from Trinkoff et al. (2017):

- Research has shown that well-trained CNAs are essential to providing quality care in NHs (Trinkoff et al., 2013, 2016)
- Receiving adequate training can increase CNA job satisfaction and retention (Han et al., 2014), and decrease turnover rates; important factors that may affect care quality. In fact, CNAs themselves felt
- Training did not adequately prepare CNAs for their jobs
- CNAs expressed the need for more training hours, particularly for more clinical time (Hernández-Medina et al., 2006; Sengupta et al., 2010)
- Recently, the Institute of Medicine recommended that at least 120 total hours, or 3 weeks, of total training be required for CNAs. The current study's finding of 4 weeks for total

training hours adds 1 week to that recommendation. This extra week of training could be critical.

References

Han, K., Trinkoff, A. M., Storr, C. L., Lerner, N., Johantgen, M., & Gartrell, K. (2014). Associations between state regulations, training length, perceived quality and job satisfaction among certified nursing assistants: Cross-sectional secondary data analysis. *International Journal of Nursing Studies*, *51*, 1135–1141. https://doi.org/10.1016/j.ijnurstu.2013.12.008

Hernandez-Medina, E., Eaton, S., Hurd, D., & White, A. (2006). *Training programs for certified nursing assistants* [Executive summary]. Retrieved from The AARP Public Policy Institute: https://assets.aarp.org/rgcenter/il/2006_08_cna.pdf.

Institute of Medicine (2008). *Retooling for an aging America: Rebuilding the health care workforce* [Report brief]. Retrieved from http://www.nationalacademies.org/hmd/reports/2008/retooling-for-an-aging-america-building-the-health-care-workforce.aspx

Office of the Inspector General (OIG) (2002). *Nurse aide training* [Executive summary]. Retrieved from Department of Health and Human Services: https://oig.hhs.gov/oei/reports/oei-05-01-00030.pdf

Trinkoff, A. M., Yang, B. K., Storr, C. L., Zhu, S., Lerner, N. B., & Han, K. (2017). Determining the CNA training-hour requirement for quality care in U. S. nursing homes. *Journal of Nursing Regulation*, *8*(1), 1-10.

FYI

To: The State Board of Nursing Nurse Aide Committee

From: Vivienne Pierce McDaniel

January 02, 2017

I have spent considerable time evaluating four NAEPs. The NAEP that seems to be the most geriatric specific program is North Carolina's. Duke University's nursing program played an integral role in developing that program. Perhaps we can partner with the VCU's gerontological program or University of Virginia's Geriatric Nursing program.

I had a conversation with Deborah Rinker, Customer Sales Representative from Hartman's Publishing in November. The Hartman's Nursing Assistant Care- Long Term Care and Home Care, second edition is an excellent text and aligns well with our NAEP curriculum. We have been provided a crosswalk for NAEP coordinators who use the text. I have reviewed the Crosswalk that Deborah Rinker sent from Hartman's. She sent me the text book that goes with the crosswalk. I'm trying to determine if there is additional information that we can add to the NAEP curriculum.

I think that adding some of the discussion questions in the different units is something we should discuss at the next meeting. Also, some of the other nurse aide programs I reviewed provide test banks. If the committee think that is feasible, I can work on that, albeit it will take some time.

To improve training for NAEP instructors, and to ensure they are better prepared to teach student nurse aides geriatric care processes, I recommend that we develop an annual CNA nurse educator's conference that offers workshops, vendors, etc. Deborah Rinker and I discussed this and she has sent me information from other states that offer conferences for NAEP coordinators and instructors.

> Deborah Rinker said this: "*The states that have a CNA educators meeting that we have attended at Arizona, South Carolina, Ohio, Pennsylvania, Illionois, and Iowa. When you are ready to get into this deeper, let me know and we can get you links to the sights of these conferences and contacts that can let you know what brings the nurses to their meeting. All of these have been around for a few years and they do evaluation forms so can improve the meetings." I have attached a copy of a letter we send out when we are checking out a conference before we attend it. Conferences that meet this list usually have attendance of large percentage of the programs. Most of these conferences have 150 people in attendance. They haven't always had that many but they do now.*

Hello Vivienne,

Thank you for the information regarding the conference! Gatherings like this one can be a great place for us to share thoughts, challenges, and ideas with nursing assistant instructors and program coordinators. Because our sales representatives spend so much time preparing for and traveling to conferences, we want to make sure this trip is a good fit for us. To that end, can you please take a few minutes to answer the following questions? Your responses will help us decide whether or not we should attend this year's conference.

- Will a representative from a state agency that approves nursing assistant training attend?
- Will someone from the nursing assistant competency testing organization attend?
- How does your conference set-up encourage foot traffic to the exhibitor tables?
- Are continuing education credits given to attendees?
- Approximately how many nursing assistant instructors or program coordinators attended this conference last year? How many are you expecting this year?
- Are vendors invited to join meetings and discussions during this conference? And do you have a detailed itinerary you can share at this point?

Please feel free to share anything else we should know about your conference. Thank you so much for your time. We look forward to working with you!

Be Heard at Hartman!

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NURSE AIDE CARE MODEL FOR GERIATRICS

EDUCATING THE LONG-TERM CARE NURSE AIDE WORKFORCE

The Prevention Module of the 4-Part Geriatric Initiative for Vocational Education on Person-Centered Care (GIVEPCC) Project

Vivienne McDaniel, MSN, RN
Doctor of Nursing Practice Student
Walden University

THE NURSE AIDES ROLE IN GERIATRIC CARE

General Problems

- Nurse aide students do not have a standardized evidence-based geriatric care process to guide them in their practice.
- Nurse aide training lacks a geriatric framework
- Not enough skills practice and clinical hours

Background

- Nurse aide training has not kept pace with the growing needs of chronically ill geriatric residents (OIG, 2002).
- Nurse aides provide over 65% of care in long-term care (LTC) settings (Trinkoff et al., 2017)
- There are no standardized procedures and protocols for nurse aide practice

Purpose

- Adequately prepared nurse aides are crucial if nursing home residents are to receive quality care (Hernandez-Medina et al., 2006).

Literature Review

- Literature supports a need for enhancing nurse aide education (IOM, 2008; OIG, 2002; Trinkoff et al. 2017,), but a gap exists for the type of interventions to improve student nurse aide training
- Number of hours for training are limited (Trinkoff et al., 2017)
- Nurse aides lack geriatric competence (IOM, 2008)
- Training has not kept pace with nursing home practices and new technologies (OIG, 2002)

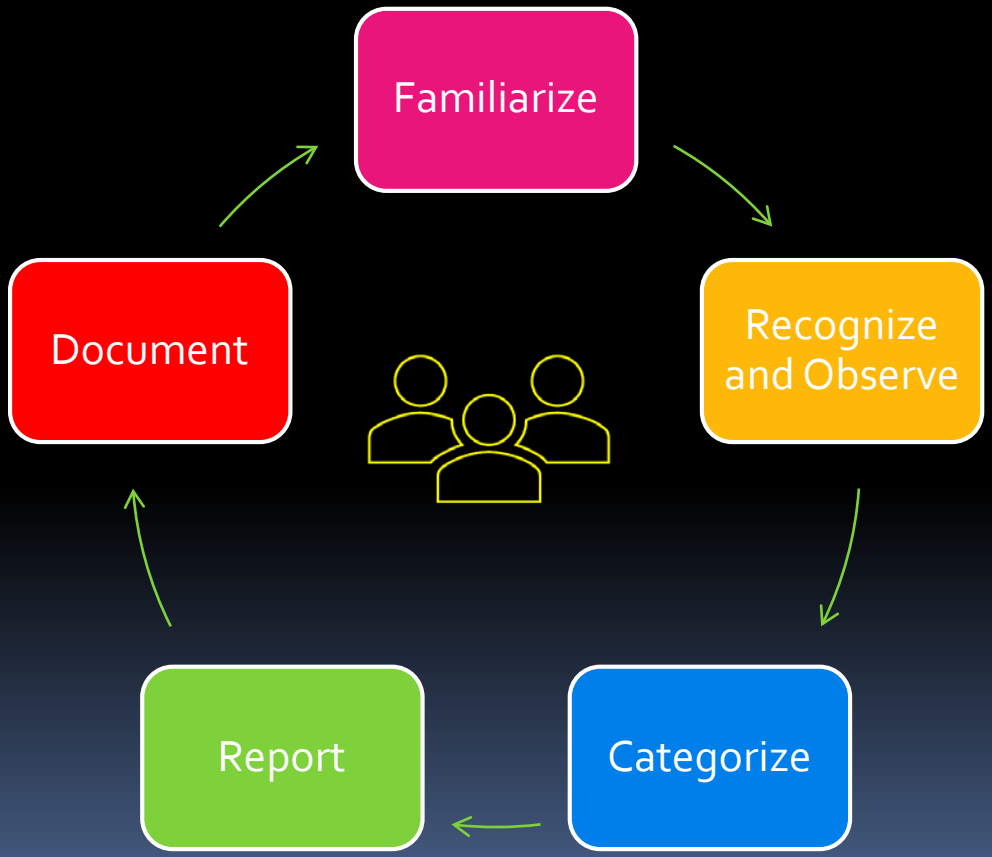
Strategies for Improving Nurse Aide Roles

- Provide nurse aides with additional training in recognizing and reporting status changes in at-risk geriatric residents
- Empower nurse aides to be able to report status changes using a standardized care process
- Teach nurse aides how to be integral participates of the resident care team

Recommendations for Improving Nurse Aide Training

- Increase the number of NAEP curriculum hours to better prepare student nurse aides for "real world" LTC settings that house the geriatric population.
- Integrate an appropriate geriatric framework(s) in the NAEP curriculum.
- Introduce nurse aides to a care process that guides them in recognizing undesirable status changes in geriatric residents.

NURSE AIDES CANNOT ASSESS, BUT THEY CAN



FAMILIARIZE

- Take the time to acquaint yourself to the resident and family members
- Know your unit and facility
- Know your CNA associates and other co-workers
- Know your assignment
- Know best practices for providing care

Recognize and Observe

Observe the resident's normal state or base-line

Recognize and observe immediate changes in status

Recognize and observe subtle changes in status

CATEGORIZE (STATUS CHANGES)

PHYSICAL

Eating, Toileting (intake/output)

Skin integrity

Pain

Weight change

Mobility

Sleep pattern

MENTAL

Agitated/increased nervousness

Confused

Communicates Less

Seems different than usual

Mood

Behavior

REPORT STATUS CHANGES IN:

- Vital signs (breathing/respirations, pulse, blood pressure, heart rate)
- Skin integrity
- Bladder/bowel
- Social habits, sleeping habits, mood
- Eating habits, weight loss, weight gain

DOCUMENT STATUS CHANGES IN:

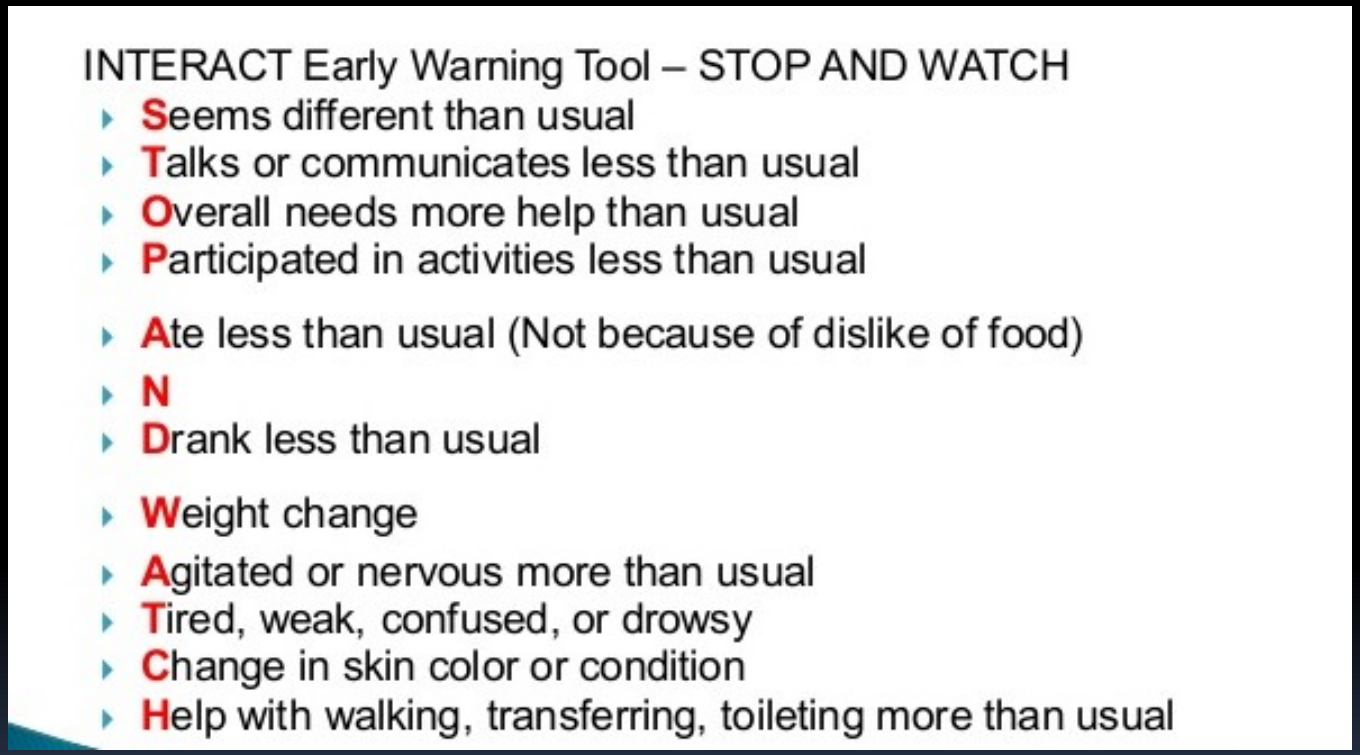
- Vital signs (breathing/respirations, pulse, blood pressure, heart rate)
- Skin integrity
- Bladder/bowel
- Social habits, sleeping habits, mood
- Eating habits, weight loss, weight gain


Familiarize
Recognize
Observe
Categorize
Report
Document
Resident
Family
Members

The INTERACT Stop & Watch Tool

- The INTERACT (Interventions to Reduce Care Transfers) Quality Improvement Program (Ouslander & Shutes, 2014)
- Use the INTERACT Stop and Watch tool to report status changes in residents.
- Use the INTERACT Stop & Watch tool to prevent unnecessary hospitalizations and other avoidable sentinel events.

INTERACT Early Warning Stop and Watch Tool



https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3921692/
http://www.pathway-interact.com/

Provide Nurse Aide Instructors with Geriatric Specific Resources

Geriatric Models of Care for Nurse Aide Instructors

- The Grace Model (Geriatric Resources for Assessment and Care of Elders)
- The Kindred Healthcare Model of Post-acute Care
- The Guided Care Model
- The NICHE Model (Nurses Improving Care of Healthsystem Elders)
- The Stanford Chronic Disease Self-Management Program (CDSMP)
- The Wisconsin Star Method
- The INTERACT Quality Improvement Program

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