CAPA
CALIFORNIA ACADEMY OF PAs
California Academy of PAs
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THE PHYSICIAN ASSISTANT DIRECT PAYMENT RULE 2022

WHAT PROVIDERS NEED TO KNOW

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Empowering Healthcare

APRIL-JUNE 2022

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The CAPA magazine is the official publication of the California Academy of PAs. This publication is devoted to informing PAs to enable them to better serve the public health and welfare. The publisher assumes no responsibility for unsolicited material. Letters to the editor are encouraged; the publisher reserves the right to publish, in whole or in part, all letters received. Byline articles express the opinion of the author and do not necessarily reflect the views or policies of the California Academy of PAs.

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CALIFORNIA ACADEMY OF PAs
Empowering Healthcare

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President's Message

Happy Spring CAPA Family,

We're back! CAPA finally had its first CAPA at Napa conference in beautiful Napa Valley on February 26, 2022. One may think that maybe this is a small event to celebrate in the grand scheme of things but let me paint this picture in a different light. After over two years of being unable to congregate and celebrate our profession, it was a small, albeit spectacular, get-together to be amongst fellow PAs. A special thank you to our CME Chair Scott Martin, our CME Committee members Beverly Ruppert, Curtis Fowler, Aaron Kan, Jason Fisher-Beck, and Thomas Bale, our CAPA Board leaders, and our CAPA staff Teresa Chien, Danielle Van Dalsem and Lisa Russo for making our post-pandemic, post-lockdown premiere in-person event a resounding success.

As we collectively begin our transition out of this pandemic, it remains imperative that PAs remain in the forefront of healthcare. We, as a profession, have filled massive voids within the healthcare system that has provided countless patients with appropriate and timely care. I have definitely felt a shift within my patient population with respect to what a PA is and what a PA can do. I have found this transition very empowering. I believe that we can use this momentum to continue to not only educate our patients, clinical and hospital administrators and other healthcare providers about the PA profession, but also continue to foster a "Team Approach" to medicine. As we continue to educate ourselves with our craft and take ownership of our role in patient care, we reduce uncertainty about the PA profession. This, in turn, will improve morale and productivity within the PA community and foster belongingness within the healthcare team.

As younger cohorts of healthcare providers graduate, they have all been exposed to and trained within inter-professional learning groups, wherein they learn the roles of different healthcare providers within the healthcare team. Students learn how to recognize patients' needs and ascertain who the healthcare provider would be for that individual need. I foresee upcoming graduates entering their practice environment with this structure in mind and establishing a team-based approach to medicine. As this occurs, we as PAs will continue to establish and make mainstream SB 697 such that we can continue our work towards our ultimate goal, "Optimal Team Practice." We also continue to work together with CAPA's legal team and officers to keep abreast of current legislation and bills pertaining to PAs, as we continue to grow and prosper as a profession.

Thank you CAPA family for your continued support. With the spring blooms come new hope. I wish you all a very happy and healthy warm season!

Saloni Swarup, PA-C

Meet CAPA's Newest Team Member, Lisa Russo!

The newest addition to the CAPA team is Events & Meetings Manager, Lisa Russo! Lisa started this past January and jumped right in with hosting a Controlled Substances Education Course and finalizing details for CAPA at Napa. She received her degree in Natural Resources and Animal Science from the University of Connecticut and has spent the last three years as a program coordinator for an environmental nonprofit organization in Nevada. As her focus now shifts to planning CAPA's Virtual Rounds and fall conference, Lisa is looking forward to learning more about the PA profession so that she can help to provide worthwhile CME events. Be sure to introduce yourself at our next in-person meeting and feel free to reach out to Lisa directly at lisa@capanet.org!

EXECUTIVE ORDER

By Teresa Chien, Executive Director

When I first joined the CAPA team two years ago, one of my top priorities was to lay out a strategic plan to guide CAPA in its objectives and pursuits. In preparation for drafting this plan with CAPA leaders, I spent my first months gathering feedback and assessing what the issues were. The assessment resulted in four categories of concern.

- Lack of or inaccurate public awareness of PAs
- Desire for parity, in practice and in opportunities
- An overfocus on family practice
- Lack of career and professional practice support

In previous issues, I shared the ways in which CAPA is addressing the lack of career and professional support and the overfocus on family practice. This time, I will provide an overview of our work battling PAs' public awareness problem.

The Public Awareness Problem

Though this profession has a long 60-year history, the fact of the matter is, it is still a young profession relative to those of physicians and nurses. As a result, there are far fewer PAs than physicians and nurse practitioners (NPs) in California (14,000 vs. 115,000 and 27,000 respectively). The general public may never come across a PA in their medical interactions, and if they do, they may not even know that their treating clinician is a PA. For those who are aware of PAs, there is much confusion about what exactly PAs are, what they do, and how they are different from NPs and physicians.

First, the 'physician assistant' title doesn't always help. Almost every PA has their own story of being mistaken for a physician or medical assistant. To patients (and even some employers), if you're not one or the other, then what do you do?

Second, there is little distinction between PAs and NPs. Arguably, the educational background and training of PAs should be more sought after due to its scope, flexibility, and adaptability compared to NPs' necessity to specialize. Yet most healthcare employers are unaware of the difference and see the two professions as interchangeable. Physicians, healthcare administrators, public health officials, and legislators must understand the difference in order to make the best decisions for their health systems or practices and for public health.

Finally, outdated laws along with misinterpretations of current law (SB 697) contribute to many misconceptions of PA practice. Questions about what 'physician supervision' means, the DSA vs. practice agreements, and what PAs can or cannot do abound at the CAPA office. The confusion around PA scope of practice creates an illusion of complexity when working with PAs, which dampens PAs' employment prospects, muddles public perception, and devalues the contributions you all make in the lives of thousands of patients.

What CAPA Has Been Doing

Though not under the best circumstances, the pandemic brought about several opportunities for CAPA to set the record straight about PAs. Over the last two years, CAPA has repeatedly made a case for and educated legislators and health officials about the value of PAs, particularly at the height of COVID surges. Through assertive advocacy and factual information-sharing, CAPA has:

- Persuaded the governor's administration to issue regulatory waivers permitting PAs to practice at the top of their license and participate fully in the COVID response.
- Corrected the California Health Corps' gross omission of PAs in their healthcare providers recruitment initiative.
- Battled with the California Department of Public Health (CDPH) and the Los Angeles County Department of Public Health to include PAs in the COVID vaccination effort.
- Corrected the CDPH's misinformed All Facilities Letter 72.1, mistakenly notifying healthcare facilities of APPs' inability to order home health after the expiration of California's waiver.
- Persuaded the Department of Healthcare Services to include PAs in their California Children's Services Provider Panel. (in implementation phase)
- Collaborated with the California Primary Care Association to educate community health centers and administrators on maximizing PA utilization. (ongoing)

And this is just the beginning. With the national effort to roll out the title change beginning to trickle down to states, CAPA will begin its own title change efforts soon. CAPA also expects to reconvene each year to consider possible outreach and education efforts involving collaborative and stakeholder relations. Our immediate goal is to ensure that critical decision-makers have a clear understanding of PAs' roles within the medical team and the value-add they bring to healthcare.

How Your Membership Is Shaping CAPA

Correcting public perception of PAs is a massive endeavor – one that will eventually involve working with AAPA and, most likely, other state constituents. However, as with everything, we are limited by time, human, and financial resources. CAPA is only able to represent you and do the work we do because of a strong membership. We are thankful every day for members like you who join or renew year after year, because you understand the value and importance of organized medicine. However, we need many more like you to do the kind of large-scale work necessary for public awareness.

So consider this a gentle reminder: If you have not yet renewed, please do so today, particularly when your participation comes with 20 complimentary units of CME this year. (Ask CAPA staff about this!) If you have renewed, THANK YOU! We wouldn't have gotten this far without you.

The Physician Assistant Direct Payment Rule 2022: What Providers Need to Know

By Nancy Clark

With the 2022 Centers for Medicare and Medicaid Services final rule, physician assistants ("PAs") joined the ranks of physicians, nurse practitioners and clinical nurse specialists in having the ability to receive payments directly from Medicare. Previously, they had to be employed by a billable entity (e.g., physician, group or facility) and reassign their services. Payment would go directly to the entity, not the PA.

Since we are now only just into the implementation phase, it may be too early to assess the outcome, but we can speculate on how this may influence health care delivery.

The rule change likely reflects the impact of nonphysician practitioners' delivery of medical care, especially primary care. The prevalence of PAs caring for patients is seen in almost every type of facility, including physician's offices, clinics, hospitals and long-term care facilities. In outpatient settings, these PAs can furnish services "incident-to" a physician when certain requirements are met. In this instance, the reimbursement for the entity is at the physician fee schedule rate. In some other settings, services can be provided as "split/shared" where the service and documentation requirements are shared between the PAs and the physician. These rules, too, are changing, perhaps also based on the evolving models of health care delivery.

Reimbursement for independent services will not change based on the new regulations. PAs still receive 85% (or other carrier-designated amount) of the physician fee schedule. In this way, the PA will not directly benefit via increased compensation. However, PAs can now practice independently, if they so choose, and if the services provided are within the scope of practice for their region. This could lead PAs to form medical practices with others or work independently as self-employed contractors. These new models could supplement health care entities that rely on outsourced employees, such as those that provide telehealth, home-based or remote digital services.

While adoption by commercial carriers is not mandatory, we frequently see them follow behind federal guidelines. Based on the reduced reimbursement to this group of providers, as compared with physicians, the change may promote better health care affordability for some frequently provided services. According to the Bureau of Labor Statistics, employment for PAs is expected to grow by 31% from 2020 to 2030. As such, the setting is ripe for change.

So, what should physician assistants do now? For those that are operating under a traditional employment relationship with a physician or group practice, there is no need to make any changes. Given that most commercial insurers have not yet adopted direct payment methodology, changing the current status could potentially create confusion when billing for services in this setting. However, for those PAs desiring new opportunities, the removal of previous restrictions allows for greater options. These providers can choose to join health care staffing companies or hospital-based group practices since they can now reassign their Medicare payments to the organization or hospital.

Another issue addressed by this legislation is the ongoing concern over true transparency of services rendered. Direct billing will result in appropriate data collection of services provided, which will identify the increase in PA productivity that is recognized, but not always adequately captured. Further, as health care moves towards quality reporting, such as the Merit-Based Incentive Program ("MIPS"), this will diminish the negative effect that PAs experience when their services are billed as "incident-to" or "split-shared" under a physician's identifier.

Most importantly, PAs should monitor state and federal regulations as well as commercial carrier guidelines in order to ensure that their service delivery, documentation, coding and billing adhere to all compliance requirements. This is paramount to collecting and retaining proper reimbursement for the services rendered. Following these measures will assist in protecting earned revenue and maintaining the integrity of this valuable, growing profession.

Nancy Clark, CPC, COC, CPB, CPMA, CPC-I, COPC, AAPC Fellow, leads the Health Care Medical Coding Services at Eisner Advisory Group, LLC. She specializes in coding and documentation reviews and educating providers and their staff. She is passionate about helping medical professionals understand and implement the required but sometimes confusing documentation guidelines so they can focus on treating patients. She can be reached on LinkedIn or at Nancy.Clark@eisneramper.com.

PAs Can Improve Health Outcomes for Rural Californians

By David J. Bunnell, MSHS, PA-C, DFAAPA

By 2030 Californians may be short 10,000 primary care providers.[1] It is estimated that communities need 60 to 80 primary care providers per 100,000 people, but in the Inland Empire and the San Joaquin Valley there are only 35 and 39 per 100,000 people respectively.[1] According to the Rural Health Information Hub, people living in rural regions experience disparities in health based on "geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, limited access to healthcare specialists and subspecialists, and limited job opportunities."[2]

PA practice is well suited for rural practice and has widespread acceptance by patients and physicians.[3] PAs are being viewed as help for struggling communities.[3] There have been suggestions that telehealth technologies can be a conduit for physician collaboration with PAs who live and work in rural towns.[4] Another way PA practice can be supported is through provider-to-provider communication in which a specialist provides clinical decision-making support to a local provider.

PAs were considered equal partners in the California Policy Research Center's Issue Brief entitled, "Improving Recruitment and Retention of Primary Care Practitioners in Rural California."[5] Recruitment and retention is seen as a long-standing problem.[5] People choose to practice in rural communities because they are drawn to the work and the characteristics of the healthcare organization are attractive to them.[5]

The California Policy Research Center paper recommended loan repayment and support for placement services to increase the number of providers.[5] Connecting academic health centers to partner with rural areas for training and research is suggested to bring the attention of academics to contribute to rural health equity.[5] Bringing health professions training programs to rural areas to train local providers with ties to the community can be a key to long-term success.[5] Focusing on reimbursement for Federally Qualified Health Centers and Critical Access Hospitals is vital to maintain the public health infrastructure.[5] Embracing the current telehealth revolution can only help rural populations if high speed internet is available to these communities.[5]

The California Academy of PAs can embrace this moment by supporting rural PAs with education and legislative advocacy, assisting PA programs in obtaining rural health student clinical precepting sites, and engaging in healthcare advocacy for patients to keep PAs in the conversation to work for rural health equity.

PA Bunnell is Director of Assessment and Assistant Professor of PA Medicine at Frostburg State University which focuses on rural and underserved patient care. He is the American Academy of Physician Associates Liaison to the American Medical Association and the Immediate Past President of the Association of Pas in Cardiothoracic and Vascular Surgery.

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What is a Doctor of Medical Science (DMS) Degree and Is It Right For Me?

By Dr. Linda Sekhon DHSc, PA-C, Founding Chair, DMS Program
Dr. Shaun Lynch PhD, PA-C, Director of Curriculum
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Over the past few years, the physician assistant (PA) profession has seen an increase in the number of institutions offering a Doctor of Medical Science (DMS) degree. The DMS is a doctoral program of study designed to supplement the knowledge base of PAs and equip them to innovate, lead, and make decisions to improve patient care and healthcare delivery. Several health professions (e.g., pharmacy, physical therapy, occupational therapy, nursing) have already transitioned towards doctorate level education by advancing knowledge in the context of the workplace. Given that healthcare delivery continues to shift towards improved quality of care and patient outcomes, PAs must possess the information and skills to provide safe, efficient, and effective care.

Many DMS curricula are designed for PAs interested in expanding their understanding of medical knowledge and research, while advancing their personal and professional leadership skills. The DMS degree is a natural evolution of the rigorous and intensive PA curriculum offered in entry level PA programs. In fact, we believe that PAs already provide a high level of medical care and DMS programs should not teach you what you already know. Instead, the DMS should build upon your existing knowledge by augmenting education focused on strengthening the application of evidence-based medicine and developing business, education, and leadership skills. As a result, this enhanced skill set focused on knowledge application and improving communication, problem-solving, and critical thinking will create opportunities for increased decision-making and upward professional mobility.

One of the many benefits of pursuing the DMS degree is convenience. Most DMS programs are 100% online, offering flexibility for the busy PA to obtain an advanced degree while continuing to work within their respective communities.

Additionally, many programs are self-paced and allow the learner to choose the number of courses taken per module or semester. Meanwhile, DMS programs can differ among offered concentrations and coursework. Some examples include courses focused on health professions education, healthcare administration, leadership, emergency management and global health, and advanced professional practice. Lastly, most DMS programs require the completion of a scholarly project or doctoral capstone for degree attainment.

There are many questions PAs should ask themselves in evaluating if a DMS degree is right for them. First, why do you want to pursue further formal education? Increase knowledge and develop a specific skill set in a certain area? Change jobs or career? Earn a doctoral credential? Second, what are the knowledge and skills you want to obtain? Leadership/Administrative? Education? Research? Third, which program and curriculum is best aligned to conveniently fulfill your needs. Fourth, how will you manage the pursuit of education while managing the responsibilities of work, family, and life? While cost is certainly a consideration, some programs offer Bridge programs or credit variances for recent graduates. Therefore, it is important to research specific programs to ensure alignment with your individual goals.

The DMS is more than the letters behind your name. The skills obtained from this degree not only open doors for PAs, but keep those doors open for others to come along behind you. This is an exciting time for the PA profession. The general and medical world will continue to see its rapid growth in the coming years.

CMS Releases 2022 Physician Fee Schedule Rule

PAs authorized to receive direct payment under Medicare

Reprinted with permission from the American Academy of Physician Assistants.

The Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicare program, released the 2022 Physician Fee Schedule final rule. The rule updates a number of Medicare coverage and payment policies that impact PAs, physicians and other health professionals. Some of the key provisions of the rule, which take effect on January 1, 2022, are highlighted below.

Direct Payment

In the rule, CMS permanently authorized PAs to receive direct payment from the Medicare program. Currently, payment for services provided by PAs is required to be made to the PA's employer. The inability to be paid directly hindered PAs from fully participating in certain practice, employment, and ownership arrangements, prevented them from reassigning their payments in a manner similar to physicians and APRNs, and created additional administrative barriers to hiring and utilizing PAs.

Similar to most physicians and nurse practitioners (NPs) who already have access to direct payment, the majority of PAs will maintain their current W-2 employment relationships with reimbursement for their services continuing to flow to their employers. However, being eligible for direct payment will be beneficial to PAs who want to work as independent contractors, own a practice or medical corporation, and who work in certified Rural Health Clinics.

The change only applies to Medicare and does not affect reimbursement policies pertaining to Medicaid or commercial payers. Also, Medicare regulations defer to state law. If state law or regulations prohibit a PA from receiving direct payment, those restrictions would have to be removed before Medicare will directly pay PAs in the state.

Split/Shared Visit Billing

CMS made significant changes to longstanding policies for split (or shared) E/M visits. Critical care services and certain visits occurring in skilled and non-skilled nursing facilities, which previously had been excluded, will be eligible for split (or shared) billing beginning January 1.

CMS also changed the definition of a "substantive portion" of a split/shared service, which is used to determine if a claim for a service jointly performed by a PA (or NP) and physician can be billed under the physician's name and National Provider Identifier (NPI) number. Medicare payment is made at 100 percent when billed under the physician's name as opposed to 85 percent if billed under the name of a PA or NP. In order for the services to be billable under the physician's name, the physician must perform a substantive portion of the service. For 2022, a substantive portion of the service by a physician is defined as: 1) the physician personally performing either the history, exam, or medical decision making (in its entirety), or 2) the physician spending more than half of the total time by both the physician and the PA (or NP) on face-to-face and non-face-to-face patient care activities.

For services already defined as time-based such as critical care and discharge management, the substantive portion of care can only be determined based on which health professional spent more than half the combined time providing care to the patient.

Beginning in 2023, only time will be used to define a substantive portion of care which means the health professional who spends the majority of time providing care to the patient is the one under whom the service should be billed.

Other requirements that must be met for a physician to bill a service as split/shared under their name/NPI

- The physician and PA (or NP) must work for the same group

CMS Releases 2022 Physician Fee Schedule Rule

- The physician and PA (or NP) must see the patient on the same calendar day
- The services must be performed in a hospital, facility, or hospital outpatient office
- Documentation in the medical record must identify the physician and nonphysician practitioner who performed the visit. The individual who performed the substantive portion of the visit (and therefore bills for the visit) must sign and date the medical record

CMS plan to require a modifier that will be required to be placed on split (or shared) claims to inform future policy considerations and help ensure program integrity. That modifier code has not yet been released.

Behavioral Health Flexibilities

In recognition of the toll the COVID-19 pandemic has played on behavioral/mental health, the agency finalized its proposed behavioral health flexibilities that will make it easier for Medicare beneficiaries to access needed behavioral/mental health services from PAs, physicians, and certain other health professionals. This increased access is largely achieved by expanding the ways telehealth can be used to provide behavioral/mental health services. Specifically, CMS will now include a patient's home as an allowed originating site for mental health services after the end of the public health emergency, allow certain audio-only mental health services be provided to beneficiaries located in their home (if the beneficiary is unable, or does not wish, to use two-way audio/visual technology), and authorize RHCs and FQHCs to provide mental health visits via telemedicine. AAPA supported CMS' proposed flexibilities and suggested further actions CMS could take, such as communicating to the commercial payers with whom CMS works about the need to eliminate unnecessary or obsolete restrictions on PAs providing behavioral/mental health. Such policy changes would bolster the number of PAs practicing in relevant behavioral health specialties and alleviate access concerns in a time when demand is increasing.

Direct Supervision

CMS sought input on whether the temporary ability to use audiovisual communication to meet the requirements of direct supervision during the Public Health Emergency should be ended, continued, or made permanent. Typically, direct physician supervision is required when PAs and NPs deliver care in the office or clinic under Medicare's "incident to" billing provision with PA- or NP-provided services being billed under the name of a physician. AAPA provided comments to CMS opposing the use of direct supervision via audiovisual communication as it relates to PAs and NPs out of concern that it would increase "incident to" billing. "Incident to" billing "hides" the professional services of both PAs and NPs and leads to a lack of transparency in data collection and analysis. CMS decided to make no changes or decisions regarding this issue until a later date. Note that "incident to" billing is an option and not a requirement under Medicare. PAs (and NPs) always have the authority to submit claims for their services under their own name and NPI number with reimbursement at 85 percent of the physician payment. In our comments to CMS, AAPA was not opposed to allowing direct supervision by audiovisual communication for professionals such as registered nurses, medical assistants and other health personnel who do not have the ability to bill the Medicare program.

RHC and FQHC-employed Hospice Attending Physicians

CMS is implementing Section 132 of the Consolidated Appropriations Act of 2021 that will allow both Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to receive payment for hospice "attending physician" services. PAs are considered attending physicians under the Medicare hospice benefit. Currently, PAs, physicians, and nurse practitioners (NPs) employed by or under contract with an RHC or FQHC are unable to act in the capacity of a hospice attending physician during the time they are working in an RHC or FQHC. If an RHC or FQHC-employed PA, physician or NP chose to provide hospice attending physician services, it was required that those hospice services be delivered outside of their hours worked at the RHC or FQHC, not conflict with an employment agreement, and not violate Medicare prohibitions on comingling. The policy finalized in the 2022 Physician Fee Schedule will remove restrictions on RHC- or FQHC-employed or contracted PAs, physicians and NPs providing hospice attending physician services while working at the RHC or FQHC, and these centers will be authorized to receive payment for such services under the RHC all-inclusive rate and FQHC prospective payment system, respectively. AAPA requested CMS also modify hospice policies that are restrictive of hospice-employed PAs, but CMS determined such policies outside the scope of the current rule.

Rural Health Clinic (RHC) Payment Rate Increases

Certified rural health clinics are paid on a per visit/encounter basis as opposed to being reimbursed on a fee-for-service methodology for each individual service provided. RHCs have a payment limit or cap on the maximum amount that will be paid per visit. Currently enrolled independent RHCs (typically owned by PAs and physicians) and provider-based RHCs in larger hospitals will receive an increase in their per visit payment limit over an 8-year period (2021-2028). After that 8-year period, the per visit limit will be updated each year by the percentage increase in Medicare Economic Index (MEI).

Medicare Conversion Factor Cuts

Due to pre-established payment methodologies, a series of standard technical proposals and the expiration of a 3.75 percent legislative payment bump implemented in 2021, CMS lowered the Medicare payment conversion factor from $34.89 to $33.59 for 2022, a decrease of approximately 3.7 percent. This decrease impacts all health professionals.

Remote Patient Monitoring - A Smart and Efficient Way to Manage Patient Health

As we are still in the midst of COVID-19, many in healthcare are thinking about ways to better connect and care for our older patients. According to the CDC, approximately 85% of older adults have at least one chronic health condition, and 60% have at least two chronic conditions, including Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), hypertension, and diabetes. For many older people, coping with and managing chronic conditions while maintaining an independent and fulfilled quality of life can be challenging.

With patients' health in mind, clinicians can support by connecting with them via monitoring. Often, clinicians may underestimate how much patients want to be in control of their medical care. Studies have shown that in the long run, monitoring patients can improve their adherence to treatment, increase well-being, and save clinicians time and money while adding new sources of revenue.

What is Remote Patient Monitoring?

Remote Patient Monitoring (RPM) uses digital technology to capture and monitor patients' vitals and transmit them in real-time for monitoring and intervention. Physicians and clinicians manage their chronic patients remotely while increasing revenue. It is a proactive approach to value-based patient care.

RPM is a dynamic and efficient clinical tool to deliver healthcare. It allows the care team to receive a more frequent view of the patient's vital signs associated with his/her chronic conditions such as hypertension, congestive heart failure, COPD, and diabetes. Patients benefit from consistent regular monitoring of their vitals between visits, which not only increases their engagement but also helps them take charge of their health. With vitals being collected in real-time, clinicians can intervene and make proactive decisions to improve their patients' health and avoid catastrophic events.

RPM is delivered mostly by wireless measurement devices. Today, the most common monitoring devices include blood pressure monitors, pulse oximeters, weight scales, body

temperature, and blood glucose meters. Once patients collect their vitals, the data is transmitted in real-time to their physician and/or care team. These biometric devices are cost-effective, FDA-cleared, Bluetooth enabled, and most are supported by either WiFi or LTE wireless connectivity.

Benefits of RPM Implementation

In recent years, RPM has gained much attention and adoption as research has shown its efficacy in patient care. As a result, "it is an effective and efficient way for clinicians to closely monitor patients' chronic conditions, especially our senior patients, without them physically visiting a doctor's office or clinic. Implementing RPM programs at physician's practices, clinics, and health systems is a win for clinicians and patients.

The following are some key benefits of RPM for physicians, clinical staff, and patients:

Physicians and Clinical Staff:

- Improve patient care and long-term outcomes
- Monitor a patient's data in real-time
- Intervene and proactively provide actionable steps
- Build stronger relationships with patients
- Reach many patients in a more cost-effective way
- Reduce health care costs and hospital readmission
- Track progress and identify next steps to meet patients' health needs
- Receive Medicare and Medicaid reimbursement without additional new patients

Patients:

- Become more actively involved in their own healthcare
- Build more knowledge on personal health, awareness, and engagement

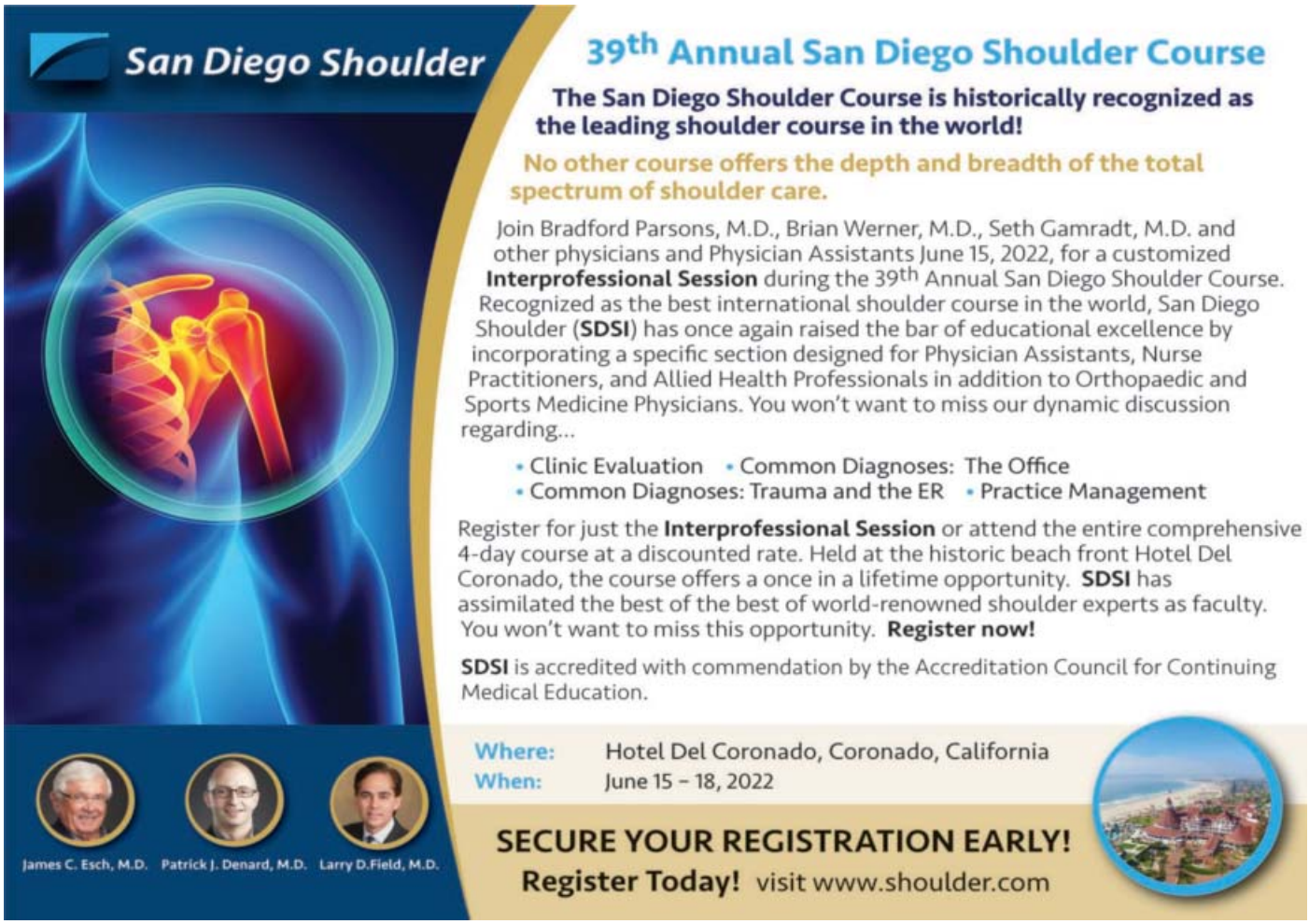
- Improve their adherence to treatment
- Increase their well-being
- Appreciate at-home convenience, consistent monitoring, and early intervention

In addition to better patient care, the Centers for Medicare and Medicaid Services (CMS) has a robust RPM reimbursement. As of spring of 2021, the Center of Connected Health Policy reported that twenty-six states have some form of RPM reimbursement in their Medicaid programs. On average, Medicare reimburses $120 per patient per month. The RPM codes are CPT 99453, CPT 99454, CPT 99457, and CPT 99458. You can learn the details of the CPT codes at the American College of Physicians (ACP) website. Furthermore, CMS published a document responding to Medicare fee-for-service billing in which it includes some answers to RPM reimbursement.

How to get started with RPM?

RPM is now and for the future. A successful RPM program begins with a thoughtful and supportive partnership to ensure that you reach your practice, patient, and revenue goals. As there are various RPM programs available, it is crucial to evaluate your needs first, then survey how these programs can meet the needs of your target patients. It is common to launch the RPM program targeting a specific condition with one RPM device. For example, a practice may want to begin with some hypertension patients by monitoring their blood pressure for one to three months. Once these patients have been successfully onboarded and monitored, physicians can gradually expand the program to provide patients with other chronic conditions using additional RPM devices. Again, when you are reviewing RPM programs, be sure to learn about the flexibility, features, and functions of the services available.

AdaptivMD provides Remote Patient Monitoring System (RPM) for patients who want to maintain their independent living while staying connected with their family and healthcare team. The system allows healthcare providers to manage chronic patients remotely and make timely health decisions to improve patient outcomes while yielding a positive revenue stream for their practice. AdaptivMD's mission is to use telemedicine and remote monitoring to reduce health disparities, improve quality of life, and allow people to maintain independent lives longer.



Meet the 2022 Recipients of CAPA's Student Scholarships

CAPA congratulates this year's four student scholarship recipients! We had a record number of applications this year and each of these students stood out due to their outstanding academic success and their dedication to the promotion and advancement of the PA profession. CAPA's volunteer leaders recognized unique and inspiring traits in each and every recipient and look forward to including them as future CAPA leaders and professional colleagues! We are proud to call each of these recipients not only CAPA members, but our 2022 CAPA Student Scholarship Recipients! Congratulations!

2022 Ray Dale Memorial Scholarship

Livier Camarena Sanchez, PA-S
Stanford University

Livier Camarena Sanchez is a first-year PA Student at Stanford University. In 2019, she completed her bachelor's degree in Biological Sciences and a minor in Chemistry from Stanislaus State University. Prior to attending PA school, she was a medical scribe in a local Emergency Department hospital where she learned the importance of preventative health and determinants that affect health. Outside the classroom, Livier enjoys going on walks, exploring new places, and spending time with her family and dogs.

2022 Ruth Webb Diversity Scholarship

Catherine Santizo, PA-S
USC Keck School of Medicine

Catherine Santizo is a second-year student at the Keck School of Medicine Primary Care PA Program. She graduated from CSUN in 2017 and worked as a medical assistant and medical scribe while preparing to apply to her dream school. As a PA student, she volunteered with USC's Pipeline Program, was a National Medical Fellowships PCLP scholar and loves to take part in community health events. After graduation, she plans to work in a primary care setting, particularly family medicine, and continue to increase health literacy among marginalized communities. Her goal as a future PA is to increase health equity in disadvantaged areas like the one she grew up in.

2022 Community Service Scholarship

Danielle Rauch, PA-S
Marshall B. Ketchum University

Danielle was born and raised in Orange County, California, and received her B.S. in Biology at the University of California, Riverside. After a decision to change career paths from teacher to PA, Danielle co-founded a Pre-PA Club and enrolled in an EMT program. She worked for the next 6 years as an EMT and ER tech before accepting a seat in Marshall B. Ketchum's School of PA Studies for the class of 2022. She currently serves her class as Vice President, Pre-PA Mentorship Club board member, and AAPA Representative and looks forward to graduating alongside her classmates in November 2022.

2022 Stuart Pinto Memorial Scholarship

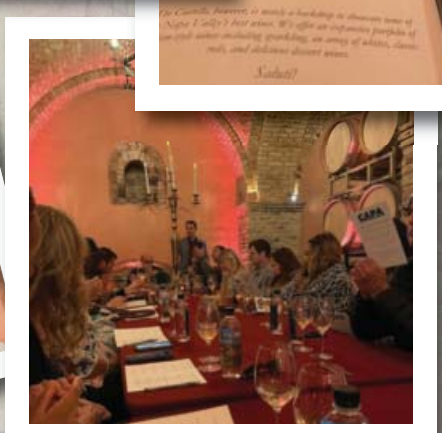
Elizabeth Peña, PA-S
Touro University

Elizabeth Peña is from California's East Bay and is a first-year dual PA and MPH student at Touro University. She is a first-generation graduate student and is planning to pursue a career in primary care after becoming certified. She has experience working with Bay Area youth and vulnerable populations in Oakland. Elizabeth is passionate about promoting and diversifying the PA profession to help meet the needs of California's diverse populations. She also serves as her program's CAPA student representative. During her study breaks, she enjoys watching short films.

CAPA at Napa

CALIFORNIA ACADEMY OF PAs

CAPA thanks all the attendees and exhibitors for their participation this year! We especially want to thank **Eisai** for supporting CAPA at Napa with an education grant!



PA Training Innovation Promotes Equity for Sickle Cell Disease

By Sandra Fineman, MPAS, PA-C
Marshall B. Ketchum University, School of PA Studies
Stefanie Sacknoff, PA-C
Division of Hematology/Oncology, University of California San Diego
Jolene Bastas, MSW, Judith R. Baker, DrPH, MHSA
Center for Inherited Blood Disorders, Orange, CA

In this second of a four-article series on PA's advancing health equity for Sickle Cell Disease (SCD), we explore how a PA School's partnership with a state consortium leads to a training innovation that utilizes PAs as core team members who promote health equity for SCD. Didactic material, clinical rotations, curriculum design partners, and relevance are outlined to stimulate course reproducibility statewide, which could help reduce provider shortages in the field of hematology.

Why should PA training prioritize promoting Health Equity for Sickle Cell Disease? Health equity is lagging for the 100,000 Americans diagnosed with Sickle Cell Disease (SCD).[1] This rare catastrophic disorder primarily affects the same racial and ethnic minorities who struggle with persistent discrimination in health care and the broader society. Severe shortages of expert SCD providers contribute to avoidable SCD morbidity and foreshortened lifespan.[2] However, PA's knowledgeable in SCD team-based management care can improve population health and be essential SCD clinic team members.[3] Yet, no formal SCD specialty training exists for PA students in California.

A PA Training Innovation in SCD: In 2020, Marshall B. Ketchum University's School of PA Studies partnered with Networking California for Sickle Cell Care (NCSCC), a state SCD consortium, to create and pilot a six-week certificate elective in SCD for students nearing graduation. The course's chief features are remote didactics and a clinical rotation at the Center for Inherited Blood Disorders (CIBD), which also serves as the lead agency for the NCSCC and a federal 13 state regional SCD collaborative, simultaneously serving as a nationally recognized SCD clinic.

Course didactics involve six lectures from expert SCD faculty clinicians, community health workers, patient/family members, advocates, and policy leaders. Course readings, student projects, and reflections round out didactics. To foster faculty/student engagement, Cohort 1 lectures were synchronous (over Zoom). These lectures were recorded and archived for asynchronous viewing by subsequent cohorts. Lecture series topics were SCD Medical overview – pediatrics and adults; Collaboration with Community Health Workers on the SCD Team; Reproductive Issues in Women; Understanding and addressing SCD health disparities; PA's Transforming Healthcare for SCD; and Understanding Obstacles: Patient/Parent perspectives.

Clinical Rotation: The four to six-week (36-40 hours/week) clinical rotation provides the PA student with hands-on patient care experience under the guidance of a board-certified preceptor. During the clinical rotations, students have the opportunity to apply the skills learned in the didactic phase and gain valuable experience in being part of an interdisciplinary team of healthcare professionals. Impromptu real-time case-focused teaching, based on patient problems presented to the multidisciplinary SCD team, supplement the patient care experience.

Course Evaluation: The SCD certificate course achieved proof of principle. Five students from the first two cohorts completed the course. Cohort three began in January 2022. Didactics, clinical rotation, and preceptorship experience were rated highly by all students. Objective knowledge gains quantified in pre/post-tests, and proposed changes to practice further demonstrate that the course serves as a valuable foundation in guideline informed care and SCD equity. Didactics were feasible to administer remotely. Recommended course changes include increased patient volume and 1:1 access to a PA working in an SCD clinic.

Relevance: This certificate course to promote health equity for SCD is highly relevant to PA educators, students, and licensed professionals. The innovations are multifaceted and generalizable. The didactics being offered remotely, in combination with student projects, reflections, and readings, serve as a promising educational bundle that has achieved proof of principle and could be tailored to different specialties, valuable in these pandemic times. Conducting the clinical rotation at an SCD Specialty Center is a strategic placement that ensures that PA students will see sufficient numbers of rare disorder patients to gain hands-on experience.

Partnering with State/regional leaders in the federal SCD network offers connectivity breadth and depth, not typically available at single institutions. Broad connections offer students valuable referrals nationwide for future employment in SCD. Conversely, the partnership offers connectivity depth - with local faculty, local PA SCD mentors, local SCD specialty clinics needed for clinical rotations, and prospects for local continuing education. The SCD focus gives PA educators opportunities to substantively address a major health disparity. Lastly, the didactic content ensures that PA educators address equity and attract an applicant pool interested in reducing health disparities.

Where can PA's find work in SCD Centers? California hosts several pediatric SC Centers, primarily at Children's Hospitals. The NCSCC is establishing a network of adult SCD clinics statewide; see the sources section for information.

What's next for the course? Future improvements involve contracting with a PA experienced with SCD care to provide mentorship and informal consultation. In late 2021, the course expanded as a pilot for nurse practitioners at Charles R Drew University of Medicine and Science, California's only Historically Black College, which also hosts a PA School, further evidence of the model's reproducibility.

How can PA Schools explore adopting the certificate elective in SCD? As the NCSCC continues to focus on growing California's sickle cell workforce and health care delivery statewide, it is evident that PAs Schools will play a key role in building the pipeline of clinicians knowledgeable about guideline informed care. That pipeline is essential to expanding access to exceptional, comprehensive team-based care. We welcome PA schools to explore adopting this course. To learn more contact Sandra Fineman: sfineman@ketchum.edu, Jolene Bastas: jbastas@c3dibd.org, or Dr. Judith Baker: JBaker@c3dibd.org

Also see: Networking California for Sickle Cell Care: https://sicklecellcare-ca.com/, and California's 2018 Sickle Cell Action Plan, an initiative of the Pacific Sickle Cell Regional Collaborative.

[1] National Academies of Sciences, Engineering, and Medicine. Addressing Sickle Cell Disease: A Strategic Plan and Blueprint for Action. The National Academies Press; 2020. http://doi.org/10.17226/25632

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"Health equity is lagging for the 100,000 Americans diagnosed with Sickle Cell Disease (SCD). This rare catastrophic disorder primarily affects the same racial and ethnic minorities who struggle with persistent discrimination in health care and the broader society."

PLANNING THROUGH THE AGES FOR 30 SOMETHINGS

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1. Save for Retirement. Longer life expectancies and less governmental assistance means you'll need a pretty large nest egg to provide for decades you may spend in retirement. So what's the good news? In your thirties you have time and compound interest on your side which means if you start now you can make saving easier over the rest of your lifetime. Consider this: If you save $1,000 per month starting at age 30, assuming a 6% return you could save $1.38M by age 65 but if you wait until age 40 to start saving you would need to save more than double each month to save the same amount!

You should aim to save 15% of your pay check to get on track for retirement but if you don't think it's possible, you need to take a closer look at how you prioritize your money. You'll kick yourself in your forties if you don't start saving now because you'll likely need to save twice as much per month to catch up and have to save twice as much at a time when family needs and expenses are typically at their peak.

2. Create Back-Up Plan for Family. You need to be sure that your loved ones are cared for in case you aren't around, so it's time to get life insurance and an estate plan. Term life insurance to replace your income during your working years is quite affordable in your thirties. While an estate plan is likely to cost you a few thousand dollars, it's vital to carry out your wishes and nominate guardians if you aren't there to care for your family and protect you if you become incapacitated.

3. Schedule Family Financial Life Meetings. Your thirties is a great time to get into the habit of regularly reviewing your financial picture and your goals. This regular meeting is even more important if you're married because no two people have the same views on how to best use resources to meet your goals and allows you to get on the same page. You'll want to map out your short-term goals (e.g., car repair, travel costs to friend's wedding), mid-term goals (buying a home, large trip) and long-term goals (retirement and college funding) and track your progress in writing so you can monitor your progress each meeting. Let us know if you would like to participate in an upcoming workshop or are interested in our downloadable family financial meeting agenda.

4. Align Your Resources To Your Goals. A budget doesn't limit you; it allows you to use your resources for what's important to you. One budgeting tool we like is to break up your income into three categories with 50% allocated to needs (housing, transportation, food), 30% allocated to wants (cable, vacations, dinner out) and 20% allocated to meeting your financial priorities (saving for retirement, paying down debt, creating an emergency fund). You choose what you spend within each bucket but the key is to spend only what you have allocated to each bucket. To see if your spending falls within the 50/30/20 method, you'll need to track expenses, discussed next.

5. Track Expenses. To align your resources to your goals, you need to know where your money goes each month. You can download Beacon Pointe's expense worksheet to get started or use technology to track your expenses over time. Mint.com is a popular budgeting website that categorizes your spending on credit cards or you can track as you spend by noting daily spending on the notes function of your smartphone or consider a popular app such as Ace Budget to track and categorize expenses.

6. Create an Emergency Fund. Unexpected emergencies arise and you want to cover them without charging up your credit card or relying on family. A good rule of thumb is that you should have enough cash reserves to cover three to six months of expenses.

7. Check Your Credit. If your credit score is low, lenders, insurers or employers view you as less reliable so you'll pay more to borrow or get insurance and could even be passed over for a job. For information on how to request your credit reports and understand and improve you score, click here.

8. Keep Debt in Check. While saving for retirement is important, paying off credit card debt makes more financial sense and can even save you money by improving your credit. Before you save for retirement, use funds from the 20% of your income bucket allocated for savings to pay down your highest interest rate card first then paying off cards charging lower interest rates. Once your cards are paid off, only charge what you are able to afford to pay off each month which shouldn't be a problem as long as you stick to your budget. If you have student loans, split your savings resources between paying of student loan debt and saving for your retirement. Just be sure to make student loan payments and speak with your lender if you are having difficulties in making payments. For information on options in repaying federal student loans, click here.

9. Learn About Investing. Now that you are starting to save you need to learn the basics of investing. You should know how to evaluate your investment performance and determine whether your asset allocation fits your needs. Let us know if you would like to participate in a basics of investing workshop or want us to take a second look at how you've structured your investments.

CMS Continues To Modernize By Expanding Reimbursement For Digital Health Services

By Roger A. Cohen, Anne Brendel and Matt Wetzel
Goodwin Procter LLP

The COVID-19 Public Health Emergency ("PHE") fundamentally changed the healthcare industry, forcing healthcare providers and patients onto their computers and phones to enable continuation of care when patients were mandated to stay home across the country. Prior to the COVID-19 PHE, approximately 12,500 Medicare beneficiaries received telehealth services and only 106 telehealth services were reimbursable. By October 2020, over 24.5 million (of 63 million) Medicare beneficiaries received telehealth services.

The Centers for Medicare and Medicaid Services (CMS) first began reimbursing remote patient monitoring ("RPM") services in 2019 and expanded coverage for RPM services each year. As of January, 1 2022, CMS further expanded remote care by recognizing therapeutic monitoring ("RTM") services as Medicare-reimbursable services under the CMS' CY 2022 Medicare Physician Fee Schedule ("PFS") Final Rule ("CY 2022 Final Rule"). Under the CY 2022 Final Rule, CMS also expanded coverage of telehealth services by removing access barriers — increasing access to mental healthcare nationwide.

Medicare Coverage of RTM

While similar to RPM, RTM has a few notable differences. First, RTM involves the collection of non-physiological data, including medication adherence, therapy and medication responses, and pain levels. This data may be patient reported or digitally uploaded, whereas RPM data is physiological and may only be digitally uploaded. Further, RTM codes may only be used to monitor health conditions (e.g., musculoskeletal system status, respiratory system status, and therapy adherence and response). Finally, primary billers of RTM services are projected to be physiatrists, nurse practitioners, and physical therapists while RPM services are primary billed by physicians and ancillary providers, such as physician assistants.

The CY 2022 PFS Final Rule adds coverage for the following RTM Codes:

- CPT code 98980: Remote therapeutic monitoring treatment management services, physician/other qualified healthcare professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes.

- CPT code 98981: Remote therapeutic monitoring treatment management services, physician/other qualified healthcare professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes.

- Practice Expense-only RTM codes:

    - CPT code 98975: Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment.

    - CPT code 9897: Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s)

CMS Continues To Modernize By Expanding Reimbursement For Digital Health Services

supply with scheduled e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days.

- o CPT code 98977: Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor.

Permanent Telemental Health Medicare Reimbursement Changes

CMS first established reimbursement for certain audio-only telemental health services in its Medicare and Medicaid Programs' Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency Final Rule. CMS was primarily focused on continuation of care for opioid use disorders ("OUD"). CMS further expanded coverage for telehealth audio-only services (e.g., E/M services) on an interim basis in its CY 2021 PFS Final Rule.

While still trailing far behind commercial third-party payor policies, CMS has further softened its historic requirement for real-time two-way audio-video technology for telehealth services and has recognized that audio-only telehealth may be appropriate in certain circumstances for the provision of mental health services (i.e., the evaluation, diagnosis, and treatment of mental health conditions) provided by rural health clinics ("RHCs"), federally qualified health centers ("FQHCs"), and opioid treatment programs.

Notably, CMS also provided some insight into post-pandemic telehealth reimbursement and technology requirements, stating, "[f]or telehealth services other than mental health care, we continue to believe that two-way, audio/video communications technology is the appropriate, general standard that will apply for telehealth services after the PHE, so we do not believe it would be appropriate for these codes to remain on the telehealth list after the end of the PHE."

RHCs and FQHCs

To address the concerns that, following the PHE, without changes to the definition of "mental health visits," RHCs and FQHCs would no longer be paid for telemental health services, CMS finalized its proposal "to revise the current regulatory language for RHC or FQHC mental health visits to include visits furnished using interactive, real-time telecommunications technology and for RHCs and FQHCs to report and be paid for mental health visits furnished via real-time, telecommunication technology in the same way they currently do when these services are furnished in-person..." during the PHE.

Further, CMS noted that RHCs and FQHCs would be paid for telemental health visits at the same rate as in-person visits.

Opioid Treatment Program Counseling and Therapy

CMS approved the use of audio-only telephone calls following the COVID-19 PHE for substance use counseling and therapy, including group therapy, furnished by opioid treatment programs where two-way audio-video technology is not available to the beneficiary (i.e., the beneficiary is not capable of using two-way audio-video technology or has not consented to the use of such technology) and other applicable requirements are met. CMS deferred to the treating clinicians to determine when and if in-person sessions were necessary for SUD and co-occurring mental health disorders.8

CMS also clarified that practitioners may continue to use the therapy/counseling add-on HCPCs code G2080 for audio-only telephone sessions following the conclusion of the COVID-19 PHE.

The Future: Medicare Telemental Health Services Coverage for Patients Located in Their Homes

Following recently enacted legislation that added individual's homes as a permissible originating site location9, CMS proposed to offer coverage for telemental health services provided to Medicare beneficiaries in their homes via audio-only technology with a caveat that the provider must have the capacity to furnish two-way, audio-video telehealth services. CMS is currently in the process of finalizing a service-level modifier for such services. However, a physician or practitioner must have furnished a Medicare reimbursable item or service in-person without the use of telehealth within six months prior to the initial telemental health service and once within twelve months of each subsequent telehmental health visit.10 There are some exceptions to the periodic subsequent in-person visit requirements, including when the risk of an in-person visit outweighs the benefits; however, there are no exceptions to the initial in-person visit requirement.

Staying up-to-date on regulatory and reimbursement changes remains incredibly important for digital healthcare providers to ensure that they are receiving appropriate payments for the services they provide and making informed business decisions when it comes to service area expansions and market entries.

Building Resilient Psyches in Children of Immigrants:

A Student's Commentary

By Elliot Yamin PA-S, USC Keck School of Medicine '24

Resiliency is not a prescription, but rather a curated preventative remedy for children in immigrant families (CIF). One in four American children can be classified as CIF, as noted in 2019 [1]. California houses the highest immigrant population in the U.S., the majority from Latin America or Asia [2]. Notably, California was the primary state of residence for CIF with parents from Armenia, Iran, Afghanistan, and Ukraine [3]. Due to CIF patient potentiality, building acceptance for cultural backgrounds in healthcare is crucial to the trajectory of wellness. CIF have a risk for poor health outcomes due to an association with exposures to stressors aecting epigenetic pathways [4]. Even so, a meta-analysis demonstrated that psychotic disorders among immigrants persist into the next generation [9]. The relevance in learning about the CIF population stems from strengthening resilience utilizing pharmacological, psychological, and lifestyle interventions since trauma, chronic adversity, and stressful life events aect development, neurochemicals, and functional neural circuitry [8]. Psychological stressors and resilient protective factors (RPF) contribute to the risk of changing epigenetic mechanisms in CIF [6]. RPF decreases epigenetic changes while psychological stress increases these risks. RPF may consist of social support, optimism, subjective social status, educational support, perceived self-worth, healthy coping strategies, or productive practices. Adversity for CIF may include discrimination (racism, xenophobia, antisemitism, islamophobia), poor living conditions, financial hardships, separation, lack of education, unemployment, bullying, and minority stressors. When exposed to toxic environments, CIF become linked with a variety of health problems that can induce heightened physiological and psychological states; hypothesized to cause acute and chronic conditions that cause symptoms like anxiousness, gastrointestinal issues, changes in blood pressure, and cortisol spikes. Some CIF, but not all, may need counseling for migrational health issues, communicable and noncommunicable diseases, oral health, nutrition and growth, developmental and educational considerations, disruptions to basic experiences that allow for health development, emotional and behavioral problems in relation to identity formation, and other apparent or subliminal conditions [5]. While excessive stressors have been shown to have detriments on physical and mental health, we should promote RPF to counteract clinical findings.

The health inequities of CIF become more apparent when we recognize the amount of pressure placed on being the family's first to navigate new territories, ensuring that they are *perfectly* getting it done or living life *right*. Bearing the role as a trailblazer, CIF may be apprehensive of seeking treatment due to shame, guilt, fear, and not to

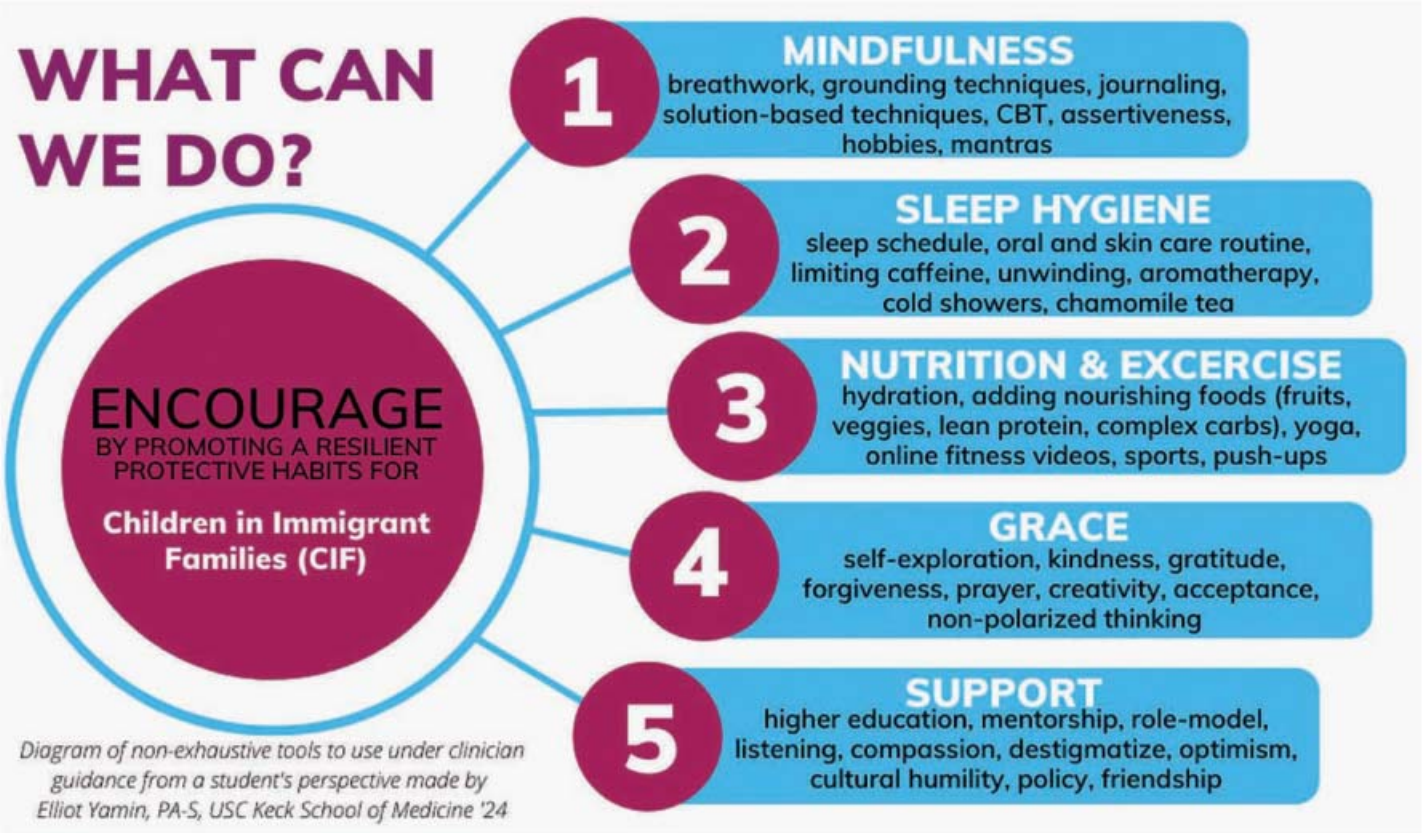

Diagram of non-exhaustive tools to use under clinician guidance from a student's perspective made by Elliot Yamin, PA-S, USC Keck School of Medicine '24

mention the unknowingness of how to use health insurance. By using the "LEARN" process (listen, explain, acknowledge, recommend, negotiate), we can value CIF by developing patient-centered systems that assess cross-cultural issues engaging in curiosity, empathy, and respect [5]. Improving systematic areas will heighten CIF quality of life by acknowledging adversity. Suggesting to work on legislative aspects, community regards, and interpersonal features will help advance health disparities amongst CIF [7]. In order to reduce laxity to stress-related pathology, CIF should be enabled to respond and master the challenges of life, as they may have never been advised well enough to handle. Maybe even digging a little bit deeper when CIF say, "everything is okay," as their normal can hold great weight. CIF hold strong multicultural identities that have the opportunity to embrace the progress of our country's health.

"While certain factors might make some individuals more resilient than others, resilience isn't necessarily a personality trait that only some people possess. On the contrary, resilience involves behaviors, thoughts, and actions that anyone can learn and develop." [10].

From my perspective, CIF are the link to facilitating familial healing, enhancing physical and mental well being of all generations by multiple folds. As a CIF, I am subjected to and witness the acculturation process which is used as a protective strategy, in an attempt to transform culture, assimilate and integrate, to live with ease in America. Conflict, in the self or interpersonal relationships, tends to arise when CIF core values are enhanced or challenged. Other CIF may have chosen to route through marginalization or separation to maintain traditional cultural identity to cope with rapid generational changes. CIF should work on developing RPF through directing their energy– motivating condence in one's self, rening communication, problem-solving capacity, realistic planning, and regulating impulses. CIF hold endless profound resilient attributes: resourceful, reliability, communal-suciency, perseverance, goal-orientated, foresightful, compartmentalization, maturity, hopeful, independence, skepticism, strategical, and supportive. Furthermore, personal lives can pose dierent levels of responsibilities and dynamics impacting the defense of RPFs. Targeting societal structures will aid in healing CIF circumstances, addressing points such as bias, employment, higher education, public benets, environmental conditions, hospital and clinic access, family values, social connections, language, history, and socioeconomic status. For the welfare of CIF, we can promote resilient protective habits to combat physical and psychological stressors. Mindfulness, sleep hygiene, nutrition & exercise, grace, and support are tools we can use that encourage resilience to reduce health-compromising epigenetic changes. Withall, the fresh generations of CIF Californians are a powerful group of individuals, who are providing contemporary waves of contributions to all communities.

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NorthBay Health Care

Jose Barros, PA-C, *Associate*
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Brianna Cardenas, PA-C, *Fellow*
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Dillan Firestone, PA-C, *Fellow* PNMG

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Ke'Era Macon, PA, *Fellow*
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Sharp Grossmont Hospital

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Katherine Garner, EMT, *Affiliate*
Cross Country Staffing Network

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Michael Ross, PA-C, *Associate*
Optum

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Carolyn Le, PA-C, *Associate*

Verenisse Bejarano, PA-C, *Associate*
Dignity Health

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Zenith Health

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Centric Health

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Christopher Ludlow, PA-C, *Affiliate*

Hector Gonzalez, PA, *Associate*
UCI Medical Center

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University of Saint Joseph, Connecticut

Jeffrey Sabido, PA-C, *Associate*
VA Northern California Health Care System

Ramon Gonzalez, PA, *Associate*
MVP Family Practice & Sports Medicine

Kameko Oshiro, PA-C, *Associate*

Rose Hare, PA, *Associate*
Center of San Antonio Grand Rounds

Jessica Smith, PA, *Fellow*

Gabrielle Temple, PA, *Fellow*

Physician Assistant, Nuclear Medicine
Sutter Health Valley Area
Sacramento

Sutter Medical Group is seeking a full time Physician Assistant or Nurse Practitioner to join an established Nuclear Medicine practice in Roseville, CA.

Willingness to participate in continued education and development of skillsets in support of program development and responsibilities within the service line.

(Minimum 2+ years of experience as an NP/PA is required)
Duties may include, but not limited to, seeing follow-up patients, patient history, clearing patients for stress tests, post procedure evaluations. Applicant must also be comfortable with Electronic Medical Records. Candidates must be Nationally Certified and eligible for a California and DEA License.
Sutter Medical Group is a successful 1,100+ member multi-specialty group offering the opportunity to be part of a progressive, financially sound and collaborative organization. SMG is recognized as a Top Performing Physician Group by the Integrated Healthcare Association. Our members are dedicated to providing the highest quality and most complete health care possible to the people in the communities we serve in the greater Sacramento Sierra Region of Amador, Placer, Sacramento, Solano and Yolo Counties.

Join us and enjoy:
- Competitive salaries, excellent benefits, and generous vacation time
- Financial support for CME opportunities
- Advanced practice technology, including Electronic Medical Records
- A positive work-life balance and Northern California's natural beauty and lifestyle

Contact Information:
Michelle Pedler, Physician Recruiter
Sutter Health Valley Area
Develops@sutterhealth.org

Physician Assistant
Saddleback Pulmonary Associates
Laguna Hills

Looking for a full time PA to work at a busy private practice in beautiful South Orange County. You will be seeing patients in the office as well as

JOB POSTINGS continued

the hospital. It is a pulmonary/sleep practice and we also do hospitalist work. Will consider new graduate when residency/clinic training is complete. Competitive pay with great benefits. Must be licensed Physician Assistant . Email CV to drshahinian@cox.net

- Medical, Dental and Vision Insurance
- Paid time off
- 401k

Urgent Care Physician Assistant
GoHealth Urgent Care
San Francisco

GoHealth is seeking an experienced Urgent Care Physician Assistant in full or part time roles.

GoHealth Urgent Care is a different kind of practice.

- Partnering with Dignity Health allows us to reach beyond the episodic patient treatment of traditional urgent care.
- Our state-of-the-art centers are beautiful, patient-friendly and equipped with imaging, labs, and an advanced ECW EMR.
- Our patient satisfaction scores validate our focus on the quality of care.

A GoHealth Urgent Care career offers:

- More autonomy with mentoring and support when you need it.
- An on-site staff of Rad Techs and Medical Assistants who assist you by taking vitals, reviewing medications, applying splints, and administering meds and vaccines. Scribes are also offered at busier locations to work alongside our providers.
- Competitive compensation and comprehensive benefits package through Dignity Health.
- Professional support and options for best practice from one of the nation's fastest-growing urgent care networks.

Minimum Qualifications:

- 2 years recent experience treating acute/episodic conditions in both pediatric and adult patient populations (all ages).
- Emergency Medicine and/or Urgent Care experience required.
- Comfortable with minor procedures (sutures, casts, splints, etc.), initial reads of EKGs and X-rays.

If you are looking to take your career to the next level, we look forward to speaking with you. Lee.meyer@gohealthuc.com

Physician Assistant Faculty, PT & FT
Betty Irene Moore School of Nursing at UC Davis
Sacramento

The Betty Irene Moore School of Nursing at UC Davis seeks innovative and highly motivated master's-degree or doctorally prepared physician assistants to join the faculty in the Master of Health Services — Physician Assistant Studies Degree Program at UC Davis Health in Sacramento, California.

A dynamic team of interprofessional faculty focuses on preparing new primary-care providers, including physician assistants and family nurse practitioners, especially for underserved areas. Nearly 60 percent of UC Davis physician assistant graduates work in primary care. Launched with a vision to advance health through leadership, the Betty Irene Moore School of Nursing at UC Davis seeks physician assistant faculty to collaborate with faculty from multiple disciplines and further this vision to prepare clinicians who deliver care as members of health care teams. Faculty fully participate in the development of the school's high-impact and interprofessional programs.

Physician assistant faculty provide a combination of clinical care and clinical teaching activities, including didactic instruction, clinical skills lab instruction, curriculum development and assessment and coordination of course activities related to the didactic and clinical phases of the program.

Part-time and full-time, non-tenured positions at the assistant and associate rank in the Health Sciences Clinical Professor (HSCP) Series are available at UC Davis Health, which is located on a modern, 140-acre campus in Sacramento, California. The Sacramento campus is home to the School of Nursing, School of Medicine, UC Davis Medical Center (including a level-I trauma center and burn unit, and a full range of outpatient services), a fully accredited children's hospital, and an NCI-designated comprehensive cancer center. Practice locations include UC Davis Health Medical Center, UC Davis department and primary care network clinics, Sacramento County clinics, local FQHCs and other clinical sites.

For more information:
If you are interested in more information, please send an email with your questions to tamlewis@ucdavis.edu.

Full position announcement and application details can be found at http://nursing.ucdavis.edu/ourteam/join.

Physician Assistant
County of Sonoma Department of Health Services
Santa Rosa

The County of Sonoma Department of Health Services is seeking California-licensed candidates to fill a full-time Physician Assistant position in the Behavioral Health Division.

Starting Salary up to $64.46/hour ($134,535/year) plus a cash allowance of approximately $3.45/hour.*

Working at the County offers expansive opportunities for growth and development, the ability to be a part of a challenging and rewarding work environment that provides continuous training, education, and the satisfaction of knowing that you are working to better our communities. You can also look forward to some excellent benefits*, including:

- An annual Staff Development/Wellness Benefit allowance up to $600 and ongoing education/training opportunities
- Competitive vacation and sick leave accruals, 12 paid holidays, and an additional 8 floating holiday hours per year
- County paid premium contribution to several health plan options
- County contribution to a Health Reimbursement Arrangement to help fund post-retirement employee health insurance/benefits
- Retirement fully integrated with Social Security
- May be eligible for up to 8 weeks (320 hours) of Paid Parental Leave after 12 months of County employment
- Eligibility for a salary increase after 1,040 hours for good work performance; eligibility for a salary increase for good performance every year thereafter, until reaching the top of the salary range

Under the direct supervision of a licensed Physician, the Physician's Assistant assesses complex youth and adult clients in need of medication evaluation, prescribes psychoactive medications, and monitors clients for side effects and treatment effects. This position interacts with multi-disciplinary treatment teams to plan a course of treatment and manages presenting symptoms of clients related to medication support; collaborates and integrates treatment with medical providers; assesses and evaluates changes in mental status and risk, taking appropriate actions; participates in case conferences related to complex treatment issues; participates in trainings and lectures required by the Behavioral Health Division; and may be assigned to work irregular hours and days.

JOB POSTINGS continued

Faculty, PA Program
Southern California University of Health Sciences
Whittier

Full-time University Faculty, Master of Science: Physician Assistant Program
This position is primarily responsible for serving the Master of Science: Physician Assistant program (MSPA). This position is subject to an annual Faculty Performance Appraisal (FPA) which consists of an evaluation of teaching and service. The faculty member is responsible for applying their expertise to develop and deliver courses that improve the learning outcomes of our students. In addition, the full-time faculty member will actively participate in departmental and university meetings, student selection, remediation, Physician Assistant Clinical Application (PACA) course series lab sessions, Objective Standardized Clinical Examinations (OSCE), faculty forums, white coat ceremonies, graduation, and perform additional duties as assigned by the Program Director and Assistant Provost.

ESSENTIAL DUTIES AND RESPONSIBILITIES:
- Supports the Mission, Vision, and Values of SCU
- Teaches assigned courses in accordance with Program Learning Objectives, Course
- Learning Outcomes, and Instructional Objectives.
- Supports the MSPA department and other team members
- Uses appropriate teaching strategies and methods such as, but not limited to, formal lecture, case studies, small group discussions, active learning, in-person laboratory activities, and self-directed instruction
- Modifies teaching methods based on assessment results and best practices in teaching and learning
- Assess student learning through various assessments
- Submits student grades and course reports as required i.e. attendance
- Attends and actively participates in department and university meetings
- Remains current in their discipline and updates course content as needed
- Participates in the annual FPA
- Work in a team and committee environment in a courteous and professional manner
- Maintains all licenses and certificates necessary for employment eligibility
- Performs other duties and responsibilities as assigned
- Assists with the end-of-term processes including associated reports, processing, and generating letters to students for academic standings, Dean's and President's lists Maintenance of Resource Materials.
- Scans and indexes files into the document imaging system.
- Performs other related duties as assigned by management.

MSPA PRINCIPAL FACULTY MEMBER RESPONSIBILITIES:
A Principal Faculty member is responsible for and must actively participate in the following:
- Developing, reviewing and revising as necessary the mission statement, goals and competencies of the program
- Applicant interviews
- Selecting applicants for admission to the MSPA program through collaboration with the Admissions Committee
- Provide student instruction
    - o A Principal Faculty member may be assigned the role o course lead, teaching assist, or admin assist for one or more courses per term.
    - o Student instruction may occur either in-person or virtually d pending on course assignment
    - o Teaching assignments may vary term by term depending on the needs of the program.
- Meeting the academic needs of enrolled students
    - o A Principal Faculty member is expected to be available to participate in in-person learning activities such as PACA lab sessions, OSCEs, as well as any other teaching assignment.
- Evaluate student performance
- Academic counseling and advising of students
- Provide remedial instruction as necessary
- Designing, implementing, coordinating, and evaluating the curriculum
- Evaluating the program
- Attend in-person events including the White Coat Ceremony and Graduation

QUALIFICATIONS:
- Graduate of a fully accredited PA, MD, or DO Program with at least 3 years of clinical practice experience in the U.S. NPs with applicable clinical and teaching experience will be considered. Current licensure and NCCPA certification (for PAs) is required. Exceptional candidates with less than three years of clinical experience may be considered.
- Prior faculty experience in PA or medical education, as well as interprofessional education and incorporating technology including simulation into teaching and practice, is strongly preferred. Proficiency in hands-on clinical skills is required.
- Computer skills required:
    - o MS Office 365, MS Teams and SIS system
- Other skills required:
    - o Ability to write reports, business correspondence, and procedure manuals. Ability to effectively present information and respond to questions from groups of managers, clients, customer, and the general public.
    - o Ability to prioritize work, perform well under pressure and maintain productivity despite consistent interruptions.

Physician Assistant
Corky Hull Medical Associates
Tracy

Since 1992, the Corky Hull medical group has provided occupational health services to 1500 employees at a federal distribution facility in Tracy, CA. However, the focus of this program has evolved to incorporate a strong emphasis on wellness, health promotion, and chronic disease management.

The most unique aspect of this position is that you are valued for the quality of the patient interaction, not the number of patients you see in a day. A very moderate patient volume (8-10 patients/day) allows the clinician extensive time to develop a strong working relationship with the employee/patient and gives you the opportunity to have a major impact on their physical and mental health. The clinician has full autonomy to manage their patient schedule, other work tasks, and will have a lead role working to develop the facility-wide health promotion program.

Excellent Work-Life Balance and Comprehensive Benefits: office hours 7am to 3:30pm, Mon to Fri; no call, evenings, or weekends. Competitive salary with annual raises; medical, dental, vision, and disability insurance; paid vacation, sick leave, and holidays; paid CME; and retirement plan.

Position Requirements: Seeking a personable, motivated clinician with good clinical and communication skills who values what this position has to offer. Must be able to work independently with supervision as needed. Prefer 1-2 years clinical experience but will consider new grads.

Please email your resume to corkyhullmd@gmail.com to discuss the position further.

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

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PAID
SANTA ANA, CA
PERMIT NO 949

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June 1 – July 31, 2022

Topics covered this year: Cardiovascular Conditions, Endocrinology, Women's Health, Urology, Oncology, and more!

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