2016 Summary of Actions

AAPA House of Delegates
San Antonio, TX
May 14-16, 2016

Note: Resolutions marked with * require AAPA Board of Directors ratification.
Resolutions marked with ** will be referred by the Speaker to the appropriate body and reported back to the 2017 HOD.

Resolution	Title	Line Number	Action Taken
2016-A-01-A	Article XIII -- Elections	1	Rejected
2016-A-01-B	Article XIII -- Elections	114	Adopted
2016-A-02	Article XI -- Nominating Work Group	226	Adopted
2016-A-03	Article VII -- Dual Roles with AAPA Constituent Organizations	315	Rejected
2016-A-04*	Article VI -- HOD Responsibilities	467	Adopted as Amended
2016-A-05	Article VII -- BOD and Officers Duties and Responsibilities	489	Adopted
2016-A-06	Article IV -- Constituent Organizations	509	Adopted on Consent Agenda
2016-A-07	PA Self Governance and Accountability to the Public	519	Adopted as Amended
2016-A-08**	PA Full Practice Responsibility	531	To be Referred
2016-A-09	HOD Accountability in Voting	548	Rejected
2016-A-10	Article XIII -- BOD Vacancies	558	Rejected
2016-A-11	Article XIII -- BOD Vacancies	672	Adopted
2016-A-12	Support for Uniformity in Addressing PAs	790	Adopted
2016-A-13	Generic Term PA	796	Adopted as Amended by Deletion
2016-B-01	Elimination of High Stakes Recertification Testing of PAs	806	Adopted
2016-B-02	PA Licensure	827	Rejected
2016-B-03	Maintenance of NCCPA Certification	844	Rejected
2016-B-04	Maintenance of Licensure	908	Adopted as Amended
2016-B-05	NCCPA Recertification Exam	941	Adopted as Amended
2016-B-06	Elimination of the NCCPA Recertification Exam	955	Withdrawn
2016-B-07	Certification Model	966	Rejected

2016-B-08	Use of Proper Terminology Regarding PA Certification	983	Adopted
2016-B-09	Self-Assessment	990	Adopted as Amended by Deletion
2016-C-01	Definition of Collaborating Physician	997	Rejected
2016-C-02	Guidelines for State Regulation of PAs Position Paper	1004	Adopted as Amended
2016-C-03	PA License Portability	1426	Adopted
2016-C-04	Veterans Becoming PAs	1433	Adopted on Consent Agenda
2016-C-05	Social Security Act	1440	Adopted as Amended
2016-C-06	Third Party Payers	1449	Adopted as Amended
2016-C-07	Equitable Reimbursement	1461	Adopted as Amended
2016-C-08	Access to Primary Care	1470	Adopted as Amended
2016-C-09	Prescription Drug Benefit Plans	1478	Adopted on Consent Agenda
2016-C-10	Marijuana Research	1488	Adopted as Amended
2016-C-11	Medical Marijuana Laws	1498	Adopted
2016-C-12	Marijuana Guidelines	1506	Adopted
2016-C-13	Pain Management and Opioid Abuse Crises	1525	Adopted as Amended
2016-C-14	Access to Opioid Treatment Programs	1547	Adopted on Consent Agenda
2016-D-01	Head Trauma	1554	Adopted as Amended
2016-D-02	Violence Epidemic	1569	Adopted on Consent Agenda
2016-D-03	PA Health	1589	Adopted on Consent Agenda
2016-D-04	Maintaining Professional Flexibility Position Paper	1605	Adopted
2016-D-05	NCCPA Accepting European Union Medical Specialist CME Credit	1931	Adopted
2016-D-06	Clinical Rotations Joint Task Force	1955	Adopted as Amended
2016-D-07**	Barriers to PA Student Clinical Rotations Position Paper	1971	To be Referred
2016-D-08	Nicotine Dependence Position Paper	2196	Adopted on Consent Agenda

2016-D-09	Immunizations in Children and Adults Position Paper	2581	Adopted as Amended
2016-D-10	Health Literacy Position Paper	2944	Adopted
2016-D-11	Health Disparities Position Paper	3232	Adopted on Consent Agenda
2016-D-12	Opposition to Limit/Restrict Patient Access	3449	Adopted
2016-D-13	Discrimination	3456	Adopted

Reaffirmed Policies		
HA-2100.1.1	HP-3700.1.1	HX-4400.1.6
HP-3100.3.2	HP-3700.2.1	HX-4400.1.11
HP-3200.1.5	HP-3700.2.3	HX-4400.3.1
HP-3200.7.1	HP-3700.3.1	HX-4600.1.5
HP-3300.1.5	HP-3700.4.1	HX-4600.2.4
HP-3300.1.18	HX-4100.1.6	HX-4600.3.2
HP-3300.2.7	HX-4100.1.11	HX-4600.3.3
HP-3300.2.9	HX-4200.1.8	HX-4600.3.5
HP-3500.3.1	HX-4200.5.2	HX-4600.5.8
HP-3600.1.2	HX-4300.2.4	
HP-3600.1.8	HX-4400.1.4	
Resolutions of Condolence	**Line Number**	**Purpose**
2016-COND-01	3467	Condolence for Richard L. Curtis, PA-C
2016-COND-02	3509	Condolence for Dean Minton, PA-C
2016-COND-03	3554	Condolence for Tony Di Tomasso
Resolution of Commendation	**Line Number**	**Purpose**
2016-COMM-01	3585	Commendation for Laura Gail Curtis, MPAS, PA-C, DFAAPA
House Elections	**Line Number**	
Results	3642	

Bolded text within a resolution indicates the amendments submitted and accepted during the reports of the reference committees on May 16, 2016.

Presiding Officers

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

2016-A-01-A – Rejected

Amend 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 CONSTITUENT ORGANIZATION. ~~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 to the AAPA House of Delegates or a representative to the Student Academy of the AAPA's Assembly of Representatives.
    iii. A board member, trustee, or committee chair of the Student Academy of the AAPA, PA Foundation, Society for the Preservation of Physician Assistant History, AAPA 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 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. 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. In the event that the election of the House Officers occurs later than July 1, 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 30, 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.

2016-A-01-B – Adopted

Amend 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 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 to the AAPA House of Delegates or a representative to the Student Academy of the AAPA's Assembly of Representatives.
    iii. A board member, trustee, or committee chair of the Student Academy of the AAPA, PA Foundation, Society for the Preservation of Physician Assistant History, AAPA 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 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 BOARD OF DIRECTORS ~~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. 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. In the event that the election of the House Officers occurs later than July 1, 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 30, 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.

2016-A-02 – Adopted

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 BY THE BOARD OF DIRECTORS ~~in accordance with this section~~;
c. ~~Selecting~~ ENDORSING 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~~ THREE years.
c. A candidate must have accumulated at least three distinct years of RECOGNIZED LEADERSHIP experience in the past five years THROUGH SERVICE TO THE AAPA; AN AAPA CONSTITUENT ORGANIZATION; AN AAPA AFFILIATED ORGANIZATION; AND/OR A HEALTHCARE-RELATED PROFESSIONAL OR COMMUNITY ORGANIZATION. EXAMPLES INCLUDE, BUT ARE NOT LIMITED TO: SERVICE IN THE AAPA HOUSE OF DELEGATES; THE PA FOUNDATION; PAEA; A LOCAL HOSPICE SUPPORT ORGANIZATION; A HOSPITAL BOARD.
    i. RECOGNIZED LEADERSHIP EXPERIENCE MUST BE EARNED IN, AT LEAST, TWO MAJOR AREAS OF PROFESSIONAL INVOLVEMENT.
    ii. RECOGNIZED LEADERSHIP EXPERIENCE INCLUDES A BOARD MEMBER OR ORGANIZATION OFFICER; AN ELECTED OR APPOINTED REPRESENTATIVE; OR A CHAIR OF A COMMISSION, COMMITTEE, WORK GROUP OR TASK FORCE.

~~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 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.

2016-A-03 – Rejected

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 Chief Executive Officer (CEO) 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 CEO;
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~~ 2: 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. The Chief Executive Officer shall be a non-voting member of the Board of Directors.

Section ~~4~~ 3: 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~~ 4: 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 maintenance 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 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~~ 5: 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~~ 6: 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~~ 7: 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~~ 8: 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.

2016-A-04* – Adopted as Amended (requires AAPA Board of Directors' ratification)

Amend Bylaws Article VI as follows:

ARTICLE VI House of Delegates.

Section 1: Duties and Responsibilities. The Academy shall have a House of Delegates, which shall represent the interests of the membership. The House of Delegates shall exercise the sole authority on behalf of the Academy to enact policies establishing the collective values, philosophies, and principles of the PA profession. The House of Delegates **MAY ~~shall, IF IT DEEMS NECESSARY~~**, make recommendations to the Board for granting charters to Chapters and for granting official recognition to specialty organizations. The House of Delegates **MAY ~~shall, IF IT DEEMS NECESSARY~~**, make recommendations to the Board for the establishment of Academy commissions and work groups, and shall establish such committees of the House of Delegates as necessary to fulfill its duties. The House of Delegates shall be entitled to vote on amendments to these Bylaws on behalf of the members in accordance with Article XIII of these Bylaws. The House of Delegates shall be solely responsible for establishing such rules of procedure, which are not inconsistent with these Bylaws, the Articles of Incorporation, or existing law, as may be necessary for carrying out the activities of the House (i.e. House of Delegates Standing Rules).

2016-A-05 – Adopted

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 c~~C~~hapters, recognize specialty organizations, establish AFFILIATION WITH ~~criteria for~~ caucuses AND SPECIAL INTEREST GROUPS, 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;

2016-A-06 – Adopted on Consent Agenda

Amend Bylaws Article IV as follows:

ARTICLE IV Constituent Organizations

Constituent organizations consist of state, THE DISTRICT OF COLUMBIA, U.S. TERRITORIES and federal service chapters~~,~~;; specialty organizations~~,~~;; caucuses~~,~~;; and special interest groups~~,~~;; as defined in AAPA policy.

2016-A-07 – Adopted as Amended

AAPA believes that sustaining public trust in the PA profession is the responsibility of PAs. **THEREFORE, THE GOVERNING BODIES OF AAPA, PAEA, NCCPA, AND ARC-PA SHOULD BE COMPRISED OF A MAJORITY OF PAS.** ~~**National organizations primarily representing the interests of the PA profession and the public it serves should ensure their governing bodies are PA-led. A majority composition of decision-making bodies within these national organizations therefore must be PAs.**~~ **THESE** ~~**PA-led national**~~ organizations will continue to value the involvement of other stakeholders in medicine, healthcare, and the public through consultative and advisory relationships.

2016-A-08 – Referred** (to be referred by the Speaker to the appropriate body and reported back to the 2017 HOD)

The AAPA shall be responsible for developing and upholding the broad definition of the PA profession scope of practice.

And Further Resolved

PAs are currently restricted to practice medicine under their supervising physician's scope of practice. This is a requirement for all PAs regardless of their clinical experience, education or credentials. After nearly 50 years of providing high quality medicine, PAs have earned the right to define their own scope of practice. This new concept shall be referred to as Full Practice Responsibility (FPR). This new system would allow PAs to function more autonomously by removing the currently imposed practice barrier of physician supervision. Full Practice Responsibility will be an alternative option to supervision in states that seek autonomous PA practice.

2016-A-09 – Rejected

The AAPA shall record the votes of the HOD members during the annual conference and any special meetings.

And Further Resolved

The AAPA shall make available these recorded votes to AAPA members within 30 days following the annual conference and any special meeting.

2016-A-10 – Rejected

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, AAPA 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.

2016-A-11 – Adopted

Amend Article XIII. Elections as follows:

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 to the AAPA House of Delegates or a representative to the Student Academy of the AAPA's Assembly of Representatives.
   iii. A board member, trustee, or committee chair of the Student Academy of the AAPA, PA Foundation, Society for the Preservation of Physician Assistant History, AAPA 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 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. 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. In the event that the election of the House Officers occurs later than July 1, 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 30, 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. ELIGIBLE MEMBERS, AS DESCRIBED IN SECTION 6 OF THIS ARTICLE, SHALL ELECT A NEW OFFICER AND/OR DIRECTOR FROM THE CANDIDATES PROPOSED AND ANY CANDIDATES THAT SELF- DECLARE. THE ELECTED CANDIDATE WILL TAKE OFFICE IMMEDIATELY AND WILL SERVE THE REMAINDER OF THE UN-EXPIRED TERM.

2016-A-12 – Adopted

AAPA encourages that "PA *Surname*" be established as the recommended address for PAs, unless a more suitable formal address is appropriate, such as military rank or academic role.

2016-A-13 – Adopted as Amended by Deletion

~~**HP-3100.2.2**~~
~~**AAPA recognizes graduates of all programs accredited by the Accreditation Review Commission (ARC-PA), or by one of its predecessor agencies as fulfilling the definition of the generic term "physician assistant." In consumer and professional education and relations, and in negotiations with or policies presented to state and/or federal governmental agencies, AAPA treats PAs generically, using the same criteria spelled out in the Academy's Bylaws for fellow membership.**~~

2016-B-01 – Adopted

AAPA supports assessing general medical knowledge for initial certification and licensing of PAs.

AAPA supports the use of evidence-based alternatives to testing for maintenance of certification.

AAPA opposes any requirement that PAs take a closed-book, proctored exam in a specialty area for maintenance of certification.

AAPA opposes any requirement that PAs take multiple examinations during a 10-year recertification cycle.

AAPA supports uncoupling maintenance of certification requirements from maintenance of license and prescribing privileges in state laws.

AAPA urges NCCPA and the NCCPA Foundation to undertake rigorous and replicable research to determine the relationship, if any, between taking the NCCPA recertification test and patient outcomes, safety and satisfaction.

2016-B-02 – Rejected

AAPA believes the assessment of competency for licensure is a separate and distinct process from certification.

And further resolved

AAPA supports the concept of development of a National PA Licensing Examination.

And further resolved

Expire policy HP-3500.2.1.

~~HP-3500.2.1~~
~~AAPA endorses the National Commission on Certification of Physician Assistants (NCCPA) certification exam as the only entrance standard for PAs.~~

2016-B-03 – Rejected

Amend by substitution policy HP-3500.2.1 as follows:

~~AAPA endorses the National Commission on Certification of Physician Assistants (NCCPA) certification exam as the only entrance standard for PAs.~~
THE AAPA SUPPORTS ESTABLISHING ENTRY-LEVEL STANDARDS FOR THE PROFESSION BY MEASURING A PA STUDENT'S BROAD-BASE OF MEDICAL KNOWLEDGE UPON GRADUATION FROM AN ARC-PA ACCREDITIED PROGRAM THROUGH A CERTIFYING EXAMINATION ADMINISTERED BY THE NATIONAL COMMISSION ON THE CERTIFICATION OF PHYSICIAN

ASSISTANTS (NCCPA) OR ANY SUCCESSOR ORGANIZATION RECOGNIZED BY THE ACADEMY.

And Further Resolved

Expire policy HP-3500.2.2.

~~AAPA opposes examinations given by any organization other than the NCCPA for the purpose of establishing entrance-level standards for individuals not eligible for the National Commission on Certification of Physician Assistants examination.~~

And Further Resolved

Amend by substitution policy HP-3500.2.3 as follows:

~~AAPA believes that the NCCPA certificate should be time-limited and that maintenance of a current valid certificate requires that PAs pass the Physician Assistant National Recertifying Exam (PANRE) within four attempts if initiated within the final two years of the recertification cycle.~~
THE AAPA OPPOSES ANY MANDATORY PERIODIC RECERTIFYING EXAMINATIONS REQUIRED BY THE NCCPA OR ANY SUCCESSOR ORGANIZATION RECOGNIZED BY THE ACADEMY, OR BY ANY STATE OR FEDERAL REGULATORY AGENCIES FOR CERTIFIED PAS BEYOND THE ENTRY-LEVEL.

THE AAPA DOES NOT OPPOSE THE NCCPA OR ANY SUCCESSOR ORGANIZATION RECOGNIZED BY THE ACADEMY REQUIRING CERTIFIED PAS TO PERIODICALLY OBTAIN CATEGORY 1 CONTINUING MEDICAL EDUCATION (CME) THAT INCORPORATES PROFESSIONAL SELF-ASSESSMENT AND/OR PRACTICE-IMPROVEMENT ACTIVITIES TO MAINTAIN THEIR GENERALIST CORE OF MEDICAL KNOWLEDGE. THIS CME REQUIRED SHOULD NOT EXCEED THE CURRENT REQUIREMENTS ESTABLISHED BY THE NCCPA AS OF 2015.

THE AAPA DOES NOT BELIEVE CME OR MANDATORY RECERTIFYING EXAMINATIONS MEASURES A PA'S COMPETENCY. COMPETENCY IS DEFINED AS THE ABILITY FOR AN INDIVIDUAL TO PERFORM THEIR DUTIES. THE AAPA BELIEVES A PA'S COMPETENCY IS ASSESSED AT THE PRACTICE LEVEL BY THE EMPLOYING AGENT AND/OR PRIVILEGING AND CREDENTIALING ENTITIES WHERE THE PA PRACTICES.

And Further Resolved

THE HOUSE OF DELEGATES RECOMMENDS THE AAPA BOARD OF DIRECTORS WORK WITH THE NCCPA TO ADDRESS THEIR CURRENT POLICIES REGARDING THE PA NATIONAL RECERTIFICATION PROCESS TO ASSURE THAT A PA'S CERTIFICATION: IS NOT TIME-LIMITED; DOES NOT REQUIRE A MANDATORY EXAMINATION AT THE END OF THE PA'S 10 YEAR

RECERTIFICATION CYCLE; MAINTAINS A PA'S GENERALIST CERTIFICATION; AFFORDS THOSE PAS PRACTICING IN A SUBSPECIALTY TO TAKE A PORTION OF THEIR REQUIRED CME FOCUS ON THAT SUBSPECIALTY.

2016-B-04 – Adopted as Amended

The AAPA endorses the Federation of State Medical Board's (FSMB) *Maintenance of Licensure (MOL) Guiding Principles:*

- Maintenance of licensure should support PA's commitment to lifelong learning and facilitate improvement in PA practice.
- Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders.
- Maintenance of licensure should not compromise patient care or create barriers to PA practice.
- The infrastructure to support PA compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.
- Maintenance of licensure processes should balance transparency with privacy protections.

~~**AAPA strongly encourages all state Constituent Organizations to advocate for legislation to adopt MOL processes consistent with the FSMB.**~~

And Further Resolved

The AAPA believes:

- The authority for establishing MOL requirements is strictly within the purview of state **LEGISLATIVE OR** PA regulatory authorities.
- ~~**Maintenance of certification (MOC) should not be a requirement for maintenance of licensure.**~~
- ~~**High stakes testing**~~ **Testing** should not be part of the MOL process.
- **AAPA STRONGLY ENCOURAGES ALL STATE CONSTITUENT ORGANIZATIONS TO ADVOCATE FOR LEGISLATION TO ADOPT MOL PROCESSES CONSISTENT WITH THE FSMB GUIDING PRINCIPLES AND ACADEMY POLICY.**

2016-B-05 – Adopted as Amended

- ~~**AAPA believes that the NCCPA should cease moving forward with the current implementation of any changes in the national recertification examination process.**~~
- AAPA believes the NCCPA should maintain its current national recertification examination process until representatives from the AAPA and NCCPA can agree on one that both demonstrates competency and comprehensively represents the needs of PAs in all practice settings.
- ~~**AAPA believes the NCCPA should make no changes in its current fee schedule**~~

~~for PAs and no future changes unless agreed upon by the AAPA and NCCPA.~~

- ~~If the AAPA and NCCPA cannot arrive at an agreeable solution, the AAPA should explore alternatives to the current recertification process.~~

2016-B-06 – Withdrawn

Amend policy HP-3200.2.3 as follows:

AAPA encourages the NCCPA to recognize CME Category 1 credit for continuing education activities that incorporate professional self-assessment and self-improvement activities. AAPA BELIEVES THESE ACTIVITIES SHOULD BE INTEGRATED PERIODICALLY THROUGHOUT THE PA'S 10 YEAR RECERTIFICATION PROCESS AND IN LIEU OF A WRITTEN RECERTIFICATION EXAM AT THE END OF THE 10 YEAR RECERTIFICATION CYCLE.

2016-B-07 – Rejected

The AAPA supports the following certification model for graduates of ARC-PA recognized programs:

1. Initial passing of the PANCE.
2. Completion of one hundred (100) hours of CME every two (2) years.
3. Passing of PANRE upon the 9th ninth or 10th (tenth) anniversary of PANCE certification.
4. Once the PANRE is passed, no further recertification tests would be required.

In the event a PA does not pass the PANRE, AAPA recommends a remediation plan through attainment of CME. Upon completion of the remediation plan, ongoing CME requirements of one-hundred (100) hours per two (2) years for the designation of PA-C would remain in effect.

2016-B-08 – Adopted

AAPA believes that the terms "Board Certified," "Board Exams," and "the Boards "when used in reference to PA certification are inaccurate and misleading and therefore discourages the use of these terms to refer to NCCPA certification and related examinations.

2016-B-09 – Adopted as Amended by Deletion

~~**HP-3200.2.3**~~
~~**AAPA encourages the NCCPA to recognize CME Category 1 credit for continuing education activities that incorporate professional self-assessment and self-improvement activities.**~~

2016-C-01 – Rejected

AAPA believes the definition of a collaborating physician should be amended to include Doctors of Podiatric Medicine (DPM) as the scope of practice for DPMs is similar to the scope of practice for orthopaedic physicians specializing in foot and ankle care, and the utilization of PAs by DPMs is appropriate for the training and skill set of PAs.

2016-C-02 – Adopted as Amended

Amend policy HP 3500.3.4, "Guidelines for State Regulation of PAs" as follows:

Guidelines for State Regulation of PAs

(Adopted 1988, amended 1993, 1998, 2001, 2005, 2006, 2009, 2011 and 2013)

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.

- ~~State law must include a definition of PA in order to differentiate PAs from the many other health care professionals.~~
- ~~Licensure is the most common and appropriate regulatory term and system for PAs.~~
- ~~A supervising physician is an MD or DO who accepts responsibility for the supervision of services provided by PAs.~~
- ~~For PAs who practice in Federal jurisdictions, supervision may be provided by a physician (MD or DO) who meets the licensing requirements of the federal agency.~~
- ~~Laws and regulations governing PA practice should permit utilization of PA services in a wide variety of practice settings without overburdening lists of tasks.~~
- ~~The ability to prescribe medications should be one of the medical services that physicians may delegate to PAs.~~
- ~~Each state must define the regulatory agency responsible for implementation of the law governing PAs.~~

- INCLUSION OF PAS IN STATE LAW AND DELEGATION OF AUTHORITY TO REGULATE THEIR PRACTICE TO A STATE AGENCY SERVES TO BOTH PROTECT THE PUBLIC FROM INCOMPETENT PERFORMANCE BY UNQUALIFIED MEDICAL PROVIDERS AND TO DEFINE THE ROLE OF PAS IN THE HEALTHCARE SYSTEM.
- AAPA, WHILE RECOGNIZING THE DIFFERENCES IN POLITICAL AND HEALTHCARE CLIMATES IN EACH STATE, ENDORSES STANDARDIZATION OF PA REGULATION AS A WAY TO ENHANCE APPROPRIATE AND FLEXIBLE PROFESSIONAL PRACTICE.
- THIS DOCUMENT DISCUSSES KEY CONCEPTS OF STATE REGULATION.

Introduction

Recognition of PAs as ~~health care~~ MEDICAL providers led to THE development of state laws and regulations to govern their practice. Inclusion of PAs in state law and delegation of authority to regulate their practice to a state regulatory body serves two main purposes: (1) to protect the public from incompetent performance by unqualified ~~non-physicians~~ MEDICAL PROVIDERS, and (2) to define the role of PAs in the healthcare system. Since the inception of the profession, dramatic changes have occurred in the way states have dealt with PA practice. In concert with these developments has been the creation of a body of knowledge on legislative and regulatory control of PA practice. It is now possible to state which specific concepts in PA statutes and regulations enable appropriate ~~use of~~ PRACTICE BY PAs as ~~health care~~ MEDICAL providers while protecting the public health and safety.

What follows are general guidelines on state governmental control of PA practice. The AAPA recognizes that the uniqueness of each state's political and healthcare climate will require modification of some provisions. However, standardization of PA regulation will enhance appropriate and flexible ~~utilization of~~ PA ~~services~~ PRACTICE nationwide. This document does not contain specific language for direct incorporation into statutes or regulations, nor is it inclusive of all concepts generally contained in state practice acts or regulations. Rather, its intent is to clarify key elements of regulation and to assist states as they pursue improvements in state governmental control of PAs. To see how these concepts can be adapted into legislative language, please consult the AAPA's model state legislation for PAs.

Definition of PA

~~The state law must include a definition of PA in order to differentiate PAs from other healthcare clinicians who provide direct care to patients.~~ The legal definition of PA should ~~include individuals who have graduated from accredited PA programs and have passed the national PA certifying examination administered by the National Commission on Certification of Physician Assistants (NCCPA). An exceptions clause should be included for PAs who are not accredited program graduates, but who passed the physician assistant national certifying examination (PANCE) administered by the NCCPA when it was available to non-program graduates prior to 1986~~. MEAN A HEALTHCARE PROFESSIONAL WHO MEETS THE QUALIFICATIONS ~~**DEFINED IN STATE LAW**~~ **FOR LICENSURE** AND IS LICENSED TO PRACTICE MEDICINE.

~~Accreditation~~

~~PA programs were originally accredited by the American Medical Association's Council on Medical Education (1972-1976), which turned over its responsibilities to the AMA's Committee on Allied Health Education and Accreditation (CAHEA) in 1986. CAHEA was replaced in 1994 by the Commission on Accreditation of Allied Health Education Programs (CAAHEP). On January 1, 2001, the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), which had been part of both the CAHEA and CAAAHEP systems, became a freestanding accrediting body and the only national accrediting agency for PA programs.~~

QUALIFICATIONS FOR LICENSURE

~~Because the law must recognize the eligibility for licensure of PAs who~~ QUALIFICATIONS FOR LICENSURE SHOULD INCLUDE graduate~~d~~ION from AN ACCREDITED PA program~~s~~ AND PASSAGE OF THE PA NATIONAL CERTIFYING EXAMINATION (PANCE) ADMINISTERED BY THE NATIONAL COMMISSION ON CERTIFICATION OF PAS (NCCPA) ~~**OR ANOTHER NATIONALLY RECOGNIZED CERTIFYING ORGANIZATION APPROVED BY THE ACADEMY.**~~

PA PROGRAMS WERE ORIGINALLY ACCREDITED BY THE AMERICAN MEDICAL ASSOCIATION'S COUNCIL ON MEDICAL EDUCATION (1972-1976), WHICH TURNED OVER ITS RESPONSIBILITIES TO THE AMA'S COMMITTEE ON ALLIED HEALTH EDUCATION AND ACCREDITATION (CAHEA) IN 1976. CAHEA WAS REPLACED IN 1994 BY THE COMMISSION ON ACCREDITATION OF ALLIED HEALTH EDUCATION PROGRAMS (CAAHEP). ON JANUARY 1, 2001, THE ACCREDITATION REVIEW COMMISSION ON EDUCATION FOR THE PA (ARC-PA), WHICH HAD BEEN PART OF BOTH THE CAHEA AND CAAHEP SYSTEMS, BECAME A FREESTANDING ACCREDITING BODY AND THE ONLY NATIONAL ACCREDITING AGENCY FOR PA PROGRAMS.

BECAUSE THE LAW MUST RECOGNIZE THE ELIGIBILITY FOR LICENSURE OF PAS WHO GRADUATED FROM A PA PROGRAM accredited by the earlier agencies, the ~~definition of PAs~~ LAW should specify individuals who have graduated from a PA program accredited by the ARC-PA or one of its predecessor agencies, CAHEA or CAAHEP.

~~Certification~~

The ~~definition of PA should also refer to those individuals who have passed the PA~~ QUALIFICATIONS SHOULD SPECIFICALLY INCLUDE PASSAGE OF THE national certifying examination administered by the ~~National Commission on Certification of Physician Assistants.~~ NCCPA ~~**OR ANOTHER NATIONALLY RECOGNIZED CERTIFYING ORGANIZATION APPROVED BY THE ACADEMY**~~**.** No other certifying body or examination should be considered equivalent to the NCCPA or the PANCE ~~**UNLESS APPROVED BY THE ACADEMY.**~~

~~Exceptions~~

The NCCPA, since 1986, has allowed only graduates of accredited PA programs to take its examination. However, between 1973-1986, the exam was open to individuals who had practiced as PAs in primary care for four of the previous five years, as documented by their supervising physician. Nurse practitioners and graduates of unaccredited PA programs were also eligible for the exam. An exceptions clause should be included to ~~make~~ ALLOW these individuals TO BE eligible for licensure.

Licensure

When a regulatory board has verified a PA's qualifications, it should issue a license to the applicant. Although, in the past, registration and certification have been used as the regulatory term for PAs, licensure is now the ~~most prevalent~~ designation and system USED IN ALL STATES. This is appropriate because licensure is the most stringent

form of regulation. Practice without a license is subject to severe penalties. Licensure both protects the public from unqualified providers and utilizes a regulatory term that is easily understood by healthcare consumers. ~~Licensure does not imply nor create independent practice for PAs. The profession retains its commitment to PA practice with physician supervision.~~

~~Licensure should be independent of identification or approval of supervising physicians or supervisory arrangements and independent of employment~~. APPLICANTS WHO MEET THE QUALIFICATIONS FOR LICENSURE SHOULD BE ISSUED A LICENSE. STATES SHOULD NOT REQUIRE EMPLOYMENT OR IDENTIFICATION OF A COLLABORATING PHYSICIAN (S) AS A CONDITION OR COMPONENT OF LICENSURE. A category of inactive licensure should be available for PAs who are not currently in active practice in the state. If issuance of a full license requires approval at a scheduled meeting of the regulatory agency, a temporary license should be available to applicants who meet all licensure requirements but are awaiting the next meeting of the board.

If the board uses continuous clinical practice as a requirement for licensure, it should recognize the nature of PA practice when determining requirements for PAs who are reentering clinical practice (defined as a return to clinical practice as a PA following an extended period of clinical inactivity UNRELATED TO DISCIPLINARY ACTION OR IMPAIRMENT ISSUES). ~~PAs uniformly practice with physician supervision; reentry provisions the board designs for physicians may not be appropriate for PAs.~~ Each PA reentering clinical practice will have unique circumstances. Therefore, the board should be authorized to customize requirements imposed on PAs reentering clinical practice. Acceptable options could include requiring current certification, mandating specific requirements for ~~supervision~~ COLLABORATION OR OVERSIGHT, or temporary authorization to practice for a specified period of time**.** Although it has not yet been determined conclusively that absence from clinical practice is associated with a decrease in competence, there is concern that this is the case. Reentry requirements should not be imposed for an absence from clinical practice that is less than two years in duration.

Because of the high level of responsibility of PAs, it is reasonable for licensing agencies to conduct criminal background checks on individuals who apply for licensure as PAs. Licensing agencies should have the discretion to grant or deny licensure based on the findings of background checks and information provided by applicants.

~~Supervision~~ COLLABORATION

The definition of ~~supervision~~ COLLABORATION should convey ~~the idea that direction of the medical practice of the PA is provided and assured by supervising physicians, but that this does not necessarily require the physical presence of a supervising physician at the place where services are rendered.~~ A PROCESS IN WHICH PAS AND PHYSICIANS JOINTLY CONTRIBUTE TO THE HEALTHCARE AND MEDICAL TREATMENT OF PATIENTS WITH EACH COLLABORATOR PERFORMING ACTIONS HE OR SHE IS LICENSED TO OTHERWISE PERFORM. COLLABORATION SHALL BE CONTINUOUS BUT SHALL NOT BE CONSTRUED TO REQUIRE THE PHYSICAL PRESENCE OF THE PHYSICIAN AT

THE TIME AND PLACE THAT SERVICES ARE RENDERED. It is imperative, however, that the PA and a ~~supervising~~ COLLABORATING physician ~~are or can be in contact with~~ HAVE ACCESS TO each other ~~by telecommunication~~. EVEN WHEN PRACTICING IN COLLABORATION WITH A PHYSICIAN, PAS ARE RESPONSIBLE FOR THE CARE THEY PROVIDE. NOTHING IN THE LAW SHOULD REQUIRE OR IMPLY THAT THE COLLABORATING PHYSICIAN IS RESPONSIBLE OR LIABLE FOR THE CARE PROVIDED BY THE PA UNLESS THE PA IS ACTING ON THE SPECIFIC INSTRUCTIONS OF A PHYSICIAN. ~~Supervising~~ COLLABORATING physician should be defined as an allopathic or osteopathic physician (MD or DO) licensed to practice in the state, who ~~accepts responsibility for the supervision of services provided by PAs.~~ AGREES TO COLLABORATE WITH PA(S). For PAs who practice in federal jurisdictions, ~~supervision~~ COLLABORATION may be provided by a physician (MD or DO) who meets the licensing requirements of the federal agency. Licensure in the state should not be required for federal ~~supervising~~ COLLABORATING physicians if it is not required by the federal agency. ~~In solo practice settings, provisions should be made for alternate supervision in the supervising physician's absence.~~ In group practice situations or in the hospital or its emergency department, provisions should be made for all staff physicians who so choose to ~~supervise~~ COLLABORATE WITH PAs who practice in the group or institution. ~~PAs should not see the patients of physicians who do not wish PAs to see their patients.~~

The guiding principles of ~~supervision~~ TEAM PRACTICE must be that it (a) protects the public health and safety, and (b) preserves the PA's access to physician consultation when indicated. Consequently, it is recommended that the ratio of PAs to ~~supervising~~ COLLABORATING physicians be determined by ~~supervising~~ physician(s) and PAs according to the nature of the services being provided and according to the tenets of good patient care~~, adequate supervision and legal responsibility~~. Language that specifies mandatory ratios of PAs to ~~supervising~~ COLLABORATING physicians should be avoided. In addition, there should be no limit on the number of ~~supervising~~ COLLABORATING physicians each PA may have.

~~Accountability for physician supervision of PAs may be determined by a variety of methods. In small practices, the physician supervising a PA at a specific point in time may be obvious. In large groups or in settings with multiple supervising physicians, a mechanism should be in place to document physician supervision. It should be clear which physician is supervising the PA.~~

~~The system of licensure for PAs and identification of supervising physicians should be flexible enough to permit appropriate substitution of licensed providers. Ideally, any physician with an unrestricted license should be able to supervise any licensed PA if both agree to the arrangement, the arrangement is documented in writing, and the documentation is available to the regulatory agency upon request. This allows for easy substitution of providers and facilitates PA participation in teams that provide care in group practices, and expedites the extension of care to free clinics, homeless shelters, migrant clinics, and a variety of other settings. This system also enables ready coverage~~

~~in rural areas where flexible substitution may be required to provide continuous clinic staffing.~~

Because the state licenses both physicians and PAs and can discipline or revoke or restrict the license of both types of providers, it is redundant and unnecessary for the law to require physicians or PAs to file notice of ~~supervisory~~ COLLABORATIVE arrangements with an agency. ~~State law should require documentation of a supervising physician-PA relationship that is kept on file at the clinical site and available to the regulatory agency upon request.~~

NOTWITHSTANDING THE ABOVE PROVISIONS, THESE GUIDELINES RECOGNIZE THAT MEDICINE IS RAPIDLY CHANGING. A MODIFIED MODEL MAY BE BETTER FOR SOME STATES AND THEY SHOULD THEREFORE FEEL FREE TO CRAFT ALTERNATIVE PROVISIONS. PAS PRACTICE TEAM BASED MEDICINE WITH A WIDE VARIETY OF TEAM MEMBERS TO INCLUDE PHYSICIANS. LANGUAGE IN STATE LAW SHOULD ACKNOWLEDGE CONSULTATION AND/OR COLLABORATION BETWEEN PHYSICIANS AND PAS IN A MANNER THAT ASSURES QUALITY MEDICAL CARE AND PROMOTES ACCESS.

PA PRACTICE OWNERSHIP AND EMPLOYMENT

Employment and ~~supervision~~ COLLABORATION should be regarded as separate entities. A physician's ability to ~~supervise~~ COLLABORATE WITH a PA is independent of the specifics of PA employment. In the early days of the profession the PA was commonly the employee of the physician. In current systems physicians and PAs may be employees of the same hospital or health system. In some situations the PA may be part or sole owner of a practice. PA practice owners may be the employers of their ~~supervising~~ collaborating physicians.

To allow for flexibility and creativity in tailoring healthcare systems that meet the needs of specific patient populations, a variety of practice ownership and employer-employee relationships should be available to physicians and to PAs. The ~~physician-PA~~PA-PHYSICIAN relationship is built on trust, respect, and appreciation of the unique role of each team member. No licensee should allow an employment arrangement to interfere with sound clinical judgment or to diminish or influence their ethical obligations to patients. State law provisions should authorize the regulatory authority to discipline a physician or a PA who allows employment arrangements to exert undue influence on sound clinical judgment or on their professional role and patient obligations.

DISASTERS, EMERGENCY FIELD RESPONSE AND VOLUNTEERING

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~~ COLLABORATION 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~~ COLLABORATE WITH PAs in such disaster or emergency situations should be exempt from routine documentation or ~~supervision~~ COLLABORATIVE requirements.

PAs should be granted Good Samaritan immunity to the same extent that it is available to other health professionals.

PAS WHO ARE VOLUNTEERING WITHOUT COMPENSATION OR REMUNERATION SHOULD BE SIMILARLY EXEMPTED FROM COLLABORATION PROVISIONS.

Scope of Practice

State law should permit ~~utilization of~~ PA ~~services in a wide variety of~~ PRACTICE IN ALL SPECIALTIES AND settings. In general, PAs should be permitted to provide any legal medical service that is ~~delegated to them by the supervising physician when the service is~~ within the PA's skills, EDUCATION, ~~and~~ TRAINING AND EXPERIENCE. MEDICAL SERVICES PROVIDED BY PAS MAY INCLUDE BUT ARE NOT LIMITED TO ORDERING, PERFORMING AND INTERPRETING DIAGNOSTIC STUDIES, ORDERING AND PERFORMING THERAPEUTIC PROCEDURES, FORMULATING DIAGNOSES, **PROVIDING PATIENT EDUCATION ON HEALTH PROMOTION AND DISEASE PREVENTION,** PROVIDING TREATMENT AND PRESCRIBING MEDICAL ORDERS FOR TREATMENT. THIS INCLUDES THE ORDERING, PRESCRIBING, ~~AND~~ DISPENSING, ADMINISTRATION AND PROCUREMENT OF DRUGS AND MEDICAL DEVICES. PA EDUCATION INCLUDES EXTENSIVE TRAINING IN PHARMACOLOGY AND CLINICAL PHARMACOTHERAPEUTICS. ADDITIONAL TRAINING, EDUCATION OR TESTING SHOULD NOT BE REQUIRED AS A PREREQUISITE TO PA PRESCRIPTIVE AUTHORITY. PAS WHO ARE PRESCRIBERS OF CONTROLLED MEDICATIONS SHOULD REGISTER WITH THE FEDERAL DRUG ENFORCEMENT ADMINISTRATION.

DISPENSING IS ALSO APPROPRIATE FOR PAS. THE PURPOSE OF DISPENSING IS NOT TO REPLACE PHARMACY SERVICES, BUT RATHER TO INCREASE PATIENT ABILITY TO RECEIVE NEEDED MEDICATION WHEN ACCESS TO PHARMACY SERVICES IS LIMITED. PHARMACEUTICAL SAMPLES SHOULD BE AVAILABLE TO PAS JUST AS THEY ARE TO PHYSICIANS FOR THE MANAGEMENT OF CLINICAL PROBLEMS.
~~and is provided with supervision of a physician. A list of specific tasks is overly restrictive and should be avoided. A PA's skills should not be utilized to extend the scope of the supervising physician beyond what is reasonable in the practice. Education of PAs, like that of physicians, promotes the development of practical skills in clinical problem solving and decision making. For this reason, the use of written clinical protocols should not be required as part of state laws or regulations delineating PA scope of practice. Protocols are useful for dealing with very specific clinical entities (e.g., anaphylaxis). However, protocols by their nature are rigid and rapidly outdated. Extensive clinical protocols are useful to PAs to the same extent that they are useful to physicians. They should be utilized as indicated in the clinical setting, but should not be mandated by state law or regulation.~~

State laws, regulations, and policies should allow PAs to sign any forms that require a physician signature ~~when delegated to do so by a supervising physician~~.

~~Prescribing and Dispensing~~

~~The ability to prescribe medications should be one of the medical services that physicians may delegate to PAs. Supervised prescribing, as regulated by the state and by the physician supervisor, can improve patient access to comprehensive care and provide for increased efficiency and cost effectiveness. Categories of medications to be prescribed should be consistent with the supervising physician's practice and should include controlled substances. PAs who are delegated prescribers of controlled medications should register with the federal Drug Enforcement Administration. PA education includes extensive training in pharmacology and clinical pharmacotherapeutics. Additional training, education or testing should not be required as a prerequisite to PA prescriptive authority.~~

~~Limited dispensing is also appropriate for delegation to PAs. The purpose of limited dispensing is not to replace pharmacy services, but rather to increase patient ability to receive needed medication when access to pharmacy services is limited. Pharmaceutical samples should be available to PAs just as they are to physicians for the management of clinical problems.~~

Title and Practice Protection

The ability to utilize the title of "PA" or "asociado médico" when the professional title is translated into Spanish should be limited to those who are authorized to practice by their state as a PA. The title may also be utilized by those who are exempted from state licensure but who are credentialed as a PA by a federal employer and by those who ~~are faculty at an ARC-PA accredited PA program and~~ meet all OF THE qualifications for licensure in the state but are not currently licensed. A person who is not authorized to practice as a PA should not engage in PA practice unless similarly credentialed by a federal employer. The state should have the clear authority to impose penalties on individuals who violate these provisions.

Regulatory Agencies

Each state must define the regulatory agency responsible for implementation of the law governing PAs. ALTHOUGH A variety of state agencies can be charged with this task~~.~~, THE PREFERABLE REGULATORY STRUCTURE IS A SEPARATE PA LICENSING BOARD ~~These include the State Board of Medical Examiners, the Department of Health, or boards that are selected or created to regulate PA practice. The regulatory agency has a significant impact on the practice and utilization of PAs, and some general guidelines, along with each state's administrative realities, should be considered when defining which agency will be responsible for PA regulation. This agency should include~~ COMPRISED OF a group of members who are knowledgeable about PA education, certification, and practice. Consideration should be given to including members who are representative of a broad spectrum of healthcare settings — primary care, specialty care, institutional and rural based practices.

~~A number of states have created separate PA licensing boards. Such board should be composed primarily of PAs and supervising physicians.~~ If regulation is administered by a multidisciplinary healing arts or medical board, it is strongly recommended that PAs

and physicians who ~~supervise~~ COLLABORATE WITH PAs be ~~constituent~~ FULL VOTING members of the board. ~~It is also recommended in these situations that PA advisory committees be established and actively utilized to assure PA participation in the regulatory process.~~

Any state regulatory agency charged with PA licensure should be sensitive to the manner in which it makes information available to the public. Consumers should be able to obtain information on health professionals from the licensing agency, but the agency must assure that information released does not create a risk of targeted harassment for the PA licensee or their family.

Although there is no conclusive evidence that malpractice claims history correlates with professional competence, many state regulatory agencies are required by statute to make malpractice history on licensees available to the public. If mandated to do so, the board should create a balance between the public's right to relevant information about licensees and the risk of diminishing access to subspecialty care. Because of the inherent risk of adverse outcomes, medical professionals who care for patients with high- risk medical conditions are at greater risk for malpractice claims. The board should take great care in assuring that patient access to this specialized care is not hindered as a result of posting information that could be misleading to the public. Licensee profiles should contain only information that is useful to consumers in making decisions about their healthcare professional. Healthcare professional profile data should be presented in a format that is easy to understand and supported by contextual information to aid consumers in evaluating its significance.

Discipline

AAPA ~~strongly~~ endorses the authority of designated state regulatory agencies, in accordance with due process, to discipline PAs who have committed acts in violation of state law. Disciplinary actions may include, but are not limited to, suspension or revocation of a license or approval to practice. In general, the basic offenses are similar for all health professions and the language used to specify violations and disciplinary measures to be used for PAs should be similar to that used for physicians. The law should authorize the regulatory agency to impose a wide range of disciplinary actions so that the board is not motivated to ignore a relatively minor infraction due to inadequate disciplinary choices. Programs and special provisions for treatment and rehabilitation of impaired PAs should be similar to those available for physicians. The Academy also endorses the sharing of information among state regulatory agencies regarding the disposition of adjudicated actions against PAs. The medical practice act should authorize the physician regulatory agency to IMPOSE APPROPRIATE MEASURES on doctors for failing to comply with the legal requirements placed on those who ~~supervise~~ COLLABORATE WITH PAs. Such ~~discipline~~ MEASURES should include restrictions on a physician's authority to ~~supervise~~ COLLABORATE WITH PAs.

Inclusion of PAs in Relevant Statutes and Regulations

In addition to laws and regulations that specifically regulate PA practice, PAs should be included in other relevant areas of law. This should include, but not be limited to, laws that grant patient-provider immunity from testifying about confidential information; mandates to report child and elder abuse and certain types of injuries, such as wounds

from firearms; provisions allowing the formation of professional corporations by related healthcare professionals; and mandates that promote health wellness and practice standards. Laws that govern specific medical technology should authorize THOSE APPROPRIATELY TRAINED ~~supervising~~ COLLABORATING physicians AND PAS to ~~delegate their~~ use THEM. ~~to appropriately trained and supervised PAs.~~

2016-C-03 – Adopted

AAPA supports license portability for PAs through various modes, including a Uniform Application for State Licensure for PAs, development and deployment of an interstate PA licensure compact and enhancement of the Federation of State Medical Boards' Federation Credentials Verification Service.

2016-C-04 – Adopted on Consent Agenda

Amend policy HP-3200.6.2 as follows:

The AAPA supports efforts to help US military veteranS ~~medics, and hospital corpsmen~~ become PAs.

2016-C-05 – Adopted as Amended

Amend policy HP-3600.1.1 as follows:

AAPA seeks to modernize the Social Security Act through amendments to authorize coverage of all MEDICAL, **PSYCHIATRIC** AND SURGICAL ~~physician~~ services provided by PAs and to reimburse PAs directly for covered medical services in the same manner as all other Medicare providers.

2016-C-06 – Adopted as Amended

Amend policy HP-3600.1.4 as follows:

AAPA believes it is vital to track the volume and quality of medical, **PSYCHIATRIC** and surgical services provided by PAs to assess the impact of those services on patients and on the health care system. To facilitate that effort, AAPA supports the ENROLLMENT, recognition of, and direct payment to, PAs by public and private third party payers and health care organizations. ~~AAPA is committed to maintaining the established supervising physician-PA relationship that is a central concept in the PA profession and incorporated into every state's law.~~

2016-C-07 – Adopted as Amended

Amend policy HP-3600.1.6 as follows:

The AAPA shall educate the following groups to promote equitable reimbursement FOR MEDICAL, **PSYCHIATRIC** AND SURGICAL ~~physician~~ services provided by PAs:

Centers for Medicare and Medicaid Services (CMS), third-party payers, employers, AND third-party administrators. ~~and health benefit design organizations.~~

2016-C-08 – Adopted as Amended

Amend policy HX-4600.2.5 as follows:

AAPA supports retention of the original requirement that rural health clinics utilize PAs ~~**and NPs**~~ to PROVIDE ~~extend~~ access to primary care medical services. ~~in areas that have a shortage of physicians.~~

2016-C-09 – Adopted on Consent Agenda

Amend policy HX-4600.5.2 as follows:

AAPA supports prescription drug benefit plans that are universal, mandatory for all beneficiaries, integrated into the basic benefit package, are not a financial hardship to beneficiaries, include catastrophic coverage, have a defined, comprehensive benefit, and permit health care ~~providers~~ PRESCRIBERS to select medications using appropriate medical judgment that includes consideration of cost effectiveness, safety, and efficacy.

2016-C-10 – Adopted as Amended

Amend Policy HX-4500.9 as follows:

AAPA believes that additional clinical research should be conducted on the therapeutic value, efficacy and safety of ~~**marijuana and related**~~ cannabinoids. AAPA URGES THAT MARIJUANA'S STATUS AS A FEDERAL SCHEDULE 1 CONTROLLED SUBSTANCE BE REVIEWED ~~**WITH THE GOAL OF FACILITATING**~~ TO FACILITATE AND ALLOW~~ING~~ THE CONDUCTING OF CLINICAL RESEARCH.

2016-C-11 – Adopted

AAPA recommends that in any state where medical marijuana laws exist, PAs are included as healthcare providers that can authorize or recommend the use of marijuana for patients. AAPA believes effective patient care requires the free and unfettered exchange of information on treatment options and that discussion of marijuana as an option between PAs and patients should not subject either party to criminal sanctions.

2016-C-12 – Adopted

AAPA supports continued education programs and public health based strategies relating to the abuse of marijuana, and addressing and reducing the use of marijuana.

AAPA supports public health based strategies, instead of incarceration, when dealing with persons in possession of marijuana.

AAPA discourages the use of marijuana by women who are planning to become pregnant, are pregnant, or breastfeeding and shall treat and counsel women on cessation of marijuana.

AAPA discourages the use of marijuana by those persons under the age of 21 and discourages the use of marijuana by adults who are in the presence of persons under the age of 21.

AAPA supports legislation that requires labeling and child-proof packaging of marijuana and marijuana related products and that limit advertising to adolescents.

2016-C-13 – Adopted as Amended

~~**HP-3200.2.5**~~
~~**AAPA encourages PAs to be knowledgeable of the management of pain including the appropriate use and potential misuse of controlled substances.**~~
~~***[Adopted 2002, amended 2007, reaffirmed 2012]***~~

~~**HX-4600.5.3**~~
~~**AAPA endorses the appropriate treatment of all types of pain. The treatment of pain should utilize a team approach that incorporates the following: appropriate medications, modalities, therapies and lifestyle changes, regular assessment and adjustments of treatment, and referral to pain management specialists when needed.**~~
~~***[Adopted 2002, amended 2007, reaffirmed 2012]***~~

The AAPA encourages student and graduate PAs to recognize the crises of pain management and opioid abuse. The AAPA encourages student and graduate PAs to work toward**S** a solution to these crises at the local, state, and national level**S** through advocacy, collaboration and education ~~**by educating**~~ **FOR studentS and practicing PAs about responsible opioid prescribing.** ~~**and accepted standards of monitoring patients that are on opioid medications. The treatment of pain should utilize a team approach that incorporates the following: appropriate medications, modalities, therapies and lifestyle changes, regular assessment and adjustments of treatment, and referral to pain management specialists when needed.**~~

2016-C-14 – Adopted on Consent Agenda

AAPA supports increased access to opioid treatment programs for patients with opioid use disorder, and therefore recommends identification and removal of obstacles to full PA utilization in such programs.

2016-D-01 – Adopted as Amended

Amend policy HX-4300.2.2 as follows:

AAPA shall support state laws requiring ~~helmets~~ **PROTECTIVE EQUIPMENT** for individuals participating in activities that put them at risk of traumatic BRAIN ~~head~~ injury (recreational/transportation). In addition, the AAPA shall encourage all PAs to

educate their patients, parents/guardians and the public on the value of the appropriate ~~head gear/helmets~~ **PROTECTIVE EQUIPMENT** as protection from traumatic BRAIN ~~head~~ injury. Such education should address activities in which ~~the~~ THERE IS A risk of traumatic BRAIN ~~head~~ injury~~. is increased, such as RIDING motorcycles, ATV's, bicycles, horses, scooters, skateboards, snowboards, skis and inline roller skates; PLAYING A CONTACT SPORT, SUCH AS FOOTBALL, ICE HOCKEY, OR BOXING; BATTING AND RUNNING BASES IN BASEBALL OR SOFTBALL.~~

2016-D-02 – Adopted on Consent Agenda

Amend policy HX-4400.1.7 as follows:

AAPA recognizes that ~~family~~ abuse AND VIOLENCE ~~is~~ ARE a public health epidemic in the United States.

AAPA supports medical care of abused and battered individuals which emphasizes linkages with community-based ~~family abuse~~ programs and referral agreements whenever possible.

AAPA encourages its members to participate in community-based efforts to increase the awareness of the epidemic of child, intimate partner, and elder abuse.

AAPA encourages its members to recognize that a relationship exists between substance ~~abuse~~ USE DISORDERS and ~~family~~ abuse OF INDIVIDUALS.

AAPA supports the development of educational programs addressing prevention, early recognition, reporting, treatment and the appropriate referral to prevent ~~family~~ abuse.

2016-D-03 – Adopted on Consent Agenda

Amend policy HP-3900.1.1 as follows:

The AAPA believes that all PAs should use the standard and transmission-based precautions recommended by the HEALTHCARE INFECTION PREVENTION CONTROL ADVISORY COMMITTEE (HICPAC) AND THE Centers for Disease Control and Prevention (CDC) for preventing the spread of infectious diseases AND HEALTHCARE ASSOCIATED INFECTIONS. AAPA believes employers should establish procedures to ensure that standard precautions, TRANSMISSION-BASED PRECAUTIONS, and other applicable infection control measures are enforced and that educational programs covering proper infection control procedures are available for all health care workers. Employers should ensure that timely post-exposure counseling and prophylaxis, in accordance with relevant CDC and OSHA guidelines, are available to health care workers after an exposure.

2016-D-04 – Adopted

Amend by substitution policy HP-3200.4.1 Maintaining Professional Flexibility: The Case Against Accreditation of Postgraduate PA Programs as follows:

Accreditation and Implications of Clinical Postgraduate PA Training Programs

(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 recognizes that advanced training in the clinical setting is a core facet of the professional identity formation and continuing medical education for every PA throughout his or her career.
- AAPA recognizes that advanced training in the clinical setting, the generalist foundation of entry-level PA education, and generalist model for PA certification together position the PA profession as one of the most flexible and adaptable professions in modern healthcare. This flexibility and capacity to adopt and adapt to dynamic changes in healthcare delivery make PAs invaluable assets within the U.S. healthcare workforce to improve access and improve the quality of patient-centered care for patients, families, and communities.
- AAPA believes clinical postgraduate PA training programs represent one of many innovations created by the PA profession to support continuing professional development and lifelong learning, foster interprofessional and collaborative care, advance workforce development and explore novel educational approaches to optimize healthcare delivery. Since 1971, clinical postgraduate PA training programs have provided a relatively small number of interested PAs with diverse opportunities to gain advanced clinical skills and experience in the workplace, building upon the generalist medical education offered to all PAs through entry-level PA education. Similar to the impetus of physician shortages that led to the birth of the PA profession, many of the early clinical postgraduate PA training programs arose to address provider shortages that resulted from duty-hour restrictions of medical residents.
- AAPA supports a PA-led accreditation model for clinical postgraduate PA training programs.
- AAPA believes a PA-led, national accreditation model for clinical postgraduate PA training programs should be efficient, foster continuous quality improvement, and support data collection and dissemination of program processes, impact, and outcomes.
- AAPA believes greater investment in research infrastructures is needed to support knowledge generation, dissemination of best practices, and optimization of these voluntary, workplace-based educational innovations for PAs.

Background

Task Force Composition, Collaboration with the Commission, and Guiding Principles

In November 2015, a Task Force on Accreditation of Postgraduate Training Programs was convened by the AAPA Commission on Continuing Professional Development and Education to support their efforts in reviewing and revising the current AAPA policy HP-3200.4.1 regarding the accreditation of postgraduate PA training programs as described in the position paper entitled "Maintaining Professional Flexibility: Issues Related to Accreditation of Postgraduate PA Programs." Responsible review of the policy called for assessment of the current landscape and investigation of issues impacting the PA profession related to clinical postgraduate PA training. The task force was comprised of a diverse group of experienced healthcare professionals and clinical administrators, primarily PAs but also inclusive of members from allopathic medicine, osteopathic medicine, and healthcare administration. The task force primarily focused its review on clinical postgraduate PA training programs and considered issues beyond accreditation, since a previously existing national accreditation model for postgraduate PA training programs was put in abeyance after the last amendment of this policy paper.

To frame discussions and ensure broad perspectives were addressed throughout the process, the following guiding pillars were established: leadership, evidence, quality, impact on the PA profession, adoption and adaptation. The rationale for these pillars is built upon the following observations and best practices. Scaling of transformative change will occur when leaders envision, encourage, and support innovation that supports all stakeholders, namely PAs and the patients, families, and communities they serve. Additionally, clinical postgraduate PA training experiences that facilitate leadership development among PAs are considered critically important to the future of healthcare innovation and the PA profession. Empiric evidence should be foundational to decision making, understanding that there will likely be gaps in existing data and inherent barriers to high quality research for postgraduate clinical training models. Evidence from other healthcare professions or healthcare workforce populations from large employers may be valuable; however, the unique attributes of the PA profession should be acknowledged in attempting to generalize evidence from other professions. Expert opinion balanced with stakeholder input will likely represent the most practical approach to this review and revision process. Recommendations that encourage better, more consistent data collection and reporting for future years should be considered. A prioritization of future research should be made for investigations or observational studies that relate to optimizing

quality of care, increasing access to care, and supporting optimal health for patients and communities. Careful consideration should be given for any guidance or policy recommendations that addresses structured or formalized regulatory oversight, because of its potential macro-level impact on PA practice. The careful consideration of potential long term effects of recommendations on PA practice and the practice environment should be weighed carefully, as well as the appropriate authority and rights of states in the licensure, regulation, and monitoring of PA practice. Scaling of transformative change will occur when adoption and adaptation respect and influence the cultures of the different settings in which care is delivered. This observation can be easily identified in the creation, evolution, and scaling of the PA profession since its inception nearly fifty years ago in the United States. Clinical postgraduate PA training represents a voluntary permutation of advanced training in the clinical setting that is limited to a very small percentage of the overall PA population. These disciplined, educational innovations have often evolved to meet regional and unique workforce development needs and opportunities. Task Force recommendations should respect the autonomy and unique needs of the different healthcare settings and training programs, including facets related to employers, specialty, state/region, stage of development of the learner, or regional maldistribution or shortage of physicians or other healthcare practitioners.

Methods, Findings and Recommendations

Data Collection and Stakeholder Engagement

During the period of review, deliberation and formulation of recommendations by the task force from November 2015 through February 2016, data and feedback were collected by stakeholder engagement and through systematic review of the relevant published literature. The task force reports that data gathering and engagement of stakeholders was not meant to be all inclusive or represent a census activity; rather, this data collection paired with analysis of systematic review served to better inform discussions of the task force which subsequently led to formulation of expert opinion recommendations. Stakeholders engaged included practicing and retired PAs (including those with clinical administrative roles), current or recent participants in a clinical postgraduate PA training program, PA educators, PA students, patients and families cared for by PAs, physicians and physician executives across multiple primary care and specialty areas (primarily from academic health centers or teaching hospitals), and hiring

managers within large healthcare employers. Feedback was gathered from leaders within the AAPA and PAEA. Feedback was gathered from the chair of a committee convened by the Accreditation Review Commission on Education for the Physician Assistant to reevaluate accreditation for postgraduate PA training programs. Systematic review identified approximately thirty disseminated works on postgraduate training that were critically appraised, summarized, discussed, and prepared for submission to a peer reviewed clinical journal. Finally, the task force presented its preliminary findings and recommendations during a panel session held for attendees of the AAPA Leadership and Advocacy Summit held in Arlington, Virginia in early February 2016. Participants of this summit also had the opportunity to provide feedback and pose questions which were taken back to the task force for discussion.

Highlights of Findings from Data Collection and Stakeholder Engagement

- Clinical postgraduate PA training programs prepare only a small number of PAs each year, compared to the number of students graduated from PA programs annually.
- There were 58 clinical postgraduate PA training programs identified in the United States, and most lasted 12 months with a range of 12 to 18 months.
- Clinical specialties represented by programs identified included acute care medicine, cardiology, cardiothoracic surgery, critical care and trauma, emergency medicine, family medicine, general surgery, hematology and oncology, internal medicine and hospital medicine, neonatology, obstetrics and gynecology, orthopedic surgery, otolaryngology, pediatrics, psychiatry, urgent care, and urology.
- Despite a previously existing voluntary accreditation process administered by the ARC-PA, the task force was unable to gather summary data through requests or identify comparable, readily accessible data across publicly accessible platforms on program effectiveness, trainee demographics, or longitudinal outcome data.
- There were eight programs from the 58 identified that reported having accreditation at one point through the voluntary model previously operated by the ARC-PA and subsequently placed in abeyance.
- Clinical postgraduate PA training does not appear to result in increased salary compensation (compared to PAs without this voluntary training), but evidence suggests completion of such a program favorably improved hiring process and improved the confidence levels of PAs completing the training.

- PA professional organizations generally support clinical postgraduate PA training as an optional activity for structured advanced training in the clinical setting for PAs who have an interest in pursuing such training at any stage in their careers.
- The vast majority of PAs who completed a clinical postgraduate PA training program, based a single national survey study, would recommend postgraduate PA training to others.
- Numerous individuals from various stakeholder groups felt varying vernacular for describing these types of programs (e.g. postgraduate training program, residency, fellowship, etc.) was both confusing and problematic.
- Themes gathered from feedback from a sample of physician executives overseeing clinical operations (e.g. clinical chairs, section chiefs, service line directors primarily in academic medical centers in different parts of the United States within the following specialties: dermatology, emergency medicine, family medicine, hospital medicine, internal medicine with and without intensive care, oncology, otolaryngology with head and neck surgery, and surgery) included these:
  - Experience gained through a clinical postgraduate PA training program was valued by physician leaders in some but not all specialties
  - Physicians in some specialty areas preferred to orient and train their own PAs because of the highly variable care models used within their teams (e.g. dermatology, intensive care, emergency medicine with trauma)
  - Several physician leaders commented on clinical postgraduate PA training was unnecessary and unlikely to impact a large segment of PA practice because of high market demand for PAs and satisfaction with employers of new graduates
  - Physician leaders identified key skills or behaviors that were ideal or observed favorably in PAs hired that had completed clinical postgraduate PA training: better understanding of systems based practice, experience with clinical research and administrative skills, greater appreciation for interprofessional practice and multidisciplinary care, greater assimilation into the institution's overall culture, improved leadership competencies, better understanding of the care continuum (e.g. across settings and points of care transition) and importance of continuity of care

- The vast majority of physician leaders did not believe clinical postgraduate PA training programs would create practice barriers for those not trained in postgraduate programs (e.g. recruitment issues, credentialing or licensure barriers, employer mandates, expectations from physician specialty organizations)
- A small number of physician leaders described potential advantages for employment opportunities in some specialties for PAs who complete clinical postgraduate training programs (versus those who do not) if ongoing growth in the number of entry-level PA programs continues and pushes supply over demand
- Factors described by physician leaders related to factors favorably impacting hiring practices did not include completion of a clinical postgraduate PA program (e.g. most common factors described were high level of motivation, strong desire to excel, willingness to learn, ability to receive and proactively gather feedback, flexibility, interest in pursuing scholarly or administrative opportunities, and professional experience prior to entry-level PA training)
- The vast majority of physician leaders reported that a national process for recognizing / certifying / accrediting clinical postgraduate PA training programs was very important

Systematic review for published / disseminated literature relevant to clinical postgraduate PA training produced a small yield, considering the length of time such programs have existed, and key findings include the following. The term limited study here acknowledges publications that have limited generalizability, such as being conducted at a single site, evaluating small sample sizes, or study designs that are not intended to demonstrate cause and effect.

- Trainees perceive improvements in their abilities to establish a diagnosis, to recognize disease, to think critically, and generate a differential diagnosis
- Some programs appear to help trainees develop teaching skills, promote professionalism, increase pool of available and qualified PA faculty and overcome barriers to retention
- Limited study in critical care demonstrates clinical postgraduate PA (and APRN) training positively impacted patient care and enhanced the training of other healthcare professionals in critical and intensive care settings

- Limited study in emergency medicine demonstrated that the vast majority program faculty surveyed felt PA students had sufficient training from entry level PA education for emergency medicine practice and more than half did not see a need for clinical postgraduate PA training
- Limited study reported improved recruitment and retention of PAs in rheumatology through a specialty postgraduate PA training program
- Several studies did not reveal salary differences for PAs who had completed clinical postgraduate training compared those who had not
- Limited study revealed most PA students are aware of opportunities for clinical postgraduate training but few chose to complete such training

Feedback from informal interviews and small focus groups with stakeholders revealed the following themes. Please note some feedback may be representative of only a small number of individuals or may represent perspective of a single participant. In the cases of student and patient interviews, convenience samples available to task force members were utilized. Closed online discussion groups were also leveraged to solicit feedback and facilitate discussion.

- Professional organization leaders and most PAs felt clinical postgraduate PA training should remain voluntary and available only to those PAs who want to pursue it
- Employers and hiring managers saw greater confidence as a key benefit of clinical postgraduate PA training
- Interest among clinical year PA students in postgraduate training varied widely across three sites examined (e.g. one in Southeast, one in Northeast, one in Midwest) from 5% in one class, to 20% in one class to 50% in one class
- Many students were unsure what completing clinical postgraduate PA training would mean for their careers in the long-term
- Hiring managers and some postgraduate program directors felt a well-designed, structured clinical onboarding process can be equally effective as a formal postgraduate training program in terms of bringing newly hired PAs to practice readiness and efficiency
- Most postgraduate PA program directors felt the former accreditation process was cumbersome and disconnected from important elements of workplace based training

- The pursuit of accreditation among programs that had sought accreditation was most often reported as a requirement for institutional support
- Among postgraduate PA program directors interviewed that had not sought accreditation, the most common reasons for not applying for accreditation included: the process was too onerous, accreditation was not important to the institution, and/or there was insufficient staff effort to carry out required elements of the application process
- None of the patients interviewed in focus groups had any knowledge if their provider was trained in a postgraduate PA training program; general consensus of patients was that if the provider was compassionate and addressed their needs, it was unimportant
- Many PA hiring managers conveyed concern about any steps that increased specialization requirements for practice entry; some who oversaw blended workforces of PAs and APRNs cited difficulties in meeting patient needs or inability for some APRN providers to see certain types of patients that were common in the service lines they were assigned or ask to periodically cover
- Most PA hiring managers said the supply of graduates from clinical postgraduate PA training programs was so small, it would never meet workforce needs; many said a year of experience was viewed equivocally as completion of a clinical postgraduate PA training program
- Many PA hiring managers cited a lack of evidence documenting any measureable benefits of postgraduate training that they could take to their executive leaders to justify changes in hiring practices (e.g. medical error rates, efficiency, patient engagement, clinical quality, or unnecessary costs related to practice patterns or utilization)
- A small sample of PA hiring managers representing large employers (e.g. > 250 PAs in a single organization or health system) preferred hiring new or inexperienced PAs because they felt they were easy to assimilate into their institution's culture or practice standards
- Several hiring managers and PAs reported concern over online only programs available to APRNs that were described as clinical fellowships or residencies, citing the main value of postgraduate programs comes from experiential elements

- Several hiring managers who were also involved with pharmacist workforce hiring (all in teaching hospitals) stated that pharmacists without a pharmacy practice residency (and/or specialty residency) were not or were rarely considered for employment opportunities within their institutions
- The vast majority of PA and physician stakeholders as well as leaders involved with the Association of Postgraduate PA Programs described the need for and importance of a national model for evaluating and recognizing these programs. Representatives from the Department of Veterans Affairs even cited concerns about the availability of ongoing funding for such programs (or continuation of pilot project funding) without such recognition. The Task Force endorses a national model for evaluating, supporting ongoing quality improvement, and monitoring outcome measures from clinical postgraduate PA programs.

The Task Force summarizes what we view as key elements and considerations for an optimal national model:

- The process should be PA-led and involve individuals with extensive and current experience in clinical practice
- The current standards used for evaluation of entry level PA programs are viewed as largely inappropriate for adaptation for assessment and recognition of postgraduate training, over more contemporary models applicable to workplace based training and assessment, professional identity formation and entrustability
- Accreditation through a single, national process is recommended with attention to high quality data collection, analysis and reporting
- Standards should ensure the trainee is positioned for active learning, an appropriate blend of didactic and experiential curricular activities, healthy duty-hours, and reasonable compensation and benefits
- Standards should ensure programs include PA faculty or directors, and standards should ensure sufficient administrative effort is protected to support effective program oversight
- Standards should require the collection and reporting of patient care and quality oriented outcomes of care for trainees
- The application process and requirements for assessment and reporting should be more efficient and streamlined than the previously existing model

- Standards should place greater emphasis on standardizing trainee protections, institutional resource requirements, data collection and reporting, and quality improvement requirements versus on curricular standardization

Summary

Clinical postgraduate PA training programs represent one of many innovations created by the PA profession to support continuing professional development and lifelong learning, foster interprofessional and collaborative care, advance workforce development and explore novel educational approaches to optimize healthcare delivery. Since 1971, clinical postgraduate PA training programs have provided a relatively small number of interested PAs with diverse opportunities to gain advanced clinical skills and experience in the workplace, building upon the generalist medical education offered to all PAs through entry-level PA education. Similar to the impetus of physician shortages that led to the birth of the PA profession, many of the early clinical postgraduate PA training programs arose to address provider shortages that resulted from duty-hour restrictions of medical residents. Advanced training in the clinical setting is a core facet of the professional identity formation and continuing medical education for every PA throughout his or her career. Advanced training in the clinical setting, a generalist foundation for entry-level PA education, and generalist model for certification together position the PA profession as one of the most flexible and adaptable professions in modern healthcare. This flexibility and capacity to adopt and adapt to dynamic changes in healthcare delivery make PAs invaluable assets within the U.S. healthcare workforce to improve access and improve the quality of patient-centered care for patients, families, and communities. The development of an efficient, PA-led, national model for accreditation, continuous quality improvement, and reporting on outcomes is needed. Greater investment in research infrastructures is needed to support knowledge generation, dissemination of best practices, and optimization of these voluntary, workplace-based educational innovations for PAs.

2016-D-05 – Adopted

Amend policy HP-3200.2.2 as follows:

AAPA reviews and approves for Category 1 CME credit educational activities which serve to develop, maintain, or increase the knowledge, skills and professional

performance of a PA. These may include live presentations, enduring material programs, and other educational activities. AAPA stipulates that the following activities meet the requirements for Category 1 CME credit for PAs:

- those approved for Category 1 credit by the American Medical Association (AMA) (i.e. activities sponsored by providers accredited by the Accreditation Council for Continuing Medical Education (ACCME))
- those approved for Category 1-A credit by the American Osteopathic Association (AOA)
- those approved for prescribed credit by the American Academy of Family Physicians (AAFP)
- accredited programs of the Royal College of Physicians and Surgeons of Canada (RCPSC), the College of Family Physicians of Canada (CFPC), or the Physician Assistant Certification Council of Canada (PACCC)
- THOSE APPROVED FOR CREDIT BY THE EUROPEAN UNION OF MEDICAL SPECIALISTS/EUROPEAN ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION (UMES/EACCME)

2016-D-06 – Adopted as Amended

~~The Student Academy recommends that AAPA creates and supports a joint task force with PAEA to undertake research, identify policy solutions, and develop practical approaches to increase the availability and accessibility of clinical rotations for PA students.~~

THE STUDENT ACADEMY RECOMMENDS THAT AAPA CREATE AND SUPPORT A JOINT TASK FORCE WITH PAEA TO INVESTIGATE FACTORS THAT AFFECT PRACTICING PAS' ABILITY TO SERVE AS PRECEPTORS FOR PA STUDENTS, IDENTIFY OPPORTUNITIES TO IMPROVE POLICY TO SUPPORT PRECEPTORSHIP, AND COLLABORATE WITH PAEA EFFORTS TO DEVELOP INNOVATIVE AND PRACTICAL LONG-TERM APPROACHES TO INCREASE THE AVAILABILITY AND ACCESSIBILITY OF SUSTAINABLE CLINICAL EDUCATION MODELS FOR PA STUDENTS.

2016-D-07 – Referred** (to be referred by the Speaker to the appropriate body and reported back to the 2017 HOD)

Adopt the position paper entitled "Barriers to PA Student Clinical Rotations".

Barriers to PA Student Clinical Rotations

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.

This position paper is intended to shed light on the effect that the current lack of clinical rotation sites and preceptors, the competition for positions within those limited

sites, and barriers to interstate rotations, are having on PA students and their opportunities to train at the top of their ability. PAs are uniquely positioned to lead in the new healthcare environment of team-based care. In order to keep pace with the rapidly expanding demand for more medical providers, PA students must be provided every opportunity to successfully complete their education and training, especially as more PA programs come on line and existing programs attempt to expand their cohorts.

- The AAPA believes that patients will be best served if current and future PA students have access to the highest caliber clinical rotations possible.
- The AAPA believes that PA programs and clinically practicing PAs should work together in order to:
    1. Mitigate the effect that PA inter-program competition for clinical rotation sites has on PA students; and
    2. Increase the number of hospital and office rotation sites available to PA students and ensure a diversity of rotation sites.
    3. Decrease the barriers for PAs to participate in clinical rotations in states other than where their PA program is located.

Introduction

PA programs, like allopathic and osteopathic medical schools and nurse practitioner (NP) programs, are faced with a shortage of preceptors and clinical rotation opportunities. With the rapid growth of the PA profession and the creation of new PA programs in 46 out of 50 states, the longstanding problem of rotation shortages has become even more challenging. For several years, the PA Education Association (PAEA) has attempted to address this issue by developing innovative clinical training opportunities and encouraging an atmosphere of collaboration rather than competition among PA programs. The AAPA is uniquely positioned to work with PAs and PA employers to expand the availability of preceptors and clinical rotation sites for PA students.

A Problem for PA Students, PA Programs, and the PA Profession

Quality clinical education is an important aspect of PA educational curriculum. Many required clinical rotations are in primary care settings, including family practice, pediatrics, and women's health. This is in line with the 'primary care' or 'generalist' nature of PA training and the historical foundation of the PA profession. Although the

clinical rotation site shortage is not a new challenge, only recently has the phenomenon been studied in a systematic manner, with the Joint Report of the 2013 Multi-Discipline Clerkship/Clinical Training Site Survey confirming what clinical coordinators and PA students already recognized.

The Joint Report suggests that finding rotations particularly in primary care settings is a significant issue for most PA programs. According to the report, 95 percent of PA program respondents are concerned about the number of clinical sites available, and 91 percent of PA program respondents are concerned about the availability of qualified primary care preceptors (1). Research conducted by Herrick et al. and published in the November 2015 issue of JAAPA confirmed these findings (2). The Joint Report suggests that obstetrics/gynecology and pediatrics are two of the most difficult rotations for which to find student placement (1). According to the 2013 AAPA National Survey, only 2 percent of PAs currently work in obstetrics/gynecology, and 2 percent work in pediatrics (3). The scarcity of PAs working in those specialty areas is likely both a cause and effect of the lack of clinical rotations in those areas.

The availability of preceptors and clinical rotations is not a new problem in PA education. It was first formally addressed by clinical coordinators at the 1998 Association of Physician Assistant Programs (APAP, now PAEA) Education Forum. Since that time, the Physician Assistant Education Association (PAEA) has prioritized the issue, making the development of 'a broad range of innovative clinical training opportunities' part of its strategic plan and encouraging an environment of collaboration rather than competition among PA programs (4). The continued effort of the PAEA in addressing preceptor shortage is crucial to improving the clinical education environment in the coming years. However, due to the extent of the problem and the continued growth of the PA profession the issue will be best handled if approached by the entire PA community. As the national membership organization for both PAs and PA students, with a strong advocacy program and growing relationships with PA employers, AAPA is uniquely positioned to aid in the address of this issue.

As the PA profession continues to grow rapidly, with new programs developing and the number of PA students increasing, the demand for preceptors and clinical rotation sites will only increase in the coming years. From 2015 to 2016 alone, the number of accredited PA programs grew from 199 to 226 (5, 6). In addition to an increasing

number of PA students seeking clinical rotations each year, there continues to be growth in the number of allopathic and osteopathic medical students, as well as nurse practitioner students, competing for many of the same rotations and preceptors. With the increase in PA students, the number of PAs is projected to increase 38.4% from 2012 to 2022 (7). Similarly, according to Merritt Hawkins, the demand for PAs was estimated to increase more than 300 percent between 2011 and 2014 (8). The continued growth of the PA profession depends on the growth of PA programs, and one of the essential rate-limiting factors in the growth of PA programs is clinical rotation barriers. If this issue is not addressed, the growth of the PA profession will slow and the PA profession will be less equipped to meet the sharp increase in health care demand.

Barriers to PA Clinical Rotations

According to Herrick et al., competition and shortage of preceptors are the two most commonly cited barriers to student placement, with the shortage of preceptors being due in part to a perceived reduction of productivity and/or revenue while training students (2). Preceptors are likely to weigh the perceived rewards of practice-based teaching against the perceived costs and challenges in deciding whether to accept a student placement and how to teach. Reduced productivity and increased time pressures remain key perceived negative impacts of teaching (2, 9). While many preceptors perceive patient care responsibilities to be too time consuming to allow them to be good teachers, studies have found a correlation between productivity and highly-rated teachers, with positive impacts including enhanced enjoyment of practice and keeping one's knowledge up-to-date (10, 11).

There has been a steady increase in the number of allopathic and osteopathic medical, NP and PA students over the past several decades which have not been matched by a corresponding increase in number of preceptors and clinical rotation sites. As a result, the clinical training sites that are available are overwhelmed with student applicants. The insufficient number of clinical training sites for PA students is exacerbated by inter-professional competition for such sites. According to the Association of American Medical Colleges (AAMC) there are currently 86,746 medical students enrolled in United States osteopathic and allopathic medical programs in the 2015-2016 school year (12). There has been a steady increase in medical student enrollment for the past decade. Since 2006-2007 there has been a 16 percent increase in the total number of matriculated

medical students in the last decade (12). Additionally, there were an estimated 17,000 new Nurse Practitioners (NPs) completing their academic programs in 2013-2014 (13).

The growth rate of PA schools and matriculated students has also boomed over the past decade. According to the PAEA there are currently 157 programs with continuing or probationary accreditation, 42 new programs with provisional accreditation, and 27 developing programs that are not yet accredited for a total of 226 programs nationwide at varying levels of accreditation (6). This is up from 134 programs in November 2005 (14). Cohort sizes in PA programs range from approximately 15 to 100 students. Many smaller programs would increase their class sizes, but they are limited by the availability of clinical preceptors and rotation sites. Many programs have even had to decrease their cohort sizes due to insufficient clinical sites. With an estimated growth to 273 programs by 2020, the consistent increase in students has the potential to further worsen the preceptor and clinical rotation site shortage (15).

Furthermore, there are legislative barriers to clinical rotations, particularly those between states. One example encompasses the recent development of State Authorization Reciprocity Agreements between states and institutions. This arrangement, which requires states and institutions to pay an annual fee in order to participate in accreditation, has inadvertently led to several PA programs having to curtail or eliminate out-of-state rotations. In response to this arrangement, several health professions education associations sent an April 2015 letter to Congress recommending a nationwide exemption for clinical rotations from future Department of Education regulations pertaining to state authorization (16). Unfortunately, of the seven associations listed, the PAEA was not listed, and for the organizations listed, the dilemma with state authorization's effect on clinical rotation sites continues.

<u>The Unique Position of the AAPA in Working Toward a Solution</u>

AAPA is the only national organization that represents PAs and which PAs voluntarily join. With more than 37,000 Fellow members (all licensed PAs), AAPA is uniquely positioned to communicate with PAs about the need for and value of precepting PA students. In addition, AAPA has the opportunity to offer PAs incentives to serve as preceptors. Already, AAPA has created a "Preceptor of the Year" award to encourage PAs to precept students. While the possibility of this award clearly signals the value of acting as a preceptor, the fact that only one individual will be recognized each year may

limit its incentive effects. Additionally, AAPA encourages PAs to help educate the next generation of PAs through its Clinical Preceptor Recognition Program, awarding the CPAAPA designation.

Currently, there are only 108 active AAPA members who have been recognized as Clinical Preceptors. AAPA also offers Category 1 CME accreditation for Preceptors through PA programs. However, there are a number of other potential incentives that AAPA could consider, including access to exclusive material, public recognition programs for all who precept, and/or discounts on AAPA products, services or membership. Many programs provide funding and incentive pay to take students from their programs. The Joint Report notes that the compensation per student per rotation for the programs that provide financial incentives is $125 per student (1). AAPA providing a discount on AAPA products, services, or membership might help to incentivize preceptors and hospitals to take students from programs who are unable to pay for student rotations due to budgetary restraints. As well, the CME offering could be promoted more visibly among PAs, and AAPA may want to consider increasing the amount of CME credit given for such participation.

AAPA's new Center for Leadership and Management (CHLM) also presents some unique opportunities for AAPA to encourage employers to add clinical rotation opportunities for PAs. Clinical rotations offer employers an opportunity to see first-hand how well a PA candidate fits into their culture, how adept they are in communicating with patients and colleagues, and how quickly they learn new skills. Many employers who now offer clinical rotations to PAs say that they often hire from these cohorts of trainees, in part because they have already been trained to the standards of that particular hospital or organization. In addition to these advantages, AAPA could consider offering discounted services and/or recognition awards to employers who provide clinical rotation opportunities to PAs.

Finally, AAPA and its constituent organizations have the most robust advocacy programs on behalf of PAs, at both the federal and state level. Since it is in the interest of state governments and the federal government to ensure that there are adequate numbers of qualified clinical providers to meet the healthcare needs of the nation, AAPA should consider advocating for financial and other incentives for individual medical providers to precept PA students, as well as financial and other incentives for employers to provide

such opportunities. The AAPA should also help to ensure that the PA profession is represented in any further discussion at the federal and state levels regarding state authorization agreements.

Conclusion

The AAPA believes that clinically practicing PAs should precept PA students in order to enrich their clinical education experience and ensure the graduation of competent health care providers. The AAPA should provide incentives to clinically practicing PAs who are AAPA members to precept PA students. The AAPA should work with PA employers, including hospitals, HMO's, and clinics, to expand the number of opportunities for PA students to gain clinical experience through rotational assignments. The AAPA should work with other PA organizations such as the PAEA to find creative solutions to the chronic problem of clinical rotation shortages and undertake a campaign urging PAs to precept PA students and to work with employers to expand clinical rotation opportunities for PA students. With these steps, the chronic issue of preceptor and clinical rotation shortages within the PA profession can begin to be addressed.

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2016-D-08 – Adopted on Consent Agenda

Amend by substitution policies HX-4200.4.1, HX-4200.4.2, HX-4200.4.3, HX-4200.4.4, HX-4200.4.5, HX-4200.4.6.1, HX-4200.4.6.2, HX-4200.4.6.3, and HX-4200.4.7 with position paper entitled "Nicotine Dependence" as follows:

~~HX-4200.4.1~~
~~AAPA shall support the position of the Surgeon General and encourage PAs to increase patient awareness as to the dangers in the use of tobacco products. All PAs should strive to eliminate the use of tobacco products from their personal lives and the lives of their colleagues and patients.~~

~~HX-4200.4.2~~
~~AAPA recognizes the public health hazards of tobacco as a leading cause of preventable disease and encourages efforts to eliminate tobacco use in this country and around the world.~~

~~HX-4200.4.3~~

~~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.~~

~~HX-4200.4.4~~
~~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 tobacco settlement funds are used for the prevention and treatment of tobacco use.~~

~~HX-4200.4.5~~
~~AAPA encourages all PAs to be actively involved in community outreach that is 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.~~

~~HX-4200.4.6.1~~
~~AAPA supports (a) development and promotion of smoking cessation materials and programs to advance consumer health-awareness among all segments of society, but especially for youth; (b) dissemination of evidence-based clinical practice guidelines concerning the treatment of patients with nicotine dependence; (c) effective use of both smoking cessation materials and evidence-based clinical practice guidelines by PAs, for the treatment of patients with nicotine dependence.~~

~~HX-4200.4.6.2~~
~~AAPA encourages PAs to model smoking cessation activities in their practices, including (a) quitting smoking and assisting their colleagues to quit; (b) inquiring of all patients at every visit about their use of tobacco in any form; (c) at every visit, counseling those who smoke to quit smoking and eliminate the use of tobacco in all forms; (d) working to prohibit all smoking in the office by patients, clinicians, and office staff; and discouraging smoking in hospitals where they work; (e) providing smoking cessation pamphlets in the waiting room; (f) becoming aware of smoking cessation programs in the community and of their success rates and, where possible, referring patients to those programs.~~

~~HX-4200.4.6.3~~
~~AAPA supports national, state, and local efforts to help PAs and PA students develop skills necessary to counsel patients to quit smoking identify gaps, including (a) identifying gaps, if any, in existing materials and programs designed to train PAs and PA students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (b) supports the production of materials and programs that would fill gaps, if any, in materials and programs to train PAs and PA students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (c) encourages constituent organizations to sponsor, support, and promote efforts that will help PAs to more effectively counsel patients to stop smoking; and (d) encourages PAs to participate in education programs to enhance their ability to help patients quit smoking.~~

~~HX-4200.4.7~~

~~The AAPA supports third-party coverage for the treatment of nicotine addiction and the management of behavioral dependence associated with tobacco use.~~

Nicotine Dependence

Executive Summary of Policy Contained in this Paper

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

- AAPA shall support the position of the Surgeon General and the U.S Preventive Service Task Force and encourage PAs to increase patient awareness as to the dangers in the use of nicotine products.

- AAPA recognizes the public health hazards of nicotine products as a leading cause of preventable disease and encourages efforts to eliminate nicotine use in this country and around the world.

- AAPA encourages PAs to work to support legislation which will eliminate the public's exposure to secondhand smoke, eliminate minors' access to nicotine products including electronic nicotine delivery systems and prohibit advertising of nicotine products.

- AAPA supports state utilization of tobacco settlement money for prevention and treatment of nicotine use. The Academy urges its constituent organizations to work with state governments and other health care and advocacy organizations to assure tobacco settlement funds are used for the prevention and treatment of nicotine use.

- AAPA encourages all PAs to be actively involved in community outreach that is directed toward providing nicotine product education based upon current evidence based guidelines to people of all ages about the dangers of nicotine with the goal of eliminating nicotine use.

- AAPA supports (a) development and promotion of nicotine cessation materials and programs to advance consumer health-awareness among all segments of

society, but especially for youth; (b) dissemination of evidence-based clinical practice guidelines concerning the treatment of patients with nicotine dependence; (c) effective use of both nicotine cessation materials and evidence-based clinical practice guidelines by PAs, for the treatment of patients with nicotine dependence.

- AAPA encourages PAs to model nicotine cessation activities in their practices, including (a) quitting nicotine products and assisting their colleagues to quit; (b) inquiring of all patients at every visit about their use of nicotine in any form; (c) at every visit, counseling those who smoke to quit smoking and-eliminate use of nicotine to eliminate use in all forms; (d) working to prohibit the use of nicotine products by all individuals in healthcare settings; (e) providing nicotine information; (f) becoming aware of nicotine cessation programs in the community and of their success rates and, where possible, referring patients to those programs.

- AAPA supports national, state, and local efforts to help PAs and PA students develop skills necessary to counsel patients to quit nicotine products , including (a) identifying gaps, if any, in existing materials and programs designed to train PAs and PA students in the behavior modification skills necessary to successfully counsel patients to stop using nicotine products; (b) supports the production of materials and programs that would fill gaps, if any, in materials and programs to train PAs and PA students in the behavior modification skills necessary to successfully counsel patients to stop using nicotine products; (c) encourages constituent organizations to sponsor, support, and promote efforts that will help PAs to more effectively counsel patients to quit using nicotine products; and (d) encourages PAs to participate in education programs to enhance their ability to help patients quit nicotine products.

- AAPA supports third-party coverage for the treatment of nicotine addiction and the management of behavioral dependence associated with nicotine use.

- AAPA supports regulation of electronic nicotine delivery systems (E-cigarettes) by the U.S. Food and Drug Administration (FDA) Center for Tobacco Products.

Introduction

In 1964, the Surgeon General's report on the health impact of smoking was released. Tobacco use has been described as "the single most important preventable risk to human health in developed countries and an important cause of premature death worldwide." [1] Between 1964 and 2014, 20 million persons in the United States died from complications related to tobacco use; approximately 10% of those were individuals who did not smoke, but rather were exposed to secondhand smoke. [2] The impact of tobacco smoke exposure is not limited to adults. Approximately 100,000 infant deaths can be attributed to exposure to tobacco smoke and the resulting low birth weight, premature birth, and sudden infant death syndrome (SIDS). [2]

Tobacco Exposure and Nicotine Use

Not only are cigarettes manufactured to increase the addictive properties, but combustion produces thousands of toxic chemicals which lead to disease and early death. [2] After half a century of research on tobacco use, new research continues to emerge demonstrating the detrimental effects of smoking. Adverse effects of tobacco smoke have been documented in all organ systems of the body. In the 2014 report from the U.S. Surgeon General the following new research findings are provided: 1) liver cancer and colorectal cancer are caused by smoking; 2) secondhand smoke exposure is a cause of cerebral vascular accident; 3) smoking increases the risk of death among cancer survivors; 4) smoking causes diabetes mellitus; and 5) smoking impairs immune function and causes rheumatoid arthritis. [2] As a result, productivity suffers from tobacco use. From 2009-2012 economic costs were estimated at over $289 billion. Losses from early death between 2005 and 2009 totaled roughly $150 billion [2]

The negative impact of tobacco smoke is not limited to the person who smokes. The U.S. Surgeon General reported no safe level of exposure to secondhand smoke. [2] Secondhand has been identified as a cause of cerebrovascular accident, ENT disease, coronary heart disease, sudden infant death syndrome, and low-birth weight [2]. The economic impact of secondhand smoke exposure in 2006 was estimated at $5.6 billion in lost productivity.

Although use of chewing tobacco has declined since the 1980s, use of snuff has increased [2]. In 2006, tobacco companies began selling snuff under cigarette brand names and produced advertisements indicating these products may be a "socially acceptable" alternative to cigarette use [2]. Use of smokeless tobacco products including chewing tobacco, snuff, and dissolvable tobacco products carry their own set of harmful consequences. Similar to tobacco cigarettes, smokeless tobacco products are highly addictive. Young adults who use smokeless tobacco are more likely to become traditional cigarette smokers [3]. Periodontal disease, tooth loss, leukoplakia, and increased risk of heart diseases have been identified as consequences of smokeless tobacco use. Smokeless tobacco use has been identified as a cause of oropharyngeal, esophageal, and pancreatic cancers [3]. Women who use smokeless tobacco during pregnancy are at increased risk for stillbirth, perinatal death, and can impact the brain development of the fetus [2].

The rise in popularity of "e-cigarettes" and other electronic nicotine delivery devices particularly among adolescents, is concerning. Public perception of e-cigarette safety seems to be favorable to tobacco cigarettes despite a lack of evidence [4]. The American Lung Association identified 500 brands and over 7,000 flavors of e-cigarettes available to the public, none of which are regulated by the Food and Drug Administration (FDA) [5]. Without FDA oversight, it is unknown what chemicals are present in e-cigarettes. Data from the 2014 National Youth Tobacco Survey showed 13.4% of high school students reported past month e-cigarette use [6]. Use of e-cigarettes now exceeds the use of other tobacco products, including cigarettes. This is troubling given most adult cigarette smokers began using during adolescence. Although restrictions on tobacco advertising have been in place since the Master Settlement Agreement, similar restrictions do not exist for e-cigarettes. Data from the 2014 National Youth Tobacco Survey showed 68.9% of middle and high school students were exposed to advertisements for e-cigarettes [7]. Little is known about secondhand exposure to e-cigarette vapors. According to the American Lung Association, carcinogens have been identified in the vapor exhaled by e-cigarette users. To date, no evidence has found that secondhand inhalation of e-cigarette vapors are safe [8].

Nicotine Cessation

Overall, tobacco smoking rates have declined since the first Surgeon General's report in 1964 however, racial, ethnic, and socioeconomic disparities persist. Major gains including warning labels on tobacco product packaging, tobacco education, smoking bans, advertising restrictions, and increased pricing have contributed to lower levels of tobacco use and the available evidence supports the use of these techniques [2]. Most individuals who smoke report attempting to quit at some point in the past and have often attempted to quit multiple times, however, providers often do not address smoking cessation during office visits. [1] Often smoking cessation requires repeated interventions however, effective treatments including prescription medication and nicotine replacement products are available and should be made available to individuals who are ready to quit. Smoking cessation improves health outcomes for the individual who smokes, those exposed to secondhand smoke, and is also cost effective. [1]

With a rise in the use of nicotine replacement products and e-cigarettes, concern has been raised regarding whether or not nicotine has a carcinogenic effect. Although in vitro studies suggest nicotine may play a role in carcinogenesis, most animal studies do not demonstrate this. Use of smokeless tobacco products have been linked to several cancers however, to date, only one study has addressed this concern among individuals who use nicotine replacement products. The results of the study showed no association between use of nicotine replacement products and malignancy [2]. Many e-cigarette users begin using the devices as tool to help quit traditional cigarettes despite lack of research to support their use in smoking cessation programs. Polosa, Caponnetto, Morjaria, Papale, Campagna & Russo (2011) conducted a pilot study of e-cigarette use for smoking cessation among 40 tobacco cigarette smokers. The authors concluded that e-cigarette use decreased tobacco cigarette use with few side effects [9]. Bullen, McRobbie, Thornley, Glover, Lin, & Laugesen (2010) found similar results in their study the effects of e-cigarettes on desire to smoke [10] Although promising, it should be noted that the e-cigarettes used in these studies contained solutions with known concentrations of nicotine and other ingredients, unlike what is currently available to the public. The authors of both papers discuss the need for further research into long-term safety and use. Additionally, there is concern regarding advertising strategies that may be targeting younger individuals and that use of e-cigarettes may increase the risk of future tobacco use.

The Centers for Disease Control and Prevention (CDC) recommend states use a comprehensive approach to tobacco cessation including the following components: 1) community programs to reduce tobacco use; 2) chronic disease control programs to reduce the burden of tobacco-related diseases; 3) school programs; 4) enforcement; 5) statewide programs; 6) counter-marketing; 7) cessation programs; 8) surveillance and evaluation; and 9) administration and management [11]. CDC suggests including e-cigarettes in these comprehensive nicotine cessation programs and restricting e-cigarette advertisements [7]

Master Settlement Agreement

Advertising by tobacco manufacturers has been shown to initiate and perpetuate cigarette smoking among adolescents and young adults. Past legal action against tobacco manufacturers has contributed to reduce tobacco use in the U.S. [2]. In 1999, the District of Columbia, 46 U.S. states, and 6 U.S. territories sued the major tobacco companies. The resulting settlement is known as the Master Settlement Agreement (MSA). [12] Under the MSA, states received billions of dollars from the major tobacco companies with the intent that the funds would support tobacco education programs and the cost of treating tobacco-related illness. Unfortunately, the MSA did not specifically require states to use the funds on tobacco-related issues and years passed states reallocated MSA funds to other budget categories. As of 2006, fifteen states did not use any MSA funds for tobacco-related programs. [12] Overall, the MSA funds have not led to robust state programs for tobacco cessation. In fact, the authors of a 2014 research study concluded states receiving higher MSA payments were associated with less effective tobacco control mechanisms. [13] The same researchers found MSA funds were allocated to health programs, but not always those pertaining to tobacco cessation. In 2015, less than 2% of MSA funds and tobacco taxes were used by states for tobacco control programs [7].

These funds should be utilized to prevent nicotine dependence and assist those with cessation. PAs are encouraged to help guide the use of these funds to achieve this goal.

Conclusions

Myriad studies conclusively demonstrate the adverse health effects of nicotine use and dependence. Despite achievements in reducing the number of individuals who use tobacco products since the 1964 Surgeon General's report on the health effects of

smoking, more work is needed. An area of growing public health concern is the use of e-cigarettes, particularly among youth. Our knowledge with regard to e-cigarettes continues to evolve as more research is conducted. Given what is known, PAs have a responsibility to act at the individual, community, and structural levels to raise awareness and promote cessation of nicotine use.

- AAPA shall support the position of the Surgeon General and the U.S Preventive Service Task Force and encourage PAs to increase patient awareness as to the dangers in the use of nicotine products.

- AAPA recognizes the public health hazards of nicotine products as a leading cause of preventable disease and encourages efforts to eliminate tobacco use in this country and around the world.

- AAPA encourages PAs to work to support legislation which will eliminate the public's exposure to secondhand smoke, eliminate minors' access to nicotine products including electronic nicotine delivery systems and prohibit advertising of nicotine products.

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practice guidelines concerning the treatment of patients with nicotine dependence; (c) effective use of both nicotine cessation materials and evidence-based clinical practice guidelines by PAs, for the treatment of patients with nicotine dependence.

- AAPA encourages PAs to model nicotine cessation activities in their practices, including (a) quitting nicotine products and assisting their colleagues to quit; (b) inquiring of all patients at every visit about their use of nicotine in any form; (c) at every visit, counseling those who smoke to quit smoking and-eliminate use of nicotine to eliminate use in all forms; (d) working to prohibit the use of nicotine products by all individuals in healthcare settings; (e) providing nicotine information; (f) becoming aware of nicotine cessation programs in the community and of their success rates and, where possible, referring patients to those programs.

- AAPA supports national, state, and local efforts to help PAs and PA students develop skills necessary to counsel patients to quit nicotine products , including (a) identifying gaps, if any, in existing materials and programs designed to train PAs and PA students in the behavior modification skills necessary to successfully counsel patients to stop nicotine products; (b) supports the production of materials and programs that would fill gaps, if any, in materials and programs to train PAs and PA students in the behavior modification skills necessary to successfully counsel patients to stop using nicotine products; (c) encourages constituent organizations to sponsor, support, and promote efforts that will help PAs to more effectively counsel patients to quit using nicotine products; and (d) encourages PAs to participate in education programs to enhance their ability to help patients quit nicotine products.

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2016-D-09 – Adopted as Amended

Amend policy HP-3300.1.15 Immunization in Children and Adults as follows:

Immunizations in Children and Adults

(Adopted 1994, amended 2004, 2006, and 2011)

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 recognizes the importance of child and adult immunization programs and the need to educate individual PAs and the public about these programs. To that end, AAPA makes the following recommendations:

- PAs should be aware of current medical guidelines AND RECOMMENDATIONS for immunization of **INFANTS,** children, ADOLESCENTS, and adults. Providers also should be aware that patients in high-risk groups, such as the chronically ill, IMMUNOSUPPRESSED, asplenic, or elderly, may need to be on different immunization schedules ~~than~~ ~~**COMPARED TO**~~ **THAN** the general population.
- Individual PAs and their practices, in cooperation with public health agencies, should promote public information campaigns to increase awareness of the

importance of immunizations and allay fears ~~and~~ OR doubts about potential ~~side~~ ADVERSE effects.

- PAs should be immunized against vaccine-preventable diseases for which health providers are at high risk, INCLUDING ANNUAL INFLUENZA VACCINATION. This not only protects PAs, but also protects patients by preventing provider-to-patient transmission.
- PAs need to educate patients and their families about the safety of our national immunization program, dispel unsubstantiated fears ABOUT VACCINATION, and promote public confidence in vaccines for the continued protection of ~~our children~~ ALL against vaccine-preventable diseases.
- PA students should have all appropriate immunizations prior to their clinical experience.
- PAs working in primary care should develop systems within their practices to promote optimum immunization of their patients. These systems might include devices such as personal immunization records for patients to carry with them and a way to easily locate each patient's immunization record in his or her medical chart. High-risk patients should be identified and special programs implemented TO OPTIMIZE VACCINE COVERAGE, such as mailing a flu vaccine reminder to all high-risk patients every fall.
- PAs working in specialty practices in hospitals and offices should recognize patients who are at high risk for vaccine-preventable diseases. They should coordinate efforts with the patients' primary care providers to insure that these patients are adequately immunized and that the primary care providers have complete immunization records.
- PAs should support the development of and participate in state and local immunization registries. Effective immunization registries have demonstrated an ability to prevent fragmentation of care, incomplete immunizations, ~~or~~ AND unnecessary over-immunization of patients because of lack of communication between various providers and programs. An objective of Healthy People 2020 is to enroll 95% of children under the age of six in population-based immunization registries.[1]

- All private and public payers should provide coverage for RECOMMENDED child and adult immunizations **AS RECOMMENDED BY THE CDC**.

INTRODUCTION

The immunization of **INFANTS,** children, ADOLESCENTS, and adults against vaccine-preventable diseases is one of the most important medical advances of the 20th century and among the most valuable health care investments that can be made. In the 20th century, the development of effective vaccines has led to a 97% or greater reduction in reported cases of diphtheria, measles, mumps, pertussis, poliomyelitis, rubella, and tetanus in the United States.[2] ~~In an economic evaluation of the recommended 7-vaccine routine immunizations in childhood, it is estimated that a savings of $5 in direct costs and $11 dollars in societal costs including the cost of immunization are realized each year.[2]~~ RECENT ECONOMIC ANALYSES FOUND THAT ROUTINE VACCINATION OF CHILDREN BORN FROM 1994 TO 2013 WILL PREVENT ABOUT 322 MILLION CASES OF DISEASE AND OVER 700,000 EARLY DEATHS, FOR A SOCIETAL COST SAVINGS OF OVER 1.3 TRILLION DOLLARS.[3] Given their proven benefit in reducing morbidity, mortality and health care costs, AGE-APPROPRIATE immunization programs ~~for children and adults~~ should be part of the medical practice of all PAs.

Childhood Immunizations

Despite great successes at controlling once common childhood diseases, such as poliomyelitis, diphtheria, measles, mumps, rubella and tetanus; significant gaps remain in VACCINATION COVERAGE IN THE UNITED STATES. ~~the public health system. In the United States~~ THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES' Healthy People ~~2010~~ 2020 initiative ~~had~~ HAS set vaccination coverage goals of 90 percent for ~~each vaccine in the 4:3:1:3:3:1 series~~ UNIVERSALLY RECOMMENDED VACCINES AMONG YOUNG CHILDREN AGES 19 TO 35 MONTHS ~~and a goal of 80% for completion of the entire series (these goals remain for the 2020 initiative), which consists of~~ INCLUDING THOSE FOR DIPTHERIA TETANUS AND PERTUSSIS (DTAP), HAEMOPHILUS INFLUENZAE TYPE B (HIB), HEPATITIS A AND B, MEASLES MUMPS AND RUBELLA (MMR), POLIO, VARICELLA, PNEUMOCOCCAL CONJUGATE VACCINE, AND ROTAVIRUS. [1] RECENT

NATIONAL COVERAGE ESTIMATES SHOWED THAT HP-2020 TARGETS OF 90% WERE MET FOR POLIOVIRUS, MMR, HEPB, AND VARICELLA, BUT NOT DTAP, HIB, HEPB BIRTH DOSE, PCV, HEPA, ROTAVIRUS, AND THE COMBINED VACCINATION SERIES.[4]

~~• four or more doses of diphtheria, tetanus and pertussis, or DTaP, vaccine;~~

~~• three or more doses FOUR DOSES of *Haemophilus influenzae* type b, or Hib, vaccine;~~

~~• three or more doses of hepatitis B vaccine; and~~

~~• one or more doses of measles, mumps and rubella, or MMR, vaccine;~~

~~• three or more doses of polio vaccine;~~

~~• one or more doses of varicella vaccine;~~

~~In 2008, coverage for the entire series was 76.1%, which was down slightly from the 2007 coverage estimate of 77.4 %.~~

~~Disparity in~~ Vaccination rates remains lower among children living below the poverty level, in ~~non-Caucasian children~~ NON-HISPANIC BLACK CHILDREN, and those living in high-risk geographic areas, such as rural, underserved, and low socio-economic regions. These surveys continue to reveal immunization rates well below the national average and/or targeted goal rates.[4]

Gaps in the system of childhood immunizations are not new. Barriers to immunization that have been identified include: lack of knowledge about immunizations, fears about vaccine safety, logistical problems that limit access to immunization services, provider lack of knowledge regarding indications for and contraindications to immunization, fragmentation of patient care causing incomplete immunization records and missed opportunities.[5]

ADOLESCENT IMMUNIZATION PROGRAMS

VACCINATION OF ADOLESCENTS IS AN IMPORTANT AND EFFECTIVE WAY TO PROTECT PRETEENS, TEENS, THEIR FRIENDS AND FAMILY MEMBERS FROM VACCINE-PREVENTABLE DISEASES SUCH AS TETANUS, DIPHTHERIA, PERTUSSIS (TDAP), AND CANCERS CAUSED BY HUMAN PAPPILLOMAVIRUS (HPV). THE ADVISORY COMMITTEE ON IMMUNIZATION

PRACTICES (ACIP) AND THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) RECOMMEND THAT ADOLESCENTS ROUTINELY RECEIVE TETANUS TOXOID, REDUCED DIPHTHERIA TOXOID, AND ACELLULAR PERTUSSIS VACCINE (TDAP), MENINGOCOCCAL CONJUGATE VACCINE, AND HPV VACCINE. HEALTHY PEOPLE 2020 GOALS FOR 80% VACCINATION COVERAGE AMONG ADOLESCENTS AGED 13-15 WERE ACHIEVED OR NEARLY ACHIEVED IN RECENT YEARS FOR TDAP AND MENINGOCOCCAL CONJUGATE VACCINE, HOWEVER WERE LAGGING FOR COMPLETE COVERAGE FOR THE 3-DOSE HPV VACCINE AMONG FEMALES. [1,6] THIS DISPARITY IN VACCINATION COVERAGE INDICATES MANY MISSED OPPORTUNITIES TO ADMINISTER HPV VACCINATION IN ADDITION TO TDAP AND MENINGOCOCAL CONJUGATE VACCINE DURING THE SAME CLINICAL VISIT.

Adult Immunization Programs

Adult immunization programs do not receive the same priority as efforts to immunize children, despite the fact that most deaths from vaccine-preventable disease occur in adults. Between 50,000 and 90,000 adults die each year from VACCINE PREVENTABLE DISEASES SUCH AS pneumococcal infection, influenza and hepatitis B ~~combined~~.[7]

Despite availability and effectiveness of vaccines, current immunization rates fall below those recommended in Healthy People 2020. In addition to deaths from pneumococcal pneumonia, flu and hepatitis B; each year ~~a smaller number of~~ adult deaths occur ~~that are a continuum of the problem of~~ DUE TO inadequately immunized children. A majority of the US cases of tetanus and diphtheria today occur in adults who were inadequately immunized as children. Furthermore, the recent resurgence in measles, mumps and rubella, ~~although~~ seen primarily among unimmunized preschool children, also occurred in a significant number of young adults. Most vaccine failures in adults occurred among those who did not have a primary response to the MMR vaccine administered in childhood. Waning immunity does not seem to be an important factor. It is now strongly recommended that everyone born since 1956 receive a two-dose measles

immunization. Because mumps and rubella have shown similar, though less pronounced, epidemiologic patterns of reemergence, the vaccine of choice is MMR.[7]

~~Barriers to immunizations for adults are similar to the barriers for children. It should also be noted that adult immunization rates are lower than pediatric immunization rates for another very basic reason: adult immunizations are largely voluntary, while children (through their parents) are subject to public health imperatives requiring them to be immunized before they can enter school.~~

UNFORTUNATELY, ADULT VACCINATION COVERAGE ESTIMATES FOR THE FOUR VACCINES INCLUDED IN HEALTHY PEOPLE 2020 (INFLUENZA, PNEUMOCOCCAL, HERPES ZOSTER, AND AMONG HEALTHCARE PROVIDERS, HEPATITIS B) REMAIN BELOW TARGET LEVELS.[8] THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) RECOMMENDS VACCINATIONS FROM BIRTH THROUGH ADULTHOOD TO PROVIDE A LIFETIME OF IMMUNITY. BUT WHILE CHILDHOOD VACCINATION RATES ARE RELATIVELY HIGH, MOST ADULTS ARE NOT VACCINATED AS RECOMMENDED PER THE ADULT SCHEDULE. PAS ARE ENCOURAGED TO FOLLOW THE MOST UP-TO-DATE VACCINE SCHEDULE FROM CDC.[7]

IMPROVING VACCINATION RATES

The ~~Centers for Disease Control and Prevention (~~CDC~~)~~ recommends that institutions develop standing orders and reminder systems to help improve vaccination rates among adults. Overcoming the low immunization rates among adults will require better reimbursement and a sustained, cooperative effort in both the public and private sectors to educate providers, patients, and policymakers about indicated vaccine uses and the need for effective delivery.

More widespread immunization strategies include new methods of vaccine delivery (nasally administered sprays) and new combination vaccines. Nasal administration of the influenza vaccine would reduce the expense associated with intramuscular vaccination and would be more practical, especially amongst pediatric patients (over five years of age). The immunization action coalition (IAC)[9] continues to promote a national immunization registry as a national goal in Healthy People 2020, specifying that 95% of children from birth to age six should fully participate in an operational, population-based immunization registry.

Challenges

CHALLENGES TO IMMUNIZATIONS PROGRAMS FOR ADULTS ARE SIMILAR TO THOSE IN CHILDREN.[10] Challenges for assuring access and availability of vaccines include: 1) unprecedented vaccine delays, 2) diminished number of vaccine suppliers, 3) disparities in geographic and socioeconomic populations, and 4) erosion of insurance coverage for immunizations.

ADULT IMMUNIZATION RATES ARE LOWER THAN PEDIATRIC IMMUNIZATION RATES IN PART BECAUSE ADULT IMMUNIZATIONS ARE LARGELY VOLUNTARY, HAVE INCONSISTENT INSURANCE COVERAGE (OR OTHER FINANCIAL BARRIERS), WHILE CHILDREN ARE SUBJECT TO PUBLIC HEALTH POLICIES AND SCHOOL MANDATES REQUIRING IMMUNIZATIONS BEFORE SCHOOL ENTRY. BARRIERS FOR ADULT IMMUNIZATION INCLUDE:

- LACK OF HEALTHCARE PROVIDER FAMILIARITY WITH CURRENT VACCINE GUIDELINES;
- LACK OF AWARENESS AMONG BOTH PATIENTS AND PROVIDERS OF POTENTIAL RISKS INVOLVING VACCINE PREVENTABLE DISEASE;
- LACK OF RESOURCES TO MAINTAIN AN ADEQUATE SUPPLY OF VACCINE
- OR LACK OF INFRASTRUCTURE WITHIN HEALTHCARE SYSTEMS TO ACHIEVE HIGH IMMUNIZATION RATES IN ADULTS[10]

Influenza Vaccination of Health Care Personnel

Influenza transmission and outbreaks in health care facilities are well documented. Health care workers (HCW) acquire influenza from their patients or transmit the disease to patients, staff and their contacts. Because HCW provide care to patients at high risk for complications of influenza, HCW should be considered a high priority group when expanding influenza vaccine use. In 2010 the Infectious Disease Society of America (IDSA) supported universal immunization of health care workers against influenza by health care institutions through mandatory vaccination programs. It was felt that this was the most effective means to protect patients from the transmission of seasonal and pandemic influenza by health care workers.[11]

Vaccine Safety

PAs need to educate patients and their families about the safety of our national immunization program, dispel unsubstantiated fears ABOUT and promote public confidence in vaccines for the continued protection of ~~our~~ **INFANTS,** children, ADOLESCENTS, AND ADULTS against vaccine-preventable diseases.

Summary

The results of inadequate immunizations among **INFANTS,** children, ADOLESCENTS, and adults are unnecessary deaths, avoidable hospitalizations and the associated costs~~,~~ and life-long disabilities caused by the sequelae of potentially preventable diseases. ~~The fact remains that~~ S~~s~~afe, effective vaccines are available but underutilized, AND ~~Even~~ patients who routinely see health care providers ~~may~~ ARE not ~~be adequately~~ OFTEN educated about recommended immunizations~~, missing opportunities for receiving this type of protection~~. HEALTHCARE PROVIDERS SHOULD BE FAMILIAR WITH THE LATEST IMMUNIZATION SCHEDULE. THEY SHOULD MAKE CLEAR, EVIDENCE-BASED VACCINE RECOMMENDATIONS FOR ALL ELIGIBLE PATIENTS AND IMMUNIZE AT ALL OPPORTUNITIES INCLUDING WELL, SICK AND FOLLOW-UP VISITS.

Recommendations

AAPA recognizes the importance of child and adult immunization programs and the need to educate individual PAs and the public about these programs. To that end, AAPA makes the following recommendations:

- PAs should be aware of current medical guidelines AND RECOMMENDATIONS for immunization of **INFANTS,** children, ADOLESCENTS, and adults. Providers also should be aware that patients in high-risk groups, such as the chronically ill, IMMUNOSUPPRESSED, asplenic, or elderly, may need to be on different immunization schedules ~~than~~ ~~**COMPARED TO**~~ **THAN** the general population.
- Individual PAs and their practices, in cooperation with public health agencies, should promote public information campaigns to increase awareness of the

importance of immunizations and allay fears ~~and~~ OR doubts about potential ~~side~~ ADVERSE effects.

- PAs should be immunized against vaccine-preventable diseases for which health providers are at high risk, INCLUDING ANNUAL INFLUENZA VACCINATION. This not only protects PAs, but also protects patients by preventing provider-to-patient transmission.
- PAs need to educate patients and their families about the safety of our national immunization program, dispel unsubstantiated fears ABOUT VACCINATION, and promote public confidence in vaccines for the continued protection of ~~our children~~ ALL against vaccine-preventable diseases.
- PA students should have all appropriate immunizations prior to their clinical experience.
- PAs working in primary care should develop systems within their practices to promote optimum immunization of their patients. These systems might include devices such as personal immunization records for patients to carry with them and a way to easily locate each patient's immunization record in his or her medical chart. High-risk patients should be identified and special programs implemented TO OPTIMIZE VACCINE COVERAGE, such as mailing a flu vaccine reminder to all high-risk patients every fall.
- PAs working in specialty practices in hospitals and offices should recognize patients who are at high risk for vaccine-preventable diseases. They should coordinate efforts with the patients' primary care providers to insure that these patients are adequately immunized and that the primary care providers have complete immunization records.
- PAs should support the development of and participate in state and local immunization registries. Effective immunization registries have demonstrated an ability to prevent fragmentation of care, incomplete immunizations, ~~or~~ AND unnecessary over-immunization of patients because of lack of communication between various providers and programs. An objective of Healthy People 2020 is to enroll 95% of children under the age of six in population-based immunization registries.[1]

- All private and public payers should provide coverage for ~~RECOMMENDED~~ **INFANT,** child, ADOLESCENT and adult immunizations **AS RECOMMENDED BY THE CDC**.

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2016-D-10 – Adopted

Amend policy HP-3300.1.9.1 Health Literacy: Broadening Definitions, Intensifying Partnerships, and Identifying Resources as follows:

Health Literacy: Broadening Definitions, Intensifying Partnerships and Identifying Resources

(Adopted 2006 and amended 2011)

Executive Summary of Policies 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 the PA profession can participate in addressing the problems of health literacy by

- adopting expanded definitions of health literacy THAT INCLUDE THE INDIVIDUAL AND PUBLIC HEALTH PERSPECTIVES
- optimizing efforts to INCREASE HEALTH KNOWLEDGE, SELF EFFICACY, SELF MANAGEMENT BEHAVIORS, AND POSITIVE OUTCOMES ~~create information and communication partnerships~~ with patients
- participating in LOCAL COMMUNITY GROUPS TO PROVIDE SOCIAL SUPPORT AND ADVOCACY ~~strategic and multi-sector partnerships centered on assessing and addressing health literacy~~ LEADING TO SUSTAINABLE CHANGES BEHAVIOR CHANGES CONDUCIVE TO BETTER HEALTH
- identifying and utilizing resources TO INCREASE OPPORTUNITIES FOR PATIENT ACTIVATION, ACCESS TO CARE, AND DEVELOPMENT OF SKILLS TO INCREASE PHYSICAL AND MENTAL WELL BEING ~~such as the US Department of Health and Human Services' Universal Precautions Toolkit and Healthy People 2020 directives.~~

Call to Action

Recent efforts by AAPA and other organizations to focus on health literacy have resulted in a broadened health literacy definition, and increasing focus on the shared responsibility of providers and patients to create information and communication partnerships. Sophisticated and clinician-focused resources now exist to provide PAs and other clinicians with tools to improve patient health literacy. National efforts to form strategic organizational partnerships provide rich opportunity for AAPA to participate in efforts to address this problem impacting the health of millions of Americans.

Accordingly, AAPA believes that the PA profession can further address this critical social and medical problem by

- adopting expanded definitions of health literacy THAT INCLUDE THE INDIVIDUAL AND PUBLIC HEALTH PERSPECTIVES
- optimizing efforts to INCREASE HEALTH KNOWLEDGE, SELF EFFICACY, SELF MANAGEMENT BEHAVIORS, AND POSITIVE OUTCOMES ~~create information and communication partnerships~~ with patients

- participating in LOCAL COMMUNITY GROUPS TO PROVIDE SOCIAL SUPPORT AND ADVOCACY ~~strategic and multi-sector partnerships centered on assessing and addressing health literacy~~ LEADING TO SUSTAINABLE CHANGES BEHAVIOR CHANGES CONDUCIVE TO BETTER HEALTH
- identifying and utilizing resources TO INCREASE OPPORTUNITIES FOR PATIENT ACTIVATION, ACCESS TO CARE, AND DEVELOPMENT OF SKILLS TO INCREASE PHYSICAL AND MENTAL WELL BEING ~~such as the US Department of Health and Human Services' Universal Precautions Toolkit and Healthy People 2020 directives~~.

AAPA believes that individual and organizational participation in these steps has the potential to decrease and eliminate the negative health impact of inadequate communication ~~partnerships~~ between providers and patients. By using available resources, PAs empower patients, increase provider awareness of the impact of communication gaps, and improve the health of patients.

Increased Estimates of Number of Patients Impacted

In May 2004 the Institute of Medicine (IOM) released the comprehensive report, *Health Literacy: A Prescription to End Confusion*, defining health literacy as "The degree to which individuals have the capacity to obtain, process, and understand basic health information and service needed to make appropriate health decisions." [1] At that time it was estimated that half of the United States adult population, nearly 90 million people, had difficulty understanding and acting on health information. According to the more recent May 2010 *National Action Plan to Improve Health Literacy* from the Department of Health and Human Services' Office of Disease Prevention and Health Promotion, new estimates indicate that inadequate health literacy now affects the health of most adults, with almost 90% of Americans having "…difficulty using the everyday health information that is routinely available in our health care facilities, retail outlets, media, and communities". [2]

The increasing problem of health literacy is not surprising given the variety of tools needed to navigate the U.S. health care system and process the often complex information and treatment decisions patients face. In order to accomplish these tasks, individuals need SKILLS AND ABILITIES SUCH AS: ~~to be:~~

- CULTURAL AND CONCEPTUAL KNOWLEDGE
- NUMERACY SKILLS
- LISTENING, WRITING, AND READING SKILLS
- COMMUNICATION SKILLS
- COMPREHENSION OF HEALTHCARE INFORMATION AND DECISION MAKING
- SOCIAL SKILLS TO FUNCTION AS A HEALTHCARE CONSUMER
- ~~visual literate (able to understand graphs or other information),~~

- ~~computer literate (able to operate a computer),~~
- ~~infomation literate (able to obtain and apply relevant information), and~~
- ~~numerically or computationally literate (able to calculate or reason numerically).~~

~~[3]~~

AN INDIVIDUAL WITH ADEQUATE HEALTH LITERACY HAS THE ABILITY TO TAKE RESPONSIBILITY FOR THEIR OWN HEALTH AS WELL AS THE HEALTH OF THEIR COMMUNITY. [3, 4], THE FOCUS OF HEALTH LITERACY HAS BROADENED FROM THE INDIVIDUAL PERSPECTIVE TO A SOCIETAL FOCUS BY LINKING HEALTH LITERACY TO ECONOMIC GROWTH, SOCIO-CULTURAL, AND POLITICAL CHANGE. [4, 5]
PUBLIC HEALTH LITERACY RECOGNIZES THE MULTI-DIMENSIONAL IMPACT OF HEALTH LITERACY ON GROUPS AND COMMUNITIES. ACCORDING TO NUTBEAN [6] THERE ARE THREE DIMENSIONS OF HEALTH LITERACY: FUNCTIONAL HEALTH LITERACY REFERS TO HAVING THE BASIC SKILLS OF READING AND WRITING NECESSARY TO FUNCTION IN EVERYDAY SITUATIONS; INTERACTIVE HEALTH LITERACY REFERS TO HAVING ADVANCED COGNITIVE SKILLS USED TO EXTRACT MEANING AND INFORMATION FROM DIFFERENT FORMS OF COMMUNICATION; CRITICAL HEALTH LITERACY REFERS TO MORE ADVANCED COGNITIVE SKILLS COMBINED WITH THE SOCIAL SKILLS NEEDED TO APPLY AND ANALYZE INFORMATION TO EXERT GREATER CONTROL OVER ONE'S LIFE.

"Universal Precautions" and Health Literacy

In April 2010, the U.S. Department of Health and Human Services' Agency for Health Care Research and Quality released a *Health Literacy Universal Precautions Toolkit* offering primary care practices a way to assess and improve their health literacy efforts with patients. [~~4~~ 7] The toolkit assumes that it is difficult to identify those patients who may not understand health information and instead recommends that each practice create an environment where patients of all literacy levels can thrive. [~~4~~ 7] The resources provided in the toolkit are designed to help practices take a systematic approach to reducing the complexity of medical care and ensure that patients can succeed in the health care environment.

~~Expanded Understanding of~~ THE Role of PAS IN HEALTH LITERACY ~~the Clinician~~

AAPA created policy in 2010 that acknowledged the evolving view of health literacy, embracing more shared responsibility of the patient and the provider. HP-3300.1.7.2 reads:
"The AAPA encourages PAs to identify and utilize reliable and accurate consumer health information to encourage patient compliance 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. [~~5~~ 8]

The cultural component of this policy also reshapes the CONVENTIONAL belief that health literacy is simply about reading, missing the larger context of factors that impact patient-provider communication. PAs CAN PLAY A ROLE IN IMPROVING

HEALTH LITERACY BY PROVIDING COMMUNITY AND INDIVIDUAL SUPPORT PROMOTING EMPOWERMENT AND AUTONOMY. RESEARCH HAS SHOWN THAT IMPROVING HEALTH LITERACY LEADS TO LOWER HEALTHCARE COSTS, INCREASED HEALTH KNOWLEDGE, SHORTER HOSPITALIZATION, INCREASED SELF EFFICACY, AND POSITIVE HEALTH BEHAVIORS [9, 10]. ADVANCING HEALTH LITERACY IN THE COMMUNITY MAY LEAD TO GREATER EQUALITY AND SUSTAINABLE CHANGES IN PUBLIC HEALTH [11].

~~Referring to patients as having "low" or "poor" health literacy may stigmatize patients who struggle to understand medical information, and my also remove responsibility for establishment of information partnerships away from providers. Assigning the responsibility of "low" health literacy to patients decreases provider accountability, and places the burden of creating such partnerships primarily on the shoulders of the patient.~~

~~The December 2010 release of the U.S. Department of Health and Human Services report, *Healthy People 2020*, demonstrates this conceptual shift in the view of health literacy, moving away from viewing health literacy as a patient skill-set, judged on a spectrum of "good-bad," and "high-low."~~ A more partnered patient-provider approach to health care communication is emerging in national policy. This is underscored by Healthy People 2020 Health Communication and Health Information Technology objectives found in table 1. [~~6~~ 12]

Table 1

Healthy People 2020 Objectives for
Health Communication and Health Information Technology

- HC/HIT–1.1 Increase the proportion of persons who report their health care provider always gave them easy-to-understand instructions about what to do to take care of their illness or health condition.
- HC/HIT–1.2 Increase the proportion of persons who report their health care provider always asked them to describe how they will follow the instructions.
- HC/HIT–1.3 Increase the proportion of persons who report their health care providers' office always offered help in filling out a form.
- HC/HIT–2: Increase the proportion of persons who report that their health care providers have satisfactory communication skills.
- HC/HIT–2.1 Increase the proportion of persons who report that their health care provider always listened carefully to them.
- HC/HIT–2.2 Increase the proportion of persons who report that their health care provider always explained things so they could understand them.
- HC/HIT–2.3 Increase the proportion of persons who report that their health care provider always showed respect for what they had to say.

- HC/HIT–2.4 Increase the proportion of persons who report that their health care provider always spent enough time with them.

Source: US Department of Health and Human Services. Healthy People 2020.

~~Emergency~~ EMERGENCE of the "Health Information Literacy" Concept

While the medical community continues to expand its understanding of the complexity of health literacy, medical librarians have combined the American Library Association's definition of "information literacy" with the traditional notion of "health literacy." The result has been the concept of "health information literacy," described by the Medical Library Association (MLA) as "the set of abilities needed to recognize a health information need, identify likely information sources and use them to retrieve relevant information, assess the quality of the information and its applicability to a specific situation, and analyze, understand, and use the information to make good health decisions." [~~7~~ 13] Resources available from the MLA may help to raise clinician awareness of their key role in assessing and addressing patient health literacy status, their obligation to partner with patients in this effort, and opportunities to engage with health information experts to improve the health of patients.

Call to Develop Strategic Partnerships

Many recent guidelines call for the development of partnerships to increase the effectiveness of efforts to address health literacy. As noted in the National Action Plan, "this…plan seeks to engage organizations, professionals, policymakers, communities, individuals, and families in a linked, multisector effort to improve health literacy." [2] These partnerships may include other medical associations, state chapters, special interest groups, specialty organizations, patient-advocacy groups, medical librarians, health information technology organizations, and other information specialists.

Resources for PAs

Efforts by individual PAs and PA organizations can be enhanced by guidelines and projects that have been developed to assist the medical community in addressing health literacy. They include:

- *Healthy People 2020* guideline that provides a structure focused on clinical activity. Its metrics to measure national success in addressing health literacy issues provide a valuable perspective that can be used to guide clinical efforts at the practice level. [~~6~~ 12]
- The *Health Literacy Universal Precautions Toolkit* targets clinical activity with its proposed framework to support clinicians in understanding the scope and breadth of health literacy challenges and in proposing a specific shift in how clinicians view patient care. [~~4~~ 7]
- The *National Action Plan* provides broader direction to organizations, professions, policymakers, and communities, highlighting strategies and actions

that organizations and professions can take to set and achieve organizational goals. [2]

- The MLA's "Resources for Health and Information Professionals" may support clinician efforts to improve their health communication with patients.
- MEDLINEPLUS – HTTPS://WWW.NLM.NIH.GOV/MEDLINEPLUS

  THE NATIONAL LIBRARY OF MEDICINE'S CONSUMER HEALTH PORTAL FOR PATIENTS AND HEALTH PROFESSIONALS. THIS SITE LINKS TO THE NATIONAL INSTITUTE OF HEALTH AND PROVIDES TUTORIALS, GRAPHS, AUDIO INSTRUCTIONS, AND RESOURCES IN DIFFERENT LANGUAGES.
- NIH SENIORHEALTH - HTTP://NIHSENIORHEALTH.GOV/ - A SITE DESIGNED FOR OLDER ADULTS AND CAREGIVERS. SITE INCLUDES LARGE TEXTS AND A FEATURE FOR VISUALLY IMPAIRED. THIS SITE INCLUDES A SENIOR HEALTH TOOLKIT HTPP//NIHSENIORHEALTH.GOVTOOLKIT.HTLM FOR CAREGIVERS AND PROVIDERS TO ACCESS.
- UNDERSTANDING MEDICAL WORDS HTTP://WWW.NLM.NIH.GOV/MEDLINEPLUS/MEDICALWORDS.HTML . AN INTERACTIVE SITE THAT HELPS PATIENTS UNDERSTAND HOW MEDICAL WORDS ARE FORMED.

SUMMARY

AAPA believes that the PA profession can participate in addressing the problems of health literacy by

- adopting expanded definitions of health literacy THAT INCLUDE THE INDIVIDUAL AND PUBLIC HEALTH PERSPECTIVES
- optimizing efforts to INCREASE HEALTH KNOWLEDGE, SELF EFFICACY, SELF MANAGEMENT BEHAVIORS, AND POSITIVE OUTCOMES ~~create information and communication partnerships~~ with patients
- participating in LOCAL COMMUNITY GROUPS TO PROVIDE SOCIAL SUPPORT AND ADVOCACY ~~strategic and multi-sector partnerships centered on assessing and addressing health literacy~~ LEADING TO SUSTAINABLE BEHAVIOR CHANGES CONDUCIVE TO BETTER HEALTH

- identifying and utilizing resources TO INCREASE OPPORTUNITIES FOR PATIENT ACTIVATION, ACCESS TO CARE, AND DEVELOPMENT OF SKILLS TO INCREASE PHYSICAL AND MENTAL WELL BEING. ~~such as the US Department of Health and Human Services' Universal Precautions Toolkit and Healthy People 2020 directives.~~

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2016-D-11 – Adopted on Consent Agenda

Amend policy BA-2200.2 "Health Disparities: Promoting the Equitable Treatment of All Patients" as follows:

Health Disparities: Promoting the Equitable Treatment of All Patients

(Adopted 2011)

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 will STRIVE ~~work~~ to:

1. Enhance and create organizational outreach and strategic partnerships aimed at decreasing and eliminating health disparities, INVOLVING BUT NOT LIMITED TO EDUCATION, EMPLOYMENT, HOUSING, GEOGRAPHIC LOCATION AND PUBLIC ACCOMODATION.
2. ELIMINATE HEALTH DISPARITIES IN ALL AREAS INCLUDING BUT NOT LIMITED TO: RACE, ETHNICITY, SEX, GENDER IDENTITY, SEXUAL ORIENTATION, DISABILTY STATUS OR SPECIAL HEALTH CARE NEEDS.
3. Increase PA awareness of health disparities.
4. Create and promote health equity tools and resources for PAs.
5. Utilize THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES "HEALTHY PEOPLE" COLLABORATIVE ~~Healthy People 2020~~ as a template for increased organizational efforts to

support health surveillance systems that track outcomes. ~~by race and ethnicity, gender, sexual identity and orientation, disability status or special health care needs, and geographic location.~~

6. SUPPORT LEGISLATION AND POLICY THAT ELIMINATES DISPARITIES.

Introduction

Health disparities are differences in health among groups of people that are closely tied to social or demographic factors such as race, SEX ~~gender~~, income, or geographic region. Decades ago, the issue of health disparities was seen primarily as one of race and ethnicity. As the focus on health disparities has sharpened ~~over the last decade~~, definitions have broadened to include gender, sexual orientation, ~~or~~ gender identity**,** religion, socioeconomic status, mental health, geographic location, and other characteristics typically linked to discrimination or exclusion. [1]

Accompanying this more sophisticated understanding of health disparities has been a growing body of research demonstrating healthcare inequities. Data suggest that increasing provider awareness of health disparities, social determinants of health, and implicit bias can decrease the impact of health disparities.

Current public policy interest in health disparities offers unprecedented opportunities for AAPA and individual PAs to join in global efforts to promote health equity. Increased understanding of the social determinants of health and the role that clinician beliefs and behaviors may play in disparities has made the need for increasing provider awareness and action more urgent than ever.

Mounting Evidence of Health Disparities

The release of the Institute of Medicine's (IOM) 2003 report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," provided sobering evidence of persistent, extensive health disparities. The report identified complex contributing factors including how health systems operate, bureaucratic processes, biases of health care professionals, and patients' behaviors. [1~~2~~]

The National Plan for Action~~, currently a draft document from the National Partnership for Action to End Health Disparities,~~ includes compelling data that substantiates the far-reaching and negative impact of health disparities on the health of minority populations. Striking examples include disparities in cardiovascular disease, diabetes, HIV/AIDS, infant mortality, oral health, mental health, and healthcare quality and access. [2~~3~~]

The American Public Health Association's brief, "Health Disparities: The Basics," offers a snapshot of data related to health disparities for broader populations: high infant mortality rates among ethnic and racial minorities, risk for obesity among people with lower income and education, cervical cancer rate among Vietnamese-American women five times higher than among Caucasian American women, and the high incidence of chronic illnesses among rural residents. [3~~4~~]

One example of the recent expansion of the definition of disparities is the inclusion of lesbian, bisexual, gay and transgender (LGBT) populations in the overall examination of heath disparities. A study "How to Close the LGBT Health Disparities Gap," from the Center for American Progress, reports on health disparities in the lesbian, gay, bisexual and transgender populations. The report states that the LGBT population faces higher rates of cancer, mental illnesses, substance abuse, and delaying care, and lower rates for mammograms, and health insurance than the adult heterosexual population. [45] Additionally, Healthy People 2020 included LGBT disparities in its overview for the first time [51]

Social Determinants of Health

Social determinants of health include social, economic and political forces under which people live, which are key to creating and maintaining health status gaps between specific populations. They include wealth/income, education, legislation, nutrition, physical environment, health care, housing, employment, stress and racism/discrimination. [5]

There is a growing body of research on ~~racism~~ RACIAL INEQUITY and its related stresses as a social determinant of health. When studies control for socioeconomic status, blacks have poorer health than white counterparts. Middle-class blacks have poorer health than middle-class whites, with middle-class whites living an average of 10 years longer than their middle-class black counterparts. [6]

Implicit Bias and Unconscious Stereotyping

Implicit bias and stereotyping by clinicians are seen increasingly as likely contributors to health inequities. [~~7,8~~]6,7] Stereotyping allows clinicians to make complex decisions in short periods of time. Researchers have extensively described how this mechanism operates, and have shown that stereotypes are often activated subliminally, with quick associations caused by a variety of triggers. For example, clinicians subliminally exposed to African American stereotype-laden words are more likely to evaluate the same hypothetical patient more negatively than when exposed to more neutral language.

While still a relatively new area of research, studies have demonstrated unequal care for patients presenting to the same facilities, and seeing the same providers. [89] Clinical stereotyping can be exacerbated by the uncertainty occurring when a cultural gap between the provider and the patient occurs, as well as by increased time pressures placed on provider-patient interactions. These triggers may lead to situations where well-intentioned PAs create a discriminatory pattern of care, causing "… powerful effects on thinking and actions at an implicit, unconscious level, even among well-meaning, well-educated persons who are not overtly biased." [~~10~~09]

Data from psychology research suggest that increasing provider awareness of implicit bias and stereotyping can decrease the activation of PAs' own biases. Such research supports aggressive efforts by the AAPA to increase provider awareness of bias and stereotyping, with the goal of promoting more equitable care of all patients. [10-14] The Harvard Implicit Association Test (https://implicit.harvard.edu/implicit/demo/) provides an opportunity to explore personal unconscious biases. [15]

Action Plan

Therefore, AAPA will ~~work~~ STRIVE to:

1. Enhance and create organizational outreach and strategic partnerships aimed at decreasing and eliminating health disparities, INVOLVING BUT NOT LIMITED TO EDUCATION, EMPLOYMENT, HOUSING, GEOGRAPHIC LOCATION AND PUBLIC ACCOMODATION
2. ELIMINATE HEALTH DISPARITIES IN ALL AREAS INCLUDING BUT NOT LIMITED TO: RACE, ETHNICITY, SEX, GENDER IDENTITY, SEXUAL ORIENTATION, DISABILTY STATUS OR SPECIAL HEALTH CARE NEEDS.
3. Increase PA awareness of health disparities.
4. Create and promote health equity tools and resources for PAs.
5. Utilize THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES "HEALTHY PEOPLE" COLLABORATIVE ~~Healthy People 2020~~ as a template for increased organizational efforts to support health surveillance systems that track outcomes. ~~by race and ethnicity, gender, sexual identity and orientation, disability status or special health care needs, and geographic location~~.
6. SUPPORT LEGISLATION AND POLICY THAT ELIMINATES DISPARITIES.

These actions are consistent with AAPA ~~Strategic Plan, Goal VIII, Health of the Public, which charges the Academy to demonstrate leadership in decreasing health disparities. [16]~~VALUES AS EXPLAINED IN THE STRATEGIC PLAN "WE COMMIT TO THE HIGHEST STANDARDS AND SEEK TO ELIMINATE DISPARITIES AND BARRIERS TO QUALITY HEALTH CARE." [16]

Conclusion

AAPA believes that enhancing strategic partnerships, supporting increased provider and organizational awareness of health disparities, creating and promoting clinically relevant resources, and supporting data collection related to health disparities will result in decreased health inequities and result in the improved health of all patients.

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2016-D-12 – Adopted

Amend policy HX-4600.1.9 as follows:

The AAPA opposes actions ~~by Pharmacists~~ that limit or restrict patient access to care~~,~~ ~~such as refusing to fill prescriptions,~~ based on personal or religious beliefs.

2016-D-13 – Adopted

Amend policy HX-4600.1.6 as follows:

AAPA ~~supports legislative and health policies that will eliminate the social,~~ RECOGNIZES THAT DISCRIMINATION ~~education, employment, and housing, inequities that~~ contributeS to HEALTH disparities ~~in health~~. AAPA SUPPORTS LEGISLATION AND POLICIES THAT WILL ELIMINATE DISCRIMINATION.

Resolutions of Condolence

2016-COND-01

Resolution of Condolence
Richard L. Curtis, PA-C
May 2016

Whereas, the New Jersey State Society of PAs suffered a great loss with the passing of Richard L. Curtis, PA-C, on Thursday, February 04, 2016 at Capital Healthcare Center in Hopewell, NJ.

Whereas, Richard L. Curtis, enlisted in the United States Army where he became a Special Forces Green Beret and served two tours in Vietnam

Whereas, Richard L. Curtis started his career as a medical specialist within the Special Forces and then trained to be a PA (United States Army PA Program) and after 26 years retired with the rank of Chief Warrant Officer (CW3)

Whereas, Mr. Curtis, consistently received accommodations from the Military including the Army Commendation Medal for Superior Service on five occasions

Whereas, Richard L. Curtis was acknowledged as the 2005 recipient of NJSSPA ‘s Lifetime Achievement Award in the PA Profession for his dedication to the advancement of the PA profession from all aspects including education, clinical, political, and legal over one’s entire career

Whereas, Richard L. Curtis practiced during a time when PA were not well accepted in the State of NJ and was one of the first PAs on staff at Robert Wood Johnson University and Saint Peter’s University Hospitals

Whereas, Richard L. Curtis demonstrated his quest for knowledge and desire to educate not only his patients but other healthcare professionals as well not only through personal interaction but through numerous journal publications

Whereas, Richard L. Curtis had a love for traveling the world and a County Western enthusiast who also enjoyed hand crafting leather art will truly be missed by his family, friends, congregation, and co-workers

Resolved, that the House of Delegates of the American Academy of PAs recognize Richard L. Curtis' contributions to the country and to the community, and be it further

Resolved that a copy of this resolution be provided to his loving wife of 51 years, Francis Curtis and his family with deepest sympathy from the members of the American Academy of PAs.

2016-COND-02

Resolution of Condolence
Dean Minton, PA-C
May 2016

Whereas, Dean Minton was born and raised in rural North Wilkesboro, North Carolina; and,

Whereas, Dean attended Mars Hill Junior College, Wake Forest University and subsequently earned his Master of Divinity at Southern Baptist Theological Seminary in Louisville, Kentucky; and,

Whereas, Dean Minton became an ordained Baptist minister and served as a chaplain in the US Air Force for 27 years, after which he retired as a Lieutenant Colonel; and,

Whereas, Dean decided to enter a second career, and attended the Bowman Gray (Wake Forest) PA Program, graduating in 1983; and,

Whereas, Dean worked as a PA in the Department of Family and Community Medicine at Bowman Gray, and then as a PA and Family Therapist for the Winston Center for Psychotherapy; and,

Whereas, Dean moved to Charlotte in 1988 where he was a PA and Family Therapist with Mecklenburg Psychiatric Associates, and in 1992 went to work as a PA for Carolinas Medical Center Department of Psychiatry until he retired in 1999; and,

Whereas, Dean served as on the board of the North Carolina Academy of PAs, and eventually as its President in 1990; and,

Whereas, Dean was instrumental in starting Charlotte's regional chapter, the Metrolina Association of PAs (MAPA) and set up MAPA's first webpage and served as MAPA President and Secretary until he retired in 1999; and,

Whereas, Dean had a passion to help others, advocating for patients and mentoring new PAs, all of which made him instrumental to the growth of the PA profession in North Carolina; and,

Whereas, the PA profession lost a kind soul, a pioneer, and an all-around great guy when Dean passed away on March 23, 2016,

Resolved, that the House of Delegates of the American Academy of PAs recognize Dean Minton's many contributions to his profession and his community, and be it further

Resolved, that a copy of this resolution be provided to his family with deepest sympathy from the members of the American Academy of PAs.

2016-COND-03

Resolution of Condolence
Tony Di Tomasso
May 2016

Whereas Tony Di Tomasso, as a representative of Glaxo Smith Kline gave unsurpassed support to the PA profession;

Whereas "Tony D" led GSK in developing education platforms for healthcare providers, many focused on PAs;

Whereas as a Trustee of the PA Foundation, Tony served six years supporting the philanthropic efforts of PAs;

Whereas as the Veterans Affairs Representative to GSK, "Tony D" made sure monetary and compassionate support was brought to the Veterans Caucus and other Federal Service PA organizations to enable them to carry on their mission,;

Whereas "Tony D" was instrumental in developing a GSK web portal to support women in healthcare practice, focusing on female veterans in their service to our great country;

Whereas "Tony D" was a great colleague, both professional and a dear personal friend of many, many PAs;

Whereas "Tony D" was a "Brother from another mother" to many, many PAs;

And, whereas "Tony D" left us this past November we remember and honor him with this resolution for all his love, joy, and support he brought to PAs everywhere.

Resolutions of Commendation

2016-COMM-01

Resolution of Commendation
Laura Gail Curtis, MPAs, PA-C, DFAAPA
May 2016

Whereas, Laura Gail Curtis became a PA in 1981 graduating from the Bowman Gray School of Medicine beginning her formal career in healthcare, and

Whereas, five years later she began educating future PAs at Wake Forest University, resulting in her touching the lives of and mentoring hundreds of future PAs, and

Whereas, she served her state chapter, filling the roles of Professional Practices and Relations Committee Chair, Health Committee Chair, President-Elect, President, and Past President for the North Carolina Academy, and

Whereas, she served with distinction from 1992-2007 on the North Carolina Medical Board and its PA Advisory Committee, and

Whereas, she started her leadership career in the HOD as a delegate for the great state of North Carolina beginning in 1988 and continuing until 2011, and

Whereas, she participated in thoughtful and honest debate throughout her service as a delegate challenging issues when necessary yet always keeping the good of the House, the profession and the academy in the forefront, and

Whereas, she steeped herself in parliamentary procedure and gave freely of her time to the delegates and the house officers in whatever capacity was necessary, and

Whereas, she served with distinction as a House reference committee member and chair numerous times, and

Whereas, she advanced her AAPA HOD leadership with election as Second Vice Speaker to the HOD in 2010 with continued service until 2011, and

Whereas, she pressed forward with her HOD service through election as First Vice Speaker to the AAPA HOD in 2011 serving until 2013, and

Whereas, she rose to the top of the leadership team in the AAPA HOD with her election as Speaker of the HOD and Vice President of the AAPA in 2013 continuing to 2016, and

Whereas, she has served in all of these roles in an untiring manner, fully committed to the responsibilities associated with each role and conducting herself as a role model to others, including her fellow house officers, the delegates, tellers, Sergeants-at-Arms, and

Whereas she mentored many future House Officers of the AAPA HOD sharing her wisdom, kindness, and humor, and

Whereas, she has been elected to continue her service to the profession and the Academy as its future President, and

Whereas, in addition, PA Curtis has exemplified all that is good about the PA profession through her caring and compassionate service, be it

Resolved that the AAPA HOD honors and commends Gail Curtis, MPAS, PA-C for her sustained and selfless service and commitment to the HOD, the Academy and the PA profession.

House Elections 2016	**Results**
Vice President/Speaker	David Jackson

First Vice Speaker	William Reynolds
Second Vice Speaker	Todd Pickard
Nominating Work Group	Brandi Ritter
	Peggy Walsh