2015 Summary of Actions
AAPA House of Delegates
San Francisco, CA
May 23-25, 2015

Note: Resolutions marked with ** require AAPA Board of Directors ratification.

Resolution	Title	Line Number	Action Taken
2015-A-01	Student Academy Delegates	1	Adopted on Consent Agenda
2015-A-02	Elected Delegates	22	Adopted on Consent Agenda
2015-A-03	Secretary-Treasurer Duties	54	Adopted on Consent Agenda
2015-A-04**	Chief Executive Officer	209	Adopted as Amended
2015-A-05	Board Committees	235	Rejected
2015-A-06	Amendments to the Bylaws	277	Adopted
2015-A-07**	Nominating Work Group	337	Adopted as Amended
2015-A-08(a)**	Elections	410	Adopted as Amended
2015-A-08(b)	Elections	461	Adopted
2015-A-09**	Board of Directors Vacancies	529	Adopted on Consent Agenda
2015-A-10	Alternate Delegates	645	Adopted on Consent Agenda
2015-A-11	Alternate Delegates 2	651	Adopted on Consent Agenda
2015-A-12**	Fellow Membership Criteria	657	Adopted as Amended
2015-A-13	Voting Rights for Retired Membership	678	Rejected
2015-A-14	Hospice Reimbursement	702	Adopted
2015-A-15	Tobacco Legislation	708	Adopted on Consent Agenda
2015-A-16	Tobacco Use	717	Adopted on Consent Agenda
2015-A-17	Providing Evidence-Based Education about the Dangers of Smoking	727	Adopted on Consent Agenda
2015-B-01	PA Practice	736	Adopted as Amended
2015-B-02	Payment Policy as Differentiating Factor	746	Adopted as Amended
2015-B-03	PA Obligations	755	Adopted on Consent Agenda

2015-B-04	NCCPA Entrance-Level Standards	780	Adopted on Consent Agenda
2015-B-05	Social Security Act	789	Adopted on Consent Agenda
2015-B-06	Public and Private Insurers	804	Adopted on Consent Agenda
2015-B-07	Provider Lists	812	Adopted on Consent Agenda
2015-B-08	Telemedicine Position Paper	820	Adopted as Amended
2015-B-09	Professional Competence Position Paper	992	Adopted as Amended
2015-B-10	Physician Associate or Physician Assistant as the Title of the PA Profession	1196	Rejected
2015-B-11	Recertification Exam Cycle	1203	Rejected
2015-B-12	Clinical Doctorate for PAs	1207	Rejected
2015-B-13	Global HIV/AIDS Epidemic Position Paper	1212	Adopted on Consent Agenda
2015-B-14	Emerging Infectious Diseases	1602	Adopted on Consent Agenda
2015-B-15	Medical Home	1610	Adopted as Amended
2015-B-16	Breastfeeding	1655	Adopted on Consent Agenda
2015-B-17	Compilation of Data to Support Scope-of-Practice Legislation	1664	Rejected
2015-B-18	Hepatitis Screening	1674	Rejected
2015-B-19	Support for Birth Cohort Screening for Hepatitis C Virus	1680	Rejected
2015-B-20	AAPA Opposes Entry-Level Degree	1687	Adopted - Reaffirmed
2015-B-21	Optional Specialty Exams	1693	Rejected - Expired
2015-B-22	Practice in a Given Specialty	1700	Adopted - Reaffirmed
2015-C-01	Human Trafficking	1707	Adopted as Amended
2015-C-02	Decriminalization of Victims of Human Trafficking	1714	Rejected
2015-C-03	Scientific Integrity and Public Policy Position Paper	1719	Adopted on Consent Agenda
2015-C-04	Improving Children's Access to Health Care Position Paper	1799	Adopted as Amended
2015-C-05	Primary Care	1909	Adopted as Amended
2015-C-06	Accreditation Site Teams	1932	Adopted on

			Consent Agenda
2015-C-07	Promotion of PAs	1939	Adopted on Consent Agenda
2015-C-08	The PA in Disaster Response: Core Guidelines Position Paper	1952	Adopted on Consent Agenda
2015-C-09	Physical Activity	2429	Adopted on Consent Agenda
2015-C-10	Responsible Sexual Behavior	2445	Adopted on Consent Agenda
2015-C-11	Substance Abuse	2453	Adopted on Consent Agenda
2015-C-12	Chronic Disease Management	2464	Adopted on Consent Agenda
2015-C-13	Health Literacy	2482	Adopted on Consent Agenda
2015-C-14	Public Awareness of Organ and Tissue Transplantation	2492	Adopted on Consent Agenda
2015-C-15	Climate Change	2499	Adopted as Amended

Reaffirmed Policies		
HA-2100.2.1	HP-3300.3.1	HX-4300.1.2
HP-3100.1.1	HP-3300.3.2	HX-4300.2.3
HP-3200.2.6	HP-3800.1.1	HX-4400.1.5
HP-3200.2.6.1	HX-4100.1.1	HX-4400.1.8
HP-3200.3.4	HX-4100.1.3	HX-4400.1.9
HP-3200.3.7	HX-4100.1.4	HX-4400.2.1
HP-3200.4.5	HX-4100.1.9	HX-4500.4
HP-3200.5.1	HX-4100.2.1	HX-4600.2.6
HP-3200.5.2	HX-4100.2.2	HX-4600.5.9
HP-3200.6.1	HX-4200.1.2	HX-4600.6.3
HP-3300.1.1	HX-4200.3.1	HX-4600.6.4
HP-3300.1.2	HX-4200.3.2	HX-4700.1.1
HP-3300.2.1	HX-4200.3.3	HX-4700.4.1
HP-3300.2.3	HX-4200.4.2	HX-4800.1
HP-3300.2.6	HX-4200.5.1	

New Business	**Line Number**	**Action Taken**
2015-NB-01	2511	Motion Passed Unanimously

Resolutions of Condolence	**Line Number**	**Purpose**
2015-COND-01	2519	Condolence for Iain Keir Todd
2015-COND-02	2547	Condolence for David Michael Jones
2015-COND-03	2636	Condolence for Marisa Eve Girawong

Resolution of Commendation	**Line Number**	**Purpose**

2015-COMM-01	2667	Commendation for US Public Health Service PAs
2015-COMM-02	2736	Special Resolution of Positive Energy for Karl Wagner
House Elections	**Line Number**	
Results	2761	

Bolded text within a resolution indicates the amendments submitted and accepted during the reports of the reference committees on May 25, 2015.

Presiding Officers

L. Gail Curtis, MPAS, PA-C, DFAAPA	Speaker
David Jackson, DHSc, PA-C, DFAAPA	First Vice Speaker
William Reynolds, MPAS, PA-C, DFAAPA	Second Vice Speaker

2015-A-01 – Adopted on Consent Agenda

Amend Bylaws Article V as follows:

ARTICLE V Student Academy.

Section 1: Purpose. The Student Academy of the AAPA is the national representative body of the AAPA student members and, as such, while embracing all the AAPA policies and purposes, the Student Academy further strives to serve students.

Section 2: Assembly of Representatives. The Student Academy shall have an Assembly of Representatives ("AOR"), which shall represent the interests of the AAPA student members. The AOR shall be composed of representatives of the student members as set forth in the Student Academy Bylaws and policies. The AOR is responsible for determining the process for ~~selection~~ ELECTION of the student delegates to the AAPA House of Delegates in accordance with Article VI, Section 2.

Section 3: Student Director. The Student Director of the Academy shall be elected in the manner set forth in the Student Academy Bylaws and policies, and in accordance with the requirements of North Carolina law.

2015-A-02 – Adopted on Consent Agenda

Amend Bylaws Article VI, Section 2 as follows:

ARTICLE VI House of Delegates.

Section 2: Composition. The voting membership of the House of Delegates shall consist of the immediate past and current House Officers, one delegate elected by each officially recognized specialty organization, one delegate ELECTED from each caucus, delegates ELECTED from Chapters, and delegates ELECTED from the Student Academy of the American Academy of Physician Assistants. All delegates, other than those of the Student Academy, shall be fellow members of the Academy. Student delegates shall be student or fellow members of the Academy. The delegates from the Chapters, specialty organizations, and caucuses are elected by the fellow members of those organizations. THE DELEGATES FROM THE STUDENT ACADEMY ARE ELECTED BY THE STUDENT MEMBERS OF THE ASSEMBLY OF REPRESENTATIVES. Chapter and Student Academy delegate seats shall be allocated as follows:

a. Chapter Delegates. Each Chapter shall be entitled to two (2) delegates. Additional delegates will be apportioned among the Chapters according to the number of Academy fellow members within the jurisdiction of each as of January 31 of each year. When the number of fellow members within a Chapter's jurisdiction exceeds 220, it will be apportioned a third delegate. An additional delegate will be apportioned for each 300 additional members within a Chapter's jurisdiction thereafter. The Academy's Constituent Relations Work Group will develop and recommend to the Board the definition of the Chapters' jurisdiction.

b. Student Academy Delegates. The Student Academy shall be entitled to one delegate for each 850 Student Academy members as of January 31 of each year.

2015-A-03 – Adopted on Consent Agenda

Amend Bylaws Article VII as follows:

ARTICLE VII Board of Directors and Officers of the Corporation.

Section 1: Board Duties and Responsibilities. The Academy shall have a Board of Directors, which, in accordance with North Carolina law, shall be responsible for the management of the Corporation, including, but not limited to, management of the Corporation's property, business, and financial affairs. In addition to the duties and responsibilities conferred upon it by statute, by the Articles of Incorporation, or by these Bylaws, it is expressly declared that the Board of Directors shall have the following duties and responsibilities:

a. To grant charters to Chapters, recognize specialty organizations, establish criteria for caucuses, and establish Academy commissions or work groups as may be in the best interests of the Academy, taking into consideration any recommendations of the House of Delegates thereon;
b. To appoint or remove the Executive Vice President pursuant to the affirmative vote of a two-thirds (2/3) majority of the Directors;
c. To direct the activities of the Academy's national office through the Executive Vice President;
d. To provide for the management of the affairs of the Academy in such a manner as may be necessary or advisable;
e. To establish committees necessary for the performance of its duties;
f. To establish, regularly review, and update the Academy's management plan to attain the goals of the Academy;
g. To call special meetings of the House of Delegates as provided under Article VI, Section 4;
h. To report the activities of the Board of Directors for the preceding year to the House of Delegates and members at the Academy's annual meeting;
i. To establish the amount and timing of Academy membership dues and assessments;
j. To review and determine, on no less than an annual basis, how to implement those policies enacted by the House of Delegates on behalf of the Academy that establish the collective values, philosophies, and principles of the PA profession. If it determines that implementation of one or more such policies will require an inadvisable expenditure of Academy resources, or is otherwise not presently prudent or feasible, the board shall, at its earliest convenience, report to the House the reasons for its decision.

Section 2: Dual Roles with AAPA Constituent Organizations. Members of the AAPA Board of Directors may not hold elected voting positions in the Academy's

constituent organizations. Directors may hold elected or appointed non-voting positions in the Academy's constituent organizations.

Section 3: Board Composition. There shall be the following members of the Board of Directors: five (5) Academy Officers, five (5) Directors-at-large, one (1) Student Director, and the First Vice Speaker and Second Vice Speaker. The First Vice Speaker and Second Vice Speaker are voting members of the Board of Directors by virtue of position. The terms of office shall be as specified in Article XIII, Section 2.

Section 4: Officers of the Corporation. The Officers of the Corporation shall be a President, a President-elect, a Vice President, a Secretary-Treasurer, and the Immediate Past President ("Academy Officers"). The Academy Officers are voting members of the Board of Directors by virtue of position.

Section 5: Duties of Officers of the Corporation.

a. The President shall be the chief spokesperson for the Academy. The President shall report to the House of Delegates and the members at the annual meeting of the Academy with an account of the activities of the Board for the past year and its recommendations for the House of Delegates.
b. The President-elect shall succeed to the office of President at the expiration of the President's term or earlier should that office become vacant for any reason.
c. The Vice President is the Speaker of the House of Delegates and shall represent the House of Delegates to the Board of Directors and shall perform such other duties as shall be assigned by the Board of Directors.
d. The Secretary-Treasurer shall:
    i. be responsible for adequate and proper accounts of the properties and funds of the Academy;
    ii. give a full report to the membership at the annual meeting;
    iii. deposit or call to be deposited all monies and other valuables in the name and to the credit of the Academy with such depositories as may be designated by the Board of Directors;
    iv. OVERSEE disburseMENT OF the funds of the Academy as may be ordered by the Board of Directors;
    v. render to the Board of Directors, whenever it may request it, an account of all the transactions as Secretary-Treasurer, and of the financial conditions of the Academy;
    vi. OVERSEE THE maintainANCE OF the records of the Academy including the records of the Board of Directors and of the House of Delegates;
    vii. execute the general correspondence;
    viii. attest the signature of the Academy Officers;
    ix. CAUSE ~~affix~~ the corporate seal TO BE AFFIXED on documents so requiring; and
    x. have such other powers and perform such other duties as may be prescribed by the President or the Board of Directors.

e. The Immediate Past President shall perform such other duties as may be assigned by the President or the Board of Directors.

Section 6: Meetings of the Board of Directors.

a. Regular and Special Meetings. The Board of Directors shall hold such regular meetings at such time and at such places as designated by Board policy, but in no event shall there be fewer than two such meetings in any calendar year. Regular meetings of the Board may be held without notice. Special meetings shall be called by the Secretary-Treasurer at the request of the President or upon written request to the President of at least 20 percent of the members of the Board then in office. The object of such special meetings shall be stated in the meeting notice, and no business other than that specified in the notice shall be transacted at the meeting. Notice of a special meeting shall be provided not less than two (2) days before the meeting.

b. Quorum. A majority of the membership of the Board then in office shall constitute a quorum for the purposes of transacting business.

c. Manner of Acting. The affirmative vote of a majority of the Directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, except as otherwise provided by law, by the Articles of Incorporation, or by these Bylaws. Each Director shall have one (1) vote on all matters submitted to a vote of the Board of Directors. No Director voting by proxy shall be permitted.

d. Teleconferencing. To the extent permitted by law, any person participating in a meeting of the Board of Directors may participate by means of conference telephone or by any means of communication by which all persons participating in the meeting are able to hear one another, and otherwise fully participate in the meeting. Such participation shall constitute presence in person at the meeting.

e. Action by Unanimous Written Consent. Any action required to be taken at a meeting of the Board of Directors or any action which may be taken at a meeting of the Board of Directors may be taken without a meeting if a consent in writing, setting forth the action so taken, is signed by all of the Directors entitled to vote with respect to the subject matter thereof. A Director's consent to action taken without a meeting may be in electronic form and delivered by electronic means.

Section 7: Chair of the Board. The Board of Directors may elect a Chair of the Board from among its members. The Chair of the Board shall have such duties and responsibilities and may be elected according to such procedures as may be determined by the Board from time to time.

Section 8: Executive Committee. The Executive Committee of the Board of Directors shall consist of the President, Vice President, President-elect, Immediate Past President, Chair of the Board, and Secretary-Treasurer. The Executive Committee shall be empowered to act for the Board of Directors on emergency matters only. Actions of the Executive Committee shall be reported to the Board of Directors no later than the

Board's following meeting. All such Committee actions must be reviewed and ratified by the Board of Directors and shall be included in the official Board minutes.

Section 9: Resignation or Removal of Directors and Officers of the Corporation. Any Director or Academy Officer may resign at any time by giving written notice to the President or the Board of Directors. Such resignation shall take effect at the time specified in such notice, or, if no time is specified, at the time such resignation is tendered. Any Director-at-large, Student Director, or Academy Officer (excluding the Vice President) may be removed from office at any time, with or without cause, by the affirmative majority vote of those members entitled to elect them. Removal may only occur at a meeting called for that purpose, and the meeting notice shall state that the purpose, or one of the purposes, of the meeting is removal of the Director or Officer. Vacancies in these positions shall be filled in accordance with Article XIII, Section 10 of these Bylaws. Removal of the Vice President/Speaker shall be done in accordance with Article VI, Section 3 of these Bylaws pertaining to House Officers.

2015-A-04 – Adopted as Amended

Amend by substitution Bylaws Article VIII as follows:

~~ARTICLE VIII Executive Vice President.~~

~~An Executive Vice President (EVP) may be employed by the Academy. The EVP shall have such rights, powers, duties, and responsibilities as may be set forth by the Board of Directors from time to time, consistent with that provided in any employment agreement. The EVP shall be bonded at the expense of the Academy in such amounts as the Board of Directors may require. The Executive Vice President shall have no vote in the meetings of the Board of Directors. The Executive Vice President shall be under the control and supervision of the Board of Directors and, in the case of his/her death, resignation, or removal, the Board of Directors shall have the power to fill the vacancy.~~

ARTICLE VIII CHIEF EXECUTIVE OFFICER

THE CHIEF EXECUTIVE OFFICER (CEO) IS AN EMPLOYEE OF THE ACADEMY. THE CEO SHALL BE BONDED AT THE EXPENSE OF THE ACADEMY IN SUCH AMOUNTS AS THE BOARD OF DIRECTORS MAY REQUIRE. THE CEO SHALL BE A NON-VOTING MEMBER OF THE BOARD OF DIRECTORS. THE CEO SHALL BE UNDER THE ~~CONTROL~~ **DIRECTION** AND ~~SUPERVISION~~ **OVERSIGHT** OF THE BOARD OF DIRECTORS AND, IN THE CASE OF HIS/HER DEATH, RESIGNATION, OR REMOVAL; THE BOARD OF DIRECTORS SHALL HAVE THE POWER TO FILL THE VACANCY.

2015-A-05 – Rejected

Amend Bylaws Article X as follows:

ARTICLE X Board Committees; Academy Commissions and Work Groups; Task Forces, Ad Hoc Groups.

Section 1: Board Committees. The Board of Directors, by resolution adopted by a majority of the Directors present at a meeting at which a quorum is present, may establish and appoint such Board Committees as may be necessary to carry out the duties of the Board. Only members of the Board of Directors shall be eligible to serve AS VOTING MEMBERS on Board Committees, and each Board Committee shall have two or more members, who shall serve at the pleasure of the Board. Board Committees may exercise the Board's authority only to the extent specified by the Board of Directors by resolution, or by the Articles of Incorporation or these Bylaws. A Board Committee shall not, however, (1) authorize distributions; (2) recommend to members or approve dissolution, merger or the sale, pledge, or transfer of all or substantially all of the corporation's assets; (3) elect, appoint, or remove Directors, or fill vacancies on the Board of Directors or any of its committees; or (4) adopt, amend, or repeal the Articles of Incorporation or the Bylaws. The designation of and the delegation of authority to any such committee shall not operate to relieve the Board of Directors, or any individual Director, of any responsibility imposed upon them by law.

Section 2: Other Committees. Other committees not having and exercising the authority of the Board of Directors in the management of the Corporation may be designated by the Board of Directors or by the House of Delegates as follows:

a. Commissions and Work Groups. The House of Delegates shall recommend to the Board the establishment of commissions and work groups of the Academy. The Board of Directors shall establish such commissions and work groups and set forth the respective duties, responsibilities, and membership eligibility requirements thereof, as the Board may deem advisable. With the exception of the Nominating Work Group, the Board of Directors shall appoint commission and work group chairs and members according to procedures established by the Board.
b. Task Forces, Ad Hoc Groups and Other Committees. The Board of Directors may establish and appoint such Academy task forces and ad hoc groups and set forth the respective duties, responsibilities, and membership eligibility requirements thereof, as the Board may deem advisable. The House Speaker may establish and appoint such House Committees and ad hoc groups as may be necessary to carry out the duties of the House of Delegates.

2015-A-06 – Adopted

Amend Bylaws Article XIV as follows:

ARTICLE XIV Amendments.

Section 1: To be adopted, an amendment to these Bylaws shall be approved by the Board of Directors and by a two-thirds (2/3) vote of all delegates present and voting of the House of Delegates.

Section 2: A proposal for the amendment or repeal of existing Bylaws provisions or adoption of new Bylaws provisions shall be initiated by (a) the Board of Directors, (b)

any commission, (c) any Chapter, (d) any officially recognized specialty organization, (e) any caucus, (f) the Student Academy, or (g) the collective House Officers.

Section 3: Proposed amendments shall be in such form as the HOUSE OFFICERS ~~Academy's Judicial Affairs Commission~~ prescribe~~s~~.

Section 4: Amendments may be filed for presentation at the next annual meeting of the House of Delegates or for consideration in an electronic vote.

Section 5: Each amendment to be presented at the annual meeting of the House of Delegates shall be filed with the JUDICIAL AFFAIRS Commission at least three (3) months prior to that meeting. The Judicial Affairs Commission's proposed amendments shall be exempt from the three (3) month filing requirement.

a. To be considered for electronic vote of the House of Delegates, amendments must be submitted 150 days or greater before the annual meeting of the House of Delegates.

Section 6: Proposals that are not initiated by the Board of Directors will be presented to the Board of Directors substantially in the form presented to the JUDICIAL AFFAIRS Commission with such technical changes and conforming amendments to the proposal or existing Bylaws as the JUDICIAL AFFAIRS Commission shall deem necessary or desirable.

a. If for presentation at the next annual House of Delegates meeting, the proposal ~~must~~ MAY be considered and acted upon ~~at least 60 days~~ prior to the annual meeting of the House. The proposed amendments along with the Board of Directors' action thereon, shall be distributed~~, in the form approved by the Board of Directors,~~ to each member of the House of Delegates at least 30 days prior to the annual House meeting in connection with the meeting notice required by Article VI, Section 4.

b. If the proposal is to be submitted for electronic consideration of the House of Delegates, the proposed amendments along with the Board of Directors' action thereon, shall be distributed~~, in the form approved by the Board of Directors,~~ to each member of the House of Delegates within 15 days of Board of Directors' action. The House of Delegates will then vote on the proposal in accordance with the Standing Rules on electronic voting.

Section 7: Proposed amendments that come to the House of Delegates with the prior approval of the Board of Directors will become effective upon approval of the House by a two-thirds (2/3) vote of all delegates present and voting.

Section 8: If the House of Delegates approves a proposed amendment by a two-thirds (2/3) vote of all delegates present and voting, that was either not approved by the Board of Directors, or was amended by the House of Delegates, then the proposed amendment as passed by the House of Delegates, will be submitted to the Board of Directors for its action.

2015-A-07 – Adopted as Amended

Amend Bylaws Article XI as follows:

ARTICLE XI Nominating Work Group.

Section 1: Duties and Responsibilities. The Nominating Work Group shall carry out such duties and responsibilities as (1) are set forth in these Bylaws; and (2) are established by the Board of Directors in accordance with Article X, Section 2, subject to the approval of the House of Delegates. Such duties and responsibilities shall include:

a. Receiving applications from potential candidates seeking nomination for the positions of president-elect, secretary-treasurer, and directors-at-large;
b. Evaluating all candidates seeking nomination according to the qualification criteria set forth in these Bylaws and according to such other selection guidelines as may be established in accordance with this section;
c. Selecting a single or multiple slate of candidates for each nominated position.

Section 2: Composition; Method of Election or Appointment. The Nominating Work Group is composed of seven (7) members of which five (5) are elected by plurality vote at the House of Delegates annual meeting. Two members are appointed by the Board of Directors. Nominating Work Group candidates should pre-declare their candidacy; however, write-in candidates, and nominations and self-declarations from the House floor will be accepted at the time of elections. The House of Delegates shall determine procedures for the election of non-board appointed members to the Nominating Work Group.

Section 3: Eligibility and Qualifications. Nominating Work Group members may not run for any of the positions they are evaluating for the upcoming election. Additionally:

a. A candidate must be a fellow member of the AAPA.
b. A candidate must have been an AAPA fellow member **AND/OR STUDENT MEMBER** for the last five years.
c. A candidate must have accumulated at least three distinct years of experience in the past five years in at least two of the following major areas of professional involvement:
    i. An AAPA or constituent organization officer, board member, committee, council**,** commission, work group, or task force chair
    ii. A delegate or alternate to the AAPA House of Delegates **OR A REPRESENTATIVE TO THE STUDENT ACADEMY OF THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS ASSEMBLY OF REPRESENTATIVES**
    iii. TRUSTEE, BOARD MEMBER OR COMMITTEE CHAIR OF THE **STUDENT ACADEMY OF THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS,** PA Foundation, Society for the Preservation of Physician Assistant History, Physician Assistant Education Association or American Academy of Physician Assistants Political Action Committee.
    iv. AAPA board appointees.

d. Any calendar year or Academy year in which the candidate served in more than one area of professional involvement shall be counted as one distinct year of experience.

e. With the exception of the board-appointed members, a Nominating Work Group member cannot hold any other elected office or commission or work group position in the AAPA during the time of service on the Nominating Work Group.

Section 4: Term of Service. The term of service for members of the Nominating Work Group shall be two (2) years. Terms shall be staggered. Individuals appointed to temporarily fill a vacancy shall be eligible to run for the vacated seat. The unexpired term the appointee previously filled shall not be counted as a filled term for purposes of determining work group tenure.

Section 5: Vacancies. Nominating Work Group vacancies shall be filled in the following manner:

a. Board-appointed Member. The Board of Directors shall appoint a replacement member to fill the remainder of the unexpired term.

b. Elected Members. The House Officers shall appoint a temporary replacement member. The temporary appointees shall serve until replaced by the House of Delegates in the following manner: (1) the position shall be declared open for election at the next House of Delegates election and shall be filled by appropriate election process; and (2) upon completion of the election, the temporary appointee shall continue to serve until the newly elected work group member takes office at the next change of office.

2015-A-08(a) – Adopted as amended

Amend Article XIII as follows:

Article XIII Elections.

Section 1: Positions to be Filled by Election. Elected positions include Directors-at-large; one Student Director; the Academy Officer positions of President-elect and Secretary-Treasurer; and the House Officer positions of Speaker, First Vice Speaker, and Second Vice Speaker; and such number of members of the Nominating Work Group as may be set forth in Article XI of these Bylaws. The House Officer positions shall be filled by the House of Delegates in the manner prescribed by Article VI, Section 3. The Student Director shall be elected in the manner prescribed by Article V, Section 3. The Nominating Work Group positions shall be filled by the House of Delegates in the manner prescribed by Article XI. All other elected positions shall be filled in the manner prescribed by this Article XIII.

Section 2: Term of Office. The term of office for the Academy Officer positions of President, President-elect, and Immediate Past President shall be one year. The term of office for the Student Director shall be one year. The term of office for Directors-at-large and for the Academy Officer position of Secretary-Treasurer shall be two years. The term of service for House Officer positions shall be one year.

Section 3: Eligibility and Qualifications of Candidates for Elected Positions Other Than Student Director or Nominating Work Group Member.

a. A candidate must be a fellow member of the AAPA.
b. A candidate must be a member of an AAPA Chapter.
c. A candidate must have been an AAPA fellow member **AND/OR STUDENT MEMBER** for the last three years.
d. A candidate must have accumulated at least three distinct years of experience in the past five years in at least two of the following major areas of professional involvement. This experience requirement will be waived for currently sitting AAPA board members who choose to run for a subsequent term of office.
    i. An AAPA or constituent organization officer, board member, committee, council, commission, work group, task force chair.
    ii. A delegate or alternate to the AAPA House of Delegates **OR A REPRESENTATIVE TO THE STUDENT ACADEMY OF THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS ASSEMBLY OF REPRESENTATIVES**.
    iii. A board member, trustee, or committee chair of the **STUDENT ACADEMY OF THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS,** PA Foundation, Society for the Preservation of Physician Assistant History, American Academy of Physician Assistants Political Action Committee, Physician Assistant Education Association or National Commission on Certification of Physician Assistants.
    iv. AAPA board appointee.

Section 4: Self-declaration of Candidacy. Self-declaration, in accordance with policy, shall be permitted in the election of Academy Officers, Directors-at-large, and House Officers.

2015-A-08(b) – Adopted

Amend Article XIII as follows:

Article XIII Elections

Section 5: Time of Elections. The time of House Officers' elections is prescribed in Article VI, Section 3. The ~~Governance Commission~~ BOARD OF DIRECTORS shall determine the timing of elections of all other positions, in accordance with the requirements of these Bylaws.

Section 6: Eligibility of Voters. For all positions other than the Student Director, House Officer, and Nominating Work Group positions, eligible voters are fellow members listed on the Academy membership roster as of the date that is fifteen (15) days before the election.

Section 7: Election Procedures. The Governance Commission shall determine the procedures for the election of Academy Officers and Directors-at-large, including the dates for distribution and return of ballots, subject to the requirements of the North

Carolina Nonprofit Corporation Act. Voting shall be by mail or electronic ballots. The Academy staff shall manage the ballot distribution. The procedures for electing the House Officers are prescribed in Article VI, Section 3; and the procedures for electing the Student Director are prescribed in Article V, Section 3; and the procedures for electing members of the Nominating Work Group shall be determined by the House of Delegates in accordance with Article XI, Section 2.

Section 8: Vote Necessary to Elect. A plurality of the votes cast shall elect the Directors-at-large and the Academy Officers (excluding the Vice President), so long as the number of votes cast equals or exceeds a quorum of one (1) percent of the members entitled to vote in the election. In the case of a tie vote, the HOUSE OF DELEGATES SHALL VOTE TO DECIDE THE ELECTION FROM AMONG THE CANDIDATES WHO TIED. ~~Governance Commission shall determine the process for selecting the winner~~. The vote necessary to elect the House of Delegates Officers (including the Speaker, who shall serve as the Vice President of the Academy) shall be prescribed in Article VI, Section 3.

Section 9: Commencement of Terms. The term of office for all elected positions, including Directors-at-large, the Student Director, Academy Officers, and House Officers, shall begin on JULY 1. ~~June 10.~~ In the event that the election of the House Officers occurs later than JULY 1, ~~June 10,~~ the new House Officers will take office at the close of the meeting during which they were elected.

Section 10: Vacancies. Academy Officers and Directors, and House Officers may resign or be removed as provided in these Bylaws. The method of filling positions vacated by the holder prior to completion of term shall be as follows:

a. OFFICE OF THE PRESIDENT. The President-elect shall become the President to serve the unexpired term. The President-elect shall then serve his/her own successive term as President.

b. OFFICE OF THE PRESIDENT-ELECT. In the event of a vacancy in the office of President-elect, the Immediate Past President shall assume the duties, but not the office of the President-elect while continuing to perform the duties of Immediate Past President. The Nominating Work Group will prepare a slate of candidates. The House of Delegates shall elect a new President-elect from the candidates proposed and any candidates that self-declare, who will take office immediately upon election and will serve the remainder of the un-expired term.

c. SPEAKER; FIRST VICE SPEAKER; SECOND VICE-SPEAKER. A vacancy in the positions of the Speaker, First Vice Speaker, or Second Vice Speaker shall be filled in the manner prescribed by the House of Delegates Standing Rules, and in accordance with Article VI, Section 3 of these Bylaws.

d. STUDENT ACADEMY BOARD MEMBER. A vacancy in the Student Director position shall be filled in the manner prescribed by the Student Academy Bylaws.

e. OTHER BOARD VACANCIES. All other vacancies occurring in the Board of Directors shall be filled by a vote of the majority of the remaining members of the Board from a slate of candidates prepared by the Nominating Work Group. All terms of office for such appointees to the Board of Directors shall expire June 30 ~~10~~, or until their

successor has been duly elected and assumed office. The remaining term of the vacated seat, if any, will be filled at the next regularly scheduled election.

2015-A-09 – Adopted on Consent Agenda

Amend AAPA Bylaws Article XIII as follows:

ARTICLE XIII Elections.

Section 1: Positions to be Filled by Election. Elected positions include Directors-at-large; one Student Director; the Academy Officer positions of President-elect and Secretary-Treasurer; and the House Officer positions of Speaker, First Vice Speaker, and Second Vice Speaker; and such number of members of the Nominating Work Group as may be set forth in Article XI of these Bylaws. The House Officer positions shall be filled by the House of Delegates in the manner prescribed by Article VI, Section 3. The Student Director shall be elected in the manner prescribed by Article V, Section 3. The Nominating Work Group positions shall be filled by the House of Delegates in the manner prescribed by Article XI. All other elected positions shall be filled in the manner prescribed by this Article XIII.

Section 2: Term of Office. The term of office for the Academy Officer positions of President, President-elect, and Immediate Past President shall be one year. The term of office for the Student Director shall be one year. The term of office for Directors-at-large and for the Academy Officer position of Secretary-Treasurer shall be two years. The term of service for House Officer positions shall be one year.

Section 3: Eligibility and Qualifications of Candidates for Elected Positions Other Than Student Director or Nominating Work Group Member.

a. A candidate must be a fellow member of the AAPA.
b. A candidate must be a member of an AAPA Chapter.
c. A candidate must have been an AAPA fellow member for the last three years.
d. A candidate must have accumulated at least three distinct years of experience in the past five years in at least two of the following major areas of professional involvement. This experience requirement will be waived for currently sitting AAPA board members who choose to run for a subsequent term of office.

i. An AAPA or constituent organization officer, board member, committee, council, commission, work group, task force chair.
ii. A delegate or alternate to the AAPA House of Delegates.
iii. A board member, trustee, or committee chair of the PA Foundation, Society for the Preservation of Physician Assistant History, American Academy of Physician Assistants Political Action Committee, Physician Assistant Education Association or National Commission on Certification of Physician Assistants.
iv. AAPA board appointee.

Section 4: Self-declaration of Candidacy. Self-declaration, in accordance with policy, shall be permitted in the election of Academy Officers, Directors-at-large, and House

Officers.

Section 5: Time of Elections. The time of House Officers' elections is prescribed in Article VI, Section 3. The Governance Commission shall determine the timing of elections of all other positions, in accordance with the requirements of these Bylaws.

Section 6: Eligibility of Voters. For all positions other than the Student Director, House Officer, and Nominating Work Group positions, eligible voters are fellow members listed on the Academy membership roster as of the date that is fifteen (15) days before the election.

Section 7: Election Procedures. The Governance Commission shall determine the procedures for the election of Academy Officers and Directors-at-large, including the dates for distribution and return of ballots, subject to the requirements of the North Carolina Nonprofit Corporation Act. Voting shall be by mail or electronic ballots. The Academy staff shall manage the ballot distribution. The procedures for electing the House Officers are prescribed in Article VI, Section 3; and the procedures for electing the Student Director are prescribed in Article V, Section 3; and the procedures for electing members of the Nominating Work Group shall be determined by the House of Delegates in accordance with Article XI, Section 2.

Section 8: Vote Necessary to Elect. A plurality of the votes cast shall elect the Directors-at-large and the Academy Officers (excluding the Vice President), so long as the number of votes cast equals or exceeds a quorum of one (1) percent of the members entitled to vote in the election. In the case of a tie vote, the Governance Commission shall determine the process for selecting the winner. The vote necessary to elect the House of Delegates Officers (including the Speaker, who shall serve as the Vice President of the Academy) shall be prescribed in Article VI, Section 3.

Section 9: Commencement of Terms. The term of office for all elected positions, including Directors-at-large, the Student Director, Academy Officers, and House Officers, shall begin on June 10. In the event that the election of the House Officers occurs later than June 10, the new House Officers will take office at the close of the meeting during which they were elected.

Section 10: Vacancies. Academy Officers and Directors, THE STUDENT DIRECTOR and House Officers may resign or be removed as provided in these Bylaws. The method of filling positions vacated by the holder prior to completion of term shall be as follows:

a. Office of the President. The President-elect shall become the President to serve the unexpired term. The President-elect shall then serve his/her own successive term as President.

b. Office of the President-elect. In the event of a vacancy in the office of President-elect, the Immediate Past President shall assume the duties, but not the office of the President-elect while continuing to perform the duties of Immediate Past President. The Nominating Work Group will prepare a slate of candidates. The House of Delegates shall elect a new President-elect from the candidates proposed and any candidates that self-declare, who will take office immediately upon election and will

serve the remainder of the un-expired term.

c. Speaker; First Vice Speaker; Second Vice-Speaker. A vacancy in the positions of the Speaker, First Vice Speaker, or Second Vice Speaker shall be filled in the manner prescribed by the House of Delegates Standing Rules, and in accordance with Article VI, Section 3 of these Bylaws.

d. Student Academy Board Member. A vacancy in the Student Director position shall be filled in the manner prescribed by the Student Academy Bylaws.

e. Other Board Vacancies. ~~All other vacancies occurring in the Board of Directors shall be filled by a vote of the majority of the remaining members of the Board from a slate of candidates prepared by the Nominating Work Group. All terms of office for such appointees to the Board of Directors shall expire June 10, or until their successor has been duly elected and assumed office. The remaining term of the vacated seat, if any, will be filled at the next regularly scheduled election.~~ THE NOMINATING WORK GROUP WILL PREPARE A SLATE OF CANDIDATES. THE HOUSE OF DELEGATES SHALL ELECT FROM THE CANDIDATES PROPOSED AND ANY CANDIDATE WHO HAS SELF- DECLARED, WHO WILL TAKE OFFICE IMMEDIATLEY UPON ELECTION AND WILL SERVE THE REMAINDER OF THE UN-EXPIRED TERM.

2015-A-10 – Adopted on Consent Agenda

Amend Bylaws Article XI, Section 3, Subsection ii., to read as follows:

ii. A delegate ~~or alternate~~ to the AAPA House of Delegates

2015-A-11 – Adopted on Consent Agenda

Amend Bylaws Article XIII, Section 3, Subsection ii., to read as follows:

ii. A delegate ~~or alternate~~ to the AAPA House of Delegates

2015-A-12 – Adopted as Amended

Amend Article III as follows:

Article III Membership

Section 3: Fellow Members. A fellow member shall be a PA who is a graduate of a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), or by one of its predecessor agencies (Committee on Allied Health Education and Accreditation [CAHEA], Commission on Accreditation of Allied Health Education Programs [CAAHEP]) or who has passed the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA) or an examination administered by another agency approved by the Academy. Fellow members must satisfy

such continuing medical and/or medically related educational requirements as may be prescribed by the Academy. Non-clinical fellow members will not be required to maintain continuing medical education (CME). ~~**Fellow members shall vote** for Academy Officers and Directors with the exception of the Vice President, and Student Director, **and shall be eligible to hold office.**~~ **FELLOW MEMBERS SHALL HAVE THE PRIVILEGE OF VOTING AND BE ELIGIBLE TO HOLD OFFICE.**

2015-A-13 – Rejected

Amends Bylaws Article III, Section 10 and Article VI, Section 2 as follows:

Article III Membership

Section 10: Retired Members. A retired member shall be a PA who is a former fellow member who has chosen to retire from the profession, and opts to be classified as a retired member. Retired members shall be entitled to privileges of the floor~~, but shall not be entitled to vote or hold office.~~ AND TO VOTE FOR ACADEMY OFFICERS AND DIRECTORS WITH THE EXCEPTIONS OF THE VICE PRESIDENT, FIRST VICE SPEAKER, SECOND VICE SPEAKER AND STUDENT DIRECTOR. RETIRED MEMBERS MAY NOT HOLD OFFICE EXCEPT FOR DELEGATE/ALTERNATE POSITIONS IN THE HOD.

ARTICLE VI House of Delegates.

Section 2: Composition. The voting membership of the House of Delegates shall consist of the immediate past and current House Officers, one delegate elected by each officially recognized specialty organization, one delegate from each caucus, delegates from Chapters, and delegates from the Student Academy of the American Academy of Physician Assistants. All delegates, other than those of the Student Academy, shall be fellow OR RETIRED memberS of the Academy. Student delegates shall be student or fellow members of the Academy. The delegates from the Chapters, specialty organizations, and caucuses are elected by the fellow members of those organizations. Chapter and Student Academy delegate seats shall be allocated as follows:

2015-A-14 – Adopted

AAPA supports the continuity of care that comes from providing hospice medicine to our patients and will support legislation to remove barriers to reimburse PAs that provide hospice care.

2015-A-15 – Adopted on Consent Agenda

Amend policy HX-4200.4.3 as follows:

AAPA encourages PAs to work to SUPPORT LEGISLATION WHICH WILL eliminate the public's exposure to secondhand smoke, eliminate minors' access to tobacco products INCLUDING ELECTRONIC NICOTINE DELIVERY SYSTEMS, and prohibit advertising of tobacco products.

2015-A-16 – Adopted on Consent Agenda

Amend policy HX-4200.4.4 as follows:

AAPA supports state utilization of tobacco settlement money for prevention and treatment of tobacco use. The Academy urges its constituent organizations to work with state governments and other health care and advocacy organizations to assure ~~appropriate use of tobacco settlement funds~~ TOBACCO SETTLEMENT FUNDS ARE USED FOR THE PREVENTION AND TREATMENT OF TOBACCO USE.

2015-A-17 – Adopted on Consent Agenda

Amend HX-4200.4.5 as follows:

AAPA encourages ~~all~~ PAs to be actively involved in community outreach that is ~~directly involved in educating~~ DIRECTED TOWARD PROVIDING TOBACCO EDUCATION BASED UPON CURRENT EVIDENCE BASED GUIDELINES TO people of all ages about the dangers of smoking with the goal of eliminating tobacco use.

2015-B-01 – Adopted as Amended

Amend policy HP-3100.2.1 by substitution as follows:

~~PAs practice medicine with supervision by licensed physicians. As members of the health care team, PAs provide a broad range of medical services that would otherwise be provided by physicians.~~

PAS PRACTICE MEDICINE IN TEAMS WITH PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS.

2015-B-02 – Adopted as Amended

Amend policy HP-3100.2.3 as follows:

The AAPA opposes any regulations, ~~or~~ guidelines OR PAYMENT POLICIES that differentiate between PAs on the basis of length of ~~training~~ EDUCATIONAL program or academic credentials granted, if those PAs otherwise meet all criteria for fellow membership in the Academy.

2015-B-03 – Adopted on Consent Agenda

Amend policy HP-3400.1.1 by substitution as follows:

~~It is the obligation of each team of physician-PA team to ensure that the physician assistant's scope of practice is identified; that delegation of medical tasks is appropriate to the physician assistant's level of competence; that the relationship of and access to the supervising physician is defined; and that a process of performance evaluation is established. Adequate and responsible supervision of the PA contributes to both high~~

~~quality patient care and continued professional growth. AAPA is committed to the concept of physician assistant practice of medicine with supervision by licensed physicians.~~

IT IS THE OBLIGATION OF EACH PA TO ENSURE THAT:

- THE INDIVIDUAL PA'S SCOPE OF PRACTICE IS BROADLY IDENTIFIED;
- THE SCOPE IS APPROPRIATE TO THE INDIVIDUAL PA'S LEVEL OF TRAINING AND EXPERIENCE;
- ACCESS TO THE COLLABORATING PHYSICIAN IS DEFINED;
- A PROCESS FOR COLLABORATION IS ESTABLISHED.

AAPA IS COMMITTED TO THE CONCEPT OF TEAM-BASED COLLABORATIVE PRACTICE BETWEEN THE PA AND PHYSICIAN TO ACHIEVE THE HIGHEST LEVEL OF QUALITY, COST EFFECTIVE CARE FOR PATIENTS AND CONTINUED PROFESSIONAL GROWTH AND LIFELONG LEARNING.

2015-B-04 – Adopted on Consent Agenda

Amend policy HP-3500.2.2 as follows:

The AAPA ~~American Academy of Physician Assistants~~ opposes examinations given by ANY ORGANIZATION OTHER THAN THE NCCPA ~~individual states~~ for the purpose of establishing entrance-level standards for individuals not eligible for the National Commission on Certification of Physician Assistants examination.

2015-B-05 – Adopted on Consent Agenda

Amend policy HP-3600.1.1 by substitution as follows:

~~AAPA shall explore and pursue avenues to cause amendment of the Social Security Act to permit Medicare Part B coverage of physician services provided by PAs and to clarify that the reimbursement and employment relationship are distinctly separate from supervision as defined by state law~~

AAPA SEEKS TO MODERNIZE THE SOCIAL SECURITY ACT THROUGH AMENDMENTS TO AUTHORIZE COVERAGE OF ALL PHYSICIAN SERVICES PROVIDED BY PAS AND TO REIMBURSE PAS DIRECTLY FOR COVERED MEDICAL SERVICES IN THE SAME MANNER AS ALL OTHER MEDICARE PROVIDERS.

2015-B-06 – Adopted on Consent Agenda

Amend policy HP-3600.1.3 as follows:

The AAPA ~~American Academy of Physician Assistants~~ believes it is essential that all public and private insurers ENROLL PAS AND cover ~~physician~~ MEDICAL AND SURGICAL services provided by PAs in all practice settings.

2015-B-07 – Adopted on Consent Agenda

Amend policy HX-4600.3.1 as follows:

AAPA believes that health plans, PAYERS AND ~~or~~ provider networks should list PAs in their provider directories. PAs should be SPECIFICALLY included on the list of providers to allow patients the option of seeking care from a ~~physician~~ PA ~~team~~.

2015-B-08 – Adopted as Amended

Adopt the position paper on Telemedicine.

Introduction

Telemedicine is expected to play an increasingly important role in the delivery of healthcare. The ability of PAs to utilize telemedicine technologies for the practice of medicine and to be appropriately included as providers in any and all rules, regulations or legislation involving telemedicine is critical to assuring that PAs remain fully integrated in all aspects of medical practice, as well as in emerging models of care.

PAs are essential members of the healthcare team. It is critical that PAs remain in the forefront of this emerging trend, and that AAPA be fully engaged in ensuring the ability of PAs to practice fully. The growth in the use of telemedicine represents both a significant opportunity for the advancement of the PA profession, but also holds an important risk. If the practice of telemedicine fails to: 1) allow for the efficient utilization of PAs, and/or 2) recognize PA contributions to the healthcare system; the profession will be at a distinct disadvantage as the healthcare system continues to evolve.

~~At the same time, the~~ AAPA must provide guidance to PAs wishing to engage in the practice of medicine via telemedicine technologies~~,~~. ~~and current policy HX-4500.1 while necessary, is insufficient towards this end.~~ Other healthcare professional organizations, such as American Medical Association and Federation of State Medical Boards, have put forward similar proposals. ~~The AAPA's Advocacy Commission therefore believes this policy is critical to advancing the PA profession.~~

Telemedicine Definition

Telemedicine, for the purposes of this policy, means the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location. This policy is not intended to address provider-to-provider consultations and interactions using telemedicine technologies. Telemedicine encompasses a variety of applications, services and other forms of telecommunications technology. Telemedicine typically involves the application of technology to provide or support healthcare delivery by replicating the interaction of a traditional, in-person encounter between a provider and a patient. Telemedicine may be provided real-time through the use of technologies such as secure videoconferencing, or may be performed in an asynchronous manner through the use of store-and-forward technology, as appropriate to the case-specific patient presentation and/or specialty. As the technology is constantly changing, this policy will not address all of the technologies that might be used in the practice of telemedicine.

Licensure

PAs are licensed to practice medicine. Telemedicine technology provides another means by which to carry out the practice of medicine under a current PA license. Patients benefit when health professionals are licensed in the state in which the patient resides. State standards can be sensitive to state realities, and patients should have the ability to seek redress against a licensee in the state where the patient is located. For this reason any licensure system must provide appropriate patient protection and access. Since one of the goals of telemedicine is to increase access to care, AAPA opposes geographic restrictions and limitations on the provision of care. PAs providing care via telemedicine must be knowledgeable of individual state requirements governing the practice of telemedicine within the state. AAPA opposes a separate telemedicine license for PAs and supports reciprocal relationships with neighboring states and multistate compacts whereby a license to practice medicine in one state facilitates licensure in other states for the purposes of reducing barriers to individual providers, and patients from use of this means for obtaining healthcare services.

Establishing a Provider-Patient Relationship

A provider-patient relationship is fundamental to the provision of quality medical care. A PA using telemedicine technologies in the provision of medical services must take appropriate steps to establish a provider-patient relationship and conduct all evaluations and history of the patient consistent with prevailing standards of care specific to the individual patient presentation. Establishing a provider-patient relationship includes, but is not limited to, obtaining a medical history, describing treatment risks, benefits, and alternatives, arranging appropriate follow up care, and maintaining complete and accurate health records. The provider-patient relationship may be formed via telemedicine or via an initial in-person consultation according to the individual PA's professional judgment and as appropriate to the case-specific patient presentation. Understanding that the appropriateness of the use of telemedicine technologies can be specialty specific, and to a greater extent case-specific, the appropriateness of the use of telemedicine technologies and the method for establishing the provider-patient relationship should be left to the individual PA's professional judgment.

Patient Disclosures and Consent to Treatment

PAs should avoid rendering medical advice and/or care using telemedicine technologies without fully verifying and authenticating the identity and location of the requesting patient, disclosing the identity and credentials of themselves as a rendering provider, and obtaining necessary general consent to treatment that would be applicable to similar services provided in-person. Patient education regarding the scope of telemedicine services prior to the start of a telemedicine encounter must be provided. This should include at minimum, but not limited to the following:

- Identification and authentication of the patient, the PA and the PA's credentials
- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, appointment scheduling, patient education, etc.)
- Patient understanding that the PA determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter
- Details on security measures, as well as potential risks to privacy, taken with the use of telemedicine technologies.

- Express patient consent for forwarding patient-identifiable information to third parties

Evaluation and Treatment of the Patient

The delivery of telemedicine services must follow evidence-based practice guidelines, to the extent that they are available, to ensure patient safety, quality of care and positive health outcomes. The delivery of telemedicine services must be consistent with state scope of practice laws and regulations. Diagnosis, treatment and consultation recommendations made through the use of telemedicine technologies, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional in-person encounters. Prescribing medications, in-person or via telemedicine, is at the professional discretion of the individual PA. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the PA in accordance with current standards of practice and consequently carry the same accountability as prescriptions issued during traditional in-person encounters.

Continuity of Care

The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating provider(s), which includes at a minimum identifying the patient's existing medical home and treating provider(s) and providing to the latter a copy of the records associated with telemedicine encounters. Patients should be able to seek, with relative ease, follow up care or information from the PA who conducts an encounter using telemedicine technologies. PAs practicing telemedicine must make medical records associated with telemedicine care available to the patient, and subject to the patient's consent, any identified care provider of the patient immediately after the encounter.

Referrals for Emergency Services

An emergency plan is required and must be provided by the PA to the patient when the care provided via telemedicine indicates that a referral to an acute care facility or emergency room for treatment is necessary for the safety of the patient.

Medical Records and Patient Confidentiality

The medical record should include, if applicable, copies of all patient-related electronic communications, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the telemedicine services provided. Informed consents, if applicable, obtained in connection with a telemedicine encounter should also be filed in the medical record. The patient record established during the provision of telemedicine services must be complete, and accessible consistent with all established laws and regulations governing patient healthcare records. PAs should meet applicable federal and state legal requirements of medical/health information privacy, including compliance with the Health Insurance and Accountability Act (HIPAA) and state privacy, confidentiality, security and medical retention rules. Transmissions, including patient e-mail, prescriptions, laboratory and test results, must be secure within existing technology.

Liability Coverage

The AAPA encourages PAs to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.

Reimbursement

Payment for telemedicine services should be based on the service provided and not on the health professional who delivered the service. Reimbursement at both the originating and/or distant site should adequately reflect the actual cost of providing the service.

Continuing Medical Education (CME)

The AAPA supports the development of educational opportunities related to the provision of telemedicine, but is opposed to requirements for examination, certification, or mandatory CME requirements in order to provide telemedicine services.

Conclusion

The United States is entering a new era of healthcare delivery with a significant expansion in use of telemedicine. However, the current system of health professional licensure and practice regulations may limit both a patient's access and choice surrounding use of these technologies, as well as it may limit PA practice of telemedicine. Requiring duplicate licenses and maintaining separate practice rules in each state has become an impediment to the use of telemedicine. Such state-by-state approaches prohibit people from receiving critical, often life-saving medical services that may be available to their neighbors living just across the state line.

A number of approaches have been put forward regarding licensure including interstate compacts, mutual state recognition and even national licensure. Regardless of the approach used, AAPA must remain vigilant in ensuring that PAs are adequately represented and protected in any such discussions to ensure we may continue to serve the nation's patients through both traditional and evolving methods of delivering healthcare services. All laws, policies or programs involving telemedicine practice should include PAs, either by specifically naming PAs, including PAs in the definition of provider or other similar term, or by implication. Additionally, PAs who provide medical care, electronically or otherwise, must maintain the highest degree of professionalism and ethics. PAs must always place the welfare of the patient first, with the highest value placed on quality of care, maintenance of appropriate standards of practice, and adhering to the ethical standards of the profession.

2015-B-09 – Adopted as Amended

Amend policy HP-3700.4.2, Professional Competence Position Paper as follows:

Introduction

The American Academy of Physician Assistants (AAPA) has had a long-standing interest in identifying the determinants of professional competence and in assisting PAs in maintaining their competence. AAPA has an important role in helping PAs acquire and maintain the knowledge, skills, and attributes needed to deliver high quality healthcare. A national focus on medical errors and patient safety, and an emphasis on cost-effective, quality care have sharpened the attention of the public, legislators, regulators, employers,

educators and health professionals on the importance of maintaining and demonstrating professional competence.

Maintenance of professional competence is a lifelong process, and is motivated by a number of factors, including curiosity, self-identified gaps in knowledge, and the desire to provide the very best care to patients. Competence requires that the PA develops knowledge and skills through continuous professional development. This includes traditional continuing medical education (CME), self study and application of knowledge from professional journals and publications, self-reflective and performance improvement CME (PI-CME), chart and peer review, and utilization of learning portfolios. Initial certification by the National Commission on Certification of Physician Assistants (NCCPA), required by all states in order to practice as a PA, is one part of demonstrating professional competence. Recertification, while not required in all states, is highly recommended as one way to demonstrate a commitment to maintaining professional competence.

Competence, Competencies and Competency-based Education

The concept of professional competence has evolved over the last 40 years from a one-dimensional construct representing "specialized knowledge" to a more global one which includes the *application* of specialized knowledge. Furthermore, competence implies a minimum level of proficiency or a threshold in performance. The most common definition of professional competence used today is Epstein and Hundert's which defines it as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served." [1]

The distinction between "competence" and "competency" should be made, as the terms are often used interchangeably. Webster's dictionary defines a "competency" as an "ability or fitness." A competency is a single skill or function, yet it includes the underlying knowledge, abilities and attitudes necessary for optimal performance. It must be performed to a specific standard under specific conditions. A competency is usually written as a broad composite statement detailing an observable set of behaviors reflecting components of knowledge, skills and attitudes. Competence, on the other hand, is more expansive and all encompassing. It represents the *totality* of knowledge, skills, attributes, behaviors and attitudes (or competencies), as well as, the ability to orchestrate these competencies into the full range of activities necessary for professional practice. Competence also implies a minimum level of proficiency or threshold in performance.

To prepare for professional practice, PAs complete a competency-based educational program which is considered to be the "gold standard" for training PAs for clinical practice. Competency-based education provides the construct for curriculum development, accreditation standards, practice statutes, and certification. [2] Entry-level programs consist of didactic and clinical experiences designed to provide a core of clinical knowledge, technical skills, and problem-solving abilities fundamental to competent clinical practice. Upon completion of an entry level program, it is assumed that a practitioner possesses the general characteristics and has acquired the requisite proficiencies during professional education. Initial certification, conferred by the NCCPA, verifies that an entry-level practitioner has demonstrated a minimum level of knowledge and skills, or competence.

The concept of competency-based education is not always well understood. Competency-based education was first introduced in the United States addressing teacher education in the early 1960's. Health professions began looking at the framework in the 1970's and generally stated competencies were created. For over 40 years the PA profession has been one of the few health professions to embrace competency-based education and created unique assessment tools to measure student competence. Interest in competency-based education in the health professions grew in the late 1990's resulting in the transformation of other health professions education programs from traditional time-based education to competency-based education.

The Physician Assistant Education Association (PAEA), formerly known as the Association of Physician Assistant Programs, with funding from the Health Resources and Services Administration, published a document entitled, *Meeting the Objective: Physician Assistant Education, Curriculum Objectives Resource Guide* in 2005. [3] This web-based document has assisted programs in focusing on outcome-based education, a primary principle of competency-based education. Integration of outcome-based education into PA education helps to ensure PAs are adequately prepared with the appropriate clinical competencies to enter a dynamic healthcare environment.

AAPA, PAEA, NCCPA and the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) defined the competencies for the PA profession. These competencies were adapted from those developed by the Accreditation Council for Graduate Medical Education for physicians but identify areas specific to PA practice. The competencies were endorsed by all four organizations and disseminated to PAs in 2005. The organizations identified six general areas of competency for competent PA practice including:

- Patient care
- Medical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice

An overarching competency PAs must possess is the ability to practice interdependently in the physician/PA team: A skill that requires medical knowledge, professionalism, and interpersonal and communication skills, but is more than the sum of these parts. NCCPA, in conjunction with AAPA, ARC-PA, and PAEA, has developed the *Physician Assistant Competencies: A Self-Evaluation Tool* which is designed to assess strengths in each competency domain. This form of self-assessment can likewise reveal areas ~~of~~ in need of improvement for a given competency, which then can be utilized to direct learning activities.

Assessment of Competence

Most aspects of professional competence, and certainly overall competence, are difficult and expensive to measure. All physician specialty boards require significant efforts from physicians to show ongoing professional competence. This includes the need to take written exams, which primarily measure one aspect of competence, namely medical knowledge. Additionally, evidence of peer-review and self-assessment are

required by many physician boards for on-going certification in a variety of medical specialties. [4] Since competence is multidimensional, its assessment should also be multidimensional, preferably having a performance-based component. These assessment exercises sample behaviors performed in the artificial testing situation. In order to measure competence, one needs to be able to evaluate the knowledge, skills, and abilities represented by those behaviors in the actual practice setting. Entry-level PA programs like many physician residency programs have long used performance-based tests, such as patient management problems, objective structured clinical examinations, and standardized patients.

The physician profession under the leadership of the American Board of Medical Specialties has embraced a model of ongoing assessment called "maintenance of certification" (MOC). [5] Maintenance of certification is an ongoing process of assessment and improvement in four components. The first component is evidence of professional standing, such as licensure. The second component is evidence of commitment to life-long learning and self-assessment, such as CME. The third component is evidence of cognitive expertise based on a valid and reliable examination. The final component is demonstration of evaluation of performance in practice including such skills as communication and professionalism.

~~**Maintenance of certification**~~ **HISTORICALLY, CERTIFICATION MAINTENANCE** for PAs~~, **as it is currently defined, requires PAs to**~~ **INCLUDED** obtain**ING** 100 CME ~~**hours**~~ **CREDITS** every two years and successful completion of a recertification examination every **SIX** ~~**six TEN**~~ years. In January ~~**2010**~~ **2014**, NCCPA ~~**proposed**~~ **IMPLEMENTED** changes to ~~**MOC**~~ **CERTIFICATION MAINTENANCE** for PAs ~~**which would**~~ includ**eING** additional requirements for self-assessment and ~~**clinical quality**~~ **PERFORMANCE** improvement **CME** activities, and an extension of the recertification **EXAMINATION** cycle FROM SIX to 10 years. Self-assessment and ~~**quality**~~ **PERFORMANCE** improvement activities are important activities and PAs should participate in them. ~~However, PAs are not physicians; therefore physician models should be carefully applied to the PA profession.~~ ~~**New**~~ **THE ACCREDITATION CRITERIA FOR THESE NEW CME** requirements ~~**for PAs must be**~~ **ENSURE THAT APPROVED ACTIVITIES ARE** relevant, meaningful and validated, not ~~**be**~~ overly burdensome to practicing PAs, and be available to PAs who are not currently licensed or practicing clinically.

Continuing Professional Development

AAPA has endorsed continuing professional development (CPD) as a model to better integrate CME and other educational activities into a more comprehensive approach to maintaining professional competence. AAPA policy defines CPD as "a process that includes ongoing identification of learning needs, development of a learning plan, acquisition of new knowledge and skills, application to practice, and reassessment." Traditional CME, which is a component of CPD, has focused primarily on the competency domains of medical knowledge and patient care. Delivery of quality patient care requires more than just proficiency of medical knowledge but proficiency in other competency areas as well. CPD provides a more expansive framework for the ongoing acquisition of knowledge, skills, and attitudes that define clinical competence. By using the CPD model and including activities such as quality improvement activities, peer

review, patient surveys, chart audits, and the use of learning portfolios PAs have the means to not only increase clinical knowledge and skill levels, but to also enhance other competency domains such as system-based practice and professionalism, which will translate into improved patient care.

Conclusions

Professional competence is multidimensional. The dimensions of competence evolve as a PA's career evolves. Achieving competence, as demonstrated in knowledge, skills, abilities, attitudes and behaviors, is a lifelong process, motivated by both self-interest and a commitment to providing the highest quality care. The entry-level PA educational program lays the foundation for application of the competencies in clinical practice. Upon entering clinical practice, it is the responsibility of the individual PA to continue their life-long learning. Safeguarding the public begins with national certification, but initial certification does not ensure continued competence, only a demonstrated minimum level of entry knowledge and skills. For life-long learning, PAs must engage in continuing professional development, using a variety of modalities to continuously assess and improve their knowledge, skills and attitudes with the goal of improving patient care outcomes.

Recertification represents part of a process that should encourage PAs to remain competent through periodic reassessment of strengths and deficiencies, as well as participation in professional development activities. Although a periodic written examination can only yield a useful measurement of cognitive ability, a multidimensional assessment process can truly reflect the competence that comes from the pursuit of lifelong learning. However, care should be taken to apply a model that is appropriate to the unique and valued role of PAs in health care.

The public is demanding more rigorous accountability from healthcare professionals. Whether it is a focus on competency-based education, certification or recertification, the PA profession has long been a leader in demonstrating its commitment to competence. Likewise, AAPA is committed to helping PAs to maintain the knowledge and skills necessary to achieve professional competence in order to deliver the highest quality health care.

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2015-B-10 – Rejected

Amend policy HP-3100.1.1 as follows:

The AAPA recognizes that "physician assistant" OR "PHYSICIAN ASSOCIATE" MAY BE USED as the official title for the PA profession.

2015-B-11 – Rejected

AAPA supports a recertification exam cycle of 20 years.

2015-B-12 – Rejected

AAPA supports that PA programs that require over 120 credit hours should confer a clinical doctorate as the degree awarded.

2015-B-13 – Adopted on Consent Agenda

Amend policy HX-4200.2.2, Global Epidemic HIV/AIDS Position Paper as follows:

Global Epidemic HIV/AIDS
(Adopted 2005 and amended 2010)

Executive Summary of Policy Contained in this Paper
Summaries will lack rationale and background information, and may lose nuance of policy. You are highly encouraged to read the entire paper.

- AAPA supports proven/demonstrable/international efforts to curb the global HIV/AIDS epidemic.
- AAPA supports participation of all nations in a coordinated global effort to reduce the incidence of HIV/AIDS.

- AAPA recognizes the direct role of prevention programs in reducing the incidence of new HIV infection.
- AAPA supports national and international prevention strategies that include counseling and testing programs, programs with special focus on young adults, programs to prevent mother-to-child vertical transmission, PROVISION OF PRE-EXPOSURE PROPHYLAXIS (PREP) AND NON-OCCUPATIONAL POST-EXPOSURE PROPHYLAXIS (nPEP) IN ACCORDANCE WITH ESTABLISHED RECOMMENDATIONS AND GUIDELINES, and legislative efforts to promote women's rights AND SEX WORKERS' RIGHTS.
- AAPA ENCOURAGES PROVIDERS TO SCREEN ALL INDIVIDUALS AGES 13 TO 64 FOR HIV AT LEAST ONCE, WITH FOLLOW-UP TESTING BASED ON RISK, IN ACCORDANCE WITH THE CDC RECOMMENDATION.
- AAPA believes that treatment programs should be SUSTAINABLE AND expanded to provide ESSENTIAL ~~life-prolonging~~ antiretroviral therapy ~~and that such programs must be sustainable~~.
- AAPA supports the creation of specially-trained HIV/AIDS medical providers to augment new and existing GLOBAL prevention and treatment efforts. ~~in. developing countries~~.
- AAPA believes that international, national, and community leaders should be strong and vocal advocates for HIV/AIDS education, prevention and treatment efforts.
- AAPA believes that community leaders should promote equality and that people with HIV/AIDS should not experience discrimination or bias.
- AAPA supports the giving of unrestricted financial support to global AIDS efforts without ideological or political influence on the distribution of funding.

Introduction

~~Recognition of Acquired Immune Deficiency Syndrome (AIDS) came in the early 1980s and was soon found to be related to infections with a retrovirus in the genus of lentivirus from the family Retroviridae, the Human ImmuneOdeficiency Virus (HIV).~~ According to the most recent World Health Organization (WHO) data, approximately ~~33~~5 million people are living with HIV world-wide[1] and there were ~~2~~1.5 million deaths secondary to complications from AIDS in ~~2008~~ 2013. THIS REPRESENTS A DECREASE IN THE NUMBER OF DEATHS ANNUALLY SINCE 2008. ~~The number of deaths per year has remained stable since 2000.[2]~~ Approximately 2.~~7~~1 million people were newly infected with HIV in ~~2008~~2013; however, the overall number of new infections has decreased ~~by 17%~~ since 2001. This is attributed, in part, to global efforts in education and prevention. THE OVERALL DECLINE IN DEATHS DUE TO COMPLICATIONS FROM AIDS CAN BE ATTRIBUTED TO ADVANCES IN PHARMACOTHERAPEUTICS AND IMPROVED ACCESS TO ANTIRETROVIRAL THERAPY. ~~Similarly, the overall number of deaths due to complications from AIDS has decreased by 10% over the past 5 years, which is attributed to advances in pharmacotherapeutics.[2,3]~~ Yet, the magnitude of the ongoing pandemic is vast. ~~and the scope of the crisis can only be appreciated by discussing the history of HIV/AIDS.~~

~~History~~

~~The origins of the human immunodeficiency virus began in Africa over a century ago. Molecular epidemiology studies have shown that HIV type 1 (HIV-1) evolved with the Pan troglodytes troglodytes subspecies of chimpanzee, although the virus does not cause disease in the chimpanzee. These animals have traditionally served as a food~~

~~source for populations in parts of Sub-Saharan Africa.[2] The most likely mechanism of transmission of HIV-1 from chimpanzee to human was through contamination of an open wound with the infected blood of a chimpanzee during the butchering process.[35] Sporadic cases of HIV infection among humans were isolated and unrecognized for decades prior to 1980. Several demographic changes and social conditions combined to potentiate a rapid spread of the virus among humans and led to the current epidemic. The factors that have been cited are as follows: massive migration of rural populations to urban areas; the disruption of the family unit due to migratory employment opportunities; sexual promiscuity; greater opportunities for international travel; increased access to commercial sex workers; and contamination of the blood supply.[46] By the time the phenomenon of AIDS was becoming recognized, global HIV infections were fairly pervasive.~~

Global Impact of HIV

~~The global epidemic started in Africa and rapidly spread to the developed world. Increased mass transportation and international employment facilitated the spread of the disease. During the 1970s there were shifting societal attitudes toward sexuality and drug use.~~ Because of the pathogenesis of HIV infections, men who have sex with men (MSM), those WHO ~~that~~ injected ~~illicit~~ drugs and health care workers were all at immediate risk for contracting HIV. Multiple sexual partners and the presence of concomitant sexually transmitted infections facilitated HIV transmission. Similarly, needle sharing and/or high risk sexual activity led to HIV exposure in those that used injected drugs. ~~This same pattern was seen as the disease spread in other developed nations, such as Canada, Australia, and those of Western Europe.[46]~~ -ALTHOUGH HIV INFECTIONS WORLDWIDE OCCUR PREDOMINATELY THROUGH HETEROSEXUAL CONTACT, ~~Today,~~ MSM and those using ~~illicitly~~ injected drugs continue to represent significant epidemiological categories4,5. ~~However, HIV infections worldwide occur predominantly through heterosexual contact due to the increased prevalence of the HIV virus and co-infections that cause inflamation.[4,52,6,7]~~

Screening, diagnostic and treatment efforts have raised awareness, detection and management of HIV/AIDS globally over the past decade. Yet, HIV/AIDS remains a global disease. Of the ~~33.4~~ 35 million people infected with HIV, an estimated ~~22.4~~ 24.7 million live in Sub-Saharan Africa.[2] ~~Although Africa is home to only 11 percent of the world's population, 67% of the world's population living with HIV reside in Sub-Saharan Africa with subsequent decreases in life expectancy and increased childhood mortality.[2,8]~~ In fact, Sub-Saharan Africa accounted for ~~1.4~~ 1.1 million of the ~~2~~ 1.5 million (~~72~~73%) people that died from HIV-RELATED COMPLICATIONS in the world in 2013 ~~2008~~.[23] ~~HIV infection rates, while declining world-wide, continue to impact all parts of the world, especially in Asia, the former Soviet Bloc, countries of Eastern Europe, and the Caribbean.[6] The situation is made worse by regional widespread access to commercial sex workers and the use of illegal drugs.[2,7]~~

Certain geographic and demographic populations are affected disproportionally by the incidence of infection. For example, Sub-Saharan Africa accounts for ~~over 60%~~ 70% of HIV infections and this is due to economic, political and cultural PHENOMENA ~~phenomenon~~[3]. DESPITE A GENERAL DECLINE IN THE NUMBER OF NEW HIV INFECTIONS GLOBALLY, EASTERN EUROPE, CENTRAL ASIA, THE MIDDLE EAST, AND NORTHERN AFRICA CONTINUE TO SEE INCREASES IN NEW HIV INFECTIONS[1]. ~~From a geographic perspective, in Ethiopia, people who live in urban communities are eight times more likely to have HIV compared to people in rural areas.[2]~~ WHILE MANY AREAS OF THE WORLD ARE EXPERIENCING A DECLINE IN

HIGH RISK BEHAVIOR, JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS) REPORTS SOME COUNTRIES ARE SEEING AN INCREASE IN THE NUMBER OF SEXUAL PARTNERS ONE HAS AND A DECREASE IN CONDOM USE[5]. In Latin America, North America and Europe, the number of new cases of HIV is most notable among MSM which is attributed to a rise in sexual risk behaviors.[2,74]

The epidemic is exceptionally difficult for women due to an imbalance of physical, financial, and/or cultural power. Thus, women in much of the world are ~~powerless~~ LESS ABLE to avoid contracting HIV infections due to these power imbalances. INTIMATE PARTNER VIOLENCE RAISES ONE'S RISK OF ACQUIRING HIV AS WOMEN WITH AN ABUSIVE PARTNER HAVE DIFFICULTY NEGOTIATING CONDOM USE, IF THEY ARE ABLE TO AT ALL[5]. The morbidity and mortality among the female population secondary to HIV/AIDS is devastating to families and communities. Worldwide, women now account for MORE THAN half of all adults with HIV/AIDS[24]. Women are more likely to lose jobs, lose income, raise children, and face stigma and discrimination. In addition to managing their own illness, the burden of caring for others often falls to women. Young girls frequently leave school to care for sick parents or younger siblings. The AIDS epidemic AFFECTS THE ENTIRE FAMILY ~~is clearly a family illness~~, and impacts children of HIV infected mothers in multiple dimensions (e.g., born to an HIV infected mother, orphaned by a parent who died secondary to AIDS, or left to care for a parent or family member with AIDS)[15]. SEX WORKERS AND TRANSGENDER WOMEN ALSO EXPERIENCE INCREASED RISK OF ACQUIRING HIV, MYRIAD SOCIOECONOMIC CONSEQUENCES OF INFECTION AND BARRIERS TO ACCESSING MEDICAL CARE[5].

Ethnic minorities have a disproportionate burden of HIV infections and progression to AIDS. Even in developed countries, young people of color are at higher risk than their white counterparts. More than half of new HIV cases in the United States occur among ethnic minorities.[74]

The distribution of available resources for prevention and treatment also reflects disparities. Antiretroviral therapy (ART) decreases HIV mortality by approximately 80% and over the past five years, the number of people receiving therapy has increased dramatically. ~~Current data indicate that 2.9 million people have benefitted from prolonged survival due to ART.[2]~~ People with HIV are living longer due to advances in ART. Globally, THE NUMBER OF PERSONS LIVING WITH HIV/AIDS (PLWHA) RECEIVING ART HAS INCREASED THREE FOLD SINCE 2010[5]. ~~about 43% of HIV patients are treated with ART, whereas five years ago, merely seven percent were treated with ART.[2]~~ ALTHOUGH GLOBALLY THE NUMBER OF PLWHA RECEIVING ART HAS INCREASED TO 10.6 MILLION, PEOPLE IN LOW INCOME COUNTRIES REPRESENT A DISPROPORTIONALLY LOW NUMBER OF THOSE WHO ARE RECEIVING TREATMENT[5]. This INCREASE IN PLWHA ON ART has been attributed to coordinated educational and therapeutic ~~efforts within~~ efforts in certain populations. FOR EXAMPLE, THE WORLD HEALTH ORGANIZATION (WHO) CALLED FOR INCREASED USE OF ART AMONG PREGNANT WOMEN TO REDUCE MOTHER-TO-CHILD TRANSMISSION. THROUGH THESE PROGRAMS, THE NUMBER OF WOMEN RECEIVING ART DURING PREGNANCY INCREASED FROM 57% TO 62% IN JUST ONE YEAR[5]. A 52% REDUCTION WAS SEEN IN THE NUMBER OF NEW HIV INFECTIONS AMONG CHILDREN FROM 2001 TO 2012[5]. ~~For example, in Sub-Saharan Africa, women who~~

~~are breastfeeding and have HIV may get access to ART and education regarding alternatives to breastfeeding to prevent vertical transmission.[4] With ART and alternative feeding options, the rate of vertical transmission decreases from 35% without treatment to about 1%.[2] Other targeted subgroups include pregnant women with HIV, children, and people with concomitant tuberculosis.[10]~~ DESPITE GLOBAL EFFORTS TO INCREASE THE NUMBER OF PLWHA ON ART, SOME HIGH-PREVALENCE POPULATIONS SUCH AS INJECTION DRUG USERS (IDU) AND TRANSGENDER INDIVIDUALS MAY NOT BE RECEIVING TREATMENT DUE TO SOCIOECONOMIC BARRIERS TO CARE AND FEAR OF OR ACTUAL DISCRIMINATION[5].

The world's poorest countries face shortages of healthcare providers. International health leaders ~~– including the United Nations (UN), the World Health Organization (WHO), Institute of Medicine (IOM) and the Joint Learning Initiative on Human Resources for Health and Development – identify~~ REPORT the shortage of health care workers as one of the largest constraints to antiretroviral drug programs and meeting people's basic health care needs. Sub-Saharan Africa must add the equivalent of one million health workers through recruitment, retention, and training to achieve UN Millennium Goals for health[10 6]. The solution will require a combination of leadership from within each country, financial support and donations of time and human resources. One proposed solution includes a medical service corps through which resource-rich countries would train medical providers and community health workers[9,11 ;12 7,8,9] .

PREP AND NPEP

THE U.S. PUBLIC HEALTH SERVICE RECENTLY RELEASED CLINICAL PRACTICE GUIDELINES FOR THE ADMINISTRATION OF PREEXPOSURE PROPHYLAXIS (PREP) FOR HIV PREVENTION IN THE UNITED STATES[10]. IN HIGH-RISK INDIVIDUALS INCLUDING MSM, HETEROSEXUAL MEN AND WOMEN WITH RISK FACTORS, SERODISCORDANT COUPLES, AND IDU DAILY ORAL PREP HAS BEEN SHOWN TO DECREASE THE RISK OF HIV ACQUISITION WHEN EXISTING HIV INFECTION HAS BEEN RULED OUT. IN ADDITION TO ORAL ANTIRETROVIRAL MEDICATIONS, PARTICIPANTS IN PREP STUDIES ALSO RECEIVED ACCESS TO CONDOMS, RISK REDUCTION EDUCATION AND COUNSELING, AND TREATMENT FOR OTHER SEXUALLY TRANSMITTED INFECTIONS. SCREENING FOR HIV SHOULD BE DONE NO LESS THAN EVERY 3 MONTHS WHILE A PATIENT IS ON PREP[10].

FOR INDIVIDUALS WHO SEEK MEDICAL CARE LESS THAN 72 HOURS AFTER A POSSIBLE EXPOSURE TO THE INFECTIOUS BODY FLUIDS OF A PERSON KNOWN TO HAVE HIV, THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES STATES THAT NON-OCCUPATIONAL POST-EXPOSURE PROPHYLAXIS (NPEP) MAY BE BENEFICIAL TO REDUCING TRANSMISSION[11]. IN INSTANCES WHERE THE HIV STATUS OF AN INDIVIDUAL IS UNKNOWN OR A PATIENT PRESENTS MORE THAN 72 HOURS AFTER THE EXPOSURE PROVIDERS SHOULD USE CLINICAL JUDGMENT TO DETERMINE WHETHER OR NOT THE USE OF NPEP IS WARRANTED. DATA SUPPORTING THE EFFICACY OF NPEP COME FROM SEVERAL TYPES OF STUDIES INCLUDING ANIMAL MODELS, PERINATAL CLINICAL TRIALS, STUDIES OF TRANSMISSION FOLLOWING HEALTH CARE EXPOSURES AND CLINICAL OBSERVATION[11]. IMPLEMENTATION OF A RANDOMIZED CONTROL TRIAL FOR NPEP IS UNLIKELY FOR ETHICAL REASONS.

HIV SCREENING

HIV SCREENING HAS TREMENDOUS PUBLIC HEALTH IMPLICATIONS. INDIVIDUALS WHO ARE UNAWARE OF THEIR HIV STATUS ARE MORE LIKELY TO TRANSMIT HIV THAN THOSE WHO KNOW THEIR STATUS AND EARLY TREATMENT OF HIV CAN REDUCE SEXUAL TRANSMISSION[12,13,14]. FOR THE INDIVIDUAL, EARLY LINKAGE TO CARE IS ASSOCIATED WITH HIV VIRAL LOAD SUPPRESSION AND IMPROVED LONG TERM HEALTH OUTCOMES[15]. THE CDC RECOMMENDS HIV SCREENING FOR EVERYONE AGES 13 TO 64 AT LEAST ONCE, WITH FOLLOW-UP TESTING BASED ON INDIVIDUAL RISK[16].

~~Impact of HIV on Global Medical Practice~~

~~One tangible result of the HIV/AIDS epidemic was the development of Universal Precautions, now more broadly termed Standard Precautions. Universal Precautions encompassed a series of protocols to protect against blood borne pathogens. Standard Precautions expanded on this concept to include blood borne pathogens, bodily fluids, skin and mucous membranes.[16] The medical practice enhancements required for standard precautions have added some cost but also significantly impacts medical care globally by reducing inadvertent infections in providers and patients alike.~~

Summary

HIV/AIDS is a global emergency with long-term public health consequences. Clearly, the international community has identified HIV/AIDS as a prominent agenda item and demands significant contributions in order to effectively implement sustainable educational, preventive and therapeutic interventions. [9,14] Readers should refer to the CDC, WHO and UNAIDS~~s~~ for up-to-date references and resources (below) as the list is extensive and in constant flux and outside the scope of this policy paper.[2,7,9]

Conclusions

- AAPA supports proven/demonstrable/international efforts to curb the global HIV/AIDS epidemic.
- AAPA supports participation of all nations in a coordinated global effort to reduce the incidence of HIV/AIDS.
- AAPA recognizes the direct role of prevention programs in reducing the incidence of new HIV infection.
- AAPA supports national and international prevention strategies that include counseling and testing programs, programs with special focus on young adults, programs to prevent mother-to-child vertical transmission, PROVISION OF PRE-EXPOSURE PROPHYLAXIS (PREP) AND NON-OCCUPATIONAL POST-EXPOSURE PROPHYLAXIS (nPEP) IN ACCORDANCE WITH ESTABLISHED RECOMMENDATIONS AND GUIDELINES, and legislative efforts to promote women's rights AND SEX WORKERS' RIGHTS.
- AAPA ENCOURAGES PROVIDERS TO SCREEN ALL INDIVIDUALS AGES 13 TO 64 FOR HIV AT LEAST ONCE, WITH FOLLOW-UP TESTING BASED ON RISK, IN ACCORDANCE WITH THE CDC RECOMMENDATION.
- AAPA believes that treatment programs should be SUSTAINABLE AND expanded to provide ESSENTIAL ~~life-prolonging~~ antiretroviral therapy ~~and that such programs must be sustainable~~.
- AAPA supports the creation of specially-trained HIV/AIDS medical providers to augment new and existing GLOBAL prevention and treatment efforts. ~~in. developing countries~~.

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- AAPA believes that community leaders should promote equality and that people with HIV/AIDS should not experience discrimination or bias.
- AAPA supports the giving of unrestricted financial support to global AIDS efforts without ideological or political influence on the distribution of funding.

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Resources

World Health Organization http://www.who.int/hiv/en/

~~United Nations Programme on HIV/AIDS~~

~~http://www.unaids.org/en/AboutUNAIDS/default.asp~~

Pan American Health Organization, PAHO Response to HIV http://new.paho.org/hq/index.php?option=com_content&task=view&id=903&Itemid=1020

Centers for Disease Control and Prevention (CDC), Selected *MMWR* articles http://www.cdc.gov/hiv/resources/reports/mmwr/

CDC HIV/AIDS Statistics and Surveillance http://www.cdc.gov/hiv/topics/surveillance/resources/reports/

~~APIDS: AIDS Public Information Data Set Data through December 2002~~

~~http://www.cdc.gov/hiv/software/apids.htm~~

2015-B-14 – Adopted on Consent Agenda

AAPA encourages PAs to actively obtain the most current epidemiological information available on emerging infectious disease threats and to utilize evidenced based practices to reduce the spread of emerging infectious diseases amongst patients and healthcare workers. Furthermore, PAs are encouraged to remain knowledgeable on evidenced based treatments for patients diagnosed with emerging infectious diseases.

2015-B-15 – Adopted as Amended

Amend policy HX-4700.4.2 as follows:

~~AAPA supports the medical home concept as a means to expand access, REDUCE LONG TERM COST, and improve the quality of patient care THAT IS RECEIVED BY ALLOWING FOR IMPROVED PATIENT CARE COORDINATION AND INTERDISCIPLINARY COMMUNICATION.~~

~~A medical home provides coordinated and integrated care that is patient- and family-centered, culturally appropriate, committed to quality, and safety, AND cost-effectiveNESS affordable, and provided by a health care team led by a HEALTH CARE PROFESSIONAL THAT MAY INCLUDE a physician or PA PAS.~~

~~The principles of the medical home can apply to any setting where continuing, longitudinal primary or specialty care is provided. By virtue of their education, credentials, and fundamental support for team care, PAs are qualified to serve as patients' personal providers in the patient-centered medical home. PAs are qualified to lead the medical home and are committed to physician-PA team practice.~~

~~AAPA believes that coordination of care has value that requires a reasonable level of payment.~~

AAPA SUPPORTS THE MEDICAL HOME CONCEPT AS A MEANS TO EXPAND ACCESS, REDUCE LONG-TERM COST, IMPROVE THE QUALITY OF PATIENT CARE AND THE HEALTH OF POPULATIONS BYALLOWING IMPROVED PATIENT CARE COORDINATION AND INTERDISCIPLINARY COMMUNICATION.

A MEDICAL HOME PROVIDES COORDINATED AND INTEGRATED CARE THAT IS PATIENT- AND FAMILY-CENTERED, CULTURALLY APPROPRIATE, COMMITTED TO QUALITYAND SAFETY, AND IS COST-EFFECTIVE. THIS CARE IS PROVIDED BY A TEAM LED BY A HEALTH CARE PROFESSIONAL THAT INCLUDES PAS.

THE PRINCIPLES OF THE MEDICAL HOME CAN APPLY TO ANY SETTING WHERE CONTINUING, LONGITUDINAL PRIMARY OR SPECIALTY CARE IS PROVIDED. BY VIRTUE OF THEIR EDUCATION, CREDENTIALS, AND FUNDAMENTAL SUPPORT FOR TEAM CARE, PAS ARE QUALIFIED TO SERVE AS PATIENTS' PERSONAL PROVIDERS IN THE PATIENT-CENTERED MEDICAL HOME. PAS ARE QUALIFIED TO LEAD THE MEDICAL HOME AND ARE COMMITTED TO PHYSICIAN-PA TEAM PRACTICE.

AAPA BELIEVES THAT COORDINATION OF CARE HAS VALUE THAT REQUIRES A REASONABLE LEVEL OF PAYMENT.

2015-B-16 – Adopted on Consent Agenda

Amend policy HX- 4200.1.5 as follows:

AAPA endorses ~~human~~ EXCLUSIVE breastfeeding, when possible, FOR ABOUT THE FIRST 6 MONTHS OF LIFE, FOLLOWED BY BREASTFEEDING WITH COMPLEMENTARY FOOD INTRODUCTION UNTIL AT LEAST 12 MONTHS OF AGE. ~~and when it is the choice of the nursing mothers.~~

2015-B-17 – Rejected

The House of Delegates recommends the AAPA Board of Directors develop a volunteer task force to investigate the number, type and most common reasons that clinicians have been reprimanded and/or counseled by the Drug Enforcement Agency, Boards of Medicine, and Boards of Nursing (as appropriate). The purpose of this information gathering is to disseminate this information to aid state organizations in scope-of-practice legislation by specific request only and to help support states in modernizing their practice acts and regulations.

2015-B-18 – Rejected

AAPA supports the Center for Disease Control and U.S. Preventive Services Task Force recommendation for a one-time screening of patients born between 1945-65 for Hepatitis C and refer the appropriate patients for treatment.

2015-B-19 – Rejected

The AAPA encourages PAs to offer individuals born between 1945 and 1965 a one-time Hepatitis C Virus (HCV) screening; counsel those who are HCV-infected on the avoidance of liver toxic agents and of the increased risk of developing cirrhosis and hepatocellular carcinoma; and refer for appropriate treatment.

2015-B-20 – Adopted – Reaffirmed (part of the 5-year review process and got pulled for debate)

HP-3200.1.4
AAPA opposes the entry-level doctorate for PAs.

2015-B-21 – Rejected – Expired (part of the 5-year review process and got pulled for debate)

HP-3200.4.4
The AAPA strongly discourages PAs from taking optional specialty examinations offered by the NCCPA on the basis that such examinations are not in line with the founding principles of the PA education model or standards of PA practice.

2015-B-22 – Adopted – Reaffirmed (part of the 5-year review process and got pulled for debate)

HP-3200.4.3
The AAPA opposes any NCCPA requirement that PAs must practice for an identified time in a given specialty practice as a precondition for specialty certification.

2015-C-01 – Adopted as Amended

PAs should ~~be aware of the problem of human trafficking in their communities and~~ be aware of community resources for identifying and aiding the victims of human trafficking. THE AAPA SHOULD SUPPORT LEGISLATIVE EFFORTS TO DECRIMINALIZE THE VICTIMS OF HUMAN TRAFFICKING.

2015-C-02 – Rejected

AAPA should support legislative efforts to "decriminalize" the victims of human trafficking.

2015-C-03 – Adopted on Consent Agenda

Amend policy HX-4500.5 - Scientific Integrity and Public Policy Position Paper as follows:

Scientific Integrity and Public Policy

Executive Summary of Policy Contained in this Paper

Summaries will lack rationale and background information, and may lose nuance of policy. You are highly encouraged to read the entire paper.

- AAPA believes that government agencies should appoint members and other advisors based upon their expertise and qualifications
- AAPA believes that the public policy development process must be open and transparent.
- AAPA believes scientific research and discussion should be free from undue political, religious, financial or other ideological influence.
- AAPA believes that in the arenas of public policy and scientific research, safeguards can ensure the integrity of the processes and the results.

~~In recent years it has become increasingly accepted that p~~Patient outcomes ~~can~~ MAY be improved by IMPLEMENTATION ~~the practice~~ of evidence based medicine. Access to quality information FOR BOTH MEDICAL PROVIDERS AND PATIENTS is essential for ~~PAs and other health care providers to provide~~ PROVISION OF evidence based care ~~to individual patients~~ IN ALL PRACTICE SETTINGS. In this same way, public health policy should be based on THE BEST, MOST valid scientific evidence.

A wide variety of ~~government~~ INSTITUTIONS AND agencies determine POLICIES THAT IMPACT health ~~policy~~ CARE in this country. These ~~agencies~~ POLICY-MAKERS rely on committees, councils, task forces, and other groups to review ~~current~~ information and provide ideas and opinions to assist them in formulating sound public policies. The AAPA

believes that ~~government~~ ALL agencies should appoint members and other advisors based upon their expertise and qualifications. Diversity of backgrounds and perspectives are desirable. No one should be chosen or eliminated based solely on their religious or political beliefs. Advisors and committee members should disclose conflicts of interest. THOSE ~~Any individual who personally has or~~ whose employer/INTERESTS ~~has~~ HAVE a financial stake in ~~the~~ POLICY outcomeS ~~of a policy decision~~ should not BE IN A POSITION TO DIRECTLY AFFECT THOSE POLICY DECISIONS. ~~serve on that group.~~ Further, the AAPA believes that the public policy development process must be open and transparent.

AAPA believes scientific research and discussion should be free from undue political, religious, financial, or other ideological influence. Research must be held to high standards of objectivity and accuracy; methods must be disclosed and results be reproducible. Peer review of the research is essential to the process. Peer reviewers must be 100chosen based upon their qualifications, with diversity of backgrounds and perspectives again being optimal. Valid scientific conclusions should not be dismissed for ideological reasons.

~~Recognizing that completely eliminating individual biases is impossible, t~~The AAPA believes safeguards should be in place to ensure the integrity of the processes and the results of scientific research and public policy. Uncompromised commitment to the scientific process and to balanced representation based on qualifications will ensure the best possible public policy. Allowing scientific and medical research to move forward and advance public health policy benefits us all.

Summary

In summary, AAPA endorses the following statements:

- AAPA believes that government agencies should appoint members and other advisors based upon their expertise and qualifications
- AAPA believes that the public policy development process must be open and transparent.
- AAPA believes scientific research and discussion should be free from undue political, religious, financial or other ideological influence.
- AAPA believes that in the arenas of public policy and scientific research, safeguards can ensure the integrity of the processes and the results.

Resources

The Global Science Forum and the Ministry of Education, Culture, Sports, Science and Technology of Japan (MEXT), proceedings from the workshop Best Practices for Ensuring Scientific Integrity and Preventing Misconduct, Organization for Economic Co-Operation and Development Global Science Forum, February 22-23, 2007 Tokyo Japan http://www.oecd.org/dataoecd/37/17/40188303.pdf accessed March 17, 2010.

The Science & Environmental Policy Project and George Mason University's International Institute, Conference Report: Scientific Integrity in the Public Policy Process, May 24-25, 1993, Washington D.C. http://www.sepp.org/Archive/conferences/conferences/sippp.html Accessed March 17, 2010.

American Association for the Advancement of Science U.S. Office of Research Integrity, Conference Report: The Role and Activities of Scientific Societies in Promoting Research

Integrity April 10, 2000, Washington D.C. http://www.aaas.org/spp/sfrl/projects/report.pdf. Accessed March 17, 2010.

2015-C-04 – Adopted as Amended

Amend Policy HX-4600.1.7, Improving Children's Access to Health Care Position Paper as follows:

Improving Children's Access to
Health Care ~~THROUGH SUPPORT OF SECOND PARENT ADOPTION~~
(Adopted 2004 and reaffirmed 2009)

Executive Summary of Policy Contained in this Paper
Summaries will lack rationale and background information and may lose nuance of policy. You are highly encouraged to read the entire paper.

The AAPA supports co-parent or second parent adoption in order to protect the child's right to maintain continuing legal relationships with both parents, thereby creating security and access to health care for the child.

The AAPA believes that the following benefits result from co-parent or second parent adoption:

1. The child's legal right of relationship with both parents is protected.
2. The second parent's custody rights and responsibilities are also guaranteed if the legal parent were to die or become incapacitated, OR THE COUPLE SEPARATES.
3. The requirement for child support for both parents is established in the event of the parents' separation.
4. The child's eligibility for health benefits from both parents
5. The legal grounds are provided for either parent to provide consent for medical care and to make education, health care and other important decisions on behalf of the child, and the basis for financial security for children is created in the event of the death of either parent by ensuring eligibility to all appropriate entitlements, such as social security survivors' benefits.

The increasing diversity of the American family ~~within the last 50 years~~ has challenged society to ~~create a~~ recognize new definitionS of ~~the~~ family ~~unit~~. Included in that diversity are families IN WHICH CHILDREN ARE parented by unmarried couples, OR COUPLES WHOSE MARITAL STATUS IS NOT AFFORDED THE SAME LEGAL PROTECTION FROM STATE TO STATE.[1] This changing demography of America has resulted in the visible emergence of non-traditional families and parenting structures. Despite these changes, the central core of the family has remained constant. Families are individuals who join together to meet each other's basic needs and provide nurturing, security, and love. Families also exist to meet responsibilities, obligations and commitments to each other and the society in which they exist.

With increasing frequency, children are raised in families in which there is only one biological or adoptive legal parent. The second individual in a parental role

is called the "co-parent" and/or "second parent." Under current laws, the security of a two parent family may be in jeopardy if the legally recognized parent should die, be declared incompetent, or if the couple separates. CHILDREN DESERVE TO KNOW THAT THEIR RELATIONSHIPS WITH BOTH OF THEIR PARENTS ARE STABLE AND SHOULD BE LEGALLY RECOGNIZED.[2]

~~Our changing society requires us to examine and tend to the health care needs of emerging families.~~ Like other professional medical associations, the AAPA has endorsed the goals of the Healthy People 2010 project, which is "firmly dedicated to the principle that "regardless of age, gender, race or ethnicity, income, education, geographic location, disability, and sexual orientation-every person in every community across the nation deserves equal access to comprehensive, culturally competent, community-based health care systems…" (Healthy People 2010, 2000). ~~BY denying some families equal adoption rights, we deny PREVENT children in these families equal access to "comprehensive and culturally competent" health care, consequently contradicting the principles of healthy people 2010. FROM ENJOYING THE PSYCHOLOGIC AND LEGAL SECURITY THAT COMES FROM HAVING TWO WILLING, CAPABLE, AND LOVING PARENTS, AND THE LEGAL PROTECTIONS THAT PROVIDE SECURITY AND PERMANENCE.~~[3]

Providing all qualified adults with co-parent/second parent adoption rights promotes the health of children by giving them the legal and social benefits of two parents along with subsequent access to health care. Co-parent and/or second parent adoption ~~would~~ provideS legal grounds for either parent to make decisions on behalf of the child, such as providing medical consent and ensuring the child's eligibility to access the health care benefits of both parents.

Providing all qualified adults with co-parent/second parent adoption rights promotes the health of children by giving them the legal and social benefits of two parents along with subsequent access to health care. Co-parent and/or second parent adoption ~~would~~ provideS legal grounds for either parent to make decisions on behalf of the child, such as providing medical consent and ensuring the child's eligibility to access the health care benefits of both parents.

Conclusion

AAPA supports co-parent or second parent adoption in order to protect the child's right to maintain continuing legal relationships with both parents, thereby creating security and access to health care for the child.

AAPA believes that the following benefits result from co-parent or second parent adoption:

1. The child's legal right of relationship with both parents is protected.

2. The second parent's custody rights and responsibilities are also guaranteed if the legal parent were to die or become incapacitated, OR THE COUPLE SEPARATES.

3. The requirement for child support from both parents is established in the event of the parents' separation.

4. The child's eligibility for health benefits from both parents is ensured.

5. The legal grounds are provided for either parent to provide consent for medical care and to make education, health care and other important decisions on behalf of the child, and the basis for financial security for children is created in the event of the death of either parent by ensuring eligibility to all appropriate entitlements, such as social security survivors' benefits.

Sources

1. http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/ama-policy-regarding-sexual-orientation.page Resolution H-60.940
2. http://www.aafp.org/about/policies/all/children-health.html
3. http://pediatrics.aappublications.org/content/109/2/339.abstract?sid=a64c7e9b-4138-4a0a-be6a-089bbc494873

2015-C-05 – Adopted as Amended

Amend policy HP-3200.5.4 by substitution as follows:

~~In order to promote PAs moving into Primary Care (as defined by the federal government) AAPA will add to its legislative agenda initiatives to allow PAs in primary care to deduct interest on student loans or provide loan forgiveness to PAs.~~

~~AAPA SUPPORTS LEGISLATIVE INITIATIVES, AS WELL AS STATE AND FEDERAL PROGRAMS, THAT SUPPORT PAS IN PRIMARY CARE SPECIALITIES (AS DEFINED BY THE FEDERAL GOVERNMENT) AND THAT MAY SERVE TO INCENTIVIZE PAS TO SELECT PRIMARY CARE SPECIALTY AREAS OF PRACTICE. SUCH INITIATIVES INCLUDE, BUT ARE NOT LIMITED TO, LOAN FORGIVENESS PROGRAMS, EDUCATIONAL GRANTS TO INSTITUTIONS THAT EMPHASIZE PRIMARY CARE, AND EDUCATIONAL GRANTS TO INDIVIDUALS WHO WISH TO SPECIALIZE IN PRIMARY CARE.~~

AAPA SUPPORTS LEGISLATIVE INITIATIVES, AS WELL AS, STATE AND FEDERAL PROGRAMS THAT SUPPORT PAS IN PRIMARY CARE SPECIALTIES (AS DEFINED BY THE FEDERAL GOVERNMENT) AND THAT MAY SERVE TO INCENTIVIZE PAS TO SELECT PRIMARY CARE SPECIALTY AREAS OF PRACTICE.

2015-C-06 – Adopted on Consent Agenda

Amend policy HP-3300.2.4 as follows:

AAPA endorses and encourages that health care accrediting agencies utilize PAs on ~~local~~ accreditation site teams.

2015-C-07 – Adopted on Consent Agenda

Amend policy HP-3400.2.4 by substitution as follows:

~~AAPA shall promote the physician assistant profession to hospital administrators and other health care leaders as a cost-effective way to provide quality care by improving patient access and enhancing continuity of care.~~

AAPA SHALL PROMOTE THE PA PROFESSION TO HOSPITAL ADMINISTRATORS, HEALTH CARE LEADERS AND PA EMPLOYERS AS A COST-EFFECTIVE, TEAM-BASED AND PATIENT-CENTERED WAY TO IMPROVE THE QUALITY, ACCESS AND CONTINUITY OF PATIENT CARE.

2015-C-08 – Adopted on Consent Agenda

Amend by substitution policy HX-4600.4.1, The PA in Disaster Response: Core Guidelines Position Paper as follows:

The PA in Disaster Response: Core Guidelines

Executive Summary of Policy Contained in this Paper

Summaries will lack rationale and background information and may lose nuance of policy.

You are highly encouraged to read the entire paper.

- **AAPA** believes PAs are established and valued participants in the healthcare system of this country and are fully qualified to deliver medical services during disaster relief efforts.
- **AAPA** supports educational activities that prepare the profession for participation in disaster medical planning, training and response.
- **AAPA** will work with all appropriate disaster response agencies to update their policies, in order to improve the appropriate utilization of PAs to their fullest capabilities in disaster situations, including expedited credentialing during disasters.
- **AAPA** believes PAs should participate directly with state, local and national public health, law enforcement and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals, and practices in preparation for all disasters that affect our communities, nation and the world.
- **AAPA** supports the concept of photo IDs to identify qualified medical personnel during a disaster response.
- **AAPA** recognizes the National Disaster Medical System (NDMS) as an exemplary model for PA participation in disaster response.
- **AAPA** supports the imposition of criminal and civil sanctions on those providers who intentionally and recklessly disregard public health guidelines during federal, state or local emergencies and public health crises.

Introduction

Natural and man-made disasters, such as tornadoes or terrorist attacks, typically result in an urgent need for medical care in the affected areas. PAs may well be called upon to provide immediate healthcare services during times of urgent need.

In recent years, large-scale disasters like 9/11 and Hurricane Katrina have raised concerns about our ability to respond in an effective and coordinated manner to the medical (and other) needs created by these disasters. These catastrophic disasters can result in a high number of casualties, create chaos in the affected community and larger society, and drastically affect local and regional healthcare systems.

The definition of disaster adopted by the World Health Organization and the United Nations is "the result of a vast ecological breakdown in the relationships between man and his environment, a serious and sudden disruption on such a scale that the stricken community needs extraordinary efforts to cope with it, often with outside help or international aid."[1] The most common medical definition of a disaster is an event that results in casualties that overwhelm the healthcare system in which the event occurs. A health disaster encompasses the compromising of both public health and medical care to individual victims. It is possible to evaluate the changes that a disaster has caused by measuring these against the baselines established for the affected society or community before the disaster event.

From a medical or public health standpoint, a disaster begins when it first is recognized as a disaster, and is overcome when the health status of the community is restored to its pre-event state. Responses to disasters aim to:

1. Reverse adverse health effects caused by the event
2. Modify the hazard responsible for the event (reducing the risk of the occurrence of another event)
3. Decrease the vulnerability of the society to future events
4. Improve disaster preparedness to respond to future events.

Because disasters can strike without warning and in areas often unprepared for such events, it is essential for all PAs to have a solid foundation in the practical aspects of disaster preparedness and response.

All disasters follow a cyclical pattern known as the disaster cycle, which describes four reactionary stages:

1. Preparedness
2. Response
3. Recovery
4. Mitigation and prevention.

The emergency management community is faced with constant changes, such as demographic shifts, technology advances, environmental changes and economic uncertainty. In addition, all facets of the emergency management community can face increasing complexity and decreasing predictability in their operating environments. Complexity may take the form of additional incidents, new and unfamiliar threats, more information to analyze, new players and participants, sophisticated (but potentially incompatible) technologies, and high public expectations. These combinations can create very difficult and challenging environments for all healthcare providers, especially those with little background or experience in disaster medicine.

One of the major areas of uncertainty surrounds the evolving needs of at-risk populations. As U.S. demographics change, we will have to plan to serve increasing numbers of elderly patients and individuals with limited English proficiency, as well as physically isolated populations. There is the possibility of pandemic victims; and in the event of either single or large multi-casualty events, large numbers of injured or ill patients attended to by a fractured infrastructure made up of healthcare responders with little training and/or resources.

Disaster medicine evolved out of the combination of emergency medicine and disaster management. The PA profession is well qualified to function in the field of disaster medicine. PAs come from diverse backgrounds and are very capable of working in communities affected by natural and man-made disasters. Our profession was "born" from those serving our country and returning from combat situations, and we are as a profession well known as being resourceful and capable of meeting and exceeding professional expectations.

The AAPA recommends that all PAs become more familiar with the tenets and challenges of disaster medicine and working in austere environments.

This paper provides basic guidelines for those PAs who are able and willing to assist in a disaster relief effort.

Preparation Through Education

In addition to understanding the principles of critical event management, effective disaster response requires training and preparation for austere practice conditions and unanticipated assignments. Unless absolutely necessary, disaster medicine should not be practiced by PAs who do not possess the knowledge and skills needed to function effectively in the specialized environment of the disaster scene. PAs should therefore prepare in advance of disasters or mass casualty events. Preparation should be done through an established relief organization and should address healthcare and non-healthcare aspects of disaster response. Disaster response competencies for healthcare workers have been developed by several organizations, including the Association for Prevention Teaching and Research and the National Disaster Life Support Foundation (see **Resources**).

The following are core competencies that all PAs should have regarding disaster medicine:

1. Basic knowledge of the National Incident Management System's Incident Command System, along with local and state emergency services and management.
2. Recognize the importance of safety in disaster response situations, including protective equipment, decontamination and site security.
3. Have a working knowledge of the principles of triage in a disaster setting.
    a. Do the greatest good for the greatest number and maximize survival.
4. Learn how to develop the clinical competence to provide effective care with extremely limited resources.
    a. Maintain certifications in BLS, ACLS, and PALS, and, if possible, specialty training such as Advanced Disaster Life Support, Advanced Trauma Life Support, and Advanced Disaster Medical Response.
    b. Stay up to date with ever-changing disaster medical information from various AAPA-approved web sites like the Centers for Disease Control (CDC), National Disaster Medical Systems (NDMS), National Incidence

Management System (NIMS), Health and Human Services (HHS), Federal Emergency Management Administration (FEMA), and others.

5. Learn how to prescribe treatment plans along with an understanding of psychological first aid and caring for patients and responders during and after mass casualty events.
6. Understand the ethical and legal issues in disaster response for PAs. These include:
    a. Their professional and moral responsibility to treat victims
    b. Their rights and responsibilities to protect themselves from harm
    c. Issues surrounding their responsibilities and rights as volunteers
    d. Associated liability issues.
7. Always keep the protection of public health as a professional core responsibility, regardless of education or training.

Credentials and Roles

Verification of certification, licensure or qualifications is nearly impossible at a disaster site. Yet it is certainly in the best interests of the afflicted to receive care from legitimate, competent clinicians. AAPA supports the concept of voluntary state or national medical photo IDs to identify all qualified medical personnel during disaster response. States such as New York have implemented such programs in the wake of recent major disasters.

Most medical relief workers participate via nongovernmental organizations (NGOs), on Disaster Medical Assistance Teams (DMATs) through the U.S. National Disaster Medical System (NDMS), or through other teams organized by charities or state and local governments. Volunteering through established emergency response organizations helps to ensure verification of all responders' credentials in advance. In addition, all workers should carry copies of their license and certification to present when needed.

Response teams often include healthcare providers who have not trained together and are not familiar with one another's background, skills and scope of practice. They also may find themselves in austere conditions with few medical resources available. Team members should explain their training and skills to one another and talk about how they will share responsibilities. PAs needs to be able to articulate the PA role and scope of practice educating other team members about PA capabilities while facilitating consensus regarding their respective disaster roles and who will supply what levels of emergency care. For example, who is best prepared to suture lacerations? Set a broken arm? Insert an emergency chest tube? Participants should discuss these kinds of issues as their team begins working together.[2]

There will be situations when PAs are the most qualified healthcare providers available to serve as medical officers for a disaster-stricken area. In these situations, PAs should recognize the need for their skills and abilities and be willing to assume the required responsibility for the benefit of the team. PAs who find themselves in such situations should seek out additional medical resources as needed.

State Laws/Federal Exemptions

In some cases, governors waive state licensure requirements during disasters, but this is not always the case. In the aftermath of Hurricane Katrina in 2005, the governors of Louisiana and Missouri waived licensure requirements for all healthcare professionals

for a period of time, but the governors of Texas and Mississippi did not. Texas and Mississippi streamlined their application processes, but still required licensure by their state boards. PAs should not assume that disaster response organizations either understand or ensure compliance with licensure requirements. PAs should research the steps necessary to practice in the affected area before assisting with domestic response initiatives. PAs should also keep in mind that Good Samaritan laws do not provide either authorization to practice or, in most cases, liability protection when they are working in disaster relief situations.

One way to ensure both proper authorization to practice and protection from liability is to participate through established federal response organizations. DMAT members, for example, are required to maintain appropriate certifications and state licensure. However, when a DMAT is federally activated, its members become federal employees and are exempt from state licensure requirements. In addition, as federal employees they are protected by the Federal Tort Claims Act, under which the federal government becomes the defendant in the event of a malpractice claim. It should be noted that DMATs are primarily a domestic asset and, with the exception of the International Medical-Surgical Response Team (IMSuRT) component of NDMS, their preparedness, training and credentialing is limited to the United States. In contrast, members of the Medical Reserve Corps may be deployed internationally or domestically.

The AAPA Guidelines for State Regulation of PAs and the AAPA Model State Legislation both include model language regarding PA licensure during disaster conditions. This language reads:

> *PAs should be allowed to provide medical care in disaster and emergency situations. This may require the state to adopt language exempting PAs from supervision provisions when they respond to medical emergencies that occur outside the place of employment. This exemption should extend to PAs who are licensed in other states or who are federal employees. Physicians who supervise PAs in such disaster or emergency situations should be exempt from routine documentation or supervision requirements. PAs should be granted Good Samaritan immunity to the same extent that it is available to other health professionals.*

Responding to International Crises

Outside of the United States, government programs and NGOs must ensure that U.S. providers have permission to offer medical care in the disaster area. Well-prepared response organizations should be able to prevent in advance any licensing problems that can thwart efforts to deploy to the disaster area. Even so, it remains incumbent upon PAs to ensure that they are properly authorized to practice medicine in the region where they have assumed patient care roles. The international arena presents a myriad of issues that may not exist on the domestic front. Cultural beliefs, governmental regulations, political instability, and lack of established standards of healthcare may all present complications. PAs need to investigate international disaster relief standards and response organizations before volunteering. PAs also need to consider the possibility that host countries may refuse foreign assistance, and should be respectful of that decision.

Beware the Ill-prepared Relief Worker

Research substantiates two categories of resource problems that typically arise during disaster response: needs that are a direct result of the disaster, and those resulting from the additional demands placed on resources by relief workers themselves.

Ill-prepared relief workers can compound disaster situations by increasing demands on potentially limited resources. They may need water, food and shelter; have incompatible radio systems that complicate communications; or be unwilling to accept unexpected assignments. These responder-generated demands can be somewhat alleviated through foresight, preparedness courses and individual preparation for the new roles often encountered found in complex situations.[3,4] Responders may need to be fully self-sufficient so as to not drain precious, limited resources and further deplete supplies for survivors.

Each group that responds to a disaster brings its own logistical capabilities, priorities, goals and expectations. Coordinating this sudden ad hoc network of organizations can be a very big challenge. As a rule, in a multi-organizational response to a disaster, the more unfamiliar responders are with their tasks and with their co-workers, the less efficient and the more resource-intensive is the response.[3,5] PA relief workers should be aware of the efforts and objectives of these other response operations, and ensure that efforts to provide medical care don't hamper efforts to provide clean water, electrical power or other necessities.

Disaster Response Standards

In preparation for the multifaceted aspects of disaster response, clinicians should become familiar with generally accepted standards for re-establishing basic societal functions. The Sphere Project (*www.sphereproject.org*), an international coalition that includes the International Red Cross/Red Crescent and other experienced response organizations, has developed a comprehensive set of standards setting forth what they believe people affected by disasters have a right to expect from humanitarian assistance. The Sphere Project aims to improve the quality of assistance provided to people affected by disasters and to enhance the accountability of the humanitarian system in disaster response.

The standards outline the basic societal functions that should be addressed, the degree to which organizations should strive to restore them, and minimum goals that should be seen as interim steps to complete recovery. According to the Sphere Project, these basic functions are:

- Clothing, bedding and household items
- Water supply, water quality, latrines, and other sanitation facilities
- Supply and security of food stores, nutrition, and monitoring of vitamin deficiencies
- Healthcare, including preventive and surveillance measures.

The Sphere Project and other medical relief organizations also emphasize that, in addition to meeting acute medical needs, effective relief includes health promotion measures such as vaccinations and hand-washing, as well as monitoring programs for early detection of disease outbreaks.

Nutrition monitoring is also essential to the health of disaster survivors. Malnutrition can be the most serious public health problem caused by a disaster, and may be a leading cause of death from it, whether directly or indirectly. Food aid has an immediate impact on human health and survival and, while it may not be a formal part of

a medical team's role, the need for adequate nutrition reinforces the importance of coordinated disaster response.

Finally, the provision of aid following a disaster should be free of political, cultural, religious or ideological restrictions. The need for organizational policies reflecting cultural tolerance and for individual workers to be sensitive to the population they serve should go without saying. Unfortunately, relief efforts are often derailed by basic misunderstandings of local customs. Failure to recognize cultural healthcare beliefs in the affected population may also result in some patients choosing not to visit disaster medical facilities. Medical care should not be offered in such a way that patients must put aside their beliefs to receive it. Participation through an established organization can help to minimize cultural offense. Individuals also should commit to a personal effort at cultural understanding.[2,6]

Standards for Crisis Care

A recent Institute of Medicine (IOM) report proposed guidelines for the standard of care in disaster situations. In that report, the IOM defines crisis standards of care as:

> "A substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster. This change in the level of care delivered is justified by specific circumstances and is formally declared by a state government, in recognition that crisis operations will be in effect for a sustained period. The formal declaration that crisis standards of care are in operation enables specific legal/regulatory powers and protections for healthcare providers in the necessary tasks of allocating and using scarce medical resources and implementing alternate care facility operations." [7]

The care available to a community during a time of disaster will vary based on the resources available. There will typically be a continuum of care from "conventional" to "contingency" and "crisis" levels. [8] In "conventional" care, health and medical care conforms to the normal and expected standards for that community. "Contingency" care develops as a response to a surge in demand and seeks to provide patient care that remains functionally equivalent to conventional care while taking into account available space, staff and supplies. The overall delivery of care may remain fairly consistent with community standards. A community may be able to stay in either conventional or contingency modes for a longer period through disaster planning and preparedness.

"Crisis" care occurs when resources, personnel and structures are stretched or nonexistent and conventional or contingency standards are no longer possible. Implementation of the crisis standard of care is not an optional decision but is forced by the circumstances. The move to crisis care mode is an attempt to adjust resources in the hope of preserving health, reducing loss of life, and preventing or managing injuries for as many members of the community as possible. Communities that are well prepared for disasters should be able to return quickly to either a conventional or contingency level of care once the restricted resources are resupplied.

Many communities may not automatically recognize this continuum. Therefore, preparations should include discussions that help define the continuum that would exist during a crisis situation. During the response to a surge in needed care, communities would need to be able to evaluate their changing needs and to communicate their situation to others to aid in their response. The crisis standard of care seeks to provide a

basis for such evaluation and communication of changing needs during evolving disasters.

It is also important to have in place a process for allocating resources to address the most compelling interests of the community. This process requires certain elements to prevent general misunderstanding and an erosion of public trust, including fairness, transparency, consistency, proportionality and accountability. These can only be achieved through community and provider engagement, education and communication. A formalized process also requires active collaboration among all stakeholders. Actions to be taken during crisis management need the force of law and authoritative enforcement to preserve the benefit to the challenged community.

Guidelines for PAs Responding to Disasters

1. PAs should participate in disaster relief through established channels
    a. Consider joining non-governmental organizations, government agencies, State Medical Assistance Teams, Disaster Medical Assistance Teams, or other organized groups with a focus in providing disaster services. The AAPA's Disaster Medicine Association of PAs can help provide direction as well.
    b. Participate in work place disaster planning.
    c. Stay current with information from reliable resources.
    d. Make every effort not to become a victim of the event or to cause harm to others.
2. PAs should support comprehensive, team-based healthcare.
    a. Become proficient in the National Incident Management System's Incident Command System.
    b. Learn to be flexible in working in unfamiliar places and circumstances – many times you have to become comfortable with "hurry up and wait" scenarios.
3. PAs should prepare for and expect the possibility of coping with scarce medical resources and nonmedical assignment in disaster situations.
    a. Participate in local disaster planning events.
    b. Participate in various webinars, table top drills, etc…
    c. Bookmark federal and state websites that have an abundance of current information for medical providers, which might include:
        i. Centers for Disease Control (CDC)
        ii. Federal Emergency Management Agency (FEMA)
        iii. Department of Homeland Security (DHS)
        iv. Health and Human Resources (HHS)
        v. State Medical Assistance Team (SMAT)
4. PAs should be prepared to provide documentation of their qualifications at any disaster site.
    a. Always have access to a portable file containing hard copies ofyour driver's license, medical license, DEA license, and any specialty certifications.
5. PAs involved in medical relief efforts should be familiar with standards of disaster response and develop printed and electronic quick reference resources, including
    a. Disaster triage guides (i.e., Start, Jump Start, and others)

b. Triage coding guides
c. Decontamination principles
d. Treatment guidelines for victims of biological, chemical, radiological, or natural disasters (e.g., hurricanes, tornadoes, floods, cold/heat emergencies, pandemics.)

6. PAs should maintain a high degree of cultural sensitivity when working with all populations.

Principles of Disaster Triage:

- The fundamental difference between disaster triage and normal triage is in the number of casualties. Care is aimed at doing the most good for the most patients (assuming limited resources).
- Definitive care is not a priority.
- Care is initially limited to the opening of airways and controlling external hemorrhage; no CPR in mass casualty events.
- The disaster triage system (US) is color coded: red, yellow, green and black, as follows:
  - Red: First priority, most urgent. Life-threatening shock or airway compromise present, but patient is likely to survive if stabilized.
  - Yellow: Second priority, urgent. Injuries have systemic implications but not yet life threatening. If given appropriate care, the patients should survive without immediate risk.
  - Green: Third priority: non-urgent. Injuries localized, unlikely to deteriorate.
  - Black: Dead. Any patient with no spontaneous circulation or ventilation is classified dead in a mass casualty situation. No CPR is given. You may consider placement of catastrophically injured patients in this category (dependent) on resources. These patients are classified as "expectant." Goals should be adequate pain management. Overzealous efforts towards these patients are likely to have deleterious effect on other casualties.

Summary

AAPA endorses the following statements to promote and support disaster preparedness and response activities and the integration of PAs as key personnel in mitigating the impact of disasters:

- **AAPA** believes PAs are established and valued participants in the healthcare system of this country and are fully qualified to deliver medical services during disaster relief efforts.
- **AAPA** supports educational activities that prepare the profession for participation in disaster medical planning, training and response
- **AAPA** will work with all appropriate disaster response agencies to update their policies in order to improve the appropriate utilization of PAs to their fullest capabilities in disaster situations, including expedited credentialing during disasters.
- **AAPA** believes PAs should participate directly with state, local and national public health, law enforcement and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals and practices in preparation for all disasters that affect our communities, nation and the world.

- **AAPA** supports the concept of photo IDs to identify qualified medical personnel during a disaster response.
- **AAPA** recognizes the National Disaster Medical System (NDMS) as an exemplary model for PA participation in disaster response,
- **AAPA** supports the imposition of criminal and civil sanctions on those providers who intentionally and recklessly disregard public health guidelines during federal, state, or local emergencies and public health crises.

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7. THE SPHERE PROJECT, http://www.sphereproject.org/ (last visited Mar. 24, 2015).
8. Bruce M. Altevogt et al., INST. OF MED. OF THE NAT'L ACAD., GUIDANCE FOR ESTABLISHING CRISIS STANDARDS OF CARE FOR USE IN DISASTER SITUATIONS: A LETTER REPORT (2009).
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Resources

ASS'N FOR PREVENTION TEACHING AND RESEARCH, CLINICIAN COMPETENCIES FOR EMERGENCY PREPAREDNESS BROCHURE

Basic Disaster Life Support Course, NAT'L DISASTER LIFE SUPPORT FOUND., http://www.ndlsf.org/common/content.asp?PAGE=347 (last visited Mar. 24, 2015).

Public Health Ethics in Disasters, U.N.C. GILLINGS SCH. OF GLOBAL PUB. HEALTH, http://www.sph.unc.edu/ethics/public_health_ethics_in_disasters/ (last visited Mar. 24, 2015).

Public Health Ethics for Emergency Responders, U.N.C. GILLINGS SCH. OF GLOBAL PUB. HEALTH, http://www.sph.unc.edu/ethics/public_health_ethics_in_disasters_-_emergency_responders_12753_10533.html (last visited Mar. 24, 2015).

Lawrence O. Gostin & Dan Hanfling, *National Preparedness for a Catastrophic Emergency: Crisis Standards of Care*, *302* J. AM. MED. ASS'N 2365, 2365-66 (2009).

Raina M. Merchant, Janet E. Leigh & Nicole Lurie, *Health Care Volunteers and Disaster Response — First, Be Prepared*, 362 NEW ENG. J. MED. 872, 872-73 (2010).

COL. U. SCH. OF NURSING CTR. FOR HEALTH POL'Y & CENTERS FOR DISEASE CONTROL AND PREVENTION, BIOTERRORISM & EMERGENCY READINESS: COMPETENCIES FOR ALL PUBLIC HEALTH WORKERS (2002), *available at* http://training.fema.gov/emiweb/downloads/bioterrorism%20and%20emergency%20readiness.pdf.

Emergency Preparedness and Response, Centers for Disease Control and Prevention, http://emergency.cdc.gov/ (last updated Mar. 24, 2015).

2015-C-09 – Adopted on Consent Agenda

Amend policy HX- 4200.1.7 as follows:

AAPA strongly recommends that PAs promote AND EDUCATE ABOUT THE PHYSIOLOGICAL AND PSYCHOLOGICAL ~~the health~~ benefits of ~~regular~~ physical activity AND ENCOURAGE EVERYONE TO ESTABLISH A LIFETIME COMMITMENT TO A REGULAR PHYSICAL ACTIVITY ROUTINE. ~~as an important part of health promotion and disease prevention.~~

And be it further resolved that HX- 4200.1.8 be rescinded:

~~PAs should educate patients and families about the physiological and psychological benefits of physical activity and encourage everyone to establish a lifetime commitment to a regular physical activity routine.~~

2015-C-10 – Adopted on Consent Agenda

Amend policy HX-4600.6.5 as follows:

AAPA believes all PAs should advocate responsible sexual behavior including education on methods to prevent unintended pregnancy and sexually transmitted ~~diseases~~ INFECTIONS.

2015-C-11 – Adopted on Consent Agenda

Amend policy HX-4200.1.6 as follows:

AAPA recognizes THE SIGNIFICANT PUBLIC HEALTH IMPLICATIONS OF SUBSTANCE ABUSE, TO INCLUDE BOTH NON-MEDICAL USE OF

PRESCRIPTION DRUGS AND ILLICIT substance USE, ~~abuse as a major public health problem~~ and encourages PAs to take an active role in eliminating substance abuse. The AAPA supports the education of all PAs in the early identification, treatment and prevention of substance abuse.

2015-C-12 – Adopted on Consent Agenda

Amend policy HP-3300.1.3 as follows:

AAPA encourages and supports the incorporation of health promotion and disease prevention into PA practice, through advocacy of healthy lifestyles, ~~and~~ preventive medicine ~~practices~~, AND THE PROMOTION OF HEALTHY BEHAVIORS THAT WILL IMPROVE THE MANAGEMENT OF CHRONIC DISEASES to reduce the risk of illness, injury, and premature death. Preventive measures include the identification of risk factors, e.g. family history, substance abuse, and domestic violence; immunization against communicable diseases; and promotion of safety practices.

PAs should routinely implement recommended clinical preventive services appropriate to the patient's age, gender, race, family history and individual risk profile. Preventive services offered to patients should be evidence-based and demonstrate clinical efficacy. PAs should be familiar with the most current authoritative clinical preventive service guidelines and recommendations.

2015-C-13 – Adopted on Consent Agenda

Amend policy HP-3300.1.9.2 as follows:

The AAPA encourages PAs to identify and utilize reliable and accurate consumer health information ON SPECIFIC DISEASE STATES to encourage patient ~~compliance~~ ADHERENCE and improve health education. Health education information should be evidence based and appropriate to the patient's culture and level of literacy. Provision of such resources is consistent with AAPA efforts to promote health literacy.

2015-C-14 – Adopted on Consent Agenda

Amend policy HP-3300.1.8.1 as follows:

PAs knowledgeable in the area of organ and tissue transplantation should become actively involved with educating THE PUBLIC AND other health professionals.

2015-C-15 – Adopted as Amended

~~The AAPA encourage PAs to recognize the effects of globalization and climate change on public health. PAs should develop knowledge and skills about the interaction between climate change and health in order to effect positive health changes among individuals and communities.~~

THE AAPA ENCOURAGES PAS TO RECOGNIZE AND UNDERSTAND THE PUBLIC HEALTH EFFECTS OF GLOBALIZATION AND CLIMATE CHANGE.

New Business

2015-NB-01 – Motion Passed Unanimously

I move that the AAPA House of Delegates ratify the selection of all Alternate Delegates to the 2015 HOD that have been identified to the House of Delegates Credentials committee at this time.

Resolutions of Condolence

2015-COND-01

Resolution of Condolence
Iain Keir Todd, PA-C
May 2015

Whereas, the American Academy of Physician Assistants suffered a great loss with the passing of Iain Keir Todd, PA-C, 60, in January 2015;

Whereas, Keir Todd exemplified the role of PA to his patients, colleagues, and peers throughout the country;

Whereas, Keir Todd was devoted to the American Academy of Physician Assistants, as a distinguished fellow; a board member of the Association of Physician Assistants in Psychiatry; and a University professor, with an intense devotion to the integrity of the profession;

Whereas, the dedication, wit, intelligence, talents, and dynamic sense of humor of Keir Todd made an unquestionable impact on the lives of all he encountered professionally and personally;

Be it resolved, that the House of Delegates of the American Academy of Physician Assistants recognizes Iain Keir Todd's many contributions to his profession and his community;

And be it further resolved, that a copy of this resolution be provided to his wife, Regina, and his family with deepest sympathy from the members of the American Academy of Physician Assistants.

2015-COND-02

Resolution of Condolence
David Michael Jones, MPAS, PA-C

Whereas Dave Jones was born on October 31, 1945, in Seattle Washington to Dorothea and K.C. Jones; and

Whereas Dave Jones graduated Pasco High School in 1963; and

Whereas Dave Jones earned a Bachelor's Degree in History in 1968 and a second Bachelor's Degree in Zoology in 1970, both from the University of Washington; and

Whereas Dave Jones served as a member of the U.S. Army Reserves from 1965 until 1971; and

Whereas Dave Jones married Karen Rose Wick in 1969, and had a son, Tucker, in 1973; and

Whereas Dave Jones served as a volunteer fire fighter and emergency medicine technician (EMT) from 1970 until 2014; and

Whereas Dave Jones, in 1975, joined the 9th class of students at the MEDEX Northwest Physician Assistant (PA) Program at the University of Washington in the early days of the PA profession and became certified as a PA in 1976 and earned a third Bachelor's Degree in Primary Health Care in 1978; and

Whereas Dave Jones in 1980 moved to Condon, Oregon with his wife and son to practice medicine as a physician assistant and, with Dennis Bruneau, another PA, served as the only medical providers in Gilliam County and among the first PAs in Oregon to practice with remote supervision and the first PAs in the country to receive independent prescription-writing authority; and

Whereas Dave Jones in 1988 was named "Rural PA of the Year" by the American Academy of Physician Assistants; and

Whereas Dave Jones in 1988 served his first term as President of the Oregon Society of Physician Assistants (OSPA) and then in 1995, served a second term as president; and

Whereas Dave Jones was committed to lifelong learning and, in 2000, earned a Master's Degree in Physician Assistant Studies from the University of Nebraska; and

Whereas Dave Jones served on the OSPA Board of Directors for many years and, as a member of the Legislative Committee of OSPA, advocated on behalf of PAs in support of legislation to optimize the practice of PAs and recognize their important role on the health care team; and

Whereas Dave Jones received the award for "Outstanding Contributions to Rural Health" in 2008 from the Oregon Office of Oregon Rural Health at their annual Rural Health Conference; and

Whereas Dave Jones served as a member of the Oregon Rural Health Coordinating Council for more than 20 years and as Chair from 1989 to 1991 and again from 2002 to 2004; and

Whereas Dave Jones served as a member of the Physician Assistant Committee of the Oregon Medical Board (OMB) from 2006 to 2012 and served several times as a consultant to the Board, reviewing cases under investigation by the OMB; and

Whereas Dave Jones was recognized by the OHSU PA Program with the Karen Whitaker Knapp Service Award, named for the retired former Director of the Oregon Office of Rural Health, for his commitment to rural practice and his service to the Condon community as well as his contributions to the PA Program; and

Whereas Dave Jones served as a member of the Condon School Board, the Condon Child Care Board of Trustees and the Tri-County Home Health Agency Board of Trustees; and

Whereas Dave Jones served as the Gilliam County medical examiner until the time of his death; and

Whereas Dave Jones was beloved by the Condon community he served so selflessly and will be remembered by thousands of patients as a trusted advisor and friend, by his neighbors and friends for his unique sense of humor and booming voice, the medical community as a dedicated educator and ambassador, by his PA friends for his advocacy in support of the advancement of the PA profession in Oregon and by his family as a devoted husband, father, grandfather and uncle; and

Whereas Dave Jones leaves a legacy of care, compassion and service to his adopted community and to rural health in Oregon; and

Whereas Dave Jones passed away on January 23, 2015 and will be greatly missed by his wife Karen Jones, his son and daughter-in-law Tucker and Stacy Jones, his grandsons Rowan and Harris Jones, his sister and brother-in-law Patricia and Duane Rencken, and many nieces and nephews as well as his many PA colleagues across the state; now, therefore,

Be it resolved that we, the members of the AAPA House of Delegates, honor Dave Jones for a lifetime of exemplary character, upstanding citizenship and selfless service as a physician assistant;

And be it further resolved, that a copy of this resolution be sent to the family of Dave Jones as an expression of our sympathy and condolences.

2015-COND-03

Resolution of Condolence
Marisa Eve Girawong, PA-C
May 2015

Whereas, the New Jersey State Society of Physician Assistants suffered a great loss with the passing of Marisa Girawong, PA-C, on Saturday, April 25, 2015 during the tragic earthquake which resulted in an avalanche in Nepal;

Whereas, Marisa Girawaong, represented the PA profession as a member of the healthcare team in Emergency Medicine at East Orange General Hospital prior to her venture to Everest Base Camp in Nepal;

Whereas she served a physician assistant in wilderness medicine and this was her second trip to Nepal at the Everest base camp;

Whereas, Marisa Girawong truly enjoyed serving those in need with her dedication to global health and mountain medicine;

Whereas, Marisa Girawong's energetic and caring personality will be missed by her family, friends, colleagues, and patients,

Be it resolved, that the House of Delegates of the American Academy of Physician Assistants recognizes Marisa Girawong's contributions to the community;

And be it further resolved that a copy of this resolution be provided to her brother, Chris Girawong, and his family with deepest sympathy from the members of the American Academy of Physician Assistants.

Resolutions of Commendation

2015-COMM-01

Resolution of Commendation
US Public Health Service PAs
May 2015

Whereas, the 2014 Ebola outbreak was the largest in history and the first Ebola outbreak in West Africa Countries including Sierra Leone, Liberia and Guinea;

Whereas, with an approximately 50 percent death rate, there was stress on the healthcare workforce and healthcare system, including the loss of health care workers caring for the sick;

Whereas, the President of the United States (POTUS) declared the "Ebola epidemic in West Africa and the humanitarian crisis there a top national security priority for the United States" on September 16, 2014;

Whereas, the United States Commissioned Corps was activated to care for Ebola patients throughout that region, bolstering international confidence to respond and to provide hope for those who were fighting Ebola on the front lines;

Whereas, the US Public Health Service (USPHS) was the only US government asset in West Africa providing direct patient care;

Be it resolved that the AAPA House of Delegates assembled on this Memorial Day, May 25, 2015, remembers those who lost their battle to Ebola and commends the PA Ebola fighters:

RADM Epi Elizondo

CAPT Robin Hunter Buskey

CDR Tracy Branch

CDR Thomas Janisko

CDR Mark McKinnon

CDR Roque Miramontes

CDR Josef Rivero

CDR Adam Tahiru

LCDR Brian Burt

LCDR Thomas Gera

LCDR Phil Jaquith

LCDR Phillip LaFleur

LCDR Pascale Lecuire

LCDR Paul Licata

LCDR Pieter Van Horn

LT Thuy Le

LT Daniel Quist

LT Brandon Wyche

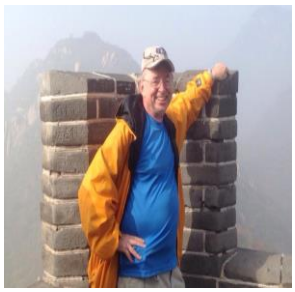
LTJG Gary Montgomery

Be it further resolved and known that these brave USPHS PAs served nobly and selflessly to provide high-quality care to international and Liberian healthcare workers and responders who were or suspected to be infected with Ebola Virus Disease.

2015-COMM-02

Resolution of Positive Energy
Karl Wagner

May 2015



Whereas Karl Wagner has served his country with military service
. . . And continues to provide care to military men and women as a PA;

Whereas Mr. Wagner graduated from the Physician Associate program at Yale;

Whereas Karl Wagner serves his profession as
. . . A leader within the Michigan Academy,
. . . A long term teller with the HOD,
. . . An educator of PA students and mentor to pre-PA students;

Whereas Karl Wagner served his patients to the fullest;

Whereas Karl Wagner suffers severe illness and has been hospitalized for the past three months requiring he give up his place among Michigan delegation;

Be it resolved, that the 2015 House of Delegates of the American Academy of Physician Assistants recognize Karl Wagner and wish him well with a resounding "Thinking of you, Karl".

House Elections 2015	**Results**
Vice President/Speaker	L. Gail Curtis
First Vice Speaker	David Jackson
Second Vice Speaker	William Reynolds
Nominating Work Group	Alisha DeTroye
	Mark McKinnon
	John Trimbath