PAs Practicing in Emergency Medicine and Urgent Care: 2021 Survey Results

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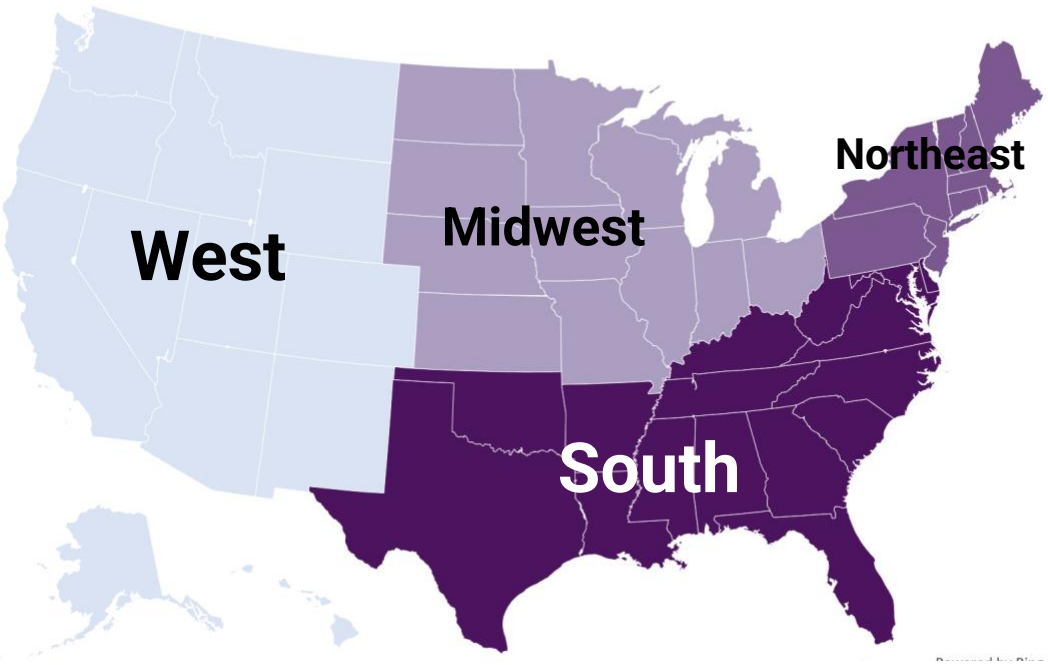
Executive Summary and Key Findings

Physician assistants (PAs) practicing in the Emergency Medicine (EM) discipline and Urgent Care (UC) practice setting significantly contribute to the U.S. health care delivery capacity. In a collaborative effort, the National Commission on Certification of Physician Assistants (NCCPA) and the Society of Emergency Medicine Physician Assistants (SEMPA) conducted a national cross-sectional online survey of PAs practicing in EM and UC. This endeavor aimed to repeat our prior joint report from 2009 and obtain updated information to quantify the characteristics of PAs in EM and UC and the vital roles they play in U.S. healthcare. The survey assessed the following primary domains: 1) education and training characteristics; 2) attributes of positions; 3) cases seen and routine tasks performed; 4) professional benefits and compensation; and 5) importance of factors related to being a PA. In addition to descriptive results, this report presents detailed findings evaluating potential differences in responses to questions covering each of the abovementioned topic areas by gender, U.S. region, and the number of years certified.

Figure 1 illustrates the breakdown of U.S. states and the regions that were used in the examination of potential differences in responses to the questions in the survey. One-third of participants were from the South (33.7%), followed by the Northeast (23.4%), Midwest (22.0%), and West (20.9%).

Figure 1. U.S. states and their regions



Education and Training Characteristics

In terms of education, three-quarters of PAs reported receiving a master's degree upon completing their entry-level PA program. Almost a third (31.8%) said they obtained a Master of Science in Physician Assistant studies in addition to their entry-level PA degree, and 9.0% completed an EM/UC PA residency/fellowship program. Of those who completed residency/fellowship, more than a third (38.2%) indicated practicing as a PA before entering residency/fellowship, with 3-5 years being the most frequent response for years practicing before starting. Most found PA residency/fellowship "extremely valuable" and received a pay increase following program completion. We found a multitude of differences in education and training by PA characteristics. For example, female PAs, those certified for 10 or fewer years, and PAs in the Midwest were more likely to complete a master's degree. Male PAs and those certified for 10 or fewer years had the highest proportions of confirming to have completed PA residency/fellowship.

PA Position Attributes

Most participants reported that they are full-time staff PAs in either non-academic or academic teaching hospitals working primarily in the main emergency department (ED) or main ED and fast track. More than a third (39.2%) identified that the area in which their principal clinical position is located is an urban setting, followed by 35.1% who said suburban and 20% rural. The vast majority of PAs reported being employed by either a multi-site EM group or hospital/ healthcare system. A quarter of PAs cited being in a leadership/administrative position. Over a third felt that they are a decision-maker or key influencer when decisions are made regarding equipment, supplies, and medications in their practice. Slightly more than 15% indicated that their employer requires taking call. The mean and median days of call per month were 3.5 and 2.0, respectively. Approximately 44% currently work with physician residents. Of these, over half reported that they staff both the same and different areas as physician residents in their position. In terms of differences in position attributes, males, PAs certified for 11 to 20 years, and those from the West U.S. region were more likely to be lead/supervising PAs. Female PAs, those certified for 21 years or longer and from the Northeast, had the highest proportions of reporting to practice in an academic/teaching hospital. Compared to females, male PAs were more likely to report practicing in a rural setting and be in a leadership/administrative position.

Cases Seen and Routine Tasks Performed

Over half (53.0%) stated routinely treating high (ESI 1-2) followed by medium (ESI 2-3) patients (43.6%). In terms of requirements for presenting patients to collaborating/supervising physician, a third said that there are only guidelines but no established regulations, while 37.2% indicated that there are no requirements. The majority of PAs performed the following basic procedures daily: diagnostics (i.e., basic laboratory interpretation, slit lamp exam, EKG interpretation; 96.0%), initial radiographic interpretation (i.e., X-rays, plain films; 89.8%), wound care management (78.4%), and therapeutic procedures (i.e., fracture, dislocation, or epistaxis management; 64.7%). Almost 22% of participants performed basic hemodynamic techniques (i.e., peripheral IV access, EJ access, I/O access) daily. Our data showed that PAs performed basic invasive airway management (i.e., intubation, mechanical ventilation, capnography, non-

invasive airway management) and anesthesia (i.e., procedural anesthesia, conscious sedation) less often. Regarding advanced procedures, PAs cited performing advanced radiographic interpretation (i.e., initial read of CT scans, ultrasound, MR; 24.6%) daily, wound management (i.e., wound debridement, wound closure; 27.0%) monthly, lumbar puncture (44.2%), resuscitation (i.e., trauma/major medical, cardiac arrests, etc.; 30.2%), paracentesis (25.6%), ultrasound-guided procedures (25.1%), and diagnostic ultrasound (17.8%) a few times per year. Almost three-quarters of PAs said they never perform thoracentesis (74.8%). Analyzing cases seen and procedures performed by PA characteristics, a consistent pattern emerged in that PAs certified the longest (21 or more years), and males were more likely to perform many of the basic and advanced procedures more frequently. Given that male PAs are older than female PAs on average in the PA profession, more in-depth analyses of these findings are needed to see if the pattern remains after controlling for age.

Professional Benefits and Compensation

In terms of total income from principal position in the previous year, over 64% of PAs earned more than $120,000. The highest proportion of PAs (15.6%) selected that their income was $120,001 - $130,000, followed by $130,000 - $140,000 (13.3%). Many PAs reported that they receive a bonus (54.0%), holiday (50.6%), night rate (45.3%), and overtime (42.2%) pay; however, fewer indicated that they receive evening rate (18.8%), weekend (14.9%), and on-call pay (14.3%). Regarding employer benefits, almost half of participants stated that their health (45.9%) and dental insurance (44.9%) are partially covered by their employer. Most PAs reported that they receive malpractice insurance in full (92.1%), while about a third receive short-term disability (37.7%), long-term disability (31.5%), and life insurance (32.3%) in full. More than half of survey participants (55.6%) reported that they receive vacation leave, while fewer receive sick leave (45.3%) and holiday paid time off (21.5%). Over a third of PAs acknowledged that their employer makes contributions to 401K/403(b), including match dollar-for-dollar (34.6%), retirement fund (38.5%), and specific dollar amount (37.0%). Fewer cited profit share (18.8%) and pension (15.1%). When parsing income by PA characteristics, our analyses revealed that male PAs compared to females, were more likely to earn over $120,000 (77.3% vs. 54.2%). PAs certified for 21 or more years and those certified for 11 to 20 years were more likely to earn over $120,000 than those certified 10 or fewer years (72.2% vs. 70.1% vs. 56.6%). Regarding differences in earning over $120,000 by U.S. regions, PAs in the West had the highest proportion (73.5%), followed by Northeast (65.5%), South (62.7%), and Midwest (55.2%).

Importance of Factors Related to Being a PA

The top factors rated as extremely important for PAs were managing work and life balance (69.4%), followed by keeping a job (60.0%), developing/maintaining a strong PA/physician relationship (58.9%), managing work stress (53.6%), and establishing/maintaining their position/role within their current work setting (41.9%). Fewer PAs rated finding a job (33.7%), starting their career (29.4%), having enough employer funds for CME (23.1%), and earning CME (22.4%) as extremely important. The factors rated least important included advocacy/legislative issues, dealing with state regulatory issues, dealing with practice policies, and obtaining

practice resources. Female PAs compared to males and those certified for 10 or fewer years compared to the other certification year groups were more likely to rate managing work and life balance, managing work stress, finding a job, and starting a career as extremely important.

Introduction and Background

Purpose of the Report

Physician assistants (PAs) practicing in the Emergency Medicine (EM) discipline and Urgent Care (UC) practice setting substantially contribute to health care in the US, enhance access to care, and render high-quality clinical service. In a collaborative effort, the National Commission on Certification of Physician Assistants (NCCPA) and the Society of Emergency Medicine Physician Assistants (SEMPA) conducted a national cross-sectional online survey of PAs practicing in EM and UC. This endeavor aimed to repeat our prior joint report from 2009. Given the changes in U.S. health care since 2009 and the growing number of PAs choosing to practice in EM and UC, we sought to obtain updated information to quantify the characteristics of PAs practicing in these areas and help delineate their contributions to U.S. healthcare. The survey examines the following primary topic areas: 1) education and training characteristics; 2) attributes of positions; 3) cases seen and routine tasks performed; 4) professional benefits and compensation; and 5) importance of factors related to being a PA. In addition to descriptive results, this report presents detailed findings evaluating potential differences in responses to questions covering each of the abovementioned domains by gender, U.S. region, and the number of years certified. Our findings may be useful and of interest to PAs practicing in EM and UC, other PAs interested in these disciplines, policymakers, workforce planners, health system leadership, as well as others.

General Overview of the Survey

Discussions between NCCPA and SEMPA concerning the objectives of the study and planning occurred throughout 2021. The content of this survey was based on prior 2008 and 2016 versions administered to PAs in EM. Questions from the 2016 survey were iteratively modified, and new ones were added. The draft survey was finalized by late August and piloted with PAs practicing in EM along with representatives from NCCPA and SEMPA. The survey instrument contained closed-ended items whereby the response choices were provided, as well as open-ended questions where PAs could write in a response. The survey was administered through the Qualtrics online survey platform. The recipient population was based on the information contained in NCCPA's database, as well as the information PAs provided when completing their NCCPA PA Professional Profile. The selection criteria included PAs who were certified as of August 31, 2021, confirmed they worked in EM in their principal or secondary clinical position, or reported to practice in the UC setting. PAs were excluded from the survey if they had previously opted out from receiving surveys from NCCPA or if they had an invalid email noted in their record. This resulted in 16,373 PAs fitting inclusion criteria for participation. The NCCPA/SEMPA survey was launched on September 9, 2021, and closed on October 13, 2021. The survey was disseminated to 16,373 PAs; however, 355 emails were undeliverable, resulting in 16,018 being successfully delivered with the invitation to participate and a unique survey link.

Of the 16,018 who received the invitation, 1,876 PAs participated for a response rate of 11.7%. After excluding PAs that reported not practicing clinically and not currently practicing in EM or UC in principal or secondary position, the final analytical sample size was 1,830. When compared to the overall national population of Certified PAs practicing in the discipline of EM or UC setting, our sample was representative in terms of key characteristics, including gender, years certified, and U.S. region (see Table 1). In addition to descriptive statistics (counts, percentages, means, and medians), we conducted Chi-square tests for independence, Fisher-Freeman-Halton Exact tests, Mann-Whitney tests, and Kruskal Wallis tests, as appropriate, exploring if there were statistically significant differences by gender, U.S. region, and years certified on 1) education and training characteristics; 2) attributes of positions; 3) cases seen and routine tasks performed; 4) professional benefits and compensation; and 5) importance of factors related to being a PA. Statistically significant findings from Kruskal Wallis tests were followed up with pairwise tests with Bonferroni correction for multiple testing.

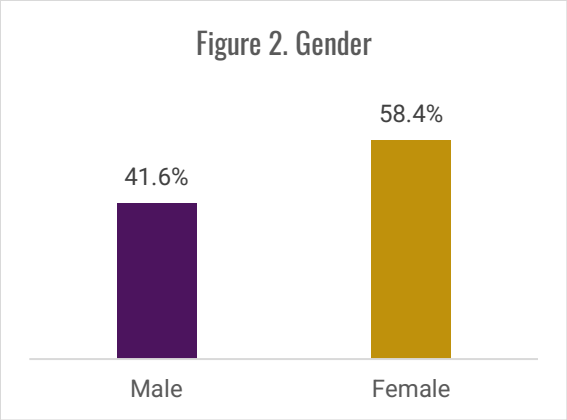
Table 1. Key Characteristics Comparing 2021 PA Professional Profile Data of PAs in EM and UC and NCCPA/SEMPA Survey PA Participant Data

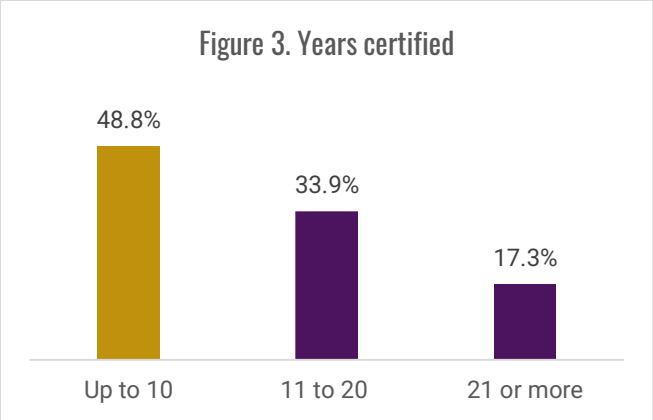
		2021 NCCPA data	Survey participant data
Gender	Male	39.2%	41.6%
	Female	60.8%	58.4%
Years Certified	Up to 10	54.6%	48.8%
	11 to 20	30.1%	33.9%
	21+	15.3%	17.3%
U.S. Region	Midwest	19.9%	22.0%
	Northeast	24.6%	23.4%
	South	34.2%	33.7%
	West	21.3%	17.3%

NCCPA/SEMPA Survey Results

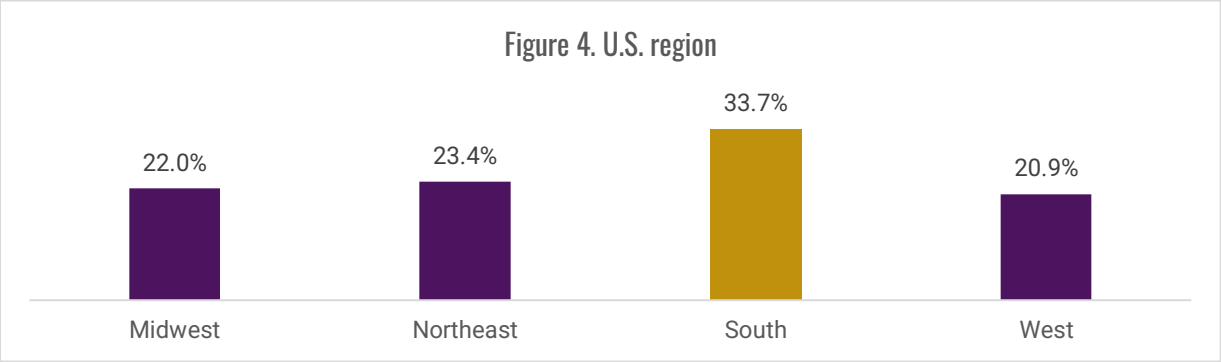
Participant Demographic Characteristics

We first present PA survey participant characteristics. As can be seen in Figures 2 and 3, a slight majority were female (58.4%), with almost half (48.8%) certified for 10 or fewer years.

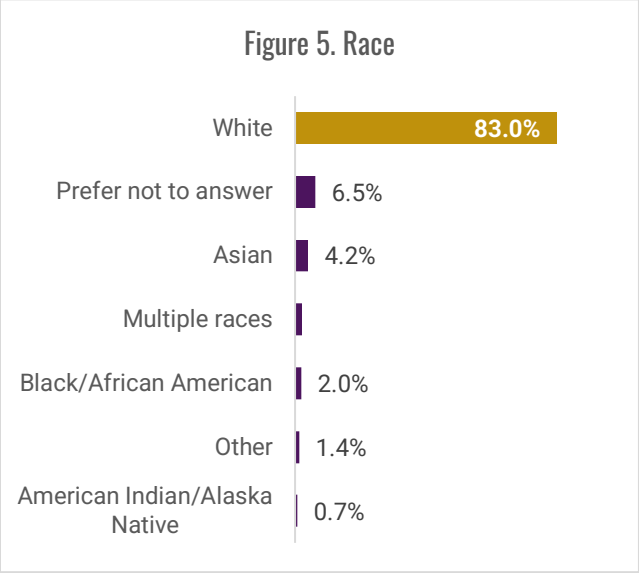


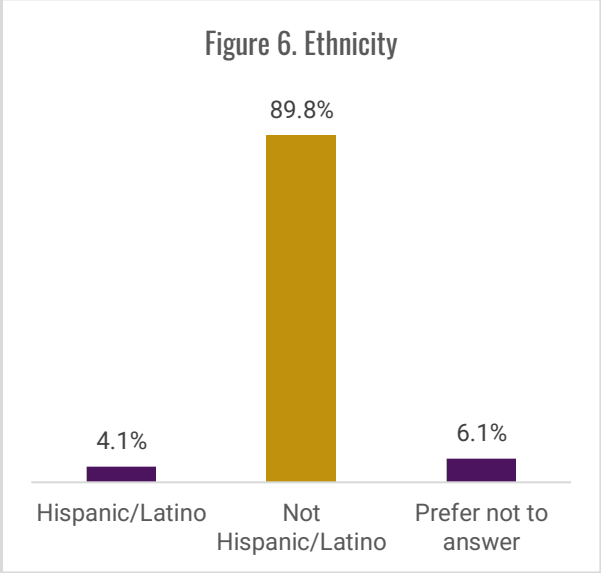


In terms of U.S. regions, about a third (33.7%) of PA participants reside in the South, followed by Northeast (23.4%), Midwest (22.0%), and West (20.9%; Figure 4).



Regarding race, the majority of survey participants (83.0%) were white, while 4.2% were Asian and 2.0% were Black/African American (Figure 5). Figure 6 illustrates that 4.1% were Hispanic/Latino.





Education and Training Characteristics

Degree upon Completion of Entry-Level PA Program

PAs were inquired about what degree they received upon completion of their entry-level PA program. The majority (74.5%) identified that they completed a master's degree, followed by a bachelor's degree (17.5%) and certificate (5.2%; Figure 7). When this question was analyzed by demographics/years certified, we found statistically significant differences by gender, years certified, and U.S. region (all p<0.001). Females were more likely to earn a master's degree (82.3% vs. 63.5%). In comparison, males had a higher likelihood of earning a bachelor's degree (24.8% vs. 12.3%), certificate (7.2% vs. 3.7%), and an associate's degree (3.5% vs. 1.1%; Figure 8).

Figure 7. What degree did you receive upon completion of your entry-level PA program?

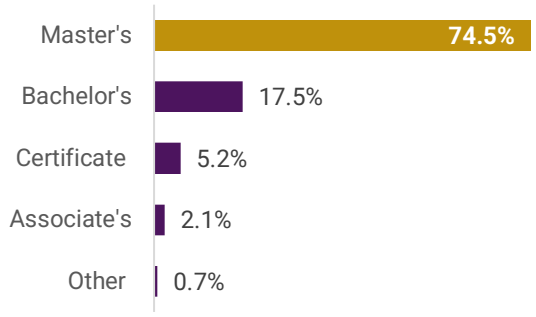
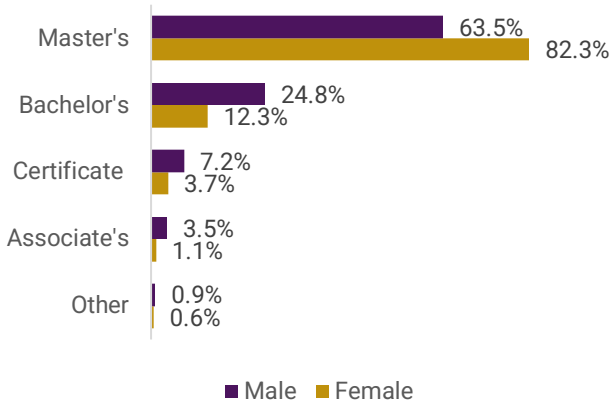
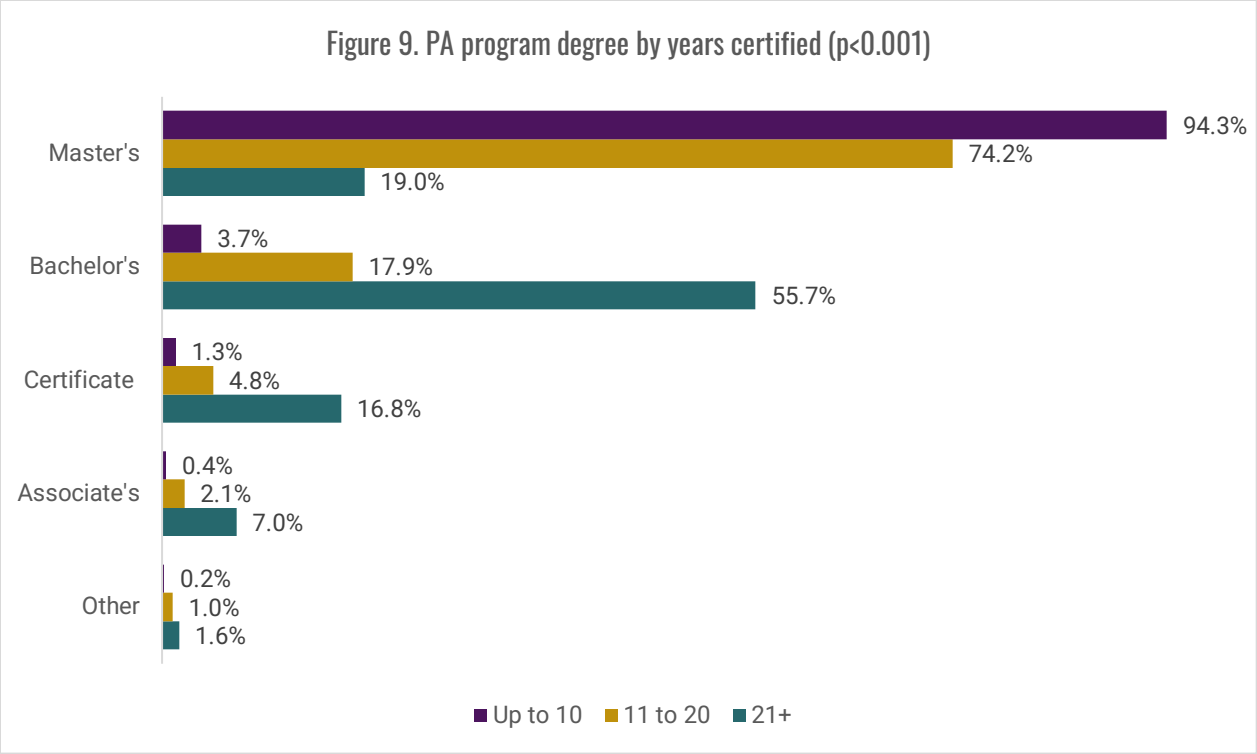


Figure 8. Degree by gender (p<0.001)

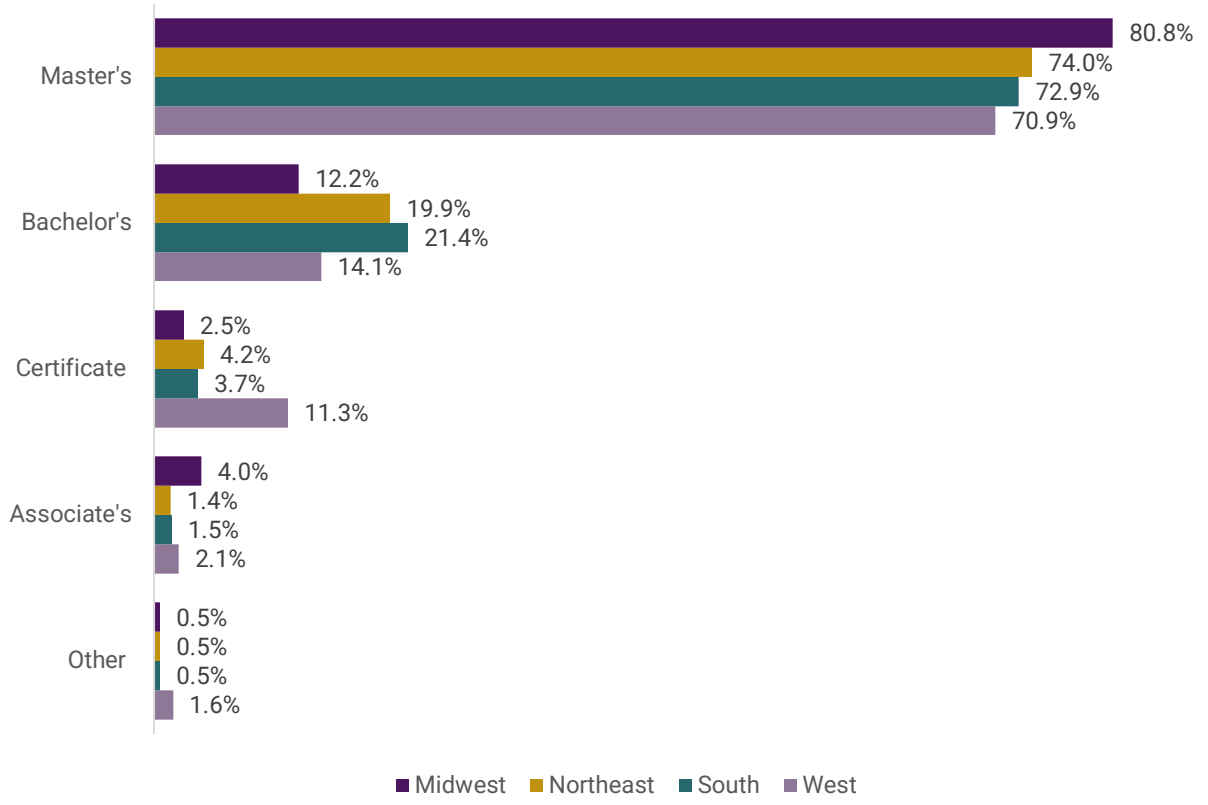


When it comes to years certified, PAs who were certified for up to 10 years versus the other certification year groups had a higher likelihood of completing a master's degree upon completing their entry-level PA program (Figure 9). PAs certified for 21 years or longer had the highest proportion of reporting to have earned a bachelor's degree, certificate, and associate's degree respondents certified for fewer years.



Compared to other U.S. regions, PAs residing in the Midwest had a higher likelihood of earning a master's degree. Participants living in the South had the highest proportion of marking that they completed a bachelor's degree while those in the West had the highest percentage of reporting to have a certificate (Figure 10).

Figure 10. PA program degree by U.S. region (p<0.001)



Postgraduate Educational Degree(s)

Figure 11 depicts the type(s) of postgraduate educational degree(s) that PAs obtained in addition to their entry-level PA program. A little less than half (43.6%) indicated that they did not obtain an additional degree, followed by Master of Science in Physician Assistant Studies (MSPAS; 31.8%), Master of Science (MS; 7.5%), and Master of Medical Science (MMSc; 7.1%).

Figure 11. What type(s) of postgraduate educational degree(s) did you obtain in addition to your entry-level PA program (check all that apply)?

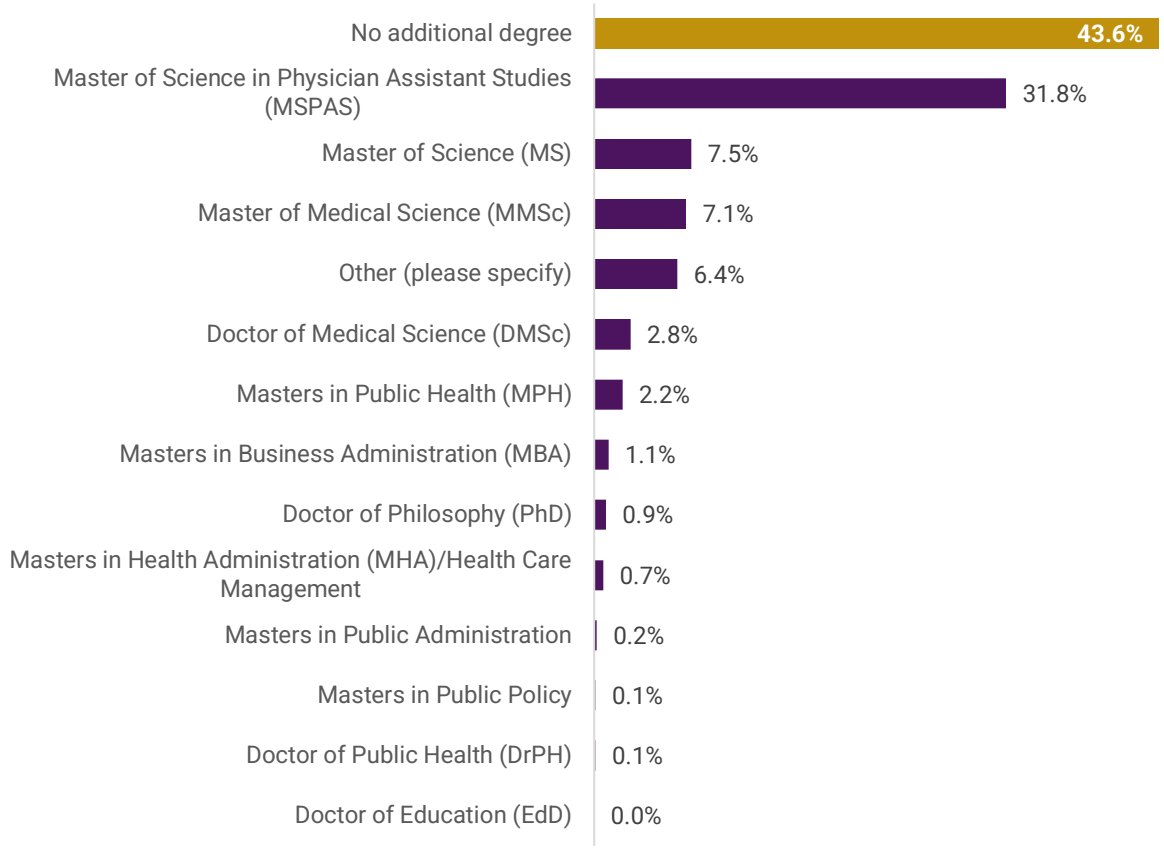


Table 2 depicts the postgraduate degree completed parsed by gender. Compared to males, females were more likely to have MSPAS (35.4% vs. 26.8%; p<0.001). Males were more likely to indicate other (9.5% vs. 4.2%; p<0.001), Doctor of Medical Science (DMSc; 4.7% vs. 1.5%; p<0.001), and Masters in Business Administration (MBA; 2.4% vs. 0.3%; p<0.001).

Table 2. Postgraduate Degree by Gender

Degree	Female	Male	p-value
Doctor of Education (EdD)	0.0%	0.0%	n/a*
Doctor of Public Health (DrPH)	0.1%	0.0%	n/a*
Masters in Public Policy	0.0%	0.1%	n/a*
Masters in Public Administration	0.1%	0.4%	0.314
Masters in Health Administration (MHA)/Health Care Management	0.9%	0.3%	0.138
Doctor of Philosophy (PhD)	0.9%	0.8%	0.738
Masters in Business Administration (MBA)	0.3%	2.4%	<0.001
Masters in Public Health (MPH)	2.6%	1.7%	0.193
Doctor of Medical Science (DMSc)	1.5%	4.7%	<0.001
Other	4.2%	9.5%	<0.001
Master of Medical Science (MMSc)	7.6%	6.3%	0.293

Master of Science (MS)	8.1%	6.8%	0.330
Master of Science in Physician Assistant Studies (MSPAS)	35.4%	26.8%	<0.001
No additional degree	41.9%	46.0%	0.079

**Statistical test could not be conducted due to small sample sizes*

The results presented in Table 3 reflect a detailed characterization of postgraduate degree by years certified. PAs who were certified for up to 10 years compared to those 11 to 20 and 21 or longer were more likely to attain MSPAS (36.8% vs. 30.3% and 20.9%; p<0.001). PAs certified for 21 years or longer had the highest proportion of indicating other (p=0.002) and no additional degree (p<0.001).

Table 3. Postgraduate Degree by Years Certified

Degree	Up to 10	11 to 20	21+	p-value
Doctor of Education (EdD)	0.0%	0.0%	0.0%	n/a*
Doctor of Public Health (DrPH)	0.0%	0.0%	0.3%	n/a*
Masters in Public Policy	0.0%	0.0%	0.3%	n/a*
Masters in Public Administration	0.1%	0.2%	0.6%	0.242**
Masters in Health Administration (MHA)/Health Care Management	0.4%	0.5%	1.6%	0.098**
Doctor of Philosophy (PhD)	0.7%	1.0%	1.3%	0.595
Masters in Business Administration (MBA)	0.8%	1.4%	1.6%	0.357
Masters in Public Health (MPH)	1.7%	3.1%	2.2%	0.205
Doctor of Medical Science (DMSc)	2.7%	3.5%	1.9%	0.334
Other	5.0%	6.1%	10.8%	0.002
Master of Medical Science (MMSc)	7.0%	7.6%	6.3%	0.772
Master of Science (MS)	8.4%	7.6%	5.1%	0.154
Master of Science in Physician Assistant Studies (MSPAS)	36.8%	30.3%	20.9%	<0.001
No additional degree	40.6%	43.2%	52.8%	<0.001

**Statistical test could not be conducted due to small sample sizes*
*** Fisher-Freeman-Halton Exact test*

Postgraduate degree type by U.S. region is shown in Table 4. PAs residing in the Midwest had the highest proportion of earning MSPAS (p=0.020), while those in the West were more likely to achieve MMSc (p=0.024). Those in the South and West had slightly higher proportions of completing a DMSc after their entry-level PA program (p=0.014) compared to PAs in Midwest and Northeast U.S. regions. Finally, PAs in the Northeast were more likely than PAs in all other U.S. regions to have an MBA (p=0.009).

Table 4. Postgraduate Degree by U.S. Region

Degree	Midwest	Northeast	South	West	p-value
Doctor of Education (EdD)	0.0%	0.0%	0.0%	0.0%	n/a*
Doctor of Public Health (DrPH)	0.0%	0.2%	0.0%	0.0%	n/a*
Masters in Public Policy	0.0%	0.0%	0.2%	0.0%	n/a*
Masters in Public Administration	0.0%	0.5%	0.3%	0.0%	0.454**
Masters in Health Administration (MHA)/Health Care Management	0.5%	1.2%	0.6%	0.3%	0.473**
Doctor of Philosophy (PhD)	1.2%	0.7%	1.1%	0.3%	0.399**
Masters in Business Administration (MBA)	0.5%	2.8%	0.8%	0.5%	0.009**
Masters in Public Health (MPH)	1.2%	2.1%	2.3%	3.4%	0.240

Doctor of Medical Science (DMSc)	1.0%	1.9%	3.9%	3.9%	0.014
Other	4.0%	6.1%	7.0%	8.4%	0.077
Master of Medical Science (MMSc)	6.0%	4.4%	8.1%	9.4%	0.024
Master of Science (MS)	8.7%	9.1%	6.8%	5.8%	0.210
Master of Science in Physician Assistant Studies (MSPAS)	38.1%	31.6%	29.4%	29.6%	0.020
No additional degree	41.5%	43.8%	45.9%	41.6%	0.444

**Statistical test could not be conducted due to small sample sizes*
*** Fisher-Freeman-Halton Exact test*

Emergency Medicine or Urgent Care PA Residency/Fellowship Program

In addition to postgraduate degree, survey participants were asked if they had completed an EM or UC PA residency/fellowship program. The majority (91.0%) identified that they had not completed a PA residency/fellowship (Figure 12). When completion of EM or UC PA residency/fellowship program was assessed by gender, we found that females were slightly less likely to complete a residency/fellowship program (7.8% vs. 10.8%; p=0.027; Figure 13).

Figure 12. Did you complete an emergency medicine or urgent care PA residency/fellowship program?

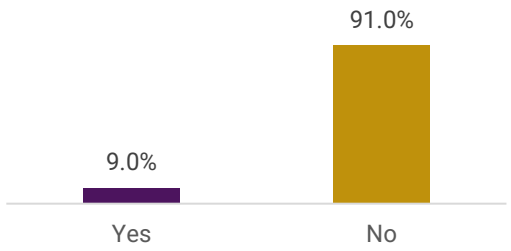
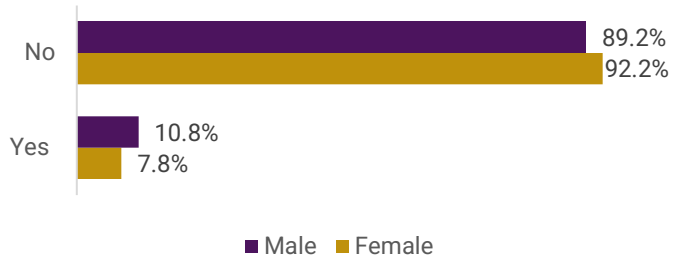
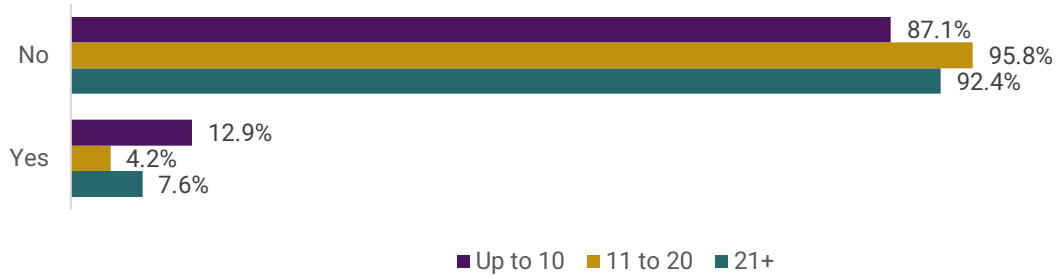


Figure 13. Completed PA residency/fellowship program by gender (p=0.027)



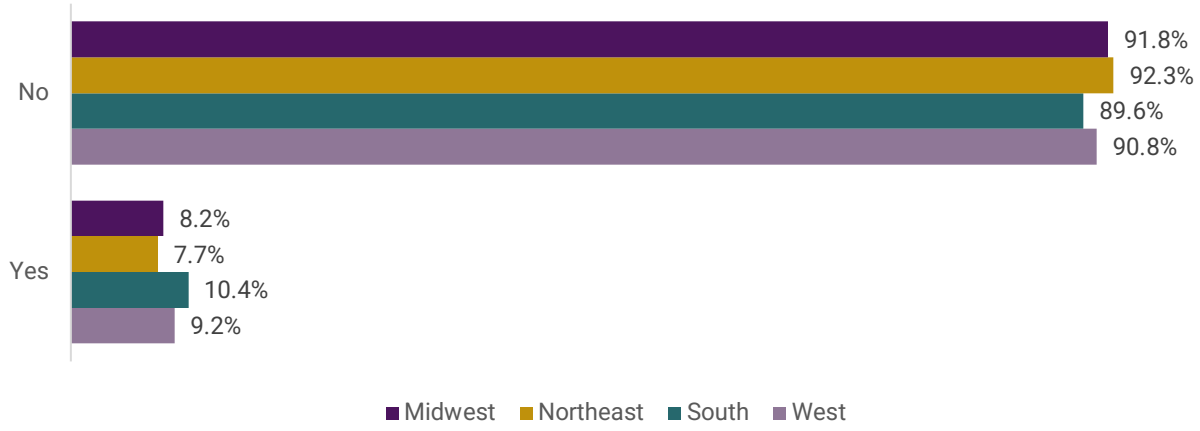
Regarding years certified, statistically significant differences were found (p<0.001) on the likelihood of completing a residency/fellowship. PAs certified up to 10 years vs. 11 to 20 and 21 or more years had the highest proportion of reporting to have completed a residency/fellowship program (12.9% vs. 4.2% and 7.6%; Figure 14).

Figure 14. Completed PA residency/fellowship program by years certified (p<0.001)



Differences were not found to be statistically significant on the likelihood of completing PA residency/fellowship by U.S. regions (p=0.457; Figure 15).

Figure 15. Completed PA residency/fellowship program by U.S. regions (p=0.457)



Duration of PA Residency/Fellowship Program

The following section focuses on PAs who have completed a residency/fellowship program in EM or UC. Of those who had completed a PA residency/fellowship program in EM or UC, 41.2% indicated that their program lasted for 12 months, 34.5% 18 months, and 24.2% "other"; Figure 16). In an open-ended text box available for explaining "other" as the answer choice, most responses were 6 months, 14 months, and 24 months. When the duration of the PA residency/fellowship program was assessed by gender, we did not find statistically significant differences (Figure 17; p=0.564).

Figure 16. What was the duration of your PA residency/fellowship program?

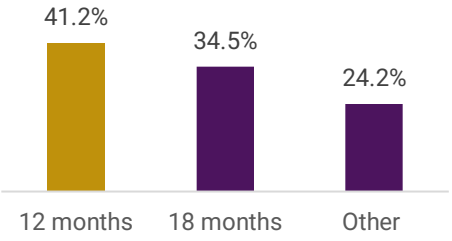
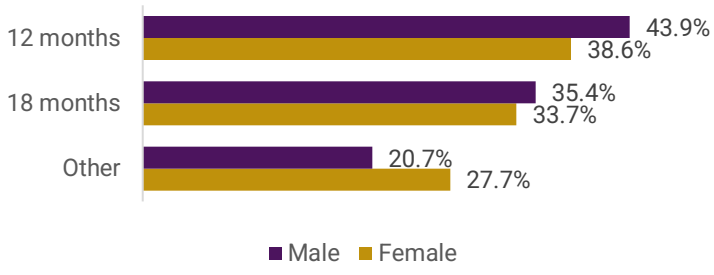


Figure 17. Duration of PA residency/fellowship program by gender (p=0.564)



We found a statistically significant relationship between years certified and the duration of the residency/fellowship program (p<0.001; Figure 18). Participants who were certified for 11 to 20 years had the highest proportion of completing the program in 18 months, while those who were certified for 21 years or more had the highest proportion of selecting "other".

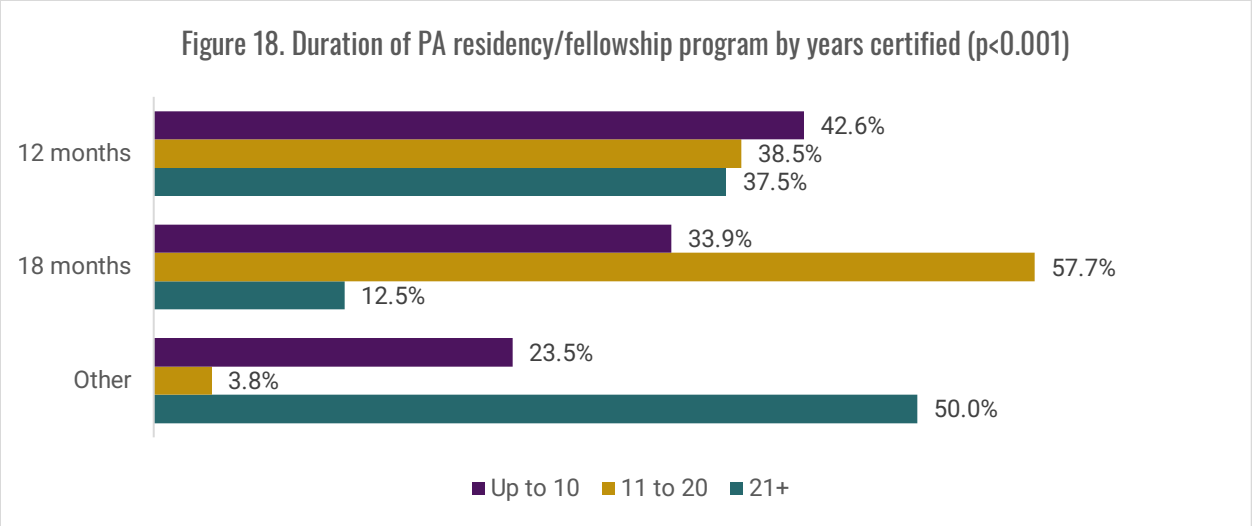
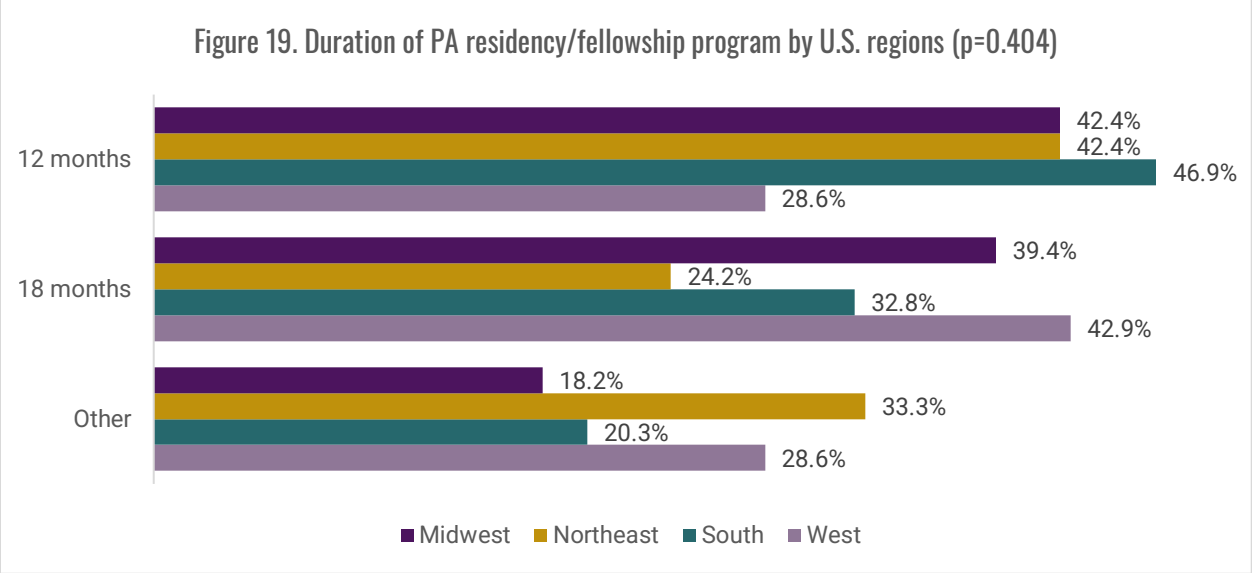


Figure 19 summarizes the relationship between the duration of residency/fellowship and U.S. regions. Although not statistically significant (p=0.404), PAs residing in the South had a slightly higher percentage of specifying that their PA residency/fellowship program lasted 12 months compared to the other regions.



Practicing as a PA Before Entering PA Residency/Fellowship Program

Of those who had completed a PA residency/fellowship program in EM or UC, 38.2% noted that they practiced as a PA before entering the program (Figure 20). When this question was parsed by demographics/years certified, we found statistically significant differences by gender (p<0.001), years certified (p<0.001), and U.S. regions (p=0.006). Males were more likely than females to practice as a PA before entering their residency/fellowship (56.1% vs. 20.5%; Figure 21).

Figure 20. Did you practice as a PA before entering your PA residency/fellowship program?

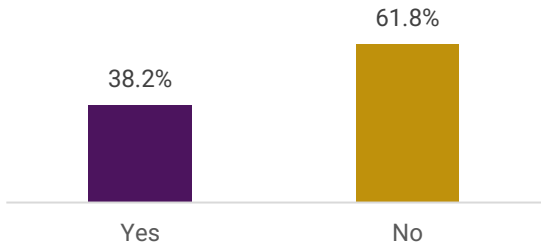
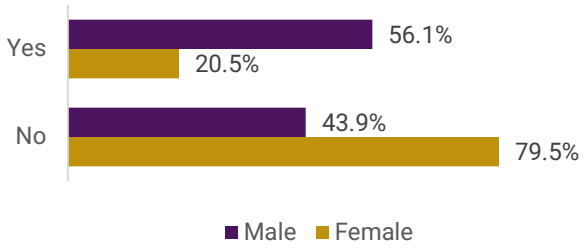


Figure 21. Practice as a PA before PA residency/fellowship program by gender (p<0.001)



Participants who were certified for 10 years or fewer had a much lower proportion when compared to PAs certified for 11 to 20 and 21 or more years to have practiced as a PA before entering residency/fellowship (22.6% vs. 73.1% and 75.0%; Figure 22). Figure 23 displays that PAs in the South had the highest percentage of practicing as a PA before entering PA residency/fellowship program for EM or UC.

Figure 22. Practice as a PA before PA residency/fellowship program by years certified (p<0.001)

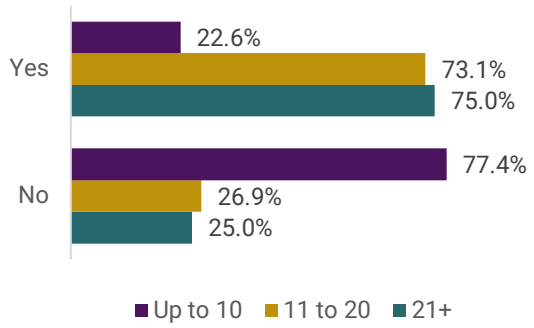
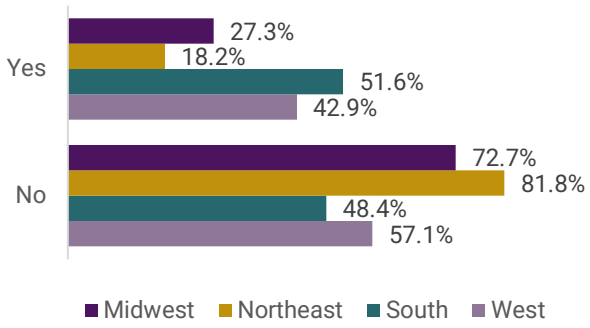


Figure 23. Practice as a PA before PA residency/fellowship program by U.S. regions (p=0.006)



Years Practicing as a PA Before Entering PA Residency/Fellowship Program

Of respondents who practiced as a PA before entering PA residency/fellowship program, 36.5% did so for 3-5 years, followed by 31.7% who said they practiced for more than 5 years (Figure 24). Differences were not found to be statistically significant for years practicing as a PA before residency/fellowship program by gender (Figure 25).

Figure 24. How many years did you practice as a PA before entering your PA residency/fellowship program?

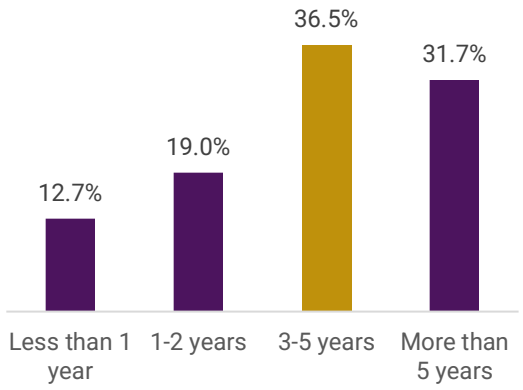
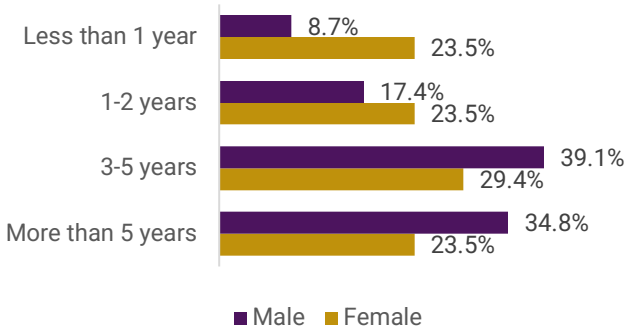


Figure 25. Years practicing as a PA before PA residency/fellowship program by gender (p=0.362)**

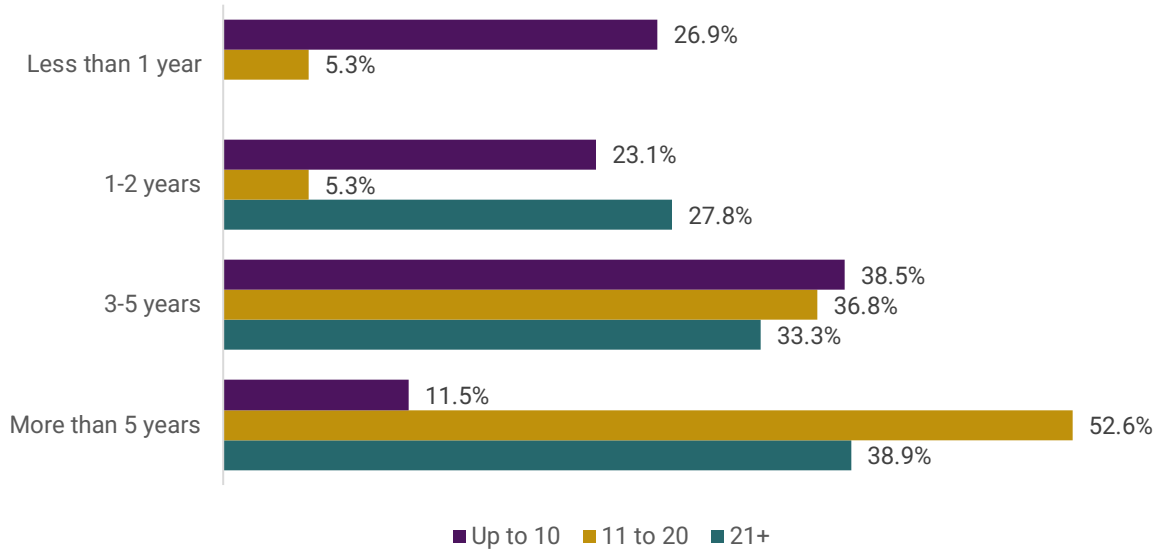
** *Fisher-Freeman-Halton Exact test*



Participants who were certified for 11 to 20 years had the highest proportion (52.6%) of practicing as a PA for more than 5 years before entering a PA residency/fellowship, while those who were certified for up to 10 years had the highest proportion (38.5%) of practicing for 3-5 years (p=0.010; Figure 26).

Figure 26. Years practicing as a PA before PA residency/fellowship program by years certified (p=0.010)**

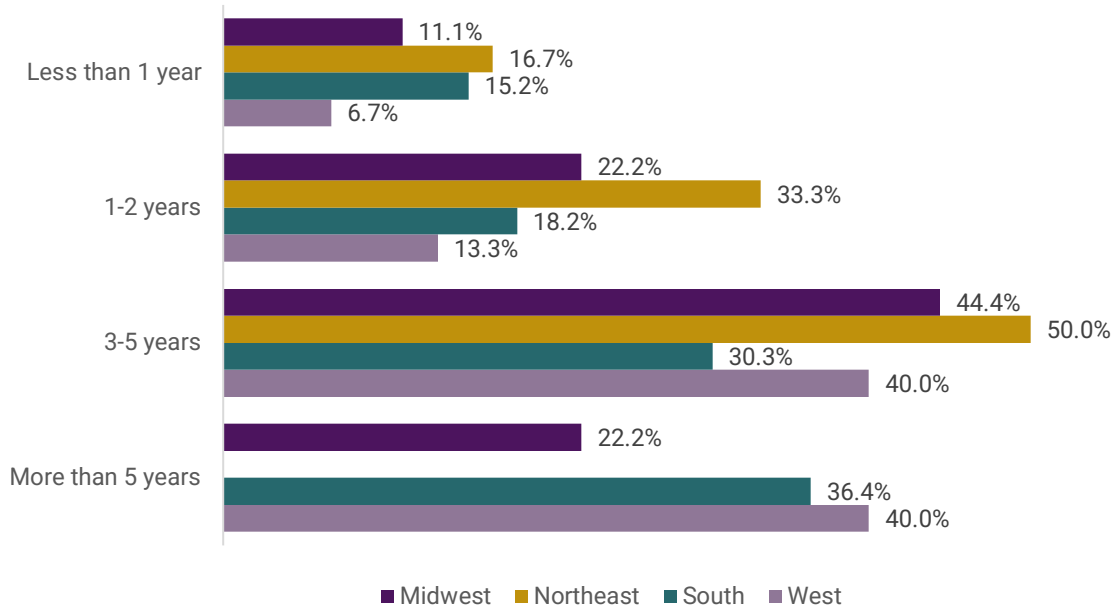
** *Fisher-Freeman-Halton Exact test*



The association between years practicing as a PA before a PA residency/fellowship program and U.S. region was not statistically significant (p=0.775; Figure 27).

Figure 27. Years practicing as a PA before PA residency/fellowship program by U.S. regions (p=0.775)**

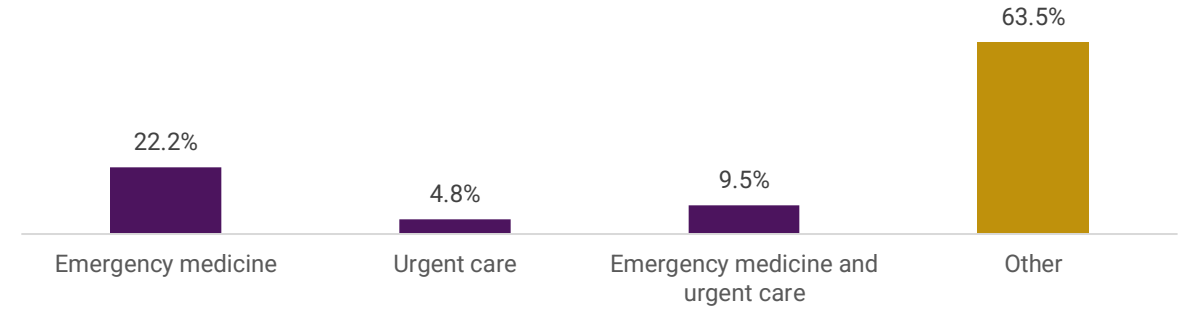
** *Fisher-Freeman-Halton Exact test*



Original Specialty Before PA Residency/Fellowship Program

Regarding original specialty before entering a PA residency/fellowship program, 63.5% stated that their original discipline was an area other than EM or UC (Figure 28). Slightly less than a quarter (22.2%) affirmed that their original specialty was EM.

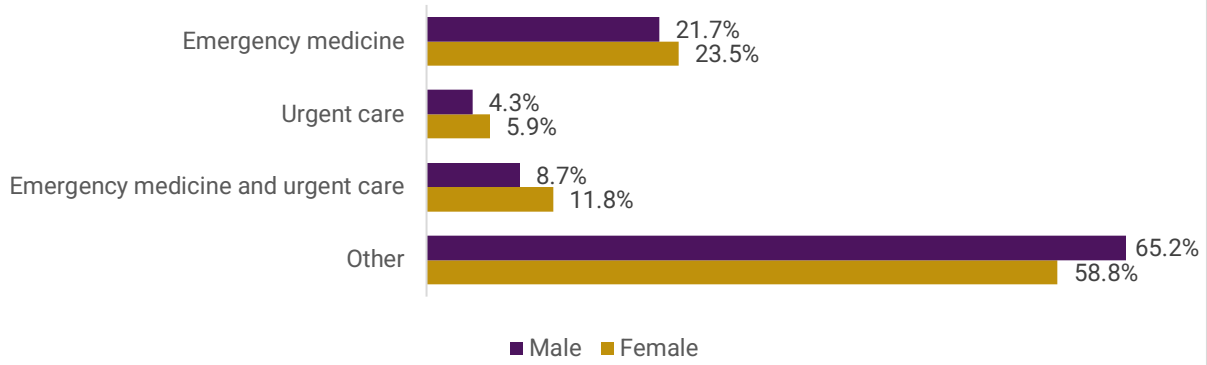
Figure 28. What was or were your original specialty area(s) before entering your PA residency/fellowship program?



As can be seen in Figure 29, differences by gender were not found to be statistically significant (p=0.959).

Figure 29. Original specialty before PA residency/fellowship program by gender (p=0.959)**

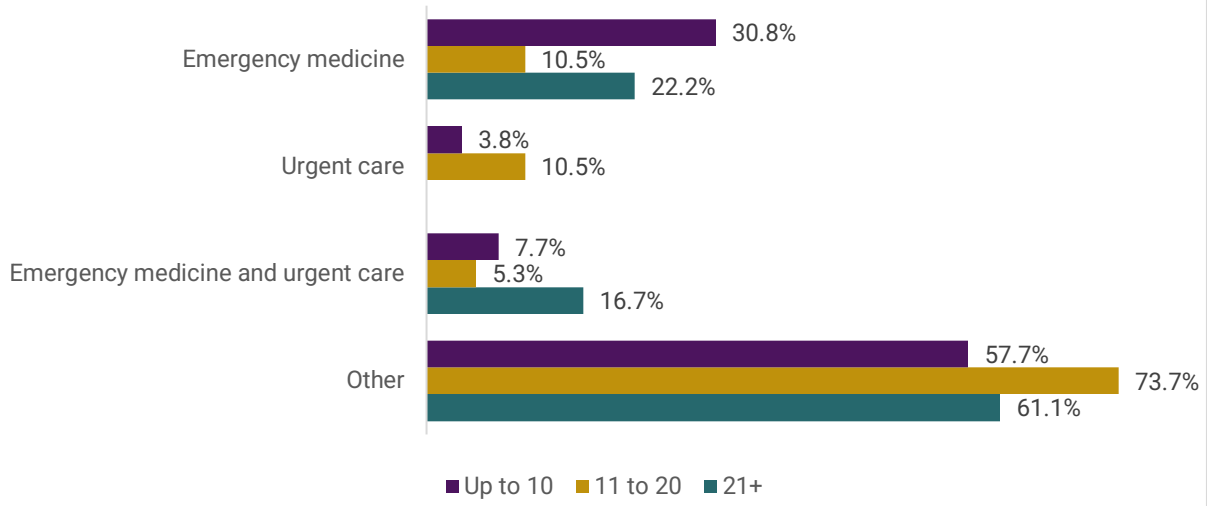
** *Fisher-Freeman-Halton Exact test*



Similarly, the relationship between original specialty and years certified (p=0.457) was not statistically significant, but those who were certified for 11 to 20 years had a higher percentage than PAs in the other certification year groups of selecting that they practiced in a specialty other than EM or UC before entering a PA residency/fellowship program (Figure 30).

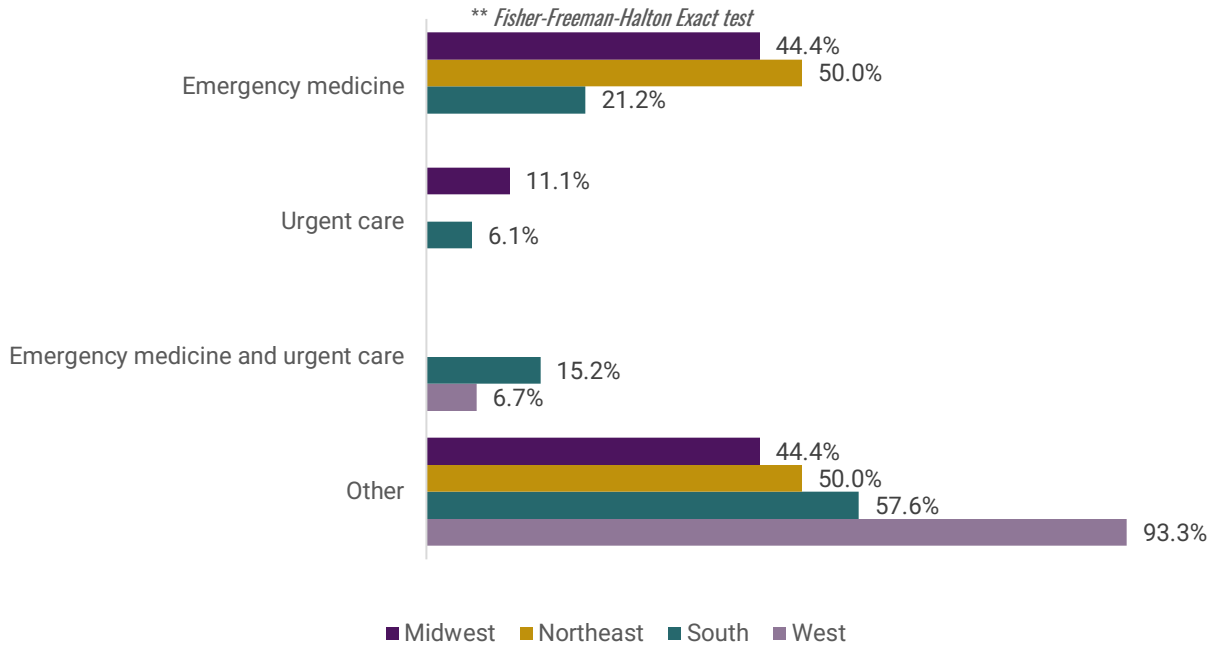
Figure 30. Original specialty before PA residency/fellowship program by years certified (p=0.457)**

** *Fisher-Freeman-Halton Exact test*



When compared to all other regions, PAs residing in the West had the highest proportion of indicating that they practiced in a specialty other than EM or UC before entering a PA residency/fellowship program; however, this finding was not statistically significant (p=0.056; Figure 31).

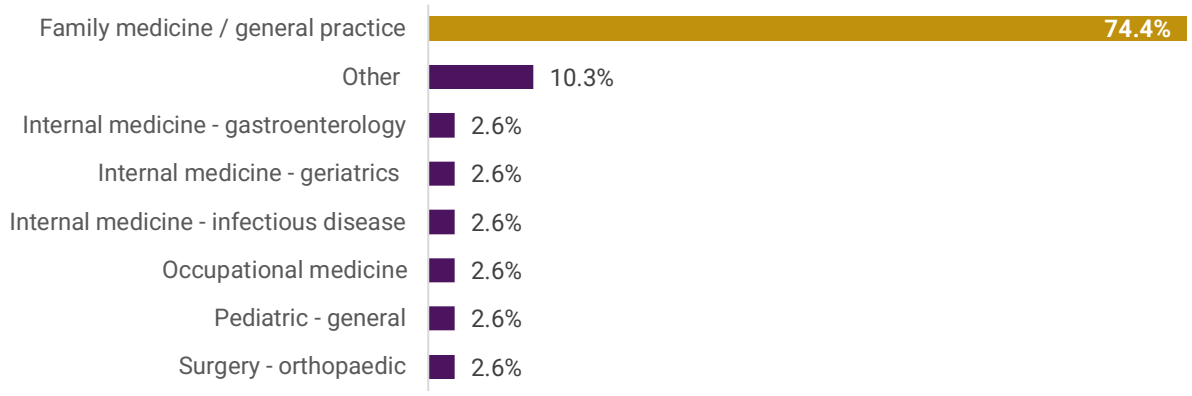
Figure 31. Original specialty before PA residency/fellowship program by U.S. regions (p=0.056)**



Principal Specialty Area Before Entering PA Residency/Fellowship Program

PAs who selected "other" for original specialty before residency/fellowship were provided with 70 response options for specific disciplines and asked to identify the specialty they practiced in. Almost three-quarters of PAs (74.4%) narrowed family medicine/general practice as the discipline they practiced prior to entering a PA residency/fellowship program (Figure 32).

Figure 32. Please indicate the principal specialty area you practiced before entering your PA residency/fellowship program.



The highest proportion of males (82.8%) and females (50%) reported practicing in family medicine/general practice as a PA before entering into a PA residency/fellowship program (Table 5).

Table 5. Principal Specialty Area Before Entering PA Residency/Fellowship by Gender

Specialty	Female	Male	p-value
Family medicine/general practice	50.0%	82.8%	n/a*
Internal medicine – gastroenterology	10.0%	0.0%	
Internal medicine – geriatrics	0.0%	3.4%	
Internal medicine – infectious disease	10.0%	0.0%	
Occupational medicine	10.0%	0.0%	
Other	0.0%	13.8%	
Pediatric – general	10.0%	0.0%	
Surgery – orthopaedic	10.0%	0.0%	

**Statistical test could not be conducted due to small sample sizes*

As shown in Table 6, 80.0% of PAs who were certified for up to 10 years, 78.6% of those certified between 11 and 20 years, and 60.0% of PA certified for 21 years or longer expressed that they practiced in family medicine/general practice before PA residency/fellowship.

Table 6. Principal Specialty Area Before Entering PA Residency/Fellowship by Years Certified

Specialty	Up to 10	11 to 20	21+	p-value
Family medicine/general practice	80.0%	78.6%	60.0%	n/a*
Internal medicine – gastroenterology	0.0%	0.0%	10.0%	
Internal medicine – geriatrics	0.0%	7.1%	0.0%	
Internal medicine – infectious disease	0.0%	0.0%	10.0%	
Occupational medicine	0.0%	0.0%	10.0%	
Other	6.7%	14.3%	10.0%	
Pediatric – general	6.7%	0.0%	0.0%	
Surgery – orthopaedic	6.7%	0.0%	0.0%	

**Statistical test could not be conducted due to small sample sizes*

In terms of U.S. regions, 84.6% of PAs residing in the West and 84.2% in the South listed family medicine/general practice as the area they practiced before entering a PA residency/fellowship program (Table 7).

Table 7. Principal Specialty Area Before Entering PA Residency/Fellowship by U.S. Region

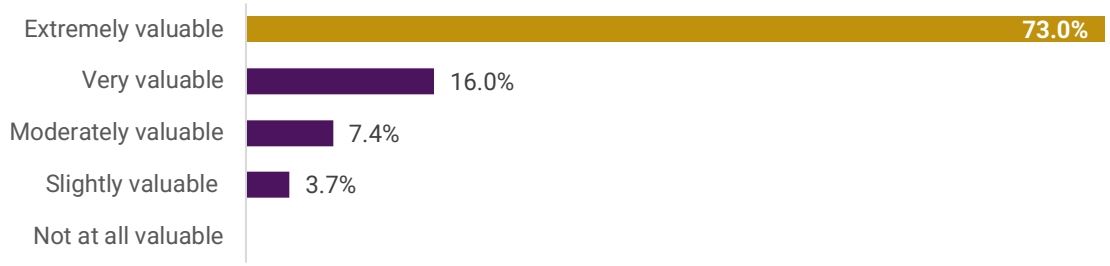
Specialty	Midwest	Northeast	South	West	p-value
Family medicine/general practice	25.0%	33.3%	84.2%	84.6%	n/a*
Internal medicine – gastroenterology	0.0%	0.0%	5.3%	0.0%	
Internal medicine – geriatrics	0.0%	0.0%	5.3%	0.0%	
Internal medicine – infectious disease	0.0%	33.3%	0.0%	0.0%	
Occupational medicine	25.0%	0.0%	0.0%	0.0%	
Other	25.0%	33.3%	0.0%	15.4%	
Pediatric – general	0.0%	0.0%	5.3%	0.0%	
Surgery – orthopaedic	25.0%	0.0%	0.0%	0.0%	

**Statistical test could not be conducted due to small sample sizes*

PA Residency/Fellowship Program Being Valuable Educational Experience

Figure 33 demonstrates that the vast majority of PAs who completed a PA residency/fellowship program found it valuable as an educational experience for practicing in EM/UC. In fact, none of the PAs we surveyed considered their PA residency/fellowship "not at all valuable."

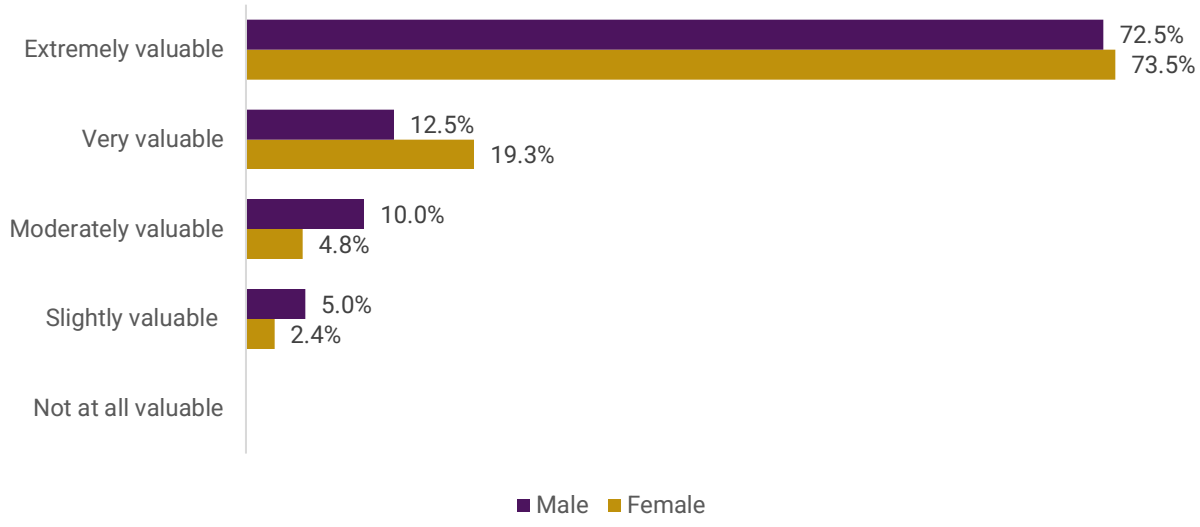
Figure 33. To what degree did you find the PA residency/fellowship a valuable educational experience for practicing in emergency medicine/urgent care?



We did not detect differences on value perceptions by gender (p=0.353; Figure 34) or years certified (p=0.833; Figure 35).

Figure 34. Degree to which you found PA residency/fellowship program valuable by gender (p=0.353)**

** *Fisher-Freeman-Halton Exact test*



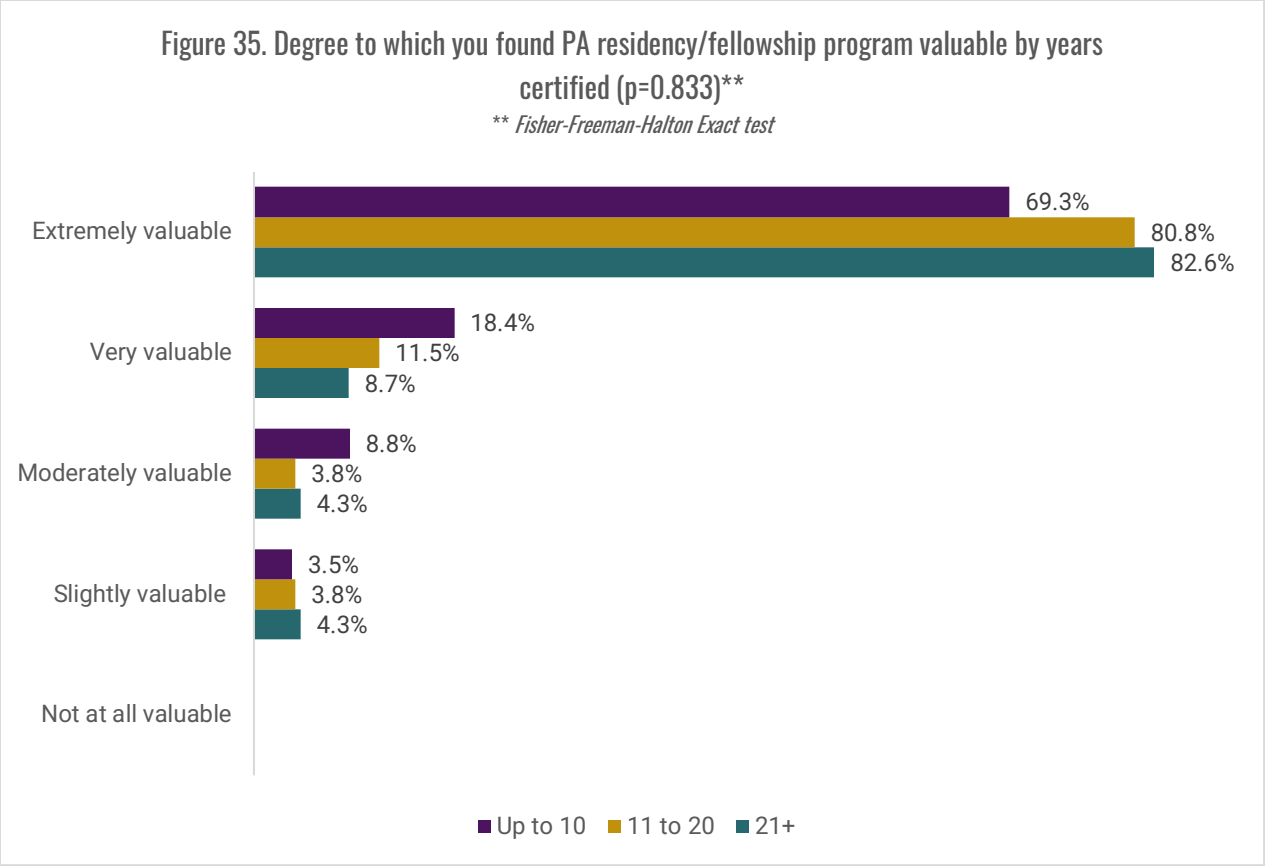
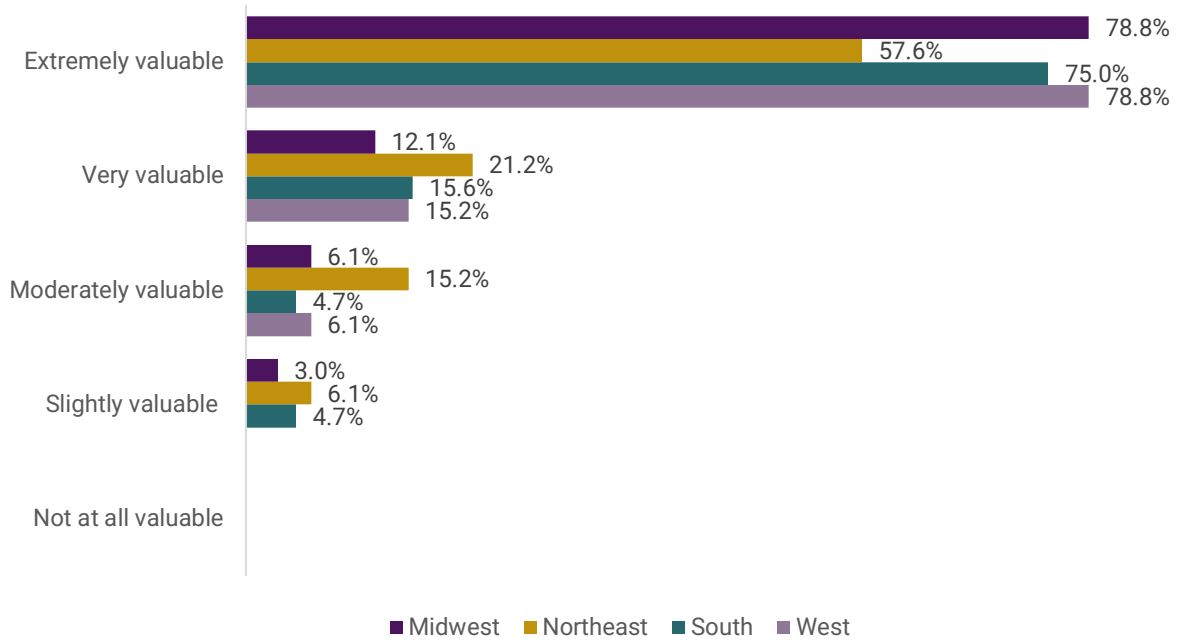


Figure 36 shows that PAs who reside in the Northeast had a slightly less favorable value perception of their residency/fellowship than those in the other U.S. regions. Statistical tests could not be conducted due to the sparse data in some of the categories to how valuable the PA program was by U.S. region.

Figure 36. Degree to which you found PA residency/fellowship program valuable by U.S. region*

**Statistical test could not be conducted due to small sample sizes*



Pay Increase Following Completion of PA Residency/Fellowship Program

Figure 37 illustrates that 65.0% of PAs who completed a PA residency/fellowship program received a pay increase after completing the program. We found statistically significant differences between males and females ($p<0.001$), years certified ($p=0.011$), and U.S. regions ($p=0.023$). Females were more likely than males to indicate they received a pay increase following the completion of their PA residency/fellowship program (78.3% vs. 51.2%; Figure 38).

Figure 37. Did you receive a pay increase following the completion of your PA residency/fellowship program?

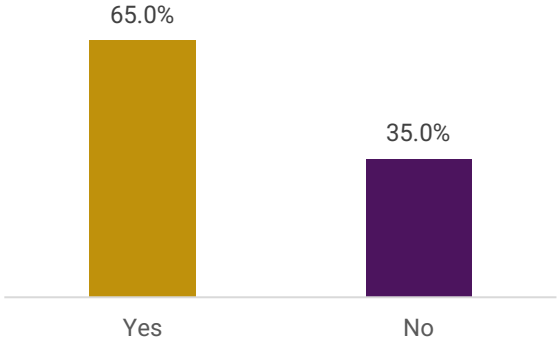
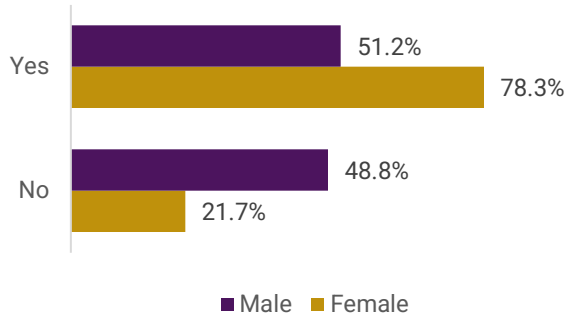


Figure 38. Pay increase following PA residency/fellowship program by gender ($p<0.001$)



PAs certified for up to 10 years were more likely to document receiving a pay increase after completing their residency/fellowship vs. PAs certified 11 to 20 and 21 or more years (71.9% vs. 42.3% and 56.5%; Figure 39). Regarding U.S. regions, PAs residing in the Midwest (81.8%), compared to Northeast (75.6%), South (54.7%), and West (57.6%), had a higher likelihood of confirming that they have received a pay increase due to the residency/fellowship (Figure 40).

Figure 39. Pay increase following the completion of PA residency/fellowship by years certified (p=0.011)

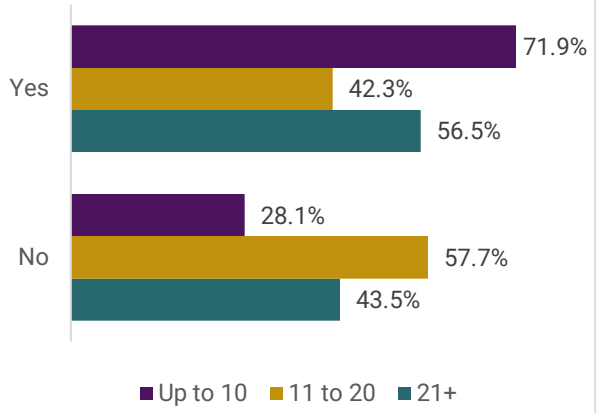
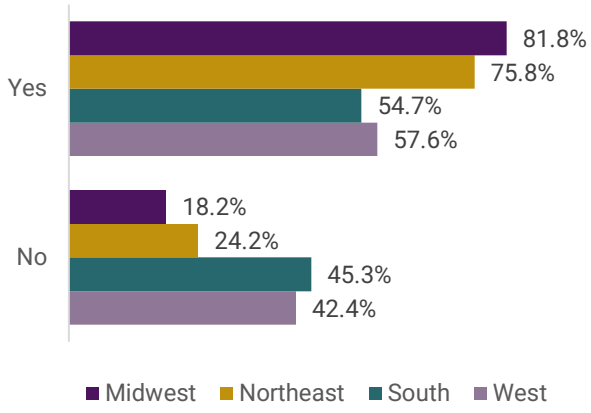


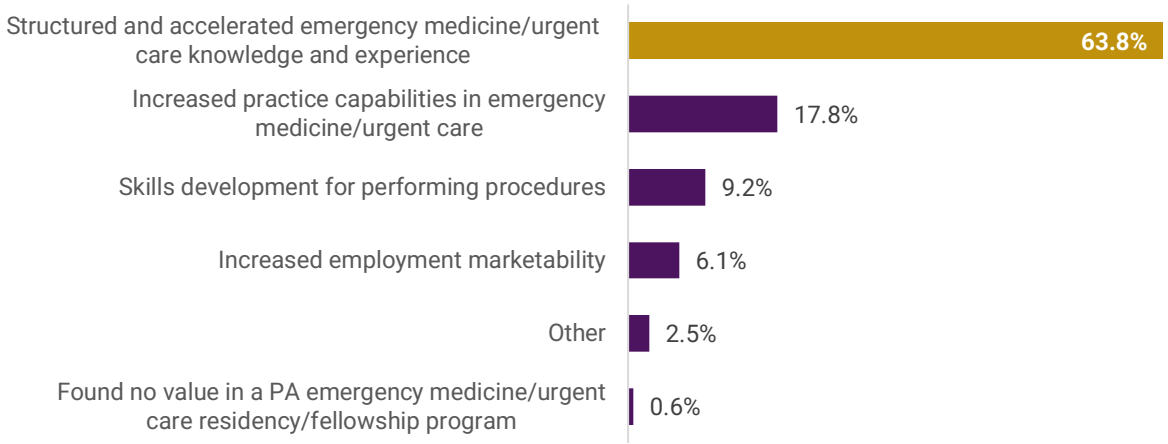
Figure 40. Pay increase following the completion of PA residency/fellowship by U.S. region (p=0.023)



Most Valuable Aspect of PA Residency/Fellowship Program

Figure 41 enumerates that 63.8% felt that the most valuable aspect of participating in a PA residency/fellowship program was "structured and accelerated emergency medicine/urgent care knowledge and experience."

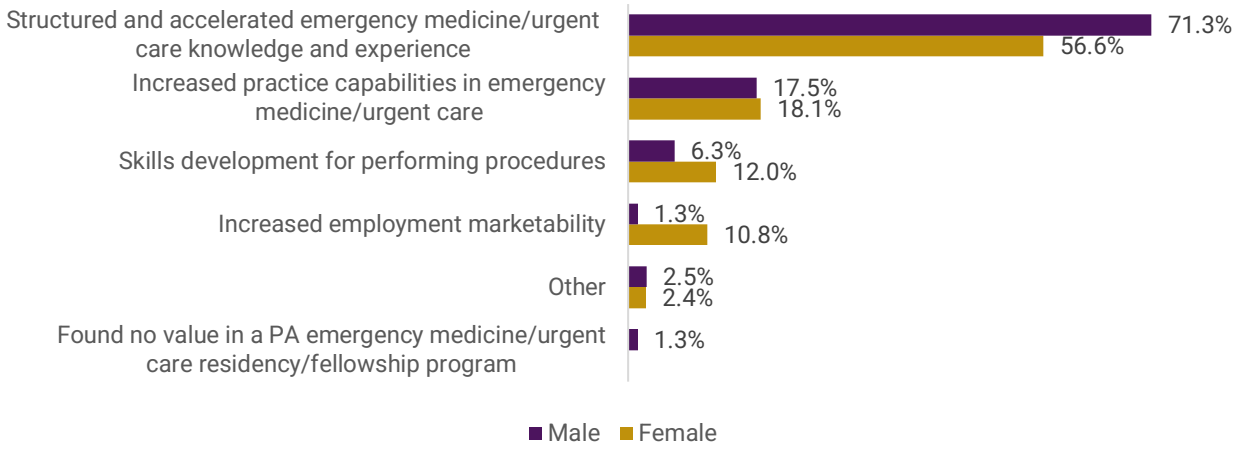
Figure 41. What was the most valuable aspect of participating in a PA residency/fellowship program?



As shown in Figure 42, 71.3% of males and 56.6% of females indicated that structured and accelerated knowledge and experience was the most valuable aspect of completing a PA residency/fellowship program.

Figure 42. Most valuable aspect of PA residency/fellowship program by gender*

**Statistical test could not be conducted due to small sample sizes*



With respect to years certified, 73.1% of PAs who were certified for 11 to 20 years believed that structured and accelerated knowledge and experience was the most valuable aspect of completing a PA residency/fellowship program (Figure 43).

Figure 43. Most valuable aspect of PA residency/fellowship program by years certified*

**Statistical test could not be conducted due to small sample sizes*

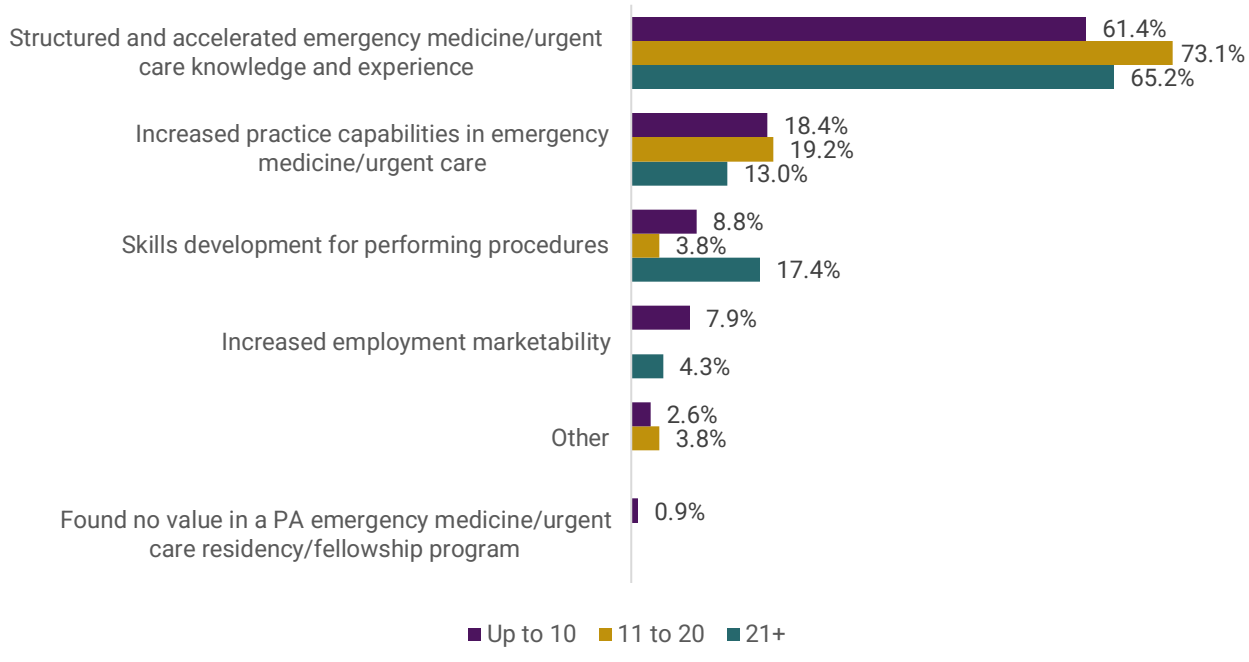
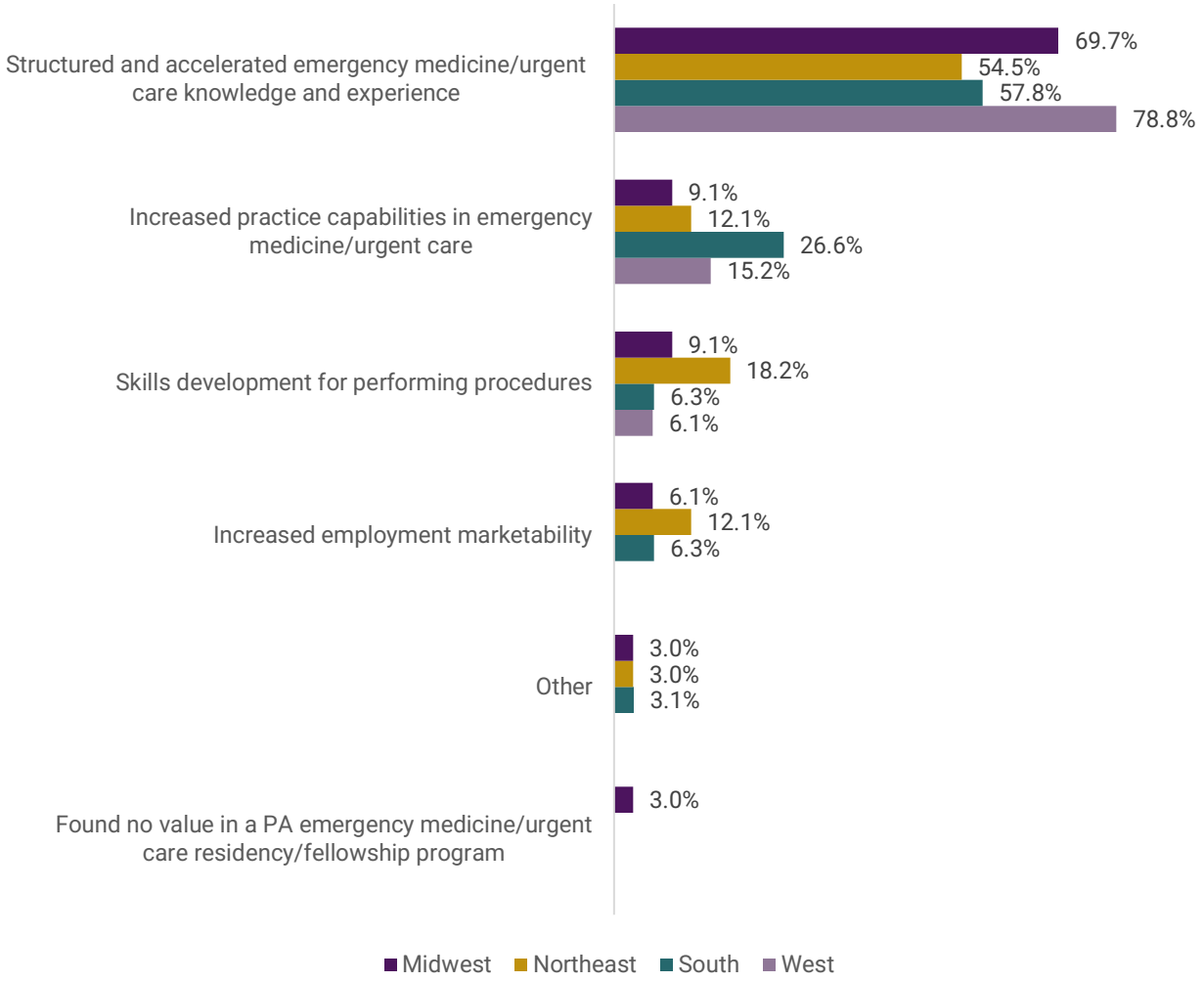


Figure 44 shows that the respondents in the West had a higher percentage than the other U.S. regions, perceiving structured and accelerated knowledge and experience as the most valuable aspect of completing a PA residency/fellowship program.

Figure 44. Most valuable aspect of PA residency/fellowship program by U.S. region*

**Statistical test could not be conducted due to small sample sizes*

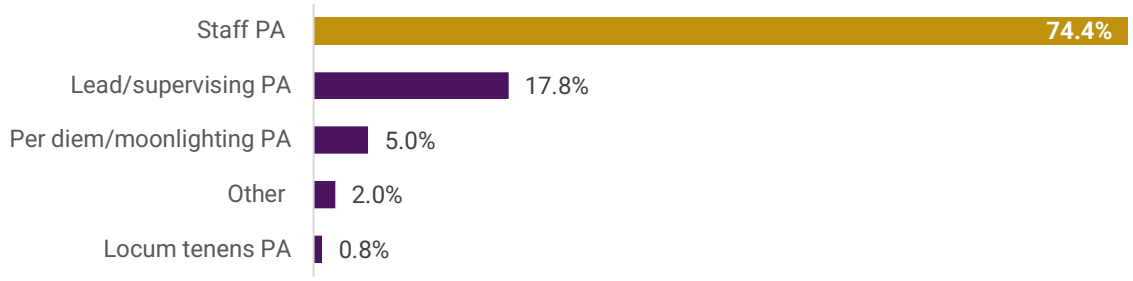


PA Position Attributes

Current Position/Title for Principal Clinical Position

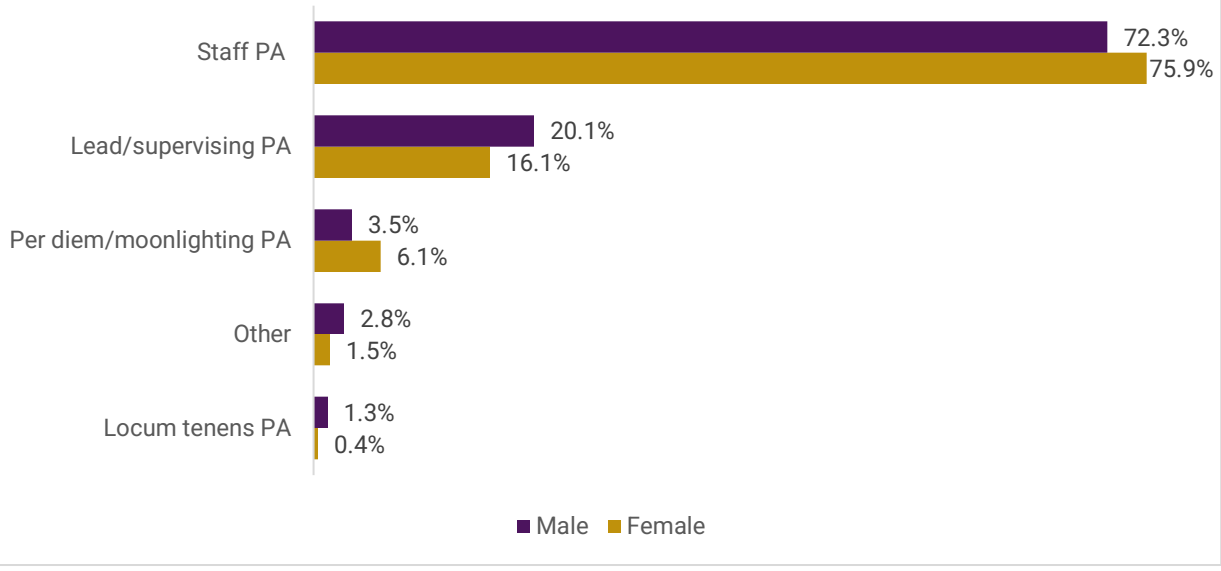
PAs were presented with a myriad of questions regarding the attributes of their positions. One of the first was about their current position/title. The majority (74.4%) mentioned that they are staff PAs, followed by 17.8% who disclosed that they are lead/supervising PAs (Figure 45).

Figure 45. What is your current position/title for your principal clinical position?



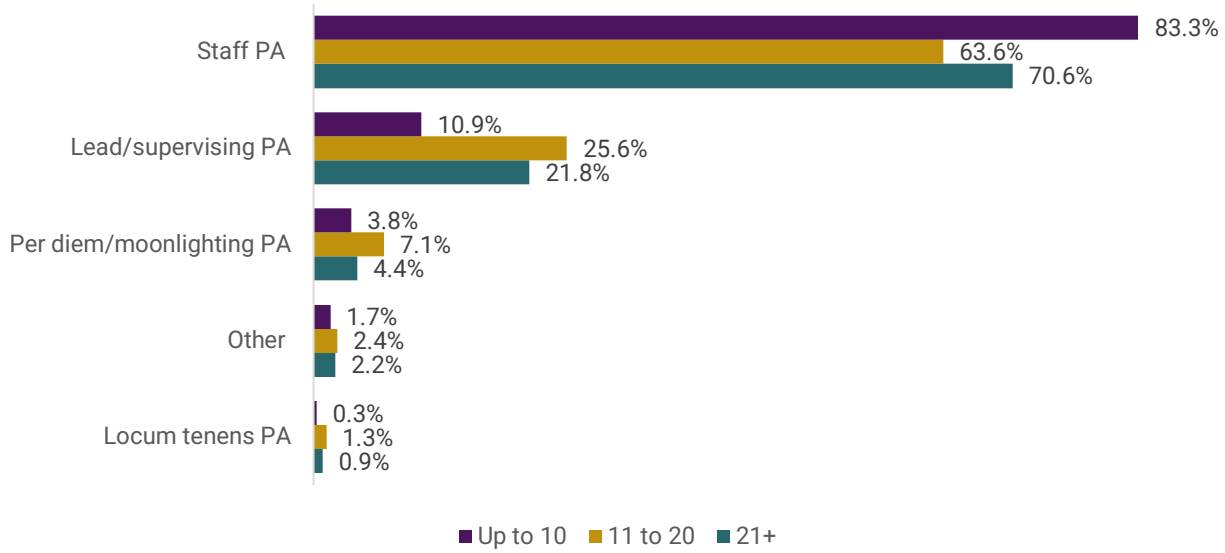
When the current position/title of the principal clinical position was analyzed by demographics/years certified, we found statistically significant differences by gender ($p<0.001$), years certified ($p<0.001$), and U.S. region ($p=0.004$). Females were more likely to indicate staff PA (75.9% vs. 72.3%), while males had a higher likelihood of reporting lead/supervising PA (20.1% vs. 16.1%; Figure 46).

Figure 46. Current position/title for principal clinical position by gender ($p<0.001$)



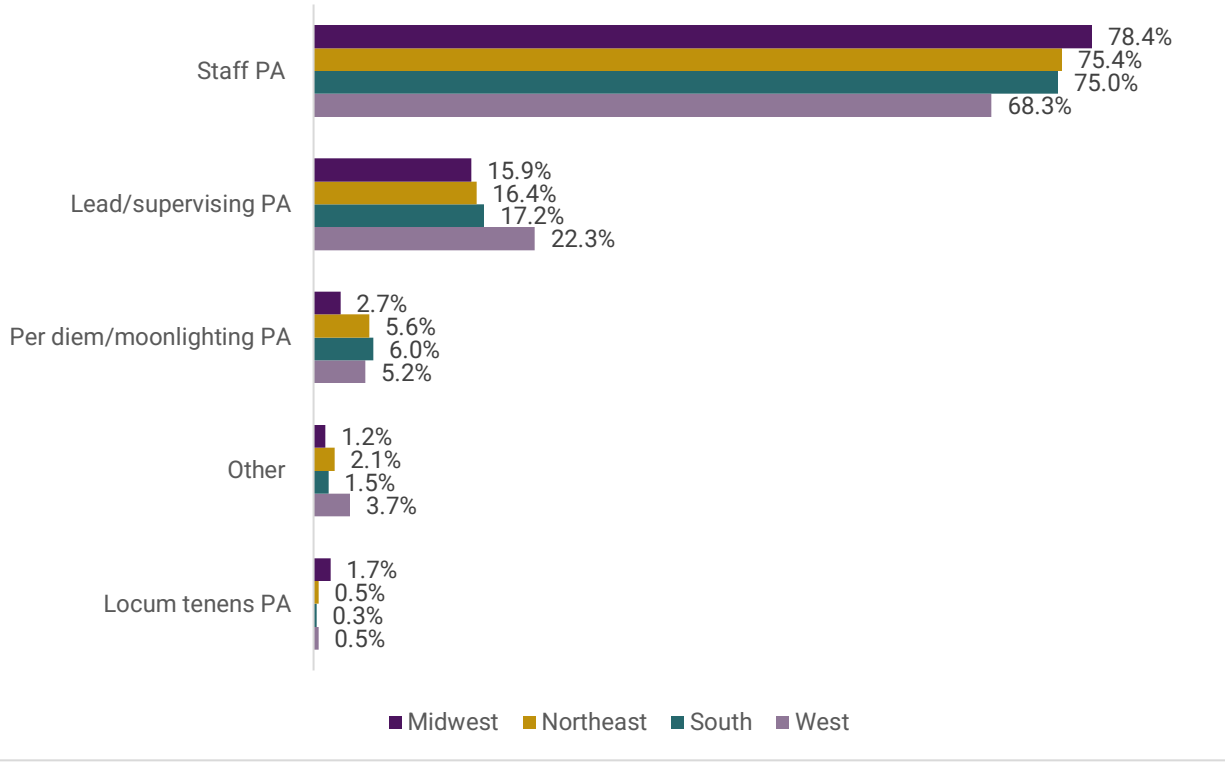
Participants who were certified up to 10 years vs. 11 to 20 and 21 or more had a higher likelihood of acknowledging to be a staff PA (83.3% vs. 63.6% and 70.6%), while those certified 11 to 20 years had the highest proportion of selecting that they are lead/supervising PAs (Figure 47).

Figure 47. Current position/title for principal clinical position by years certified (p<0.001)



PAs residing in the Midwest, compared to the other U.S. regions, had the highest proportion of indicating that they are staff PAs for their principal clinical position, while those in the West had the highest percentage of affirming being a lead/supervising PAs (Figure 48).

Figure 48. Current position/title for principal clinical position by U.S. regions (p=0.004)



Specialty of Principal Clinical Position

When asked which specialty PAs practice in for their principal clinical position, 88.7% listed EM, and 6.4% specified UC (Figure 49). We did not detect significant differences by gender (p=0.603). Figure 50 depicts that female and male PA had almost identical proportions of indicating to practice in EM and the same proportion of reporting to practice in UC.

Figure 49. Please indicate which specialty you practice in for your principal clinical position

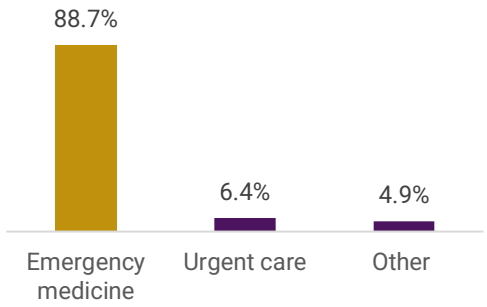
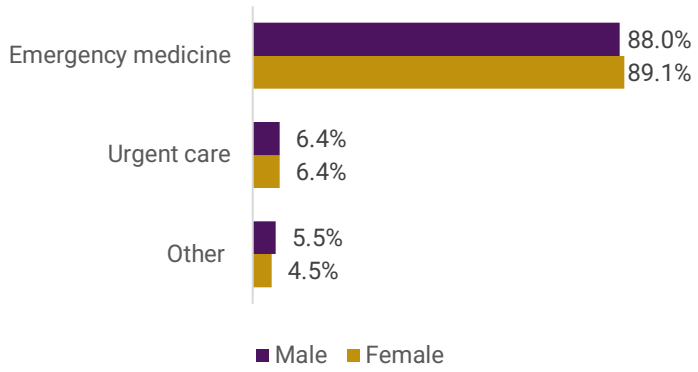
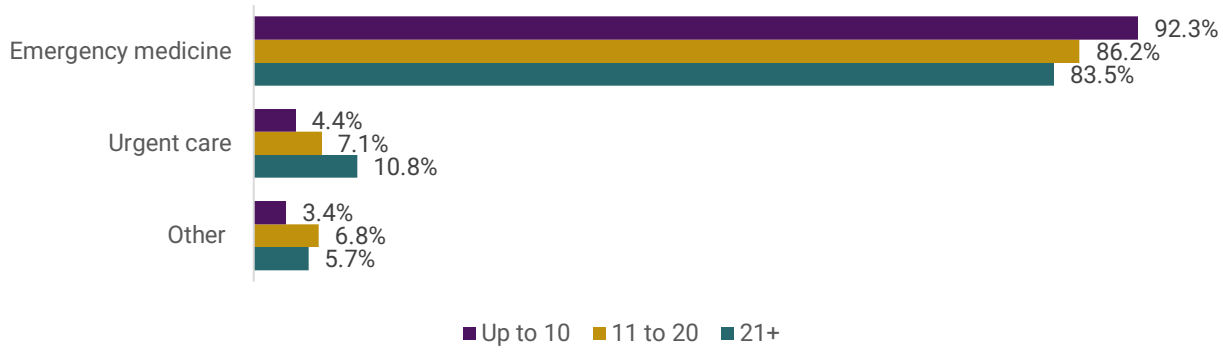


Figure 50. Principal specialty by gender (p=0.603)

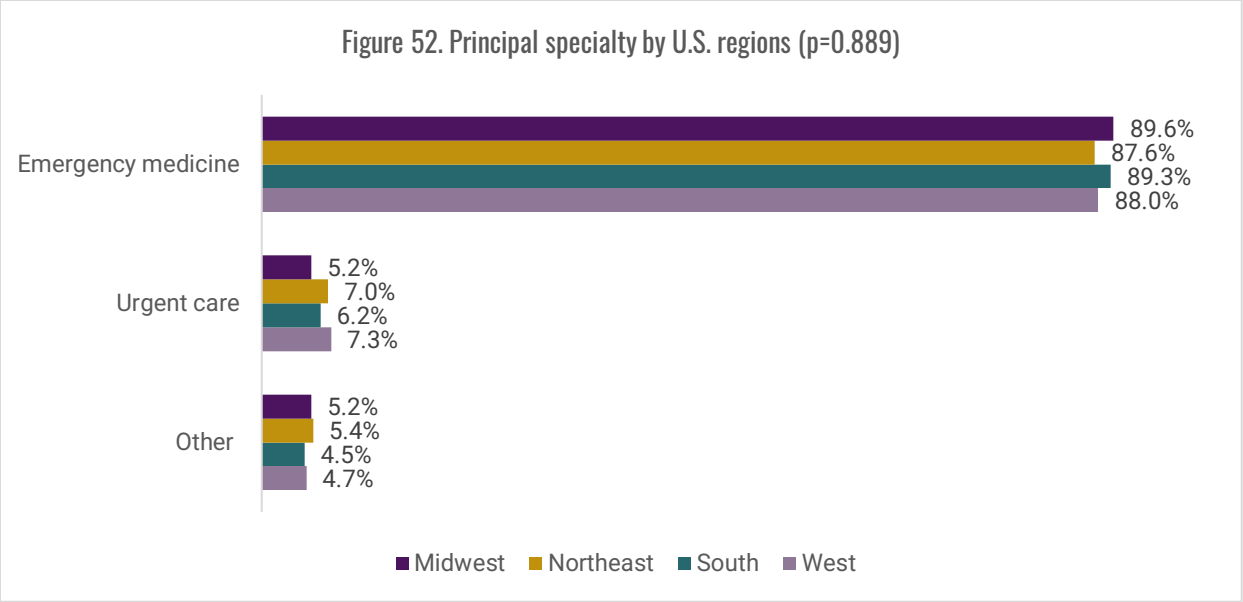


The highest proportion of participants certified for up to 10 years cited EM as their specialty, while those certified for 21 years or more had the highest proportion of choosing UC as their response for principal specialty (p<0.001; Figure 51).

Figure 51. Principal specialty by years certified (p<0.001)

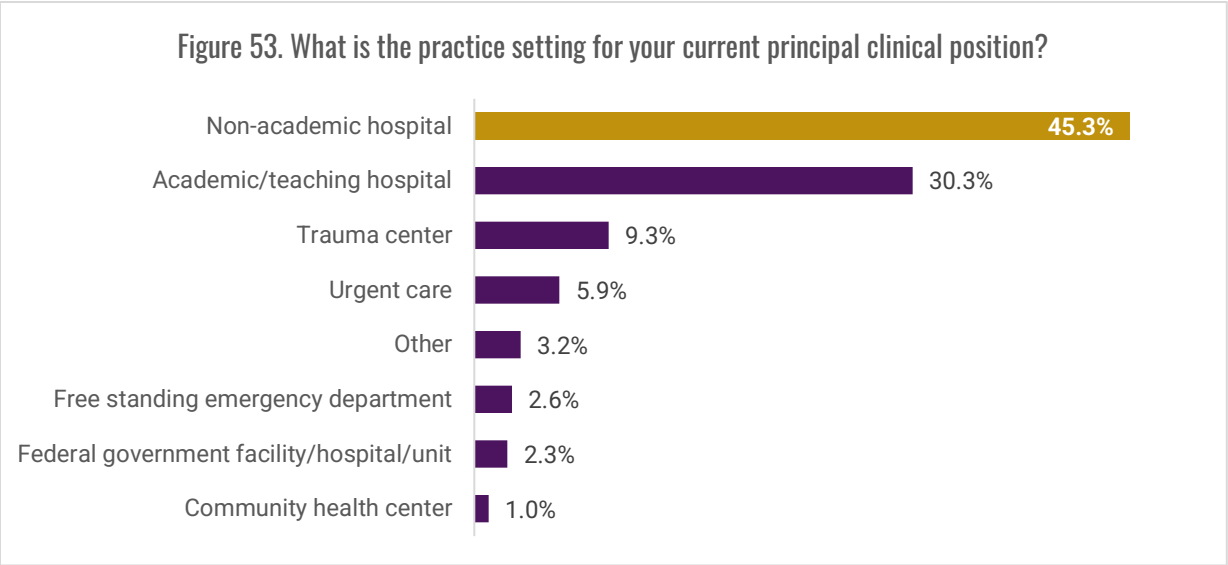


The pattern of principal specialty was similar when parsed by U.S. regions and not found to be statistically significant (p=0.889; Figure 52).

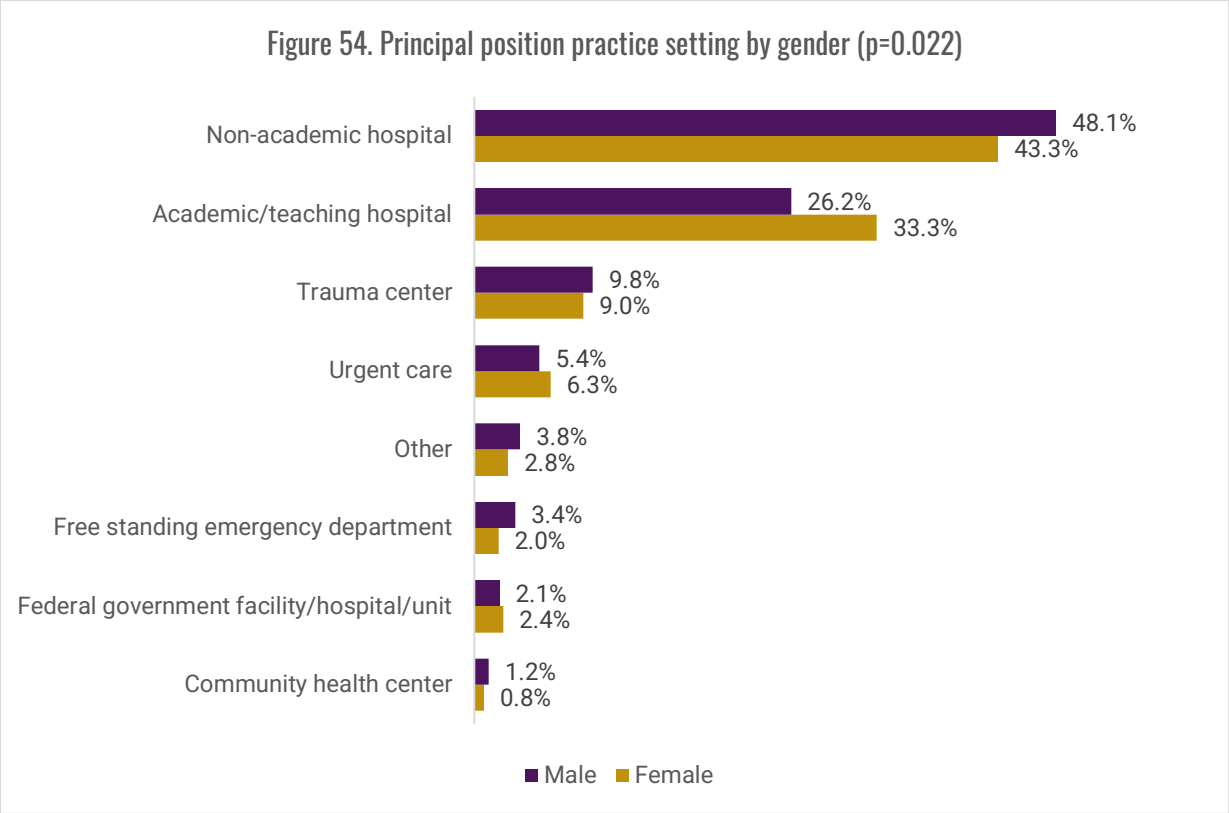


Practice Setting for Current Principal Clinical Position

Almost half (45.3%) noted that they practice in a non-academic hospital, while 30.3% practice in an academic/teaching hospital (Figure 53). When this question was assessed by demographics/years certified, we found statistically significant relationships with gender (p=0.022), years certified (p=0.016), and U.S. regions (p<0.001).



Males were more likely than females to practice in a non-academic hospital (48.1% vs. 43.3%), while females had a higher likelihood than males of working in an academic/teaching hospital (33.3% vs. 26.2%; Figure 54).



PAs certified for up to 10 years were more likely than the other certification year groups to practice in a non-academic hospital, while PAs who were certified for 21 years or longer had a slightly higher proportion of practicing in an academic/teaching hospital (Figure 55).

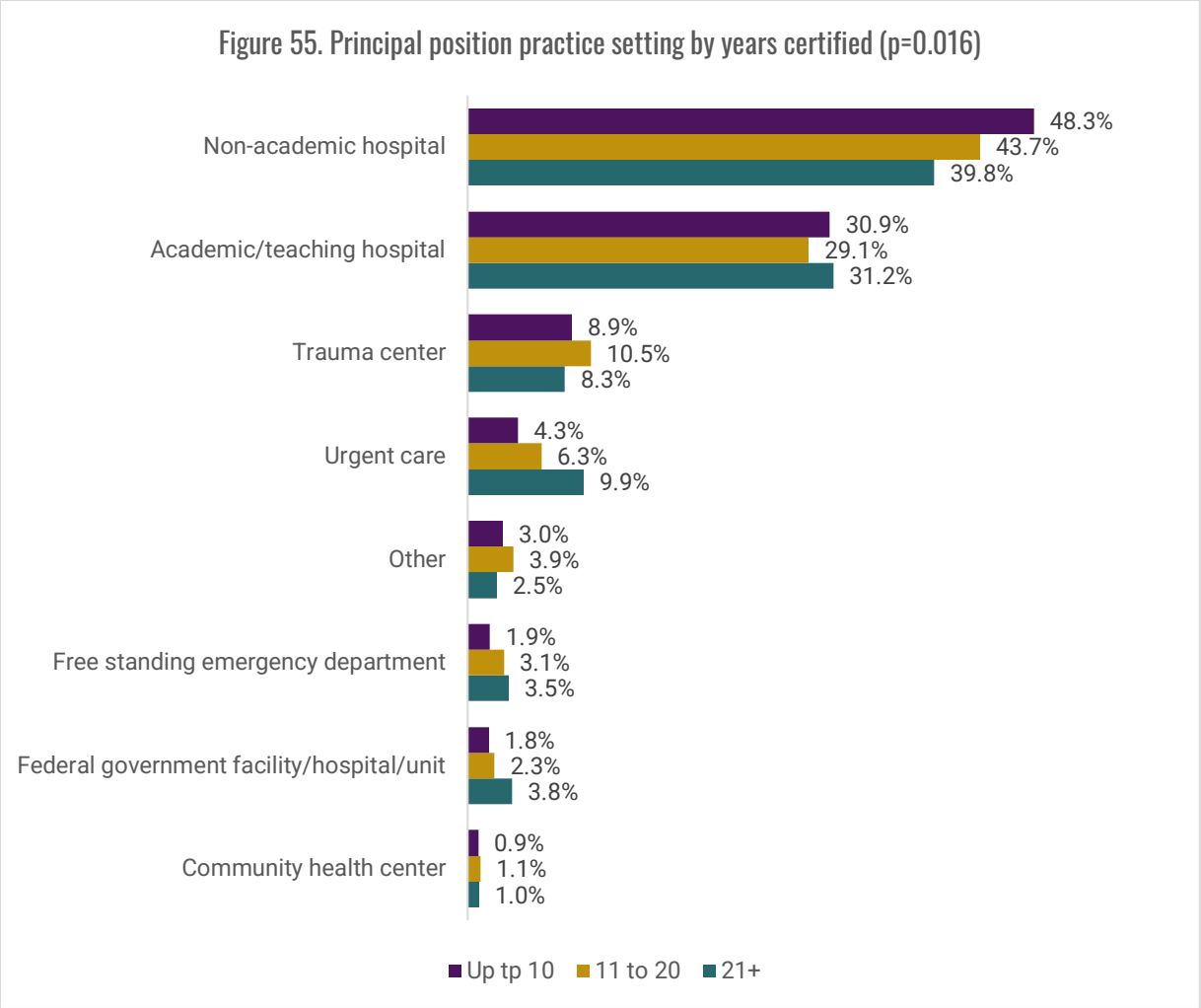
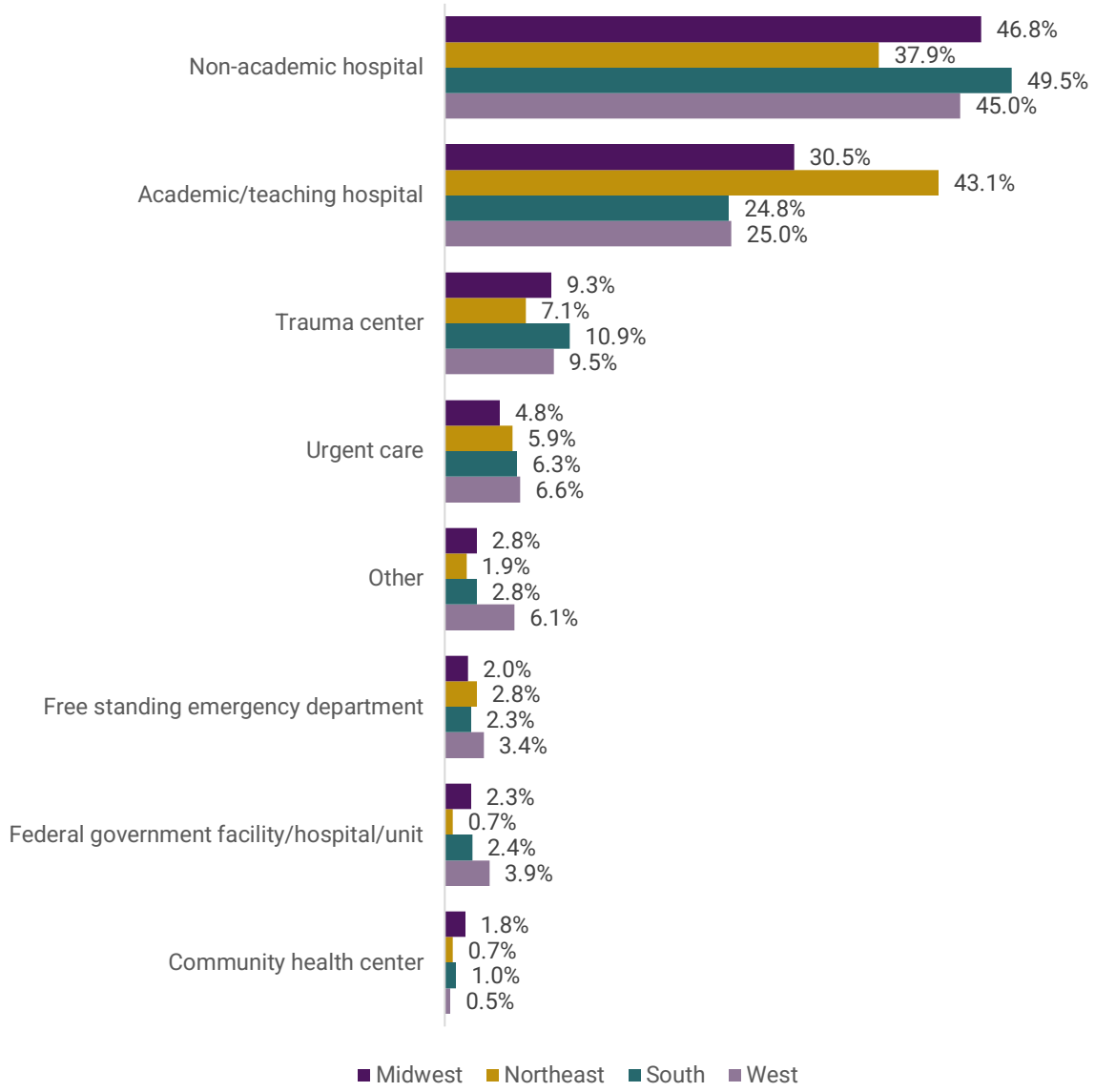


Figure 56 depicts practice setting for principal clinical position by U.S. region. Participants in the South had the highest proportion of selecting that they practice in a non-academic hospital compared to PAs residing in all other U.S. regions. Participants in the Northeast (43.1%) were more likely to state that they practice in an academic/teaching hospital versus PAs in the Midwest (30.5%), South (24.8%), and West (25.0%).

Figure 56. Principal position practice setting by U.S. region (p<0.001)



Area of Work

Survey participants who reported working in a non-academic hospital or an academic/teaching hospital were asked which area of the department they primarily work. A little more than half (52.5%) of respondents identified that they work primarily in the main emergency department, while 38.1% work in the main emergency department and fast track (Figure 57). Figure 58 illustrates that males were significantly more likely to indicate they work in the main emergency department (62.9% vs. 45.3%; p<0.001), while females were more likely to specify that they work primarily in the main emergency department and fast track (43.9% vs. 29.7%).

Figure 57. In what area do you primarily work?

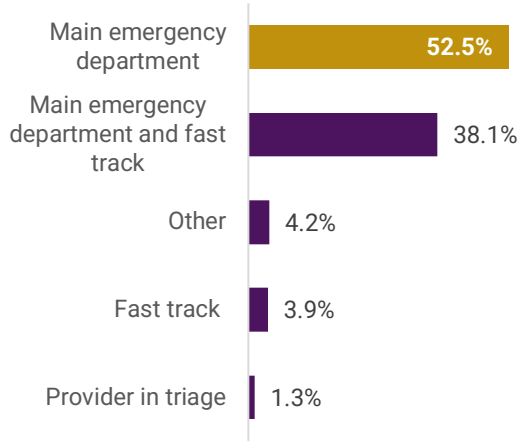
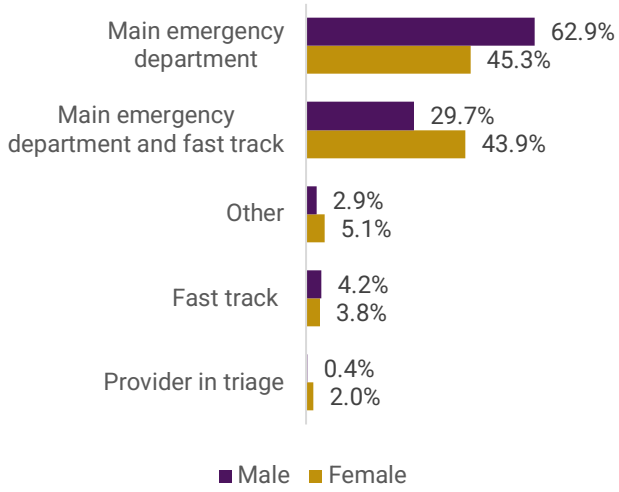
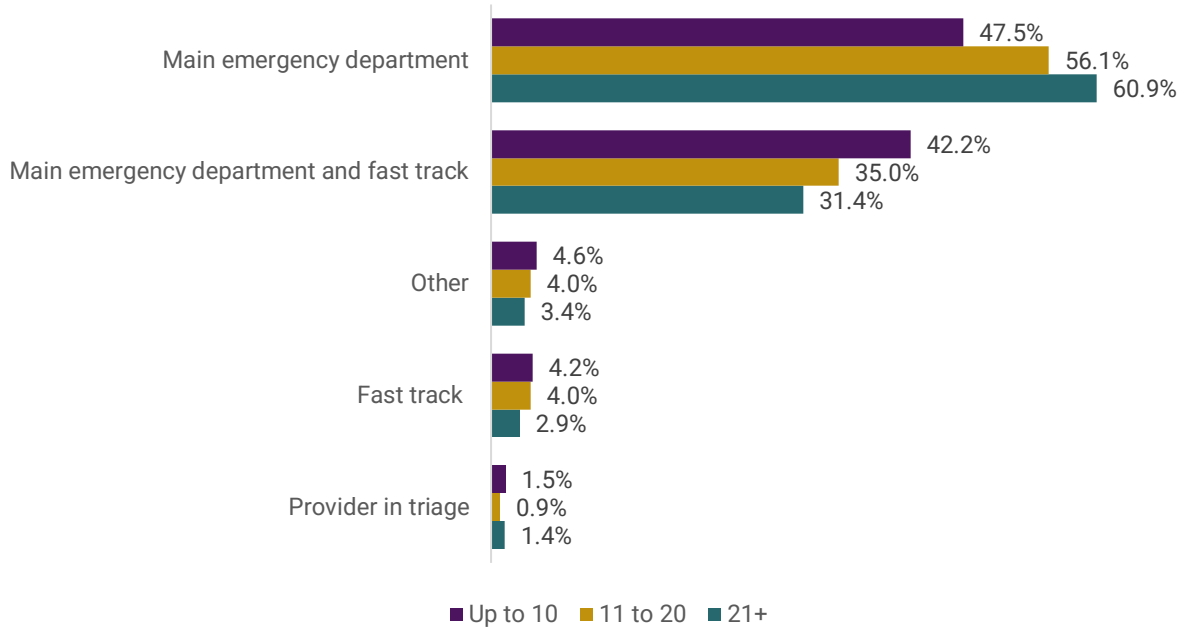


Figure 58. Area of work by gender (p<0.001)



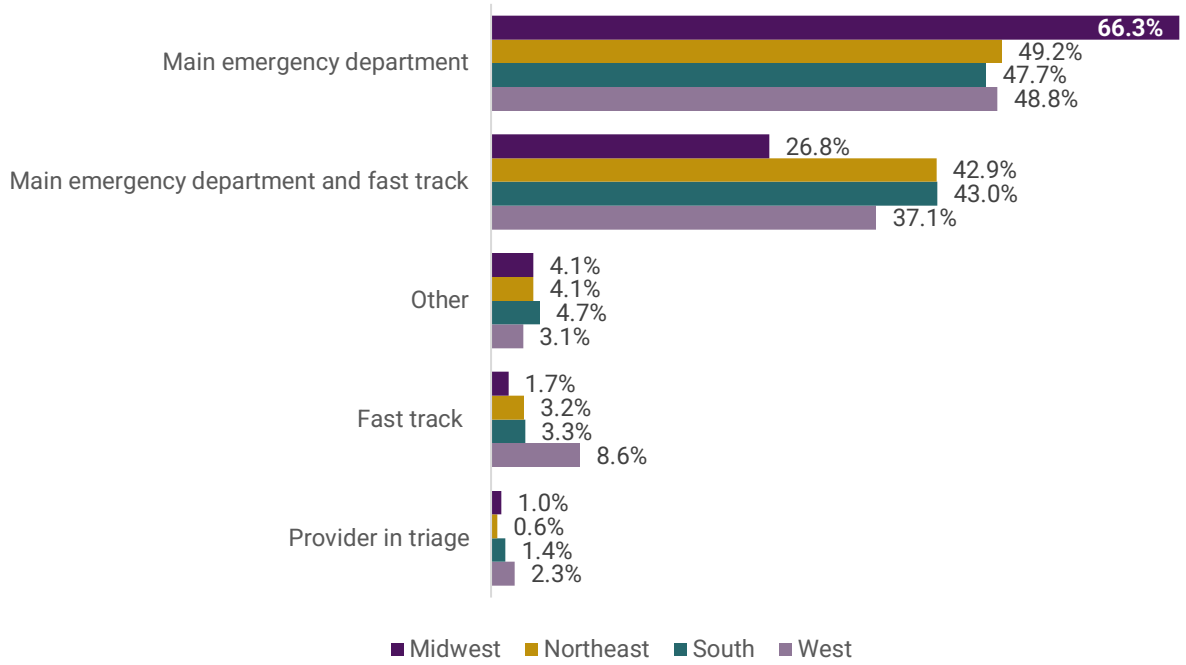
PAs who were certified for 21 years or longer compared to the other certification year groups were slightly more likely to make known that they work primarily in the main emergency department, but this finding did not reach statistical significance (p=0.052; Figure 59).

Figure 59. Area of work by years certified (p=0.052)



Regarding U.S. regions, statistically significant differences in areas of work were found (p<0.001). Significantly higher proportions of participants in the Midwest compared to the other U.S. regions acknowledged that they primarily work in the main emergency department (Figure 60).

Figure 60. Area of work by U.S. region (p<0.001)



Employment Status at Principal Clinical Position

The vast majority (87.9%) of survey participants said that their employment status is full-time (Figure 61). Only 8.3% marked that they work part-time. When employment status was analyzed by gender, we found that males were slightly in terms of proportion difference but statistically significantly more likely to describe their employment status as full-time (91.8% vs. 85.1%; p<0.001; Figure 62).

Figure 61. What is your employment status at your principal clinical position?

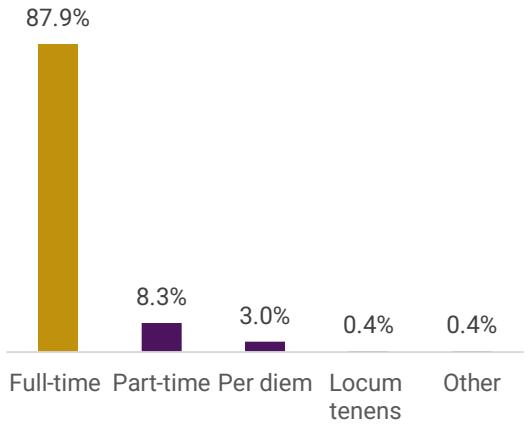
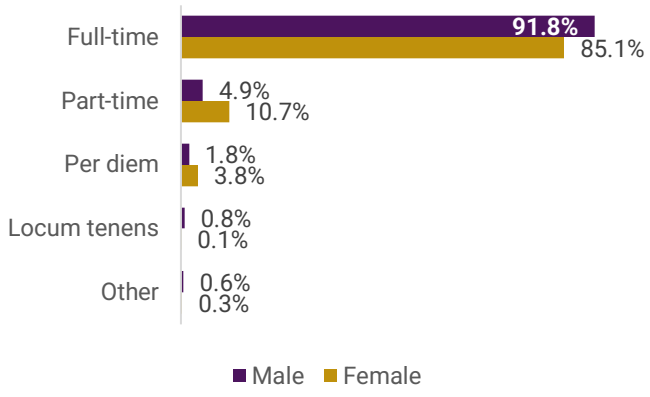


Figure 62. Principal position employment status by gender (p<0.001)**

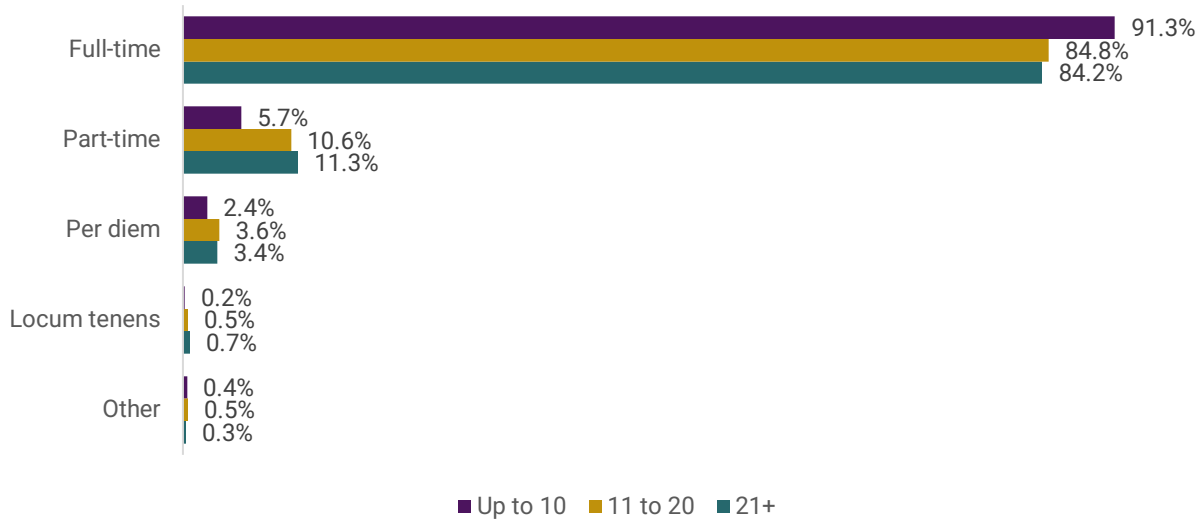
***Fisher-Freeman-Halton Exact test*



Statistically significant differences in employment status were also found for years certified (p=0.005). As shown in Figure 63, PAs who were certified for up to 10 years had a higher proportion (91.3%) of being employed full-time when compared with PAs certified for 11 to 20 years (84.8%) and 21 years or more (84.2%).

Figure 63. Principal position employment status by years certified (p=0.005)**

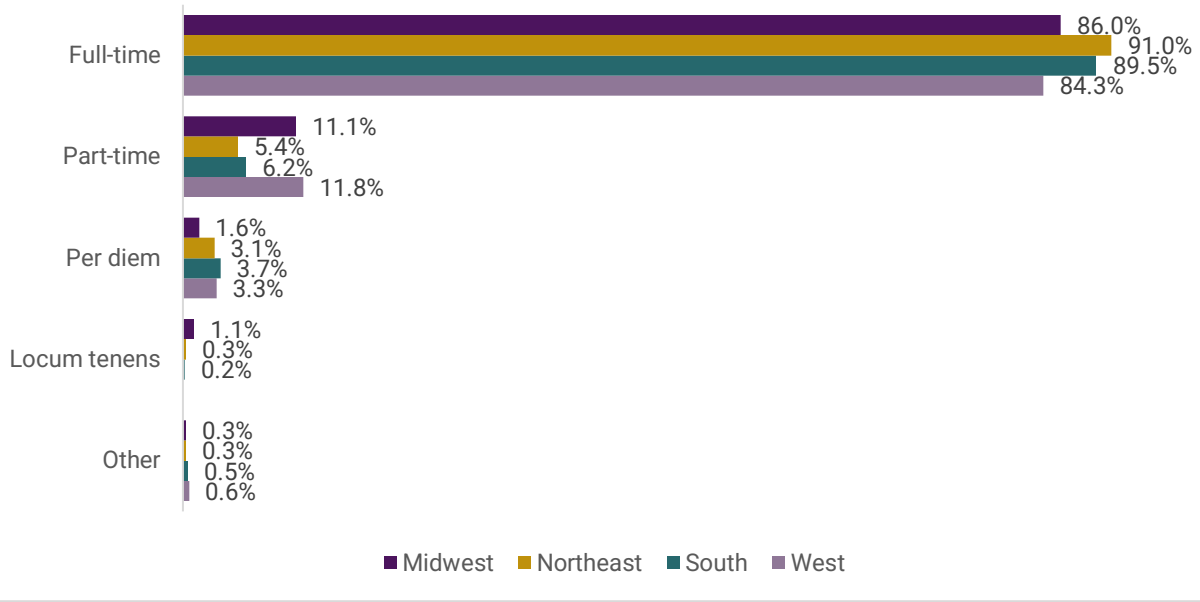
***Fisher-Freeman-Halton Exact test*



Participants residing in the Northeast compared to the other U.S. regions were more likely to indicate that they work full-time (p=0.003; Figure 64).

Figure 64. Principal position employment status by U.S. region (p=0.003)**

*** Fisher-Freeman-Halton Exact test*



Employment by Group Type

The highest percentage (42.4%) of survey respondents affirmed that they are primarily employed by a multi-site EM group, while 38.6% said hospital/healthcare system (Figure 65). We did not detect a significant association between group type and gender (p=0.512; Figure 66); however, there were differences by years certified (p=0.016) and U.S. region (p<0.001).

Figure 65. What type of group are you primarily employed by today?

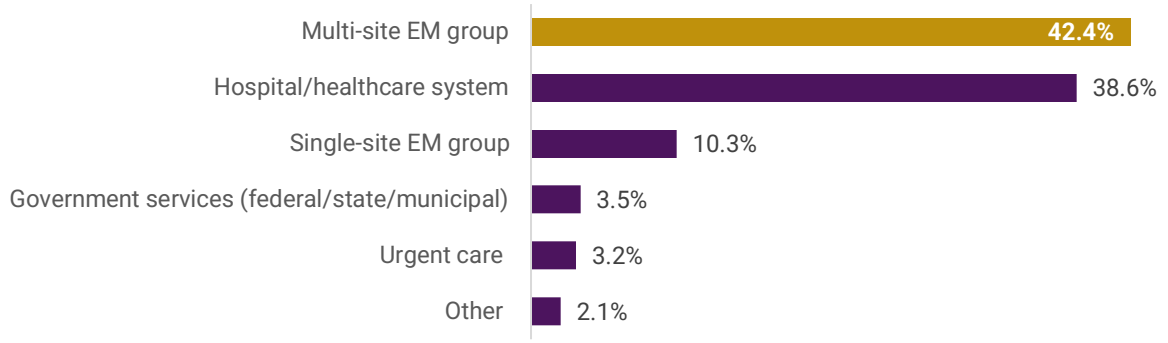
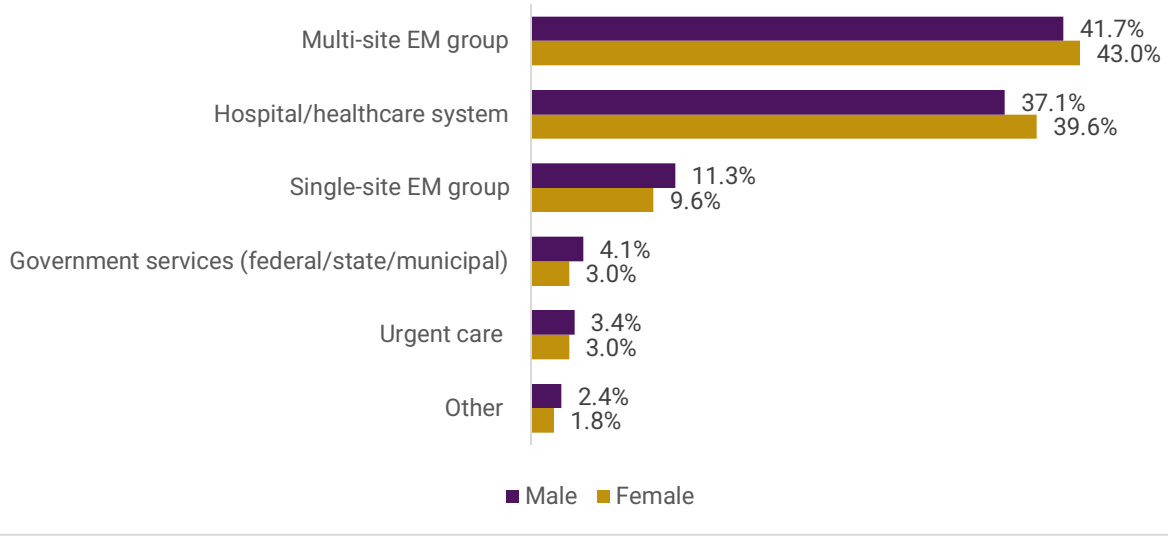


Figure 66. Type of group by gender (p=0.512)



Significantly higher proportions of PAs who were certified for 11 to 20 years were employed by a multi-site EM group (Figure 67), while those certified for 21 years or more had a slightly higher percentage of being employed by a hospital/healthcare system than PAs in the other certification year groups.

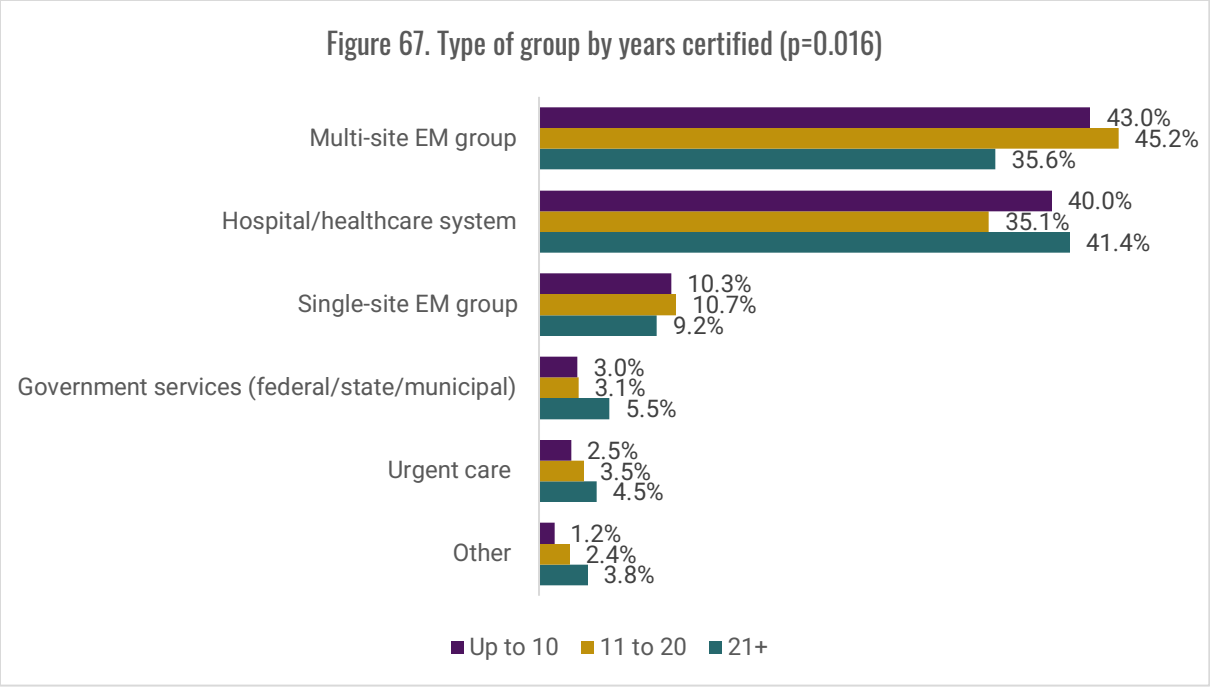
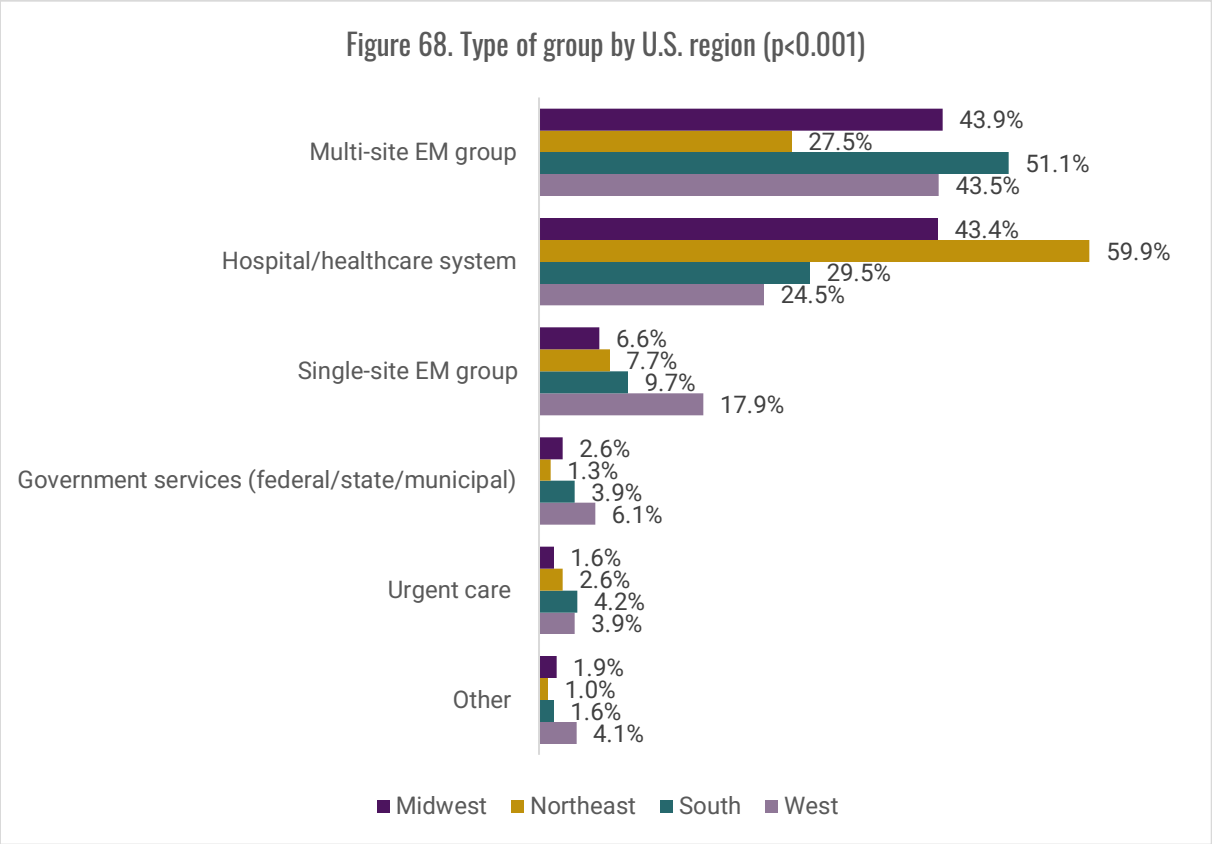


Figure 68 shows that participants residing in the Northeast were less likely than PAs in the other U.S. regions to identify that a multi-site EM group employed them; they were more likely to cite being employed by a hospital/healthcare system.



Employment Type

Most (92.4%) survey participants considered themselves employees (Figure 69). Few (3.7%) listed themselves as independent contractors, a partner in a group (2.9%), and self-employed (1.1%).

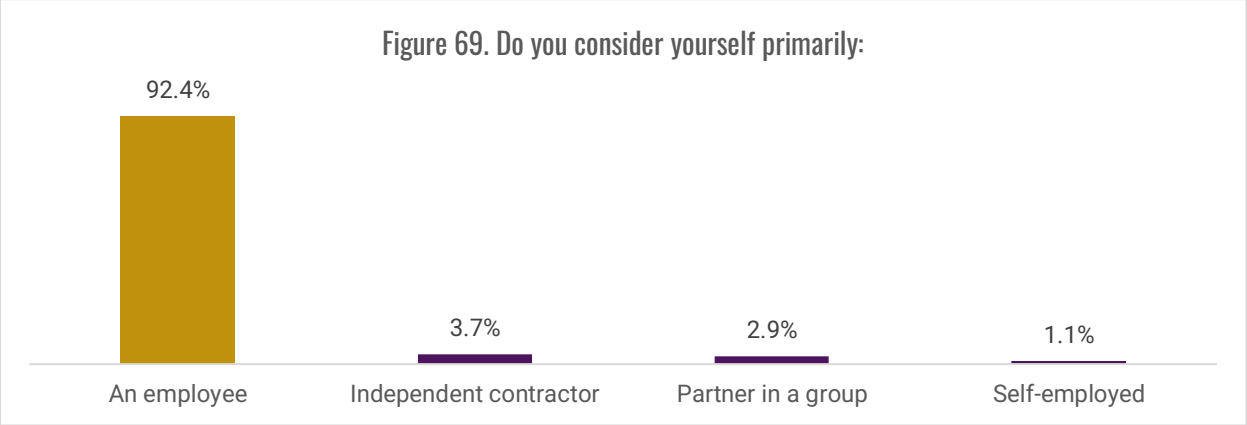


Figure 70 delineates the association of employment type with gender. We found statistically significant differences ($p<0.001$) whereby females were more likely to consider themselves an employee than males (94.5% vs. 89.4%).

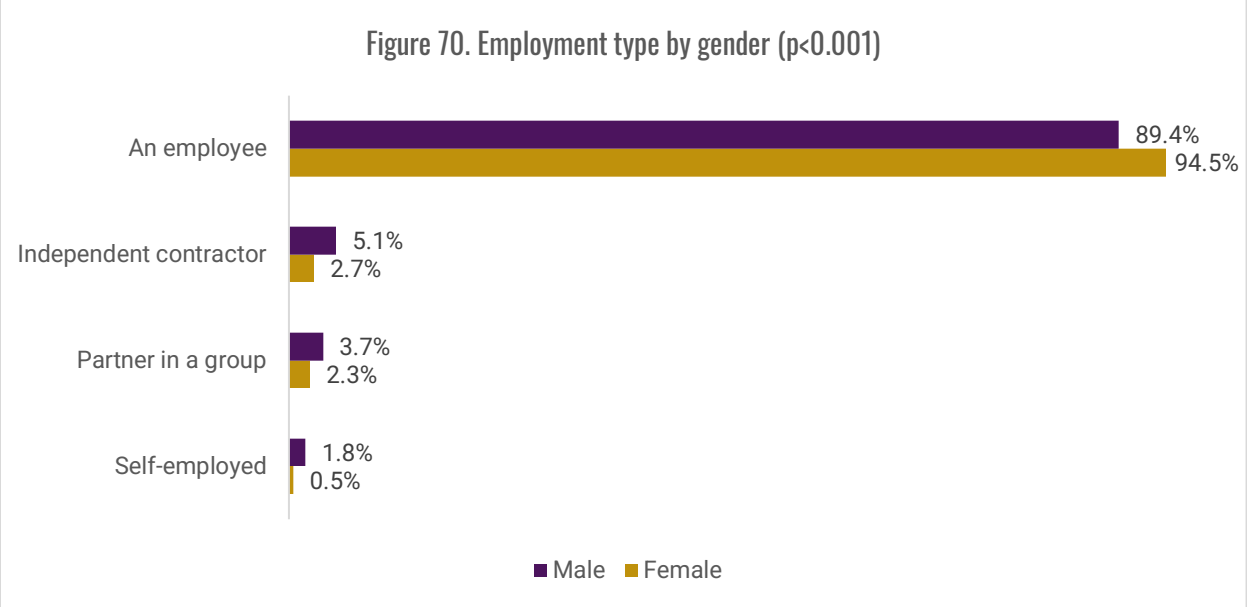


Figure 71 depicts that PAs who were certified for up to 10 years, compared to the other certification year groups, had the highest proportion of identifying themselves as employees ($p=0.002$).

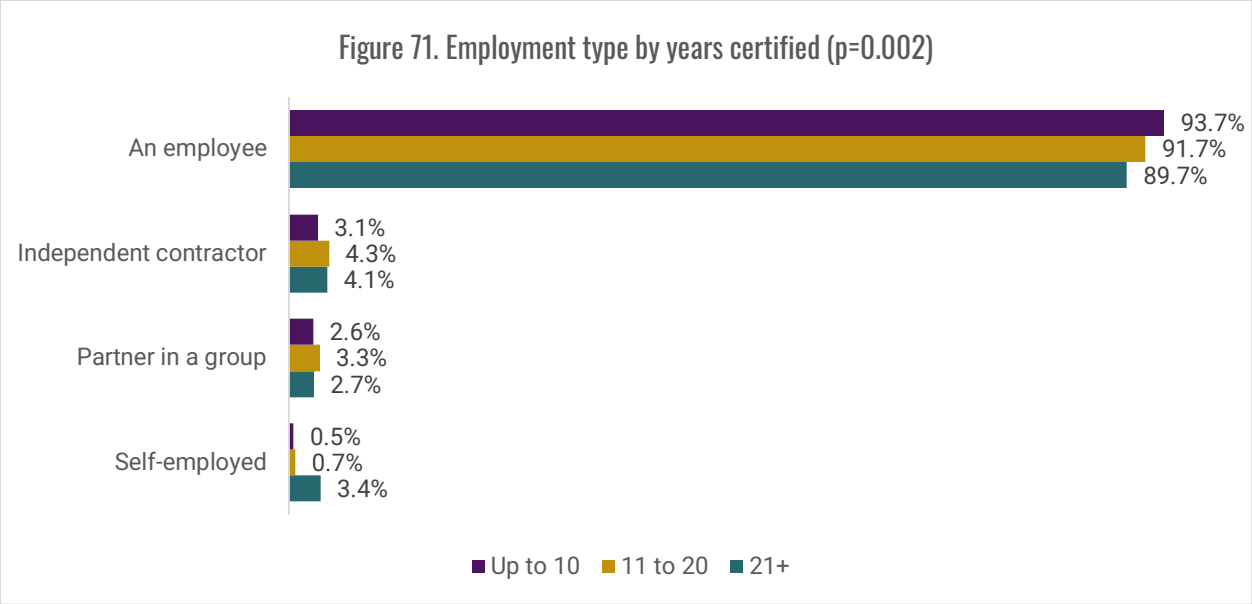
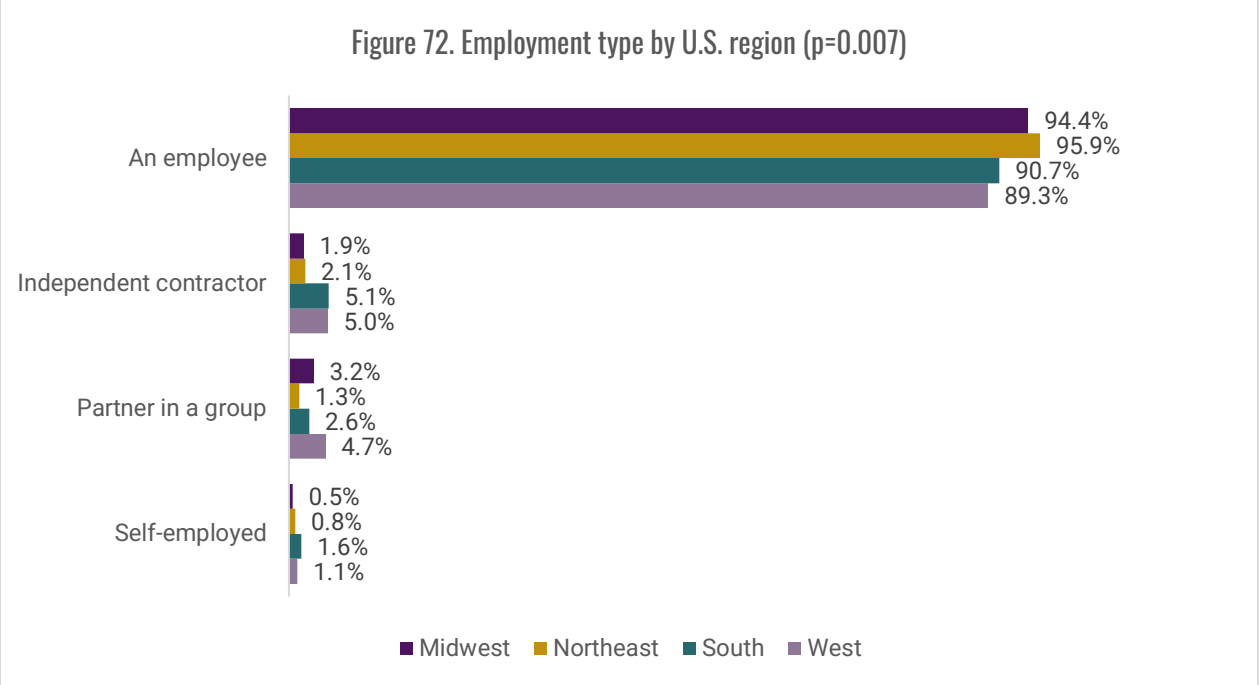


Figure 72 pertains to employment type parsed by U.S. region. Participants residing in the Northeast were slightly more likely to describe themselves as employees than participants in the other U.S. regions (p=0.007).



Principal Employment Arrangement

When asked about their principal employment arrangement, 68.4% said they are contracted, 29.0% at-will, and 2.6% “other” (Figure 73). As demonstrated in Figure 74, principal employment

arrangement did not statistically differ based on gender (p=0.655), with proportions being almost identical for male and female PAs.

Figure 73. How would you describe your principal employment arrangement?

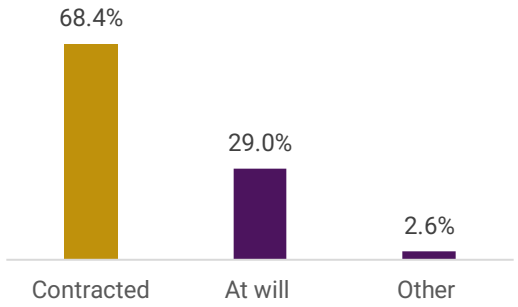
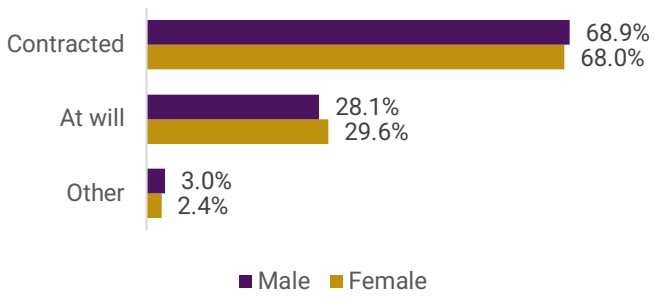


Figure 74. Principal employment arrangement by gender (p=0.655)



Regarding years certified, statistically significant differences were found (p=0.003) on principal employment arrangement. PAs certified for up to 10 years vs. 11-20 and 21 or longer were more likely to consider themselves contracted (Figure 75). Differences were also found to be statistically significant for U.S. regions (p=0.022), whereby PAs residing in the South had the highest proportion of identifying their principal employment arrangement as contracted (Figure 76).

Figure 75. Principal employment arrangement by years certified (p=0.003)

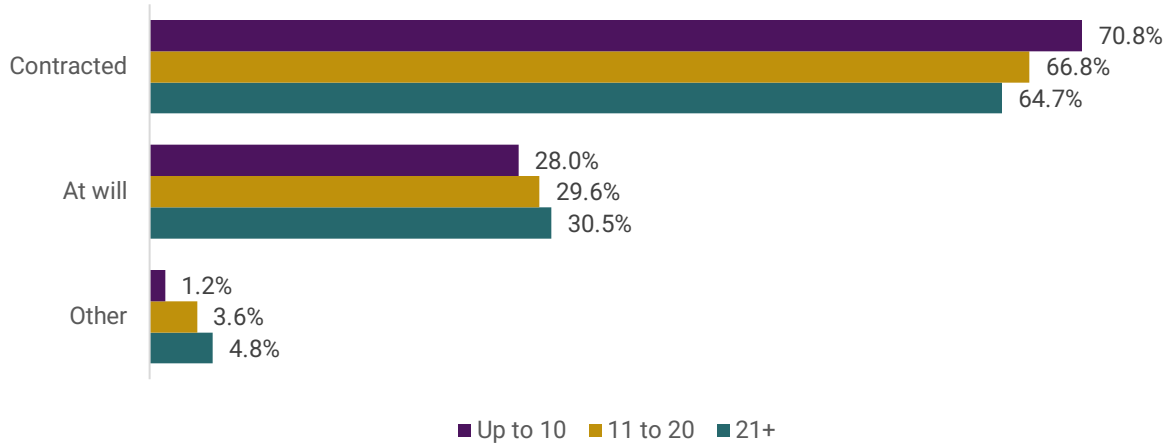
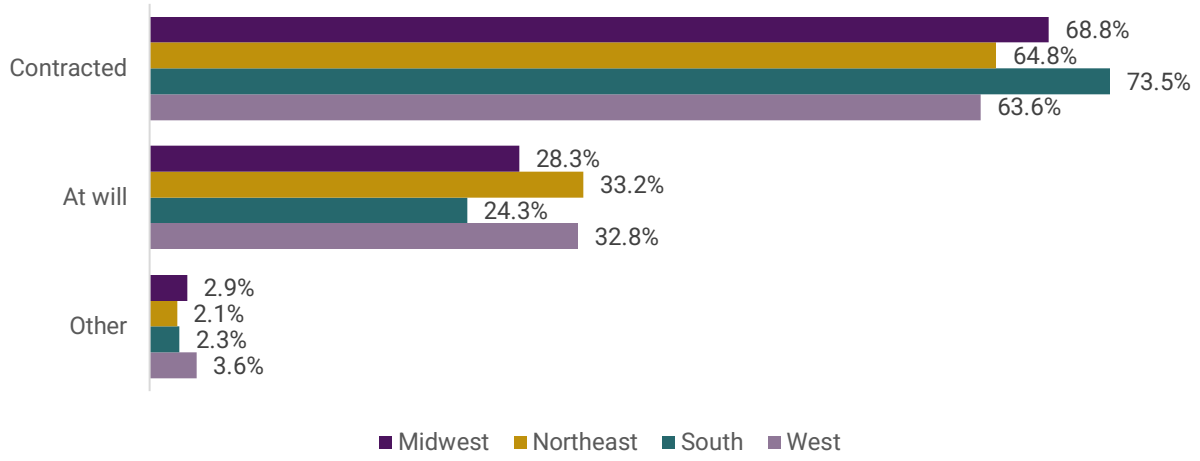


Figure 76. Principal employment arrangement by U.S. region (p=0.022)



Urban-Rural Setting of Principal Clinical Practice

More than a third (39.2%) of survey participants indicated that the area in which their principal clinical position is located is in an urban setting (Figure 77). This is followed by 35.1% who said suburban, 20.0% rural, and 5.7% reported multiple areas. Differences were found to be statistically significant for area of principal clinical practice by gender (p<0.001; Figure 78) and U.S. region (p=0.018; Figure 80), but not by years certified (p=0.222; Figure 79). Females were more likely to work in urban (41.1% vs. 36.4%) and suburban areas (37.8% vs. 31.4%), while males were more likely to work in rural areas (26.7% vs. 15.3%).

Figure 77. Which of the following best describes the area in which your principal clinical practice is located?

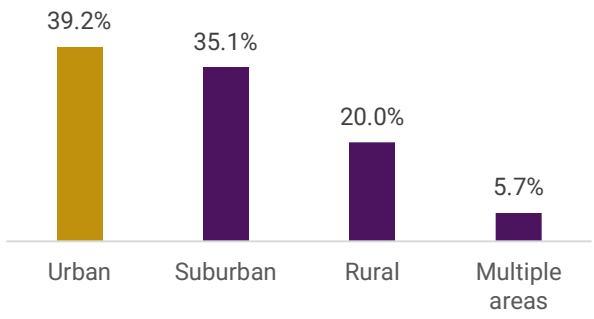


Figure 78. Urban-rural setting of principal clinical practice by gender (p<0.001)

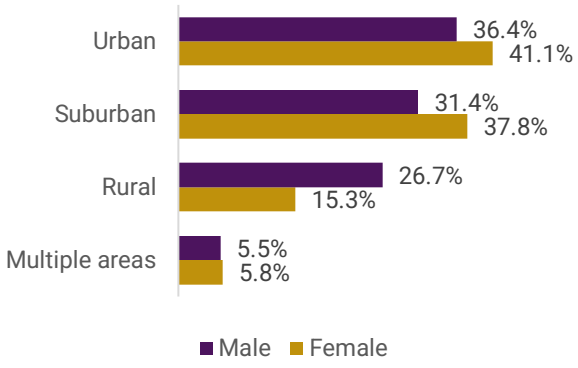
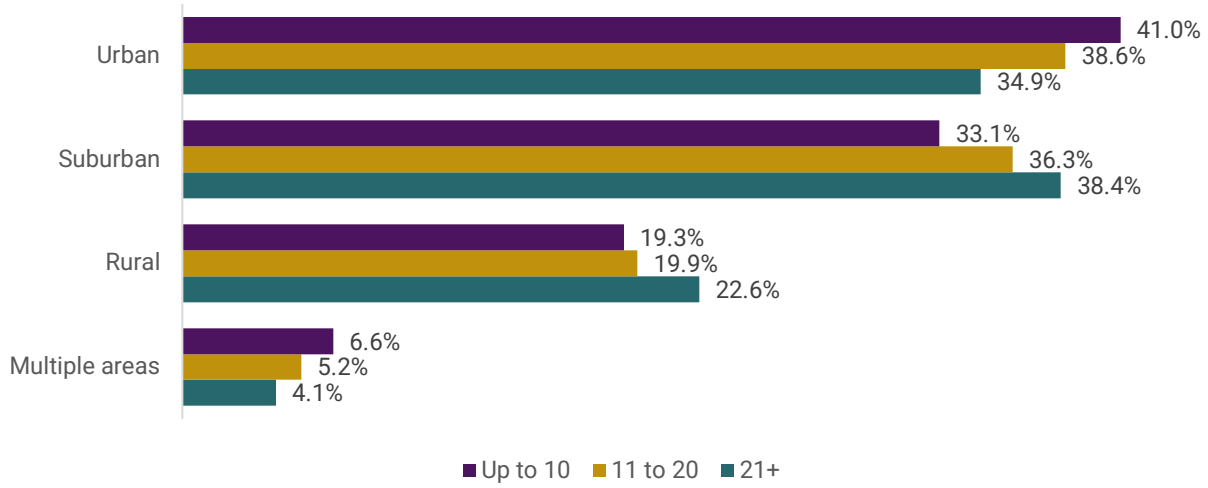
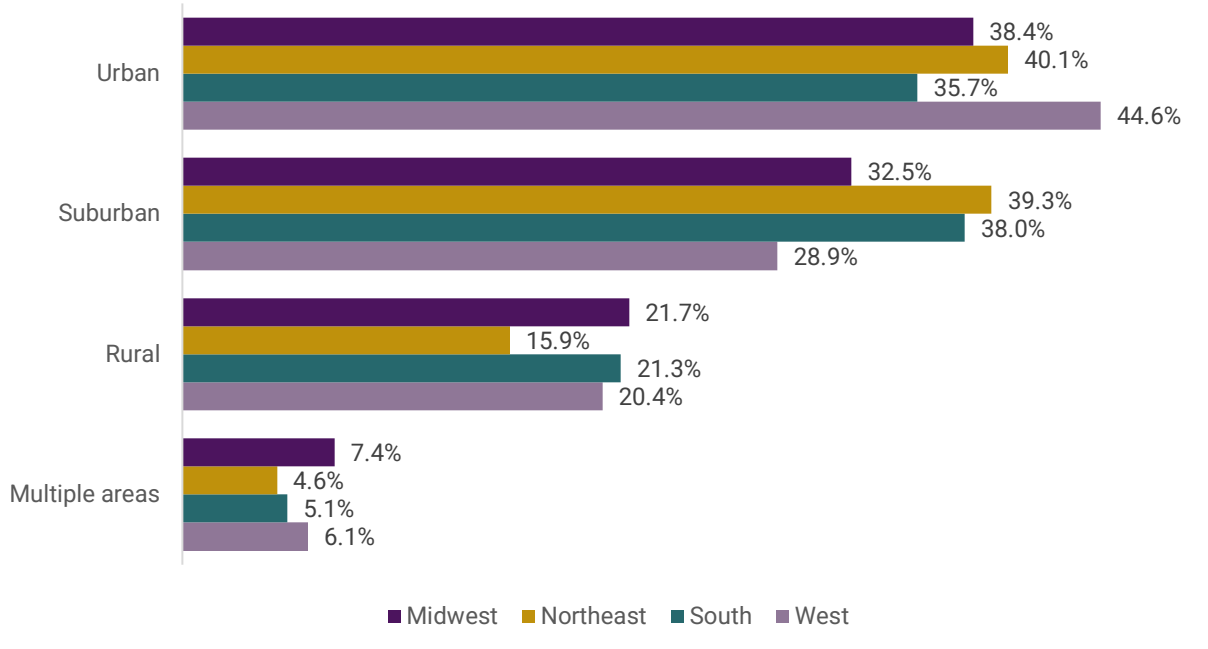


Figure 79. Urban-rural setting of principal clinical practice by years certified (p=0.222)



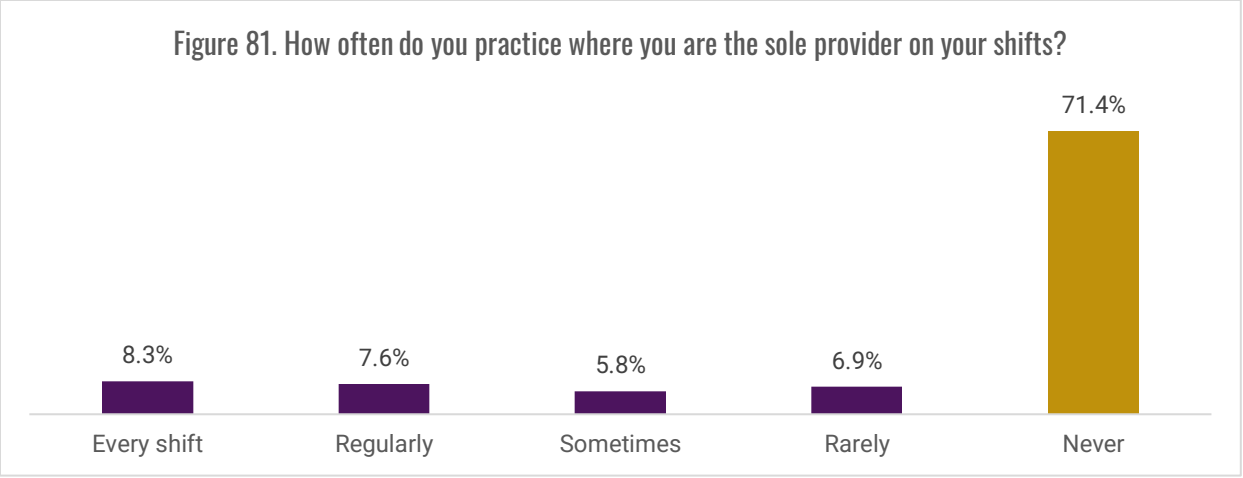
PAs in the West were more likely to report practicing in an urban area than PAs in other U.S. regions.

Figure 80. Urban-rural setting of principal clinical practice by U.S. region (p=0.018)

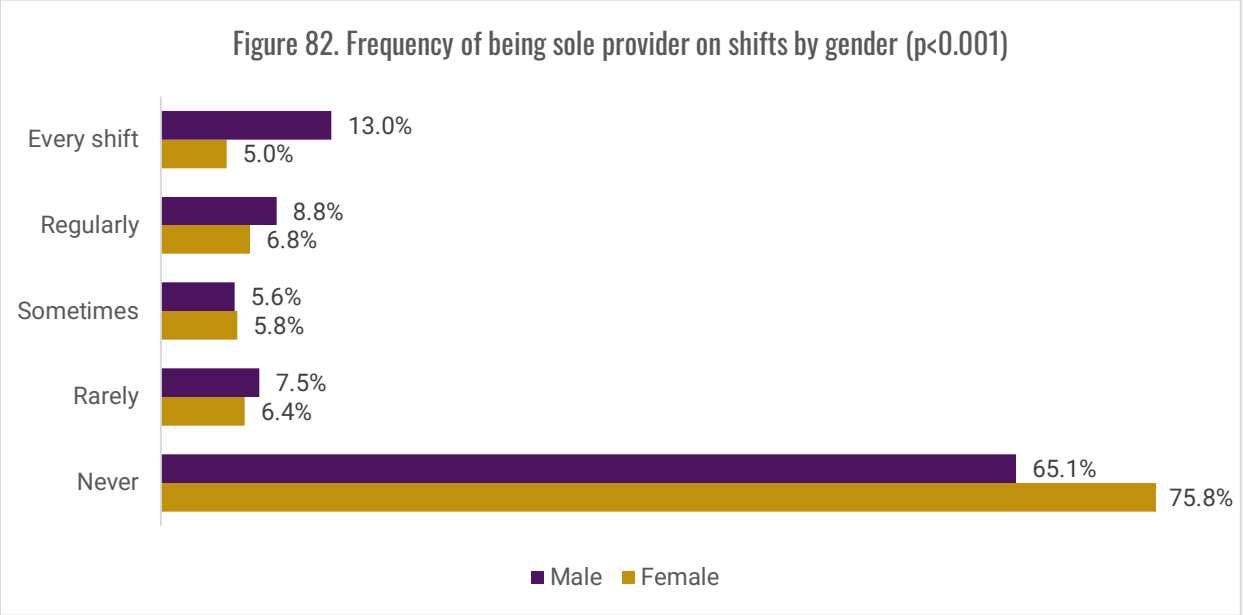


Frequency of Being Sole Provider on Shifts

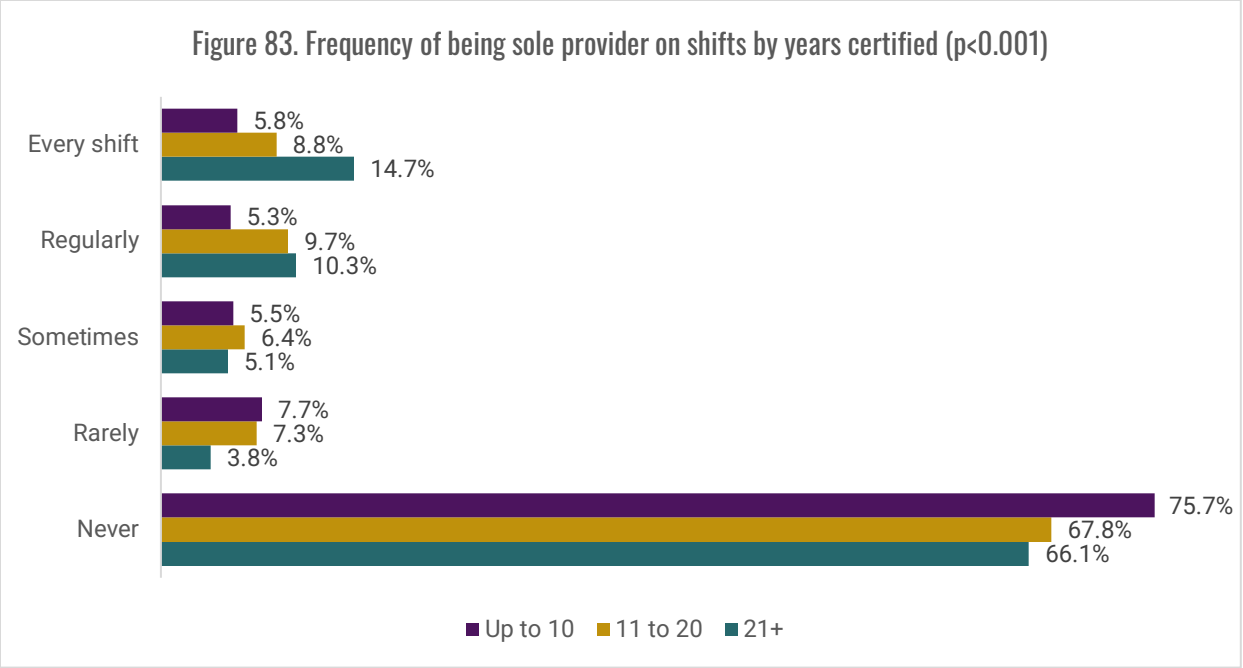
The majority of PAs (71.4%) expressed that they are never the sole provider on their shifts, while 8.3% marked that they are the sole provider on every shift (Figure 81).



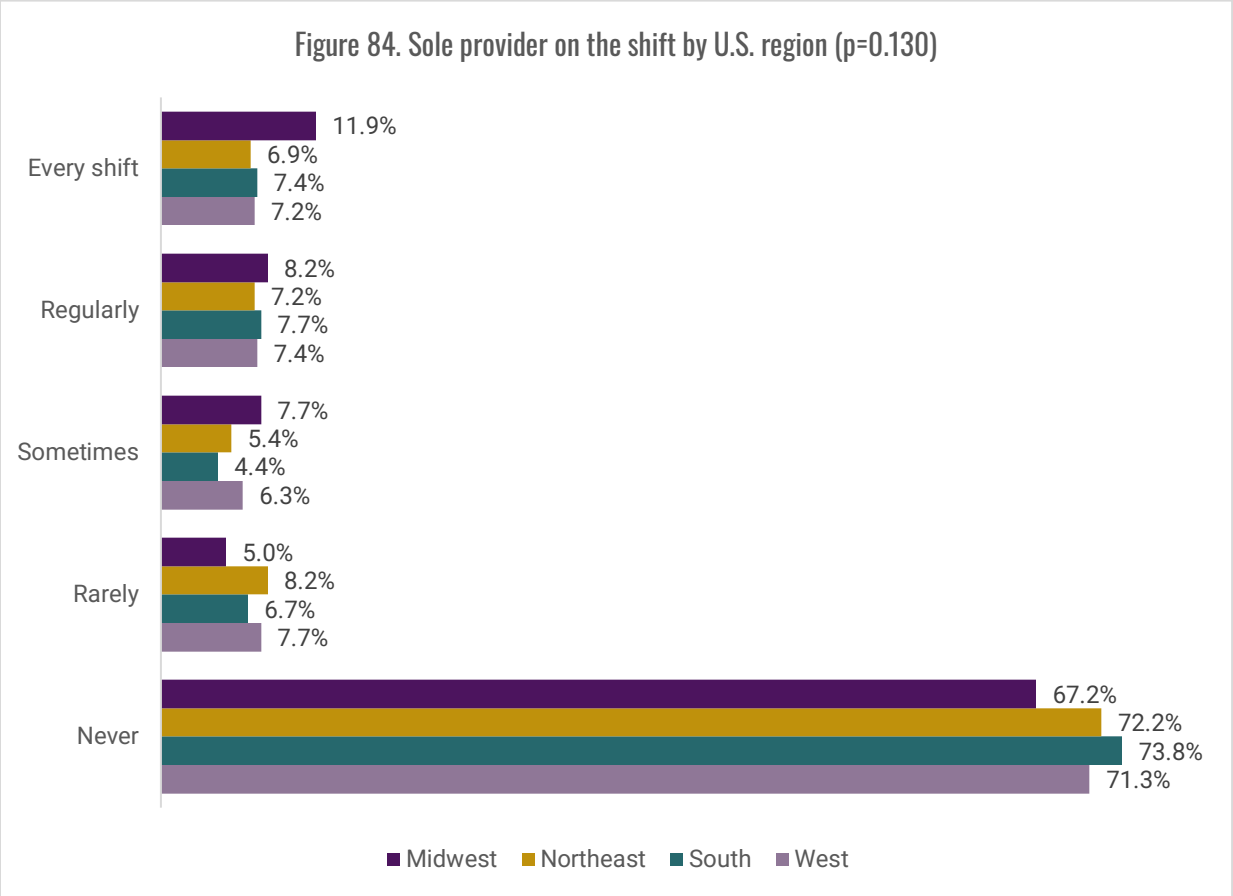
Females were more likely than males to report that they are never the sole provider on shifts (75.8% vs. 65.1%), while males were more likely than females to indicate they are the sole provider on every shift (13.0% vs. 5.0%; Figure 82).



PAs certified for up to 10 years had a higher proportion of selecting that they are never the sole provider on their shifts than PAs certified for 11-20 and 21 years or longer (75.7% vs. 67.8 and 66.1%; p<0.001; Figure 83).



Differences were not found to be statistically significant for the frequency of being a sole provider on shifts by U.S. region (p=0.130; Figure 84).



Utilize Telemedicine to Consult with Collaborating/Supervising Physician

Slightly more than three-quarters (78.6%) never utilize telemedicine to consult with their collaborating/supervising physician (Figure 85). Females were more likely to indicate that they never utilize telemedicine to consult with their collaborating/supervising physician compared to males (80.8% vs. 75.6%; p=0.035; Figure 86).

Figure 85. How often do you utilize telemedicine to consult with your collaborating/supervising physician?

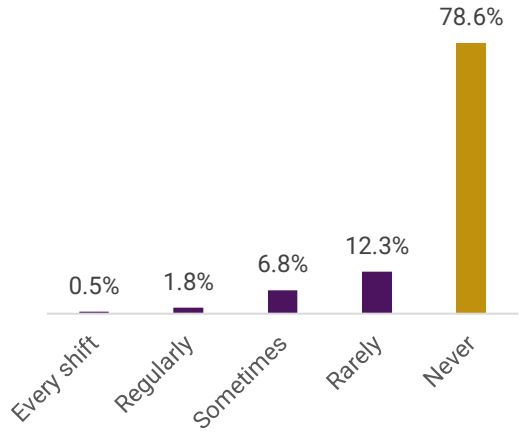


Figure 86. Utilize telemedicine to consult with collaborating/supervising physician by gender (p=0.035)**

** *Fisher-Freeman-Halton Exact test*

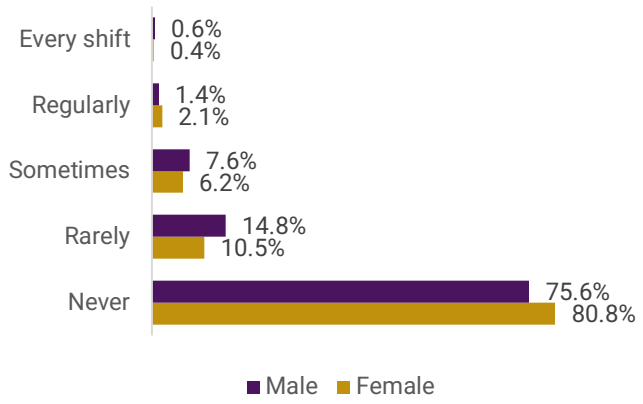
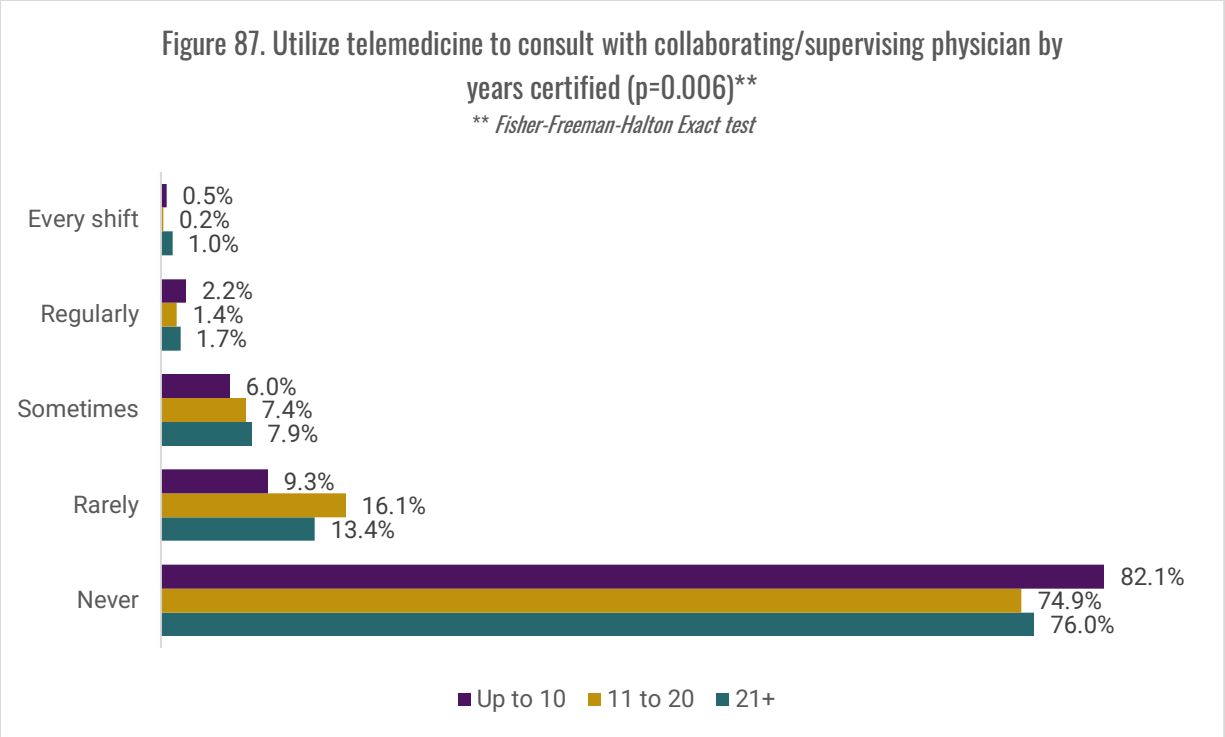
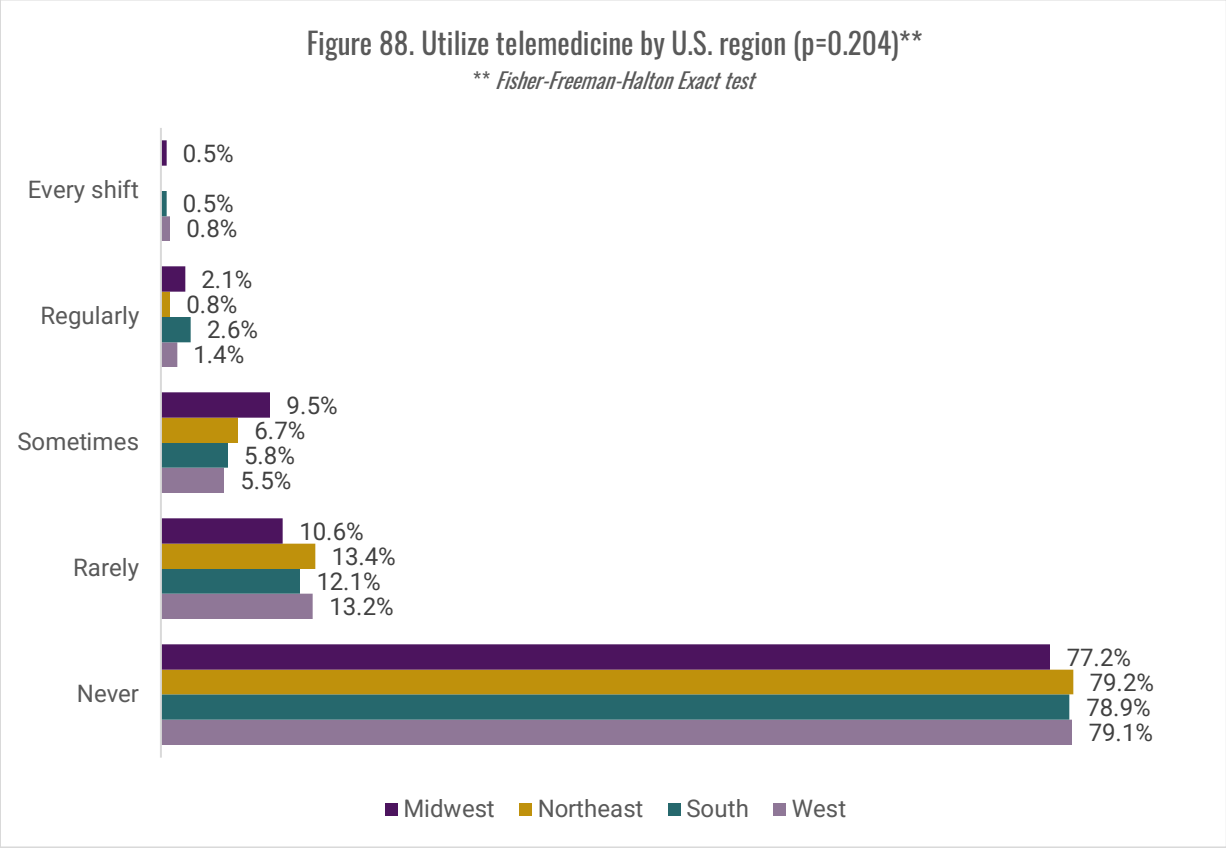


Figure 87 illustrates that participants certified for up to 10 years had a higher proportion of selecting that they never utilize telemedicine when consulting with their collaborating/ supervising physician than PAs in other certification year groups (p=0.006).



We did not detect statistically significant differences by U.S. region (p=0.204; Figure 88).



Decisions Made in Practice Regarding Equipment, Supplies, Etc.

Survey participants were inquired about the role they play in decision-making for their practice concerning equipment, supplies, medication, etc. Almost half (46.0%) of participants felt that they do have some input, 20.8% are the decision-maker, 18.2% have no input at all, and 15.1% are key influencers (Figure 89).

Figure 89. When decisions are made regarding equipment, supplies, medications, etc., in your practice:

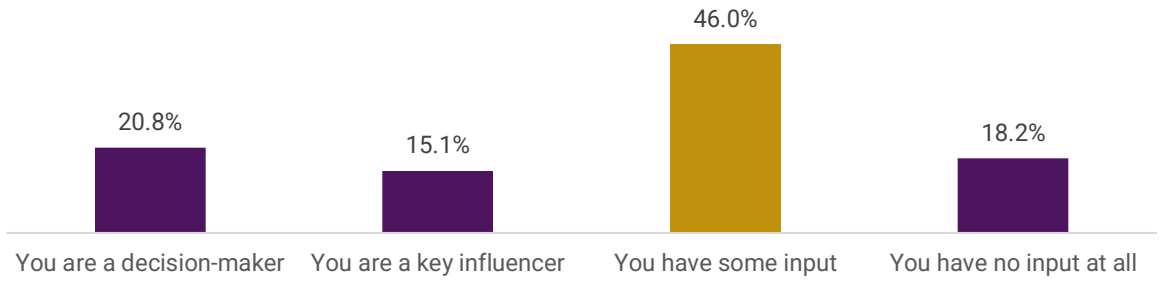
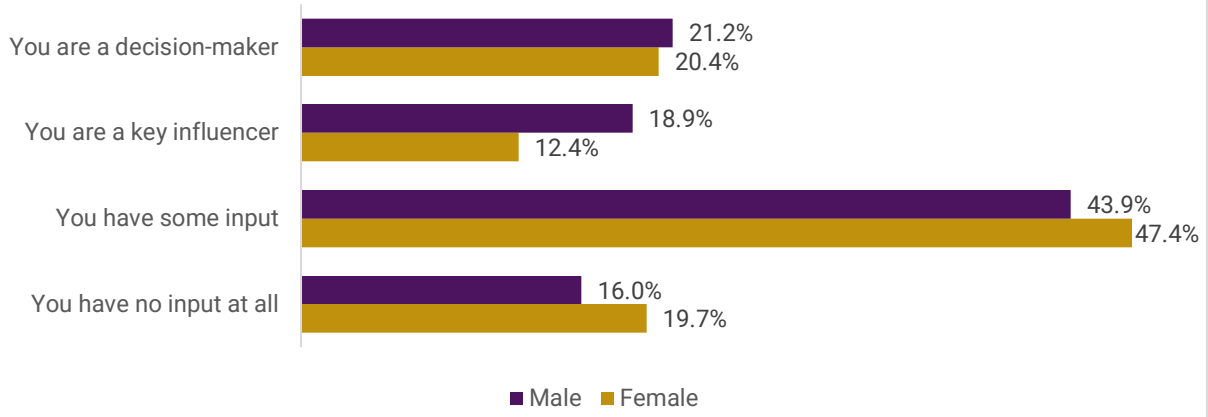


Figure 90 shows that female PAs were more likely to have some input than males (47.4% vs. 43.9%; p=0.001). Conversely, males were more likely to express being a decision-maker and key influencer.

Figure 90. Decisions made in practice regarding equipment, supplies, etc. by gender (p=0.001)



We found statistically significant differences when evaluating decision-making by years certified (p=0.001; Figure 91), but not by U.S. region (p=0.737; Figure 92). PAs certified for 21 or more years had a higher proportion of acknowledging that they have some input when it comes to decisions made in their practice than PAs certified up to 10 and 11-20 years (54.1% vs. 44.8% and 43.6%).

Figure 91. Decisions made in practice regarding equipment, supplies, etc. by years certified (p=0.001)

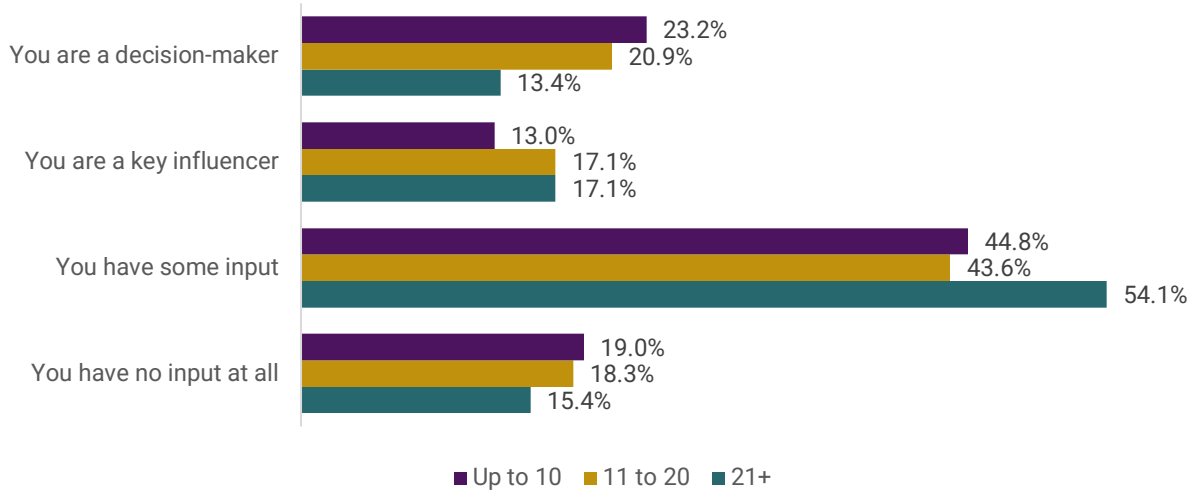
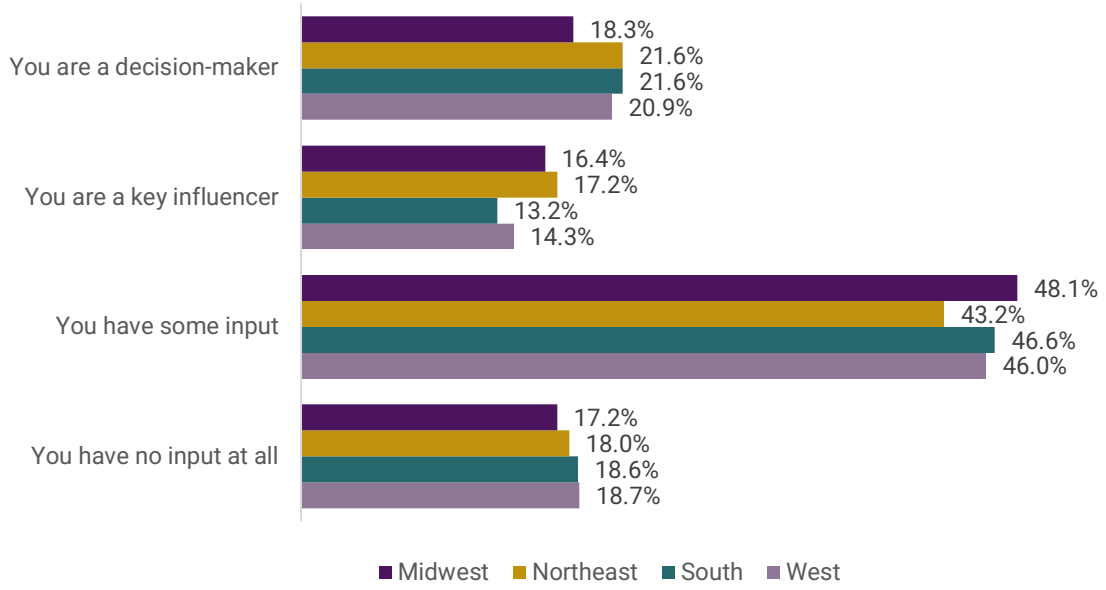


Figure 92. Decisions made in practice regarding equipment, supplies, etc. by U.S. region (p=0.737)



Hours Worked in a Typical Week at Principal Clinical Position

When we asked PAs how many hours they work in a typical week at their principal clinical position, the overall mean and median were 36.9 and 36.0 hours, respectively. Table 8 quantifies the relationship between hours worked and gender, years certified, and U.S. region. Males had a higher mean of hours worked than females (38.5 vs. 35.7; p<0.001). We detected a

statistically significant relationship between hours worked per week and U.S. regions (p<0.001). Further pairwise comparisons using the Bonferroni correction for multiple tests revealed that differences were between West and Northeast (35.6 vs. 36.5; p=0.032), West and South (35.6 vs. 38.3; p<0.001), and Midwest and South (36.2 vs. 38.3; p=0.005).

Table 8. Hours Worked in a Typical Week by Characteristics

Characteristics		Mean	Median	p-value
Gender	Female	35.7	36.0	<0.001
	Male	38.5	36.0	
Years Certified	Up to 10	37.2	36.0	0.403
	11 to 20	36.1	36.0	
	21+	37.5	36.0	
U.S. Region	Midwest	36.2	36.0	<0.001
	Northeast	36.5	36.0	
	South	38.3	36.0	
	West	35.6	36.0	

Employer Call Requirement

Over 15% of participants noted that their employer requires them to take call (Figure 93). When this question was examined by gender, statistically significant differences were not found (p=0.066; Figure 94).

Figure 93. Does your employer require you to take call?

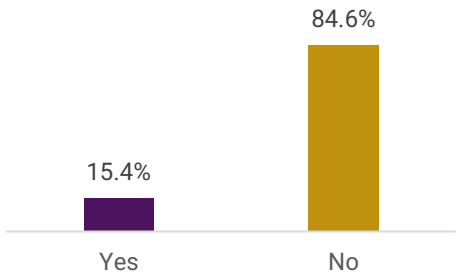
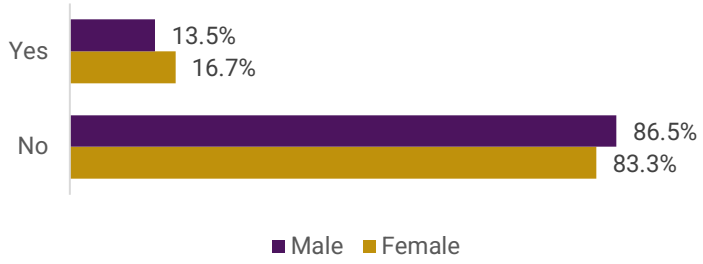


Figure 94. Employer PA call requirement by gender (p=0.066)



Statistically significant differences were revealed when requirement to take call was assessed by years certified (p=0.043) and U.S. region (p=0.005). PAs certified for up to 10 years compared to those 11 to 20 and 21 or longer were more likely to indicate that they are required to take call (17.6% vs. 12.8% and 14.0%; Figure 95). Furthermore, we found that PAs in the West had the lowest proportion of declaring that they were required to take call (Figure 96).

Figure 95. Employer PA call requirement by years certified (p=0.043)

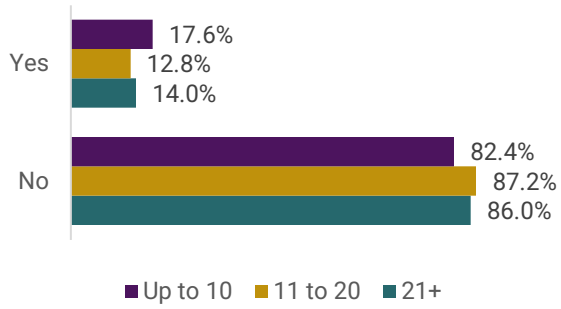
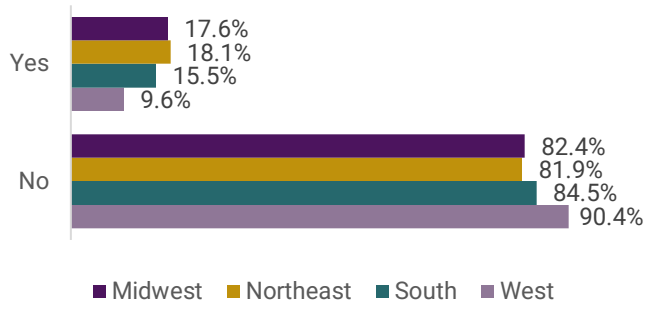


Figure 96. Employer PA call requirement by U.S. region (p=0.005)



Days on Call per Month

Survey participants who responded "yes" to being required to take call were further asked how many days of call they average per month. Of the 15.4% of participants that indicated they were required to take call the mean was 3.5 and a median of 2.0 days. We did not detect significant differences by years certified or U.S. region; however, there were differences by gender (p=0.001). When days of call was evaluated by gender, we observed that males had a significantly higher mean than females (4.7 vs. 2.8; Table 9).

Table 9. Days of Call per Month by Characteristics

Characteristics		Mean	Median	p-value
Gender	Female	2.8	1.0	0.001
	Male	4.7	2.0	
Years Certified	Up to 10	2.5	2.0	0.060
	11 to 20	4.7	2.0	
	21+	4.7	2.0	
U.S. Region	Midwest	4.2	1.0	0.288
	Northeast	2.6	1.0	
	South	3.3	2.0	
	West	4.3	2.0	

Work with Physician Residents in Practice

Almost half of PAs (44.2%) reported working with physician residents in their practice (Figure 97). Our analyses demonstrated differences by gender (p=0.038), with females more likely than

males to provide an affirmative response that they currently work with physician residents in their practice (46.3% vs. 41.2%; Figure 98).

Figure 97. Do you currently work with physician residents in your practice?

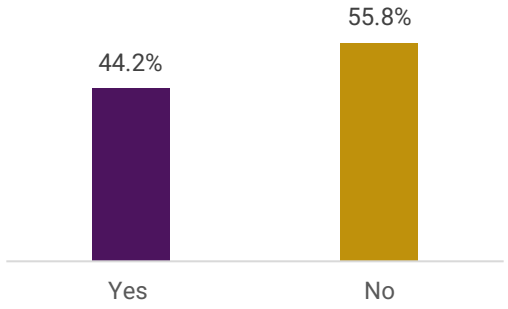
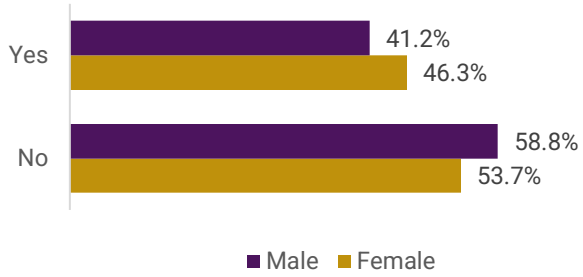


Figure 98. Currently work with physician residents in your practice by gender (p=0.038)



Differences were not identified to be statistically significant for working with physician residents by years certified (p=0.600; Figure 99), but a statistically significant association was detected with U.S. region (p=0.027). Compared to other U.S. regions, PAs residing in the Northeast had the highest proportion of indicating that they work with physician residents in their practice (Figure 100).

Figure 99. Currently work with physician residents in your practice by years certified (p=0.600)

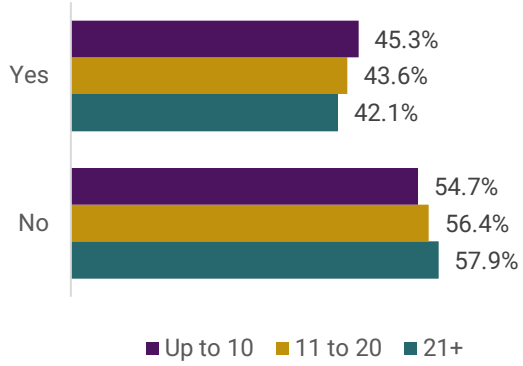
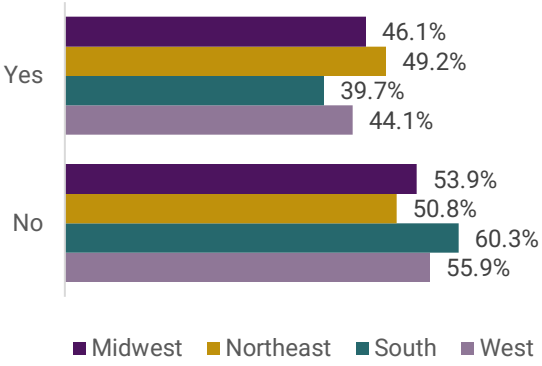
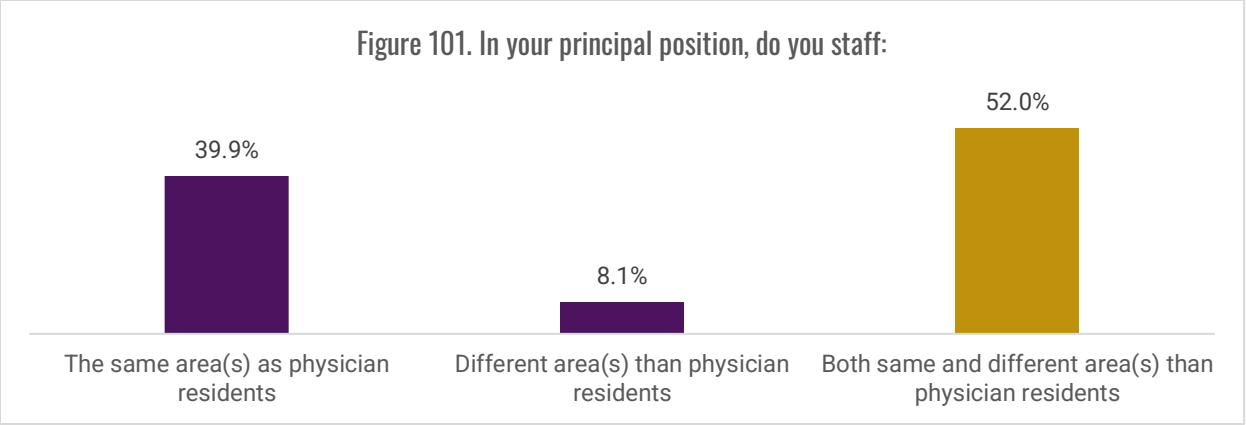


Figure 100. Currently work with physician residents in your practice by U.S. region (p=0.027)

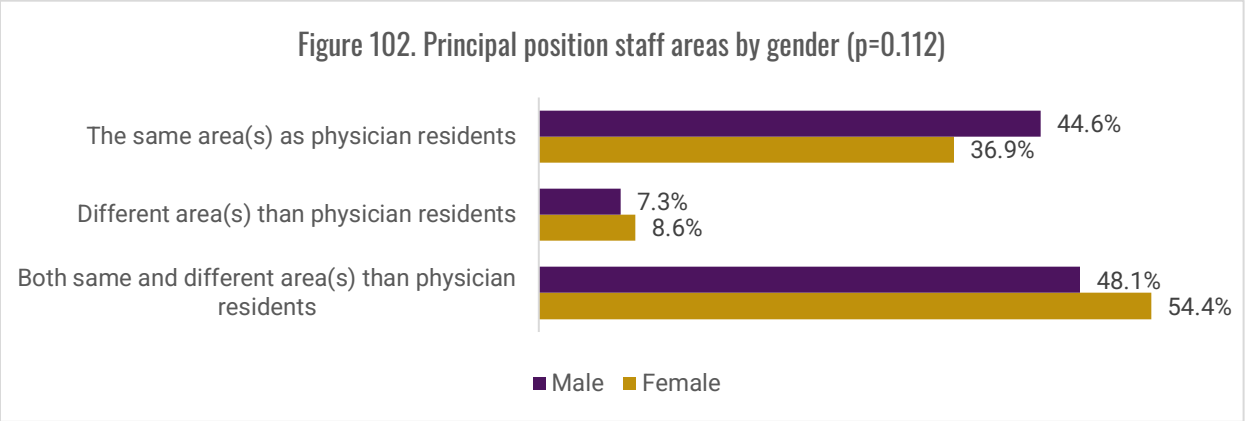


Principal Position Staff Areas

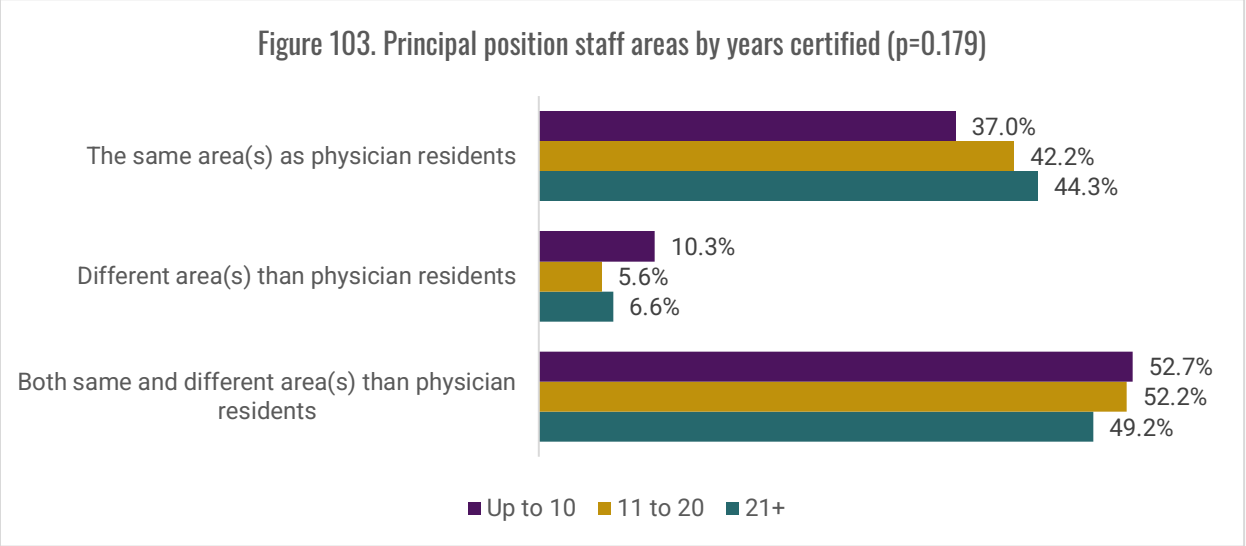
PAs who currently work with physician residents (44.2%) were further inquired about how they staff physician residents in their principal position. Over half of the participants (52.0%) noted they staff both the same and different area(s) than physician residents, and 39.9% reported they staff the same area(s) as physician residents (Figure 101).



We did not discover significant differences by gender (p=0.112), but females had a higher proportion of citing that they staff both the same and different area(s) than physician residents compared to males (54.4% vs. 48.1%; Figure 102).

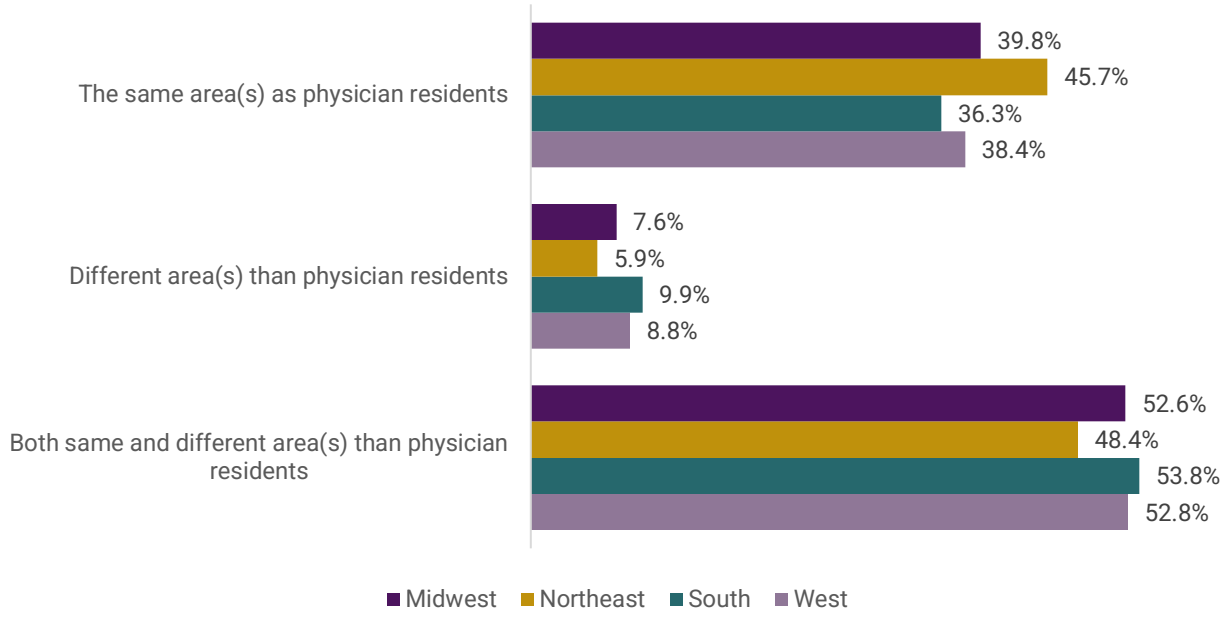


The association between principal position staff areas and years certified was not statistically significant (p=0.179; Figure 103).



In terms of U.S. region, statistically significant differences were also not observed (p=0.513; Figure 104).

Figure 104. Principal position staff areas by U.S. region (p=0.513)



Leadership/Administrative Position in Practice Setting

When PAs were asked if they were in a leadership/administrative position in their employment practice, 25.3% responded in the affirmative (Figure 105). We ascertained significant differences by gender (p<0.001; Figure 106) and years certified (p<0.001; Figure 107), but not by U.S. region (p=0.154; Figure 108). Males were more likely to select that they are in a leadership/administrative position compared to females (29.8% vs. 22.2%).

Figure 105. Are you in a leadership/administrative position in your practice setting?

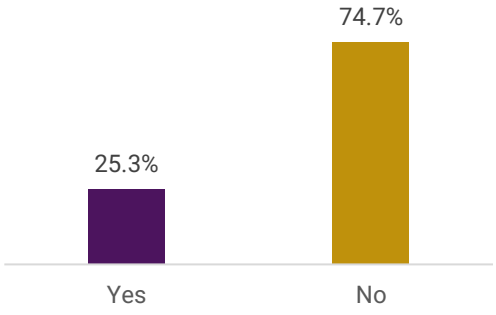
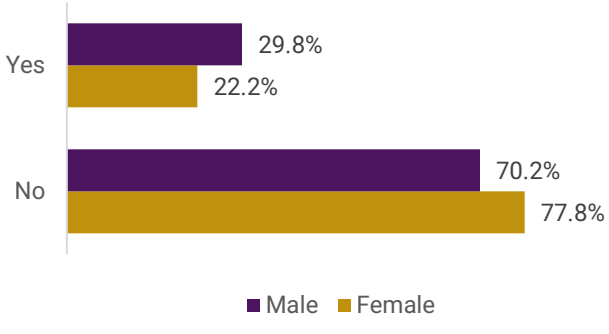


Figure 106. Leadership/administrative position in practice setting by gender (p<0.001)



Participants who were certified for 11 to 20 years were more likely to acknowledge that they are in a leadership/administrative position in their employment practice compared to those certified up to 10 and 21 or more years (33.0% vs. 18.4% vs. 29.8%).

Figure 107. Leadership/administrative position in practice setting by years certified (p<0.001)

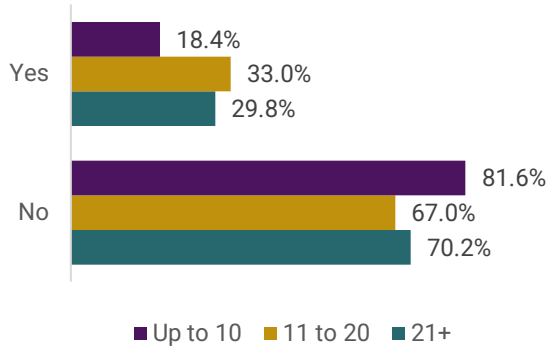
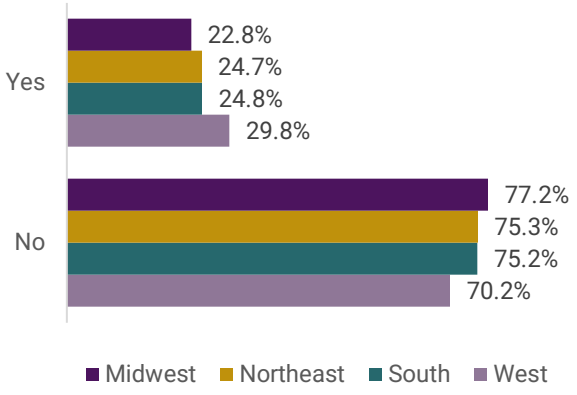


Figure 108. Leadership/administrative position in practice setting by U.S. region (p=0.154)



Position or Lecture at a PA Program

PAs were asked if they hold a position with or lecture at a PA program; 18.2% responded in the affirmative (Figure 109). We found statistically significant differences when we assessed this question by gender (p=0.002). Males were more likely to report that they hold a position with or lecture at a PA program than females (21.7% vs. 15.7%; Figure 110).

Figure 109. Do you hold a position with or lecture at a PA program?

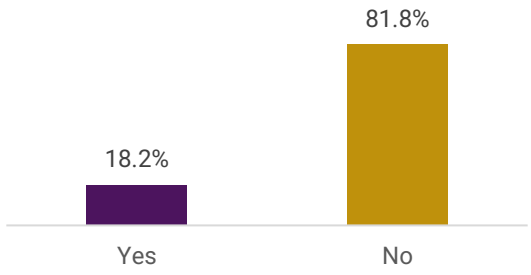
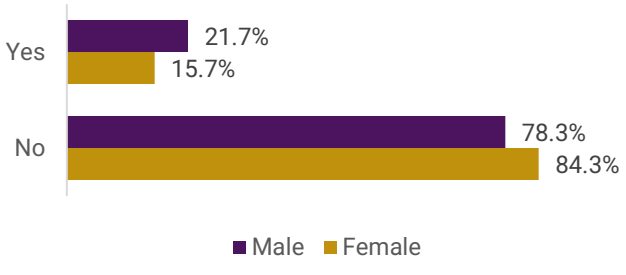
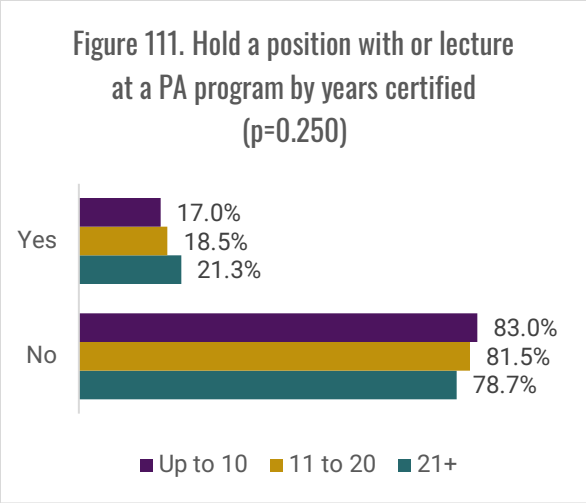
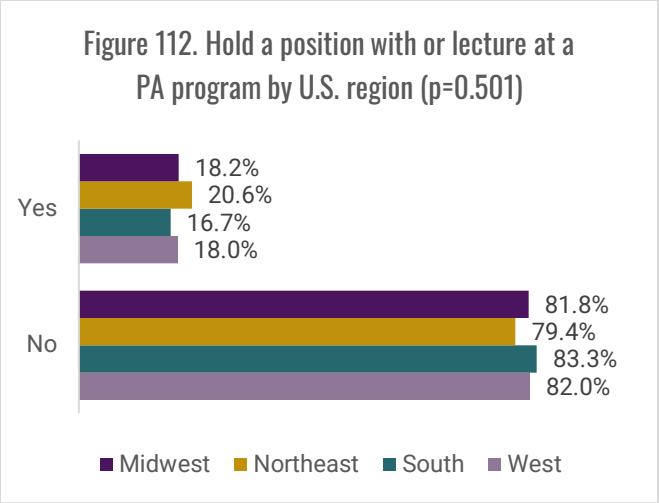


Figure 110. Hold a position with or lecture at a PA program by gender (p=0.002)



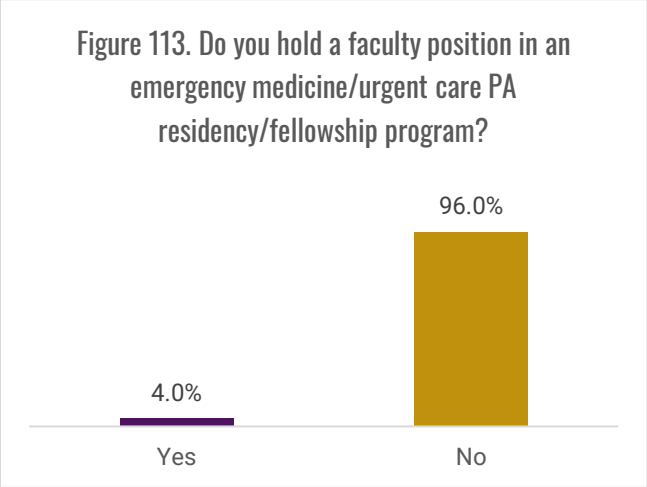
Statistically significant differences were not found by years certified (p=0.250; Figure 111) and U.S. region (p=0.501; Figure 112).

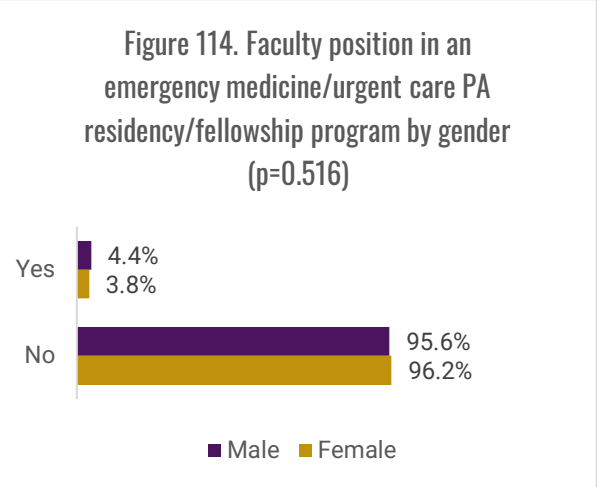




Faculty Position in an Emergency Medicine/Urgent Care PA Residency/Fellowship Program

Figure 113 illustrates that 4.0% of respondents identified that they hold a faculty position in an EM/UC PA residency/fellowship program. We did not detect a significant relationship by gender (p=0.516; Figure 114).





Similarly, the relationship between faculty position and years certified (p=0.158; Figure 115) and U.S. region (p=0.343; Figure 116) were not found to be statistically significant.

Figure 115. Faculty position in an emergency medicine/urgent care PA residency/fellowship program by years certified (p=0.158)

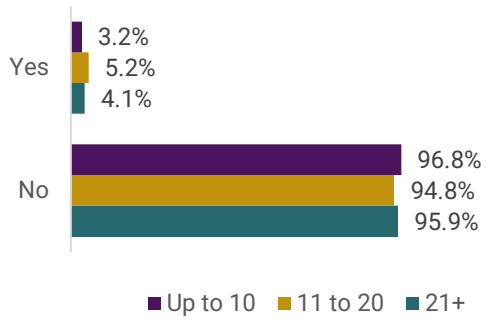
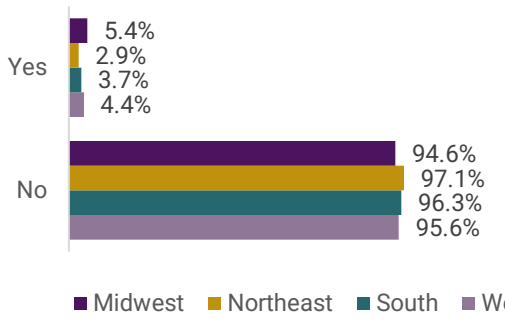


Figure 116. Faculty position in an emergency medicine/urgent care PA residency/fellowship program by U.S. region (p=0.343)



Emergency Medicine/Urgent Care PA Residency/Fellowship at Principal Practice

Most survey participants (81.4%) stated that their principal practice does not have an EM/UC PA residency/fellowship program, while 13.6% indicated they have a PA residency/fellowship, and 4.9% were not sure (Figure 117). Females were more likely than males to report that their principal practice has an EM PA residency (14.7% vs. 12.2%; p=0.013; Figure 118).

Figure 117. Does your principal practice have an emergency medicine/urgent care PA residency/fellowship?

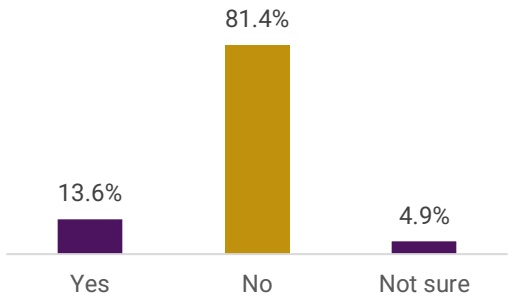
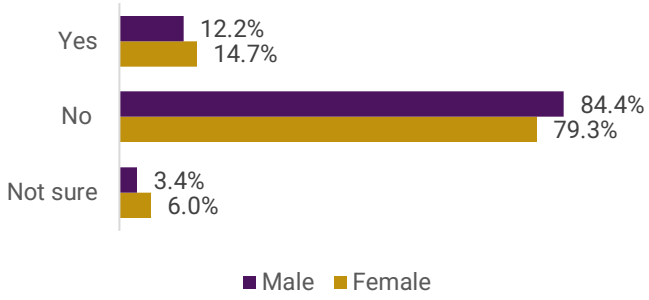


Figure 118. Principal practice has an emergency medicine/urgent care PA residency/fellowship by gender (p=0.013)



PAs who were certified for up to 10 years were more likely to report that their principal practice has an EM PA residency vs. PAs certified 11 to 20 and 21 or more years (15.0% vs. 13.9% and 9.3%; p=0.008; Figure 119). Regarding U.S. regions, PAs residing in the Northeast (17.7%), compared to Midwest (16.6%), South (10.6%), and West (11.0%), had the highest likelihood of indicating that their principal practice has an EM/UC PA residency/fellowship (p=0.014; Figure 120).

Figure 119. Principal practice has an emergency medicine/urgent care PA residency/fellowship by years certified (p=0.008)

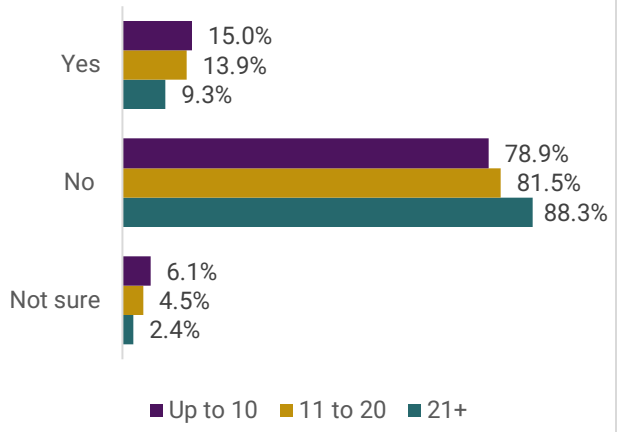
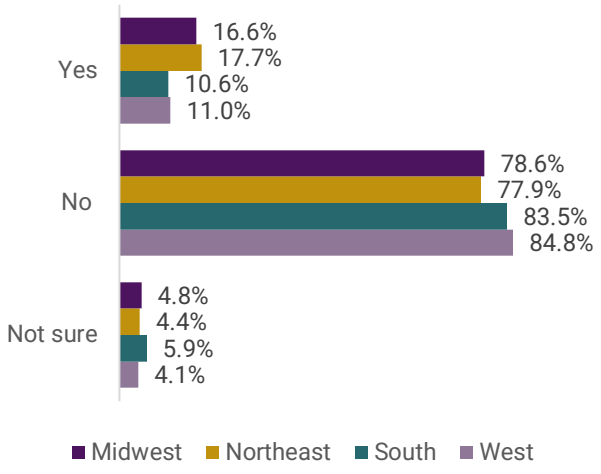


Figure 120. Principal practice has an emergency medicine/urgent care PA residency/fellowship by U.S. region (p=0.014)



PA Students Rotating Through Practice Setting

Majority of PAs (69.5%) selected that PA students currently rotate through their practice setting (Figure 121). Females had a similar percentage to males, indicating PA students currently rotate through their practice setting (69.7% vs. 69.2%; p=0.809; Figure 122).

Figure 121. Do PA students currently rotate through your practice setting?

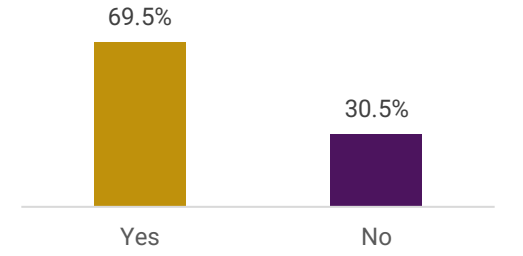
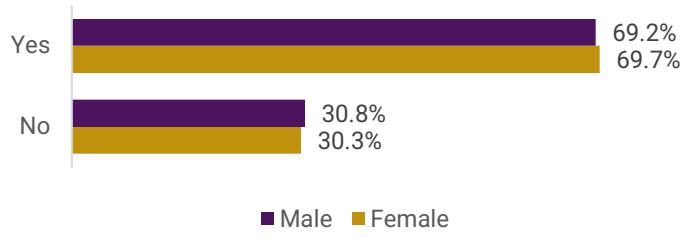
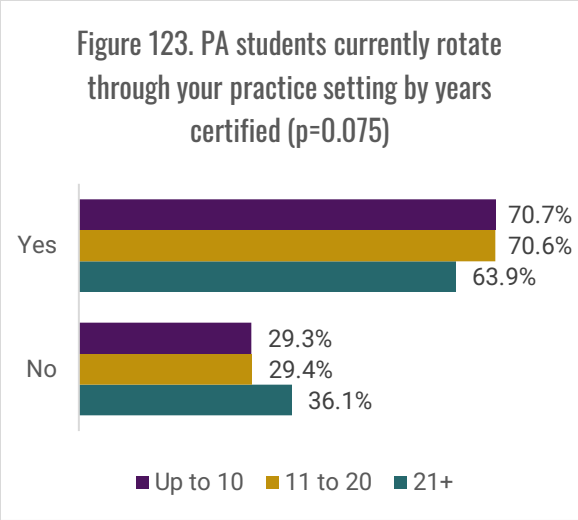
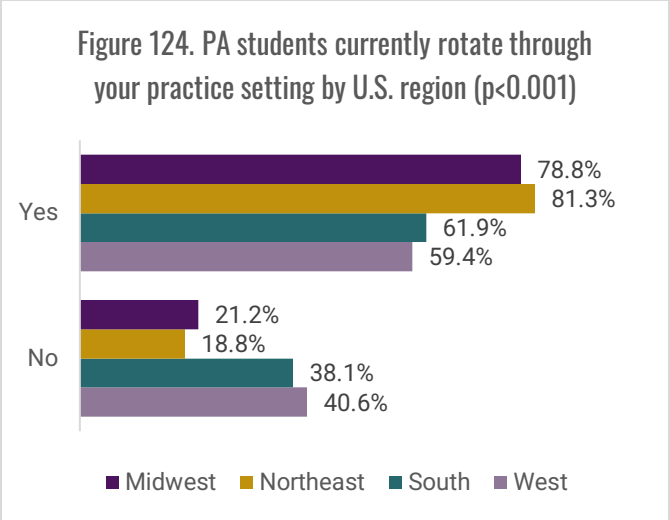


Figure 122. PA students currently rotate through your practice setting by gender (p=0.809)



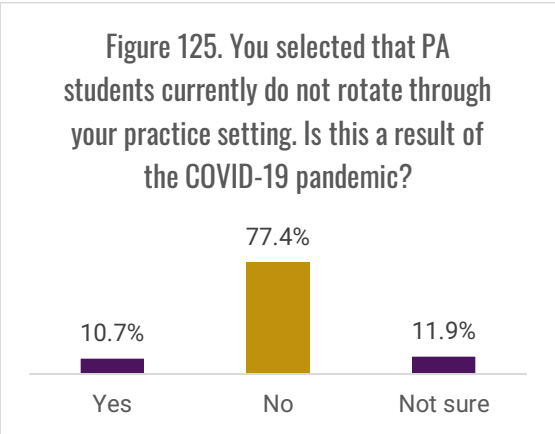
Similarly, statistically significant differences were not found when we parsed PA students currently rotating through practice setting by years certified (p=0.075; Figure 123). Participants residing in the Northeast (81.3%), compared to Midwest (78.8%), South (61.9%), and West (59.4%), had the highest likelihood of reporting that PA students currently rotate through their practice setting (p<0.001; Figure 124).

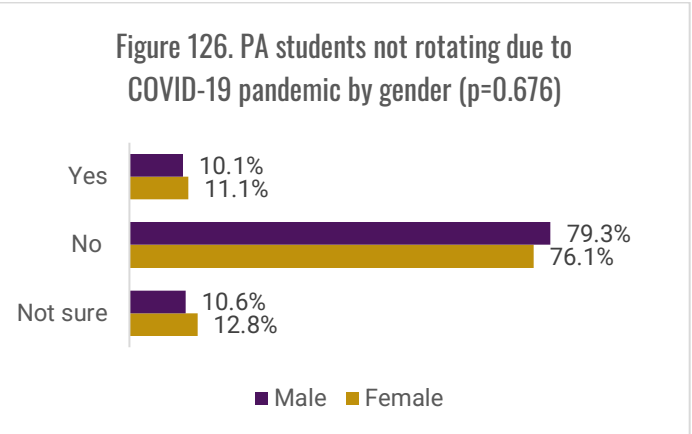




PA Students Not Rotating Due to COVID-19 Pandemic

Survey participants who indicated that PA students do not currently rotate through their practice setting (30.5%) were asked if this resulted from the COVID-19 pandemic. Only 10.7% said that this was due to the pandemic (Figure 125). We did not detect significant differences by gender (p=0.676; Figure 126) or U.S. regions (p=0.733; Figure 128), but there were differences by years certified (p=0.003; Figure 127).





Participants who were certified for up to 10 years had the highest percentage of reporting that PA students are not currently rotating through their practice setting due to the COVID-19 pandemic compared to those in other certification year groups.

Figure 127. PA students not rotating due to COVID-19 pandemic by years certified (p=0.003)

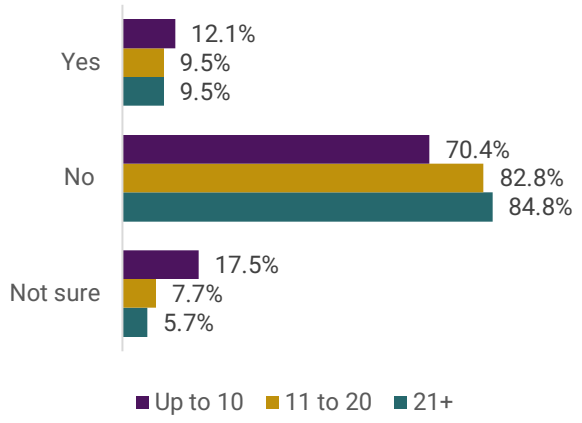
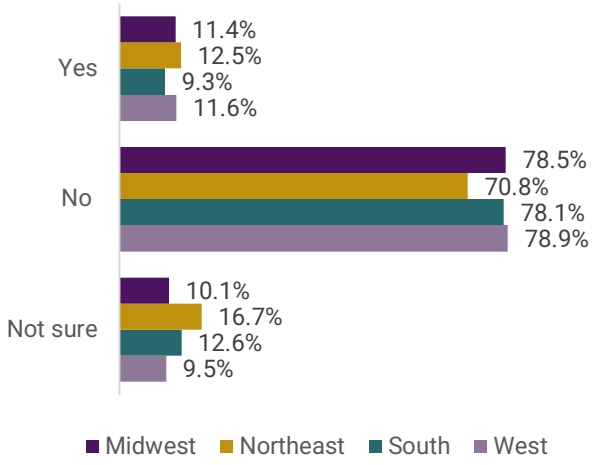


Figure 128. PA students not rotating due to COVID-19 pandemic by U.S. region (p=0.733)



Practice Setting Allows Shadowing

The majority (69.4%) of respondents identified that their practice setting allows shadowing, followed by 17.4% who stated their practice setting does not allow shadowing, and 13.2% who were not sure (Figure 129). When this question was analyzed by demographics/years certified, we found statistically significant differences by gender (p=0.043), years certified (p=0.002), and U.S. region (p<0.001). When compared to females, males were more likely to select that their practice setting allows shadowing (71.9% vs. 67.6%; Figure 130).

Figure 129. Does your practice setting allow shadowing?

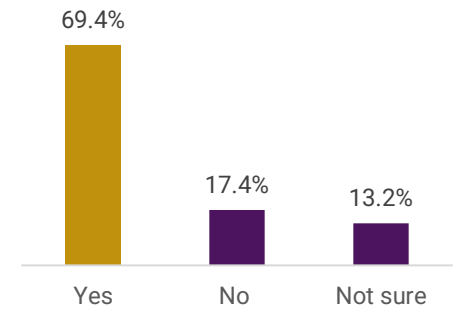
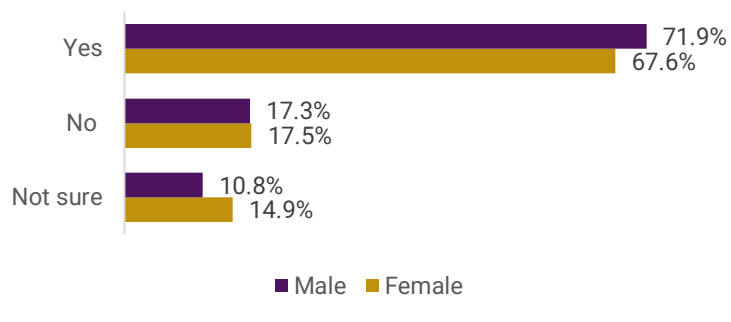
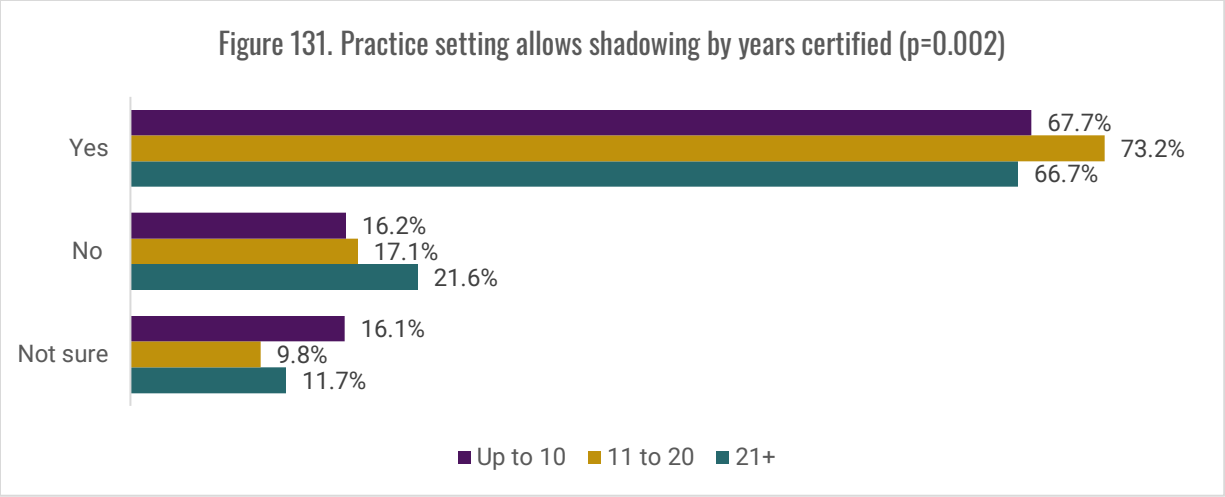


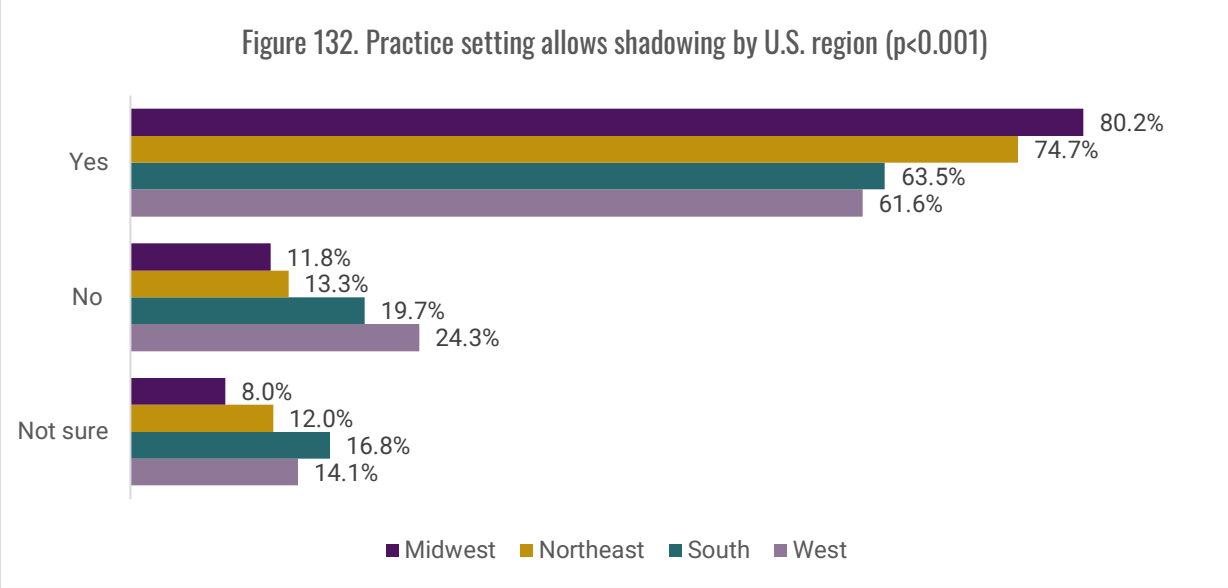
Figure 130. Practice setting allows shadowing by gender (p=0.043)



Participants who were certified for 11 to 20 years were more likely to indicate that their practice setting allows shadowing compared to those certified up to 10 and 21 or more years (73.2% vs. 67.7% and 66.7%; Figure 131).



Participants residing in the Midwest (80.2%), compared to those in the Northeast (74.7%), South (63.5%), and West (61.6%), had the highest likelihood of stating that their practice setting allows shadowing (Figure 132).



Practice Not Allowing Shadowing Due to COVID-19 Pandemic

Survey participants who indicated that their practice setting does not allow shadowing (17.4%) were asked if this resulted from the COVID-19 pandemic. The majority of these participants (74.8%) indicated that this was not a result of the pandemic, while 20.1% stated it was (Figure 133). Statistically significant differences were not found for differences by gender (p=0.071; Figure 134), years certified (p=0.615; Figure 135), and U.S. region (p=0.270; Figure 136).

Figure 133. You selected that your practice setting does not allow shadowing. Is this a result of the COVID-19 pandemic?

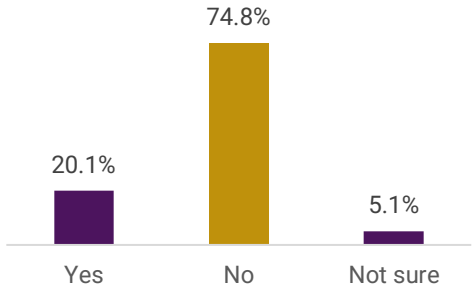


Figure 134. Practice does not allow shadowing due to COVID-19 pandemic by gender (p=0.071)

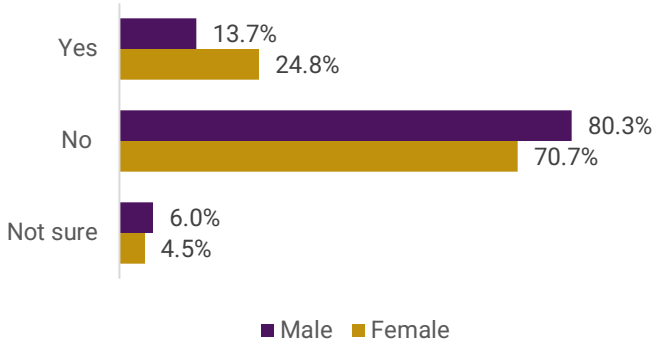


Figure 135. Practice does not allow shadowing due to COVID-19 pandemic by years certified (p=0.615)**

***Fisher-Freeman-Halton Exact test*

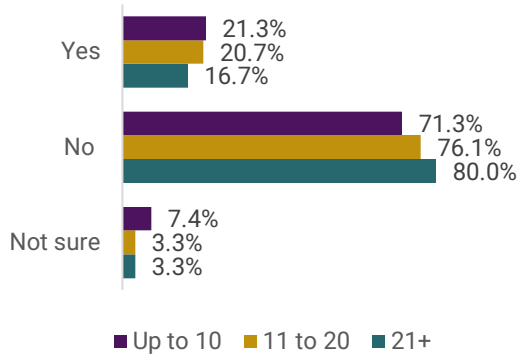
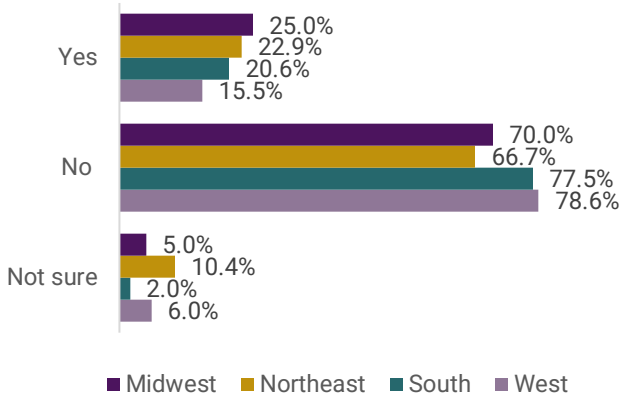


Figure 136. Practice does not allow shadowing due to COVID-19 pandemic by U.S. region (p=0.270)**

***Fisher-Freeman-Halton Exact test*



Cases Seen and Routine Tasks Performed

Highest Degree of Patient Acuity Routinely Treated

Figure 137 illustrates that more than half (53.0%) of PAs identified that the highest degree of patient acuity they routinely treat is high (ESI 1-2), followed by 43.6% stating medium (ESI 2-3) and 3.4% low (ESI 4-5). Statistically significant differences were discerned for gender ($p<0.001$), with males being more likely than females to treat a high (ESI 1-2) degree of patient acuity (60.5% vs. 47.7%); females were more likely to treat a medium (ESI 2-3) degree of patient acuity (48.5% vs. 36.7%; Figure 138).

Figure 137. What is the highest degree of patient acuity you routinely treat?

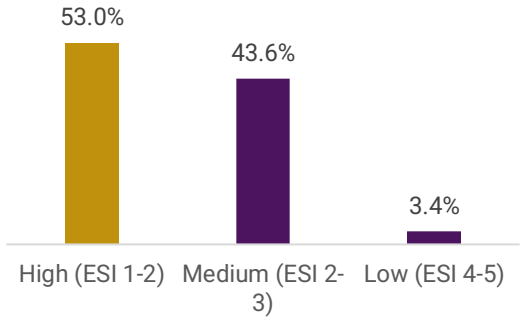
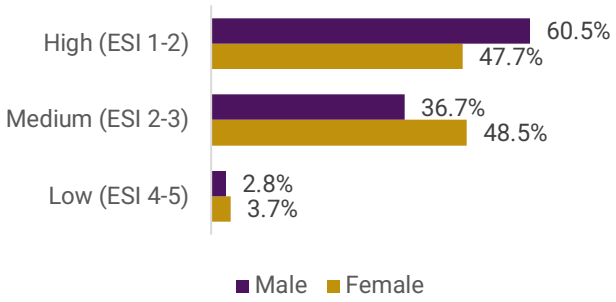


Figure 138. Highest degree of patient acuity treated by gender (p<0.001)



Statistically significant associations with years certified were not demonstrated (p=0.127; Figure 139); however, they were observed with U.S. region (p<0.001; Figure 140). PAs in the Midwest (59.8%) were more likely to treat high (ESI 1-2) patient acuity vs. PAs in the Northeast (57.3%), South (51.0%), and West (44.6%).

Figure 139. Highest degree of patient acuity treated by years certified (p=0.127)

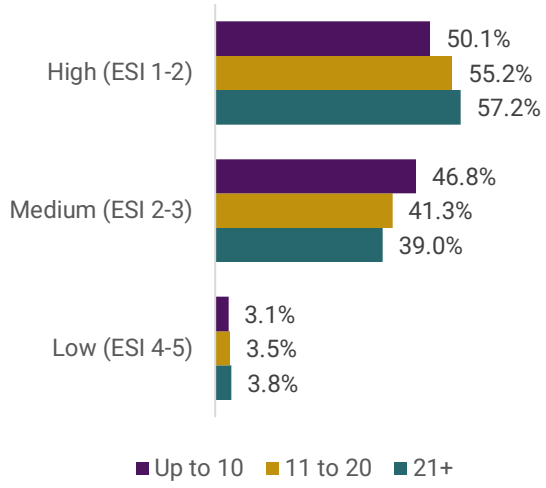
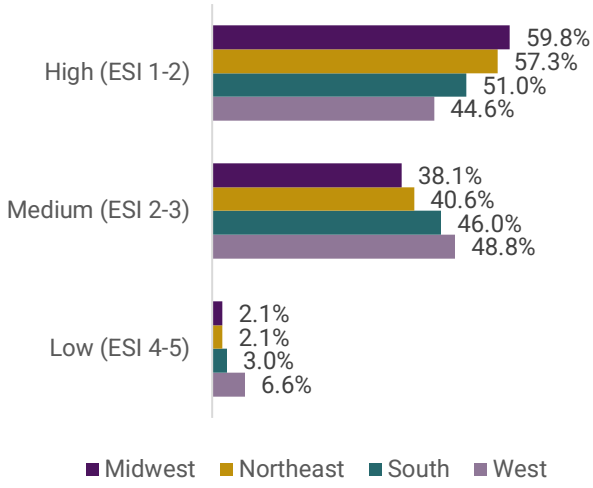


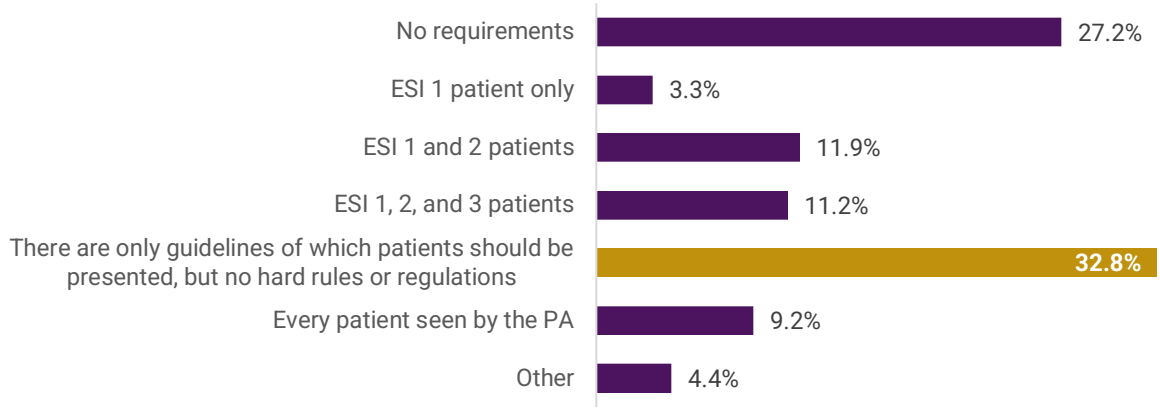
Figure 140. Highest degree of patient acuity treated by U.S. region (p<0.001)



Type of Patients Group/Hospital Requires Presenting to Collaborating/Supervising Physician

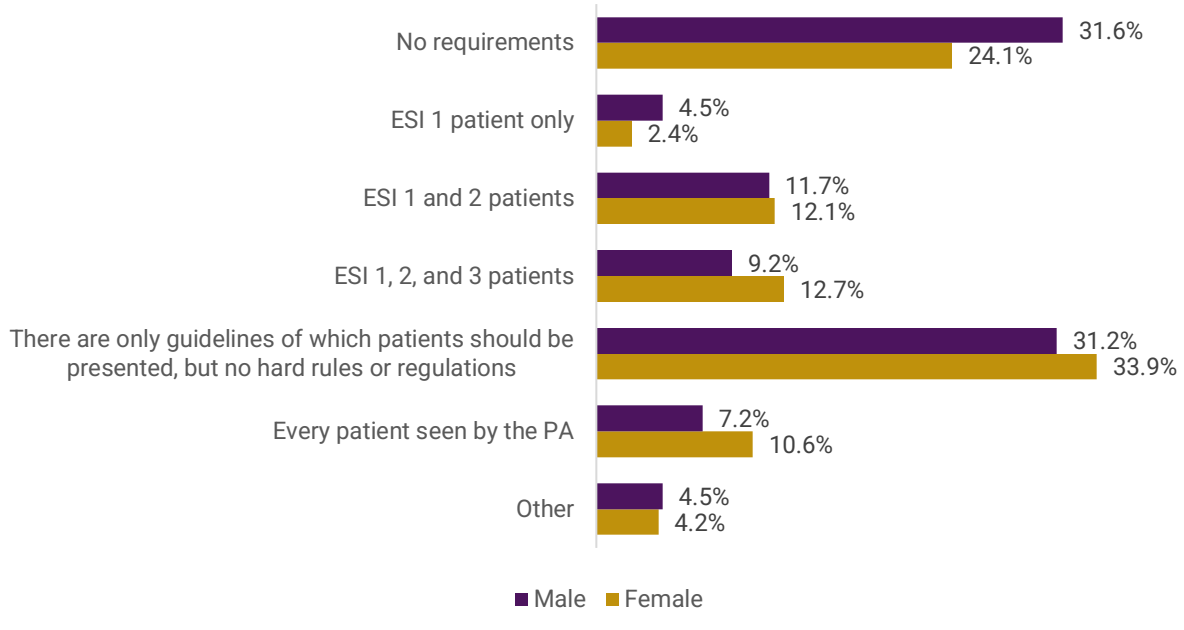
When PAs were inquired about what type of patients their group/hospital requires them to present to their collaborating/supervising physician, 32.8% believed that there are only guidelines of which patients should be presented, but no hard rules or regulations (Figure 141). Over a quarter (27.2%) specified that there are no requirements for presenting patients to collaborating/supervising physicians.

Figure 141. What type of patients does your group/hospital require you to present to your collaborating/supervising physician?



Females were more likely to detail that there are only guidelines of which patients should be presented, but no hard rules or regulations compared to males (33.9% vs. 31.2%; p<0.001; Figure 142). Males were more likely than females to say that there were no requirements (31.6% vs. 24.1%).

Figure 142. Type of patients presented to collaborating/supervising physician by gender (p<0.001)



Compared to the other certification year groups, PAs certified for 21 or more years had the highest proportion of citing that there are only guidelines but no hard rules when it comes to the type of patients presented to collaborating/supervising physicians (p=0.008; Figure 143).

Figure 143. Type of patients presented to collaborating/supervising physician by years certified (p=0.008)

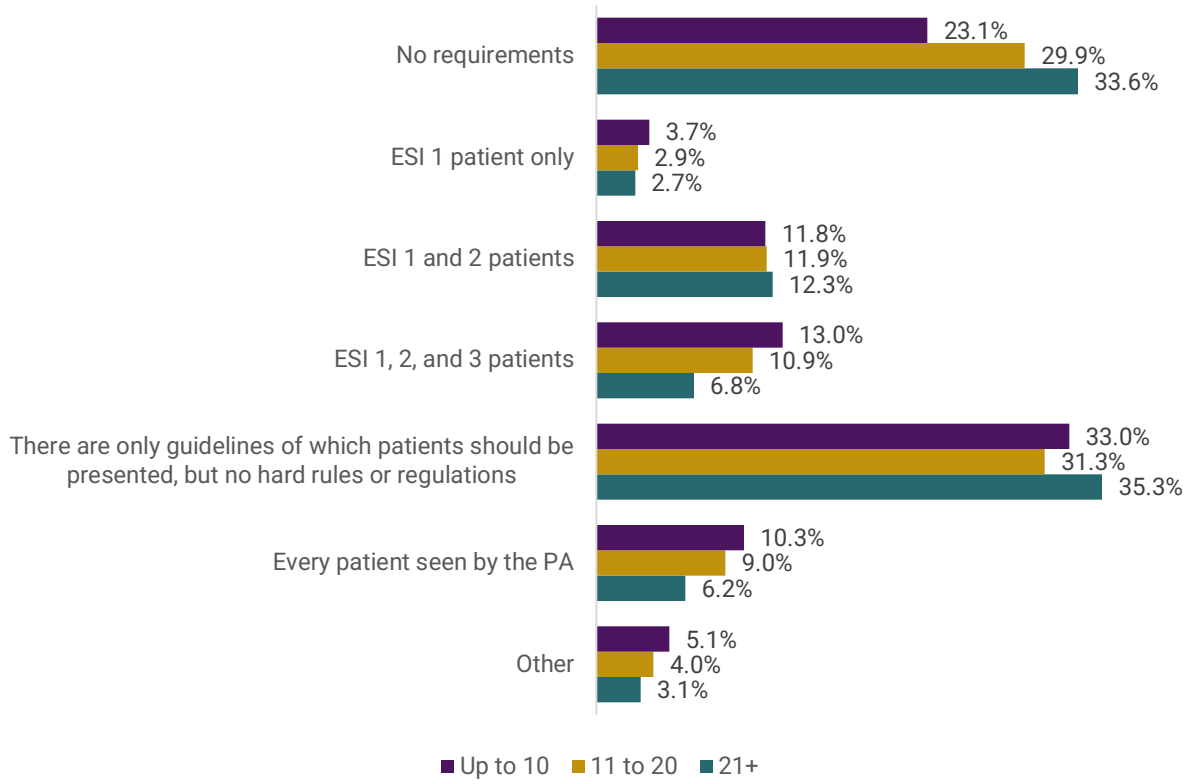
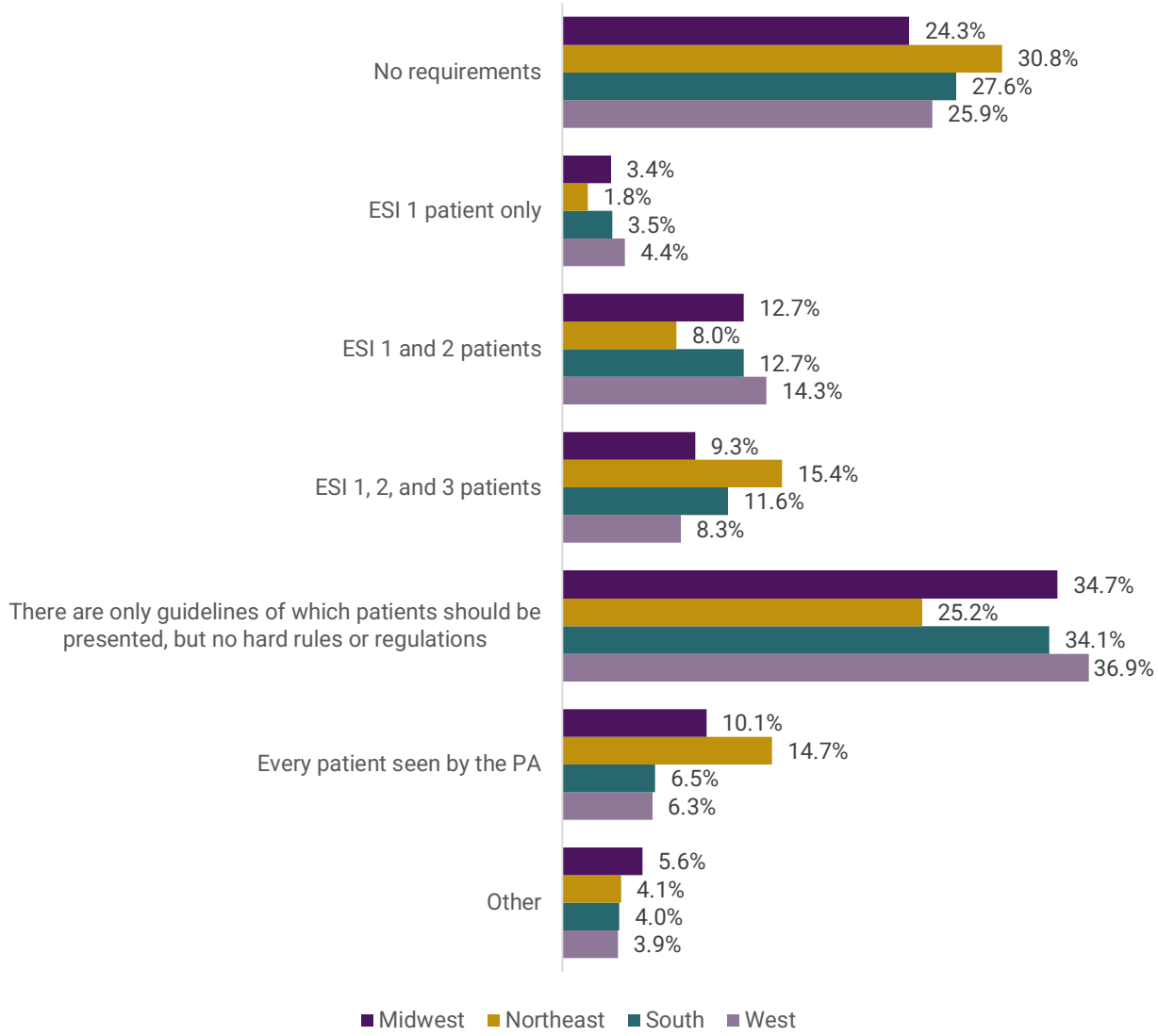


Figure 144 depicts a statistically significant relationship between type of patients presented to collaborating/supervising physician and U.S. region (p<0.001). Participants in the West (36.9%) had the highest proportion of selecting that there are only guidelines of which patients should be presented, but no hard rules or regulations vs. PAs in the Midwest (34.7%), South (34.1%), and Northeast (25.2%).

Figure 144. Type of patients presented to collaborating/supervising physician by U.S. region (p<0.001)



Principal Position Basic Procedures: Basic Diagnostics

Survey respondents were queried about how often they perform specific basic procedures: daily, weekly, monthly, a few times per year, or never. Almost all PAs (96.0%) marked that they perform basic diagnostics (i.e., basic laboratory interpretation, slit lamp exam, EKG interpretation) daily (Figure 145).

Figure 145. Basic diagnostics (i.e., basic laboratory interpretation, slit lamp exam, EKG interpretation)

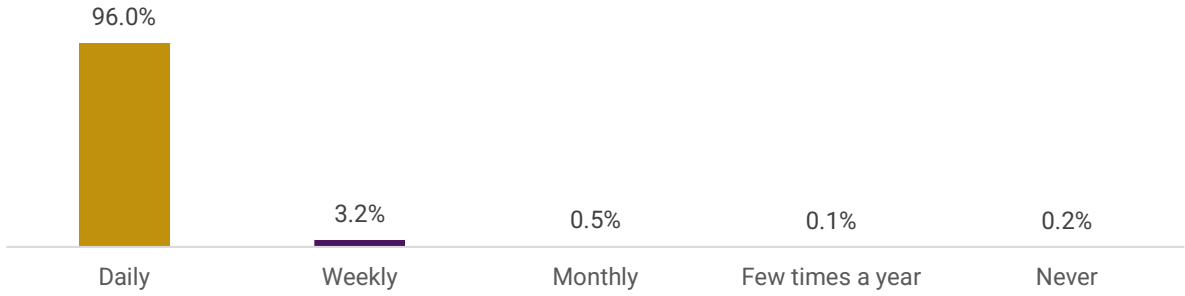


Table 10 depicts the frequency of performing basic diagnostics by gender, years certified, and U.S. region. Regardless of gender, years certified, or U.S. region, the vast majority perform basic diagnostics daily. Statistical tests could not be conducted due to the sparse data in some of the frequency categories of the basic diagnostics variable.

Table 10. Basic Diagnostics by Characteristics

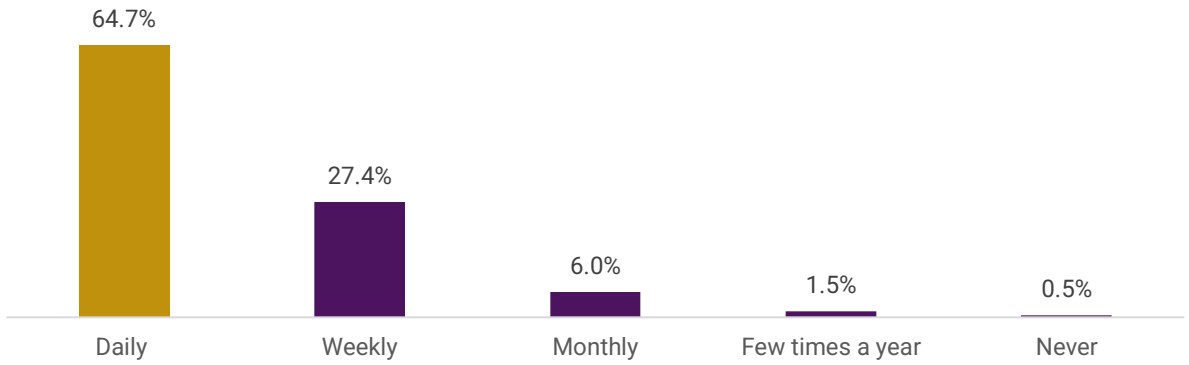
Characteristics		Daily	Weekly	Monthly	Few times per year	Never	p-value
Gender	Female	95.6%	3.5%	0.7%	0.2%	0.0%	n/a*
	Male	96.6%	2.8%	0.1%	0.0%	0.4%	
Years Certified	Up to 10	97.6%	1.8%	0.5%	0.1%	0.0%	n/a*
	11 to 20	94.5%	4.8%	0.5%	0.2%	0.0%	
	21+	94.5%	4.1%	0.3%	0.0%	1.0%	
U.S. Region	Midwest	97.1%	2.9%	0.0%	0.0%	0.0%	n/a*
	Northeast	95.4%	3.9%	0.8%	0.0%	0.0%	
	South	96.1%	3.2%	0.2%	0.2%	0.4%	
	West	95.3%	3.0%	1.1%	0.3%	0.3%	

**Statistical test could not be conducted due to small sample sizes*

Principal Position Basic Procedures: Therapeutic Procedures

Almost two-thirds of PAs (64.7%) responded that they perform therapeutic procedures (i.e., fracture, dislocation, or epistaxis management) daily, followed by 27.4% weekly (Figure 146).

Figure 146. Therapeutic procedures (i.e., fracture, dislocation or epistaxis management)



Statistically significant differences were detected by gender (p<0.001), but not for years certified (p=0.200) or U.S. region (p=0.068). We found males were more likely than females to perform therapeutic procedures daily (72.5% vs. 59.1%; Table 11).

Table 11. Therapeutic Procedures by Characteristics

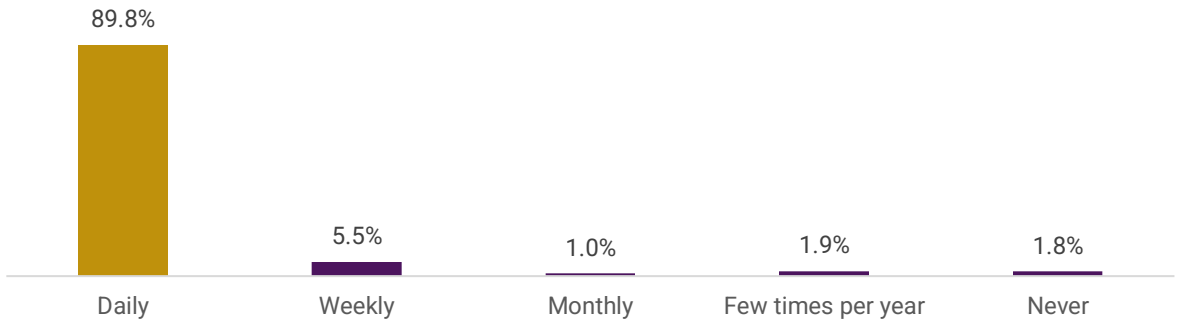
Characteristics		Daily	Weekly	Monthly	Few times per year	Never	p-value
Gender	Female	59.1%	30.6%	7.6%	2.2%	0.5%	<0.001
	Male	72.5%	22.9%	3.8%	0.4%	0.4%	
Years Certified	Up to 10	62.3%	29.5%	6.5%	1.3%	0.4%	0.200**
	11 to 20	65.4%	26.5%	5.7%	2.1%	0.3%	
	21+	69.9%	23.3%	5.1%	0.7%	1.0%	
U.S. Region	Midwest	60.8%	29.1%	9.0%	0.5%	0.5%	0.068**
	Northeast	64.8%	27.2%	6.2%	1.5%	0.3%	
	South	64.3%	29.2%	4.4%	1.4%	0.7%	
	West	68.9%	23.1%	5.2%	2.5%	0.3%	

*** Fisher-Freeman-Halton Exact test*

Principal Position Basic Procedures: Basic Initial Radiographic Interpretation

Similarly, most of the participants (89.8%) indicated that they perform basic initial radiographic interpretation (i.e., X-rays, plain films) daily (Figure 147). Only 5.5% of participants said they perform basic initial radiographic interpretation weekly.

Figure 147. Basic initial radiographic interpretation (i.e., X-rays, plain films)



We ascertained statistically significant differences when parsing the frequency of performing basic initial radiographic interpretation by gender (p=0.008). Males were more likely than females to state that they performed basic initial radiographic interpretation daily (92.9% vs. 87.5%; Table 12). PAs certified for 21 or more years vs. PAs in other certification year groups were significantly more likely to select that they perform basic initial radiographic interpretation daily (p=0.002). No significant relationships were revealed when we assessed the frequency of performing basic initial radiographic interpretation with U.S. region (p=0.147).

Table 12. Basic Initial Radiographic Interpretation by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	p-value
Gender	Female	87.5%	6.6%	1.2%	2.2%	2.4%	0.008
	Male	92.9%	4.0%	0.7%	1.4%	1.0%	
Years Certified	Up to 10	87.1%	7.0%	1.1%	1.9%	2.9%	0.002
	11 to 20	91.0%	4.5%	1.0%	2.6%	0.9%	
	21+	94.9%	3.4%	0.7%	0.3%	0.7%	
U.S. Region	Midwest	85.7%	8.2%	1.1%	2.4%	2.6%	0.147
	Northeast	91.3%	4.4%	1.0%	1.0%	2.3%	
	South	91.4%	4.4%	0.5%	2.3%	1.4%	
	West	89.8%	5.8%	1.7%	1.7%	1.1%	

Principal Position Basic Procedures: Basic Hemodynamic Techniques

Figure 148 shows that 28.0% of PAs selected that they perform basic hemodynamic techniques (i.e., peripheral IV access, EJ access, I/O access) a few times per year. Almost one-quarter of PAs (23.4%) enumerated that they never perform these techniques, while 21.6% carry them out daily.

Figure 148. Basic hemodynamic techniques (i.e., peripheral IV access, EJ access, I/O access)

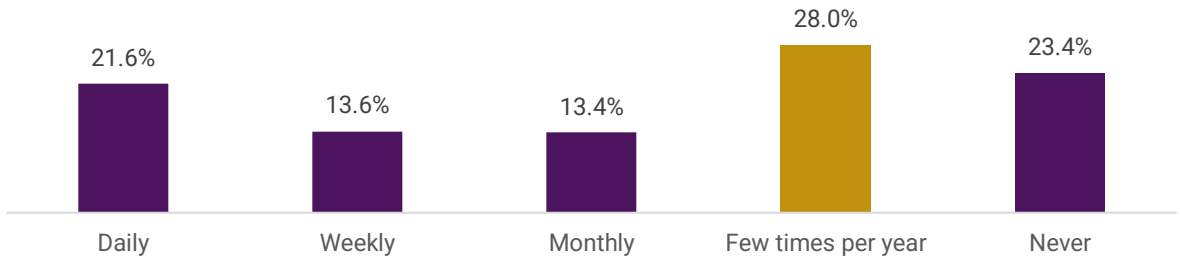


Table 13 illustrates the relationship between the frequency of performing basic hemodynamic interpretation and gender, years certified, and U.S. region. We observed statistically significant differences by gender (p<0.001), finding that females were more likely than males to report that they never perform these techniques (31.2% vs. 12.4%). PAs certified for up to 10 years were less likely to perform these techniques daily than PAs in other certification year groups (p=0.011). Differences were also determined to be statistically significant for U.S. regions (p=0.037), whereby PAs residing in the Northeast vs. all other regions had the highest proportion of citing that they perform basic hemodynamic techniques daily.

Table 13. Basic Hemodynamic Interpretation by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	p-value
Gender	Female	15.5%	9.6%	12.8%	30.9%	31.2%	<0.001
	Male	30.1%	19.2%	14.3%	24.0%	12.4%	
Years Certified	Up to 10	19.6%	12.2%	15.5%	28.2%	24.5%	0.011
	11 to 20	21.1%	15.7%	10.6%	28.9%	23.7%	
	21+	28.1%	13.4%	13.0%	26.0%	19.5%	
U.S. Region	Midwest	18.3%	10.3%	13.2%	31.5%	26.7%	0.037
	Northeast	24.7%	14.9%	15.9%	25.7%	18.8%	
	South	22.3%	15.3%	13.2%	26.2%	23.0%	
	West	20.7%	12.7%	11.0%	30.0%	25.6%	

Principal Position Basic Procedures: Basic Wound Care Management

Figure 149 pertains to how often PAs perform basic wound care management (i.e., incision and drainage, superficial wound closures). The majority of respondents (78.4%) selected that they carried out basic wound care management daily, followed by 18.3% weekly.

Figure 149. Basic wound care management (i.e., incision and drainage, superficial wound closures)

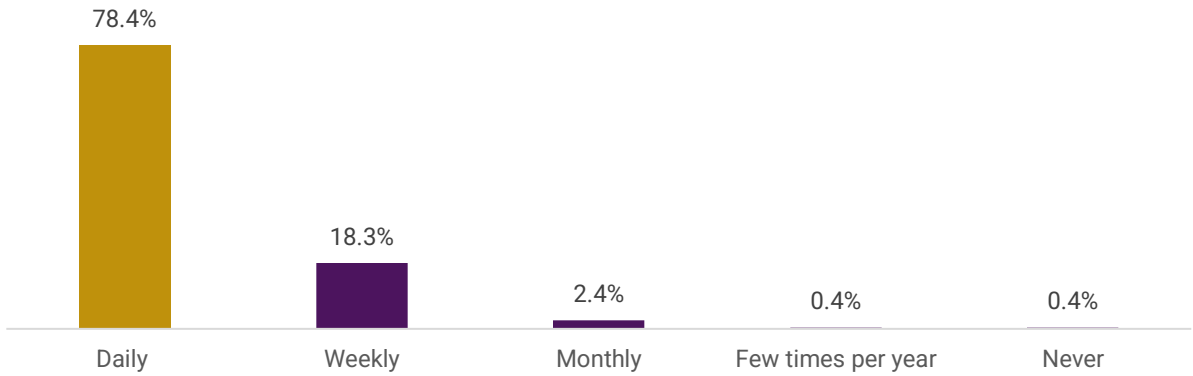


Table 14 depicts the association between the frequency of performing basic wound care management and demographics/years certified. We did not uncover statistically significant differences by gender (p=0.200), years certified (p=0.367) or U.S. region (p=0.332).

Table 14. Basic Wound Care Management by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	p-value
Gender	Female	76.8%	19.2%	3.0%	0.5%	0.4%	0.200**
	Male	80.6%	17.1%	1.6%	0.3%	0.4%	
Years Certified	Up to 10	77.1%	19.7%	2.2%	0.5%	0.5%	0.367**
	11 to 20	78.2%	18.0%	3.3%	0.3%	0.2%	
	21+	82.5%	15.1%	1.4%	0.3%	0.7%	
U.S. Region	Midwest	75.4%	21.2%	2.9%	0.3%	0.3%	0.332**
	Northeast	77.9%	19.3%	2.1%	0.8%	0.0%	
	South	78.4%	18.5%	2.3%	0.2%	0.7%	
	West	82.4%	14.0%	2.5%	0.6%	0.6%	

** *Fisher-Freeman-Halton Exact test*

Principal Position Advanced Procedures: Invasive Airway Management

The next section covers the performance of specific advanced procedures where participants could respond with daily, weekly, monthly, few times per year, never, and not yet (new PA). A third of PAs (34.3%) identified that they perform invasive airway management (i.e., intubation, mechanical ventilation, capnography, non-invasive airway management) a few times per year, followed by 31.2% who never performed these tasks and 15.9% who perform these tasks monthly (Figure 150).

Figure 150. Invasive airway management (i.e., intubation, mechanical ventilation, capnography, non-invasive airway management)

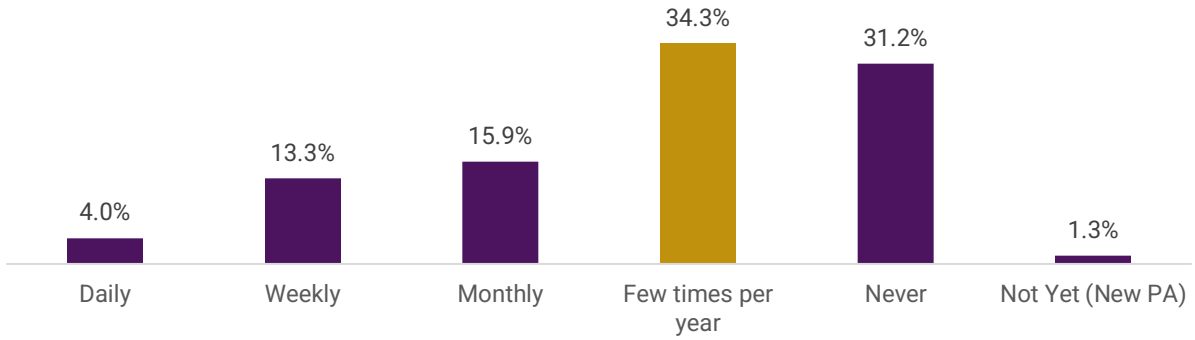


Table 15 displays the statistically significant relationships found when we assessed the frequency of performing invasive airway management by gender (p<0.001), years certified (p<0.001), and U.S. region (p=0.006). Males had higher proportions than females of selecting that they perform invasive airway management in their principal clinical position daily (5.6% vs. 2.8%), weekly (18.4% vs. 9.8%), and monthly (20.5% vs. 12.6%). PAs certified for 21 years, or longer than those certified for up to 10 and 11-20 years, were more likely to report implementing invasive airway management daily and weekly. PAs residing in the Midwest had the highest proportion of stating they performed this procedure a few times per year.

Table 15. Invasive Airway Management by Characteristics

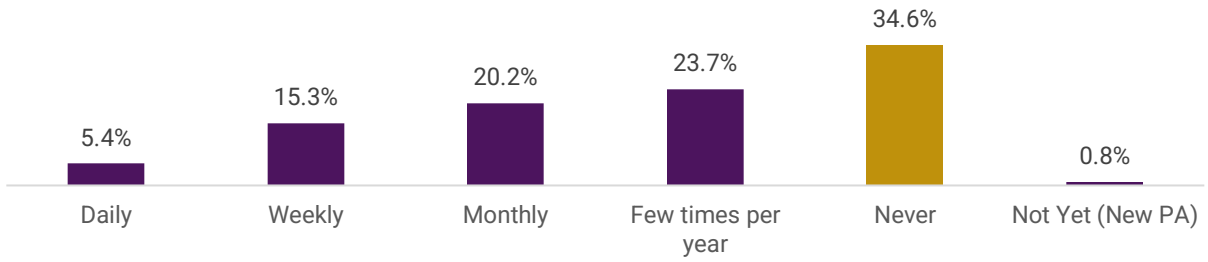
Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	2.8%	9.8%	12.6%	35.6%	37.5%	1.7%	<0.001
	Male	5.6%	18.4%	20.5%	32.3%	22.5%	0.7%	
Years Certified	Up to 10	3.6%	12.2%	17.3%	34.9%	29.4%	2.6%	<0.001**
	11 to 20	3.5%	13.0%	14.7%	35.1%	33.7%	0.0%	
	21+	6.2%	17.5%	14.0%	30.8%	31.5%	0.0%	
U.S. Region	Midwest	2.1%	13.2%	14.8%	38.1%	30.2%	0.6%	0.006
	Northeast	2.6%	14.7%	18.8%	36.0%	26.2%	1.2%	
	South	6.3%	14.4%	14.4%	31.6%	32.0%	1.8%	
	West	3.9%	10.5%	15.7%	32.8%	36.6%	1.6%	

** *Fisher-Freeman-Halton Exact test*

Principal Position Advanced Procedures: Anesthesia

More than one-third (34.6%) of survey participants identified that they never perform anesthesia (i.e., procedural anesthesia, conscious sedation); 23.7% perform anesthesia a few times per year, followed by 20.2% monthly (Figure 151).

Figure 151. Anesthesia (i.e., procedural anesthesia, conscious sedation)



When the frequency of performing anesthesia in principal clinical position was explored by gender, we identified that females were more likely than males to specify that they never perform anesthesia (39.2% vs. 28.1%; p<0.001; Table 16). PAs certified for 11-20 years had a higher proportion of expressing that they never perform anesthesia than PAs certified for up to 10 and 21 years or longer (36.2% vs. 34.8% and 30.8%; p<0.001). Regarding U.S. region, statistically significant differences were also discerned (p=0.003) in the frequency of performing anesthesia. PAs in the Midwest had the highest proportion of stating that they never perform anesthesia compared to the other U.S. regions.

Table 16. Anesthesia by Characteristics

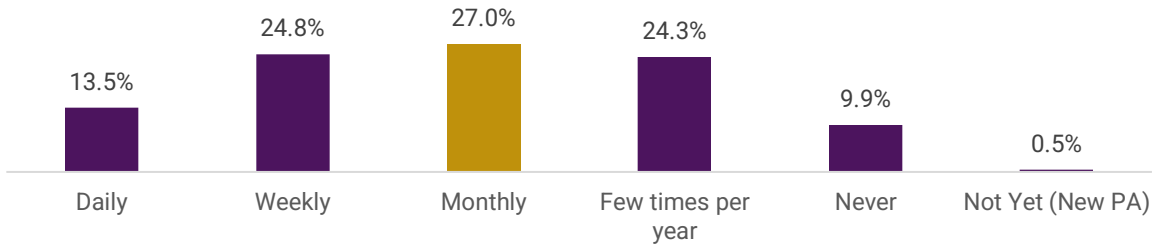
Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	4.4%	12.0%	19.4%	24.0%	39.2%	1.0%	<0.001
	Male	6.8%	20.1%	21.2%	23.3%	28.1%	0.6%	
Years Certified	Up to 10	3.9%	14.7%	22.4%	22.6%	34.8%	1.7%	<0.001**
	11 to 20	6.1%	14.5%	17.3%	26.0%	36.2%	0.0%	
	21+	8.6%	18.8%	19.5%	22.3%	30.8%	0.0%	
U.S. Region	Midwest	2.9%	12.7%	20.9%	26.5%	36.0%	1.1%	0.003
	Northeast	3.6%	13.6%	22.4%	26.5%	32.9%	1.0%	
	South	7.0%	14.8%	18.6%	23.9%	34.8%	0.9%	
	West	7.4%	20.7%	19.6%	17.4%	34.7%	0.3%	

***Fisher-Freeman-Halton Exact test*

Principal Position Advanced Procedures: Advanced Wound Management

Figure 152 details how often PAs perform advanced wound management (i.e., wound debridement, wound closure). More than a quarter of respondents (27.0%) reported performing this technique monthly, 24.8% weekly, followed by 24.3% a few times per year.

Figure 152. Advanced wound management (i.e., wound debridement, deep wound closure)



When we evaluated the frequency of performing advanced wound management by demographics/years certified, we found statistically significant differences by gender (p<0.001), years certified (p<0.001), and U.S. region (p=0.001; Table 17). Males were more likely than females to select that they perform advanced wound management daily (15.8% vs. 11.8%), weekly (28.7% vs. 22.0%), and monthly (28.1% vs. 26.3%). PAs certified for 21 or more years had the highest proportion of performing these techniques weekly compared to those in other certification year groups. Participants residing in the West were more likely to acknowledge that they performed advanced wound management weekly than those in other U.S. regions (p=0.001).

Table 17. Advanced Wound Management by Characteristics

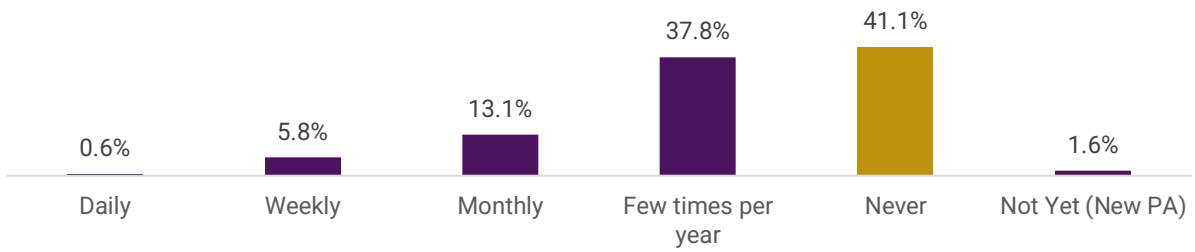
Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	11.8%	22.0%	26.3%	27.4%	12.2%	0.4%	<0.001
	Male	15.8%	28.7%	28.1%	20.1%	6.8%	0.6%	
Years Certified	Up to 10	9.9%	21.9%	29.0%	26.1%	12.2%	1.0%	<0.001**
	11 to 20	15.9%	24.6%	26.8%	24.7%	8.0%	0.0%	
	21+	18.8%	33.2%	21.9%	18.5%	7.5%	0.0%	
U.S. Region	Midwest	9.8%	20.4%	29.4%	29.1%	11.1%	0.3%	0.001
	Northeast	12.1%	23.1%	25.7%	25.2%	13.6%	0.3%	
	South	15.8%	24.8%	27.2%	22.8%	8.4%	0.9%	
	West	15.2%	31.1%	25.6%	20.7%	7.2%	0.3%	

*** Fisher-Freeman-Halton Exact test*

Principal Position Advanced Procedures: Defibrillation/Cardioversion

Many survey participants (41.1%) stated that they never perform defibrillation/cardioversion, followed by 37.8% who perform it a few times per year, and 13.1% who perform it monthly (Figure 153).

Figure 153. Defibrillation/cardioversion



The association between the frequency of performing defibrillation/cardioversion and gender was statistically significant (p<0.001). Females were more likely to say that they never perform this procedure compared to males (48.6% vs. 30.5%; Table 18). We detected statistically significant differences by years certified (p=0.008). PAs certified for 11 to 20 years had the highest proportion of stating they never perform defibrillation/cardioversion compared to the other certification year groups. Regarding U.S. region, PAs residing in the South had the highest percentage of identifying that they never use defibrillation/cardioversion in their principal clinical position compared to other U.S. regions (p=0.001).

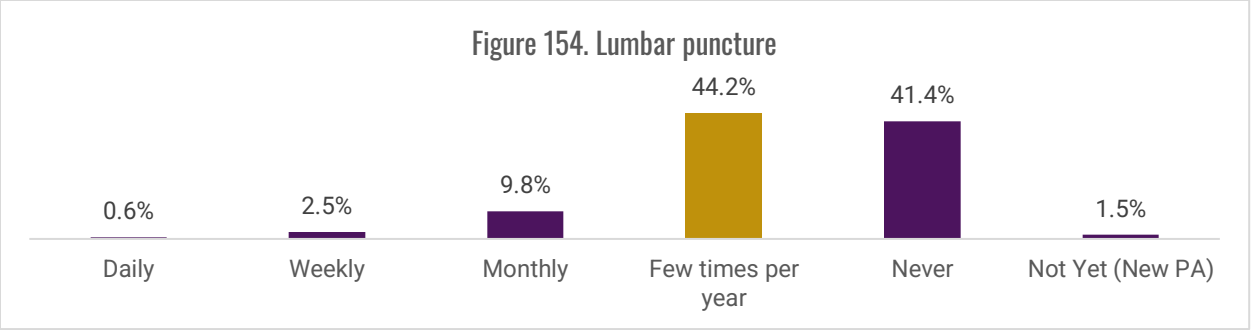
Table 18. Defibrillation/Cardioversion by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	0.5%	3.8%	9.5%	35.8%	48.6%	1.8%	<0.001
	Male	0.7%	8.6%	18.1%	40.7%	30.5%	1.4%	
Years Certified	Up to 10	0.2%	5.5%	12.5%	38.9%	40.1%	2.8%	0.008**
	11 to 20	1.2%	5.2%	13.1%	36.5%	43.6%	0.3%	
	21+	0.3%	7.9%	14.4%	37.3%	39.0%	1.0%	
U.S. Region	Midwest	0.5%	4.0%	14.3%	41.5%	37.8%	1.9%	0.001
	Northeast	0.3%	4.6%	15.4%	40.4%	36.8%	2.6%	
	South	0.9%	9.0%	9.7%	34.1%	45.2%	1.2%	
	West	0.6%	4.1%	14.6%	36.6%	43.0%	1.1%	

** *Fisher-Freeman-Halton Exact test*

Principal Position Advanced Procedures: Lumbar Puncture

Almost half of PAs (44.2%) selected they perform lumbar puncture a few times per year, while 41.4% specified that they never perform lumbar puncture, followed by 9.8% who noted they perform it monthly (Figure 154).



When we parsed the frequency of performing lumbar puncture by gender, we found that females were more likely than males to indicate they never perform lumbar puncture (45.4% vs. 35.7%; p<0.001; Table 19). Statistically significant differences were detected for years certified (p<0.001). Those who were certified for up to 10 years had the highest proportion reporting that they perform lumbar puncture a few times per year compared to those certified 11-20 and 21 or more years (47.2% vs. 41.7% and 40.8%). Concerning the U.S. region, PAs residing in the Northeast were more likely to state that they carry out lumbar puncture a few times per year than those in other U.S. regions (p<0.001).

Table 19. Lumbar Puncture by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	0.6%	1.7%	8.4%	42.2%	45.4%	1.7%	<0.001
	Male	0.6%	3.7%	11.9%	47.0%	35.7%	1.1%	
Years Certified	Up to 10	0.5%	2.3%	8.3%	47.2%	39.0%	2.8%	
	11 to 20	1.0%	1.6%	11.1%	41.7%	44.5%	0.2%	<0.001**
	21+	0.0%	5.1%	11.6%	40.8%	42.1%	0.3%	
U.S. Region	Midwest	0.3%	1.3%	6.6%	43.1%	46.3%	2.4%	
	Northeast	0.3%	2.8%	8.2%	51.4%	36.0%	1.3%	<0.001
	South	0.7%	3.2%	10.2%	38.1%	46.2%	1.6%	
	West	1.1%	2.5%	14.3%	47.4%	34.2%	0.6%	

*** Fisher-Freeman-Halton Exact test*

Principal Position Advanced Procedures: Thoracentesis

Figure 155 shows that 74.8% of PAs never perform thoracentesis. One out of five (19.4%) marked that they perform thoracentesis a few times per year.

Figure 155. Thoracentesis

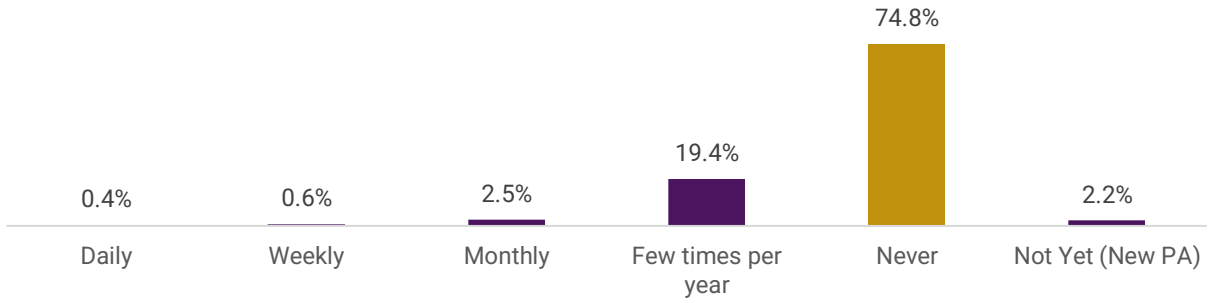


Table 20 displays the statistically significant differences found by gender (p<0.001), years certified (p<0.001), and U.S. region (p=0.030). Females, compared to males, were more likely to select that they never perform thoracentesis (81.5% vs. 65.5%). PAs certified for 11 to 20 years had a slightly higher percentage of detailing that they have never performed thoracentesis than those certified for up to 10 and 21 years or longer (76.0% vs. 75.7% vs. 70.2%). Participants residing in the Northeast compared to the other U.S. regions were more likely to indicate that they never perform thoracentesis.

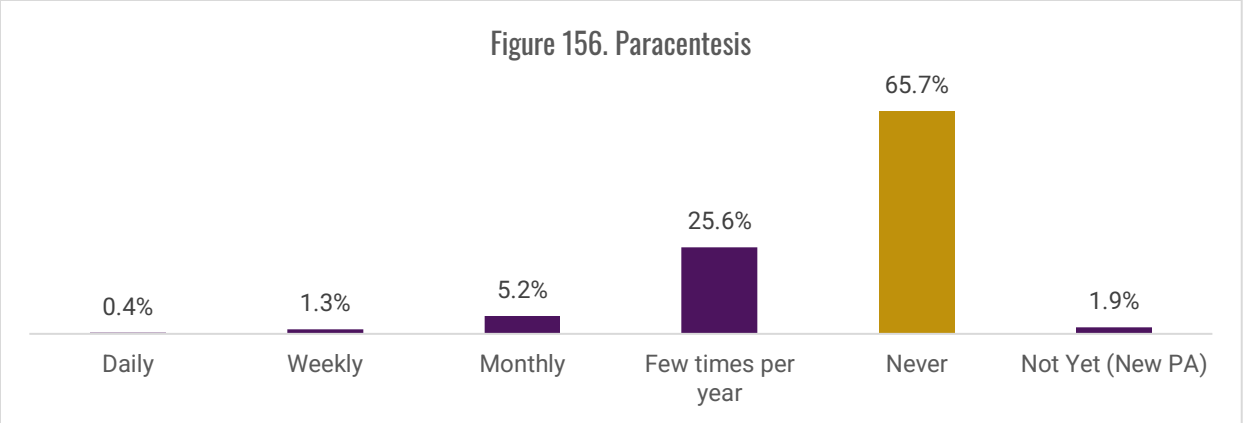
Table 20. Thoracentesis by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	0.5%	0.5%	1.2%	13.7%	81.5%	2.6%	<0.001**
	Male	0.3%	0.8%	4.2%	27.4%	65.5%	1.7%	
Years Certified	Up to 10	0.4%	0.6%	2.3%	17.3%	75.7%	3.7%	
	11 to 20	0.7%	0.9%	1.0%	20.9%	76.0%	0.5%	<0.001**
	21+	0.0%	0.3%	5.8%	22.3%	70.2%	1.4%	
U.S. Region	Midwest	0.3%	0.8%	1.1%	18.0%	76.5%	3.4%	
	Northeast	0.3%	0.3%	2.8%	15.9%	78.1%	2.6%	0.030**
	South	0.5%	0.5%	2.6%	18.5%	76.1%	1.8%	
	West	0.6%	1.1%	3.3%	25.6%	68.0%	1.4%	

** *Fisher-Freeman-Halton Exact test*

Principal Position Advanced Procedures: Paracentesis

The majority of survey participants (65.7%) identified that they never perform paracentesis, while 25.6% said that they complete this procedure a few times per year (Figure 156).



When we assessed paracentesis by demographics/years certified, we determined statistically significant differences by gender (p=0.004), years certified (p<0.001), and U.S. region (p<0.001; Table 21). Females were more likely to select that they never perform paracentesis compared to males (68.3% vs. 62.0%). PA certified for 21 or more years had the highest proportion of reporting that they never perform paracentesis compared to those in other certification year groups. PAs in the South had the highest percentage of stating that they never perform paracentesis compared to other U.S. regions.

Table 21. Paracentesis by Characteristics

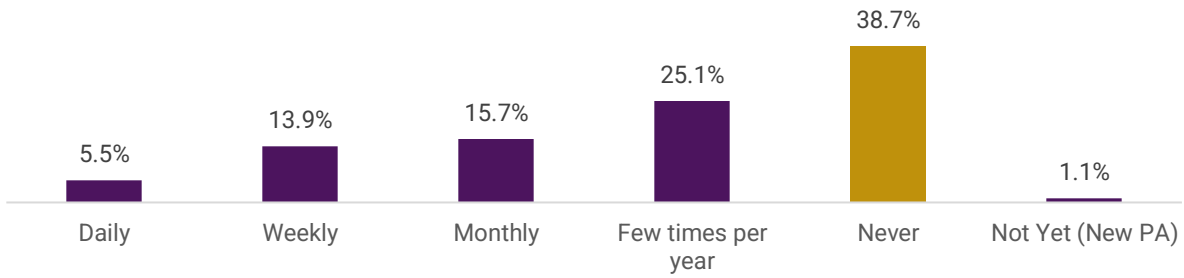
Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	0.4%	0.7%	4.3%	24.0%	68.3%	2.3%	0.004
	Male	0.3%	2.1%	6.4%	28.0%	62.0%	1.3%	
Years Certified	Up to 10	0.4%	1.2%	6.7%	27.4%	61.3%	3.0%	<0.001**
	11 to 20	0.5%	1.6%	2.9%	25.1%	69.4%	0.5%	
	21+	0.0%	1.0%	5.1%	21.6%	70.9%	1.4%	
U.S. Region	Midwest	0.3%	0.8%	3.2%	24.6%	68.3%	2.9%	<0.001**
	Northeast	0.0%	0.8%	5.7%	29.3%	62.7%	1.5%	
	South	0.5%	0.7%	3.3%	20.6%	73.1%	1.8%	
	West	0.6%	3.3%	9.6%	30.9%	54.3%	1.4%	

** *Fisher-Freeman-Halton Exact test*

Principal Position Advanced Procedures: Ultrasound-Guided Procedures

Figure 157 illustrates that 38.7% of survey respondents reported they never perform ultrasound-guided procedures, followed by a few times per year (25.1%), monthly (15.7%), and weekly (13.9%).

Figure 157. Ultrasound guided procedures



We evaluated the frequency of performing ultrasound-guided procedures, finding statistically significant differences by gender and years certified (both p<0.001). Females were more likely than males to describe that they never perform ultrasound-guided procedures (43.9% vs. 31.5%; Table 22). Almost half of participants who were certified for 21 or more years stated that they never perform ultrasound-guided procedures compared to those in other certification year groups. Differences were not found to be statistically significant for the frequency of performing ultrasound-guided procedures by U.S. region (p=0.088).

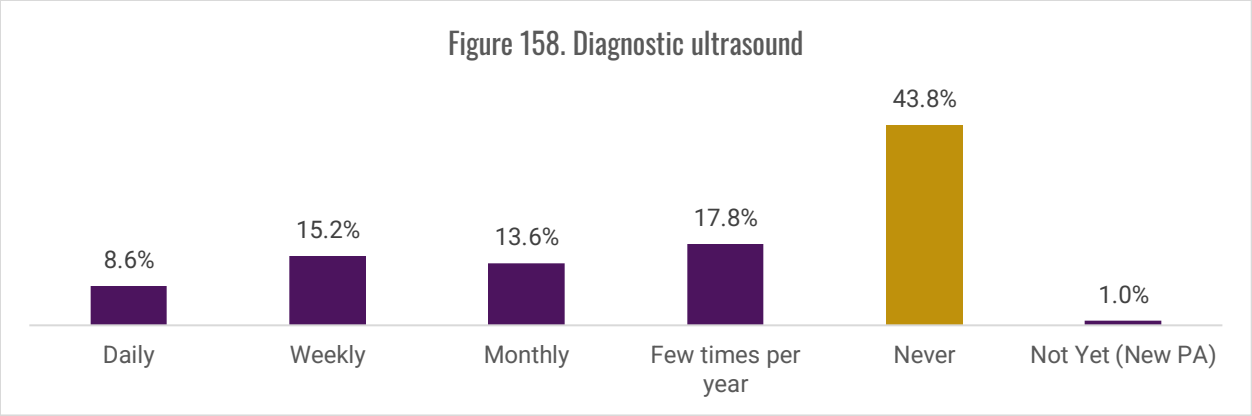
Table 22. Ultrasound-Guided Procedures by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	3.9%	11.6%	12.8%	26.3%	43.9%	1.5%	<0.001
	Male	7.6%	17.1%	19.8%	23.4%	31.5%	0.6%	
Years Certified	Up to 10	6.7%	15.0%	17.6%	26.0%	32.9%	1.8%	
	11 to 20	4.2%	12.8%	14.9%	26.1%	42.0%	0.0%	<0.001**
	21+	4.5%	12.7%	12.0%	20.5%	49.0%	1.4%	
U.S. Region	Midwest	2.6%	11.4%	15.9%	27.8%	40.2%	2.1%	0.088
	Northeast	7.2%	15.4%	16.7%	25.4%	34.4%	0.8%	
	South	5.4%	13.2%	14.9%	23.6%	42.0%	0.9%	
	West	6.6%	16.0%	15.7%	24.0%	36.9%	0.8%	

*** Fisher-Freeman-Halton Exact test*

Principal Position Advanced Procedures: Diagnostic Ultrasound

Almost half of respondents (43.8%) noted that they never perform diagnostic ultrasound, followed by 17.8% who perform it a few times per year, and 15.2% weekly (Figure 158).



Females were more likely to select that they never perform diagnostic ultrasound compared to males (47.9% vs. 38.0%; p<0.001; Table 23). Regarding years certified, statistically significant differences were found (p<0.001). PAs certified for 21 or more years vs. up to 10 and 11-20 were significantly more likely never to perform this procedure. When we parsed the frequency of performing diagnostic ultrasound procedures by U.S. region, we found statistically significant differences (p=0.011). Participants residing in the South had the highest proportion of indicating that they never perform diagnostic ultrasound procedures.

Table 23. Diagnostic Ultrasound by Characteristics

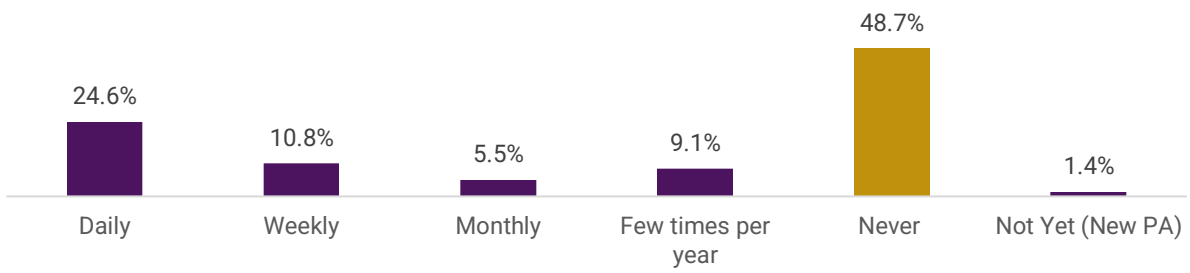
Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	7.3%	13.0%	12.6%	18.2%	47.9%	1.0%	<0.001
	Male	10.5%	18.2%	15.1%	17.2%	38.0%	1.0%	
Years Certified	Up to 10	9.3%	15.8%	16.4%	19.6%	37.4%	1.6%	<0.001**
	11 to 20	6.9%	14.7%	13.0%	16.8%	48.6%	0.0%	
	21+	9.9%	14.4%	7.2%	14.7%	52.4%	1.4%	
U.S. Region	Midwest	8.2%	15.1%	11.6%	19.8%	43.7%	1.6%	0.011
	Northeast	9.8%	14.9%	13.0%	20.1%	40.9%	0.5%	
	South	5.3%	14.6%	14.2%	16.0%	48.7%	1.2%	
	West	12.9%	16.5%	14.3%	16.3%	39.4%	0.6%	

** *Fisher-Freeman-Halton Exact test*

Principal Position Advanced Procedures: Advanced Radiographic Interpretation

Figure 159 depicts that almost half of PAs (48.7%) stated they never perform advanced radiographic interpretation (i.e., initial read of CT scans, ultrasound, MR). Almost one-quarter of participants (24.6%) reported performing this procedure daily.

Figure 159. Advanced radiographic interpretation (i.e., initial read of CT scans, ultrasound, MR)



The results in Table 24 reflect a detailed characterization of the frequency of performing advanced radiographic interpretation by gender, years certified, and U.S. region. Females, compared to males, were significantly more likely to indicate that they have never perform advanced radiographic interpretation (55.8% vs. 38.7%; p<0.001). We did not detect significant differences by years certified (p=0.115). Similarly, the relationship between the frequency of performing advanced radiographic interpretation and U.S. regions was not found to be statistically significant (p=0.894).

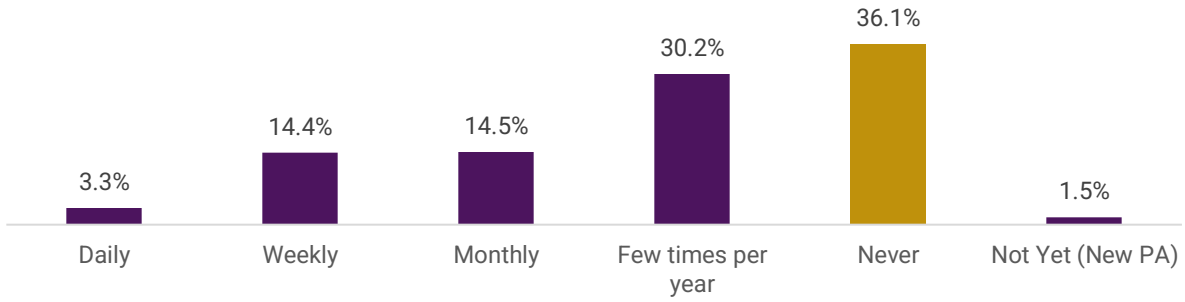
Table 24. Advanced Radiographic Interpretation by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	19.8%	8.8%	5.0%	9.2%	55.8%	1.4%	<0.001
	Male	31.2%	13.7%	6.2%	8.9%	38.7%	1.3%	
Years Certified	Up to 10	25.3%	12.3%	6.4%	8.2%	46.1%	1.8%	0.115
	11 to 20	23.9%	8.7%	4.3%	9.2%	53.1%	0.9%	
	21+	24.0%	11.0%	5.5%	11.3%	47.3%	1.0%	
U.S. Region	Midwest	23.8%	12.2%	6.9%	9.5%	45.8%	1.9%	0.894
	Northeast	26.5%	11.3%	3.9%	9.3%	47.8%	1.3%	
	South	24.1%	10.0%	5.4%	8.3%	50.8%	1.4%	
	West	24.0%	10.2%	6.1%	9.4%	49.6%	0.8%	

Principal Position Advanced Procedures: Resuscitation

Over one-third (36.1%) of respondents identified that they never perform resuscitation (i.e., trauma/major medical, cardiac arrests, etc.), followed by 30.2% reporting they carry it out a few times per year, and 14.5% perform it monthly (Figure 160).

Figure 160. Resuscitation (i.e., trauma/major medical, cardiac arrests, etc.)



When we examined the frequency of performing resuscitation by gender, we found that females were significantly more likely than males to indicate that they never perform this procedure (42.3% vs. 27.4%; p<0.001; Table 25). Statistically significant differences were also detected when we assessed the frequency of performing resuscitation by years certified (p=0.003). Participants who were certified for 11 to 20 years had the highest proportion of stating that they never perform resuscitation compared to those in other certification year groups. Regarding U.S. region, PAs residing in the West (46.0%), compared to those in the Midwest (35.4%), Northeast (27.5%), and South (36.2%), had the highest likelihood of selecting that they never perform resuscitation in their principal position (p<0.001).

Table 25. Resuscitation by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	2.8%	9.9%	12.8%	30.6%	42.3%	1.6%	<0.001
	Male	4.0%	20.8%	16.9%	29.5%	27.4%	1.4%	
Years Certified	Up to 10	2.8%	13.4%	15.2%	30.2%	36.0%	2.5%	0.003
	11 to 20	4.0%	12.5%	15.1%	30.8%	37.2%	0.5%	
	21+	3.4%	21.2%	11.6%	28.8%	34.2%	0.7%	
U.S. Region	Midwest	3.4%	11.4%	14.8%	33.1%	35.4%	1.9%	<0.001
	Northeast	2.8%	16.7%	20.1%	31.6%	27.5%	1.3%	
	South	4.2%	17.6%	10.4%	30.2%	36.2%	1.4%	
	West	2.2%	10.2%	14.6%	25.3%	46.0%	1.7%	

Professional Benefits and Compensation

Current Pay Structure

Many respondents (58.4%) stated that their current pay structure is hourly, while 37.4% indicated that it is salary based, and 4.1% selected other (Figure 161). Statistically significant

differences were not found when current pay structure was assessed by gender (p=0.642; Figure 162) or years certified (p=0.426; Figure 163).

Figure 161. What is your current pay structure?

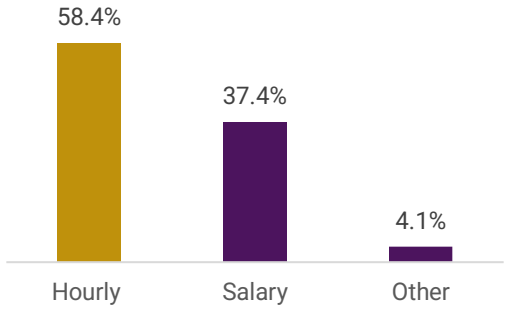
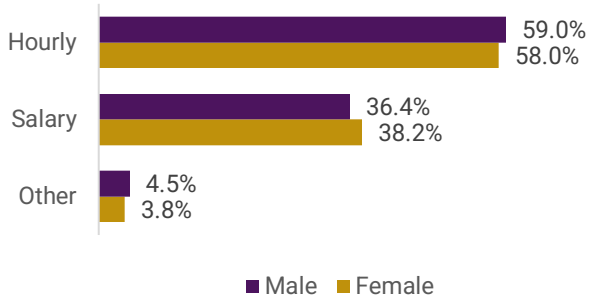


Figure 162. Current pay structure by gender (p=0.642)



When pay structure was parsed by U.S. region, we found statistically significant differences (p<0.001). Compared to all other areas, PAs residing in the West were more likely to report hourly as their current pay structure (Figure 164).

Figure 163. Current pay structure by years certified (p=0.426)

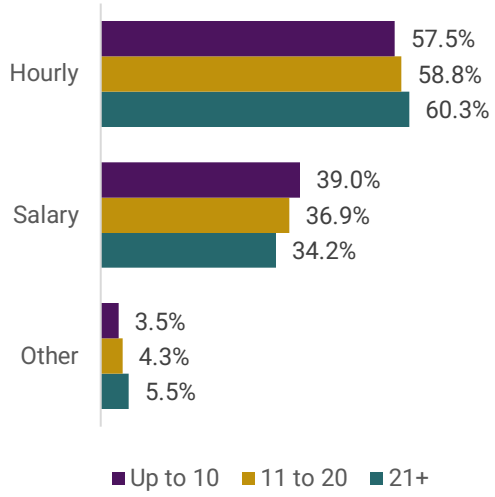
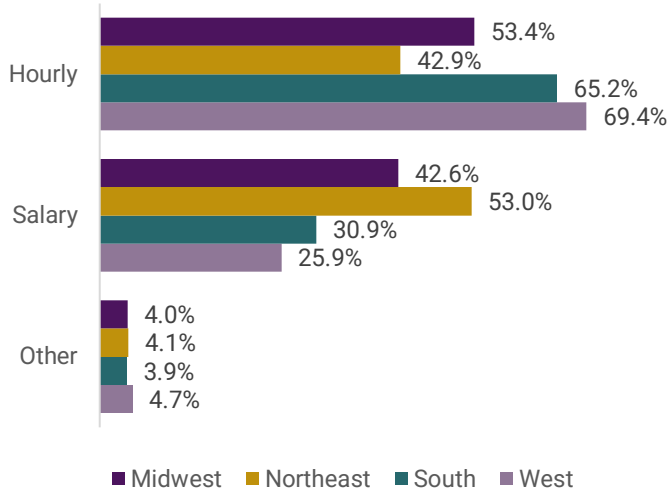


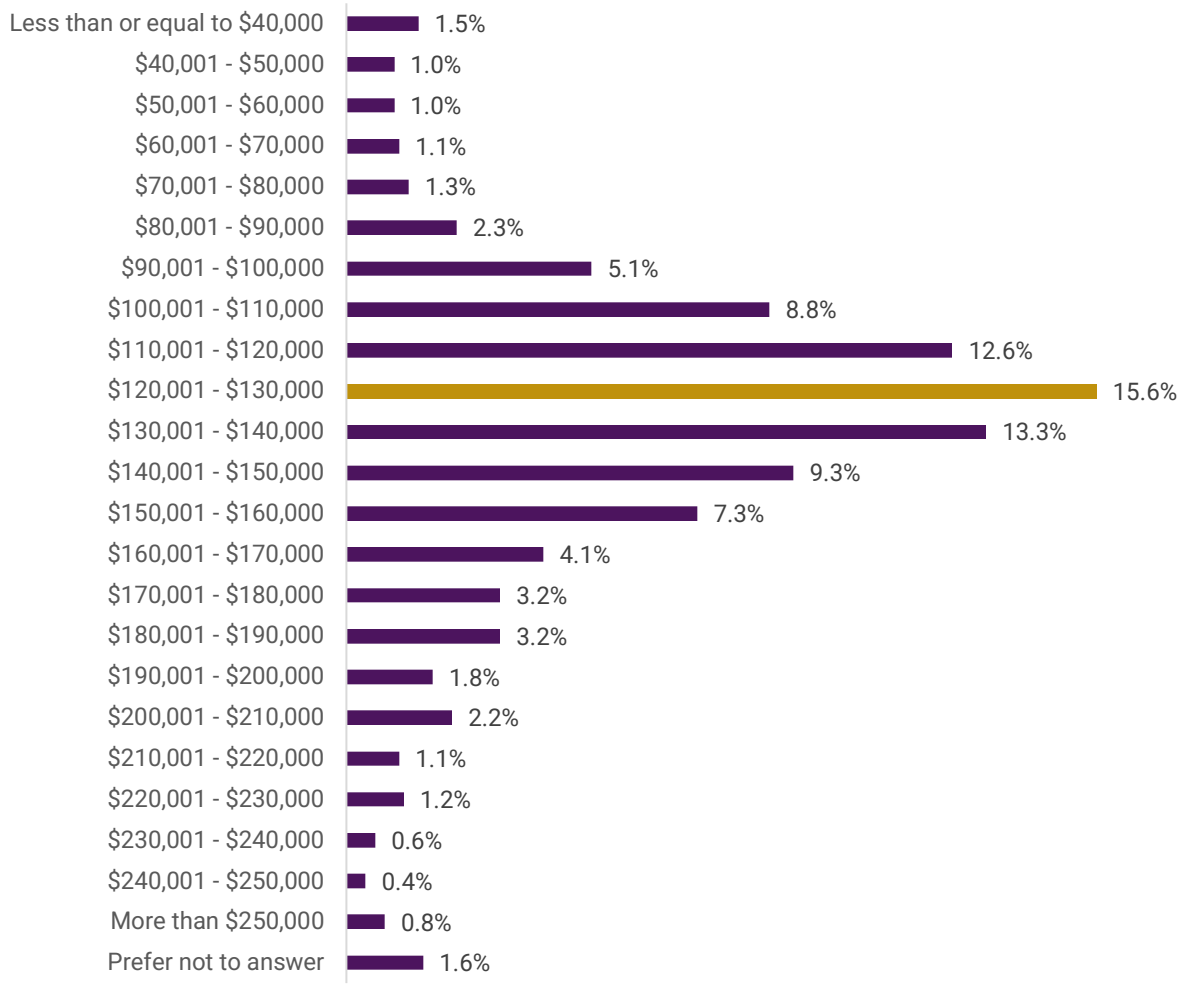
Figure 164. Current pay structure by U.S. region (p<0.001)



Principal Position Total Income Before Taxes

Survey participants were asked to estimate their total income before taxes from January to December of the last calendar year for their principal clinical position. The highest proportion of PA (15.6%) identified that their total income was in the range of $120,001 - $130,000, followed by 13.3% who said $130,001 - $140,000 and 12.6% indicated $110,001 - $120,000 (Figure 165).

Figure 165. For your principal clinical position, please estimate your total income before taxes from January - December of the last calendar year.



When total income of principal clinical position was evaluated by gender, we found statistically significant differences ($p<0.001$). The pattern of results suggests that a higher proportion of males reported earnings in the top brackets of income categories (i.e., $130,000 to more than $250,000; Table 26).

Table 26. Principal Position Income by Gender

Income	Female	Male	p-value
Less than or equal to $40,000	1.8%	1.0%	<0.001
$40,001 - $50,000	1.2%	0.7%	
$50,001 - $60,000	1.2%	0.7%	
$60,001 - $70,000	1.4%	0.6%	
$70,001 - $80,000	2.1%	0.1%	
$80,001 - $90,000	3.0%	1.3%	
$90,001 - $100,000	6.7%	2.7%	

$100,001 - $110,000	10.5%	6.4%	
$110,001 - $120,000	16.4%	7.2%	
$120,001 - $130,000	17.0%	13.6%	
$130,001 - $140,000	11.8%	15.4%	
$140,001 - $150,000	8.0%	11.2%	
$150,001 - $160,000	6.7%	8.2%	
$160,001 - $170,000	2.7%	5.9%	
$170,001 - $180,000	1.8%	5.1%	
$180,001 - $190,000	1.9%	4.9%	
$190,001 - $200,000	1.2%	2.5%	
$200,001 - $210,000	1.2%	3.5%	
$210,001 - $220,000	0.6%	1.8%	
$220,001 - $230,000	0.7%	1.8%	
$230,001 - $240,000	0.2%	1.1%	
$240,001 - $250,000	0.2%	0.7%	
More than $250,000	0.2%	1.6%	
Prefer not to answer	1.3%	2.0%	

Statistically significant differences were detected by years certified (p<0.001). PAs certified for up to 10 years had the highest proportion of indicating that their total income is $120,001 - $130,000 (Table 27). Participants certified for 21 or more years had the highest percentage of selecting $140,001 - $150,000 as their total income.

Table 27. Principal Position Income by Years Certified

Income	Up to 10	11 to 20	21+	p-value
Less than or equal to $40,000	1.1%	2.1%	1.4%	<0.001**
$40,001 - $50,000	0.6%	1.0%	2.1%	
$50,001 - $60,000	0.5%	1.4%	1.7%	
$60,001 - $70,000	1.1%	0.9%	1.4%	
$70,001 - $80,000	1.1%	1.6%	1.4%	
$80,001 - $90,000	2.9%	1.4%	2.4%	
$90,001 - $100,000	6.7%	2.9%	4.5%	
$100,001 - $110,000	12.2%	6.6%	3.4%	
$110,001 - $120,000	16.8%	9.2%	7.2%	
$120,001 - $130,000	17.8%	14.5%	11.3%	
$130,001 - $140,000	13.1%	14.4%	11.6%	
$140,001 - $150,000	7.6%	9.9%	13.0%	
$150,001 - $160,000	6.4%	8.3%	8.2%	
$160,001 - $170,000	3.5%	3.5%	6.8%	
$170,001 - $180,000	2.5%	3.6%	4.1%	
$180,001 - $190,000	1.8%	3.8%	5.8%	
$190,001 - $200,000	1.3%	2.4%	1.7%	
$200,001 - $210,000	0.8%	3.8%	2.7%	
$210,001 - $220,000	0.5%	1.9%	1.4%	
$220,001 - $230,000	0.5%	2.1%	1.4%	
$230,001 - $240,000	0.2%	0.7%	1.4%	
$240,001 - $250,000	0.4%	0.3%	0.7%	
More than $250,000	0.2%	0.9%	2.1%	
Prefer not to answer	0.4%	2.9%	2.4%	

** *Fisher-Freeman-Halton Exact test*

Concerning U.S. region, differences were also found to be statistically significant (p=0.007). PAs in the Midwest were more likely to cite their income as $110,001 - $120,000 compared to all other U.S. regions (Table 28). PAs residing in the Northeast (16.5%) were slightly more likely to state that their income is $120,001 - $130,000 vs. those in the Midwest (15.6%), South (14.8%), and West (16.0%).

Table 28. Principal Position Income by U.S. region

Income	Midwest	Northeast	South	West	p-value
Less than or equal to $40,000	1.9%	1.0%	1.9%	0.8%	0.007**
$40,001 - $50,000	1.1%	0.5%	1.2%	1.1%	
$50,001 - $60,000	0.8%	1.0%	0.7%	1.7%	
$60,001 - $70,000	1.1%	0.8%	0.7%	1.9%	
$70,001 - $80,000	1.6%	0.8%	1.1%	1.9%	
$80,001 - $90,000	4.0%	1.5%	1.9%	1.9%	
$90,001 - $100,000	6.3%	4.4%	5.4%	3.9%	
$100,001 - $110,000	10.6%	10.3%	9.3%	4.4%	
$110,001 - $120,000	15.6%	13.1%	13.5%	7.4%	
$120,001 - $130,000	15.6%	16.5%	14.8%	16.0%	
$130,001 - $140,000	11.6%	14.7%	13.9%	12.7%	
$140,001 - $150,000	8.2%	11.3%	8.6%	9.4%	
$150,001 - $160,000	6.3%	6.7%	8.1%	8.0%	
$160,001 - $170,000	3.7%	4.4%	3.7%	4.7%	
$170,001 - $180,000	2.6%	3.6%	2.8%	3.9%	
$180,001 - $190,000	1.3%	3.9%	2.5%	5.5%	
$190,001 - $200,000	1.3%	1.0%	1.1%	3.9%	
$200,001 - $210,000	1.9%	1.3%	2.5%	3.0%	
$210,001 - $220,000	0.8%	1.0%	1.2%	1.4%	
$220,001 - $230,000	1.1%	0.0%	1.2%	2.2%	
$230,001 - $240,000	0.0%	0.8%	0.5%	1.1%	
$240,001 - $250,000	0.3%	0.3%	0.7%	0.3%	
More than $250,000	0.5%	0.0%	1.1%	1.4%	
Prefer not to answer	1.9%	1.3%	1.6%	1.7%	

** *Fisher-Freeman-Halton Exact test*

Type of Pay: Bonus Pay

For the next section, PAs were asked whether they receive certain pay types in their principal clinical position, including bonus pay, night rate pay, evening rate pay, weekend pay, holiday pay, overtime pay, and on-call pay. Figure 166 demonstrates that over half of PAs (54.0%) receive bonus pay.

Figure 166. Bonus pay

Table 29 shows the association between bonus pay and demographics/years certified. We did not detect statistically significant differences by gender (p=0.686), years certified (p=0.058), and U.S. region (p=0.505).

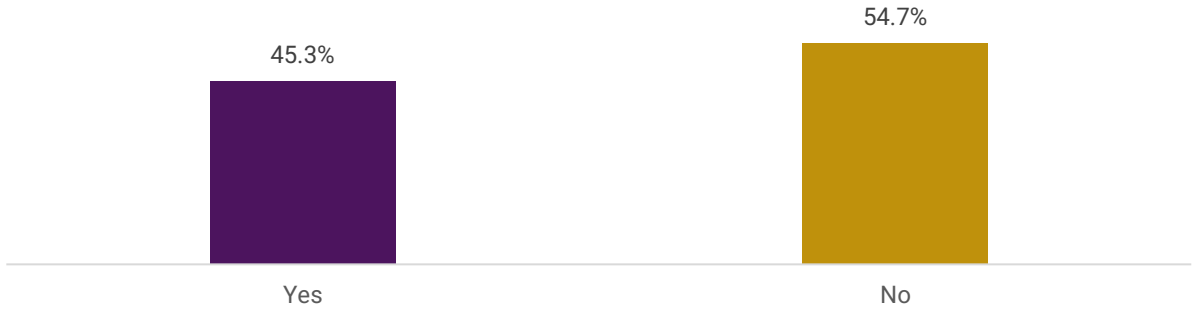
Table 29. Bonus Pay by Characteristics

Characteristics		Yes	No	p-value
Gender	Female	54.4%	45.6%	0.686
	Male	53.4%	46.6%	
Years Certified	Up to 10	56.3%	43.7%	0.058
	11 to 20	53.5%	46.5%	
	21+	48.3%	51.7%	
U.S. Region	Midwest	51.6%	48.4%	0.505
	Northeast	53.2%	46.8%	
	South	54.3%	45.7%	
	West	57.0%	43.0%	

Type of Pay: Night Rate Pay

Almost half of respondents (45.3%) stated that they receive night rate pay (Figure 167).

Figure 167. Night rate pay



When night rate pay was parsed by demographics/years certified, we found statistically significant differences by gender (p=0.003), years certified (p=0.022), and U.S. region (p=0.005; Table 30). Females were more likely than males to state that they receive night rate pay (48.3% vs. 41.0%). Survey participants who were certified for up to 10 years were more likely to select that they receive night rate pay compared to those certified for 11 to 20 and 21 or longer (48.6% vs. 42.7% and 40.8%). Participants residing in the West had the highest proportion of noting they receive night rate pay than other U.S. regions.

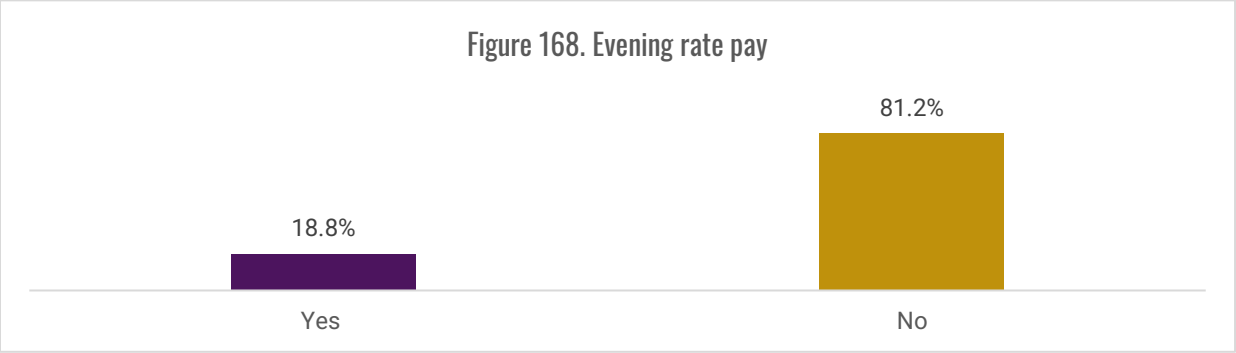
Table 30. Night Rate Pay by Characteristics

Characteristics		Yes	No	p-value
Gender	Female	48.3%	51.7%	0.003
	Male	41.0%	59.0%	
Years Certified	Up to 10	48.6%	51.4%	0.022
	11 to 20	42.7%	57.3%	
	21+	40.8%	59.2%	
U.S. Region	Midwest	39.9%	60.1%	0.005
	Northeast	45.5%	54.5%	
	South	43.9%	56.1%	
	West	52.6%	47.4%	

Type of Pay: Evening Rate Pay

Only 18.8% of participants indicated that they receive evening rate pay (Figure 168).

Figure 168. Evening rate pay



When evening rate pay was assessed by gender, we found that females, compared to males, were significantly more likely to state that they receive evening rate pay (21.9% vs. 14.5%; p<0.001; Table 31). We did not detect statistically significant differences by years certified (p=0.519), but a statistically significant relationship was found by U.S. region (p=0.013). PAs residing in the West (23.1%) were more likely to state that they receive evening rate pay vs. PAs in the Midwest (20.9%), Northeast (18.3%), and South (15.1%).

Table 31. Evening Rate Pay by Characteristics

Characteristics		Yes	No	p-value
Gender	Female	21.9%	78.1%	<0.001
	Male	14.5%	85.5%	
Years Certified	Up to 10	19.6%	80.4%	0.519
	11 to 20	17.3%	82.7%	
	21+	19.5%	80.5%	
U.S. Region	Midwest	20.9%	79.1%	0.013
	Northeast	18.3%	81.7%	
	South	15.1%	84.9%	
	West	23.1%	76.9%	

Type of Pay: Weekend Pay

As shown in Figure 169, only 14.9% of PAs receive weekend pay.

Weekend pay analyzed by gender, years certified, and U.S. region is shown in Table 32. Females were significantly more likely than males to mark that they receive weekend pay (16.4% vs. 12.9%; p=0.042). Regarding years certified, statistically significant differences were not detected (p=0.461). Participants residing in the Midwest had the highest proportion of selecting that they receive weekend pay compared to other U.S. regions (p=0.013).

Table 32. Weekend Pay by Characteristics

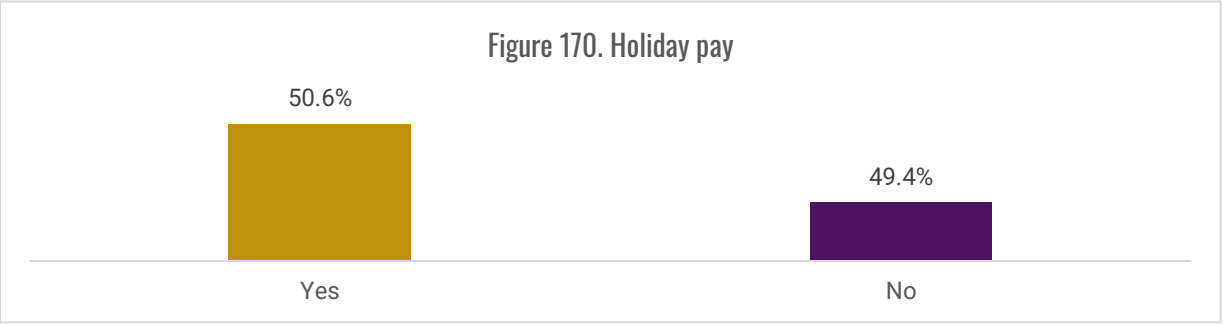
Characteristics		Yes	No	p-value
Gender	Female	16.4%	83.6%	0.042
	Male	12.9%	87.1%	
Years Certified	Up to 10	15.2%	84.8%	0.461
	11 to 20	13.7%	86.3%	
	21+	16.8%	83.2%	

U.S. Region	Midwest	24.1%	75.9%	0.013
	Northeast	16.7%	83.3%	
	South	8.1%	91.9%	
	West	14.0%	86.0%	

Type of Pay: Holiday Pay

Half of survey participants (50.6%) indicated that they receive holiday pay (Figure 170).

Figure 170. Holiday pay



We did not uncover differences by gender (p=0.434), or years certified (p=0.443); however, there were differences by U.S. region (p<0.001; Table 33). Participants in the Midwest (58.7%) had a significantly higher percentage of reporting they receive holiday pay vs. those in the Northeast (47.0%), South (44.3%), and West (55.6%).

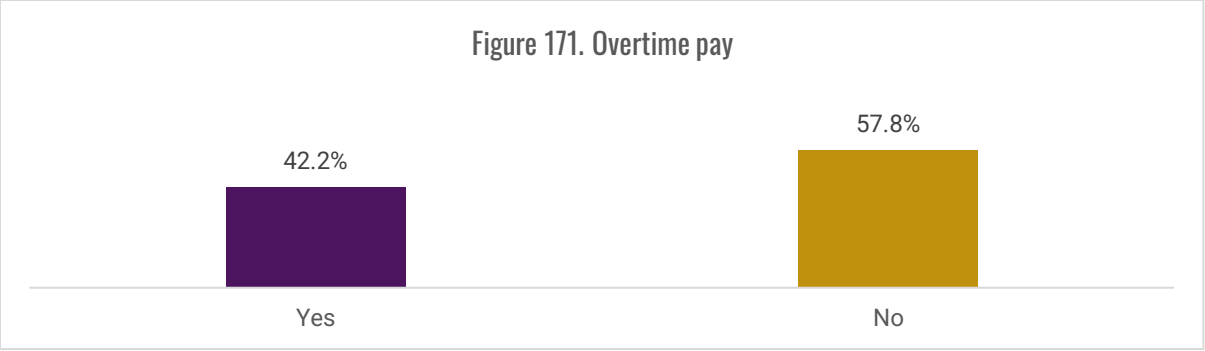
Table 33. Holiday Pay by Characteristics

Characteristics		Yes	No	p-value
Gender	Female	51.4%	48.6%	0.434
	Male	49.4%	50.6%	
Years Certified	Up to 10	50.9%	49.1%	0.443
	11 to 20	51.7%	48.3%	
	21+	47.3%	52.7%	
U.S. Region	Midwest	58.7%	41.3%	<0.001
	Northeast	47.0%	53.0%	
	South	44.3%	55.7%	
	West	55.6%	44.4%	

Type of Pay: Overtime Pay

Figure 171 shows that 42.2% of respondents receive overtime pay.

Figure 171. Overtime pay



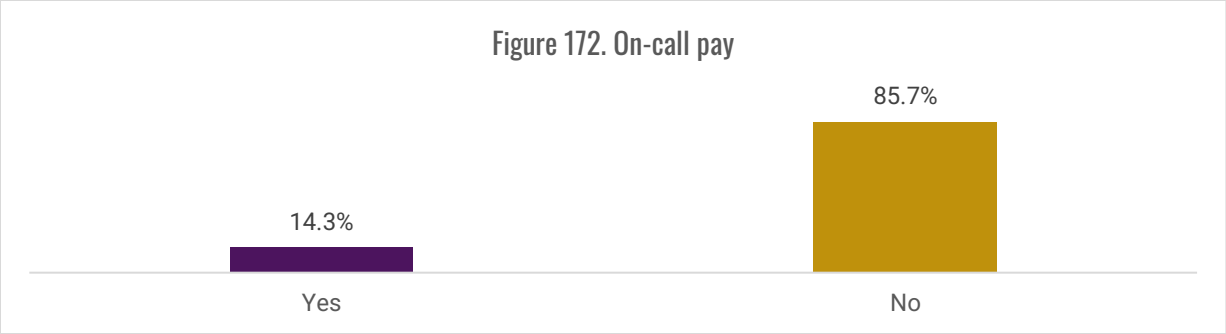
The results in Table 34 reflect a detailed characterization of overtime pay by gender, years certified, and U.S. region. Differences were not found to be statistically significant for overtime pay by gender (p=0.060), but females had a slightly higher proportion than males indicating that they receive overtime pay (44.1% vs. 39.5%). The relationship between overtime pay and years certified was also not significant (p=0.110), but PAs certified for 11 to 20 years had a lower proportion of reporting to receive overtime pay. Concerning U.S. region, PAs residing in the Northeast compared to other U.S. regions had a significantly higher proportion of reporting that they receive overtime pay (p<0.001).

Table 34. Overtime Pay by Characteristics

Characteristics		Yes	No	p-value
Gender	Female	44.1%	55.9%	0.060
	Male	39.5%	60.5%	
Years Certified	Up to 10	43.0%	57.0%	0.110
	11 to 20	39.1%	60.9%	
	21+	46.2%	53.8%	
U.S. Region	Midwest	44.4%	55.6%	<0.001
	Northeast	51.9%	48.1%	
	South	30.1%	69.9%	
	West	48.8%	51.2%	

Type of Pay: On-call Pay

Only 14.3% of PAs identified that they receive on-call pay (Figure 172).



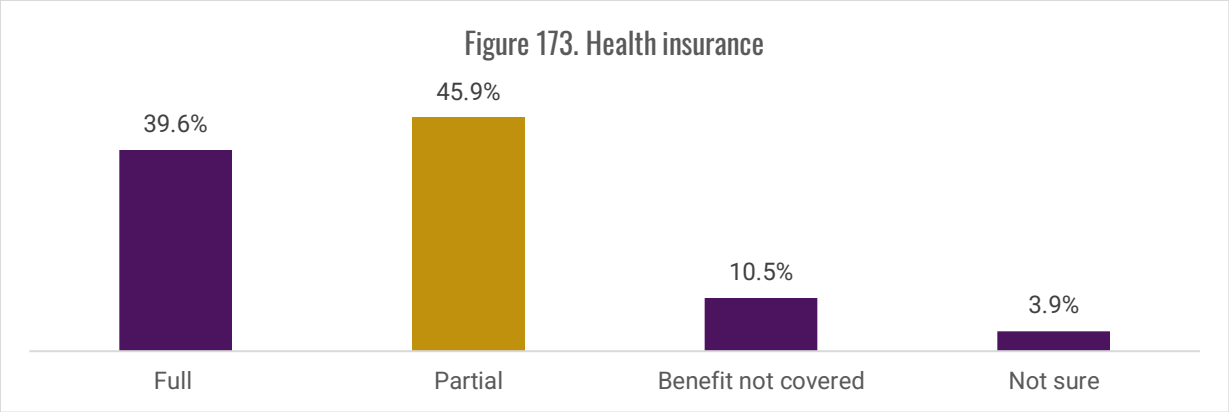
On-call pay parsed by gender, years certified, and U.S. region is depicted in Table 35. We did not detect significant differences by gender (p=0.105), years certified (p=0.525), or U.S. region (p=0.059).

Table 35. On-Call Pay by Characteristics

Characteristics		Yes	No	p-value
Gender	Female	15.5%	84.5%	0.105
	Male	12.7%	87.3%	
Years Certified	Up to 10	15.3%	84.7%	0.525
	11 to 20	13.1%	86.9%	
	21+	14.0%	86.0%	
U.S. Region	Midwest	13.8%	86.2%	0.059
	Northeast	10.8%	89.2%	
	South	14.9%	85.1%	
	West	17.6%	82.4%	

Employer Benefits: Health Insurance

PAs were asked to identify the level that their current employer pays for the following benefits: health insurance, dental insurance, malpractice insurance, short-term disability, long-term disability, and life insurance. Almost half of the survey participants (45.9%) reported that their current employer partially covers health insurance (Figure 173). Many PAs (39.6%) indicated their employer fully covers their health insurance.



When health insurance was evaluated by gender, we found statistically significant differences (p<0.001). Females were slightly more likely than males to receive partial health insurance (46.6% vs. 44.9%; Table 36). Half (51.0%) of participants who were certified for 21 or more years stated that they receive partial health insurance from their employer, which was higher than for PAs in the other certification year groups (p<0.001). Participants who reside in the West (49.3%) were significantly more likely to report they receive full health insurance vs. PAs in the Midwest (40.7%), Northeast (36.0%), and South (35.3%; p<0.001).

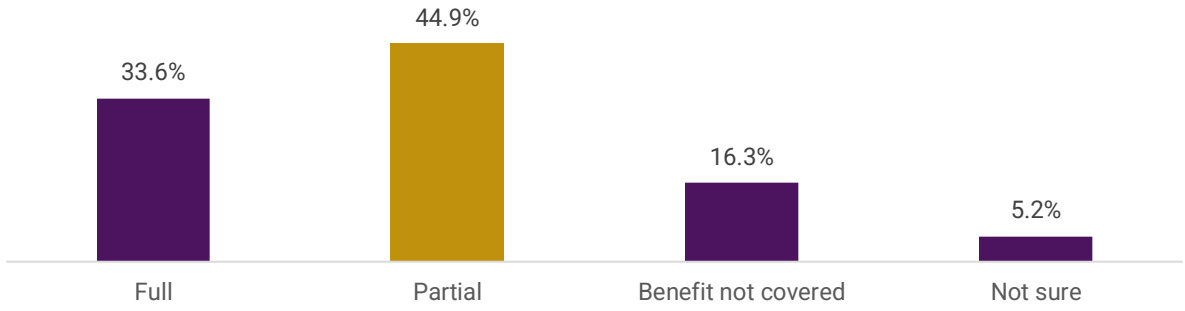
Table 36. Health Insurance by Characteristics

Characteristics		Full	Partial	Benefit not covered	Not sure	p-value
Gender	Female	37.1%	46.6%	10.9%	5.4%	<0.001
	Male	43.2%	44.9%	10.0%	1.8%	
Years Certified	Up to 10	43.3%	44.5%	7.3%	4.8%	<0.001
	11 to 20	38.1%	45.3%	13.0%	3.6%	
	21+	32.2%	51.0%	14.7%	2.1%	
U.S. Region	Midwest	40.7%	46.0%	10.3%	2.9%	<0.001
	Northeast	36.0%	52.4%	7.2%	4.4%	
	South	35.3%	47.1%	12.8%	4.7%	
	West	49.3%	36.9%	10.5%	3.3%	

Employer Benefits: Dental Insurance

Many survey participants (44.9%) indicated that they receive partial dental insurance, while 33.6% receive full dental coverage (Figure 174).

Figure 174. Dental insurance



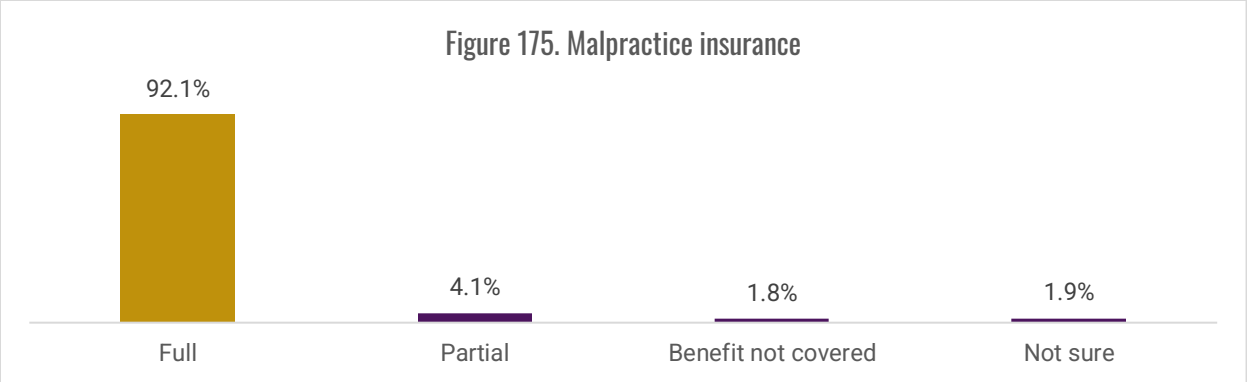
We observed statistically significant differences by gender (p<0.001), years certified (p<0.001), and U.S. region (p<0.001; Table 37). Males were slightly more likely than females to identify that they receive full dental insurance (35.2% vs. 32.5%) and partial dental insurance (45.6% vs. 44.3%). PAs certified for 21 or more years were more likely to report partial dental insurance compared to those up to 10 and 11 to 20 (50.3% vs. 42.5% and 45.3%). PAs residing in the Northeast (52.7%) were significantly more likely to state that they receive partial dental insurance vs. PAs in the Midwest (44.4%), South (46.0%), and West (35.0%).

Table 37. Dental Insurance by Characteristics

Characteristics		Full	Partial	Benefit not covered	Not sure	p-value
Gender	Female	32.5%	44.3%	15.6%	7.6%	<0.001
	Male	35.2%	45.6%	17.2%	2.0%	
Years Certified	Up to 10	38.6%	42.5%	12.5%	6.4%	<0.001
	11 to 20	31.0%	45.5%	18.5%	5.0%	
	21+	24.7%	50.3%	22.6%	2.4%	
U.S. Region	Midwest	36.8%	44.4%	15.9%	2.9%	<0.001
	Northeast	32.4%	52.7%	8.7%	6.2%	
	South	26.5%	46.0%	20.7%	6.7%	
	West	43.0%	35.0%	17.6%	4.4%	

Employer Benefits: Malpractice Insurance

Almost all the respondents (92.1%) indicated that their employer fully covers malpractice insurance (Figure 175).



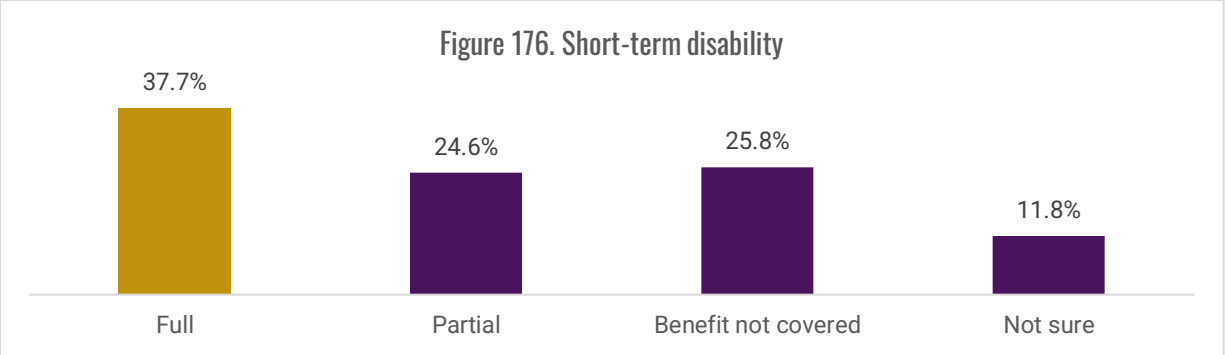
Males were significantly more likely than females to state that their employer covered their malpractice insurance fully (93.2% vs. 91.3%; p=0.021; Table 38). Regarding years certified, statistically significant differences were found (p=0.006). Survey participants certified for 21 or more years had the highest proportion of stating that their employer fully covered their malpractice insurance compared to other certification year groups. The association between malpractice insurance and U.S. region was not statistically significant (p=0.293).

Table 38. Malpractice Insurance by Characteristics

Characteristics		Full	Partial	Benefit not covered	Not sure	p-value
Gender	Female	91.3%	4.0%	1.8%	2.8%	0.021
	Male	93.2%	4.2%	1.8%	0.7%	
Years Certified	Up to 10	91.3%	4.9%	1.1%	2.6%	0.006
	11 to 20	92.2%	4.3%	2.1%	1.4%	
	21+	94.2%	1.4%	3.4%	1.0%	
U.S. Region	Midwest	94.2%	3.7%	1.1%	1.1%	0.293
	Northeast	90.7%	4.6%	1.3%	3.3%	
	South	91.2%	4.2%	2.6%	1.9%	
	West	92.8%	3.9%	1.9%	1.4%	

Employer Benefits: Short-term Disability

Figure 176 illustrates that 37.7% of participants noted that their employer fully covers their short-term disability, followed by 25.8% stating that this benefit is not covered, and 24.6% selecting partial.



The results in Table 39 depict the relationship between short-term disability and gender, years certified, and U.S. region. We found statistically significant differences when parsing short-term disability benefit by gender (p<0.001). Males were more likely than females to acknowledge that their employer fully covers their short-term disability (40.5% vs. 35.8%). PAs certified for up to 10 years were more likely to cite that their employer fully covers their short-term disability compared to those 11 to 20 and 21 or longer (39.2% vs. 36.9% and 35.3%; p<0.001). Concerning U.S. region, participants residing in the Midwest (44.4%) had the highest percentage of reporting that their employer covers their short-term disability in full vs. those in the Northeast (40.1%). South (29.2%), and West (41.9%; p<0.001).

Table 39. Short-Term Disability by Characteristics

Characteristics		Full	Partial	Benefit not covered	Not sure	p-value
Gender	Female	35.8%	24.2%	25.6%	14.5%	<0.001
	Male	40.5%	25.3%	26.1%	8.1%	
Years Certified	Up to 10	39.2%	23.7%	21.7%	15.4%	<0.001
	11 to 20	36.9%	24.6%	29.1%	9.5%	
	21+	35.3%	27.4%	31.2%	6.2%	
U.S. Region	Midwest	44.4%	24.3%	22.0%	9.3%	<0.001
	Northeast	40.1%	27.8%	17.5%	14.7%	
	South	29.2%	24.1%	34.8%	12.0%	
	West	41.9%	22.6%	24.2%	11.3%	

Employer Benefits: Long-Term Disability

Almost one-third of PAs (31.5%) said that their employer fully covers long-term disability (Figure 177). Over a quarter of respondents (28.7%) selected partial, followed by 25.1% stating this benefit is not covered by their employer.

Figure 177. Long-term disability

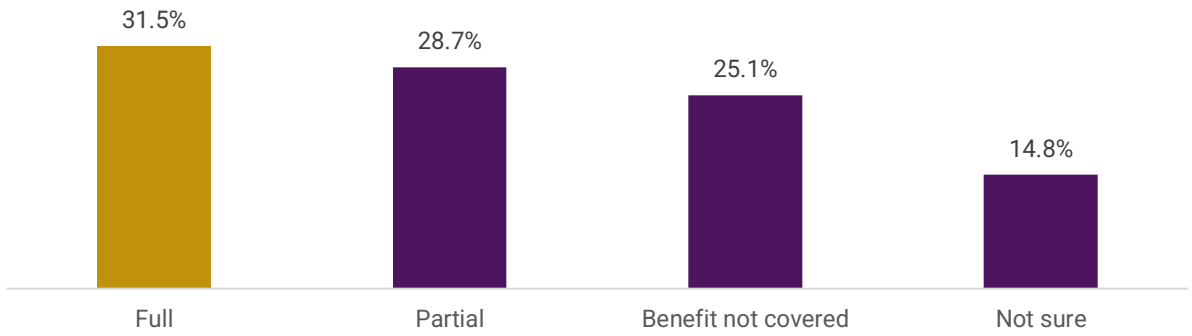


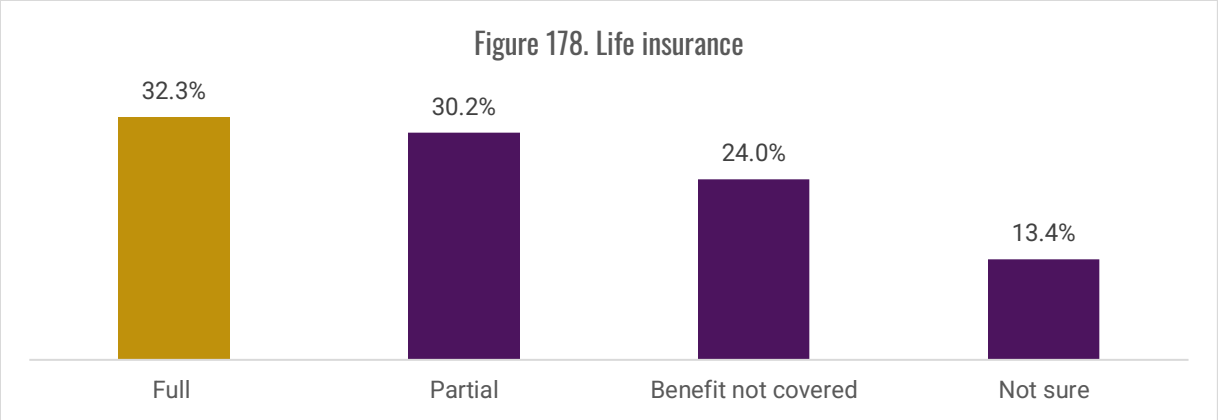
Table 40 reveals statistically significant differences when we analyzed long-term disability by gender (p<0.001), years certified (p<0.001), and U.S. region (p<0.001). Males compared to females were more likely to select that their employer fully covers long-term disability (33.1% vs. 30.3%). PAs certified for 21 or more years had the highest proportion of selecting they do not receive this benefit compared to those in other certification year groups. Regarding U.S. region, PAs residing in the Midwest (38.6%) were significantly more likely to state that they receive long-term disability in full vs. PAs in the Northeast (31.4%), South (26.9%), and West (31.4%).

Table 40. Long-Term Disability by Characteristics

Characteristics		Full	Partial	Benefit not covered	Not sure	p-value
Gender	Female	30.3%	27.2%	24.0%	18.5%	<0.001
	Male	33.1%	30.8%	26.7%	9.5%	
Years Certified	Up to 10	32.3%	27.9%	20.2%	19.6%	<0.001
	11 to 20	32.4%	28.0%	27.5%	12.1%	
	21+	27.4%	32.2%	34.2%	6.2%	
U.S. Region	Midwest	38.6%	29.6%	19.6%	12.2%	<0.001
	Northeast	31.4%	32.9%	17.0%	18.8%	
	South	26.9%	26.5%	33.0%	13.5%	
	West	31.4%	26.4%	27.0%	15.2%	

Employer Benefits: Life Insurance

Figure 178 illustrates that 32.3% of PAs receive life insurance in full, followed by 30.2% partially covered, and 24.0% selected that their employer does not cover this benefit.



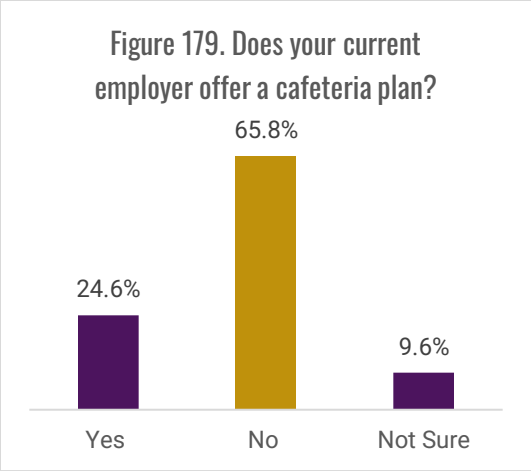
We found statistically significant differences by gender (p<0.001). Males were more likely than females to state that their employer fully pays for life insurance (34.6% vs. 30.7%; Table 41). Similarly, the relationship between life insurance and years certified was found to be statistically significant (p<0.001); PAs certified for 21 or more years had the highest proportion of stating that their employers fully cover life insurance compared to those certified up to 10 and 11-20 years (34.9% vs. 33.0% and 30.1%). Concerning U.S. region, participants residing in the Midwest, compared to all other regions, had the highest proportion of selecting that their employer fully covers life insurance (p<0.001).

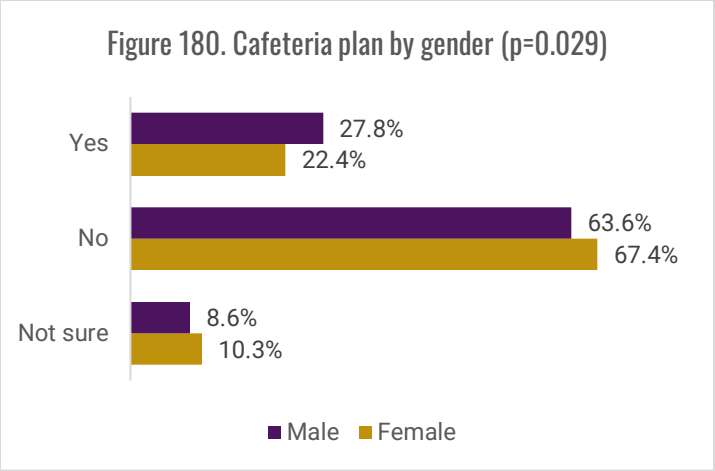
Table 41. Life Insurance by Characteristics

Characteristics		Full	Partial	Benefit not covered	Not sure	p-value
Gender	Female	30.7%	29.3%	23.2%	16.8%	<0.001
	Male	34.6%	31.5%	25.3%	8.6%	
Years Certified	Up to 10	33.0%	29.4%	20.5%	17.2%	<0.001
	11 to 20	30.1%	31.1%	27.0%	11.8%	
	21+	34.9%	30.8%	28.4%	5.8%	
U.S. Region	Midwest	35.7%	33.3%	19.8%	11.1%	<0.001
	Northeast	33.9%	30.3%	17.7%	18.0%	
	South	30.6%	28.5%	27.7%	13.2%	
	West	30.0%	29.5%	29.2%	11.3%	

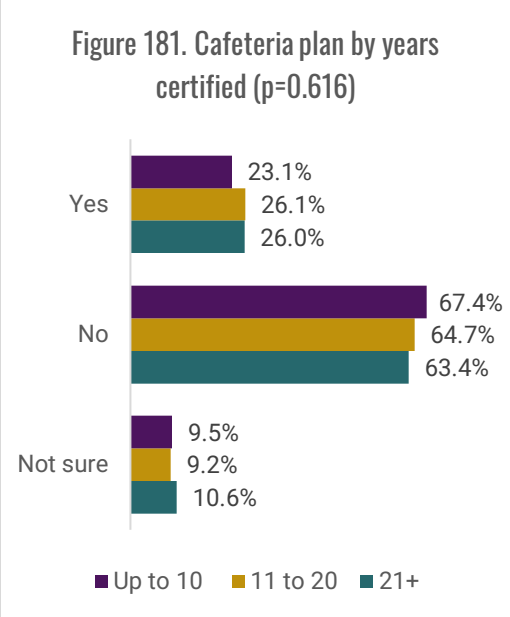
Cafeteria Plan Offered

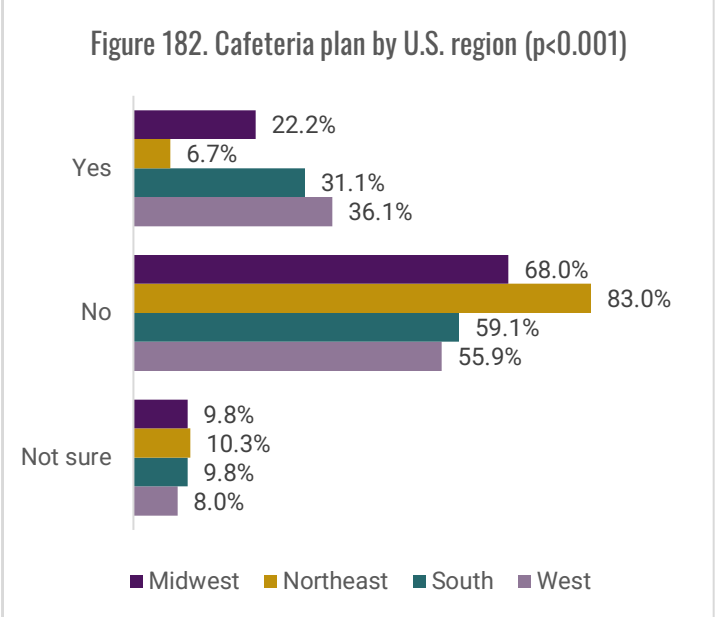
One-quarter of PAs (24.6%) identified that their current employer offers a cafeteria plan (Figure 179). Statistically significant differences were found between cafeteria plan being provided by employer and gender (p=0.029). Males, compared to females, were more likely to mark that their employer offers a cafeteria plan (27.8% vs. 22.4%; Figure 180).





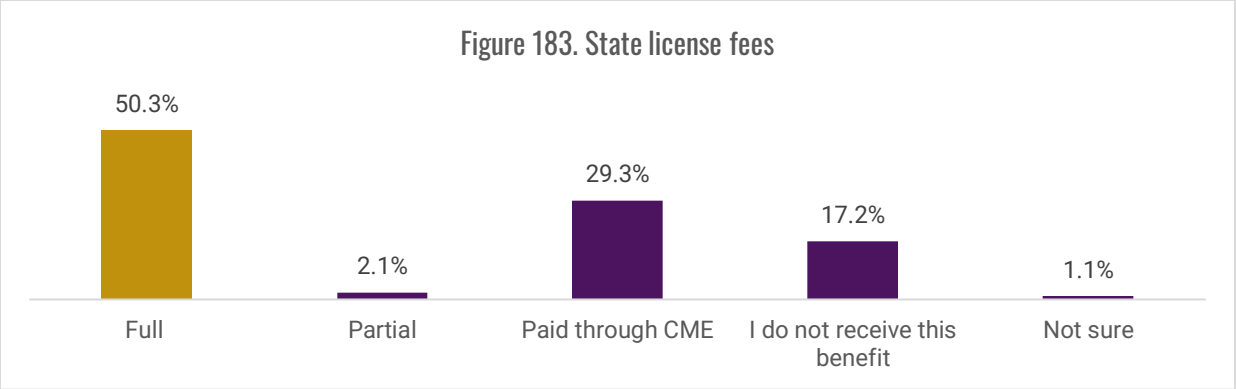
We did not detect statistically significant differences by years certified (p=0.616), but respondents who were certified for up to 10 years had a lower proportion of stating that their employer offers a cafeteria plan than PAs in the other certification year groups (Figure 181). Concerning U.S. region, participants residing in the West (36.1%) were significantly more likely to mention that they are offered a cafeteria plan vs. PAs in the Midwest (22.2%), Northeast (6.7%), and South (31.1%; p<0.001; Figure 182).





Employer Covers Fees/Dues: State License Fees

In the next section, we asked PAs at what level does their current employer pay for the following benefits: state license fees, state AAPA chapter dues, DEA fees, NCCPA fees, SEMPA fees, and AAPA dues. Half of the respondents (50.3%) stated that their employer fully covers their state license fees, followed by 29.3% who reported that state license fees are paid through CME (Figure 183).



We found statistically significant differences when parsing state license fees by gender (p=0.005). Females were more likely to say that their state license fees are paid through CME compared to males (31.6% vs. 26.1%; Table 42). PAs certified up to 10 years had a higher proportion of reporting that their employer fully covers state licensing fees than PAs certified for 11-20 and 21 years or longer (55.1% vs. 50.3% and 48.6%). Regarding U.S. region, PAs residing in the South had a slightly lower percentage than those in the other U.S. regions to state that their employer fully covers their state license fees (p<0.001).

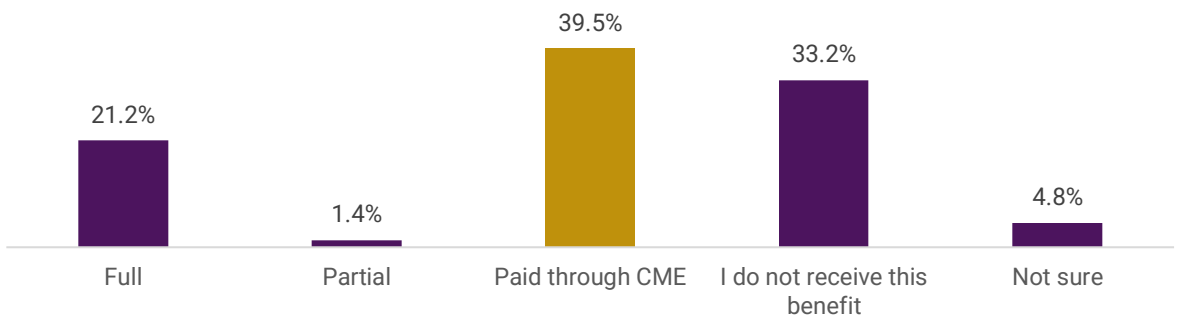
Table 42. State License Fees by Characteristics

Characteristics		Full	Partial	Paid through CME	I do not receive this benefit	Not sure	p-value
Gender	Female	49.8%	1.5%	31.6%	15.5%	1.5%	0.005
	Male	51.0%	2.8%	26.1%	19.5%	0.6%	
Years Certified	Up to 10	55.1%	1.7%	20.5%	21.2%	1.4%	<0.001
	11 to 20	50.3%	3.3%	27.2%	18.5%	0.7%	
	21+	48.6%	1.3%	33.9%	14.8%	1.3%	
U.S. Region	Midwest	54.5%	2.4%	31.5%	11.4%	0.3%	<0.001
	Northeast	50.9%	1.5%	33.9%	12.1%	1.5%	
	South	45.0%	2.1%	31.8%	19.7%	1.4%	
	West	54.0%	2.2%	18.5%	24.2%	1.1%	

Employer Covers Fees/Dues: State AAPA Chapter Dues

Over one-third of participants (39.5%) specified that their state AAPA chapter dues are paid through CME, followed by 33.2% who do not receive this benefit, and 21.2% said this benefit is fully covered by their employer (Figure 184).

Figure 184. State AAPA chapter dues



The association between state AAPA chapter dues and gender, years certified, and U.S. region was significant (all p<0.001; Table 43). Females were more likely than males to report that their state AAPA chapter dues are paid through CME (42.9% vs. 34.7%). Survey participants who were certified for up to 10 years were significantly more likely to identify that their state AAPA chapter dues are paid through CME compared to those 11 to 20 and 21 or more years (46.0% vs. 36.2% and 27.7%). PAs residing in the Midwest had higher proportions of indicating that these dues are fully covered compared to the other U.S. regions.

Table 43. State AAPA Chapter Dues by Characteristics

Characteristics		Full	Partial	Paid through CME	I do not receive this benefit	Not sure	p-value
Gender	Female	19.2%	0.7%	42.9%	32.3%	4.8%	<0.001
	Male	23.9%	2.3%	34.7%	34.5%	4.7%	
Years Certified	Up to 10	17.2%	0.4%	46.0%	30.3%	6.1%	<0.001
	11 to 20	22.5%	2.2%	36.2%	35.1%	4.0%	
	21+	29.8%	2.4%	27.7%	37.7%	2.7%	
U.S. Region	Midwest	25.4%	0.5%	44.2%	26.5%	3.4%	<0.001
	Northeast	21.3%	1.5%	44.2%	25.7%	7.2%	
	South	19.9%	1.6%	38.5%	36.2%	3.9%	
	West	18.7%	1.7%	31.4%	43.3%	5.0%	

Employer Covers Fees/Dues: DEA Fees

Half of participants (53.6%) acknowledged that their DEA fees are fully covered by their current employer, followed by 26.5% paid through CME and 17.5% who do not receive this benefit (Figure 185).

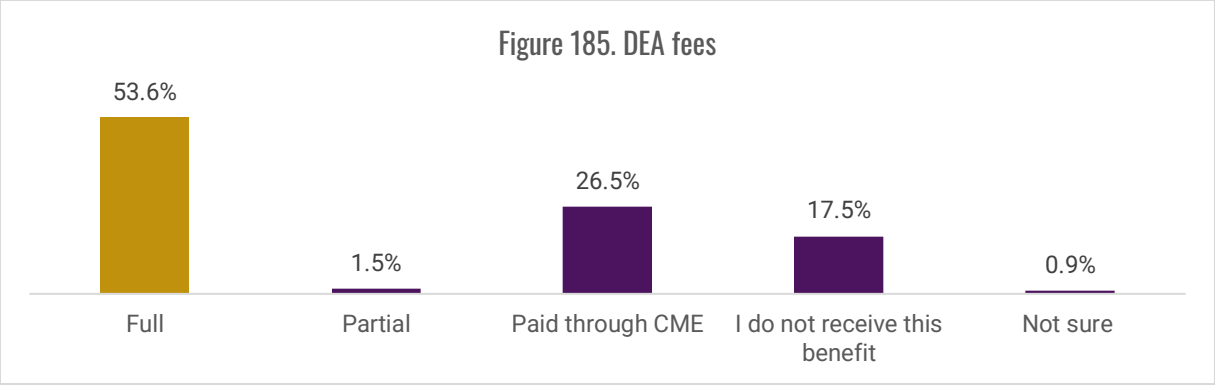


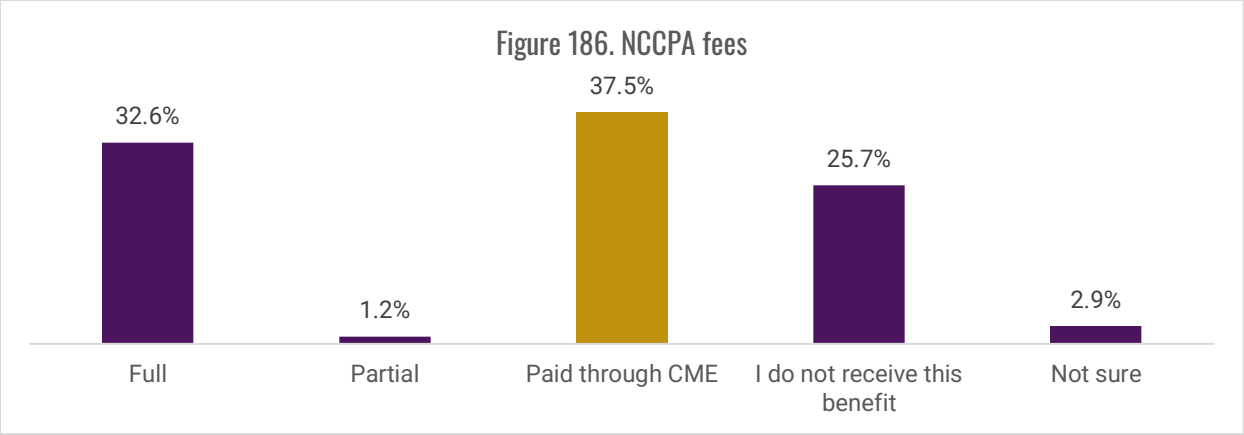
Table 44 displays the relationship between DEA fee coverage and gender, years certified, and U.S. region. Males had a similar percentage to females, indicating that their employer fully covers their DEA fees (53.7% vs. 53.6%; p=0.193). A statistically significant relationship was revealed when we parsed DEA fee coverage by years certified (p=0.001) and U.S. region (p<0.001). PAs certified for 21 or more years had the highest proportion of selecting that their DEA fees are covered in full compared to those in other certification year groups. PAs in the Midwest vs. all other areas were slightly more likely to indicate that their employer fully covers DEA fees.

Table 44. DEA Fees by Characteristics

Characteristics		Full	Partial	Paid through CME	I do not receive this benefit	Not sure	p-value
Gender	Female	53.6%	1.0%	27.6%	16.8%	1.0%	0.193
	Male	53.7%	2.3%	24.9%	18.4%	0.8%	
Years Certified	Up to 10	52.9%	1.0%	29.7%	15.3%	1.1%	0.001
	11 to 20	52.8%	2.4%	26.3%	17.8%	0.7%	
	21+	57.2%	1.4%	17.5%	22.9%	1.0%	
U.S. Region	Midwest	57.7%	1.6%	30.2%	10.3%	0.3%	<0.001
	Northeast	54.5%	1.3%	30.6%	12.1%	1.5%	
	South	48.3%	1.6%	26.4%	22.7%	1.1%	
	West	57.0%	1.7%	18.5%	22.0%	0.8%	

Employer Covers Fees/Dues: NCCPA Fees

Many PAs (37.5%) stated that their NCCPA fees are paid through CME, followed by 32.6% who are fully covered, and 25.7% that do not receive this benefit (Figure 186).



We found a statistically significant association when assessing NCCPA fee coverage by gender (p=0.003). Females were more likely than males to report that their NCCPA fees are paid through CME (39.8% vs. 34.3%; Table 45). PAs certified for up to 10 years were significantly more likely to note that their NCCPA fees were paid through CME than those in other certification year groups (p<0.001). We found a statistically significant association between NCCPA fees and U.S. region (p<0.001). Significantly higher proportions of PAs residing in the Midwest stated that their employer fully covers their NCCPA fees, while those in the Northeast had the highest proportion of reporting these fees are paid through CME.

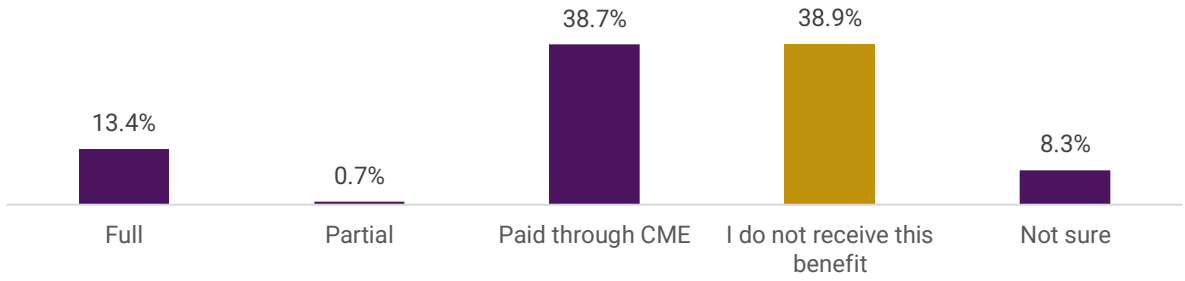
Table 45. NCCPA Fees by Characteristics

Characteristics		Full	Partial	Paid through CME	I do not receive this benefit	Not sure	p-value
Gender	Female	31.7%	0.6%	39.8%	24.4%	3.5%	0.003
	Male	33.8%	2.1%	34.3%	27.7%	2.1%	
Years Certified	Up to 10	30.8%	0.5%	43.0%	22.1%	3.6%	<0.001
	11 to 20	32.5%	1.9%	35.5%	27.3%	2.8%	
	21+	37.7%	2.1%	26.0%	32.9%	1.4%	
U.S. Region	Midwest	39.9%	0.8%	39.9%	18.3%	1.1%	<0.001
	Northeast	30.8%	1.3%	43.4%	21.1%	3.3%	
	South	28.8%	1.4%	36.6%	29.9%	3.3%	
	West	32.8%	1.4%	30.3%	31.7%	3.9%	

Employer Covers Fees/Dues: SEMPA Fees

Regarding SEMPA fees, 38.9% of PAs marked that they do not receive this benefit, followed by 38.7% who said these fees are paid through CME (Figure 187).

Figure 187. SEMPA dues



Concerning gender, females were significantly more likely to have SEMPA dues paid through CME (41.0% vs. 35.6%; p<0.001; Table 46). Statistically significant differences were found by years certified (p<0.001). PAs certified for up to 10 years had the highest percentage of reporting that this benefit is paid through CME compared to those certified 11-20 and 21 years or longer (45.0% vs. 36.7% and 25.0%). Regarding U.S. region, PAs residing in the West had the highest percentage (45.5%) of selecting that they do not receive this benefit vs. PAs in the Midwest (36.0%), Northeast (32.1%), and South (40.9%; p=0.039).

Table 46. SEMPA Dues by Characteristics

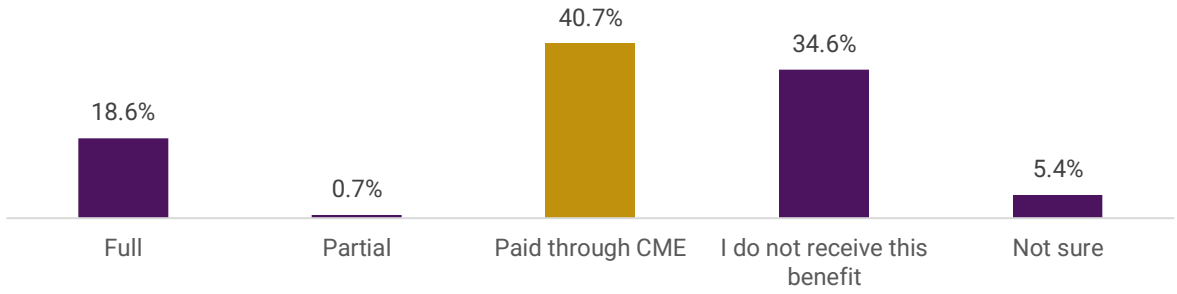
Characteristics		Full	Partial	Paid through CME	I do not receive this benefit	Not sure	p-value
Gender	Female	11.4%	0.3%	41.0%	38.1%	9.3%	<0.001
	Male	16.2%	1.3%	35.6%	40.0%	6.9%	
Years Certified	Up to 10	11.2%	0.6%	45.0%	34.2%	9.0%	<0.001
	11 to 20	14.4%	0.9%	36.7%	40.7%	7.4%	
	21+	17.8%	0.7%	25.0%	48.6%	7.9%	
U.S. Region	Midwest	13.8%	0.5%	41.8%	36.0%	7.9%	0.039**
	Northeast	14.4%	0.3%	43.2%	32.1%	10.0%	
	South	14.2%	1.1%	36.0%	40.9%	7.7%	
	West	10.7%	0.8%	35.3%	45.5%	7.7%	

***Fisher-Freeman-Halton Exact test*

Employer Covers Fees/Dues: AAPA Dues

For AAPA dues, 40.7% of PAs identified that this benefit is paid through CME, followed by 34.6% who do not receive this benefit and 18.6% whose AAPA dues are fully covered (Figure 188).

Figure 188. AAPA dues



The results presented in Table 47 reflect a characterization of AAPA dues by gender, years certified, and U.S. region. Females, compared to males, were significantly more likely to state that their AAPA dues are paid through CME (44.2% vs. 35.7%; p=0.002). Participants who were certified for 21 or more years were more likely to cite that they do not receive this benefit compared to those certified up to 10 and 11 to 20 years (40.4% vs. 30.7% and 37.2%; p<0.001). PAs residing in the Northeast had a slightly higher percentage than those in the other U.S. regions reporting that their AAPA dues are paid through CME (p<0.001).

Table 47. AAPA Dues by Characteristics

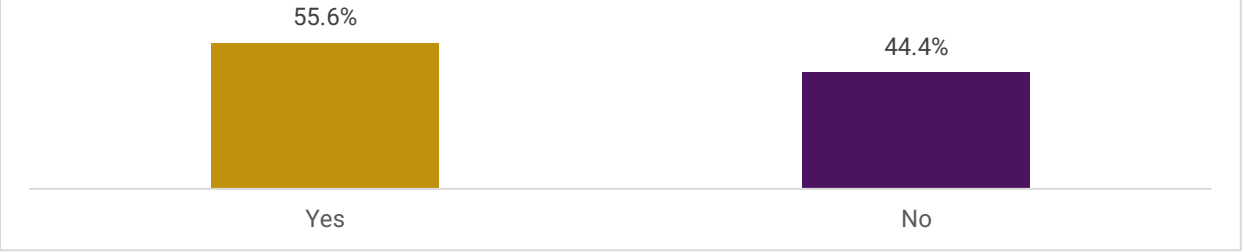
Characteristics		Full	Partial	Paid through CME	I do not receive this benefit	Not sure	p-value
Gender	Female	16.7%	0.4%	44.2%	33.0%	5.6%	0.002
	Male	21.3%	1.1%	35.7%	36.7%	5.1%	
Years Certified	Up to 10	16.5%	0.1%	46.6%	30.7%	6.1%	<0.001
	11 to 20	17.6%	1.2%	38.8%	37.2%	5.2%	
	21+	26.7%	1.4%	27.7%	40.4%	3.8%	
U.S. Region	Midwest	24.6%	0.3%	45.0%	27.2%	2.9%	<0.001**
	Northeast	18.8%	0.8%	46.3%	27.8%	6.4%	
	South	16.5%	1.1%	38.3%	37.8%	6.3%	
	West	15.7%	0.6%	34.2%	44.1%	5.5%	

***Fisher-Freeman-Halton Exact test*

Paid Time Off Received: Vacation

The following section looks at paid time off received in the form of vacation, sick leave, holiday, and other. For vacation, 55.6% of participants stated that they receive this type of paid time off (Figure 189).

Figure 189. Vacation



Vacation paid time off by gender, years certified, and U.S. region is displayed in Table 48. We did not detect significant differences by gender (p=0.748) or years certified (p=0.202); however, there were differences by U.S. region (p<0.001). Participants in the Northeast were significantly more likely to note that they receive vacation paid time off vs. PAs in the Midwest, South, and West (70.7% vs. 55.6%, 43.4%, and 58.7%).

Table 48. Vacation by Characteristics

Characteristics		Yes	No	p-value
Gender	Female	55.3%	44.7%	0.748
	Male	56.1%	43.9%	
Years Certified	Up to 10	55.0%	45.0%	0.202
	11 to 20	54.2%	45.8%	
	21+	60.3%	39.7%	
U.S. Region	Midwest	55.6%	44.4%	<0.001
	Northeast	70.7%	29.3%	
	South	43.4%	56.6%	
	West	58.7%	41.3%	

Paid Time Off Received: Sick Leave

Almost half of PAs (45.3%) identified that they receive sick leave as paid time off (Figure 190).

Figure 190. Sick leave

Table 49 demonstrates the relationship between sick leave and gender, years certified, and U.S. region. We did not detect statistically significant differences by gender (p=0.164), but we did find differences by years certified (p=0.018) and U.S. region (p<0.001). PAs who were certified for 21 or more years had the highest proportion (51.7%) of stating they receive sick leave as paid time off compared to up to 10 (42.4%) and 11 to 20 (46.4%). Participants who reside in the West had a significantly higher percentage (60.6%) than those in the Midwest (40.2%), Northeast (55.5%), and South (32.2%).

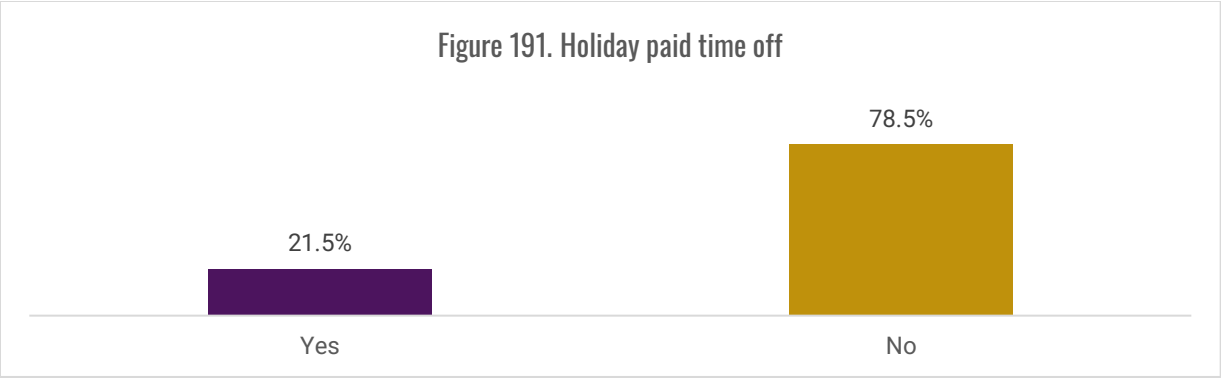
Table 49. Sick Leave by Characteristics

Characteristics		Yes	No	p-value
Gender	Female	43.9%	56.1%	0.164
	Male	47.3%	52.7%	
Years Certified	Up to 10	42.4%	57.6%	0.018
	11 to 20	46.4%	53.6%	
	21+	51.7%	48.3%	
U.S. Region	Midwest	40.2%	59.8%	<0.001
	Northeast	55.5%	44.5%	
	South	32.2%	67.8%	
	West	60.6%	39.4%	

Paid Time Off Received: Holiday Paid Time Off

More than one-fifth of respondents (21.5%) identified that they receive holiday paid time off (Figure 191).

Figure 191. Holiday paid time off



The results illustrated in Table 50 reflect a detailed characterization of holiday paid time off by gender, years certified, and U.S. region. We found statistically significant differences by years certified (p<0.001) and U.S. region (p<0.001), but not by gender (p=0.148). Compared to those in other certification year groups, PAs certified for 21 or more years were more likely to state that

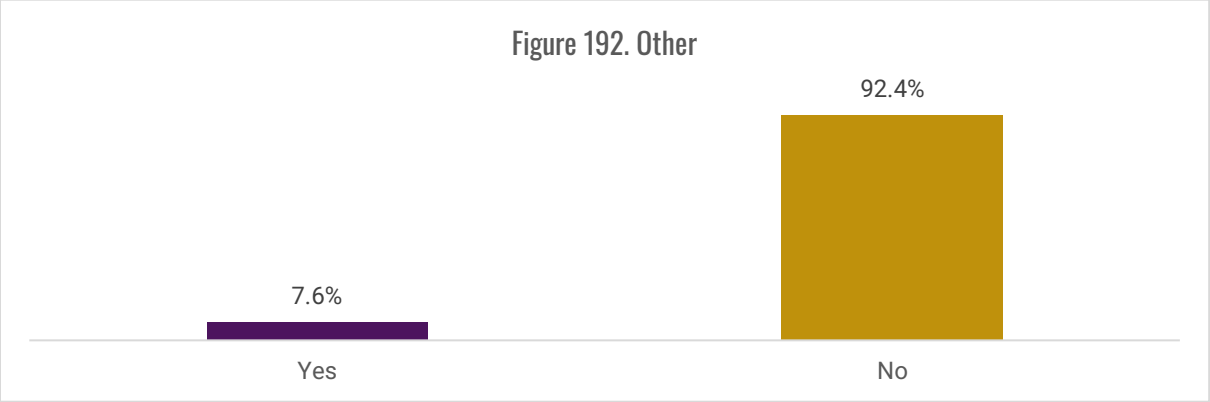
they receive holiday paid time off. PAs in the Northeast had a significantly higher proportion compared to other U.S. regions to select that they receive holiday paid time off.

Table 50. Holiday Paid Time Off by Characteristics

Characteristics		Yes	No	p-value
Gender	Female	20.2%	79.8%	0.148
	Male	23.2%	76.8%	
Years Certified	Up to 10	18.1%	81.9%	<0.001
	11 to 20	22.7%	77.3%	
	21+	28.8%	71.2%	
U.S. Region	Midwest	19.3%	80.7%	<0.001
	Northeast	32.4%	67.6%	
	South	16.5%	83.5%	
	West	19.8%	80.2%	

Paid Time Off Received: Other

Only 7.6% of participants indicated receiving “other” paid time off (Figure 192).



“Other” paid time off by gender, years certified, and U.S. region is presented in Table 51. We did not detect statistically significant differences by gender (p=0.447), years certified (p=0.159), or U.S. regions (p=0.075).

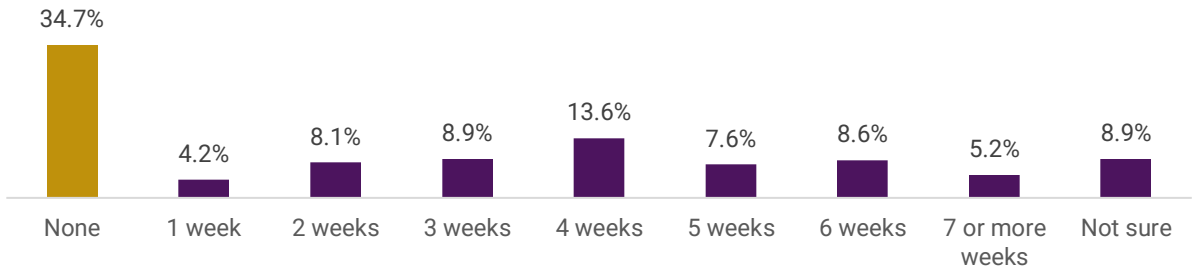
Table 51. Other by Characteristics

Characteristics		Yes	No	p-value
Gender	Female	8.1%	91.9%	0.447
	Male	7.1%	92.9%	
Years Certified	Up to 10	6.4%	93.6%	0.159
	11 to 20	8.8%	91.2%	
	21+	8.9%	91.1%	
U.S. Region	Midwest	5.8%	94.2%	0.075
	Northeast	10.5%	89.5%	
	South	6.9%	93.1%	
	West	7.7%	92.3%	

Total Paid Time Off Per Year

One-third of PAs (34.7%) specified that they are not allotted any paid time off per year, including vacation and sick leave, while 13.6% indicated that they receive 4 weeks, followed by 8.9% for 3 weeks and not sure (Figure 193).

Figure 193. How much total paid time off are you allotted per year, including vacation and sick leave?



Males and females had the same proportion of indicating that they are not allotted any paid time off per year (34.7%; p=0.514; Figure 194). Regarding years certified, we did find statistically significant differences (p<0.001). PAs certified for 11 to 20 years were slightly more likely to state that they are not allotted any paid time off per year compared to PAs certified up to 10 and 21 or more years (36.5% vs. 35.3% vs. 29.8%; Figure 195).

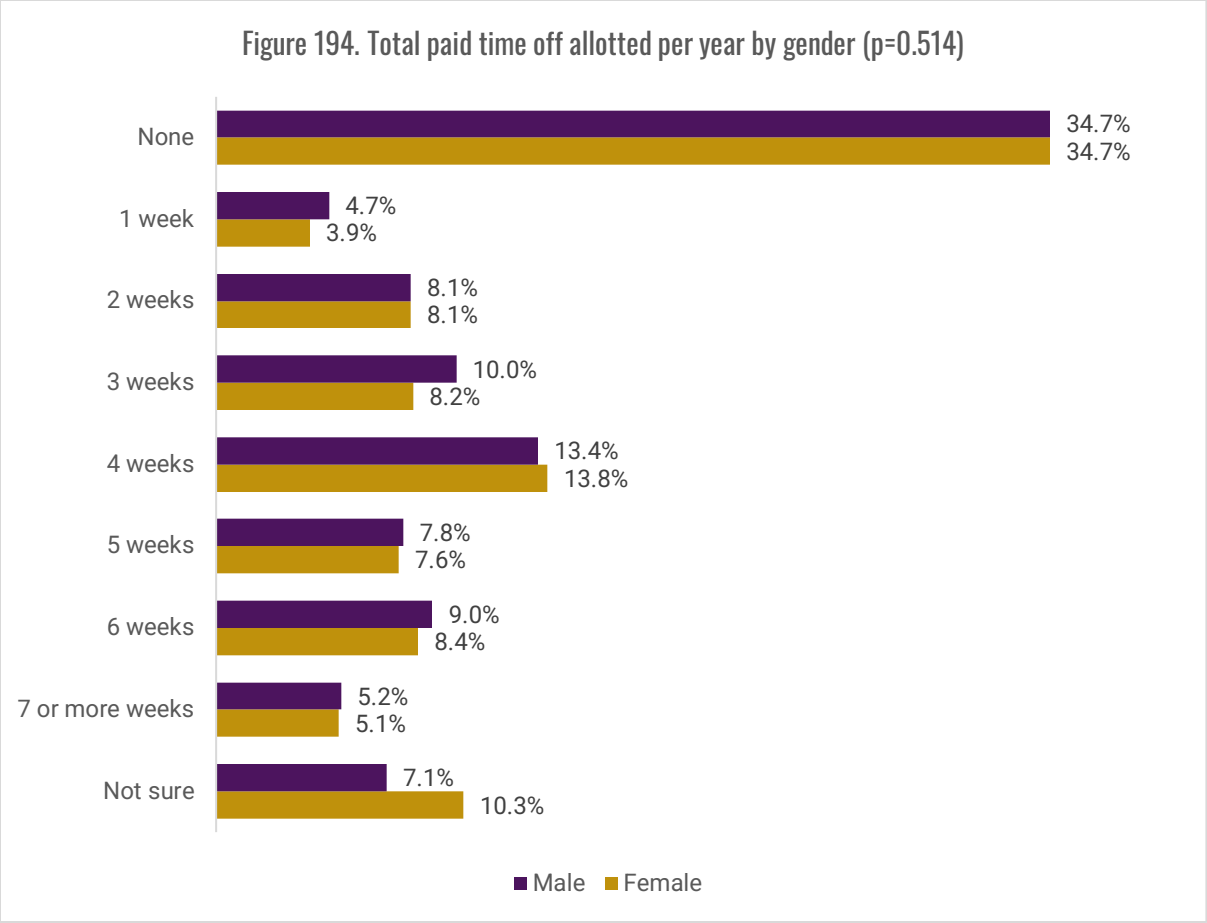
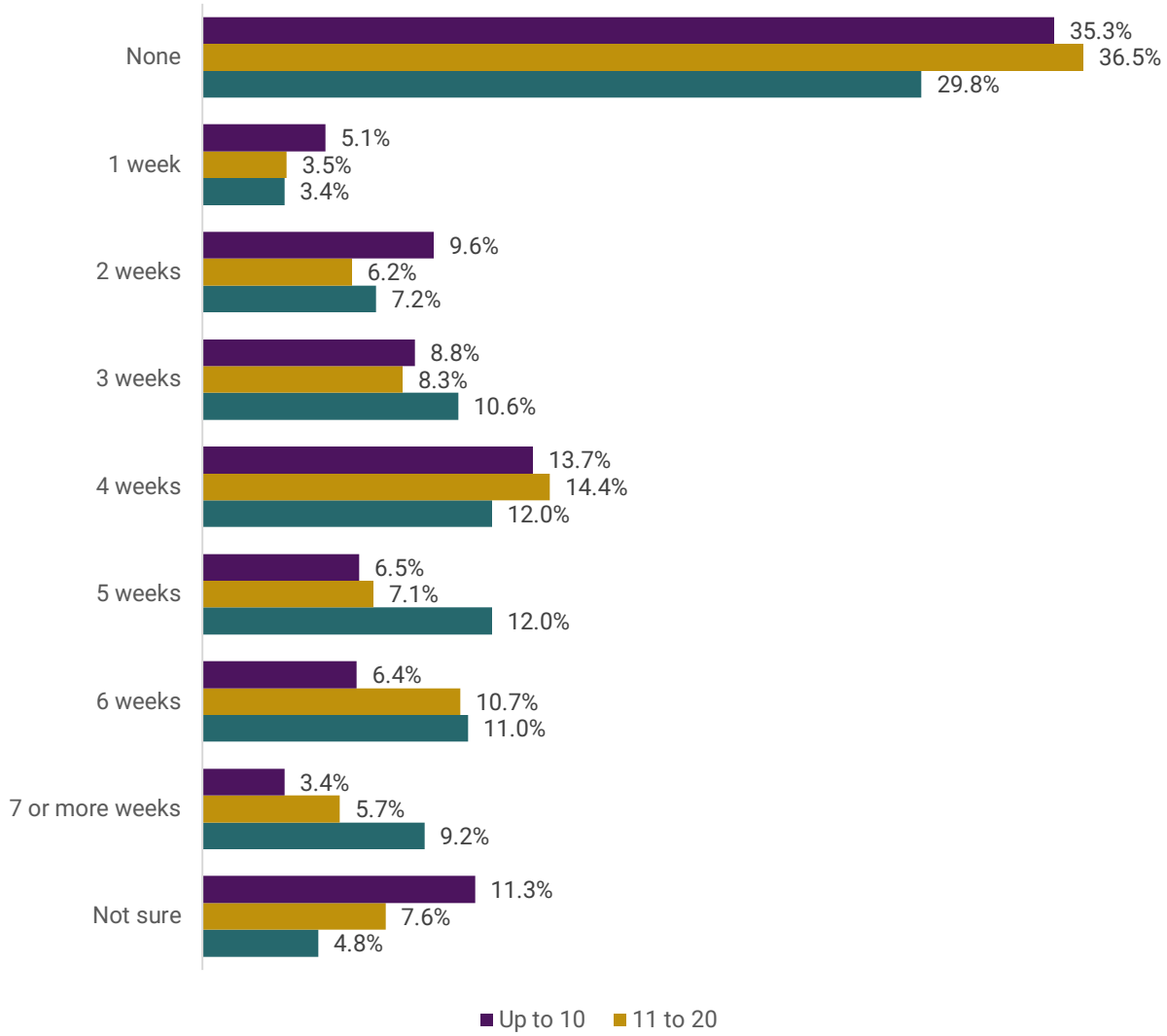


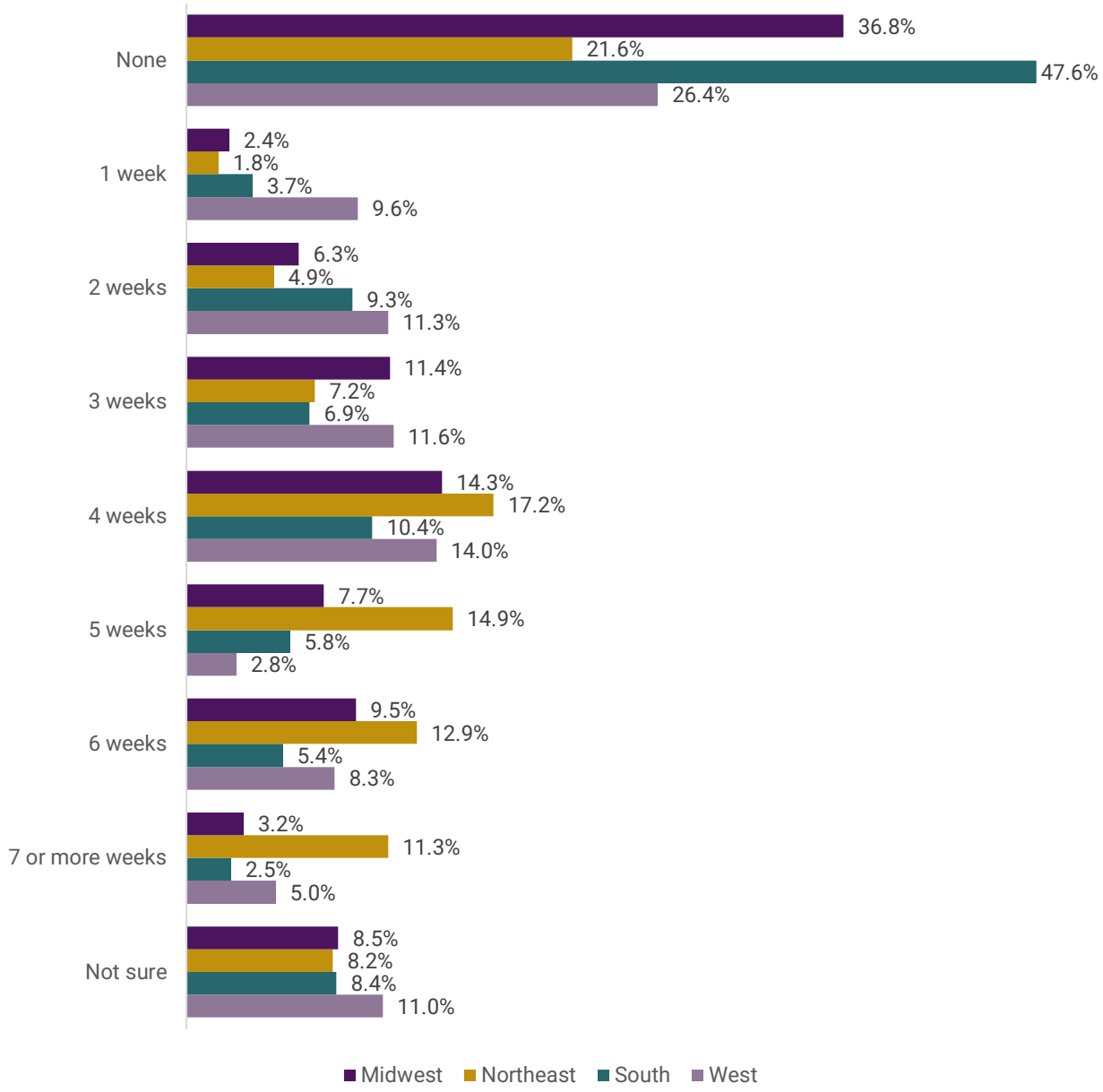
Figure 194. Total paid time off allotted per year by gender (p=0.514)
None
1 week
2 weeks
3 weeks
4 weeks
5 weeks
6 weeks
7 or more weeks
Not sure
34.7%
34.7%
4.7%
3.9%
8.1%
8.1%
10.0%
8.2%
13.4%
13.8%
7.8%
7.6%
9.0%
8.4%
5.2%
5.1%
7.1%
10.3%
Male
Female

Figure 195. Total paid time off allotted per year by years certified (p<0.001)



Participants who reside in the South were more likely to mark that they are not allotted any paid time off than those in the Midwest, Northeast, and West (47.6% vs. 36.8%, 21.6%, and 26.4%; p<0.001; Figure 196).

Figure 196. Total paid time off allotted per year by U.S. region (p<0.001)



Paid Holidays Per Year

PAs were inquired about how many paid holidays they receive per year. On average, participants receive 2.4 paid holidays. We did not observe statistically significant differences by gender (p=0.400; Table 52). There was a statistically significant difference between years certified on number of paid holidays per year (p=0.004). Subsequent pairwise comparisons revealed that there was a difference between being certified up to 10 years compared to 21 or more years (2.2 vs. 3.1; p=0.003). We also detected statistically significant differences between U.S.

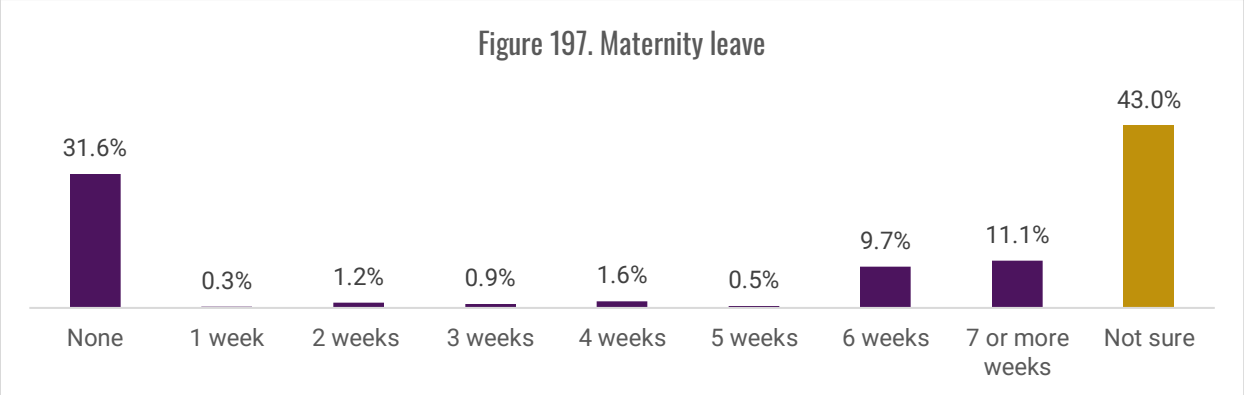
regions and paid holidays per year (p=0.003). Further pairwise testing showed that participants who reside in the Northeast had a higher average of paid holidays than those in the South (3.0 vs. 2.1; p=0.002).

Table 52. Paid Holidays per Year by Characteristics

Characteristics		Mean	Median	p-value
Gender	Female	2.3	0.0	0.400
	Male	2.6	0.0	
Years Certified	Up to 10	2.2	0.0	0.004
	11 to 20	2.5	0.0	
	21+	3.1	0.0	
U.S. Region	Midwest	2.4	0.0	0.003
	Northeast	3.0	0.0	
	South	2.1	0.0	
	West	2.3	0.0	

Paid Weeks Allotted Per Year: Maternity Leave

Figure 197 displays the number of paid weeks that PAs' employer allotted for maternity leave; 43.0% of survey participants indicated they are unsure if they are allotted maternity leave. Almost a third of respondents (31.6%) reported none, followed by 11.1% who receive 7 or more weeks.



As shown in Table 53, males were more likely than females to indicate that they are not sure if their employer offers maternity leave (51.7% vs. 36.9%; p<0.001).

Table 53. Maternity Leave by Gender

	Male	Female	p-value
None	31.5%	31.7%	
1 week	0.4%	0.2%	
2 weeks	1.1%	1.2%	
3 weeks	1.1%	0.8%	
4 weeks	1.7%	1.5%	<0.001**
5 weeks	0.3%	0.7%	
6 weeks	5.2%	12.9%	
7 or more weeks	6.9%	14.1%	
Not sure	51.7%	36.9%	

** *Fisher-Freeman-Halton Exact test*

Concerning years certified, we found statistically significant differences (p=0.001). Participants who were certified for 21 or more years had the highest proportion of stating that they are not sure if their employer offers maternity leave than those in other certification year groups (Table 54).

Table 54. Maternity Leave by Years Certified

	Up to 10	11 to 20	21+	p-value
None	30.2%	34.4%	30.1%	
1 week	0.1%	0.2%	1.0%	
2 weeks	1.4%	1.2%	0.3%	
3 weeks	1.2%	0.3%	1.4%	
4 weeks	2.0%	1.2%	1.0%	0.001**
5 weeks	0.7%	0.2%	0.7%	
6 weeks	10.5%	11.1%	4.8%	
7 or more weeks	12.0%	11.1%	8.6%	
Not sure	41.8%	40.3%	52.1%	

** *Fisher-Freeman-Halton Exact test*

Table 55 depicts maternity leave by U.S. region. PAs in the Northeast were more likely than PAs in the other areas to indicate that they are not sure if they receive maternity leave (p<0.001).

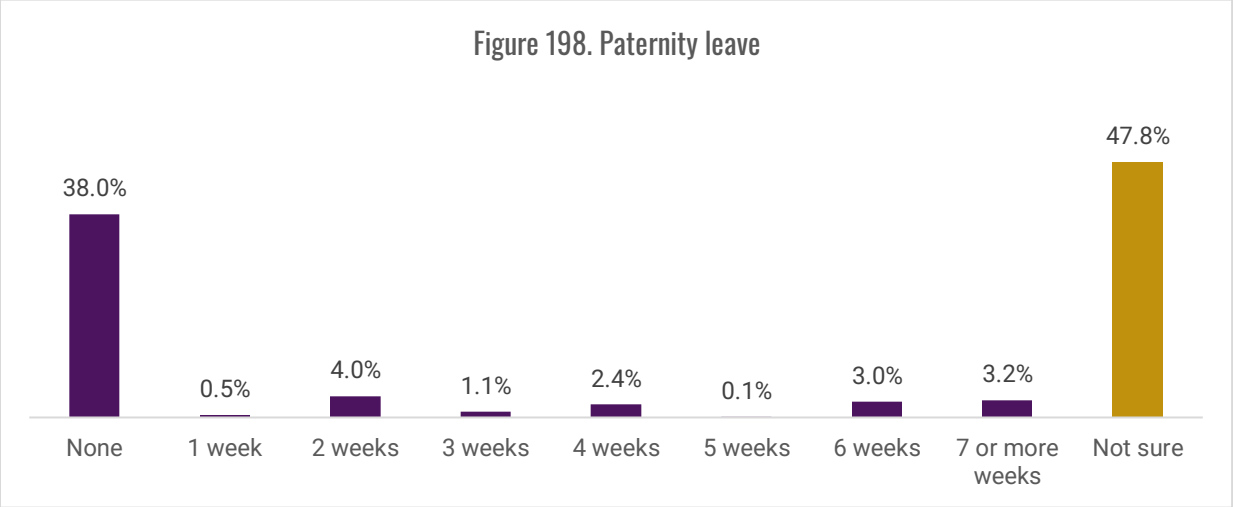
Table 55. Maternity Leave by U.S. Region

	Midwest	Northeast	South	West	p-value
None	32.8%	22.1%	39.2%	28.4%	
1 week	0.3%	0.0%	0.5%	0.3%	
2 weeks	0.3%	1.8%	1.6%	0.8%	
3 weeks	0.3%	1.5%	0.9%	1.1%	
4 weeks	1.9%	1.8%	1.1%	1.9%	<0.001**
5 weeks	1.1%	0.5%	0.5%	0.0%	
6 weeks	14.0%	10.0%	6.9%	9.4%	
7 or more weeks	14.0%	12.1%	10.0%	8.8%	
Not sure	35.4%	50.1%	39.4%	49.3%	

** *Fisher-Freeman-Halton Exact test*

Paid Weeks Allotted Per Year: Paternity Leave

Figure 198 shows paternity leave among survey participants with 47.8% indicating they are not sure if their employer offers this benefit. Many PAs (38.0%) reported they are not offered paternity leave, followed by 4.0% who are allotted two weeks.



We did not detect statistically significant differences by gender (p=0.081), but females had a higher proportion of stating that they are not sure if their employer offers paternity leave compared to males (49.9% vs. 44.8%; Table 56).

Table 56. Paternity Leave by Gender

	Male	Female	p-value
None	39.4%	37.0%	
1 week	0.7%	0.3%	
2 weeks	3.8%	4.1%	
3 weeks	1.8%	0.5%	
4 weeks	3.0%	1.9%	0.081**
5 weeks	0.1%	0.1%	
6 weeks	3.0%	3.0%	
7 or more weeks	3.4%	3.1%	
Not sure	44.8%	49.9%	

** *Fisher-Freeman-Halton Exact test*

PAs who were certified for 21 or more years were more likely to report that they are not sure if their employer offers paternity leave vs. PAs certified up to 10 and 11 to 20 years (52.7% vs. 48.3% and 44.6%; p=0.001; Table 57).

Table 57. Paternity Leave by Years Certified

	Up to 10	11 to 20	21+	p-value
None	36.3%	41.3%	36.0%	
1 week	0.4%	0.3%	1.0%	
2 weeks	5.8%	2.9%	1.0%	0.001**
3 weeks	0.7%	1.0%	2.1%	
4 weeks	2.8%	1.9%	2.1%	
5 weeks	0.1%	0.0%	0.3%	

6 weeks	3.2%	3.1%	2.1%	
7 or more weeks	2.4%	4.7%	2.7%	
Not sure	48.3%	44.6%	52.7%	

** *Fisher-Freeman-Halton Exact test*

Regarding U.S. regions, PAs residing in the Northeast (56.0%), compared to Midwest (44.4%), South (41.7%), and West (52.3%), had the highest likelihood of stating that they are not sure if their employer offers paternity leave (p=0.001; Figure 58).

Table 58. Paternity Leave by U.S. Region

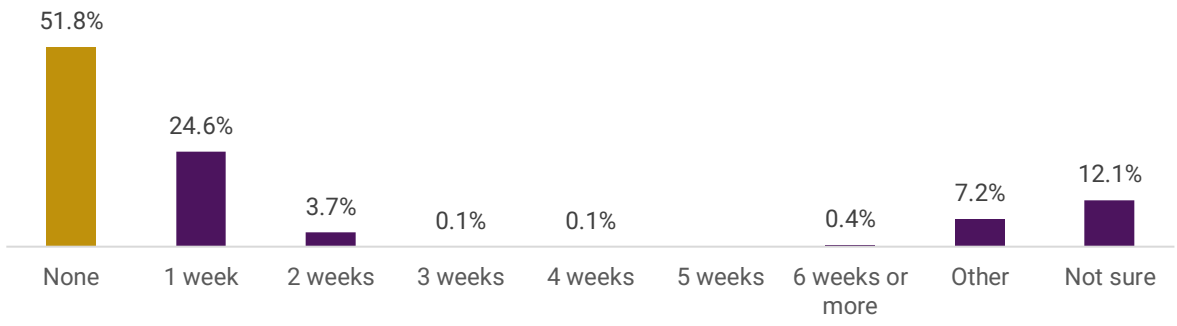
	Midwest	Northeast	South	West	p-value
None	43.1%	28.3%	45.0%	31.7%	
1 week	0.3%	0.5%	0.7%	0.3%	
2 weeks	4.2%	5.9%	3.7%	2.2%	
3 weeks	0.8%	0.8%	0.9%	1.9%	
4 weeks	2.4%	2.1%	2.3%	2.8%	0.001**
5 weeks	0.3%	0.0%	0.2%	0.0%	
6 weeks	3.4%	1.8%	2.8%	4.1%	
7 or more weeks	1.1%	4.6%	2.8%	4.7%	
Not sure	44.4%	56.0%	41.7%	52.3%	

** *Fisher-Freeman-Halton Exact test*

Time Off Allotted for CME Per Year

Over half of the PAs (51.8%) acknowledged that they do not receive time off for CME, followed by 24.6% who receive one week (Figure 199).

Figure 199. How much time off are you allotted for CME per year?



As shown in Table 59, we detected differences by gender (p<0.001), years certified (p<0.001), and U.S. region (p<0.001) on time off allotted for CME per year. Males were more likely than females to indicate that they do not receive time off allotted for CME (53.1% vs. 50.9%). Participants who were certified for 11 to 20 years had a slightly higher percentage than those certified for up to 10 and 21 years or longer of citing they do not receive time off for CME (52.8% vs. 52.6% vs. 47.6%). Survey participants who reside in the South had the highest percentage of selecting that they do not receive time off for CME compared to all other U.S. regions.

Table 59. Time Off Allotted for CME per Year by Characteristics

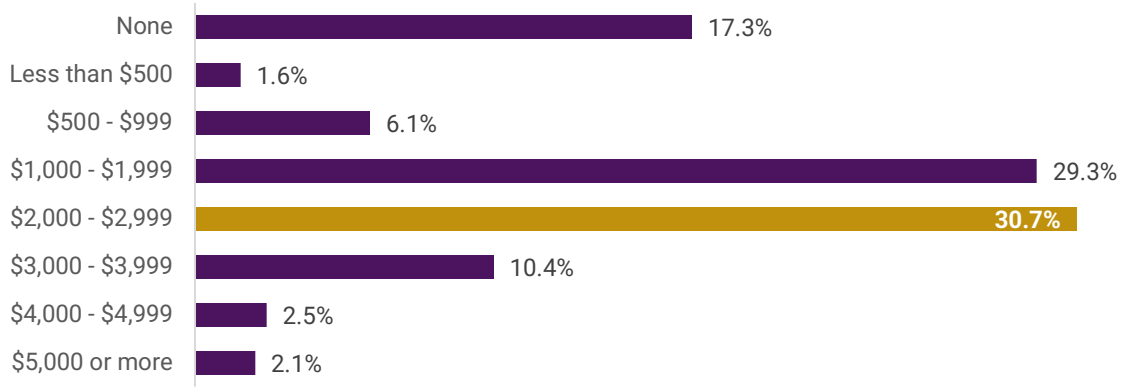
Characteristics		None	1 week	2 weeks	3 weeks	4 weeks	5 weeks	6 or more weeks	Other	Not sure	p-value
Gender	Female	50.9%	23.8%	2.6%	0.2%	0.2%	0.0%	0.3%	8.4%	13.7%	0.002**
	Male	53.1%	25.8%	5.2%	0.0%	0.0%	0.0%	0.4%	5.6%	9.7%	
Years Certified	Up to 10	52.6%	20.9%	2.2%	0.1%	0.1%	0.0%	0.5%	6.9%	16.7%	<0.001**
	11 to 20	52.8%	25.8%	4.5%	0.2%	0.2%	0.0%	0.2%	7.4%	9.0%	
	21+	47.6%	32.9%	6.5%	0.0%	0.0%	0.0%	0.3%	7.9%	4.8%	
U.S. Region	Midwest	52.4%	25.1%	3.2%	0.5%	0.0%	0.0%	0.3%	7.9%	10.6%	<0.001**
	North-east	38.6%	37.3%	4.1%	0.0%	0.5%	0.0%	0.8%	8.0%	10.8%	
	South	60.8%	18.3%	3.3%	0.0%	0.0%	0.0%	0.4%	5.8%	11.4%	
	West	51.2%	20.4%	4.4%	0.0%	0.0%	0.0%	0.0%	8.0%	16.0%	

** *Fisher-Freeman-Halton Exact test*

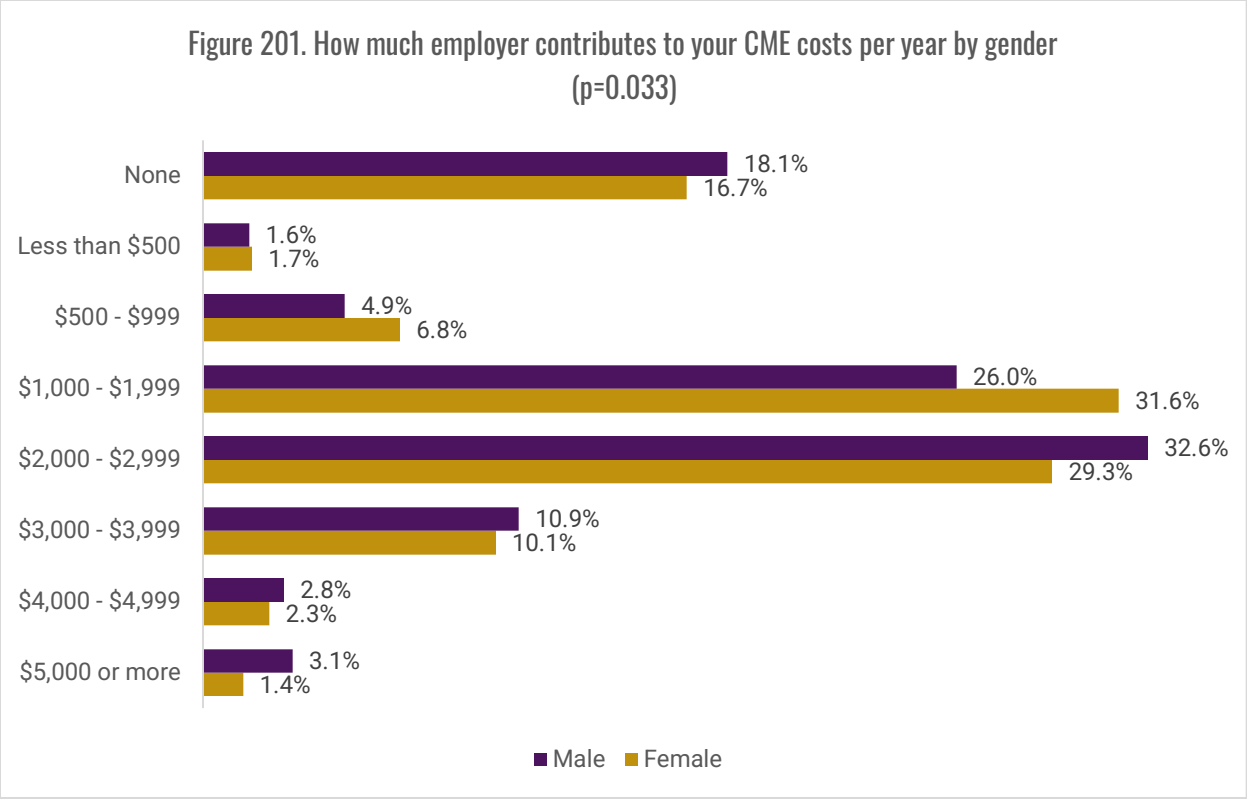
Employer Contribution to CME Costs Per Year

When survey participants were asked how much their employer contributes to their CME costs per year, 30.7% said $2,000 - $2,999, followed by 29.3% with $1,000 - $1,999 and 17.3% expressed that their employer does not contribute to their CME (Figure 200).

Figure 200. How much does your employer contribute to your CME costs per year?

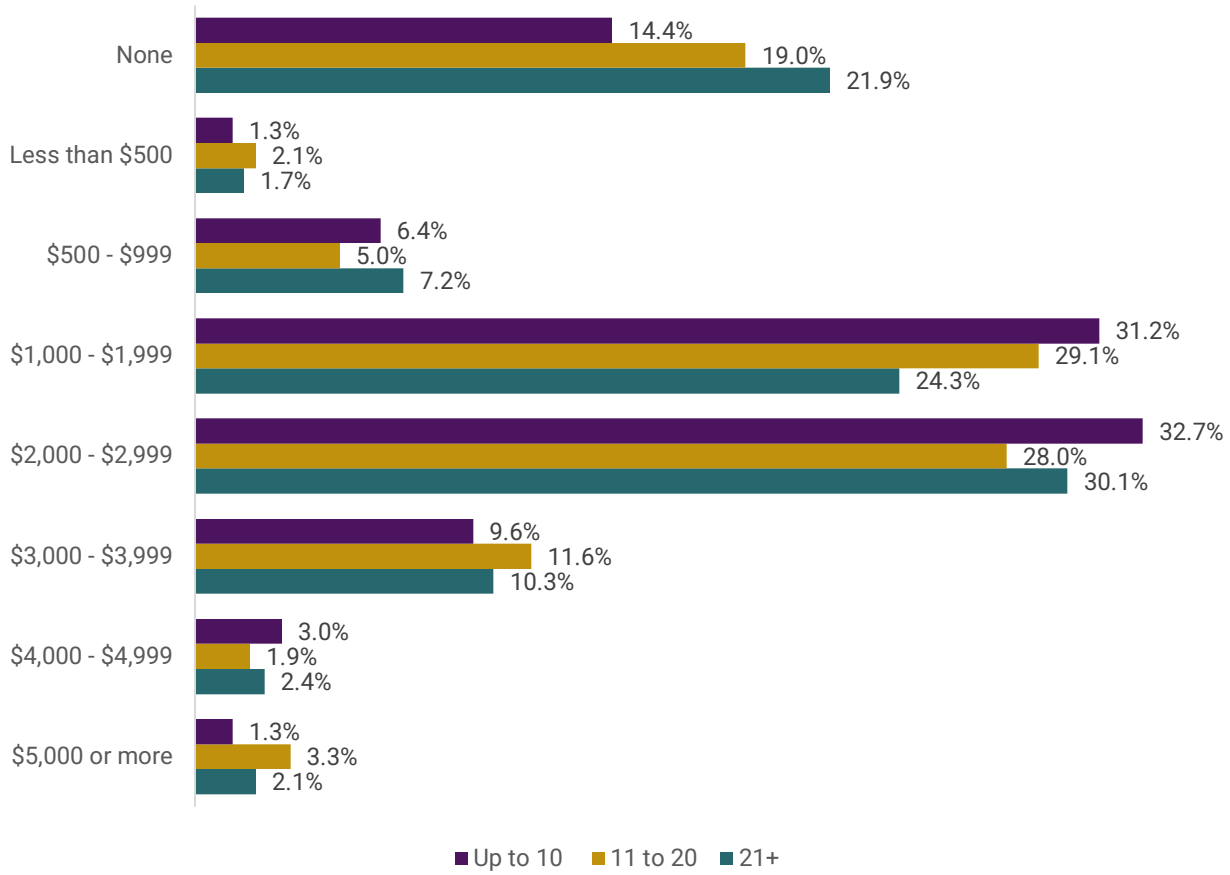


When CME contributions were evaluated by gender, we found statistically significant differences (p=0.033). Males were more likely than females to note that they receive $2,000 - $2,999 in contributions to CME costs (32.6% vs. 29.3%; Figure 201). Females were more likely to indicate that their employer contributes $1,000 - $1,999 to CME costs (31.6% vs. 26.0%).



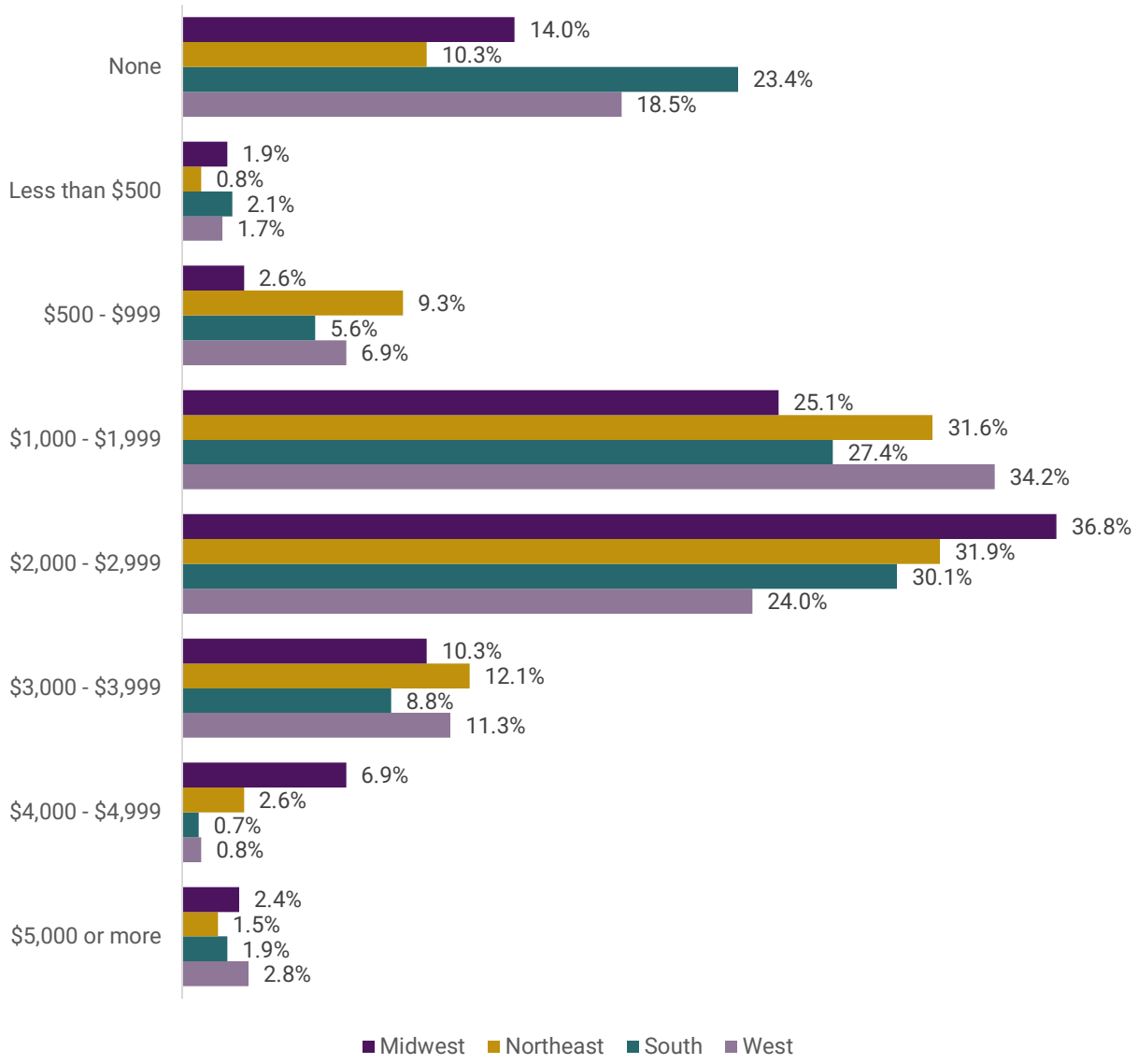
Participants certified for up to 10 years were significantly more likely to state that their employer contributes $2,000 - $2,999 to their CME costs vs. PAs certified 11 to 20 and 21 or more years (32.7% vs. 28.0% and 30.1%; p=0.021; Figure 202).

Figure 202. How much employer contributes to your CME costs per year by years certified (p=0.021)



The relationship between CME contributions and U.S. region was found to be statistically significant ($p<0.001$). Participants who reside in the Midwest (36.8%), compared to Northeast (31.9%), South (30.1%), and West (24.0%), had the highest likelihood of indicating that their employer contributes $2,000 - $2,999 to their CME costs (Figure 203).

Figure 203. How much employer contributes to your CME costs per year by U.S. region (p<0.001)



Contributions Employer Makes to 401K/403(b): Match Dollar-for-Dollar

For the next section, PAs were inquired about the type(s) of contribution(s) that their employer makes to their 401K/403(b). About a third (34.6%) of survey participants marked that their employer does match dollar-for-dollar when it comes to contributions to their 401K/403(b) (Figure 204).

Figure 204. Match dollar-for-dollar

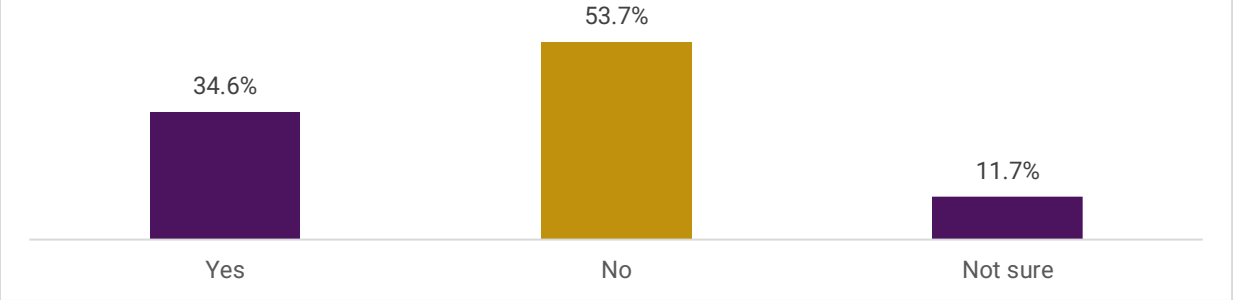


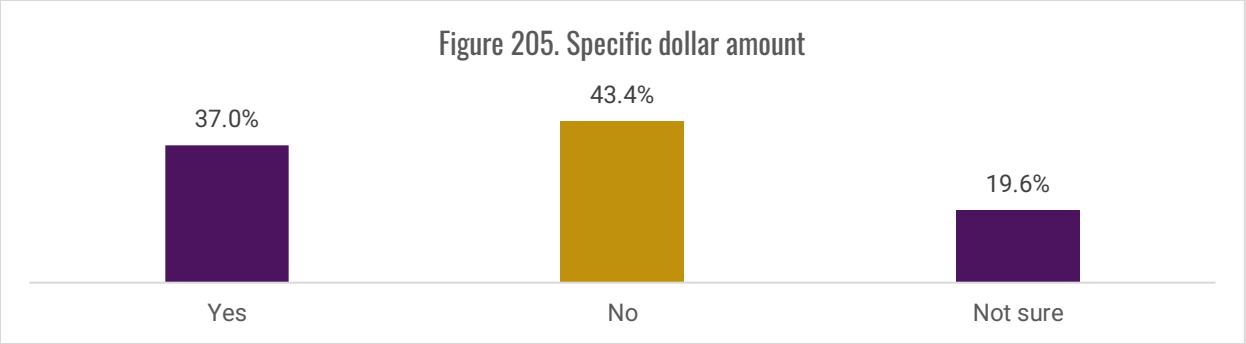
Table 60 depicts the relationship between dollar-for-dollar match for 401K/403(b) by gender, years certified, and U.S. region. Statistically significant differences were found by gender ($p<0.001$) and U.S. region ($p=0.045$), but not by years certified ($p=0.284$). Males were more likely than females to indicate that their employer matches dollar-for-dollar contributions to their 401K (38.5% vs. 31.8%). Participants residing in the West had a slightly higher percentage than those in the other U.S. regions to report a dollar-for-dollar match.

Table 60. Match Dollar-for-Dollar by Characteristics

Characteristics		Yes	No	Not sure	p-value
Gender	Female	31.8%	54.1%	14.1%	<0.001
	Male	38.5%	53.1%	8.4%	
Years Certified	Up to 10	34.4%	53.0%	12.6%	0.284
	11 to 20	34.2%	53.5%	12.3%	
	21+	36.0%	56.2%	7.9%	
U.S. Region	Midwest	36.0%	55.5%	8.5%	0.045
	Northeast	29.0%	56.5%	14.5%	
	South	36.3%	51.0%	12.7%	
	West	36.4%	53.2%	10.5%	

Contributions Employer Makes to 401K/403(b): Specific Dollar Amount

Many participants (43.4%) said that their employer does not contribute a specific dollar amount to their 401K/403(b), while 37.0% responded in the affirmative (Figure 205).



Specific dollar amount for 401K/403(b) by gender, years certified, and U.S. region are shown in Table 61. Males were significantly more likely than females to state that their employer does contribute a specific dollar amount to their 401K (40.1% vs. 34.9%; p<0.001). We did not detect differences by years certified (p=0.471). The association between specific dollar amount by U.S. region was statistically significant (p=0.044). Participants in the Midwest had a slightly higher percentage than the other areas to state that their employer does contribute a specific dollar amount to their 401K.

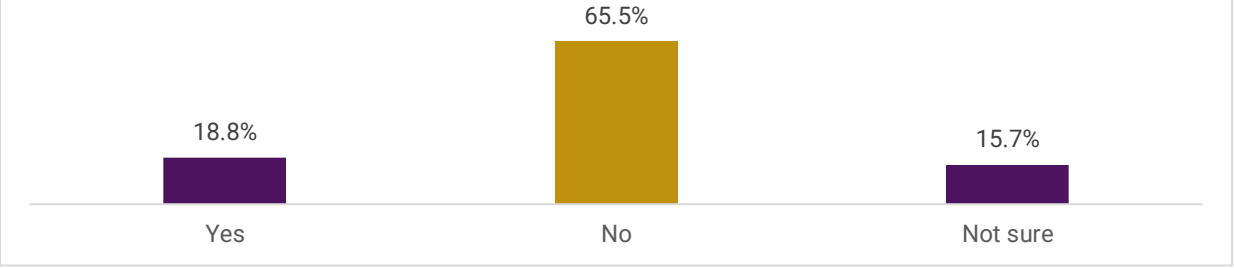
Table 61. Specific Dollar Amount by Characteristics

Characteristics		Yes	No	Not sure	p-value
Gender	Female	34.9%	41.3%	23.8%	<0.001
	Male	40.1%	46.3%	13.6%	
Years Certified	Up to 10	37.6%	41.7%	20.7%	0.471
	11 to 20	35.8%	44.8%	19.4%	
	21+	38.0%	45.5%	16.4%	
U.S. Region	Midwest	40.0%	43.7%	16.3%	0.044
	Northeast	39.4%	38.6%	22.0%	
	South	33.7%	44.3%	22.0%	
	West	36.9%	46.6%	16.5%	

Contributions Employer Makes to 401K/403(b): Profit Share

Figure 206 shows that 18.8% of respondents specified that their employer contributes profit share to their 401K/403(b).

Figure 206. Profit share



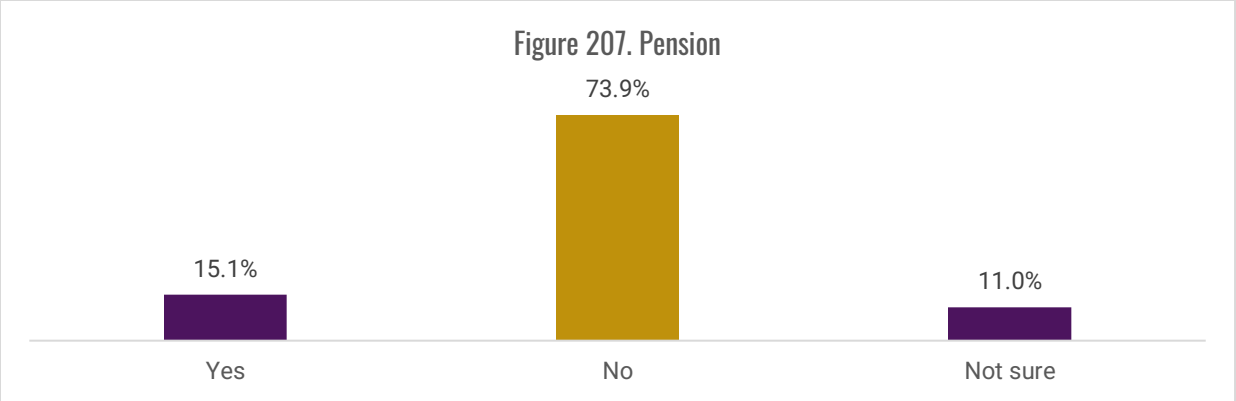
When profit share was assessed by demographics/years certified, we found statistically significant differences by gender (p<0.001), years certified (p<0.001), and U.S. region (p<0.001; Table 62). Males were more likely than females to report that their employer contributes profit share (20.3% vs. 17.8%). PAs certified for 11 to 20 years were more likely to select that they receive profit share compared to those certified up to 10 and 21 or more years (19.4% vs. 18.8% and 17.8%). Regarding U.S. regions, PAs residing in the Midwest (25.3%), compared to those in the Northeast (11.1%), South (17.5%), and West (22.6%), had the highest likelihood of identifying that they receive profit share.

Table 62. Profit Share by Characteristics

Characteristics		Yes	No	Not sure	p-value
Gender	Female	17.8%	62.0%	20.2%	<0.001
	Male	20.3%	70.4%	9.3%	
Years Certified	Up to 10	18.8%	60.7%	20.5%	<0.001
	11 to 20	19.4%	68.4%	12.2%	
	21+	17.8%	73.3%	8.9%	
U.S. Region	Midwest	25.3%	62.1%	12.5%	<0.001
	Northeast	11.1%	72.3%	16.6%	
	South	17.5%	63.7%	18.9%	
	West	22.6%	64.5%	12.9%	

Contributions Employer Makes to 401K/403(b): Pension

Few PAs (15.1%) reported that their employer offers a pension (Figure 207).



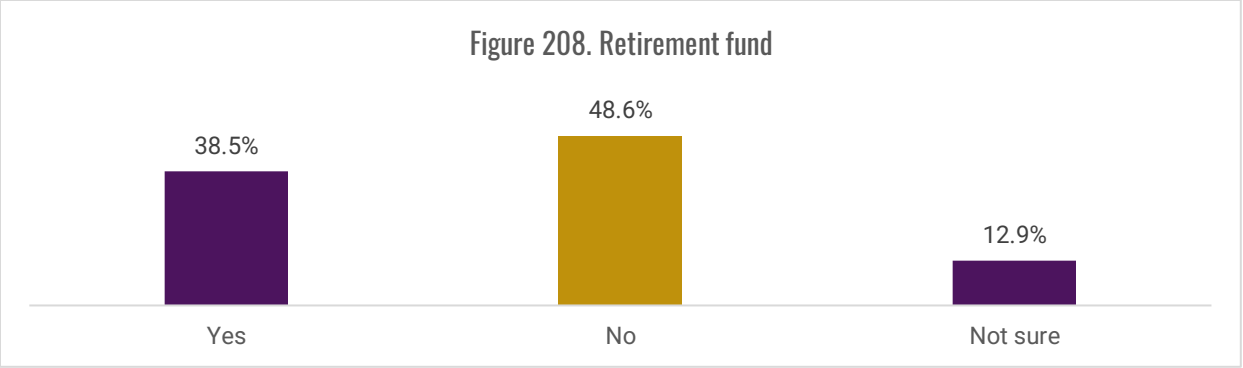
The association between being offered a pension and gender, years certified, and U.S. region are shown in Table 63. We detected differences by gender (p<0.001). Males were more likely than females to indicate that their employer offers a pension plan (16.6% vs. 14.0%). PAs certified for 21 or more years were more likely to report that their employer offers a pension vs. PAs certified up to 10 and 11 to 20 years (19.9% vs. 14.1% and 14.1%; p<0.001). Regarding U.S. regions, PAs residing in the Midwest (18.9%), compared to Northeast (17.1%), South (9.2%), and West (18.2%), had the highest likelihood of stating that their employer offers a pension (p<0.001).

Table 63. Pension by Characteristics

Characteristics		Yes	No	Not sure	p-value
Gender	Female	14.0%	72.1%	13.9%	<0.001
	Male	16.6%	76.3%	7.1%	
Years Certified	Up to 10	14.1%	71.5%	14.4%	<0.001
	11 to 20	14.1%	77.8%	8.2%	
	21+	19.9%	72.9%	7.2%	
U.S. Region	Midwest	18.9%	71.7%	9.3%	<0.001
	Northeast	17.1%	73.8%	9.1%	
	South	9.2%	76.9%	13.9%	
	West	18.2%	71.3%	10.5%	

Contributions Employer Makes to 401K/403(b): Retirement Fund

Figure 208 depicts that 38.5% of PAs said their employer contributes to their retirement fund.



As shown in Table 64, we found differences in whether employer contributes to retirement fund by gender (p<0.001) and years certified (p<0.001), but not by U.S. region (p=0.086). Females, compared to males, were more likely to cite that their employer contributes to their retirement fund (39.9% vs. 36.4%). PAs certified for up to 10 years had the highest proportion of confirming that their employer contributes to a retirement fund vs. other certification year groups.

Table 64. Retirement Fund by Characteristics

Characteristics		Yes	No	Not sure	p-value
Gender	Female	39.9%	43.8%	16.3%	<0.001
	Male	36.4%	55.4%	8.2%	
Years Certified	Up to 10	41.7%	40.8%	17.5%	<0.001
	11 to 20	36.3%	54.3%	9.4%	
	21+	33.6%	59.2%	7.2%	
U.S. Region	Midwest	42.1%	46.4%	11.5%	0.086
	Northeast	40.7%	46.1%	13.2%	
	South	34.9%	49.6%	15.5%	
	West	38.0%	51.8%	10.2%	

Compensation for Leadership/Administrative Time

Survey participants who expressed that they are in a leadership/administrative position in their practice setting were further asked about attributes of their position. Of the 25.3% of participants who identified that they are in a leadership/administrative position, 43.6% reported they are compensated for their leadership/administrative time with additional pay (Figure 209). Less than a quarter (21.6%) said they receive no compensation and 21.3% receive non-clinical time.

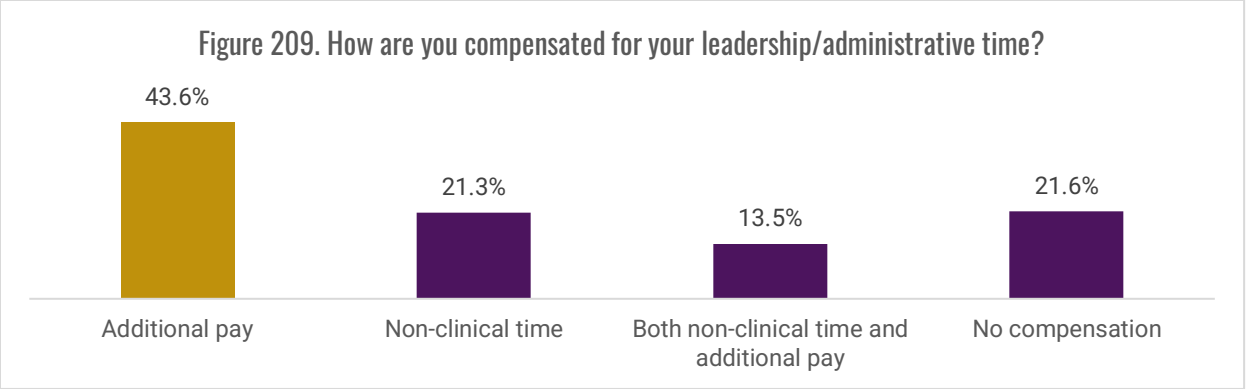
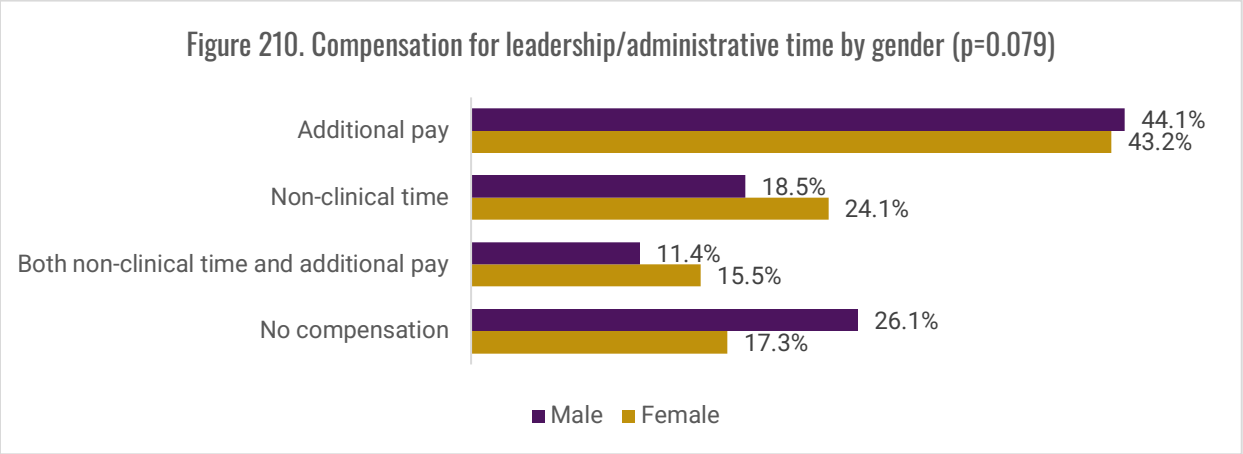
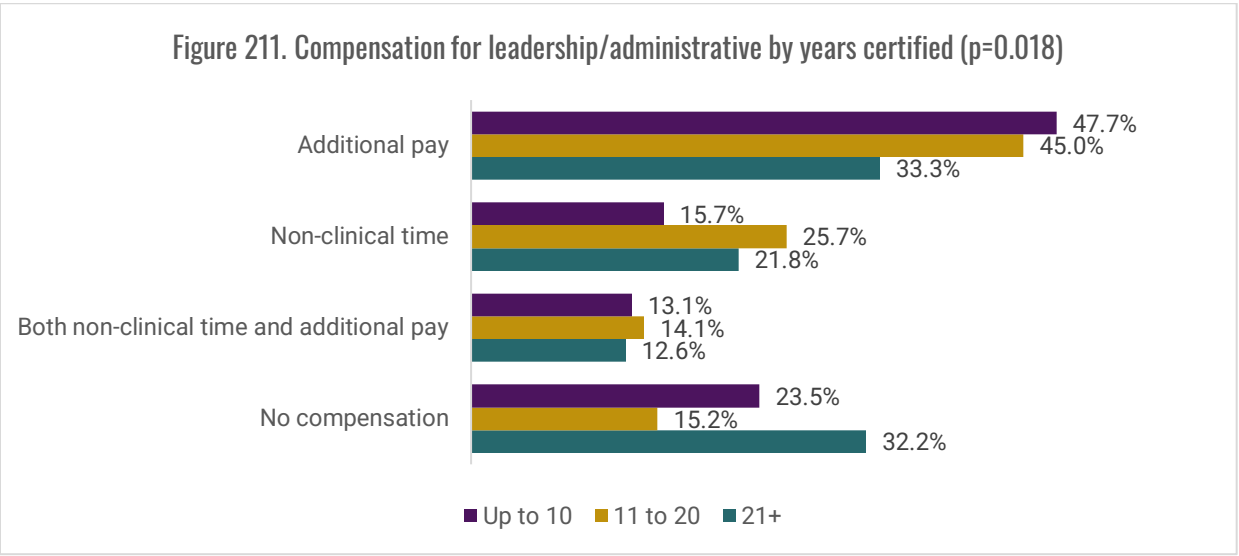


Figure 210 shows male and female PAs had similar proportions, indicating that they received additional pay (44.1% vs. 43.2%; p=0.079).

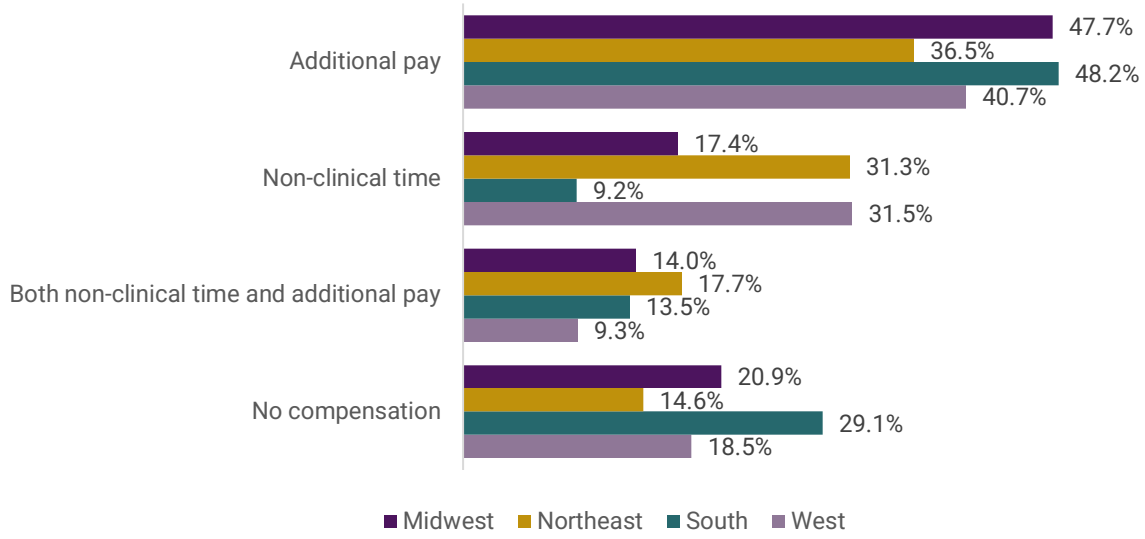


Participants certified for up to 10 years were more likely to acknowledge receiving additional pay as compensation for their leadership/administrative position vs. those certified for 11-20 and 21 or more years (47.7% vs. 45.0% and 33.3%; p=0.018; Figure 211).



Participants who reside in the Northeast were less likely than those in the other areas to note that they receive additional pay as compensation for their leadership/administrative position (p<0.001; Figure 212).

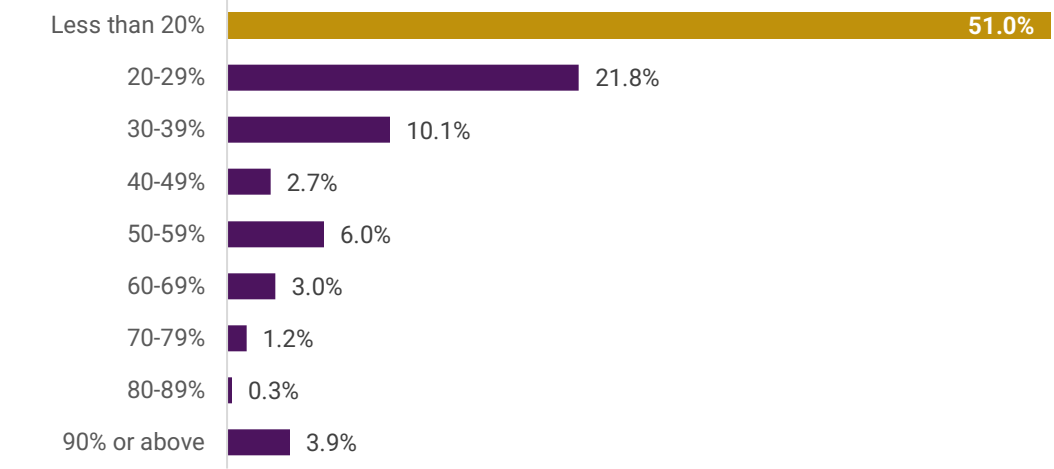
Figure 212. Compensation for leadership/administrative by U.S. region (p<0.001)



Compensated Time Spent on Leadership/Administrative Time

Figure 213 illustrates that 51.0% of participants who work in a leadership/administrative position said they spend less than 20% of the compensated time on leadership/administrative tasks. Only 21.8% reported spending 20-29% of their compensated time on leadership/administrative tasks.

Figure 213. What percent of compensated time do you spend on leadership/administrative tasks?



We did not detect significant differences by gender (p=0.668), but males compared to females had a higher proportion of reporting that they spend less than 20% of compensated time on leadership/administrative tasks (55.1% vs. 47.5%; Table 65).

Table 65. Percent of Compensated Time Spent on Leadership/Administrative Tasks by Gender

	Male	Female	p-value
Less than 20%	55.1%	47.5%	
20 – 29%	22.4%	21.2%	
30 – 39%	7.1%	12.8%	
40 – 49%	2.6%	2.8%	
50 – 59%	6.4%	5.6%	0.668**
60 – 69%	2.6%	3.4%	
70 – 79%	0.6%	1.7%	
80 – 89%	0.0%	0.6%	
90% or above	3.2%	4.5%	

** *Fisher-Freeman-Halton Exact test*

The relationship between compensated time and years certified was not significant (p=0.818; Table 66).

Table 66. Percent of Compensated Time Spent on Leadership/Administrative Tasks by Years Certified

	Up to 10	11 to 20	21+	p-value
Less than 20%	52.2%	49.7%	52.5%	
20 – 29%	24.3%	19.9%	22.0%	
30 – 39%	11.3%	10.6%	6.8%	
40 – 49%	3.5%	1.9%	3.4%	
50 – 59%	3.5%	8.7%	3.4%	0.818**
60 – 69%	2.6%	3.1%	3.4%	
70 – 79%	0.9%	1.2%	1.7%	
80 – 89%	0.0%	0.6%	0.0%	
90% or above	1.7%	4.3%	6.8%	

** *Fisher-Freeman-Halton Exact test*

Concerning U.S. region, PAs residing in the West were more likely than those in the other regions of noting that they spend less than 20% of compensated time on leadership/administrative tasks (p=0.034; Table 67).

Table 67. Percent of Compensated Time Spent on Leadership/Administrative Tasks by U.S. Region

	Midwest	Northeast	South	West	p-value
Less than 20%	55.9%	42.0%	49.0%	58.0%	
20 – 29%	14.7%	17.3%	27.6%	25.0%	
30 – 39%	8.8%	13.6%	11.2%	6.8%	
40 – 49%	7.4%	1.2%	1.0%	2.3%	
50 – 59%	4.4%	11.1%	3.1%	5.7%	0.034**
60 – 69%	1.5%	4.9%	3.1%	2.3%	
70 – 79%	1.5%	3.7%	0.0%	0.0%	
80 – 89%	0.0%	1.2%	0.0%	0.0%	
90% or above	5.9%	4.9%	5.1%	0.0%	

** *Fisher-Freeman-Halton Exact test*

Leadership/Administrative Hours Compensated

Survey participants who work in a leadership/administrative position are compensated for an average of 6.9 hours of leadership/administrative hours per week, with a median of 5.0 hours. Table 68 depicts leadership/administrative hours compensated by gender, years certified, and U.S. region. Statistically significant differences were not detected by gender (p=0.839), years certified (p=0.194), or U.S. region (p=0.263).

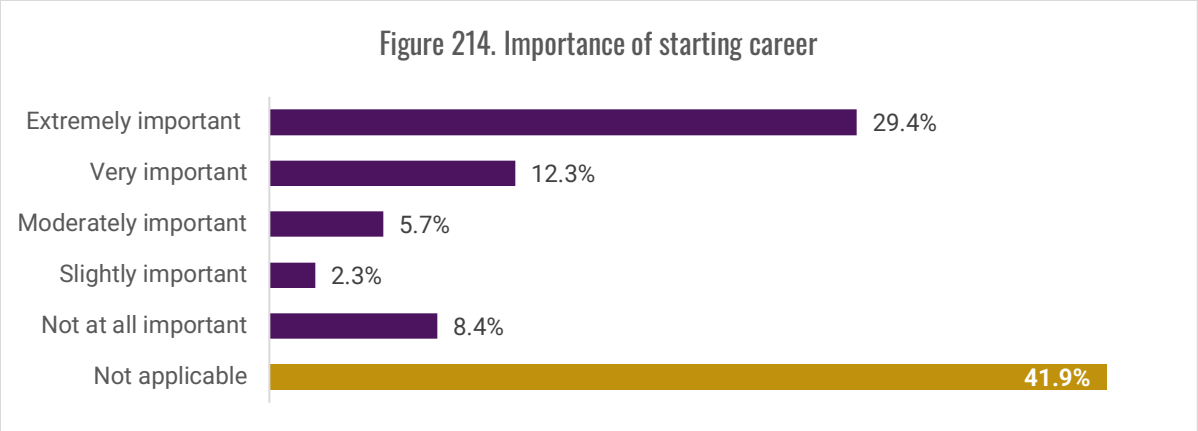
Table 68. Leadership/Administrative Hours Compensated by Characteristics

Characteristics		Mean	Median	p-value
Gender	Female	7.0	5.0	0.839
	Male	6.8	4.5	
Years Certified	Up to 10	6.2	4.0	0.194
	11 to 20	7.2	5.0	
	21+	7.6	5.0	
U.S. Region	Midwest	6.5	4.0	0.263
	Northeast	8.3	5.0	
	South	6.5	5.0	
	West	6.4	4.0	

Importance of Factors Related to Being a PA

Importance of Starting Career

For the next section, survey participants were asked to indicate how important a variety of factors related to being a PA are. Almost half of PAs (41.9%) indicated that the importance of starting their career is not applicable, 29.4% indicated that it was extremely important, and 12.3% indicated it was very important (Figure 214).



The results presented in Table 69 reflect a detailed characterization of the importance of starting a career by gender, years certified, and U.S. region. Males were slightly more likely than females to state it was not applicable (42.2% vs. 41.7%; p=0.020). PAs certified for up to 10 years were more likely to state that starting a career is extremely important compared to PAs certified for 11 to 20 and 21 or more years (36.9% vs. 25.0% and 16.3%; p<0.001). Participants in the South were more likely than PAs in other areas to indicate that starting their career is extremely important (p=0.004).

Table 69. Importance of Starting Career by Characteristics

Characteristics		Extremely important	Very important	Moderately important	Slightly important	Not at all important	N/A	p-value
Gender	Female	31.0%	12.4%	6.3%	2.1%	6.5%	41.7%	0.020
	Male	27.1%	12.2%	4.8%	2.7%	11.0%	42.2%	
Years Certified	Up to 10	36.9%	17.4%	6.1%	1.8%	46.0%	33.2%	<0.001
	11 to 20	25.0%	8.3%	6.7%	2.6%	9.5%	47.9%	
	21+	16.3%	5.6%	2.6%	3.3%	17.0%	55.2%	
U.S. Region	Midwest	31.6%	10.2%	4.8%	0.8%	9.3%	43.2%	0.004
	Northeast	26.1%	14.3%	6.3%	3.3%	8.2%	41.8%	
	South	34.4%	10.7%	5.3%	3.6%	7.8%	38.2%	
	West	22.9%	15.0%	6.2%	0.9%	8.5%	46.5%	

Importance of Finding a Job

A third of respondents (33.7%) indicated that finding a job is extremely important, while 32.7% said it is not applicable (Figure 215).

Figure 215. Importance of finding a job

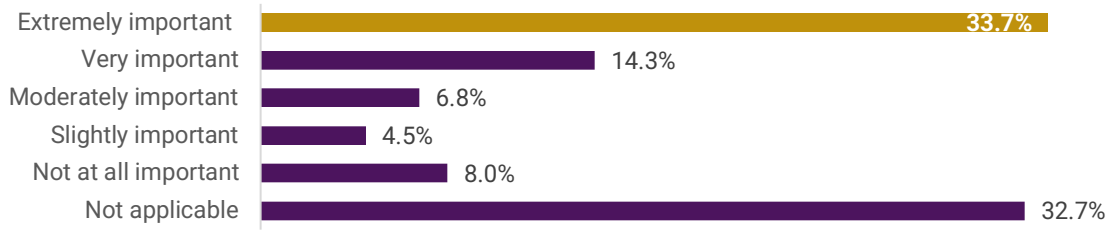


Table 70 demonstrates the statistically significant association between the importance of finding a job and gender (p<0.001), years certified (p<0.001), and U.S. region (p=0.028). Females were more likely to identify that finding a job was extremely important compared to males (35.7% vs. 31.0%). Participants who were certified for up to 10 years had the highest percentage of stating that finding a job was extremely important than those in other certification year groups. Concerning U.S. region, participants residing in the South (40.3%) were more likely to report that finding a job was extremely important vs. PAs in the Midwest (35.0%), Northeast (28.3%), and West (28.2%).

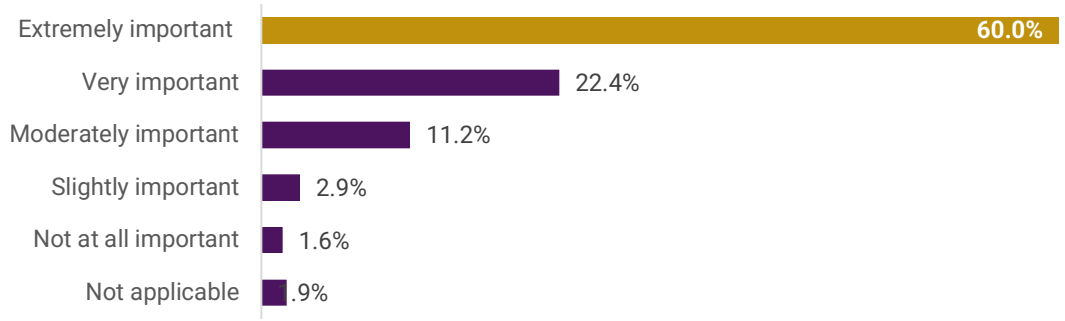
Table 70. Importance of Finding a Job by Characteristics

Characteristics		Extremely important	Very important	Moderately important	Slightly important	Not at all important	N/A	p-value
Gender	Female	35.7%	14.5%	5.4%	4.1%	5.0%	35.3%	<0.001
	Male	31.0%	14.2%	8.6%	5.0%	12.2%	29.1%	
Years Certified	Up to 10	39.7%	18.6%	6.2%	4.3%	4.5%	26.7%	<0.001
	11 to 20	31.4%	11.5%	7.2%	4.8%	8.9%	36.2%	
	21+	21.1%	7.8%	7.4%	4.4%	16.3%	43.0%	
U.S. Region	Midwest	35.0%	13.0%	5.6%	4.0%	8.2%	34.2%	0.028
	Northeast	28.3%	16.8%	8.8%	3.8%	8.0%	34.3%	
	South	40.3%	12.2%	6.5%	4.2%	7.3%	29.6%	
	West	28.2%	16.5%	5.9%	6.2%	9.1%	34.1%	

Importance of Keeping Job

Almost two-thirds of PAs (60.0%) of survey participants indicated that keeping a job was extremely important (Figure 216). Nearly a quarter (22.4%) selected that this was very important, and 11.2% moderately important.

Figure 216. Importance of keeping job



When we parsed the importance of keeping a job by gender, years certified, and U.S. region, we found statistically significant differences by years certified (p<0.001), but not by gender (p=0.053) and U.S. region (p=0.505). Participants who were certified for up to 10 years were more likely than those who were certified for 11 to 20 and 21 or more years to indicate that keeping their job was extremely important (62.1% vs. 61.6% vs. 50.7%; Table 71).

Table 71. Importance of Keeping Job by Characteristics

Characteristics		Extremely important	Very important	Moderately important	Slightly important	Not at all important	N/A	p-value
Gender	Female	59.8%	21.5%	12.5%	3.5%	1.3%	1.4%	0.053
	Male	60.2%	23.6%	9.3%	2.1%	2.1%	2.6%	
Years Certified	Up to 10	62.1%	24.5%	9.4%	2.3%	0.8%	0.9%	<0.001
	11 to 20	61.6%	19.9%	12.4%	3.0%	1.5%	1.7%	
	21+	50.7%	21.5%	13.7%	4.4%	4.4%	5.2%	
U.S. Region	Midwest	62.1%	22.0%	9.9%	2.8%	2.0%	1.1%	0.505
	Northeast	55.8%	27.7%	10.2%	3.3%	1.1%	1.9%	
	South	62.4%	20.2%	11.6%	2.3%	1.5%	1.9%	
	West	58.5%	20.6%	12.9%	3.5%	2.1%	2.4%	

Importance of Developing/Maintaining a Strong PA/Physician Relationship

When survey participants were asked about the importance of developing/maintaining a strong PA/physician relationship, 58.9% indicated it was extremely important, followed by 28.8% who reported it was very important (Figure 217).

Figure 217. Importance of developing/maintaining a strong PA/physician relationship

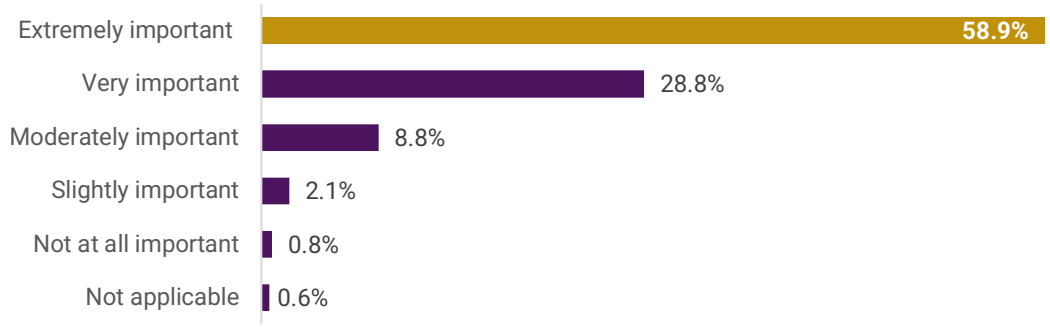


Table 72 depicts the importance of developing/maintaining a strong PA/physician relationship by demographics/years certified. Females were significantly more likely than males to state that developing/maintaining a strong PA/physician relationship was extremely important (62.8% vs. 53.5%; p<0.001). Statistically significant differences were not found by years certified (p=0.153) and U.S. region (p=0.237).

Table 72. Importance of Developing/Maintaining a Strong PA/Physician Relationship by Characteristics

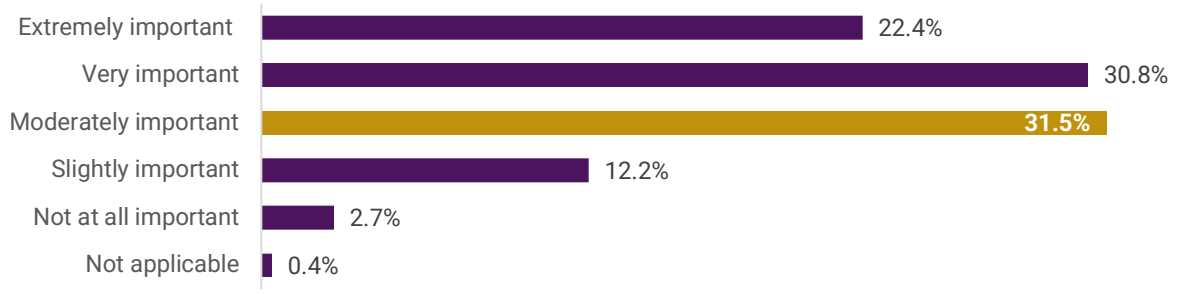
Characteristics		Extremely important	Very important	Moderately important	Slightly important	Not at all important	N/A	p-value
Gender	Female	62.8%	26.7%	8.0%	1.4%	0.3%	0.7%	<0.001
	Male	53.5%	31.6%	9.8%	3.2%	1.4%	0.6%	
Years Certified	Up to 10	59.1%	29.9%	8.6%	1.5%	0.4%	0.4%	0.153**
	11 to 20	61.0%	26.0%	8.9%	2.4%	1.1%	0.6%	
	21+	54.1%	31.1%	8.9%	3.3%	1.1%	1.5%	
U.S. Region	Midwest	57.6%	29.1%	10.2%	2.0%	0.8%	0.3%	0.237**
	Northeast	54.4%	32.1%	8.8%	2.5%	0.8%	1.4%	
	South	63.2%	25.0%	9.0%	1.5%	0.6%	0.8%	
	West	58.2%	30.9%	7.1%	2.9%	0.9%	0.0%	

** *Fisher-Freeman-Halton Exact test*

Importance of Earning CME

Almost one-third of PAs reported that earning CME is moderately important (31.5%) and very important (30.8%), followed by 22.4% who identified that it was extremely important (Figure 218).

Figure 218. Importance of earning CME



The results presented in Table 73 reflect a detailed characterization of the importance of earning CME by gender, years certified, and U.S. region. Females compared to males were more likely to indicate that earning CME was very important (32.1% vs. 29.1%; p=0.014). PAs certified for up to 10 years had a higher proportion of stating that earning CME is moderately important vs. PAs certified 11-20 and 21 or more years (35.2% vs. 30.8% and 22.2%; p<0.001). The relationship between the importance of earning CME and U.S. region (p=0.530) was not found to be statistically significant.

Table 73. Importance of Earning CME by Characteristics

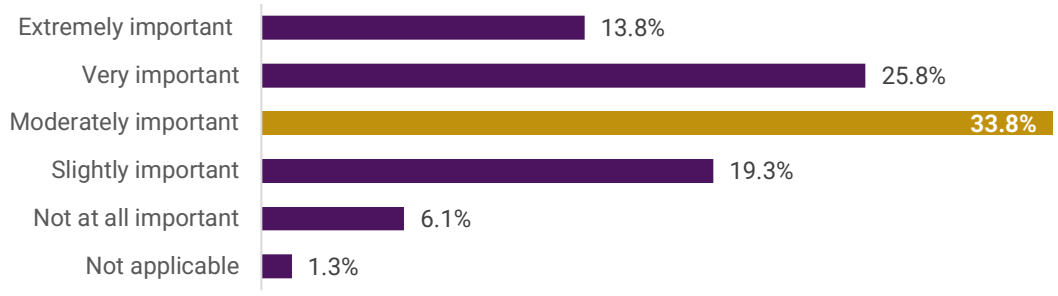
Characteristics		Extremely important	Very important	Moderately important	Slightly important	Not at all important	N/A	p-value
Gender	Female	22.3%	32.1%	32.7%	11.0%	1.7%	0.2%	0.014
	Male	22.6%	29.1%	29.8%	13.9%	3.9%	0.8%	
Years Certified	Up to 10	19.1%	31.4%	35.2%	11.6%	2.7%	0.0%	<0.001**
	11 to 20	23.2%	29.9%	30.8%	13.2%	2.6%	0.4%	
	21+	30.4%	31.1%	22.2%	11.9%	2.6%	1.9%	
U.S. Region	Midwest	22.6%	29.7%	34.7%	10.5%	2.5%	0.0%	0.530**
	Northeast	20.6%	29.9%	32.7%	13.7%	2.5%	0.5%	
	South	24.6%	31.5%	28.6%	11.8%	2.5%	1.0%	
	West	20.6%	31.8%	31.5%	12.9%	3.2%	0.0%	

** *Fisher-Freeman-Halton Exact test*

Importance of Dealing with Practice Policies

Figure 219 refers to the importance of dealing with practice policies where 33.8% indicated it was moderately important, followed by 25.8% very important, and 19.3% slightly important.

Figure 219. Importance of dealing with practice policies



As shown in Table 74, the relationship between the importance of dealing with practice policies and gender (p=0.224), years certified (p=0.269), and U.S. region (p=0.241) was not found to be statistically significant.

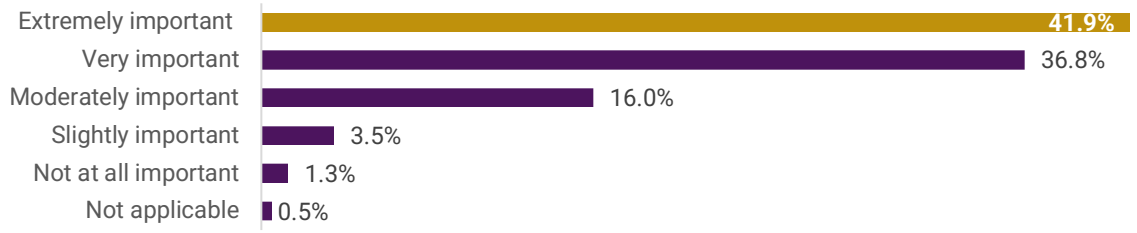
Table 74. Importance of Dealing with Practice Policies by Characteristics

Characteristics		Extremely important	Very important	Moderately important	Slightly important	Not at all important	N/A	p-value
Gender	Female	12.1%	25.3%	34.6%	20.2%	6.4%	1.4%	0.224
	Male	16.1%	26.5%	32.7%	17.9%	5.7%	1.1%	
Years Certified	Up to 10	11.9%	25.5%	33.7%	21.3%	6.5%	1.2%	0.269
	11 to 20	14.8%	24.9%	33.8%	19.1%	6.1%	1.3%	
	21+	17.0%	28.5%	34.1%	13.7%	5.2%	1.5%	
U.S. Region	Midwest	11.6%	25.4%	34.5%	21.8%	5.4%	1.4%	0.241
	Northeast	14.3%	25.8%	31.0%	20.6%	7.1%	1.1%	
	South	16.6%	25.6%	34.0%	15.3%	7.3%	1.3%	
	West	11.2%	26.5%	35.6%	21.5%	4.1%	1.2%	

Importance of Establishing/Maintaining Position/Role Within Current Work Setting

Many respondents (41.9%) stated that establishing/maintaining their position/role within their current work setting was extremely important, followed by 36.8% very important, and 16.0% moderately important (Figure 220).

Figure 220. Importance of establishing/maintaining position/role within current work setting



The importance of establishing/maintaining a position/role within current work setting by gender, years certified, and U.S. region are shown in Table 75. We did not detect significant differences by gender (p=0.187) or U.S. region (p=0.250); however, there were differences by years certified (p=0.011). Participants who were certified 11 to 20 years had the highest proportion of indicating that establishing/maintaining their position/role within current work setting was extremely important vs. those certified up to 10 and 21 or more years (44.3% vs. 40.0% and 42.6%).

Table 75. Importance of Establishing/Maintaining Position/Role Within Current Work Setting by Characteristics

Characteristics		Extremely important	Very important	Moderately important	Slightly important	Not at all important	N/A	p-value
Gender	Female	41.6%	38.2%	14.8%	3.7%	1.0%	0.8%	0.187
	Male	42.3%	34.9%	17.6%	3.3%	1.7%	0.2%	
Years Certified	Up to 10	40.0%	41.4%	14.1%	3.1%	1.0%	0.4%	0.011**
	11 to 20	44.3%	32.5%	18.4%	3.5%	0.9%	0.4%	
	21+	42.6%	32.2%	16.7%	4.8%	2.6%	1.1%	
U.S. Region	Midwest	40.4%	41.2%	12.7%	3.7%	1.1%	0.8%	0.250**
	Northeast	39.3%	39.3%	15.4%	4.4%	0.8%	0.8%	
	South	45.4%	33.6%	16.4%	3.1%	1.1%	0.4%	
	West	41.2%	34.7%	18.8%	3.2%	2.1%	0.0%	

** *Fisher-Freeman-Halton Exact test*

Importance of Managing Work Stress

A slight majority (53.6%) of PAs indicated that managing work stress was extremely important, 30.9% very important, and 11.0% moderately important (Figure 221).

Figure 221. Importance of managing work stress

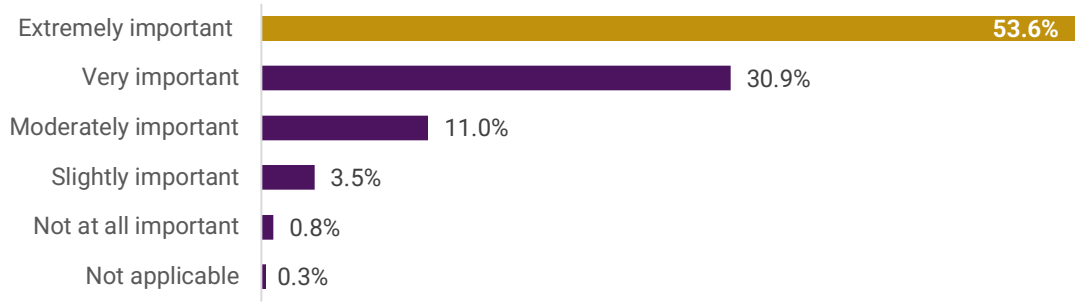


Table 76 demonstrates the association between the importance of managing work stress and gender (p<0.001), years certified (p=0.001), and U.S. region (p=0.733). Females were more likely to indicate that managing work stress was extremely important compared to males (56.4% vs. 49.7%). Participants who were certified for up to 10 years were more likely to report that managing work stress was extremely important versus PAs certified for 11 to 20 and 21 or more years (57.2% vs. 50.8% and 48.9%).

Table 76. Importance of Managing Work Stress by Characteristics

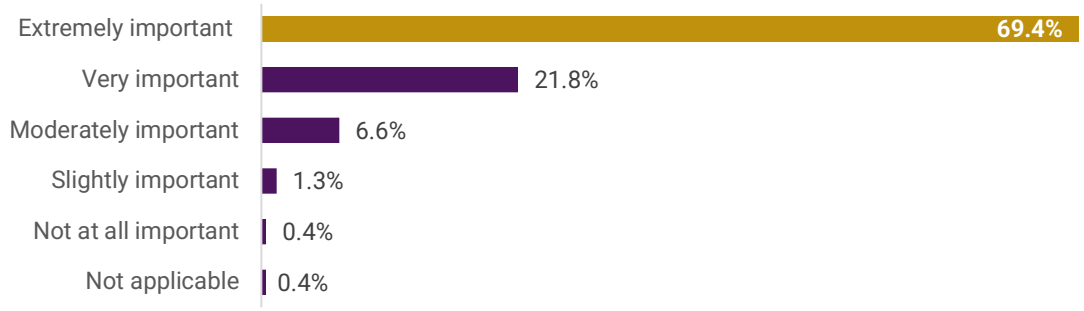
Characteristics		Extremely important	Very important	Moderately important	Slightly important	Not at all important	N/A	p-value
Gender	Female	56.4%	30.9%	9.5%	2.6%	0.2%	0.4%	<0.001
	Male	49.7%	30.9%	13.1%	4.7%	1.5%	0.2%	
Years Certified	Up to 10	57.2%	30.7%	8.9%	2.7%	0.4%	0.1%	0.001**
	11 to 20	50.8%	33.0%	11.1%	3.9%	0.7%	0.4%	
	21+	48.9%	27.0%	16.7%	4.8%	1.9%	0.7%	
U.S. Region	Midwest	52.8%	31.9%	10.5%	3.7%	0.8%	0.3%	0.733**
	Northeast	56.9%	27.7%	10.2%	3.6%	1.1%	0.5%	
	South	55.0%	30.7%	10.1%	3.4%	0.4%	0.4%	
	West	48.8%	33.2%	13.8%	3.2%	0.9%	0.0%	

** *Fisher-Freeman-Halton Exact test*

Importance of Managing Work and Life Balance

More than two-thirds of survey participants (69.4%) identified that managing work and life balance was extremely important, followed by 21.8% who stated it was very important, and 6.6% moderately important (Figure 222).

Figure 222. Importance of managing work and life balance



The importance of managing work and life balance by gender (p=0.003), years certified (p<0.001), and U.S. region (p=0.492) is shown in Table 77. Females were more likely than males to select that managing work, and life balance was extremely important (72.2% vs. 65.5%). PAs certified for up to 10 years versus other certification year groups had the highest proportion, indicating that managing work and life balance was extremely important.

Table 77. Importance of Managing Work and Life Balance by Characteristics

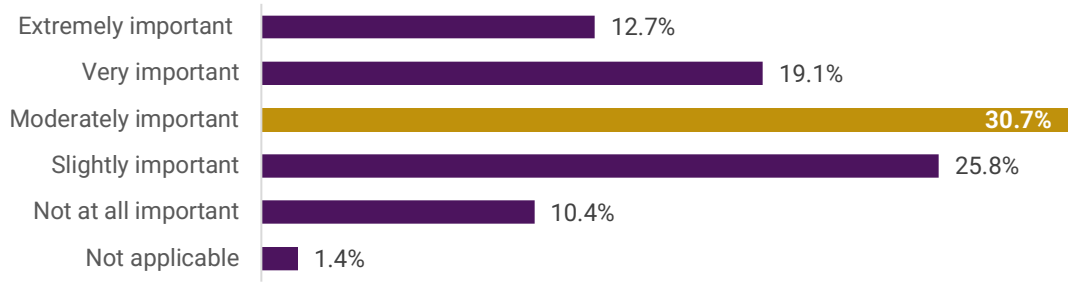
Characteristics		Extremely important	Very important	Moderately important	Slightly important	Not at all important	N/A	p-value
Gender	Female	72.2%	21.1%	5.3%	0.9%	0.1%	0.4%	0.003*
	Male	65.5%	22.9%	8.4%	2.0%	0.9%	0.3%	
Years Certified	Up to 10	73.8%	20.6%	4.6%	0.8%	0.1%	0.0%	<0.001**
	11 to 20	67.5%	22.4%	8.3%	1.1%	0.2%	0.4%	
	21+	60.4%	24.1%	8.9%	3.3%	1.9%	1.5%	
U.S. Region	Midwest	67.5%	22.9%	7.9%	1.1%	0.6%	0.0%	0.492**
	Northeast	72.8%	20.1%	4.9%	1.4%	0.3%	0.5%	
	South	70.4%	21.9%	6.3%	0.8%	0.8%	0.4%	
	West	65.9%	22.6%	7.6%	2.4%	2.4%	0.6%	

** *Fisher-Freeman-Halton Exact test*

Importance of Advocacy/Legislative Issues

Figure 223 refers to the importance of advocacy/legislative issues. Almost one-third of PAs (30.7%) felt that advocacy/legislative issues were moderately important, followed by 25.8% slightly important, and 19.1% very important.

Figure 223. Importance of advocacy/legislative issues



When we parsed the importance of advocacy/legislative issues by demographics/years certified (Table 78), we found statistically significant association with gender (p=0.037) and years certified (p=0.005), but not by U.S. region (p=0.083). Females were slightly more likely than males to report that advocacy/legislative issues were moderately important (31.0% vs. 30.3%). PAs who were certified for up to 10 years were slightly more likely than those certified 11-20, and 21 or more years to select that advocacy/legislative issues were moderately important (31.9% vs. 28.9% vs. 30.7%).

Table 78. Importance of Advocacy/Legislative Issues by Characteristics

Characteristics		Extremely important	Very important	Moderately important	Slightly important	Not at all important	N/A	p-value
Gender	Female	10.4%	19.8%	31.0%	27.3%	10.0%	1.5%	0.037
	Male	15.8%	18.2%	30.3%	23.6%	10.8%	1.2%	
Years Certified	Up to 10	9.3%	20.5%	31.9%	27.1%	9.7%	1.5%	0.005
	11 to 20	15.4%	16.9%	28.9%	26.7%	11.3%	0.7%	
	21+	17.0%	19.6%	30.7%	20.0%	10.4%	2.2%	
U.S. Region	Midwest	13.3%	17.8%	28.8%	29.9%	7.9%	2.3%	0.083
	Northeast	11.3%	18.7%	34.6%	24.7%	9.3%	1.4%	
	South	13.5%	20.8%	30.2%	21.2%	13.2%	1.1%	
	West	12.1%	18.5%	29.1%	29.7%	9.7%	0.9%	

Importance of Having Enough Employer Funds for CME

Over 27% of respondents stated that having enough employer funds for CME were very important, while 26.8% indicated that this was moderately important and 23.1% extremely important (Figure 224).

Figure 224. Importance of having enough employer funds for CME

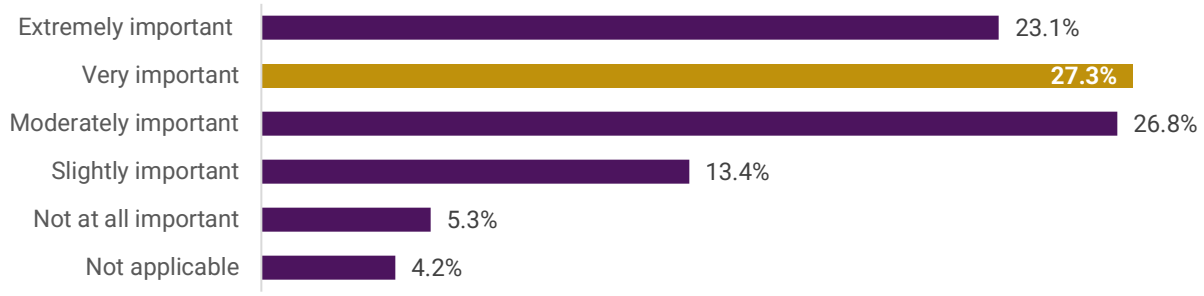


Table 79 demonstrates rated importance of having enough employer funds for CME by gender, years certified, and U.S. region. The association between gender and having enough employer funds for CME was not significant (p=0.058). PAs certified for up to 10 years had the highest proportion of selecting that having enough employer funds for CME was very important compared to those in other certification year groups (p<0.001). PAs in the South had a higher proportion than the other areas of saying that having enough employer funds for CME was extremely important (p=0.003).

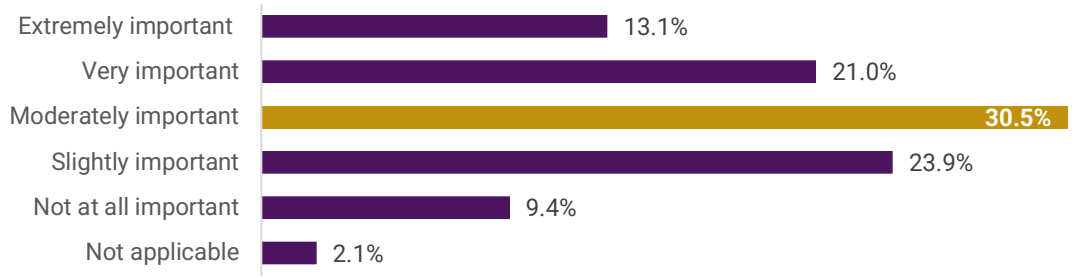
Table 79. Importance of Having Enough Employer Funds for CME by Characteristics

Characteristics		Extremely important	Very important	Moderately important	Slightly important	Not at all important	N/A	p-value
Gender	Female	22.6%	29.9%	25.7%	13.5%	4.3%	4.0%	0.058
	Male	23.8%	23.6%	28.3%	13.3%	6.6%	4.4%	
Years Certified	Up to 10	22.8%	30.2%	27.6%	13.9%	3.1%	2.3%	<0.001
	11 to 20	23.7%	25.0%	26.9%	12.8%	6.9%	4.6%	
	21+	22.6%	23.3%	24.1%	13.0%	8.5%	8.5%	
U.S. Region	Midwest	21.5%	30.2%	30.2%	11.6%	4.2%	2.3%	0.003
	Northeast	23.1%	26.9%	30.2%	12.9%	4.7%	2.2%	
	South	26.3%	27.3%	22.5%	12.8%	5.0%	6.1%	
	West	20.0%	24.4%	25.9%	16.8%	7.6%	5.3%	

Importance of Dealing with State Regulatory Issues

Almost one-third (30.5%) of PAs identified that dealing with state regulatory issues was moderately important, followed by 23.9% slightly important, and 21.0% very important (Figure 225).

Figure 225. Importance of dealing with state regulatory issues



The rated importance of dealing with state regulatory issues by gender, years certified, and U.S. region are shown in Table 80. Females were more likely than males to indicate that dealing with state regulatory issues was moderately important (31.5% vs. 29.1%; p=0.046). When we analyzed the importance of dealing with state regulatory issues by years certified, we found statistically significant differences (p=0.002). Participants certified for up to 10 years were slightly more likely than those certified 11-20 and 21 or more years to state that dealing with state regulatory issues was moderately important (32.4% vs. 27.5% vs. 31.1%). However, statistically significant differences were not found by U.S. region (p=0.358).

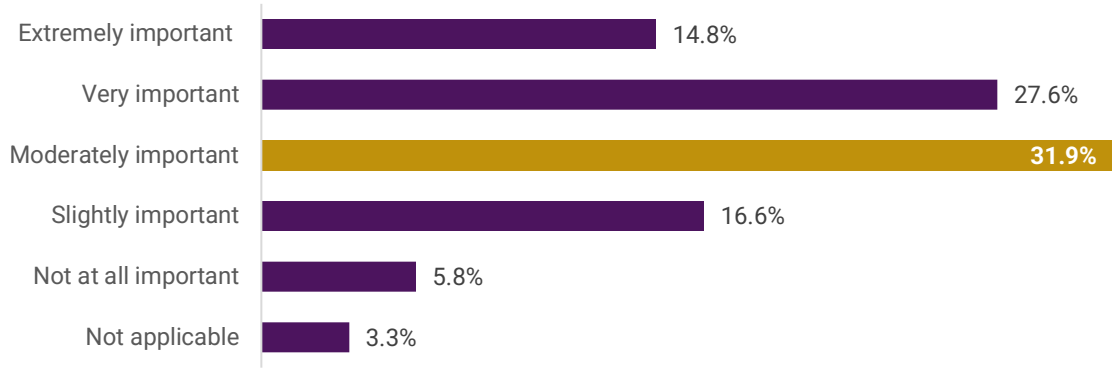
Table 80. Importance of Dealing with State Regulatory Issues by Characteristics

Characteristics		Extremely important	Very important	Moderately important	Slightly important	Not at all important	N/A	p-value
Gender	Female	11.3%	20.1%	31.5%	25.8%	9.0%	2.3%	0.046
	Male	15.7%	22.3%	29.1%	21.2%	9.9%	1.8%	
Years Certified	Up to 10	11.1%	21.0%	32.4%	24.8%	8.6%	2.1%	0.002
	11 to 20	14.3%	20.4%	27.5%	25.2%	11.7%	0.9%	
	21+	16.7%	22.2%	31.1%	18.5%	7.0%	4.4%	
U.S. Region	Midwest	13.0%	17.8%	30.8%	27.4%	8.5%	2.5%	0.358
	Northeast	11.3%	20.6%	33.2%	22.0%	11.0%	1.9%	
	South	15.3%	24.2%	28.2%	22.5%	8.0%	1.7%	
	West	12.1%	19.7%	30.6%	24.4%	10.9%	2.4%	

Importance of Obtaining Practice Resources

Almost a third of PAs (31.9%) reported that obtaining practice resources were moderately important, followed by 27.6% who said it was very important (Figure 226).

Figure 226. Importance of obtaining practice resources



The importance of obtaining practice resources by gender, years certified, and U.S. region are shown in Table 81. We found statistically significant differences by years certified (p=0.043), but not by gender (p=0.415) or U.S. region (p=0.949). PAs certified for up to 10 years were more likely to state that obtaining practice resources was moderately important vs. PAs certified 11 to 20 and 21 or more years (33.3% vs. 30.8% and 30.4%).

Table 81. Importance of Obtaining Practice Resources by Characteristics

Characteristics		Extremely important	Very important	Moderately important	Slightly important	Not at all important	N/A	p-value
Gender	Female	13.4%	28.7%	32.8%	16.0%	5.8%	3.4%	0.415
	Male	16.7%	26.1%	30.7%	17.5%	5.9%	3.2%	
Years Certified	Up to 10	13.9%	29.3%	33.3%	16.8%	4.3%	2.5%	0.043
	11 to 20	15.4%	24.9%	30.8%	17.6%	8.0%	3.3%	
	21+	15.9%	28.1%	30.4%	14.1%	5.9%	5.6%	
U.S. Region	Midwest	13.0%	26.3%	33.1%	18.1%	5.4%	4.2%	0.949
	Northeast	15.7%	27.2%	32.4%	15.9%	5.5%	3.3%	
	South	16.0%	29.6%	29.4%	16.2%	6.1%	2.7%	
	West	13.5%	26.5%	34.1%	16.5%	6.2%	3.2%	

Appendix

Specialty of Secondary Clinical Position

When asked which specialty PAs practice in for their secondary clinical position, more than half (54.6%) indicated that they do not have a secondary clinical position (Figure 227). Slightly less than a quarter (22.8%) said they work in EM for their secondary clinical position, while 14.6% reported working in UC.

Figure 227. Please indicate which specialty you practice in for your secondary clinical position.

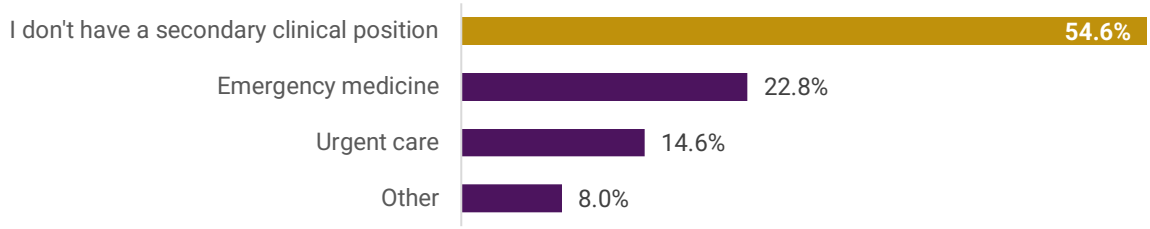


Table 82 depicts a statistically significant relationship between principal and secondary position specialties (p<0.001). PAs practicing in the discipline of EM in their principal specialty had the highest proportion of not having a secondary clinical position. In contrast, those in UC and other had the highest proportion of reporting to practice in EM in their secondary clinical position.

Table 82. Principal Clinical Position by Secondary Clinical Position

		Principal clinical position			
		Emergency medicine	Urgent care	Other	p-value
Secondary clinical position	Emergency medicine	17.3%	58.1%	76.7%	<0.001
	Urgent care	15.3%	7.7%	11.1%	
	I don't have a secondary clinical position	58.9%	29.9%	8.9%	
	Other	8.5%	4.3%	3.3%	

When the secondary clinical position was analyzed by demographics/years certified, we found statistically significant differences by gender (p<0.001) and U.S. region (p=0.034). Females were more likely than males to indicate not having a secondary clinical position (58.9% vs. 48.6%; Figure 228). Males were more likely than females to indicate their secondary clinical specialty as EM (27.9% vs. 19.3%). Differences were not found to be statistically significant for secondary position specialty by years certified (p=0.280; Figure 229).

Figure 228. Secondary specialty by gender (p<0.001)

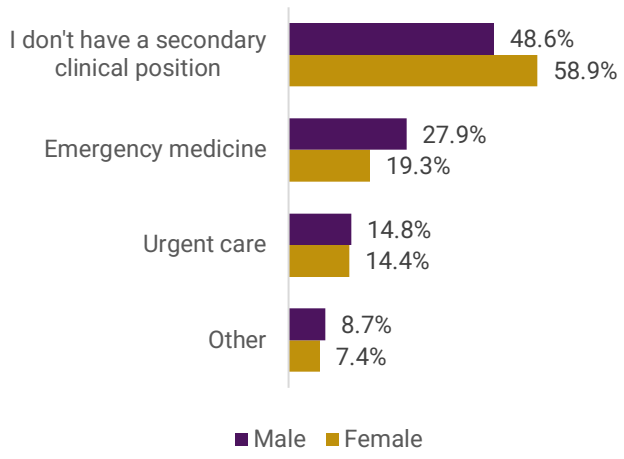
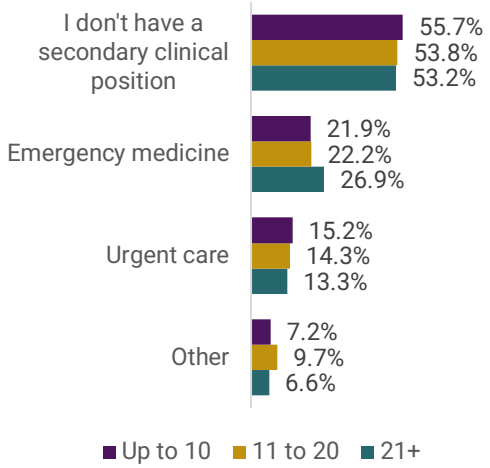
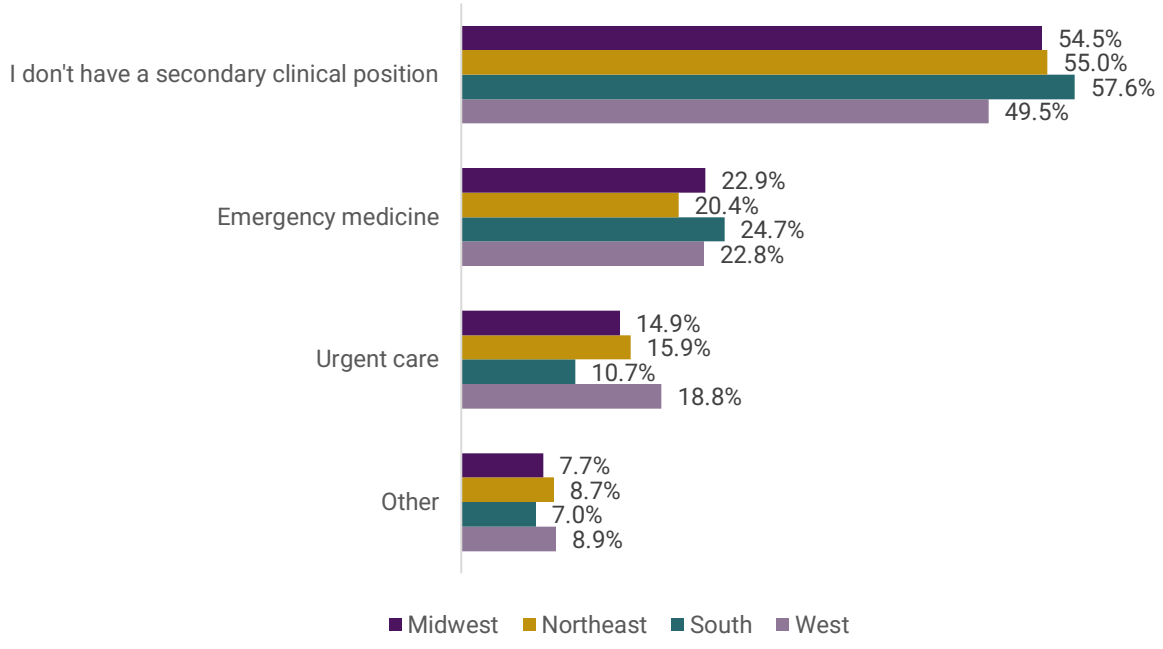


Figure 229. Secondary specialty by years certified (p=0.280)



Concerning U.S. regions, PA respondents residing in the South had the highest proportion of reporting that they do not have a secondary clinical position; however, they also had a slightly higher percentage compared to the other U.S. regions of stating that they work in EM as their secondary specialty (Figure 230). Participants in the West had the highest percentage of indicating UC as their secondary specialty.

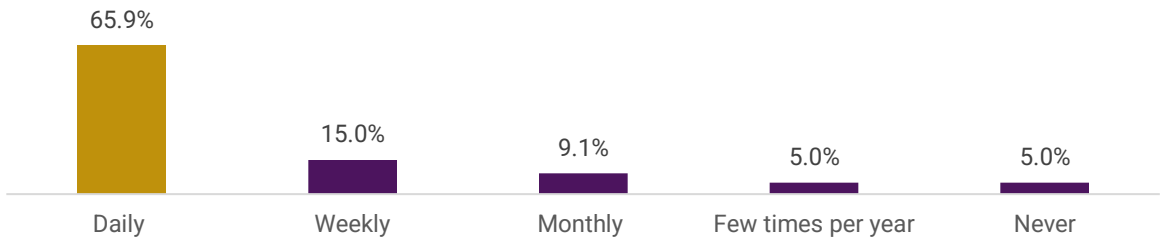
Figure 230. Secondary specialty by U.S. region (p=0.034)



Secondary Position Basic Procedures: Basic Diagnostics

The rest of the report is focused on PAs who answered that they had a secondary clinical position (45.4%). The following section presents how often PAs perform certain basic procedures in their secondary clinical position. Respondents could choose daily, weekly, monthly, a few times a year, or never. When asked about basic diagnostics (i.e., basic laboratory interpretation, slit lamp exam, EKG interpretation) in the secondary position, most participants (65.9%) indicated that they perform this procedure daily (Figure 231).

Figure 231. Secondary position basic diagnostics (i.e., basic laboratory interpretation, slip lamp exam, EKG interpretation)



The results presented in Table 83 reflect a detailed characterization of basic diagnostics conducted in secondary position by gender, years certified, and U.S. region. We did not find statistically significant differences by gender (p=0.770), years certified (p=0.696) or U.S. region (p=0.207).

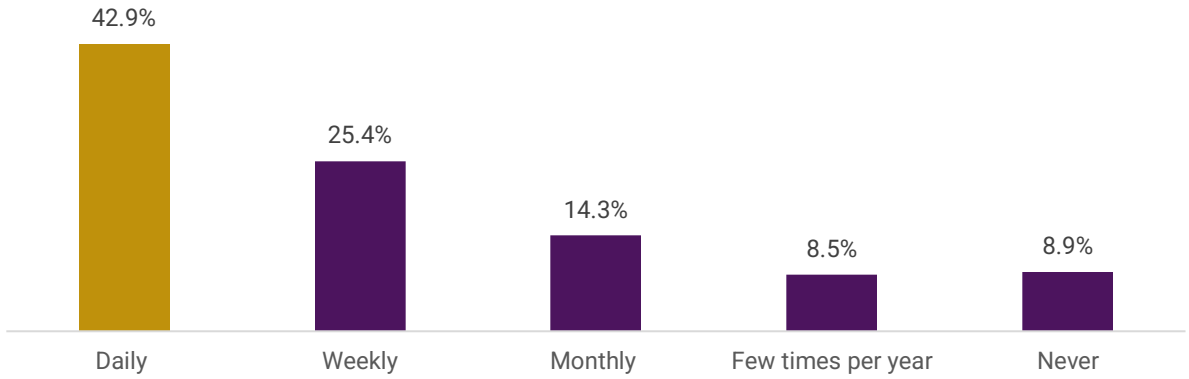
Table 83. Secondary Position Basic Diagnostics by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	p-value
Gender	Female	63.6%	15.7%	10.4%	5.4%	5.0%	0.770
	Male	68.3%	14.3%	7.7%	4.6%	5.0%	
Years Certified	Up to 10	65.1%	15.3%	10.0%	5.4%	4.2%	0.696
	11 to 20	66.1%	13.3%	10.6%	5.0%	5.0%	
	21+	67.3%	17.3%	4.1%	4.1%	7.1%	
U.S. Region	Midwest	66.7%	12.2%	11.4%	4.9%	4.9%	0.207
	Northeast	63.6%	18.2%	9.1%	8.3%	0.8%	
	South	63.7%	14.4%	8.8%	4.4%	8.8%	
	West	69.4%	15.7%	7.5%	3.0%	4.5%	

Secondary Position Basic Procedures: Therapeutic Procedures

When asked about therapeutic procedures (i.e., fracture, dislocation, or epistaxis management) in the secondary position, 42.9% of PAs identified performing these procedures daily, followed by 25.4% weekly and 14.3% monthly (Figure 232).

Figure 232. Secondary position therapeutic procedures (i.e., fracture, dislocation, or epistaxis management)



We did not find a statistically significant relationship when we assessed therapeutic procedures in the secondary position by gender (p=0.222), years certified (p=0.526), or U.S. region (p=0.215; Table 84).

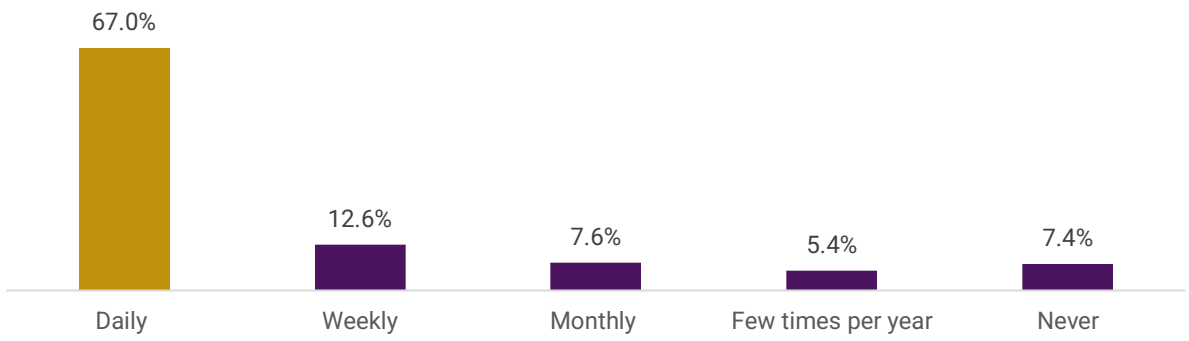
Table 84. Secondary Position Therapeutic Procedures by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	p-value
Gender	Female	41.4%	22.9%	15.4%	9.3%	11.1%	0.222
	Male	44.4%	28.2%	13.1%	7.7%	6.6%	
Years Certified	Up to 10	41.4%	26.1%	13.4%	9.2%	10.0%	0.526
	11 to 20	47.2%	20.6%	16.7%	7.8%	7.8%	
	21+	38.8%	32.7%	12.2%	8.2%	8.2%	
U.S. Region	Midwest	39.8%	22.8%	20.3%	6.5%	10.6%	0.215
	Northeast	44.6%	27.3%	14.9%	9.9%	3.3%	
	South	41.9%	26.3%	10.0%	8.8%	13.1%	
	West	45.5%	24.6%	13.4%	9.0%	7.5%	

Secondary Position Basic Procedures: Basic Initial Radiographic Interpretation

Most participants (67.0%) said that they perform basic initial radiographic interpretation (i.e., X-ray, plain films) in the secondary position (Figure 233). Almost 13% reported performing these interpretations weekly and 7.6% monthly.

Figure 233. Secondary position basic initial radiographic interpretation (i.e., X-ray, plain films)



When we parsed basic initial radiographic interpretation in secondary position by demographics/years certified (Table 85), we did not find statistically significant differences by gender (p=0.300) or years certified (p=0.789); however, we did find an association with U.S. region (p=0.040). Participants in the West (70.1%) were more likely to state that they perform basic initial radiographic interpretation in their secondary position daily versus PAs in the Midwest (65.9%), Northeast (65.3%), and South (66.3%).

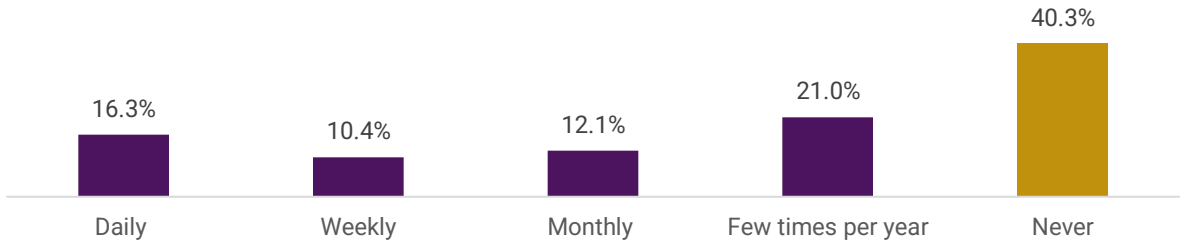
Table 85. Secondary Position Basic Initial Radiographic Interpretation by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	p-value
Gender	Female	64.3%	12.1%	8.2%	7.1%	8.2%	0.300
	Male	69.9%	13.1%	6.9%	3.5%	6.6%	
Years Certified	Up to 10	65.1%	12.3%	8.0%	6.5%	8.0%	0.789
	11 to 20	66.7%	13.9%	8.9%	3.9%	6.7%	
	21+	72.4%	11.2%	4.1%	5.1%	7.1%	
U.S. Region	Midwest	65.9%	10.6%	12.2%	2.4%	8.9%	0.040
	Northeast	65.3%	19.0%	5.0%	7.4%	3.3%	
	South	66.3%	9.4%	6.3%	6.9%	11.3%	
	West	70.1%	12.7%	7.5%	4.5%	5.2%	

Secondary Position Basic Procedures: Basic Hemodynamic Techniques

Many participants (40.3%) selected that they have never performed basic hemodynamic techniques (i.e., peripheral IV access, EJ access, I/O access) in their secondary clinical position (Figure 234). Almost a quarter (21.0%) perform these techniques a few times per year.

Figure 234. Secondary position basic hemodynamic techniques (i.e., peripheral IV access, EJ access, I/O access)



The associations between basic hemodynamic interpretation in secondary position and gender, years certified, and U.S. region are shown in Table 86. Females were significantly more likely than males to indicate that they never perform basic hemodynamic techniques (52.3% vs. 27.0%; p<0.001). We did not find statistically significant differences by years certified (p=0.227). Participants in the Northeast had a higher proportion of indicating never performing basic hemodynamic techniques in their secondary position (p=0.033).

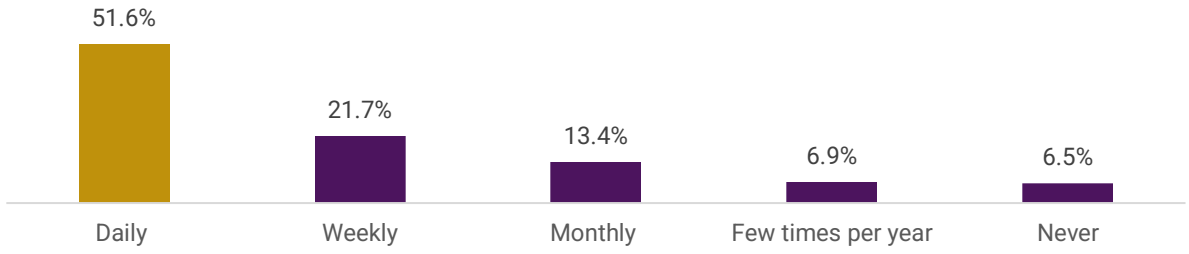
Table 86. Secondary Position Basic Hemodynamic Interpretation by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	p-value
Gender	Female	11.8%	8.6%	10.4%	16.8%	52.5%	<0.001
	Male	21.2%	12.4%	13.9%	25.5%	27.0%	
Years Certified	Up to 10	12.6%	11.1%	13.4%	19.5%	43.3%	0.227
	11 to 20	21.1%	7.8%	11.1%	20.6%	39.4%	
	21+	17.3%	13.3%	10.2%	25.5%	33.7%	
U.S. Region	Midwest	15.4%	9.8%	12.2%	17.1%	45.5%	0.033
	Northeast	13.2%	8.3%	12.4%	19.8%	46.3%	
	South	18.8%	15.0%	5.6%	25.0%	35.6%	
	West	17.2%	7.5%	18.7%	20.9%	35.8%	

Secondary Position Basic Procedures: Basic Wound Care Management

Just over half (51.6%) of PAs identified that they perform basic wound care management (i.e., incision and drainage, superficial wound closures) daily, followed by 21.7% who performed it weekly, and 13.4% monthly (Figure 235).

Figure 235. Secondary position basic wound care management (i.e., incision and drainage, superficial wound closures)



When we parsed frequency of performing basic wound care management in secondary position by gender, years certified, and U.S. region, we did not find statistically significant associations with gender (p=0.583), years certified (p=0.816), or U.S. region (p=0.424; Table 87).

Table 87. Secondary Position Basic Wound Care Management by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	p-value
Gender	Female	49.3%	23.9%	13.6%	6.1%	7.1%	0.583
	Male	54.1%	19.3%	13.1%	7.7%	5.8%	
Years Certified	Up to 10	49.4%	24.9%	12.3%	6.5%	6.9%	0.816
	11 to 20	53.9%	17.2%	15.0%	7.8%	6.1%	
	21+	53.1%	21.4%	13.3%	6.1%	6.1%	
U.S. Region	Midwest	51.2%	19.5%	17.9%	5.7%	5.7%	0.424
	Northeast	49.6%	21.5%	17.4%	8.3%	3.3%	
	South	50.6%	23.1%	10.0%	6.9%	9.4%	
	West	55.2%	22.4%	9.0%	6.7%	6.7%	

Secondary Position Advanced Procedures: Invasive Airway Management

The next few sections are focused on the frequency of performing advanced procedures in secondary clinical position. The majority of survey participants (61.8%) stated that they never perform invasive airway management (i.e., intubation, mechanical ventilation, capnography, non-invasive airway management) in their secondary position (Figure 236).

Figure 236. Secondary position invasive airway management (i.e., intubation, mechanical ventilation, capnography, non-invasive airway management)

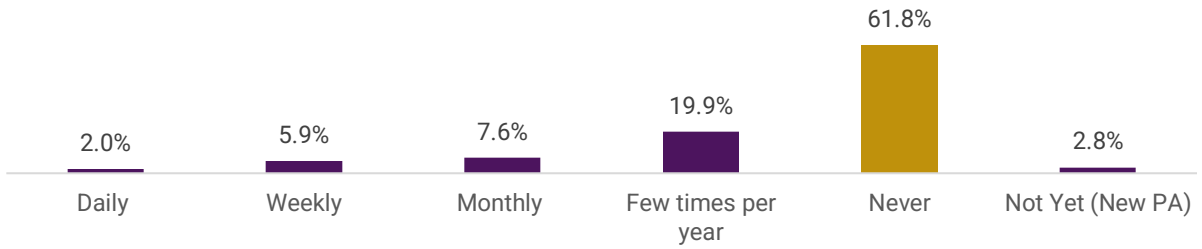


Table 88 displays secondary position invasive airway management by gender, years certified, and U.S. region. Females were significantly more likely than males to indicate that they never perform these procedures (66.4% vs. 56.8%; p=0.024). We did not find statistically significant associations by years certified (p=0.408) and U.S. region (p=0.345).

Table 88. Secondary Position Invasive Airway Management by Characteristics

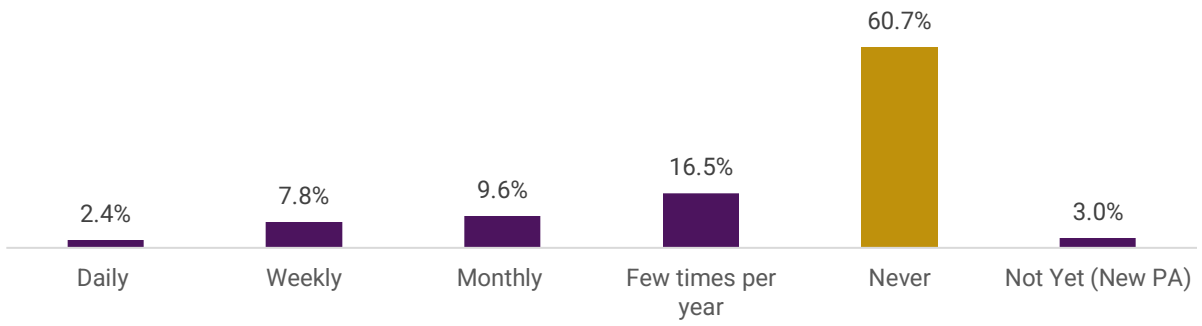
Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	1.4%	4.3%	5.4%	18.6%	66.4%	3.9%	0.024
	Male	2.7%	7.7%	10.0%	21.2%	56.8%	1.5%	
Years Certified	Up to 10	1.5%	5.0%	7.3%	17.6%	65.5%	3.1%	0.408**
	11 to 20	3.9%	5.6%	7.8%	21.7%	58.9%	2.2%	
	21+	0.0%	9.2%	8.2%	22.4%	57.1%	3.1%	
U.S. Region	Midwest	0.8%	5.7%	6.5%	23.6%	60.2%	3.3%	0.345**
	Northeast	0.0%	4.1%	8.3%	19.8%	62.8%	5.0%	
	South	5.0%	6.9%	8.1%	15.0%	63.1%	1.9%	
	West	1.5%	6.7%	7.5%	21.6%	61.2%	1.5%	

** *Fisher-Freeman-Halton Exact test*

Secondary Position Advanced Procedures: Anesthesia

Almost two-thirds (60.7%) of PAs identified that they never perform anesthesia in their secondary clinical position (Figure 237). Almost 17% perform this procedure a few times per year and 9.6% monthly.

Figure 237. Secondary position anesthesia (i.e., procedural anesthesia, conscious sedation)



Frequency of performing anesthesis in secondary position by gender, years certified, and U.S. region is shown in Table 89. Females were significantly more likely to report that they never perform anesthesia in their secondary position than males (66.1% vs. 54.8%; p=0.026). PAs who were certified for up to 10 years had the highest proportion of stating that they have never performed anesthesia, but this finding was not significant (p=0.903). Similarly, the relationship between performing anesthesia in the secondary position and U.S. region was not significant (p=0.119).

Table 89. Secondary Position Anesthesia by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	1.8%	6.4%	6.8%	15.0%	66.1%	3.9%	0.026
	Male	3.1%	9.3%	12.7%	18.1%	54.8%	1.9%	
Years Certified	Up to 10	1.9%	7.7%	8.4%	14.2%	64.4%	3.4%	0.903
	11 to 20	2.8%	7.8%	11.1%	18.3%	57.8%	2.2%	
	21+	3.1%	8.2%	10.2%	19.4%	56.1%	3.1%	
U.S. Region	Midwest	2.4%	4.1%	12.2%	18.7%	58.5%	4.1%	0.119**
	Northeast	0.0%	6.6%	9.1%	21.5%	57.0%	5.8%	
	South	3.8%	10.6%	7.5%	13.8%	63.1%	1.3%	
	West	3.0%	8.2%	10.4%	13.4%	63.4%	1.5%	

** *Fisher-Freeman-Halton Exact test*

Secondary Position Advanced Procedures: Advanced Wound Management

Over one-third (35.3%) of respondents stated that they never perform advanced wound management (i.e., wound debridement, deep wound closure) in their secondary clinical position (Figure 238).

Figure 238. Secondary position advanced wound management (i.e., wound debridement, deep wound closure)

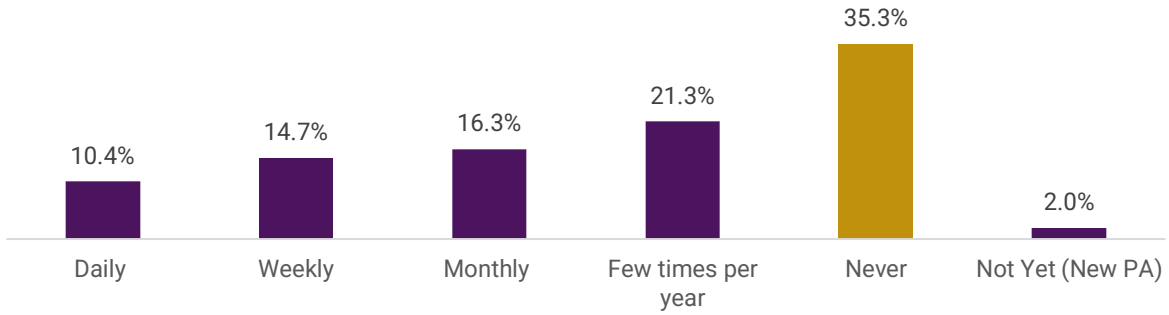


Table 90 demonstrates the frequency of performing advanced wound care management in secondary position by gender, years certified, and U.S. region. Females were more likely to indicate that they never perform this procedure than males (40.7% vs. 29.3%; p=0.004). PAs certified for up to 10 years were more likely to state that they never perform advanced wound management vs. PAs certified 11 to 20 and 21 or more years (42.1% vs. 27.8% and 30.6%; p=0.013). We did not find a significant association between the frequency of performing this procedure and U.S. region (p=0.094).

Table 90. Secondary Position Advanced Wound Management by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	9.6%	12.1%	13.6%	20.4%	40.7%	3.6%	0.004
	Male	11.2%	17.4%	19.3%	22.4%	29.3%	0.4%	
Years Certified	Up to 10	7.3%	14.6%	11.5%	22.6%	42.1%	1.9%	0.013
	11 to 20	15.0%	12.8%	21.7%	20.6%	27.8%	2.2%	
	21+	10.2%	18.4%	19.4%	19.4%	30.6%	2.0%	
U.S. Region	Midwest	8.9%	11.4%	20.3%	20.3%	36.6%	2.4%	0.094
	Northeast	6.6%	11.6%	16.5%	28.1%	33.1%	4.1%	
	South	15.0%	15.0%	11.3%	18.1%	39.4%	1.3%	
	West	9.7%	19.4%	18.7%	20.1%	31.3%	0.7%	

Secondary Position Advanced Procedures: Defibrillation/Cardioversion

The majority of PAs (65.1%) identified that they never perform defibrillation/cardioversion in their secondary clinical position (Figure 239).

Figure 239. Secondary position defibrillation/cardioversion

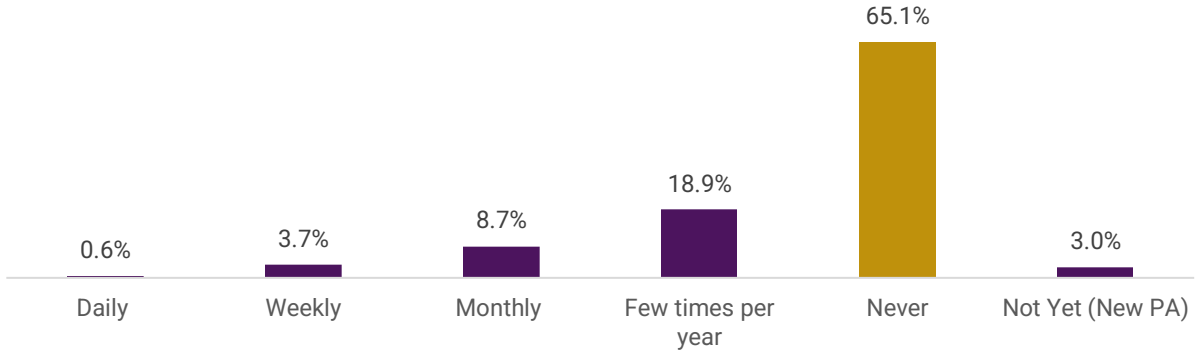


Table 91 illustrates the association between frequency of performing defibrillation/cardioversion in secondary position and gender, years certified, and U.S. region. Females were more likely than males to indicate that they never perform defibrillation/cardioversion (72.1% vs. 57.5%; p<0.001). PAs who were certified for up to 10 years had a higher proportion of reporting that they never perform defibrillation/cardioversion in their secondary clinical position compared to those certified 11 to 20 and 21 or more years (69.0% vs. 62.8% and 59.2%), but these findings were not significant (p=0.729). Statistically significant differences were also not found by U.S. region (p=0.075).

Table 91. Secondary Position Defibrillation/Cardioversion by Characteristics

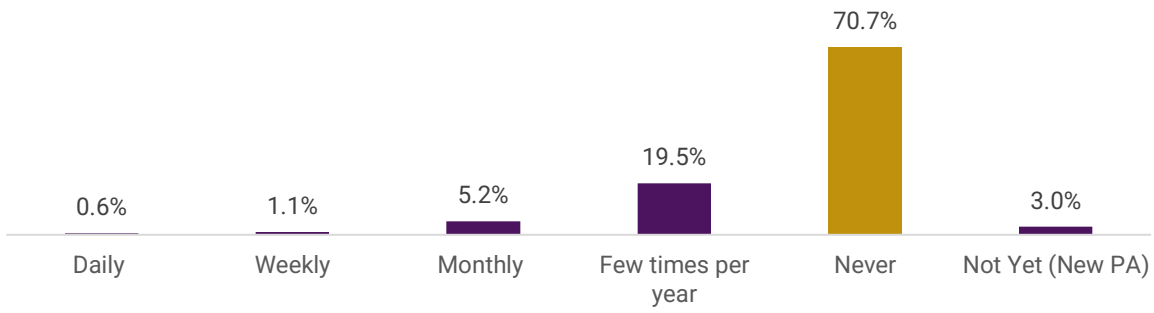
Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	0.7%	2.9%	6.1%	13.9%	72.1%	4.3%	<0.001
	Male	0.4%	4.6%	11.6%	24.3%	57.5%	1.5%	
Years Certified	Up to 10	0.4%	2.7%	7.7%	17.2%	69.0%	3.1%	0.729**
	11 to 20	1.1%	4.4%	9.4%	20.0%	62.8%	2.2%	
	21+	0.0%	5.1%	10.2%	21.4%	59.2%	4.1%	
U.S. Region	Midwest	0.8%	0.0%	10.6%	23.6%	61.8%	3.3%	0.075**
	Northeast	0.0%	1.7%	7.4%	20.7%	65.3%	5.0%	
	South	1.3%	6.9%	6.9%	15.6%	67.5%	1.9%	
	West	0.0%	5.2%	10.4%	17.2%	64.9%	2.2%	

** *Fisher-Freeman-Halton Exact test*

Secondary Position Advanced Procedures: Lumbar Puncture

The majority of respondents (70.7%) said they never perform lumbar puncture in their secondary clinical position (Figure 240). Almost 20% reported that they perform this procedure a few times per year.

Figure 240. Secondary position lumbar puncture



The frequency of performing lumbar puncture in secondary position by demographics/years certified is shown in Table 92. Statistically significant differences were not found by gender (p=0.186), years certified (p=0.917) or U.S. region (p=0.109).

Table 92. Secondary Position Lumbar Puncture by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	0.7%	1.1%	4.3%	16.8%	72.9%	4.3%	0.186**
	Male	0.4%	1.2%	6.2%	22.4%	68.3%	1.5%	
Years Certified	Up to 10	0.8%	0.4%	4.6%	20.3%	70.5%	3.4%	0.917**
	11 to 20	0.6%	1.7%	5.6%	18.3%	71.7%	2.2%	
	21+	0.0%	2.0%	6.1%	19.4%	69.4%	3.1%	
U.S. Region	Midwest	0.8%	0.0%	2.4%	17.1%	76.4%	3.3%	0.109**
	Northeast	0.0%	0.8%	5.0%	19.0%	70.2%	5.0%	
	South	1.3%	1.3%	5.6%	15.0%	74.4%	2.5%	
	West	0.0%	2.2%	7.5%	27.6%	61.2%	1.5%	

** *Fisher-Freeman-Halton Exact test*

Secondary Position Advanced Procedures: Thoracentesis

Most respondents (82.6%) identified that they never perform thoracentesis in their secondary clinical position, followed by 11.1% who perform it a few times per year (Figure 241).

Figure 241. Secondary position thoracentesis

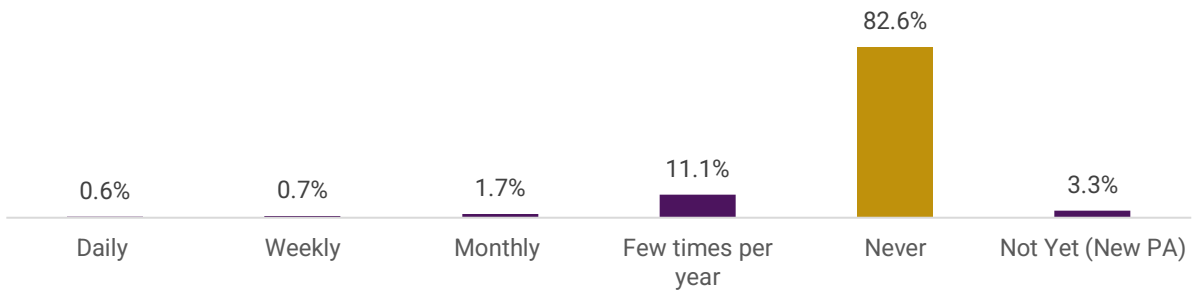


Table 93 displays the frequency of performing thoracentesis in secondary position by gender, years certified, and U.S. region. We did not find statistically significant differences by gender (p=0.056), years certified (p=0.864), or U.S. regions (p=0.532).

Table 93. Secondary Position Thoracentesis by Characteristics

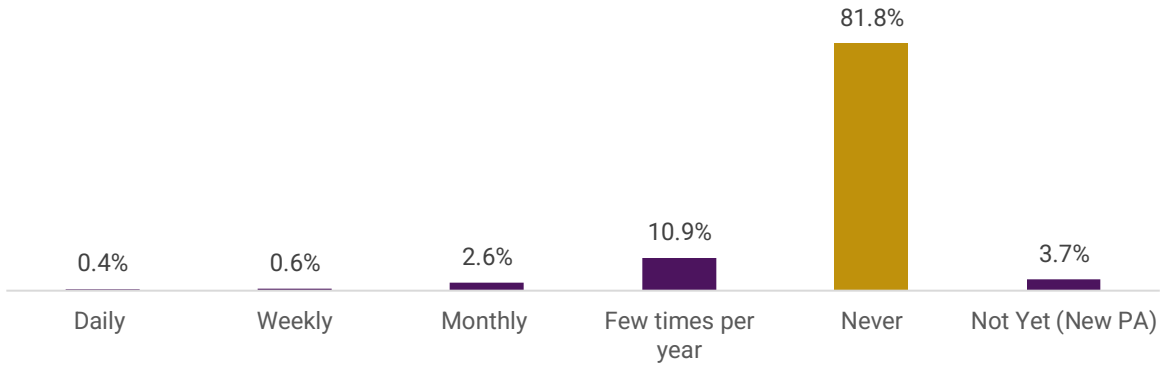
Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	0.4%	0.7%	1.4%	7.5%	85.7%	4.3%	0.056**
	Male	0.8%	0.8%	1.9%	15.1%	79.2%	2.3%	
Years Certified	Up to 10	0.8%	0.4%	1.5%	9.6%	83.9%	3.8%	0.864**
	11 to 20	0.6%	1.7%	2.2%	11.7%	81.1%	2.8%	
	21+	0.0%	0.0%	1.0%	14.3%	81.6%	3.1%	
U.S. Region	Midwest	1.6%	0.0%	0.8%	12.2%	82.1%	3.3%	0.532**
	Northeast	0.0%	0.8%	1.7%	8.3%	82.6%	6.6%	
	South	0.6%	0.6%	1.9%	10.0%	84.4%	2.5%	
	West	0.0%	1.5%	2.2%	14.2%	80.6%	1.5%	

** *Fisher-Freeman-Halton Exact test*

Secondary Position Advanced Procedures: Paracentesis

Most PAs (81.8%) stated that they never perform paracentesis in their secondary clinical position, followed by 10.9% who perform it a few times per year (Figure 242).

Figure 242. Secondary position paracentesis



Performing paracentesis in secondary position by gender, years certified, and U.S. region is shown in Table 94. Males had a higher proportion than females indicating that they never perform paracentesis (82.2% vs. 81.4%), but these findings are not significant (p=0.618). Similarly, the relationships between frequency of performing paracentesis and years certified (p=0.709) or U.S. region (p=0.339) were not found to be significant.

Table 94. Secondary Position Paracentesis by Characteristics

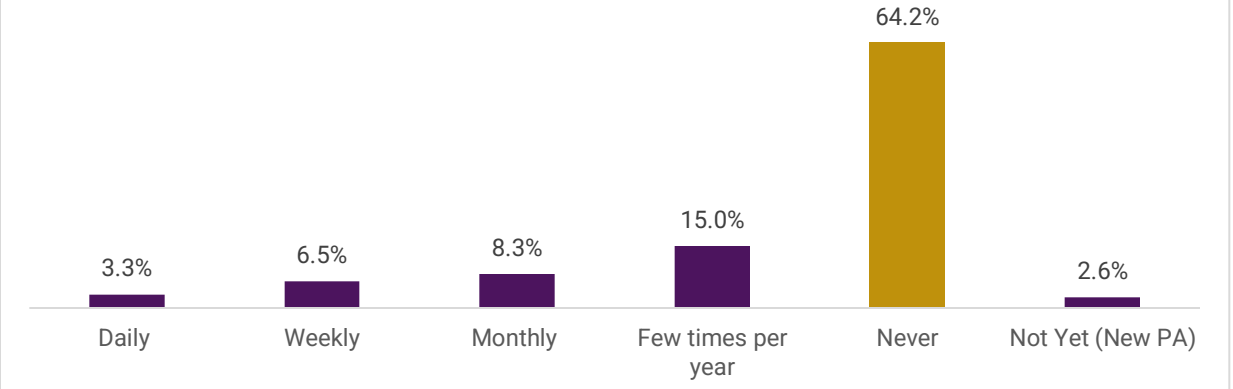
Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	0.4%	0.7%	2.5%	10.0%	81.4%	5.0%	0.618**
	Male	0.4%	0.4%	2.7%	12.0%	82.2%	2.3%	
Years Certified	Up to 10	0.4%	0.4%	3.8%	9.6%	81.2%	4.6%	0.709**
	11 to 20	0.6%	1.1%	1.1%	11.7%	82.8%	2.8%	
	21+	0.0%	0.0%	2.0%	13.3%	81.6%	3.1%	
U.S. Region	Midwest	0.8%	0.0%	1.6%	9.8%	82.9%	4.9%	0.339**
	Northeast	0.0%	0.8%	3.3%	13.2%	76.9%	5.8%	
	South	0.6%	0.0%	1.3%	8.8%	86.3%	3.1%	
	West	0.0%	1.5%	4.5%	12.7%	79.9%	1.5%	

** *Fisher-Freeman-Halton Exact test*

Secondary Position Advanced Procedures: Ultrasound-Guided Procedures

Almost two-thirds of PAs (64.2%) identified that they never perform ultrasound-guided procedures in their secondary clinical position, followed by 15.3% who perform these procedures a few times per year, and 8.3% monthly (Figure 243).

Figure 243. Secondary position ultrasound-guided procedures



When we analyzed secondary position ultrasound-guided procedures by demographics/years certified (Table 95), we found statistically significant differences by gender (p=0.032), but not by years certified (p=0.339) or U.S. region (p=0.309). Females compared to males were more likely to indicate that they never perform ultrasound-guided procedures (68.2% vs. 59.8%).

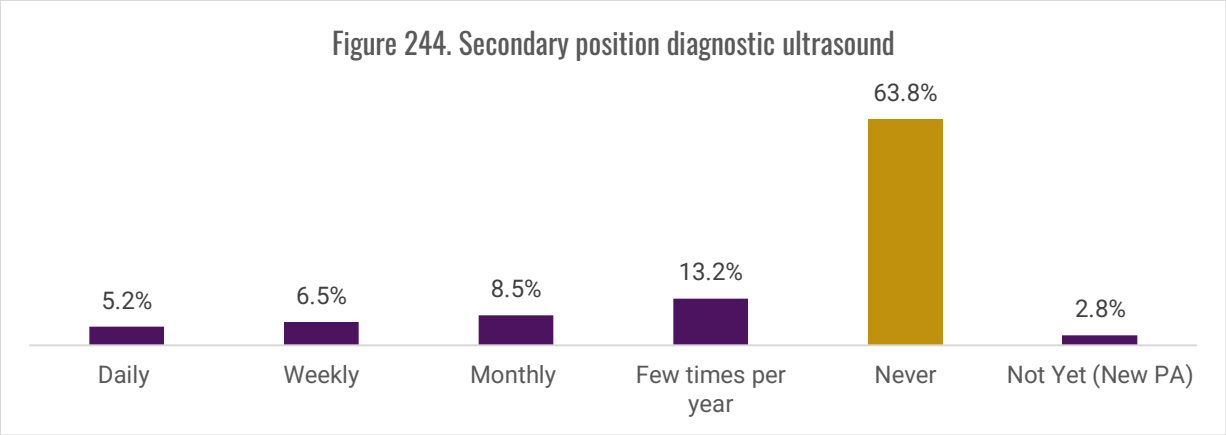
Table 95. Secondary Position Ultrasound-Guided Procedures by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	2.9%	4.3%	7.9%	12.9%	68.2%	3.9%	0.032
	Male	3.9%	8.9%	8.9%	17.4%	59.8%	1.2%	
Years Certified	Up to 10	4.6%	6.5%	10.3%	15.3%	60.5%	2.7%	0.339
	11 to 20	2.2%	8.3%	7.8%	12.8%	66.7%	2.2%	
	21+	2.0%	3.1%	4.1%	18.4%	69.4%	3.1%	
U.S. Region	Midwest	4.9%	3.3%	8.1%	13.0%	67.5%	3.3%	0.309**
	Northeast	3.3%	4.1%	9.9%	16.5%	62.0%	4.1%	
	South	2.5%	7.5%	5.0%	13.8%	69.4%	1.9%	
	West	3.0%	10.4%	11.2%	17.2%	56.7%	1.5%	

** *Fisher-Freeman-Halton Exact test*

Secondary Position Advanced Procedures: Diagnostic Ultrasound

Almost two-thirds of respondents (63.8%) reported that they never performed diagnostic ultrasounds in their secondary clinical position, followed by 13.2% who perform diagnostic ultrasounds a few times per year, and 8.5% monthly (Figure 244).



The results of parsing frequency of performing diagnostic ultrasound in secondary position by gender, years certified, and U.S. region are shown in Table 96. We found statistically significant differences by gender (p=0.009), but not by years certified (p=0.355) and U.S. region (p=0.183). Females were more likely to indicate that they never perform diagnostic ultrasounds compared to males (68.2% vs. 59.1%).

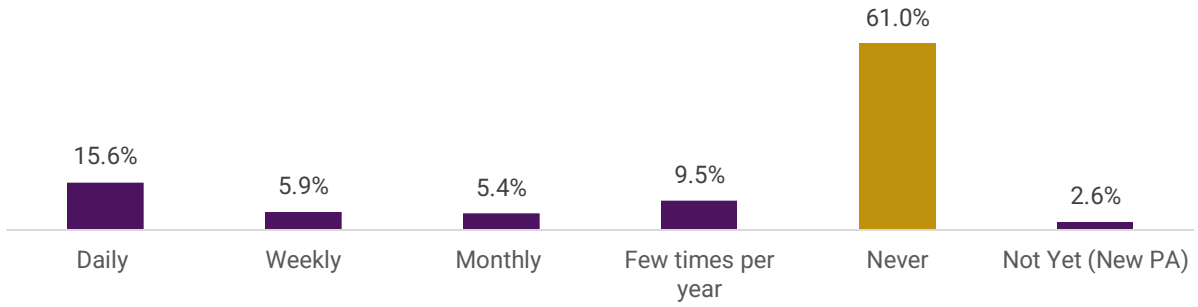
Table 96. Secondary Position Diagnostic Ultrasound by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	5.0%	3.9%	6.8%	11.8%	68.2%	4.3%	0.009
	Male	5.4%	9.3%	10.4%	14.7%	59.1%	1.2%	
Years Certified	Up to 10	6.5%	5.4%	9.6%	15.7%	60.2%	2.7%	0.355
	11 to 20	4.4%	8.3%	8.9%	8.3%	67.2%	2.8%	
	21+	3.1%	6.1%	5.1%	15.3%	67.3%	3.1%	
U.S. Region	Midwest	6.5%	6.5%	7.3%	8.1%	68.3%	3.3%	0.183
	Northeast	3.3%	4.1%	7.4%	15.7%	64.5%	5.0%	
	South	4.4%	5.6%	6.3%	16.3%	65.6%	1.9%	
	West	6.7%	9.7%	13.4%	11.9%	56.7%	1.5%	

Secondary Position Advanced Procedures: Advanced Radiographic Interpretation

Most respondents (61.0%) reported that they never perform advanced radiographic interpretation (i.e., initial read of CT scans, ultrasound, MRI) in their secondary clinical position (Figure 245). Almost 16% of participants indicated that they perform advanced radiographic interpretation daily.

Figure 245. Secondary position advanced radiographic interpretation (i.e., initial read of CT scans, ultrasound, MRI)



When we analyzed advanced radiographic interpretation by gender, years certified, and U.S. region (Table 97), we found statistically significant differences by gender (p=0.003), but not by years certified (p=0.830) or U.S. region (p=0.826). Females were more likely than males to state that they never perform advanced radiographic interpretation (66.8% vs. 54.8%; p=0.003).

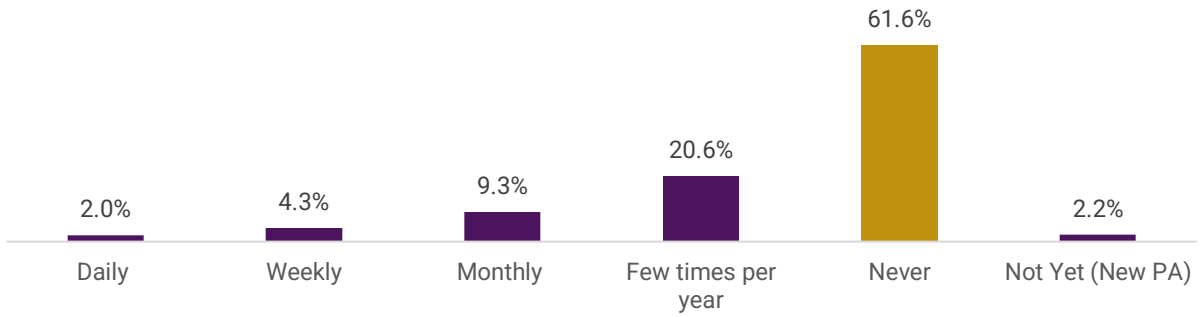
Table 97. Secondary Position Advanced Radiographic Interpretation by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	12.1%	5.0%	3.2%	8.9%	66.8%	3.9%	0.003
	Male	19.3%	6.9%	7.7%	10.0%	54.8%	1.2%	
Years Certified	Up to 10	16.5%	5.4%	4.6%	8.4%	62.8%	2.3%	0.830
	11 to 20	15.0%	6.7%	4.4%	9.4%	61.7%	2.8%	
	21+	14.3%	6.1%	9.2%	12.2%	55.1%	3.1%	
U.S. Region	Midwest	16.3%	6.5%	6.5%	7.3%	60.2%	3.3%	0.826
	Northeast	17.4%	3.3%	5.8%	13.2%	57.0%	3.3%	
	South	16.9%	5.6%	4.4%	6.9%	63.7%	2.5%	
	West	11.9%	7.5%	5.2%	11.2%	62.7%	1.5%	

Secondary Position Advanced Procedures: Resuscitation

The majority of PAs (61.6%) identified that they never perform resuscitation (i.e., trauma/major medical, cardiac arrests, etc.) in their secondary clinical position, followed by 20.6% who perform resuscitation a few times per year, and 9.3% monthly (Figure 246).

Figure 246. Secondary position resuscitation (i.e., trauma/major medical, cardiac arrests, etc.)



The results presented in Table 98 reflect a detailed characterization of resuscitation performed in the secondary position by gender, years certified, and U.S. region. Females were significantly more likely to indicate that they never perform resuscitation compared to males (67.1% vs. 55.6%; p=0.008). We did not find statistically significant differences when we parsed resuscitation by years certified (p=0.280) and U.S. region (p=0.266).

Table 98. Secondary Position Resuscitation by Characteristics

Characteristics		Daily	Weekly	Monthly	Few times per year	Never	Not Yet	p-value
Gender	Female	1.4%	2.1%	7.9%	18.2%	67.1%	3.2%	0.008
	Male	2.7%	6.6%	10.8%	23.2%	55.6%	1.2%	
Years Certified	Up to 10	1.5%	3.4%	8.4%	18.8%	65.5%	2.3%	0.280**
	11 to 20	3.9%	3.3%	10.0%	22.2%	58.9%	1.7%	
	21+	0.0%	8.2%	10.2%	22.4%	56.1%	3.1%	
U.S. Region	Midwest	2.4%	2.4%	8.9%	25.2%	57.7%	3.3%	0.266**
	Northeast	0.8%	2.5%	7.4%	28.1%	57.9%	3.3%	
	South	2.5%	6.9%	10.6%	16.3%	62.5%	1.3%	
	West	2.2%	4.5%	9.7%	14.9%	67.2%	1.5%	

** *Fisher-Freeman-Halton Exact test*

Hours Worked in a Typical Week at Secondary Clinical Position

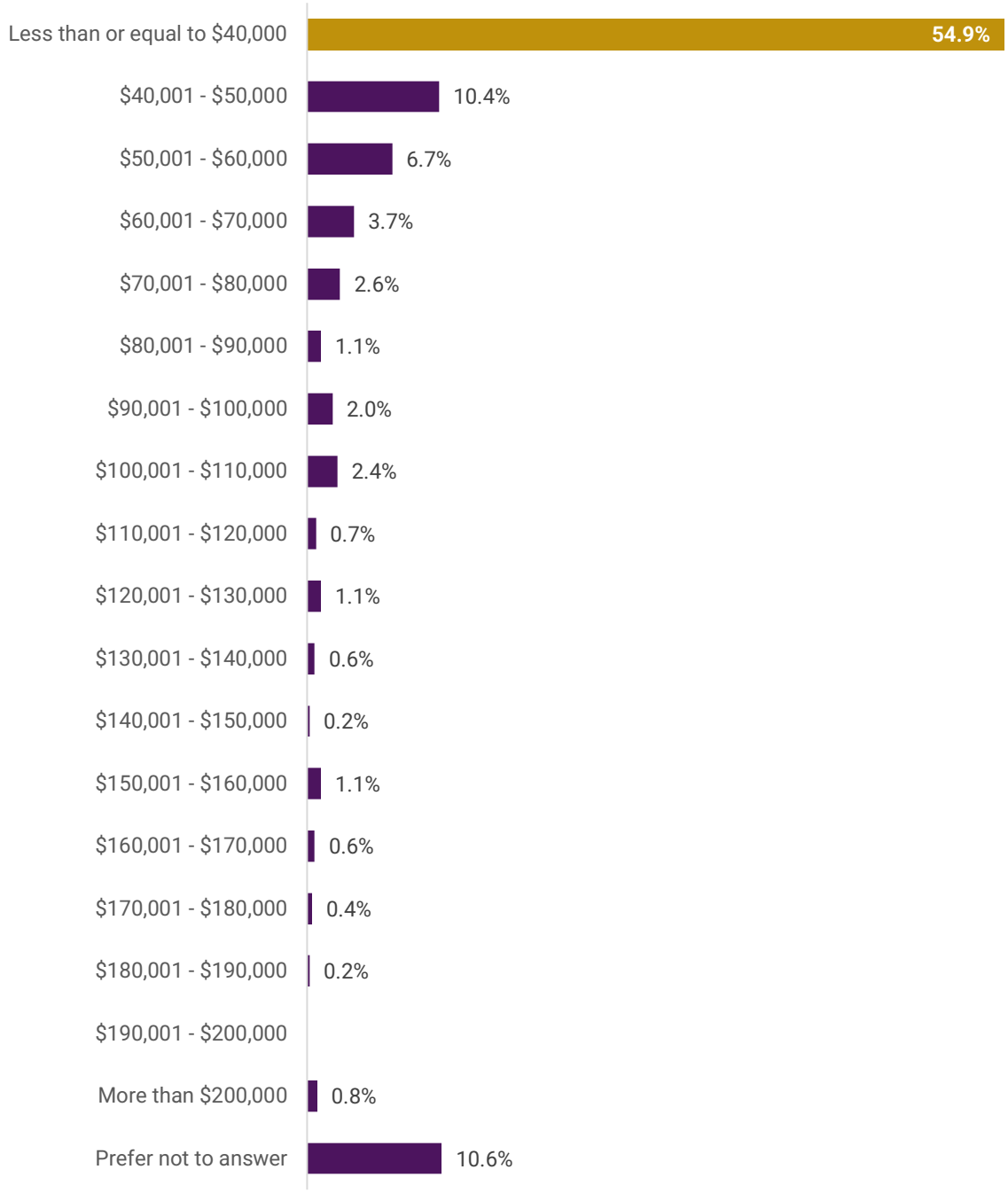
When we asked participants how many hours they work in a typical week at their secondary clinical position, the mean was 11.4 and a median of 10.0 hours in a typical week. When hours worked in a typical week in secondary position was analyzed by gender, we found that males had a higher mean of hours worked than females (12.5 vs.10.1; p=0.011; Table 99). There were no significant differences in hours worked in secondary position by years certified (p=0.064). and U.S. regions (p=0.065).

Table 99. Hours Worked in a Typical Week in Secondary Position by Characteristics				
Characteristics		Mean	Median	P-value
Gender	Female	10.1	10.0	0.011
	Male	12.5	10.0	
Years Certified	Up to 10	10.4	9.0	0.064
	11 to 20	11.2	10.0	
	21+	13.8	10.0	
U.S. Region	Midwest	10.1	8.0	0.065
	Northeast	10.8	10.0	
	South	12.7	10.0	
	West	11.1	10.0	

Total Income Before Taxes for Secondary Clinical Position

Of the 45.4% of survey participants who identified having a secondary clinical position, 54.9% reported that their income of the last calendar year for the secondary position was less than or equal to $40,000 (Figure 247). Over 10% indicated earning in the range of $40,001 - $50,000.

Figure 247. For your secondary clinical position, please estimate your total income before taxes from January - December of the last calendar year.



Females were more likely than males to report that they earned less than or equal to $40,000 in their secondary clinical position (61.1% vs. 48.3%; p=0.047; Table 100).

Table 100. Secondary Clinical Position Income by Gender

Income	Female	Male	p-value
Less than or equal to $40,000	61.1%	48.3%	
$40,001 - $50,000	10.4%	10.4%	
$50,001 - $60,000	5.7%	7.7%	
$60,001 - $70,000	2.5%	5.0%	
$70,001 - $80,000	1.4%	3.9%	
$80,001 - $90,000	0.7%	1.5%	
$90,001 - $100,000	0.7%	3.5%	
$100,001 - $110,000	2.1%	2.7%	
$110,001 - $120,000	0.7%	0.8%	
$120,001 - $130,000	0.7%	1.5%	0.047**
$130,001 - $140,000	0.7%	0.4%	
$140,001 - $150,000	0.0%	0.4%	
$150,001 - $160,000	1.4%	0.8%	
$160,001 - $170,000	0.4%	0.8%	
$170,001 - $180,000	0.0%	0.8%	
$180,001 - $190,000	0.0%	0.4%	
$190,001 - $200,000	0.0%	0.0%	
More than $200,000	0.0%	1.6%	
Prefer not to answer	11.4%	9.7%	

** *Fisher-Freeman-Halton Exact test*

Participants who were certified for up to 10 years were significantly more likely to indicate that they earned less than or equal to $40,000 in their secondary position versus PAs certified 11 to 20 and 21 or more years (63.6% vs. 46.7% and 46.9%; p=0.016; Table 101).

Table 101. Secondary Clinical Position income by Years Certified

Income	Up to 10	11 to 20	21+	p-value
Less than or equal to $40,000	63.6%	46.7%	46.9%	
$40,001 - $50,000	8.8%	11.7%	12.2%	
$50,001 - $60,000	5.0%	9.4%	6.1%	
$60,001 - $70,000	3.4%	2.8%	6.1%	
$70,001 - $80,000	1.5%	3.3%	4.1%	
$80,001 - $90,000	1.1%	1.1%	1.0%	
$90,001 - $100,000	1.1%	2.8%	3.1%	
$100,001 - $110,000	2.7%	2.8%	1.0%	
$110,001 - $120,000	1.1%	0.0%	1.0%	
$120,001 - $130,000	0.8%	2.2%	0.0%	0.016**
$130,001 - $140,000	0.0%	0.6%	2.0%	
$140,001 - $150,000	0.0%	0.6%	0.0%	
$150,001 - $160,000	0.0%	2.8%	1.0%	
$160,001 - $170,000	0.8%	0.6%	0.0%	
$170,001 - $180,000	0.4%	0.6%	0.0%	
$180,001 - $190,000	0.0%	0.6%	0.0%	
$190,001 - $200,000	0.0%	0.0%	0.0%	
More than $200,000	0.0%	0.6%	3.0%	
Prefer not to answer	9.6%	11.1%	12.2%	

** *Fisher-Freeman-Halton Exact test*

We did not find statistically significant differences when parsing income from secondary clinical position by U.S. region (p=0.129; Table 102).

Table 102. Secondary Clinical Position Income by U.S. Region

Income	Midwest	Northeast	South	West	p-value
Less than or equal to $40,000	56.1%	57.9%	52.5%	54.5%	
$40,001 - $50,000	7.3%	12.4%	10.6%	11.2%	
$50,001 - $60,000	4.9%	5.0%	7.5%	9.0%	
$60,001 - $70,000	3.3%	2.5%	6.3%	2.2%	
$70,001 - $80,000	1.6%	5.0%	1.9%	2.2%	
$80,001 - $90,000	1.6%	0.0%	0.6%	1.5%	
$90,001 - $100,000	0.8%	0.8%	1.9%	4.5%	
$100,001 - $110,000	0.8%	3.3%	4.4%	0.7%	
$110,001 - $120,000	0.0%	0.8%	0.0%	2.2%	
$120,001 - $130,000	3.3%	0.0%	0.6%	0.7%	0.129**
$130,001 - $140,000	0.8%	0.0%	1.3%	0.0%	
$140,001 - $150,000	0.0%	0.0%	0.0%	0.7%	
$150,001 - $160,000	0.0%	1.7%	1.3%	1.5%	
$160,001 - $170,000	0.8%	0.8%	0.6%	0.0%	
$170,001 - $180,000	0.0%	0.8%	0.0%	0.7%	
$180,001 - $190,000	0.0%	0.0%	0.6%	0.0%	
$190,001 - $200,000	0.0%	0.0%	0.0%	0.0%	
More than $200,000	0.8%	0.0%	0.6%	1.4%	
Prefer not to answer	17.9%	9.1%	9.4%	6.7%	

** *Fisher-Freeman-Halton Exact test*