



**Business, Consumer Services,
and Housing Agency
Department of Consumer Affairs**

Physician Assistant Board

2016 Sunset Review Report

**Submitted December 1, 2015
to the Senate Committee on Business,
Professions and Economic Development
and the Assembly Committee on
Business and Professions**



Board Members

Robert E. Sachs, PA-C, Professional Member, President

Jed Grant, PA-C, Professional Member, Vice-President

Charles J. Alexander, Ph.D., Public Member

Michael Bishop, M.D., Professional Member

Sonya Earley, PA, Professional Member

Javier Esquivel-Acosta, PA, Professional Member

Catherine Hazelton, Public Member

Xavier Martinez, Public Member

Physician Assistant Board

Glenn L. Mitchell, Jr., Executive Officer

State of California

Edmund G. Brown, Jr., Governor

Anna M. Caballero, Secretary, Business, Consumer Services and Housing Agency

Awet Kidane, Director, Department of Consumer Affairs

Additional copies of this report can be obtained from www.pac.ca.gov

Physician Assistant Board
2005 Evergreen Street, Suite 1100
Sacramento, CA 95815
(916) 561-8780

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Section 1 – Background and Description of the Board and Regulated Profession

Provide a short explanation of the history and function of the board.¹ Describe the occupations/profession that are licensed and/or regulated by the board (Practice Acts vs. Title Acts).

The creation of the Physician Assistant Board (Board) of the State of California occurred in response to the genesis of the physician assistant profession itself, which began over fifty years ago and has since evolved throughout the nation.

In 1961, the concept of "physician assistant" originated in an article written by Charles L. Hudson, MD, in the Journal of the American Medical Association, calling for "an advanced medical assistant with special training, intermediate between that of the technician and that of the doctor, who could not only handle any technical procedures but could also take some degree of medical responsibility."

In 1965 the first Physician Assistant training program commenced at Duke University in North Carolina. The program was established with the admission of four ex-military corpsmen into a two-year program, headed by Eugene A. Stead, MD. In the early 1970s, the United States Congress took steps toward facilitating the development of physician assistant practice by allocating funds totaling over eleven million dollars for PA education programs through Health Manpower Educational Initiative Awards.

In California, the Physician's Assistant Law (Statutes of 1970, Chapter 1327) was passed, introducing a new category of health care provider, termed the "physician's assistant," to redress "the growing shortage and geographic maldistribution of health care services in California." This law, in part,

- 1) permitted the supervised delegation of certain medical services to these physician assistants, thus freeing physicians to focus their skills on other procedures;
- 2) conferred upon the then Medical Board of Examiners (BME) of California the approval and certification of physician assistant training programs and the approval of applications of licensed physicians to supervise physician assistants; and
- 3) established the Advisory Committee on Physician's Assistant Programs (ACPAP), later amended to also include jurisdiction over nurse practitioners (Statutes of 1972, Chapter 933).

The purpose of this legislation was to prepare for future initiatives to "establish a system of certifying or licensing physician's assistants so that the quality of service is insured," and the MBE, in conjunction with the ACPAP, was charged with recommending how to do so, as well as with formulating criteria for approval of both PA training programs and for supervising physicians.

¹ The term "board" in this document refers to a board, bureau, commission, committee, department, division, program, or agency, as applicable. Please change the term "board" throughout this document to appropriately refer to the entity being reviewed.

The need to fulfill this legislative intent and to utilize the considerable clinical experience of returning Vietnam veterans interested in civilian medical practice and capable of alleviating the continuing health care shortage in under-served areas, as well as the need to combat growing dissatisfaction with the organization of the BME, soon prompted a number of political proposals to address these concerns. One such bill (AB1XX), authored by Assemblyman Barry Keene, passed into law in 1975. This legislation renamed the BME the Board of Medical Quality Assurance (BMQA) and revised its original structure into three autonomous divisions (Division of Medical Quality, Division of Licensing, and Division of Allied Health Professions). To assist the Board in its responsibilities, The Division of Allied Health Professions (DAHP) was given statutory authority over nine committees that were given purview over the licensing and disciplining of specific allied health professions. One such committee became the newly established Physician's Assistant Committee, decreed by a separate legislative initiative that passed within the same time period.

The creative bill (AB 392) was introduced by Assemblyman Gordon Duffy on January 6, 1975, amended several times, and then signed into law on September 9, 1975, by Governor Edmund G. Brown, Jr. This legislation (Statutes of 1975, Chapter 634) enacted "The Physician's Assistant Practice Act," which abolished the Advisory Committee on Physician's Assistants and Nurse Practitioner Programs and created, instead, the Physician's Assistant Examining Committee (PAC) in order to:

- 1) "establish in this chapter a framework for the development of a new category of health care manpower—the physician's assistant;"
- 2) "encourage the more effective utilization of the skills of physicians by enabling them to delegate health care tasks to qualified physician's assistants where such delegation is consistent with the patient's health and welfare;"
- 3) "encourage the utilization of physician's assistants by physicians, and to provide that existing legal constraints should not be an unnecessary hindrance to the more effective provision of health care services;" and
- 4) "allow for innovative development of programs for the education of physician's assistants."

This legislation then prescribed the new Committee's membership, powers, duties, and relationship to the BMQA and DAHP in accomplishing these goals. To this very day, the Committee, now called the Physician Assistant Board, continues on in its responsibility to facilitate and encourage physician assistant service by advocating and enforcing regulations necessary to licensing, monitoring, and expanding physician assistant practice, by assuring the public that all PA licensees, approved supervising physicians, and PA training programs have met certain minimum requirements, and by protecting the public, as well as the profession, from inadequately trained, unethical, or incompetent practitioners.

SB 1236 (Price, Statutes of 2012, Chapter 332,) changed the name of the Physician Assistant Committee to Physician Assistant Board (Board).

Physician Assistant Practice Act

The primary responsibility of the Board is to protect California consumers from incompetent, and/or fraudulent practice through the enforcement of the Physician Assistant Practice Act under Division

2, Chapter 7.7, of the Business and Professions Code, and through the Physician Assistant Regulations (Title 16, Division 13.8) of the California Code of Regulations (CCR). Under the Department of Consumer Affairs, the Board promotes safe practice of physician assistants by:

- Approval of the educational and training requirements of physician assistants.
- Licensing of physician assistants.
- Promoting the health and safety of California health care consumers by enhancing the competence of physician assistants.
- Coordinating investigation and disciplinary processes.
- Providing information and education regarding the Board or physician assistant professionals to California consumers.
- Managing a diversion/monitoring program for physician assistants with alcohol/substance abuse problems.

The also collaborates with others regarding legal and regulatory issues that involve physician assistant activities or the profession.

Within the physician assistant profession, the Board establishes and maintains entry standards of qualification and conduct primarily through its authority to license. With over 10,000 licensed physician assistants, the Board regulates and establishes standards for the education and training of physician assistant practice.

1. Describe the make-up and functions of each of the board's committees (Section 12, Attachment B).

The Board consists of nine members who serve four-year terms and may be reappointed. The Board is currently comprised of: one physician member from the Medical Board of California, four licensed physician assistants, and four public members. The Governor appoints the four physician assistant members and two public members. The Speaker of the Assembly and the Senate Rules Committee each appoint one public member. Board members play a critical role as policy and decision makers in licensing requirements, disciplinary matters, approval of physician assistant training programs, contracts, budget issues, legislation and regulatory proposals, and consumer and public outreach.

Committees serve as an important component of the Board to address specific issues referred by the public, the Legislature, the Department of Consumer Affairs or recommended by staff. Committees are generally composed of at least two Board members who are charged with gathering public input, exploring alternatives to the issues, and making recommendations to the full Board. The Board does not have committees established by statutes or regulations, but the Board chairperson may appoint task forces and committees as issues arise.

The Legislative Committee created on May 20, 2013

The purpose of the committee is to review legislation that would impact the Board, licensees, and consumers and make recommendations to the Board regarding possible positions on proposed legislation.

The committee is comprised of Board members Sonya Earley, PA-C and Catherine Hazelton.

Education/Workforce Development Committee created on May 4, 2015

The purpose of the committee is to examine education and workforce issues regarding physician assistants and the need to address health care needs of California consumers.

The committee is comprised of Board members Charles J. Alexander, Ph.D. and Jed Grant, PA-C

Table 1a. Attendance			
Charles J. Alexander, Ph.D. – Current member			
Date Appointed:	February 5, 2013		
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	02/11/2013	Sacramento	No
Quarterly Board Meeting	05/20/2013	Sacramento	Yes
Quarterly Board Meeting	08/26/2013	Sacramento	Yes
Quarterly Board Meeting	12/09/2013	Sacramento	Yes
Quarterly Board Meeting	02/24/2014	Sacramento	Yes
Quarterly Board Meeting	05/19/2014	Sacramento	Yes
Quarterly Board Meeting	08/19/2014	Sacramento	Yes
Quarterly Board Meeting	11/03/2014	Sacramento	Yes
Interim Teleconference Board Meeting	01/16/2015	Various	Yes
Quarterly Board Meeting	02/09/2015	Sacramento	Yes
Quarterly Board Meeting	05/04/2015	Sacramento	Yes

Table 1a. Attendance			
Michael Bishop, M.D. – Current member			
Date Appointed:	June 18, 2013		
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	08/26/2013	Sacramento	Yes
Quarterly Board Meeting	12/09/2013	Sacramento	Yes
Quarterly Board Meeting	02/24/2014	Sacramento	Yes
Quarterly Board Meeting	05/19/2014	Sacramento	Yes
Quarterly Board Meeting	08/19/2014	Sacramento	Yes
Quarterly Board Meeting	11/03/2014	Sacramento	Yes
Interim Teleconference Board Meeting	01/16/2015	Various	Yes
Quarterly Board Meeting	02/09/2015	Sacramento	Yes
Quarterly Board Meeting	05/04/2015	Sacramento	Yes

Table 1a. Attendance			
Roslynn Byous, PA-C			
Date Appointed:	February 4, 2008		
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	08/22/2011	Sacramento	Yes
Personal Presence Subcommittee Meeting	10/03/2011	Sacramento	Yes
Interim Teleconference Meeting	10/10/2011	Various	Yes
Quarterly Board Meeting	11/10/2011	Sacramento	Yes
Personal Presence Subcommittee Teleconference Meeting	12/15/2011	Various	Yes

*Served during grace year.

Table 1a. Attendance**Sonya Early, PA – Current member**

Date Appointed: February 5, 2013

Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	02/11/2013	Sacramento	Yes
Quarterly Board Meeting	05/20/2013	Sacramento	Yes
Quarterly Board Meeting	08/26/2013	Sacramento	Yes
Quarterly Board Meeting	12/09/2013	Sacramento	Yes
Quarterly Board Meeting	02/24/2014	Sacramento	Yes
Quarterly Board Meeting	05/19/2014	Sacramento	No
Quarterly Board Meeting	08/19/2014	Sacramento	Yes
Quarterly Board Meeting	11/03/2014	Sacramento	Yes
Interim Teleconference Board Meeting	01/16/2015	Various	Yes
Quarterly Board Meeting	02/09/2015	Sacramento	Yes
Quarterly Board Meeting	05/04/2015	Sacramento	Yes

Table 1a. Attendance**Cristina Gomez-Vidal Diaz – Current member**

Date Appointed:	November 22, 2005		
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	08/22/2011	Sacramento	Yes
Personal Presence Subcommittee Meeting	10/03/2011	Sacramento	No
Interim Teleconference Meeting	10/10/2011	Various	Yes
Quarterly Board Meeting	11/10/2011	Sacramento	No
Personal Presence Subcommittee Teleconference Meeting	12/15/2011	Various	No
Quarterly Board Meeting	02/06/2012	Sacramento	Yes
Quarterly Board Meeting	05/07/2012	Sacramento	Yes
Quarterly Board Meeting	08/06/2012	Sacramento	Yes
Quarterly Board Meeting	10/29/2012	Sacramento	Yes
Quarterly Board Meeting	12/10/2012	Sacramento	Yes
Quarterly Board Meeting	02/11/2013	Sacramento	Yes
Quarterly Board Meeting	05/20/2013	Sacramento	Yes
Quarterly Board Meeting	08/26/2013	Sacramento	Yes
Quarterly Board Meeting	12/09/2013	Sacramento	No
Quarterly Board Meeting	02/24/2014	Sacramento	Yes
Quarterly Board Meeting	05/19/2014	Sacramento	No
Quarterly Board Meeting	08/19/2014	Sacramento	Yes
Quarterly Board Meeting	11/03/2014	Sacramento	Yes
Interim Teleconference Board Meeting	01/16/2015	Various	Yes
Quarterly Board Meeting	02/09/2015	Sacramento	No
Quarterly Board Meeting	05/04/2015	Sacramento	Yes

*Served during grace year.

Table 1a. Attendance			
Jed Grant, PA-C – Current member			
Date Appointed:	February 5, 2013		
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	02/11/2013	Sacramento	Yes
Quarterly Board Meeting	05/20/2013	Sacramento	Yes
Quarterly Board Meeting	08/26/2013	Sacramento	Yes
Quarterly Board Meeting	12/09/2013	Sacramento	Yes
Quarterly Board Meeting	02/24/2014	Sacramento	Yes
Quarterly Board Meeting	05/19/2014	Sacramento	Yes
Quarterly Board Meeting	08/19/2014	Sacramento	Yes
Quarterly Board Meeting	11/03/2014	Sacramento	Yes
Interim Teleconference Board Meeting	01/16/2015	Various	Yes
Quarterly Board Meeting	02/09/2015	Sacramento	Yes
Quarterly Board Meeting	05/04/2015	Sacramento	Yes

Table 1a. Attendance			
Catherine Hazelton – Current member			
Date Appointed:	January 15, 2013		
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	02/11/2013	Sacramento	Yes
Quarterly Board Meeting	05/20/2013	Sacramento	Yes
Quarterly Board Meeting	08/26/2013	Sacramento	Yes
Quarterly Board Meeting	12/09/2013	Sacramento	No
Quarterly Board Meeting	02/24/2014	Sacramento	No
Quarterly Board Meeting	05/19/2014	Sacramento	Yes
Quarterly Board Meeting	08/19/2014	Sacramento	Yes
Quarterly Board Meeting	11/03/2014	Sacramento	Yes
Interim Teleconference Board Meeting	01/16/2015	Various	Yes
Quarterly Board Meeting	02/09/2015	Sacramento	No
Quarterly Board Meeting	05/04/2015	Sacramento	Yes

Table 1a. Attendance			
Steven Klompus, PA			
Date Appointed:	January 21, 2006		
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	08/22/2011	Sacramento	Yes
Personal Presence Subcommittee Meeting	10/03/2011	Sacramento	No
Interim Teleconference Meeting	10/10/2011	Various	Yes
Quarterly Board Meeting	11/10/2011	Sacramento	Yes
Personal Presence Subcommittee Teleconference Meeting	12/15/2011	Various	No
Quarterly Board Meeting	02/06/2012	Sacramento	Yes
Quarterly Board Meeting	05/07/2012	Sacramento	Yes
Quarterly Board Meeting	08/06/2012	Sacramento	Yes
Quarterly Board Meeting	10/29/2012	Sacramento	Yes
Quarterly Board Meeting	12/10/2012	Sacramento	Yes

*Served during grace year.

Table 1a. Attendance			
Reginald Low, M.D.			
Date Appointed:	February 4, 2008		
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	08/22/2011	Sacramento	Yes
Personal Presence Subcommittee Meeting	10/03/2011	Sacramento	No
Interim Teleconference Meeting	10/10/2011	Various	Yes
Quarterly Board Meeting	11/10/2011	Sacramento	No
Personal Presence Subcommittee Teleconference Meeting	12/15/2011	Various	No
Quarterly Board Meeting	02/06/2012	Sacramento	No
Quarterly Board Meeting	05/07/2012	Sacramento	No

Table 1a. Attendance			
Xavier Martinez – Current member			
Date Appointed:	February 6, 2014		
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	02/24/2014	Sacramento	Yes
Quarterly Board Meeting	05/19/2014	Sacramento	No
Quarterly Board Meeting	08/19/2014	Sacramento	Yes
Quarterly Board Meeting	11/03/2014	Sacramento	Yes
Interim Teleconference Board Meeting	01/16/2015	Various	Yes
Quarterly Board Meeting	02/09/2015	Sacramento	Yes
Quarterly Board Meeting	05/04/2015	Sacramento	Yes

Table 1a. Attendance			
Robert E. Sachs, PA-C – Current member			
Date Appointed:	April 1, 1993		
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	08/22/2011	Sacramento	Yes
Personal Presence Subcommittee Meeting	10/03/2011	Sacramento	Yes
Interim Teleconference Meeting	10/10/2011	Various	Yes
Quarterly Board Meeting	11/10/2011	Sacramento	Yes
Personal Presence Subcommittee Teleconference Meeting	12/15/2011	Various	Yes
Quarterly Board Meeting	02/06/2012	Sacramento	Yes
Quarterly Board Meeting	05/07/2012	Sacramento	Yes
Quarterly Board Meeting	08/06/2012	Sacramento	Yes
Quarterly Board Meeting	10/29/2012	Sacramento	Yes
Quarterly Board Meeting	12/10/2012	Sacramento	Yes
Quarterly Board Meeting	02/11/2013	Sacramento	Yes
Quarterly Board Meeting	05/20/2013	Sacramento	Yes
Quarterly Board Meeting	08/26/2013	Sacramento	Yes
Quarterly Board Meeting	12/09/2013	Sacramento	Yes
Quarterly Board Meeting	02/24/2014	Sacramento	Yes
Quarterly Board Meeting	05/19/2014	Sacramento	Yes
Quarterly Board Meeting	08/19/2014	Sacramento	Yes
Quarterly Board Meeting	11/03/2014	Sacramento	Yes
Interim Teleconference Board Meeting	01/16/2015	Various	Yes
Quarterly Board Meeting	02/09/2015	Sacramento	Yes
Quarterly Board Meeting	05/04/2015	Sacramento	Yes

*Reappointed after serving the Board from 1993 to 2008.

Table 1a. Attendance			
Shaquawn Schasa			
Date Appointed:	June 5, 2007		
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	08/22/2011	Sacramento	Yes
Personal Presence Subcommittee Meeting	10/03/2011	Sacramento	No
Interim Teleconference Meeting	10/10/2011	Various	Yes
Quarterly Board Meeting	11/10/2011	Sacramento	Yes
Personal Presence Subcommittee Teleconference Meeting	12/15/2011	Various	No
Quarterly Board Meeting	02/06/2012	Sacramento	Yes
Quarterly Board Meeting	05/07/2012	Sacramento	Yes
Quarterly Board Meeting	08/06/2012	Sacramento	Yes
Quarterly Board Meeting	10/29/2012	Sacramento	Yes
Quarterly Board Meeting	12/10/2012	Sacramento	Yes

*Served during grace year.

Table 1a. Attendance			
Rosalee Shorter – Current member until resignation on 07/01/2015			
Date Appointed:	February 5, 2013		
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	02/11/2013	Sacramento	Yes
Quarterly Board Meeting	05/20/2013	Sacramento	No
Quarterly Board Meeting	08/26/2013	Sacramento	Yes
Quarterly Board Meeting	12/09/2013	Sacramento	Yes
Quarterly Board Meeting	02/24/2014	Sacramento	Yes
Quarterly Board Meeting	05/19/2014	Sacramento	Yes
Quarterly Board Meeting	08/19/2014	Sacramento	Yes
Quarterly Board Meeting	11/03/2014	Sacramento	Yes
Interim Teleconference Board Meeting	01/16/2015	Various	Yes
Quarterly Board Meeting	02/09/2015	Sacramento	Yes
Quarterly Board Meeting	05/04/2015	Sacramento	Yes

Table 1a. Attendance			
Steven Stumpf, Ed.D.			
Date Appointed:	May 15, 2009		
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	08/22/2011	Sacramento	Yes
Personal Presence Subcommittee Meeting	10/03/2011	Sacramento	No
Interim Teleconference Meeting	10/10/2011	Various	Yes
Quarterly Board Meeting	11/10/2011	Sacramento	Yes
Personal Presence Subcommittee Teleconference Meeting	12/15/2011	Various	No
Quarterly Board Meeting	02/06/2012	Sacramento	Yes
Quarterly Board Meeting	05/07/2012	Sacramento	Yes
Quarterly Board Meeting	08/06/2012	Sacramento	Yes
Quarterly Board Meeting	10/29/2012	Sacramento	Yes
Quarterly Board Meeting	12/10/2012	Sacramento	Yes

*Served during grace year.

Table 1a. Attendance			
Shelia Young			
Date Appointed:	June 5, 2007		
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	08/22/2011	Sacramento	Yes
Personal Presence Subcommittee Meeting	10/03/2011	Sacramento	No
Interim Teleconference Meeting	10/10/2011	Various	Yes
Quarterly Board Meeting	11/10/2011	Sacramento	Yes
Personal Presence Subcommittee Teleconference Meeting	12/15/2011	Various	No

Table 1b. Board Member Roster					
Member Name (Include Vacancies)	Date First Appointed	Date Re-appointed	Date Term Expires	Appointing Authority	Type (public or professional)
Charles J. Alexander	2/5/2013		1/1/2016	Governor	Public
Michael Bishop, M.D.	6/18/2013		1/1/2016	Governor	Professional
Roslynn Byous, PA-C	2/4/2008		1/1/2011	Governor	Professional
Sonya Earley, PA	2/5/2013		1/1/2016	Governor	Professional
Cristina Gomez-Vidal Diaz	11/22/2005		1/1/2015	Senate	Public
Jed Grant, PA-C	2/5/2013	1/8/2015	1/1/2019	Governor	Professional
Catherine Hazelton	1/15/2013		1/1/2016	Assembly	Public
Steven Klompus, PA	1/21/2006	3/17/2008	1/1/2012	Governor	Professional
Reginald Low, M.D.	2/4/2008		1/1/2012	Governor	Professional
Xavier Martinez	2/6/2014	1/8/2015	1/1/2019	Governor	Public
Robert Sachs, PA-C	4/1/1993	3/9/2015	1/1/2019	Governor	Professional
Shaquawn Schasa	6/5/2007	3/17/2008	1/1/2012	Governor	Public
Rosalee Shorter*	2/5/2013	2/11/2015	1/1/2017	Governor	Professional
Steven Stumpf, Ed.D.	5/15/2009		1/1/2013	Assembly	Public
Shelia Young	6/5/2007		1/1/2011	Governor	Public
Vacant				Governor	Professional

*Ms. Shorter resigned her position on 7/1/2015

2. In the past four years, was the board unable to hold any meetings due to lack of quorum? If so, please describe. Why? When? How did it impact operations?

Since the submission of the last sunset report in 2012, the Board has not been impacted by a lack of quorum, and, therefore, has held every scheduled meeting.

3. Describe any major changes to the board since the last Sunset Review, including:

- **Internal changes (i.e., reorganization, relocation, change in leadership, strategic planning)**
 - **Leadership Change:** Elberta Portman, who served as the Board's Executive Officer since 2007 retired in November 2012. Glenn L. Mitchell, Jr. was appointed as the Board's Executive Officer on December 17, 2012. Mr. Mitchell has been with the Board for almost thirty years.
 - **Strategic Plan:** The Board updated and adopted a new Strategic Plan for 2014 to 2018 on February 24, 2014.
- **All legislation sponsored by the board and affecting the board since the last sunset review.**

The Board has not sponsored any legislation since the last sunset report.

The following legislation impacts the Board and licensees:

AB 415 (Logue, Chapter 547, Statutes of 2011)

The “Telehealth Advancement Act of 2011,” replaced the term “telemedicine” with the term “telehealth” in the Medical Practice Act, and removed the requirement for a written, signed patient waiver prior to the provision of telehealth services provided by health care practitioners, including physician assistants.

SB 233 (Pavley, Chapter 333, Statutes of 2011)

This bill clarified existing law to explicitly permit appropriate licensed health care personnel, including physician assistants, acting within their scope of practice, to provide treatment and consultations in the emergency department of a medical facility.

SB 943 (Committee on Business, Professions and Economic Development, Chapter 350, Statutes of 2011)

Previously, the law required the Board to issue a license to a physician assistant applicant who, among other things, provides evidence of either successful completion of an approved program, as defined, or a resident course of professional instruction (medical school) meeting certain requirements.

This bill requires that applicants provide evidence of successful completion of an approved physician assistant program only, deleting the medical school requirement.

AB 1588 (Atkins, Chapter 742, Statutes of 2012)

This bill requires boards, including the Physician Assistant Board, with certain exceptions, to waive the renewal fees, continuing education requirements, and other renewal requirements as determined by the Board, if any are applicable, of any licensee or registrant who is called to active duty as a member of the United States Armed Forces or the California National Guard if certain requirements are met. The bill, except as specified, prohibits a licensee or registrant from engaging in any activities requiring a license while a waiver is in effect. The bill requires a licensee or registrant to meet certain renewal requirements within a specified time period after being discharged from active duty service prior to engaging in any activity requiring a license. The bill requires a licensee or registrant to notify the Board of his or her discharge from active duty within a specified time period.

AB 1896 (Chesbro, Chapter 119, Statutes of 2012)

This bill exempted all health care practitioners, including physician assistants, employed by a Tribal Health Program from California licensure, as long as the practitioner is licensed in another state.

AB 1904 (Block, Chapter 399, Statutes of 2012)

This bill requires a board within the Department of Consumer Affairs, including the Physician Assistant Board, to expedite the licensure process for an applicant who holds a license in the same profession or vocation in another jurisdiction and is married to, or in a legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders.

SB 1236 (Price, Chapter 332, Statutes of 2012)

This bill renames the Physician Assistant Committee as the Physician Assistant Board, make various conforming changes relative to this change in designation, and extend the

operation of the Board until January 1, 2017. The bill revises the composition of the Board and specifies that the Board is subject to review by the appropriate policy committees of the Legislature. This bill also requires that 800-series reporting apply to physician assistants.

SB 1274 (Wolk, Chapter 793, Statutes of 2012)

This bill allowed California Shriners Hospitals to begin billing health carriers for services rendered by practitioners, including physician assistants, notwithstanding the prohibition on the corporate practice of medicine.

AB 110 (Blumenfield, Chapter 20, Statutes of 2013)

This bill made numerous appropriations, including the transfer of funds from the Physician Assistant Board to the Department of Justice for operation of the CURES program.

AB 154 (Atkins, Chapter 662, Statutes of 2013)

This bill makes it a public offense, punishable by a fine not exceeding \$10,000 or imprisonment, or both, for a person to perform an abortion if the person does not have a valid license to practice as a physician and surgeon, except that it would not be a public offense for a person to perform an abortion by medication or aspiration techniques in the first trimester of pregnancy if he or she holds a license or certificate authorizing him or her to perform the functions necessary for an abortion by medication or aspiration techniques. The bill also requires a nurse practitioner, certified nurse-midwife, or physician assistant to complete training, as specified, and to comply with standardized procedures or protocols, as specified, in order to perform an abortion by aspiration techniques, and indefinitely authorizes a nurse practitioner, certified nurse-midwife, or physician assistant who completed a specified training program and achieved clinical competency to continue to perform abortions by aspiration techniques. The bill deletes the references to a nonsurgical abortion and deletes the restrictions on assisting with abortion procedures.

AB 258 (Chavez, Chapter 227, Statutes of 2013)

This bill requires, on or after July 1, 2014, every state agency that requests on any written form or written publication, or through its internet website, whether a person is a veteran, to request that information in a specified manner.

AB 512 (Rendon, Chapter 111, Statutes of 2013)

This bill extends the date that authorizes out-of-state licensed health care practitioners to treat patients at sponsored free health care events in California from January 1, 2014 to January 1, 2018.

AB 635 (Ammiano, Chapter 707, Statutes of 2013)

This bill revises provisions from the current pilot program authorizing prescription of opioid antagonists for treatment of drug overdose and limiting civil and criminal liability, expands these provisions statewide, and removes the 2016 sunset date.

AB 1057 (Medina, Chapter 693, Statutes of 2013)

This bill requires each board, including the Physician Assistant Board, commencing January 1, 2015, to inquire in every application for licensure if the individual applying for licensure is serving in, or has previously served in, the military.

SB 304 (Lieu, Chapter 515, Statutes of 2013)

This bill, effective July 1, 2014, requires that investigators of the Medical Board of California who have the authority of a peace officer be in the Department of Consumer Affairs Division of Investigation and protects the positions, status, and rights of those employees who are subsequently transferred as a result of these provisions. The bill also, effective July 1, 2014, created within the Division of Investigation the Health Quality Investigation Unit.

Previously, the Board utilized the services of the Medical Board of California Investigation Unit. Now, the Department of Consumer Affairs Division of Investigations Health Quality Investigation Unit handles physician assistant investigations.

SB 352 (Pavley, Chapter 286, Statutes of 2013)

This bill deletes the requirement that the services performed by the medical assistant be in a specified clinic when under the specific authorization of a physician assistant, nurse practitioner, or certified nurse-midwife. The bill would prohibit a nurse practitioner, certified nurse-midwife, or physician assistant from authorizing a medical assistant to perform any clinical laboratory test or examination for which the medical assistant is not authorized, as specified, a violation of which would constitute unprofessional conduct.

SB 493 (Hernandez, Chapter 469, Statutes of 2013)

This bill establishes advanced practice pharmacists, thereby allowing an expanded scope of practice for pharmacists, and allows advanced practice pharmacists to perform physical assessments, request and evaluate drug related testing, and refer patients to other health care providers, among other things.

SB 494 (Monning, Chapter 684, Statutes of 2013)

This bill requires a health care service plan licensed by the Department of Managed Health Care to ensure one primary care physician for every 2,000 enrollees and authorizes up to an additional 1,000 enrollees for each full-time equivalent non-physician medical practitioner supervised by that primary care physician until January 1, 2019.

SB 809 (DeSaulnier, Chapter 400, Statutes of 2013)

This bill establishes the CURES Fund within the State Treasury to receive funds to be allocated, upon appropriation by the Legislature, to the Department of Justice for the purposes of funding CURES, and would make related findings and declarations.

This bill, beginning April 1, 2014, requires an annual fee of \$6 to be assessed on specified licensees, including licensees authorized to prescribe, order, administer, furnish, or dispense controlled substances, and require the regulating agency of each of those licensees to bill and collect that fee at the time of license renewal. The bill authorizes the Department of Consumer Affairs to reduce, by regulation, that fee to the reasonable cost of operating and maintaining CURES for the purpose of regulating those licensees, if the reasonable regulatory cost is less than \$6 per licensee. The bill requires the proceeds of the fee to be deposited into the CURES Fund for the support of CURES. The bill also permits specified insurers, health care service plans, qualified manufacturers, and other donors to voluntarily contribute to the CURES Fund, as described.

AB 1841 (Mullin, Chapter 333, Statutes of 2014)

This bill specifies that the “technical supportive services” a medical assistant may perform in those California State Board of Pharmacy licensed facilities also includes handing to a patient a properly labeled and prepackaged prescription drug, other than a controlled substance, ordered by a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife.

AB 2139 (Eggman, Chapter 568, Statutes of 2014)

When a health care provider, as defined, makes a diagnosis that a patient has a terminal illness, existing law requires the health care provider to provide the patient, upon the patient’s request, with comprehensive information and counseling regarding legal end-of-life options, as specified, and provide for the referral or transfer of a patient, as provided, if the patient’s health care provider does not wish to comply with the patient’s request for information on end-of-life options.

This bill applies these provisions to another person authorized to make health care decisions, as defined, for a patient with a terminal illness diagnosis. The bill additionally requires the health care provider to notify, except as specified, the patient or, when applicable, the other person authorized to make health care decisions, when the health care provider makes a diagnosis that a patient has a terminal illness, of the patient’s and the other authorized person’s right to comprehensive information and counseling regarding legal end-of-life care options.

SB 1083 (Pavley, Chapter 438, Chapter 2014)

This bill amends the Physician Assistant Practice Act to authorize a physician assistant to certify disability, after performance of a physical examination by the physician assistant under the supervision of a physician and surgeon consistent with the act. The bill expands the definition of practitioner to include a physician assistant. This bill requires the Employment Development Department to implement these provisions on or before January 1, 2017.

SB 1226 (Correa, Chapter 657, Statutes of 2014)

This bill, on and after July 1, 2016, requires a board, including the Physician Assistant Board, to expedite, or when applicable assist, the initial licensure process for an applicant who supplies satisfactory evidence to the Board that he or she has served as an active duty member of the Armed Forces of the United States and was honorably discharged.

SB 2102 (Ting, Chapter 420, Statutes of 2014)

This bill requires the Board to collect and report specific demographic data relating to its licensees, subject to a licensee’s discretion to report his or her race or ethnicity, to the Office of Statewide Health Planning and Development. The bill requires the board to collect this data at least biennially, at the times of both issuing an initial license and issuing a renewal license.

AB 637 (Campos, Chapter 217, Statutes of 2015)

This bill authorizes the signature of a nurse practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law to create a valid Physician Orders for Life Sustaining Treatment form (POLST).

AB 679 (Allen, Chapter 778, Statutes of 2015)

This bill delays an existing requirement for prescribers and dispensers to register on the Controlled Substance Utilization Review and Evaluation System prescription drug database by January 1, 2016 to July 1, 2016.

SB 337 (Pavley, Chapter 536, Statutes of 2015)

This bill requires that the medical record for each episode of care for a patient identify the physician and surgeon who is responsible for the supervision of the physician assistant. The bill deletes those medical record review provisions, and, instead, requires the supervising physician and surgeon to use one or more of described review mechanisms. By adding these new requirements, the violation of which would be a crime, this bill imposes a state-mandated local program by changing the definition of a crime.

This bill establishes an alternative medical records review mechanism, and would authorize the supervising physician and surgeon to use the alternative mechanism, or a sample review mechanism using a combination of the 2 described mechanisms, as specified, to ensure adequate supervision of the administration, provision, or issuance by a physician assistant of a drug order to a patient for Schedule II controlled substances.

SB 464 (Hernandez, Chapter 387, Statutes of 2015)

This bill, notwithstanding any other law, authorizes a physician and surgeon, a registered nurse acting in accordance with the authority of the Nursing Practice Act, a certified nurse-midwife acting within the scope of specified existing law relating to nurse-midwives, a nurse practitioner acting within the scope of specified existing law relating to nurse practitioners, a physician assistant acting within the scope of specified existing law relating to physician assistants, or a pharmacist acting within the scope of a specified existing law relating to pharmacists to use a self-screening tool that will identify patient risk factors for the use of self-administered hormonal contraceptives by a patient, and, after an appropriate prior examination, to prescribe, furnish, or dispense, as applicable, self-administered hormonal contraceptives to the patient. The bill authorizes blood pressure, weight, height, and patient health history to be self-reported using the self-screening tool.

SB 800 (Committee on Business, Professions and Economic Development, Chapter 426, Statutes of 2015)

Previously, the Physician Assistant Practice Act requires the Physician Assistant Board to annually elect a chairperson and vice chairperson from among its members.

This bill would require the annual election of a president and vice president from among its members.

- **The following regulation changes have been completed since the last Sunset Report.**
 - 2012 – Requirements for Preceptors – 1399.536 Amended:
This proposal would expand the type of licensed health care providers who may act as preceptors to include physicians and surgeons, physician assistants, registered nurses who have been certified in advanced practice, certified nurse midwives, licensed clinical social workers, marriage and family therapists, licensed educational psychologists, and licensed psychologists.

- 2013 - Sponsored Free Health Care Events – 1399.620, 1399.621, 1399.622, 1399.623
Adopted:
This statute provides a regulatory framework for certain health care events at which free care is offered to uninsured or under-insured individuals by volunteer health care practitioners where those practitioners may include individuals who may be licensed in one or more states, but are not licensed in California.
- 2013 – Technical Clean-up Section 100 – 1399.501, 1399.502, 1399.503, 1399.506, 1399.507, 1399.507.5, 1399.511, 1399.521, 1399.521.5, 1399.523, 1399.523.5, 1399.526, 1399.527, 1399.530, 1399.540, 1399.543, 1399.545, 1399.547, 1399.557, 1399.557, 1399.570, 1399.571, 1399.572, 1399.610, 1399.612, 1399.616, 1399.617, 1399.618, 1399.619 Amended:
Name changed from Physician Assistant Committee to Physician Assistant Board.
- 2013 – Review of Physician Assistant Application; Processing Time – 1399.512
Repealed.
- 2014 – Sponsored Free Health Care Events – 1399.621 Amended:
Section 100 – update Department of Consumer Affairs form 901-A.
- 2014 - Personal Presence – Medical Board of California Regulatory Package – 1399.541 Amended:
This proposal would permit a physician assistant to act as a first or second assistant in surgery without the personal presence of the supervising physician if the supervising physician is immediately available to the physician assistant. “Immediately available” means able to return to the patient, without delay, upon the request of the physician assistant or to address any situation requiring the supervising physician’s services.

4. Describe any major studies conducted by the board (cf. Section 12, Attachment C).

Since the last sunset report the Board has not conducted any major studies.

5. List the status of all national associations to which the board belongs.

- Does the board’s membership include voting privileges?
- List committees, workshops, working groups, task forces, etc., on which board participates.
- How many meetings did board representative(s) attend? When and where?
- If the board is using a national exam, how is the board involved in its development, scoring, analysis, and administration?

The Physician Assistant Board is not a member of any national associations, and thus, has not attended any national association conferences.

The Board utilizes the National Commission on Certification of PA's (NCCPA) Physician Assistant National Certifying Examination (PANCE) as its licensing examination.

The Board is not involved in the PANCE’s examinations development, scoring, analysis, or administration.

**Section 2 –
Performance Measures and Customer Satisfaction Surveys**

6. Provide each quarterly and annual performance measure report for the board as published on the DCA website (Section 12, Attachment E)

		2011 – 2012 Fiscal Year					2012 – 2013 Fiscal Year				
Measure	Target	1 st Qtr	2 nd Qtr	3 rd Qtr	4 th Qtr	Annual	1 st Qtr	2 nd Qtr	3 rd Qtr	4 th Qtr	Annual
Volume – Number of complaints and convictions received.	N/A	64	64	47	79	254	67	72	65	78	282
Intake – Average cycle time from complaint receipt to investigator assignment.	10	12	15	12	11	12.5	10	16	8	11	11.25
Intake and Investigation – Average cycle time from complaint receipt to closure of investigation time.	150	118	113	101	82	103.5	85	74	98	98	88.75
Formal Discipline – Average number of days to complete entire enforcement process.	540	520	483	825	477	576.25	576	1066	700	110	613
Probation Intake – Average number of days from monitor assignment to first probationer contact..	14	3	4	4	4	3.75	5	7	5	1	4.5
Probation Violation Response – Average number of days from date probation violation reported to appropriate action initiated by monitor.	7	8	2	3	3	4	7	5	7	2	5.25

		2013 – 2014 Fiscal Year					2014 – 2015 Fiscal Year				
Measure	Target	1 st Qtr	2 nd Qtr	3 rd Qtr	4 th Qtr	Annual	1 st Qtr	2 nd Qtr	3 rd Qtr	4 th Qtr	Annual
Volume – Number of complaints and convictions received.	N/A	84	85	86	96	351	76	81	*	*	*
Intake – Average cycle time from complaint receipt to investigator assignment.	10	8	12	11	15	11.5	16	17	*	*	*
Intake and Investigation – Average cycle time from complaint receipt to closure of investigation time.	150	93	*	*	*	*	*	*	*	*	*
Formal Discipline – Average number of days to complete entire enforcement process.	540	473	*	*	*	*	*	*	*	*	*
Probation Intake – Average number of days from monitor assignment to first probationer contact..	14	3	N/A	4	N/A	3.5	N/A	N/A	*	*	*
Probation Violation Response – Average number of days from date probation violation reported to appropriate action initiated by monitor.	7	N/A	N/A	3	N/A	3	N/A	N/A	*	*	*

*Consistent data not yet available from BreEZe.

7. Provide results for each question in the board’s customer satisfaction survey broken down by fiscal year. Discuss the results of the customer satisfaction surveys.

The Board receives few customer satisfaction surveys. Generally, it has been our experience that consumers tend to submit surveys when they are unhappy with the services they have received from the Board.

The Board often receives inquiries and complaints that are not related to the Board, consumer protection, and licensing. Consumers are often confused in that they think we provide “physician assistance.” The belief is that we are able to “assist” consumers with their concerns regarding their physicians, medical care, medical insurance related matters, and medical record concerns. By taking on the “assistants” role we are happy to assist them and refer them to the appropriate agencies that would be best able to respond to their inquiries.

Board staff reviews the survey results and proactively address concerns and implement changes to policies and procedures in regard to the survey feedback received. The Board's goal is to ensure that consumers, applicants, licensees, and interested others receive excellent customer service. **(Section 12, Attachment F)**

1. Thinking about your most recent contact with us, how would you rate the availability of staff to assist you?

Response	FY 11/12	FY 12/13	FY 13/14	FY 14/15
Excellent	5	2	2	2
Very Good	0	0	1	0
Good	0	0	1	2
Fair	1	0	1	0
Poor	3	2	5	1
Not applicable	0	1	0	1

2. When requesting information or documents, how would you rate the timeliness with which the information or documents was/were provided?

Response	FY 11/12	FY 12/13	FY 13/14	FY 14/15
Excellent	4	1	2	2
Very Good	0	0	1	0
Good	0	0	0	0
Fair	1	0	0	0
Poor	4	2	6	2
Not applicable	0	2	1	2

3. When you visited our web site, how would you rate the ease of locating information?

Response	FY 11/12	FY 12/13	FY 13/14	FY 14/15
Excellent	4	2	2	2
Very Good	1	0	1	0
Good	2	0	2	0
Fair	1	0	2	1
Poor	1	3	3	3
Not applicable	0	0	0	0

4. When you submitted an application, how would you rate the timeliness with which your application was processed?

Response	FY 11/12	FY 12/13	FY 13/14	FY 14/15
Excellent	3	1	2	1
Very Good	0	0	0	0
Good	0	0	0	1
Fair	0	0	0	0
Poor	4	2	3	2
Not applicable	2	2	4	2

5. When you filed a complaint, how would you rate the timeliness of the complaint process?

Response	FY 11/12	FY 12/13	FY 13/14	FY 14/15
Excellent	1	0	0	0
Very Good	0	0	0	0
Good	0	0	0	0
Fair	1	0	0	0
Poor	2	2	4	1
Not applicable	4	3	5	5

6. When you contacted us, were your service needs met? If no, please explain.

Response	FY 11/12	FY 12/13	FY 13/14	FY 14/15
Yes	4	2	4	3
No	4	2	5	3

7. Additional comments or suggestions.

The following written comments were received as part of the customer satisfaction survey.

FY 2011/2012

- NO, I wrote a letter about the caliber of the horrible attitude and rudeness that I experienced when I called the hotline for questions on my renewal by Lynn, I would be embarrassed to have this person working for me.
- I submitted my renewal approximately three weeks ahead of time by overnight mail. It was signed for on the 27th of July. I was then told that the address my renewal was sent to, (the address the web site provides) was not the address that would be consistent with efficient processing.
- I wanted to know if my renewal check was received that I mailed 3 weeks ago and I was not able to receive an answer. I was told to send another check with an additional \$10 fee for the expedited service.

FY 2012/2013

- The California Physician Assistant Committee is horrible! As a Physician Assistant with a husband in the military, I have had to move many times due to his career. Never have I had more difficulty with a PA office trying to obtain a license! When we were first moving here, I had to mail paperwork in 3 times because it was being lost! These were certified letters! How am I supposed to start working if I can't be licensed because of your office's errors? I suppose pay checks fall from the sky! The woman on the phone said that a lot of the mail gets dropped off at the Medical Board's office next door and that it just sits there for months. That no one from either office drops off mail that belongs to the other office. I finally had to tell her to get off her a** and go over and get it or I would file a complaint! The same thing happened to a PA friend of mine that moved to Bakersfield. Your office lost multiple documents that were being sent to the Medical Board's office. When I found out that she was trying to get a CA license for OVER 6 MONTHS I told her about what happened to me. Suddenly, the problem was fixed when she told your employees about sending them multiple forms...which by the way we have to pay to send and have notarized.

FY 2013/2014

- No, the service that I requested was not met, and the physicians so far, has seem to treat patients as clients. My health is a matter of earning money to them instead of having empathy to the patients.
- I found information to complete application.
- Trying to verify my license, which is due for renewal the end of the month, I paid the bill 10/9 and I'm trying to see if my information has been updated, but it doesn't even come

up with my license number at all! Now I'm going in circles, being re-directed to the same dead ends. Time consuming and frustrating.

- Incompetence at its finest. Do you people really get paid for what you do?
- Made phone contact with Sacramento office and received great help.
- Because family health center Dr. should help me but she do not do, also she told me do not go to work. I am only 42 years old. I need just only Dr. to sign that it. She want do it for me. Anyway I am in San Diego, CA.
- You never bothered to contact me despite the fact the PA I complained about ignored HIPPA guidelines, interfered with my care with other doctors and sent false information to my insurance because Jews don't get autoimmune disorders-apparently they just lie. Oddly I'm not Jewish but it's awesome none of your laws are actually enforced.

FY 2014/2015

- Not yet
- Spoke with a real live person!!!
- It was a total waste of time.
- Office closed Sunday and info not available on website.

Section 3 – Fiscal and Staff

Fiscal Issues

8. Describe the board's current reserve level, spending, and if a statutory reserve level exists.

Table 2 indicates the Board's fund condition for the past four fiscal years and the expected fund condition through 2016/17 fiscal year. The fund currently has a 14 month reserve. Given the Board's small budget and limited revenue sources, it is believed that the month's in reserve is necessary to cover unexpected expenses.

The Board typically spends approximately 92% of its budget authority and reverts approximately 8% each year.

9. Describe if/when a deficit is projected to occur and if/when fee increase or reduction is anticipated. Describe the fee changes (increases or decreases) anticipated by the board.

Current projections do not indicate a deficit will occur in the next four fiscal years. Therefore, the Board does not anticipate that a fee increase will be required.

(Dollars in Thousands)	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16	FY 2016/17
Beginning Balance	2,174	973	1,240	1,531	1,763	1,833
Revenues and Transfers	1,367	1,423	1,569	1,646	1,594	1,595
Total Revenue	\$2,062	\$2,420	\$2,865	\$3,201	\$3,357	\$3,428
Budget Authority						
Expenditures	1,089	1,180	1,334	1,437	1,524	1,546
Loans to General Fund	-1,500	0	0	0	0	0
Accrued Interest, Loans to General Fund	0	0	0	0	0	0
Loans Repaid From General Fund	0	0	0	0	0	0
Fund Balance	\$973	\$1,240	\$1,531	\$1,763	\$1,833	\$1,882
Months in Reserve	9.9	11.2	12.8	13.9	14.2	14.3

10. Describe the history of general fund loans. When were the loans made? When have payments been made to the board? Has interest been paid? What is the remaining balance?

The Board made a \$1.5 million General Fund (GF) loan during FY 2011/12. No payments have been made to the Board, but the Board has accrued interest from this loan.

11. Describe the amounts and percentages of expenditures by program component. Use Table 3. Expenditures by Program Component to provide a breakdown of the expenditures by the board in each program area. Expenditures by each component (except for pro rata) should be broken out by personnel expenditures and other expenditures.

Over the last four fiscal years, the average expenditure for the Board was \$941,000. These expenditures exclude the pro-rata amounts and are broken down as 66% on enforcement, 6% on licensing, 4% on administration, and 11% on diversion. Also, personnel expenditure for the Board was \$397,000. These personnel expenditures are broken down as 17% on enforcement, 25% on licensing, 42% on administration, and 16% on diversion.

	FY 2011/12		FY 2012/13		FY 2013/14		FY 2014/15	
	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E
Enforcement	64	469	63	522	60	732	75	753
Examination	0	0	0	0	0	0	0	0
Licensing	95	49	95	55	90	55	113	66
Administration*	176	47	198	40	138	36	161	39
DCA Pro Rata	0	101	0	106	0	131	0	134
Diversion (if applicable)	64	107	63	126	60	109	75	90
TOTALS	\$398	\$773	\$419	\$848	\$348	\$1,062	\$424	\$1,082

*Administration includes costs for executive staff, board, administrative support, and fiscal services.

12. Describe license renewal cycles and history of fee changes in the last 10 years. Give the fee authority (Business and Professions Code and California Code of Regulations citation) for each fee charged by the board.

Business and Professions Code Section 3523 establishes the birthdate renewal cycle for physician assistant licenses. Physician assistant licenses expire at 12 midnight on the last day of the birth month every two years. Thus, the cycle is a biennial renewal fee cycle.

Application, initial license, renewal, delinquency, and duplicate license fees are at their statutory limits as established by Business and Professions Code Section 3521.1.

The last physician assistant application and renewal fee change took place in fiscal year 2001/02.

Prior to the fee change, the initial license fee was \$100.00. After July 1, 2000, the fee increased to \$200.00.

Previously, the biennial renewal fee was \$150.00. For licenses expiring on or after July 1, 2000, the renewal fee increased to \$250.00. For licenses expiring on or after July 1, 2002, the renewal fee increased to \$300.00.

Fee increases were necessary as supervising physician application and renewal fees provided approximately 60% of the Board's revenue. The supervising physician approvals were eliminated effective July 1, 2001.

Other Fees

Diversion Program participants

Previously, Diversion Program participants paid a \$100 participation fee with the Board paying the remaining fee.

On January 19, 2011, Title 16, California Code of Regulations Section 1399.557 became effective which requires Board-referred participants to pay the full monthly participation fee charged by the program contractor. Self-referral participants pay 75% of the participation fee. The current program participation fee is \$338.15.

CURES fee

Effective with April 2014 physician assistant license renewals, licensees are assessed \$6 annually (\$12 per renewal cycle) which is collected at the time of renewal of the license to cover the operation and maintenance of the Controlled Substance Utilization Review and Evaluation System (CURES) pursuant to Business and Professions Code Section 208 (SB 809 – DeSaulnier, Chapter 400, Statutes of 2013).

Table 4. Fee Schedule and Revenue							(list revenue dollars in thousa
Fee	Current Fee Amount	Statutory Limit	FY 2011/12 Revenue	FY 2012/13 Revenue	FY 2013/14 Revenue	FY 2014/15 Revenue	% of Total Revenue
License Verification	\$10.00	N/A	\$4	\$5	\$4	\$4	.28%
Duplicate License	\$10.00	N/A	\$3	\$32	\$3	\$2	.20%
Citation/Fine	Various	N/A	\$2.75	\$5.	\$4.8	\$6.05	.32%
App/Initial License	\$225.00	1 year	\$159	\$157	\$173	\$246	12.41%
Renewals	\$300.00	2 Years	\$1193	\$1250	\$1308.	\$1377	86.56%
Delinquent Fee	\$25.00	1 year	\$3	\$3	\$3	\$4	.23%

13. Describe Budget Change Proposals (BCPs) submitted by the board in the past four fiscal years.

No Board-sponsored budget change proposals were submitted by the Board in the past four fiscal years.

Staffing Issues

14. Describe any board staffing issues/challenges, i.e., vacancy rates, efforts to reclassify positions, staff turnover, recruitment and retention efforts, succession planning.

The Board staff is comprised of an Executive Officer, two full-time Associate Governmental Program Analysts (AGPA), one full-time Staff Services Analyst (SSA), and one half-time Office Technician (OT).

One AGPA serves as the Board's enforcement analyst, the other AGPA serves as the Board's lead licensing analyst. The Board's SSA functions as the Board's administrative analyst. The OT functions as the Board's licensing technician, issuing physician assistant licenses.

Core staff tends to remain with the Board for long periods of time. The Board's former executive officer was with the Board for seven years. The former AGPA-Enforcement was with the Board for almost twenty years until her retirement. The current AGPA-Enforcement has been with the Board for almost ten years. The current Executive Officer has served at the Board for almost thirty years.

Succession planning and knowledge transfer are ongoing challenges at the Board due to the limited number of positions authorized. While the limited number of positions presents challenges it also presents opportunities at the Board. Existing staff are exposed to and become knowledgeable about most of the Board's functions, including administration, licensing, and enforcement.

Staff is encouraged to become cross-trained and be aware of Board functions outside their area of knowledge and training. This ensures that when existing staff are on vacation, ill or when positions become vacant, the Board continues to function by staff being capable of performing the job duties.

Due to their expanded knowledge of job functions, staff is encouraged to apply for vacant positions within the Board. This helps ensure that knowledge transfer takes place. Many existing staff has taken advantage of promotional opportunities at the Board.

15. Describe the board's staff development efforts and how much is spent annually on staff development (Section 12, Attachment D).

Staff is encouraged to attend training to allow for enhancement of their existing skills or to learn new skills.

Many of the training classes are offered by the Department of Consumer Affairs and other state agencies. These classes are offered at no cost to the Board.

The Board's office technician recently completed the Department's "Completed Staff Work" classes which will prepare that employee for advancement to analyst classification positions.

Section 4 – Licensing Program

16. What are the board's performance targets/expectations for its licensing² program? Is the board meeting those expectations? If not, what is the board doing to improve performance?

The Board's goal is to initially review applications and respond to the applicants within two weeks of receiving their application. Generally, applications that do not have issues with regard to conviction, or disciplinary actions taken against other licenses are reviewed, processed, and licenses issued within two to four weeks of receipt of the application.

The Board has been meeting the processing expectations it has set. Some applications can go beyond the four week target time. Reasons for the increased processing times include:

- awaiting documentation from outside agencies,
- delays in receiving fingerprint clearances,
- initial application submitted is incomplete, and
- delays in cashiering application and initial licensing fees.

While these issues are outside of the Board's control, every effort is made to review and process the applications as quickly as possible. Additionally, applications may be delayed because applicants have criminal convictions, or disciplinary actions taken against other licenses they hold. Obviously, the Board requires additional time to review these applications to make an appropriate determination regarding the issuance of the license.

² The term "license" in this document includes a license certificate or registration.

17. Describe any increase or decrease in the board's average time to process applications, administer exams and/or issue licenses. Have pending applications grown at a rate that exceeds completed applications? If so, what has been done by the board to address them? What are the performance barriers and what improvement plans are in place? What has the board done and what is the board going to do to address any performance issues, i.e., process efficiencies, regulations, BCP, legislation?

Applicants are required to meet the following requirements for licensure set forth in Business and Professions Code Section 3519:

- Provide evidence of successful completion of an approved physician assistant training program.
- Take and pass the NCCPA PANCE exam.
- Not be subject to denial of licensure under Division 1.5 (commencing with Section 475) or Section 3527.
- Pay all required fees.

Additionally, applicants must be fingerprinted and; if applicable, provide verification of other health care related licenses.

The Board's average time to process applications has been fairly consistent over the last four fiscal years. The Board believes the implementation of BreEZe in October 2013 has decreased the processing time for physician assistant applications, leading to greater efficiency within the Board's licensing program.

Several performance barriers that are more often experienced by the Board include:

- Influx of received applications – the Board experiences an increase in applications typically between May through September as many students graduate from their physician assistant program during this time.
- Fingerprint card rejections – if the manual card is rejected for any reason the Board submits a second card, which takes approximately two weeks to process. If the second card is rejected, the Board must submit a "name search," with the Department of Justice which may take an additional 30 days. Additionally, delays may be experienced for applicants who use the live scan process due to prints not clearly obtained by the live scan operator and occasional transmittal issues between the Department of Justice and the Board.
- The Licensing Technician is a half-time position.

The Board has addressed these barriers by implementing the following procedures:

- Deficiency and license issued notices to applicants are generated by BreEZe, which results in consistent and standardized correspondence, with less time for staff to prepare and address notices. Staff also communicates with the applicants via email which decreases the response time for needed documents.
- The fingerprint process is out of the Board's control; however, if the applicant is going to be in California we encourage them to utilize the live scan process while in California.
- Since all staff is crossed trained in each area of the Board's functions, other staff are able to cover the position in the absence of the Licensing Technician.

18. How many licenses or registrations does the board issue each year? How many renewals does the board issue each year?

Table 6. Licensee Population

		FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
Physician Assistant	Active	8646	9101	9482	10293
	Out-of-State	637	682	#	#
	Out-of-Country	5	3	#	#
	Delinquent	187	232	294	318

#With the implementation of BreZE the Board does not track this information.

Table 7a. Licensing Data by Type

	Application Type	Received	Approved	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 2011/12	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	704	689	5	689	10	0	0	68	0	68
	(Renewal)	3977	3977	n/a	3977	n/a	n/a	n/a	n/a	n/a	n/a
FY 2012/13	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	698	701	24	701	27	0	2	65	0	65
	(Renewal)	4210	4210	n/a	4210	n/a	n/a	n/a	n/a	n/a	n/a
FY 2013/14	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	852	779	34	779	41	0	1	53	48	58
	(Renewal)	4360	4360	n/a	4360	n/a	n/a	n/a	n/a	n/a	n/a
FY 2014/15	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	991	869	66	870	59	35	37	43	57	29
	(Renewal)	4705	4705	n/a	4705	n/a	n/a	n/a	n/a	n/a	n/a

* Optional. List if tracked by the board.

Table 7b. Total Licensing Data				
	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
Initial Licensing Data:				
Initial License Applications Received	704	698	852	991
Initial License Applications Approved	689	701	779	869
Initial License Applications Closed	5	24	34	66
License Issued	689	701	779	870
Initial License/Initial Exam Pending Application Data:				
Pending Applications (total at close of FY)	10	27	41	59
Pending Applications (outside of board control)*	0	0	0	35
Pending Applications (within the board control)*	0	2	1	37
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):				
Average Days to Application Approval (All - Complete/Incomplete)	68	65	53	43
Average Days to Application Approval (incomplete applications)*	0	0	48	57
Average Days to Application Approval (complete applications)*	68	65	58	29
License Renewal Data:				
License Renewed	3977	4210	4360	4705
* Optional. List if tracked by the board.				

19. How does the board verify information provided by the applicant?

a. What process does the board use to check prior criminal history information, prior disciplinary actions, or other unlawful acts of the applicant?

The Board requires that all applicants submit to criminal background checks as part of the licensing review process.

Two questions on the application for licensure require that applicants disclose under penalty of perjury any disciplinary actions, denials, or convictions related to licenses held in other health care professions and in other states. Applicants are also required to disclose criminal convictions. If an applicant discloses criminal convictions, they must also submit, as part of their application, certified arrest and court documents as well as an explanation of the matter. If arrest or court documents are no longer available, the applicant must obtain from the respective agency letters stating that the documents are no longer available.

Applicants must also include on the application if they have a medical condition that may impair their ability to practice as a physician assistant with reasonable skill and safety.

The training program verification, completed by the applicant's physician assistant training program, includes a questions related to absences, disciplinary actions, or any other sanctions.

All applicants are required to submit “Live Scan” electronic fingerprints or fingerprint cards (for those applicants who are not located in California and, thus unable to utilize the Live Scan system) in order to obtain criminal history clearances from the California Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI).

Applicants with criminal backgrounds are subject to additional review. Board staff and the Executive Officer, based on their review, may issue a clear license, a probationary license with specific terms and conditions, or deny the application. Applicants may appeal the decision and request a hearing before an administrative law judge, pursuant to the Administrative Procedures Act.

Physician assistant licenses are not issued until background clearance is obtained from both the DOJ and FBI. Additionally, since applicants are fingerprinted, the Board is then notified of any subsequent criminal conviction information. Based on this information, the Board is able to determine if disciplinary action should be taken against the licensee.

b. Does the board fingerprint all applicants?

Yes, all applicants for licensure are fingerprinted. Fingerprints are used to obtain criminal history records from the DOJ and FBI for convictions of crimes substantially related to the practice as a physician assistant.

c. Have all current licensees been fingerprinted? If not, explain.

All applicants for licensure as a physician assistant have been fingerprinted and subject to DOJ and FBI background checks as part of the licensure process. Fingerprinting of applicants has occurred since physician assistants were first licensed in 1976.

d. Is there a national databank relating to disciplinary actions? Does the board check the national databank prior to issuing a license? Renewing a license?

Yes, the Board utilizes the National Practitioner Data Bank (NPDB) as part of the initial application process to determine disciplinary actions that may have been taken against applicants who have been licensed in other health care categories in or out of California. The Board believes that the NPDB is a valuable tool to assist in determining an applicant's fitness for licensure. Additionally, the Board reports to the NPDB.

The Board does not query the NPDB for license renewals.

e. Does the board require primary source documentation?

Yes, the Board requires primary source documentation as part of the licensure process.

Documents required in the application process include:

- Certification of completion of a physician assistant training program. Certification must be submitted directly from the training program to the Board.
- Certification of passing score of the Physician Assistant National Certification Examination. Certifications must be submitted directly from the National Commission on Certification of Physician Assistants to the Board.
- Verification of licensure or registration as a physician assistant and/or other health care provider from other states or agencies. Verifications must be submitted directly from the respective licensing agencies to the Board.

- Applicants must be fingerprinted. Fingerprints are used to obtain the criminal history records from the Federal Bureau of Investigation and the California Department of Justice for convictions of crimes substantially related to the practice as a physician assistant.

20. Describe the board's legal requirement and process for out-of-state and out-of-country applicants to obtain licensure.

The Board's licensing process is the same for in-state, out-of-state, and out-of-country applicants. No additional or alternative applicant review processes occur to determine eligibility of in-state, out-of-state, or out-of-country applicants. All applicants for licensure must meet the same licensing requirements.

21. Describe the board's process, if any, for considering military education, training, and experience for purposes of licensing or credentialing requirements, including college credit equivalency.

a. Does the board identify or track applicants who are veterans? If not, when does the board expect to be compliant with BPC § 114.5?

The physician assistant application (paper and online) contains a question asking applicants if they have served in the military. We are also now asking licensees who renew their licenses to report to us their current or past military service. This information is added to their licensing records.

b. How many applicants offered military education, training or experience towards meeting licensing or credentialing requirements, and how many applicants had such education, training or experience accepted by the board?

Physician assistants who were trained and serve in the military are educated and meet the same qualification standards as civilian physician assistants. Military physician assistants attend the U.S. military's Interservice Physician Assistant Program (IPAP), which is ARC-PA approved. IPAP students then take and pass the National Commission on Certification of Physician Assistants (NCCPA) Physician Assistant National Certifying Examination (PANACE).

Military physician assistants meet the same requirements as is required for California licensure.

Therefore, military physician assistants would not be seeking equivalency credit.

c. What regulatory changes has the board made to bring it into conformance with BPC § 35?

Title 16, California Code of Regulations Section 1399.530(b) states that educational programs accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) are deemed approved by the Board. Therefore, if a physician assistant training program is approved by ARC-PA, the training program is also approved by the Board.

Because the Board's role is approving physician assistant training program, the Board is not involved in evaluating education, training, and experience of potential applicants applying for admission to a physician assistant training program.

Ultimately, physician assistant training programs review an applicant's background, including military or civilian experience, in determining their acceptance into the program.

It should be noted that the Board has approved the Interservice Physician Assistant Program (IPAP). IPAP is a military physician assistant training program located at the Academy of Health Sciences, Army Medical Center and School, at Fort Sam Houston, San Antonio, Texas. IPAP has an educational agreement with the University of Nebraska Medical Center, Omaha, Nebraska.

The program's mission is to educate and train physician assistants for the uniform services, including the United States Army, Air Force, Navy, and Coast Guard.

The IPAP program meets the ARC-PA standards, and is, thus approved by the Board. IPAP graduates must also take and pass the PANCE exam to work as military physician assistants.

Graduates of the program are also eligible for licensure as physician assistants in California.

d. How many licensees has the board waived fees or requirements for pursuant to BPC § 114.3, and what has the impact been on board revenues?

Since Business and Professions Code section 114.3 was added, the Board has received 2 requests for fee waivers. Both requests were granted.

Fee waivers granted pursuant to Business and Professions Code section 114.3 have had no impact on the Board's revenue.

e. How many applications has the board expedited pursuant to BPC § 115.5?

Since Business and Professions Code section 115.5 was added, the Board has expedited 15 applications for licensure. Generally all applications regardless of their type are processed within two to four weeks.

22. Does the board send No Longer Interested notifications to DOJ on a regular and ongoing basis? Is this done electronically? Is there a backlog? If so, describe the extent and efforts to address the backlog.

Yes, pursuant to California Penal Code section 11105.2(d), the Board submits No Longer Interested notifications to the Department of Justice on a regular and ongoing basis. For example, when a physician assistant application is abandoned by the applicant, the Board submits a No Longer Interested notification to DOJ.

No, the No Longer Interested notifications are not set electronically. They are submitted by FAX to the DOJ.

The Board is not experiencing a backlog with regard to submittal of the No Longer Interested notifications.

Examinations

Table 8. Examination Data		
National Examination: Physician Assistant National Certifying Examination (PANCE)		
	License Type	Physician Assistant
	Exam Title	PANCE
FY 2011/12	# of 1 st Time Candidates	6054
	Pass %	91%
FY 2012/13	# of 1 st Time Candidates	6335
	Pass %	93%
FY 2013/14	# of 1 st Time Candidates	6495
	Pass %	94%
FY 2014/15	# of 1 st time Candidates	7435
	Pass %	95%
	Date of Last OA	2015
	Name of OA Developer	Arbet Consulting
	Target OA Date	Every 5 years

23. Describe the examinations required for licensure. Is a national examination used? Is a California specific examination required?

Yes, a national examination is used. Title 16, California Code of Regulations Section 1399.507 states that the written examination for licensure of the physician assistants is the examination administered by the National Commission on Certification of Physician Assistants (NCCPA).

There is currently no California-specific examination required.

The examination used by the Board, which is owned and administered by the NCCPA is called the Physician Assistant National Certifying Examination (PANCE).

According to the NCCPA, exam questions are developed by committees comprising of physician assistants and physicians selected based on their item writing skills, experience and demographic characteristics (i.e., practice specialty, geographic region, practice setting, etc.). The test committee members each independently write a certain number of test questions or items, and then, each item then goes through an intense review by content experts and medical editors from which only some items emerge for pre-testing. Every NCCPA exam includes both scored and pre-test items, and examinees have no way of distinguishing between the two. This allows NCCPA to collect important statistics about how the pre-test items perform on the exam, which informs the final decision about whether a particular question meets the standards for inclusion as a scored item on future PANCE or Physician Assistant National Recertifying Examination (PANRE) exams. The PANRE is the NCCPA's recertification examination.

When NCCPA exams are scored, candidates are initially awarded 1 point for every correct answer and 0 points for incorrect answers to produce a raw score. After examinees' raw scores have been computed by two independent computer systems to ensure accuracy, the scored response records for PANCE and PANRE examinees are entered into a maximum

likelihood estimation procedure, a sophisticated, mathematically-based procedure that uses the difficulties of all the scored items in the form taken by an individual examinee as well as the number of correct responses to calculate that examinee's proficiency measure. This calculation is based on the *Rasch model* and equates the scores, compensating for minor differences in difficulty across different versions of the exam. Thus, in the end, all proficiency measures are calculated as if everyone took the same exam

Finally, the proficiency measure is converted to a scaled score so that results can be compared over time and among different groups of examinees. The scale is based on the performance of a reference group (some particular group of examinees who took the exam in the past) whose scores were scaled so that the average proficiency measure was assigned a scaled score of 500 and the standard deviation was established at 100. The minimum reported score is 200, and the maximum reported score is 800.

24. What are pass rates for first time vs. retakes in the past 4 fiscal years? (Refer to Table 8: Examination Data)

The Board does not gather statistical data on applications regarding any past PANCE examinations taken. If an applicant for licensure is not able to pass the PANCE within one year of application, their application is abandoned and they must reapply for licensure.

25. Is the board using computer based testing? If so, for which tests? Describe how it works. Where is it available? How often are tests administered?

Yes, the PANCE is a computer-based examination comprised of questions that assess basic medical and surgical knowledge. The PANCE is administered at Pearson VUE testing centers located throughout the U.S. The PANCE is administered on a year-round basis. Generally, no testing takes place the last week of December.

Initially, applicants applying for the PANCE contact the NCCPA and submit an application fee of \$475. The PANCE is given on a year-round basis. Applicants may take the PANCE seven days after training program completion and one time in any 90-day period or three times in a calendar year, whichever is fewer.

The PANCE is a five-hour examination which includes 300 multiple-choice questions administered in five blocks of 60 questions. The applicant has 60 minutes to complete each block. There is a total of 45 minutes allotted for breaks between blocks.

Applicants are required to submit two forms of valid and current identification. One piece of identification must contain a photograph. Both must contain a printed name and signature.

To ensure examination security, no personal belongings are allowed in the testing room. The PANCE is managed and observed by test center staff with the aid of audio and video monitors and recording equipment.

Pearson VUE staff provides brief instructions on the use of the computer equipment. Test takers also have the opportunity to complete a brief tutorial before starting the test session.

The NCCPA notifies applicants of the examination results generally within two weeks after the test date. Applicants are responsible for authorizing the NCCPA to release their examination scores to the Board.

26. Are there existing statutes that hinder the efficient and effective processing of applications and/or examinations? If so, please describe.

The Board does not believe that existing statutes hinder the efficient and effective processing of applications or examinations.

School approvals

27. Describe legal requirements regarding school approval. Who approves your schools? What role does BPPE have in approving schools? How does the board work with BPPE in the school approval process?

Business and Professions Code section 3513 states that the Board shall recognize the approval of training programs for physician assistants accredited by a national accrediting agency approved by the Board, shall be deemed approved by the Board. If no national accrediting organization is approved by the Board, the Board may examine and pass upon the qualifications of, and may issue certificates of approval for, programs for the education and training of physician assistants that meet Board standards.

Physician Assistant regulations specify that if an educational program has been approved by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), those programs shall be deemed approved by the Board. Thus, the Board approves physician assistant training programs accredited by ARC-PA.

BPPE does not have a role in approving physician assistant training programs. Therefore, the Board does not work with BPPE in the training program approval process.

28. How many schools are approved by the board? How often are approved schools reviewed? Can the board remove its approval of a school?

As of June 2015, there are 196 ARC-PA accredited physician assistant training programs.

According to ARC-PA, the maximum length of time between validation visits is seven years. A physician assistant training program, once accredited, remains accredited until the program formally terminates its accreditation status or the ARC-PA terminates the program's accreditation through a formal action.

Yes, the physician assistant regulations permit the Board to disapprove a physician assistant training program which does not comply with Board education and training requirements. Additionally, if a training program has their accreditation terminated by ARC-PA, Board approval is automatically terminated as well.

What are the board's legal requirements regarding approval of international schools?

The Board does not have legal authority to approve international physician assistant training programs.

Continuing Education/Competency Requirements

29. Describe the board's continuing education/competency requirements, if any. Describe any changes made by the board since the last review.

Business and Professions Code section 3524.5 states that the Board may require a licensee to complete continuing medical education as a condition of license renewal. The requirement may be met by requiring no more than 50 hours of continuing medical education every two years or by accepting certification by the National Commission on Certification of Physician Assistants as evidence of compliance with the continuing medical education requirements.

Title 16 California Code of Regulations section 1399.615 states that physician assistants who renew their license are required to complete 50 hours of approved continuing medical education during the last two years of the renewal cycle. Approved continuing medical education is designated as Category 1 course work. Additionally, licensees can meet the continuing medical education requirement by being certified by the National Commission on Certification of Physician Assistants at the time of renewal.

a. How does the board verify CE or other competency requirements?

Title 16, California Code of Regulations, Section 1399.615 states that physician assistants may demonstrate their compliance with the Board's continuing medical education requirements by either:

1) Completion of 50 hours of approved Category 1 (preapproved) medical education. The CME must have been obtained from providers that are designed Category 1 (preapproved) by one of the following:

- American Academy of Physician Assistants (AAPA).
- American Medical Association (AMA).
- American Osteopathic Association Council on Continuing Medical Education (AOACCME).
- American Academy of Family Physicians (AAFP).
- Accreditation Council for Continuing Medical Education (ACCME).
- A state medical society recognized by the ACCME.

Or,

2) Certification by the National Commission on Certification of Physician Assistants (NCCPA)

Yes, the Board verifies compliance with continuing medical education requirements. At the time of renewal, licensees are required to self-certify that they have met the Board's continuing medical education requirement, have been granted an exemption, or are renewing their license in inactive status.

Those licensees who do not meet the requirements are placed in an inactive status and may not practice until such time as they meet the continuing medical education requirements. When the licensee submits proof of continuing medical education compliance to the Board they are removed from inactive status and can once again practice.

b. Does the board conduct CE audits of licensees? Describe the board's policy on CE audits.

No, the Board has not yet conducted CE audits of licensees. Due to the implementation of BreEZe the Board's ability to properly conduct and manage an auditing program for CE has been delayed.

On July 1, 2012, the Department of Consumer Affairs BreEZe project moved into a "hard freeze." The hard freeze impacted the Board's, as well as all DCA entity's, ability to make any programming changes to the existing Applicant Tracking System (ATS) and Consumer Affairs System (CAS) legacy systems used prior to implementation of BreEZe. The hard freeze was implemented by DCA to ensure that any additional changes to the existing legacy systems would not negatively impact the roll out of BreEZe.

The hard freeze negatively impacted the Board's ability to conduct CE audits because CAS couldn't be upgraded to accommodate the Board's need to conduct CE audits. Additionally, the Board's ability to verify CE compliance was also impacted in that the CAS system, which could not be updated to "read" the CE compliance question on the renewal notice.

Because the Board was legally required to verify CE compliance a "Hard Freeze Exemption" request was submitted to the Department of Consumer Affairs Change Control Board to seek an exemption to allow the CAS system to be updated to "read" and verify the CE compliance statement on the renewal application. The Board's request for an exemption to update CAS to "read" the CE question was rejected.

Therefore, the unmodified CAS system would not recognize the CE compliance question on the renewal notice and would renew the license. Board staff would receive the notices several weeks later and would be required to manually review every notice and "unrenew" those licensees who certified that they were not in compliance with the Board's CE requirements. This practice continued until implementation of BreEZe in October 2013.

c. What are consequences for failing a CE audit?

It is considered unprofessional conduct for a physician assistant to misrepresent his or her compliance with continuing medical education regulations and disciplinary action may be taken against a licensee who fails to comply with the Board's continuing medical education requirements.

Additionally, physician assistants who are found by an audit not to have completed the required number of hours of approved continuing medical education at the time of renewal are required to make up any deficiency during the next biennial renewal period. If a physician assistant fails to make up the deficient hours during the following renewal period they are ineligible for license renewal, placed in an inactive status, and may not practice as a physician assistant until such time as the deficient hours are documented to the Board.

d. How many CE audits were conducted in the past four fiscal years? How many fails? What is the percentage of CE failure?

As stated in section B, the Board has not yet conducted CE audits. Due to ongoing implementation and system issues with existing Release 1 BreEZe entities, which includes the Board, and the transition of additional Release 2 DCA Boards to the system

The Board has recognized that during the implementation of BreEZe and the ongoing stabilization issues the Board cannot expect at this time to rely on BreEZe system to be

modified to allow the Board to conduct CE audits. Therefore, the Board has determined that the most effective alternative is to develop its own computer program to randomly select licensees and manage the Board's CE program not using the BreEZe system.

Because Board staff does not have the ability to develop computer programs, staff are currently working with another DCA board to assist in the development of a program outside the BreEZe system that will allow for the ability to conduct CE audits.

e. What is the board's course approval policy?

Programs are approved by the Board for continuing medical education if they are designated as Category 1 (Preapproved) by one of the following sponsors:

- American Academy of Physician Assistants (AAPA).
- American Medical Association (AMA).
- American Osteopathic Association Council on Continuing Medical Education (AOACCME).
- American Academy of Family Physicians (AAFP).
- Accreditation Council for Continuing Medical Education (ACCME).
- A state medical society recognized by the ACCME.

f. Who approves CE providers? Who approves CE courses? If the board approves them, what is the board application review process?

The Board does not approve continuing medical education courses. Courses designated as Category 1 are sponsored and approved by:

- American Academy of Physician Assistants (AAPA).
- American Medical Association (AMA).
- American Osteopathic Association Council on Continuing Medical Education (AOACCME).
- American Academy of Family Physicians (AAFP).
- Accreditation Council for Continuing Medical Education (ACCME).
- A state medical society recognized by the ACCME.

g. How many applications for CE providers and CE courses were received? How many were approved?

The Board does not approve continuing medical education providers, and, therefore, has not received any applications.

h. Does the board audit CE providers? If so, describe the board's policy and process.

The Board does not approve continuing medical education providers, and, thus, does not conduct audits of providers.

i. Describe the board's effort, if any, to review its CE policy for purpose of moving toward performance based assessments of the licensee's continuing competence.

The Board has not reviewed its CE policy for the purpose of moving toward performance based assessments of the licensee's continuing competence.

**Section 5 –
Enforcement Program**

30. What are the board’s performance targets/expectations for its enforcement program? Is the board meeting those expectations? If not, what is the board doing to improve performance?

The Board has established performance targets for its enforcement program.

The target to complete complaint intake is 10 days. The average over the past four years is 11 days slightly higher than the target.

The Board’s overall target for completing investigations is 150 days from the time the complaint is received until the investigation is completed. The average over the past four years is 110 days so the Board is meeting its overall target for completing investigations.

The target to complete formal discipline within an average of 540 days (18 months) from the time the complaint is received and the disciplinary decision is ordered. The average time to complete a disciplinary case over the past four years is 595 days.

The Board is not currently meeting the 540 day target, however, the average total number of days to close a complaint from receipt, investigation, and disciplinary action decreased from 633 days during the last sunset review to 595 days for the past four fiscal years. Due to the limited number of disciplinary cases processed at the Board, one lengthy case may dramatically increase the average days to complete a case.

Complaint processing and investigations comprise the majority of the Board’s enforcement actions. An investigation may be closed without formal action, with a citation and fine, warning letter, public reprimand, or referred to the Office of the Attorney General for disciplinary action.

While the Board is meeting its overall target for investigations, the average number of days to complete a formal field investigation over the past four years was 260 days. The Board previously contracted with the Medical Board of California’s (MBC) enforcement unit to handle its complaints and conduct investigations. Currently, the MBC continues to handle the complaint process, while the Department of Consumer Affairs, Division of Investigation and Enforcement (DOI) handles the Board’s investigations.

The Board staff continues working with the MBC and DOI to reduce the average time for completing formal investigations. Board staff contacts in a timely manner the assigned investigators and requests updates on the progress of the investigation to determine what resources will be necessary to complete the that investigation.

As stated in the Board's last report, since most disciplinary cases require a formal investigation to obtain the information and records required, reducing the formal field investigation time will also reduce the time frame for disciplinary cases.

In an attempt to reduce the AG processing time, Board staff works with the assigned Deputy Attorney General (DAG) to receive updates on the progress of each case. The Board staff requests that the DAG request a hearing date from OAH as soon as the Notice of Defense is received since the OAH calendar is usually full. This practice may save a month of time. The average time to be assigned a calendared hearing date acceptable to all parties is generally 5 to 6 months.

The enforcement process is complex and involves several agencies including the Board members and staff, physician assistant experts, physician expert consultants, investigators, and MBC analyst. The Board uses the legal and judicial services provided by the Office of the Attorney General and the Office of Administrative Hearings.

With the involvement of several agencies, there are many factors that may contribute to increasing the number of days to complete the disciplinary process, including investigator workload, vacant positions, training new employees, deputy attorney general workload, and the length of time to schedule or calendar time for a hearing with the Office of Administrative Hearings.

The Board works with all parties involved throughout each phase of the disciplinary process in an attempt to reduce the total number of days it takes to complete enforcement actions from receipt of the complaint to the final decision.

31. Explain trends in enforcement data and the board's efforts to address any increase in volume, timeframes, ratio of closure to pending cases, or other challenges. What are the performance barriers? What improvement plans are in place? What has the board done and what is the board going to do to address these issues, i.e., process efficiencies, regulations, BCP, legislation?

As stated in the Board's prior report, the number of criminal convictions/arrest notices increased over the past four years resulting in an increase in accusations filed for criminal convictions (primarily Driving Under the Influence) over the past four years: 37 in 2011/12, 41 in 2012/13, 46 in 2013/14, and 30 in 2014/15. The Board fingerprints all applicants and receives subsequent arrest and convictions notifications from the Department of Justice. Many of these convictions result in seeking disciplinary action against the licensee.

The Board continues to believe that this increase may be a result of the regulation adopted in 2009 requiring all licensees to disclose convictions of any violation of law in California or any other state or country, omitting traffic infractions under \$300 not involving alcohol, on the renewal notice. Licensees are also required to disclose if they have been denied a license, or been disciplined by another licensing authority.

Title 16 of the California Code of Regulations, Section 1399.547, requires that physician assistants inform patients that they are licensed and regulated by the Board. Physician assistants may provide the information in one of the three ways:

- Prominently posting a sign in an area of their offices conspicuous to patients, in at least 48-point type in Arial font.
- Including the notification in a written statement, signed and dated by the patient or patient's representative, and kept in that patient's file, stating the patient understands the physician assistant is licensed and regulated by the Board.
- Including the notification in a statement on letterhead, discharge instructions, or other document given to a patient or the patient's representative, where the notification is placed immediately above the signature line for the patient in at least 14-point type.

Consumers are thus made aware of the appropriate licensing agency to contact regarding filing complaints or general information about physician assistants.

Physician assistants are now subject to 800-series reporting. This has also led to an increase in disciplinary matter to be reviewed for possible action.

There is now more consumer awareness with regard to physician assistant licensure. Consumers have 24-hour access to licensing data as well as links to disciplinary documents.

Many consumers are now aware of the need to verify license information through the efforts of the Department to educate them. The Board supports these efforts and also attempts to educate consumers about the need for license verification.

The Board will continue to monitor the number of complaints submitted regarding compliance with the new requirement.

Table 9a. Enforcement Statistics				
	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
COMPLAINT				
Intake (Use CAS Report EM 10)				
Received	269	244	316	286
Closed	265	286	7	283
Referred to INV	229	241	312	282
Average Time to Close	8	11	11	11
Pending (close of FY)	87	7	14	12
Source of Complaint (Use CAS Report 091)				
Public	189	162	116	142
Licensee/Professional Groups	12	10	7	12
Governmental Agencies	28	13	12	16
Other	40	59	101	116
Conviction / Arrest (Use CAS Report EM 10)				
CONV Received	37	41	46	30
CONV Closed	37	40	43	33
Average Time to Close	10	5	7	12
CONV Pending (close of FY)	0	1	3	0
LICENSE DENIAL (Use CAS Reports EM 10 and 095)				
License Applications Denied	0	0	2	2
SOIs Filed	1	3	5	2
SOIs Withdrawn	0	0	2	1
SOIs Dismissed	0	0	0	0
SOIs Declined	0	0	0	0
Average Days SOI	92	289	194	182
ACCUSATION (Use CAS Report EM 10)				
Accusations Filed	12	17	19	21
Accusations Withdrawn	1	0	0	0
Accusations Dismissed	0	0	0	0
Accusations Declined	1	1	0	0
Average Days Accusations	161	203	172	170
Pending (close of FY)	20	25	26	37

Table 9b. Enforcement Statistics (continued)

	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
DISCIPLINE				
Disciplinary Actions(Use CAS Report EM 10)				
Proposed/Default Decisions	1	2	2	2
Stipulations	9	2	2	2
Average Days to Complete	991	701	526	558
AG Cases Initiated	23	29	39	39
AG Cases Pending (close of FY)	20	30	26	37
Disciplinary Outcomes(Use CAS Report 096)				
Revocation	1	3	6	5
Voluntary Surrender	3	2	6	1
Suspension	0	0	0	1
Probation with Suspension	0	0	1	1
Probation	9	6	15	9
Probationary License Issued	9	4	13	16
Other	0	0	0	0
PROBATION				
New Probationers	9	5	15	15
Probations Successfully Completed	5	5	4	7
Probationers (close of FY)	56	57	47	56
Petitions to Revoke Probation	1	1	1	1
Probations Revoked	1	3	2	5
Probations Modified	0	0	0	1
Probations Extended	0	0	0	0
Probationers Subject to Drug Testing	30	31	31	32
Drug Tests Ordered	38	177	335	441
Positive Drug Tests	1	1	3	1
Petition for Reinstatement Granted	1	0	0	1
DIVERSION				
New Participants	3	5	17	9
Successful Completions	5	8	6	5
Participants (close of FY)	22	13	13	12
Terminations	2	5	11	5
Terminations for Public Threat	0	1	0	0
Drug Tests Ordered	978	687	547	542
Positive Drug Tests	29	3	6	4

Table 9c. Enforcement Statistics (continued)				
	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
INVESTIGATION				
All Investigations (Use CAS Report EM 10)				
First Assigned	276	281	355	318
Closed	247	279	267	234
Average days to close	111	102	118	170
Pending (close of FY)	103	105	194	281
Desk Investigations (Use CAS Report EM 10)				
Closed	207	222	230	320
Average days to close	79	67	77	118
Pending (close of FY)	63	49	66	68
Non-Sworn Investigation (Use CAS Report EM 10)				
Closed	40	57	31	87
Average days to close	280	237	214	310
Pending (close of FY)	40	56	64	52
Sworn Investigation				
Closed (Use CAS Report EM 10)	0	0	0	0
Average days to close	0	0	0	0
Pending (close of FY)	0	0	0	0
COMPLIANCE ACTION (Use CAS Report 096)				
ISO & TRO Issued	0	0	0	0
PC 23 Orders Requested	1	3	1	1
Other Suspension Orders	0	0	0	0
Public Letter of Reprimand	0	0	0	0
Cease & Desist/Warning	0	0	0	0
Referred for Diversion	0	0	0	0
Compel Examination	0	0	0	0
CITATION AND FINE (Use CAS Report EM 10 and 095)				
Citations Issued	1	9	19	9
Average Days to Complete	149	153	262	360
Amount of Fines Assessed	250	5600	9800	2500
Reduced, Withdrawn, Dismissed	0	0	450	0
Amount Collected	2750	5250	4100	6050
CRIMINAL ACTION				
Referred for Criminal Prosecution	0	0	0	5

Table 10. Enforcement Aging						
	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15	Cases Closed	Average %
Attorney General Cases (Average %)						
Closed Within:						
1 Year	3	2	17	3	25	35%
2 Years	2	2	9	7	20	27%
3 Years	3	8	5	4	20	27%
4 Years	4	1	3	0	8	11%
Over 4 Years	0	0	0	0	0	0%
Total Cases Closed	12	13	34	14	73	100%
Investigations (Average %)						
Closed Within:						
90 Days	158	186	172	86	602	1%
180 Days	54	54	45	51	204	20%
1 Year	18	23	27	59	127	12%
2 Years	15	16	19	32	82	.08%
3 Years	2	1	4	6	13	.01%
Over 3 Years	0	0	0	0	0	0
Total Cases Closed	247	280	267	234	1028	33.1%

32. What do overall statistics show as to increases or decreases in disciplinary action since last review.

The overall statistics indicate that the number of disciplinary actions taken over the past four fiscal years has increased over the previous Sunset Report review period. The Board files approximately 19 accusations and takes approximately 17 disciplinary actions per year.

The average number of Interim Suspension Order (ISO) and PC23s has increased from an average of one per year during the last sunset review to an average of five each year for the last four fiscal years.

The total number of complaints received stayed fairly consistent for FY 2011/12 at 269, FY 2012/13 at 244, with an increase for FY 2013/14 at 316 and FY 2014/15 at 286. The average number of complaints received per year over the past four fiscal years is 282 compared to 195 during the previous sunset review. As our licensing population continues to increase, we anticipate the number of complaints to increase at the same rate. Additionally, mandatory 800-series reporting and self-reporting of arrests and convictions create a greater awareness that may also increase the number of complaints received and disciplinary actions taken.

The Board issued an average of ten probationary licenses per year for the past four fiscal years. Probationary licenses are developed by staff and approved by the Board members. The probationary license process allows the Board to place an applicant on probation without denying the license and going through the formal hearing process through the Office of the Attorney General and the Office of Administrative Hearings. Probationary licenses are granted in cases such as a recent driving under the influence (DUI) and minor application

issues/violations. The probationary license is a quick, less expensive way to address minor issues that need remediation. Additionally, the probationary license has established a disciplinary record in the event that the licensee has not remediated. The Board is then able to seek additional action. The probationary license process protects the public because safeguards are in place through the probationary terms and conditions.

33. How are cases prioritized? What is the board's compliant prioritization policy? Is it different from DCA's *Complaint Prioritization Guidelines for Health Care Agencies* (August 31, 2009)? If so, explain why.

The Board does not have mandated complaint prioritization and uses the Department of Consumer Affairs Complaint Prioritization Guidelines for Health Care Agencies. Complaints that are reviewed and within the Board's jurisdiction are given a priority level of Urgent, High, or Routine.

Urgent Priority complaints are given the highest priority and generally involve an act resulting in serious injury or death or potential to cause consumer harm such as practicing under the influence of alcohol or drugs, mental or physical impairments affecting competency, furnishing controlled substances without a prescription, and aiding and abetting unlicensed activity resulting in patient harm.

Most urgent cases are sent immediately to the Department of Consumer Affairs Division of Investigation Health Quality Investigation Unit for investigation.

Based on the investigation, it is then determined if the complaint remains as an urgent complaint, if so, then the complaint is reprioritized to either a high or routine matter.

Routine complaints are processed quickly, but, not given a higher priority as with urgent or high priority complaints.

34. Are there mandatory reporting requirements? For example, requiring local officials or organizations, or other professionals to report violations, or for civil courts to report to the board actions taken against a licensee. Are there problems with the board receiving the required reports? If so, what could be done to correct the problems?

SB 1236 (Price, Chapter 332, Statutes of 2012) added physician assistants to the 800-series reporting requirements. (Business and Professions Code sections 800, 801.1, 802.5, 803, 803.1, 803.6, and 805).

These requirements further enhance the Board's mandate of consumer protection by requiring reporting to the Board physician assistant malpractice actions, hospital disciplinary actions, as well as self-reporting by physician assistants of indictments and convictions.

The reporting requirements also apply to professional liability insurers, self-insured governmental agencies, physician assistant and/or their attorneys and employers, peer review bodies, such as hospitals to report specific disciplinary actions, restrictions, revoked privileges, and suspensions.

Prior to making these reporting requirements mandatory, the Board encouraged agencies to voluntarily submit 800-series reports to the Board for review and possible action. Upon receipt of these reports, the Board opened complaints and took disciplinary action if appropriate.

The Board does not appear to have problems receiving the reports.

35. Does the board operate with a statute of limitations? If so, please describe and provide citation. If so, how many cases have been lost due to statute of limitations? If not, what is the board's policy on statute of limitations?

The Board does not operate with a statute of limitations. The Board, however, generally follows the Medical Board of California's statute of limitations as established by Business and Professions Code section 2230.5, which is three years.

The Board will proceed with cases that have reached the three year statute of limitations limit, which ensures greater consumer protection.

36. Describe the board's efforts to address unlicensed activity and the underground economy.

As a consumer protection agency, the Board is concerned with individuals holding themselves out as physician assistants. The Board investigates and takes action against such individuals.

The Department of Consumer Affairs, Division of Investigation Health Quality Investigation Unit, Operation Safe Medicine Unit was originally created by the Medical Board of California to address unlicensed activity. This unit's role is to investigate complaints of unlicensed activity for individuals practicing medicine. The Board also utilizes the services of Operation Safe Medicine as a key component in its efforts to address the unlicensed practice of physician assistants.

The Board cooperates with Federal, local, and private organizations to criminally prosecute individuals for unlicensed activity.

Additionally, the Board encourages employers and consumers to verify individuals to ensure that they are licensed to practice as a physician assistant.

Cite and Fine

37. Discuss the extent to which the board has used its' cite and fine authority. Discuss any changes from last review and describe the last time regulations were updated and any changes that were made. Has the board increased its maximum fines to the \$5,000 statutory limit?

The Board established its citation and fine program pursuant to Business and Professions Code section 125.9, 148, and 3510 effective March 1996. Title 16, California Code of Regulations Section 1399.570 authorizes the Board's Executive Officer to issue a citation which may include a fine and an order of abatement.

The citation and fine program is a useful enforcement tool to address minor violations that do not merit more formal types of discipline, but, nevertheless, require action. The citation and fine program attempts to address, correct, and educate licensees for minor violations of laws and regulations governing the practice.

Additionally, the program is useful in establishing a formal record of action taken against a licensee in the event that the licensee faces additional violation issues. For example, generally, licensees who are convicted of a first time DUI are issued a citation and fine. If the licensee has a second DUI, the Board has addressed the first DUI and, therefore, has already

established a record of action to address and seek more formal disciplinary action against the licensee.

Since the Board's last Sunset Report, the citation and fine regulations have not been amended.

Title 16, California Code of Regulations Section 1399.571(b)(3) states that the fine for a violation shall be from \$100 to \$5000.

38. How is cite and fine used? What types of violations are the basis for citation and fine?

The Board's citation and fine program is an additional enforcement tool in which minor violations of physician assistant laws and regulations that do not rise to the level of more formal discipline can be addressed and remediated. The concept is that the minor violations can be addressed so that more formal actions, hopefully, will not need to be taken in the future.

Citations and fines may be issued as a result of a formal investigative process when the investigation determines the case is not serious enough to warrant more formal discipline. The violation can be more serious than that required by an educational letter. Often, a licensee may have faced actions by another licensing board or agency, but the Board is unable to take more formal disciplinary action against the licensee, so, a citation is an appropriate means to address the matter. Minor criminal convictions may also result in the issuance of a citation and fine.

Citations are subject to public disclosure and are part of the licensee's verification record. Additionally, the citation document is also part of the licensee's verification record and available for inspection by consumers.

39. How many informal office conferences, Disciplinary Review Committees reviews and/or Administrative Procedure Act appeals of a citation or fine in the last 4 fiscal years?

The table below lists the number of citations issued, informal appeals, and formal hearing requests.

Fiscal Year	Citations Issued	Informal Appeal	Formal Hearing
FY 2011/12	1	0	0
FY 2012/13	9	0	0
FY 2013/14	19	2	0
FY 2014/15	9	1	0

40. What are the 5 most common violations for which citations are issued?

Typically, the following are common violations resulting in the issuance of citations:

- Conviction of a crime (such as a DUI, shoplifting, etc.).
- Failure to maintain adequate medical records/failure to order appropriate laboratory tests.

- Failure to obtain and/or review patient medical history.
- Writing drug orders for scheduled medication without patient specific authority.
- Practicing with an expired license.

41. What is average fine pre- and post- appeal?

Over the last four fiscal years, the average citation fine pre-appeal is \$523 and the average post-appeal is \$488.

42. Describe the board's use of Franchise Tax Board intercepts to collect outstanding fines.

Business and Professions Code section 125.9 authorizes the Board to include the full amount of the outstanding unpaid fine to the licensee's renewal. The Board may place a hold on the license renewal if the licensee fails to pay the fine amount. The fine must be paid before the licensee may renew their license.

Cost Recovery and Restitution

43. Describe the board's efforts to obtain cost recovery. Discuss any changes from the last review.

In most cases, the Board requests cost recovery for disciplinary actions. The Board, however, does not request cost recovery for the issuance of probationary licenses since there are no investigative or other legal costs incurred for the issuance of this type of license.

In most cases, the Board seeks cost recovery for reimbursement of investigative, expert review, and Office of the Attorney General case prosecution costs. The Board does not seek cost recovery for cost associated with hearings held before an Administrative Law Judge.

The Board has the ability to negotiate cost recovery amounts when entering into a stipulated decision. In addition, the Board's Manual of Disciplinary Guidelines and Model Disciplinary Orders contain a cost recovery term. Administrative Law Judge's using the guidelines for proposed decisions would be aware of the Board's cost recovery requirements.

Licensees or probationers wishing to surrender their license are required to pay the cost recovery amount prior to the submittal of a Petition for Reinstatement or before the reinstated license is issued.

In most cases, the Board does not actively seek collection of the cost recovery amount or submit them to the Franchise Tax Board for collection because the benefit of accepting the surrendered license thus removes the licensee from practice, ensuring consumer protection.

Additionally, by accepting the surrender, the Board does not incur additional costs associated with the hearing which are not subject to cost recovery. The cost of a hearing, which would include Attorney General, Administrative Law Judge, and court reporter costs are typically higher than the outstanding cost recovery.

If a case does result in a hearing, the Board, typically, requests the full amount of cost recovery for the investigation and Attorney General costs up to the hearing. The Administrative Law Judge in issuing a proposed decision may reduce or dismiss cost recovery.

If a license is revoked by the Board, cost recovery is pursued through the Franchise Tax Board.

There has been change in the Board's cost recovery efforts since the last report. Licensees are now able to pay the cost recovery and probation monitoring costs online via the BreEZe system.

44. How many and how much is ordered by the board for revocations, surrenders and probationers? How much do you believe is uncollectable? Explain. –

Cost recovery for each case varies depending on the complexity of the complaint or if the case goes to formal investigation conducted by a sworn investigator. The more complex the case, the higher the costs of investigation, expert review, and Deputy Attorney General hours for filing and prosecuting the case. In cases of criminal convictions that do not require a formal investigation, the cost recovery is minimal.

In most cases of revocation, the cost recovery is uncollectable and submitted to the Franchise Tax Board. The actual amount of collected by the Franchise Tax Board is minimal because often the person has relocated outside of California and the cost recovery is not collectable.

The table below shows the number of revocations, surrenders, and probations and the amount of cost recovery ordered for each category.

Fiscal Year	No. Revoked/ Total Cost Recovery	No. Surrender/ Total Cost Recovery	No. Probation/ Total Cost Recovery
2011/12	2 - \$22,341	4 - \$85,289	8 - \$74,700
2012/13	3 - \$11,380	0	6 - \$51,425
2013/14	5 - \$50,401	5 - \$47,077	6 - \$45,439
2014/15	3 - \$9,860	1 - \$450	8 - \$52,840

45. Are there cases for which the board does not seek cost recovery? Why?

The Board does not pursue cost recovery for the issuance of probationary licenses because the development and issuance of these licenses does not involve investigative or prosecution costs associated with the development of more formal disciplinary documents. Individuals issued probationary licenses are responsible for the payment of probation monitoring costs.

Additionally, when the Board accepts a stipulated settlement for license surrender, in most cases, the cost recovery is negotiated to apply only if the licensee petitions the Board for reinstatement of the license. The benefit is that the licensee is no longer able to practice, thus, avoiding possible consumer harm.

46. Describe the board's use of Franchise Tax Board intercepts to collect cost recovery.

The Board submits to the Franchise Tax Board Intercepts Collection program cases of revocation where there is any outstanding balance of cost recovery.

47. Describe the board's efforts to obtain restitution for individual consumers, any formal or informal board restitution policy, and the types of restitution that the board attempts to collect, i.e., monetary, services, etc. Describe the situation in which the board may seek restitution from the licensee to a harmed consumer.

The Board does not, typically, order restitution because of the complex nature of determining and assessing damages. Consumers have the option of seeking civil remedies through the

judicial system to obtain compensation for damages as a result of harm committed by a licensee.

Table 11. Cost Recovery (list dollars in thousands)				
	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
Total Enforcement Expenditures				
Potential Cases for Recovery *	12	17	19	21
Cases Recovery Ordered	12	17	19	21
Amount of Cost Recovery Ordered	166	30	14	64
Amount Collected	51	55	47	50
* "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the license practice act.				

Table 12. Restitution (list dollars in thousands)				
	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
Amount Ordered	n/a	n/a	n/a	n/a
Amount Collected	n/a	n/a	n/a	n/a

Section 6 – Public Information Policies

48. How does the board use the internet to keep the public informed of board activities? Does the board post board meeting materials online? When are they posted? How long do they remain on the board's website? When are draft meeting minutes posted online? When does the board post final meeting minutes? How long do meeting minutes remain available online?

The internet has become an important method of keeping consumers, applicants, licensees, and interested others informed of the Board's activities.

Yes, the Board posts meeting materials online. Generally, the meeting materials packet is placed on the website approximately one week before the meeting. These items remain on the website indefinitely. Draft meeting minutes are included in the meeting packet and posted at the same time as the meeting materials. Final meeting minutes are posted on the website after being approved by the Board. Meeting minutes remain on the website indefinitely.

The Board also posts on the website agendas, notices of regulatory hearings, and disciplinary actions.

Viewers of the Board's website have the ability to join an email subscription service which allows subscribers to receive information about the Board and its activities.

49. Does the board webcast its meetings? What is the board's plan to webcast future board and committee meetings? How long to webcast meetings remain available online?

Yes, the Board webcasts its Board meetings. The Board began webcasting the meetings in 2011. Webcasts of Board meetings from 2011 to present remain on the Board's website indefinitely.

50. Does the board establish an annual meeting calendar, and post it on the board's web site?

Yes, the Board establishes an annual meeting calendar generally at the last meeting of the calendar year. The annual meeting calendar is then posted on the Board's website.

51. Is the board's complaint disclosure policy consistent with DCA's *Recommended Minimum Standards for Consumer Complaint Disclosure*? Does the board post accusations and disciplinary actions consistent with DCA's *Web Site Posting of Accusations and Disciplinary Actions* (May 21, 2010)?

Yes, the Board's complaint disclosure policy is consistent with DCA's *Recommended Minimum Standards for Consumer Complaint Disclosure* policy.

The Board discloses the following information:

- Disciplinary actions including Statement of Issues, Accusations, Petitions to Revoke Probation, Final Decisions, Interim Suspension Orders, PC-23s, Dismissed Accusations, and Public Letters of Reprimand.
- Probationary Licenses
- Citations issued. Citations are posted for five years after compliance.

All disciplinary actions and citations are available on the Board's website. The documents may also be obtained by contacting the Board.

Per DCA's *Web Site Posting of Accusations and Disciplinary Actions* policy, the Board posts disciplinary actions on the website.

52. What information does the board provide to the public regarding its licensees (i.e., education completed, awards, certificates, certification, specialty areas, disciplinary action, etc.)?

The public may verify physician assistant licenses by contacting the Board by telephone, in writing, or by visiting the Board's website. The Board's online verification system is through the DCA BreEZe system.

The following physician assistant licensing information is disclosed:

- License Number
- Licensee Name
- License Type
- License Status (such as renewed, delinquent)
- License Secondary Status (such as name change)

- Expiration Date
- Original Issue Date
- Address of Record
- Public Record Actions (if any) including:
 - Administrative Disciplinary Actions
 - Court Orders
 - Misdemeanor Convictions
 - Felony Convictions
 - Malpractice Judgements
 - Probationary Licenses
 - Hospital Disciplinary Actions
 - License Issued with Public Reprimands
 - Administrative Citations Issued
 - Administrative Actions Taken by Other States or the Federal Government
 - Arbitration Awards

53. What methods are used by the board to provide consumer outreach and education?

The Board, in recognizing its role as a consumer protection agency, utilizes the following methods for consumer outreach and education:

- Board website: www.pac.ca.gov
- Email subscription notifications via the website
- Webcasting Board meetings
- Articles printed in Department of Consumer Affairs and Medical Board of California newsletters
- Telephonic responses to inquiries
- Responses to written correspondence
- Responses to email correspondence
- Printing and distribution of Board brochures
- Speaking engagements by Board members and staff to consumer, student, and licensee groups

The Board recognizes that the website is a powerful tool in providing information to consumers, applicants, licensees, students, supervising physician and surgeons, and interested others. Efforts are constantly made to review and update the contents on the website to ensure that it is useful.

It is interesting to note that the Board adopted Title 16, California Code of Regulations Section 1399.547 in 2011 which implemented the provisions of Business and Professions Code Section 138.

Title 16, California Code of Regulations Section 1399.547 requires that licensees must provide notification to patients the fact that the licensee is regulated by the Board. The notification must include the Board's name, telephone number, and website address.

The Board believes that this regulation is a useful consumer protection tool. We have discovered that not only do consumers contact us because of complaints, they also inquire about physician assistants in general. Many consumers are interested in learning more about the profession. It provides Board staff with the opportunity to interact with consumers and provided valuable educational information regarding consumer protection.

Section 7 – Online Practice Issues

54. Discuss the prevalence of online practice and whether there are issues with unlicensed activity. How does the board regulate online practice? Does the board have any plans to regulate internet business practices or believe there is a need to do so?

Physician assistant practice normally does not lend itself to online practice because patients are generally physically seen by the practitioner. Additionally, physician assistants are dependent upon a supervising physician. In most cases, any online presence would be associated with the practice of their supervising physician.

As stated in our last Sunset Report we have not received any complaints regarding this issue. At present, there are no plans to regulate the internet business practices of physician assistants.

Section 8 – Workforce Development and Job Creation

55. What actions has the board taken in terms of workforce development?

Physician assistant education and workforce concerns are ongoing issues with the Board.

The Board created a Physician Assistant Education/Workforce Development Committee to look into education and workforce issues for physician assistants.

Business and Professions Code Section 3513 states that the Board shall recognize the approval of training programs for physician assistants accredited by a national accrediting agency approved by the Board shall be deemed approved by the Board. If no national accrediting organization is approved by the Board, the Board may examine and pass upon the qualifications of, and may issue certificates of approval for, programs for the education and training of physician assistants that meet Board standards.

Physician assistant regulations specify that if an educational program has been approved by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), those programs shall be deemed approved by the Board. Thus, the Board approves physician assistant training programs accredited by ARC-PA.

The decision by ARC-PA requiring that all currently accredited programs confer Master's Degrees to those students who matriculate into the program after 2020 has been a concern of

the Board because the Board's mission to protect the public by ensuring that they receive safe and appropriate health care from qualified physician assistants, which includes supporting access to health care for California consumers. There is concern that closing physician assistant training programs may lead to a lack of access to quality affordable health care provided by physician assistants.

Programs accredited prior to 2013 that do not currently offer a Master's degree must transition to conferring a graduate degree which should be awarded by the sponsoring institution, upon all physician assistant students who matriculate into the program after 2020.

This decision has resulted in the closure of two California-based physician assistant programs who offered degrees at the Associate Degree level. They were unable to retain their ARC-PA accreditation.

Former Board member, Steven H. Stumpf, Ed.D, addressed the education and workforce issue in an October 19, 2012 paper. **(See Section 12, attachment G)** Dr. Stumpf recognized that the ARC-PA policy, along with the implementation of health care reform, would result in the need for additional physician assistants. He also recognized the need for additional California-based physician assistant training programs.

The Board continues to have concerns with ARC-PA in that eliminating the Associate Degree programs significantly changes the applicant pool for physician assistant training in California, potentially creating a significant barrier for those who do not have a Baccalaureate Degree upon entering physician assistant training.

The Board has made efforts to reach out to ARC-PA in an attempt to work with them to address the Board's concerns with regard to their accreditation standards and the impact they have on California's health care needs. Unfortunately, ARC-PA has made little or no effort to work with the Board.

The Board examined several alternatives to relying on ARC-PA for California physician assistant training program approval. **(See Section 12, attachment H)** Specifically, should the Board accredit California physician assistant training programs? Challenges associated with California accreditation of physician assistant training programs include:

- Cost: The Board would need to approve and adopt educational standards. Mechanisms for enforcement would need to be put in place. Additional staff would be required to verify compliance and administer an accreditation program.
- Certification: Currently, graduates of a California approved physician assistant training program would not be eligible to take the Physician Assistant National Certification Examination (PANCE). The PANCE is used as the Board's licensing examination. There would be a need to develop a California-only licensing examination. This would be a very costly process. Additionally, licensees could not be credentialed at most hospitals. Also, those licensees could not practice outside of the state, work for the federal government, or bill if working in a federally qualified rural health clinic.
- Patient Confusion: This would create a "two-tiered" system where a California program physician assistant may be seen alongside an ARC-PA approved graduate, but could not be seen by one or the other due to billing or other concerns. Because of this, patients could be confused or perceive bias, thinking that they are not getting an equal level of care.

- Likely opposition: Many in the physician assistant professions are opposed to state accreditation and would likely fight to stop it. This may result in a negative reflection on physician assistants, and may cause regulatory problems as the Legislature and consumers may have difficulty understanding the nuanced differences between state and nationally certified licensees. This may lead to consumers opting not to see a physician assistant, passage of laws to restrict physician assistant practice, or a supervising physician opting not to hire one, all of which would reduce access to the quality health care physician assistants are currently delivering in California.

The Board continues to explore ways to address this issue.

Currently there are eight physician assistant programs in California. These programs include:

Institution Name	Location	Date First Accredited	Next ARC-PA Review
Loma Linda University	Loma Linda	9/15/2000	March 2017
Marshall B. Ketchum University (*provisional)	Fullerton	3/7/2014	March 2017
Samuel Merritt University	Oakland	4/1/1999	September 2018
Stanford University	Palo Alto	3/1/1976	September 2019
Touro University - California	Vallejo	9/2/2002	September 2018
University of California-Davis	Davis	3/1/1974	March 2017
University of Southern California (LA)	Alhambra	10/1/1975	September 2018
Western University of Health Sciences	Pomona	5/1/1990	March 2020

The following California physician assistant programs have lost or are losing their ARC-PA accreditation:

Institution Name	Location	Date Opened	Date Closed
San Joaquin Valley College	Visalia	March 2003	October 2015
Moreno Valley College	Riverside	April 1999	October 2016

It should be noted that several new physician assistant training programs are seeking ARC-PA accreditation. These programs include:

Institution Name	Applied for ARC-PA Provisional Accreditation	First Class
California Baptist University	Yes	September 2016
Chapman University	Yes	January 2017
Charles R. Drew University of Medicine and Science	Yes	August 2016
Dominican University of California	Yes	Unknown
Southern California University of Health Sciences	Yes	Planned for Fall 2016
University of La Verne	Yes	2017
University of the Pacific	Yes	Spring 2017

The ARC-PA has determined that the institutions meet the basic eligibility requirements to apply for provisional accreditation. They do not yet possess an accreditation status from the ARC-PA, nor is there any guarantee that they will achieve provisional accreditation.

"Accreditation-Provisional" is an accreditation status granted by ARC-PA when the plans and resource allocation, if fully implemented as planned, of a proposed program that has not yet enrolled students appear to demonstrate the program's ability to meet the ARC-PA *Standards* or when a program holding accreditation-provisional status appears to demonstrate continued progress in complying with the *Standards* as it prepares for the graduation of the first class (cohort) of students. Accreditation-Provisional does not ensure any subsequent accreditation status. It is limited to no more than five years from matriculation of the first class. Accreditation-Provisional remains in effect until the program achieves accreditation-continued after its third review, closes or withdraws from the accreditation process, or until accreditation is withdrawn for failure to comply with the *Standards*. (Reference: ARC-PA)

Examples of the Board's efforts are compliant with a variety of work force development related legislation including:

- AB 2102 (Ting, Chapter 420, Statutes of 2014) requires the Board of Registered Nursing, Physician Assistant Board, Respiratory Care Board, and the Board of Vocational Nursing and Psychiatric Technicians to report specific demographic data relating to licensees to the Office of Statewide Health Planning and Development (OSHDP).
- AB 154 (Atkins, Chapter 662, Statutes of 2013) requires a nurse practitioner, certified nurse-midwife, or physician assistant to complete training, as specified, and to comply with standardized procedures or protocols, as specified, in order to perform an abortion by aspiration techniques, and would indefinitely authorize a nurse practitioner, certified nurse-midwife, or physician assistant who completed a specified training program and achieved clinical competency to continue to perform abortions by aspiration techniques.
- SB 352 (Pavley, Chapter 286, Statutes of 2013) allows physicians to delegate medical assistant supervision to physician assistants and nurse practitioners.

- SB 494 (Monning, Chapter 684, Statutes of 2013) requires a health care service plan licensed by the Department of Managed Health Care to ensure one primary care physician for every 2,000 enrollees and authorizes up to an additional 1,000 enrollees for each full-time equivalent non-physician medical practitioner supervised by that primary care physician until January 1, 2019.
- The Board collects, biennially, at the time of both issuing the initial license and at the time of license renewal the following data:
 - Location of practice, including city, county, and ZIP code
 - Race or ethnicity (licensee option to report)
 - Gender
 - Languages spoken
 - Educational background
 - Classification of primary practice

The Board has a Memorandum of Understanding with the OHSPD Healthcare Workforce Clearinghouse Program and has been begun reporting to them the required demographic data.

The Board believes partnering with the OHSPD Healthcare Workforce Clearinghouse Program is a reasonable method to address workforce issues. The Clearinghouse also supports healthcare accessibility through the promotion of a diverse and competent workforce while providing an analysis of California's healthcare infrastructure and coordinating healthcare workforce issues. As a partner, the Board is responsible for licensing and regulation of physician assistants. Additionally, the Board maintains and is able to provide the Clearinghouse certain demographic information related to licensees.

The Board supports legislation that promotes the more efficient use of health care providers, including physician assistants.

As the health care landscape in California continues to evolve, the Board is committed to ensuring that it continues to monitor and address the health care needs of California.

56. Describe any assessment the board has conducted on the impact of licensing delays.

The Board has not conducted any assessments on the impact of licensing delays. The Board has not experienced major backlogs or delays in issuing physician assistant licenses. The impact of the implementation of BreEZe to manage the Board's licensing program has been minimal as the BreEZe licensing program functions as designed.

The Board is aware that it is imperative to issue licenses as quickly as possible to ensure that licensees are able to join the workforce. Board staff continues to seek ways to evaluate our licensing processes and procedures to ensure that they licenses are issued on a timely basis.

57. Describe the board's efforts to work with schools to inform potential licensees of the licensing requirements and licensing process.

It has been a tradition at the Board to provide California physician assistant training program presentations regarding licensing, regulations, and enforcement. Board members, have on

occasion, also provided presentations. The presentations allow students to meet licensing staff and learn about the application process. It is also an opportunity for Board staff to provide students additional information regarding physician assistant laws and regulations.

In recent fiscal years, due to budget and travel restrictions, the Board has not been able to provide as many presentations as it would like. As an alternative, Board staff has been able to provide teleconference presentations. Additionally, the Board's website contains a section devoted to applicants to assist them in the application process.

58. Provide any workforce development data collected by the board, such as:

a. Workforce shortages

The Board has gathered workforce development data from the Office of Statewide Health Planning and Development's Health Care Clearinghouse. **(Section 12, Attachment I)**

b. Successful training programs.

As stated above, two California physician assistant training programs have lost their ARC-PA accreditation. However, seven new California programs are in the process of obtaining ARC-PA accreditation.

Section 9 – Current Issues

59. What is the status of the board's implementation of the Uniform Standards for Substance Abusing Licensees?

The Board approved a regulatory change that will amend Title 16, California Code of Regulations Section 1399.523 to incorporate by reference the 4th edition of the Board's "Physician Assistant Board Manual of Model Disciplinary Guidelines and Model Disciplinary Orders." The amendments to the Board's guidelines incorporate the provisions of the Uniform Standards for Substance Abusing Licensees.

The regulatory package has been submitted to the Department of Consumer Affairs for review and approval. Upon the Department's approval, the regulatory package will be submitted to the Office of Administrative Law for their review and approval.

The Board looks forward to the approval of the regulatory change and implementation of the Uniform Standards as an additional consumer protection tool.

60. What is the status of the board's implementation of the Consumer Protection Enforcement Initiative (CPEI) regulations?

In response to the Department of Consumer Affairs Consumer Protection Enforcement Initiative (CPEI) to overhaul the enforcement processes used by healing arts boards, regulations became effective in November 2011 to implement enhancements to the Board's enforcement program.

The enhancements include:

- The ability of the Board's Executive Officer or designee to accept default decisions and approval settlement agreements for surrender or interim suspension of a license.

- Authorizes the Board to order an applicant to submit to a physical or mental examination if there is reasonable belief that the applicant may be unsafe to practice.
- Mandates that individuals registering as sex offenders shall have their license revoked.
- Defines “unprofessional conduct” to include the failure to report an indictment charging a felony, arrest, or conviction of a licensee.
- “Unprofessional conduct” would also entail the inclusion of provisions in civil dispute settlement agreements prohibiting a person from contacting, cooperating with, filing, or withdrawing a complaint with the Board.
- Establishes that it is “unprofessional conduct” to fail to provide lawfully requested documents or cooperating with an investigation.

These regulatory changes provide the Board additional enforcement tools to ensure consumer protection.

61. Describe how the board is participating in development of BreEZe and any other secondary IT issues affecting the board.

The implementation of BreEZe has been an ongoing challenge for the Board and staff. In hindsight, the Board did not have sufficient staff to devote to the many hours needed to develop and implement BreEZe. Additionally, Board staff did not possess the depth of knowledge needed to essentially develop the system. In past IT projects, Board staff provided input on the operational needs and what processes were required to develop the program. IT personnel would then create the program per the Board’s specifications. Staff was not required to have an in depth of knowledge of the “internal workings” of the program required to develop the system. This wasn’t the case with the BreEZe project. It appears that Board staff was more or less developing the program. It was assumed by Board staff that IT staff, more knowledgeable in programming, would actually develop the system. While many boards within the Department have staff with such a depth of knowledge, unfortunately, this Board did not.

Fortunately, the Board, through a shared services agreement, utilizes the services of the Medical Board of California (MBC) Information Systems Branch (ISB) for our IT needs. ISB has been a life saver in the assistance and advice that they have provided Board staff in implementing and navigating BreEZe. Their professionalism and assistance provided to the Board has greatly assisted staff in understanding, implementing, and updating BreEZe. Board staff believes that with assistance provided by ISB we have a better understanding of the system and are able to work more efficiently with the system, and thus providing better services to consumers, applicants, and licensees.

ISB staff also providing help desk services for our licensees who utilizing BreEZe.

The Board generally agrees with the findings of the California State Auditor audit of the BreEZe system. The audit validated many of the concerns of Board staff regarding the development and implementation of BreEZe. It appears that the Department of Consumer Affairs has acknowledged the findings and has become proactive in addressing these findings. Board staff also believes that BreEZe staff is better able to assist the Board with implementation issues. BreEZe staff seems to now have a better understanding of the Board’s depth of knowledge and are able to better assist us.

The Board continues to have concerns with the functionality and reliability of the BreEZe licensing and enforcement reports. It appears that BreEZe staff is working with the BreEZe boards to address these issues and our hope is that soon we will be able to rely on and have confidence in the accuracy of the reports.

The Board is also concerned with the implementation cost of BreEZe. It appears that at this time the ultimate costs are unknown. While the Board currently has sufficient reserves to address BreEZe costs, there are still concerns with the unknown cost factor of this project.

On a more positive note, it appears that the Board's licensing program in BreEZe has functioned since roll out without any major issues. We have not experienced delays in processing and issuing physician assistant licenses through BreEZe.

The Board was able to offer online renewals through BreEZe in May 2015. Again, it appears that the system is functioning as designed and we have not experienced major issues with this feature. Our licensees are happy that they now can renew on line and no longer need to send payments to the Board. The license is updated upon completion of the online transaction. Board staff has received many positive comments about the ability to renew online. The online renewal system has also decreased the number of paper renewals received by Board staff. Staff has also seen a decrease in last minute paper renewals needing to be processed at the end of each month.

In conclusion, the Board has initially struggled with the implementation of BreEZe. However, with the assistance of BreEZe and Medical Board of California ISB staff, the Board is hopeful that the issues will be resolved allowing us to fully utilize the services provided by BreEZe.

Section 10 – Board Action and Response to Prior Sunset Issues

Include the following:

- 1. Background information concerning the issue as it pertains to the board.**
- 2. Short discussion of recommendations made by the Committees/Joint Committee during prior sunset review.**
- 3. What action the board took in response to the recommendation or findings made under prior sunset review.**
- 4. Any recommendations the board has for dealing with the issue, if appropriate.**

ISSUES FROM PRIOR SUNSET REPORT OF 2012

ISSUE #1: NEED FOR CONTINUED ENHANCEMENT OF THE COMMITTEE'S INTERNET SERVICES AND IMPLEMENTATION OF BREEZE

It was pointed out by the Board in the previous report that there has been an increased use of the internet and computer technology to provide services and information to consumers and licensees.

It was pointed out that even with the increased use of the internet; the Board was still unable to provide online renewals of licenses, which would also allow the use of credit cards to make payments. Additionally, it was reported that renewals are often delayed

because the licensee did not mail a payment six to eight weeks prior to the renewal date and the license is then placed in a delinquent status and the licensee is unable to work.

The report also pointed out that the Board was in the initial process of establishing a new integrated licensing and enforcement system, BreEZe. BreEZe was to replace the older and outdated legacy systems, CAS and ATS.

It was recommended by the Business, Professions, and Economic Development staff that the Board should provide an update on the current status of its efforts to fully implement electronic payments of fees and online application and renewal processing. The Committee staff also recommended that the Board should continue to explore ways to enhance its internet services to licensees and members of the public.

The Board converted over to the BreEZe system in early October 2013. All Board renewal, verification, licensing, and enforcement processes were converted over to the new system. Early in the roll out, online physician assistant applications were added to BreEZe.

In May 2015, BreEZe was updated to allow licensees to renew and pay for their renewals online. Additionally, probationers may make their cost recovery and probation monitoring costs payments online. Licensees may also pay fines associated with citations online as well.

Consumers can now file complaints online through the BreEZe system.

The Board continues to work with the Department of Consumer Affairs BreEZe team to enhance its ability to fully exploit the services provided by BreEZe.

The Board continues to seek ways to enhance its website to ensure that it is user friendly and provides information and services that benefit consumers, applicants, and licensees. The Board's website is viewed as a work in progress and updated on a regular basis.

The website contains meeting agenda, meeting materials, and minutes, as well as other information about the Board and its members. For easy access to information available, individual tabs were created for consumers, applicants, licensees, and supervising physicians. Board meetings are now webcast and they are available on the Board's website.

ISSUE #2: CHANGE THE COMPOSITION AND NAME OF THE PHYSICIAN ASSISTANT COMMITTEE

In 2005, the JLSRC asked whether the Committee (now Physician Assistant Board) should continue under the jurisdiction of the Medical Board of California, be given statutory independence as an independent board, merged with the Medical Board of California, or have its operations and functions assumed by the Department of Consumer Affairs.

The Committee continued its current status with ties to the Medical Board of California and reliance on the Medical Board for investigative and some administrative services.

At a July 2010 meeting, the Committee agreed to seek legislation to change its name from the Physician Assistant Committee to Physician Assistant Board. The change was not intended to alter the current cooperative working relationship with the Medical Board of California.

It was recommended by the Business, Professions, and Economic Development staff that consideration be given to changing the name of the Committee to the Physician Assistant Board. Consideration should also be given to replacing the physician member of the Committee with a physician assistant to constitute a simple majority of professional members, in keeping with many other health boards. It was also recommended that the Medical Board physician member no longer vote.

SB 1236 (Price Statutes of 2012, Chapter 332) renamed the Physician Assistant Committee as the Physician Assistant Board, extended the operation of the Board until January 1, 2017, and revised the composition of the Board. The Board consists of four physician assistants, four public members, and one physician and surgeon member of the Medical Board of California.

ISSUE#3 NEED FOR EMPLOYER REPORTING

Business and Professions Code Section 800-series provided several reporting mandates for the Medical Board of California as well as other health professions to assist licensing boards in protecting consumers and licensees who have had actions taken against them. It was pointed out by the Board that 800-series reporting did not include physician assistants. While the Board encouraged voluntary 800-series reporting, it was not mandated. The Board wished to be included in 800-series reporting to further assist in its role of consumer protection.

It was recommended by the Business, Professions, and Economic Development staff that 800-series reporting requirements of the Business and Professions Code apply to physician assistants.

SB 1236 (Price Statutes of 2012, Chapter 332), among other things, mandated 800-series reporting for physician assistants.

ISSUE #4 CONTINUING EDUCATION AUDITS

AB 2482 (Maze/Bass Chapter 76, Statutes of 2008) authorized the Board to require a licensee to complete continuing medical education (CME) as a condition of license renewal.

In June 2010 regulations became effective to implement the provisions of AB 2482.

It was previously stated that the Board verifies compliance with the CME requirement through a self-reporting question on the renewal application. It was also stated that the Board wishes to conduct random audits to verify compliance with the CME requirements. The Board had not yet conducted an audit.

It was recommended by the Business, Professions, and Economic Development staff that the Board explain the lack of self-reporting audits and plans to implement audits.

Due to ongoing BreEZe implementation and system issues with the current Release 1 Boards and the roll out of Release 2 Boards by the end of 2015, the Board's ability to properly conduct and manage an auditing program for CE has been delayed and the Board has been unable to conducted audits.

On July 1, 2012, the Department of Consumer Affairs BreEZe project moved into a "hard freeze." The hard freeze impacted all Department of Consumer Affairs (DCA) boards, including the Physician Assistant Board's ability to make any programming changes to the existing Applicant Tracking System (ATS) and Consumer Affairs System (CAS) legacy

systems used prior to the implementation of BreEZe. The hard freeze was implemented by DCA to ensure that any additional changes to the existing legacy systems would not negatively impact the roll out of BreEZe.

The hard freeze negatively impacted the Board's ability to conduct CE audits because CAS couldn't be upgraded to accommodate the Board's need to conduct CE audits. Additionally, the Board's ability to verify CE compliance was also impacted in that the CAS system was not updated to "read" the CE compliance question on the renewal notice.

Because the Board was legally required to verify CE compliance, a "Hard Freeze Exemption" request was submitted to the Department of Consumer Affairs Change Control Board to seek an exemption to allow the CAS system to be updated to "read" and verify the CE compliance statement on the renewal application. The Board's request for an exemption to update CAS to "read" the CE question was rejected.

Therefore, the unmodified CAS system would not recognize the CE compliance question on the renewal notice and would renew the license. Board staff would receive the notices several weeks later and would be required to manually review every notice and "un-renew" those licensees who certified that they were not in compliance with the Board's CE requirements. This practice continued until implementation of BreEZe in October 2013.

The Board has come to recognize that during the implementation of BreEZe and the ongoing stabilization issues the Board cannot expect at this time to rely on BreEZe system to be modified to allow the Board to conduct CE audits. Therefore, the Board has determined that the most effective alternative is to develop a computer program to randomly select licensees and manage the Board's CE program not using the BreEZe system.

Because Board staff does not have the ability to develop computer programs, staff are currently working with the Medical Board of California to assist in the development of a program outside the BreEZe system that will allow for the ability to conduct CE audits.

ISSUE #5 PROMOTING AND UNDERSTANDING WORKFORCE DEVELOPMENT ISSUES FOR PHYSICIAN ASSISTANTS

In establishing the physician assistant profession in California, the legislature intended to address, "the growing shortage and maldistribution of health care services in California" by eliminating "existing legal constraints" that constitute "an unnecessary hindrance to the more effective provision of health care services." It has been recognized that physician assistants effectively and safely been able to provide health care services in a number of settings including medically underserved areas.

It has been recognized that due to health care reform, including the implementation of the Patient Protection and Affordable Care Act, there exists a need for additional health care providers to accommodate the additional consumers who will be eligible to receive health care services. As more consumers enter the health care system, a more efficient use of health care providers will be required. Physician assistants are able to provide health care services to California consumers by working with other members of the health care team including physicians, nurses, medical assistants, and other health care providers.

It was recommended by the Business, Professions, and Economic Development staff that the Board makes efforts to increase the physician assistant workforce and ensure participation of its licensees in the state's health care delivery system.

Physician assistant education and workforce concerns are ongoing issues with the Board.

AB 2102 (Ting, Chapter 420 Statutes of 2014) requires the Board of Registered Nursing, Physician Assistant Board, Respiratory Care Board, and the Board of Vocational Nursing and Psychiatric Technicians to report specific demographic data relating to licensees to the Office of Statewide Health Planning and Development (OSHPD).

The Board collects, biennially, at the time of both issuing the initial license and at the time of license renewal the following data:

- Location of practice, including city, county, and ZIP code
- Race or ethnicity (licensee option to report)
- Gender
- Languages spoken
- Educational background
- Classification of primary practice

The Board has a Memorandum of Understanding with the OHSPD Healthcare Workforce Clearinghouse Program and has been begun reporting to them the required demographic data.

The Board believes partnering with the OHSPD Healthcare Workforce Clearinghouse Program is a reasonable method to address workforce issues. The Clearinghouse also supports healthcare accessibility through the promotion of a diverse and competent workforce while providing an analysis of California's healthcare infrastructure and coordinating healthcare workforce issues. As a partner, the Board is responsible for licensing and regulation of physician assistants. Additionally, the Board maintains and is able to provide the Clearinghouse certain demographic information related to licensees.

The Board created a Physician Assistant Education/Workforce Development Committee to look into education and workforce issues for physician assistants.

Regarding physician assistant education and training, the Board has been concerned with the decision by the ARC-PA, (the national physician assistant training program accreditation agency) to require that all physician assistant training programs be at the Master's Degree level by 2020. This has led to the closure of several associate level programs.

The Board has also supported legislation that promotes the more efficient use of health care providers, including physician assistants. For example, SB 352 (Pavley, Chapter 286 Statutes of 2013) allows physicians to delegate medical assistant supervision to physician assistants and nurse practitioners.

As the health care landscape in California continues to evolve, the Board is committed to ensuring that it continues to monitor and address the health care needs of California consumers.

ISSUE #6 CONTINUED REGULATION BY THE COMMITTEE

The Business, Professions, and Economic Development Background Paper from the last Sunset Report noted that the Board has shown over the years a strong commitment to improve its overall efficiency and worked cooperatively with the Legislature and the Committee to bring about necessary changes.

It was recommended by the Business, Professions, and Economic Development staff that the physician assistant profession continues to be regulated by a "Physician Assistant Board," with five professional members and four public members, in order to protect the interests of the public and be reviewed once again in four years.

SB 1236 (Price Statutes of 2012, Chapter 332) renamed the Physician Assistant Committee as the Physician Assistant Board, extended the operation of the Board until January 1, 2017, and revised the composition of the Board.

Section 11 – New Issues

This is the opportunity for the board to inform the Committees of solutions to issues identified by the board and by the Committees. Provide a short discussion of each of the outstanding issues, and the board's recommendation for action that could be taken by the board, by DCA or by the Legislature to resolve these issues (i.e., policy direction, budget changes, and legislative changes) for each of the following:

1. Issues that were raised under prior Sunset Review that have not been addressed.

As previously stated, Issue # 4 regarding the recommendation to explain the lack of audits and plans to implement audits has not yet been accomplished. The Board, recognizing that at this time BreEZe will not be able to be configured to perform CME audits has elected to develop a CME program outside of BreEZe to conduct random audits for CME compliance.

2. New issues that are identified by the board in this report.

Disciplinary action taken against another California health care professional licensing board.

Many physician assistants possess licenses in other health care fields. These fields include, but are not limited to nurse, nurse practitioner, chiropractor, EMT, paramedic, etc.

Based on Business and Professions Code Sections 141, the Board may take disciplinary action against a licensee who has been disciplined by another state, by any agency of the federal government, or by another country for any act substantially related to the practice of a physician assistant.

However, the Board lacks legal authority to take disciplinary action against a licensee who has been disciplined by another California health care professional licensing board.

It would seem logical that if the Board can take disciplinary action against a licensee based on out-of-state discipline it should be able to do so in the case of a California licensed health care provider.

The Board is requesting that legislation be introduced to allow the Board to discipline a licensee based on discipline by another California health care professional licensing board in addition to out-of-state discipline. Such a legislative change would further enhance the Board's mandate of consumer protection.

Suggested language may state:

"The board may take disciplinary action against a physician assistant or deny an application for a license based on denial of licensure, revocation, suspension, restriction, surrender, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board."

Board member composition: Medical Board of California Physician and Surgeon Member

It was recommended by the Senate Committee on Business, Professions and Economic Development Background Paper for the Physician Assistant Committee that the Medical Board of California Physician and Surgeon member should continue as a voting member of the Board.

It was stated that it would not appear to be necessary for this member to vote if the primary focus of the Board is on the practice of physician assistants. The Board, however, continues a unique relationship with the Medical Board of California in that the Medical Board provides many services to the Board and physician assistants may not practice without the supervision of a physician.

SB 1236 (Price, Chapter 332 Statutes of 2012) amended Business and Professions Code Section 3505. It stated that the physician and surgeon member appointed by the Medical Board of California shall serve as an ex officio, nonvoting member whose functions shall include reporting to the Medical Board of California on the actions or discussions of the Board.

The Board respectfully requests that the Medical Board of California physician and surgeon member to once again be permitted to become a voting member of the Board.

The Board has always valued the participation, guidance, and input of the Medical Board physician member. Since physician assistants must be supervised by a physician many issues involve both boards.

The Board is concerned that not being permitted to vote will discourage Medical Board of California members from wishing to be appointed to the Physician Assistant Board. Today, members of the Medical Board of California may attend in person or watch Board meetings and report back to the Medical Board. By allowing the Medical Board member to vote this would ensure that they would like to be appointed to the Board and willing to actively participate in Board deliberations and actions.

Additionally, the Boards rulemaking authority is limited to regulating physician assistants. However, the Medical Board of California has authority to adopt regulations that govern physician assistant actions that fall within the Medical Board's jurisdiction. While the Board is authorized to make recommendations to the Medical Board over matters such as scope

of practice of physicians, jurisdiction over the scope of practice for physician assistants lies solely with the Medical Board of California.

Because the Medical Board of California has jurisdiction over physician assistant scope of practice matters, it would seem reasonable that the physician member of the Medical Board should be a voting member.

3. New issues not previously discussed in this report.

Please see above, Section 11, #2.

4. New issues raised by the Committees.

There are no new issues raised by the Committees.

Section 12 – Attachments

Please provide the following attachments:

- A. Physician Assistant Board Policy Manual.
- B. Current organizational chart showing relationship of committees to the board and membership of each committee (cf., Section 1, Question 1).
- C. Major studies, the Board did not do any major studies (cf., Section 1, Question 4).
- D. Year-end organization charts for last four fiscal years. Each chart should include number of staff by classifications assigned to each major program area (licensing, enforcement, administration, etc.) (cf., Section 3, Question 15).
- E. Physician Assistant Board Performance Measures as published on the Department of Consumer Affairs website.
- F. Physician Assistant Board Customer Service Satisfaction Survey.
- G. How Shall the PAC Address the California Physician Assistant Workforce Shortage?
- H. Report on Alternative Accreditation, presented at the May 4, 2015 Board meeting by The Education/Workforce Development Committee.
- I. Office of Statewide Health Planning and Development' Health Care Clearinghouse Fact Sheet.

Section 13 – Board Specific Issues

Diversioin

Discuss the board's diversion program, the extent to which it is used, the outcomes of those who participate, the overall costs of the program compared with its successes

The Board's diversion/monitoring program was established in 1990. The Board along with six other Department of Consumer Affairs boards currently contracts with MAXIMUS to provide monitoring services.

Although participants may self-enroll in the program, a majority of the Board's participants are board-referrals required to participate and successfully complete the program as a condition of probation.

As of August 1, 2015, the Board's Diversion Program has 3 self-referred and 9 Board-referred for a total of 12 participants.

It should be noted that the Board's program is not a true "diversion" program in which licensees avoid disciplinary action by enrolling in the program. Participants are not "diverted" from disciplinary action; rather, participants are monitored for compliance with program terms and conditions.

The Board's diversion program is a useful tool in monitoring licensees with drug and alcohol problems. Additionally, the program is also an effective and major component of the Board's enforcement program in monitoring probationers who are subject to participation in the diversion program as a condition of their probation. Diversion program clinical case managers work closely with Board probation monitors to ensure that probationers are in compliance with all terms of probation. By working cooperatively, an added layer of monitoring and compliance is achieved. The Board has found that probation monitors are generally not equipped or trained to deal with probationers with drug and alcohol issues. Having diversion program clinical case managers trained in substance abuse monitoring, the drug and alcohol aspects of the probationer greatly assists in achieving probationary compliance and quickly addressing noncompliance issues.

The goal is for a participant's successful completion of the program. Often, probationers are clinically evaluated and deemed not requiring participation in the program. Those individuals, though not required to participate in the program are, nevertheless, required to remain abstinent from drugs and alcohol and are subject to random drug testing for the complete probation term. Participants that do not comply with the terms of the diversion program are subject to further disciplinary action which may include revocation of the license.

Diversion program costs have shifted to participants in the program. In December 2010, the Office of Administrative Law approved a regulatory change in which Title 16 California Code of Regulations Section 1399.557 was adopted. This section requires licensees required to participate in the diversion program to pay the full amount of the monthly participation fee charged by the contractor. Licensees voluntarily enrolling in the program pay 75% of the monthly fee charged by the contractor.

Initially, when the program was created in 1990 the Board absorbed the participant participation fee. Due to an increase in the number of participants enrolled in the program, which increased the Board's costs, the Board began in July 2004 assessing a \$100 monthly participation fee. The Board absorbed the remainder of the fee charged by the program.

In adopting the regulation, the Board believed that participants be assessed a fee for participation in the program as it reinforces accountability and responsibility for their monitoring and recovery.

The Board believed that participants mandated to participate in the program as a condition of probation should be assessed the full amount due to the disciplinary nature of their participation. Licensees who have been disciplined pay the cost of investigation and probation monitoring. Likewise, diversion program participants should pay for their participation in the program, as well.

As an incentive for self-referral to the program for licensees who have drug and alcohol issues, the Board believed that reducing the participation fee and requiring a payment of 75% of the full amount would encourage self-referrals and address their issues early in their addiction prior to escalating to a disciplinary matter.

The participation fee is collected by the contractor, Maximus.

Attachment

A

PHYSICIAN ASSISTANT BOARD

POLICY MANUAL

Updated February 9, 2015

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GENERAL AREA: Administration

SPECIFIC SUBJECT: Attendance

STATEMENT:

A report on member attendance will be presented to the Executive and Budget Committee and given to the full Board.

INITIAL POLICY REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAB: 12/12/94

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 01/20/95

REVIEWED AND RECOMMENDED MODIFICATION BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 11/20/03

MODIFICATION APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 11/20/03

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Administration

SPECIFIC SUBJECT: Conflict of Interest

STATEMENT:

A Board member is expected to exercise impartial and reasoned judgment in all matters brought before the Board. It is the policy of the Physician Assistant Board that members may sometimes need to recuse themselves to ensure such impartiality. Illustrative of these times are when a member (or someone in the member's immediate family) has close personal knowledge of, or substantial business interests with, an individual or entity brought before the Board for enforcement or decision of any sort.

NECESSITY:

In order for any deliberative body to ensure the trust placed in it by the government and the public, it is necessary to avoid any bias or perception of bias by individual Board members. To reassure all parties of the impartial nature of discussions and decisions, Board members who have personal involvement or business interests relevant to a decision must refrain from interjecting opinion or bias into those discussions. It is appropriate that members who have or may reasonably be perceived as having inappropriate interest or bias in a matter should recuse themselves from discussion and voting in that matter.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 2/26/04

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Administration

SPECIFIC SUBJECT: Experts: Role of Special Services and Content Experts

STATEMENT:

From time to time, the Physician Assistant Board (PAB) may require special services, certain content experts, or consultants for specific projects and problems. Such services are arranged by means of state approved contracts authorized by state law. Such individuals functioning as specialists serve as contractual consultants to (e.g.,) the Executive Officer, the full Board, or a committee of PAB. Consistent with state law, such individuals may not serve as members of committees; nor may they function as (e.g.,) ex officio members of the PAB.

NECESSITY:

The PAB may require expert assistance in fulfilling its responsibilities to the consumers of California. Still, the actual decision makers in PAB operations and decisions must remain those individuals duly appointed to the Board. Consequently, although consultants and others may provide information and other expertise to the PAB, their role will remain that of advisor or consultant -- not that of decision-maker, Board member, or committee member in any sense.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 2/26/04

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Administration

SPECIFIC SUBJECT: Outreach, Information, Complaints

STATEMENT:

Outreach and consumer education shall be provided by the PAB to consumers regarding the role of the PAB and how to file complaints against practitioners. This information shall be provided by the PAB through:

1. A toll-free (800) telephone number placed in most California telephone directories,
2. PAB's newsletter,
3. Information and special bulletins distributed to all current licensees of the PAB,
4. Information provided to state depository libraries,
5. Speaking engagements by PAB members and staff,
6. Press releases and public affairs announcements,
7. Telephone responses,
8. Written, FAX, and E-mail inquiries, and
9. The PAB website.

Additional sources of information concerning PAB and the complaint process specifically shall include:

1. Various services and information of the Medical Board of California,
2. Osteopathic Medical Board of California, and
3. Services and publications of the Department of Consumer Affairs.

NECESSITY:

Incumbent in the oversight responsibility of the PAB is the provision of information concerning the practices and roles of the PA practitioners, as well as specific information that promotes understanding of and means of access to the process of making complaints against practicing PAs and their supervising physicians. This information must be made available to every Californian through the most diverse media possible.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 2/26/04

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Administration

SPECIFIC SUBJECT: Projects: Approval for New Projects

STATEMENT:

The Chair of the Physician Assistant Board will be responsible for approving all new projects submitted by Physician Assistant Board members and staff. New projects will be submitted in writing to the Executive Officer for perspective and feasibility. The Executive Officer will then seek approval of the Chair.

NECESSITY:

Fiscal responsibility and appropriate utilization of resources is essential to protect the integrity and purpose of the Department of Consumer Affairs and the Physician Assistant Board. Annual meetings, ongoing projects and travel plans are the responsibility of the Executive and Budget Committees. Additional requests for new projects need to be carefully reviewed by the Chair and Executive Officer for cost and appropriate contribution to the goals of the Physician Assistant Board. The final decision will rest with the Chair of the Physician Assistant Board.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 10/05/95

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 10/27/95

REVIEWED BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 10/28/04

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Administration

SPECIFIC SUBJECT: Training/Orientation of Newly Appointed Board Members

STATEMENT:

Newly appointed Board members are expected to become familiar with PAB policies and regulations, as well as key laws relating to PAB practices and programs. Within the first thirty days of appointment if possible, but certainly before the sixth month of appointment, new members will meet with the Executive Officer of the PAB and the PAB Chair or the Chair's designee for orientation to PAB's mission and goals and for instruction in relevant policies, procedures, regulations, and laws.

NECESSITY:

Board members must understand the practices, the procedures, and the standards of the medical and physician assistant professions, state government, and the PAB. Such understanding must be built on a foundation of knowledge of:

1. Policies that govern the PAB and its committees;
2. Board regulations that relate to PA practices; and
3. State laws and regulations that define the nature, scope, minimum standards of performance, etc., of PA practices.

In addition, Board members are required by California law to complete the following training:

1. Board Member Orientation Training (within one year of assuming office, even if serving on another Board);
2. Ethics Training (within the first 6 months of appointment and repeated every 2 years throughout their term);
3. Sexual Harassment Prevention Training (every 2 years); and,
4. Defensive Driver Online Training (every 4 years).

In addition, after appointment, Board members will receive a Form 700 (Statement of Economic Interests and Conflict of Interest Filing) packet from the Department of Consumer Affairs. The Form 700 "Assuming Office" form must be filed within 30 days of a new Board member appointment. Appointees must file the Form 700 Annual Statement every April 1. Appointees must file a Form 700 "Leaving Office" Statement within 30 days of leaving the Physician Assistant Board.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 10/28/04

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Administration

SPECIFIC SUBJECT: Travel: Approval of Unscheduled Travel

STATEMENT:

The Chair of the Physician Assistant Board will be responsible for approving all unscheduled travel plans submitted by Physician Assistant Board members and staff. Unscheduled travel plans will be submitted in writing to the Executive Officer for perspective and feasibility. The Executive Officer will then seek approval of the Chair.

NECESSITY:

Fiscal responsibility and appropriate utilization of resources is essential to protect the integrity and purpose of the Department of Consumer Affairs and the Physician Assistant Board. Annual meetings, ongoing projects and travel plans are the responsibility of the Executive and Budget Committee. Additional requests for unscheduled travel need to be carefully reviewed by the Chair and Executive Officer for cost and appropriate contribution to the goals of the Physician Assistant Board. The final decision will rest with the Chair of the Physician Assistant Board.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION THE PAC: 10/05/95

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 10/27/95

REVIEWED BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 10/28/04

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Licensing

SPECIFIC SUBJECT: Criminal History: Responses to Criminal History Reports (a.k.a., rap sheets)

STATEMENT:

Criminal history reports concerning prospective licensees who self-report a prior conviction shall be examined and evaluated by the PAB Executive Officer or his/her designee. If there exist one or more criminal convictions significantly related to practice as a PA, PAB delegates to the Executive Officer in accordance with Title 16, California Code of Regulations Section 1399.503, discretion to respond appropriately, including:

1. Issuing a notification of intent to deny the license;
2. Issuing a Statement of Issues if the applicant seeks to pursue the license; and
3. Proceeding through the administrative law process.

The Executive Officer shall make full and regular reports (typically, quarterly) to the PAB concerning actions taken on the basis of application review by the Executive Officer, including review of information pertaining to criminal convictions.

NECESSITY:

PAB and the PA profession are committed to the highest standards of professional conduct that promote the health, safety, and welfare of the citizens of California. When apparent issues arise in the application process that may affect these goals, the PAB is committed to rapid, fair, and consistent responses. While the PAB, of course, retains oversight responsibility, the Executive Officer or his/her designee is delegated the responsibility of timely and efficient evaluations and appropriate responses to criminal history reports.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 10/28/04

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Disciplinary/Enforcement Action

SPECIFIC SUBJECT: Administrative Hearings

STATEMENT:

Administrative hearings shall be conducted in compliance with the Administrative Procedures Act (Government Code Sections 11500 and following). In addition, licensees who file petitions for penalty relief to reinstate license, modify terms of probation, or terminate probation may also be heard before an ALJ with participation by the members of the PAB according to the criteria set forth in Business and Professions Code Section 3530.

NECESSITY:

Administrative hearings on accusations against PAB licensees must be conducted thoroughly and completely, but also with sensitivity to differing situations and choices by individuals accused of misconduct. It is important to PAB's obligations both to the citizens of California and to the accused licensee or other parties that equitable procedures, as provided within the context of the Administrative Procedures Act, be available, accessible, and followed consistently.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED AND RECOMMENDED MODIFICATION BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 6/30/05

MODIFICATION APPROVED BY PHYSICIAN ASSISTANT COMMITTEE: 6/30/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Disciplinary/Enforcement Action

SPECIFIC SUBJECT: ALJ Decisions: Acceptance Standards for ALJ Decisions

STATEMENT:

Disciplinary decisions proposed by administrative law judges shall be evaluated on a case-by-case basis by the PAB. The Board shall evaluate such proposals on the basis of five criteria; that is, proposed decisions must attempt to:

1. Be based on the community standards of medical/health care and standards of practice;
2. Respond to the situation in a way consistent with the nature and degree of the violation;
3. Serve as a reflection of the PABs commitment to protect the health and safety of the citizens of California;
4. Be reasonable and practical in terms of implementation; and,
5. Be equitable and consistent with decisions made in earlier, similar cases, utilizing model orders and disciplinary guidelines adopted by the Board and set forth in regulation.

Decisions judged in writing by any Board member not to meet one or more of these criteria may be judged unacceptable by the Board. The Board will then discuss the decision in closed session. If the Board votes to reject the proposed decision, it can call up the hearing transcript, request written argument from the parties, and decide the case itself.

NECESSITY:

The PAB has great respect for the administrative hearing process as practiced in California. Whenever possible, the Board wishes to, and expects to, accept *proposed* decisions made through that process. Still, the Board cannot abrogate its responsibility to guarantee that the complex issues of medical practice be decided in ways that are medically sound, fair, and effective in promoting the highest standards of the PA profession, while protecting consumers.

Therefore, the PAB reserves the right to evaluate each proposed decision based upon the aforementioned criteria in order to fulfill these Board responsibilities of high standards of PA practice and consumer protection.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED AND RECOMMENDED MODIFICATIONS BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 6/30/05

MODIFICATIONS APPROVED BY PHYSICIAN ASSISTANT COMMITTEE: 6/30/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Disciplinary/Enforcement Action

SPECIFIC SUBJECT: Information: Disclosure of Information

STATEMENT:

Disciplinary action is public information once an accusation has been filed. The information disclosed shall be the accusation and decision documents.

Information concerning citations or citations and fines shall be disclosed once the citation or citation and fine are issued. Such citation information shall be provided on request, but it shall be accompanied by the explanation that payment of a citation is considered a satisfactory resolution of the matter for purposes of public disclosure but is not tantamount to an admission of a violation.

Disciplinary information, excluding information about citations or citations and fines as discussed above, shall be disclosed to the public by means of the *MBC Newsletter*, and *PAB Update*, and the PAB website. In addition, in accordance with DCA policy, the PAB shall provide a copy of the accusation and decision without charge to any member of the public upon request.

NECESSITY:

The PAB is required to comply with the Bagley-Keene Open Meetings Act, the California Public Records Act, and other applicable laws. Additionally, the PAB believes that its role in protecting the health, safety, and welfare of California citizens is best fulfilled in an atmosphere of open communication with members of the public. Consumers and patients must be accorded easily accessible means of identifying those practitioners found in violation of applicable statutes and regulations. Moreover, the prevention of future violations may be best accomplished when it is clear that information concerning violations, and the name of the physician assistant who has committed a violation, is accurately and promptly disclosed publicly.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED AND RECOMMENDED MODIFICATIONS BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 6/30/05

MODIFICATIONS APPROVED BY PHYSICIAN ASSISTANT COMMITTEE: 6/30/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Disciplinary/Enforcement Action

SPECIFIC SUBJECT: Education through Disciplinary Action

STATEMENT:

Disciplinary questions and consumer complaints shall be highlighted in the various communication media used by the Board. Such matters shall include, for example, cases of illegal prescribing (vis a vis, transmitting a physician's prescription), and questions about the PAB's alcohol and drug diversion program. Relevant communication media shall include, but are not limited to, discussions at Board meetings, newsletter articles, press releases, and public speaking occasions.

NECESSITY:

The PAB believes that education in legal matters and professional conduct matters that are subjects of discipline can be a valuable help in encouraging the best possible PA care for California's citizens. Such education can be accomplished in part by publicizing instances of especially harmful and unacceptable conduct -- and the discipline that resulted from that unacceptable conduct. The PAB strives to promote safe, honest, and ethical behavior by its licensees in order to reduce or preclude the need for the Board to take action to protect consumers.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED AND RECOMMENDED MODIFICATIONS BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 6/30/05

MODIFICATIONS APPROVED BY PHYSICIAN ASSISTANT COMMITTEE: 6/30/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Investigations

SPECIFIC SUBJECT: Investigative Staff and Services

STATEMENT:

The PAB shall contract primarily with the Department of Consumer Affairs' Division of Investigation (DOI) for the use of investigators and investigative services.

NECESSITY:

Evidence obtained during investigations involving PA behavior and practice must meet a standard of clear and convincing evidence for use in court. As sworn peace officers, DOI investigators are trained to obtain this level of evidence. Such contracting with the Department of Consumer Affairs' unit represents an efficient and effective approach to PAB investigations. Moreover, since DOI investigates complaints against physicians such an arrangement is appropriate since PAs by definition provide medical services under the supervision of physicians approved by either the MBC or the OMBC to supervise PAs.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED AND RECOMMENDED MODIFICATION BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 10/6/05

MODIFICATION APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 10/6/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Investigations

SPECIFIC SUBJECT: Priority of Complaints

STATEMENT:

The PAB has decided that the Department of Consumer Affairs' Division of Investigation's case prioritization categories shall be used and applied to complaints about the conduct of licensed PAs or persons describing themselves as licensed PAs.

NECESSITY:

In order to ensure prompt, effective, and consistent treatment of complaints, the PAB endorses the need for complaints to be processed according to time frames related to the severity of the alleged offense. The Division of Investigation's system of complaint prioritization has been judged by the PAB to be a fair and effective means of assuring that urgent complaints are addressed in an efficient and timely manner.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED AND RECOMMENDED MODIFICATION BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 10/6/05

MODIFICATION APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 10/6/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Investigations

SPECIFIC SUBJECT: Time Limitations

STATEMENT:

The standard investigation in a typical case shall be limited initially to no more than twenty (20) hours of investigative work. Investigators (contracted through the DCA's Division of Investigation) are asked to contact the PAB Enforcement Coordinator or the Executive Officer to request prior approval of additional time to complete particular cases. Such additional time may be granted at the discretion of the PAB's Executive Officer or his/her designee based on the facts presented. Alternative ways of efficiently and effectively completing the investigation shall be considered before an approval for additional time is granted.

NECESSITY:

Investigations must be thorough and systematic, but they also need to be efficient and consistent. The provision of standard initial time frames for investigations allows these activities to be managed equitably. The allowance for additional contracted time ensures that particularly complex or wide-ranging situations are investigated adequately and cost efficiently to ensure that the PAB fulfills its consumer protection obligation.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED AND RECOMMENDED MODIFICATION BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 10/6/05

MODIFICATION APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 10/6/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Enforcement

SPECIFIC SUBJECT: Auditing of Enforcement Cost

STATEMENT:

The PAB Executive Officer or his/her designee shall collect monthly and annual enforcement cost reports provided by the Office of Administrative Hearings, the Office of the Attorney General, and the Department of Consumer Affairs' Division of Investigation, in addition to CALSTARS reports. These collected reports shall be reviewed on a monthly basis by the Executive Officer.

NECESSITY:

The efficient use of public moneys depends in part on wise and prudent outlays even for something as critical as enforcement. Prudent allocation of funds -- and any future use of funds -- cannot occur without a systematic and regular monitoring of the current use of funds. Monthly analyses by the Executive Officer allow him/her to prepare the materials and information for Board review.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED AND RECOMMENDED MODIFICATIONS BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 10/6/05

MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 10/6/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Enforcement

SPECIFIC SUBJECT: Consultants: Selection of Expert Consultants

STATEMENT:

Expert consultants for matters of investigation shall be selected by the PAB's Executive Officer on the bases of the following submitted information, selection criteria, and process:

Submitted Information. Potential expert consultants shall submit to the PAB Executive Officer:

1. A curriculum vitae;
2. Two professionally-relevant references;
3. A statement of areas of expertise and experience; and
4. Evidence of knowledge in/history of testifying and/or giving depositions.

Selection Criteria. Potential expert consultants may be evaluated on the basis of:

1. The appropriateness and relevance of their education, training, and the needs of the PAB;
2. The background factors listed in Submitted Information above;
3. Evidence of diagnostic and analytical ability in reviewing matters;
4. Level of credibility, reputation, and professional status;
5. Ability to translate complex medical issues orally and in writing for laypersons (e.g., deputy attorneys general, juries, ALJs);
6. Record of any disciplinary actions or judgments against the . applicant expert consultant by PAB, hospitals, or any other agencies, excluding minor traffic violations; and
7. Evidence of productive, effective, and successful testimonial skills.

Selection Process. Potential expert consultants may be selected by the following process steps:

1. A review and confirmation of submitted materials by the Executive Officer or designee;
2. An interview by the Executive Officer and PAB Enforcement Analyst;
3. Evaluation of the potential consultant by the Executive Officer in terms of the seven (7) selection criteria listed above;
4. Evaluation of candidate's written and oral responses to a "sample" case;
5. Selection as expert consultant by the Executive Officer; and
6. Notification of the expert consultant and briefing on administrative procedures to be followed.

NECESSITY:

Enforcement is a primary and fundamental duty of the PAB. The Board is committed to fulfilling this responsibility with the utmost care, fairness, and effectiveness. When it is determined that expert witnesses are crucial to the enforcement process, the selection of such witnesses must be accomplished efficiently, but with the highest degree of professionalism. A clear, effective, and thorough selection process, therefore, is a pivotal part of the enforcement process.

**REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED
FOR PRESENTATION TO THE PAC: 04/05/97**

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 10/6/05

**EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN
ASSISTANT BOARD: 02/09/2015**

GENERAL AREA: Enforcement

SPECIFIC SUBJECT: Evaluation of Consultants: Assignment and
Evaluation of Expert Consultants

STATEMENT:

The Board's assignment of an expert consultant and the evaluation and possible re-assignment of that consultant are integrally connected and may be conducted in the following manner:

1. Approved and selected expert consultants shall be assigned initially to fairly simple and straightforward cases;
2. First reports by expert consultants shall be reviewed and evaluated by the PAB's Executive Officer and Enforcement Analyst, and feedback shall be given to the consultant;
3. The expert consultant shall be deemed acceptable if he/she is characterized by:
 - a. Evidence of technical and medical expertise;
 - b. Credibility and professionalism;
 - c. Systematic and thorough modes of investigation and analysis;
 - d. Clarity and specificity in conclusions and recommendations;
 - e. Clarity and effectiveness in both oral and written communication, including presentations at hearings and trials;
 - f. Efficiency in preparing timely reports.
4. The reports shall be compared to those of other more senior PA expert consultants;
5. Newly contracted expert consultants shall receive oral critique of their work by PAB's Executive Officer and/or more senior PA expert consultants. Their work will be evaluated as "standard/acceptable" or "needs improvement" or "unacceptable";
6. An expert consultant whose initial work has been evaluated as unacceptable by the Executive Officer (see 3 a-f above) shall be assigned no future cases;
7. An expert consultant whose work is deemed acceptable or "needs improvement" (see 3 a-f above) shall enter a probationary period of evaluation, the length of which is determined by the Executive Officer, using criteria listed in 3 a-f above;
8. During the probationary period, the work of the expert consultant shall be continually evaluated by the Executive Officer, using criteria listed in 3 a-f above;
9. At the conclusion of specified probationary period, successfully performing expert consultants shall be assigned to more complex cases and situations.

NECESSITY:

Just as enforcement is a major commitment of the PAB, expert consultants are crucial to the fulfillment of that commitment. Despite the Board's careful and systematic selection of candidates for the role of expert consultants, both the evaluation of their performance and the methodical process of using effective consultants on increasingly complex cases are pivotal elements in the highest standards of enforcement activities.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 10/6/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Enforcement

SPECIFIC SUBJECT: Mail Ballot Voting

STATEMENT:

When considering any enforcement action (proposed decision, stipulation or default decision) by mail ballot, votes from two or more Board members to do anything other than adopt means that the item will be held for review and discussion during closed session at the next scheduled Board meeting unless the time for action (100 days) is set to expire before the next regularly scheduled meeting. In such a case, a meeting will be scheduled to discuss the case by teleconference, if necessary.

NECESSITY:

A protocol must be established to allow Board members to present questions and concerns regarding proposed actions to one another-for discussion and resolution. This better allows the Board to make informed and compassionate decisions and allows the Board to offer meaningful feedback to the parties where necessary.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 12/12/94

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 01/20/95

REVIEWED AND RECOMMENDED MODIFICATION BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 10/6/05

MODIFICATION APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 10/6/05

REVIEWED AND RECOMMENDED MODIFICATION BY THE COMMITTEE: 5/31/07

MODIFICATION APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 5/31/07

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Enforcement

SPECIFIC SUBJECT: Vote: Quorum for Deciding Disciplinary Cases

STATEMENT:

For mail votes a quorum will consist of a majority of nine Board members, or five votes as required by Business and Professions Code Section 3511. A majority decision, at a meeting or by mail, will consist of a majority of the quorum. A fax, email, or a telephone vote by a member is acceptable if the paper copy is mailed within 72 hours.

NECESSITY:

The Board must define for the public, profession, and members the term voting quorum as used by the Physician Assistant Board.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 12/12/94

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 01/20/95

REVIEWED BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 10/6/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Legislation

SPECIFIC SUBJECT: Definition of the Positions Taken by the Physician Assistant Board Regarding Proposed Legislation

STATEMENT:

As required the Physician Assistant Board will adopt by the Board as a whole, requiring a forum, the following positions regarding pending or proposed legislation.

Oppose: The Board will actively oppose proposed legislation and demonstrate opposition through letters, testimony and other action necessary to communicate the oppose position taken by the PAB.

Oppose unless Amended: The Board will communicate to the author that they are opposed to the bill but would possibly reconsider their position if certain amendments were made. The Board would direct staff to submit proposed amendments with a letter to the author.

Watch: The watch position adopted by the Board will indicate concern regarding the proposed legislation. The PAB staff and members will closely monitor the progress of the proposed legislation and amendments before taking oppose, disapprove, approve, or support position.

Support if Amended: The Board will communicate to the author they may be willing to support the bill if certain amendments are considered by the author, but will not actively lobby the legislature regarding the proposed legislation.

Support: The Board will actively support proposed legislation and demonstrate support through letters, testimony and any other action necessary to communicate the support position taken by the PAB.

NECESSITY:

The Physician Assistant Board needs clearly defined positions to adopt regarding proposed legislation. Defining the level of activity involved in any position taken allows the committee to take considered, reasoned, and consistent positions and actions regarding proposed legislation.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 10/05/95

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 10/27/95

REVIEWED BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 10/6/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Legislation

SPECIFIC SUBJECT: Legislative Committee: Role and Operating Procedures

STATEMENT:

Role of Committee and Basic Operating Procedures

1. The Physician Assistant Board's Legislative Committee ("the committee") is created to identify legislation about which the Physician Assistant Board of the State of California ("the Board") may want to be notified and /or take a position.
2. The committee shall be comprised of two members appointed by the Chair.
3. The committee reviews state legislation relevant to the Board or the education or practice of physician assistants in California. The committee may place on the agenda of the Board's public meetings legislation it recommends the Board consider. The committee may recommend the Board adopt a support, oppose, watch or other position on legislation as defined in the Policy Manual (Legislation, page 23). The committee or the Board may suggest additional actions, including but not limited to sending letters to the Legislature, recommending amendments to legislation or testifying at legislative hearings.
4. The committee's recommendation may be distributed and/or included with the Board's agenda package, if available. Board members may use the materials to take a position at those meetings if so desired.
5. The Board's staff should provide the committee with guidance on selecting and understanding legislation, as further defined below.
6. At Board meetings, the committee, or any individual Board members, may ask the Board to take a position regardless of whether a specific position was recommended in advance of the Board meeting.
7. If the Board chooses to send the Legislature a letter of support, opposition, or another position on specific legislation, the staff drafts the letter based on the Board's decision, and the committee chair approves the letter. If the committee chair is unavailable, the other committee member or the Board Chair may sign the letter. On behalf of the Board, the staff sends the approved letter to the author, and any other recipients designated by the committee, including the committee reviewing the legislation, the department, or other relevant individuals.
8. In recognition of the limited time and resources committee members have to review legislation, committee members are not expected to spend more than 30 hours per year evaluating legislation, preparing recommendations, and preparing follow-up materials.

Sources of information

1. The Board, its members, and the Board's staff may ask the committee to review specific pieces of legislation.
2. The committee will consider any relevant bills identified by the Medical Board of California, the Department of Consumer Affairs' legislative office (DCA), and California Academy of Physician Assistants (CAPA), other health care related organizations or agencies, or other members of the public.
 - a. Staff seeks lists and analyses of bills relevant to physician assistants and shares with committee members.

- b. Staff provides committee members with contact information for DCA, or other individuals at the aforementioned organizations and others they may contact for additional information.
3. Committee members review recent legislative committee and floor analyses to learn about key issues, fiscal and policy impacts, and supporters and opponents. In some cases, it may also be helpful to review legislative language, particularly if a bill has not yet been reviewed by a state legislative committee. Analysis, legislative language, votes and other official information is available here: <http://leginfo.legislature.ca.gov/faces/billSearchClient.xhtml>
4. Optionally, committee members may want to conduct additional review, such as contacting the author's office to request a fact sheet or clarification or conducting an internet news search for reactions to the legislation.

Preparing for Board meetings

1. At least one month prior to Board meeting, staff will provide the committee members with a relevant bill list as noted above.
2. The committee members review the materials obtained from the above sources and, at least three weeks prior to Board meetings, determine and/or develop agenda items and materials.
3. At least two weeks before Board meetings, committee members send staff agenda items and materials for any legislation the committee wants the Board to consider.
4. Materials sent to the Board will include the summary document prepared by the committee, the most recent, relevant bill language, and analysis of bills in question. The summary document may include recommended positions and a brief explanation of the recommendation. At least one copy of the text of the bill will be available at the Board meeting.
5. At the Board meetings, the committee, or any individual Board members may make a motion that the Board take a position on a bill.

NECESSITY:

The Physician Assistant Board needs a method to be informed of proposed legislation so that, where appropriate, it may take a position on bills. This structure allows the Board to receive timely notice of relevant bills so that it may take considered, reasoned, and consistent positions and actions regarding proposed legislation.

**REVIEWED BY THE LEGISLATION COMMITTEE AND APPROVED FOR
PRESENTATION TO THE PHYSICIAN ASSISTANT BOARD: 08/26/13**

APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 08/26/13

**EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN
ASSISTANT BOARD: 02/09/2015**

GENERAL AREA: General

SPECIFIC SUBJECT: Professional Reporting Requirements

STATEMENT:

If a Board member has knowledge that another physician assistant may be in violation of, or has violated, any of the statutes or regulations administered by the Board, the Board member is encouraged to report this information to the Executive Officer and is also expected to cooperate with the Executive Officer in furnishing information or assistance as may be required.

NECESSITY:

Business and Professions Code Section 3504.1 states that "protection of the public shall be the highest priority for the Physician Assistant Board in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

When a Board member witnesses or has knowledge of any alleged violations that member is encouraged to report those violations to the Executive Officer, thus maintaining the highest standard of professional conduct to promote the health, safety, and welfare of the citizens of California.

REVIEWED AND APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 11/03/14

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

Attachment

B

**Physician Assistant Board
Committee Organization Chart
Fiscal Year 2012/13**

**Physician Assistant
Board**

Legislative Committee

Committee Chair – Catherine Hazelton
Committee Member – Sonya Earley

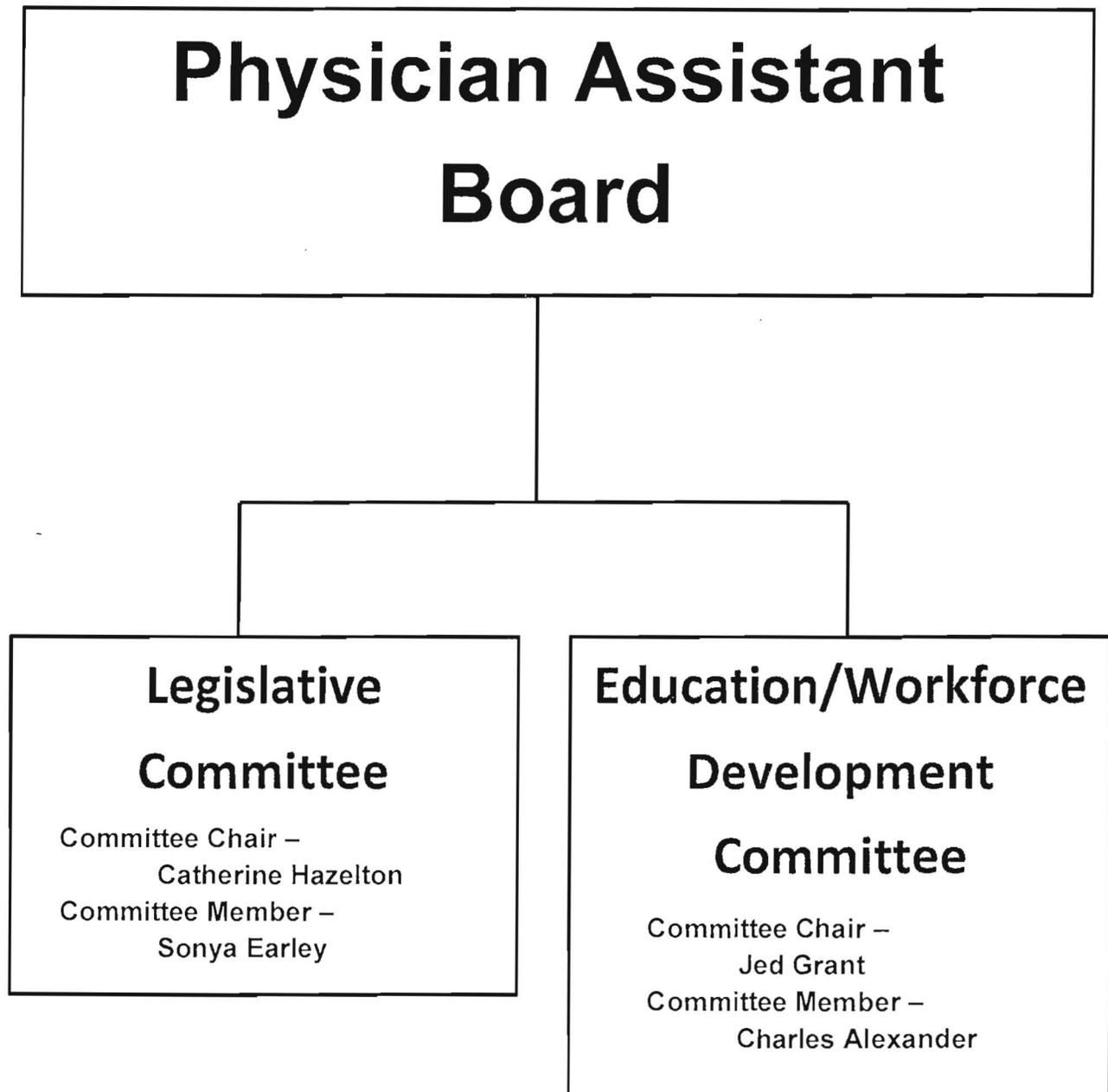
**Physician Assistant Board
Committee Organization Chart
Fiscal Year 2013/14**

**Physician Assistant
Board**

Legislative Committee

Committee Chair – Catherine Hazelton
Committee Member – Sonya Earley

**Physician Assistant Board
Committee Organization Chart
Fiscal Year 2014/15**



Attachment

C

The Board
did not have
any Major
Studies

Attachment

D

DEPARTMENT OF CONSUMER AFFAIRS

PHYSICIAN ASSISTANT COMMITTEE

7/16/12

Executive Officer

Elberta Portman
602-110-6606-001

ENFORCEMENT

AGPA
Dianne Tincher
602-110-5393-002

[Empty box]

DIVERSION

AGPA
Glenn Mitchell
602-110-5393-001

ADMINISTRATION

Staff Services Analyst (G)
Lynn Forsyth
602-110-5157-001

LICENSING

Office Technician
Julie Caldwell (1/2 time)
602-110-1139-001

Staff Services Analyst
CPEI LT .4

position not filed due to 5% personnel savings

Probation Monitors (602-110-5393-907)

AGPA- Retired Annuitant (4)
Barbara Emilio (1/4 time)
Michael Brown 1/4 time
Robert Sherer (1/4 time)
Michael Seamons (1/4 time)

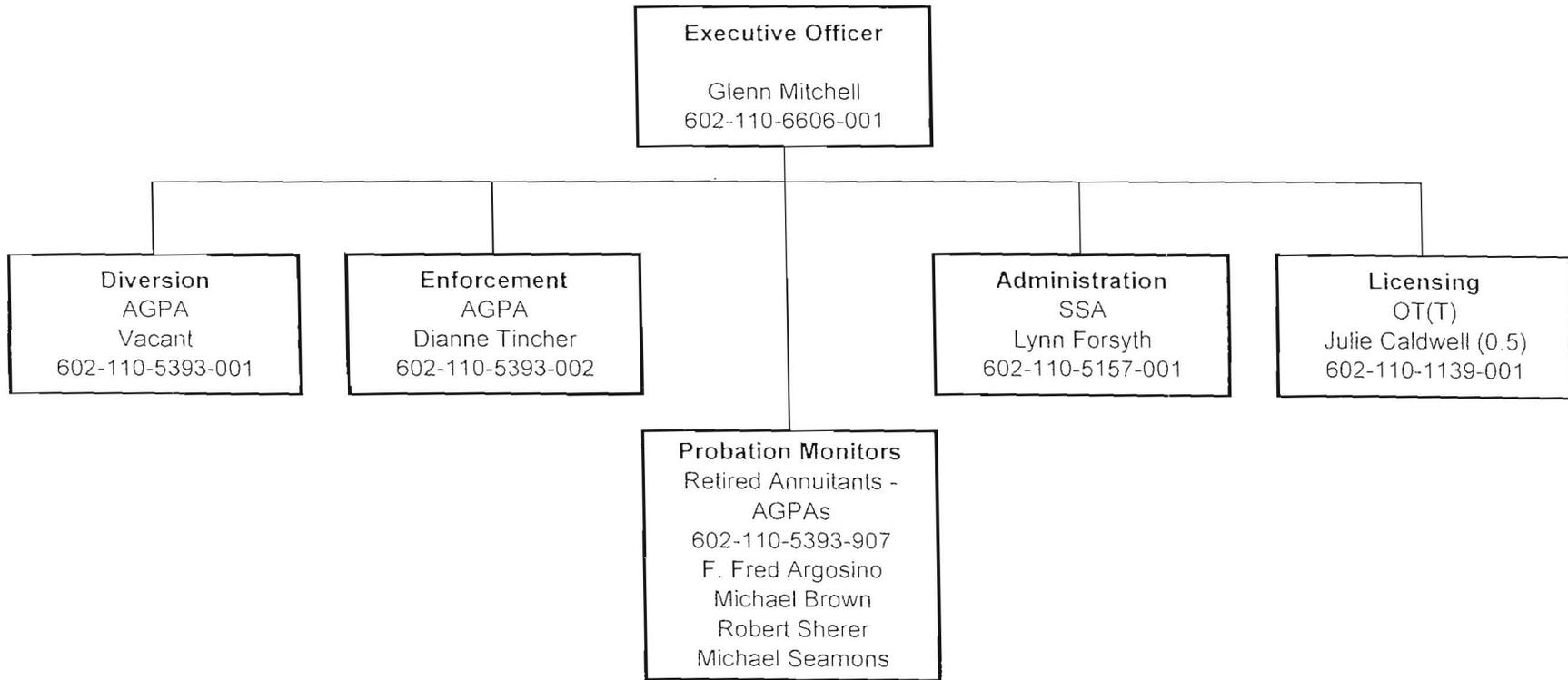
Elberta Portman 7-17-12

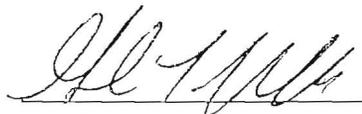
Executive Officer

Date

Classification & Pay Analyst

Date



 1 Jan 2013
Glenn Mitchell, Executive Officer Date

Classification & Pay Analyst

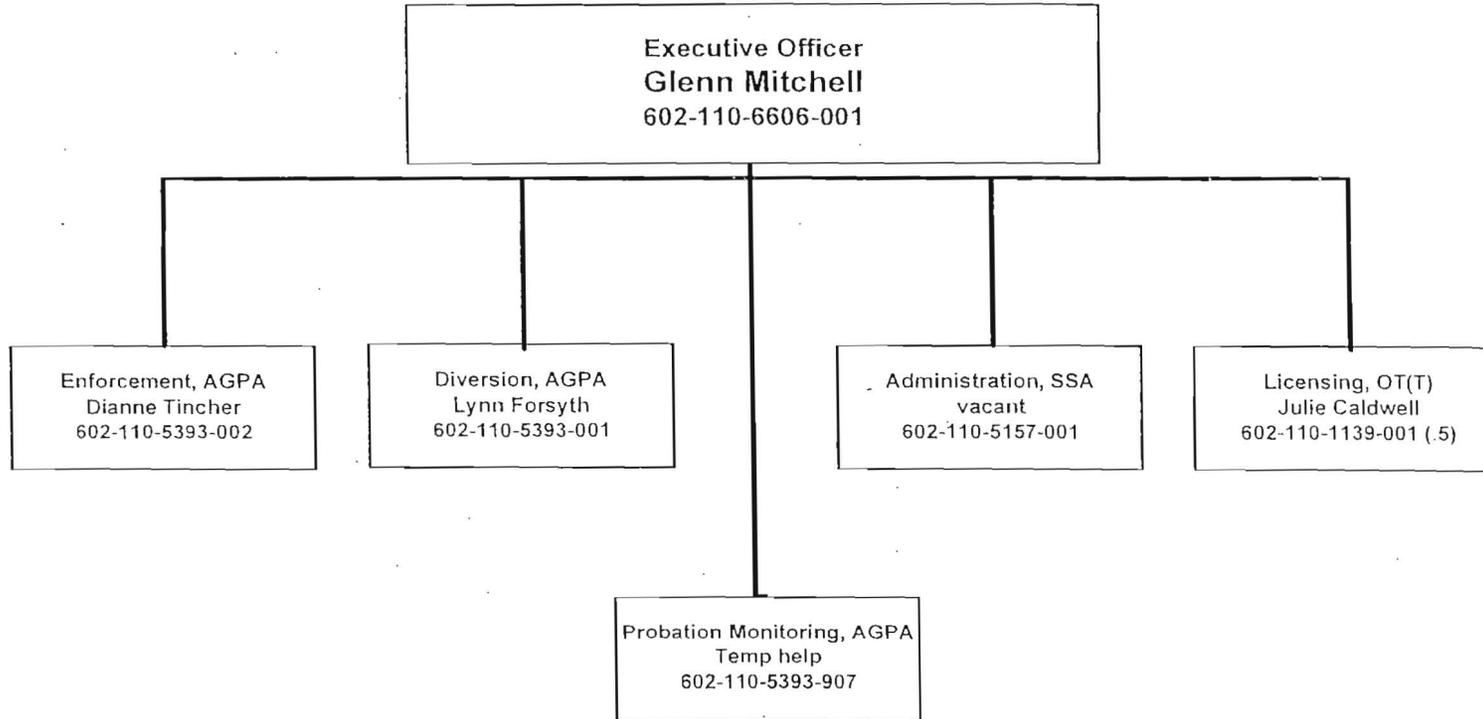
Date

Department of Consumer Affairs (DCA)
Physician Assistant Board

January 1, 2014 - Yearly

Current

FY 2013/2014
Authorized Positions: 4.5
Blanket: 1.0



DCA Personnel Analyst

Date

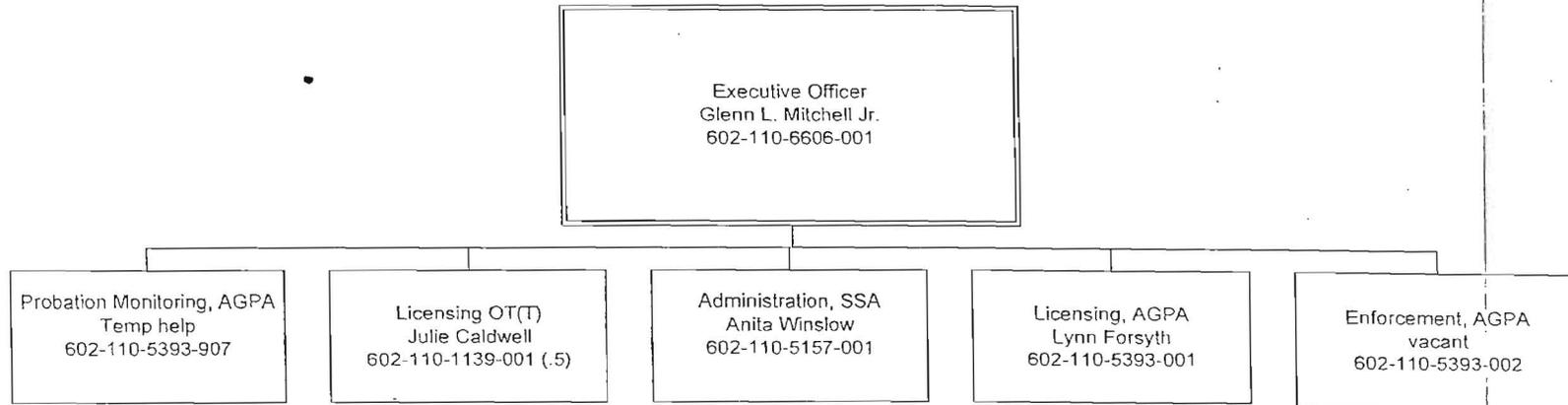
Glenn Mitchell 21 Feb 14
Glenn Mitchell, Executive Officer Date

January 1, 2015

Department of Consumer Affairs
Physician Assistant Board

Current
FY 2014-2015
Authorized Positions 4.5
Blanket 1.0

+All positions are CORI



11 Dec 14

Glenn L. Mitchell Jr., Executive Officer

Date

DCA Personnel Analyst,

Date

Attachment

E

Physicians Assistant Committee

Performance Measures Annual Report (2011 – 2012 Fiscal Year)

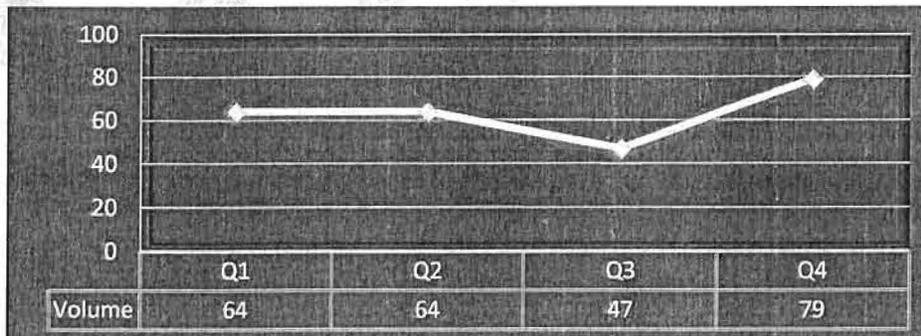
To ensure stakeholders can review the Committee's progress in meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures are posted publicly on a quarterly basis.

This annual report represents the culmination of the four quarters worth of data.

Volume

Number of complaints and convictions received.

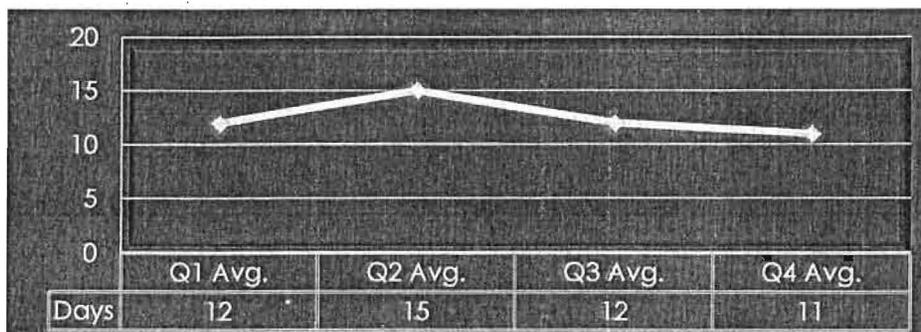
The Committee had an annual total of 254 this fiscal year.



Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

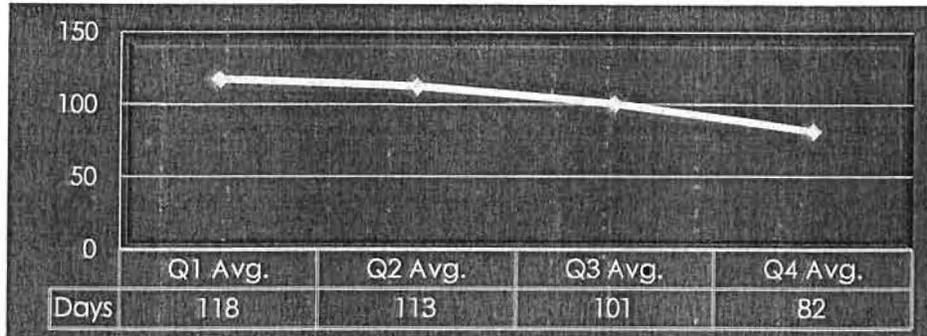
The Committee has set a target of 10 days for this measure.



Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

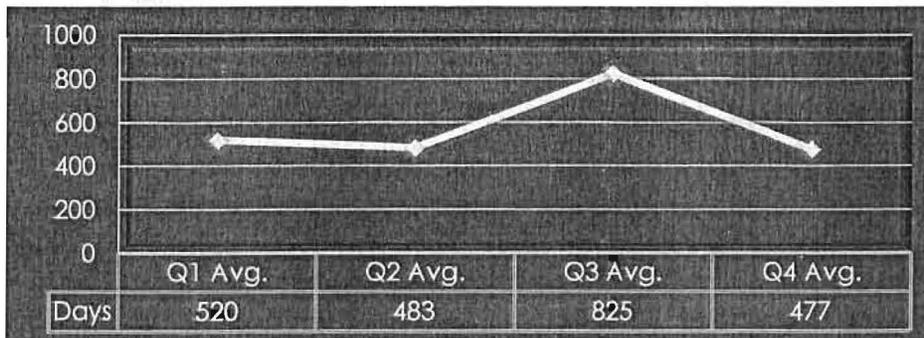
The Committee has set a target of 150 days for this measure.



Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Committee, and prosecution by the AG)

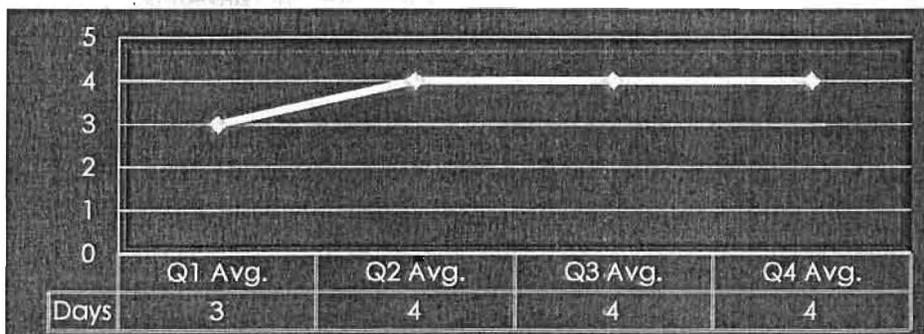
The Committee has set a target of 540 days for this measure.



Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

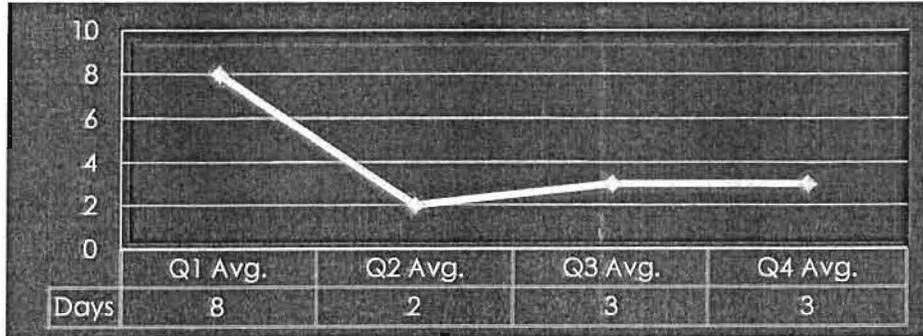
The Committee has set a target of 14 days for this measure.



Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

The Board has set a target of 7 days for this measure.



Performance Measures

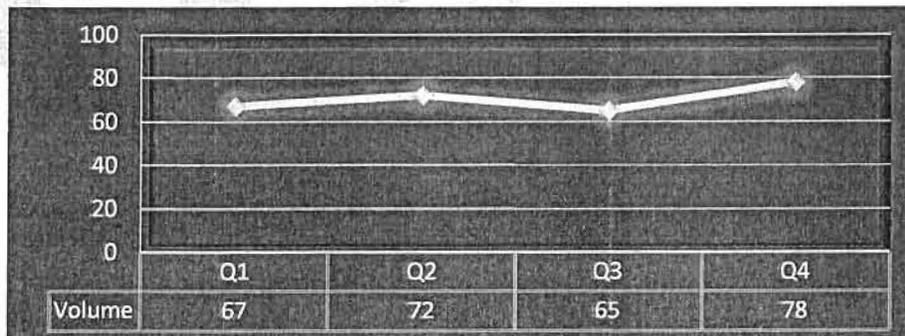
Annual Report (2012- 2013 Fiscal Year)

To ensure stakeholders can review the Board's progress in meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures are posted publicly on a quarterly basis.

Volume

Number of complaints and convictions received.

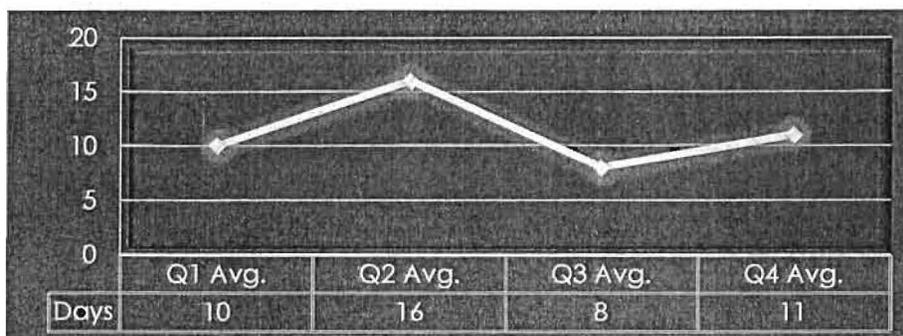
The Board had an annual total of 282 this fiscal year.



Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

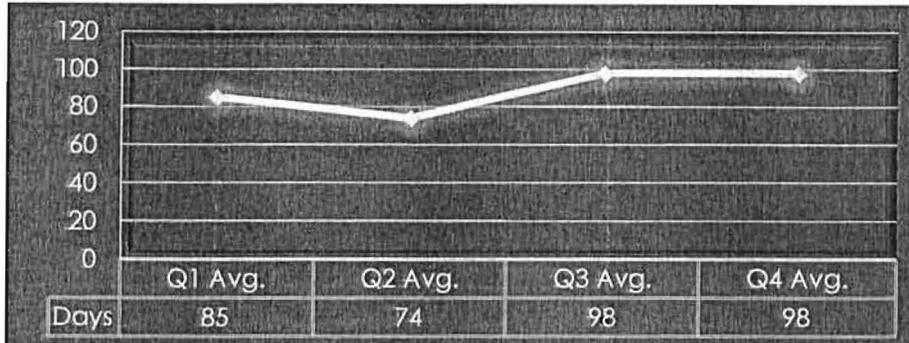
The Board has set a target of 10 days for this measure.



Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

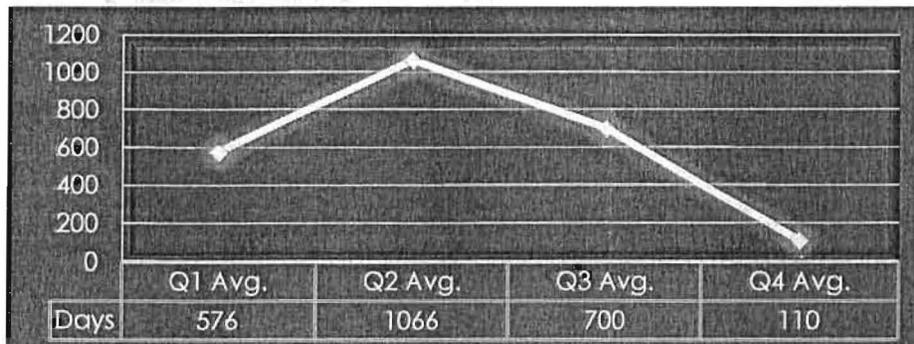
The Board has set a target of 150 days for this measure.



Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board, and prosecution by the AG)

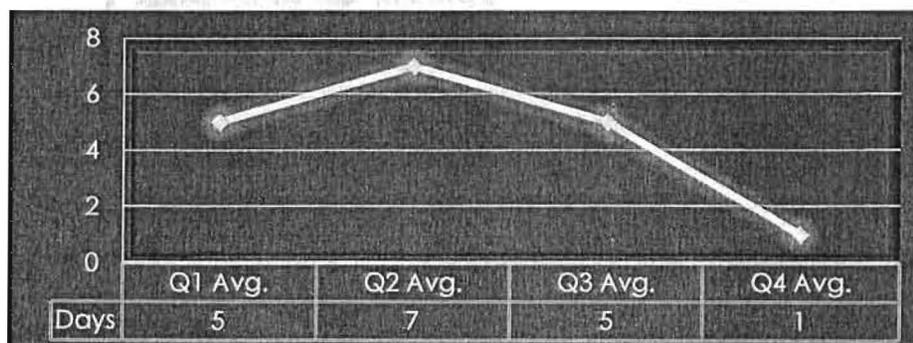
The Board has set a target of 540 days for this measure.



Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

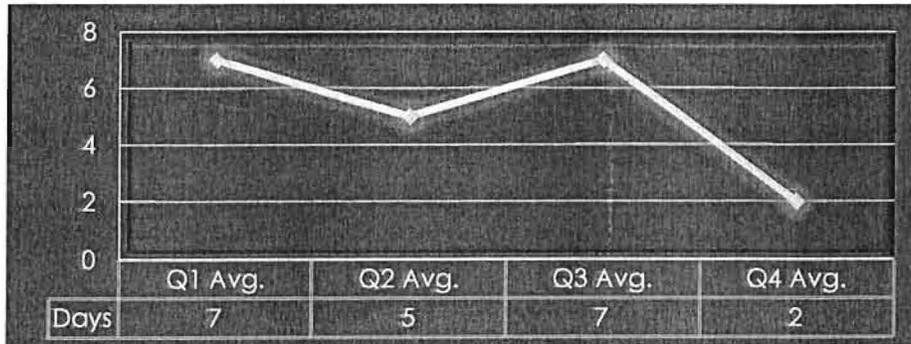
The Board has set a target of 14 days for this measure.



Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

The Board has set a target of 7 days for this measure.

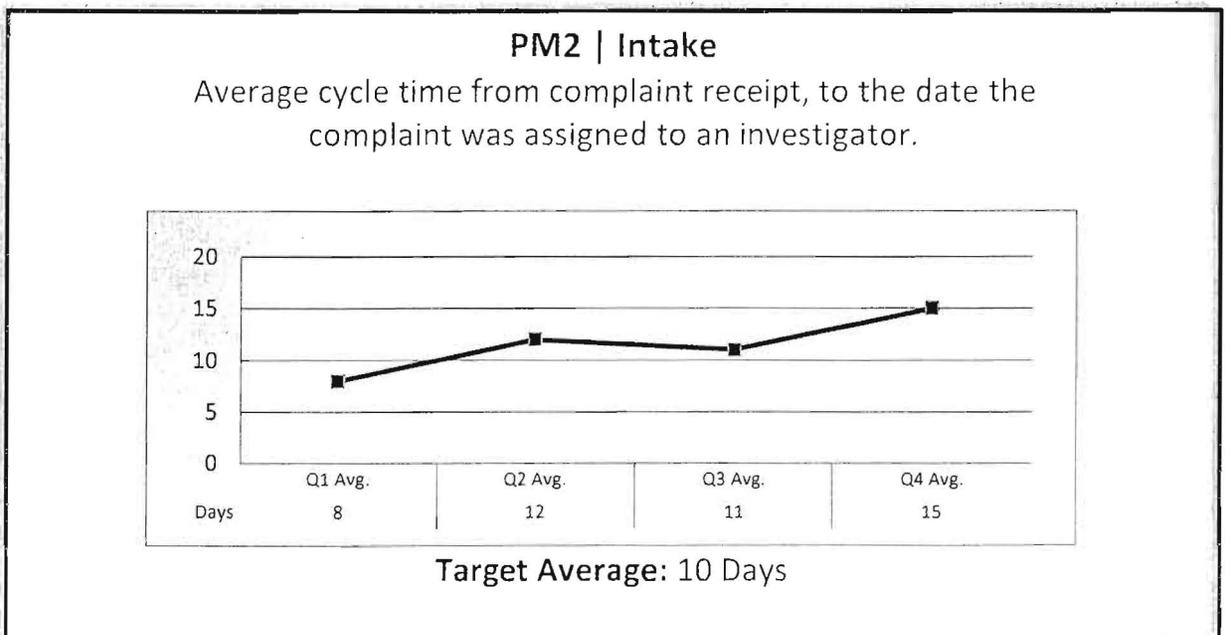
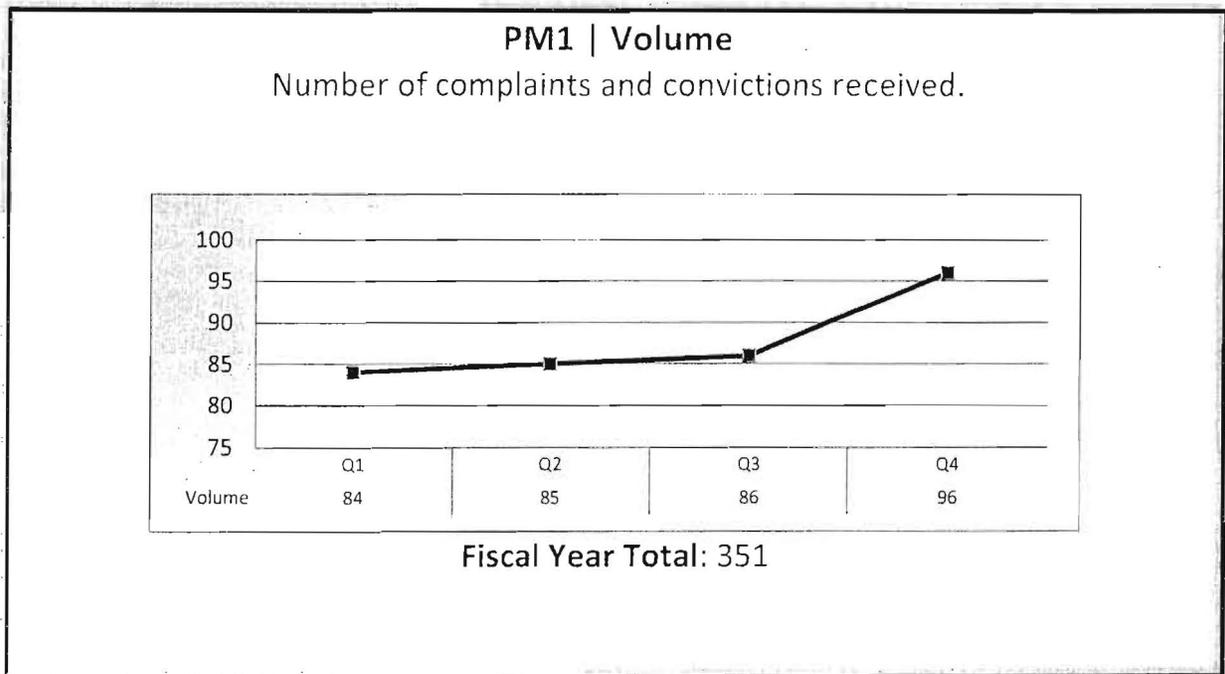


Physicians Assistant Board

Performance Measures

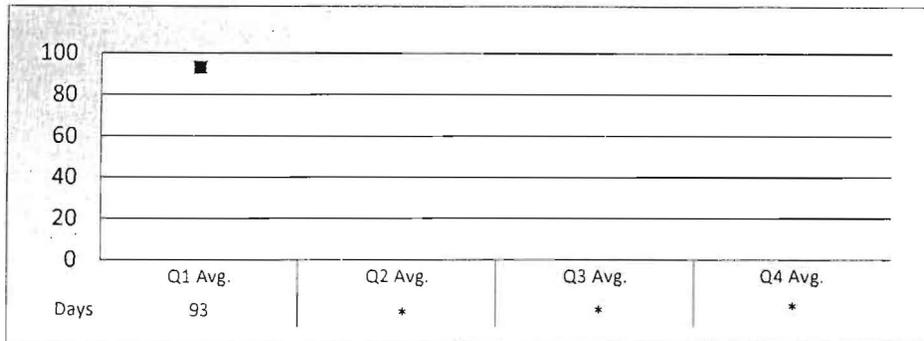
Annual Report (2013 – 2014 Fiscal Year)

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly and annual basis.



PM3 | Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

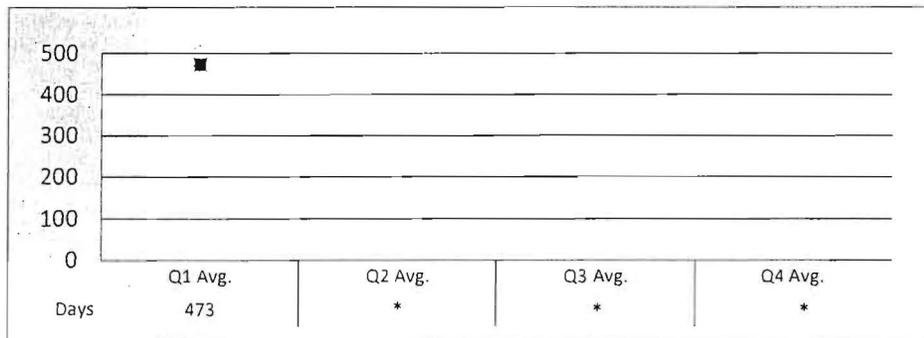


Target Average: 150 Days

**Consistent data not yet available from BreEZe.*

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board and prosecution by the AG).

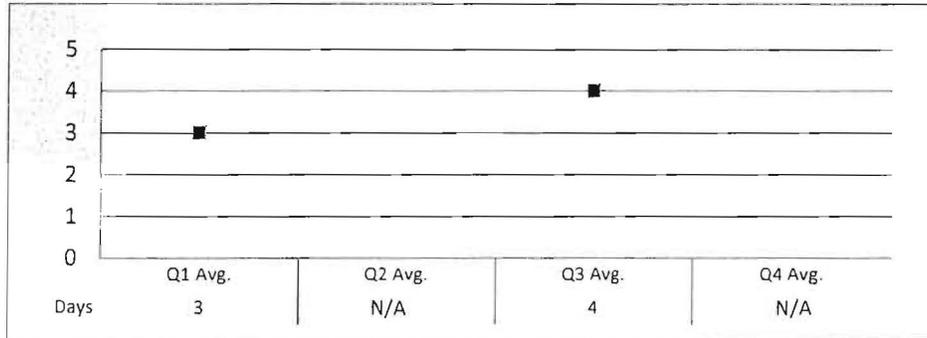


Target Average: 540 Days

**Consistent data not yet available from BreEZe.*

PM7 | Probation Intake

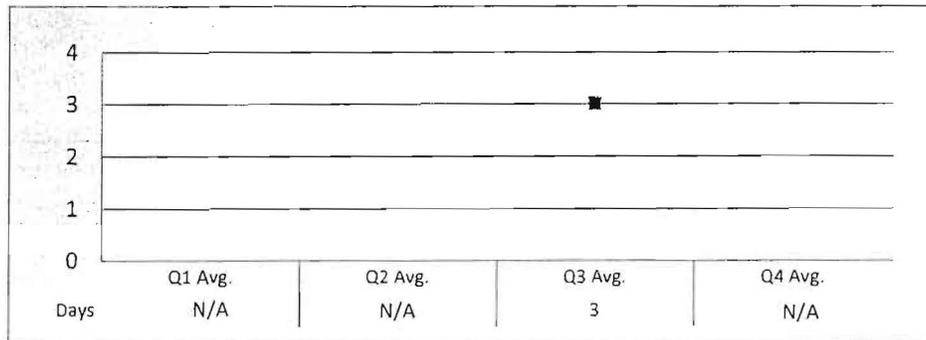
Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.



Target Average: 14 Days

PM8 | Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

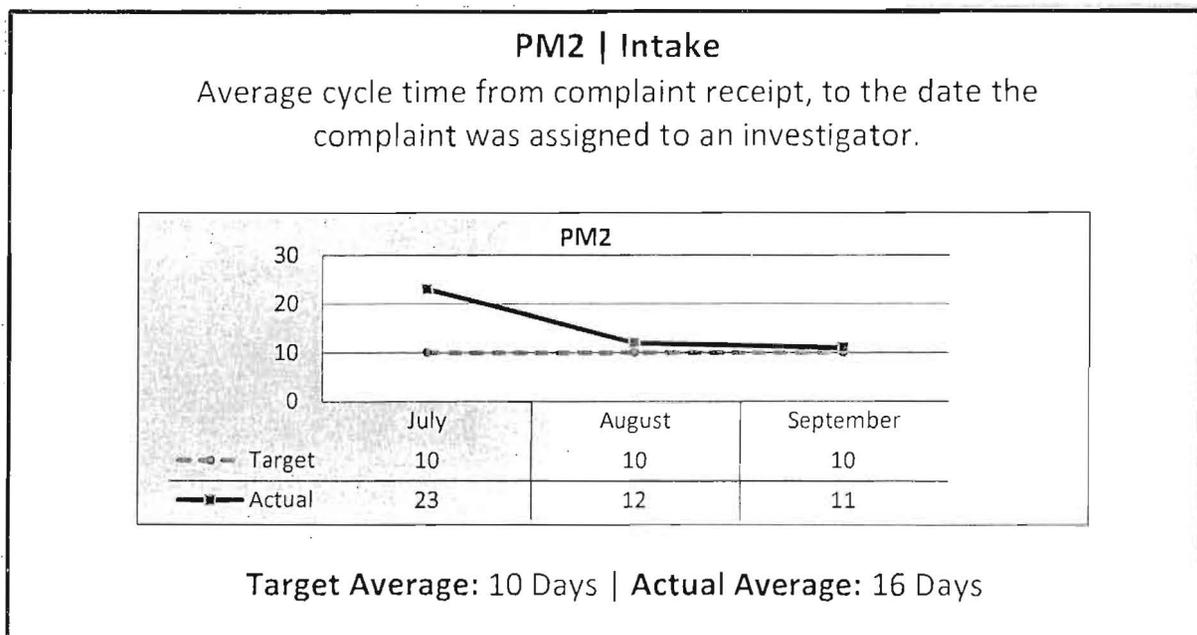
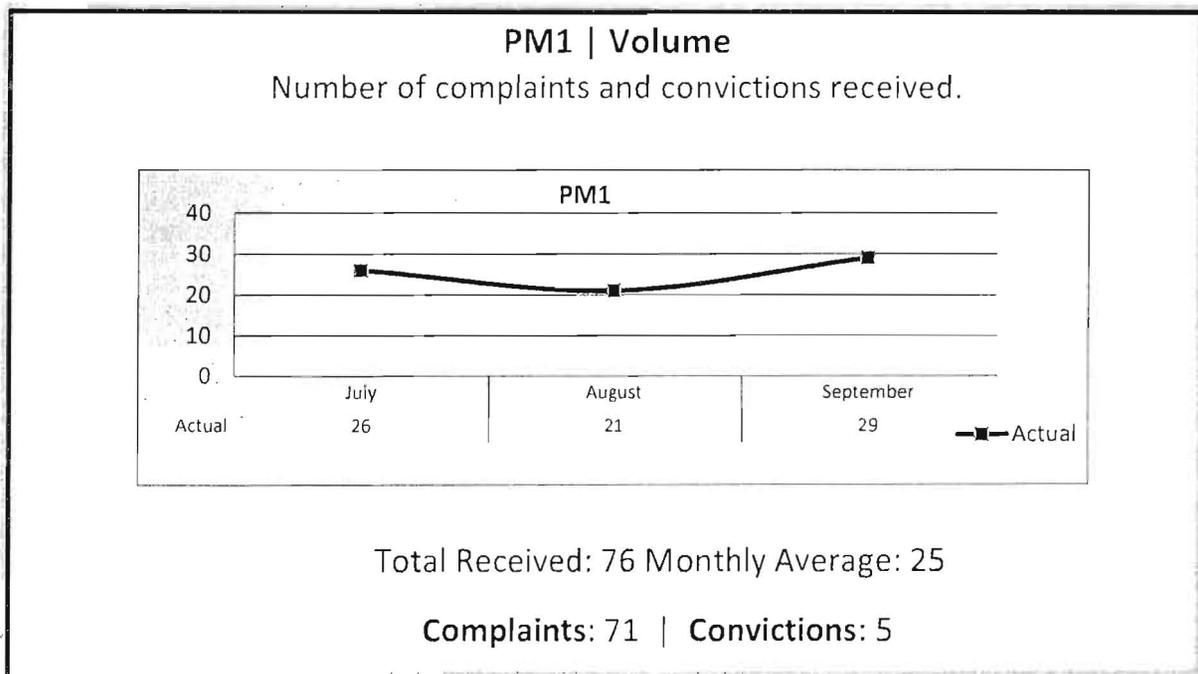


Target Average: 7 Days

Performance Measures

Q1 Report (July - September 2014)

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.



PM3 | Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Consistent data not yet available from BreEZe.

Target Average: 150 Days | Actual Average: N/A

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board and prosecution by the AG).

Consistent data not yet available from BreEZe.

Target Average: 540 Days | Actual Average: N/A

PM7 | Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

The Board did not contact any new probationers this quarter.

Target Average: 14 Days | Actual Average: N/A

PM8 | Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

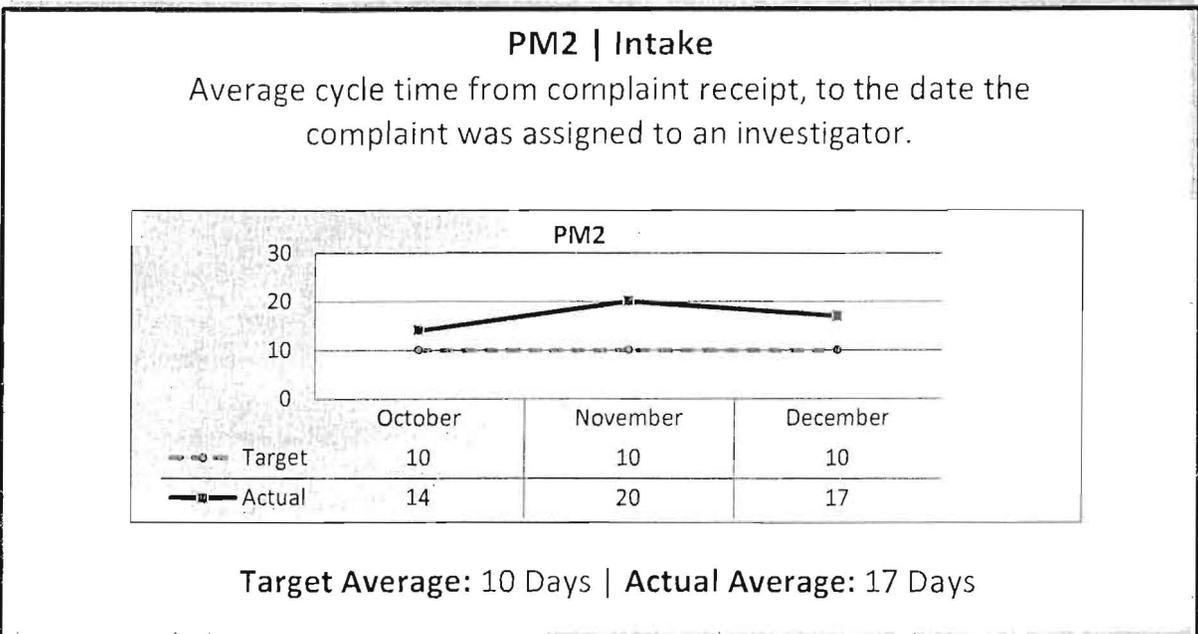
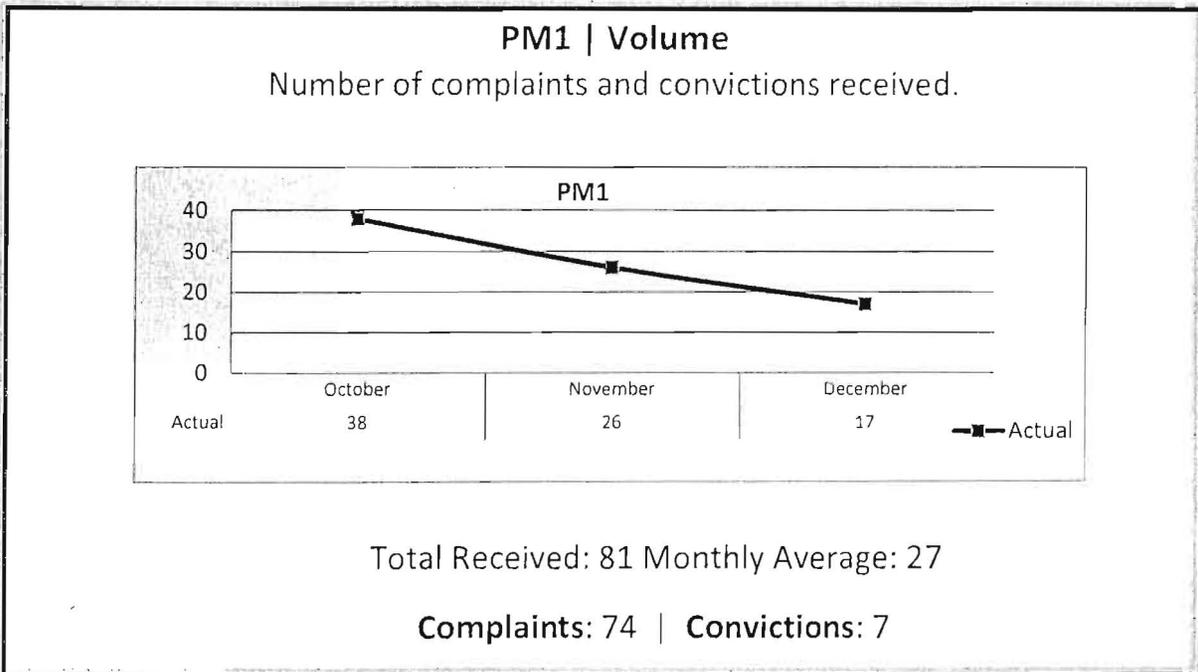
The Board did not report any new probation violations this quarter.

Target Average: 7 Days | Actual Average: N/A

Performance Measures

Q2 Report (October - December 2014)

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.



PM3 | Intake & Investigation

Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation)

Data Currently Unavailable.

Target Average: 150 Days | **Actual Average:** N/A

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases transmitted to the AG for formal discipline. (Includes intake, investigation, and transmittal outcome)

Data Currently Unavailable.

Target Average: 540 Days | **Actual Average:** N/A

PM7 | Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

The Board did not contact any new probationers this quarter.

Target Average: 14 Days | Actual Average: N/A

PM8 | Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

The Board did not report any new probation violations this quarter.

Target Average: 7 Days | Actual Average: N/A

Attachment

F



Department of Consumer Affairs
Physician Assistant Board

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Customer Service Satisfaction Survey

HOW ARE WE DOING?

The Physician Assistant Board continually strives to provide the best possible customer service. Please help us by taking a few minutes to complete our brief customer service satisfaction survey. You may complete the survey and submit it on-line or download the survey and mail it in.

1. Thinking about your most recent contact with us, how would you rate the availability of staff to assist you?

Excellent Very Good Good Fair Poor Not Applicable

2. When requesting information or documents, how would you rate the timeliness with which the information or documents was/were provided?

Excellent Very Good Good Fair Poor Not Applicable

3. When you visited our web site, how would you rate the ease of locating information?

Excellent Very Good Good Fair Poor Not Applicable

4. When you submitted an application, how would you rate the timeliness with which your application was processed?

Excellent Very Good Good Fair Poor Not Applicable

5. When you filed a complaint, how would you rate the timeliness of the complaint process?

Excellent Very Good Good Fair Poor Not Applicable

6. When you contacted us, were your service needs met? If no, please explain.

Yes No

7. Please provide us with any additional comments or suggestions.

Thank you for participating in our customer service satisfaction survey. We value your feedback!

*CAPTCHA: (Please enter the text found in the image below or specified in the audio link to validate the submission of your data.)



Listen To This

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Attachment

G

HOW SHALL THE PAC ADDRESS THE CALIFORNIA PHYSICIAN ASSISTANT WORKFORCE SHORTAGE?

HIGHLIGHTS FROM THIS REPORT

- The ARC-PA 2020 Master degree mandate policy will close 3 of 9 California PA training programs that typically admit students from under-represented backgrounds.
- The need for many more PAs and PCPs in general is already tremendous. The Affordable Care Act will overwhelm the California healthcare system which is already on the brink of breaking.
- There are ~8,000 PAs in California today. Six million newly insured in California will require ~4,000 new PAs.
- The Committee should consider a viable strategic plan that would foster opening 12 new programs by 2017 to address this need. Several options are; open six in 2014, followed by three new programs each year for the next three years. Gradually increase the median enrollment from 35 to 50 students over six years. Twelve new programs will have been added in four years for a total of 21 programs, graduating approximately 1,000 new PAs annually.

Prepared by the Physician Assistant Committee Education Subcommittee

Chair: Steven H. Stumpf, EdD

Member: Shaquawn D. Schasa

Public Volunteer: Tracy DelNero, PA-C, Tuoro College Physician Assistant Program

October 19, 2012

HISTORICAL OVERVIEW

1. The Physician Assistant Committee (PAC) was created by the Legislature in 1975. At the time, the California Legislature was concerned about the **existing shortage and geographic maldistribution of health care services in California**.
2. Mandates for the Physician Assistant Committee included (i) approving the educational and training requirements of Physician Assistants; and (ii) licensing of Physician Assistants.
3. The Committee does not administer its own examination. We utilize the Physician Assistant National Certifying Examination (NCCPA) administered by the National Commission on Certification for Physician Assistants (NCCPA). Therefore, there is no fiscal impact to the Committee.
4. The Committee has the authority to approve training programs however the Committee has elected to defer this task to the current accrediting body. At this time that body is the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). Historically, the ARC-PA ensures programs meet national accreditation standards. Committee regulations specify that if an educational program has been approved by the ARC-PA, that program shall be deemed approved by the Committee. These educational programs are not reviewed periodically by the Committee. Instead, if ARC-PA terminates accreditation, the Committee's approval of the school automatically terminates. Thus, as the regulations currently state, if the PA training program is ARC-PA approved, it is thereby approved by the Committee.
5. The PAC created a Program Accreditation Task Force (PATF) in November 5, 2009 to provide input and develop regulatory language regarding program accreditation. The PATF reviewed new ARC-PA standards which would require that all programs be offered at the master's degree level. A survey was conducted by the Committee for the four affected California PA training programs to determine how the new standards would impact the programs. The PATF concluded that three of the four programs did not have the capacity to transition to a master level due to legislative barriers. Because this issue continues to evolve at the national level, the task force determined that the Committee should continue to keep abreast of the latest development and take possible appropriate action as new developments occur.

NEW DEVELOPMENTS

6. The Accreditation Standards for Physician Assistant, 4th edition, mandates that all currently accredited programs confer graduate degrees to those students who matriculate (register; enroll) into the program after 2020. Programs accredited prior to 2013 that do not currently offer a graduate degree *must* transition to conferring a graduate degree, which *should* be awarded by the sponsoring institution, upon all PA students who matriculate into the program after 2020. The contiguity of the terms *must* and *should* is confusing; one term communicates a mandate while the other term suggests an option. The impact will be that every PA program not located in an institution that offers a master level degree will assume *must* is the operative

standard to which they are held. If the “elect-to-complete” option is being eliminated (see below) then the ARC PA should and must clarify their intentions as well as any ideas about exceptions.

The Introduction section of the *Standards, 4th edition*, argues the increased educational standards are necessary because “The PA profession has evolved over time to one requiring a high level of academic rigor.”¹ Institutions that sponsor PA programs are expected to incorporate this higher level of academic rigor into their programs and award an appropriate master’s degree.“ Furthermore, the 4th edition of the ARC-PA Accreditation Standards states “Sponsoring institutions applying for provisional accreditation of a new PA program must be accredited by, and in good standing with, a recognized regional accrediting agency and *must* be authorized by that agency to confer upon graduates of the PA program a graduate degree.”²

The effective meaning of the section and placement of the footnote is that all programs accredited prior to 2013 (and programs post- 2013), including those that are sponsored by community/two year institutions or the military, must transition to offering a graduate degree.”³

The ARC-PA describes two options for current training programs: (1) the existing program can affiliate with a degree-granting program that will enable the PA students at the community college to complete the master degree. The current “elect to complete” option will end. (2) The other option is to move the program to a new advanced-degree-granting institution.

This policy will eliminate all two year certificate programs located in community colleges. Admissions standards will be elevated so as to exclude students who might have qualified for a certificate program. PA programs in California will be reduced from nine to six programs. Program graduates will be reduced from 314 to 194 annually (non-degree programs are underlined in the footnote below; note that UCD is in transition to becoming a Master degree program and has admitted the first such class).⁴ The majority of the diversity in the California workforce is within these three non-degree programs. The demographics of the three programs that will be eliminated fulfill the intent of the profession to serve the underserved and reinforce diversity among the workforce. The proposed policy will effectively eliminate that intention.

EMERGING PROVIDER NEEDS IN CALIFORNIA

7. Estimating the need for primary care providers is a daunting task based upon numerous assumptions. The following formulation was used in calculating estimations:

¹ An argument defending the statement about the “evolution that requires a high level of academic rigor” is not provided.

² ARC-PA *Standards*, fourth edition Page 2 September, 2012. <http://www.arc-pa.org/documents/Standards4theditionwithclarifyingchanges9.2012fnl.pdf>

³ ARC-PA *Standards* Degree Deadline Issue <http://www.arc-pa.org/documents/Degree%20issue10.2011fnl.pdf>

⁴ USC MPAP ~40; Loma Linda MPA 24; RCC cert 25; SM MPA 25; SJCC AS ~20; Stanford/FC cert ~45; UCD ~30; Western MSPA ~90; Tuoro MSPAS ~35.

- 7.1. The number of Primary Care Providers (PCPs) currently working in California that provide a certain number of clinical services (patient visits) to a certain number of patients.
 - 7.2. Divide the services by the patients and arrive at an estimate of services per patient per year (actually, there are figures for this ratio expressed as services per 1,000 patients).
 - 7.3. Divide the total services by PCPs and arrive at a ratio of visits per PCP.
 - 7.4. Estimate the total number of patients in 2014 after the Affordable Care Act (ACA) enrolls new patients into insurance products in California, including Medi-Cal.
 - 7.5. Multiply the total post-ACA enrollees (patients in 2014) by the ratio of services per patient per year to arrive at the expected number of services in 2014.
 - 7.6. Apply percentage of PAs working in primary care.
 - 7.7. Multiply the expected number of services times the ratio of visits per PCP to arrive at the required number of PCPs.
8. Common metrics for estimating workforce needs: One metric tracks number of patients that are assigned to any given provider. For example, the panel size used by teaching hospitals and the VA is 1,500 patients per physician and 1,200 per nurse practitioner.⁵ PCPs include PAs, NPs and physicians. Approximately 50% of all Nurse Practitioners 40% of all PAs⁶ (and 20% of all MDs⁷) are in primary care. In 2011 there were, in California, approximately 12,403 primary care physicians; 8,857 primary care Nurse Practitioners; and 2,689 primary care PAs in California (adjusted proportionally).⁸ The California patient population includes insured and uninsured. Projections for presently uninsured who will become insured apply.

The total insured population of CA in 2010 was 29,737,000. The current combined primary care workforce in California is approximately 55,000 physicians, PAs and NPs. However, estimating the PCP need based upon patients (the unduplicated count) or newly insured is insufficient. What we need to know is the duplicated count; that is, the number of ambulatory care visits that require coverage by the various primary care providers, including physicians, PAs and NPs.

We have used data collected under the 2010 National Ambulatory Medical Care Survey (NAMCS) to calculate a reliable estimate of visits per PCP. NAMCS is a national probability sample survey of visits to office-based physicians conducted by the National Center for Health Statistics, Centers for Disease Control and Prevention. It is a component of the National Health Care Surveys which measure health care utilization across a variety of health care providers.⁹ Here is what we found.

⁵ LADHS Primary Care Capacity Update, March 2012; <http://itup.org/blog/2012/03/15/ladhs-primary-care-capacity-update/>

⁶ Ibid

⁷ Primary Care Workforce Facts and Stats No. 2. The Number of Nurse Practitioners and Physician Assistants Practicing Primary Care in the United States. <http://www.ahrq.gov/research/pcwork2.htm>

⁸ Kaiser Family Foundation Statehealthfacts.org
<http://www.statehealthfacts.org/comparemaptable.jsp?cat=8&ind=440>

⁹ NAMCS Micro-Data File Documentation 2010
ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NAMCS/doc2010.pdf

Table 1: Visits per PCP, 2010 NAMCS

total Services	MD/PCP type	total MDs	visits/MD	per wk
213,770,403	Fam Prx	6,237	34274.56	659.13
139,843,147	Int Med	2,217	63077.65	1213.03
132,247,267	Peds	3,501	37774.14	726.43
80,076,190	Ob/Gyn	2,461	32538.07	625.73
565,937,007	all PCPs	14,416	39257.56	754.95

PCPs are separated into primary care physician specialties (e.g., family practice, internal medicine) then summed across all groups. These are national data. NAMCS does not break out data by states. The mean visits per week for a PCP physician is 754.95, or **755**. NAMCS does not collect data for NPs and PAs. Each record is for visits in a given physician practice group. The physicians are counted individually, i.e., if there are three physicians in a group then the count is 3. Services conducted by a PA or NP are “rolled into” the total.

9. How many new patients in California will result from enrollment in the Affordable Care Act in 2014? In 2010, there were 7.4 million beneficiaries, which constituted a fifth of all Californians.¹⁰ A UCLA study estimates that three million Californians ages 0-64 will become eligible for Medi-Cal coverage and three million will be eligible for the Exchange.¹¹ Sum these two figures and we can estimate there will be 13.4 million beneficiaries seeking healthcare in 2014. If we apply the Kaiser and LADHS assignment metrics we can roughly project the following PCPs are needed to meet the need.

10. What is the calculated number of expected services/visits in 2014? This figure is extrapolated from 2007 data from the National Health Care surveys and California Kaiser Family Foundation provider use data. In 2007, the number of ambulatory care visits (to physician offices, hospital outpatient and emergency departments) was 1.2 billion. The number of ambulatory care visits per 100 persons was 405.¹² The number of total physician office visits in 2007 was estimated at 1 billion. The number of visits to physician offices per 100 persons was 344. The percent of visits made to primary care physicians was 56.6%. The most frequent reason for a visit was general medical examination and the most commonly diagnosed condition was “essential hypertension.”¹³

In 2011 there were 23,608 PCP providers in California including physicians, nurse practitioners and physician assistants, and \$7.4 million insured beneficiaries in all insurance programs. In 2014 there will be 13.4 million insured. Calculating with an average of 405 visits per one hundred patients in 2007 we can forecast a 55.2% increase in the number of

¹⁰ Yoo K. The Affordable Care Act and the Residually Uninsured. Insure the Uninsured Project, 1-27-2012

¹¹ UCLA Center for Health Policy Research, Lavarreda SA and Cabezas L. “Two-Thirds of California’s Seven Million Uninsured May Obtain Coverage Under Health Care Reform,” February 2011, at <http://www.healthpolicy.ucla.edu/pubs/files/twothirdspb-2-16-2011.pdf>.

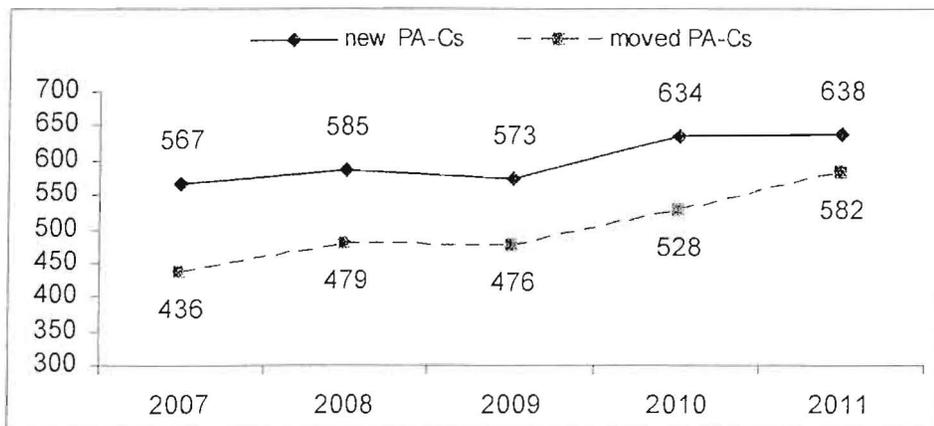
¹² Ambulatory Medical Care Utilization Estimates for 2007: tables 1, 3, http://www.cdc.gov/nchs/data/series/sr_13/sr13_169.pdf

¹³ National Ambulatory Medical Care Survey: 2009 Summary Tables, http://www.cdc.gov/nchs/data/ahcd/namcs_summary/2009_namcs_web_tables.pdf

visits for 13.4 million beneficiaries. The subsequent number of additional PCPs is estimated to be 36,645, or an increase of 13,307 new PCP providers.

The Physician Assistant Committee reported 8,372 licensees in 2011 which included 638 newly licensed PA-Cs; a 5.3% growth rate from 2010. This is offset by a “loss rate” of 8.8% which is the number of PA-Cs no longer reporting a California address. In 2011 this total was 582. The number of PA-Cs moving out of state has steadily increased since 2007. We are losing almost as many PAs as are being newly licensed in the state. In order to meet the coverage needs of the currently and newly insured, the number of California PAs must be increased by approximately 55% to meet the need for PCP PAs by 2014. This figure – which is approximately 4,000 - is obviously out of reach for 2014 and almost certainly by 2020. It should be equally obvious that reducing the numbers of PA training programs will undermine an already poor foundation for treating patients in California thereby conflicting with the PAC mission that includes “Promoting the health and safety of California health care consumers by enhancing PA competence.”

Figure 1: newly licensed PA-Cs Compared to Those Moving Out of State: 2007 through 2011



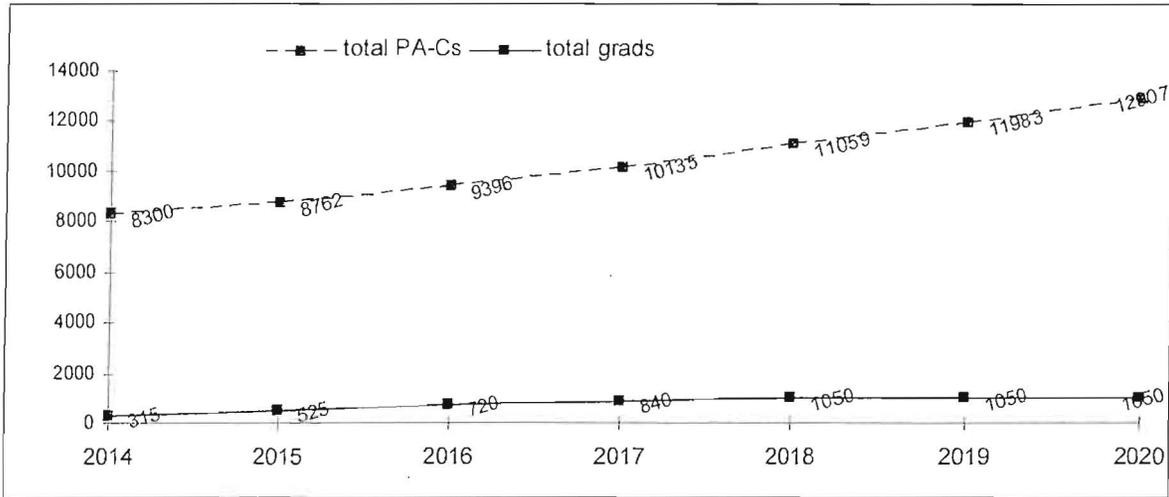
Consequences of eliminating three of nine existing PA programs: The ARC-PA proposes to eliminate three of nine programs in 2020. If the goal is to fill the PCP gap then this plan is obviously moving in the WRONG direction. Nine California programs graduate approximately 600 new PAs each year of which 40% (~250) will work in primary care. At present levels, i.e., with no program growth and a “loss rate” we estimate to be 12%, a net 160 new PAs will have been added to the PCP workforce by 2020. ARC-PA is implementing the new graduate degree requirement with no documentation of need or how it will improve patient safety or the quality of practicing PAs.

We need to add 12 new programs soon as possible. If the goal is to add another 4,000 PCP PAs by 2020, how many new programs would need to be created? If the median class size is 35, we could achieve our goal in four years by adding twelve new programs over that period with a median class size starting at 35 and escalating to 50 by 2018.¹⁴

¹⁴ Among the 9 current programs the median class size is 30; the mean is 37.

Proposals for increasing the numbers of PCPs (primary care providers) include (i) increasing the number of training programs, (ii) increasing the size of existing programs, (iii) creating fast track programs for international medical graduates, and (iv) shifting the burden of direct care for patients with chronic illness to entry-level providers such as Registered Nurses, Licensed Vocational Nurses and Medical Assistants. We are suggesting we can do a better job in helping fill the PCP gap with an additional 4,000 new PAs in four years.

Figure 2: Total PAs Increase as Total Programs Increase to 21 Over Four Years



Signals the Healthcare System Will Be Overwhelmed: Healthy Way LA (HWLA) is a Los Angeles County program that has enrolled more than 200,000 new eligible participants in Medi-Cal since 2011. The program enrolls and assigns new patients formerly not enrolled in Medi-Cal who will become eligible under the Affordable Care Act in 2013. In the first ten months the HWLA program assigned 22,000 of these new patients to “Community Partners”, i.e., clinics and practice groups, which immediately overwhelmed the CPs. Assignment of the new patients to medical homes was suspended in January 2012.¹⁵ The “success” of the Los Angeles model has resulted in implementation of the pre-enrollment approach throughout the state.

A large proportion of the newly insured persons in California will be enrolled in a medical home that is most likely to be a Federally Qualified Health Center. The Healthy Way LA (HWLA) program was implemented in mid-2011 as a strategy for Los Angeles County to get a head start enrolling uninsured patients in a medical home. Hospitals and clinics that enroll uninsured patients in HWLA will be able to convert those patients to Medi-Cal in 2014. These sites will see greatly increased revenues from new enrollments that will result in the creation of new positions for new primary care clinicians.

¹⁵ Status Report on the Healthy Way Los Angeles Enrollment and the 1115 Medicaid Waiver. Health Service LAC memo from Mitchell H. Katz, MD to LAC Board of Supervisors, January 13 2010. http://lahealthaction.org/library/cms1_173216.pdf Los Angeles County Health Services “Status Report on Healthy Way Los Angeles Enrollment.” January 13, 2012. http://file.lacounty.gov/bc/q1_2012/cms1_173216.pdf

IS TAKING ACTION TO INCREASE THE NUMBER OF PHYSICIAN ASSISTANTS WITHIN THE SCOPE OF THE PAC?

11. One can argue that it is beyond the scope of the PAC to change regulations by utilizing its authority to create a licensing exam and program accreditation process. Regulatory boards are in principle reactive and not proactive. Therefore, a strong case must be made for the importance of the PAC to react in order to protect California consumers. The PAC must, therefore, frame any action as a response to the need to fill the gap in primary care providers.

A board operating under the DCA can approve training programs. The board has the option of outsourcing the process or hiring its own staff. There is no requirement the DCA board affiliate with a DOE or other accreditation body, although the board may elect to do so.

The mission of all DCA boards is to protect consumers by disciplining licensees who have broken the law, and ensuring education/training occurs at the level of highest quality. Each board writes its own regulations to ensure these goals are met. The process for writing regulations can take at least two years given time required for drafting, soliciting public comments, review by the Office of Legislative Analysis for conflicts with existing statute, and the PAC voting on final language. In the least, regulatory language must be written to guide the process. The PAC must determine if legislation is also required. Legislation might quicken the timeline because regulations would derive directly from statute requiring PAC administration of program approval along with an in-state licensing process.

- 11.1 **How DCA boards create exams:** DCA boards contract with the Office of Professional Educational Services (OPES) or other identified agencies which is a unit under the DCA. The OPES will either do the work themselves to construct an exam or suggest sources for contracting out the work. There is no requirement that any board use the DCA OPES, however, it is probably the preferred route. Costs are involved for developing, administering and scoring a licensing exam. An estimate of exam construction costs is essential prior to undertaking the task.
- 11.2 **How DCA boards administer exams:** The board may also contract with OPES to conduct and score the exam. Releasing scores to examinees should originate with the licensing board. Test-taking formats include manual completion, local computer station, or online. All scoring formats are machine operated.
- 11.3 **Costs for administering a licensing exam:** The cost of developing a new licensing exam can be broken out by the two principal functions: (1) creation and maintenance of the item bank, and (2) administering and scoring the exam. Costs vary depending on the modality for administration; e.g., hand completed and scored, local computer station, or online. The current PANCE exam must be taken when the program graduate seeks initial licensure. Licensing must be renewed at regular intervals. The cost for the PANCE is \$475 for the initial license and \$350 for subsequent renewals.
- 11.3 **Constraints of accrediting training programs and administering a licensing exam:** The goal for the PA Committee undertaking the two tasks of approving schools along with creating and administering a licensing exam is to create an expanded PA workforce for California consumers. The undertaking is complicated however it is hardly impossible. There are plenty of precedents of other DCA boards undertaking this

process. However, there will be one very significant constraint. PAs licensed in California will need to graduate from an ARC-PA school in order to become certified by PANCE if they wish to practice outside CA. This could reduce the number of PAs willing to enroll in a PAC approved PA program. Of course, this disadvantage might be offset by (1) a rapid increase in the number of PA programs in California (the nine current programs could double within a few years); (2) the availability of lower cost PA programs located in community colleges that offer a certificate slated for extinction by the ARC-PA; and (3) the availability of new clinical positions in a state where the numbers of newly enrolled Medi-Cal is expected to triple. Other constraints include locating new clinical training sites for students of 12 new PA programs.

11.4 **Recent PAC regulatory activity:** The PAC recently approved regulatory language that requires licensed PAs to earn a minimum of 50 category 1 CMEs every two years in order to maintain certification. These hours must be logged (\$80 fee) and recorded with the NCCPA. This component of quality assurance/consumer protection has already been addressed and managed by the PAC.

12. Next steps??

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Yoo K. The Affordable Care Act and the Residually Uninsured. Insure the Uninsured Project, 1-27-2012

Attachment

H

Report on Alternative Accreditation

Background

Two physician assistant (PA) training programs in California are scheduled to close due to accreditation action taken by Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). This is a major of concern of the California Physician Assistant Board because of our mission to protect the public by ensuring they receive safe and appropriate health care from well qualified licensed PAs, which includes supporting access to health care for those in our state. If there is a shortage of PAs because of the closure of California programs there may be an exacerbation of a lack of access to quality affordable health care provided by PAs. Additionally the Board has regulatory authority over PA training programs in the state.

The Board has addressed this concern by sending a letter to the ARC-PA, to which they did not initially respond. However, after a second letter ARC-PA responded to the board saying that they do not answer to any state boards. This Board currently accepts ARC-PA accreditation as the required accreditation pathway for PA training programs in California; however it may approve alternate pathways per existing regulations (16 CCR 1399.530). A sub-committee on education was formed at the last Board meeting to look into alternative accreditation of PA training programs in California.

History and Interrelationship of National Physician Assistant Organizations

The Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) has its origins in the American Medical Association in 1971 and has been accrediting PA programs since 1972. It has progressed from subcommittees of the American Medical Association (AMA), such as the Committee on Allied Education and Accreditation (CAHEA), which became Commission on Accreditation of Allied Health Education Programs (CAAHEP), ultimately becoming an independent organization in 2001. ARC-PA has always been closely affiliated with the American Academy of Physician Assistants (AAPA), which is the national professional organization for physician assistants and was founded in 1968. The California Academy of Physician Assistants (CAPA) is a constituent organization (state chapter) of the AAPA. It is the professional organization for Physician Assistants in California.

In 2004 ARC-PA was recognized by the Council for Higher Education Accreditation (CHEA) which is currently the accrediting organization for the ARC-PA. The American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians, the American College of Surgeons, the American Medical Association (AMA), and the Physician Assistant Education Association (PAEA) all cooperate with the ARC-PA as collaborating organizations to establish, maintain, and promote appropriate standards of quality for entry level education of physician assistants (PAs) and to provide recognition for educational programs that meet the minimum requirements outlined in these Standards. ARC-PA Commissioners are elected by the ARC-PA from a slate of nominees submitted by the ARC-PA collaborating organizations. Starting in January 2020, ARC-PA will require an entry level master's degree for new physician assistants.

The National Commission on Certification of Physician Assistants (NCCPA) is the national certifying body for physician assistants (PA) and was established by the AMA and the National Board of Medical Examiners in 1974. The NCCPA administers the Physician Assistant National Certifying Examination (PANCE), which is the summative evaluation used to measure basic competency of a physician assistant,

and is accepted by annual vote of the board as the certifying examination for licensure for this state. Graduation from an ARC-PA accredited training program is required to be eligible to sit for the PANCE. NCCPA certification, denoted by the use of the abbreviation "PA-C", is required for credentialing at hospitals and by Medicare/Medicaid as well as most insurance companies for billing purposes. Annual Continuing Medical Education (CME) requirements as well as the Physician Assistant National Recertifying Examination (PANRE) are required to maintain NCCPA certification. The board currently accepts valid national certification as evidence of compliance with the CME requirements for licensure in California.

The Physician Assistant Education Association (PAEA) is the professional organization of Physician Assistant's educational faculty and was founded in 1972. All accredited PA programs are members of the PAEA, which provides services to faculty, students, applicants and other stakeholders. In November 2009, PAEA adopted two position policies that: 1) PAEA endorses the master's degree as the entry-level and terminal degree of the profession; and 2) PAEA opposes the entry-level doctorate for physician assistants.

Issues with the ARC-PA

Workforce: The ARC-PA's decision to withdraw the accreditation of two programs in California has raised concern for workforce supply. Currently the process for a PA program to become ARC-PA accredited takes approximately 2-3 years. There are currently 10 PA programs in California, four in the bay area or northern part of the state, one in the central valley, and 5 in the southern half of the state. One program in the San Bernardino/Riverside area and one in the central valley are closing within approximately 18 months. There are 12 programs in the planning stages of accreditation and six of those have been approved by the ARC-PA to enter the accreditation process. Of those six approved programs four are in southern California and two are in northern California. Of the programs currently approved to enter the accreditation pathway or accredited, three are in the San Bernardino/Riverside area and one is in northern part of the central valley. Additionally, two programs in California have formed a collaborative to recruit, train, and return providers to the central valley. Given the numbers of programs in the process of becoming accredited in California it is likely that ARC-PA accredited programs will be able to fill the training needs for PAs in California.

Standards, degree, and transparency: As mentioned above ARC-PA Standards will now require a Master's degree as the entry level degree for the profession by 2020. This requirement was supported by most stakeholders, though it remains a controversial issue in the profession. The PA profession has always been competency based and there are currently three Certificate, two Associates, and six Baccalaureate PA programs in the US which graduates students that pass the PANCE, and practice to the same standard as the graduates of the other 185 programs that offer a Master's degree. This issue has implication for California because two Associates and one of the Certificate programs are in this State. Both of the Associate degree programs have affiliation agreements with another institution to offer a Master's degree pathway for qualified students. Both of the Associate degree programs in California have had accreditation withdrawn and are teaching out the remaining students enrolled. The requirement for the Master's degree significantly changes the applicant pool for PA training in the state, potentially creating a significant barrier for those who do not have a Baccalaureate degree upon entering PA training. Because the ARC-PA gives the word *should* nearly the same requirements as the word *must* in their standards, a sponsoring institution needs to offer the Master's degree which creates a significant problem for the State's Associate degree programs, which have sponsoring institutions that are not credentialed to offer the graduate degree. Furthermore, this situation may create the

perception that the ARC-PA is using selective enforcement of the standards to push non-graduate degree programs to closure. Additionally, due to the varied methods and approaches for training PAs, some of the ARC-PA standards are somewhat vague so as to allow programs the flexibility to train PAs in a way that is most effective for that particular program. For example, in California many of our PA programs have an extensive network of outpatient clinics used for clinical training rather than being mostly hospital based as may be more common in some programs in the eastern states. Finally, the subjective aspect of accreditation and vagueness of some standards, combined with the inability to disclose publicly the nature of the citations or accreditation issues due to privacy concerns of the program and sponsoring institution, appear to be a lack of transparency and may be perceived as something other than objective evaluation and enforcement of the standards. The ARC-PA has been clear in stating that it does not have an agenda other than enforcement of compliance with the standards. As stated in *Notes to Programs Spring 2015*, "Demonstration by an applicant or accredited program of their compliance with the accreditation standards for physician assistant education is the determinant in the accreditation decision-making process of the ARC-PA."

Perceptions and Positions: This subcommittee informally surveyed ten program directors and various stakeholders both within and outside of California regarding their perceptions of the ARC-PA, and discussed trends to see if the perceived issues in California are common nationally. This data was not subjected to formal statistical analysis but does yield some useful information. Here is what the surveyed found:

- 80% of program directors feel the ARC-PA is fair in enforcement of standards, however 30% perceived some bias, possibly due to inter-rater variability (site visitors are peers).
- 80% of program directors perceive that the ARC-PA has an agenda or ulterior motive underlying the enforcement of the standards, however there was no clear consensus on the specific agenda. Most common perception was that the ARC-PA is trying to close non-graduate degree programs.
- 100% of program directors feared retribution, mostly enhanced scrutiny, if speaking out about the ARC-PA. All were careful to ensure they would not be identified as a respondent to the survey.
- 60% of program directors would support an alternative accreditation pathway nationally; however 100% expressed significant concerns about possible unintended consequences and issues related especially to state only accreditation.
- 80% of program directors felt the ARC-PA standards are fair, though 40% expressed some concern about being too broad or too specific in certain areas, or possibly biased in favor of programs associated with a medical school.
- 90% of program directors felt the ARC-PA is not responsive to the concerns of programs, but most agreed there is a pathway through the PAEA to address concerns. Several commented on communications with ARC-PA: "unpleasant"" rude" "unprofessional""unnecessarily harsh".

CAPA has no official position on state accreditation, however did express some concerns about it. The Physician Assistant Education Association (PAEA) has noted a trend of the ARC-PA stacking citations on programs. For example, the program would be cited for faulty data collection, then would be cited on every standard related to data collection, analysis, application, and program self analysis such that the

citations become circular. They have no position on state accreditation or alternative accreditation pathways. There is a PAEA task force on accreditation issues.

Again, ARC-PA responded to our letter by saying they do not answer to state boards. The Chair of the Committee was careful to explain that she was not speaking for the ARC-PA but that her personal perception is that there may be more of a problem with presentation than content. She was invited to attend the meeting today.

The subcommittee recognizes and appreciates the letter from the chair of the assembly committee on higher education, Mr. Jose Medina. Mr. Medina is concerned about effects of the closure of the Moreno Valley College (MVC) PA Program and expressed concerns about the policy and procedure followed by the ARC-PA related to the decision to withdraw accreditation. He has requested a review of the ARC-PAs accreditation action. Unfortunately, the subcommittee does not have access to all of the relevant documents and is not in a position to verify or validate the conclusions reached by the ARC-PA in regards to the decision to withdraw accreditation for the MVC program. The ARC-PA is accredited by the Council for Higher Education (CHEA), which is in a position to verify that the ARC-PA followed its own policies, as well as the CHEA accreditation standards.

Possible problems associated with State Accreditation of PA programs

Cost: Standards would have to be written and approved. A mechanism for enforcement would have to be put into place. Staff would need to be hired to verify compliance. The various details for all of this would have to be worked out, regulations passed, and a budget approved. This lengthy process would not put more PAs into the workforce for several years.

Certification: Currently a graduate of a California approved PA training program would not be eligible to take the PANCE. The state would have to develop and administer a certifying examination. The PA could not be credentialed at most hospitals, and would not be eligible to bill Medicare/Medicaid. Additionally the PA could not practice outside the state and could not work for the federal government or bill if working in a federally qualified rural health clinic.

Patient confusion: This would in effect create a two tiered system where a California program PA graduate may be seen alongside an ARC-PA approved graduate, but could not be seen by one or the other due to billing or other concerns. Because of this patients could be confused or perceive bias, thinking they are not getting an equal level of care.

Likely opposition: Many in the profession are opposed to state accreditation and would likely fight to stop it. This may result in a negative reflection on PAs in California, and may cause regulatory problems as the state legislature and consumer may have difficulty understanding the nuanced differences between state and nationally certified PAs. This may lead to the consumer opting not to see a PA, passage of laws to restrict PA practice, or a supervising physician opting not to hire one, all of which would reduce access to quality health care PAs are currently delivering in California.

Possible board actions

The following are possible board actions that the subcommittee recommends.

- Direct staff to draft a letter to CHEA expressing concern about ARC-PAs actions in California and ask them to investigate further.

- Direct staff to contact PAEA and give input to, or possibly participate in the task force on accreditation.
- Direct staff to contact ARC-PA and ask for a timeline on California PA programs accreditation which will assist us in health care workforce planning.
- Direct staff to contact NCCPA to see if they will consider California accredited PA program graduates eligible to take the PANCE.

The subcommittee recognizes the following action may be needed in the future, but recommends no action be taken at this point:

- Direct staff to identify partners in the legislature and identify what regulatory changes are needed to move ahead on state accreditation.

Public Comment

Attachment

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Physician Assistants (PA) practice medicine under the supervision of physicians. They are formally trained to provide diagnostic, therapeutic, and preventive healthcare services. Specific duties of PAs are determined by their supervising physicians and by State law. Working as members of a healthcare team, they take medical histories, examine and treat patients, order and interpret laboratory tests and X-rays, and make diagnoses. They also treat minor injuries by suturing, splinting, and casting. The PAs record patients' progress, instruct and counsel patients, and order or carry out therapy. They may administer immunizations and injections, perform minor surgery, and assist in surgery. If they meet the legal requirements, PAs may prescribe some medications.

Wages and Benefits

The median wage for PAs in California is \$102,537 annually, or \$49.29 hourly. *The median is the point at which half of the workers earn more and half earn less.

Annual Wages for 2014	Low (25 th Percentile)	Median* (50 th Percentile)	High (75 th Percentile)
California	\$83,386	\$102,537	\$119,362

Source: EDD/LMID Occupational Employment Statistics Survey, 2014.

Annual Job Openings

In California, an average of 280 new job openings per year is expected for PAs, plus an additional 150 job openings due to net replacement needs, resulting in a total of 430 job openings.

Estimated Average Annual Job Openings Physician Assistants			
Geographic Area (Estimated Year-Projected Growth)	Jobs From Growth	Jobs Due to Net Replacements	Total Annual Job Openings
California (2012-2022)	280	150	430

Source: EDD/LMID Projections of Employment by Occupation

Industries Employing PAs

Industry Title	Percent of Total Employment for Occupation in California
Offices of Physicians	51.7%
Employment Services	13.0%
Outpatient Care Centers	11.1%
General Medical and Surgical Hospitals	10.8%
Federal Government	1.5%

Source: EDD/LMID Staffing Patterns, 2014

Projections of Employment

Occupational Employment Projections estimate the changes in occupational employment over time resulting from industry growth, technological changes, and other factors. In California, the number of PAs is expected to grow much faster than the average growth rate for all occupations. Jobs for PAs are expected to increase by 33.7%, or 2,800 jobs between 2012 and 2022.



Source: EDD/LMID Projections of Employment by Occupation

Source: Employment Development Department, Labor Market Information Division (EDD/LMID), 2014.

Note: The "Physician Assistants in California" report was based on a survey and used 2010-2020 and 2012 data from EDD/LMID, so data reported may vary in this Fact Sheet due to different reporting periods.



Fact Sheet

Occupational Employment Projections 2012-2022¹

2014

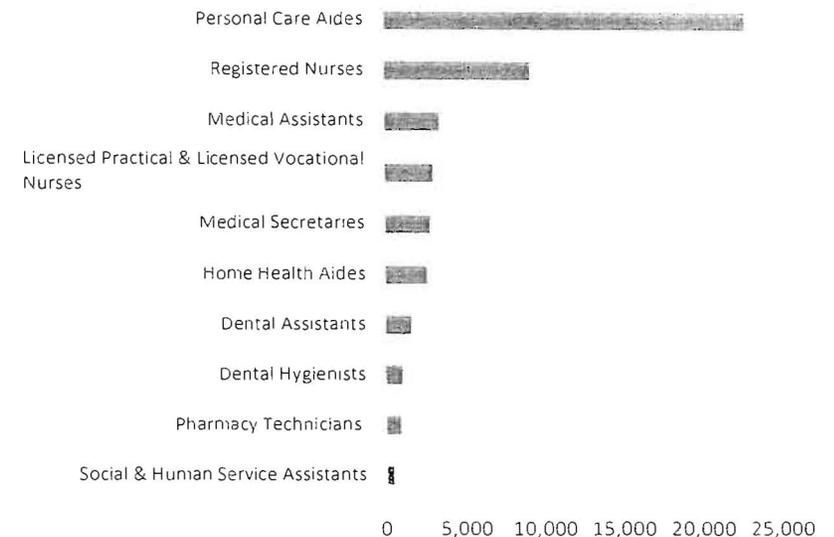
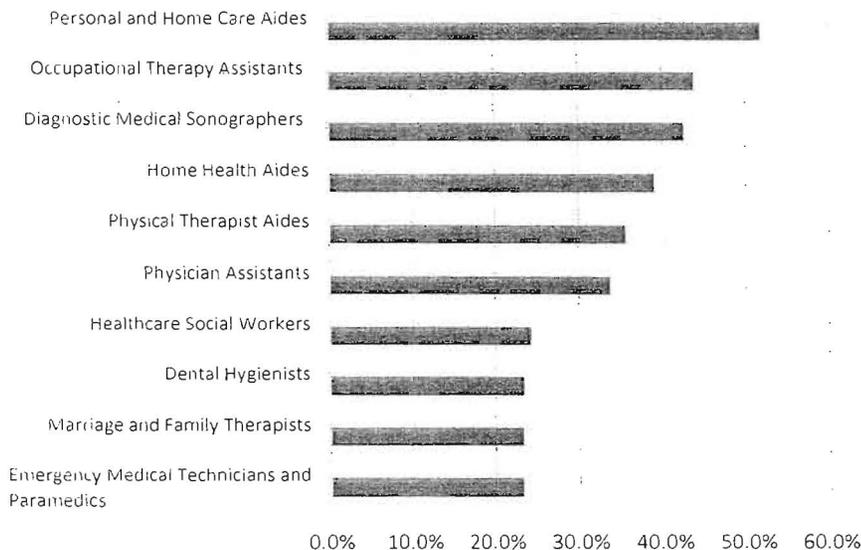
The following information is based on the State of California Employment Development's Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections.

Top Ten Fastest Growing Health Occupations

Health Occupation Title	Percent Change	Employment 2012	Employment 2022	Top Industries Employing this Occupation
Personal and Home Care Aides	51.8%	386,900	587,200	Private Households
Occupational Therapy Assistants	43.8%	1,600	2,300	Offices of Other Health Practitioners
Diagnostic Medical Sonographers	42.6%	4,700	6,700	Office of Physicians
Home Health Aides	39%	44,900	62,400	Community Care Facility for the Elderly
Physical Therapist Aides	35.6%	4,500	6,100	Offices of Other Health Practitioners
Physician Assistants	33.7%	8,300	11,100	Offices of Physicians
Healthcare Social Workers	24.2%	13,200	16,400	General Medical & Surgical Hospitals
Dental Hygienists	23.4%	21,800	26,900	Offices of Dentists
Marriage and Family Therapists	23.3%	6,000	7,400	Individual and Family Services
Emergency Medical Technicians and Paramedics	23.2%	16,800	20,700	Other Ambulatory Health Care Services

Top Ten Health Occupations with the Most Job Openings

Health Occupation Title	Total Annual Job Openings	Top Industries Employing this Occupation
Personal Care Aides	22,800	Private Households
Registered Nurses	9,230	General Medical & Surgical Hospitals
Medical Assistants	3,450	Office of Physicians
Licensed Practical & Licensed Vocational Nurses	3,040	Nursing Care Facilities
Medical Secretaries	2,810	Office of Physicians
Home Health Aides	2,610	Community Care Facility for the Elderly
Dental Assistants	1,640	Office of Dentists
Dental Hygienists	1,060	Office of Dentists
Pharmacy Technicians	900	Health & Personal Care Stores
Social & Human Service Assistants	483	Individual and Family Services



¹Source of Data: Employment Development Department, Labor Market Information Division Public Master File, June 2014.



HEALTHCARE WORKFORCE CLEARINGHOUSE

Fact Sheet

OSHPD
Office of Statewide Health Planning and Development

California Occupational Employment Projections: Life, Physical and Social Science Occupations¹

2012-2022

The following table shows health occupations with the “Average Annual Job Opening” in California based on the Occupational Employment Statistics (OES) data survey responses from employers and expected industry growth. The projections are estimates of jobs created from economic growth, and jobs created when workers retire or permanently leave an occupation and need to be replaced. The 2014 first quarter wages are the most recent wage estimates available for the 2012-2022 projections. “N/A” in a field means that the data are not available.

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Biological Scientists, All Other	9,000	10,100	120	260	380	\$37.42	\$77,831
Biological Technicians	11,100	13,000	180	330	520	\$21.71	\$45,163
Clinical, Counseling, and School Psychologists	24,900	27,300	230	680	910	\$39.57	\$82,313
Environmental Scientists and Specialists, Including Health	14,900	19,300	440	440	880	\$38.81	\$80,715
Medical Scientists, Except Epidemiologists	28,000	33,000	510	590	1,100	\$45.49	\$94,616
Microbiologists	4,500	5,400	80	130	210	\$42.43	\$88,262
Psychologists, All Other	1,300	1,400	10	40	50	\$48.65	\$101,202
Social Scientists and Related Workers	45,400	53,700	820	1,280	2,100	N/A	N/A

¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.

Note: Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.

There may be more current information on the EDD-LMID website: http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.



Fact Sheet

OSHPD
Office of Statewide Health
Planning and Development

California Occupational Employment Projections: Community and Social Service Occupations¹

2012-2022

The following table shows health occupations with the “Average Annual Job Opening” in California based on the Occupational Employment Statistics (OES) data survey responses from employers and expected industry growth. The projections are estimates of jobs created from economic growth, and jobs created when workers retire or permanently leave an occupation and need to be replaced. The 2014 first quarter wages are the most recent wage estimates available for the 2012-2022 projections. “N/A” in a field means that the data are not available.

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Child, Family, and School Social Workers	28,600	32,300	370	610	980	\$22.78	\$47,389
Counselors, All Other	4,500	5,200	70	100	170	\$21.09	\$43,868
Health Educators	7,100	8,400	140	180	320	\$24.84	\$51,658
Healthcare Social Workers	13,200	16,400	320	280	600	\$31.46	\$65,448
Marriage and Family Therapists	6,000	7,400	140	130	270	\$24.66	\$51,294
Mental Health Counselors	10,600	12,000	140	230	370	\$19.88	\$41,339
Mental Health and Substance Abuse Social Workers	11,200	12,500	140	240	370	\$22.45	\$46,701
Rehabilitation Counselors	13,900	16,400	250	300	550	\$14.35	\$29,835
Substance Abuse and Behavioral Disorder Counselors	9,600	11,400	180	210	380	\$17.34	\$36,068
Social Workers, All Other	14,000	15,100	110	300	400	\$30.62	\$63,698
Social and Human Service Assistants	39,900	46,800	690	1,040	1,730	\$16.02	\$33,316

¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.

Note: 1. Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.

There may be more current information on the EDD-LMID website: http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.





HEALTHCARE WORKFORCE
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California Occupational Employment Projections: Education, Training, Library and Production Occupations¹ 2012-2022

The following table shows health occupations with the "Average Annual Job Opening" in California based on the Occupational Employment Statistics (OES) data survey responses from employers and expected industry growth. The projections are estimates of jobs created from economic growth, and jobs created when workers retire or permanently leave an occupation and need to be replaced. The 2014 first quarter wages are the most recent wage estimates available for the 2012-2022 projections. "N/A" in a field means that the data are not available.

Education, Training, and Library Occupations

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Health Specialties Teachers, Postsecondary	11,900	16,300	450	180	620	[6]*	\$80,573
Nursing Instructors and Teachers, Postsecondary	3,900	5,300	140	60	200	[6]*	\$86,137
Psychology Teachers, Postsecondary	5,400	6,300	80	80	160	[6]*	\$73,228

Production Occupations

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Medical Appliance Technicians	1,200	1,300	20	40	60	\$18.76	\$39,022
Ophthalmic Laboratory Technicians	2,200	2,400	20	80	100	\$15.65	\$32,567

¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.

Note: Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.

There may be more current information on the EDD-LMID website: http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.



HEALTHCARE WORKFORCE
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Fact Sheet

OSHPD
Office of Statewide Health
Planning and Development

California Occupational Employment Projections: Healthcare Practitioners and Technical Occupations¹ 2012-2022

The following table shows health occupations with the “Average Annual Job Opening” in California based on the Occupational Employment Statistics (OES) data survey responses from employers and expected industry growth. The projections are estimates of jobs created from economic growth, and jobs created when workers retire or permanently leave an occupation and need to be replaced. The 2014 first quarter wages are the most recent wage estimates available for the 2012-2022 projections. “N/A” in a field means that the data are not available.

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Anesthesiologists	3,400	4,000	60	90	140	N/A	N/A
Athletic Trainers	1,200	1,400	20	30	50	N/A	\$49,959
Audiologists	1,000	1,300	30	20	50	\$40.70	\$84,650
Cardiovascular Technologists and Technicians	3,400	4,300	90	50	140	\$30.26	\$62,949
Chiropractors	3,200	3,300	10	60	80	\$32.25	\$67,077
Dental Hygienists	21,800	26,900	510	560	1,060	\$48.23	\$100,312
Dentists, General	14,400	15,600	110	350	470	\$65.60	\$136,450
Diagnostic Medical Sonographers	4,700	6,700	200	70	260	\$41.83	\$87,018
Dietetic Technicians	3,400	4,200	80	30	120	\$14.33	\$29,805
Dietitians and Nutritionists	7,800	9,300	150	90	240	\$34.74	\$72,257
Emergency Medical Technicians and Paramedics	16,800	20,700	390	460	850	\$14.40	\$29,947
Family and General Practitioners	17,400	19,500	210	440	640	\$90.00	>187,200

¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.

Note: 1. Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.

There may be more current information on the EDD-LMID website: http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.



HEALTHCARE WORKFORCE
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Fact Sheet

OSHDPD
Office of Statewide Health
Planning and Development

California Occupational Employment Projections: Healthcare Practitioners and Technical Occupations¹ 2012-2022

The following table shows health occupations with the “Average Annual Job Opening” in California based on the Occupational Employment Statistics (OES) data survey responses from employers and expected industry growth. The projections are estimates of jobs created from economic growth, and jobs created when workers retire or permanently leave an occupation and need to be replaced. The 2014 first quarter wages are the most recent wage estimates available for the 2012-2022 projections. “N/A” in a field means that the data are not available.

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Health Diagnosing and Treating Practitioners, All Other	7,300	8,300	110	150	260	\$33.35	\$69,363
Health Technologists and Technicians, All Other	15,000	18,900	390	150	540	\$20.85	\$43,382
Healthcare Practitioners and Technical Workers, All Other	6,100	7,000	90	170	260	\$26.75	\$55,634
Internists, General	6,400	6,900	50	160	210	N/A	N/A
Licensed Practical and Licensed Vocational Nurses	60,700	76,300	1,560	1,480	3,040	\$25.11	\$52,225
Medical and Clinical Laboratory Technicians	16,000	20,500	450	420	870	\$20.48	\$42,593
Medical Records and Health Information Technicians	16,500	19,900	340	440	780	\$19.61	\$40,782
Nuclear Medicine Technologists	1,500	1,700	30	20	50	\$45.89	\$95,445

¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.

Note: 1. Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.

There may be more current information on the EDD-LMID website: http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.

California Occupational Employment Projections: Healthcare Practitioners and Technical Occupations¹ 2012-2022

The following table shows health occupations with the “Average Annual Job Opening” in California based on the Occupational Employment Statistics (OES) data survey responses from employers and expected industry growth. The projections are estimates of jobs created from economic growth, and jobs created when workers retire or permanently leave an occupation and need to be replaced. The 2014 first quarter wages are the most recent wage estimates available for the 2012-2022 projections. “N/A” in a field means that the data are not available.

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Obstetricians and Gynecologists	2,700	2,900	20	70	90	N/A	N/A
Occupational Health and Safety Specialists	7,200	8,900	170	200	360	\$37.20	\$77,386
Ophthalmic Laboratory Technicians	2,200	2,400	20	80	100	\$15.65	\$32,567
Optometrists	4,700	5,400	70	140	210	\$49.01	\$101,940
Opticians, Dispensing	7,500	8,800	130	210	350	\$18.04	\$37,514
Pharmacists	26,900	31,000	410	640	1,050	\$65.42	\$136,066
Pediatricians, General	5,400	5,900	50	140	190	\$75.03	\$156,067
Psychiatrists	5,200	5,800	60	130	190	N/A	N/A
Physicians and Surgeons, All Other	27,900	31,500	350	700	1,050	N/A	N/A
Physician Assistants	8,300	11,100	280	150	430	\$49.29	\$102,537
Physical Therapists	16,400	21,100	470	400	870	\$43.83	\$91,156
Pharmacy Technicians	31,400	37,200	590	310	900	\$18.48	\$38,445
Psychiatric Technicians	8,400	8,500	10	80	100	\$26.74	\$55,624

¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.

Note: 1. Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.

There may be more current information on the EDD-LMID website: http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.





HEALTHCARE WORKFORCE
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Fact Sheet

California Occupational Employment Projections: Healthcare Practitioners and Technical Occupations ¹ 2012-2022

The following table shows health occupations with the “Average Annual Job Opening” in California based on the Occupational Employment Statistics (OES) data survey responses from employers and expected industry growth. The projections are estimates of jobs created from economic growth, and jobs created when workers retire or permanently leave an occupation and need to be replaced. The 2014 first quarter wages are the most recent wage estimates available for the 2012-2022 projections. “N/A” in a field means that the data are not available.

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Radiation Therapists	1,100	1,300	20	20	40	\$47.15	\$98,066
Recreational Therapists	1,400	1,600	20	30	50	\$32.40	\$67,390
Respiratory Therapists	14,100	16,600	250	200	450	\$36.66	\$76,253
Registered Nurses	254,500	297,400	4,300	4,930	9,230	\$45.87	\$95,415
Radiologic Technologists	15,000	17,600	260	210	470	\$34.35	\$71,437
Surgeons	5,800	6,700	90	150	230	N/A	N/A
Speech-Language Pathologists	11,200	12,800	160	170	330	\$40.65	\$84,549
Surgical Technologists	9,400	11,800	240	90	330	\$27.41	\$57,000
Therapists, All Other	3,800	5,000	120	50	160	\$26.47	\$55,037

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Planning and Development

¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.
Note: 1. Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.
There may be more current information on the EDD-LMID website: http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.



HEALTHCARE WORKFORCE
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Fact Sheet

OSHPD
Office of Statewide Health
Planning and Development

California Occupational Employment Projections: Healthcare Support Occupations¹

2012-2022

The following table shows health occupations with the “Average Annual Job Opening” in California based on the Occupational Employment Statistics (OES) data survey responses from employers and expected industry growth. The projections are estimates of jobs created from economic growth, and jobs created when workers retire or permanently leave an occupation and need to be replaced. The 2014 first quarter wages are the most recent wage estimates available for the 2012-2022 projections. “N/A” in a field means that the data are not available.

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Dental Assistants	45,200	52,200	700	940	1,640	\$17.71	\$36,850
Healthcare Support Workers, All Other	12,400	14,100	170	240	400	\$19.14	\$39,802
Home Health Aides	44,900	62,400	1,760	850	2,610	\$11.18	\$23,267
Massage Therapists	17,200	20,300	310	180	500	\$17.09	\$35,540
Medical Assistants	81,600	100,500	1,890	1,560	3,450	\$15.83	\$32,940
Medical Equipment Preparers	6,600	8,000	130	130	260	\$20.30	\$42,231
Medical Transcriptionists	4,600	4,800	20	90	100	\$22.29	\$46,362
Occupational Therapy Assistants	1,600	2,300	60	40	100	\$32.92	\$68,470
Psychiatric Aides	2,500	2,700	20	50	70	\$13.51	\$28,103
Physical Therapist Assistants	4,500	6,100	150	100	250	\$30.83	\$64,137
Physical Therapist Aides	5,900	7,900	200	130	330	\$13.06	\$27,166
Pharmacy Aides	9,000	10,000	100	170	270	\$11.79	\$24,516
Orderlies	5,000	5,700	70	100	170	\$16.36	\$34,039

¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.

Note: 1. Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.

There may be more current information on the EDD-LMID website: http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.



HEALTHCARE WORKFORCE
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Fact Sheet

California Occupational Employment Projections: Personal Care, Service, Office, Administrative Support¹

2012-2022

The following table shows health occupations with the "Average Annual Job Opening" in California based on the Occupational Employment Statistics (OES) data survey responses from employers and expected industry growth. The projections are estimates of jobs created from economic growth, and jobs created when workers retire or permanently leave an occupation and need to be replaced. The 2014 first quarter wages are the most recent wage estimates available for the 2012-2022 projections. "N/A" in a field means that the data are not available.

Personal Care and Service Occupations

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Fitness Trainers and Aerobics Instructors	28,500	31,500	300	340	640	\$22.93	\$47,702
Personal Care Aides	386,900	587,200	20,030	2,770	22,800	\$10.33	\$21,473
Personal Care and Service Workers, All Other	4,800	5,400	60	130	200	\$11.29	\$23,478

Office and Administrative Occupations

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Medical Secretaries	68,500	88,400	1,990	830	2,810	\$17.77	\$36,949

¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.
Note: 1. Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.
There may be more current information on the EDD-LMID website: http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.



¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.

*Note: Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.

**Data sources: U.S. Bureau of Labor Statistics' Current Employment Statistics (CES) March 2013 benchmark, Quarterly Census of Employment and Wages (QCEW) industry employment, and Occupational Employment Statistics (OES) data.

- Occupational employment projections include self-employed, unpaid family workers, private household workers, farm, and nonfarm employment.
- N/A - Information is not available.
- Occupations with employment below 1,000 in 2012 are excluded.
- The use of occupational employment projections as a time series is not encouraged due to changes in the occupational, industrial, and geographical classification systems; changes in the way data are collected; and changes in the OES survey reference period.

[2] New jobs are only openings due to growth and do not include job declines. If an occupation's employment change is negative, there is no job growth and new jobs are set to zero. New jobs may not equal numerical change.

[3] Replacement needs estimate the number of job openings created when workers retire or permanently leave an occupation and need to be replaced.

[4] Total jobs are the sum of new jobs and replacement needs.

[5] Median hourly and annual wages are the estimate 50th percentile of the distribution of wages; 50 percent of workers in an occupation earn wages below, and 50 percent earn wages above the median wage. The wages are from 2014 first quarter and do not include self-employed or unpaid family workers.

[6] In occupations where workers do not work full-time all year-round, it is not possible to calculate an hourly wage.

There may be more current information on the EDD-LMID website:

http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.

Attachment

A

PHYSICIAN ASSISTANT BOARD

POLICY MANUAL

Updated February 9, 2015

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GENERAL AREA: Administration

SPECIFIC SUBJECT: Attendance

STATEMENT:

A report on member attendance will be presented to the Executive and Budget Committee and given to the full Board.

INITIAL POLICY REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAB: 12/12/94

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 01/20/95

REVIEWED AND RECOMMENDED MODIFICATION BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 11/20/03

MODIFICATION APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 11/20/03

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Administration

SPECIFIC SUBJECT: Conflict of Interest

STATEMENT:

A Board member is expected to exercise impartial and reasoned judgment in all matters brought before the Board. It is the policy of the Physician Assistant Board that members may sometimes need to recuse themselves to ensure such impartiality. Illustrative of these times are when a member (or someone in the member's immediate family) has close personal knowledge of, or substantial business interests with, an individual or entity brought before the Board for enforcement or decision of any sort.

NECESSITY:

In order for any deliberative body to ensure the trust placed in it by the government and the public, it is necessary to avoid any bias or perception of bias by individual Board members. To reassure all parties of the impartial nature of discussions and decisions, Board members who have personal involvement or business interests relevant to a decision must refrain from interjecting opinion or bias into those discussions. It is appropriate that members who have or may reasonably be perceived as having inappropriate interest or bias in a matter should recuse themselves from discussion and voting in that matter.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 2/26/04

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Administration

SPECIFIC SUBJECT: Experts: Role of Special Services and Content Experts

STATEMENT:

From time to time, the Physician Assistant Board (PAB) may require special services, certain content experts, or consultants for specific projects and problems. Such services are arranged by means of state approved contracts authorized by state law. Such individuals functioning as specialists serve as contractual consultants to (e.g.,) the Executive Officer, the full Board, or a committee of PAB. Consistent with state law, such individuals may not serve as members of committees; nor may they function as (e.g.,) ex officio members of the PAB.

NECESSITY:

The PAB may require expert assistance in fulfilling its responsibilities to the consumers of California. Still, the actual decision makers in PAB operations and decisions must remain those individuals duly appointed to the Board. Consequently, although consultants and others may provide information and other expertise to the PAB, their role will remain that of advisor or consultant -- not that of decision-maker, Board member, or committee member in any sense.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 2/26/04

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Administration

SPECIFIC SUBJECT: Outreach, Information, Complaints

STATEMENT:

Outreach and consumer education shall be provided by the PAB to consumers regarding the role of the PAB and how to file complaints against practitioners. This information shall be provided by the PAB through:

1. A toll-free (800) telephone number placed in most California telephone directories,
2. PAB's newsletter,
3. Information and special bulletins distributed to all current licensees of the PAB,
4. Information provided to state depository libraries,
5. Speaking engagements by PAB members and staff,
6. Press releases and public affairs announcements,
7. Telephone responses,
8. Written, FAX, and E-mail inquiries, and
9. The PAB website.

Additional sources of information concerning PAB and the complaint process specifically shall include:

1. Various services and information of the Medical Board of California,
2. Osteopathic Medical Board of California, and
3. Services and publications of the Department of Consumer Affairs.

NECESSITY:

Incumbent in the oversight responsibility of the PAB is the provision of information concerning the practices and roles of the PA practitioners, as well as specific information that promotes understanding of and means of access to the process of making complaints against practicing PAs and their supervising physicians. This information must be made available to every Californian through the most diverse media possible.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 2/26/04

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Administration

SPECIFIC SUBJECT: Projects: Approval for New Projects

STATEMENT:

The Chair of the Physician Assistant Board will be responsible for approving all new projects submitted by Physician Assistant Board members and staff. New projects will be submitted in writing to the Executive Officer for perspective and feasibility. The Executive Officer will then seek approval of the Chair.

NECESSITY:

Fiscal responsibility and appropriate utilization of resources is essential to protect the integrity and purpose of the Department of Consumer Affairs and the Physician Assistant Board. Annual meetings, ongoing projects and travel plans are the responsibility of the Executive and Budget Committees. Additional requests for new projects need to be carefully reviewed by the Chair and Executive Officer for cost and appropriate contribution to the goals of the Physician Assistant Board. The final decision will rest with the Chair of the Physician Assistant Board.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 10/05/95

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 10/27/95

REVIEWED BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 10/28/04

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Administration

SPECIFIC SUBJECT: Training/Orientation of Newly Appointed Board Members

STATEMENT:

Newly appointed Board members are expected to become familiar with PAB policies and regulations, as well as key laws relating to PAB practices and programs. Within the first thirty days of appointment if possible, but certainly before the sixth month of appointment, new members will meet with the Executive Officer of the PAB and the PAB Chair or the Chair's designee for orientation to PAB's mission and goals and for instruction in relevant policies, procedures, regulations, and laws.

NECESSITY:

Board members must understand the practices, the procedures, and the standards of the medical and physician assistant professions, state government, and the PAB. Such understanding must be built on a foundation of knowledge of:

1. Policies that govern the PAB and its committees;
2. Board regulations that relate to PA practices; and
3. State laws and regulations that define the nature, scope, minimum standards of performance, etc., of PA practices.

In addition, Board members are required by California law to complete the following training:

1. Board Member Orientation Training (within one year of assuming office, even if serving on another Board);
2. Ethics Training (within the first 6 months of appointment and repeated every 2 years throughout their term);
3. Sexual Harassment Prevention Training (every 2 years); and,
4. Defensive Driver Online Training (every 4 years).

In addition, after appointment, Board members will receive a Form 700 (Statement of Economic Interests and Conflict of Interest Filing) packet from the Department of Consumer Affairs. The Form 700 "Assuming Office" form must be filed within 30 days of a new Board member appointment. Appointees must file the Form 700 Annual Statement every April 1. Appointees must file a Form 700 "Leaving Office" Statement within 30 days of leaving the Physician Assistant Board.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 10/28/04

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Administration

SPECIFIC SUBJECT: Travel: Approval of Unscheduled Travel

STATEMENT:

The Chair of the Physician Assistant Board will be responsible for approving all unscheduled travel plans submitted by Physician Assistant Board members and staff. Unscheduled travel plans will be submitted in writing to the Executive Officer for perspective and feasibility. The Executive Officer will then seek approval of the Chair.

NECESSITY:

Fiscal responsibility and appropriate utilization of resources is essential to protect the integrity and purpose of the Department of Consumer Affairs and the Physician Assistant Board. Annual meetings, ongoing projects and travel plans are the responsibility of the Executive and Budget Committee. Additional requests for unscheduled travel need to be carefully reviewed by the Chair and Executive Officer for cost and appropriate contribution to the goals of the Physician Assistant Board. The final decision will rest with the Chair of the Physician Assistant Board.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION THE PAC: 10/05/95

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 10/27/95

REVIEWED BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 10/28/04

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Licensing

SPECIFIC SUBJECT: Criminal History: Responses to Criminal History Reports (a.k.a., rap sheets)

STATEMENT:

Criminal history reports concerning prospective licensees who self-report a prior conviction shall be examined and evaluated by the PAB Executive Officer or his/her designee. If there exist one or more criminal convictions significantly related to practice as a PA, PAB delegates to the Executive Officer in accordance with Title 16, California Code of Regulations Section 1399.503, discretion to respond appropriately, including:

1. Issuing a notification of intent to deny the license;
2. Issuing a Statement of Issues if the applicant seeks to pursue the license; and
3. Proceeding through the administrative law process.

The Executive Officer shall make full and regular reports (typically, quarterly) to the PAB concerning actions taken on the basis of application review by the Executive Officer, including review of information pertaining to criminal convictions.

NECESSITY:

PAB and the PA profession are committed to the highest standards of professional conduct that promote the health, safety, and welfare of the citizens of California. When apparent issues arise in the application process that may affect these goals, the PAB is committed to rapid, fair, and consistent responses. While the PAB, of course, retains oversight responsibility, the Executive Officer or his/her designee is delegated the responsibility of timely and efficient evaluations and appropriate responses to criminal history reports.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 10/28/04

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Disciplinary/Enforcement Action

SPECIFIC SUBJECT: Administrative Hearings

STATEMENT:

Administrative hearings shall be conducted in compliance with the Administrative Procedures Act (Government Code Sections 11500 and following). In addition, licensees who file petitions for penalty relief to reinstate license, modify terms of probation, or terminate probation may also be heard before an ALJ with participation by the members of the PAB according to the criteria set forth in Business and Professions Code Section 3530.

NECESSITY:

Administrative hearings on accusations against PAB licensees must be conducted thoroughly and completely, but also with sensitivity to differing situations and choices by individuals accused of misconduct. It is important to PAB's obligations both to the citizens of California and to the accused licensee or other parties that equitable procedures, as provided within the context of the Administrative Procedures Act, be available, accessible, and followed consistently.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED AND RECOMMENDED MODIFICATION BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 6/30/05

MODIFICATION APPROVED BY PHYSICIAN ASSISTANT COMMITTEE: 6/30/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Disciplinary/Enforcement Action

SPECIFIC SUBJECT: ALJ Decisions: Acceptance Standards for ALJ Decisions

STATEMENT:

Disciplinary decisions proposed by administrative law judges shall be evaluated on a case-by-case basis by the PAB. The Board shall evaluate such proposals on the basis of five criteria; that is, proposed decisions must attempt to:

1. Be based on the community standards of medical/health care and standards of practice;
2. Respond to the situation in a way consistent with the nature and degree of the violation;
3. Serve as a reflection of the PABs commitment to protect the health and safety of the citizens of California;
4. Be reasonable and practical in terms of implementation; and,
5. Be equitable and consistent with decisions made in earlier, similar cases, utilizing model orders and disciplinary guidelines adopted by the Board and set forth in regulation.

Decisions judged in writing by any Board member not to meet one or more of these criteria may be judged unacceptable by the Board. The Board will then discuss the decision in closed session. If the Board votes to reject the proposed decision, it can call up the hearing transcript, request written argument from the parties, and decide the case itself.

NECESSITY:

The PAB has great respect for the administrative hearing process as practiced in California. Whenever possible, the Board wishes to, and expects to, accept *proposed* decisions made through that process. Still, the Board cannot abrogate its responsibility to guarantee that the complex issues of medical practice be decided in ways that are medically sound, fair, and effective in promoting the highest standards of the PA profession, while protecting consumers.

Therefore, the PAB reserves the right to evaluate each proposed decision based upon the aforementioned criteria in order to fulfill these Board responsibilities of high standards of PA practice and consumer protection.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED AND RECOMMENDED MODIFICATIONS BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 6/30/05

MODIFICATIONS APPROVED BY PHYSICIAN ASSISTANT COMMITTEE: 6/30/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Disciplinary/Enforcement Action

SPECIFIC SUBJECT: Information: Disclosure of Information

STATEMENT:

Disciplinary action is public information once an accusation has been filed. The information disclosed shall be the accusation and decision documents.

Information concerning citations or citations and fines shall be disclosed once the citation or citation and fine are issued. Such citation information shall be provided on request, but it shall be accompanied by the explanation that payment of a citation is considered a satisfactory resolution of the matter for purposes of public disclosure but is not tantamount to an admission of a violation.

Disciplinary information, excluding information about citations or citations and fines as discussed above, shall be disclosed to the public by means of the *MBC Newsletter*, and *PAB Update*, and the PAB website. In addition, in accordance with DCA policy, the PAB shall provide a copy of the accusation and decision without charge to any member of the public upon request.

NECESSITY:

The PAB is required to comply with the Bagley-Keene Open Meetings Act, the California Public Records Act, and other applicable laws. Additionally, the PAB believes that its role in protecting the health, safety, and welfare of California citizens is best fulfilled in an atmosphere of open communication with members of the public. Consumers and patients must be accorded easily accessible means of identifying those practitioners found in violation of applicable statutes and regulations. Moreover, the prevention of future violations may be best accomplished when it is clear that information concerning violations, and the name of the physician assistant who has committed a violation, is accurately and promptly disclosed publicly.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED AND RECOMMENDED MODIFICATIONS BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 6/30/05

MODIFICATIONS APPROVED BY PHYSICIAN ASSISTANT COMMITTEE: 6/30/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Disciplinary/Enforcement Action

SPECIFIC SUBJECT: Education through Disciplinary Action

STATEMENT:

Disciplinary questions and consumer complaints shall be highlighted in the various communication media used by the Board. Such matters shall include, for example, cases of illegal prescribing (vis a vis, transmitting a physician's prescription), and questions about the PAB's alcohol and drug diversion program. Relevant communication media shall include, but are not limited to, discussions at Board meetings, newsletter articles, press releases, and public speaking occasions.

NECESSITY:

The PAB believes that education in legal matters and professional conduct matters that are subjects of discipline can be a valuable help in encouraging the best possible PA care for California's citizens. Such education can be accomplished in part by publicizing instances of especially harmful and unacceptable conduct -- and the discipline that resulted from that unacceptable conduct. The PAB strives to promote safe, honest, and ethical behavior by its licensees in order to reduce or preclude the need for the Board to take action to protect consumers.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED AND RECOMMENDED MODIFICATIONS BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 6/30/05

MODIFICATIONS APPROVED BY PHYSICIAN ASSISTANT COMMITTEE: 6/30/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Investigations

SPECIFIC SUBJECT: Investigative Staff and Services

STATEMENT:

The PAB shall contract primarily with the Department of Consumer Affairs' Division of Investigation (DOI) for the use of investigators and investigative services.

NECESSITY:

Evidence obtained during investigations involving PA behavior and practice must meet a standard of clear and convincing evidence for use in court. As sworn peace officers, DOI investigators are trained to obtain this level of evidence. Such contracting with the Department of Consumer Affairs' unit represents an efficient and effective approach to PAB investigations. Moreover, since DOI investigates complaints against physicians such an arrangement is appropriate since PAs by definition provide medical services under the supervision of physicians approved by either the MBC or the OMBC to supervise PAs.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED AND RECOMMENDED MODIFICATION BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 10/6/05

MODIFICATION APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 10/6/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Investigations

SPECIFIC SUBJECT: Priority of Complaints

STATEMENT:

The PAB has decided that the Department of Consumer Affairs' Division of Investigation's case prioritization categories shall be used and applied to complaints about the conduct of licensed PAs or persons describing themselves as licensed PAs.

NECESSITY:

In order to ensure prompt, effective, and consistent treatment of complaints, the PAB endorses the need for complaints to be processed according to time frames related to the severity of the alleged offense. The Division of Investigation's system of complaint prioritization has been judged by the PAB to be a fair and effective means of assuring that urgent complaints are addressed in an efficient and timely manner.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED AND RECOMMENDED MODIFICATION BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 10/6/05

MODIFICATION APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 10/6/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Investigations

SPECIFIC SUBJECT: Time Limitations

STATEMENT:

The standard investigation in a typical case shall be limited initially to no more than twenty (20) hours of investigative work. Investigators (contracted through the DCA's Division of Investigation) are asked to contact the PAB Enforcement Coordinator or the Executive Officer to request prior approval of additional time to complete particular cases. Such additional time may be granted at the discretion of the PAB's Executive Officer or his/her designee based on the facts presented. Alternative ways of efficiently and effectively completing the investigation shall be considered before an approval for additional time is granted.

NECESSITY:

Investigations must be thorough and systematic, but they also need to be efficient and consistent. The provision of standard initial time frames for investigations allows these activities to be managed equitably. The allowance for additional contracted time ensures that particularly complex or wide-ranging situations are investigated adequately and cost efficiently to ensure that the PAB fulfills its consumer protection obligation.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED AND RECOMMENDED MODIFICATION BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 10/6/05

MODIFICATION APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 10/6/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Enforcement

SPECIFIC SUBJECT: Auditing of Enforcement Cost

STATEMENT:

The PAB Executive Officer or his/her designee shall collect monthly and annual enforcement cost reports provided by the Office of Administrative Hearings, the Office of the Attorney General, and the Department of Consumer Affairs' Division of Investigation, in addition to CALSTARS reports. These collected reports shall be reviewed on a monthly basis by the Executive Officer.

NECESSITY:

The efficient use of public moneys depends in part on wise and prudent outlays even for something as critical as enforcement. Prudent allocation of funds -- and any future use of funds -- cannot occur without a systematic and regular monitoring of the current use of funds. Monthly analyses by the Executive Officer allow him/her to prepare the materials and information for Board review.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED AND RECOMMENDED MODIFICATIONS BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 10/6/05

MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 10/6/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Enforcement

SPECIFIC SUBJECT: Consultants: Selection of Expert Consultants

STATEMENT:

Expert consultants for matters of investigation shall be selected by the PAB's Executive Officer on the bases of the following submitted information, selection criteria, and process:

Submitted Information. Potential expert consultants shall submit to the PAB Executive Officer:

1. A curriculum vitae;
2. Two professionally-relevant references;
3. A statement of areas of expertise and experience; and
4. Evidence of knowledge in/history of testifying and/or giving depositions.

Selection Criteria. Potential expert consultants may be evaluated on the basis of:

1. The appropriateness and relevance of their education, training, and the needs of the PAB;
2. The background factors listed in Submitted Information above;
3. Evidence of diagnostic and analytical ability in reviewing matters;
4. Level of credibility, reputation, and professional status;
5. Ability to translate complex medical issues orally and in writing for laypersons (e.g., deputy attorneys general, juries, ALJs);
6. Record of any disciplinary actions or judgments against the applicant expert consultant by PAB, hospitals, or any other agencies, excluding minor traffic violations; and
7. Evidence of productive, effective, and successful testimonial skills.

Selection Process. Potential expert consultants may be selected by the following process steps:

1. A review and confirmation of submitted materials by the Executive Officer or designee;
2. An interview by the Executive Officer and PAB Enforcement Analyst;
3. Evaluation of the potential consultant by the Executive Officer in terms of the seven (7) selection criteria listed above;
4. Evaluation of candidate's written and oral responses to a "sample" case;
5. Selection as expert consultant by the Executive Officer; and
6. Notification of the expert consultant and briefing on administrative procedures to be followed.

NECESSITY:

Enforcement is a primary and fundamental duty of the PAB. The Board is committed to fulfilling this responsibility with the utmost care, fairness, and effectiveness. When it is determined that expert witnesses are crucial to the enforcement process, the selection of such witnesses must be accomplished efficiently, but with the highest degree of professionalism. A clear, effective, and thorough selection process, therefore, is a pivotal part of the enforcement process.

**REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED
FOR PRESENTATION TO THE PAC: 04/05/97**

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 10/6/05

**EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN
ASSISTANT BOARD: 02/09/2015**

GENERAL AREA: Enforcement

SPECIFIC SUBJECT: Evaluation of Consultants: Assignment and
Evaluation of Expert Consultants

STATEMENT:

The Board's assignment of an expert consultant and the evaluation and possible re-assignment of that consultant are integrally connected and may be conducted in the following manner:

1. Approved and selected expert consultants shall be assigned initially to fairly simple and straightforward cases;
2. First reports by expert consultants shall be reviewed and evaluated by the PAB's Executive Officer and Enforcement Analyst, and feedback shall be given to the consultant;
3. The expert consultant shall be deemed acceptable if he/she is characterized by:
 - a. Evidence of technical and medical expertise;
 - b. Credibility and professionalism;
 - c. Systematic and thorough modes of investigation and analysis;
 - d. Clarity and specificity in conclusions and recommendations;
 - e. Clarity and effectiveness in both oral and written communication, including presentations at hearings and trials;
 - f. Efficiency in preparing timely reports.
4. The reports shall be compared to those of other more senior PA expert consultants;
5. Newly contracted expert consultants shall receive oral critique of their work by PAB's Executive Officer and/or more senior PA expert consultants. Their work will be evaluated as "standard/acceptable" or "needs improvement" or "unacceptable";
6. An expert consultant whose initial work has been evaluated as unacceptable by the Executive Officer (see 3 a-f above) shall be assigned no future cases;
7. An expert consultant whose work is deemed acceptable or "needs improvement" (see 3 a-f above) shall enter a probationary period of evaluation, the length of which is determined by the Executive Officer, using criteria listed in 3 a-f above;
8. During the probationary period, the work of the expert consultant shall be continually evaluated by the Executive Officer, using criteria listed in 3 a-f above;
9. At the conclusion of specified probationary period, successfully performing expert consultants shall be assigned to more complex cases and situations.

NECESSITY:

Just as enforcement is a major commitment of the PAB, expert consultants are crucial to the fulfillment of that commitment. Despite the Board's careful and systematic selection of candidates for the role of expert consultants, both the evaluation of their performance and the methodical process of using effective consultants on increasingly complex cases are pivotal elements in the highest standards of enforcement activities.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 04/05/97

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 04/24/97

REVIEWED BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 10/6/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Enforcement

SPECIFIC SUBJECT: Mail Ballot Voting

STATEMENT:

When considering any enforcement action (proposed decision, stipulation or default decision) by mail ballot, votes from two or more Board members to do anything other than adopt means that the item will be held for review and discussion during closed session at the next scheduled Board meeting unless the time for action (100 days) is set to expire before the next regularly scheduled meeting. In such a case, a meeting will be scheduled to discuss the case by teleconference, if necessary.

NECESSITY:

A protocol must be established to allow Board members to present questions and concerns regarding proposed actions to one another-for discussion and resolution. This better allows the Board to make informed and compassionate decisions and allows the Board to offer meaningful feedback to the parties where necessary.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 12/12/94

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 01/20/95

REVIEWED AND RECOMMENDED MODIFICATION BY THE EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE SENT TO FULL COMMITTEE: 10/6/05

MODIFICATION APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 10/6/05

REVIEWED AND RECOMMENDED MODIFICATION BY THE COMMITTEE: 5/31/07

MODIFICATION APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 5/31/07

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Enforcement

SPECIFIC SUBJECT: Vote: Quorum for Deciding Disciplinary Cases

STATEMENT:

For mail votes a quorum will consist of a majority of nine Board members, or five votes as required by Business and Professions Code Section 3511. A majority decision, at a meeting or by mail, will consist of a majority of the quorum. A fax, email, or a telephone vote by a member is acceptable if the paper copy is mailed within 72 hours.

NECESSITY:

The Board must define for the public, profession, and members the term voting quorum as used by the Physician Assistant Board.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 12/12/94

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 01/20/95

REVIEWED BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 10/6/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Legislation

SPECIFIC SUBJECT: Definition of the Positions Taken by the Physician Assistant Board Regarding Proposed Legislation

STATEMENT:

As required the Physician Assistant Board will adopt by the Board as a whole, requiring a forum, the following positions regarding pending or proposed legislation.

Oppose: The Board will actively oppose proposed legislation and demonstrate opposition through letters, testimony and other action necessary to communicate the oppose position taken by the PAB.

Oppose unless Amended: The Board will communicate to the author that they are opposed to the bill but would possibly reconsider their position if certain amendments were made. The Board would direct staff to submit proposed amendments with a letter to the author.

Watch: The watch position adopted by the Board will indicate concern regarding the proposed legislation. The PAB staff and members will closely monitor the progress of the proposed legislation and amendments before taking oppose, disapprove, approve, or support position.

Support if Amended: The Board will communicate to the author they may be willing to support the bill if certain amendments are considered by the author, but will not actively lobby the legislature regarding the proposed legislation.

Support: The Board will actively support proposed legislation and demonstrate support through letters, testimony and any other action necessary to communicate the support position taken by the PAB.

NECESSITY:

The Physician Assistant Board needs clearly defined positions to adopt regarding proposed legislation. Defining the level of activity involved in any position taken allows the committee to take considered, reasoned, and consistent positions and actions regarding proposed legislation.

REVIEWED BY THE EXECUTIVE AND BUDGET SUBCOMMITTEE AND APPROVED FOR PRESENTATION TO THE PAC: 10/05/95

APPROVED BY THE PHYSICIAN ASSISTANT COMMITTEE: 10/27/95

REVIEWED BY EDUCATION AND PUBLIC AFFAIRS SUBCOMMITTEE: 10/6/05

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: Legislation

SPECIFIC SUBJECT: Legislative Committee: Role and Operating Procedures

STATEMENT:

Role of Committee and Basic Operating Procedures

1. The Physician Assistant Board's Legislative Committee ("the committee") is created to identify legislation about which the Physician Assistant Board of the State of California ("the Board") may want to be notified and /or take a position.
2. The committee shall be comprised of two members appointed by the Chair.
3. The committee reviews state legislation relevant to the Board or the education or practice of physician assistants in California. The committee may place on the agenda of the Board's public meetings legislation it recommends the Board consider. The committee may recommend the Board adopt a support, oppose, watch or other position on legislation as defined in the Policy Manual (Legislation, page 23). The committee or the Board may suggest additional actions, including but not limited to sending letters to the Legislature, recommending amendments to legislation or testifying at legislative hearings.
4. The committee's recommendation may be distributed and/or included with the Board's agenda package, if available. Board members may use the materials to take a position at those meetings if so desired.
5. The Board's staff should provide the committee with guidance on selecting and understanding legislation, as further defined below.
6. At Board meetings, the committee, or any individual Board members, may ask the Board to take a position regardless of whether a specific position was recommended in advance of the Board meeting.
7. If the Board chooses to send the Legislature a letter of support, opposition, or another position on specific legislation, the staff drafts the letter based on the Board's decision, and the committee chair approves the letter. If the committee chair is unavailable, the other committee member or the Board Chair may sign the letter. On behalf of the Board, the staff sends the approved letter to the author, and any other recipients designated by the committee, including the committee reviewing the legislation, the department, or other relevant individuals.
8. In recognition of the limited time and resources committee members have to review legislation, committee members are not expected to spend more than 30 hours per year evaluating legislation, preparing recommendations, and preparing follow-up materials.

Sources of information

1. The Board, its members, and the Board's staff may ask the committee to review specific pieces of legislation.
2. The committee will consider any relevant bills identified by the Medical Board of California, the Department of Consumer Affairs' legislative office (DCA), and California Academy of Physician Assistants (CAPA), other health care related organizations or agencies, or other members of the public.
 - a. Staff seeks lists and analyses of bills relevant to physician assistants and shares with committee members.

- b. Staff provides committee members with contact information for DCA, or other individuals at the aforementioned organizations and others they may contact for additional information.
3. Committee members review recent legislative committee and floor analyses to learn about key issues, fiscal and policy impacts, and supporters and opponents. In some cases, it may also be helpful to review legislative language, particularly if a bill has not yet been reviewed by a state legislative committee. Analysis, legislative language, votes and other official information is available here: <http://leginfo.legislature.ca.gov/faces/billSearchClient.xhtml>
4. Optionally, committee members may want to conduct additional review, such as contacting the author's office to request a fact sheet or clarification or conducting an internet news search for reactions to the legislation.

Preparing for Board meetings

1. At least one month prior to Board meeting, staff will provide the committee members with a relevant bill list as noted above.
2. The committee members review the materials obtained from the above sources and, at least three weeks prior to Board meetings, determine and/or develop agenda items and materials.
3. At least two weeks before Board meetings, committee members send staff agenda items and materials for any legislation the committee wants the Board to consider.
4. Materials sent to the Board will include the summary document prepared by the committee, the most recent, relevant bill language, and analysis of bills in question. The summary document may include recommended positions and a brief explanation of the recommendation. At least one copy of the text of the bill will be available at the Board meeting.
5. At the Board meetings, the committee, or any individual Board members may make a motion that the Board take a position on a bill.

NECESSITY:

The Physician Assistant Board needs a method to be informed of proposed legislation so that, where appropriate, it may take a position on bills. This structure allows the Board to receive timely notice of relevant bills so that it may take considered, reasoned, and consistent positions and actions regarding proposed legislation.

REVIEWED BY THE LEGISLATION COMMITTEE AND APPROVED FOR PRESENTATION TO THE PHYSICIAN ASSISTANT BOARD: 08/26/13

APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 08/26/13

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

GENERAL AREA: General

SPECIFIC SUBJECT: Professional Reporting Requirements

STATEMENT:

If a Board member has knowledge that another physician assistant may be in violation of, or has violated, any of the statutes or regulations administered by the Board, the Board member is encouraged to report this information to the Executive Officer and is also expected to cooperate with the Executive Officer in furnishing information or assistance as may be required.

NECESSITY:

Business and Professions Code Section 3504.1 states that "protection of the public shall be the highest priority for the Physician Assistant Board in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

When a Board member witnesses or has knowledge of any alleged violations that member is encouraged to report those violations to the Executive Officer, thus maintaining the highest standard of professional conduct to promote the health, safety, and welfare of the citizens of California.

REVIEWED AND APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 11/03/14

EDITED/UPDATED VERSION MODIFICATIONS APPROVED BY THE PHYSICIAN ASSISTANT BOARD: 02/09/2015

Attachment

B

**Physician Assistant Board
Committee Organization Chart
Fiscal Year 2012/13**

**Physician Assistant
Board**

Legislative Committee

**Committee Chair – Catherine Hazelton
Committee Member – Sonya Earley**

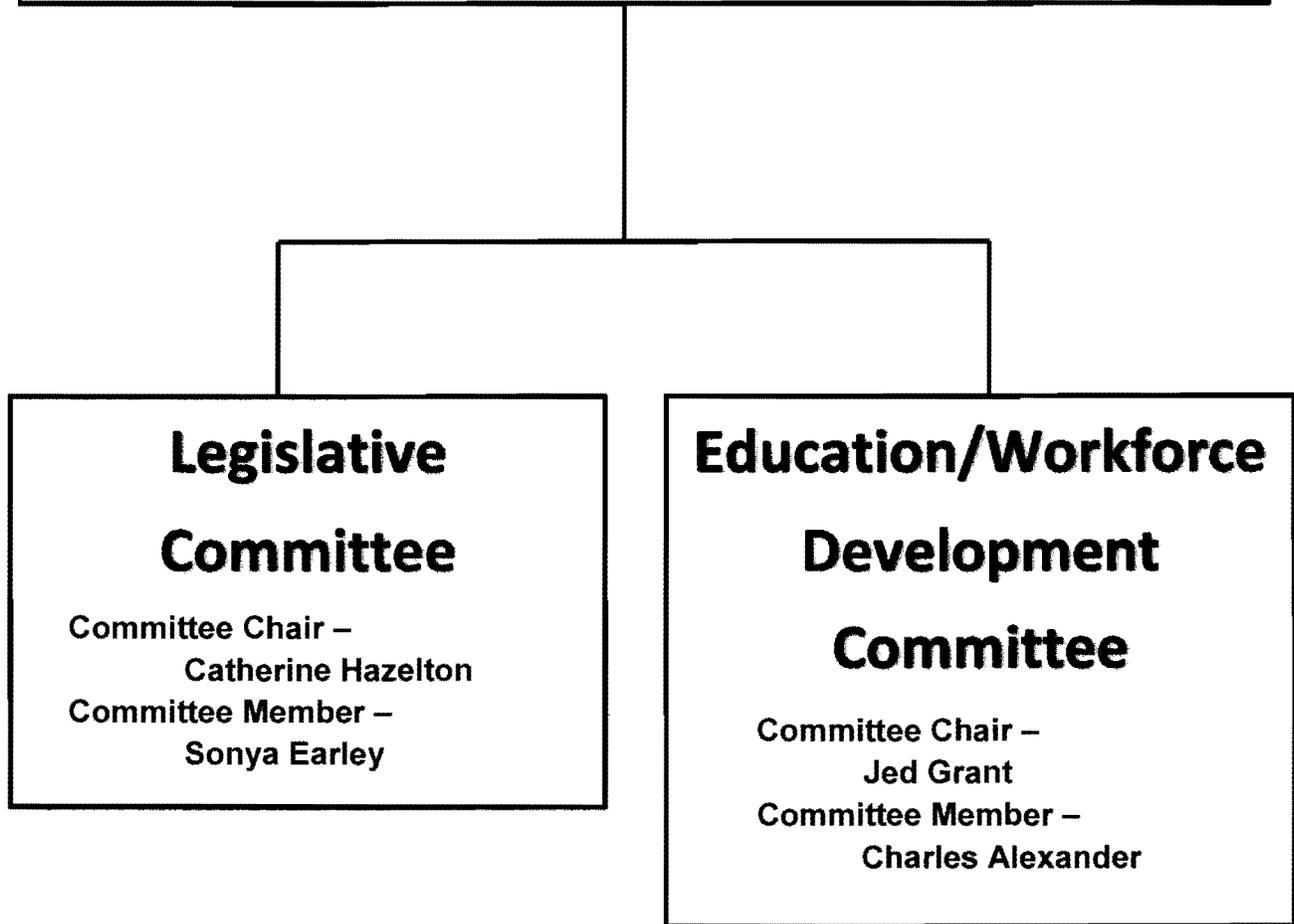
**Physician Assistant Board
Committee Organization Chart
Fiscal Year 2013/14**

**Physician Assistant
Board**

Legislative Committee

**Committee Chair – Catherine Hazelton
Committee Member – Sonya Earley**

**Physician Assistant Board
Committee Organization Chart
Fiscal Year 2014/15**



Attachment

C

**The Board
did not have
any Major
Studies**

Attachment

D

DEPARTMENT OF CONSUMER AFFAIRS

PHYSICIAN ASSISTANT COMMITTEE

7/16/12

Executive Officer
Elberta Portman
602-110-6606-001

ENFORCEMENT

AGPA
Dianne Tincher
602-110-5393-002

DIVERSION

AGPA
Glenn Mitchell
602-110-5393-001

ADMINISTRATION

Staff Services Analyst (G)
Lynn Forsyth
602-110-5157-001

LICENSING

Office Technician
Julie Caldwell (1/2 time)
602-110-1139-001

Staff Services Analyst
CPEI LT .4

position not filed due to 5% personnel savings

Probation Monitors (602-110-5393-907)

AGPA- Retired Annuitant (4)
Barbara Emilio (1/4 time)
Michael Brown 1/4 time
Robert Sherer (1/4 time)
Michael Seamons (1/4 time)

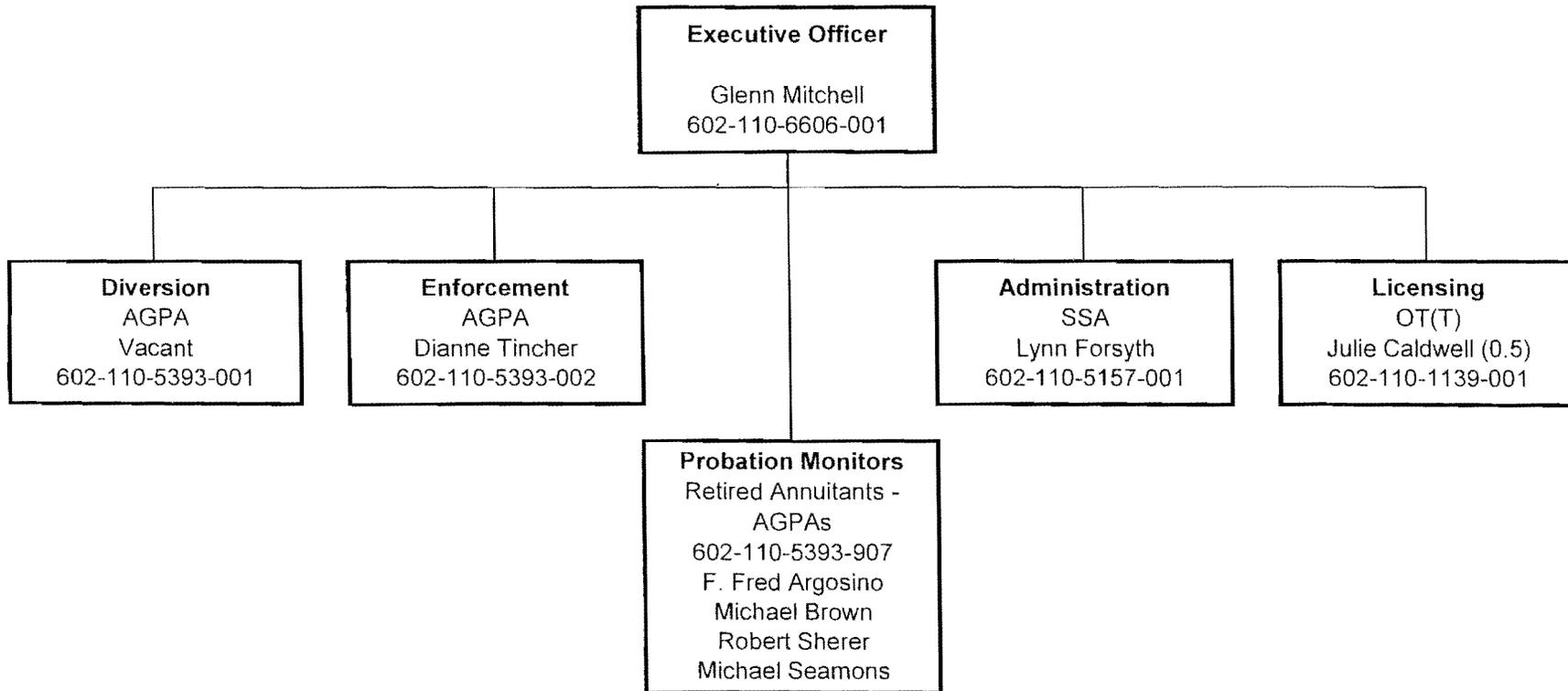
Elberta Portman 7-17-12

Executive Officer

Date

Classification & Pay Analyst

Date



 1 Jan 2013
Glenn Mitchell, Executive Officer Date

Classification & Pay Analyst

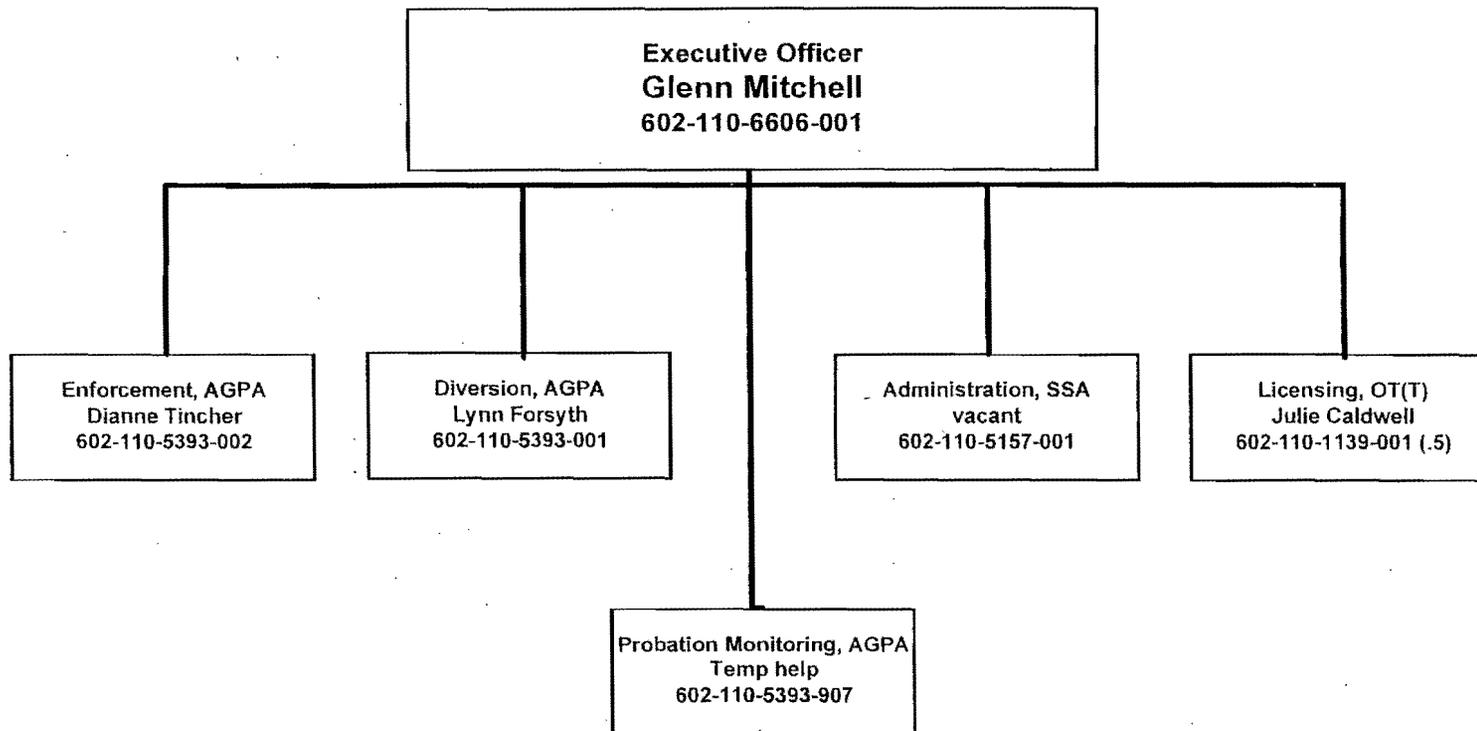
Date

Department of Consumer Affairs (DCA)
Physician Assistant Board

Current

January 1, 2014 - Yearly

FY 2013/2014
Authorized Positions: 4.5
Blanket: 1.0



DCA Personnel Analyst

Date


Glenn Mitchell, Executive Officer

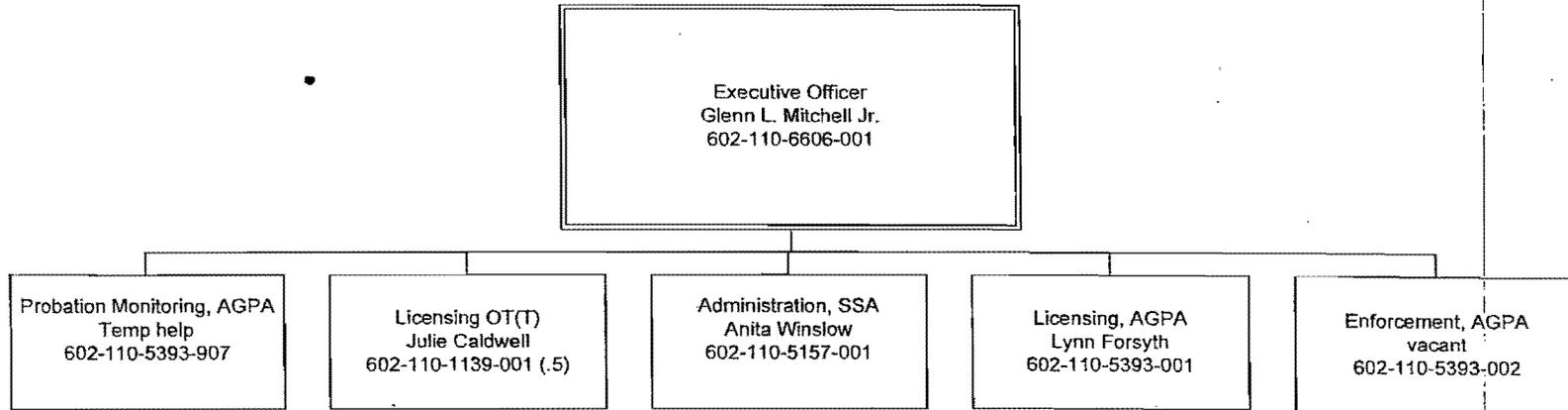
Date

January 1, 2015

Department of Consumer Affairs
Physician Assistant Board

Current
FY 2014-2015
Authorized Positions 4.5
Blanket 1.0

+All positions are CORI



11 Dec 14

Glenn L. Mitchell Jr., Executive Officer

Date

DCA Personnel Analyst,

Date

Attachment

E

Physicians Assistant Committee

Performance Measures Annual Report (2011 – 2012 Fiscal Year)

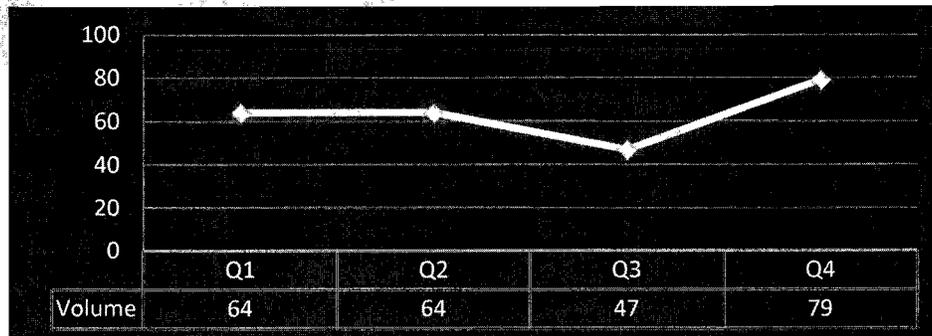
To ensure stakeholders can review the Committee's progress in meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures are posted publicly on a quarterly basis.

This annual report represents the culmination of the four quarters worth of data.

Volume

Number of complaints and convictions received.

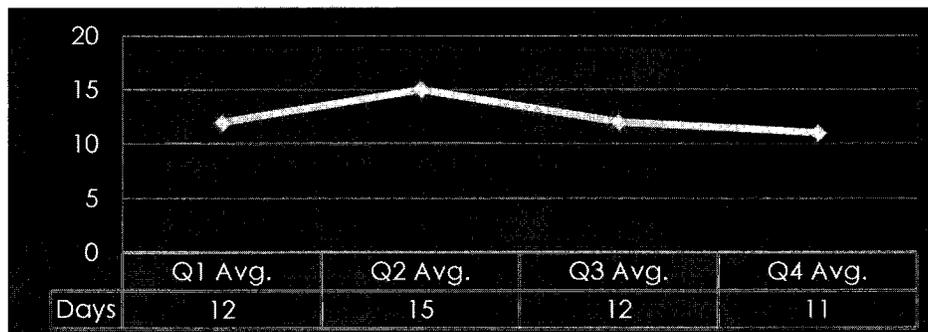
The Committee had an annual total of 254 this fiscal year.



Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

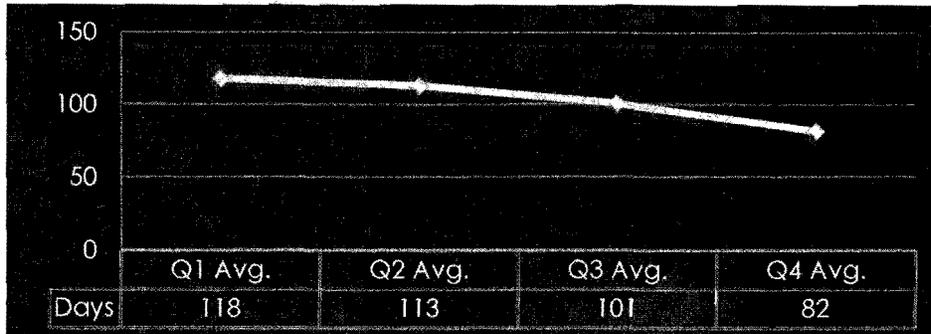
The Committee has set a target of 10 days for this measure.



Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

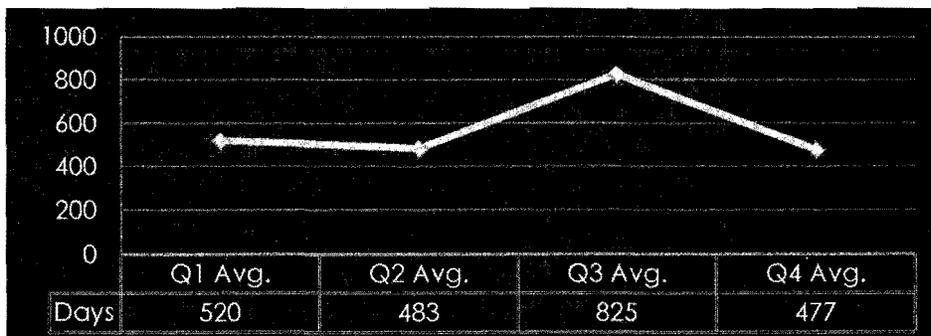
The Committee has set a target of 150 days for this measure.



Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Committee, and prosecution by the AG)

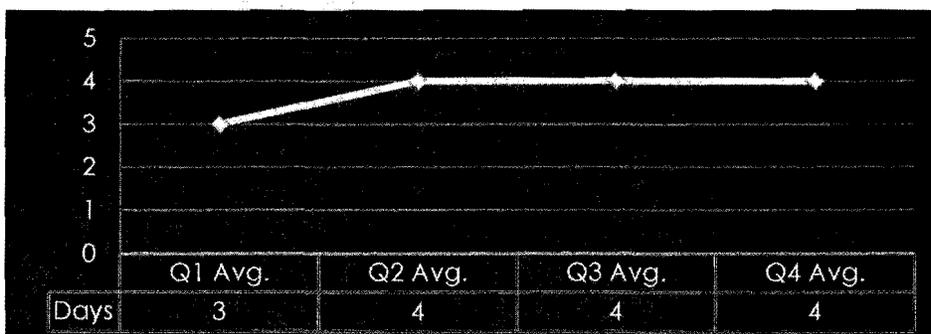
The Committee has set a target of 540 days for this measure.



Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

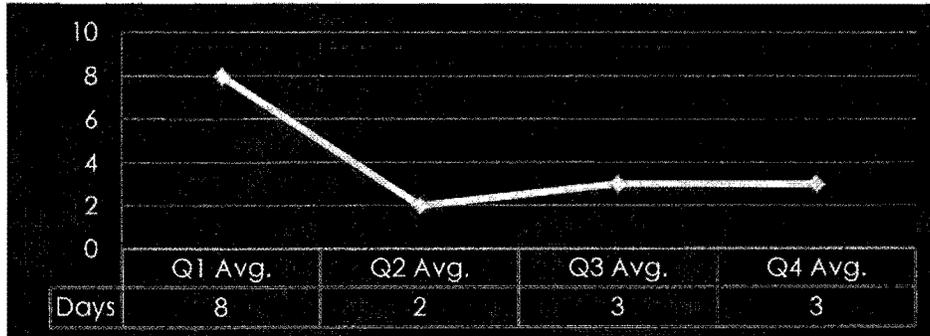
The Committee has set a target of 14 days for this measure.



Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

The Board has set a target of 7 days for this measure.



Physicians Assistant Board

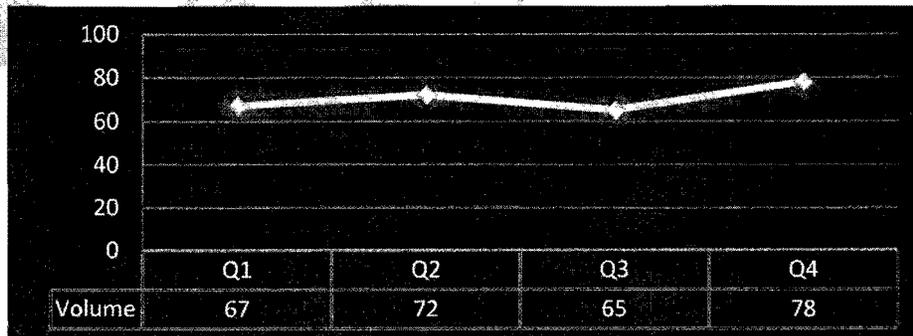
Performance Measures Annual Report (2012– 2013 Fiscal Year)

To ensure stakeholders can review the Board's progress in meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures are posted publicly on a quarterly basis.

Volume

Number of complaints and convictions received.

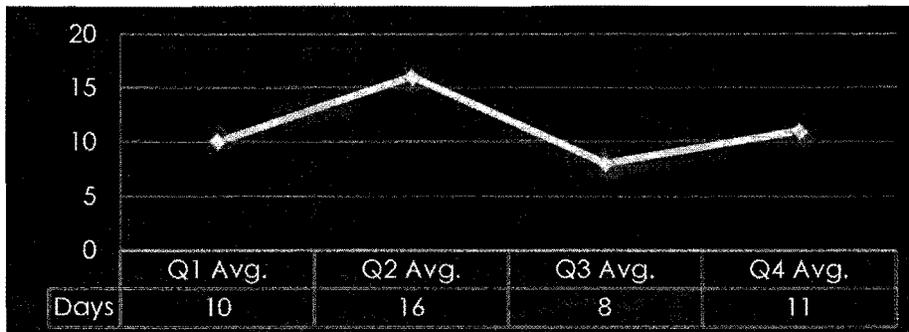
The Board had an annual total of 282 this fiscal year.



Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

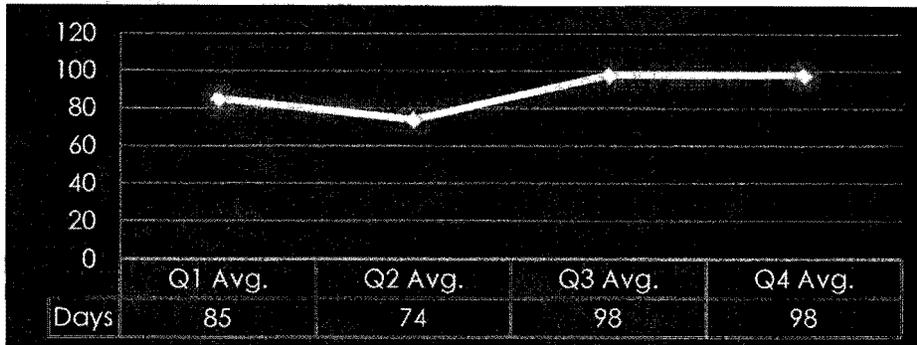
The Board has set a target of 10 days for this measure.



Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

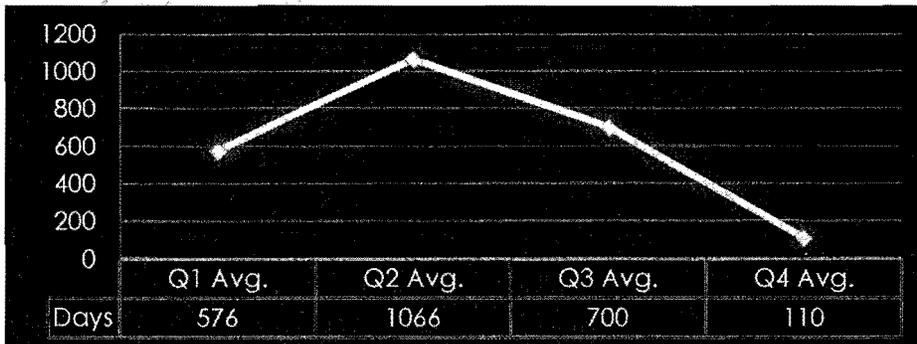
The Board has set a target of 150 days for this measure.



Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board, and prosecution by the AG)

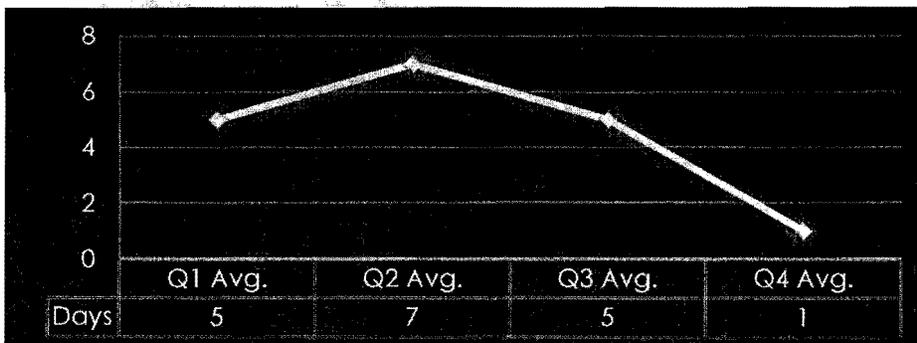
The Board has set a target of 540 days for this measure.



Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

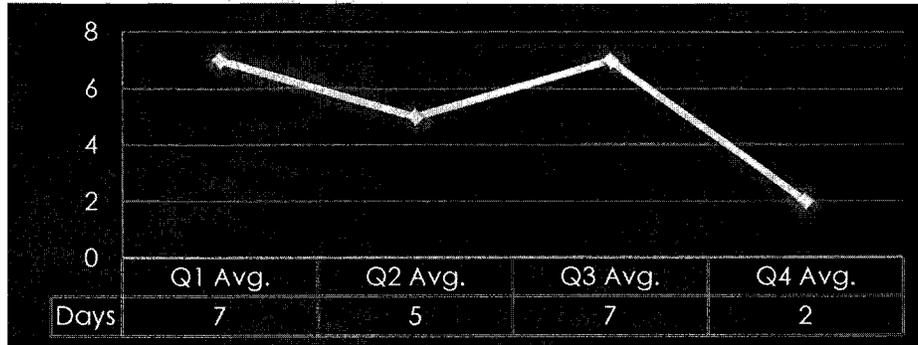
The Board has set a target of 14 days for this measure.



Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

The Board has set a target of 7 days for this measure.

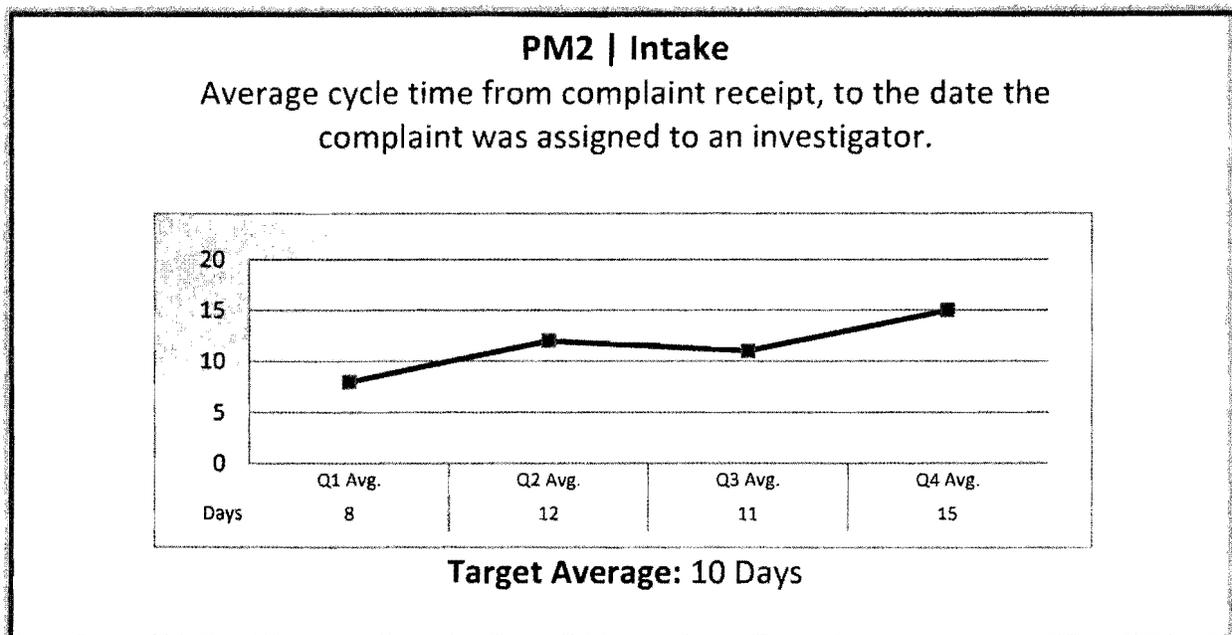
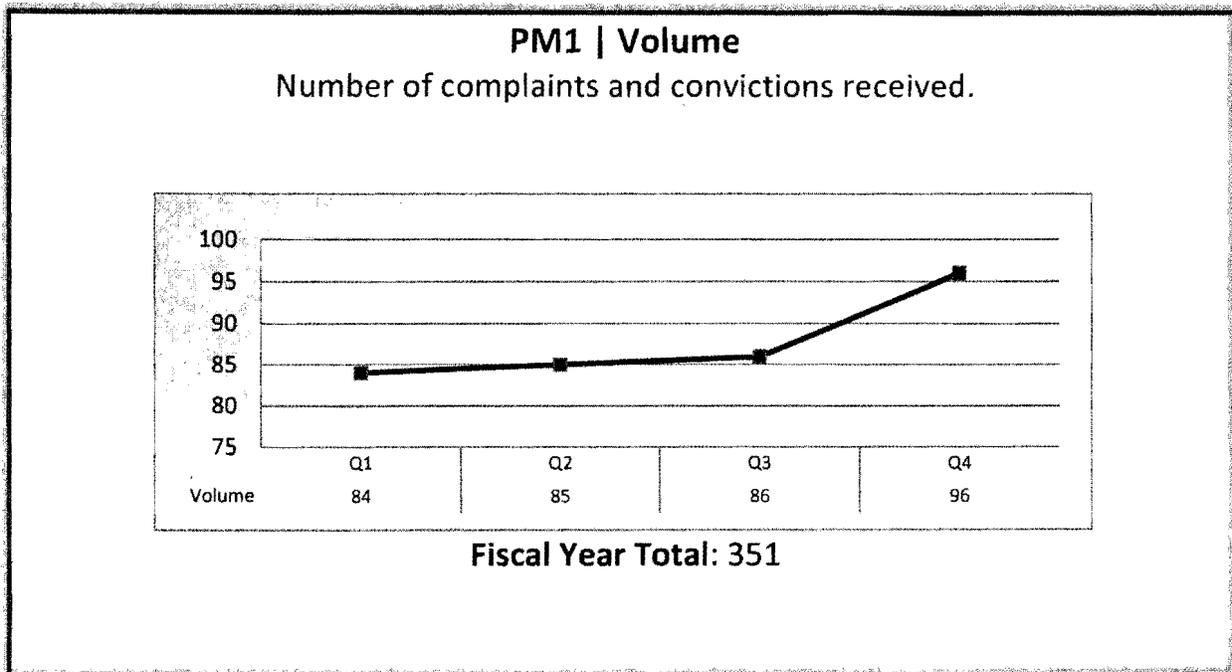


Physicians Assistant Board

Performance Measures

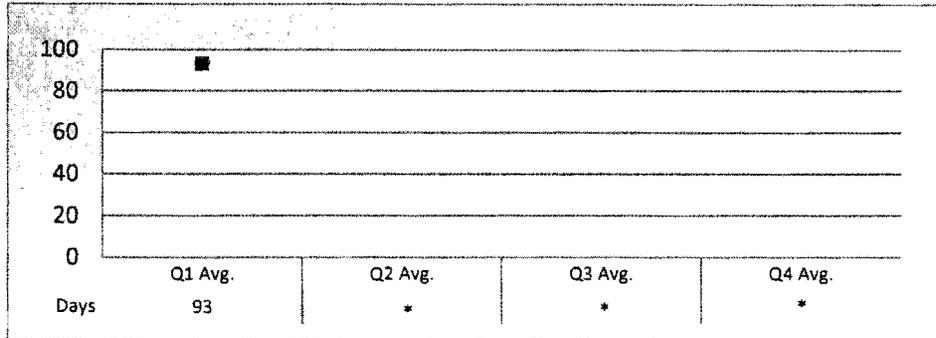
Annual Report (2013 – 2014 Fiscal Year)

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly and annual basis.



PM3 | Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

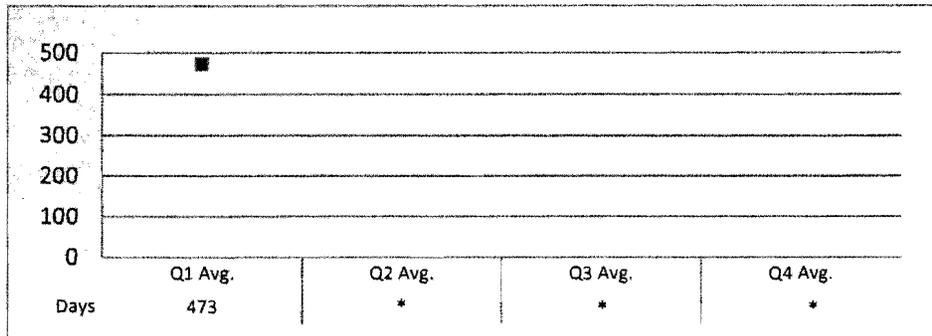


Target Average: 150 Days

**Consistent data not yet available from BreZE.*

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board and prosecution by the AG).

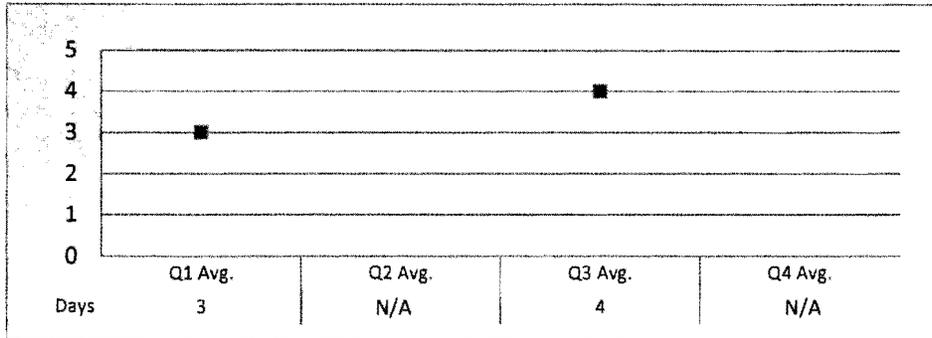


Target Average: 540 Days

**Consistent data not yet available from BreZE.*

PM7 | Probation Intake

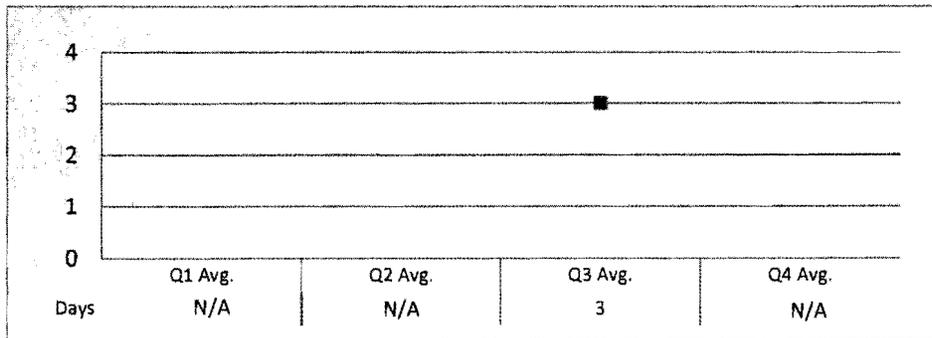
Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.



Target Average: 14 Days

PM8 | Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

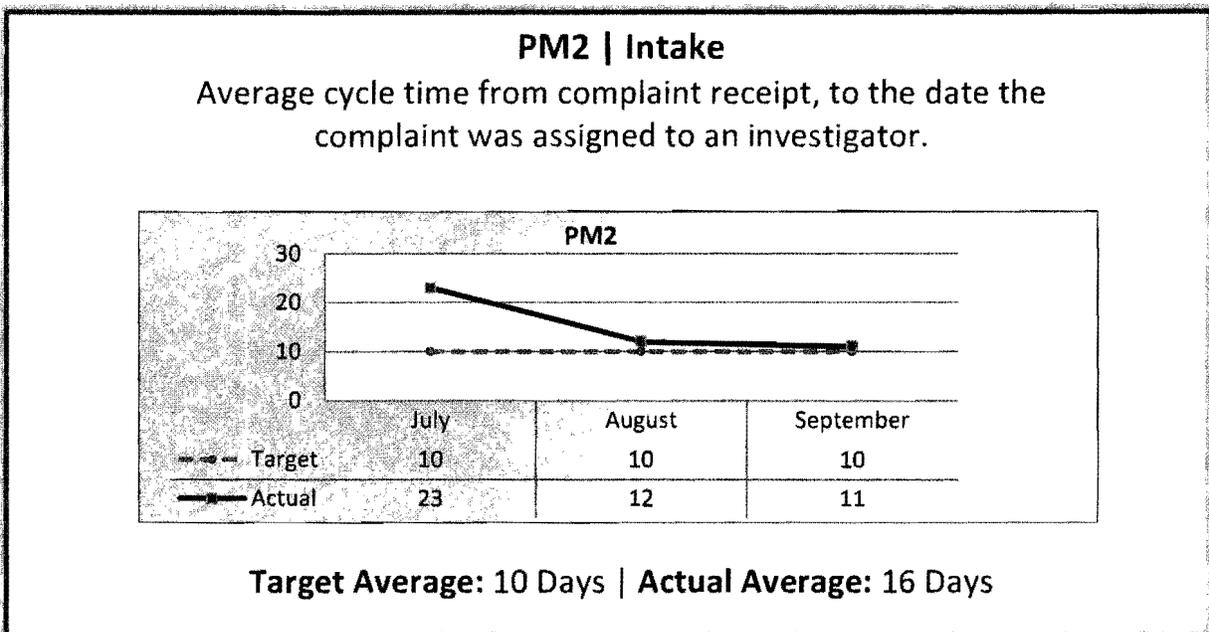
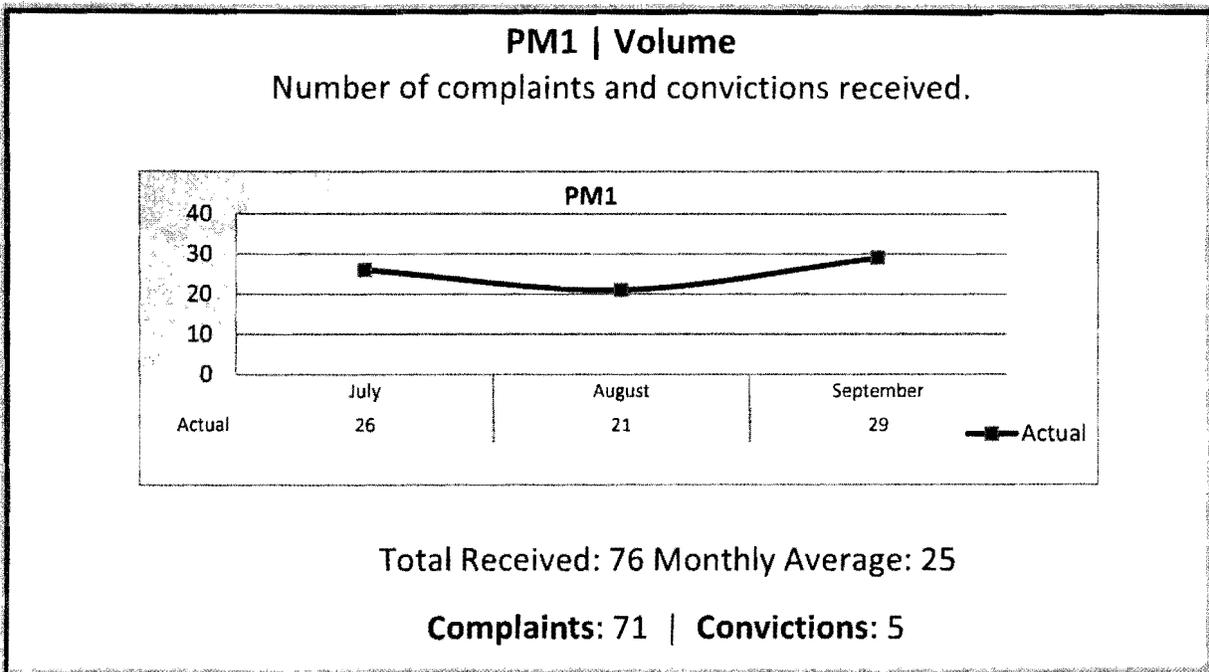


Target Average: 7 Days

Performance Measures

Q1 Report (July - September 2014)

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.



PM3 | Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Consistent data not yet available from BreEZe.

Target Average: 150 Days | Actual Average: N/A

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board and prosecution by the AG).

Consistent data not yet available from BreEZe.

Target Average: 540 Days | Actual Average: N/A

PM7 | Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

The Board did not contact any new probationers this quarter.

Target Average: 14 Days | Actual Average: N/A

PM8 | Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

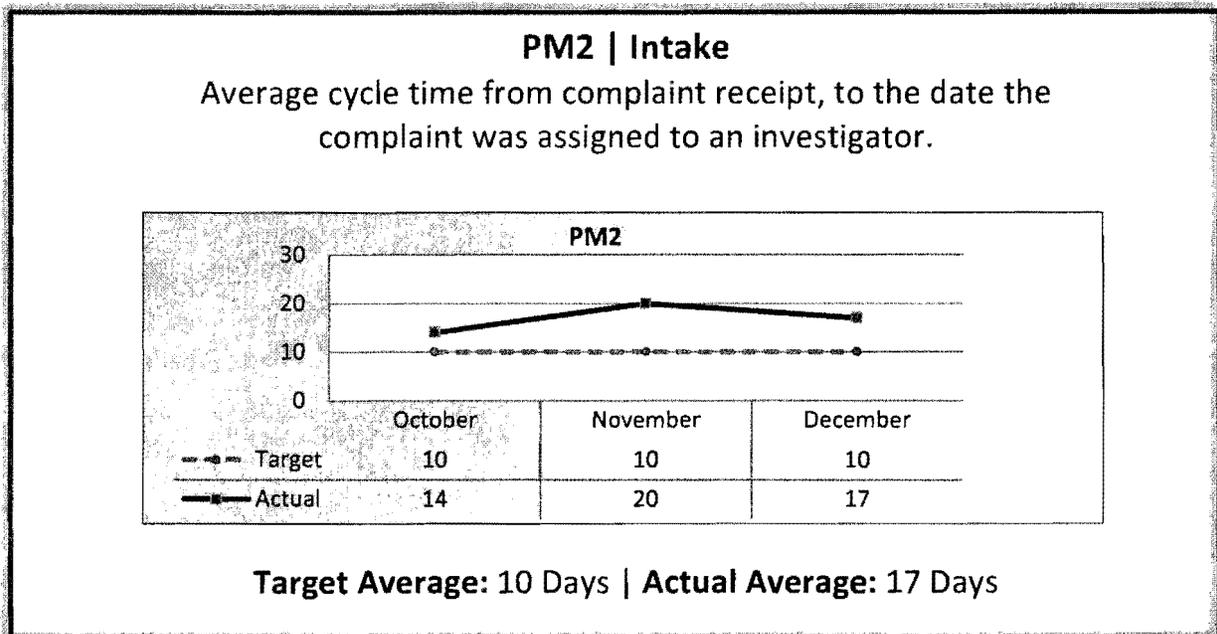
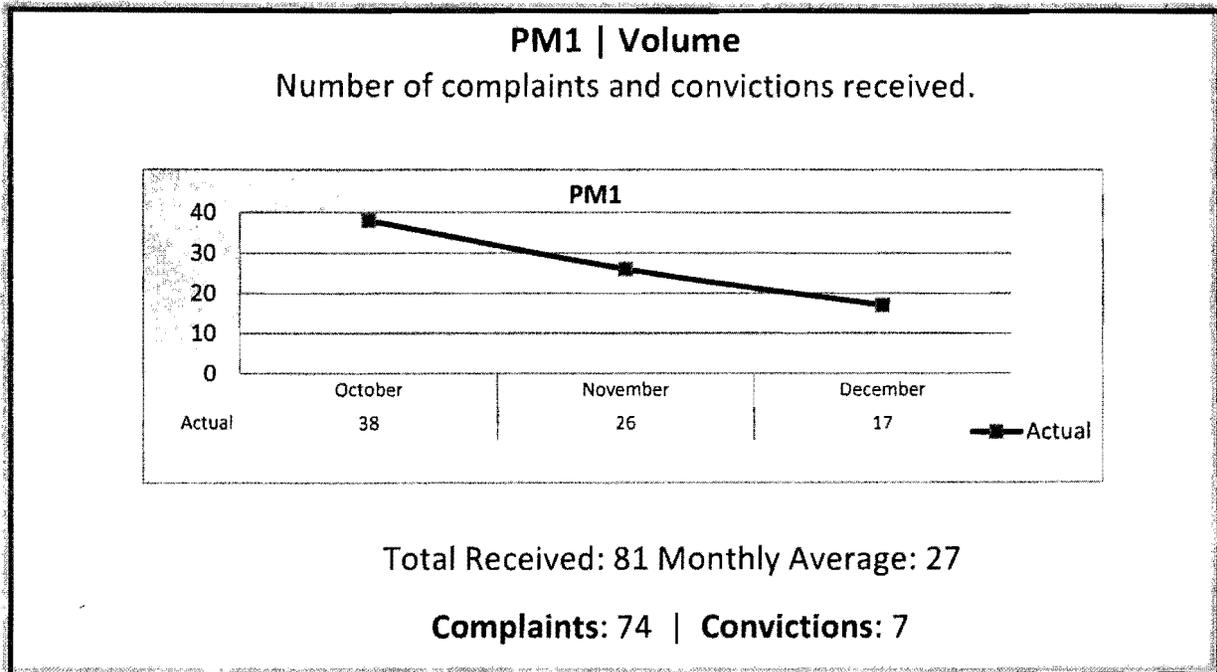
The Board did not report any new probation violations this quarter.

Target Average: 7 Days | Actual Average: N/A

Performance Measures

Q2 Report (October - December 2014)

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.



PM3 | Intake & Investigation

Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation)

Data Currently Unavailable.

Target Average: 150 Days | Actual Average: N/A

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases transmitted to the AG for formal discipline. (Includes intake, investigation, and transmittal outcome)

Data Currently Unavailable.

Target Average: 540 Days | Actual Average: N/A

PM7 | Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

The Board did not contact any new probationers this quarter.

Target Average: 14 Days | Actual Average: N/A

PM8 | Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

The Board did not report any new probation violations this quarter.

Target Average: 7 Days | Actual Average: N/A

Attachment

F



Department of Consumer Affairs
Physician Assistant Board

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Customer Service Satisfaction Survey

HOW ARE WE DOING?

The Physician Assistant Board continually strives to provide the best possible customer service. Please help us by taking a few minutes to complete our brief customer service satisfaction survey. You may complete the survey and submit it on-line or download the survey and mail it in.

1. Thinking about your most recent contact with us, how would you rate the availability of staff to assist you?

Excellent Very Good Good Fair Poor Not Applicable

2. When requesting information or documents, how would you rate the timeliness with which the information or documents was/were provided?

Excellent Very Good Good Fair Poor Not Applicable

3. When you visited our web site, how would you rate the ease of locating information?

Excellent Very Good Good Fair Poor Not Applicable

4. When you submitted an application, how would you rate the timeliness with which your application was processed?

Excellent Very Good Good Fair Poor Not Applicable

5. When you filed a complaint, how would you rate the timeliness of the complaint process?

Excellent Very Good Good Fair Poor Not Applicable

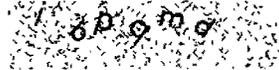
6. When you contacted us, were your service needs met? If no, please explain.

Yes No

7. Please provide us with any additional comments or suggestions.

Thank you for participating in our customer service satisfaction survey. We value your feedback!

*CAPTCHA: (Please enter the text found in the image below or specified in the audio link to validate the submission of your data.)



Listen To This

Submit

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Attachment

G

HOW SHALL THE PAC ADDRESS THE CALIFORNIA PHYSICIAN ASSISTANT WORKFORCE SHORTAGE?

HIGHLIGHTS FROM THIS REPORT

- The ARC-PA 2020 Master degree mandate policy will close 3 of 9 California PA training programs that typically admit students from under-represented backgrounds.
- The need for many more PAs and PCPs in general is already tremendous. The Affordable Care Act will overwhelm the California healthcare system which is already on the brink of breaking.
- There are ~8,000 PAs in California today. Six million newly insured in California will require ~4,000 new PAs.
- The Committee should consider a viable strategic plan that would foster opening 12 new programs by 2017 to address this need. Several options are; open six in 2014, followed by three new programs each year for the next three years. Gradually increase the median enrollment from 35 to 50 students over six years. Twelve new programs will have been added in four years for a total of 21 programs, graduating approximately 1,000 new PAs annually.

Prepared by the Physician Assistant Committee Education Subcommittee

Chair: Steven H. Stumpf, EdD

Member: Shaquawn D. Schasa

Public Volunteer: Tracy DelNero, PA-C, Tuoro College Physician Assistant Program

October 19, 2012

HISTORICAL OVERVIEW

1. The Physician Assistant Committee (PAC) was created by the Legislature in 1975. At the time, the California Legislature was concerned about the **existing shortage and geographic maldistribution of health care services in California**.
2. Mandates for the Physician Assistant Committee included (i) approving the educational and training requirements of Physician Assistants; and (ii) licensing of Physician Assistants.
3. The Committee does not administer its own examination. We utilize the Physician Assistant National Certifying Examination (NCCPA) administered by the National Commission on Certification for Physician Assistants (NCCPA). Therefore, there is no fiscal impact to the Committee.
4. The Committee has the authority to approve training programs however the Committee has elected to defer this task to the current accrediting body. At this time that body is the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). Historically, the ARC-PA ensures programs meet national accreditation standards. Committee regulations specify that if an educational program has been approved by the ARC-PA, that program shall be deemed approved by the Committee. These educational programs are not reviewed periodically by the Committee. Instead, if ARC-PA terminates accreditation, the Committee's approval of the school automatically terminates. Thus, as the regulations currently state, if the PA training program is ARC-PA approved, it is thereby approved by the Committee.
5. The PAC created a Program Accreditation Task Force (PATF) in November 5, 2009 to provide input and develop regulatory language regarding program accreditation. The PATF reviewed new ARC-PA standards which would require that all programs be offered at the master's degree level. A survey was conducted by the Committee for the four affected California PA training programs to determine how the new standards would impact the programs. The PATF concluded that three of the four programs did not have the capacity to transition to a master level due to legislative barriers. Because this issue continues to evolve at the national level, the task force determined that the Committee should continue to keep abreast of the latest development and take possible appropriate action as new developments occur.

NEW DEVELOPMENTS

6. The Accreditation Standards for Physician Assistant, 4th edition, mandates that all currently accredited programs confer graduate degrees to those students who matriculate (register; enroll) into the program after 2020. Programs accredited prior to 2013 that do not currently offer a graduate degree *must* transition to conferring a graduate degree, which *should* be awarded by the sponsoring institution, upon all PA students who matriculate into the program after 2020. The contiguity of the terms *must* and *should* is confusing; one term communicates a mandate while the other term suggests an option. The impact will be that every PA program not located in an institution that offers a master level degree will assume *must* is the operative

standard to which they are held. If the “elect-to-complete” option is being eliminated (see below) then the ARC PA should and must clarify their intentions as well as any ideas about exceptions.

The Introduction section of the *Standards, 4th edition*, argues the increased educational standards are necessary because “The PA profession has evolved over time to one requiring a high level of academic rigor.”¹ Institutions that sponsor PA programs are expected to incorporate this higher level of academic rigor into their programs and award an appropriate master’s degree.” Furthermore, the 4th edition of the ARC-PA Accreditation Standards states “Sponsoring institutions applying for provisional accreditation of a new PA program *must* be accredited by, and in good standing with, a recognized regional accrediting agency and *must* be authorized by that agency to confer upon graduates of the PA program a graduate degree.”²

The effective meaning of the section and placement of the footnote is that all programs accredited prior to 2013 (and programs post- 2013), including those that are sponsored by community/two year institutions or the military, must transition to offering a graduate degree.”³

The ARC-PA describes two options for current training programs: (1) the existing program can affiliate with a degree-granting program that will enable the PA students at the community college to complete the master degree. The current “elect to complete” option will end. (2) The other option is to move the program to a new advanced-degree-granting institution.

This policy will eliminate all two year certificate programs located in community colleges. Admissions standards will be elevated so as to exclude students who might have qualified for a certificate program. PA programs in California will be reduced from nine to six programs. Program graduates will be reduced from 314 to 194 annually (non-degree programs are underlined in the footnote below; note that UCD is in transition to becoming a Master degree program and has admitted the first such class).⁴ The majority of the diversity in the California workforce is within these three non-degree programs. The demographics of the three programs that will be eliminated fulfill the intent of the profession to serve the underserved and reinforce diversity among the workforce. The proposed policy will effectively eliminate that intention.

EMERGING PROVIDER NEEDS IN CALIFORNIA

7. Estimating the need for primary care providers is a daunting task based upon numerous assumptions. The following formulation was used in calculating estimations:

¹ An argument defending the statement about the “evolution that requires a high level of academic rigor” is not provided.

² ARC-PA *Standards*, fourth edition Page 2 September, 2012. <http://www.arc-pa.org/documents/Standards4theditionwithclarifyingchanges9.2012fnl.pdf>

³ ARC-PA *Standards* Degree Deadline Issue <http://www.arc-pa.org/documents/Degree%20issue10.2011fnl.pdf>

⁴ USC MPAP ~40; Loma Linda MPA 24; RCC cert 25; SM MPA 25; SJCC AS ~20; Stanford/FC cert ~45; UCD ~30; Western MSPA ~90; Tuoro MSPAS ~35.

- 7.1. The number of Primary Care Providers (PCPs) currently working in California that provide a certain number of clinical services (patient visits) to a certain number of patients.
 - 7.2. Divide the services by the patients and arrive at an estimate of services per patient per year (actually, there are figures for this ratio expressed as services per 1,000 patients).
 - 7.3. Divide the total services by PCPs and arrive at a ratio of visits per PCP.
 - 7.4. Estimate the total number of patients in 2014 after the Affordable Care Act (ACA) enrolls new patients into insurance products in California, including Medi-Cal.
 - 7.5. Multiply the total post-ACA enrollees (patients in 2014) by the ratio of services per patient per year to arrive at the expected number of services in 2014.
 - 7.6. Apply percentage of PAs working in primary care.
 - 7.7. Multiply the expected number of services times the ratio of visits per PCP to arrive at the required number of PCPs.
8. Common metrics for estimating workforce needs: One metric tracks number of patients that are assigned to any given provider. For example, the panel size used by teaching hospitals and the VA is 1,500 patients per physician and 1,200 per nurse practitioner.⁵ PCPs include PAs, NPs and physicians. Approximately 50% of all Nurse Practitioners 40% of all PAs⁶ (and 20% of all MDs⁷) are in primary care. In 2011 there were, in California, approximately 12,403 primary care physicians; 8,857 primary care Nurse Practitioners; and 2,689 primary care PAs in California (adjusted proportionally).⁸ The California patient population includes insured and uninsured. Projections for presently uninsured who will become insured apply.

The total insured population of CA in 2010 was 29,737,000. The current combined primary care workforce in California is approximately 55,000 physicians, PAs and NPs. However, estimating the PCP need based upon patients (the unduplicated count) or newly insured is insufficient. What we need to know is the duplicated count; that is, the number of ambulatory care visits that require coverage by the various primary care providers, including physicians, PAs and NPs.

We have used data collected under the 2010 National Ambulatory Medical Care Survey (NAMCS) to calculate a reliable estimate of visits per PCP. NAMCS is a national probability sample survey of visits to office-based physicians conducted by the National Center for Health Statistics, Centers for Disease Control and Prevention. It is a component of the National Health Care Surveys which measure health care utilization across a variety of health care providers.⁹ Here is what we found.

⁵ LADHS Primary Care Capacity Update, March 2012; <http://itup.org/blog/2012/03/15/ladhs-primary-care-capacity-update/>

⁶ Ibid

⁷ Primary Care Workforce Facts and Stats No. 2. The Number of Nurse Practitioners and Physician Assistants Practicing Primary Care in the United States. <http://www.ahrq.gov/research/pcwork2.htm>

⁸ Kaiser Family Foundation Statehealthfacts.org
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⁹ NAMCS Micro-Data File Documentation 2010
ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NAMCS/doc2010.pdf

Table 1: Visits per PCP, 2010 NAMCS

total Services	MD/PCP type	total MDs	visits/MD	per wk
213,770,403	Fam Prx	6,237	34274.56	659.13
139,843,147	Int Med	2,217	63077.65	1213.03
132,247,267	Peds	3,501	37774.14	726.43
80,076,190	Ob/Gyn	2,461	32538.07	625.73
565,937,007	all PCPs	14,416	39257.56	754.95

PCPs are separated into primary care physician specialties (e.g., family practice, internal medicine) then summed across all groups. These are national data. NAMCS does not break out data by states. The mean visits per week for a PCP physician is 754.95, or **755**. NAMCS does not collect data for NPs and PAs. Each record is for visits in a given physician practice group. The physicians are counted individually, i.e., if there are three physicians in a group then the count is 3. Services conducted by a PA or NP are “rolled into” the total.

9. How many new patients in California will result from enrollment in the Affordable Care Act in 2014? In 2010, there were 7.4 million beneficiaries, which constituted a fifth of all Californians.¹⁰ A UCLA study estimates that three million Californians ages 0-64 will become eligible for Medi-Cal coverage and three million will be eligible for the Exchange.¹¹ Sum these two figures and we can estimate there will be 13.4 million beneficiaries seeking healthcare in 2014. If we apply the Kaiser and LADHS assignment metrics we can roughly project the following PCPs are needed to meet the need.

10. What is the calculated number of expected services/visits in 2014? This figure is extrapolated from 2007 data from the National Health Care surveys and California Kaiser Family Foundation provider use data. In 2007, the number of ambulatory care visits (to physician offices, hospital outpatient and emergency departments) was 1.2 billion. The number of ambulatory care visits per 100 persons was 405.¹² The number of total physician office visits in 2007 was estimated at 1 billion. The number of visits to physician offices per 100 persons was 344. The percent of visits made to primary care physicians was 56.6%. The most frequent reason for a visit was general medical examination and the most commonly diagnosed condition was “essential hypertension.”¹³

In 2011 there were 23,608 PCP providers in California including physicians, nurse practitioners and physician assistants, and \$7.4 million insured beneficiaries in all insurance programs. In 2014 there will be 13.4 million insured. Calculating with an average of 405 visits per one hundred patients in 2007 we can forecast a 55.2% increase in the number of

¹⁰ Yoo K. The Affordable Care Act and the Residually Uninsured. Insure the Uninsured Project, 1-27-2012

¹¹ UCLA Center for Health Policy Research, Lavarreda SA and Cabezas L. “Two-Thirds of California’s Seven Million Uninsured May Obtain Coverage Under Health Care Reform,” February 2011, at <http://www.healthpolicy.ucla.edu/pubs/files/twothirdspb-2-16-2011.pdf>.

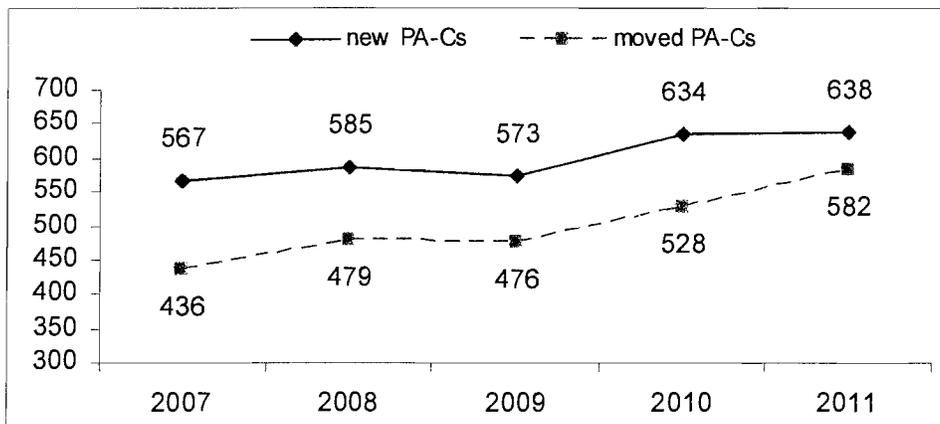
¹² Ambulatory Medical Care Utilization Estimates for 2007: tables 1, 3, http://www.cdc.gov/nchs/data/series/sr_13/sr13_169.pdf

¹³ National Ambulatory Medical Care Survey: 2009 Summary Tables, http://www.cdc.gov/nchs/data/ahcd/namcs_summary/2009_namcs_web_tables.pdf

visits for 13.4 million beneficiaries. The subsequent number of additional PCPs is estimated to be 36,645, or an increase of 13,307 new PCP providers.

The Physician Assistant Committee reported 8,372 licensees in 2011 which included 638 newly licensed PA-Cs; a 5.3% growth rate from 2010. This is offset by a “loss rate” of 8.8% which is the number of PA-Cs no longer reporting a California address. In 2011 this total was 582. The number of PA-Cs moving out of state has steadily increased since 2007. We are losing almost as many PAs as are being newly licensed in the state. In order to meet the coverage needs of the currently and newly insured, the number of California PAs must be increased by approximately 55% to meet the need for PCP PAs by 2014. This figure – which is approximately 4,000 - is obviously out of reach for 2014 and almost certainly by 2020. It should be equally obvious that reducing the numbers of PA training programs will undermine an already poor foundation for treating patients in California thereby conflicting with the PAC mission that includes “Promoting the health and safety of California health care consumers by enhancing PA competence.”

Figure 1: newly licensed PA-Cs Compared to Those Moving Out of State: 2007 through 2011



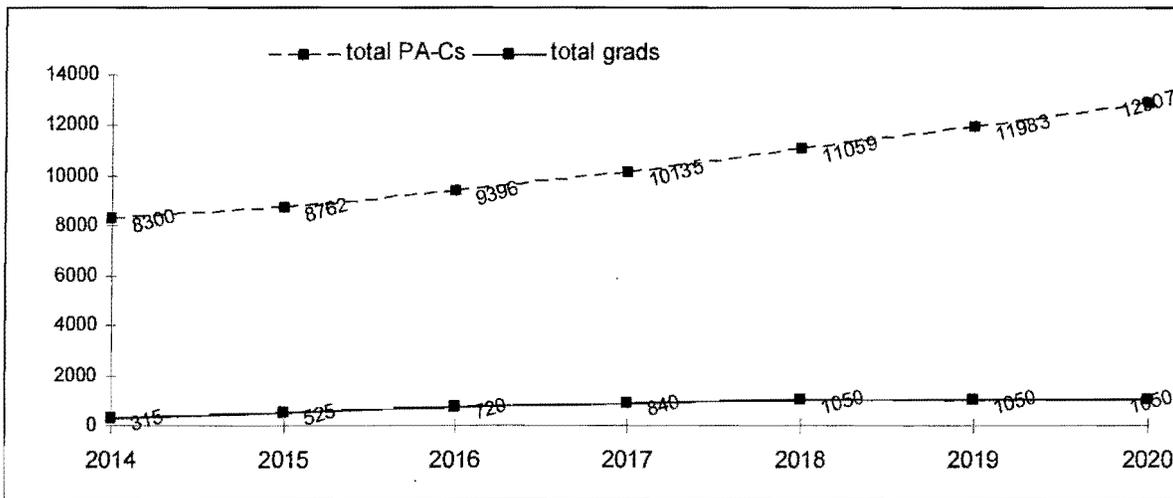
Consequences of eliminating three of nine existing PA programs: The ARC-PA proposes to eliminate three of nine programs in 2020. If the goal is to fill the PCP gap then this plan is obviously moving in the WRONG direction. Nine California programs graduate approximately 600 new PAs each year of which 40% (~250) will work in primary care. At present levels, i.e., with no program growth and a “loss rate” we estimate to be 12%, a net 160 new PAs will have been added to the PCP workforce by 2020. ARC-PA is implementing the new graduate degree requirement with no documentation of need or how it will improve patient safety or the quality of practicing PAs.

We need to add 12 new programs soon as possible. If the goal is to add another 4,000 PCP PAs by 2020, how many new programs would need to be created? If the median class size is 35, we could achieve our goal in four years by adding twelve new programs over that period with a median class size starting at 35 and escalating to 50 by 2018.¹⁴

¹⁴ Among the 9 current programs the median class size is 30; the mean is 37.

Proposals for increasing the numbers of PCPs (primary care providers) include (i) increasing the number of training programs, (ii) increasing the size of existing programs, (iii) creating fast track programs for international medical graduates, and (iv) shifting the burden of direct care for patients with chronic illness to entry-level providers such as Registered Nurses, Licensed Vocational Nurses and Medical Assistants. We are suggesting we can do a better job in helping fill the PCP gap with an additional 4,000 new PAs in four years.

Figure 2: Total PAs Increase as Total Programs Increase to 21 Over Four Years



Signals the Healthcare System Will Be Overwhelmed: Healthy Way LA (HWLA) is a Los Angeles County program that has enrolled more than 200,000 new eligible participants in Medi-Cal since 2011. The program enrolls and assigns new patients formerly not enrolled in Medi-Cal who will become eligible under the Affordable Care Act in 2013. In the first ten months the HWLA program assigned 22,000 of these new patients to “Community Partners”, i.e., clinics and practice groups, which immediately overwhelmed the CPs. Assignment of the new patients to medical homes was suspended in January 2012.¹⁵ The “success” of the Los Angeles model has resulted in implementation of the pre-enrollment approach throughout the state.

A large proportion of the newly insured persons in California will be enrolled in a medical home that is most likely to be a Federally Qualified Health Center. The Healthy Way LA (HWLA) program was implemented in mid-2011 as a strategy for Los Angeles County to get a head start enrolling uninsured patients in a medical home. Hospitals and clinics that enroll uninsured patients in HWLA will be able to convert those patients to Medi-Cal in 2014. These sites will see greatly increased revenues from new enrollments that will result in the creation of new positions for new primary care clinicians.

¹⁵ Status Report on the Healthy Way Los Angeles Enrollment and the 1115 Medicaid Waiver. Health Service LAC memo from Mitchell H. Katz, MD to LAC Board of Supervisors, January 13 2010. http://lahealthaction.org/library/cms1_173216.pdf Los Angeles County Health Services “Status Report on Healthy Way Los Angeles Enrollment.” January 13, 2012. http://file.lacounty.gov/bc/q1_2012/cms1_173216.pdf

IS TAKING ACTION TO INCREASE THE NUMBER OF PHYSICIAN ASSISTANTS WITHIN THE SCOPE OF THE PAC?

11. One can argue that it is beyond the scope of the PAC to change regulations by utilizing its authority to create a licensing exam and program accreditation process. Regulatory boards are in principle reactive and not proactive. Therefore, a strong case must be made for the importance of the PAC to react in order to protect California consumers. The PAC must, therefore, frame any action as a response to the need to fill the gap in primary care providers.

A board operating under the DCA can approve training programs. The board has the option of outsourcing the process or hiring its own staff. There is no requirement the DCA board affiliate with a DOE or other accreditation body, although the board may elect to do so.

The mission of all DCA boards is to protect consumers by disciplining licensees who have broken the law, and ensuring education/training occurs at the level of highest quality. Each board writes its own regulations to ensure these goals are met. The process for writing regulations can take at least two years given time required for drafting, soliciting public comments, review by the Office of Legislative Analysis for conflicts with existing statute, and the PAC voting on final language. In the least, regulatory language must be written to guide the process. The PAC must determine if legislation is also required. Legislation might quicken the timeline because regulations would derive directly from statute requiring PAC administration of program approval along with an in-state licensing process.

- 11.1 **How DCA boards create exams:** DCA boards contract with the Office of Professional Educational Services (OPES) or other identified agencies which is a unit under the DCA. The OPES will either do the work themselves to construct an exam or suggest sources for contracting out the work. There is no requirement that any board use the DCA OPES, however, it is probably the preferred route. Costs are involved for developing, administering and scoring a licensing exam. An estimate of exam construction costs is essential prior to undertaking the task.
- 11.2 **How DCA boards administer exams:** The board may also contract with OPES to conduct and score the exam. Releasing scores to examinees should originate with the licensing board. Test-taking formats include manual completion, local computer station, or online. All scoring formats are machine operated.
- 11.3 **Costs for administering a licensing exam:** The cost of developing a new licensing exam can be broken out by the two principal functions: (1) creation and maintenance of the item bank, and (2) administering and scoring the exam. Costs vary depending on the modality for administration; e.g., hand completed and scored, local computer station, or online. The current PANCE exam must be taken when the program graduate seeks initial licensure. Licensing must be renewed at regular intervals. The cost for the PANCE is \$475 for the initial license and \$350 for subsequent renewals.
- 11.3 **Constraints of accrediting training programs and administering a licensing exam:** The goal for the PA Committee undertaking the two tasks of approving schools along with creating and administering a licensing exam is to create an expanded PA workforce for California consumers. The undertaking is complicated however it is hardly impossible. There are plenty of precedents of other DCA boards undertaking this

process. However, there will be one very significant constraint. PAs licensed in California will need to graduate from an ARC-PA school in order to become certified by PANCE if they wish to practice outside CA. This could reduce the number of PAs willing to enroll in a PAC approved PA program. Of course, this disadvantage might be offset by (1) a rapid increase in the number of PA programs in California (the nine current programs could double within a few years); (2) the availability of lower cost PA programs located in community colleges that offer a certificate slated for extinction by the ARC-PA; and (3) the availability of new clinical positions in a state where the numbers of newly enrolled Medi-Cal is expected to triple. Other constraints include locating new clinical training sites for students of 12 new PA programs.

- 11.4 **Recent PAC regulatory activity:** The PAC recently approved regulatory language that requires licensed PAs to earn a minimum of 50 category 1 CMEs every two years in order to maintain certification. These hours must be logged (\$80 fee) and recorded with the NCCPA. This component of quality assurance/consumer protection has already been addressed and managed by the PAC.

12. Next steps??

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Yoo K. The Affordable Care Act and the Residually Uninsured. Insure the Uninsured Project, 1-27-2012

Attachment

H

Report on Alternative Accreditation

Background

Two physician assistant (PA) training programs in California are scheduled to close due to accreditation action taken by Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). This is a major of concern of the California Physician Assistant Board because of our mission to protect the public by ensuring they receive safe and appropriate health care from well qualified licensed PAs, which includes supporting access to health care for those in our state. If there is a shortage of PAs because of the closure of California programs there may be an exacerbation of a lack of access to quality affordable health care provided by PAs. Additionally the Board has regulatory authority over PA training programs in the state.

The Board has addressed this concern by sending a letter to the ARC-PA, to which they did not initially respond. However, after a second letter ARC-PA responded to the board saying that they do not answer to any state boards. This Board currently accepts ARC-PA accreditation as the required accreditation pathway for PA training programs in California; however it may approve alternate pathways per existing regulations (16 CCR 1399.530). A sub-committee on education was formed at the last Board meeting to look into alternative accreditation of PA training programs in California.

History and Interrelationship of National Physician Assistant Organizations

The Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) has its origins in the American Medical Association in 1971 and has been accrediting PA programs since 1972. It has progressed from subcommittees of the American Medical Association (AMA), such as the Committee on Allied Education and Accreditation (CAHEA), which became Commission on Accreditation of Allied Health Education Programs (CAAHEP), ultimately becoming an independent organization in 2001. ARC-PA has always been closely affiliated with the American Academy of Physician Assistants (AAPA), which is the national professional organization for physician assistants and was founded in 1968. The California Academy of Physician Assistants (CAPA) is a constituent organization (state chapter) of the AAPA. It is the professional organization for Physician Assistants in California.

In 2004 ARC-PA was recognized by the Council for Higher Education Accreditation (CHEA) which is currently the accrediting organization for the ARC-PA. The American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians, the American College of Surgeons, the American Medical Association (AMA), and the Physician Assistant Education Association (PAEA) all cooperate with the ARC-PA as collaborating organizations to establish, maintain, and promote appropriate standards of quality for entry level education of physician assistants (PAs) and to provide recognition for educational programs that meet the minimum requirements outlined in these Standards. ARC-PA Commissioners are elected by the ARC-PA from a slate of nominees submitted by the ARC-PA collaborating organizations. Starting in January 2020, ARC-PA will require an entry level master's degree for new physician assistants.

The National Commission on Certification of Physician Assistants (NCCPA) is the national certifying body for physician assistants (PA) and was established by the AMA and the National Board of Medical Examiners in 1974. The NCCPA administers the Physician Assistant National Certifying Examination (PANCE), which is the summative evaluation used to measure basic competency of a physician assistant,

and is accepted by annual vote of the board as the certifying examination for licensure for this state. Graduation from an ARC-PA accredited training program is required to be eligible to sit for the PANCE. NCCPA certification, denoted by the use of the abbreviation "PA-C", is required for credentialing at hospitals and by Medicare/Medicaid as well as most insurance companies for billing purposes. Annual Continuing Medical Education (CME) requirements as well as the Physician Assistant National Recertifying Examination (PANRE) are required to maintain NCCPA certification. The board currently accepts valid national certification as evidence of compliance with the CME requirements for licensure in California.

The Physician Assistant Education Association (PAEA) is the professional organization of Physician Assistant's educational faculty and was founded in 1972. All accredited PA programs are members of the PAEA, which provides services to faculty, students, applicants and other stakeholders. In November 2009, PAEA adopted two position policies that: 1) PAEA endorses the master's degree as the entry-level and terminal degree of the profession; and 2) PAEA opposes the entry-level doctorate for physician assistants.

Issues with the ARC-PA

Workforce: The ARC-PA's decision to withdraw the accreditation of two programs in California has raised concern for workforce supply. Currently the process for a PA program to become ARC-PA accredited takes approximately 2-3 years. There are currently 10 PA programs in California, four in the bay area or northern part of the state, one in the central valley, and 5 in the southern half of the state. One program in the San Bernardino/Riverside area and one in the central valley are closing within approximately 18 months. There are 12 programs in the planning stages of accreditation and six of those have been approved by the ARC-PA to enter the accreditation process. Of those six approved programs four are in southern California and two are in northern California. Of the programs currently approved to enter the accreditation pathway or accredited, three are in the San Bernardino/Riverside area and one is in northern part of the central valley. Additionally, two programs in California have formed a collaborative to recruit, train, and return providers to the central valley. Given the numbers of programs in the process of becoming accredited in California it is likely that ARC-PA accredited programs will be able to fill the training needs for PAs in California.

Standards, degree, and transparency: As mentioned above ARC-PA Standards will now require a Master's degree as the entry level degree for the profession by 2020. This requirement was supported by most stakeholders, though it remains a controversial issue in the profession. The PA profession has always been competency based and there are currently three Certificate, two Associates, and six Baccalaureate PA programs in the US which graduates students that pass the PANCE, and practice to the same standard as the graduates of the other 185 programs that offer a Master's degree. This issue has implication for California because two Associates and one of the Certificate programs are in this State. Both of the Associate degree programs have affiliation agreements with another institution to offer a Master's degree pathway for qualified students. Both of the Associate degree programs in California have had accreditation withdrawn and are teaching out the remaining students enrolled. The requirement for the Master's degree significantly changes the applicant pool for PA training in the state, potentially creating a significant barrier for those who do not have a Baccalaureate degree upon entering PA training. Because the ARC-PA gives the word *should* nearly the same requirements as the word *must* in their standards, a sponsoring institution needs to offer the Master's degree which creates a significant problem for the State's Associate degree programs, which have sponsoring institutions that are not credentialed to offer the graduate degree. Furthermore, this situation may create the

perception that the ARC-PA is using selective enforcement of the standards to push non-graduate degree programs to closure. Additionally, due to the varied methods and approaches for training PAs, some of the ARC-PA standards are somewhat vague so as to allow programs the flexibility to train PAs in a way that is most effective for that particular program. For example, in California many of our PA programs have an extensive network of outpatient clinics used for clinical training rather than being mostly hospital based as may be more common in some programs in the eastern states. Finally, the subjective aspect of accreditation and vagueness of some standards, combined with the inability to disclose publicly the nature of the citations or accreditation issues due to privacy concerns of the program and sponsoring institution, appear to be a lack of transparency and may be perceived as something other than objective evaluation and enforcement of the standards. The ARC-PA has been clear in stating that it does not have an agenda other than enforcement of compliance with the standards. As stated in *Notes to Programs Spring 2015*, "Demonstration by an applicant or accredited program of their compliance with the accreditation standards for physician assistant education is the determinant in the accreditation decision-making process of the ARC-PA."

Perceptions and Positions: This subcommittee informally surveyed ten program directors and various stakeholders both within and outside of California regarding their perceptions of the ARC-PA, and discussed trends to see if the perceived issues in California are common nationally. This data was not subjected to formal statistical analysis but does yield some useful information. Here is what the surveyed found:

- 80% of program directors feel the ARC-PA is fair in enforcement of standards, however 30% perceived some bias, possibly due to inter-rater variability (site visitors are peers).
- 80% of program directors perceive that the ARC-PA has an agenda or ulterior motive underlying the enforcement of the standards, however there was no clear consensus on the specific agenda. Most common perception was that the ARC-PA is trying to close non-graduate degree programs.
- 100% of program directors feared retribution, mostly enhanced scrutiny, if speaking out about the ARC-PA. All were careful to ensure they would not be identified as a respondent to the survey.
- 60% of program directors would support an alternative accreditation pathway nationally; however 100% expressed significant concerns about possible unintended consequences and issues related especially to state only accreditation.
- 80% of program directors felt the ARC-PA standards are fair, though 40% expressed some concern about being too broad or too specific in certain areas, or possibly biased in favor of programs associated with a medical school.
- 90% of program directors felt the ARC-PA is not responsive to the concerns of programs, but most agreed there is a pathway through the PAEA to address concerns. Several commented on communications with ARC-PA: "unpleasant"" rude" "unprofessional""unnecessarily harsh".

CAPA has no official position on state accreditation, however did express some concerns about it. The Physician Assistant Education Association (PAEA) has noted a trend of the ARC-PA stacking citations on programs. For example, the program would be cited for faulty data collection, then would be cited on every standard related to data collection, analysis, application, and program self analysis such that the

citations become circular. They have no position on state accreditation or alternative accreditation pathways. There is a PAEA task force on accreditation issues.

Again, ARC-PA responded to our letter by saying they do not answer to state boards. The Chair of the Committee was careful to explain that she was not speaking for the ARC-PA but that her personal perception is that there may be more of a problem with presentation than content. She was invited to attend the meeting today.

The subcommittee recognizes and appreciates the letter from the chair of the assembly committee on higher education, Mr. Jose Medina. Mr. Medina is concerned about effects of the closure of the Moreno Valley College (MVC) PA Program and expressed concerns about the policy and procedure followed by the ARC-PA related to the decision to withdraw accreditation. He has requested a review of the ARC-PAs accreditation action. Unfortunately, the subcommittee does not have access to all of the relevant documents and is not in a position to verify or validate the conclusions reached by the ARC-PA in regards to the decision to withdraw accreditation for the MVC program. The ARC-PA is accredited by the Council for Higher Education (CHEA), which is in a position to verify that the ARC-PA followed its own policies, as well as the CHEA accreditation standards.

Possible problems associated with State Accreditation of PA programs

Cost: Standards would have to be written and approved. A mechanism for enforcement would have to be put into place. Staff would need to be hired to verify compliance. The various details for all of this would have to be worked out, regulations passed, and a budget approved. This lengthy process would not put more PAs into the workforce for several years.

Certification: Currently a graduate of a California approved PA training program would not be eligible to take the PANCE. The state would have to develop and administer a certifying examination. The PA could not be credentialed at most hospitals, and would not be eligible to bill Medicare/Medicaid. Additionally the PA could not practice outside the state and could not work for the federal government or bill if working in a federally qualified rural health clinic.

Patient confusion: This would in effect create a two tiered system where a California program PA graduate may be seen alongside an ARC-PA approved graduate, but could not be seen by one or the other due to billing or other concerns. Because of this patients could be confused or perceive bias, thinking they are not getting an equal level of care.

Likely opposition: Many in the profession are opposed to state accreditation and would likely fight to stop it. This may result in a negative reflection on PAs in California, and may cause regulatory problems as the state legislature and consumer may have difficulty understanding the nuanced differences between state and nationally certified PAs. This may lead to the consumer opting not to see a PA, passage of laws to restrict PA practice, or a supervising physician opting not to hire one, all of which would reduce access to quality health care PAs are currently delivering in California.

Possible board actions

The following are possible board actions that the subcommittee recommends.

- Direct staff to draft a letter to CHEA expressing concern about ARC-PAs actions in California and ask them to investigate further.

- Direct staff to contact PAEA and give input to, or possibly participate in the task force on accreditation.
- Direct staff to contact ARC-PA and ask for a timeline on California PA programs accreditation which will assist us in health care workforce planning.
- Direct staff to contact NCCPA to see if they will consider California accredited PA program graduates eligible to take the PANCE.

The subcommittee recognizes the following action may be needed in the future, but recommends no action be taken at this point:

- Direct staff to identify partners in the legislature and identify what regulatory changes are needed to move ahead on state accreditation.

Public Comment

Attachment

|

Physician Assistants (PA) practice medicine under the supervision of physicians. They are formally trained to provide diagnostic, therapeutic, and preventive healthcare services. Specific duties of PAs are determined by their supervising physicians and by State law. Working as members of a healthcare team, they take medical histories, examine and treat patients, order and interpret laboratory tests and X-rays, and make diagnoses. They also treat minor injuries by suturing, splinting, and casting. The PAs record patients' progress, instruct and counsel patients, and order or carry out therapy. They may administer immunizations and injections, perform minor surgery, and assist in surgery. If they meet the legal requirements, PAs may prescribe some medications.

Wages and Benefits

The median wage for PAs in California is \$102,537 annually, or \$49.29 hourly. *The median is the point at which half of the workers earn more and half earn less.

Annual Wages for 2014	Low (25 th Percentile)	Median* (50 th Percentile)	High (75 th Percentile)
California	\$83,386	\$102,537	\$119,362

Source: EDD/LMID Occupational Employment Statistics Survey, 2014.

Annual Job Openings

In California, an average of 280 new job openings per year is expected for PAs, plus an additional 150 job openings due to net replacement needs, resulting in a total of 430 job openings.

Estimated Average Annual Job Openings Physician Assistants			
Geographic Area (Estimated Year-Projected Growth)	Jobs From Growth	Jobs Due to Net Replacements	Total Annual Job Openings
California (2012-2022)	280	150	430

Source: EDD/LMID Projections of Employment by Occupation

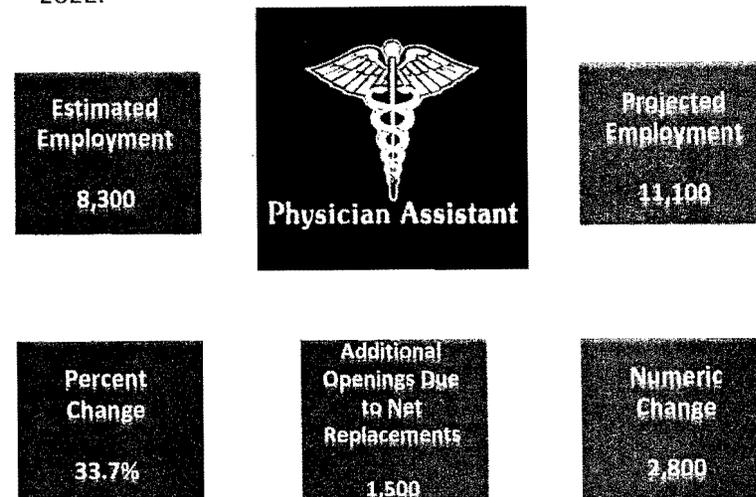
Industries Employing PAs

Industry Title	Percent of Total Employment for Occupation in California
Offices of Physicians	51.7%
Employment Services	13.0%
Outpatient Care Centers	11.1%
General Medical and Surgical Hospitals	10.8%
Federal Government	1.5%

Source: EDD/LMID Staffing Patterns, 2014

Projections of Employment

Occupational Employment Projections estimate the changes in occupational employment over time resulting from industry growth, technological changes, and other factors. In California, the number of PAs is expected to grow much faster than the average growth rate for all occupations. Jobs for PAs are expected to increase by 33.7%, or 2,800 jobs between 2012 and 2022.



Source: EDD/LMID Projections of Employment by Occupation

Source: Employment Development Department, Labor Market Information Division (EDD/LMID), 2014.

Note: The "Physician Assistants in California" report was based on a survey and used 2010-2020 and 2012 data from EDD/LMID, so data reported may vary in this Fact Sheet due to different reporting periods.



Fact Sheet

Occupational Employment Projections 2012-2022¹

2014

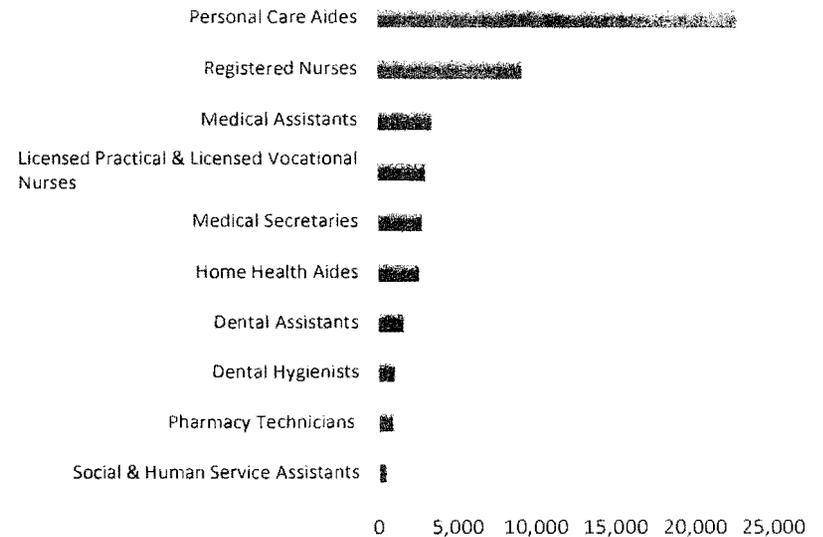
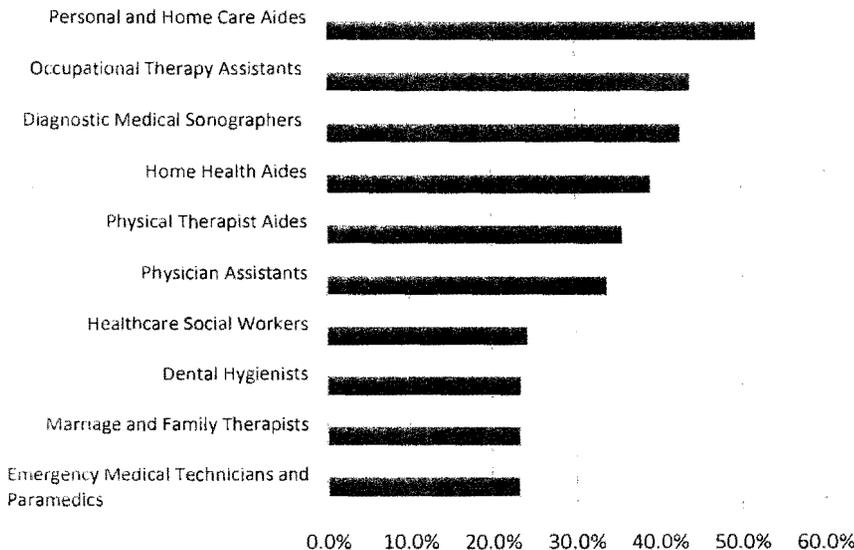
The following information is based on the State of California Employment Development's Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections.

Top Ten Fastest Growing Health Occupations

Health Occupation Title	Percent Change	Employment 2012	Employment 2022	Top Industries Employing this Occupation
Personal and Home Care Aides	51.8%	386,900	587,200	Private Households
Occupational Therapy Assistants	43.8%	1,600	2,300	Offices of Other Health Practitioners
Diagnostic Medical Sonographers	42.6%	4,700	6,700	Office of Physicians
Home Health Aides	39%	44,900	62,400	Community Care Facility for the Elderly
Physical Therapist Aides	35.6%	4,500	6,100	Offices of Other Health Practitioners
Physician Assistants	33.7%	8,300	11,100	Offices of Physicians
Healthcare Social Workers	24.2%	13,200	16,400	General Medical & Surgical Hospitals
Dental Hygienists	23.4%	21,800	26,900	Offices of Dentists
Marriage and Family Therapists	23.3%	6,000	7,400	Individual and Family Services
Emergency Medical Technicians and Paramedics	23.2%	16,800	20,700	Other Ambulatory Health Care Services

Top Ten Health Occupations with the Most Job Openings

Health Occupation Title	Total Annual Job Openings	Top Industries Employing this Occupation
Personal Care Aides	22,800	Private Households
Registered Nurses	9,230	General Medical & Surgical Hospitals
Medical Assistants	3,450	Office of Physicians
Licensed Practical & Licensed Vocational Nurses	3,040	Nursing Care Facilities
Medical Secretaries	2,810	Office of Physicians
Home Health Aides	2,610	Community Care Facility for the Elderly
Dental Assistants	1,640	Office of Dentists
Dental Hygienists	1,060	Office of Dentists
Pharmacy Technicians	900	Health & Personal Care Stores
Social & Human Service Assistants	483	Individual and Family Services



¹Source of Data: Employment Development Department, Labor Market Information Division Public Master File, June 2014.



Fact Sheet



California Occupational Employment Projections: Life, Physical and Social Science Occupations¹

2012-2022

The following table shows health occupations with the "Average Annual Job Opening" in California based on the Occupational Employment Statistics (OES) data survey responses from employers and expected industry growth. The projections are estimates of jobs created from economic growth, and jobs created when workers retire or permanently leave an occupation and need to be replaced. The 2014 first quarter wages are the most recent wage estimates available for the 2012-2022 projections. "N/A" in a field means that the data are not available.

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Biological Scientists, All Other	9,000	10,100	120	260	380	\$37.42	\$77,831
Biological Technicians	11,100	13,000	180	330	520	\$21.71	\$45,163
Clinical, Counseling, and School Psychologists	24,900	27,300	230	680	910	\$39.57	\$82,313
Environmental Scientists and Specialists, Including Health	14,900	19,300	440	440	880	\$38.81	\$80,715
Medical Scientists, Except Epidemiologists	28,000	33,000	510	590	1,100	\$45.49	\$94,616
Microbiologists	4,500	5,400	80	130	210	\$42.43	\$88,262
Psychologists, All Other	1,300	1,400	10	40	50	\$48.65	\$101,202
Social Scientists and Related Workers	45,400	53,700	820	1,280	2,100	N/A	N/A

¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.

Note: Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.

There may be more current information on the EDD-LMID website: http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.



Fact Sheet

OSHPD
Office of Statewide Health Planning and Development

California Occupational Employment Projections: Community and Social Service Occupations¹

2012-2022

The following table shows health occupations with the “Average Annual Job Opening” in California based on the Occupational Employment Statistics (OES) data survey responses from employers and expected industry growth. The projections are estimates of jobs created from economic growth, and jobs created when workers retire or permanently leave an occupation and need to be replaced. The 2014 first quarter wages are the most recent wage estimates available for the 2012-2022 projections. “N/A” in a field means that the data are not available.

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages (3)	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Child, Family, and School Social Workers	28,600	32,300	370	610	980	\$22.78	\$47,389
Counselors, All Other	4,500	5,200	70	100	170	\$21.09	\$43,868
Health Educators	7,100	8,400	140	180	320	\$24.84	\$51,658
Healthcare Social Workers	13,200	16,400	320	280	600	\$31.46	\$65,448
Marriage and Family Therapists	6,000	7,400	140	130	270	\$24.66	\$51,294
Mental Health Counselors	10,600	12,000	140	230	370	\$19.88	\$41,339
Mental Health and Substance Abuse Social Workers	11,200	12,500	140	240	370	\$22.45	\$46,701
Rehabilitation Counselors	13,900	16,400	250	300	550	\$14.35	\$29,835
Substance Abuse and Behavioral Disorder Counselors	9,600	11,400	180	210	380	\$17.34	\$36,068
Social Workers, All Other	14,000	15,100	110	300	400	\$30.62	\$63,698
Social and Human Service Assistants	39,900	46,800	690	1,040	1,730	\$16.02	\$33,316

¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.
 Note: 1. Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.
 There may be more current information on the EDD-LMID website: http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.



HEALTHCARE WORKFORCE CLEARINGHOUSE

Fact Sheet



California Occupational Employment Projections: Education, Training, Library and Production Occupations¹ 2012-2022

The following table shows health occupations with the "Average Annual Job Opening" in California based on the Occupational Employment Statistics (OES) data survey responses from employers and expected industry growth. The projections are estimates of jobs created from economic growth, and jobs created when workers retire or permanently leave an occupation and need to be replaced. The 2014 first quarter wages are the most recent wage estimates available for the 2012-2022 projections. "N/A" in a field means that the data are not available.

Education, Training, and Library Occupations

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Health Specialties Teachers, Postsecondary	11,900	16,300	450	180	620	[6]*	\$80,573
Nursing Instructors and Teachers, Postsecondary	3,900	5,300	140	60	200	[6]*	\$86,137
Psychology Teachers, Postsecondary	5,400	6,300	80	80	160	[6]*	\$73,228

Production Occupations

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Medical Appliance Technicians	1,200	1,300	20	40	60	\$18.76	\$39,022
Ophthalmic Laboratory Technicians	2,200	2,400	20	80	100	\$15.65	\$32,567

¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.
Note: Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.
There may be more current information on the EDD-LMID website: http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.



HEALTHCARE WORKFORCE
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Fact Sheet

OSHPD
Office of Statewide Health Planning and Development

California Occupational Employment Projections: Healthcare Practitioners and Technical Occupations ¹ 2012-2022

The following table shows health occupations with the "Average Annual Job Opening" in California based on the Occupational Employment Statistics (OES) data survey responses from employers and expected industry growth. The projections are estimates of jobs created from economic growth, and jobs created when workers retire or permanently leave an occupation and need to be replaced. The 2014 first quarter wages are the most recent wage estimates available for the 2012-2022 projections. "N/A" in a field means that the data are not available.

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Anesthesiologists	3,400	4,000	60	90	140	N/A	N/A
Athletic Trainers	1,200	1,400	20	30	50	N/A	\$49,959
Audiologists	1,000	1,300	30	20	50	\$40.70	\$84,650
Cardiovascular Technologists and Technicians	3,400	4,300	90	50	140	\$30.26	\$62,949
Chiropractors	3,200	3,300	10	60	80	\$32.25	\$67,077
Dental Hygienists	21,800	26,900	510	560	1,060	\$48.23	\$100,312
Dentists, General	14,400	15,600	110	350	470	\$65.60	\$136,450
Diagnostic Medical Sonographers	4,700	6,700	200	70	260	\$41.83	\$87,018
Dietetic Technicians	3,400	4,200	80	30	120	\$14.33	\$29,805
Dietitians and Nutritionists	7,800	9,300	150	90	240	\$34.74	\$72,257
Emergency Medical Technicians and Paramedics	16,800	20,700	390	460	850	\$14.40	\$29,947
Family and General Practitioners	17,400	19,500	210	440	640	\$90.00	>187,200

¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.

Note: 1. Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.

There may be more current information on the EDD-LMID website: http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.



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Fact Sheet

OSHPD

Office of Statewide Health Planning and Development



California Occupational Employment Projections: Healthcare Practitioners and Technical Occupations¹ 2012-2022

The following table shows health occupations with the “Average Annual Job Opening” in California based on the Occupational Employment Statistics (OES) data survey responses from employers and expected industry growth. The projections are estimates of jobs created from economic growth, and jobs created when workers retire or permanently leave an occupation and need to be replaced. The 2014 first quarter wages are the most recent wage estimates available for the 2012-2022 projections. “N/A” in a field means that the data are not available.

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Health Diagnosing and Treating Practitioners, All Other	7,300	8,300	110	150	260	\$33.35	\$69,363
Health Technologists and Technicians, All Other	15,000	18,900	390	150	540	\$20.85	\$43,382
Healthcare Practitioners and Technical Workers, All Other	6,100	7,000	90	170	260	\$26.75	\$55,634
Internists, General	6,400	6,900	50	160	210	N/A	N/A
Licensed Practical and Licensed Vocational Nurses	60,700	76,300	1,560	1,480	3,040	\$25.11	\$52,225
Medical and Clinical Laboratory Technicians	16,000	20,500	450	420	870	\$20.48	\$42,593
Medical Records and Health Information Technicians	16,500	19,900	340	440	780	\$19.61	\$40,782
Nuclear Medicine Technologists	1,500	1,700	30	20	50	\$45.89	\$95,445

¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.

Note: 1. Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.

There may be more current information on the EDD-LMID website: http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.

California Occupational Employment Projections: Healthcare Practitioners and Technical Occupations¹ 2012-2022

The following table shows health occupations with the "Average Annual Job Opening" in California based on the Occupational Employment Statistics (OES) data survey responses from employers and expected industry growth. The projections are estimates of jobs created from economic growth, and jobs created when workers retire or permanently leave an occupation and need to be replaced. The 2014 first quarter wages are the most recent wage estimates available for the 2012-2022 projections. "N/A" in a field means that the data are not available.

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages (3)	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Obstetricians and Gynecologists	2,700	2,900	20	70	90	N/A	N/A
Occupational Health and Safety Specialists	7,200	8,900	170	200	360	\$37.20	\$77,386
Ophthalmic Laboratory Technicians	2,200	2,400	20	80	100	\$15.65	\$32,567
Optometrists	4,700	5,400	70	140	210	\$49.01	\$101,940
Opticians, Dispensing	7,500	8,800	130	210	350	\$18.04	\$37,514
Pharmacists	26,900	31,000	410	640	1,050	\$65.42	\$136,066
Pediatricians, General	5,400	5,900	50	140	190	\$75.03	\$156,067
Psychiatrists	5,200	5,800	60	130	190	N/A	N/A
Physicians and Surgeons, All Other	27,900	31,500	350	700	1,050	N/A	N/A
Physician Assistants	8,300	11,100	280	150	430	\$49.29	\$102,537
Physical Therapists	16,400	21,100	470	400	870	\$43.83	\$91,156
Pharmacy Technicians	31,400	37,200	590	310	900	\$18.48	\$38,445
Psychiatric Technicians	8,400	8,500	10	80	100	\$26.74	\$55,624

¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.

Note: 1. Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.

There may be more current information on the EDD-LMID website: http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.



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OSHDPD

Office of California Health Planning and Development

California Occupational Employment Projections: Healthcare Practitioners and Technical Occupations¹ 2012-2022

The following table shows health occupations with the “Average Annual Job Opening” in California based on the Occupational Employment Statistics (OES) data survey responses from employers and expected industry growth. The projections are estimates of jobs created from economic growth, and jobs created when workers retire or permanently leave an occupation and need to be replaced. The 2014 first quarter wages are the most recent wage estimates available for the 2012-2022 projections. “N/A” in a field means that the data are not available.

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Radiation Therapists	1,100	1,300	20	20	40	\$47.15	\$98,066
Recreational Therapists	1,400	1,600	20	30	50	\$32.40	\$67,390
Respiratory Therapists	14,100	16,600	250	200	450	\$36.66	\$76,253
Registered Nurses	254,500	297,400	4,300	4,930	9,230	\$45.87	\$95,415
Radiologic Technologists	15,000	17,600	260	210	470	\$34.35	\$71,437
Surgeons	5,800	6,700	90	150	230	N/A	N/A
Speech-Language Pathologists	11,200	12,800	160	170	330	\$40.65	\$84,549
Surgical Technologists	9,400	11,800	240	90	330	\$27.41	\$57,000
Therapists, All Other	3,800	5,000	120	50	160	\$26.47	\$55,037

¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.

Note: 1. Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.

There may be more current information on the EDD-LMID website: http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.



HEALTHCARE WORKFORCE
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Fact Sheet

OSHDP

Office of Statewide Health
Planning and Development

California Occupational Employment Projections: Healthcare Support Occupations¹

2012-2022

The following table shows health occupations with the "Average Annual Job Opening" in California based on the Occupational Employment Statistics (OES) data survey responses from employers and expected industry growth. The projections are estimates of jobs created from economic growth, and jobs created when workers retire or permanently leave an occupation and need to be replaced. The 2014 first quarter wages are the most recent wage estimates available for the 2012-2022 projections. "N/A" in a field means that the data are not available.

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Dental Assistants	45,200	52,200	700	940	1,640	\$17.71	\$36,850
Healthcare Support Workers, All Other	12,400	14,100	170	240	400	\$19.14	\$39,802
Home Health Aides	44,900	62,400	1,760	850	2,610	\$11.18	\$23,267
Massage Therapists	17,200	20,300	310	180	500	\$17.09	\$35,540
Medical Assistants	81,600	100,500	1,890	1,560	3,450	\$15.83	\$32,940
Medical Equipment Preparers	6,600	8,000	130	130	260	\$20.30	\$42,231
Medical Transcriptionists	4,600	4,800	20	90	100	\$22.29	\$46,362
Occupational Therapy Assistants	1,600	2,300	60	40	100	\$32.92	\$68,470
Psychiatric Aides	2,500	2,700	20	50	70	\$13.51	\$28,103
Physical Therapist Assistants	4,500	6,100	150	100	250	\$30.83	\$64,137
Physical Therapist Aides	5,900	7,900	200	130	330	\$13.06	\$27,166
Pharmacy Aides	9,000	10,000	100	170	270	\$11.79	\$24,516
Orderlies	5,000	5,700	70	100	170	\$16.36	\$34,039

¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.

Note: 1. Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.

There may be more current information on the EDD-LMID website: http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.



HEALTHCARE WORKFORCE
CLEARINGHOUSE

Fact Sheet

OSHPD

Office of Strategic Health
Planning and Development

California Occupational Employment Projections: Personal Care, Service, Office, Administrative Support¹

2012-2022

The following table shows health occupations with the "Average Annual Job Opening" in California based on the Occupational Employment Statistics (OES) data survey responses from employers and expected industry growth. The projections are estimates of jobs created from economic growth, and jobs created when workers retire or permanently leave an occupation and need to be replaced. The 2014 first quarter wages are the most recent wage estimates available for the 2012-2022 projections. "N/A" in a field means that the data are not available.

Personal Care and Service Occupations

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Fitness Trainers and Aerobics Instructors	28,500	31,500	300	340	640	\$22.93	\$47,702
Personal Care Aides	386,900	587,200	20,030	2,770	22,800	\$10.33	\$21,473
Personal Care and Service Workers, All Other	4,800	5,400	60	130	200	\$11.29	\$23,478

Office and Administrative Occupations

Occupational Title	Estimated Employment 2012**	Projected Employment 2022	Average Annual Job Openings			2014 First Quarter Wages [5]	
			New Jobs [2]	Replacement Needs [3]	Total Jobs [4]	Median Hourly	Median Annual
Medical Secretaries	68,500	88,400	1,990	830	2,810	\$17.77	\$36,949

¹Source of Data: Employment Development Department-Labor Market Information Division Statewide 2012-2022 Occupational Employment Projections, September, 2014.

Note: 1. Occupational titles are based on the Standard Occupational Classification (SOC) system used by United States Department of Labor, Bureau of Labor Statistics.

There may be more current information on the EDD-LMID website: http://www.labormarketinfo.edd.ca.gov/LMID/Projections_of_Employment_by_Industry_and_Occupation.html.



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**Data sources: U.S. Bureau of Labor Statistics' Current Employment Statistics (CES) March 2013 benchmark, Quarterly Census of Employment and Wages (QCEW) industry employment, and Occupational Employment Statistics (OES) data.

- Occupational employment projections include self-employed, unpaid family workers, private household workers, farm, and nonfarm employment.
- N/A - Information is not available.
- Occupations with employment below 1,000 in 2012 are excluded.
- The use of occupational employment projections as a time series is not encouraged due to changes in the occupational, industrial, and geographical classification systems; changes in the way data are collected; and changes in the OES survey reference period.

[2] New jobs are only openings due to growth and do not include job declines. If an occupation's employment change is negative, there is no job growth and new jobs are set to zero. New jobs may not equal numerical change.

[3] Replacement needs estimate the number of job openings created when workers retire or permanently leave an occupation and need to be replaced.

[4] Total jobs are the sum of new jobs and replacement needs.

[5] Median hourly and annual wages are the estimate 50th percentile of the distribution of wages; 50 percent of workers in an occupation earn wages below, and 50 percent earn wages above the median wage. The wages are from 2014 first quarter and do not include self-employed or unpaid family workers.

[6] In occupations where workers do not work full-time all year-round, it is not possible to calculate an hourly wage.

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