BOARD OF PHYSICAL THERAPY

Special Committee Meeting on Licensure Compact

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
2nd Floor Conference Center
Training Room #2

Tuesday, September 27, 2016
1:30 p.m.

AGENDA

CALL TO ORDER

ISSUE FOR DISCUSSION:

- **Physical Therapy Licensure Compact**

ATTACHMENTS:

- Licensure Statistics
- Code of Virginia – Chapter 34.1 of Title 54.1
- Regulations – 18VAC112-20-10 et seq.
- FSBPT Documentation:
  - Milestones
  - Current Status of Compact as of 7/6/2016
  - Physical Therapy Licensure Compact
  - Article – Portability & a Physical Therapy Compact
  - Article – Licensure Portability: Assuring Access to Quality Care in Physical Therapy
  - Interstate Compacts: Background and History
  - Interstate Compact – Process
- DHP Workforce Studies – PT/PTA
- Virginia Nurse Licensure Compact

ADJOURNMENT

Board of Physical Therapy
Special Committee Meeting
on
Licensure Compact

Information Packet

- Licensure Statistics
- Code of Virginia – Chapter 34.1 of Title 54.1
- Regulations – 18VAC112-20-10 et seq.
- FSBPT Documentation:
  - Milestones
  - Current Status of Compact as of 7/6/2016
  - Physical Therapy Licensure Compact
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  - Article – Licensure Portability: Assuring Access to Quality Care in Physical Therapy
  - Interstate Compacts: Background and History
  - Interstate Compact – Process
- DHP Workforce Studies – PT/PTA
- Virginia Example:
  - Article 6. Nurse Licensure Compact

September 27, 2016

License Count Report for Physical Therapy

Board	Occupation	State	License Status	License Count
Physical Therapy				
	Direct Access Certification			
	Direct Access Certification	Virginia	Current Active	1,070
	Direct Access Certification	Out of state	Current Active	45
	Direct Access Certification	Out of state	Current Inactive	1
	Total for Direct Access Certification			1,116
	Physical Therapist			
	Physical Therapist	Virginia	Current Active	6,125
	Physical Therapist	Virginia	Current Inactive	88
	Physical Therapist	Virginia	Probation - Currei	2
	Physical Therapist	Out of state	Current Active	1,928
	Physical Therapist	Out of state	Current Inactive	127
	Physical Therapist	Out of state	Probation - Currei	2
	Total for Physical Therapist			8,272
	Physical Therapist Assistant			
	Physical Therapist Assistant	Virginia	Current Active	2,727
	Physical Therapist Assistant	Virginia	Current Inactive	41
	Physical Therapist Assistant	Virginia	Probation - Currei	1
	Physical Therapist Assistant	Out of state	Current Active	487
	Physical Therapist Assistant	Out of state	Current Inactive	31
	Total for Physical Therapist Assistant			3,287
Total for Physical Therapy				12,675

Virginia Department of Health Professions

COUNT OF CURRENT LICENSES*

BOARD SUMMARY

FISCAL YEAR 2016, QUARTER ENDING 06/30/2016

Quarter Breakdown	
Quarter 1	July 1st - September 30th
Quarter 2	October 1st - December 31st
Quarter 3	January 1st - March 31st
Quarter 4	April 1st - June 30th

**CURRENT LICENSES BY BOARD AND OCCUPATION AS OF THE LAST DAY OF THE QUARTER*

	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	CURRENT Q4 2016
Audiology/Speech Pathology	4019	4093	3936	4104	4418	4674	4653	4840	4944	4992	4720	4802
Counseling	6788	6960	7098	6545	7026	7183	7256	7042	7249	7490	7597	7808
Dentistry	13103	13226	12617	13140	13390	13507	12782	13753	13999	14186	14319	14184
Funeral Directing	2484	2516	2379	2471	2521	2543	2313	2506	2540	2573	2618	2497
Long Term Care Administrator	2030	2079	1968	2054	2107	2176	1922	2058	2115	2165	2206	2087
Medicine	61299	61769	61910	61789	62714	62617	62816	64137	65337	65922	66177	67447
Nurse Aide	53995	53989	53751	53098	54250	54491	53695	53834	54568	54402	54374	54477
Nursing	159261	159067	159315	159974	162346	161891	161569	163058	164128	163594	163637	164199
Optometry	1896	1915	1852	1906	1927	1946	1856	1915	1931	1963	1874	1914
Pharmacy	34021	34800	33321	34398	35424	36750	34226	35476	36365	37218	34741	35972
Physical Therapy	10170	10390	10574	10901	11401	11647	10533	11000	10908	11075	11240	11702
Psychology	3696	3799	3888	3624	3893	4017	4093	3876	4028	4141	4253	4360
Social Work	5923	6076	6242	6350	6481	6590	6741	6306	6544	6690	6828	7057
Veterinary Medicine	6833	6882	6651	6897	7029	7108	6888	7187	7304	7370	7112	7376
AGENCY TOTAL	365518	367561	365502	367251	374927	377140	371343	376988	381960	383781	381696	385882

Code of Virginia

Chapter 34.1 of Title 54.1 – Physical Therapy

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§ 54.1-3473. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Board" means the Board of Physical Therapy.

"Physical therapist" means any person licensed by the Board to engage in the practice of physical therapy.

"Physical therapist assistant" means any person licensed by the Board to assist a physical therapist in the practice of physical therapy.

"Practice of physical therapy" means that branch of the healing arts that is concerned with, upon medical referral and direction, the evaluation, testing, treatment, reeducation and rehabilitation by physical, mechanical or electronic measures and procedures of individuals who, because of trauma, disease or birth defect, present physical and emotional disorders. The practice of physical therapy also includes the administration, interpretation, documentation, and evaluation of tests and measurements of bodily functions and structures within the scope of practice of the

physical therapist. However, the practice of physical therapy does not include the medical diagnosis of disease or injury, the use of Roentgen rays and radium for diagnostic or therapeutic purposes or the use of electricity for shock therapy and surgical purposes including cauterization.

(2000, c. 688; 2001, c. 858.)

§ 54.1-3474. Unlawful to practice without license; continuing competency requirements.

A. It shall be unlawful for any person to practice physical therapy or as a physical therapist assistant in the Commonwealth without a valid unrevoked license issued by the Board.

B. The Board shall promulgate regulations establishing requirements to ensure continuing competency of physical therapists and physical therapist assistants, which may include continuing education, testing, or such other requirements as the Board may determine to be necessary.

C. In promulgating continuing competency requirements, the Board shall consider (i) the need to promote ethical practice, (ii) an appropriate standard of care, (iii) patient safety, (iv) application of new medical technology, (v) appropriate communication with patients, and (vi) knowledge of the changing health care system.

D. The Board may approve persons who provide or accredit programs to ensure continuing competency.

(2000, c. 688; 2001, c. 858.)

§ 54.1-3475. Board of Physical Therapy; appointment; qualifications; officers; nominations.

A. The Board of Physical Therapy shall regulate the practice of physical therapy and carry out the provisions of this chapter regarding the qualifications, examination, licensure and regulation of physical therapists and physical therapist assistants and shall have the general powers and duties of a health regulatory board pursuant to § 54.1-2400.

B. The Board shall be appointed by the Governor and shall be composed of seven members, five of whom shall be physical therapists who have been in active practice for at least seven years prior to appointment with at least three of such years in Virginia; one shall be a licensed physical therapist assistant; and one shall be a citizen member. Members shall be appointed for terms of four years and shall serve until their successors are appointed. The initial appointments shall provide for staggered terms with two members being appointed for a one-year term, two members being appointed for a two-year term, two members being appointed for a three-year term, and one member being appointed for a four-year term. Vacancies occurring other than by expiration of term shall be filled for the unexpired term. No person shall be eligible to serve on the Board for more than two successive full terms.

C. The Board shall annually elect a president and a vice-president.

D. Nominations for the professional members of the Board may be chosen by the Governor from a list of at least three names for each vacancy submitted by the Virginia Physical Therapy Association, Inc. The Governor may notify the Association of any professional vacancy other than by expiration of a term and nominations may be submitted by the Association. The Governor shall not be bound to make any appointments from among such nominees.

(2000, c. 688.)

§ 54.1-3476. Exemptions.

This chapter shall not apply to the performance of the duties of any commissioned or contract physical therapist or physical therapist assistant while practicing in the United States Armed Services, United States Public Health Service or United States Veterans Administration as based on requirements under federal regulations for state licensure of health care providers, or to a physical therapist or a physical therapist assistant licensed or certified and in good standing with the applicable regulatory agency in the state, District of Columbia, or Canada where the practitioner resides when the practitioner is in Virginia temporarily to practice for no longer than sixty days (i) in a summer camp or in conjunction with patients who are participating in recreational activities, (ii) in continuing education programs, or (iii) by rendering at any site any health care services within the limits of his license or certificate, voluntarily and without compensation, to any patient of any clinic which is organized in whole or in part for the delivery of health care services without charge as provided in § 54.1-106.

(2000, c. 688.)

§ 54.1-3477. Requirements for licensure as a physical therapist.

An applicant for licensure as a physical therapist shall submit evidence, verified by affidavit and satisfactory to the Board, that the applicant:

1. Is eighteen years of age or more;

2. Is a graduate of a school of physical therapy approved by the American Physical Therapy Association or is a graduate of a school outside of the United States or Canada which is acceptable to the Board; and

3. Has satisfactorily passed an examination approved by the Board.

(2000, c. 688.)

§ 54.1-3478. Requirements for licensure as a physical therapist assistant.

An applicant for licensure as a physical therapist assistant shall submit evidence, verified by affidavit and satisfactory to the Board, that the applicant:

1. Is eighteen years of age or more;

2. Is a graduate of a two-year college-level education program for physical therapist assistants acceptable to the Board; and

3. Has satisfactorily passed an examination approved by the Board.

(2000, c. 688.)

§ 54.1-3479. Licensure by examination or endorsement; traineeships.

A. The Board shall provide for the examinations to be taken by applicants for licensure as physical therapists and physical therapist assistants. The Board shall, on the basis of such examinations, issue or deny licenses to applicants to practice physical therapy or perform the duties of a physical therapist assistant. Any applicant who feels aggrieved at the result of his examination may appeal to the Board.

B. The Board, in its discretion, may issue licenses to applicants upon endorsement by boards of other appropriate authorities of other states or territories or the District of Columbia with which reciprocal relations have not been established if the credentials of such applicants are satisfactory and the examinations and passing grades required by such other boards are determined to be equivalent to those required by the Virginia Board.

C. The Board, in its discretion, may provide for the limited practice of physical therapy by a graduate physical therapist or physical therapist assistant enrolled in a traineeship program as defined by the Board under the direct supervision of a licensed physical therapist.

D. In granting licenses to out-of-state applicants, the Board may require physical therapists or physical therapist assistants to meet the professional activity requirements or serve traineeships according to regulations promulgated by the Board.

(2000, c. 688.)

§ 54.1-3480. Refusal, revocation or suspension.

A. The Board may refuse to admit a candidate to any examination, may refuse to issue a license to any applicant, and may suspend for a stated period of time or indefinitely or revoke any license or censure or reprimand any person or place him on probation for such time as it may designate for any of the following causes:

1. False statements or representations or fraud or deceit in obtaining admission to the practice, or fraud or deceit in the practice of physical therapy;

2. Substance abuse rendering him unfit for the performance of his professional obligations and duties;

3. Unprofessional conduct as defined in this chapter;

4. Intentional or negligent conduct that causes or is likely to cause injury to a patient or patients;

5. Mental or physical incapacity or incompetence to practice his profession with safety to his patients and the public;

6. Restriction of a license to practice physical therapy in another state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction;

7. Conviction in any state, territory or country of any felony or of any crime involving moral turpitude;

8. Adjudged legally incompetent or incapacitated in any state if such adjudication is in effect and the person has not been declared restored to competence or capacity; or

9. Conviction of an offense in another state, territory or foreign jurisdiction, which if committed in Virginia would be a felony. Such conviction shall be treated as a felony conviction under this section regardless of its designation in the other state, territory or foreign jurisdiction.

B. The Board shall refuse to admit a candidate to any examination and shall refuse to issue a license to any applicant if the candidate or applicant has had his certificate or license to practice physical therapy revoked or suspended, and has not had his certificate or license to so practice reinstated, in another state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction.

(2000, c. 688; 2001, c. 858; 2003, cc. 753, 762; 2004, c. 64.)

§ 54.1-3480.1. Continuing education.

As a prerequisite to renewal of a license or reinstatement of a license, each physical therapist shall be required to take biennial courses relating to physical therapy as approved by the Board. The Board shall prescribe criteria for approval of courses of study and credit hour requirements. The Board may approve alternative courses upon timely application of any licensee. Fulfillment of education requirements shall be certified to the Board upon a form provided by the Board and shall be submitted by each licensed physical therapist at the time he applies to the Board for the renewal or reinstatement of his license. The Board may waive individual requirements in cases of certified illness or undue hardship.

(2001, c. 315.)

§ 54.1-3481. Unlawful designation as physical therapist or physical therapist assistant; penalty.

A. It shall be unlawful for any person who is not licensed under this chapter, or whose license has been suspended or revoked or who licensure has lapsed and has not been renewed, to use in conjunction with his name the letters or words "R.P.T.," "Registered Physical Therapist," "L.P.T.," "Licensed Physical Therapist," "P.T.," "Physical Therapist," "Physio-therapist,"

"P.T.T.," "Physical Therapy Technician," "P.T.A.," "Physical Therapist Assistant," "Licensed Physical Therapist Assistant," or to otherwise by letters, words, representations or insignias assert or imply that he is a licensed physical therapist. The title to designate a licensed physical therapist shall be "P.T." The title to designate a physical therapist assistant shall show such fact plainly on its face.

B. No person shall advertise services using the words "physical therapy" or "physiotherapy" unless those services are provided by a physical therapist or physical therapist assistant licensed pursuant to this chapter.

C. A complaint or report of a possible violation of this section by any person who is licensed, certified, registered, or permitted, or who holds a multistate licensure privilege issued by any of the health regulatory boards within the Department of Health Professions shall be referred to the applicable board within the Department for disciplinary action.

D. Nothing in this section shall be construed to restrict or limit the legally authorized scope of practice of any profession licensed, certified, registered, permitted, or recognized under a multistate licensure privilege issued by any of the health regulatory boards within the Department of Health Professions prior to January 1, 2010.

(2000, c. 688; 2010, cc. 70, 368.)

§ 54.1-3482. Practice of physical therapy; certain experience and referrals required; physical therapist assistants.

A. It shall be unlawful for a person to engage in the practice of physical therapy except as a licensed physical therapist, upon the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with his practice agreement, or a licensed physician assistant acting under the supervision of a licensed physician, except as provided in this section.

B. A physical therapist who has completed a doctor of physical therapy program approved by the Commission on Accreditation of Physical Therapy Education or who has obtained a certificate of authorization pursuant to § 54.1-3482.1 may evaluate and treat a patient for no more than 30 consecutive days after an initial evaluation without a referral under the following conditions: (i) the patient is not receiving care from any licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with his practice agreement, or a licensed physician assistant acting under the supervision of a licensed physician for the symptoms giving rise to the presentation at the time of the presentation to the physical therapist for physical therapy services or (ii) the patient is receiving care from a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with his practice agreement, or a licensed physician assistant acting under the supervision of a licensed physician at the time of his presentation to the physical therapist for the symptoms giving rise to the presentation for physical therapy services and (a) the patient identifies a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with his practice agreement,

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

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

D. Invasive procedures within the scope of practice of physical therapy shall at all times be performed only under the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, a licensed nurse practitioner practicing in accordance with his practice agreement, or a licensed physician assistant acting under the supervision of a licensed physician.

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

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

G. However, a licensed physical therapist may provide, without referral or supervision, physical therapy services to (i) a student athlete participating in a school-sponsored athletic activity while such student is at such activity in a public, private, or religious elementary, middle or high school, or public or private institution of higher education when such services are rendered by a

licensed physical therapist who is certified as an athletic trainer by the National Athletic Trainers' Association Board of Certification or as a sports certified specialist by the American Board of Physical Therapy Specialties; (ii) employees solely for the purpose of evaluation and consultation related to workplace ergonomics; (iii) special education students who, by virtue of their individualized education plans (IEPs), need physical therapy services to fulfill the provisions of their IEPs; (iv) the public for the purpose of wellness, fitness, and health screenings; (v) the public for the purpose of health promotion and education; and (vi) the public for the purpose of prevention of impairments, functional limitations, and disabilities.

2000, c. 688; 2001, c. 858; 2002, cc. 434, 471; 2003, c. 496; 2005, c. 928; 2007, cc. 9, 18; 2015, cc. 724, 746.

§ 54.1-3482.1. Certain certification required.

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

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

2007, cc. 9, 18; 2015, cc. 724, 746

§ 54.1-3483. Unprofessional conduct.

Any physical therapist or physical therapist assistant licensed by the Board shall be considered guilty of unprofessional conduct if he:

1. Engages in the practice of physical therapy under a false or assumed name or impersonates another practitioner of a like, similar or different name;

2. Knowingly and willfully commits any act which is a felony under the laws of this Commonwealth or the United States, or any act which is a misdemeanor under such laws and involves moral turpitude;

3. Aids or abets, has professional contact with, or lends his name to any person known to him to be practicing physical therapy illegally;

4. Conducts his practice in such a manner as to be a danger to the health and welfare of his patients or to the public;

5. Is unable to practice with reasonable skill or safety because of illness or substance abuse;

6. Publishes in any manner an advertisement that violates Board regulations governing advertising;

7. Performs any act likely to deceive, defraud or harm the public;

8. Violates any provision of statute or regulation, state or federal, relating to controlled substances;

9. Violates or cooperates with others in violating any of the provisions of this chapter or regulations of the Board; or

10. Engages in sexual contact with a patient concurrent with and by virtue of the practitioner/patient relationship or otherwise engages at any time during the course of the practitioner/patient relationship in conduct of a sexual nature that a reasonable patient would consider lewd and offensive.

(2000, c. 688; 2001, c. 858.)

Commonwealth of Virginia

VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

REGULATIONS GOVERNING THE PRACTICE OF PHYSICAL THERAPY

Title of Regulations: 18 VAC 112-20-10 et seq.

Statutory Authority: Chapter 34.1 of Title 54.1 of the ***Code of Virginia***

Revised: November 4, 2015

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CHAPTER 20

REGULATIONS GOVERNING THE PRACTICE OF PHYSICAL THERAPY

Part I. General Provisions.

18VAC112-20-10. Definitions.

In addition to the words and terms defined in § 54.1-3473 of the Code of Virginia, the following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Active practice" means a minimum of 160 hours of professional practice as a physical therapist or physical therapist assistant within the 24-month period immediately preceding renewal. Active practice may include supervisory, administrative, educational or consultative activities or responsibilities for the delivery of such services.

"Approved program" means an educational program accredited by the Commission on Accreditation in Physical Therapy Education of the American Physical Therapy Association.

"CLEP" means the College Level Examination Program.

"Contact hour" means 60 minutes of time spent in continuing learning activity exclusive of breaks, meals or vendor exhibits.

"Direct supervision" means a physical therapist or a physical therapist assistant is physically present and immediately available and is fully responsible for the physical therapy tasks or activities being performed.

"Discharge" means the discontinuation of interventions in an episode of care that have been provided in an unbroken sequence in a single practice setting and related to the physical therapy interventions for a given condition or problem.

"Evaluation" means a process in which the physical therapist makes clinical judgments based on data gathered during an examination or screening in order to plan and implement a treatment intervention, provide preventive care, reduce risks of injury and impairment, or provide for consultation.

"FCCPT" means the Foreign Credentialing Commission on Physical Therapy.

"FSBPT" means the Federation of State Boards of Physical Therapy.

"General supervision" means a physical therapist shall be available for consultation.

"National examination" means the examinations developed and administered by the Federation of State Boards of Physical Therapy and approved by the board for licensure as a physical therapist or physical therapist assistant.

"PRT" means the Practice Review Tool for competency assessment developed and administered by FSBPT.

"Re-evaluation" means a process in which the physical therapist makes clinical judgments based on data gathered during an examination or screening in order to determine a patient's response to the treatment plan and care provided.

"Support personnel" means a person who is performing designated routine tasks related to physical therapy under the direction and supervision of a physical therapist or physical therapist assistant within the scope of this chapter.

"TOEFL" means the Test of English as a Foreign Language.

"Trainee" means a person seeking licensure as a physical therapist or physical therapist assistant who is undergoing a traineeship.

"Traineeship" means a period of active clinical practice during which an applicant for licensure as a physical therapist or physical therapist assistant works under the direct supervision of a physical therapist approved by the board.

"TSE" means the Test of Spoken English.

"Type 1" means continuing learning activities offered by an approved organization as specified in 18VAC112-20-131.

"Type 2" means continuing learning activities which may or may not be offered by an approved organization but shall be activities considered by the learner to be beneficial to practice or to continuing learning.

18VAC112-20-20. (Repealed)

18VAC112-20-25. Current name and address.

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

18VAC112-20-26. Criteria for delegation of informal fact-finding proceedings to an agency subordinate.

A. Decision to delegate.

In accordance with § 54.1-2400 (10) of the Code of Virginia, the board may delegate an informal fact-finding proceeding to an agency subordinate upon determination that probable cause exists that a practitioner may be subject to a disciplinary action.

B. Criteria for delegation. Cases that may not be delegated to an agency subordinate include, but are not limited to, those that involve:

1. Intentional or negligent conduct that causes or is likely to cause injury to a patient;

2. Mandatory suspension resulting from action by another jurisdiction or a felony conviction;

3. Impairment with an inability to practice with skill and safety;

4. Sexual misconduct;

5. Unauthorized practice.

C. Criteria for an agency subordinate.

1. An agency subordinate authorized by the board to conduct an informal fact-finding proceeding may include board members and professional staff or other persons deemed knowledgeable by virtue of their training and experience in administrative proceedings involving the regulation and discipline of health professionals.

2. The executive director shall maintain a list of appropriately qualified persons to whom an informal fact-finding proceeding may be delegated.

3. The board may delegate to the executive director the selection of the agency subordinate who is deemed appropriately qualified to conduct a proceeding based on the qualifications of the subordinate and the type of case being heard.

18VAC112-20-27. Fees.

A. Unless otherwise provided, fees listed in this section shall not be refundable.

B. Licensure by examination.

1. The application fee shall be $140 for a physical therapist and $100 for a physical therapist assistant.

2. The fees for taking all required examinations shall be paid directly to the examination services.

C. Licensure by endorsement. The fee for licensure by endorsement shall be $140 for a physical therapist and $100 for a physical therapist assistant.

D. Licensure renewal and reinstatement.

1. The fee for active license renewal for a physical therapist shall be $135 and for a physical therapist assistant shall be $70 and shall be due by December 31 in each even-numbered year.

2. The fee for an inactive license renewal for a physical therapist shall be $70 and for a physical therapist assistant shall be $35 and shall be due by December 31 in each even-numbered year.

3. A fee of $25 for a physical therapist assistant and $50 for a physical therapist for processing a late renewal within one renewal cycle shall be paid in addition to the renewal fee.

4. The fee for reinstatement of a license that has expired for two or more years shall be $180 for a physical therapist and $120 for a physical therapist assistant and shall be submitted with an application for licensure reinstatement.

E. Other fees.

1. The fee for an application for reinstatement of a license that has been revoked shall be $1,000; the fee for an application for reinstatement of a license that has been suspended shall be $500.
2. The fee for a duplicate license shall be $5, and the fee for a duplicate wall certificate shall be $15.

3. The fee for a returned check shall be $35.

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

5. The application fee for direct access certification shall be $75 for a physical therapist to obtain certification to provide services without a referral.

Part II. Licensure Requirements.

18VAC112-20-30. General requirements.

Licensure as a physical therapist or physical therapist assistant shall be by examination or by endorsement.

18VAC112-20-40. Education requirements: graduates of approved programs.

A. An applicant for licensure who is a graduate of an approved program shall submit documented evidence of his graduation from such a program with the required application and fee.

B. If an applicant is a graduate of an approved program located outside of the United States or Canada, he shall provide proof of proficiency in the English language by passing TOEFL and TSE or the TOEFL iBT, the Internet-based tests of listening, reading, speaking and writing by a score determined by the board or an equivalent examination approved by the board. TOEFL iBT or TOEFL and TSE may be waived upon evidence that the applicant's physical therapy program was taught in English or that the native tongue of the applicant's nationality is English.

18VAC112-20-50. Education requirements: graduates of schools not approved by an accrediting agency approved by the board.

A. An applicant for initial licensure as a physical therapist who is a graduate of a school not approved by an accrediting agency approved by the board shall submit the required application and fee and provide documentation of the physical therapist's certification by a report from the FCCPT or of the physical therapist eligibility for licensure as verified by a report from any other credentialing agency approved by the board that substantiates that the physical therapist has been evaluated in accordance with requirements of subsection B.

B. The board shall only approve a credentialing agency that:

1. Utilizes the FSBPT Coursework Evaluation Tool for Foreign Educated Physical Therapists, based on the year of graduation, and utilizes original source documents to establish substantial equivalency to an approved physical therapy program;

2. Conducts a review of any license or registration held by the physical therapist in any country or jurisdiction to ensure that the license or registration is current and unrestricted or was unrestricted at the time it expired or was lapsed; and

3. Verifies English language proficiency by passage of the TOEFL and TSE examination or the TOEFL iBT, the Internet-based tests of listening, reading, speaking and writing or by review of evidence that the applicant's physical therapy program was taught in English or that the native tongue of the applicant's nationality is English.

C. An applicant for licensure as a physical therapist assistant who is a graduate of a school not approved by the board shall submit with the required application and fee the following:

1. Proof of proficiency in the English language by passing TOEFL and TSE or the TOEFL iBT, the Internet-based tests of listening, reading, speaking and writing by a score determined by the board or an equivalent examination approved by the board. TOEFL iBT or TOEFL and TSE may be waived upon evidence that the applicant's physical therapist assistant program was taught in English or that the native tongue of the applicant's nationality is English.

2. A copy of the original certificate or diploma which has been certified as a true copy of the original by a notary public, verifying his graduation from a physical therapy curriculum.

If the certificate or diploma is not in the English language, submit either:

a. An English translation of such certificate or diploma by a qualified translator other than the applicant; or

b. An official certification in English from the school attesting to the applicant's attendance and graduation date.

3. Verification of the equivalency of the applicant's education to the educational requirements of an approved program for physical therapist assistants from a scholastic credentials service approved by the board:

D. An applicant for initial licensure as a physical therapist or a physical therapist assistant who is not a graduate of an approved program shall also submit verification of having successfully completed a 1,000-hour traineeship within a two-year period under the direct supervision of a licensed physical therapist. The board may grant an extension beyond two years for circumstances beyond the control of the applicant, such as temporary disability or mandatory military service.

1. The traineeship shall be in accordance with requirements of 18VAC112-20-140.

2. The traineeship requirements of this part may be waived if the applicant for a license can verify, in writing, the successful completion of one year of clinical physical therapy practice as a licensed physical therapist or physical therapist assistant in the United States, its territories, the District of Columbia, or Canada, equivalent to the requirements of this chapter.

18VAC112-20-60. Requirements for licensure by examination.

Every applicant for initial licensure by examination shall submit:

1. Documentation of having met the educational requirements specified in 18VAC112-20-40 or 18VAC112-20-50;

2. The required application, fees and credentials to the board; and

3. Documentation of passage of the national examination as prescribed by the board.

18VAC112-20-65. Requirements for licensure by endorsement.

A. A physical therapist or physical therapist assistant who holds a current, unrestricted license in the United States, its territories, the District of Columbia, or Canada, may be licensed in Virginia by endorsement.

B. An applicant for licensure by endorsement shall submit:

1. Documentation of having met the educational requirements prescribed in 18VAC112-20-40 or 18VAC112-20-50. In lieu of meeting such requirements, an applicant may provide evidence of clinical practice consisting of at least 2,500 hours of patient care during the five years immediately preceding application for licensure in Virginia with a current, unrestricted license issued by another U. S. jurisdiction;

2. The required application, fees, and credentials to the board;

3. A current report from the Healthcare Integrity and Protection Data Bank (HIPDB);

4. Evidence of completion of 15 hours of continuing education for each year in which the applicant held a license in another U.S. jurisdiction, or 60 hours obtained within the past four years;

5. Documentation of passage of an examination equivalent to the Virginia examination at the time of initial licensure or documentation of passage of an examination required by another state at the time of initial licensure in that state; and

6. Documentation of active practice in physical therapy in another U. S. jurisdiction for at least 320 hours within the four years immediately preceding his application for licensure. A physical therapist who does not meet the active practice requirement shall:

a. Successfully complete 320 hours in a traineeship in accordance with requirements in 18VAC112-20-140; or

b. Document that he meets the standard on the PRT within the two years preceding application for licensure in Virginia and successfully complete 160 hours in a traineeship in accordance with the requirements in 18VAC112-20-140.

C. A physical therapist assistant seeking licensure by endorsement who has not actively practiced physical therapy for at least 320 hours within the four years immediately preceding his application

for licensure shall successfully complete 320 hours in a traineeship in accordance with the requirements in 18VAC112-20-140.

18VAC112-20-70. Traineeship for unlicensed graduate scheduled to sit for the national examination.

A. Upon approval of the president of the board or his designee, an unlicensed graduate who is registered with the Federation of State Boards of Physical Therapy to sit for the national examination may be employed as a trainee under the direct supervision of a licensed physical therapist until the results of the national examination are received.

B. The traineeship, which shall be in accordance with requirements of 18VAC112-20-140, shall terminate two working days following receipt by the candidate of the licensure examination results.

C. The unlicensed graduate may reapply for a new traineeship while awaiting to take the next examination. A new traineeship shall not be approved for more than one year following the receipt of the first examination results.

18VAC112-20-80. (Repealed)

18VAC112-20-81. Requirements for direct access certification.

A. An applicant for certification to provide services to patients without a referral as specified in § 54.1-3482.1 of the Code of Virginia shall hold an active, unrestricted license as a physical therapist in Virginia and shall submit evidence satisfactory to the board that he has one of the following qualifications:

1. Completion of a transitional program in physical therapy as recognized by the board; or

2. At least three years of postlicensure, active practice with evidence of 15 contact hours of continuing education in medical screening or differential diagnosis, including passage of a postcourse examination. The required continuing education shall be offered by a provider or sponsor listed as approved by the board in 18VAC112-20-131 and may be face-to-face or online education courses.

B. In addition to the evidence of qualification for certification required in subsection A of this section, an applicant seeking direct access certification shall submit to the board:

1. A completed application as provided by the board;

2. Any additional documentation as may be required by the board to determine eligibility of the applicant; and

3. The application fee as specified in 18VAC112-20-27.

Part III. Practice Requirements.

18VAC112-20-90. General responsibilities.

A. The physical therapist shall be responsible for managing all aspects of the physical therapy care of each patient and shall provide:

1. The initial evaluation for each patient and its documentation in the patient record;

2. Periodic reevaluation, including documentation of the patient's response to therapeutic intervention; and

3. The documented status of the patient at the time of discharge, including the response to therapeutic intervention. If a patient is discharged from a health care facility without the opportunity for the physical therapist to reevaluate the patient, the final note in the patient record may document patient status.

B. The physical therapist shall communicate the overall plan of care to the patient or his legally authorized representative and shall also communicate with a referring doctor of medicine, osteopathy, chiropractic, podiatry, or dental surgery, nurse practitioner or physician assistant to the extent required by §54.1-3482 of the Code of Virginia.

C. A physical therapist assistant may assist the physical therapist in performing selected components of physical therapy intervention to include treatment, measurement and data collection, but not to include the performance of an evaluation as defined in 18 VAC 112-20-10.

D. A physical therapist assistant's visits to a patient may be made under general supervision.

E. A physical therapist providing services with a direct access certification as specified in § 54.1-3482 of the Code of Virginia shall utilize the Direct Access Patient Attestation and Medical Release Form prescribed by the board or otherwise include in the patient record the information, attestation and written consent required by subsection B of § 54.1-3482 of the Code of Virginia.

18VAC112-20-100. Supervisory responsibilities.

A. A physical therapist shall be fully responsible for any action of persons performing physical therapy functions under the physical therapist's supervision or direction.

B. Support personnel shall only perform routine assigned tasks under the direct supervision of a licensed physical therapist or a licensed physical therapist assistant, who shall only assign those tasks or activities that are nondiscretionary and do not require the exercise of professional judgment.

C. A physical therapist shall provide direct supervision to no more than three individual trainees at any one time.

D. A physical therapist shall provide direct supervision to a student in an approved program who is satisfying clinical educational requirements in physical therapy. A physical therapist or a physical

therapist assistant shall provide direct supervision to a student in an approved program for physical therapist assistants.

18VAC112-20-110. (Repealed).

18VAC112-20-120. Responsibilities to patients.

A. The initial patient visit shall be made by the physical therapist for evaluation of the patient and establishment of a plan of care.

B. The physical therapist assistant's first visit with the patient shall only be made after verbal or written communication with the physical therapist regarding patient status and plan of care. Documentation of such communication shall be made in the patient's record.

C. Documentation of physical therapy interventions shall be recorded on a patient's record by the physical therapist or physical therapist assistant providing the care.

D. The physical therapist shall reevaluate the patient as needed, but not less than according to the following schedules:

1. For inpatients in hospitals as defined in §32.1-123 of the Code of Virginia, it shall be not less than once every seven consecutive days.

2. For patients in other settings, it shall be not less than one of 12 visits made to the patient during a 30-day period, or once every 30 days from the last reevaluation, whichever occurs first.

3. For patients who have been receiving physical therapy care for the same condition or injury for six months or longer, it shall be at least every 90 days from the last reevaluation.

Failure to abide by this subsection due to the absence of the physical therapist in case of illness, vacation, or professional meeting, for a period not to exceed five consecutive days, will not constitute a violation of these provisions.

E. The physical therapist shall be responsible for ongoing involvement in the care of the patient to include regular communication with a physical therapist assistant regarding the patient's plan of treatment.

Part IV. Renewal or Relicensure Requirements.

18VAC112-20-130. Biennial renewal of license.

A. A physical therapist and physical therapist assistant who intends to continue practice shall renew his license biennially by December 31 in each even-numbered year and pay to the board the renewal fee prescribed in 18VAC112-20-27.

B. A licensee whose licensure has not been renewed by the first day of the month following the month in which renewal is required shall pay a late fee as prescribed in 18VAC112-20-27.

C. In order to renew an active license, a licensee shall be required to:

1. Complete a minimum of 160 hours of active practice in the preceding two years; and

2. Comply with continuing competency requirements set forth in 18VAC112-20-131.

18VAC112-20-131. Continued competency requirements for renewal of an active license.

A. In order to renew an active license biennially, a physical therapist or a physical therapist assistant shall complete at least 30 contact hours of continuing learning activities within the two years immediately preceding renewal. In choosing continuing learning activities or courses, the licensee shall consider the following: (i) the need to promote ethical practice, (ii) an appropriate standard of care, (iii) patient safety, (iv) application of new medical technology, (v) appropriate communication with patients, and (vi) knowledge of the changing health care system.

B. To document the required hours, the licensee shall maintain the Continued Competency Activity and Assessment Form that is provided by the board and that shall indicate completion of the following:

1. A minimum of 20 of the contact hours required for physical therapists and 15 of the contact hours required for physical therapist assistants shall be in Type 1 courses. For the purpose of this section, "course" means an organized program of study, classroom experience or similar educational experience that is directly related to the clinical practice of physical therapy and approved or provided by one of the following organizations or any of its components:

a. The Virginia Physical Therapy Association;

b. The American Physical Therapy Association;

c. Local, state or federal government agencies;

d. Regionally accredited colleges and universities;

e. Health care organizations accredited by a national accrediting organization granted authority by the Centers for Medicare and Medicaid Services to assure compliance with Medicare conditions of participation;

f. The American Medical Association -Category I Continuing Medical Education course;

g. The National Athletic Trainers Association; and

h. The FSBPT.

2. No more than 10 of the contact hours required for physical therapists and 15 of the contact hours required for physical therapist assistants may be Type 2 activities or courses, which may or may not be offered by an approved organization but which shall be related to the clinical practice of physical

therapy. Type 2 activities may include but not be limited to consultation with colleagues, independent study, and research or writing on subjects related to practice.

3. Documentation of specialty certification by the American Physical Therapy Association may be provided as evidence of completion of continuing competency requirements for the biennium in which initial certification or recertification occurs.

4. Documentation of graduation from a transitional doctor of physical therapy program may be provided as evidence of completion of continuing competency requirements for the biennium in which the physical therapist was awarded the degree.

5. A physical therapist who can document that he has taken the PRT may receive 10 hours of Type 1 credit for the biennium in which the assessment tool was taken. A physical therapist who can document that he has met the standard of the PRT may receive 20 hours of Type 1 credit for the biennium in which the assessment tool was taken.

C. A licensee shall be exempt from the continuing competency requirements for the first biennial renewal following the date of initial licensure by examination in Virginia.

D. The licensee shall retain his records on the completed form with all supporting documentation for a period of four years following the renewal of an active license.

E. The licensees selected in a random audit conducted by the board shall provide the completed Continued Competency Activity and Assessment Form and all supporting documentation within 30 days of receiving notification of the audit.

F. Failure to comply with these requirements may subject the licensee to disciplinary action by the board.

G. The board may grant an extension of the deadline for continuing competency requirements for up to one year for good cause shown upon a written request from the licensee prior to the renewal date.

H. The board may grant an exemption for all or part of the requirements for circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

18VAC112-20-135. Inactive license.

A. A physical therapist or physical therapist assistant who holds a current, unrestricted license in Virginia shall, upon a request on the renewal application and submission of the required renewal fee of $70 for a physical therapist and $35 for a physical therapist assistant, be issued an inactive license.

1. The holder of an inactive license shall not be required to meet active practice requirements.

2. An inactive licensee shall not be entitled to perform any act requiring a license to practice physical therapy in Virginia.

B. A physical therapist or physical therapist assistant who holds an inactive license may reactivate his license by:

1. Paying the difference between the renewal fee for an inactive license and that of an active license for the biennium in which the license is being reactivated;

2. Providing proof of 320 active practice hours in another jurisdiction within the four years immediately preceding application for reactivation.

a. If the inactive physical therapist licensee does not meet the requirement for active practice, the license may be reactivated by completing 320 hours in a traineeship that meets requirements prescribed in 18VAC112-20-140 or documenting that he has met the standard of the PRT within the two years preceding application for reactivation of licensure in Virginia and successfully completing 160 hours in a traineeship in accordance with requirements in 18VAC112-20-140.

b. If the inactive physical therapist assistant licensee does not meet the requirement for active practice, the license may be reactivated by completing 320 hours in a traineeship that meets the requirements prescribed in 18VAC112-20-140.

3. Completing of the number of continuing competency hours required for the period in which the license has been inactive, not to exceed four years.

18VAC112-20-136. Reinstatement requirements.

A. A physical therapist or physical therapist assistant whose Virginia license is lapsed for two years or less may reinstate his license by payment of the renewal and late fees as set forth in 18VAC112-20-27 and completion of continued competency requirements as set forth in 18VAC112-20-131.

B. A physical therapist or physical therapist assistant whose Virginia license is lapsed for more than two years and who is seeking reinstatement shall:

1. Apply for reinstatement and pay the fee specified in 18VAC112-20-27;

2. Complete the number of continuing competency hours required for the period in which the license has been lapsed, not to exceed four years; and

3. Have actively practiced physical therapy in another jurisdiction for at least 320 hours within the four years immediately preceding applying for reinstatement.

a. If a physical therapist licensee does not meet the requirement for active practice, the license may be reinstated by completing 320 hours in a traineeship that meets the requirements prescribed in 18VAC112-20-140 or documenting that he has met the standard of the PRT within the two years preceding application for licensure in Virginia and

successfully completing 160 hours in a traineeship in accordance with requirements in 18VAC112-20-140.

b. If a physical therapist assistant licensee does not meet the requirement for active practice, the license may be reinstated by completing 320 hours in a traineeship that meets the requirements prescribed in 18VAC112-20-140.

18VAC112-20-140. Traineeship required.

A. The traineeship shall be approved by the board, and under the direction and supervision of a licensed physical therapist.

B. Supervision and identification of trainees:

1. There shall be a limit of two physical therapists assigned to provide supervision for each trainee.

2. The supervising physical therapist shall countersign patient documentation (i.e., notes, records, charts) for services provided by a trainee.

3. The trainee shall wear identification designating them as a "physical therapist trainee" or a "physical therapist assistant trainee."

C. Completion of traineeship.

1. The physical therapist supervising the trainee shall submit a report to the board at the end of the required number of hours on forms supplied by the board.

2. If the traineeship is not successfully completed at the end of the required hours, as determined by the supervising physical therapist, the president of the board or his designee shall determine if a new traineeship shall commence. If the president of the board determines that a new traineeship shall not commence, then the application for licensure shall be denied.

3. The second traineeship may be served under a different supervising physical therapist and may be served in a different organization than the initial traineeship. If the second traineeship is not successfully completed, as determined by the supervising physical therapist, then the application for licensure shall be denied.

18VAC112-20-150. (Repealed.)

18VAC112-20-151. (Repealed.)

Part IV. Standards of Practice.

18VAC112-20-160. Requirements for patient records.

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

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

C. Practitioners shall properly manage and keep timely, accurate, legible and complete patient records.

D. Practitioners who are employed by a health care institution, school system or other entity, in which the individual practitioner does not own or maintain his own records, shall maintain patient records in accordance with the policies and procedures of the employing entity.

E. Practitioners who are self-employed or employed by an entity in which the individual practitioner does own and is responsible for patient records shall:

1. Maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:

a. Records of a minor child shall be maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child;

b. Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative; or

c. Records that are required by contractual obligation or federal law may need to be maintained for a longer period of time.

2. From March 30, 2010, post information or in some manner inform all patients concerning the time frame for record retention and destruction. Patient records shall only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding.

F. When a practitioner is closing, selling or relocating his practice, he shall meet the requirements of § 54.1-2405 of the Code of Virginia for giving notice that copies of records can be sent to any like-regulated provider of the patient's choice or provided to the patient.

18VAC112-20-170. Confidentiality and practitioner-patient communication.

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

B. Communication with patients.

1. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately present information to a patient or his legally authorized representative in understandable terms and encourage participation in decisions regarding the patient's care.

2. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a treatment or procedure provided or directed by the practitioner in the treatment of any disease or condition.

3. Before any invasive procedure is performed, informed consent shall be obtained from the patient and documented in accordance with the policies of the health care entity. Practitioners shall inform patients of the risks, benefits, and alternatives of the recommended invasive procedure that a reasonably prudent practitioner in similar practice in Virginia would tell a patient. In the instance of a minor or a patient who is incapable of making an informed decision on his own behalf or is incapable of communicating such a decision due to a physical or mental disorder, the legally authorized person available to give consent shall be informed and the consent documented.

4. Practitioners shall adhere to requirements of § 32.1-162.18 of the Code of Virginia for obtaining informed consent from patients prior to involving them as subjects in human research with the exception of retrospective chart reviews.

C. Termination of the practitioner/patient relationship.

1. The practitioner or the patient may terminate the relationship. In either case, the practitioner shall make the patient record available, except in situations where denial of access is allowed by law.

2. A practitioner shall not terminate the relationship or make his services unavailable without documented notice to the patient that allows for a reasonable time to obtain the services of another practitioner.

18VAC112-20-180. Practitioner responsibility.

A. A practitioner shall not:

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

2. Knowingly allow persons under his supervision to jeopardize patient safety or provide patient care outside of such person's scope of practice or area of responsibility. Practitioners shall delegate patient care only to persons who are properly trained and supervised;

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

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

B. A practitioner shall not knowingly and willfully solicit or receive any remuneration, directly or indirectly, in return for referring an individual to a facility or institution as defined in § 37.2-100 of the Code of Virginia, or hospital as defined in § 32.1-123 of the Code of Virginia.

Remuneration shall be defined as compensation, received in cash or in kind, but shall not include any payments, business arrangements, or payment practices allowed by Title 42, § 1320a-7b(b) of the United States Code, as amended, or any regulations promulgated thereto.

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

D. A practitioner shall report any disciplinary action taken by a physical therapy regulatory board in another jurisdiction within 30 days of final action.

18VAC112-20-190. Sexual contact.

A. For purposes of § 54.1-3483 (10) of the Code of Virginia and this section, sexual contact includes, but is not limited to, sexual behavior or verbal or physical behavior that:

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

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

B. Sexual contact with a patient.

1. The determination of when a person is a patient for purposes of § 54.1-3483 (10) of the Code of Virginia is made on a case-by-case basis with consideration given to the nature, extent, and context of the professional relationship between the practitioner and the person. The fact that a person is not actively receiving treatment or professional services from a practitioner is not determinative of this issue. A person is presumed to remain a patient until the patient-practitioner relationship is terminated.

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

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

D. Sexual contact between a practitioner and a key third party shall constitute unprofessional conduct if the sexual contact is a result of the exploitation of trust, knowledge or influence derived from the professional relationship or if the contact has had or is likely to have an adverse effect on

patient care. For purposes of this section, key third party of a patient shall mean spouse or partner, parent or child, guardian, or legal representative of the patient.

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

18VAC112-20-200. Advertising ethics.

A. Any statement specifying a fee, whether standard, discounted or free, for professional services that does not include the cost of all related procedures, services and products which, to a substantial likelihood, will be necessary for the completion of the advertised service as it would be understood by an ordinarily prudent person shall be deemed to be deceptive or misleading, or both. Where reasonable disclosure of all relevant variables and considerations is made, a statement of a range of prices for specifically described services shall not be deemed to be deceptive or misleading.

B. Advertising a discounted or free service, examination, or treatment and charging for any additional service, examination, or treatment that is performed as a result of and within 72 hours of the initial office visit in response to such advertisement is unprofessional conduct unless such professional services rendered are as a result of a bona fide emergency. This provision may not be waived by agreement of the patient and the practitioner.

C. Advertisements of discounts shall disclose the full fee that has been discounted. The practitioner shall maintain documented evidence to substantiate the discounted fees and shall make such information available to a consumer upon request.

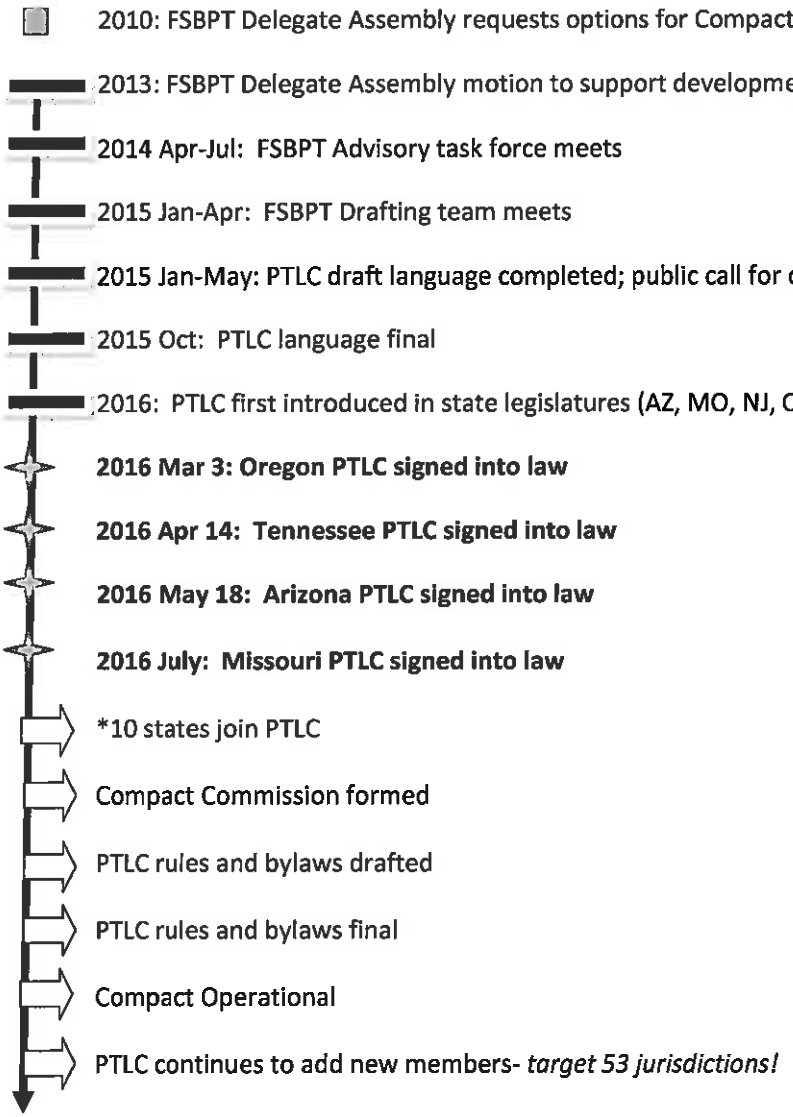
D. A licensee shall not use the term "board certified" or any similar words or phrase calculated to convey the same meaning in any advertising for his practice unless he holds certification in a clinical specialty issued by the American Board of Physical Therapy Specialties.

E. A licensee of the board shall not advertise information that is false, misleading, or deceptive. For an advertisement for a single practitioner, it shall be presumed that the practitioner is responsible and accountable for the validity and truthfulness of its content. For an advertisement for a practice in which there is more than one practitioner, the name of the practitioner or practitioners responsible and accountable for the content of the advertisement shall be documented and maintained by the practice for at least two years.

F. Documentation, scientific and otherwise, supporting claims made in an advertisement shall be maintained and available for the board's review for at least two years.

Physical Therapy Licensure Compact
Milestones

The road to an operational Compact to increase access to physical therapy services and improve licensure portability for PTs and PTAs:



2010: FSBPT Delegate Assembly requests options for Compact be explored

2013: FSBPT Delegate Assembly motion to support development of a Compact

2014 Apr-Jul: FSBPT Advisory task force meets

2015 Jan-Apr: FSBPT Drafting team meets

2015 Jan-May: PTLC draft language completed; public call for comments

2015 Oct: PTLC language final

2016: PTLC first introduced in state legislatures (AZ, MO, NJ, OR, TN)

2016 Mar 3: Oregon PTLC signed into law

2016 Apr 14: Tennessee PTLC signed into law

2016 May 18: Arizona PTLC signed into law

2016 July: Missouri PTLC signed into law

*10 states join PTLC

Compact Commission formed

PTLC rules and bylaws drafted

PTLC rules and bylaws final

Compact Operational

PTLC continues to add new members- *target 53 jurisdictions!*

** The Compact shall come into effect on the date on which the Compact statute is enacted into law in the tenth member state. However the compact will not be operational for licensees until the Commission finalizes the PTLC rules.*

Physical Therapy Licensure Compact

Current Status
As of 7/6/2016

***Advisory Task Force (April-July 2014)*: Complete**

Composed of state board members, board administrators, state senator, physical therapists, lawyers, APTA representatives, and with representatives from the Council of State Governments (CSG) providing technical assistance, the advisory task force assembled by FSBPT examined the concept of a compact for physical therapy broadly. The task force's work culminated in a set of proposals about what the final compact product should look like and recommended moving forward with the drafting of a Physical Therapy Licensure Compact (PTLC).

***Drafting Team (January-April 2015)*: Complete**

The drafting team assembled by FSBPT was tasked with actually drafting the statutory language of the PTLC. CSG again provided technical assistance and support with the drafting of the statutory language. The drafting team crafted the language based on the recommendations of the advisory group, as well as concepts and issues that came up during their own discussions. The PTLC draft document was released to a broad audience for a public comment period in May 2015. After receiving comments, the drafting team debated suggested changes and developed the final product on October 6, 2015.

***Education*: (October 2015-ongoing)**

Education of physical therapy licensing boards, licensees, and legislators is paramount to the success of the PTLC. Once the PTLC language was completed, FSBPT began an enthusiastic campaign to educate the membership regarding the Compact.

Presentations focusing on the PTLC were given at the FSBPT 2015 Leadership Issues Forum and Annual Meeting and jointly with APTA at other meetings. Since October 2015, FSBPT staff has presented to multiple physical therapy licensing boards interested in the PTLC. Additionally, FSBPT staff testified in support of the Compact in front of the Oregon (November 2015) and Missouri legislatures (February 2016). FSBPT entered into an official partnership with CSG to provide state-by-state technical assistance and education before and during state legislative sessions; educational efforts will be continue after enactment to maximize membership in the PTLC.

FSBPT has also partnered with APTA as they begin an educational campaign reaching out to their leadership and membership regarding the PTLC.

Legislation: **(January 2016-ongoing)**

Jan/Feb 2016	PTLC bills introduced in AZ, MO, OR, and TN
Feb 2016	Oregon bill passes both chamber of legislature Tennessee bill passes the Senate Arizona bill passes the House
Mar 2016	**Oregon Governor signs the PTLC into law making Oregon the first state to be a member of the PTLC**
Apr 2016	**Tennessee Governor signs the PTLC into law**
May 2016	**Arizona Governor signs the PTLC into law**
July 2016	**Missouri Governor signs the PTLC into law**

***Enactment*: (Projected mid-2017)**

The PTLC will activate when ten states pass legislation to join the Compact. Based on the interest communicated by a number of states, by the conclusion of the 2017 legislative session, the PTLC should pass in ten states and be enacted.

***Transition*: (12-18 month post-Enactment)**

The PTLC shall come into effect on the date on which the statute is enacted into law in the tenth member state. However, the PTLC will not be operational for licensees until the Compact Commission finalizes some standard start-up activities, including the first Commission meetings where the member states meet to discuss development of rules, regulations, bylaws, etc. by which the PTLC will be governed.

Finally, when the compact body is able to run independently, licensees will be able to take advantage of the benefits of the PTLC. This is when licensees will begin to work in states other than their home-license state with a Compact Privilege rather than a license.

PHYSICAL THERAPY LICENSURE COMPACT

SECTION 1. PURPOSE

The purpose of this Compact is to facilitate interstate practice of physical therapy with the goal of improving public access to physical therapy services. The practice of physical therapy occurs in the state where the patient/client is located at the time of the patient/client encounter. The Compact preserves the regulatory authority of states to protect public health and safety through the current system of state licensure.

This Compact is designed to achieve the following objectives:

1. Increase public access to physical therapy services by providing for the mutual recognition of other member state licenses;
2. Enhance the states' ability to protect the public's health and safety;
3. Encourage the cooperation of member states in regulating multi-state physical therapy practice;
4. Support spouses of relocating military members;
5. Enhance the exchange of licensure, investigative, and disciplinary information between member states; and
6. Allow a remote state to hold a provider of services with a compact privilege in that state accountable to that state's practice standards.

SECTION 2. DEFINITIONS

As used in this Compact, and except as otherwise provided, the following definitions shall apply:

1. **"Active Duty Military"** means full-time duty status in the active uniformed service of the United States, including members of the National Guard and Reserve on active duty orders pursuant to 10 U.S.C. Section 1209 and 1211.

2. **"Adverse Action"** means disciplinary action taken by a physical therapy licensing board based upon misconduct, unacceptable performance, or a combination of both.
3. **"Alternative Program"** means a non-disciplinary monitoring or practice remediation process approved by a physical therapy licensing board. This includes, but is not limited to, substance abuse issues.
4. **"Compact privilege"** means the authorization granted by a remote state to allow a licensee from another member state to practice as a physical therapist or work as a physical therapist assistant in the remote state under its laws and rules. The practice of physical therapy occurs in the member state where the patient/client is located at the time of the patient/client encounter.
5. **"Continuing competence"** means a requirement, as a condition of license renewal, to provide evidence of participation in, and/or completion of, educational and professional activities relevant to practice or area of work.
6. **"Data system"** means a repository of information about licensees, including examination, licensure, investigative, compact privilege, and adverse action.
7. **"Encumbered license"** means a license that a physical therapy licensing board has limited in any way.
8. **"Executive Board"** means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.
9. **"Home state"** means the member state that is the licensee's primary state of residence.

10. **"Investigative information"** means information, records, and documents received or generated by a physical therapy licensing board pursuant to an investigation.
11. **"Jurisprudence Requirement"** means the assessment of an individual's knowledge of the laws and rules governing the practice of physical therapy in a state.
12. **"Licensee"** means an individual who currently holds an authorization from the state to practice as a physical therapist or to work as a physical therapist assistant.
13. **"Member state"** means a state that has enacted the Compact.
14. **"Party state"** means any member state in which a licensee holds a current license or compact privilege or is applying for a license or compact privilege.
15. **"Physical therapist"** means an individual who is licensed by a state to practice physical therapy.
16. **"Physical therapist assistant"** means an individual who is licensed/certified by a state and who assists the physical therapist in selected components of physical therapy.
17. **"Physical therapy," "physical therapy practice," and "the practice of physical therapy"** mean the care and services provided by or under the direction and supervision of a licensed physical therapist.
18. **"Physical Therapy Compact Commission" or "Commission"** means the national administrative body whose membership consists of all states that have enacted the Compact.

19. **"Physical therapy licensing board" or "licensing board"** means the agency of a state that is responsible for the licensing and regulation of physical therapists and physical therapist assistants.

20. **"Remote State"** means a member state other than the home state, where a licensee is exercising or seeking to exercise the compact privilege.

21. **"Rule"** means a regulation, principle, or directive promulgated by the Commission that has the force of law.

22. **"State"** means any state, commonwealth, district, or territory of the United States of America that regulates the practice of physical therapy.

SECTION 3. STATE PARTICIPATION IN THE COMPACT

A. To participate in the Compact, a state must:

1. Participate fully in the Commission's data system, including using the Commission's unique identifier as defined in rules;
2. Have a mechanism in place for receiving and investigating complaints about licensees;
3. Notify the Commission, in compliance with the terms of the Compact and rules, of any adverse action or the availability of investigative information regarding a licensee;
4. Fully implement a criminal background check requirement, within a time frame established by rule, by receiving the results of the Federal Bureau of Investigation record search on criminal background checks and use the results in making licensure decisions in accordance with Section 3.B.4.;
5. Comply with the rules of the Commission;

6. Utilize a recognized national examination as a requirement for licensure pursuant to the rules of the Commission; and

7. Have continuing competence requirements as a condition for license renewal.

B. Upon adoption of this statute, the member state shall have the authority to obtain biometric-based information from each physical therapy licensure applicant and submit this information to the Federal Bureau of Investigation for a criminal background check in accordance with 28 U.S.C. §534 and 42 U.S.C. §14616.

C. A member state shall grant the compact privilege to a licensee holding a valid unencumbered license in another member state in accordance with the terms of the Compact and rules.

D. Member states may charge a fee for granting a compact privilege

SECTION 4. COMPACT PRIVILEGE

A. To exercise the compact privilege under the terms and provisions of the Compact, the licensee shall:

1. Hold a license in the home state;

2. Have no encumbrance on any state license;

3. Be eligible for a compact privilege in any member state in accordance with Section 4D, G and H;

4. Have not had any adverse action against any license or compact privilege within the previous 2 years;

5. Notify the Commission that the licensee is seeking the compact privilege within a remote state(s);

6. Pay any applicable fees, including any state fee, for the compact privilege;

7. Meet any jurisprudence requirements established by the remote state(s) in which the licensee is seeking a compact privilege; and

8. Report to the Commission adverse action taken by any non-member state within 30 days from the date the adverse action is taken.

B. The compact privilege is valid until the expiration date of the home license. The licensee must comply with the requirements of Section 4.A. to maintain the compact privilege in the remote state.

C. A licensee providing physical therapy in a remote state under the compact privilege shall function within the laws and regulations of the remote state.

D. A licensee providing physical therapy in a remote state is subject to that state's regulatory authority. A remote state may, in accordance with due process and that state's laws, remove a licensee's compact privilege in the remote state for a specific period of time, impose fines, and/or take any other necessary actions to protect the health and safety of its citizens. The licensee is not eligible for a compact privilege in any state until the specific time for removal has passed and all fines are paid.

E. If a home state license is encumbered, the licensee shall lose the compact privilege in any remote state until the following occur:

1. The home state license is no longer encumbered; and

2. Two years have elapsed from the date of the adverse action.

F. Once an encumbered license in the home state is restored to good standing, the licensee must meet the requirements of Section 4A to obtain a compact privilege in any remote state.

G. If a licensee's compact privilege in any remote state is removed, the individual shall lose the compact privilege in any remote state until the following occur:

1. The specific period of time for which the compact privilege was removed has ended;

2. All fines have been paid; and

3. Two years have elapsed from the date of the adverse action.

H. Once the requirements of Section 4G have been met, the license must meet the requirements in Section 4A to obtain a compact privilege in a remote state.

SECTION 5. ACTIVE DUTY MILITARY PERSONNEL OR THEIR SPOUSES

A licensee who is active duty military or is the spouse of an individual who is active duty military may designate one of the following as the home state:

A. Home of record;

B. Permanent Change of Station (PCS); or

C. State of current residence if it is different than the PCS state or home of record.

SECTION 6. ADVERSE ACTIONS

A. A home state shall have exclusive power to impose adverse action against a license issued by the home state.

B. A home state may take adverse action based on the investigative information of a remote state, so long as the home state follows its own procedures for imposing adverse action.

C. Nothing in this Compact shall override a member state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation shall remain non-public if required by the member state's laws. Member states must require licensees who enter any alternative programs in lieu of discipline to agree not to practice in any other member state during the term of the alternative program without prior authorization from such other member state.

D. Any member state may investigate actual or alleged violations of the statutes and rules authorizing the practice of physical therapy in any other member state in which a physical therapist or physical therapist assistant holds a license or compact privilege.

E. A remote state shall have the authority to:

1. Take adverse actions as set forth in Section 4.D. against a licensee's compact privilege in the state;

2. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses, and the production of evidence. Subpoenas issued by a physical therapy licensing board in a party state for the attendance and testimony of witnesses, and/or the production of evidence from another party state, shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel

expenses, mileage, and other fees required by the service statutes of the state where the witnesses and/or evidence are located; and

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

F. Joint Investigations

1. In addition to the authority granted to a member state by its respective physical therapy practice act or other applicable state law, a member state may participate with other member states in joint investigations of licensees.

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

SECTION 7. ESTABLISHMENT OF THE PHYSICAL THERAPY COMPACT COMMISSION.

A. The Compact member states hereby create and establish a joint public agency known as the Physical Therapy Compact Commission:

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

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

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

B. Membership, Voting, and Meetings

1. Each member state shall have and be limited to one (1) delegate selected by that member state's licensing board.

2. The delegate shall be a current member of the licensing board, who is a physical therapist, physical therapist assistant , public member, or the board administrator.

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

4. The member state board shall fill any vacancy occurring in the Commission.

5. Each delegate shall be entitled to one (1) vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission.

6. A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

7. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

C. The Commission shall have the following powers and duties:

1. Establish the fiscal year of the Commission;

2. Establish bylaws;

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

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

5. Promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all member states;

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

7. Purchase and maintain insurance and bonds;

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

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

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

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

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

13. Establish a budget and make expenditures;

14. Borrow money;

15. Appoint committees, including standing committees comprised of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the bylaws;

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

17. Establish and elect an Executive Board; and

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

D. The Executive Board

The Executive Board shall have the power to act on behalf of the Commission according to the terms of this Compact

1. The Executive Board shall be comprised of nine members:

a. Seven voting members who are elected by the Commission from the current membership of the Commission;

b. One ex-officio, nonvoting member from the recognized national physical therapy professional association; and

c. One ex-officio, nonvoting member from the recognized membership organization of the physical therapy licensing boards.

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

3. The Commission may remove any member of the Executive Board as provided in bylaws.

4. The Executive Board shall meet at least annually.

5. The Executive Board shall have the following Duties and responsibilities:

a. Recommend to the entire Commission changes to the rules or bylaws, changes to this Compact legislation, fees paid by Compact member states such as annual dues, and any commission Compact fee charged to licensees for the compact privilege;

b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;

d. Maintain financial records on behalf of the Commission;

e. Monitor Compact compliance of member states and provide compliance reports to the Commission;

f. Establish additional committees as necessary; and

g. Other duties as provided in rules or bylaws.

E. Meetings of the Commission

1. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Section 9.

2. The Commission or the Executive Board or other committees of the Commission may convene in a closed, non-public meeting if the Commission or Executive Board or other committees of the Commission must discuss:

   a. Non-compliance of a member state with its obligations under the Compact;

   b. The employment, compensation, discipline or other matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

   c. Current, threatened, or reasonably anticipated litigation;

   d. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;

   e. Accusing any person of a crime or formally censuring any person;

   f. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

   g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

   h. Disclosure of investigative records compiled for law enforcement purposes;

i. Disclosure of information related to any investigative reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the Compact; or

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

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

4. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.

F. Financing of the Commission

1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

2. The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

3. The Commission may levy on and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a rule binding upon all member states.

4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the member states, except by and with the authority of the member state.

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

G. Qualified Immunity, Defense, and Indemnification

1. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss

of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

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

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the

scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

SECTION 8. DATA SYSTEM

A. The Commission shall provide for the development, maintenance, and utilization of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensed individuals in member states.

B. Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the data system on all individuals to whom this Compact is applicable as required by the rules of the Commission, including:

1. Identifying information;
2. Licensure data;
3. Adverse actions against a license or compact privilege;
4. Non-confidential information related to alternative program participation;
5. Any denial of application for licensure, and the reason(s) for such denial; and
6. Other information that may facilitate the administration of this Compact, as determined by the rules of the Commission.

C. Investigative information pertaining to a licensee in any member state will only be available to other party states.

D. The Commission shall promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license. Adverse action information pertaining to a licensee in any member state will be available to any other member state.

E. Member states contributing information to the data system may designate information that may not be shared with the public without the express permission of the contributing state.

F. Any information submitted to the data system that is subsequently required to be expunged by the laws of the member state contributing the information shall be removed from the data system.

SECTION 9. RULEMAKING

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

B. If a majority of the legislatures of the member states rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact within 4 years of the date of adoption of the rule, then such rule shall have no further force and effect in any member state.

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

D. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least thirty (30) days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rulemaking:

1. On the website of the Commission or other publicly accessible platform; and

2. On the website of each member state physical therapy licensing board or other publicly accessible platform or the publication in which each state would otherwise publish proposed rules.

E. The Notice of Proposed Rulemaking shall include:

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

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

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

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

F. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

G. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

1. At least twenty-five (25) persons;

2. A state or federal governmental subdivision or agency; or

3. An association having at least twenty-five (25) members.

H. If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing. If the hearing is held via electronic means, the Commission shall publish the mechanism for access to the electronic hearing.

1. All persons wishing to be heard at the hearing shall notify the executive director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five (5) business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. All hearings will be recorded. A copy of the recording will be made available on request.

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

I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

J. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

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

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

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

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

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

4. Protect public health and safety.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

SECTION 10. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

A. Oversight

1. The executive, legislative, and judicial branches of state government in each member state shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

2. All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of this Compact which may affect the powers, responsibilities or actions of the Commission.

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

B. Default, Technical Assistance, and Termination

1. If the Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

   a. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to cure the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the member states, and all rights, privileges and benefits conferred by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

3. Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

4. A state that has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

5. The Commission shall not bear any costs related to a state that is found to be in default or that has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices. The

prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

C. Dispute Resolution

1. Upon request by a member state, the Commission shall attempt to resolve disputes related to the Compact that arise among member states and between member and non-member states.

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

D. Enforcement

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

2. By majority vote, the Commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the Commission has its principal offices against a member state in default to enforce compliance with the provisions of the Compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney's fees.

3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

SECTION 11. DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR PHYSICAL THERAPY PRACTICE AND ASSOCIATED RULES, WITHDRAWAL, AND AMENDMENT

A. The Compact shall come into effect on the date on which the Compact statute is enacted into law in the tenth member state. The provisions, which become effective at that time, shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the implementation and administration of the Compact.

B. Any state that joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

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

1. A member state's withdrawal shall not take effect until six (6) months after enactment of the repealing statute.

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

D. Nothing contained in this Compact shall be construed to invalidate or prevent any physical therapy licensure agreement or other cooperative arrangement between a member state and a non-member state that does not conflict with the provisions of this Compact.

E. This Compact may be amended by the member states. No amendment to this Compact shall become effective and binding upon any member state until it is enacted into the laws of all member states.

SECTION 12. CONSTRUCTION AND SEVERABILITY

This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution of any party state, the Compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

Federation of State Boards of Physical Therapy

Portability & a Physical Therapy Licensure Compact

Introduction:

In the current healthcare environment, portability of licensed individuals has been identified by many as a critical issue. The federal government has communicated concern about the current portability barriers and there have been several bills submitted to Congress in attempts to address this issue (military spouses, dual licensure system, etc).

With the changing healthcare system, evolution of physical therapy education, mobile communications between patient and client, mobility of patients accessing care, large healthcare corporations/insurance companies, and the advent of new ways in which to deliver care such as telemedicine, the ability of a clinician to practice across jurisdictional boundaries with minimal barriers is an issue coming to the forefront.

State boundaries and differences in licensure and practice requirements have been identified as barriers to access to healthcare. The potential positive impacts on public protection with increasing licensure portability include:

- increased patient access to qualified providers
- continuity of care for patient as they relocate or vacation
- enhanced disciplinary data and improve notification
- improved information sharing between jurisdictions

There are two ways to increase portability for licensure: 1) increase the efficiencies of the current system that requires licensure to practice in each state and 2) enhance the current system in a way that licensure is not required in each state but still maintains the critical public protection safeguards. In 2013, the FSBPT Delegate Assembly supported the exploration of a license compact to address the portability issues.

Licensure Compact

Although there have been numerous changes in the healthcare practice environment, until the Nurse Licensure Compact was introduced in the late 1990s, there had been little in the way of innovation in the fundamental processes of health professional licensure. Efficiency improvements such as online processing and electronic renewals have been seen, but generally the single-state system of licensing remains the current model for most professions in most states. In the last two years however, at least two additional healthcare groups, physicians and emergency responders, are exploring the development of an interstate licensure compact for mutual recognition which would allow the sharing of disciplinary action among all compact states and seamless practice across state lines without delay.

Portability & a Physical Therapy Licensure Compact

An interstate compact is an agreement between states to enact legislation and enter into a contract for a specific, limited purpose or address a particular policy issue. Interstate compacts should not be entered into casually by a state. Compact agreements are unique in their duality as statute and contract and each state must understand the implications of entering into a contract and the terms required of all compact members. With this dual nature, the compact language will supersede other conflicting statute. There is little flexibility to alter the initial or future versions of the statutory language; changes cannot be made if the effect would qualify as a material difference to the compact.

According to the National Center for Interstate Compacts, more than 200 interstate compacts are currently in existence, and any one state is on average a member of 25 interstate compacts. The majority of compacts in effect currently fit into one of three categories: border, advisory, or regulatory. Whereas border and advisory compacts have been seen since colonial times, regulatory compacts, such as the Nurse Licensure Compact, are a phenomenon of the 20th century. This type of compact is typically used to "create ongoing administrative agencies whose rules and regulations may be binding on the states to the extent authorized by the compact."

Interstate compacts can be crafted to address the issues specific to the individual profession. Typically, terms of the compact will include, but not be limited to, the ability for single state or multi-state practice recognition, the required jurisdiction of licensure, and handling of the disciplinary process. Regardless of whether or not a compact is in place, the professional is expected to know and abide by the differences in the practice acts in any state in which he/she practices. Opponents to a compact may argue that if a compact was adopted in all 50 states it would be akin to national licensure. Implementation by all states does not automatically default to a national license due to the influence of state practice acts. Each state still retains the independence to withdraw from the compact at any time as well as maintain its own standard via the practice act.

The National Council of State Boards of Nursing (NCSBN) first developed a licensure compact for licensed nurses 14 years ago and currently has 24 states participating. They are now beginning the development of a compact for Advanced Practice Nurses. The Federation of State Medical Boards (FSMB) is well into the process of developing a compact for medical doctors and osteopaths. The National Association of State EMS Officials (NASEMSO) is midway through the process of developing a licensure compact. Several other regulatory groups have expressed an interest in exploring a compact. There may be some significant advantages for to explore the concept of a compact with other regulatory groups who all have similar concerns and issues.

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https://www.ncsbn.org/nlc.htm

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Licensure Portability: Assuring Access to Quality Care in Physical Therapy

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Abstract

The concurrent circumstances of an increasingly mobile workforce, disparities in access to healthcare, and the ability to deliver care through technology (e.g., telehealth) present the need and the opportunity for practice across state borders. Over the past four years, the Federation of State Boards of Physical Therapy (FSBPT) has explored professional licensure models that will allow cross border practice. This paper reviews FSBPT's exploratory process and describes some of the advantages of an interstate compact. It concludes that if agreement among state licensing boards can be achieved, a compact could serve as a viable means to increase patient access to quality physical therapy care.

Keywords: Licensure, physical therapy, telehealth, telerehabilitation

The Federation of State Boards of Physical Therapy (FSBPT) is a membership organization whose mission is to protect the public by providing service and leadership that promotes safe and competent physical therapy practice. FSBPT's membership is comprised of the 53 jurisdictional licensing boards in the United States.

FSBPT and its member jurisdictions have of late, become very interested in the ability of licensees to move and practice with ease across state lines. Attention to this issue has been precipitated by two deepening challenges: increasing workforce expectations for employee mobility, and uneven access to healthcare. FSBPT further recognized that such challenges are global in nature, transcending state and national boundaries. State and provincial based countries were not only dealing with portability within their own countries but were beginning to explore mutual recognition between countries (Australia Health Practitioner Regulation Agency, 2013; Physiotherapy Board of Australia, 2014; Government of Canada, 2013; Gouvernement du Québec, 2013).

FSBPT's attention to interstate practice was also fueled by concurrent technological advances. Innovative technologies were developing that increasingly allowed practice that did not require the practitioner and the consumer to be in the same location. This trend allows more access to remote areas as well as access to specialists who may

not necessarily be located in proximity to the patient.

FSBPT recognized that the current model of state-based regulation, which had historically served the public well, needed to be modified. Licensure was designed to protect the public, however, the limitations in portability and ability to practice across state lines was preventing access and potentially good care. There was, moreover, no interest on the part of FSBPT to eliminate state-base regulation, but instead, to change how it worked to allow increased mobility of licensees with the result of extending access to high quality care. There was a concrete realization that telehealth was a viable delivery mode for healthcare and that the current licensure system was an impediment to the use of telehealth in physical therapy. This is a story of learning, discussing and sharing between multiple professions as well as international physiotherapy regulators.

In 2010, FSBPT's delegate assembly, representing the 53 member jurisdictions, asked FSBPT to review the nursing licensure compact as a potential model for improving portability. The National Council of State Boards of Nursing (NCSBN) has been a leader in dealing with the licensure portability challenge. NCSBN developed a nursing compact over 10 years ago and currently has 24 participating states (Nurse Licensure Compact Administrators, 2012). It allows a nurse licensed in one jurisdiction to practice in the other participating compact states provided the nurse meets certain requirements.

In brief, interstate compacts are not a new concept but have been around since the inception of this country (de Golian, 2014). The driver's license is a readily understandable example of how a licensure compact might work. Once a resident of the United States has a driver's license in one state, he or she is able to drive in any of the 50 states or territories. This is the result of an interstate compact. FSBPT's report back to its delegate assembly recognized the benefits of the nursing compact but did not recommend pursuing any portability initiative until further exploration of alternate options was completed.

Concerns with a licensure compact included: 1) the resistance within some states to implement the nursing compact which resulted in a slow implementation, 2) the need for an effective way to deal with licensees who violated regulations within a jurisdiction, and 3) how the disciplinary process would work when licensee was authorized to practice in multiple jurisdictions.

In 2011 and 2012, the FSBPT explored multiple options to ease the process of physical therapists getting licensed and practicing in multiple states. Such approaches as an expedited license, a credentials verification/storage service and a uniform application were considered. In spring 2013, FSBPT noted that the Federation of State Medical Boards (FSMB) Delegate Assembly passed an initiative to explore a licensure compact for licensure of physicians (Federation

of State Medical Boards, 2013). This caused the FSBPT to refocus on the concept of a compact. It made sense that regulated healthcare professions would approach and solve the portability issue in a similar manner versus each profession developing different approaches. FSBPT was intrigued. In its explorations, FSBPT learned a couple of key points related to interstate compacts:

1. A compact can be designed to meet the needs of the particular profession and does not have to be based on any other profession's model. This concept opened the door for learning and gaining insight from other professions who were ahead of FSBPT in implementing a compact.
2. Since establishing a compact was ultimately a legislative process, there was potential momentum that could be gained via multiple professions developing a compact. The state legislatures would already be exposed to the licensure compact as a means to deal with portability.
3. There were multiple other professions, beyond nursing, either developing a compact or exploring a compact.
4. The Council of State Governments (CSG), a non-partisan group, was available as a resource. CSG had experts in the implementation and running of state compacts. This gave them both a historical perspective and governmental contacts (Council of State Governments, 2011; de Golian, 2014).

The FSBPT Board of Directors brought the concept of a licensure compact for physical therapy to its Leadership Issues Forum (LIF). The LIF is a meeting of the leadership of the organization, including delegate representatives from its member states. Current regulatory issues and topics are discussed and explored in LIF.

LIF participants were very favorable to the concept of a licensure compact for physical therapy. Therefore, FSBPT next sought and obtained support from its delegate assembly for the initial exploration of a physical therapy compact. Conceptual discussions also began with other stakeholders including the professional association, the American Physical Therapy Association (APTA).

Currently, FSBPT is in the initial portion of the advisory phase of developing a compact. This phase includes meetings that will include important stakeholders, including the public, to determine if some agreement can be achieved on a model for a compact. If agreement can be reached, the group will also make recommendations on how the compact will operate. The next step, provided FSBPT moves forward, would be the drafting phase wherein the statute language would be developed. The drafting phase is followed by the implementation phase in which states begin the legislative process for implementing the compact. The intent of the compact will be to address issues of practice across state lines including via telehealth technologies to improve access to consumers.

To modify a historical model of licensure that has served the public well for many years will not be easy but, in an increasingly global world, interstate licensing agreements provide a means to ensure access to high quality care, while promoting continuity between patients and healthcare providers. FSBPT is very excited about the possibilities of bringing the state-based licensure system up to date in order to meet the needs of consumers of physical therapy within the US. It hopes that other professions will also seize this opportunity to develop a more uniform approach to the issue of portability and practice across state lines.

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Interstate Compacts: Background and History

About Interstate Compacts

Interstate compacts are contracts between two or more states creating an agreement on a variety of issues, such as specific policy challenges, regulatory matters and boundary settlements. States have used interstate compacts to address a variety of issues, including:

- Establishing a legal relationship to resolve a specific dispute, i.e. rights for use of water resources;
- Creating independent, multistate agencies that can more effectively address specific policy problems, i.e. the Port Authority of New York and New Jersey; and
- Establishing uniform guidelines and standards for member states to follow.

In addition, compacts allow states to maintain their sovereignty by allowing them to act collectively outside the confines of federal legislation or regulation. When used effectively, compacts provide regional or national policy solutions without interference from the federal government. Compacts also let states develop a dynamic, self-regulatory system that remains flexible enough to address changing needs.

History of Compacts

Interstate compacts are not new. They date back to the country's founding as a way to resolve disputes between colonies. Since 1789, compacts have grown beyond bi-state agreements into national and regional creations with both advisory and regulatory responsibilities. What has changed in the past century is the increased sophistication and use of interstate compacts to create administrative agencies to solve ongoing state problems.

Primary Purposes of Compacts

Interstate compacts can:

- Resolve boundary disputes;
- Manage the interstate allocation of natural resources; and
- Create interstate administrative agencies, including compacts, in the following policy areas:
    - Interstate transportation
    - Taxation
    - Environmental matters
    - Regulation
    - Education
    - Corrections
    - Public safety

Notable Interstate Compacts Affiliated with CSG

- Interstate Compact for Adult Offender Supervision—This compact exists to ensure public safety by creating standard rules for transferring adult offenders from one state to another state.

- Interstate Compact for Juveniles—This compact aims to enhance public safety by improving interstate supervision of juvenile offenders and delinquents.

- Interstate Compact on Educational Opportunity for Military Children—This compact, which was developed jointly by CSG and the Department of Defense, replaces the widely varying policies affecting transitioning military students by addressing key educational issues encountered by military families.

- Midwest Interstate Passenger Rail Compact—Administered from CSG's Midwest Office, this compact brings together state leaders from across the region to advocate for passenger rail improvements. Formed by compact agreement in 2000, the compact's current members are Illinois, Indiana, Iowa, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio and Wisconsin.

- Emergency Management Assistance Compact—Administered by CSG's affiliate organization, the National Emergency Management Association, EMAC is a mutual aid agreement and partnership among states that exists because, from hurricanes to earthquakes and from wildfires to toxic waste spills, all states share a common enemy: the constant threat of disaster.

- Great Lakes–St. Lawrence River Water Resources Compact—Since 2001, the Council of Great Lakes Governors has worked to develop a framework of binding agreements among the Great Lakes states and Canadian provinces for managing the Great Lakes resource. The culmination of this effort is the new Great Lakes–St. Lawrence River Basin Water Resources Compact. The agreement details how states and provinces will manage and protect the Great Lakes and St. Lawrence River Basin.

Advantages and Disadvantages of Interstate Compacts

Advantages	Disadvantages
Flexible and enforceable	Lengthy and challenging process
Interstate uniformity without federal intervention	Lack of familiarity with the mechanism among state government officials and the public
States maintaining collective sovereignty	Perceived loss of individual state sovereignty
Alternative to federal pre-emption	Delegation of state regulatory authority to an interstate agency

About NCIC

The National Center for Interstate Compacts combines policy research with best practices, and functions as a membership association, serving the unique needs of compact administrators, compact commissions and the state agencies in which interstate compacts are located. The center promotes the use of interstate compacts as an ideal tool to meet the demand for cooperative state action, to develop and enforce stringent standards, and to provide an adaptive structure for states that can evolve to meet new and changing demands over time.

NCIC's mission is to serve as an information clearinghouse, a provider of training and technical assistance, and a primary facilitator in assisting states in the review, revision and creation of new interstate compacts as solutions to multi-state problems or alternatives to federal preemption.

More Information

For more information on interstate compacts, including news on recent state and federal legislation, a searchable database of compacts, links to relevant state statutes, and legal and historical information, visit the National Center for Interstate Compacts at www.csg.org (keyword: interstate compacts) or contact Crady deGolian at cdegolian@csg.org.

Interstate Compact – Process

The development of an interstate compact should be a deliberate and well planned process. The Council of State Government's (CSG) experience through several interstate compact efforts has established that procedural planning and political strategy often reduces or eliminates obstacles during the project. To that end, the development of an interstate compact involves:

- Creating and convening an Advisory Board to guide the early policy analysis and formulate recommendations;
- Developing a national Drafting Team, composed of compact and other subject matter experts who will craft the new compact;
- Facilitating the new interstate compact in the states, seeking national enactment by all impacted states and relevant jurisdictions;
- Overseeing the transition to the new interstate compact, including development of governing and administrative processes and training states on the new agreement;
- Maintaining and enhancing the new compact as it becomes operational.

Model Process

Advisory Board	Drafting Team	Education and Outreach
• Composed of state officials, stakeholders, issue experts; • Examine the issues and current policy spectrum of issue; • Examine best practices and alternative structures; • Establish recommendations as to the content of an interstate compact; and • Examine the need for Congressional Consent.	• Composed of 5-8 state officials, issue and compact experts (typically some overlap w/ Advisory); • Craft interstate compact solution based on Advisory Group recommendations; and • Circulate draft compact to Advisory Board and relevant stakeholder groups for comment.	• Identify legislative champions • Convene legislative briefing to educate policymakers and stakeholder groups about the new interstate agreement • Develop resource kit and project web site to supplement legislative briefing; • Provide technical assistance to states considering the new compact.

National Center for Interstate Compacts
C/O The Council of State Governments
www.csg.org/ncic

Virginia's Physical Therapist Workforce: 2014

Healthcare Workforce Data Center

April 2015

Virginia Department of Health Professions
Healthcare Workforce Data Center
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804-367-2115, 804-527-4466(fax)
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Follow us on Tumblr: ***www.vahwdc.tumblr.com***

5,704 Physical Therapists voluntarily participated in this survey. *Without their efforts the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Physical Therapy express our sincerest appreciation for your ongoing cooperation.*

Thank You!

Virginia Department of Health Professions

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The Physical Therapy Workforce: At a Glance:

The Workforce	
Licensees:	7,590
Virginia's Workforce:	6,151
FTEs:	5,300

Survey Response Rate	
All Licensees:	75%
Renewing Practitioners:	91%

Demographics	
% Female:	76%
Diversity Index:	31%
Median Age:	40

Background	
Rural Childhood:	28%
HS Degree in VA:	37%
Prof. Degree in VA:	36%

Education	
Doctorate:	51%
Masters:	24%

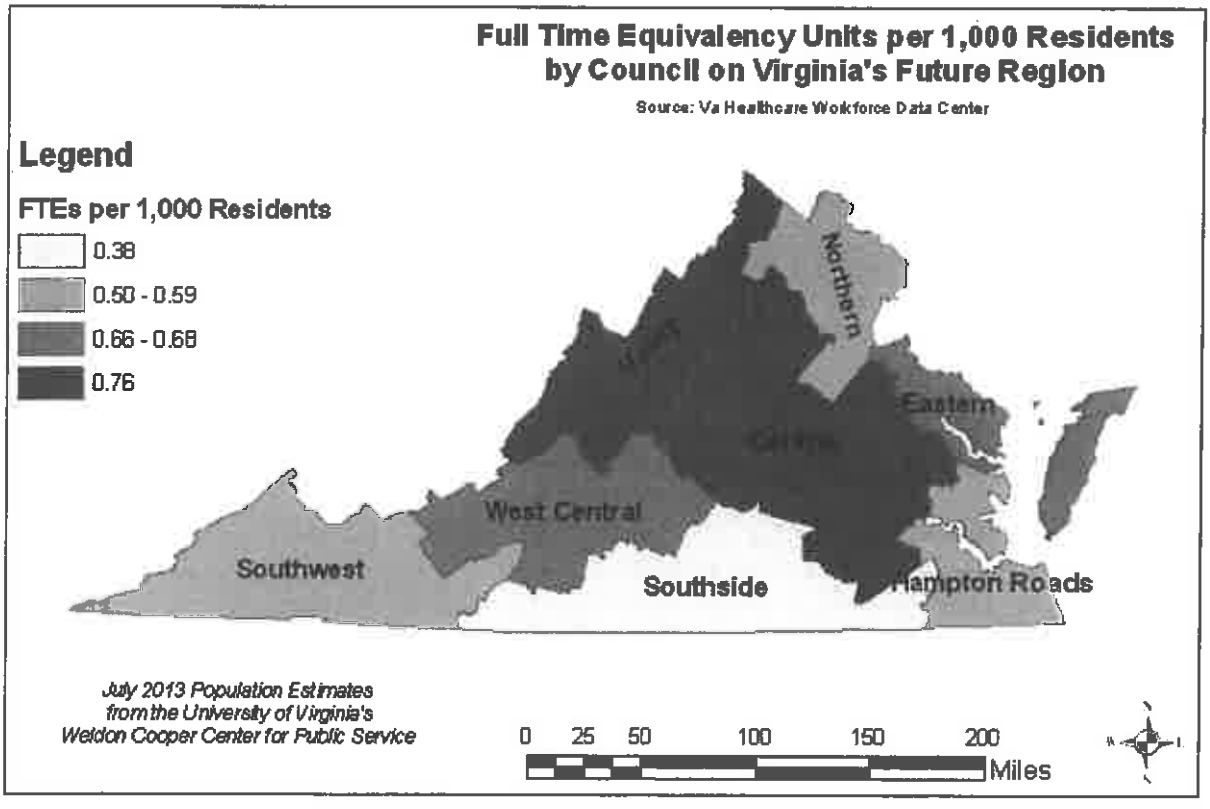
Finances	
Median Inc.:	$70k-$80k
Health Benefits:	64%
Under 40 w/ Ed debt:	72%

Current Employment	
Employed in Prof.:	97%
Hold 1 Full-time Job:	62%
Satisfied?:	97%

Job Turnover	
Switched Jobs in 2014:	9%
Employed over 2 yrs:	58%

Primary Roles	
Patient Care:	86%
Administration:	5%
Education:	1%

Source: Va. Healthcare Workforce Data Center



Results in Brief

5,704 physical therapists (PTs) voluntarily took part in the 2014 Physical Therapy Workforce Survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place in December during even-numbered years for PTs. These survey respondents represent 75% of the 7,590 PTs who are licensed in the state and 91% of renewing practitioners.

The HWDC estimates that 6,151 PTs participated in Virginia's workforce during the survey period, which is defined as those who worked at least a portion of the year in the state or who live in the state and intend to return to work in the profession at some point in the future. Virginia's PT workforce provided 5,300 "full-time equivalency units" during the survey time period, which the HWDC defines simply as working 2,000 hours a year (or 40 hours per week for 50 weeks with 2 weeks off).

Nearly three-quarter of all PTs are female, and the median age of the PT workforce is 40. In a random encounter between two PTs, there is a 31% chance that they would be of different races or ethnicities, a measure known as the diversity index. For the Virginia population as a whole, this same probability is 54%.

28% of PTs grew up in a rural area, and 16% of these professionals currently work in non-Metro areas of the state. Overall, just 9% of Virginia's PTs work in non-Metro areas of the state. Meanwhile, 37% of PTs went to high school in Virginia, and 36% also received their professional degree in the state. In total, nearly half of all PTs received some form of education in the state.

More than half of all PTs earned a Doctorate as their highest professional degree, while nearly one-quarter of the PT workforce earned a Masters degree. 44% of all PTs currently have educational debt, including 72% of those professionals who are under the age of 40. For those PTs with education debt, the median debt load is between $60,000 and $70,000.

97% of PTs are currently employed in the profession, and involuntarily unemployment is nearly nonexistent at the moment. 62% of Virginia's PTs hold one full-time position, while 18% have multiple positions. 58% of PTs have been at their primary work location for at least two years, while nearly one-quarter of all PTs worked at a new location at some point in 2014.

Half of all PTs receive a salary at their primary work location, while 36% receive a hourly wage. The median annual income for Virginia's PT workforce is between $70,000 and $80,000. Among professional who receive either a salary or an hourly wage at their primary work location, 84% receive at least one employer-sponsored benefit, including 64% who receive health insurance. 97% of PTs indicate they are satisfied with their current employment situation, including 69% who indicate they are "very satisfied".

63% of all PTs work at a for-profit establishment, while just 2% work for the federal government. Group Private Practices currently employ 15% of all PTs in Virginia, the most of any establishment type in the state. Home Health Care Companies and Outpatient Rehabilitation Facilities are also common establishment types for Virginia's PT workforce.

A typical PT spends nearly all of her time in caring for patients. In fact, 86% of all PTs serve a patient care role, meaning that at least 60% of their time is spent in that activity. In addition, the typical PT also spends a small amount of time in administrative and educational tasks. In fact, 5% of all PTs serve an administrative role at their job.

51% of all PTs expect to retire by the age of 65. Although only 3% of the current workforce expects to retire in the next two years, half of the current workforce does expect to retire by 2039. Meanwhile, over the next two years, just 1% of all PTs expect to leave the profession, and 4% expect to leave the state. However, 28% of Virginia's PT workforce expects to pursue additional educational opportunities within the next two years, and 12% expect to increase their patient care activities.

A Closer Look:

Licensees		
License Status	#	%
Renewing Practitioners	5,953	78%
New Licensees	734	10%
Non-Renewals	903	12%
All Licensees	7,590	100%

Source: Va. Healthcare Workforce Data Center

HWDC surveys tend to achieve very high response rates. 91% of renewing PTs submitted a survey. These represent 75% of PTs who held a license at some point in 2014.

Response Rates			
Statistic	Non Respondents	Respondent	Response Rate
By Age			
Under 30	529	535	50%
30 to 34	424	971	70%
35 to 39	253	889	78%
40 to 44	169	883	84%
45 to 49	131	766	85%
50 to 54	120	632	84%
55 to 59	78	492	86%
60 and Over	182	536	75%
Total	**1,886**	**5,704**	**75%**
New Licenses			
Issued in 2014	545	189	26%
Metro Status			
Non-Metro	112	382	77%
Metro	894	4,541	84%
Not in Virginia	869	759	47%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed PTs

Number:	7,590
New:	10%
Not Renewed:	12%

Response Rates

All Licensees:	75%
Renewing Practitioners:	91%

Response Rates	
Completed Surveys	5,704
Response Rate, all licensees	75%
Response Rate, Renewals	91%

Source: Va. Healthcare Workforce Data Center

Definitions

1. **The Survey Period:** The survey was conducted in December 2014.
2. **Target Population:** All PTs who held a Virginia license at some point in 2014.
3. **Survey Population:** The survey was available to PTs who renewed their licenses online. It was not available to those who did not renew, including some PTs newly licensed in 2014.

At a Glance:

Workforce

2014 PT Workforce:	6,151
FTEs:	5,300

Utilization Ratios

Licensees in VA Workforce:	81%
Licensees per FTE:	1.43
Workers per FTE:	1.16

Source: Va. Healthcare Workforce Data Center

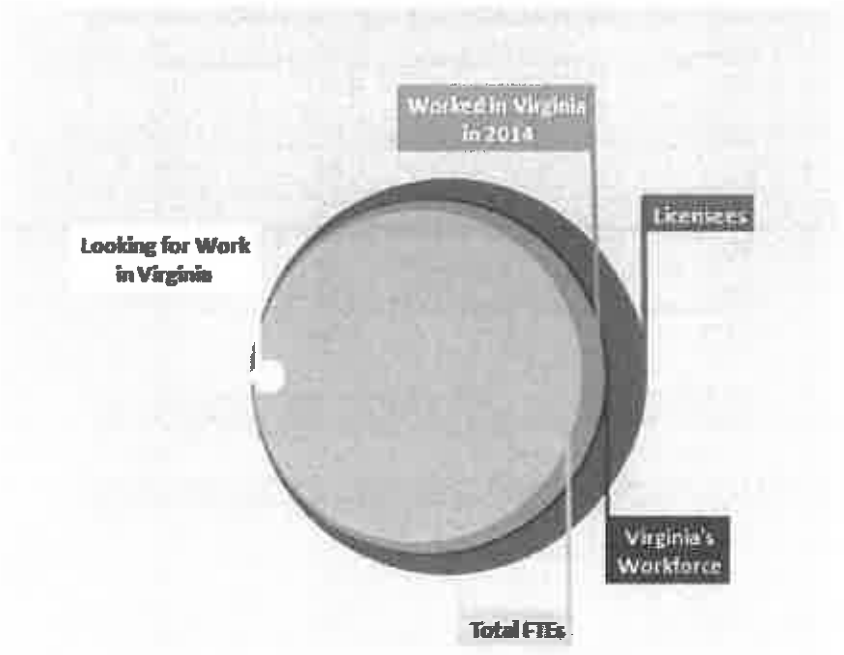
Definitions

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

Virginia's PT Workforce		
Status	**#**	**%**
Worked in Virginia in Past Year	6,097	99%
Looking for Work in Virginia	54	1%
Virginia's Workforce	6,151	100%
Total FTEs	5,300	
Licensees	7,590	

Source: Va. Healthcare Workforce Data Center

This report uses weighting to estimate the figures in this report. Unless otherwise noted, figures refer to the Virginia Workforce only. For more information on HWDC's methodology visit: www.dhp.virginia.gov/hwdc



Source: Va Healthcare Workforce Data Center

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 30	221	25%	662	75%	883	15%
30 to 34	260	23%	876	77%	1,135	19%
35 to 39	190	23%	656	78%	846	15%
40 to 44	231	29%	559	71%	790	14%
45 to 49	155	24%	493	76%	648	11%
50 to 54	116	20%	456	80%	572	10%
55 to 59	104	24%	320	76%	424	7%
60 +	150	28%	378	72%	527	9%
Total	1,426	25%	4,400	76%	5,825	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

% Female:	76%
% Under 40 Female:	77%

Age

Median Age:	40
% Under 40:	49%
% 55+:	16%

Diversity

Diversity Index:	31%
Under 40 Div. Index:	36%

Source: Va. Healthcare Workforce Data Center

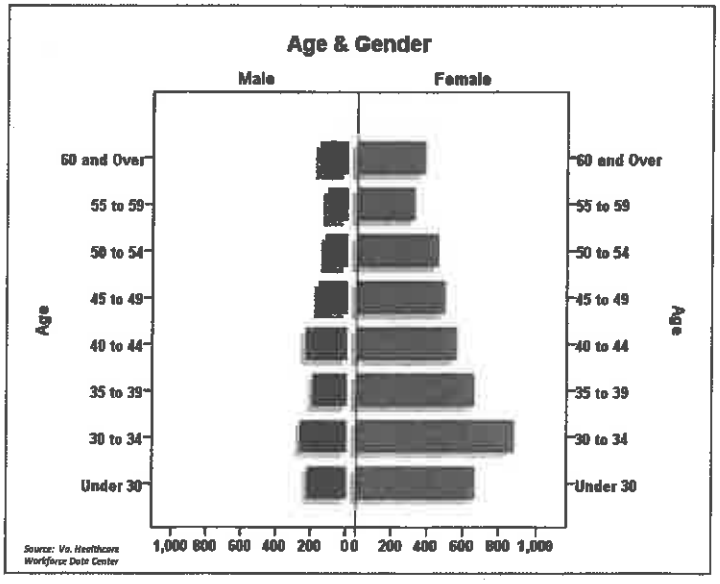
Race & Ethnicity					
Race/ Ethnicity	Virginia*	PTs		PTs under 40	
	%	#	%	#	%
White	64%	4,776	82%	2,255	79%
Black	19%	237	4%	127	4%
Asian	6%	505	9%	324	11%
Other Race	0%	66	1%	32	1%
Two or more races	2%	100	2%	55	2%
Hispanic	8%	125	2%	59	2%
Total	100%	5,810	100%	2,854	100%

*Population data in this chart is from the US Census, ACS 1-yr estimates, 2011 vintage.

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two PTs, there is a 31% chance that they would be of a different race/ethnicity (a measure known as the diversity index). For Virginia's population as a whole, the comparable number is 54%.

Nearly half of all PTs are under the age of 40, and 77% of these professionals are female. In addition, there is a 36% chance that two randomly chosen PTs from this group would be of a different race or ethnicity.



At a Glance:

Childhood

Urban Childhood:	13%
Rural Childhood:	28%

Native Sons

HS in Virginia:	37%
Prof. Education in VA:	36%
HS/Prof. Edu. in VA:	46%

Location Choice

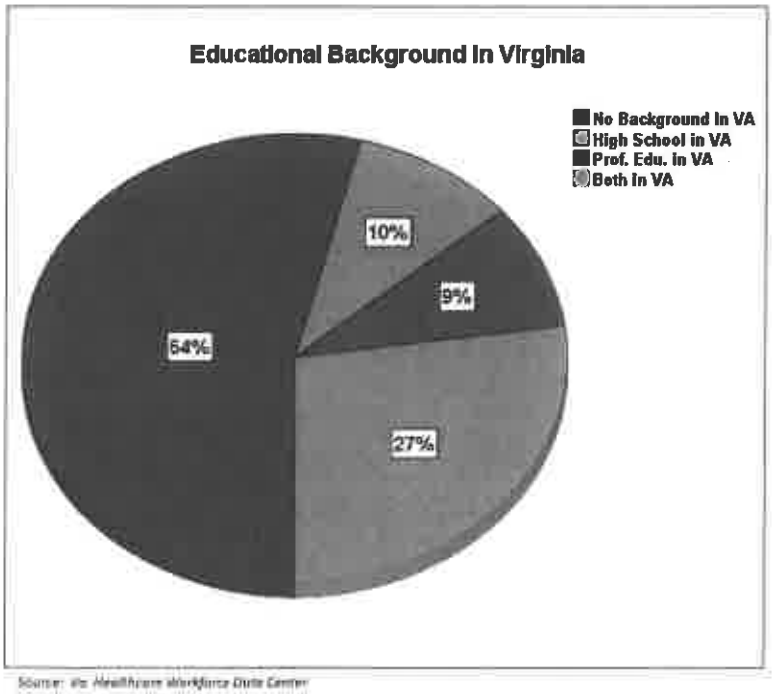
% Rural to Non-Metro:	16%
% Urban/Suburban to Non-Metro:	6%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Primary Location: USDA Rural Urban Continuum		Rural Status of Childhood Location		
Code	Description	Rural	Suburban	Urban
	Metro Counties			
1	Metro, 1 million+	21%	66%	13%
2	Metro, 250,000 to 1 million	38%	50%	13%
3	Metro, 250,000 or less	41%	49%	11%
	Non-Metro Counties			
4	Urban pop 20,000+, Metro adj	47%	36%	17%
6	Urban pop, 2,500-19,999, Metro adj	43%	44%	13%
7	Urban pop, 2,500-19,999, nonadj	65%	22%	13%
8	Rural, Metro adj	44%	46%	10%
9	Rural, nonadj	57%	32%	11%
	Overall	**28%**	**60%**	**13%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

28% of PTs grew up in self-described rural areas, and 16% of these professionals currently work in Non-Metro counties. Overall, 9% of Virginia's PT workforce works in non-Metro counties of the state.

Top Ten States for PT Recruitment

Rank	All PTs			
	High School	#	PT School	#
1	Virginia	2,153	Virginia	2,076
2	Outside U.S./Canada	542	New York	503
3	New York	508	Pennsylvania	415
4	Pennsylvania	416	Outside U.S./Canada	404
5	Maryland	336	North Carolina	273
6	New Jersey	190	Florida	245
7	Ohio	141	Massachusetts	205
8	North Carolina	135	Washington, D.C.	165
9	Florida	107	Maryland	144
10	Massachusetts	106	California	99

Source: Va. Healthcare Workforce Data Center

37% of PTs received their high school degree in Virginia, while 36% received their initial professional degree in the state.

Among PTs who have been licensed in the past five years, 37% received their high school degree in Virginia, while 36% received their initial professional degree in the state.

Rank	Licensed in the Past 5 Years			
	High School	#	PT School	#
1	Virginia	715	Virginia	688
2	Outside U.S./Canada	210	Outside U.S./Canada	163
3	New York	152	New York	152
4	Pennsylvania	140	Pennsylvania	131
5	Maryland	109	Florida	112
6	North Carolina	67	North Carolina	89
7	Ohio	56	Washington, D.C.	70
8	New Jersey	42	Massachusetts	52
9	Florida	28	Maryland	46
10	Illinois	28	Tennessee	39

Source: Va. Healthcare Workforce Data Center

19% of licensed PTs did not participate in Virginia's workforce in 2014. 95% of these PTs worked at some point in the past year, including 92% who currently work as PTs.

At a Glance:

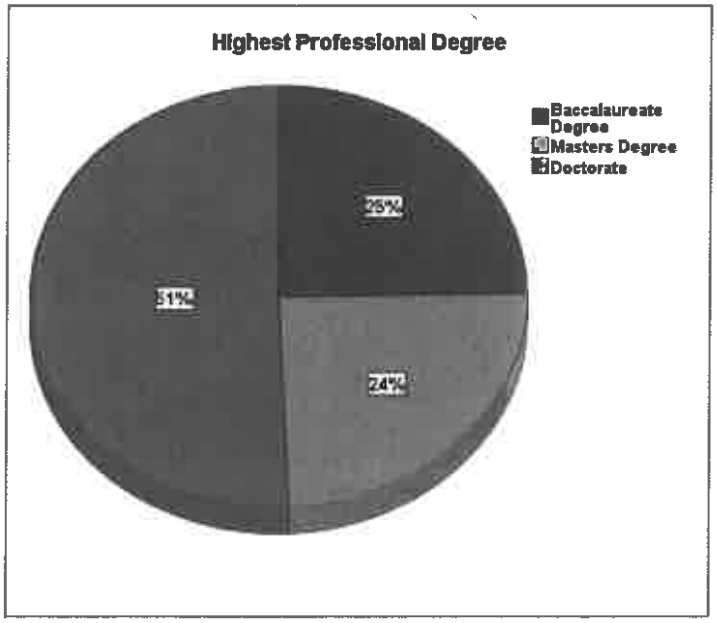
Not in VA Workforce

Total:	1,443
% of Licensees:	19%
Federal/Military:	8%
Va Border State/DC:	17%

A Closer Look:

Highest Professional Degree		
Degree	#	%
Baccalaureate Degree	1,436	25%
Masters Degree	1,418	24%
Doctorate	2,940	51%
Total	5,794	100%

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Nearly one-quarter of all PTs hold a Master's degree as their highest professional degree, while more than half have earned a Doctorate.

44% of PTs currently have educational debt, including 72% of those under the age of 40. For those PTs with educational debt, the median debt burden is between $60,000 and $70,000.

Educational Debt				
Amount Carried	All PTs		PTs under 40	
	#	%	#	%
None	3,013	56%	745	28%
Less than $20,000	342	6%	222	8%
$20,000-$39,999	386	7%	279	10%
$40,000-$59,999	375	7%	289	11%
$60,000-$79,999	329	6%	292	11%
$80,000-$99,999	278	5%	248	9%
$100,000-$119,999	221	4%	212	8%
$120,000 or More	409	8%	386	14%
Total	5,356	100%	2,672	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Top Certifications

Clinical Instructor (APTA):	5%
Othopaedics:	4%
At Least One Cert.:	14%

Top Credentials:

Dry Needling:	6%
Exercise/Physical Ther.:	3%
At Least One Cred.:	23%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

APTA Recognition of Advanced Proficiency		
Proficiency Area	#	%
Clinical Instructor (APTA)	289	5%
Orthopaedics	276	4%
Sports	48	1%
Geriatrics	46	1%
Neurology	46	1%
Pediatrics	35	1%
Cardiovascular & Pulmonary	5	0%
Clinical Electrophysiology	2	0%
Women's Health	19	0%
Other	175	3%
At least 1 Certification	867	14%

Source: Va. Healthcare Workforce Data Center

Credentials		
Area	#	%
Dry Needling	342	6%
Exercise/Physical Therapy	194	3%
Athletic Training	184	3%
Early Intervention	158	3%
Lymphedema Therapy	150	2%
Wound Care	40	1%
Massage Therapy	35	1%
Orthotics	16	0%
Assistive Technology	15	0%
Credentials, Nursing	12	0%
Prosthetics	6	0%
Occupational Therapy	5	0%
Art/Dance Therapy	3	0%
Chiropractry	3	0%
Other	516	8%
At least 1 Credential		

Source: Va. Healthcare Workforce Data Center

14% of all PTs hold at least one APTA certification, while nearly one-quarter of Virginia's PT workforce holds at least one credential. Clinical Instructor (APTA) was the most common certification proficiency area, while Dry Needling was the most common credentialed proficiency area.

At a Glance:

Employment

Employed in Profession: 97%
Involuntarily Unemployed: 0%

Positions Held

1 Full-Time: 62%
2 or more Positions: 18%

Weekly Hours:

40 to 49: 50%
60 or more: 3%
Less than 30: 19%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Current Work Status		
Status	#	%
Employed, capacity unknown	2	0%
Employed in a physical therapy related capacity	5,643	97%
Employed, NOT in a physical therapy related capacity	45	1%
Not working, reason unknown	0	0%
Involuntarily unemployed	17	0%
Voluntarily unemployed	91	2%
Retired	17	0%
Total	5,815	100%

Source: Va. Healthcare Workforce Data Center

97% of licensed PTs are currently employed in the profession, and involuntarily unemployed is nearly nonexistent at the moment. 62% of all PTs currently hold one full-time job, while 18% have multiple positions. Half of PTs work between 40 and 49 hours per week, while just 3% of PTs work at least 60 hours per week.

Current Positions		
Positions	#	%
No Positions	125	2%
One Part-Time Position	1,110	19%
Two Part-Time Positions	293	5%
One Full-Time Position	3,503	61%
One Full-Time Position & One Part-Time Position	607	11%
Two Full-Time Positions	6	0%
More than Two Positions	119	2%
Total	5,763	100%

Current Weekly Hours		
Hours	#	%
0 hours	125	2%
1 to 9 hours	159	3%
10 to 19 hours	327	6%
20 to 29 hours	575	10%
30 to 39 hours	933	16%
40 to 49 hours	2,885	50%
50 to 59 hours	539	9%
60 to 69 hours	138	2%
70 to 79 hours	22	0%
80 or more hours	23	0%
Total	5,726	100%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Income		
Hourly Wage	#	%
Volunteer Work Only	19	0%
Less than $30,000	326	7%
$30,000-$39,999	214	4%
$40,000-$49,999	282	6%
$50,000-$59,999	427	9%
$60,000-$69,999	915	19%
$70,000-$79,999	877	18%
$80,000-$89,999	781	16%
$90,000-$99,999	481	10%
$100,000-$109,999	287	6%
$110,000-$119,999	83	2%
$120,000 or more	170	4%
Total	4,863	100%

At a Glance:

Earnings

Median Income: $70k-$80k

Benefits

Employer Health Ins.: 64%

Employer Retirement: 67%

Satisfaction

Satisfied 97%

Very Satisfied: 69%

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	#	%
Very Satisfied	3,943	69%
Somewhat Satisfied	1,562	27%
Somewhat Dissatisfied	146	3%
Very Dissatisfied	42	1%
Total	5,693	100%

Source: Va. Healthcare Workforce Data Center

The typical PT earned between $70,000 and $80,000 in 2014. In addition, among PTs who received either an hourly wage or a salary at their primary work location, 64% received health insurance and 67% had access to a retirement plan.

Employer-Sponsored Benefits			
Benefit	#	%	% of Wage/Salary Employees
Paid Vacation	3,879	69%	75%
Retirement	3,499	62%	67%
Health Insurance	3,379	60%	64%
Dental Insurance	3,041	54%	59%
Paid Sick Leave	2,926	52%	56%
Group Life Insurance	2,346	42%	47%
Signing/Retention Bonus	740	13%	15%
Total	4,448	79%	84%

*From any employer at time of survey.

A Closer Look:

Underemployment in Past Year		
In the past year did you . . .?	#	%
Experience Involuntary Unemployment?	96	2%
Experience Voluntary Unemployment?	295	5%
Work Part-time or temporary positions, but would have preferred a full-time/permanent position?	126	2%
Work two or more positions at the same time?	1,188	19%
Switch employers or practices?	552	9%
Experienced at least 1	1,868	30%

Source: Va. Healthcare Workforce Data Center

Only 2% of Virginia's PTs experienced involuntary unemployment at some point in 2014. By comparison, Virginia's average monthly unemployment rate was 5.2%.[1]

At a Glance:

Unemployment Experience 2014

Involuntarily Unemployed:	2%
Underemployed:	2%

Turnover & Tenure

Switched Jobs:	9%
New Location:	24%
Over 2 years:	58%
Over 2 yrs, 2nd location:	42%

Employment Type

Salary/Commission:	36%
Hourly Wage:	50%

Source: Va. Healthcare Workforce Data Center

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at this Location	116	2%	110	7%
Less than 6 Months	445	8%	270	17%
6 Months to 1 Year	459	8%	175	11%
1 to 2 Years	1,354	24%	350	22%
3 to 5 Years	1,267	22%	312	20%
6 to 10 Years	900	16%	199	13%
More than 10 Years	1,124	20%	151	10%
Subtotal	5,664	100%	1,567	100%
Did not have location	68		4,548	
Item Missing	418		36	
Total	6,151		6,151	

Source: Va. Healthcare Workforce Data Center

58% of PTs have worked at their primary location for more than 2 years—the job tenure normally required to get a conventional mortgage loan.

Half of all PTs received a salary at their primary work location, while 36% received an hourly wage.

Employment Type		
Primary Work Site	#	%
Salary/ Commission	2,435	50%
Hourly Wage	1,784	36%
By Contract	433	9%
Business/ Practice Income	222	5%
Unpaid	21	0%
Subtotal	4,894	100%

[1] As reported by the US Bureau of Labor Statistics. The not seasonally adjusted monthly unemployment rate ranged from 5.6% in January/February to 4.5% in December.

At a Glance:

Concentration

Top Region:	32%
Top 3 Regions:	74%
Lowest Region:	2%

Locations

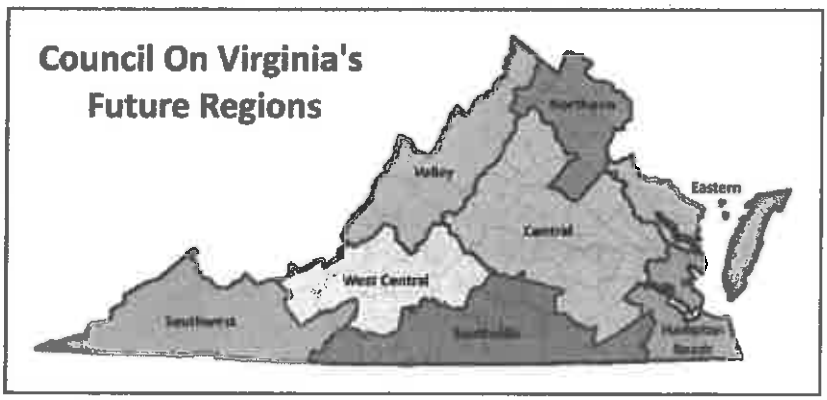
2 or more (2014):	28%
2 or more (Now*):	26%

Source: Va. Healthcare Workforce Data Center

Nearly three-quarters of all PTs work in one of three regions of the state: Northern Virginia, Central Virginia, and Hampton Roads.

A Closer Look:

Regional Distribution of Work Locations				
COVF Region	Primary Location		Secondary Location	
	#	%	#	%
Central	1,303	23%	338	21%
Eastern	89	2%	21	1%
Hampton Roads	1,074	19%	297	19%
Northern	1,809	32%	416	26%
Southside	169	3%	49	3%
Southwest	201	4%	78	5%
Valley	394	7%	106	7%
West Central	520	9%	148	9%
Virginia Border State/DC	35	1%	47	3%
Other US State	68	1%	89	6%
Outside of the US	3	0%	3	0%
Total	5,665	100%	1,592	100%
Item Missing	417		11	



Number of Work Locations				
Locations	Work Locations in 2014		Work Locations Now*	
	#	%	#	%
0	54	1%	125	2%
1	4,060	71%	4,124	72%
2	875	15%	848	15%
3	509	9%	487	9%
4	102	2%	55	1%
5	36	1%	21	0%
6 or More	70	1%	47	1%
Total	5,707	100%	5,707	100%

*At the time of survey completion, December 2014.

Source: Va. Healthcare Workforce Data Center

26% of all PTs currently have multiple work locations, while 28% of PTs have had at least two work locations over the past year.

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	3,501	63%	1,097	72%
Non-Profit	1,590	29%	317	21%
State/Local Government	337	6%	102	7%
Veterans Administration	43	1%	5	0%
U.S. Military	53	1%	6	0%
Other Federal Government	4	0%	2	0%
Total	5,528	100%	1,529	100%
Did not have location	68		4,548	
Item Missing	554		73	

Source: Va. Healthcare Workforce Data Center

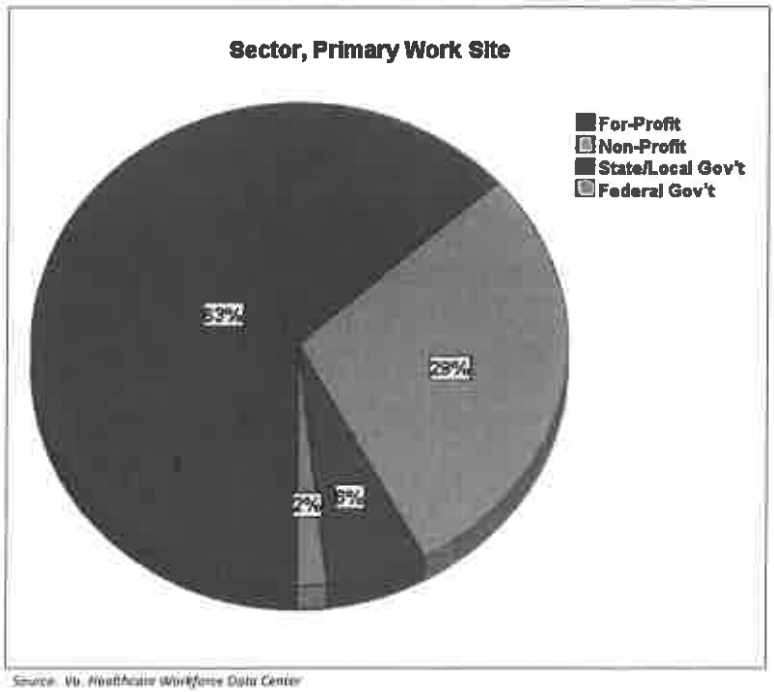
At a Glance:
(Primary Locations)

Sector
For Profit: 63%
Federal: 2%

Top Establishments
Group Private Practice: 15%
Home Health Care: 15%
Outpatient Rehab.: 14%

Source: Va. Healthcare Workforce Data Center

More than 90% of all PTs work in the private sector, including 63% who work for at for-profit establishments. Another 6% of Virginia's PT workforce worked for either state or local governments.

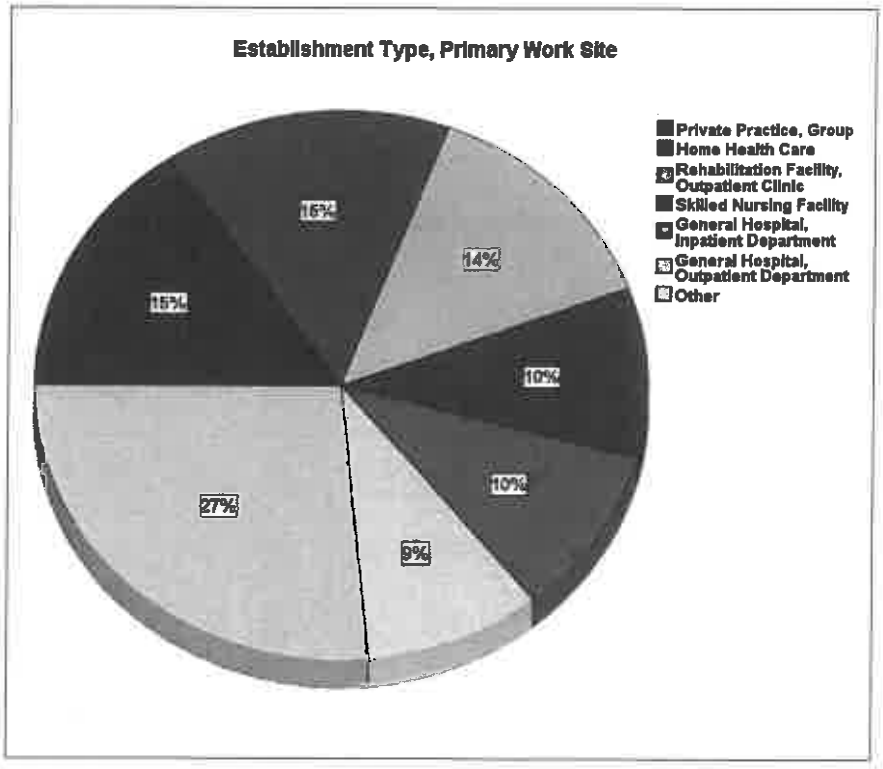


Source: Va. Healthcare Workforce Data Center

Establishment Type	Location Type			
	Primary Location		Secondary Location	
	#	%	#	%
Private Practice, Group	837	15%	139	9%
Home Health Care	820	15%	309	20%
Rehabilitation Facility, Outpatient Clinic	738	14%	99	7%
Skilled Nursing Facility	542	10%	281	19%
General Hospital, Inpatient Department	537	10%	171	11%
General Hospital, Outpatient Department	508	9%	69	5%
Private Practice, Solo	368	7%	80	5%
Rehabilitation Facility, Residential/Inpatient	245	5%	80	5%
K-12 School System	165	3%	29	2%
Academic Institution	147	3%	83	5%
Assisted Living or Continuing Care Facility	133	2%	70	5%
Physician Office	132	2%	21	1%
Other	249	5%	81	5%
Total	5,421	100%	1,512	100%
Did Not Have a Location	68		4548	

Group Private Practices are the most common establishment type among Virginia's PTs with a primary work location. Home Health Care and Outpatient Rehabilitation Facilities were also typical primary establishment types.

Home Health Care was the most common establishment type among PTs who also had a secondary work location. Skilled Nursing Facilities and the Inpatient Department of Hospitals were also common secondary establishment types.



Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

A Typical PT's Time

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

Roles

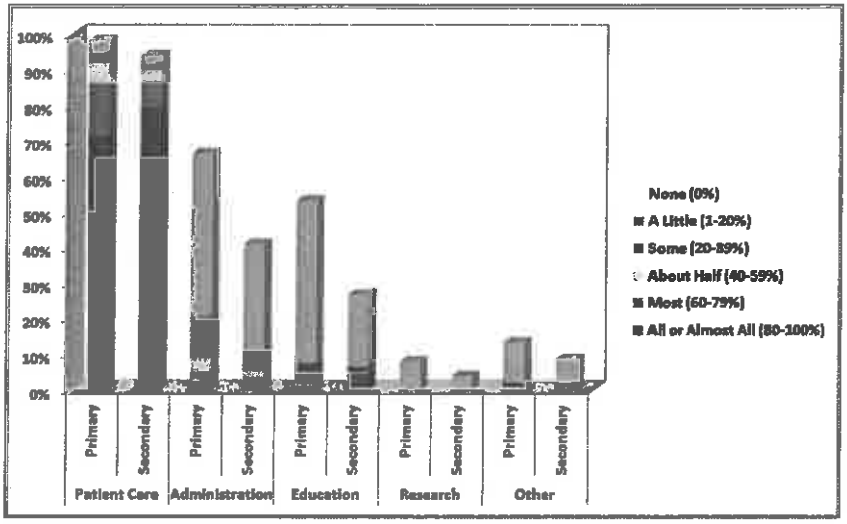
Patient Care:	86%
Administrative:	5%
Education:	1%

Patient Care PTs

Median Admin Time:	1%-9%
Ave. Admin Time:	1%-9%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

The typical PT spends most of her time in patient care activities. In fact, 86% of all PTs fill a patient care role, defined as spending at least 60% of her time in that activity. A small number of PTs also fill either an administrative or an educational role at their primary work location.

Time Allocation										
Time Spent	Patient Care		Admin.		Education		Research		Other	
	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site
All or Almost All (80-100%)	**71%**	**80%**	**3%**	**2%**	**1%**	**5%**	**0%**	**0%**	**0%**	**0%**
Most (60-79%)	15%	7%	2%	1%	1%	0%	0%	0%	0%	0%
About Half (40-59%)	6%	3%	4%	2%	1%	0%	0%	0%	0%	1%
Some (20-39%)	3%	1%	12%	6%	6%	1%	0%	0%	1%	1%
A Little (1-20%)	4%	2%	46%	30%	46%	20%	8%	4%	11%	7%
None (0%)	2%	6%	33%	59%	47%	73%	92%	96%	87%	91%

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All PTs		PTs over 50	
	#	%	#	%
Under age 50	121	2%	-	-
50 to 54	248	5%	11	1%
55 to 59	701	13%	87	6%
60 to 64	1,569	30%	380	28%
65 to 69	1,714	33%	559	40%
70 to 74	483	9%	213	15%
75 to 79	114	2%	47	3%
80 or over	29	1%	8	1%
I do not intend to retire	241	5%	76	6%
Total	5,220	100%	1,381	100%

At a Glance:

Retirement Expectations

All PTs

Under 65:	51%
Under 60:	20%

PTAs 50 and over

Under 65:	35%
Under 60:	7%

Time until Retirement

Within 2 years:	3%
Within 10 years:	15%
Half the workforce:	by 2039

Source: Va. Healthcare Workforce Data Center

51% of all PTs expect to retire before the age of 65, while 17% plan on working until at least age 70. Among PTs who are age 50 and over, 35% still expect to retire by age 65, while 25% plan on working until at least age 70.

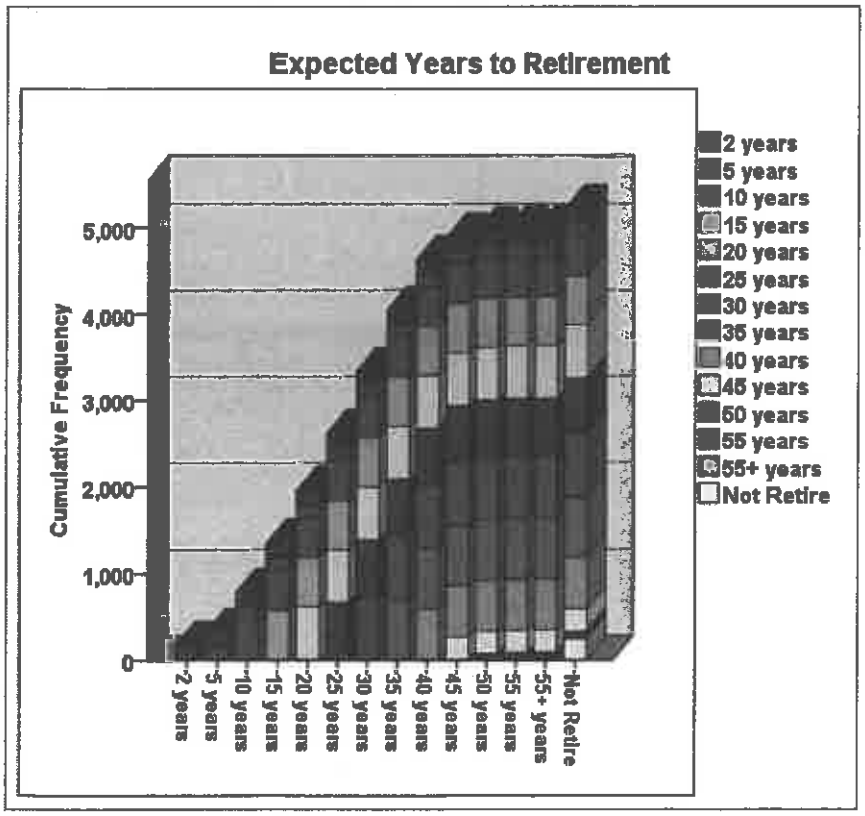
Within the next two years, just 1% of Virginia's PTs expect to leave the profession and 4% plan on leaving the state. Meanwhile, 28% of PTs plan on pursing additional educational opportunities, and 12% also plan to increase patient care hours. In addition, 19% of PTs plan to certify/recertify for direct access.

Future Plans		
1 Year Plans:	#	%
Decrease Participation		
Leave Profession	53	1%
Leave Virginia	268	4%
Decrease Patient Care Hours	590	10%
Decrease Teaching Hours	15	0%
Increase Participation		
Increase Patient Care Hours	736	12%
Increase Teaching Hours	683	11%
Pursue Additional Education	1,744	28%
Return to Virginia's Workforce	41	1%
Certify for Direct Access	1,148	19%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for PTs. Only 3% of PTs expect to retire within the next two years, while 15% plan on retiring in the next ten years. Half of the current PT workforce expects to be retired by 2039.

Time to Retirement			
Expect to retire within. . .	#	%	Cumulative %
2 years	165	3%	3%
5 years	148	3%	6%
10 years	464	9%	15%
15 years	568	11%	26%
20 years	611	12%	37%
25 years	659	13%	50%
30 years	727	14%	64%
35 years	701	13%	63%
40 years	591	11%	89%
45 years	261	5%	94%
50 years	64	1%	95%
55 years	13	0%	95%
In more than 55 years	7	0%	95%
Do not intend to retire	241	5%	100%
Total	5,220	100%	



Source: Va. Healthcare Workforce Data Center

Using these estimates, retirements will begin to reach 10% of the current workforce starting in 2029. Retirements will peak at 14% of the current workforce around 2044 before declining to under 10% of the current workforce again around 2059.

At a Glance:

FTEs

Total:	5,300
FTEs/1,000 Residents:	0.642
Average:	0.87

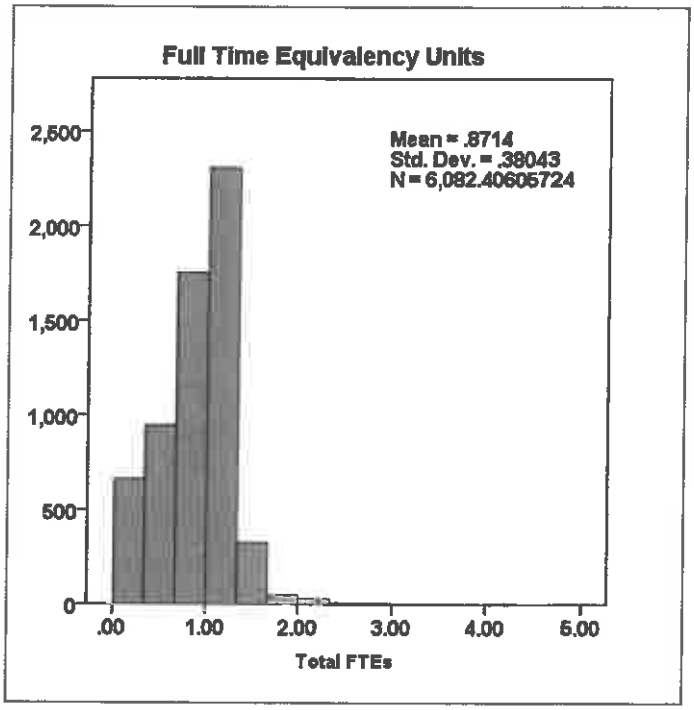
Age & Gender Effect

Age, Partial Eta^2:	Small
Gender, Partial Eta^2:	Medium

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

Source: Va. Healthcare Workforce Data Center

A Closer Look:

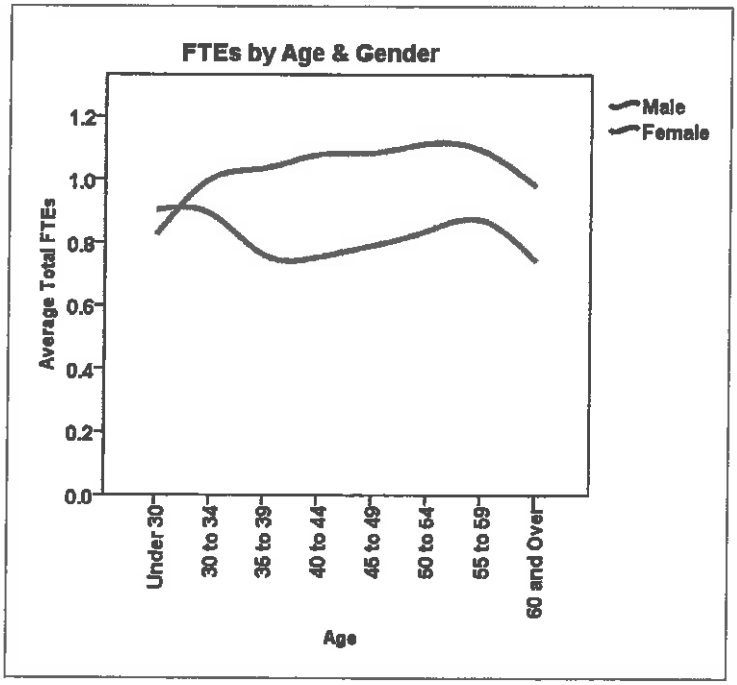


Source: Va. Healthcare Workforce Data Center

The average PT provided 0.87 FTEs in 2014, or approximately 33 hours per week for 52 weeks. Although FTEs appear to vary by age and gender, statistical tests did not verify that a difference exists.[2]

Full-Time Equivalency Units		
Age	**Average**	**Median**
	Age	
Under 30	0.89	1.03
30 to 34	0.92	1.01
35 to 39	0.82	0.88
40 to 44	0.85	0.87
45 to 49	0.86	0.84
50 to 54	0.89	0.91
55 to 59	0.93	1.01
60 and Over	0.80	0.77
	Gender	
Male	1.01	1.05
Female	0.83	0.89

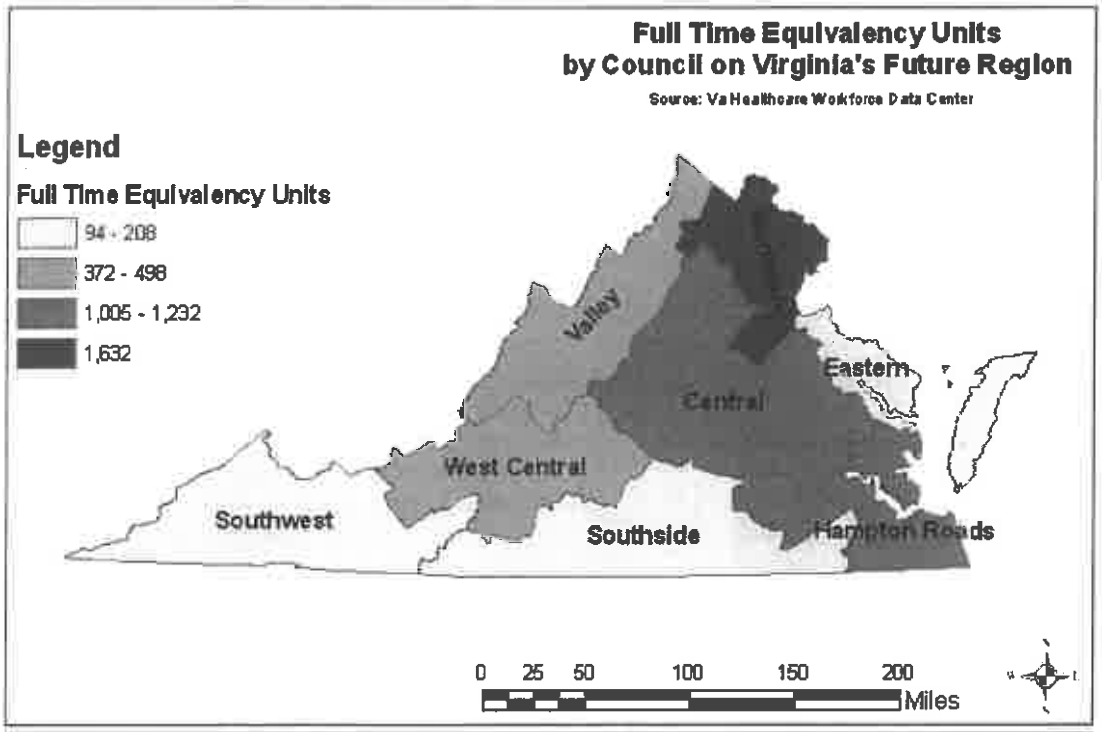
Source: Va. Healthcare Workforce Data Center

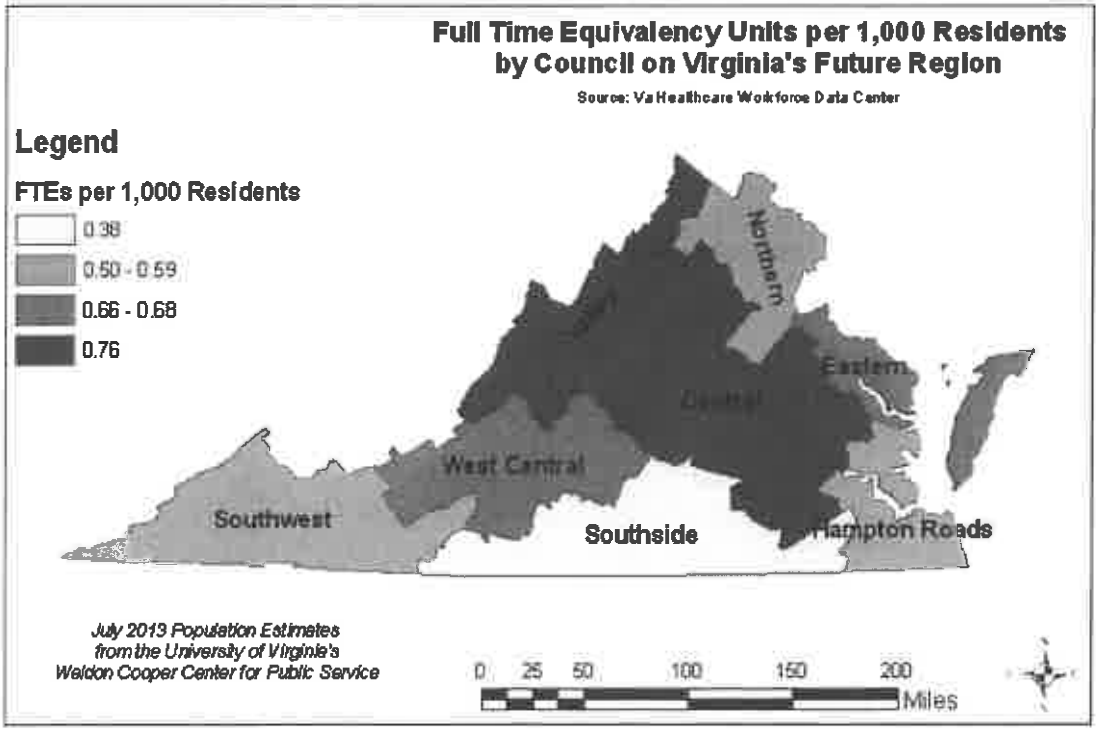


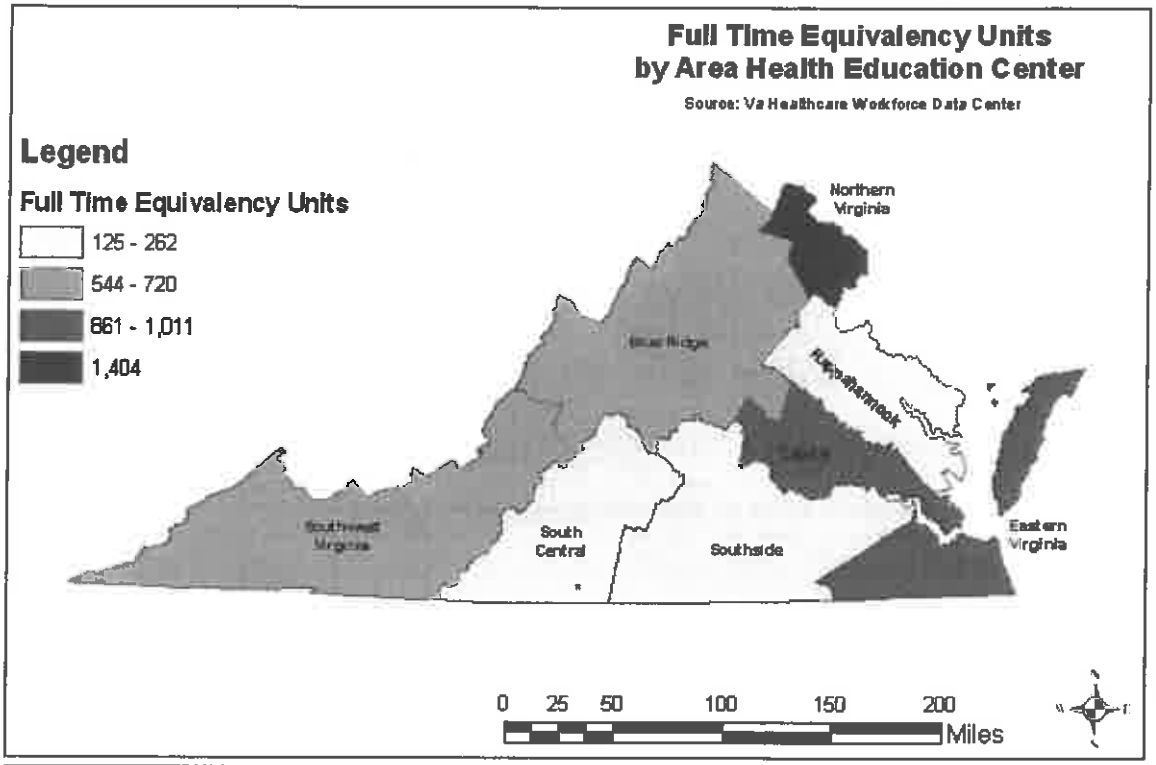
Source: Va. Healthcare Workforce Data Center

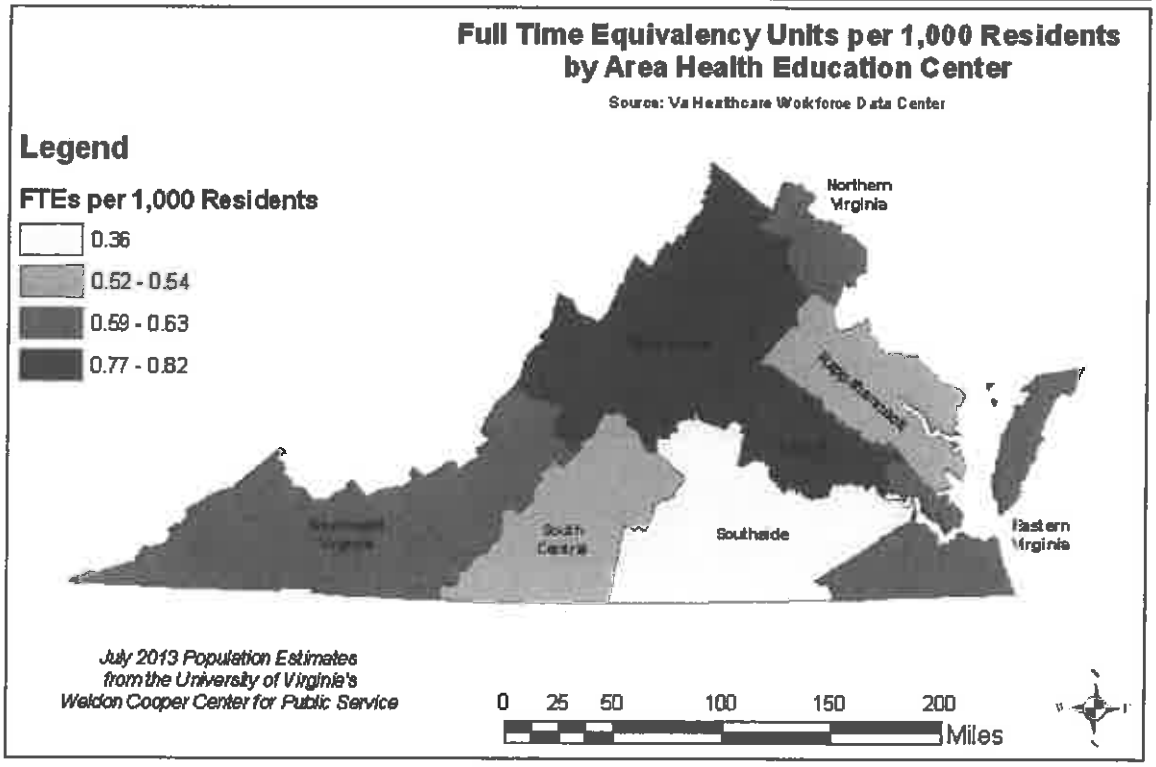
[2] Due to assumption violations in Mixed between-within ANOVA (Levene's Test and Interaction effect were significant).

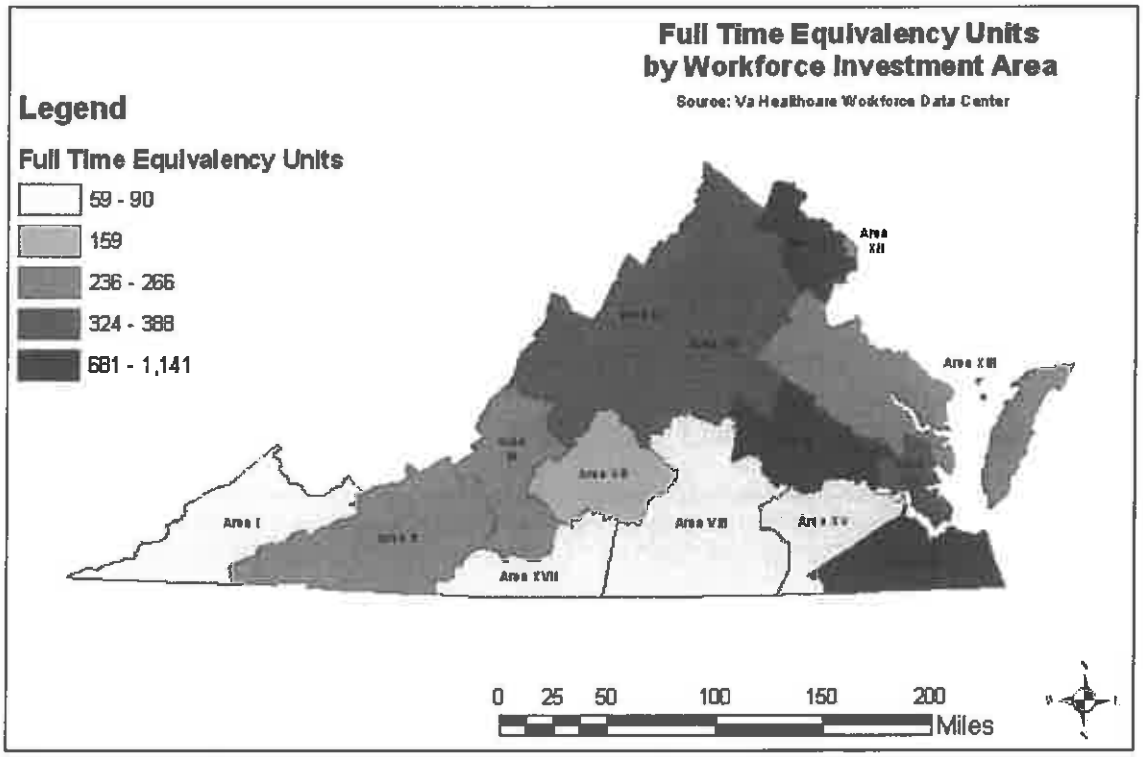
Council on Virginia's Future Regions

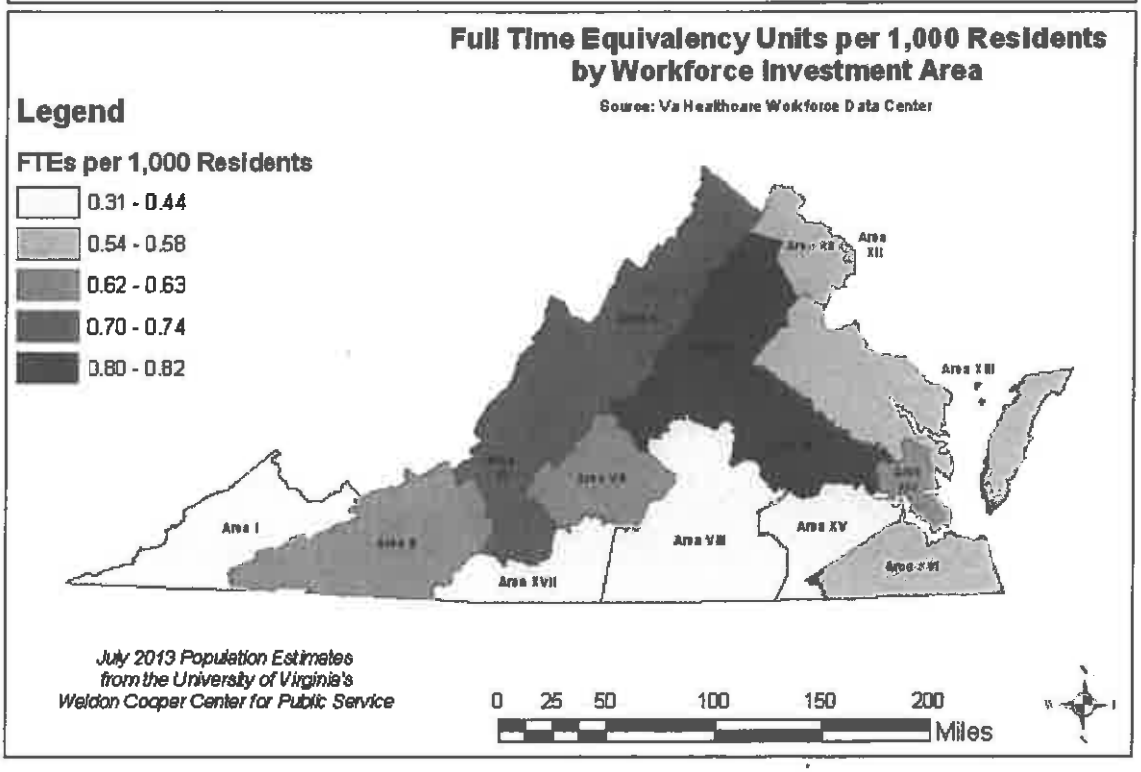


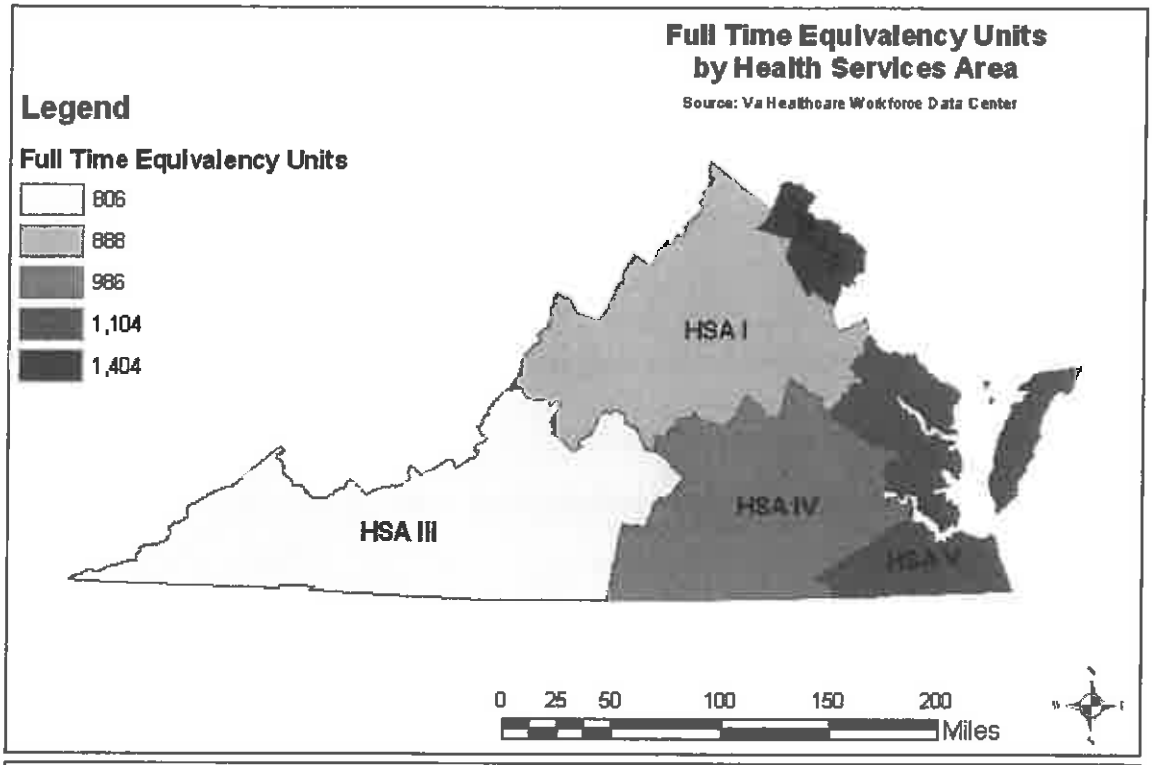


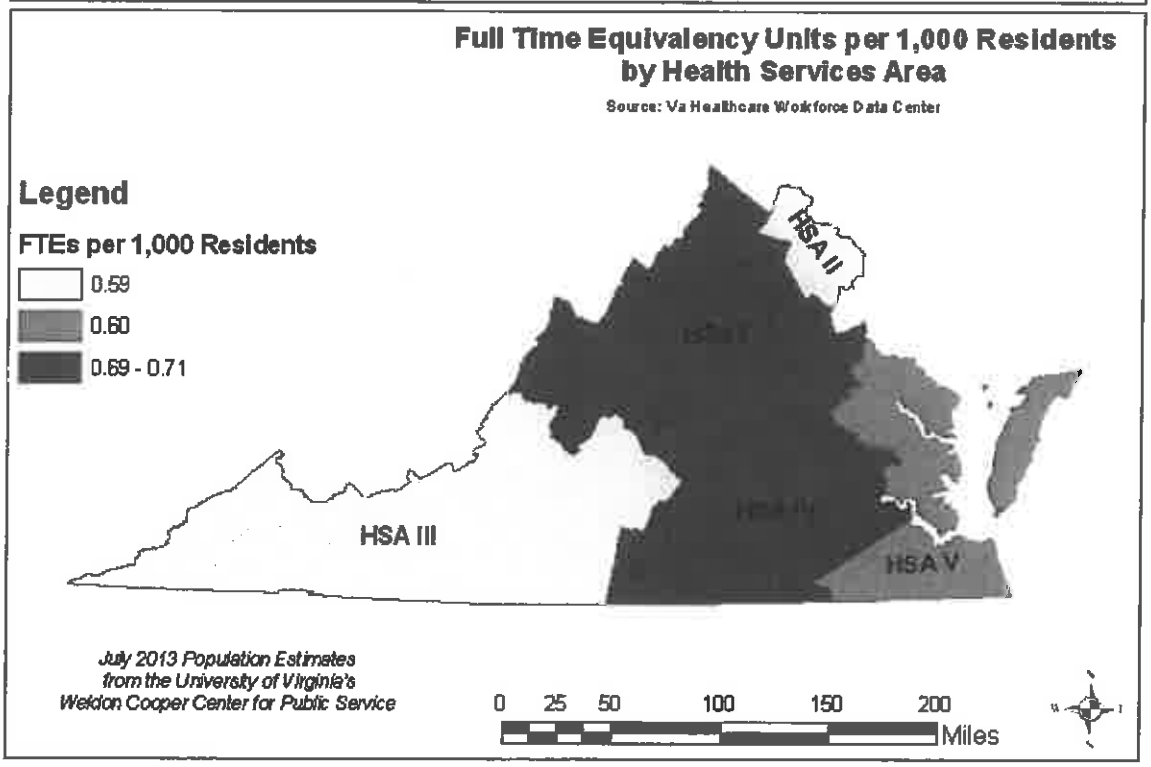

Full Time Equivalency Units
by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
125 - 262
544 - 720
661 - 1,011
1,404
Northern Virginia
Southwest Virginia
South Central
Southside
Eastern Virginia
0 25 50 100 150 200
Miles

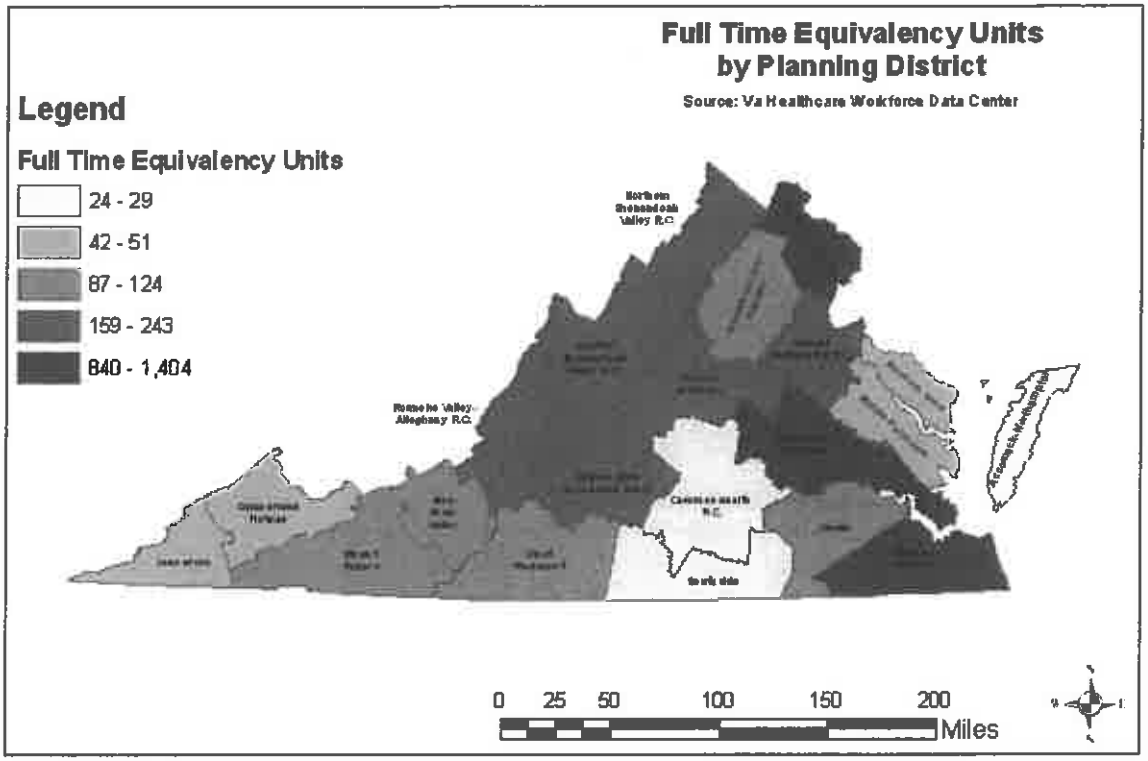

Full Time Equivalency Units per 1,000 Residents
by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.36
0.52 - 0.54
0.59 - 0.63
0.77 - 0.82
Northern Virginia
South Central
Southside
Eastern Virginia
July 2013 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200
Miles

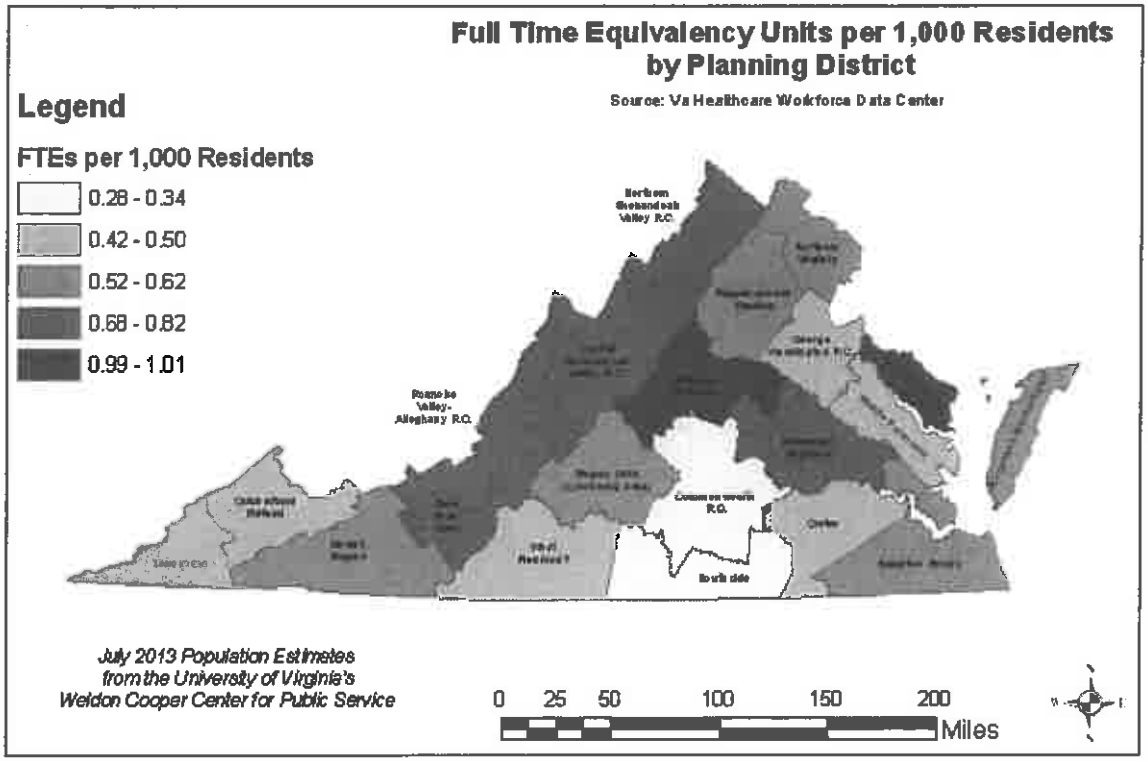

Full Time Equivalency Units
by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
59 - 90
159
236 - 266
324 - 388
681 - 1,141
Area XII
Area XIII
Area I
Area VIII
Area XV
Area XVII
0 25 50 100 150 200
Miles


Full Time Equivalency Units per 1,000 Residents
by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.31 - 0.44
0.54 - 0.58
0.62 - 0.63
0.70 - 0.74
0.80 - 0.82
Area XII
Area XIII
Area I
Area VIII
Area XV
Area XVII
July 2013 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200
Miles


Full Time Equivalency Units
by Health Services Area
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
806
888
986
1,104
1,404
HSA I
HSA III
HSA IV
HSA V
0 25 50 100 150 200
Miles


Full Time Equivalency Units per 1,000 Residents
by Health Services Area
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.59
0.60
0.69 - 0.71
HSA II
HSA III
HSA V
July 2013 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200
Miles


Full Time Equivalency Units
by Planning District
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
24 - 29
42 - 51
87 - 124
159 - 243
840 - 1,404
Roanoke Valley-Alleghany R.C.
Commonwealth R.C.
0 25 50 100 150 200
Miles


Full Time Equivalency Units per 1,000 Residents
by Planning District
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.28 - 0.34
0.42 - 0.50
0.52 - 0.62
0.68 - 0.82
0.99 - 1.01
Roanoke Valley-Alleghany R.C.
Commonwealth R.C.
July 2013 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200
Miles

Appendices

Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min	Max
Metro, 1 million+	4,236	83.66%	1.19526	1.040662	1.786437
Metro, 250,000 to 1 million	468	81.62%	1.225131	1.06667	1.831083
Metro, 250,000 or less	731	84.13%	1.188618	1.034879	1.776511
Urban pop 20,000+, Metro adj	74	86.49%	1.15625	1.006698	1.728134
Urban pop 20,000+, nonadj	0	NA	NA	NA	NA
Urban pop, 2,500-19,999, Metro adj	170	78.82%	1.268657	1.104566	1.896137
Urban pop, 2,500-19,999, nonadj	98	74.49%	1.342466	1.168828	2.006452
Rural, Metro adj	100	71.00%	1.408451	1.226279	2.105073
Rural, nonadj	52	76.92%	1.3	1.131855	1.942983
Virginia border state/DC	661	57.34%	1.744063	1.518482	2.606681
Other US State	967	39.30%	2.544737	2.215595	3.803369

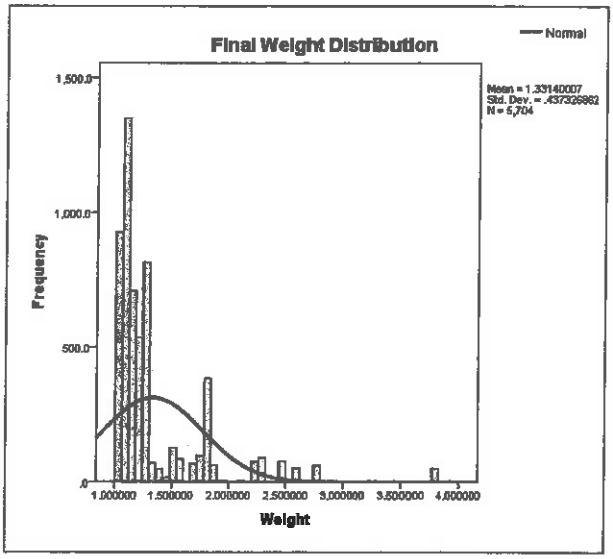
Age	Age Weight			Total Weight	
	#	Rate	Weight	Min	Max
Under 30	1,064	50.28%	1.988785	1.728134	3.803369
30 to 34	1,395	69.61%	1.436663	1.248373	2.747487
35 to 39	1,142	77.85%	1.284589	1.11623	2.456659
40 to 44	1,052	83.94%	1.191393	1.035248	2.27843
45 to 49	897	85.40%	1.171018	1.017544	2.239465
50 to 54	752	84.04%	1.189873	1.033928	2.275524
55 to 59	570	86.32%	1.158537	1.006698	2.215595
60 and Over	718	74.65%	1.339552	1.16399	2.561771

See the Methods section on the HWDC website for details on HWDC Methods:

Final weights are calculated by multiplying the two weights and the overall response rate:

Age Weight x Rural Weight x Response Rate = Final Weight.

Overall Response Rate: 0.751515



Virginia's Physical Therapist Assistant Workforce: 2014

Healthcare Workforce Data Center

April 2015

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
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Richmond, VA 23233
804-367-2115, 804-527-4466(fax)
E-mail: ***HWDC@dhp.virginia.gov***

Follow us on Tumblr: ***www.vahwdc.tumblr.com***

2,289 Physical Therapist Assistants voluntarily participated in this survey. *Without their efforts the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Physical Therapy express our sincerest appreciation for your ongoing cooperation.*

Thank You!

Virginia Department of Health Professions

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Director

Jaime H. Hoyle, J.D.
Chief Deputy Director

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Appendix B: The 2012 Physical Therapist Assistant Survey ..... **Error! Bookmark not defined.**

The PTA Workforce: At a Glance:

The Workforce	
Licensees:	3,025
Virginia's Workforce:	2,695
FTEs:	2,264

Survey Response Rate	
All Licensees:	76%
Renewing Practitioners:	90%

Demographics	
% Female:	79%
Diversity Index:	29%
Median Age:	42

Background	
Rural Childhood:	46%
HS Degree in VA:	61%
Prof. Degree in VA:	75%

Education	
Associate or Higher:	98%
Bachelors:	1%

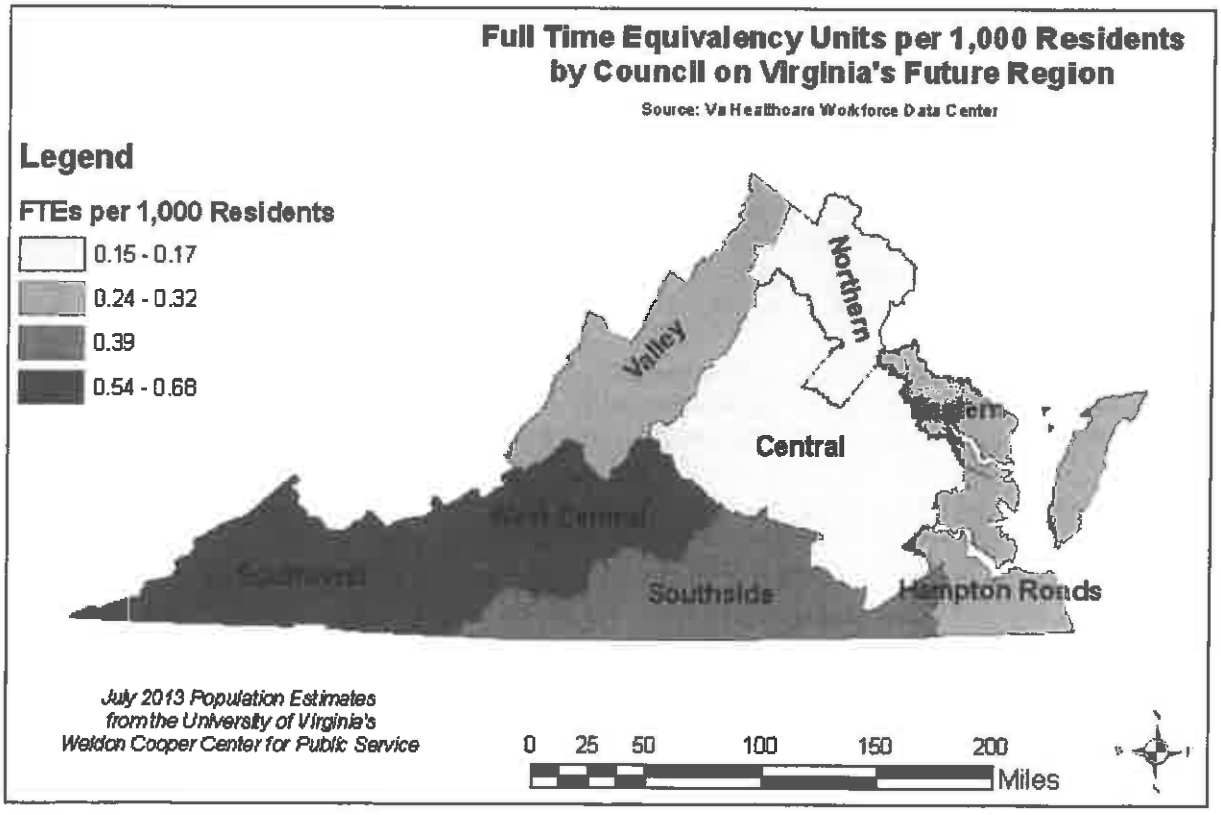
Finances	
Median Inc.:	$50k-$60k
Health Benefits:	58%
Under 40 w/ Ed debt:	54%

Current Employment	
Employed in Prof.:	96%
Hold 1 Full-time Job:	67%
Satisfied?:	97%

Job Turnover	
Switched Jobs in 2014:	10%
Employed over 2 yrs:	57%

Primary Roles	
Patient Care:	89%
Administration:	3%
Other:	1%

Source: Va Healthcare Workforce Data Center



Results in Brief

2,289 physical therapist assistants (PTAs) voluntarily took part in the 2014 Physical Therapist Assistant Workforce Survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place every December on even-numbered years for PTAs. These survey respondents represent 76% of the 3,025 PTAs who are licensed in the state and 90% of renewing practitioners.

The HWDC estimates that 2,695 PTAs participated in Virginia's workforce during the survey period, which is defined as those who worked at least a portion of the year in the state or who live in the state and intend to return to work in the profession at some point in the future. Virginia's PTA workforce provided 2,264 "full-time equivalency units" during the survey time period, which the HWDC defines simply as working 2,000 hours a year (or 40 hours per week for 50 weeks with 2 weeks off).

Nearly 80% of PTAs are female, and the median age of all PTAs is 42. In a random encounter between two PTAs, there is a 29% chance that they would be of different races or ethnicities, a measure known as the diversity index. For the Virginia population as a whole, this same probability is 54%.

Nearly half of all PTAs grew up in a rural area, and approximately one-third of these professionals currently work in non-Metro areas of the state. Overall, 21% of PTAs work in non-Metro areas of the state. Meanwhile, 61% of PTAs went to high school in Virginia, and 75% also received their professional degree in the state.

80% of all PTAs in the state earned an Associate of Applied Science degree as their highest professional degree. 35% of all PTA currently have educational debt, including 54% of those PTAs who are under the age of 40. For those PTAs with education debt, the median debt load is between $18,000 and $20,000.

96% of PTAs are currently employed in the profession, and only 1% are involuntarily unemployed at the moment. More than two-thirds of Virginia's PTAs hold one full-time position, while 17% have multiple positions. 57% of PTAs have been at their primary work location for at least two years, while more than one-quarter of all PTAs began work at a new location in 2014.

Three-quarters of Virginia's PTAs receive an hourly wage at their primary work location, while 16% receive a salary. The median annual income for PTAs is between $50,000 and $60,000. Among professional who receive an hourly wage or salary at their primary work location, 81% receive at least one employer-sponsored benefit, including 58% who receive employer-sponsored health insurance. 97% of PTAs indicate they are satisfied with their current employment situation, including 71% who indicate they are "very satisfied".

More than 90% of all PTAs work in the private sector, including 72% who work at a for-profit establishment. More than 60% of all PTAs worked at one of three establishment types during the past year: Skilled Nursing Facilities, Home Health Care Organizations, and Outpatient Rehabilitation Facilities.

A typical PTA spends nearly all of her time in caring for patients. In fact, 89% of all PTAs serve a patient care role, meaning that at least 60% of their time is spent in that activity. However, the typical PTA also spends a limited amount of time in administrative tasks, and 3% of all PTAs also serve an administration role at their jobs.

Half of all PTAs expect to retire by the age of 65. Although only 2% of the current workforce expects to retire in the next two years, half of the current workforce expects to retire by 2039. Over the next two years, just 1% of all PTAs expect to leave the profession, while 4% expect to move outside Virginia. However, 27% of Virginia's PTA workforce expects to pursue additional educational opportunities within the next two years, and 15% expect to increase their patient care activities.

A Closer Look:

Licensees		
License Status	#	%
Renewing Practitioners	2,462	81%
New Licensees	268	9%
Non-Renewals	295	10%
All Licensees	3,025	100%

Source: Va. Healthcare Workforce Data Center

HWDC surveys tend to achieve very high response rates. 90% of renewing PTAs submitted a survey. These represent 76% of PTAs who held a license at some point in 2014.

Response Rates	
Completed Surveys	2,289
Response Rate, all licensees	76%
Response Rate, Renewals	90%

Source: Va. Healthcare Workforce Data Center

Response Rates			
Statistic	Non Respondents	Respondent	Response Rate
By Age			
Under 30	173	289	63%
30 to 34	124	355	74%
35 to 39	81	307	79%
40 to 44	85	344	80%
45 to 49	77	327	81%
50 to 54	59	280	83%
55 to 59	70	226	76%
60 and Over	67	161	71%
Total	**736**	**2,289**	**76%**
New Licenses			
Issued in 2014	199	69	26%
Metro Status			
Non-Metro	78	393	83%
Metro	424	1,636	79%
Not in Virginia	231	258	53%

Source: Va. Healthcare Workforce Data Center

Definitions

1. **The Survey Period:** The survey was conducted in December 2014.
2. **Target Population:** All PTAs who held a Virginia license at some point in 2014.
3. **Survey Population:** The survey was available to PTAs who renewed their licenses online. It was not available to those who did not renew, including some PTAs newly licensed in 2014.

At a Glance:

Workforce

2014 PTA Workforce:	2,695
FTEs:	2,264

Utilization Ratios

Licensees in VA Workforce:	89%
Licensees per FTE:	1.34
Workers per FTE:	1.19

Source: Va. Healthcare Workforce Data Center

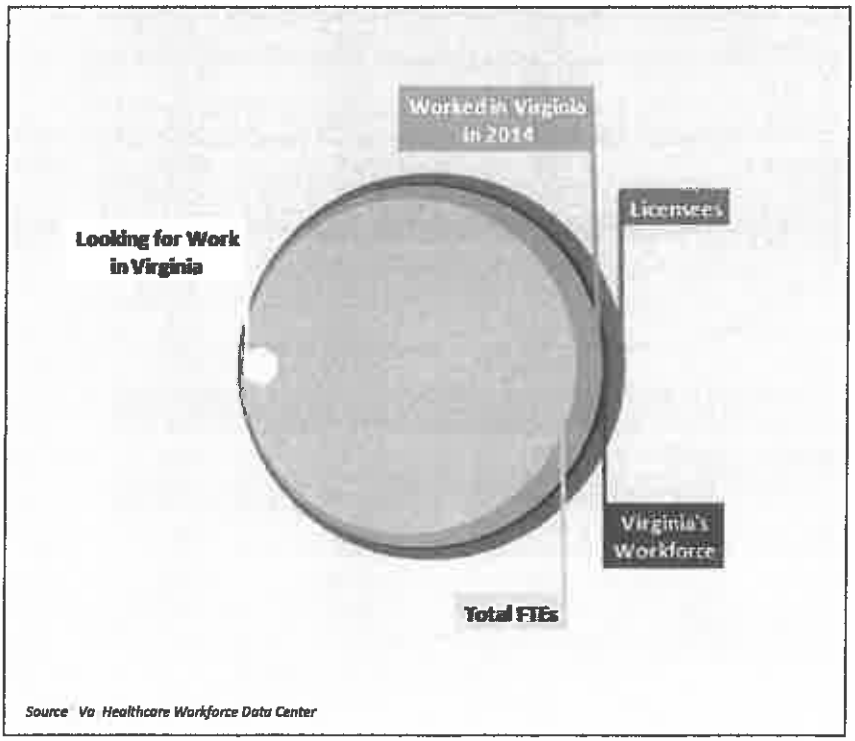
Definitions

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

Virginia's PTA Workforce		
Status	**#**	**%**
Worked in Virginia in Past Year	2,670	99%
Looking for Work in Virginia	26	1%
Virginia's Workforce	2,695	100%
Total FTEs	2,264	
Licensees	3,025	

Source: Va. Healthcare Workforce Data Center

This report uses weighting to estimate the figures in this report. Unless otherwise noted, figures refer to the Virginia Workforce only. For more information on HWDC's methodology visit: www.dhp.virginia.gov/hwdc



Source: Va. Healthcare Workforce Data Center

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 30	84	21%	317	79%	401	16%
30 to 34	103	25%	316	75%	420	17%
35 to 39	77	24%	248	76%	325	13%
40 to 44	83	23%	276	77%	359	14%
45 to 49	73	22%	261	78%	334	13%
50 to 54	42	15%	244	85%	286	11%
55 to 59	44	18%	198	82%	241	9%
60 +	39	22%	139	78%	179	7%
Total	545	21%	1,999	79%	2,544	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

% Female:	79%
% Under 40 Female:	77%

Age

Median Age:	42
% Under 40:	45%
% 55+:	17%

Diversity

Diversity Index:	29%
Under 40 Div. Index:	33%

Source: Va. Healthcare Workforce Data Center

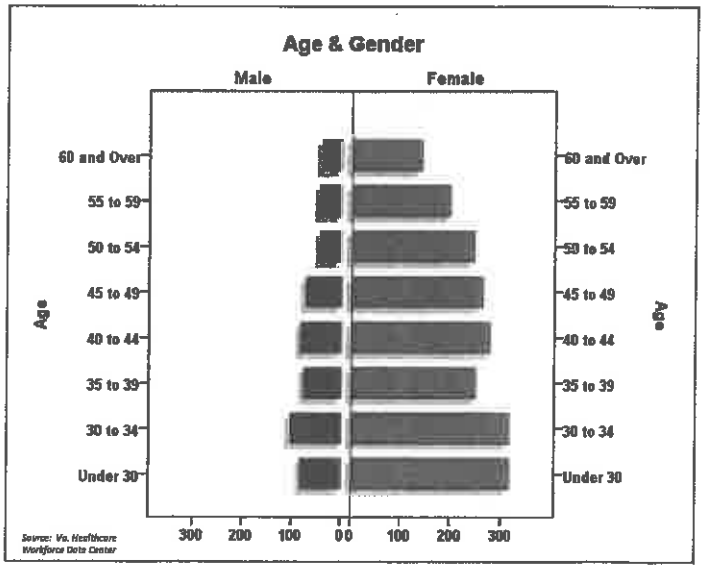
Race & Ethnicity					
Race/ Ethnicity	Virginia*	PTAs		PTAs under 40	
	%	#	%	#	%
White	64%	2,142	84%	938	81%
Black	19%	184	7%	90	8%
Asian	6%	64	3%	43	4%
Other Race	0%	28	1%	15	1%
Two or more races	2%	48	2%	24	2%
Hispanic	8%	86	3%	39	3%
Total	100%	2,551	100%	1,151	100%

*Population data in this chart is from the US Census, ACS 1-yr estimates, 2011 vintage.

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two PTAs, there is a 29% chance that they would be of a different race/ethnicity (a measure known as the diversity index). For Virginia's population s a whole, the comparable number is 54%.

45% of all PTAs are under the age of 40, and 77% of these professionals are female. In addition, there is a one-in-three chance that two randomly chosen PTAs from this group would be of a different race or ethnicity.



At a Glance:

Childhood

Urban Childhood:	12%
Rural Childhood:	46%

Native Sons

HS in Virginia:	61%
Prof. Education in VA:	75%
HS/Prof. Edu. in VA:	78%

Location Choice

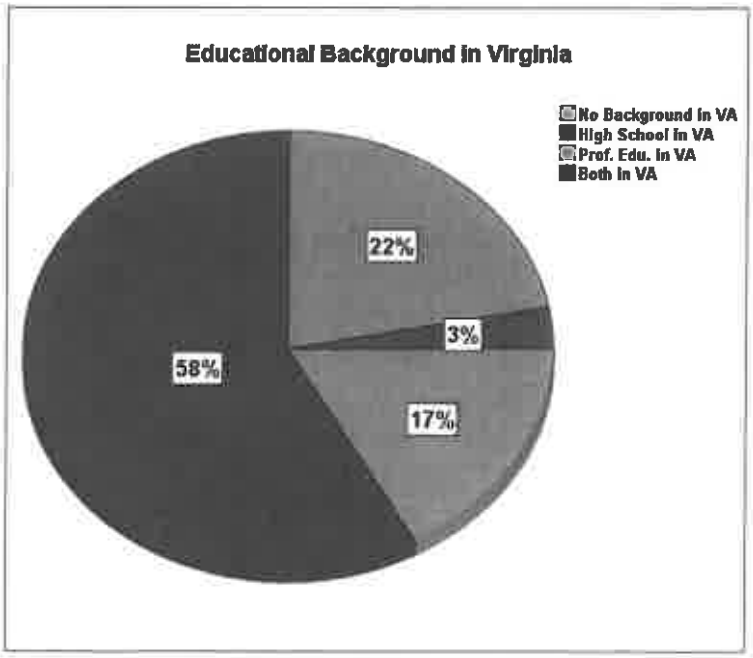
% Rural to Non-Metro:	34%
% Urban/Suburban to Non-Metro:	9%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Primary Location: USDA Rural Urban Continuum		Rural Status of Childhood Location		
Code	Description	Rural	Suburban	Urban
	Metro Counties			
1	Metro, 1 million+	27%	58%	14%
2	Metro, 250,000 to 1 million	46%	41%	13%
3	Metro, 250,000 or less	61%	29%	9%
	Non-Metro Counties			
4	Urban pop 20,000+, Metro adj	73%	22%	5%
6	Urban pop, 2,500-19,999, Metro adj	79%	16%	5%
7	Urban pop, 2,500-19,999, nonadj	84%	15%	1%
8	Rural, Metro adj	78%	15%	7%
9	Rural, nonadj	64%	30%	6%
	Overall	**46%**	**43%**	**11%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

46% of PTAs grew up in self-described rural areas, and 34%of these professionals currently work in Non-Metro counties. Overall, 21% of Virginia's PTA workforce works in non-Metro counties of the state.

Top Ten States for PTA Recruitment

Rank	All PTAs			
	High School	#	PTA School	#
1	Virginia	1,544	Virginia	1,858
2	Pennsylvania	134	New York	74
3	New York	121	Pennsylvania	68
4	Outside U.S./Canada	88	North Carolina	58
5	West Virginia	70	West Virginia	49
6	North Carolina	58	Maryland	47
7	Florida	51	Florida	47
8	Ohio	48	Ohio	30
9	Maryland	43	Tennessee	24
10	New Jersey	37	Kentucky	21

Source: Va. Healthcare Workforce Data Center

61% of PTAs received their high school degree in Virginia, while 75% received their initial professional degree in the state.

Among PTAs who have been licensed in the past five years, 58% received their high school degree in Virginia, while 71% received their initial professional degree in the state.

Rank	Licensed in the Past 5 Years			
	High School	#	PTA School	#
1	Virginia	514	Virginia	604
2	Pennsylvania	47	West Virginia	32
3	Outside U.S./Canada	33	Maryland	25
4	West Virginia	28	New York	20
5	New York	26	Florida	20
6	Florida	22	Pennsylvania	17
7	North Carolina	18	North Carolina	16
8	Ohio	18	Ohio	12
9	Texas	14	Tennessee	12
10	New Jersey	14	Texas	9

Source: Va. Healthcare Workforce Data Center

11% of licensed PTAs did not participate in Virginia's workforce in 2014. 93% of these PTAs worked at some point in the past year, including 85% who currently work as PTAs.

At a Glance:

Not in VA Workforce

Total:	330
% of Licensees:	11%
Federal/Military:	8%
Va Border State/DC:	11%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Education

Associate of Applied Sci.: 80%
Associate of Science: 18%

Educational Debt

With debt: 35%
Under age 40 with debt: 54%
Median debt: $18k-$20k

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Professional Degree		
Degree	#	%
Certificate	10	0%
Associate of Applied Science	2,037	80%
Associate of Science	453	18%
Baccalaureate	27	1%
Other	26	1%
Total	2,553	100%

Source: Va. Healthcare Workforce Data Center

Highest Non-Professional Degree		
Degree	#	%
Certificate	228	11%
Associate of Applied Science	552	26%
Associate of Science	205	10%
Baccalaureate	764	36%
Masters	76	4%
Doctorate/Professional	11	1%
Other	264	13%
Total	2,099	100%

Source: Va. Healthcare Workforce Data Center

80% of PTAs have an Associate of Applied Science as their highest professional degree, while 36% have earned a Baccalaureate as their highest non-professional degree.

35% of PTAs currently have educational debt, including 54% of those under the age of 40. For those PTAs with educational debt, the median debt burden is between $18,000 and $20,000.

Educational Debt				
Amount Carried	All PTAs		PTA's under 40	
	#	%	#	%
None	1,524	65%	488	46%
Less than $4,000	115	5%	53	5%
$4,000-$7,999	89	4%	52	5%
$8,000-$11,999	108	5%	77	7%
$12,000-$15,999	66	3%	52	5%
$16,000-$19,999	48	2%	35	3%
$20,000-$23,999	83	4%	58	6%
$24,000-$27,999	65	3%	48	5%
$28,000 or more	234	10%	188	18%
Total	2,332	100%	1,051	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Top Certifications

Geriatrics:	4%
Women's Health:	2%
At Least One Cert.:	7%

Top Credentials:

Massage Therapy:	4%
Athletic Training:	2%
At Least One Cred.:	16%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

APTA Recognition of Advanced Proficiency		
Proficiency Area	#	%
Geriatrics	105	4%
Women's Health	61	2%
Neuromuscular	45	2%
Aquatic	29	1%
Acute Care	24	1%
Education	21	1%
Cardiovascular & Pulmonary	16	1%
Pediatric	11	0%
Sports	6	0%
Oncology	5	0%
At least 1 Certification	183	7%

Source: Va. Healthcare Workforce Data Center

Credentials		
Area	#	%
Massage Therapy	100	4%
Athletic Training	53	2%
Exercise Physiology	33	1%
Nursing	22	1%
Kinesiotherapy	13	0%
Medical Assistant	7	0%
Art/Dance Therapy	4	0%
Occupational Therapy	4	0%
Orthotic/Prosthetic Technician	2	0%
Orthopedic Technician	2	0%
Orthotic/Prosthetic Fitter	1	0%
Other	226	8%
At least 1 Credential	426	16%

Source: Va. Healthcare Workforce Data Center

Only 7% of Virginia's PTAs currently hold at lease one APTA certification, while 16% hold at least one credential. Geriatrics is the most common APTRA certification, and Message Therapy is the most common credential.

At a Glance:

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

Positions Held
1 Full-Time: 67%
2 or more Positions: 17%

Weekly Hours:
40 to 49: 47%
60 or more: 2%
Less than 30: 15%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Current Work Status		
Status	#	%
Employed, capacity unknown	0	0%
Employed in a physical therapy related capacity	2,458	96%
Employed, NOT in a physical therapy related capacity	32	1%
Not working, reason unknown	0	0%
Involuntarily unemployed	12	1%
Voluntarily unemployed	47	2%
Retired	5	0%
Total	2,554	100%

Source: Va. Healthcare Workforce Data Center

96% of licensed PTAs are currently employed in the profession, and only 1% of PTAs are involuntarily unemployed at the moment. Two-thirds of all PTAs currently hold one full-time job, while 17% have multiple positions. Nearly half of PTAs work between 40 and 49 hours per week, while just 2% of PTAs work at least 60 hours per week.

Current Positions		
Positions	#	%
No Positions	64	3%
One Part-Time Position	405	16%
Two Part-Time Positions	119	5%
One Full-Time Position	1,648	65%
One Full-Time Position & One Part-Time Position	238	9%
Two Full-Time Positions	5	0%
More than Two Positions	55	2%
Total	2,534	100%

Source: Va. Healthcare Workforce Data Center

Current Weekly Hours		
Hours	#	%
0 hours	64	3%
1 to 9 hours	63	3%
10 to 19 hours	96	4%
20 to 29 hours	208	8%
30 to 39 hours	733	30%
40 to 49 hours	1,175	47%
50 to 59 hours	99	4%
60 to 69 hours	18	1%
70 to 79 hours	6	0%
80 or more hours	20	1%
Total	2,482	100%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Income		
Hourly Wage	**#**	**%**
Volunteer Work Only	4	0%
Less than $10,000	60	3%
$10,000-$19,999	41	2%
$20,000-$29,999	111	5%
$30,000-$39,999	265	13%
$40,000-$49,999	540	26%
$50,000-$59,999	556	26%
$60,000-$69,999	309	15%
$70,000-$79,999	161	8%
$80,000-$89,999	52	2%
$90,000-$99,999	14	1%
$100,000 or more	6	0%
Total	**2,119**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Earnings
Median Income: $50k-$60k

Benefits
Employer Health Ins.: 58%
Employer Retirement: 56%

Satisfaction
Satisfied 97%
Very Satisfied: 71%

Job Satisfaction		
Level	**#**	**%**
Very Satisfied	1,757	71%
Somewhat Satisfied	648	26%
Somewhat Dissatisfied	64	3%
Very Dissatisfied	18	1%
Total	**2,488**	**100%**

Source: Va. Healthcare Workforce Data Center

The typical PTA earned between $50,000 and $60,000 in 2014. In addition, among PTAs who received either a wage or a salary at their primary work location, 58% received health insurance and 56% had access to a retirement plan.

Employer-Sponsored Benefits			
Benefit	**#**	**%**	**% of Wage/Salary Employees**
Paid Vacation	1,774	72%	75%
Health Insurance	1,384	56%	58%
Retirement	1,332	54%	56%
Paid Sick Leave	1,325	54%	56%
Dental Insurance	1,308	53%	55%
Group Life Insurance	991	40%	43%
Signing/Retention Bonus	160	7%	6%
Receive At Least One Benefit	**1,947**	**79%**	**81%**

*From any employer at time of survey.

A Closer Look:

Underemployment in Past Year		
In the past year did you . . .?	#	%
Experience Involuntary Unemployment?	76	3%
Experience Voluntary Unemployment?	116	4%
Work Part-time or temporary positions, but would have preferred a full-time/permanent position?	167	6%
Work two or more positions at the same time?	506	19%
Switch employers or practices?	264	10%
Experienced at least 1	856	32%

Source: Va. Healthcare Workforce Data Center

Only 3% of Virginia's PTAs experienced involuntary unemployment at some point in 2014. By comparison, Virginia's average monthly unemployment rate was 5.2%.[1]

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at this Location	64	3%	85	12%
Less than 6 Months	147	6%	117	16%
6 Months to 1 Year	269	11%	106	15%
1 to 2 Years	598	24%	159	22%
3 to 5 Years	571	23%	133	18%
6 to 10 Years	413	17%	78	11%
More than 10 Years	419	17%	52	7%
Subtotal	2,481	100%	731	100%
Did not have location	33		1,931	
Item Missing	181		34	
Total	2,695		2,695	

Source: Va. Healthcare Workforce Data Center

Three-quarters of all PTAs receive an hourly wage at their primary work location, while 16% receive a salary or commission.

At a Glance:

Unemployment Experience 2014

Involuntarily Unemployed: 3%
Underemployed: 6%

Turnover & Tenure

Switched Jobs: 10%
New Location: 26%
Over 2 years: 57%
Over 2 yrs, 2nd location: 36%

Employment Type

Hourly Wage: 75%
Salary/Commission: 16%

Source: Va. Healthcare Workforce Data Center

57% of PTAs have worked at their primary location for more than 2 years—the job tenure normally required to get a conventional mortgage loan.

Employment Type		
Primary Work Site	#	%
Salary/ Commission	325	16%
Hourly Wage	1,562	75%
By Contract	175	8%
Business/ Practice Income	14	1%
Unpaid	4	0%
Subtotal	2,080	100%

Source: Va. Healthcare Workforce Data Center

[1] As reported by the US Bureau of Labor Statistics. The not seasonally adjusted monthly unemployment rate ranged from 5.6% in January/February to 4.5% in December.

At a Glance:

Concentration

Top Region:	24%
Top 3 Regions:	60%
Lowest Region:	2%

Locations

2 or more (2014):	30%
2 or more (Now*):	27%

Source: Va. Healthcare Workforce Data Center

60% of all PTAs work in one of three regions of the state: Hampton Roads, Northern Virginia, and West Central Virginia.

A Closer Look:

Regional Distribution of Work Locations				
COVF Region	Primary Location		Secondary Location	
	#	%	#	%
Central	314	13%	104	14%
Eastern	48	2%	19	3%
Hampton Roads	582	24%	155	21%
Northern	477	19%	138	18%
Southside	157	6%	35	5%
Southwest	307	12%	89	12%
Valley	148	6%	45	6%
West Central	414	17%	141	19%
Virginia Border State/DC	4	0%	2	0%
Other US State	23	1%	21	3%
Outside of the US	0	0%	1	0%
Total	2,474	100%	750	100%
Item Missing	189		16	

Source: Va. Healthcare Workforce Data Center

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Number of Work Locations				
Locations	Work Locations in 2014		Work Locations Now*	
	#	%	#	%
0	26	1%	61	2%
1	1,710	69%	1,759	71%
2	360	14%	371	15%
3	296	12%	254	10%
4	35	1%	20	1%
5	20	1%	8	0%
6 or More	45	2%	18	1%
Total	2,491	100%	2,491	100%

*At the time of survey completion, December 2014.

Source: Va. Healthcare Workforce Data Center

27% of all PTAs currently have multiple work locations, while 30% of PTAs have had at least two work locations over the past year.

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	1,738	72%	574	81%
Non-Profit	517	21%	101	14%
State/Local Government	102	4%	22	3%
Veterans Administration	8	0%	3	0%
U.S. Military	35	1%	5	1%
Other Federal Government	13	1%	3	0%
Total	2,413	100%	708	100%
Did not have location	33		1,931	
Item Missing	248		56	

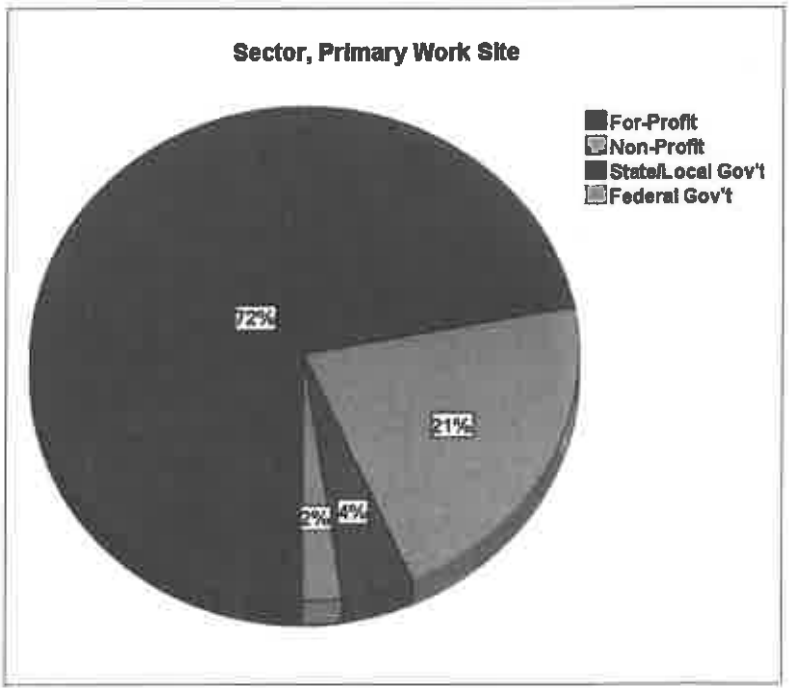
Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Sector
For Profit: 72%
Federal: 2%

Top Establishments
Skilled Nursing Facility: 27%
Home Health Care: 19%
Outpatient Rehab.: 15%

More than 90% of all PTAs work in the private sector, including 72% who work for at for-profit establishments. Another 4% of Virginia's PTA workforce also worked for either state or local governments.



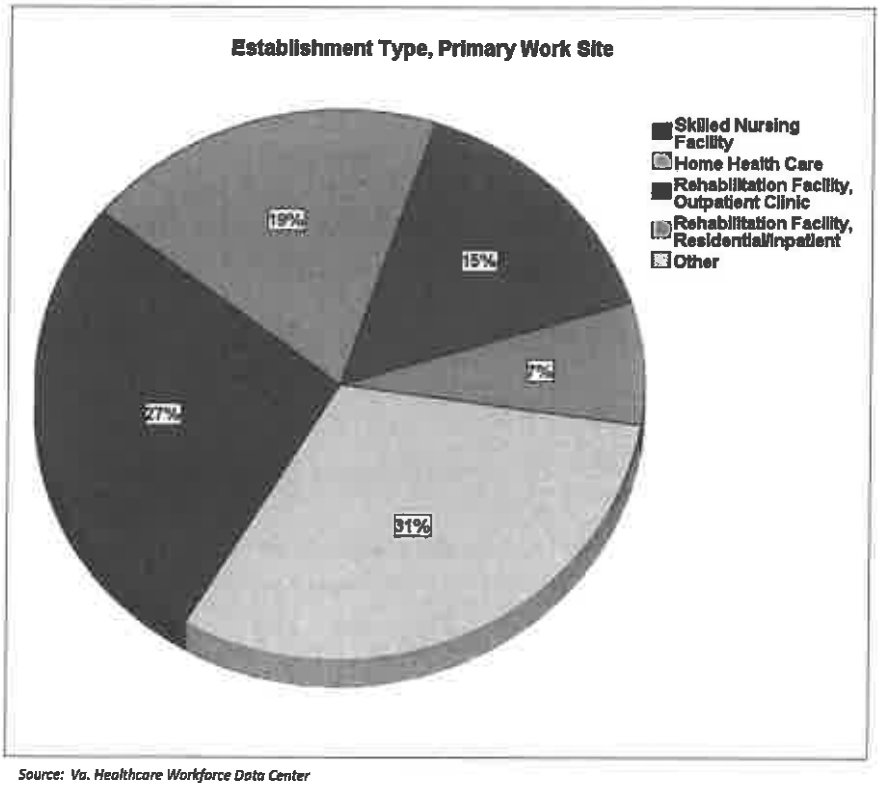
Source: Va. Healthcare Workforce Data Center

Establishment Type	Location Type			
	Primary Location		Secondary Location	
	#	%	#	%
Skilled Nursing Facility	646	27%	225	33%
Home Health Care	454	19%	164	24%
Rehabilitation Facility, Outpatient Clinic	358	15%	54	8%
Rehabilitation Facility, Residential/Inpatient	169	7%	61	9%
General Hospital, Outpatient Department	134	6%	9	1%
Private Practice, Group	133	6%	36	5%
General Hospital, Inpatient Department	130	6%	43	6%
Assisted Living or Continuing Care Facility	119	5%	51	7%
Private Practice, Solo	73	3%	10	1%
K-12 School System	38	2%	3	0%
Physician Office	33	1%	0	0%
Academic Institution	12	1%	5	1%
Other	58	2%	22	3%
Total	2,357	100%	683	100%
Did Not Have a Location	33		1931	

Source: Va. Healthcare Workforce Data Center

Skilled Nursing Facilities are the most common establishment type among Virginia's PTAs with a primary work location. Home Health Care and Rehabilitation Facilities were also typical primary establishment types.

One-third of all SLPs with a secondary work location were employed at a Skilled Nursing Facility, while nearly one-quarter worked at a Home Health Care establishment.



Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

A Typical PTA's Time

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

Roles

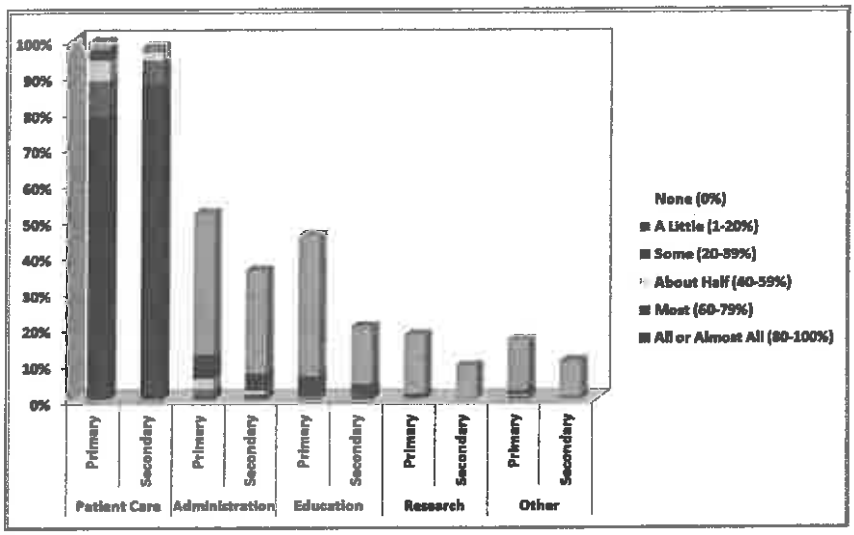
Patient Care:	89%
Administrative:	3%
Other:	1%

Patient Care PTAs

Median Admin Time:	0%
Ave. Admin Time:	1%-9%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

The typical PTA spends nearly all of her time in patient care activities. In fact, 89% of all PTAs fill a patient care role, defined as spending at least 60% of her time in that activity. The typical PTA also usually spends a small amount of time performing administrative duties during the course of her day.

Time Allocation										
Time Spent	Patient Care		Admin.		Education		Research		Other	
	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site
All or Almost All (80-100%)	79%	87%	1%	1%	0%	1%	0%	0%	0%	0%
Most (60-79%)	10%	7%	2%	0%	0%	0%	0%	0%	0%	0%
About Half (40-59%)	6%	2%	3%	1%	0%	0%	0%	0%	0%	0%
Some (20-39%)	3%	0%	7%	5%	6%	3%	1%	0%	1%	0%
A Little (1-20%)	2%	1%	39%	29%	39%	16%	16%	9%	14%	10%
None (0%)	1%	2%	48%	64%	54%	80%	82%	91%	84%	89%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All PTAs		PTAs over 50	
	#	%	#	%
Under age 50	80	4%	-	-
50 to 54	127	6%	4	1%
55 to 59	289	13%	49	8%
60 to 64	643	28%	193	31%
65 to 69	732	32%	250	40%
70 to 74	193	9%	75	12%
75 to 79	34	2%	9	1%
80 or over	21	1%	4	1%
I do not intend to retire	142	6%	47	7%
Total	2,263	100%	631	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All PTAs

Under 65:	50%
Under 60:	22%

PTAs 50 and over

Under 65:	39%
Under 60:	8%

Time until Retirement

Within 2 years:	2%
Within 10 years:	14%
Half the workforce:	by 2039

Source: Va. Healthcare Workforce Data Center

One-half of all PTAs expect to retire before the age of 65, while 17% plan on working until at least age 70. Among PTAs who are age 50 and over, 39% still expect to retire by age 65, while 21% plan on working until at least age 70.

Within the next two years, just 1% of Virginia's PTAs expect to leave the profession and 4% plan on leaving the state. Meanwhile, 27% of PTAs plan on pursing additional educational opportunities, and 15% also plan to increase patient care hours.

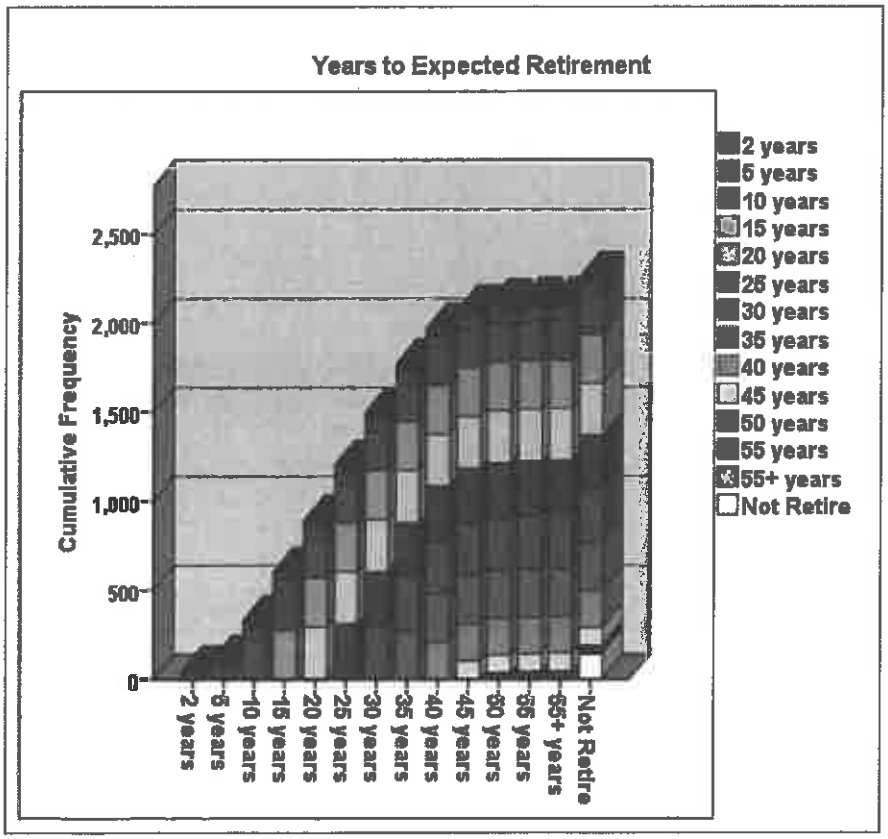
Future Plans		
1 Year Plans:	#	%
Decrease Participation		
Leave Profession	31	1%
Leave Virginia	105	4%
Decrease Patient Care Hours	140	5%
Decrease Teaching Hours	10	0%
Increase Participation		
Increase Patient Care Hours	402	15%
Increase Teaching Hours	253	9%
Pursue Additional Education	728	27%
Return to Virginia's Workforce	21	1%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for PTAs. Only 2% of PTAs expect to retire within the next two years, while 14% plan on retiring in the next ten years. Half of the current PTA workforce expects to be retired by 2039.

Time to Retirement			
Expect to retire within. . .	#	%	Cumulative %
2 years	44	2%	2%
5 years	65	3%	5%
10 years	217	10%	14%
15 years	276	12%	27%
20 years	291	13%	39%
25 years	310	14%	53%
30 years	295	13%	66%
35 years	272	12%	64%
40 years	205	9%	87%
45 years	100	4%	92%
50 years	32	1%	93%
55 years	8	0%	93%
In more than 55 years	5	0%	94%
Do not intend to retire	142	6%	100%
Total	2,263	100%	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Using these estimates, retirements will begin to reach 10% of the current workforce starting in 2024. Retirements will peak at 14% of the current workforce around 2039 before declining to under 10% of the current workforce again around 2054.

At a Glance:

FTEs

Total:	2,264
FTEs/1,000 Residents:	0.274
Average:	0.85

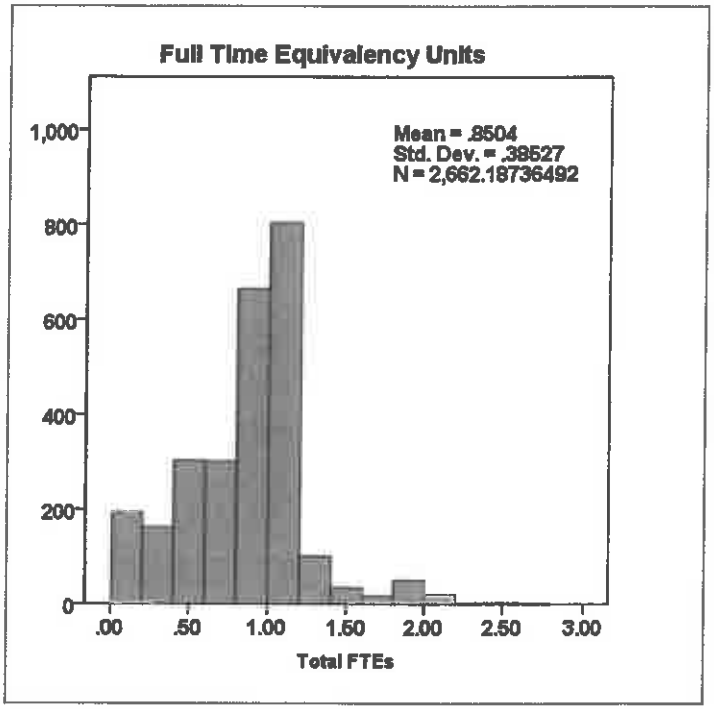
Age & Gender Effect

Age, Partial Eta^2:	Negligible
Gender, Partial Eta^2:	Small

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

Source: Va. Healthcare Workforce Data Center

A Closer Look:

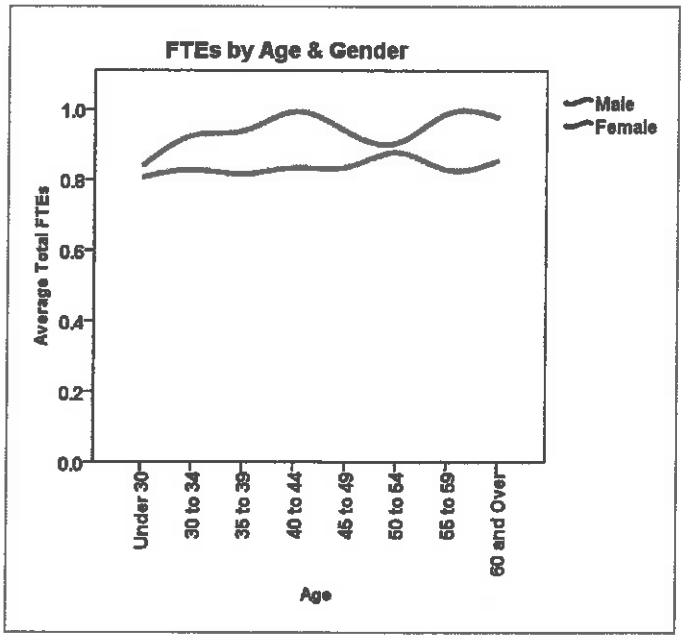


Source: Va. Healthcare Workforce Data Center

The average PTA provided 0.85 FTEs in 2014, or approximately 33 hours per week for 52 weeks. Although FTEs appear to vary by gender, statistical tests did not verify that a difference exists.[2]

Full-Time Equivalency Units		
Age	Average	Median
Age		
Under 30	0.81	0.90
30 to 34	0.86	0.96
35 to 39	0.81	0.89
40 to 44	0.86	0.91
45 to 49	0.84	0.93
50 to 54	0.89	0.96
55 to 59	0.83	0.93
60 and Over	0.97	0.96
Gender		
Male	0.93	0.99
Female	0.83	0.92

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

[2] Due to assumption violations in Mixed between-within ANOVA (Levene's Test was significant).

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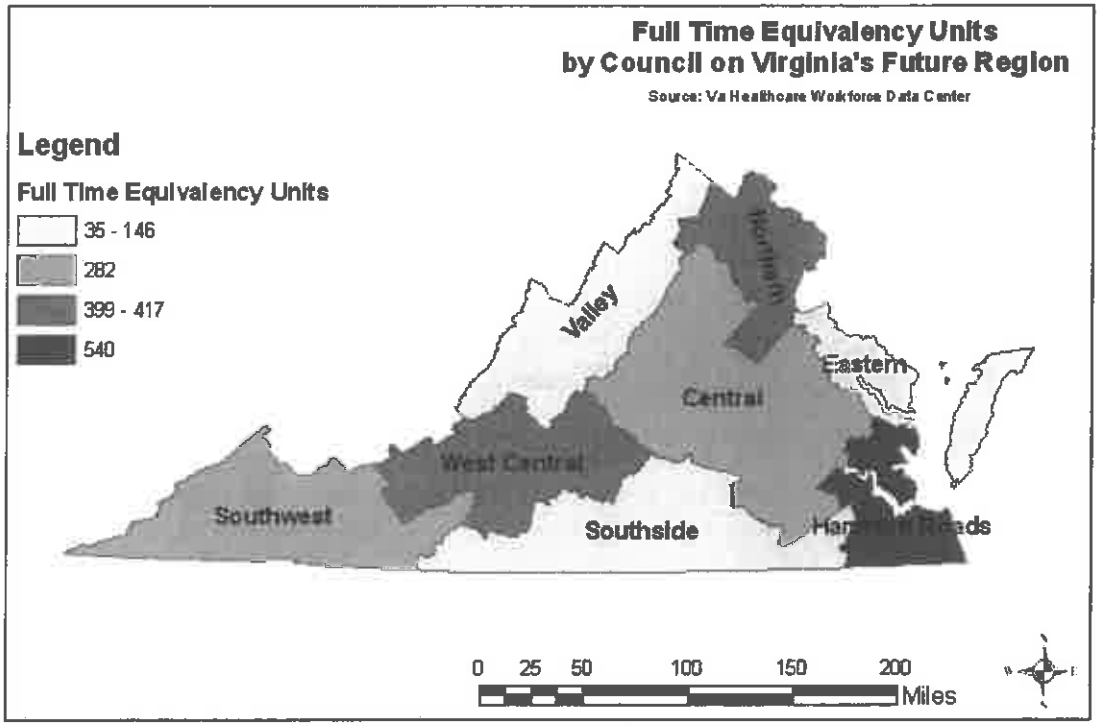
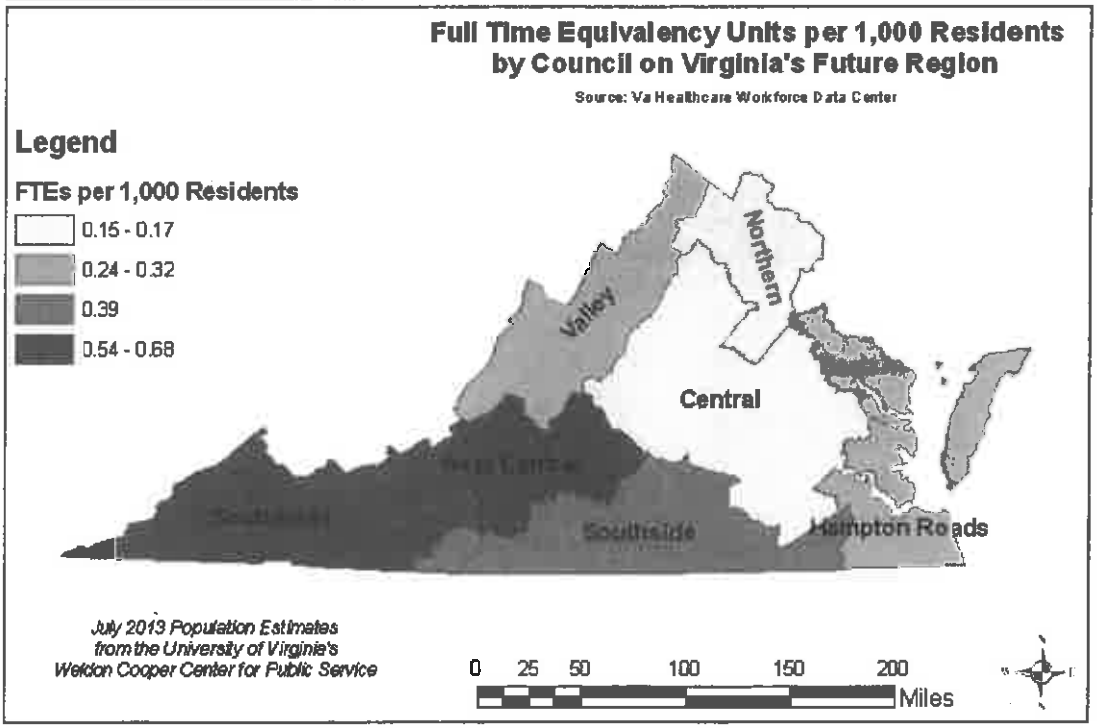
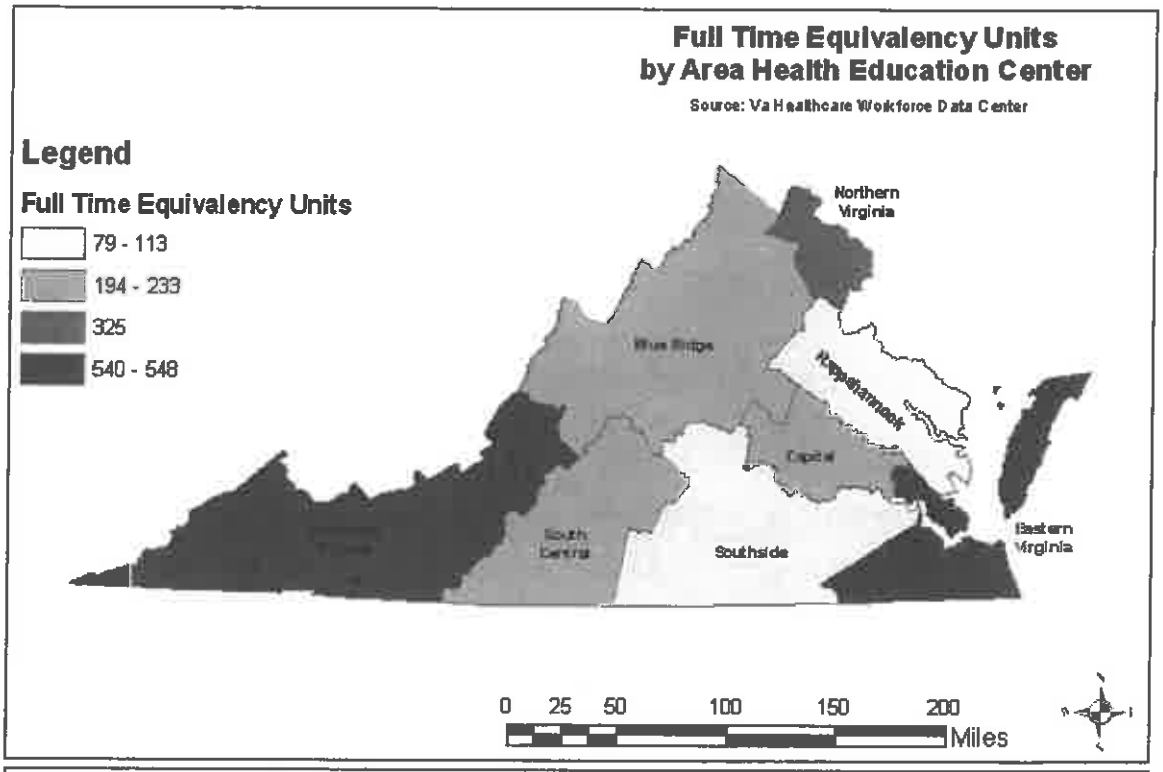
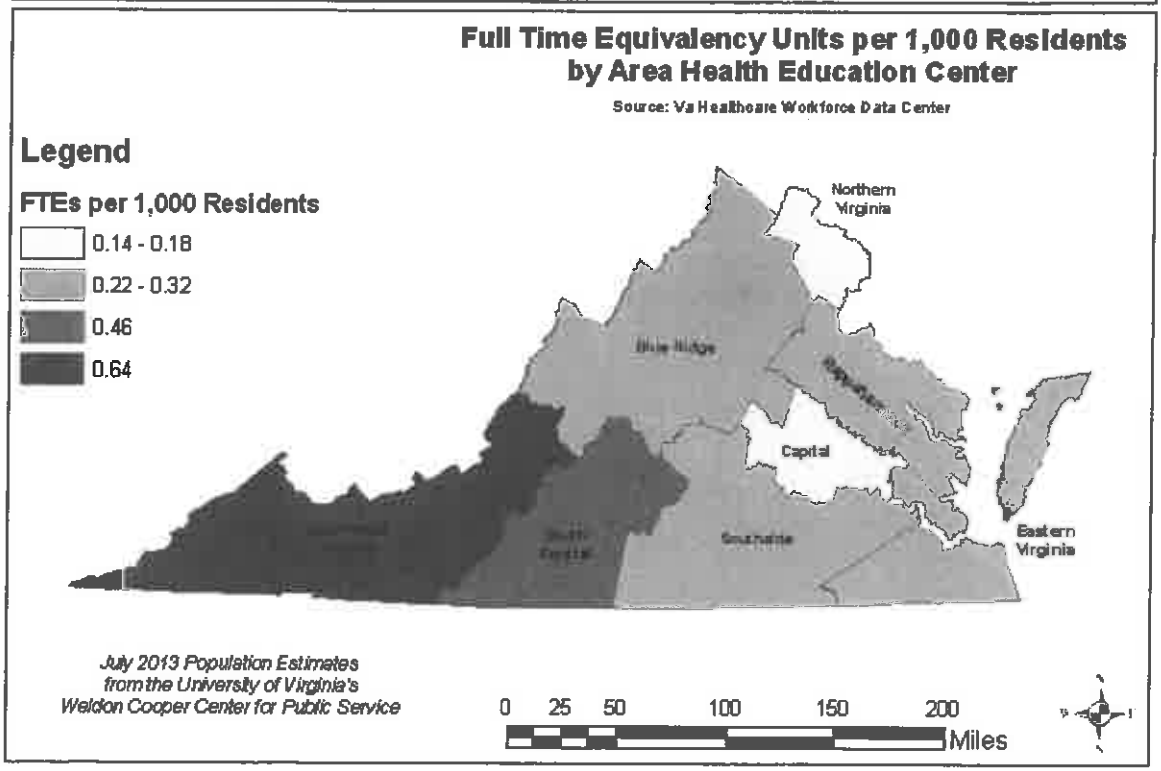
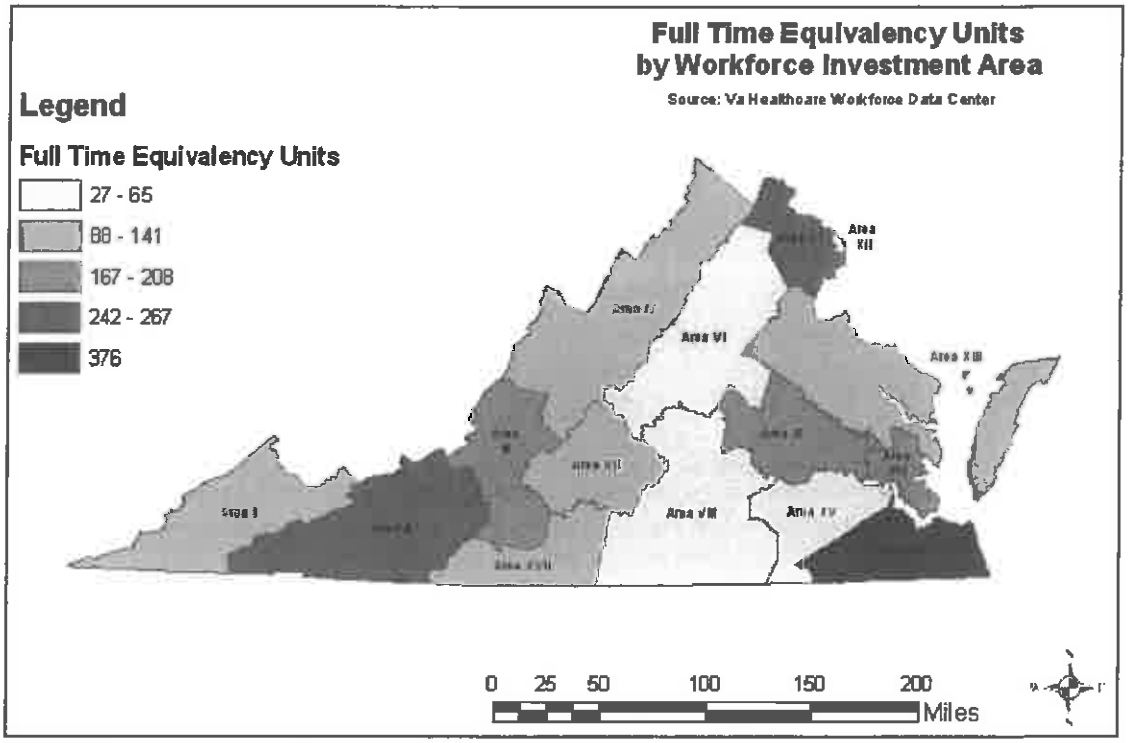
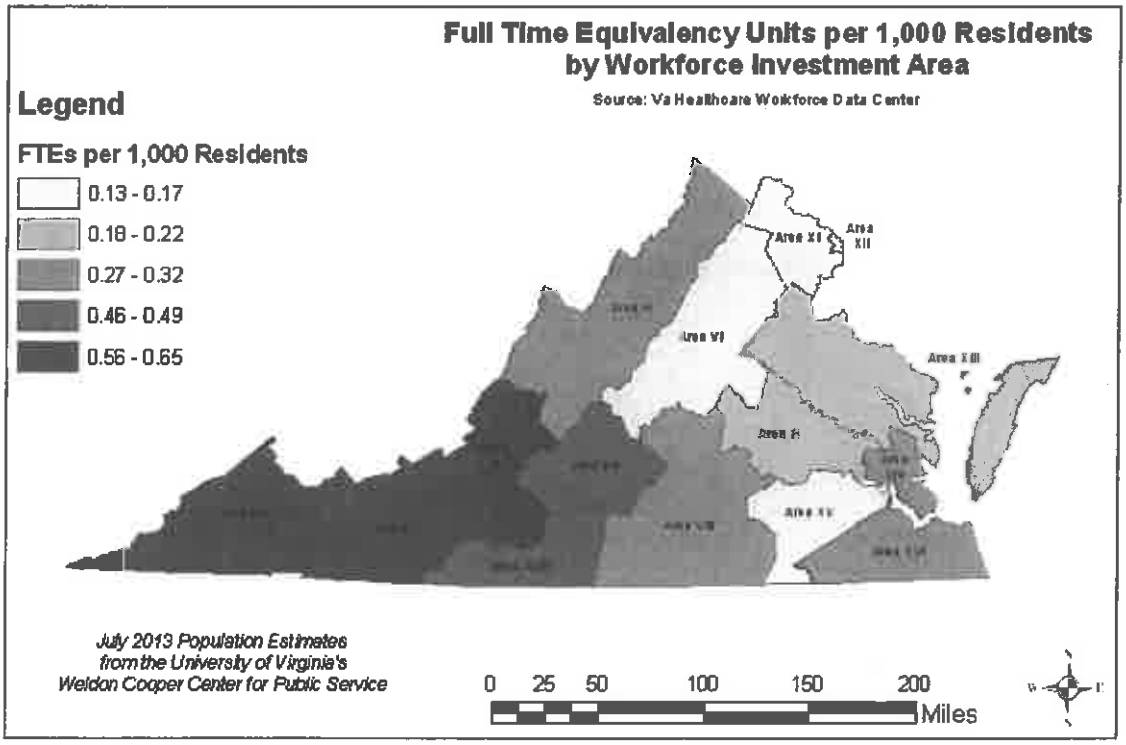


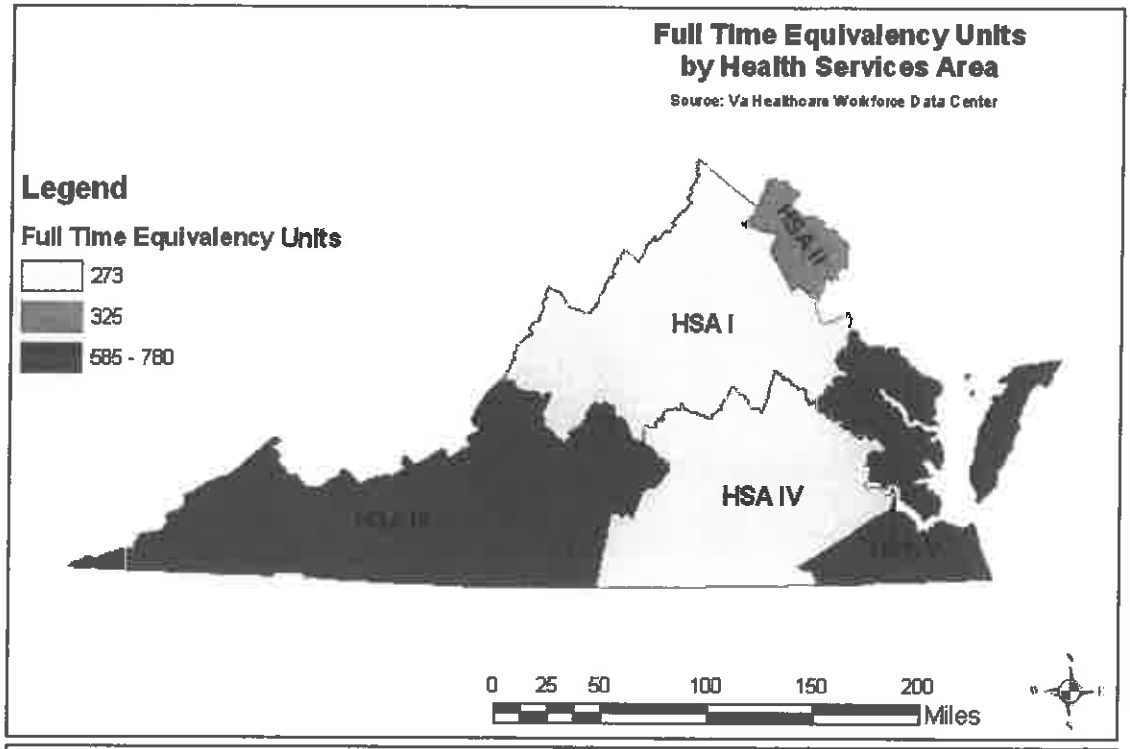


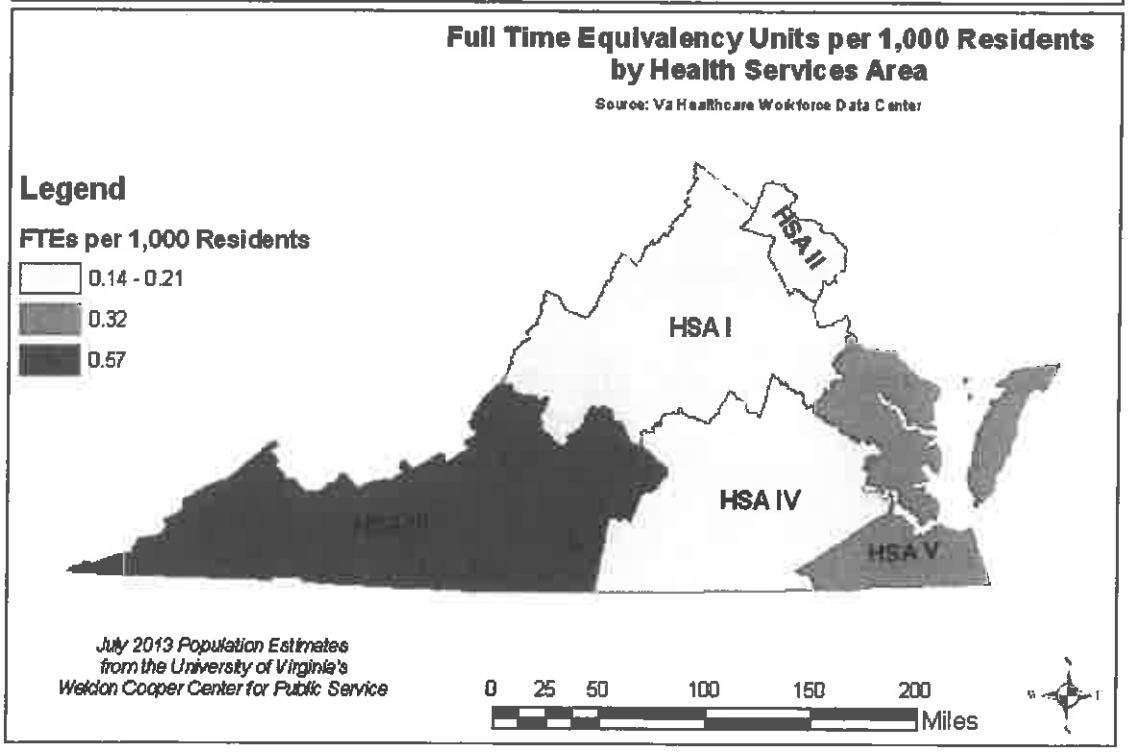

Full Time Equivalency Units
by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
79 - 113
194 - 233
325
540 - 548
Northern Virginia
Blue Ridge
Rappahannock
Capital
South Central
Southside
Eastern Virginia
0 25 50 100 150 200
Miles

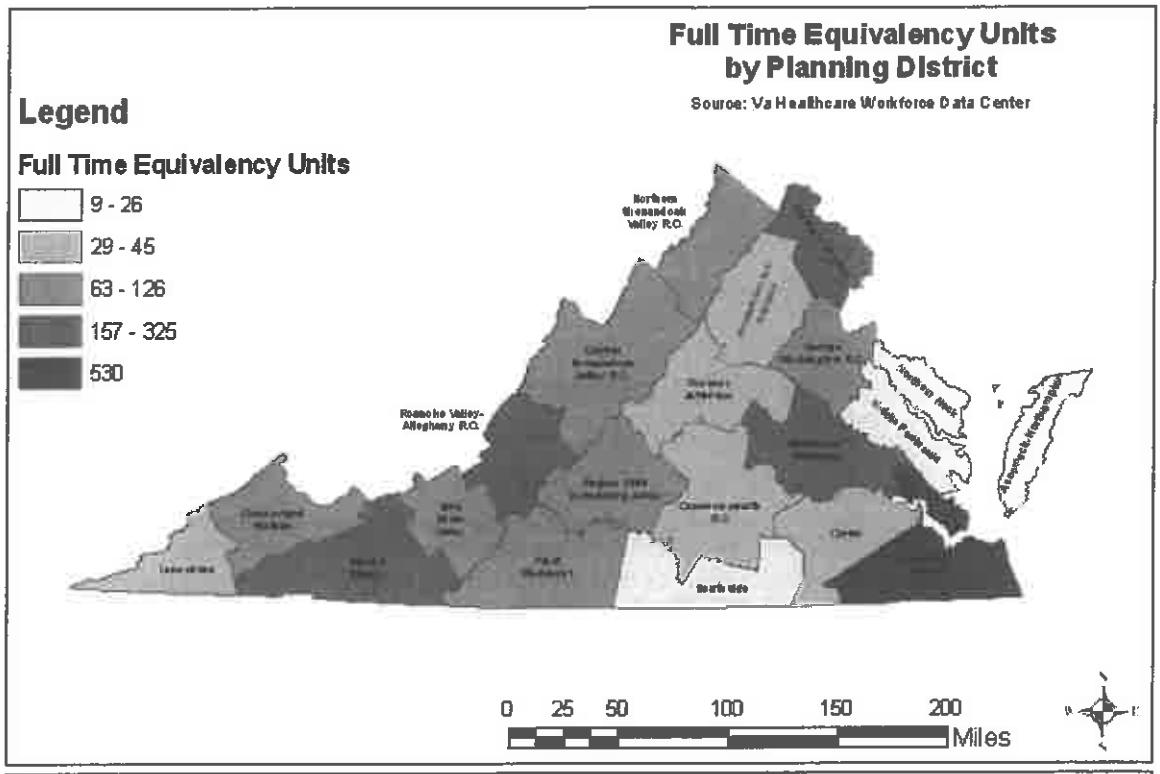

Full Time Equivalency Units per 1,000 Residents
by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.14 - 0.18
0.22 - 0.32
0.46
0.64
Northern Virginia
Blue Ridge
Capital
Eastern Virginia
July 2013 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200
Miles

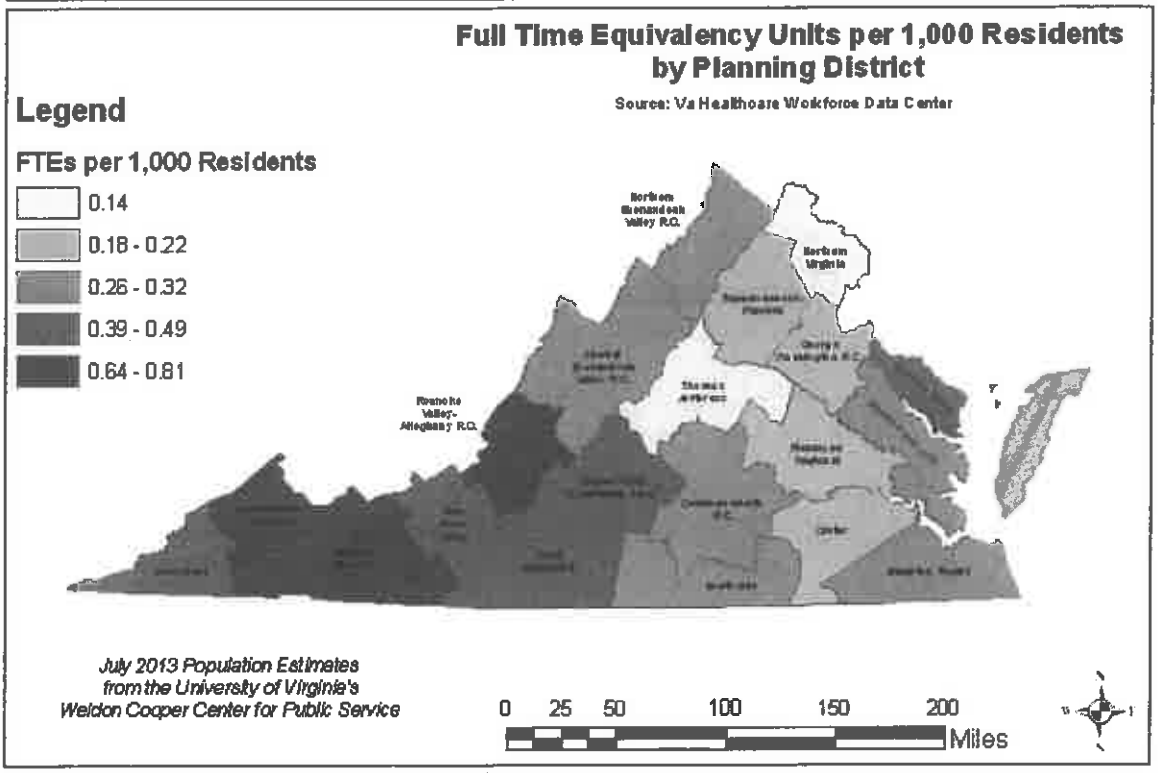

Full Time Equivalency Units
by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
27 - 65
88 - 141
167 - 208
242 - 267
376
Area XII
Area VI
Area XIII
Area VIII
Area IV
0 25 50 100 150 200
Miles


Full Time Equivalency Units per 1,000 Residents
by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.13 - 0.17
0.18 - 0.22
0.27 - 0.32
0.46 - 0.49
0.56 - 0.65
Area XII
Area VI
Area XIII
Area IV
July 2013 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200
Miles


Full Time Equivalency Units
by Health Services Area
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
273
325
585 - 780
HSA II
HSA I
HSA IV
HSA III
HSA V
0 25 50 100 150 200
Miles


Full Time Equivalency Units per 1,000 Residents
by Health Services Area
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.14 - 0.21
0.32
0.57
HSA II
HSA I
HSA IV
HSA III
HSA V
July 2013 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200
Miles


Full Time Equivalency Units
by Planning District
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
9 - 26
29 - 45
63 - 126
157 - 325
530
Northern Shenandoah Valley R.C.
Roanoke Valley-Alleghany R.C.
0 25 50 100 150 200
Miles


Full Time Equivalency Units per 1,000 Residents
by Planning District
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.14
0.18 - 0.22
0.26 - 0.32
0.39 - 0.49
0.64 - 0.81
Northern Shenandoah Valley R.C.
Northern Virginia
Roanoke Valley-Alleghany R.C.
July 2013 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200
Miles

Appendix A: Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min	Max
Metro, 1 million+	1,436	77.65%	1.287892	1.17989	1.557916
Metro, 250,000 to 1 million	409	85.33%	1.17192	1.073643	1.417628
Metro, 250,000 or less	215	80.00%	1.25	1.145176	1.512079
Urban pop 20,000+, Metro adj	65	89.23%	1.12069	1.026709	1.355657
Urban pop 20,000+, nonadj	0	NA	NA	NA	NA
Urban pop, 2,500-19,999, Metro adj	148	83.11%	1.203252	1.102348	1.45553
Urban pop, 2,500-19,999, nonadj	149	87.25%	1.146154	1.050038	1.38646
Rural, Metro adj	67	74.63%	1.34	1.227628	1.620949
Rural, nonadj	42	76.19%	1.3125	1.202434	1.587683
Virginia border state/DC	263	64.26%	1.556213	1.42571	1.882494
Other US State	226	39.38%	2.539326	2.326379	3.07173

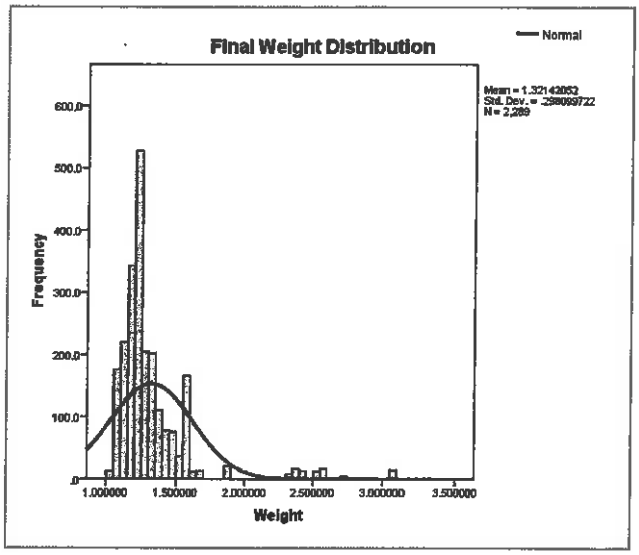
Age	Age Weight			Total Weight	
	#	Rate	Weight	Min	Max
Under 30	462	62.55%	1.598616	1.355657	3.07173
30 to 34	479	74.11%	1.349296	1.144229	2.592663
35 to 39	388	79.12%	1.263844	1.071764	2.428467
40 to 44	429	80.19%	1.247093	1.057559	2.396281
45 to 49	404	80.94%	1.235474	1.047706	2.373955
50 to 54	339	82.60%	1.210714	1.026709	2.326379
55 to 59	296	76.35%	1.309735	1.11068	2.516646
60 and Over	228	70.61%	1.416149	1.200922	2.721121

See the Methods section on the HWDC website for details on HWDC Methods:

Final weights are calculated by multiplying the two weights and the overall response rate:

Age Weight x Rural Weight x Response Rate = Final Weight.

Overall Response Rate: 0.756694



Article 6. Nurse Licensure Compact.

§ 54.1-3030. (For contingent repeal, see Editor's note) Definitions.

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

"Adverse action" means a home or remote state action.

"Alternative program" means a voluntary, non-disciplinary monitoring program approved by a nurse licensing board.

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

"Current significant investigative information" means:

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

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

"Head of the nurse licensing board" means the Executive Director of the Board of Nursing as used to define the compact administrator.

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

"Home state action" means any administrative, civil, equitable or criminal action permitted by the home state's laws which are imposed on a nurse by the home state's licensing board or other authority including actions against an individual's license such as: revocation, suspension, probation or any other action which affects a nurse's authorization to practice.

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

"Multistate licensure privilege" means current, official authority from a remote state permitting the practice of nursing as either a registered nurse or a licensed practical nurse in such party state. All party states have the authority, in accordance with existing state due process law, to take actions against the nurse's privilege such as: revocation, suspension, probation or any other action which affects a nurse's authorization to practice.

Board of Nursing Compact

"Nurse" means a registered nurse or licensed practical nurse, as those terms are defined in § 54.1-3000.

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

"Remote state" means a party state, other than the home state, where the patient is located at the time nursing care is provided, or, in the case of the practice of nursing not involving a patient, in such party state where the recipient of the nursing practice is located.

"Remote state action" means any administrative, civil, equitable or criminal action permitted by a remote state's laws which are imposed on a nurse by the remote state's licensing board or other authority including actions against an individual's multistate licensure privilege to practice in the remote state, and cease and desist and other injunctive or equitable orders issued by remote states or the licensing boards thereof.

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

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

2003, c. 249.

§ 54.1-3031. (For contingent repeal, see Editor's note) Findings and declaration of purpose for compact.

A. The party states find that:

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

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

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

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

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

Board of Nursing Compact

B. The general purposes of this Compact are to:

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

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

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

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

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

2003, c. 249.

§ 54.1-3032. (For contingent repeal, see Editor's note) General provisions and jurisdiction.

A. A license to practice registered nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a multistate licensure privilege to practice as a registered nurse in such party state. A license to practice licensed practical nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a multistate licensure privilege to practice as a licensed practical nurse in such party state. In order to obtain or retain a license, an applicant must meet the home state's qualifications for licensure and license renewal as well as all other applicable state laws.

B. Party states may, in accordance with state due process laws, limit or revoke the multistate licensure privilege of any nurse to practice in their state and may take any other actions under their applicable state laws necessary to protect the health and safety of their citizens. If a party state takes such action, it shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.

C. Every nurse practicing in a party state must comply with the state practice laws of the state in which the patient is located at the time care is rendered. In addition, the practice of nursing is not limited to patient care, but shall include all nursing practice as defined by the state practice laws of a party state. The practice of nursing will subject a nurse to the jurisdiction of the nurse licensing board and the courts, as well as the laws, in that party state.

D. This Compact does not affect additional requirements imposed by states for advanced practice registered nursing. However, a multistate licensure privilege to practice registered nursing granted by a party state shall be recognized by other party states as a license to practice registered nursing if one is required by state law as a precondition for qualifying for advance practice registered nurse authorization.

E. Individuals not residing in a party state shall continue to be able to apply for nurse licensure as provided for under the laws of each party state. However, the license granted to these individuals will not be recognized as granting the privilege to practice nursing in any other party state unless explicitly agreed to by that party state.

2003, c. 249.

§ 54.1-3033. (For contingent repeal, see Editor's note) Applications for licensure in a party state.

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

B. A nurse in a party state shall hold licensure in only one party state at a time, issued by the home state.

C. A nurse who intends to change primary state of residence may apply for licensure in the new home state in advance of such change. However, new licenses will not be issued by a party state until after a nurse provides evidence of change in primary state of residence satisfactory to the new home state's licensing board.

D. When a nurse changes primary state of residence by:

1. Moving between two party states, and obtains a license from the new home state, the license from the former home state is no longer valid;

2. Moving from a non-party state to a party state, and obtains a license from the new home state, the individual state license issued by the non-party state is not affected and will remain in full force if so provided by the laws of the non-party state;

3. Moving from a party state to a non-party state, the license issued by the prior home state converts to an individual state license, valid only in the former home state, without the multistate licensure privilege to practice in other party states.

2003, c. 249.

§ 54.1-3034. (For contingent repeal, see Editor's note) Adverse actions.

In addition to the general provisions described in § 54.1-3032, the following provisions apply:

1. The licensing board of a remote state shall promptly report to the administrator of the coordinated licensure information system any remote state actions including the factual and legal basis for such action, if known. The licensing board of a remote state shall also promptly report

any significant current investigative information yet to result in a remote state action. The administrator of the coordinated licensure information system shall promptly notify the home state of any such reports.

2. The licensing board of a party state shall have the authority to complete any pending investigations for a nurse who changes primary state of residence during the course of such investigations. It shall also have the authority to take appropriate actions, and shall promptly report the conclusions of such investigations to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any such actions.

3. A remote state may take adverse action affecting the multistate licensure privilege to practice within that party state. However, only the home state shall have the power to impose adverse action against the license issued by the home state.

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

5. The home state may take adverse action based on the factual findings of the remote state, so long as each state follows its own procedures for imposing such adverse action.

6. Nothing in this Compact shall override a party state's decision that participation in an alternative program may be used in lieu of licensure action and that such participation shall remain non-public if required by the party state's laws. Party states must require nurses who enter any alternative programs to agree not to practice in any other party state during the term of the alternative program without prior authorization from such other party state.

2003, c. 249.

§ 54.1-3035. (For contingent repeal, see Editor's note) Additional authorities invested in party state nursing licensing boards.

Notwithstanding any other powers, party state nurse licensing boards shall have the authority to:

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

2. Issue subpoenas for both hearings and investigations which require the attendance and testimony of witnesses, and the production of evidence. Subpoenas issued by a nurse licensing board in a party state for the attendance and testimony of witnesses, and/or the production of evidence from another party state, shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel

expenses, mileage and other fees required by the service statutes of the state where the witnesses and/or evidence are located;

3. Issue cease and desist orders to limit or revoke a nurse's authority to practice in their state; and

4. Promulgate uniform rules and regulations as provided for in subsection C of § 54.1-3037.

2003, c. 249.

§ 54.1-3036. (For contingent repeal, see Editor's note) Coordinated licensure information system.

A. All party states shall participate in a cooperative effort to create a coordinated database of all licensed registered nurses and licensed practical nurses. This system will include information on the licensure and disciplinary history of each nurse, as contributed by party states, to assist in the coordination of nurse licensure and enforcement efforts.

B. Notwithstanding any other provision of law, all party states' licensing boards shall promptly report adverse actions, actions against multistate licensure privileges, any current significant investigative information yet to result in adverse action, denials of applications, and the reasons for such denials, to the coordinated licensure information system.

C. Current significant investigative information shall be transmitted through the coordinated licensure information system only to party state licensing boards.

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

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

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

G. The Compact administrators, acting jointly with each other and in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection and exchange of information under this Compact.

2003, c. 249.

Board of Nursing Compact

§ 54.1-3037. (For contingent repeal, see Editor's note) Compact administration and interchange of information.

A. The head of the nurse licensing board, or his designee, of each party state shall be the administrator of this Compact for his state.

B. The Compact administrator of each party state shall furnish to the Compact administrator of each other party state any information and documents including, but not limited to, a uniform data set of investigations, identifying information, licensure data, and disclosable alternative program participation information to facilitate the administration of this Compact.

C. Compact administrators shall have the authority to develop uniform rules to facilitate and coordinate implementation of this Compact. These uniform rules shall be adopted by party states, under the authority invested by subdivision 4 of § 54.1-3035.

2003, c. 249.

§ 54.1-3038. (For contingent repeal, see Editor's note) Immunity.

No party state or the officers or employees or agents of a party state's nurse licensing board who act in accordance with the provisions of this Compact shall be liable on account of any act or omission in good faith while engaged in the performance of their duties under this Compact. Good faith in this article shall not include willful misconduct, gross negligence, or recklessness.

2003, c. 249.

§ 54.1-3039. (For contingent repeal, see Editor's note) Entry into force, withdrawal and amendment.

A. This Compact shall enter into force and become effective as to any state when it has been enacted into the laws of that state. Any party state may withdraw from this Compact by enacting a statute repealing the same, but no such withdrawal shall take effect until six months after the withdrawing state has given notice of the withdrawal to the executive heads of all other party states.

B. No withdrawal shall affect the validity or applicability by the licensing boards of states remaining party to the Compact of any report of adverse action occurring prior to the withdrawal.

C. Nothing contained in this Compact shall be construed to invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a non-party state that is made in accordance with the other provisions of this Compact.

D. This Compact may be amended by the party states. No amendment to this Compact shall become effective and binding upon the party states unless and until it is enacted into the laws of all party states.

2003, c. 249.

§ 54.1-3040. (For contingent repeal, see Editor's note) Construction and severability.

A. This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is declared to be contrary to the constitution of any party state or of the United States or the applicability thereof to any government, agency, person or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person or circumstance shall not be affected thereby. If this Compact shall be held contrary to the constitution of any state party thereto, the Compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

B. In the event party states find a need for settling disputes arising under this Compact:

1. The party states may submit the issues in dispute to an arbitration panel which will be comprised of an individual appointed by the Compact administrator in the home state; an individual appointed by the Compact administrator in the remote state(s) involved; and an individual mutually agreed upon by the Compact administrators of all the party states involved in the dispute.

2. The decision of a majority of the arbitrators shall be final and binding.

2003, c. 249.

Article 6.1. Nurse Licensure Compact.

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

A. The party states find that:

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

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

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

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

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

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

B. The general purposes of this Compact are to:

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

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

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

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

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

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

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

2016, c. 108.

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

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

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

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

"Coordinated licensure information system" means an integrated process for collecting, storing, and sharing information on nurse licensure and enforcement activities related to nurse licensure

laws that is administered by a nonprofit organization composed of and controlled by licensing boards.

"Current significant investigative information" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

2016, c. 108.

Board of Nursing Compact

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

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

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

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

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

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

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

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

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

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

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

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

9. Is not currently enrolled in an alternative program;

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

11. Has a valid United States social security number.

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

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

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

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

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

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

2016, c. 108.

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

Board of Nursing Compact

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

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

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

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

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

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

2016, c. 108.

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

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

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

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

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

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

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

4. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses, as well as the production of evidence. Subpoenas issued by a licensing board in a party state for the attendance and testimony of witnesses or the production of evidence from another party state shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state in which the witnesses or evidence are located.

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

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

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

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

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

2016, c. 108.

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

A. All party states shall participate in a coordinated licensure information system of all licensed registered nurses (RNs) and licensed practical/vocational nurses (LPNs/VNs). This system will

include information on the licensure and disciplinary history of each nurse, as submitted by party states, to assist in the coordination of nurse licensure and enforcement efforts.

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

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

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

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

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

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

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

1. Identifying information;

2. Licensure data;

3. Information related to alternative program participation; and

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

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

Board of Nursing Compact

2016, c. 108.

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

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

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

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

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

B. Membership, voting, and meetings.

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

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

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

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

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

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

b. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation;

d. Negotiation of contracts for the purchase or sale of goods, services, or real estate;

e. Accusing any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigatory records compiled for law-enforcement purposes;

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

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

6. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.

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

1. Establishing the fiscal year of the Commission;

2. Providing reasonable standards and procedures:

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

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

3. Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings, and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the administrators vote to close a meeting in whole or in part. As soon as practicable, the Commission must make public a

copy of the vote to close the meeting revealing the vote of each administrator, with no proxy votes allowed;

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

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

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

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

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

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

G. The Commission shall have the following powers:

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

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

3. To purchase and maintain insurance and bonds;

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

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

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

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

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

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

10. To establish a budget and make expenditures;

11. To borrow money;

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

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

14. To adopt and use an official seal; and

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

H. Financing of the Commission.

1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

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

3. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same, nor shall the Commission pledge the credit of any of the party states, except by, and with the authority of, such party state.

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

Board of Nursing Compact

I. Qualified immunity, defense, and indemnification.

1. The administrators, officers, executive director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of Commission employment, duties or responsibilities, provided that nothing in this subdivision shall be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional, willful, or wanton misconduct of that person.

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

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

2016, c. 108.

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

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

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

C. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least sixty (60) days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a notice of proposed rulemaking:

1. On the website of the Commission; and

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

D. The notice of proposed rulemaking shall include:

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

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

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

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

E. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

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

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

1. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing. All hearings will be recorded, and a copy will be made available upon request.

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

H. If no one appears at the public hearing, the Commission may proceed with promulgation of the proposed rule.

I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

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

K. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in this Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the

effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

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

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

3. Meet a deadline for the promulgation of an administrative rule that is required by federal law or rule.

L. The Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing, and delivered to the Commission, prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

2016, c. 108.

§ 54.1-3040.9. (Contingent effective date -- see note) Oversight, dispute resolution, and enforcement.

A. Oversight.

1. Each party state shall enforce this Compact and take all actions necessary and appropriate to effectuate this Compact's purposes and intent.

2. The Commission shall be entitled to receive service of process in any proceeding that may affect the powers, responsibilities, or actions of the Commission and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process in such proceeding to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

B. Default, technical assistance and termination.

1. If the Commission determines that a party state has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other party states of the nature of the default, the proposed means of curing the default, or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to cure the default, the defaulting state's membership in this Compact may be terminated upon an affirmative vote of a majority of the administrators, and all rights, privileges, and benefits conferred by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

3. Termination of membership in this Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor of the defaulting state and to the executive officer of the defaulting state's licensing board and to each of the party states.

4. A state whose membership in this Compact has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

5. The Commission shall not bear any costs related to a state that is found to be in default or whose membership in this Compact has been terminated unless agreed upon in writing between the Commission and the defaulting state.

6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district in which the Commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorney fees.

C. Dispute resolution.

1. Upon request by a party state, the Commission shall attempt to resolve disputes related to the Compact that arise among party states and between party and non-party states.

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

3. In the event the Commission cannot resolve disputes among party states arising under this Compact:

a. The party states may submit the issues in dispute to an arbitration panel, which will be comprised of individuals appointed by the Compact administrator in each of the affected party states and an individual mutually agreed upon by the Compact administrators of all the party states involved in the dispute.

b. The decision of a majority of the arbitrators shall be final and binding.

D. Enforcement.

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

2. By majority vote, the Commission may initiate legal action in the U.S. District Court for the District of Columbia or the federal district in which the Commission has its principal offices against a party state that is in default to enforce compliance with the provisions of this Compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney fees.

3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

2016, c. 108.

§ 54.1-3040.10. (Contingent effective date -- see note) Effective date, withdrawal, and amendment.

A. This Compact shall become effective and binding on the earlier of the date of legislative enactment of this Compact into law by no less than twenty-six (26) states or December 31, 2018. All party states to this Compact that also were parties to the prior Nurse Licensure Compact (Prior Compact) superseded by this Compact shall be deemed to have withdrawn from said Prior Compact within six (6) months after the effective date of this Compact.

B. Each party state to this Compact shall continue to recognize a nurse's multistate licensure privilege to practice in that party state issued under the Prior Compact until such party state has withdrawn from the Prior Compact.

C. Any party state may withdraw from this Compact by enacting a statute repealing the same. A party state's withdrawal shall not take effect until six (6) months after enactment of the repealing statute.

D. A party state's withdrawal or termination shall not affect the continuing requirement of the withdrawing or terminated state's licensing board to report adverse actions and significant investigations occurring prior to the effective date of such withdrawal or termination.

E. Nothing contained in this Compact shall be construed to invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a non-party state that is made in accordance with the other provisions of this Compact.

F. This Compact may be amended by the party states. No amendment to this Compact shall become effective and binding upon the party states unless and until it is enacted into the laws of all party states.

G. Representatives of non-party states to this Compact shall be invited to participate in the activities of the Commission, on a nonvoting basis, prior to the adoption of this Compact by all states.

2016, c. 108.

Board of Nursing Compact

§ 54.1-3040.11. (Contingent effective date -- see note) Construction and severability.

This Compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this Compact shall be severable, and if any phrase, clause, sentence, or provision of this Compact is declared to be contrary to the constitution of any party state or of the United States, or if the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person, or circumstance shall not be affected thereby. If this Compact shall be held to be contrary to the constitution of any party state, this Compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

2016, c. 108.