



## **Meeting Notice**

**February 3, 2011**

**Physician Assistant Committee  
UC Davis Medical Campus  
4610 "X" Street, Room 1204  
Sacramento, CA 95817  
9:15 A.M. – 5:00 P.M.**

## **AGENDA**

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

1. Call to Order by Chairman (Klompus)
2. Roll Call (Forsyth)
3. Approval of November 18, 2010 Meeting Minutes (Klompus)
4. Public Comment on Items not on the Agenda (Klompus)
5. Reports
  - a. Chair's Report (Klompus)
  - b. Executive Officer's Report (Portman)
  - c. Licensing Program Activity Report (Bronson)
  - d. Diversion Program Activity Report (Mitchell)
  - e. Enforcement Program Activity Report (Tincher)
6. Department of Consumer Affairs' Report (Stiger)
7. Report on the Physician Assistant Education and Training Subcommittee (Heppler)
8. Update on Health Care Reform (Portman)
9. Update on Enforcement Actions/Disciplinary Process (Heppler)
10. Maximus Presentation regarding the Diversion Program (Linda Ryan)
11. Legislation of Interest to the Physician Assistant Committee (Klompus)

12. Agenda Items for Next Meeting (Klompus)
13. **CLOSED SESSION:** Pursuant to Section 11126(c) (3) of the Government Code, the Committee will move into closed session to deliberate on disciplinary matters

RETURN TO OPEN SESSION

14. Adjournment (Klompus)

Note: Agenda discussion and report items are subject to action being taken on them during the meeting by the committee at its discretion. All times when stated are approximate and subject to change without prior notice at the discretion of the Committee. Agenda items may be taken out of order and total time allocated for public comment on particular issues may be limited.

Notice: The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Lynn Forsyth at (916) 561-8785 or email [Lynn.Forsyth@mbc.ca.gov](mailto:Lynn.Forsyth@mbc.ca.gov) or send a written request to the Physician Assistant Committee, 2005 Evergreen Street, Suite 1100, Sacramento, California 95815. Providing your request at least five (5) business days before the meeting will help to ensure availability of the request.



**Physician Assistant Committee**

2005 Evergreen Street, Suite 1100, Sacramento, CA 95815  
Telephone: (916) 561-8780 FAX: (916) 263-2671  
Website: [www.pac.ca.gov](http://www.pac.ca.gov) Email: [pacommittee@mbc.ca.gov](mailto:pacommittee@mbc.ca.gov)

**November 18, 2010**

**Physician Assistant Committee  
2005 Evergreen Street – Hearing Room 1150  
Sacramento, CA 95815  
9:15 A.M. – 5:00 P.M.**

1. Call to Order by Chairman

Chairman Klompus called the meeting to order at 9:20 a.m.

2. Roll Call

Staff called the roll. A quorum was present.

Committee Members Present: Steve Klompus, PA  
Roslynn Byous, PA, Ph.D.  
Cristina Gomez-Vidal Diaz  
Reginald Low, M.D.  
Shaquawn D. Schasa  
Steven Stumpf, Ph.D.  
Shelia Young

Staff Present: Elberta Portman, Executive Officer  
Kurt Heppler, Staff Counsel, Dept. of Consumer Affairs (DCA)  
Glenn Mitchell, Regulation and Lead Licensing Analyst  
Dianne Tincher, Enforcement Analyst  
Lynn Forsyth, Staff Services Analyst

3. Approval of Minutes of February 18, 2010 Meeting

The February 18, 2010 minutes were approved as written.  
(m/Byous, s/Dr. Low, motion passes)

Approval of Minutes of July 26, 2010 Meeting

After a brief discussion, the July 26, 2010 minutes were approved with the following amendment:

Motion to amend the July 26<sup>th</sup> minutes to attach to Item 15 the Briefing Paper on Title 16 of the California Code of Regulations, Section 1399.530, as submitted by legal counsel.  
(m/Young, s/Schasa, motion passes)

4. Public Comment on Items not on the Agenda

There were no comments received from the public for this agenda item.

5. Reports

a. Chair's Report

Chairman Klompus introduced Kurt Heppler, legal counsel for the Department of Consumer Affairs, who is temporarily tentatively assigned to the PAC in the absence of Claire Yazigi while on leave.

b. Executive Officer's Report

Ms. Portman reported that due to current budget conditions, the Department requested that every board to identify a 5% savings for the 2010/2011 fiscal year within the personnel services budget line item. Ms Portman stated that the requested 5% has been identified and communicated to DCA.

Ms. Portman stated that the PAC meeting agenda and packet is now available on the PAC website, in order to be more transparent and accessible to consumers and licensees.

Ms. Portman reported that staff continues to be busy with licensing, enforcement and the budget. Ms. Portman also reported she and Glenn Mitchell met with Richard Wonacott, Deputy Director, Division of Legislative and Policy Review, to discuss three legislative proposals for 2011.

Ms. Portman reported that she has been asked to participate on the Department's Policy Review Committee as a representative of a healing arts board.

Ms. Portman reported that Dianne Tincher is working on improvements to the PAC probation program. Ms. Portman also reported that Dianne has developed an initial contact letter for each probationer.

Ms. Portman reported that each board is tracking their performance measures for enforcement processing. All of the Performance Reports will be posted on the DCA website.

In the area of personnel, Ms. Portman reported the Consumer Protection Enforcement Initiative positions will not be filled at this time due to the current hiring freeze.

c. Licensing Program Activity Report

Between July 1, 2010 and October 2010, 241 physician assistant licenses were issued. As of October 1, 2010, 7,838 physician assistant licenses are renewed and current. Currently there are a total of 182 California approved training programs

d. Diversion Program Activity Report

As of October 1, 2010, the Diversion Program has 24 participants, 5 self-referred participants and 19 Committee referrals. There have been 97 participants since program implementation in 1990.

e. Enforcement Program Activity Report

Between July 1, 2009 and September 30, 2010 there were 75 pending complaints, 27 pending investigations, 42 current probationers and 25 pending cases at the Office of the Attorney General.

6. Department of Consumer Affairs' Report

Kim Kirchmeyer, Department of Consumer Affairs' Deputy Director, reported that on August 31<sup>st</sup> the Department received a Governor's directive to cease hiring employees. The directive stated that there may be limited circumstances where exceptions from the directive may be necessary for the preservation, protection of human life and safety, emergency disaster response, or the provision of 24 hour medical care. Only the most critical exceptions will be approved, and to date the department has had 5 exceptions granted. Ms. Kirchmeyer stated that personnel employed within the Department of Consumer Affairs are permitted to transfer internally.

On behalf of the Department, Ms. Kirchmeyer thanked the Committee for allowing the Executive Officer to go forward with proposed regulations regarding SB 1111. If approved, these regulations will allow the Executive Officer to expedite the investigation and prosecution process.

7. Presentation Regarding Committee Member's Role in Regard to Representations Made to the Public and Scope of Department of Consumer Affairs Legal Representation of the Committee

Staff Counsel, Kurt Heppler, gave a brief overview of Members' roles and legal representation of the Committee. He stated that the Committee itself (as a group) has the power to adopt regulations, disciplinary guidelines and establish policy. In certain circumstances that power may be granted to an individual member.

Staff Counsel, Kurt Heppler, explained that when legal issues arise the counsel's allegiance is limited to the Committee itself, not to individual members.

8. Consideration of Proposal to Amend Regulations Regarding Physician Assistant Training Program Approval by the Physician Assistant Committee (Article 3 of Division 13.8 of the California Code of Regulations)

Staff Counsel Kurt Heppler, stated that the purpose of regulation is to implement specific statutes. The Committee has legal authority to adopt, implement, interrupt, make specific

or otherwise carryout the provisions of a statute.

Mr. Heppler, stated that Business and Professions Code Section 3513 states, "Physician Assistant training programs that are accredited by a national accrediting agency approved by the Committee shall be deemed approved by the Committee under this section". Mr. Heppler stated that the Committee then adopted §1399.530(b) stated, "those educational programs accredited by the Accreditation Review Commission on Education for the Physician Assistant ("ARC-PA") shall be deemed approved by the Committee. Nothing in this section shall be construed to prohibit the committee from disapproving an educational program which does not comply with the requirements of this article. Approval under this section terminates automatically upon termination of an educational program's accreditation of ARC-PA."

Mr. Heppler stated that it is not the role of the Committee to provide PA training programs a "safe harbor" or "shelter" for civil litigation. The Committees' primary role is consumer protection.

During the public comment portion of this item, Michael De Rosa of Samuel Merritt University, stated that the current regulation conflicts with the new national accrediting standards. He added that he also believes that PA training programs may be in compliance with the national accreditation standards and perhaps are out of compliance with the PA regulations.

After a discussion, a motion was made to create a sub-committee consisting of interested parties, educators, committee members, and staff counsel to present proposals to the Committee at the next meeting.

(m/Dr. Low, s/Stumpf, motion passes)

9. Consideration of Proposal to Amend Regulations Regarding Requirements for Preceptors in Training Programs. (California Code of Regulations 1399.536)

After a brief discussion it was decided that this would be revisited within the previous item and discussed at the next meeting.

10. Nomination and Election of Physician Assistant Committee Officers

Ms. Young made a motion to nominate Steven Klompus as Chairperson. Motion was carried to elect Mr. Klompus as Chairman for 2011.

(m/Young, s/Diaz, motion passes)

Ms. Byous made a motion to nominate Shelia Young as Vice-Chairperson. Motion was carried to elect Ms. Young as Vice-Chairperson for 2011.

(m/Byous, s/Diaz, motion passes)

11. Approval of Passing Score for PA Initial Licensing Examinations and 2011 Dates and Locations for PA Initial Licensing Examination

Discussion ensued and a motion was made and seconded to approve the licensing examination scores and exam site locations for 2011.  
(m/Schasa, s/Stumpf, 1 abstention, motion passes)

12. Report of the Department of Consumer Affairs' July 27<sup>th</sup> Training Day

Ms. Schasa reported that the Department of Consumer Affairs' Training Day was conducted on July 27<sup>th</sup> at the Sacramento Public Library and presented by Director Brian Stiger. Ms. Schasa stated that the training was based in an open forum and covered DCA's roles and functions as well as DCA's goals and expectations from all committee members. Ms. Schasa also reported that the training was a great refresher course on expectations as members and an opportunity to interact with other members.

13. Report on Committee's Strategic Plan Accomplishments

Ms. Portman reported that the strategic plan objective for increased licensing fees was reviewed and it was determined that there is no current need to request a fee change. A regulation proposal is being processed to require Diversion program participants to pay their monitoring costs. Ms. Portman also reported that the current Physician Assistant application was recently revised to require the applicant to submit both the application fee and the initial license fee at the time the application is first submitted. This process reduces application processing times.

Ms. Portman reported that regarding the strategic plan objective for enforcement, an enforcement process flowchart has been posted on the website. The flowchart will provide information to consumers on how complaints are processed. The PAC is working on several regulations to enhance the enforcement program. Ms. Portman also reported that licensees are now required to report any convictions at the time they renew their license.

Ms. Portman reported that regarding the strategic plan objective for education and outreach, the PAC has made three visits to physician assistant training programs to provide and discuss licensing requirements, laws, regulations and other information of interest to the students.

Ms. Portman reported that regarding the objective for administrative efficiency, the PAC web site is constantly being enhanced and now includes more disciplinary information in order to inform interested parties, including consumers, and provide transparency.

14. Legislation of Interest to the Physician Assistant Committee

SB 294, SB 389, SB 1069, AB 471, AB 1310, AB 2386, AB 2699

The current status of the following bills was discussed:

SB 294, Authored by Negrete McLeod

Chaptered by Secretary of State. Chapter 695, Statutes of 2010

Among other things, this bill will make the Physician Assistant Committee inoperative on January 1, 2013 and repealed on January 1, 2014.

SB 1069, Authored by Senator Pavley

Chaptered by Secretary of State. Chapter 512, Statutes of 2010

This law makes changes to the Physician Assistant Practice Act regarding supervision of PAs, and authorizes a PA to perform physical exams and other specified medical services, and sign and attest to any document evidencing those examinations or other services. It also makes changes to other codes regarding performance of examinations.

AB 2699, Authored by Assembly Member Bass,

Chaptered by Secretary of State. Chapter 270, Statutes of 2010

This bill provides until January 1, 2014, an exemption from the licensure and regulation requirements for a health care practitioner (including PAs), who offers or provides health care services through a sponsored event. The PAC staff is working with DCA and other interested parties to implement this bill.

15. **1:00 PM Regulations Public Hearing**

Regulation hearing on Title 16, Division 13.8 of the California Code of Regulations, Section 1399.547 – Notification to Consumers

This proposal would implement Business and Professions Code Section 138 by requiring physician assistant licensees to notify consumers that they are licensed by the Physician Assistant Committee.

Business and Professions Code Section 138 requires that every board within the Department of Consumer Affairs adopt regulations requiring its licensees to provide notification to their customers that the practitioner is licensed by the state.

The regulatory hearing was called to order at 1:00 p.m. by Chairman Klompus. A full quorum was present. There was no oral or written testimony received. The hearing was closed at 1:10 p.m.

A motion was made to adopt the proposed regulatory changes to Title 16, Division 13.8 of the California Code of Regulations as described in the notice published in the California Regulatory Notice. The Committee also moved to authorize the Executive Officer to make non-substantive changes as may be necessary to finalizing the regulation's adoption. (m/Young, s/Schasa, motion passes)

16. **1:15 PM Regulations Public Hearing**

Regulation hearing on Title 16, Division 13.8 of the California Code of Regulations, Sections 1399.503, 1399.507.5, 1399.523, 1399.523.5, 1399.527.5 - Consumer Protection Initiative and Enhancements to Enforcement Program

This proposal would make specific regulatory changes to enhance the Committee's mandate of consumer protection.

This proposal would delegate authority to the Executive Officer the ability to accept default decisions, to approve settlement agreements for revocation, surrender, default decisions, or interim suspension of a license.

This proposal would authorize the Committee to order an applicant for licensure to submit to a physical or mental examination if it appears that the applicant may be unable to safely perform the duties and functions of a physician assistant due to physical or mental illness affecting competency. Additionally, if after receiving the evaluation report the Committee determines that the applicant is unable to practice safely, the Committee may deny the application.

This proposal would also require that in specific cases of a licensee having sexual contact with a patient or any finding that a licensee has committed a sex offense, or been convicted of a sex offense, a proposed decision would contain an order revoking the license. The proposed order could not contain an order staying the revocation of the license.

Additionally, this proposal would define required disciplinary action to be taken by the Committee against registered sex offenders who are applicants or licensees.

The proposal would, in addition to conduct described in Business and Professions Code Section 3527, define "Unprofessional Conduct" as prohibiting the inclusion of provisions in civil dispute settlement agreements prohibiting a person from contacting, cooperating with, filing, or withdrawing a complaint with the Committee.

The definition of "Unprofessional Conduct" would also include failure of the licensee to provide lawfully requested documents; the commission of any act of sexual abuse or misconduct; failure to cooperate with an investigation pending against the licensee; failure to report an indictment, charging a felony, arrest, conviction of the licensee; failure to report any disciplinary action taken by another licensing entity or authority; or failure to comply with a court order issued in the enforcement of a subpoena mandating the release of records to the Committee.

The regulatory hearing was called to order at 1:15 p.m. by Chairman Klompus. A full quorum was present.

A written comment was received from Joel S. Moskowitz, Attorney at Law. Mr. Moskowitz wrote in opposition to the proposed amendment to Section 1399.503. He stated that the measure, as drafted, does not conform to the Administrative Procedure Act. He added that the summary of the measure is misleading, and the effect is unwise, unfair and subject to abuse.

To address the concerns raised by Mr. Moskowitz, the following amendments to Section 1399.503 were proposed. Delete the phrase, "but not limited to" and delete "revocations."

Legal counsel, Kurt Heppler, stated that these amendments should address clarity and necessity issues with the proposed language. Additionally, the phrase "but not limited to" is imprecise should be eliminated.

Because licensees who have failed to respond to the Accusation or agreed to a Stipulated Settlement, there is little discretion for the Committee to exercise in those situations. Mr. Heppler added that licensees rarely agree to a revocation, therefore, this term was eliminated.

Mr. Heppler also stated that section 1399.527.5 should also be amended to eliminate the phrase, "but is not limited to," again because this phrase is imprecise.

A written comment was received from Stuart Seaborn of Disability Rights California. Mr. Seaborn stated that the proposed language ignores the Americans with Disabilities Act's requirement that an employer's decision to subject an employee to physical or mental examinations be based on objective evidence rather than the mere appearance of an issue that could affect the applicant's ability to perform.

Mr. Heppler stated that the applicant indicates on the application (question 18) if they have a condition which in any way impairs or limits their ability to practice medicine with reasonable skill and safety. An evaluation may be triggered by the applicant affirmatively acknowledging they have a condition which would impair or limit their ability to practice medicine. Each application would be reviewed on a case-by-case basis. All applicants must demonstrate fitness for licensure. To address Mr. Seaborn's concerns, Mr. Heppler recommended that the proposed language in Section 1399.507.5 be modified to state that an evaluation may be required whenever it reasonably appears that an applicant's ability to perform the duties of a physician assistant may be impaired by mental or physical illness.

A brief discussion ensued.

A motion was made to accept the following amendments to the proposed language for a 15-day comment period. The Committee also moved to authorize the Executive Officer to make non-substantive changes as may be necessary to finalizing the regulation's adoption.

- Section 1399.503: "including the ability to accept default decisions and the approve settlement agreements for the surrender or interim suspension of a license."
- Section 1399.507.5: "In addition to any other requirement for licensure, whenever it reasonably appears that an applicant for a license may be unable to perform as a physician assistant safely because the applicant's ability to perform may be impaired due to mental illness or physical illness affecting competency, the Committee may require the applicant to be examined by one or more physicians and surgeons or psychologists designated by the Committee."
- Section 1399.527.5: In addition to the conduct described in Section 3527 of the Code, "unprofessional conduct" also includes the following:"

(m/Diaz, s/Stumpf, motion passes)

The hearing was closed at 1:30 p.m.

## 17. Diversion Program Update

Glenn Mitchell, Regulation and Lead Licensing Analyst, gave a brief update on the Diversion Program. DCA is currently working with Maximus to implement provisions contained in SB 1441. Mr. Mitchell stated that currently there are 23 participants in the Diversion program.

18. Schedule of 2011 Meeting Dates and Locations

The Committee members agreed to the following dates and tentative locations as follows:

February 3<sup>rd</sup> UC Davis in Sacramento

May 19<sup>th</sup> Sacramento

August 25<sup>th</sup> Los Angeles/or location in the Central Valley

November 10<sup>th</sup> Sacramento

19. Agenda Items for Next Meeting

1. Report from the Physician Assistant Education and Training Sub-committee
2. CMA Diversion Committee
3. Update on Health Care Reform
4. Update on Breeze Program
5. Update on Enforcement Actions/disciplinary Process
6. Speaker from Maximus regarding the Diversion Program

20. **CLOSED SESSION:** Pursuant to Section 11126(c) (3) of the Government Code, the Committee will move into closed session to deliberate on disciplinary matters

21. **CLOSED SESSION:** Pursuant to Section 11126(a) (1) of the Government Code, the Committee will move into closed session to conduct the annual evaluation of the Executive Officer

**RETURN TO OPEN SESSION**

22. Adjournment

The meeting adjourned at 1:30 p.m.

**DEPARTMENT OF CONSUMER AFFAIRS**  
**BUDGET REPORT**  
**AS OF 12/31/2010**

PHYSICIAN ASSISTANT COMMITTEE  
 FM 06

PHYSICIAN ASSISTANT COMMITTEE

FM 06

PHYSICIAN ASSISTANT COMMITTEE

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
<b>PERSONAL SERVICES</b>								
<b>SALARIES AND WAGES</b>								
003 00 CIVIL SERVICE-PERM	202,263	16,076	92,569	0	0	92,569	109,694	
033 04 TEMP HELP (907)	0	2,237	10,358	0	0	10,358	(10,358)	
063 00 STATUTORY-EXEMPT	81,732	6,496	37,407	0	0	37,407	44,325	
063 03 COMM MEMBER (911)	16,000	900	1,700	0	0	1,700	14,300	
083 00 OVERTIME	0	0	10	0	0	10	(10)	
<b>TOTAL SALARIES AND WAGES</b>	<b>299,995</b>	<b>25,709</b>	<b>142,044</b>	<b>0</b>	<b>0</b>	<b>142,044</b>	<b>157,951</b>	<b>52.65%</b>
<b>STAFF BENEFITS</b>								
103 00 OASDI	20,340	1,347	7,772	0	0	7,772	12,568	
104 00 DENTAL INSURANCE	1,758	229	1,340	0	0	1,340	418	
105 00 HEALTH/WELFARE INS	36,657	2,878	15,940	0	0	15,940	20,717	
106 01 RETIREMENT	54,388	4,497	25,795	0	0	25,795	28,593	
125 00 WORKERS' COMPENSATIO	5,044	0	0	0	0	0	5,044	
125 15 SCIF ALLOCATION COST	0	127	881	0	0	881	(881)	
134 00 OTHER-STAFF BENEFITS	0	1,013	5,659	0	0	5,659	(5,659)	
134 01 TRANSIT DISCOUNT	0	0	56	0	0	56	(56)	
135 00 LIFE INSURANCE	0	8	50	0	0	50	(50)	
136 00 VISION CARE	445	35	218	0	0	218	227	
137 00 MEDICARE TAXATION	0	361	1,992	0	0	1,992	(1,992)	
<b>TOTAL STAFF BENEFITS</b>	<b>118,632</b>	<b>10,494</b>	<b>59,705</b>	<b>0</b>	<b>0</b>	<b>59,705</b>	<b>58,927</b>	<b>49.67%</b>
<b>SALARY SAVINGS</b>								
141 00 SALARY SAVINGS	(23,434)	0	0	0	0	0	(23,434)	
<b>TOTAL SALARY SAVINGS</b>	<b>(23,434)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(23,434)</b>	<b>100.00%</b>
<b>TOTAL PERSONAL SERVICES</b>	<b>395,193</b>	<b>36,204</b>	<b>201,748</b>	<b>0</b>	<b>0</b>	<b>201,748</b>	<b>193,445</b>	<b>48.95%</b>
<b>OPERATING EXPENSES &amp; EQUIPMENT</b>								
<b>FINGERPRINTS</b>								
213 04 FINGERPRINT REPORTS	24,890	561	3,264	0	0	3,264	21,626	
<b>TOTAL FINGERPRINTS</b>	<b>24,890</b>	<b>561</b>	<b>3,264</b>	<b>0</b>	<b>0</b>	<b>3,264</b>	<b>21,626</b>	<b>86.89%</b>
<b>GENERAL EXPENSE</b>								
201 00 GENERAL EXPENSE	6,557	0	0	0	0	0	6,557	
206 00 MISC OFFICE SUPPLIES	0	486	525	0	0	525	(525)	
207 00 FREIGHT & DRAYAGE	0	86	92	0	0	92	(92)	

DEPARTMENT OF CONSUMER AFFAIRS

PHYSICIAN ASSISTANT COMMITTEE

BUDGET REPORT

AS OF 12/31/2010

FM 06

RUN DATE 1/12/2011  
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PHYSICIAN ASSISTANT COMMITTEE

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
213 02 ADMIN OVERHEAD-OTHR	0	20	220	0	220	(220)	
217 00 MTG/CONF/EXHIBIT/SHO	0	561	2,024	5,778	7,801	(7,801)	
<b>TOTAL GENERAL EXPENSE</b>	<b>6,557</b>	<b>1,153</b>	<b>2,860</b>	<b>5,778</b>	<b>8,637</b>	<b>(2,080)</b>	<b>-31.73%</b>
<b>PRINTING</b>	<b>4,673</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>4,673</b>	
241 00 PRINTING	0	2	21	0	21	(21)	
242 02 REPRODUCTION SVS	0	0	309	1,011	1,320	(1,320)	
244 00 OFFICE COPIER EXP	0	2	330	1,011	1,341	3,332	71.30%
<b>TOTAL PRINTING</b>	<b>4,673</b>	<b>2</b>	<b>330</b>	<b>1,011</b>	<b>1,341</b>	<b>3,332</b>	<b>71.30%</b>
<b>COMMUNICATIONS</b>	<b>8,339</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8,339</b>	
251 00 COMMUNICATIONS	0	242	1,121	0	1,121	(1,121)	
252 00 CELL PHONES,PDA,PAGE	0	146	506	0	506	(506)	
257 01 TELEPHONE EXCHANGE	0	389	1,627	0	1,627	6,712	80.49%
<b>TOTAL COMMUNICATIONS</b>	<b>8,339</b>	<b>389</b>	<b>1,627</b>	<b>0</b>	<b>1,627</b>	<b>6,712</b>	<b>80.49%</b>
<b>POSTAGE</b>	<b>19,230</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>19,230</b>	
261 00 POSTAGE	0	1	11	0	11	(11)	
262 00 STAMPS, STAMP ENVEL	0	0	1,321	0	1,321	(1,321)	
263 05 ALLOCATED POSTAGE-DC	0	0	747	0	747	(747)	
263 06 ALLOCATED POSTAGE-ED	0	1	2,078	0	2,078	17,152	89.19%
<b>TOTAL POSTAGE</b>	<b>19,230</b>	<b>1</b>	<b>2,078</b>	<b>0</b>	<b>2,078</b>	<b>17,152</b>	<b>89.19%</b>
<b>TRAVEL: IN-STATE</b>	<b>28,299</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>28,299</b>	
291 00 TRAVEL: IN-STATE	0	0	892	0	892	(892)	
292 00 PER DIEM-I/S	0	0	1,268	0	1,268	(1,268)	
294 00 COMMERCIAL AIR-I/S	0	0	525	0	525	(525)	
296 00 PRIVATE CAR-I/S	0	86	326	0	326	(326)	
297 00 RENTAL CAR-I/S	0	0	60	0	60	(60)	
301 00 TAXI & SHUTTLE SERV-	0	86	3,072	0	3,072	25,227	89.14%
<b>TOTAL TRAVEL: IN-STATE</b>	<b>28,299</b>	<b>86</b>	<b>3,072</b>	<b>0</b>	<b>3,072</b>	<b>25,227</b>	<b>89.14%</b>
<b>TRAINING</b>	<b>1,096</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,096</b>	
331 00 TRAINING	0	0	0	0	0	1,096	100.00%
<b>TOTAL TRAINING</b>	<b>1,096</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,096</b>	<b>100.00%</b>
<b>FACILITIES OPERATIONS</b>	<b>55,958</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>55,958</b>	
341 00 FACILITIES OPERATION	0	3,526	21,313	21,473	42,786	(42,786)	
343 00 RENT-BLDG/GRND/NON S	0	64	318	0	318	(318)	
347 00 FACILITY PLING-DGS	0	0	0	0	0	0	

DEPARTMENT OF CONSUMER AFFAIRS

PHYSICIAN ASSISTANT COMMITTEE

BUDGET REPORT  
AS OF 12/31/2010

RUN DATE 1/12/2011  
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PHYSICIAN ASSISTANT COMMITTEE

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
<b>TOTAL FACILITIES OPERATIONS</b>	55,958	3,589	21,631	21,473	43,104	12,854	22.97%
<b>C/P SVS - INTERDEPARTMENTAL</b>							
382 00 CONSULT/PROF-INTERDE	1,899	0	0	0	0	1,899	
<b>TOTAL C/P SVS - INTERDEPARTMENTAL</b>	<b>1,899</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,899</b>	<b>100.00%</b>
<b>C/P SVS - EXTERNAL</b>							
402 00 CONSULT/PROF SERV-EX	28,561	0	0	0	0	28,561	
418 02 CONS/PROF SVS-EXTRNL	0	5,804	24,993	50,054	75,046	(75,046)	
<b>TOTAL C/P SVS - EXTERNAL</b>	<b>28,561</b>	<b>5,804</b>	<b>24,993</b>	<b>50,054</b>	<b>75,046</b>	<b>(46,485)</b>	<b>-162.76%</b>
<b>DEPARTMENTAL SERVICES</b>							
424 03 OIS PRO RATA	55,877	3,879	23,275	0	23,275	32,602	
427 00 INDIRECT DISTRB COST	43,726	3,498	20,990	0	20,990	22,736	
427 01 INTERAGENCY SVS	7,717	0	0	0	0	7,717	
427 02 SHARED SVS-MBC ONLY	98,682	24,671	49,342	49,340	98,682	0	
427 30 DOI - PRO RATA	1,479	140	842	0	842	637	
427 34 PUBLIC AFFAIRS PRO R	3,015	308	1,850	0	1,850	1,165	
427 35 CCED PRO RATA	1,835	170	1,019	0	1,019	816	
<b>TOTAL DEPARTMENTAL SERVICES</b>	<b>212,331</b>	<b>32,666</b>	<b>97,318</b>	<b>49,340</b>	<b>146,658</b>	<b>65,673</b>	<b>30.93%</b>
<b>CONSOLIDATED DATA CENTERS</b>							
428 00 CONSOLIDATED DATA CE	5,128	1,056	1,434	1,066	2,500	2,628	
<b>TOTAL CONSOLIDATED DATA CENTERS</b>	<b>5,128</b>	<b>1,056</b>	<b>1,434</b>	<b>1,066</b>	<b>2,500</b>	<b>2,628</b>	<b>51.25%</b>
<b>DATA PROCESSING</b>							
432 00 MAINTENANCE-IT	3,086	0	0	0	0	3,086	
<b>TOTAL DATA PROCESSING</b>	<b>3,086</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3,086</b>	<b>100.00%</b>
<b>CENTRAL ADMINISTRATIVE SERVICES</b>							
438 00 PRO RATA	42,294	0	21,147	0	21,147	21,147	
<b>TOTAL CENTRAL ADMINISTRATIVE SERVICES</b>	<b>42,294</b>	<b>0</b>	<b>21,147</b>	<b>0</b>	<b>21,147</b>	<b>21,147</b>	<b>50.00%</b>
<b>MAJOR EQUIPMENT</b>							
452 00 REPLACEMENT-EQPT	13,000	0	0	0	0	13,000	
472 00 ADDITIONAL EQUIPMENT	6,000	0	0	0	0	6,000	
<b>TOTAL MAJOR EQUIPMENT</b>	<b>19,000</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>19,000</b>	<b>100.00%</b>
<b>ENFORCEMENT</b>							
396 00 ATTORNEY GENL-INTERD	246,418	24,170	160,040	0	160,040	86,378	
397 00 OFC ADMIN HEARNG-INT	75,251	22,375	35,855	0	35,855	39,396	
414 31 EVIDENCE/WITNESS FEE	492	337	6,923	0	6,923	(6,431)	

# DEPARTMENT OF CONSUMER AFFAIRS

## BUDGET REPORT AS OF 12/31/2010

RUN DATE 1/12/2011  
PAGE 4

PHYSICIAN ASSISTANT COMMITTEE

FM 06

PHYSICIAN ASSISTANT COMMITTEE

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
418 97 COURT REPORTER SERV'S	0	0	1,629	0	1,629	(1,629)	
427 32 INVEST SVS-MBC ONLY	205,870	7,819	56,267	0	56,267	149,603	
<u>TOTAL ENFORCEMENT</u>	<u>528,031</u>	<u>54,701</u>	<u>260,713</u>	<u>0</u>	<u>260,713</u>	<u>267,318</u>	<u>50.63%</u>
<b>MINOR EQUIPMENT</b>							
226 00 MINOR EQUIPMENT	4,000	0	0	0	0	4,000	
<u>TOTAL MINOR EQUIPMENT</u>	<u>4,000</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>4,000</u>	<u>100.00%</u>
<u>TOTAL OPERATING EXPENSES &amp; EQUIPMEN</u>	<u>993,372</u>	<u>100,008</u>	<u>440,466</u>	<u>128,721</u>	<u>569,187</u>	<u>424,185</u>	<u>42.70%</u>
<b>PHYSICIAN ASSISTANT COMMITTEE</b>							
	<u>1,388,565</u>	<u>136,212</u>	<u>642,215</u>	<u>128,721</u>	<u>770,935</u>	<u>617,630</u>	<u>44.48%</u>
	<u>1,388,565</u>	<u>136,212</u>	<u>642,215</u>	<u>128,721</u>	<u>770,935</u>	<u>617,630</u>	<u>44.48%</u>

# **Physician Assistant Committee**

## **Meetings – 2011**

February 3, 2011 – Sacramento

May 19, 2011 – Possible Southern California

August 25, 2011 – Sacramento

November 10 2011 - Sacramento

# State Pay Period Calendar for 2011

## JANUARY 2011 21 Days 168 Hours

SU	M	TU	W	TH	F	SA
					1	
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

## FEBRUARY 2011 21 Days 168 Hours

SU	M	TU	W	TH	F	SA
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	1				

## MARCH 2011 22 Days 176 Hours

SU	M	TU	W	TH	F	SA
			2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

## APRIL 2011 21 Days 168 Hours

SU	M	TU	W	TH	F	SA
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

## MAY 2011 22 Days 176 Hours

SU	M	TU	W	TH	F	SA
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

## JUNE 2011 22 Days 176 Hours

SU	M	TU	W	TH	F	SA
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

## JULY 2011 22 Days 176 Hours

SU	M	TU	W	TH	F	SA
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1					

## AUGUST 2011 22 Days 176 Hours

SU	M	TU	W	TH	F	SA
		2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

## SEPTEMBER 2011 22 Days 176 Hours

SU	M	TU	W	TH	F	SA
			1	2	3	
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

## OCTOBER 2011 21 Days 168 Hours

SU	M	TU	W	TH	F	SA
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

## NOVEMBER 2011 22 Days 176 Hours

SU	M	TU	W	TH	F	SA
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

## DECEMBER 2011 22 Days 176 Hours

SU	M	TU	W	TH	F	SA
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

**PHYSICIAN ASSISTANT COMMITTEE**

**LICENSING PROGRAM ACTIVITY**

*Submitted by: Linda Bronson*

**INITIAL LICENSES**

	<i>Oct 1, 2010 – Dec 1, 2010</i>	<i>Oct 1, 2009 – Dec 1, 2009</i>
<i>Initial Licenses</i>	<i>126</i>	<i>158</i>

**SUMMARY OF RENEWED/CURRENT LICENSES**

	<i>As of Dec 1, 2010</i>	<i>As of Dec 1, 2009</i>
<i>Physician Assistant</i>	<i>7,988</i>	<i>7,834</i>

**PHYSICIAN ASSISTANT TRAINING PROGRAMS**

*Pending Applications*            *0*  
*Currently Approved*            *157*

**PHYSICIAN ASSISTANT COMMITTEE  
DIVERSION PROGRAM**

**ACTIVITY REPORT**

California licensed physician assistants participating in the Physician Assistant Committee drug and alcohol diversion program:

	As of 1 February 2011	As of 1 February 2010	As of 1 February 2009
Voluntary referrals	05	07	05
Committee referrals	20	13	12
Total number of participants	25	20	17

**HISTORICAL STATISTICS**

(Since program inception: 1990)

Total intakes into program as of 1 February 2011.....	98
Closed Cases as of 1 February 2011	
• Participant expired.....	1
• Successful completion.....	20
• Dismissed for failure to receive benefit.....	4
• Dismissed for non-compliance.....	23
• Voluntary withdrawal.....	18
• Not eligible.....	7
Total closed cases.....	73

**OTHER DCA BOARD DIVERSION PROGRAM PARTICIPANTS**

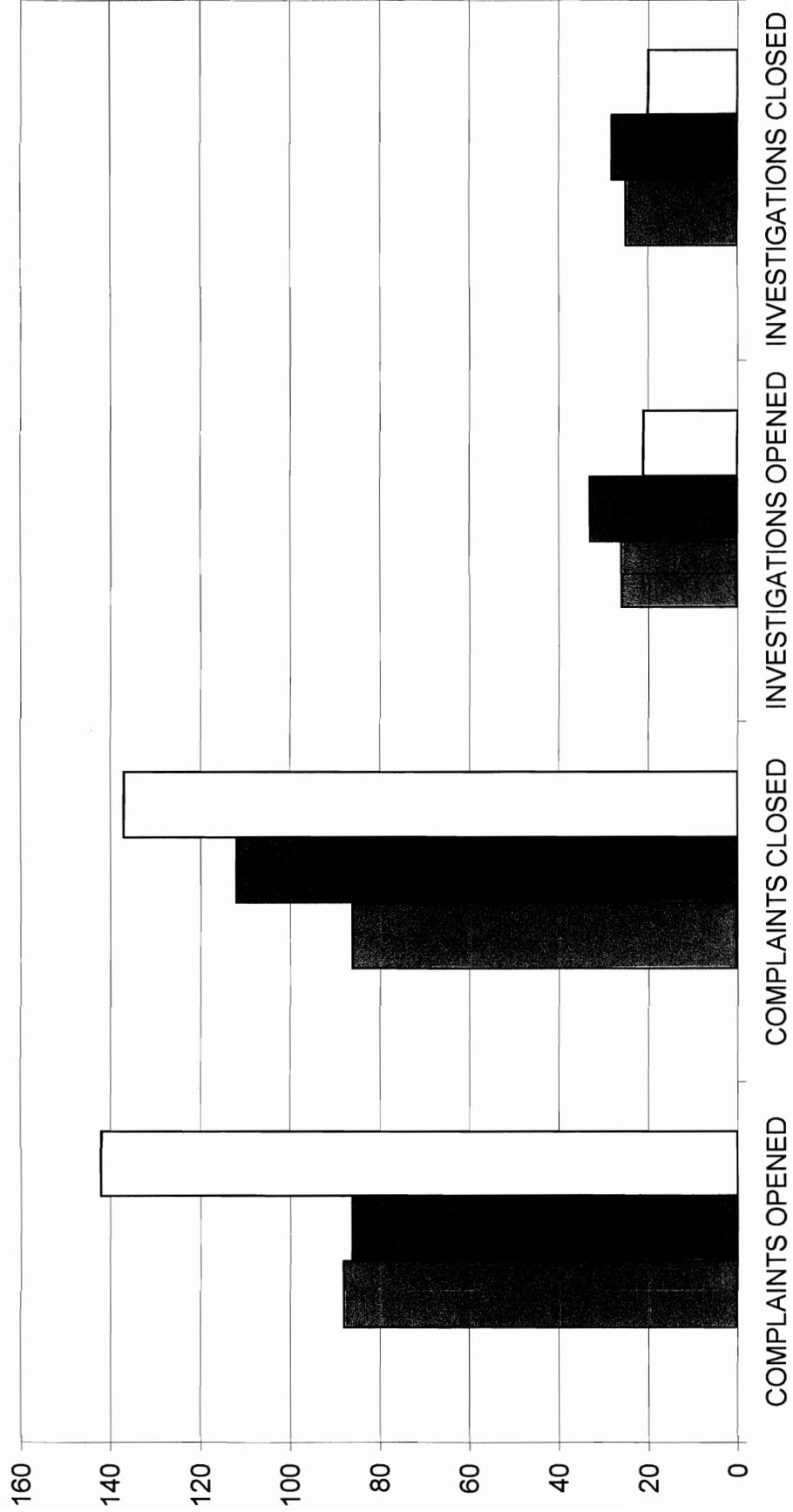
(As of 31 December 2010)

Dental Board of California.....	42
Osteopathic Medical Board of California.....	09
Board of Pharmacy.....	76
Physical Therapy Board of California.....	16
Board of Registered Nursing.....	493
Veterinary Board of California.....	4

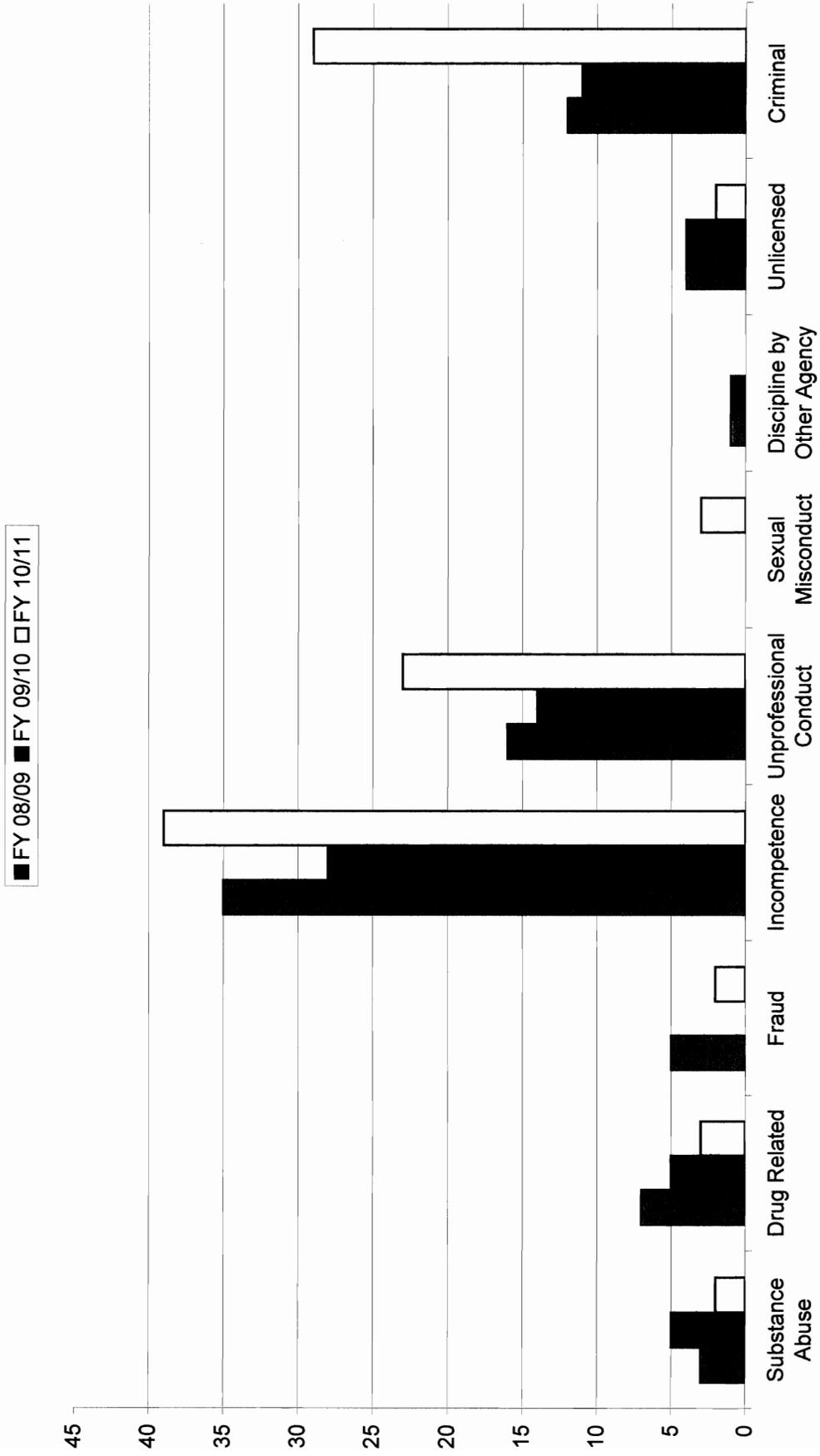


**PHYSICIAN ASSISTANT COMMITTEE  
COMPLAINTS AND INVESTIGATIONS  
JULY 1 THROUGH DECEMBER 31**

■ FY 08/09 ■ FY 09/10 □ FY 10/11

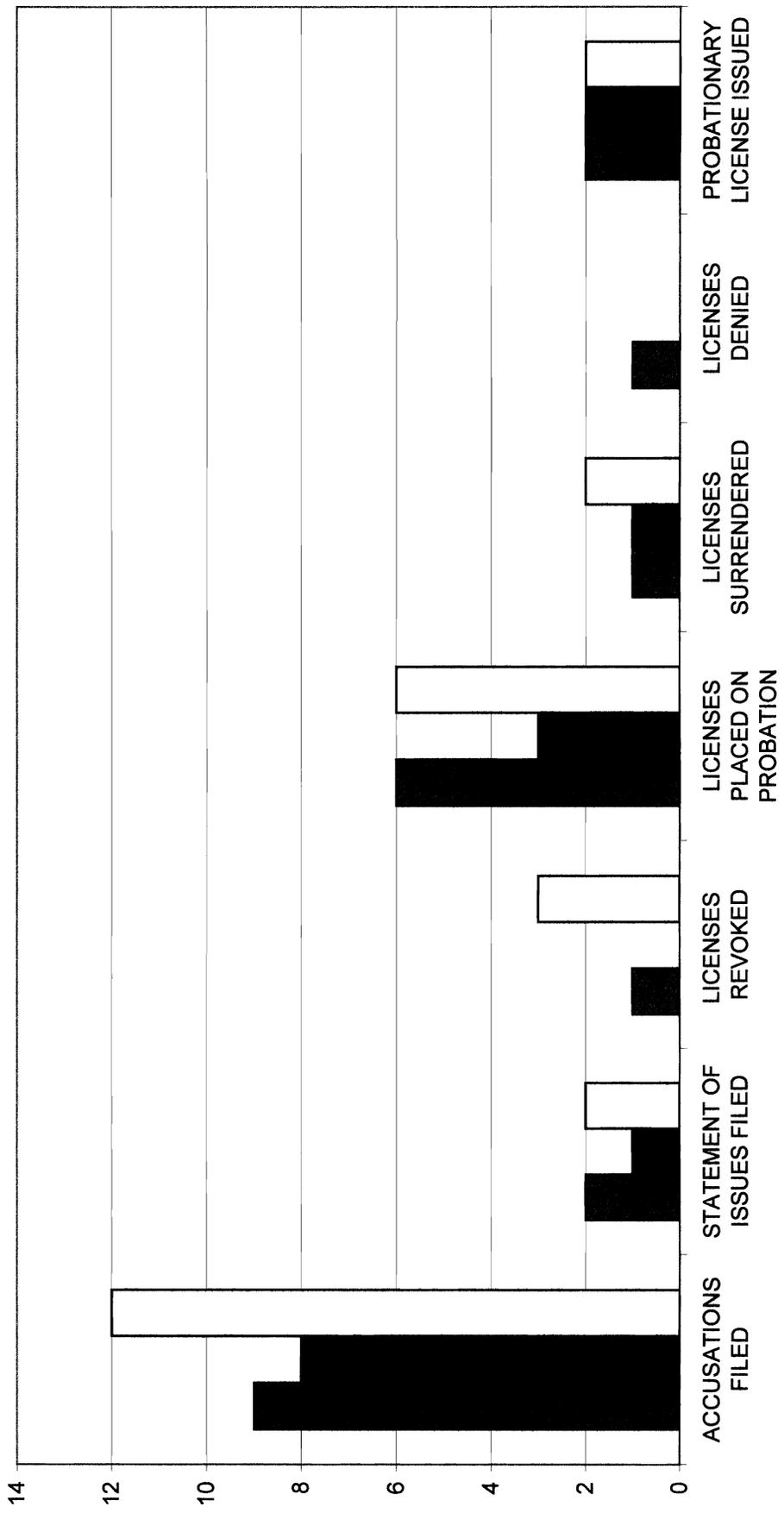


**PHYSICIAN ASSISTANT COMMITTEE  
CATEGORY OF COMPLAINTS RECEIVED  
JULY 1 THROUGH DECEMBER 31**

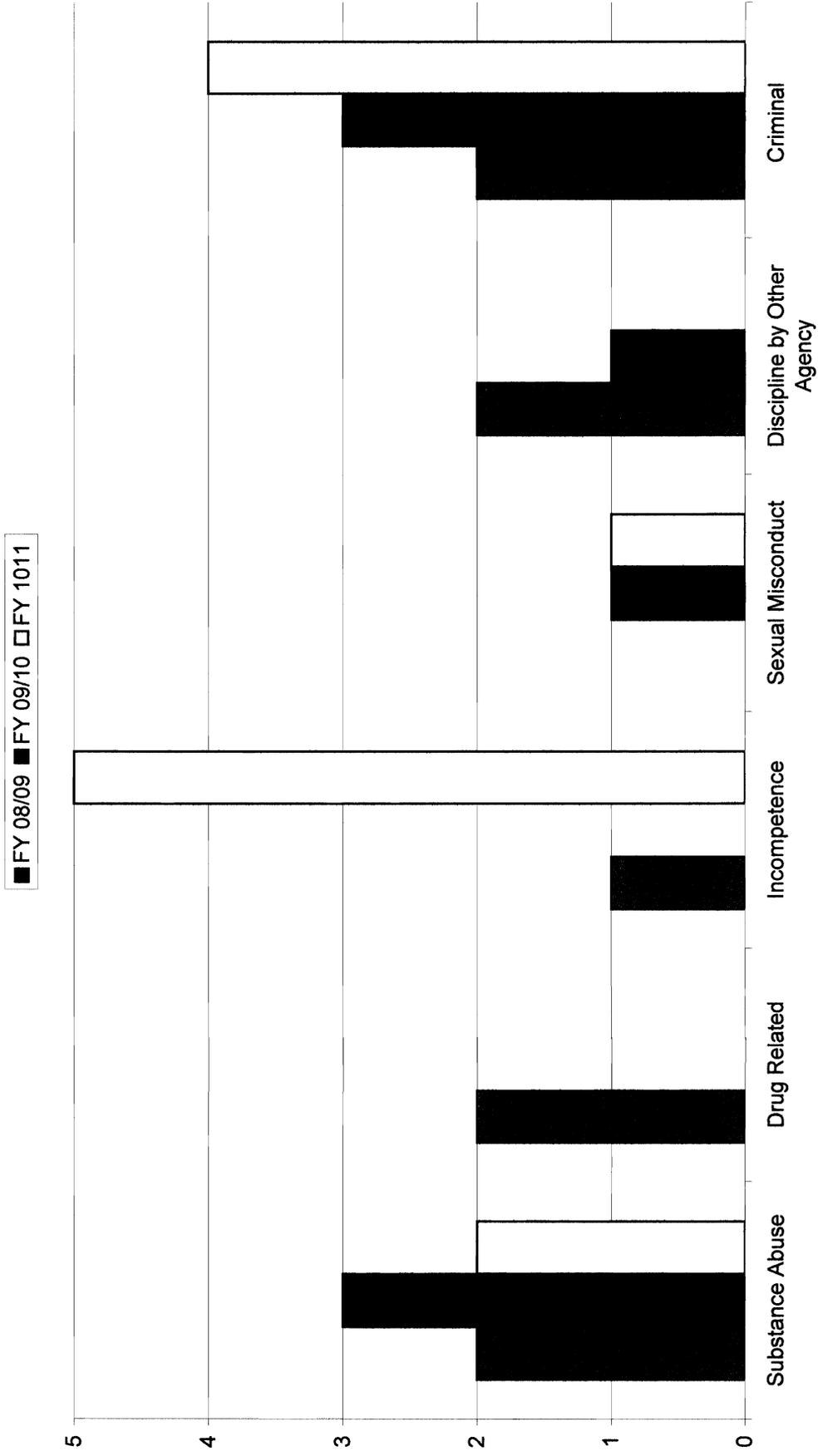


**PHYSICIAN ASSISTANT COMMITTEE  
DISCIPLINARY ACTIONS  
JULY 1 THROUGH DECEMBER 31**

■ FY 08/09 ■ FY 09/10 □ FY 10/11



**PHYSICIAN ASSISTANT COMMITTEE  
CATEGORY OF ACCUSATIONS FILED  
JULY 1 THROUGH DECEMBER 31**



**Physician Assistant Committee  
Cases Over 8 Months Old  
As of December 31, 2010**

***Investigations***

Total Number of Investigations pending: 31

Number of Investigations over 8 months old: 15

Status of Cases over 8 months old:

<b><u># of cases</u></b>	<b><u>Status</u></b>
8	Scheduling/subpoena for Interview/records
1	At Medical consultant
3	Obtaining medical records
2	Working on final report
1	Working within MBC priorities/staffing

***Disciplinary Actions***

Total Number of Disciplinary Cases pending: 22

Number of Disciplinary Cases over 8 months old: 7

Status of Cases over 8 months old:

<b><u># of cases</u></b>	<b><u>Status</u></b>
3	Waiting for hearing date
1	Working on Accusation
1	Working on Stipulation
1	Waiting for effective date of decision
1	Non adopt

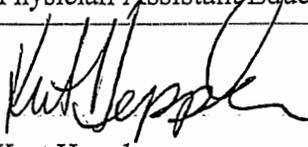
**Physician Assistant Committee  
Cost Recovery  
As of December 31, 2010**

<u>Cost Recovery</u>	<u>Amount</u>	<u># of Probationers</u>
Ordered over last 5 years	\$194,913	37
Received over last 5 years	\$103,578	44
Outstanding balance	\$ 93,466	17
Uncollectable amount*	\$ 90,899	12

\*The uncollectable amount is from licenses that were surrendered, revoked, or sent to FTB over the last 5 years. The cost recovery would be required to be paid in full if they applied for a reinstatement of the license.



## MEMORANDUM

<b>DATE</b>	January 12, 2011
<b>TO</b>	Members, Physician Assistant Education Subcommittee
<b>FROM</b>	 Kurt Heppler Senior Staff Counsel
<b>SUBJECT</b>	Proposed Revisions to Section 1399.530 and Following Of Title 16 of the California Code of Regulations

This memo offers guidance to the members of the Physician Assistant Education Subcommittee (Subcommittee) as they contemplate making recommendations to the Physician Assistant Committee (Committee) regarding possible revisions to the relevant regulations relating to the approval of physician assistant (PA) training and educational programs. The Subcommittee was tasked with the responsibility of reviewing the existing regulatory scheme to determine if it reflects the current PA educational environment.

### I. *Background*

As the Subcommittee considers its task, perhaps some background information would prove helpful. The Committee is the state agency charged with the responsibilities of licensing PA's and disciplining those who violate the applicable statutes and regulations. (See Bus. & Prof. Code, §§ 3509, 3527.)<sup>1</sup> The Committee has the obligation to establish standards and issue licenses of approval for the education and training of PA's. (§ 3509, subd. (a).) Specifically, Section 3513 of the Code provides:

“The committee shall recognize the approval of training programs for physician assistants approved by a national accrediting organization. Physician assistant training programs accredited by a *national accrediting agency approved by the committee shall be deemed approved by the committee under this section*. If no national accrediting organization is approved by the committee, the committee may examine and pass upon the qualification of, and may issue certificates of approval for, programs for the education and training of physician assistants that meet committee standards.” (Emphasis added.)

<sup>1</sup> All further statutory references are to the Business and Professions Code unless otherwise indicated.

## SUBCOMMITTEE MEMBERS

January 12, 2011

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The purpose of a regulation is to implement, interpret or make specific statute. The test for a valid regulation is that it must be: 1) consistent and not in conflict with the statute and 2) reasonably necessary to effectuate the purpose of the statute. (Gov. Code, § 13342.2.) To this end, the Committee has adopted section 1399.530 of title 16 of the California Code of Regulations, which provides:

“(a) A program for instruction of physician assistants shall meet the following requirements for approval:

(1) The educational program shall be established in educational institutions accredited by an accrediting agency recognized by Council for Higher Education Accreditation ("CHEA") or its successor organization, or the U.S. Department of Education, Division of Accreditation, which are affiliated with clinical facilities that have been evaluated by the educational program.

(2) The educational program shall develop an evaluation mechanism to determine the effectiveness of its theoretical and clinical program.

(3) Course work shall carry academic credit; however, an educational program may enroll students who elect to complete such course work without academic credit.

(4) The medical director of the educational program shall be a physician who holds a current license to practice medicine from any state or territory of the United States or, if the program is located in California, holds a current California license to practice \_\_\_\_\_ medicine.

(5) The educational program shall require a three-month preceptorship for each student in the outpatient practice of a physician or equivalent experience which may be integrated throughout the program or may occur as the final part of the educational program in accordance with Sections 1399.535 and 1399.536.

(6) Each program shall submit an annual report regarding its compliance with this section on a form provided by the committee.

(b) *Those educational programs accredited by the Accreditation Review Commission on Education for the Physician Assistant ("ARC-PA") shall be deemed approved by the committee.* Nothing in this section shall be construed to prohibit the committee from disapproving an educational program which does not comply with the requirements of this article. Approval under this section terminates automatically upon termination of an educational program's accreditation of ARC-PA.” (Emphasis added.)

In practical, real world terms, the Committee relies on ARC-PA's accreditation almost exclusively. If an educational program is accredited by ARC-PA, the Committee considers the program approved and no further inquiry on the part of the Committee is conducted.

While reliance of ARC-PA's accreditation may seem like a straightforward endeavor, the matter is complicated by other existing regulations adopted by the Committee. Of particular interest is section 1399.536 of the CCR, which provides:

“(a) Preceptors participating in the preceptorship of an approved program shall:

(1) Be *licensed physicians* who are engaged in the practice of medicine which practice is sufficient to adequately expose preceptees to a full range of experience. The practice need

## SUBCOMMITTEE MEMBERS

January 12, 2011

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not be restricted to an office setting but may take place in licensed facilities, such as hospitals, clinics, etc.

(2) Not have had the privilege to practice medicine terminated, suspended, or otherwise restricted as a result of a final disciplinary action (excluding judicial review of that action) by any state medical board or any agency of the federal government, including the military, within 5 years immediately preceding his or her participation in a preceptorship.

(3) By reason of medical education, specialty and nature of practice be sufficiently qualified to teach and supervise preceptees.

(4) *Not be assigned to supervise more than one preceptee at a time.*

(5) Teach and supervise the preceptee in accordance with the provisions and limitations of sections 1399.540 and 1399.541.

(6) Shall in conjunction with his or her use of a preceptee, charge a fee for only those personal and identifiable services which he or she, the preceptor, renders. The services of the preceptee shall be considered as part of the global services provided and there shall be no separate billing for the services rendered by the preceptee.

(7) Obtain the necessary patient consent as required in section 1399.538.

(b) It shall be the responsibility of the approved program to assure that preceptors comply with the foregoing requirements.” (Emphasis added.)

While section 1399.536 addresses preceptors, other sections of the Committee’s regulations speak to curricula and other components necessary for program approval.

### II. *Possible Inconsistency Between ARC-PA Accreditation Standards and the Committee’s Regulations and Items to Consider If Revisions are Warranted*

The Committee understands that ARC-PA’s accreditation standards may not be consistent with its regulations, as the standards allow for licensed healthcare providers other than licensed physicians and surgeons to act as preceptors, and allows preceptor-preceptee ratios in excess of one-to-one. Consequently, an education program – one accredited by ARC-PA and therefore deemed approved by the Committee – may not be in compliance with the Committee’s own regulations. There may be other inconsistencies as well.

It is presumably not prudent public policy for the Committee to have in place regulations that may be inconsistent as applied to PA training programs. As the Subcommittee tackles this issue, the following concepts should be considered:

1. **Public Protection.** Whenever the Committee exercises its licensing, disciplinary, or regulatory functions, consumer protection is the highest priority. (See §3504.1.)

2. **Training Environment and its Current Status.** The sections related to preceptors and training was first adopted more than twenty-five years ago. If the Subcommittee suggests amendments or revisions to the relevant regulatory sections, it may well want to consider the current national and in-state training PA educational requirements. This concept is critically important if the Committee elected not to rely on another entity’s accreditation and approve

SUBCOMMITTEE MEMBERS

January 12, 2011

Page 4

educational programs itself. At this time, the Committee does not have the staff, resources or the educational expertise to directly approve PA training programs.

**3. Regulatory Standards.** If the Subcommittee recommends regulatory changes or amendments, the proposed regulations must meet clarity, necessity, and other standards. In other words, the revisions must be precise, specific, and necessary. For example, if the Committee elected to allow other healthcare providers to act as preceptors, it must define with particularity who those providers are.

I look forward to the Subcommittee's meeting on January 19, 2011. Please contact me if you have any questions.

## REPORT ON THE PHYSICIAN ASSISTANT EDUCATION AND TRAINING PROGRAM

### BUSINESS AND PROFESSIONS CODE

**3509.** It shall be the duty of the committee to:

- (a) Establish standards and issue licenses of approval for programs for the education and training of physician assistants.
- (b) Make recommendations to the board concerning the scope of practice for physician assistants.
- (c) Make recommendations to the board concerning the formulation of guidelines for the consideration of applications by licensed physicians to supervise physician assistants and approval of such applications.
- (d) Require the examination of applicants for licensure as a physician assistant who meet the requirements of this chapter.

### CALIFORNIA CODE OF REGULATIONS

#### Article 3. Education and Training

##### **1399.528. Identification of a Primary Care Physician's Assistant and Trainees in Approved Programs**

HISTORY:

1. Renumbering and amendment to section 1399.539 filed 9-20-83; effective thirtieth day thereafter (Register 83, No. 39).

##### **1399.530. General Requirements for an Approved Program.**

(a) A program for instruction of physician assistants shall meet the following requirements for approval:

(1) The educational program shall be established in educational institutions accredited by an accrediting agency recognized by Council for Higher Education Accreditation ("CHEA") or its successor organization, or the U.S. Department of Education, Division of Accreditation, which are affiliated with clinical facilities that have been evaluated by the educational program.

(2) The educational program shall develop an evaluation mechanism to determine the effectiveness of its theoretical and clinical program.

(3) Course work shall carry academic credit; however, an educational program may enroll students who elect to complete such course work without academic credit.

(4) The medical director of the educational program shall be a physician who holds a current license to practice medicine from any state or territory of the United States or, if the program is located in California, holds a current California

license to practice medicine.

(5) The educational program shall require a three-month preceptorship for each student in the outpatient practice of a physician or equivalent experience which may be integrated throughout the program or may occur as the final part of the educational program in accordance with Sections 1399.535 and 1399.536.

(6) Each program shall submit an annual report regarding its compliance with this section on a form provided by the committee.

(b) Those educational programs accredited by the Accreditation Review Commission on Education for the Physician Assistant ("ARC-PA") shall be deemed approved by the committee. Nothing in this section shall be construed to prohibit the committee from disapproving an educational program which does not comply with the requirements of this article. Approval under this section terminates automatically upon termination of an educational program's accreditation of ARC-PA.

NOTE: Authority cited: Section 3510, Business and Professions Code.

Reference: Sections 3509 and 3513, Business and Professions Code.

HISTORY:

<sup>1</sup>. Renumbering and amendment of former section 1399.524 to section 1399.530 filed 9-20-83; effective thirtieth day thereafter (Register 83, No. 39).

2. Renumbering and amendment of former article 3 heading to article 4, redesignation of sections 1399.530–1399.532, 1399.535, 1399.536, 1399.538 and 1399.539 as new article 3, and amendment of section 1399.530(a) and (f) filed 7-18-85; effective thirtieth day thereafter (Register 85, No. 32).

3. Amendment filed 1-8-90; operative 2-7-90 (Register 90, No. 3).

4. Change without regulatory effect amending subsection (a) filed 7-25-94 pursuant to section 100, Title 1, California Code of Regulations (Register 94, No. 30).

5. Amendment filed 11-21-2000; operative 12-21-2000 (Register 2000, No. 47).

6. Change without regulatory effect amending section filed 3-3-2005 pursuant to section 100, title 1, California Code of Regulations (Register 2005, No. 9).

**1399.531. Curriculum Requirements for an Approved Program for Primary Care Physician Assistants.**

(a) The curriculum of a program for instruction of primary care physician assistants shall include adequate theoretical instruction in or shall require as prerequisites to entry into the program the following basic education core:

- (1) Chemistry
- (2) Mathematics, which includes coursework in algebra
- (3) English
- (4) Anatomy and Physiology
- (5) Microbiology
- (6) Sociology or cultural anthropology
- (7) Psychology

All instruction in the basic education core shall be at the junior college level or its equivalent with the exception of chemistry which may be at the junior college or high school level.

(b) The curriculum of an educational program shall also include or require as prerequisites adequate theoretical and clinical instruction which includes direct patient contact where appropriate, in the following clinical science core:

- (1) Community Health and Preventive Medicine
- (2) Mental Health
- (3) History taking and physical diagnosis
- (4) Management of common diseases (acute, chronic, and emergent) including first aid
- (5) Concepts in clinical medicine and surgery, such as:
  - growth and development
  - nutrition
  - aging
  - infection
  - allergy and sensitivity
  - tissue healing and repair
  - oncology
- (6) Common laboratory and screening techniques
- (7) Common medical and surgical procedures
- (8) Therapeutics, including pharmacology
- (9) Medical ethics and law
- (10) Medical socioeconomics
- (11) Counseling techniques and interpersonal dynamics

NOTE: Authority cited: Section 3510, Business and Professions Code. Reference cited: Sections 3509 and 3513, Business and Professions Code.

HISTORY:

1. Renumbering and amendment of former Section 1399.525 to Section 1399.531 filed 9-20-83; effective thirtieth day thereafter (Register 83 No. 39).
2. Amendment filed 1-8-90; operative 2-7-90 (Register 90, No. 3).
3. Repealer of subsection (a)(1), subsection renumbering, amendment of paragraph preceding subsection (b) and repealer of subsection (c) filed 11-21-2000; operative 12-21-2000 (Register 2000, No.47).

**1399.532. Requirements for an Approved Program for the Specialty Training of Physician Assistants.**

A program for the specialty training of physician assistants shall meet the general requirements of Section 1399.530, except that a specialty training program need not be located in an educational institution and need not provide academic credit for its coursework, and shall either

- (a) accept only trainees who have completed a primary care training program;
- or,
- (b) provide the curriculum set forth in Section 1399.531 in addition to any specialty instruction it may provide.

NOTE: Authority cited: Section 3510, Business and Professions Code. Reference: Sections 3509 and 3513, Business and Professions Code.

HISTORY:

1. New section filed 9-20-83; effective thirtieth day thereafter (Register 83, No. 39).
2. Amendment filed 3-17-87; effective thirtieth day thereafter (Register 87, No. 12).

**1399.535. Requirements for Preceptorship Training.**

An approved program shall have a preceptorship training program which meets the following criteria:

- (a) Continuous orientation of preceptors to the goals and purposes of the total educational program as well as the preceptorship training;
- (b) Establishment of a program whereby the preceptor shall not be the sole person responsible for the clinical instruction or evaluation of the preceptee.

NOTE: Authority cited: Section 3510, Business and Professions Code.

Reference: Sections 3509 and 3513, Business and Professions Code.

HISTORY: 1. Renumbering and amendment of former section 1399.526 to section 1399.535 filed 9-20-83; effective thirtieth day thereafter (Register 83, No. 39).

**1399.536. Requirements for Preceptors.**

- (a) Preceptors participating in the preceptorship of an approved program shall:
  - (1) Be licensed physicians who are engaged in the practice of medicine which practice is sufficient to adequately expose preceptees to a full range of experience. The practice need not be restricted to an office setting but may take place in licensed facilities, such as hospitals, clinics, etc.
  - (2) Not have had the privilege to practice medicine terminated, suspended, or otherwise restricted as a result of a final disciplinary action (excluding judicial review of that action) by any state medical board or any agency of the federal government, including the military, within 5 years immediately preceding his or her participation in a preceptorship.
  - (3) By reason of medical education, specialty and nature of practice be sufficiently qualified to teach and supervise preceptees.
  - (4) Not be assigned to supervise more than one preceptee at a time.
  - (5) Teach and supervise the preceptee in accordance with the provisions and limitations of sections 1399.540 and 1399.541.
  - (6) Shall in conjunction with his or her use of a preceptee, charge a fee for only those personal and identifiable services which he or she, the preceptor, renders. The services of the preceptee shall be considered as part of the global services provided and there shall be no separate billing for the services rendered by the preceptee.
  - (7) Obtain the necessary patient consent as required in section 1399.538.
- (b) It shall be the responsibility of the approved program to assure that preceptors comply with the foregoing requirements.

NOTE: Authority cited: Section 3510, Business and Professions Code.

Reference: Sections 3509 and 3513, Business and Professions Code.

HISTORY:

1. Renumbering and amendment of former section 1399.527 to section 1399.536

filed 9-20-83; effective thirtieth day thereafter (Register 83, No. 39).

2. Change without regulatory effect filed 2-5-91 pursuant to section 100, Title 1, California Code of Regulations (Register 91, No. 11).

3. Amendment of subsection (a)(2) filed 11-21-2000; operative 12-21-2000 (Register 2000, No. 47).

**1399.538. Patient Informed Consent.**

No trainee including preceptees in any approved program shall render general medical services to any patient except in emergencies unless said patient has been informed that such services will be rendered by that trainee. In cases where the medical service to be rendered by the trainee is surgical in nature or where the trainee is to assist in a surgical procedure except in emergencies, the patient on each occasion shall be informed of the procedure to be performed by that trainee under the supervision of the program's instructors or physician preceptors and have consented in writing prior to performance to permit such rendering of the surgical procedure by the trainee. It shall be the responsibility of the approved educational program to assure that the instructors or physician preceptors obtain the necessary consent.

NOTE: Authority cited: Section 3510, Business and Professions Code.

Reference: Section 3513, Business and Professions Code.

HISTORY:

1. Renumbering and amendment of former section 1399.510 to section 1399.538 filed 9-20-83; effective thirtieth day thereafter (Register 83, No. 39).

**1399.539. Identification of Trainees in Approved Programs.**

A trainee enrolled in an approved program for physician assistants shall at all times wear an identification badge on an outer garment and in plain view, which states the student's name and the title:

PHYSICIAN ASSISTANT STUDENT  
or  
PHYSICIAN ASSISTANT TRAINEE

NOTE: Authority cited: Section 3510, Business and Professions Code.

Reference: Sections 3509 and 3513, Business and Professions Code.

HISTORY:

1. Renumbering and amendment of former section 1399.528 to section 1399.539 filed 9-20-83; effective thirtieth day thereafter (Register 83, No. 39).

## SECTION A: ADMINISTRATION

### INTRODUCTION

The administrative operation of a PA program involves collaboration between the faculty and administrative staff of the program and the sponsoring institution. As such, the sponsoring institution is explicitly committed to the success of the program. The program provides an environment that fosters intellectual challenge and a spirit of inquiry. Well-defined policies reflect the missions and *goals* of the program and sponsoring institution. Program documents *accurately* reflect lines of institutional and programmatic responsibility as well as individual responsibilities. Resources support the program in accomplishing its mission.

### A1 SPONSORSHIP

- A1.01 When more than one institution is involved in the provision of academic and/or clinical education, responsibilities of the respective institutions for instruction and supervision of students *must* be clearly described and documented in a manner signifying agreement by the involved institutions.
- A1.02 There *must* be written and signed agreements between the PA program and/or sponsoring institution and the *clinical affiliates* used for *supervised clinical practice experiences* that define the responsibilities of each party related to the educational program for students.

ANNOTATION: Agreements typically specify whose policies govern and document student access to educational resources and clinical experiences. While one agreement between the sponsoring institution and clinical entity to cover multiple professional disciplines is acceptable, these agreements include specific notations acknowledging the terms of participation between the PA program and clinical entity.

### Institution Responsibilities

- A1.03 The sponsoring institution is responsible for:
- a) supporting the planning by *program faculty* of curriculum design, course selection and program assessment,
  - b) hiring faculty and staff,
  - c) complying with ARC-PA accreditation *Standards* and policies,
  - d) permanently maintaining student transcripts,
  - e) conferring the credential and/or academic degree which documents satisfactory completion of the educational program,
  - f) ensuring that all PA personnel and student policies are consistent with federal and state statutes, rules and regulations,
  - g) addressing appropriate security and personal safety measures for PA students and faculty in all locations where instruction occurs and
  - h) *teaching out* currently matriculated students in accordance with the institution's regional accreditor or federal law in the event of program closure and/or loss of accreditation.

- A1.04 The sponsoring institution *must* provide the opportunity for continuing professional development of the program director and *principal faculty* by supporting the development of their clinical, teaching, scholarly and administrative skills.

ANNOTATION: Professional development involves remaining current with clinical and academic skills and developing new skills needed for position responsibilities. The types of opportunities supported by institutions vary and may include supporting the PA *principal faculty* members in maintaining their *NCCPA* certification status, funding to attend continuing education conferences, non-vacation time to attend professional organizational meetings, funding to attend professional organizational meetings, time for clinical practice, time for research/scholarly activities, time to pursue advanced degree and/or tuition remission for an advanced degree, payment of dues and fees related to certification maintenance and/or time needed for review and study.

- A1.05 The sponsoring institution *must* provide academic and *student health services* to PA students that are *equivalent* to those services provided other *comparable* students of the institution.

ANNOTATION: Academic *student services* typically include academic advising, tutoring, career services, financial aid, computing and library.

- A1.06 The sponsoring institution *should* provide PA students and faculty at geographically *distant campus* locations *comparable* access to services and resources that help students reach their academic and career *goals* similar to those available to students and faculty on the main campus.

ANNOTATION: The types of services and resources that help students reach their academic and career *goals* typically include academic advising, tutoring, career services, financial aid, computing and library resources and access. Faculty services and resources include those that are available to *instructional faculty* at the main campus, such as computing and technology resources, library resources and access and employee assistance. The program is expected to inform students and faculty if certain services are only available to them on the main campus.

#### Institution Resources

- A1.07 The sponsoring institution *must* provide the program with *sufficient* financial resources to operate the educational program and fulfill obligations to matriculating and enrolled students.

- A1.08 The sponsoring institution *must* provide the program with the human resources necessary to operate the educational program and to fulfill obligations to matriculating and enrolled students.

ANNOTATION: Human resources include the faculty and staff needed on a daily and ongoing basis, as well as those needed for specific program related activities such as maintaining records and processing admission applications. They include *sufficient administrative* and *technical support staff* to support faculty in accomplishing their assigned tasks. Student-workers may be used, but do not substitute for *administrative* and *technical support staff*.

ANNOTATION: The number of *principal faculty* may need to exceed the 3.0 FTE minimum in order to accommodate student needs in larger programs and, depending upon the academic and administrative complexity of the program and responsibilities assigned to faculty within the program.

A2.04 *Principal faculty* and the program director *should* have academic appointments and privileges *comparable* to other faculty with similar academic responsibilities in the institution.

A2.05 *Principal faculty* and the program director *must* actively participate in the processes of:

- a) developing, reviewing and revising as necessary the mission statement for the program,
- b) selecting applicants for admission to the PA program,
- c) providing student instruction,
- d) evaluating student performance,
- e) academic counseling of students,
- f) assuring the availability of remedial instruction,
- g) designing, implementing, coordinating, evaluating curriculum and
- h) evaluating the program.

ANNOTATION: Not every *principal faculty* member is expected to participate in each of the program related activities. Other individuals involved in the program may also participate in these activities.

#### Program Director

A2.06 The program director *must* be a PA or a physician.<sup>3</sup>

- a) If the program director is a PA, s/he *must* hold current *NCCPA* certification.<sup>3</sup>
- b) If the program director is a physician, s/he *must* hold current licensure as an allopathic or osteopathic physician in the state in which the program exists and *must* be certified by an *ABMS-* or *AOA-*approved specialty board.<sup>4</sup>

A2.07 The program director *must* not be the medical director.

A2.08 The program director *must* provide effective leadership and management.

A2.09 The program director *must* be knowledgeable about and responsible for program:

- a) organization,
- b) administration,
- c) fiscal management,
- d) continuous review and *analysis*,
- e) planning,
- f) development and
- g) participation in the accreditation process.

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<sup>3</sup> Programs accredited prior to 9/1/10 will be held to this standard only when a new program director is appointed.

<sup>4</sup> Physician program directors appointed before 3/1/06 *should* be board certified, those appointed on or after 3/1/06 *must* be board certified.

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A2.10 The program director *must* supervise the medical director, principal and *instructional faculty* and staff in all activities that directly relate to the PA program.

Medical Director

A2.11 The medical director *must* be:  
a) a currently licensed allopathic or osteopathic physician<sup>5</sup> and  
b) certified by an ABMS- or AOA-approved specialty board.<sup>6</sup>

A2.12 The medical director *must* be an active participant in the program.

ANNOTATION: The medical director supports the program director in insuring that both didactic instruction and *supervised clinical practice experiences* meet current practice standards as they relate to the PA role in providing patient care. The medical director is actively involved in developing the mission statement for the program; providing instruction; evaluating student performance; designing, implementing, coordinating and evaluating curriculum and evaluating the program.

Instructional Faculty

A2.13 *Instructional faculty must* be:  
a) qualified through academic preparation and/or experience to teach assigned subjects and  
b) knowledgeable in course content and effective in teaching assigned subjects.

ANNOTATION: *Instructional faculty* include more than physician assistants. They include individuals with advanced degrees, experience or previous academic background in a field or discipline.

A2.14 In addition to the *principal faculty*, there *must* be *sufficient instructional faculty* to provide students with the necessary attention, instruction and *supervised clinical practice experiences* to acquire the knowledge and competence required for entry into the profession.

ANNOTATION: *Instructional faculty* participate in the evaluation of student performance and in the identification of students who are not achieving course and program *learning outcomes*.

A2.15 The program *should* not rely primarily on resident physicians for didactic or clinical instruction.

A2.16 All *instructional faculty* serving as *supervised clinical practice experience preceptors* *must* hold a valid license that allows them to practice at the clinical site.

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<sup>5</sup> Medical directors appointed on or after 3/1/06 *should* have their current licensure in the state in which the program exists.

<sup>6</sup> Medical directors appointed before 3/1/06 *should* be board certified, those appointed on or after 3/1/06 *must* be board certified.

### Student Records

- A3.19 Student files kept by the program *must* include documentation:
- a) that the student has met *published* admission criteria including *advanced placement* if awarded,
  - b) that the student has met institution and program health screening and immunization requirements,
  - c) of student performance while enrolled,
  - d) of *remediation* efforts and outcomes,
  - e) of summaries of any formal academic/behavioral disciplinary action taken against a student and
  - f) that the student has met requirements for program completion.
- A3.20 PA students *must* not have access to the academic records or other confidential information of other students or faculty.
- A3.21 Student *health records* are confidential and *must* not be accessible to or reviewed by *program, principal or instructional faculty* or staff except for immunization and tuberculosis screening results which may be maintained and released with written permission from the student.

### Faculty Records

- A3.22 *Principal faculty* records *must* include:
- a) current job descriptions that include duties and responsibilities specific to each *principal faculty* member and
  - b) current curriculum vitae.
- A3.23 The program *must* have current curriculum vitae for each *course director*.

## **SECTION B: CURRICULUM AND INSTRUCTION**

### INTRODUCTION

The program curriculum prepares students to provide patient centered care and collegially work in physician-PA teams in an interprofessional team environment. The curriculum establishes a strong foundation in health information technology and evidence-based medicine and emphasizes the importance of remaining current with the changing nature of clinical practice.

Section B addresses all aspects of the curriculum. The professional curriculum for PA education includes applied medical, behavioral and social sciences; patient assessment and clinical medicine; supervised clinical practice; and health policy and professional practice issues. Issues relating to individual professional responsibility and working in the health care delivery system are included in the clinical preparatory section of this *Standards* section and apply to supervised clinical practice settings in the clinical curriculum.

Programs need not have discrete courses for each of the instructional areas discussed within this section. However, *learning outcomes* related to all instructional areas are important elements of the curriculum and course syllabi.

The standards in section B1 apply to the entire curriculum of the program and have application to all curricular components.

## **B1 CURRICULUM**

- B1.01 The curriculum *must* be consistent with the mission and *goals* of the program.
- B1.02 The curriculum *must* include core knowledge about established and evolving biomedical and clinical sciences and the application of this knowledge to patient care.
- B1.03 The curriculum *must* be of *sufficient* breadth and depth to prepare the student for the clinical practice of medicine.
- B1.04 The curriculum design *must* reflect sequencing that enables students to develop the *competencies* necessary for current and evolving clinical practice.

ANNOTATION: The concept of sequencing refers to the coordination and integration of content both horizontally and vertically across the curriculum. It does not mandate that content be delivered in separate courses with traditional discipline names. Appropriate sequencing involves considering overall program design and integration of content. Content and course sequencing *should* build upon previously achieved student learning.

- B1.05 The curriculum *must* include instruction about intellectual honesty and appropriate academic and professional conduct.
- B1.06 The curriculum *must* include instruction to prepare students to provide medical care to patients from diverse populations.

ANNOTATION: Quality health care education involves an ongoing consideration of the constantly changing health care system and the impact of racial, ethnic and socioeconomic health disparities on health care delivery. Instruction related to medical care and *diversity* prepares students to evaluate their own values and avoid stereotyping. It assists them in becoming aware of differing health beliefs, values and expectations of patients and other health care professionals that can affect communication, decision-making, compliance and health outcomes.

- B1.07 The curriculum *must* include instruction related to the development of problem solving and medical decision-making skills.
- B1.08 The curriculum *must* include instruction to prepare students to work collaboratively in interprofessional patient centered teams.

ANNOTATION: Such instruction includes content on the roles and responsibilities of various health care professionals, emphasizing the team approach to patient centered care beyond the traditional physician-PA team approach. It assists students in learning the principles of interprofessional practice and includes opportunities for students to apply these principles in interprofessional teams within the curriculum.

- B1.09 For each didactic and clinical course, the program *must* define and publish *instructional objectives* that guide student acquisition of required *competencies*.

ANNOTATION: *Instructional objectives* stated in measurable terms allow assessment of student progress in developing the *competencies* required for entry into practice. They address learning expectations of students and the level of student performance required for success.

- B1.10 The program *should* orient *instructional faculty* to the specific *learning outcomes* it requires of students.

ANNOTATION: Program and *principal faculty* need to work collaboratively with *instructional faculty* in designing courses with appropriate *learning outcomes* and student assessment tools that reflect the *learning outcomes* expected of students.

- B1.11 The program *must* ensure educational equivalency of course content, student experience and access to didactic and laboratory materials when instruction is:
- a) conducted at geographically separate locations and/or
  - b) provided by different pedagogical and instructional methods or techniques for some students.

## **B2 CLINICAL PREPARATORY INSTRUCTION**

- B2.01 While programs may require specific course(s) as prerequisites to enrollment, those prerequisites *must* not substitute for more advanced applied content within the professional component of the program.
- B2.02 The program curriculum *must* include instruction in the following areas of applied medical sciences and their application in clinical practice:
- a) anatomy,
  - b) physiology,
  - c) pathophysiology,
  - d) pharmacology and pharmacotherapeutics,
  - e) the genetic and molecular mechanisms of health and disease.
- B2.03 The program curriculum *must* include instruction in clinical medicine covering all organ systems.
- B2.04 The program curriculum *must* include instruction in interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families and other health professionals.
- B2.05 The program curriculum *must* include instruction in patient evaluation, diagnosis and management.

ANNOTATION: Instruction in patient assessment and management includes caring for patients of all ages from initial presentation through ongoing follow-up. It includes instruction in interviewing and eliciting a medical history; performing complete and focused physical examinations; generating differential diagnoses; and ordering and interpreting diagnostic studies. Patient management instruction addresses acute and

longitudinal management. Instruction related to treatment plans is patient centered and inclusive, addressing medical issues, patient education and referral.

- B2.06 The program curriculum *must* include instruction in the provision of clinical medical care across the life span.

ANNOTATION: Preclinical instruction prepares PAs to provide preventive, emergent, acute, chronic, rehabilitative, palliative and end-of-life care. It includes content relevant to prenatal, infant, children, adolescent, adult and elderly populations.

- B2.07 The program curriculum *must* include instruction in technical skills and procedures based on current professional practice.

- B2.08 The program curriculum *must* include instruction in the social and behavioral sciences as well as normal and abnormal development across the life span.

ANNOTATION: Social and behavioral sciences prepare students for primary care practice. Instruction includes detection and treatment of substance abuse; human sexuality; issues of death, dying and loss; response to illness, injury and stress; principles of violence identification and prevention; and psychiatric/behavioral conditions.

- B2.09 The program curriculum *must* include instruction in basic counseling and patient education skills.

ANNOTATION: Instruction in counseling and patient education skills is patient centered, culturally sensitive and focused on helping patients cope with illness, injury and stress, adhere to prescribed treatment plans and modify their behaviors to more healthful patterns.

- B2.10 The program curriculum *must* include instruction to prepare students to search, interpret and evaluate the medical literature, including its application to individualized patient care.

ANNOTATION: This instruction assists students in maintaining a critical, current and operational knowledge of new medical findings required for the prevention and treatment of disease. Instruction often includes topics such as framing of research questions, sampling methods, interpretation of basic biostatistical methods, and the limits of medical research. The use of common medical databases to access medical literature is also included.

- B2.11 The program curriculum *must* include instruction in health care delivery systems and health policy.

- B2.12 The program curriculum *must* include instruction in concepts of public health as they relate to the role of the practicing PA.

ANNOTATION: Instruction in concepts of public health includes an appreciation of the public health system and the role of health care providers in the prevention of disease and maintenance of population health. It includes participating in disease surveillance, reporting and intervention.

- B2.13 The program curriculum *must* include instruction in patient safety, quality improvement, prevention of medical errors and risk management.
- B2.14 The program curriculum *must* include instruction about PA licensure, credentialing and laws and regulations regarding professional practice.
- B2.15 The program curriculum *must* include instruction regarding reimbursement, documentation of care, coding and billing.
- B2.16 The program curriculum *must* include instruction in the principles and practice of medical ethics.
- B2.17 The program curriculum *must* include instruction in the PA profession, its historical development and current trends.

ANNOTATION: Instruction related to PA professional issues addresses the physician-PA team relationship, political issues that affect PA practice, the PA professional organizations.

### **B3 SUPERVISED CLINICAL PRACTICE**

- B3.01 PA students *must* be clearly identified in the clinical setting to distinguish them from physicians, medical students and other health profession students and graduates.
- B3.02 *Supervised clinical practice experiences must* enable students to meet program expectations and acquire the *competencies* needed for clinical PA practice.

ANNOTATION: It is expected that the program expectations of students will address the types of patient encounters essential to preparing them for entry into practice. It is expected that at a minimum these will include preventive, emergent, acute, and chronic patient encounters.

- B3.03 *Supervised clinical practice experiences must* provide sufficient patient exposure to allow each student to meet program-defined requirements with patients seeking:
- medical care across the life span to include, infants, children, adolescents, adults, and the elderly,
  - women's health (to include prenatal and gynecologic care),
  - care for conditions requiring surgical management, including pre- operative, intra-operative, post-operative care and
  - care for behavioral and mental health conditions.
- B3.04 *Supervised clinical practice experiences must* occur in the following settings:
- outpatient,
  - emergency department,
  - inpatient and
  - operating room.

ANNOTATION: While patients often use emergency departments for primary care complaints, students are expected to interact with patients needing emergent care in this setting. Urgent care centers may be used for *supervised clinical practice experiences*, but do not replace the requirement to have students in emergency departments.

B3.05 *Instructional faculty* for the supervised clinical practice portion of the educational program *must* consist primarily of practicing physicians and PAs.

B3.06 *Supervised clinical practice experiences should* occur with:

- a) physicians who are specialty board certified in their area of instruction,
- b) PAs teamed with physicians who are specialty board certified in their area of instruction or
- c) other licensed health care providers experienced in their area of instruction.

ANNOTATION: It is expected that the program will provide *supervised clinical practice experiences* with *preceptors* who are prepared by advanced medical education or by experience. The ARC-PA will only consider *supervised clinical practice experiences* occurring with physician preceptors who are not board certified or with other licensed health care providers serving as *preceptors* when they are evaluated and determined by the program faculty to be appropriate for the specified area of instruction, under circumstances unique to the program.

B3.07 *Supervised clinical practice experiences should* occur with *preceptors* practicing in the following disciplines:

- a) family medicine,
- b) internal medicine,
- c) general surgery,
- d) pediatrics,
- e) ob/gyn and
- f) behavioral and mental health care.

ANNOTATION: PA education requires a breadth of *supervised clinical practice experiences* to help students appreciate the differences in approach to patients taken by those with varying specialty education and experience. *Supervised clinical practice experiences* used for *required rotations* are expected to address the fundamental principles of the above disciplines as they relate to the clinical care of patients. Subspecialists serving as *preceptors* might, by advanced training or current practice, be too specialty focused to provide the fundamental principles for *required rotations* in the above disciplines. Reliance on subspecialists as *preceptors* in the above disciplines is contrary to the intent of this standard.

## SECTION C: EVALUATION

### INTRODUCTION

It is important for programs to have a robust and systematic process of ongoing self-assessment to review the quality and effectiveness of their educational practices, policies and outcomes. This process *should* be conducted within the context of the mission and *goals* of both the sponsoring institution and the program, using the *Accreditation Standards for Physician Assistant Education (Standards)* as the point of reference. A well-developed process occurs throughout the academic year and across all phases of the program. It critically assesses all aspects of the program relating to sponsorship, resources, students, operational policies, curriculum and clinical sites. The process is used to identify strengths and weaknesses and

*should* lead to the development of plans for corrective intervention with subsequent evaluation of the effects of the interventions.

## C1 ONGOING PROGRAM SELF-ASSESSMENT

C1.01 The program *must* implement an ongoing program self-assessment process that is designed to document program effectiveness and foster program improvement.

ANNOTATION: A well designed self-assessment process reflects the ability of the program in collecting and interpreting evidence of student learning, as well as program administrative functions and outcomes. The process incorporates the study of both quantitative and qualitative performance data collected and critically analyzed by the program. The process provides evidence that the program gives careful thought to data collection, management and interpretation. It shows that outcome measures are used in concert with thoughtful evaluation about the results, the relevance of the data and the potential for improvement or change.

C1.02 The program *must* apply the results of ongoing program self-assessment to the curriculum and other dimensions of the program.

## C2 SELF-STUDY REPORT <sup>7</sup>

C2.01 The program *must* prepare a self-study report as part of the application for continuing accreditation that *accurately* and *succinctly* documents the process and results of ongoing program self-assessment. The report *must* follow the guidelines provided by the ARC-PA and, at a minimum, *must* document:

- a) the program process of ongoing self- assessment,
- b) results of critical *analysis* from the ongoing self-assessment,
- c) faculty evaluation of the curricular and administrative aspects of the program,
- d) modifications that occurred as a result of self-assessment,
- e) self-identified program strengths and areas in need of improvement and
- f) plans for addressing areas needing improvement.

ANNOTATION: The ARC-PA expects results of ongoing self-assessment to include critical *analysis* of student evaluations for each course and *rotation*, student evaluations of faculty, failure rates for each course and *rotation*, student *remediation*, student *attrition*, *preceptor* evaluations of students' preparedness for *rotations*, student exit and/or graduate evaluations of the program, the most recent five-year first time and aggregate graduate performance on the *PANCE*, sufficiency and effectiveness of faculty and staff, faculty and staff *attrition*.

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<sup>7</sup> Programs applying for provisional accreditation *must* complete a descriptive report, as opposed to a self study report, as described in section D and the application for provisional accreditation.



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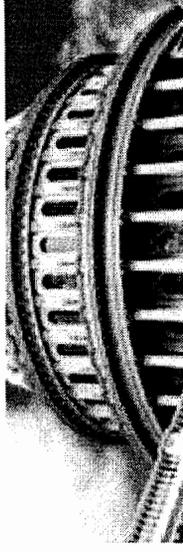
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## The Affordable Care Act in California

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June 2010

Signed into law in March, the federal Affordable Care Act (ACA) will transform the way Californians obtain and pay for health insurance. Estimates are that once the law is fully implemented, 94% of the state's population will be covered by a health plan, through either an employer, a new health insurance exchange market, or expansions to public benefit programs such as Medi-Cal.

To support the implementation of national health reform in California and advance the effectiveness of public coverage programs, CHCF is embarking on a series of publications, including:

- *Implementing National Health Reform in California: Changes to Public and Private Insurance* (June 2010, Manatt Health Solutions) provides an initial assessment of the work ahead as California begins to implement the provisions of the ACA related to health insurance. It identifies the specific elements in the law that the state must or may follow, with a particular focus on the component tasks, decisions, and actions.
- *Insurance Provisions of the Affordable Care Act: An Implementation Timeline for California* (May 2010, Manatt Health Solutions) is a tool for state policymakers and other stakeholders that charts the decade-long implementation schedule for the provisions of the ACA that relate to both public and private health insurance. It is published in two formats: a single 11 x 17-inch page or two 8.5 x 11-inch pages.
- *The Affordable Care Act: What Californians Should Know* (May 2010) is a two-page page guide designed to acquaint consumers with the key reforms in the law and what their coverage options will be after the major pieces are in place. JPEG files of the four central elements are available for use in newsletters and other educational materials.

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Note: The download The Affordable Care Act: What Californians Should Know was updated July 23, 2010, to correct two elements of the reform timeline graphic on page 2. The corresponding JPEG in the Zip file has also been replaced.

Video of Testimony at Joint Hearing in May 2010

Marian Mulkey, director of CHCF's Health Reform and Public Programs Initiative, testified on the California implementation of federal health reform at a joint hearing of the California Senate Health Committee and Assembly Health Committee on May 12, 2010, and discussed provisions within the Affordable Care Act and the implications for California. View the full hearing on The California Channel site.

Document Downloads

Implementing National Health Reform in California: Changes to Public and Private Insurance (823k)

Insurance Provisions of the Affordable Care Act: An Implementation Timeline for California (8x11) (93k)

Insurance Provisions of the Affordable Care Act: An Implementation Timeline for California (11x17) (89k)

The Affordable Care Act: What Californians Should Know (474k)

The Affordable Care Act: What Californians Should Know -- Four Images in JPG Format (1.57Mb)

Related CHCF Pages

Press Release 5/25/10 -- Implementing Federal Health Reform in California: CHCF Responds

Reader Comments

1 07/28/2010 Gary McDonald

I have been trying to get MRMIP, the California High Risk Pool, to acknowledge that they are going to have to drop altogether their \$750K lifetime limit on benefits and raise their ridiculously inadequate annual benefit limit of 75K to 750K come January 1, 2011 re: Patient's Bill of Rights on the new healthcare.gov website.

Reps at MRMIP say they are waiting for "federal guidance". The guidance, it seems to me, is in the law itself.

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It's true the feds can grant them a waiver on the annual limits, but to do so would be to contradict their own language in the Patients Bill of Rights about how pernicious annual limits are. To allow them for people who have serious health problems ( the very people the high risk pools are supposed to serve) would be hypocritical beyond imagination.

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# The Affordable Care Act: What Californians Should Know

May 2010

Signed into law in March 2010, the federal legislation known as the Affordable Care Act is designed to make it easier for millions of Americans to obtain, pay for, and keep the coverage they need. After the law is fully implemented in 2014, estimates are that 94 percent of Californians will be insured, either through their employer, a new exchange market, or expansions to public benefit programs. This guide is intended to orient California consumers to the coming changes in the coverage landscape, the key reforms the law contains, and what their options will be once all the pieces are in place.

## Highlights of the Law

### Bars insurers from:

- Denying coverage because of pre-existing medical conditions.
- Dropping the coverage of people who become sick.
- Charging higher premiums because of health issues.

### Requires large employers to:

- Provide health insurance, or be subject to potential penalties.

### Encourages small employers to:

- Provide coverage in exchange for tax credits.

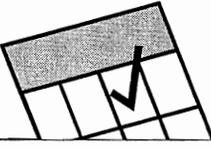
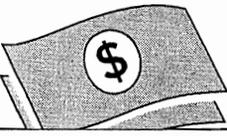
### Requires individuals to:

- Obtain health insurance or pay a penalty, unless they qualify for certain exemptions.

### Allows parents to:

- Extend their health insurance to children up to the age of 26.

## Changes for Californians with No Insurance

Annual Income		Coverage Options 	Cost 
Individual 	Family of Four 		
Up to \$14,400	Up to \$29,327	<b>Eligible for Medi-Cal.</b> Low-income Californians who are U.S. citizens, as well as most legal immigrants, can enroll in Medi-Cal, the state's Medicaid program.	Copayments of \$1 to \$5 for selected services. A provider may not refuse care if a patient cannot pay for the cost of a visit.
Up to \$43,320	Up to \$88,200	<b>Eligible to buy subsidized private coverage through a new health insurance exchange market.</b> Participating insurers must offer a package of "essential" benefits that covers at least 60% of health care expenses.	Buyer's share of premium may not exceed 2% of annual income at the low end of the earning scale to 9.5% at the top. Yearly limits on out-of-pocket costs also apply.
\$43,321 and above	\$88,201 and above	<b>Required to buy private coverage.</b> Ineligible for subsidy.	Subject to market rates. Individuals who remain uninsured will be liable for penalties of up to 2.5% of their income unless they qualify for certain exemptions.

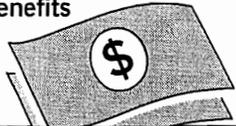
### What if I'm sick and need coverage before 2014, but no insurer will sell it to me?

Uninsured Californians with health problems may qualify for insurance through a temporary, state-run program at standard market rates, with no lifetime or annual payout limits. Contact the California Major Risk Medical Insurance Program, (800) 289-6574 or [www.mrmib.ca.gov](http://www.mrmib.ca.gov).

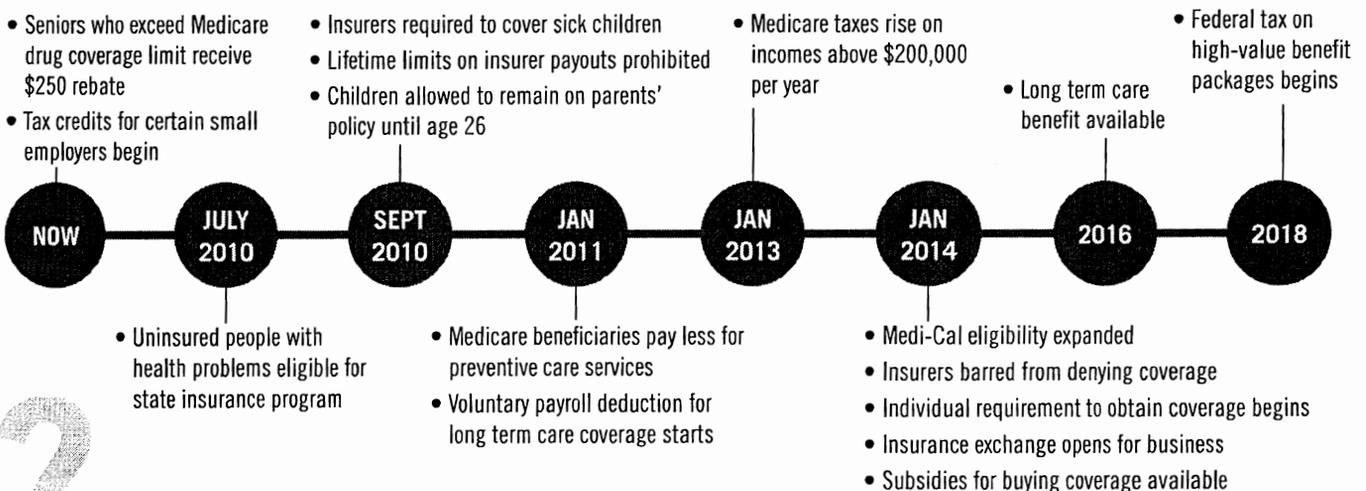


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## Changes for Californians with Insurance

Source of Coverage	Coverage Options 	New Costs and Benefits 
<p>Employer Plan</p> 	<ul style="list-style-type: none"> <li>• <b>Stay in employer plan.</b> If your employer continues to offer coverage, you can keep it.</li> <li>• <b>Shop for coverage through the insurance exchange.</b> Small businesses and people whose employer offers only minimal benefits, or who must pay more than 9.5% of their income in premiums, can look for better options in the exchange.</li> <li>• <b>Participate in long term care insurance.</b> A new payroll deduction will allow employees to qualify for long term care benefits after a five-year waiting period. The program is voluntary; those who do not opt out will be enrolled automatically.</li> </ul>	<p>Lifetime dollar limits on insurance payouts are eliminated.</p> <p>Medicare taxes will increase for individuals with annual incomes above \$200,000, or families earning more than \$250,000.</p> <p>Annual contributions to Flexible Spending Accounts will be capped at \$2,500, and can no longer be used for over-the-counter drugs.</p> <p>Employer-provided insurance valued at \$10,200 or higher (\$27,500 for families) will be subject to federal tax.</p>
<p>Individual Policy</p> 	<ul style="list-style-type: none"> <li>• <b>Keep current plan.</b> If your insurer continues to offer the same coverage, you can renew it. However, new policies must comply with federal minimum coverage standards; older plans that don't meet this test cannot enroll new customers.</li> <li>• <b>Shop for coverage through the insurance exchange.</b> Individuals with incomes below \$43,320 can qualify for federal tax credits to help offset premium costs.</li> </ul>	<p>Lifetime dollar limits on insurance payouts are eliminated. Caps on out-of-pocket costs apply.</p> <p>Medicare taxes will increase for individuals with annual incomes above \$200,000, or families earning more than \$250,000.</p>
<p>Medicare</p> 	<ul style="list-style-type: none"> <li>• <b>Basic benefits and eligibility.</b> No change. All Californians who qualify under today's rules will continue to do so.</li> <li>• <b>Medicare Advantage.</b> Federal subsidies for Medicare Advantage plans will be eliminated, which may cause the private insurers who sell them to cut benefits, reduce enrollment, or raise premiums.</li> <li>• <b>Access to services.</b> Physicians who treat Medicare patients in rural areas, inner cities, and other underserved areas will be paid a 10% bonus, which may make it easier for beneficiaries to obtain care.</li> </ul>	<p>Free annual check-ups and wellness programs, including screening tests.</p> <p>Gaps in drug coverage phased out, beginning with \$250 rebate.</p> <p>Monthly premium payments for drug coverage will increase for individuals with incomes above \$85,000 and households earning more than \$170,000.</p>

### Reform Timeline: When the Changes Happen



### Where to go for more information

Details on the health reform law are available at [healthreform.gov](http://healthreform.gov). General questions can be emailed to [healthreform@hhs.gov](mailto:healthreform@hhs.gov).

# Insurance Provisions of the Affordable Care Act: An Implementation Timeline for California

**Medi-Cal Expansion**

- State may expand Medi-Cal coverage to a new eligibility group. (4/1/10)
- State must define "benchmark benefits," including "wraparound" benefits for children.
- State must make changes to state law, amend the Medi-Cal State Plan, and modify application and enrollment systems.

**Changes in Eligibility and Enrollment Rules**

- State must monitor CMS guidance to determine how to implement the modified adjusted gross income (MAGI) formula and its effect upon eligibility for beneficiaries already in the program.

**Maintenance of Effort (MOE)**

- State must maintain Medi-Cal and Healthy Families eligibility levels, standards and procedures.

**Dual Eligible Coverage Coordination**

- State may pursue Home and Community Based Services option. (4/1/10)
- State may pursue new Money Follows the Person Demonstration Projects. (4/22/10)

**Enrollment Standards**

- HHS Secretary to develop interoperable and secure standards and protocols for enrollment in federal and state health and human services programs. (9/23/10)

**Dual-Eligible Special Needs Plans must contract with state.** (1/1/13)

**Enrollment Simplification**

- State must implement procedures to simplify Medi-Cal and Healthy Families enrollment. (1/1/14)

State may be able to get federal support for an existing consumer assistance office or establish a new one, pending federal guidance. (3/23/10)

Comptroller General must appoint CO-OP Advisory Board. (6/23/10)

HHS must establish an Internet portal for consumers to identify coverage options. (7/1/10)

HHS must make available exchange planning grants for the state. (3/2/11)

**2010**

**APR**

- Temporary High-Risk Pool**
  - State must inform HHS that it intends to apply for an HHS contract to operate the pool. (4/30/10)
- Premium Rate Review**
  - State must review plan premium rates, pending federal guidance. (3/23/10)
- Temporary High-Risk Pool**
  - HHS must establish temporary high-risk pool program. (6/23/10)
- New Insurance Standards**
  - Health plans:
    - May not impose lifetime limits on essential benefits and may only impose restricted annual limits on coverage. (9/23/10)
    - May not rescind coverage except in cases of fraud and abuse. (9/23/10)
    - Must provide preventive services without cost-sharing. (9/23/10)
    - Must provide coverage for dependents up to age 26. (9/23/10)
    - May be required to report quality data, pending federal guidance. (9/23/10)
    - May not discriminate coverage eligibility or benefits in favor of highly compensated individuals. (9/23/10)
    - Must implement internal claims appeals and external review processes. (9/23/10)
    - May not withhold coverage due to pre-existing conditions for children under 19. (9/23/10)

**2011**

**DEC**

- New Insurance Standards**
  - National Association of Insurance Commissioners must develop medical loss ratio calculation guidelines. (12/31/10)
- New Insurance Standards**
  - HHS must develop standardized format for benefits summary and coverage information. (3/23/11)

State must require federal guidance to determine whether the state will opt to create a Basic Health Plan. (Prior to 2014)

**MOE requirements for adults lifted.** State may begin modifying Medi-Cal eligibility levels, standards, and income levels for adults. (1/1/14)

**MOE requirements for children lifted.** State may begin modifying Medi-Cal eligibility levels, standards, and income levels for children. (1/1/19)

**Medi-Cal Expansion**

- State must provide Medi-Cal coverage for all individuals under 133% FPL. (1/1/14)
- State must transition children ages 6-18 with family incomes between 100-133% FPL from Healthy Families to Medi-Cal. (1/1/14)

**Changes in Eligibility and Enrollment Rules**

- State must apply modified adjusted gross income formula for Medi-Cal and Healthy Families. (1/1/14)

**Enrollment Simplification**

- State must implement procedures to simplify Medi-Cal and Healthy Families enrollment. (1/1/14)

HHS must award loans and grants for CO-OPS. (7/1/13)

State must possess an operational exchange. (1/1/14)

**2012**

- New Insurance Standards**
  - HHS must promulgate regulations for health plan quality-reporting requirements. (3/23/12)
  - Health plans must provide benefits summary and coverage information to individuals, following a standardized format. (3/23/12)
- Temporary High-Risk Pool**
  - Program ends. (12/31/13)
- Temporary Reinsurance Programs**
  - State must adopt model regulations and establish transitional reinsurance program. (1/1/14)
- Federal Risk Corridor**
  - Payment adjustments begin. (1/1/14)
- Permanent Risk Adjustment**
  - State must establish permanent risk adjustment program. (1/1/14)
- New Insurance Standards**
  - Health plans:
    - May not impose annual limits on essential benefits. (1/1/14)
    - Must sell and continue insurance policies to interested individuals and employers. (1/1/14)
    - May not withhold adult coverage due to pre-existing conditions. (1/1/14)
    - May not apply waiting periods for coverage in excess of 90 days. (1/1/14)

**2013**

- Temporary High-Risk Corridor**
  - Federal risk corridor payments end. (1/1/17)

State may create a Basic Health Plan for targeted individuals. (1/1/14)

**Enhanced Federal Support for Children's Health**

- State may transition Healthy Families-eligible children to Medi-Cal or comparable coverage in the exchange. HHS must certify pediatric coverage in the exchange is comparable. (4/1/15)
- Last year of new federal CHIP funding. (9/30/15)
- State will start drawing 88% federal matching funds rate for Healthy Families. (10/1/15)
- State may start enrolling Healthy Families-eligible children in the exchange. (10/1/15)

State must possess an operational exchange. (1/1/14)

**2014**

- Temporary High-Risk Pool**
  - Program ends. (12/31/13)
- Temporary Reinsurance Programs**
  - State must adopt model regulations and establish transitional reinsurance program. (1/1/14)
- Federal Risk Corridor**
  - Payment adjustments begin. (1/1/14)
- Permanent Risk Adjustment**
  - State must establish permanent risk adjustment program. (1/1/14)
- New Insurance Standards**
  - Health plans:
    - May not impose annual limits on essential benefits. (1/1/14)
    - Must sell and continue insurance policies to interested individuals and employers. (1/1/14)
    - May not withhold adult coverage due to pre-existing conditions. (1/1/14)
    - May not apply waiting periods for coverage in excess of 90 days. (1/1/14)

**2015**

**2016**

**2017**

**2018**

**2019**

State may create a Basic Health Plan for targeted individuals. (1/1/14)



For more information, visit: [www.chcf.org/healthreform](http://www.chcf.org/healthreform)