AAPA Mission

AAPA leads the profession and empowers our members to advance their careers and enhance patient health.

AAPA Vision

PAs transforming health through patient-centered, team-based medical practice.

AAPA Values

Leadership and Service
We inspire a shared vision to lead the profession, emphasize service to our members, and enhance the ability of PAs to serve patients and their communities.

Unity and Teamwork
We embrace the strength of our members and constituent and partner organizations to speak with one voice for the profession and work together to transform health.

Accountability and Transparency
We listen, deliver results, take ownership for our actions and operate in an environment of openness and trust.

Excellence and Equity
We commit to the highest standards and seek to eliminate disparities and barriers to quality healthcare.
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2) Accreditation and Implications of Clinical Postgraduate PA Training Programs
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3) Guidelines for Updating Medical Staff Bylaws: Credentialing and Privileging PAs
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4) Guidelines for State and Territory Regulation of PAs
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5) Guidelines for the PA Serving as an Expert Witness
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33) Tobacco Use Disorder (Adopted 2016, amended 2021)
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35) Attempts to Change a Minor's Sexual Orientation, Gender Identity, or Gender Expression 
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36) Human Trafficking in the United States (Adopted 2019) 
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37) Non-Physician Licensure for Medical School Graduates (Adopted 2019) 
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38) Genetic and Genomic Testing (Adopted 2019) 
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40) Vaping: Use of Electronic Nicotine Delivery Systems (Adopted 2020) 
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41) Disparities in Maternal Morbidity and Mortality (Adopted 2021) 
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AAPA BYLAWS

AAPA BYLAWS

ARTICLE I      Name.

The name and title by which this corporation shall be known is the American Academy of Physician Associates, Inc., herein referred to as the Academy or AAPA.

ARTICLE II     Purpose and Mission.

The Academy is organized and shall be operated exclusively to ensure the professional growth, personal excellence, and recognition of PAs, and to support their efforts to enable them to improve the quality, accessibility, and cost-effectiveness of patient-centered healthcare. To represent PAs and PA students so as to maximize the benefit of their services to the public, the Academy shall:

a. Encourage its membership to render quality service to the health professions and to the public;
b. Develop, sponsor, and evaluate continuing medical or medically related education programs for the PA;
c. Assist in the development of role definition for the PA;
d. Assist with the coordination and standardization of curricula for the PA;
e. Participate in the accreditation of PA training programs;
f. Participate in the development of criteria leading to certification of the PA;
g. Develop, coordinate, and participate in studies having an impact either directly or indirectly on the PA profession;
h. Serve as a public information center with respect to its members, health professions, and the public.

Notwithstanding any other provision of these Bylaws, the Academy shall exercise its powers, rights, and privileges, whether conferred by this instrument, or by the laws of the state of North Carolina or otherwise, to carry on such other activities as are permissible for corporations exempt from federal income tax under Section 501(c)(6) of the Internal Revenue Code of 1986.

ARTICLE III      Membership.

Section 1: Eligibility. Membership in this Academy shall be open to all individuals wishing to participate in promoting the purposes of the Academy. Specifically, membership shall consist of individuals who are cognizant of their obligation to the public and who meet the requirements for membership as defined by AAPA’s Articles of Incorporation, these Bylaws, and such other of AAPA’s rules and policies that may be established from time to time. Membership in the Academy is an honor that confers upon the individual certain rights and responsibilities. Adherence to AAPA’s Articles of Incorporation, these Bylaws, and AAPA’s rules and policies, and generally acting in a manner that is consistent with AAPA’s mission, is a condition of membership.

Section 2: Classes of Membership. The membership shall consist of fellow, student, affiliate, associate, honorary, retired, pre-PA and such other members as may be recognized by the Academy.

Section 3: Fellow Members. A fellow member shall be a PA who is a graduate of a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA),
or by one of its predecessor agencies (Committee on Allied Health Education and Accreditation [CAHEA], Commission on Accreditation of Allied Health Education Programs [CAAHEP]) or who has passed the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA) or an examination administered by another agency approved by the Academy. Fellow members must satisfy such continuing medical and/or medically related educational requirements as may be prescribed by the Academy. Non-clinical fellow members will not be required to maintain continuing medical education (CME). Fellow members shall be entitled to vote and hold office.

Section 4: **Student Members.** A student member is an individual who is enrolled in an ARC-PA or successor agency approved PA program. Student members are only eligible to hold elected office in the Student Academy or as otherwise provided in these Bylaws. The Student Board of Directors and apportioned student members of the House of Delegates shall be entitled to vote in AAPA General Elections.

Section 5: **Affiliate Members.** Affiliate members shall consist of individuals from other health professions who desire to associate with the Academy. Affiliate members shall not be entitled to vote or hold office.

Section 6: **Associate Members.** Associate members shall consist of representatives of businesses engaged in selling products or services to PAs or individuals employed by government agencies who do not qualify for any other membership category. Associate members shall not be entitled to vote or hold office.

Section 7: **Honorary Members.** Honorary membership may be conferred by the Academy upon non-PAs who have rendered distinguished service to the PA profession. Honorary members shall not be entitled to vote or hold office. All honorary members shall be exempt from the payment of dues.

Section 8: **Retired Members.** A retired member shall be a PA who is a former fellow member who has chosen to retire from the profession and opts to be classified as a retired member. Retired members shall not be entitled to vote or hold office.

Section 9: **Pre-PA Members.** A pre-PA member is an individual who plans to apply to PA school. Pre-PA members shall not be entitled to vote or hold office.

Section 10: **Applications for Membership.** All applications for membership shall be in a format approved by the Membership Department of the National Office. There shall be issued to each member a certificate of membership in such form as may be determined by the Membership Department of the National Office; title to such certificate shall remain at all times with the Academy.

Section 11: **Suspension or Revocation of Membership.** Membership in the Academy may be suspended or revoked as provided in Article IX. Any member who has been suspended or has their membership revoked shall not be entitled to any of the rights or benefits of this Academy or be permitted to take part in any of the proceedings until their membership has been reinstated.

Section 12: **Non-Discriminatory Policy.** AAPA will remain non-discriminatory in granting membership.

Section 13: **Annual Meeting.** There shall be an annual meeting of those members who are entitled to vote for Directors, to be held during the Academy’s annual conference, or at such other time and place as may be determined by the Board of Directors. Notice of the place, date, and time of the annual meeting
shall be given to those members who are entitled to vote for Directors at least 30 days but not more than
60 days before the meeting date. Notice may be delivered by electronic means.

ARTICLE IV Constituent Organizations.

Constituent organizations consist of state, the District of Columbia, U.S. territories and federal services
chapters; specialty organizations; caucuses; and special interest groups; as defined in AAPA policy.

ARTICLE V Student Academy of AAPA.

Section 1: Purpose. The Student Academy of AAPA is the national representative body of AAPA
student members. The Student Academy embraces AAPA’s mission with a focus on student-oriented
engagement, professional development and advocacy.

Section 2: Membership. The Student Academy consists of student members of AAPA as defined in
AAPA Bylaws Article III, Section 4.

Section 3: Student Academy Relationship Within AAPA. AAPA grants the Student Academy the
right to operate as a subsidiary unit representing AAPA student members.
   a. AAPA reserves the right to monitor the Student Academy’s adherence to AAPA’s Bylaws and
      policies.
   b. The Student Academy retains the right to address student concerns and issues, provided that the
      Student Academy adheres to the Bylaws, policies and procedures of AAPA.
   c. In order to fulfill its fiduciary responsibility, AAPA’s Board of Directors will be apprised of
      Student Academy activities to ensure the Student Academy’s compliance with AAPA Bylaws,
      policies and procedures, per Article VII. Section 1.

Section 4: Student Academy Board of Directors. The Student Academy Board of Directors directs
the activities of the Student Academy.
   a. The Student Academy President serves on AAPA’s Board of Directors as the Student Director.
      This Student Director shall have all rights and privileges of any other member of such Board.
   b. The Student Academy Board of Directors is composed of the President, President-elect, HOD
      Chief Delegate, Regional and Functional Directors, and Advisors, as set forth in AAPA and
      Student Academy policies.
   c. Election procedures are defined in these Bylaws and Student Academy policies.
   d. The duties of Student Academy Board members are defined in the Student Academy policies,
      in accordance with these Bylaws and AAPA policies and procedures.

Section 5: Assembly of Representatives. The Student Academy shall have an Assembly of
Representatives (“AOR”) to foster information sharing and engagement between the Student Academy
Board and student members and provide a forum for students to bring forward issues for consideration.
The AOR shall be composed of student member representatives as set forth in the Student Academy
policies.

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 make recommendations to the Board for granting
charters to Chapters and for granting official recognition to specialty organizations. The House of
Delegates may 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 XIV 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).

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

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

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

Section 3: House Officers. The House of Delegates shall elect from among its members the following House Officers: a Speaker (who shall also serve as Vice President of the Academy), a First Vice Speaker, and a Second Vice Speaker (the First Vice Speaker and the Second Vice Speaker are not Officers of the Corporation).

a. Election and Term of Service. Each House Officer shall be elected by a majority of votes cast. No absentee or proxy vote shall be cast. The Governance Commission shall determine the general procedures for House Officers elections. The terms of office shall be as specified in Article XIII, Section 2.

b. Delegate-at-large Designation. Each House Officer elected shall become a delegate-at-large during the term(s) as a House Officer, plus one additional year as an immediate past House Officer. The delegates-at-large shall be accorded all the rights and privileges of elected delegates.

c. Duties of House Officers.

i. The Speaker shall preside at all meetings of the House of Delegates.

ii. The First Vice Speaker shall assume the duties of the Speaker in the event of the absence of the Speaker, or in the event of vacancy in the position of Speaker.

iii. The Second Vice Speaker will assume the duties of the First Vice Speaker in the absence of the First Vice Speaker, or in the event of vacancy in the position of First Vice Speaker.
iv. The Second Vice Speaker shall be responsible for verification of the credentials of the delegates, for compiling the records of all general meetings of the House of Delegates, and for submitting such records to the Secretary-Treasurer of the Academy for filing with the Academy’s books and records.

d. Resignation or Removal of House Officers. Any House Officer may resign at any time by giving written notice to the Speaker, the President of the Academy, 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 House Officer may be removed from office at any time, with or without cause, by the affirmative majority vote of the House of Delegates. 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 House Officer. Vacancies in these positions shall be filled in accordance with Article VI, Section 3 and Article XIII, Section 9 of these Bylaws.

Section 4: Meetings of the House of Delegates.

a. Annual and Special Meetings. The House of Delegates shall hold an annual meeting. Special meetings of the House of Delegates shall be called by the Speaker upon written request of 25 percent or more of the currently credentialed delegates. Special meetings of the House shall also be called by a two-thirds (2/3) affirmative vote of the Board of Directors or by a majority affirmative vote of the House Officers. The object of such special meetings shall be stated in the meeting notice, and no other business other than that specified in the notice shall be transacted at the meeting.

b. Notice. Notice of the place, date, and time of the annual meeting of the House of Delegates shall be given to each member of the House of Delegates at least 30 days before the meeting date. If proposed Bylaws amendments are to be presented to the House of Delegates for approval at the annual House meeting, the notice of the meeting shall include a description of the proposed amendments to be approved and must be accompanied by a copy or summary of the proposed amendments. Notice of the place, date, and time of a special meeting of the House of Delegates shall be given to each member of the House of Delegates at least five (5) days before the meeting date. Notice of a special meeting shall include a description of the matter or matters for which the meeting is called. Notice of the annual meeting or a special meeting may be delivered by electronic means.

c. Quorum. A majority of the total number of the currently credentialed delegates shall constitute a quorum at any meeting of the House of Delegates. Unless otherwise stated in the Bylaws, an affirmative vote by a majority of the delegates present and voting shall constitute action of the House.

d. Mail and Electronic Voting. Mail and electronic voting of the House of Delegates will be permitted for any House business. Mail and electronic votes will be called for by the Speaker of the House when directed by: (i) a simple majority of the House Officers; (ii) a two-thirds affirmative vote of the Board of Directors; or (iii) a call from 25 percent of delegates currently credentialed. Additionally, mail and electronic votes will be called for by the Speaker when there is a vacancy in an elected office of the House during the time period between regularly scheduled House elections. The House Officers and Academy staff shall determine the procedures for voting on issues requiring a mail or electronic ballot, subject to the requirements of the North Carolina Nonprofit Corporation Act.
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 affiliation with 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;
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 AAPA’s Board of Directors may not hold elected voting positions in the Academy’s constituent organizations (COs). Directors may hold elected or appointed non-voting positions in the Academy’s COs.

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

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

Section 5:  Duties of Officers of the Corporation.

a. The President shall be the chief spokesperson for the Academy. The President shall report to the House of Delegates and the members at the annual meeting of the Academy with
an account of the activities of the Board for the past year and its recommendations for the
House of Delegates.
b. The President-elect shall succeed to the office of President at the expiration of the
President’s term or earlier should that office become vacant for any reason.
c. The Vice President is the Speaker of the House of Delegates and shall represent the
House of Delegates to the Board of Directors and shall perform such other duties as shall
be assigned by the Board of Directors.
d. The Secretary-Treasurer shall:
i. be responsible for adequate and proper accounts of the properties and funds of the
   Academy;
ii. give a financial report to the membership at the annual meeting;
iii. oversee disbursement of the funds of the Academy as may be ordered by the Board
    of Directors;
iv. 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;
v. oversee the maintenance of the records of the Academy including the records of the
    Board of Directors and of the House of Delegates;
vi. execute general correspondence of the Academy, as needed;
vii. attest the signature of the Academy Officers;
viii. have such other powers and perform such other duties as may be prescribed by the
    President or the Board of Directors.
e. The Immediate Past President shall perform such other duties as may be assigned by the
   President or the Board of Directors.

Section 6: Meetings of the Board of Directors.

a. Regular and Special Meetings. The Board of Directors shall hold such regular meetings at
   such time and at such places as designated by Board policy, but in no event shall there be
   fewer than two such meetings in any calendar year. Regular meetings of the Board may be
   held without notice. Special meetings shall be called by the Secretary-Treasurer at the
   request of the President or upon written request to the President of at least 20 percent of the
   members of the Board then in office. The object of such special meetings shall be stated in
   the meeting notice, and no business other than that specified in the notice shall be
   transacted at the meeting. Notice of a special meeting shall be provided not less than two
   (2) days before the meeting.
b. Quorum. A majority of the membership of the Board then in office shall constitute a
   quorum for the purposes of transacting business.
c. Manner of Acting. The affirmative vote of a majority of the Directors present at a meeting
   at which a quorum is present shall be the act of the Board of Directors, except as otherwise
   provided by law, by the Articles of Incorporation, or by these Bylaws. Each Director shall
   have one (1) vote on all matters submitted to a vote of the Board of Directors. No Director
   voting by proxy shall be permitted.
d. Teleconferencing. To the extent permitted by law, any person participating in a meeting of
   the Board of Directors may participate by means of conference telephone or by any means
   of communication by which all persons participating in the meeting are able to hear one
   another, and otherwise fully participate in the meeting. Such participation shall constitute
   presence in person at the meeting.
e. Action by Unanimous Written Consent. Any action required to be taken at a meeting of the
   Board of Directors or any action which may be taken at a meeting of the Board of Directors
   may be taken without a meeting if a consent in writing, setting forth the action so taken, is
signed by all of the Directors entitled to vote with respect to the subject matter thereof. A Director's consent to action taken without a meeting may be in electronic form and delivered by electronic means.

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

Section 8: Executive Committee. The Executive Committee of the Board of Directors shall consist of the President, Vice President, President-elect, Immediate Past President, Chair of the Board, Secretary-Treasurer, and CEO. The CEO shall be an ex-officio, non-voting member of the Executive Committee. The Executive Committee shall be empowered to act for the Board of Directors on emergency matters only. When there are sensitive and confidential matters involving the CEO, they may be excluded from Executive Committee discussions and actions. Actions of the Executive Committee shall be reported to the Board of Directors no later than the Board’s following meeting. All such Committee actions must be reviewed and ratified by the Board of Directors and shall be included in the official Board minutes.

Section 9: Resignation or Removal of Directors and Officers of the Corporation. Any Director or Academy Officer may resign at any time by giving written notice to the President or the Board of Directors. Such resignation shall take effect at the time specified in such notice, or, if no time is specified, at the time such resignation is tendered. Any Director-at-large, Student Director, or Academy Officer 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 9 of these Bylaws.

ARTICLE VIII Chief Executive Officer.

The Chief Executive Officer (CEO) is an employee of the Academy. The CEO shall be bonded at the expense of the Academy in such amounts as the Board of Directors may require. The CEO shall be a non-voting member of the Board of Directors. The CEO shall be under the direction and oversight of the Board of Directors and, in the case of the CEO’s death, resignation, or removal; the Board of Directors shall have the power to fill the vacancy.

ARTICLE IX Judicial Affairs.

Section 1: The Board of Directors shall be responsible for the internal judicial affairs of the Academy.

Section 2: The Academy has the inherent right through the Board of Directors to discipline, suspend, or expel an Academy member or Academy-recognized PA organization.

Section 3: Anyone may in good faith refer charges against any Academy member or constituent organization believed to have violated the Academy Articles, Bylaws, policies, or rules, or for acting in a manner inconsistent with AAPA’s mission.

Section 4: The Academy, after due notice and hearing, may discipline any member or constituent organization for a violation of the Academy Articles, Bylaws, policies, or rules, or for unethical or unprofessional conduct, or for acting in a manner inconsistent with AAPA’s mission. The notice and hearing procedures for such disciplinary actions may be determined by the Board of Directors from time to time.
Section 5: If any member has their PA license or temporary permit currently revoked as the result of a final adjudicated disciplinary action for violation of their professional practice statutes or regulations, then their AAPA membership shall be automatically revoked.

Section 6: Any individual who has their PA license or temporary permit currently revoked as the result of a final adjudicated disciplinary action for violation of their professional practice statutes or regulations shall be ineligible to apply for AAPA membership during the period of that revocation.

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

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

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

a. Commissions and Work Groups. The House of Delegates shall recommend to the Board the establishment of commissions and work groups of the Academy. The Board of Directors shall establish such commissions and work groups and set forth the respective duties, responsibilities, and membership eligibility requirements thereof, as the Board may deem advisable. With the exception of the Nominating Work Group, the Board of Directors shall appoint commission and work group chairs and members according to procedures established by the Board.

b. Task Forces, Ad Hoc Groups and Other Committees. The Board of Directors may establish and appoint such Academy task forces and ad hoc groups and set forth the respective duties, responsibilities, and membership eligibility requirements thereof, as the Board may deem advisable. The House Speaker may establish and appoint such House Committees and ad hoc groups as may be necessary to carry out the duties of the House of Delegates.

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. Annually evaluate the environment and recommend to the Governance Commission any skills, capabilities or other characteristics that will support a diverse and high-performing Board of Directors.
b. Support communication and education efforts to inform all members of elected leadership opportunities and how to qualify for those positions.
c. Identify and recruit qualified members and encourage a broad slate of candidates to run for elected positions within AAPA.
d. 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.
e. 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, five (5) of which 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.

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 AAPA.
b. A candidate must have been an AAPA fellow member and/or student member for the last 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 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 AAPA’s 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.
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 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.

ARTICLE XII     Rules of Order.

In the absence of any provisions to the contrary in these Bylaws, all meetings of the Academy, the Board of Directors and the House of Delegates shall be governed by the parliamentary rules and usages contained in the current edition of *The Standard Code of Parliamentary Procedure*.

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.**

a. 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 office for House Officer positions shall be one year.

b. Officers’ and Directors’ positions will automatically be resigned effective at the end of the leadership year if the individual runs for an alternate office.

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 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 AAPA’s House of Delegates or a representative to the Student Academy of AAPA’s Assembly of Representatives.

iii. A board member, trustee, or committee chair of the Student Academy of AAPA, PA Foundation, Physician Assistant History Society, AAPA’s Political Action
Committee, Physician Assistant Education Association or National Commission on Certification of Physician Assistants.

iv. AAPA Board appointee.

e. A candidate for House Officer must have been a seated delegate for a minimum of two years in the past five years.

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: Eligible Voters.

a. Eligible voters for President-elect, Secretary-Treasurer, and Directors-at-large are fellow members, the Student Board of Directors and apportioned student members of the House of Delegates.

b. Eligible voters for House Officers and for elected members of Nominating Work Group are voting members of the House of Delegates who are present at the time of the election.

c. Eligible voters for the Student Academy positions of President-elect, Director of Diversity and Outreach, Director of Student Communications, and Chief Delegate are student members.

d. Eligible voters for Student Academy Regional Directors are student members from within the respective region.

e. For all positions, eligible voters must be current members in good standing (fellow or student) as of the date that is fifteen (15) days before the respective election.

Section 6: Election Procedures. The Governance Commission shall determine the timing and procedures for all Academy elections, ensuring House elections take place at the annual meeting of the House of Delegates in accordance with the North Carolina Nonprofit Corporation Act and these Bylaws.

Section 7: 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 Officers (including the Speaker, who shall serve as the Vice President of the Academy) shall be prescribed in Article VI, Section 3.

Section 8: 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 9: 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 a 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. Eligible members, as described in Section 5 of this Article, shall elect a new President-elect 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.
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.** The Nominating Work Group will prepare a slate of candidates. Eligible members, as described in Section 5 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.

**ARTICLE XIV  ** **Bylaws Amendments.**

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

Section 2: A proposal for the amendment or repeal of existing Bylaws provisions or adoption of new Bylaws provisions shall be initiated by (a) the Board of Directors, (b) any commission or work group, (c) any Chapter, (d) any officially recognized specialty organization, (e) any caucus, (f) the Student Academy, or (g) the collective House Officers.

Section 3: Proposed amendments shall be in such form as the House Officers prescribe.

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

Section 5: Each proposed Bylaws amendment to be presented at the annual meeting of the House of Delegates shall be filed with the House Officers at least three (3) months prior to that meeting.

a. The Governance Commission will review submitted proposed bylaws amendments for governance-related gaps or conflicts. They may either recommend technical changes to the House Officers or submit confirming amendments. Any proposed Bylaws amendments resulting from this review shall be exempt from the three (3) month filing requirement, but shall be submitted to the House Officers no later than 45-days prior to the House of Delegates’ meeting in order to comply with the distribution deadline in Article VI, Section 4.

Section 6: Bylaws amendments to be considered for an electronic vote of the House of Delegates must be submitted at least 150 days prior to the annual meeting of the House of Delegates. Otherwise, the resolutions will be considered at the annual meeting of the House. Amendments to be considered electronically are subject to review by the Governance Commission as reflected in Section 5.a of this Article.

Section 7: Proposed Bylaws amendments that are not initiated by the Board of Directors will be presented to the Board in their final form. Any proposed Bylaws amendment may be considered and acted upon by the Board prior to the annual meeting or prior to an electronic vote of the House. Any Board vote on a proposed Bylaws amendment prior to the convening of the House, shall be reported to the delegates in advance of the meeting or electronic vote.
Section 8: Proposed amendments that come to the House of Delegates with the prior approval of the Board of Directors will become effective upon approval of the House by a two-thirds (2/3) vote of all delegates present and voting.

Section 9: If the House of Delegates approves a proposed amendment by a two-thirds (2/3) vote of all delegates present and voting, that was either not approved by the Board of Directors, or was amended by the House of Delegates, then the proposed amendment as passed by the House of Delegates, will be submitted to the Board of Directors for its action.
The purpose of parliamentary procedure is to conduct the orderly transaction of business efficiently and effectively through an orderly democratic process. Embodied in parliamentary procedure are the following fundamental principles:

1) All members have equal rights, privileges, and obligations.
2) The will of the majority always prevails.
3) The rights of the minority must always be observed.
4) Full and free discussion of every proposed resolution is an established right of the members.
5) Every member has the right to equal process to understand the resolution before them and the effect it will have if adopted.
6) All meetings must be characterized by civility, fairness, and good faith.

It is the responsibility of the Speaker to preside over the House of Delegates and to always govern in accordance with the above principles. The Speaker must recognize the right of the House to challenge and reverse any decision made by the Speaker with regard to execution of procedure and the interpretation of its decisions.

The Speaker, in recognizing the will of the House, must govern in a manner that lends credibility to the process of decision-making. The documents of authority which outline this governance are as follows (in order of precedence):

1. North Carolina non-profit law
2. AAPA’s Articles of Incorporation
3. AAPA’s Bylaws
4. Standing rules of AAPA’s House of Delegates

The Standing Rules of the House exist to refine its procedural processes to conform to the nature of the House and its operations. Standing Rules are adopted rules of procedure that add to or vary from the accepted parliamentary authority. These rules take precedence over The Standard Code of Parliamentary Procedure and serve as a guide to enhance the efficient operations of the House. These rules are always subject to refinement, modification, or suspension at the will of the House.

The following two types of non-policy documents are utilized to guide AAPA:

(1) Procedures: These documents outline the mechanisms and procedures to handle routine business transactions and day-to-day operations. Procedures are matters of form, process, method, and application of other policies.

(2) Rules: These are regulations that guide or prescribe everyday conduct. Each functional unit is responsible for establishing its own rules of procedures and conduct (i.e.: House Standing Rules, AAPA Board Manual, AAPA Staff Handbook, etc.).

The intention of the HOD is to allow for transparent communication utilizing a deliberative process regarding the policies of AAPA. The deliberative process requires open debate and consideration of information by all delegates following parliamentary procedures. In order to facilitate a deliberative process, HOD participants are expected to maintain decorum in accordance with the following:
• Communication in all formats should always be conducted in a respectful manner.

• Debate should be reserved for the meetings of the House so all delegates may hear and participate in that debate. The information considered during such debate informs the final decisions of the delegates.

• Requesting information from resolution authors is considered valid.
  o Delegates or reference committees can request clarification or further insight from authors regarding the intent or content of resolutions, but authors/sponsors should not present any unsolicited information.

• All promotional efforts, such as marketing, advertising, or campaigning regarding resolutions are outside the deliberative process of the HOD and are therefore prohibited.

Non-compliance with these principals interferes with the deliberative process and may require intervention by the House Officers.

SR-1200 POLICY MANUAL

SR-1205
Responsibility of the annual publication of AAPA’s Policy Manual shall remain solely with the House Officers, who shall, determine its organization, review it for policy conflicts, and classify all policies that have been adopted, amended, and expired. The House Officers shall have the authority to correct typographical, format, and/or grammatical errors if they do not alter the intent of the policy.

SR-1210
Terminal policy is defined as policy that either has a set period during which it is in effect or has no current or future policy value. The House of Delegates authorizes the House Officers to delete terminal policies, as they occur. The Speaker shall report on all actions taken on terminal policies in a subsequent Speaker’s Update.

SR-1215
Transitory and/or temporary measures are defined as those to be carried out before the next House meeting. These will not be included in the published AAPA Policy Manual. The Speaker shall report on all actions taken on transition and/or temporary measures in a subsequent Speaker’s Update.

SR-1220
The House of Delegates determines policy that establishes the collective values, philosophies, and principles of the PA profession.

There are two vehicles utilized to articulate AAPA policy.

(1) Policy Statement:
A policy statement is a relatively short, concise statement setting AAPA’s position on a particular topic and is reflective (supportive) of AAPA’s mission, vision, and values. Policy statements may also include philosophical decisions that may affect or recommend allocation of resources, activities, and relationships among the Board, House of Delegates, commissions, work groups, constituent organizations, and staff departments. A policy statement brought to the House for approval or review may be amended on the floor of the House.
(2) **Policy Paper:**
A policy paper presents a more in-depth examination of AAPA policy on a particular topic and includes current and relevant supporting information and data. It is distinguished from a policy statement by its supporting information citing current data from a variety of sources and may include a bibliography. A policy paper brought to the House for approval or review may be amended on the floor of the House.

When policy statements and policy papers are under consideration, they are termed “draft” and become policy only when the House of Delegates or Board of Directors, as appropriate, approves them.

SR-1225
Policies and policy papers adopted by the House shall expire five years after adoption unless revised, referred, or reaffirmed at a meeting of the HOD during the year of expiration.

**SR-1300 ANNUAL REPORTS**

SR-1305
AAPA’s President, President-elect, Secretary/Treasurer, CEO, and commissions, work groups, and task forces, as appropriate, may submit annual reports to the House of Delegates.

SR-1310
Annual reports to be included in the HOD meeting materials must be received by the HOD Staff Advisor by a date determined by the Speaker.

**SR-2000 HOUSE OF DELEGATES - GENERAL**

**SR-2100 Duties and Responsibilities**

SR-2105
The Members of the House of Delegates are considered fiduciaries of AAPA when they are exercising that authority granted to them in AAPA’s Articles of Incorporation and are subject to fiduciary duties with respect to that limited authority. Further, meetings of the House of Delegates must be treated as Director Meetings as the House of Delegates is acting to enact policies establishing the collective values, philosophies, and principles of the PA profession.

SR-2110
Without prejudice to the duties and responsibilities confirmed by statute, by the Articles of Incorporation, or by the Bylaws, AAPA’s House of Delegates shall be solely responsible for setting policies that establish the collective values, philosophies, and principles of the PA profession. The House of Delegates may: (a) make recommendations to the Board for granting charters to chapters, officially recognizing specialty organizations, and affiliating with special interest groups; (b) make recommendations to the Board for the establishment of AAPA commissions and work groups. In addition, the House of Delegates shall: (a) vote on amendments to the Bylaws; (b) establish such rules of procedure as may be necessary for carrying out the responsibilities of the House; and (c) establish such committees or task forces of the House of Delegates, as necessary, to fulfill its duties.

**SR-2200 Composition**

SR-2205
The voting membership of the House of Delegates shall consist of the delegates-at-large, an apportioned number of delegates elected by fellow members of chapters, one delegate elected by fellow members of
each officially recognized specialty organization and each affiliated caucus, and elected Student Academy delegates.

SR-2210
Each chapter shall be entitled to two (2) delegates. Additional delegates for the leadership year from July 1st to June 30th will be apportioned among the chapters according to the number of AAPA fellow members within the jurisdiction of each chapter as of January 31 of each year. When the number of AAPA fellow members within a chapter’s jurisdiction exceeds 220, it will be apportioned a third delegate. An additional delegate will be apportioned for each 300 additional members within a chapter’s jurisdiction thereafter. The Constituent Relations Work Group will recommend to the Board of Directors the definition of a chapter’s jurisdiction. For apportionment purposes, if a fellow member does not indicate their chapter designation, then their mailing address will determine their default chapter affiliation.

SR-2215
The Student Academy shall be entitled to one delegate for the leadership year from July 1st to June 30th for each 850 Student Academy members as of January 31 of each year.

SR-2220
The term of office for delegates to the House shall be July 1 through June 30. Each person can only hold one delegate seat per term.

SR-2225
One delegate from each represented body will be designated as chief delegate in a manner prescribed by that organization.

SR-2230
All eligible chapters, caucuses, and specialty organizations shall submit an official notification of delegates elected to the HOD Staff Advisor by July 1 of each year. The process for the identification of delegates shall be established by staff with the approval of the House Officers. Chapters, caucuses, and specialty organizations that fail to meet the July 1 deadline, will not be eligible to participate in meetings of the HOD until they come into compliance and are approved by the House Officers no later than 2 weeks prior to any meeting of the House.

SR-2235
A delegate must be an AAPA fellow member or student member in good standing.

SR-2240
If a constituent organization (CO) of AAPA has had its charter, recognition, or affiliation agreement revoked, the Credentialing Committee will remove that CO from the list of delegations eligible to participate in the HOD. The delegates elected by that CO will be notified that they will not be eligible to participate in any HOD business until their CO is brought into compliance with AAPA policy and their agreement is restored.

SR-2245
Current members of AAPA’s Board of Directors, current chairs (or their designee) of commissions, work groups, and task forces, Past Presidents of AAPA, and Past Speakers of the House of Delegates shall be advisory members of the House of Delegates. As such, they shall have the right to speak and debate during general sessions of the HOD.

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SR-2250
Official Observers are representatives from organizations with interests and goals consistent with those of AAPA, who desire a relationship with AAPA’s House of Delegates. The House grants official observer status by approval of a resolution for an organization to become an official observer. Official Observers are granted the privilege of the floor. At the discretion of the House Officers, official observers may receive some or all of the published materials of the House as deemed relevant to their interests.

SR-2255
The organizations currently granted Official Observer status in the House of Delegates are the Physician Assistant Education Association (PAEA), the National Commission on the Certification of Physician Assistants (NCCPA), and the Accreditation Review Commission on the Education for the Physician Assistant, Inc. (ARC-PA).

SR-2260
The House Officers may grant Provisional Official Observer status to organizations. Permanent Official Observer status must be ratified by the House.

SR-2265
Official Guests are the invited visitors of the House Officers or Board of Directors. They do not receive published House materials, nor do they automatically have the privilege of the floor. Official Guests must request the privilege of the floor for consideration by the Speaker.

SR-2270
No members of the media will be permitted to join/view the annual HOD meeting without the prior consent of the Speaker.

SR-2300 Meetings and Rules of Order

SR-2305
The House of Delegates shall have an annual meeting. Special meetings of the House of Delegates shall be called by the Speaker upon written request of twenty-five (25) percent or more of the delegates who are apportioned and eligible to vote. Special meetings of the House shall also be called by a two-thirds (2/3) affirmative vote of the Board of Directors or a majority affirmative vote of the House Officers.

SR-2310
The House may meet in an open meeting to which any AAPA member or officially recognized observer may be admitted. Other individuals may be admitted at the discretion of the Speaker. However, no one under 18 years of age will be admitted during any session of the House, formal or informal, except at the discretion of the Speaker of the House. Notice of meetings of the House of Delegates shall be given to each delegate at least 30 days before in-person meetings. By a majority vote of the delegates present and voting, an open meeting may be moved into a closed meeting. A closed meeting shall be restricted to fellow and student members of AAPA and to such persons as the delegates determine. By a two-thirds vote of the delegates present and voting, an open meeting may be moved into an executive meeting. An executive meeting shall be limited to the voting membership of the House.

SR-2315
A general session of the annual HOD meeting is defined as a session when the HOD is in session to conduct business. During a general session, the floor of the House is closed/sealed for voting by apportioned, seated delegates and/or for testimony by apportioned, seated delegates and other individuals authorized by the Speaker.
SR-2320
Unauthorized recording and/or live streaming of HOD proceedings is prohibited without prior permission of the Speaker.

SR-2325
Each delegate eligible to vote is entitled to one (1) vote. No proxy or absentee votes may be cast.

SR-2330
A majority of the total number of delegates who are apportioned and eligible to vote must be seated to establish a quorum at any meeting of the House of Delegates. Once a quorum has been established, a vote by a majority of the seated delegates shall constitute an action of the House. Any exception to action by a majority vote is specifically delineated in AAPA Bylaws or policy or in the American Institute of Parliamentarians Standard Code of Parliamentary Procedure.

SR-2335
Except as provided for in SR-3010 of these House of Delegates Standing Rules, only seated delegates may introduce business, make motions, or vote.

SR-2340
Debate on a motion and discussion on an issue shall include input from proponents and opponents. The Speaker may limit the length of time allotted for debate on a particular topic. A delegate who has not spoken is privileged over one who has already discussed the motion. Each speaker shall be limited to five minutes on initial presentation, and three minutes on any subsequent presentation. The Speaker may call on individuals to provide information as expert witnesses whose testimony shall be limited to the provision of information.

SR-2345
A motion to vote immediately must be presented formally. When attempting to end the debate, a delegate may not precede the motion to vote immediately with testimony.

SR-2350
A vote using an electronic polling platform shall be equivalent to a standing counted vote. It is not subject to division.

SR-2355
Roll call voting of the House of Delegates will be permitted after an appropriate motion, second, and passage by a three-fourths (3/4) vote of the delegates who are seated. The procedure for a roll call vote will be determined by the Speaker.

SR-2360
The Speaker may extend the privilege to speak to any AAPA member, national office staff member or other non-AAPA members.

SR-2365
Delegates will receive a copy of AAPA Conflict of Interest and Disclosure Policies and shall complete the disclosure form at the start of each leadership year, or prior to beginning service in the HOD if the appointment does not align with the leadership year. Delegates are responsible for updating their disclosure forms as soon as they are aware of any new potential conflict. At the start of each leadership year, the Credentialing Committee will receive a copy of AAPA’s Conflict of Interest and Disclosure Policies and instruction on implementation of the policy.
The Credentialing Committee, with the aid of governance staff, will evaluate the disclosure forms in accordance with AAPA’s Conflict of Interest and Disclosure Policies and determine whether a particular transaction, relationship or other arrangement may constitute an actual, potential, or perceived conflict of interest, and if so, how to resolve the matter.

Prior to any convening of the HOD, the Credentialing Committee will provide a written report to the Speaker. If there is a delegate who has disclosed a relationship requiring mitigation, the report should contain the name of the delegate(s), the relationship disclosed and the mitigating action. The Speaker may choose to amend the mitigating action. Supplemental reports will be provided as necessary once the HOD meeting convenes.

The Speaker will provide a compliance report to the Board of Directors’ Internal Affairs Committee that will include confirmation that all delegates have submitted a disclosure form and a copy of the Credentialing Committee report, including any Speaker amendments.

SR-2370
Persons who have a potential conflict of interest in the matter under consideration must publicly disclose that information before initially testifying at any hearing or meeting of the House.

A conflict of interest is defined as a financial, commercial, or other interest in the matter under consideration which may in fact, or appearance, call into question the ability of the delegate to act in the best interest of AAPA.

SR-2375
Any persons in attendance at an official meeting of the House of Delegates may be removed from the meeting if they are in violation of AAPA’s HOD Standing Rules. The Speaker of the House shall work with the Sergeant-at-Arms to inform the person of the violation. If the violation is not remediated, they will be subject to removal. Removal of a voting member of the HOD requires a motion to the body with a two-thirds (2/3) majority vote of the delegates present and voting in order to pass.

SR-2380
The Standing Rules of the House of Delegates may be amended or suspended by two-thirds (2/3) vote of seated delegates.

SR-2385
In the absence of any provisions to the contrary in the Bylaws, or Standing Rules, all meetings of the House of Delegates shall be governed by the parliamentary rules and usages contained in the current edition of The American Institute of Parliamentarians Standard Code of Parliamentary Procedure.

SR-2400 Order of Business

SR-2405
The Speaker shall determine the general order of business and agenda at all meetings of the House of Delegates.

SR-2500 Officers

SR-2505
The elected officers of the House of Delegates are: Speaker of the House/Vice President of AAPA; First Vice Speaker/Director; and Second Vice Speaker/Director.
SR-2510
Each House Officer is an HOD delegate-at-large during their term(s) as a House Officer. In addition, they will serve as an HOD delegate-at-large for one additional year as an immediate past House Officer. The delegates-at-large shall be accorded all the rights and privileges of elected delegates.

SR-2515
The Speaker presides at all HOD meetings. The First Vice Speaker assumes the duties of the Speaker in the event of the temporary absence of the Speaker. The Second Vice Speaker assumes the duties of the Speaker in the event of the temporary absence of the Speaker and the First Vice Speaker. The Second Vice Speaker keeps the records of all meetings of the House.

SR-2520
The Speaker shall report all activities and actions of the House of Delegates to the Board of Directors at its next meeting.

SR-2600 Appointed House Positions

SR-2605
The Speaker shall appoint a parliamentarian. The parliamentarian answers any questions about parliamentary procedure that arise during House proceedings and advises the presiding officer. The parliamentarian may assist delegates with procedural questions.

SR-2610
The Speaker shall appoint a Sergeant-at-Arms. The Sergeant-at-Arms preserves order during the House of Delegates meeting, maintains security of the floor, and provides support to the House Officers and delegates. During in-person meetings, the Sergeant-at-Arms, in cooperation with the Chief Teller, supervises the tellers in controlling access to the floor. The Sergeant-at-Arms is a member of the Standing Rules Committee and chairs the Credentialing Committee.

SR-2700 House of Delegates Committees

SR-2705
The Standing Rules Committee shall be appointed annually by the House Officers. Their responsibility is to review the Standing Rules and make recommendations for revision as appropriate to the House of Delegates. The Standing Rules Committee shall be composed of the Sergeant-at-Arms and at least two volunteers with House experience. The Second Vice Speaker shall serve as advisor to the Standing Rules Committee.

SR-2710
The House Elections Committee will be responsible for implementing all elections in the House. The committee will consist of three members: the chair of the Governance Commission (or their designee), one member from the House appointed by the Speaker, and the Chief Teller (or their designee). The Governance Commission must approve the procedures for election of House Officers and the Nominating Work Group.

SR-2715
The Credentialing Committee will be responsible for credentialing all delegates under the direction of the First Vice Speaker.
The Credentialing Committee shall be composed of the following: the Sergeant-at-Arms, who shall act as the chair; the staff advisor to the House of Delegates; and at least 3 other fellow or student members appointed by the House Officers.

The duties of the Credentialing Committee shall include:
1. Confirming that each CO is in compliance with officers being AAPA Fellow members.
2. Confirming that each delegate is a current AAPA Fellow or Student member.
3. Notifying delegations or delegates when they are not in compliance and providing information to bring them into compliance.
4. Staffing the credentialing desk during an in-person HOD annual meeting. The committee will be responsible for collecting any delegate change forms which must be signed by the president, secretary, secretary/treasurer, or chief delegate.
5. The committee will verify the names of credentialed delegates and distribute a delegate ribbon and any other materials needed for the meeting.
6. Collecting a disclosure form from each delegate. The committee will review the disclosure forms and notify the Speaker of any potential conflicts of interest.

SR-2800 Conference Committees

SR-2805 The Resolutions Review Committee shall be convened as necessary to review late resolutions. The Resolutions Review Committee will consist of the reference committee chairs and at least one House Officer.

SR-2810 The Tellers Committee assists the Sergeant-at-Arms in facilitating the activities of the House of Delegates during in-person meetings. The Chief Teller is appointed by the Speaker of the House. Duties include: 1) securing the House floor; 2) monitoring the activity on the House floor; 3) distributing materials in the House; 4) facilitating votes on the House floor; 5) conducting roll call votes; 6) assisting those not seated in the House to request the privilege to speak.

SR-2900 Elections

SR-2905 The procedures for the election of House Officers shall be the responsibility of the Governance Commission. One member of the Governance Commission shall serve on the House Elections Committee to oversee House elections.

SR-2910 At each annual meeting of the House of Delegates, there shall be elected from the House of Delegates a Speaker of the House/Vice President of AAPA, a First Vice Speaker of the House, and a Second Vice Speaker of the House. Each shall be elected by a majority of votes cast. No absentee or proxy vote shall be cast.

SR-2915 In the event that no majority is obtained by a House office candidate, a run-off will be conducted between the two candidates receiving the highest plurality of votes. Write-in candidates are not permitted.

SR-2920 Any candidate for a House Officer position must be a credentialed delegate and must meet all criteria outlined in Article XIII, Section 3 in order to be eligible. While not required, those interested in being a
candidate for House Officers are encouraged to seek experience in the House, such as serving on a reference committee or other HOD committee.

SR-2925
The names of candidates for the offices of Speaker of the House/Vice President of AAPA, First Vice Speaker, and Second Vice Speaker shall be read before the House of Delegates. The voting membership of the House of Delegates shall consist of delegates present at the time of elections who are apportioned and eligible to vote.

SR-2930
The House Officers’ terms shall begin July 1, or 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 or vote during which they were elected.

SR-2935
In the event of a vacancy in the office of Speaker of the House/Vice President of AAPA, the First Vice Speaker shall assume both the duties and the office of the Speaker. In the event of a vacancy in the office of First Vice Speaker, the Second Vice Speaker shall assume the duties and the office of First Vice Speaker. A vacancy in the office of Second Vice Speaker shall be filled by an electronic vote of eligible delegates who will elect from a list of candidates prepared by the Nominating Work Group. An electronic vote to fill a vacancy in the office of Second Vice Speaker will only be called if the remaining term is greater than three (3) months prior to the Annual Meeting of the HOD, or if there is an additional vacancy in the office of Speaker or First Vice Speaker.

1. Receiving a majority of the votes cast will elect a candidate for House office. In the event that no majority is obtained, a revote will be taken between the top two (2) candidates.
2. The term of office will begin immediately following the special election.

SR-2940
Five (5) members of the seven (7) member Nominating Work Group shall be elected by the House of Delegates at the Annual Meeting. The Board of Directors shall appoint two members. Nominations for this work group shall be made either at the time of call for nominations from the Governance Commission or from the floor of the House of Delegates. Members of the Nominating Work Group shall be fellow members of AAPA and shall meet such eligibility requirements as stated in the Bylaws (Article XI, Section 3). Elections for members of the Nominating Work Group shall be held at the time of election of House Officers. The term of office for elected members of the Nominating Work Group shall be a two (2) year staggered term. Members of the Nominating Work Group shall be elected by a plurality vote. The House of Delegates shall determine procedures for the election of non-Board appointed members to the Nominating Work Group Bylaws Art XI, Sect 2 & 3.

SR-2945
If a complete, unopposed slate of candidates is presented for the election of House Officers or Nominating Work Group, a simple majority of delegates seated shall be required to immediately elect the unopposed slate(s) of candidates.

SR-3000 Resolutions

SR-3005
Resolutions are proposed to define or amend policy establishing the collective values, philosophies, and principles of the PA Profession. Resolutions may further be defined as proclamations of importance to the profession such as expressions of congratulations, commendation, or condolence.

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SR-3010
Non-Bylaws resolutions may be submitted by: (a) the Board of Directors, (b) any commission, work group, or task force, (c) any chapter, (d) officially recognized specialty organizations, (e) any caucus, (f) the Student Academy, or (g) the collective House Officers. Prior to submission, resolutions should be reviewed and approved by the submitting organization’s Board and/or officers.

A proposal for the amendment or repeal of Bylaws or adoption of new Bylaws may be submitted by (a) the Board of Directors, (b) any commission or work group, (c) any chapter, (d) officially recognized specialty organizations, (e) any caucus, (f) the Student Academy, or (g) the collective House Officers.

Constituent Organizations that are not in compliance with AAPA Bylaws and policy will not be eligible to submit resolutions for consideration.

SR-3015
Resolution co-sponsorship must be indicated no later than the resolution submission deadline. Co-sponsorship should be approved by each respective constituent organization’s board of directors.

SR-3020
The House Officers shall create guidelines for resolution submission. Resolutions must be submitted in the approved format and completed in their entirety. The House Officers reserve the right to return incomplete resolution submissions to the author or rule them out of order.

SR-3025
Resolutions submitted for consideration by the House shall be numbered and assigned to a reference committee by the Speaker. Until the resolution is accepted by the House of Delegates, it may be withdrawn by the sponsor. If there are no objections by delegates or the House Officers to considering the resolutions, they are accepted. Once accepted, they will be placed on the consent agenda or referred to the appropriate reference committee. Objections to accepting a resolution can be based only on whether the resolution is in order and not on the content.

Resolutions brought to the House by a body receiving a referral from a previous House cannot be objected to or withdrawn.

After acceptance of the resolutions, they become the property of the House of Delegates and must be acted upon by the body.

SR-3030
The general consent agenda contains policies from the five-year review process under the jurisdiction of the House of Delegates, as well as any properly submitted resolutions. The Speaker has the ability to remove any resolution(s) from the consent agenda in advance of the meeting if they believe the resolution should be discussed in a reference committee hearing. Any objection from the floor to the placement of an item on the general consent agenda will result in the item being referred to a reference committee.

SR-3035
The House Officers may add relevant information during their review of resolutions, such as additional financial impact or related AAPA policies, to resolution submissions that may provide further insight to the delegates for consideration prior to the distribution of resolutions to the delegates.

SR-3040
Resolutions calling for changes in the Bylaws must comply with Bylaws Article XIV. Amendments to the Bylaws to be considered at the annual HOD meeting must be received in the national office at least three
(3) months prior to the convening of the House of Delegates. Amendments to the Bylaws to be considered for virtual vote must be received 150 days or greater prior to the convening of the House of Delegates. Other resolutions must be received in the national office at a time to be determined and published by the House Officers.

SR-3045
Late resolutions shall be defined as those resolutions submitted after the deadline established by the House Officers, but prior to the convening of the House. Sponsors who wish to submit a late resolution must notify the Speaker of their desire to do so in writing and include the resolution. This notification must occur prior to the opening session. The Resolutions Review Committee will review each late resolution and recommend to the House whether or not it believes each late resolution should be accepted for consideration. If there is no opposition to the recommendation from a seated delegate, the recommendation stands. If the recommendation is to consider the resolution, it will be assigned to a reference committee. If there is any objection to the recommendation from the floor, a two-thirds (⅔) vote of the delegates present and voting is required to accept the late resolution for consideration.

Any resolution to amend the Bylaws must comply with Article XIV of the Bylaws, as such, bylaws resolutions are not eligible for submission as a late resolution.

SR-3050
Emergency resolutions shall be defined as those resolutions submitted after the annual HOD meeting is called to order. Emergency resolutions are to be submitted under “additional new business” and distributed to the delegates for review. Emergency resolutions require an 80 percent vote of delegates present and voting for consideration.

Any resolution to amend the Bylaws must comply with Article XIV of the Bylaws, as such, bylaws resolutions are not eligible for submission as an emergency resolution.

SR-3055
A resolution may be referred for further study. A resolution referred for study will become the property of the receiving body. That body will report back at the next House of Delegates meeting. The report shall contain one of the following actions:

- A recommendation to accept or reject, or
- An amended or substitution resolution, as long as the resolution proposed deals substantially with the intent of the original resolution, or
- A progress report if the work of the body requires additional study.

Resolutions brought back to the House of Delegates as a result of a referral will be considered “new business”, and the receiving body will be considered the sponsor.

SR-3060
The chairpersons (or designee(s)) of all commissions, work groups, and task forces of AAPA shall have the privilege to make the following motions regarding any resolution their respective commission, work group, or task force has sponsored:

- Amend
- Postpone definitely (to a specific time)
- Table (at the end of the meeting, the resolution dies without a direct vote)
- Refer
SR-3065
Policy resolutions adopted by the House of Delegates that are expressions of philosophy shall become official AAPA policy.

SR-3070
Resolutions of Condolence
Resolutions of condolence should be submitted no later than 10 days prior to the convening of the House. Resolutions of condolence submitted prior to the House will be included with the Speaker’s report. Once the House convenes, all resolutions of condolence must be given to the Sergeant-at-Arms prior to the final general session. Resolutions of condolence shall automatically be accepted by the House without further comment, debate or vote. At the end of the House, the names will be read, and they will be honored with a moment of silence. The House Officers will ensure that AAPA maintains an appropriate historical archive of these resolutions. Resolutions of condolence will not be considered by the House as emergency resolutions. Resolutions submitted after the deadline are at the discretion of the Speaker. A full reading of any resolution will be at the discretion of the Speaker.

SR-3075
Special Resolutions
Special resolutions of congratulations, recognition, or other special resolutions deemed appropriate by the House Officers shall be introduced as a part of the Speaker’s report. Upon inclusion in the Speaker’s report, these resolutions shall automatically be accepted by the House without further comment, debate, or vote. The House Officers will ensure that AAPA maintains an appropriate historical archive of these resolutions. A full reading of any resolution will be at the discretion of the Speaker.

SR-3080
Delegates are encouraged to review, discuss, and evaluate each resolution before the opening of AAPA’s House of Delegates.

SR-3100 House Awards

SR-3105
The House of Delegates may present an award for outstanding service annually to an individual for their contributions to the House of Delegates, including, but not limited to, years of service, level of involvement, and commitment to the House. The House Awards Committee shall be comprised of the House Officers, Sergeant-at-Arms and Chief Teller. The committee shall determine the final criteria, award, and recipient.

SR-3200 Reference Committees

SR-3205
Reference committees may be used to conduct hearings during meetings of the House of Delegates for the purpose of receiving testimony on resolutions that have been accepted for consideration by the House.

SR-3210
At the conclusion of reference committee hearings each committee shall write and submit to the House a report containing a summary of the testimony, any reference committee research on each resolution, and a recommendation for House action on each resolution.
SR-3215
Any motion offered by a reference committee does not require a second.

SR-3220
Reference committee chairs and members are appointed by the House Officers. Each reference committee shall be composed of at least five AAPA fellow/student members. The chair of each reference committee shall be a credentialed delegate, but reference committee members are not required to be delegates.

SR-3225
The House Officers shall publish reference committee guidelines which outline the processes and procedures for conducting their work.

SR-3230
Reference committee reports will proceed as follows:
- All recommendations of the reference committee will be placed on the reference committee consent agenda.
- The Speaker will entertain requests to extract individual resolutions from the reference committee consent agenda. A resolution will be extracted upon the request of any seated delegate.
- The House will vote immediately to accept the reference committee consent agenda once all requests for extraction have been heard.
- A vote to accept the reference committee consent agenda will be a vote to accept the recommendations of the reference committee on each resolution that remained on the consent agenda.
- Extracted resolutions will then be reported out by the reference committee, considered and voted upon individually.
- Amendments recommended in reference committee reports will be considered first order amendments and will not require a second.
- When a resolution with a proposed reference committee amendment is extracted, second order amendments will not be allowed.

SR-4000 RULES SPECIFIC TO IN-PERSON MEETINGS

SR-4100 In-Person Meeting General

SR-4105
During general sessions of the HOD meeting, the Sergeant-at-Arms and tellers shall assist persons not seated in the House of Delegates in requesting the privilege to speak and confirm the membership status or conference registration of those individuals not wearing a badge.

SR-4110
The Chief Teller and the Sergeant-at-Arms will coordinate the activities of tellers during the House of Delegates. All materials and other handouts must be approved by the Speaker or their designee.

SR-4115
All communication devices shall be placed on mute. No cell phone conversations or video conferencing will be conducted in the HOD meeting room.
SR-5000  ELECTRONIC VOTE SEPARATE FROM A MEETING/VIRTUAL MEETING
GENERAL RULES

SR-5005
Any action taken by an electronic vote separate from a meeting or during a virtual meeting of the House shall have the same authority as any action taken during an in-person meeting.

SR-5010
Virtual meetings and/or electronic votes separate from a meeting of the House of Delegates will be permitted for any House business subject to the requirements of the North Carolina Nonprofit Corporation Act. Virtual meetings and/or electronic votes separate from a meeting will be called for by the Speaker of the House when directed by (1) a majority of the House Officers; 2) a two-thirds affirmative vote of the Board of Directors; or 3) a call from twenty-five (25) percent of the delegates who are apportioned and eligible to vote.

SR-5015
The House Officers and AAPA staff shall determine the procedures for voting during virtual meetings or an electronic vote separate from a meeting of the House, subject to the requirements of the North Carolina Nonprofit Corporation Act.

SR-5100  Rules Specific to an Electronic Vote Occurring Separate from a HOD Meeting

SR-5105
Notice of House of Delegates electronic votes separate from a meeting of the House shall be given to each delegate at least 5 days in advance of the scheduled vote.

SR-5110
If twenty-five (25) percent of delegates eligible to vote object to an electronic vote separate from a meeting of the House on a particular issue, it will be deferred to a meeting of the House of Delegates.

SR-5115
The options for an electronic vote will be yes or no.

SR-5120
1. For an electronic vote, receiving responses from a majority of delegates who are apportioned eligible to vote shall constitute a quorum.
2. A resolution requiring an electronic vote shall be decided by a majority of the votes cast. Except for a resolution to amend the Bylaws, which requires a 2/3 vote to pass.

SR-5125
The procedure for voting will be outlined by the House Officers.

SR-5130
Any delegate submissions or changes to the order of delegates must be submitted at least 48 hours prior to the time of the scheduled electronic vote.
SR-5200  Rules Specific to a Virtual Meeting

SR-5205  
A seated delegate during a virtual meeting is defined as a delegate fulfilling the criteria outlined in SR-2205 and must be an apportioned delegate designated in the virtual voting platform during a specified general session of the HOD meeting.

SR-5210  
Identification of the seated, apportioned delegates for general sessions of the HOD meeting must be completed by the date stated in the pre-published meeting materials.

SR-5215  
For each general session of the HOD meeting, eligible delegates will be provided access to one of their delegation’s apportioned seats utilizing the designated virtual voting platform.

SR-5220  
Delegates must complete the credentialing process, including submission of a Conflict of Interest Form by the date determined by the Speaker.

SR-5225  
The House Officers and AAPA staff will communicate the process for accessing the virtual voting platform at least 30 days prior to the virtual meeting.

SR-5230  
The presence of a quorum shall be established by the Sergeant-at-Arms according to utilizing the number of verified, apportioned delegates present in the virtual voting platform.

SR-5235  
The House Officers will determine and communicate, through the pre-published meeting materials, the process for assigning the privilege of the floor.

SR-5240  
The process for interrupting a speaker will be determined and communicated by the House Officers. This process will be communicated through the pre-published meeting materials. Interruption of speakers will only be allowed according to the rules in our parliamentary authority.

SR-5245  
Each member is responsible for their respective audio and internet connections during a virtual meeting. No action shall be invalidated on the grounds that the loss of, or poor quality of, a member’s individual connection prevented/impeded their participation during the meeting.
HA-2000.00  ACADEMY/ORGANIZATION

HA-2100.0  HOUSE ACADEMY

HA-2100.1.0  Educational Philosophy

HA-2100.1.1
AAPA shall provide, support, and promote educational policies and programs that target justice, equity, diversity and inclusion eliminating health disparities.
[Adopted 2022]

HA-2100.1.2
The annual conference provides quality, cost-effective continuing medical education, a forum for professional and social interaction, and a setting for activities of the House of Delegates and governance organizations of AAPA.

HA-2100.2.0  Leadership

HA-2100.2.1
The House of Delegates recommends AAPA’s Board of Directors provide in-person and virtual opportunities for PA volunteer leaders to conduct business successfully on behalf of the profession.
[Adopted 2010, reaffirmed 2015, amended 2021]

BA-2200.00  ACADEMY/ORGANIZATION – DEFINITION

BA-2200.1
AAPA’s definition for racial and ethnic minorities shall be persons who are Black or African American, Hispanic or Latinx, Asian, Native Hawaiian or other Pacific Islander, Native American or First Nation, or Alaska Native, or two or more races.

BA-2300.00  CONSTITUENT ORGANIZATIONS

BA-2300.1.0  Constituent Organizations, General

BA-2300.1.1
AAPA defines the following positions as officers of a constituent organization (CO): President, President-elect, Vice President, Secretary and Treasurer, and/or Secretary-Treasurer. This policy does not require any CO to have a particular office. All officers of a chapter, recognized specialty organization, or caucus are required to be and remain fellow members or student members of AAPA in good standing for the duration of their term in office. Constituent organizations are encouraged to involve PA students in their leadership activities and encouraged to confer full voting privileges upon student board members in their bylaws.
[Adopted 2012, amended 2016, 2021]

BA-2300.1.2
The time when AAPA constituent organization (CO) officers may take office may be either January or July 1. However, COs are encouraged to have a standard term of office for their elected officers beginning July 1 and continuing through June 30. The date shall be determined by the CO and reflected in the chartering agreement.
AAPA believes that all constituent organizations (COs) should adopt a code of ethics. In an effort to maintain one standard of ethical behavior for the profession, COs are strongly advised to utilize the *Guidelines for Ethical Conduct for the PA Profession* (paper on page 194).

All AAPA constituent organizations shall have a diversity contact or committee.

AAPA assists constituent organizations in maintaining active status.

Constituent organizations (COs) may not deny any form of membership to a fellow member of AAPA unless the individual’s fellow membership has been revoked for reason of an ethical or judicial nature by AAPA or by a CO through a process consistent with AAPA policies.

AAPA members who belong to more than one chapter may vote on AAPA issues in only one chapter.

A chapter of AAPA is an independent chartered PA organization that abides by the terms of the charter agreement.

The chapter retains the right to pursue individual goals and initiatives without interference from AAPA, provided that the chapter is consistent with the terms of the charter agreement.

All fellow members of a chapter must be fellow members of AAPA. Chapters may amend their bylaws to create alternative membership categories, which may include chapter members who elect not to join AAPA or are ineligible for AAPA fellow membership. Non-fellow members of chapters may be active in chapter affairs but may not participate in issues relating to AAPA, such as voting for delegates, submitting resolutions, or representing the chapter in AAPA’s House of Delegates.

Each chapter in a state, the District of Columbia or a U.S. territory should provide at least one seat to a student member on their Board of Directors. AAPA encourages these constituent organizations (COs) to
formally confer full voting privileges in their bylaws to these student board members. The location of the school should not be the sole determinant, due to the availability of online and distance learning PA programs.


BA-2300.4.0 Chartering Guidelines

BA-2300.4.1 The Board of Directors has the sole authority to charter a chapter, as well as revoke the charter of a chapter. The Board of Directors shall take into consideration any recommendations of the House of Delegates when acting on the charter of an existing chapter. There shall be only one chartered chapter per state, the District of Columbia, each U.S. territory, and each of the federal services.

Chapter applications shall be provided to the Constituent Relations Work Group (CRWG) for review. The CRWG may make a recommendation to the Board of Directors. If the chapter’s application is approved by the Board of Directors, a charter will be issued to the chapter.

A chartered chapter shall:
- Maintain a minimum of five (5) fellow members
- Sign an AAPA charter agreement
- Abide by the terms of the charter agreement

Chartered chapters meeting the requirements set by this policy may be represented in the House of Delegates in accordance with AAPA Bylaws.

Chartered chapters that fail to abide by the terms of the chapter agreement may have their charter referred to the CRWG for review. The CRWG may recommend to the Board of Directors revocation of the charter until the chapter meets the terms of the agreement. Delegates from a chapter with a revoked charter will not be seated in the House of Delegates.


BA-2300.5.0 Specialty Organizations

BA-2300.5.1 An officially recognized specialty organization shall be defined as a group of PAs that joins together in an association that represents a practice specialty and that meets the criteria for recognition. Specialty organizations recognized by AAPA must abide by the terms of its AAPA recognition agreement.

Specialty organizations provide valuable information and insight about their specialty to AAPA membership and leadership. Specialty organizations are an integral part of the complex framework that assures AAPA the maximum amount of knowledge and understanding of all issues involving PAs in that specialty. Specialty organizations strengthen the PA profession through interactions with their medical and professional counterparts. These relationships allow specialty organizations to partner with AAPA to effectively address challenges such as reimbursement, clinical practice, and regulation.


BA-2300.5.2 A specialty organization may apply for recognition by AAPA. The following are AAPA recognized specialties: 1) those holding the name of a board listed by the American Board of Medical Specialties (ABMS); 2) those specialties under the boards of internal medicine, surgery, and psychiatry named as eligible for general or subspecialty certificates; and 3) those specialties under the Board of Preventive
Medicine named as eligible for general certificates. Only one organization per ABMS specialty or subspecialty as designated above will be recognized.

BA-2300.5.3
The Board of Directors has the sole authority to recognize specialty organizations, as well as to revoke recognition of a specialty organization. The Board of Directors shall take into consideration any recommendation from the House of Delegates when acting on the recognition of an existing specialty organization.

Specialty organization applications shall be provided to the Constituent Relations Work Group (CRWG) for review. The CRWG may make a recommendation to the Board of Directors. If the specialty organization is approved by the Board of Directors, a recognition agreement will be issued to the specialty organization.

A recognized specialty organization shall:
- Maintain a minimum of 5 members
- Sign an AAPA recognition agreement
- Abide by the terms of the recognition agreement
- Meet requirements as outlined in BA-2300.5.2

Recognized specialty organizations meeting the requirements set by this policy may be represented in the House of Delegates in accordance with AAPA Bylaws.

Recognized specialty organizations that fail to abide by the terms of the recognition agreement may have their recognition referred to CRWG for review. The CRWG may recommend to the Board of Directors revocation of the recognition until the specialty organization meets the agreement’s terms. Delegates for specialty organizations that have had their recognition revoked will not be seated in the House of Delegates.

BA-2300.5.4
Specialty organization members are encouraged to be AAPA fellow members. Specialty organization may have alternative membership categories, which may include members who elect not to join AAPA or are ineligible for AAPA fellow membership.

Non-fellow members of specialty organization may be active in specialty organization affairs, but may not participate in issues relating to AAPA such as voting for AAPA delegates, submitting resolutions, or representing the specialty organization in AAPA’s governance structure.

BA-2300.5.10
Constituent organizations with a revoked recognition agreement will be ineligible to receive AAPA staff resources or financial support with the exception of assistance that would help the CO in question understand the nature of their non-compliance and the steps they can take to become compliant with AAPA policy.
[Adopted 2016, amended 2021]
BA-2300.5.11
The specialty organization retains the right to pursue individual goals and initiatives without interference from AAPA, provided that they are consistent with the terms of the recognition agreement.
[Adopted 2016, reaffirmed 2021]

BA-2300.6.0  Caucuses

BA-2300.6.1
A caucus is defined as a group of 50 or more AAPA fellow members who share a common concern, interest, or goal in the delivery of and access to healthcare. A caucus of AAPA is an independent affiliated PA organization that abides by the terms of the affiliation agreement.

BA-2300.6.2
The Board of Directors has the sole authority to affiliate with, as well as to revoke affiliation with, a caucus. The Board of Directors shall take into consideration any recommendations of the House of Delegates when acting on the affiliation of an existing caucus.

Caucus applications will be reviewed by the Constituent Relations Work Group (CRWG). The CRWG may make a recommendation to the Board of Directors. If approved by the Board of Directors, an affiliation agreement will be issued to the caucus.

An affiliated caucus shall:
- Maintain a minimum of 50 AAPA fellow members;
- Sign an AAPA affiliation agreement;
- Abide by the terms of the affiliation agreement;

Caucuses meeting the requirements set by this policy may be represented in the House of Delegates in accordance with AAPA Bylaws.

Caucuses that fail to abide by the terms of the affiliation agreement may have their affiliation reviewed by the CRWG. The CRWG may recommend to the Board of Directors revocation of the affiliation until the caucus meets the agreement’s terms. Delegates from caucuses which have had their affiliation revoked will not be seated in the House of Delegates.

BA-2300.6.4
A caucus may have alternative membership categories that may include members who elect not to join AAPA or are ineligible for AAPA membership. Caucus members who are not AAPA members may be active in caucus affairs, but may not participate in issues relating to AAPA, such as voting for AAPA delegates, submitting resolutions, or representing the caucus in AAPA’s governance structure.

BA-2300.6.13
A caucus retains the right to pursue individual goals and initiatives without interference from AAPA, provided that they are consistent with the terms of the affiliation agreement.
[Adopted 2016, reaffirmed 2021]
BA-2300.7.0 Special Interest Groups

BA-2300.7.1 Special interest groups are defined as a group of AAPA members who share a common concern, interest, or goal and desire to meet informally. A special interest group of AAPA is an independent affiliated PA group that abides by AAPA policy and the terms of the affiliation agreement. The Board of Directors has the sole authority to affiliate, or revoke affiliation with special interest groups. The Board of Directors shall take into consideration any recommendations of the House of Delegates when acting on the affiliation of an existing special interest group.

Special interest group applications will be reviewed by the Constituent Relations Work Group (CRWG). The CRWG may make a recommendation to the Board of Directors. If approved by the Board of Directors an affiliation agreement will be issued to the special interest group.

An affiliated special interest group shall:
- Maintain a minimum of five (5) AAPA fellow members as supporters
- Sign an AAPA affiliation agreement
- Abide by the terms of the affiliation agreement

Special interest groups do not have privileges in the House of Delegates.

Special interest groups that fail to abide by the terms of the affiliation agreement may have their affiliation reviewed by the CRWG. The CRWG may recommend to the Board of Directors revocation of the affiliation until the special interest group meets the agreement’s terms.


BA-2300.7.2 AAPA special interest groups are encouraged to involve PA students in their leadership activities.


BA-2300.7.3 A special interest group retains the right to pursue individual goals and initiatives without interference from AAPA, provided that they are consistent with the terms of the affiliation agreement.

[Adopted 2016, reaffirmed 2021]

BA-2400.00 ACADEMY/ORGANIZATION – GOVERNANCE

BA-2400.1.0 General

BA-2400.1.1 AAPA business is to be conducted by AAPA members.


BA-2400.1.2 The Board of Directors has sole authority for policies regarding the management of the organization, including, but not limited to, management of the organization’s property, business, financial affairs, and judicial affairs. It is responsible for setting the strategic direction of the organization.

[Adopted 2017, reaffirmed 2022]
BA-2400.2.0  Student Academy

BA-2400.2.1  In accordance with AAPA Bylaws (Article V, Section III), AAPA monitors the Student Academy’s adherence to AAPA’s Bylaws and policies. The Student Academy will submit a revised copy of its governing documents, within thirty (30) days of each revision, to AAPA’s Governance Commission for review.


BA-2400.2.2.1  The student delegation to the House of Delegates represents PA students and is the appropriate group for students to submit policy statements and policy papers relating to the collective values, philosophies, and principles of the PA profession.


BA-2400.2.2.2  Student Academy members are represented and provide input to AAPA through the Student Academy Board of Directors, student delegation to the House of Delegates, the Student Director of AAPA’s Board of Directors, and student member volunteers serving on AAPA commissions, work groups and task forces.


BA-2400.3.0  Commissions, Work Groups, and Task Forces

BA-2400.3.1.0  Commission

A commission is a group that carries out the volunteer work of AAPA. Each commission is given unique annual charges rooted in AAPA’s policy and business priorities and initiatives.

Each commission has a chair and an even number of members, allowing for an overall odd number of members to facilitate majority voting. Each commission should include at least three (3) AAPA members with expertise and experience in the subject matter, as well as at least one BOD member and an AAPA staff member. Outside experts may be appointed as members if additional expertise is required.

All commission members who are PAs must be members of AAPA and members of a constituent organization.

In addition to overseeing the responsibilities of the commission, commission chairs oversee the activities of work groups and task forces that exist beneath the umbrellas of their respective commissions.


BA-2400.3.2.0  Work Group of a Commission

A work group is a leadership body existing beneath a commission, that has a technical role related to achieving the charges of that commission.

Each work group has a chair and an even number of members, allowing for an overall odd number of members to facilitate majority voting. A work group has a designated staff advisor to support the group’s work. A work group chair reports to the chair of the respective commission under which it was established.

All work group members who are PAs shall be members of AAPA and a constituent organization.

BA-2400.3.3.0 Task Force of a Commission or Work Group
A task force is a temporary group created on an as needed basis that exists beneath a commission or work group. Its life span is based on the charges of the group.

A task force addresses a specific issue related to the charges of that commission or work group that is too time or labor intensive to be addressed as part of normal commission or work group responsibilities.

A task force has a chair and an even number of members, allowing for an overall odd number of members to facilitate majority voting.

A task force chair reports to the chair of the respective commission or work group under which it was established.
[Adopted 2010, reaffirmed 2016, amended 2015, 2021]

BA-2400.3.5
The appointment of members of AAPA commissions and work groups shall take into consideration the multifaceted concept of diversity including but not limited to sexual, financial, racial, ethnic, cultural, religious, age and one’s abilities.

BA-2400.4.0 Commissions and Work Groups—Charges

BA-2400.4.1 Commission on Research and Strategic Initiatives
The commission will:

• Support building the profession’s research capabilities by serving as advisors to AAPA in establishing research priorities to guide AAPA’s Research Grant program, AAPA-PAEA Research Fellowship applicants, and research at AAPA 2021.

• Identify and monitor select journals for new research related to Optimal Team Practice, develop article summaries with key insights and potential implications, and share with AAPA staff for inclusion in the research bibliography to support advocacy efforts.

• Identify and evaluate external data sets for potential acquisition by AAPA.

• Collect informal qualitative feedback from PAs in administrative and clinical leadership positions to better understand their pathway into leadership as well as barriers and supports they encountered to enhance AAPA’s efforts to increase the opportunities for PAs in administrative and clinical leadership.

• Support AAPA Research and the AAPA Operating Plan by providing ad hoc feedback on survey development, refining research questions, and evaluating external requests for research support as required.

• Review AAPA policies assigned by the House Officers, to include but not limited to Five-Year Policy Review, and provide recommended action for consideration by the appropriate body.

• Collaborate with other commissions, organizations, and staff, as needed, to ensure cross-organizational strategy, research, and planning.
• The Chair will submit an annual report to the Board of Directors summarizing the accomplishments of the Commission. This report will also be shared with the House of Delegates. The Chair will attend the House of Delegates meeting to testify, as needed, regarding policies and resolutions related to the work of the Commission.


BA-2400.4.2 Commission on Government Relations and Practice Advancement
The commission will:

• Advise AAPA staff on the impact of new healthcare models and value-based healthcare delivery on PAs and serve as a resource on PA payment policy.

• Identify current and/or emerging barriers to practice and discuss options for their elimination.

• Identify opportunities where PAs can be leaders that might require federal or state legislative or regulatory changes for that to occur.

• Share real world examples of how autonomous PAs are in their daily practice and how they make decisions today, partner with physicians etc. for use in advocacy efforts.

• Provide feedback and advice on OTP implementation. Encourage state and federal legislators to support the advancement of OTP proposals and spread the message about OTP to fellow PAs.

• Encourage PAs to get involved in advocacy at the federal and state level.

• Provide suggestions of external organizations that could be potential partners on either advocacy efforts or business initiatives.

• Review AAPA policies assigned by the House Officers, to include but not limited to Five-Year Policy Review, and provide recommended action for consideration by the appropriate body.

• Collaborate with other commissions, organizations, and staff, as needed, to ensure cross-organizational strategy, research, and planning processes.

• The Chair will submit an annual report to the Board of Directors summarizing the accomplishments of the Commission. This report will also be shared with the House of Delegates. The Chair will attend the House of Delegates meeting to testify, as needed, regarding policies and resolutions related to the work of the Commission.


BA-2400.4.3 Commission on Continuing Professional Development and Education
The commission will:

• Advise education staff on elements of AAPA’s overall education program and strategy. This includes consulting on the CME accreditation process and associated criteria, identifying specialty areas for content development based on emerging opportunities for the profession, and providing recommendations regarding format and scope of specialty programming.
• Identify, read, and help staff apply learning from documents and articles about trends in continuing professional development in the health professions as they apply to PA practice.

• Work with staff to support decision-making regarding the mix of educational content for the annual conference and help to develop/recruit sessions. This process should take into account any thematic focus of the conference, the AAPA Strategic Plan, AAPA’s National Health Priorities, optimal models of PA practice, ways to provide enhanced learning opportunities, and the development of new skill sets needed by faculty to facilitate learning.

• Participate in conference proposal grading, review comments provided by the Conference Proposal Graders, curate the CME content, and finalize the conference program.

• Work with staff to provide input on strategies to improve the experience and ensure the relevance of AAPA conferences and small meetings.

• Review AAPA policies assigned by the House Officers, to include but not limited to Five-Year Policy Review, and provide recommended action for consideration by the appropriate body.

• Collaborate with other commissions, organizations, and staff, as needed, to ensure cross-organizational strategy, research, and planning.

• The Chair will submit an annual report to the Board of Directors summarizing the accomplishments of the Commission. This report will also be shared with the House of Delegates. The Chair will attend the House of Delegates meeting to testify, as needed, regarding policies and resolutions related to the work of the Commission.


BA-2400.4.4 Commission on the Health of the Public
The commission will:

• Review opportunities for AAPA participation in the development or endorsement of external clinical guidelines and position papers, collaborating with subject matter experts, appropriate constituent organizations or other stakeholders, as necessary. Following review and using previously established criteria (medical/scientific soundness; alignment with AAPA policy; alignment with AAPA Strategic Plan), author recommendation to the Board.

• Evaluate potential AAPA participation in external clinical outreach opportunities, applying previously established criteria (medical/scientific soundness; alignment with AAPA policy; alignment with AAPA Strategic Plan) and taking into consideration the broad effect on PA practice and resources (staff/funding) available. Following evaluation and in collaboration with appropriate stakeholders (SMEs, COs) make a recommendation to staff or BOD regarding AAPA’s participation.

• In collaboration with appropriate stakeholders (SMEs, COs), evaluate opportunities for AAPA’s participation related to emerging clinical public health issues and AAPA’s National Health Priorities, taking into consideration the broad effect on PA practice and resources (staff/funding) available. Following evaluation, provide a recommendation to staff or BOD regarding AAPA’s participation.

• Conduct an AAPA policy gap analysis regarding emerging clinical public health issues and revise existing policy as required and/or draft new policies to address these issues.
• Review AAPA policies assigned by the House Officers, to include but not limited to Five-Year Policy Review, and provide recommended action for consideration by the appropriate body.

• Collaborate with other commissions, organizations, and staff, as needed, to ensure cross-organizational strategy, research, and planning processes.

• The Chair will submit an annual report to the Board of Directors summarizing the accomplishments of the Commission. This report will also be shared with the House of Delegates. The Chair will attend the House of Delegates meeting to testify, as needed, regarding policies and resolutions related to the work of the Commission.


BA-2400.4.5 Judicial Affairs Commission

The commission will:

• Implement the AAPA judicial affairs responsibilities reflected in AAPA Bylaws and policy, to include but not limited to, member/non-member complaints, election challenges, and membership issues related to adjudicated disciplinary actions.

• Collaborate with other commissions and staff (and AAPA legal counsel as needed) to provide guidance on judicial or ethics-related issues and policies.

• As needed, review the AAPA Judicial Affairs Manual to ensure it remains aligned with state law, ethics, AAPA Bylaws and policy, and best practices.

• Carry out other charges as may be directed by the Board of Directors.

• Review AAPA policies assigned by the House Officers, to include but not limited to Five-Year Policy Review, and provide recommended action for consideration by the appropriate body.

• Collaborate with other commissions, organizations, and staff, as needed, to ensure cross-organizational strategy, research, and planning.

• The Chair will submit an annual report to the Board of Directors summarizing the accomplishments of the Commission. This report will also be shared with the House of Delegates. The Chair will attend the House of Delegates meeting to testify, as needed, regarding policies and resolutions related to the work of the Commission.


BA-2400.4.6 Governance Commission

The commission will:

• Review emerging corporate governance issues and practices and make appropriate recommendations to the Board.

• In accordance with the AAPA Bylaws Article XIV Section 5a, review all Bylaws amendments to be considered at the House of Delegates for the purpose of ensuring proposed changes and amendments conform with existing policies.
• As an impartial body, establish consistent policies and procedures to bring parity to all AAPA elections with dual goals of increasing member transparency and election engagement (candidate and voter).

• Advise the Nominating Work Group and Constituent Relations Work Group as needed to ensure alignment with applicable AAPA policies.

• Carry out the duties assigned in section 9.3 of the AAPA Judicial Affairs Manual.

• As needed, review AAPA governance documents to identify and eliminate conflicting and inconsistent language.

• Review AAPA policies assigned by the House Officers, to include but not limited to five-year policy review, and develop recommendations for consideration by the appropriate body.

• Collaborate with other commissions, organizations, and staff, as needed, to ensure cross-organizational strategy, research, and planning.

• The Chair will submit an annual report to the Board of Directors summarizing the accomplishments of the Commission. This report will also be shared with the House of Delegates. The Chair will attend the House of Delegates meeting to testify, as needed, regarding policies and resolutions related to the work of the Commission.


BA-2400.4.8
Constituent Relations Work Group (of the Governance Commission):
The work group will:

• Review Constituent Organization (CO) applications and make recommendations to the Board of Directors.

• Seek opportunities for AAPA to enhance and advance CO relations.

• Oversee the CO awards program.

• Recommend the revocation of a CO Affiliation/Recognition Agreement in the event of non-compliance.

• At the annual meeting of the House of Delegates, present a report providing the status of all constituent organizations.

• Review the charter of each Constituent Organization on a five-year cycle and make recommendations to the Board of Directors for its consideration.

• Review AAPA policies assigned by the House Officers, to include but not limited to Five-Year Policy Review, and provide recommended action for consideration by the appropriate body.

• Collaborate with other commissions, organizations, and staff, as needed, to ensure
complimentary cross organizational strategy, research, and planning processes.

• The Chair will submit an annual report to the Board of Directors summarizing the accomplishments of the Work Group. This report will also be shared with the House of Delegates. The Chair will attend the House of Delegates meeting to testify, as needed, regarding policies and resolutions related to the work of the Work Group.

• Carry out other activities as may be requested by the Governance Commission or Board of Directors.

BA-2400.4.10 Commission on Diversity, Equity, and Inclusion
The commission will:

• Review AAPA policy on health equity to identify gaps and opportunities for creating problem solving resolutions for HOD consideration and action.

• Support AAPA’s five-year strategic plan by recommending initiatives to mobilize the profession as champions in responding to national public health priorities.

• Serve as healthcare subject matter advisors to AAPA as it relates to health inequity, and the PA profession’s policy, education, advocacy, and resources.

• Support collaborative efforts and programs with other stakeholders in efforts to diversify the PA profession.

• Collaborate with other commissions, organizations, and staff, as needed, to ensure cross-organizational implementation around equity and inclusion program initiatives.

• Provide guidance and support to sister organizations’ mentorship efforts for historically marginalized students and the creation of sustainable student pipeline strategies.

• Review AAPA policies assigned by the House Officers, to include but not limited to Five-Year Policy Review, and provide recommended action for consideration by the appropriate body.

• The Chair will submit an annual report to the Board of Directors summarizing the accomplishments of the Commission. This report will also be shared with the House of Delegates. The Chair will attend the House of Delegates meeting to testify, as needed, regarding policies and resolutions related to the work of the Commission.
[Adopted 2020, amended 2021, 2022]

BA-2400.5.0 Board of Directors

BA-2400.5.1
AAPA’s Board of Directors may provide interim approval of policy for which they do not have specific guidelines from the House between meetings of the House with the following restrictions:
1) The Board of Directors may not alter or amend the function of the House of Delegates.
2) The item receiving interim approval by the Board of Directors must be presented to the House of Delegates for final approval at its next regular meeting.
3) A complete report, justifying the need for interim approval will be communicated by the Speaker to all delegates within forty-five (45) days of the Board of Directors action.


BA-2500.00 ACADEMY/ORGANIZATION – OPERATIONS

BA-2500.1.0 Academy Rules

BA-2500.1.1
AAPA prohibits any person speaking on behalf of AAPA without consent of the organization.

BA-2500.1.2
AAPA’s logo may not be altered in any way without permission. Any contemplated use must have prior AAPA approval.

BA-2500.1.4
Outside legal counsel will not be engaged on behalf of an individual AAPA member unless the case is determined to have significant ramifications on the PA profession. The President of AAPA and Speaker of the House, in conjunction with the Chief Executive Officer, shall evaluate the significance of the case and make a recommendation to AAPA’s Board of Directors for final decision.

BA-2500.1.5
Notwithstanding any restrictions in information distribution policy, AAPA may distribute email addresses, practice and home addresses and phone numbers from the masterfile to assist AAPA constituent organizations (COs) with their legislative and regulatory activities. A CO can request this for free up to twice a calendar year. A condition of receiving the list is that the CO must sign a rental list agreement. COs will be responsible for developing and formatting the message and distributing the communication via its own provider or channels.

BA-2500.1.6
AAPA may provide, for a fee, a CO with a PA contact list that contains USPS mailing address, phone number and email address, to the extent they exist in AAPA’s database and that AAPA has permission to share this data, up to a maximum of four times a calendar year. The CO can select up to four states, or four specialties, or four federal service chapters, including their own, for each request. The list can be used by the CO for membership, CME or advocacy activities. A condition of receiving the list is that the CO must sign an AAPA data use agreement. COs will be responsible for developing and formatting the message and distributing the communication via its own provider or channels.
[Adopted 2014, amended 2019]
BA-2500.2.0  Membership/Membership Services

BA-2500.2.1  AAPA recognizes PAs who are eligible for fellow membership but whose special circumstances make payment of fellow member dues an unreasonable hardship. PAs requesting a reduced fellow membership fee may petition AAPA’s membership department for consideration.

BA-2500.2.2  AAPA shall recognize those AAPA Fellow and Sustaining Members who have distinguished themselves among their colleagues through the distinguished fellows program.

BA-2500.2.3  AAPA may recognize excellence and significant contributions to the PA profession through its Awards. AAPA Awards are overseen by the Awards Committee.

BA-2500.3.0  Information on the Profession

BA-2500.3.2  AAPA supports the designation of National PA Week commencing on October 6.

BA-2500.4.0  Strategic Goals

BA-2500.4.1  AAPA's strategic plan, in alignment with our mission, vision and values, will guide the work of the organization.
[Adopted 2013, amended 2017, reaffirmed 2022]

BA-2500.4.3  AAPA leadership and national office staff will incorporate diversity and equity in their planning, actions, and discussions on behalf of the PA profession in publications and media activities, in the selection of commissions, work groups, task force members, and awards.

BA-2600.00  ELECTIONS

BA-2600.1.0  Rules and Regulations for Election of Officers and Directors at Large - Elections/Voting

BA-2600.1.1  AAPA supports an electronic means of balloting for the officers and directors-at-large of AAPA. The protection of confidentiality shall be of the highest priority in the balloting process. Anonymity will be respected to the extent possible to ensure the security of the balloting process.

BA-2600.1.3  The official AAPA ballot shall identify those candidates endorsed by the Nominating Work Group.
BA-2800.00  JUDICIAL AFFAIRS COMMISSION

BA-2800.1.0  Complaints

BA-2800.1.1
AAPA Complaint Procedures
See: Judicial Affairs Manual

BA-2800.1.3
Procedure for filing a complaint against an AAPA Constituent Organization
See: Judicial Affairs Manual

BA-2800.2.0  Challenging a General AAPA Election

BA-2800.2.1
A challenge of an AAPA general election must be made to the Judicial Affairs Commission while the election is in progress or within one calendar month of the date of the announcement of the election results. Elections may be challenged by a candidate or a member eligible to vote in that election.

BA-2800.2.2
The grounds for challenging the election are as follows:
1. Voting by ineligible persons
2. The procedures for holding an election as outlined in AAPA Bylaws and policy are not observed.
3. Negligence in conducting the election.

BA-2800.2.3
1. The Judicial Affairs Commission will investigate any challenged general election and will report its findings and recommendations to the Board of Directors
2. If the election is challenged while in progress, it will continue unless a recommendation from the Judicial Affairs Commission and a decision by the Board of Directors is made to stop the election and declare it void.
3. If the election is challenged after the announcement of election results, the new officers will assume their elected office and remain in office until a recommendation from the Judicial Affairs Commission and a decision is made by the Board of Directors. Any board member (as determined by the Judicial Affairs Commission) involved in a challenged election will not participate in the Board of Directors deliberation and decision on the election challenge.
4. If the Judicial Affairs Commission finds that the illegal votes cast or the illegal practices engaged in could have changed the election results, then the Board of Directors will void the election. If the Judicial Affairs Commission finds that the illegal votes cast or the illegal practices engaged in could not have changed the results of the election, then the Board of Directors need not void the election.
5. This entire process must be completed, and members notified of action taken within eight weeks of the challenge. If necessary, the Board may approve a single four-week extension.

BA-2800.2.4
Challenging a House Election

Any election conducted by the House of Delegates may be challenged by any seated delegate by
- Rising to a point of order or inquiry.
- Bringing their concerns to the Judicial Affairs Commission.
If any election conducted by the House of Delegates is challenged while the House of Delegates is in session, it may be declared void by a majority of delegates present and voting is repeated.

If any election conducted by the House of Delegates is challenged after the close of the House session, the process followed for challenging general election results will be followed.

**BA-2800.3.0 Adjudication Procedures for the Discipline of Elected Officials of AAPA**


*See: Judicial Affairs Manual*

**HP-3000 Profession**

**HP-3200 Title**

HP-3210 (formerly HP-3100.1.1)

AAPA affirms "physician associate" as the official title for the PA profession.


HP-3220 (formerly HP-3100.1.2)

AAPA shall adopt “asociado médico” as the official Spanish translation for physician associate.


HP-3230 (formerly HP-3100.1.4)

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.

* [Adopted 2016, reaffirmed 2021]

HP-3240 (formerly HP-3100.1.3.2)

PAs should encourage employers, third party payers, educators, researchers, and the government to utilize the term “PA” or “physician associate” to increase transparency and visibility of PAs throughout the healthcare system.

* [Adopted 2008, reaffirmed 2013, amended 2018]

HP-3250 (formerly HP-3100.1.3.1)

AAPA believes that PAs should be referred to as PAs (physician associates/asociado medicos). AAPA believes that PA/APRN should be used if both professions are referred to collectively.

* [Adopted 2018, amended 2022]

HP-3260 (formerly HP-3100.1.3)

AAPA discourages the use of terms such as midlevel providers, physician extenders, allied health professionals or any other terms that devalue PAs’ contribution to healthcare.

* [Adopted 2018]

**HP-3400 Role**

HP-3410 (formerly HP-3100.2.1)

PAs practice patient-centered, team-based medicine with physicians and other healthcare professionals.

HP-3420 (formerly HP-3100.3.1)
PAs are healthcare professionals licensed or, in the case of those employed by the Federal Government, credentialed to practice medicine. PAs provide medical and surgical services as a member of a healthcare team, based on their education, training, and experience. PAs exercise independent medical decision making within their scope of practice.

HP-3600 PA Organizations

HP-3610 General

HP-3612 (formerly HP-3100.4.1)
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. These organizations will continue to value the involvement of other stakeholders in medicine, healthcare, and the public through consultative and advisory relationships.
[Adopted 2016, reaffirmed 2021]

HP-3614 (formerly HX-4100.1.10.2)
AAPA supports collaboration with the Student Academy and our cross organizations (ARC-PA, PAEA, and NCCPA) in initiatives on diversity, equity, and inclusion for the PA profession.
[Adopted 2021]

HP-3620 NCCPA

HP-3622 (formerly HP-3200.4.4)
AAPA believes that NCCPA must limit its role to that of a certifying body and focus its resources on improving the certification process. AAPA further believes that disciplinary actions by NCCPA must be restricted to matters dealing with the examination, such as falsifications of applications for certification or cheating on an examination, not serving as the arbiter of morals for PAs. Allegations or evidence of criminal behavior, moral turpitude, or unprofessional behavior received by the commission should be returned to the sender with the suggestion that it be sent to appropriate state regulatory agencies, the Federation of State Medical Boards, and/or the National Practitioner Data Bank.

HP-3624 (formerly HP-3500.3.6)
AAPA opposes unsolicited lobbying activities by the NCCPA related to PA state or federal practice statutes or regulations, scope of practice, employment, payer credentialing or reimbursement requirements.
[Adopted 2017, amended 2022]

HP-3626 (formerly HP-3800.1.1.1)
AAPA urges NCCPA and the NCCPA Foundation to undertake rigorous and replicable research to determine the value of the NCCPA recertification test in terms of value to PAs, PA employers, health policy makers, and patients/patient outcomes.
[Adopted 2016, amended 2021]
HP-3630  **Political Action Committee**

HP-3632 (formerly HP-3100.4.2)
AAPA encourages the PA Political Action Committee (PA PAC) to communicate with the appropriate state chapters while considering contributions to candidates within that state. AAPA encourages the PA PAC to consider the overall voting record of a legislator in light of AAPA policy statements before contributing to that legislator’s campaign.


HP-3640  **Physician Assistant History Society**

HP-3642 (formerly HP-3300.4.1)
AAPA encourages PAs and their representative organizations to contribute to and actively participate in efforts to preserve and study our unique professional history through the Physician Assistant History Society.


HP-4000  **PA Education**

HP-4200  **Entry-Level**

HP-4220  **Program Accreditation**

HP-4222 (formerly HP-3200.3.1)
AAPA recognizes the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), as the body that accredits educational programs for PAs. AAPA also recognizes that the criteria used by the ARC-PA require graduates of these programs to be adequately prepared in a broad base of general medical competencies. It is the policy of AAPA that all PAs eligible for certification by the National Commission on Certification of Physician Assistants be provided with this broad-based medical background.


HP-4240  **Curriculum**

HP-4242 (formerly HP-3200.1.1)
AAPA believes competency-based professional education at ARC-PA accredited entry-level PA programs followed by life-long learning are critical components for competent PA practice.

*Adopted 2007, amended 2017, reaffirmed 2012, 2022*

HP-4244 (formerly HP-3200.1.1.1)
AAPA supports and encourages the inclusion of innovative teaching methods in PA education and believes new technologies should be utilized, when appropriate, to enhance didactic and supervised clinical practice experience.

*Adopted 2019*

HP-4246 (formerly HP-3200.1.5)
AAPA recognizes that PA education exists based on unique mission-driven and geographical needs in a variety of educational institutions and models.

*Adopted 2006, reaffirmed 2011, 2016, 2021*
PA Student Supervised Clinical Practice Experiences – Recommendations to Address Barriers (paper on page 303)

HP-4250 (formerly HP-3200.1.7)
AAPA acknowledges the importance and supports the delivery of interprofessional curricula that includes PA practice and the PA’s role in the seamless delivery of high-quality patient care. AAPA should provide education to other healthcare professions regarding the PA’s role on the healthcare team.
[Adopted 2021, amended 2022]

HP-4252 (formerly HP-3200.3.2)
AAPA believes that it is vital for graduate PAs to be involved in the education of student PAs. This involvement may include but is not limited to 1) recruitment of new students 2) participation in the selection of new students 3) classroom instruction and 4) clinical preceptorship. AAPA will, through its publications, programs and services, encourage its members to actively participate in these educational opportunities.

HP-4254 (formerly HP-3200.3.4)
AAPA believes it is necessary to assure the public that those persons who prescribe medication or write drug orders or are involved directly in prescriptive practices must be qualified to do so. Specifically, in order that PAs provide adequate patient care, the PA must have a basic understanding of pharmacology and therapeutics, including the indications, contraindications, adverse effects, and complications of commonly used drugs.

HP-4256 (formerly HX-4400.1.7)
AAPA supports the incorporation of all forms of injury control and prevention in the education of PA students. Additionally, AAPA encourages PA program faculty to support students as they encounter difficult situations.
[Adopted 2019]

HP-4258
AAPA encourages the incorporation of education on the recognition of symptoms and treatment guidelines of button battery/coin ingestion to current curriculum of PA programs and continuing medical education for practicing PAs.
[Adopted 2022]

HP-4260 Degree

HP-4262 (formerly HP-3200.1.3)
AAPA recognizes that PA education is conducted at the graduate level and supports awarding the master’s degree as the terminal degree.

HP-4264 (formerly HP-3200.7.1)
AAPA encourages institutions of higher education that sponsor PA education to establish the Master’s Degree as the terminal degree for tenure and promotion of PA program faculty.
AAPA supports PA-specific post-professional doctoral degrees as one option for PAs to engage in lifelong learning.
[ Adopted 2021 ]

AAPA opposes a mandatory entry-level doctorate for PAs.
[ Adopted 2010, reaffirmed 2015, amended 2021 ]

**HP-4280 Recruitment and Retention**

In order to ensure diversity of age, gender, racial, cultural, sexual orientation, religion, sex, educational background, economic and disability status within the profession; AAPA strongly endorses the efforts of PA educational programs to develop partnerships aimed at broadening diversity among qualified applicants for PA program admission. Furthermore, AAPA supports ongoing, systematic and focused efforts to reduce undue barriers to entry for applicants and attract and retain students, faculty, staff and others from demographically diverse backgrounds.

AAPA supports the consideration of race, ethnicity, gender, and other aspects of identity and experience in admissions under holistic review to help ensure a diverse workforce that includes underrepresented minorities in medicine to address health disparities.
[ Adopted 2021 ]

**Diversity and Inclusion in PA Education** (paper on page 231)

AAPA affirms its commitment to non-discrimination in membership, scholarship and leadership opportunities, and encourages constituent organizations to offer equitable and inclusive treatment of all student members, regardless of their educational setting.
[ Adopted 2021, reaffirmed 2022 ]

AAPA supports efforts to help U.S. military veterans become PAs.
[ Adopted 2011, amended 2016, reaffirmed 2021 ]

AAPA believes that PA students should have access to cost-free or low-cost healthcare and mental health services or coverage.
[ Adopted 2022 ]

**HP-4300 Education Funding**

AAPA shall actively promote the participation of PAs in National Health Service Corps scholarship and loan repayment programs.
AAPA recognizes the vital importance of scholarship dollars to the continued growth and survival of the profession.


AAPA urges all federal, state, local and privately funded programs to include and recruit PAs in all healthcare scholarship and loan repayment programs.


AAPA believes it is sound public policy to strengthen the U.S. healthcare workforce by providing federal and state government support for PA education. Such support includes expanded student loans and scholarships including National Health Service Corps scholarships and loan repayment programs; postgraduate programs; and federal grants and faculty development initiatives; and other forms of assistance including research. Grants to PA programs should include investments to expand high quality clinical education sites where PA students can train and function with interprofessional teams. Government funding for PA education to maintain and expand PA education and faculty training, along with optional postgraduate programs, will help assure the highest level of healthcare delivery in the United States. Government funding for research on best practices in education will ensure that effective educational outcomes will lead to high quality, safe healthcare delivery.

While AAPA maintains its belief that adequate knowledge is obtained through PA education for professional practice, PAs have the opportunity to increase their knowledge through optional clinical postgraduate training programs. Eligible PA postgraduate training programs should qualify for any federal or state funding available to other eligible non-physician postgraduate training programs.


AAPA supports initiatives for increased funding for development and operation of PA programs at Historically Black Colleges and Universities, predominantly black institutions, Hispanic-Serving Institutions, and rural serving institutions.

[Adopted 2018]

AAPA supports initiatives for increased federal loan limits to provide parity with loan limits available to other healthcare professional students.

[Adopted 2018]

**Postgraduate Education**

Accreditation and Implications of Clinical Postgraduate PA Training Programs (paper on page 102)


**Specialty Certification**

AAPA recognizes the important role of the PA in the areas of medical specialization, but feels that education in the specialty areas must be concurrent with or after education in general medicine as
described in the Accreditation Standards for Physician Assistant Education of the Accreditation Review Commission on Education for the Physician Assistant.


HP-4640 (formerly HP-3200.4.2)

Specialty Certification, Clinical Flexibility, and Adaptability (paper on page 207)

[Adopted 2017, amended 2022]

HP-4660 (formerly HP-3200.4.3)

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

[Adopted 2010, reaffirmed 2015, 2020]

HP-4800 Continuing Education

HP-4820 (formerly HP-3200.2.1)

AAPA recognizes the concept of continuing professional development (CPD) as a means to maintain competence and ensure the delivery of high quality care. CPD is a process that includes ongoing identification of learning needs, development of a learning plan, acquisition of new knowledge and skills, application to practice, personal reflection and reassessment.

Continuing medical education consists of clinical and professional educational activities that serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a PA uses to provide services for patients, the public, and the profession. Continuing medical education is a formal component of CPD. All continuing medical education reported should comply with this definition, regardless of whether it is reported as Category 1 (pre-approved) or Category 2 (elective).


HP-4840 (formerly HP-3200.2.2)

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)


HP-4860 (formerly HP-3200.2.4)

AAPA adopts the Accreditation Council for Continuing Medical Education (ACCME) standards for integrity and independence in accredited continuing education and its associated interpretive policies as part of its own accreditation system.

AAPA recommends all required continuing medical education be offered in formats that allow for remote participation, when appropriate, in order to ensure timely and equitable access.
[Adopted 2019]

AAPA supports approved PA programs in awarding Category 1 CME credit to graduate PAs who precept PA students.
[Adopted 2014, reaffirmed 2019]

The preceptors of accredited PA programs may earn two Category 1 credits per week for each PA student they precept with no maximum.
[Adopted 2019, amended 2022]

HP-5000 Professional Practice

HP-5200 Clinical Competency

AAPA recognizes life-long learning provides opportunities to improve competencies, supports preparedness for certification/licensure and increases the vitality and efficiency of a practice by providing learning opportunities which are intended to improve performance in practice and patient outcomes.

AAPA believes it is the ethical responsibility of the practicing PA to maintain a level of competence sufficient to practice medicine safely and effectively. A component of that commitment is demonstrated by participating in continuing educational activities which are scientifically valid, evidence-based, commercially unbiased, and based on principles of effective adult learning.

HP-5240 (formerly HP-3700.4.2)
Professional Competence (paper on page 153)

HP-5260 (formerly HP-3700.4.3)
Competencies for the PA Profession (paper on page 254)

HP-5400 Non-Clinical Roles

AAPA values the involvement of PAs in AAPA who, although not practicing clinically, remain involved in positions related to healthcare delivery, including, but not limited to, health professional education, healthcare administration, healthcare policy or regulation, or serving in an elected capacity in government.

AAPA encourages PAs to seek election to federal, state, and local office.
[Adopted 2012, amended 2017, reaffirmed 2022]
HP-5460 (formerly HP-3300.2.3)
AAPA recognizes and encourages the active participation of PAs in policy making, administration, government affairs, research, and other non-clinical roles.

HP-5462
AAPA strongly encourages PAs to become active leaders in administrative roles of their practice.
[Adopted 2022]

HP-5480
AAPA supports life-long learning and professional development for PAs that will enhance advancement opportunities in senior and executive leadership roles. The profession encourages all PAs that are interested in executive leadership to seek educational opportunities that will augment the strong PA clinical foundation and provide future opportunities to advance the profession and improve patient-care systems.
[Adopted 2022]

HP-5500 (formerly HP-3300.2.4)
AAPA endorses and encourages that healthcare accrediting agencies utilize PAs on accreditation site teams.

HP-5520 (formerly HP-3700.1.5)
Guidelines for the PA Serving as an Expert Witness (paper on page 129)

HP-5600   Healthcare Systems

HP-5620   General

HP-5622 (formerly HP-3400.1.2)
AAPA believes that team-based care leads to better patient outcomes.

HP-5624 (formerly HP-3400.1.3)
AAPA supports expanded healthcare access for all people. AAPA encourages innovation in healthcare delivery and is committed to the model of interprofessional team care. AAPA maintains that continuity of care is a high priority; therefore, communication between the episodic care provider and the primary provider should be maximized within the constraints of regulation, patient confidentiality and patient preference.

HP-5626 (formerly HP-3100.2.3)
AAPA opposes practice statutes and regulations, or payment policies that treat PAs differently on the basis of length of, or the specific academic credentials granted upon graduation from their PA educational program.

HP-5628 (formerly HX-4700.3.1)
The Role of In-Store or Retail-Based Convenient Care Clinics (paper on page 268)
[Adopted 2017, amended 2022]
AAPA recognizes the burden created by shortages of healthcare services in the United States. AAPA is committed to raising awareness of the quality, availability and cost-effectiveness of care that PAs provide to meet anticipated demands for healthcare services. AAPA supports efforts that promote solutions to healthcare shortages and expand access to care provided by PAs.

AAPA supports legislative initiatives, as well as, state and federal programs that support PAs in primary care specialties (as defined by the Federal Government) and that may serve to incentivize PAs to select primary care specialty areas of practice.
[Adopted 2010, amended 2015, reaffirmed 2020]

AAPA believes services provided by PAs teams should be counted when federal and state governments determine the primary healthcare service needs of medically underserved and health professional shortage areas. Recognition of PA productivity should not be done in such a way as to decrease patient access to care.

AAPA shall promote the optimal utilization of PAs to employers, legislators, policy makers, patients and other healthcare stakeholders. This includes providing information and data on PA scope of practice, quality of care, cost-effectiveness, reimbursement, and other relevant topics.

AAPA shall promote the PA profession to hospital administrators, senior executives, and other healthcare leaders as critical to delivering high quality, safe, team based patient-centered care that improves patient access, patient experience and quality outcomes across the healthcare continuum.

AAPA encourages all healthcare accreditation organizations to recognize, support and endorse the role of PAs in every healthcare facility they accredit and strongly encourages those organizations to include PAs in their accreditation language.
[Adopted 2019]

AAPA believes that PAs should be listed in the provider directories of all public and commercial payers, health plans and provider networks to allow patients the option of selecting care from a PA. PAs should be eligible to self-select the specialty in which they practice for designation in provider directories.

AAPA supports the full scope of practice for PAs operating in the surgical and procedural subspecialties by the promotion of state, federal and institutional policy focused on the advancement of technical skills for PAs.
[Adopted 2019]
Supporting PA Practice in Settings External to Clinics and Hospitals: Adoption of Home-centered Care (paper on page 355)
[Adopted 2021]

AAPA believes that payer policies and state and federal regulation and rules should recognize and encourage the utilization of PAs in hospice and palliative care medicine. Any payer, state or federal barriers limiting PAs from working to the full extent of their education and experience should be eliminated to authorize PAs to deliver needed care to hospice patients.
[Adopted 2015, amended 2020]

PAs as Medical Review Officers (paper on page 142)

Managed Care

PAs as Medicaid Managed Care Providers (paper on page 149)

Regulation/Certification

Credentialing/Privileges

AAPA believes the integrity of PA credentials should be assured through a credentialing, and where applicable, a privileging process aligned with the physician process. Credentialing is a process for validating the background and assessing the qualifications of healthcare professionals to provide healthcare services in an institution, managed care organization, or provider network. Privileging is the process that healthcare organizations employ to authorize practitioners to provide specific services to their patients. Privileges granted to PAs should be consistent with state laws and regulations and hospital bylaws.

AAPA recognizes that many federally employed PAs are exempt from state licensing laws and regulations and are subject to PA criteria established by federal agencies or by Congress.
AAPA believes:
- Federally employed PAs should be graduates of a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or one of its predecessor agencies.
- PAs must pass the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA).
- Federally employed PAs should not be required to have a state license to obtain full practice privileges (including prescribing), to be credentialed in a federal facility, or to participate in a federal activity such as a disaster medical team. Federally employed PAs may opt to hold a state license.
AAPA strongly recommends and actively supports all efforts to ensure that a graduate of any medical school or PA program, international or within the United States, who wishes to obtain credentials to practice as a PA, must attend and successfully complete a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) and pass the Physician Assistant National Certifying Exam (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA).


Guidelines for Updating Medical Staff Bylaws: Credentialing and Privileging PAs (paper on page 111)

[Adopted 2012, amended 2017, 2018]

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

[Adopted 2016, reaffirmed 2021]

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


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.


AAPA supports exploring the use of evidence-based alternatives to a closed-book proctored exam for maintenance of certification, and advocates for consultation amongst NCCPA, AAPA, PAEA, ARC-PA and other PA stakeholders to reach a carefully considered conclusion regarding the optimal method of demonstrating and supporting continued competency for PAs across all practice settings.

[Adopted 2019]

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

[Adopted 2016, amended 2021]

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.

[Adopted 2016, reaffirmed 2021]

HP-5868 (formerly HP-3500.3.4.3)
AAPA believes the authority for establishing maintenance of licensure (MOL) and licensure portability requirements is strictly within the purview of state legislative or PA regulatory authorities.

AAPA strongly encourages all PA state chapters to advocate for legislation to adopt MOL and licensure portability processes consistent with the Federation of State Medical Boards’ (FSMB) guiding principles and AAPA policy.

[Adopted 2016, amended 2021]

HP-5870 (formerly HP-3500.3.5)
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.

[Adopted 2016, reaffirmed 2021]

HP-5880 Regulations/Rules

HP-5882 (formerly HP-3400.1.2.1)
AAPA opposes any mandatory policy, regulation or restriction in state or federal law that limits the number of PAs and physicians that can form collaborative relationships. AAPA believes that the number of PA and physician collaborative relationships should be determined at the practice level.

[Adopted 2018]

HP-5884 (formerly HP-3500.3.4)
Guidelines for State and Territory Regulation of PAs (paper on page 122)

HP-5886 (formerly HP-3500.3.4.4)
AAPA opposes the inclusion of non-PA healthcare professionals in PA state practice acts.

[Adopted 2017, amended 2022]

HP-6000 PA Employment

HP-6020 Practice Ownership

HP-6022 (formerly HP-3500.3.7.1)
AAPA supports the right of PAs to be sole owners, form partnerships, or otherwise have an ownership interest in any corporation authorized by state law to provide professional or healthcare services.
AAPA encourages state constituent organizations and the Academy to advocate for the removal of arbitrary statutes, regulations, and policies that create barriers to full participation as officers and/or directors and direct reimbursement to PAs and practices regardless of the ownership of the business. [Adopted 2021]

HP-6040 Contracts/Compensation

HP-6042 (formerly HP-3500.4.1)
AAPA opposes the use of non-compete clauses in PA’s employment contracts. These covenants violate a PA’s right to practice their profession, negatively impact various aspects of patient care and access to care, and ultimately put financial interests ahead of patient and community care. [Adopted 2009, reaffirmed 2014, amended 2018]

HP-6044 (formerly HP-3600.1.8)
AAPA believes in equity in compensation for all PAs. PA compensation should be based on the knowledge, skills, and abilities of the PA as well as relevant job factors, including, but not limited to, practice setting, specialty, and geographic location. Compensation should never be based on attributes of personal identity, including, but not limited to gender, ethnicity, race, sexual orientation, religion, or nationality.

AAPA believes a combination of educational initiatives, including implicit bias training and salary negotiation, provided at both the student and professional PA career phases, as well as advocacy for transparency regarding compensation at the institutional level and the elimination of pay secrecy policies at the state and national level will enable greater equity in compensation. AAPA also encourages additional research on disparities in compensation. [Adopted 2011, reaffirmed 2016, amended 2021]

HP-6200 International Education/Practice

HP-6220 (formerly HP-3700.3.2)
*Licensure Eligibility for PAs Trained Abroad* (paper on page 225)

HP-6240 (formerly HP-3700.3.1)
Guidelines for PAs Working Internationally
1. PAs should establish and maintain appropriate healthcare team relationships.
2. PAs should accurately represent their skills, training, professional credentials, identity, or service.
3. PAs should provide only those services for which they are qualified via their education and/or experiences, and in accordance with all pertinent legal and regulatory processes.
4. PAs should respect the culture, values, beliefs, and expectations of the patients, local healthcare providers, and the local healthcare systems.
5. PAs should be aware of the role of the traditional healer and support a patient’s decision to utilize such care.
6. PAs should take responsibility for being familiar with, and adhering to the customs, laws, and regulations of the country where they will be providing services.
7. When applicable, PAs should identify and train local personnel who can assume the role of providing care and continuing the education process.
8. PA students require the same supervision abroad as they do domestically.
9. PAs should provide the best standards of care and strive to maintain quality abroad.
10. Sustainable programs that integrate local providers and supplies should be the goal.
11. PAs should assign medical tasks, as appropriate, to nonmedical volunteers only when they have the competency and supervision needed for the tasks for which they are assigned.


HP-6400  **Uniformed Services**

HP-6420  **Active Duty**

HP-6422 (formerly HP-3100.3.2)
All branches of the uniformed services shall be encouraged to delineate a well-defined peacetime and wartime mission for PAs based on the individual service component needs and requirements.

AAPA shall request that the various uniformed services peacetime and wartime missions should reflect, as closely as possible, the broad-based medical training and skills of PAs in accordance with the current accreditation standards for PA education.


HP-6424 (formerly HX-4100.12.1)
AAPA believes there is no valid reason to exclude transgender individuals from military service.

[Adopted 2019]

HP-6426 (formerly HX-4600.1.6.2)
AAPA believes that medical care afforded to transgender service members should be determined by the patient and medical provider according to the same standards of care that apply to non-transgender (cisgender) personnel.

[Adopted 2019]

HP-6428 (formerly HX-4600.3.2)
If Congress acts to require medical personnel to register with the selective service, prior to implementation, the Congress shall encourage all branches of the uniformed services to have in place their individual emergency wartime mission requirements which will allow PAs to provide healthcare services based on their training and, as closely as possible, in accordance with the current accreditation standards for PA education.


HP-6430 (formerly HX-4600.3.3)
Government and private employers should be encouraged to assure continued equality of pay for retired and reserve component PAs who are called to active military duty.


HP-6440  **Veterans**

HP-6442 (formerly HP-3300.2.5)
To ensure meaningful involvement of PAs in the Veterans Health Administration (VA) and promote equal and fair opportunities for PAs, AAPA supports the continuation of the role of a full-time Director of Physician Assistant Services at the VA, who shall be responsible to and report to the Assistant Deputy Under Secretary of Health for patient care services on all matters dealing with PA issues. Furthermore, AAPA supports the allocation of adequate resources and staff necessary for full effectiveness.

HP-6444 (formerly HX-4600.1.11)
AAPA believes PAs should advocate and facilitate care for veterans of the uniformed forces of the United States and their families including National Guard and Reserve Forces. AAPA supports education for all PAs regarding the medical and psychosocial needs of all veterans and their families. AAPA encourages PAs to be aware of the services and resources in their communities that assist veterans and their families to obtain the most up to date care.
[Adopted 2008, reaffirmed 2013, 2018]

HP-6600  **Direct to Consumer Interactions**

HP-6620 (formerly HP-3300.2.8.1)
AAPA believes Direct to Consumer Advertising (DTCA) that is presented in a responsible and ethical manner may be of some value to patients. Such information should be scientifically substantiated, accurately presented, and free of bias and false or misleading claims. DTCA and marketing of pharmaceuticals, medical devices, surgical procedures, and consumer-ordered diagnostic testing may create significant patient safety concerns if it leads patients to seek healthcare solutions without consulting with a qualified healthcare professional.

PAs should:
- maintain objectivity regarding advertised pharmaceuticals, medical devices, treatments, and diagnostic testing;
- evaluate the patient’s understanding of the requested entity;
- provide appropriate counseling related to the patient’s request;
- maintain commitment to providing value-based and evidence-based care and only prescribe or recommend a pharmaceutical, medical device, treatment, or diagnostic test that will benefit the patient.
[Adopted 2019]

HP-6640 (formerly HP-3700.1.6)
**False or Deceptive Healthcare Advertising** (paper on page 271)

HP-6660 (formerly HX-4600.5.8)
AAPA shall actively engage in efforts to educate healthcare advertisers about PA prescribing authority and practices. AAPA shall encourage healthcare advertisers to avoid such language as "only your doctor can diagnose" or "only your doctor can prescribe."

HP-6800  **Reimbursement**

HP-6820 (formerly HP-3200.3.5)
AAPA shall continue to educate and serve as a resource to students, programs, and graduate PAs on issues concerning reimbursement for medical services provided by PAs.

HP-6840 (formerly HP-3600.1.1)
AAPA seeks to modernize the Social Security Act through amendments to authorize coverage of all medical, psychiatric and surgical services provided by PAs and to reimburse PAs directly for covered medical services in the same manner as all other Medicare providers.
HP-6860 (formerly HP-3600.1.3)
AAPA believes it is essential that all public and commercial payers enroll PAs, authorize claims for services performed by a PA to be submitted under the name/NPI number of the PA and cover medical and surgical services provided by PAs in all practice settings.

HP-6880 (formerly HP-3600.1.4)
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 healthcare system. To facilitate that effort, AAPA supports the enrollment, recognition of, and direct payment to, PAs by public and private third-party payers and healthcare organizations.
[Adopted 2011, amended 2016, reaffirmed 2021]

HP-6900 (formerly HP-3600.1.6)
AAPA shall educate the following groups to promote equitable reimbursement for medical, psychiatric and surgical services provided by PAs: Centers for Medicare and Medicaid Services (CMS), third-party payers, employers, and third-party administrators.

HP-6920 (formerly HX-4600.1.3)
AAPA believes coverage for the treatment of mental health and substance use disorders should be available, nondiscriminatory and covered at the same benefit level as other medical care.

AAPA believes reimbursement for PAs providing mental health and substance use disorder care should be provided in the same manner as other medical services provided by PAs.

AAPA believes no insurance company, third-party payer or health services organization shall impose a practice, education or collaboration requirement that is inconsistent with or more restrictive than existing PA state law.

HP-7000 Ethics/Behavior

HP-7020 General

HP-7022 (formerly HP-3700.1.1)
AAPA believes that PAs must acknowledge their individual responsibilities to patients, society, other health professionals, and to themselves; and in meeting their responsibilities, their actions should be guided by the Guidelines for Ethical Conduct for the PA Profession. AAPA believes the endorsement of the Guidelines for Ethical Conduct is a professional responsibility that underscores the principle of self-regulation.

HP-7024 (formerly HP-3700.1.1.1) PA Oath
"I pledge to perform the following duties with honesty, integrity, and dedication, remembering always that my primary responsibility is to the health, safety, welfare, and dignity of all human beings:

I recognize and promote the value of diversity and I will treat equally all persons who seek my care.

I will uphold the tenets of patient autonomy, beneficence, non-maleficence, justice, and the principle of informed consent.
I will hold in confidence the information shared with me in the course of practicing medicine, except where I am authorized to impart such knowledge.

I will be diligent in understanding both my personal capabilities and my limitations, striving always to improve my practice of medicine.

I will actively seek to expand my intellectual knowledge and skills, keeping abreast of advances in medical art and science.

I will work with other members of the healthcare team to assure compassionate and effective care of patients.

I will uphold and enhance community values and use the knowledge and experience acquired as a PA to contribute to an improved community.

I will respect my professional relationship with physicians and other members of the healthcare team.

I recognize my duty to perpetuate knowledge within the profession.

These duties are pledged with sincerity and on my honor."

[Adopted 2021]

HP-7026 (formerly HP-3700.1.2)

Guidelines for Ethical Conduct for the PA Profession (paper on page 194)

HP-7040 Disciplinary Process

HP-7042 (formerly HP-3700.2.1)

AAPA believes that AAPA members have an obligation to disclose what they believe in good faith to be unethical or unprofessional conduct, without reprimand or retaliation.

HP-7044 (formerly HP-3700.2.3)

AAPA will follow judicial review processes that encompass confidentiality, due notification, fair and equitable process, and an appeal procedure that protect the rights of the members involved.

HP-7200 PA Health and Wellness

HP-7220 Occupational Safety

HP-7222 (formerly HP-3900.1.1)

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 healthcare
workers. Employers should ensure that timely post-exposure counseling and prophylaxis, in accordance with relevant CDC and OSHA guidelines, are available to healthcare workers after an exposure.


HP-7224 (formerly HP-3900.1.3)
AAPA strongly recommends that all PAs be appropriately vaccinated per the recommendations of the Advisory Committee on Immunization Practice (ACIP) of the Centers for Disease Control and Prevention (CDC).


HP-7226 (formerly HX-4400.1.4)
AAPA supports the right of access to medical care and opposes all acts of violence, intimidation and reprisal directed against PAs, other healthcare providers, patients and their respective families. AAPA believes that PAs have a right to practice in an environment that makes every attempt to protect providers and staff from dangerous work environments. AAPA opposes violence directed against medical facilities as an infringement of the individual’s right of access to medical care.


**HP-7240  Personal Wellness**

HP-7242 (formerly HP-3900.1.4)
AAPA supports and encourages awareness and recognition of professional burnout in all healthcare providers and education on the prevention of burnout. AAPA supports and encourages all healthcare providers to engage in a comprehensive multi-pronged strategy for prevention of professional burnout.

[Adopted 2018]

HP-7244 (formerly HP-3700.1.3)

*PA Impairment and Wellness* (paper on page 144)


HP-7246 (formerly HP-3700.1.3.2)
AAPA shall support in principle the chemically dependent PA who has acknowledged their illness, engaged in a recovery program, and persists in a lifestyle compatible with ongoing recovery.


**HP-7400  Quality Assurance**

**HP-7420  General**

HP-7422 (formerly HP-3800.1.1)
AAPA believes that every PA is responsible for the delivery of cost-effective, accessible, quality healthcare. Furthermore, AAPA believes that every patient deserves care that is safe, effective, patient-centered, timely, efficient, and equitable.

PAs should take a role in ensuring that patient care is evidence-based, coordinated, integrated, and interdisciplinary.

PAs should be active participants and leaders in promoting patient safety, as well as evaluating and improving the quality of care for patients.

AAPA believes that effective peer-review is an essential part of quality healthcare. AAPA encourages the development and maintenance of voluntary and professionally directed peer-review. The membership is encouraged to actively participate in any peer review process involving the review of PAs.  

HP-7426 (formerly HX-4700.1.1)  
**Quality Incentive Programs** (paper on page 251)  

HP-7440  **Risk Management**

HP-7442 (formerly HP-3800.2.1)  
AAPA believes that fair and comprehensive reform of the medical liability insurance system is needed. The goals of a fair medical liability insurance system include:

- Compensation for injured patients  
- Reduction of medical errors  
- Assurance that quality and access to care will not be compromised  
- Fairness to patients and providers  
- Support for the use of apologies  
- Timely and accurate reporting of adverse events  
- Assurance of affordable medical liability insurance  
- Assurance of the availability of medical care  
- Minimal impact on the cost of healthcare

AAPA also believes that caps on non-economic damages are appropriate only if they are part of comprehensive medical liability insurance reform whose impact is borne equitably by attorneys, insurers, providers, and patients.  

HP-7444 (formerly HP-3800.2.2)  
**Acknowledging and Apologizing for Adverse Outcomes** (paper on page 273)  

HP-8000  **Practice Standards**

HP-8200  **Access to Care**

HP-8220  **General**

HP-8222 (formerly HP-3300.2.10)  
PAs have an ethical and legal obligation to use appropriately trained medical interpreters for their patients with limited ability to speak or understand English.  
*See:  Use of Medical Interpreters for Patients with Limited English Proficiency* (paper on page 217)  

HP-8224 (formerly HP-3800.1.2)  
AAPA believes that patient and family-centered care is beneficial to patients, family members, and healthcare professionals.
PAs should help educate patients, families, providers and institutions of the value of the patient- and family-centered care.

AAPA encourages PAs to participate and integrate patient- and family-centered care into their own practices.  
[Adopted 2009, reaffirmed 2014, 2019]

HP-8226 (formerly HP-3300.2.7)  
AAPA encourages PAs to provide care for medically underserved populations and/or practice in medically under resourced areas to address health disparities.  

HP-8228 (formerly HX-4600.1.8)  
*Promoting the Access, Coverage and Delivery of Healthcare Services* (paper on page 99)  
[Adopted 2018]

HP-8230 (formerly HX-4600.1.9)  
AAPA opposes actions that limit or restrict patient access to care based on personal or religious beliefs.  

HP-8232 (formerly HX-4700.4.2)  
AAPA supports the medical home concept as a means to expand access, reduce long-term cost, and improve the quality of patient care and the health of populations by allowing improved patient care coordination and interdisciplinary communication.

A medical home provides coordinated and integrated care that is patient- and family-centered, culturally appropriate, committed to quality and safety, and is cost-effective. This care is provided by a team led by a healthcare professional that includes PAs.

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

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

HP-8234 (formerly HX-4500.7)  
PAs (1) advocate the appropriate placement of automated external defibrillators; (2) support increasing government and industry funding for the purchase of automated external defibrillator devices; (3) encourage the American public to become trained in CPR and the use of automated external defibrillators; and (4) advocate for legislation to be passed to provide immunity from liability for those who, in good faith, and without expectation of compensation, provide and use AEDs in emergency situations.  
[Adopted 2008, reaffirmed 2013, 2018]

HP-8236  
AAPA believes that PAs should (1) advocate the appropriate placement of tourniquets in public spaces; (2) support increasing government and industry funding for the purchase of tourniquets; (3) encourage the American public become trained in recognizing and stopping life-threatening hemorrhage; and (4) advocate for legislation to be passed to provide immunity from liability for those who, in good faith, and without expectation of compensation, provide hemorrhage control in emergency situations.
**[Adopted 2022]**

**HP-8240  Health Disparity**

HP-8242
AAPA shall support the formation of “strategic partnerships” with other organizations that seek to address and eliminate health disparity gaps.

*Adopted 2022*

HP-8244 (formerly HX-4600.1.6)
AAPA shall support legislation and policies to eliminate discrimination that contributes to health disparities.


HP-8246
AAPA supports PA activities to acquire the knowledge, skills, and attitudes necessary to provide culturally effective care with the goal of eliminating health disparity gaps.

*Adopted 2022*

HP-8248 (formerly HX-4600.1.6.1)

*Health Disparities: Promoting the Equitable Treatment of All Patients* (paper on page 279)

*Adopted 2011, amended 2016, reaffirmed 2021*

HP-8250 (formerly HX-4600.2.6)
AAPA should make it a priority to promote the PA profession and highlight the role of PAs to patients and leaders of healthcare organizations, such as community hospitals, free medical clinics, federal qualified health centers, state health departments, etc. in underserved communities to improve access to care and reduce health disparities.

*Adopted 2005, reaffirmed 2015, amended 2010, 2020*

HP-8252
AAPA recognizes the unique healthcare needs of at-risk and under resourced communities, including differences in immigrant status, adversely affecting their physical, mental health, and overall wellbeing. AAPA supports development of programs to address social, political, economic, educational, environmental, and systemic barriers including discrimination which widen the gap of health disparities resulting in detrimental negative outcomes. AAPA encourages PAs to continue promoting and delivering innovative community-oriented, high quality healthcare to all people, eliminating barriers, advancing access, and improving outcomes. Any incentives offered by government or private entities promoting more equitable and accessible care should be available to PAs.

*Adopted 2022*

**HP-8260  Rural Health**

HP-8262 (formerly HP-3500.3.1)
AAPA supports the continuation of the certified Rural Health Clinics (RHCs) program to improve access to care in rural medically underserved areas. Certified RHCs program regulations should be flexible and rational, allowing certified RHCs to meet the needs of patients in a timely and cost-effective manner. AAPA believes the cost-based reimbursement mechanism for certified RHCs should be continued or an equivalent reimbursement mechanism should be developed to cover the costs of providing primary care medical services to rural Medicare and Medicaid patients and protect the financial viability of certified...
RHCs. AAPA encourages retention of the original federal requirement that certified RHCs utilize PAs to provide medical care.


HP-8264 (formerly HX-4600.2.1)
AAPA supports the expansion of the national medical care safety net system by allowing rural health clinics to contract with community health centers to provide medical care to uninsured patients at the rural health clinic.


HP-8266 (formerly HX-4600.2.2)
**Rural Health Clinics** (paper on page 190)


HP-8268 (formerly HX-4600.2.3)
AAPA supports the current law which allows rural health clinics to maintain certification regardless of the shortage area designation status until such time as a process has been developed that ensures continuation of access to appropriate care for the patients served by the clinics.


**HP-8280 Public Health Crisis/Disaster Response**

HP-8282 (formerly HX-4600.4.1)
**The PA in Disaster Response: Core Guidelines** (paper on page 159)


**HP-8300 Prescription Medication**

HP-8302 (formerly HP-3300.1.17)
AAPA believes that all PAs should become knowledgeable of programs that make available prescription medications free of charge or at a reduced cost for patients.


HP-8304 (formerly HX-4600.5.9)
AAPA believes that safe and affordable prescription medications should be available for all patients. AAPA encourages pharmaceutical manufacturers to be transparent regarding the costs of their products and to expand their programs of assistance to the under- and un-insured. All health plans and government agencies should negotiate medication prices with suppliers and manufacturers.


HP-8306 (formerly HX-4600.5.2)
AAPA supports ensuring that prescription drug benefit plans offer transparent drug pricing, consumer and prescriber friendly formularies and place limitations on pharmacy benefit managers’ (PBMs) influence in determining drug pricing.

AAPA also supports transparent disclosure of fees that commercial insurers, Medicare Part D Pharmacy Plans and pharmacy benefit managers may collect to offset costs of plan administration. Many of these fees are undisclosed, unregulated and directly increase prescription costs to patients.

In support of improving patient care, AAPA also encourages policies that allow prescribers the ability to consistently: determine safe and effective treatment options at the point-of-care; to understand and
communicate anticipated medication costs to patients; and to identify if medications are subject to step-
therapy or other utilization management requirements including prior authorization.

HP-8308 (formerly HX-4600.5.1)
AAPA supports appropriate and compliant access to samples of prescription drugs from pharmaceutical
manufacturers for the practicing PA.

**HP-8320 Immigrant Health**

HP-8322 (formerly HX-4600.8.2)
AAPA supports the opportunity of people of the world to immigrate to the United States in accordance
with the law to seek the opportunities that our nation holds for its citizens, without discrimination.
[Adopted 2017, reaffirmed 2022]

HP-8324 (formerly HX-4600.1.10)
AAPA believes that all patients deserve access to healthcare and opposes the establishment of local,
federal, or state initiatives that require healthcare providers to refuse care to undocumented persons or to
report suspected undocumented persons to authorities.

HP-8326 (formerly HX-4600.8.1)
AAPA recognizes that policies disrupting families and communities living in the United States have
significant negative physical and mental health implications, particularly when minor children are
involved. AAPA reiterates its support of the duty of PAs to deliver high quality-care to all patients
regardless of their immigration or citizenship status.
[Adopted 2017, amended 2022]

**HP-8400 Technology**

**HP-8420 Information Technology**

HP-8422 (formerly HX-4200.1.3)
AAPA supports systems of personal medical identification containing an individual’s key medical
information and encourages all PAs to promote their use to patients.

HP-8424 (formerly HX-4500.3)
AAPA believes to ensure accountability for the provision of care provided by each member of the
healthcare team, electronic health record (EHR) systems, computerized provider order entry (CPOE)
systems, reimbursement and claims systems, and other health information technology systems should
individually recognize and appropriately attribute PA-provided patient care data to individual PAs.

Health information technology systems should be designed, developed, and implemented with PA input
in a manner that benefits patients, PAs, and the healthcare team by improving quality, transparency and
accuracy.
[Adopted 2013, amended 2018]
HP-8426 (formerly HX-4600.5.4)
AAPA believes information technology should enable PAs to write electronic prescriptions in compliance with all state and federal guidelines. Therefore, AAPA encourages all electronic prescription software companies to incorporate the required parameters to facilitate efficient electronic prescribing by PAs and to ensure that PAs remain in compliance with both state and federal laws and rules.
[Adopted 2012, reaffirmed 2017, amended 2022]

**HP-8440 Point-of-Care Ultrasound**

HP-8442 (formerly HP-3300.1.22.1)
AAPA recognizes the value and supports the advancement of point-of-care ultrasound (POCUS) in PA clinical practice. AAPA endorses, supports, and promotes the development of POCUS educational opportunities.
[Adopted 2021]

**HP-8600 Human Rights**

HP-8620 (formerly HX-4100.1.3)
AAPA opposes all forms of sexual harassment.

HP-8640 (formerly HP-3300.1.4)
AAPA supports equal rights for all persons and supports policy guaranteeing such rights.

HP-8660 (formerly HX-4100.1.7)
AAPA opposes participation of PAs in the torture or inhuman treatment or punishment of individuals in relation to detention or imprisonment.

HP-8680 (formerly HX-4100.1.8)
AAPA endorses the World Medical Association Declaration of Tokyo which provides guidelines concerning torture or other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.

HP-8700 (formerly HX-4100.12)
AAPA opposes all forms of gender discrimination.
[Adopted 2020]

HP-8720 (formerly HX-4100.13)
AAPA opposes all forms of racism.
[Adopted 2021]

HP-8740 (formerly HX-4100.13.1)
AAPA recognizes that racism, in its systemic, structural, institutional, and interpersonal forms, is an ongoing urgent threat to public health, the advancement of health equity, and excellence in the delivery of medical care.

AAPA affirms its commitment to anti-racism values, defined as the intent to change institutional culture, policies, practices, and procedures to remove systemic, structural, institutional, and interpersonal racism.
AAPA supports the elimination of all forms of racism.  
[Adopted 2020]

HP-8760 (formerly HX-4100.14)  
AAPA denounces the use of excessive force by all law enforcement agencies and police officials against all people of color and members of vulnerable populations.

AAPA recognizes in an effort to achieve health equity, the imbalance in the use of force fueled by racial injustice and inequality must come to a halt.

AAPA affirms its commitment to maintaining and securing the safety and health of the public by advocating for effective community policing, robust training and education of de-escalation tactics, as well as the institution of accountability measures for all law enforcement agencies and officials.  
[Adopted 2021]

HP-8780 (formerly HX-4400.1.14)  
**Human Trafficking in the United States** (paper on page 323)  
[Adopted 2019]

**HP-8800 Diversity, Equity, and Inclusion**

HP-8820 (formerly HX-4100.1.10)  
AAPA is committed to respecting the values and diversity of all individuals irrespective of race, ethnicity, culture, faith, sex, gender identity or expression and sexual orientation. When differences between people are respected everyone benefits. Embracing diversity celebrates the rich heritage of all communities and promotes understanding and respect for the differences among all people.  

HP-8840 (formerly HX-4100.1.10.1)  
AAPA leadership and national office staff is committed to fostering a culture that embraces the value of justice, diversity, equity, and inclusion within the Academy, and within our profession.

AAPA recognizes that embracing the principles of diversity, equity, and inclusion (DEI) in the workplace is essential to improved collaboration and morale as well as greater innovation, productivity, tolerance and representation in the work we do both internally and externally within our communities.

AAPA is committed to promoting partnerships and programs that allow us to innovate and implement the changes required to meet our DEI goals.

AAPA is committed to empowering PAs with information, tools, and resources to address inequities in their daily practice and by using AAPA resources (staffing, finances, and strategic planning) to allow PAs to be the change agents for DEI in their practices and in their communities.

AAPA will incorporate change management techniques that demand accountability, measurement, and ongoing monitoring for the effectiveness of DEI initiatives.

AAPA applies the following criteria for meeting AAPA’s Commitment to Diversity, Equity, and Inclusion.
1. DEI is placed as an ongoing overarching goal as part of AAPA’s Strategic Plan outlining measurable steps necessary to achieve DEI within AAPA.

2. DEI initiatives are included in annual budgets, timelines for actions are in place and there are mechanisms to audit the Plan, Do, Study, Act (PDSA) Cycles.

3. AAPA implements partnerships and programs that attract more underrepresented minorities to the profession through collaboration to develop opportunities for innovative changes to DEI inequities in healthcare.

4. AAPA promotes or creates initiatives with all our partners to collectively voice and support policy and legislative solutions to address DEI, health and social issues, justice, tolerance, and address changes to eliminate health disparities (local, state, national and international).

5. AAPA will continue to support constituent organizations and make extraordinary efforts to have representation of all human beings at the decision table.

6. The CEO will report on DEI annually to AAPA’s HOD.

[Adopted 2021]

HP-8860 (formerly HX-4100.2.1)
AAPA supports the full integration of persons with disabilities into society and supports their full participation in educational, employment, community living, and health opportunities.

HP-8880 (formerly HX-4100.2.2)
AAPA supports national, state, and community efforts that enhance the quality of life for persons with disabilities.

HP-9000 Clinical Standards

HP-9200 General

HP-9220 (formerly HP-3700.1.7)
AAPA defines family as any person or persons who play a significant role in an individual’s life. This may include persons not legally related to the individual. AAPA recognizes that PAs are obligated to follow state and federal laws regarding family, however, AAPA encourages PAs to acknowledge, respect and consider any non-legally or non-genetically related family members.
[Adopted 2010, reaffirmed 2015, 2020]

HP-9240 (formerly HX-4600.1.2)
AAPA supports the free and transparent exchange of information between the patient and provider necessary to make informed healthcare decisions. AAPA opposes any intrusion into the provider-patient relationship that inhibits the provider’s ability to deliver necessary medical services. AAPA supports creation of virtual methods and patient decision aids designed to facilitate shared decision-making and informed consent in an efficient, lawful, and ethical manner between patient and provider.

HP-9260 (formerly HX-4500.6) Scientific Integrity and Public Policy (paper on page 249)
AAPA encourages and supports the incorporation of health promotion and disease prevention into PA practice, through advocacy of healthy lifestyles, preventive medicine, and the promotion of healthy behaviors that will improve the management of chronic diseases to reduce the risk of illness, injury, and premature death. Preventive measures include the identification of risk factors, e.g., family history, substance abuse, and domestic violence; immunization against communicable diseases; and promotion of safety practices.

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


AAPA endorses the use of the U.S. Department of Health and Human Services’ report Healthy People and its subsequent initiatives which serve as a guide to improve the health of the nation.

All PAs should become familiar with the goals and objectives of Healthy People initiatives to improve health promotion, health equity, and disease prevention in their communities.


AAPA recognizes the U.S. Preventive Services Task Force recommendations as unique and innovative in the field of preventive medicine and supports their utilization as one resource in the practice of preventive medicine.


AAPA strongly recommends that PAs promote and educate about the physiological and psychological benefits of physical activity and encourage everyone to establish a lifetime commitment to a regular physical activity routine.


 AAPA is opposed to the use of tanning beds by adolescents and young adults under 18 years of age.

[Adopted 2012, reaffirmed 2017, 2022]

AAPA encourages state chapters to pursue and support legislation to restrict the use of tanning beds by individuals under 18 years of age.
HP-9580 (formerly HX-4300.1.5)
PAs should educate patients of all ages about the dangers of tanning and the importance of full skin exams yearly.  
[Adopted 2012, reaffirmed 2017, 2022]

**HP-9600 Health Literacy**

HP-9620 (formerly HP-3300.1.9.0)
AAPA will promote measures to reduce the barrier of limited health literacy by encouraging the development and use of literacy-appropriate patient education material by PAs. These measures are encouraged through inclusion of culturally diverse health literacy components in continuing education programs as well as undergraduate and graduate education curricula.  

HP-9640 (formerly HP-3300.1.9.1)
*Health Literacy: Broadening Definitions, Intensifying Partnerships and Identifying Resources* (paper on page 261)  

HP-9660 (formerly HP-3300.1.9.2)
AAPA encourages PAs to identify and utilize reliable and accurate consumer health information on specific disease states to encourage patient knowledge and understanding and improve health education. Health education information should be evidence-based and appropriate to the patient’s culture, language, and level of literacy. Provision of such resources is consistent with AAPA efforts to promote health literacy.  
[Adopted 2010, amended 2015, 2020]

**HP-9800 Safety**

**HP-9820 General**

HP-9822 (formerly HX-4300.1.1)
AAPA encourages and supports accurate and appropriate labeling of foods, dietary supplements, herbal preparations, over-the-counter and prescription medications, cosmetics, and personal care products that clearly illustrate ingredients, potential health hazards and adverse reactions, indications for usage, and contraindications. For those products not regulated by the FDA, AAPA strongly encourages manufacturers to provide consumers with information on the quality of a product and to be in compliance with the United States Pharmacopeia Standards.  

HP-9824
AAPA supports the legislation and the use of safety-related labeling for button/coin batteries and more secure closure of compartments of products containing a button/coin battery.  
[Adopted 2022]
AAPA encourages all citizens to follow the manufacturer's guidelines regarding the use of all safety features on motorized vehicles.  

AAPA and its chapters actively encourage all states to enact mandatory seatbelt legislation for both front and rear occupants of a vehicle. AAPA supports child restraint laws and encourages PAs to discuss evidence-based recommendations for best practices in the choice of child restraint system to optimize safety in passenger vehicles for children from birth through adolescence. AAPA supports further research that aims to improve the safety of children in motor vehicles, to include school transportation.  

AAPA supports legislation that bans the non-emergent use of hand-held communication devices while operating a moving vehicle.  
[Adopted 2011, reaffirmed 2016, 2021]

AAPA supports national and state legislative initiatives to require mandatory drug and alcohol screening by law enforcement officials of all drivers in fatal and serious injury motor vehicular crashes.  

PAs, by virtue of their education and legal scope of practice as professionals who provide medical care in teams, are qualified to order and monitor the use of patient restraint and seclusion. This applies to restraints when used in conjunction with a medical or surgical procedure and when used for behavioral reasons. Restraint or seclusion should only be for the purpose of protecting the patient or others or to improve a patient's functional well-being, and only if less intrusive interventions have been determined to be ineffective. Hospitals, health systems, accrediting and certifying bodies should ensure that their policies authorize PAs to order and monitor the use of restraint and seclusion, as allowed by state law.  

AAPA believes that patients have the right to be free of all forms of seclusion and physical and chemical restraint that are not medically necessary. Seclusion and restraint should not be used as a means of coercion, discipline, convenience, or retaliation. Seclusion and restraint should only be used according to accepted medical standards for the purpose of protecting the patient or others and to improve a patient's functional well-being and only if less intrusive interventions have been determined to be ineffective.  

PAs are encouraged to identify key factors that may lead to violence in all ages and to be familiar with and initiate appropriate interventions, including but not limited to, all legally required notifications to
address these situations when occurring within their practice setting and/or the community. Interventions may also include innovative and multidisciplinary efforts.

HP-9884 (formerly HX-4400.1.1)
AAPA will develop and maintain working relationships with groups and organizations committed to preventing violence through the development of multifaceted, multidisciplinary approaches including non-violent conflict resolution and a focus on prevention of bullying.
[ Adopted 2019 ]

HP-9886 (formerly HX-4400.1.2)
AAPA encourages legislative efforts, at all levels of government, that are aimed at evidence-based interventions to reduce violence and protect patients, particularly those from vulnerable populations. Where evidence does not exist, AAPA encourages the continued scientific, non-partisan research into the subject matter.
[ Adopted 2019 ]

HP-9888 (formerly HX-4400.1.5)
AAPA recognizes that abuse and violence are a public health epidemic in the United States. AAPA supports medical care of individuals who have encountered violence including, but not limited to, abuse, neglect and human trafficking and emphasizes linkages with community-based programs and referral agreements whenever possible. PAs should be aware of organizational and state requirements regarding the examination, documentation, and reporting of suspected or reported intentional injury, neglect or abuse. If necessary, PAs are to provide timely referrals to institutions that can perform these services.
[ Adopted 2019 ]

HP-9890 (formerly HX-4400.1.6)
AAPA believes that PAs should be well-versed in community resources available to prevent violence, particularly interventions aimed at vulnerable populations. PAs should also be aware of the potential effects of media violence and should encourage parents and guardians to be cognizant of content to which family members may be exposed.
[ Adopted 2019 ]

HP-9892 (formerly HX-4400.1.12)
AAPA believes that PAs should be aware of the potential effects of media violence on their patients and within their community. PAs should consider involvement in professional organizations and community activities that seek to reduce the amount of violence, cyberbullying, and other problematic content in media materials. PAs should encourage increased parental involvement in their children’s computer activities, media exposure, use of social media and game-playing decisions. PAs should make information on media literacy available to patients and families.

HP-9894 (formerly HX-4400.2.1)
AAPA opposes the proliferation and utilization of weapons of mass destruction and supports the immediate pursuit of global nuclear disarmament. AAPA supports the continued education of its membership and the public at large of the public health and medical ramifications of chemical, biological, radiological agents, nuclear warfare and terrorism.
AAPA supports policies, educational programs, and research that will effectively reduce homicide, suicide and other violence that occurs through the use of firearms. As AAPA represents the diverse membership of PAs, AAPA supports:

1. Reporting by PAs to law enforcement agencies persons in their care exhibiting behavior dangerous to themselves or others.
2. Supporting state legislation that allows PAs to counsel patients regarding firearm safety.
3. Participation in and/or advocacy of educational programs on the safe storage and use of firearms.
4. Participation in and/or advocacy of training programs for the safe use and employment of firearms.
5. Enforcement of current laws for the purposes of public safety regarding firearms.


Proliferation and Dispersal of Anti-personnel Weapons (paper on page 284)

[Adopted 2012, reaffirmed 2017, 2022]

AAPA supports the removal of federal restrictions on the study of gun violence by the CDC.

[Adopted 2018]

HP-10000  Substance Use Disorder

HP-10020  General

AAPA encourages PAs to identify patients with substance use disorders and initiate treatment which may include medication assisted treatment as well as referral to qualified behavioral health providers.


AAPA recognizes the significant public health implications of substance use disorders, to include both non-medical use of prescription drugs and illicit substances use and encourages PAs to take an active role in eliminating substance use disorders. AAPA supports the education of all PAs in the early identification, treatment and prevention of substance use disorders.

[Adopted 2005, reaffirmed 2010, amended 2015, 2021]

AAPA supports needle/syringe exchange programs and legal access to sterile injection equipment as effective public health measures for reducing the transmission of bloodborne pathogens. In particular, AAPA endorses:

- establishment of needle/syringe exchange programs by public health departments and other organizations to support the use of sterile needles/syringes by individuals who inject drugs and other substances;

- government funding to support access to sterile needles and syringes;
• amendment of state paraphernalia laws and needle/syringe prescription and dispensing laws to allow legal access to and possession of injection equipment; and

• PA involvement in direct patient education and counseling regarding the attainment of sterile needles/syringes either through established exchange programs, or by prescription or over-the-counter in states where allowed.


HP-10028 (formerly HX-4200.2.1.1)
AAPA endorses establishment of supervised injection facilities in order to decrease the adverse health, social and economic consequences of the ingestion of illicit drugs, and supports the amendment of all pertinent federal, state and local laws necessary to allow the establishment of supervised injection facilities.
[Adopted 2018]

HP-10030 (formerly HX-4200.2.1.2)
AAPA encourages state constituent organizations to advocate for the establishment of supervised injection facilities.
[Adopted 2018]

HP-10032 (formerly HX-4600.5.10)
AAPA supports the use of Prescription Drug Monitoring Programs (PDMP) for the prescribing and dispensing of controlled substances at the state level including the ability of prescribers and dispensers to query other states for similar information.
[Adopted 2018]

HP-10040  Alcohol

HP-10042 (formerly HX-4200.3.1)
AAPA advocates for responsible behavior concerning alcohol use and mitigating alcohol-related harms. AAPA encourages public education efforts regarding its potential for abuse and encourages alcohol screening as part of routine primary care and as part of specialty care where unknown alcohol use could affect patient care and outcomes.

HP-10044 (formerly HX-4200.3.2)
AAPA supports legislation that encourages states to impose minimum mandatory sanctions against drivers convicted of driving under the influence of alcohol and that encourages states to establish comprehensive alcohol-traffic safety programs which would help to assure stronger laws, stringent enforcement, and effective rehabilitation programs.

HP-10046 (formerly HX-4200.3.3)
AAPA recognizes the consequences of underage drinking and supports comprehensive strategies to prevent underage access to and consumption of alcohol, including:
1. That it be illegal for individuals under the age of 21 to drive with any measurable amount of alcohol in their bodies.
2. That retailers and individuals be held accountable/liable for negligently providing alcohol, including powdered alcohol, to a minor.
3. That underage exposure to promotion of alcoholic beverages be limited; advertisers promoting alcoholic beverages should be required to provide balanced time for the promotion of responsible alcohol use.
4. That all beverages and substances containing alcohol, such as medications, be labeled appropriately.

HP-10060  Cannabinoids

HP-10062 (formerly HX-4600.7.1)
AAPA believes that additional clinical research should be conducted on the therapeutic value and efficacy and safety of cannabinoids. AAPA urges that the status of cannabinoids as a federal Schedule I controlled substance be reviewed to facilitate and allow the conducting of clinical research.

HP-10064 (formerly HX-4600.7.2)
AAPA recommends that in any state where medical cannabinoids laws exist, PAs are included as healthcare providers that can authorize or recommend the use of cannabinoids for patients. AAPA believes effective patient care requires the free and unfettered exchange of information on treatment options and that discussion of cannabinoids as an option between PAs and patients should not subject either party to criminal sanctions.
[Adopted 2016, amended 2021]

HP-10066 (formerly HX-4600.7.3)
AAPA supports continued education programs and public health-based strategies addressing and reducing the non-medical use of cannabinoids.

AAPA supports public health-based strategies and local legislation in lieu of incarceration, when dealing with persons in possession of non-medical use cannabinoids.
[Adopted 2016, amended 2022]

HP-10068 (formerly HX-4600.7.4)
AAPA discourages the use of cannabinoids by persons who are planning to become pregnant, are pregnant, or breastfeeding and shall treat and counsel on cessation of cannabinoids.
[Adopted 2016, amended 2021]

HP-10070 (formerly HX-4600.7.5)
AAPA discourages the non-medical use of cannabinoids by those persons under the age of 21 and discourages the non-medical use of cannabinoids by adults who are in the presence of persons under the age of 21.
[Adopted 2016, amended 2021]

HP-10072 (formerly HX-4600.7.6)
AAPA supports labeling and child-proof packaging of cannabinoids and cannabinoid-related products and that limits advertising to adolescents.
[Adopted 2016, amended 2021]
HP-10080  Opioids

HP-10082 (formerly HX-4200.7.1)
AAPA encourages student and graduate PAs to recognize the crises of pain management and opioid use disorder. AAPA encourages student and graduate PAs to work towards a solution to these crises at the local, state, and national levels through advocacy, collaboration and education for students and practicing PAs about responsible opioid prescribing. AAPA further supports the utilization of prescription drug monitoring programs as a tool to practice responsible opioid prescribing.
[Adopted 2016, amended 2021]

HP-10084 (formerly HX-4200.7.2)
AAPA supports PAs as vital members of the healthcare team in the treatment of Opioid Use Disorder. AAPA further supports PAs having the same buprenorphine specific educational requirements and patient capitation limits as physicians when treating Opioid Use Disorder.
[Adopted 2018]

HP-10086 (formerly HX-4200.7.3)
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.
[Adopted 2016, reaffirmed 2021]

HP-10088 (formerly HX-4200.7.4)
AAPA supports the expansion of hospital-to-community care of patients with Opioid Use Disorder (OUD), including the initiation of medication assisted treatment (MAT) in hospitals and emergency rooms. This includes accessing community-based follow-up upon discharge from hospitals or emergency rooms where OUD medications have been initiated.
[Adopted 2019]

HP-10090 (formerly HX-4200.7.5)
AAPA supports ongoing efforts to remove obstacles to PAs being fully utilized in the treatment of Opioid Use Disorder (OUD). This includes supporting PA-physician parity regarding training requirements to prescribe buprenorphine, as well as optimizing resources for PAs to navigate the separate buprenorphine and methadone exemption processes.
[Adopted 2019]

HP-10092
AAPA encourages federal, state, and local regulatory bodies to consider reducing restrictions on the use of methadone in the treatment of Opioid Use Disorder.
[Adopted 2022]

HP-10094 (formerly HX-4600.5.5)
AAPA endorses increasing public access to naloxone for secondary administration for the reversal of opioid overdoses and supports the establishment and expansion of naloxone prescribing distribution programs.
[Adopted 2012, amended 2017, reaffirmed 2022]

HP-10096 (formerly HX-4600.5.6)
AAPA advocates for legislative and/or regulatory changes to remove legal and regulatory barriers to prescribing, dispensing, or distributing naloxone for secondary administration for the reversal of opioid overdoses.
[Adopted 2012, amended 2017, reaffirmed 2022]
State chapters are encouraged to collaborate with public health agencies, addiction treatment organizations, local and state medical societies, patient advocacy organizations, and other entities to seek legislative and/or regulatory changes to remove barriers to the prescribing, dispensing, or distribution of naloxone for secondary administration for the reversal of opioid overdoses.

[Adopted 2012, amended 2017, reaffirmed 2022]

**HP-10100  Performance Enhancing Drugs**

HP-10102 (formerly HX-4200.1.2)
AAPA encourages patient and healthcare provider awareness and education as to the dangers in the use of anabolic steroids, steroid supplements, and performance-enhancing products and procedures (PEPS) for body building and sports performance.


**HP-10120  Tobacco**

HP-10122 (formerly HX-4200.4.0.1)
*Tobacco Use Disorder* (paper on page 295)

[Adopted 2016, amended 2021]

HP-10124 (formerly HX-4200.4.0.2)
*Vaping: Use of Electronic Nicotine Delivery Systems* (paper on page 341)

[Adopted 2020]

**HP-10200  Alternative Medicine**

HP-10220 (formerly HP-3300.1.14)
AAPA supports the informed and evidence-based use of complementary and alternative medicine modalities by patients and PAs for conditions amenable to these therapies.

[Adopted 2019]

**HP-10400  “Conversion or Reparative” Therapy**

HP-10420 (formerly HX-4200.6.1)
AAPA opposes any treatment directed specifically at changing sexual orientation or gender identity.


HP-10440 (formerly HX-4200.6.2)
*Attempts to Change a Minor's Sexual Orientation, Gender Identity, or Gender Expression* (paper on page 318)

[Adopted 2017, reaffirmed 2022]

**HP-10600  Correctional Healthcare**

HP-10620 (formerly HX-4100.1.2)
AAPA encourages all of the nations’ correctional facilities to seek accreditation through on-site evaluation using the National Commission on Correction Health Care’s (NCCHC) *Standards for Health Services in Jails* and *Standards for Health Services in Prisons*.
A PA, as a member of a healthcare profession, should not participate in an execution. Participation in an execution includes, but is not limited to, the following actions: (1) prescribing or administering medications or substances that are part of the execution procedure; (2) monitoring vital signs on site or remotely (including monitoring electrocardiograms); (3) attending or observing an execution as a PA; and (4) rendering technical or professional advice regarding execution.

In a case where the method of execution is lethal injection, the following actions would also constitute participation in the execution: (1) selecting injection sites (2) starting intravenous lines as a port for an injection device (3) prescribing, preparing, administering, or supervising lethal injection drugs or their doses or types (4) inspecting, testing, or maintaining lethal injection devices and (5) consulting with or supervising lethal injection personnel.

The following actions do not constitute participation in an execution: (1) certifying death, provided that the condemned has been declared dead by another person who is legally authorized to declare death in that jurisdiction (2) witnessing an execution in a totally non-professional capacity (3) witnessing an execution at the specific voluntary request of the condemned person, provided that the PA observes the execution in a non-professional capacity (4) relieving the acute suffering of a condemned person who is awaiting execution, including providing medication at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.

HP-10800  Emergency Medicine

A PA, as a member of a healthcare profession, should not participate in an execution. Participation in an execution includes, but is not limited to, the following actions: (1) prescribing or administering medications or substances that are part of the execution procedure; (2) monitoring vital signs on site or remotely (including monitoring electrocardiograms); (3) attending or observing an execution as a PA; and (4) rendering technical or professional advice regarding execution.

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AAPA recommends hospitals allocate staff so that the staffing ratios are balanced throughout the hospital to avoid overburdening the emergency department staff while maintaining patient safety.


AAPA acknowledges the goals of EMS Agenda 2050 and the role that PAs can have, in collaboration with EMS providers, to provide care in the pre-hospital setting and expand ability for EMS agencies to support preventative health and community-centered programs.

[Adopted 2022]

**Environmental Health**

AAPA recommends hospitals allocate staff so that the staffing ratios are balanced throughout the hospital to avoid overburdening the emergency department staff while maintaining patient safety.


HP-10920

AAPA acknowledges the goals of EMS Agenda 2050 and the role that PAs can have, in collaboration with EMS providers, to provide care in the pre-hospital setting and expand ability for EMS agencies to support preventative health and community-centered programs.

[Adopted 2022]

HP-11000

AAPA encourages PAs to acquire the knowledge and skills necessary to recognize the influence that environment has on the health of individuals and their communities.

[Adopted 2010, reaffirmed 2015, 2020]

HP-11040

AAPA supports continued educational efforts to keep the PA profession informed on issues of environmental health in publications and through continuing educational opportunities.

[Adopted 2010, reaffirmed 2015, 2020]

HP-11060

AAPA encourages PAs to actively participate in the development and sharing of the knowledge regarding effects of the environment on the health of their patients and the larger community.

AAPA encourages PAs to limit their personal impact on the environment through conservation, wise-use and recycling as an example to their patients and community.

[Adopted 2010, reaffirmed 2015, 2020]

HP-11080

AAPA supports development of strategic alignments that would promote reasoned societal momentum, valuing the best available science, to address critical issues of environmental impact on health.

AAPA supports legislative and regulatory actions that decrease the impact of anthropogenic waste and emissions as a means of decreasing exposure to toxic substances and environmental insults.

[Adopted 2010, reaffirmed 2015, 2020]

HP-11100

AAPA encourages PAs to recognize and understand the public health effects of globalization and climate change.

[Adopted 2015, reaffirmed 2020]

HP-11120

AAPA encourages its membership to be aware of medical consequences of toxic waste.

HP-11200  Genetics and Genomics

HP-11220 (formerly HP-3300.1.21.1)

Genetic and Genomic Testing (paper on page 332)
[Adopted 2019]

HP-11240 (formerly HX-4100.1.6)
AAPA believes that genetic information should not be used to discriminate against individuals or their families. AAPA supports state and federal legislation designed to protect the confidentiality of genetic information and to prevent discrimination based on that information.

HP-11260 (formerly HX-4500.4)
AAPA endorses a legally enforceable ban on the cloning of human beings for the purpose of reproduction. However, AAPA supports stem cell research, including the use of nuclear transplantation techniques (also known as research or therapeutic cloning) in order to realize the enormous potential health benefits this technology offers.

HP-11400  Infectious Disease

HP-11420  General

HP-11422 (formerly HP-3300.1.13.4)
AAPA encourages PAs to actively obtain the most current epidemiological information available on emerging infectious disease threats and to utilize evidence-based practices to reduce the spread of emerging infectious diseases amongst patients and healthcare workers. Furthermore, PAs are encouraged to remain knowledgeable on evidence based treatments for patients diagnosed with emerging infectious diseases.
[Adopted 2015, reaffirmed 2020]

HP-11440  Antimicrobial Resistance

HP-11442 (formerly HP-3300.1.13.1)
AAPA believes that PAs should be aware of antimicrobial stewardship and resistance in their clinical practice through detection and containment of resistant pathogens and proper antibiotic use. This involves continuous education for PAs and PA students on advancing technologies. The Centers for Disease Control and Prevention (CDC) and the Infectious Diseases Society of America (IDSA) produce a number of documents describing these issues and how clinicians can respond. PAs must recognize that the issue extends beyond the clinical arena. Furthermore, AAPA believes that further research and development is essential to combatting this problem.
[Adopted 2019]

HP-11444 (formerly HP-3300.1.13.2)
Antimicrobial Resistance (paper on page 220)
HP-11460  HIV/AIDS

HP-11462 (formerly HX-4100.1.5)
AAPA supports laws, policies, regulations, and judicial precedents regarding people living with HIV/AIDS that are in accordance with the following principles:

(1) should not place unique or additional burdens on such individuals solely as a result of their HIV status; and

(2) should instead demonstrate a public health-oriented, evidence-based, medically accurate, and contemporary understanding of—

(A) the multiple factors that lead to HIV transmission;
(B) the relative risk of HIV transmission routes;
(C) the current health implications of living with HIV;
(D) the associated benefits of treatment and support services for people living with HIV; and
(E) the impact of punitive HIV-specific laws and policies on public health, on people living with or affected by HIV, and on their families and communities.


HP-11464 (formerly HX-4200.2.2)
Global Epidemic HIV/AIDS (paper on page 239)

HP-11480  Hepatitis C

HP-11482 (formerly HX-4200.2.3)
AAPA supports increased focus on addressing the Hepatitis C epidemic. This will include: alignment with Centers for Disease Control and Prevention (CDC) recommendations for all adults aged 18 years and older to be screened for Hepatitis C at least once in a lifetime and supports the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts.

[Adopted 2017, amended 2022]

HP-11600  Mental Health

HP-11620 (formerly HP-3300.1.18)
AAPA believes evaluation of mental health and appropriate diagnosis and treatment, prevention, and screening of mental illness and consideration of patients’ mental health are essential to overall patient well-being and improved health outcomes. As per the World Health Organization’s definition, AAPA also believes that optimal health is composed of physical, mental and social well-being and not merely the absence of disease or infirmity.


HP-11640 (formerly HP-3300.1.20)
AAPA supports the National Action Alliance for Suicide Prevention’s report, “Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe,” as a guide for PAs.

[Adopted 2018]
HP-11800  Neurology

HP-11820 (formerly HX-4300.2.2)
AAPA shall support state laws requiring protective equipment for individuals participating in activities that put them at risk of traumatic brain injury. In addition, AAPA shall encourage all PAs to educate their patients, parents/guardians, and the public on the value of the appropriate protective equipment as protection from traumatic brain injury. Such education should address activities in which there is a risk of traumatic brain injury.

AAPA supports the adoption of evidence-based guidelines for the evaluation and management of concussions by all athletic organizations and encourages further research in the diagnosis, treatment, and prevention of chronic traumatic encephalopathy.

HP-12000  Obesity

HP-12020 (formerly HP-3300.1.11.1)
AAPA encourages PAs to become educated about the prevention and treatment of overweight and obesity for both the adult and pediatric population. AAPA encourages PAs to take an active leadership role in educating their patients and the public about the chronic and multi-factorial nature of the disease of obesity, which includes genetic factors, infections, hypothalamic injury, weight promoting medications, weight promoting medical conditions, nutritional imbalance, and/or environmental factors.

PAs are encouraged to understand adiposopathy and how this contributes to metabolic disease. PAs are encouraged to understand how physical forces from excess body fat contribute to biomechanical health consequences of obesity. AAPA also encourages PAs to become educated on obesity stigma and weight bias, and how this can impact patient care and a patient’s health. AAPA encourages PAs to use person-first language and non-stigmatizing obesity terminology, as well as to provide an office environment which comfortably accommodates patients with obesity.

AAPA encourages PAs to be educated on the appropriate diagnosis and assessment of a patient with overweight or obesity, as well as on how to formulate a comprehensive treatment plan, including nutrition, physical activity, behavior modification, and, if medically appropriate, pharmacology, and bariatric surgery/ endoscopic procedures. PAs are encouraged to have referral sources available for patients with overweight and obesity when appropriate, and refer to obesity medicine specialists and/or bariatric programs, exercise physiologists, dietitians, sleep specialists, psychologists, or other referral sources, when needed.
[Adopted 2018]

HP-12200  Oral Health

HP-12220 (formerly HP-3300.1.5)
AAPA encourages all PAs to take an active role in oral disease prevention and oral health promotion. PAs should increase awareness and knowledge of oral disease, explore ways to incorporate screening and prevention into practice, and collaborate with dental health professionals for the management and/or referral of oral disease.
[Adopted 2011, reaffirmed 2016, amended 2021]
**HP-12400  Organ Donation**

HP-12420 (formerly HP-3300.1.8.1)
AAPA encourages PAs to be familiar with the criteria for identifying potential organ/tissue donors and supports multi-organ and tissue donation. PAs should be involved where appropriate in the discussion regarding donation and subsequent acquisition of organ/tissue donation as is medically indicated. Furthermore, PAs who are knowledgeable in the area of organ and tissue donation and transplantation should be actively involved in education of those in healthcare as well as the general public.
[Adopted 2018]

HP-12440 (formerly HX-4200.5.1)
AAPA supports organ and tissue donation and notes that transplantation should be made available based on need rather than ability to pay.
[Adopted 2018]

**HP-12600  Palliative Care/End of Life**

HP-12620 (formerly HP-3300.1.16)
AAPA encourages PAs to utilize educational resources to become aware of the medical, legal, social, and ethical issues surrounding Advance Directives for Medical Care. PAs are encouraged to facilitate open discussion with patients and their family members concerning an individual's right to make treatment choices. PAs are encouraged to collaborate with other healthcare professionals to facilitate discussions in communities, bringing this complex issue into the public forum.

HP-12640 (formerly HP-3300.1.19.1)
AAPA believes that palliative medicine is a core component of PA practice and encourages all PAs to acquire training in this discipline commensurate with their clinical practice.
[Adopted 2018]

HP-12660 (formerly HP-3300.1.19.2)
AAPA supports inclusion of PAs in any proposed educational funding for healthcare providers in hospice and palliative medicine.
[Adopted 2018]

HP-12680 (formerly HP-3300.1.19.3)
AAPA believes in partnering with other relevant associations including the PAEA, Patient Quality of Life Coalition (PQLC), American Academy of Hospice and Palliative Medicine (AAHPM), National Hospice and Palliative Care Organization (NHPCO), and ARC-PA to advance the progress of palliative care education and practice.
[Adopted 2018, amended 2022]

HP-12700 (formerly HP-3700.1.4)
*End-of-Life Decision Making* (paper on page 172)

HP-12720
AAPA believes that federal and state regulations should remove existing barriers for PA management of the seriously ill and patients who elect to use their hospice benefit at state and national levels.
[Adopted 2022]
HP-12800  Pediatrics

HP-12820 (formerly HX-4200.1.5)
AAPA endorses exclusive breast or chest feeding when possible, for about the first 6 months of life, unless medically contraindicated. Continued breast/chest feeding (along with complementary food introduction) is recommended for at least the first year of the infant’s life and then as mutually desired by the parent and infant.

HP-12840 (formerly HX-4200.7.6)
Medications in Children (paper on page 337)
[Adopted 2019]

HP-12860 (formerly HX-4600.1.7)
Support for Co-parent or Second Parent Adoptions Regardless of Gender (paper on page 223)

HP-13000  Reproductive Health/Obstetrics and Gynecology

HP-13020 (formerly HP-3300.1.10.0)
AAPA believes that all PAs should provide or refer to someone who can provide information about emergency contraception to victims of sexual assault and as a part of routine family planning.

HP-13040 (formerly HX-4600.6.2)
AAPA supports over-the-counter nonprescription status of emergency contraception pills.

HP-13060 (formerly HX-4200.1.8)
AAPA believes that timely access to ongoing prenatal care is essential to optimizing pregnancy outcomes. PAs should be engaged in providing, or aware of programs within their communities that provide access to affordable, quality and culturally competent preconception and prenatal care.

HP-13080 (formerly HX-4200.1.10)
Disparities in Maternal Morbidity and Mortality (paper on page 343)
[Adopted 2021]

HP-13100 (formerly HX-4600.6.1)
AAPA opposes restrictions and attempts to restrict the availability of and access to reproductive healthcare.

HP-13120 (formerly HX-4600.6.3)
AAPA encourages its members to work with schools and parents within their communities to establish evidence-based programs for reproductive health education in schools.

HP-13140 (formerly HX-4600.6.4)
AAPA supports equitable and confidential access to comprehensive sexual and reproductive health information and services, to include family planning and birth control options, that are evidence-based,
developmentally appropriate, culturally sensitive, and available in a telehealth capacity when face to face care is not optimal.


HP-13160 (formerly HX-4600.6.5)
AAPA believes all PAs should advocate for and promote evidence-based reproductive and sexual health interventions in order to prevent unintended pregnancies and sexually transmitted infections. AAPA should advocate to ensure that reproductive and sexual health promotion and preventive interventions are available via telehealth technology.

[Adopted 2005, reaffirmed 2010, amended 2015, 2021]

**HP-13200 Virtual Medicine/Telehealth**

HP-13220 (formerly HX-4500.1)
AAPA believes that telemedicine that follows best practice guidelines improves access to cost-effective, quality healthcare. AAPA encourages PAs and PA students to become competent in best practices of telemedicine technology and the clinical delivery of telemedicine services.


HP-13240
AAPA encourages PAs and PA students to advocate for appropriate resource allocation to support development of telemedicine programs. AAPA supports the elimination of barriers to implementation and utilization of telemedicine services for patients, providers and the healthcare system.

[Adopted 2022]

HP-13260 (formerly HX-4500.2)
*Telemedicine* (paper on page 287)

[Adopted 2015, amended 2021]
Promoting the Access, Coverage and Delivery of Healthcare Services
(Adopted 2018)

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

- AAPA believes the primary goal of our healthcare system is to ensure that everyone in America has access to quality, affordable healthcare.
- AAPA opposes policies that discriminate against patients on the basis of pre-existing conditions, health status, race, sex, age, socio-economic status or other discriminatory demographic or geographic factors.
- AAPA supports a healthcare system that provides essential health services to all patients.
- AAPA supports confronting resource and care limitations while encouraging the use of evidence-based medicine and comparative-effectiveness research.
- AAPA supports policies that optimize the utilization of primary care in our healthcare system.
- AAPA supports policies that promote coordinated, patient-focused care that improves quality and outcomes for patients and their families.
- AAPA supports placing emphasis on health and wellness promotion and disease prevention.
- AAPA supports patient choice of qualified providers, including PAs.
- AAPA recognizes that reform may include changes to the medical liability insurance system and are supportive of policies that enhance transparency and trust between providers and patients.
- AAPA is governed by these principles and is not an advocate for any specific approach to restructuring or financing of the healthcare system.

AAPA encourages policy makers to pursue policies that improve the American healthcare system and ensure everyone in America has access to high-quality, affordable healthcare. AAPA supports policies that prioritize meeting patient needs through evidence-based medicine and that embrace AAPA’s guiding principles.

AAPA’s guiding principles promote policies that protect patients from discrimination based on pre-existing conditions, health status, race, sex, socio-economic or other discriminatory demographic or health-related factors. The principles also call for access to affordable high-quality healthcare coverage that provides meaningful and robust coverage for all patients. As healthcare
providers, PAs believe all patients must have access to a range of essential health services such as maternity care, emergency services, prescription drugs, and treatment for substance abuse and mental health needs. Patients should be satisfied with the type and quality of care being provided. Also, patients should be able to choose a qualified provider that is the best fit for their needs without facing restrictions in obtaining their medical care.

In partnership with our patients and the broader healthcare community, AAPA believes PAs and all healthcare providers should be held to the highest professional standards of evidence-based care and medical ethics.

AAPA and the PA profession are committed to working with the Federal Government, states, territories, tribes, patients, and all stakeholders to improve the United States’ healthcare system. AAPA sets forth the following principles to direct its efforts.

**Principles**

- AAPA believes the primary goal of our healthcare system is to ensure that everyone in America has access to quality, affordable healthcare.
- AAPA opposes policies that discriminate against patients on the basis of pre-existing conditions, health status, race, sex, age, socio-economic status or other discriminatory demographic or geographic factors.
- AAPA supports a healthcare system that provides essential health services to all patients.
- AAPA supports confronting resource and care limitations while encouraging the use of evidence-based medicine and comparative-effectiveness research.
- AAPA supports policies that optimize the utilization of primary care in our healthcare system.
- AAPA supports policies that promote coordinated, patient-focused care that improves quality and outcomes for patients and their families.
- AAPA supports placing emphasis on health and wellness promotion and disease prevention.
- AAPA supports patient choice of qualified providers, including PAs.
- AAPA recognizes that reform may include changes to the medical liability insurance system and are supportive of policies that enhance transparency and trust between providers and patients.
- AAPA is governed by these principles and is not an advocate for any specific approach to restructuring or financing of the healthcare system.
Conclusion

AAPA believes policies adopted at the state or federal level should protect coverage for patients, assure access to care provided by PAs and other providers, as well as maintain coverage of essential health benefits for our patients. Patients should have access to a variety of health services and be satisfied with the type and quality of care available. Patients should not experience restrictions due to pre-existing conditions or face other arbitrary condition-based exclusions. We believe following these principles will ensure access to high quality healthcare and improve the quality and transparency of the care available to all Americans.
Accreditation and Implications of Clinical Postgraduate PA Training Programs

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 throughout every PA’s 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 AAPA’s Commission on Continuing Professional Development and Education to support their efforts in reviewing and revising the current AAPA policy HP-4420 regarding the accreditation of postgraduate physician associate training programs as described in the position paper entitled “Maintaining Professional Flexibility: Issues Related to Accreditation of Postgraduate Physician Associate 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 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 AAPA’s 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, orthopaedic 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:
  o 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 measurable 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 throughout every PA’s 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.
Guidelines for Updating Medical Staff Bylaws: 
Credentialing and Privileging PAs 

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

• AAPA believes PAs must seek the right to exercise clinical privileges via the healthcare entity’s organized medical staff process. The process and criteria for a request for medical staff clinical privileges must be outlined in medical staff bylaws.
• AAPA believes PAs should be voting members of the medical staff. Bylaws should afford PA representation with full voting rights on medical staff committees, including the medical executive committee.
• AAPA believes medical staff bylaws should require that each PA wishing to provide medical care to the healthcare entity’s patients and seeks to be considered for clinical privileges regardless of the PA’s employment arrangements, whether the PA is directly employed by the entity granting the privileges or another independent entity.
• AAPA opposes specialty certification as a requirement for PA credentialing or privileging.
• AAPA believes the duration of medical staff appointments and clinical privileges should be the same for physicians and PAs.
• AAPA believes bylaws should give PAs the right to due process when actions taken by the medical staff or governing board adversely affect the PA’s clinical privileges.
• AAPA believes the criteria and process for peer review, grievances and corrective actions for PAs should be clearly articulated in the bylaws. The process should involve PA peers and conform to the process applied to physicians.
• AAPA believes bylaws should provide mechanisms to carry out quality assurance with respect to PAs. Peer review of PAs should be conducted by peers – ideally, other PAs in the same area of clinical specialty.
• AAPA believes bylaws should require PA participation in continuing medical education that relates to their practice and their privileges.
• AAPA believes bylaws should include language enabling PAs to provide care during emergency or disaster situations, as well as EMTALA specific provisions as required.
Introduction

PAs are highly skilled medical professionals who practice in every medical and surgical specialty. PAs are employed by many different entities, including but not limited to: hospitals and healthcare systems, independent medical practices, hospital medicine groups, retail and convenient care practices and staffing agencies, or as independent contractors. PAs provide medical care in virtually every setting, including emergency departments, inpatient services, surgical suites, outpatient clinics and critical care/intensive care units. Requirements for PA practice are defined by state law and organizational policy. All state laws allow the flexibility of physicians to be off-site when a PA is providing care. Most organizations develop policies and definitions based on the language used in their state’s laws and regulations governing PA practice. Federal facilities and federally employed PAs, however, are governed by federal agency guidelines, not state law.

The criteria and process for granting clinical privileges to PAs must be outlined in the medical staff bylaws. (1) Like the process for physicians, the organized medical staff is required to review and verify the credentials of practitioners to ensure that those who provide medical care are competent and qualified to provide specified levels of care. In order to provide patient care services in the hospital or other healthcare facilities, PAs must seek delineation of their clinical privileges, which are then recommended for approval by the medical staff, and ultimately granted by the governing body.

This policy is intended to guide the organized medical staff in making appropriate changes to the bylaws regarding medical staff membership and clinical privileges for PAs. The guidelines can be applied and adapted to suit the individual organization’s requirements and needs. Where possible, sample language has been included.

Definition of PA

Medical staff bylaws usually begin with definitions of terms. This section should include a definition of PA. It should generally conform to the definition used in state law. In the case of federally employed PAs, the legal definition is found in federal regulations or policies, rather than state law. All states currently require that a PA

- be a graduate of a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or one of its predecessor agencies and/or (2)
- pass the initial exam given by the National Commission on Certification of Physician Assistants (NCCPA),
- be licensed to practice as a PA.

Federally employed PAs must meet the first two criteria, but are typically not required to be licensed as federal agencies are not governed by state laws. Many states require current certification for
licensure. In some instances, employers may require current certification as a condition of employment.

(3)

The following definition serves as an example.

A PA is an individual who is a graduate of a PA program approved by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or one of its predecessor agencies, and/or has been certified by the National Commission on Certification of Physician Assistants (NCCPA). The individual meets the necessary legal requirements for licensure to practice as a PA.

**PAs as Members of the Medical Staff**

PAs should be voting members of the medical staff. PAs provide a broad range of services that otherwise would be performed by physicians. They exercise a high level of medical decision-making and autonomy in providing patient care as members of medical and surgical teams. Medical staff privileges enable/authorize clinicians to diagnose illness and perform other medical level of care functions in the hospital. Medical staff “membership” is not a pre-requisite for a hospital to grant PAs or physicians clinical privileges. However, medical staff membership allows PAs a voice in developing and implementing hospital and medical staff policies and ensures participation in programs to review the quality and appropriateness of patient care. It is important that PAs participate in the system in which medical care policies are made and communicated. (4)

In the majority of states, the organized medical staff and hospital governing boards decide which types of practitioners will be granted medical staff membership. Medicare’s Conditions of Participation for Hospitals, as well as the Joint Commission Medical Staff Standards (4) allow PA medical staff membership. The Medicare Conditions of Participation for Hospitals clearly state that, in addition to MD and DO members, “In accordance with state law, including scope-of-practice laws, the medical staff may also include other categories of physicians…and non-physician practitioners who are determined to be eligible for appointment by the governing body.” (5) The Medicare surveyors’ manual further specifies that hospitals can appoint PAs to the medical staff. (6) State law should be consulted; as the makeup of medical staff membership is occasionally dictated there.

On occasion, PAs have been erroneously categorized as allied health professionals or under nursing structures. PAs, by definition, are providers of medical care and, as such, are not part of the allied health field or nursing profession. The National Commission on Allied Health, convened by an act of Congress in 1992, defined an allied health professional as “a health professional (other than a registered nurse or PA).” The Federal Bureau of Health Professions also uses this definition for allied health and classifies PAs as medical providers. (7)
AAPA discourages the use of terms such as midlevel providers, physician extenders, allied health professionals or any other terms that devalue PAs’ contribution to healthcare. AAPA believes whenever possible, PAs should be referred to as PAs. AAPA recognizes entities may use the terms “advanced practice providers” or “advanced practice clinicians” which should only refer to PAs and APRNs. PAs should encourage employers, third party payers, educators, researchers, and the government to utilize the term “PA” or “physician associate” to increase transparency and visibility of PAs throughout the healthcare system. (8)

Medical staff membership language might state:

Membership on the medical staff shall be extended to PAs, physicians, dentists, podiatrists, advanced practice nurses, and clinical psychologists who continuously meet the qualifications, standards, and requirements set forth in these bylaws and who are appointed by the hospital’s governing body.

**Credentialing PAs**

Medical staff bylaws specify professional criteria for medical staff membership and clinical privileges. Four core criteria that should be met when credentialing licensed independent practitioners, including:

- current licensure
- relevant training or experience
- current competence and
- the ability to perform privileges requested.

As applied to PAs, these criteria might include:

- evidence of graduation from an ARC-PA (or predecessor) accredited PA program
- evidence of national certification
- letters from previous employers, physicians, PA peers, or PA program faculty attesting to scope and level of performance
- verified logs of clinical procedures, previous competency evaluations, or attestations from previous employers about competence
- personal attestation as to physical and mental health status
- evidence of adequate professional liability insurance
- information on any past or pending professional liability or disciplinary actions.

When credentialing a PA, a query should be made to the National Practitioner Data Bank (NPDB) regarding the individual’s medical malpractice payments and any adverse action against medical licensure and clinical privileges. Entities that make malpractice payments on behalf of PAs have been required to
report that information to the NPDB since its inception in 1990. Since March 2010, employers and regulators have been required to report to the NPDB adverse professional review actions taken against PAs. Queries about licensure actions taken against PAs can be made to the Federation of State Medical Boards (FSMB). Though all state licensing boards are encouraged to report disciplinary actions to the FSMB, it is impossible to ascertain whether all actions are reported, so it is important that hospitals also query individual boards in all states where the PA has been licensed.

The American Medical Association’s (AMA) Physician Profile Service as well as the Federation Credentials Verification Service (FCVS) offers PA credentials verification. Credentialing professionals should confirm a PA’s education program completion and graduation dates, national certification number and status, and current and historical state licensure information.

**PA Privileges**

The PA profession is rooted in a solid educational foundation in medicine and surgery that prepares PAs to practice in any specialty or care setting. The medical staff bylaws should require that each PA be granted clinical privileges by whom that PA is employed. As previously noted, medical staff membership should not be a requirement for granting of clinical privileges.

The medical staff bylaws should stipulate that all clinical privileges granted to a PA should be consistent with all applicable state and federal laws and regulations. Typically, privileges for a PA are delineated using a form and process identical to or very similar to that used for physicians. Because PAs provide medical and surgical services, their privileges mirror those of the physicians.

The process for granting clinical privileges is usually discussed in four places in the bylaws: the article concerned with clinical privileges, the article describing the structure of the credentials committee, the article describing the duties of department chairs, and the article describing procedures for hearing and appeal. The process of granting clinical privileges may vary considerably from one hospital to another, but generally the process should include the following: 1) completion in a timely fashion; 2) department chairs, if they exist, should make specific recommendations for clinical privileges; 3) an appeal mechanism for adverse decisions; and 4) the governing board should have ultimate authority to grant clinical privileges. An application for renewal of clinical privileges should be processed in essentially the same manner as that for granting initial privileges.

Privilege determinations – at reappointment or other interim times – might also include observed clinical performance, quality improvement data, and other outcome metrics as determined by the hospital and the organized medical staff.

Other requirements of physician members of the medical staff also may apply to PAs. For example, if hospital policy requires that a department chair approves physician privilege requests before they are submitted to the medical staff credentials committee, then the same should apply to PAs.
Joint Commission-accredited hospitals, PAs, like physicians, are required to be evaluated using a focused professional practice evaluation (FPPE) for new privileges or expansion of privileges and ongoing professional practice evaluation (OPPE) for bi-annual reappointment. (9)

Expanding Privileges

PAs are educated in the medical model of evaluation, diagnosis, and treatment. They are committed to life-long learning through clinical experience and continuing medical education. Increasing responsibilities as a PA gains experience are a natural progression and the key to effective integration of PAs in the delivery of healthcare. Additionally, evolving medical interventions and technology are continuously being developed and may require a new delineation of privileges to implement. Thus, like physicians, PAs may need to request additional privileges.

Competency surrounding such privileges should be determined at the practice/department level based on the PA’s education and experience.

Specialty and Subspecialty Privileges

When PAs request privileges for specialized procedures or other highly technical, specialty-related care, their qualifications should be assessed just as they would be for any other privilege — verification of specialized training in the clinical setting, previous privileges, relevant CME, a documented skills assessment, or performance of procedures under direct proctoring by a physician, PA, or other healthcare provider granted privileges to perform the procedure.

AAPA is committed to lifelong learning and encourages advanced educational opportunities (such as Pediatric Advanced Life Support (PALS) or Advanced Trauma Life Support (ATLS)), as well as verification of specific course completion. However, AAPA does oppose specialty certification as a criterion for the following: 1) entry into specialty practice, 2) licensure, 3) credentialing, 4) third-party reimbursement. (10) The PA profession currently does not have a system of specialty credentialing like the specialty boards system developed by physicians. Because there are other ways to assess PA competency, AAPA believes imposing specialty boards or specialty exams is unnecessary and would undermine the basic construct of the profession, which is to be broadly educated medical providers with the versatility and adaptability to meet changing healthcare needs.

Duration and Renewal of Appointments

Duration of appointments and privileges should be the same for physicians and PAs. The renewal/re-appointment process should also be aligned with that required of physicians.

Due Process

The bylaws should give the PA the right to request the initiation of due process procedures when actions taken by the medical staff or the governing board adversely affect the PA’s clinical privileges. The Medicare Conditions of Participation for Hospitals Interpretive Guidelines (11) as well as
accreditation standards from the Joint Commission (12) specifically require a fair hearing and appeals process for addressing adverse decisions made against medical staff members and others holding clinical privileges. The process should include PA peer reviewers.

**Corrective Action**

The criteria and process for disciplining adverse decisions against PAs should be articulated in the bylaws. The process should involve PA peers and conform to the process applied to physicians.

**Quality Assurance**

The bylaws should provide for effective mechanisms to carry out quality assurance responsibilities with respect to PAs. Peer review of PA practice should be conducted by peers – ideally other PAs in the same area of clinical specialty. If the staff does not include other PAs in the same or similar specialty, PA peers from outside the hospital should be requested to participate in the evaluation.

**Continuing Education**

The medical staff bylaws should require participation by PAs in continuing medical education that relates, at least in part, to their regular practice and to their clinical privileges. These requirements should correlate with state law, certification and licensure requirements, as applicable.

**Committees**

Bylaws should allow PA representation with full medical staff prerogatives with voting rights on all standing medical staff committees, including but not limited to the medical executive committee, credentials committee, quality and safety committees, peer review committees, pharmacy and therapeutics committee, and emergency response committees.

**Discrimination**

The fundamental criteria for medical staff membership or clinical privileges should be directly related to the delivery of quality medical care, professional ability and judgment, and community need. Medical staff membership or particular clinical privileges should not be denied on the basis of color, creed, race, religion, age, ethnic or national origin, political beliefs, disability, socioeconomic status, sex, sexual orientation, or gender identity.

**EMTALA Provisions**

The Emergency Medical Treatment and Labor Act of 1986 (EMTALA) regulations require that hospital bylaws identify who is considered “qualified medical personnel” for the following areas: medical screening exams (13), certifying false labor (14), emergency call (15) and transferring patients. (16) The EMTALA law and regulations require that the hospital’s written policies must specify that PAs are qualified personnel. Individual PAs must have privileges to perform these EMTALA functions.
**Participation in Disaster and Emergency Care**

The bylaws should include language enabling PAs to provide care during emergency or disaster situations. The bylaws should state that the chief executive or the chief executive’s designee may grant temporary clinical privileges when appropriate and that emergency privileges may be granted when the hospital’s emergency management plan has been activated. The hospital’s emergency preparedness plan should include PAs in its identification of care providers authorized to respond in emergency or disaster situations.

Bylaws language might state:

> In case of an emergency, any member of the medical staff, house staff, and any licensed health practitioner, limited only by the qualifications of their license and regardless of service or staff status, shall be permitted to render emergency care. They will be expected to do everything possible to save the life of a patient, utilizing all resources of the hospital as necessary, including the calling of any consultations necessary or desirable. Any PA or physician acting in an emergency or disaster situation shall be exempt from the hospital’s usual bylaws provisions to the extent allowed by state law in disaster or emergency situations.

**Conclusion**

- PAs must seek delineation of their clinical privileges. The process and criteria for which must be outlined in medical staff bylaws.
- PAs should be voting members of the medical staff.
- Medical staff bylaws should require that each PA be granted clinical privileges to provide medical care to patients in the facility, regardless of by whom that PA is employed.
- AAPA opposes specialty certification examinations as a requirement for PA credentialing or privileging.
- Duration of appointments and privileges should be the same for physicians and PAs.
- Bylaws should give PAs the right to due process when actions taken by the organized medical staff or governing board adversely affect the PA’s clinical privileges.
- The criteria and process for corrective action should be spelled out for PAs in the bylaws. The process should involve PA peers and conform to the process applied to physicians.
- Bylaws should provide mechanisms to carry out quality assurance with respect to PAs. Peer review of PAs should be conducted by peers – ideally, other PAs in the same area of clinical specialty.
- Bylaws should require PA participation in continuing medical education that relates to their practice and their privileges.
• Bylaws should allow PA representation on standing medical staff committees, including the medical executive committee, credentialing committees, and others.
• Bylaws should include language enabling PAs to provide care during emergency or disaster situations.

Endnotes
(2) Several states have no explicit educational requirement. However, because those states require national certification and because only graduates of accredited programs are eligible for the national certification exam, the certification requirements in the laws of those states are the functional equivalent of an educational requirement.
(3) Upon graduation from an accredited PA program, PAs must pass an initial certifying exam. To maintain current certification, PAs must complete 100 hours of continuing medical education every two years and pass a recertification every ten years.
(4) Joint Commission Hospital Accreditation Manual, Standard MS.01.01.01, EP 3: “The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: Qualifications for appointment to the medical staff.
Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff must be composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians as listed at 482.12(c)(1) and non-physician practitioners who are determined to be eligible for appointment by the governing body.”
(5) CMS -3244-P, October 24, 2011 Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation (proposed rule) provides the following commentary from CMS: “Alternatively, a hospital could establish categories within its medical staff to create distinctions between practitioners who have full membership, and a new category for those who could be classified as having an ‘associate’, ‘special’ or ‘limited’ membership. Such a structure is neither required nor suggested; we are providing it here as a possible way to align all of its practitioners under the ‘Medical Staff’ rules.”
https://www.cms.gov/CFCsAndCoPs/Downloads/CMS3244P.pdf
(6) 42CFR482.22(a) Centers for Medicare and Medicaid Services State Operations Manual, Appendix A-Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, (Rev. 151, 11-20-15) A-0339, Standard 482.22(a), Retrieved December 2, 2016:

“Non-physician practitioners

Furthermore, the governing body has the authority, in accordance with State law, to grant medical staff privileges and membership to non-physician practitioners. The regulation allows hospitals and their medical staffs to take advantage of the expertise and skills of all types of practitioners who practice at the hospital when making recommendations and decisions concerning medical staff privileges and membership.”


(7) 42USCS §295p; Title 42. The Public Health and Welfare, Chapter 6A – Public Health Services


(9) Joint Commission Hospital Accreditation Manual, Standard MS.08.01.03: “Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.”


(11) Medicare Conditions of Participation Interpretive Guidelines, A-0341/§482.22(a)(2) “Each practitioner who is a member of the medical staff or who holds medical staff privileges is subject to the medical staff’s bylaws, rules, and regulations, in addition to all the requirements of the Medical Staff Condition of Participation. The medical staff and the governing body must enforce its medical staff requirements and take appropriate actions when individual members or other practitioners with privileges do not adhere to the medical staff’s bylaws, regulations, and rules. They must likewise afford all members/practitioners who hold privileges the protections and due process rights provided for in the bylaws, rules and regulations.”


(12) Joint Commission Hospital Accreditation Manual, Standard MS.10.01.01 There are mechanisms including a fair hearing and appeal process for addressing adverse decisions regarding
reappointment, denial, reduction, suspension, or revocation of privileges that may relate to quality of care, treatment, and services issues.

(13) 42 CFR §489.24(a)(1)(i)

(14) 42 CFR §489.24(b) Definitions

(15) In its guidance about on-call duties, CMS provides some specifics about PAs taking call: see the State Operations Manual Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases (Rev. 60, 07-16-10) §489.20(r)(2) and §489.24(j)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf page 31: “If it is permitted under the hospital’s policies, an on-call physician has the option of sending a representative, i.e., directing a licensed non-physician practitioner as his or her representative to appear at the hospital and provide further assessment or stabilizing treatment to an individual. This determination should be based on the individual’s medical need and the capabilities of the hospital and the applicable State scope of practice laws, hospital by-laws and rules and regulations.”

(16) The EMTALA regulations allow “qualified medical personnel” other than physicians to order the transfer of emergency patients. If a PA certifies transfer of an unstable patient to another emergency department, the law requires that the PA first consult with a physician before ordering the transfer. Subsequently, the physician must co-sign the order within a timeframe specified in hospital policy. See 42 CFR § 489.24 (e)(ii)(C): “If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.”

Guidelines for State and Territory Regulation of PAs

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

- AAPA believes inclusion of PAs in state and territory law and delegation of authority to regulate their practice to a state and territory 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 and territory, endorses standardization of PA regulation as a way to enhance appropriate and flexible professional practice.
- When referencing states throughout this paper, the intent is to also be inclusive of U.S. territories and the District of Columbia.

Introduction
Recognition of PAs as medical providers led to the development of state and territory laws and regulations to govern PA practice. Inclusion of PAs in state and territory law and delegation of authority to regulate their practice to a state and territory regulatory body serves two main purposes: (1) to protect the public from incompetent performance by unqualified 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 and territories 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 practice by PAs as medical providers while protecting the public health and safety.

What follows are general guidelines on state and territory governmental control of PA practice. AAPA recognizes that the uniqueness of each state and territory’s political and healthcare climate will require modification of some provisions. However, standardization of PA regulation will enhance appropriate and flexible PA 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 and territory practice acts or regulations. Rather, its intent is to clarify key elements of regulation and to assist states and territories as they pursue improvements in state and territory governmental control of PAs. To see how these concepts can be adapted into legislative language, please consult AAPA’s model state and territory legislation for PAs.
**Definition of PA**

The legal definition of PA should mean a healthcare professional who meets the qualifications for licensure and PA practice should be considered the practice of medicine.

**Qualifications for Licensure**

Qualifications for licensure should include graduation from an accredited PA program and passage of the PA National Certifying Examination (PANCE) administered by the National Commission on Certification of PAs (NCCPA).

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 law should specify individuals who have graduated from a PA program accredited by the ARC-PA or one of its predecessor agencies.

The qualifications should specifically include passage of the national certifying examination administered by the NCCPA. No other certifying body or examination should be considered equivalent to the NCCPA or the PANCE.

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 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. 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.

Applicants who meet the qualifications for licensure should be issued a license. States and territories should streamline the licensure process and not require unnecessary steps including, but not limited to, employment or identification of a supervising, collaborating, or other specific relationship with a physician(s), jurisprudence exams, or board approval of practice elements 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 or territory. Regulatory agency staff should be empowered to approve an uncomplicated PA license application without direct board action. If issuance of a full license requires approval or ratification 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.

When a PA returns to clinical practice following an extended period of clinical inactivity unrelated to disciplinary action or impairment issues, the board should be authorized to issue a license and allow applicants to practice to the full extent of their education, training and experience. 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 unrestricted licensure, requiring continuing medical education, development of a personalized re-entry plan, which may include supervised practice, or temporary authorization to practice for a specified period of time. It has not been determined that absence from clinical practice is associated with a decrease in competence, therefore, re-entry 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 and/or fingerprinting for PA license applicants. Licensing agencies should have the discretion to grant or deny licensure based on the findings of background checks and information provided by applicants.

**Optimal Team Practice**

Since the inception of the profession, PAs have embraced team-based patient-centered practice and continue to do so. Because both PAs and physicians are trained in the medical model and use similar clinical reasoning, PA and physician collaboration is effective and valued.

Optimal team practice addresses the needs in an evolving medical practice; today’s healthcare environment requires flexibility in the composition of teams and the roles of team members to meet the diverse needs of patients. Therefore, the manner in which PAs, physicians and other healthcare providers work together should be determined at the practice level.

Within state and territory laws and regulations, optimal team practice occurs when PAs are not required to have a specific relationship with any other healthcare provider to practice to the full extent of their education, training and experience. PAs will continue to consult, collaborate, or refer when necessary, as indicated by the patient’s condition and the standard of care, and in accordance with the PA’s competencies. Alternative requirements diminish team flexibility and therefore limit patient access.
to care, without improving patient safety. By removing administrative restriction, PAs and their teams will have greater flexibility to more effectively care for patients.

Currently, the administrative relationship requirement puts all providers involved at risk of disciplinary action for reasons unrelated to patient care or outcomes. State and territory law should recognize PAs as responsible for the care they provide to their patients.

Optimal team practice is applicable to all PAs, regardless of specialty or experience. Whether a PA is early career, changing specialty or simply encountering a condition with which they are unfamiliar, the PA is responsible for seeking consultation as necessary to ensure that the patient’s treatment is consistent with the standard of care.

**PA Practice Payment, Ownership, and 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, health system, or large practice. In some situations, the PA may be part or sole owner of a practice. PA practice owners may be the employers of 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 PAs. The healthcare team 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 and territory law provisions should authorize the regulatory authority to discipline a PA or other healthcare provider 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 without requiring a specific relationship with a physician or other healthcare provider. This may require the state or territory to adopt language that permits PAs to respond to emerging public health threats, sudden emergencies, or other events necessitating emergency medical care, regardless of setting, provided the care is within the PA’s education, training, and experience.

This exemption should extend to PAs who are licensed in states or territories other than where the care is provided or who are federal employees. PAs should be granted “Good Samaritan” immunity to the same extent that it is available to other health professionals under the laws of the state or territory in which the care is rendered.

PAs who are volunteering without compensation or remuneration should be permitted to provide medical care as indicated by the patient’s condition and the standard of care, and in accordance
with the PA’s education, training, and experience. State and territory law should not require a specific relationship between a PA, physician, or any other healthcare provider for a PA to volunteer.

**Scope of Practice**

State and territory law should permit PA practice in all specialties and settings. In general, PAs should be permitted to provide any legal medical service that is within the PA’s education, training and experience, and be determined at the practice level.

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, dispensing, administration and procurement of drugs and medical devices. PA education includes extensive training in pharmacology and clinical pharmacotherapeutics.

Additional training, certificates of added qualifications (CAQs), 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 United States Drug Enforcement Administration and relevant state or territory agencies.

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.

State and territory laws, regulations, and policies should allow PAs to sign any forms that require a physician signature.

**Title and Practice Protection**

The ability to utilize the title of “PA,” “physician associate” (or its predecessor “physician assistant”) or “asociado médico” when the professional title is translated into Spanish should be limited to those who are authorized to practice by their state or territory as a PA. The title may also be utilized by those who are exempted from state or territory licensure but who are credentialed as a PA by a federal employer and by those who meet all of the qualifications for licensure in the state or territory but are not currently licensed. A person who is not authorized to practice as a PA should not engage in PA practice unless credentialed as a PA by a federal employer. The state or territory should have the clear authority to impose penalties on individuals who violate these provisions.

**Regulatory Agencies**

Each state and territory must define the regulatory agency responsible for implementation of the law governing PAs. Although a variety of state and territory agencies can be charged with this task, the
preferable regulatory structure is a separate PA licensing board responsible for the licensure, discipline, and regulation of PAs and comprised of a majority of PAs, with other 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.

If regulation is administered by a multidisciplinary healing arts or medical board, it is strongly recommended that PAs and physicians who practice with PAs be full voting members of the board.

Any state or territory 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 and territory 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 endorses the authority of designated state and territory regulatory agencies, in accordance with due process, to discipline PAs who have committed acts in violation of state or territory 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 other licensed healthcare professionals in the state or territory. 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. AAPA
also endorses the sharing of information among state or territory regulatory agencies regarding the disposition of adjudicated actions against 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 and regulations that specifically enumerate physicians and nurse practitioners, including provisions 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 PAs to use them.

For all programs, states and territories should include PAs in the definition of primary care provider when the PA is practicing in the medical specialties that define a physician as a primary care provider.

It is in the best interest of patients, payers and providers that PA-provided services are measured and attributed to PAs; therefore, state and territory law should ensure that PAs who render services to patients be identified as the rendering provider through the claims process and be eligible to be reimbursed directly by public and private insurance.
Guidelines for the PA Serving as an Expert Witness

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.

- A PA serving as an expert witness should have current experience and knowledge in the area(s) about which the PA is to testify.
- A PA expert must objectively evaluate facts and provide an opinion. If no opinion can be derived from available facts, this should be stated to the attorney.
- The PA’s review of medical facts should be thorough, fair, and impartial and should not exclude any relevant information in order to create a view favoring either the plaintiff or the defendant. The PA serving as an expert witness should champion what the PA believes to be the truth.
- A PA giving testimony does not attack performance that which falls within accepted standards of practice or support obviously deficient practice.
- A PA offering an opinion should know what constitutes customary practice. Testimony about innovation in medical practice should be identified as such.
- The PA should testify truthfully and consistently, recognizing any testimony may be subject to peer review.
- The PA should not accept a contingency fee – compensation based on the outcome of a case in which testimony is given – or derive personal, financial, or professional favor in addition to compensation.

Introduction
A PA may serve as a witness in a legal proceeding in one of several capacities. (1) These guidelines discuss serving as expert witness and giving opinions in professional liability (medical malpractice) cases. Accompanying notes and references outline other roles a PA may have as a witness or consultant, preparation for testifying, legal terms, strategies and tactics that may be encountered.

It is the intent of AAPA to inform PAs about the duties PAs have, as healthcare professionals, to society, the legal system, and the profession. These guidelines and comments are not legal advice. PAs involved in legal matters are urged to obtain legal advice from a qualified attorney.

A PA may be called upon or directed to give an expert medical opinion in the judicial system because knowledge about medicine and PA practice is generally considered beyond the average judge or juror’s experience. A patient who alleges injury (plaintiff) and the judge or jury will need opinions about
standards of medical care, if and how a standard of care was met, and, if not, how falling below a standard caused injury to the patient. The practitioner (defendant) may also need expert opinions and may serve as an expert witness in one’s own behalf.

The responsibility of providing a professional opinion as an expert witness should be undertaken after careful self-evaluation and thorough preparation with an attorney. The PA should have an understanding of medical, legal and ethical principles involved. (2)

**Guideline 1:** A PA serving as an expert witness should have current experience and knowledge in the area(s) about which the PA is to testify. (3)

A PA’s knowledge and experience alone may not sufficiently satisfy an attorney or qualify the PA to testify in court as an expert witness. Maturity, integrity, composure and other personal characteristics should be evaluated with an attorney prior to offering testimony. Prior testimony, income from testifying, potential conflicts of interest with, or bias toward, other parties involved in the case may render a PA unsuitable as a witness. If, after meeting with an attorney, the PA is unclear on issues about which the PA will testify, feels uncomfortable offering an opinion, or has no opinion; voluntary testimony should not be given.

**Guideline 2:** A PA serving as an expert witness must objectively evaluate facts and provide an opinion. If no opinion can be derived from available facts, this should be stated to the attorney. The PA’s review of medical facts should be thorough, fair, and impartial and should not exclude any relevant information in order to create a view favoring either the plaintiff or the defendant. The PA serving as an expert witness should champion what the PA believes to be the truth.

PAs serving as expert witnesses have an ethical responsibility to the profession. The Guidelines for Ethical Conduct for the PA Profession admonishes a PA from participating in an activity that will discredit or dishonor the profession. Providing an expert opinion in a judicial process is never a trivial matter. There are risks to the witness, profession, other parties, and society. Yet, AAPA Policy further asks PAs to expose without fear or favor, any illegal or unethical conduct in the medical profession. Participating in a judicial proceeding as an expert witness, like peer review, is a necessary obligation of the profession and its members. Expert opinion may support or criticize a colleague.

This duty, to serve for the good of society and the courts, is a guiding principle. This responsibility may override the concept that PAs should act, in these situations, as advocates for a patient or serve only a patient’s interest. Expert opinion may help or hinder a patient’s cause.

**Guideline 3:** It is incumbent upon a PA giving testimony in legal proceedings that the PA does not attack performance that falls within
accepted standards of practice or, conversely, support obviously deficient practice. Since experts establish the standards of practice in a given case, care should be exercised to ensure that such standards do not narrowly reflect the experts’ views to the exclusion of other acceptable choices.

An expert witness should recognize that there is uncertainty inherent in medical practice. It is a dynamic and changing discipline based on concepts of probability rather than on absolute certainty. Principles drawn from the experience of a number of patients and providers are applied to individual patients with hope for success. Further, with technologically advanced medical care, both benefits and risks are likely to be increased. Risks of complication in the practice of technical specialties can be frequent and/or severe. In providing expert testimony, a PA should have in mind a clear distinction between the occurrence of unavoidable and/or severe complications which do not represent malpractice (good medical care, but a bad outcome), and the occurrence due to negligence (poor medical care that contributes to or causes a bad outcome).

Testimony is usually given concerning customary or standard practice. Innovation in medical practice is sometimes considered in a legal proceeding. An innovation may or may not fall outside of the standard of care. Many advances in medical practice rely on innovation.

**Guideline 4:** A PA offering an opinion should know what constitutes customary practice. Testimony about innovation in medical practice should be identified as such.

A PA may offer an expert opinion several times in one legal proceeding or in several separate proceedings. Expert testimony offered by the PA in previous cases and proceedings is often reviewed and compared by attorneys and other experts. All testimony should be truthful and consistent.

**Guideline 5:** The PA should testify truthfully and consistently, recognizing any testimony may be subject to peer review.

Custom and rules governing compensation for legal witnesses vary. The PA should be fairly compensated for time spent preparing, appearing and testifying as an expert witness.

**Guideline 6:** The PA should not accept a contingency fee — compensation based on the outcome of a case in which testimony is given — or derive personal, financial, or professional favor in addition to compensation.

**Summary of AAPA Guidelines for the PA Serving as an Expert Witness**

The PA should have current experience and ongoing knowledge in the areas of clinical practice about which the PA is testifying.

The PA should objectively evaluate the facts and provide an opinion. The PA’s review of medical facts should be thorough, fair and impartial and should not exclude any relevant information in order to
create a view favoring either the plaintiff or the defendant. The PA serving as an expert witness should champion what the PA believes to be the truth, not the cause of one party in a dispute.

The PA’s testimony should reflect an evaluation of performance considering generally accepted standards, neither condemning performance that clearly falls within generally accepted practice standards nor condoning performance that clearly falls below these standards. The PA should examine the relationship of an alleged substandard practice to the outcome and acknowledge, when necessary or uncertain, that a deviation from a practice standard is not always causally related to a bad outcome. The PA should make a clear distinction between medical malpractice and the occurrence of unavoidable complications, which do not arise from negligence.

The PA should identify testimony about customary practice and testimony about innovation.

The PA should offer testimony recognizing it may be subject to peer review. Testimony given should be truthful and consistent.

The PA expert witness should be fairly compensated for time spent preparing, appearing and testifying. The PA should not accept a contingency fee based on the outcome of a case in which testimony is given, or derive personal, financial or professional favor in addition to compensation.

**Recommended Reading**

AAPA. “Guidelines for Ethical Conduct for the PA Profession,” May 2013.

Babitsky S. The Ten Biggest Mistakes Experts Make During Deposition.


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**Endnotes**

1 Testimony may be given at the request of either party in a lawsuit. Testimony may be given by affidavit, at a deposition, transcribed and then used in court by either party, or testimony may be given directly in court. There are several types of medical testimony.
When a PA has a prior relationship, such as treating or providing a consultation for the patient, there is a duty to assist that patient in legal matters pertaining to the medical care. RS Toth, Legal Medicine: Legal Dynamics of Medical Encounters, American College of Legal Medicine; Mosby (St Louis) 1988. An example of this is treating a patient who was involved in an automobile accident or job-related injury and later testifying about the observed injuries or extent of disability. In this circumstance, the PA may testify voluntarily or, less frequently, may be compelled by subpoena to give factual testimony. The testimony may be given in person or in writing.

In contrast, a non-treating PA may provide expert opinion testimony in a malpractice case about a standard of care -- possessing and using that degree of skill and learning which is customarily expected of practitioners acting under the same or similar circumstances. During litigation, a general standard of care is applied to the facts of a case by the introduction of expert witness testimony. See Toth.

Time spent preparing for and giving testimony, possible future court appearances and compensation for these services should be agreed upon with the attorney before undertaking these activities.

During testimony, a factual (perceipient) witness may be asked to give an opinion and in doing so offers expert testimony without being called as an expert witness. Similarly, a PA performing chart review as an expert consultant in a legal matter may be called upon to give an expert opinion. To understand your situation and to prepare adequately for testifying you should ask the attorney who wants your services or testimony to specify the request in writing. This may be a letter, contract, or, less often, a formal notice (a subpoena) to compel your testimony. A subpoena, citation or other court order may be issued, if only to help the attorney follow legal procedures should you not be available or qualified to testify.

Whether compelled or testifying voluntarily and regardless of your intent to provide only factual testimony or consultation, you still may be asked to give an expert opinion. An attorney should advise you on the best course of action.

There sometimes are exceptions for having to give expert, opinion testimony. There may be insufficient information on which to base an opinion. Also, a practitioner who treats a patient may refrain from giving an expert opinion on the standard of care in a malpractice case if the injury is alleged to have occurred before the practitioner's care and someone else is alleged to have caused the injury.

Legal jurisdictions have rules about expert opinion, qualifications of experts, applicable fees and types of testimony. Local custom in the medical and legal communities may dictate fees that are appropriate.

Testimony given by a PA expert may cover one or several areas such as clinical practice and procedures, professional standards, conduct and ethics, scope of practice or statutes and regulations.
relating to practice. In civil and criminal proceedings, PA experts may also offer testimony such as cause of injury or disability, extent of temporary or permanent disability, and medical findings in assault or abuse cases.

3 The Federal Rules of Evidence define an expert witness as anyone "...qualified as an expert by knowledge, skill, experience, training, or education." (Rule 702) Although most cases in which a PA might testify will be conducted in state courts, which are governed by the particular state's rules of evidence, Federal Rules of Evidence will be cited here to offer generic illustration. There are expert witnesses representing every type of human activity (accountants, engineers, homemakers, mechanics, nurses, physicians, etc.).

4 The legal definition of negligence has four elements: (1) that the PA owed a legal duty to the patient. A PA owes each patient the duty to possess and use on the patient's behalf that degree of knowledge, skill, and care usually exercised by reasonable practitioners under similar circumstances. This duty creates a standard of care for various medical acts. (2) That the PA breached the duty, failed to comply with the standard of care. (3) That the patient sustained actual damages, such as physical impairment, emotional injuries and/or financial consequences. (4) That the PA's breach of duty proximally caused the patient's injuries. All four elements must be satisfied for a finding of negligence. Expert witness testimony is often needed to support any or all of these elements. Expert opinion testimony often defines the standard of care in malpractice cases. KM Leonetti, in The Professional Liability Handbook: A Basic Guide for Physician Assistants, AAPA (Alexandria), 1990. RS Toth, Legal Medicine: Legal Dynamics of Medical Encounters, American College of Legal Medicine; Mosby (St Louis), 1988. MD McCafferty and SM Meyer, Medical Malpractice Bases of Liability, McGraw Hill (Colorado Springs), 1985.
Immunizations in Children and Adults  

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 all patient populations and certain high-risk individuals, such as the chronically ill, immunosuppressed, asplenic, or elderly. High-risk populations may need to be on different immunization schedules.
- 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 or doubts about potential adverse effects.
- PAs should be immunized against vaccine-preventable diseases including annual influenza. PAs should also be immunized with the severe acute respiratory syndrome coronavirus (SARS-CoV-2) vaccination series. All vaccinations should be administered unless there is a clinical contraindication due to the PA’s medical history. This not only protects PAs, but also decreases the risk of 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 to protect against vaccine-preventable diseases.
- PA students, like practicing PAs, should have all appropriate immunizations prior to starting their clinical experience.
- PAs 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 and easily accessible documentation of the patient’s immunization record in the patient’s medical chart. High-risk patients should be identified and targeted programs implemented to ensure compliance, such as automated reminders.
- PAs working in specialty practices should recognize patients who are at high risk for vaccine-preventable diseases. Collaboration with the patients’ primary care providers will ensure compliance with immunization schedules.
• 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, and unnecessary over-immunization of patients.

• All private and public payers should cover 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 healthcare 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.(1) Recent economic analyses found that routine vaccination of children born from 1994 to 2018 will prevent about 419 million cases of disease and more than 936,000 early deaths, for a societal cost savings of more than 1.9 trillion dollars.(2) Given their proven benefit in reducing morbidity, mortality and healthcare 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 U.S. Department of Health and Human Services’ Healthy People 2030 initiative has set vaccination coverage goals of 90-95 percent universally recommended vaccines among young children ages 19 to 35 months including those for diphtheria 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. In addition, there is a push to reduce the proportion of children who get no recommended vaccines by age two years. Recent national coverage estimates showed that HP-2020 targets of 90-95% were met for the above-mentioned vaccinations.

Vaccination rates remains lower among children living below the poverty level, in 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 papillomavirus (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, Healthy People 2030 goals were lagging for complete coverage for the HPV vaccine among adolescents (target – 80%; 2018 data – 48%). (3)(6)(7) This disparity in vaccination coverage indicates many missed opportunities to administer HPV vaccination in addition to TDaP and meningococcal conjugate vaccine during the same clinical visit.

Adult Immunization Programs

Adult immunization programs do not receive the same priority as efforts to immunize children, even though most deaths from vaccine-preventable disease occur in adults. Between 5,000 and 56,000 adults die each year from vaccine-preventable diseases such as pneumococcal infection, influenza and hepatitis B. (8)

Despite availability and effectiveness of vaccines current immunization rates fall below those recommended in Healthy People 2030. In addition to deaths from pneumococcal pneumonia, flu and hepatitis B; each year adult deaths occur due to inadequately immunized children. A majority of the U.S. cases of tetanus and diphtheria today occur in adults who were inadequately immunized as children. Furthermore, the recent resurgence in measles, mumps and rubella; 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. (8)(9)

Unfortunately, adult vaccination coverage estimates for the four vaccines included in Healthy People 2030 (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. (9)(11)
Improving Vaccination Rates

The 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 vaccines would reduce the expense associated with intramuscular vaccination and would be more practical, especially amongst pediatric patients (over five years of age). Healthy People 2030 is also developing an objective to promote an operational, population-based immunization registry.

Challenges

Challenges to immunization programs for adults are similar to those in children. Yet 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. Challenges for assuring access and availability of vaccines include (12):

- Unprecedented vaccine delays;
- Diminished number of vaccine suppliers;
- Disparities of geographic and socioeconomic populations;
- Erosion of insurance coverage for immunizations;
- 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.

COVID-19 Vaccine

The CDC recommends that all people eligible get a COVID-19 vaccine to help protect against severe illness. For this reason, it is imperative that all PAs serve as trusted healthcare providers that can promote vaccine efficacy and increase vaccine use among their patients. As COVID-19 is a highly contagious respiratory virus, transmission and outbreaks in the community and especially within healthcare facilities are well documented. (16)(17) Because PAs regularly provide care to patients at high risk for complications of COVID-19, PAs should be immunized as per the recommendation of the Centers for Disease Control and Prevention Advisory Committee on Immunization Practice. Use of the
FDA-approved COVID-19 vaccine is recommended for persons aged ≥5 years as the benefits of the prevention of infection and associated hospitalization or death outweigh vaccine-associated risks.

**Influenza Vaccination of Healthcare Personnel**

Influenza transmission and outbreaks in healthcare facilities are well documented. Healthcare 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 healthcare workers against viral illnesses by healthcare institutions through mandatory vaccination programs. It was felt that this was the most effective means to protect patients from the transmission of viral illnesses by healthcare workers.

(14)

**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 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. Safe, effective vaccines are available but underutilized, and patients who routinely see healthcare providers are not often educated about recommended immunizations. 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. PAs should educate their patients and their families about the SARS-CoV-2 virus vaccine series, unsubstantiated information and promote public confidence in the SARS-CoV-2 vaccine series to protect infants, children, adolescents, and adults against the SARS-CoV-2 virus. PAs should support local initiatives to make these vaccines accessible to all approved populations including themselves.

**Bibliography**


PAs as Medical Review Officers

The Federal Government requires mandatory drug and alcohol testing as a safety precaution for more than seven million transportation workers, such as bus drivers, railroad workers, airline mechanics, and flight crews. Extensive rules governing alcohol and drug tests were issued by the U.S. Department of Transportation (DOT) in 2001. The rules were developed to protect workers’ rights and the integrity of the program through validity testing of the specimens. Validity testing was added to the program as a safeguard after lab mistakes resulted in innocent workers being labeled cheaters or drug abusers and being fired from their jobs. Regulations governing all aspects of the drug and alcohol testing programs are published in the Federal Register and in specific publications of the DOT. One part of these regulations, the definition of the Medical Review Officer, has had a negative impact on the healthcare delivery systems of companies and transit agencies that employ PAs.

The role of a Medical Review Officer (MRO) is mandated through 49 Code of Federal Regulations (CFR) subpart g and defined in 49 CFR 40.3. According to these regulations, a medical review officer is “a person who is a licensed physician and who is responsible for receiving and reviewing laboratory results generated by an employer’s drug testing program and evaluating medical explanations for certain drug test results.” To qualify as an MRO, the individual must (a) be licensed as a physician (doctor of medicine or osteopathy) in any jurisdiction in the U.S., Canada, or Mexico; (b) possess basic knowledge in controlled substance abuse disorders (including knowledge of alternative medical explanations for laboratory confirmed drug test results), issues related to adulterated and substituted specimens, and the dot regulations; (c) receive qualification training as an MRO; and (d) receive at least 12 continuing medical education units every three years that are relevant to performing MRO functions.

Federal law requires eight basic responsibilities of an MRO: (1) acting as an independent gatekeeper and advocate for the accuracy and integrity of the drug testing process; (2) providing quality assurance review of the drug testing process; (3) determining whether there is a legitimate medical explanation for confirmed positive, adulterated, substituted, and invalid drug test results from the laboratory; (4) providing medical review of the employees’ test results but not necessarily establishing a doctor-patient relationship with the employees whose tests are reviewed; (5) investigating and correcting problems where possible and notifying the appropriate parties (HHS, dot, employers, service agents); (6) ensuring the timely flow of test results to employers; (7) protecting the confidentiality of the drug testing information; and (8) performing all functions in compliance with dot regulations. PAs are not mentioned in these federal regulations and therefore they may not function as MROs, even if the role is allowable within state guidelines.
AAPA believes that the medical knowledge and training necessary to ensure competence as an MRO are not limited to licensed physicians. As practitioners trained in the medical model to provide physician services, PAs have the background necessary to perform successfully the duties of an MRO. The Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) is the accrediting body for PA educational programs.

According to the ARC-PA’S published accreditation standards for PA education, PA education must include clinical laboratory medicine and pharmacology, (3) providing knowledge of the basis of laboratory analysis and an understanding of actions and interactions of pharmaceutical and non-pharmaceutical drugs. Many PAs receive training in drug abuse problems and all must be trained in patient counseling. (3) PAs are qualified to obtain a complete medical history and to integrate that information with a physical examination and other biomedical data, such as laboratory test results, to reach an accurate diagnosis. PAs are also trained to respect patient confidentiality, (3) which is an important aspect of any successful anti-drug program.

PAs who work in occupational medicine and other specialties and settings may perform pre-employment physicals, evaluate and treat work-related injuries, ensure safety in the workplace, and determine ability to return to work after illness, injury, or when taking prescribed medications. These PAs may routinely screen and evaluate drug testing results and follow appropriate chain of custody procedures for programs other than those of DOT. PAs, given additional education provided in MRO training seminars currently not open to them, would be very competent MROs and would contribute significantly to the success of DOT anti-drug programs.

References
1. 49 Code of Federal Regulations 40.121.
2. 49 Code of Federal Regulations 40.123
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 defines PA impairment as any physical, mental or behavioral condition that interferes with the ability to safely engage in professional activities.
- AAPA encourages research in the area of PA impairment, particularly in the type and impact of external factors adversely affecting PAs, including workplace stress, litigation issues, and restructuring of the healthcare delivery systems.

AAPA defines PA impairment as any physical, mental or behavioral condition that interferes with the ability to safely engage in professional activities. Performance of clinical and professional activities while impaired puts patients at risk and may be indicative of an acute and/or chronic illness and/or progressive substance use disorder.

PAs have a responsibility to protect patients and the public by recognizing their own impairment and identifying and assisting impaired colleagues who are unable to practice with reasonable skill and safety to patients because of impairment.

PAs recognizing their own impairment should report concerns confidentially to an appropriate supervisor or healthcare professional, report to the appropriate committee within their organization, and seek guidance on self-reporting laws within their state in order to seek treatment and protect their license.

PAs should recognize impairment in other healthcare professionals and should seek guidance from an impairment committee established by a state or local professional society, employer, or licensing board with how to appropriately address that individual’s impairment.

PA continuing medical education and student programs through the Physician Assistant Education Association should include components for education and prevention, as well as identification and treatment of impaired healthcare professionals /PAs.

AAPA encourages research in the area of PA impairment, particularly in the type and impact of external factors adversely affecting PAs, including workplace stress, litigation issues, and restructuring of the healthcare delivery systems.

AAPA endorses the following recommendations, which are modeled on the Federation of State Medical Boards’ policy, “Physician Wellness and Burnout.” (1)
For AAPA and constituent organizations, AAPA recommends that

1. PA organizations educate PAs about potential connections between PA burnout, mental health issues, substance use disorder, addiction, wellness, and patient safety.
2. PA organizations advocate for PA wellness and promote the availability of wellness education, support, and treatment.
3. PA organizations highlight the importance of self-care with an aim to reducing stigma attached to seeking treatment for health issues, particularly ones related to mental health.
4. PA organizations educate their members about resources available for recognizing and referring peers who may have problems related to mental health, addiction, substance use, or burnout.

For PA entry-level and postgraduate training programs, AAPA recommends that

1. Physician Assistant Education Association and the Association of Postgraduate PA Programs support efforts to improve the culture of medicine by facilitating open conversations about provider mental health, addiction, substance use disorder, and burnout.
2. PA education programs teach PA students to value self-care and understand the connections between provider wellness and safe patient care.
3. PA programs, postgraduate training programs, and their accrediting bodies provide support and the means for students to safely raise issues related to PA student health and well-being.

For hospitals/health systems and employers, AAPA recommends that

1. Hospitals ensure that their credentialing process does not discourage PAs or other health professionals from seeking needed treatment.
2. Hospitals ensure that their policies and procedures are adopted with consideration given to the impact they have on the health of the hospital workforce. Decisions impacting the health of hospital and health system employees should be made with adequate input from individuals representing that workforce.
3. Employers make resources and programs available to employees, including time and physical space for making connections with colleagues and pursuing personal goals that add meaning to work lives.

For professional malpractice insurers, AAPA recommends that

1. Insurance carriers revise, where possible, professional liability insurance applications to ensure that being able to complete the application would not discourage PAs or other healthcare professionals from seeking necessary medical treatment.
2. In evaluating the quality of care provided by PAs, insurers should look beyond cost-saving measures and use metrics related to PA health and should incentivize practice patterns that contribute to PA wellness.

For accrediting organizations, AAPA recommends that

1. Accreditation standards for PA education programs, postgraduate PA training programs, hospitals, and healthcare facilities require policies and resources aimed at protecting the health of healthcare professionals and healthcare professionals-in-training.

For individual PAs, AAPA recommends that

1. Individual PAs attend to their own health and well-being in order to provide care of the highest standard. This includes a responsibility to self-assess for indicators of mental health problems, addiction, substance use disorder, or burnout and seek help or treatment when necessary. PAs are encouraged to make use of services of state professional health programs, which can be accessed confidentially in instances where patient harm has not occurred.

2. Individual PAs inform themselves of their ethical and legal duties to report issues related to incompetence and unsafe care delivered by professional colleagues.

3. Individual PAs talk with peers about the importance of self-care, treatment-seeking, and potential threats to themselves and their patients presented by mental health problems, addiction, substance use disorder, or burnout.

4. Individual PAs seek an appropriate work-life balance, with particular focus on activities with restorative potential.

For PA licensing boards, AAPA recommends that

1. PA state licensing boards evaluate whether it is necessary to include probing questions about an applicant’s mental health, addiction, or substance use on licensure applications. They should consider whether information being gathered in the interests of patient safety could be obtained through means less likely to discourage applicants from seeking treatment. For example, some boards subscribe to national practitioner data bank notifications and other notification services that provide information about arrests or convictions, including for driving under the influence. These can serve as proxies for asking about impairment. In addition, applicants should pass a criminal background check as a condition of licensure.

2. Licensure questions differentiate between the illness with which an applicant has been diagnosed and the impairments that may result. Application questions must focus only on current impairment and not on illness, diagnosis, or previous treatment in order to comply with the Americans with Disabilities Act.
3. Questions that address the mental health of applicants should be posed in the same manner as questions about physical health, as there is no distinction between impairment that might result from physical and mental illness that would be meaningful in the context of the provision of safe treatment to patients.

Where boards retain questions about the health of applicants on licensing applications, AAPA recommends language from the American Psychiatric Association:

Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (yes/no)

4. PA licensing boards consider offering “safe haven non-reporting” to PA licensure applicants who are receiving appropriate treatment for mental health or addiction. Under such a program, PAs who are monitored by, and in good standing with, the recommendations of a state or territorial professional health program (PHP) (2) would be permitted to apply for licensure or license renewal without having to disclose their diagnosis or treatment to the board.

5. PA licensing boards ensure that the personal health information of licensees related to an illness or diagnosis is not publicly disclosed as part of a board’s processes. Information disclosed must relate only to impairment of professional abilities, medical malpractice, and professional misconduct.

6. Licensing applications, licensing board websites, and other official communications emphasize the importance of PA health, self-care, and seeking treatment for all health conditions. Licensing boards should share information about PHPs; services offered through professional societies, and any other relevant programs. Making this information public assists PAs and also helps to inform patients of the connection between provider wellness and patient care.

7. PA licensing boards ensure that their policies and procedures for working with PAs who have been identified as impaired are fair, reasonable, and protect patients. All such processes should be clearly explained and publicly available.

References

2. A “professional health program” or “physician health program” (PHP) is a confidential resource for licensed healthcare professionals or those in training who are suffering from addictive, psychiatric, medical, behavioral or other potentially impairing conditions. PHPs coordinate effective detection, evaluation, treatment, and continuing care monitoring of physicians with these conditions. This coordination and documentation of a participant’s progress allows PHPs to provide documentation verifying a participant’s compliance with treatment and/or continuing care recommendations. (Source, Federation of State Physician Health Programs, https://goo.gl/q9mnhr. Accessed February 19, 2019.)
PAs as Medicaid Managed Care Providers

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.

PAs are a critical part of the health workforce providing care for Medicaid patients. To facilitate the enhanced ability of PAs to deliver services to these patients, AAPA believes that states should include the following provisions in Medicaid managed care plans:

- PAs should be specifically included in plan networks to ensure adequate availability of primary and specialty care options within a reasonable geographic proximity to patients. (4)
- PAs should be enrolled, credentialed and reimbursed in the same manner as physicians by both requiring PAs be identified on claim forms for all services they provide, as well as allowing direct payment to PAs.
- PAs should be recognized as primary care providers when delivering primary care services.
- To improve access to care, PAs should be included in provider directories.
- States should assign PAs a patient panel similar in size to physicians to encourage the utilization of PAs on the healthcare team.
- State Medicaid programs should establish regulations that are consistent with PA state law, without imposing additional limitations on the scope of PA practice or establishing unnecessary or overly-restrictive collaboration requirements or practice agreements.
- Policies pertaining to PAs should be codified in electronic provider manuals available on an accessible website.

Background

Financed jointly by the Federal Government and states, Medicaid is the nation’s healthcare lifeline for certain low-income residents. Medicaid is a state-administered program and each state has some degree of flexibility in determining guidelines regarding eligibility and services. While federal law mandates who is eligible for coverage and the broad categories of services that must be provided, each participating state designs and administers its own program by 1- setting certain income and asset eligibility requirements; 2- selecting which optional groups and services to cover; 3- determining the scope of mandatory and optional services, and 4- deciding whether and how certain health professionals are covered.

A combination of existing trends including the expansion of Medicaid as a result of the Affordable Care Act and rising health costs have intensified the growth of both enrollment and spending
on the Medicaid program. For fiscal year 2017, Medicaid was estimated to account for $375 billion in federal spending and $230 billion in state spending. (1) One approach states have taken to constrain their financial obligations is to shift some or all Medicaid enrollees from fee-for-service Medicaid plans to a managed care arrangement. By 2016, approximately 65 million Medicaid recipients in 39 states, or more than 80% of the total Medicaid recipients, (2) received coverage under managed care.

Medicaid managed care delivery plans are arrangements between state Medicaid agencies and managed care organizations (MCOs), typically commercial insurers, to provide care to Medicaid beneficiaries in exchange for a prepaid fixed amount per enrollee. This financing arrangement incentivizes increased coordination of beneficiary care and promotes primary care interventions in order to reduce costs. This arrangement also allows the MCO to keep what portion of the fixed amount remains after care is provided. Oversight is conducted by states to ensure care quality is not compromised by reductions of services. Managed care delivery has demonstrated the ability to lower unnecessary service utilization and better direct beneficiaries to obtain their care at the most efficient healthcare location, which in turn can hold down costs. When implementing Medicaid managed care programs, states are responsible for developing and maintaining a sufficient network of health professionals to ensure adequate access to care.

Medicaid managed care arrangements typically involve a primary care health professional, known as a primary care provider, who acts as gatekeeper and coordinates the delivery of care. State Medicaid programs include different professionals in their lists of primary care providers. Family physicians, general practitioners, pediatricians and internists are routinely included. Some states also include PAs (physician associates), obstetricians/gynecologists and nurse practitioners in their definitions of primary care providers. Other states are not as explicit as to who may be designated a primary care provider, but provide options to describe the primary care team, such as specifying that either 1- PAs and nurse practitioners (NPs) may serve in association or collaboration with physicians, 2- physicians may be supported by PAs and NPs, or 3- the managed care organization may determine the composition of the primary care network.

**PAs as Medicaid Providers**

As states experiment with different methods of improving access and reducing the cost of medical care, it is important to recognize the contributions of PAs. In all 50 states and the District of Columbia, PAs provide Medicaid beneficiaries with quality healthcare services. A relatively high proportion of PAs practice in areas with large Medicaid populations. PAs in those practices have demonstrated a commitment to caring for this patient population. Studies show that there is little difference in the quality of care and level of patient satisfaction when care is provided by a PA as opposed to a physician.
States have also found that including PAs on medical teams that provide care for Medicaid patients improves access to care for beneficiaries. Medicaid-eligible residents who are located in areas with limited access to primary care services often find it difficult, if not impossible, to obtain timely and appropriate healthcare services. This situation can lead to instances in which residents do not seek necessary primary care and enter the healthcare system when illnesses have progressed, resulting in higher medical costs. In a time of worsening physician shortage, having PAs available, and implementing policies to ensure patients are aware of PAs as an option for care provision, can mitigate access concerns that may cause costly delays in treatment. PAs, if unencumbered by restrictive policy, are well poised to be part of the solution to such access issues as data from the Bureau of Labor Statistics found that PAs are the third fastest growing healthcare profession, with a projected growth rate of 37% between 2016 and 2026. (3)

Federal and state Medicaid regulations that restrict PAs from practicing to the full extent of their education and training exacerbate issues of patient access to quality care. Any practice limitation that is more restrictive than state law limits the ability of PAs to provide those medically-necessary services that PAs are legally authorized, and qualified, to deliver. Regulations that inappropriately limit the types of services PAs may deliver, prevent PAs from acting in leadership positions such as leading patient-centered medical home teams, deny coverage for PAs first assisting at surgery, or that require rigid collaborative practice and supervision agreements, serve to limit access to care for Medicaid beneficiaries. Moreover, it is important to promote continuity of care. When patients are satisfied with their current providers of care, they should be allowed, or even encouraged, to maintain those healthcare relationships under a Medicaid managed care program.

Recommendations

PAs are a critical part of the health workforce providing care for Medicaid patients. To facilitate the enhanced ability of PAs to deliver services to these patients, AAPA believes that states should include the following provisions in Medicaid managed care plans:

- PAs should be specifically included in plan networks to ensure adequate availability of primary and specialty care options within a reasonable geographic proximity to patients. (4)
- PAs should be enrolled, credentialed and reimbursed in the same manner as physicians by both requiring PAs be identified on claim forms for all services they provide, as well as allowing direct payment to PAs.
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• Policies pertaining to PAs should be codified in electronic provider manuals available on an accessible website.

References
2. https://data.medicaid.gov/Enrollment/Managed-Care-Enrollment-Summary/tv8z-wdjd/data
4. https://www.aafp.org/about/policies/all/medicaid-principles.html
Professional Competence

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 is committed to helping PAs to maintain the knowledge and skills necessary to achieve professional competence in order to deliver the highest quality healthcare.

Introduction
AAPA has had a long-standing interest in identifying the determinants of professional competence and in assisting PAs in maintaining their competence. AAPA has an important role in helping PAs acquire and maintain the knowledge, skills, and attributes needed to deliver high quality healthcare. A national focus on medical errors and patient safety, and an emphasis on cost-effective, quality care has sharpened the attention of the public, legislators, regulators, employers, educators and health professionals on the importance of maintaining and demonstrating professional competence.

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

Competence, Competencies and Competency-based Education
The concept of professional competence has evolved over the last 40 years from a one-dimensional construct representing “specialized knowledge” to a more global one which includes the application of specialized knowledge. Furthermore, competence implies a minimum level of proficiency or a threshold in performance. The most common definition of professional competence used today is Epstein and Hundert’s which defines it as “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served.” (1)
The distinction between “competence” and “competency” should be made, as the terms are often used interchangeably. Webster’s dictionary defines a “competency” as an “ability or fitness.” A competency is a single skill or function, yet it includes the underlying knowledge, abilities and attitudes necessary for optimal performance. It must be performed to a specific standard under specific conditions. A competency is usually written as a broad composite statement detailing an observable set of behaviors reflecting components of knowledge, skills and attitudes. Competence, on the other hand, is more expansive and all encompassing. It represents the totality of knowledge, skills, attributes, behaviors and attitudes (or competencies), as well as, the ability to orchestrate these competencies into the full range of activities necessary for professional practice. Competence also implies a minimum level of proficiency or threshold in performance.

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

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

The Physician Assistant Education Association (PAEA), formerly known as the Association of Physician Assistant Programs, with funding from the Health Resources and Services Administration, published a document entitled, Meeting the Objective: Physician Assistant Education, Curriculum Objectives Resource Guide in 2005. (3) This web-based document has assisted programs in focusing on outcome-based education, a primary principle of competency-based education. Integration of outcome-based education into PA education helps to ensure PAs are adequately prepared with the appropriate clinical competencies to enter a dynamic healthcare environment.
AAPA, PAEA, NCCPA and the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) defined the competencies for the PA profession. These competencies were adapted from those developed by the Accreditation Council for Graduate Medical Education for physicians but identify areas specific to PA practice. The competencies were endorsed by all four organizations and disseminated to PAs in 2005. The organizations identified six general areas of competency for competent PA practice including:

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

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

**Assessment of Competence**

Most aspects of professional competence, and certainly overall competence, are difficult and expensive to measure. All physician specialty boards require significant efforts from physicians to show ongoing professional competence. This includes the need to take written exams, which primarily measure one aspect of competence, namely medical knowledge. Additionally, evidence of peer-review and self-assessment are required by many physician boards for on-going certification in a variety of medical specialties. (4) Since competence is multidimensional, its assessment should also be multidimensional, preferably having a performance-based component. These assessment exercises sample behaviors performed in the artificial testing situation. In order to measure competence, one needs to be able to evaluate the knowledge, skills, and abilities represented by those behaviors in the actual practice setting. Entry-level PA programs like many physician residency programs have long used performance-based tests, such as patient management problems, objective structured clinical examinations, and standardized patients.

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

Historically, certification maintenance for PAs, included obtaining 100 CME credits every two years and successful completion of a recertification examination every six years. In January 2014, NCCPA implemented changes to certification maintenance for PAs including additional requirements for self-assessment and performance improvement CME activities, and an extension of the recertification examination cycle from six to 10 years. Self-assessment and performance improvement activities are important activities and PAs should participate in them. The accreditation criteria for these new CME requirements ensure that approved activities are relevant, meaningful and validated, not overly burdensome to practicing PAs, and available to PAs who are not currently licensed or practicing clinically.

**Continuing Professional Development**

AAPA has endorsed continuing professional development (CPD) as a model to better integrate CME and other educational activities into a more comprehensive approach to maintaining professional competence. AAPA policy defines CPD as “a process that includes ongoing identification of learning needs, development of a learning plan, acquisition of new knowledge and skills, application to practice, and reassessment.” Traditional CME, which is a component of CPD, has focused primarily on the competency domains of medical knowledge and patient care. Delivery of quality patient care requires more than just proficiency of medical knowledge but proficiency in other competency areas as well. CPD provides a more expansive framework for the ongoing acquisition of knowledge, skills, and attitudes that define clinical competence. By using the CPD model and including activities such as quality improvement activities, peer review, patient surveys, chart audits, and the use of learning portfolios PAs have the means to not only increase clinical knowledge and skill levels, but to also enhance other competency domains such as system-based practice and professionalism, which will translate into improved patient care.

**Conclusions**

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

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

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

References


Additional Resources

2. Fineberg, HV. Health Reform beyond Health Insurance. President’s Address Institute of Medicine Annual Meeting. 10/12/09


4. Board on Health Care Services. America’s Uninsured Crisis: Consequences for Health and Health Care. 2/23/09
The PA in Disaster Response: Core Guidelines

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Preparation Through Education**

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

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

1. Basic knowledge of the National Incident Management System’s Incident Command System, along with local and state emergency services and management.
2. Recognize the importance of personal safety in disaster response situations, including having the proper protective equipment (PPE), training and ability to provide decontamination to both self and patients.
3. Recognize that PPE is typically not provided or may not be adequate at a disaster site, especially those sponsored by non-governmental organizations (NGOs). PAs should be prepared to bring their own PPE appropriate based on specific hazard vulnerability analysis.
4. Have a working knowledge of the principles of triage in a disaster setting.
5. Understand how to provide services to patients under the challenges of surge capacity in resource constrained settings.
6. Understand implementation of crisis standards of care and utilization of alternative care facilities.
7. Understand hospital preparedness and hazard vulnerability.
8. Understand the basic tenets of fatality management.
9. Develop coping mechanisms to deal with emotional and psychological stress that frequently occur during and after disasters.
10. Learn how to develop the clinical competence to provide effective care with extremely limited resources.
   a. Maintain certifications in BLS, ACLS, and PALS
   b. Recognizing the need for proficiency in trauma, maintenance of advance trauma life support (ATLS) certification would be recommended every four years.
   c. Additional specialty training that is highly recommended include: Advanced Disaster Life Support, Advanced Disaster Medical Response and advanced hazard life support. Prepare and take the National Healthcare Disaster Certification (NHDP-BC) offered by the American Nurses Credentialing Center (ANCC) or equivalent certification examination. Note that the ANCC certification will be retired December 31, 2022.
   d. Stay up to date with ever-changing disaster medical information from various AAPA-approved websites like the Centers for Disease Control (CDC), National Disaster Medical Systems (NDMS), National Incidence Management System (NIMS), Health and Human Services (HHS), Federal Emergency Management Administration (FEMA), and others.
11. Learn how to prescribe treatment plans along with an understanding of psychological first aid and caring for patients and responders during and after mass casualty events.
12. Understand the ethical and legal issues in disaster response for PAs. These include:
   a. Their professional and moral responsibility to treat victims
   b. Their rights and responsibilities to protect themselves from harm
   c. Issues surrounding their responsibilities and rights as volunteers
   d. Associated liability issues.
13. Always keep the protection of public health as a professional core responsibility, regardless of education or training.

Credentials and Roles

Verification of certification, licensure or qualifications is nearly impossible at a disaster site. Yet it is certainly in the best interests of the afflicted to receive care from legitimate, competent clinicians. AAPA supports the concept of voluntary state or national medical photo IDs to identify all qualified
medical personnel during disaster response. States such as New York have implemented such programs in the wake of recent major disasters. Most medical relief workers participate via non-governmental organizations (NGOs) or federal teams such as: disaster medical assistance teams (through the National Disaster Medical System), federal citizens response teams (CERT), Medical Reserve Corp. There are also various state teams including: state medical assistance teams (SMAT) or through other teams organized by charities or state/local governments. Volunteering through established emergency response organizations helps to ensure verification of all responder’s credentials in advance of a disaster event. In addition, all workers should carry copies of their license and relevant certifications to present when requested.

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

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

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

**State Laws/Federal Exemptions**

In some cases, governors waive state licensure requirements during disasters, but this is not always the case. In the aftermath of Hurricane Katrina in 2005, the governors of Louisiana and Missouri waived licensure requirements for all healthcare professionals for a period of time, but the governors of Texas and Mississippi did not. Texas and Mississippi streamlined their application processes, but still required licensure by their state boards. PAs should not assume that disaster response organizations either understand or ensure compliance with licensure requirements. PAs should research the steps necessary to
practice in the affected area before assisting with domestic response initiatives. PAs should also keep in mind that Good Samaritan laws do not provide either authorization to practice or, in most cases, liability protection when they are working in disaster relief situations.

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

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

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

**Responding to International Crises**

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

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

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

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

Disaster Response Standards

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

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

- Clothing, bedding and household items
- Water supply, water quality, latrines, and other sanitation facilities
- Supply and security of food stores, nutrition, and monitoring of vitamin deficiencies
- Healthcare, including preventive and surveillance measures.
The Sphere Project and other medical relief organizations also emphasize that, in addition to meeting acute medical needs, effective relief includes health promotion measures such as vaccinations and hand-washing, as well as monitoring programs for early detection of disease outbreaks.

Nutrition monitoring is also essential to the health of disaster survivors. Malnutrition can be the most serious public health problem caused by a disaster and may be a leading cause of death from it, whether directly or indirectly. Food aid has an immediate impact on human health and survival and, while it may not be a formal part of a medical team’s role, the need for adequate nutrition reinforces the importance of coordinated disaster response.

Finally, the provision of aid following a disaster should be free of political, cultural, religious or ideological restrictions. The need for organizational policies reflecting cultural mindfulness and for individual workers to be sensitive to the population they serve should be understood. Unfortunately, relief efforts are often derailed by basic misunderstandings of local customs. Failure to recognize cultural healthcare beliefs in the affected population may also result in some patients choosing not to visit disaster medical facilities. Medical care should not be offered in such a way that patients must put aside their beliefs to receive it. Participation through an established organization can help to minimize cultural offense. Individuals also should commit to a personal effort to increase their cultural mindfulness and understanding of healthcare customs of the populations they are serving. (2)(6)

**Standards for Crisis Care**

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

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

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

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

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

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

**Guidelines for PAs Responding to Disasters**

1. PAs should participate in disaster relief through established channels
   a. Consider joining non-governmental organizations, government agencies, State Medical Assistance Teams, Disaster Medical Assistance Teams, or other organized groups with a focus in providing disaster services. AAPA’s Disaster Medicine Association of PAs can help provide direction as well.
   b. Participate in workplace disaster planning.
   c. Stay current with information from reliable resources.
   d. Make every effort not to become a victim of the event or to cause harm to others.

2. PAs should support comprehensive, team-based healthcare.
   a. Become proficient in the National Incident Management System’s Incident Command System.
b. Learn to be flexible in working in unfamiliar places and circumstances – many times you have to become comfortable with “hurry up and wait” scenarios.

3. PAs should prepare for and expect the possibility of coping with scarce medical resources and nonmedical assignment in disaster situations.
   a. Participate in local disaster planning events.
   b. Participate in various webinars, tabletop drills, etc.…
   c. Bookmark federal and state websites that have an abundance of current information for medical providers, which might include:
      i. Centers for Disease Control (CDC)
      ii. Federal Emergency Management Agency (FEMA)
      iii. Emergency Management Institute
      iv. Department of Homeland Security (DHS)
      v. Health and Human Resources (HHS)
      vi. State Medical Assistance Team (SMAT)

4. PAs should be prepared to provide documentation of their qualifications at any disaster site.
   a. Always have access to a portable file containing hard copies of your driver's license, medical license, DEA license, and any specialty certifications.

5. PAs involved in medical relief efforts should be familiar with standards of disaster response and develop printed and electronic quick reference resources, including
   a. Disaster triage guides (i.e., Start, Jump Start, and others)
   b. Triage coding guides
   c. Decontamination principles
   d. Treatment guidelines for victims of biological, chemical, radiological, or natural disasters (e.g., hurricanes, tornadoes, floods, cold/heat emergencies, pandemics.)

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

**Principles of Disaster Triage:**

- The fundamental difference between disaster triage and normal triage is in the number of casualties. Care is aimed at doing the most good for the most patients (assuming limited resources).
- Definitive care is not a priority.
- Care is initially limited to the opening of airways and controlling external hemorrhage (STOP THE BLEED); no CPR in mass casualty events.
- The disaster triage system (US) is color coded: red, yellow, green and black, as follows:
o Red: First priority, most urgent. Life-threatening shock or airway compromise present, but patient is likely to survive if stabilized.

o Yellow: Second priority, urgent. Injuries have systemic implications but not yet life threatening. If given appropriate care, the patients should survive without immediate risk.

o Green: Third priority, non-urgent. Injuries localized, unlikely to deteriorate.

o Black: Dead. Any patient with no spontaneous circulation or ventilation is classified dead in a mass casualty situation. No CPR is given. You may consider placement of catastrophically injured patients in this category (dependent) on resources. These patients are classified as “expectant.” Goals should be adequate pain management. Overzealous efforts towards these patients are likely to have deleterious effect on other casualties.

Summary

AAPA endorses and promotes the support of disaster preparedness, national resiliency by providing education and training resources, and response activities and the integration of PAs as key personnel in mitigating the impact of disasters. PAs are established and valued participants in the healthcare system of this country and are fully qualified to deliver medical services during disaster relief efforts. As such, AAPA supports educational activities that prepare the profession for participation in disaster medical planning, training and response and will work with all appropriate disaster response agencies to update their policies in order to improve the appropriate utilization of PAs to their fullest capabilities in disaster situations, including expedited credentialing during disasters.

AAPA believes PAs should participate directly with state, local and national public health, law enforcement and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals and practices in preparation for all disasters that affect our communities, nation and the world. AAPA recognizes the National Disaster Medical System (NDMS) as an exemplary model for PA participation in disaster response. Finally, AAPA supports the imposition of criminal and civil sanctions on those providers who intentionally and recklessly disregard public health guidelines during federal, state, or local emergencies and public health crises.

AAPA supports the future of disaster medicine training programs that strive to:
1. Develop consensus on which educational models or tools would best prepare our medical workforce.
2. Develop standardized training programs applicable to all medical providers regardless of training or background.
3. Develop competency based medical education which can be measured against benchmarks focused on all-hazard disaster curricula and training courses.
4. Be inter-professional in training and foster an academic environment to disseminate information.
5. Recognize the urgent need to implement epidemiological disease research. Aapa recognizes that research guides evidence and contributes to the design and selection of risk-reduction interventions as well as the creation of best practices and standards.
6. Strive to develop a nation that can become resilient to all disasters with strong and capable medical workforce members.

References


Resources
Federal Emergency Management Emergency Management Institute
https://training.fema.gov/is/searchis.aspx?search=pds
IS-120.C An Introduction to Exercises
IS-235C Emergency Planning
IS-250.B Leadership and Influence

Suggested Textbooks

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National Center for Disaster Medicine and Public Health (January 2022) https://ncdmph.usuhs.edu/

Ass’n for Prevention Teaching and Research, Clinician Competencies for Emergency Preparedness Brochure


End-of-Life Decision Making  

Introduction
“A dying man needs to die, as a sleepy man needs to sleep, and there comes a time when it is wrong, as well as useless, to resist.”

Stewart Alsop

(1) Life is a continuum framed by the mysteries of birth and death. As medical science has advanced, it has succeeded in modifying events at both ends of the continuum, but death remains inevitable. Despite clinical interventions -- and sometimes because of them -- society and healthcare professionals face a tangle of dilemmas at the end of life.

(2) PAs are students and practitioners of the science of life. Death is an integral part of each life, making end-of-life problems an appropriate subject of serious study for PAs. The growth of medical technology and knowledge has increasingly blurred the line between life and death. Many advances are double-edged: techniques that rescue one person from premature and needless death can cause suffering, indignity, and financial ruin for another person whose death is inevitable.

(3) Every death takes place in a unique set of circumstances. These include the clinical aspects of disease; the ethical and religious beliefs of the patient and caregivers; physical and emotional tolerance of pain; and the availability and acceptability of measures to prolong life and/or reduce suffering.

(4) Although ethical and moral principles are often considered absolute and unchanging, they are actually dynamic and evolving, defined largely by society. From one generation to the next, changes in knowledge, values, and social structure have resulted in substantial shifts in the limits of what is morally and ethically acceptable regarding death and many other subjects.

Historical Background

(5) For thousands of years, many nomadic peoples practiced active euthanasia when elders could no longer function independently or keep up with the tribe. In ancient Greece, assisted suicide was officially sanctioned: "Whoever no longer wishes to live shall state his reasons to the Senate. If your existence is hateful to you...abandon life." (Libanius) Japanese culture long considered suicide an acceptable option to escape dishonor or advance military goals.

(6) During the Renaissance, scientific enlightenment merged with Christian philosophy and a more stable social structure to form the basis of many modern Western views on ethics and morality. In Thomas More's Utopia, "the Utopians treat the sick with great kindness and leave
nothing undone to restore their health...but if a disease is not merely beyond treatment, but is also a constant source of pain and agony, the priests and magistrates remind him that he is not up to all the tasks of life, is troublesome to others and a burden to himself, and is now outliving his own death."

(7) In modern times, end-of-life quandaries have been fueled by the explosion of clinical advances enabling the postponement of death, indefinitely in many cases. The use of mechanical ventilators to assist breathing began a mere four decades ago. Then came defibrillators, hemodialysis, cardiopulmonary resuscitation, pacemakers, heart-lung bypass, and ventricular assist devices, not to mention vast progress in pharmacologic life support and parenteral nutrition.

(8) As technology boomed, medical decision making shifted away from physicians, whose primacy had been unchallenged for centuries. A more informed, consumer-minded, and anti-authoritarian public began to demand a greater role in making decisions about their own medical care. (1) Here are some milestones in the evolution of this debate:

(9) Euthanasia, while still technically illegal, becomes socially and politically acceptable under certain circumstances in the Netherlands in the early 1970s. (2)

(10) *On Death and Dying*, by Elizabeth Kubler-Ross, published in 1969, brings the process of death into the realm of popular discussion. (3)

(11) In 1974, the first hospice in the U.S. is founded by Hospice Inc., in New Haven, CT.

(12) The parents of Karen Ann Quinlan, a young woman in a "persistent vegetative state," petition to have their daughter removed from artificial life support. The request is granted on appeal in 1976. Quinlan lives for several years after life support is withdrawn. (4)

(13) California passes its "Natural Death Act" in 1976, allowing competent adults to control decisions about withholding, refusing, or withdrawing life support.

(14) The Hemlock Society, which advocates assisted suicide and voluntary euthanasia in cases of terminal illness, is founded in 1980 by Derek Humphrey, who two years earlier had published an account of assisting in the suicide of his terminally ill wife.

(15) The *Journal of the American Medical Association* publishes “It's Over, Debbie”, an anonymous account of active euthanasia written by a house officer, in 1988. (5)

(16) In the case of Nancy Cruzan, who had been comatose since 1983, the U.S. Supreme Court ruled in 1990 that a person whose wishes are clearly known has the right to refuse life-sustaining medical treatment. (6)

(17) In 1990, Jack Kevorkian, MD, is charged with murder in the death of Janet Adkins, the first in a long and highly publicized series of assisted suicides linked to the Michigan pathologist. (7)
In 1991, Derek Humphrey publishes *Final Exit*, which contains suicide "how-to" advice for terminally ill persons and achieves widespread readership. (8)

In 1991, a National Opinion Research Center poll reveals that legalized euthanasia by physicians at the request of terminally ill patients is supported by more than 60% of Americans. (9)

Timothy Quill, MD, a New York internist, describes in *The New England Journal of Medicine* in 1991 how he assisted a leukemia patient's suicide by prescribing a lethal quantity of barbiturates. His soul-searching account is viewed by many as the antithesis of Dr. Kevorkian's techniques. (10)

The emergence of Acquired Immunodeficiency Syndrome (AIDS) has had significant impact in turning society’s attention toward end-of-life decision making. This tragic illness that affects predominantly young adults and is very frequently fatal has dramatically increased an entire generation’s awareness of its own mortality. Among persons who have contracted AIDS, the questions shift away from “Will I die?” to “Where would I like to be when I die?” and “How would I like to die?” and “Who will be with me when I die?” The struggles of these individuals to face the philosophical and practical aspects of their mortality have brought a myriad of end-of-life issues out of the shadows and into the light.

**Legal Issues at the End of Life**

The following definitions may help to clarify discussions about end-of-life decisions.

**Suicide:** the intentional taking of one's own life.

**Assisted suicide:** providing information, medication (or other means) or direct assistance that enables a person to take their own life. The final action remains with the person who wishes to die.

**Euthanasia:** deliberately bringing about the death of another to spare the individual suffering. In this context, a painless and humane death delivered to a person who is terminally ill.

**Passive euthanasia:** the act of withdrawing support or intervention necessary to keep a patient alive, such as unplugging a ventilator or stopping parenteral feeding.

**Active euthanasia:** direct intervention by another person to cause death, for example, by injecting a lethal dose of a drug.

**Voluntary euthanasia:** performed on a patient who has made clear the wish to die, but is unable to act on it. (11)
Double effect euthanasia: provision of palliative treatment that may have fatal side effects; i.e., steadily rising doses of morphine, intended to control pain and agitation, also "inadvertently" hasten death by depressing respiration. (12)

Terminal sedation: after removal of life sustaining devices, a person is heavily sedated for comfort until death occurs.

Advance directive: explicit instructions and guidelines regarding an individual's desires for treatment, comfort, and resuscitative efforts in the event of terminal illness or incapacitation.

Suicide or attempted suicide, while not technically legal, is not prosecuted or punished in any state. All states, however, have prohibitions on intentionally causing the death of another or inducing an individual to commit suicide. At present, assisted suicide is explicitly banned in at least 30 states. (13) On March 6, 1996, the first physician-assisted suicide case decided at the federal appellate level found a Washington state ban on physician-assisted suicide to be unconstitutional. The law in question had allowed "passive" withdrawal or withholding of life support, but prohibited "active" assisted suicide. The decision by the U.S. Court of Appeals for the Ninth Circuit affirmed and clarified a 1994 judgment that had declared the state law unconstitutional. In an 8-3 decision, the appellate court stated, “We hold that insofar as the Washington statute prohibits physicians from prescribing life-ending medication for use by terminally ill, competent adults who wish to hasten their own deaths, it violates the Due Process Clause of the Fourteenth Amendment (to the U.S. Constitution).” (14)

Less than a month after the Ninth Circuit Court decision, the U.S. Court of Appeals for the Second Circuit struck down a New York law prohibiting assisted suicide. The court found the state had no rational basis for distinguishing between competent, terminally ill patients who may legally choose to refuse medical treatment or have care withdrawn, and patients who choose to end their lives by self-administration of drugs prescribed by their physicians. The court held that “physicians who are willing to do so may prescribe drugs to be self-administered by mentally competent patients who seek to end their lives during the final stages of a terminal illness.” (15)

The states of Washington and New York appealed the two circuit court decisions to the U.S. Supreme Court, which heard the case on January 8, 1997. The Supreme Court ruled that terminally ill patients do not have a constitutionally protected right to assisted suicide. The ruling against a constitutional right refers the issue back into state legislatures and courts. (16)

The risk of criminal liability in withdrawing or withholding life support at the request of a patient or surrogate is exceedingly small. Risk increases somewhat if a clinician directly causes a patient's death by administering a lethal dose of medicine. "Assisting" in a suicide by providing medical advice or means (e.g., a prescription) also carries significant risk of prosecution. (18) In
1999, a Michigan court convicted Dr. Jack Kevorkian of second degree murder for administering a lethal injection to a patient suffering from Lou Gehrig’s Disease (People vs. Kevorkian). He was sentenced to 10-25 years’ imprisonment. Conviction in such cases is rare if the clinician has acted ethically and compassionately in accordance with the patient's wishes.

(36) Several states have mounted efforts to legalize assisted suicide. A 1991 initiative -- also in the state of Washington -- was defeated in a general election by a 54 to 46% vote. Although the bill's underlying premise seemed to elicit substantial support, there was also strong concern about inadequate safeguards against potential abuse. A year later, a similar initiative in California with broader safeguards was defeated by a similar margin. In 1994, Oregon voters passed a measure permitting a physician to supply a terminally ill patient with a prescription for a lethal amount of drugs, the Death with Dignity Act. The hotly contested bill, which passed by a narrow margin, was actively opposed by the American Medical Association, and its implementation blocked by litigation. (19) In 2006, the United States Supreme Court upheld the Oregon Death with Dignity Act in a 6-3 opinion. The court rules that the controlled substances act does not prohibit the use of controlled substances for physician-assisted suicide (Gonzales vs. Oregon no. 04-623).

(37) In 2005, the United States Supreme Court upheld the right of the Florida State Court to order the removal of a feeding tube in the case of Terri Schiavo. It was the sixth time the Supreme Court refused to intervene in the prolonged litigation between the patient’s husband and parents.

(38) The debate over assisted suicide points up the distinction between legalizing an action and decriminalizing it. Legalization makes an action legal in a defined set of circumstances. Decriminalization maintains the prohibition against an action, but reduces the gravity of the charge and the severity of the penalty, usually to a misdemeanor. Absence of criminal liability by no means precludes the possibility of civil liability, such as suits for medical malpractice or wrongful death.

(39) After including safeguards against abuse, in 2008, initiative 1000, the Washington State Death with Dignity Act, was approved by 58% of votes. The law, which closely imitates the Oregon Death with Dignity Act, went into effect March 6, 2009. The act allows a competent adult with a terminal illness to make a written request for medication to be self-administered to end their life. The act includes civil, criminal, and professional disciplinary safeguards for providers who participate in the patient’s request.

(40) Another law that has exerted substantial impact on end-of-life decision making is the Patient Self-Determination Act (PL 101-508, 104 Stat 1388-321), enacted as an amendment to Medicare statutes in 1990. This act required states to develop or enact measures to inform patients of their decision-making rights regarding treatment, life support, and resuscitation. Details vary
from state to state, but the goal of alerting patients to their options regarding advance directives upon admission to a hospital or nursing home has been broadly realized.

**Ethical Considerations**

(41) Ethics, or principles of moral conduct, are not fixed and static, but subject to change and interpretation. Social, historical, cultural, racial, political, professional, and religious influences all shape the ethical beliefs that affect the actions of healthcare providers and patients.

(42) Four generally accepted principles of bioethics are autonomy, beneficence, nonmaleficence, and justice.

(43) **Autonomy**, strictly speaking, is self-rule. To be truly autonomous, one must be capable of making decisions and choices. (20)

(44) **Beneficence** is acting in what is (or is judged to be) the patient's best interest. It is often equated with paternalism.

(45) **Nonmaleficence** means to do no harm, to impose no unnecessary or unacceptable burden upon the patient.

(46) **Justice** means that patients in similar circumstances should receive similar care. It also refers to norms for the fair distribution of resources, risks, and costs.

(47) For centuries, the healing professions, like the clergy, assumed a parental role. Physicians possessed a storehouse of scientific knowledge not accessible to the general public. Their healing endeavors were often cloaked in ritual and quasi-mysticism. Patients were considered incapable of choosing among complicated scientific theories, and physicians were expected to choose for them. Thus, emerged the concept of the beneficent healer, and society came to accept medical paternalism and beneficence as one.

(48) Over the past three decades, a gradual but inexorable shift has taken place in the field of bioethics. Patients have become better educated and more capable of understanding scientific data. Medicine has become more accessible and somewhat de-mystified. From the mid-1960s on, authority figures -- physicians included -- have been subject to more challenge and scrutiny. As money has become more a focus of healthcare decisions and debate, physicians' aura of moral authority has eroded.

(49) In this milieu of change, patient autonomy has evolved as the primary precept of bioethics. In the last 20 years, substantial reforms have been undertaken in the fields of law, ethics, and medical education, all revolving around the patient's right to choose. (1) Often, it is assumed that the principles of autonomy and beneficence are in conflict. This is true if one equates beneficence and paternalism, but the terms are not equivalent or interchangeable. In some circumstances, paternalism might be maleficent -- for example, if it violates a patient's right to
choose. And beneficence may be far from paternal, since it may consist of educating the patient to enable their informed choice. Beneficence may complement autonomy.

(50) Nonmaleficence as an ethical principle requires that a provider "first, do no harm." This is a tangled issue in end-of-life decision making, since the same acts may be interpreted as harmful or beneficial depending on the circumstances and on participants' values and perspectives. For example, if a comatose patient with no advance directive is kept on life support in the ICU, is not harm inflicted through physical discomfort and financial hardship? On the other hand, if life support is withdrawn, is the patient not harmed by being deprived of even the remotest chance of recovery?

(51) The principle of justice is not a simplistic implication that all patients should receive the same treatments and resources. It does require that all patients be accorded respect for their individuality and autonomy. All should receive the same opportunity to be informed and choose their course of treatment. It also requires that scarce resources be allocated fairly (for example, on patients with a good chance of recovery rather than on those for whom treatment will be futile).

(21)

Cooperative End-of-Life Decision Making

(52) A society's beliefs are reflected in its laws and ethical principles. The individual struggling with difficult decisions about death and dying can turn to those principles for guidance, but will rarely find that they provide all the answers. Ultimately, death is not societal but solitary and supremely personal. However, as medicine has succeeded in prolonging life, greater numbers of people have become enmeshed in the process of an individual's death. At the dying patient's bedside are family, loved ones, clergy, healthcare providers, technicians and, in absentia, lawyers, ethicists, and even third-party payers. Each brings a set of priorities, beliefs, and values, and achieving complete harmony among them is usually impossible. If the goal of end-of-life decision making is to make the process of dying as humane and compassionate as possible, it is essential to minimize conflict and maximize cooperation for the patient's benefit. One way to enhance cooperation is by understanding the internal and external influences that affect the patient, the patient's family, and clinicians, especially physicians and PAs.

Patient and family concerns

(53) Often, the first question asked by patient or family in cases of serious illness or injury is, "Is this condition terminal?" If death seems imminent, the next question is almost always, "How much time is left?" The longing for certainty is natural, but these questions are usually impossible to answer satisfactorily. PAs and physicians have seen too many unexpected deaths and unforeseen recoveries to make firm predictions or speak in absolute terms. Patients and families
may then become frustrated by what they perceive as a lack of competence, concern, or communication. They want answers, which the clinician often simply cannot provide -- sometimes giving rise to an adversarial relationship.

(54) The next big question often pertains to suffering. "Will I be in pain? Can you control it? Will I have to be sedated or unconscious in order to be comfortable?" Studies have shown that many patients fear pain less than the loss of control. (22)

(55) Finances are a third major concern for patients and families. "What will all this care cost? Is it covered by insurance? Will my family or loved ones be bankrupted to provide me with a few extra days or weeks of existence?"

(56) Faced with the prospects of uncertainty, pain, loss of control, and financial ruin, some patients and families begin to consider options other than intensive medical intervention. They may choose no therapy other than pain control (palliative therapy). They may even consider suicide, assisted suicide, or some form of euthanasia.

(57) PAs should be prepared and willing to discuss advance directives and living wills with their patients. Concerns with advance directives often center around several areas:

(58) Families may believe their loved one is not competent or capable enough to formulate an informed advance directive. They may believe the patient is too upset to be rational or doesn't understand all the options.

(59) Patients often worry that family members will contradict their advance directive.

(60) Patients and families are concerned lest physicians override their wishes. In fact, some studies suggest that physicians may do just that in up to 25% of cases, even when the wishes of the patient were clear. (23)(24)

(61) In situations where patients decline to draw up an advance directive or living will, they should at least be encouraged to enact a health-care power of attorney, designating a family member, loved one, or friend as a surrogate with the authority to make medical care decisions for an incapacitated individual. This may avoid the "majority rule" mode of decision making that often arises when no advance directive exists.

(62) Patients and families should also learn about the availability of home care and hospice services. Hospice in particular can be an invaluable resource. Not only do the volunteers and nurses provide bedside care and family support, but they can also assist with education, planning, and accessing social services.

(63) Questions of a moral or religious nature often arise in end-of-life decisions. In Western culture, matters of life and death have been traditionally presumed to be in God's hands. As technology has placed more moral weight onto human shoulders, many patients feel guilt over
wishing for death or asking to die. They fear condemnation for choosing the time and manner of their own death, and may seek moral validation through the active or tacit approval and even the assistance of others, especially "authority" figures such as a clergy member, physician, or PA.

The major premises of American bioethics are based on values that are predominately western, white, and middle class. The values and beliefs of other races and cultures may differ significantly. For example, the perception and expression of pain is significantly influenced by cultural and racial factors. At the end of life, cultures that are more family oriented, such as Korean, Chinese, or Mexican, may place much less emphasis on patient autonomy and fully-informed individual consent. Others may be likely to insist on aggressive, life-sustaining treatment. Studies have shown that substantially fewer minority patients make use of advance directives, even when such directives are readily available. (25)

While it is wrong to ignore the effects of culture and ethnicity on end-of-life planning, it is equally wrong to assume that all members of a particular cultural or ethnic heritage share the same values and beliefs. Providers must individualize their care of dying patients and their families, while remaining sensitive to cultural variables such as language, family dynamics, religion, economics, pain behaviors, and alternative healing practices. In some situations, providers may need to seek assistance from religious leaders, traditional healers, translators, and cultural consultants. (25)

Evaluating requests for assistance in dying

End-of-life decisions are influenced by factors including uncertainty, fear, pain, ethical and moral concerns, financial factors, and family support (or lack of it). When patients express a desire for active involvement in their own death in any manner, family and providers should carefully evaluate their state of mind and intent. Such requests may actually represent:

feelings of abandonment by family or the medical establishment.

desire for more effective symptom control, or simply more control over treatment and surroundings.

concern about becoming a financial burden.

clinical depression. (Terminally ill patients often suffer from depression, and it is wrong to assume that it is a natural part of the disease process; treatment often improves quality of life.)

reaction to real or perceived conflicts with family members, or a belief that others expect them to "pass away quietly."

Determining true intent at this stressful juncture can be very difficult. A person may request death because no other reasonable options seem possible. Thus, some requests may be
interpreted as an invitation to better and more open communication, rather than a genuine wish to
die. (26)

(73) As a final guideline in conflicts over end-of-life decision making, clinicians and family
members should recall the first principle of bioethics: patient autonomy. The patient's right to
choose is primary, provided that the choice is informed, uncoerced, and does not seriously
conflict with the autonomy of others.

Caregivers' concerns

(74) For physicians, PAs, and other caregivers, the death of a patient is a complicated and trying
event, provoking a host of ambivalent thoughts and feelings. Clinicians must meet the emotional,
ethical, and legal challenges of caring for the dying while maintaining their own personal and
professional integrity and values.

(75) The relationship of patient to healthcare provider is a two-way interaction with mutual
obligations, uncertainties, and rewards. Events affect both parties; beliefs and values of one may
subtly or overtly affect the other. Those who care for the dying owe it to their patients and
themselves to scrutinize their own attitudes, which may influence the kind of care they deliver.

(76) Many studies have shown that the values, beliefs, and emotional health of the clinician
are an integral part of the care and counseling given to the dying person. (27) For example,
patient choices depend not only on what information is given, but also how it is presented. Up to
20% of patients who have chosen a particular option will change their mind if the information is
presented differently. (28) A 1990 study showed that physician recommendations to withdraw life
support in the ICU were rejected by patient or family only 2% of the time. (29)

(77) Diagnosis appears to affect physician attitudes about discussing resuscitation or do-not-
resuscitate (DNR) orders. One study documented that up to 50% of AIDS and cancer patients had
been involved in such decisions, but only 5 to 15% of patients with cirrhosis or congestive heart
failure had such involvement, despite similar severity of illness and prognosis. (30) Physicians
have been documented as underestimating chronically ill patients' quality of life and may
incorrectly assume that such persons would wish to refuse life-sustaining interventions. (31) And,
unfortunately, undertreatment of the pain, agitation, and depression associated with terminal
illnesses persists. (32)(33) Treatment decisions may be strongly influenced by the provider's own
anxieties about the prospects of disability, aging, and death. (27) Recent studies have shown that
clinicians are reluctant to discuss advance directives with many patients who would welcome
such a discussion. Their own opinions as to the appropriateness of resuscitating a patient were
identified as strong determinants of whether or not such discussions were initiated. (24)(34)
The evidence is compelling: those who care for dying patients must examine and understand their own feelings, beliefs, and limitations regarding the process of dying. Caregivers often try, consciously or not, to validate their own beliefs by convincing others to share them. Religious and moral convictions are subject to infinite shadings and interpretations. Clinicians who are aware of, and comfortable with, their own beliefs are less likely to feel either conflicted or compromised.

PAs must recognize their own values with regard to pain and suffering and the physical process of dying. Many clinicians seem to value stoicism in themselves and others; they rarely ask for help and may look down on those who do. Others are so uncomfortable with human suffering that, if they cannot relieve it, they withdraw. (27) Some value alertness and control over comfort in their own lives. By projecting their values and priorities onto the care of a dying patient, clinicians may make incorrect assumptions about the patient's wishes for sedation and symptom control.

Supporting patient autonomy may be easier said than done. Here is a short "examination of conscience" for clinicians:

Do I feel challenged or threatened if a patient questions my judgment or seeks another opinion?
Do I often disagree with patients over treatment plans?
Do I ever initiate tests or treatments without discussing them first, on the assumption that I know best?
Do I ever ignore a patient's specific directives, thinking that they just don't apply in this circumstance?

The clinician's comfort zone

The autonomy of the healthcare provider matters, too. Clinicians possess expert knowledge and should be free to use it in their best judgment. Respect for patient autonomy does not obligate the use of unproven or inappropriate treatment modalities. The clinician's morals and ethics must also be respected. If they conflict with those of the patient, the patient should be notified and allowed to seek another caregiver with more compatible attitudes and values.

Care for the terminally ill covers a range bounded by two extremes, from "do everything possible to sustain life" to "active euthanasia." In between lie all the subtle gradations of care: palliation, non-initiation of life support, withdrawal of mechanical support, withdrawal of nutritional support, terminal sedation, suicide, assisted suicide. No one can identify a single position on the continuum and apply it to every case. However, it is equally impossible for most clinicians to be comfortable from one end of the range to the other.
Rather, clinicians must establish a "comfort zone" wherein they can provide maximum benefit to the patient while adhering to their own moral convictions. The breadth and position of this comfort zone may change over time as skills and experience are gained.

Private Decisions, Public Demands

While end-of-life decisions are made in a very private setting, the framework upon which these decisions are based is shaped in the public arena. Some difficult questions cannot be addressed on the individual level, and society must make these broader decisions.

Strong arguments for and against liberalization of assisted suicide and euthanasia have raged over the past two decades. Legalization efforts have met with mixed results: voters reconfirmed Oregon’s Death with Dignity Act in 1997 and enacted Washington’s Death with Dignity Act in 2008, but a similar initiative failed by a wide margin (29% to 71%) in Michigan in 1999 and a narrow margin in Maine (49% to 51%) in 2000.

Opponents of liberalization often cite the so-called "slippery slope" argument: once restrictions are loosened; the process will be difficult to regulate and control. (11)(36) Those who fear the liberalized “slippery slope” express concerns that economically and socially vulnerable patients (for example, the poor, homeless, imprisoned, or disabled) may be inappropriately encouraged or “assisted” with suicide. They often point to the Dutch experience, which has found that in some cases of euthanasia, no request for assisted dying was documented. (2) As Steven Miles, MD, has stated, "Law is too blunt an instrument and the psychology of 'rational' or 'irrational' suicides...is too murky to selectively empower only 'good' decisions by 'ideal' physicians. The legalization of assisted suicide would empower not only physicians with good relationships (with their patients), but also those with transient, inadequate, or troubled relationships.” (27)

However, there may be more than one slippery slope. Just as liberalization of assisted suicide could have unintended consequences, so too could absolute restriction on assisted suicide. For example, in many cases a patient’s request for assistance with suicide leads to a dialogue that results not in death, but in improved communication, better symptom control, and more appropriate use of available resources. Providers who fear criminal prosecution may be reluctant to enter into any discussion in which the patient mentions suicide or assistance with suicide. This could have a profoundly chilling effect on provider-patient communication.

Judging from the public record, society wants change -- but they want it to be cautious and considered. Americans seem to want a legal framework that allows for compassion and flexibility but protects against abuse. One answer may be decriminalization within well-defined guidelines. For example, the recently passed Oregon initiative required that a patient's request be
in writing and signed before two witnesses who agree that the patient is competent and acting voluntarily. Two physicians must agree that the patient is terminally ill and likely to die within six months, and counseling is required if depression is suspected. (19) Timothy Quill, MD, has suggested additional guidelines that are admirable in intent but may be difficult to comply with. For example, "the physician must be sure that the patient's judgment is not distorted." Certainty in this regard may be elusive. Other guidelines suggested by Quill are more concrete, such as the need for clear documentation and mandatory consultation. (22) Various criteria also exist for DNR orders and withdrawal of life support. (37) While clinicians, legislators and ethicists may propose guidelines, it will remain society's responsibility to adopt and abide by them.

Cost and Justice

(93) Inevitably, issues of cost will play a part in this debate. The financial burdens of a lingering death loom large in end-of-life decision making, but the costs of facilitating death are seldom considered. Legal advice, financial consultation, psychological testing and treatment, mandatory medical consultations, increased record keeping, and the activity of ethics committees all require money.

(94) Issues of access and justice also arise. In theory, all patients who need such services should be able to access them. In reality, will society extend end-of-life options to the uneducated, uninsured and impoverished? Will those in special populations, including managed care organizations and programs such as Medicare and Medicaid, have equal opportunity for any benefits that arise from policy reform?

Special Concerns for PAs

(95) The patient is the central figure in end-of-life decision making, but PAs have an important role to play. In some cases, the PA will be the dying patient's primary healthcare provider and chief advocate. All medical caregivers have a prime responsibility to ensure the patient's well-being. In doing so, however, they must act in accordance with their own ethical principles. PAs also have a unique responsibility arising from their relationship with supervising physicians, who share liability for the PA’s actions.

(96) Within this context, it is easy to imagine scenarios that could place PAs in awkward or troublesome situations:

(97) Against a dying patient's wishes, a supervising physician intervenes in the patient's well-established relationship with a PA.

(98) A patient requests a PA's assistance in making or implementing end-of-life decisions, but a physician ethically opposed to the chosen course forbids the PA's participation.
A physician is willing to grant a patient's request for withdrawal of life support, although the PA strongly recommends consideration of other issues such as depression or pain control.

A PA has two supervising physicians who share call and hospital duties, but have widely divergent moral and/or ethical views on end-of-life issues.

A precarious spot and divided loyalties may characterize the PA’s position in such circumstances. The optimal course is to discuss end-of-life issues with the supervising physician before potential conflicts arise. When discord persists, the PA must remember that the physician bears the ultimate liability and, therefore, the final responsibility for clinical decision making. A PA who believes that legal or ethical precepts are being violated is responsible for speaking out in an appropriate and timely manner. (38)

Conclusion

Life is a process with death as an integral part of the continuum. In the past, death has sometimes been relegated to a separate and distinct entity, isolated from human experience -- an interruption, an end, a form of oblivion. Science has given us the ability to prolong, sometimes indefinitely, the process of dying. With this ability comes the awesome responsibility of deciding when and how to use it. American society has been struggling with this responsibility. In recent years the contentious, sometimes heated, debate has spread from the bedside to legislative chambers and courtrooms.

Even though many questions remain to be answered, the debate has helped focus attention on one undeniable fact. Our society and our profession have much room for improvement in the care of those who are near the end of their lives. The real issues and problems are much more complex and far-reaching than the relatively narrow question of assisted suicide. Although this is a crucial and controversial question, perhaps its truest benefit has been to open and broaden the discussion of other issues surrounding end-of-life decision making.

Not one of these issues exists in a vacuum, nor will most be resolved soon. That does not mean that improvements cannot take place as the debate continues. In light of the discussion presented in this paper, AAPA believes that:

The ethical principles of patient autonomy and informed choice are of primary importance in end-of-life decision making. The autonomy of the healthcare provider must also be respected. Laws, policies, or unwritten rules that interfere with communication between provider and patient, or that inappropriately restrict patient autonomy, should be condemned.

PAs and other providers who care for dying patients must be knowledgeable in managing that care. They should be able to recognize and treat physical and psychological conditions that adversely affect the patient’s comfort and emotional well-being. These providers should have
specific and appropriate training in pain management and in the counseling of dying patients and their families.

(107) End-of-life decision making is far more inclusive than limited discussions of assisted suicide or euthanasia. “Assistance in dying” includes many interrelated aspects -- from planning, counseling, and advance directives to clinical care. Every point on the continuum of clinical care has unique moral, ethical, and legal implications for both patient and provider. A well-established therapeutic relationship with a clinician, based on mutual trust, respect, knowledge, and understanding, is essential to assisting a patient with any of these critical issues and decisions.

(108) Information about advance directives should be available in all healthcare settings, including outpatient clinics, home health agencies, pharmacies, and public health facilities. PAs should be prepared and willing to discuss advance directives with their patients.

(109) PAs have a legal and ethical responsibility to the supervising physician, as well as to the patient. PAs should inform and involve the physician in all near-death planning. The PA should not withdraw life support without the supervising physician’s agreement.

(110) In some circumstances, certain terminally ill patients may find a dignified and painless death by suicide preferable to a continued life of pain and suffering. However, PAs and all providers must recognize that not all patients who request assistance with suicide really wish to die. They may suffer from depression, need better symptom control, or need more information to better understand their options.

(111) Any request for assistance and support from a terminally ill patient, whether or not it involves suicide, should be treated seriously and respectfully. PAs should be aware that their comments, demeanor, and attitudes can profoundly affect patients who are in a suggestible and vulnerable time of their lives.

(112) AAPA does not advocate assisted suicide. However, AAPA feels that the ethical, compassionate, well-intentioned provider who discusses voluntary self-termination of life by competent informed terminally ill patients is not to be subject to prosecution.

(113) PAs are front line caregivers for the dying. They should take a leadership role in educating the public, policymakers, other health professionals, and their patients regarding the need for enlightened and progressive policies in this area. AAPA believes that the most effective way to minimize the issue of assisted suicide is to optimize care and maximize quality of life for patients at the end of life.
References


15. Miner, Quill v Vacco. 80 F 3d, 715 2nd Cir (1996)


26 Quill TE. Doctor, I want to die. Will you help me? JAMA 1993; 270:870-3.


Rural Health Clinics

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

The Rural Health Clinic Services Act of 1977 increases primary care services in underserved areas by utilizing PAs and other non-physician providers. Certified rural health clinics receive cost-based compensation for treating Medicare and Medicaid patients. AAPA policies for effective administration of the RHC program are identified in this paper.

Background
To make quality healthcare available to millions of children and adults living in medically underserved rural areas, the Federal Government created the rural health clinics program in 1977. This program, authorized by Public Law 95-210, the Rural Health Clinic Services Act, assures Medicare and Medicaid reimbursement to certified clinics staffed by PAs and nurse practitioners (NPs) working with physician supervision. The purpose of the rural health clinic (RHC) program is to increase primary care medical services in rural, physician shortage areas by utilizing PAs and NPs and providing cost-based compensation for care of Medicare and Medicaid patients.

The concept of reimbursing clinics for services provided by PAs and NPs to poor and elderly rural Americans had widespread support. The 1977 legislation was endorsed by medical, PA, and nursing organizations, as well as insurers, unions, provider groups, senior citizens, educators, and public officials. The program, however, failed to thrive until, more than a decade later, Congress made a series of changes that reduced burdensome paperwork, increased payment levels, and enhanced technical assistance and awareness. Modifications to state PA laws, such as relaxation of on-site supervision requirements and the delegation of prescriptive authority, have also contributed to the program’s success. As a result, the number of certified rural health clinics has grown from less than 600 in 1990 to approximately 3700 in 2008.

The rural health clinic program is fulfilling its goal of increasing access to primary medical care in rural areas. The PAs, NPs, and physicians in these clinics provide access to primary and emergency services in many communities in which medical services would not otherwise exist.

In addition to increasing access to care, RHCs often stabilize the rural healthcare delivery system and the economy of rural communities. They help reduce the migration of patients and healthcare dollars to urban areas. They employ qualified local residents and support local businesses, such as pharmacies, office suppliers, printers, nursing homes, and other merchants. They provide rural residents and businesses with access to needed primary and emergency services and thus make living and working in a
rural community possible for many families. RHCs also play an important role in the education of future rural providers by serving as clinical training sites for PA students and others.

Rural health clinics care for large numbers of Medicare, Medicaid, and uninsured patients. A 2003 national survey revealed that approximately 56% of patient visits in rural health clinics are covered by Medicare or Medicaid and approximately 15% of patients are uninsured. (3) Clinics continue to exist because of the reimbursement methodology that helps to provide financial stability. Approximately 50 percent of clinics are subject to a federal cap. Unlike a fee-for-service practice where Medicare payment is based on charges for all services provided, a rural health clinic is paid based on costs calculated into an all-inclusive rate that is reconciled and adjusted annually. The rate is subject to an inflationary adjustment each year based upon the Medicare economic index. The rate has not been adjusted to reflect changes since the inception of the resource based relative value scale methodology for fee-for-service payments.

In addition, Medicaid payments to rural health clinics in the majority of states are paid based upon a prospective payment system that was calculated using rates from 1999-2000. In many states this does not reflect the current costs of care.

The rural health clinics program is an essential component of rural healthcare delivery today. It has been successful in delivering healthcare to previously underserved areas. Steps should be taken to ensure that this program continues so people in rural areas will have access to primary care and emergency services.

**Recommendations**

- AAPA supports continuation of the rural health clinic program to meet the goal of improving access to care in rural medically underserved areas.
- AAPA also supports retention of the original requirement that RHCs utilize PAs in order to extend access to primary care medical services in areas that have a shortage of physicians. The purpose of the RHC program is to increase access to healthcare in medically underserved rural areas through utilization of PAs and NPs.
- In light of the 2004 federal requirements that RHCS establish a comprehensive quality assessment and performance improvement program, AAPA recommends that the cost of developing and maintaining these programs be captured in the clinic’s per visit payment rate.
- Recognizing the economic difficulties of providing healthcare services in rural underserved areas, AAPA recommends the continuation of cost-based reimbursement for RHCs or the development of an alternative payment mechanism that would protect their financial viability and cover the costs of providing services to rural Medicare and Medicaid patients. RHCs should not be required to compute patient co-payments into any Medicare co-payment cap. In addition, the Medicaid
rates in states using a prospective payment system methodology for rural health clinics should be updated to reflect actual costs of providing care.

- Rural health clinics that employ PAs at the minimum 50 percent staffing level or higher should be eligible for the Medicaid electronic health record incentives contained in the American Recovery and Reinvestment Act of 2009 and for future incentives authorized by Congress.

- Because of the important role that rural health clinics play in delivering care to rural communities, RHCs should be considered an integral part of the national safety net provider system along with community and migrant health centers, federally qualified health centers, and free clinics.

- AAPA encourages the Federal Government to make the following improvements to the Rural Health Clinic Services Act, its regulations, and implementation:

  - Allow PAs and NPs to contract to provide medical services at RHCs;
  - Add preventive primary health services to the list of covered services for which rural health clinics are reimbursed by Medicare and Medicaid;
  - Set per visit payment levels that cover the actual costs of providing care;
  - Adjust the per visit payment cap to the same level as rural federally qualified health centers that provide comparable or similar medical services;
  - Permit RHCs to participate in the Federal Government’s section 340b discount drug pricing program so as to increase patient access to needed medications;
  - Include RHCs in federal funding programs that enhance care for rural underserved populations, such as those programs available to community and migrant health centers and FQHCs;
  - Maintain the authority of a governor to designate areas as rural for the purposes of the RHC program;
  - Allow clinics that have obtained and comply with the shortage area facility designation requirements but who lose their traditional health professional shortage area, medically underserved area, or governor's designation to be considered essential providers for the purpose of retaining their RHC designation;
  - Allow clinics that are actively involved in the education and training of PA students to be eligible for designation as an essential community provider;
  - Allow clinics that are certified as medical homes to retain their RHC designation;
  - Allow sufficient time (at least 18 months) from the date a clinic is notified of the loss of its certification for its transition out of the program;
• Require all clinics to demonstrate during a waiver period that they are making a good faith effort to recruit PAs and NPs;
• Encourage RHCs to offer specialty services that can be billed under traditional Medicare part b without violating commingling provisions;
• Avoid the imposition of new regulatory requirements that add cost and administrative burden to RHCs;
• Include RHCs as recipients of electronic health record incentive payments;
• Maintain eligibility for Medicaid payments for any RHC that has lost its certification regardless of the clinic ownership.

References
2. Federal Register, Vol.73, No.125, June 27, 2008.
Guidelines for Ethical Conduct for the PA Profession

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.

- Individual PAs must use their best judgment in a given situation while considering the preferences of the patient, the healthcare team, clinical information, ethical principles, and legal obligations.
- The four main bioethical principles which broadly guided the development of these guidelines are patient autonomy, beneficence, nonmaleficence, and justice.
- The statement of values within this document defines the fundamental values the PA profession strives to uphold. The primary value is the PA’s responsibility to the health, safety, welfare, and dignity of all human beings.

Introduction
The PA profession has revised its code of ethics several times since the profession began. Although the fundamental principles underlying the ethical care of patients have not changed, the societal framework in which those principles are applied is constantly changing. Economic pressures, social pressures of church and state on the healthcare system, technological advances, and changing patient demographics continually transform the landscape in which PAs practice. This policy, as written, reflects a point in time and should be reviewed though that lens. It is a living document to be continually reviewed and updated to reflect the changing times, be they related to societal evolutions or the advancement of medical science.

Previous codes of the profession were brief lists of tenets for PAs to live by in their professional lives. This document departs from that format by going a step further and describing how these tenets apply to PA practice. Each situation is unique. Individual PAs must use their best judgment in a given situation while considering the preferences of the patient and the healthcare team, clinical information, ethical principles, and legal obligations. Context and/or casuistry (extracting reasoning from case study), often play key roles in decision making.

Four main bioethical principles broadly guided the development of these guidelines: patient autonomy, beneficence, nonmaleficence, and justice.

Autonomy, strictly speaking, means self-rule. Patients have the right to make autonomous decisions and choices, and PAs should respect these decisions and choices.

Beneficence means that PAs should act in the patient’s best interest. In certain cases, respecting the patient’s autonomy and acting in their best interests may be difficult to balance.
Nonmaleficence means to do no harm, to impose no unnecessary or unacceptable burden upon the patient.

Justice means that patients in similar circumstances should receive similar care. Justice also applies to norms for the fair distribution of resources, risks, and costs.

PAs are expected to behave both legally and morally. They should know and understand the local, state and federal laws governing their practice. Likewise, they should understand the ethical responsibilities of being a healthcare professional. Legal requirements and ethical expectations will not always be in agreement. Generally speaking, the law describes minimum standards of acceptable behavior, and ethical principles delineate the highest moral standards of behavior.

When faced with an ethical dilemma, PAs may find the guidance they need in this document. If not, they may wish to seek guidance elsewhere – possibly from a hospital ethics committee, an ethicist, trusted colleagues, or other AAPA policies. PAs should seek legal counsel when they are concerned about the potential legal consequences of their decisions.

The following sections discuss ethical conduct of PAs in their professional interactions with patients, physicians, colleagues, other health professionals, and the public. The "Statement of Values" within this document defines the fundamental values that the PA profession strives to uphold. These values provide the foundation upon which the guidelines rest. The guidelines were written with the understanding that no document can encompass all actual and potential ethical responsibilities, and PAs should not regard them as comprehensive.

**Statement of Values of the PA Profession**

- PAs hold as their primary responsibility the health, safety, welfare, and dignity of all human beings.
- PAs uphold the tenets of patient autonomy, beneficence, nonmaleficence, and justice.
- PAs recognize and promote the value of diversity.
- PAs do not discriminate; PAs treat equally all persons who seek their care.
- PAs hold in confidence the patient-specific information shared in the course of practicing medicine.
- PAs actively seek to expand their knowledge and skills, keeping abreast of advances in medicine. PAs assess their personal capabilities and limitations, striving always to improve their practice of medicine.
- PAs work with other members of the healthcare team to provide compassionate and effective care of patients.
- PAs use their knowledge and experience to contribute to a healthy community and the improvement
of public health.

- PAs respect their professional relationship with all members of the healthcare team.
- PAs share and expand clinical and professional knowledge with PAs and PA students.

**The PA and Patient**

**PA Role and Responsibilities**

The principal value of the PA profession is to respect the health, safety, welfare, and dignity of all human beings. This concept is the foundation of the patient–PA relationship. PAs have an ethical obligation to see that each of their patients receives appropriate care. PAs should be sensitive to the beliefs and expectations of the patient. PAs should recognize that each patient is unique and has an ethical right to self-determination.

PAs are professionally and ethically committed to providing nondiscriminatory care to all patients. While PAs are not expected to ignore their own personal values, scientific or ethical standards, or the law, they should not allow their personal beliefs to restrict patient access to care. A PA has an ethical duty to offer each patient the full range of information on relevant options for their healthcare. If personal moral, religious, or ethical beliefs prevent a PA from offering the full range of treatments available or care the patient desires, the PA has an ethical duty to refer a patient to another qualified provider. That referral should not restrict a patient’s access to care. PAs are obligated to care for patients in emergency situations and to responsibly transfer patients if they cannot care for them.

PAs should always act in the best interests of their patients and as advocates when necessary. While respecting the law, PAs should actively resist policies that restrict free exchange of medical information whether the restrictions are coming from their institution, regulators or legislators. For example, PAs should inform patients of financial incentives to limit care, use resources in a fair and efficient way, and avoid arrangements or financial incentives that conflict with the patient’s best interests.

**The PA and Diversity**

The PA should respect the culture, values, beliefs, and expectations of the patient.

**Nondiscrimination of Patients and Families**

PAs should not discriminate against classes or categories of patients in the delivery of needed healthcare. Such classes and categories include gender, color, creed, race, religion, age, ethnic or national origin, political beliefs, nature of illness, disability, socioeconomic status, physical stature, body size, gender identity, marital status, or sexual orientation.

*See also section on Nondiscrimination in the Workplace and Classroom.*
**Initiation and Discontinuation of Care**

In the absence of a preexisting patient–PA relationship, the PA is under no ethical obligation to care for a person unless no other provider is available. A PA is morally bound to provide care in emergency situations and, when necessary, to arrange proper follow-up. PAs should keep in mind that contracts with health insurance plans might define a legal obligation to provide care to certain patients.

Care can be discontinued for many reasons, some positive (such as retirement or a new position) and some negative (such as threatening behavior by the patient or demonstrating non-compliance with recommended medical care).

A professional relationship with an established patient may be discontinued as long as proper procedures are followed. The patient should be provided with adequate notice, offer to transfer records, and arrange for continuity of care if the patient has an ongoing medical condition. In the event that discontinuation is the result of a problematic relationship, discontinuation should be undertaken only after a serious attempt has been made to clarify and understand the expectations and concerns of all involved parties.

If the patient decides to terminate the relationship, they are entitled to access appropriate information contained within their medical record.

Many regulatory boards have rules or position statements addressing termination of care. PAs should understand any regulatory requirements before taking action.

**Informed Consent**

PAs have a duty to protect and foster an individual patient’s free and informed choices. The doctrine of *informed* consent means that a PA provides adequate information that is comprehensible to a patient or patient surrogate who has medical decision-making capacity. At a minimum, this should include the nature of the medical condition, the objectives of the proposed treatment, treatment options, possible outcomes, and the risks involved. PAs are expected to be committed to the concept of shared decision making, which involves assisting patients in making decisions that account for medical, situational and personal factors.

*See also, AAPA policy paper, Use of Medical Interpreters for Patients with Limited English Proficiency.*

In caring for adolescents, the PA must understand all of the laws and regulations in the PA’s jurisdiction that are related to the ability of minors to consent to or refuse healthcare. Adolescents should be encouraged to involve their families in healthcare decision making. The PA is expected to understand consent laws pertaining to emancipated or mature minors.

*See also, the section on Confidentiality and AAPA’s policy paper, Attempts to Change a Minor’s Sexual Orientation, Gender Identity, or Gender Expression.*
When the person giving consent is a patient’s surrogate, a family member, or other legally authorized representative, the PA should take reasonable care to assure that the decisions made are consistent with the patient’s best interests and personal preferences, if known. If the PA believes the surrogate’s choices do not reflect the patient’s wishes or best interests, the PA should work to resolve the conflict. This may require the use of additional resources, such as an ethics committee.

Confidentiality

PAs should maintain confidentiality. By maintaining confidentiality, PAs respect patient privacy and help to prevent discrimination based on medical conditions. If patients are confident that their privacy is protected, they are more likely to seek medical care and more likely to discuss their problems candidly.

In cases of adolescent patients, family support is important but should be balanced with the patient’s need for confidentiality and the PA’s obligation to respect their emerging autonomy. Adolescents may not be of age to make independent decisions about their health, but providers should respect that they soon will be. To the extent they can, PAs should allow these emerging adults to participate as fully as possible in decisions about their care. It is important that PAs be familiar with and understand institutional policies and local, state and federal laws and regulations in their jurisdictions that relate to the confidentiality rights of adolescent patients.

See also, the section on Informed Consent.

Any communication about a patient conducted in a manner that violates confidentiality is unethical. Because written, electronic, and verbal information may be intercepted or overheard, the PA should always be aware of anyone who might be monitoring communication about a patient.

PAs should use and advocate for methods of storage and transmission of patient information that minimize the likelihood of data becoming available to unauthorized persons or organizations. Computerized record keeping and electronic data transmission present unique challenges that can make the maintenance of patient confidentiality difficult. PAs should advocate for policies and procedures that secure the confidentiality of patient information.

The Patient and the Medical Record

PAs have an obligation to keep information in the patient’s medical record confidential. Information should be released only with the written permission of the patient or the patient’s legally authorized representative. Specific exceptions to this general rule may exist (e.g., workers compensation, communicable disease, HIV, knife/gunshot wounds, abuse, substance abuse). It is important that a PA be familiar with and understand the institutional policies and local, state and federal laws and regulations that relate to the release of information. For example, stringent legal restrictions on release of genetic test results and mental health records often exist.
Both ethically and legally, a patient has certain rights to know the information contained in the patient’s medical record. While the chart is legally the property of the practice or the institution, the information in the chart is the property of the patient. Most states have laws that provide patients access to their medical records. The PA should know the laws and facilitate patient access to the information.

**Disclosure of Medical Errors**

A patient deserves complete and honest explanations of medical errors and adverse outcomes. The PA should disclose the error to the patient if such information is significant to the patient’s interests and well-being. Errors do not always constitute improper, negligent, or unethical behavior, but failure to disclose them may.

*See AAPA policy paper, Acknowledging and Apologizing for Adverse Outcomes.*

**Care of Family Members and Co-workers**

Treating oneself, co-workers, close friends, family members, or students whom the PA supervises or teaches is contextual (2)(3) and casuistic (extracting reason from case study). For example, it might be ethically acceptable to treat one’s own child for a case of otitis media, but it probably is not acceptable to treat one’s spouse for depression. PAs should be aware that their judgment might be less than objective in cases involving friends, family members, students, and colleagues and that providing “curbside” care might sway the individual from establishing an ongoing relationship with a provider. If it becomes necessary to treat a family member or close associate, a formal patient-provider relationship should be established, and the PA should consider transferring the patient’s care to another provider as soon as it is practical. If a close associate requests care, the PA may wish to assist by helping them find an appropriate provider.

There may be exceptions to this guideline, for example, when a PA runs an employee health center or works in occupational medicine. Even in those situations, the PA should be sure they do not provide informal treatment, but provide appropriate medical care in a formally established patient-provider relationship.

**Genetic Testing**

Evaluating the risk of disease and performing diagnostic genetic tests raise significant ethical concerns. PAs should be informed about the benefits and risks of genetic tests. Testing should be undertaken only after proper informed consent is obtained. If PAs order or conduct the tests or have access to the results as a consequence of patient care, they should assure that appropriate pre- and post-test counseling is provided.

PAs should be sure that patients understand the potential consequences of undergoing genetic tests – from impact on patients themselves, possible implications for other family members, and potential use of the information by insurance companies or others who might have access to the information.
Because of the potential for discrimination by insurers, employers, or others, PAs should be particularly aware of the need for confidentiality concerning genetic test results.

**Reproductive Decision Making**

Patients have a right to access the full range of reproductive healthcare services, including fertility treatments, contraception, sterilization, and abortion. PAs have an ethical obligation to provide balanced and unbiased clinical information about reproductive healthcare.

When the PA's personal values conflict with providing full disclosure or providing certain services such as sterilization or abortion, the PA need not become involved in that aspect of the patient's care. By referring the patient to a qualified provider who is willing to discuss and facilitate all treatment options, the PA fulfills their ethical obligation to ensure the patient’s access to all legal options.

**End of Life**

Among the ethical principles that are fundamental to providing compassionate care at the end of life, the most essential is recognizing that dying is a personal experience and part of the life cycle.

PAs should provide patients with the opportunity to plan for end of life care. Advance directives, living wills, durable power of attorney, and organ donation should be discussed during routine patient visits.

PAs should assure terminally-ill patients that their dignity is a priority and that relief of physical and mental suffering is paramount. PAs should exhibit non-judgmental attitudes and should assure their terminally-ill patients that they will not be abandoned. To the extent possible, patient or surrogate preferences should be honored, using the most appropriate measures consistent with their choices, including alternative and non-traditional treatments. PAs should explain palliative and hospice care and facilitate patient access to those services. End of life care should include assessment and management of psychological, social, and spiritual or religious needs.

While respecting patients’ and their family’s wishes for particular treatments when possible, PAs also must weigh their ethical responsibility to withhold futile treatments and to help patients understand such medical decisions. The same is true for evaluating a request to provide assistance in dying.

A PA should not make these decisions in a vacuum. Prior to taking action, the PA should review institutional policy and legal standards. A PA should also consider seeking guidance from the hospital ethics committee, an ethicist, trusted colleagues, a supervisor, or other AAPA policies.

*See also, AAPA policy paper, End-of-Life Decision Making.*

**The PA and Individual Professionalism**

**Conflict of Interest**

PAs should place service to patients before personal material gain and should avoid undue influence on their clinical judgment. Trust can be undermined by even the appearance of improper
influence. Examples of excessive or undue influence on clinical judgment can take several forms. These may include financial incentives, pharmaceutical or other industry gifts, and business arrangements involving referrals. PAs should disclose any actual or potential conflict of interest to their patients.

Acceptance of gifts, trips, hospitality, or other items is discouraged. Before accepting a gift or financial arrangement, PAs should consider the guidelines of the American College of Physicians, “What would the public or my patients think of this arrangement?” (4)

Professional Identity

PAs should not misrepresent directly or indirectly, their skills, training, professional credentials, or identity. PAs should uphold the dignity of the PA profession and accept its ethical values.

Competency

PAs should commit themselves to providing competent medical care and extend to each patient the full measure of their professional ability as dedicated, empathetic healthcare providers. Providing competent care includes seeking consultation with other providers and referring patients when a patient’s condition exceeds the PA’s education and experience, or when it is in the best interest of the patient. PAs should also strive to maintain and increase the quality of their healthcare knowledge, cultural sensitivity, and cultural competence through individual study, self-assessment and continuing education.

Sexual Relationships

It is unethical for PAs to become sexually involved with patients. It also may be unethical for PAs to become sexually involved with former patients or key third parties. The legal definition may vary by jurisdiction, but key third parties are generally individuals who have influence over the patient such as spouses or partners, parents, guardians, or surrogates. PAs should be aware of and understand institutional policies and local, state and federal laws and regulations regarding sexual relationships.

Sexual relationships generally are unethical because of the PA’s position of authority and the inherent imbalance of knowledge, expertise, and status. Issues such as dependence, trust, transference, and inequalities of power may lead to increased vulnerability on the part of the current or former patients or key third parties.

However, there are some contexts where a strict moratorium, particularly when extended to third parties, may not be feasible (3). In these cases, the PA should seek additional resources or guidance from a supervisor, a hospital ethics committee, an ethicist or trusted colleagues. PAs should seek legal counsel when they are concerned about the potential legal consequences of their decisions.

Nondiscrimination in the Workplace and Classroom

It is unethical for PAs to engage in or condone any form of discrimination. Discrimination is defined as any behavior, action, or policy that adversely affects an individual or group of individuals due to disparate treatment, disparate impact, or the creation of a hostile, inequitable or intimidating work or
learning environment. This includes, but is not limited to, discrimination based on sex, color, creed, race, religion, age, ethnic or national origin, political beliefs, nature of illness, disability, socioeconomic status, physical stature, body size, gender identity, marital status, or sexual orientation.

*See also, the sections on Nondiscrimination of Patients and Families, and Sexual Harassment*

**Sexual Harassment**

It is unethical for PAs to engage in or condone any form of sexual harassment. Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature when:

- Such conduct has the purpose or effect of interfering with an individual's work or academic performance or creating an intimidating, hostile or offensive work or academic environment, or
- Accepting or rejecting such conduct affects or may be perceived to affect professional decisions concerning an individual, or
- Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's training or professional position.

*See also, the section on Nondiscrimination in the Workplace and Classroom.*

**The PA and Other Professionals**

**Team Practice**

PAs should be committed to working collegially with other members of the healthcare team to assure integrated, well-managed, and effective care of patients. PAs should strive to maintain a spirit of cooperation with other healthcare professionals, their organizations, and the general public. The PA should consult with all appropriate team members whenever it will safeguard or advance the welfare of the patient. This includes seeking assistance in situations of conflict with a patient or another healthcare professional.

**Resolution of Conflict Between Providers**

While a PA’s first responsibility is the best interest of the patient, it is inevitable that providers will sometimes disagree when working as members of a healthcare team. When conflicts arise between providers in regard to patient care, it is important that patient autonomy and the patient’s trusted relationship with each member of the healthcare team are preserved. If providers disagree on the course of action, it is their responsibility to discuss the options openly and honestly with each other, and collaboratively with the patient.

It is unethical for a PA to circumvent the other members of the healthcare team or attempt to disparage or discredit other members of the team with the patient. In the event a PA has legitimate
concerns about a provider’s competency or intent, those concerns should be reported to the proper authorities.

PAs should be aware of and take advantage of available employer resources to mitigate and resolve conflicts between providers.

Illegal and Unethical Conduct

PAs should not participate in or conceal any activity that will bring discredit or dishonor to the PA profession. They should report illegal or unethical conduct by healthcare professionals to the appropriate authorities.

Impairment

PAs have an ethical responsibility to protect patients and the public by recognizing their own impairment and identifying and assisting impaired colleagues. “Impaired” means being unable to practice medicine with reasonable skill and safety because of physical or mental illness, loss of motor skills, or excessive use or abuse of drugs and alcohol.

PAs should be able to recognize impairment in any member of the healthcare team and should seek assistance from appropriate resources to encourage these individuals to obtain treatment.

See also, AAPA policy paper, PA Impairment.

Complementary, Alternative and Integrative Health

When a patient asks about complementary, alternative and/or integrative health approaches, the PA has an ethical obligation to gain a basic understanding of the therapy(ies) being considered or used and how the treatment will affect the patient. PAs should do appropriate research, including seeking advice from colleagues who have experience with the treatment or experts in the therapeutic field. If the PA believes the complementary, alternative or integrative health is not in the best interest of the patient, the PA should work diligently to dissuade the patient from using it, advise other treatment, and perhaps consider transferring the patient to another provider.

The PA and the Healthcare System

Workplace Actions

PAs may face difficult personal decisions to withhold medical services when workplace actions (e.g., strikes, sick-outs, slowdowns, etc.) occur. The potential harm to patients should be carefully weighed against the potential improvements to working conditions and, ultimately, patient care that could result. In general, PAs should individually and collectively work to find alternatives to such actions in addressing workplace concerns.
PAs as Educators

All PAs have a responsibility to share knowledge and information with patients, other health professionals, students, and the public. The ethical duty to teach includes effective communication with patients so that they will have the information necessary to participate in their healthcare and wellness.

See also, AAPA policy paper, PA Student Supervised Clinical Practice Experiences - Recommendations to Address Barriers.

PAs and Research

The most important ethical principle in research is honesty. This includes assuring subjects’ informed consent, following treatment protocols, and accurately reporting findings. Fraud and dishonesty in research must be reported to maintain the integrity of the available data in research.

PAs are encouraged to work within the oversight of institutional review boards and institutional animal care and use committees as a means to ensure that ethical standards are maintained.

PAs involved in research must be aware of potential conflicts of interest. Any conflict of interest must be disclosed. The patient’s welfare takes precedence over the proposed research project.

PAs are encouraged to undergo research ethics education that includes periodic refresher courses to be maintained throughout the course of their research activity. PAs must be educated on the protection of vulnerable research populations.

Sources of funding for the research must be included in the published reports.

The security of personal health data must be maintained to protect patient privacy.

Plagiarism is unethical. Incorporating the words of others, either verbatim or by paraphrasing, without appropriate attribution is unethical and may have legal consequences. When submitting a document for publication, any previous publication of any portion of the document must be fully disclosed.

PAs as Expert Witnesses

The PA expert witness should testify to what they believe to be the truth. The PA’s review of medical facts should be thorough, fair, and impartial.

The PA expert witness should be fairly compensated for time spent preparing, appearing, and testifying. The PA should not accept a contingency fee based on the outcome of a case in which testimony is given or derive personal, financial, or professional favor in addition to compensation.

See also, AAPA policy paper, Guidelines for the PA Serving as an Expert Witness.

The PA and Society

Lawfulness

PAs have the dual duty to respect the law and to work for positive change to laws that will enhance the health and well-being of the community.
Executions

PAs, as healthcare professionals, should not participate in executions because to do so would violate the ethical principle of beneficence.

See also, AAPA policy HX-10640.

Access to Care / Resource Allocation

PAs have a responsibility to use healthcare resources in an appropriate and efficient manner so that all patients have access to needed healthcare. Resource allocation should be based on societal needs and policies, not the circumstances of an individual patient–PA encounter. (1) PAs participating in policy decisions about resource allocation should consider medical need, cost-effectiveness, efficacy, and equitable distribution of benefits and burdens in society.

Community Well Being

PAs should work for the health, well-being, and the best interest of both the patient and the community. Sometimes there is a dynamic moral tension between the well-being of the community in general and the individual patient. Conflict between an individual patient’s best interest and the common good is not always easily resolved. When confronted with this situation, a PA may seek guidance from a supervisor, a hospital ethics committee, an ethicist, trusted colleagues, or other AAPA policies.

In general, PAs should be committed to upholding and enhancing community values, be aware of the needs of the community, and use the knowledge and experience acquired as professionals to contribute to an improved community.

Conclusion

AAPA recognizes its responsibility to aid the PA profession as it strives to provide high quality, accessible healthcare. PAs wrote these guidelines for themselves and other PAs. The ultimate goal is to honor patients and earn their trust while providing the best and most appropriate care possible. At the same time, PAs must understand their personal values and beliefs and recognize the ways in which those values and beliefs can impact the care they provide.

References

   https://geiselmed.dartmouth.edu/cfm/resources/ethics/full-book.pdf


6. AAPA Policy Papers:
   Guidelines for the PA Serving as an Expert Witness
   
   PA Impairment
   
   End-of-Life Decision Making
   
   Use of Medical Interpreters for Patients with Limited English Proficiency
   
   Acknowledging and Apologizing for Adverse Outcomes
   
   Health Disparities: Promoting the Equitable Treatment of All Patients
   *(Adopted 2011, amended 2016, reaffirmed 2021)* Cited at HP-8248
   
   PA Student Supervised Clinical Practice Experiences - Recommendations to Address Barriers
   
   Attempts to Change a Minor's Sexual Orientation, Gender Identity, or Gender Expression
   *(Adopted 2017, reaffirmed 2022)* Cited at HP-10440
Specialty Certification, Clinical Flexibility, and Adaptability
[Adopted 2017, amended 2022]

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 flexibility to adapt to the needs of the healthcare system is a unique attribute of the PA profession that creates value to the health system by allowing PAs to be deployed and redeployed within the healthcare system to address critical workforce shortages and increase patient access to care.

• AAPA recognizes that the flexibility and adaptability of the PA profession is closely associated with the broad generalist training that PAs receive, coupled with an orientation toward lifelong learning that allows them to adapt to many practice settings.

• AAPA recognizes that changes in PA practice have resulted in the majority of PAs practicing in specialty areas, creating desire among PAs to be recognized for their expertise, and for employers to distinguish more qualified from less qualified applicants.

• AAPA is opposed to the use of specialty certification as a criterion for the following: 1) entry into specialty practice, 2) licensure, 3) credentialing, 4) third-party reimbursement.

• AAPA recognizes that specialty certification may have a useful role in the career development and promotional path of a PA within a health system, but this must be carefully balanced against the potential barriers that it may represent to clinical flexibility and adaptability.

• AAPA endorses approaches to specialty training that emphasize formative development of the knowledge and competencies that a PA will need to practice in the specialty rather than a summative evaluation of knowledge.

• AAPA recommends consideration of a portfolio approach that incorporates external validation of relevant Entrustable Professional Activities (EPAs) or similar competency-based assessments as a more comprehensive and textured approach for evaluating the qualifications of a PA.

• Research should be conducted to determine if there is a link between specialty certification and improved quality of care, and whether or not any such improvement would offset the potential losses to the system of the flexibility and adaptability inherent in the current model.
**Background**

The PA profession was created in the late 1960s as a response to a shortage of primary care physicians and a need to extend the availability of medical services for patients beyond what physicians alone were able to provide. The initial idea was that physicians would be able to delegate many routine tasks to this new medical professional. The training pattern that emerged and was eventually formalized through accreditation of PA programs was a curriculum averaging 26 months that combined a didactic grounding in the basic sciences with a clinical apprenticeship model emphasizing general medical knowledge and its application in a primary care setting. (1) The profession was originally designed to be physician-dependent. Once in practice, PAs would form dyadic collaborative relationships with physicians, who would take moral and legal responsibility for the PA’s work and extend the PA’s scope of practice as the PA demonstrated competency related to specific tasks. (2) This model has changed over time. In particular, the role of PA-physician collaboration has been redefined in a way that has tended toward increasing levels of PA autonomy. Regardless, the PA model has produced a remarkably flexible medical professional who can be trained fairly quickly and readily available to address unmet needs of patients and the healthcare system in general.

The flexibility of the PA to function in multiple venues is an attribute that is highly prized among physicians, the healthcare system, and PAs. PAs regularly take advantage of this flexibility. An analysis of PA cohorts between 1969 and 2008 found that 49% of PAs had changed specialties at least once in their careers, 24% made specialty switches to another specialty class (i.e., primary care to a surgical specialty), and 11% reported practicing in at least three specialties during their career. (3) In surveys conducted by AAPA between 2015 and 2018, PAs report changing specialties at rates ranging from 5.5% to 6.5% each year. (4) The generalist training, coupled with a culture that emphasizes lifelong learning, has been seen as the keys to this adaptability and, as a result, specialty certification has been viewed by many members of the profession as a specific threat to flexibility and adaptability. AAPA has had policy opposing specialty certification since 2002. (5)

At its founding, the PA model rested on two assumptions. The first assumption was that most PAs would enter the primary care workforce, and the second was that physicians would be the primary employers of PAs. (1) Both of these assumptions are challenged by the realities of contemporary PA practice. Health systems have emerged as direct employers of PAs, altering the paradigm of the PA working with their supervising physician in a mentor role that was initially designed for the profession. (6) This has resulted in a fundamental change to the dyadic PA-physician model and the assumed apprenticeship-mentor relationship that was intended to regulate PA practice.

There has also been a longstanding trend of PAs moving away from primary care toward specialty practice. In 1974, 68.8% of PAs were in primary care practice. (1) According to 2020 NCCPA
data, 24.4% of certified PAs report practicing in primary care specialties (family medicine, general internal medicine, pediatrics) indicating that three (3) out of four (4) PAs are involved in specialty practice. (7) This has created an anomaly whereby a profession with a generalist training model and an assumed primary care trajectory is now dominated by specialty practice.

NCCPA introduced Certificates of Added Qualifications (CAQs) in 2011. (8) In 2016, NCCPA proposed a change to the recertification process whereby at the time of recertification PAs would choose a specialty exam relevant to their practice and, if an exceptional level of performance was achieved, examinees would be eligible to be awarded a CAQ, in addition to the renewal of the PA-C credential should they desire to pursue CAQ and were willing to meet the additional requirements. After a spirited debate, this proposal was withdrawn. NCCPA redesigned PANRE around what it had identified as “core knowledge” in an effort to ensure that it is focused on knowledge relevant to practicing PAs in all specialties. (9) Participation in the CAQ has shown modest growth but remains low.

Health systems have responded to the need to prepare PAs for specialty practice by developing postgraduate programs. From 2007-2014, ARC-PA offered voluntary accreditation for these programs. (8) The process was then held in abeyance, so only eight clinical postgraduate training programs received accreditation. ARC-PA accreditation of postgraduate programs resumed in January of 2020 with nine organizations achieving accreditation as of March of 2021. The number of non-accredited postgraduate programs has continued to grow. As of 2022, the Association of Postgraduate PA Programs lists 143 programs in 35 specialties. It is reasonable to assume that the number of programs that seek ARC-PA accreditation will also increase now that accreditation has resumed. Overall, postgraduate fellowship programs range from well-structured and accredited to those with more informal curricula that may be regarded as “onboarding” programs that train PAs for their roles within a specific health system. The capacity of these programs is low, with most capable of accommodating one to four trainees per cohort. A recent review concluded that if these postgraduate programs are to continue to exist, they should adhere to more consistent standards. (10)(11)

Given the current nature of PA practice, what is the role of specialty certification? How does the profession preserve the flexibility that has created so much value for the healthcare system and the patients they serve, while addressing the needs of health systems in assessing the competencies and experience of PAs? How does the profession accommodate the understandable desire of specialized PAs to be formally recognized for their expertise, or to gain a credential that would facilitate their promotion within an established healthcare system’s defined structure for career advancement?

To address these questions, AAPA’s Commission on Continuing Professional Development built upon work of a task force it had convened in 2017, reviewed new developments, updated data, and conducted surveys with stakeholders to understand current perspectives on specialty certification.
Stakeholder Input

A member of the 2017 task force conducted a review of literature related to PA specialty certification, PA roles and professional responsibility, PA workforce distribution among specialties, and factors influencing specialty choice. A summary of each relevant article was prepared for task force members, and the full text was made available to all members upon request. The literature about PA specialty certification is sparse, making it difficult to draw conclusions from existing scholarly research. For this reason, the commission utilized a series of surveys that were administered to various stakeholders in order to obtain information about PA specialty certification.

A survey was sent to six PA specialty organizations affiliated with AAPA that currently have a CAQ associated with their specialty and two additional organizations for which a new CAQ relevant to their specialty has been announced. Responses were received from seven organizations. PAs in Cardiothoracic and Vascular Surgery declined to participate stating that they were debating their position internally and planned to publish an official statement in the near future. To gain an employer perspective, a survey was sent to the PAs who participate in the PAs in Administration, Management, and Supervision (PAAMS) group in AAPA’s social networking site known as “Huddle.” 17 responses were received. Of these, six reported holding a director title, five held a “lead” title, one reported a title of “chief PA,” other titles included “supervisor” and “transition to practice manager” or simply “PA.” All but three respondents had titles indicating that they had responsibility for managing PAs and NPs.

Questions posed to the specialty organizations focused on whether or not the organization had a formal position related to specialty certification and, if so, what that position was.

Additional questions explored whether or not there were specialty certifications available to PAs, of which the task force may not have been aware. Additionally, they were asked when specialty certification might be important to ensuring patient safety, and under what circumstances consideration of specialty certification might not be appropriate. PAs involved in supervision and management were asked how specialty certification is used within their institutions for hiring and promotion.

Interprofessional Certifications Open to PAs

The seven specialties for which NCCPA offers a CAQ and the two specialties for which a CAQ has been announced but not yet available were determined to be the most relevant to this discussion (Table 1). However, the commission was able to identify many interprofessional certifications administered by other organizations that are open to PAs and other medical professionals. There are numerous life support certifications open to PAs that may not be related to a specific specialty, but may be required for a PA to function in a specific role, such as the “code team” in a medical facility. These non-NCCPA certifications are summarized in Table 2. For the purposes of this analysis, the task force
considered information from each of these certifications; however, there is currently no global definition for PA specialty certification.

<table>
<thead>
<tr>
<th>Specialty CAQs</th>
<th>Number Held*</th>
<th>Number of PAs in Specialty**</th>
<th>Estimated Percent of PAs in Specialty with CAQ ***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular and thoracic surgery</td>
<td>67</td>
<td>2,729</td>
<td>2.4</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>1,124</td>
<td>13,219</td>
<td>8.5</td>
</tr>
<tr>
<td>Hospital medicine</td>
<td>199</td>
<td>3,859</td>
<td>5.1</td>
</tr>
<tr>
<td>Nephrology</td>
<td>36</td>
<td>397</td>
<td></td>
</tr>
<tr>
<td>Orthopaedic surgery</td>
<td>258</td>
<td>11,597</td>
<td>2.2</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>78</td>
<td>2,000</td>
<td>3.9</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>588</td>
<td>1,887</td>
<td>31.2</td>
</tr>
<tr>
<td>Dermatology</td>
<td>N/A</td>
<td>4,350</td>
<td>N/A</td>
</tr>
<tr>
<td>Hospice &amp; Palliative</td>
<td>N/A</td>
<td>3,859</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*NCCPA as of November 2021 from a data set with a reported denominator of 148,560
** NCCPA 2021 Statistical Report with an overall denominator of 148,560
*** Calculated using different data sets so valid only as a rough estimate

Table 2: Interprofessional PA-eligible Specialty Certifications*

<table>
<thead>
<tr>
<th>Credential</th>
<th>Sponsor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Cardiac Life Support (ACLS)</td>
<td>Various</td>
</tr>
<tr>
<td>Advanced Trauma Life Support (ATLS)</td>
<td>Various</td>
</tr>
<tr>
<td>Pediatric Advanced Life Support (PALS)</td>
<td>Various</td>
</tr>
<tr>
<td>Approved Clinical Supervisor (ACS)</td>
<td>Center for Credentialing &amp; Education</td>
</tr>
<tr>
<td>Registered Diagnostic Medical Sonographer (RDMS)</td>
<td>American Registry for Medical Diagnostic Sonography</td>
</tr>
<tr>
<td>Board Certified Advanced Diabetes Management (BC-ADM)</td>
<td>American Association of Diabetes Educators</td>
</tr>
<tr>
<td>Certified Clinical Densitomterist (CCD)</td>
<td>International Society for Clinical Densitometry</td>
</tr>
<tr>
<td>Certified Diabetes Care and Education Specialist (CDCES)</td>
<td>Certification Board for Diabetes Care and Education</td>
</tr>
<tr>
<td>Certified Menopause Practitioner (NCMP)</td>
<td>North American Menopause Society</td>
</tr>
<tr>
<td>HIV Specialist™ (AAHIVS)</td>
<td>American Academy of HIV Medicine</td>
</tr>
<tr>
<td>Fellow of the American College of Critical Care Medicine (FCCM)</td>
<td>American College of Critical Care Medicine</td>
</tr>
<tr>
<td>Master of the American College of Critical Care Medicine (MCCM)</td>
<td>American College of Critical Care Medicine</td>
</tr>
<tr>
<td>Multiple Sclerosis Clinical Specialist (MSCS)</td>
<td>The Consortium of Multiple Sclerosis Centers</td>
</tr>
</tbody>
</table>
Results

Of the six specialty organizations responding to the questionnaire, two organizations had official positions endorsing the CAQ in their specialty. The Society of Emergency Medicine PAs and the Society of Dermatology PAs are the only AAPA-affiliated specialty organizations with a position endorsing the CAQ in their specialty. The Association of PAs in Psychiatry had previously indicated that they endorsed the CAQ. However, current leadership is unaware of a previous endorsement and feels that the topic merits periodic reassessment. When asked about using the credential as a marker for patient safety and quality, three organizations indicated they felt that this use of the CAQ was inappropriate, two felt it was appropriate and another organization was unsure. While there was a greater range of opinions than in 2017, responding organizations are generally opposed to specialty certification in situations where it is used as a criterion for the following:

- Licensure
- Credentialing
- Entry into specialty practice
- Third-party reimbursement

Those PA specialty organizations that saw a role for specialty certification indicated that added qualifications could allow PAs to identify a level of specialty knowledge beyond generalist training. Others commented that it might be helpful in defining core competencies for a specialty, and to enhance ability of PAs to compete for jobs with other providers such as NPs, who do have specialty training.

Based on the responses received from the PAAMS group, it appears that specialty certification is not routinely required when hiring a PA; however, it may facilitate promotion within a healthcare system.

Alternative Models

The Association of Rheumatology Health Professionals, which includes PA members, has worked with the American College of Rheumatology to produce a modular curriculum for PAs and NPs entering rheumatology practice. This program confers CME/CE credits and awards a certificate upon completion.

Discussion

Potential Advantages of Specialty Certification

Specialty certification has a number of potential advantages for PAs and other stakeholders within the healthcare system. First, it provides external validation of a PA’s expertise. Second, specialty
certification may be helpful to a PA who is seeking promotion within an established “clinical ladder” program in a health system. Often, these promotion structures have been established within a nursing structure that has long recognized the role of specialty certification as a means of promotion. Discouraging PAs from taking advantage of this pathway for promotion may disadvantage PAs who are seeking to advance into leadership positions. Third, holding a specialty certification may enable a PA to compete more effectively for jobs within a specialty by giving employers a criterion for distinguishing one applicant from another. Finally, specialty certification may provide patients with assurance that the PA providing care for them is qualified to do so.

Concerns about Specialty Certification

The main concern about specialty certification is that its adoption will limit both entry into specialty practice and movement among specialties. The CAQ model requires 2,000 to 4,000 hours of experience in the field, including procedures and patient care activities that are considered to be core to the field depending on the specialty, including procedures and patient care activities that are considered to be core to the field, in order to establish eligibility to take the exam. While this is generally compatible with the PA model where one is trained as a generalist and gains experience through work-related experience, if holding a specialty certification becomes an entry criterion, it will favor those already in the field while barring entry to other PAs. This could create shortages of PAs who are able to engage in the field if not enough PAs holding the certification are available, and increasing costs to the system through higher salary requirements.

If specialty certification were to become a mandatory requirement for entry into PA practice in a specialty, a likely consequence would be the establishment of formal training programs; this would further reduce flexibility and adaptability by restricting PA practice to areas where one is trained and certified. PAs could find themselves working within the same rigid structures as physicians and nurse practitioners. Not only would PAs lose the ability to move from specialty to specialty, but healthcare systems would lose the ability for PAs to be available in areas where there are workforce gaps. This could result in higher costs for the system and reduced access for patients.

When Might Specialty Certification be Appropriate?

The most compelling case for requiring specialty certification would be if a clear relationship between specialty certification and patient outcomes, including quality of care, could be demonstrated. Currently, there is a paucity of such evidence. This link has been difficult to demonstrate in physician literature. In a review of 33 findings by Sharp and colleagues, 16 demonstrated a positive relationship between certification status and desirable clinical outcomes. Fourteen showed no association, and an additional three showed a negative relationship, although the studies showing a negative relationship
suffered from insufficient case mix. (12) Research should be conducted to determine if any relationship between specialty certification and patient outcomes exists in the context of PA specialty practice.

While AAPA remains opposed to using specialty certification as a criterion for hiring in a specialty position, one specific circumstance where specialty certification might play a helpful role in PA practice is within the promotion structures of a health system. In this context, gaining specialty certification may allow a PA to meet a requirement to be promoted with the system’s defined “clinical ladder” program. This seems appropriate because its use is not to deny access to the “ladder,” but merely to meet a criterion for moving from one rung to a higher rung of the ladder.

**What Uses of Specialty Certification Would be Inappropriate?**

We conclude that any use of specialty certification is inappropriate if its use results in 1) reduced flexibility for PAs to move among care settings, 2) reduced ability of healthcare systems to address critical workforce needs, 3) higher costs to the system, and 4) reduced access to promotion for PAs without the credential who are otherwise deserving of promotion, 5) reduced access to care, unless this is balanced by compelling evidence that specialty certification results in higher quality care. Until this evidence is available, we oppose the consideration of specialty certification in the following situations:

- As a criterion for entry into specialty practice employment settings
- As a criterion for licensure
- As a criterion for credentialing
- As a criterion for reimbursement

**An Alternative Proposal**

A clinical “portfolio” approach that allows PAs to provide a more rounded portrait of their clinical experiences and competencies might meet the needs of stakeholders who are currently looking to specialty certification as a marker of competence. Portfolios have been used in the U.K. for trainees in the health professions and for periodic revalidation. (13)(14)(15)(16) They are in current use among U.S. medical students, residents, and fellows, and their potential for the PA profession is being explored. (17) Unlike current specialty certifications that document that an individual has passed a knowledge test, a portfolio such as AAPA’s “PA Portfolio” maintained by the PA with certain portions subject to external validation could allow a PA to display information related to formal and informal training, relevant CME, procedures performed with associated proficiency documentation, and relevant certificates or certifications to prospective employers, credentialing authorities, insurance companies, and other stakeholders. Of particular interest would be the ability to document assessed proficiency with Entrustable Professional Activities (EPAs) important within a field. (18) EPAs are comprised of activities that a medical professional can be trusted to perform without supervision after verification of competency. U.S. medical students, residents, and fellows use this model. Standardized lists of EPAs are being developed,
along with methods for assessing them. (19) This would allow stakeholders to make informed decisions about individual PAs based on a broad understanding of the PA’s professional standing and experience, rather than relying on a solitary marker such as specialty credentialing. Microcredentialling and digital badging are an emerging technology that allows the holder of the credential to share it in electronic formats in a way that allows an assessor to audit it back to the issuer and may enhance the credibility of formally assessed competencies communicated in an electronic portfolio.

**Conclusions**

The PA model adds value to the healthcare system by supplying a medical professional who can be educated and trained rapidly and deployed throughout the system to address unmet needs. This flexibility and adaptability should be fiercely protected in order to avoid losing this unique advantage. As the model of PA practice evolves, employers and other stakeholders are looking for ways to assess the qualifications and competencies of PAs. The profession should respond to these legitimate concerns in a way that demonstrates the expertise of PAs, but does not inhibit the flexibility of the profession.

Specialty certification could be problematic in that it may restrict the ability of PAs to move throughout the healthcare system as needs arise. Some of the concerns about specialty certification are already being realized, since employers in some areas are already using it as a criterion for hiring.

There may be an appropriate role for specialty certification in facilitating a PA’s advancement within a healthcare system’s promotion pathway or enhancing the ability of PAs to compete for jobs with other providers. However, this must be balanced against the ability of PAs to move within the healthcare system to meet gaps in patient care, thereby diminishing the value of the profession to the healthcare system and to patients. As the relationship between specialty certification and quality of care is unknown, research should be conducted to determine if such a relationship exists. In addition, further research on PA specialty certifications overall should be conducted. The profession should take steps to allow PAs to provide stakeholders with rich and nuanced information about a PA’s background and experience, rather than credentials that rely primarily on knowledge testing.

**References**


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Use of Medical Interpreters for Patients with Limited English Proficiency

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.

- PAs have an ethical and legal obligation to use appropriately trained medical interpreters for their patients with limited ability to speak or understand English.

PAs provide vitally important services to patients. The effectiveness of the care delivered by PAs depends heavily on the establishment of a PA-patient relationship based on empathy, confidence, trust, and the free flow of communication. The exchange of information can be difficult when the two parties involved speak different languages.

Language difficulties have been identified as one of the leading barriers to obtaining effective healthcare in the United States (1). The number of people in the United States with limited English proficiency (LEP) is increasing. The 2016 census data shows that 65.5 million individuals speak a language other than English at home (2).

Based on Title VI of the 1964 Civil Rights Act, which promises equal access to federally assisted programs and activities to everyone in the United States, the Office of Civil Rights (OCR) of the Department of Health and Human Services issued a policy guidance that affects PAs and other healthcare providers (3). The document clarifies a requirement that recipients of federal assistance provide translation services at no cost to people whose ability to read, speak, or understand English is limited. This means that healthcare providers who accept Medicare and Medicaid payment for their services to LEP patients should provide them with effective language assistance. The goal is to make sure that all patients receive quality medical care, even in circumstances where a healthcare professional and a patient speak different languages.

It is a challenge to determine how to overcome the communication barrier that could leave patients without adequate or appropriate medical attention. Because the diversity of healthcare providers does not match, either ethnically or geographically, the diversity of the patient population, the use of qualified medical interpreters is a critical part of the solution.

Competent medical interpretation requires a specialized set of skills that extends beyond the knowledge of two languages. The use of an interpreter who lacks the competency to accurately convey technical information can lead to misdiagnoses and inappropriate treatments (4). It also places healthcare providers at greatly increased legal risk. There are significant drawbacks to using a patient’s friends or family, especially children, as interpreters. These include the likelihood of inaccurate translations, omissions, additions, substitutions, volunteered answers, personal opinions, and other problems. The use
of untrained interpreters also increases the risk of breaching patient privacy and confidentiality requirements (5).

Trained, professional medical interpreters are held to high standards by codes of ethics to which they must adhere (6). This helps preserve the confidentiality of patient information. In addition, professional interpreters should be able to provide not only accurate translations, but also culturally and socially informed explanations.

The Office of Civil Rights requires healthcare providers with publicly-assisted LEP patients to have reasonable policies and procedures in place (3). This may include hiring bilingual staff who are trained and competent interpreters, hiring staff interpreters, contracting with an outside interpreter service, arranging for the services of voluntary community interpreters, and using a telephone language interpreter service. Patients may be referred to nearby facilities that have translators, but providers are obligated to follow up to make sure that appropriate care is given. Written materials that are routinely provided to patients, such as consent forms and medication instructions, must be translated. LEP patients must also be notified of their right to free language assistance. OCR says that friends, family, and minor children may be used as interpreters only after patients have been informed of their right to free translation services and have declined their use.

OCR requires that covered providers ensure that they are using competent interpreters. Interpreters may hold formal certification. Alternatively, they may prove their competence through demonstrated proficiency in both English and the other language, orientation and training that includes the skills and ethics of interpreting, fundamental knowledge in both languages of any specialized terms or concepts, sensitivity to the LEP patient’s culture, and the ability to convey information in both languages accurately.

The requirements of assuring interpreter competency and underwriting the cost of providing interpreter services are two stumbling blocks to full and effective implementation of the OCR guidance. Nevertheless, compliance is required by all covered providers. OCR investigates all complaints, reports, or other information that allege or indicate noncompliance with Title VI of the Civil Rights Act. OCR will provide technical assistance, consultation, and reasonable timetables in such cases, but failure to resolve the problem could result in exclusion from the Medicare or Medicaid program, referral to the Department of Justice for enforcement proceedings, or other actions.

*The Guidelines for Ethical Conduct for the PA Profession* are clear in their emphasis on PA-patient relationships; respect for dignity, confidentiality, and diversity; non-discrimination; informed consent; and other principles that come into play when treating LEP patients.
Summary

An increasing proportion of the population of the United States is not fluent in English. When it comes to providing healthcare, it is appropriate to use medical interpreters that are not only fluent in the language, but also culturally aware in order to provide the most accurate interpretation possible. This is important from an ethical standpoint, but also a medicolegal one, and mandated by federal regulations.

References


• Antimicrobial resistance is a complex and critical global public health issue.
• Acquired resistance to antimicrobials is compounded by overuse of these agents, inappropriate prescribing practices, broad agricultural use of antimicrobials, and a limited pipeline of new agents.
• PAs should be informed of resources and recommendations by the Centers for Disease Control and Prevention and the Infectious Diseases Society of America.
• PAs should optimize their prescribing practices, ensuring appropriate diagnostics are ordered, regimens are adjusted in a timely fashion in accordance with diagnostic results, the appropriate drug and dose are provided, and duration of therapy is commensurate with the characteristics of the infection being treated.
• PAs should stay current on antimicrobial resistance issues and provide counseling to patients and families on actions they can take to prevent infection, including discussion and setting expectations regarding when antimicrobials are appropriate to use and when they may not be.

Antimicrobial resistance (AMR) is a critical public health issue, affecting millions globally. The Centers for Disease Control and Prevention (CDC) cites that each year, at least 2.8 million people become infected with antibiotic-resistant bacteria, resulting in at least 35,000 deaths. (1) In addition to being a public health issue, AMR is an economic issue. The Infectious Diseases Society of America (IDSA) indicates the cost of treating resistant infections in the United States is between $21 and $34 billion annually. (2) The impact of AMR on the economic picture in the United States is extensive and includes billions of dollars in healthcare-related costs and lost wages due to inability to work. (3)

While many microorganisms naturally evolve over time as a result of interactions with their environment, thus becoming intrinsically resistant to antimicrobial compounds, there are several key drivers accelerating the process of acquired resistance or compounding this issue (4):

• Overuse of antimicrobials
• Inappropriate prescribing practices
• Broad agricultural use
• Limited pipeline of new antimicrobials
Overuse of Antimicrobials

Overuse has been a longstanding problem and was first anticipated by Sir Alexander Fleming in 1945. (5) Antimicrobial use in the United States is high, with some states averaging more than one treatment per person per year. (5) Additionally, in some countries, antibiotics are not regulated and are available to consumers over the counter which may also lead to overuse on the premise of availability and ease of access. (5) Studies have shown a direct relationship between antibiotic consumption and the development of resistant pathogens, thus underscoring the importance of judicious antimicrobial use. (5)

Inappropriate Prescribing Practices

When antibiotics are prescribed inappropriately, they are of questionable benefit to patients. Studies have shown the indication for treatment, selection of agent, and duration of therapy to be incorrect in up to half of cases. (5) Subinhibitory and subtherapeutic concentrations of antibiotics can lead to increased virulence and have been implicated in strain diversification, among other issues. (5) In addition, prescribing antibiotics for patients when they are not needed (e.g., viral upper respiratory tract infection, etc.) not only subjects patients to the side effects of the medication but the practice itself directly contributes to the development of antimicrobial resistance. (6)

Broad Agricultural Use

A major use of antibiotics in agriculture is through administration to animals with the intent to prevent infection and promote growth. (5) Resistant bacteria are subsequently passed along from animals to humans through the consumption of meat. (5) Additionally, the antibiotics consumed by the animals are eliminated through urine and feces which is then discharged into groundwater, surface runoff, and fertilizer. (5) In some areas, antibiotics are sprayed on trees and essentially function as pesticides in this setting. (5)

Limited Pipeline of New Antimicrobials

The availability of new antimicrobial agents is relatively limited, largely due to complexity in the life cycle of a drug, including the process of bringing the drug to market. Examples of issues in this space include, but are not limited to, lower profit margin of antimicrobials compared to drugs developed for chronic diseases, unpredictable timeline for the development of microbial resistance to the mechanism of action of the drugs, and tendency to hold newer antimicrobials as “last resort” kind of therapy in order to have an arsenal available for serious and resistant infections. (5) These factors potentially disincentivize pharmaceutical companies from research and development in antimicrobials due to uncertainty of the return on investment.

Recommendations
Combating or slowing the development of antimicrobial resistance is a global public health priority requiring collaboration of medicine, agriculture, and government entities worldwide. Actions PAs should take are listed throughout this paper.

Other efforts that will be essential to combating or slowing the development of antimicrobial resistance include developing improved diagnostic methods, encouraging actions that lead to research and development for new antimicrobials, improving tracking processes of antimicrobial resistance, and encouraging the judicious use of antimicrobials in agriculture. (5) In addition to the action steps PAs can take every day in their clinical practice, PAs can encourage government agencies and healthcare systems to consider these other actions in their approach to addressing antimicrobial resistance.

References

Support for Co-parent or Second Parent Adoptions Regardless of Gender

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

AAPA supports co-parent or second parent adoption regardless of a parent’s gender in order to protect the child’s right to legally empowered parents, thereby creating security and access to healthcare for the child.

AAPA opposes arbitrary gender-based legislative constraints to co-parent and second parent adoption.

AAPA believes that the following benefits result from co-parent or second parent adoption:
1. The child’s legal right of relationship with their parents regardless of gender is protected.
2. The second parent’s custody rights and responsibilities are also guaranteed if the legal parent were to die or become incapacitated, or the couple separates.
3. The requirement for child support for their parents is established in the event of the parents’ separation.
4. The child’s eligibility for health benefits from their parents.
5. The legal grounds are provided for each individual parent to provide consent for medical care and to make education, healthcare, and other important decisions on behalf of the child, and the basis for financial security for children is created in the event of the death of either parent by ensuring eligibility to all appropriate entitlements, such as social security survivors’ benefits.

The increasing diversity of the American family has challenged society to recognize new definitions of family. Included in that diversity are families in which children are parented by unmarried couples, or couples whose marital status is not afforded the same legal protection from state to state. (1) This changing demography of America has resulted in the visible emergence of non-traditional families and parenting structures. Despite these changes, the central core of the family has remained constant. Families are individuals who join together to meet each other’s basic needs and provide nurturing, security, and love regardless of gender. Families also exist to meet responsibilities, obligations and commitments to each other and the society in which they exist.

With increasing frequency, children are raised in families in which there is only one biological or adoptive legal parent. The second individual in a parental role is called the "co-parent" and/or "second parent." Under current laws, the security of a family may be in jeopardy if the legally recognized parent
should die, be declared incompetent, or if the couple separates. Children deserve to know that their relationships with their parents are stable and should be legally recognized. (2)

Like other professional medical associations, AAPA has endorsed the goals of the Healthy People 2010 project, which is “firmly dedicated to the principle that “regardless of age, gender, race or ethnicity, income, education, geographic location, disability, and sexual orientation—every person in every community across the nation deserves equal access to comprehensive, culturally competent, community-based healthcare systems…” (Healthy People 2010, 2000).

Providing all qualified adults with co-parent/second parent adoption rights promotes the health of children by giving them the legal benefits of legally empowered parents along with subsequent access to healthcare. co-parent and/or second parent adoption provides legal grounds for either parent to make decisions on behalf of the child, such as providing medical consent and ensuring the child’s eligibility to access the healthcare benefits of their parents.

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

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

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

Sources

3. http://pediatrics.aappublications.org/content/109/2/339.abstract?sid=a64c7e9b-4138-4a0a-be6a-089bfc494873
Licensure Eligibility for PAs Trained Abroad

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.

- PAs, whether citizens of the U.S. or other countries, who are trained in programs not in the United States, should be required to graduate from ARC-PA accredited entry-level programs and take the NCCPA examination to be eligible to practice.
- PA programs that have the interest and capacity to offer PAs trained abroad an opportunity for advanced standing should consider doing so.

PAs in the U.S.

Physicians around the world have sought and received help from many types of healthcare workers. Until recently, however, PAs have been a uniquely American phenomenon. Now, educational programs for PAs exist in several countries. Some of these programs have been independently developed; others have been assisted by American PA educators. The early graduates of these programs will be the pioneers who seek recognition and acceptance of PA practice in their own countries. However, it is likely that some graduates will immigrate to the United States, where they will qualify for visas as PAs under the Immigration and Nationality Act if their education is comparable to that obtained by their U.S. counterparts. (See Appendix 1 for background on immigration requirements.) It also appears possible that PA programs may be established outside the U.S. Borders, similar to off-shore medical schools, for the purpose of training American citizens as PAs.

Currently, state PA licensure laws contain two standard requirements related to education and examination. The education requirement is graduation from a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessors. The examination requirement is passage of the Physician Assistant National Certification Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA).

As things stand now, PAs trained abroad will not be able to meet either of these two state requirements for licensure. At this time, there are no ARC-PA accredited programs outside the United States. International accreditation is a very difficult and expensive proposition and the ARC-PA has no plans to extend the scope of its activities. Eligibility for the PANCE depends upon graduation from an ARC-PA accredited PA program.

Without changes to state laws, PAs trained abroad will be unable to qualify for licensure. Faced with this dilemma, these PAs and their advocates could put pressure on the NCCPA to change its eligibility criteria and on legislatures and state licensing boards to change laws and regulations.
To avoid the problems that could result from this situation, the PA profession must be prepared with recommendations for government policymakers. These recommendations should have as their goal, first and foremost, the protection of the public health and safety. However, they should also reflect the PA profession’s tradition of inclusiveness and its ethical principles of fairness and non-discrimination. Any policy proposed by AAPA should not seek to limit competition and should recognize the diversity of culture in the United States and the important role played by immigrants from all corners of the world in founding and shaping this nation. It should also recognize the workforce shortages in the U.S. and the need for additional healthcare providers.

Licensure Requirements for PAs Trained Abroad

AAPA believes that the following represents a framework for PAs trained abroad who wish to become licensed in the United States.

- A visa screening or credentialing organization, such as the Commission on Graduates of Foreign Nursing Schools or other recognized entity, should verify the PA education, PA licensure, experience, and English proficiency of non-U.S. citizen PAs trained abroad, as is currently required by federal law for international healthcare workers, entering the United States.
- PAs trained abroad should apply for acceptance at an ARC-PA accredited entry-level PA program. They should present evidence of their prior education and experience and request credit for coursework completed.
- Entry-level PA programs should consider applications from PAs trained abroad and offer advanced standing, if appropriate, to those who meet their admission criteria.
- The education for these individuals in U.S. PA programs is envisioned to include four components:
  - Credit for some of the coursework and/or rotations done in their own country and/or in the United States;
  - Didactic coursework in those areas for which they did not receive advanced standing;
  - Mandatory didactic coursework about physician-PA role and team practice and standards of care in the United States;
  - Clinical rotations.
- Only those programs with the interest and resources necessary to handle this complement of students should do so. Those that lack the faculty or clinical rotations or that would face state or institutional barriers would not have to offer this educational experience to PAs trained outside the United States.

In summary, non-U.S. citizen PAs trained abroad who wish to enter the U.S. for the purposes of working as PAs should have their education, experience, license, and English proficiency verified by
CGFNS or another approved visa screening organization. They would submit their certification with their visa applications. If granted visas, they would come to the U.S., where they would apply for admission to an accredited PA program. Programs that choose to accept these individuals, including American citizens who have obtained PA training abroad, can apply their own admission criteria and may consider granting advanced standing to the limits established by the program’s sponsoring institution. After admission and graduation from an accredited PA program, these individuals would be eligible to sit for the PANCE. Passage of the PANCE would make them eligible for state licensure.

This system is similar to the one that exists for physicians (see Appendix 2) in that it requires additional supervised education in the U.S. Completion of this education would be followed by a requirement to take the same NCCPA examination that is given to U.S. graduates prior to licensure.

The proposal described above does not necessarily require every PA trained abroad to repeat their entire education after arriving in this country. AAPA believes it is appropriate to evaluate separately each individual who has received PA education outside the U.S. and to give credit for coursework and/or rotations completed in their own country or in the U.S.

AAPA acknowledges that there are cultural and educational differences among the countries of the world, and that the knowledge needed to practice according to the standards of care of each country can vary substantially. That is why AAPA recommends that PAs trained abroad seeking licensure be required to have additional supervised clinical education at an accredited entry-level PA program and be taught more about the PA role as part of physician-led teams in the U.S. healthcare system.

AAPA hopes, with the adoption of this document, that other countries will adopt similar practice requirements for American PAs who wish to work abroad. While American PAs may have much to contribute, it is essential to respect cultural differences and values and to be knowledgeable about health system norms, allocation of resources, and treatment of conditions common to the population before working in another country.

Appendix 1. Immigration Procedures for Foreign Healthcare Workers

Immigration law requires that individuals wishing to enter the United States on either a temporary or permanent basis must apply to the U.S. State Department for a visa. There are two major categories of visas: non-immigrant and immigrant. Non-immigrant visas are given to individuals who wish to come to the U.S. on a temporary basis and for a specific purpose. There are approximately 60 different non-immigrant visa classifications, in areas such as business, education, pleasure, and temporary work. Immigrant visas are given to individuals who intend to live and work permanently in the U.S. These visas are either family- or employment-based.

The law specifies the documentation that must accompany visa applications. For example, individuals applying for H-1B visas (temporary work in a specialty occupation such as law or
engineering) must submit evidence regarding education or experience and qualifications. In some cases, a permanent or temporary state license to practice must be obtained prior to approval of the visa application.

There are specific provisions in the law regarding foreign physicians and nurses. In 1996, Congress amended the Immigration and Nationality Act to add, among other things, provisions related to other foreign healthcare workers. The 1996 amendments require all immigrants and non-immigrants coming to the U.S. as healthcare workers to be screened and certified by the Commission on Graduates of Foreign Nursing Schools (CGFNS) or an equivalent independent credentialing organization approved by the U.S. Attorney General. Healthcare workers are defined as physical and occupational therapists, medical technicians and clinical laboratory scientists, speech language pathologists and audiologists, and PAs.

The screening organization must verify that the alien’s education, training, license, and experience are comparable to those required for an American healthcare worker of the same type; that they are authentic, and, in the case of a license, unencumbered. The foreign healthcare worker must also have an appropriate level of proficiency in written and spoken English. If the majority of states licensing the profession in which the alien intends to work recognize a test that predicts an applicant’s success on the profession’s licensing or certification examination, then the alien must have passed that test.

Anyone who meets these criteria is given a certificate that becomes part of the foreign healthcare worker’s visa application.

**CGFNS**

Based on its capabilities and established track record, as well as the specific reference to the organization in the law, CGFNS has been authorized by the Department of Homeland Security (DHS) to review the qualifications of all the types of foreign healthcare workers mentioned above.

CGFNS uses committees composed of members of each particular profession to establish the standards against which they assess the comparability of foreign education. All the members of the CGFNS Physician Assistant Professional Standards Committee have expertise in PA education and accreditation and are familiar with the issues surrounding foreign medical graduates.

The PA Professional Standards Committee began its work in May 2001. Using the American accreditation standards for PA educational programs as a basis for its work, the group has developed a document that describes, in detail, the curriculum content that they consider essential, including education on the special relationship between physicians and PAs. The document is more specific than the ARC-PA accreditation standards, particularly in the areas of pharmacotherapeutics, clinical skills, and diagnostic testing and imaging as they are practiced in the United States. The committee is confident that the standards will prevent unqualified individuals from gaining visas as PAs.
Other Visa Screening Agencies

To gain recognition as a visa screening and certifying agency from the Department of Homeland Security, which now houses the agencies concerned with immigration issues, an organization must meet fairly stringent criteria. It must have the ability to evaluate credentials and English competency. It must maintain comprehensive and current information on foreign educational institutions, and it must have no conflict of interest regarding whether an alien receives a visa. The organization’s ability to conduct examinations outside the United States is also considered before it is recognized by DHS.

The Department of Homeland Security has recognized, in addition to CGFNS, the Foreign Credentialing Commission on Physical Therapy and the National Board on Certification of Occupational Therapists as screening agencies for PTs and OTs, respectively. DHS does not limit the number of organizations it will recognize to perform the visa screening function for any given healthcare profession, nor does it review the educational equivalency standard used by each organization.

Appendix 2 - Requirements for Graduates of Foreign Medical Schools

Graduates of foreign medical schools who apply for visas to enter the United States as members of the medical profession or to receive graduate medical education (GME) must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG).

ECFMG certification is necessary before foreign medical school graduates or foreign-trained physicians can enter an accredited residency program, take Step 3 of the U.S. Medical Licensing Examination (USMLE), or, in most states, obtain a license to practice medicine.

ECFMG certification is obtained by:

- passing Steps 1 and 2 of the USMLE. Step 1 has approximately 350 multiple-choice test items, divided into seven 60-minute blocks, focused on the understanding and application of basic science concepts. Step 2 includes test questions in clinical subjects and requires the development of a diagnosis and prognosis, as well as identification of disease mechanisms and treatments. It has approximately 400 multiple-choice questions divided into eight 60-minute blocks.
- passing the Test of English as a Foreign Language (TOEFL).
- successfully completing a day-long Clinical Skills Assessment that evaluates the ability to gather and interpret clinical patient data by obtaining a relevant medical history, performing a focused physical exam, and composing a written record of the patient encounter. Proficiency in spoken English and appropriate interpersonal skills are also evaluated by standardized patients at 11 testing stations.
- verifying completion of four credit years at a medical school listed in the International Medical Education Directory, maintained by the Foundation for Advancement of International Medical Education and Research, a non-profit foundation of ECFMG. (Some diplomas, such as those for
Licensed Medical Practitioner or Assistant Medical Practitioner, and some licenses, such as those for stomatology, ayurvedic or homeopathic medicine, are not acceptable.)

- ECFMG certification is necessary in order to take Step 3 of the USMLE, which has approximately 500 multiple-choice test items administered over two days. Step 3 content reflects a data-based model of generalist medical practice in the United States and includes computer-based case simulations.

To obtain a license to practice, graduates of foreign medical schools are required to pass the USMLE (all three steps within a certain time period). There is frequently a limit on the number of attempts allowed to pass each step. Applicants must also complete at least one year of graduate medical education in an accredited residency program. More than half the states require foreign medical school graduates to complete three years of GME. Licensure requirements for foreign medical school graduates are more stringent than for graduates of accredited U.S. medical schools.
Diversity and Inclusion in PA Education

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

- AAPA believes that the quality and accessibility of healthcare improves when PAs reflect the race, ethnicity and culture of the patient populations they serve.
- AAPA supports affirmative action programs and other diversity enhancement initiatives in PA education with the goal of increasing the diversity and cultural competence of PAs entering the profession.

Introduction
A more diverse healthcare force may improve both access to healthcare as well as the health status of minority populations. Research has shown that minority physicians are more likely to practice in medically underserved areas. Patients express strong preference for racial/ethnic concordance with their healthcare providers. (1) One study of the effect of race and gender on the physician-patient partnership showed that patients who saw physicians of their own race rated the decision-making style of the provider as more participatory and involved. (2) As members of the healthcare team, PAs who are ethnically and culturally diverse are equally important to improving access and quality of care.

Educational Benefits of Diversity
The educational benefit of diversity among students for both minority and majority students is well established. In a meta-analysis of diversity research, Smith et al concluded that diversity initiatives positively impact institutional satisfaction, involvement, and academic growth for both minority and majority students. Students who interact with other students from varied backgrounds show greater growth in critical thinking skills and tend to be more engaged in learning. Student surveys reveal that those students who are educated in diversified environments rate their own academic, social and interpersonal skills higher than those from homogeneous programs. These students who interact with peers from diverse backgrounds are more likely to engage in community service and demonstrate greater awareness and acceptance of people from other cultures. (3)

Similar results were found in a 2000 survey of medical students about the relevance of diversity among students in their medical education. (4) A telephone survey was conducted of 639 medical students enrolled in all four years of the Harvard and University of California San Francisco medical schools. A majority of students reported that diversity enhanced discussion and was more likely to foster serious discussions of alternative viewpoints. Understanding of medical conditions and treatments was also reported to be enhanced by diversity in the classroom. Concerns about the equity of the healthcare system,
access to medical care for the underserved, and concerns about cultural competence were also thought to be increased by interactions with diverse peers as well as faculty. The majority of students agreed with published reports of many investigators that the medical profession should represent the country’s racial and ethnic composition to a larger degree. (4)

A study published in 2019 looked at the effect of exposure to members of the LGBT community on medical students. The study found greater exposure with LGBT individuals during medical school was predictive regarding the amount of explicit and implicit bias expressed towards patients during residency. (5)

In January 2004, the Institute of Medicine released a report entitled In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce. The report reinforces the importance of increasing racial and ethnic diversity among health professionals. Greater diversity among healthcare professionals is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, better patient-provider communication, and better educational experiences for all students while in training. The report goes on to make recommendations to policy makers, accreditation agencies and health professions educators on strategies to increase the diversity of the healthcare workforce. (6)

Current demographics show that the PA profession is similar to other health professions and not concordant with the US population (see Table 1).

<table>
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<th>Table 1</th>
<th>Matriculant Data (7)</th>
<th>Practicing PAs (8)</th>
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</table>
AAPA believes that the quality and accessibility of healthcare improves when PAs reflect the race, ethnicity and culture of the patient populations they serve. This would require changes on the national, state and local levels. For example, the profession could expand research and outreach into urban communities with the sole goal of increasing diverse PA student recruitment.

To effect these changes on the national level, AAPA believes that the federal government should continue supporting efforts to diversify the healthcare workforce. This may be through a variety of funding methods such as (a) providing continued and adequate funding for the Title VII health professions programs, which fund the Primary Care Training Enhancement Grants, Health Careers Opportunity Programs and the Scholarships for Disadvantaged Students Program, (b) encouraging innovation at PA education programs by authorizing grants for research related to PA education, and (c) prioritizing grant applications for institutions providing post-baccalaureate opportunities to Hispanic Americans and increasing funding available for PA programs at Historically and Predominantly Black Institutions of Higher Education, among other provisions. Since patients are more likely to seek care from providers who look like them (11), access to care for underserved populations could be expanded by facilitating PA program development at Historically Black Colleges and Universities and other Minority Serving Institutions. PA students can be assisted by instituting borrowing parity with their peers in the health professions under the Federal Direct Stafford Loan Program. Many patients from rural and disadvantaged backgrounds seek care at federally qualified health centers, rural health clinics, and critical access hospitals. Establishing new or expanding existing clinical training sites at these facilities would address the clinical training site shortages, increase the number of clinical preceptors and provide experiences for students at federally qualified health centers, rural health clinics, and critical access hospitals and increase the number of graduates who work in these areas. (12)

**Affirmative Action**

The U.S. Supreme Court has long recognized the critical benefits of student diversity affirmed in research and practice; and has consistently held that diversity is a compelling interest. The U.S. Supreme Court affirms the educational benefits derived from having a diverse student body, Grutter V. Bollinger et al. (13) and Gratz et al. V. Bollinger Et Al. (14) Diverse learning environments allows PA students the ability to enhance their critical thinking and analytical skills. It prepares PA students to succeed in an increasingly diverse interconnected environment, break down stereotypes, reduce bias, and enable PA programs to fulfill their role in enhancing recruitment and retention opportunities to students of all backgrounds. (15)

The Civil Rights Act of 1964 prohibits discrimination based on race and gender. In 1978 in the Regents of the University of California v. Bakke case, a white medical school applicant claimed ‘reverse discrimination’ in the admissions policies of the UC Davis medical school. In that case the Supreme
Court upheld the use of race as “one of many factors” that could be considered in admissions decisions. (16) It did place limits in specific policies by ruling that ‘quotas’ could not be used. In the 1996 Hopwood v. Texas case, the Fifth Circuit barred racial preferences in admissions decisions in those states covered by the circuit. The US Supreme Court declined to hear the case. (17)

In 2003, two landmark affirmative action cases, were considered both involving the University of Michigan. In Gratz V. Bollinger, the court ruled that the point system used by the University to increase diversity in undergraduate admissions was unconstitutional. (14) In the 2003 Grutter V. Bollinger case, the Court in a 5 to 4 decision, upheld the University of Michigan Law School’s admissions policies used to increase diversity. (13) Justice O’Connor explained that race can be considered a “plus” factor in admissions if that factor is considered in the context of a “highly individualized, holistic review of each applicant’s file, giving serious consideration to all the ways an applicant might contribute to a diverse educational environment.” (13)

The 2013 Fisher V. University of Texas at Austin Case (Fisher 1) overturned the lower court ruling, which was in favor of the University admission policies, stating that they did not adequately use the standards laid down in the previous Bakke and Bollinger cases. (18) In 2016 the Fisher V. University of Texas at Austin Case (Fisher 2) subsequently upheld the University’s affirmative action admissions policies as constitutional. (19) Thus far the Supreme Court has upheld admissions policies designed to increase diversity as long as they are narrowly defined and do not involve quotas. The state legislatures have weighed in on these issues with ten states limiting the use of affirmative action-based admissions policies.

In 2018-2019, two cases challenging affirmative action-based admissions policies worked their way through the lower courts. The most high-profile case involved allegations that the affirmative action-based admissions policies at Harvard University discriminates against Asian Americans. The 2019 US Justice Department has sided with the plaintiff against Harvard. (20) A similar case involving University of North Carolina Chapel Hill is also in litigation.

In October 2019 there was a ruling in the Students for Fair Admissions (SFFA) vs. President and Fellows of Harvard College (Harvard Corporation). (21) In this case an anti-affirmative action group, Students for Fair Admissions, sued Harvard for discrimination on behalf of Asian American students. Judge Allison Burroughs of the US District Court in Massachusetts upheld Harvard’s admission policies and procedures finding that Harvard’s “race conscious admissions passes constitutional muster.” She noted that someday these policies would not be needed but “until we are race conscious, admissions programs that survive strict scrutiny will have an important place in society and help ensure that colleges and universities can offer a diverse atmosphere that fosters learning, improves scholarship, and encourages mutual respect and understanding.” She further pointed out that Harvard does not “have any
racial quotas” and “does not result in under-qualified students being admitted in the name of diversity”. This decision was supported by Harvard and many higher education groups. (21) SFFA state that they will appeal the decision to the Court of Appeals and to the U.S. Supreme Court if necessary.

The challenge remains for all institutions to determine the type of plan that will consider race in such a way as to achieve that critical mass but does not utilize a point or quota system. The controversy over and challenge to affirmative action is not likely to end with the Court’s rulings in these cases. Institutions of higher education, including medical schools and PA programs, are now faced with the challenge of promoting diversity through affirmative action programs that are within the legal standard set by the court.

**Affirmative Action in Medical Education**

Supporters of affirmative action in medical education believe that such programs are necessary to meet the social mandate to address the future healthcare needs of the increasingly multicultural population by training physicians who reflect the diversity of that population. Until medical school applications from all backgrounds emerge from the educational pipeline with comparable academic credentials, affirmative action programs are proposed as the solution to ensuring that an equally diverse population of providers enters the healthcare workforce. (22)

**Accreditation Standards related to Diversity and Inclusion**

In the 5th edition of the Accreditation Standards for the PA Profession, the Accreditation Review Commission on Education for the Physician Assistant, Inc. (ARC-PA) created a set of diversity and inclusion standards. The ARC-PA defined diversity as “differences within and between groups of people that contribute to variations in habits, practices, beliefs and/or values”. The inclusion of different people (including but not limited to gender and race/ethnicity, age, physical abilities, sexual orientation, socioeconomic status) in a group or organization. Diversity includes all the ways in which people differ, and it encompasses all the different characteristics that make one individual or group different from another. The ARC-PA’s chosen definition of inclusion is, “the active, intentional and ongoing engagement with diversity in ways that increase awareness, content knowledge, cognitive sophistication and empathic understanding of the complex ways individuals interact within systems and institutions. The act of creating involvement, environments and empowerment in which any individual or group can be and feel welcomed, respected, supported, and valued to fully participate.”

The standards related to diversity and inclusion as listed in the 5th Edition of the ARC-PA Accreditation Standards state:

A1.11 The sponsoring institution must demonstrate its commitment to student, faculty and staff diversity and inclusion by:

A) Supporting the program in defining its goal(s) for diversity and inclusion,
B) Supporting the program in implementing recruitment strategies,
C) Supporting the program in implementing retention strategies, and
D) Making available, resources which promote diversity and inclusion. (23)

**Diversity and Competence**

Professional competence has been defined as “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served.” (24) The therapeutic relationship and affective/moral dimensions of competence depend, in part, upon cultural rather than scientific competence. Cultural competence can be defined as a set of academic and personal skills that allow individuals to gain increased understanding and appreciation of cultural differences among groups. (24) Cultural competence is not achieved solely from reading textbooks or attending lectures. Recruitment and retention of diverse student populations allows individuals to educate each other about cultural differences in health beliefs and experience of illness, to confront prejudice and prior assumptions, and to experience dealing with racial conflict in a sensitive manner. PAs must strive to develop cultural competence as one aspect of professional competence.

**Summary**

AAPA believes that the quality and accessibility of healthcare improves when PAs reflect the race, ethnicity and culture of the patient populations they serve. Therefore, AAPA supports affirmative action programs and other diversity enhancement initiatives in PA education with the goal of increasing the diversity and cultural competence of PAs entering the profession.

**References**


17. Hopwood v. Texas, 78 F.3d 932 (5th Cir. 1996)


Global Epidemic HIV/AIDS

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

- AAPA supports proven, demonstrable, international efforts to curb the global HIV/AIDS epidemic through a coordinated effort.
- AAPA supports national and international prevention strategies that include screening programs, programs with particular focus on young adults, programs to prevent mother-to-child vertical transmission, programs focused on at-risk populations including SGM and racial/ethnic minorities, routine education on and provision of preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) following evidence-based medicine, and legislative efforts to promote women’s rights and sex workers’ rights.
- AAPA supports the destigmatization of HIV infection and structural change to eliminate disparities among minorities.
- AAPA supports the representation of women (cis- and transgender) at all local, state, federal, and international levels of HIV research, education, and planning; addressing sexual transmission, perinatal transmission, parenteral transmission, childcare, and family care issues as they relate to women at every level.
- AAPA supports the identification of intersectional identities (SGM, racial/ethnic minorities, mental health, and substance use) associated with HIV transmission to ensure all social determinants of health are addressed in order to optimize overall health, including programming and research.
- AAPA encourages routine opt-out-based HIV screening, free of stigma, to diagnose all people with HIV as early as possible.
- AAPA supports specially-trained HIV/AIDS medical providers to augment new and existing global prevention and treatment efforts and increase HIV workforce capacity through scholarships and student loan repayment.
- AAPA supports access to HIV services, including prevention and treatment of HIV, which is affirming and free of stigma for all people regardless of immigration status and inclusive of black, indigenous, and people of color.
- AAPA supports routine perinatal HIV testing and increased funding, research, and education for perinatal HIV prevention.
• AAPA believes that international, national, and community leaders should be strong and vocal advocates for HIV/AIDS education, prevention and treatment efforts that promote equality and that people living with HIV/AIDS should not experience discrimination or bias.

• AAPA supports the giving of unrestricted financial support to global HIV/AIDS efforts, including but not limited to, HIV services, care, housing, and research, without ideological or political influence on the distribution of funding.

• AAPA supports increasing awareness that individuals living with HIV who are virally suppressed on antiretroviral medication cannot sexually transmit HIV. Healthcare providers should be aware that “undetectable = untransmittable” while ensuring that the decision to initiate antiretrovirals is informed and autonomous.

• AAPA supports rapid and patient-centered initiation of effective ART directly after HIV diagnosis to achieve sustained viral suppression and minimize transmission.

• AAPA supports increasing access to patient-centered, evidence-based, prevention of new HIV transmissions, including PReP, PEP, and syringe services programs.

• AAPA supports surveillance, reporting, and response to HIV outbreaks.

Global Impact of HIV

Because of the pathogenesis and epidemiology of HIV infections, certain populations are at increased risk for contracting HIV including: sexual and gender minorities (SGM), men who have sex with men (MSM), persons who inject drugs (PWID) and healthcare workers. Multiple sexual partners and the presence of concomitant sexually transmitted infections facilitated HIV transmission. Similarly, needle/device sharing and/or high risk sexual activity leads to HIV exposure in PWID. (14) Although HIV infections worldwide occur predominately through heterosexual contact, SGM including MSM and PWID continue to represent significant epidemiological categories in the United States and internationally. (1)(2)

The US Department of Health and Human Services (HHS) 2019 plan targets geographic areas disproportionately affected by Human Immunodeficiency Virus (HIV), with a goal to reduce new HIV infections by 75% in 5 years and at least 90% in 10 years. Achieving success in this initiative will require an immediate, substantial, and persistent response. (3)(4) Screening, diagnostic and treatment efforts have raised awareness, detection and management of HIV/AIDS globally over the past decade. Yet, HIV/AIDS remains a global public health crisis. Sub-Saharan Africa remains the most severely impacted, with 1 in every 25 adults living with HIV (LWH), which accounts for more than two thirds of the people living with HIV (PLWH) worldwide (5). The disparity in disease burden of HIV is evident in the fact that 61% of HIV related deaths occurred in Sub-Saharan Africa. (6) Despite a general decline in the number of new
HIV infections globally, Eastern Europe, Central Asia, the Middle East, and Northern Africa continue to see increases in new HIV infections. (7) While many areas of the world are experiencing a decline in high risk behavior, the Joint United Nations Programme on HIV/AIDS (UNAIDS) reports some countries are seeing an increase in the number of sexual partners one has and a decrease in condom use. (7) In Latin America, North America and Europe, the number of new cases of HIV is most notable among MSM which is attributed to sexual risk, anatomic susceptibility, and high community prevalence. (1)

The epidemic is exceptionally difficult for women due to an imbalance of physical, financial, and/or cultural power. Thus, women in much of the world are less able to avoid contracting HIV infections due to these power imbalances. Intimate partner violence raises one’s risk of acquiring HIV as women with an abusive partner have difficulty negotiating condom use, if they can. (7) The morbidity and mortality among the female population due to HIV/AIDS is devastating to families and communities. Worldwide, women now account for more than half of all adults with HIV/AIDS. (2) Women are more likely to lose jobs, lose income, raise children, and face stigma and discrimination. In addition to managing their own illness, the burden of caring for others often falls to women. Young girls frequently leave school to care for sick parents or younger siblings. The HIV/AIDS epidemic affects the entire family and impacts children of mothers LWH in multiple dimensions (e.g., born to an HIV infected mother LWH, orphaned by a parent who died of HIV-related complications or left to care for a parent or family member). (2) Commercial sex workers (CSW) and transgender women (TGW) also experience increased risk of acquiring HIV, a myriad of socioeconomic consequences of infection and barriers to accessing medical care. (2)(8)

Racial and ethnic minorities have a disproportionate burden of HIV and an increased risk of progression to AIDS. Young people of color are at higher risk than their white counterparts. More than half of new HIV cases in the US occur among racial and ethnic minorities. (2)(8)

The distribution of available resources for prevention and treatment also reflects disparities. Antiretroviral therapy (ART) decreases HIV mortality by approximately 80%. Globally, the number of (PLWH) receiving ART has increased threefold since 2010. Although globally the number of PLWH receiving ART has increased to 23.3 million, people in low income countries represent a disproportionally low number of those who are receiving ART. This increase in PLWH on ART has been attributed to coordinated educational and therapeutic efforts in certain populations. For example, the World Health Organization (WHO) called for increased use of ART among pregnant women to reduce mother-to-child transmission. Through these programs, the number of women receiving ART during pregnancy increased from 44% globally in 2012 to 82% in 2018. Between 2010 and 2018, there was also a 41% reduction in mother to child transmission of HIV. Despite global efforts to increase the number of PLWH on ART,
some high-prevalence populations, including PWID and transgender individuals, may not be receiving treatment due to socioeconomic barriers to care and fear of or actual discrimination. (2)

The world’s poorest countries face disproportionate shortages of healthcare workers (HCW). International health leaders report the shortage of HCW as one of the largest constraints to ART programs and meeting people’s basic healthcare needs. As of 2013, the global workforce fell short of the number of HCW needed for essential health services by 17.3 million. (9) The solution will require a combination of leadership from within each country, financial support and donations of time and human resources. One proposed solution includes a medical service corps through which resource-rich countries would train medical providers and community health workers. (2)(9)(10)

**Healthcare Providers’ Responsibility**

With increased utilization of ARVs to reduce the burden and transmission of HIV, healthcare providers with prescriptive authority, including PAs, are in a unique and responsible position. HIV epidemiologic data and clinical research on PrEP fails to address sexual and gender diversity. The literature particularly lacks robust data on gender diverse individuals who were assigned female at birth and identify as male (including transgender men) and individuals who don’t identify exclusively with either a male or female gender (including gender non-binary, gender fluid, and two-spirit identities). Regardless of sexual or gender identity the following risk factors for sexual transmission of HIV should be considered in all patients: (11)

- Residing in areas of high HIV incidence (8)(12)(13)
- Not use barrier protection consistently (unwilling, unable, or have barriers to negotiating use with partners) (8)(12)(13)
- Recent diagnosis of a bacterial STI (8)(12)(13)(14)
- Engaging in anal intercourse (8)(12)(13)(15)
- Engaging in transactional sex (i.e., sex for money, drugs, or housing) (8)(12)(13)
- Having sexual partners who are at high risk for unsuppressed HIV (i.e., partners with social and institutional barriers to HIV testing and treatment) (8)(12)(13)
- Having more than one sexual partner (8)(12)(13)
- Individuals with partners with more than one sexual partner (8)(12)(13)

Stigma fuels the disproportionate effects of HIV on marginalized communities, including sexual, gender, racial, ethnic, and other minorities, especially those with intersecting socioeconomic status, mental health, and substance use concerns. Stigma drives barriers to utilize prevention, screening/testing, diagnosis, linkage to care, treatment, and maintenance in treatment. (8) Mental health disparities and substance use affect individuals’ ability to engage in HIV services, including both treatment and prevention. Intersecting minority status among SGMs, ethnic/racial minorities, substance use, and mental
health disparities must be concurrently addressed. HIV services can only be comprehensively addressed through destigmatization and structural change.

**PrEP**

Pre-exposure prophylaxis (PrEP) is essential to reducing the incidence of HIV infection. PrEP is indicated for individuals at ongoing risk of HIV acquisition among adults, adolescents >35kg. (13)(18) PrEP prescription is the responsibility of healthcare providers across specialties, including primary care providers and ID specialists. Healthcare providers, including primary care providers, must become as proficient with medical management of HIV PrEP as they are with other common diagnoses such as hypertension, hyperlipidemia, and diabetes. PrEP use is supported by the US Preventive Services Task Force (USPSTF), and CDC guidelines for prescribing and monitoring PrEP should be followed. Screening for HIV should be performed prior to PrEP initiation and no less than every 3 months while a patient uses PrEP. When PrEP is prescribed, clinicians should provide access to proven effective risk-reduction services. Patients should be encouraged and empowered to use PrEP in combination with other effective prevention methods as desired and appropriate for each individual patient. (8)(18)(12)(13)

The Food and Drug Administration (FDA) approved the first indication of an oral medication to reduce the risk of HIV infection in 2012. Years later, awareness, access, and uptake of HIV PrEP are inadequate. (13) Further, use disparities have emerged along racial and ethnic lines, geographic regions, and SGMs, widening the social determinant gap among people with new HIV infections. In the US, only 7% of the estimated 1.1 million people with indications were prescribed PrEP in 2016; (19) black and Hispanic people have the lowest rates of PrEP prescription, and only 27% of the PrEP prescriptions were in the southern states in 2016. (19) PrEP use depends on an individual’s ability to access and afford medication and PrEP related services such as regular medical visits and laboratory costs. The USPSTF Grade A recommendation or PrEP suggests implementation in clinical practice and routine coverage by payors (i.e., private and public medical insurance) in the US. (20) Further development of patient-centered options, including longer-acting injectable, implantable, and other alternate dosing strategies, will increase PrEP access.

For individuals not on PrEP who seek medical care within 72 hours after a possible exposure to infectious body fluids of a person known to be LWH, the US Department of HHS recommends considering non-occupational post-exposure prophylaxis (nPEP) to reduce transmission. (15) PEP should be initiated as soon as possible and providers and institutions should work to eliminate barriers to expeditious PEP initiation. Expert consultation is recommended but should not delay PEP initiation. PEP users should complete a 28-day course of medication and undergo regular laboratory testing, including HIV testing at the time of initiation and through at least six months of completion. (12)(20)
In instances where the HIV status of an individual is unknown, providers should use clinical judgment to determine whether the use of nPEP is warranted. Data supporting the efficacy of nPEP comes from several types of studies including animal models, perinatal clinical trials, studies of transmission following healthcare exposures and clinical observation. Implementing a randomized, controlled trial for nPEP is unlikely for ethical reasons. All persons who report receipt of 1 or more courses of nPEP should be provided risk education counseling and intervention services, including consideration of pre-exposure prophylaxis. (15)(18)

**Routine HIV Screening**

HIV screening has tremendous public health implications for PLWH and their sexual partners. PLWH who are unaware of their status are 3.5 times more likely to transmit HIV, and early initiation of ARVs for PLWH could reduce sexual transmission by 40%. (1)(21)(22) Early linkage to care is associated with HIV viral load suppression and improved long term health outcomes. (1)(21)(22) In addition to individuals with risk factors, all people, ages 13 to 64 (23) years in all clinical settings must be provided routine HIV screenings (antigen/antibody combination testing preferred), with annual or more frequent rescreening offered to gay/same-gender-loving, bisexual, and other MSM. (24)(25) Routine screening should be offered in an opt-out model (i.e., notifying the individual that the test will be performed, given the option to decline, and inferred assent unless the individual declines testing). Strong consideration should be given for more frequent HIV screening (for example, every 3 to 6 months) of people with ongoing risk. (1)(24) In 2017, HIV incidence rates were highest in the south, accounting for 51% of incident infections in the US in 2018. (1) Black Americans, who account for 13% of the US population, were disproportionately burdened with 43% of HIV diagnoses, despite a lower incidence of reported risk behaviors. Although HIV diagnoses among women have decreased in recent years, around 7,000 women are diagnosed with HIV in the US each year. One in nine women living with HIV are unaware of their status, and women of color continue to be disproportionately affected. In 2018, black women accounted for 58% of HIV infections but only 13% of the female population of the US. (1) Routine, opt-out screening for HIV is recommended for all pregnant individuals, consistent with the Centers for Disease Control (CDC) guidance. Although few perinatal transmissions occur in the us each year (39 children in 2017), the occurrence is associated with a lack of testing in the prenatal period and at the time of birth. (1)(8)

**Initiate Antiretrovirals (ARVs) Rapidly and Effectively to Achieve Sustained Viral Suppression**

HIV cannot be sexually transmitted from an individual who maintains an undetectable viral load – a concept known as treatment as prevention (TasP) or undetectable=untransmittable (U=U). The PARTNER and PARTNER2 trials evaluated serodiscordant couples where the partner LWH is virally suppressed on ART and the partner without HIV is not on ARV prevention (i.e., PEP or PrEP). The
PARTNER trial showed no genetically linked HIV transmission among 1,166 couples with >58,000 condomless sexual acts. The PARTNER2 study showed no genetically linked HIV transmission among 782 MSM couples engaging in >76,000 condomless acts. (26)(27)(28)

Although ARV initiation carries a significant public health benefit, ARV initiation should be patient-centered focused on the individual's health. Clinicians must empower people with the information they need to make an informed and autonomous decision to initiate ARV. Access to ARV includes regimens as determined by the individual and their provider, which should be covered by all payors (i.e., private and public medical insurance as well as local, state, national, and international programs) without barriers such as prior authorization. Maintenance of ART and ongoing care with a provider trained in HIV management is essential for the health and quality of life of PLWH.

Widespread implementation of test and treat models providing access to ART within 72 hours of HIV diagnosis would reduce the timeline to achieving viral suppression and minimize the window of potential transmission. New York City’s sexual health clinics have shown that immediate initiation of ART at the time of diagnosis resulted in high rates of linkage to care (84%) and rapid viral load suppression (87% among those with follow-up viral load testing). (29)

A shortage of treatment providers and resources prevent newly diagnosed persons from accessing care promptly, with some waiting months for an appointment with an HIV specialist. The US Health Resources and Services Administration (HRSA) could increase the capacity of the HIV workforce by designating funded jurisdictions as health professional shortage areas (HPSA), thereby allowing medical providers in programs funded by the Ryan White HIV/AIDS Program to qualify for scholarships and student loan repayment through the National Health Service Corps (NHSC). (4)

**Rapid Response to Potential HIV Outbreaks**

Identifying patterns of rapid spread of HIV which might otherwise go unrecognized allows for swift public health action. States with a substantially rural HIV burden are most vulnerable to an HIV outbreak and need focused attention to enhance epidemiologic investigations. New HIV diagnoses and associated laboratory results must be promptly reported to local and state health departments to curb public health emergencies. In areas where HIV and opioid epidemics intersect, modernizing legislation surrounding buprenorphine prescribing for medication-assisted treatment (MAT) and establishing needle/device exchange or syringe service programs would enrich long-term risk reduction opportunities. (4)

**Summary**

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

References

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**Resources**
3. Centers for Disease Control and Prevention (CDC) [https://www.cdc.gov/hiv/default.html](https://www.cdc.gov/hiv/default.html)
Scientific Integrity and Public Policy

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

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

Patient outcomes are potentially improved through the utilization of evidence-based medical practice. The delivery of high-quality health information to medical providers and patients is essential to improving health outcomes in all practice settings. As a result, public health policy should reflect the findings of the most up to date scientific evidence.

Many institutions and agencies collaborate to develop health policy. Policy-makers rely on committees, councils, task forces, and other groups to review information and provide ideas to assist them in formulating sound public policies. AAPA believes that all agencies and institutions should appoint aptly qualified individuals to serve on the various committees, councils and task force groups. Recruitment of personnel that reflects diversity and inclusion is commendable. Discrimination based on race, sex, gender, gender identity, religion or political preference is not recommended. Advisors and committee members are expected to disclose known or potential conflicts of interest. Those whose employer/interests have a financial stake in policy outcomes should not be in a position to directly affect those policy decisions. Further, AAPA believes that the public policy development process must be open, ongoing and transparent.

AAPA believes scientific research and discussion should be free from undue political, religious, financial, or other ideological influence. Research must be held to high standards of objectivity and accuracy; methods must be disclosed and results be reproducible. Peer review of the research is essential to the process. Peer reviewers must be chosen based upon their qualifications, with diversity of backgrounds and perspectives again being optimal. Valid scientific conclusions should not be dismissed for ideological reasons.
AAPA believes safeguards should be in place to ensure the integrity of the processes and the results of scientific research and public policy. Uncompromised commitment to the scientific process and balanced representation based on qualifications will ensure the best possible public policy. Allowing scientific and medical research to move forward and advance public health policy benefits us all.

**Resources**


Quality Incentive Programs  

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

- AAPA believes quality incentives can be a useful tool to improve patient care if the metrics adopted are clinically relevant, fully include PAs and are developed with the input of patients and healthcare professionals.
- AAPA supports patient-centered efforts, such as appropriately developed and implemented quality incentive programs, to improve health outcomes and reduce unnecessary and duplicative healthcare treatments and tests.
- AAPA believes that to be effective, incentive programs must rely on timely, accurate data that attributes medical services to the health professional who delivered the care.
- AAPA believes PAs are a vital part of improving healthcare outcomes and access to care. PAs should be an integral part of the process development and decision-making processes of incentive programs.

The concept of incentivizing behaviors is widely used in healthcare. Patients are incentivized to reduce the utilization of unnecessary high-cost medical treatment, be more responsible for their health status and increase the use of preventive services. Payers are incentivized to provide more coordinated care, monitor how satisfied patients are with the care received and focus on patient outcomes and quality. Incentives provided to health providers (health professionals and facilities) are the focus of this paper.

Many incentives used to modify the behavior of providers are financial in nature. Other components of incentive programs may seek to rate or compare one provider to another with the idea that patients and payers will select and utilize the highest-rated provider.

Incentives are often formalized under official programs that adjust the level of reimbursement dependent on a provider’s ability to meet metrics for a desired change or improvement. One method is the promise of monetary reward for a desired behavior or outcome, known as one-sided risk. Another method is the use of both monetary reward for meeting goals, as well as financial penalties for failure to meet such goals, commonly referred to as two-sided risk. Incentive programs frequently persuade providers to begin their participation using one-sided risk before elevating the stakes to a two-sided risk approach which offers both greater rewards and greater risk.
Metrics and goals may be established by comparing health professionals or hospitals/facilities to one another on the bases of quality, outcomes, price, patient satisfaction or other metrics established by public health authorities or payers.

To date, data regarding the effectiveness of various incentive programs in producing positive outcomes is incomplete, mixed, or not well understood. For this reason, a diverse array of programs has been and continues to be developed to improve incentives to optimally modify behavior.

**Examples of Provider Incentive Programs**

Incentives in healthcare are not new, but they are evolving. Below are some examples of current provider incentive programs.

**The Quality Payment Program (QPP)**

Established by the Medicare Access and CHIP Reauthorization Act, the QPP combines various prior Medicare quality and value programs (the PQRS, value-based modifier, meaningful use) into one. The QPP replaced disparate incentive concepts with one program that focuses on incentivizing value (both an increase in quality and a decrease in costs), as well as appropriate use of electronic health record technology and continued improvement. This program, which consists of two tracks, the Merit-based Incentive Payment System and Advanced Alternative Payment Models, uses both financial reward and risk. The QPP strives to achieve benefits for multiple stakeholders, including financial benefits for high-performing health professionals, increased results with no additional cost for Medicare, and better care received by patients.

**Care Models**

Much like states can be “laboratories of democracy,” new and innovative care models can be pilot reimbursement arrangements intended to test numerous incentive methods to see what works for potential future expansion or replication. Various payment models seek to provide increased flexibility to provide care in a more effective manner or seek to reduce redundant or inefficient services. Examples of care models include accountable care organizations and the use of bundled payments, both of which incentivize specified levels of quality in care at target costs. These care models have been promoted and tracked by the Center for Medicare and Medicaid Innovation.

**PAs and Incentive Programs**

Incentive models which seek to reduce cost while maintaining high-quality care will increasingly recognize the benefit of utilizing PAs due to the enhanced value PAs present (lower cost of employment versus the high level of productivity).

However, PAs have concerns regarding potential shortcomings in the implementation of incentive programs, as program design may cause exclusionary practices or disadvantage those PAs that do
participate. AAPA recommends the following steps to ensure optimal program design for PA participation:

- The role and function of PAs should be specifically considered in the design process of any incentive program.
- There must be no prohibition of the participation of PAs in incentive programs. Occasionally, physician-centric language is used in verbiage when detailing the guidelines of incentive programs. As PAs (and advanced practice registered nurses) are a significant component of the healthcare delivery workforce, it is essential that they be formally incorporated into incentive programs.
- Steps must be taken to address the detrimental effect of inaccurate and incomplete data. Incentive programs must rely on accurate, actionable data for incentives to be effective. Serious data accuracy problems occur with incentive programs that rely on inaccurate information such as requiring or allowing services delivered by PAs to be billed/reported as being provided by physicians with whom the PA works. Only with proper attribution can health professionals receive incentives reflective of the care they provide. In addition to the incentive program seeking to make accurate assessments, the results of incentive programs are frequently made public on an individual health professional level by identifying a professional’s volume and quality of care. These results are then used by patients to make care delivery decisions. Without accurate data, information would be incomplete for both the program and patients.

Incentives, both financial and non-financial, if properly designed and using accurate data, can be effective methods to meet health goals by motivating and encouraging certain types of behavior and activities by providers. AAPA supports incentive programs that 1) incorporate the PA perspective; 2) include PAs as full participants; 3) are clinically relevant and appropriate; 4) do not harm healthcare professionals’ relationships with patients; and 5) collects and utilizes data that allows patient care and incentives to be accurately attributed to the health professional who delivers the care.
Introduction

This document defines the specific knowledge, skills, and attitudes that physician associates (PAs) in all clinical specialties and settings in the United States should be able to demonstrate throughout their careers. This set of competencies is designed to serve as a roadmap for the individual PA, for teams of clinicians, for healthcare systems, and other organizations committed to promoting the development and maintenance of professional competencies among PAs. While some competencies are acquired during the PA education program, others are developed and mastered as PAs progress through their careers.

The PA professional competencies include seven competency domains that capture the breadth and complexity of modern PA practice. These are: (1) knowledge for practice, (2) interpersonal and communication skills, (3) person-centered care, (4) interprofessional collaboration, (5) professionalism and ethics, (6) practice-based learning and quality improvement, and (7) society and population health. The PA competencies reflect the well-documented need for medical practice to focus on surveillance, patient education, prevention, and population health. These revised competencies reflect the growing autonomy of PA decision-making within a team-based framework and the need for the additional skills in leadership and advocacy.

As PAs develop greater competency throughout their careers, they determine their level of understanding and confidence in addressing patients’ health needs, identify knowledge and skills that they need to develop, and then work to acquire further knowledge and skills in these areas.

This is a lifelong process that requires discipline, self-evaluation, and commitment to learning throughout a PA’s professional career.

Background

The PA competencies were originally developed in response to the growing demand for accountability and assessment in clinical practice and reflected similar efforts conducted by other healthcare professions. In 2005, a collaborative effort among four national PA organizations produced the first Competencies for the Physician Assistant Profession. These organizations are the National Commission on Certification of Physician Assistants, the Accreditation Review Commission on Education for the Physician Assistant, the American Academy of PAs, and the Physician Assistant Education Association (PAEA, formerly the Association of Physician Assistant Programs). The same four organizations updated and approved this document in 2012.
Methods

This version of the Competencies for the Physician Associate Profession was developed by the Cross-Org Competencies Review Task Force, which included two representatives from each of the four national PA organizations. The task force was charged with reviewing the professional competencies as part of a periodic five-year review process, as well as to “ensure alignment with the Core Competencies for New PA Graduates,” which were developed by the Physician Assistant Education Association in 2018 to provide a framework for accredited PA programs to standardize practice readiness for new graduates.

The Cross-Org Competencies Review Task Force began by developing the following set of guiding principles that underpinned this work:

1. PAs should pursue self- and professional development throughout their careers.
2. The competencies must be relevant to all PAs, regardless of specialty or patient care setting.
3. Professional competencies are ultimately about patient care.
4. The body of knowledge produced in the past should be respected, while recognizing the changing healthcare environment.
5. The good of the profession must always take precedence over self-interest.

The task force reviewed competency frameworks from several other health professions. The result is a single document that builds on the Core Competencies for New PA Graduates and extends through the lifespan of a PA’s career.

The competencies were drawn from three sources: the previous Competencies for the Physician Associate Profession, PAEA’s Core Competencies for New PA Graduates, and the Englander et al article Toward a Common Taxonomy of Competency Domains for the Health Professions and Competencies for Physicians which drew from the competencies of several health professions. (1) The task force elected not to reference the source of each competency since most of these competencies were foundational to the work of multiple health professions and are in the public domain. The task force acknowledges the work of the many groups that have gone before them in seeking to capture the essential competencies of health professions.

Competencies

1. Knowledge for Practice

Demonstrate knowledge about established and evolving biomedical and clinical sciences and the application of this knowledge to patient care. PAs should be able to:

1.1 Demonstrate investigative and critical thinking in clinical situations.
1.2 Access and interpret current and credible sources of medical information.
1.3 Apply principles of epidemiology to identify health problems, risk factors, treatment strategies, resources, and disease prevention/health promotion efforts for individuals and populations.
1.4 Discern among acute, chronic, and emergent disease states.
1.5 Apply principles of clinical sciences to diagnose disease and utilize therapeutic decision-making, clinical problem-solving, and other evidence-based practice skills.
1.6 Adhere to standards of care, and to relevant laws, policies, and regulations that govern the delivery of care in the United States.
1.7 Consider cost-effectiveness when allocating resources for individual patient or population-based care.
1.8 Work effectively and efficiently in various healthcare delivery settings and systems relevant to the PA’s clinical specialty.
1.9 Identify and address social determinants that affect access to care and deliver high quality care in a value-based system.
1.10 Participate in surveillance of community resources to determine if they are adequate to sustain and improve health.
1.11 Utilize technological advancements that decrease costs, improve quality, and increase access to healthcare.

2. Interpersonal and Communication Skills

Demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. PAs should be able to:

2.1 Establish meaningful therapeutic relationships with patients and families to
ensure that patients’ values and preferences are addressed and that needs and goals are met to deliver person-centered care.

2.2 Provide effective, equitable, understandable, respectful, quality, and culturally competent care that is responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

2.3 Communicate effectively to elicit and provide information.

2.4 Accurately and adequately document medical information for clinical, legal, quality, and financial purposes.

2.5 Demonstrate sensitivity, honesty, and compassion in all conversations, including challenging discussions about death, end of life, adverse events, bad news, disclosure of errors, and other sensitive topics.

2.6 Demonstrate emotional resilience, stability, adaptability, flexibility, and tolerance of ambiguity.

2.7 Understand emotions, behaviors, and responses of others, which allows for effective interpersonal interactions.

2.8 Recognize communication barriers and provide solutions.

3. **Person-centered Care**

Provide person-centered care that includes patient- and setting-specific assessment, evaluation, and management and healthcare that is evidence-based, supports patient safety, and advances health equity. PAs should be able to:

3.1 Gather accurate and essential information about patients through history-taking, physical examination, and diagnostic testing.

3.2 Elicit and acknowledge the story of the individual and apply the context of the individual’s life to their care, such as environmental and cultural influences.

3.3 Interpret data based on patient information and preferences, current scientific evidence, and clinical judgment to make informed decisions about diagnostic and therapeutic interventions.

3.4 Develop, implement, and monitor effectiveness of patient management plans.

3.5 Maintain proficiency to perform safely all medical, diagnostic, and surgical procedures considered essential for the practice specialty.

3.6 Counsel, educate, and empower patients and their families to participate in their care and enable shared decision-making.
3.7 Refer patients appropriately, ensure continuity of care throughout transitions between providers or settings, and follow up on patient progress and outcomes.

3.8 Provide healthcare services to patients, families, and communities to prevent health problems and to maintain health.

4. **Interprofessional Collaboration**
Demonstrate the ability to engage with a variety of other healthcare professionals in a manner that optimizes safe, effective, patient- and population-centered care. PAs should be able to:

4.1 Work effectively with other health professionals to provide collaborative, patient-centered care while maintaining a climate of mutual respect, dignity, diversity, ethical integrity, and trust.

4.2 Communicate effectively with colleagues and other professionals to establish and enhance interprofessional teams.

4.3 Engage the abilities of available health professionals and associated resources to complement the PA’s professional expertise and develop optimal strategies to enhance patient care.

4.4 Collaborate with other professionals to integrate clinical care and public health interventions.

4.5 Recognize when to refer patients to other disciplines to ensure that patients receive optimal care at the right time and appropriate level.

5. **Professionalism and Ethics**
Demonstrate a commitment to practicing medicine in ethically and legally appropriate ways and emphasizing professional maturity and accountability for delivering safe and quality care to patients and populations. PAs should be able to:

5.1 Adhere to standards of care in the role of the PA in the healthcare team.

5.2 Demonstrate compassion, integrity, and respect for others.

5.3 Demonstrate responsiveness to patient needs that supersede self-interest.

5.4 Show accountability to patients, society, and the PA profession.

5.5 Demonstrate cultural humility and responsiveness to a diverse patient populations, including diversity in sex, gender identity, sexual orientation, age, culture, race,
ethnicity, socioeconomic status, religion, and abilities.

5.6 Show commitment to ethical principles pertaining to provision or withholding of care, confidentiality, patient autonomy, informed consent, business practices, and compliance with relevant laws, policies, and regulations.

5.7 Demonstrate commitment to lifelong learning and education of students and other healthcare professionals.

5.8 Demonstrate commitment to personal wellness and self-care that supports the provision of quality patient care.

5.9 Exercise good judgment and fiscal responsibility when utilizing resources.

5.10 Demonstrate flexibility and professional civility when adapting to change.

5.11 Implement leadership practices and principles.

5.12 Demonstrate effective advocacy for the PA profession in the workplace and in policymaking processes.

6. Practice-based Learning and Quality Improvement

Demonstrate the ability to learn and implement quality improvement practices by engaging in critical analysis of one’s own practice experience, the medical literature, and other information resources for the purposes of self-evaluation, lifelong learning, and practice improvement. PAs should be able to:

6.1 Exhibit self-awareness to identify strengths, address deficiencies, and recognize limits in knowledge and expertise.

6.2 Identify, analyze, and adopt new knowledge, guidelines, standards, technologies, products, or services that have been demonstrated to improve outcomes.

6.3 Identify improvement goals and perform learning activities that address gaps in knowledge, skills, and attitudes.

6.4 Use practice performance data and metrics to identify areas for improvement.

6.5 Develop a professional and organizational capacity for ongoing quality improvement.

6.6 Analyze the use and allocation of resources to ensure the practice of cost-effective healthcare while maintaining quality of care.

6.7 Understand of how practice decisions impact the finances of their organizations, while keeping the patient’s needs foremost.

6.8 Advocate for administrative systems that capture the productivity and value of PA
practice.

7. **Society and Population Health**
Recognize and understand the influences of the ecosystem of person, family, population, environment, and policy on the health of patients and integrate knowledge of these determinants of health into patient care decisions. PAs should be able to:

7.1 Apply principles of social-behavioral sciences by assessing the impact of psychosocial and cultural influences on health, disease, care seeking, and compliance.

7.2 Recognize the influence of genetic, socioeconomic, environmental, and other determinants on the health of the individual and community.

7.3 Improve the health of patient populations

7.4 Demonstrate accountability, responsibility, and leadership for removing barriers to health.
Health Literacy: Broadening Definitions, Intensifying Partnerships and Identifying Resources

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 with patients
• participating in local community groups to provide social support and advocacy 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 mental well-being.

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 with patients
• participating in local community groups to provide social support and advocacy 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.
AAPA believes that individual and organizational participation in these steps has the potential to decrease and eliminate the negative health impact of inadequate communication 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 healthcare 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. healthcare 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:

- 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

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 Nutbeam (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. (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. (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 healthcare environment.

The Role of PAs in Health Literacy

AAPA created policy in 2010 that acknowledged the evolving view of health literacy, embracing more shared responsibility of the patient and the provider. HP-9660 reads:

> 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. (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)

A more partnered patient-provider approach to healthcare communication is emerging in national policy. This is underscored by Healthy People 2020 Health Communication and Health Information Technology objectives found in table 1. (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 healthcare 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 healthcare provider always asked them to describe how they will follow the instructions.
- **HC/HIT–1.3** Increase the proportion of persons who report their healthcare providers’ office always offered help in filling out a form.
- **HC/HIT–2** Increase the proportion of persons who report that their healthcare providers have satisfactory communication skills.
- **HC/HIT–2.1** Increase the proportion of persons who report that their healthcare provider always listened carefully to them.
- **HC/HIT–2.2** Increase the proportion of persons who report that their healthcare provider always explained things so they could understand them.
- **HC/HIT–2.3** Increase the proportion of persons who report that their healthcare provider always showed respect for what they had to say.
- **HC/HIT–2.4** Increase the proportion of persons who report that their healthcare provider always spent enough time with them.


#### 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.” (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. (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. (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.
  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 Senior Health - 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 http://nihseniorhealth.gov/toolkit/toolkit.html 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 problem of health literacy. This can be done by adopting expanded definitions of health literacy which include the individual and public health perspectives. As well as optimizing efforts to increase health knowledge,
self-efficacy, self-management behaviors and positive outcomes with patients. In addition, participating in local community groups to provide social support and advocacy leading to sustainable behavior changes conducive to better health. Lastly, by identifying and utilizing resources to increase opportunities for patient activation, access to care, and development of skills to increase physical and mental well-being.

References

The Role of In-Store or Retail-Based Convenient Care Clinics
(Adopted 2017, amended 2022)

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 proposes that retail clinics:

- Seek to establish referral systems for appropriate treatment if the patient’s condition is beyond the scope of services provided by the clinic; and
- Seek to establish formal connections with appropriate practices to provide continuity of care and encourage a medical home for patients.
- AAPA believes that these statements complement related AAPA policy HP-5624, which states:
  - “AAPA supports expanded healthcare access for all people. AAPA encourages innovation in healthcare delivery.”
  - “AAPA maintains that continuity of care is a high priority; therefore, communication between the episodic care provider and the primary provider should be maximized within the constraints of regulation, patient confidentiality and patient preference.”


Delivery of healthcare in America keeps changing. Consumer preferences affect all businesses and healthcare is no exception. Retail health clinics, particularly those store-based locations, are a response to demands for low cost, convenient services.

Located in supermarkets, pharmacies and high traffic retail outlets, these clinics typically provide medical services for a specific list of conditions. They are open for extended hours and are staffed primarily by PAs and nurse practitioners. Further, retail health clinics have played a significant role in the COVID-19 pandemic.

The first of these retail clinics opened in 2000. Today there are more than 3,300 such clinics in the US, Canada and Mexico with the majority of the industry located in the United States specifically. (1) Currently retail health clinics are present in 44 states and the District of Columbia and have provided more than 50 million patient visits. The first clinics were co-founded by a family physician as a way to make care more convenient. Shortly after, retail companies joined the ranks to start several of these chains. Only a handful of retail clinics are owned by physician groups or hospital systems. In July 2006, CVS Corporation acquired MinuteClinic, the first and largest operator of in-store clinics in the country. Walmart, Walgreens and Kroger are some of the other retailers operating in this space. Retailers like the clinics because they are another service to offer their customers, drawing them into the store where they
shop while waiting to be seen and where they can have their prescriptions filled. In addition, numerous companies partner with these clinics to ensure these clinic services available to their employees. In a newer model, some retailers partner with a local healthcare organization or hospital system to staff and run their in-store clinic.

Consumer acceptance of store-based health clinics is high. Prescriptions can be filled easily and quickly in the store. For the uninsured, who often can’t afford medical care, the low cost is a bonus. For the insured, the clinics are a convenience, a better option than waiting for an appointment or spending hours in the emergency department for a minor complaint.

Store-based health clinics use electronic medical records. Some systems permit patients to retrieve test results and establish a personal health record. The MinuteClinic electronic system makes patient records available at any of its clinics nationwide and enables the sharing of clinical data amongst healthcare organizations that use the same EMR. According to the available literature, most of the clinics transmit medical charts to the patient’s primary care provider or refer people to medical practices in the community that are accepting new patients. Scope of service at retail clinics is expanding. Many patients lack a medical home. Retail clinics can offer preventive care, wellness screening, acute visits, physicals, and many more services. Many point of care tests are available to assist in diagnosis and treatment.

Studies have shown retail clinics provide comparable, if not better care, than other medical settings for the same conditions. (1)(2) Those same studies reveal that clinics are able to provide this care at a reduced cost. One such study, published in the American Journal of Managed Care, compared the quality of care at retail clinics to that in ambulatory care facilities and emergency departments. This study concluded its findings “are consistent with previous studies that demonstrate quality of care is not compromised, and even appears superior, in retail clinics for specific acute condition. When taken together with evidence suggesting that retail clinics are more cost-effective and even cost saving to patients, these results underscore the promise of retail clinics in offering care of higher quality and lower cost at a time of primary care shortages.

The presence of in-store clinics offers some benefits to healthcare providers in the community by offering options for patients and ensuring continuity of care by communicating with the primary care provider or by assisting patients in identifying a primary care provider. Retail clinics also relieve the pressure to stay open in the evening or on weekends. They also may reduce some of the burden on hospital emergency departments.

The store-based health clinics provide employment opportunities for physicians, nurse practitioners and PAs. A review of the retail clinic websites reveals full and part-time job openings in many parts of country, with competitive salaries and benefits. Exposure to new patients in these settings
may increase public awareness of the PA profession. It is vital that state PA practice laws are not overly restrictive to prevent PA employment in these important centers.

Although in-store clinics increase access, they do not offer a perfect solution. Ideally all patients would have a medical home, but there are many areas in the country that due to provider shortages, patients don’t have access to a medical home. For patients without a medical home, retail clinics are on the front lines of providing preventive, wellness, acute, and chronic care. For patients with primary care providers, new EMR options and system integration, medical history is readily available and interchange of records allows for communication with PCPs.

AAPA supports expanded healthcare access for all people and encourages innovation in healthcare delivery. AAPA maintains that continuity of care is a high priority; therefore, communication between the retail-based providers and primary care providers should be maximized within the constraints of regulation, patient confidentiality and patient preference. The role of in-store or retail-based convenient care clinics has afforded many PAs the ability to provide medical care to patients who lack access to a primary care provider (PCP) or medical home. This method of delivering healthcare to the general population will continue to grow in its ability to offer an alternative method of accessing medical care provided by PAs and other healthcare providers. AAPA supports increasing opportunities for PAs in retail healthcare and works with its constituent organizations to remove barriers to retail clinic system employment of PAs. PAs can play a key role in leadership in retail clinic systems, and AAPA encourages expansion of leadership opportunities for PAs in retail healthcare.

References
False or Deceptive Healthcare Advertising  

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

• AAPA believes that providers, including PAs, should not use deceptive practices or
advertisements that do not represent benefits ordinarily obtained by patients. Clinicians should
not make claims regarding painless or miraculous cures; promote unproven or scientifically
unsound modalities not supported by evidence-based studies, nor make inflated statements about
their qualifications. In addition, they should not mislead patients about the scope of services
offered.

• AAPA also believes that ethical providers should make every effort to ensure that their patients
are exposed to accurate information so they can make informed choices about treatment.

False Advertising in Healthcare

False or deceptive advertising is an act of deliberately misleading people about products, services,
or companies in general by reporting false or misleading information or data in advertising or other
promotional materials. False advertising is a type of fraud and it is a crime. (1)

In an era when health providers have begun to market their services aggressively, deceptive
healthcare advertising poses significant risks to the public. Fraudulent claims may entice consumers to
undergo costly, ineffective, and even more importantly, dangerous medical procedures. (2)

In the United States, the Federal Trade Commission (FTC) is empowered and directed by law to
prevent unfair or deceptive acts or practices in or affecting commerce. The Federal Trade Commission
Act also prohibits the false advertisement of “food, drugs, devices, services, or cosmetics.” (3)

According to the FTC, advertisements should be accurate and not contain explicit false claims or
misrepresentations of material fact. They must not by implication create false or unjustified expectations,
and they must contain certain information if the absence of that information would make the ad
misleading. Finally, the claims in advertisements must be substantiated. (4)

Accurate information about healthcare choices is vital to consumers. Each year, consumers spend
hundreds of billions of dollars on healthcare products and services. Advertising plays an important role in
informing consumers about the availability, cost, and other features of these products and services. (3)

Role of Providers

A successful provider-patient relationship is based on trust. The patient trusts that the healthcare
provider has the appropriate training and skills, will listen to the patient’s complaints and symptoms, and
will advise the patient accurately and objectively about the alternative courses of treatment. It is essential to this relationship that the patient has confidence that the provider is honest and is not manipulating the information presented for any purpose. Because the patient is often in a relatively uninformed position, patients usually assume that the provider is telling them all they need to know and that what they are told is accurate.

For this reason, false and deceptive advertising by providers destroys the trust relationship between the provider and patient that is essential to quality medical care. Misrepresentation may harm patients by making them less likely to seek out treatments they need or vulnerable to accepting treatments that are not useful or necessary. (4)

**Conclusion**

AAPA believes that providers, including PAs, should not use deceptive practices or advertisements that do not represent benefits ordinarily obtained by patients. Clinicians should not make claims regarding painless or miraculous cures, promote unproven or scientifically unsound modalities not supported by evidence-based studies, nor make inflated statements about their qualifications. In addition, they should not mislead patients about the scope of services offered.

AAPA also believes that ethical providers should make every effort to ensure that their patients are exposed to accurate information so they can make informed choices about treatment.

**References**

Acknowledging and Apologizing for Adverse Outcomes

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

- AAPA believes that patients deserve complete and honest explanations of adverse outcomes and apologies for medical mistakes.
- AAPA also supports not only the current science around disclosure and apology during care delivery, but also encourages PAs to be active participants in local disclosure programs.
- AAPA commits to providing education to PAs and advancing the science of medical error disclosure.

Disclosing Errors

Improving healthcare quality and reducing preventable adverse events in care delivery continue to be a top priority for the United States healthcare system. Since the Institute of Medicine (IOM) published its 1999 report titled “To Err Is Human: Building a Safer Health System,” emphasis and effort in reducing preventable injury and improving care delivery have taken place. Further, the discipline of disclosure of medical error has seen significant advancement.

The IOM’s 1999 report reported that as many as 98,000 people die each year as a result of medical error (1). A 2016 study by researchers at Johns Hopkins Medicine published in BMJ expanded the number to 251,000 deaths per year, making medical errors the third leading cause of death in the U.S. behind cardiac disease and cancer (2). Adverse outcomes can occur in any healthcare setting, including inpatient, outpatient, home and long-term care (3). Further, preventable harm from care delivery impacts not only patients, but families, caregivers, staff and communities (3).

Healthcare organizations that establish a culture of quality and safety are more likely to proactively identify a crisis management plan. These plans include processes that enhance communication between and among all stakeholders (3). Thus, every healthcare organization should establish a plan to address adverse events. The response should be prioritized to include 1) the patient and family; 2) the frontline staff, and 3) the organizational response (i.e., initiate root cause analysis and crisis management team) (3).

The Patient and Family

The patient and family must be the priority of the healthcare organization and the provider before, during and after an adverse event (3). Disclosing medical errors respects patient autonomy and truth-
telling, is desired by patients, and has been endorsed by many ethicists and professional organizations (4). According to AAPA’s Guidelines for Ethical Conduct for the PA Profession, PAs should disclose errors to patients if such information is significant to the patient’s interests and well-being. As disclosure science in healthcare continues to develop, much of the data generated highlights the fundamental importance of openly admitting error (5). A number of studies suggest that both the public and healthcare professionals generally agree that medical errors causing harm should be disclosed to the patient, an apology rendered, and, in some cases, fair compensation be negotiated. This process has demonstrated a reduction in litigation costs and has been widely adopted by health systems both academic and federal (6).

**The Frontline Staff**

Healthcare staff can become the “second victims” of adverse events (3). This may occur secondary to blaming behaviors, damage to personal or professional reputation, and unresolved feelings of sorrow and loss (3). Organizations with an existing crisis management plan, a shared process of root cause analysis and culture of inclusion promote patient-centered quality and safety. (3)

**The Organizational Response**

The culture of safe and high-quality healthcare begins with the organizational leader, who proactively develops a crisis management plan and assumes shared responsibility when adverse events take place (3). Following an adverse event, it is critical for leaders to include all stakeholders in the root cause analysis (3). This process enhances communication, promotes healing and ensures learning takes place (3). Most importantly, leadership must ensure that the patient and family are clearly informed throughout the process of the investigation (3).

**Policy and Legislation**

To counter the perceived risk of increased liability, a majority of states have adopted apology laws that exempt all or some expressions of regret, sympathy, or compassion from being considered as admissions of liability in medical malpractice lawsuits (7)(8).

The Sorry Works! Coalition, an advocate for legislative, policy and cultural change believes that full disclosure addresses the root cause of the medical malpractice crisis better than any other approach currently under consideration (9). The coalition teaches healthcare, insurance, and legal professionals how to stay connected with patients and families after adverse medical events with a three-step process of empathy, review, and resolution (10).

While the coalition believes that legislative action or mandates are not necessary preconditions for implementation of a full disclosure program, they recognize that some prefer the security provided by legislation that reduces liability.
Conclusion

In the spirit of patient-centered care, AAPA believes that patients deserve complete and honest explanations of adverse outcomes and apologies for medical mistakes. AAPA also supports not only the current science around disclosure and apology during care delivery, but also encourages PAs to be active participants in local disclosure programs.

References

2. Makary MA, Daniel A. Medical Error-the Third Leading Cause of Death in the US. BMJ. 2016; 353:i2139
Routine Vaccination for Human Papillomavirus

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

• AAPA supports routine HPV vaccination for the prevention of HPV-related diseases, which include cancer.
• AAPA supports coverage of HPV vaccination by all insurers as well as public funding for HPV vaccination for underinsured or uninsured patients.
• AAPA encourages all PAs to discuss and recommend HPV vaccination for their patients in the appropriate populations.
• PAs should continue to discuss the importance of safer sex with all their patients and continue to advise routine screening for HPV associated cancers in accordance with accepted guidelines.

Human papillomavirus (HPV) is the most common sexually transmitted infection in the United States (U.S.). HPV is associated with oropharyngeal, anal, cervical, vaginal, vulvar, and penile cancers as well as condyloma, precancerous conditions of the cervix, and recurrent respiratory papillomatosis. Furthermore, appropriate condom usage does not completely confer protection from HPV-related disease as transmission can occur through contact with infected skin. An estimated 30,700 HPV-related cancers occur annually in the U.S., with approximately 62% of these cancers occurring in women and 38% of these cancers occurring in men. (1) HPV related illness results in significant cost to the healthcare system with an estimated $8 billion spent annually in the U.S. on the treatment and prevention of HPV-related disease. (2)

Vaccines against HPV have the potential to significantly reduce morbidity and mortality and have been available since 2006. The U.S. Office of Disease Prevention and Health Promotion Healthy People 2020 initiative (HP2020) has established a goal of achieving an 80% HPV vaccination rate for girls and boys. (3) In 2015, 49.8% of boys aged 13-17 years had received coverage with at least 1 dose of vaccine while only 28.1% had received all 3 doses. (4) Similarly, in 2015, only 62.8% of girls had received coverage with at least 1 dose of vaccine while only 41.9% had received all 3 doses. (4) While vaccination rates increased in 2015 compared to 2014, they remain well below the HP2020 target.

Vaccines that are approved by the Food and Drug Administration (FDA) should be administered to all individuals as per the recommendations of the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practice (ACIP). (5)
HPV immunization has proven to be highly effective in preventing cervical cancers and follow up studies show no waning of protection five years after immunization with statistical models predicting protection for more than 20 years. (6) Vaccination is most effective prior to the onset of any type of sexual activity and the immune response is optimal in the target age group.

Some parents and clinicians are uncomfortable broaching the subject of sexuality with patients in the target age group and as a result may be reluctant to discuss the need for vaccination. PAs can play a key role in initiating an objective, patient-centered discussion on the benefits of vaccination against HPV in the same manner they recommend all routine immunizations. Strong communication with patients and caregivers about the safety and benefits of HPV vaccination is directly associated with vaccine uptake. (7)(8) PAs are well-positioned to provide such education as practitioners of evidence-based medicine. Messages which focus on HPV vaccination as a means of cancer prevention may be more efficacious than messages which focus on prevention of a sexually transmitted infection.

**Recommendations**

- AAPA supports routine HPV vaccination for the prevention of HPV-related diseases, which include cancer.
- AAPA supports coverage of HPV vaccination by all insurers as well as public funding for HPV vaccination for underinsured and uninsured patients.
- AAPA encourages all PAs to discuss and recommend HPV vaccination for their patients in the appropriate populations.
- PAs should continue to discuss the importance of safer sex with all their patients and continue to advise routine screening for HPV associated cancers in accordance with accepted guidelines.

**Conclusion**

AAPA supports routine HPV vaccination for the prevention of HPV-related diseases, which include cancer. In addition, AAPA supports coverage of HPV vaccination by all insurers as well as public funding for HPV vaccination for underinsured and uninsured patients. Furthermore, AAPA encourages all PAs to discuss and recommend vaccination for their patients in the appropriate populations. PAs should continue to discuss the importance of safer sex with all their patients and continue to advise routine screening for HPV associated cancers in accordance with accepted guidelines.

**References**

1. Centers for Disease Control and Prevention. HPV and cancer.


Health Disparities: Promoting the Equitable Treatment of All Patients
(Adopted 2011, amended 2016, reaffirmed 2021)

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 to:
- 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 accommodation.
- Eliminate health disparities in all areas including but not limited to: race, ethnicity, sex, gender identity, sexual orientation, disability status or special healthcare needs.
- Increase PA awareness of health disparities.
- Create and promote health equity tools and resources for PAs.
- Utilize the U.S. Department of Health and Human Services “Healthy People” collaborative as a template for increased organizational efforts to support health surveillance systems that track outcomes.
- 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, 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, definitions have broadened to include gender, sexual orientation, 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 healthcare professionals, and patients’ behaviors. (1)

The National Plan for Action 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)

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)

One example of the recent expansion of the definition of disparities is the inclusion of lesbian, bisexual, gay and transgender populations in the overall examination of health 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 (LB), and health insurance than the adult heterosexual population. (4) Additionally, Healthy People 2020 included LGBT disparities in its overview for the first time. (5)

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, healthcare, housing, employment, stress and racism/discrimination. (5)

There is a growing body of research on 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. (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. (8) 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.” (9)

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 AAPA to increase provider awareness of bias and stereotyping, with the goal of promoting more equitable care of all patients. (11)(12)(13)(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 strive to:

1. Enhance and create organizational outreach and strategic partnerships aimed at decreasing and eliminating health disparities, including but limited to education, employment, housing, geographic location and public accommodation.

2. Eliminate health disparities in all areas including but not limited to: race, ethnicity, sex, gender identity, sexual orientation, disability status or special healthcare needs.

3. Increase PA awareness of health disparities.

4. Create and promote health equity tools and resources for PAs.

5. Utilize the U.S. Department of Health and Human Services “Healthy People” collaborative as a template for increased organizational efforts to support health surveillance systems that track outcomes.


These actions are consistent with AAPA’s values as explained in the strategic plan “We commit to the highest standards and seek to eliminate disparities and barriers to quality healthcare.” (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.

References


Proliferation and Dispersal of Anti-personnel Weapons
(Adopted 2012, reaffirmed 2017, 2022)

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

- AAPA believes in supporting national and international efforts to reach a permanent ban on the use and proliferation of landmines.
- AAPA advocates for expanded support by the United States for programs to clear landmines.
- AAPA advocates for continued support by the United States to provide long-term assistance to victims of landmines.
- PAs should understand the risk for injury and death (particularly among children) from other types of unexploded ordnance.
- AAPA supports programs currently aimed at clearance of landmines, and assistance to victims, and recognizes the contribution that our country has made to clear landmines and assist victims. The dangers from unexploded ordnance should not be overlooked as they pose a risk to healthcare workers and others providing care. Advocacy for a permanent international ban on other unexploded ordnance is necessary.

Introduction
Persistence of armed unexploded ordnance (UXO) such as landmines present a significant public health risk in many countries. (1) This is particularly tragic, since the healthcare infrastructure in post-war countries is typically ill equipped to manage acute devastating trauma or support amputees. In addition, the consequences of landmines extend beyond the borders of those countries. Health-care workers and nongovernmental organizations employees are at increased risk of injuries as they themselves provide assistance in areas of conflict.

Injuries Associated with Landmines and Unexploded Ordnance
In 2003, the Centers for Disease Control and Prevention (CDC) estimated that there were 60-70 million landmines scattered throughout the world. As many as 70 countries have retained munitions, and it estimated that 24,000 persons, mostly civilians, are killed or injured annually by landmines and other unexploded ordnance (UXO). (1)(2) Beside land mines, several other types of anti-personnel munitions can persist in an armed but undetonated state. These include grenades, mortar and artillery shells, expended rockets, and cluster munitions. Cluster munitions are compound bombs that contain hundreds of bomblets which are designed to remain active beyond the initial explosion, disperse and detonate secondarily. It is not uncommon for bomblets to remain undetonated and dangerous for years.
Data from limited published studies indicate that children account for approximately one half of injuries and deaths from all types of UXO. Adult males suffer the majority of civilian casualties from landmines, often when traveling or farming. Children under 18 years of age are more than two times more likely to be injured by other types of UXO, while playing or tending animals. (1)(2) Those who survive the initial trauma are left with disfiguring and disabling injuries, including blindness and amputations. The social, medical and rehabilitative infrastructure is not capable of assisting these individuals.

To its credit, the U.S. is the world’s biggest provider of financial and technical assistance to mine clearance programs and other programs that destroy conventional weapons around the world. (3)(4)(5) U.S. Humanitarian Mine Action Program (a federal interagency partnership) has invested more than $1.5 billion in mine clearance action in nearly 50 countries over the last three decades. (6) In 2009, the United States Department of State declared the western hemisphere, from the Arctic to the border of Columbia was free from unexploded ordnance, including landmines. (6)

The United States last used antipersonnel mines in 1991 (in Operation Desert Storm), has not exported them since 1992, and has not produced landmines since 1997. (3) However; it still retains 10.4 million of stockpiled antipersonnel mines for potential future use. (3)

It remains one of only 38 countries (including Cuba, Russia, and China) in the world that have not joined the Mine Ban Treaty (the Ottawa protocol), in force since 1999. (7) In addition, in 2008, the U.S. refused to join 80 counties in signing a 2008 treaty to ban cluster munitions and it continues to oppose such a ban, claiming these weapons are legitimate tactical defensive weapons. (8)

The impact of politics should not be understated. It is plausible that a divergence of opinions among federal departments exists, over the issue of security versus humanitarianism. In late 2009, the Obama administration undertook an extensive review of America’s policy related to use of landmines and other anti-personnel weapons, after initially reporting that it would maintain the policy established by the prior administration. In 2011, without yet concluding its review, the U. S. attended the eleventh meeting of states parties to the land mine treaty as an observer. (9)

**Conclusion**

AAPA supports all efforts leading to a permanent ban on the production, stockpiling, trade and use of indiscriminate antipersonnel weapons such as landmines and cluster munitions; and supports the United States government’s significant ongoing involvement in safely removing these weapons and in assisting victims of antipersonnel weapons.

**References**


**Executive Summary of Policy Contained in this Paper**

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

- AAPA opposes geographic restrictions and limitations on the provision of care by PAs in telemedicine.
- AAPA opposes the requirement of separate telemedicine licenses for PAs.
- AAPA encourages PAs to verify that their medical liability insurance policy covers telemedicine services, in particular, telemedicine services provided across state lines before the delivery of any telemedicine service and for medical liability insurers to use "base rate stratification" on outcome data instead of "perceived risk" to avoid unnecessarily high financial burdens on PAs wanting to provide patient care via telemedicine.
- AAPA supports payment parity for services rendered, whether in person or remote. Alternative payment models, such as value-based payments, may be further explored and utilized to potentiate the benefits of telemedicine services.
- AAPA supports the development of educational opportunities in the didactic coursework and clinical rotations for PA students related to the provision of telemedicine.
- AAPA is opposed to requirements for examination, certification, or mandatory CME requirements to provide telemedicine services.

**Introduction**

Telemedicine has become an essential component in the delivery of healthcare in the age of the COVID-19 pandemic. (1) PAs (physician associates) have become engaged in this area of care, indicating greater utilization of telemedicine technologies for the practice of medicine as well as other emerging models of healthcare. As this modality of care delivery expands and becomes increasingly integrated across the healthcare system, PAs must be included as providers in any and all legislation, laws, or regulations involving telemedicine.

The growth of telemedicine represents a significant opportunity for the advancement of the PA profession but also holds an important risk. PAs must be at the forefront of this rapidly growing area of practice. Further, it is paramount that AAPA be fully engaged in ensuring the ability of PAs to practice to the full scope of their education, training, experience, and competencies as legislation, regulations, and policies regarding telemedicine are considered at state and federal levels. If the practice of telemedicine fails to: 1) allow for the efficient utilization of PAs, or 2) recognize PA contributions to the healthcare
system, the profession will be at a distinct disadvantage as the healthcare system continues to evolve.

AAPA must provide continued guidance to PAs wishing to utilize telemedicine technologies in the practice of medicine. Other prominent healthcare organizations, such as the American Medical Association (2) and the Federation of State Medical Boards, (3) have put forward similar statements.

By incorporating telemedicine education in the didactic coursework as well as seeking telemedicine educational opportunities throughout the clinical year, students are prepared to practice in all healthcare settings.

**Telemedicine Definition**

Telemedicine is the practice of medicine, delivery of healthcare services and education, via information and communication technologies, to a patient who is not in the same physical location as the healthcare professional. Telemedicine eliminates or reduces traditional barriers to care such as access, time, and geography. Telemedicine is provided real-time through technologies such as synchronous secure video conferencing (real-time/live connection between patient and PA) or telephonic encounters where video is not available or unreliable. (4) Telemedicine is also performed in an asynchronous manner (patient data collection and PA review at different times) through the use of store-and-forward technology, remote patient monitoring (RPM), and mobile health (mHealth). (4) As technology and care delivery modalities are continually changing, this policy cannot address all of the technologies available in the practice of telemedicine. Similarly, this policy is not intended to address provider-to-provider consultations and interactions using telemedicine technologies.

**Licensure**

The goal of telemedicine is to increase patient access to healthcare services. PAs are licensed to practice medicine via telemedicine modalities in all settings, states, and the District of Columbia. (5) AAPA opposes geographic restrictions and limitations on the provision of care by PAs in telemedicine. AAPA also opposes the requirement of separate telemedicine licenses for PAs. PAs should be allowed to care for patients in any jurisdiction via telemedicine without regard to the PA's physical location in relation to the patient's location or to a collaborative physician where one is required. Further, clinical responses to disasters, such as those related to the COVID-19 virus, for example, have underscored the critical need for evolving approaches to licensure, inclusive of reciprocity provisions or license portability, to streamline deployment and flexibility of clinicians via remote means. Therefore, AAPA supports states collaborating to increase license portability. The establishment of interstate license portability (6) would allow a PA to hold a license to practice medicine in one state, which in turn facilitates licensure or privilege to practice in other states. Reciprocal licensure arrangements, license portability, and multistate compacts reduce barriers to healthcare services for all patients. (6) PAs are responsible for knowing the requirements governing the practice of telemedicine in the state where the
patient resides when providing care with telemedicine. Patients should have the ability to seek redress in their state against any healthcare licensee. For this reason, any licensure system must provide appropriate patient protection and access.

**Education**

Modern medical education of the PA student should include new or augmented curriculum on telemedicine. The American Telemedicine Association has developed specific guidelines (7) for educating physicians. Partnering with the American Telemedicine Association or using these guidelines are two options for developing comprehensive telemedicine education for PA students.

**Establishing a Provider-Patient Relationship**

A provider-patient relationship is fundamental to the delivery of quality healthcare services. A PA using telemedicine technologies when providing medical services must take appropriate steps to establish a provider-patient relationship. Establishing a provider-patient relationship, built on trust and communication, using telemedicine technologies presents unique challenges and demands a clinician develop their webside manner - notably different than the traditional concept of bedside manner. Effective communication while obtaining a medical history, developing a treatment plan, and describing risks, benefits, and the plan of care should increase patient trust in the provider when care is delivered via remote means. The PA will conduct all evaluations and history of the patient consistent with prevailing standards of care specific to the individual patient presentation. The PA is expected to recommend appropriate follow-up care and maintain complete and accurate health records. The provider-patient relationship may be formed via telemedicine according to the PA's professional judgment as appropriate to the patient presentation and applicable state laws. The use of telemedicine technologies, as well as the method for establishing the provider-patient relationship, should be left to the PA's professional judgment.

**Patient Disclosures and Consent to Treatment**

The general consent to treatment, applicable to similar services provided in-person, should include at minimum the following:

- Types of transmissions permitted using telemedicine technologies (e.g., prescription refills, appointment scheduling, patient education, etc.)
- Patient’s understanding that the PA determines if the condition being diagnosed or treated is appropriate for a telemedicine encounter
- Details on security measures, as well as potential risks to privacy, with the use of telemedicine technologies, provided to the patient
- Express patient consent for forwarding patient-identifiable information to third parties as appropriate

All telemedicine encounters, following general consent, must include identification and
verification of the patient, the PA, and the PA's credentials.

**Evaluation and Treatment of the Patient**

The delivery of telemedicine services follows evidence-based practice guidelines to ensure patient safety, quality of care, and positive health outcomes. Telemedicine services are consistent with the scope of practice laws and regulations of the state where the patient is located. Standard of care in telemedicine is the same as when care is rendered in person.

**Continuity of Care**

The provision of telemedicine services includes care coordination with the patient's medical home and/or existing treating provider(s). The telemedicine provider should make every effort to secure a medical home or primary provider when one does not exist. Patients should be able to seek follow-up care or information from the rendering provider. PAs practicing telemedicine must make medical records associated with telemedicine encounters available to the patient, and subject to the patient's consent, any identified care provider of the patient within a reasonable amount of time after the encounter.

Further, the provision of care via telemedicine may necessitate referral to services external to a PA’s practice setting. Practice in a telemedicine environment may impact a clinician's knowledge and familiarity with referral networks and affiliations local to the patient's geography. When utilizing telemedicine as a complement to care, such as in an integrated primary care setting, a PA may already be familiar with best practices regarding referral to services external to their care setting. However, in such settings where the PA may be less familiar, in particular settings such as direct-to-consumer (DTC) telemedicine, the same standards for referral should apply as those found in an urgent or emergency care. Organizations and clinicians are encouraged to define guidance regarding referral to external clinical services, including the extent to which they are involved in coordinating care on behalf of the patient. This guidance should clarify to both clinicians and patients the means to support appropriate continuity of care aligned to the organization's clinical scope, though is not intended to obligate an organization to ensure continuity is achieved on behalf of the patient.

**Referrals for Emergency Services**

In the normal course of telemedicine, referral to acute or emergency services may be necessary. A provider or provider system should establish protocols and/or recommendations for referral to such services. The PA is encouraged to communicate with the acute care or emergency room facility when possible for continuity of care and as dictated by their professional discretion. An emergency plan is required and must be provided by the PA to the patient when the care provided via telemedicine indicates a referral to an acute care facility or emergency room is necessary.

**Medical Records and Patient Confidentiality**

The patient record established during the provision of telemedicine services must be secure,
encrypted, complete, and accessible. Access to and maintenance of patient records must be consistent with all established state and federal laws and regulations governing patient healthcare records.

**Liability Coverage**

AAPA encourages PAs to verify that their medical liability insurance policy covers telemedicine services, in particular, telemedicine services provided across state lines before the delivery of any telemedicine service. AAPA encourages medical liability insurers to utilize "base rate stratification" on outcome data rather than "perceived risk" to avoid an unnecessarily high financial burden on PAs wanting to provide patient care via telemedicine.

**Reimbursement**

Payment for telemedicine services should be equitable and based on the service provided. AAPA supports payment parity for services rendered, whether in person or remote. Alternative payment models, such as value-based payments, may be further explored and utilized to potentiate the benefits of telemedicine services. (8)

**Continuing Medical Education**

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

**Conclusion**

The United States has entered a new era of healthcare delivery with a significant expansion in the use of telemedicine. Telemedicine utilization and implementation has grown exponentially over the past decades and will continue to further develop as a best practice in modern medicine. The value of telemedicine is a critical component in the nationwide COVID-19 virus response. Further, beyond response to healthcare emergencies and disasters, expanded use of telemedicine technologies has been shown to reduce healthcare expenses and increase access and timeliness of care for all patients, especially for medically underserved areas. (9) (10)

The current system of health professional licensure and practice regulations may limit patient access and choice surrounding the use of these critical and essential care technologies. Notably, these professional licensure and practice regulations may also restrict PA practice in this care space. Access to care is impeded when separate rules exist for telemedicine as compared to in-person care. State-by-state or provider-specific regulations prohibit patients from receiving care - whether routine or critical, often life-saving medical services. These legislative inconsistencies and restrictions yield variable outcomes in driving access, quality, and continuity of care.

Our profession must have a competitive and decisive practice strategy for the future of healthcare to include access to and delivery of healthcare services by PAs as well as ensuring telemedicine...
educational opportunities for PA students. AAPA encourages both the Physician Assistant Education Association (PAEA) and Accreditation Review Commission on Education for the Physician Assistant, Inc. (ARC-PA) to promote the training of PA students in the use of telemedicine utilizing a robust knowledge base curriculum with an emphasis on personable skill sets, known as "webside manner." (11) Doing so will add value to our core competencies of medical knowledge, patient care, and practice-based learning. Integrating telemedicine training and concepts into PA education will prepare PA students to deliver healthcare to all patients, especially the medically underserved across the United States (U.S.). Healthcare delivery is changing rapidly, and our current and future healthcare providers must have the clinical reasoning, technological knowledge, and capacity to utilize the modalities that telemedicine will require now and in the future.

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

The U.S. and our healthcare system-at-large face unique and significant challenges. The national COVID-19 virus response has underscored the challenges inherent to our healthcare delivery apparatus, as well as the opportunity for telemedicine to serve as a robust and meaningful tool in delivering patient care. (12) Before the COVID-19 virus, telehealth reimbursements were approximately $3 billion annually. Recent reports estimate as much as $250 billion, or 20% of the annual spend on outpatient care could shift to telemedicine over the long term. (13) AAPA recognizes the enormous potential of telemedicine services to help achieve the optimistic ideals of the healthcare triple or quadruple aim: better patient care experience, better outcomes, lower cost, and greater provider well-being. (9) (10) In furthering progress toward these ideals, AAPA believes PAs must play a critical role in this growth and evolution of telemedicine and associated care technologies. In the coming decade(s), care delivery via telemedicine modalities will become normalized and routine. Investing now as both practicing clinicians and in training our students and newest professionals will dictate our success in this field, and more broadly, as a profession in the healthcare space.
References


Tobacco Use Disorder
(Adopted 2016, amended 2021)

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 positions 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, prohibit advertising of nicotine products, and support third-party coverage for the treatment of nicotine addiction and the management of behavioral dependence associated with nicotine use.
- AAPA supports state utilization of tobacco settlement money for prevention and treatment of nicotine use. AAPA urges its constituent organizations to work with state governments and other healthcare 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 tobacco use disorder; (c) effective use of both nicotine cessation materials and evidence-based clinical practice guidelines by PAs, for the treatment of patients with tobacco use disorder.
- 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 or vaping products) 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 more than $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 “vaping products” 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 more than 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 2019 High School Youth Risk Behavior Study showed 32.7% of high school students reported current use of electronic vapor products which has increased from 24.1% in 2015 (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 is safe (8).
**Evolving Data**

1. The Journal of American Medicine notes the ongoing epidemic of acute lung injury from e-cig and vaping products “Since March 2019, there has been an ongoing epidemic of acute lung injury secondary to the use of e-cigarettes, with over 2600 cases and 60 deaths reported all over the United States.”

2. Irreversible lung damage and lung disease from e-cig chemicals

3. The American Lung Association warns against the use of all e-cigarettes. The Centers for Disease Control (CDC) and the U.S. Food and Drug Administration, along with state and local health departments, have been investigating multi-state reports of lung injury (referred to by CDC as Evali) associated with e-cigarette and vaping product use.

**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.

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 tobacco use disorder 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. 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. 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.
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References


7. Singh, T., Marynak, K., Arrazola, R.A., Cox, S., Rolle, I.V., & King, B. A. (2016). Vital signs: Exposure to electronic cigarette advertising among middle school and high school students—United States, 2014 MMWR Weekly, United States, 2014 January 8, 2016 / 64(52);1403 retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6452a3.htm?s_cid=mm6452a3_w


PA Student Supervised Clinical Practice Experiences – Recommendations to Address Barriers

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

- AAPA supports working with PAEA, ARC-PA and NCCPA to communicate the benefits of precepting students to PAs, patients, and employers.
- AAPA supports working with PA employers to expand the range of opportunities for PA students to gain clinical experience through SCPE.
- AAPA supports suggesting modifications to the ARC-PA Standards in order to ensure quality SCPE continue with increased emphasis on flexibility and innovation.
- AAPA supports collaborating with PAEA to develop an information toolkit for PA programs and preceptors to utilize concerning benefits and helpful tips for precepting.
- AAPA supports working with PAEA to increase awareness among PA educators of the additional limitation that pre-PA shadowing requirements may create for PA student placement in SCPE.
- AAPA supports the consideration of collaboration with external medical organizations to look at ways to support an interprofessional, collaborative clinical training model.

Introduction

‘SCPE,’ or Supervised Clinical Practice Experience, is the standardized term used to refer to ‘clinical rotations’ or ‘clerkships’. According to ARC-PA, SCPE are “supervised student encounters with patients that include comprehensive patient assessment and involvement in patient care decision making and which result in a detailed plan for patient management” (1). They allow students to acquire competencies and meet program standards needed for entry into clinical PA practice. They provide an essential component of PA program curriculum. PA students complete approximately 2,000 hours of SCPE in various settings and locations by graduation (2). SCPE include the previous terminology which refers to clinical rotations that occur after didactic education. They offer PA students the opportunity to learn patient care skills and to apply the knowledge and decision making developed during their didactic education in a variety of clinical practice environments.

PA programs, like allopathic and osteopathic medical schools and nurse practitioner (NP) programs, are faced with a shortage of preceptors and SCPE for their students. For several years, PAEA has addressed this issue by developing innovative clinical training opportunities and encouraging an atmosphere of collaboration rather than competition among PA programs. AAPA, along with PAEA,
ARC-PA, and NCCPA, is uniquely positioned to work with PAs, PA employers, and PA programs to help expand the availability of preceptors and SCPE for PA students.

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

Quality clinical education is a critical component of the PA educational curriculum. Many required SCPE are in primary care settings, including family practice, pediatrics, and women’s health. This is in line with the generalist nature of PA training and the historical foundation of the PA profession. Although the SCPE shortage is not a new challenge, only recently has the phenomenon been studied in a systematic manner. PAEA worked in collaboration with the Association of American Medical Colleges (AAMC), the American Association of Colleges of Osteopathic Medicine (AACOM), and the American Association of Colleges of Nursing (AACN), to produce the 2013 Joint Report of the Multi-Discipline Clerkship/Clinical Training Site Survey confirming what clinical coordinators and PA students already recognized.

The Joint Report suggests that securing SCPE, particularly in primary care settings, is a significant issue for most PA programs. The report included responses from 137 out of 163 PA programs surveyed. 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 (3). Research conducted by Herrick et al. and published in the November 2015 issue of JAAPA confirmed these findings (4). The Joint Report suggests that obstetrics/gynecology and pediatrics are two of the most difficult SCPE in which to find student placement (3). According to the NCCPA Statistical Profile of Certified PAs, less than two percent of PAs currently work in obstetrics/gynecology and three percent work in pediatrics and pediatric subspecialties (5).

As the PA profession continues to grow rapidly, with new programs developing and the number of PA students increasing, the demand for preceptors and SCPE will only continue to increase in the coming years. The continued growth of the profession depends on the growth of PA programs, and one of the essential rate-limiting factors in the growth of these programs is SCPE barriers.

The availability of preceptors and SCPE was first formally addressed by clinical coordinators at the 1998 Association of Physician Assistant Programs (APAP, now PAEA) Education Forum. Since that time, 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 (7). PAEA also works independently as the main source of research and data regarding the state of PA education. The continued efforts of the PAEA in identifying and addressing the preceptor shortage are 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.

Many have looked to ARC-PA to limit the number of accredited PA educational programs in order to solve the problem, as ARC-PA is the agency responsible for accrediting these programs. The ARC-PA mission includes defining the standards for PA education, evaluating PA educational programs to ensure compliance, and, thereby, protecting the public, including current and prospective PA students (8). However, ARC-PA must continue to accredit new programs that meet the eligibility criteria and accreditation standards, lest they violate restraint of trade laws. Still, the quality of PA education and PA practice is partially a result of the Standards, defined and evaluated for compliance by ARC-PA. The growing shortage of SCPE and preceptors during a period of rapid growth of the profession necessitates that ARC-PA maintain a close watch on quality and adapt the Standards in response to the changing environment. ARC-PA is a free-standing independent organization. However, when they do their open call for their review of the standards, they do take into consideration input from external stakeholders including organizations like AAPA, PAEA, and individually practicing PAs. It is incumbent upon AAPA and its members to carefully review the ARC-PA standards when they come up for review and to provide feedback and suggestions regarding expansion of programs and maintenance of adequate, qualified SCPE sites.

Each of the four national PA organizations (AAPA, PAEA, ARC-PA, and NCCPA) has collectively contributed to the growth of the profession and quality of healthcare that PAs provide each day. For this growth and practice quality to continue, these four organizations are encouraged to work together in an unprecedented manner to provide input and address the issue of clinical preceptor and SCPE shortage. The long-term solutions will require actions from each of these organizations, each acting within its already established mission and philosophy. Because the current model of clinical education is not sustainable and cannot support the projected demand for PAs in the coming decades, now is the time for action. In order to shape the future of the PA profession and American healthcare while supporting the continued supply of PAs throughout the 21st century, these organizations are encouraged to find common ground on which to collaborate.

**Barriers to Supervised Clinical Practice Experiences**

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 (4). Preceptors are likely to weigh the perceived rewards of practice-based teaching against the perceived costs and challenges in their decision whether to precept students and how to teach them. Reduced productivity and increased time pressures remain key negative impacts of teaching for some providers (4)(9). While many preceptors stress that
patient care responsibilities are 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).

Competition from a steady increase in the numbers of allopathic (MD), osteopathic (DO), offshore allopathic medical students, NP, and PA students over the past several decades without a corresponding increase in the number of preceptors and SCPE is a second barrier to SCPE. This interprofessional competition leaves existing SCPE overwhelmed with students causing interprofessional competition for such sites. According to the Association of American Medical Colleges (AAMC), there were 86,746 medical students enrolled in United States osteopathic and allopathic medical programs during the 2015-2016 school year (Association of American Medical Colleges, 2015). There has also been a steady increase in U.S. 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 (12). These figures do not include medical students at offshore allopathic medical schools (i.e., those in the Caribbean and other countries) who send many of their students to the U.S. to complete clinical training. There are two accrediting bodies for offshore medical schools, the Accreditation Commission on Colleges of Medicine (ACCM) and the Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP). These governing bodies currently accredit 15 medical schools with more than 15,000 students annually enrolled. Additionally, there were an estimated 17,000 new nurse practitioners (NPs) completing their academic programs in 2013-2014 (13).

PA programs have experienced exponential growth over the last few decades. Cohort sizes in PA programs range from approximately 15 to 100 students. Lack of availability and sufficient quality and quantity of SCPE is limiting the ability of some programs to increase their cohort sizes or even maintain their current cohort size. The consistent increase in students has the potential to further exacerbate the preceptor and SCPE shortage (6).

An often overlooked issue that may create an additional barrier to SCPE placement for PA students is the requirement of some PA programs that their pre-PA applicants obtain shadowing hours. Most of these programs require healthcare experience including "shadowing a physician or PA” to be an acceptable form of experience, and the number of hours required ranges from 50 to 1000, with 500 hours being the most common. Two programs specifically request 20 hours of shadowing as their only required form of healthcare experience prior to applying (15). The concern, then, is that these requests for shadowing experiences are in direct competition with PA student SCPE placement, and it is often less stressful for providers to simply have an individual shadowing them for a few days as opposed to having a student to precept which requires a great deal more supervision, clinical education, and paperwork.
Thus, while the concept of pre-PA shadowing may be valuable, it also has the potential to complicate an already challenging climate for current PA student placement.

Furthermore, there are legislative barriers to SCPE, particularly those between states. One example involves the emergence of State Authorization requirements since approximately 2010. Each state regulates education provided within their state, with most determining that provision of clinical education for students from training programs outside their state require “authorization”. These requirements vary widely, from simple paperwork in some states to lengthy procedures and thousands of dollars in others, resulting in many programs curtailing 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 SCPE from future Department of Education (DOE) regulations pertaining to state authorization (16). In spite of DOE setting aside national requirements for authorization, states considered clinical training across state lines as providing education in their state, requiring authorization. A solution for most states developed independently from the DOE. The National Council for State Authorization Reciprocity Agreements (NC-SARA) establishes reciprocity for educational requirements across state lines. States are members, and then each institution joins their state organization. So, PA programs that meet their state requirements and whose institutions are approved essentially meet requirements for state authorization in 47 states. Currently, three states (California, Florida, and Massachusetts) do not belong to NC-SARA, which means that clinical placements across state lines in those states may trigger an additional requirement for state authorization (17).

**AAPA-PAEA Joint Task Force Survey**

In 2016, AAPA’s Board of Directors (BOD) established a Joint Task Force (JTF) between AAPA and 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 availability and accessibility of sustainable clinical education models for PA students.” The AAPA-PAEA Joint Task Force (JTF) is made up of students, early career PAs, experienced PAs, PAs in hospital administration, and PA educators. The JTF held monthly meetings beginning in October 2016 to discuss barriers and possible solutions to shortages regarding SCPE. Additionally, they conducted an informal survey of external stakeholders to gather a wide range of input and ideas regarding the matter, the results of which are reviewed below. The JTF used this survey and direct inquiry to investigate current incentives for precepting students in a clinical setting, and they also reviewed publicly available policy from other PA organizations such as the Accreditation Review Commission on Education for the PA (ARC-PA) and National Commission on Certification of PAs (NCCPA). The JTF utilized the research and information gathered to revise and present this policy paper for consideration in the 2017 HOD.
The JTF conducted an informal survey on the topic of clinical preceptor and SCPE shortages, seeking the opinions of several key stakeholder groups on this important issue. The stakeholders were comprised of seven groups identified by the JTF to offer critical perspectives on the challenges of precepting, including PAs in administration of large health systems, PAs who have never precepted, students and early career PAs, PAEA members, former preceptors who have stopped precepting, long time preceptors, and those who provided opposition testimony to the Student Academy of AAPA (SAAAPA) position paper submitted in Resolution D-07 of the 2016 HOD. The survey included 63 respondents who were contacted specifically as individuals or as part of a larger cohort because they belonged to one of the key stakeholder groups. The respondents were asked about several different topics including whether precepting is a professional obligation, the top barriers to precepting PA students and how to minimize these barriers, the top incentives for precepting and how to make these a reality, and long-term and short-term solutions for ameliorating the SCPE shortage.

**Obligation to Precept**

Overwhelmingly, respondents felt that precepting PA students is an excellent way to contribute to the growth of the PA profession and to give back to the profession. However, many disagreed with the use of the word ‘obligation.’ Those that agreed commented that it was a meaningful way to pass on knowledge gained through years of practice to incoming PAs, as well as an excellent means to keep one’s medical knowledge current. Medicine is a profession of lifelong learning, and precepting students engages this critical function daily. These respondents indicated that students can bring a fresh attitude to the profession and remind preceptors of why they chose to become PAs.

Several individuals, however, argued that some PAs are not strong in teaching or are not motivated to teach, thus a precepting mandate would not necessarily ensure quality SCPE. Additionally, some students commented that they would rather learn from a preceptor who is genuinely engaged in teaching and possesses a desire to precept. Some indicated that PAs’ true professional obligation is to the care of their patients; if they perceive that precepting detracts from that, then they should not precept. Additionally, these respondents cited time constraints and difficulty honoring the high volume of precepting and shadowing requests as additional reasons that PAs should not be obligated to precept.

**Top Barriers to Precepting and How to Minimize These Barriers**

Among the questions posed to those surveyed was to list the top barriers to PAs precepting students. Several themes developed in their responses including:

- Lack of adequate time or space to precept,
- Loss of productivity and/or financial cost related to precepting a student,
- Unclear expectations of the specific requirements of precepting,
• Competition among PA programs, as well as DO, MD and NP programs for sites and preceptors,
• Lack of support or permission from one’s administration, and
• Inadequate communication between PA programs and preceptors.

While not all of these barriers present opportunities for straightforward solutions, some bring to light potential ways to improve the shortage of preceptors both now and in the future.

Respondents offered some suggestions for how to minimize each of these barriers. As to time and space, they recommended sharing students among providers, not requiring students to see every patient an individual preceptor treats, having students perform necessary chart and results review, and utilization of scribes by the provider if available. Although peer-reviewed research is limited, utilization of trained medical scribes has shown the potential to decrease the amount of time spent on required patient documentation, therefore potentially enabling the practitioner to focus more on the SCPE educational process (18). In support of the concept of student sharing among providers, The Liaison Committee on Medical Education (LCME) requires that MD students receive some interprofessional training. This could be used to leverage inclusion of PAs on MD training teams (19). Many of the ideas concerning remedies for loss of productivity or financial cost echo the suggestions for creating an efficient, time effective workspace. In addition, it is critical for organizations like AAPA and PAEA to work with healthcare systems and providers to help them understand how to incorporate student education and training into their systems. It is important to provide support for the numerous motivated and productive PAs who are willing to precept PA students without risk of financial penalty (i.e., loss of time and RVUS).

One of the most commonly cited concerns among survey participants was the lack of clear understanding about the expectations of precepting a student. While some of these expectations are specific to each program, many aspects of precepting are universal. Respondents repeatedly suggested that a standard precepting toolkit or workshops that guide preceptors in the basic requirements of teaching PA students would be beneficial. This could be achieved through the development of a standardized “PA student passport” or educational checklist that would be common to all PA students and that might include a summary of a student’s didactic education and the skills that PA students are reasonably expected to perform. This could also be achieved by the implementation of Entrustable Professional Activities (EPAs) into PA education, which will be further discussed in the section on Long-Term Solutions. Survey participants also reported wanting more resources regarding best practices and teaching in a clinical setting.

In response to competition among PA, NP, DO and MD programs for SCPE placements, the survey respondents offered recommendations such as streamlining credentialing processes for students to increase efficiency of on-boarding and allowing for flexibility in the types of sites that qualify for
particular rotations, i.e., allowing specialty surgical practices to satisfy the requirement for a general surgery SCPE (discussed further below). Other innovative recommendations included allowing for some clinical competencies to be completed during the didactic year, permitting interested students to complete rotations in areas like healthcare administration or PA education where demand for placement is lower, and connecting with community housing authorities to help find lodging for students in more rural areas to open these regions to more SCPE.

Respondents recommended that the lack of support or permission from one’s administration can be addressed by showing administrators the benefits of precepting students and by learning more about why they discourage or do not allow precepting. Solutions might include offering to collaborate with administrators in order to determine what changes can be made to overcome these concerns and to introduce policies or by-laws that allow PAs to precept. Recognition for systems or sites that are ‘student-friendly’ or provide excellence in SCPE may also encourage support. Survey participants also valued the conversation with healthcare system administrators regarding recruitment and hiring opportunities that can come from SCPE.

Finally, many survey respondents lamented the lack of adequate communication between PA programs and preceptors. Stakeholders reported that some programs offer little to no communication with SCPE sites and preceptors once a relationship has been established and a contract signed, relying on their students to pick up the communication trail and offer gratitude for their preceptors’ service. While students offering thanks to their preceptors is certainly encouraged, survey participants expressed that preceptors need to hear from PA program faculty more consistently. Preceptors need to have basic information from programs about student level of education, expectations, timing and duration of SCPE, and benefits for precepting. The respondents stated that this could be achieved through more consistent site visits by program faculty or cultivated even further by inviting preceptors to be involved in clinical curriculum development.

**Most Important Incentives for Precepting and Short-Term Solutions to Make Them a Reality**

Another question addressed in the JTF’s informal survey considered what incentives might encourage more PAs to precept and how to make these incentives a reality. Several overarching themes became apparent in these responses as well.

Increasing the amount of AAPA Category 1 CME credit offered to PA preceptors was one of the most common suggestions. Currently, AAPA Category 1 CME credits can be earned for every PA student precepted. This increase in CME value might incentivize more PAs to take PA students for SCPE. Alternatively, developing a system of PAs applying directly to AAPA for Category 1 CME credits, with programs only providing documentation of preceptor contact time with students, might streamline the process for precepting PAs and programs.
Compensation, in various forms, proved to be a top recommendation. Some forms mentioned include financial compensation, discounts on AAPA membership, products, or conferences, loan repayment, tax credits, and reimbursement for productivity coverage and teaching. The Joint Report notes that the compensation per student per rotation for the programs that provide financial incentives is $125 per student (1). New data from PAEA’s 2016 Program Survey indicates that 35.4% of accredited PA programs now pay for clinical sites, representing a 13.1% increase from 2013. Clinical sites cost programs an average of $232 per week (21). However, not all programs are able to pay for SCPE due to budgetary restraints; thus, this remains an area of much debate (21). It was suggested that AAPA and PAEA follow the utilization rates for tax incentive programs approved in Georgia, Colorado, and Maryland, to determine if such programs are a powerful incentive and warrant promotion in other states.

Stakeholders valued adjunct faculty status and inclusion in other program benefits for preceptors, such as UpToDate access, research opportunities, faculty engagement, curriculum involvement, or access to library resources. They also valued gestures of recognition and gratitude. Examples include thank you notes from a student or program; recognition from one’s administration, state, or program; Preceptor of the Year awards; a PA program-sponsored lunch for a preceptor’s office; and local media engagement.

Finally, many healthcare systems, clinics and practices use precepting as a recruitment tool for new providers. This is beneficial both to the student and the preceptor, as the student has the possibility of receiving a job offer from a clinical site, while preceptors can use that time as an informal interview process and begin to orient the student to the specifics of their practice or hospital.

**Long-Term Solutions**

A final question asked stakeholders about long-term solutions to increase SCPE. Overarching themes regarding long-term solutions include collaboration, value, and innovation.

PAEA has called for collaboration between programs, preceptors, and constituent organizations in the recruitment, retention, and sharing of SCPE (22). Among recommendations from stakeholders was the idea to share SCPE sites in order to develop a national database with the potential to distribute student placement nationwide recognizing that there may be issues relating to contractual agreements between PA programs and clinical sites as well as federal legislation to be considered. In turn, this program could be utilized as a workforce pipeline for PAs by training PA students in communities with underserved patient populations, enabling new PAs to effectively address healthcare shortages. In order to ensure proper implementation of such a system inter-organization cooperation is paramount.

The value of precepting PA students can also be emphasized through a paradigm shift in the way precepting is marketed to the healthcare community, focusing on emphasizing the value of precepting students. In the long term, precepting PA students offers the potential for added value for health systems rather than a burden. In the stakeholder interviews, it was noted that early exposure of PA students to
future employers (i.e., health systems, private practices, etc.) can improve patient flow, provide patient education, address patient safety issues, and help with charting and medical documentation.

Innovation is a final long-term goal. Among core SCPE requirements, shortages are most often mentioned in general surgery, pediatrics, and women's health. There is an opportunity, as ARC-PA reviews current *Standards*, to provide some relief and flexibility in identifying sites for core SCPE student placements.

As an example, there are barriers to clinical training in pediatrics. General pediatricians have been increasingly resistant to participating in the training of PA students. In trying to engage PAs in pediatrics to take on the preceptor role, we find that fewer than 3% of PAs practice in pediatrics, and most of them are in sub-speciality pediatrics. Language that allows some combination of specialty pediatrics with simulation, or other innovations, could provide relief of perceived shortages without impacting program goals for such training.

Some years ago, the requirement in the *Standards* for obstetrics/gynecology experiences was reframed to allow training in women's health settings. This allowed flexibility for programs to meet the *Standards* in a broader range of settings. While these settings remain in somewhat short supply, the change allowed for flexibility and innovation. This might be used as an example for added flexibility in the *Standards* going forward.

An additional innovation receiving increased attention in PA education is Entrustable Professional Activities (EPAs). EPAs describe ‘units of work’ that a student or graduate should be able to perform at a certain level of education, distinct from competencies which describe abilities. According to Lohenry et al., EPAs “answer the question, ‘What can a PA, medical graduate, or medical resident be entrusted to do?’” (23) This concept has been used in medicine in order to bridge the gap between skill-level and preparation of medical graduates and expectations of residency programs. Likewise, it may serve the same purpose in PA education to bridge a gap between didactic and clinical education and between graduation and employment. It would allow competency-based training, with the possibility that some students would meet program educational goals more quickly. This might result, in some cases, with students progressing to graduation with a requirement for less time in clinical settings while still meeting program goals. It could result in the need for fewer preceptors. The potential of this concept will become clearer as programs adopt EPAs and explore the impact they will have on PA education.

**The Unique Position of AAPA in Working Toward a Solution**

AAPA is the only national organization that represents PAs making the organization uniquely positioned to communicate with PAs about the value of precepting PA students. AAPA contains in its membership one of the greatest networks of potential clinical educators for PA students, and its relationships and advocacy efforts with employers throughout the U.S. is also a potential source of
growth. In addition, AAPA has an opportunity to offer PAs incentives to serve as preceptors. Current incentives offered by AAPA include:

- **Clinical Preceptor Recognition Program (24):**
  - Committed to showing appreciation of “educating the next generation of PAs”
  - Awards the Clinical Preceptor of AAPA (CPAAPA) designation
  - 197 active AAPA members as of February 2019
- **Preceptor of the Year Award:**
  - Recognizes outstanding efforts by preceptors to prepare students for clinical practice
  - Initially awarded in 2013
  - One preceptor is acknowledged annually; 4 awards have been granted
  - The JTF recommend that AAPA works with PAEA to co-promote this award, consider looking at regionalization of the award, with an ultimate goal of awarding an annual award from each of the five regions.
- **Category 1 CME:**
  - AAPA grants two AAPA Category 1 CME credits per week of clinical teaching for each student they precept
  - Maximum of 20 Category 1 CME credits per calendar year
  - AAPA has received 535 unique requests for Category 1 CME credit for preceptors from PA programs since 2013. These requests came from 175 programs.

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 the federal and state governments to ensure that there are adequate numbers of qualified medical providers to meet the healthcare needs of the nation, AAPA and its members would do well to advocate for incentives for individual medical providers to precept PA students, as well as incentives for employers to provide such opportunities. AAPA and PAEA are strongly encouraged to help ensure the PA profession is represented in any further discussions at the federal or state levels regarding state authorization agreements (NC-SARA). Addressing this issue aligns with AAPA’s strategic commitments to “equip PAs for expanded opportunities in healthcare, advance the PA identity, and create progressive work environments for PAs.” (25). AAPA’s values of unity and teamwork reflect its commitment to work with PAEA, ARC-PA, and NCCPA to address issues such as this (26).

**Conclusion**

AAPA urges clinically practicing PAs with the willingness and ability to precept PA students, thus enriching their clinical education experience and ensuring the graduation of competent healthcare providers. This is consistent with current AAPA policy HP-4252.
AAPA supports working with PAEA, ARC-PA and NCCPA to communicate the benefits of precepting students to PAs, patients, and employers.

AAPA supports working with PAEA to increase the number of AAPA Category 1 CME credits available to PAs who precept and simplify the CME application process for PA programs.

AAPA supports working with PA employers to expand the range of opportunities for PA students to gain clinical experience through SCPE.

AAPA supports suggesting modifications to the ARC-PA Standards in order to ensure quality SCPE continue with increased emphasis on flexibility and innovation.

AAPA supports collaborating with PAEA to develop an information toolkit for PA programs and preceptors to utilize concerning benefits and helpful tips for precepting.

AAPA supports working with PAEA to increase awareness among PA educators of the additional limitation that pre-PA shadowing requirements may create for PA student placement in SCPE.

AAPA supports working with PAEA to investigate the feasibility of developing a national database of SCPE with the utilization of a CASPA-like centralized platform for PA students nationwide.

AAPA supports the consideration of collaboration with external medical organizations to look at ways to support an interprofessional, collaborative clinical training model.

Working together, the PAEA, AAPA, and all involved stakeholders can address the SCPE shortage and work toward a more sustainable model of PA education through some of the measures outlined above. Still, solutions are not limited to those listed in this paper. This long-standing issue will require continued innovation and refinement over the course of many years. A culture of collaboration among organizations, leaders, and other stakeholders within the PA community benefits these efforts. In the end, PA education will continue to be a model of quality and compassionate care, esteemed by the medical and patient communities alike.

References


https://www.aapa.org/career/leadership-opportunities/clinical-preceptor-recognition-program/
(AAPA. (2016). About AAPA)
Attempts to Change a Minor’s Sexual Orientation, Gender Identity or Gender Expression
[Adopted 2017, reaffirmed 2022]

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.

- Efforts to change an individual’s sexual orientation, gender identity, or gender expression are not supported by credible evidence and have been disavowed by behavioral health experts and associations.
- Efforts to change an individual’s sexual orientation, gender identity, or gender expression perpetuate outdated views of gender roles and identities as well as the negative stereotype that being a sexual or gender minority or identifying as lesbian, gay, bisexual, or transgender is an abnormal aspect of human development.
- Efforts to change an individual’s sexual orientation, gender identity, or gender expression are coercive, can be harmful, and should not be part of treatment plan.

Review of the Evidence
The mission of the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health and Human Services (HHS) is to improve the behavioral health of the nation. As such, SAMHSA endeavors to improve public health and eliminate health disparities facing all vulnerable communities, including sexual and gender minority populations.

In 2015, SAMHSA collaborated with the American Psychological Association, and convened a panel of behavioral health professionals (e.g., researchers and clinicians from psychology, social work, and psychiatry) with expertise in the fields of gender development, gender identity, and sexual orientation in children and adolescents. Based on the best research and scholarly material available, that convening established professional consensus with respect to efforts to change a minor’s sexual orientation, gender identity, or gender expression, and ultimately resulted in this report:


The purpose of this 76-page report is to provide “accurate information about effective and ineffective therapeutic practices related to children’s and adolescent’s sexual orientation and gender identity”.

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As per the report, “Conversion therapy – efforts to change an individual’s sexual orientation, gender identity, or gender expression – is a practice that is not supported by credible evidence and have been disavowed by behavioral health experts and associations. Conversion therapy perpetuates outdated views of gender roles and identities as well as the negative stereotype that being a sexual or gender minority or identifying as lesbian, gay, bisexual, or transgender, is an abnormal aspect of human development. Most importantly, it may put young people at risk of serious harm”.

Additional information on this topic, including statements of professional consensus, research overview, approaches to ending the use of conversion therapy, guidance for families, providers and educators, as well as references, and a glossary of terms can be found within the report and accessed online. http://store.samhsa.gov/shin/content/SMA15-4928/SMA15-4928.pdf

**Recommendation**

AAPA endorses the consensus statements of the 2015 SAMHSA publication (1) noted below, resulting from the convening of subject matter experts in the fields of psychology, social work and psychiatry as part of the collaboration between the American Psychological Association and the Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services, and as follows:

**PROFESSIONAL CONSENSUS ON CONVERSION THERAPY WITH MINORS**

- AAPA believes that same-gender sexual orientation (including identity, behavior, and/or attraction) and variations in gender identity and gender expression are a part of the normal spectrum of human diversity and do not constitute a mental disorder.
- AAPA believes that there is limited research on conversion therapy efforts among children and adolescents; however, none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.
- AAPA believes that interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatments. Directing a child to be conforming to any gender expression or sexual orientation or directing the parents to place pressure for specific gender expressions, gender identities, and sexual orientations are inappropriate and reinforce harmful gender and sexual orientation stereotypes.

**PROFESSIONAL CONSENSUS ON SEXUAL ORIENTATION IN YOUTH**

- AAPA believes that same-gender sexual identity, behavior, and attraction are not mental disorders. Same-gender sexual attractions are part of the normal spectrum of sexual orientation.
Sexual orientation change in children and adolescents should not be a goal of mental health and behavioral interventions.

- AAPA believes that sexual minority children and adolescents are especially vulnerable populations with unique developmental tasks who lack protections from involuntary or coercive treatment, and whose parents and guardians need accurate information to make informed decisions about behavioral health treatment.

- AAPA believes that there is a lack of published research on efforts to change sexual orientation among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter sexual orientation. Given the research on the secondary outcomes of such efforts, the potential for risk of harm suggests the need for other models of behavioral health treatment.

- AAPA believes that behavioral health professionals provide accurate information on sexual orientation, gender identity, and expression; increase family and school support; and reduce rejection of sexual minority youth. Behavioral health practitioners identify sources of distress and work to reduce distress experienced by children and adolescents. Behavioral health professionals provide efforts to encourage identity exploration and integration, adaptive coping, and family acceptance to improve psychological well-being.

PROFESSIONAL CONSENSUS ON GENDER IDENTITY AND GENDER EXPRESSION IN YOUTH

Consensus on the Overall Phenomenon of Gender Identity and Gender Expression

- AAPA believes that variations in gender identity and expression are normal aspects of human diversity and do not constitute a mental disorder. Binary definitions of gender may not reflect emerging gender identities.

- AAPA believes that pre-pubertal children and peri-pubertal adolescents who present with diverse gender expressions or gender dysphoria may or may not develop a transgender identity in adolescence or adulthood. In pubertal and post-pubertal adolescents, diverse gender expressions and transgender identity usually continue into adulthood.

Consensus on Efforts to Change Gender Identity

- AAPA believes that there is a lack of published research on efforts to change gender identity among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter gender identity.

- AAPA believes that it is clinically inappropriate for behavioral health professionals to have a prescriptive goal related to gender identity, gender expression, or sexual orientation for the ultimate developmental outcome of a child’s or adolescent’s gender identity or gender expression.
AAPA believes that mental health and behavioral interventions aimed at achieving a fixed outcome, such as gender conformity, including those aimed at changing gender identity or gender expression, are coercive, can be harmful, and should not be part of treatment. Directing the child or adolescent to conform to any particular gender expression or identity or directing parents and guardians to place pressure on the child or adolescent to conform to specific gender expressions and/or identities, is inappropriate and reinforces harmful gender stereotypes.

Consensus on Appropriate Therapeutic Intervention for Youth with Gender-Related Concerns

- AAPA believes that children and adolescents experiencing gender-related concerns are an especially vulnerable population with unique developmental tasks. Parents and guardians need accurate scientific information to make informed decisions about appropriate mental health and behavioral interventions, including whether or not to initiate a social gender transition or, in the case of peripubertal, pubertal, and post-pubertal adolescents, medical intervention. Treatment discussions should respect the child’s and adolescent’s developing autonomy, recognizing that adolescents are still transitioning into adult decision-making capacities.

- AAPA believes that approaches that focus on developmentally-appropriate identity exploration, integration, the reduction of distress, adaptive coping, and family acceptance to improve psychological wellbeing are recommended for children and adolescents of all ages experiencing gender-related concerns.

Pre-Pubertal Children

- AAPA believes that gender expression and gender identity are interrelated and difficult to differentiate in prepubertal children and are aspects of identity that develop throughout childhood. Therefore, a detailed psychological assessment should be offered to children and families to better understand the present status of a child’s gender identity and gender expression, as well as any associated distress.

Peri-Pubertal Adolescents

- For peri-pubertal adolescents, the purpose of pubertal suppression is to provide time to support identity exploration, to alleviate or avoid potential distress associated with physical maturation and secondary sex characteristics, and to improve future healthy adjustment. If pubertal suppression is being considered, it is strongly recommended that parents or guardians and medical providers obtain an assessment by a licensed behavioral health provider to understand the present status of a peri-pubertal adolescent’s gender identity or gender expression and associated distress, as well as to provide developmentally-appropriate information to the peripubertal adolescent, parents or guardians, and other healthcare professionals involved in the peri-pubertal adolescent’s care. The purpose of the assessment is to advise and inform treatment decisions.
regarding pubertal suppression after sharing details of the potential risks, benefits, and implications of pubertal suppression, including the effects of pubertal suppression on behavioral health disorders, cognitive and emotional development, and future physical and sexual health.

**Pubertal and Post-Pubertal Adolescents**

- Decision-making regarding one’s developing gender identity is a highly individualized process and takes many forms. For pubertal and post-pubertal adolescents, if physical gender transition (such as hormone therapy or gender affirming surgeries) is being considered, it is strongly recommended that adolescents, parents, and providers obtain an assessment by a licensed behavioral health provider to understand the present status of an adolescent’s gender identity and gender expression and associated distress, as well as to provide developmentally-appropriate information to adolescents, parents or guardians, and other healthcare professionals involved in the pubertal or post-pubertal adolescent’s care. If physical transition is indicated, the potential risks, benefits, and implications of the transition-related procedures being considered – including the effects on behavioral health disorders, cognitive and emotional development, and potentially irreversible effects on physical health, fertility, and sexual health – are presented to the adolescent and parents or guardians. Withholding timely physical gender transition interventions for pubertal and post-pubertal adolescents, when such interventions are clinically indicated, prolongs gender dysphoria and exacerbates emotional distress.

**Reference**

**Human Trafficking in the United States**  
[Adopted 2019]

**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 (American Academy of PAs) condemns human trafficking in all its forms and everywhere it is practiced.
- AAPA urges PAs to be alert in identifying and caring for victims of human trafficking. PAs should ensure that they are well-informed about the medical, psychological and spiritual needs of trafficked persons as well as the resources for victims available in their communities.
- AAPA encourages PAs to use their knowledge and expertise proactively to help prevent the crime of human trafficking from occurring in their local communities and abroad.
- AAPA encourages educational programs to train students to recognize trafficking prior to entering full-time practice.
- AAPA encourages PAs to fully comply with all local, state, and federal statutes as mandatory reporters and to use their positions as medical professionals to stop human trafficking.

**Introduction**

After a brief explanation about human trafficking in healthcare, this policy paper will seek to show how PAs can be integral in the concerted effort to stop human trafficking in the U.S. by presenting relevant data, definitions, and guidelines for moving forward.

In 2000, the U.S. Congress passed the Trafficking Victims Protection Act of 2000 (TVPA) which defined forms of trafficking as follows:

- Sex trafficking: the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; (and)
- Labor trafficking: the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. (1)

According to the CDC, Human Trafficking is a preventable health problem that has far-reaching public health consequences associated with sexual violence, intimate partner violence, child abuse and neglect. (2) Though the exact numbers of those affected by human trafficking is difficult to determine, advocacy organizations such as Polaris, which operates the National Human Trafficking Hotline,
estimates that the number of victims reaches into the hundreds of thousands. (3) In 2017, Polaris identified 7,255 victims of sex trafficking, 1,979 victims of labor trafficking, 542 victims of both sex and labor trafficking, and 838 victims in which the form of trafficking was not specified. (3) An estimated 87.7% of victims will see a provider in a hospital during their captivity. (4) About 63-68% of these encounters occur in an emergency department, and 21.4% occur in urgent care clinics. (4) The likelihood of victims encountering a PA is stark as 8.9% of PAs work in emergency departments and 6.1% in urgent care centers. (4) Surveys of trafficking victims support these estimates and reveal that most were seen by a healthcare provider during the time they were being exploited. (3) The populations vulnerable to becoming trafficked victims that are also likely to encounter healthcare providers includes, but is not limited to, individuals who have been abused as children, children in foster care, victims of violence, sexual and gender minorities (including lesbian, gay, bisexual, transgender, and queer), undocumented immigrants, and those with a history of substance abuse. (5) Healthcare providers need to remain aware of vulnerable populations in order to identify victims and increase the level of care to this patient population.

**Public Health Issue**

As with many public health issues, trafficking is preventable, and it is contingent on a multidisciplinary approach that will heavily involve the healthcare provider. The CDC has a program called “Using Evidence-based Strategies in Your Violence Prevention Efforts” to help implement steps for public health networks to provide safety and prevention practices. The CDC wants communities to be aware that encouraging healthy behaviors in relationships, fostering safe homes and neighborhoods, reducing demands for commercial sex, and eliminating business profits from related transactions are all integral to preventing trafficking. (6) The National Human Trafficking Hotline is a toll-free anti-trafficking hotline available to answer calls from victims and anyone reporting suspected cases of trafficking from anywhere within the United States. (3) The hotline is an integral tool in providing advice for concerned citizens, services for victims, and bringing perpetrators to law enforcement’s attention. (3) PAs can utilize this free hotline if they encounter suspected cases of trafficking at work or in their communities. The national hotline and the online National Human Trafficking and Referral Directory provide the general public and medical professionals with referrals for case management, shelters, legal services, mental health services in the victim’s local community. (3) It is critical for the medical community to use these resources and to increase collaboration with all relevant local agencies including immigration agencies, law enforcement, and health departments.

**Training Current Medical Personnel**

Though human trafficking is a public health issue, many healthcare workers are under-trained and unaware of how to recognize and help victims. A study of San Francisco Bay area emergency departments (EDs) showed that among 258 ED personnel, 29% thought human trafficking was a problem
in their ED population, however, only 13% of the study participants felt confident or very confident that they could identify a victim of human trafficking, and fewer than 3% had ever been trained to recognize victims. (7) To our knowledge, there is no specific study addressing PAs and their knowledge or training in identifying trafficking victims. Fortunately, as awareness has increased, resources have been developed to fill in these knowledge gaps and provide training for medical professionals. The Health and Human Services (HHS) Office on Trafficking in Persons, an office of the Administration for Children & Families, has developed a training program called SOAR. (8) SOAR seeks to apply a public health approach to equip professionals to identify, treat, and respond appropriately to human trafficking. The Office on Trafficking in Persons also provides detailed U.S. state and territory profiles detailing the gender and types of locations in which victims were located. (8) Healthcare workers can utilize these tools to best understand their individual state or territory’s unique trafficking characteristics and to more readily identify victims in their distinct communities. (5) Additionally, the U.S. Department of Homeland Security implemented The Blue Campaign which has assessment tools and protocols to best manage care for trafficked victims. (9) Increased awareness and increased reporting of human trafficking may also increase the demand for healthcare workers trained in forensic exams. (5) PAs can help meet these needs by becoming trained in forensic sexual assault examinations which can be an essential service for victims, especially in rural areas where there may be less resources. Some states have dedicated funding to train medical providers on human trafficking and other states need to follow suit to provide training as well as assistance to victims. There are many training tools available for medical professionals and PAs should advocate that their workplace provides essential training.

**Health Consequences to Recognize**

Victims of trafficking require comprehensive psychosocial and healthcare services to address many of the subsequent issues that result from involuntary servitude, particularly in women and girls. Physical health issues to be addressed are sequelae of STIs, physical injuries, chronic untreated medical conditions, pregnancy and related complications, malnutrition, exhaustion, HIV/AIDS, skin conditions, GI disorders, periodontal disease, and TB. (5) Some psychological conditions that survivors face include anxiety, PTSD, suicidality, substance abuse, depression, self-harm, insomnia, hypervigilance, rage control problems, and dissociative disorders. (5) In their policy statement, the American Academy of Pediatrics urges healthcare providers to be aware that major mental health issues can precede human trafficking and actually contribute to the victim’s vulnerability. (5) These underlying mental health problems can be used as a ploy by the trafficker to discredit the victim. (5) The United National Global Initiative to Fight Trafficking in Persons (UN.GIFT) created a handbook to guide healthcare workers in comprehensive care of trafficked victims. (10) There is limited data on the frequency and variability of victims’ health concerns but the CDC urges healthcare providers to be familiar with other more researched related public
health issues that increase the risk for trafficking including child maltreatment, intimate partner violence, runaway/homeless youth, substance misuse, and poverty. (11) Though victims may be more easily identified in the emergency department or in urgent care, PAs working in primary care, OB/GYN, psychiatry, and pediatrics can play an important role in continued care for survivors. Training for all PAs, not just those in emergency medicine, is key for the survivor’s recovery, mental health, and safety. PAs in every specialty should work with their state and local organizations as well as their clinic or hospital social workers to provide comprehensive care for survivors as they take steps towards physical and mental healing.

**Training Future Healthcare Workers**

As awareness of human trafficking increases on the federal level, medical education programs must follow suit and should equip future medical professionals to recognize and treat victims. Doctors, nurse practitioners, and PAs who completed training admit to being more comfortable and ready to report suspected cases of trafficking as well as give adequate care for victims. Training on human trafficking should be incorporated into PA program curriculum so that all PA students and graduates are able to identify patients who are at risk and are equipped with the resources to support and treat victims. PAs have the opportunity to take the initiative in training students which will have a lasting impact on this under-recognized public health and safety issue. Incorporating training on human trafficking identification and treatment in all PA programs will equip PAs to be at the forefront in the fight to end human trafficking in the U.S. Though we do not have specific estimate on the cost of incorporating this training into PA educational curriculum, many of the training resources and most of the statistical data are publicly available therefore, the financial impact should be minimal. Like other evolutions in medicine, the cost to providing up-to-date training to students should be considered a necessity in PA program curriculums.

**Advocate for Policy Changes**

The AMA, in their Policy Forum, propose that the U.S. Healthcare system is poised to be at the forefront of data collection and research that is evidence-based and grounded ethically in nonmaleficence, justice, and autonomy for all patients. (11) These principles that guide our healthcare system could be the missing piece in this public health issue that is impacting minorities and females at a disparate rate with physical and emotional abuse, inhuman living conditions, poor sanitation, inadequate nutrition and delay in seeking healthcare. As human trafficking is viewed as not merely a legal concern but also a health concern, the research community can work collaboratively with federal, state, and local agencies to end human trafficking.
**Conclusion**

PAs are uniquely placed in their employment settings where human trafficking victims are encountered and have a responsibility to unite and stand against human trafficking. PAs can be a vital part of the future to end this human right violation. We encourage all PAs to be educated, advocate, and participate in ending human trafficking by using their skillset to identify and care for victims and bring perpetrators to appropriate authorities.

**References**

assn.org/article/who-your-waiting-room-health-care-professionals-culturally-responsive-and-trauma-informed-first/2017-01
Non-Physician Licensure for Medical School Graduates
[Adopted 2019]

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 opposes the creation of new categories of licensure for medical school graduates who have not completed the requirements of physician licensure.
- AAPA opposes legislation which would categorize such licensees as PAs in any circumstances.
- AAPA supports efforts to increase access to healthcare in underserved areas by improving outdated state laws and regulations which place non-evidence-based limits on PA practice.
- Several states have either considered or enacted legislation to allow medical school graduates who have not completed the requirements of physician licensure to become licensed as “assistant physicians,” “graduate registered physicians,” “associate physicians,” or other, similarly-named practitioners. Proposed AAPA policies regarding this new category of licensure are identified in this paper.

Background

In 2014, Missouri became the first state to create a category of licensure for medical school graduates who have completed Step 1 and Step 2 of the United States Medical Licensing Exam (USMLE) but have not matched with a residency. (1) These licensees, called “assistant physicians,” or APs, are intended to mitigate healthcare provider shortages. APs are authorized to provide many of the same medical services as PAs and nurse practitioners (NPs), including prescribing Schedule III-V controlled medications and Schedule II hydrocodone medications. They are also subject to supervision requirements which are substantively similar to the supervision requirement for PAs. However, unlike PAs and NPs, APs are largely restricted to practicing primary care in rural or urban underserved areas. APs may also refer to themselves as “doctor.”

There remain some unanswered questions regarding reimbursement for APs in Missouri. Missouri law states that APs shall be considered PAs for the purposes of regulations under the Centers for Medicare and Medicaid Services (CMS). However, as of August 2018, CMS and its contractors have declined to recognize APs, either as PAs or as their own category of practitioner. It also remains unclear whether private insurers will recognize APs for reimbursement purposes.

Other states have created categories of licensure for unmatched medical school graduates. Examples include Arkansas (“graduate registered physicians”), Kansas (“special permit holders”), and
Utah (“associate physicians”). Several other states, including Mississippi, New Hampshire, and Oklahoma have considered legislation to establish similar categories of licensure.

While the idea of licensing unmatched medical school graduates is popular with state legislatures, it remains controversial in the medical community. In 2014, the American Medical Association (AMA) adopted policy in response to the Missouri law which states:

RESOLVED, That our American Medical Association oppose special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education or American Osteopathic Association training program, or have not completed at least one year of accredited postgraduate U.S. medical education. (2)

There is no question that increased access to healthcare services is needed in many areas of the country. However, this category of licensure was created to satisfy the specific needs of medical school graduates who have not completed their medical training. The goal of professional licensure is to standardize and guarantee the qualifications of licensees and protect the public from unqualified practitioners. Licensing individuals who have failed to compete a specific course of study is contrary to this goal.

The licensure of unmatched medical graduates may also lead to unintended consequences. First, titles such as “assistant physician” have the potential to confuse patients, health systems, payers, and other providers. PAs have provided patient care for more than 50 years, and the PA title is familiar to healthcare consumers and professionals. The introduction of a new practitioner with a similar name and often, a similar scope of practice, may lead to errors in medical records or reimbursement for care provided as well as a lack of clarity regarding a practitioner’s qualifications.

Additionally, proposals which attempt to place licensees in the same category as PAs without requiring that they satisfy the requirements of becoming a PA are problematic, even if they do so only in limited circumstances. States and the Federal Government have specific statutory and/or regulatory definitions for PAs, all of which include the requirement that a PA have completed an accredited PA educational program and passed the national certification examination administered by the National Commission on Certification of Physician Assistants. Attempting to add licensees to these definitions without meeting their qualifications can lead to denial of payment for non-PA licensees, ultimately causing hardship for patients. It could also lead to violations of state title protection laws, which prohibit non-PAs from holding themselves out to the public as PAs.

Finally, as a practical matter, it is unlikely that licensing medical school graduates who have failed to secure a residency will have a significant impact on healthcare provider shortages. Many of these new licensees are expected to continue to seek a residency, resulting in a high potential for turnover.
**Recommendations**

- AAPA opposes the creation of new categories of licensure for medical school graduates who have not completed the requirements of physician licensure.
- AAPA opposes legislation which would categorize such licensees as PAs in any circumstances.
- AAPA supports efforts to increase access to healthcare in underserved areas by improving outdated state laws and regulations which place non-evidence-based limits on PA practice.

**References**

1. Missouri Revised Statutes 334.036.
Genetic and Genomic Testing
(Adopted 2019)

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 recommends best practices for incorporation of genetic testing into medical practice including evaluation of the validity and clinical utility of such tests, performing testing in accordance with an individual’s personal and/or family history, and consideration of relevant ethical, legal, and social issues associated with genetic/genomic testing.
- AAPA supports appropriate pre- and post-genetic/genomic testing counseling which may include referral to a qualified specialist. Testing should be done in collaboration with a qualified healthcare professional who can provide the appropriate guidance and counseling for the patient.
- AAPA believes a patient’s genetic/genomic information should be kept confidential and disclosed to third parties only with the informed consent of the individual tested.
- AAPA strongly opposes any discrimination on the basis of an individual’s genetic or genomic information. AAPA strongly opposes limitations imposed by payers on patients based upon their genetic/genomic information or request for genetic services.
- AAPA recommends PAs complete continuing education in risk assessment for genetic diseases and disorders, how to manage inherited predisposition to these conditions, and how to clinically manage these conditions.

Within the past decade, powerful and sophisticated technologies have emerged to identify genetic and genomic mutations that may increase a person’s risk for a disease or may be implicated in a particular disease. These technologies hold significant potential to provide broad-reaching benefit to society, ranging from the opportunity for early recognition of risk for developing a disease or disorder to developing therapies that target specific mutations, all of which may serve to improve patient outcomes.

Alongside this rapid pace of growth of scientific knowledge, discovery, and progress comes the need for sensitivity to the ethical, legal, and social issues and ramifications associated with this technology as well as the need for ongoing education on risk assessment, appropriate application of these technologies, and appropriate counseling for patients on testing findings. This policy paper offers recommendations and practical guidance for PAs in their everyday medical practice.

Advances in genetics and genomics have led to the growing availability and use of genetic testing in clinical practice. As these new technologies become increasingly applicable to the clinical care of
patients, PAs need to acquire and demonstrate competencies that afford the best possible care for patients within the scope of their practice. Genetic and genomic tests, like other types of diagnostic tests, should be evaluated with respect to analytical validity, clinical validity and clinical utility. (1)(2)

AAPA recommends that genetic testing be pursued as a targeted approach according to a patient’s personal and/or family history rather than a broad-based approach. A broad-based approach increases the chance of identifying an incidental finding, which a patient may not wish to know about, and increases the chance of having a variant of uncertain significance, which is a finding with limited information where the impact on the patient’s health is uncertain. Both may increase the patient’s anxiety and confusion as to how this impacts their health. A targeted approach would only assess the genetic information that is applicable to the reason for ordering the genetic/genomic testing.

The availability of consumer-ordered testing is likely to grow in the coming years, and some genetic tests can be obtained by patients on their own today. AAPA recommends patients access FDA-approved tests or tests performed through a CLIA-certified lab when pursuing genetic/genomic testing as the Clinical Laboratory Improvement Amendments Act of 1988 (known as CLIA) and the FDA provide minimal threshold quality standards. As with other consumer-ordered diagnostic testing, AAPA recommends such testing be done in collaboration with a qualified healthcare professional.

Incidental findings in genetic/genomic testing are a common occurrence, especially when using broad-based technologies such as a chromosomal microarray, whole exome sequencing, and whole genome sequencing. Incidental findings may include benign alterations that may not strongly impact a patient or their health, pathogenic alterations that may have a strong impact on the patient, their health, and the health of their family members, and abnormalities of unclear significance. Disclosure of incidental findings to patients and their families is a delicate task that requires sensitivity.

AAPA recommends in-depth discussion of potential outcomes of genetic testing take place between the patient and provider, as part of the informed consent process, before genetic/genomic testing is initiated. Patients should be aware of the possible outcomes including, but not limited to, normal results, abnormal results, variants of uncertain significance, and incidental findings. PAs should also be aware of other healthcare professionals with an expertise in genetics, such as a geneticist or genetic counselor, in the event that clarification or a referral is needed.

PAs should be aware of and assist patients in navigating the issues around genetic testing decisions, understanding of results and their impact including possible emotional, behavioral consequences on the patient, family and community.

The cost of genetic tests can be prohibitive for patients, at times costing thousands of dollars. (3) Depending on the testing and potential diagnosis, this cost may also extend to family members who would require testing in addition to the patient. Payers should aim to be nimble in their evaluation of the
various genetic/genomic tests available, be transparent about their evaluation processes, and clearly communicate the financial responsibility that those they insure will bear for such testing, counseling on the testing results, and associated care needs.

Genetic information is considered health information and is subject to provisions of the Health Insurance Portability and Accountability Act of 1996. (4) Even so, vulnerabilities to the misuse of genetic/genomic information remain, and vigilant actions should be pursued to mitigate those vulnerabilities. (5)

AAPA supports state and federal legislation, such as The Genetic Information Nondiscrimination Act (GINA) of 2008 and other laws and policies, that confer protections to individuals by prohibiting discrimination on the basis of genetic/genomic information. (6,7)

Genetics and genomics education in PA programs has increased over the past several years; however, many PAs may not have received this training due to the newness of many of the tests. The PA Genomic Competencies outlines recommendations for an appropriate knowledge base for all PAs. Continuing education is one way to increase knowledge in these areas for all PAs.

**Recommendations**

- AAPA recommends best practices for incorporation of genetic testing into medical practice including evaluation of the validity and clinical utility of such tests as well as consideration of relevant ethical, legal, and social issues associated with genetic/genomic testing.
- AAPA recommends genetic/genomic testing in accordance with an individual’s personal and/or family history and discourages the indiscriminate use of genetic/genomic testing.
- AAPA recommends patients access FDA-approved tests or tests performed through a CLIA-certified lab when pursuing genetic/genomic testing. Such testing should be done in collaboration with a qualified healthcare professional who can provide the appropriate guidance and counseling for the patient.
- AAPA recommends that PAs adopt an inter-professional approach regarding awareness of and discussion regarding the psychological and psychosocial risks and benefits of decisions to undergo genetic/genomic testing, results, and incidental findings of such testing for the patient, their family, and community.
- AAPA supports appropriate pre- and post-genetic/genomic testing counseling which may include referral to a qualified specialist.
- AAPA recommends best practices be identified for disclosure of and counseling of patients on testing findings, including incidental findings.
- AAPA supports payer policies that provide coverage for patients suspected to be at risk for a genetic disease or disorder. Such coverage should include, but not be limited to, risk assessment and preventive services as well as genetic counseling services.
- AAPA believes a patient’s genetic/genomic information should be kept confidential and disclosed to third parties only with the informed consent of the individual tested.
- AAPA strongly opposes any discrimination on the basis of an individual’s genetic or genomic information. AAPA strongly opposes limitations imposed by payers on patients based upon their genetic/genomic information or request for genetic services.
- AAPA recommends PAs complete continuing education in risk assessment for genetic diseases and disorders, how to manage inherited predisposition to these conditions, and how to clinically manage these conditions.

**Select Resources for PAs**

- American College of Medical Genetics and Genomics (ACMG): https://www.acmg.net/.

In conclusion, genetic and genomic testing holds substantial promise in an era of personalized medicine. As with other powerful and complex technologies, there are many considerations with the implementation of this technology in clinical practice. PAs are encouraged to attain the needed competencies in this area of medicine in order to provide optimal patient care and experience.

**References**


Medications in Children
(Adopted 2019)

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

- AAPA supports the safe use of opioid containing medications in children.
- AAPA supports evidence-based recommendations from the U.S. Food and Drug Administration (FDA), the American Academy of Pain Medicine (AAPM), the American Society of Addiction Medicine (ASAM), the American Pain Society (APS), the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) regarding the need to provide appropriate pain relief to children as well as avoiding unsafe practices when prescribing opioid containing medications to children.
- AAPA supports the FDA recommendation that prescription cough and cold medicines containing codeine or hydrocodone should not be utilized in children under the age of 18 years.
- PAs should be aware of the dangers of the use of codeine and hydrocodone in children and the need to limit their use as treatments for cough suppression.

Use of Codeine and Hydrocodone
In 2016 the FDA examined the use of opioid medications in response to the opioid abuse epidemic. Codeine products and hydrocodone including opioid-containing antitussive (OCA) products and pain medications came under scrutiny with their use in children. As codeine is a prodrug that must be metabolized in the liver, the response to the medication is unpredictable and varies from no effect to high sensitivity. (1) A major concern with utilizing codeine in the pediatric population is the unpredictable pharmacokinetics and pharmacodynamics, particularly in CYP2D6 ultra rapid metabolizers. (2) The large variations in conversion of codeine predisposes children to be at a higher risk of opioid toxicity. “The relative immaturity of hepatic enzymes systems that metabolize drugs in young children may enhance the risk of adverse effects of such medications.” (3) Potential adverse side effects from codeine are respiratory depression and death, particularly in children under the age of 12 years. (4)

It has been well established that there is limited evidence that cough suppression in children younger than 6 years is necessary or beneficial, and that the medications available have little efficacy. (1,5,6) Therapy should be directed at the underlying condition causing the cough for lasting benefit. (3) when used as recommended, the products are safe. When taken for extended periods, OTC cough remedies are associated with significant morbidity and mortality and can cause overdoses even when
administered correctly. (7) In January 2018, the FDA went a step further in stripping codeine and hydrocodone of the indication for the treatment of cough in children younger than the age of 18 years. (6) With the United States currently battling an opioid abuse epidemic, PAs need to be aware of these new recommendations and put them into practice. PAs further need to provide information to families about the FDA’s stance on the use of OCA products. Educational opportunities for PAs would include more effective treatment modalities for cough.

Treatment of Acute Pain in Children

It has been reported that the use of codeine for pain postoperatively for adenotonsillectomy for Obstructive Sleep Apnea (OSA) carried a higher risk for death. (4) Therefore, in April 2017 the FDA issued a contraindication to using codeine to treat pain or cough in children under the age of 12 years, and a warning about using it in children aged 12 – 18 years who are obese or who have OSA or severe lung disease.

Opioids should be prescribed when necessary for moderate to severe acute pain that has not responded to other medication. Opioid medication should always be prescribed at the lowest effective dose and for the shortest duration necessary. Only short acting opioid medications should be utilized for acute pain issues. Utilization of non-opioid pain medication as well as non-pharmacological management of pain should be encouraged and utilized in combination with prescribed opioid medications. (8)

Treatment of Chronic Pain in Children

Safe and prudent treatment of chronic pain in children should include efforts to utilize non-pharmacological approaches to achieve pain relief. For example, the CDC guidelines cite evidence indicating that cognitive behavioral therapy and other modalities can be effective in treating chronic pain in children. (9) PAs should be aware of state and national guidelines, laws and regulations pertaining to safe opioid prescribing practices.

While extreme care and caution is warranted in the treatment of children with opioids, there is also evidence that chronic pain is often undertreated in pediatric populations. A coalition of organizations including AAPA have noted that the use of extended relief/long acting opioid medications may be indicated in the treatment of chronic pain in children. When well prescribed and used as prescribed, opioids can be a valuable tool to effectively treat pain. (10) PAs should use the lowest effective dose to provide analgesia while providing adequate pain control. For long term pain, management is augmented with consultation with a palliative care team, pain specialist, or referral to a specialized multidisciplinary pain clinic.

A 2017 document from the American Society of Regional Anesthesia notes the challenge of treating chronic pain in children. The document noted:
“Chronic pain involves complex interactions of biological, psychological, and social factors. Untreated pain during infancy and childhood leads to hypersensitivity pain through a “rewiring” of the peripheral as well as central nervous system leading to long changes in pain perception. Failure to control pain can have lifelong implications including poor coping strategies. Pediatric chronic pain management requires a comprehensive, multidisciplinary approach. This includes both non-pharmacologic and pharmacologic treatment as necessary, with a team of pain management physicians, integrative health specialists, child life specialists, physical therapists, psychologists, social workers, and acupuncturists”. (11)

Recommendations

- AAPA supports the safe use of opioid containing medications in children.
- AAPA supports evidence-based recommendations from the U.S. Food and Drug Administration (FDA), the American Academy of Pain Medicine (AAPM), the American Society of Addiction Medicine (ASAM), the American Pain Society (APS), the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) regarding the need to provide appropriate pain relief to children as well as avoiding unsafe practices when prescribing opioid containing medications to children.
- AAPA supports the FDA recommendation that prescription cough and cold medicines containing codeine or hydrocodone should not be utilized in children under the age of 18 years.

Conclusion

AAPA supports regulations and legislation that promote the safe use of codeine and hydrocodone in children under the age of 18 years, while supporting the need to remove potential obstacles to the appropriate treatment of pain in children. AAPA stands in support of the FDA’s recommendations for the restriction of the use of codeine and hydrocodone for cough suppression in children. AAPA encourages all PAs be aware of the risks and benefits of opioid containing medications for the management of pain in children. AAPA further encourages all PAs to keep prescribing practices in line with evidence-based guidelines when addressing pain management in children.

References

3. Committee on Drugs, American Academy of Pediatrics. Use of Codeine and Dextromethorphan Containing Cough Remedies in Children. *Pediatrics* 1997; 99;918


Vaping: Use of Electronic Nicotine Delivery Systems
(Adopted 2020)

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 recommends against the use of electronic nicotine delivery systems (ENDS), a practice commonly referred to as ‘vaping,’ for all patients due to the association with e-cigarette associated lung injury (EVALI).
- AAPA recommends that adults use FDA approved methods for smoking cessation and the use of combustible tobacco is not suggested as one of these methods.

Vaping is the use of an electronic nicotine delivery system (ENDS) to heat a liquid into an aerosol that is inhaled into the lungs. Many substances can be used with ENDS and may contain flavoring, nicotine, THC, and other harmful chemicals. These flavoring agents contain diacetyl, which is a known cause of bronchiolitis obliterans, commonly known as popcorn lung. Vaping has been associated with many cases of lung injury and even death. Pulmonary symptoms are most common including shortness of breath, wheezing, chest pain, and coughing, however, some cases have reported gastrointestinal issues such as nausea, vomiting, and diarrhea. Fever, fatigue, weight loss, and tachycardia have also been reported. Antibiotics have not been beneficial and corticosteroids have been helpful for symptom relief. Radiographic imaging can show bilateral pulmonary infiltrates or diffuse ground glass opacities.

These ENDS devices are not an FDA approved method for smoking cessation and have become popular among children and young adults. Nicotine is known to impair brain development in children therefore, it is especially important for this population to abstain from use. It is not recommended for children or any patient. Smokers should consider FDA approved methods for smoking cessation.

Conclusion

For this reason, PAs should consider EVALI in patients with pulmonary symptoms in the absence of an alternative diagnosis, especially in those with a history of vaping in the last 90 days. The CDC continues to research EVALI to discover the true cause of these illnesses and we support this investigation for the health and safety of our patients. We encourage all PAs to inquire about vaping use and to educate patients of the risk associated with use. We also encourage all PAs to report suspected cases to their local and state health departments to aid in identifying the cause.
References


Disparities in Maternal Morbidity and Mortality
(Adopted 2021)

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

- Maternal morbidity is one of the leading preventable causes of death worldwide.
- Collaborations between professional organizations, non-governmental organizations, and governmental agencies will be essential to end preventable maternal morbidity and mortality globally, and to close disparities in maternal health outcomes.
- Solutions for maternity care issues pertaining to pregnancy, childbirth, and the postpartum period should ensure:
  - all third-party payers cover the postpartum period for one year.
  - funding for clinical training on health inequity and implicit bias.
  - the development of broader networks of maternity care providers in rural areas and maternity care deserts.
  - further reduction in barriers to practice for PAs in obstetrics.
- Solutions for closing disparities in maternal health outcomes should ensure:
  - improvements in confidential surveillance methods (data collection processes and quality measures) that provide timely and accurate data on maternal mortality rates.
  - pregnancy medical home models which would include establishing relationships for high risk patients with healthcare coordinators and social services.
  - development and support for maternal morbidity and mortality review boards at a state/territory/DC level which provides protection to the providers.
  - critical investments in social determinants of health that influence maternal health outcomes, like housing, transportation, and nutrition.
  - funding to community-based organizations that are working to improve maternal health outcomes and promote equity.
  - study of the unique maternal health risks facing pregnant and postpartum veterans and support VA maternity care coordination programs.
  - Growth and diversification of the perinatal workforce to ensure that every mom in America receives culturally congruent maternity care and support.
  - Support for moms with maternal mental health conditions and substance use disorders.
  - Improvement of maternal healthcare and support for incarcerated moms.
• Investment in digital tools like telehealth to improve maternal health outcomes in underserved areas.

• Promotion of innovative payment models to incentivize high-quality maternity care and non-clinical perinatal support.

• Investment in federal programs to address the unique risks for and effects of COVID-19 during and after pregnancy and to advance respectful maternity care in future public health emergencies.

• Investment in community-based initiatives to reduce levels of and exposure to climate change-related risks for moms and babies.

• Promotion of maternal vaccinations to protect the health and safety of moms and babies.

**Introduction**

The term “maternal mortality” means a death occurring during or within a one-year period after pregnancy, caused by pregnancy-related or childbirth complications, including a suicide, overdose, or other death resulting from a mental health or substance use disorder attributed to or aggravated by pregnancy-related or childbirth complications. (1) Maternal mortality is one of the leading preventable causes of death worldwide that has been recognized as a public health crisis. Approximately 300,000 deaths occur globally each year from pregnancy, childbirth, and postpartum complications which is likely an undercount due to a lack of uniformity in data collection. (2)

**Global Burden**

In low resource settings, increased access to quality healthcare has improved the maternal mortality ratio ([MMR], number of maternal deaths per 100,00 live births), however, the vast disparities among different populations and demographics still exist, and 94% of maternal deaths remain in low and middle-income countries. (2,3) When discussing maternal morbidity and mortality on the global stage, it is important to consider the Sustainable Development Goals (SDGs) set forth by the United Nations, which include 17 goals with 169 targets that all UN Member States have agreed to work towards achieving by the year 2030; they set out a vision for a world free from poverty, hunger and disease. Maternal health is an included topic as part of Goal 3.1 which aims to “reduce the global maternal mortality ratio to less than 70 per 100,000 live births. (4)

**U.S. Statistics**

Among comparable developed countries, the United States (U.S.) has the highest maternal and infant mortality rates. Annually in the U.S., there are 700 deaths attributable to pregnancy or delivery complications, and short or long-term severe consequences to health are experienced by 50,000. (5) The term severe maternal morbidity (SMM) means a health condition, including mental health conditions and
substance use disorders, attributed to or aggravated by pregnancy or childbirth that results in significant short-term or long-term consequences to the health of the individual who was pregnant. (6) Both maternal mortality and SMM have been steadily increasing since 1993. The overall rate of SMM increased almost 200% from 49.5 in 1993 to 144.0 in 2014, driven in part by blood transfusions. (6) Excluding transfusions, the rate of SMM increased by about 20% over this period, from 28.6 in 1993 to 35.0 in 2014. (6) The two most common SMM procedures after blood transfusion are hysterectomy which has increased 55% over this period, and ventilation or temporary tracheostomy which increased by about 93%. (7) Additional factors that seem to compound these high rates of SMM include wide racial and ethnic disparities in maternal health outcomes as well as caps in maternity care services in many communities, particularly in rural areas. In the postpartum period, there is still a significantly high rate of maternal deaths due to preventable complications experienced during pregnancy, such as preterm labor, infections, and gestational diabetes. This further emphasizes the importance of expanding access to care beyond the traditional one postpartum visit.

Table 1. Causes of Pregnancy Related Death in the US: 2014-2017

During pregnancy, maternal comorbidities can be exacerbated, resulting in complications that could lead to death. Table 1 highlights some of the most common causes of pregnancy related deaths, which includes some chronic conditions as well. (8) For instance, cardiovascular events, cardiomyopathy, and strokes will increase in a patient with poorly controlled hypertension, diabetes, and chronic heart disease. Congenital heart disease, valvular heart disease, cardiomyopathy, and pulmonary hypertension also pose a risk for pregnant patients, and the prevalence among pregnant patients has increased significantly by 24.7% from 2003-2012. (9) Major adverse cardiac events (MACE) have also increased dramatically by 18.8% during the same period. (9) The racial disparities seen in cardiovascular complications in pregnancy is quite severe and are syndemic to all women of color with Black women being three to four times more likely to die from pregnancy-related causes than white women. Further discussion of racial disparities is followed below.
Racial Health Disparities

As Table 2 and 3 highlights, between 2014 to 2017, there were 41.7 pregnancy-related deaths per 100,000 live births in non-Hispanic Black patients, which is three times more than patients of Hispanic or Latinx origin (11.6). (8,10) Black women are 243% more likely to die from pregnancy or child-birth-related causes compared to white women. (10) This racial disparity has persisted for decades due to racism, sexism, and other systemic barriers that have contributed to income inequality.

Table 2. Pregnancy Related Mortality Ratio by Race/Ethnicity: 2014-2017

Although there are numerous factors which contribute to increased rates of maternal mortality, over ⅓ of them are related to hypertensive disorders. Other chronic conditions such as obesity are known to be associated with low socioeconomic status, which contributes to the increased rates of morbidity and mortality. Both obesity and low socioeconomic status are known to have increased prevalence in certain communities. (11) Known risk factors for conditions such as preeclampsia include the following: pre-existing hypertension, renal disease, obesity, and collagen vascular disorders. (11)
According to the American College of Obstetrics and Gynecology hypertensive disorders can be classified as: pre-eclampsia/eclampsia, chronic hypertension, chronic hypertension with superimposed preeclampsia, and gestational hypertension. The importance of community reproductive health education is highlighted when a woman is diagnosed with gestational hypertension or preeclampsia when normotension is seen in the second trimester is actually false and due to the normal physiological response to pregnancy. The prevalence of maternal hypertension is seen at different rates in the following populations: 2.2% Chinese, 2.9% Vietnamese, 8.9% American Indian/Alaska Native, and 8.9% African American. (11)

Through the use of billing data, a study involving 65,286,425 women helped identify that among those who were admitted for delivery, there were 7764 women diagnosed with stroke. (12) Among those diagnosed with pregnancy induced or gestational hypertension, Black and Hispanic mothers had higher stroke risk than non-Hispanic whites. Minority women with chronic hypertension, including Black, Hispanic, and Asian Pacific Islanders had a two times higher stroke risk. Among those who were normotensive, only Blacks had a higher incidence of stroke. (12)

Although the overall incidence of stroke has declined in the United States, maternal stroke affects 30 in 100,000 pregnancies with ⅓ occurring during the delivery hospitalization. (12) Multiple factors may be contributing to the increased events seen, including advanced maternal age, obesity, hypertension, and diabetes mellitus. The longstanding impact of stroke not only affects quality of life but also has financial impacts as well as prolonged disability. The impact of disease states which have been considered preventable are significant. Case reviews suggest that 30-60% of the pre-eclampsia deaths were attributed to intracranial hemorrhage and with timely treatment with antihypertensive medications pregnancy morbidity and mortality can be reduced.

**Surveillance in the U.S.**

The U.S. utilizes two main national surveillance and reporting systems. The Center for Disease Control and Prevention (CDC) National Vital Statistics System (NVSS) is a federal system that provides maternal mortality ratios based on death certificate information, but it does not include deaths occurring after 43 days of delivery. The Pregnancy Mortality Surveillance System (PMSS) is specifically for pregnancy-related deaths and depends on states to submit data for patients ages 12 to 55 who died within one year of pregnancy. In fact, data on maternal deaths is submitted on a voluntary basis and some states choose to opt-out. (13)

The United States has only recently joined the rest of the developed world in establishing an infrastructure for systematically assessing maternal deaths. On December 21, 2018, the Preventing Maternal Deaths Act (HR 1318) was signed into law. This legislation sets up a federal infrastructure and allocates resources to collect and analyze data on every maternal death in every state. The bill intended to
establish and support existing maternal mortality review committees (MMRCs) in states and tribal nations across the country through federal funding and reporting of standardized data.

Using the data gathered, MMRCs are optimized when they provide recommendations and develop strategies to prevent problems that arise during the prenatal and postpartum periods. While all MMRCs collect information to try to understand factors related to deaths during pregnancy, delivery, and the postpartum period, including healthcare and clinical factors, some also focus on social determinants of health, such as housing, food access, violence, community safety, structural racism, and economic circumstances.

Many state committees consist of public-private partnerships involving health providers, the state department of health staff, and representatives from maternal and child health-related organizations. In 2016, a collaboration among the Association of Maternal & Child Health Programs, the Centers for Disease Control and Prevention (CDC) Foundation, and the CDC’s Division of Reproductive Health initiated the Building US Capacity to Review and Prevent Maternal Deaths program, an effort aimed at assisting states in launching and improving the capacity of MMRCs.

In 2019, the status of maternal mortality reviews across the United States remained inconsistent. Thirty-eight states had active MMRCs recognized by the CDC. Several more recently passed laws but had not yet begun reviewing cases. A total of 46 states and the District of Columbia held some level of maternal death review, a steady increase from the 22 committees that existed in 2010. Authorization is in place in 33 states and the District of Columbia that codifies these committees in the statute.

Even where MMRC’s exist, state MMRCs currently vary in how data is collected, which data is collected, how frequently it is reported, and to whom, and who has access to maternal mortality data. This variability affects the nature of the evidence collected and the conclusions that can be drawn from the work of MMRCs. State laws and regulations also vary in describing the potential or required uses of information gleaned from these committees and any next steps or actions. For example, some states only mandate review and development of internal reports with no required action, while other states also mandate follow-up action via system-level changes. A few states experiencing small numbers of maternal deaths have either expanded their MMRCs to include severe maternal morbidity or have combined review of maternal deaths with other death reviews such as fetal and infant mortality reviews.

**Social Determinants of Health**

The term social determinants of maternal health mean non-clinical factors that impact maternal health outcomes, including:

(A) economic factors, which may include poverty, employment, food security, support for and access to lactation and other infant feeding options, housing stability, and related factors;
(B) neighborhood factors, which may include quality of housing, access to transportation, access to childcare, availability of healthy foods and nutrition counseling, availability of clean water, air and water quality, ambient temperatures, neighborhood crime and violence, access to broadband, and related factors;

(C) social and community factors, which may include systemic racism, gender discrimination or discrimination based on other protected classes, workplace conditions, incarceration, and related factors;

(D) household factors, which may include ability to conduct lead testing and abatement, car seat installation, indoor air temperatures, and related factors;

(E) education access and quality factors, which may include educational attainment, language and literacy, and related factors; and

(F) healthcare access factors, including health insurance coverage, access to culturally congruent healthcare services, providers, and non-clinical support, access to home visiting services, access to wellness and stress management programs, health literacy, access to telehealth and items required to receive telehealth services, and related factors.

**Historic Structural Racism in the U.S**

Structural racism is defined as a system where public policies, institutional policies, and cultural representations work to reinforce and perpetuate racial inequity. (17) Distrust of the healthcare systems exists among Black patients in the United States, initiated by a history of reproductive oppression and slavery. In the south, slave owners collaborated with physicians to manage Black women's fertility with surgical procedures to reproductive organs, which had a two-fold consequence of increased slave breeding and medical experimentation on Black women. Dr. James Marion Sims, dubbed the father of gynecology, is well known to have experimented on enslaved Black women such as Anarcha, Lucy, Betsey, and others. (15) Black women were utilized to test new surgical instruments and techniques. Morphine was employed to reduce their screams during invasive vaginal surgeries which were conducted without anesthesia or consent. Through the 19th century, a new movement of eugenics and forced sterilization on Black women became vogue as a means of social-sexual control by eliminating those perceived to be inferior or expendable. The resulting lack of trust in the healthcare system and the government is understandable for these reasons. This mistrust has led to delay in seeking care, resulting in complications that progress unmanaged until it is too late. (15)

The Three Delays model, used widely to investigate events contributing to maternal deaths, began with the work of Thaddeus and Maine. This model acknowledges delay in seeking care, delay in arrival to an appropriate medical care facility, and delay in receiving adequate care once in the medical facility. (16) Recent efforts have been made to improve on this model, including, identifying near misses that could
have led to maternal death more rapidly. (16) Utilizing the three delays model in combination with this near miss approach, aims to reduce maternal mortality.

**Current Structural Factors**

Structural factors that currently inform maternal health disparities in the US include State-level opt-outs Medicaid expansion (in particular, in the South) after the implementation of the Patient Protection and Affordable Care Act. Among these states, those with the highest MMRs include Georgia (46.2 maternal deaths per 100,000 live births overall, and 66.6 maternal deaths per 100,000 live births among Black women), Louisiana (44.8 maternal deaths per 100,000 live births overall, 72.6 per 100,000 live births among Black women). (17)

Compounding this disparity is a limit of 60 days for postpartum coverage by Medicaid. Medicaid pays for more than four in ten births nationally and is the focus of some federal and state efforts to improve maternity care. Federal law requires that all states expand Medicaid eligibility to pregnant patients with incomes up to 138% of the federal poverty level ($29,435 annually for a family of three). (18) Pregnancy related coverage must last through 60 days postpartum or qualify for federal subsidies to purchase coverage through ACA Marketplace plans. However, in the states that have not adopted the ACA’s Medicaid expansion, postpartum patients need to re-qualify for Medicaid as parents to stay on the program, but eligibility levels for parents are much lower than for pregnant patients. As a result, many parents in non-expansion states become uninsured after pregnancy related coverage ends 60 days postpartum because, even though they are low income, their income is still too high to qualify for Medicaid as parents. (18) Approximately half of all maternal deaths occur up to a year postpartum. Coverage during this vulnerable time is essential to preventing MMR and SMM. (18)

Delay in arrival to an appropriate medical care facility is partially due to structural racism, perpetuating racial disparities. Economic inequality greatly impacts a woman’s ability to seek quality medical care. It has been noted that African American women earn approximately 63 cents for every dollar earned by White, non-Hispanic men. (19)

People of color are frequently segregated in communities that lack quality health facilities and providers, experience food deserts that lack nutritious food options, and live in hazardous housing conditions in un-walkable neighborhoods. Economic barriers impact the decisions as to which neighborhoods one lives and highlights the need for more affordable housing options for individuals with low income. (20) Black and Latinx communities are more likely to experience "maternity care deserts" where hospital systems close down without appropriate alternatives. In addition, although lifestyle changes such as exercise are often recommended for chronic conditions such as hypertension, diabetes, and obesity, many women are living in environments that are not conducive to safe performance of these activities. (11)
Delay in receiving adequate care once in an appropriate medical facility has been most notably framed as the Swiss cheese model of system failures proposed by James Reason. This model is used in risk analysis and mitigation to examine and review medical errors and safety incidents. Swiss cheese is a metaphor for slices representing human systems and organizational defenses and the holes are weaknesses or individual system errors. (21) By identifying the areas of weakness or “holes”, a system can aim to reduce maternal morbidity and mortality. Reported areas of improvement include communication, preparing for rare critical events through simulation training, developing protocols for important medications used in labor and delivery, increasing hospitalist coverage, developing an effective departmental infrastructure that includes effective peer review, providing risk management education about high-risk clinical areas that have the potential to result in catastrophic injury, and staffing the unit for all contingencies during all hours, day and night. (22)

Another potential cause of delay is in the inadequate availability of qualified medical care practitioners. Physician Associates (PAs) are well situated to respond to the need for obstetric care as PAs are uniquely trained in a medical model and through lifelong learning, remain knowledgeable, versatile, and adaptable across primary care and specialty settings. (23,24) This unique professional design enables PAs to address medical comorbidities in reproductive age patients and provide quality maternity care. PAs demonstrate competence in all primary medicine disciplines and stay abreast of medical management, including cardiac, pulmonary, gastrointestinal, and rheumatologic diseases. Thus, for example, when 27% of maternal deaths are noted to be cardiac-related, a medically-trained PA that remains proficient in the identification and management of cardiac illness is important. PAs enhance access to medical care in urban, suburban, and in particular, rural areas, as more than half of all rural counties have no hospital that offers maternity care. Additionally, PAs are qualified to quickly identify potential threats to maternal health and provide the appropriate medical care promptly or mobilize patients to the proper facilities if their facility does not offer a particular service.

**Conclusion**

Maternal morbidity is one of the leading preventable causes of death worldwide. Solutions for maternity care issues pertaining to pregnancy, childbirth and the postpartum period should ensure all third-party payers cover the postpartum period for one year, funding for clinical training on health inequity and implicit bias, developing broader networks of maternity care providers in rural areas and maternity care deserts, and further reduction in barriers to practice for PAs in obstetrics, as well as improvements in confidential surveillance methods (data collection processes and quality measures) that provide timely and accurate data on maternal mortality rates.

Solutions for closing disparities in maternal health outcomes should ensure: assistance in providing access for mothers to quality nutrition; pregnancy medical home models which would include
establishing relationships for high risk patients with healthcare coordinators and social services; development and support for maternal morbidity and mortality review boards at a state/territory/DC level which provides protection to the providers; critical investments in social determinants of health that influence maternal health outcomes, like housing, transportation, and nutrition; funding to community-based organizations that are working to improve maternal health outcomes and promote equity; study of the unique maternal health risks facing pregnant and postpartum veterans and support VA maternity care coordination programs; growth and diversification of the perinatal workforce to ensure that every mom in America receives culturally congruent maternity care and support; support for moms with maternal mental health conditions and substance use disorders; improvement of maternal healthcare and support for incarcerated moms; investment in digital tools like telehealth to improve maternal health outcomes in underserved areas; promotion of innovative payment models to incentivize high-quality maternity care and non-clinical perinatal support; investment in federal programs to address the unique risks for and effects of COVID-19 during and after pregnancy and to advance respectful maternity care in future public health emergencies; investment in community-based initiatives to reduce levels of and exposure to climate change-related risks for moms and babies; and promotion of maternal vaccinations to protect the health and safety of moms and babies.

Collaborations between professional organizations, non-governmental organizations and governmental agencies will be essential to end preventable maternal morbidity and mortality globally, and to close disparities in maternal health outcomes.

References


Supporting PA Practice in Settings External to Clinics and Hospitals:
Adoption of Home-centered Care
(Adopted 2021)

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

- AAPA believes that PAs have the skillset to offer primary and specialty care to a patient in the comfort of the patient’s home. AAPA adopts the term home-centered care to describe the medical care rendered by a certified clinician to a patient in a setting external to a hospital or traditional outpatient clinic. Existing delivery models include telemedicine and house calls, and other innovative medical care delivery models could be included as they are developed.
- AAPA supports PA knowledge of home-centered care by supporting initiatives to expand affordable access to telemedicine and house calls. AAPA will promote primary and continuing medical education for PAs seeking more information regarding home-centered care.
- AAPA encourages facilities and third-party payors to promote (a) utilization of home-centered care (b) advocate for the PA’s ability to safely deliver home centered care to stake-holders (c) advocate for reimbursement and malpractice insurance to PAs at parity to other clinicians providing home-centered care (d) promote business and infrastructure development that embraces home-centered care.
- AAPA believes that removing barriers to PA practice in this setting - such as geographic proximity requirements to collaborating physicians or patients when providing medical services - will substantially increase affordability, patient access to care, and encourage more PAs to engage in home-centered care.

When it comes to improving healthcare, PAs are called to lead the charge. PAs are “versatile and cost-effective clinicians” (Cawley, 1), a characteristic that proved its wide-spread recognition when the Centers for Medicare and Medicaid Services (CMS) granted significant ordering rights to PAs as part of the COVID-19 pandemic response. As discussed in two AAPA white papers, CMS recognizes and reimburses PAs’ orders for Home Healthcare (“Telehealth & Telemedicine by PAs During the COVID-19 Pandemic”) and has developed a robust reimbursement schedule for telehealth and telemedicine services (“PAs and Home Health”). However, those nearly instantaneous grants are shadowed by an expiration date. In keeping with AAPA’s efforts to make these solutions permanent, PAs should continue to express that they have the training, versatility, and resilience to deliver medical care through evolving, extra-clinical and extra-hospital medical delivery platforms. In addition, other reimbursement stake-holders and
policy makers that have influence over PA scope of practice could appreciate PAs’ flexibility more completely if AAPA is able to succinctly express that PAs are already competent to deliver care safely and effectively over these platforms. Therefore, AAPA recommends the adoption of a term called home-centered care to describe the extra-clinical and extra-hospital settings wherein medical care can be safely provided between provider and patient.

**Definition of “home-centered care” and inclusive delivery models:**

“Home-centered care” is the delivery of medical care rendered by a certified clinician to a patient in a setting external to a hospital or traditional outpatient clinic. The types of medical practice acceptable for these settings is identical to that in the “outpatient” setting: chronic and acute care for both primary providers and specialist providers. At present, both telemedicine and house calls are established examples of home-centered care.

**Rationale for development of term “home-centered care”:**

Despite the well-established use of house calls and the rapidly expanding use of telemedicine, significant legislative and practical restrictions must be overcome to achieve optimal use of these delivery models. Current stigma, inconsistent marketing terminology, and disproportionate adoption of these platforms are all factors that AAPA could be reduced by utilizing a single term to describe the broader applicability of delivering care in the home.

AAPA believes that adoption of home-centered care will be acceptable to clinician groups and stakeholders. This term promotes the utilization of available and affordable technologies to improve patient experience and provider satisfaction. For example, home-centered care is consistent with the American Medical Association’s (AMA) “Patient Centered Medical Home” model to “include care for [the patient] across all stages of life by managing acute and chronic illness, providing preventative services, and end of life care.” Additionally, the AMA believes the best and safest care involves collaboration “... with an interdisciplinary team, the patient, and the patient’s community to navigate the course of treatment” (“Principles of the Patient Centered Medical Home”), which includes the PAs involvement. As patients adopt the philosophy of the patient-centered medical home, the medical field is seeing the consumer market demand flexible and transparent access to medical care. To deliver a more complete menu of options in the patient-centered medical home, AAPA believes that literal acknowledgement of safe and effective home-centered care delivery models should be promoted.

AAPA believes that the definitions of “home” and “homebound” should be given by the medical community. At present, these definitions have been generated by insurance companies to dictate the scope of their reimbursement. In having definitions only from the insurance companies, the definitions have become cemented walls that have defined a provider’s scope of practice and limited innovation. As above, the COVID-19 pandemic demonstrated that the providers, patients, and medical delivery platforms
are there - sustainable and existing. What is not present at the moment are statements from the medical community that extend the definitions of “home” and “homebound” beyond the definitions created for reimbursement purposes. As PAs, we will define these terms for medical services.

**Definition of “home”:**

The “home” is defined as the location of the patient seeking medical services outside of a hospital or clinic. AAPA believes that it is reasonable to consider a patient’s “home” to include a patient’s place of employment or school; a dedicated room in a public facility with Wi-Fi capability (e.g., a library or police station); or other physical location where a HIPAA-compliant software/hardware is secured and the patient confirms attests that they have achieved sufficient privacy for medical evaluation. This broad and less restrictive definition of home, with complimentary leniency to defining “homebound” (below), promotes convenient, quality access to care for individuals regardless of location.

**Definition of “homebound” and candidacy for home-centered care services:**

AAPA will loosely define “homebound” as the condition wherein the patient prefers or requires medical care to be delivered in a setting external to a hospital or a clinic.

To encourage elective utilization of home-centered care, AAPA encourages the use of CMS definitions for “homebound” effective 2019, which states that the medical necessity for medical delivery in the home (as we now define as “home-centered care”) will be left to the discretion of the provider and/or patient, and there is no longer a requirement to document a justification for why medical care was delivered in the home in lieu of the office (“Medicare Program; revisions to Payment Policies Under the Physician Fee Schedule and Other revisions to Part B for CT 2019”).

The above statement appears to be a logical definition to the medical provider: the majority of treatment decisions and medical decisions regarding where care is delivered is ultimately left to the discretion of the medical provider. However, the provider can see that the definition for “homebound” was significantly more restrictive until this new definition was ratified. For example, the 2014 definition of ‘homebound” as defined by Medicare’s CMS Manual System, Chapter 15, is already unrecognizable compared to the 2019 version: The 2014 version of “homebound” includes only patients with physical limitations due to “need for supportive devices”, “assistance of another person to leave their place of residence”, “having a condition such that leaving the home is contraindicated”, or psychologically limited in a debilitating manner (“Definition of Homebound Patient Under the Medicare Home Health (HH) Benefit”, p. 5-6). The 2014 Medicare definitions for reimbursement also stated that “feebleness or insecurity brought on by advanced age would not meet one of the conditions…” (p. 6), but this restriction is now obsolete. The 2019 Medicare Physician Fee Schedule Final Rule advised that the medical necessity for medical delivery in the home will be left to the discretion of the provider and/or patient, and there is no longer a requirement to document a justification for why medical care was delivered in the
home in lieu of the office (“Medicare Program; revisions to Payment Policies Under the Physician Fee Schedule and Other revisions to Part B for CT 2019”). This is a trend that is already influencing the market. In fact, several third-party payors have capitalized on the market-advantage, convenience, and cost-effectiveness of home-centered care delivery models (Lakin) (Landi) (Donolan). It is therefore clear that the term “homebound” is becoming less of a factor in determining a patient’s candidacy for home-centered care, and it is also clear that the definitions created by important stake-holder have a significant influence on the practical application of medical care.

Additional definitions:

Establishing consistent terminology aids employers, providers, and patients communicate their needs more effectively. AAPA acknowledges several acceptable, interchangeable terms in the marketplace to describe home-centered care services, as well as similar terms that do not describe the PA’s role within the healthcare team. AAPA believes that the following are acceptable, market-approved terms to describe the home-centered care delivery models that a PA can provide as of August 2020 in the United States of America:

**Acceptable Synonyms for telemedicine:** “Remote medicine”, “Virtual Medicine”

**Similar, but inappropriate terms for the PA’s clinical services include:** “telehealth”.

Telemedicine services involve the use of electronic communication and software to provide clinical services remotely. Medical care can only be provided by a clinician. In contrast, telehealth describes the delivery of non-clinical services, such as public health functions, surveillance, and provider training, in addition to medical services (“What’s the difference between telemedicine and telehealth?”). AAPA does not recommend that “telehealth” is used to describe the PA’s role in home-centered care.

**Acceptable Synonyms for house calls:** None

**Similar, but inappropriate terms for the PA’s clinical services include:** “home care”, “home healthcare”, “home visits”.

These terms include an array of services associated with skilled nursing or short-term rehabilitation services that are supplemental to the medical care that a PA or certified provider can provide (“Medicare & Home Health Care”). AAPA does not recommend that “home care”, “home healthcare”, or “home visits” are used to describe the PA’s role in home-centered care.

**Conclusion**

AAPA supports the utilization of the term home-centered care to succinctly describe extra-clinical and extra-hospital medical care delivery between clinicians and patients. Third-party payors have defined the terms of engagement between patient and provider using business-motivated logic and it is time for the medical community to explain that we have the skills, the software, the hardware, the community resources, and the innate training to open home-centered care to all patients in all specialties,
as appropriate per the condition of the patient. Using the term home-centered care can help promote imagination and innovation during legislation hearings, moving the conversation beyond the refining grossly archaic practice restrictions for house calls and the naive fears for safety & efficacy during virtual visits. In addition, home-centered care can encourage innovation in other areas of medicine - ones that cannot be perceived yet today, but could be a critical component in the future of medicine. PAs are already seeing the market demand more flexible and reliable access to care, and this policy is an affirmation that PAs can lead the conversation to do exactly that.

References


<https://www.fiercehealthcare.com/tech/rising-demand-for-home-healthcare-dispatch-health-scores-135m-funding-round-led-by-optum?mkt_tok=eyJpIjoiTVdKaU16VmlOR0ZpTVRjeiIsInQiOiJjWTQzNlwvQ1N1NmdHbGZKcUx2ZWV4NG1NbW0yZFhqMFFEQ1lxbVhMNVN2RXBBN3pFdUdZOU5GZmo1ZUhocGlxRXVmc0x5MTN5RmN2NXNKXC9bXZlMVwZmk4MDBySGlMITVYWlFldFYxeVJQZlZudWlwd0hld21qMXArXC94U1RuYU12ZHdSblwvbjNFQml6ZFRpd3ZVVDI5dz09In0%3D&m rkid=75136914>. Accessed July 27, 2020.

