

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)
- | | | |
|--|---|---|
| <input type="radio"/> White | <input type="radio"/> Black or African American | <input type="radio"/> Other (Specify) _____ |
| <input type="radio"/> American Indian or Alaska Native | <input type="radio"/> Asian | <input type="radio"/> Prefer not to answer |
| <input type="radio"/> Native Hawaiian / other Pacific Islander | <input type="radio"/> 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 (<i>Street address, city, state, zip code</i>)		Not Applicable
Primary		<input type="checkbox"/>
Secondary		<input type="checkbox"/>
Tertiary		<input type="checkbox"/>
21. At how many remote sites do you practice? _____		
Site (1) address		<input type="checkbox"/>
Site (2) address		<input type="checkbox"/>
Site (3) address		<input type="checkbox"/>

22. Please indicate your current area of practice

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

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	%
31. Medicaid/ Apple Health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	%
32. Tricare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	%

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 246-918-812(2)?

No

Yes

38. Are you exempt from the pain specialist consultation requirement in WAC 246-918-810, based upon one or more sets of criteria for exemption listed in WAC 246-918-812?

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 _____

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 State Medical Commission (MQAC), PO Box 47866, Olympia, WA 98504

Questions: Washington State Medical Commission-Demographics

Email: Medical.Demographics@doh.wa.gov or

Fax: (360) 236-2795

Website: <http://www.doh.wa.gov/MedicalDemographics>

WAC 246-918-810: Consultation—Recommendations and requirements.

(1) The physician assistant shall consider, and document the consideration, referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic noncancer pain patients who are under eighteen years of age, or who are at risk for medication misuse, abuse, or diversion. The management of pain in patients with a history of substance abuse or with comorbid psychiatric disorders may require extra care, monitoring, documentation, and consultation with, or referral to, an expert in the management of such patients.

(2) The mandatory consultation threshold for adults is one hundred twenty milligrams morphine equivalent dose (MED)(oral). In the event a practitioner prescribes a dosage amount that meets or exceeds the consultation threshold of one hundred twenty milligrams MED (orally) per day, a consultation with a pain management specialist as described in WAC 246-918-813 is required, unless the consultation is exempted under WAC 246-918-811 or 246-918-812. Great caution should be used when prescribing opioids to children with chronic noncancer pain and appropriate referrals to a specialist is encouraged.

(a) The mandatory consultation shall consist of at least one of the following:

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

(ii) A telephone consultation between the pain management specialist and the physician assistant;

(iii) An electronic consultation between the pain management specialist and the physician assistant; or

(iv) 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.

(b) A physician assistant shall document each mandatory consultation with the pain management specialist. Any written record of the consultation by the pain management specialist shall be maintained as a patient record by the specialist. If the specialist provides a written record of the consultation to the physician assistant, the physician assistant shall maintain it as part of the patient record.

(3) Nothing in this chapter shall limit any person's ability to contractually require a consultation with a pain management specialist at any time. For the purposes of WAC 246-918-800 through 246-918-813, "person" means an individual, a trust or estate, a firm, a partnership, a corporation (including associations, joint stock companies, and insurance companies), the state, or a political subdivision or instrumentality of the state, including a municipal corporation or a hospital district.

WAC 246-918-812: Consultation—Exemptions for the physician assistant.

The physician assistant is exempt from the consultation requirement in WAC 246-918-810 if one or more of the following qualifications are met:

(1) The sponsoring physician is a pain management specialist under WAC 246-918-813; or

(2) The sponsoring physician and the physician assistant has successfully completed, within the last two years, a minimum of twelve continuing education hours (Category 1 for physicians) on chronic pain management, with at least two of these hours dedicated to long-acting opioids; or

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