CAPA
CALIFORNIA ACADEMY OF PAs
California Academy of PAs
Established 1976
July-Sept 2022

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Empowering Healthcare

JULY-SEPT 2022

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CAPA
CALIFORNIA ACADEMY OF PAs
Empowering Healthcare

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President's Message

Happy Summer CAPA Family!

It was just a little over a month ago that California leaders attended AAPA's House of Delegates 2022 in Indianapolis, Indiana. This was the first congregation of leaders from all over the nation after we faced and continue to face a post-pandemic world. To have the opportunity to sit on the floor and discuss AAPA legislation and policy in person was truly magical. It was a great experience to listen to various leaders share their thoughts on important topics such as OTP, title change, and PA utilization, to name a few. The myriad of opinions is not only thought-provoking, but also grounding when we face similar challenges in our home states. It is definitely reassuring to see that we have a team of leaders all over the nation that we can reach out to as and when needed.

> *"The tag of this year's AAPA conference is #PAsGoBeyond. This is an absolutely spot-on catchphrase to describe the essence of our profession. "*

The tag of this year's AAPA conference is #PAsGoBeyond. This is an absolutely spot-on catchphrase to describe the essence of our profession. Showcasing this very fact, Jennifer Orozco interviewed Hayley Arceneaux, the very first PA to go into space. Another event included Simone Biles, a decorated Olympic gymnastics athlete who was interviewed by Jane Pauley, CBS Sunday Morning show anchor. Together these ladies dissected mental health via Simone Biles' experience at the latest Olympics in Tokyo where she highlighted how she prioritized her mental health during a very tumultuous time. We PA's can definitely take a page out of this book as we are only helpful to our patients when we are performing at an optimal level. We have to take care of ourselves too.

Since my last message, I have a few updates to share with you:

- Since last year, CAPA has been advocating and dialoguing with the Department of Children's Health Services (DCHS) to include PAs as paneled providers for California Children's Services (CCS) Special Care Centers (SCC). In April, DCHS finally determined that it will update the list of approved paneled providers to include PAs as an option for the core team. This change will be implemented over the next year and DCHS will provide quarterly updates to CAPA on its progress. Eternal gratitude needs to be given to our legal counsel and CAPA leaders, who fervently pursued this request for months, and to DCHS for listening to reason and realizing how limited their workforce is without PAs.

- California Primary Care Association (CPCA) has invited CAPA to join a Workforce Policy Coalition to be among the stakeholders for future meetings/discussions. With a seat at the table, we will be able to provide up-to-date metrics with respect to the profession, PA schools, PA fellowships, etc. in California that will assist CPCA in advocating for primary care providers including PAs.

- CAPA is proud to bring back our Virtual Rounds. Course content can be accessed between June 1st and July 31st through CAPA's educational hub. Please contact the CAPA office for additional information.

- After our success with CAPA at Napa, we bring you another opportunity for an in-person conference again this year. CAPACon 2022 will run from October 6 to October 9, 2022 in Carlsbad California. Please contact the CAPA office for additional information.

And as always, CAPA leaders have the ongoing task of working with our legal counsel to keep abreast of current bills and policy as they make their way through Sacramento. We continue to promote education, advocacy and keep abreast of legislative changes that directly or indirectly affect our profession. Our work doesn't stop at the end of the business day here at CAPA.

Having completed a full term now as president, I am more cognizant than ever of the amount of work and the complexities in trying to reach our goals, and ultimately, our mission. If you are reading this, I know you are already a member and thank you for recognizing the importance of a united front. But if you feel that more can and should be done, I urge you to come onto CAPA's leadership – whether on a committee or on the Board – and share your skills and talents with us. CAPA is always seeking more volunteer leaders to assist us in getting to our goals faster, so we welcome your participation! I am open to answering any questions you might have about CAPA's leadership structure, so don't hesitate to message me at capa@capanet.org. I am looking forward to hearing from you!

Until next time CAPA family, take care.

Saloni Swarup, PA-C
CAPA President

EXECUTIVE ORDER

By Teresa Chien, Executive Director

Among the top frustrations PAs express to CAPA is the lack of parity in employment opportunities between nurse practitioners (NPs) and PAs. Though I generally don't like to pit advanced practice providers against each other, it's hard to argue against the evidence. In running a quick query on Indeed.com, 2,096 PA jobs in California were pulled while the same query pulled 3,457 NP jobs at the time of this publication. Even if one takes into account that some of the posts ask for either a PA or NP, it does not discount the fact that there are 60% more jobs available to NPs than there are to PAs. So why the discrepancy? Examining this from a macro level, the parity issue seems to stem largely from three challenges: PAs' public awareness problem, a lack of PA champions, and the profession's own internal difficulties.

The Parity Problem

In the last issue, I alluded to the public awareness problem PAs and this profession experience. The general public, and even some in the healthcare community, do not know or understand what a PA does. The education and training of PAs is little known, and the historical relationship between PAs and physicians overshadows the practice changes made by SB 697. Many still mistakenly believe that PAs practice only at the delegation of a supervising physician. These misconceptions lead those in a hiring capacity to believe that 1) there is less administrative burden when hiring NPs, and; 2) NPs are more skilled and competent. Given how much autonomy SB 697 has brought to PA practice, along with the education and 2,000+ hours of clinical training PAs receive in school (compared to the 500 required of NPs), the realities of your profession could not be further from public perception.

The profession's shorter history relative to nurses may also be PAs' Achilles heel for a while. Though the NP profession began in 1965 – around the same time as the PA profession – nursing, as a whole, started in the mid-1800s. Nurses have had many more years to mentor each other, protect their own, and carve out leadership positions that champion more opportunities for APRNs (advanced practice registered nurses). The latter is one of the greatest defining reasons why NPs are sought after for roles that PAs are equally, if not more qualified, to fill.

The PA profession has not evolved similarly because, up until recently, PA practice has been inextricably tied to physicians and the urgent need to fill a healthcare gap. Patients have always been PAs' priority and that is evident in the large percentage of PAs in clinical positions. But what about leadership positions? We are beginning to see some PAs in leadership and managerial roles across the various practice settings. But to level the playing field the way frustrated PAs want, more PAs need to be in those positions to educate medical teams and help create opportunities for other PAs, just as APRNs have. Your profession needs more champions!

But above all else – above misconceptions and lack of champions – are PAs' own lack of awareness and possible apathy. CAPA will be the first to admit that we need to do a better job educating all PAs, not just our members, on the threats and challenges to their profession. If PAs don't know that their profession is under attack, how can we expect them to take action? Even among those who do know, there is an unspoken expectation that "someone else will handle it." Case in point: CAPA has presented various challenges to the profession over the years to thousands of non-member PAs, resulting in less than 5% taking action, i.e. joining CAPA or donating to efforts. This is where the NPs have an advantage. The are adept at making each other responsible for the success of their profession. The minute an NP graduates, mentors encourage them to join their association and support their profession's long-term agenda. PAs must do the same, particularly with the profession evolving so quickly. We have a chance at shaping the evolution the way you want.

What Can PAs Do?

CAPA has already piloted some initial solutions to address the parity problem. These solutions will be examined and refined in an upcoming strategic leadership and planning retreat CAPA is hosting. We hope to share some of the strategies with you soon.

However, no amount of planning will have any impact if CAPA lacks the support and resources to implement the plan. Currently, there are 27,000 NPs and 14,000 PAs in California. In sheer numbers, PAs are already at a disadvantage. CAPA has advocated this far for PAs with only 25% of California PAs among our membership. Imagine what is possible if all 14,000 PAs were members! That level of strength is hard for the state and healthcare organizations to ignore.

Before coming to CAPA, I worked with various specialty physician associations. When I asked one doctor why they were a member, he said, "No one else is going to protect my job except me, and no one cares about this [profession] except those in it. So I better at least do the bare minimum." How do we persuade more PAs to do the bare minimum?

If you have suggestions or opinions, we want to hear them! Please write to capa@capanet.org or teresa@capanet.org.

National Suicide Prevention Lifeline to Transition to 988

Beginning July 16, 2022, 988 will be the new, easy-to-remember three-digit dialing code connecting people to the existing National Suicide Prevention Lifeline, where compassionate, accessible care and support is available for anyone experiencing mental health-related distress—whether that is thoughts of suicide, mental health or substance use crisis, or any other kind of emotional distress. People can also dial 988 if they are worried about a loved one who may need crisis support.

The 988 dialing code is just a first step toward strengthening and transforming crisis care in this country. For those in crisis, 988 will serve as a universal entry point so that no matter where patients live, they can reach a trained crisis counselor who can help. Over time, the vision for 988 is to have additional crisis services available in communities across the nation, much the way emergency medical services work.

Need for 988

Too many people are experiencing suicidal crisis or mental health-related distress without the support and care they need, and sadly, the pandemic has only made a bad situation worse when it comes to mental health and wellness in America.

There are urgent realities driving the need for crisis service transformation across our country. Suicide is the second leading cause of death amongst preteens and adults ages 25-34 according to the U.S. Centers for Disease Control and Prevention. Additionally, from April 2020 to 2021, over 100,000 individuals died from drug overdoses.

The Lifeline

The Lifeline is a national network of over 200 local, independent crisis centers equipped to help people in mental health related distress or experiencing a suicidal crisis via call, chat, or text. The Lifeline provides free and confidential support to people in suicidal crisis or mental health-related distress 24 hours a day, 7 days a week, across the U.S.

Numerous studies have shown that the Lifeline works—most callers are significantly more likely to feel less depressed, less suicidal, less overwhelmed, and more hopeful after speaking to a Lifeline crisis counselor.

Lifeline Access

Moving to 988 does not mean the original 1-800-273-8255 Lifeline number goes away. After July 16, 2022, using either number will get people to the same services. The new 988 is simply an easier-to-remember way to access a strengthened and expanded network of crisis call centers.

For more information about the transition, visit https://www.samhsa.gov/find-help/988.

If you're interested in volunteering or becoming a crisis counselor, you can apply at https://www.samhsa.gov/find-help/988/jobs.

**Information provided by Hanah Collins, Senior Marketing and Communications Manager, National Suicide Prevention Lifeline.*

Beverly Hills Physicians Launch Program Offering PA Students Real-World Experience in Surgery

Beverly Hills Physicians (BHP), a health and beauty medical group based in Greater Los Angeles, is offering clinical rotation opportunities to students in Masters in Physician Assistant Studies (MPAS) programs from area colleges and universities. Participating educational institutions will include the University of the Pacific Health Sciences and Southern California University of Health Sciences.

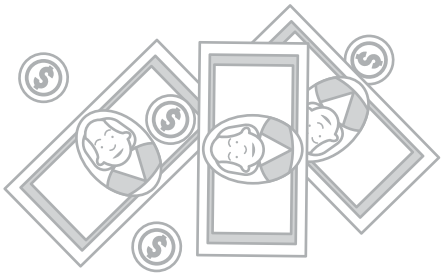
BHP Medical Director and Managing Partner Dr. Kevin Hayavi says that the new clinical rotation program will allow PAs in training to work alongside surgeons and other medical professionals to obtain in-depth, hands on, real-world experience in operating rooms.

"We believe that the next generation of physician assistants needs the best and most complete training possible," Dr. Hayavi said. "PAs are becoming an increasingly important part of the healthcare community. The need for highly trained medical personnel is growing very fast as the number of patients increases. As licensed practitioners who can provide many of the same services as MDs, they are filing a growing niche in all areas of healthcare."

He further adds, "Beverly Hills Physicians was established over two decades ago and we've enjoyed some real success. The PA internship program is a chance for us to give back to the community and to the healthcare field at large. BHP also benefits as the program definitely bolsters our already outstanding services by giving us more flexibility on behalf of patients and freeing up our plastic surgeons to focus exclusively on providing outstanding care to all of our patients."

BHP offers the full range of plastic surgeries and cosmetic procedures, as well as the latest in weight loss medicine. Those interested in learning more about clinical rotations for student PAs can visit their website at https://beverlyhillsphysicians.com/or call (310) 620-7911. Beverly Hills Physicians operates locations throughout the Greater LA area as well as Ventura County and Orange County.

Accounting Basics for Healthcare Professionals



Written by Alex Evans, PharmD, MBA

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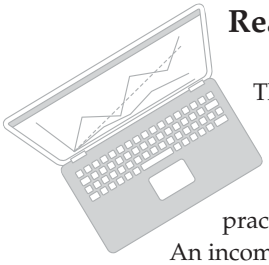
Anyone who runs a business should have a basic understanding of accounting. And healthcare professionals are no exception. Whether you work in a private practice, a community clinic, retail clinic, or a hospital, all healthcare facilities must keep up with their finances.

Knowing accounting basics will help you feel more confident about speaking with your medical and accounting teams and will certainly serve you well if you pursue leadership or managerial roles later.

Types of financial statements

Financial statements are formal records of a practice's business and finances. There are four core financial statements:

- **Income statement:** This statement details how much money was earned over a specific period. It is equal to a monthly budget in personal finance.
- **Balance sheet:** A balance sheet lists all of the practice's assets, liabilities, and equity. In personal finance, this is equal to your bank account, retirement account, and loans.
- **Statement of cash flows:** This statement traces where a practice's cash went over a period of time.
- **Statement of retained earnings:** A statement of retained earnings shows how much of a practice's earnings are kept over a specific period versus paid out to shareholders as dividends.



Reading the income statement

The income statement is the most common statement a department manager sees. It lists revenue and expenses. And it shows how much money the practice earned over a specific time period. An income statement can be created for almost any time period. But by far the most common practice is to produce it monthly, with the previous month's statement produced in the first week of the current month.

Accrual and cash accounting

One challenge with producing the income statement is when to recognize revenue and expenses. Accrual and cash refer to two different methods companies can choose from. Accrual accounting records revenue and expenses in the time period it is earned or incurred, not in the time period the money is received or paid. And it provides the most accurate picture of a company's finances.

Cash accounting, on the other hand, recognizes revenue and expenses when they are received or paid out. Because of this, revenue does not match expenses in that time period, which makes it hard to measure the company's financial health. Revenue recorded in the current month, for example, could have actually been earned months ago.

For these reasons, in this article we'll look at accounting only from an accrual perspective. Now, let's take a look at some of the key parts of the income statement.

Gross revenue

Gross revenue is the total amount of money earned before any expenses or deductions are subtracted. It is most often at the top — or even the very first line — of an income statement.

Payroll

Payroll is usually one of the largest expenses in any business. It includes payroll incurred during the time period of the income statement. It is not the total salaries paid for the time period, but the total amount in salaries earned. Payroll also includes benefits and employer-paid taxes, like FICA taxes.

COGS

COGS stands for cost of goods sold. It is the cost for the items or services sold within the time period of the reported income statement. COGS is not the cost of items purchased during that time period, which is a common misconception. Some of the purchased items will be sold within that time period, while others will be kept as inventory.

Gross revenue and net revenue

Gross margin, also known as "gross profit," is gross revenue minus COGS. It also often appears on the income statement.

Net revenue, on the other hand, is the amount of money earned after all expenses and deductions — including taxes — are taken out. It is the true profit for that time period. And it is perhaps the most important number for managers and investors.

Accounting Basics for Healthcare Professionals

The budget

A budget is a detailed plan for the fiscal year that outlines what the practice expects to earn and spend in that year. Budgets can be either static or flexible.

Static budgets

Static budgets do not change with the unit of activity, which means the amount of sales. In a provider's office, that might be the number of patients seen, the total retail value units (RVU), or some other metric of productivity. RVUs are a method for calculating reimbursement for services provided by healthcare providers. In simplest terms, each CPT code billed by a provider is assigned an RVU. And the RVU determines the reimbursement amount when the CPT code is billed.

Flexible budgets

Flexible budgets, on the other hand, will change throughout the fiscal year depending on the practice's productivity. Variable budgets have the advantage of allowing department managers to decide if their expenses are meeting expectations.

Budgets are often based on historical volumes, but this also has disadvantages. For example, it can encourage department managers at the end of the year to spend money on things they don't need, just so their budget will include higher expenses the following year.

Inventory

Inventory is the amount of product waiting to be sold. It is different from COGS, which is product that has already been sold. There are two types of inventory methods: perpetual and periodic.

Perpetual inventories are used for very expensive items and to track every item in real time, while a periodic inventory is used for less expensive items or those harder to track in real time. A hospital, for example, would keep a perpetual inventory of their MRI machines, but would keep a periodic inventory of supplies like bandages and gloves.

Periodic inventories require the practice's inventory to be counted on a regular basis, such as every 6 months or once a year. After the inventory is counted, it is compared to the expected inventory and an adjustment is made based on that difference.

Accounting jargon

One of the challenges in learning to "speak business" is the various terminology, all referring to the same concept. Here is a guide to some of the most common ones you'll hear:

- **Top-line revenue:** This term is another way of saying gross revenue. It gets its name from being listed at the top of an income statement.
- **Bottom-line revenue:** Bottom-line revenue, or net revenue, gets its name from being listed at the bottom of an income statement.
- **P and L:** This is short for the profit and loss statement, also known as the income statement.
- **Turns or turnover:** Both terms mean inventory turnover ratio. This is a ratio that measures how much inventory is sold and bought in a given time period.
- **AP and AR:** AP and AR are short for accounts payable and accounts receivable. They are the amount you owe other people and the amount other people owe you, respectively.
- **Closing the books:** This phrase means gathering all the information needed to produce a financial statement, guaranteeing its accuracy, and producing the financial statement. Most accounting departments do this once per month to produce the income statement. But they also do it again once per year to start the new fiscal year.

The bottom line

Whether you are a frontline provider or manager, or work in an administrative role, it's important to have a good grasp of the basics of accounting. It can help you read your department's income statements, understand your budget, and better communicate with your organization's administration, finance, and accounting departments.

Key takeaways:

- **Financial statements record a practice's business activities and finances. There are four core financial statements: the income statement, balance sheet, statement of cash flows, and statement of retained earnings.**
- **The financial statement department managers and frontline staff will most commonly see is the income statement. It reports the amount of money earned and spent over a specific time period. And the largest numbers on it are usually gross revenue, payroll, COGS (costs of goods sold), and net revenue.**
- **A practice or department uses a budget to plan how much they should earn and spend for the upcoming fiscal year. Budgets can be static, meaning they do not change as productivity changes. Or they can be flexible, meaning they go up and down as productivity changes.**

Physician Assistant Salaries in California

California has recently been named one of the highest-paying states in the nation for physician assistants. In fact, in 2014 the United States Department of Labor published reports indicating the Santa Rosa-Petaluma region was the fourth highest-paying metropolitan area for physician assistants in the country. At that time, physician assistants working here earned an average annual salary of $133,910 and an average hourly wage of $64.38.

Along with substantial salary offers, California also stood out as one of the largest employers of physician assistants in 2014. For example:

- California held the second highest employment level of physician assistants in the country
- The Los Angeles-Long Beach-Glendale area held the second highest employment level for physician assistants among all other metropolitan areas in the country
- Yuba City held the fourth highest concentration of physician assistant jobs compared with all other metropolitan areas in the country

Physician assistants can expect an optimistic occupational outlook in the coming years. The federal government predicts that the number of physician assistants working in California will rise from 8,300 in 2012 to 11,100 by 2022. The employment projection shows that the field of physician assisting will experience around 430 annual job openings.

Experience Yields High Salaries for Physician Assistants in California

In 2021, the United States Department of Labor reported that physician assistants employed in California earned an average annual salary of $136,920 and an average hourly wage of $65.83. Physician assistants that aspire to earn more than this state average are advised to gain several years of experience fine-tuning their clinical skills.

In that same year, entry-level physician assistants collected an average annual salary of $51,600 and an average hourly wage of $24.80. Mid-level physician assistants received twice this amount, while the most experienced physician assistants in California were handsomely paid an average annual salary of $174,760 and an average hourly wage of $84.02.

In 2021, the United States Department of Labor reported average salary statistics for physician assistants employed in several of California's major regions:

Area name	Annual mean wage(2)	Annual median wage(2)
Bakersfield, CA(0012540)	137100	128190
Chico, CA(0017020)	138720	152480
El Centro, CA(0020940)	141940	153170
Fresno, CA(0023420)	133440	128850
Hanford-Corcoran, CA(0025260)	124290	125490
Los Angeles-Long Beach-Anaheim, CA(0031080)	129210	124580
Madera, CA(0031460)	130100	144610
Merced, CA(0032900)	145690	152130
Modesto, CA(0033700)	152300	152480
North Coast Region of California nonmetropolitan area(0600003)	139680	131080
North Valley-Northern Mountains Region of California nonmetropolitan area(0600007)	139930	132240
Oxnard-Thousand Oaks-Ventura, CA(0037100)	139820	131230
Redding, CA(0039820)	132190	125380
Riverside-San Bernardino-Ontario, CA(0040140)	129890	127240
Sacramento-Roseville-Arden-Arcade, CA(0040900)	153400	163920
Salinas, CA(0041500)	128840	128190
San Diego-Carlsbad, CA(0041740)	127660	128690
San Francisco-Oakland-Hayward, CA(0041860)	164150	166770
San Jose-Sunnyvale-Santa Clara, CA(0041940)	163720	166900
San Luis Obispo-Paso Robles-Arroyo Grande, CA(0042020)	139040	131240
Santa Cruz-Watsonville, CA(0042100)	144040	136660
Santa Maria-Santa Barbara, CA(0042200)	123420	124540
Santa Rosa, CA(0042220)	157720	164620
Stockton-Lodi, CA(0044700)	129290	129210
Vallejo-Fairfield, CA(0046700)	162030	164620
Visalia-Porterville, CA(0047300)	139010	127610
Yuba City, CA(0049700)	144990	149140

Footnotes:
(2) Annual wages have been calculated by multiplying the corresponding hourly wage by 2,080 hours.

Postgraduate PA School Residency and Fellowship Programs

One of the best things about being a PA (for both the PA *and* their employer) is its flexibility. You are educated to be the Swiss Army knife of medical providers with the ability to jump from specialty to specialty as needed without having to dedicate another seven to eleven years to more education and training. There is a reason why the PA profession is listed among the top ten professions in the country.

However, most PAs, whether new or experienced, are oftentimes thrown into a medical team with little more than 30 days of training in a specialty, then expected to perform at the level of a seasoned professional. While on-the-job experience is good, depending on the practice setting, a PA may or may not receive the kind of hands-on training necessary to provide the top-level care all PAs want to give.

To adapt and support the current rend of PAs transitioning into specialty practice, more postgraduate programs are being established. At the time of this publication, there are 85 postgraduate PA programs. Referred to as residencies or fellowships, these programs provide advanced learning in various medical and surgical specialties.

PA Residency Program Accreditation

Unlike PA schools, which must undergo a rigorous accreditation process through the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), **PA residency programs do not require a formal accreditation.** Currently, there are two accrediting bodies for PA residency programs.

- **ARC-PA:** There are only 8 ARC-PA accredited clinical residencies for PAs in the US. Accreditation is voluntary through ARC-PA and does ensure a certain level of educational standards, but it is not required and offers no current benefit. In 2014, the ARC-PA suspended its post-graduate accreditation to reassess its own educational quality criteria and approval process.

- **Association of Postgraduate PA Programs (APPAP):** APPAP maintains a large, but certainly not comprehensive, list of post-graduate programs in the US. Post-graduate programs are not required to be registered with APPAP and certain membership criteria must be met to be eligible. While there are benefits to being registered with APPAP, there are also expensive membership fees that programs may not wish to spend their money on.

It should be noted that APPAP or ARC-PA accreditation is not necessarily an indication or measure of a program's quality. Many solid or recommended residency programs do not obtain accreditation for financial or business reasons that have no connection with or impact on the program's educational or training content.

The Pros and Cons of PA Residency Programs

Like most important decisions, there are advantages and disadvantages to completing a PA residency/fellowship program. It is the ultimately your decision whether post-graduate education is beneficial and appropriate for your career, and which program is best for your level of education and experience.

Pros of PA Residency Programs

- Residency programs allow the PA to gain both clinical and didactic knowledge that would take years of on-the-job training to attain. It provides a faster paced, formalized training program of supervised practice, which allows PAs to be utilized much faster than new graduates.

- The PA can develop judgment and technical abilities in a specialized practice area, thus increasing their confidence in their chosen specialties.

- Many employers give preference to residency-trained PAs.

- Residency programs can be a great way to transition to a specialty practice for PAs looking for a new challenge or lateral mobility.

- It is generally agreed upon that most employers are willing to pay more for a PA who has completed a residency program.

Cons of PA Residency Programs

- PAs who jump into specialty without residencies begin earning immediately and may learn just as much training on the job as those who completed residencies.
- Even though employers are willing to pay more for a PA who completed a residency, the salary maxes out and becomes equal to those who did not do a residency program.
- Residency requires more education, increasing the duration and cost of schooling. Adding on more expenses and loans for residency programs may put you in more debt and leave you with more accumulated interest.
- It is surmised that rewarding those who complete residency programs with larger salaries results in pressure for PAs to complete specialty residency training.
- Residencies require more education, therefore delaying those PAs from entering the employment market on a full-time basis, exacerbating the lack of healthcare providers issue California is already experiencing.

Is A Residency Right For You?

The decision to pursue or not pursue a PA residency is complex and multi-factored. If considering this as part of your career path, care should be taken in reviewing the specific residency, its scope, and the potential for employment after completion. While this may be a great investment in one's profession and scope of practice, for another, the financial costs and time commitment may not be feasible. PAs are encouraged to do their homework on their residencies of interest and consider the most important life factors that enrolling in a residency would impact.

PA Residency FAQ

- **What about my PA school loans?** You can defer student loans during your residency and some programs offer loan repayment.
- **Do I get paid during my residency?** Most residencies provide stipends of $40,000 - $75,000 and require 40-80 hours per week, up to 6 days per week.
- **How many hours will I be required to work?** The average program length is 12 months, but some programs are up to 24 months long.
- **How competitive is the process?** 10-30 people interview at each program annually and accept on average 1-4 residents.

California Residencies

Arrowhead Regional Medical Center Orthopaedic-SurgeryPA Fellowship Program
Colton, CA
turpenh@armc.sbcounty.gov
(909) 580-3390

Arrowhead Regional Medical Center Emergency Medicine Residency Program
Colton, CA
EMResidency@armc.sbcounty.gov
(909) 580-2159

Arrowhead Regional Medical Center OB/GYN PA Fellowship Program
Colton, CA
armcobynpafellowship@gmail.com
(909) 580-3474

Riverside University Health System Orthopaedic Surgery Residency
Moreno Valley, CA
k.miranda@ruhealth.org
(951) 486-4698

Shasta Community Health Center PA Post-Graduate Primary Care Fellowship Program
Redding, CA
nppafellowship@shastahealth.org
(530) 246-5904

UCSF Fresno Emergency Medicine PA Residency
Fresno, CA
fresno-em.pa.residency@ucsf.edu
(559) 499-6440

UCSF Fresno Orthopaedic Surgery PA Residency Program
Fresno, CA
fresno-ortho.pa.residency@ucsf.edu
(559) 459-4004

Governor Newsom Signs Landmark MICRA Modernization Bill Into Law

On May 23, 2022, Governor Gavin Newsom, signed Assembly Bill 35 into law, putting an end to a decades long political battle over the Medical Injury Compensation Reform Act (MICRA).

Since MICRA was enacted in the '70s, there has been a balance between compensatory justice for injured patients and maintaining an affordable and accessible health care system for all Californians. However, California's medical provider communities, including CAPA, have repeatedly had to defend MICRA through expensive battles at the ballot, in the courtroom, and in the legislature. This year, the healthcare community was again faced with another costly initiative battle.

The Fairness for Injured Patients Act (FIPA), which had qualified for the November 2022 ballot, would have obliterated existing safeguards for out-of-control medical lawsuits and would have resulted in skyrocketing health care costs. But after several discussions and meetings, proponents of FIPA and protectors of MICRA were able to achieve a meaningful consensus through a revised framework that could protect both the rights of injured patients while keeping MICRA's essential guardrails solidly in place for patients and providers alike.

"For nearly 50 years MICRA closed the door to justice for patients injured by medical negligence," said Nick Rowley, author and principal funder of the FIPA. "This agreement makes the law better and will help injured patients have better access to the courts and increase accountability in health care. The legislative resolution we reached ends a decades long political fight that pitted patients and families against insurance companies. Solving our most protracted problems requires us to listen to each other and keep an open mind. That's what happened here, and is an example I hope others will follow."

Lisa Maas, Executive Director of Californians Allied for Patient Protection, the coalition for which CAPA is a member, adds "This bill will help to ensure health care providers can keep their doors open while also balancing the financial needs of patients with health care related injuries."

The updated framework will extend the long-term predictability and affordability of medical liability protections for those providing medical care in California while providing a fair and reasonable increase to limits on non-economic damages for medical negligence beginning January 1, 2023, with gradual increases thereafter.

The legislation will most notably adjust MICRA's cap on non-economic damages, which is currently limited to $250,000. This new law will increase the existing limit to $350,000 for non-death cases and $500,000 for wrongful death cases on January 1, 2023, followed by incremental increases over 10 years to $750,000 for non-death cases and $1,000,000 for wrongful death cases, after which a 2.0% annual inflationary adjustment will apply.

The proposal will also create three separate categories of caps, which could apply depending on the facts of each case. Additionally, a healthcare provider or healthcare institution can only be held liable for damages under one category regardless of how the categories are applied or combined. The new categories include:

- One cap for health care providers (regardless of the number of providers or causes of action)
- One cap for health care institutions (regardless of the number of providers or causes of action)
- One cap for unaffiliated health care institutions or a provider at that institution that commit a separate and independent negligent act.

AB 35 passed through the California Legislature with nearly unanimous support, demonstrating broad bipartisan support. As part of the landmark agreement reflected in AB 35, proponents of the FIPA have withdrawn the initiative. The initiative cannot be returned to the November 2022 ballot.

California's new modernized MICRA statutes will provide predictability and affordability of medical liability insurance rates for decades to come, while protecting existing safeguards against skyrocketing health care costs. It will also bring greater accountability, patient safety and trust by making it possible for physicians and patients to have a full and open conversation after an unforeseen outcome.

CAPP Coalition Protecting MICRA

American Nurses Association\California
BETA Healthcare Group
California Academy of Physician Assistants
California Association for Nurse Practitioners
California Association of Health Facilities
California Dental Association
California Healthcare Insurance Company
California Hospital Association
California Medical Association
Central Valley Health Network
Medical Insurance Exchange of California
NORCAL Insurance Company
Osteopathic Physicians & Surgeons of California
Planned Parenthood Affiliates of California
The Dentists Insurance Company
The Doctors Company

The Journey of Being a First-Generation Student in the Medical Field

By Lizette Grajales, PA-S, Stanford School of Medicine, Physician Assistant (PA) Studies

The obvious need to increase ethnic and racial diversity in the medical field has become a popular topic in recent years. Within the Physician Assistant profession, as the field grows there is an increased demand for more minority representation and cultural diversity. This means improving diversity in the workforce as well as in the classroom setting. But what does that endeavor look like for students of color?

Within the group of underrepresented minorities, there is a subgroup of students who are the first in their family to pursue higher education. As first-generation students, the journey to get into the medical field is riddled with financial obstacles, limited knowledge, lack of resources and little to no support. Once the medical training starts, the stressful experience is accompanied by the frightening realization that you may be one of the only students of color from a disadvantaged background in your classroom. Within a small academic program, which many PA programs tend to be, that can be overwhelming. And that's the case for some of my peers.

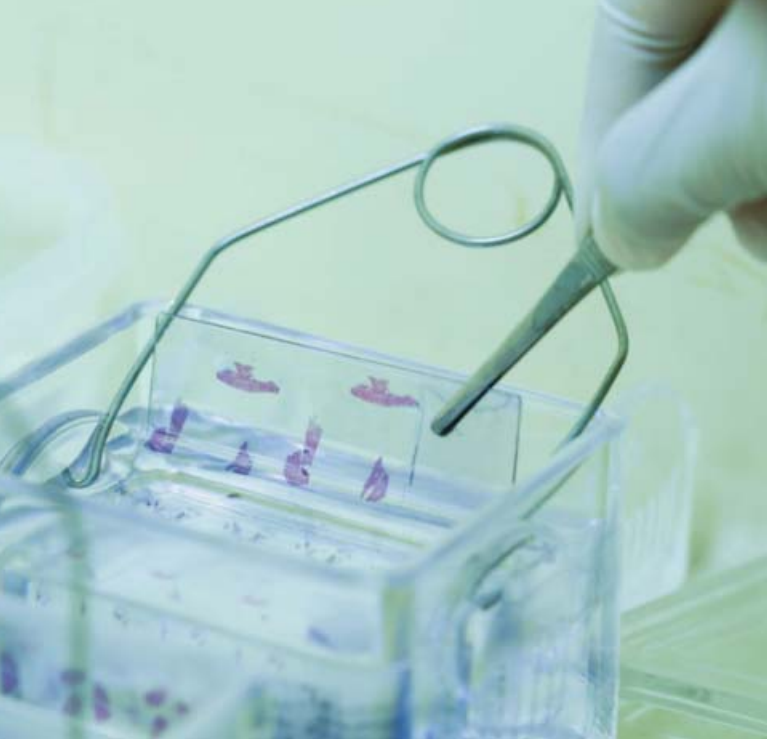
As a first-generation Latina, and one of two Latina women in my year in the Stanford PA program, one of my goals has been to increase visibility and representation for Latinas in the PA profession. This has taken me to connect with other Latinx classmates and faculty all throughout Stanford Medicine. Recently, I have found myself having discussions about the environment we learn and work in at Stanford University. It came to my attention that many of us feel like these environments are starkly contrasting with the ones we grew up in. Here, these are affluent neighborhoods with extravagant goods we are not used to consuming and prices we can't afford. It often feels uncomfortable, like we don't belong here. One student brought up an interesting point about feeling guilty to be living in such a prestigious institution and enjoying such luxuries that come with being a student here while all around us there are disadvantaged communities struggling to get by. The main topic of discussion then became - what are we doing as future providers to support those neighboring communities that remind us a lot of our own families?

One of the ways some of my peers and I have decided to combat the feeling of not belonging is by becoming involved in the Latino Medical Student Association (LMSA) and using the space to uplift Latinx voices and culture. We have connected with faculty members throughout Stanford to begin planning ways to support local businesses, volunteer in community clinics, and highlight Latinx representation on campus. Among our efforts to start doing just that was a Cinco de Mayo celebration we hosted where we proudly celebrated Mexican culture right on the front lawn of our medical school building.

While we are incredibly grateful for this opportunity to be leaders in our community, we must take a moment to reflect on why we feel the responsibility to do so. There may be a variety of resources and student groups advertised as support for students like us, but that's not always enough. They do not hide the simple fact that these institutions, these environments were not made for students like us. Just our presence in the classroom setting is a form of representation, a celebration of Mexican culture on the front lawn is a form of resistance. We live with the silent realization every day that we feel the need to prove we deserve this spot, that we do in fact belong here. We sit in class listening to a lecture about systemic racism and how it affects patients when many of us have experienced it in real life. After class, we go to meetings to plan events that celebrate our cultures and educate our classmates on our identities. During our lunch breaks we take phone calls with family members making sure to meet any caretaking responsibilities we still maintain for our families at home, often because they don't speak English and we are their only interpreters. At night after volunteering, we go home to a place that doesn't feel like home to squeeze in last minute studying. Then our families tell us how proud they are, and we tell them how much we miss them, and we go to sleep feeling like we didn't do enough.

So what does it take to be a student of color trying to increase diversity in the field?

It takes courage, resilience & patience. A deep understanding that we exist in places that were never meant for us and the courage to do it anyways. It means being patient with our classmates when they don't understand our frustrations or can't comprehend how certain material is triggering. It means getting involved when you can and uplifting the voices of those who are voiceless. But it also means being compassionate with ourselves when we don't exceed our own extraordinarily impossible expectations. It means accepting that as much as we may want to juggle doing community outreach, being voracious advocates for patients, serving as representation for our cultures, and learning a challenging medical education curriculum, sometimes we can't. Sometimes just getting through classes is all we can handle, and that is enough. Because we are enough, and we do belong.



Improving Health Equity: PA's Role in Providing Comprehensive Care for Adults with Sickle Cell Disease in Outpatient Clinics

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How can a PA optimize patient health in ambulatory sickle cell clinics? This is the focus of our third article exploring how PAs can advance health equity for Sickle Cell Disease (SCD) in California.

To review, SCD is a complex, chronic, inherited blood disorder. It disproportionately affects people of African descent, as well as Latin Americans, South Asians, and those from Mediterranean areas. Tragically, people with SCD experience healthcare disparities, mostly due to a critical lack of comprehensive, evidence-based care for adults, and also due to institutional racism, clinical workforce shortages, and chronic under-funding for the disorder.[1,2] Collectively, these disparities result in patients not having access to much needed health care services.[3] Severe shortages of expert SCD providers contribute to avoidable SCD morbidity and foreshortened lifespan.[4] However, PAs knowledgeable in SCD team-based management can improve population health. As medical professionals, PAs are critical members of SCD clinical teams, providing comprehensive assessment and treatment services in the outpatient setting. A landmark paper published in Blood Advances identifies advanced practice providers as an essential component necessary for a functional and effective comprehensive adult sickle cell center.[5]

To address SCD health inequities, Networking California for Sickle Cell Care (NCSCC) funded by California's 2019 Budget Act and guided by the State's 2018 Sickle Cell Action Plan, is actively establishing a network of adult SCD clinics. These new adult SCD outpatient clinics provide specialty care in counties where the largest numbers of adults with SCD live. NCSCC's goal is to establish 10 comprehensive clinics statewide by 2023. PAs who are knowledgeable about evidence informed SCD care are key members of the clinical teams being started.

Coordinated team-based outpatient management is vital to comprehensive care for people with chronic and complex disorders like SCD which affects multiple organ systems. Regular care in the outpatient setting can dramatically reduce acute care utilization and prevent SCD complications.[6] When red blood cells sickle, they adhere to one another creating vascular occlusion, vessel damage and promote inflammatory markers resulting in multi system complications. This can affect cardiovascular, pulmonary, neurological, ophthalmological, musculoskeletal, and renal systems. When outpatient team members initiate annual surveillance screening and prescribe hydroxyurea and promote adherence to treatment, health care utilization costs are lowered[7] and patients report improved sense of wellbeing,[8] while also decreasing risk for complications.

In 2014, the NHLBI issued "Evidence-Based Management of Sickle Cell Disease: Expert Panel Report (EPR), 2014".[9] These guidelines were developed by an expert panel composed of health care professionals from family medicine, general internal medicine, adult and pediatric hematology, psychiatry, transfusion medicine, obstetrics and gynecology, emergency department nursing, and evidence-based medicine. These guidelines are intended to help people living with SCD receive high quality care by articulating the best science-based recommendations to inform practice decisions for affected individuals of all ages. The guidelines assist SCD health care professionals – including PAs - offer the best diagnostic and treatment strategies for routine SCD health maintenance, the recognition and treatment of SCD related acute and chronic complications and comorbidities.[10-14]

PA Sickle Cell Disease Best Practices for health monitoring in the outpatient clinic. One PA best practice is to ensure patients are up to date with annual surveillance imaging and exams as outlined by the NHLBI expert panel report and American Society of Hematology (ASH) clinical practice guidelines on Sickle Cell Disease. ASH SCD Guidelines[10-14] are available in areas where clinical practice was highly variable, and where guidance was limited and uncertain. The five ASH SCD Guidelines are on: cardiopulmonary and kidney disease, cerebrovascular disease, stem cell transplantation, transfusion support, and pain (both acute and chronic). PA clinical monitoring for adults with SCD includes echocardiograms, pulmonary function tests,

iron overload screening with ferritin, abdominal and cardiac MRI, proteinuria and kidney disease screening, reproductive health, immunizations, ophthalmologic and dental exams. Based on results of these screenings, PAs can refer patients to the correct specialists and ensure appropriate management thus delaying disease progression.

PA Best Practices for prescribing Sickle Cell disease modifying therapies: Hydroxyurea decreases morbidity and mortality in SCD and is the most important therapeutic that changes the disease trajectory. Despite its benefits, a large number of SCD adults are either not started on this medication or do not adhere to therapy for various reasons.[15,16] PAs can ensure prescription of hydroxyurea and also assist with monitoring and promoting treatment adherence. In addition to hydroxyurea, there are three other FDA approved medications for SCD, including L - Glutamine, Crizanlizumab and Voxelotor, which a knowledgeable PA can prescribe based on the clinical scenario.

PA SCD Best Practices in the outpatient clinic for Sickle Cell Disease acute care, pain, and treatment plans: PAs also evaluate individuals in outpatient clinics for acute visits, pain management assessments, and medication management. These visits can be done in ambulatory clinics both in person and via telehealth depending on the complexity of the case. PAs being readily available to manage the daily needs of people with SCD can prevent and/or reduce the need for acute care resources such as the Emergency Room or inpatient service enhancing quality of life while simultaneously reducing costs.

In summary, the PA plays an integral role in improving health equity for people with Sickle Cell Disease by executing and facilitating access to evidence-based care in the ambulatory clinic setting. The versatile, collaborative nature of the PA profession provides invaluable skills suited to outpatient team-based SC clinics, reducing avoidable emergency room visits and inpatient admissions, helping patients thrive. As part of healthcare teams, PAs can prevent morbidities and promote healthy lifestyles, improving patients' overall wellness. As the Networking California for Sickle Cell Care initiative continues to build adult SCD outpatient clinics statewide, PAs will play a key role in expanding access to exceptional, comprehensive care. For more information on Networking California for Sickle Cell Care, see: https://sicklecellcare-ca.com/

"Severe shortages of expert SCD providers contribute to avoidable SCD morbidity and foreshortened lifespan. However, PAs knowledgeable in SCD team-based management can improve population health. "

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Potential Pitfalls of Telehealth Prescribing

By Lara D. Compton, Ellen L. Janos, Cassandra L. Paolillo
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While Congress has acted to extend certain COVID-era telehealth flexibilities (mostly related to Medicare coverage) beyond the Public Health Emergency (PHE), the future of prescribing controlled substances via telehealth is uncertain. Although the American Telemedicine Association and other industry groups continue to advocate for changes to allow telehealth providers to prescribe controlled substances in certain circumstances, without further action by Congress or the Drug Enforcement Administration (DEA), telehealth providers who prescribe controlled substances will need to conduct an in-person examination of the patient once the PHE ends.

Despite recent investigations into certain telehealth prescribing practices involving controlled substances, signs point to the DEA eventually making permanent changes to allow some controlled substances to be prescribed via telehealth. For example, in 2018, Congress directed the DEA to create a telemedicine special registration program as part of the SUPPORT for Patients and Communities Act, and in recent months, several states have loosened their requirements for telehealth prescribing. However, the PHE flexibility and anticipated changes do not fully address the risks involved for telehealth prescribers, which should be mitigated given the heightened scrutiny around prescribing controlled substances. Below are two key areas that telehealth prescribers should evaluate and address by implementing appropriate safeguards as necessary.

"Telehealth providers must also use their clinical judgment to ensure that the telehealth encounter is adequate to meet the standard of care for prescribing the controlled substance indicated."

State Requirements for Prescribing and Standard of Care

As any multi-state provider knows, getting a handle on different states' regulatory requirements is a constant challenge. The federal Controlled Substances Act and DEA regulations set the requirement of an in-person examination prior to issuing a prescription except in limited situations (including the current PHE) as a baseline for prescribing controlled substances via telehealth. However, several states have more stringent requirements. For example, several states require in-person examinations prior to prescribing a controlled substance without any exceptions or with exceptions that are narrower than the DEA's exceptions. State laws around renewing and reissuing prescriptions also vary, and telehealth providers need to navigate how often an in-person or audio-visual visit needs to occur in order to renew a prescription.

Telehealth providers operating in multiple states should carefully consider all relevant state laws when developing protocols around prescribing controlled substances. Providers can either adopt specific protocols for each individual state or, alternatively, adopt protocols that comply with the most stringent state requirements. Regardless of the approach, protocols should allow individual clinicians to exercise their professional judgment while complying with all relevant state law.

In addition, telehealth providers should, to the best of their ability, monitor changes in law and regulation and update relevant protocols as necessary.

In California, an appropriate prior examination and a medical indication is required for all prescription drugs, but the examination may be performed using telehealth provided it meets the standard of care and the prescriber obtains and documents the patient's consent (may be verbal or written) to the use of telehealth.[1] As of October 1, 2021, California providers are required to obtain consent to telehealth (the COVID-19 waiver is no longer in effect).

Telehealth providers must also use their clinical judgment to ensure that the telehealth encounter is adequate to meet the standard of care for prescribing the controlled substance indicated. In many circumstances, an audio-visual visit will enable the provider to gather adequate information to make a diagnosis and determine that a controlled substances is the appropriate treatment, but this may not always be the case. Once a controlled substance is prescribed, the prescriber should also ensure that mechanisms for clinically appropriate follow-up are also in place.

For telehealth providers focused on only one aspect of the patient's care, it can be difficult to obtain a full picture of the patient's health. Telehealth providers and their pharmacy partners should adopt systems to ensure that systems are in place to combat over-prescribing and screen for medications that could have adverse effects when taken together. Providers should also implement policies and procedures to ensure that clinicians can verify telehealth patients' identities and confirm that patients have the capacity to consent to treatment.

Demonstrating Compliance

For individual providers who are licensed and providing telehealth services to patients in multiple states with different regulatory schemes, it is very challenging to stay on top of the various requirements. Strong, clinically supported policies, procedures and protocols are key, but they should not be so prescriptive as to interfere with the providers' individual clinical judgment. Telehealth providers should adopt strong compliance programs to support clinical best practices, and any marketing materials should be developed by, or in close collaboration with, the clinical teams.

As mentioned above, in California, telehealth may only be used by prescribers of controlled substances if medically indicated and the standard of care can be met. The same standard of care applies to in-person and telehealth examinations, and the Medical Board of California (MBC) has made it clear in guidance that in-person examinations enhance the opportunity to confirm if a patient needs the identified medication or to rule out other medical conditions.[2] For safety reasons an in-person examination will likely be preferred by the MBC for controlled substances, and as a result evidence-based written treatment protocols developed by clinicians designed to confirm the need for medication and rule out other medical conditions should be followed. Further, a detailed medical record documenting all steps of the patient encounter including the details of the patient examination should be maintained supporting a health care provider's decision to prescribe a controlled substance. Additionally, health care practitioners must consult the California Controlled Substance Utilization Review and Evaluation System (CURES) before prescribing a schedule II, III, or IV controlled substance for the first time and at least once every 4 months thereafter if the patient is still using the substance (unless an exemption applies)[3] and thus maintaining documentation in the medical record that this step has been taken (or which exemption applies) is recommended. Providers should also be aware that a report to CURES is required when controlled substances are dispensed, and that various agencies including the California Department of Justice and provider licensing boards use CURES data as an investigation tool and have the capability to identify and investigate providers who prescribe controlled substances in a manner that is concerning to the agencies.[5]

In California, it is a provider's responsibility to review and approve all telehealth marketing materials to ensure compliance with advertising requirements for professional medical services. Among other things, such advertising may not create false or unjustified expectations of favorable results and price advertising must be exact.[6] Furthermore, if providers utilize a management services organization or other unlicensed service provider for marketing services, physicians must remain in control of advertising and marketing activities to avoid potential corporate practice of medicine issues.[7] In these situations, physician review and approval should be documented.

While the use of telehealth has become more widely accepted in the wake of the COVID-19 pandemic and continues to play a huge role in increasing access to care, prescribing of controlled substances using telehealth is heavily regulated and will continue to be scrutinized by state and federal agencies. As telehealth's prevalence has increased, so too will enforcement efforts targeting telehealth providers, especially when controlled substances are involved. Providers should stay up to date on the status of the PHE, telehealth waivers on the state and federal levels, and enforcement activities focusing on telehealth providers.

[1]Cal. Bus & Prof Code 2242; 2290.5; 4022

[2]Medical Board of California, "Internet Prescribing - Information for Physicians" available at https://www.mbc.ca.gov/Resources/Medical-Resources/Internet-Prescribing.aspx#

[3]Cal. Health & Safety Code 11165.4

[4]Medical Board of California, "Controlled Substance Utilization Review and Evaluation System (CURES) Mandatory Consultation – Frequently Asked Questions" available at https://www.mbc.ca.gov/Download/Documents/CURES-FAQ.pdf

[5]Cal. Health & Safety Code 11165

[6]Cal. Bus. & Prof Code 651

[7]Cal. Bus. & Prof Code 2052

PA Productivity and Value

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Measuring a health professional's productivity is important in determining their contribution to care, revenue generation, and job performance. However, accurately measuring or comparing an individual's contribution or productivity can be challenging. Variations in practice settings, patient complexity, services provided, and resources used all affect a healthcare professional's productivity. PAs can be negatively affected when productivity measurements are quantified by financial contribution alone. This occurs when the services personally performed by a PA are billed under the name of, and attributed to, a physician.

Lack of attribution of services to PAs who provided the care may inadvertently devalue a PA's "measured productivity". When PAs are not formally recognized as providers of services, when billing mechanisms allow for services to be attributed to a physician, or when PAs contribute to bundled payments, the ability to track a PA's contribution is compromised. In instances of Medicare's "incident to" billing, in which the professional services provided by PAs are submitted under the name and NPI of the physician with whom the PA works, measurement of PA value and productivity is flawed and undervalued. A similar problem can occur for services provided in a hospital setting when both a PA and a physician personally perform a percentage of the service, but the work of both professionals is combined and billed under the physician as a Medicare "split/shared" visit.

PA contribution can similarly be "lost" when services are part of a global surgical package. Because reimbursement for many surgical procedures is bundled into a single payment for all pre-, intra-, and post- operative care, PAs providing pre- and post-operative services may have productivity misattributed to the physician.

When measuring productivity, it is important to ensure the most accurate data is used and understand limitations in attribution that may skew measurement. Measuring Relative Value Units (RVUs), a resource- based relative value scale, or revenue alone may provide an incomplete picture of a PA's productivity, particularly when billing mechanisms, such as "incident to" or bundled payments, are used or when PAs provide health care services that are not directly reimbursable (such as triage, care coordination, and on-call services).

Value is more than productivity

While some view value and productivity as interchangeable, they are not the same. Contributions of a health professional other than revenue often provide a more complete and accurate assessment of value. Measures of gross billing, net revenue, patient volume, and RVUs may not demonstrate a PA's overall contribution. Considering factors such as contribution to practice efficiency, patient satisfaction, and quality and outcome measures, in addition to productivity, may better assess a PA's value to a practice.

Possible Measures for Value and Productivity

PA value and productivity may be measured by any one or any combination of the metrics in the following table depending on the unique characteristics of the practice, services rendered, workflow, and other factors.

Measures of PA Productivity & Value		
Value Component	**Examples of Measurement**	**Value Benefit**
Productivity		
Direct Measures of Productivity	Individual work RVUs, total RVUs, charges, payments received	Revenue, practice sustainability
Indirect Measures of Productivity	Number of patient encounters, number of documentations/entries in EHR, portions of global services performed, group work RVUs, total RVUs, charges, payments received	
Clinical Measures of Productivity	Hours worked, hours on-call, time spent providing patient education (when not separately payable), contribution to research, participation in quality improvement activities	
Quality & Outcomes		
	Attainment of quality measures (e.g. BP or Hgb AIC), percentage of patients receiving guideline-directed management, hospital lengths of stay, readmission rates, post-operative infection rates	Improved care and outcomes, value-based payments
Patient Satisfaction		
	Average of patient satisfaction scores, percentage of scores in top quartile, subset of overall scores (e.g. provider and care delivery components)	Patient engagement, improved adherence to medications and medical management, better health outcomes
Access to Care		
	Average time until available appointment, percent of patients that can be seen within a certain timeframe from requesting an appointment	Improved care and outcomes, patient satisfaction, increased throughput
Care Coordination		
	Numbers of prescriptions ordered/refilled, timely responses to patient inquiries via portal or phone, forms or prior authorizations completed, communications with other providers	Increased practice efficiency, patient satisfaction, improved adherence to medications and medical management, better care and health outcomes
Resource Use		
	Adherence with Appropriate Use Criteria, ratios of costs/outcomes	Value-based payments

California's Mandatory Retirement Savings Program May Help PAs With Financial Planning

In 2021, the California legislature passed a bill to establish a state-run retirement savings plan for employees in the private sector. The intent was to offer a simply way for every California worker to save for retirement. The CalSavers Retirement Savings Program (CalSavers) was the result of this legislation, and it may help PAs working in small private practices, who own their own practice, or who are locum tenens.

CalSavers Retirement Savings Program (CalSavers) is a state-run retirement savings program for private-sector employees whose employers do not offer a retirement program. The program was slowly introduced to employers over the last two years, providing a deadline based on employer size. **For employers with at least five employees and do not already offer a qualified workplace retirement savings plan, June 30, 2022, was the final deadline to offer and facilitate employee access to CalSavers.**

CalSavers auto-enrolls employees in a standard savings and investment election after an employer provides them with their payroll list. Employees can customize their savings amount and their investment preferences. Employees may also choose to opt-out of the program.

Eligible Employers

An employer's general obligation is limited to:

- Registering for CalSavers
- Creating a payroll list to add employees to CalSavers This will begin the automatic enrollment process.
- Calculating the appropriate deduction for each employee (shown on the employer's account page)
- Submitting employee contributions to the CalSavers program, and
- Keeping the payroll list up-to-date

Limited Employer Role

CalSavers does not have any employer fees and does not require any employer contributions. Employers just need to send in the employee contribution. **Employers are not fiduciaries of the program.** Employers are not involved in managing investment options or processing distributions. CalSavers provides information on the program to the employee and will answer questions that employees have. It is strongly advised that employers remain neutral not encourage or discourage participation in CalSavers or provide any investment advice.

Employee Decision Period

Once an employer has added their employee list to CalSavers, the enrollment process beings. Employees will have 30 days to decide to complete registration or opt out. If they do not make a selection, they will be automatically enrolled in the program.

An employee has three options:

1. Do Nothing. If an eligible employee takes no action within 30 days, they will be automatically enrolled with the standard savings and investment elections as follows:

- 5% of the employee's gross income earned with the employer.
- Initial contributions will be invested in the CalSavers Money Market Fund for 30 days, after which all subsequent contributions, along with any earnings in the Money Market Fund, will be re-allocated to a CalSavers Target Retirement Fund based on saver age and the year closest to when a person that age is expected to retire.

2. Customize the Account. The employee can choose to customize the account, for instance by changing the contribution rate and investment choices.

3. Opt Out. An employee can opt out of participating in CalSavers at any time online, by phone, or mailing in a form. An employee can rejoin the program and begin contributing at any time through the same methods.

4. Independent Contractors or employees who work for a company with less than 5 employees. Employees who work for an employer that is not mandated to participate in CalSavers or are self-employed may opt to enroll on their own accord by visiting the CalSavers website to enroll independently.

Penalties for Non-Compliance

An eligible employer that, without good cause, fails to allow its eligible employees to participate in CalSavers, will be required to pay a fine of up to $250 per eligible employee. Further non-compliance will result in an additional penalty of $500 per eligible employee.

Additional information can be found at www.calsavers.com for both employers and employees, including instructions for enrollment and investment options.

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FQHC, RHC and Tribal FQHC Providers May Now Submit Claims for COVID-19 Vaccine Administration

In March 2022, the Centers for Medicare and Medicaid Services (CMS) approved the California Department of Health Care Services' (DHCS) State Plan Amendment (SPA 21-0020) for reimbursement of COVID-19 vaccine administration during vaccine-only visits for Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), and Tribal FQHCs. Effective retroactively to November 2, 2020, the aforementioned providers may receive reimbursement up to $67 per shot for administration of the COVID-19 vaccine during vaccine-only encounters.

Vaccine-only encounters are visits where the administration of the COVID-19 vaccine does not meet the criteria for billable office visits.

Although DHCS asked providers to hold claims until its systems were prepared to process claims under SPA 21-0020, it also indicated that it will automatically reprocess claims previously submitted. These claims will be automatically reprocessed at the lower of either the $67 rate or the billed charge if less than $67.

Providers who already billed Medi-Cal for the reimbursement of a COVID-19 vaccine-only encounters and entered a billed amount less than $67 can void and resubmit their claims electronically following the instructions in the "Electronic Methods for Eligibility Transactions and Claim Submissions" section of the Part 1 provider manual. Providers who elect to void and resubmit claims via hard copy, must request a void using the

Claims Inquiry Form, and then resubmit the claim using the Appeal Form (90-1) once the provider has received confirmation of the void on their Remittance Advice Details.

DHCS has also indicated it intends to waive timely filing requirements for providers that appropriately held COVID-19 vaccine claims. "Late" claims should be filed with delay reason code "10" and remarks indicating a COVID-19 vaccine was administered. For more detailed instructions and links to claims forms, visit the DHCS site (**https://bit.ly/3OgMKEf**).

For COVID-19 vaccines that were administered during a qualifying office visit, FQHC, RHC, and Tribal FQHC providers are entitled to reimbursement at their individual PPS/APM rates. Providers are reminded that each administration of the COVID-19 vaccine either falls under a qualifying office visit or a vaccine-only encounter, not both.

Virtual Reality Can Be Adapted to Tackle Social Determinants of Health

Virtual reality (VR) (computer-produced settings where objects and scenes seem to be real, making users feel they are engrossed in their surroundings), is not merely used for fun and games anymore. Applications include business, military training, entertainment, and education.

In the field of medicine, VR technology offers educators a way to simplify obstacles that may exist such as scheduling, physical locations, and making representative scenarios for students to develop their clinical experience. Recently, a new Boston University School of Medicine (BUSM) study, reported in the journal *Academic Medicine*, presents the viability of using VR technology to concentrate on strategies for looking into social determinants of health (SDOH) using an interprofessional technique.

"The American Association of Medical Colleges (AAMC) has acknowledged the importance of training future physicians to identify and address SDOH, however medical students and physician assistants often lack this training. Social workers, meanwhile, have extensive SDOH training, however, few medical professionals have opportunities to engage in inter-professional training with social workers." –Pablo Buitron de la Vega, MD, MSc, Corresponding Author and Assistant Professor of Medicine, BUSM

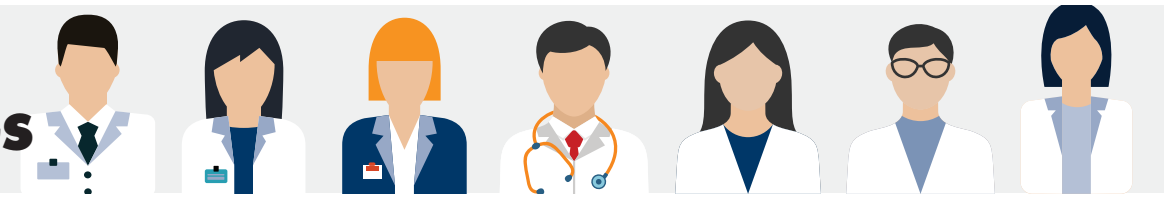
To test the scholastic influence of this emerging learning technology, physician assistant (PA), medical (MD), and social work (SW) students were engaged in VR simulated learning environments (SLEs) to learn how to look into SDOH collectively. PA and MD students learned patient engagement approaches from SW students, while the SW students improved their healthcare leadership capability.All three groups of students found this kind of learning acceptable, appreciating the hands-on VR inter-professional training and communicating interest in addition to learning more about the scope of one another's role and community resources accessible to patients. According to Buitron de la Vega, this research not only intended to enhance the ability of medical students to screen for SDOH but also to help nurture an inter-professional partnership between domains and a better understanding of the different roles essential to a comprehensive healthcare team.

Increased adoption of VR during the COVID-19 pandemic has decreased the cost associated with this type of technology and has made this a more realistic learning model for health professional schools to adopt in the future. –Pablo Buitron de la Vega, MD, MSc, Corresponding Author and AssistantProfessor of Medicine, BUSM

Journal Reference:

De La Vega, B., et al. (2022) Virtual Reality Simulated Learning Environments: A StrategyTo Teach Interprofessional Students About Social Determinants Of Health. AcademicMedicine. doi.org/10.1097/ACM.0000000000004776.
Source: https://www.bumc.bu.edu/busm/

JOB POSTINGS



FT/PT Emergency Department Physician Assistant
Emergency Medicine Specialists of Orange County
Orange

Part-time and full-time Emergency Medicine positions available at Providence, St. Joseph Hospital and Children's Hospital of Orange County. Our group has staffed the Emergency Departments at both hospitals since 1976. We provide competitive compensation and an outstanding, diverse work culture. This is a rare opportunity to join a truly premier, independent group of Emergency Medicine providers in an outstanding location in Orange County, CA. Please send your CV and cover letter to Cindy Carter and Dan Starr M.D. at ccarter@emsoc.net

Physician Assistant
Spine & Nerve Diagnostic Center
Granite Bay

Are you a proactive, sincere PA who wants to excel in one area of expertise—Pain Management? Are you naturally conscientious in completing your work and like to stay busy? This is a predictable, low risk-taking environment where we will support you to succeed. Despite being a narrowed specialty, there will still be variety in your work. We thrive on long-lasting relationships with our co-workers and our patients in an honest and respectful environment.

Spine & Nerve Diagnostic Center is a multidisciplinary, chronic pain group composed of physicians, Nurse Practitioners, Physician Assistants and ancillary practitioners. Our team of providers focuses on finding the cause of chronic pain, and then tailoring the most effective course of treatment for each patient. We are seeking a full-time Physician Assistant to join us.

The successful candidate will evaluate and direct patient care under our diagnostic guidelines and treatment protocols, including the use of proprietary interventional spine procedures, physical therapy, psychology, and responsible medication management. As a member of our clinical team, responsibilities would include:

- See approximately 18 patients per day
- Accurately monitor and formulate a differential diagnosis from assessments conducted within the clinic setting
- Evaluate and recommend treatment options pursuant to practice specific protocols and evidenced-based guidelines
- Review treatment related reports and correspondence
- Monitor and document the effectiveness of treatment in relation to patient pain, function, quality of life, and coping skills
- Work effectively and efficiently within Sutter's EPIC electronic medical records system
- Document collaborative discussions with and guidance from group physicians

Benefits & Compensation

- Health, dental, and vision
- Annual CME time-off and financial allowance
- PTO & Holidays
- 401(k)

Please submit a copy of your resume to mtong@spinenerve.com.

Principal Faculty
Touro University, California
Vallejo

The Principal Faculty is a member of the Touro University California College of Education and Health Sciences Joint Master of Science in Physician Assistant Studies/Master of Public Health Program. Primary responsibilities include teaching and evaluating students, serving as a student advisor, assisting in curriculum development, and serving as a member of committees essential to the functioning of the Program. (see capanet.org for full description)

Clinical Practice Responsibilities: PA/MD/DO/NP faculty will work one day at a local federally qualified health clinic providing mission-oriented care and precepting students on their clinical rotation. A stipend will be provided for faculty who perform these duties. Opportunities at the county exist in urgent care, psychiatry, family medicine, pediatrics, and women's health. PharmD faculty will have the option for a one-day clinical release to maintain clinical pharmacist practice. Faculty practicing one day/week are still responsible for the duties and responsibilities listed in their job descriptions.

Required:

- Master's degree or higher from a US accredited college or university
- Eligibility for licensure in the state of California as a physician assistant, nurse or advanced nurse practitioner, board-certified physician, or pharmacist
- Current NCCPA certification if a physician assistant
- A minimum of 3 years of clinical experience

Preference: A minimum of 2 years of teaching experience. An interest in public health

To apply, visit https://apptrkr.com/3134281

Physician Assistant, Otolaryngology/Head & Neck Surgery
Kaiser Permanente
Union City

This role will afford the opportunity to see and manage a wide variety of head and neck disease. Under the supervision of our surgeons, our Physician Assistant will be able to perform many in office procedures including but not limited to nasal endoscopy, laryngoscopy, excision of subcutaneous masses, epistaxis control, myringotomy and tube placement, incision and drainage of abscesses, nasal fracture reduction, ultrasound exams, and ultrasound guided fine needle aspiration.

We envision our Physician Assistants as high level providers, working at the top of their license. Our Physician Assistant will hone critical thinking, clinical decision making, and patient care skills through the collaboration and mentorship of MD colleagues. Our departmental onboarding process involves didactic learning sessions with our surgeons, gradual introduction of new patient problems and procedures, and continuous supervision and instruction. We aim to provide a supportive environment with ongoing learning opportunities and excellent work life balance.

Under the direction of supervising physicians, the Physician Assistant provides high quality, efficient, patient-focused care. The Physician Assistant responsibilities may include managing patients in the office, hospital, ED and/or perioperative setting. While primarily a clinic-based position, the physician assistant will also be needed to first assist in the operating room on occasion. The Physician Assistant's daily responsibilities may vary based upon the department & supervising physician needs.

Desired Candidate Attributes:

- Excellent communication and interpersonal skills
- Critical thinking/good clinical judgment
- Strong work ethic
- Adaptability/Flexibility
- Eagerness to learn/humility to identify areas for growth
- Initiative and motivation

To apply, please send a copy of your CV to: Sarfraz.Hussain@kp.org

Physician Assistant - Orthopaedics
Center for Orthopaedic Specialists
Tarzana

Center for Orthopaedic Specialists (COS) is actively seeking a highly qualified, full-time Physician Assistant who wants to be part of a dynamic, multi-specialty team, dedicated to providing the best musculoskeletal health care to the San Fernando Valley. COS consists of nine board-certified orthopaedic surgeons, actively seeing patients in four offices and all focused on providing the highest quality of care. Our practice has an immediate need for a PA that will work directly with two surgeons, specializing in total joint and sports medicine, with time split between the OR and clinic. Duties will also include medication refills for the group and regular after-hours office call, consisting of one day per week.

COS is affiliated with Providence Health & Services, which is a not-for-profit system of hospitals, clinics, and medical groups with a mission to serve everyone, especially the poor and vulnerable.

We offer a comprehensive compensation and benefits package. For more information about our practice and office locations, please visit: www.cosortho.com

Physician Assistant
Vistasol Management Inc
El Monte

Family Practice Medical Group looking for an energetic, motivated licensed Physician Assistant or Family Nurse Practitioner. full time. Locations in El Monte and Montebello. Spanish speaker preferred. shifts Monday to Friday . Experienced or new graduates welcome to apply as we are willing to train. Great working environment, opportunity to grow, benefits. Bilingual Spanish Preferred.

Associate Director, Admissions & Recruitment
University of California, San Diego
La Jolla

The University of California San Diego School of Medicine Physician Assistant Education program invites applications for a 12-month, full-time position to serve as founding Director of Admissions and Recruitment (DAR). In this role, the DAR is responsible for the coordination and supervision of the program's competitive admissions process and marketing/recruitment strategy.

The duties and responsibilities of the DAR are as follow:

- Manage recruitment and admission of students by overseeing the design, printing, and distribution of print and internet materials related to admissions and application materials
- Organize and lead recruitment events and functions
- Manage and respond to requests for information
- Prepare reports regarding the admission process as requested
- Serve as the primary academic advisor for program applicants

JOB POSTINGS continued

- Manage the receipt and review of all application materials and coordinate the activities of the program's selection committee.
- Monitor and maintain the program's web footprint
- Organize and lead annual admissions process and recruitment strategy evaluation and continuous improvement

Didactic teaching responsibilities include teaching, evaluating, and advising didactic and clinical year physician assistant students. This position includes a clinical release day to provide clinical care in the UCSD Medical Center system. Additional duties include but are not limited to the following:

- Attend meetings, committees, events, and activities of the Program, department, and University as assigned
- Participate in scholarly activity, professional activity, and research as mutually agreed with the program director
- Other duties and activities as assigned by the program director

Applying https://employment.ucsd.edu/director-of-admissions-and-recruitment-116658/job/19245644

The UCSD PA Program is also seeking to fill the positions of:
Associate Director, Research & Assessment
Associate Director, Didactic Education
Associate Director, Clinical Education and Simulation.

Please visit capanet.org for details.

Physician Assistant
Healthcare Service Partners Inc.
Rancho Santa Margarita

Healthcare Service Partners, Inc (HSP) is seeking a full-time Physician Assistant to join our team! This is a surgical first assist position, no rounding or clinic. Duties include surgical assisting for all surgical cases except cardiac.

Benefits

- Health insurance
- Vacation (PTO)
- Sick Time
- CME Time
- CME allowance
- Professional license
- Professional memberships
- Life and Short-Term disability policy
- IRA/Retirement with matching
- Annual bonus

To apply, send CV or resume to hspincorporated@gmail.com

Surgical First Assist PA
Sutter Health
Sacramento

Sutter Medical Group (SMG) seeks a full-time Surgical First Assist PA or RNFA to join our team in Sacramento, CA.

- Minimum 2+ years of clinical experience
- This position will primarily be in Sacramento, with some rotations in Roseville and Auburn.

This position is only inpatient first assisting with no patient care duties, i.e. no rounding, no call, and no clinic responsibilities. The position will be Monday through Friday, with no nights or weekends. The PA will assist with the following specialties: general, vascular, orthopedics, gynecology, and oncology with surgical platforms to include robotics, laparoscopic and open cases.

Robotic experience is a plus. However, all candidates will be considered with the appropriate training, background, and interpersonal skills. Applicant must be Nationally Certified and eligible for a California and DEA License.

Medical Group Information:

Sutter Medical Group is a successful, 1,100+ member multi-specialty group offering physicians the opportunity to build their practices within a progressive, financially sound, and collaborative organization. SMG is recognized as a Top Performing Physician Group by the Integrated Healthcare Association. Our members are dedicated to providing the highest quality and most complete health care possible to the people in the communities we serve in the greater Sacramento Valley Area of Amador, Placer, Sacramento, Solano, and Yolo Counties.

Join us and enjoy:

- Generous compensation with bonus potential
- Benefits package, including medical, dental, and vision
- 401(k) matching
- CME allowance
- Paid time off benefits (vacation, holiday, etc.)
- Robust retirement program
- A positive work-life balance and Northern California's natural beauty and lifestyle

Please email your resume to Develops@sutterhealth.org

CAPA
CALIFORNIA ACADEMY of PAs
Empowering Healthcare
11870 Santa Monica Blvd., Ste. 106580
Los Angeles, CA 90025
capanet.org

Address Service Requested

CAPACON2022

CALIFORNIA ACADEMY of PAs

Thursday, October 6th - Sunday, October 9th, 2022
Westin Carlsbad Resort & Spa
Carlsbad, CA

Held during PA Week, this 3.5-day conference will encompass lectures and hands-on workshops for a total of 48 Cat. 1 CME possible. But it's not all business! Check out CAPA's brand new career expo, the Student Challenge Bowl, and the CAPA exclusive Taste of Carlsbad food tour while you're there!

Early Bird Registration Ends August 1!

Early Bird Member $365 | After August 1 $525

CAPACareers

CAPA Student Challenge Bowl

A Taste of Carlsbad — Carlsbad Food Tours

REGISTER HERE