Advisory Board on Physician Assistants

Virginia Board of Medicine

October 4, 2018
1:00 p.m.

Advisory Board on Physician Assistants

Board of Medicine
Thursday, October 4, 2018 @ 1:00 p.m.
9960 Mayland Drive, Suite 201, Henrico, Virginia
Training Room 2

Call to Order	
Emergency Egress Procedures - William Harp, MD	i
Roll Call – ShaRon Clanton	
Approval of Minutes of February 1, 2018	1-3
Adoption of the Agenda	
Public Comment on Agenda Items (15 minutes)	
New Business	
1. Periodic review of regulations – Elaine Yeatts	4-16.1
2. Virginia's Licensed Radiologic Technologist Workforce: 2017 – Elizabeth Carter, PhD	17-48
3. Request for Advisory Opinion or Guidance re PA Supervision	49-52
4. Board member badges	-----
5. 2019 Meeting Calendar	53-54
6. Election of Officers	----
Announcements	
Adjournment	

Next meeting date: January 24, 2019 @ 1:00 p.m.

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

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Training Room 2

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

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DRAFT UNAPPROVED

ADVISORY BOARD ON PHYSICIAN ASSISTANTS
Board of Medicine
February 1, 2018, 1:00 PM
9960 Mayland Drive, Suite 201
Richmond, VA
Training Room 2

The Advisory Board on Physician Assistants met Thursday, February 1, 2018, at 1:00 p.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, Virginia.

MEMBERS PRESENT:	Portia Tomlinson, PA-C, Chair Rachel Carlson, PA-C, Vice Chair Frazier W. Frantz, MD Thomas Parish, PA-C Tracey Dunn, Citizen
MEMBERS ABSENT:	None
STAFF PRESENT:	William L. Harp, MD, Executive Director R. Alan Heaberlin, Deputy Executive Director Elaine Yeatts, Senior Regulatory Analyst ShaRon Clanton, Licensing Specialist
GUESTS PRESENT:	David Falkenstein, VAPA A. Rose Rutherford, VAPA Robert Glasgow, PA-C, VAPA

Call to Order-Portia Tomlinson, PA-C Chair

Portia Tomlinson called the meeting to order.

Emergency Egress Procedures-Alan Heaberlin

Mr. Heaberlin provided the emergency egress instructions.

Roll Call-ShaRon Clanton

Roll was called, and a quorum was declared.

Approval of Minutes October 5, 2017 1-2

Rachel Carlson moved to adopt the minutes. The motion was seconded and carried.

Adoption of Agenda

Tom Parish moved to adopt the Agenda. The motion was seconded and carried.

Public Comment on Agenda Items (15 minutes)

None

NEW BUSINESS

1. Legislative Update

   Mrs. Yeatts provided a legislative update. No action was required.

2. Discussion of Final Regulations for Prescribing Opioids.

   Upon motion made by Rachel Carlson, the Advisory Board voted to recommend to the full Board that annotations on prescriptions to indicate "acute" "post-op" and "chronic" be included. The vote was unanimous.

3. Discussion of Draft Regulations on Laser Hair Training and Supervision

   The Advisory Board reviewed the proposed regulations, "Supervision and Direction for Laser Hair Removal," that were developed by a Board of Medicine Regulatory Advisory Panel on November 20, 2017. The Advisory Board will again review the regulations when the public comment period has closed.

4. Recommendation of Proposed Regulations on Definitions of Supervision and Weight Loss Rules.

   The Advisory Board reviewed the proposed changes to the Definition of Supervision and Weight Loss Rules, the Requirements for a Practice Agreement, the Responsibilities of the Supervisor and the Responsibilities of the Physician Assistant. Ms. Carlson moved to recommend adoption of the amendments to the Full Board. The motion was seconded and carried

Announcements

Mr. Heaberlin gave the current license stats for PA's as 3, 599 active and 25 inactive. He noted that 221 new licenses have been issued since the beginning of FY2018. He also reviewed a change in the requirements for FORM B's made possible by an accompanying National Practitioners' Data Bank report.

Next Scheduled Meeting

June 7, 2018 @ 1:00 p.m.

Adjournment

The meeting adjourned at 2:15 p.m.

_____
Portia Tomlinson, PA-C, Chair

_____
William L. Harp, M.D., Executive Director

_____
ShaRon Clanton, Licensing Specialist

Commonwealth of Virginia

REGULATIONS

GOVERNING THE PRACTICE OF PHYSICIAN ASSISTANTS

VIRGINIA BOARD OF MEDICINE

Title of Regulations: 18 VAC 85-50-10 et seq.

Statutory Authority: § 54.1-2400 and Chapter 29 of Title 54.1 of the *Code of Virginia*

Revised Date: September 20, 2018

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Part I. General Provisions.

18VAC85-50-10. Definitions.

A. The following words and terms shall have the meanings ascribed to them in §54.1-2900 of the Code of Virginia:

"Board."

"Physician assistant."

B. The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Group practice" means the practice of a group of two or more doctors of medicine, osteopathy, or podiatry licensed by the board who practice as a partnership or professional corporation.

"Institution" means a hospital, nursing home or other health care facility, community health center, public health center, industrial medicine or corporation clinic, a medical service facility, student health center, or other setting approved by the board.

"NCCPA" means the National Commission on Certification of Physician Assistants.

"Practice agreement" means a written agreement developed by the supervising physician and the physician assistant that defines the supervisory relationship between the physician assistant and the physician, the prescriptive authority of the physician assistant, and the circumstances under which the physician will see and evaluate the patient.

"Supervision" means the supervising physician has on-going, regular communication with the physician assistant on the care and treatment of patients, is easily available, and can be physically present or accessible for consultation with the physician assistant within one hour.

18VAC85-50-20. (Repealed.)

18VAC85-50-21. 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 given by the board to any such licensee shall be validly given when mailed to the latest address of record provided or served to the licensee. Any change of name or 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.

18VAC85-50-30. Public participation guidelines.

A separate board regulation, 18VAC85-11, entitled Public Participation Guidelines, provides for involvement of the public in the development of all regulations of the Virginia Board of Medicine.

18VAC85-50-35. Fees.

Unless otherwise provided, the following fees shall not be refundable:

1. The initial application fee for a license, payable at the time application is filed, shall be $130.

2. The biennial fee for renewal of an active license shall be $135 and for renewal of an inactive license shall be $70, payable in each odd-numbered year in the birth month of the licensee. For 2019, the fee for renewal of an active license shall be $108 and the fee for renewal of an inactive license shall be $54.

3. The additional fee for late renewal of licensure within one renewal cycle shall be $50.

4. A restricted volunteer license shall expire 12 months from the date of issuance and may be renewed without charge by receipt of a renewal application that verifies that the physician assistant continues to comply with provisions of §54.1-2951.3 of the Code of Virginia.

5. The fee for review and approval of a new protocol submitted following initial licensure shall be $15.

6. The fee for reinstatement of a license pursuant to §54.1-2408.2 of the Code of Virginia shall be $2,000.

7. The fee for a duplicate license shall be $5, and the fee for a duplicate wall certificate shall be $15.

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

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

10. The fee for an application or for the biennial renewal of a restricted volunteer license shall be $35, due in the licensee's birth month. An additional fee for late renewal of licensure shall be $15 for each renewal cycle.

Part II. Requirements for Practice as a physician assistant.

18VAC85-50-40. General requirements.

A. No person shall practice as a physician assistant in the Commonwealth of Virginia except as provided in this chapter.

B. All services rendered by a physician assistant shall be performed only under the continuous supervision of a doctor of medicine, osteopathy, or podiatry licensed by this board to practice in the Commonwealth.

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

The applicant seeking licensure as a physician assistant shall submit:

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

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

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

4. Documentation that the applicant has not had a license or certification as a physician assistant suspended or revoked and is not the subject of any disciplinary proceedings in another jurisdiction.

18VAC85-50-55. Provisional licensure.

Pending the outcome of the next examination administered by the NCCPA, an applicant who has met all other requirements of 18VAC85-50-50 at the time his initial application is submitted may be granted provisional licensure by the board. The provisional licensure shall be valid until the applicant takes the next subsequent NCCPA examination and its results are reported, but this period of validity shall not exceed 30 days following the reporting of the examination scores, after which the provisional license shall be invalid.

18VAC85-50-56. Renewal of license.

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

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

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

B. Any physician assistant who allows his NCCPA certification to lapse shall be considered not licensed by the board. Any such assistant who proposes to resume his practice shall make a new application for licensure.

18VAC85-50-57. Discontinuation of employment.

If for any reason the assistant discontinues working in the employment and under the supervision of a licensed practitioner, a new practice agreement shall be entered into in order for the assistant either to be reemployed by the same practitioner or to accept new employment with another supervising physician.

18VAC85-50-58. Inactive licensure.

A. A physician assistant who holds a current, unrestricted license in Virginia shall, upon a request on the renewal application and submission of the required fee, be issued an inactive license.

1. The holder of an inactive license shall not be required to maintain certification by the NCCPA.

2. An inactive licensee shall not be entitled to practice as a physician assistant in Virginia.

B. An inactive licensee may reactivate his license upon submission of:

1. The required application;

2. Payment of the difference between the current renewal fee for inactive licensure and the renewal fee for active licensure for the biennium in which the license is being reactivated; and

3. Documentation of having maintained certification or having been recertified by the NCCPA.

C. The board reserves the right to deny a request for reactivation to any licensee who has been determined to have committed an act in violation of §54.1-2915 of the Code of Virginia or any provisions of this chapter.

18VAC85-50-59. Registration for voluntary practice by out-of-state licensees.

Any physician assistant who does not hold a license to practice in Virginia and who seeks registration to practice under subdivision 27 of §54.1-2901 of the Code of Virginia on a voluntary basis under the auspices of a publicly supported, all volunteer, nonprofit organization that sponsors the provision of health care to populations of underserved people shall:

1. File a complete application for registration on a form provided by the board at least five business days prior to engaging in such practice. An incomplete application will not be considered;

2. Provide a complete record of professional licensure in each state in which he has held a license and a copy of any current license;

3. Provide the name of the nonprofit organization, the dates and location of the voluntary provision of services;

4. Pay a registration fee of $10; and

5. Provide a notarized statement from a representative of the nonprofit organization attesting to its compliance with provisions of subdivision 27 of §54.1-2901 of the Code of Virginia.

18VAC85-50-60. (Repealed.)

18VAC85-50-61. Restricted volunteer license.

A. A physician assistant who held an unrestricted license issued by the Virginia Board of Medicine or by a board in another state as a licensee in good standing at the time the license expired or became inactive may be issued a restricted volunteer license to practice without compensation in a clinic that is organized in whole or in part for the delivery of health care services without charge in accordance with §54.1-106 of the Code of Virginia.

B. To be issued a restricted volunteer license, a physician assistant shall submit an application to the board that documents compliance with requirements of §54.1-2928.1 of the Code of Virginia and the application fee prescribed in 18VAC85-50-35.

C. The licensee who intends to continue practicing with a restricted volunteer license shall renew biennially during his birth month, meet the continued competency requirements prescribed in subsection D of this section, and pay to the board the renewal fee prescribed in 18VAC85-50-35.

D. The holder of a restricted volunteer license shall not be required to attest to hours of continuing education for the first renewal of such a license. For each renewal thereafter, the licensee shall attest to obtaining 50 hours of continuing education during the biennial renewal period with at least 25 hours in Type 1 and no more than 25 hours in Type 2 as acceptable to the NCCPA.

18VAC85-50-70 to 18VAC85-50-100. (Repealed.)

Part IV. Practice Requirements .

18VAC85-50-101. Requirements for a practice agreement.

A. Prior to initiation of practice, a physician assistant and his supervising physician shall enter into a written or electronic practice agreement that spells out the roles and functions of the assistant.

1. The supervising physician shall be a doctor of medicine, osteopathy, or podiatry licensed in the Commonwealth who has accepted responsibility for the supervision of the service that a physician assistant renders.

2. Any such practice agreement shall take into account such factors as the physician assistant's level of competence, the number of patients, the types of illness treated by the physician, the nature of the treatment, special procedures, and the nature of the physician availability in ensuring direct physician involvement at an early stage and regularly thereafter.

3. The practice agreement shall also provide an evaluation process for the physician assistant's performance, including a requirement specifying the time period, proportionate to the acuity of care and practice setting, within which the supervising physician shall review the record of services rendered by the physician assistant.

4. The practice agreement may include requirements for periodic site visits by supervising licensees who supervise and direct assistants who provide services at a location other than where the licensee regularly practices.

B. The board may require information regarding the level of supervision with which the supervising physician plans to supervise the physician assistant for selected tasks. The board may also require the supervising physician to document the assistant's competence in performing such tasks.

C. If the role of the assistant includes prescribing for drugs and devices, the written practice agreement shall include those schedules and categories of drugs and devices that are within the scope of practice and proficiency of the supervising physician.

D. If the initial practice agreement did not include prescriptive authority, there shall be an addendum to the practice agreement for prescriptive authority.

E. If there are any changes in supervision, authorization, or scope of practice, a revised practice agreement shall be entered into at the time of the change.

18VAC85-50-110. Responsibilities of the supervisor.

The supervising physician shall:

1. Review the clinical course and treatment plan for any patient who presents for the same acute complaint twice in a single episode of care and has failed to improve as expected. The supervising physician shall be involved with any patient with a continuing illness as noted in the written or electronic practice agreement for the evaluation process.

2. Be responsible for all invasive procedures.

a. Under supervision, a physician assistant may insert a nasogastric tube, bladder catheter, needle, or peripheral intravenous catheter, but not a flow-directed catheter, and may perform minor suturing, venipuncture, and subcutaneous intramuscular or intravenous injection.

b. All other invasive procedures not listed in subdivision 2 a of this section must be performed under supervision with the physician in the room unless, after directly observing the performance of a specific invasive procedure three times or more, the supervising physician attests on the practice agreement to the competence of the physician assistant to perform the specific procedure without direct observation and supervision.

3. Be responsible for all prescriptions issued by the assistant and attest to the competence of the assistant to prescribe drugs and devices.

18VAC85-50-115. Responsibilities of the physician assistant.

A. The physician assistant shall not render independent health care and shall:

1. Perform only those medical care services that are within the scope of the practice and proficiency of the supervising physician as prescribed in the physician assistant's practice agreement. When a physician assistant is to be supervised by an alternate supervising physician outside the scope of specialty of the supervising physician, then the physician assistant's functions shall be limited to those areas not requiring specialized clinical judgment, unless a separate practice agreement for that alternate supervising physician is approved and on file with the board.

2. Prescribe only those drugs and devices as allowed in Part V (18VAC85-50-130 et seq.) of this chapter.

3. Wear during the course of performing his duties identification showing clearly that he is a physician assistant.

B. An alternate supervising physician shall be a member of the same group or professional corporation or partnership of any licensee who supervises a physician assistant or shall be a member of the same hospital or commercial enterprise with the supervising physician. Such alternating supervising physician shall be a physician licensed in the Commonwealth who has registered with the board and who has accepted responsibility for the supervision of the service that a physician assistant renders.

C. If, due to illness, vacation, or unexpected absence, the supervising physician or alternate supervising physician is unable to supervise the activities of his assistant, such supervising physician may temporarily delegate the responsibility to another doctor of medicine, osteopathic medicine, or podiatry.

Temporary coverage may not exceed four weeks unless special permission is granted by the board.

D. With respect to assistants employed by institutions, the following additional regulations shall apply:

1. No assistant may render care to a patient unless the physician responsible for that patient has signed the practice agreement to act as supervising physician for that assistant. The board shall make available appropriate forms for physicians to join the practice agreement for an assistant employed by an institution.

2. Any such practice agreement as described in subdivision 1 of this subsection shall delineate the duties which said physician authorizes the assistant to perform.

3. The assistant shall, as soon as circumstances may dictate, report an acute or significant finding or change in clinical status to the supervising physician concerning the examination of the patient. The assistant shall also record his findings in appropriate institutional records.

E. Practice by a physician assistant in a hospital, including an emergency department, shall be in accordance with § 54.1-2952 of the Code of Virginia.

18VAC85-50-116. Volunteer restricted license for certain physician assistants.

The issuance of a volunteer restricted license and the practice of a physician assistant under such a license shall be in accordance with the provisions of §54.1-2951.3 of the Code of Virginia.

18VAC85-50-117. Authorization to use fluoroscopy.

A physician assistant working under the supervision of a licensed doctor of medicine or osteopathy specializing in the field of radiology is authorized to use fluoroscopy for guidance of diagnostic and therapeutic procedures provided such activity is specified in his protocol and he has met the following qualifications:

1. Completion of at least 40 hours of structured didactic educational instruction and at least 40 hours of supervised clinical experience as set forth in the Fluoroscopy Educational Framework for the Physician Assistant created by the American Academy of Physician Assistants (AAPA) and the American Society of Radiologic Technologists (ASRT); and

2. Successful passage of the American Registry of Radiologic Technologists (ARRT) Fluoroscopy Examination.

Part V. Prescriptive Authority.

18VAC85-50-120. [Repealed]

18VAC85-50-130. Qualifications for approval of prescriptive authority.

An applicant for prescriptive authority shall meet the following requirements:

1. Hold a current, unrestricted license as a physician assistant in the Commonwealth;

2. Submit a practice agreement acceptable to the board prescribed in 18VAC85-50-101. This practice agreement must be approved by the board prior to issuance of prescriptive authority;

3. Submit evidence of successful passing of the NCCPA exam; and

4. Submit evidence of successful completion of a minimum of 35 hours of acceptable training to the board in pharmacology.

18VAC85-50-140. Approved drugs and devices.

A. The approved drugs and devices which the physician assistant with prescriptive authority may prescribe, administer, or dispense manufacturer's professional samples shall be in accordance with provisions of §54.1-2952.1 of the Code of Virginia:

B. The physician assistant may prescribe only those categories of drugs and devices included in the practice agreement as submitted for authorization. The supervising physician retains the authority to restrict certain drugs within these approved categories.

C. The physician assistant, pursuant to §54.1-2952.1 of the Code of Virginia, shall only dispense manufacturer's professional samples or administer controlled substances in good faith for medical or therapeutic purposes within the course of his professional practice.

18VAC85-50-150. (Repealed.)

18VAC85-50-160. Disclosure.

A. Each prescription for a Schedule II through V drug shall bear the name of the supervising physician and of the physician assistant.

B. The physician assistant shall disclose to the patient that he is a licensed physician assistant, and also the name, address and telephone number of the supervising physician. Such disclosure shall either be included on the prescription or be given in writing to the patient.

18VAC85-50-170. (Repealed.)

Part V. Standards of Professional Conduct.

18VAC85-50-175. Confidentiality.

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. Unauthorized use or disclosure of confidential information received from the Prescription Monitoring Program shall be grounds for disciplinary action

18VAC85-50-176. Treating and prescribing for self or family.

A. Treating or prescribing shall be based on a bona fide practitioner-patient relationship, and prescribing shall meet the criteria set forth in § 54.1-3303 of the Code of Virginia.

B. A practitioner shall not prescribe a controlled substance to himself or a family member, other than Schedule VI as defined in § 54.1-3455 of the Code of Virginia, unless the prescribing occurs in an emergency situation or in isolated settings where there is no other qualified practitioner available to the patient, or it is for a single episode of an acute illness through one prescribed course of medication.

C. When treating or prescribing for self or family, the practitioner shall maintain a patient record documenting compliance with statutory criteria for a bona fide practitioner-patient relationship.

18VAC85-50-177. Patient records.

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

B. Practitioners shall properly manage patient records and shall maintain timely, accurate, legible and complete records.

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

18VAC85-50-178. Practitioner-patient communication.

A. Except as provided in § 32.1-127.1:03 F of the Code of Virginia, a practitioner shall accurately inform a patient or his legally authorized representative of his medical diagnoses, prognosis and prescribed treatment or plan of care. A practitioner shall not deliberately make a false or misleading statement regarding the practitioner's skill or the efficacy or value of a medication, treatment, or procedure prescribed or directed by the practitioner in the treatment of any disease or condition.
B. A practitioner shall present information relating to the patient's care to a patient or his legally authorized representative in understandable terms and encourage participation in the decisions regarding the patient's care.

C. Before surgery or any invasive procedure is performed, informed consent shall be obtained from the patient in accordance with the policies of the health care entity. Practitioners shall inform patients of the risks, benefits, and alternatives of the recommended surgery or invasive procedure that a reasonably prudent practitioner in similar practice in Virginia would tell a patient.

1. 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.

2. An exception to the requirement for consent prior to performance of surgery or an invasive procedure may be made in an emergency situation when a delay in obtaining consent would likely result in imminent harm to the patient.

3. For the purposes of this provision, "invasive procedure" shall mean any diagnostic or therapeutic procedure performed on a patient that is not part of routine, general care and for which the usual practice within the health care entity is to document specific informed consent from the patient or surrogate decision-maker prior to proceeding.

18VAC85-50-179. 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 subordinates to jeopardize patient safety or provide patient care outside of the subordinate's scope of practice or area of responsibility. Practitioners shall delegate patient care only to subordinates 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. Advocating for patient safety or improvement in patient care within a health care entity shall not constitute disruptive behavior provided the practitioner does not engage in behavior prohibited in A 3 of this section.

18VAC85-50-180. Vitamins, minerals and food supplements.

A. The recommendation or direction for the use of vitamins, minerals or food supplements and the rationale for that recommendation shall be documented by the practitioner. The recommendation or direction shall be based upon a reasonable expectation that such use will result in a favorable patient outcome, including preventive practices, and that a greater benefit will be achieved than that which can be expected without such use.

B. Vitamins, minerals, or food supplements, or a combination of the three, shall not be sold, dispensed, recommended, prescribed, or suggested in doses that would be contraindicated based on the individual patient's overall medical condition and medications.

C. The practitioner shall conform to the standards of his particular branch of the healing arts in the therapeutic application of vitamins, minerals or food supplement therapy.

18VAC85-50-181. Pharmacotherapy for weight loss.

A.A practitioner shall not prescribe amphetamine, Schedule II, for the purpose of weight reduction or control.

B. A practitioner shall not prescribe controlled substances, Schedules III through VI, for the purpose of weight reduction or control in the treatment of obesity, unless the following conditions are met:

1. An appropriate history and physical examination, are performed and recorded at the time of initiation of pharmacotherapy for obesity by the prescribing physician, and the physician reviews the results of laboratory work, as indicated, including testing for thyroid function;

2. If the drug to be prescribed could adversely affect cardiac function, the physician shall review the results of an electrocardiogram performed and interpreted within 90 days of initial prescribing for treatment of obesity;

3. A diet and exercise program for weight loss is prescribed and recorded;

4. The patient is seen within the first 30 days following initiation of pharmacotherapy for weight loss, by the prescribing physician or a licensed practitioner with prescriptive authority working under the supervision of the prescribing physician, at which time a recording shall be made of blood pressure, pulse, and any other tests as may be necessary for monitoring potential adverse effects of drug therapy;

5. The treating physician shall direct the follow-up care, including the intervals for patient visits and the continuation of or any subsequent changes in pharmacotherapy. Continuation of prescribing for treatment of obesity shall occur only if the patient has continued progress toward achieving or maintaining a target weight and has no significant adverse effects from the prescribed program.

C. If specifically authorized in his practice agreement with a supervising physician, a physician assistant may perform the physical examination, review tests, and prescribe Schedules III through VI controlled substances for treatment of obesity as specified in subsection B of this section.

18VAC85-50-182. Anabolic steroids.

A physician assistant shall not prescribe or administer anabolic steroids to any patient for other than accepted therapeutic purposes.

18VAC85-50-183. Sexual contact.

A. For purposes of § 54.1-2915 A 12 and A 19 of the Code of Virginia and this section, sexual contact includes, but is not limited to, sexual behavior or verbal or physical behavior which:

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 § 54.1-2915 A 19 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.

18VAC85-50-184. Refusal to provide information.

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.

DOCUMENTS INCORPORATED BY REFERENCE

Fluoroscopy Educational Framework for the Physician Assistant, December 2009, American Academy of Physician Assistants, 950 North Washington Street, Alexandria, VA 22314 and the American Society of Radiologic Technologists, 15000 Central Avenue, SE, Albuquerque, NM 87123

Virginia's Physician Assistant Workforce: 2017

Healthcare Workforce Data Center

January 2018

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
9960 Mayland Drive, Suite 300
Richmond, VA 23233
804-367-2115, 804-527-4466(fax)
E-mail: *HWDC@dhp.virginia.gov*

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

2,752 Physician 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 Medicine express our sincerest appreciation for your ongoing cooperation.*

Thank You!

Virginia Department of Health Professions

David E. Brown, DC
Director

Lisa R. Hahn, MPA
Chief Deputy Director

Healthcare Workforce Data Center Staff:

Dr. Elizabeth Carter, PhD	Yetty Shobo, PhD	Laura Jackson, BSHSA	Christopher Coyle
Executive Director	*Deputy Director*	*Operations Manager*	*Research Assistant*

Physician Assistant Advisory Board

Chair

Thomas Parish, PA-C
Virginia Beach

Vice-Chair

Portia Tomlinson, PA-C
Roanoke

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The Physician Assistant Workforce: At a Glance:

The Workforce

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Virginia's Workforce:	3,171
FTEs:	2,973

Survey Response Rate

All Licensees:	70%
Renewing Practitioners:	87%

Demographics

Female:	72%
Diversity Index:	32%
Median Age:	38

Background

Rural Childhood:	30%
HS Degree in VA:	42%
Prof. Degree in VA:	36%

Education

Masters:	79%
Baccalaureate:	12%

Finances

Median Inc.:	$100k-$110k
Health Benefits:	73%
Under 40 w/ Ed debt:	73%

Current Employment

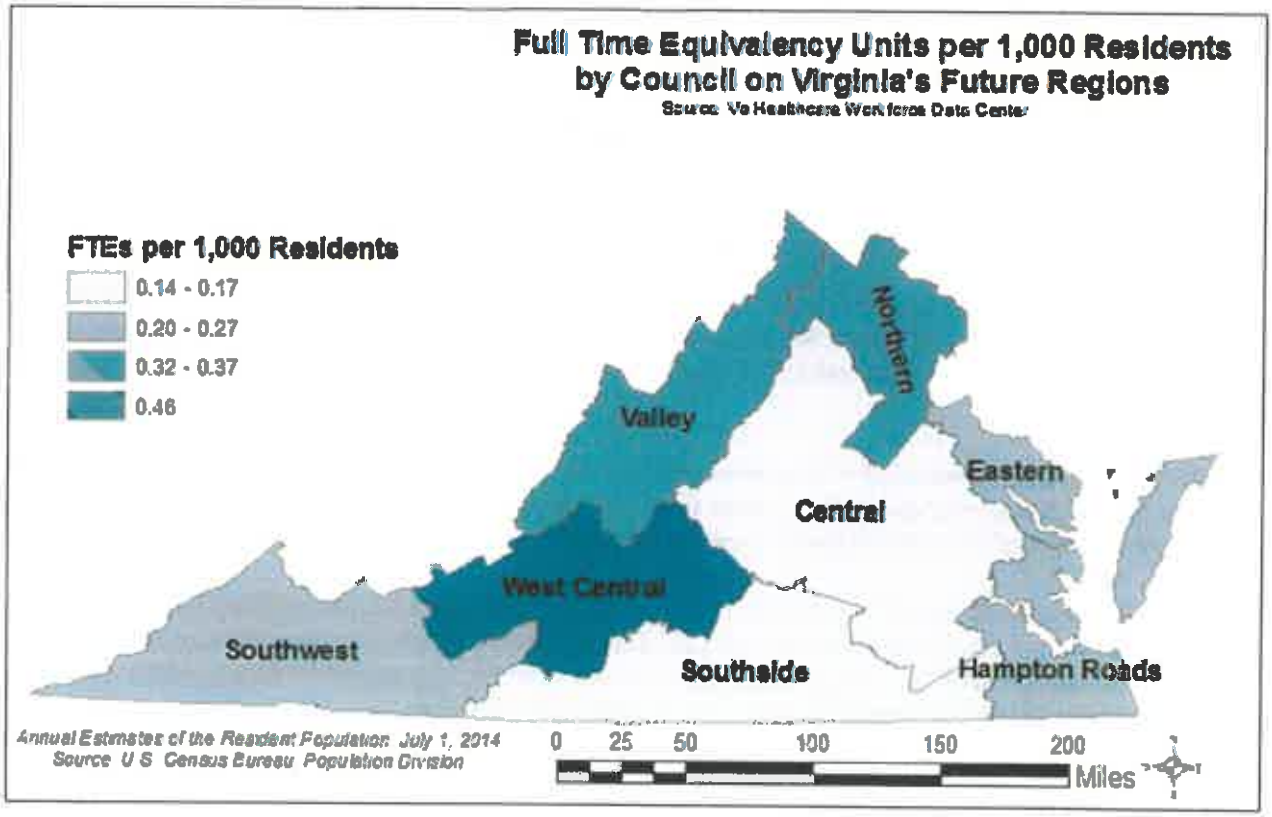
Employed in Prof.:	97%
Hold 1 Full-time Job:	71%
Satisfied?:	96%

Job Turnover

Switched Jobs in 2017:	11%
Employed over 2 yrs:	52%

Primary Roles

Patient Care:	92%
Administration:	2%
Education:	2%



Results in Brief

Nearly 2,752 physician assistants voluntarily took part in the 2017 Physician 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 during the birth month of a physician assistant on every odd-numbered year. These survey respondents represent 70% of the 3,958 physician assistants who are licensed in the state and 87% of renewing practitioners.

The HWDC estimates that 3,171 physician assistants 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 physician assistant workforce provided 2,973 "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).

72% of physician assistants are female. The median age of all physician assistants is 38. In a random encounter between two physician assistants, there is a 32% 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 56%. Meanwhile, for physician assistants who are under the age of 40, the diversity index decreases to 29%.

Nearly one-third of physician assistants grew up in a rural area, and 15% of these professionals currently work in non-Metro areas of the state. Meanwhile, 42% of Virginia's physician assistants graduated from high school in Virginia, while 36% received their initial professional degree in the state. In total, nearly half of Virginia's physician assistant workforce has some educational background in the state.

79% of physician assistants have a master's degree as their highest professional degree, while 12% hold a baccalaureate degree. 73% of physician assistants who are under the age of 40 currently have educational debt. The median debt burden for those with educational debt is between $70,000 and $80,000.

97% of physician assistants were employed in the profession at the time of the survey. 71% hold one full-time position, while another 11% hold one part-time position. Less than 1% of physician assistants are involuntarily unemployed, while more than half have been at their primary work location for at least two years.

The median annual income for physician assistants is between $100,000 and $110,000, while one in four earn more than $110,000 per year. In addition to monetary compensation, nearly 90% receive at least one employer-sponsored benefit, including 72% who receive employer-sponsored health insurance. 96% of physician assistants indicate they are satisfied with their current employment situation, including 67% who indicate they are "very satisfied".

71% of all physician assistants work in Northern Virginia, Hampton Roads or Central Virginia. 61% of physician assistants work in for-profit establishments, while 28% work in the non-profit sector. With respect to establishment type, about one-third of physician assistants work in a single-specialty group practice, while 13% work in the emergency department of hospitals.

Physician assistants spend nearly all of their time in patient care activities, with most of the remaining time spent on administrative tasks and educational activities. More than nine out of ten physician assistants serve a patient care role, meaning that at least 60% of their time is spent in patient care activities.

44% of physician assistants expect to retire by the age of 65. Only 9% of the current workforce expect to retire in the next decade, while half the current workforce expects to retire by 2047. Over the next two years, only 5% of the current workforce plan on leaving either the state or the profession. Meanwhile, 11% expect to pursue additional educational opportunities, whereas 8% plan on spending more time in patient care activities.

Summary of Trends

The number of licensed physician assistants has grown by 34% since 2013. Similarly, the number in the Virginia workforce grew by 33%, from 2,382 in 2013 to 3,171 in 2017. Although the full time equivalency units provided by the workforce grew at a lesser rate, a 28% increase was still recorded. These trends also featured in the survey response rates which increased from 82% to 87% for eligible respondents.

The diversity trends in the profession is mixed. Whereas there is declining gender diversity as females' proportion increasing from 69% in 2013 to 72% of the workforce in 2017, the racial/ethnic diversity index increased from 29% to 32%, indicating increasing racial ethnic diversity in the profession. For those under age 40, the index increased from 26% to 29%. The median age of physician assistants has not changed much since 2013. It was 37 years until 2015 but increased to 38 in 2017. The percent under age 40 also dropped from 58% in 2013 to 57% in 2017 and the percent above age 55 increased from 11% to 12% in the same period. The percent of physician assistants working in rural areas also increased from 7% in 2013 to 8% in 2015 but is now back to 7% in 2017.

The educational attainment of the physician assistant workforce has increased over time. The percent with a Master's degree increased from 70% to 79%. In the same period, there was a decline in those holding a baccalaureate degree from 17% in 2013 to 12% in 2017. Thus, it is not surprising that the median education debt amount increased from between $90,000 and $100,000 in 2013 to between $100,000 and $110,000 in 2017. However, the percent with education debt declined from 63% to 60% in the same period. For those under age 40, the percent reporting education debt declined from 80% in 2013 to 73% in 2017.

The financial outlook also improved in other areas for physician assistants. The median income increased from between $90,000 and $100,000 to $100,000 to $110,000. However, the percent earning more than $100,000 declined from 38% in 2013 to 22% in 2017. The percent receiving health insurance increased from 71% to 73%. The most reported specialty for the physician assistants remained the same. Emergency medicine, family medicine, and orthopedics remained the three most mentioned specialty.

The job market for physician assistants has stayed positive over time. Ninety-seven percent were employed in the profession in all the three surveys and involuntary unemployment has stayed at 1% or less. The percent holding one full time job declined slightly from 72% to 71% and the percent reporting they are satisfied with their current employment situation declined from 97% to 96%. The establishment in which physician assistants are employed stayed constant between 2015 and 2017; 68% are still employed with for-profit and 28% with non-profit establishments. However, it declined from 2013 when 63% were employed in for-profit establishment and 24% were employed in non-profit establishment. The percent of physician assistants without hospital privilege increased from 39% to 43%.

The plans of physician assistants has changed only slightly. The percent expecting to retire by age 65 declined from 46% to 44% and the percent planning to retire at age 60 declined from 27% to 26%. The percent planning to retire within 2 years of the survey stayed at 2% whereas those planning to retire within a decade of the survey increased from 8% in 2013 to 9% in 2017. Those planning to increase their teaching hours declined from 13% to 11% between 2013 and 2017 whereas those planning on pursuing additional education declined from 15% to 11%.

A Closer Look:

Licensee Counts		
License Status	#	%
Renewing Practitioners	3,163	80%
New Licensees	416	11%
Non-Renewals	379	10%
All Licensees	3,958	100%

Source: Va. Healthcare Workforce Data Center

Our surveys tend to achieve very high response rates. 87% of renewing physician assistants submitted a survey. These represent nearly two-thirds of physician assistants who held a license at some point in 2017.

Response Rates			
Statistic	Non Respondents	Respondent	Response Rate
By Age			
Under 30	299	154	34%
30 to 34	323	595	65%
35 to 39	197	586	75%
40 to 44	147	442	75%
45 to 49	84	348	81%
50 to 54	46	233	84%
55 to 59	38	169	82%
60 and Over	72	225	76%
Total	1,206	2,752	70%
New Licenses			
Issued in 2017	416	0	0%
Metro Status			
Non-Metro	31	133	81%
Metro	738	2,102	74%
Not in Virginia	437	514	54%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed Physician Asst.

Number:	3,958
New:	11%
Not Renewed:	10%

Survey Response Rates

All Licensees:	70%
Renewing Practitioners:	87%

Source: Va. Healthcare Workforce Data Center

Response Rates	
Completed Surveys	2,752
Response Rate, all licensees	70%
Response Rate, Renewals	87%

Source: Va. Healthcare Workforce Data Center

Definitions

1. **The Survey Period:** The survey was conducted in December 2017.
2. **Target Population:** All physician assistants who held a Virginia license at some point in 2017.
3. **Survey Population:** The survey was available to those who renewed their licenses online. It was not available to those who did not renew, including some professionals newly licensed in 2017.

At a Glance:

Workforce

2017 Workforce:	3,171
FTEs:	2,973

Utilization Ratios

Licensees in VA Workforce:	80%
Licensees per FTE:	1.33
Workers per FTE:	1.07

Source: Va. Healthcare Workforce Data Center

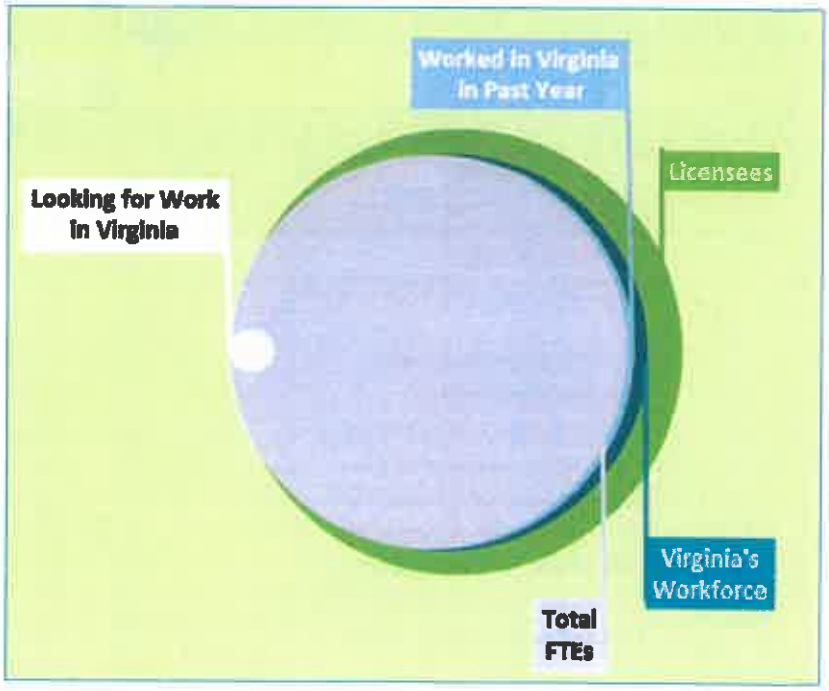
Definitions

1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time in 2017 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 Physician Assistant Workforce		
Status	#	%
Worked in Virginia in Past Year	**3,133**	**99%**
Looking for Work in Virginia	**37**	**1%**
Virginia's Workforce	**3,171**	**100%**
Total FTEs	**2,973**	
Licensees	**3,958**	

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	54	15%	312	85%	366	13%
30 to 34	109	16%	580	84%	689	24%
35 to 39	114	20%	467	80%	581	20%
40 to 44	131	33%	271	67%	402	14%
45 to 49	126	42%	174	58%	299	10%
50 to 54	81	45%	100	55%	182	6%
55 to 59	70	49%	73	51%	144	5%
60 +	129	64%	71	36%	200	7%
Total	813	28%	2,049	72%	2,863	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

% Female:	72%
% Under 40 Female:	83%

Age

Median Age:	38
% Under 40:	57%
% 55+:	12%

Diversity

Diversity Index:	32%
Under 40 Div. Index:	29%

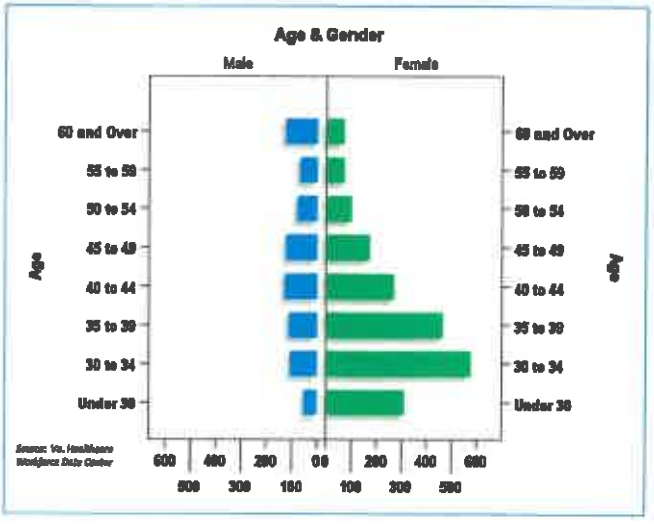
Race & Ethnicity					
Race/ Ethnicity	Virginia*	Physician Assistants		Physician Asst. Under 40	
	%	#	%	#	%
White	63%	2,334	82%	1,358	84%
Black	19%	151	5%	65	4%
Asian	6%	131	5%	76	5%
Other Race	0%	39	1%	12	1%
Two or more races	3%	72	3%	39	2%
Hispanic	9%	123	4%	70	4%
Total	100%	2,849	100%	1,621	100%

*Population data in this chart is from the US Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2015.

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two physician assistants, there is a 32% 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 56%.

72% of all physician assistants are women, including four out of five of those under the age of 40. The median age of physician assistants is 38. Meanwhile, 57% of physician assistants are under the age of 40, while 12% are over the age of 55.



At a Glance:

Childhood

Urban Childhood:	12%
Rural Childhood:	30%

Virginia Background

HS in Virginia:	42%
Prof. Education in VA:	36%
HS/Prof. Educ. in VA:	47%

Location Choice

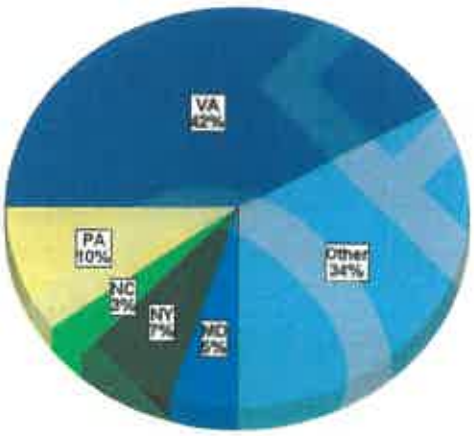
% Rural to Non-Metro:	15%
% Urban/Suburban to Non-Metro:	4%

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	49%	42%	9%
3	Metro, 250,000 or less	43%	51%	5%
	Non-Metro Counties			
4	Urban pop 20,000+, Metro adj	55%	24%	21%
6	Urban pop, 2,500-19,999, Metro adj	64%	30%	5%
7	Urban pop, 2,500-19,999, nonadj	79%	15%	6%
8	Rural, Metro adj	68%	26%	5%
9	Rural, nonadj	31%	69%	0%
	Overall	30%	59%	12%

Source: Va. Healthcare Workforce Data Center

High School Location

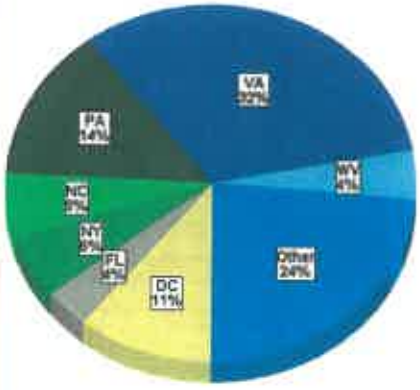


Source: Va. Healthcare Workforce Data Center

30% of physician assistants grew up in self-described rural areas, while 7% of the current physician assistant workforce works in non-Metro counties.

Nearly half of Virginia's physician assistants have a background (i.e., a high school or professional degree) in the state.

Location, Initial Professional Degree



Source: Va. Healthcare Workforce Data Center

Top Ten States for Physician Assistant Recruitment

Rank	All Physician Assistants			
	High School	#	Professional School	#
1	Virginia	1,175	Virginia	1,009
2	Pennsylvania	290	Pennsylvania	391
3	New York	197	Washington, D.C.	264
4	Maryland	132	North Carolina	170
5	North Carolina	85	New York	150
6	Florida	81	West Virginia	119
7	Outside of U.S.	81	Florida	86
8	West Virginia	79	Nebraska	65
9	California	66	Tennessee	60
10	New Jersey	64	Georgia	57

Source: Va. Healthcare Workforce Data Center

42% of all physician assistants received their high school degree in Virginia, while 36% earned their initial professional degree in the state.

Among physician assistants who were licensed in the past five years, 39% received their high school degree in Virginia, while 35% received their initial professional degree in the state.

Rank	Licensed in the Past 5 Years			
	High School	#	Professional School	#
1	Virginia	451	Virginia	399
2	Pennsylvania	135	Pennsylvania	170
3	New York	77	North Carolina	82
4	Maryland	49	Washington, D.C.	76
5	North Carolina	43	New York	64
6	Florida	41	Florida	48
7	California	37	West Virginia	47
8	Outside of U.S.	32	Tennessee	45
9	Michigan	29	Texas	20
10	New Jersey	28	Nebraska	19

Source: Va. Healthcare Workforce Data Center

20% of licensed physician assistants did not participate in Virginia's workforce in 2017. 97% worked at some point in the past year, and 90% currently work in the profession. 20% work for federal agencies, including 9% who are in the military.

At a Glance:

Not in VA Workforce

Total:	781
% of Licensees:	20%
Federal/Military:	20%
Va Border State/DC:	22%

At a Glance:

Education

Masters Degree:	79%
Baccalaureate Degree:	12%

Educational Debt

Carry debt:	60%
Under age 40 w/ debt:	73%
Median debt:	$70k-$80k

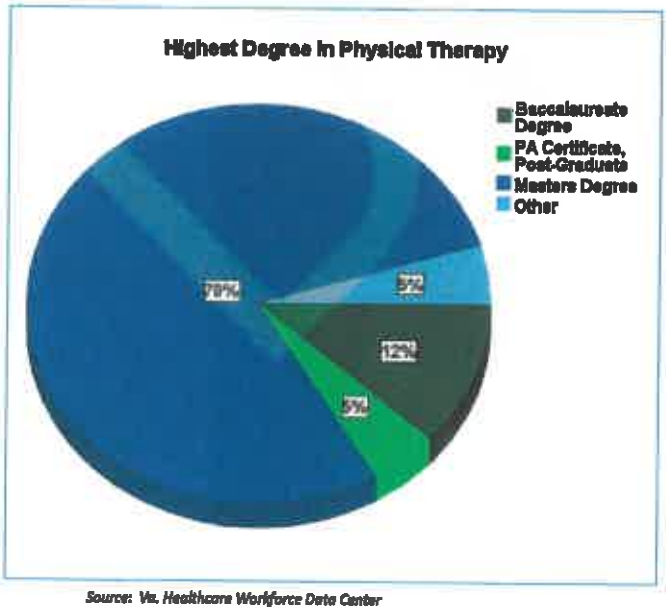
Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Professional Degree		
Degree	#	%
P.A. Certificate (Undergraduate)	80	3%
Associate	27	1%
Baccalaureate	325	12%
P.A. Certificate (Postgraduate)	132	5%
Masters	2,194	79%
Doctorate	27	1%
Total	2,785	100%

Source: Va. Healthcare Workforce Data Center

60% of all physician assistants currently carry educational debt, including 73% of those under age 40. For those who do have educational debt, the median amount is between $70,000 and $80,000.



Source: Va. Healthcare Workforce Data Center

Educational Debt				
Amount Carried	All		Under 40	
	#	%	#	%
None	1,048	40%	405	27%
Less than $10,000	96	4%	50	3%
$10,000-$19,999	87	3%	44	3%
$20,000-$29,999	106	4%	57	4%
$30,000-$39,999	130	5%	77	5%
$40,000-$49,999	85	3%	58	4%
$50,000-$59,999	116	4%	75	5%
$60,000-$69,999	94	4%	66	4%
$70,000-$79,999	89	3%	69	5%
$80,000-$89,999	115	4%	91	6%
$90,000-$99,999	79	3%	61	4%
$100,000-$109,999	103	4%	84	6%
$110,000 and more	461	18%	367	24%
Total	2,609	100%	1,505	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Primary Specialties

Emergency Medicine:	18%
Family Medicine:	15%
Orthopedics:	12%

Secondary Specialties

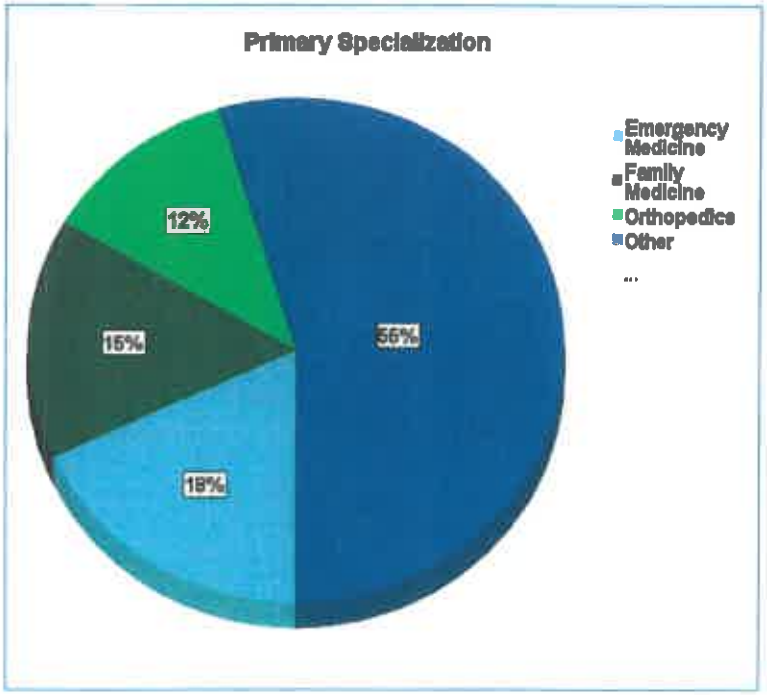
Family Medicine:	9%
Emergency Medicine:	8%
Orthopedics:	4%

Source: Va. Healthcare Workforce Data Center

Specialties				
Specialty	Primary Specialty		Secondary Specialty	
	#	%	#	%
Emergency Medicine	509	18%	175	8%
Family Medicine	436	15%	196	9%
Orthopedics	333	12%	79	4%
Internal Medicine	153	5%	77	3%
Dermatology	131	5%	26	1%
Cardiovascular Surgery	96	3%	30	1%
Cardiology	85	3%	34	2%
General Surgery	76	3%	38	2%
Hospital Medicine	76	3%	45	2%
Psychiatry	65	2%	18	1%
All Other Specialties	678	24%	494	22%
No Specialty	186	7%	1,030	46%
Total	2,824	100%	2,241	100%

Source: Va. Healthcare Workforce Data Center

Nearly half of all physician assistants have a primary specialty in one of three areas: Emergency Medicine, Family Medicine and Orthopedics.



Source: Va. Healthcare Workforce Data Center

Current Employment Situation

At a Glance:

Employment
Employed in Profession: 97%
Involuntarily Unemployed: <1%

Positions Held
1 Full-time: 71%
2 or More Positions: 16%

Weekly Hours:
40 to 49: 50%
60 or more: 5%
Less than 30: 8%

A Closer Look:

Current Work Status		
Status	#	%
Employed, capacity unknown	0	0%
Employed in profession	2,724	97%
Employed, NOT in profession	19	1%
Not working, reason unknown	0	0%
Involuntarily unemployed	9	<1%
Voluntarily unemployed	59	2%
Retired	2	<1%
Total	2,813	100%

Source: Va. Healthcare Workforce Data Center

Current Positions		
Positions	#	%
No Positions	70	3%
One Part-Time Position	304	11%
Two Part-Time Positions	52	2%
One Full-Time Position	1,975	71%
One Full-Time Position & One Part-Time Position	351	13%
Two Full-Time Positions	9	<1%
More than Two Positions	35	1%
Total	2,796	100%

Source: Va. Healthcare Workforce Data Center

Current Weekly Hours		
Hours	#	%
0 hours	70	2%
1 to 9 hours	23	1%
10 to 19 hours	77	3%
20 to 29 hours	138	5%
30 to 39 hours	572	20%
40 to 49 hours	1,397	50%
50 to 59 hours	392	14%
60 to 69 hours	97	3%
70 to 79 hours	27	1%
80 or more hours	25	1%
Total	2,819	100%

Source: Va. Healthcare Workforce Data Center

97% of licensed physician assistants are employed in the profession, and less than 1% are involuntary unemployed. 72% of physician assistants have one full-time job, while 16% have two or more positions. 48% of physician assistants work between 40 and 49 hours per week. Only 6% of physician assistants work at least 60 hours per week.

A Closer Look:

Income		
	#	%
Volunteer Work Only	8	<1%
$20,000 or less	17	1%
$20,000-$29,999	23	1%
$30,000-$39,999	32	1%
$40,000-$49,999	40	2%
$50,000-$59,999	66	3%
$60,000-$69,999	63	3%
$70,000-$79,999	82	4%
$80,000-$89,999	280	12%
$90,000-$99,999	367	16%
$100,000-$109,999	408	18%
$110,000-$119,999	301	13%
$120,000 or more	634	27%
Total	2,321	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Hourly Earnings
Median Income: $100k-$110k

Benefits
Employer Health Insrnce: 73%
Employer Retirement: 73%

Satisfaction
Satisfied: 96%
Very Satisfied: 67%

Employer-Sponsored Benefits			
Benefit	#	%	% of Wage/Salary Employees
Health Insurance	1,953	72%	73%
Retirement	1,943	71%	73%
Dental Insurance	1,740	64%	66%
Paid Sick Leave	1,535	56%	57%
Group Life Insurance	1,304	48%	49%
Signing/Retention Bonus	519	19%	20%
Receive at least one benefit*	2,390	88%	89%

*From any employer at time of survey.
Source: Va. Healthcare Workforce Data Center

The median annual income for physician assistants is between $100,000 and $110,000. 88% of physician assistants receive at least one employer-sponsored benefit, including 73% who receive health insurance.

96% of physician assistants are satisfied with their jobs, including nearly seven out of ten who are very satisfied.

Job Satisfaction		
Level	#	%
Very Satisfied	1,869	67%
Somewhat Satisfied	811	29%
Somewhat Dissatisfied	79	3%
Very Dissatisfied	29	1%
Total	2,788	100%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Underemployment in Past Year		
In the past year did you . . .?	#	%
Experience Involuntary Unemployment?	21	1%
Experience Voluntary Unemployment?	166	5%
Work Part-time or temporary positions, but would have preferred a full-time/permanent position?	48	2%
Work two or more positions at the same time?	519	16%
Switch employers or practices?	340	11%
Experienced at least 1	888	28%

Source: Va. Healthcare Workforce Data Center

Only 1% of Virginia's physician assistants were involuntary unemployed at some point in 2017. For comparison, Virginia's average monthly unemployment rate was 3.8%.[1]

At a Glance:

Unemployment Experience 2017

Involuntarily Unemployed: 1%
Underemployed: 2%

Stability

Switched: 11%
New Location: 22%
Over 2 years: 52%
Over 2 yrs, 2nd location: 45%

Employment Type

Salary/Commission: 71%
Hourly Wage: 29%

Source: Va. Healthcare Workforce Data Center

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at this Location	55	2%	46	6%
Less than 6 Months	175	6%	83	11%
6 Months to 1 Year	271	10%	81	10%
1 to 2 Years	817	30%	217	28%
3 to 5 Years	685	25%	174	22%
6 to 10 Years	423	15%	99	13%
More than 10 Years	321	12%	78	10%
Subtotal	2,748	100%	778	100%
Did not have location	41		2,376	
Item Missing	382		16	
Total	3,171		3,171	

Source: Va. Healthcare Workforce Data Center

More than half of physician assistants have worked at their primary location for more than 2 years.

Over two-thirds of physician assistants received a salary at their primary work location, while 29% received an hourly wage.

Employment Type		
Primary Work Site	#	%
Salary/ Commission	1,647	71%
Hourly Wage	665	29%
By Contract	0	0%
Business/ Practice Income	0	0%
Unpaid	9	0%
Subtotal	2,321	100%

Source: Va. Healthcare Workforce Data Center

[1] As reported by the US Bureau of Labor Statistics. The non-seasonally adjusted monthly unemployment rate ranged from 3.4% in December to 4.2% in January 2017. At the time of this publication, results from December were preliminary.

Work Site Distribution

At a Glance:

Concentration

Top Region:	31%
Top 3 Regions:	71%
Lowest Region:	1%

Locations

2 or more (2017):	25%
2 or more (Now*):	26%

Source: Va. Healthcare Workforce Data Center

71% of physician assistants work in one of three regions: Northern Virginia, Hampton Roads or Central Virginia.

A Closer Look:

Regional Distribution of Work Locations				
COVF Region[2]	Primary Location		Secondary Location	
	#	%	#	%
Central	449	16%	111	14%
Eastern	30	1%	8	1%
Hampton Roads	653	24%	176	22%
Northern	841	31%	210	27%
Southside	65	2%	21	3%
Southwest	97	4%	29	4%
Valley	178	6%	46	6%
West Central	383	14%	108	14%
Virginia Border State/DC	26	1%	25	3%
Other US State	22	1%	48	6%
Outside of the US	2	0%	1	0%
Total	2,746	100%	783	100%
Item Missing	385		13	

Source: Va. Healthcare Workforce Data Center

Council On Virginia's Future Regions

Number of Work Locations				
Locations	Work Locations in 2017		Work Locations Now*	
	#	%	#	%
0	41	1%	65	2%
1	2,335	74%	1,979	71%
2	398	13%	368	13%
3	278	9%	255	9%
4	40	1%	36	1%
5	26	1%	28	1%
6 or More	53	2%	43	2%
Total	3,171	100%	2,774	100%

*At the time of survey completion, December 2017.

Source: Va. Healthcare Workforce Data Center

74% of physician assistants had just one work location in 2017, while another 25% had two or more work locations during the year.

[2] These are now referred to as VA Perform's regions: http://vaperforms.virginia.gov/Regions/regionalScorecards.php

Establishment Type

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	**1,601**	**61%**	**471**	**63%**
Non-Profit	**731**	**28%**	**217**	**29%**
State/Local Government	**90**	**3%**	25	3%
Veterans Administration	**74**	**3%**	6	**1%**
U.S. Military	**120**	**5%**	22	3%
Other Federal Gov't	**28**	**1%**	8	**1%**
Total	**2,644**	**100%**	**749**	**100%**
Did not have location	**41**		**2,376**	
Item Missing	**485**		45	

Source: Va. Healthcare Workforce Data Center

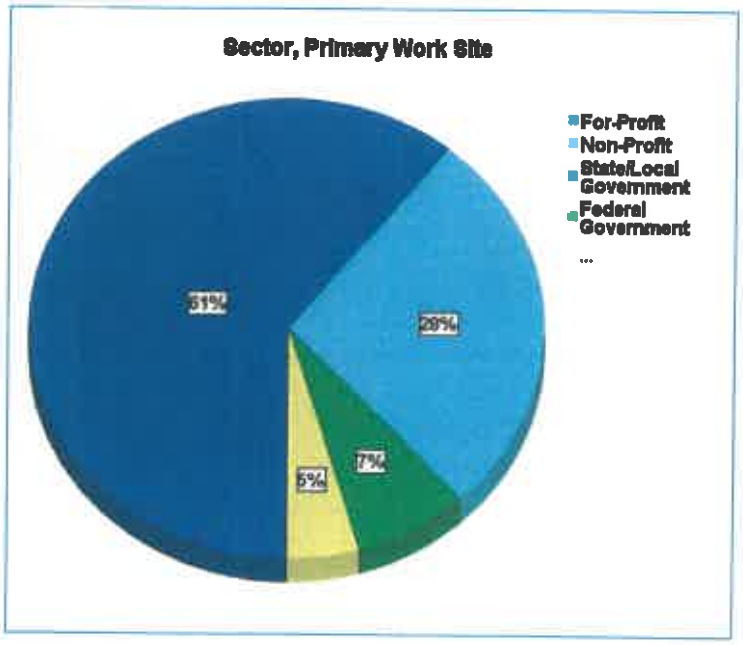
At a Glance:
(Primary Locations)

Sector
For Profit: 61%
Federal: 8%

Top Establishments
Group Practice: (Single Specialty) 32%
Hospital: (Emergency Dept.) 13%
Group Practice: (Multi-Specialty) 11%

Source: Va. Healthcare Workforce Data Center

61% of physician assistants work in for-profit establishments, while another 28% work at non-profit institutions. Meanwhile, 8% of physician assistants work for the federal government.



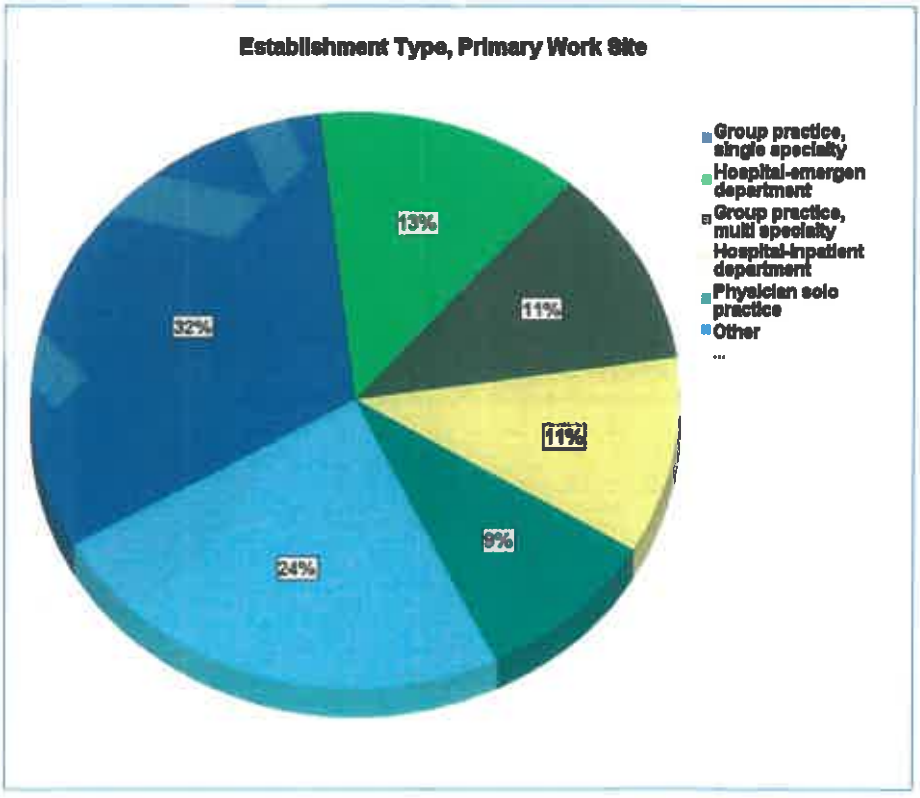
Source: Va. Healthcare Workforce Data Center

Top 10 Location Type				
Establishment Type	Primary Location		Secondary Location	
	#	%	#	%
Group Practice (Single Specialty)	816	32%	160	22%
Hospital (Emergency Dept.)	340	13%	159	22%
Group Practice (Multi-Specialty)	292	11%	43	6%
Hospital (Inpatient Dept.)	285	11%	86	12%
Physician (Solo Practice)	237	9%	65	9%
Hospital (Outpatient Dept.)	164	6%	29	4%
Community Clinic/Outpatient Care Center	104	4%	41	6%
Academic Institution (Teaching/Research)	77	3%	22	3%
Academic Institution (Patient Care)	50	2%	12	2%
Nursing home/Long Term Care Facility	23	1%	5	1%
All Other Types	200	8%	105	14%
Total	2,587	100%	726	100%
Does not have location	41		2,376	

Source: Va. Healthcare Workforce Data Center

43% of physician assistants work in a group practice, including close to a third who work in a group practice with a single specialty. Meanwhile, nearly a third of physician assistants work in a hospital, including 13% who work in an emergency department.

For those physician assistants with a secondary work location, 22% work in a group practice with a single specialty, while 22% work in the emergency department of a hospital.



Source: Va. Healthcare Workforce Data Center

At a Glance:

Top Tasks Performed

Managed Care of Patients (Outpatient): 72%
Minor Surgical Procedures: 56%

# of Hospitals w/ Privileges

None: 43%
One: 31%
More than One: 26%

Tasks Performed		
Task	#	%
Managed Care of Patients (Outpatient)	1,690	72%
Minor Surgical Procedures	1,308	56%
Manage Care of Patients (Inpatient)	779	33%
Supervise/Manage Other Clinical Staff	656	28%
First Assist at Surgery	536	23%
Supervise/Manage Other PAs	364	15%
At Least One Task Performed	2,350	

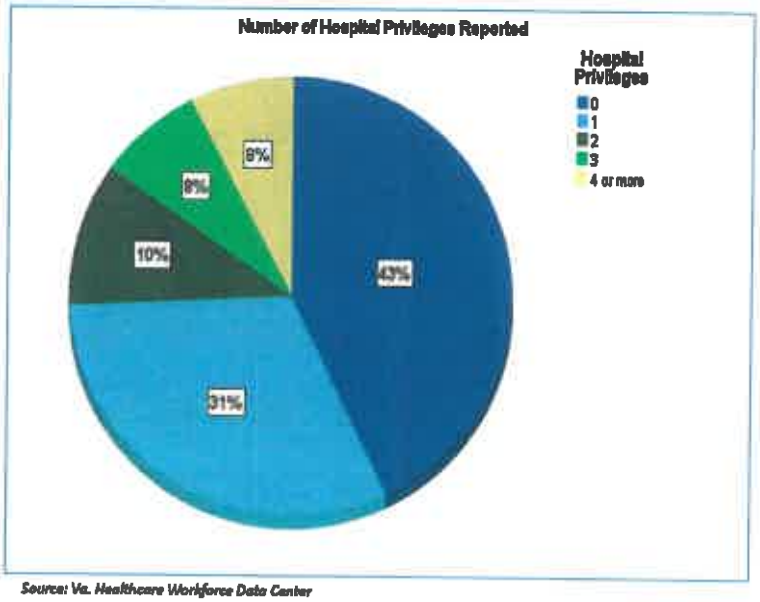
Source: Va. Healthcare Workforce Data Center

More than half of all physician assistants managed outpatient care and participated in minor surgical procedures at their place of work.

About one-third of physician assistants have hospital privileges at one hospital. In addition, just over one-quarter of physician assistants have privileges at multiple hospitals.

Hospital Privileges		
# of Hospitals	#	%
None	1,136	43%
1	836	31%
2	279	10%
3	201	8%
4 or More	204	8%
Total	2,655	100%

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Typical Time Allocation

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

Roles

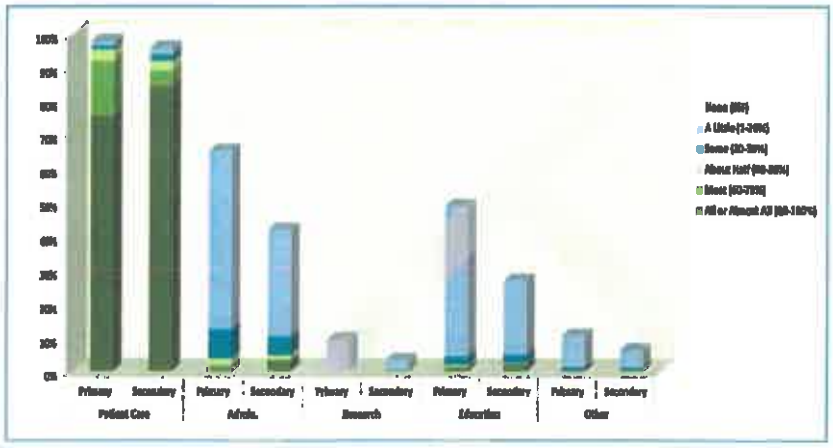
Patient Care:	92%
Administration:	2%
Education:	2%
Research:	0%

Administration Time

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

A typical physician assistant spends most of her time in patient care activities. More than 90% of physician assistants fill a patient care role, defined as spending 60% or more of their time in that activity.

Time Spent	Time Allocation									
	Patient Care		Admin.		Research		Education		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%)	76%	85%	1%	3%	0%	0%	1%	2%	0%	0%
Most (60-79%)	16%	5%	1%	1%	0%	0%	1%	0%	0%	0%
About Half (40-59%)	3%	3%	2%	1%	0%	0%	0%	0%	0%	0%
Some (20-39%)	1%	2%	9%	5%	0%	0%	2%	2%	1%	1%
A Little (1-20%)	1%	2%	53%	31%	10%	3%	44%	22%	9%	5%
None (0%)	2%	4%	35%	58%	90%	97%	51%	73%	89%	94%

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Median Weekly Visits

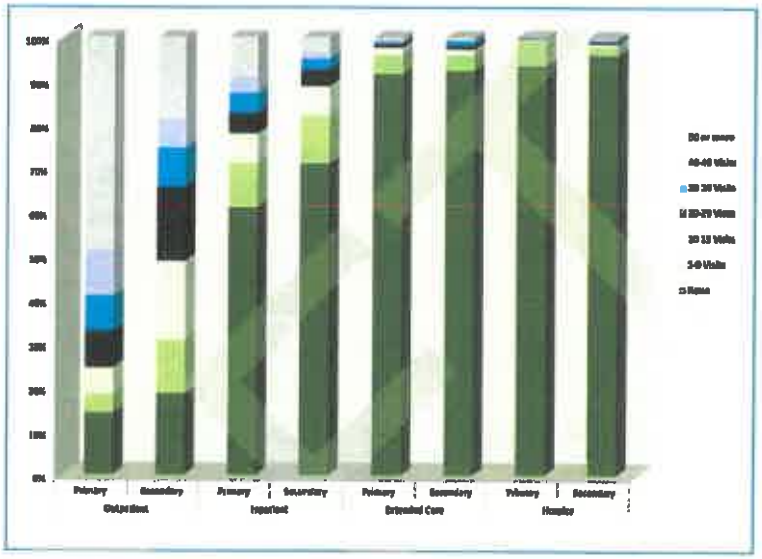
Outpatient:	40-49
Inpatient:	None
Extended Care:	None
Hospice:	None

% With Visits

Outpatient:	86%
Inpatient:	39%
Extended Care:	8%
Hospice:	7%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

Weekly Patient Visits

Visits Per Week	Outpatient		Inpatient		Extended Care		Hospice	
	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site
None	14%	19%	61%	71%	92%	92%	93%	96%
1-9 Visits	4%	12%	10%	11%	4%	4%	6%	2%
10-19 Visits	6%	18%	7%	7%	2%	1%	0%	1%
20-29 Visits	8%	17%	5%	4%	1%	1%	0%	1%
30-39 Visits	8%	9%	4%	2%	0%	1%	0%	0%
40-49 Visits	10%	7%	4%	1%	0%	0%	0%	1%
50 or More Visits	49%	19%	9%	4%	1%	0%	0%	0%

Source: Va. Healthcare Workforce Data Center

A typical physician assistant spends most of their patient care time in an outpatient setting. Nearly 60% of physician assistants had at least 40 outpatient visits per week, while a majority of professionals did not have any inpatient, extended care or hospice visits in a given week.

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All		Over 50	
	#	%	#	%
Under age 50	79	3%	-	-
50 to 54	101	4%	3	1%
55 to 59	292	11%	23	5%
60 to 64	661	26%	93	20%
65 to 69	936	37%	195	43%
70 to 74	249	10%	75	17%
75 to 79	49	2%	13	3%
80 or over	31	1%	8	2%
I do not intend to retire	151	6%	43	10%
Total	2,550	100%	454	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All Professionals

Under 65:	44%
Under 60:	19%

50 and over

Under 65:	26%
Under 60:	6%

Time until Retirement

Within 2 years:	2%
Within 10 years:	9%
Half the workforce:	By 2047

Source: Va. Healthcare Workforce Data Center

44% of physician assistants expect to retire by the age of 65. Meanwhile, 19% expect to work until at least age 70, including 6% who do not intend to retire at all. Among those physician assistants who are age 50 and over, more than one-quarter still plan on retiring by 65, while approximately 31% expect to work until at least age 70.

Within the next two years approximately 5% of physician assistants expect to leave either the profession or Virginia. Meanwhile, 11% of physician assistants plan on pursuing additional educational opportunities, and 11% plan on increasing teaching hours.

Future Plans		
2 Year Plans:	#	%
Decrease Participation		
Leave Profession	34	1%
Leave Virginia	116	4%
Decrease Patient Care Hours	241	8%
Decrease Teaching Hours	12	0%
Increase Participation		
Increase Patient Care Hours	264	8%
Increase Teaching Hours	348	11%
Pursue Additional Education	341	11%
Return to Virginia's Workforce	18	1%

Source: Va. Healthcare Workforce Data Center

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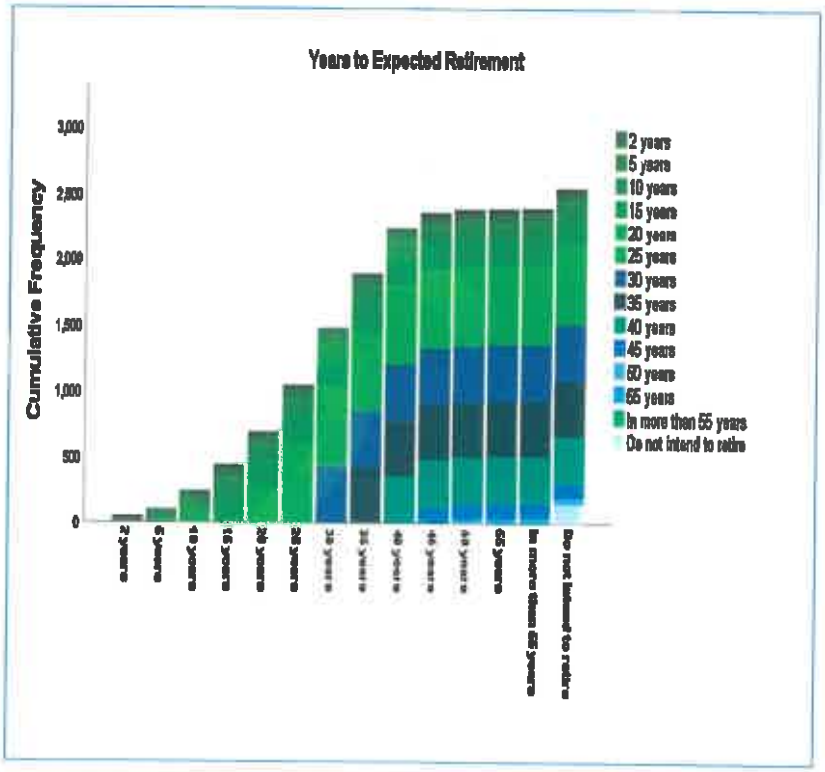
By comparing retirement expectation to age, we can estimate the maximum years to retirement. Only 2% of physician assistants plan on retiring in the next two years, while 9% plan on retiring in the next ten years. Half of the current physician assistant workforce expects to be retired by 2047.

Time to Retirement			
Expect to retire within. . .	#	%	Cumulative %
2 years	48	2%	2%
5 years	54	2%	4%
10 years	139	5%	9%
15 years	198	8%	17%
20 years	251	10%	27%
25 years	352	14%	41%
30 years	432	17%	58%
35 years	417	16%	74%
40 years	352	14%	88%
45 years	120	5%	93%
50 years	25	1%	94%
55 years	8	0%	94%
In more than 55 years	3	0%	94%
Do not intend to retire	151	6%	100%
Total	2,550	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 2037. Peak retirement years will take place around 2047, when 17% of the current workforce expects to retire every five years. After 2047, retirements will not permanently fall below 10% of the current workforce during a five-year time interval until 2065.

Full-Time Equivalency Units

At a Glance:

FTEs

Total:	2,973
Average:	0.95

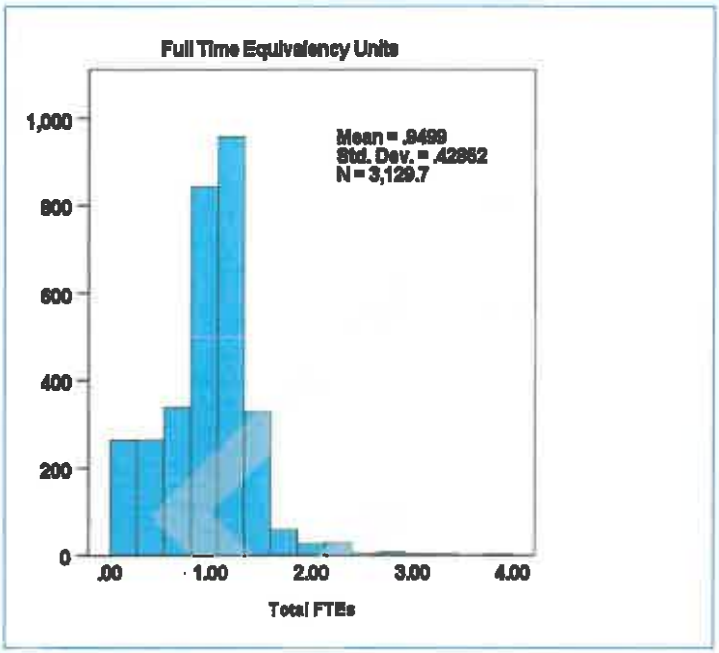
Age & Gender Effect

Age, Partial Eta^2:	0.015
Gender, Partial Eta^2:	0.014

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

.01=Small Effect
.06=Medium Effect
138=Large Effect

A Closer Look:

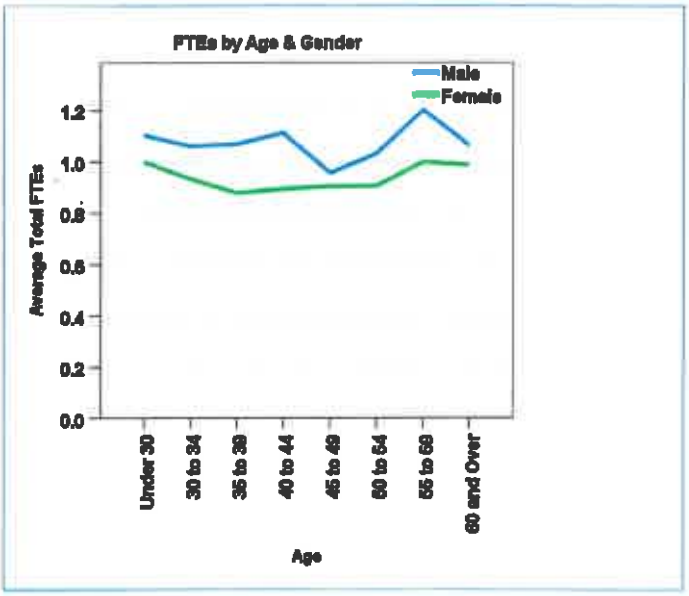


Source: Va. Healthcare Workforce Data Center

The average physician assistant provided 0.99 FTEs in 2017, or about 38 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	Average	Median
Age		
Under 30	1.02	1.10
30 to 34	0.89	0.95
35 to 39	0.92	0.95
40 to 44	1.02	1.10
45 to 49	0.86	0.84
50 to 54	0.95	0.96
55 to 59	1.08	1.10
60 and Over	1.02	1.03
Gender		
Male	1.07	1.13
Female	0.93	0.95

Source: Va. Healthcare Workforce Data Center

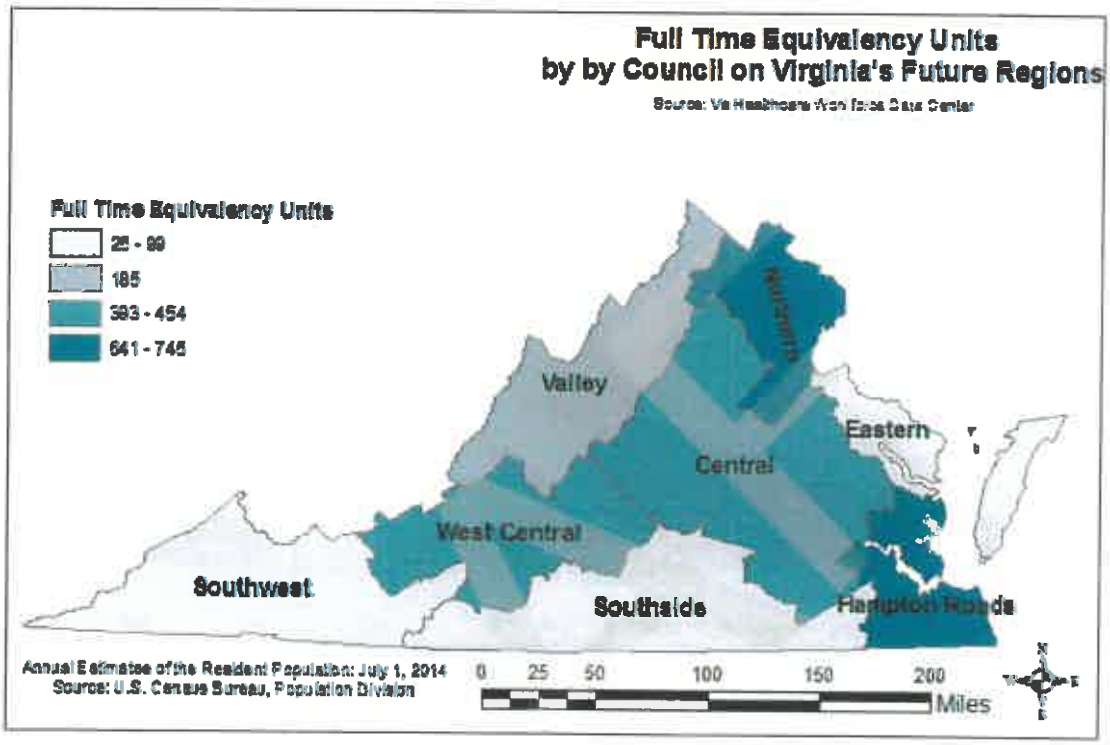


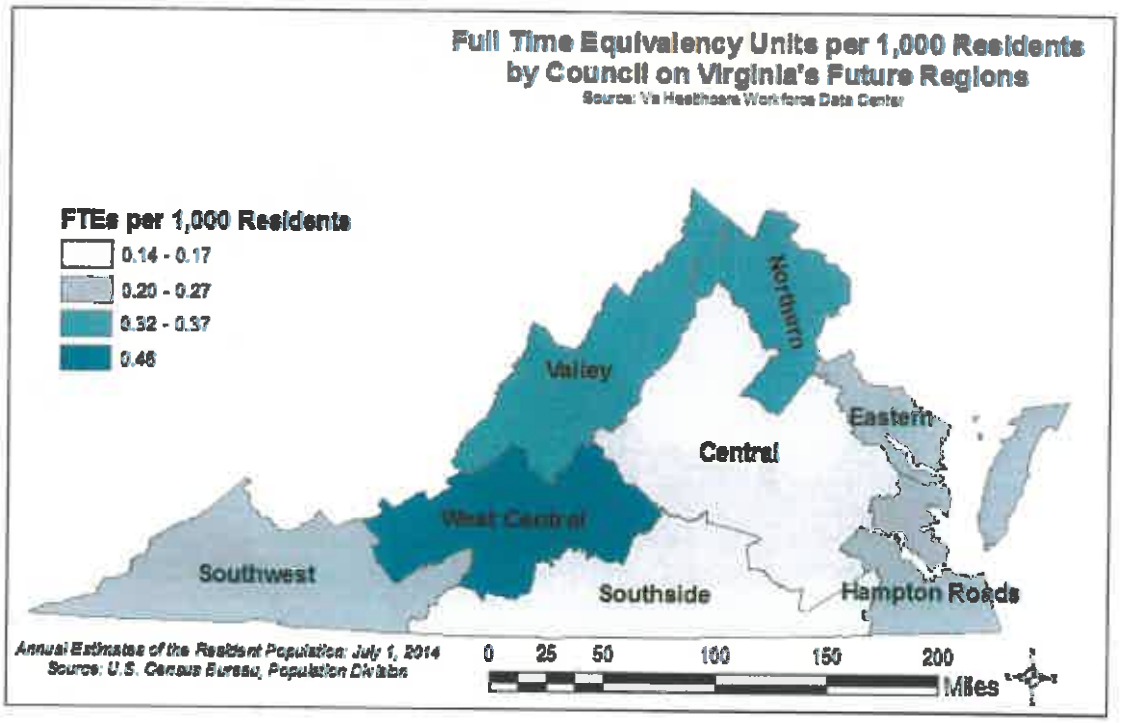
Source: Va. Healthcare Workforce Data Center

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

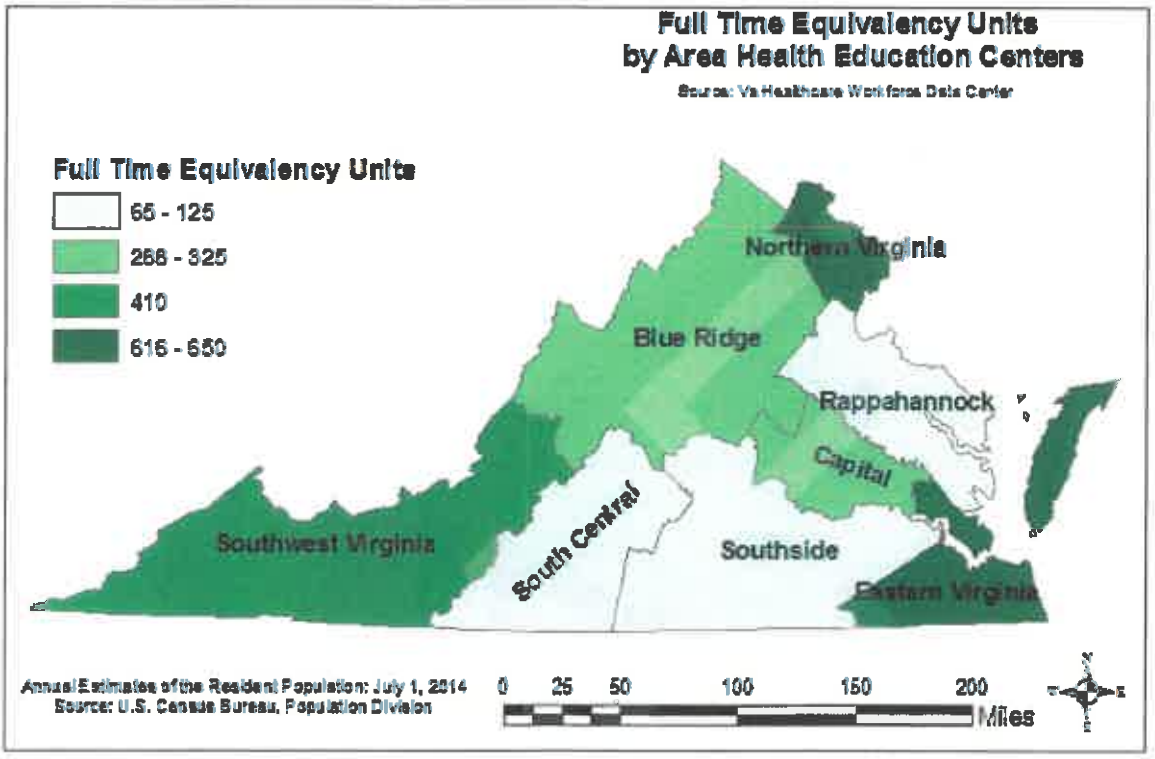
Maps

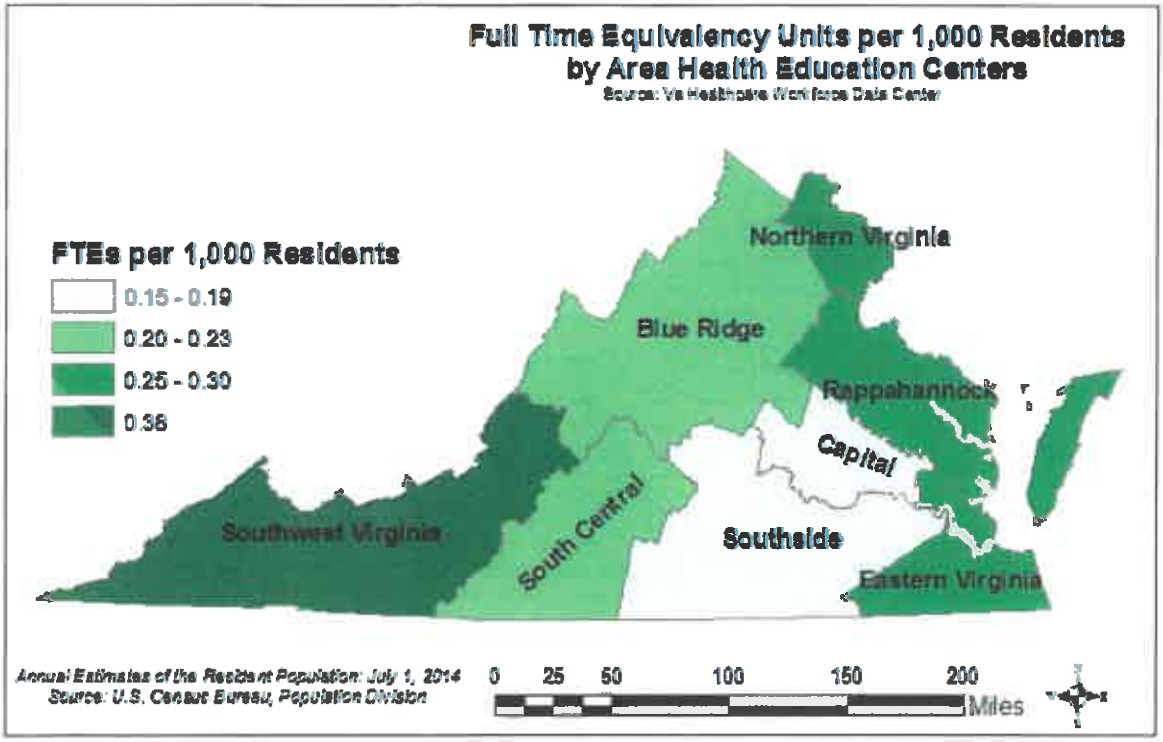
Council on Virginia's Future Regions



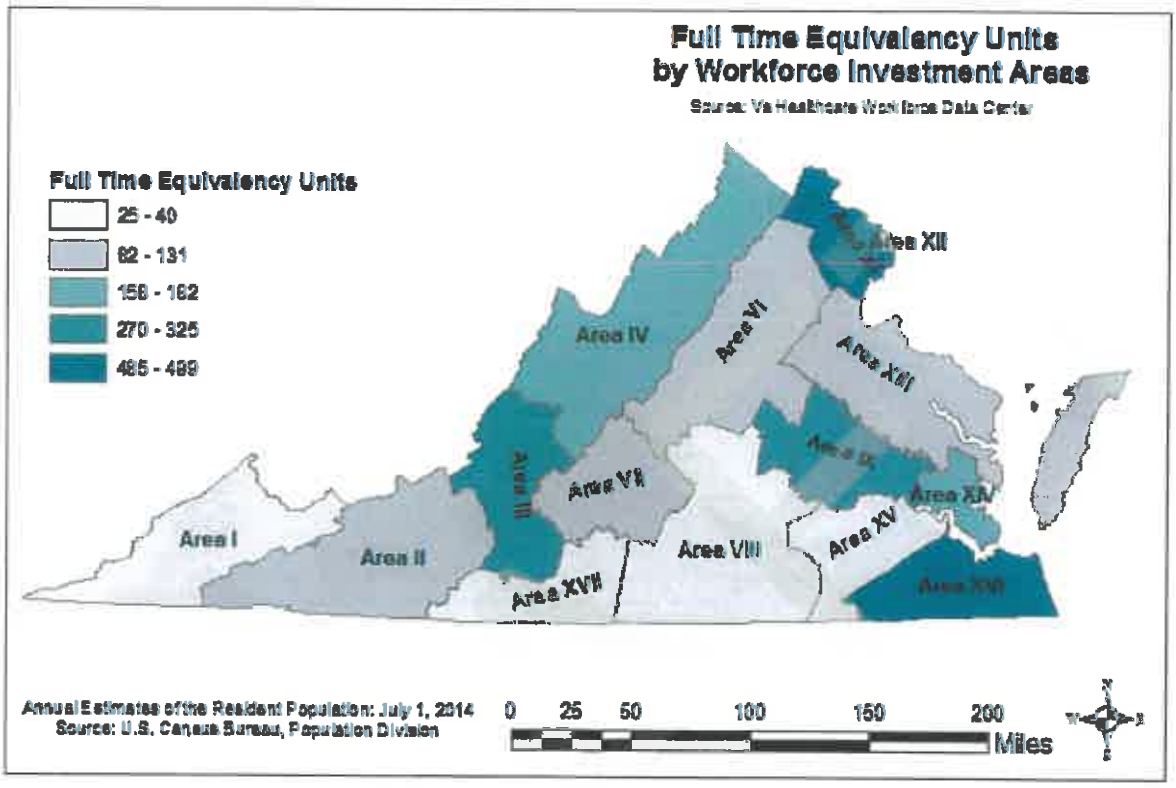


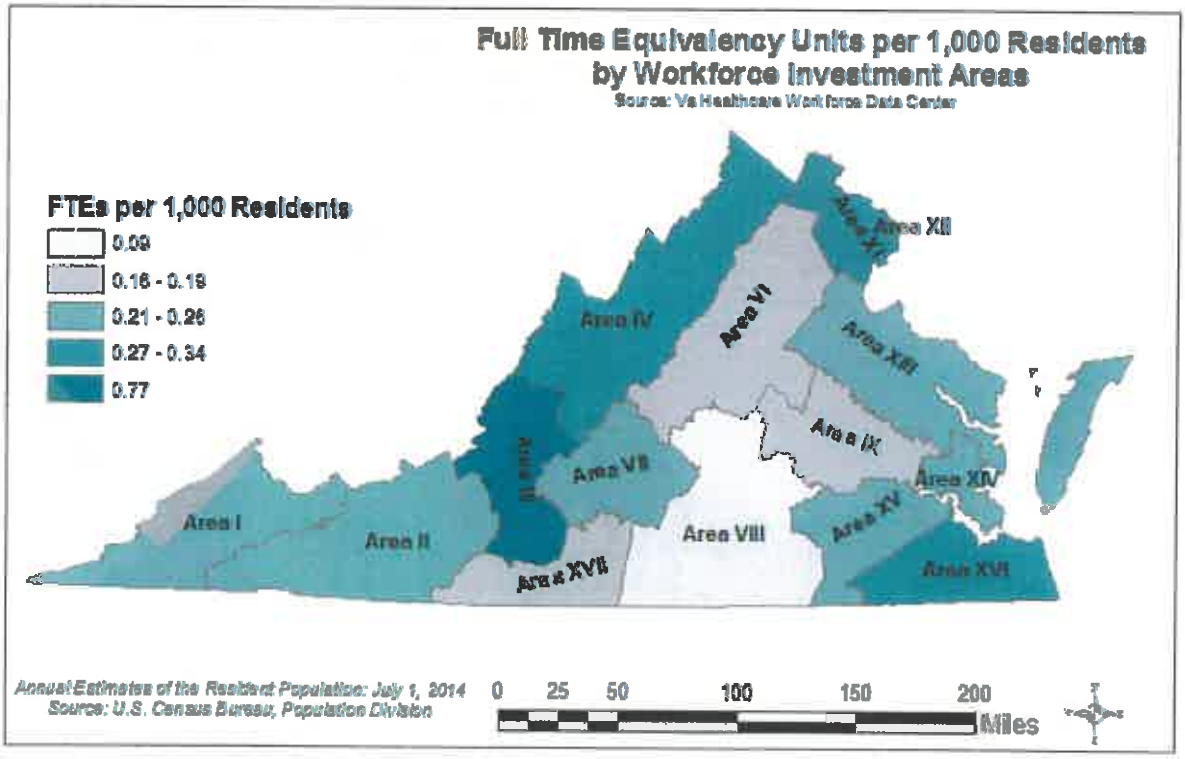
Area Health Education Center Regions



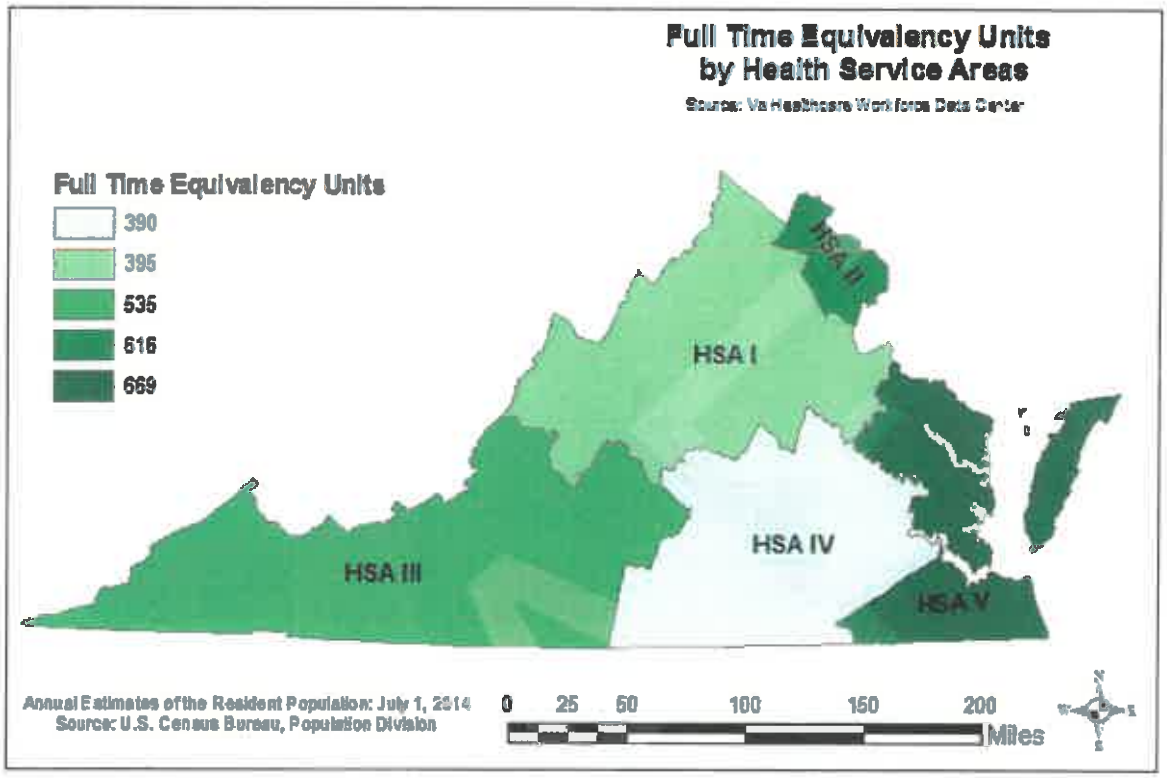


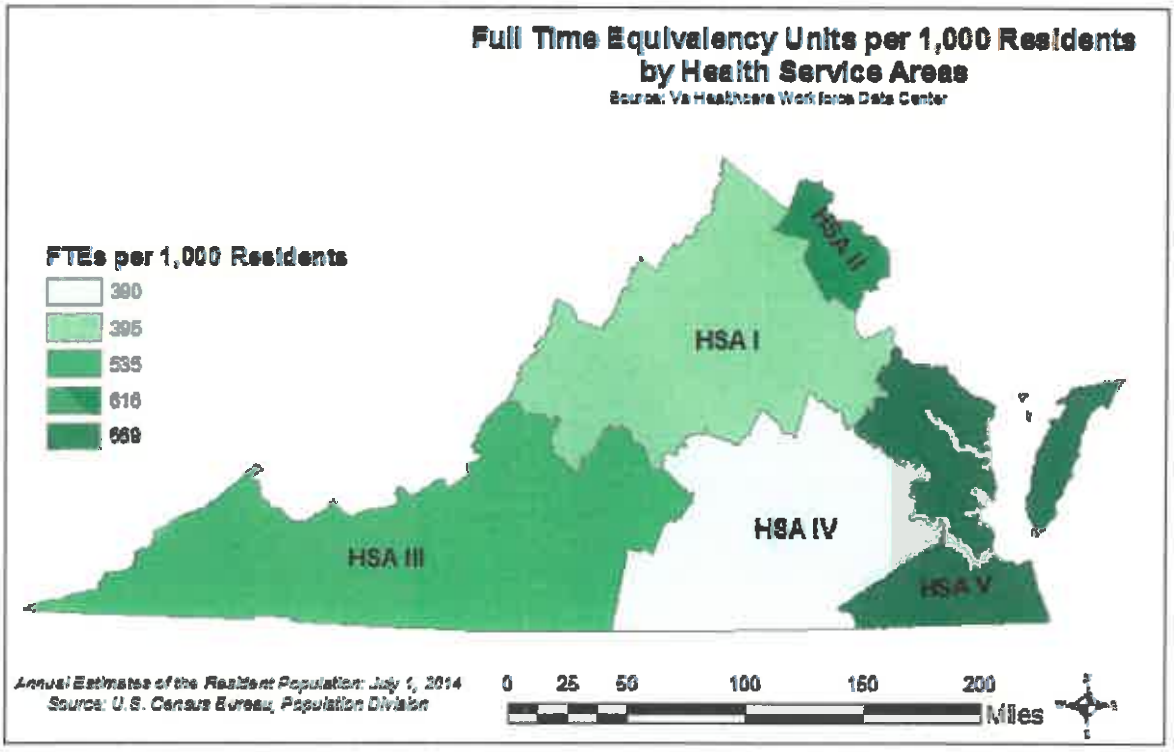
Workforce Investment Areas



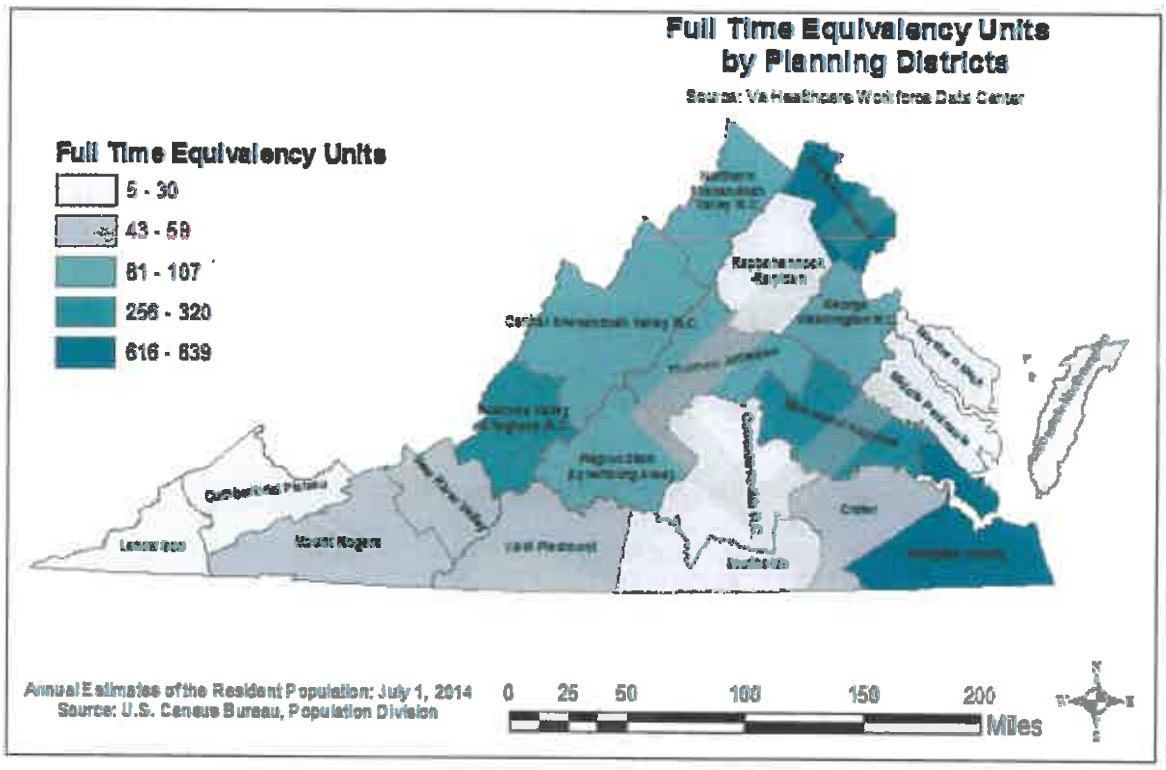


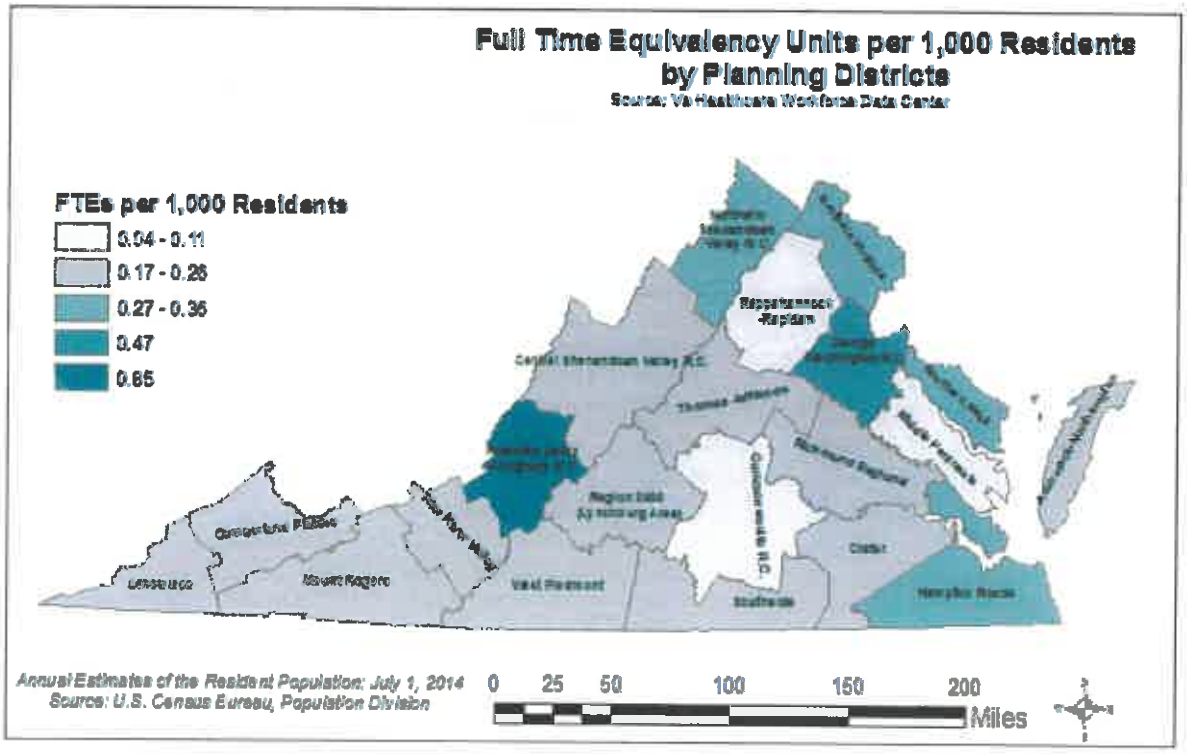
Health Services Areas





Planning Districts





Appendix

Weights

Rural Status	Location Weight #	Rate	Weight	Total Weight Min	Max
Metro, 1 million+	2154	73.96%	1.352165725	1.125773043	2.765540635
Metro, 250,000 to 1 million	372	72.58%	1.377777778	1.147096878	2.817924134
Metro, 250,000 or less	314	76.11%	1.313807531	1.09383715	2.687087867
Urban pop 20,000+, Metro adj	27	77.78%	1.285714286	1.070447547	2.629629664
Urban pop 20,000+, nonadj	0	NA	NA	NA	NA
Urban pop, 2,500-19,999, Metro adj	61	83.61%	1.196078431	0.995819396	2.446300363
Urban pop, 2,500-19,999, nonadj	40	85.00%	1.176470588	0.979494488	2.406197078
Rural, Metro adj	27	77.78%	1.285714286	1.070447547	2.629629664
Rural, nonadj	9	66.67%	1.5	1.248855472	1.393567614
Virginia border state/DC	483	58.39%	1.712765957	1.425998092	3.503064577
Other US State	468	49.57%	2.017241379	1.67949529	4.125798266

Source: Va. Healthcare Workforce Data Center

Age	Age Weight #	Rate	Weight	Total Weight Min	Max
Under 30	453	34.00%	2.941558442	2.406197078	4.125798266
30 to 34	918	64.81%	1.542857143	1.262058335	2.163994852
35 to 39	783	74.84%	1.336177474	1.092994207	1.87410817
40 to 44	589	75.04%	1.332579186	1.090050804	1.869061249
45 to 49	432	80.56%	1.24137931	1.015449235	1.741145284
50 to 54	279	83.51%	1.197424893	0.979494488	1.67949529
55 to 59	207	81.64%	1.224852071	1.001929941	1.717964355
60 and Over	297	75.76%	1.32	1.07976102	1.851417818

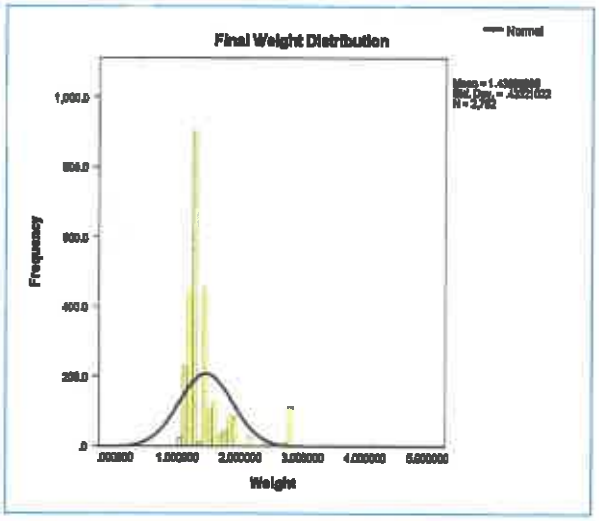
Source: Va. Healthcare Workforce Data Center

See the Methods section on the HWDC website for details on HWDC Methods: www.dhp.virginia.gov/hwdc/

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

ageweight x ruraiweight x response rate = final weight.

Overall Response Rate: 0.6953



Source: Va. Healthcare Workforce Data Center

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July 31, 2018

Jennifer Deschenes, J.D., M.S.
Deputy Executive Director, Discipline
Virginia Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

Re: Request for Advisory Opinion or Guidance re PA Supervision

Dear Jennifer:

I am writing in follow up to the many communications we have had over the years and particularly in the past month. You have been clear in representing that neither you nor Board staff can provide legal advice or presumptive opinions while nevertheless being empathetic to the fact that some incongruities in the laws and regulations governing Physician Assistants make them difficult to apply in certain instances. I mean no disrespect when I say that the laws seem counter intuitive. To try and best overcome this impasse, I am seeking either an advisory opinion or official guidance from the Board via whatever process or mechanism is available or better suited to achieve that goal.

My client is a hospital system ("hospital"), but my question is applicable to a variety of entities. The hospital wants to utilize the services of its employed physician assistants ("PAs") for the mutual benefit of its patients and its on-call physicians, but in the hypothetical I will pose, one or more provisions of the operative statute seems to work against all parties involved.

HYPOTHETICAL:

The hospital employs no orthopedic surgeons. The position of Chairman for the Department of Orthopedics rotates amongst practitioners in the 3 major orthopedic practices in the community. The practices, while working in concert to provide coordinated services to the hospital, are nonetheless competitors. Each of these practices share calls at the hospital—also on a rotating basis. To facilitate with that process, the hospital hires a PA to be on-site at the hospital and available to the on-call orthopedist who would serve as that PA's "supervising" physician while on-call.

My client and I do not want their good intentions to service these patients by providing after-hours coverage as outlined in the hypothetical to contravene the language or intent of the statutory language. More specifically, Va. Code Section § 54.1-2952B (ii) states that:

"...No person shall have control of or supervisory responsibility for any physician assistant who is not employed by the person or the person's business entity."

Even if the PA enters into practice agreement as defined in 18VAC85-50-115. *"Responsibilities of the physician assistant"* it appears that the on-call orthopedist cannot supervise the PA pursuant to in 18VAC85-50-10(B) 1, - even as an "alternating supervisor" because under the definitions:

"Alternate supervising physician" means a member of the same group or professional corporation or partnership of any licensee, any hospital or any commercial enterprise with the supervising physician."

In short , even with a well-defined practice agreement in place and with his or her direct or continuous physical presence, in the above mentioned scenario, the community orthopedist cannot control or have supervisory responsibility over the PA because if they are not both employed by the same person or the person's business entity. Pasted below is Virginia Code § 54.1-2952 regarding the "supervision of assistants by licensed physician, or podiatrist; services that may be performed by assistants; responsibility of licensee; employment of assistants." Even if the licensees were to meet all other requirements of the statute, if they do not conform to the sole provision relating to employment arrangements between the PA and the physician (which I have highlighted in yellow), they would risk being in violation.

"§ 54.1-2952. Supervision of assistants by licensed physician, or podiatrist; services that may be performed by assistants; responsibility of licensee; employment of assistants.

A. A physician or a podiatrist licensed under this chapter may supervise physician assistants and delegate certain acts which constitute the practice of medicine to the extent and in the manner authorized by the Board. The physician shall provide continuous supervision as required by this section; however, the requirement for physician supervision of physician assistants shall not be construed as requiring the physical presence of the supervising physician during all times and places of service delivery by physician assistants. Each team of supervising physician and physician assistant shall identify the relevant physician assistant's scope of practice, including the delegation of medical tasks as appropriate to the physician assistant's level of competence, the physician assistant's relationship with and access to the supervising physician, and an evaluation process for the physician assistant's performance.

Activities shall be delegated in a manner consistent with sound medical practice and the protection of the health and safety of the patient. Such activities shall be set

forth in a practice supervision agreement between the physician assistant and the supervising physician or podiatrist and may include health care services which are educational, diagnostic, therapeutic, preventive, or include treatment, but shall not include the establishment of a final diagnosis or treatment plan for the patient unless set forth in the practice supervision agreement. Prescribing or dispensing of drugs may be permitted as provided in § 54.1-2952.1. In addition, a licensee is authorized to delegate and supervise initial and ongoing evaluation and treatment of any patient in a hospital, including its emergency department, when performed under the direction, supervision and control of the supervising licensee. When practicing in a hospital, the physician assistant shall report any acute or significant finding or change in a patient's clinical status to the supervising physician as soon as circumstances require and shall record such finding in appropriate institutional records. The physician assistant shall transfer to a supervising physician the direction of care of a patient in an emergency department who has a life-threatening injury or illness. Prior to the patient's discharge, the services rendered to each patient by a physician assistant in a hospital's emergency department shall be reviewed in accordance with the practice agreement and the policies and procedures of the health care institution. A physician assistant who is employed to practice in an emergency department shall be under the supervision of a physician present within the facility.

Further, unless otherwise prohibited by federal law or by hospital bylaws, rules, or policies, nothing in this section shall prohibit any physician assistant who is not employed by the emergency physician or his professional entity from practicing in a hospital emergency department, within the scope of his practice, while under continuous physician supervision as required by this section, whether or not the supervising physician is physically present in the facility. The supervising physician who authorizes such practice by his physician assistant shall (I) retain exclusive supervisory control of and responsibility for the physician assistant and (II) be available at all times for consultation with both the physician assistant and the emergency department physician. Prior to the patient's discharge from the emergency department, the physician assistant shall communicate the proposed disposition plan for any patient under his care to both his supervising physician and the emergency department physician. No person shall have control of or supervisory responsibility for any physician assistant who is not employed by the person or the person's business entity.

B. No physician assistant shall perform any delegated acts except at the direction of the licensee and under his supervision and control. No physician assistant practicing in a hospital shall render care to a patient unless the physician responsible for that patient has signed the practice agreement, pursuant to regulations of the Board, to act as supervising physician for that physician assistant. Every licensee, professional corporation or partnership of licensees, hospital or commercial enterprise that employs a physician assistant shall be fully responsible for the acts of the physician assistant in the care and treatment of human beings.

C. Notwithstanding the provisions of § 54.1-2956.8:1, a licensed physician assistant who (I) is working under the supervision of a licensed doctor of medicine or

osteopathy specializing in the field of radiology, (ii) has been trained in the proper use of equipment for the purpose of performing radiologic technology procedures consistent with Board regulations, and (iii) has successfully completed the exam administered by the American Registry of Radiologic Technologists for physician assistants for the purpose of performing radiologic technology procedures may use fluoroscopy for guidance of diagnostic and therapeutic procedures."

I am struggling to understand why the parties should be required to enter into a tenuous written employment agreement to comply with a legal provision that neither directly nor indirectly contributes to better patient care. Further, should it even be necessary in the face of the other existing provisions of § 54.1-2952 and 18 VAC 85-50-10 et seq. which govern the scope and standards of practice that do impact patient care. I am respectfully requesting official guidance from the Board to enable my client to determine how best to proceed. If my interpretation of the law is correct and my client is precluded from the supervisory arrangement referenced in the hypothetical without the on-call physician and the PA being employed by the same entity, then I am seeking either an Advisory Opinion or Guidance Document that might provide a more viable avenue for the parties to accomplish their goal to have the "control of or supervisory responsibility for any physician assistant who is not employed by the person or the person's business entity."

Our proposal to permit the supervision of a PA by a physician not employed by the same practice as the PA is at most a cosmetic distinction in the hypothetical. The on-call physicians will be providing the oversight and safeguards for patient safety which are the bedrock upon which the laws are based. In this context, it is the practice agreement between the PA and physician which governs the shared duty of care provided each patient, not the employment relationship between the parties. If it was the intent of the law at its inception to ensure that the most qualified physician exercise control/supervision over the PA, it can be and is accomplished equally as well with the on-call physician and PA referenced in our proposal. If the goal is to provide accountability and to ensure the best patient care and outcomes, our scenario demonstrates the requisite hands-on treatment, supervision and written agreements in an evolving health care system.

Please let me know if you need additional information for me to seek such guidance or if you or the Board believes there are other more expeditious routes to accomplish this. Thank you for your kind assistance and consideration.

Sincerely,

Michael L. Goodman

Virginia Board of Medicine
2019 Board Meeting Dates

Full Board Meetings

February 14-16, 2019	DHP/Richmond, VA	Board Rooms TBA
June 13-15, 2019	DHP/Richmond, VA	Board Rooms TBA
October 17-19, 2019	DHP/Richmond, VA	Board Rooms TBA

Times for the above meetings are 8:30 a.m. to 5:00 p.m.

Executive Committee Meetings

April 5, 2019	DHP/Richmond, VA	Board Rooms TBA
August 2, 2019	DHP/Richmond, VA	Board Rooms TBA
December 6, 2019	DHP/Richmond, VA	Board Rooms TBA

Times for the above meetings are 8:30 a.m. to 5:00 p.m.

Legislative Committee Meetings

January 11, 2019	DHP/Richmond, VA	Board Rooms TBA
May 17, 2019	DHP/Richmond, VA	Board Rooms TBA
September 6, 2019	DHP/Richmond, VA	Board Rooms TBA

Times for the above meetings are 8:30 a.m. to 1:00 p.m.

Credentials Committee Meetings

January 9, 2019	February 20, 2019	March 13, 2019
April 17, 2019	May 29, 2019	June 26, 2019
July 24, 2019	August 21, 2019	September 25, 2019
October 23, 2019	November 13, 2019	December (TBA), 2019

Times for the Credentials Committee meetings - TBA

Advisory Board on:

Behavioral Analysts			10:00 a.m.
January 21	May 20	September 30	
Genetic Counseling			1:00 p.m.
January 21	May 20	September 30	
Occupational Therapy			10:00 a.m.
January 22	May 21	October 1	
Respiratory Care			1:00 p.m.
January 22	May 21	October 1	
Acupuncture			10:00 a.m.
January 23	May 22	October 2	
Radiological Technology			1:00 p.m.
January 23	May 22	October 2	
Athletic Training			10:00 a.m.
January 24	May 23	October 3	
Physician Assistants			1:00 p.m.
January 24	May 23	October 3	
Midwifery			10:00 a.m.
January 25	May 24	October 4	
Polysomnographic Technology			1:00 p.m.
January 25	May 24	October 4	

Joint Boards of Medicine and Nursing

TBA