Advisory Board on Physician Assistants

Virginia Board of Medicine

October 23, 2025

1:00 p.m.

Virginia Department of Health Professions

Advisory Board on Physician Assistants

Board of Medicine

Thursday, October 23, 2025, at 1:00 p.m.

9960 Mayland Drive, Suite 201, Henrico, VA

Training Room 1

Call to Order – Justin Hepner, PA-C, Chair

Emergency Egress Procedures – Kathleen LaMotte

Roll Call – Kathleen LaMotte

Introduction of Members – Justin Hepner, PA-C, Chair

Approval of minutes from June 12, 2025, Meeting

Adoption of the Agenda

Public Comment on Agenda Items (15 minutes)

New Business

1. Regulatory Update – Erin Barrett
2. Recommendation of draft amendments for licensure by endorsement – Erin Barrett
3. Report on PA education and scope of practice nationally – Erin Barrett
4. Compact update – Justin Hepner, PA-C, Chair
5. Election of Officers – Justin Hepner, PA-C, Chair
6. Approval of 2026 Meeting Calendar –Chair
7. Orientation to the Board – Michael Sobowale

Announcements

Next meeting: Thursday, February 5, 2026, at 1:00 p.m.

Adjournment

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

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

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

Training Room 1

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

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

<< DRAFT >>

ADVISORY BOARD ON PHYSICIAN ASSISTANTS
Minutes
June 12, 2025

The Advisory Board on Physician Assistants met on Thursday, June 12, 2025, at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Justin Hepner, PA-C, Chair
Erin Myers, PA-C, Vice-Chair
Lucy Treene, PA-C
Tracey Dunn, Citizen

MEMBERS ABSENT: Brian Hanrahan, MD

STAFF PRESENT: William L. Harp, MD - Executive Director
Jennifer Deschenes - Deputy Executive Director, Discipline
Michael Sobowale, LLM - Deputy Executive Director, Licensure
Colanthia Opher - Deputy Executive Director, Medical Licensure and Administration
Kathleen LaMotte - Board Administrator
Erin Barrett, JD - DHP Director of Legislative and Regulatory Affairs
Matthew Novak, DHP Policy and Economic Analyst
Roslyn Nickens, Licensing Supervisor
Jamie Culp, Licensing Specialist
Denise Christian, Licensing Specialist
Erin Pollard, Licensing Specialist

GUESTS PRESENT: Robert Glasgow, PA - VAPA
Jonathan Williams - VAPA

Call to Order

Justin Hepner called the meeting to order at 1:10 p.m.

Emergency Egress Procedures

Kathleen LaMotte announced the emergency egress instructions.

Roll Call

Ms. LaMotte called the roll; a quorum was declared.

Introduction of Members

Mr. Hepner asked everyone in the room to introduce themselves.

Approval of Minutes

Ms. Dunn moved to approve the minutes from the October 10, 2024 meeting as amended, correcting an error in the spelling of a member of the public's name. Ms. Treene seconded. The motion passed unanimously.

Adoption of Agenda

Ms. Dunn moved to adopt the agenda as presented. The motion was seconded by Ms. Treene and passed unanimously.

Public Comment on Agenda Items

None received.

New Business

1. **Legislative Report**

   Erin Barrett reviewed items pertaining to the Board of Medicine from the 2025 General Assembly (GA) session. This included two vetoed bills supporting unconscious bias training, a new reporting system for threats made against healthcare professionals, a study to be completed by DHP regarding the scope of practice of physician assistants, a new license type for anesthesiologist assistants, a pathway to allow for licensure by endorsement for professions that do not currently have one, a recommendation for education on communication with children diagnosed with autism spectrum disorder to be disseminated to DHP licensees, the elimination of the Board of Health Professions and the absorption of the Board's duties by boards and divisions of DHP.

   Report on Status of Regulatory /Policy Actions

   Matthew Novak reviewed the status of the Advisory Board's regulatory actions. The process to implement Virginia's entry into the PA Compact is still ongoing. The periodic review changes recommended in October of 2024 will become effective July 3.

2. **Recommendation of proposed stage language for patient care team requirements**
   Ms. Barrett noted that the Advisory Board is asked to recommend proposed stage changes to the Board of Medicine regarding the responsibilities of the patient care team physician or podiatrist. This recommended language is based upon the Notice of Intended Regulatory Action (NOIRA).

The Advisory Board discussed the implications of a patient care team physician being available "at all times" but was satisfied with the requirement that the collaborating or consulting physician is required to arrange coverage when they are not available. Being available to speak by phone was seen as a reasonable interpretation of the collaboration and consultation clause.

The Advisory advocated for the removal of "complex" from the phrase "for complex clinical cases and patient emergencies" as being difficult term define. Practice agreements for physician assistants state that consulting physicians should always be available for consultation and collaboration in all cases.

MOTION: Ms. Myers moved to recommend the proposed stage changes to the Board of Medicine as amended. Mr. Hepner seconded, and the motion carried 3 – 1.

3. **Recommendation of proposed stage language for patient care team physician name on prescriptions**

   This change would remove the requirement for a prescription to bear the name of the patient care team physician. The Advisory Board discussed how the notification requirement would be met. DHP Staff said that licensees would be notified when the revised regulation took effect.

   MOTION: Ms. Harper moved to recommend the proposed stage changes to the Board of Medicine. Ms. Treene seconded, and the motion passed unanimously.

Licensing Report

Jamie Culp provided the following licensing statistics for physician assistants:

Total Licensed in Commonwealth of Virginia - 7,131
Total Licenses Issued from January 1, 2025 to June 9, 2025 - 402

- 71 by reciprocity
- 46 from MD
- 13 from DC
- 12 from both

Current Application Processing Days- 35 days

Clearance Rate- 99%

Announcements

Next Scheduled Meeting

The next scheduled meeting is Monday, October 23, 2025 at 1:00 p.m.

Mr. Sobowale advised that at future meetings, there will be no paper agenda packet. Advisory members will have their items pre-loaded on a laptop for viewing during the meeting. The agenda packet will also be projected o screen for the public to see. Agency staff will continue to send out the Notice of the meeting by email ahead of time.

Adjournment

Justin Hepner, Chair, adjourned the meeting at 2:00 p.m.

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William L. Harp, MD, Executive Director

Board of Medicine – Advisory Board on Physician Assistants
Regulatory Actions
As of September 22, 2025

In the Governor's Office

None.

In the Secretary's Office

VAC	Stage	Subject Matter	Submitted from agency	Time in current location	Notes
18VAC85-50	NOIRA	Implementation of the PA Compact	4/14/2025	154 days	Implement regulations to facilitate entry into the PA Compact.
18VAC85-50	Fast-Track	Creation of reinstatement process for physician assistants with lapsed licenses	10/29/2024	31 days	These changes voted on by ad board and full board in October 2024

At DPB or OAG

VAC	Stage	Subject Matter	Submitted from agency	Time in current location	Notes
18VAC85-50	Proposed	Removal of patient care team physician or podiatrist name from prescriptions issued by physician assistants	8/7/2025	DPB; 7 days	Removes requirement that prescriptions issued by PA include physician or podiatrist's name. Result of petition for rulemaking.

Recently effective/awaiting publication

None.

Other

VAC	Subject Matter	Submitted for publication	Effective Date	Notes
18VAC85-50	Amendment to requirements for patient car team physician or podiatrist consultation and collaboration	2/5/2025	3/10/2025	The executive committee at their last meeting did not vote to adopt proposed stage regulations and requested this action return to a subsequent executive committee meeting.

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

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

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

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

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

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

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

18VAC85-50-51. Licensure by endorsement requirements

An applicant for licensure by endorsement shall submit the following:

1. Evidence of a current, active license in a United States jurisdiction or Canada that is in good standing;
2. A completed application and fee;
3. Evidence of current certification issued by the NCCPA; and
4. A current report from the National Practitioner Data Bank

18VAC85-50-56. Renewal of license.

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

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

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

B. No physician assistant who allows a NCCPA certification to lapse shall be considered licensed by the board. Any such physician assistant who proposes to resume practice shall make a new application for licensure.

COMMONWEALTH of VIRGINIA

Arne W. Owens
Director

Department of Health Professions
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TO: The Honorable Mark D. Sickles
Chair, House Committee on Health and Human Services

The Honorable Ghazala F. Hashmi
Chair, Senate Committee on Education and Health

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

DATE: October 1, 2025

RE: Study on Physician Assistant Scope of Practice pursuant to HB2489 of the 2025 General Assembly Session

This report is submitted in compliance with HB2489 of the 2025 General Assembly, which required the Department of Health Professions to:

> Conduct a study on expansion of the scope of practice for physician assistants in the Commonwealth as a means to increase autonomy in the profession. Such study shall include a review of the education and training requirements for physician assistants in the Commonwealth, as well as a survey of such requirements in the other states and the scope of practice in such states, and an analysis of the costs and benefits to patients of increased autonomy for physician assistants in the Commonwealth. The Department shall submit a report with its findings and recommendations to the Chairs of the House Committee on Health and Human Services and Senate Committee on Education and Health by November 1, 2025.

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 Janet Kelly, Secretary of Health and Human Resources

Preface

This report is submitted in compliance with Chapter 569 (HB2489) of the 2025 Acts of Assembly, which required:

> The Department of Health Professions [to] conduct a study on expansion of the scope of practice for physician assistants in the Commonwealth as a means to increase autonomy in the profession. Such study shall include a review of the education and training requirements for physician assistants in the Commonwealth, as well as a survey of such requirements in the other states and the scope of practice in such states, and an analysis of the costs and benefits to patients of increased autonomy for physician assistants in the Commonwealth.

HB2489 requires the Department to submit this report to the Chairs of the House Committee on Health and Human Services and Senate Committee on Education and Health by November 1, 2025.

Contents

I. Executive Summary

Training requirements for physician assistants ("PAs") are consistent across the United States, including in Virginia. The scope of practice for PAs, however, varies nationally depending on state law. Virginia uses the collaborative practice model, which allows PAs to operate within a team-based model as recommended by the American Academy of Physician Associates ("AAPA").

As described below, costs to patients may arise related to diagnostic errors in situations with greater PA autonomy, but benefits would likely outweigh any costs to patients related to defensive medicine by a significant amount. Information from states with expanded scopes of practice for PAs regarding costs and benefits of that expanded practice has not been published.

II. Education and training requirements for physician assistants

Education and training requirements for PAs are relatively consistent nationally. Generally, PAs are educated at a master's level and complete 24 – 27 months of academic instruction which includes didactic and clinical training. This education follows hard science prerequisites, generally resulting in a university degree.[1]

According to the AAPA, all U.S. states require PAs to graduate from an accredited program and pass the Physician Assistant National Certifying Examination ("PANCE").[2] In Virginia, Virginia Code § 54.1-2951.1 and 18VAC85-50-50 require an applicant for licensure to have completed an educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant ("ARC-PA").[3] Accredited training includes classroom instruction in anatomy, physiology, biochemistry, pharmacology, physical diagnosis, pathophysiology, microbiology, clinical laboratory science, behavioral science, and medical ethics.[4] Students in accredited programs complete more than 2,000 hours of clinical rotations in medical and surgical disciplines with emphasis on primary care. Rotations may include disciplines such as family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, and psychiatry.[5]

To renew a PA license in Virginia, a licensee must maintain certification from the National Commission on Certification of Physician Assistants ("NCCPA").[6] While not part of initial education and training to obtain a license as a PA, continued NCCPA certification requires 100 credits of continuing medical education every two years. Additionally, PAs must pass the Physician Assistant National Recertifying Exam ("PANRE") or the Physician Assistant National Recertifying Exam-Longitudinal Assessment ("PANRE-LA") by the end of the 10th year of the certifying maintenance cycle.

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[1] Some PA programs will allow entry from high school or only partial college credit, but those programs are longer in length, often requiring four to six years of training. *See* American Academy of Physician Associates at https://www.aapa.org/career-central/become-a-pa/.

[2] The PANCE assesses clinical knowledge, clinical reasoning, and other medical skills and professional behaviors deemed important for entry-level practice as a PA. PANCE consists of five blocks of 60 questions with 60 minutes to complete each block. *See* National Commission of Physician Assistants website regarding PANCE, available at https://www.nccpa.net/become-certified/.

[3] ARC-PA is the independent accrediting body for physician assistant training. Accreditation by ARC-PA requires a peer review process that includes documentation and periodic site visit evaluations to substantiate compliance with accreditation standards. ARC-PA reports collaboration with the American Academy of Family Physicians, AAPA, the American Academy of Pediatrics, the American College of Physicians, the American Medical Association, the PA Educational Association ("PAEA"), the Society of Emergency Medicine PAs, the Association of PAs in Psychiatry, the Society of PAs in Family Medicine, the Society of PAs in Pediatrics, and the Association of PAs in Obstetrics and Gynecology. ARC-PA only accredits programs within the United States, including United States territories. *See* https://www.arc-pa.org/about/.

[4] *See* https://www.aapa.org/career-central/become-a-pa/.

[5] *Id.*

[6] *See* 18VAC85-50-56.

III. Scope of practice models for physician assistants

Scope of practice for PAs varies across U.S. jurisdictions. In general, PAs practice with some level of physician or other healthcare provider oversight. Most states require supervision, collaboration, or a combination of supervision and collaboration, with lesser amounts of practice requiring supervision. Virginia uses the collaborative practice model, which allows PAs to operate in a team-based model as recommended by the AAPA.

Supervision models utilize PAs as a dependent practitioner in a patient care setting. These models require close physician or other healthcare provider supervision and may include requirements for co-signatures, chart review, and on-site supervision. Twenty-two states use a supervisory practice model: Arkansas; California; Connecticut; Florida; Georgia; Hawaii; Idaho; Kansas; Kentucky; Louisiana; Massachusetts; Mississippi; Nebraska; Nevada; New Jersey; New York; North Carolina; Ohio, Pennsylvania; South Carolina; Texas; and Washington.

The collaboration model represents a team-based approach to patient care and often allows the PA and healthcare collaborators to determine appropriate oversight, communication, chart review, and consultation levels for the patient care team. Sixteen states and the District of Columbia use a collaborative practice model: Delaware; Illinois; Indiana; Maine; Maryland; Michigan; Minnesota; Missouri; Oklahoma; Oregon; Rhode Island; Tennessee; Vermont; Virginia; West Virginia; and Wisconsin. Some states require that a practice agreement be approved or filed with a state licensing board, while others require the practitioners to maintain a collaborative practice agreement.[7]

Two states use a combination of supervision and collaboration. Colorado requires supervision but permits a PA to collaborate with a physician following completion of more than 5,000 practice hours. Colorado also requires supervision of PAs changing specialty for 3,000 practice hours in the new specialty.[8] New Mexico requires supervision of PAs but allows a collaborative practice model for PAs in primary care with more than three years of practice.

Eight states have eliminated the legal requirement for a specific relationship between a PA and a physician or other healthcare provider. These states are considered the U.S. jurisdictions that permit the most autonomy for PA practice. Within these eight jurisdictions, the requirements to obtain that level of autonomy vary:

- Utah allows practice without a specific relationship with a physician or other healthcare provider after 10,000 hours of practice.

[7] Virginia does not require PAs or collaborating healthcare practitioners to file practice agreements with the Board. Va. Code § 54.1-2951.1(D). Legislation in the 2016 General Assembly Session eliminated a previous regulatory requirement that PAs submit practice agreements to the Board for approval.

[8] Virginia does not license PAs by specialty, but instead provides a general license to practice, consistent with a license to practice medicine. *See* Va. Code §§ 54.1-2951.1 and 54.1-2951.2; *compare* Va. Code § 54.1- 2932.

- Arizona, Iowa, Montana, and New Hampshire allow practice without a specific relationship with a physician or other healthcare provider after 8,000 hours of practice.
- South Dakota allows practice without a specific relationship with a physician or other healthcare provider after 6,000 hours of practice.
- North Dakota allows practice without a specific relationship with a physician or other healthcare provider after 4,000 hours of practice.
- Wyoming does not have a requirement to obtain or maintain a specific relationship with a physician or other healthcare provider.

States also vary in prescriptive authority for PAs. Thirty-one states and the District of Columbia allow PAs to prescribe Schedules II – V and all non-controlled substances without exception.[9] Nineteen states limit prescribing in some way.[10] These limitations include exclusion of certain schedules of drugs (such as Schedule II), limitation on the amount of drugs that may be prescribed (such as limiting to a three-day supply), requiring a physician review of medication prescribed, or limiting prescription options to a formulary.

[9] These states include: Alabama; Alaska; Arkansas; California; Colorado; Connecticut; Delaware; Hawaii; Idaho; Indiana; Iowa; Kansas; Louisiana; Maine; Maryland; Michigan; Minnesota; Mississippi; Nebraska; Nevada; New Hampshire; New York; North Dakota; Oregon; Rhode Island; Utah; Vermont; Virginia; Washington; Wisconsin; Wyoming; and the District of Columbia.

[10] These states include: Arizona; Florida; Georgia; Illinois; Kentucky; Massachusetts; Missouri; Montana; New Jersey; New Mexico; North Carolina; Ohio; Oklahoma; Pennsylvania; South Carolina; South Dakota; Tennessee; Texas; and West Virginia.

IV. Costs and benefits to patients of increased autonomy of physician assistants in Virginia

A. Costs to patients.

Potential costs to patients for increased autonomy of PAs in Virginia may include an increase in adverse patient outcomes due to less physician-directed care. While several studies have been performed in this area over the last twenty years, patient impact from the expansion of PA autonomy in states without a requirement to maintain a specific relationship with a physician has not yet been studied. Such changes in PA scope of practice occurred within the last six years, beginning in 2019. Studies regarding patient outcomes in states with the most permissive practice models may emerge as more states adopt this model and after more time elapses in which to study patient outcomes.

An article published in 2023 in the Journal of Medical Regulation presented findings from a study of medical malpractice payment reports on the National Practitioner Data Bank ("NPDB") for PAs from 2010 – 2019, comparing malpractice data to state scope of practice requirements. Overall, the study did not find an increased rate of medical malpractice payment reports in states with permissive models of PA care.[11] The article posited that if permissive PA practice models presented a threat to patient safety and an increased risk of malpractice,

> there should be a greater number of malpractice payments against PAs in states with permissive compared to restrictive PA practice laws and regulations. Reported malpractice payments serve as an approximation of the acts or omissions constituting medical errors or negligence, are highly correlated with adverse patient outcomes, and have been used as a surrogate measure of serious adverse medical events.[12]

The study found, however, that states with more permissive regulatory environments for PA practice were not associated with increases in medical malpractice payment reports for PAs. In contrast, an earlier study which reviewed NPDB practice reports for physicians, PAs, and nurse practitioners from 2005 – 2014 found a higher rate of diagnosis-related malpractice reports for PAs (52.8%) than for physicians (31.9%).[13] Yet another study noted that the benefits of reliance on PAs would outweigh any costs to patients related to defensive medicine[14] as a result of diagnostic errors.[15]

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[11] S. DePalma, M. DePalma, S. Kolhoff, N. Smith, *Medical Malpractice Payment Reports of Physician Assistants/Associates Related to State Practice Laws and Regulations*, 109 J. OF MED. REG. No. 4 (2023), 27 – 37.
[12] *Id.* at 28.
[13] D. Brock, J. Nicholson, R. Hooker, *Physician Assistant and Nurse Practitioner Malpractice Trends,* 74 MED. CARE RES. REV. 613-24 (Oct. 2017).
[14] In this situation, defensive medicine refers to additional tests and treatments to avoid litigation or malpractice.
[15] B. Walia, H. Banga, and D. Larsen, *Increased Reliance on Physician Assistants: an Access-Quality Tradeoff?* 10 JOURNAL OF MARKET ACCESS AND HEALTH POLICY (2022) at 3.

B. Benefits to patients.

While a potential benefit to patients of greater access to care may be noted, there is no guarantee that increased autonomy of PAs will directly result in the availability of more practitioners in health care deserts. There is some evidence that a model of practice that includes more autonomous PAs may increase coverage in rural areas, though. While not directly comparable, autonomous nurse practitioners are more likely to practice in rural areas compared to non-autonomous nurse practitioners. The DHP Healthcare Workforce Data Center determined, using 2023 licensing data, that autonomous nurse practitioners are more likely to be practicing in rural areas and areas with low numbers of full-time equivalent physicians than non-autonomous nurse practitioners.[16] Increasing health care coverage in areas lacking significant options for medical care requires a multi-pronged approach, of which increasing capacity of mid-level practitioners plays a part.

A likely potential benefit to patients of greater autonomy of PAs is an overall lower cost of healthcare.

> Given the large average salary difference between PAs and physicians, it stands to reason that a shift toward PAs would have the direct effect of lowering healthcare costs . . . In fact, several studies find statistical evidence that an increased presence of PAs and nurse practitioners lowers healthcare costs.[17]

Various studies have concluded[18] that expansion of scope of practice for PAs does not result in harmful or low-quality care. Several studies have instead indicated less intensive treatment for patients with no noted increase in adverse outcomes.[19] These studies must be viewed alongside those that indicate a higher diagnostic error rate of PAs.[20]

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[16] *See* Appendix 1.
[17] Walia, *supra* note 15 at 2.
[18] B. McMichael, *Healthcare Licensing and Liability*, 95 INDIANA LAW JOURNAL 821 – 881 (2020) (providing an extensive empirical analysis of all births in the United States from 1998 – 2015, concluding that allowing APRNs and PAs to practice with more autonomy reduced the use of medically intensive procedures); J. Mafi, *et al.*, *US Emergency Care Patterns Among Nurse Practitioners and Physician Assistants Compared with Physicians; a Cross-Sectional Analysis*, 12 BMJ OPEN Iss. 4 (Apr. 2022); P. Morgan, *et al., Impact of Physicians, Nurse Practitioners, and Physician Assistants on Utilization and Costs for Complex Patients*, 38 HEALTH AFFAIRS Iss. 6 (June 2019) (finding that use of nurse practitioners and PAs as primary care providers for complex patients with diabetes was associated with less use of acute care services and lower total costs in reviewing 2012-13 data from the Department of Veterans Affairs); D. Johnson, *et al.*, 132 AM. J. MED. Iss. 11 (Nov. 2019) (finding advanced practice providers (nurse practitioners and PAs) did not provide statistically significant differences in quality of care to physicians and can provide high quality care in clinical settings).
[19] McMichael, *supra* note 18; Morgan, *supra* note 18.
[20] Walia, *supra* note 15 at 3.

V. Conclusion

In conclusion, training requirements for PAs across the U.S. are consistent with Virginia requirements. The scope of practice for physician assistants varies depending on state law. Virginia uses the collaborative practice model, which allows PAs to operate in a team-based model as recommended by the AAPA.

Costs to patients may arise related to diagnostic errors under more autonomous practice models, but benefits are likely to outweigh any costs related to defensive medicine by a significant amount. Information from states with expanded scopes of practice for PAs regarding costs and benefits of that expanded practice has not been published. Given the limitations of the Department of Health Professions as a licensing and disciplinary agency for healthcare practitioners in the Commonwealth, a more in-depth cost benefit analysis of altering PA scope of practice in Virginia may need to be undertaken by dedicated research bodies, such as the Joint Commission on Health Care.

Appendix 1

Summary Statistics

Summary Statistics – nurse practitioner

Department of Health Professions

	Autonomous (n=5,626)	Non-Autonomous (n=2,183)
Mean age	49	44
Female	92%	93%
White	74%	71%
Black	16%	15%
Asian	4%	7%
Hispanic	3%	4%
Other	3%	3%
More than Master's degree	32%	17%
Median hours worked/week	44%	43%
Job satisfaction	93%	94%
Less than 10 years licensed as NP	49%	71%
Median income	$110,000-$120,000	$100,000-$110,000
Median debt	$0	$25,000

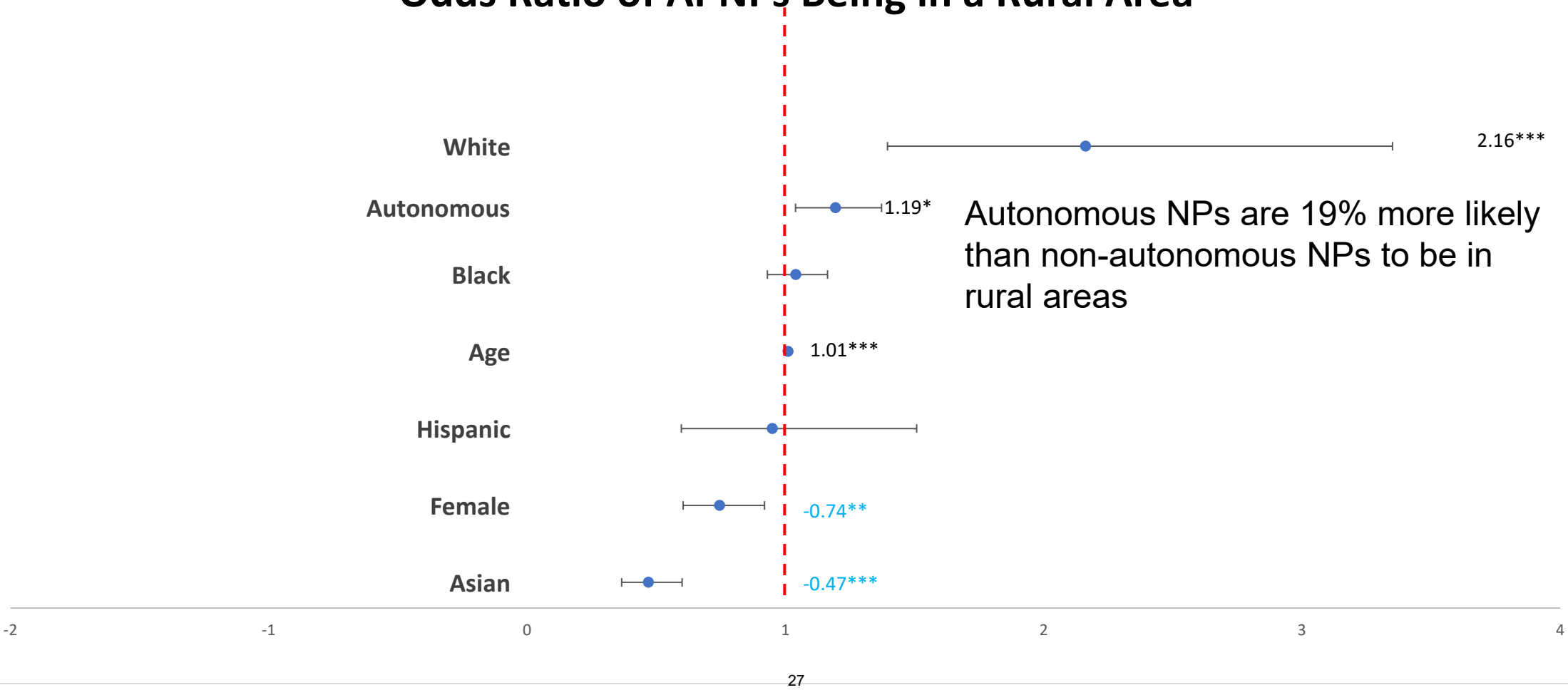
Practice settings – nurse practitioner

	Autonomous	Non-autonomous
Physician Office	7%	9%
Private practice, solo	4%	2%
Private practice, group	8%	6%
Clinic, Primary Care or Non-Specialty (e.g. FQHC, Retail or Free Clinic)	25%	23%
Hospital, Inpatient Department	9%	15%
Hospital, Outpatient Department	5%	6%
Hospital, Emergency Department	1%	3%
Mental Health, or Substance Abuse, Outpatient Center	9%	4%
Rural	15%	12%
In county/city with <1 physician FTE/1,000 Population	11%	8%
Primary care specialty	76%	78%

Logistic Regression Results

Department of Health Professions

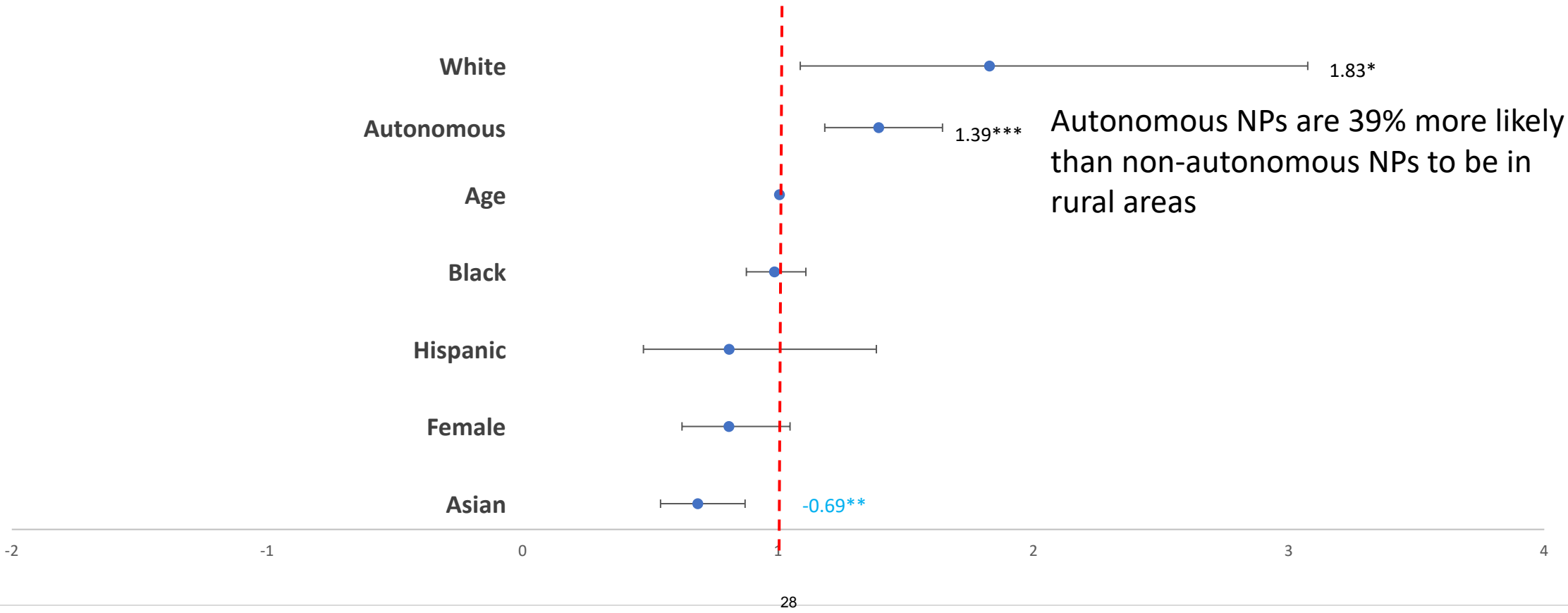
Odds Ratio of APNPs Being in a Rural Area



Autonomous NPs are 19% more likely than non-autonomous NPs to be in rural areas

Chi-square (DF, p): 159.58 (7, 0.001); Nagelkerke R Square: 0.03

Odds Ratio of APNPs Being in a Low Physician FTE Area



Autonomous NPs are 39% more likely than non-autonomous NPs to be in rural areas

Chi-square (DF, p): 65.36 (7, 0.001); Nagelkerke R Square: 0.02

Limitations and Conclusion

As suggested in the literature and as hypothesized in this study, autonomous APNPs in Virginia were more likely to be practicing in rural areas

Autonomous APNPs also appear to be filling the gaps where there were few physicians available

Limitations and Conclusion

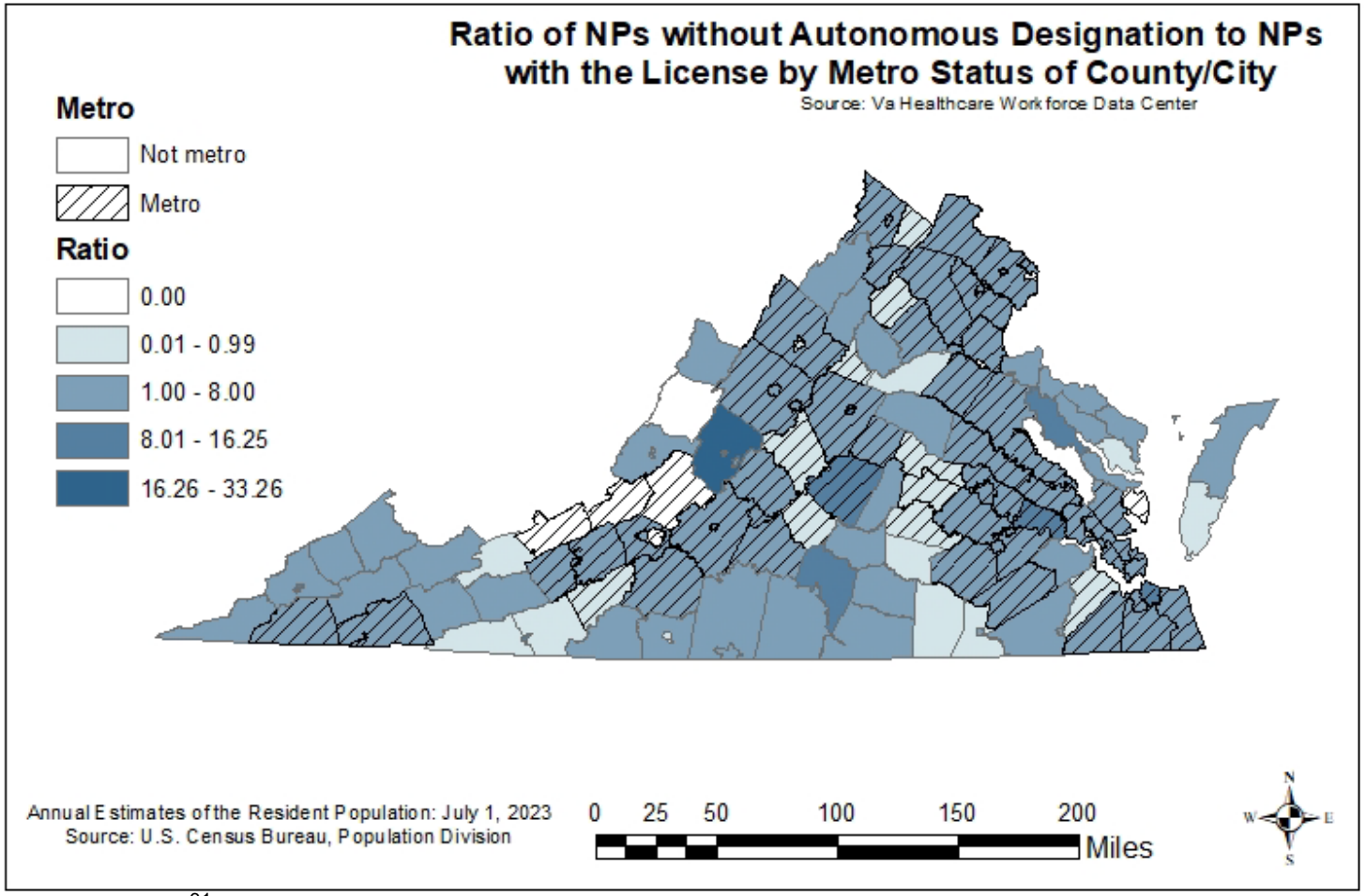
About 10% of APNPs reported multiple specialties and autonomous designation does not always equate practice

Findings support literature on importance of APNPs for rural areas and areas with low physician access; conclusions are made within limitations of the survey and data used

Department of Health Professions

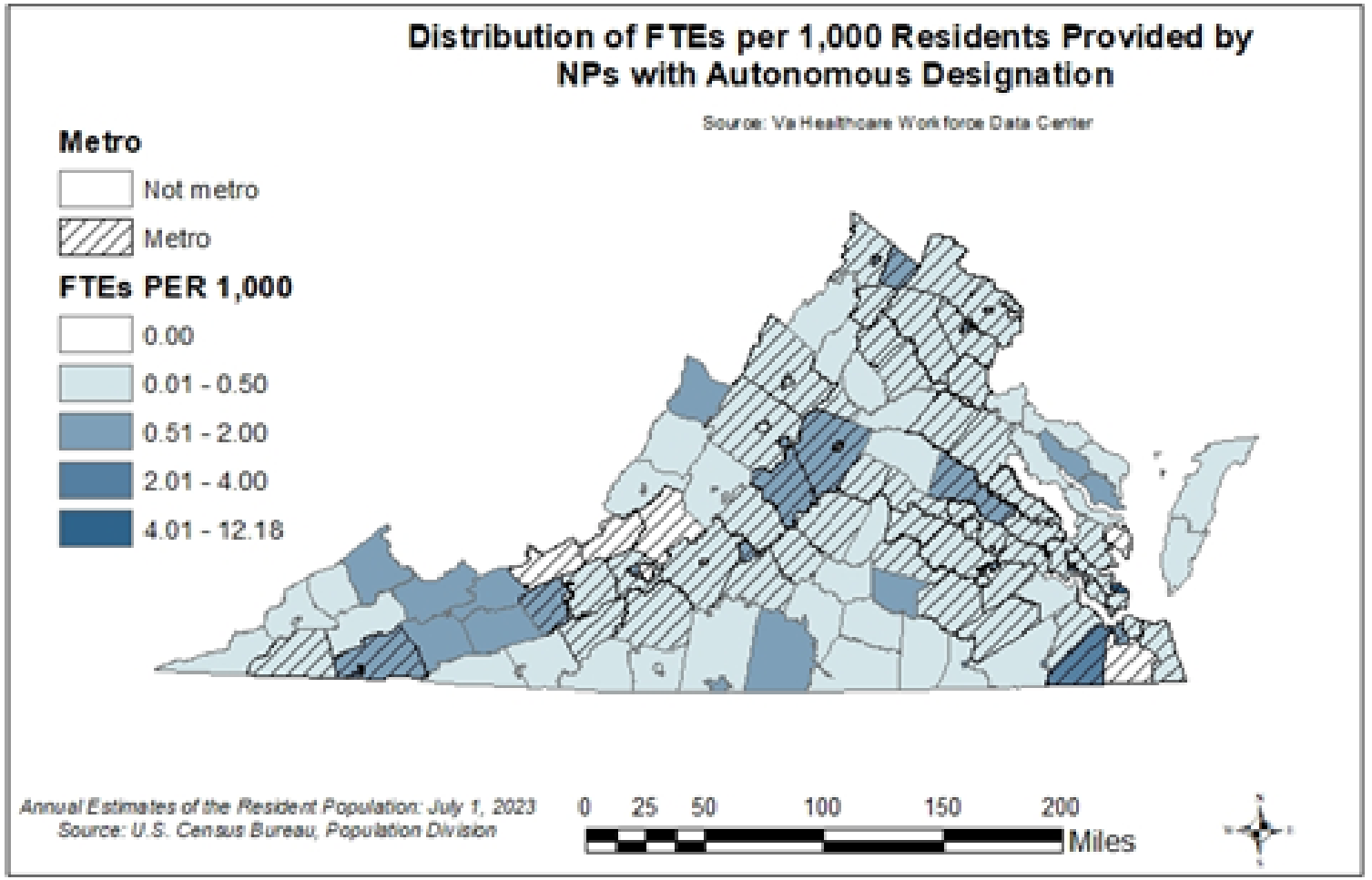
In 2024, there were 5,626 NPs who did not have autonomous designations in Virginia; they provided 7,024 FTEs. There were another 2,183 NPs with autonomous designation who provided 2,716 FTEs in the state.

This map shows the distribution of the ratio of the FTEs provided by NPs without an autonomous designation to those with the designation. Lighter blue (<1) indicates more NPs with autonomous designation than those without. Even though there are fewer NPs with the designation, in non-metro areas (without hatch), they were more likely to report higher FTEs than those without the designation.



Department of Health Professions

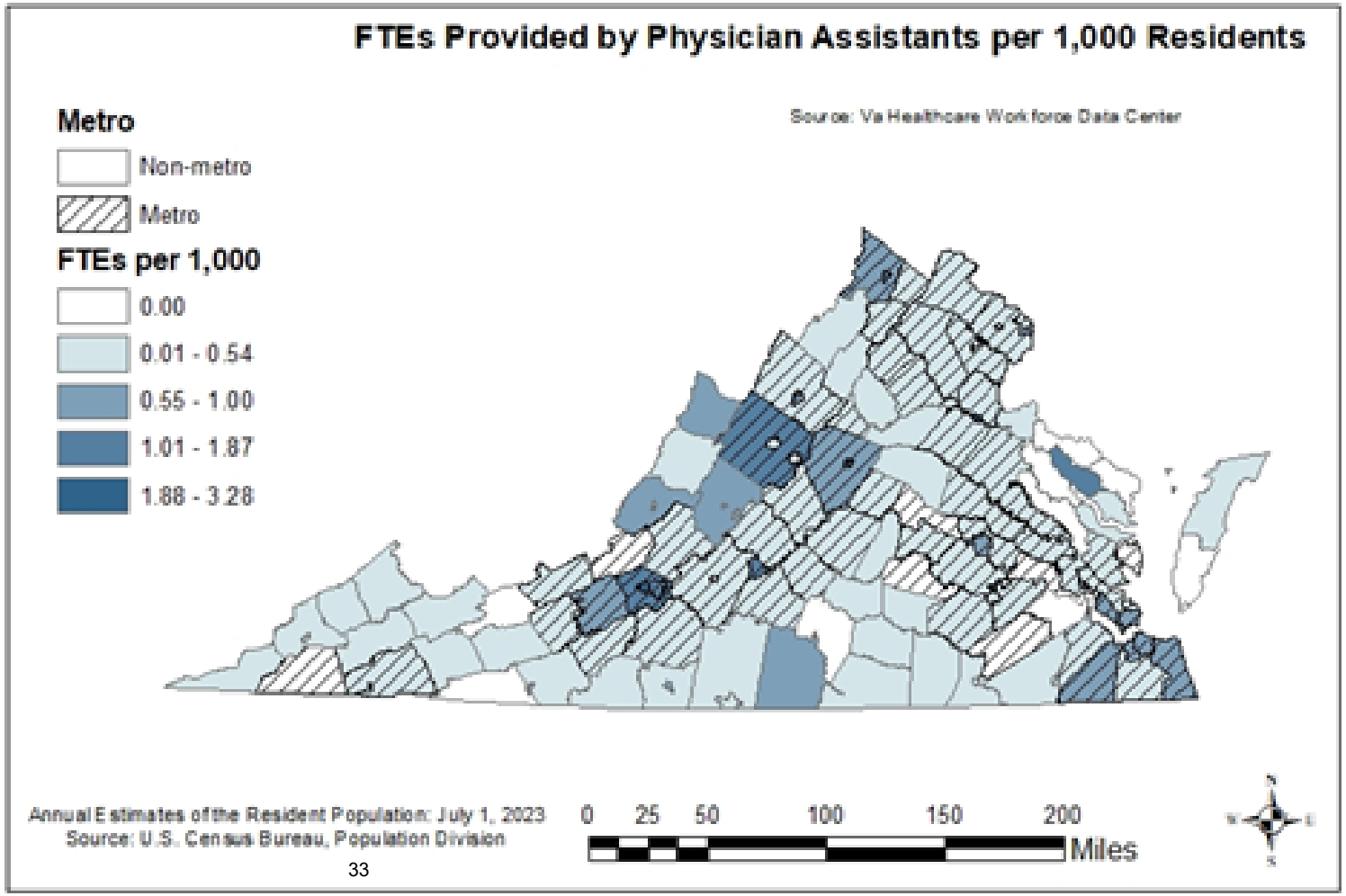
This map shows the distribution of NPs with autonomous designation in Virginia. Counties with higher concentration of FTEs per capita provided by these NPs (in darker blue) were more likely to be non-metro areas.



Department of Health Professions

In 2023, when the most recent PA workforce survey occurred, there were 5,174 PAs in VA workforce and they provided 4,478 FTEs.

Counties with higher concentration of physician assistants per capita (in darker blue) were more likely to be metro areas.



PA COMPACT

What is the PA Licensure Compact?

The PA Licensure Compact is an interstate occupational licensure compact for physician assistants/associates (PAs). The compact provides a streamlined process via a compact privilege for PAs to practice in other compact member states without the need to obtain multiple state licenses. States join the compact by legislatively enacting the model compact legislation.

What You Need to Know

- The model compact legislation has been finalized and is available for state adoption.
- Qualifying PAs in a compact member state who meet all compact requirements may practice in other compact member states via a compact privilege, which is considered to be equivalent to a license.
- A PA will utilize the data system to obtain individual compact privileges for any participating state they wish to practice.
- The PA Licensure Compact Commission was activated in September 2024 after seven states adopted the model language. Historically, the process for a licensure compact to become fully operational can take up to 24 months after its activation.

Compact Benefits

- Maintains public safety and reduces application time through a shared data system
- Increases collaboration among compact member states
- Facilitates multistate practice by reducing the burden of maintaining multiple licenses
- Improves access to PA services and the use of telehealth
- Improves continuity of care when patients or PAs relocate
- Supports relocating practicing PA military spouses
- Expands employment opportunities for PAs into new markets
- Preserves PA state-based scope of practice

Additional Information

Resources on pacompact.org:

- Model Legislation
- Legislative Map
- FAQs
- Commission Work

AAPA American Academy of PAs

CSG The Council of State Governments

fsmb FEDERATION OF STATE MEDICAL BOARDS

NCCPA Certification. Excellence.®

HRSA Grant Disclaimer

The PA Licensure Compact was made possible by the Health Resources and Services Administration of the U.S. Department of Health and Human Services as part of the Licensure Portability Grant Program (H1MRH24097). The contents are those of the author(s) and do not necessarily represent the official views of nor an endorsement by the HRSA, HHS or the U.S. government.

Legislative Update

As of September 2025, there are 19 Compact Member States. Active legislation is currently filed in New Jersey, Michigan, and Massachusetts. Click here to view a map of legislation introduced in each state.

State	Bill number	Effective date
Utah	SB 35	3-May-23
Delaware	SB 116	21-Jul-23
Wisconsin	SB 400	8-Dec-23
Minnesota	HF 5247	25-May-24
Washington	HB 1917	6-Jun-24
West Virginia	SB 667	6-Jun-24
Virginia	HB 324	1-Jul-24
Maine	LD 2043	16-Jul-24
Colorado	SB 24-018	7-Aug-24
---post inaugural meeting--		
Ohio	SB 28	24-Oct-24
Oklahoma	HB 3781	1-Nov-24
Nebraska	LB 1215	1-Jan-25
Tennessee	SB 1727	1-Jan-25
Kansas	HB 2069, signed 4/9/25	1-Jul-25
Montana	HB 183, signed 4/3/25	1-Jul-25
Iowa	HF 300	1-Jul-25
Connecticut	HB 7287	1-Jul-25
Arkansas	SB 101, became law 3/18/25	90 days after end of session
North Carolina	H67	1-Jan-26

Committee Synopsis

Executive Committee

- March 2025: Received responses to a Data System RFI. Full Commission viewed presentations by four of the RFI respondents.

- May–August 2025: Prepared Data System RFP.

Communications

- Created a PA Compact newsletter to be distributed quarterly.
- Updated the PA Compact development timeline on PA Compact website.
- Reviewed and updated FAQs on PA Compact website.

Finance

- Created and regularly updates a draft budget for the commission.

Rules

- Drafted rules 2, 3, and 5 related to the compact privilege process and data system management.

Compact Development Timeline

Summer 2019	Compact project started.
Fall 2019	FSMB convenes meeting with state regulatory boards to discuss outline of compact.
November 2022	Compact legislation finalized and made available for state adoption.
May 2024	The compact activation threshold of seven participating states is met.
September 2024	Compact Commission holds its inaugural meeting.
October 2024	Executive, Rules, Finance, and Communications Committees convene and begin developing compact infrastructure.
April 2025	Data System RFI responses received and reviewed.

May 2025	Executive Committee begins developing Data System RFP.
Ongoing	Commission and committee meetings; rule and policy development; onboarding of new Member States.
Current – 2026	Development and implementation of Data System.
Early 2027 (projected)	Compact Commission begins granting compact privileges to practice.

FAQ Highlight

Q. How does the compact affect PAs who hold multiple single state licenses?

A. PAs may elect to not renew their additional single state licenses and instead apply for compact privileges in those states provided they are members of the compact. A practitioner must maintain at least one single state license, which serves as their qualifying license for their compact privilege(s). The process for applying for a compact privilege in lieu of a single state license will be further expounded upon by commission rule.

Questions? See the PA Compact FAQs, or email pacompact@csg.org.

Adopted: September 29, 2022

BYLAWS FOR

ADVISORY BOARDS OF THE BOARD OF MEDICINE

Article I - Members of the Advisory Board

The appointments and limitations of service of the members shall be in accordance with the applicable statutory provision of the advisory board governing such matters.

Article II - Officers

Section 1. Titles of Officers - The officers of the advisory board shall consist of a chairman and vice-chairman elected by the advisory board. The Executive Director of the Board of Medicine shall serve in an advisory capacity.

Section 2. Terms of Office - The chairman and vice-chairman shall serve for a one-year term and may not serve for more than two consecutive terms in each office. The election of officers shall take place at the first meeting after July 1, and officers shall assume their duties immediately thereafter.

Section 3. Duties of Officers.

(a) The chairman shall preside at all meetings when present, make such suggestions as may deem calculated to promote and facilitate its work, and discharge all other duties pertaining by law or by resolution of the advisory board. The chairman shall preserve order and conduct all proceedings according to and by parliamentary rules and demand conformity thereto on the part of the members. The chairman shall appoint all committees as needed.

The chairman shall act as liaison between the advisory board and the Board of Medicine on matters pertaining to licensing, discipline, legislation and regulation of the profession which the advisory board represents.

When a committee is appointed for any purpose, the chairman shall notify each member of the appointment and furnish any essential documents or information necessary.

(b) The vice-chairman shall preside at meetings in the absence of the chairman and shall take over the other duties of the chairman as may be made necessary by the absence of the chairman.

Article III - Meetings

Section 1. There shall be at least one meeting each year in order to elect the chairman and vice-chairman and to conduct such business as may be deemed necessary by the advisory board.

Section 2. Quorum - Three members shall constitute a quorum for transacting business.

Section 3. Order of Business - The order of business shall be as follows:

(a) Calling roll and recording names of members present
(b) Approval of minutes of preceding regular and special meetings
(c) Adoption of Agenda
(d) Public Comment Period
(e) Report of Officers
(f) Old Business
(g) New Business

The order of business may be changed at any meeting by a majority vote.

Article IV - Amendments

Amendments to these bylaws may be proposed by presenting the amendments in writing to all advisory board members prior to any scheduled advisory board meeting. If the proposed amendment receives a majority vote of the members present at that advisory board meeting, it shall be represented as a recommendation for consideration to the Board of Medicine at its next regular meeting.

Advisory Board on:

Behavioral Analysts			**10:00 a.m.**
Mon –February 2	May 11	September 28	
Genetic Counseling			**1:00 p.m.**
Mon –February 2	May 11	September 28	
Occupational Therapy			**10:00 a.m.**
Tues – February 3	May 12	September 29	
Respiratory Care			**1:00 p.m.**
Tues - February 3	May 12	September 29	
Acupuncture			**10:00 a.m.**
Wed - February 4	May 13	September 30	
Radiological Technology			**1:00 p.m.**
Wed - February 4	May 13	September 30	
Athletic Training			**10:00 a.m.**
Thurs - February 5	May 14	October 1	
Physician Assistants			**1:00 p.m.**
Thurs - February 5	May 14	October 1	
Midwifery			**10:00 a.m.**
Fri - February 6	May 15	October 2	
Polysomnographic Technology			**2:30 p.m.**
Fri - February 6	May 15	October 2	
Surgical Assisting			**10:00 a.m.**
Mon - February 7	May 18	October 5	

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). Vouchers submitted after the 30-day deadline cannot be approved.

In order for the agency to be in compliance with the state travel regulations, please submit your request for today's meeting on or before

November 23, 2025