COMMONWEALTH of VIRGINIA

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TO: The Honorable Ralph S. Northam
Governor of Virginia

The Honorable Mark D. Sickles
Chair, House Committee on Health, Welfare and Institutions

The Honorable L. Louise Lucas
Chair, Senate Committee on Education and Health

The Honorable Patrick A. Hope
Chair, Joint Commission on Health Care

FROM: William L. Harp, M.D.
Executive Director, Board of Medicine

Jay P. Douglas, R.N.
Executive Director, Board of Nursing

DATE: October 29, 2021

RE: **Report on Nurse Practitioners Authorized for Autonomous Practice**

Attached is the report of the Boards on information related to the practice of nurse practitioners without a practice agreement that includes certain data, complaints and disciplinary actions, and recommended modifications pursuant to an enactment clause in Chapter 776 of the 2018 Acts of the Assembly.

Should you have questions about this report, please feel free to contact David Brown, D.C., Director of the Department of Health Professions at david.brown@dhp.virginia.gov or (804) 367-4450, Jay Douglas, R.N., Executive Director of the Board of Nursing at jay.douglas@dhp.virginia.gov or (804) 367-4623, or William Harp, M.D. at william.harp@dhp.virginia.gov or (804) 367-4621.

Virginia Department of Health Professions

REPORT ON THE IMPLEMENTATION OF 2018 HOUSE BILL 793: NURSE PRACTITIONERS; PRACTICE AGREEMENTS

OCTOBER 1, 2021

VIRGINIA BOARDS OF MEDICINE AND NURSING

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VIRGINIA BOARDS OF MEDICINE AND NURSING

Report on the Implementation of 2018 House Bill 793: Nurse Practitioners; practice agreements[1]

I. Executive Summary

House Bill 793 (2018) permitted Licensed Nurse Practitioners, excluding certified nurse midwives, certified registered nurse anesthetists, and clinical nurse specialists, to practice without a practice agreement upon submission of proof of completion of the equivalent of five years of full-time clinical experience (hereafter referred to as Autonomous LNP). This Report is provided to the Virginia General Assembly pursuant to the HB 793 Enactment Clause.

The study period of this Report is February 6, 2019 through June 30, 2021. Of the 1,257 Autonomous LNPs identified, approximately 90% reported primary care and psych/mental health specialties. The geographic distribution of Autonomous NPs is presented by County both in composite and per 1,000 residents. The per capita data (see page 3) suggests that Autonomous NPs provide at least some care in the more underserved areas of the Commonwealth, including the Eastern Shore, Southwest, Northern Neck, Southside, and Shenandoah Valley.

The complaint rate of both Autonomous NPs and physicians is higher compared to other professions regulated by the Department of Health Professions, but the violation rate is lower. The five (5) Autonomous LNP cases involved the inability to safely practice; drug-related, patient care, and criminal activity. These are similar case categories to other nursing and medicine cases.

Finally, the recommendations identified and discussed (but not voted on) by the Committee of the Joint Boards of Nursing and Medicine at its meeting on June 16 were compiled by DHP staff into an initial draft of this Report, which was then provided to the Boards of Nursing and Medicine for consideration at each board's subsequent business meeting.

At its meeting on July 20, 2021, the Board of Nursing approved the Report as written (see page 5). The Executive Committee of the Board of Medicine, at its meeting on August 6, 2021, accepted some but not all of the recommended modification of the Act (see table on page 6).

The key differences between the Board of Nursing and Board of Medicine recommendations are that the Board of Medicine supported continuing to require 5 years of collaboration with a physician before autonomous practice, while the BON supported requiring only 2 years of collaboration, with either a physician or experienced licensed nurse practitioner, or eliminating the practice agreement requirement entirely.

[1] See House Bill 793 for the legislative summary, text, and history of the bill.

II. Background

House Bill 793 (2018) eliminated the requirement for a practice agreement with a patient care team physician for a licensed nurse practitioner ("LNP") who has completed the equivalent of at least five years of full-time clinical experience and submitted an attestation from the patient care team physician. Upon approval by the Board of Nursing, this LNP may practice autonomously (Autonomous LNP). HB793 also required a report from the Boards of Medicine and Nursing as set forth in the enactment clause below:

> ***Enactment Clause from HB793 (2018)***
> ***4. That the Boards of Medicine and Nursing shall report on data on the implementation of this act, including the number of nurse practitioners who have been authorized to practice without a practice agreement, the geographic and specialty areas in which nurse practitioners are practicing without a practice agreement, and any complaints or disciplinary actions taken against such nurse practitioners, along with any recommended modifications to the requirements of this act including any modifications to the clinical experience requirements for practicing without a practice agreement, to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health and the Chairman of the Joint Commission on Health Care by November 1, 2021.***

This Report provides the most recent responsive data available as of June 30, 2021 and the recommended modifications to the clinical experience requirements from the Boards of Medicine and Nursing.

III. Number of Autonomous Licensed Nurse Practitioners ("Autonomous LNP") and Specialty Areas

The first Autonomous LNP designation was issued on February 6, 2019. As of June 30, 2021, there were 1,257 Autonomous LNPs with 1,290 designations. Designations are classified according to specialty area(s); 33 practitioners have two specialty areas. Because of this duplication, the numbers in the table below do not reflect exact numbers of discrete clinicians in the specialty area.

Adult/Geriatric Acute: 97 (7.7%)	Pediatric Acute: ~10 (<1%)
Adult/Geriatric Primary: 144 (11.5%)	Pediatric Primary: 56 (4.5%)
Family: 770 (61.3%)	Psychiatric/Mental: 144 (11.5%)
Neonatal: ~10 (<1%)	Women's Health: 31 (2.5%)

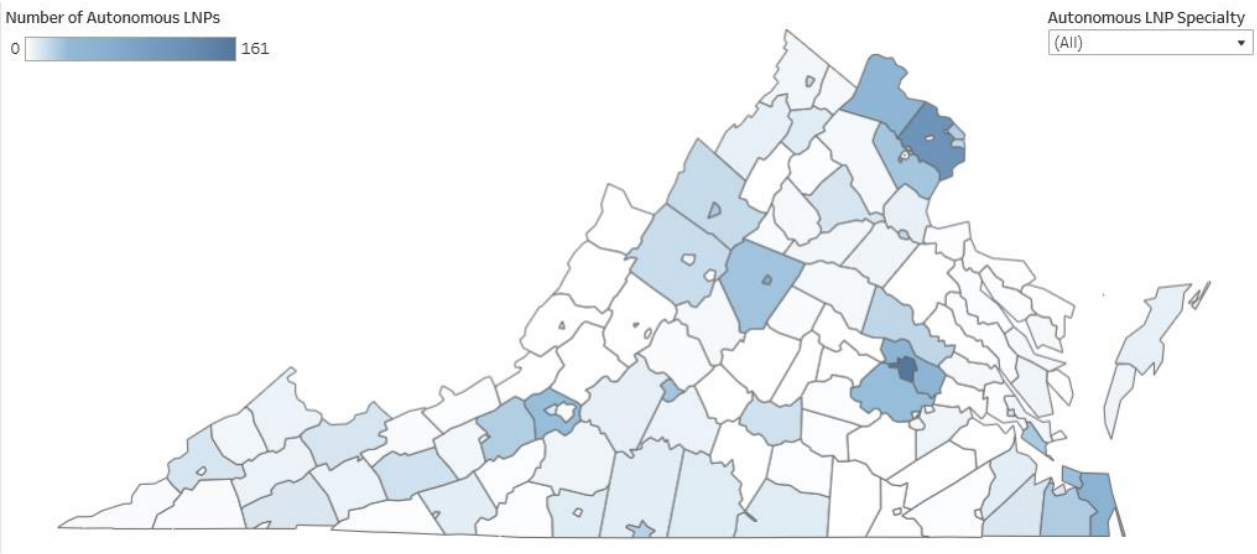
IV. Geographic Distribution of Specialty Areas

A Tableau® interactive data visualization was created to provide insight into the geographic practice specialty distribution of Virginia's Autonomous LNPs. It is posted online and is accessible at: https://public.tableau.com/app/profile/rajana.siva/viz/npspecialtycounts/Story1?publish=yes the user has access to a dropdown menu that enables selection of all or specific specialty areas.

Of the 1,257 Autonomous LNP designations issued as of June 30, 2021, there were 1,132 practice locations identified on the Autonomous LNP designation applications submitted to the Board of Nursing leaving 125 practice locations unidentified. The map and accompanying table automatically populate with data based upon the specialty selection at the time of Autonomous LNP designation application.

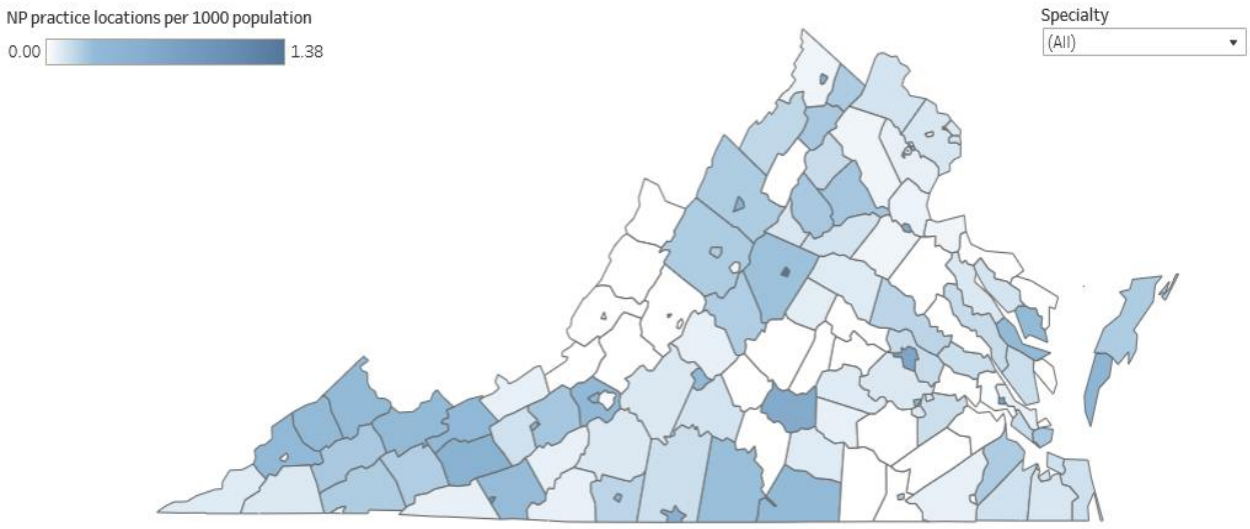
The screen shot below demonstrates the composite geographic distribution of all Autonomous LNP practice locations by County.

Composite Autonomous LNP Practice Locations by County



The screen shot below reflects the geographic distribution of the practice locations per 1000 residents by County represents the availability of Autonomous LNPs to provide care per capita. Appendix 1 includes the maps and tables of each specialty in hardcopy form.

Autonomous LNP Practice Locations per 1,000 Residents/County



When the data on geographic location are presented per capita, it appears that Autonomous NPs provide care in the more underserved areas of the Commonwealth.

V. Complaints and Disciplinary Actions Against Autonomous Nurse Practitioners

To provide information and context on the volume and types of complaints received, DHP staff analyzed DHP's disciplinary case tracking data referencing "Cases Received" for the February 6, 2019 to June 30, 2021 period (similar to the standard measures tracked in the DHP Biennial Report). Additionally, because complaints do not necessarily equate to substantiated misconduct, staff 1) determined the rate of cases closed with a final disposition of violations per 1,000 licensees and 2) analyzed the categories of cases with a violation final disposition to provide additional information on the types of cases involved (See Appendix 2).

For Autonomous LNPs, as noted in the table below, the complaint rate was 87.50 and the violation rate was 3.98. These rates are similar to the rates for physicians where the complaint rate is 92.85 and the violation rate is 3.33. Compared to the rates across all DHP professions, the complaint rate for both Autonomous LNPs and physicians is higher, but the violation rate lower.

Received (within Jurisdiction only)	Closed	Violation	Complaint Rate/1,000 Lic	Violation Rate/ 1,000 Lic	Licensees
110	**77**	**5**	**87.50**	**3.98**	**1257**

Specific Cases

While five cases may not offer enough data to be statistically significant, the cases with a finding of a violation (also termed a "founded" case) against an Autonomous LNP are summarized below. The founded Autonomous LNP cases involve the inability to safely practice; drug-related, patient care, and criminal activity. These are similar case categories to other nursing and medicine cases. (See Appendix 3)

Disciplinary Actions Pertaining to LNPs as of June 30, 2021

A search of *License Lookup* for the period January 1, 2019 to June 30, 2021 revealed public disciplinary records on five (5) individuals:

Respondent A - Family Practice and Authorization to Prescribe. An Order issued December 3, 2020 required participation in the Health Practitioners Monitoring Program.

Respondent B – Adult Acute Geriatric and Authorization to Prescribe. An order issued December 11, 2020 required participation in the Health Practitioners Monitoring Program.

Respondent C – Family Practice and Authorization to Prescribe. An order issued September 13, 2019 rendered a Reprimand for prescribing outside of a bona-fide practitioner-patient relationship and outside of an emergency and failing to document the rationale in the patient's record.

Respondent D – Family Practice and Authorization to Prescribe. An order issued November 20, 2020 rendered a Reprimand and approved course in opiate prescribing regarding a case of continued opiate prescribing for a patient with a history of opioid addiction and noncompliance with pain management. On February 22, 20201, the Board notified the Respondent of compliance with the order.

Respondent E – Family Practice (out of state). Mandatory suspension (§54.1-2409) issued July 21, 2020 for felony criminal conviction for conspiracy to commit Medicaid fraud.

VI. Recommended Modifications to the Requirements of this Act

The Committee of the Joint Boards of Nursing and Medicine ("Committee") met on June 16, 2021 and identified and discussed (but did not vote on) the potential recommendations below. The Board of Medicine and Board of Nursing subsequently met, and each voted on the recommendations:

- Apply existing national data and data to be collected during the DHP study (Budget Amendment – SB1100) on Advanced Practice Registered Nurses ("APRNs") to decisions regarding amending of this Act.
- Adopt the criteria for APRN practice as outlined in the National Council of State Boards of Nursing APRN compact in order to better respond to healthcare needs by increasing access to nurse practitioners across state lines through standardizing APRN scope of practice.

- Collect data on nurse practitioners who have completed two years of clinical experience prior to being permitted to practice without a practice agreement for comparison to the data on those who have completed five years of experience.
- Amend the Act to enable nurse practitioners who hold licenses in both Virginia and another jurisdiction to use attestation of clinical experience in the other jurisdiction for the requisite years to practice without a practice agreement.
- Permit non-autonomous nurse practitioners to establish a practice agreement with an Autonomous LNP.
- Permit a nurse practitioner seeking autonomous practice to document evidence of the duration of clinical practice directly.
- Modify the Act to require two years of clinical experience prior to practicing without a practice agreement.
- Eliminate the practice agreement requirement from the Act entirely.

DHP staff compiled the recommendations from this discussion into modifications of the Act in accordance with the Enactment Clause in the Report. The initial draft of this Report was then provided to the Boards of Nursing and Medicine for consideration at each board's subsequent meeting, the results of which are as follows:

BOARD OF NURSING - At its meeting on July 20, 2021, the Board of Nursing approved the Report as written. It also requested that the per capita data be added to the report and the categories of disciplinary actions be moved to the appendix in the final Report to the General Assembly.

BOARD OF MEDICINE - At its meeting on August 6, 2021, the Executive Committee of the Board of Medicine considered each recommended modification of the Act in the initial draft Report, the results of which are provided in the following table:

Modifications in Draft Report to BON/BOM	BOM Recommendations
• Apply existing national data and data to be collected during the DHP study (Budget Amendment – SB1100) on Advanced Practice Registered Nurses ("APRNs") to decisions regarding amending of this Act.	**Accept, but change "apply" to "consider**". The existing national data may help inform the General Assembly's perspective, but the Virginia data will be most crucial to its decision.
• Adopt the criteria for APRN practice as outlined in the National Council of State Boards of Nursing APRN compact in order to better respond to healthcare needs by increasing access to nurse practitioners across state lines through standardizing APRN scope of practice.	**Accept as presented**. The APRN practice criteria may or may not increase access to care. However, they will facilitate practice across state lines.
• Amend the Act to enable nurse practitioners who hold licenses in both Virginia and another jurisdiction to use attestation of clinical experience in the other jurisdiction for the requisite years to practice without a practice agreement.	**Accept as presented**. Many nurses hold a license in more than one state. It is reasonable that any clinical experience under a practice agreement can be used to fulfill the requisite years of experience.
• Follow the precedent that was set in 2021 legislation regarding licensed nurse practitioners in the category of certified nurse midwives (see §54.1-2957(H)) by providing the option for experienced nurse practitioners to enter into a practice agreement with less experienced nurse practitioners.	**Not accept**. A less experienced nurse practitioner should establish a practice agreement with a physician, not an autonomous NP. There is value in the collaborative team model.
• Permit a licensed nurse practitioner to provide documentary evidence of completion of two years of clinical experience directly to the Boards in lieu of the patient care team physician attestation in order to practice without a practice agreement.	**Accept but remove "two" and replace with "the" before years of service.**
• Collect data on nurse practitioners who have completed two years of clinical experience prior to being permitted to practice without a practice agreement for comparison to the data on those who have completed five years of experience.	**Accept as presented.**
• Modify the Act to require two years of clinical experience prior to practicing without a practice agreement.	**Not accept**. Continue with the 2018 legislation and require 5 years of clinical experience prior to practicing without a practice agreement.
• Eliminate the practice agreement requirement from the Act because 1) a core competency of nurse practitioner education includes collaboration with the patient care team to achieve optimal care outcomes, and 2) disciplinary actions against nurse practitioners who have practiced without a practice agreement identified in this Report did not reveal a greater safety risk to the public.	**Not accept.**

VII. Appendices

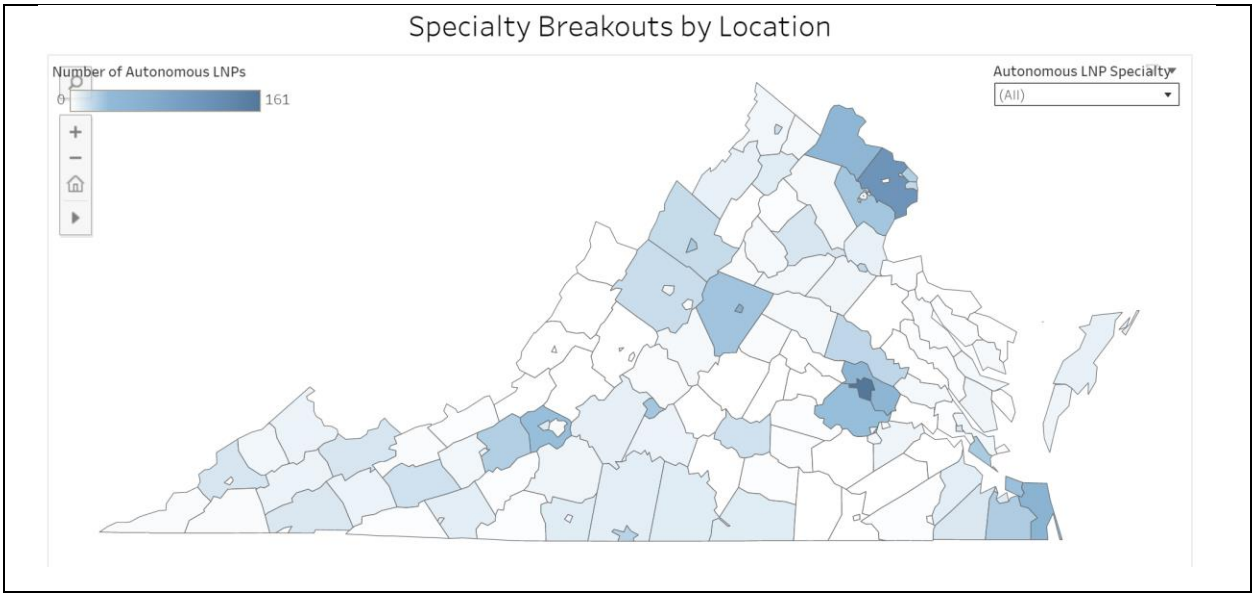
Appendix 1

Autonomous Licensed Nurse Practitioner Practice Locations, Overall and by Specialty

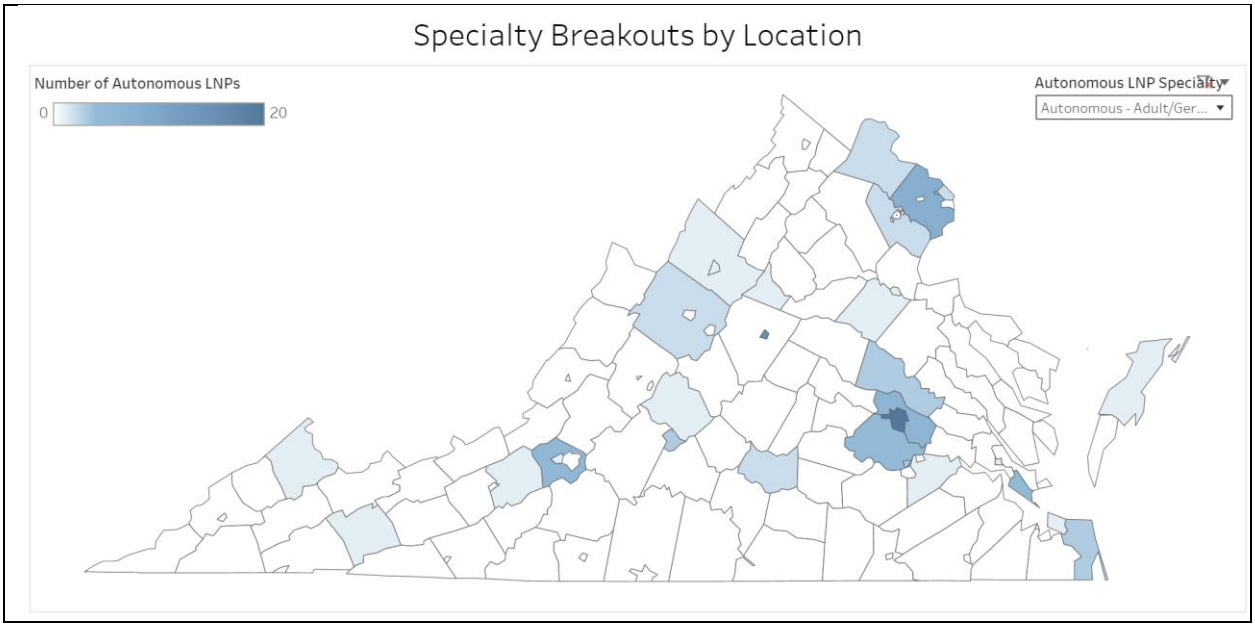
Map Extracts from the online Tableau®

https://public.tableau.com/app/profile/rajana.siva/viz/npspecialtycounts/Dashboard2

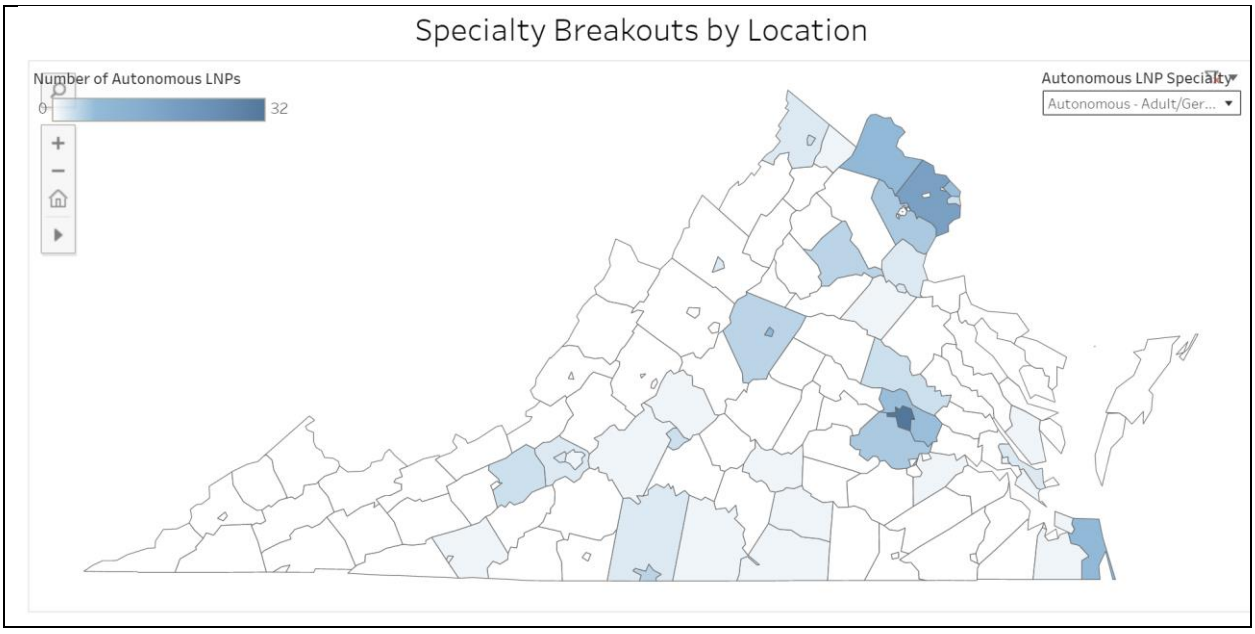
All



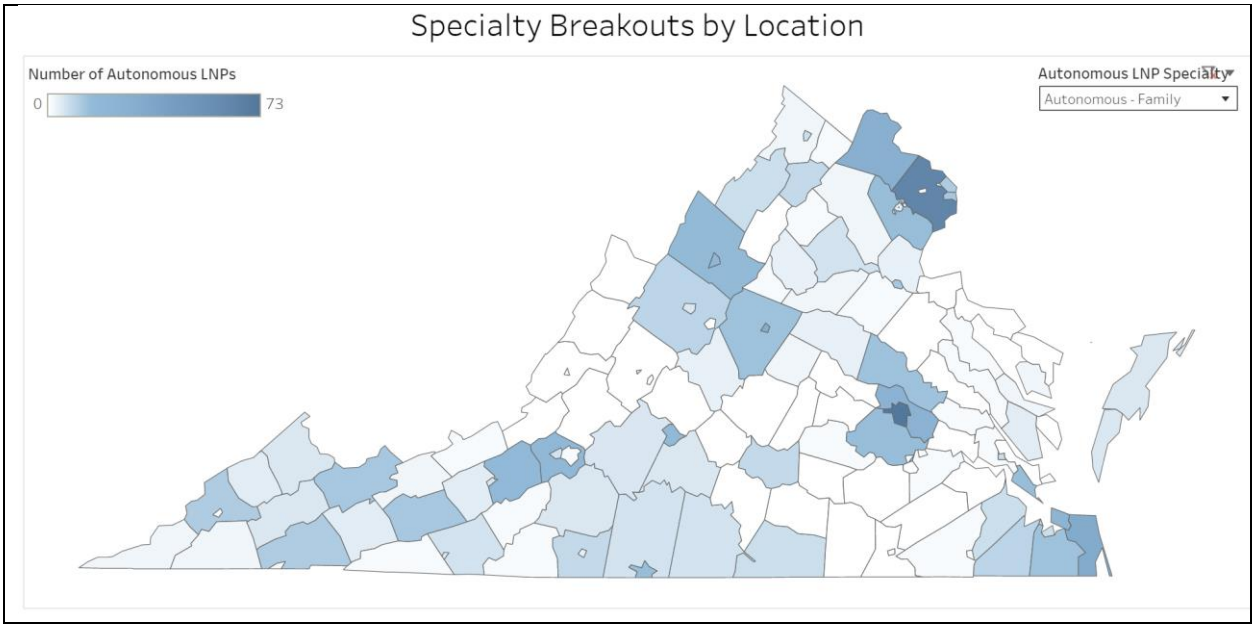
Adult/Geriatric Acute



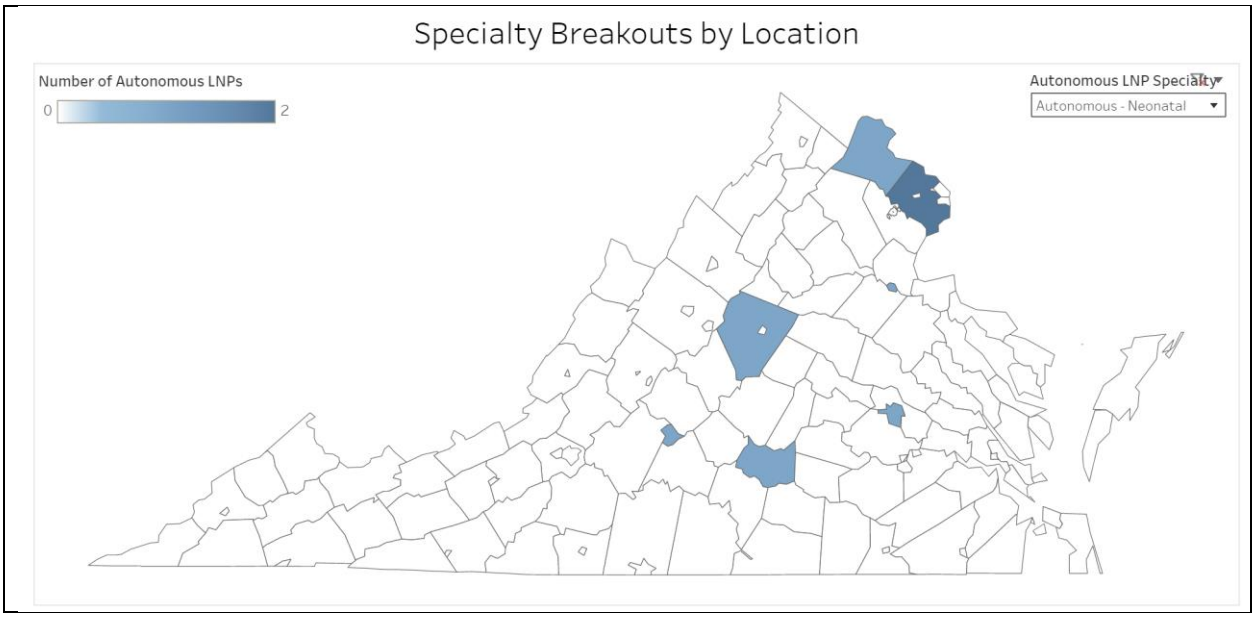
Adult/Geriatric Primary



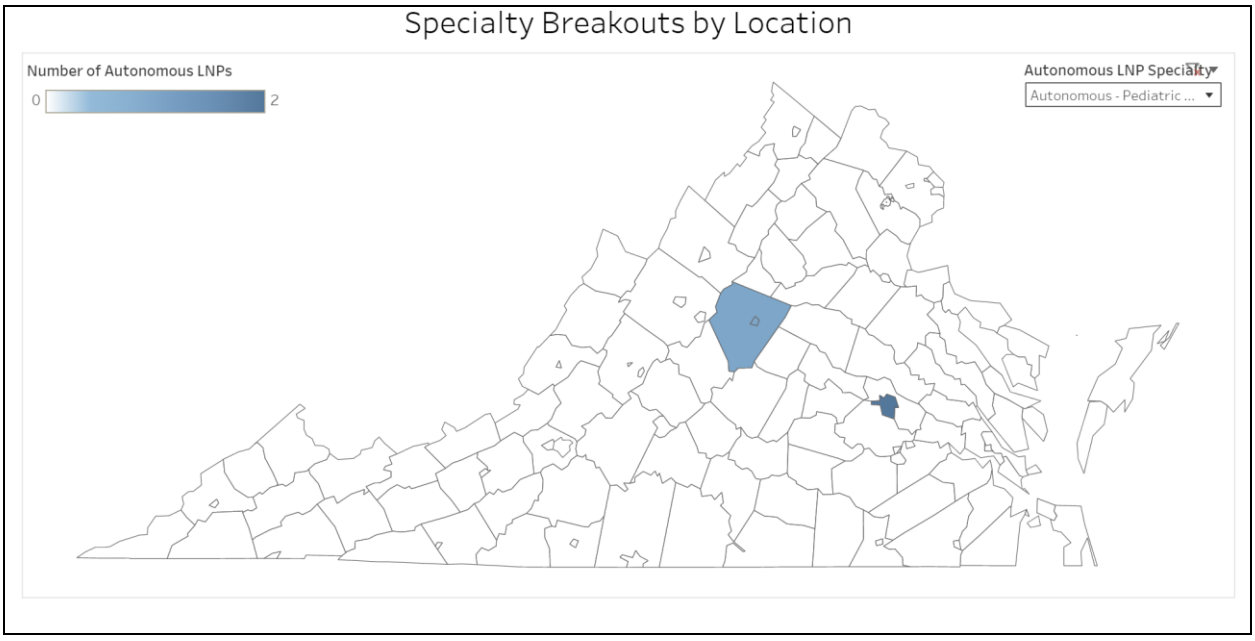
Family



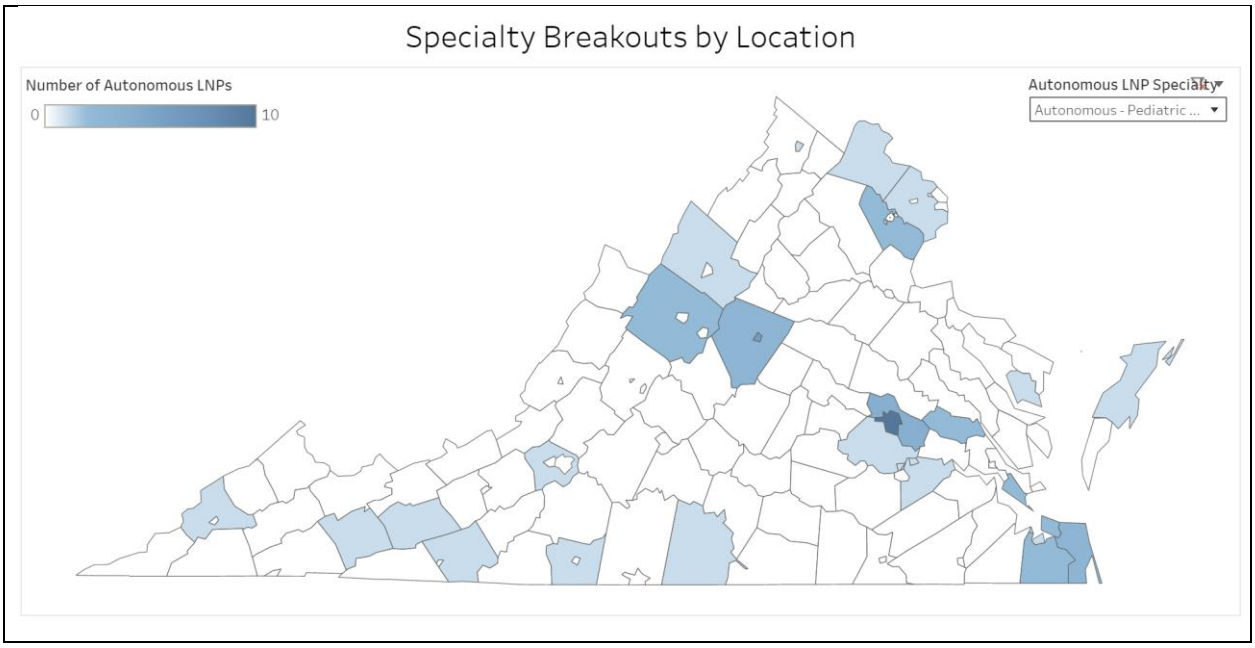
Neonatal



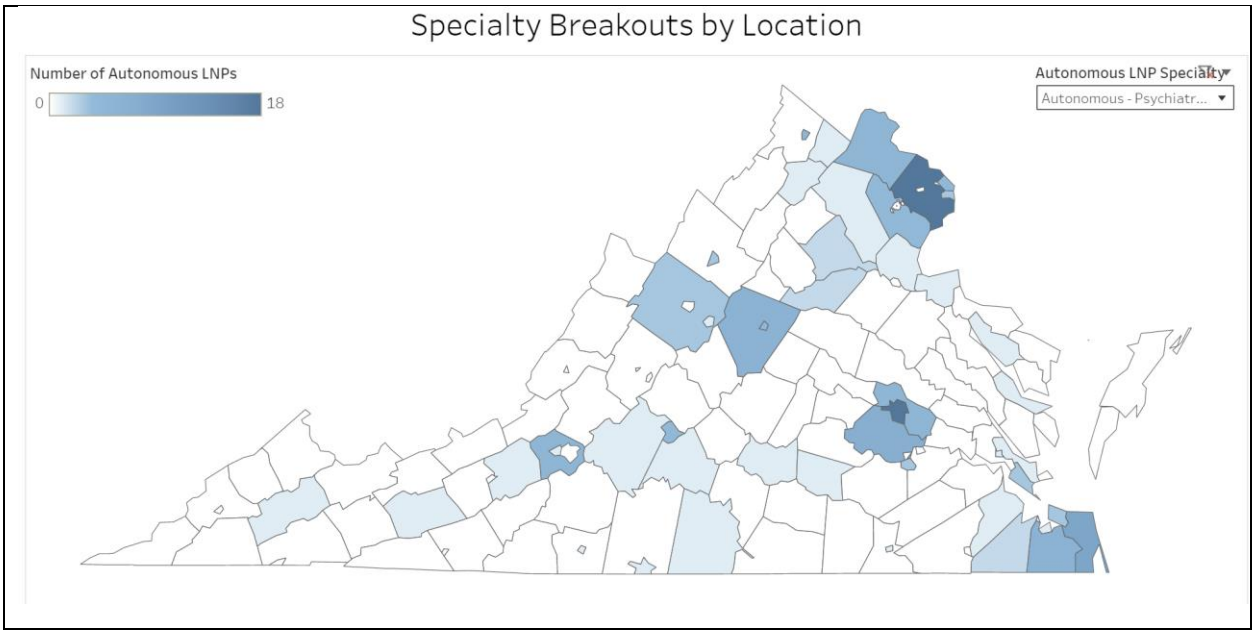
Pediatric Acute



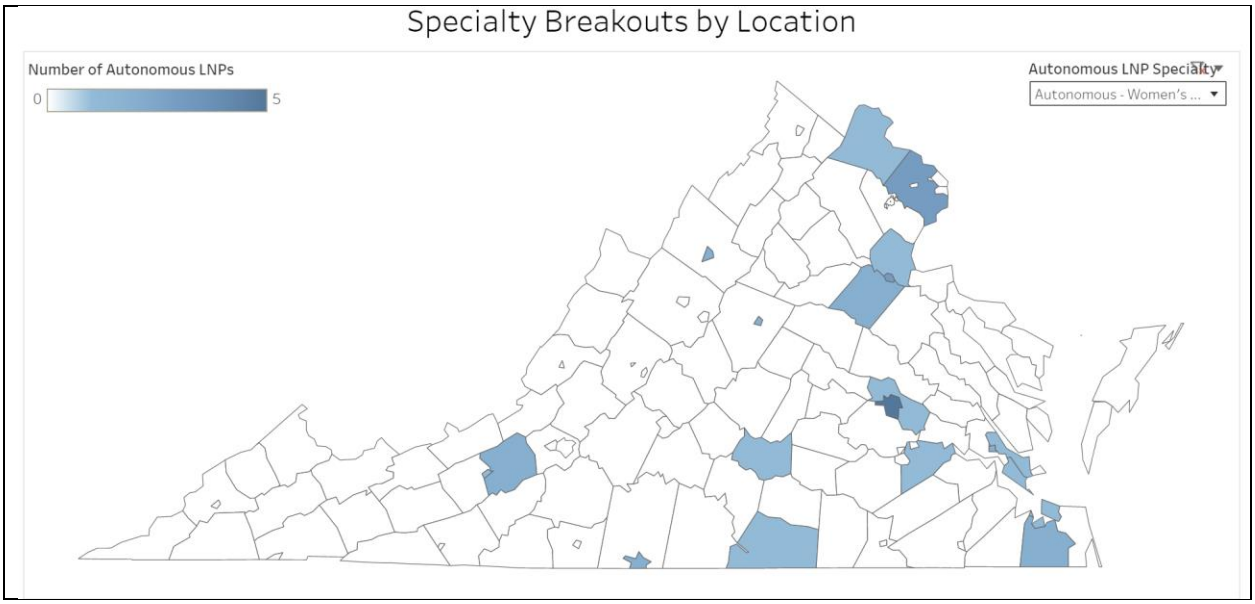
Pediatric Primary



Psychiatric/Mental



Women's Health



Appendix 2

Complaints and Disciplinary Actions: Baselines

To provide baseline information and context on the volume and types of complaints received by the Department of Health Professions' disciplinary case tracking data,[2] referencing "Cases Received" in the system from the February 6, 2019 to April 30, 2021 period. The complaints received per 1,000 licensees' rates for the agency overall, by board, and by profession follow.

Complaints do not necessarily equate to substantiated misconduct, the rate of cases closed with a final disposition of violation per 1,000 licensees is provided. This measure gives insight into boards' assessments of actual harm to the public. Here, too, the results are at the agency, board, and profession levels.

The agency received 15,510 complaints within the jurisdiction of a licensing board.

Complaints Received per 1,000 Agency Licensees

Received (within Jurisdiction only)	Closed	Violation	Complaint [3] Rate/1k Lic	Violation Rate/ 1k Lic	Licensees
16,848	**12,094 (72% of received)**	**1,711**	**38.32**	**3.90**	**437,474**

The rate of **all** complaints received per 1,000 licensees within boards' jurisdiction was 38.32, and the overall violation rate was 3.90.

Complaints Received Rate per 1,000 Licensees by Board

Board	Rate/1k	Board	Rate/1k
Audiology/Speech-Language Pathology	5.46	**Optometry**	42.55
Counseling	22.78	**Pharmacy**	38.57
Dentistry	70.06	**Physical Therapy**	8.40
Funeral Directors/Embalmers	58.30	**Psychology**	54.47
Long-term Care Administrators	83.11	**Social Work**	20.67
Medicine	60.79	**Veterinary Medicine**	97.9
Nursing	25.10		

[2] Data are from DHP's standard monthly download of internal disciplinary case processing.

[3] The Rate of Complaints Received per 1,000 Licensees and Rate of Violations per 1,000 Licensees are similar to the standard measures tracked in the DHP Biennial Report. They are calculated, respectively, as follows: (#Cases Received/#Licensees) x 1,000 and (#Cases with Violation final disposition/#Licensees) x 1,000..

The complaint rate ranged from a low of 5.46 for the Board of Audiology and Speech-Language Pathology to a high of 97.9 for the Board of Veterinary Medicine. For the Board of Nursing, the rate was 25.10.

Pursuant to a complaint, an investigation is completed, evidence reviewed, and adjudication processes completed. A Board may close a case with a finding of a violation or without one. A final disposition with a violation confirms that the licensee has engaged in professional misconduct.

The table below shows baseline rate of violation per 1,000 licensees by board for those cases received and closed during the period.

Violation Rate per 1000 Licensees by Board

Board	Rate/1k	Board	Rate/1k
Audiology/Speech-Language Pathology	0.88	**Optometry**	1.93
Counseling	0.87	**Pharmacy**	16.7
Dentistry	2.62	**Physical Therapy**	0.96
Funeral Directors/Embalmers	5.64	**Psychology**	1.02
Long-term Care Administrators	3.96	**Social Work**	0.25
Medicine	2.83	**Veterinary Medicine**	0.12
Nursing	2.42		

Violation rates are much lower than complaint rates, and range from a low for Veterinary Medicine of 0.12 to a high for Pharmacy (includes facility violations). The Board of Nursing's violation rate is a 2.42. The average (mean) across all boards is 3.02.

Profession

Within the agency, there are over 60 regulated professions in addition to a number of facility types. The following tables provide a rank ordering of the rate of complaints and of violations per 1,000 licensees for 51 professions.[4]

Profession	Complaint Rate/1KLic	Profession	Violation Rate/1KLic
Ltd Radiologic Technologist	1.84	Ltd Radiologic Technologist	0
Clinical Nurse Specialist	2.45	Lic. Clinical Social Worker	0.37
Speech-Language Pathologist	4.27	Dental Hygienist	0.49
Dental Hygienist	4.76	Sub Abuse Tx Practitioner	0.51
Occupational Therapist	5.36	Occupational Therapy Asst	0.59
Physician Selling CS	5.38	Intern & Resident	0.59
Occupational Therapy Asst	5.87	Behavioral Analyst	0.6
Sub Abuse Tx Practitioner	7.11	Physician Assistant	0.6
Radiologic Technologist	8.32	Speech-Language Pathologist	0.85
Physical Therapist	8.95	Physical Therapist	0.95
Physical Therapist Asst	10.16	Lic Clinical Psychologist	0.96
Athletic Trainer	10.27	QMHP-Child	0.99
QMHP-Child	11.22	Lic Professional Counselor	0.99
Respiratory Therapist	12.46	Lic Marriage & Family Therapist	1.05
Behavioral Analyst	13.24	Occupational Therapist	1.07
Intern & Resident	13.82	QMHP-Adult	1.32
School Speech-Language Pathologist	14.74	Physical Therapist Asst	1.37
Restricted Volunteer	15.15	Respiratory Therapist	1.44
Registered Nurse	15.35	Veterinary Technician	1.69
QMHP-Adult	18.58	Athletic Trainer	1.71
Polysomnographic Technologist	20.28	Lic. Nurse Practitioner	1.71
Veterinary Technician	20.3	Registered Nurse	1.72
Lic Massage Therapist	20.49	Physician Selling CS	1.79
Pharmacy Technician	20.78	Certified Nurse Aide	2.29
Pharmacist	21.7	TPA Optometrist	2.33
Lic Acupuncturist	24.39	Clinical Nurse Specialist	2.45
Lic. Clinical Social Worker	26.48	School Speech-Language Pathologist	2.46
Certified Nurse Aide	30.6	Doctor of Osteopathy	2.64

[4] Facility cases are excluded.

Profession	Complaint Rate/1KLic	Profession	Violation Rate/1KLic
Physician Selling Drugs	30.67	Assisted Living Facility Administrator	2.9
Lic. Marriage & Family Therapist	31.41	Nursing Home Administrator	3.01
Lic. Practical Nurse	37.18	Medicine & Surgery	3.33
Physician Assistant	37.78	Lic. Practical Nurse	3.77
Lic Nurse Practitioner	39.76	Radiologic Technologist	4.05
Lic Professional Counselor	44.03	Pharmacist	4.27
Medication Aide	45.59	Sex Offender Tx Provider	4.47
TPA Optometrist	48.83	Genetic Counselor Temp	4.68
Lic. Clinical Psychologist	59.56	Dentist	4.76
Funeral Service Intern	70.18	Lic Massage Therapist	4.95
Doctor of Osteopathy	70.96	Lic Acupuncturist	5.22
Chiropractor	71.47	Medication Aide	6.32
Funeral Service Licensee	71.93	Funeral Service Licensee	6.37
Sex Offender Tx Provider	76.06	Chiropractor	6.81
Medicine & Surgery	92.85	Veterinarian	7.59
Assisted Living Facility Administrator – Administrator-in-Training	93.02	Pharmacy Technician	10.12
Assisted Living Administrator	97.1	Polysomnographic Technologist	12.17
Nursing Home Administrator	107.54	Physician Selling Drugs	12.27
Veterinarian	125.06	Podiatrist	12.64
Dentist	131.41	Restricted Volunteer	15.15
Podiatrist	158.84	Funeral Service Intern	17.54
Genetic Counselor Temp	222.2	Assisted Living Facility Administrator— Administrator-in-Training	46.51

The complaint rate per 1,000 licensees ranges from 1.87 for Limited Radiologic Technologist to 222.2 for Genetic Counselor Temporary. Note that the violation rate is lower, with a range of near 0 for Limited Radiologic Technologist to 46.51 for Assisted Living Administrator – Administrator-in-Training. The respective average (mean)[5] for each measure is 43.68 and 4.66. Note the arrows indicating the approximate locations of these means in the rankings above.

[5] The complaint rate median was 24.39; the standard deviation was 110.18. The violation rate median was 2.45 and standard deviation was 23.26

Appendix 3

Types of Non-Administrative Cases by Profession

The top categories across all boards are ranked below. It is important to note that cases docketed in categories related to license issuance or renewal (i.e., continuing education, reinstatement, and eligibility) and compliance cases were excluded.

AGENCY

1. **Business Practice Issues**
2. **Inability to Safely Practice**
3. **Drug-Related, Patient Care**
4. **Abuse, Abandonment & Neglect**
5. **Criminal Activity**
6. **Standard of Care – Diagnosis/Treatment**

BOARD OF NURSING (excluding CNAs)

1. **Inability to Safely Practice**
2. **Drug-Related, Patient Care**
3. **Abuse, Abandonment & Neglect**
4. **Criminal Activity**
5. **Action by Another Board – Patient Care**

BOARD OF MEDICINE

1. **Unlicensed Activity**
2. **Inability to Safely Practice**
3. **Drug-Related-Patient Care**
4. **Standard of Care-Diagnosis/Treatment**
5. **Criminal Activity**
6. **Abuse, Abandonment & Neglect**

LICENSED NURSE PRACTITIONERS (Non-Autonomous)

1. **Drug-Related-Patient Care**
2. **Inability to Safely Practice**
3. **Action-by-Another Board, Patient Care**
4. **Criminal Activity**

REGISTERED NURSES

1. **Inability to Safely Practice**
2. **Drug-Related, Patient Care**
3. **Action by Another Board, Patient Care**
4. **Criminal Activity**
5. **Abuse, Abandonment & Neglect**

MEDICINE & SURGERY (M.D.)

1. **Inability to Safely Practice**
2. **Drug-Related, Patient Care**
3. **Standard of Care, Diagnosis/Treatment**
4. **Criminal Activity**
5. **Abuse/Abandonment/Neglect**
6. **Standard of Care, Surgery**
7. **Business Practice Issues**