Physician Assistant Census for Workforce Planning

I: Physician Assistant Information

1. Last Name, Suffix (eg. Sr., Jr.)_____ 2. First Name _____ 3. Middle Name _____

4. Sex ☐Male ☐Female 5. Date of Birth (mm/dd/yyyy) _____/_____/_____

6. How would you classify your race/ethnicity? (please check all that apply)
☐White ☐Black or African American ☐Other (Specify) _____
☐American Indian or Alaska Native ☐Asian ☐Prefer not to answer
☐Native Hawaiian / other Pacific Islander ☐Hispanic

7. Do you have a DEA Number? ☐Yes ☐No

8. NPI Number _____ ☐I do not have a NPI Number

9. Do you currently reside in Washington State? ☐Yes ☐No

10. Residence City _____ 11. Residence State _____ 12. Residence Zip Code _____

13. In what state did you obtain your physician assistant degree? _____
☐I did not obtain my physician assistant degree in the United States
In which country did you obtain your physician assistant degree? _____

14. Are you currently certified by NCCPA?
☐No
☐Yes: What is your NCCPA certificate of added qualification? _____
☐I do not have a certificate of added qualification

15. Have you retired from clinical practice?
☐Yes (Skip to question 33)
☐No

16. Do you plan on retiring from clinical practice in the next 12 months?
☐No (Skip to question 18)
☐Yes

17. Upon retirement from clinical practice, will you convert your license to "retired active"?
☐Yes
☐No: Why will you not convert your license? _____

II: Practice Information

18. Do you currently practice in WA? ☐Yes ☐No

19. Do you have an ownership interest in any practice? ☐Yes ☐No

20. Please Provide your Place of Practice *(Street address, city, state, zip code)*		Not Applicable
Primary		☐
Secondary		☐
Tertiary		☐
21. At how many remote sites do you practice? _____		
Site (1) address		☐
Site (2) address		☐
Site (3) address		☐

22. Please indicate your current area of practice

Area of Practice	Principal	Secondary	Sponsoring Physician's Specialty
Adolescent Medicine	☐	☐	☐
Allergy and Immunology	☐	☐	☐
Anesthesiology	☐	☐	☐
Cardiology	☐	☐	☐
Child Psychiatry	☐	☐	☐
Colon and Rectal Surgery	☐	☐	☐
Critical Care Medicine	☐	☐	☐
Dermatology	☐	☐	☐
Emergency Medicine	☐	☐	☐
Endocrinology	☐	☐	☐
Family Medicine/General Practice	☐	☐	☐
Gastroenterology	☐	☐	☐
Geriatric Medicine	☐	☐	☐
Gynecology Only	☐	☐	☐
Infectious Diseases	☐	☐	☐
Internal Medicine (General)	☐	☐	☐
Nephrology	☐	☐	☐
Neurological Surgery	☐	☐	☐
Neurology	☐	☐	☐
Obstetrics and Gynecology	☐	☐	☐
Occupational Medicine	☐	☐	☐
Ophthalmology	☐	☐	☐
Orthopedic Surgery	☐	☐	☐
Otolaryngology	☐	☐	☐
Pathology	☐	☐	☐
Pediatrics (General)	☐	☐	☐
Physical Med. & Rehab.	☐	☐	☐
Plastic Surgery	☐	☐	☐
Preventive Medicine/Public Health	☐	☐	☐
Psychiatry	☐	☐	☐
Pulmonology	☐	☐	☐
Radiation Oncology	☐	☐	☐
Radiology	☐	☐	☐
Rheumatology	☐	☐	☐
Surgery (General)	☐	☐	☐
Thoracic Surgery	☐	☐	☐
Urology	☐	☐	☐
Vascular Surgery	☐	☐	☐
Other (Please Specify)			

23. Is your primary clinical practice?
☐ Office based
☐ Hospital based
☐ Neither: Please explain _____

24. How many sponsoring physicians and alternates are in your practice? _____

25. How many delegation agreements have you listed as a participant? _____

26. On average, how often are your delegation agreements updated? (please select only one answer)
☐ Weekly ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

27. For patient related activities, indicate your practice arrangement and size of group. (please check all that apply)
☐ Single Specialty Group: Size of medical group _____
☐ Multi-Specialty Group: Size of medical group _____
☐ Solo Practitioner
☐ Employee of a hospital or clinic
☐ State or Federal Employer
☐ Other: Please Describe _____

28. Are interpretation services offered at your practice?
☐ No
☐ Yes: What languages are offered for interpretation (via phone, in person, staff etc.) at your practice? (please check all that apply)
☐ English ☐ Korean ☐ French ☐ Spanish ☐ Russian ☐ Mandarin Chinese ☐ Do not know ☐ Other _____

29. Do you speak any language(s) other than English, well enough to communicate with your patients? (please check all that apply)
☐ None ☐ Korean ☐ French ☐ Spanish ☐ Russian ☐ Mandarin Chinese ☐ Other _____

Are you accepting new patients covered by:

	Yes	No	I do not know	Percentage of your patient population that currently uses this insurance
30. Medicare	☐	☐	☐	%
31. Medicaid/ Apple Health	☐	☐	☐	%
32. Tricare	☐	☐	☐	%

33. In the past 12 months, how many weeks did you work or volunteer in a clinical setting? For example, if you work all year and take two weeks of vacation, you would work 50 weeks. _____

34. In a typical work week, indicate the average number of hours dedicated to the following professional activities?
- Clinical (not volunteer) _____hours per week
- Research _____ hours per week
- Administration (committees, management) _____ hours per week
- Education (preceptor, clinical professor) _____ hours per week
- Volunteer Clinical _____ hours per week
- Other: Please describe _____ hours per week _____

RCW 41.05.700 defines Telemedicine as the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. "Telemedicine" does not include the use of audio-only telephone, facsimile, or email.

35. Do you provide telehealth / telemedicine?

☐ No

☐ Yes: a) How many hours per week do you practice telehealth/ telemedicine? _____

b) Please describe the setting in which you practice telehealth/ telemedicine

_____

c) What percentage of your telemedicine/ telehealth population is provided to patients located in WA?_____%

36. Do you prescribe opioids for patients with chronic noncancer pain?

☐ No

☐ Yes: Please estimate the number of patients in the past month _____

37. Have you completed the pain management CME as described in WAC 246-918-890(2)?

☐ No

☐ Yes

38. Are you exempt from the pain specialist consultation requirement in WAC 246-918-880, based upon one or more sets of criteria for exemption listed in WAC 246-918-890 ?

☐ No

☐ Yes

39. Do you have colleague(s) to whom you can refer pain patients?

☐ No

☐ Yes: How many?_____

40. Do you treat patients through nontraditional therapies? (e.g. complementary or alternative medicine, natural, homeopathic)

☐ No

☐ Yes: Please indicate which type_____

41. **Part III: Contact Information**

Do you have any comments regarding your current practice you would like to share?

Please enter contact information should our office have questions

Name _____ Title_____

Phone Number _____ Email Address _____

Have you completed this census on behalf of another person? ☐ Yes ☐ No

Name of person completing this census _____

Name of person for whom this census was completed _____

Return to: Washington Medical Commission, PO Box 47866, Olympia, WA 98504

Questions: *Washington Medical Commission-Demographics*
Email: medical.demographics@wmc.wa.gov or

Website: http://www.wmc.wa.gov/demographics

WAC 246-918-880: Consultation-Recommendations and requirements.

BACK TO QUESTION 38

(1) The physician assistant shall consider referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic pain patients who are under eighteen years of age or who are potential high-risk patients.

(2) The mandatory consultation threshold is one hundred twenty milligrams MED. In the event a physician assistant prescribes a dosage amount that meets or exceeds the consultation threshold of one hundred twenty milligrams MED per day, a consultation with a pain management specialist as described in WAC 246-918-895 is required, unless the consultation is exempted under WAC 246-918-885 or 246-918-890.

(3) The mandatory consultation must consist of at least one of the following:

(a) An office visit with the patient and the pain management specialist;

(b) A telephone, electronic, or in-person consultation between the pain management specialist and the physician assistant;

(c) An audio-visual evaluation conducted by the pain management specialist remotely where the patient is present with either the physician assistant or a licensed health care practitioner designated by the physician assistant or the pain management specialist; or

(d) Other chronic pain evaluation services as approved by the commission.

(4) A physician assistant shall document each consultation with the pain management specialist.

WAC 246-918-890: Consultation—Exemptions for the physician assistant.

BACK TO QUESTION 37

The physician assistant is exempt from the consultation requirement in WAC 246-918-880 if one or more of the following qualifications are met:

(1) The physician assistant is a pain management specialist under WAC 246-918-895;

(2) The physician assistant has successfully completed a minimum of twelve category I continuing education hours on chronic pain management within the previous four years. At least two of these hours must be dedicated to substance use disorders;

(3) The physician assistant is a pain management physician assistant working in a multidisciplinary chronic pain treatment center or a multidisciplinary academic research facility; or

(4) The physician assistant has a minimum of three years of clinical experience in a chronic pain management setting, and at least thirty percent of their current practice is the direct provision of pain management care.