Virginia Department of Health Professions

Boards of Medicine and Nursing Workgroup on SB30 Item 288 #4s

July 8, 2026
10:00 a.m.

Boards of Medicine and Nursing Workgroup
on SB30 Item 288 #4s

Wednesday, July 8, 2026
10:00 a.m.

Perimeter Center
9960 Mayland Drive, Suite 201, Board Room 3
Henrico, VA 23233

Call to Order and Roll Call

Emergency Egress Procedures..... i

Introduction of Work Group Members

Adoption of Agenda

Public Comment on Agenda Items

New Business

1. Charge of the Work Group – Matt Novak.....

2. Discussion: Budget Bill – SB60 Item 288 #4s..... 2

3. Next Steps .....

4. Announcements/Reminders…….3.

5. Adjourn

PERIMETER CENTER CONFERENCE CENTER
EMERGENCY EGRESS OF BOARD AND TRAINING ROOMS

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

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

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

Board Room

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

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

2026 Session

Budget Amendments - SB30 (Floor Approved)

Bill Order » Item 288 #4s

Joint Boards of Nursing and Medicine Workgroup (language only)

Item 288 #4s

Health and Human Resources

Department of Health Professions

Language

Page 333, after line 10, insert:
"E. The Department of Health Professions shall convene a stakeholder workgroup to review the structure and purpose of the Committee of the Joint Boards of Nursing and Medicine. The work group shall consider pathways to modernize the Joint Boards structure and governance of advanced practice registered nurses. The work group shall consist of representatives from the Virginia Council of Nurse Practitioners, Virginia Nurses Association, Virginia Association of Nurse Anesthetists, Medical Society of Virginia, and other stakeholders deemed appropriate by the Department. The workgroup shall report its findings to the Governor and General Assembly by November 1, 2026."

Explanation

(This amendment is a language only amendment directing the Department of Health Professions to convene a stakeholder workgroup to review the structure and purpose of the Committee of the Joint Boards of Nursing and Medicine. The workgroup will report its findings to the Governor and General Assembly by November 1, 2026.)

- The travel regulations require that "travelers must submit the Travel Expense Reimbursement Voucher within 30 days after completion of their trip". (CAPP Topic 20335, State Travel Regulations, p.7). If you submit your reimbursement after the 30-day deadline, please be aware that it cannot be approved.

- In order for the agency to be in compliance with the travel regulations, please submit your request for today's meeting no later than

Virginia Board of Nursing and Medicine Committee of Joint Boards
History, Structure and Processes

APRNs practice in one of 4 roles – nurse practitioner (NP), certified registered nurse anesthetist (CRNA), certified nurse midwife (CNM) or clinical nurse specialist (CNS). They are jointly regulated by the Boards of Nursing and Medicine in Virginia. In its 2023 session, the Virginia General Assembly amended the Code replacing the umbrella title of "nurse practitioner" with "advanced practice registered nurse" bringing Virginia statute further into alignment with the 2008 Consensus Model for APRN Regulation.

History of APRN Regulation in Virginia

The regulations governing APRNs were initially promulgated in 1975 and included supervision of NP and CRNA practice. The following year, regulations for CNMs were added. By 1986, Virginia certified CRNAs, CNMs, and NPs by population focus. Shortly thereafter 1988, the status of APRNs changed from certified to licensed, and regulations were amended modifying the definition of supervision. In 1989, Virginia began registering for CNSs. Notably, common functional role competencies for CNS practice were not delineated nationally until 1998, which may explain the delay on the part of Virginia in shifting CNS regulation from certification to full licensure in 2021.

The Virginia General Assembly has incrementally expanded APRN practice through amendments to the Virginia Code. From provisional practice status to legal changes enabling insurance reimbursement and Schedule II-VI prescriptive authority to granting full practice authority to NPs and CNMs when criteria are met, the Commonwealth has incrementally grown closer to alignment with the APRN Consensus Model.

Committee of the Joint Boards of Nursing and Medicine

The Committee of the Joint Boards of Nursing and Medicine (CJB) was created by regulation and is comprised of 6 members, 3 members from each of the Boards of Nursing and Medicine, appointed by the respective board presidents. The CJB schedules five business meetings per year to administer the Regulations Governing the Licensure of Nurse Practitioners (18VAC90-30-10 et seq.). In addition, the CJB considers APRN disciplinary and applicant cases at the formal and informal proceeding levels as well as Agency Subordinate Recommendations.

Licensure

Virginia APRNs are licensed consistently with their education and certification in a specialty (population focus) as follows (see 18VAC90-30-70):

- Family nurse practitioner
- Adult/geriatric primary care nurse practitioner
- Adult/geriatric acute care nurse practitioner
- Psychiatric nurse/mental health practitioner
- Women's health nurse practitioner
- Pediatric/primary care nurse practitioner
- Pediatric/acute care nurse practitioner
- Neonatal nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist
- Certified nurse midwife
- Licensed Certified Midwife

Prepared by National Council of State Boards of Nursing (NCSBN)

FAQ: Joint Regulation of APRNs and Standard of Care

1. **In the 27 states with FPA, how many have BON sole jurisdiction over APRNs?**

   In all 27 states with full practice authority, as defined by AANP, the BON has sole jurisdiction over the regulation of APRNs. Jurisdiction is defined as having licensure, practice, and disciplinary authority over APRNs.

   Other States/Roles:

   - In North Carolina, CNMs are regulated jointly by the BOM and BON, and CNMs are eligible to retire their collaborative agreements after 8,000 hours of practice.
   - In Arkansas, a Full Independent Practice Credentialing Committee is created in the Dept. of Health governing CNPs and CNS' practicing without a collaborative agreement. The committee is made up of 4 physicians and 4 CNPs. The committee's powers include
     - Approves/denies applications for "certificates of full independent practice authority"
     - Reviews complaints among certificants
     - Reviews recommendations by BOM and BON
     - Hold hearings for actions taken to suspend or revoke certificate

2. **How many states have regulatory structures in place that are not just BON regulation of APRNs, and what does this look like?**
   a. Alabama
      i. CNPs and CNMs are jointly regulated
      ii. There is a Joint Committee of the State Board of Medical Examiners and the Board of Nursing for Advanced Practice Nurses.
         1. Committee structure:
            a. Two physicians
            b. One RN
            c. One licensed physician engaged in collab practice with a CNP
            d. One CNP engaged in collab practice
            e. One CNM engaged in collab practice
         2. Committee Responsibilities
            a. Recommend rules and regs for regulating collaborative practice of CNPs and CNMs
            b. Recommend formulary of legend drugs

   b. North Carolina
      i. CNPs and CNMs are jointly regulated by the Boards of Medicine and Nursing

   c. Virginia
      i. APRNs are jointly licensed and regulated by the Boards of Medicine and Nursing.
      ii. Rulemaking
         1. Laws regulating APRNs are in the Medical Practice Act but there are no regulations relating to APRNs in BOM regulations.
         2. Regulations pertaining to APRNs are recommended by the Committee of the Joint Boards of Medicine and Nursing, must be approved by both boards, are housed under the BON.

3. **What are the problems with medical board regulation of APRNs? What problems have experts like the FTC cited?**
   - **Concerns:**
     - **Loss of expertise**
       - BONs are expert nursing regulators. Regulation of APRNs should be done by individuals most familiar with the education, certification, scope and standards of practice of that profession.
       - The Texas Board of Nursing has been regulating APRNs since 1980.
     - **Costly and Duplicative**
       - When South Dakota retired joint regulation of CNPs and CNMs, the fiscal analysis found that the state would save $71,000 annually.
       - Duplicative cost of joint regulation/sole BOM regulation as APRNs are licensed registered nurses who are regulated by Boards of Nursing.
     - **Ignoring national standards**
       - Proposed guidance dating back to the early 1990s called on BONs to regulate APRNs.
       - 2008 Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education set regulatory guidelines for APRNs by boards of nursing.
     - **Antiquated**
       - The last state to adopt joint regulation was South Dakota over 20 years ago. They have since retired joint regulation in 2017.
       - In 2021, Delaware and Massachusetts removed physician-controlled regulatory board oversight over various APRN regulatory functions.
     - **Anti-competitive**
       - The American Medical Association, the largest trade organization for physicians, adopted a new policy in 2023 to call on APRNs to be regulated by physician-controlled regulatory boards. The policy was part of the AMA's fight against "scope creep", so it can be deduced that it was made in an effort to prevent removing unnecessary barriers to APRN patient care.
   - **FTC**
     - Re: amendment to move APRN regulation under the physician-controlled regulatory board:
       - "We urge you to consider whether to allow independent regulatory boards dominated by medical doctors and doctors of osteopathy to regulate APRN prescribing, given the risk of bias due to professional and financial self-interest" (FTC Comment Letter to WV, 2016).
       - "Such an amendment would raise concerns about potential biases and conflicts of interest. The Institute of Medicine has argued that common restrictions on independent APRN practice and prescribing are not evidence-based, and that historically entrenched forms of training and care delivery, dated or erroneous beliefs about the training or performance of APRNs, and professional bias are factors in physician opposition to regulatory reform" (FTC Comment Letter to KS, 2020).

4. **Are there any examples where medical board regulation of APRNs has run afoul of the law, and where the medical board overstepped, overreached, or even blocked legislative intent?**
    a. In Mississippi, the MS BOM promulgated rules to govern collaborative practice agreements entered into by physicians. Despite no statutory reference to mileage or other geographic restrictions, the MS BOM adopted regulations prohibiting physicians who are in collaborative agreements with APRNs from entering into such agreement if their "practice location is greater than seventy-five (75) miles from the primary office of the physician". This rule promulgation by the MS BOM impacted access to care and APRN practice greatly.
    b. In July 2023, Missouri Governor Parsons signed into law a bill removing the authority of the BOM and BON from regulating 'geographic proximity". The BON moved to eliminate rulemaking around the geographic proximity requirement, but by January 2024, the BOM had failed to eliminate their rulemaking. The legislature's Joint Committee on Administrative Rules met to question the BOM on why they failed to implement the law by eliminating the joint administrative rule that requires APRNs to be within 75 miles of their collaborating physician. The BOM subsequently met and voted to remove the mileage rule.

5. **How does the standard of care change with passage of full practice authority? Are regulatory agencies responsible for redefining the standard of care and promulgating new rules?**
    a. The standard of care does not change with the passage of full practice authority. APRNs are educated and certified to provide a range of services, whether or not they are required to be in a contract with a physician. APRNs care for patients using the general standard of care that applies to all professions.
    b. In Florida passage of HB 607 created a path to autonomous practice for many APRNs and also created a Council on APRN Autonomous Practice. The charge of the council was to recommend standards of practice for APRNs who practice autonomously to the Board of Nursing. The council is purely advisory in nature, met only twice, and recommended the following statement on standards of practice for autonomous APRNs, which was then approved by the Florida Board of Nursing:
        i. **<u>Rule 64B9-4.021, FAC Standards for Autonomous Practice- Effective 10/26/2021</u>**
        Advanced practice registered nurses who are registered pursuant to Section 464.0123, F.S., shall engage in autonomous practice only in a manner that meets the General Standard of Practice. The General Standard of Practice shall be that standard of practice, care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similarly situated, educated, and licensed Advanced Practice Registered Nurses.
        Rulemaking Authority 464.0123 FS. Law Implemented 464.0123 FS. History–New 10-26-21.

AMA Policy Change Signals APRN Regulatory Fights Ahead

Nicole Livanos, JD, MPP

It is perhaps apparent that boards of *nursing* have historically regulated advanced practice registered *nurses* (APRNs). APRNs are registered nurses who go on to receive advanced graduate-level degrees or higher in a role (ie, certified registered nurse anesthetist, certified nurse-midwife, clinical nurse specialist, or certified nurse practitioner [CNP]) and population foci (National Council of State Boards of Nursing [NCSBN], 2008). As advanced nursing roles became more prevalent, the need for regulating these professionals became apparent, and the regulator governing their registered nursing license and practice was the obvious and appropriate actor. As early as 1992, NCSBN proposed guidance for boards of nursing to adopt licensure for APRNs (NCSBN, 1992). In 2008, the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education* (referred to as the "Consensus Model") set national standards for APRN regulation by boards of nursing (NCSBN, 2008). With 100% of boards of nursing regulating APRNs, one may wonder why this topic is timely and ripe for discussion today. This article outlines the current policy environment for regulation of APRNs and arguments against a recent policy change.

2023 American Medical Association Policy Change

In June 2023, the American Medical Association (AMA) House of Delegates (HOD) considered many wide-ranging topics, including the study of psychedelic agents, artificial intelligence, and the social isolation and loneliness epidemic. However, the AMA's meeting agenda also included reconsideration of a policy change to recommend disrupting the longtime regulatory structure for APRNs (O'Reilly, 2023). The AMA Board of Trustees, in a meeting held ahead of the AMA HOD meeting, recommended the below amendment to Policy H-360.987, titled "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice":

> *(5)* ~~*Physicians should encourage*~~ *Certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists shall be licensed and regulated jointly by the state medical and nursing boards* ~~*explore the feasibility of working together to coordinate their regulatory initiatives and activities.*~~ *(Modify Current HOD Policy)* (AMA, 2023a).*

A Reference Committee report detailing the discussion around the Board of Trustee's recommendation stated, "Your Reference Committee heard that medical boards in many states already license and regulate a variety of non-physicians including physician assistants, and that medical boards in several states also jointly regulate nurse practitioners and other advanced practice registered nurses" (AMA, 2023b). When brought before the HOD in June 2023, the voting body voted to adopt the amendment and thereby "issued a call for certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives and clinical nurse specialists to be licensed and regulated jointly by the state medical and nursing boards" (Robeznieks, 2023). This effort is part of the AMA's fight against what they describe as "scope creep", lobbying at the state and federal level against removing barriers to APRN care. By enacting this new policy, the AMA is likely to commit additional resources and dollars to make changes to APRN regulatory structures across the states (AMA, 2023c).

The State of the States: APRN Regulation

The AMA made an attempt at a similar policy change that failed in 2017. Just like at that time, only a handful of states have joint regulation of APRNs by boards of medicine. Since 2017, joint regulatory oversight by physician-dominated boards has been untangling rather than spreading. In only three states—Alabama, North Carolina, and Virginia—some or all APRNs are regulated jointly by the respective nursing and physician regulatory boards (Virginia Department of Health Professions, 2021). In a handful of additional states, there are areas of shared rulemaking authority between boards on matters related to supervisory or collaborative agreements.

This article is an update to the *JNR* Volume 8/Issue 3 October 2017 article "Physicians Look to Disrupt Longtime Regulatory Tradition for APRNs."

* Underlined text indicates new text, text that is struck through indicates deletion of existing policy, and text without underline or strike-through indicates maintained existing policy.

In Alabama, a joint committee between the two boards regulates APRN practice (Hayes et al., 2023). In North Carolina, CNPs and certified nurse midwives are under joint regulation by the board of nursing and medical board. For CNPs, a Nurse Practitioner Joint Subcommittee develops rules to govern the practice of CNPs, but rules are codified by the nursing board and medical board separately (NC Board of Nursing, 2022). In Virgina, antiquated laws dating back to 1973 authorized joint regulation of APRNs by the boards of nursing and medicine (Virginia Department of Health Professions, 2021). Nursing advocates across these three states continue to push for the removal of joint regulation. For example, a 2021 Virginia Department of Health Professions report recommended that regulation of APRNs be "solely under the Board of Nursing" (Virginia Department of Health Professions, 2021). Action to remove joint regulation by the physician-dominated Virginia Board of Medicine would be in line with recent actions in jurisdictions across the country, including in Delaware and Massachusetts.

In 2021, Delaware House of Representatives Bill 141 ran as companion legislation to Representative Melissa Minor-Brown's APRN Compact legislation (Del. H.R. 21, 2021). House Bill 141 aligned Delaware with the Consensus Model in part by eliminating the Board of Medical Licensure and Discipline's authority to approve or deny disciplinary decisions by the board of nursing over APRNs who have been granted independent practice authority (Del. H.R. 141, 2021). The bill, signed into law by Governor Carney (Del. Code, tit. 24, 2021), also removed physician representatives from the state's ARPN Committee (Del. H.R. 141, 2021). Also in 2021, APRNs in Massachusetts achieved full practice authority with the signing of Senate Bill 2984, An Act Promoting a Resilient Health Care System That Puts Patients First (Joyce, 2021). The Act removed oversight by the state board of registration in medicine over APRN prescriptive authority (Mass. Gen. Laws ch. 112, 2019, 2020; Mass. Gen. Laws ch. 260, 2020).

Concerns regarding the AMA HOD Policy

Antitrust Concerns

Anti-competitive concerns remain with the adoption of the new HOD policy just as they did surrounding the organization's previous attempts at such policy change. In a 2014 policy paper, the Federal Trade Commission (FTC) noted that when physicians were involved in APRN practice, "it may be in the economic self-interest of those physicians to propose and advocate the adoption of restrictions on APRN licensure and scope of practice; and such physicians might be biased towards doing so" (FTC, 2014). It can be inferred, then, that physician involvement in promulgation of rules and regulations governing APRN practice, as would be the case under a joint regulatory structure, could lead to physician self-interested governing. These types of biased actions can lead to the elimination of "APRNs as an important source of safe, lower-cost competition" and other anticompetitive effects (FTC, 2014). In an opinion concluding that restrictions on APRNs in West Virginia would have anticompetitive impacts, the FTC specifically addressed regulation of APRN prescriptive authority by the "independent regulatory boards dominated by medical doctors and doctors of osteopathy" as carrying a "risk of bias due to financial self-interest" (FTC, 2016, p. 2). Thus, the FTC "strongly suggest[s] that it may be problematic to have independent regulatory boards dominated by medical doctors and doctors of osteopathy serve as regulators of APRN prescribing" (FTC, 2016, p. 7).

The FTC has expressed concern even in those states where the regulatory body charged with regulating physicians also regulates additional professions such as physician assistants and physical therapists. As noted above, testimony in support of the AMA policy change cited boards of medicine regulating additional professions as justification for the policy change impacting APRN regulation (AMA, 2023b, p. 7). In a 2020 opinion issued in Kansas, the FTC urged against the legislature adopting an amendment to APRN legislation that would move APRN regulation under the Board of Healing Arts in the state, stating it would "raise concerns about potential biases and conflicts of interest" (FTC, 2020, p. 9).

All of the aforementioned FTC reports and opinions also included concerns related to the Supreme Court decision in North Carolina Board of Dental Examiners v. Federal Trade Commission Supreme Court, especially as it relates to active market participants seated on regulatory boards making regulatory decisions that impact a competitive profession's practice (FTC, 2014, 2016, 2020). The case involved a dental board in North Carolina, with the majority of its' members licensed dentists, and the FTC's market competition concerns over actions the board took when attempting to regulate the teeth whitening services being provided by non-dentist competitors (*North Carolina Board of Dental Examiners v. Federal Trade Commission,* n.d.). Should the AMA HOD policy result in greater presence of regulation of APRNs by physician-dominated boards, the number of actions taken by physician-dominated boards that impact APRNs will likely increase, thus increasing the risk of antitrust violations among the medical boards.

Access to Care Concerns

By observing actions taken by physician regulatory boards that impact APRN practice or regulation, we already know that there are impacts on access to safe and quality APRN care. For example, the Missouri Board of Healing Arts, which consists of seven physicians, has rulemaking authority over a geographic proximity provision governing collaborative agreements between APRNs and physicians (Missouri Division of Professional Registration, n.d.; Simonton, 2022). During COVID-19, Missouri Governor Parsons waived the geographic proximity rule, which required APRNs to practice within 75 miles of the physician with whom they held a collaborative practice agreement (Simonton, 2022). When the waiver expired in December 2021, both the Missouri Board of

Nursing and the Missouri Board of Healing Arts discussed removing the requirement permanently. However, "At a joint meeting between the two on March 28, the Board of Nursing voted to remove it and the Board of Healing Arts voted to keep it. A rule change cannot be filed unless both entities agree" (Simonton, 2022).

Even without a need for agreement between boards, medical board decisions can have an impact on APRN practice and access to care in the state. For example, the physician-dominated Mississippi State Board of Medical Licensure (MSBML) has rulemaking authority governing a physician licensee's participation in a collaborative practice agreement with an APRN. This has resulted in the promulgation of rules governing geographic proximity between the physician collaborator and the APRN, similar to that in Missouri (MSBML, 2023). Although modifications have been made to the rule in recent years, with the Mississippi Academy of Family Physicians noting in their newsletter that "The [MSBML] has approved a measure to release nurse practitioners from the requirement that they practice within 75 miles of their collaborating primary care physician," the physician-controlled board has maintained restrictions for all other APRNs in collaborative practice agreements (Mississippi Academy of Family Physicians, 2018).

Response to the AMA HOD Policy

A swift and robust response followed the news of the HOD policy adoption that threatened APRN regulation as regulators, practitioners, and patients have come to know it. NCSBN, in their response, set the stage by reminding the public—and the AMA—that boards of nursing "have the unique experience and expertise to license, regulate and discipline nurses at all levels of practice from licensed practical/vocational nurses, to registered nurses to APRNs" (NCSBN, 2023). Maryann Alexander, Chief Officer of Nursing Regulation at NCSBN, stated, "Adding the needless oversight of state medical boards does nothing to enhance patient protection but has the potential to add unnecessary bureaucracy that may actually slow down the regulatory process and impede access to care" (NCSBN, 2023). The American Association of Nurse Anesthesiology (AANA) echoed the sentiment of expertise provided by boards of nursing: "State nursing boards are uniquely qualified to oversee the practice of nursing, qualifications that state boards of medicine lack" (AANA, 2023). The AANA also stated familiar concerns regarding the policy posing impediments to competition (AANA, 2023).

State associations expressed opposition to the AMA policy as well. Texas Nurse Practitioners' (TNP) President Cindy Weston commented on the policy's potential harm for Texans accessing high-quality care (Cusack, 2023). TNP also echoed concerns of the FTC's previous statements, stating the following:

> *As recent court decisions have ruled, there are harmful effects of allowing one profession to regulate another, competing profession. Extending oversight of NPs to the Medical Board could result in unnecessary restrictions of NP practice, negatively impacting patient choice, access, and the regulatory costs of health care in Texas* (Cusack, 2023).

Challenges Ahead

The AMA policy enactment occurred despite the increased concerns raised by the FTC in recent years and several states' successful attempts to remove barriers to access to care by removing regulation of APRNs from the purview of physician-controlled regulatory boards. Although state physician lobbing organizations already advocate for regulation of APRNs by boards of medicine, often during debate of APRN independent practice legislation, it is likely that the new AMA policy will result in more attempts at joint, or sole, regulation by physician-controlled regulatory boards of APRNs in the coming 2024 legislative session. Nursing stakeholders and coalition partners must work to educate lawmakers on the recent AMA policy and the threats they pose to access to care in their states and to healthcare market competition.

References

American Association of Nurse Anesthesiology. (2023, June 15). *AANA Denounces AMA's Action to Regulate Advanced Practice Registered Nurses Through State Boards of Medicine* [News release]. https://www.aana.com/news/aana-denounces-amas-action-to-regulate-advanced-practice-registered-nurses-through-state-boards-of-medicine/

American Medical Association. (2023a). *Report of the Board of Trustees: B of T Report 12-A-23*. https://www.ama-assn.org/system/files/a23-handbook-refcom-b.pdf

American Medical Association. (2023b). *Report of Reference Committee B*. https://www.ama-assn.org/system/files/a23-refcomm-b-annotated.pdf

American Medical Association. (2023c, August 14). Advocacy in action: Fighting scope creep. https://www.ama-assn.org/practice-management/scope-practice/advocacy-action-fighting-scope-creep

Cusack, E. (2023, June 19). *TNP statement against joint regulation of nurse practitioners*. Texas Nurse Practitioners. https://www.texasnp.org/news/643780/TNP-Statement-on-Joint-Regulation-of-Nursing-and-Medical-Boards.htm

Del. Code, tit. 24, Amend. § 1902, Reg. Sess. (2021). https://legis.delaware.gov/json/BillDetail/GenerateHtmlDocumentSessionLaw?sessionLawId=58536&docTypeId=13&sessionLawName=chp111

Del. H.R. 21, 151st Gen. Assem. (2021). https://www.legis.delaware.gov/BillDetail/48202

Del. H.R. 141, 151st Gen. Assem. (2021). https://legis.delaware.gov/BillDetail/58536

Federal Trade Commission. (2014, March). *Policy perspectives: Competition and the regulation of advanced practice nurses*. https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf

Federal Trade Commission. (2016, February 10). [Letter to Kent Leonhardt]. https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-senate-west-virginia-concerning-competitive-impact-wv-senate-bill-516-regulation/160212westvirginiacomment.pdf

Federal Trade Commission. (2020, January 9). [Letter to Daniel R. Hawkins]. https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-kansas-house-representatives-concerning-kansas-house-bill-2412/v200006kansashb2412aprnscomment.pdf

Hayes, W., Baker, N. R., Benson, P., & O'Keefe, L. C. (2023). The state of advanced practice registered nursing in Alabama. *Journal of Nursing Regulation, 13*(4), 44–53. https://doi.org/10.1016/S2155-8256(23)00030-3

Joyce, M. (2021, January 5). Massachusetts expands access to nurse practitioner care. *National Nurse-Led Care Consortium*. https://nurseledcare.phmc.org/advocacy/policy-blog/item/926-massachusetts-expands-access-to-nurse-practitioner-care.html

Mass. Gen. Laws ch. 112 § 80e (2019). https://law.justia.com/codes/massachusetts/2019/part-i/title-xvi/chapter-112/section-80e/

Mass. Gen. Laws ch. 112 § 80e (2020). https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter112/Section80E

Mass. Gen. Laws ch. 260 (2020). https://malegislature.gov/Laws/SessionLaws/Acts/2020/Chapter260

Mississippi Academy of Family Physicians. (2018, February 10). MSBML removes NP collaborative mileage restriction. *Mississippi Academy of Family Physicians E-Newsletter*. https://myemail.constantcontact.com/MSBML-Removes-NP-Collaborative-Mileage-Restriction.html?soid=1102230218895&aid=ZpnM7CBkvnM

Mississippi State Board of Medical Licensure. (2023, July). *Administrative Code*. https://www.msbml.ms.gov/sites/default/files/Rules_Laws_Policies/07-2023Administrative%20Code.pdf

Missouri Division of Professional Registration. (n.d.). Missouri Board of Registration for the Healing Arts. https://pr.mo.gov/healingarts-board-membership.asp

National Council of State Boards of Nursing. (2008, July 7). *Consensus Model for APRN Regulation: Licensure Accreditation, Certification & Education*. https://www.ncsbn.org/public-files/Consensus_Model_for_APRN_Regulation_July_2008.pdf

National Council of State Boards of Nursing. (2023, June 16). *NCSBN opposes American Medical Association amendment on APRNs* [News release]. https://www.ncsbn.org/news/ncsbn-opposes-ama-amendment-on-aprns

NC Board of Nursing. (2022, December 28). *Nurse Practitioner Laws & Rules*. https://www.ncbon.com/practice-nurse-practitioner-nurse-practitioner-laws-rules

North Carolina Board of Dental Examiners v. Federal Trade Commission. (n.d.). *Oyez*. Retrieved September 12, 2023, from https://www.oyez.org/cases/2014/13-534

O'Reilly, K. B. (2023, June 14). *Highlights from the 2023 AMA Annual Meeting*. AMA. https://www.ama-assn.org/house-delegates/annual-meeting/highlights-2023-ama-annual-meeting

Robeznieks, A. (2023, June 13). *Emergency departments must be led by physicians.* AMA. https://www.ama-assn.org/practice-management/scope-practice/emergency-departments-must-be-led-physicians

Simonton, T. (2022, May 10). *Bill that would loosen requirements for nurses has uncertain future.* Columbia Missourian. https://www.columbiamissourian.com/news/state_news/bill-that-would-loosen-requirements-for-nurses-has-uncertain-future/article_668c17a2-cfa4-11ec-ab6b-e747bfb1e010.html

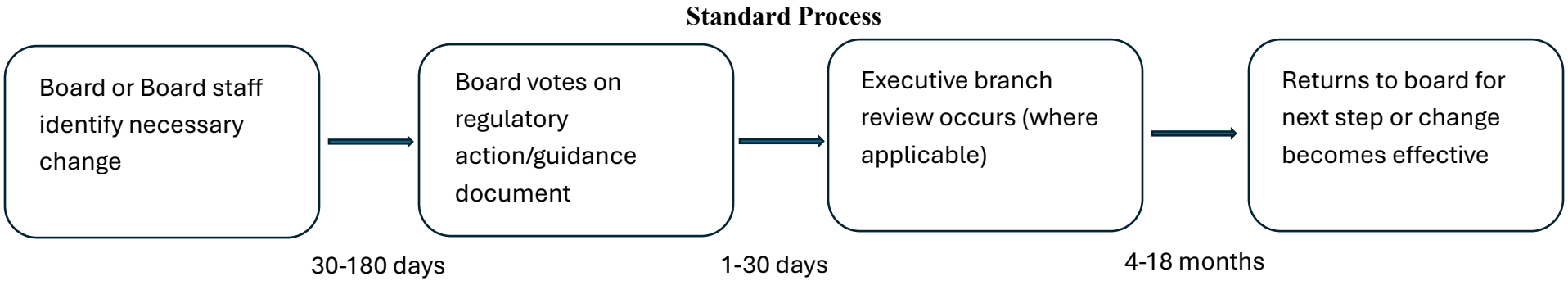
Virginia Department of Health Professions. (2021). *Report on Advanced Practice Registered Nurses (Chapter 552, Item 309. C., 2021)*. https://rga.lis.virginia.gov/Published/2021/HD18/PDF

Nicole Livanos, JD, MPP, is Director, State Affairs, National Council of State Boards of Nursing, Chicago, Illinois.

Corresponding author: Nicole Livanos, nlivanos@ncsbn.org.

Conflicts of Interest: None.

Regulatory Process Chart



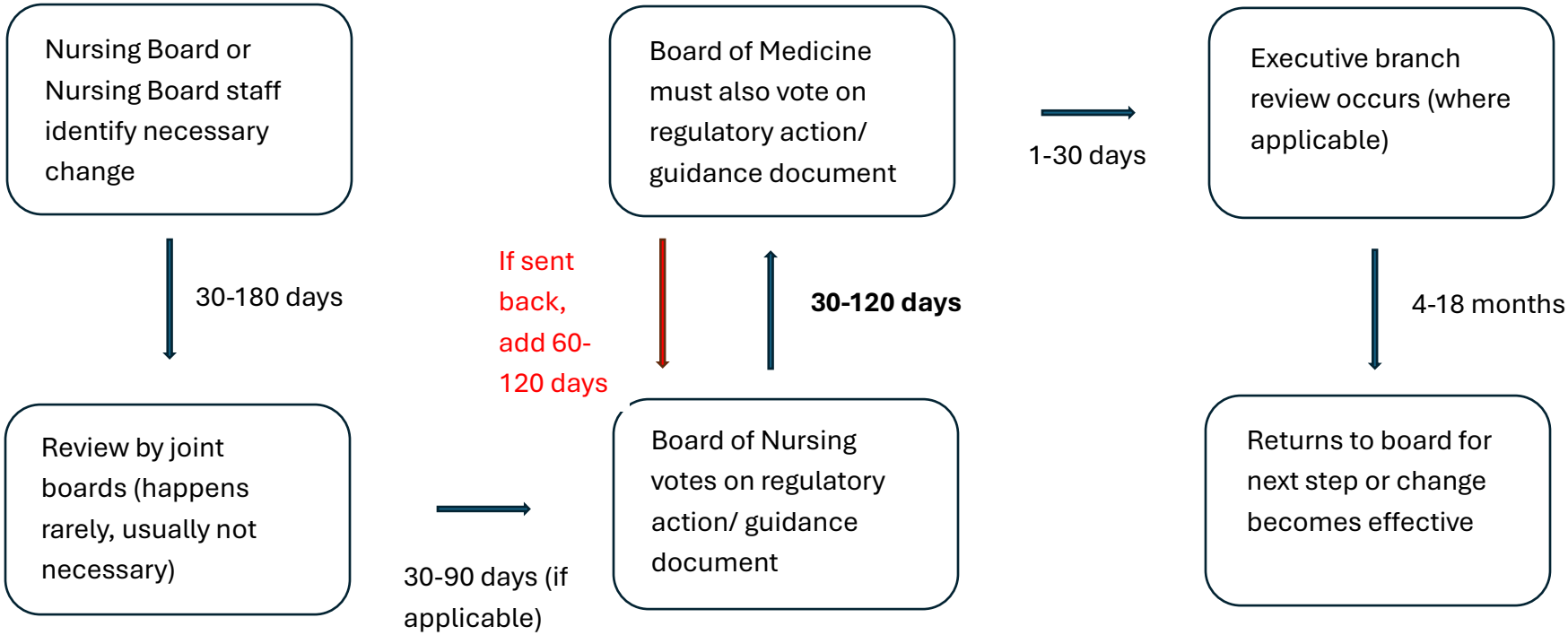
Factors that affect overall timelines include:

- Whether regulatory committee review is needed;
- Whether board agrees with changes or if extensive discussion occurs;
- Length of time of different stages of review;
- Timing of submission to executive branch and registrar

Example executive branch review timelines from actions taken in the last 2 years (does not include planning or "dead" time):

- Fast-Track action (Nursing) – **287 days**;
- Fast-Track action (Medicine) – **213 days**;
- Exempt action (Nursing) – **177 days**;
- Exempt action (Medicine) – **119 days**

Joint Boards Regulatory Process



Examples of delay exclusive to Joint Boards:

- All APRN actions are usually delayed from entering executive branch review at minimum one month, likely longer going forward;
- APRN periodic reviews were recently delayed 3 months due to a canceled Medicine meeting;
- Any changes made by BOM to an action or guidance document already approved by BON would send the action back to BON for approval, indicated by the red language above.

COMMONWEALTH of VIRGINIA

Arne W. Owens
Director

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

www.dhp.virginia.gov
PHONE (804) 367- 4400

TO: The Honorable Louise L. Lucas
Chairman, Senate Committee on Education and Health

FROM: Arne W. Owens
Director, Virginia Department of Health Professions

DATE: December 21, 2023

RE: Report Reviewing SB1105 of the 2023 General Assembly Session

This report is submitted by the Department of Health Professions in compliance with the request from the Chairman of the Senate Committee on Education and Health to review SB1105, which was passed by indefinitely during the 2023 General Assembly Session.

Should you have questions about this report, please feel free to contact me at (804) 367-4648 or arne.owens@dhp.virginia.gov.

AO/EB
Enclosure

CC: The Honorable John Littel, Secretary of Health and Human Resources

Preface

This report is submitted in compliance with the request submitted pursuant to Rule 20(o) of the Rules of the Senate, under which rule the Chairman of the Senate Committee on Education and Health directed the Department of Health Professions "to review SB1105, which was passed by indefinitely during the 2023 Session of the General Assembly." The Chairman further stated that:

> The purpose of this review is to consider whether this legislation should include a change in the composition of the Board of Nursing in order to adequately regulate Advanced Practice Registered Nursing in the Commonwealth, and to consider any other changes that may be necessary in order to consider participation in the Advanced Practice Registered Nurse Compact to facilitate multistate licensure.

The Department's review of SB1105 and the regulation of advanced practice registered nurses in the Commonwealth follows.

Table of Contents

I. Executive Summary

Pursuant to Rule 20(o) of the Rules of the Senate of Virginia, the Senate Committee on Education and Health referred the subject matters contained in Senate Bill 1105 to the Department of Health Professions for study. This legislation sought to remove joint oversight of Nurse Practitioners[1] (hereinafter referred to as "advanced practice registered nurses" or "APRNs") by the Boards of Nursing and Medicine and place licensing and regulation of advanced practice registered nurses solely within the Board of Nursing.

SB1105 was passed by indefinitely by the Senate Education and Health committee during the 2023 General Assembly session by a vote of 13-1.

II. 2023 Legislation

SB1105, filed during the 2023 General Assembly session, sought to remove joint licensure of advanced practice registered nurses by the Boards of Nursing and Medicine and solely license advanced practice registered nurses under the Board of Nursing. SB1105 was only one piece of legislation regarding APRNs filed during the 2023 session, as three other bills also sought to make legislative changes to APRNs. Of those three, one was signed into law.[2]

III. Advanced Practice Registered Nurses Overview

Advanced practice registered nurses are registered nurses who have completed graduate-level education and have achieved national certification which qualifies them to provide direct care to patients in a particular role at an advanced level. Each state defines APRN roles and scopes of practice through statutes and regulations, resulting in significant statutory and regulatory variability. As APRNs became a more common and integral part of the health care system, national nursing organizations began to come together and consider the issues that contribute to this variability across states. In 2008, the National Council of State Boards of Nursing[3] ("NCSBN") and the Advanced Practice Nursing Consensus Work Group developed the Consensus Model for APRN Regulation[4] ("APRN Consensus Model") to guide all states toward a national standard for APRN licensure and practice.[5]

---

[1] Chapter 183 of the 2023 Acts of Assembly replaced all references of Nurse Practitioner in statute with Advanced Practice Registered Nurse, consistent with the 2008 APRN Consensus Model adopted by the National Council of State Boards of Nursing (NCSBN).

[2] SB975, enrolled in Chapter 183 of the 2023 Acts of Assembly (see FN 1). The other bills were HB2183 (ARPN autonomous practice upon licensure) and HB2287 (CRNAs working in consultation with physicians rather than under supervision of physicians).

[3] NCSBN is an independent, not-for-profit organization through which nursing regulatory bodies act and confer on matters of common interest and concern affecting public health, safety, and welfare, including the development of nursing licensure examinations.

[4] APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee, Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education, NAT'L COUNCIL STATE BDS. NURSING (Jul 2008).

[5] APRN Consensus Model, *available at* https://www.ncsbn.org/public-files/Consensus_Model_for_APRN_Regulation_July_2008.pdf.

IV. APRN Consensus Model

The APRN Consensus Model presents strategies for state legislatures and regulatory boards to implement when establishing licensure, accreditation, certification, and education of APRNs. According to the model, an APRN shall have completed an accredited graduate-level education program preparing them for one of four recognized APRN roles: Certified Nurse Practitioner ("CNP"), Certified Nurse Midwife ("CNM"), Certified Registered Nurse Anesthetists ("CNRA"), or Certified Nurse Specialist ("CNS"). An APRN shall also have passed a national certification examination and obtained licensure. In addition to being educated in one of the four roles, the Consensus Model recommends that APRNs be educated in at least one of six population foci: family-individual across the lifespan, adult-gerontology, neonatal, pediatrics, women's health/gender-related, or psych/mental health. Finally, and perhaps most importantly for Virginia, Boards of Nursing must solely license APRNs under the Consensus Model.

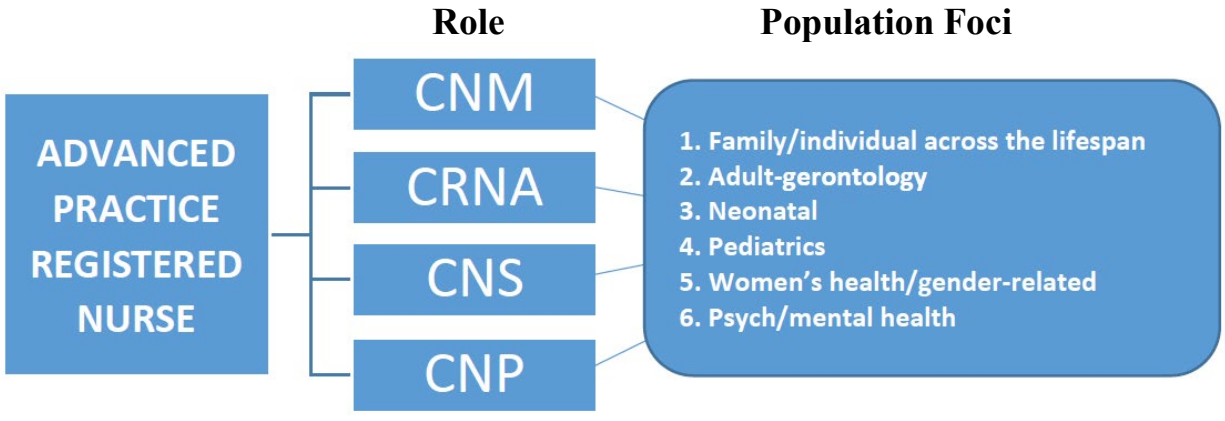
The following chart illustrates the definitions of the four APRN roles and describes the recommendations regarding APRN practice, licensure authority, and prescriptive authority as outlined in the APRN Consensus Model. Recommendations for legislative changes to make Virginia law consistent with the Consensus Model and the APRN Compact are discussed in Part X, below.

Figure 1: Definitions of APRN Roles and Recommendations of Consensus Model

	APRN	CNP	CNM	CRNA	CNS
Definition	A licensed independent practitioner who has completed a graduate-level education program preparing him/her for one of the four APRN roles; passed a national certification examination; and provides direct care to patients.	Practices autonomously as primary care CNPs and acute care CNPs, which have separate competencies and certification processes; prepared to treat patients with undifferentiated symptoms or established diagnoses.	Provides a full range of primary health care services to women including gynecologic, family planning, preconception, prenatal, postpartum, childbirth, and newborn care and treats male partners of their female clients for STDs.	Provides the full spectrum of patients' anesthesia care and anesthesia-related care for individuals, including those with immediate, severe, or life-threatening illnesses or injury.	Integrates care across the continuum and through three spheres of influence: patient, nurse, system; primary goal of the CNS is continuous improvement of patient outcomes and nursing care.
Licensure Authority	APRNs are to be licensed solely by Boards of Nursing (except in states where state boards of nurse-midwifery or midwifery regulate nurse-midwives).				
Independent Practice	Responsible for complying with rules established by the Boards of Nursing and recognizing the limits of their knowledge and experience, and shall consult or refer to other health care providers as appropriate.				
Independent Prescriptive Authority	Boards of Nursing shall grant prescribing, ordering, and dispensing authority through the APRN license.				

The following graphic illustrates the regulatory model for licensing structure recommended by the APRN Consensus Model:

Figure 2: Recommendation for Licensing Structure



V. APRN Compact

In August 2020, NCSBN adopted a model act which serves as the basis for state legislation to enact the Advanced Practice Registered Nurse Compact ("APRN Compact" or "Compact"). The APRN Compact allows APRNs to have one multistate license with the ability to practice in all Compact states.[6] The Compact is modeled after the APRN Consensus Model and the Nurse Licensure Compact ("NLC"). It will go into effect once seven states have enacted legislation. At the time of writing, three states have enacted legislation to join the APRN Compact and seven states introduced legislation to enact the APRN Compact during 2023 legislative sessions.[7] In order to be eligible for a multistate license, an APRN must be a legal resident of a Compact state and meet the Uniform Licensure Requirements for a multistate privilege as well as home state licensure requirements. The home state maintains the authority over the license, and a remote state may take adverse action against a licensee's privilege to practice within that remote state.

Compacts make it possible for licensees to practice across state lines outside their home state without applying for a separate license in that remote state, thereby eliminating redundant regulatory processes and duplicative fees. Compacts increase access to care and expand the workforce while eliminating delays in providing care to patients. The APRN Compact would be no different. Additionally, military spouses who are nurses currently enjoy the benefits of the NLC and may find the APRN Compact a useful mechanism for portable licensure. Virginia currently provides expedited licensure to military members and spouses under Virginia Code § 54.1-119. Implementation of the APRN Compact would eliminate the licensure application process entirely for those military spouse APRNs from other Compact states.[8]

Once the APRN Compact obtains enough member states and goes into effect, there will be a delay before the Compact begins issuing licenses with multistate privileges. During this period, the Compact Commission, which consists of representatives from member states, will create Compact rules and set up the infrastructure needed to administer the APRN Compact. Experience operationalizing the NLC may expedite the initiation of issuance of licenses with multistate privileges.

VI. National APRN Regulation

NCSBN collects data on the various state boards, including board composition and regulation of nursing practice. A look at NCSBN board data highlights the areas where other states operate similarly to Virginia and areas where Virginia is an outlier.

While there continues to be significant variation in state APRN regulatory structures, states and territories ("U.S. jurisdictions") collectively have grown closer to conformity with the APRN Consensus Model. Over half (28) of U.S. jurisdictions authorize all four APRN roles to practice and prescribe independently, although in some the APRN must meet prerequisites to do so. Twenty

[6] APRN Model Compact, Article III(d), *available at* https://www.aprncompact.com/files/FINAL_APRNCompact_8.12.20.pdf.
[7] Utah, North Dakota, and Delaware have enacted legislation to join the Compact.
[8] Notably, the Department of Defense supports compacts as a general rule and has provided grants to professions to develop compacts.

U.S. jurisdictions are in full alignment with the APRN Consensus Model, permitting independent practice and prescribing upon initial licensure as an APRN. At the national level, the Department of Veterans Affairs authorizes independent practice within its healthcare system.

Most U.S. jurisdictions require APRN licensure for practice and APRNs may be subject to disciplinary action by those boards. In four states, including Virginia, APRNs are jointly regulated by the Boards of Nursing and Medicine. This dual oversight creates a significant barrier to APRN Consensus Model alignment and potential APRN Compact adoption. Due to the great variation among state regulatory authorities for each APRN role, this section of the report will consider each role separately.

A. Certified Nurse Practitioner

Consensus Model Definition: CNPs are prepared to diagnose and treat patients with undifferentiated symptoms as well as those with established diagnoses. Both primary and acute care CNPs provide initial, ongoing, and comprehensive care, including taking comprehensive histories, providing physical examinations and other health assessment and screening activities, and diagnosing, treating, and managing patients with acute and chronic illnesses and diseases. Certified nurse practitioners are prepared to practice as primary care CNPs and acute care CNPs, which have separate national consensus-based competencies and separate certification processes.

National: The generic umbrella title of "nurse practitioner" has gradually phased out and been replaced with "advanced practice registered nurse." "Certified nurse practitioner" was adopted in the APRN Consensus Model and many other states to refer to one of the four APRN roles. Some U.S. jurisdictions continue to use "nurse practitioner" to refer to all four APRN roles. Virginia was one such state until the 2023 General Assembly Session, where the designation APRN was adopted to bring Virginia closer in line with the Consensus Model. (*See* below.)

Virginia: Chapter 183 of the 2023 Acts of Assembly codified the term "Advanced Practice Registered Nurse" and made "nurse practitioner" one of the four APRN roles. This change brings Virginia in line with the APRN Consensus Model in this area. Notably, the role referred to as CNP nationally is referred to as nurse practitioner or NP in Virginia Code.

Independent Practice: NCSBN defines independent practice as requiring no collaborative agreement with a physician, supervision by a physician, or conditions for practice. While independent practice has the least amount of disparity between jurisdictions, the requirements to practice independently vary greatly. Thirty-seven U.S. jurisdictions (including Virginia) currently grant CNPs the ability to obtain independent practice upon initial licensure or through a transition-to-practice model in which a specific number of practice hours are completed under a form of supervision prior to independent practice. Of the U.S. jurisdictions which utilize a transition-to-practice model, Virginia's five year

(9,000 hour) clinical practice requirement is the most extreme, with Connecticut a distant second with a requirement of three years (5,400 hours).[9]

Independent Prescriptive Authority: NCSBN considers an APRN to have prescriptive authority if they may administer, prescribe, or distribute controlled substances or devices and equipment. Such authority is considered independent if there are no requirements that the APRN maintain a written collaborative agreement with a physician or be supervised in their prescriptive authority. There are 35 U.S. jurisdictions (including Virginia) that grant CNPs independent prescriptive authority, exceeding that of any other APRN role.[10] Nurse practitioners in Virginia may prescribe Schedule II through VI drugs.

B. Certified Nurse Midwife

Consensus Model Definition: CNMs provide a full range of primary health care services to women throughout the lifespan, including gynecologic care, family planning services, preconception care, prenatal and postpartum care, childbirth, and care of the newborn. The practice includes treating the male partner of their female clients for sexually transmitted diseases and reproductive health. This care is provided in diverse settings, which may include home, hospital, birth center, and a variety of ambulatory care settings including private offices and community and public health clinics.

National: All jurisdictions recognize the CNM role. Boards of Medicine and Nursing jointly regulate CNMs in Virginia and North Carolina, while New Jersey and Pennsylvania Boards of Medicine solely regulate CNMs. In other jurisdictions, Boards of Nursing solely regulate CNMs, except five states which regulate CNMs through Departments of Health or Boards of Midwifery.

Virginia: A "certified nurse midwife" is an APRN "who is certified in the specialty of nurse midwifery and who is jointly licensed by the Boards of Medicine and Nursing."

Independent Practice: NCSBN defines independent practice as having no requirements "for a written collaborative agreement…supervision, [or] conditions for practice." Recent legislation in Virginia allows CNMs to practice without a practice agreement after completion of 1,000 hours of clinical experience attested to by a physician or an experienced CNM who supervised such experience. Thirty-two states (including Virginia) plus D.C., Guam, American Samoa, and the Northern Mariana Islands allow CNMs to obtain independent practice authority.

---

[9] Virginia Code § 54.1-2957(I) requires a nurse practitioner provide evidence of five years of full-time clinical experience under supervision prior to autonomous practice. The next closest requirement by state is Connecticut, which requires three years of active practice prior to independent practice. California, Massachusetts, New York, West Virginia, Florida, Maine, Vermont, South Dakota, and Colorado all impose clinical practice requirements ranging from 4,600 hours at the most (California) and 750 hours at the least (Colorado) prior to independent practice. *See* Kleinspell, et al., *Addressing Barriers to APRN Practice: Policy & Reg. Implications During COVID-19*, J. Nurs. Reg. Apr. 2023; 14-1: 13-20.

[10] A map of states that grant CNPs prescriptive authority can be found on the NCSBN website at https://www.ncsbn.org/nursing-regulation/practice/aprn/campaign-for-consensus/aprn-consensus-implementation-status/cnp-independent-prescribing-map.page.

Prescriptive Authority: Nationally, there is great disparity between jurisdictions on the level of prescriptive authority held by CNMs. While CNMs have been granted the authority to write prescriptions in all fifty states and the District of Columbia, the level of authority varies from direct supervision as provided in a practice agreement to independent authority. Thirty-two jurisdictions currently provide CNMs with independent prescriptive authority. Virginia provides independent prescriptive authority for CNMs who have completed 1,000 supervised clinical hours as noted above.

C. Certified Registered Nurse Anesthetist

Consensus Model Definition: CRNAs provide the full spectrum of anesthesia care and anesthesia-related care for individuals across the lifespan, whose health status may range from healthy through all recognized levels of acuity, including persons with immediate, severe, or life-threatening illnesses or injury. This care is provided in diverse settings, including hospital surgical suites and obstetrical delivery rooms; critical access hospitals; acute care; pain management centers; ambulatory surgical centers; and the offices of practitioners such as surgeons, dentists, podiatrists and ophthalmologists.

National: In most U.S. jurisdictions, CRNA practice is governed exclusively by laws governing nursing and Board of Nursing regulations. No jurisdiction other than Virginia jointly regulates CRNAs under Boards of Medicine and Nursing.

Virginia: A "certified registered nurse anesthetist" is an APRN who is "certified in the specialty of nurse anesthesia, who is jointly licensed by the Boards of Medicine and Nursing pursuant to Virginia Code § 54.1-2957, and who practices under the supervision of a doctor of medicine, osteopathy, podiatry, or dentistry but is not subject to the practice agreement requirement described in § 54.1-2957."

Independent Practice: CRNAs practice independently in 37 jurisdictions. In Virginia, a CRNA "shall practice under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry." "Supervision" as it relates to CRNAs is not defined in statute. No practice agreement is required due to this supervisory requirement.

Prescriptive Authority: Nationally, there is great disparity between jurisdictions on the level of prescriptive authority held by CRNAs. Thirty jurisdictions currently allow CRNAs to obtain independent prescriptive authority. While able to prescribe, CRNAs do not have independent prescriptive authority in Virginia due to the supervisory requirement. CRNAs have the authority to prescribe Schedule II through Schedule VI controlled substances to a patient requiring anesthesia, as part of the periprocedural care of such patient. "Periprocedural" means the period beginning prior to a procedure and ending at the time the patient is discharged.

D. Clinical Nurse Specialist

Consensus Model: A CNS integrates care across the continuum and through three spheres of influence: patient, nurse, and system. The three spheres are overlapping and interrelated, but each sphere possesses a distinctive focus. In each of the spheres of influence, the primary goal of the CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress and facilitate ethical decision-making. Virginia registered CNSs in 1989 and only began licensing CNSs in July 2021. Notably, common functional role competencies for CNS practice were not delineated until 1998, which may explain the delay on the part of Virginia and other states in shifting CNS regulation from certification to full licensure.

National: CNSs are solely regulated by Boards of Nursing in nearly every jurisdiction with only 2 jurisdictions allowing some regulation of CNSs by Boards of Pharmacy relevant to CNS prescriptive authority. The only U.S. jurisdictions which do not recognize the CNS role are American Samoa, Mississippi, Pennsylvania, and New Hampshire.

Virginia: In Virginia, a "clinical nurse specialist" is an APRN who is "certified in the specialty of clinical nurse specialist and who is jointly licensed by the Committee of the Joint Boards pursuant to Virginia Code § 54.1-2957." No other jurisdictions follow this regulatory model.

Independent Practice: Thirty-six jurisdictions allow CNSs to practice independently. CNSs in Virginia are required to practice in "consultation with a licensed physician in accordance with a practice agreement between the nurse practitioner and the licensed physician" when prescribing controlled substances.[11] A CNS who does not prescribe controlled substances may practice "in the practice category in which he is certified and licensed without a written or electronic practice agreement."

Prescriptive Authority: Twenty-seven jurisdictions grant CNSs the authority to prescribe independently. Virginia does not authorize CNSs to independently prescribe controlled substances. However, CNSs holding a license for prescriptive authority may prescribe Schedules II through VI controlled substances, but in accordance with any prescriptive authority included in a practice agreement.

VII. Virginia APRN Regulation

The Medical Practice Act (Va. Code § 54.1-2900 *et seq.*) contains Virginia statutory law governing APRNs, but Board of Medicine regulations do not contain regulations governing APRN licensure or practice. Such regulations are contained in the regulatory chapters for the Board of Nursing. Approval of those regulations governing APRNs, however, must go through a cumbersome multi-step process. Regulations may be, but are not required to be, first recommended

[11] Va. Code § 54.1-2957(J).

by the Committee of the Joint Boards of Medicine and Nursing ("Committee of the Joint Boards" or "Committee"). Regulations must be approved by both the Board of Medicine and the Board of Nursing separately, either following recommendation or by action of the Boards without recommendation.[12]

The purpose of the Committee of the Joint Boards is to administer the Regulations Governing the Licensure of Nurse Practitioners.[13] The Committee consists of three members from the Board of Nursing and three members from the Board of Medicine. An optional advisory committee pursuant to 18VAC90-30-30(B) has also been appointed. Business meetings and disciplinary proceedings are scheduled five times per year; because there are often no agenda items for the business meetings, they are frequently canceled.

Although the Committee is made up of members of two boards, and although both boards jointly regulate APRNs, the administrative costs and burdens of the Committee are borne by the Board of Nursing. This includes scheduling and coordination of disciplinary proceedings for APRNs, which must be held separately from normal Board of Nursing disciplinary cases due to the requirement to include the Board of Medicine. This two board structure delays discipline, regulatory changes, and even the adoption or amendment of guidance documents unnecessarily. The Board of Nursing, with multiple APRN Board members, is fully capable of regulating and disciplining APRNs.

VIII. Board Composition Nationally

Throughout the U.S., 58% of Boards of Nursing are housed within an umbrella agency, similar to Virginia. 81% of boards are made up of 13 members or less, with 19% comprised of 14-17 members. 86% of states mandate a minimum of four RN board members, and 81% of boards require one to three board members be LPNs. 86% of states mandate between one and three citizen (or public) members, while 10% of states require a minimum of one physician board member. Finally, 32% of states require a minimum of one other representative on the board, such as a board member licensed in a non-healthcare profession.[14]

In 76% of states and territories in the U.S., statutes mandate inclusion of between one and three APRNs as board members. 19% of states and territories do not mandate any inclusion of APRNs on the board. NCSBN states, however, that in most cases APRNs may qualify as RN board members and so may fill an RN board seat. This can increase the number of APRNs on a board who bring insight and expertise to the regulatory and disciplinary process. 71% of states do not dictate board seats for specific APRN roles. Virginia border states make up three of the 14 states that do mandate specific practitioner roles for board members. Of the states that require specific

[12] This cumbersome process, and the creation in regulation of the Committee of the Joint Boards of Nursing and Medicine, stems from the statutory requirement that the Board of Medicine and the Board of Nursing jointly regulate APRNs. *See, e.g.*, Va. Code § 54.1-2957(B).
[13] 18VAC90-30-30(A).
[14] *See* NCSBN 2022 Board Structure Survey, *available at* https://www.ncsbn.org/public-files/Board_Structure_Survey_2022.pdf.

roles, 79% and 86% respectively require that nurse practitioners and nurse anesthetists sit on the board, followed by nurse midwives and clinical nurse specialists at 43% and 50% respectively.[15]

IX. Board Composition in Virginia

The Virginia Board of Nursing is composed of 14 members, among the largest Boards of Nursing in the U.S., with the following required configuration:

- 8 members must be RNs, at least 2 of which must be APRNs;
- 2 members must be LPNs;
- 3 members must be citizen members; and
- 1 member must be an RN or LPN.[16]

The number of APRNs serving on the Board at any one time may exceed the minimum of two depending on the licensure status of the RN gubernatorial appointees. To be appointed to the Board, each member must be a resident of the Commonwealth and a citizen of the United States, as well as hold the required educational credential or the license type for the seat that the appointee will fill. Members must also have a minimum of five years of practice experience and three years of practice in the Commonwealth immediately preceding the appointment or reappointment.[17]

Board Composition Options. Registered nurses and licensed practical nurses make up the vast majority of licensees governed by the Board of Nursing.[18] Under the current composition requirements, more than two APRNs can be appointed to the Board by the Governor. Thus, without requiring additional APRN Board members via legislative change, any elected Governor of the Commonwealth could appoint additional APRNs if the Board felt it needed their expertise to conduct Board business.

The legislative addition of an APRN advisory board is also an option to ensure professional representation on disciplinary and policy issues. Advisory boards may make recommendations to the full Board, but the full Board retains discretion regarding whether to accept or reject recommendations of an advisory board. For example, licensed massage therapists, also regulated by the Board of Nursing, do not have a dedicated seat on the Board but instead are represented by an advisory board pursuant to Virginia Code § 54.1-3029.1. Although the addition of an APRN advisory board would provide a dedicated entity for APRNs, it would require elimination of the existing APRN positions on the full Board[19] thus limiting participation of APRNs in Board business and decision-making.

---

[15] *Id.*
[16] Virginia Code § 54.1-3002.
[17] Virginia Code § 54.1-3003.
[18] For example, as of June 30, 2023, the Board of Nursing reported 119,873 licensed registered nurses and 27,381 licensed practical nurses. By contrast, 18,738 licensed APRNs were reported. *See* Current Count of Licensees, Quarterly Summary, *available at* https://www.dhp.virginia.gov/about/stats/2023Q4/04CurrentLicenseCountQ4FY2023.pdf.
[19] The health professions within the Department of Health Professions utilize 14 advisory boards, none of which includes a voting member on the associated licensing board. *Compare* Va. Code §§ 54.1-3029.1 (creating Advisory Board on Massage Therapy) and 54.1-3002 (specifying composition of Board of Nursing, which does not include a licensed massage therapist or member of the advisory board).

X. Legislative Changes Needed

To facilitate future participation in the APRN Compact, the Virginia Code requires legislative changes to regulation and oversight of APRNs. First, the Code changes would need to eliminate joint licensing of APRNs and make the Board of Nursing the sole licensing and regulating board for APRNs. Second, restrictions on APRN independent practice must be repealed.

Elimination of joint licensure and regulation.

The primary legislative change required to join the APRN Compact is to amend the Virginia Code to eliminate joint licensure and regulation by the Boards of Medicine and Nursing. In 2016, the Federal Trade Commission referred to medical doctors regulating APRNs as anticompetitive, writing: "[w]e urge you to consider whether to allow independent regulatory boards dominated by medical doctors and doctors of osteopathy to regulate[20] APRN prescribing, given the risk of bias due to professional and financial self-interest."[21] This potential change requires that all APRN statutory language move from Chapter 29 of Title 54.1 to Chapter 30 of Title 54.1. Such changes include the following:

- Move definitions for advanced practice registered nurse, certified nurse midwife,[22] certified registered nurse anesthetist, clinical nurse specialist, and nurse practitioner from Virginia Code § 54.1-2900 to Virginia Code § 54.1-3000;
- Move Virginia Code §§ 54.1-2957.001, 54.1-2957, 54.1-2957.01, 54.1-2957.02, 54.1-2957.03 to Chapter 30 of Title 54.1;
- Amend references throughout the Code to the Medical Practice Act which addresses APRNs, such as in Virginia Code §§ 32.1-134.2, 32.1-282, 32.1-263(C), 54.1-2972, and 54.1-3301.9; and
- Statutes governing APRNs amended to remove references to the Committee of the Joint Boards or to remove the phrase "licensed by the Boards of Medicine and Nursing."

[20] Although the Board of Medicine jointly regulates APRNs with the Board of Nursing, the Board of Medicine can refuse to adopt actions approved by the Board of Nursing related to APRNs, thus stopping the action at issue and having an outsize influence on APRN regulation. For example, if the Board of Nursing approved regulatory amendments related to APRN practice, but the Board of Medicine subsequently rejected those amendments, the amendments would not take effect.

[21] FTC Staff Comment, Competitive Impacts of S. 516 (Feb. 2016), at 2, *available at* https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-senate-west-virginia-concerning-competitive-impact-wv-senate-bill-516-regulation/160212westvirginiacomment.pdf.

[22] Note, the definition and statutes related to licensed certified midwives and licensed professional midwives should not be moved, as these are different practice types and are not considered APRNs.

Repeal of restrictions on APRN independent practice.

The Compact states that APRNs who hold multistate licensure privileges under the APRN Compact shall be authorized to provide patient care independent of a supervisory or collaborative relationship with a healthcare provider. Therefore, a second major statutory change required is to amend the Code to authorize all APRNs to practice independently. This entails the following:

- Eliminate the statutory requirement (and all language referring to it) that NPs, CNMs, and CNSs enter into a practice agreement. Such language is currently found in Virginia Code §§ 54.1-2957 and 54.1-2957.01.
- Remove the supervisory requirement for CRNA practice currently found in Virginia Code § 54.1-2957.

It is important to note that these legislative changes address practice agreements and independent practice, not the ability to prescribe. Under the Compact rules, issuance of an APRN multistate license includes prescriptive authority for noncontrolled prescription drugs. Since all drugs prescribed in Virginia are considered controlled substances, the APRN must satisfy all Virginia prescriptive authority requirements in order to be granted or to renew such authority. As a result, no legislative changes are needed regarding prescribing of controlled substances by APRNs.

XI. Conclusion

As noted in this report, Virginia is an extreme outlier in its regulation of APRNs. This structure not only impacts Virginia's readiness to join the APRN Compact, it affects the Commonwealth's ability to attract healthcare talent from other jurisdictions. This may negatively impact the ability of citizens of the Commonwealth to receive timely and quality healthcare. Additionally, the oversight requirement impacts access to care due to availability of collaborating physicians willing to enter into practice agreements with APRNs.[23] Although eighteen U.S. jurisdictions currently authorize independent practice of APRNs upon initial licensure, no evidence exists to indicate that APRN independent practice poses a public safety risk. The advantages of APRN independent practice have the potential to improve health outcomes in some of the most at-risk areas in Virginia. Changes required for entry into the APRN Compact will allow Virginia to join other states in expanding healthcare access for the citizens of the Commonwealth.

[23] *See* FTC Policy Perspectives, Competition and the Regulation of Advanced Practice Registered Nurses (Mar. 2014), *available at* https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf, for additional information on this topic.