**Committee of Joint Boards of Nursing and Medicine**
**and Advisory Committee of Joint Boards of Nursing and Medicine**

Department of Health Professions
Perimeter Center - 9960 Mayland Drive, Conference Center, Suite 201, Henrico, Virginia 23233

**Business Meeting Agenda**
**April 11, 2018 at 10:00 A.M. in Board Room 2**

**Call To Order** - Louise Hershkowitz, CRNA, MSHA; Chair

**Establishment of Quorum**

**Announcement**
- Welcome to new Joint Boards Members: Joyce A. Hahn, PhD, RN, NEA-BC, FNAP

**Review of Minutes**
- February 7, 2018 Business Meeting
- February 7, 2018 Special Conference Committee

**Public Comment**

**Dialogue with Agency Director** – **Dr. Brown**

**Old Business:**
- Regulatory Update – **Ms. Yeatts**
- Report on 2018 General Assembly – **Ms. Yeatts**

**Policy Forum:** Dr. Carter, Healthcare Workforce Data Center (HWDC) Executive Director, and Dr. Shobo, PhD, HWDC Deputy Executive Director
- Virginia's Nurse Practitioner Workforce: Composition by Specialty 2018 Report

**New Business**
- Board of Nursing Executive Director Report – **Ms. Douglas**
- Development of Regulatory Time related to HB 793 (NP Bill)

**Probable Cause Review** - Joint Boards Members Only

**Next Meeting - Thursday, May 17, 2018, at 9:00 A.M in Training Room 1**
- HB 793 Regulatory Proposal meeting – Joint Boards Members and Advisory Committee Members

**Adjourn**

**2:00 P.M** – Disciplinary Proceeding begins

# VIRGINIA BOARD OF NURSING
# COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
# BUSINESS MEETING MINUTES
**February 7, 2018**

DRAFT

TIME AND PLACE: The meeting of the Committee of the Joint Boards of Nursing and Medicine was convened at 9:04 A.M., February 7, 2018 in Board Room 2, Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

MEMBERS PRESENT:
Louise Hershkowitz, CRNA. MSHA; Chair
Marie Gerardo, MS, RN, ANP-BC
Kevin O'Connor, MD
Kenneth Walker, MD

MEMBERS ABSENT:
Joyce A. Hahn, PhD, RN, NEA-BC, FNAP
Lori Conklin, MD

ADVISORY COMMITTEE MEMBERS PRESENT:
Kevin E. Brigle, RN, NP
Mark Coles, RN, BA, MSN, NP-C
Wendy Dotson, CNM, MSN
Sarah E. Hobgood, MD
Thokozeni Lipato, MD
Stuart F. Mackler, MD
Janet L. Setnor, CRNA

STAFF PRESENT:
Jay P. Douglas, MSM, RN, CSAC, FRE; Executive Director; Board of Nursing
Robin L. Hills, DNP, RN, WHNP; Deputy Executive Director for Advanced Practice; Board of Nursing
Lisa Speller-Davis, BSN, RN; Policy Assistant; Board of Nursing
Huong Vu, Executive Assistant; Board of Nursing
Darlene Graham, Discipline Staff; Board of Nursing

OTHERS PRESENT:
Charis Mitchell, Assistant Attorney General; Board Counsel
David Brown, DC; Director; Department of Health Professions
Elaine Yeatts, Senior Policy Analyst, Department of Health Professions
William L. Harp, MD, Executive Director; Board of Medicine

IN THE AUDIENCE:
Kelsey Hall, RN, University of Virginia (UVA) Student
Diana Rodriguez, RN, UVA Student
Mary Duggan, American Association of Nurse Practitioners (AANP)
Kassie Schroth, Medical Society of Virginia

INTRODUCTIONS: Committee members, Advisory Committee members and staff members introduced themselves.

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

ANNOUNCMENT: Ms. Hershkowitz welcomed Ms. Setnor as the CRNA member on the Advisory Committee to the Committee of the Joint Boards of Nursing and Medicine.

REVIEW OF MINUTES: The minutes of October 11, 2017 Special Conference Committee, Formal Hearing, and Business Meeting, were reviewed. Ms. Gerardo moved to accept all of the minutes as presented. The motion was seconded and passed unanimously.

PUBLIC COMMENT: There was no public comment received.

OLD BUSINESS: **Regulatory Update:**

Ms. Yeatts reviewed the chart of regulatory actions as provided in the Agenda.

Ms. Yeatts presented proposed changes to the Pain Management Emergency Regulations:

- **18VAC90-40. Regulations for Prescriptive Authority for Nurse Practitioners**
  - **220(D) Opioid therapy for chronic pain**
    8/24/17: "*The practitioner shall order and review a urine drug screen or serum medication levels at the initiation of chronic pain management and at least every three months for the first year of treatment and at least every six months thereafter.*"
    Proposed: To reduce costs and to allow practitioners to retain discretion whether or not to administer a test as noted in the Economic Impact Analysis, it has been proposed to change "*and at least every three months for the first year of treatment and at least every six months thereafter*" to ***at the initiation of chronic pain management and randomly at least once per year***.
  - **18VAC90-40-270. Treatment with buprenorphine**
    8/24/17: "*For patients who have a demonstrated intolerance to naloxone; such prescriptions for the mono-product shall not exceed 3% of the total prescriptions for buprenorphine written by the prescriber, and the exception shall be clearly documented in the patient's medical record.*"
    Proposed: Change "3%" to **7-8%**
  - **Adding Sickle Cell Disease** to the list of exemptions.
  - **Adding the requirement** that the indication of use (acute or chronic) be noted on the written prescription.
  - **Specifically identifying Tramadol** as an atypical opioid

**Update on NOIRA for Eliminating of a Separate Prescriptive Authority License:**

Ms. Yeatts stated that the NOIRA is still at the Secretary's Office and will not be reviewed until the General Assembly regular session has ended.

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**Proposed Regulations for Performance of and for Supervision and Direction of Laser Hair Removal:**
Ms. Yeatts noted that the HB2119 was passed by the 2017 General Assembly and became law as of July 1, 2017. Ms. Yeatts stated that the regulations for nurse practitioners will need to be amended to define "direction and supervision."

Board of Medicine (BOM) Regulatory Advisory Panel (RAP) on Laser Hair Removal met on November 20, 2017 to develop draft regulations that provide guidance regarding the statutory language: " . . . *or by a properly trained person under the direction and supervision of a licensed* . . ."

Ms. Yeatts added that copies of supporting documents are presented for the Committee's review and action. She suggested the Committee approve the proposed regulations as recommended by the BOM RAP. Dr. O'Connor moved to approve the proposed regulations as presented. The motion was seconded and carried unanimously.

**Report on 2018 General Assembly:**
Ms. Yeatts reviewed the Report of the 2018 General Assembly that contains bills relevant to nurse practitioner practice.

Ms. Yeatts provided a copy of the most current version of HB793 and reviewed the proposed amendments. Ms. Yeatts commented that the bill:

- Eliminates the requirement for a practice agreement with a patient care team physician for nurse practitioners who are licensed by the BOM and BON and have completed at least certain numbers of hour of clinical experience as a licensed, certified nurse practitioner.
- Replaces the term "patient care team physician" with the term "collaborating provider."
- 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 of a practice agreement.
- Establishes title protection for advanced practice registered nurses, nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists and otherwise does not affect certified registered nurse anesthetists or certified nurse midwives.
- Contains technical amendments.

Ms. Yeatts noted that she anticipated there would be changes to this bill. Ms. Yeatts responded to questions from the Advisory Committee and Joint Boards members.

Ms. Dodson commented that she understood the goal of the bill is not independence practice but autonomous practice as all mid-level providers

routinely consult with others on complex cases and situations is beyond their expertize.

DIALOGUE WITH AGENCY DIRECTOR:

Dr. Brown reported the following:

- There are many new people in the House this year. More bills have been assigned to DHP than in previous years.
- Governor Northam made serval appointments that affect DHP:
  - Lisa Speller-Davis as Policy Assistant assigned to Board of Nursing
  - Barbara Allison-Bryant as DHP Chief Deputy who will start in March 2018
  - Dr. Brown was reappointed as DHP Director

Dr. Brown added that Lisa Hahn, current DHP Chief Deputy, has transferred into the DHP Chief Operation Officer (COO) position, as of November 2017.

POLICY FORUM:

**2017 Virginia's Licensed Nurse Practitioner Workforce:**

Drs. Carter and Shobo reviewed the report provided in the Agenda package noting that HRSA Health Workforce projected a sufficient supply of nurse practitioners in 2025.

Ms. Hershkowitz requested Dr. Carter breakout the most recent data into the 3 categories of LNPs -- CRNAs, CNMs, and NPs – to be presented at the April 11th Committee of the Joint Boards meeting. The Committee of the Joint Boards will discuss in April the need for additional questions to be included in the NP workforce survey. Ms. Dodson asked that the number of licensees for each category be included in the April reports.

RECESS: The Board recessed at 10:50 AM

RECONVENTION: The Board reconvened at 11:05 AM

NEW BUSINESS:

**Board of Nursing Executive Director Report:**

Ms. Douglas reported the following:

- The issue of separate prescriptive authority licensure is addressed in the NOIRA.
- Board of Nursing will have an intern this summer who will assist Board staff in cleaning up the NP licensing data with particular attention to specialty categories. Once this project is completed, NP data will be provided to NURSYS.
- Board staff continues to receive many questions from Office Managers, HR Personnel, and Practice Managers regarding the scope of practice of nurse practitioners.

**RECOMMENDATIONS AND CONSENT ORDER FOR CONSIDERATION**

CLOSED MEETING: Ms. Gerardo moved that the Committee of the Joint Boards of Nursing and Medicine and the Board of Nursing convene a closed meeting pursuant to Section 2.2-3711(A)(27) of the *Code of Virginia* at 11:15 A.M. for the purpose of deliberation to consider Agency Subordinate recommendations and Consent Order. Additionally, Ms. Gerardo moved that Ms. Douglas, Dr. Hills, Ms. Speller-Davis, Ms. Vu, 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 Committee in its deliberations. The motion was seconded and carried unanimously.

RECONVENTION: The Committee reconvened in open session at 11:25 P.M.

Ms. Gerardo moved that the Committee of the Joint Boards of Nursing and Medicine and 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.

**Margaret Lankford Hockeborn, LNP 0024-086760**
Dr. O'Connor moved to accept the Agency Subordinate recommendation to reprimand Margaret Lankford Hockeborn. The motion was seconded and carried unanimously.

**Michael Jahrling St. John, LNP 0024-172383**
Dr. O'Connor moved to accept the Agency Subordinate recommendation to indefinitely suspend the license of Michael Jarhling St. John to practice as a nurse practitioner in the Commonwealth of Virginia. The motion was seconded and carried unanimously.

**Patricia Anne O'Neil-Sears, LNP 0024-092286**
Dr. O'Connor moved to accept the Agency Subordinate recommendation to indefinitely suspend the right of Patricia Anne O'Neil-Sears to renew her license to practice as a nurse practitioner in the Commonwealth of Virginia. The motion was seconded and carried unanimously.

**Jennifer Anne Sargent, LPN 0024-173398**
Dr. O'Connor moved to accept the consent order to indefinitely suspend the license of Jennifer Anne Sargent to practice as a nurse practitioner in the Commonwealth of Virginia. The said suspension is stayed upon proof of Ms. Sargent's entry into a Contract with the Virginia Health Practitioners' Monitoring Program (HPMP) and comply with all terms and conditions of the HPMP for the period specified by the HPMP. The motion was seconded and passed unanimously.



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ADJOURNMENT: As there was no additional business, the meeting was adjourned at 11:27 A.M.

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

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VIRGINIA BOARD OF NURSING
SPECIAL CONFERENCE COMMITTEE OF THE BOARD OF NURSING AND THE COMMITTEE OF THE JOINT BOARDS OF NURSING AND MEDICINE
MINUTES
February 7, 2018

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 1:05 P.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:
Robin Hills, DNP, WHNP, Deputy Director, Board of Nursing
Anne Joseph, Deputy Director, Administrative Proceedings Division

CONFERENCES SCHEDULED: **Sergio Arancibia, RN, LNP, 0001-193046; 0024-168466**

Mr. Arancibia appeared, accompanied by Kevin Weldon, 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 2:31 P.M. for the purpose of deliberation to reach a decision in the matter of Mr. Arancibia. Additionally, Ms. Gerardo moved that 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 3:38 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 of reprimand and require Mr. Arancibia to complete (3) NCSBN courses within 90 days of entry of the Order and provide proof of completion to the Board, to practice as a professional nurse in the Commonwealth of Virginia.

The motion was seconded and carried unanimously.

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An Order will be entered. As provided by law, this decision shall become a Final Order thirty days after service of such order on Mr. Arancibia unless a written request to the Board for a formal hearing on the allegations made against him is received from Mr. Arancibia 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.

ACTION: Dr. Walker moved to issue an Order of reprimand and require Mr. Arancibia to complete (3) NCSBN courses within 90 days of entry of the Order and provide proof of completion to the Board, to practice as a nurse practitioner in the Commonwealth of Virginia.

The motion was seconded and carried unanimously.

An Order will be entered. As provided by law, this decision shall become a Final Order thirty days after service of such order on Mr. Arancibia unless a written request to the Board for a formal hearing on the allegations made against him is received from Mr. Arancibia 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 3:42 P.M.

Robin L. Hills, DNP, RN, WHNP
Deputy Executive Director

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# Agenda Item: Regulatory Actions - Chart of Regulatory Actions
## As of April 10, 2018

| | | |
|---|---|---|
| [18 VAC 90 - 30] | Regulations Governing the Licensure of Nurse Practitioners | Supervision and direction of laser hair removal [Action 4863]<br>*Proposed – at AG office* |
| [18 VAC 90 - 40] | Regulations for Prescriptive Authority for Nurse Practitioners | Elimination of separate license for prescriptive authority [Action 4958]<br>*NOIRA – At Secretary's Office for 26 days* |
| [18 VAC 90 - 40] | Regulations for Prescriptive Authority for Nurse Practitioners | Prescribing of opioids [Action 4797]<br>Proposed - *At Secretary's Office for 130 days* |

# Report of the 2018 General Assembly

# Committee of the Joint Boards

**HB 226 Patients; medically or ethically inappropriate care not required.**

*Chief patron:* Stolle

*Summary as passed House:*

**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. This bill is identical to SB 222.

**HB 793 Nurse practitioners; practice agreements.**

*Chief patron:* Robinson

*Summary as passed:*

**Nurse practitioners; practice agreements.** Eliminates the requirement for a practice agreement with a patient care team physician for a licensed nurse practitioner who has completed the equivalent of at least five years of full-time clinical experience and submitted an attestation from his patient care team physician stating (i) that the patient care team physician has served as a patient care team physician on a patient care team with the nurse practitioner pursuant to a practice agreement; (ii) that while a party to such practice agreement, the patient care team physician routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed; and (iii) the period of time for which the patient care team physician practiced with the nurse practitioner under such a practice agreement. The bill requires that a nurse practitioner authorized to practice without a practice agreement (a) only practice within the scope of his clinical and professional training and limits of his knowledge and experience and consistent with the applicable standards of care, (b) consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided, and (c) establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers. The bill requires (1) the Boards of Medicine and Nursing to jointly promulgate regulations governing the practice of nurse practitioners without a practice agreement; (2) the Department of Health Professions, by November 1, 2020, to report to the General Assembly a process by which nurse practitioners who practice without a practice agreement may be included in the online Practitioner Profile maintained by the Department of Health Professions; and (3) the Boards of Medicine and Nursing to report information related to the practice of nurse practitioners without a practice agreement that includes certain data, complaints and disciplinary actions, and recommended modifications to the provisions of this bill 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, 2021.

**HB 842 Controlled paraphernalia; possession or distribution, hypodermic needles and syringes, naloxone.**

*Chief patron:* LaRock

*Summary as passed House:*

**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. The bill also allows the dispensing or distributing of hypodermic needles and syringes by persons authorized to dispense naloxone. The bill contains an emergency clause.

03/02/18 Governor: Approved by Governor-Chapter 97 (effective 3/2/18)

**HB 915 Military medical personnel program; personnel may practice under supervision of physician, etc.**

*Chief patron:* Stolle

*Summary as passed House:*

**Military medical personnel program; supervision.** Directs the Department of Veterans Services to establish a program in which military medical personnel may practice and perform certain delegated acts that constitute the practice of medicine or nursing under the supervision of a licensed physician or podiatrist or the chief medical officer of an organization participating in such program, or his designee who is licensed by the Board of Medicine and supervising within his scope of practice. The bill allows the chief medical officer of an organization participating in such program to, in consultation with the chief nursing officer of such organization, designate a registered nurse licensed by the Board of Nursing or practicing with a multistate licensure privilege to supervise military personnel participating in such program while engaged in the practice of nursing. This bill is identical to SB 829.

**HB 1251 CBD oil and THC-A oil; certification for use, dispensing.**

*Chief patron:* Cline

*Summary as passed:*

**CBD oil and THC-A oil; certification for use; dispensing.** Provides that a practitioner may issue a written certification for the use of cannabidiol (CBD) 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 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. As introduced, this bill was a recommendation of the Joint Commission on Health Care. The bill contains an emergency clause. This bill is identical to SB 726.

03/09/18 Governor: Approved by Governor-Chapter 246 (effective 3/9/18)

**HB 1377 Epinephrine; possession and administration at outdoor educational programs.**

*Chief patron:* Torian

*Summary as passed:*

**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 and provides liability protection for such employees.

**HB 1378 Surgical assistants; renewal of registration.**

*Chief patron:* Robinson

*Summary as passed House:*

**Registration of surgical assistants; renewal of registration.** Provides that in cases in which a surgical assistant was initially registered on the basis of a credential as a surgical assistant or surgical first assistant issued by the National Board of Surgical Technology and Surgical Assisting, the National Surgical Assistant Association, or the National Commission for the Certification of Surgical Assistants or a successor thereof, the surgical assistant must attest that such credential is still current upon applying for renewal of his registration as a surgical assistant.

**HB 1524 Health record retention; practitioners to maintain records for a minimum of six years.**

*Chief patron:* Ingram

*Summary as passed:*

**Board of Medicine; regulations related to retention of patient records; time.** Requires health care practitioners licensed by the Board of Medicine to maintain health records for a minimum of six years following the last patient encounter. The bill also provides that practitioners are not required to maintain health records for longer than 12 years from the date of creation except for (i) health records of a minor child, which shall be maintained until the patient reaches the age of 18 or becomes emancipated, with a minimum of six years following the last patient encounter, and (ii) health records that are required by contractual obligation or federal law to be maintained longer.

03/16/18 Governor: Governor's Action Deadline Midnight, April 9, 2018

**SB 330 THC-A oil; dispensing, tetrahydrocannabinol levels.**

*Chief patron:* Dunnavant

*Summary as passed:*

**CBD and THC-A oil.** Adds cannabidiol oil (CBD oil) or THC-A oil to the list of covered substances the dispensing of which must be reported to the Prescription Monitoring Program. The bill requires a practitioner, prior to issuing a written certification for CBD oil or THC-A oil to a patient, to request information from the Director of the Department of Health Professions for the purpose of determining what other covered substances have been dispensed to the patient.

The bill requires the Board of Pharmacy to (i) promulgate regulations that include a process for registering CBD oil and THC-A oil products and (ii) require an applicant for a pharmaceutical processor permit to submit to fingerprinting and provide personal descriptive information to be forwarded through the Central Criminal Records Exchange to the Federal Bureau of Investigation for a criminal history record search. The bill requires a pharmacist or pharmacy technician, prior to the initial dispensing of each written certification, to (a) make and maintain for two years a paper or electronic copy of the written certification that provides an exact image of the document that is clearly legible;(b) view a current photo identification of the patient, parent, or legal guardian; and (c) verify current board registration of the practitioner and the corresponding patient, parent, or legal guardian. The bill requires that, prior to any subsequent dispensing of each written certification, the pharmacist, pharmacy technician, or delivery agent view the current written certification; a current photo identification of the patient, parent, or legal guardian; and the current board registration issued to the patient, parent, or legal guardian.

Finally, the bill requires a pharmaceutical processor to ensure that the percentage of tetrahydrocannabinol in any THC-A oil on site is within 10 percent of the level of tetrahydrocannabinol measured for labeling and to establish a stability testing schedule of THC-A oil.

EMERGENCY

03/30/18 Governor: Approved by Governor-Chapter 567 (effective 3/30/18)

**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.

02/01/18 Senate: Continued to 2019 in Education and Health (15-Y 0-N)

**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.

02/08/18 Senate: Continued to 2019 in Education and Health (15-Y 0-N)

**SB 511 Optometry; scope of practice.**

*Chief patron:* Suetterlein

*Summary as passed:*

**Optometry; scope of practice.** Provides that the practice of optometry includes the evaluation, examination, diagnosis, and treatment of abnormal or diseased conditions of the human eye and its adnexa by the use of medically recognized and appropriate devices, procedures, or technologies but that it does not include treatment through surgery, including laser surgery, other invasive modalities, or the use of injections, except for certain injections by TPA-certified optometrists and for the treatment of emergency cases of anaphylactic shock with intramuscular epinephrine. The bill authorizes a TPA-certified optometrist to administer therapeutic pharmaceutical agents by injection for the treatment of chalazia by means of an injection of a steroid included in Schedule VI controlled substances, provided that the optometrist provides written evidence that he has completed certain training requirements to the Board of Optometry.

**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 bill has an expiration date of July 1, 2022. This bill is identical to HB 1173.

**SB 728 Prescription Monitoring Program; prescriber and dispenser patterns, annual review, report.**

*Chief patron:* Dunnavant

*Summary as passed Senate:*

**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. This bill is identical to HB 313.

**SB 832 Prescription Monitoring Program; adds controlled substances included in Schedule V 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. This bill is identical to HB 1556.

**SB 882 Prescription refill; protocol.**

*Chief patron:* DeSteph

*Summary as passed Senate:*

**Prescription refill; approval.** Provides that a prescriber may authorize a registered nurse or licensed practical nurse to approve additional refills of a prescribed drug for no more than 90 consecutive days, provided that (i) the drug is classified as a Schedule VI drug; (ii) there are no changes in the prescribed drug, strength, or dosage; (iii) the prescriber has a current written protocol, accessible by the nurse, that identifies the conditions under which the nurse may approve additional refills; and (iv) the nurse documents in the patient's chart any refills authorized for a specific patient pursuant to the protocol and the additional refills are transmitted to a pharmacist in accordance with the allowances for an authorized agent to transmit a prescription orally or by facsimile pursuant to current law and regulations of the Board of Pharmacy.

# *Virginia's Licensed Nurse Practitioner Workforce: Comparison by Specialty*

Healthcare Workforce Data Center

April 2018

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***

***3,273 Licensed Nurse Practitioners 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, DC**
*Director*

**Barbara Allison-Bryan, MD**
*Chief Deputy Director*

*Healthcare Workforce Data Center Staff:*

Dr. Elizabeth Carter, PhD
*Executive Director*

Yetty Shobo, PhD
*Deputy Director*

Laura Jackson
*Operations Manager*

Christopher Coyle
*Research Assistant*

# Joint Boards of Nursing and Medicine

***Chair***

Louise Hershkowitz, CRNA, MSHA
*Reston*

***Members***

Lori D. Conklin, MD
*Charlottesville*

Kevin O'Connor, MD
*Leesburg*

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## Results in Brief

This report breaks down survey findings for Certified Registered Nurse CRNAs (CRNA), Certified Nurse CNMs (CNM), and Certified Nurse Practitioners (CNPs). Of the 3,273 Licensed Nurse Practitioners (NPs) who took part in the 2017 Licensed Nurse Practitioner Workforce Survey, 638 were CRNAs, 98 were CNMs, and 2,537 were CNPs. CNPs make up the highest proportion of NPs. Over three-quarters of NPs are CNPs whereas CNMs constitute only 3% of NPs.

The HWDC estimates that 8,215 NPs 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 NP at some point in the future. Of these, 1,569 were CRNAs, 236 were CNMs and 6,410 were CNPs.

Eighteen percent of NPs did not participate in the NP workforce in the past year. CRNAs were least likely to report working in the state workforce last year; 22% of CRNAs did not participate in the state workforce in the past year compared to 19% of CNMs and 17% of CNPs.

Nine out 10 NPs are female; CNMs are all female whereas slightly less than three-quarters of CRNAs are female. The median age of all NPs is 46; this is the median age of CRNAs and CNPs as well. However, the median age of CNMs is 49. In a random encounter between two NPs, there is a 33% chance that they would be of different races or ethnicities, a measure known as the diversity index. CRNAs were the most diverse with 36% diversity index whereas CNMs and CNPs had 21% and 33% diversity index, respectively.

One-third of all NPs grew up in a rural area. However, when broken down by specialty, 43% of CNMs did. About a quarter of CRNAs grew up in rural area whereas 35% of CNPs did. Overall, 10% of NPs work in rural areas. CNPs had the highest workforce participation in rural areas. 12% of CNPs work in rural areas compared to 6% and 3% of CRNAs and CNMs, respectively. CNPs were most likely to be educated in the state; 61% of CNPs reported attending a high school or professional school in the state compared to 40% of CRNAs and CNMs.

CRNAs had the highest educational attainment with 12% reporting a doctorate degree; only 4% of CNMs and 8% of CNPs did. Not surprisingly, CRNAs also were most likely to report education debt and they reported the highest median education debt. CRNA reported $80-$90k in education debt whereas others reported $50k-$60k. 16% of CRNAs reported over $120,000 in education debt compared to 11% of CNMs and 5% of CNPs.

CRNAs also reported the highest median annual income; they reported $120k-$130k in median income. The average for all other NPs is between $100,000 and $110,000. 83% of CRNAs reported more than $120,000 in median income compared to 28% of CNMs and 13% of CNPs. In addition, 85% of CNMs received at least one employer-sponsored benefit, compared to 84% of CRNAs and 81% of CNPs. Overall, 95% of NPs are satisfied with their current employment situation. However, only 83% of CNMs are satisfied compared to 97% of CRNAs and 94% of CNPs.

CRNAs had the highest participation in the private sector, 87% of them worked in the sector compared to 83% of CNPs and 78% of CNMs. Meanwhile, CRNAs had lowest percent working in state or local government. Close to a third of CNMs reported employment instability in the past year compared to 30% of CNPs and 24% of CRNAs.

A typical NP spends nearly all of her time treating patients. 89% of NPs serve a patient care role, meaning that at least 60% of their time is spent in patient care activities. CRNAs were most likely to fill a patient care role; 93% of CRNAs filled such a role compared to 89% and 88% of CNMs and CNPs, respectively.

A third of CNMs plan to retire within the next decade compared to 24% of CRNAs and 20% of CNPs. About 43%, 32% and 35% of CRNAs, CNMs, and CNPs, respectively, plan to retire by the age of 65. Further, 30%, 19%, and 23% of CRNAs, CNMs, and CNPs, respectively, who are age 50 or over expect to retire by the same age. Meanwhile, 3%, 8%, and 6% of CRNAs, CNMs, and CNPs, respectively, do not plan to retire at all.

## A Closer Look:

2,037 of NPs reported their first specialty as CRNA; 279 had first specialty of CNM, 7,722 had other first specialties. Of the 7,722, 26 had a second specialty of CNM and six had a second specialty of CRNA. Therefore, after assigning any mention of CNM as CNM and similarly for CRNAs, "At a Glance" shows the break down. Over three-quarters are CNPs and less than 5% are CNMs.

**At a Glance:**

**Licensed NPs**

| | |
|---|---|
| Total: | 10,038 |
| CRNA: | 2,043 |
| CNM: | 305 |
| CNP: | 7,690 |

**Response Rates**

| | |
|---|---|
| All Licensees: | 33% |
| Renewing Practitioners: | 81% |

*Source: Va. Healthcare Workforce Data Center*

| Response Rates | | | | |
|---|---|---|---|---|
| | CRNA | CNM | CNP | Total |
| Completed Surveys | 638 | 98 | 2,537 | **3,273** |
| Response Rate, all licensees | 31% | 32% | 33% | **33%** |
| Response Rate, Renewals | 77% | 81% | 81% | **81%** |

*Source: Va. Healthcare Workforce Data Center*

*Our surveys tend to achieve very high response rates. 81% of renewing NPs submitted a survey. These represent 33% of NPs who held a license at some point during the licensing period. Response rates vary among the different specialty groups.*

| Response Rate by Metro Status | | | | |
|---|---|---|---|---|
| | CRNA | CNM | CNP | All |
| Non-Metro | 40% | 25% | 37% | **37%** |
| Metro | 39% | 37% | 37% | **38%** |
| Not in Virginia | 13% | 13% | 15% | **14%** |

*Source: Va. Healthcare Workforce Data Center*

| Not in Workforce in Past Year | | | | |
|---|---|---|---|---|
| | CRNA | CNM | CNP | All |
| % of Licensees not in VA Workforce | 22% | 19% | 17% | **18%** |
| % in Federal Employee or Military: | 8% | 20% | 21% | **18%** |
| % Working in Virginia Border State or DC | 19% | 38% | 26% | **25%** |

*Source: Va. Healthcare Workforce Data Center*

*CRNAs were most likely to not be working in the state workforce whereas CNMs were most likely to be working in border states.*

## Closer Look:

### At a Glance:

**Workforce**
Virginia's NP Workforce: 8,215
FTEs: 7,323

**Workforce by Specialty**
CRNA: 1,569
CNM: 236
CNP: 6,410

**FTE by Specialty**
CRNA: 1,447
CNM: 242
CNP: 5,634

*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 NP Workforce | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | CRNA | | CNM | | CNP | | All | |
| Status | # | % | # | % | # | % | # | % |
| Worked in Virginia in Past Year | 1,558 | 99% | 231 | 98% | 6,280 | 98% | 8,070 | 98% |
| Looking for Work in Virginia | 10 | 1% | 5 | 2% | 130 | 2% | 145 | 2% |
| Virginia's Workforce | 1,569 | 100% | 236 | 100% | 6,410 | 100% | 8,215 | 100% |
| Total FTEs | 1,447 | | 242 | | 5,634 | | 7,323 | |
| Licensees | 2,043 | | 305 | | 7,690 | | 10,038 | |

*Source: Va. Healthcare Workforce Data Center*

*CNPs provided about 77% of the nurse practitioner FTEs in the state. CRNAs provided 20% whereas CNMs provided 3% of the FTEs.*

## Closer Look:

| Age & Gender | | | | | | |
|---|---|---|---|---|---|---|
| Age | Male | | Female | | Total | |
| | # | % Male | # | % Female | # | % in Age Group |
| Under 30 | 24 | 7% | 330 | 93% | 354 | 5% |
| 30 to 34 | 67 | 6% | 1,087 | 94% | 1,154 | 15% |
| 35 to 39 | 121 | 11% | 1,010 | 89% | 1,131 | 15% |
| 40 to 44 | 133 | 14% | 827 | 86% | 960 | 13% |
| 45 to 49 | 63 | 7% | 860 | 93% | 922 | 12% |
| 50 to 54 | 100 | 12% | 731 | 88% | 831 | 11% |
| 55 to 59 | 91 | 11% | 720 | 89% | 811 | 11% |
| 60 + | 155 | 12% | 1,165 | 88% | 1,319 | 18% |
| **Total** | **754** | **10%** | **6,729** | **90%** | **7,483** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

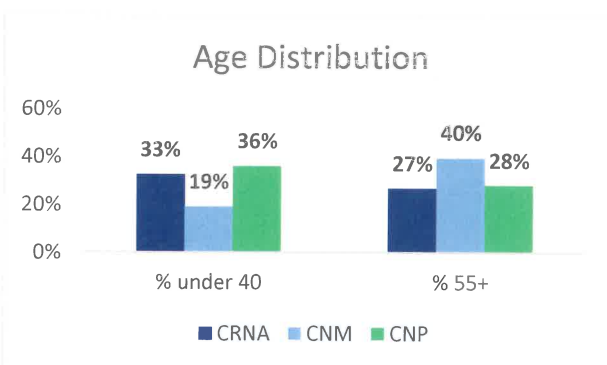
### At a Glance:

**Gender**
% Female: 90%
% Under 40 Female: 92%

**% Female by Specialty**
CRNA: 73%
CNM: 100%
CNP: 94%

**% Female <40 by Specialty**
CRNA: 78%
CNM: 100%
CNP: 95%

*Source: Va. Healthcare Workforce Data Center*




*Source: Va. Healthcare Workforce Data Center*

*Median age is 49 for CNMs and 46 for others.*

**Age & Gender by Specialty** *Source: Va. Healthcare Workforce Data Center*

| Age | CRNA | | | | CNM | | | | CNP | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Female | | Total | | | | | | | | | |
| | # | % Female | # | % in Age Group | # | % Female | # | % in Age Group | # | % Female | # | % in Age Group |
| Under 30 | 19 | 67% | 29 | 2% | 10 | 100% | 10 | 5% | 301 | 95% | 316 | 5% |
| 30 to 34 | 163 | 84% | 195 | 13% | 19 | 100% | 19 | 9% | 905 | 96% | 940 | 16% |
| 35 to 39 | 193 | 76% | 256 | 18% | 12 | 100% | 12 | 6% | 804 | 93% | 863 | 15% |
| 40 to 44 | 171 | 72% | 239 | 16% | 32 | 100% | 32 | 15% | 624 | 91% | 689 | 12% |
| 45 to 49 | 125 | 75% | 168 | 12% | 28 | 100% | 28 | 14% | 706 | 97% | 726 | 12% |
| 50 to 54 | 128 | 73% | 176 | 12% | 25 | 100% | 25 | 12% | 578 | 92% | 630 | 11% |
| 55 to 59 | 104 | 72% | 145 | 10% | 44 | 100% | 44 | 21% | 572 | 92% | 622 | 11% |
| 60 + | 159 | 64% | 251 | 17% | 39 | 100% | 39 | 19% | 966 | 94% | 1,030 | 18% |
| **Total** | **1,063** | **73%** | **1,458** | **100%** | **209** | **100%** | **209** | **100%** | **5,457** | **94%** | **5,815** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Race/ Ethnicity | Virginia* | NPs | | NPs under 40 | |
|---|---|---|---|---|---|
| | % | # | % | # | % |
| White | 63% | 6,083 | 81% | 2,032 | 78% |
| Black | 19% | 647 | 9% | 235 | 9% |
| Asian | 6% | 357 | 5% | 183 | 7% |
| Other Race | 0% | 116 | 2% | 37 | 1% |
| Two or more races | 3% | 124 | 2% | 58 | 2% |
| Hispanic | 9% | 165 | 2% | 75 | 3% |
| **Total** | **100%** | **7,492** | **100%** | **2,619** | **100%** |

Race & Ethnicity

* 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:

**Diversity**
Diversity Index: 33%
Under 40 Div. Index: 38%

**By Specialty**
CRNA: 36%
CNM: 21%
CNP: 33%

*Source: Va. Healthcare Workforce Data Center*

### Age, Race, Ethnicity & Gender

| Race/ Ethnicity | CRNA NPs | | CRNA NPs under 40 | | CNM NPs | | CNM NPs under 40 | | CNP NPs | | CNP NPs under 40 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | # | % | # | % | # | % | # | % | # | % | # | % |
| White | 1,161 | 79% | 342 | 72% | 184 | 88% | 38 | 94% | 4,737 | 81% | 1,652 | 78% |
| Black | 113 | 8% | 45 | 10% | 5 | 2% | 0 | 0% | 528 | 9% | 189 | 9% |
| Asian | 118 | 8% | 69 | 15% | 0 | 0% | 0 | 0% | 240 | 4% | 114 | 5% |
| Other Race | 16 | 1% | 3 | 1% | 0 | 0% | 0 | 0% | 100 | 2% | 34 | 2% |
| Two or more races | 31 | 2% | 8 | 2% | 7 | 3% | 0 | 0% | 86 | 1% | 50 | 2% |
| Hispanic | 26 | 2% | 6 | 1% | 12 | 6% | 3 | 6% | 127 | 2% | 67 | 3% |
| **Total** | **1,465** | **100%** | **473** | **100%** | **209** | **100%** | **41** | **100%** | **5,818** | **100%** | **2,106** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Rural Childhood**

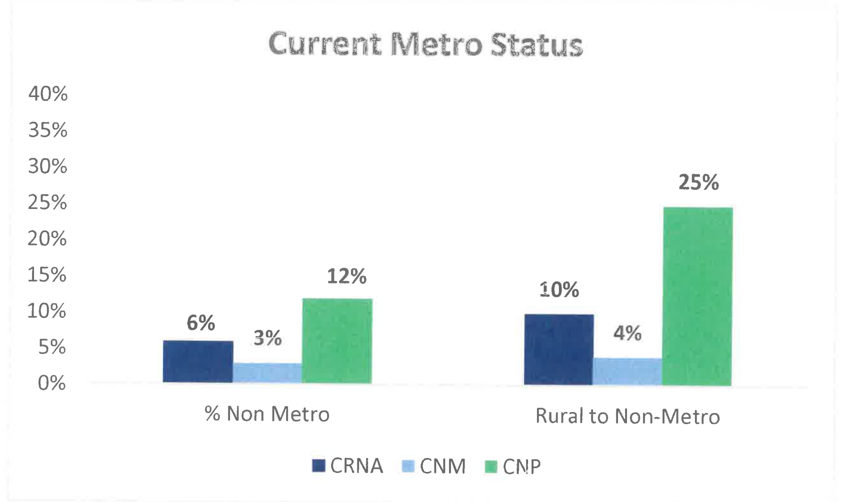
CRNA: 26%
CNM: 43%
CNP: 35%
All: 33%

**Non-Metro Location**

CRNA: 6%
CNM: 3%
CNP: 12%
All: 10%

*Source: Va. Healthcare Workforce Data Center*

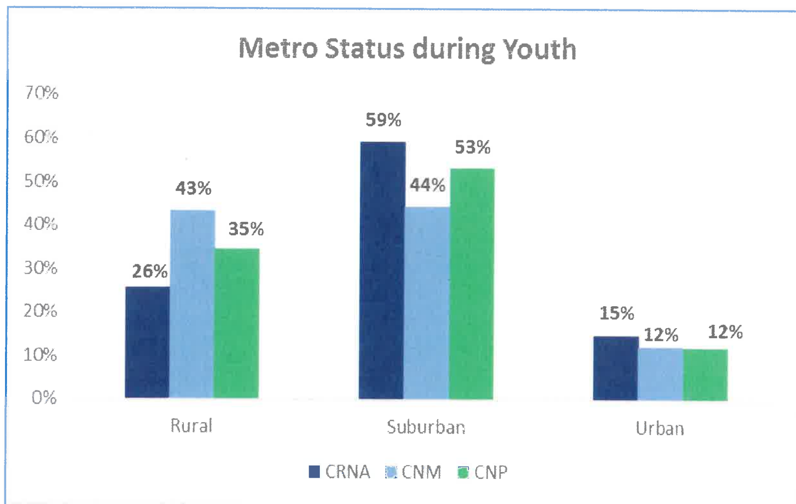
## A Closer Look:




*Source: Va. Healthcare Workforce Data Center*

| | HS in VA | Prof. Ed. in VA | HS or Prof in VA | NP Degree in VA |
|---|---|---|---|---|
| CRNA | 31% | 33% | 39% | 40% |
| CNM | 29% | 37% | 40% | 25% |
| CNP | 49% | 56% | 61% | 63% |
| **Total** | **45%** | **51%** | **56%** | **58%** |

*Source: Va. Healthcare Workforce Data Center*




*Source: Va. Healthcare Workforce Data Center*

*CNPs were most likely to have been educated in the state. CNMs were least likely to have obtained their NP education in the state. CNPs had the highest percent reporting a non-metro work location.*

## At a Glance:

**Median Educational Debt**

| | |
|---|---|
| CRNA: | $80k-$90k |
| CNM: | $70k-$80k |
| CNP: | $50k-$60k |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

*CRNAs were most likely to carry education debt and they reported the highest median education debt. 51% and 79% of all CRNAs and CRNAs, respectively, under age 40 carried education debt. Their median debt was $80k-$90k.*

| | Highest Degree | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | CRNA | | CNM | | CNP | | All | |
| Degree | # | % | # | % | # | % | # | % |
| **NP Certificate** | 182 | 13% | 5 | 2% | 118 | 2% | 305 | 4% |
| **Master's Degree** | 1,090 | 75% | 164 | 80% | 4,563 | 80% | 5,817 | 79% |
| **Post-Masters Cert.** | 10 | 1% | 26 | 13% | 564 | 10% | 599 | 8% |
| **Doctorate of NP** | 96 | 7% | 7 | 3% | 349 | 6% | 451 | 6% |
| **Other Doctorate** | 70 | 5% | 3 | 1% | 141 | 2% | 213 | 3% |
| **Post-Ph.D. Cert.** | 0 | 0% | 0 | 0% | 2 | 0% | 2 | 0% |
| **Total** | **1,447** | **100%** | **204** | **100%** | **5,737** | **100%** | **7,388** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

| | Educational Debt | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Amount Carried | CRNA | | CNM | | CNP | | All | |
| | All NPs | NPs < 40 | All NPs | NPs < 40 | All NPs | NPs < 40 | All NPs | NPs < 40 |
| **None** | 49% | 21% | 56% | 19% | 53% | 34% | 52% | 31% |
| **$10,000 or less** | 2% | 3% | 6% | 12% | 5% | 7% | 5% | 7% |
| **$10,000-$19,999** | 2% | 1% | 0% | 0% | 5% | 6% | 4% | 5% |
| **$20,000-$29,999** | 3% | 1% | 5% | 0% | 5% | 5% | 4% | 4% |
| **$30,000-$39,999** | 4% | 7% | 7% | 7% | 4% | 5% | 4% | 5% |
| **$40,000-$49,999** | 3% | 5% | 0% | 0% | 4% | 6% | 4% | 6% |
| **$50,000-$59,999** | 4% | 4% | 2% | 0% | 5% | 7% | 4% | 6% |
| **$60,000-$69,999** | 2% | 5% | 1% | 0% | 3% | 5% | 3% | 4% |
| **$70,000-$79,999** | 3% | 2% | 5% | 12% | 3% | 5% | 3% | 4% |
| **$80,000-$89,999** | 4% | 8% | 2% | 0% | 3% | 4% | 3% | 4% |
| **$90,000-$99,999** | 2% | 3% | 0% | 0% | 3% | 5% | 3% | 4% |
| **$100,000-$109,999** | 3% | 7% | 4% | 14% | 2% | 3% | 2% | 4% |
| **$110,000-$119,999** | 2% | 1% | 0% | 0% | 1% | 1% | 1% | 1% |
| **$120,000 or more** | 16% | 33% | 11% | 36% | 5% | 9% | 8% | 14% |
| **Total** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Employed in Profession**

| | |
|---|---|
| CRNA: | 97% |
| CNM: | 95% |
| CNP: | 96% |

**Involuntary Unemployment**

| | |
|---|---|
| CRNA: | 0% |
| CNM: | 2% |
| CNP: | <1% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| | Current Weekly Hours | | | |
|---|---|---|---|---|
| Hours | CRNA | CNM | CNP | All |
| **0 hours** | 2% | 5% | 3% | 3% |
| **1 to 9 hours** | 0% | 1% | 2% | 2% |
| **10 to 19 hours** | 3% | 1% | 3% | 3% |
| **20 to 29 hours** | 7% | 4% | 9% | 8% |
| **30 to 39 hours** | 17% | 16% | 19% | 19% |
| **40 to 49 hours** | 60% | 30% | 47% | 49% |
| **50 to 59 hours** | 10% | 24% | 13% | 12% |
| **60 to 69 hours** | 1% | 16% | 3% | 3% |
| **70 to 79 hours** | 0% | 1% | 1% | 1% |
| **80 or more hours** | 0% | 1% | 1% | 1% |
| **Total** | **100%** | **100%** | **100%** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

*Over half of CRNAs work 40-49 hours and 12% work more than 50 hours whereas over 40% of CNMs work more than 50 hours. Close to half of CNPs work 40-49 hours and about 17% work more than 50 hours.*

| | Current Positions | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | CRNA | | CNM | | CNP | | All | |
| Positions | # | % | # | % | # | % | # | % |
| **No Positions** | 26 | 2% | 10 | 5% | 159 | 3% | 194 | 3% |
| **One Part-Time Position** | 161 | 11% | 26 | 13% | 868 | 15% | 1,056 | 15% |
| **Two Part-Time Positions** | 49 | 3% | 5 | 3% | 221 | 4% | 276 | 4% |
| **One Full-Time Position** | 1,004 | 70% | 140 | 69% | 3,669 | 65% | 4,813 | 66% |
| **One Full-Time Position & One Part-Time Position** | 163 | 11% | 22 | 11% | 617 | 11% | 802 | 11% |
| **Two Full-Time Positions** | 3 | 0% | 0 | 0% | 13 | 0% | 16 | 0% |
| **More than Two Positions** | 29 | 2% | 0 | 0% | 60 | 1% | 89 | 1% |
| **Total** | **1,435** | **100%** | **204** | **100%** | **5,608** | **100%** | **7,246** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| | Employer-Sponsored Benefits* | | | |
|---|---|---|---|---|
| **Benefit** | **CRNA** | **CNM** | **CNP** | **All** |
| **Signing/Retention Bonus** | 20% | 17% | 12% | 14% |
| **Dental Insurance** | 64% | 36% | 57% | 58% |
| **Health Insurance** | 66% | 56% | 63% | 63% |
| **Paid Leave** | 67% | 80% | 70% | 70% |
| **Group Life Insurance** | 59% | 38% | 51% | 52% |
| **Retirement** | 76% | 66% | 71% | 72% |
| **Receive at least one benefit** | **84%** | **85%** | **81%** | **82%** |

*From any employer at time of survey.

*Source: Va. Healthcare Workforce Data Center*

### At a Glance:

**Median Income**
CRNA: $120k-$130k
CNM: $90k-$100k
CNP: $90k-$100K
All: $100k-$110k

**Percent Satisfied**
CRNA: 97%
CNM: 83%
CNP: 94%

*Source: Va. Healthcare Workforce Data Center*

*CRNAs reported $120k-$130k in median income. All other NPs, including CNMs, reported $90k-$100k in median income. CNMs were least satisfied with their current employment situation whereas CRNAs were most satisfied. 4% of CNMs also were very dissatisfied whereas 1% or less of the other NPs, including CRNAs, were very dissatisfied.*

| | Income | | | |
|---|---|---|---|---|
| **Hourly Wage** | **CRNA** | **CNM** | **CNP** | **All** |
| **Volunteer Work Only** | 0% | 2% | 1% | 1% |
| **Less than $40,000** | 1% | 4% | 5% | 4% |
| **$40,000-$49,999** | 0% | 4% | 3% | 3% |
| **$50,000-$59,999** | 2% | 7% | 4% | 4% |
| **$60,000-$69,999** | 0% | 9% | 5% | 4% |
| **$70,000-$79,999** | 1% | 9% | 8% | 6% |
| **$80,000-$89,999** | 1% | 9% | 13% | 11% |
| **$90,000-$99,999** | 2% | 10% | 20% | 16% |
| **$100,000-$109,999** | 5% | 6% | 17% | 15% |
| **$110,000-$119,999** | 4% | 11% | 10% | 9% |
| **$120,000 or more** | 83% | 28% | 13% | 27% |
| **Total** | **100%** | **100%** | **100%** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Employment Instability in Past Year | | | | |
|---|---|---|---|---|
| **In the past year did you . . .?** | **CRNA** | **CNM** | **CNP** | **All** |
| Experience Involuntary Unemployment? | 1% | 2% | 1% | 1% |
| Experience Voluntary Unemployment? | 3% | 3% | 5% | 5% |
| Work Part-time or temporary positions, but would have preferred a full-time/permanent position? | 1% | 4% | 3% | 2% |
| Work two or more positions at the same time? | 17% | 12% | 17% | 17% |
| Switch employers or practices? | 5% | 14% | 11% | 10% |
| **Experienced at least 1** | **24%** | **32%** | **30%** | **29%** |

*Source: Va. Healthcare Workforce Data Center*

### At a Glance:

**Involuntarily Unemployed**
CRNA: 1%
CNM: 2%
CNP: 1%

**Underemployed**
CRNA: 1%
CNM: 4%
CNP: 3%

**Over 2 Years Job Tenure**
CRNA: 70%
CNM: 39%
CNP: 55%

*Source: Va. Healthcare Workforce Data Center*

| Tenure | Job Tenure at Location | | | | | |
|---|---|---|---|---|---|---|
| | CRNA | | CNM | | CNP | |
| | Primary | Secondary | Primary | Secondary | Primary | Secondary |
| Not Currently Working at this Location | 2% | 5% | 3% | 8% | 2% | 8% |
| < 6 Months | 5% | 11% | 17% | 13% | 10% | 15% |
| 6 Months-1 yr | 5% | 11% | 14% | 15% | 12% | 11% |
| 1 to 2 Years | 19% | 21% | 27% | 21% | 21% | 22% |
| 3 to 5 Years | 24% | 21% | 19% | 27% | 23% | 23% |
| 6 to 10 Years | 21% | 19% | 13% | 11% | 12% | 13% |
| > 10 Years | 25% | 12% | 8% | 5% | 20% | 9% |
| **Subtotal** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

*CNMs were most likely to be paid by salary or commission. Nearly three-quarters of them were paid that way, compared to 68% of CNPs and 58% of CRNAs.*

| Forms of Payment | | | | |
|---|---|---|---|---|
| **Primary Work Site** | **CRNA** | **CNM** | **CNP** | **All** |
| Salary/ Commission | 58% | 74% | 68% | 66% |
| Hourly Wage | 39% | 20% | 28% | 30% |
| By Contract | 3% | 4% | 3% | 3% |
| Other | 0% | 2% | 1% | 1% |
| **Subtotal** | **100%** | **100%** | **100%** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**% in Top 3 Regions**
CRNA: 81%
CNM: 73%
CNP: 69%

**More than 2 Locations**
CRNA: 27%
CNM: 29%
CNP: 22%

*Source: Va. Healthcare Workforce Data Center*

*Northern Virginia has the highest proportion of CRNAs and CNMs whereas CNPs were mostly concentrated in the Central region.*

## A Closer Look:

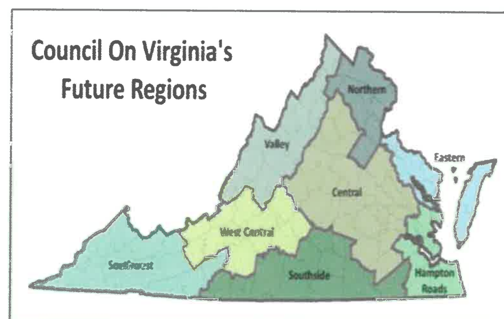
| Regional Distribution of Work Locations | | | | | | |
|---|---|---|---|---|---|---|
| COVF Region | CRNA | | CNM | | CNP | |
| | Primary | Secondary | Primary | Secondary | Primary | Secondary |
| Central | 28% | 16% | 11% | 8% | 28% | 22% |
| Eastern | 1% | 2% | 1% | 0% | 1% | 1% |
| Hampton Roads | 23% | 26% | 20% | 25% | 17% | 17% |
| Northern | 31% | 29% | 42% | 14% | 25% | 21% |
| Southside | 2% | 1% | 0% | 0% | 3% | 3% |
| Southwest | 2% | 2% | 1% | 0% | 7% | 12% |
| Valley | 3% | 2% | 14% | 24% | 7% | 6% |
| West Central | 6% | 8% | 9% | 12% | 10% | 8% |
| Virginia Border State/DC | 3% | 5% | 0% | 4% | 1% | 2% |
| Other US State | 2% | 7% | 1% | 13% | 2% | 7% |
| Outside of the US | 0% | 1% | 0% | 0% | 0% | 1% |
| **Total** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

| Number of Work Locations Now* | | | | | | |
|---|---|---|---|---|---|---|
| Locations | CRNA | | CNM | | CNP | |
| | # | % | # | % | # | % |
| 0 | 28 | 2% | 10 | 5% | 193 | 3% |
| 1 | 1,011 | 71% | 134 | 66% | 4,120 | 74% |
| 2 | 217 | 15% | 48 | 24% | 698 | 13% |
| 3 | 139 | 10% | 8 | 4% | 449 | 8% |
| 4 | 15 | 1% | 0 | 0% | 30 | 1% |
| 5 | 8 | 1% | 3 | 1% | 15 | 0% |
| 6 + | 3 | 0% | 0 | 0% | 40 | 1% |
| **Total** | **1,421** | **100%** | **204** | **100%** | **5,545** | **100%** |

*At survey completion (birth month of respondents)

*Source: Va. Healthcare Workforce Data Center*



## Establishment Type

### A Closer Look:

| Sector | Location Sector | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | CRNA | | CNM | | CNP | | All | |
| | Primary | Sec | Primary | Sec | Primary | Sec | Primary | Sec |
| **For-Profit** | 51% | 63% | 60% | 83% | 51% | 53% | 51% | 56% |
| **Non-Profit** | 36% | 25% | 18% | 17% | 32% | 31% | 33% | 29% |
| **State/Local Government** | 6% | 4% | 9% | 0% | 10% | 12% | 9% | 10% |
| **Veterans Administration** | 3% | 1% | 0% | 0% | 3% | 1% | 3% | 1% |
| **U.S. Military** | 4% | 7% | 12% | 0% | 3% | 2% | 3% | 3% |
| **Other Federal Government** | 0% | 0% | 1% | 0% | 1% | 2% | 1% | 1% |
| **Total** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

*CRNAs had the highest participation in the private sector, 87% of them worked in the sector compared to 83% of CNPs and 78% of CNMs. Meanwhile, CRNAs had the lowest percent working in state or local government.*

## At a Glance:

**(Primary Locations)**

**For-Profit Primary Sector**

CRNA: 63%
CNM: 60%
CNP: 51%

**Top Establishments**

CRNA: Inpatient Department
CNM: Group Private Practice
CNP: Primary Care Clinic

*Source: Va. Healthcare Workforce Data Center*

| Electronic Health Records (EHRs) and Telehealth | | | | |
|---|---|---|---|---|
| | CRNA | CNM | CNP | All |
| **Meaningful use of EHRs** | 10% | 26% | 36% | 30% |
| **Remote Health, Caring for Patients in Virginia** | 1% | 2% | 9% | 8% |
| **Remote Health, Caring for Patients Outside of Virginia** | 1% | 1% | 2% | 2% |
| **Use at least one** | **11%** | **29%** | **39%** | **34%** |

*Source: Va. Healthcare Workforce Data Center*

*A third of the state NP workforce use EHRs. 8% also provided remote health care for Virginia patients. CNPs were most likely to report using at least one EHR or telehealth whereas CRNAs were least likely to report doing so.*

| Establishment Type | Location Type | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | CRNA | | CNM | | CNP | | All | |
| | Primary | Sec | Primary | Sec | Primary | Sec | Primary | Sec |
| **Hospital, Inpatient Department** | 43% | 37% | 21% | 13% | 15% | 14% | 21% | 19% |
| **Clinic, Primary Care or Non-Specialty** | 0% | 1% | 6% | 0% | 23% | 19% | 18% | 15% |
| **Physician Office** | 1% | 1% | 11% | 29% | 11% | 4% | 9% | 4% |
| **Private practice, group** | 4% | 2% | 28% | 22% | 9% | 5% | 9% | 5% |
| **Academic Institution (Teaching or Research)** | 12% | 2% | 4% | 20% | 8% | 10% | 9% | 9% |
| **Hospital, Outpatient Department** | 11% | 15% | 7% | 0% | 7% | 3% | 8% | 5% |
| **Ambulatory/Outpatient Surgical Unit** | 16% | 28% | 0% | 0% | 1% | 0% | 4% | 6% |
| **Clinic, Non-Surgical Specialty** | 0% | 0% | 0% | 0% | 4% | 5% | 3% | 3% |
| **Hospital, Emergency Department** | 1% | 0% | 1% | 0% | 3% | 5% | 2% | 3% |
| **Long Term Care Facility, Nursing Home** | 0% | 0% | 0% | 0% | 3% | 4% | 2% | 3% |
| **Private practice, solo** | 0% | 0% | 1% | 0% | 2% | 2% | 2% | 2% |
| **Mental Health, or Substance Abuse, Outpatient Center** | 0% | 0% | 0% | 0% | 2% | 3% | 1% | 2% |
| **Public Health Agency** | 0% | 0% | 3% | 4% | 1% | 2% | 1% | 1% |
| **Other Practice Setting** | 12% | 13% | 18% | 13% | 11% | 24% | 12% | 22% |
| **Total** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

*The inpatient department of a hospital was the most mentioned primary work establishment on average for NPs. This average was driven primarily by CRNAs. For CNMs, private practice was the most mentioned primary work establishment whereas for CNPs, primary care clinic was the most mentioned primary work establishment.*

## At a Glance:

### (Primary Locations)

**Patient Care Role**

CRNA: 93%
CNM: 89%
CNP: 88%

**Education Role**

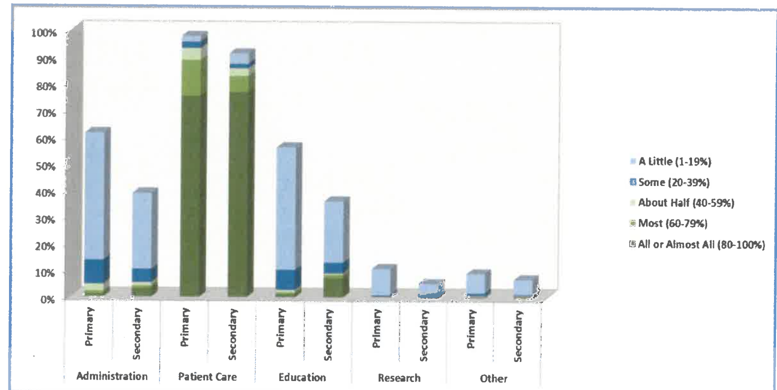
CRNA: 1%
CNM: 1%
CNP: 2%

**Admin Role**

CRNA: 2%
CNM: 4%
CNP: 2%

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:




*Source: Va. Healthcare Workforce Data Center*

*On average, 89% of all NPs fill a patient care role, defined as spending 60% or more of their time on patient care activities. CRNAs were most likely to fill a patient care role; 93% of CRNAs filled such role compared to 89% and 88% of CNMs and CNPs, respectively.*

| Time Spent | Patient Care Time Allocation | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | CRNA | | CNM | | CNP | | All | |
| | Prim. Site | Sec. Site | Prim. Site | Sec. Site | Prim. Site | Sec. Site | Prim. Site | Sec. Site |
| All or Almost All (80-100%) | 86% | 88% | 66% | 52% | 73% | 74% | 75% | 77% |
| Most (60-79%) | 7% | 1% | 23% | 33% | 15% | 6% | 13% | 6% |
| About Half (40-59%) | 3% | 2% | 3% | 0% | 5% | 3% | 4% | 3% |
| Some (20-39%) | 1% | 1% | 1% | 0% | 3% | 2% | 2% | 2% |
| A Little (1-20%) | 1% | 2% | 5% | 0% | 2% | 5% | 2% | 4% |
| None (0%) | 1% | 6% | 1% | 15% | 3% | 9% | 2% | 9% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Future Plans | | | | | | |
|---|---|---|---|---|---|---|
| | CRNA | | CNM | | CNP | |
| 2 Year Plans: | # | % | # | % | # | % |
| **Decrease Participation** | | | | | | |
| Leave Profession | 15 | 1% | 0 | 0% | 38 | 1% |
| Leave Virginia | 29 | 2% | 15 | 6% | 162 | 3% |
| Decrease Patient Care Hours | 130 | 8% | 37 | 16% | 576 | 9% |
| Decrease Teaching Hours | 5 | 0% | 3 | 1% | 62 | 1% |
| **Increase Participation** | | | | | | |
| Increase Patient Care Hours | 52 | 3% | 28 | 12% | 599 | 9% |
| Increase Teaching Hours | 83 | 5% | 53 | 23% | 802 | 13% |
| Pursue Additional Education | 80 | 5% | 27 | 11% | 907 | 14% |
| Return to Virginia's Workforce | 5 | 0% | 0 | 0% | 47 | 1% |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Retirement within 2 Years**
CRNA: 6%
CNM: 7%
CNP: 5%

**Retirement within 10 Years**
CRNA: 24%
CNM: 33%
CNP: 20%

*Source: Va. Healthcare Workforce Data Center*

*43%, 32% and 35% of CRNAs, CNMs, and CNPs, respectively, expect to retire by the age of 65. Further, 30%, 19%, and 23% of CRNAs, CNMs, and CNPs, respectively, who are age 50 or over expect to retire by the same age. Meanwhile, 3%, 8%, and 6% of CRNAs, CNMs, and CNPs, respectively, do not plan to retire at all.*

| Expected Retirement Age | CRNA | | CNM | | CNP | | All | |
|---|---|---|---|---|---|---|---|---|
| | All NPs | NP >50 yrs | All NPs | NP >50 yrs | All NPs | NP >50 yrs | All NPs | NP >50 yrs |
| Under age 50 | 1% | - | 4% | - | 1% | - | 1% | - |
| 50 to 54 | 3% | 0% | 0% | 0% | 2% | 0% | 2% | 0% |
| 55 to 59 | 9% | 4% | 3% | 0% | 6% | 3% | 7% | 3% |
| 60 to 64 | 31% | 25% | 25% | 19% | 25% | 20% | 26% | 21% |
| 65 to 69 | 40% | 46% | 49% | 52% | 39% | 44% | 40% | 44% |
| 70 to 74 | 13% | 19% | 8% | 12% | 15% | 19% | 14% | 19% |
| 75 to 79 | 1% | 2% | 1% | 2% | 4% | 4% | 3% | 4% |
| 80 or over | 0% | 1% | 1% | 0% | 1% | 2% | 1% | 1% |
| I do not intend to retire | 3% | 3% | 8% | 15% | 6% | 8% | 5% | 7% |
| **Total** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** | **100%** |

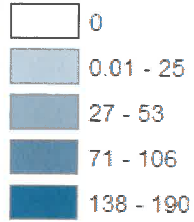
*Source: Va. Healthcare Workforce Data Center*

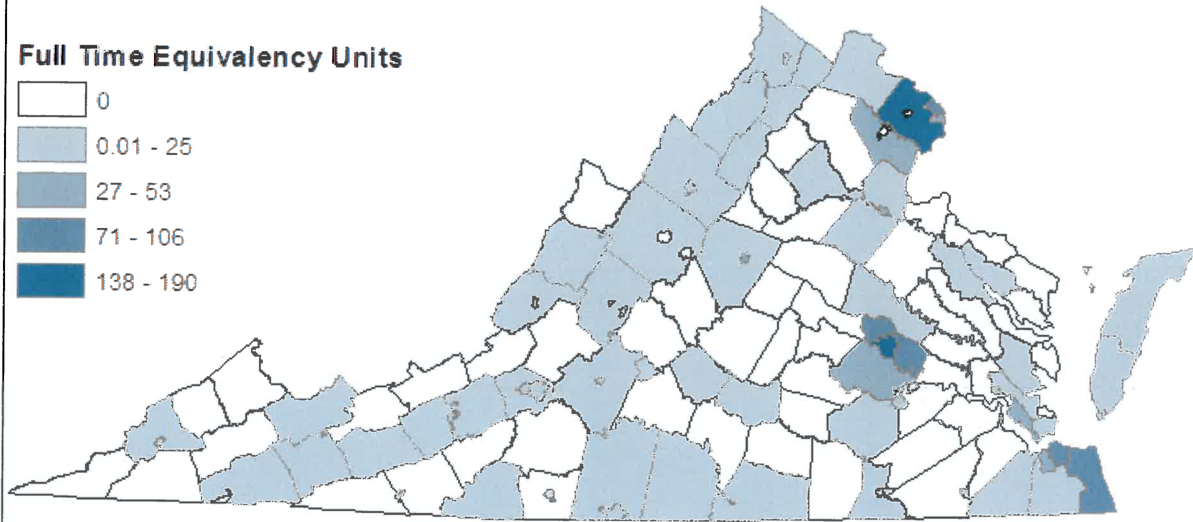
| | Time to Retirement | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | CRNA | | CNM | | CNP | | All | |
| Expect to retire within. . . | # | % | # | % | # | % | # | % |
| 2 years | 74 | 6% | 13 | 7% | 260 | 5% | 347 | 5% |
| 5 years | 66 | 5% | 5 | 3% | 149 | 3% | 220 | 3% |
| 10 years | 171 | 13% | 45 | 24% | 583 | 12% | 799 | 12% |
| 15 years | 129 | 10% | 29 | 15% | 624 | 13% | 782 | 12% |
| 20 years | 171 | 13% | 5 | 3% | 537 | 11% | 713 | 11% |
| 25 years | 197 | 15% | 24 | 13% | 579 | 12% | 801 | 12% |
| 30 years | 201 | 15% | 17 | 9% | 675 | 14% | 894 | 14% |
| 35 years | 158 | 12% | 28 | 15% | 641 | 13% | 827 | 13% |
| 40 years | 87 | 7% | 3 | 1% | 379 | 8% | 469 | 7% |
| 45 years | 12 | 1% | 0 | 0% | 191 | 4% | 203 | 3% |
| 50 years | 0 | 0% | 0 | 0% | 54 | 1% | 54 | 1% |
| 55 years | 0 | 0% | 3 | 1% | 5 | 0% | 7 | 0% |
| In more than 55 years | 0 | 0% | 0 | 0% | 5 | 0% | 5 | 0% |
| Do not intend to retire | 36 | 3% | 15 | 8% | 291 | 6% | 342 | 5% |
| **Total** | **1,304** | **100%** | **186** | **100%** | **4,973** | **100%** | **6,463** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

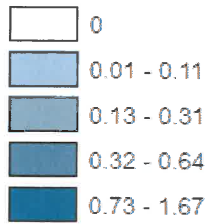
*Using these estimates, retirements will begin to reach over 10% of the current workforce every 5 years by 2027. Retirements will peak at 14% of the current workforce around 2047 before declining to under 10% of the current workforce again around 2057.*

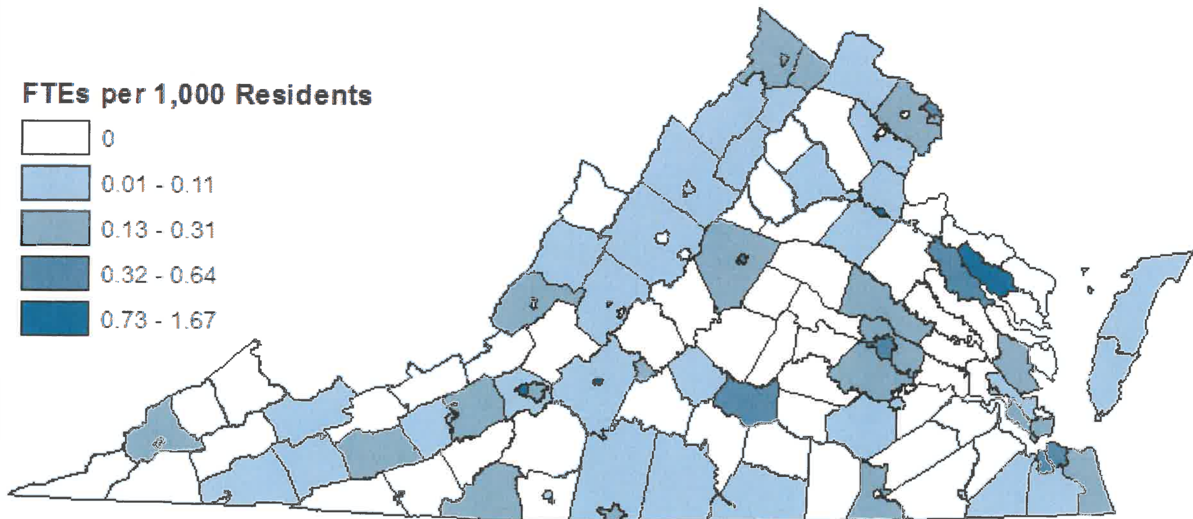
## Certified Registered Nurse Anesthetists: Full Time Equivalency Units



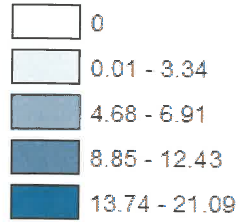



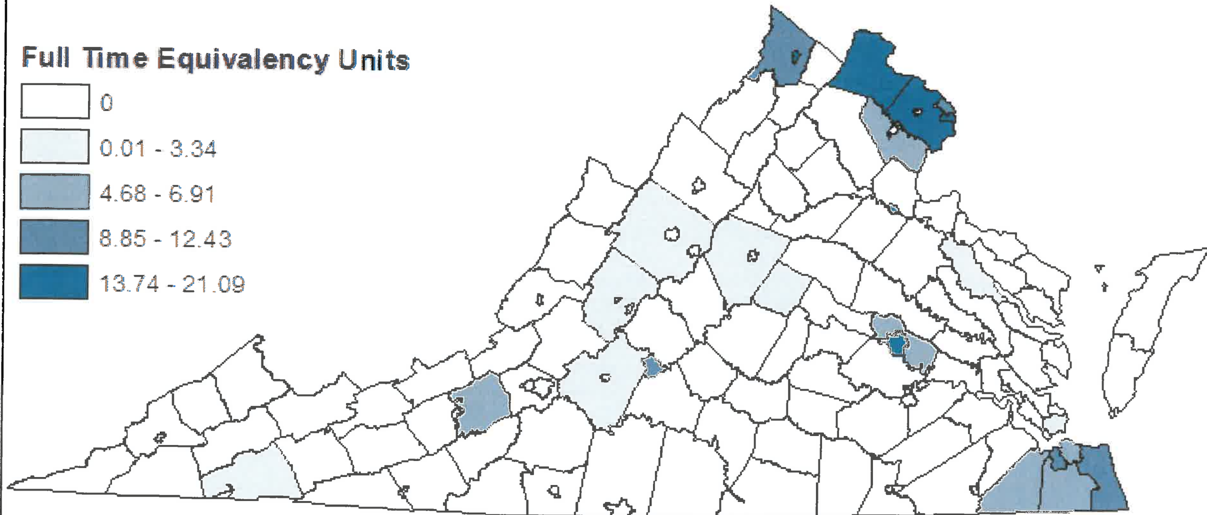
## FTEs per 1,000 Residents



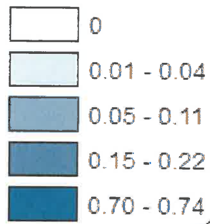



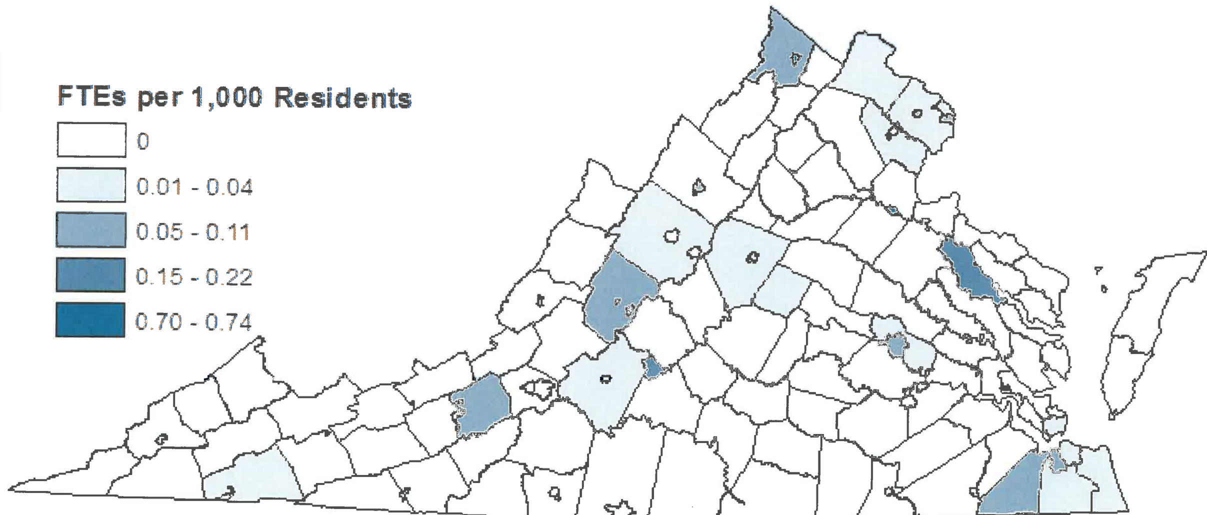
## Certified Nurse Midwives: Full Time Equivalency Units



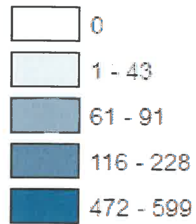



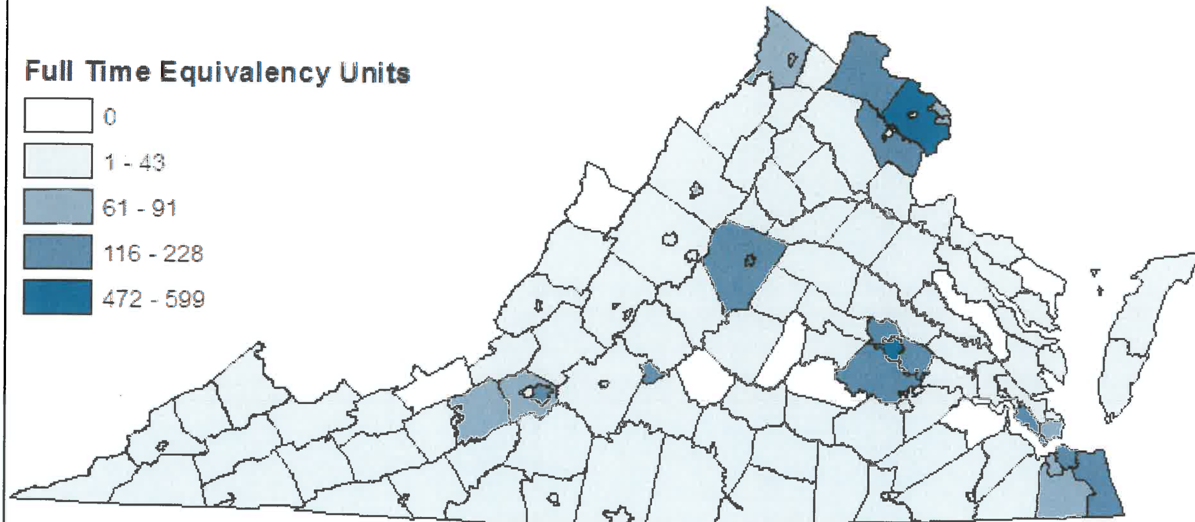
## FTEs per 1,000 Residents



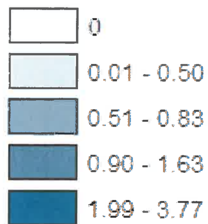



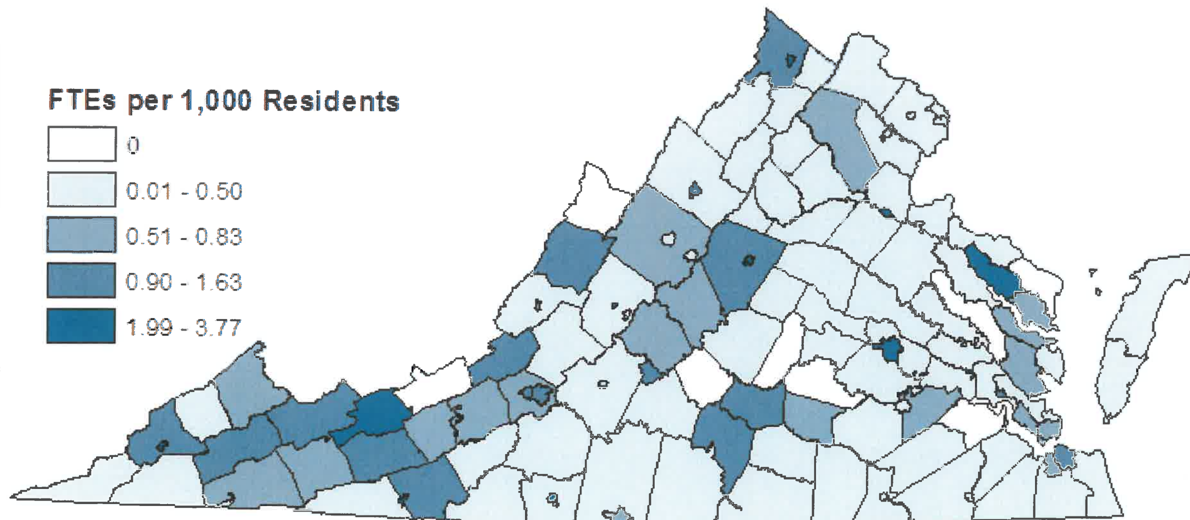
## Certified Nurse Practitioners: Full Time Equivalency Units



## FTEs per 1,000 Residents



## Implementation of HB793
## (Autonomous practice for certain nurse practitioners)

**Tentative Timeline:**

**04/11/18** Discussion of legislation and plan for promulgation of emergency regulations which must be effective by 1/9/19

**05/17/18** Committee of Joint Boards to receive public comment, consider draft regulations, and make recommendations

**07/17/18** Board of Nursing to adopt emergency regulations/NOIRA

**08/3/18** Board of Medicine to adopt emergency regulations/NOIRA

**Implementation upon effective date of regulation.**

**Topics for consideration in adoption of regulations to amend Chapters 30 (NP Licensure) and 40 (Prescriptive Authority):**

- **Equivalent of at least five years of full-time clinical experience**
- **Routinely practiced in a practice area included within the category for which the NP was certified and licensed**
- **Fee associated with submission of attestation and issuance of autonomous designation**
- **Acceptance of "other evidence" demonstrating that the applicant met the requirements**
- **Endorsement of experience in other states**
- **Unprofessional conduct – falsification of attestation**

## VIRGINIA ACTS OF ASSEMBLY — CHAPTER

*An Act to amend and reenact §§ 22.1-271.7, 32.1-263, 32.1-282, 54.1-2901, 54.1-2903, 54.1-2957, 54.1-2957.01, 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.*

[H 793]

Approved

**Be it enacted by the General Assembly of Virginia:**

**1. That §§ 22.1-271.7, 32.1-263, 32.1-282, 54.1-2901, 54.1-2903, 54.1-2957, 54.1-2957.01, 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.

**§ 54.1-2901. 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

118 him, such activities or functions as are nondiscretionary and do not require the exercise of professional
119 judgment for their performance and which are usually or customarily delegated to such persons by
120 practitioners of the healing arts, if such activities or functions are authorized by and performed for such
121 practitioners of the healing arts and responsibility for such activities or functions is assumed by such
122 practitioners of the healing arts;
123 7. The rendering of medical advice or information through telecommunications from a physician
124 licensed to practice medicine in Virginia or an adjoining state, or from a licensed nurse practitioner, to
125 emergency medical personnel acting in an emergency situation;
126 8. The domestic administration of family remedies;
127 9. The giving or use of massages, steam baths, dry heat rooms, infrared heat or ultraviolet lamps in
128 public or private health clubs and spas;
129 10. The manufacture or sale of proprietary medicines in this Commonwealth by licensed pharmacists
130 or druggists;
131 11. The advertising or sale of commercial appliances or remedies;
132 12. The fitting by nonitinerant persons or manufacturers of artificial eyes, limbs or other apparatus or
133 appliances or the fitting of plaster cast counterparts of deformed portions of the body by a nonitinerant
134 bracemaker or prosthetist for the purpose of having a three-dimensional record of the deformity, when
135 such bracemaker or prosthetist has received a prescription from a licensed physician, licensed nurse
136 practitioner, or licensed physician assistant directing the fitting of such casts and such activities are
137 conducted in conformity with the laws of Virginia;
138 13. Any person from the rendering of first aid or medical assistance in an emergency in the absence
139 of a person licensed to practice medicine or osteopathy under the provisions of this chapter;
140 14. The practice of the religious tenets of any church in the ministration to the sick and suffering by
141 mental or spiritual means without the use of any drug or material remedy, whether gratuitously or for
142 compensation;
143 15. Any legally qualified out-of-state or foreign practitioner from meeting in consultation with legally
144 licensed practitioners in this Commonwealth;
145 16. Any practitioner of the healing arts licensed or certified and in good standing with the applicable
146 regulatory agency in another state or Canada when that practitioner of the healing arts is in Virginia
147 temporarily and such practitioner has been issued a temporary authorization by the Board from
148 practicing medicine or the duties of the profession for which he is licensed or certified (i) in a summer
149 camp or in conjunction with patients who are participating in recreational activities, (ii) while
150 participating in continuing educational programs prescribed by the Board, or (iii) by rendering at any
151 site any health care services within the limits of his license, voluntarily and without compensation, to
152 any patient of any clinic which is organized in whole or in part for the delivery of health care services
153 without charge as provided in § 54.1-106;
154 17. The performance of the duties of any active duty health care provider in active service in the
155 army, navy, coast guard, marine corps, air force, or public health service of the United States at any
156 public or private health care facility while such individual is so commissioned or serving and in
157 accordance with his official military duties;
158 18. Any masseur, who publicly represents himself as such, from performing services within the scope
159 of his usual professional activities and in conformance with state law;
160 19. Any person from performing services in the lawful conduct of his particular profession or
161 business under state law;
162 20. Any person from rendering emergency care pursuant to the provisions of § 8.01-225;
163 21. Qualified emergency medical services personnel, when acting within the scope of their
164 certification, and licensed health care practitioners, when acting within their scope of practice, from
165 following Durable Do Not Resuscitate Orders issued in accordance with § 54.1-2987.1 and Board of
166 Health regulations, or licensed health care practitioners from following any other written order of a
167 physician not to resuscitate a patient in the event of cardiac or respiratory arrest;
168 22. Any commissioned or contract medical officer of the army, navy, coast guard or air force
169 rendering services voluntarily and without compensation while deemed to be licensed pursuant to
170 § 54.1-106;
171 23. Any provider of a chemical dependency treatment program who is certified as an "acupuncture
172 detoxification specialist" by the National Acupuncture Detoxification Association or an equivalent
173 certifying body, from administering auricular acupuncture treatment under the appropriate supervision of
174 a National Acupuncture Detoxification Association certified licensed physician or licensed acupuncturist;
175 24. Any employee of any assisted living facility who is certified in cardiopulmonary resuscitation
176 (CPR) acting in compliance with the patient's individualized service plan and with the written order of
177 the attending physician not to resuscitate a patient in the event of cardiac or respiratory arrest;
178 25. Any person working as a health assistant under the direction of a licensed medical or osteopathic

179 doctor within the Department of Corrections, the Department of Juvenile Justice or local correctional
180 facilities;
181 26. Any employee of a school board, authorized by a prescriber and trained in the administration of
182 insulin and glucagon, when, upon the authorization of a prescriber and the written request of the parents
183 as defined in § 22.1-1, assisting with the administration of insulin or administrating glucagon to a
184 student diagnosed as having diabetes and who requires insulin injections during the school day or for
185 whom glucagon has been prescribed for the emergency treatment of hypoglycemia;
186 27. Any practitioner of the healing arts or other profession regulated by the Board from rendering
187 free health care to an underserved population of Virginia who (i) does not regularly practice his
188 profession in Virginia, (ii) holds a current valid license or certificate to practice his profession in another
189 state, territory, district or possession of the United States, (iii) volunteers to provide free health care to
190 an underserved area of the Commonwealth under the auspices of a publicly supported all volunteer,
191 nonprofit organization that sponsors the provision of health care to populations of underserved people,
192 (iv) files a copy of the license or certification issued in such other jurisdiction with the Board, (v)
193 notifies the Board at least five business days prior to the voluntary provision of services of the dates and
194 location of such service, and (vi) acknowledges, in writing, that such licensure exemption shall only be
195 valid, in compliance with the Board's regulations, during the limited period that such free health care is
196 made available through the volunteer, nonprofit organization on the dates and at the location filed with
197 the Board. The Board may deny the right to practice in Virginia to any practitioner of the healing arts
198 whose license or certificate has been previously suspended or revoked, who has been convicted of a
199 felony or who is otherwise found to be in violation of applicable laws or regulations. However, the
200 Board shall allow a practitioner of the healing arts who meets the above criteria to provide volunteer
201 services without prior notice for a period of up to three days, provided the nonprofit organization
202 verifies that the practitioner has a valid, unrestricted license in another state;
203 28. Any registered nurse, acting as an agent of the Department of Health, from obtaining specimens
204 of sputum or other bodily fluid from persons in whom the diagnosis of active tuberculosis disease, as
205 defined in § 32.1-49.1, is suspected and submitting orders for testing of such specimens to the Division
206 of Consolidated Laboratories or other public health laboratories, designated by the State Health
207 Commissioner, for the purpose of determining the presence or absence of tubercle bacilli as defined in
208 § 32.1-49.1;
209 29. Any physician of medicine or osteopathy or nurse practitioner from delegating to a registered
210 nurse under his supervision the screening and testing of children for elevated blood-lead levels when
211 such testing is conducted (i) in accordance with a written protocol between the physician or nurse
212 practitioner and the registered nurse and (ii) in compliance with the Board of Health's regulations
213 promulgated pursuant to §§ 32.1-46.1 and 32.1-46.2. Any follow-up testing or treatment shall be
214 conducted at the direction of a physician or nurse practitioner;
215 30. Any practitioner of one of the professions regulated by the Board of Medicine who is in good
216 standing with the applicable regulatory agency in another state or Canada from engaging in the practice
217 of that profession when the practitioner is in Virginia temporarily with an out-of-state athletic team or
218 athlete for the duration of the athletic tournament, game, or event in which the team or athlete is
219 competing;
220 31. Any person from performing state or federally funded health care tasks directed by the consumer,
221 which are typically self-performed, for an individual who lives in a private residence and who, by
222 reason of disability, is unable to perform such tasks but who is capable of directing the appropriate
223 performance of such tasks; or
224 32. Any practitioner of one of the professions regulated by the Board of Medicine who is in good
225 standing with the applicable regulatory agency in another state from engaging in the practice of that
226 profession in Virginia with a patient who is being transported to or from a Virginia hospital for care.
227 B. Notwithstanding any provision of law or regulation to the contrary, military medical personnel, as
228 defined in § 2.2-2001.4, while participating in a pilot program established by the Department of Veterans
229 Services pursuant to § 2.2-2001.4, may practice under the supervision of a licensed physician or
230 podiatrist.
231 **§ 54.1-2903. What constitutes practice.**
232 Any person shall be regarded as practicing the healing arts who actually engages in such practice as
233 defined in this chapter, or who opens an office for such purpose, or who advertises or announces to the
234 public in any manner a readiness to practice or who uses in connection with his name the words or
235 letters "Doctor," "Dr.," "M.D.," "D.O.," "D.P.M.," "D.C.," "Healer," *"N.P.,"* or any other title, word,
236 letter or designation intending to designate or imply that he is a practitioner of the healing arts or that
237 he is able to heal, cure or relieve those suffering from any injury, deformity or disease. No person
238 regulated under this chapter shall use the title "Doctor" or the abbreviation "Dr." in writing or in
239 advertising in connection with his practice unless he simultaneously uses a clarifying title, initials,

abbreviation or designation or language that identifies the type of practice for which he is licensed.

Signing a birth or death certificate, or signing any statement certifying that the person so signing has rendered professional service to the sick or injured, or signing or issuing a prescription for drugs or other remedial agents, shall be prima facie evidence that the person signing or issuing such writing is practicing the healing arts within the meaning of this chapter except where persons other than physicians are required to sign birth certificates.

**§ 54.1-2957. Licensure and practice of nurse practitioners.**

A. As used in this section:

*"Clinical experience" means the postgraduate delivery of health care directly to patients pursuant to a practice agreement with a patient care team physician.*

"Collaboration" means the communication and decision-making process among *a nurse practitioner, patient care team physician, and other health care providers who are* members of a patient care team related to the treatment *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 subsection H, a~~ *Every* 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~~ *other than a nurse practitioner licensed by the Boards of Medicine and Nursing as a certified nurse midwife or a certified registered nurse anesthetist or a nurse practitioner who meets the requirements of subsection I* shall maintain appropriate collaboration and consultation, as evidenced in a written or electronic practice agreement, with at least one patient care team physician. ~~Nurse practitioners~~ *A nurse practitioner who meets the requirements of subsection I may practice without a written or electronic practice agreement. A nurse practitioner who is licensed by the Boards of Medicine and Nursing as a certified nurse midwife shall practice pursuant to subsection H. A nurse practitioner* who ~~are~~ *is a* certified registered nurse anesthetists shall practice under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry. ~~Nurse practitioners~~ *A nurse practitioner who is* appointed as *a* medical ~~examiners~~ *examiner* pursuant to § 32.1-282 shall practice in collaboration with a licensed doctor of medicine or osteopathic medicine who has been appointed to serve as a medical examiner pursuant to § 32.1-282. Collaboration and consultation among nurse practitioners and patient care team physicians 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~~ *Boards* of Medicine and ~~the Board of~~ Nursing shall jointly promulgate regulations specifying collaboration and consultation among physicians and nurse practitioners working as part of patient care teams that shall include the development of, and periodic review and revision of, a written or electronic practice agreement; guidelines for availability and ongoing communications that define consultation among the collaborating parties and the patient; and periodic joint evaluation of the services delivered. Practice agreements shall include ~~a provision~~ *provisions* for ~~appropriate physician~~ *(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 patient care team physician and (ii)* input *from appropriate health care providers* in complex clinical cases and patient emergencies and for referrals. Evidence of a practice agreement shall be maintained by 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.

E. The Boards *of Medicine and Nursing* 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. *A nurse practitioner to whom a license is issued by endorsement may practice without a practice agreement with a patient care team physician pursuant to subsection I if such application provides an attestation to the Boards that the applicant has completed the equivalent of at least five years of full-time clinical experience, as determined by the Boards, in accordance with the laws of the state in which the nurse practitioner was licensed.*

F. Pending the outcome of the next National Specialty Examination, the Boards may jointly grant temporary licensure to nurse practitioners.

G. In the event a physician who is serving as a patient care team physician dies, becomes disabled, retires from active practice, surrenders his license or has it suspended or revoked by the Board, or relocates his practice such that he is no longer able to serve, and a nurse practitioner is unable to enter into a new practice agreement with another patient care team physician, 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 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 and to have access to appropriate ~~physician~~ input *from appropriate health care providers* in complex clinical cases and patient emergencies and for referrals. The designee or his alternate of the Boards shall grant permission for the 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 and of access to physician input.

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. A nurse practitioner, 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 has completed the equivalent of at least five years of full-time clinical experience as a licensed nurse practitioner, as determined by the Boards, may practice in the practice category in which he is certified and licensed without a written or electronic practice agreement upon receipt by the nurse practitioner of an attestation from the patient care team physician stating (i) that the patient care team physician has served as a patient care team physician on a patient care team with the nurse practitioner pursuant to a practice agreement meeting the requirements of this section and § 54.1-2957.01; (ii) that while a party to such practice agreement, the patient care team physician routinely practiced with a patient population and in a practice area included within the category for which the nurse practitioner was certified and licensed; and (iii) the period of time for which the patient care team physician practiced with the nurse practitioner under such a practice agreement. A copy of such attestation shall be submitted to the Boards together with a fee established by the Boards. Upon receipt of such attestation and verification that a nurse practitioner satisfies the requirements of this subsection, the Boards shall issue to the nurse practitioner a new license that includes a designation indicating that the nurse practitioner is authorized to practice without a practice agreement. In the event that a nurse practitioner is unable to obtain the attestation required by this subsection, the Boards may accept other evidence demonstrating that the applicant has met the requirements of this subsection in accordance with regulations adopted by the Boards.*

*A nurse practitioner authorized to practice without a practice agreement pursuant to this subsection shall (a) only practice within the scope of his clinical and professional training and limits of his knowledge and experience and consistent with the applicable standards of care, (b) consult and collaborate with other health care providers based on the clinical conditions of the patient to whom health care is provided, and (c) establish a plan for referral of complex medical cases and emergencies to physicians or other appropriate health care providers.*

*A nurse practitioner practicing without a practice agreement pursuant to this subsection shall obtain and maintain coverage by or shall be named insured on a professional liability insurance policy with limits equal to the current limitation on damages set forth in § 8.01-581.15.*

362 **§ 54.1-2957.01. Prescription of certain controlled substances and devices by licensed nurse**
363 **practitioners.**
364 A. In accordance with the provisions of this section and pursuant to the requirements of Chapter 33
365 (§ 54.1-3300 et seq.), a licensed nurse practitioner, other than a certified registered nurse anesthetist,
366 shall have the authority to prescribe Schedule II through Schedule VI controlled substances and devices
367 as set forth in Chapter 34 (§ 54.1-3400 et seq.). ~~Nurse practitioners shall have such prescriptive authority~~
368 ~~upon the provision~~
369 *B. A nurse practitioner who does not meet the requirements for practice without a written or*
370 *electronic practice agreement set forth in subsection I of § 54.1-2957 shall prescribe controlled*
371 *substances or devices only if such prescribing is authorized by a written or electronic practice*
372 *agreement entered into by the nurse practitioner and a patient care team physician. Such nurse*
373 *practitioner shall provide* to the ~~Board~~ *Boards* of Medicine and ~~the Board of~~ Nursing ~~of~~ such evidence
374 as ~~they~~ *the Boards* may jointly require that the nurse practitioner has entered into and is, at the time of
375 writing a prescription, a party to a written or electronic practice agreement with a patient care team
376 physician that clearly states the prescriptive practices of the nurse practitioner. Such written or electronic
377 practice agreements shall include the controlled substances the nurse practitioner is or is not authorized
378 to prescribe and may restrict such prescriptive authority as described in the practice agreement. Evidence
379 of a practice agreement shall be maintained by a nurse practitioner pursuant to § 54.1-2957. Practice
380 agreements authorizing a nurse practitioner to prescribe controlled substances or devices pursuant to this
381 section *either* shall ~~either~~ be signed by the patient care team physician ~~who is practicing as part of a~~
382 ~~patient care team with the nurse practitioner~~ or shall clearly state the name of the patient care team
383 physician who has entered into the practice agreement with the nurse practitioner.
384 ~~B.~~ It shall be unlawful for a nurse practitioner to prescribe controlled substances or devices pursuant
385 to this section unless *(i)* such prescription is authorized by the written or electronic practice agreement
386 *or (ii) the nurse practitioner is authorized to practice without a written or electronic practice agreement*
387 *pursuant to subsection I of § 54.1-2957.*
388 C. The ~~Board of Nursing and the Board~~ *Boards* of Medicine *and Nursing* shall promulgate ~~such~~
389 regulations governing the prescriptive authority of nurse practitioners as are deemed reasonable and
390 necessary to ensure an appropriate standard of care for patients. ~~Regulations promulgated pursuant to~~
391 ~~this section~~ *Such regulations* shall include~~, at a minimum, such~~ requirements as may be necessary to
392 ensure continued nurse practitioner competency, which may include continuing education, testing, or any
393 other requirement, and shall address the need to promote ethical practice, an appropriate standard of
394 care, patient safety, the use of new pharmaceuticals, and appropriate communication with patients.
395 D. This section shall not limit the functions and procedures of certified registered nurse anesthetists
396 or of any nurse practitioners which are otherwise authorized by law or regulation.
397 E. The following restrictions shall apply to any nurse practitioner authorized to prescribe drugs and
398 devices pursuant to this section:
399 1. The nurse practitioner shall disclose to the patient at the initial encounter that he is a licensed
400 nurse practitioner. Any ~~member of a patient care team~~ *party to a practice agreement* shall disclose, upon
401 request of a patient or his legal representative, the name of the patient care team physician and
402 information regarding how to contact the patient care team physician.
403 2. Physicians shall not serve as a patient care team physician on a patient care team at any one time
404 to more than six nurse practitioners.
405 F. This section shall not prohibit a licensed nurse practitioner from administering controlled
406 substances in compliance with the definition of "administer" in § 54.1-3401 or from receiving and
407 dispensing manufacturers' professional samples of controlled substances in compliance with the
408 provisions of this section.
409 G. Notwithstanding any provision of law or regulation to the contrary, a nurse practitioner licensed
410 by the Boards of ~~Nursing and~~ Medicine *and Nursing* in the category of certified nurse midwife and
411 holding a license for prescriptive authority may prescribe (i) Schedules II through V controlled
412 substances in accordance with any prescriptive authority included in a practice agreement with a licensed
413 physician pursuant to subsection H of § 54.1-2957 and (ii) Schedule VI controlled substances without
414 the requirement for inclusion of such prescriptive authority in a practice agreement.
415 **§ 54.1-3300. Definitions.**
416 As used in this chapter, unless the context requires a different meaning:
417 "Board" means the Board of Pharmacy.
418 "Collaborative agreement" means a voluntary, written, or electronic arrangement between one
419 pharmacist and his designated alternate pharmacists involved directly in patient care at a single physical
420 location where patients receive services and (i) any person licensed to practice medicine, osteopathy, or
421 podiatry together with any person licensed, registered, or certified by a health regulatory board of the
422 Department of Health Professions who provides health care services to patients of such person licensed

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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

606 whom he is currently receiving care; (b) the patient gives written consent for the physical therapist to
607 release all personal health information and treatment records to the identified practitioner; and (c) the
608 physical therapist notifies the practitioner identified by the patient no later than 14 days after treatment
609 commences and provides the practitioner with a copy of the initial evaluation along with a copy of the
610 patient history obtained by the physical therapist. Treatment for more than 30 consecutive days after
611 evaluation of such patient shall only be upon the referral and direction of a licensed doctor of medicine,
612 osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in
613 accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant
614 acting under the supervision of a licensed physician. A physical therapist may contact the practitioner
615 identified by the patient at the end of the 30-day period to determine if the practitioner will authorize
616 additional physical therapy services until such time as the patient can be seen by the practitioner. A
617 physical therapist shall not perform an initial evaluation of a patient under this subsection if the physical
618 therapist has performed an initial evaluation of the patient under this subsection for the same condition
619 within the immediately preceding 60 days.

620 C. A physical therapist who has not completed a doctor of physical therapy program approved by the
621 Commission on Accreditation of Physical Therapy Education or who has not obtained a certificate of
622 authorization pursuant to § 54.1-3482.1 may conduct a one-time evaluation that does not include
623 treatment of a patient without the referral and direction of a licensed doctor of medicine, osteopathy,
624 chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his~~
625 ~~practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the
626 supervision of a licensed physician; if appropriate, the physical therapist shall immediately refer such
627 patient to the appropriate practitioner.

628 D. Invasive procedures within the scope of practice of physical therapy shall at all times be
629 performed only under the referral and direction of a licensed doctor of medicine, osteopathy,
630 chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with ~~his~~
631 ~~practice agreement~~ *the provisions of § 54.1-2957*, or a licensed physician assistant acting under the
632 supervision of a licensed physician.

633 E. It shall be unlawful for any licensed physical therapist to fail to immediately refer any patient to a
634 licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, or a licensed nurse
635 practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957* when
636 such patient's medical condition is determined, at the time of evaluation or treatment, to be beyond the
637 physical therapist's scope of practice. Upon determining that the patient's medical condition is beyond
638 the scope of practice of a physical therapist, a physical therapist shall immediately refer such patient to
639 an appropriate practitioner.

640 F. Any person licensed as a physical therapist assistant shall perform his duties only under the
641 direction and control of a licensed physical therapist.

642 G. However, a licensed physical therapist may provide, without referral or supervision, physical
643 therapy services to (i) a student athlete participating in a school-sponsored athletic activity while such
644 student is at such activity in a public, private, or religious elementary, middle or high school, or public
645 or private institution of higher education when such services are rendered by a licensed physical
646 therapist who is certified as an athletic trainer by the National Athletic Trainers' Association Board of
647 Certification or as a sports certified specialist by the American Board of Physical Therapy Specialties;
648 (ii) employees solely for the purpose of evaluation and consultation related to workplace ergonomics;
649 (iii) special education students who, by virtue of their individualized education plans (IEPs), need
650 physical therapy services to fulfill the provisions of their IEPs; (iv) the public for the purpose of
651 wellness, fitness, and health screenings; (v) the public for the purpose of health promotion and
652 education; and (vi) the public for the purpose of prevention of impairments, functional limitations, and
653 disabilities.

654 **§ 54.1-3482.1. Certain certification required.**

655 A. The Board shall promulgate regulations establishing criteria for certification of physical therapists
656 to provide certain physical therapy services pursuant to subsection B of § 54.1-3482 without referral
657 from a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse
658 practitioner practicing in accordance with ~~his practice agreement~~ *the provisions of § 54.1-2957*, or a
659 licensed physician assistant acting under the supervision of a licensed physician. The regulations shall
660 include but not be limited to provisions for (i) the promotion of patient safety; (ii) an application
661 process for a one-time certification to perform such procedures; and (iii) minimum education, training,
662 and experience requirements for certification to perform such procedures.

663 B. The minimum education, training, and experience requirements for certification shall include
664 evidence that the applicant has successfully completed (i) a transitional program in physical therapy as
665 recognized by the Board or (ii) at least three years of active practice with evidence of continuing
666 education relating to carrying out direct access duties under § 54.1-3482.

667 **2. That the Boards of Medicine and Nursing shall jointly promulgate regulations to implement the**
668 **provisions of this act, which shall govern the practice of nurse practitioners practicing without a**
669 **practice agreement in accordance with the provisions of this act, to be effective within 280 days of**
670 **its enactment.**
671 **3. That the Department of Health Professions shall, by November 1, 2020, report to the General**
672 **Assembly a process by which nurse practitioners who practice without a practice agreement may**
673 **be included in the online Practitioner Profile maintained by the Department of Health Professions.**
674 **4. That the Boards of Medicine and Nursing shall report on data on the implementation of this**
675 **act, including the number of nurse practitioners who have been authorized to practice without a**
676 **practice agreement, the geographic and specialty areas in which nurse practitioners are practicing**
677 **without a practice agreement, and any complaints or disciplinary actions taken against such nurse**
678 **practitioners, along with any recommended modifications to the requirements of this act including**
679 **any modifications to the clinical experience requirements for practicing without a practice**
680 **agreement, to the Chairmen of the House Committee on Health, Welfare and Institutions and the**
681 **Senate Committee on Education and Health and the Chairman of the Joint Commission on Health**
682 **Care by November 1, 2021.**