

Advisory Board on Physicians Assistants

Board of Medicine

February 7, 2013, 1:00 PM

9960 Mayland Drive, Suite 201

Richmond, VA

Board Room 1

Page

Call to Order – Rachel Carlson, PA-C Chair

Emergency Egress Procedures – Rachel Carlson, PA-C

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Roll Call – ShaRon Clanton

Approval of Minutes of June 28, 2012 and December 6, 2012

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Adoption of the Agenda

Public Comment on Agenda Items (15 minutes)

NEW BUSINESS

1. Health Practitioners Survey – Dr. Elizabeth Carter
2. Legislative Report – Elaine Yeatts
3. Review of Regulatory Revisions – Elaine Yeatts
4. 2013 Meeting Calendar
5. Election of Officers
6. Conflict of Interest Training

6-13

14-28

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Announcements

Next Scheduled Meeting: June 6, 2013 @ 1:00 p.m.

Adjournment

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

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

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

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

Board Room 1

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

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

**ADVISORY BOARD ON PHYSICIAN ASSISTANTS
MINUTES**

June 28, 2012

The Advisory Board on Physician Assistants met Thursday, June 28, 2012, at 10:15 a.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, Virginia. Rachel Carlson, PA-C, Chair, called the meeting to order. A quorum was declared.

MEMBERS PRESENT: Rachel Carlson, PA-C, Chair
Thomas Parish, PA-C, Vice-Chair
Paul Marino, PA-C

MEMBERS ABSENT: James Potter, MD
Kishore Thota

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

CALL TO ORDER

Ms. Carlson called the meeting to order.

Let it be noted for the record that Ms. Carlson announced the Emergency Evacuation Instructions.

ROLL CALL

Roll was called and a quorum declared.

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APPROVAL OF MINUTES DATED FEBRUARY 3, 2011

Mr. Parish moved to approve the minutes dated February 3, 2011. The motion was seconded and carried.

ADOPTION OF AGENDA

Mr. Parrish moved to approve the adoption of the agenda. Ms. Yeatts asked that the Status of Proposed Regulations be added. The motion to adopt with Ms. Yeatts' addition was seconded and carried.

PUBLIC COMMENT ON AGENDA ITEMS

Mr. Falkenstein, representing VAPA, addressed the Advisory Board regarding the requirements for the use of fluoroscopy by PA's and provided the Advisory with the document on training agreed to by the AAPA and the ARRT. He further requested that the clause "within one hour" be removed from the definition of "General Supervision" being considered in the draft regulations. He addressed the authority of physician assistants to write Do Not Resuscitate Orders (DNR Orders). He noted that nurse practitioners can write DNR orders and that the Committee of the Joint Boards of Nursing and Medicine describe this authority in a guidance document. He requested that the Board of Medicine create a guidance document that addresses the authority of physician assistants to write DNR orders.

NEW BUSINESS

1. Legislative Report from the 2012 General Assembly

Mrs. Yeatts reviewed bills from the 2012 Session of the General Assembly relevant to the profession of physician assisting.

2. Physician Assistants signing DNR papers

The authority for a PA to write DNR orders must be included in the written protocol as a delegated act by the supervising physician and must be performed in consultation with the physician. Guidance Document 85-8 was reviewed.

3. Definition of General Supervision

Dr. Harp discussed the definitions of general supervision and continuous supervision in the proposed regulations. The concept of continuous supervision was deemed to mean that the supervisor was continuously available, either in-person or electronically, for routine and rapid consultation.

4. Adoption of Amended Regulations for Physician Assistants

Mrs. Yeatts reviewed the proposed regulations as presented including Authorization to use Fluoroscopy written as a new section, 18VAC85-50-117. Paul Marino moved to recommend the Adoption of Amended Regulations for Physician Assistants to the Executive Committee on August 3, 2012.

ANNOUNCEMENTS

Ms. Carlson announced the proposed changes coming into effect in 2014 concerning NCCPA certification with the general examination moving to every 10 years; however, PA's will be required to maintain certification with 100 hours of CME every 2 years.

NEXT SCHEDULED MEETING

October 4, 2012

ADJOURNMENT

Thomas Parish moved to adjourn. The motion was seconded and carried.

Rachel Carlson, PA-C, Chair

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

ShaRon Clanton, Licensing Specialist

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**PUBLIC HEARING ON PROPOSED REGULATIONS FOR THE SUPERVISION OF
PHYSICIAN ASSISTANT PRACTICE
MINUTES**

December 6, 2012

A public hearing of the Virginia Board of Medicine was held on Thursday, December 6, 2012, at 8:55 a.m. at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, Richmond, Virginia.

MEMBERS PRESENT: Wayne Reynolds, DO

STAFF PRESENT: William L. Harp, MD, Executive Director
Alan Heaberlin, Deputy Executive Director
Elaine Yeatts, Senior Regulatory Analyst

GUESTS PRESENT: David Falkenstein, PA, VAPA
Hunter Jamerson,

CALL TO ORDER: Wayne Reynolds, DO called the meeting to order.

PUBLIC COMMENT ON AGENDA ITEMS

Mr. Falkenstein, representing the Virginia Academy of Physician Assistants, addressed the Board regarding the proposed changes by offering the Academy's support and to encourage the full Board of Medicine to adopt the changes as written.

Mr. Jamerson, representing the Virginia Academy of Family Physicians, addressed to Board regarding the proposed changes by offering the Academy's support and to recommend passage of the regulations.

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ADJOURNMENT

There being no more comments offered to the Board, Dr. Reynolds adjourned the meeting at 9:00 a.m.

Wayne Reynolds, DO, Chair

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

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Report of the 2013 General Assembly

Board of Medicine - Advisory Boards

HB 1352 Health care records; increases maximum copying fee that a health provider may charge.

Chief patron: Habeeb

Summary as introduced:

Health care records; copying fees. Increases the maximum fee that a health care provider may charge for retrieving, reviewing, and preparing copies of patient records in response to a subpoena duces tecum or a request by the patient, his attorney, or his executor or administrator. The maximum fee is raised from \$0.50 to \$0.75 per page for up to 50 pages and from \$0.25 to \$0.50 per page for documents in excess of 50 pages. The bill also raises the maximum search and handling fee from \$10 to \$20.

11/29/12 House: Referred to Committee for Courts of Justice

01/10/13 House: Assigned Courts sub: #2 Civil

01/21/13 House: Subcommittee failed to recommend reporting (3-Y 4-N)

01/23/13 House: Subcommittee recommends reporting with amendment(s) (5-Y 1-N)

HB 1422 Interchangeable biosimilar biological products; permits pharmacists to dispense.

Chief patron: O'Bannon

Summary as introduced:

Dispensing of interchangeable biosimilar biological products. Permits pharmacists to dispense a biosimilar that has been licensed by the U.S. Food and Drug Administration as interchangeable with a prescribed biological product unless the prescriber indicates such substitution is not authorized or the patient insists on dispensing of the prescribed biological product. The bill requires any pharmacist who dispenses an interchangeable biosimilar to inform the patient prior to dispensing the biosimilar, provide notification of the substitution to the prescriber, and record the brand name or the product name and name of the manufacturer of the biosimilar on the record of dispensing and the prescription label.

01/21/13 House: Engrossed by House - floor substitute HB1422H1

01/22/13 House: Read third time and passed House (91-Y 6-N 1-A)

01/22/13 House: VOTE: PASSAGE (91-Y 6-N 1-A)

01/23/13 Senate: Referred to Committee on Education and Health

HB 1444 Medications; administration by certain employees or contract service providers.

Chief patron: O'Bannon

Summary as introduced:

Administration of medications by employees or contract service providers of providers licensed by the Department of Behavioral Health and Developmental Services. Provides that employees of or persons providing services pursuant to a contract with a provider licensed by the Department of Behavioral Health and Developmental Services may administer insulin, glucagon, and epinephrine in certain circumstances; provides protection from liability for certain acts related to such administration; and requires the Board of Nursing to promulgate regulations governing training in the administration of epinephrine by persons authorized to administer epinephrine.

01/22/13 House: Impact statement from DPB (HB1444E)
01/22/13 House: Read third time and passed House BLOCK VOTE (98-Y 0-N)
01/23/13 Senate: Referred to Committee on Education and Health

HB 1463 Tramadol; adds to list of Schedule IV controlled substances.

Chief patron: Yost

Summary as introduced:

Schedule IV controlled substances; tramadol. Adds tramadol, an opiate painkiller, to the list of Schedule IV controlled substances.

12/28/12 House: Referred to Committee on Health, Welfare and Institutions
01/07/13 House: Impact statement from VCSC (HB1463)
01/11/13 House: Assigned HWI sub: #2
01/24/13 House: Subcommittee recommends reporting with amendment(s) (7-Y 0-N)

HB 1468 Public schools; possession & administration of epinephrine by employees of local governing bodies.

Chief patron: Greason

Summary as introduced:

Public schools; possession and administration of epinephrine. Adds employees of local governing bodies and employees of local health departments to the lists of individuals who are permitted to possess and administer epinephrine and not be held liable for civil damages when certain conditions are met. The bill also requires local school boards to include in policies for the possession and administration of epinephrine a provision adding any employee of a local governing body or an employee of a local health department who is authorized by a prescriber and trained in the administration of epinephrine to administer the drug to any student believed to be having an anaphylactic reaction.

EMERGENCY

01/23/13 House: Emergency clause added
01/23/13 House: Engrossed by House as amended HB1468E
01/24/13 House: Read third time and passed House BLOCK VOTE (99-Y 0-N)

HB 1499 Emergency medical services personnel; administration of medications.

Chief patron: Stolle

Summary as introduced:

Administration of medications. Clarifies the circumstances under which emergency medical services personnel may administer medications and provides that emergency medical services personnel may administer medications pursuant to an oral or written order or standing protocol.

01/22/13 House: Read third time and passed House BLOCK VOTE (98-Y 0-N)
01/23/13 Senate: Referred to Committee on Education and Health

HB 1501 Pharmacy; collaborative agreements.

Chief patron: O'Bannon

Summary as introduced:

Pharmacy; collaborative agreements. Clarifies parties with whom a pharmacist may enter into a collaborative

agreement; provides that a patient who does not wish to participate in a collaborative procedure must notify the prescriber of his decision; and provides that a prescriber may elect to have a patient not participate in a collaborative agreement by contacting the pharmacist or his designated alternative pharmacist or by documenting his decision on the patient's prescription. The bill also clarifies that collaborative agreements may be in writing or in electronic form.

01/24/13 House: Committee amendments agreed to
01/24/13 House: Engrossed by House as amended HB1501E
01/24/13 House: Printed as engrossed 13100522D-E
01/25/13 House: Read third time and passed House BLOCK VOTE (98-Y 0-N)

HB 1516 Pharmacies; access to the Prescription Monitoring Program.

Chief patron: Lewis

Summary as introduced:

Pharmacies; access to the Prescription Monitoring Program. Requires every pharmacy permitted by the Board of Pharmacy to ensure that at least one pharmacist who is physically present at the pharmacy shall have access to the Prescription Monitoring Program at all times.

01/03/13 House: Prefiled and ordered printed; offered 01/09/13 13102118D
01/03/13 House: Referred to Committee on Health, Welfare and Institutions
01/15/13 House: Assigned HWI sub: #1

HB 1564 Drugs; administration by a person to a child in private school.

Chief patron: Orrock

Summary as introduced:

Administration of drugs; private schools, private nursery schools, and private preschools. Provides that nothing shall prevent the administration of drugs by a person to a child in a private nursery school or preschool that is accredited by the Virginia Council for Private Education and exempt from licensure by the Board of Social Services, or in a private school that is accredited by the Virginia Council for Private Education in accordance with standards prescribed by the Board of Education, provided such person has completed an approved training program, obtained written authorization of the parent, and administers drugs dispensed from a pharmacy and maintained in the original labeled container only to the child identified on the prescription label and in accordance with the prescriber's instructions.

01/17/13 House: Read second time and engrossed
01/18/13 House: Read third time and passed House BLOCK VOTE (98-Y 0-N)
01/21/13 Senate: Referred to Committee on Education and Health

HB 1644 Birth control; definition.

Chief patron: Watts

Summary as introduced:

Birth control; definition. Adds a definition of birth control. "Birth control" means contraceptive methods that are approved by the U.S. Food and Drug Administration. Birth control shall not be considered abortion for the purposes of Title 18.2.

01/07/13 House: Prefiled and ordered printed; offered 01/09/13 13101037D
01/07/13 House: Referred to Committee for Courts of Justice

HB 1666 Professional counselors; establishes minimum education requirements for licensure.

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Chief patron: Yost

Summary as introduced:

Licensure of professional counselors. Establishes minimum education requirements for licensure as a professional counselor and provides that an applicant must have received a master's degree from a program in which the primary emphasis is on preparation for the practice of counseling. The bill exempts individuals who meet all other requirements for licensure as a professional counselor related to coursework and completion of a supervised residency by July 1, 2017, from provisions related to completion of a graduate degree.

01/07/13 House: Referred to Committee on Health, Welfare and Institutions

01/11/13 House: Assigned HWI sub: #2

01/24/13 House: Subcommittee recommends reporting with amendment(s) (7-Y 0-N)

HB 1672 Naloxone; administration by unlicensed individual in cases of opiate overdose.

Chief patron: O'Bannon

Summary as introduced:

Naloxone; administration in cases of opiate overdose. Provides that nothing shall prohibit an unlicensed individual from administering naloxone to a person who is experiencing or is about to experience a life-threatening opiate overdose, provided the unlicensed individual has completed a training program approved by the Board of Health. The bill also requires the Board of Health and the Board of Pharmacy to work together with law-enforcement agencies to develop a pilot program for the training of law-enforcement personnel and provision of nasally administered naloxone to law-enforcement personnel for the purpose of enabling law-enforcement personnel to administer naloxone to persons experiencing opiate overdose and to work together with recovery support organizations and other stakeholders to develop a pilot program for the training of members of the public and provision of nasally administered naloxone to members of the public for the purpose of enabling members of the public who have received such training to administer naloxone to persons experiencing opiate overdose.

01/07/13 House: Referred to Committee on Health, Welfare and Institutions

01/11/13 House: Assigned HWI sub: #1

HB 1702 Counseling, Board of; confirmation of appointments by General Assembly.

Chief patron: Carr

Summary as introduced:

Board of Counseling; confirmation of appointments by General Assembly. Provides that all appointments to the Board of Counseling that are made by the Governor shall be subject to confirmation by the General Assembly.

01/08/13 House: Referred to Committee on Privileges and Elections

01/11/13 House: Assigned P & E sub: Appointments

01/11/13 House: Impact statement from DPB (HB1702)

01/24/13 House: Subcommittee recommends reporting (7-Y 0-N)

01/25/13 House: Reported from Privileges and Elections (22-Y 0-N)

HB 1704 Prescription Monitoring Program; disclosure of information to local chief law enforcement officer.

Chief patron: Stolle

Summary as introduced:

Prescription Monitoring Program; disclosure of information to local law enforcement. Adds an agent designated by the chief law-enforcement officer of any county or city to the list of individuals to whom the Department of Health

Professions must disclose information relevant to a specific investigation of a specific recipient or of a specific dispenser or prescriber upon request.

01/22/13 House: Read third time and passed House BLOCK VOTE (98-Y 0-N)
01/22/13 House: VOTE: BLOCK VOTE PASSAGE (98-Y 0-N)
01/23/13 Senate: Constitutional reading dispensed
01/23/13 Senate: Referred to Committee on Education and Health
01/24/13 House: Impact statement from DPB (HB1704E)

HB 1778 Mammography; provider must notify patient about dense breast tissue.

Chief patron: Filler-Corn

Summary as introduced:

Mammography results; information about dense breast tissue. Clarifies the conditions under which a mammography services provider must notify a patient of dense breast tissue and adds language to the notice that must be sent to patients under the existing law.

01/24/13 House: Read second time
01/24/13 House: Committee substitute agreed to 13104024D-H1
01/24/13 House: Engrossed by House - committee substitute HB1778H1
01/25/13 House: Read third time and passed House BLOCK VOTE (98-Y 0-N)
01/25/13 House: VOTE: BLOCK VOTE PASSAGE (98-Y 0-N)

HB 1791 Practitioners; suspension of license, etc., by health regulatory agency.

Chief patron: Garrett

Summary as introduced:

Suspension of license, registration or certificate by a health regulatory agency; practice pending appeal. Prohibits a practitioner of the healing arts whose license, certificate, registration, or permit has been suspended or revoked by a health regulatory board from engaging in practice pending appeal of the board's order.

01/15/13 House: Referred to Committee for Courts of Justice
01/21/13 House: Subcommittee recommends reporting (8-Y 0-N)
01/22/13 House: Assigned Courts sub: #2 Civil
01/23/13 House: Reported from Courts of Justice (17-Y 0-N)
01/25/13 House: Read first time

HB 1876 Sterilization operations; for persons capable of informed consent.

Chief patron: McClellan

Summary as introduced:

Sterilization operations for persons capable of informed consent. Eliminates the requirement for a 30-day waiting period prior to a sterilization operation for persons who are over the age of 18 and capable of giving informed consent who have not previously become the natural or adoptive parent of a child.

01/08/13 House: Referred to Committee on Health, Welfare and Institutions
01/17/13 House: Reported from Health, Welfare and Institutions (21-Y 1-N)
01/17/13 House: Impact statement from DPB (HB1876)
01/18/13 House: Motion to rerefer to committee agreed to
01/18/13 House: Rereferred to Health, Welfare and Institutions

HB 1933 Lyme disease; disclosure of information to patients.

Chief patron: Comstock

Summary as introduced:

Lyme disease; disclosure of information to patients. Requires physicians to provide each patient for whom a test for the presence of Lyme disease is ordered with a notice about Lyme disease, about testing for Lyme disease, and about the need to contact his physician with questions or concerns about Lyme disease.

01/09/13 House: Prefiled and ordered printed; offered 01/09/13 13102771D

01/09/13 House: Referred to Committee on Health, Welfare and Institutions

01/14/13 House: Impact statement from DPB (HB1933)

01/15/13 House: Assigned HWI sub: #1

HB 2120 Health care practitioner, licensed; procedure for physical evidence recovery kit examination.

Chief patron: Herring

Summary as introduced:

Individual incapable of making an informed decision; procedure for physical evidence recovery kit examination.

Provides that a licensed health care provider may perform a physical evidence recovery kit examination for a person who is believed to be the victim of a sexual assault and who is incapable of making an informed decision regarding consent to such examination when there is an immediate need to conduct the examination, no legally authorized representative is available to provide consent, and a capacity reviewer provides written certification that the person is incapable of providing informed consent and that the examination should be performed.

01/09/13 House: Referred to Committee on Health, Welfare and Institutions

01/15/13 House: Referred from Health, Welfare and Institutions

01/15/13 House: Referred to Committee for Courts of Justice

01/18/13 House: Impact statement from DPB (HB2120)

01/25/13 House: Assigned Courts sub: #1 Criminal

HB 2136 Methasterone and prostanazol; added to list of Schedule III controlled substances.

Chief patron: Hodges

Summary as introduced:

Adding methasterone and prostanazol to Schedule III. Adds methasterone and prostanazol to Schedule III.

01/22/13 House: Reported from Health, Welfare and Institutions (22-Y 0-N)

01/23/13 House: Read first time

01/24/13 House: Read second time and engrossed

01/25/13 House: Read third time and passed House BLOCK VOTE (98-Y 0-N)

01/25/13 House: VOTE: BLOCK VOTE PASSAGE (98-Y 0-N)

HB 2161 Nurses; authority to possess and administer oxygen to treat emergency medical conditions.

Chief patron: O'Bannon

Summary as introduced:

Nurses; authority to possess and administer oxygen to treat emergency medical conditions. Provides that a prescriber may authorize registered nurses and licensed practical nurses to possess oxygen for administration in treatment of emergency medical conditions.

01/22/13 House: Reported from Health, Welfare and Institutions (22-Y 0-N)
01/23/13 House: Read first time
01/24/13 House: Read second time and engrossed
01/25/13 House: Read third time and passed House BLOCK VOTE (98-Y 0-N)
01/25/13 House: VOTE: BLOCK VOTE PASSAGE (98-Y 0-N)

HB 2181 Medical equipment suppliers; delivery of sterile water and saline.

Chief patron: Hodges

Summary as introduced:

Medical equipment suppliers; delivery of sterile water and saline. Adds sterile water and saline to the list of prescription drugs and devices that a permitted medical equipment supplier may receive, store, and distribute to a consumer.

01/22/13 House: Reported from Health, Welfare and Institutions (22-Y 0-N)
01/23/13 House: Read first time
01/24/13 House: Read second time and engrossed
01/25/13 House: Read third time and passed House BLOCK VOTE (98-Y 0-N)
01/25/13 House: VOTE: BLOCK VOTE PASSAGE (98-Y 0-N)

HB 2312 Pharmacies; clarifies definition of compounding, etc.

Chief patron: Jones

Summary as introduced:

Compounding pharmacies. Clarifies the definition of "compounding" and adds a requirement for a current inspection report for registration or renewal of a registration for a nonresident pharmacy.

01/18/13 House: Presented and ordered printed 13103613D
01/18/13 House: Referred to Committee on Health, Welfare and Institutions
01/25/13 House: Impact statement from DPB (HB2312)

HJ 571 JCHC; study of feasibility of developing program of trained primary care personnel.

Chief patron: Hope

Summary as introduced:

JCHC; study of the feasibility of developing a program of trained primary care personnel to extend the reach of primary care services and reduce health care costs in the Commonwealth; report. Directs the Joint Commission on Health Care to study (i) the feasibility of developing and (ii) the potential impacts on access to and the quality and cost of health care resulting from implementation of a program whereby individuals are trained to provide primary health care services through telephone contacts and home visits, in accordance with standardized protocols and under the supervision of a licensed nurse or physician, using the Grande-Aides model or a similar program.

12/18/12 House: Prefiled and ordered printed; offered 01/09/13 13100760D
12/18/12 House: Referred to Committee on Rules
01/16/13 House: Assigned Rules sub: Studies

SB 858 Surgical assistants and surgical technologists; licensure and certification by Board of Medicine.

Chief patron: Blevins

Summary as introduced:

Surgical technologists and surgical assistants. Requires certification for surgical technologists and licensure for surgical assistants, and provides requirements for such certification and licensure. The bill creates the Advisory Board of Surgical Technology and Surgical Assisting to assist the Board of Medicine in the regulation of surgical technologists and surgical assistants.

01/03/13 Senate: Prefiled and ordered printed; offered 01/09/13 13101106D

01/03/13 Senate: Referred to Committee on Education and Health

01/09/13 Senate: Assigned Education sub: Health Professions

01/09/13 Senate: Impact statement from DPB (SB858)

SB 898 Practitioners; Board of Medicine to revoke license of certain (Twomey bill).

Chief patron: Reeves

Summary as introduced:

Board of Medicine; license revocation (Twomey bill). Makes it mandatory for the Board to revoke a license of a practitioner who engages in sexual contact with a patient under certain circumstances and provides that the person whose license has been revoked may not apply for reinstatement for five years. Under current law, revocation is at the Board's discretion and the person may apply for reinstatement after three years.

01/09/13 Senate: Assigned Education sub: Health Professions

01/24/13 Senate: Reported from Education and Health with substitute (15-Y 0-N)

01/24/13 Senate: Committee substitute printed 13103765D-S1

01/25/13 Senate: Constitutional reading dispensed (40-Y 0-N)

SB 950 Practitioners of medicine, etc.; updates terminology in sections governing licensure, etc.

Chief patron: Garrett

Summary as introduced:

Practice of medicine and other healing arts. Updates terminology in sections governing licensure of practitioners of the healing arts, provides for use of electronic communication, and eliminates the Psychiatric Advisory Board.

01/07/13 Senate: Referred to Committee on Education and Health

01/15/13 Senate: Assigned Education sub: Health Professions

01/24/13 Senate: Reported from Education and Health (15-Y 0-N)

01/25/13 Senate: Constitutional reading dispensed (40-Y 0-N)

SB 1250 Prescription Monitoring Program; Board of Pharmacy to identify "drugs of concern".

Chief patron: Puckett

Summary as introduced:

Designation and reporting of drugs of concern. Authorizes the Board of Pharmacy to identify "drugs of concern" and requires prescribers to report prescription drugs of concern to the Prescription Monitoring Program.

01/09/13 Senate: Presented and ordered printed 13103116D

01/09/13 Senate: Referred to Committee on Education and Health

01/15/13 Senate: Assigned Education sub: Health Care

Notice of Periodic Review

Board of Medicine

Pursuant to Executive Order 14 (2010) and §§ 2.2-4007.1 and 2.2-4017 of the Code of Virginia, the Board of Medicine is conducting a periodic review of:

18VAC85-15	Regulations Governing Delegation to an Agency Subordinate
18VAC85-40	Regulations Governing the Practice of Respiratory Care
18VAC85-50	Regulations Governing the Practice of Physician Assistants
18VAC85-80	Regulations Governing the Licensure of Occupational Therapists
18VAC85-101	Regulations Governing the Licensure of Radiologic Technologists and Radiologic Technologists-Limited
18VAC85-110	Regulations for Licensed Acupuncturists
18VAC85-120	Regulations Governing the Licensure of Athletic Trainers
18VAC85-130	Regulations Governing the Practice of Licensed Midwives

The review is part of the **Governor's Regulatory Reform Project with the goal of:**

- Repealing regulations that are unnecessary or no longer in use;
- Reducing unnecessary regulatory burdens on individuals, businesses, and other regulated groups; and
- Identifying statutes that require unnecessary or overly burdensome regulations.

Further, the Board is seeking comment on whether this regulation should be terminated, amended, or retained in its current form. Public comment is sought on the review of any issue relating to this regulation, including whether the regulation (i) is necessary for the protection of public health, safety, and welfare or for the economical performance of important governmental functions; (ii) minimizes the economic impact on small businesses in a manner consistent with the stated objectives of applicable law; and (iii) is clearly written and easily understandable.

The comment period begins November 5, 2012 and ends on December 5, 2012.

Comments may be submitted online to the Virginia Regulatory Town Hall at:
<http://www.townhall.virginia.gov/L/Forums.cfm>.

Comments may also be sent to Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 9960 Mayland Drive, Suite 300, Henrico, VA 23233 or faxed to (804) 527-4434 or emailed to elaine.yeatts@dhp.virginia.gov.

Following the close of the public comment period, a report of the periodic review will be posted on the Town Hall and published in the Virginia Register of Regulations.

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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***

Periodic review – Regulatory Reform Project

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email: medbd@dhp.virginia.gov

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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:

"Committee" means the Advisory Committee on Physician Assistants as specified in §54.1-2950.1 of the Code of Virginia.

"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.

"Protocol Practice agreement" means a set of directions 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:

1. "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. 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.
2. "Direct supervision" means the physician is in the room in which a procedure is being performed.
3. "General supervision" means the supervising physician is easily available and can be physically present or accessible for consultation with the physician assistant within one hour.
4. "Personal supervision" means the supervising physician is within the facility in which the physician's assistant is functioning.

5. "Supervising physician" means the 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.

6. "Continuous supervision" means the supervising physician has on-going, regular communication with the physician assistant on the care and treatment of patients.

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, 18VAC85-10-10 et seq., 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.
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, such assistant ~~and~~ or the employing practitioner shall so inform the board. A new ~~proposed~~ practice agreement shall be submitted to the board and approved by the board 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 ~~protocol~~ practice agreement.

A. Prior to initiation of practice, a physician assistant and his supervising physician shall submit a written ~~protocol~~ practice agreement which spells out the roles and functions of the assistant. Any such ~~protocol~~ 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. The ~~protocol~~ 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.

B. The board may require information regarding the level of supervision, i.e. "direct," "personal" or "general," 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 ~~protocol~~ 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.

B. A new practice agreement must be submitted with the initial application for prescriptive authority and whenever there have been any changes in supervision, authorization or scope of practice.

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

The supervising physician shall:

1. See and evaluate any patient who presents the same complaint twice in a single episode of care and has failed to improve significantly. Such physician involvement shall occur not less frequently than every fourth visit for a continuing illness.
2. Be responsible for all invasive procedures.
 - a. Under general 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 above must be performed under direct supervision unless, after directly supervising the performance of a specific invasive procedure three times or more, the supervising physician attests to the competence of the physician assistant to perform the specific procedure without direct supervision by certifying to the board in writing the number of times the specific procedure has been performed and that the physician assistant is competent to perform the specific procedure. After such certification has been accepted and approved by the board, the physician assistant may perform the procedure under general 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 ~~protocol~~ 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 ~~protocol~~ 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. 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, osteopathy, or podiatry. The supervising physician so delegating his responsibility shall report such arrangement for coverage, with the reason therefor, to the board office in writing, subject to the following provisions:

1. For planned absence, such notification shall be received at the board office at least one month prior to the ~~supervising physician's~~ absence of both the supervising and alternative supervising physicians;

2. For sudden illness or other unexpected absence that necessitates temporary coverage, the board office shall be notified as promptly as possible, but in no event later than one week; and

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

C. 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 ~~protocol~~ practice agreement to act as supervising physician for that assistant. The board shall make available appropriate forms for physicians to join the ~~protocol~~ practice agreement for an assistant employed by an institution.

2. Any such ~~protocol~~ 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.

D. 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.

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 ~~protocol~~ practice agreement acceptable to the board prescribed in 18VAC85-50-101. This ~~protocol~~ 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. ~~Protocol regarding prescriptive authority.~~ (Repealed).

- A. ~~A physician assistant with prescriptive authority may prescribe only within the scope of the written protocol as prescribed in 18VAC85-50-101.~~
- B. ~~A new protocol must be submitted with the initial application for prescriptive authority and with the application for each biennial renewal, if there have been any changes in supervision, authorization or scope of practice.~~

18VAC85-50-160. Disclosure.

- A. Each prescription 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 may be included on the prescription pad or may 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.

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.

Advisory Board on:

Occupational Therapy 10:00 a.m.

February 5 June 4 October 8

Respiratory Care 1:00 p.m.

February 5 June 4 October 8

Acupuncture 10:00 a.m.

February 6 June 5 October 9

Radiological Technology 1:00 p.m.

February 6 June 5 October 9

Athletic Training 10:00 a.m.

February 7 June 6 October 10

Physician Assistants 1:00 p.m.

February 7 June 6 October 10

Midwifery 10:00 a.m.

February 8 June 7 October 11

Polysomnographic Technology 1:00 p.m.

February 8 June 7 October 11

Joint Board of Nursing and Medicine 9:00 a.m.

TBA

000029

The travel regulations require that “travelers must submit the Travel Expense Reimbursement Voucher within 30 days after completion of their trip.” (CAPP Topic 20335, State Travel Regulations, P.7)

In order for the agency to be in compliance with the state travel regulations, please submit your request for today’s meeting no later than February 15, 2013

Virginia's Physician Assistant Workforce: 2010-2011

Healthcare Workforce Data Center

September 2012

Virginia Department of Health Professions
Healthcare Workforce Data Center
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Healthcare Workforce Data Center Advisory Council

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Christopher Bailey	Senior Vice President, Virginia Hospital and Healthcare Association
The Honorable George Barker	Senate of Virginia
Peter Blake	Vice Chancellor for Workforce Services Virginia Community College System
Arthur Garson, Jr., MD, MPH	Vice President and Provost University of Virginia
JoAnne Kirk Henry, EdD, RNC	Emerita Faculty Virginia Commonwealth University School of Nursing
Michael Jurgensen	Senior VP, Health Policy & Planning Medical Society of Virginia
Timothy O. Kestner, MLA	Economist, Virginia Employment Commission
Daniel G. LeBlanc	Senior Advisor to the Governor for Workforce
William L. Lukhard	Executive Council, AARP
P. J. Maddox	Professor and Chair, Health Administration and Policy George Mason University
Tod Massa	Director of Policy Research and Data Warehousing State Council of Higher Education in Virginia
Susan Motley, CEO	Virginia Nurses Association
The Honorable John O'Bannon, III	Virginia House of Delegates
Sandra Whitley Ryals	Director, Virginia Department of Health Professions
David C. Sarrett, DMD, MS	Program Director, Area Health Education Centers (AHEC) Associate Vice President for Health Sciences Virginia Commonwealth University
The Honorable Marilyn Tavenner	Secretary of Health and Human Resources
Kathy H. Wibberly, Ph.D.	Director, Division of Primary Care and Rural Health Office of Minority Health and Public Health Policy Virginia Department of Health

Physician Assistant Workforce Workgroup

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Healthcare Workforce Data Center

Overview

The Virginia Department of Health Profession's Healthcare Workforce Data Center (HWDC) collects and disseminates workforce information on Virginia's licensed healthcare practitioners. The 2007 report of the Governor's Health Reform Commission recommended that the HWDC be established within the Department of Health Professions (DHP) due to its existing repository of licensure information for over 80 professions. In the spring of 2008, HWDC was launched with Workforce Investment Act grant funding and continues with support from the Department and shared grant funding from the U.S. Health Resources Services Administration on behalf of the new Virginia Health Workforce Development Authority and other partner organizations.

With significant input and collaborative effort from key stakeholders and experts, HWDC has developed initial supply and demand forecasts for physicians and nurses, published results from existing physician and nursing workforce surveys originally developed by the Board of Medicine and Board of Nursing, updated and launched revised surveys as well as developed new workforce surveys as listed in the "Current Collection" in the HWDC Survey Timetable below. Beginning in winter 2012, HWDC began development of audiology & speech language pathology surveys and long term care administrator surveys which are poised for rollout later this fiscal year.

HWDC Survey Timetable

In Current Collection:

Medical Doctors
Doctors of Osteopathy
Registered Nurses and
Licensed Practical Nurses
Certified Nurse Aides
Physician Assistants
Nurse Practitioners
Licensed Professional Counselors
Clinical Psychologists
Licensed Clinical Social Workers
Pharmacists
Pharmacy Technicians
Dentists
Dental Hygienists

Projected 2012 Rollout:

Speech-Language Pathologists
Audiologists
Long-Term Care Administrators
Physical Therapists
Physical Therapy Assistants

Proposed:

Occupational Therapists
Occupational Therapy Assistants

The Physician Assistant Workforce Survey

Methodology

The Physician Assistant Workforce Survey is administered to Physician Assistants through the Department of Health Professions' online renewal process. Physician assistants renew their license on their birthday in every odd year. Currently, HWDC surveys are only available to those renewing their licenses online. New Virginia licensees and those returning from a long absence did not have access to the online survey. Additionally, paper renewals were available. The survey was not offered to students or new applicants. This survey was conducted for those renewing from May 1st, 2010 to April 30, 2012. The survey text is available in Appendix B.

Response Rates

The survey's population is all persons holding physician assistant licenses in Virginia during the renewal cycle. From this population, we are particularly interested in those who worked or were available to work in Virginia: Virginia's Physician Assistant Workforce. Our sample is a convenience sample of licensed professionals who renewed their licenses and chose to renew online. This method, along with the voluntary efforts of practitioners, results in good overall response rates (see below).

The methodology excludes some, but not all, physician assistants first licensed in the Commonwealth during the renewal cycle. Since the renewal cycle is two years long and ongoing, most newly licensed physician assistants had an opportunity to renew. The number of new licensees in the table below reflects those who did NOT have an opportunity to renew within the renewal cycle.

Statistic	Physician Assistants
Renewing Licensees	1,979
Non-renewals	26
New Licensees	274
Total Licensees	2,279
Completed Surveys	1,683
Response Rate, All Licensees	74%
Response Rate, Renewing Practitioners	85%

Our methodology also excludes physician assistants who were scheduled to renew but did not renew their licenses during the renewal period. These physician assistants left the profession, left the Commonwealth, or renewed late. These physician assistants may have different patterns of employment than our respondents. The methodology also excludes physician assistants who choose to renew using paper renewals. These physician assistants may be older, less technologically savvy or lack access to high speed internet (e.g., rural practitioners).

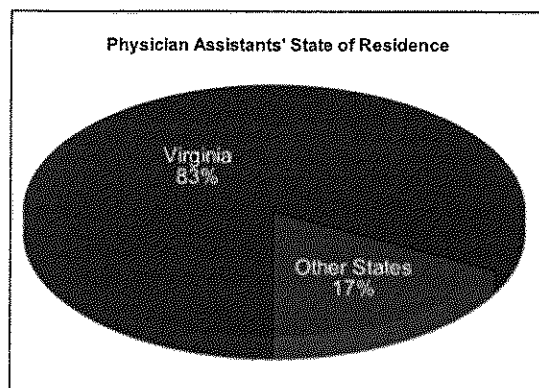
Weighted Estimates

Using administrative data in our licensee files, we are able to determine response rates based on age in five year categories and on the rural status of the licensee's address of record with the department. We do find statistically significant differences in response rates by these variables, with each having a moderate effect on response rates.¹ To account for differences in response rates by these key characteristics this report uses weighted estimates. The HWDC assigns a weight to each response based on the overall response rate of physician assistants based on two characteristics:

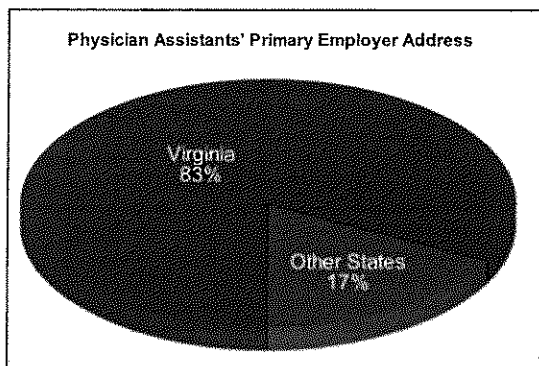
- 1) The age of the respondent, in five year categories, and
- 2) The rural status of the respondent's mailing address.

For the latter, the HWDC uses a measure of rurality developed by the US Department of Agriculture known as the Rural-Urban Continuum Code. More information on these codes is available on the USDA website here: <http://www.ers.usda.gov/Data/Rurality/RuralUrban/>. Response rates may vary on other important characteristics such as race/ethnicity, gender, specialty or worksite characteristics. However, the HWDC does not have population level data on these characteristics to generate response rates and weights. For more information on weights, see Appendix A. Due to the rounding of weighted data in HWDC's statistical software, weighting may result in some minor anomalies in tables and other presented data (e.g., data may not add to totals in tables).

Virginia's Licensed Physician Assistants



Not all of Virginia's licensed physician assistants live or work in the state. Out-of-state practitioners maintain licenses in-state for a variety of reasons. Those serving in the military or working for the federal government must maintain a license, but they may do so in any state. Retired physician assistants may maintain their licenses for prestige or occasional practice. Licensed physician assistants may consult or occasionally travel to Virginia to care for their patients, particularly those practicing in Virginia's border jurisdictions.



Overall, 83 percent of all physician assistants with a Virginia license reside within the Commonwealth. In addition, 83 percent of respondents who listed a primary employer indicated that this location is in Virginia.

¹ For the five-year categorical age variable, the relevant statistic was the following: $\chi^2 (11, N = 2,276) = 177.295, p = .000$. Cramer's V score was .279, indicating a moderate effect for age on response rates. For the rural status variable, the relevant statistic was the following: $\chi^2 (8, N = 2,103) = 22.102, p = .005$. Cramer's V score was .103, indicating a small effect for rurality on response rates. It should be noted that the chi-squared test on age violated the minimum expected cell frequency assumption, which was five percent below the minimum 80 percent value. This was due to the small sample size for respondents age 70 and over.

Virginia's Physician Assistant Workforce

Virginia's physician assistant workforce consists of respondents who reported working and who identified at least one practice location in Virginia. If a respondent indicated practicing but did not list a location, state of residence or mailing address was used as a proxy to determine participation in Virginia's workforce. Virginia's workforce also includes those who reside in Virginia and are not working, but who intend to return to the workforce at some point. Those familiar with federal data should note that this is a broader measure than the Bureau of Labor Statistics' civilian labor force which includes only those who are employed or those who are actively seeking work and excludes those in the military.

Using these criteria and weighted responses, the HWDC estimates that 1,891 physician assistants participated in Virginia's workforce. Approximately 83 percent of physician assistants who held a license in Virginia during this period participated in Virginia's physician assistant workforce.

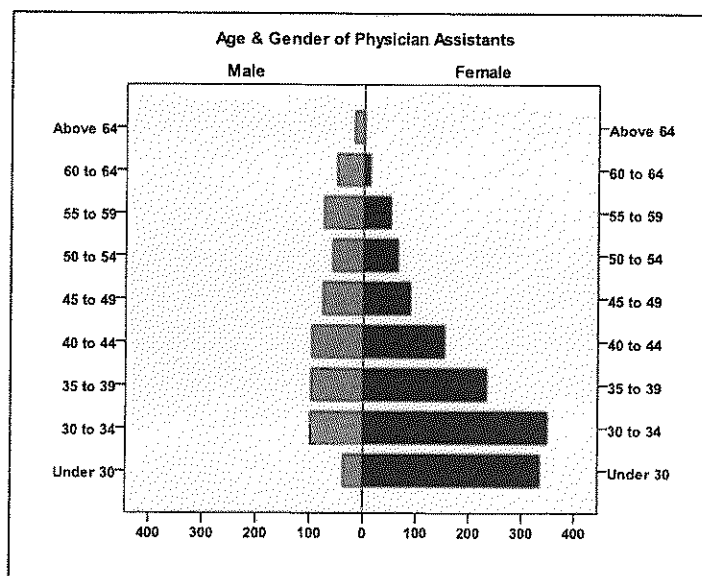
Statistic	Physician Assistants
Working in Virginia	1,825
Not working, plans to return to work, resides in Virginia	66
<i>Virginia's Physician Assistant Workforce</i>	<i>1,891</i>
Licensees	2,279
Proportion of Licensees in Virginia's Physician Assistant Workforce	83%

Virginia's Physician Assistant Workforce

Demographics

Age & Gender

Overall, two-thirds of physician assistants were female. The median age for all physician assistants was 37 years. However, significant differences existed between men and women. The median age of all male physician assistants was 43 years, while the median age of all female physician assistants was 34 years. In addition, whereas male physician assistants were evenly distributed across the age spectrum, female physician assistants were more likely to be under 40 years of age. More than 70 percent of all female physician assistants were under the age of 40, but nearly 55 percent of male physician assistants were above this age.



License Transaction Rate by Age (Unweighted, All Physician Assistants)

For physician assistants under the age of 30, new licensees made up 35 percent of all licensees, which was considerably higher than the overall average of 12 percent. For no other age group were new licenses more than 9 percent of all issued licenses. For all groups above the age of 33, more than 90 percent of all issued licenses were renewals. Across all age groups, the number of expired licenses was negligible. The overall average was one percent, and no age group had an expiration rate of more than two percent, even among those approaching retirement age. Additionally, even though overall numbers were small, no one over age 60 allowed his or her license to expire, while there were several new licensees in this age group.

Age	Physician Assistants		
	Renewed	Allowed to expire	New Licenses
	%	%	%
Under 30	65%	0%	35%
30 to 35	89%	2%	9%
35 to 39	91%	1%	8%
40 to 44	93%	1%	6%
45 to 49	95%	2%	3%
50 to 54	95%	1%	4%
55 to 59	94%	1%	5%
60 to 64	93%	0%	7%
Above 65	92%	0%	8%
Total	87%	1%	12%

Diversity

Among all physician assistants, more than four-fifths were non-Hispanic white, which makes them overrepresented with respect to the approximately two-thirds of Virginians who are non-Hispanic white. No other racial/ethnic category accounted for more than 10 percent of all physician assistants, and all were underrepresented with respect to their overall numbers in the Virginia population. With respect to physician assistants under the age of 30, the distribution of all race/ethnicities was similar to the distribution seen in the overall population of physician assistants.

Race/ Ethnicity	Est. 2011 Virginia Population		Physician Assistants		All PAs under 30	
		%	Weighted Estimate	%	Weighted Estimate	%
Hispanic of any race	660,730	8%	59	3%	10	3%
White, non-Hispanic	5,222,122	64%	1,555	83%	314	84%
Black, non-Hispanic	1,548,069	19%	126	7%	26	7%
American Indian or Alaskan Native	21,474	0%	2	0%	0	0%
Asian or Pacific Islander	463,913	6%	100	5%	20	5%
Other Race ²	-	-	28	1%	4	1%
Two or more races	180,296	2%	0	0%	0%	0%

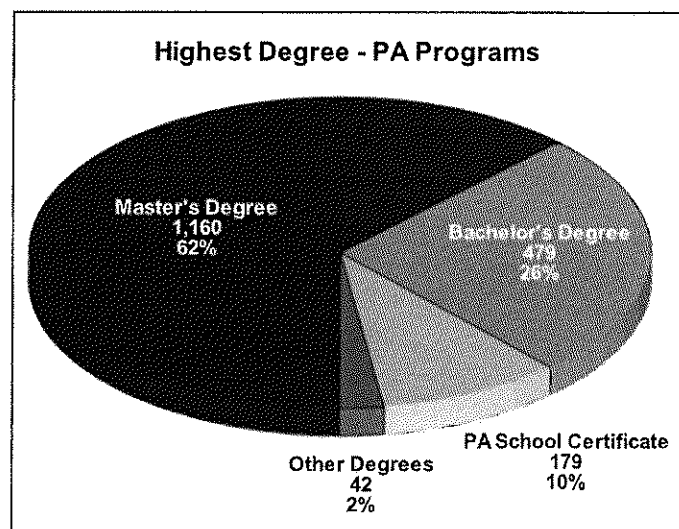
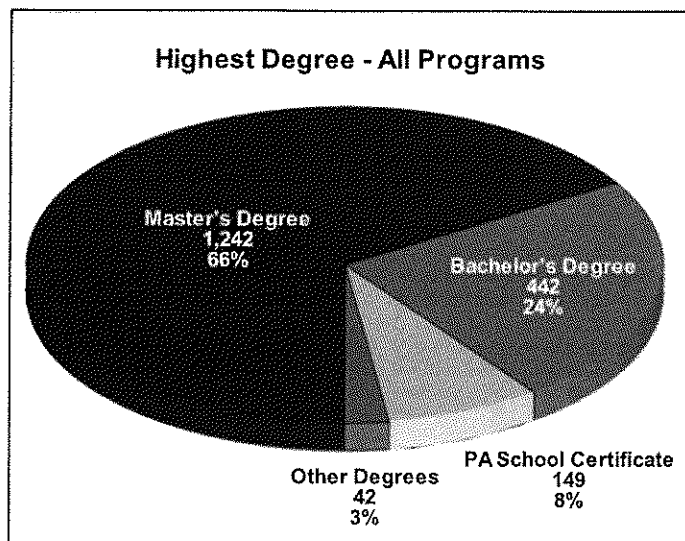
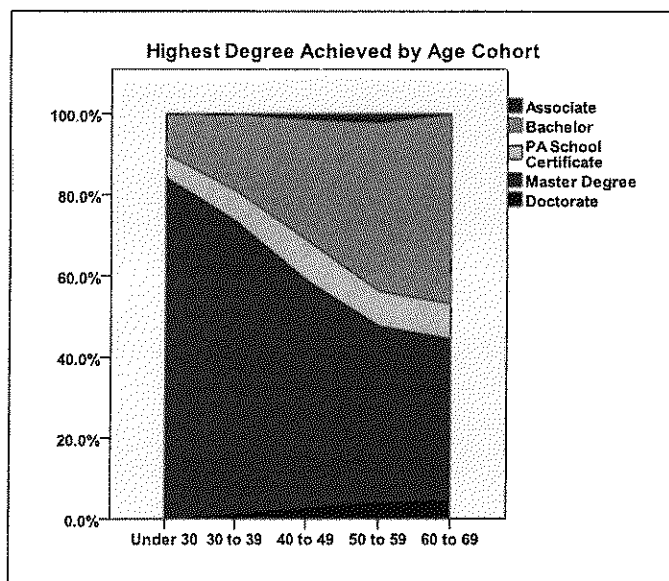
² The U.S. Census Bureau no longer provides an estimate for people included in the "Other Race" category in 2011. Instead, people who select this category are reallocated into another racial group.

Education

Highest Degree Achieved

The highest degree obtained by physician assistants was consistent across both physician assistant programs and all educational institutions. A majority of all physician assistants received a master's degree, while most of the remainder received either a bachelor's degree or a physician assistant certificate. Very few physician assistants reported having either an associate's degree or a doctorate as their highest degree.

Approximately 80 percent of physician assistants under the age of 30 held a master's degree, but the percentage of physician assistants with master's degrees tailed off slowly among other age cohorts. Instead, nearly half of all physician assistants between the age of 60 and 69 held a bachelor's degree as their highest collegiate credential. In addition, physician assistants in this age cohort were more likely to hold doctorate degrees. Meanwhile, the percentage of physician assistants with a physician assistant certificate did not vary widely among age cohorts.



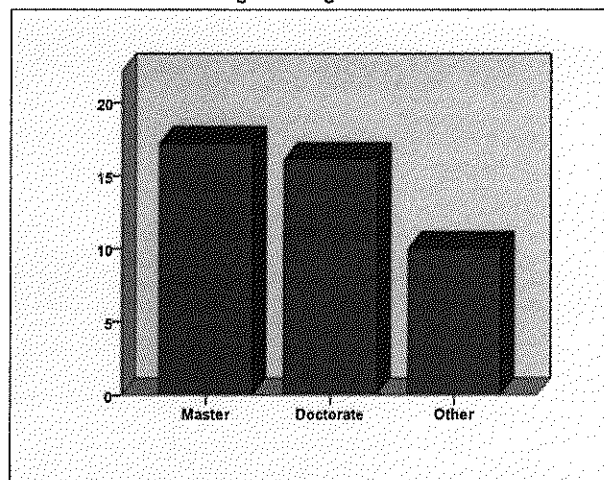
Current Education

Currently Seeking Degree?	Physician Assistants	
	Number	%
No	1,815	97%
Yes	53	3%
Total	1,868	100%

Only three percent of all physician assistants are currently enrolled in an institution of higher learning in order to obtain a more advanced degree. These respondents attended 21

different educational institutions, but only three schools – Nova Southeastern University (10), the University of Nebraska (9) and A.T. Still University (3) – were currently being attended by more than one physician assistant. All three of the above schools offer online/distance education opportunities.

Degree Being Pursued

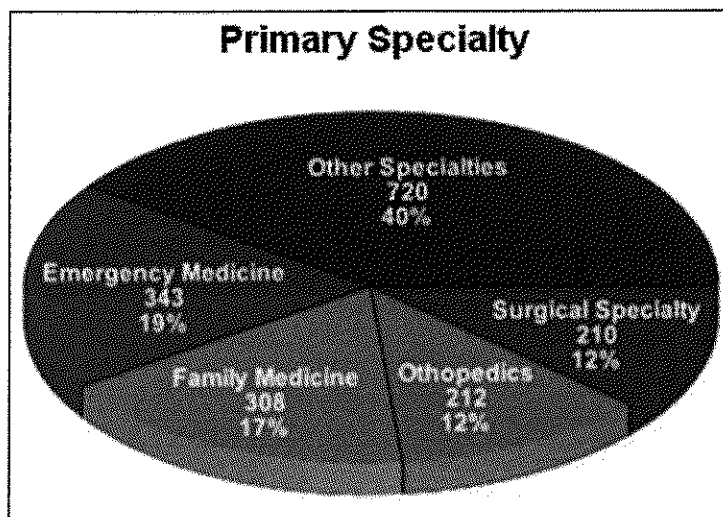


Employment

Employer Specialty

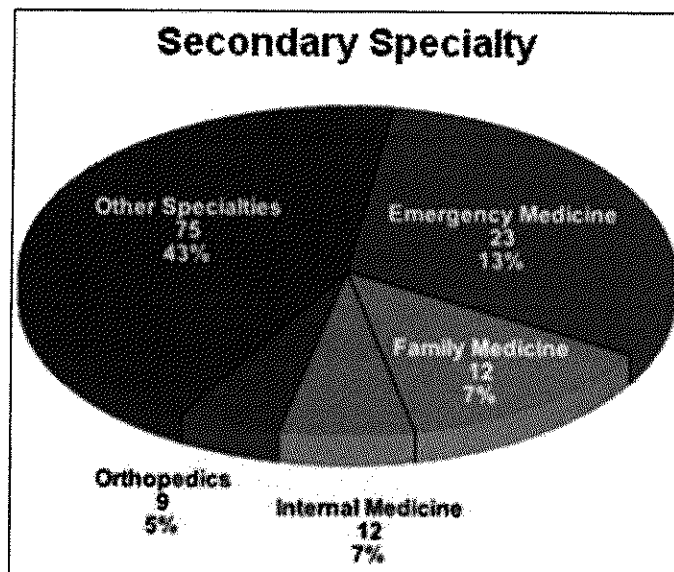
Physician assistants focused on five main specialties at their primary employer: emergency medicine (19%), family medicine (17%), orthopedics (12%), surgical specialty (12%) and internal medicine (9%). In addition, "Other" was the primary specialty of 17 percent of physician assistants. Within this category, there were more than 20 physician assistants in four categories: dermatology (59), urgent care (35), pain management (25) and pulmonary/critical care (24). Fifty-five percent of physician assistants performed invasive procedures at their primary employer.

Primary Specialty



Specialty	Primary		Secondary	
	Number	%	Number	%
Emergency Medicine	343	19%	55	32%
Family Medicine	308	17%	23	13%
Other	299	17%	51	29%
Orthopedics	212	12%	9	5%
Surgical Specialty	210	12%	6	3%
Internal Medicine	158	9%	12	7%
Cardiology	45	3%	5	3%
Gastroenterology	41	2%	0	0%
OB/GYN	22	1%	1	1%
Radiology	23	1%	0	0%
Pediatrics	21	1%	1	1%
Psychiatry	20	1%	4	2%
General Surgery	18	1%	0	0%
Urology	18	1%	0	0%
Geriatric Medicine	14	1%	0	0%
Oncology	14	1%	0	0%
Pediatric Specialty	13	1%	0	0%
Neurology	7	0%	1	1%
Industrial Medicine	5	0%	1	1%
Correctional Medicine	2	0%	5	3%
Total	1793	100%	174	100%

Overall, 174 physician assistants also had a specialty at their secondary employer. Of those, emergency medicine (32%) was the most popular specialty. In addition, family medicine was the specialty of 13 percent of physician assistants. 29 percent of physician assistants did not have a specialty on the survey list. Within this category, 43% specialized in urgent or critical care. Forty-five percent of physician assistants performed invasive procedures at their secondary employer.

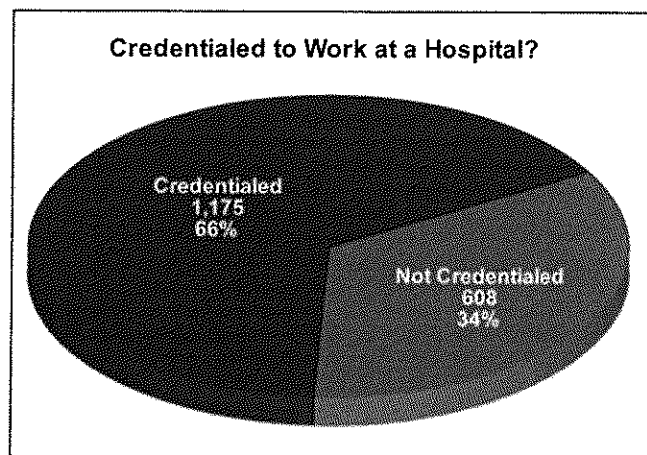


Hospital Credentials

Number	Primary		Secondary	
	Number	%	Number	%
Zero	320	23%	81	51%
One	744	54%	64	41%
Two	174	13%	9	6%
Three	66	5%	2	1%
Four	24	2%	1	1%
Five	16	1%	1	1%
Six	7	1%	0	0%
Seven	22	2%	0	0%
Eight	1	0%	0	0%
Nine	1	0%	0	0%
Total	1,375	100%	158	100%

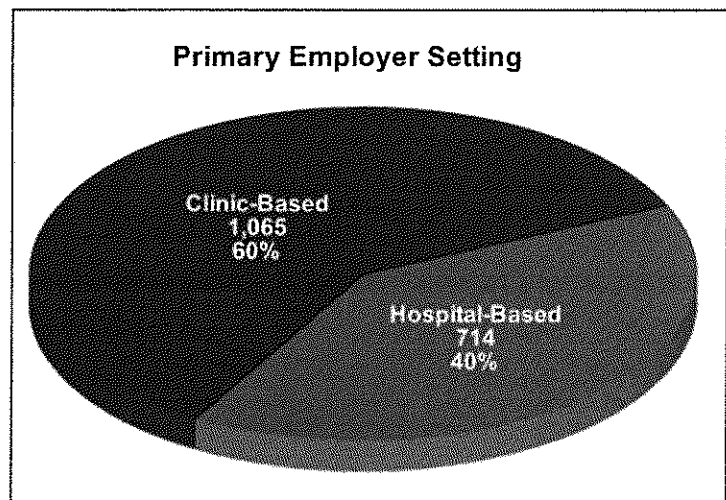
Approximately two-thirds of physician assistants were credentialed to work in a hospital. The majority of physician assistants saw patients at just one hospital, while nearly 20 percent saw patients at either two or three hospitals. Less than 10 percent of all physician assistants saw patients at four or more hospitals.

For physician assistants with secondary employers, a majority did not see patients in a hospital setting. Among those who did see patients in a hospital, the vast majority saw them at just one hospital.



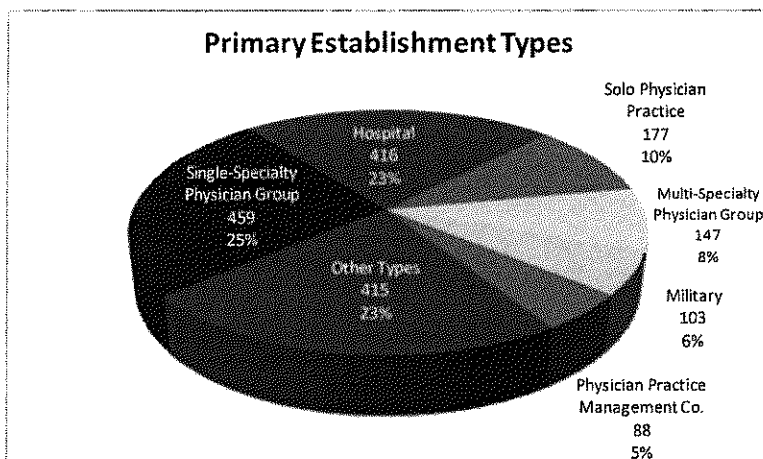
Primary Employer

Sixty percent of all physician assistants worked in a clinic-based setting with their primary employer; the remainder worked with a hospital-based primary employer.



Primary Establishment Type

Physician assistants worked primarily in two main establishment types: single-specialty physician groups (24%) and hospitals (22%). No other establishment type was cited by more than ten percent of physician assistants, but multi-specialty physician groups (9%), the military (5%) and physician practice management companies (5%) were each cited by at least five percent of all physician assistants.



Primary Establishment Types	Physician Assistants	
	Number	%
Single-Specialty Physician Group	459	25%
Hospital	416	23%
Solo Physician Practice	177	11%
Multi-Specialty Physician Group	147	8%
Military	103	6%
Physician Practice Management Co.	88	5%
Urgent Care Center	70	4%
Other	60	3%
Community Health Center	59	3%
Academics – University	47	3%
Veterans Administration	39	2%
University Hospital	33	2%
Integrated Health Delivery System	30	2%
Self-Employed/Independent Contractor	19	1%
Academics	14	1%
Medical Staffing Agency	14	1%
HMO	13	1%
Nursing Home/LOC Facility	8	0%
Corrections System	7	0%
Hospice	1	0%
Urgent Surgical Center	1	0%
Total	1,805	100%

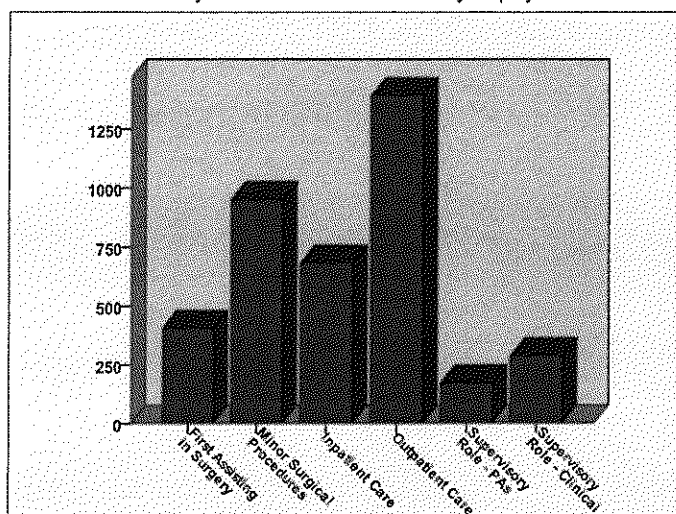
Primary Functions Performed

Nearly three-quarters of all physician assistants managed patient care in an outpatient setting, which was the most common primary function performed. Additionally, nearly half assisted in minor surgical procedures. Physician assistants were not as involved in managerial or supervisory roles: only 15 percent of physician assistants had managerial responsibility over clinical staff, and fewer than 10 percent had any responsibility over fellow physician assistants. Note that respondents could select multiple functions from the list.

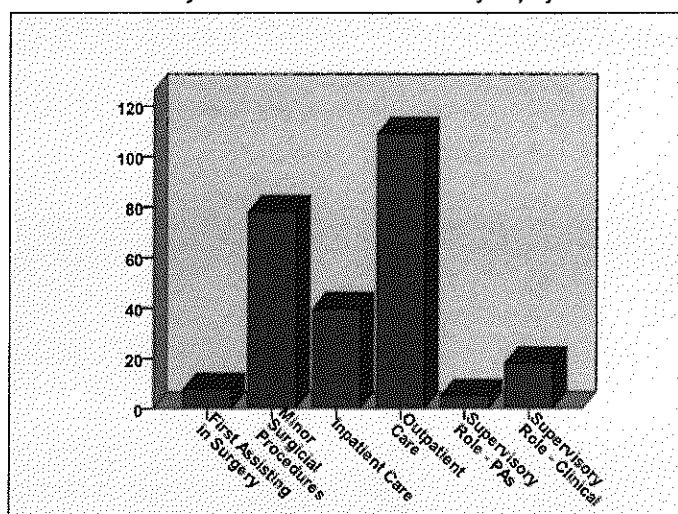
This distribution was roughly similar for physician assistants who had a secondary employer. Three-fifths of all physician assistants with secondary employers managed patient care in an outpatient setting, while more than two-fifths assisted in minor surgical procedures. However, physician assistants with secondary employers were relatively less likely to first assist in surgery or manage patient care in an inpatient setting. In addition, relatively few physician assistants were involved in a managerial or supervisory role.

Functions	Primary		Secondary	
	Number	%	Number	%
Surgery				
First Assisting	405	21%	8	4%
Minor Procedures	952	49%	78	43%
Patient Care Management				
Inpatient	681	35%	39	22%
Outpatient	1,393	72%	109	60%
Managerial/Supervisory Role				
Responsibility of PAs	171	9%	5	3%
Responsibility of Clinical Staff	288	15%	18	10%

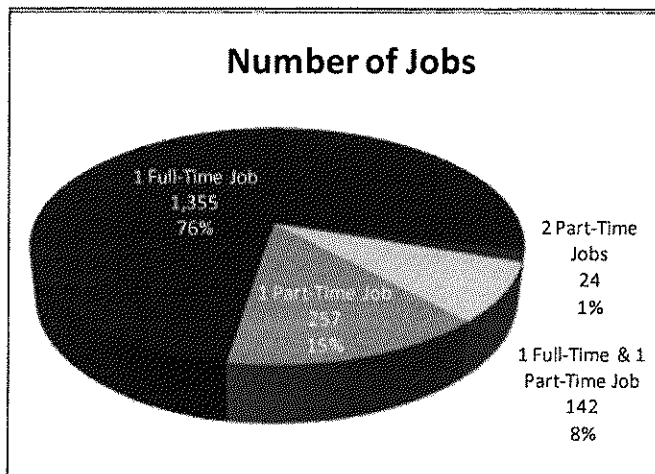
Primary Functions Performed - Primary Employer



Primary Functions Performed - Secondary Employer



Hours Worked



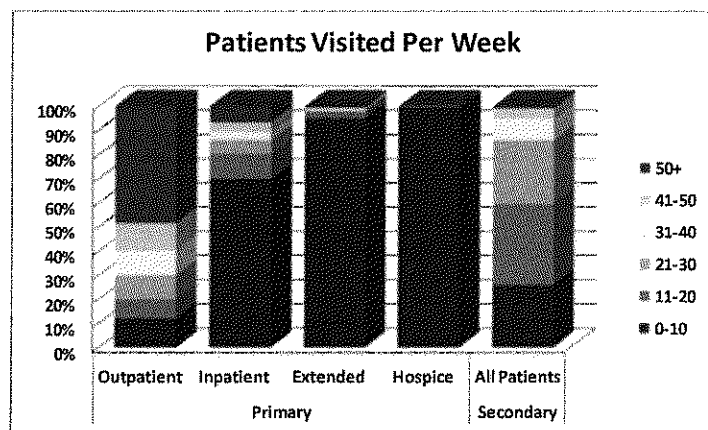
More than three-fourths of all employed physician assistants had one full-time job. Only nine percent of physician assistants held two jobs; all physician assistants who had two jobs worked in a part-time capacity in that second position.

Number of Jobs	Physician Assistants	
	Number	%
One Part-Time Job	257	14%
One Full-Time Job	1,355	76%
Two Part-Time Jobs	24	1%
One Full-Time Job and One Part-Time Job	142	8%
Total	1,778	100%

Employer Workload

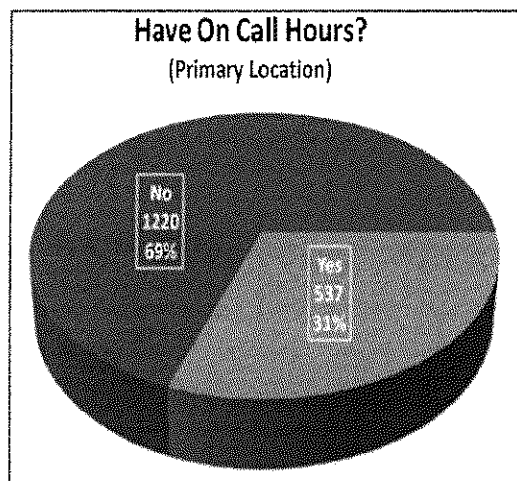
A majority of physician assistants had less than ten inpatient, extended and hospice visits per week. Nearly half had more than 50 outpatient visits per week, and 80 percent had at least 20 outpatient visits per week. Only 20 percent of physician assistants had 20 inpatient visits, and only a negligible percentage of physician assistants had at least 20 extended or hospice visits per week.

For secondary employers, all patients were aggregated together into one overall statistic. In total, 60 percent of all physician assistants who had a secondary employer had less than 20 patient visits per week, and more than three-quarters had less than 30 such visits per week.



Patients Visited Per Week	Primary								Secondary	
	Outpatient		Inpatient		Extended		Hospice		All Patients	
	Number	%	Number	%	Number	%	Number	%	Number	%
0-10	213	12%	1,117	70%	1,444	95%	1,493	100%	24	26%
11-20	140	8%	166	10%	38	3%	5	0%	31	34%
21-30	170	10%	89	6%	9	1%	1	0%	24	26%
31-40	177	10%	55	3%	11	1%	0	0%	8	9%
41-50	200	11%	64	4%	6	0%	0	0%	4	4%
50+	842	48%	108	7%	12	1%	1	0%	1	1%
Total	1,742	100%	1,599	100%	1,520	100%	1,500	100%	92	100%
Estimated Median	48.70	-	7.16	-	5.26	-	5.02	-	17.39	-

Extended Hours for Primary Employer



Only 31 percent of all physician assistants were on call with their primary employer. Among those who were on call, nearly half were on call for hours totaling at most 2 days per month. Only 14 percent were on call for a week or more per month. Only 14 physician assistants were on call with a secondary employer, the majority of whom were on call for at most three days per month.

On-Call Hours Per Month	Primary		Secondary	
	Number	%	Number	%
1 - 24	110	26%	4	29%
25 - 48	95	22%	3	21%
49 - 72	50	12%	3	21%
73 - 96	25	6%	0	0%
97 - 120	44	10%	0	0%
121 - 144	11	3%	0	0%
145 - 168	30	7%	1	7%
169+	59	14%	3	21%
Total	424	100%	14	100%

Employment Hours Breakdown (All Employers)

Three-quarters of physician assistants spent more than 30 hours per week on patient care, while an overwhelming majority of physician assistants spent less than five hours per week in all other activities. Among activities other than patient care, more than ten percent of physician assistants spent at least five hours a week in education, administration and precepting activities. Fewer than 10 percent of physician assistants spent more than five hours per week in quality assurance, research and volunteer activities.

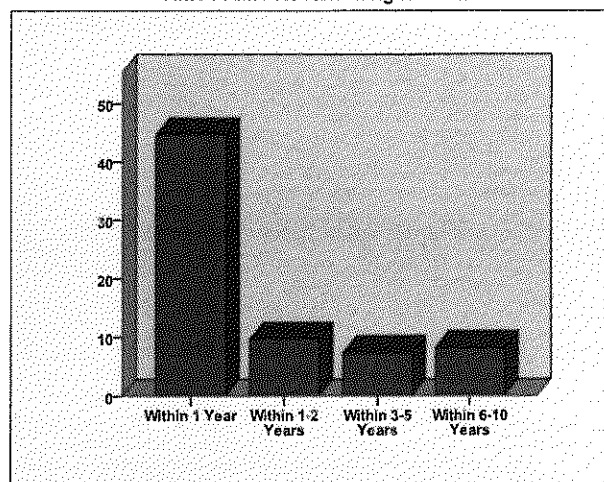
Number of Hours Per Week	Patient Care		Education		Admin.		Precepting		Quality Assurance		Research		Volunteer		Other	
	Num.	%	Num.	%	Num.	%	Num.	%	Num.	%	Num.	%	Num.	%	Num.	%
1-5	27	2%	1,141	89%	1,029	77%	940	80%	1,051	92%	975	96%	934	98%	598	95%
6-10	41	3%	79	6%	199	15%	129	11%	68	6%	28	3%	11	1%	17	3%
11-15	23	1%	13	1%	64	5%	30	3%	13	1%	6	1%	2	0%	7	1%
16-20	59	4%	1	0%	23	2%	31	3%	4	0%	0	0%	1	0%	5	1%
21-25	83	5%	2	0%	4	0%	8	1%	3	0%	4	0%	1	0%	0	0%
26-30	168	10%	7	1%	8	1%	10	1%	2	0%	0	0%	0	0%	1	0%
30+	1,218	75%	45	3%	9	1%	21	2%	5	0%	3	0%	0	0%	3	0%
Total	1,619	100%	1,288	100%	1,336	100%	1,169	100%	1,146	100%	1,016	100%	949	100%	631	100%

Returning to Work

Timeline for Return	Physician Assistants	
	Number	%
Within 1 Year	45	64%
Within 1-2 Years	10	14%
Within 3-5 Years	7	10%
Within 6-10 Years	8	11%
Total	70	100%

In total, 70 unemployed physician assistants indicated their desire to return to Virginia's workforce at some point in the future. Of those, nearly two-thirds planned to return within the next year and 78 percent within the next two years.

Time Frame for Returning to Work

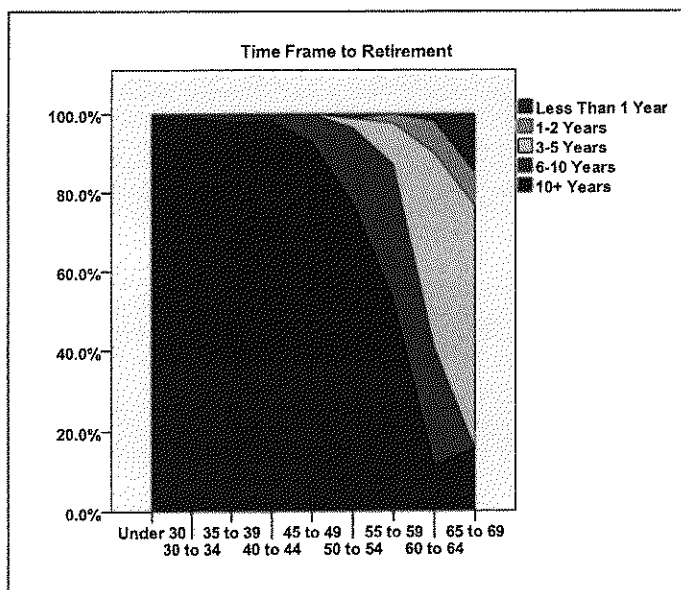


Retirement

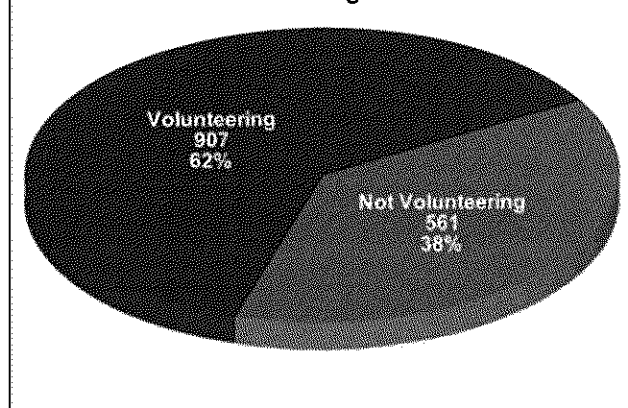
Ninety percent of all physician assistants were planning on staying in the profession for at least the next ten years, while only four percent planned on retiring within the next five years. Once they reach retirement, more than 60 percent plan on volunteering in some capacity related to their former jobs.

Almost all physician assistants under the age of 45 plan on remaining in the workforce for at least the next decade. It is not until physician assistants reach their 50s when they contemplate retiring within the next decade. Even for physician assistants in their 60s, a majority plan on remaining in the workforce for at least the next three years. In addition, less than 20 percent of physician assistants who are between the ages of 65 and 69 plan on retiring within the next year.

Timeline for Retirement	Physician Assistants	
	Number	%
Less Than One Year	5	0%
1-2 Years	10	1%
3-5 Years	53	3%
6-10 Years	99	6%
10+ Years	1,473	90%
Total	1,640	100%



Plans for Volunteering After Retirement



Full Time Equivalency Units

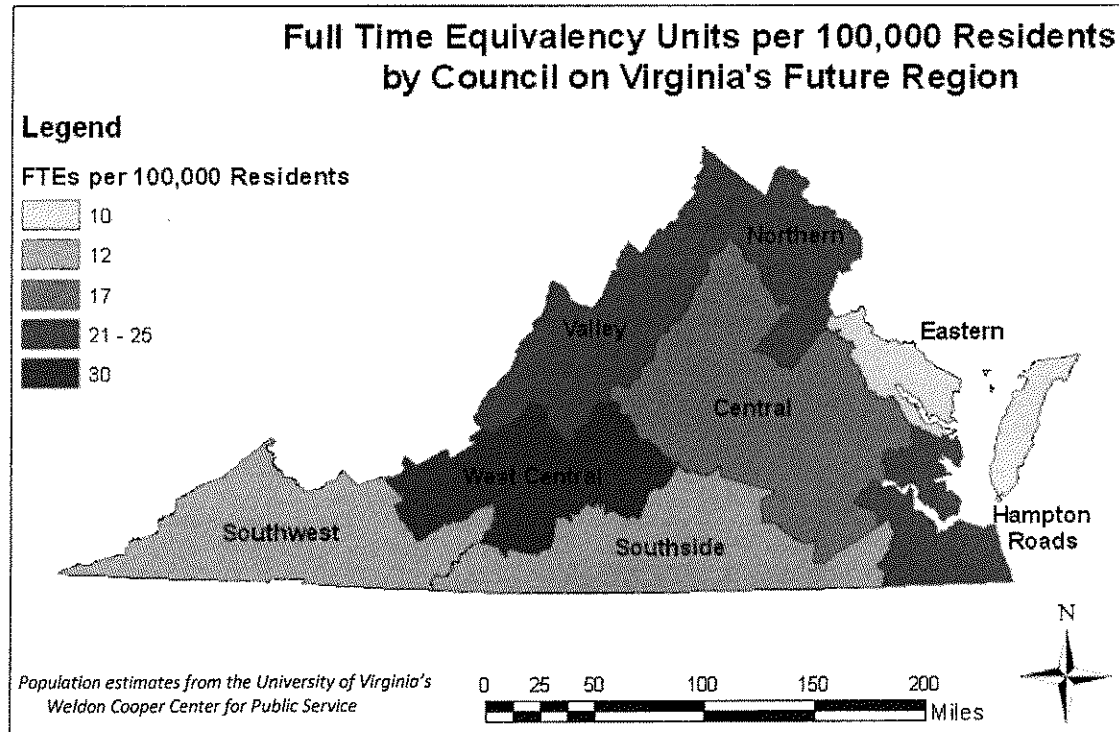
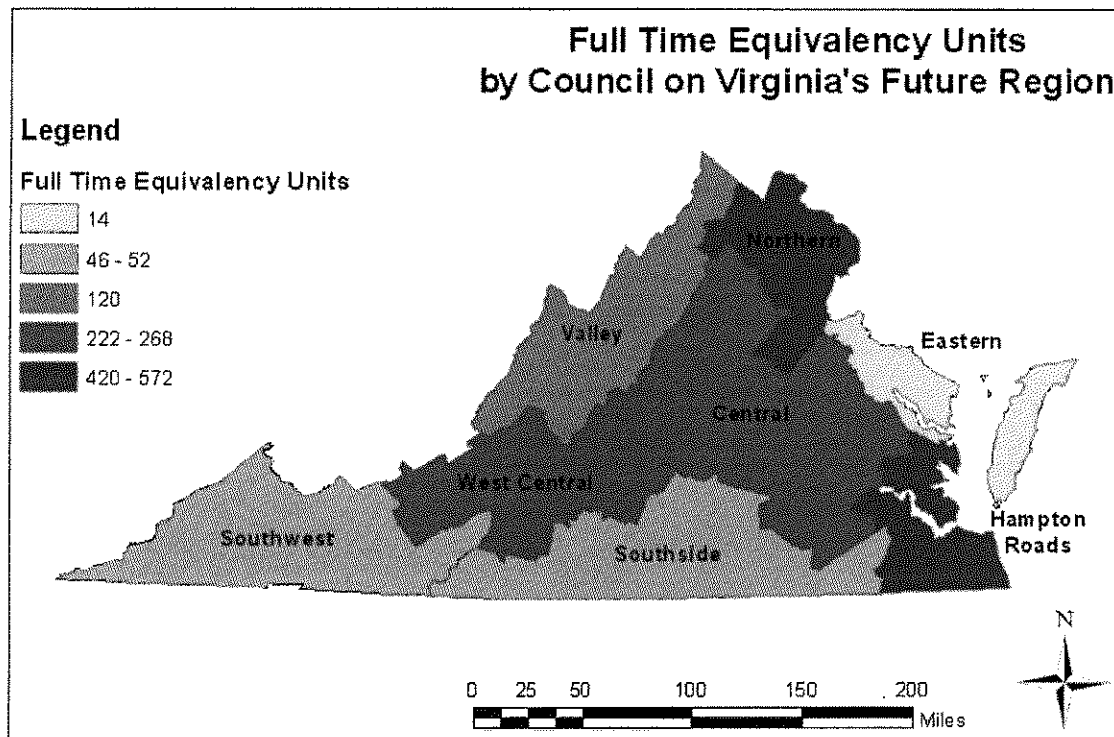
Economists and human resources professionals often refer to Full Time Equivalency units (or FTEs) when discussing labor market participation. Conceptually, an FTE represents one full time worker or one full time position. One FTE may be provided by two part-time workers or one full time worker. Alternatively, one worker with one full time job and one part time job may provide 1.5 FTEs. FTEs provide an easy way to compare labor or job supply while accounting for differing levels of work supplied by individuals.

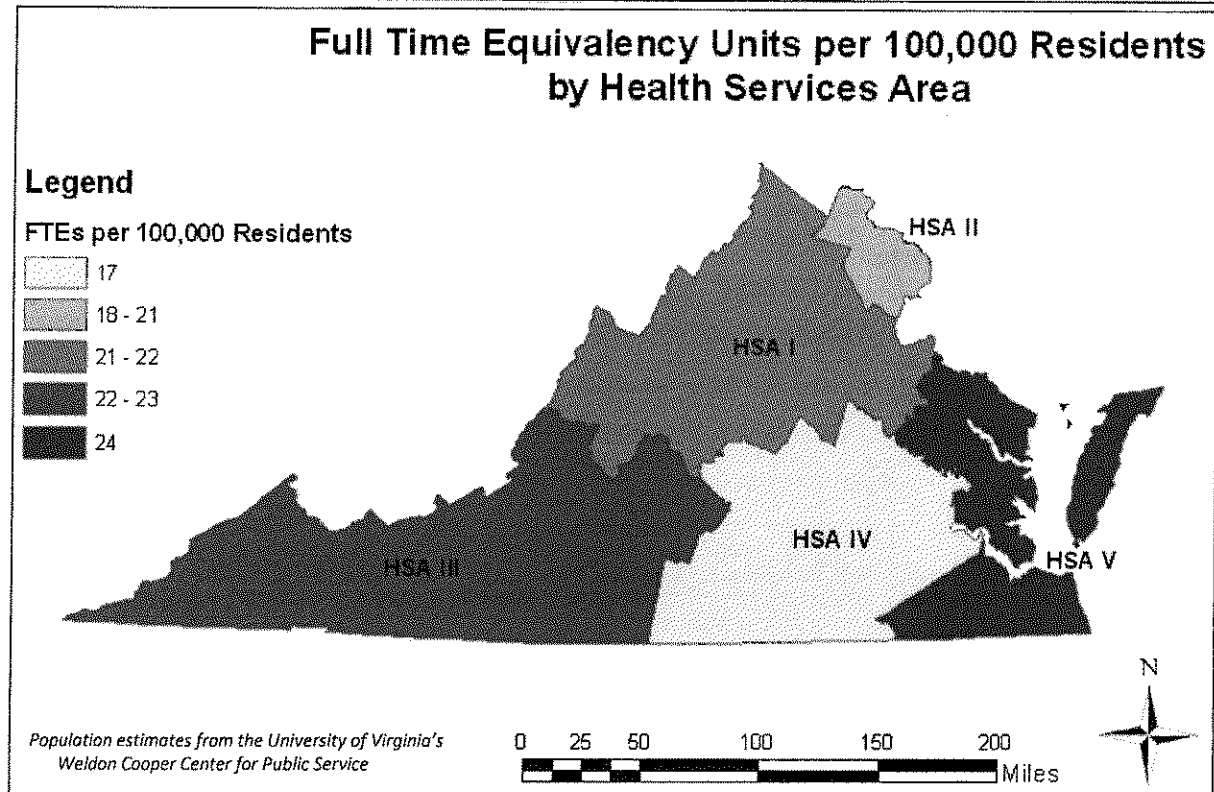
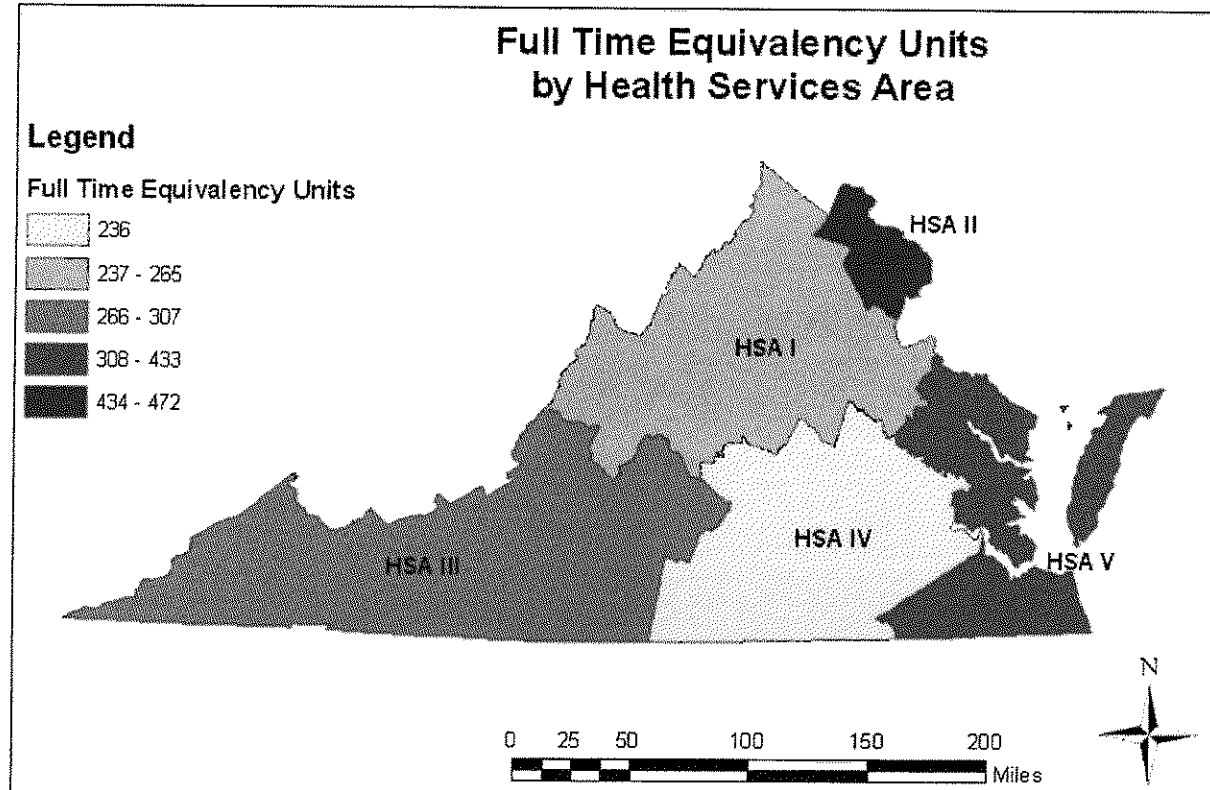
FTEs are defined using a variety of methods. Human resources professionals (and employees) often think in terms of positions or jobs, with one full time position equivalent to one FTE and one part time position equivalent to 0.5 FTEs. Economists (and payroll professionals), however, often need more precise measures of hours worked. Economists often use hours worked. Using FTEs, however, provides a human scale for examining data and provides for easy benchmarking across data sources.

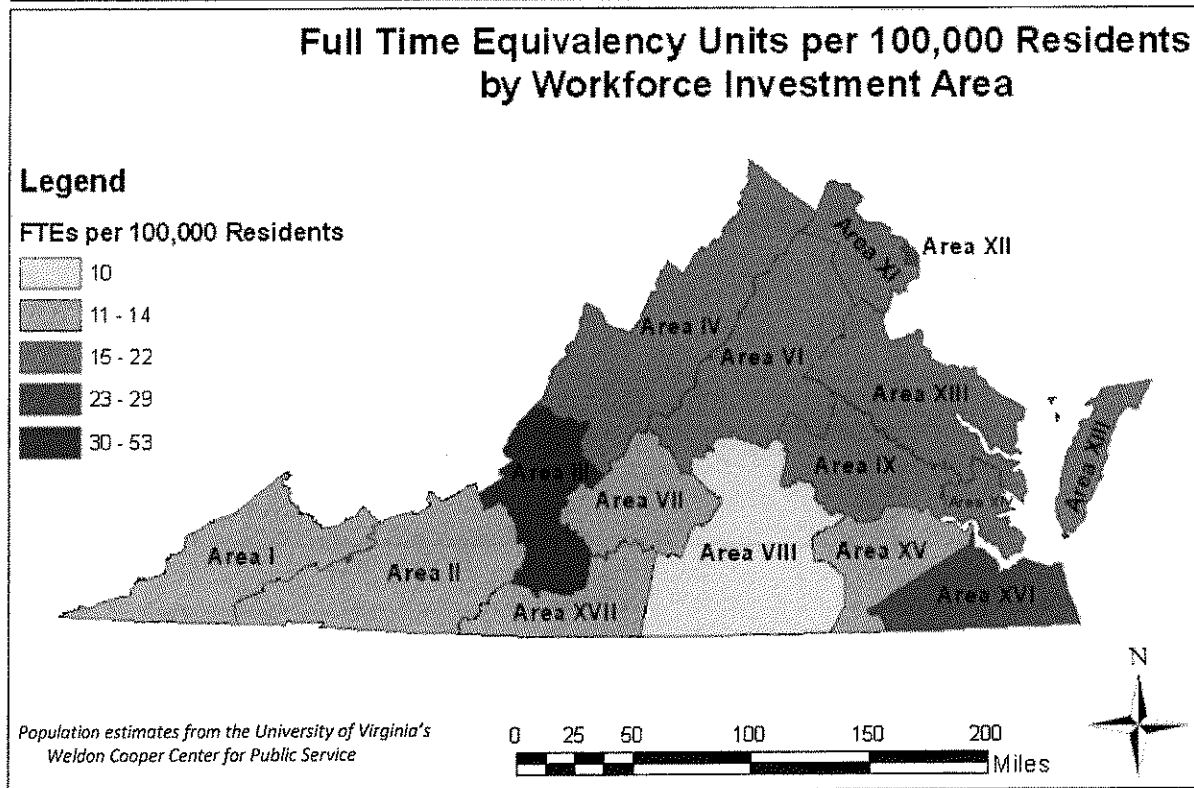
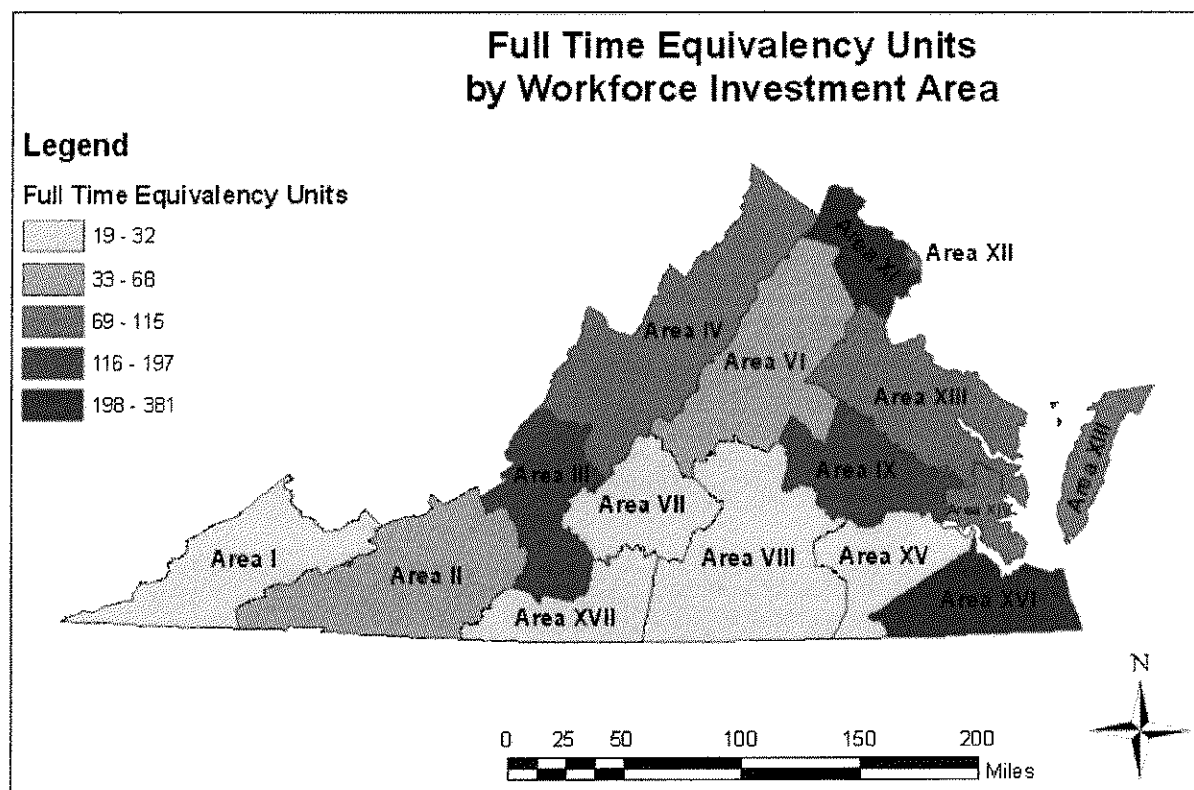
Age	Total FTEs	
	Mean	Sum
Under 30	.99	374
30 to 34	.93	421
35 to 39	.86	296
40 to 44	.89	224
45 to 49	.95	160
50 to 54	.93	117
55 to 59	.87	111
60 to 64	.85	56
65 and over	.81	15
Total	.92	1775

When using FTEs, readers are cautioned to look closely at how FTEs are defined. Does FTE refer to positions, or is it derived from hours worked (or some other measure of services provided, such as patients seen)? How many hours equates to one FTE? Unless defined equivalently, direct comparisons of FTEs require caution. In many cases, direct comparisons are not appropriate. For this iteration of the physician assistant survey, the HWDC estimated FTEs by examining each physician assistant's reported work hours at his or her primary, secondary and tertiary work locations. Physician assistants reporting part time work were assigned 0.5 FTEs for the location, while those reporting full time work were assigned 1.0 FTEs. If the PA reported having a work location but did not report work hours, he or she was assigned 1.0 FTEs for the primary location and 0.5 FTEs for any additional locations. This affected an estimated 47 PAs. FTEs were then summed. More recent HWDC surveys, including the new physician assistant survey, take a closer look at the actual number of hours worked by physician assistants across all work locations, and uses these figures to calculate FTEs.

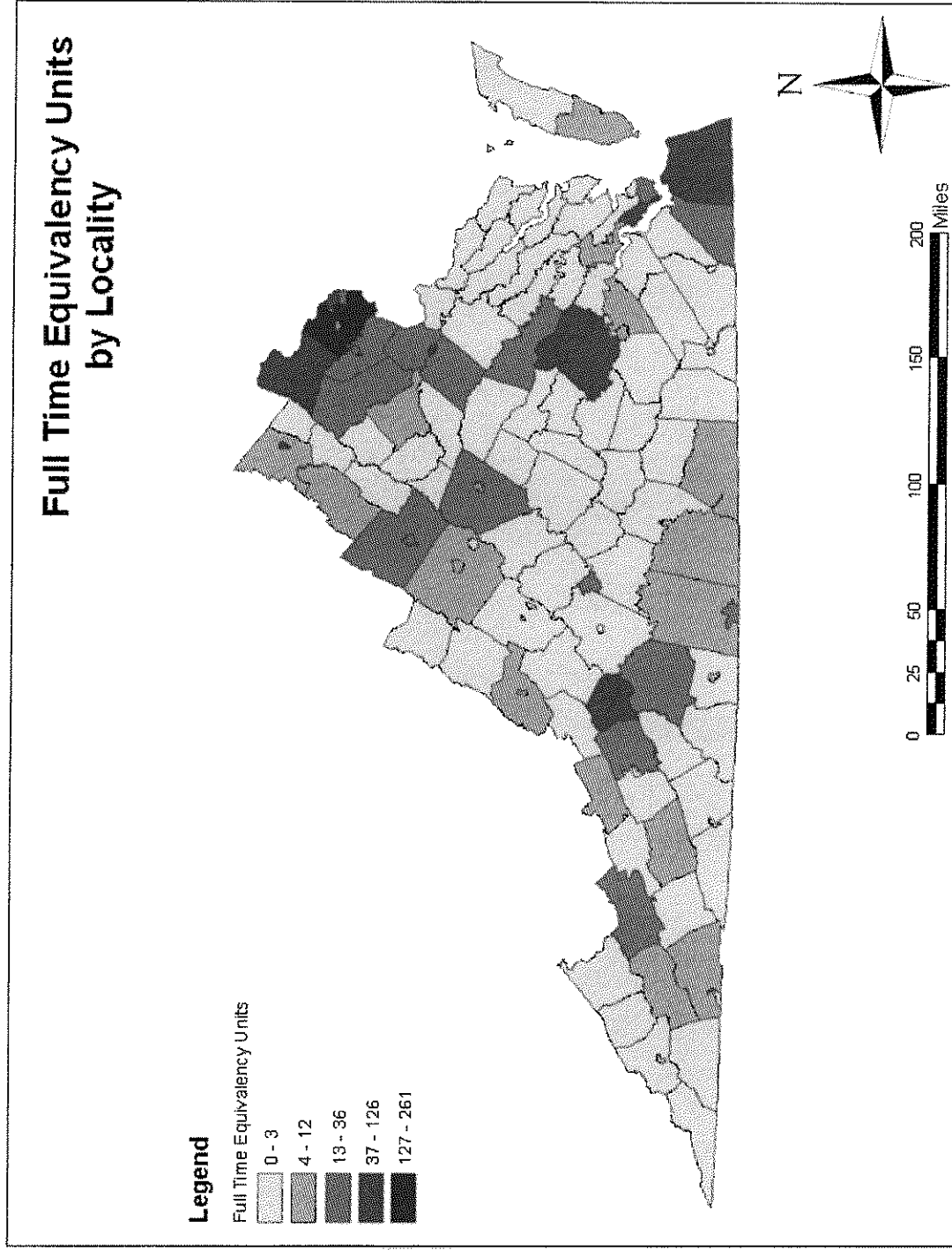
FTEs by age, along with the FTE per individual in the age group, are reported in the table above. All told, the 1,825 Virginia physician assistants who worked during the survey period provided approximately 1,775 FTEs at their primary, secondary and tertiary locations, or about 0.92 FTEs per physician assistant. FTEs and FTEs per 100,000 residents are displayed geographically in the following maps. Since this iteration of the physician assistant survey only collected data on the location of the primary employer, all FTEs are assigned to this location. If the primary employer's location was missing, we used the physician assistant's mailing address as a proxy.







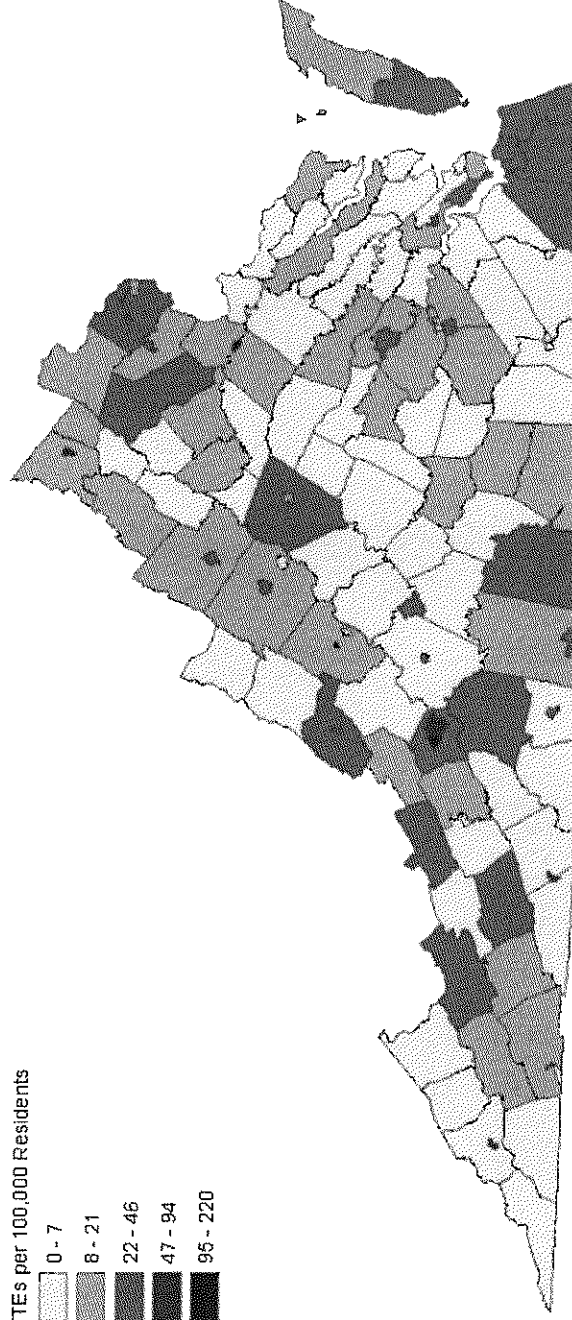
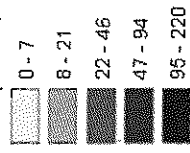




Full Time Equivalency Units per 100,000 Residents by Locality

Legend

FTEs per 100,000 Residents



Population estimates from the University of Virginia's
Weldon Cooper Center for Public Service



Appendices

Appendix A: Weights

Final weights were calculated by multiplying the two weights and the overall response rate within each profession:
 $\text{ageweight} \times \text{ruralweight} \times \text{responserate} = \text{final weight}.$

Age	Response Rate	Weight
Under 30	.494118	2.023810
30 to 34	.762089	1.312183
35 to 39	.784461	1.274760
40 to 44	.796721	1.255144
45 to 49	.857143	1.166667
50 to 54	.805031	1.242188
55 to 59	.796053	1.256198
60 to 64	.851351	1.174603
65 to 69	.909091	1.100000
70 to 74	.500000	2.000000
75 to 79	1.000000	1.000000
80 and over	0.000000	0.000000

Rural Status	Response Rate	Weight
Metro, 1 million+	.748659	1.335722
Metro, 250,000 to 1 million	.867188	1.153153
Metro, 250,000 or less	.704614	1.419162
Urban pop 20,000+, Metro adj	.807692	1.238095
Urban pop 20,000+, nonadj	0.000000	0.000000
Urban pop, 2,500-19,999, Metro adj	.803030	1.245283
Urban pop, 2,500-19,999, nonadj	.652174	1.533333
Rural, Metro adj	.684211	1.461538
Rural, nonadj	.812500	1.230769
VA Border State/D.C.	.678445	1.473958
Other U.S. state	.687500	1.454545

Appendix B: The Physician Assistant Survey

1	In which state do you currently reside?	drop down
1.a.	If Virginia, what brought you to Virginia?	dropdown
		Virginia native
		Relocated to Virginia
		Military
		Residency
2	Ethnicity/Race	drop down
		White
		Black, African American, or Negro
		American Indian or Alaska Native
		Hispanic, Latino or Spanish Origin
		Asian Indian
		Chinese
		Filipino
		Japanese
		Korean
		Vietnamese
		Other Asian
		Native Hawaiian
		Guamanian or Chamorro
		Samoan
		Other Pacific Islander
		Some Other Race
3	Gender	Male
		Female
	EDUCATION	
4	Highest Degree Currently Held	drop down
		Certificate from a PA School
		Associate's degree
		Baccalaureate degree
		Master's degree
		Doctorate
5	Highest degree received from PA program	drop down
		Certificate from a PA School
		Associate's degree
		Baccalaureate degree
		Master's degree
		Doctorate
6	What year did you graduate from the PA program?	fill in blank

7	Are you currently enrolled in an education program leading to an advanced degree?	yes or no
7.a.	If yes, please list the degree your are seeking.	fill in blank
7.b.	If yes, what school are you attending?	fill in blank
WORK STATUS		
8	If you are currently NOT working as a PA, please skip to question number 36.	
9	What is your primary practice specialty?	drop down
		Cardiology
		Correctional Medicine
		Emergency medicine
		Family Medicine
		Gastroenterology
		General surgery
		Geriatric medicine
		Industrial medicine
		Internal medicine
		Neurology
		OB/GYN
		Oncology
		Orthopedics
		Pediatrics
		Psychiatry
		Radiology
		Urology
		Pediatric Specialty
		Surgical Specialty
		Other
9.a.	Other: please list	fill in blank
9.b.	Do you perform invasive procedures in your specialty?	yes or no
10	Are you credentialed to work at a hospital?	yes or no
10.a.	If yes, please list the hospital.	fill in blank
11	Primary Employer	
		hospital based
		clinic based
12	In how many hospitals do you see patients for your primary employer?	fill in blank

13	Which one of the following types of organizations best describes the setting for your primary employer?	drop down
		Academics
		Academics-University
		Community Health Center/Clinic
		Corrections system
		Freestanding urgent care center
		Freestanding urgent surgical center
		HMO
		Home Health Agency
		Hospice
		Hospital
		Integrated Health Delivery System
		Medical Staffing Agency
		Military
		Multi Specialty Physician Group
		Nursing Home or LOC Facility
		Physician Practice Management Company
		Self Employed or an Independent Contractor
		Single Specialty Physician Group Practice
		Solo Physician Practice
		University Hospital
		VA (Veterans Administration)
		Other
13.a.	If other, please specify.	fill in blank
14	Please identify the functions you perform while working at your primary practice location.	check all that apply
		First Assisting at Surgery
		Minor Surgical Procedures
		Manage the Care of Patients in an Inpatient Setting
		Manage the Care of Patients in an Outpatient Setting
		Supervisory/Managerial Responsibilities for Other PA
		Supervisory/Managerial Responsibilities for Clinical Staff
15	What is your primary practice employers location?	street address, state, zip
16	On average, how many hours do you work at this primary practice employers location per week?	
		Full time: 32 hrs or more /week
		Part time: less than 32 hrs/ week
17	Please indicate the number of visits/encounters that you handle in a typical week at this primary practice employer location.	
17.a.	Out-patient visits	drop down
		0-10 visits/encounters

		11-20 visits/encounters
		21-30 visits/encounters
		31-40 visits/encounters
		41-50 visits/encounters
		51+ visits/encounters
17.b.	In-patient visits	drop down
		0-10 visits/encounters
		11-20 visits/encounters
		21-30 visits/encounters
		31-40 visits/encounters
		40+ visits/encounters
		51+ visits/encounters
17.c.	Extended Care	drop down
		0-10 visits/encounters
		11-20 visits/encounters
		21-30 visits/encounters
		31-40 visits/encounters
		40+ visits/encounters
		51+ visits/encounters
17.d.	Hospice	drop down
		0-10 visits/encounters
		11-20 visits/encounters
		21-30 visits/encounters
		31-40 visits/encounters
		40+ visits/encounters
		51+ visits/encounters
18	Are you on call for your primary practice employer?	yes or no
18.a.	If yes, how many hours per month?	fill in blank
19	What is the approximate percent of your patients at this primary practice employer on Medicaid?	drop down
		1-10%
		11-20%
		21-30%
		31-40%
		41-50%
		51-60%
		61-70%
		71-80%
		81-90%
		91-100%
20	What is the approximate percent of your patients at this primary practice employer on Medicare?	drop down
		1-10%

		11-20%
		21-30%
		31-40%
		41-50%
		51-60%
		61-70%
		71-80%
		81-90%
		91-100%
21	What is the approximate percent of your patients at this primary practice employer on private insurance?	drop down
		1-10%
		11-20%
		21-30%
		31-40%
		41-50%
		51-60%
		61-70%
		71-80%
		81-90%
		91-100%
22	What percent of patients at this primary practice setting are self pay.	drop down
		1-10%
		11-20%
		21-30%
		31-40%
		41-50%
		51-60%
		61-70%
		71-80%
		81-90%
		91-100%
23	If you do NOT have a secondary practice employer, please skip to number 35	
24	Who is your second practice employer?	fill in blank
25	At your secondary practice employer what is your specialty?	
		Cardiology
		Correctional Medicine
		Emergency medicine
		Family Medicine
		Gastroenterology
		General surgery
		Geriatric medicine

		Industrial medicine
		Internal medicine
		Neurology
		OB/GYN
		Orthopedics
		Pediatrics
		Psychiatry
		Radiology
		Urology
		Pediatric Specialty
		Surgical Specialty
		Other
25.a.	Other: please list	fill in blank
25.b.	Do you perform invasive procedures in your specialty at this secondary practice location?	yes or no
26	At your secondary practice employer, on average, how many hours do you work per week?	
		Full time: 32 hrs or more /week
		Part time: less than 32 hrs/ week
27	At your secondary practice employer, how many patient care hours do you work per week?	fill in blank
28	At your secondary practice employer, how many hours each week do you see patients in your specialty area?	fill in blank
28.a.	At your secondary practice employer, indicate the number of visits/encounters that you handle in a typical week.	fill in blank
29	At your secondary practice employer, are you on call?	yes or no
29.a.	If yes, how many hours per month?	fill in blank
30	At your secondary practice employer, in how many hospitals do you see patients?	fill in blank
31	Please identify the functions you perform while working at your secondary practice location.	check all that apply
		First Assisting at Surgery
		Minor Surgical Procedures
		Manage the Care of Patients in an Inpatient Setting
		Manage the Care of Patients in an Outpatient Setting
		Supervisory/Managerial Responsibilities for Other PA
		Supervisory/Managerial Responsibilities for Clinical Staff

32	Do you have a third practice employer?	yes or no
33	If you do NOT have a third practice employer, please skip to number 35	
34	What is the average number of hours you work per week at your third practice setting?	fill in blank
35	Please indicate the typical number of hours per week you spend in each of the following activities for all practice locations combined.	
35.a.	Patient Care	drop down
		1-5 hours per week
		6-10 hours per week
		11-15 hours per week
		16-20 hours per week
		21-25 hours per week
		26-30 hours per week
		30 plus hours per week
35.b.	Academia	drop down
		1-5 hours per week
		6-10 hours per week
		11-15 hours per week
		16-20 hours per week
		21-25 hours per week
		26-30 hours per week
		30 plus hours per week
35.c.	Administrative	drop down
		1-5 hours per week
		6-10 hours per week
		11-15 hours per week
		16-20 hours per week
		21-25 hours per week
		26-30 hours per week
		30 plus hours per week
35.d.	Precepting	drop down
		1-5 hours per week
		6-10 hours per week
		11-15 hours per week
		16-20 hours per week
		21-25 hours per week
		26-30 hours per week
		30 plus hours per week
35.e.	Quality Assurance	drop down
		1-5 hours per week

		6-10 hours per week
		11-15 hours per week
		16-20 hours per week
		21-25 hours per week
		26-30 hours per week
		30 plus hours per week
35.f.	Research	drop down
		1-5 hours per week
		6-10 hours per week
		11-15 hours per week
		16-20 hours per week
		21-25 hours per week
		26-30 hours per week
		30 plus hours per week
35.g.	Volunteer	drop down
		1-5 hours per week
		6-10 hours per week
		11-15 hours per week
		16-20 hours per week
		21-25 hours per week
		26-30 hours per week
		30 plus hours per week
35.h.	Other	drop down
		1-5 hours per week
		6-10 hours per week
		11-15 hours per week
		16-20 hours per week
		21-25 hours per week
		26-30 hours per week
		30 plus hours per week
36	If you are NOT practicing now, do you plan to return to PA work?	
		No
		Yes
36.a.	If yes, what is the timeframe you anticipate returning to PA work?	
		Within one year
		Within 1-2 years
		Within 3-5 years
		Within 6-10 years
		More than 10 years from now
37	When do you plan to retire?	
		In less than one year

		In the next 1-2 years
		In the next 3-5 years
		In the next 6-10 years
		More than 10 years from now
38	After retirement, do you plan to volunteer in some area of healthcare?	yes or no
38.a.	If yes, which area of healthcare?	fill in blank

Appendix C: The 2012 Physician Assistant Workforce Survey

While striving to maintain continuity, the HWDC continuously improves its surveys based on results of previous surveys. The HWDC has adopted a standard survey template to serve as the basis of all of its workforce surveys. The 2012 Pharmacy Survey incorporates standard survey template and includes elements specific to the Pharmacist survey. Please note that the survey appears online through our licensing renewal system. The final appearance of the survey for practitioners is dictated by this system. The HWDC may add additional changes before implementing the 2012 survey.

Physician Assistant Survey		
Instructions:		
The following survey will assist policymakers at the state, federal and local levels assess the adequacy of the current <i>your profession</i> workforce and project future workforce trends in relation to Virginia's changing population and health needs. It will help us advance the practice of <i>your profession</i> and to improve the health of all Virginians. By law, information collected as part of this survey is confidential. License numbers and other individually identifying information are removed from Healthcare Workforce Data Center data sets. The Healthcare Workforce Data Center only releases information in the aggregate or to qualified research organizations who meet our strict confidentiality standards. Participation in this survey is voluntary.		
The survey questions are designed to allow comparisons across professions, and among state and federal data collection efforts. Some of the questions, particularly the demographic questions, match Federal data collection standards.		
Education and Background		
1)	Year of Birth:	Dropdown: 1996 to 1920 (reverse order)
2)	Sex:	Dropdown: Male/Female
Please select the items that best describe your race/ethnicity. Please answer both question 3a about Hispanic origin and 3b about race/ethnicity.		
3a)	Select one:	Check one
		Hispanic, Latino or Spanish Origin
		Not Hispanic, Latino or Spanish Origin
3b)	Select all that apply:	Check all that apply
		White
		Black or African American
		American Indian or Alaska Native
		Asian
		Native Hawaiian or Pacific Islander
		Some other race
3c)	If some other race, please specify:	Fill in the blank
4)	Where did you graduate from high school (Secondary School)?	Dropdown
		Outside of the US or Canada
		Canada
		57 US States and Territories

5)	Was your childhood spent mostly in rural, urban or suburban areas?	Dropdown: urban, rural, suburban
6)	Where did you obtain your undergraduate (Bachelor's or Associate) degree?	Dropdown
		Did not obtain an undergraduate degree
		Outside of the US or Canada
		Canada
		57 US States and Territories
7)	Where did you obtain the degree that initially qualified you to practice as a physician assistant?	Dropdown
		Outside of the US or Canada
		Canada
		57 US States and Territories
8)	Please indicate the highest level of Physician Assistant education you have completed as of today:	Dropdown
		PA Certificate, undergraduate
		Associate degree
		Baccalaureate degree
		PA Certificate, post-graduate
		Master's degree
		Doctorate
9)	Do you hold an active license to practice your profession in any other jurisdiction?	Check all that apply
		District of Columbia
		Kentucky
		Maryland
		North Carolina
		Tennessee
		West Virginia
		One or more other US states
10)	Please select the choice that best describes any primary area of specialization, training or experience you may have:	Dropdown
		No Specialty
		Addiction Medicine
		Allergy & Immunology
		Anesthesiology
		Cardiology
		Cardiovascular Surgery
		Dermatology
		Emergency Medicine
		Endocrinology
		Family Medicine
		Gastroenterology & Hepatology

		General Surgery
		Geriatrics, General
		Hospital Medicine
		Internal Medicine, General
		Neonatal Intensive Care
		Nephrology
		Neurosurgery
		OB/GYN
		Occupational Medicine
		Oncology
		Orthopedics
		Otolaryngology
		Pediatrics, General
		Pediatric Intensive Care
		Pediatric Orthopedics
		Plastic Surgery
		Psychiatry
		Radiology
		Rheumatology
		Urology
		Other
10b)	If you selected "other specialty area", please provide a brief description:	<i>Open-ended</i>
11)	Please select the choice that best describes any primary area of specialization, training or experience you may have:	<i>Dropdown</i>
		No Secondary Specialty
		Addiction Medicine
		Allergy & Immunology
		Anesthesiology
		Cardiology
		Cardiovascular Surgery
		Dermatology
		Emergency Medicine
		Endocrinology
		Family Medicine
		Gastroenterology & Hepatology
		General Surgery
		Geriatrics, General
		Hospital Medicine
		Internal Medicine, General
		Neonatal Intensive Care
		Nephrology
		Neurosurgery
		OB/GYN
		Occupational Medicine
		Oncology
		Orthopedics

		Otolaryngology
		Pediatrics, General
		Pediatric Intensive Care
		Pediatric Orthopedics
		Plastic Surgery
		Psychiatry
		Radiology
		Rheumatology
		Urology
		Other
11b)	If you selected "other specialty area", please provide a brief description:	Open-ended
Current Employment Status		
12	Which choice best describes your <i>current</i> employment or work situation?	Dropdown
		I am currently employed in a <i>my profession</i> related capacity.
		I am currently employed, but not in a <i>my profession</i> related capacity.
		I am retired.
		I am currently voluntarily unemployed (including for medical reasons).
		I am currently involuntarily unemployed.
13)	Overall, and taking into account all positions you fill, how satisfied are you with your <i>current</i> employment or work situation?	Dropdown
		Very satisfied
		Somewhat satisfied
		Somewhat dissatisfied
		Very dissatisfied
14)	How many positions do you <i>currently</i> hold?	Dropdown
	Note: There is no legal standard for part-time work, and each employer defines part-time work differently. Part-time work generally refers to workweeks of 35-hours per week or less. Per diem, temporary, contract, self-employed and seasonal workers, and workers subject to annual limits on hours should consider average hours spent working over the term of employment.	
		One part-time position
		One full-time position
		Two part-time positions
		One full-time position & one part-time position

		Two full-time positions
		More than two positions
15)	Considering all positions you <i>currently</i> fill, how long is your average workweek?	Dropdown I am not currently working 1 to 9 hours 10 to 19 hours 20 to 29 hours 30 to 39 hours 40 to 49 hours 50 to 59 hours 60 to 69 hours 70 to 79 hours 80 or more hours
16)	Do you currently have privileges in any Virginia hospitals? If so, how many?	Dropdown: None & 1 thru 10
Unless otherwise noted, the rest of the questions draws on your experiences over the past 12 months. If you did not work in the past 12 months in a capacity that drew on your profession background, please skip to question 41.		
Primary Work Location		
Question 17 through Question 23 refer to your primary place of employment, work or practice, including volunteer work, over the past 12 months. This is the location where you spend the most work hours during an average workweek, or where you spent the most weeks working in the past 12 months. You do not need to currently work at this location. These questions describe a particular work location, not an employer. Temporary or traveling workers who spend or spent a significant amount of time at a particular location should use that location as his or her primary work location. Persons who consistently work in multiple locations (e.g. temporary workers, home health, locum tenens, multi-facility rounds) should choose the location where they spent the most time or where they are based. When answering these questions, please consider the entire 12 month period.		
17)	Please select the location of your primary place of employment, work, volunteer work or practice:	Dropdown: Outside of US Virginia Border State/DC Other US State List of Virginia's Cities and Counties
18)	How long have you worked at this particular location?	Dropdown I do not currently work at this location Less than 6 months 6 months to 1 year 1 to 2 years 3 to 5 years 6 to 10 years More than 10 years

19a)	Approximate number of weeks at which at least some time was spent at this work location within the past twelve months (exclude vacation, medical leave, etc):	Dropdown: 1 week - 52 weeks
19b)	How many hours do you (or did you) work in an average workweek at this location?	Dropdown
		1 to 9 hours
		10 to 19 hours
		20 to 29 hours
		30 to 39 hours
		40 to 49 hours
		50 to 59 hours
		60 to 69 hours
		70 to 79 hours
		80 or more hours
20)	In the average workweek at this location, roughly what percentage of your working hours were spent in the following roles: (Answers should roughly equate to 100%).	Dropdown: (for each sub-question)
20a)	Administration or business-related matters	None
20c)	Direct patient care, including patient education and coordination of care	1% to 9%
20d)	Education of health professions students (including acting as preceptor)	10% to 19%
20e)	Formal research	20% to 29%
20f)	Other	30% to 39%
		50% to 59 %
		60% to 69%
		70% to 79%
		80% to 89%
		90% to 99%
		100%
21)	Please indicate the number of visits/encounters that you handle in a typical week at this primary practice employer location.	Dropdown: (for each sub-question)
21a)	Outpatient visits	None
21b)	Inpatient visits	1-9 visits/encounters
21c)	Extended care	10-19 visits/encounters
21d)	Hospice	20-29 visits/encounters
		30-39 visits/encounters
		40-49 visits/encounters
		50 or more visits/encounters
22a)	Please select the choice that best describes this location's organizational sector:	Dropdown
		For-profit (e.g. private practice, corporate)

		Non-profit (including religious affiliated)
		State/local-government
		US military
		Veteran's Administration
		Other federal government
22b)	Please select the choice that best describes this practice setting:	<i>Dropdown:</i>
		Physician solo practice
		Group practice, single specialty
		Group practice, multi specialty
		Academic institution (teaching or research)
		Academic institution (patient care role)
		Community clinic/Outpatient care center
		Home health agency
		Hospice
		Hospital-outpatient department
		Hospital-emergency department
		Hospital-inpatient department
		Independent contractor
		Insurance
		Medical staffing agency
		Mental health facility
		Nursing home/long term care facility
		Outpatient surgical center
		Other
22c)	If you selected "other practice setting" please provide a brief description:	<i>Open-ended</i>
23)	Please indicate how you are (were) personally compensated for activities at this location:	<i>Dropdown</i>
		Salary/Commission
		Hourly wage
		By contract
		Business/Practice income
		Volunteer, unreimbursed
If you only had one practice location in the past 12 months, please skip to question 34. If you had additional practice locations, please continue.		
Secondary Work Location		

Question 24 through Question 31 refer to your secondary place of work or practice, including volunteer work, over the past 12 months. This is the location where you spend the second most work hours during an average workweek, or where you spent the second most weeks working in the past 12 months. You do not need to currently work at this location. These questions describe a particular work location, not an employer. Temporary or traveling workers who spend or spent a significant amount of time at a secondary location should use that location as his or her secondary work location. Persons who consistently worked in multiple locations (e.g. temporary workers, home health, locum tenens, multi-facility rounds) in addition to a primary location should choose the secondary location where they spent the most time or where they are based. When answering these questions, please consider the entire 12 month period.

24	Is this location with the same employer or practice as your primary location, or a different employer/practice?	Dropdown
		Same employer or practice
		Different employer or practice
25)	Please select the location of your primary place of employment, work, volunteer work or practice:	Dropdown:
		Outside of US
		Virginia Border State/DC
		Other US State
		List of Virginia's Cities and Counties
26)	How long have you worked at this particular location?	Dropdown
		I do not currently work at this location
		Less than 6 months
		6 months to 1 year
		1 to 2 years
		3 to 5 years
		6 to 10 years
		More than 10 years
27a)	Approximate number of weeks at which at least some time was spent at this work location within the past twelve months (exclude vacation, medical leave, etc):	Dropdown: 1 week - 52 weeks
27b)	How many hours do you (or did you) work in an average workweek at this location?	Dropdown
		1 to 9 hours
		10 to 19 hours
		20 to 29 hours
		30 to 39 hours
		40 to 49 hours
		50 to 59 hours
		60 to 69 hours
		70 to 79 hours
		80 or more hours
28)	In the average workweek at this location, roughly what percentage of your working	Dropdown: (for each sub-question)

	hours were spent in the following roles: (Answers should roughly equate to 100%).	
28a)	Administration or business-related matters	None
28c)	Direct patient care, including patient education and coordination of care	1% to 9%
28d)	Education of health professions students (including acting as preceptor)	10% to 19%
28e)	Formal research	20% to 29%
28f)	Other	30% to 39%
		50% to 59 %
		60% to 69%
		70% to 79%
		80% to 89%
		90% to 99%
		100%
29)	Please indicate the number of visits/encounters that you handle in a typical week at this primary practice employer location.	Dropdown: (for each sub-question)
29a)	Outpatient visits	None
29b)	Inpatient visits	1-9 visits/encounters
29c)	Extended care	10-19 visits/encounters
29d)	Hospice	20-29 visits/encounters
		30-39 visits/encounters
		40-49 visits/encounters
		50 or more visits/encounters
30a)	Please select the choice that best describes this location's organizational sector:	Dropdown
		For-profit (e.g. private practice, corporate)
		Non-profit (including religious affiliated)
		State/local-government
		US military
		Veteran's Administration
		Other federal government
30b)	Please select the choice that best describes this practice setting:	Dropdown:
		Physician solo practice
		Group practice, single specialty
		Group practice, multi specialty
		Academic institution (teaching or research)
		Academic institution (patient care role)
		Community clinic/Outpatient care center
		Home health agency
		Hospice
		Hospital-outpatient department

		Hospital-emergency department
		Hospital-inpatient department
		Independent contractor
		Insurance
		Medical staffing agency
		Mental health facility
		Nursing home/long term care facility
		Outpatient surgical center
		Other
30c)	If you selected "other practice setting" please provide a brief description:	<i>Open-ended</i>
31)	Please indicate how you are (were) personally compensated for activities at this location:	<i>Dropdown</i>
		Salary/Commission
		Hourly wage
		By contract
		Business/Practice income
		Volunteer, unreimbursed
If you had only two locations in the past 12 months, please skip to question 34. If you had additional practice locations, please continue.		
32)	How many total work locations have you had over the past 12 months?	<i>Dropdown</i>
		3
		4
		5
		6 or more
33)	How many work locations do you have currently?	<i>Dropdown</i>
		3
		4
		5
		6 or more
Employment Information		
<i>The Healthcare Workforce Data Center collects compensation information to assess the balance of supply and demand in the state and in localities, and to assist students in planning health careers and choosing specialties. Information from these questions will only be presented in the aggregate. The confidentiality of information for these and all questions is protected by law. All questions are voluntary.</i>		
34)	Within the past 12 months, have you experienced any of the following:	<i>Check all that apply</i>
		Voluntary unemployment (including for medical reasons)?
		Involuntary unemployment (including for medical reasons)?

		Switched employers/practices?
		Worked part-time or temporary positions, but would have preferred a full-time or permanent position?
		Worked two or more positions at the same time?
35)	Do you perform any of the following tasks in your work as a physician assistant?	Check all that apply
		First assist at surgery
		Minor surgical procedures
		Supervise/Manage other PAs
		Supervise/Manage other clinical staff
		Manage care of patients, inpatient
		Manage care of patients, outpatient
36)	What is your estimated annual net income from your profession related activities?	Dropdown:
		Volunteer work only
		Less than \$20,000
		\$20,000-\$29,999
		\$30,000-\$39,999
		\$40,000-\$49,999
		\$50,000-\$59,999
		\$60,000-\$69,999
		\$70,000-\$79,999
		\$80,000-\$89,999
		\$90,000-\$99,999
		\$100,000-\$109,999
		\$110,000-\$119,999
		\$120,000 or more
37)	Do you receive any of the following benefits from any current employer?	Check all that apply:
		Paid Leave
		Health Insurance
		Dental Insurance
		Retirement (401k, Pension, etc.)
		Group Life Insurance
		Signing/retention bonus
38)	What is your estimated current educational debt?	Dropdown:
		None
		Less than \$10,000
		\$10,000-\$19,999
		\$20,000-\$29,999
		\$30,000-\$39,999
		\$40,000-\$49,999
		\$50,000-\$59,999
		\$60,000-\$69,999

		\$70,000-\$79,999
		\$80,000-\$89,999
		\$90,000-\$99,999
		\$100,000-\$109,999
		\$110,000-\$119,999
		\$120,000 or more
39)	At what age do you plan to retire from <i>your profession</i> ?	Dropdown Under age 50 50 to 54 55 to 59 60 to 64 65 to 69 70 to 74 75 to 79 80 or over I do not intend to retire
40)	Within the next two years do you plan to do any of the following:	Check all that apply Retire Cease working in <i>your profession</i> Continue working in <i>your profession</i> , but cease working in Virginia Increase patient care hours Decrease patient care hours Increase time spent teaching <i>your profession</i> Decrease time spent teaching <i>your profession</i> Pursue additional <i>your profession</i> education
End of Questionnaire for active practitioners-Thank you!		
41)	If you did not practice, teach or otherwise work in <i>your profession</i> within the past twelve months, did/are you. . . ?	Check all that apply: I am retired. Work occasionally for charity/consultation/special patients? Pursue <i>your profession</i> education or certifications? Pursue education not related to <i>your profession</i> ? Work in another profession or field? Experience temporary voluntary unemployment (including for medical reasons)? Experience temporary involuntary unemployment?

42)	Do you provide any volunteer, mentoring or other services within <i>your profession</i> in Virginia? If so, approximately how many hours in the past year?	Dropdown: None 1-25 hours 26-50 hours 51-75 hours 76-100 hours Over 100 hours
43)	Do you expect to begin working in <i>your profession</i> in Virginia? If so, when?	Dropdown: Not currently planning to practice/work in Virginia Plan to practice/work in a volunteer capacity Yes, within the next year Yes, within 1-2 years Yes, within 3-5 years Yes, in more than 5 years Yes, do not know when
End of Questionnaire-Thank you!		

