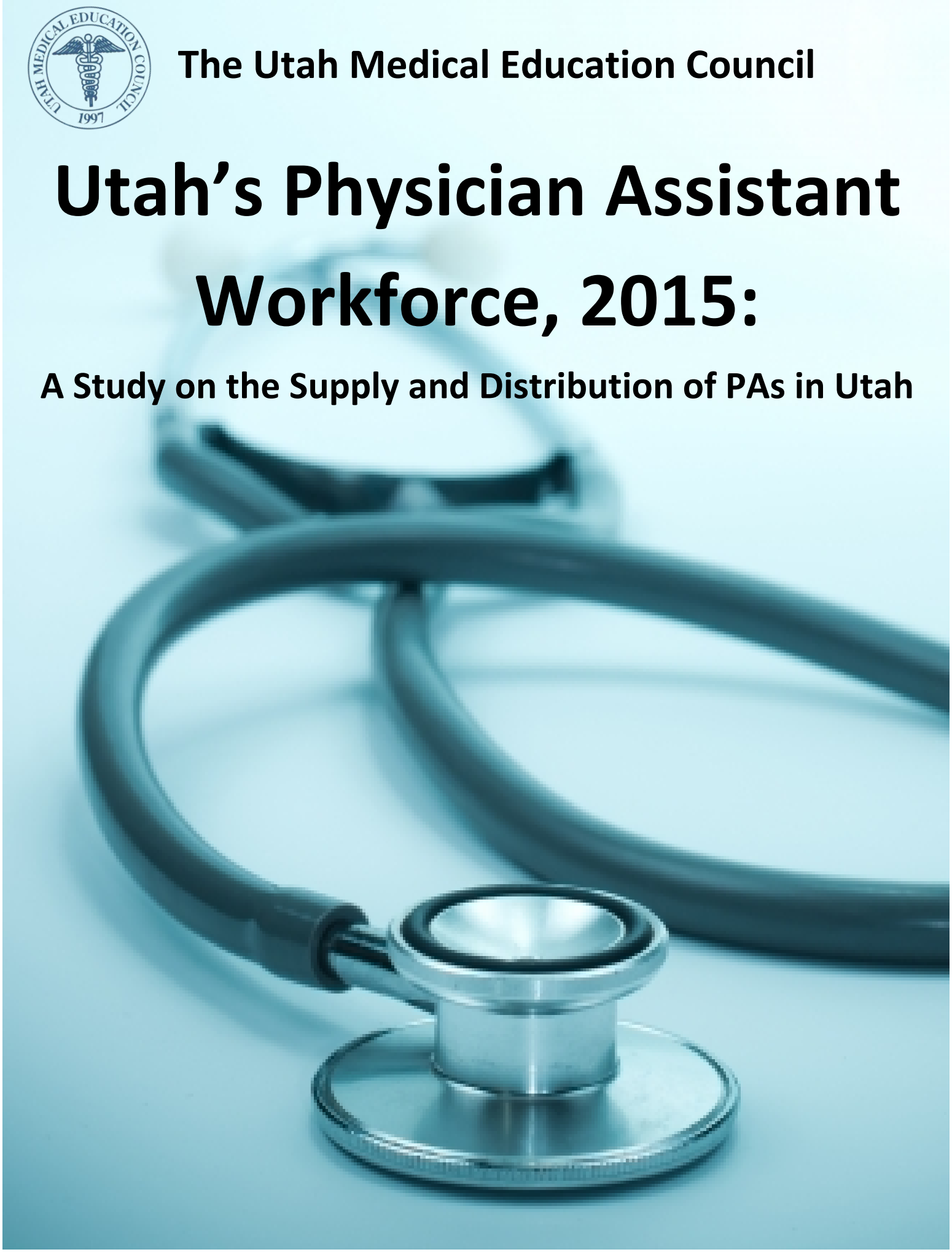
The Utah Medical Education Council

Utah's Physician Assistant Workforce, 2015:

A Study on the Supply and Distribution of PAs in Utah



UTAH'S PHYSICIAN ASSISTANT WORKFORCE, 2015:

A STUDY IN THE SUPPLY AND DISTRIBUTION OF PHYSICIAN ASSISTANTS IN UTAH

The Utah Medical Education Council

State of Utah

www.utahmec.org

2015

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Utah's Physician Assistant Workforce, 2015: *A Study of the Supply and Distribution of Physician Assistants in Utah*

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THE UTAH MEDICAL EDUCATION COUNCIL

The Utah Medical Education Council (UMEC) was created in 1997 by H.B.141 out of a need to secure and stabilize the state's supply of healthcare clinicians. This legislation authorized the UMEC to conduct ongoing healthcare workforce analyses and to assess Utah's training capacity and graduate medical education (GME) financing policies. The UMEC is presided over by an eight member board appointed by the Governor to bridge the gap between public/private health care workforce and education interests.

Our Mission

To conduct health care workforce research, to advise on Utah's health care training needs, and to influence graduate medical education (GME) financing policies.

Core Responsibilities – Healthcare Workforce

- Assess supply and demand
- Advise and develop policy
- Seek and disburse Graduate Medical Education (GME) funds
- Facilitate training in rural locations

Current Areas of Focus

- Retention of Utah trained healthcare workforce
- Facilitate rural training opportunities
- Strengthen public/private partnerships

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EXECUTIVE SUMMARY

The Physician Assistant (PA) workforce in Utah has seen steady growth over time. The number of licensed PAs in the state has risen from 700 in 2008 to 1,167 in 2014, an overall growth rate of 66.7%, with 86.1% (1,005) providing services in the state. The growth of the PA profession in Utah has slowed somewhat, down from 85.7% between 2003 and 2008, however the growth is still robust. National growth of PAs is projected to continue much faster than the average occupation (United States Department of Labor, Bureau of Labor Statistics, 2015). Due to the growth in the state, the University of Utah Physician Assistant Program (UPAP) increased their class size from 40 to 44 students in 2011. Additionally, Rocky Mountain University of Health Professions opened a new Physician Assistant Program (RMUPAP) in 2015. Its first cohort of 46 students will be graduating in 2017, with cohorts of 50 students thereafter. Assuming 50% of graduates from these programs will stay in Utah to practice, Utah will have to rely much less on bringing out-of-state PAs into Utah to meet the demand.

Physician Assistants have historically allowed medicine to reach into underserved and rural populations (Cawley, Cawthon, & Hooker, 2012) and PAs in Utah seem to be holding to that tradition. A total of 5.5% of Utah PAs work in Federally Qualified Community Health Centers, a higher percentage than both physicians (0.5%) (Utah Medical Education Council, 2012) and Nurse Practitioners (2.5%) (Utah Medical Education Council, 2013).

Although PAs work in a wide variety of settings, 53.7% work in a solo or group physician practice with the majority of those working specifically in group practices. The share of PAs practicing in hospital settings grew from 18.7% in 2008 to 25.6% in 2014.

The average age of the PA workforce has been steadily dropping. Indeed, over half (53.5%) of the workforce is under the age of 40. Because of this, 56.7% of the workforce plans on waiting at least 21 years to retire, with only 5.5% of the workforce planning to retire in the next 5 years.

Along with job growth, PAs in Utah have experienced wage growth as well. Adjusted for inflation, the median PA salary is 18.6% higher than what it was in 2008 or a 3.1% increase every year. The Utah median salary of $96,000 is comparable to the national average of $95,820 (United States Department of Labor, Bureau of Labor Statistics, 2015).

Utah has a higher percentage of PAs working in Primary Care than the national average. Currently, 43% of Utah's PA workforce works in one of the Primary Care specialties, while only 32% of the national workforce does (American Academy of Physician Assistants, 2013). When looking at specific specialties, Family Medicine and Family Medicine with Urgent Care (both categorized under Primary Care) are the two most popular in Utah with 17.4% and 15.6% of the

PA workforce respectively. Beyond that, 9.5% of PAs work in Orthopedics, 5.3% work in Emergency Medicine, and 4.0% work in General Pediatrics (also under Primary Care).

When looking at geographic distribution, PAs are fairly evenly distributed across the state. Apart from the counties in which there are no reported PAs (Juab, Morgan, and Piute), the PA population very closely resembles the Utah population. Overall, 13% of PAs work in and 14% of the general population live in rural counties.

Utah PAs work an average of 41.2 hours per week. However, Utah has a much higher percentage of part-time PAs than the national average, though full- and part-time definitions do vary by organization and employer. A total of 18.5% of PAs in Utah are working fewer than 36 hours per week, which will be considered part-time in this report. The American Academy of Physician Assistants (AAPA) defines part-time work as fewer than 32 hours per week and estimates that 5.0% of the national workforce works part-time (American Academy of Physician Assistants, 2013). In Utah, 14.5% of the workforce works fewer than 32 hours per week. A high percentage of female PAs work part-time in Utah. A total of 30.4% of women work fewer than 36 hours per week, while only 10% of male PAs do the same. No national comparison broke these numbers down by gender.

Based on population growth, medical visit rates, and retirement rates, the UMEC estimates that Utah will need between 40 and 70 new PAs each year in order to maintain current provider to population ratios as the state population ages and grows. These two numbers are based on low need and high need scenarios based on self-reported retirement (low need) and historical attrition rates (high need). Over the last several years, Utah has been increasingly reliant on importing out-of-state PAs to maintain its provider to population ratio. However, with two PA programs in the state and assuming a 50% retention rate, it is estimated that these training programs will provide 47 new PAs into the Utah workforce each year starting in 2017, thereby bringing Utah's need to import PAs from other states down to approximately 23 per year, assuming a high need scenario. Assuming a low need scenario, Utah may face a small surplus of new PAs in the workforce each year.

POLICY RECOMMENDATIONS

1. **Promote a more diverse workforce.** Only 7.8% of the PA population in Utah identifies as a racial or ethnic minority, compared to 21.8% of the general Utah population. The PA profession lags far behind the comparable APRN profession in Utah, which had 16% of its workforce identify as a racial or ethnic minority in 2013 (Utah Medical Education Council, 2013).
    a. Disseminate information regarding scholarships and loan repayment programs for minority PAs.
    b. Encourage local high schools and organizations such as United Way and the Department of Health to engage with minority populations to consider pursuing a career as a physician assistant.
2. **Continue to strengthen the rural workforce**. While the percentage of PAs choosing to work in rural settings has decreased slightly, the number in the rural workforce has gone up. However, the ratio of 30 rural PAs per 100,000 is still lower than urban populations at 34 PAs per 100,000.
    a. Support state funding for loan repayment programs for PAs who practice in rural communities.
    b. Encourage programs to target applicants who come from a rural background as they are more likely to practice in a rural setting after graduation.
3. **Enhance data collection.** The UMEC conducts periodic supply-side surveys in order to create a projection model for the future of the profession. This process would be greatly improved if the following recommendations were implemented:
    a. Develop a demand study for PAs by surveying employers and schools, thereby creating a more nuanced projection model.
    b. Support and encourage efforts to request legislative change in order to incorporate UMEC's PA survey into the licensing process.
    c. Develop and maintain a database of Utah residents who moved out of state to attend PA training programs in order to recruit them back to Utah.
    d. Closely monitor the retention rate of the upcoming RMUPAP graduates.
4. **Revise Utah's Physician Assistant Practice Act Rule.** While Utah's PA scope of practice laws are more flexible than many other states, improvements can be made by allowing practice sites to determine supervision ratios. Currently, practices can apply for a supervision ratio larger than 4 FTEs per 1 physician with extenuating circumstances.

METHODOLOGY

License Data

The Utah Division of Occupational and Professional Licensing (DOPL) provided the UMEC with information for every physician assistant license in the state. As of August 2014, there were 1,167 PAs holding licenses in Utah.

Design of Survey Instrument

In order to design the 2014 PA survey, the previous UMEC survey from 2008 was analyzed and revised to more closely match questions from the national survey sent to PAs from the American Academy of Physician Assistants (AAPA) and the national Minimum Data Set. For example, the specialties listed in the 2014 survey were expanded from the 2008 survey to match the recommendations of the national Minimum Data Set. Additionally, the UMEC consulted with the Physician Assistant Workforce Advisory Committee in the development of the survey instrument.

The advisory committee presented the survey to colleagues for field testing in order to ensure the design of the survey, thereby allowing the UMEC to collect high quality data with minimal errors. Feedback from the field test was used in the survey design.

Data Collection

The first round of mailings took place in January 2014. A second mailing was sent in April 2014 to those who had not responded. In June 2014, a third mailing was sent to those who had not yet responded as well as the newly licensed PAs. A final mailing was sent to the new licenses in August 2014 in an effort to increase the response rate among new PAs. Data collection ended in October 2014. A total of 634 surveys were returned for a 54.3% response rate. With such a high response, the analysis has a confidence interval of 95% +/- 2.6%. Each survey response was weighted with a factor of 1.841 in order to account for non-respondents.

Data Entry and Analysis

The 2015 PA Workforce Survey was processed using forms and databases created in Microsoft Access. Data entry and cleanup were done in house by UMEC staff. Once the data entry was complete, the information was imported into SPSS for statistical analysis. Analysis began in October 2014.

Survey Limitations

Respondents were asked about their work status (full-time, part-time, etc.) as well as how many hours they work per week at each practice location. The UMEC classified 36 hours per week or more as full time status, however the data do not line up exactly with respondents' self-identified work status. For example, some work sites may classify 32 hours as full-time.

The UMEC asked respondents to detail how much educational debt they had at the time of graduation. While this gives us a trend for how much school is costing and how much money PAs need to graduate, it does not give us an indication of how much of a burden this debt is on PAs and how quickly the debt is being paid off. It is recommended that in the next survey, the UMEC asks about both current debt and debt at the time of graduation.

Respondents were asked about the primary method of supervisory interaction (face-to-face, telephone, text message, email, other). While the data entry process only allowed for one response, there were a number of PAs who listed multiple responses. In those cases, the UMEC recorded only the first response. Because of this, face-to-face interactions (the first option available) may be slightly overrepresented.

Because several of the questions and response options were changed and expanded to match the national Minimum Data Set, it is difficult to compare results from UMEC's 2014 survey to the 2008 survey. For example, practice specialty options totaled 45 in 2008 while 2014's total was 71. Likewise, the total number of options for practice setting in 2008 was 19, while 2014 saw 26 setting options.

Respondents were asked if they worked on a multidisciplinary care team, what types of professionals they worked with, and what types of care they offered in multidisciplinary care teams. In addition to a fairly low response rate, there were PAs who indicated they worked on a multidisciplinary team when they did not, e.g., a Primary Care PA saying they worked on a care team, but only with Primary Care physicians. While these respondents were removed from the analysis for this question, the results still may not reflect multidisciplinary care team activities.

INTRODUCTION AND BACKGROUND

The Utah Medical Education Council has been charged with conducting periodic analyses of the medical professions in the state of Utah in order to assess workforce supply and demand. In 2000, UMEC published its first combined report of APRNs and PAs. The study of those professions was later separated into two reports. The UMEC has subsequently published two follow up PA reports in 2005 and in 2010.

The physician assistant profession in Utah has been growing rapidly over the last decade. While it has slowed down slightly in recent years, the demand for PAs is still increasing more than many other professions in the country (United States Department of Labor, Bureau of Labor Statistics, 2015).

Physician Assistants play an integral role in the medical field. PAs can work in any specialty, both primary and specialty care fields. This allows PAs to respond where they are needed, potentially easing the strain on specialties suffering from a physician shortage. PAs also tend to see more medically underserved populations and have the opportunity to play a role in providing services to a population newly covered by insurance from the Affordable Care Act.

LICENSED IN UTAH

As of May 2014, there were 1,167 active PA licenses in the state of Utah. This is an increase from 700 licenses in 2008. Within that time frame, the number of licenses increased by 66.7% for an 11.1% annual growth rate. This is a decrease from an overall growth rate of 85.7% (17.1% annual growth rate) between 2003 and 2008.

Reasons for Maintaining Utah License

Not all of the 1,167 PA licensees provide services in Utah. In 1998 and 2003, the share of PAs practicing in Utah hovered around 85% and increased to 90.7% in 2008. In 2014, however, the share of PAs licensed in the state that provide services in Utah has decreased to 86.1%.

There were 160 (13.7%) survey respondents who indicated they did not provide services in Utah. When asked why they maintained their Utah license, 57% (83) said they intend to move to Utah in the near future or are currently looking for a job in the state. Additionally, 12.7% (18) said they are letting their license expire, 11.4% (17) said they work overseas or for the military and need a license from any state, 8.9% (13) said they either volunteer from out of state or are retired and volunteer in Utah, and 6.3% (9) hold a non-clinical job in Utah.

WORKFORCE DEMOGRAPHICS

Decision to Practice in Utah

The PA population in Utah has continued to grow at a rapid rate. As of 2014, 86.1% (1,005) of PAs holding a Utah license provided clinical services in Utah. The percentages cited throughout this report are based on the 1,005 Utah licensed PAs who reported providing clinical services in the state.

The top three factors influencing PAs to practice in the state are family in Utah, lifestyle, and practice environment. Family in Utah was especially common, with 59.9% (602) of PAs in Utah citing that as the most important factor in their decision to work in the state. Although Lifestyle was the second most common choice, there was a pronounced gap with 28.6% (287) of PAs citing it as most important. These findings are consistent with those from the 2008 UMEC survey.

Table 1: Factors Influencing Decision to Practice in Utah

Factor	Rank
Family in Utah	1
Lifestyle	2
Practice Environment	3
Practice Opportunities	4
Utah Graduate	5
Military	6
Other	7

Background

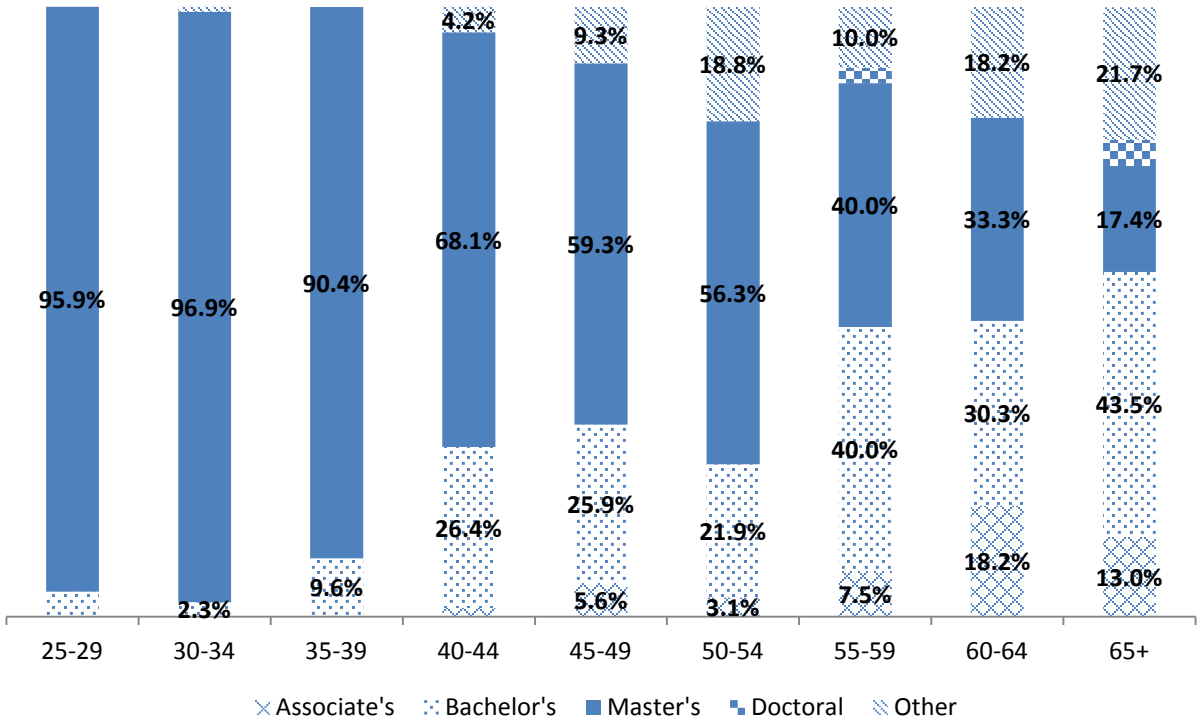
The share of the PA population that spent the majority of their childhood in Utah has gone down from 51.3% in 2008 to 43.2% (434) in 2014. Other states that PAs reported spending their childhood in were California (5.5%, 55), Idaho (3.8%, 39), Arizona (1.8%, 18), Washington and Michigan (1.5%, 15 each), and Colorado (1.3%, 13). These numbers are slightly lower than the top states providing PAs to Utah in 2008, suggesting that the PA population in Utah is becoming more stratified when considering state of origin.

A total of 51.5% (517) of PAs reported growing up primarily in a suburban environment, 31.5% (317) reported growing up primarily in a rural environment, and 16.1% (162) reported growing up primarily in an urban environment.

Education Background

Almost three-quarters of PAs (74.2%, 746) reported that the highest PA degree they had obtained was a master's degree, compared with about half (49.5%) in 2008. As the percentage of PAs with master's degrees has gone up, the percentage of PAs with a PA certificate has gone down from 29.6% in 2008 to 5.1% (52) in 2014. Indeed, the PA degree obtained is closely correlated to age, with the majority of those under age 55 holding a master's degree. Those 55 and older hold a higher share of bachelor's and associate's degrees, as well as PA certificates.

Figure 1: Highest Degree Obtained by Age Group



A total of 36.8% (370) of PAs practicing in the state graduated from the University of Utah's PA Program. This number has dropped from 47% in 2008. The number of PAs in Utah is still increasing rapidly and the reliance on PAs educated outside of Utah has continued to grow. However, with Rocky Mountain University's first PA cohort graduating in 2017, it is likely that we will see an increase of PAs trained in Utah in the coming years. Other states that provide significant numbers of PAs are Arizona (7.9%, 79), Pennsylvania (7.1%, 72), Idaho (5.5%, 55), and Nebraska (4.0%, 41).

Table 2: Top 5 PA Training Locations for Utah's PA Workforce

State	Count	Percentage
Utah	370	36.8%
Arizona	79	7.9%
Pennsylvania	72	7.1%
Idaho	55	5.5%
Nebraska	41	4.0%

Of the 43.2% (434) of PAs who grew up in Utah, 40.3% (175) were also trained in Utah while 59.3% (258) of Utah locals went out of state for their PA training before returning here to practice.

Of the 27.7% (278) of PAs who indicated they grew up out of state, 30.5% (85) were trained in Utah, while 68.2% (190) were trained elsewhere, for a total of 18.9% (190) of Utah PAs both growing up and being trained out of state. Item non-response for these survey questions was 29.1% (293).

Table 3: Training Location by State of Origin

Training Location	Raised in Utah	Raised Out of State
Utah	17.4%	8.5%
Out of State	25.7%	18.9%

Race/Ethnicity

Utah's PA Workforce continues to be predominately Caucasian. However, the share of the Caucasian workforce has gone down from 92.1% in 2008 to 88.6% (891) in 2014. A total of 1.8% (18) of Utah PAs identify as Asian, 1.6% (17) as another race, and .5% (6) as American Indian. No other races had reportable numbers[1]. Additionally, 3.3% (33) of respondents identified as Hispanic[2]. While this is an increase from 2008, the Hispanic population is still vastly underrepresented in the PA workforce, with 13.4% of Utah's population identifying as Hispanic. Utah's PA racial and ethnic demographics are similar to those of PAs nationally with 88.4% of PAs identifying as Caucasian (American Academy of Physician Assistants, 2013).

Table 4: PA Workforce and Utah Population by Race/Ethnicity

Race/Ethnicity	PA 2014	Utah 2014
Caucasian	88.6%	91.6%
Asian	1.8%	2.3%
Other	1.6%	2.3%
American Indian	0.5%	1.5%
African American	0.4%	1.3%
Pacific Islander	0.2%	1.0%
Hispanic	3.3%	13.4%

Age

The mean age of Utah's PA workforce has remained virtually unchanged. In 2008, the mean age was 42.7, compared with 41.8 today. However, the median age has fallen from 41 in 2008 to 38 today. This drop is consistent with national averages; the median age nationally has fallen from 39 in 2008 to 37 in 2013 (American Academy of Physician Assistants, 2013).

[1] 5 or fewer

[2] Unlike the 2008 survey, respondents were asked two separate questions regarding race and Hispanic ethnicity.

While most age groups grew in size from 2008 to 2014 simply from the increase in the workforce, the growth rate is highest among cohorts between ages 25 and 40. In the same time frame, the 20-24 and 50-54 year old cohorts shrank in size.

Figure 2: Age Distribution of Utah PAs 2008 and 2014

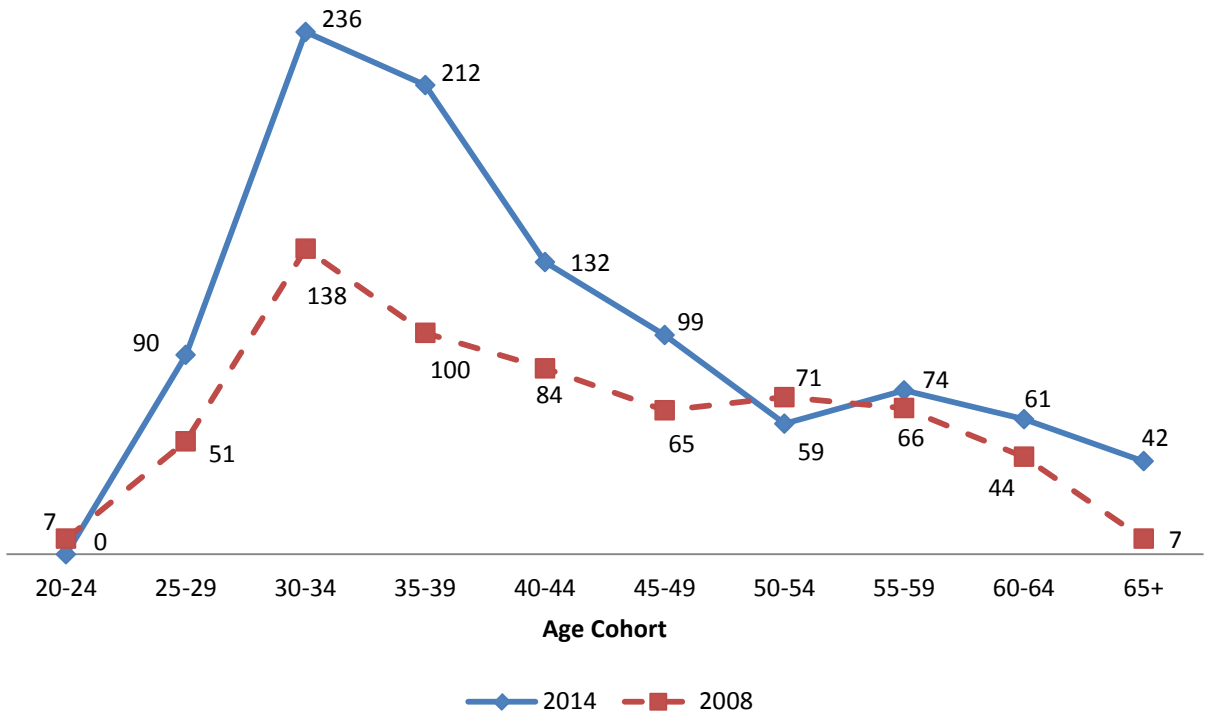


Table 5: PA Workforce by Age 2008 and 2014

Age Cohort	2008 %	2014 %	% Change
20-24	1.2%	0.0%	-100.0%
25-29	8.1%	9.0%	76.5%
30-34	21.8%	23.4%	71.0%
35-39	15.7%	21.1%	112.0%
40-44	13.2%	13.2%	57.1%
45-49	10.2%	9.9%	52.3%
50-54	11.1%	5.9%	-16.9%
55-59	10.4%	7.3%	12.1%
60-64	6.9%	6.0%	38.6%
65+	1.4%	4.2%	500.0%
Total	100%	100%	NA

As the average age for all PAs has gone down, so has the average age for PAs at the time of graduation. The mean age for PAs at graduation is 30.9, compared to 32.2 in 2008. A total of 41.2% (414) of the PA population graduated between the ages of 25 and 29, and that number increased to 53.3% (536) when adding in ages 24 and 30. For male PAs, the mean graduation age is 31.4 years, while the mean graduation age for female PAs is 30.2 years.

Compared to 2008, the average number of years since graduation has fallen to 11.6. Just over half (50.9%, 512) of PAs in Utah have fewer than 10 years of experience. As older PAs transition out of the workforce and the younger PA population grows, it is likely that we will see this trend continue, albeit slowly. Male PAs have more overall experience than female PAs. The average male PA has 13.3 years of experience while the average female PA has 9.2 years of experience. Similarly, 30.4% (179) of male PAs have more than 15 years of experience, while only 15.9% (66) of female PAs have been working in the field as long.

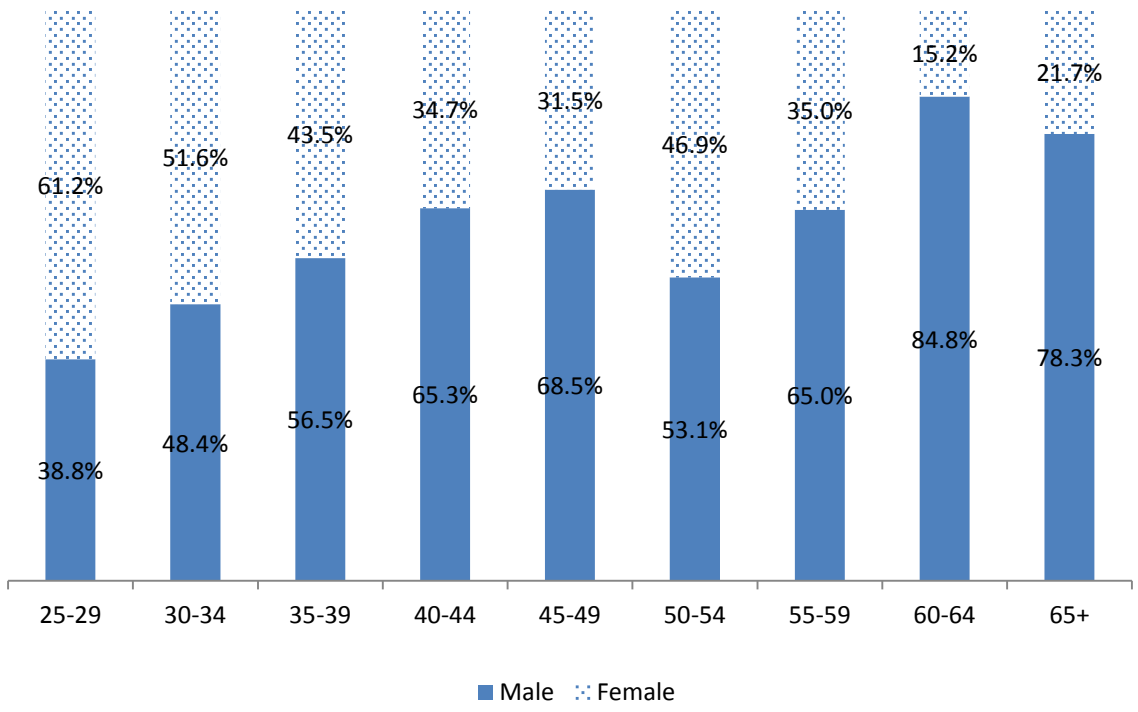
Gender

The national PA workforce continues to be disproportionally female, increasing from 59.6% in 2008 to 67.3% in 2013 (American Academy of Physician Assistants, 2013). Utah, on the other hand, lags behind with only 41.6% (418) of the PA workforce identifying as female in 2014. However, this is an increase from 39.4% in 2008 and a 67.2% (168) increase in actual numbers of female PAs practicing in Utah between 2008 and 2014. Indeed, when broken down by age, this trend is more apparent.

A total of 64.3% (269) of the female workforce is under age 40, compared to 45.8% (269) of the male workforce. This is an increase from 53.5% of female PAs and 42.4% of male PAs under 40 years old in 2008, likely indicating that although Utah currently lags behind in terms of gender parity within the profession, that dynamic may begin to shift more significantly as younger PAs enter the workforce and older PAs retire.

The shift towards a more equitable female/male ratio can be clearly seen when looking at class demographics from RMUPAP and UPAP. Rocky Mountain University's first student cohort is nearly a 50/50 split, made up of 22 females and 24 males. The University of Utah's 2014 cohort is made up of 56.8% females. Indeed, since 2010, each of UPAP's cohorts has been over 55% female with the exception of 2013, which was 45.5% female.

Figure 3: Gender by Age Cohort



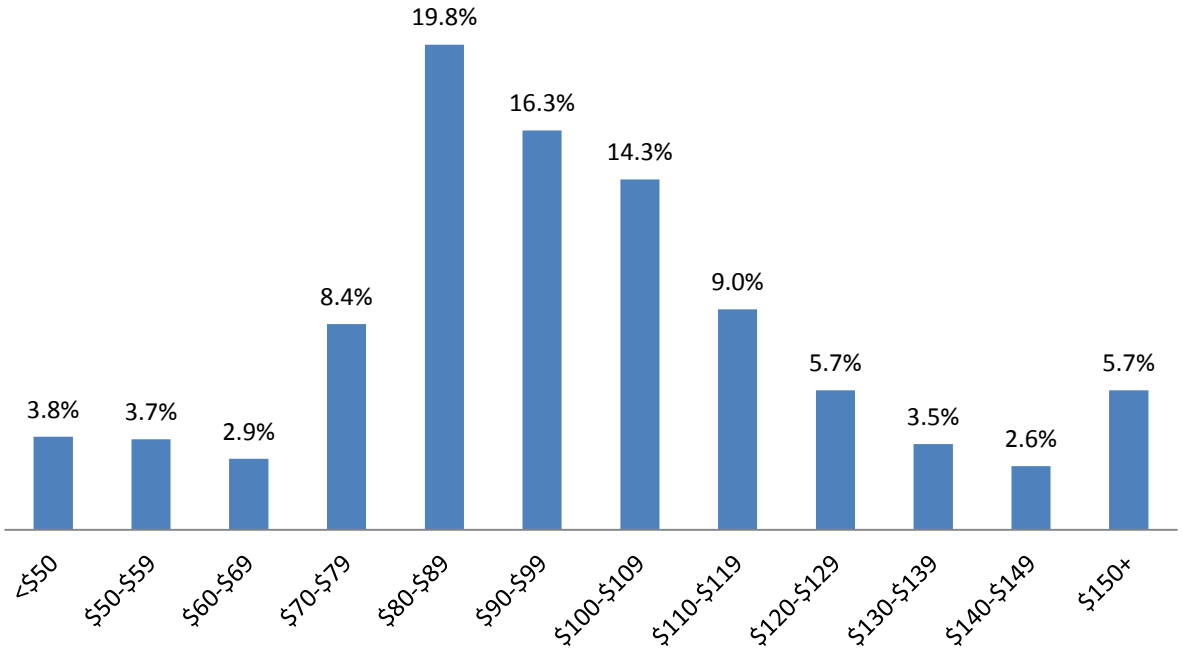
Income

The median income for PAs in Utah increased from $81,000 in 2008 to $96,000 in 2014. This is an increase of 18.6% over those six years, equating to an annual increase of 3.1%. When adjusted for inflation, the overall growth was 6.9% for a 1.2% annual increase. While these numbers are slightly lower than the growth between 2003 and 2008, incomes are still increasing, even when adjusted for inflation. A total of 55.9% (562) of PAs stated their income increased by an average of 24.5% in the last five years while 13.7% (138) said their incomes decreased by an average of 25.1% in the same time frame. Conversely, 18.1% (182) of PAs said their incomes had remained the same. Overall, Utah PAs make about the same as the national median of $95,820 (United States Department of Labor, Bureau of Labor Statistics, 2015).

The vast majority (79.1%, 795) of PAs in Utah work full-time (at least 36 hours per week) while 18.5% (186) work part-time. The median income for all full-time PAs is $97,000, while part-time PAs earn a median of $68,000. The average full time PA has a full-time equivalent (FTE) of 1.1 (1 FTE=40 hours/week), with part-time PAs working an average of .5 FTEs.

Half of the PA population (50.4%, 506) makes between $80,000 and $109,000 per year. While the income distribution spreads out beyond that, there is a higher percentage making more than $109,000 (26.4%, 265) than those making under $80,000 (18.9%, 190).

Figure 4: Yearly Income of Utah PAs



Median salary for Primary Care is slightly below the state's average of $96,000 at $92,000 while Specialty Care is slightly above the average at $97,000. However, broken down by sub-specialty, the numbers vary widely. Many of the highest and lowest earning specialties did not have reportable numbers because of the fact that there were 5 or fewer PAs working in those specialties. When looking at specialties with more than five PAs, the difference between the highest and lowest median income was 57.9%, with Internal Medicine: Neurology at the lower end ($80,000) and Surgery: Cardiovascular/cardiothoracic at the higher end ($127,000).

Table 6: Five Highest Earning Specialties

Specialty	Median Income
Surg: Cardiovascular/Cardiothoracic	$127,000
Dermatology	$119,000
Interventional Radiology	$116,000
Psychiatry	$107,000
Physical Medicine/Rehabilitation	$107,072

The median income for full-time PAs is even for those working in both Primary and Specialty Care at $97,000. However, there is variance among income for individual specialties and Primary Care specialties alone range from $86,000 to $103,000. The table below details combined median income (combined full- and part-time) for specialties with five or more PAs.

Table 7: Specialty Rankings by Median Income

Specialty	Median Income	2014 Rank	2008 Rank
Surg: Cardiovascular/Cardiothoracic	$127,000	1	2
Dermatology	$119,000	2	12
Interventional Radiology	$116,000	3	NA[3]
Psychiatry	$108,000	4	9
Physical Medicine/Rehabilitation	$108,000	5	NA
Diagnostic Radiology	$107,000	6	6
Surg: Trauma	$106,000	7	NA
IM: Oncology	$102,000	8	NA
*Family Medicine with Urgent Care	$101,000	9	NA
Surg: Vascular	$101,000	10	NA
Hospital Medicine	$100,000	11	NA
Emergency Medicine	$100,000	12	10
Surg: Urology	$98,000	13	8
Surg: Transplant	$98,000	14	NA
Occupational Medicine	$98,000	15	7
Surg: General	$98,000	16	NA
Orthopedics	$97,000	17	15
*Ped: General	$96,000	18	18
Surg: Other	$95,000	19	11
Pain Management	$95,000	20	NA
IM: Cardiology	$95,000	21	19
Allergy	$94,000	22	5
Surg: Neurological	$93,000	23	NA
Surg: Hand	$92,000	24	NA
IM: Gastroenterology	$91,000	25	13
Surg: Otolaryngology	$91,000	26	20
IM: Pulmonology	$90,000	27	24
IM: Other	$87,000	28	22
*Family Medicine	$87,000	29	21
*IM: General	$85,000	30	23
IM: Hematology	$82,000	31	NA
*Obstetrics/Gynecology	$80,000	32	28
IM: Neurology	$80,000	33	26

*Primary Care specialty

Just over half of the PAs working in Utah are employed in a solo or group physician practice. The median income for Solo Practice Physician Offices is $89,000, Single-specialty Physician

[3] NA signifies specialties that were either not ranked in 2008, or were not included in the 2008 survey as an option.

Group Practices is $98,000, and Multi-specialty Group Practices is $97,000. Critical Access Hospitals had the highest median income at $122,000 and Industrial Facilities/worksites had the second lowest median income at $80,000.

There are currently 134 PAs practicing in rural locations across Utah. Although a larger share of rural PAs practice in Primary Care than urban/suburban PAs (73.2% and 38% respectively), the median income of rural PAs is at $95,000, only slightly lower than the state median.

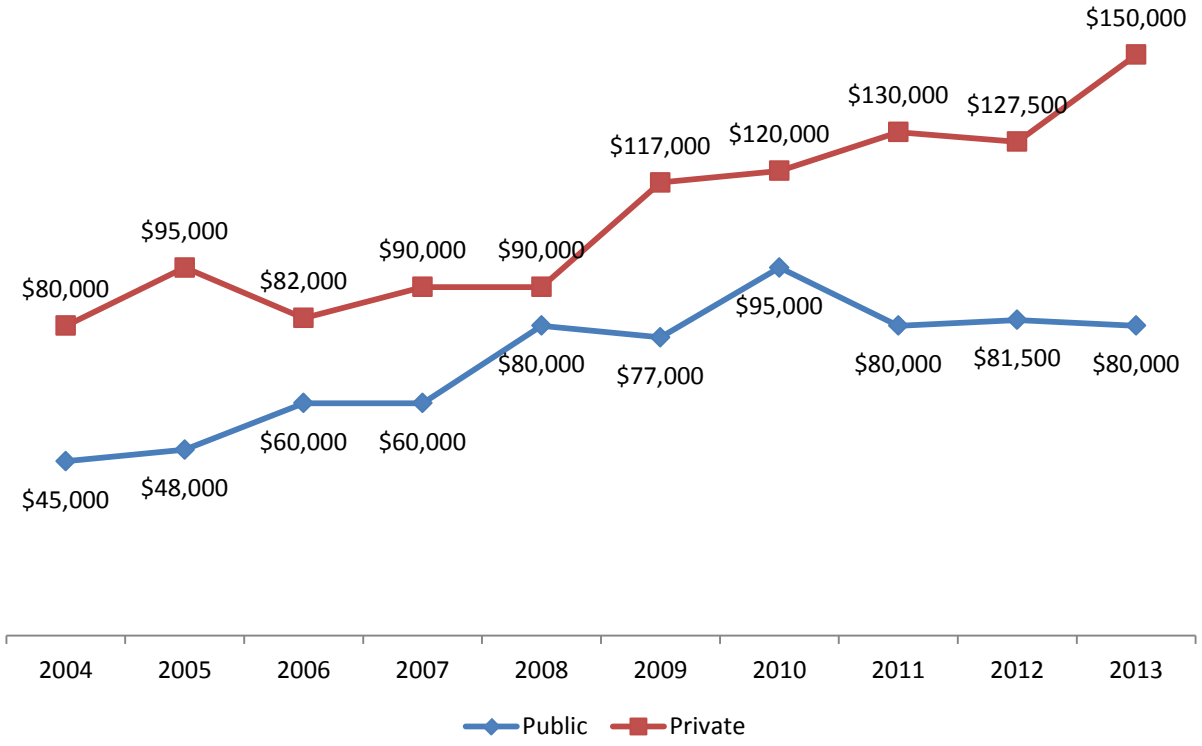
School Debt

PAs were asked how much debt they had at the time of graduation. School debt has been steadily rising since the mid-1990s, with no real signs of slowing down. Indeed, school debt has been rising faster than the rate of inflation in the last ten years. The figure below only details debt at the time of graduation. It does not reflect the current amount of debt held by a PA for their schooling.

Figure 5: Median School Debt at Time of Graduation

The number of PAs trained at private institutions has been slowly increasing since 1998. Indeed, 36.3% (365) of all PAs practicing in Utah were trained at a private institution. Students trained at private institutions are leaving school with significantly more debt than students trained at public institutions, and that gap seems to be widening in recent years.

Figure 6: Median School Debt at Time of Graduation by Private vs. Public Institutions



The average amount of school debt has risen by an average of 2.0% faster than the rate of inflation each year between 2004 and 2013. When broken down by private vs. public institutions, private debt between 2004 and 2013 has risen by an average of 2.4% faster than inflation each year, while debt from public institutions has risen by an average of 2.1% faster than inflation in the same timeframe.

PRACTICE CHARACTERISTICS

Geographic Distribution

PAs provide services in 26 of Utah's 29 counties with no reported PAs practicing in Juab, Morgan, and Piute counties. Rich County experienced a small drop (fewer than 5) in the number of PAs providing healthcare services. In contrast, the number of PAs increased in 19 counties. Urban counties saw the greatest increase in terms of numbers. Salt Lake increased by 74.6% (206), Utah by 76.9% (60), and Davis by 85.0% (34). Those three counties make up 81.1% of the overall PA growth in Utah. The following table outlines the geographic distribution of PAs by county and the growth between 2008 and 2014.

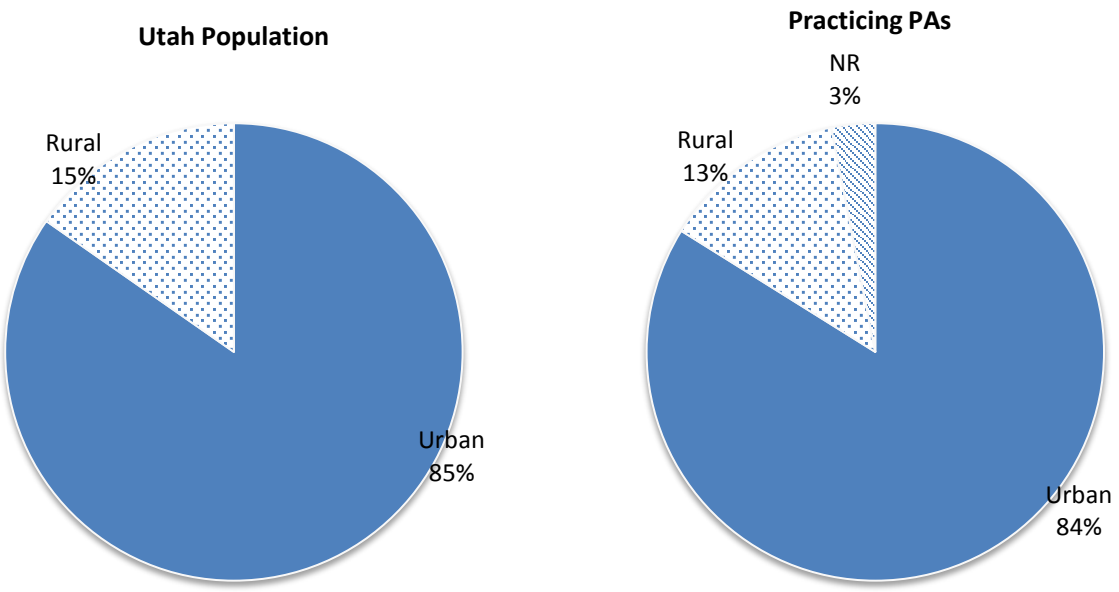
Table 8: PA Distribution by County

County	2008 Count	2014 Count	% Change
Beaver	NR	NR	100.0%
Box Elder	NR	9	125.0%
*Cache	25	33	32.0%
Carbon	7	7	0.0%
Daggett	NR	NR	100.0%
*Davis	40	74	85.0%
Duchesne	NR	11	266.7%
Emery	NR	NR	0.0%
Garfield	-	NR	-
Grand	NR	NR	0.0%
Iron	6	17	183.3%
Juab	-	-	-
Kane	NR	NR	100.0%
Millard	NR	NR	0.0%
Morgan	-	-	-
Piute	-	-	-
Rich	6	NR	-66.7%
*Salt Lake	276	482	74.6%
San Juan	NR	15	275.0%
Sanpete	NR	9	125.0%
Sevier	NR	NR	33.3%
Summit	10	17	70.0%
Tooele	18	18	0.0%
Uintah	NR	6	50.0%
*Utah	78	138	76.9%
Wasatch	NR	NR	200.0%
*Washington	37	52	40.5%
Wayne	NR	NR	100.0%
*Weber	57	70	22.8%
Not reported	34	22	N/A
Total	635	1,005	58.3%

*Urban county

Overall, 13% (134) of the PA workforce practices in rural counties. This is a slight decrease from 14% in 2008, however the share of the general population in rural counties has gone down from 24% in 2008 to 15% in 2014. Additionally, the actual number of PAs in rural counties increased from 88 in 2008 to 134 in 2014 for a 52.3% overall increase. The general rural population increased at a slower rate in the same time frame, thereby increasing the ratio of PAs to general population in rural counties.

Figure 7: 2014 Rural Population and Rural Workforce



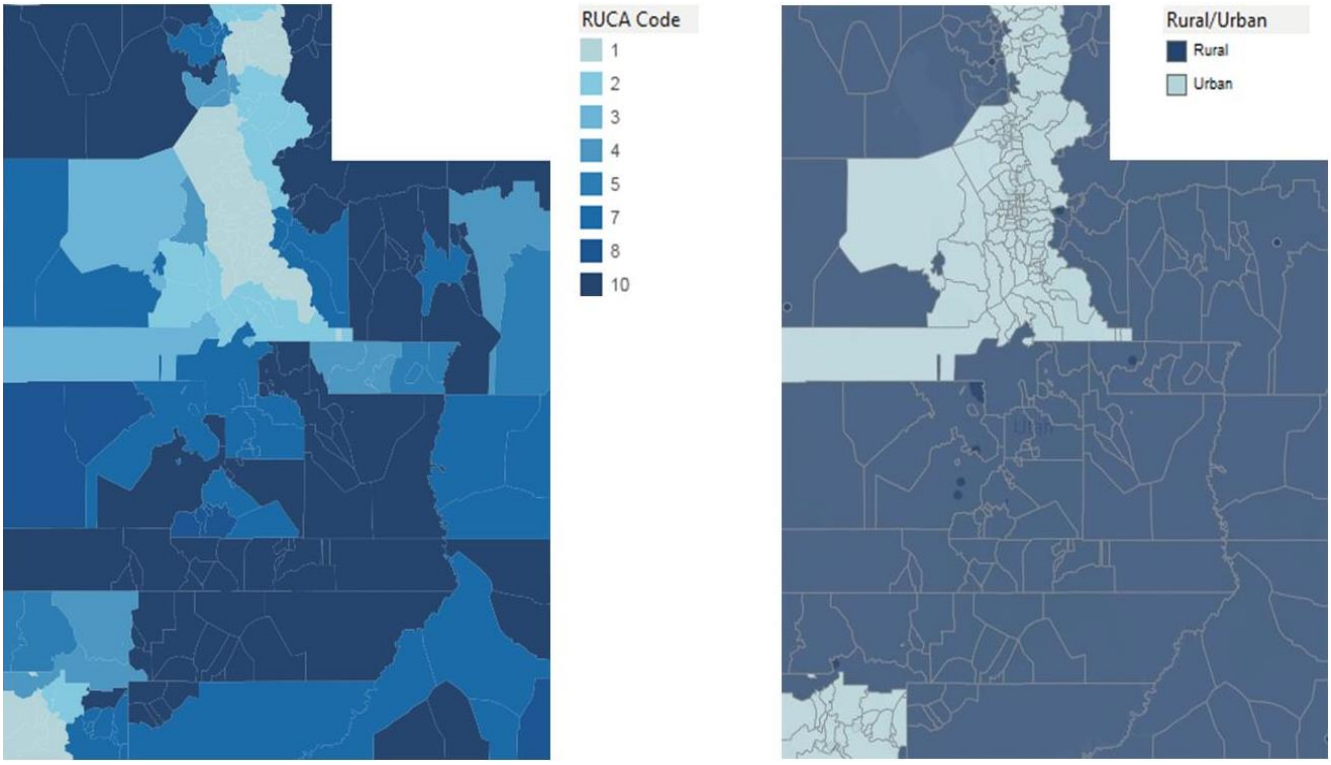
Geographic distribution of PAs can also be measured by rural-urban commuting area (RUCA) codes. Typically broken down by zip code, RUCA codes measure population density, urbanization, and daily commuting (United States Department of Agriculture, Economic Research Service, 2014). The table below outlines the detailed RUCA codes, definitions, and Utah examples.

Table 9: RUCA Codes, Definitions, and Utah Examples

RUCA Code	Definition	Examples
1. Metropolitan Core	Flow within urbanized area (UA)	Wasatch Front
1.1 Metropolitan Core	Secondary flow 30% to 50% to larger UA	NA
2. Metropolitan High Commute	Flow 30% or more to UA	Park City, Payson
2.1 Metropolitan High Commute	Secondary flow 30% to 50% to a large UA	NA
3. Metropolitan Low Commute	Flow 10% to 30% to UA	Grantsville, Mona
4. Micropolitan Core	Flow within urban cluster of 10,000-49,999 (Large UC)	Cedar City, Price
4.1 Micropolitan Core	Secondary flow 30% to 50% to a UA	Tooele
4.2 Micropolitan Core	Secondary flow 10% to 29% to a UA	Brigham City, Willard
5. Micropolitan High Commute	Flow 30% or more to Large UC	New Castle, East Carbon
5.1 Micropolitan High Commute	Secondary flow 30% to 50% to a UA	NA
5.2 Micropolitan High Commute	Secondary flow 10% to 29% to a UA	NA
6. Micropolitan Low Commute	Flow 10% to 30% to Large UC	NA
6.1 Micropolitan Low Commute	Secondary flow 10% to 29% to a UA	NA
7. Small Town Core	Flow within urban cluster of 2,500-9,999 (Small UC)	Heber City, Dugway, Roosevelt, Manti
7.1 Small Town Core	Flow 30% to 50% to a UA	Hurricane, La Verkin
7.2 Small Town Core	Flow 30% to 50% to a Large UC	NA
7.3 Small Town Core	Secondary flow 10% to 29% to a UA	Park City, Nephi
7.4 Small Town Core	Secondary flow 10% to 29% to Large UC	Garland, Tremonton
8. Small Town High Commute	Flow 30% or more to Small UC	Monroe, Sevier
8.1 Small Town High Commute	Flow 30% to 50% to a UA	NA
8.2 Small Town High Commute	Flow 30% to 50% to a Large UC	NA
8.3 Small Town High Commute	Secondary flow 10% to 29% to a UA	NA
8.4 Small Town High Commute	Secondary flow 10% to 29% to Large UC	NA
9. Small Town Low Commute	Flow 10% to 30% to Small UC	NA
9.1 Small Town Low Commute	Secondary flow 10% to 29% to a UA	NA
9.2 Small Town Low Commute	Secondary flow 10% to 29% to Large UC	NA
10. Rural Areas	Flow outside UA or UC	Duchesne, Beaver
10.1 Rural Areas	Secondary flow 30% to 50% to a UA	New Harmony
10.2 Rural Areas	Secondary flow 30% to 50% to Large UC	Parowan, Summit
10.3 Rural Areas	Secondary flow 30% to 50% to Small UC	Neola, Bluebell
10.4 Rural Areas	Secondary flow 10% to 29% to a UA	NA
10.5 Rural Areas	Secondary flow 10% to 29% to Large UC	Honeyville, Castle Dale
10.6 Rural Areas	Secondary flow 10% to 29% to Small UC	Kamas, Filmore, Kanosh

RUCA codes can break down into smaller categories: the 10 basic RUCA codes; four categories made up of urban, large rural, small rural, and isolated small rural; and two basic urban and rural categories (Skillman, Oct 2012). Although the UMEC has historically broken down geographic distribution by rural and urban counties, a breakdown of rural and urban RUCA codes is more accurate and will be used in this report in addition to a county breakdown. The maps below offer detail on how the state is broken down by the 10 basic RUCA codes as well as the rural/urban dichotomy.

Figure 8: Utah RUCA Code and Census Designated Rural/Urban Counties Maps



When looking at PA geographic distribution using both RUCA codes and counties, the PA workforce closely resembles the Utah population in most areas, excluding the 3 counties with no practicing PAs. While the geography of RUCA Codes can vary widely, as evidenced by the map above, the fact that both the population and the PA workforce are similarly distributed across RUCA Codes (see table 10) could be indicative of a well-distributed workforce. Looking at a comparison of the distribution of Utah's population and the PA workforce by county, the PA workforce doesn't appear to be as evenly distributed with population, but still within comfortable margins (see table 11).

Table 10: PA Distribution by RUCA Code

RUCA Code	Utah Population	PA Population
1	79.9%	81.2%
2	4.7%	2.0%
3	0.5%	0.2%
4	5.8%	5.1%
5	0.1%	0.0%
6	0.0%	0.0%
7	5.3%	4.0%
8	0.3%	0.7%
9	0.0%	0.0%
10	3.4%	2.9%

Table 11: PA Distribution by County

County	Utah Population	PA Population
Beaver	0.2%	0.2%
Box Elder	1.8%	0.9%
Cache	4.0%	3.3%
Carbon	0.7%	0.7%
Daggett	0.04%	0.2%
Davis	11.1%	7.4%
Duchesne	0.7%	1.1%
Emery	0.4%	0.4%
Garfield	0.2%	0.2%
Grand	0.3%	0.4%
Iron	1.6%	1.6%
Juab	0.4%	0.0%
Kane	0.3%	0.2%
Millard	0.4%	0.1%
Morgan	0.4%	0.0%
Piute	0.1%	0.0%
Rich	0.1%	0.2%
Salt Lake	37.2%	47.7%
San Juan	0.5%	1.5%
Sanpete	1.0%	0.9%
Sevier	0.7%	0.4%
Summit	1.3%	1.6%
Tooele	2.1%	1.8%
Uintah	1.2%	0.5%
Utah	19.0%	13.5%
Wasatch	0.9%	0.3%
Washington	5.1%	5.2%
Wayne	0.1%	0.2%
Weber	8.2%	7.0%

There continues to be a strong correlation between practice location and the area in which PAs grew up. Of the 29.8% (300) of PAs who grew up in a rural environment, 29.3% are practicing in a rural area, up from 23.7% in 2008. Conversely, only 5.2% (26) of PAs with a suburban background and 9.4% (15) of PAs with an urban background practice in a rural environment.

Broken down by gender, a higher percentage of men are choosing rural practices. Of those who came from a rural background, 34.6% (63) of men and 22% (26) of women are practicing in a rural county. Among the entire PA workforce, 15.0% (88) of men and 10.1% (42) of women work in rural settings. The rural workforce itself is made up of 67.6% male and 32.4% female.

Between 2003 and 2008, there was a decrease in the actual number and percentage of female PAs practicing in rural locations. However, 2014 saw an increase in both the percentage and the actual number of female PAs in rural settings. Currently, men make up 67.6% (88) of the rural workforce and women make up 32.4% (42). In comparison, 2008 saw a rural workforce made up of 78.3% male and 21.7% female.

The mean age of PAs practicing in rural areas is 42.9, only slightly higher than the state average of 41.8. While there will be a steady stream of PAs retiring and reducing their hours over the next 15 years, this will likely not affect rural areas more than urban and suburban areas.

Specialty

PAs are working in a total of 47 specialties throughout the state. Approximately 42.9% (431) of PAs practice in one of the primary care specialties (Family Medicine, Family Medicine with Urgent Care, OB/GYN, General Internal Medicine, and General Pediatrics), while 56.2% (565) practice in one of the other 42 specialties.

The move away from primary care continues, with a smaller share of PAs in Utah providing primary care services. However, while the national share of PAs practicing Primary Care decreased by 4.0%, from 36.0% in 2008 to 32.0% in 2014 (American Academy of Physician Assistants, 2013), the share of primary care practitioners in Utah only decreased by 1.3%, from 44.2% in 2008 (Utah Medical Education Council, 2010) to 42.9% in 2014. Because of the increase in the PA workforce, the actual number of Utah PAs working in Primary Care increased from 280 to 431 during the same time frame. Almost half of female PAs (48.5%, 203) and 38.9% (228) of male PAs work in Primary Care.

Figure 9: Decline in Utah and U.S. Primary Care PAs as Percentage of Workforce

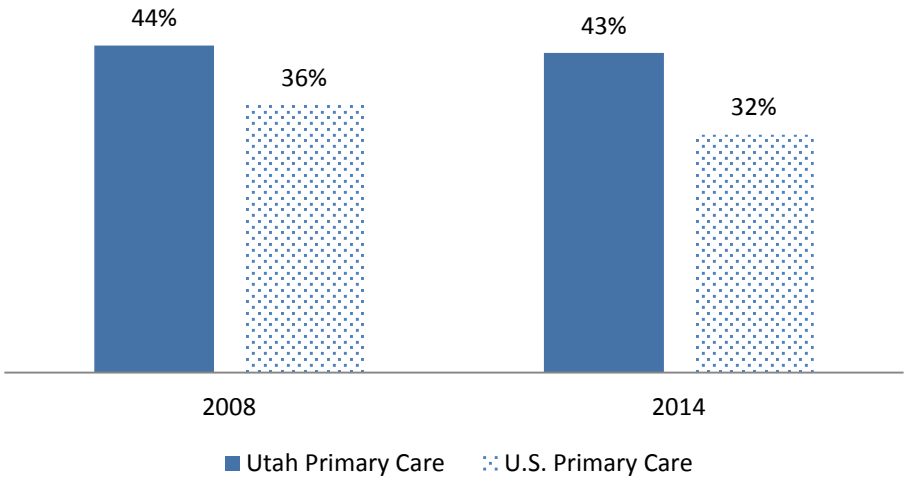


Table 12: Primary Care Specialties Utah and U.S. PA Workforce

Specialty	Utah	U.S.
Family Medicine	17.4%	14.5%
Family Medicine w/Urgent Care	15.6%	8.8%
OB/GYN	3.3%	2.0%
Pediatrics: General	4.0%	1.9%
Internal Medicine: General	2.6%	4.9%

Table 13: Primary Care Specialty and Gender

Specialty	Female	Male
Family Medicine	20.3%	15.4%
Family Medicine w/Urgent Care	12.8%	17.6%
OB/GYN	7.5%	0.3%
Pediatrics: General	3.5%	4.4%
Internal Medicine: General	4.4%	1.3%

The specialties listed in the survey instrument have changed since 2008 to better match the national Minimum Data Set (United States Department of Health and Human Services, 2013), thus it is difficult to compare which specialties have seen the most growth in Utah. For example, the 2014 survey split the Family Medicine and Family Medicine with Urgent Care specialties. If we compare these two specialties to the 2008 Family Medicine percentage, the number of PAs in these fields grew by 64.7%. Likewise, if we combine all the surgical specialties and compare the 2008 total to the 2014 total, surgery grew by 120.3%. Again, while it is difficult to directly compare 2008 to 2014 because of the nature of the specialties listed, 21 of the 27 specialties that are directly comparable to 2008 experienced growth.

Table 14: 2014 Top 15 Specialties and Change Since 2008

Specialty	2008		2014		Change	
	Count	Percent	Count	Percent	Count	Percent
Family Medicine	201	31.5%	175	17.4%	-26	-12.4%[4]
Family Medicine with Urgent Care	NA	NA	156	15.6%	NA	NA
Orthopedics	68	10.6%	96	9.5%	28	41.2%
Emergency Medicine	37	6.0%	53	5.3%	16	43.2%
Pediatrics: General	38	5.8%	41	4.0%	3	7.9%
Obstetrics/Gynecology	19	2.5%	33	3.3%	14	73.7%
Dermatology	27	4.2%	29	2.9%	2	7.4%
Surgery: Urology	19	3.0%	29	2.9%	10	52.6%
IM: Cardiology	18	2.8%	29	2.9%	11	61.1%
Occupational Medicine	NA	NA	26	2.6%	NA	NA
Surgery: Otolaryngology	12	1.9%	26	2.6%	14	116.7%
IM: General	28	4.4%	26	2.6%	-2	-7.1%
Pain Management	NA	NA	20	2.0%	NA	NA
Surgery: Cardiovascular/Cardiothoracic	NA	NA	20	2.0%	NA	NA
Internal Medicine: Oncology	NA	NA	20	2.0%	NA	NA

While on the surface individual specialty growth is not as robust as 2008, there were more specialties listed as options (45 in 2008 vs. 71 in 2014), causing more diffused results. Overall, the number of specialty care PAs grew by 68.7% (230) versus primary care at 53.9% (151) between 2008 and 2014.

While differences between gender and choice of specialty may not seem striking, they are nuanced and worth noting. Almost half (48.5%, 203) of female PAs practice in Primary Care, while slightly fewer male PAs do (38.9%, 228). Male and female PAs working in Surgery specialties are distributed virtually the same (15.0% for men and 15.6% for women). PAs working in Pediatrics are evenly distributed as well (0.6% for men and 1.3% for women). However, there are larger differences when looking at Internal Medicine and other specialties (listed in the UMEC survey, found in Appendix B). There was a higher percentage of women going into Internal Medicine (14.5% vs. 9.1% for men) and a higher percentage of men going into other specialties[5] (35.4% vs. 19.4% of women).

[4] It is likely that PAs working in Family Medicine with Urgent Care in 2008 selected Family Medicine. Thus, Family Medicine and Urgent Care combined likely grew by 64.7% and 130 PAs.

[5] "Other specialties" include those not categorized under Primary Care, Surgery, Internal Medicine, or Pediatrics; e.g. Dermatology, Psychiatry, Allergy, Occupational Medicine, etc.

Hours Worked

Utah PAs work an average of 41.2 hours per week. A total of 79.1% (795) of PAs work full time, defined as 36 or more hours per week, while 18.5% (186) work part-time, or fewer than 36 hours per week (see table 15). Full time PAs worked a mean of 45.3 hours, while part-time PAs worked a mean of 23.8 hours per week. Additionally, a higher share of female PAs worked part-time. A total of 30.4% of female PAs worked fewer than 36 hours per week, while only 10.0% of men did the same (see table 16).

Table 15: Hours Worked per Week

Hours/Week	Count	Percent
20 or fewer	66	6.6%
21-35	120	11.9%
36-40	401	39.9%
41-50	278	27.7%
51-60	91	9.1%
61+	25	2.5%
Missing	24	2.4%

Table 16: Hours Worked per Week by Gender

Hours/Week	Male Count	Male %	Female Count	Female %
20 or Fewer	20	3.4%	46	11.0%
21-35	39	6.6%	81	19.4%
36-40	232	39.5%	169	40.4%
41-50	201	34.2%	77	18.4%
51-60	63	10.7%	28	6.7%
61+	18	3.4%	7	1.7%
Missing	14	2.4%	10	2.4%

There was a small difference between genders when looking at hours worked. Male PAs worked a mean of 43.7 hours per week while female PAs worked 37.6 hours per week. A small difference continues when looking at full-time and part-time PAs as well.

Table 17: Mean Hours Worked per Week by Work Status and Gender

Work Status	Men	Women	All
Full Time	45.6	44	45.3
Part Time	24.5	23.5	23.8
All	43.7	34.6	41.2

Concurrent Worksites

A total of 17.4% (175) of PAs are working in more than one practice setting. This number has fallen from 22.9% in 2008 and 23.0% in 2003. The 2014 UMEC survey did not collect data on the reasons PAs seek out a second worksite. PAs employed at multiple sites work a mean of 34.1 hours at their primary setting and 11.2 hours at their second setting, working overall a mean of 44.8 hours per week.

Work Setting

PAs currently work in 23 different settings. Over half of all PAs in Utah (53.7%, 539) work in a solo or group physician practice and 25.6% (258) work in a hospital setting. As with the specialty options in the 2014 survey, the work setting options were changed from the 2008 survey to mirror the national Minimum Data Set, thus it can be difficult to make direct comparisons. However, group practices are still the largest employer of PAs, with 40.8% (411) employed in both single-specialty and multi-specialty group settings.

Not only were the options changed in the 2014 survey, but the number of options increased from the 2008 survey. Because of this, settings, like specialties, appear to be more stratified in terms of the share of the workforce. However, each comparable setting grew. For example, when combining all hospital settings from both surveys, the number of PAs in those settings grew by 116.8% (119 in 2008 to 258 in 2014). Of those in hospital settings, 87.9% (226) were in specialty care in 2014. This growth does not necessarily indicate a movement towards this setting, rather the significant growth in the workforce overall.

Table 18: Top 5 Work Settings with 2008 Comparisons

<table>
<tr><th rowspan="2">Work Setting</th><th colspan="2">2008</th><th colspan="2">2014</th><th rowspan="2">Count Change</th><th rowspan="2">Percent Change</th></tr>
<tr><th>Count</th><th>Percent</th><th>Count</th><th>Percent</th></tr>
<tr><td>Single-Specialty Physician Group Practice</td><td rowspan="2">263</td><td rowspan="2">41.4%</td><td>254</td><td>25.3%</td><td rowspan="2">148</td><td rowspan="2">56.3%</td></tr>
<tr><td>Multi-Specialty Physician Group Practice</td><td>157</td><td>15.6%</td></tr>
<tr><td>Solo Practice Physician Office</td><td>79</td><td>24.2%</td><td>129</td><td>12.8%</td><td>50</td><td>63.3%</td></tr>
<tr><td>Outpatient Unit of Hospital</td><td>NA</td><td>NA</td><td>87</td><td>8.6%</td><td>NA</td><td>NA</td></tr>
<tr><td>Community Health Center</td><td>31</td><td>5.1%</td><td>55</td><td>5.5%</td><td>24</td><td>77.4%</td></tr>
</table>

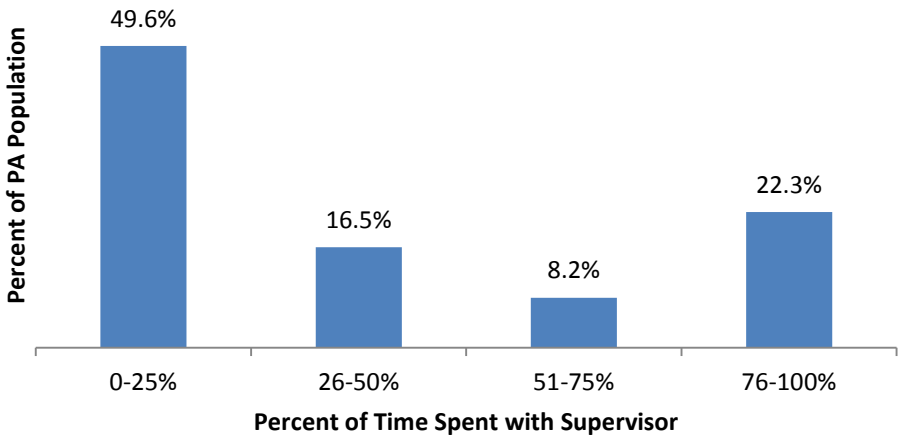
Table 19: Top 10 Work Settings with National Comparisons

Work Setting	Utah 2014	National 2013
Single-Specialty Physician Group Practice	25.3%	18.7%
Multi-Specialty Physician Group Practice	15.6%	9.2%
Solo Practice Physician Office	12.8%	10.4%
Outpatient Unit of Hospital	8.6%	7.3%
Community Health Center	5.5%	3.0%
Inpatient Unit of Hospital (not ICU/CCU)	5.3%	10.6%
Hospital Emergency Room	4.4%	9.5%
Freestanding Urgent Care Facility	3.8%	3.6%
Hospital Operating Room	2.6%	6.0%
Critical Access Hospital	2.0%	0.9%

On-Site Supervision

In the 2008 survey, PAs were asked about how they were supervised, face-to-face or telecommunication, and the percentage of how often they use each. The question asked PAs to make sure their response totaled 100%, for example, 50% face-to-face and 50% telecommunications. The 2014 survey, on the other hand, simply asked the percentage of time they spent interfacing with a supervisor in a typical week. Because of this difference, it is impossible to make a direct comparison regarding the supervision changes from 2008 to 2014.

Figure 10: 2014 Reported Time Spent with Supervisor



When asked the primary method of interfacing with a supervisor, the vast majority of respondents (86.1%, 865) indicated they primarily interact with their supervisor face-to-face. However, it should be noted that although the instructions for the question and the data entry of this question only allowed for one response, there were PAs who marked several options

(face-to-face, telephone, text message, email, other). In these cases, the data was recorded as the first response only, which was often face-to-face.

Patient Wait Times

The mean wait time for new patients is 12.9 days for all PAs. Among existing patients, the mean wait time is 4.2 days. These numbers do vary depending on specialty.

Within Primary Care, the mean wait time for new patients is 4.6 days and 2.9 days for existing patients. Specialty Care reported a mean wait time of 20 days for new patients and 5.3 for existing patients.

Table 20: Reported Median and Mean Wait Times by Primary Care and Specialty Care

Specialty Group	New Patients		Existing Patients	
	Median	Mean	Median	Mean
Primary	1.0	4.6	1.0	2.93
Specialty	5.0	20.0	2.0	5.33

When looking at specialty groups, PAs working in Internal Medicine report the highest mean patient wait time at 58.1 days. However, when removing two outliers, Internal Medicine specialties have mean wait times between 5 and 17 days for new patients. All other specialty groups report much lower mean patient wait times.

Table 21: Reported Median and Mean Patient Wait Times by Primary Specialty

Specialty	New Patients		Existing Patients	
	Median	Mean	Median	Mean
Family Medicine	2.0	5.1	1.0	2.6
Family Medicine w/Urgent Care	1.0	3.3	0.0	2.1
OB/GYN	3.0	5.2	2.0	4.3
General Internal Medicine	7.0	11.6	1.5	9.3
General Pediatrics	1.0	1.7	1.0	1.6

Table 22: Five Highest Reported Median and Mean Patient Wait Times

Specialty	New Patients		Existing Patients	
	Median	Mean	Median	Mean
IM: Other	42.0	376.9	6.0	10.0
Surg: Transplant	60.0	60.0	18.0	18.0
IM: Pulmonology	37.0	41.5	2.0	31.0
Surg: Other	19.0	10.0	6.5	6.5
Orthopedics	6.0	14.5	4.0	6.1

When comparing wait times to 2008, the mean wait time for existing patients seeing a specialty care PA went down by one day while all other mean wait times went up. In the case of new patients seeing a specialty PA, reported patient wait time went from 12.7 days in 2008 to 20 days in 2014.

Table 23: 2008 and 2014 Reported Mean Patient Wait Time by Primary Care and Specialty Care

Patient Category	Primary Care		Specialty Care	
	2008	2014	2008	2014
New Patients	3.0	4.6	12.7	20.0
Existing Patients	1.6	2.9	6.3	5.3

Accepting New Patients

Nearly half (44.7%, 449) of all PAs said their primary practice was unfilled and can accept many new patients. This is only a slight decrease from 45.4% in 2008. Only 4.6% (46) of PAs said their practice cannot accept new patients. Over a third (36.4%, 366) said their practice is nearly full and can accept a limited number of new patients.

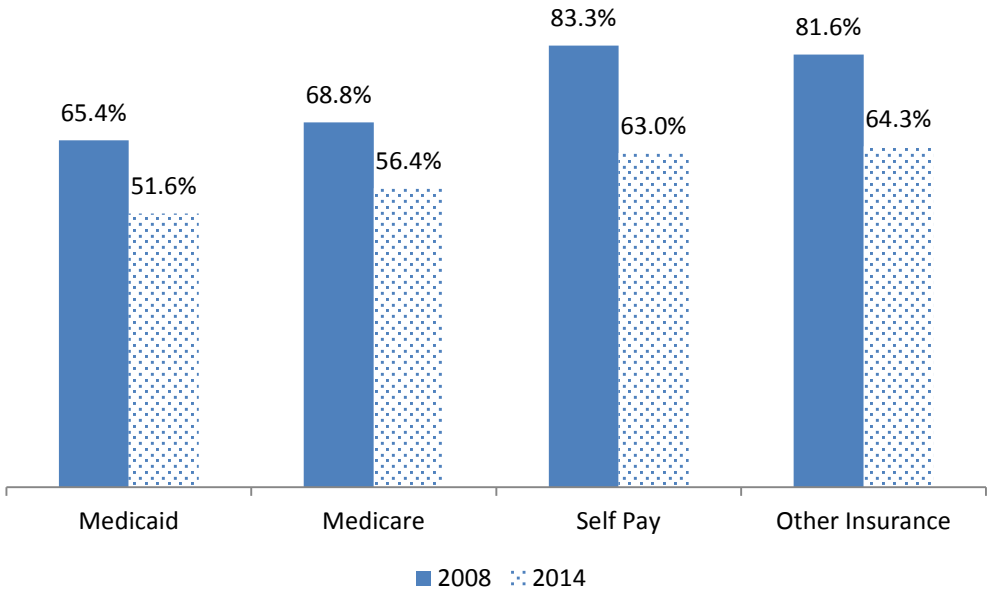
There is, however, a more significant difference in the average wait time among the different practice statuses. Not surprisingly, wait times go up depending on how full a practice is, with the exception of new patients at a full practice. However, this particular piece of data may not be accurate when considering the fact that, by definition, a full practice is not accepting new patients.

Table 24: Mean Patient Wait Times by Practice Status

Patient Type	Full	Nearly Full	Unfilled	All
New patients	17.4	22.6	4.2	12.9
Existing patients	6.8	5.6	2.6	4.2

Similar to 2008, a majority of PAs said they are accepting all payer types. However, those percentages have gone down by an average of 16% since then.

Figure 11: Percent of PAs Accepting New Insurances 2014 and 2008



There is very little difference among the productivity of PAs at practices that are full, nearly full, or unfilled. The average number of patients seen per hour for all PAs is 3.6. For practices that are full, nearly full, and unfilled, those numbers are 3.7, 3.6, and 3.7 patients per hour, respectively.

Direct Patient Care

PAs see an average of 3.6 patients per hour. Part-time PAs see 3.4 patients per hour while full-time PAs see 3.6. PAs also spend an average of 36.1 hours per week in direct patient care activities, including charting. Broken down, full-time PAs spend an average of 39.4 hours per week in direct patient care while part-time PAs spend 22 hours per week on patient care. Therefore, on average, PAs can potentially see an average of 130 patients per week. Full-time PAs can see an average of 141.8 patients while part-time PAs can see an average of 74.8 patients per week.

These numbers are significantly higher than in 2008, which reported that PAs saw a mean of 80.3 patients per week. However, the question in 2008 asked how many patients PAs saw per week while 2014 asked how many patients were seen per hour. The change was due to the idea that it is easier for PAs to estimate their hourly productivity as opposed to weekly. Likewise, the 2014 survey did not differentiate between inpatient and outpatient while the 2008 survey did.

In addition to working fewer overall hours, female PAs spend slightly less time on direct patient care than their male counterparts and therefore see fewer patients per week. However, the number of patients seen per hour is virtually the same between male and female PAs.

Table 25: Patients Seen and Direct Patient Care by Gender

	Male		Female		All	
	Full Time	Part Time	Full Time	Part Time	Full Time	Part Time
Patients per Hour	3.6	3.4	3.7	3.3	3.6	3.6
Direct Patient Hours per Week	40.1	23.6	38.0	21.3	39.4	22.0
Patients per Week	144.4	80.2	140.6	70.3	141.8	130.0

There were pronounced differences among specialty groups when looking at patients seen per hour. On average, surgery specialties saw more patients than others at 3.9 patients per hour while pediatrics was the lowest at 2 patients per hour.

There is more variance when looking at individual specialties. Each Primary Care specialty falls closely within the average with the exception of General Pediatrics (see table 26). The five specialties with the highest average patients seen per hour differ quite a bit from overall averages (see table 27).

Table 26: Patients per Hour by Primary Care Specialty

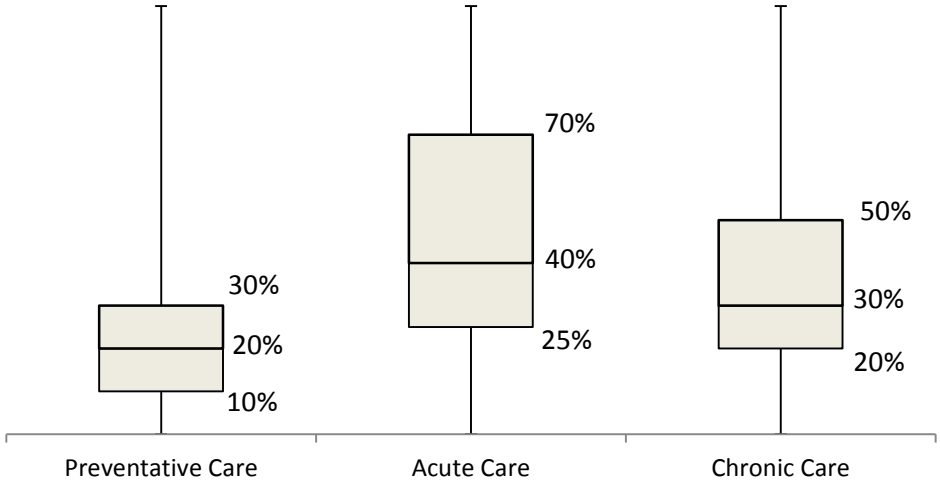
Specialty	Full Time	Part Time	All
Family Medicine	3.4	3.3	3.3
Family Medicine w/Urgent Care	3.9	3.6	3.9
OB/GYN	2.6	2.8	2.7
Ped: General	4.3	4.7	4.5
IM: General	2.8	3.0	2.9

Table 27: Top Five Specialties with Highest Patients per Hour

Specialty	Full Time	Part Time	All
Surgery: Other	8.0	NA	8.0
Public Health	NA	7.0	7.0
Surgery: Trauma	6.2	NA	6.2
Surgery: Hand	5.0	NA	5.0
Orthopedics	4.5	5.0	4.6

The survey also asked PAs to break down their direct patient care time by detailing the percent of time spent on preventative care, acute care, and chronic care. These breakdowns varied from 0% to 100% for each type of direct care; therefore, it is difficult to describe the typical or average amount of time spent on those activities. However, by breaking these data down by quartiles, we can begin to gain an idea of what types of care PAs more often spend their time on. Based on the graph below, we can see that PAs generally spend very little time on preventative care, while more PAs focus on acute care.

Figure 12: Direct Patient Care Time Types Broken Down by Quartile



Preventative Care in Specialist Practice Settings

Overall, PAs appear to practice preventative care much less than acute and chronic care. In fact, when taking the average of preventative, acute, and chronic care from each specialty, only five specialties reported spending 40% or more of their time on preventative care, while many more reported spending the majority of their time on acute or chronic care[6].

Table 28: Specialties with Highest Mean Percentage of Time Spent on Preventative Care

Specialty	Preventative	Acute	Chronic
Public Health	75%	0%	15%
OB/GYN	65%	20%	10%
Surgery: Other	60%	40%	70%
Interventional Cardiology	50%	25%	25%
IM: Endocrinology	40%	20%	40%

Table 29: Specialties with Highest Mean Percentage of Time Spent on Acute Care

Specialty	Preventative	Acute	Chronic
IM: Critical Care	0%	100%	0%
Emergency Medicine	10%	90%	10%
Occupational Medicine	30%	90%	7.5%
Surgery: Trauma	5%	87.5%	10%
Surgery: Thoracic	5%	80%	15%

[6] Mean was calculated for each type of care individually and may not total 100% for tables 28-30

Table 30: Specialties with Highest Mean Percentage of Time Spent on Chronic Care

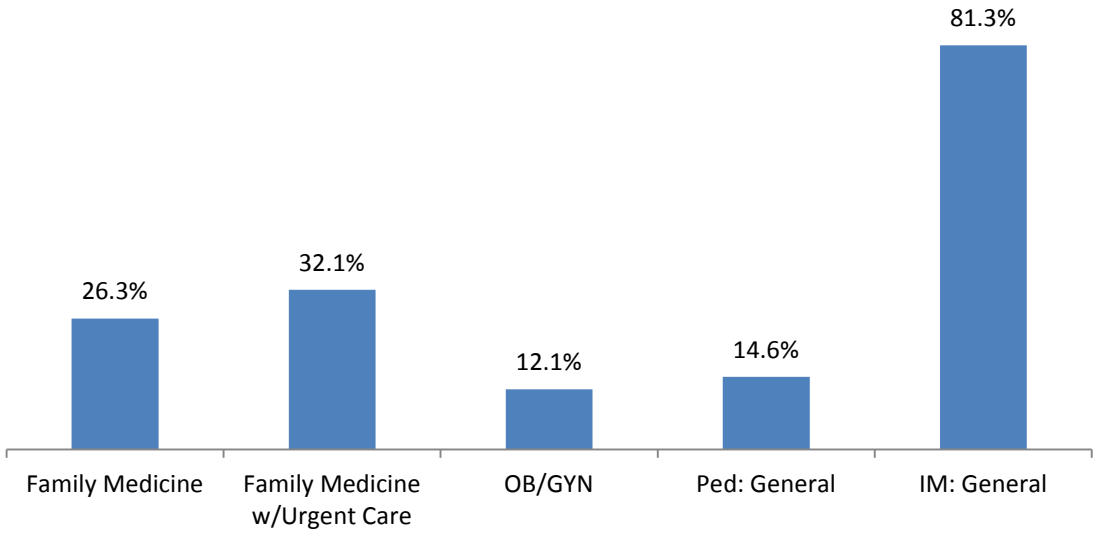
Specialty	Preventative	Acute	Chronic
Surgery: Oncology	5%	0%	95%
Pediatrics: Neurology	10%	0%	90%
IM: Nephrology	7%	0%	83%
IM: Infectious Disease	10%	55%	80%
Pain Management	12.5%	15%	80%

Multidisciplinary Care

When asked about multidisciplinary care teams, 38.3% reported that they work in a care team. Those who did were asked to detail who they worked with (primary care physician, specialty physician, other PA, APRN, and other) and the types of care on which they worked with teams (acute illness, chronic illness, disease prevention, etc.). Among PAs who reported working in a multidisciplinary team, there were several that work with either a specialty or a primary care physician only and were removed from the total count. Primary care PAs who only work with primary care physicians or specialty PAs who only work with a specialty physician likely do not operate on a true multidisciplinary team. These PAs are merely working with their supervising physician. When removing these respondents, the percentage of PAs who work on a multidisciplinary team went down to 32.8%.

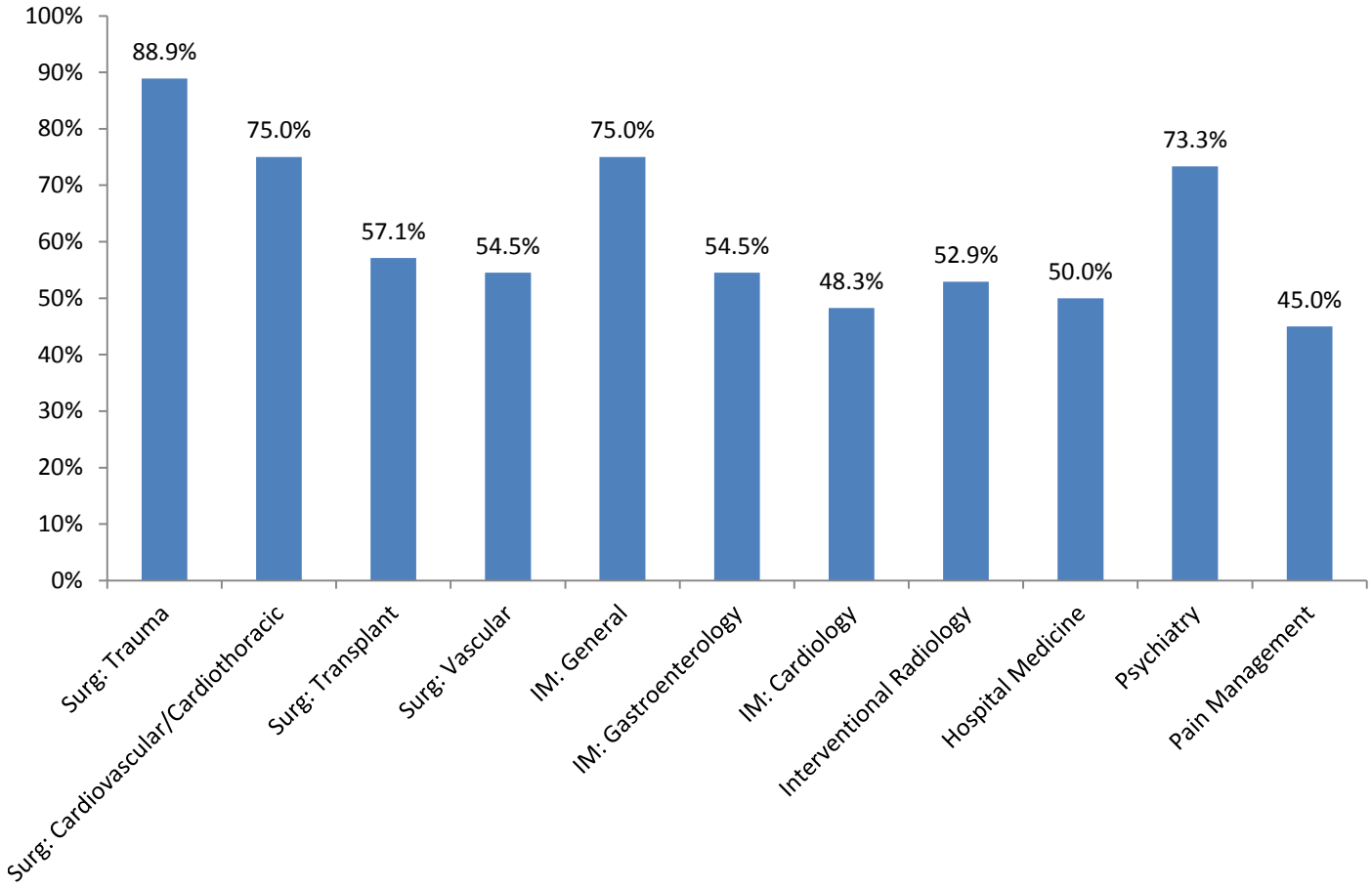
Looking at primary care specialties, only one has more than 50% of PAs reporting working on a care team.

Figure 13: Percent of PAs in Multidisciplinary Care Teams by Primary Care Specialties



There are certain specialties that were more likely to work on multidisciplinary care teams. A total of nine specialties have 50% or more of PAs working on a care team.

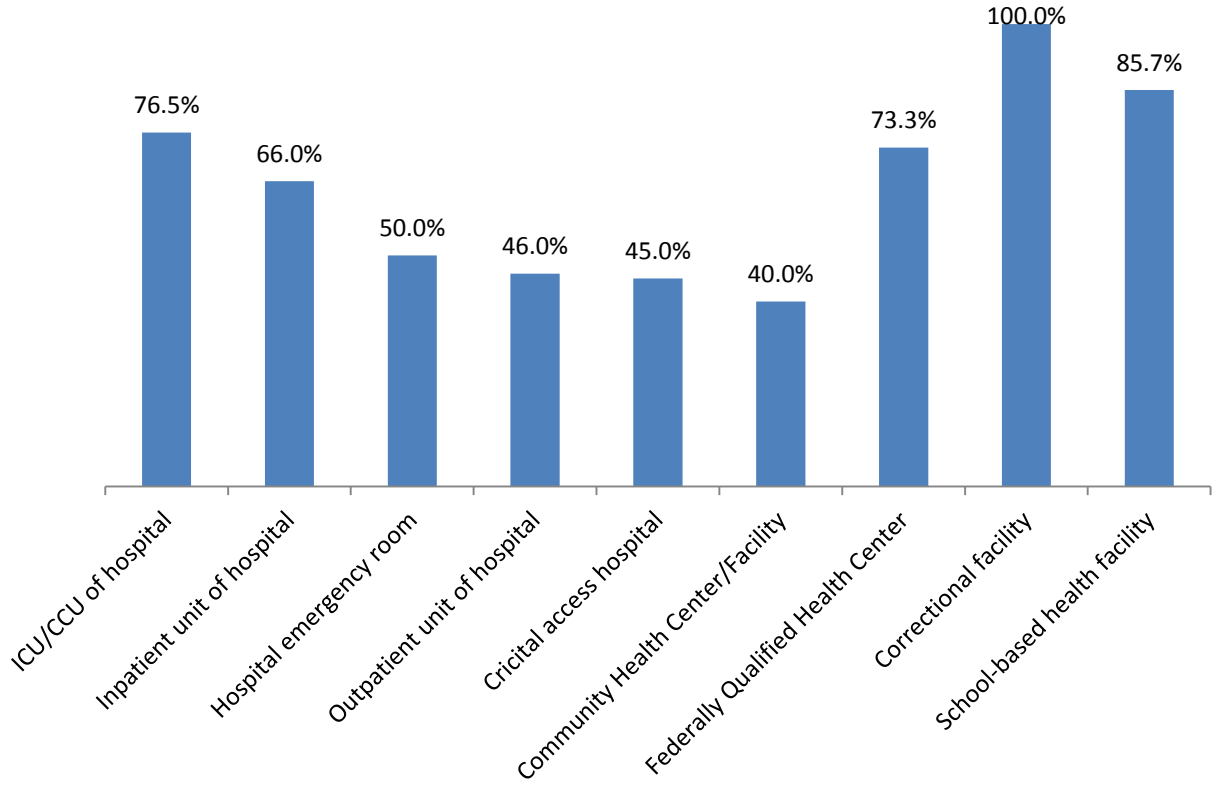
Figure 14: Specialties with 50% or More PAs on a Multidisciplinary Care Teams



There are eight specialties that do not have any PAs who reported working in a care team, which are Internal Medicine: Nephrology, Internal Medicine: Neurology, Interventional Cardiology, Pediatrics: Emergency Medicine, Pediatrics: Neurology, Public Health, Surgery: Hand, and Surgery: Thoracic.

When looking at care teams and practice settings, PAs working at correctional facilities, schools, universities, and hospitals are generally much more likely to work on care teams as opposed to PAs in other settings, as detailed in the figure below.

Figure 15: Settings with 50% or More of PAs on a Multidisciplinary Care Team



Non-Patient Care Activities

Most PAs (54.2%, 545) report working at least one hour per week on non-patient care activities. Of these, 20.9% (114) participate in classroom training, 44.6% (243) in clinical training, 42.6% (232) in administration/management, 37.2% (203) in practice management, 40.5% (221) in consulting/research, and 5.4% (29) in other activities.

PAs who are engaging in non-patient care activities spend an average of 4.9 hours per week on these activities. PAs work a weekly average of 4.1 hours on classroom training, 6.6 hours on clinical training, 5.4 hours on administration/management, 4.0 hours on practice management, 3.7 hours on consulting/research, and 5.5 hours on other activities.

Table 31: PAs in Non-Patient Care Activities

Activity	Percent	Count	Mean Hours
Classroom Training	11.4%	114	4.1
Training in Clinical Setting	24.2%	243	6.6
Administration/Management	23.1%	232	5.4
Practice Management	20.1%	203	4
Consulting/Research	22.0%	221	3.7
Other	2.9%	30	5.5

Non-English Services

Utah is becoming a more diverse state, with an estimated 14.3% of the population having a primary language other than English. The majority of this population speaks Spanish as their primary language (9.6%) (United States Census Bureau, 2013). While the 2014 survey did not ask PAs the percentage of their patients who do not speak English, if the ratio of non-English speaking patients remained the same as it was in 2008, an estimated 13.5% of PA patients spoke a language other than English.

A total of 70.7% (711) of PAs offer non-English services at their practice. Of those, 88% (626) specifically said they offer health care services in Spanish, 7.8% (55) reported offering multiple language services, usually through an interpreter, 17.9% (127) reported offering specific languages other than Spanish, and 72% (512) reported offering services in Spanish only.

Turnover and Retirement

With such a young workforce, retirement among PAs may be fairly low over the coming years. Only 5.5% (55) of PAs planned to retire within 5 years, while another 7.5% (75) planned on retiring in 6-10 years. Indeed, the majority of PAs are not planning on retiring in the near future. Over half (56.7%, 570) of the workforce reported intending to retire in 21 years or more.

Table 32: Years to Planned Retirement

Years to Retirement	Count	Percent
1-5	55	5.5%
6-10	75	7.5%
11-15	74	7.4%
16-20	96	9.6%
21-25	145	14.4%
26-30	149	14.8%
31-35	179	17.8%
36-40	82	8.2%
41+	15	1.5%
Item non-response	122	12.1%
Total	992	98.7%[7]

Expected retirement differs when looking at PAs over the age of 55, which comprise 17.6% of the workforce. PAs between the ages of 55 and 59 had an average retirement date 11 years

[7] 1.3% (13) of respondents were either already retired and working on a volunteer basis or planned on retiring the year of the survey (2014)

from now, those between 60 and 64 plan on retiring in an average of 5 years, and those 65 and older reported an average of 3 years until retirement.

Pre-Retirement Hours Reduction

Close to half (48.2%, 484) of all PAs said they plan on reducing their hours before they retire. Of those, almost a quarter (24.3%, 118) plan on reducing their hours in 0 to 5 years. The mean age of this group is 45.8. Another 11.4% (55) said they will reduce their hours in 6 to 10 years, 10.6% (52) in 11 to 15 years, 16.3% (79) in 16 to 20 years, and 12.8% (63) in 21 or more years. When asked how many hours they would cut each week, 70.3% (341) said they will cut 20 to 35 hours each week, leaving 39 FTEs to be filled over the next five years.

The share of PAs age 55 years and older who said they want to reduce their hours before retiring is slightly lower than those under 55 years of age (41.2% and 49.5% respectively). For those aged 60 and over, the maximum number of years PAs plan to wait to reduce their hours is 7 years while the maximum number of years PAs aged 55-59 plan on waiting was 15. However, the majority of those 55 years and older reported reducing their hours between 0 and 5 years.

Age Category	Years to Retire	% Reducing Hours	Years to Hour Reduction	Hours Worked After Reduction
25-29	34.0	57.1%	16.4	26.4
30-34	31.7	48.4%	17.2	26.8
35-39	27.9	53.0%	16.7	25.8
40-44	22.5	41.7%	15.2	26.0
45-49	18.8	46.3%	15.3	28.0
50-54	13.5	53.1%	9.2	26.8
55-59	10.7	45.0%	6.7	26.3
60-64	5.0	33.3%	3.7	24.6
65+	3.4	47.8%	1.9	26.1

When controlling for gender, the share of the PA workforce planning on reducing their hours differs. The correlation between gender and plans to reduce hours before retirement is statistically significant[8]. A total of 45.5% (267) of male PAs and 52% (217) of female PAs plan to reduce their hours. Women are also more likely to reduce their hours sooner than men, as detailed in the table below.

[8] r=.05

Table 33: Years to Hour Reduction by Gender

Years	Male	Female	All
0-5	19.3%	30.5%	24.3%
6-10	9.0%	14.4%	11.4%
11-15	14.5%	5.9%	10.6%
16-20	19.3%	12.7%	16.3%
21+	18.6%	5.9%	12.8%

Women who plan on reducing their hours are also more likely to be much younger. Of those who plan on reducing their hours in the next 5 years, the mean age for female PAs is 37.8 years while the mean age for male PAs is 56 years. Indeed, only 2.2% (6) of men who plan on reducing their hours in 0 to 5 years are under the age of 40. Conversely, 22.1% (48) of women who plan on reducing their hours in 0 to 5 years are under 40 years old.

WORKFORCE PROJECTIONS

In the 2012 Physician Workforce Report, the UMEC estimated that Utah would need 332 physicians each year; 151 to replace FTE losses due to hour reduction and retirement, and a net increase of 181 to keep up with population growth and an aging population. Between 2010 and 2015, Utah has experienced an estimated net growth of 141 physicians per year[9], 40 short of the UMEC's projected yearly need.

This shortage may be playing a role in the growth of PAs in Utah. According to the UMEC's 2012 physician report, specialties such as general surgery and cardiology were experiencing a physician shortage in the state (Utah Medical Education Council, 2012). While growth in specific specialties has been stratified, the number of PAs practicing in general surgery has gone up 116.7% since 2008 with PAs practicing in cardiology increasing by 61.1%. However, specialties that were not experiencing a physician shortage in 2012, such as Family Medicine and OB/GYN, have been experiencing high growth as well.

PA supply is influenced by other factors, including population growth. Utah was ranked third fastest in the U.S. in terms of state-wide population growth in 2013. Utah's growth is due to high birth rates, low mortality rates, and in-migration. (The Utah Economic Council, 2014). By 2030, the population in Utah is expected to grow to an estimated 3.91 million, a 32.3% increase from 2.95 million in 2014 (Governor's Office of Planning and Budget, 2012).

With a larger and increasingly older population, the number of visits to a medical provider will increase as well. The Utah Behavioral Risk Factor Surveillance System (BRFSS) has estimated

[9] Based on the assumption that 67% of all licensed physicians in Utah are practicing in the state, as was the case in Utah's Physician Workforce Report, 2012

that an individual in Utah sees a medical provider between 3 and 6.17 times per year, depending on age group. Conversely, 15.3% of Utah's population did not see a medical provider in 2013 because of cost (Kaiser Family Foundation, 2013).

Table 34: Utah BRFSS Annual Visit Rates to a Medical Provider

Age Range	Average Medical Visits per Year
0-19	3.00
20-64	3.72
65-84	4.98
85+	6.17

The UMEC has developed a model to project the supply of the PA workforce which takes into account a number of elements including population growth and age polarization, self-reported retirement, historical licensing data, population growth, and workforce replacement. Growth is calculated to account for a growing and aging population in Utah while replacement can be calculated using either self-reported retirement intentions from survey data or historical attrition rates from license data. These two rates differ greatly, with an average of 14 FTE losses per year over the next 15 years due to self-reported retirement and an estimated average of 44 licenses expiring each year over the same time frame, based on an historical average of 3.2% annual attrition rate from license data. Population growth and age polarization will require an increase of 21 PAs per year. An average of 5 FTEs per year will be required to account for intended pre-retirement reduction in hours reported by PAs. Looking at both growth and replacement, Utah will need between 40 and 70 new PAs annually through 2030 depending on whether the calculation is based on PA self-reported retirement intentions in the next 15 years (see figure 16: scenario 1) or on historical trends in license expiration over the last 5 years (see figure 16: scenario 2).

TRAINING CAPACITY

Utah's PA Training Environment

As of 2012, there were 164 PA programs in the U.S., an increase from 148 in 2009. The average enrollment rate rose only slightly from 44 to 44.6 first year students per year, a number that was generally between 90% and 94% of institutional capacity. Similarly, the number of first year PA student enrollment went up from 6,793 in 2008 to an estimated 7,314 in 2011 (Physician Assistant Education Association, 2011-2012).

Utah has been increasingly reliant on PAs who were trained out of state. Only 17.4% (175) of PAs were both from and trained in Utah. A quarter, 25.5% (256), were from Utah but trained

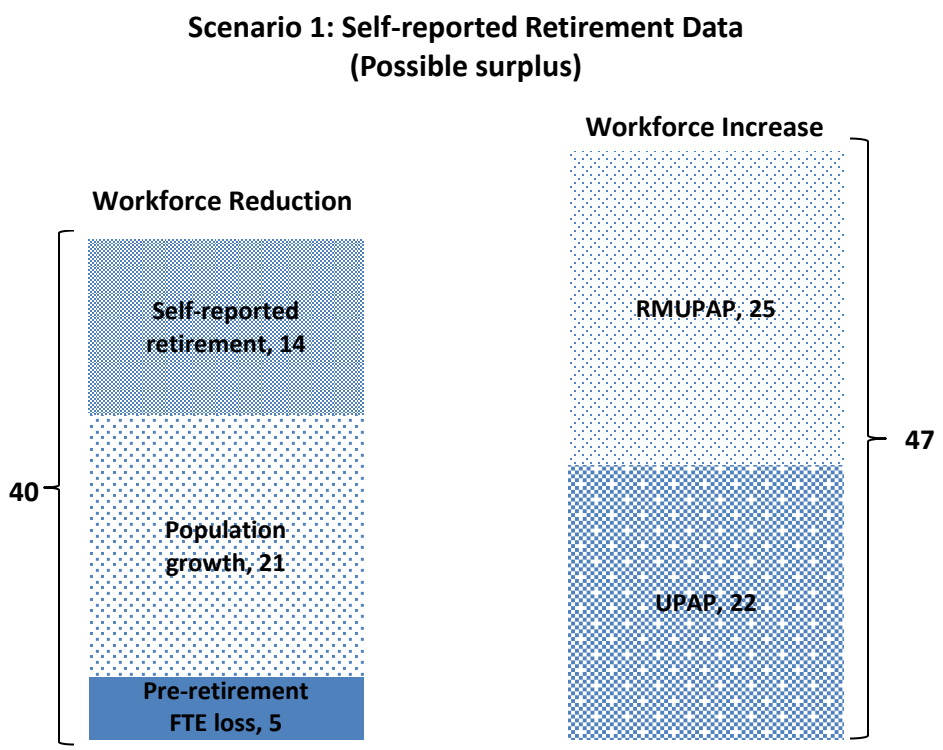
out of state, 8.5% (85) were from out of state but trained in Utah, and 18.9% (190) both grew up and were trained out of state.

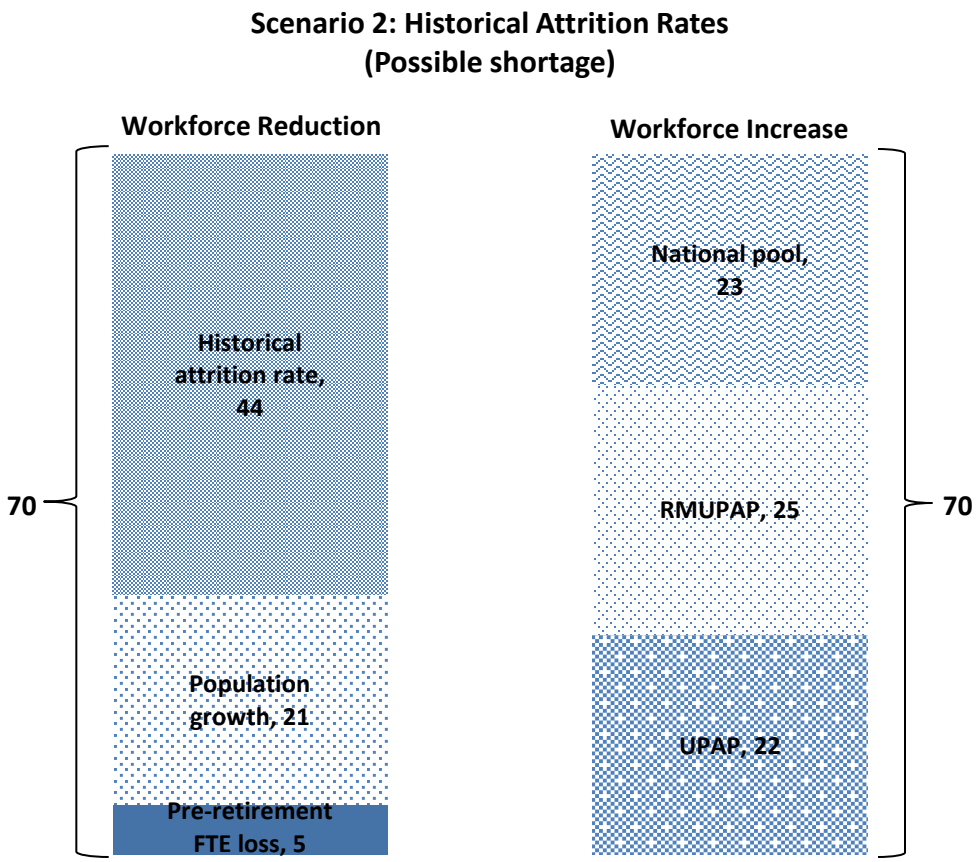
Table 35: Training Location by State of Origin

Training Location	Raised in Utah	Raised Out of State
Utah	17.4%	8.5%
Out of State	25.5%	18.9%

In 2011, UPAP increased its class size from 40 to 44 students. In addition to UPAP, Rocky Mountain University of Health Professions accepted its first cohort of PA students with a 2017 graduation date. The first class size is 46 students, but RUMPAP plans on increasing that number to 50 with their next cohort. If we assume that the current ratio of 34 PA FTEs per 100,000 in state population will stay constant as well as a 50% retention rate on graduating students staying in Utah to practice (which has historically been the case at UPAP), the two programs could possibly contribute a combined 47 new PAs to the Utah workforce annually beginning in 2018. This equates to 67.1% of Utah's yearly demand based on historical attrition rates from license data and 117.5% of Utah's yearly demand based on self-reported retirement data. It is likely that an estimated 22 new PA students retained in the state in 2015 and 2016, with that number jumping to an estimated 45 in 2017 when RMUPAP graduates its first cohort.

Figure 16: Projected PA Supply: Self-Reported Retirement vs. Historical Attrition Rate





The PA program at the University of Utah is a top ranking program, coming in 5th in the 2015 U.S. News & World Report (U.S. News & World Report, 2015), drawing in an increasing number of applicants, with an average of 775 applicants from 2009 to 2014. In that same time frame, 67.7% of each of UPAP's cohorts were in-state students. Similarly, RMUPAP had 617 applicants for its first 2015 cohort, while 73.9% of RMUPAP's first cohort was in-state students.

PA Training Laws

The American Academy of Physician Assistants (AAPA) has come up with six "key elements" to state PA practice laws: 1) "licensure" as the regulatory term (as opposed to the more simplistic "certification" or "registration"; 2) that the scope of practice be determined at the practice site; 3) adaptable supervision requirements; 4) full prescriptive authority; 5) that chart co-signature requirements be determined at the practice; and 6) that the number of PAs a physician can supervise be determined at the practice (American Academy of Physician Assistants, 2011).

The Utah Physician Assistant Practice Act currently incorporates four of the six key elements outlined by the AAPA (American Academy of Physician Assistants, 2013). While Utah still requires physicians to co-sign on certain charts and has a physician supervision limit of four FTEs, the act only requires co-signatures when prescribing schedule 2 or 3 controlled

substances and allows for exceptions to the 4 FTE limit as well as allowing licensed PAs to train PA students when the supervising physician delegates that role on a temporary basis (Utah Administrative Code, 2015). Thus, while Utah does not meet all six key elements, the state has made strides in decreasing the regulatory burden on supervising physicians and physician assistants.

CONCLUSION

Although the growth of the PA profession has slowed somewhat in recent years, Utah continues to benefit from a robust increase of PAs. An estimated 1,005 licensed PAs work in the state, a number that has climbed with every survey the UMEC has conducted.

In addition to high growth, Utah also benefits from the distribution of PAs across the state. While there are communities and counties lacking PAs, the rural to urban split within the profession closely resembles that of the general population. If Utah continues to train Utah students from rural backgrounds, rural populations are more likely to benefit from a PA in their communities.

The PA profession in Utah is also a younger workforce with a mean age of 41.8. Because of this, fewer PAs in Utah will be retiring in the near future, thereby decreasing the immediate need for replacement. However, retirement rates should be monitored as there could be a significant increase in the number of retiring PAs after 2030.

With the addition of the new PA program at the Rocky Mountain University for Health Professions in the state as well as an increase in the number of students at the University of Utah's PA program, Utah is poised to train a majority of the PAs we need in future years. This will decrease the need to import PAs from out of state and decrease the risk of not meeting demand. This is especially important as the number of individuals covered by health insurance, and therefore demand for healthcare professionals, rises across the nation.

POLICY RECOMMENDATIONS

1. **Promote a more diverse workforce.** Only 7.8% of the PA population in Utah identified as a racial or ethnic minority, compared to 21.8% of the general Utah population. The PA profession lags far behind the comparable APRN profession in Utah, which had 16% of its workforce identify as a racial or ethnic minority in 2013 (Utah Medical Education Council, 2013).
    a. Disseminate information regarding scholarships and loan repayment programs for minority PAs.
    b. Encourage local high schools and organizations such as United Way and the Department of Health to engage with minority populations to consider pursuing a career as a physician assistant.
2. **Continue to strengthen the rural workforce**. While the percentage of PAs choosing to work in rural settings has decreased slightly, the number in the rural workforce has gone up. However, the ratio of 30 rural PAs per 100,000 is still lower than urban populations at 34 PAs per 100,000.
    a. Support state funding for loan repayment programs for PAs who practice in rural communities.
    b. Encourage programs to target applicants who come from a rural background as they are more likely to practice in a rural setting after graduation.
3. **Enhance data collection.** The UMEC conducts periodic supply-side surveys in order to create a projection model for the future of the profession. This process would be greatly improved if the following recommendations were implemented:
    a. Develop a demand study for PAs by surveying employers, thereby creating a more nuanced projection model.
    b. Partner with DOPL in order to incorporate UMEC's PA survey into the licensing process.
    c. Develop and maintain a database of Utah residents who moved out of state to attend PA training programs in order to recruit them back to Utah.
    d. Closely monitor the retention rate of the upcoming RMUPAP graduates.
4. **Revise Utah's Physician Assistant Practice Act Rule.** While Utah's PA scope of practice laws are more flexible than many other states, improvements can be made by allowing practice sites to determine supervision ratios. Currently, practices can apply for a supervision ratio larger than 4 FTEs per 1 physician with extenuating circumstances.

Appendix A - Bibliography

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Appendix B – Survey Instrument

2014 Utah Medical Education Council

Physician Assistant Workforce Survey

Council Members

Utah Medical Education Council

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Karl Torgerson, PA-C

Dear Physician Assistant,

This survey is a collaborative effort of the Utah Medical Education Council, the Utah Department of Health and The Utah Academy of Physician Assistants with the cooperation of the Division of Occupational and Professional Licensing.

The purpose of this survey is to measure the adequacy of Utah's PA workforce and to make projections of capacity and future need. The data will be compared to survey data the UMEC has collected on Utah's Physicians and APRNs to evaluate the mix of health care professionals in the state.

We recognize that some of the information requested is private or proprietary in nature. The information collected will remain strictly confidential. Only de-identified, aggregate data will be published. For any questions regarding this survey please contact the UMEC at 801-526-4564.

It is very important that you complete this survey. In order to compile an accurate representation, we have specifically chosen your county for this mailing.

Please return the completed survey to the UMEC within 30 days of receipt in the enclosed postage paid envelope.

Thank you for your valuable time and participation.

Richard Campbell
Executive Director
Utah Medical
Education Council

Vicki Berger PA-C
President
Utah Association of Physician
Assistants

Utah Medical Education Council ● 230 S. 500 E. Ste. 210, Salt Lake City, Utah, 84102
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1. Do you provide any health care services in Utah? ☐ YES ☐NO
   a. **If NO, please specify why you maintain a Utah license:** _____

   b. **If NO, on a scale of 1-5 (1 being the most influential and 5 being the least influential), please rank the individual factors that have influenced your choice to work outside of Utah:**

Family _____ Wage/Pay scale _____ Climate _____
Lifestyle _____ Work Environment _____ Other (specify)_____

IF YOU DO NOT PROVIDE PROFESSIONAL SERVICES IN UTAH, PLEASE STOP NOW AND RETURN THIS SURVEY

SECTION 1: GENERAL INFORMATION, BACKGROUND AND EDUCATION

2. **What is your primary work status? (**please check **one** of the following)
   ☐ Active Full Time ☐ Retired
   ☐ Active Part Time ☐ Other (specify) _____

3. **On a scale of 1-5 (1 being the most influential and 5 being the least influential), please rank the following factors that have influenced your choice to practice in Utah:**
   Family in Utah:_____ Practice Environment:_____ Lifestyle:_____ Utah Graduate_____

   Military:_____ Practice Opportunities:_____ Other :_____ (Specify other): _____

4. **What is your gender?** ☐ Male ☐Female **(a) Age: _____** years

5. **Please describe the city/town where you spent the majority of your upbringing:**
   ☐ Rural ☐ Suburban ☐ Urban State: _____ Zip Code: _____

6. **Are you of Hispanic ethnicity?** ☐ YES ☐NO
   a. **What is your race?**
   ☐ Caucasian ☐ American Indian ☐ Asian
   ☐ African American ☐ Pacific Islander ☐ Other (please specify)_____

7. **What is your highest Physician Assistant degree attained?**
   ☐ Associate degree ☐ Master's degree
   ☐ Bachelor's degree ☐ Doctoral degree ☐ Other _____

   a. **In what state was the degree conferred?**
   State: _____ Year of degree: _____ Check one that applies:☐ State School ☐Private School

   b. **What was your total educational debt for your PA schooling at the time of graduation?** $_____

SECTION 3: YOUR WORK SETTING/ SPECIALTY

8. **Please indicate the practice Name, City, and Zip Code,** of your primary practice setting and secondary practice setting *(if applicable)* Also, please estimate the **total hours worked per week** *(not including on-call)* at each practice location.

Primary Practice Name:_____ City_____ Zip: _____ Total Hours/wk: _____
Secondary Practice Name:_____ City_____ Zip: _____ Total Hours/wk: _____

9. **Please enter a code from the list below to describe your Primary _____ and Secondary _____ practice settings:**

01= Critical access hospital
02= Hospital emergency room
03= Hospital operating room
04= Inpatient unit of hospital (not ICU/CCU)
05= ICU/CCU of hospital
06= Outpatient unit of hospital
07= Other unit of hospital
08= Solo practice physician office
09= Single-specialty physician group practice
10= Multi-specialty physician group practice
11= Community Health Center/Facility
12= Certified Rural Health Clinic
13= Federally Qualified Health Center
14= Freestanding surgical facility
15= Freestanding urgent care facility
16= Other freestanding outpatient facility
17=School-based health facility
18= University/college student health facility
19= Correctional facility
20= HMO facility
21= Industrial facility/work site
22= Mobile health unit
23= Nursing home or LTC facility
24= Patients' homes
25= Retail outlet (e.g. MinuteClinic)
26= Other_____

10. **Have you voluntarily switched employers/practices within the past two years?** ☐ YES ☐NO
    a. **If YES, please use the list of settings above to indicate the work setting you left and the work setting you moved to:**
    Setting Code Left: _____ Setting Code Moved To: _____

10. b. If you have changed work settings within the past two years, please check the reason(s) for this change of work setting. *(select all that apply)*:

☐ Higher Pay ☐ Preferred hours ☐ Moved ☐ More Challenging ☐Personal/Family Reasons
☐ Professional Advancement ☐ Work Responsibilities ☐ Better Work/Education Fit ☐ Desire for Change ☐ Other _____

11. What percentage of time during a typical clinic week do you interface with a supervising physician? _____

12. What is the primary supervisory relationship tool used between you and your supervising physician?
☐ Face to Face ☐Telephone ☐ Text Message ☐Email ☐ Other _____

13. Please enter the code from the list below which most closely resembles your:
Primary specialty: _____ Secondary specialty: _____

1 = Addiction Medicine
2 = Allergy
3 = Anesthesiology
4 = Dermatology
5 = Emergency Medicine
6 = Family Medicine
7 = Family Medicine with Urgent Care
8 = Genetics
9 = Geriatrics
10 = Hospice & Palliative Care
11 = Obstetrics/Gynecology
12 = Occupational Medicine
13 = Orthopedics
14 = Ophthalmology
15 = Pain Management
16 = Pathology
17 = Physical Medicine/Rehabilitation
18 = Psychiatry
19 = Public Health
20 = Radiation Oncology
21 = Diagnostic Radiology
22 = Interventional Cardiology
23 = Interventional Radiology
24 = Hospital Medicine
25 = Surg: General
26 = Surg: Cardiovascular/Cardiothoracic
27 = Surg: Colon & Rectal
28 = Surg: Hand
29 = Surg: Neurological
30 = Surg: Oncology
31 = Surg: Otolaryngology
32 = Surg: Pediatric
33 = Surg: Plastic
34 = Surg: Thoracic
35 = Surg: Transplant
36 = Surg: Trauma
37 = Surg: Urology
38 = Surg: Vascular
39 = Surg: Bariatric
40 = Surg: Other
41 = Ped: General
42 = Ped: Adolescent Medicine
43 = Ped: Allergy
44 = Ped: Cardiology
45 = Ped: Critlcal Care
46 = Ped: Endocrinology
47 = Ped: Gastroenterology
48 = Ped: Hematology
49 = Ped: Infectious Disease
50 = Ped: Neonatal-Perinatal
51 = Ped: Nephrology
52 = Ped: Neurology
53 = Ped: Pulmonology
54 = Ped: Rheumatology
55 = Ped: Oncology
56 = Ped: Emergency medicine
57 = Ped: Other
58 = IM: General
59 = IM: Cardiology
60 = IM: Critical Care
61 = IM: Endocrinology
62 = IM: Gastroenterology
63 = IM: Hematology
64 = IM: Immunology
65 = IM: Infectious Disease
66 = IM: Nephrology
67 = IM: Neurology
68 = IM: Pulmonology
69 = IM: Rheumatology
70 = IM: Oncology
71 = IM: Other

SECTION 4: YOUR PRACTICE

14. In a typical day, how many patients do you see per hour?

Primary Practice: _____ pts./ hr. Secondary Practice: _____ pts./hr.

15. Do you use telemedicine in your practice? ☐ YES ☐NO

a. **If YES, How many times have you ☐been referred _____ / ☐referred _____ a patient for a telemedicine consultation in the last six months? (*please check and indicate all that apply)***

b. **If YES, What types of things do you most commonly use Telemedicine for? (*check all that apply):***
☐ Second Opinion ☐ Diagnosis ☐ Follow-up ☐ Emergency ☐ Chronic Disease Management

c. **Which healthcare professionals (*excluding your supervising physician*) do you ☐consult for/ ☐receive consultation from using telemedicine? (*check all that apply):***
☐ Primary Care Physician ☐ Specialty Care Physician ☐ Other PA ☐ APRN ☐ Other_____

16. Please indicate the approximate number of hours you spend providing DIRECT PATIENT CARE each week, including charting, but excluding the hours spent providing patient care combined with teaching or training of other PAs*: (**unless all of the hours you work each week are spent in direct patient care without any teaching or training of other PAs, this should be less than the number of hours reported previously in question 8).*

Primary Practice_____ hrs./wk Secondary Practice_____ hrs./wk

a. **If you provide direct patient care, please indicate what PERCENT of the hours you spend with patients is dedicated to the following types of care:**

	Preventative Care	Acute Care	Chronic Care
Primary Practice:	_____	_____	_____
Secondary Practice:	_____	_____	_____

17. In providing direct patient care, do you work in a multidisciplinary care team? ☐ YES ☐NO

a. **If *YES*, which health care professionals *(not including your supervisory physician)* do you work with in providing different types of care? (Check all that apply)**

		Primary Care Physician	Specialist Physician	Other PA	APRN	Other
Diagnosis/ Treatment of: -	Acute Illness	☐	☐	☐	☐	_____
	Chronic Illness	☐	☐	☐	☐	_____
	Counseling	☐	☐	☐	☐	_____
	Disease Prevention	☐	☐	☐	☐	_____
	Health Maintenance	☐	☐	☐	☐	_____
	Health Promotion	☐	☐	☐	☐	_____
	Patient Education	☐	☐	☐	☐	_____
	Rehabilitation	☐	☐	☐	☐	_____
	Routine Care	☐	☐	☐	☐	_____
	Undifferentiated Care	☐	☐	☐	☐	_____
	Other_____	☐	☐	☐	☐	_____

18. Please indicate the average hours per week you spend in the following <u>NON-PATIENT CARE</u> activities:
(The total number of hours distributed between non-patient care activities should not exceed the number of hours left over after the hours reported being spent in direct patient care per week in question 15 are subtracted from the total number of hours worked per week reported in question 8).

NON-PATIENT ACTIVITY	Hrs./Wk. PRIMARY SITE	Hrs./Wk. SECONDARY SITE
a. Classroom Training of PAs or other Professionals (Clinical and/or classroom teaching of students without patient care)	_____	_____
b. Combined Patient Care with Teaching or Training of other PAs (Supervising or training of residents/ students while delivering patient care)	_____	_____
c. Administration/ Management (planning, budgeting, personnel management, NOT in support of patient care)	_____	_____
d. Practice Management (budgeting, personnel management in order to maintain operation of a practice)	_____	_____
e. Consulting/ Research (Reports, applications, surveys, etc., NOT in support of patient care)	_____	_____
f. **Other: _____** (NOT in support of patient care)	_____	_____

19. Please indicate the percentage of your patients who fall within the following age groups: (total should equal 100%)

Primary Practice:	0-19 yrs._____%	20-64 yrs._____%	65-84 yrs._____%	85+ yrs._____%	Total (100%)
Secondary Practice:	0-19 yrs._____%	20-64 yrs._____%	65-84 yrs._____%	85+ yrs._____%	Total (100%)

20. What percentage of your patients are: Male_____ %, Female _____%

21. Please indicate the percentage of your patients that fall within each payer group: (total should equal 100%)

	Primary Loc.	**Secondary Loc.**		**Primary Loc.**	**Secondary Loc.**
Medicaid	_____%	_____%	TriCare (Champus)	_____%	_____%
Medicare	_____%	_____%	Workers Comp	_____%	_____%
Managed Care	_____%	_____%	Charity	_____%	_____%
Private Ins.	_____%	_____%	Self-Pay/Uninsured	_____%	_____%

22. Do you (or your staff) provide services in any languages OTHER than English? ☐ YES ☐NO

a. **If <u>YES</u>, please specify the language(s): _____ _____ _____**

23. Please indicate the status of your primary and secondary practice location(s).

	Primary Practice	**Secondary Practice**
<u>Full</u> (practice cannot accept additional patients)	☐	☐
<u>Nearly Full</u> (practice can accept a limited number of new patients)	☐	☐
<u>Unfilled</u> (practice can accept many new patients – practice far from full)	☐	☐
<u>N/A</u> (practice site is VA, military, or corrections)	☐	☐

24. If your practice is not full, from which payer types are you accepting additional patients?

Primary Location:	☐ N/A	☐ Medicaid	☐ Medicare	☐ Self-Pay/Uninsured	☐ Other Insured	☐ Not accepting
Secondary Location:	☐ N/A	☐ Medicaid	☐ Medicare	☐ Self-Pay/Uninsured	☐ Other Insured	☐ Not accepting

25. On average, how many days must patients wait for an appointment?

Primary Practice: **New Patients**: _____days **Established Patients**: _____days

Secondary Practice: **New Patients**: _____days **Established Patients**: _____days

26. Do you provide charity care? ☐ YES ☐NO (charity does not include write-offs)

a. **If YES, In Utah: $** _____ per year **Outside Utah: $** _____ per year

b. If In Utah, for whom do you provide charity care?

☐ Children only ☐ Any person in need ☐ Any person in need ☐ Other :_____

SECTION 5: FINANCIAL OUTLOOK/ JOB SATISFACTION

27. What is your average gross compensation? (before taxes AND excluding benefits)

☐ Less than $50,000	☐ $70,000-$79,999	☐ $100,000-$109,999	☐ $130,000-$139,999
☐ $50,000-$59,999	☐ $80,000-$89,999	☐ $110,000-$119,999	☐ $140,000-$149,999
☐ $60,000-$69,999	☐ $90,000-$99,999	☐ $120,000-$129,999	☐ $150,000 or more

28. Compared to five years ago, your gross income has:

☐ Increased by _____% ☐ Decreased by _____% ☐ Remained the same

29. Within the past two years, have you experienced any of the following: (check all that apply)

☐ Voluntary unemployment
☐ Switched employers/practices
☐ Worked part-time or temporary positions, but would have preferred a full-time or permanent position
☐ Involuntary unemployment
☐ Worked two or more positions at the same time
☐ Switched practice specialty

30. At what age are you planning to retire completely from practicing? _____ yrs. old

31. Are you planning to reduce the number of hours you work before you retire? ☐ YES ☐NO

a. **If *YES***, how many hours per week will you work after this reduction in hours? _____hrs. /wk.

b. If YES, How many years from now do you intend to reduce your hours? _____ yrs.

32. Compared to last year at this time, how has your workload changed?

☐ Increased by _____% ☐ Decreased by _____% ☐ Remained the same

33. Overall, and taking into account all positions you fill, how satisfied are you with your *current* employment or work situation?

☐ Very satisfied ☐ Somewhat satisfied ☐ Somewhat dissatisfied ☐Very dissatisfied

SECTION 5: PRODUCTIVITY

If necessary, please work with administrative staff to answer these questions.
Efforts made to provide complete information will be invaluable in providing new insight into how PAs actually contribute to providing for the healthcare needs of Utah's population.

34. Please indicate *(if known)* how many of the following medical professionals are employed at your primary work setting.

Physicians:_____ APRNs:_____ Other PAs:_____

35. In your primary work setting, what percent of your practice's total RVUs do you generate annually? (indicate if n/a) _____

***36.* In your primary work setting, what is your patient panel size? (indicate if n/a) _____**
(Panel size is defined as the total number of individual patients assigned to your care).

***a.* Over what time frame is your patient panel size calculated?** ☐ Over 12 months ☐Over 18 months

***b.* What percentage of your patient panel is** (please total to 100%)**:**

Shared with another provider_____ Assigned solely to you _____ Referred to you from another provider _____

Thank You for Your Time. Please Return the Survey Using the Enclosed Prepaid Return Envelope

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