

2025-2026 Policy Manual



American Academy of Physician Associates

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.

Table of Contents

Bylaws

Article I – Name.....	9
Article II – Purpose and Mission	9
Article III – Membership	9
Article IV – Constituent Organizations	11
Article V – Student Academy of AAPA	11
Article VI – House of Delegates	12
Article VII – Board of Directors and Officers of the Corporation.....	14
Article VIII – Chief Executive Officer	17
Article IX – Judicial Affairs	17
Article X – Standing Committees, Board Committees, Academy Commissions, Work Groups, Task Forces, Ad Hoc Groups	17
Article XI – Nominating Committee	20
Article XII – Rules of Order	21
Article XIII – Elections.....	21
Article XIV – Bylaws Amendments	23

Standing Rules

SR-1000 House of Delegates Standing Rules	25
SR-1100 Philosophy of Parliamentary Procedures & Standing Rules.....	25
SR-1150 HOD Guidelines of Decorum	26
SR-1200 Policy Manual	26
SR-1300 Annual Reports	27
SR-2000 House of Delegates - General	27
SR-2100 Duties and Responsibilities.....	27
SR-2200 Composition.....	28
SR-2300 Meetings and Rules of Order.....	29
SR-2400 Order of Business	32
SR-2500 Officers	32
SR-2600 Appointed House Positions.....	32
SR-2700 House of Delegates Committees.....	32
SR-2800 Conference Committees.....	33
SR-2900 Elections	33
SR-3000 Resolutions	34
SR-3100 House Awards.....	37
SR-3200 Reference Committees.....	37
SR-4000 Rules Specific to In-Person Meetings.....	38
SR-4100 In-Person Meeting General.....	38
SR-5000 Electronic Vote Separate from a Meeting/Virtual Meeting General Rules	38
SR-5100 Rules Specific to an Electronic Vote Occurring Separate from a HOD Meeting ...	39
SR-5200 Rules Specific to a Virtual Meeting.....	39

House Academy Policy

HA-2000.00 Academy/Organization	41
HA-2100.0 House Academy	41
HA-2100.1.0 Educational Philosophy	41
HA-2100.2.0 Leadership.....	41

Board Academy Policy

BA-2200.00 Academy/Organization – Definition	41
BA-2300.00 Constituent Organizations	41
BA-2300.1.0 Constituent Organizations, General	41
BA-2300.2.0 Chapter Rules	42
BA-2300.3.0 Relationship to AAPA	42
BA-2300.4.0 Chartering Guidelines	43
BA-2300.5.0 Specialty Organizations	43
BA-2300.6.0 Caucuses	45
BA-2300.7.0 Special Interest Groups	46
BA-2400.00 Academy Organization – Governance	47
BA-2400.1.0 General	47
BA-2400.2.0 Student Academy	47
BA-2400.3.0 Commissions, Work Groups, and Task Forces	47
BA-2400.4.0 Commissions and Work Groups – Charges	48
BA-2400.5.0 Board of Directors	53
BA-2400.6.0 Healthcare Organization Liaisons	53
BA-2500.00 Academy/Organization – Operations	54
BA-2500.1.0 Academy Rules	54
BA-2500.2.0 Membership/Membership Services	55
BA-2500.3.0 Information on the Profession	55
BA-2500.4.0 Strategic Goals	55
BA-2500.5.0 Public Statements	56
BA-2600.00 Elections	57
BA-2600.1.0 Rules & Regulations for Election of Officers and Directors-at-Large – Elections/Voting	57
BA-2800.00 Judicial Affairs Commission	57
BA-2800.1.0 Complaints	57
BA-2800.1.1 AAPA Complaint Procedures	57
BA-2800.3.0 Adjudication Procedures for the Discipline of Elected Officials of the Academy	57

House Profession Policy

HP-3000 Profession	57
HP-3200 Title	57
HP-3400 Role	58
HP-3600 PA Organizations	59
HP-3610 General	59
HP-3620 NCCPA	59
HP-3630 Political Action Committee	59
HP-3640 Physician Assistant History Society	60
HP-4000 PA Education	60
HP-4200 Entry-Level	60
HP-4220 Program Accreditation	60
HP-4240 Curriculum	60
HP-4260 Degree	62
HP-4280 Recruitment and Retention	62
HP-4300 PA Education Funding	63
HP-4400 Postgraduate Education	64
HP-4600 Specialty Certification	64
HP-4800 Continuing Education	64

HP-5000 Professional Practice.....	65
HP-5200 Clinical Competency	66
HP-5400 Non-Clinical Roles	66
HP-5600 Healthcare Systems	67
HP-5620 General.....	67
HP-5640 PA Utilization and Workforce	68
HP-5680 Managed Care.....	69
HP-5800 Regulation/Certification	70
HP-5820 Credentialing/Privileges.....	70
HP-5840 Certification	70
HP-5860 Licensure.....	71
HP-5880 Regulations/Rules	71
HP-6000 PA Employment	72
HP-6020 Practice Ownership	72
HP-6040 Contracts/Compensation	72
HP-6200 International Education/Practice.....	73
HP-6400 Uniformed Services	73
HP-6420 Active Duty.....	73
HP-6440 Veterans	74
HP-6600 Direct to Consumer Interactions.....	74
HP-6800 Reimbursement.....	75
HP-7000 Ethics/Behavior	76
HP-7020 General.....	76
HP-7024 PA Oath.....	76
HP-7040 Disciplinary Process	77
HP-7200 PA Health and Wellness.....	77
HP-7220 Occupational Safety.....	77
HP-7240 Personal Wellness	78
HP-7400 Quality Assurance	78
HP-7420 General.....	78
HP-7440 Risk Management	79
HP-8000 Practice Standards	79
HP-8200 Access to Care	79
HP-8220 General.....	79
HP-8240 Health Disparity.....	81
HP-8260 Rural Health.....	82
HP-8280 Public Health Crisis/Disaster Response.....	82
HP-8300 Prescription Medication.....	82
HP-8320 Immigrant Health.....	83
HP-8400 Technology	84
HP-8420 Information Technology	84
HP-8430 Artificial Intelligence.....	84
HP-8440 Point-of-Care Ultrasound.....	85
HP-8460 Wearable Technology	85
HP-8600 Human Rights.....	86
HP-8800 Diversity, Equity, and Inclusion.....	87
HP-9000 Clinical Standards.....	88
HP-9200 General	88
HP-9400 Preventive Medicine.....	89
HP-9600 Health Literacy	90
HP-9800 Safety.....	90

HP-9820 General.....	90
HP-9840 Motor Vehicles	91
HP-9860 Restraints and Seclusion	91
HP-9880 Violence.....	91
HP-10000 Substance Use Disorder.....	93
HP-10020 General.....	93
HP-10040 Alcohol	94
HP-10060 Cannabinoids	94
HP-10080 Opioids.....	95
HP-10100 Performance Enhancing Drugs	96
HP-10120 Tobacco.....	97
HP-10200 Alternative Medicine	97
HP-10400 “Conversion or Reparative” Therapy	97
HP-10600 Correctional Healthcare.....	97
HP-10800 Emergency Medicine.....	98
HP-11000 Environmental Health.....	99
HP-11200 Genetics and Genomics	96
HP-11400 Infectious Disease.....	100
HP-11420 General.....	100
HP-11440 Antimicrobial Resistance.....	100
HP-11460 HIV/AIDS	101
HP-11480 Hepatitis C	101
HP-11490 Tuberculosis.....	101
HP-11600 Mental Health.....	101
HP-11800 Neurology	102
HP-12000 Obesity.....	102
HP-12200 Oral Health	103
HP-12400 Organ Donation	103
HP-12600 Palliative Care/End of Life	103
HP-12800 Pediatrics	104
HP-13000 Reproductive Health/Obstetrics and Gynecology	104
HP-13200 Virtual Medicine/Telehealth.....	105

Policy Papers

- 1) Promoting the Access, Coverage and Delivery of Healthcare Services (Adopted 2018, reaffirmed 2023)
Cited at HP-8228 – paper on page 106
- 2) Accreditation and Implications of Clinical Postgraduate PA Training Programs (Adopted 2005, amended 2010, 2016, 2018, 2023)
Cited at HP-4420 – paper on page 109
- 3) Guidelines for Updating Medical Staff Bylaws: Credentialing and Privileging PAs (Adopted 2012, amended 2017, 2018, 2023)
Cited at HP-5828 – paper on page 116
- 4) Guidelines for State and Territory Regulation of PAs (Adopted 1988, amended 1993, 1998, 2001, 2005, 2006, 2009, 2011, 2013, 2016, 2017, 2022)
Cited at HP-5884 – paper on page 127

- 5) Guidelines for the PA Serving as an Expert Witness (Adopted 1977, reaffirmed 2004, 2009, amended 1987, 1991, 2001, 2014, 2018, 2023)
Cited at HP-5520 – paper on page 134
- 6) Immunizations in Children and Adults (Adopted 1994, amended 2004, 2006, 2011, 2016, 2018, 2022)
Cited at HP-9520 – paper on page 138
- 7) PAs as Medical Review Officers (Adopted 1991, reaffirmed 2009, 2014, 2019, amended 2004, 2024)
Cited at HP-5662 – paper on page 145
- 8) PA Impairment and Well-being (Adopted 1990, reaffirmed 2004, 2014, amended 1992, 2009, 2019, 2024)
Cited at HP-7244 – paper on page 147
- 9) PAs as Medicaid Managed Care Providers (Adopted 1996, reaffirmed 2004, 2014, amended 1997, 2009, 2019, 2024)
Cited at HP-5682 – paper on page 150
- 10) Professional Clinical Competence (Adopted 1996, amended 2005, 2010, 2015, 2025, reaffirmed 2020)
Cited at HP-5240 – paper on page 154
- 11) The PA in Disaster Response: Core Guidelines (Adopted 2006, amended 2010, 2015, 2022)
Cited at HP-8282 – paper on page 158
- 12) Rural Health Clinics (Adopted 1997, reaffirmed 2014, 2019, amended 2004, 2009, 2024)
Cited at HP-8266 – paper on page 171
- 13) Guidelines for Ethical Conduct for the PA Profession (Adopted 2000, reaffirmed 2013, 2023, amended 2004, 2006, 2007, 2008, 2018, 2024)
Cited at BA-2300.1.3, and HP-7026 – paper on page 175
- 15) Specialty Certification, Clinical Flexibility, and Adaptability (Adopted 2017, amended 2022)
Cited at HP-4640 – paper on page 188
- 16) Use of Medical Interpreters for Patients with Limited English Proficiency (Adopted 2003, amended 2018, reaffirmed 2008, 2013, 2023)
Cited at HP-8223 – paper on page 198
- 17) Competencies for the PA Profession (Adopted 2005, reaffirmed 2010, 2018, amended 2013, 2021)
Cited at HP-5260 – paper on page 201
- 18) Health Literacy: Broadening Definitions, Intensifying Partnerships and Identifying Resources (Adopted 2006, amended 2011, 2016, reaffirmed 2021)
Cited at HP-9640 – paper on page 208

- 19) The Role of In-Store or Retail-Based Convenient Care Clinics (Adopted 2017, amended 2022)
Cited at HP-5628 – paper on page 215
- 20) False or Deceptive Healthcare Advertising (Adopted 2007, reaffirmed 2012, 2017, amended 2022)
Cited at HP-6640 – paper on page 218
- 21) Acknowledging and Apologizing for Adverse Outcomes (Adopted 2007, amended 2013, 2018, reaffirmed 2012, 2023)
Cited at HP-7444 – paper on page 220
- 22) Routine Vaccination for Human Papillomavirus (Adopted 2008, amended 2012, 2017, reaffirmed 2022)
Cited at HP-9500 – paper on page 223
- 23) Health Disparities: Promoting the Equitable Treatment of All Patients (Adopted 2011, amended 2016, reaffirmed 2021)
Cited at HP-8248 – paper on page 226
- 24) Proliferation and Dispersal of Anti-personnel Weapons (Adopted 2012, reaffirmed 2017, 2022)
Cited at HP-9898 – paper on page 231
- 25) Telemedicine (Adopted 2015, amended 2021)
Cited at HP-13260 – paper on page 234
- 26) Tobacco Use Disorder (Adopted 2016, amended 2021)
Cited at HP-10122 – paper on page 242
- 27) PA Student Supervised Clinical Practice Experiences - Recommendations to Address Barriers (Adopted 2017, amended 2018, 2021, 2022, 2025)
Cited at HP-4248 – paper on page 250
- 28) Attempts to Change a Minor's Sexual Orientation, Gender Identity, or Gender Expression (Adopted 2017, reaffirmed 2022)
Cited at HP-10440 – paper on page 264
- 29) Human Trafficking in the United States (Adopted 2019, amended 2024)
Cited at HP-8780 – paper on page 267
- 30) Non-Physician Licensure for Medical School Graduates (Adopted 2019, amended 2024)
Cited at HP-5862 – paper on page 275
- 31) Genetic and Genomic Testing (Adopted 2019, amended 2024)
Cited at HP-11220 – paper on page 278
- 32) Medications in Children (Adopted 2019, amended 2024)
Cited at HP-12840 – paper on page 283
- 33) Vaping: Use of Electronic Nicotine Delivery Systems (Adopted 2020, reaffirmed 2025)
Cited at HP-10124 – paper on page 287

- 34) Disparities in Maternal Morbidity and Mortality (Adopted 2021)
Cited at HP-13080 – paper on page 289
- 35) Supporting PA Practice in Settings External to Clinics and Hospitals: Adoption of Home-centered Care (Adopted 2021)
Cited at HP-5658 – paper on page 301
- 36) Support for Co-parent or Second Parent Adoptions Regardless of Gender (Adopted 2004, reaffirmed 2009, amended 2015, 2021)
Cited at HP-12860 – paper on page 307
- 37) Licensure Eligibility for PAs Trained Abroad (Adopted 2004, amended 2009, 2018, reaffirmed 2014, 2023)
Cited at HP-6220 – paper on page 309
- 38) Diversity and Inclusion in PA Education (Adopted 2004, reaffirmed 2009, 2014, amended 2021)
Cited at HP-4286 – paper on page 315
- 39) Global Epidemic HIV/AIDS (Adopted 2005, amended 2010, 2015, 2020, 2022)
Cited at HP-11464 – paper on page 323
- 40) Scientific Integrity and Public Policy (Adopted 2005, amended 2010, 2015, 2020, reaffirmed 2025)
Cited at HP-9260 – paper on page 333
- 41) Quality Incentive Programs (Adopted 2005, reaffirmed 2010, 2015, amended 2021)
Cited at HP-7426 – paper on page 335

AAPA BYLAWS

[Adopted by revision 2005 and 2010, amended 2006, 2009, 2011, 2012, 2014, 2015, 2016, 2017, 2018, 2019, 2021, 2022, 2023, 2024, 2025]

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 board 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, 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, representatives of businesses engaged in selling products or services to PAs, or individuals who do not qualify for any other membership category and desire to associate with the Academy. Affiliate members shall not be entitled to vote or hold office.

Section 6: 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 7: Retired Members. A retired member shall be a PA who is a former fellow member who has chosen to retire from the profession and opts to be classified as a retired member. Retired members shall be entitled to vote but shall not hold office.

Section 8: 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 9: 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 10: 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 11: Non-Discriminatory Policy. AAPA will remain non-discriminatory in granting membership.

Section 12: Annual Meeting. There shall be an annual meeting of members to be held at such time and place (in person or electronically) as may be determined by the Board of Directors. Notice of the place, date, and time of the annual meeting shall be given to members at least 30 days but not more than 60 days before the meeting date. Notice may be delivered by electronic means.

Section 13: Special Meetings. Special meetings of members who are eligible to elect directors and officers may be held as necessary by the Academy.

- a) The Board of Directors or 10 percent of the membership may call a special meeting of members.
- b) The notice for a special meeting will indicate when, where, by what means the meeting will be held (in person or electronically), and the business to be discussed. Notice will be sent to members at least seven (7) days but not more than 30 days before the meeting. Notice may be delivered electronically.
- c) The quorum for a special meeting will be the same as that which is required to elect directors and officers.

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, recognizing specialty organizations and affiliating with caucuses and special interest groups. The House of Delegates may make recommendations to the Board for establishing 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, apportioned delegates elected from Chapters, and apportioned delegates elected from the Student Academy of AAPA. All delegates, other than those of the Student Academy, must be fellow members of the Academy. Student delegates must be student or fellow members of the Academy. All delegates and extra delegates from Chapters, specialty organizations, and caucuses must be elected by the fellow members of those organizations. The delegates and extra delegates from the Student Academy must be 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 the preceding 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 the preceding year.
- c. Extra Delegates. The maximum number of extra delegates for each delegation will be determined as 50% of the apportioned seats of the delegation or five (5) extra delegates, whichever is greater. Elected extra delegates may temporarily or permanently replace a voting delegate during a meeting in accordance with the House of Delegates Standing Rules.

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 Committee 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 First Vice Speaker shall be responsible for verification of the credentials of the delegates. The Second Vice Speaker shall be responsible for compiling the records of all general meetings of the House of Delegates, submitting such records to the Secretary-Treasurer of the Academy for filing with the Academy's books and records, and for providing oversight for the Standing Rules Committee.
- 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 an affirmative two-thirds (2/3) 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 delegates who are currently credentialed and eligible to vote 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 times 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.

- A. Resignation. 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.
- B. Removal.
 - i. Any Director, including Student Director, or Academy Officer may be removed from the Board at any time, with or without cause, by the affirmative majority vote of those members entitled to elect them. ^[1]
 - ii. Removal by members may occur only 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. ^[2] The quorum for such a meeting will be the same as that which is required to elect Directors and Officers. An affirmative two-thirds (2/3) majority vote shall be required to remove a Director or Officer.

^[1] "The members may remove one or more directors elected by them with or without cause" N.C. Gen. Stat. Ann. § 55A-8-08(a)

^[2] "A director elected by members may be removed by the members only at a meeting called for the purpose of removing the director and the meeting notice shall state that the purpose, or one of the purposes, of the meeting is removal of the director" N.C. Gen Stat. Ann. § 55A-8-08(e).

- iii. Any Academy Officer may be removed from office at any time, with or without cause, by the affirmative two-thirds (2/3) vote of the Board at a meeting where a quorum is present. ^[3]
- C. Vacancies. 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 Standing Committees, Board Committees, Academy Commissions, Work Groups, Task Forces, Ad Hoc Groups.

Section 1: Standing Committees. Standing Committees are established to serve a continuing function for the Academy and may only be established and dissolved by amending these Bylaws.

^[3] "A board of directors may remove any officer at any time with or without cause." N.C. Gen. Stat. Ann. § 55A-8-43(b).

A. Governance Committee.

The Governance Committee shall be responsible for reviewing and analyzing AAPA's Bylaws, policies and other governance structures and processes to ensure they support the governance of AAPA.

- a. Duties. The responsibilities of the Governance Committee shall include:
 - I. Carrying out such duties and responsibilities as are set forth in these Bylaws, including those related to elections and Bylaws.
 - II. Carrying out other duties and responsibilities assigned by the AAPA board of directors or house of delegates.
- b. Composition. The Governance Committee shall have seven members including:
 - I. Two fellow members nominated and elected by the AAPA Board of Directors.
 - II. Two delegates nominated and elected by the House of Delegates.
 - III. One student member nominated and elected by the Student Academy Board of Directors.
 - IV. Two members of the Board of Directors appointed by the AAPA President.
- c. Terms. Elected fellow members of the Governance Committee and delegates elected by the House of Delegates to the Governance Committee may serve up to two consecutive two-year terms. Student members elected to the Governance Committee and board members appointed to the Governance Committee shall serve one-year terms.
- d. Chair. A chair shall be annually elected by the committee from among its members. A member may serve as chair for two one-year terms.
- e. Elections. Governance Committee positions will be nominated and elected in a manner determined by the respective electing body.

B. Diversity, Equity and Inclusion Committee.

The Diversity, Equity, and Inclusion Committee shall support AAPA's efforts to foster diversity in the Academy and PA profession, and to advance health equity.

Section 1: Duties and Responsibilities.

- A. The committee shall carry out such duties and responsibilities as established by the Board of Directors in accordance with AAPA policy.
- B. The House of Delegates may establish additional duties and responsibilities.

Section 2: Composition.

The structure and composition of the Diversity, Equity, and Inclusion Committee shall be set forth in Board policy.

The committee shall consist of four members-at-large positions, two members of AAPA Board of Directors, and one representative from each of the following organizations, which include but are not limited to:

African Heritage PA Caucus, LBGT PA Caucus, PAs for Latino Health, PAs in Asian Health, Fellowship of Christian PAs, Jewish Association of PAs, PAs for Health Equity, the Student Academy, PAEA, ARC-PA, NCCPA, and PAF.

Any additional constituent organizations whose mission focuses on an underrepresented group may be considered for a seat on the committee at the start of the next upcoming

leadership year if approved by two-thirds (2/3) of the committee's members. All committee position appointments (except the AAPA Board of Directors and 4 members-at-large positions) will be determined by the respective organizations as long as they meet all of the eligibility requirements as outlined in Section 3. These positions will be appointed by the respective constituent organization's board of directors. The members-at-large positions will be applied for through AAPA, and reviewed by the committee, who will make recommendations to the AAPA Board of Directors for appointment.

Section 3: Eligibility And Qualifications.

The members of the Diversity, Equity, and Inclusion Committee may serve on other committees, task forces, and commissions within AAPA or its constituent organizations.

A. Individuals must be a fellow member of AAPA except for the student who must be a student member of the AAPA.

B. Individuals must be fellow or student members of their respective constituent organizations except for the AAPA board members and the members-at-large positions.

Section 4: Chair.

A chair shall be elected annually by the committee from among its members. A member may serve as chair for two one-year terms.

Section 5: Terms of Service.

The term of service for the members of the Diversity, Equity, and Inclusion Committee shall be two years. The terms will be staggered to ensure history and continuity are maintained. Each member may serve a maximum of two consecutive terms.

C. Nominating Committee. The Nominating Committee shall be charged and composed as stated in Article XI of these Bylaws.

Section 2: 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 3: 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. 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 Committee.

Section 1: Duties and Responsibilities. The Nominating Committee 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 identify 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 to run for elected positions within AAPA.
- d. Evaluate all candidates seeking nomination according to the qualification criteria set forth in these Bylaws and according to other such selection guidelines as may be established by the committee.
- e. Inform candidates and voting members of criteria being considered for endorsement by the Nominating Committee.
- f. Endorse a single or multiple slate of candidates for each nominated position.

Section 2: Composition; Method of Election or Appointment. The Nominating Committee 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 Committee 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 Committee members may not run for any of the positions they are evaluating for elections during their term. 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 served in at least two leadership roles in the past five years through service to AAPA; the Student Academy; an AAPA constituent organization; and/or an AAPA affiliated organization. Recognized leadership roles include a board member or organization officer; an elected or appointed representative; or a chair of a commission, committee, work group or task force.
- d. A Nominating Committee member cannot hold any other elected office or commission or work group position in AAPA during their term on the Nominating Committee.

Section 4: Term of Service. The term of service for members of the Nominating Committee 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 Committee 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 Committee 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 Committee 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 Committee Member.

- a. A candidate must be a fellow member of AAPA.
- b. A candidate must be a member of an AAPA constituent organization.
- c. A candidate must have been an AAPA fellow member and/or student member for the last three years.
- d. A candidate must have served in at least two leadership roles in the Academy, Student Academy, a constituent organization or related PA organization (as defined in section (i) below) in the past five years. This experience requirement will be waived for currently sitting AAPA Board members who choose to run for a subsequent term of office.
 - i. Related PA organizations include the PA Foundation, PA History Society, AAPA'S Political Action Committee, PA Education Association, ARC-PA or National Commission on Certification of Physician Assistants.

- e. Up to one leadership role as delineated in Section (d) may be obtained by serving in an executive or equivalent role in a healthcare professional organization or a healthcare regulatory agency.
- f. 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 and retired 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 Committee 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, the Student Academy Board of Directors and apportioned members of the Student Academy delegation in the House of Delegates.
- d. Eligible voters for Student Academy Regional Directors are student members from within the respective region, the Student Academy Board of Directors and apportioned members of the Student Academy delegation in the House of Delegates.
- e. For all positions, eligible voters must be current members in good standing (fellow, student, or retired) as of the date that is fifteen (15) days before the respective election.

Section 6: Election Procedures. The Governance Committee 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. All other Academy and Student Academy elections may be held through paper or electronic balloting without a formal meeting.

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 Committee 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. OFFICE OF THE IMMEDIATE PAST PRESIDENT. When the President serves a successive term due to a vacancy, the Immediate Past President will serve an additional year unless that individual resigns or is removed from office. A vacancy in the position of Immediate Past President cannot be filled until the current President succeeds into the role.
- d. 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.
- e. STUDENT ACADEMY BOARD MEMBER. A vacancy in the Student Director position shall be filled in the manner prescribed by the Student Academy Bylaws.
- f. OTHER BOARD VACANCIES. The Nominating Committee 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, committee, task force, 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 Committee 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 Committee 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.

SR-1000 HOUSE OF DELEGATES STANDING RULES

SR-1100 PHILOSOPHY OF PARLIAMENTARY PROCEDURES AND STANDING RULES

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
5. The American Institute of Parliamentarians Standard Code of Parliamentary Procedure, current edition

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.).

SR-1150 HOD GUIDELINES OF DECORUM

SR-1155

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.
 - 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.
- Once resolutions are published, all promotional efforts, such as marketing, advertising, or campaigning regarding resolutions prior to or during the House of Delegates meeting are outside the deliberative process of the HOD and therefore are prohibited.

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

SR-1160

Candidates for election may engage in campaigning, however they must ensure their campaigning does not interfere with their professional duties and/or decorum of the HOD meeting. Campaign activities and distribution of campaign paraphernalia shall not be permitted in the room where the HOD meeting takes place. General election candidates may be present and participate in HOD business but shall not use HOD sessions as campaign opportunities.

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. Approved policy statements and policy papers will go into effect at the conclusion of the current meeting in which they were considered.

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, official observers, 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.

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 caucuses, 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 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 for each 850 Student Academy members as of January 31 of each year. Leadership year is defined in Bylaws Article XIII, Section 8.

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 a current AAPA fellow member or student member.

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, 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 privilege to provide testimony during general sessions of the HOD.

SR-2246

Commission, work group, or task force chairs shall have the privilege to provide testimony during general sessions in the HOD and shall have the privilege of conducting business, including making motions, extraction, and addressing the House, on any resolution submitted to the HOD that was sponsored by their respective group. If the chair is unable to attend the meeting, they may appoint a designee with approval of the Speaker.

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 PA Education Association (PAEA), the National Commission on 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 as defined in Bylaws Article IV, Section 4.

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.

SR-2312

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-third (2/3) vote of the delegates present and voting, a meeting may be moved into an executive meeting. An executive meeting shall be limited to the voting membership of the house and to such persons as the delegates determine.

SR-2315

A general session of the annual HOD meeting is when the HOD is in session to conduct business. During a general session, the floor of the House is closed/sealed for apportioned, seated delegates to conduct business. Other individuals authorized by the Standing Rules or the Speaker may address the House and/or make motions.

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

To establish a quorum at any meeting of the House of Delegates, Bylaw Article VI, Section 4 will be followed. Once a quorum has been established, a vote by a majority of the present and voting 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 current edition of the American Institute of Parliamentarians Standard Code of Parliamentary Procedure.

SR-2340

Discussions in meetings shall include input from eligible 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 three minutes for the initial presentation, and one minute 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. Posting of final vote tallies on social media is prohibited.

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 ($\frac{2}{3}$) 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 by two-thirds ($\frac{2}{3}$) vote of seated delegates, unless the rule in question requires a higher voting threshold for adoption, in which case the vote required to amend is the same as the vote required to adopt.

SR-2382

The Standing Rules of the House of Delegates may be suspended by two-thirds (2/3) vote of seated delegates, unless the rule in question requires a higher voting threshold for adoption, in which case the vote required to suspend is the same as the vote required to adopt.

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

House Officer offices, election, and duties are defined in Bylaw Article VI, Section 3.

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-2615

The Sergeant-at-Arms will coordinate extra delegates replacing voting delegates during a meeting.

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 Committee (or their designee), one member from the House appointed by the Speaker, and the Chief Teller (or their designee). The Governance Committee shall determine the procedures for election of House Officers and the Nominating Committee.

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 Committee. One member of the Governance Committee 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. Additionally, it is recommended that those interested in being a candidate for a House Officer are encouraged to seek experience in the House, such as serving on a reference committee or other HOD committee or task force.

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-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 Committee. 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 Committee shall be elected by the House of Delegates at the Annual Meeting. The Board of Directors shall appoint two members. Nominations for this committee shall be made either at the time of call for nominations from the Governance Committee or from the floor of the House of Delegates. Members of the Nominating Committee 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 Committee shall be held at the time of election of House Officers. The term of office for elected members of the Nominating Committee shall be a two (2) year staggered term. Members of the Nominating Committee shall be elected by a plurality vote.
Bylaws Art XI, Sect 2 & 3.

SR-2945

If a complete, unopposed slate of candidates is presented for the election of Speaker, First Vice Speaker, Second Vice Speaker or members of the Nominating Committee, a simple majority of delegates seated shall be required to immediately elect the respective unopposed slate(s) of candidates by acclamation.

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.

SR-3010

Non-Bylaws resolutions may only be submitted and cosponsored by: (a) the Board of Directors, (b) any commission, work group, or task force, (c) any chapter, (d) any officially recognized specialty organization, (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 only be submitted and cosponsored 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.

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 as soon as possible but no later than the start of General Session I. 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 they believe each late resolution should be accepted for consideration. If deemed an acceptable resolution for consideration and there is no opposition to the recommendation from a seated delegate, the recommendation stands and may be considered under “new business” in General Session I. 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 ($\frac{2}{3}$) 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” at the end of General Session II and made available 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-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 adopt the reference committee consent agenda once all requests for extraction have been heard.
- A vote to adopt the reference committee consent agenda will be a vote to adopt 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.
- Once the reference committee's amendment is disposed of, first order and second order amendments will be permitted as the rules allow.

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 credentialed and 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 of 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/imposed 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.

[Adopted 1993, reaffirmed 1998, 2003, 2008, 2013, 2018, 2024]

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.

[Adopted 1984, reaffirmed 1990, 1998, 2004, 2014, 2016, amended 1993, 1999, 2009, 2021, 2022]

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.

[Adopted 1981, reaffirmed 1990, 1995, 2000, 2005, 2016, amended 1986, 1998, 2021]

BA-2300.1.3

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 175).

[Adopted 1995, amended 1998, 2016, reaffirmed 2000, 2005, 2010, 2015, 2021]

BA-2300.1.4

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

[Adopted 2001, reaffirmed 2006, 2021, amended 2016, 2022]

BA-2300.1.6

AAPA assists constituent organizations in maintaining active status.

[Adopted 2002, amended 2004, 2008, reaffirmed 2013, 2016, 2021]

BA-2300.1.8

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.

[Adopted 1981, amended 1986, 2009, 2016, reaffirmed 1990, 1995, 2000, 2005, 2008, 2014, 2021]

BA-2300.2.0 Chapter Rules

BA-2300.2.4

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

[Adopted 1981, reaffirmed 1990, 1995, 2000, 2005, 2010, 2015, reaffirmed 2016, 2021]

BA-2300.3.0 Relationship to AAPA

BA-2300.3.1

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

[Adopted 1979, amended 2005, 2010, 2016, reaffirmed 1990, 1995, 2000, 2015, 2021]

BA-2300.3.2

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.

[Adopted 1979, amended 2016, reaffirmed 1990, 1995, 2000, 2004, 2009, 2014, 2021]

BA-2300.3.3

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.

[Adopted 1981, amended 1986, 1997, reaffirmed 1990, 1995, 2000, 2005, 2010, 2015, 2020, 2025]

BA-2300.3.4

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.

[Adopted 1981, reaffirmed 1990, 1995, 2000, 2011, amended 2006, 2016, 2021]

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) AAPA 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.

[Adopted 1981, reaffirmed 1990, 1995, 2000, 2013, amended 1988, 2003, 2008, 2016, 2021, 2024]

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.

[Adopted 2000, reaffirmed 2009, 2014, 2024 amended 2004, 2019]

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.

[Adopted 1997, amended 1998, 2014 reaffirmed 2003, 2008, 2013, 2019, 2024]

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 five (5) AAPA fellow 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.

[Adopted 1997, reaffirmed 2002, 2013, amended 2007, 2008, 2016, 2021, 2024]

BA-2300.5.4

Specialty organization members are encouraged to be AAPA fellow members. Specialty organizations 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.

[Adopted 1997, amended 2000, 2016, reaffirmed 2005, 2010, 2015, 2021]

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.

[Adopted 2000, amended 2005, 2012, 2016, reaffirmed 2010, 2021]

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.

[Adopted 2002, amended 2007, 2008, 2012, 2016, 2021, 2024]

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.

[Adopted 1997, amended 2016, reaffirmed 2002, 2007, 2012, 2021]

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.

[Adopted 1981, reaffirmed 1990, 1995, 2014, amended 1982, 1996, 2000, 2002, 2007, 2009, 2016, 2021, 2024]

BA-2300.7.2

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

[Adopted 2004, amended 2009, reaffirmed 2014, 2016, 2021]

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.

[Adopted 2000, amended 2016, reaffirmed 2005, 2010, 2015, 2021]

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 Committee for review.

[Adopted 1983, reaffirmed 1990, 1995, 2000, 2007, 2012, amended 1985, 2002, 2017, 2018, 2022]

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.

[Adopted 2005, reaffirmed 2010, 2015, amended 2017, 2022]

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.

[Adopted 2005, amended 2010, 2015, 2017, 2022]

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.

[Reaffirmed 2015, 2016, amended 1989, 1994, 1997, 1998, 2002, 2003, 2007, 2010, 2021]

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.

[Adopted 2010, reaffirmed 2015, 2016, amended 2021]

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.

[Adopted 2001, reaffirmed 2006, 2015, 2016, 2021, amended 2010, 2022]

BA-2400.4.0 Commissions and Work Groups—Charges

BA-2400.4.1 Commission on Research and Strategic Initiatives

The commission will:

- Serve as consultants as AAPA conducts in-depth reviews of the Salary Survey and PA Practice Surveys to ensure that the questions align to the strategic needs of AAPA.
- Develop a roadmap to encourage and support greater research among PAs in post-professional doctoral programs and more broadly among PAs and PA students.
- Continue existing research projects started during the 2024-2025 volunteer year and identify and begin conducting one research project utilizing AAPA data or external data sets.
- 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 or a designee will attend the House of Delegates meeting to testify, as needed, regarding policies and resolutions related to the work of the Commission.

[Adopted 2014, amended 2015, 2016, 2018, 2019, 2020, 2021, 2021, 2022, 2023, 2024, 2025]

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 leadership opportunities for PAs that require federal or state legislative or regulatory changes to achieve.
- Share real world examples of autonomous PA practice and medical decision making 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.
- Educate PAs about the importance of advocacy and encourage PAs to get involved in advocacy at the state and federal 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.

[Adopted 2014, amended 2015, 2016, 2018, 2019, 2020, 2021, 2022, 2024, reaffirmed 2025]

BA-2400.4.3 Commission on Continuing Professional Development and Education

The commission will:

- Collaborate with AAPA education staff on elements of AAPA's overall education program and strategy. This may include 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 and work with staff to address 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 and faculty. This process should take into account any thematic focus of the conference, the AAPA Strategic Plan, AAPA's National Health Priorities, cross-organizational DEI efforts, 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 specialty meetings as appropriate.
- Act as a resource for AAPA's overall education program, including annual conference, specialty meetings, Learning Central, and CME accreditation.
- Develop new policies and/or review AAPA policies assigned by the House Officers or Board of Directors, 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.

[Adopted 2014, amended 2015, 2016, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025]

BA-2400.4.4 Commission on the Health of the Public

The commission will:

- 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.
- 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.
- In collaboration with appropriate stakeholders (SMEs, COs), evaluate opportunities for AAPA's participation related to emerging clinical public health issues 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.
- May 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 established criteria, HOTP may, but is not required to, make recommendations for endorsement.
- May review opportunities to provide comments on behalf of AAPA (not endorsements) on external policies, position papers clinical guidelines, collaborating with subject matter experts, appropriate constituent organization, or other stakeholders as appropriate following established criteria make a recommendation to staff or BOD regarding AAPA's participation.
- May evaluate potential AAPA participation in external clinical outreach opportunities, applying established criteria 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) may make a recommendation to staff or BOD regarding AAPA's participation.
- 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.

[Adopted 2014, reaffirmed 2023, amended 2015, 2016, 2018, 2019, 2020, 2021, 2022, 2024, 2025]

BA-2400.4.5 Judicial Affairs Commission

The commission will:

- Implement the AAPA judicial affairs responsibilities reflected in AAPA Bylaws (Article IX) and policy, to include but not limited to, complaints against members, complaints against constituent organizations, 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 Policy 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. Advise and monitor the task force charged with reviewing and revising the Guidelines for Ethical Conduct for the PA Profession policy paper.
- 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.

[Adopted 2010, amended 2012, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025]

BA-2400.4.6 Governance Committee

The commission will:

- In accordance with Article X, Section 1(A)(a), carry out such other duties and responsibilities as are set forth in the Bylaws, including those related to elections and Bylaws; carry out other duties assigned by the AAPA board of directors or house of delegates.
- Review emerging corporate governance issues and practices and make appropriate recommendations to the Board to ensure AAPA's governance aligns with leading practices and legal standards.
- 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.
- In accordance with the AAPA Bylaws Article XIII Section 6, 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 Committee and Constituent Relations Commission as needed to ensure alignment with applicable AAPA policies.
- Carry out the duties assigned in section 8.3 of the [AAPA Judicial Affairs Manual](#).

- As needed, review AAPA governance documents to identify and eliminate conflicting and inconsistent language.
- In accordance with BA-2400.2.1 review proposed amendments to the Student Academy Policy Manual as submitted by the Student Academy.
- 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.

[Adopted 2010, reaffirmed 2023, amended 2015, 2016, 2018, 2019, 2020, 2022, 2024, 2025]

BA-2400.4.8

Constituent Relations Work Group (of the Governance Committee):

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.
- Solicit, review and make recommendations to the Awards Committee regarding the CO awards program.
- When identified, alert the Board of Directors of any policy discrepancies within CO charters.
- 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 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.
- On a rolling basis, the CRC will review the bylaws of COs regarding compliance with the affiliation agreement and standards of CO recognition.

[Adopted 2010, reaffirmed 2023, amended 2015, 2016, 2021, 2022, 2024, 2025]

BA-2400.4.10 Diversity, Equity, and Inclusion (DEI) Committee

The committee will:

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

- Support the establishment and monitoring of accountability structures as well as metrics to track progress towards DEI goals.
- Engage as thought leaders and SMEs on research, education and publications on health equity and DEI.
- 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.
- Participate in the development of and engagement to support AAPA's efforts to diversify the PA profession.
- Serve as an active partner in creating leadership opportunities to remove barriers to entry and create pipelines for diverse emerging leaders to join AAPA volunteer, Board, and healthcare organization positions.
- 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, 2023, 2024, 2025]

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.

[Adopted 1983, amended 1987, 1995, 1998, 2016, reaffirmed 1990, 2000, 2005, 2010, 2015, 2021]

BA-2400.6.0 Healthcare Organization Liaisons

BA-2400.6.1

The Board of Directors will appoint AAPA Fellow members to serve as liaisons to national healthcare organizations. The purpose of the liaison program is to foster strategic engagement with such organizations to create positive and cooperative relationships in the medical community and representing the PA profession's overall role in healthcare. Such organizations may include but are not limited to:

- Associations representing physicians or other healthcare professionals;
- Medical specialty organizations;
- Other healthcare membership organizations with which engagement would be strategically beneficial.

Factors to be considered in determining which AAPA Fellow members are the appropriate liaisons shall include:

- Background and experience with the organization or relevant subject matter.
- Recommendations from an appropriate AAPA Constituent Organization (where applicable); and
- Other elements deemed to be appropriate by the AAPA Board of Directors.

AAPA will assign a liaison to national healthcare organizations who are willing to engage in one or more of the following ways on an annual basis:

- Invitation to be present at the organization's House of Delegates, Congress of Delegates, or equivalent meeting;
- Invitation to attend a meeting of the organization's Board of Directors;
- One or more opportunities to meet in-person with one or more elected leaders of the organization, and/or its executive director; or,
- at least one virtual videoconferencing call between the liaison and one or more elected leaders of the organization, and/or its executive director.

Any national healthcare organization that declines to meet one or more of these requests will be referred to the Board of Directors to consider whether the liaison relationship should be continued. If the Board of Directors elects to discontinue a liaison relationship, AAPA will continue to monitor opportunities for engagement with that organization to assist the Board of Directors in determining whether an invitation to the liaison program should be reissued.

Any national healthcare organization that is not presently included in the liaison program, but that is willing to meet at least one of the above criteria, will be referred to the AAPA Board of Directors for a potential invitation to the liaison program. The AAPA Board of Directors will consider liaison recommendations from the House of Delegates so long as they meet the above criteria.

[Adopted 2023]

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 the consent of the organization.

[Adopted 1977, amended 2017, reaffirmed 1990, 1995, 2000, 2005, 2010, 2015, 2022]

BA-2500.1.2

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

[Adopted 1978, reaffirmed 1990, 1995, 2000, 2005, 2010, 2015, 2016, amended 1996, 2021]

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.

[Adopted 1982, amended 2015, reaffirmed 1990, 1995, 2000, 2005, 2010, 2016, 2021]

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.

[Adopted 2002, reaffirmed 2014, amended 2007, 2009, 2015, 2019]

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, reaffirmed 2024]

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.

[Adopted 1982, amended 1984, 2005, 2010, 2015, 2016, reaffirmed 1990, 1995, 2000, 2021]

BA-2500.2.2

AAPA shall recognize those AAPA Fellow and Retired Members who have distinguished themselves among their colleagues through the distinguished fellows program.

[Adopted 2007, reaffirmed 2012, 2021, amended 2016, 2022]

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.

[Adopted 1990, reaffirmed 1995, 2000, 2005, 2010, 2015, 2016, amended 1998, 2021]

BA-2500.3.0 Information on the Profession

BA-2500.3.2

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

[Adopted 2004, reaffirmed 2009, 2014, 2016, 2021]

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.

[Adopted 1995, reaffirmed 2000, 2005, 2010, 2015, amended 2016, 2021, 2022]

BA-2500.5.0

Public Statements

BA-2500.5.1

The purpose of AAPA's public statements policy is to establish a clear and consistent framework for issuing statements that align with AAPA's mission, support and advance the PA profession, and address critical issues in all aspects of healthcare, including delivery, patient care, and the workforce. Public statements should reinforce the knowledge and expertise of the PA profession, promote solutions, and demonstrate AAPA's leadership in advocating for policies that strengthen the profession and enhance patient outcomes.

Public statements should educate, advocate, and clarify AAPA's position to stakeholders on issues impacting the PA profession and the broader healthcare landscape.

AAPA may thoughtfully issue or partner on statements when there is a clear and direct link to:

- Current events or issues with clear and direct implications for the PA profession, patient care, or healthcare policy.
- Matters of national healthcare importance where AAPA's voice adds unique expertise or advances constructive solutions.
- Public health concerns where PAs play a critical role in prevention, response, or treatment.
- Legislative and policy proposals that directly affect the PA profession, healthcare workforce, or patient care.

AAPA's statements should be solution-oriented, person- or patient-focused, and demonstrate humility. The scope and tone should reflect the integrity and objectivity of the PA profession and contain a clear, concise, balanced, scientifically valid, evidence-based, and commercially unbiased presentation of facts whenever possible. AAPA will maintain editorial control of any statement it lends its name to, and public statements may utilize multiple forms of external communication.

Factors to be considered when making a public statement are:

- Relevance to AAPA's Mission, Vision, and Values: Would commentary align with and advance AAPA's mission, values, and strategic priorities?
- Historical Context: Does AAPA have documented work, existing House of Delegates policy or other policy, or guidance on the issue that would substantiate the statement?
- Impact on the PA Profession: Does the statement promote the common interest and/or improve the professional environment of PAs, their ability to practice, or their role in healthcare?
- Impact on AAPA business operations: Would a statement (or lack of a statement) by AAPA on the issue have the potential to create reputational, legal, business, or other adverse risk to AAPA or its members?
- Influence on the Healthcare System and Patient Care: Would a statement by AAPA on the issue have the potential to positively influence care delivery or patient outcomes?
- Timeliness of Statement: Is there a temporal urgency for a statement?
- Effectiveness: Would a statement by AAPA on the issue contribute meaningfully to public discourse or sentiment, advocacy efforts, or policy development?

To promote transparency and inclusivity in decision making, AAPA will consult relevant stakeholders and subject matter experts when drafting statements, when appropriate and time permitting.

The Board of Directors will exercise discretion in issuing statements and will consider unintended consequences that may undermine organizational strategy, business, and/or advocacy priorities. The presence of an AAPA policy does not require the organization to issue an external-facing statement, just as the absence of a specific policy does not prevent AAPA from doing so. When the AAPA House of

Delegates has adopted policy related to the current event or issue that the organization is commenting on, said House of Delegates policy should be referenced.

Given the ever-evolving healthcare landscape, the AAPA Board of Directors will ensure this public statements policy continues to align with AAPA's strategic priorities and the current healthcare environment.

[Adopted 2025]

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.

[Adopted 2000, reaffirmed 2007, 2016, amended 2012, 2021]

BA-2600.1.3

The official AAPA ballot shall identify those candidates endorsed by the Nominating Committee.

[Amended 2004, 2009, reaffirmed 2014, 2016, 2021]

BA-2800.00 JUDICIAL AFFAIRS COMMISSION

BA-2800.1.0 Complaints

BA-2800.1.1

AAPA Complaint Procedures

[Reaffirmed 2014, amended 2002, 2007, 2009, 2018, 2021]

See: Judicial Affairs Manual

BA-2800.1.3

Procedure for filing a complaint against an AAPA Constituent Organization

[Reaffirmed 2014, amended 2002, 2007, 2009, 2019, 2021]

See: Judicial Affairs Manual

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

[Reaffirmed 2008, 2014, amended 2009, 2019, 2021]

See: Judicial Affairs Manual

HP-3000 Profession

HP-3200 Title

HP-3210

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

[Adopted 2000, reaffirmed 2005, 2010, 2015, amended 2021]

HP-3220

AAPA shall adopt “asociado médico” as the official Spanish translation for physician associate.
[Adopted 1998, reaffirmed 2003, 2008, 2013, 2018, amended 2022]

HP-3230

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

AAPA, PAs, and all constituent organizations should inform patient groups, policymakers, health systems, employers, payers, educators, researchers, and the government about the AAPA’s adoption of the professional title “physician associate” to increase transparency and visibility of PAs throughout the healthcare system.
[Adopted 2008, reaffirmed 2013, amended 2018, 2023]

HP-3250

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

AAPA opposes the use of the title physician associate/physician assistant (Asociado Médico) and acronyms PA, PA-C by any healthcare professionals that have not met the requirements of graduating from an ARC-PA accredited PA Program and passing the PANCE at least once as outlined in current AAPA policy and position papers, the ARC-PA policy, and NCCPA requirements.

AAPA will actively engage with NCCPA, the Federation of State Medical Boards and other applicable statutory and regulatory agencies to inform them of individuals actively licensed as a PA and/or fraudulently practicing or providing health care using the title of physician associate/physician assistant, Asociado Médico or acronyms PA, PA-C without having met the educational and certification guidelines as referenced above and as outlined in state medical and PA boards.
[Adopted 2024]

HP-3400 Role

HP-3410

PAs practice patient-centered, team-based medicine with physicians and other healthcare professionals.
[Adopted 1980, reaffirmed 1990, 1993, 2000, 2005, 2010, amended 1991, 1996, 2015, 2021]

HP-3420

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.
[Adopted 1995, amended 1996, 2014, 2019, reaffirmed 2000, 2005, 2010, 2024]

HP-3600 PA Organizations

HP-3610 General

HP-3612

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

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-3616

AAPA encourages its members to become members of State Chapters, Specialty Organizations, Caucuses and/or Special Interest Groups.

[Adopted 2023]

HP-3620 NCCPA

HP-3622

AAPA believes that NCCPA must limit its role to that of a certifying body and focus its resources on improving the board 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 board 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.

[Adopted 1990, reaffirmed 1995, 2000, 2005, 2010, 2015, 2020, 2025]

HP-3624

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

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

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.

[Adopted 1983, reaffirmed 1990, 1995, 2000, 2005, 2010, 2015, 2020, 2025]

HP-3640 Physician Assistant History Society

HP-3642

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.

[Adopted 2002, amended 2007, reaffirmed 2013, 2018, 2023]

HP-4000 PA Education

HP-4010

AAPA promotes equal-opportunity support for aspiring PAs and encourages the efforts of PAs who provide free mentorship and/or coaching.

[Adopted 2023]

HP-4020

AAPA strongly encourages equal-opportunity support for aspiring PAs and recognizes the potential negative impact of for-profit pre-PA coaching on diversity in the profession.

[Adopted 2023]

HP-4200 Entry-Level

HP-4220 Program Accreditation

HP-4222

AAPA recognizes the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), as the body that accredits educational programs for PAs.

[Adopted 1979, reaffirmed 1990, 1995, 2000, 2009, 2014, 2019, amended 2004, 2023]

HP-4240 Curriculum

HP-4242

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

AAPA supports the informed and evidence-based use of innovative teaching methods in PA education that promote the development of PA graduate competencies.

[Adopted 2019, amended 2024]

HP-4245

AAPA supports the equal accessibility of test-taking tools (such as text highlight and text strike functions) in exam software utilized during PA education, initial board certification and maintenance of board certification.

[Adopted 2023]

HP-4246

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]

HP-4247

AAPA encourages the incorporation of education on gender affirming care to the current curriculum of PA programs and continuing medical education for practicing PAs.

[Adopted 2024]

HP-4248

PA Student Supervised Clinical Practice Experiences – Recommendations to Address Barriers (paper on page 250)

[Adopted 2017, amended 2018, 2021, 2022, 2025]

HP-4250

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

AAPA considers it vital for PAs to be involved in the educational and professional development of PAs, including current and future students. This involvement encompasses the spectrum of engagement from interactions with potential applicants to participation in the didactic and clinical instruction of students. This also includes continuing education and skill development of PAs and other medical professionals. AAPA will, through its publications, programs, and services, encourage its members to actively participate in these engagements and educational opportunities.

[Adopted 1994, reaffirmed 1999, 2009, 2014, 2019, amended 2004, 2024]

HP-4254

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 appropriate patient care, the PA must have an understanding of pharmacology and therapeutics, including the indications, contraindications, adverse effects, and complications of commonly used drugs.

[Adopted 1979, reaffirmed 1990, 1995, 2000, 2005, 2010, 2015, amended 2018, 2023]

HP-4256

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 - including but not limited to harassment and violence in the academic and/or workplace settings.

[Adopted 2019, amended 2024]

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-4259

AAPA values the importance of professional advocacy and encourages PA programs to equip PA students with the knowledge of their roles and responsibilities and skills to engage in professional advocacy.

AAPA encourages promoting a culture of professional advocacy by supporting initiatives that equip practicing PAs with opportunities to engage in advocacy efforts throughout their careers.

[Adopted 2025]

HP-4260 Degree

HP-4262

AAPA recognizes the master's degree as the current terminal degree for PA education.

[Adopted 2007, reaffirmed 2012, 2017, amended 2022, 2025]

HP-4264

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.

[Adopted 2006, reaffirmed 2011, 2016, 2021]

HP-4266

AAPA supports PA-specific post-professional doctoral degrees as one option for PAs to engage in life-long learning.

[Adopted 2021]

HP-4270

AAPA recognizes the rigor, breadth, and depth of current PA curricula, and supports working with relevant stakeholders on the development of a pathway to awarding an entry level PA Doctoral degree.

[Adopted 2025]

HP-4280 Recruitment and Retention

HP-4282

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.

[Adopted 1982, reaffirmed 1990, 1995, 2000, 2015, 2020, amended 2005, 2010, 2022]

HP-4283

AAPA believes that PA program institutions should create an environment that supports and promotes the scholarship of principal PA faculty.

[Adopted 2024]

HP-4284

AAPA supports the use of holistic review in admissions to help ensure a diverse workforce that includes underrepresented populations in medicine to address health disparities.

[Adopted 2021, amended 2024]

HP-4286

Diversity and Inclusion in PA Education (paper on page 315)

[Adopted 2004, reaffirmed 2009, 2014, amended 2021]

HP-4288

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]

HP-4290

AAPA supports efforts to help U.S. military veterans become PAs.

[Adopted 2011, amended 2016, reaffirmed 2021]

HP-4292

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

[Adopted 2022]

HP-4294

AAPA encourages PA programs to define, make public, and consistently apply when appropriate, leave policies, including but not limited to pregnancy-related and parental leave policy for prospective and current students. This policy should be inclusive regardless of gender identity or family composition, and considers adoption, surrogacy, and pregnancy-related complications.

[Adopted 2023]

HP-4300 Education Funding

HP-4302

AAPA shall actively promote the participation of PAs in National Health Service Corps scholarship and loan repayment programs.

[Adopted 1978, amended 2000, 2005, reaffirmed 1990, 1995, 2010, 2015, 2020, 2025]

HP-4304

AAPA recognizes the vital importance of scholarship dollars to the continued growth, diversity, and advancement of the profession.

[Adopted 1990, reaffirmed 1995, 2000, 2005, 2010, 2015, 2020, amended 2025]

HP-4306

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

[Adopted 1978, amended 2000, 2012, reaffirmed 1990, 1995, 2005, 2017, 2022]

HP-4308

AAPA believes that federal and state government support for PA education should include expanded student loan availability, loan repayment programs, scholarships including National Health Service Corps, clinical practice site development, postgraduate PA programs, grant and research opportunities, and faculty development funding. Furthermore, PA postgraduate training programs should qualify for any federal or state funding available to other non-MD/DO eligible postgraduate training programs for health professions providing comparable services.

[Adopted 2008, amended 2013, 2018, 2023]

HP-4310

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. AAPA supports initiatives for increased funding for diversifying PA programs, clinical postgraduate programs, students, faculty, and staff who are underrepresented in medicine.

[Adopted 2018, amended 2023]

HP-4312

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

[Adopted 2018, reaffirmed 2023]

HP-4400 Postgraduate Education

HP-4420

Accreditation and Implications of Clinical Postgraduate PA Training Programs (paper on page 109)

[Adopted 2005, amended 2010, 2016, 2018, 2023]

HP-4600 Specialty Certification

HP-4620

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.

[Adopted 1979, reaffirmed 1990, 1995, 2000, 2005, 2010, 2015, 2020, 2025]

HP-4640

Specialty Certification, Clinical Flexibility, and Adaptability (paper on page 188)

[Adopted 2017, amended 2022]

HP-4660

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, 2025]

HP-4800 Continuing Education

HP-4820

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. The content of CME is the body of knowledge and skills generally recognized and accepted by the profession as within the basic medical

sciences, health systems science, the discipline of clinical medicine, and the provision of healthcare to the public. CME is a formal component of CPD. All CME reported should comply with this definition, regardless of whether it is reported as Category 1 (pre-approved) or Category 2 (elective).
[Adopted 1988, reaffirmed 1990, 1993, 1998, 2005, 2019, amended 1997, 2009, 2014, 2024]

HP-4840

AAPA reviews and approves 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)

[Adopted 1979, amended 1985, 1993, 1996, 1997, 2006, 2011, 2016, reaffirmed 1990, 1998, 2003, 2021]

HP-4860

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.

[Adopted 2003, reaffirmed 2008, 2013, amended 2018, 2021]

HP-4880

AAPA recommends continuing medical education mandated by state or federal bodies be offered in formats that ensure timely and equitable access.

[Adopted 2019, amended 2024]

HP-4900

AAPA supports approved PA programs in awarding Category 1 CME credit to graduate PAs who precept PA students and preceptors of accredited PA programs and clinical postgraduate training programs may earn two Category I credits per week for each PA student or postgraduate trainee they precept with no maximum.

[Adopted 2014, reaffirmed 2019, amended 2023]

HP-5000 Professional Practice

HP-5020

AAPA recognizes the vital role PAs serve in robotic surgery and encourages the development and promotion of robotic surgery educational opportunities.

[Adopted 2025]

HP-5200 Clinical Competency

HP-5220

AAPA recognizes life-long learning provides opportunities to improve competencies, supports preparedness for board 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.

[Adopted 1987, reaffirmed 1992, 1997, 2002, 2006, 2016, amended 1996, 2003, 2011, 2021]

HP-5240

Professional Clinical Competence (paper on page 154)

[Adopted 1996, amended 2005, 2025, 2010, 2015, reaffirmed 2020]

HP-5260

Competencies for the PA Profession (paper on page 201)

[Adopted 2005, reaffirmed 2010, 2018, amended 2013, 2021]

HP-5400 Non-Clinical Roles

HP-5420

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.

[Adopted 2000, reaffirmed 2005, 2010, 2015, 2021]

HP-5440

AAPA encourages PAs to seek election to federal, state, and local office.

[Adopted 2012, amended 2017, reaffirmed 2022]

HP-5460

AAPA recognizes and encourages the active participation of PAs in policy making, administration, government affairs, research, and other non-clinical roles.

[Adopted 2000, reaffirmed 2005, 2010, 2015, 2020, 2025]

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-5490

AAPA recognizes that PAs serve vital roles in clinical and academic research including the role of principal investigator.

[Adopted 2025]

HP-5500

AAPA endorses and encourages that healthcare accrediting agencies utilize PAs on accreditation site teams.

[Adopted 2000, amended 2015, reaffirmed 2005, 2010, 2020, 2025]

HP-5520

Guidelines for the PA Serving as an Expert Witness (paper on page 134)

[Adopted 1977, reaffirmed 2004, 2009, amended 1987, 1991, 2001, 2014, 2018, 2023]

HP-5600 Healthcare Systems

HP-5620 General

HP-5622

AAPA believes that team-based care leads to better patient outcomes.

[Adopted 1997, reaffirmed 2002, 2007, 2012, 2017, amended 2022]

HP-5624

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 and supports regulation and policy that maximizes the potential for communication between the episodic care provider and the primary provider within the constraints of laws and associated rules regarding patient confidentiality and individual patient preference.

[Adopted 2003, reaffirmed 2008, 2013, amended 2018, 2023]

HP-5626

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.

[Adopted 1978, reaffirmed 1990, 1995, 2000, 2005, 2010, amended 2015, 2022]

HP-5628

The Role of In-Store or Retail-Based Convenient Care Clinics (paper on page 215)

[Adopted 2017, amended 2022]

HP-5630

AAPA supports development of governmental safeguards, when healthcare facilities and medical practices are owned by private equity, to ensure access and high-quality healthcare delivery.

[Adopted 2025]

HP-5640 PA Utilization and Workforce

HP-5642

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.

[Adopted 2006, reaffirmed 2011, 2016, amended 2021]

HP-5644

AAPA supports increased utilization of PAs providing gynecologic-obstetric care for persons throughout their lifespan as a response to maternal health workforce shortages. AAPA acknowledges the unique expertise of PAs that provide medical and surgical care to a high-risk maternal population.

[Adopted 2024]

HP-5645

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, 2025]

HP-5646

AAPA believes services provided by PAs should be recognized when federal and state governments review the healthcare service needs of medically underserved and health professional shortage areas. Recognition of PA contributions should not be done in a way that indirectly decreases patient access to care.

[Adopted 1998, reaffirmed 2003, 2008, 2013, amended 2018, 2023]

HP-5647

AAPA shall educate policymakers, healthcare systems, hospitals, employers, insurance companies, and third-party payers that PAs strengthen the maternal health workforce and respond to the maternal morbidity/mortality crisis. AAPA will continue to advocate for health policies at federal, state, and local levels that ensure PAs are included in all maternal health initiatives.

[Adopted 2024]

HP-5648

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.

[Adopted 1996, reaffirmed 2001, 2012, 2017, amended 2006, 2022]

HP-5650

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.

[Adopted 2000, reaffirmed 2005, 2025, amended 2010, 2015, 2020]

HP-5652

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, reaffirmed 2024]

HP-5654

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.

[Adopted 1999, reaffirmed 2005, 2010, amended 2000, 2015, 2021]

HP-5656

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, reaffirmed 2024]

HP-5658

Supporting PA Practice in Settings External to Clinics and Hospitals: Adoption of Home-centered Care (paper on page 301)

[Adopted 2021]

HP-5660

AAPA supports policies and regulations that recognize and promote the role of PAs in hospice and palliative medicine. Payer policies, as well as state and federal regulations, should facilitate the full utilization of PAs in these specialties. Any barriers that restrict PAs from practicing to the full extent of their education and experience should be removed to ensure they can provide essential care to hospice patients.

[Adopted 2015, amended 2020, 2025]

HP-5662

PAs as Medical Review Officers (paper on page 145)

[Adopted 1991, reaffirmed 2009, 2014, 2019, amended 2004, 2024]

HP-5680 Managed Care

HP-5682

PAs as Medicaid Managed Care Providers (paper on page 150)

[Adopted 1996, reaffirmed 2004, 2014, amended 1997, 2009, 2019, 2024]

HP-5684

AAPA supports federal legislation to allow PAs to prescribe and certify need for therapeutic shoes and inserts for individuals with diabetes to improve access, decrease cost, complications, and risk of limb loss.

[Adopted 2025]

HP-5800 Regulation/Certification

HP-5820 Credentialing/Privileges

HP-5822

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.

[Adopted 1999, amended 2009, 2019, reaffirmed 2004, 2014, 2024]

HP-5826

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).

[Adopted 1988, amended 2004, 2009, 2019, reaffirmed 1993, 1998, 2002, 2014, 2024]

HP-5828

Guidelines for Updating Medical Staff Bylaws: Credentialing and Privileging PAs (paper on page 116)

[Adopted 2012, amended 2017, 2018, 2023]

HP-5830

AAPA believes PA clinical practice evaluations should ideally be completed by a current or former PA-C.

[Adopted 2025]

HP-5840 Certification

HP-5841

AAPA supports the terms “board certification” and “board certified” to describe PA certification in all references including PANCE, PANRE, and the PA-C credential.

[Adopted 2023]

HP-5842

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

[Adopted 2016, reaffirmed 2021]

HP-5844

AAPA endorses the National Commission on Certification of Physician Assistants (NCCPA) certification exam as the only entrance standard for PAs, and opposes examinations given by any organization for the purpose of establishing entrance-level standards for individuals not eligible for the NCCPA examination.

[Adopted 2023]

HP-5860 Licensure

HP-5862

Non-Physician Licensure for Medical School Graduates (paper on page 275)

[Adopted 2019, amended 2024]

HP-5864

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

[Adopted 2016, amended 2021]

HP-5866

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

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

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

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, reaffirmed 2023]

HP-5884

Guidelines for State and Territory Regulation of PAs (paper on page 127)

[Adopted 1988, amended 1993, 1998, 2001, 2005, 2006, 2009, 2011, 2013, 2016, 2017, 2022]

HP-5886

AAPA opposes the inclusion of non-PA healthcare professionals in PA state practice acts.

[Adopted 2017, amended 2022]

HP-5888

AAPA opposes criminal penalties or retaliation against healthcare providers who aid, support, or provide standard medical care.

[Adopted 2024]

HP-6000 PA Employment

HP-6020 Practice Ownership

HP-6022

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

AAPA opposes the use of non-compete clauses in PA's employment contracts. These covenants place financial interest above community care, violate a PA's right to practice their profession, and negatively impact access to care.

[Adopted 2009, reaffirmed 2014, amended 2018, 2023]

HP-6044

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-6046

AAPA advocates for policies that establish paid family leave for all workers.

Furthermore, AAPA advocates that paid family leave policies should be equitable, inclusive, and supportive of diverse family structures, including but not limited to biological, adoptive, foster, and chosen families.

[Adopted 2025]

HP-6048

AAPA supports medical leave for PAs experiencing health conditions associated with burnout to prevent progression to impairment and protect patient safety.

AAPA supports state legislation establishing paid medical leave for healthcare workers experiencing health conditions associated with burnout and recommends that medical leave forms be concise, requiring only the minimum necessary disclosure of health information.

[Adopted 2025]

HP-6200 International Education/Practice

HP-6220

Licensure Eligibility for PAs Trained Abroad (paper on page 309)

[Adopted 2004, amended 2009, 2018, reaffirmed 2014, 2023]

HP-6240

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.

[Adopted 2001, reaffirmed 2006, 2016, amended 2011, 2021]

HP-6400 Uniformed Services

HP-6420 Active Duty

HP-6422

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.

[Adopted 1986, amended 1991, 2001, reaffirmed 1996, 2006, 2011, 2016, 2021]

HP-6424

AAPA believes there is no valid reason to exclude transgender individuals from military service.

[Adopted 2019, reaffirmed 2024]

HP-6426

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, reaffirmed 2024]

HP-6428

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.

[Adopted 1986, amended 2001, reaffirmed 1991, 1996, 2006, 2011, 2016, 2021]

HP-6430

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.

[Adopted 1986, amended 2001, reaffirmed 1991, 1996, 2006, 2011, 2016, 2021]

HP-6440 Veterans

HP-6442

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.

[Adopted 2003, amended 2004, 2009, 2014, 2019, reaffirmed 2024]

HP-6444

AAPA believes PAs should advocate and facilitate care for veterans of the uniformed forces, including the National Guard and the Reserve Forces of the United States, as well as their qualified spouses, dependents, and family caregivers. AAPA supports education for all PAs regarding the medical and psychosocial needs for veterans and their families and encourages PAs to be aware of the services and resources in their communities that can assist in accessing appropriate and necessary services.

[Adopted 2008, reaffirmed 2013, 2018, amended 2023]

HP-6600 Direct to Consumer Interactions

HP-6620

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, reaffirmed 2024]

HP-6640

False or Deceptive Healthcare Advertising (paper on page 218)

[Adopted 2007, reaffirmed 2012, 2017, amended 2022]

HP-6660

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."

[Adopted 1994, reaffirmed 1999, 2004, 2006, 2011, 2016, 2021]

HP-6800 Reimbursement

HP-6820

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.

[Adopted 1995, amended 2001, 2006, 2018, reaffirmed 2000, 2023]

HP-6840

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.

[Adopted 1981, amended 1982, 1997, 2005, 2010, 2015, 2016, reaffirmed 1990, 1995, 2000, 2021]

HP-6860

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, allow for direct payment to PAs, and cover medical and surgical services provided by PAs in all practice settings. 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.

[Adopted 1998, reaffirmed 2005, amended 2010, 2015, 2020, 2023]

HP-6880

AAPA believes healthcare laws and regulations adopted at the state or federal levels should protect coverage for patients, ensure access to care provided by PAs and maintain coverage of essential health benefits for patients.

[Adopted 2023]

HP-6890

AAPA supports moving towards value-based reimbursement that improves healthcare equity and quality.

[Adopted 2025]

HP-6900

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.

[Adopted 1995, amended 2005, 2010, 2011, 2016, reaffirmed 2000, 2021]

HP-6920

AAPA believes coverage for the treatment of mental health and substance use disorders should be available to patients and covered in the same manner as other medical care.

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

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

[Adopted 2003, reaffirmed 2008, amended 2013, 2018, 2023]

HP-6930

AAPA supports creating and promoting national legislation allowing medical providers to seek mental health assistance outside of their own in-network medical system to avoid any perceived or actual retribution, shame, or other stigmatizing responses.

[Adopted 2024]

HP-7000 Ethics/Behavior

HP-7020 General

HP-7022

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.

[Adopted 1990, amended 1991, 2001, reaffirmed 1996, 2006, 2011, 2016, 2021]

HP-7024 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

Guidelines for Ethical Conduct for the PA Profession (paper on page 175)

[Adopted 2000, reaffirmed 2013, 2023, amended 2004, 2006, 2007, 2008, 2018, 2024]

HP-7040 Disciplinary Process

HP-7042

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.

[Adopted 1990, amended 1991, 2001, reaffirmed 1996, 2006, 2011, 2016, 2021]

HP-7044

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

[Adopted 1990, amended 1991, 2001, 2006, reaffirmed 1996, 2011, 2016, 2021]

HP-7200 PA Health and Wellness

HP-7220 Occupational Safety

HP-7222

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.

[Adopted 2006, amended 2011, 2016, reaffirmed 2021]

HP-7224

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).

[Adopted 1992, amended 2003, reaffirmed 2008, 2013, 2018, 2023]

HP-7226

AAPA opposes all threats, acts of mistreatment, violence, intimidation and reprisal directed against PAs, PA students, and any other individuals present in medical facilities. Workplace violence in healthcare is unacceptable and must not be tolerated.

AAPA believes that PAs have a right to practice in an environment that is free from threats, harm, and fear. Institutions must make safety a priority through proactive measures, including but not limited to, enhanced security, de-escalation training, comprehensive mental health support, and protected time to heal for those affected by violence.

AAPA supports legislative and regulatory action to hold perpetrators accountable, strengthen workplace violence prevention programs, and establish enforceable protections for all healthcare workers under the law.

[Adopted 1996, reaffirmed 2006, 2011, 2016, amended 2001, 2019, 2024, 2025]

HP-7228

AAPA opposes violence and intimidation directed against patients and their respective families as it is an infringement of the individual's right of access to medical care.

[Adopted 2024]

HP-7240 Personal Wellness

HP-7242

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, reaffirmed 2023]

HP-7244

PA Impairment and Well-being (paper on page 147)

[Adopted 1990, reaffirmed 2004, 2014, amended 1992, 2009, 2019, 2024]

HP-7246

AAPA supports the ongoing practice of PAs with substance use disorders who have acknowledged their illness and engage in ongoing recovery efforts.

[Adopted 1987, reaffirmed 1992, 1998, 2003, 2008, 2013, amended 2018, 2023]

HP-7400 Quality Assurance

HP-7420 General

HP-7422

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.

[Adopted 2003, amended 2008, 2010, reaffirmed 2015, 2020, 2025]

HP-7424

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.

[Adopted 1997, amended 2007, reaffirmed 2002, 2012, 2017, 2022]

HP-7426

Quality Incentive Programs (paper on page 335)

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

HP-7440 Risk Management

HP-7442

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.

[Adopted 2004, amended 2009, reaffirmed 2014, 2019, 2024]

HP-7444

Acknowledging and Apologizing for Adverse Outcomes (paper on page 220)

[Adopted 2007, amended 2013, 2018, reaffirmed 2012, 2023]

HP-8000 Practice Standards

HP-8200 Access to Care

HP-8220 General

HP-8221

AAPA opposes legislative and regulatory attempts to restrict or interfere with the ability of patients to seek or utilize healthcare for any medical conditions or health outcomes.

[Adopted]

HP-8222

PAs have an ethical and legal obligation to use appropriately trained medical interpreters for their patients with limited ability to speak or understand English.

[Adopted 2003, amended 2018, reaffirmed 2008, 2013, 2023]

HP-8223

Use of Medical Interpreters for Patients with Limited English Proficiency (paper on page 198)

[Adopted 2003, amended 2018, reaffirmed 2008, 2013, 2023]

HP-8226

AAPA encourages PAs to provide care for medically underserved populations and/or practice in medically under resourced areas to address health disparities.

[Adopted 1991, reaffirmed 2001, 2006, 2016, 2021, amended 1996, 2011, 2022]

HP-8228

Promoting the Access, Coverage and Delivery of Healthcare Services (paper on page 106)

[Adopted 2018, reaffirmed 2023]

HP-8230

AAPA opposes actions that limit or restrict patient access to care based on personal or religious beliefs.

[Adopted 2006, amended 2016, reaffirmed 2011, 2021]

HP-8232

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.

[Adopted 2008, amended 2010, 2015, 2021]

HP-8234

PAs (1) advocate the appropriate placement of automated external defibrillators (AEDs); (2) support increasing government and industry funding for the purchase of AED devices; (3) encourage the American public to become trained in CPR and the use of AEDs; (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; (5) advocate for legislation to be passed in all states that AEDs be required in all schools and recommend AEDs be available within three minutes to all youth sporting events and practices; and (6) support requirement of all youth sporting organizations to mandate an emergency action plan including recommending proper training in CPR and the use of AEDs for at least one identified trained person present at all times.

[Adopted 2008, reaffirmed 2013, 2018, 2023, amended 2024]

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

AAPA supports legislation and policies that eliminate discrimination against patients through awareness, screening for, and addressing social determinants of health including, but not limited to, economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context.

[Adopted 2001, reaffirmed 2021, amended 2006, 2011, 2016, 2022, 2023, 2024]

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

Health Disparities: Promoting the Equitable Treatment of All Patients (paper on page 226)

[Adopted 2011, amended 2016, reaffirmed 2021]

HP-8250

AAPA shall promote the PA profession and highlight the role of PAs to patients and leaders of healthcare organizations in underserved communities to improve access to care and reduce health disparities.

[Adopted 2005, reaffirmed 2015, amended 2010, 2020, 2025]

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-8254

The AAPA encourages equitable representation in clinical research, which includes disaggregation and stratification of data by sex assigned at birth and by gender identity, to enhance the applicability of findings to diverse populations.

[Adopted 2025]

HP-8256

AAPA supports PAs practicing street medicine by providing medical care to unsheltered individuals on the street or in their found environment.

[Adopted 2025]

HP-8260 Rural Health

HP-8262

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.

[Adopted 1996, reaffirmed 2001, 2011, 2016, amended 2006, 2021]

HP-8264

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.

[Adopted 2004, reaffirmed 2009, 2014, 2019, 2024]

HP-8266

Rural Health Clinics (paper on page 171)

[Adopted 1997, reaffirmed 2014, 2019, amended 2004, 2009, 2024]

HP-8268

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.

[Adopted 1997, amended, 2012, reaffirmed 2002, 2007, 2017, 2022]

HP-8280 Public Health Crisis/Disaster Response

HP-8282

The PA in Disaster Response: Core Guidelines (paper on page 158)

[Adopted 2006, amended 2010, 2015, 2022]

HP-8300 Prescription Medication

HP-8302

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.

[Adopted 2002, amended 2012, reaffirmed 2007, 2017, 2022]

HP-8304

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.

[Adopted 2005, reaffirmed 2010, 2015, 2025, amended 2020]

HP-8306

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.

[Adopted 2001, reaffirmed 2006, amended 2011, 2016, 2021]

HP-8308

AAPA supports appropriate and compliant access to samples of prescription drugs from pharmaceutical manufacturers for the practicing PA.

[Adopted 1987, reaffirmed 1992, 1997, 2002, 2007, 2012, amended 2017, 2022]

HP-8310

AAPA supports PAs having the ability to order, obtain and provide medical and pharmaceutical supplies for the care of patients. AAPA shall actively engage in efforts to educate medical and pharmaceutical suppliers about PA practice to promote the ability of PAs to be recognized as qualified providers in ordering such supplies.

[Adopted 2023]

HP-8320 Immigrant Health

HP-8322

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

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.

[Adopted 2007, reaffirmed 2012, 2017, 2022]

HP-8326

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

AAPA supports systems of personal medical identification containing an individual's key medical information and encourages all PAs to promote their use to patients.

[Adopted 1979, amended 2000, 2007, reaffirmed 1990, 1995, 2012, 2017, 2022]

HP-8424

AAPA believes to ensure accountability for the care provided by PAs, electronic health record (EHR) systems, computerized provider order entry (CPOE) systems, reimbursement and claims systems, and other health information technology systems must individually recognize and appropriately attribute PA-provided patient care data to the PAs delivering the medical or surgical service.

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 care quality, transparency and access.

[Adopted 2013, amended 2018, 2023]

HP-8426

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-8428

AAPA encourages PAs and PA students to be aware and seek knowledge of emerging technology that affects patient care, including wearable physiologic and biometric data monitoring technology. PAs and PA students are encouraged to seek knowledge regarding Remote Patient Monitoring (RPM) Hospital at Home programs and all forms of virtual care to include synchronous and asynchronous care. PAs and PA students are encouraged to help their patients navigate this emerging technology and how it integrates into the clinical workflow.

[Adopted 2023]

HP-8430 **Artificial Intelligence**

HP-8432

AAPA recognizes the immense potential, both positive and negative, of artificial intelligence (AI) in healthcare. It is essential for PAs to be aware of the different types of AI and help guide their ethical and clinical implementation in order to maximize benefits while minimizing potential risks. AAPA recommends PAs to stay current on practice guidelines that include AI systems, or new roles and capacities that are required to guide health care organizations in the development of AI systems. AAPA encourages PAs to identify areas where AI can be useful to advance the quintuple aim (advancing health equity, in addition to the preceding four aims: improving population health, enhancing the care experience, reducing costs, addressing clinician burnout), which includes elimination of bias in any form.

AAPA recommends that PAs support AI-enabled clinical enhancement of the PA-patient relationship but not replacement of it.

[Adopted 2024, amended 2025]

HP-8433

AAPA advocates for enhanced logistics for the use of AI to improve real-time access to medical data and provide decision-making support for healthcare organizations.

[Adopted 2025]

HP-8434

AAPA advocates for establishing robust healthcare AI governance frameworks for AI's ethical use. AI systems must ensure fairness by promoting equitable healthcare delivery for historically marginalized communities and addressing bias through representative training datasets. AAPA advocates for transparent AI systems, which produce explainable outputs to provide patients and providers with an understanding of the rationale behind AI-driven recommendations.

[Adopted 2025]

HP-8435

AAPA prioritizes protecting patient rights and safety when AI tools are implemented. Patients should be informed about the use of AI in their care when such disclosure is feasible. Institutions deploying AI have a responsibility to promote transparency and uphold patient autonomy, including offering the option to opt out of AI-assisted decision-making when possible. AI systems must comply with applicable data security standards to ensure patient privacy.

[Adopted 2025]

HP-8436

AAPA requires that AI be used responsibly in CME submissions, presentations, publications, and other scholarly endeavors. AI-assisted publications must comply with the International Committee of Medical Journal Editors (ICMJE) standards, ensuring proper attribution while maintaining human accountability for the work's accuracy, integrity, and originality.

[Adopted 2025]

HP-8437

AAPA advocates for rigorous AI tool evaluation to demonstrate clinically meaningful patient outcomes.

AAPA advocates for evaluation metrics that prioritize patient safety, equity, and overall care efficiency.

[Adopted 2025]

HP-8440 Point-of-Care Ultrasound

HP-8442

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-8460 Wearable Technology

HP-8462

AAPA supports the use of diabetes technology for persons living with diabetes to include insulin delivery devices, continuous glucose monitoring and integration of technology into clinical practice per American Diabetes Association evidence-based guidelines. AAPA further supports increased efforts to improve access to these treatments for patients of all socioeconomic backgrounds.

[Adopted 2024]

HP-8600 Human Rights

HP-8620

AAPA opposes all forms of sexual harassment.

[Adopted 2000, reaffirmed 2005, 2010, 2015, 2025, amended 2020]

HP-8640

AAPA supports equal rights for all persons and supports policy guaranteeing such rights.

[Adopted 1982, reaffirmed 1990, 1995, 2000, 2005, 2010, 2015, 2020, 2025]

HP-8660

AAPA opposes participation of PAs in the torture or inhuman treatment or punishment of individuals in relation to detention or imprisonment and endorses the World Medical Association's Declaration of Tokyo.

[Adopted 1987, reaffirmed 1992, 1997, 2003, 2008, 2013, 2018, amended 2023]

HP-8700

AAPA opposes all forms of gender discrimination.

[Adopted 2020, reaffirmed 2025]

HP-8710

AAPA opposes all forms of discrimination or action against an individual based on their age.

[Adopted 2025]

HP-8720

AAPA opposes restrictions and attempts to restrict the availability of and access to gender affirming healthcare.

[Adopted 2023]

HP-8740

AAPA opposes all forms of racism and supports its elimination.

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.

[Adopted 2020, amended 2023]

HP-8742

AAPA opposes all forms of antisemitism and supports its elimination. Antisemitism includes a negative perception of Jews, which may be expressed as prejudice, discrimination and/or hatred toward Jews as individuals or as a group.

AAPA affirms its commitment to countering antisemitism and advocating for the safe and equal treatment of Jewish individuals in all settings and firmly rejects positions that isolate, marginalize, and reject Jewish participation.

[Adopted 2024]

HP-8750

AAPA opposes all forms of discrimination or action against an individual based on their religious beliefs or practices.

[Adopted 2024]

HP-8760

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

Human Trafficking in the United States (paper on page 267)

[Adopted 2019, amended 2024]

HP-8800 Diversity, Equity, and Inclusion

HP-8820

AAPA is committed to respecting the values and diversity of all individuals inclusive of, but not limited to, race, age, ethnicity, culture, national origin, faith, neurodiversity, veteran status, socioeconomic status, 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.

[Adopted 1995, reaffirmed 2003, 2008, amended 1997, 2013, 2018, 2023, 2025]

HP-8840

AAPA leadership and national office staff are 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

AAPA supports national, state, and community efforts to enhance the quality of life for individuals with disabilities, by removing systemic barriers, ensuring equitable access, and promoting full participation in education, employment, community living, and health opportunities.

[Adopted 1983, amended 2000, 2025, 2010, reaffirmed 1990, 1995, 2005, 2015, 2020]

HP-8862

AAPA supports efforts to ensure the appropriate development and provision of special education programs for children with disabilities.

[Adopted 2025]

HP-8870

AAPA affirms that the inclusion of transgender and non-binary youth-athletes in sports consistent with their gender identity promotes overall health and well-being. AAPA supports gender diverse youth-athlete participation for each sport consistent with the 'Framework on fairness, inclusion and non-discrimination on the basis of gender identity and sex variation' as developed by the International Olympic Committee.

[Adopted 2023]

HP-8875

AAPA supports the full integration of persons with a transgender gender modality into society and supports their full participation in educational, employment, community living, and health opportunities.

AAPA supports national, state, and community efforts that enhance the quality of life for persons with a transgender gender modality.

[Adopted 2025]

HP-9000 Clinical Standards

HP-9200 General

HP-9220

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, 2025]

HP-9240

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 the 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.

[Adopted 1992, reaffirmed 1997, 2002, 2007, 2012, 2017, amended 2022]

HP-9260

Scientific Integrity and Public Policy (paper on page 333)

[Adopted 2005, amended 2010, 2015, 2020, reaffirmed 2025]

HP-9400 Preventive Medicine

HP-9420

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.

[Adopted 1978, reaffirmed 1990, 1995, 2005, 2010, 2025, amended 2000, 2015, 2020]

HP-9440

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.

[Adopted 2002, amended 2007, 2012, reaffirmed 2017, 2022]

HP-9460

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.

[Adopted 1991, reaffirmed 1996, 2001, 2004, 2009, 2014, 2019, 2024]

HP-9480

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.

[Adopted 2005, amended 2015, reaffirmed 2010, 2020, 2025]

HP-9500

Routine Vaccination for Human Papillomavirus (paper on page 223)

[Adopted 2008, amended 2012, 2017, reaffirmed 2022]

HP-9520

Immunizations in Children and Adults (paper on page 138)

[Adopted 1994, amended 2004, 2006, 2011, 2016, 2018, 2022]

HP-9540

AAPA is opposed to the use of tanning beds by those under 18 years of age and encourages state chapters to pursue legislation to restrict the use of tanning beds in this age group.

[Adopted 2012, reaffirmed 2017, 2022, amended 2023]

HP-9580

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

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.

[Adopted 2004, reaffirmed 2009, 2014, 2019, 2024]

HP-9640

Health Literacy: Broadening Definitions, Intensifying Partnerships and Identifying Resources (paper on page 208)

[Adopted 2006, amended 2011, 2016, reaffirmed 2021]

HP-9660

AAPA encourages PAs to identify and utilize reliable and accurate consumer health information on specific disease states to encourage patient knowledge, increase communication, enhance understanding and improve health education, and encourage informed decision making. Health education information should be evidence-based and patient centric.

[Adopted 2010, amended 2015, 2020, 2025]

HP-9800 Safety

HP-9820 General

HP-9822

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 Dietary Supplement Health and Education Act (DSHEA) and the United States Pharmacopeia Standards.

[Adopted 1982, reaffirmed 1990, 1995, 2009, 2014, amended 2000, 2004, 2019, 2024]

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]

HP-9840 Motor Vehicles

HP-9844

AAPA recommends all states 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.

[Adopted 1985, reaffirmed 1990, 1995, 2000, 2005, 2015, amended 2010, 2020, 2025]

HP-9846

AAPA supports legislation that bans the non-emergent use of hand-held communication devices while operating a moving vehicle.

[Adopted 2011, reaffirmed 2016, 2021]

HP-9848

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.

[Adopted 2003, reaffirmed 2008, 2013, 2018, 2023]

HP-9860 Restraints and Seclusion

HP-9864

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. Furthermore, PAs, by virtue of their education and legal scope of practice as professionals who provide medical care, 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. 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.

[Adopted 2000, reaffirmed 2005, 2010, 2015, 2020, amended 2023]

HP-9880 Violence

HP-9882

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.

[Adopted 2000, amended 2005, reaffirmed 2010, 2015, 2020, 2025]

HP-9884

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, reaffirmed 2024]

HP-9886

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, reaffirmed 2024]

HP-9888

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, reaffirmed 2024]

HP-9890

AAPA believes that PAs should be well-versed in community resources available to prevent violence, particularly interventions aimed at vulnerable populations.

[Adopted 2019, amended 2024]

HP-9892

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 media. PAs should encourage increased monitoring, by parents and guardians, of their children's use of electronic devices for all media activities. PAs should make information on media literacy available to patients and families.

[Adopted 2006, reaffirmed 2019, amended 2009, 2014, 2024]

HP-9896

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.
6. Legislation or amendments to current firearm laws intended to protect the public at large, including waiting periods, background checks, and regulations that restrict access to firearms for individuals with violent and/or criminal histories.

7. Research on firearm-related injuries and deaths, gun violence education, and suicide risk assessment and prevention.

[Adopted 1993, reaffirmed 1998, 2005, 2010, amended 2014, 2020, 2023]

HP-9898

Proliferation and Dispersal of Anti-personnel Weapons (paper on page 231)

[Adopted 2012, reaffirmed 2017, 2022]

HP-10000 Substance Use Disorder

HP-10020 General

HP-10022

AAPA recognizes the significant public health implications of substance use disorders. AAPA supports the education of all PAs in the early identification, treatment and prevention of substance use disorders.
[Adopted 2024]

HP-10026

AAPA supports needle/syringe exchange programs, legal access and safe disposal of used 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.

[Adopted 2003, reaffirmed 2008, 2014, 2019, amended 2009, 2024]

HP-10028

AAPA endorses and encourages state constituent organizations to advocate for the establishment of supervised consumption 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 consumption facilities.

[Adopted 2018, amended 2023]

HP-10032

AAPA supports the utilization of Prescription Drug Monitoring Programs (PDMP) as a tool to practice responsible 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, amended 2023]

HP-10034

AAPA supports the principle and practice of harm reduction in the prevention and treatment of substance use disorders.

[Adopted 2025]

HP-10040 Alcohol

HP-10042

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.

[Adopted 1985, reaffirmed 1990, 1995, 2005, 2010, 2015, 2025, amended 2000, 2020]

HP-10044

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.

[Adopted 1982, reaffirmed 1990, 1995, 2000, 2005, 2010, 2015, amended 2021]

HP-10046

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.

[Adopted 1995, reaffirmed 2000, 2005, 2010, 2015, 2025, amended 2020]

HP-10060 Cannabinoids

HP-10062

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.

[Adopted 2009, reaffirmed 2014, amended 2016, 2021]

HP-10064

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

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

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

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

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

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.

[Adopted 2016, amended 2021, 2023]

HP-10084

AAPA supports PAs having the same educational requirements and patient capitation limits as physicians when treating Opioid Use Disorder with buprenorphine/buprenorphine-naloxone.

[Adopted 2018, amended 2023]

HP-10086

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

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, reaffirmed 2024]

HP-10089

AAPA supports continuation and expansion of flexibilities of the use of methadone and buprenorphine introduced by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the US Drug Enforcement Administration (DEA) during the Covid-19 Pandemic for the Treatment for Opioid Use Disorder (OUD) allowing for increased access to medication-assisted treatment, including:

- allowing opioid treatment programs dispensing methadone to provide take home medication more quickly.
- relaxed rules regarding telemedicine for buprenorphine access.

[Adopted 2023]

HP-10090

AAPA supports efforts to optimize resources for PAs to navigate the methadone exemption processes.

[Adopted 2019, amended 2023]

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

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

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]

HP-10098

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

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.

[Adopted 2002, amended 2010, reaffirmed 2005, 2015, 2020, 2025]

HP-10120 Tobacco

HP-10122

Tobacco Use Disorder (paper on page 242)

[Adopted 2016, amended 2021]

HP-10124

Vaping: Use of Electronic Nicotine Delivery Systems (paper on page 287)

[Adopted 2020, reaffirmed 2025]

HP-10200 Alternative Medicine

HP-10220

AAPA supports the informed and evidence-based use of complementary and integrative health therapies.

[Adopted 2019, amended 2024]

HP-10400 “Conversion or Reparative” Therapy

HP-10420

AAPA opposes any treatment directed specifically at changing sexual orientation or gender identity.

[Adopted 2007, amended 2017, reaffirmed 2012, 2022]

HP-10440

Attempts to Change a Minor's Sexual Orientation, Gender Identity, or Gender Expression (paper on page 264)

[Adopted 2017, reaffirmed 2022]

HP-10600 Correctional Healthcare

HP-10620

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*.

AAPA encourages all juvenile confinement facilities to seek accreditation using NCCHC's Standards for Health Services in Juvenile Confinement Facilities.

AAPA encourages all correctional health professionals to maintain their professional credentials and seek recognition through NCCHC's Certified Correctional Health Professional Program.

[Adopted 1992, amended 2012, reaffirmed 1997, 2002, 2007, 2017, 2022]

HP-10640

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.

[Adopted 1984, amended 2000, reaffirmed 1990, 1995, 2005, 2010, 2015, 2020, 2025]

HP-10800 Emergency Medicine

HP-10820

AAPA believes overcrowded emergency departments (ED) threaten access to emergency care for all patients.

[Adopted 2007, reaffirmed 2012, 2017, 2022]

HP-10840

AAPA is opposed to the practice of boarding admitted patients in the ED as it threatens the safety and quality of care of all ED patients.

[Adopted 2007, reaffirmed 2012, 2017, 2022]

HP-10860

AAPA recommends that hospital industry leaders develop boarding and diversion standards, as well as guidelines, measures, and incentives for implementation, monitoring and enforcement of these standards.

[Adopted 2007, reaffirmed 2012, 2017, 2022]

HP-10880

AAPA supports regulatory oversight that requires reporting of boarding information to CMS, and that CMS make the data publicly available, and that CMS ultimately develop a quality measure on boarding.

[Adopted 2007, reaffirmed 2012, 2017, 2022]

HP-10900

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.

[Adopted 2007, reaffirmed 2012, 2017, 2022]

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 Environmental Health

HP-11020

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, 2025]

HP-11060

AAPA encourages PAs to actively participate in the development and sharing of 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, 2025]

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, 2025]

HP-11100

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

[Adopted 2015, reaffirmed 2020]

HP-11110

AAPA acknowledges that climate change is a public health crisis, affecting both the mental and physical health of the patients and communities we serve.

AAPA advocates for policies limiting atmosphere temperature elevation and reducing greenhouse gas emissions to achieve carbon neutrality.

AAPA supports efforts to achieve environmental stability and encourages PAs to stay knowledgeable on their role in advocating for a better environment for all.

AAPA encourages all PAs and PA students to learn about the impacts of climate change on health equity.

[Adopted 2024]

HP-11120

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

[Adopted 1982, amended 2005, 2010, reaffirmed 1990, 1995, 2000, 2015, 2020, 2025]

HP-11130

AAPA acknowledges the importance of environmental health and the impact of globalization and supports educational activities that inform the PA profession and the public on these topics.

[Adopted 2025]

HP-11200 Genetics and Genomics

HP-11220

Genetic and Genomic Testing (paper on page 278)

[Adopted 2019, amended 2024]

HP-11230

AAPA denounces the use of race as a proxy for biology or genetic ancestry and encourages knowledge of the distinction between race and genetics. AAPA recognizes race is a social construct and is distinct from biology or genetic ancestry. AAPA supports eliminating race-based medicine from medical education, clinical practice, research, and policy.

[Adopted 2024]

HP-11240

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.

[Adopted 2001, reaffirmed 2006, 2011, 2016, 2021]

HP-11260

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.

[Adopted 2003, reaffirmed 2008, 2013, 2018, 2023]

HP-11400 Infectious Disease

HP-11420 General

HP-11422

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, 2025]

HP-11440 Antimicrobial Resistance

HP-11442

AAPA recognizes antimicrobial resistance is a dynamic, complex, and critical global issue that poses an urgent threat to public health. AAPA recognizes that acquired resistance to antimicrobial is compounded by the overuse of these agents, inappropriate antimicrobial prescribing practices, broad agricultural use of antimicrobials, and the limited development of new antimicrobial agents. AAPA urges PAs to be informed of resources and current recommendations from the Centers for Disease Control and Prevention, the Infectious Diseases Society of America, and other relevant advisory groups and to engage in antimicrobial stewardship consistent with these recommendations. AAPA urges PAs to educate patients, caregivers, and the public on antimicrobial resistance and appropriate antimicrobial use. AAPA encourages PAs to maintain an awareness of antimicrobial resistance trends, emerging research, and professional guidance related to the use of antimicrobial agents.

[Adopted 2019, amended 2024, 2025]

HP-11460 HIV/AIDS

HP-11462

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.

[Adopted 1992, amended 2012, reaffirmed 1997, 2002, 2007, 2017, 2022]

HP-11464

Global Epidemic HIV/AIDS (paper on page 323)

[Adopted 2005, amended 2010, 2015, 2020, 2022]

HP-11480 Hepatitis C

HP-11482

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-11490 Tuberculosis

HP-11492

AAPA recognizes the increased risk and prevalence of tuberculosis among vulnerable populations and encourages prioritization of routine screening practices to promptly identify, treat, and monitor tuberculosis within these communities.

[Adopted 2025]

HP-11600 Mental Health

HP-11620

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.

[Adopted 2006, reaffirmed 2016, amended 2011, 2021]

HP-11640

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, reaffirmed 2023]

HP-11800 Neurology

HP-11820

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.

[Adopted 1986, reaffirmed 1991, 1996, 2011, amended 2001, 2006, 2016, 2021]

HP-12000 Obesity

HP-12020

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, reaffirmed 2023]

HP-12200 Oral Health

HP-12220

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

AAPA supports organ, tissue, blood, and blood component donation and transplantation and believes:

- PAs should be familiar with the criteria for identifying potential donors.
- Eligibility criteria for the donation should be consistent with evidence-based findings for safe donation, reflect individual risk factors for donation, and be free of stigma and discrimination.
- PAs should be involved where appropriate in the discussion regarding donation and the acquisition of donations as medically indicated.
- PAs who are knowledgeable regarding donation and transplantation should be actively involved in the education of those in healthcare as well as the general public.
- Transplantation should be made available based on need rather than ability to pay.

Furthermore, AAPA supports continued risk reduction measures and rigorous testing of donated blood and/or blood products prior to transfusion.

[Adopted 2023]

HP-12600 Palliative Care/End of Life

HP-12620

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.

[Adopted 1992, reaffirmed 1997, 2003, 2008, 2013, 2018, 2023]

HP-12640

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, reaffirmed 2023]

HP-12660

AAPA supports inclusion of PAs in any proposed educational funding for healthcare providers in hospice and palliative medicine.

[Adopted 2018, reaffirmed 2023]

HP-12680

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-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

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 two (2) years then as long as mutually desired by the parent and infant.

[Adopted 1982, reaffirmed 1990, 1995, 2005, 2010, amended 2000, 2015, 2022, 2025]

HP-12840

Medications in Children (paper on page 283)

[Adopted 2019, amended 2024]

HP-12860

Support for Co-parent or Second Parent Adoptions Regardless of Gender (paper on page 307)

[Adopted 2004, reaffirmed 2009, 2014, amended 2015, 2021]

HP-12880

AAPA supports the continued development, expansion, and promotion of safe haven laws and resources.

[Adopted 2025]

HP-13000 Reproductive Health/Obstetrics and Gynecology

HP-13010

AAPA encourages PAs, as providers who increase access to reproductive healthcare, to support and provide reproductive health education, including abortion care, consistent with federal and state law.

[Adopted 2024]

HP-13020

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.

[Adopted 2004, reaffirmed 2009, 2014, 2019, 2024]

HP-13030

AAPA encourages PAs to seek certification in sexual assault forensic exams.

[Adopted 2024]

HP-13040

AAPA supports over-the-counter nonprescription status of emergency contraception pills.

[Adopted 2004, reaffirmed 2009, 2014, 2019, 2024]

HP-13060

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.

[Adopted 2006, reaffirmed 2011, 2016, amended 2021]

HP-13080

Disparities in Maternal Morbidity and Mortality (paper on page 289)

[Adopted 2021]

HP-13100

AAPA opposes restrictions and attempts to restrict the availability of and access to reproductive healthcare.

[Adopted 1992, reaffirmed 1997, 2002, 2007, 2012, 2017, amended 2022]

HP-13120

AAPA encourages its members to work with schools and parents within their communities to establish evidence-based programs for reproductive health education in schools.

[Adopted 1987, reaffirmed 1992, 2005, 2010, 2015, 2025, amended 1997, 2020]

HP-13140

AAPA believes all PAs should advocate for and promote equitable and confidential access to comprehensive, evidence-based, developmentally appropriate, and culturally sensitive sexual and reproductive health information and services. Information and services include family planning, birth control options, as well as prevention of unintended pregnancies and sexually transmitted infections. AAPA should advocate for, and support the availability of, telehealth technology in the provision of these services.

[Adopted 1983, reaffirmed 1990, 1995, 1999, 2005, 2010, 2015, amended 2020, 2023]

HP-13160

AAPA is opposed to any attempt to impose legal or regulatory penalties or retaliation against health care professionals that provide or aid in the delivery of evidence-based reproductive health services.

[Adopted 2023]

HP-13200 Virtual Medicine/Telehealth

HP-13220

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.

[Adopted 1997, reaffirmed 2002, 2007, 2012, 2017, amended 2022]

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

Telemedicine (paper on page 234)

[Adopted 2015, amended 2021]

Promoting the Access, Coverage and Delivery of Healthcare Services

(Adopted 2018, reaffirmed 2023)

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 is 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 is 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

(Adopted 2005, amended 2010, 2016, 2018, 2023)

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 board certification together position the PA profession as one of the most flexible and adaptable professions in modern healthcare.
- 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.
- AAPA believes greater investment in research and funding infrastructures is needed to support knowledge generation, dissemination of best practices, and optimization of these voluntary, workplace-based educational innovations for PAs.

Background

The Commission on Continuing Professional Development and Education (CCPDE) was charged with revising this policy which was last addressed by special purpose task force of the CCPDE in 2016 with further revision incorporated in 2018. The 2016 Task Force acknowledged that published literature addressing the topic was sparse. In the time that has elapsed, numerous publications have appeared in peer-reviewed literature addressing many of the issues of concern.

With the assistance of a scholar who is actively working and publishing in the field, the CCPDE conducted a literature review that identified nearly 30 relevant articles, the vast majority of which were published between 2018 and 2022. Because of the increasing trend of programs that enroll both PAs and NPs, and the fact that the NP profession has been developing postgraduate programs of their own, NP literature related postgraduate education was reviewed, though not at the same depth as the PA literature. Commission members were assigned papers to review and prepared summaries for use by the broader membership.

The Commission also reviewed available information from the Association of Postgraduate PA Programs (APPAP) on programs offered by its members including institutional sponsors, clinical focus, length, and number of trainee positions available. The Commission was able to identify 10 non-AAPAP programs in the Veteran's Health Administration and the military, although there may be other programs that we were unable to identify.

In addition to the considerable development of literature, several other changes have taken place since this issue was last addressed in AAPA Policy. These include the following:

- Accreditation of clinical postgraduate programs by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) in abeyance starting in 2014, resumed in 2021.
- An interprofessional accreditation for programs enrolling both PAs and NPs has been introduced by the American Nurses' Credentialing Council Advanced Practice Provider Fellowship Accreditation (ANCC APPFA) and the Consortium of Advanced Practice Providers (CAPP).
- ARC-PA is developing an interprofessional accreditation option in collaboration with the Accreditation Commission for Education in Nursing and draft standards have been released for review and comment.
- A significant minority of programs have incorporated the Doctor of Medical Science degree as an integral or option part of their programs.

Postgraduate clinical education exists within the context of transition to practice programs that are aimed primarily at new graduates and are intended to prepare them for specialized roles in the healthcare system. At one end of the spectrum are so-called "on-boarding" programs that tend to focus on an institution's specific needs and requirements. At the other end are more structured postgraduate programs often referred to as residency or fellowship programs that provide broad training in a specialty. (1) The first published survey conducted in 2008 defined postgraduate clinical training programs as being at least 6 months in duration and including both didactic and onsite clinical training. (2) A review of information available at the AAPAP website and the sites of other programs the Commission was able to find indicates that most programs are 12 months in length with a number of programs extending to 18 months. Most programs award a certificate of completion. (3) Several programs have made the completion of a Doctor of Medical Science degree either an integrated or optional part of their programs. (4)

Postgraduate clinical training programs are offered in nearly 40 specialties. Most programs enroll between 1 and 4 trainees with a few enrolling between 6 and 12. Institutional sponsors include academic institutions, academic hospitals, health systems, and medical groups.

(5) The number of institutional sponsors has grown modestly over the past decade. A 2012 publication identified 61 AAPAP-affiliated programs in 2012 (6) while Kidd and colleagues identified 71 in 2021. (3) This includes sponsors with single and multiple track programs. The number of trainee positions is often expressed as a range indicating that the number enrolled may vary from year to year. The number of training positions available in AAPAP-affiliated programs ranges between 346 and 415. (5) However, a 2021 survey estimated the number of graduates of AAPAP-affiliated programs at 200. (3) Funding is likely the limiting factor in determining how many trainees are enrolled. Emergency medicine and orthopedic surgery represent the largest number of training positions available, comprising nearly 35% of all available positions in AAPAP-affiliated institutions. (5) Given current estimates of nearly 10,000 graduates from ARC-PA accredited schools each year, postgraduate training is an opportunity for a small minority of PAs.

Benefits of Postgraduate Clinical Training

Postgraduate clinical training programs build on the generalist training that PAs receive and prepare them for specialized roles within the healthcare system. There are benefits to both trainees and sponsoring institutions. In a 2021 survey, 83% reported that they sponsored these programs to address workforce needs, 55% engaged to retain career staff, and 93% believed that these programs fostered interprofessional collaboration. (3) A study of a nurse practitioner transition to practice mentoring model without an academic component indicated that it increased employee engagement, decreased turnover, and increased productivity among participants compared with nonparticipants. (7) A program training PAs in critical care was able to retain half of their trainees and program training PAs in neonatology using a residency-style program reported retaining 95% of their trainees over a period of 5 years. (8,9) In terms of trainee outcomes, a program that trained PAs in emergency medicine alongside physician residents found that the performance of PA trainees was comparable to their physician PGY-1 colleagues across multiple assessments. (10) In a 2016 survey, trainees reported that participation made them more competitive in the job market, helped them to negotiate a higher salary, reduced orientation time, increased their confidence in their job, and positioned them for leadership. (11) Nurse practitioners participating in postgraduate clinical training programs reported similar benefits. A 2021 survey compared a large sample of NPs who had completed postgraduate training programs with nonparticipants and found that participants perceived enhanced confidence and role autonomy, improved team collaboration, increased job satisfaction, and a decreased intent to leave their role. (12)

Concerns about Postgraduate Clinical Training Programs

Concerns about postgraduate training come from several perspectives. One criticism concerns the effect on trainee's income. Trainees generally receive a stipend ranging between \$50,000 and \$80,000 per year during the training period. (3) This is considerably below the median income of \$100,000 for new graduate PAs reported in the 2022 AAPA Salary Survey. (13) While participants report that their participation in a postgraduate program made them more competitive in the job market and was useful in negotiating salary, there are no published data demonstrating that they earn higher salaries than their nonparticipant peers.

Other criticism comes from organized medicine where there is fear that the existence of these programs will draw resources from graduate medical education during a time when not all medical students are able to match into an accredited residency program. (14) Current evidence indicates that the majority of funding for programs enrolling PAs comes from sponsoring institutions and private donors with some coming from broader graduate medical education budgets. (3) It should be noted that Federal agencies with an interest in workforce development have recently shown interest in funding postgraduate training programs for nonphysicians. (15) While establishing stable funding mechanisms is an important issue for the entire enterprise, policymakers should pursue an approach that is focused on meeting the workforce needs of the healthcare system as a whole without pitting one profession against another.

Accreditation of Postgraduate Clinical Training Programs

Postgraduate training programs for PAs have existed since 1971 when the first surgical training program was established. By 1988 enough programs were in existence to justify the formation of the Association of Postgraduate Physician Assistant Programs (APPAP) to address common issues. (6) The Accreditation Review Commission of Education for the Physician Assistant (ARC-PA) introduced accreditation standards for postgraduate clinical training programs in 2008. This accreditation program was placed in abeyance in 2014 and restarted in 2021. (4) Relatively few programs sought accreditation during the time that it was available. In a survey conducted just before ARC-PA accreditation resumed, 67% indicated that they would decline accreditation with 48% citing cost as the major reason for not seeking accreditation. However, in the same survey 37% indicated that they would be interested in interprofessional accreditation if it were to become available. (3) Considering that 25% of APPAP programs currently enroll both PAs and NPs this interest is not surprising. (4) Since that time, the American Nurses Credentialing Council Advanced Practice Provider Fellowship Accreditation (ANCC APPFA) and the Consortium for Advanced Practice Providers (CAPP) have introduced interprofessional accreditation of clinical postgraduate training programs that enroll both PAs and

NPs. (16,17) ARC-PA is also developing an interprofessional accreditation program in collaboration with the Accreditation Commission for Education in Nursing and has circulated draft standards for comment. (18) A recent survey of postgraduate programs in emergency medicine and orthopedic surgery confirms the increasing interest in accreditation. Among the respondents 88% had discussed accreditation with their sponsoring institution and 76% had plans to pursue accreditation. Seven PA-only programs intend to seek accreditation through ARC-PA. Five programs that enroll both PAs and NPs intend to seek accreditation through ANCC APPFA. ANCC APPFA has received 8 new applications while CAPP has accredited 24 programs with an additional 6 programs awaiting accreditation. A total of 12 programs have been accredited through ARC-PA. When programs were asked about their motivations for seeking accreditation, external validation of the program's educational quality was cited by 59% followed by 24% seeing accreditation as a way of competing for the most qualified applicants. Cost remains the major barrier for those not pursuing accreditation (18%) followed by a perceived lack of value (6%). While this survey suffered from a low response rate (30%) and was limited to 2 specialties—albeit the ones with the highest number of trainee positions—it documents an important trend toward accreditation and the factors that are motivating these institutions to seek accreditation. (19)

Accreditation of postgraduate clinical training programs has several benefits including the following:

- It provides external validation of a program's academic rigor allowing institutions to compete for the most qualified trainees and providing future employers of these trainees with the assurance that the prospective employees have received structured and high-quality training.
- It provides a framework for research and continuous quality improvement by increasing standardization of programs through consistent standards.
- It protects trainees by ensuring that they can compete with other trainees within the institution for access to procedural training and other important training opportunities.

AAPA supports accreditation for clinical postgraduate PA training programs and interprofessional training programs that enroll PAs. Postgraduate clinical training programs that enroll PAs should seek accreditation through an agency where PAs are represented in the following areas: 1) setting of standards, 2) accreditation program governance, and 3) the survey process.

While there has been a considerable development of the literature since this issue was last addressed, greater investment in funding and research infrastructures is needed to support

knowledge generation, dissemination of best practices, and optimization of these voluntary, workplace-based educational innovations for PAs. Accreditation provides a useful framework for carrying out this work.

References

1. Ricker M, Greene C, Vail A. Advanced Practice Provider Onboarding Support Model Comparison: Is there a Superior Choice? The Internet Journal of Allied Health Sciences and Practice. 2021 Jan 01;19(3), Article 11.
2. Wiemiller MJ, Somers K, Adams MB. Postgraduate physician assistant training programs in the United States: emerging trends and opportunities. J Physician Assist Educ. 2008;19(4):58-63.
3. Kidd VD, Vanderlinden S, Hooker RS. A national survey of postgraduate physician assistant fellowship and residency programs. BMC Medical Education. 2021;21.
<https://doi.org/10.1186/s12909-021-02613-y>
4. Grabenkort R, Hilton G. PA clinical postgraduate training: a half-century of development. JAAPA. 2022; 35:57-61. DOI:10.1097/01.JAA.0000824952.52796.2f
5. The Association of Postgraduate PA Programs. <https://appap.org/programs/pa-and-joint-pa-np-postgraduate-programs-reference-chart-by-specialty/> (Accessed March 15, 2023)
6. Polansky M, Garver GJ, Wilson LN, et al. Postgraduate clinical education of physician assistants. JPEA 2012;23:39-45.
7. Erickson E, Steen D, French-Baker K, et al. Establishing organizational support for nurse practitioner/physician assistant transition to practice programs. Journal for Nurse Practitioners. 2020;17:P485-488. <https://doi.org/10.1016/j.nurpra.2020.11.018>
8. Messing J, Peters M, Vota A, et al. A residency style transition to practice program in trauma and critical care: The George Washington University Hospital Experience. JAANP. 2021;33:1017-1033. DOI# 10.1097/JXX.0000000000000523
9. Morris A, Smith R, Firtzgerald S, et al. Growing neonatal advanced practice providers via mentorship can fill a need. Advances in Neonatal Care. 2021 DOI: 10.1097/ANC.0000000000000847
10. Tsyrlunik A, Goldflam K, Coughlin R. Implementation of a physician assistant emergency medicine residency within a physician residency. Western Journal of Emergency Medicine. 2020;1:45-48. DOI: 10.5811/westjem.2020.11.49052
11. Will KK, Williams J, Hilton G, et al. Perceived efficacy and utility of postgraduate physician assistant training programs. JAAPA 2016;29:46-48. DOI: 10.1097/01.JAA.0000480569.39885.c8

12. Park J, Covelli AF, Pittman P. Effects if completing a postgraduate residency or fellowship program on primary care nurse practitioners' transition to practice. JAANP 2021;43:32-41. DOI# 10.1097/JXX.0000000000000563
13. American Academy of Physician Associate. 2022 AAPA salary report. <https://www.aapa.org/research/salary-report/customized-salary-report/> (Accessed March 15, 2023)
14. Kendall L. Graduate medical education has been threatened. American Journal of Medicine; 2020;133:1017-1018.
15. Health Resources & Services Administration. Advanced nursing education nurse practitioner residency and fellowship (ANE-NPRF) Program. Funding opportunity. https://www.hrsa.gov/grants/find-funding/HRSA-23-009?UTM_campaign=NOFO+Announcement+-+ANE+NPRF+Program&UTM_medium=email&UTM_source=GovDelivery (Accessed March 21, 2023)
16. American Nurses Credentialing Center. Advanced Practice Provider Fellowships Accreditation. <https://www.nursingworld.org/organizational-programs/accreditation/appfa/> (accessed March 15, 2023)
17. Consortium for Advanced Practice. Accreditation. <https://www.apppostgradtraining.com/accreditation/> (accessed March 15, 2023)
18. Accreditation Review Commission on Education for the Physician Assistant. Proposed ACEN/ARC-PA accreditation standards for joint NP/PA postgraduate residency programs. <https://www.arc-pa.org/proposed-acen-arc-pa-accreditation-standards-for-joint-np-pa-postgraduate-residency-programs/> (Accessed March 15, 2023).
19. Kidd VD. Exploring motivations and barriers to accreditation adoption among physician assistant and nurse practitioner emergency medicine and orthopedic surgery residency and fellowship programs. Cureus; 2023. DOI:10.7759/cureus.36490

Guidelines for Updating Medical Staff Bylaws:
Credentialing and Privileging PAs
(Adopted 2012, amended 2017, 2018, 2023)

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 have the right to exercise clinical privileges via the healthcare entity's organized medical staff process and the criteria to request clinical privileges must be clearly defined 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 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 bylaws should provide the process for performance evaluation, protected peer review, grievances, and 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 scope, license, practice and/or 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 often 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 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 examination 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. Current certification may be required by states for licensure or by employers as a condition of employment. Some payors may also require current certification to meet conditions of participation. (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 and 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 recommends following existing AAPA policy when referring to PAs in medical staff bylaws language. PAs should utilize the term “PA” or physician “associate” in a clinical setting when appropriate per applicable law(s) and regulation(s).

Medical staff membership language might state:

Membership on the medical staff shall be extended to physicians, dentists, podiatrists, PAs, 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 practitioners, include:

- current licensure
- relevant training or experience
- current competence
- 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 board certification
- letters from previous employers, physicians, PA peers, or PA program faculty attesting to scope and level of performance
- personal attestation as to physical and mental health status
- evidence of eligibility for 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(s) 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 certain adverse professional 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 board certification number and status, and current and historical state licensure information.

PA Privileges

PA education prepares PAs to practice in any specialty or care setting and to provide care to treat patients of every age. The medical staff bylaws should authorize PAs to be granted clinical privileges consistent with the types of patients they will provide care to and the services they will perform. 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 – initially, at reappointment, or other interim times – might include observed clinical performance, quality improvement data, and other outcome metrics as determined by the hospital and the organized medical staff. Verified logs of clinical procedures, previous competency evaluations, or attestations from previous employers may also be used.

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. For 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 reappointment. (8)

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. Evolving medical interventions and technology are continuously being developed and may require a new delineation of privileges to implement. Additionally, changes to state law may dictate a need to update clinical privileges. Thus, like physicians, PAs may need to request additional privileges.

Competency surrounding such privileges should be determined at the practice or 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 opposes specialty certification as a criterion for the following: 1) entry into specialty practice, 2) licensure, 3) credentialing and privileging, 4) third-party reimbursement. (9) The PA profession does not have a system of specialty certification. Because there are other ways to assess PA competency, AAPA believes imposing specialty boards or specialty examinations 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 a 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 (10) as well as accreditation standards from the Joint Commission (11) 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.

Committees

Bylaws should allow PA representation with full medical staff prerogatives and 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 (12), certifying false labor (13), emergency call (14) and transferring patients. (15) 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 a PA is employed.
- AAPA opposes specialty examinations or specialty certification 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 for PAs should be delineated in the bylaws. The process should involve PA peers and conform to the process applied to physicians.
- Bylaws should provide mechanisms to perform 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 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

- (1) See Centers for Medicare & Medicaid Services (CMS) Requirements for Hospital Medical Staff Privileging, Survey and Certification Letter 05-04, November 12, 2004, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCletter05-04.pdf> and Correlating Regulations 42CFR§ 482.12 and § 482.22 <https://www.gpo.gov/fdsys/pkg/CFR-2015-title42-vol5/xml/CFR-2015-title42-vol5-part482.xml#seqnum482.22>
- (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.”
http://www.cms.gov/manuals/downloads/som107ap_a_hospitals.pdf
- (7) 42USCS §295p; Title 42. The Public Health and Welfare, Chapter 6A – Public Health Services
- (8) 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.”*
- (9) AAPA 2022-2023 Policy Manual, *Specialty Certification, Clinical Flexibility, and Adaptability* [Adopted 2017, amended 2022] Cited at HP-4640 – paper on page 186.
<https://www.aapa.org/about/aapa-governance-leadership/house-of-delegates/policy-manual-papers-and-forms/>

- (10) 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.*”
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf
- (11) 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.
- (12) 42 CFR §489.24(a)(1)(i)
- (13) 42 CFR §489.24(b) Definitions
- (14) 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.*”
- (15) 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.”

<https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec489-24.pdf>

Guidelines for State and Territory Regulation of PAs

(Adopted 1988, amended 1993, 1998, 2001, 2005, 2006, 2009, 2011, 2013, 2016, 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 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's 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 restrictions, 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, board 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

(Adopted 1977, reaffirmed 2004, 2009, amended 1987, 1991, 2001, 2014, 2018, 2023)

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.
- The PA's review of medical facts should be thorough, fair, and impartial without intentionally or deliberately excluding any relevant information.
- A PA offering an opinion should know what constitutes standard of care.
- The PA should not accept a contingency fee or derive personal, financial, or professional favor in addition to compensation.
- The PA serving as an expert witness should not attempt to review or accept for review matters solely on behalf of either the plaintiff or the defense.

Introduction

A PA may serve as a witness in a legal proceeding in one of several capacities. 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 or plaintiff and the judge or jury will need opinions about standards of medical care, if and how a standard of care was met, or how the failure to meet the accepted standard of care caused injury to the patient. The defendant or accused practitioner may also need expert opinions or may testify on their 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.

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.

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, the 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).

Guideline 4: A PA offering an opinion should know what constitutes the standard of care. 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.

Testimony is usually given concerning standard of care 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 5: The PA should testify truthfully and consistently, recognizing any testimony may be subject to peer review.

Customs 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.

Providing expert testimony based on a contingency fee is against public policy in that it allows an expert to promote litigation out of self-interest (i.e., for the sake of collecting fees) rather than for the interest of the real party (i.e., plaintiff or defendant). Entering into a contingency agreement may be grounds for disqualification of an expert (1).

Guideline 7: The PA serving as an expert witness should not attempt to review or accept for review matters solely on behalf of either the plaintiff or defense.

When a PA serving as an expert witness solely reviews or testifies in matters pertaining to one side of a potential litigation, plaintiff or defense, it raises questions of an inherent bias in the expert's opinion or motivation for serving as an expert witness. It is the duty of an expert to provide an honest and ethical opinion regarding the standard of care no matter which party retains the expert.

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 intentionally or deliberately 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 standard of care 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 and Resources

AAPA. "Guidelines for Ethical Conduct for the PA Profession," May 2023.

The Academy of Physician Assistants in Legal Medicine (APALM). www.aapalm.org

Babitsky S. The Ten Biggest Mistakes Experts Make During Deposition.

Mangraviti JJ, Babitsky. How to Excel at Your Expert Witness Depositions. Seak 2013.

Bronstein DA. Law for the Expert Witness. CRC Press. Boca Raton, FL, December 2011.

Lubet S. Expert Testimony: A Guide for Expert Witnesses and the Lawyers Who Examine Them.

National Institute for Trial Advocacy, Notre Dame, IN, 1998.

Malone DM, Zwier PJ. Expert Rules: 100 (and more) Points You Need to Know about Expert Witnesses. Lexis/Nexis, 2012.

Malone DM, Zwier PJ. Effective Expert Testimony. National Institute for Trial Advocacy, 2006.

Poynter D. Expert Witness Handbook: Tips and Techniques for the Litigation Consultant. Para Publishing, January 2012.

Furrow, B, Greaney, T, Johnson, s, Stoltzfus Jost, T, Schwartz, r. (2015) *Health Law* (pp 277-292). West Publishing Co.

Immunizations in Children and Adults

(Adopted 1994, amended 2004, 2006, 2011, 2016, 2018, 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 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 remain 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 socioeconomic 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

1. Peter G. Childhood immunizations. N Engl J Med 1992; 327:1794-800.
2. Centers for Disease Control and Prevention. (2019, March 26). Vaccines for children (VFC). Infographic: Protecting America's Children Every Day. Retrieved November 16, 2021, from <https://www.cdc.gov/vaccines/programs/vfc/protecting-children.html>.
3. Healthy People. Gov. <http://www.healthypeople.gov/2020/default.aspx> Accessed 01/31/2011. Vaccination - Healthy People 2030. (n.d.).

- <https://health.gov/healthypeople/objectives-and-data/browse-objectives/vaccination>. Accessed 11/16/2021/.
4. Hill, HA, Elam-Evans LD, Yankey D, Singleton JA, Kolasa M. National, State, and Local Area Vaccination Coverage Among Children Aged 19 - 35 Months – United States, 2014. *Morb Mortal Wkly Rep* 2015 64(33); 889-896.
<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6433a1.htm> Accessed 2/1/16.
 5. Burns, IT., Zimmerman, RK. Immunization Barriers and Solutions. *J of Family Practice*. 2005; 54(1):S58-S62.
 6. *Increase the proportion of adolescents who get recommended doses of the HPV vaccine - IID-08*. (n.d.). Retrieved November 16, 2021, from
<https://health.gov/healthypeople/objectives-and-data/browse-objectives/vaccination/increase-proportion-adolescents-who-get-recommende-doses-hpv-vaccine-iid-08> .
 7. Kim DK, Bridges CB, Harriman KH. Advisory Committee on Advisory Committee Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older — United States, 2016. *Morb Mortal Wkly Rep* 2016; 65:88–90.
<http://www.cdc.gov/mmwr/volumes/65/wr/mm6504a5.htm>
 8. Williams WW, Lu P, O’Halloran A, Et Al. Surveillance of Vaccination Coverage Among Adult Populations United States 2014. *MMWR Surveill Summ* 2016; 65:1–36. doi:
<http://www.cdc.gov/mmwr/volumes/65/ss/ss6501a1.htm> Accessed 2/15/16
 9. Immunization Action Coalition: Vaccination Information for Healthcare Professionals.
<http://www.immunize.org/>. Accessed 01/31/2011.
 10. National Foundation for Infectious Diseases. Call to Action: Adult Vaccination Saves Lives. Bethesda, MD, 2012. <http://www.adultvaccination.org/resources/cta-adult.pdf>
Accessed February 1, 2016
 11. Infectious Diseases Society of America (IDSA): Policy on Mandatory Immunization of Health Care Workers Against Seasonal and Pandemic Influenza.
http://www.idsociety.org/uploadedFiles/IDSA/Policy_and_Advocacy/Current_Topics_and_Issues/Immunizations_and_Vaccines/Health_Care_Worker_Immunization/Statements/IDSA%20Policy%20on%20Mandatory%20Immunization%20Revision%20083110.pdf.
Accessed 2/19/16.
 12. Centers for Disease Control and Prevention. (2021, February 3). Vaccine preventable adult diseases. Retrieved November 16, 2021, from
<https://www.cdc.gov/vaccines/adults/vpd.html>.

13. Centers for Disease Control and Prevention. (2021, February 12). Adult immunization schedule by vaccine and age group. Retrieved November 16, 2021, from <https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html>.
14. Centers for Disease Control and Prevention. (2021, September 20). Coronavirus disease 2019 (COVID-19). Retrieved November 16, 2021, from <https://www.cdc.gov/dotw/covid-19/index.html>.
15. Pingali C, Yankey D, Elam-Evans LD, et al. National, Regional, State, and Selected Local Area Vaccination Coverage Among Adolescents Aged 13–17 Years — United States, 2020. *MMWR Morb Mortal Wkly Rep* 2021; 70: 1183–1190. DOI: <http://dx.doi.org/10.15585/mmwr.mm7035a1> 
16. Suwono, B., Steffen, A., Schweickert, B., Schönfeld, V., Brandl, M., Sandfort, M., Willrich, N., Eckmanns, T., & Haller, S. (2022). SARS-CoV-2 outbreaks in hospitals and long-term care facilities in Germany: a national observational study. *The Lancet regional health. Europe*, 14, 100303. <https://doi.org/10.1016/j.lanepe.2021.100303>
17. Hashan MR, Smoll N, King C, et al. Epidemiology and clinical features of COVID-19 outbreaks in aged care facilities: A systematic review and meta-analysis. *EClinicalMedicine*. 2021;33:100771. <https://doi.org/10.1016%2Fj.eclinm.2021.100771>

PAs as Medical Review Officers

(Adopted 1991, reaffirmed 2009, 2014, 2019, amended 2004, 2024)

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 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 falsely accused of using illegal drugs 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 (MRO), has a negative impact on the healthcare delivery systems of companies and transit agencies that employ PAs.

The role of an 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) complete qualification training relevant to performing MRO functions.(1)

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.(2) 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 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 successfully perform the duties of an MRO.

According to the published accreditation standards of the Accreditation Review Commission on Education for PAs, which is the accrediting organization for PA educational programs, 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. 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.

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. Additionally, PAs may routinely screen and evaluate drug testing results. PAs, given additional education provided in MRO training seminars currently not available to them, would be very competent MROs and would contribute significantly to the success of compliance with DOT policy.

References

1. 49 Code of Federal Regulations 40.121.
2. 49 Code of Federal Regulations 40.123
3. Accreditation Review Commission on Education for the Physician Assistant. Accreditation Standards for Physician Assistant Education. 2023.

PA Impairment and Well-being

(Adopted 1990, reaffirmed 2004, 2014, amended 1992, 2009, 2019, 2024)

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 encourages a multifaceted approach encompassing education, support systems, ethical responsibilities, legal protections, and collaborative efforts across the profession. Through these measures, patient safety can be upheld while supporting the well-being and rehabilitation of impaired PAs.
- Ethically, PAs bear the responsibility to safeguard patients, which entails refraining from practicing medicine when impaired, advocating for medical evaluation and treatment of impaired colleagues, and intervening when necessary.
- PAs seeking treatment for medical conditions, whether physical, mental, or behavioral, are entitled to the same legal rights and protections as any other patient.
- Hospitals and employers play a crucial role in supporting the well-being of their healthcare workforce, with policies and resources addressing mental health, addiction, and burnout.
- Licensing, credentialing organizations, and insurers should adopt fair, confidential policies regarding PA impairment and return to practice after recovery, adhering to state and federal laws on disability discrimination and healthcare privacy.

Definition of PA Impairment:

The AAPA defines PA impairment as any physical, mental, or behavioral condition that interferes with a PA's ability to safely engage in medical practice. The conditions leading to impairment may be acute or chronic in nature. It is important to note that PA impairment is usually amenable to appropriate medical treatment and/or accommodations which would allow the PA to successfully return to practice. Further, experiencing a challenge to personal well-being is not equivalent to impairment. For most PAs, challenges to personal well-being can be appropriately managed in conjunction with safe medical practice.

Personal Well-being:

Provider well-being promotion and awareness should be integrated into all aspects of the PA profession, including programs, work environments, professional organizations, and continuing medical education. Well-being education should encompass recognizing and addressing impairment issues, including those related to workplace stress, mental health issues,

substance use disorder, addiction, and other external stressors. Well-being awareness includes personal health promotion and burnout prevention, work-life balance, early recognition of challenges to personal well-being, and proactive intervention to reduce the risk for impairment. PAs are encouraged to attend to their own health and well-being, inform themselves of ethical and legal duties, and talk with knowledgeable peers about self-care and potential threats to well-being.

Ethical Responsibilities of PAs Regarding Impairment:

PAs have a responsibility to protect patients. PAs who are impaired should proactively and voluntarily refrain from practicing medicine. PAs should provide support for peers with health-related problems that might result in impairment. Any PA who has concerns that a colleague might be impaired should advocate that the colleague be offered assistance and be evaluated by competent medical personnel. The types of interventions needed can vary and may include one or more of the following: having a frank and supportive discussion with the colleague, reporting to clinical supervisors, or reporting to licensing boards. (2)

Protections for PAs Seeking Medical Treatment:

PAs who seek treatment for a medical (physical, mental, or behavioral) condition are entitled to the same legal rights and protections as any other patient. PAs who voluntarily withdraw from practice for treatment of a medical condition or require reasonable accommodations for a disability, should be free from retaliation or disciplinary action.

Support from Hospitals/Employers:

Hospitals and employers are encouraged to have policies and procedures to support the well-being of their healthcare workforce. This includes making resources and programs available to employees to address mental health, addiction, and burnout.

Licensing and Credentialing Organizations:

Licensing and credentialing organizations should have publicly available written policies regarding PA impairment and return to practice after recovery that are fair, reasonable, confidential, and fit for protecting patient safety. These policies should comply with state and federal laws regarding disability discrimination and healthcare privacy. AAPA supports the following recommendations:

- Licensing boards and credentialing organizations should refrain from asking probing questions regarding PAs' past medical history and should focus on current impairment since last renewal, not illness. Use of the following language is recommended: "Are you currently suffering from any condition for which you are not being appropriately treated

that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner?” (3)

- Medical boards and credentialing organizations should have “safe haven non-reporting” for PAs who are currently receiving appropriate medical treatment or are in stable long-term recovery.
- Medical boards and credentialing organizations should maintain confidentiality of PAs personal health information and avoid public disclosure unless it pertains to professional impairment, medical malpractice, or professional misconduct.
- In rare cases in which an impaired PA refuses to voluntarily withdraw from practice, medical boards and credentialing organizations should require that the PA cease medical practice until no longer impaired. The PA should be afforded clearly defined due process protections.

Professional Liability Insurers:

Professional malpractice insurers should similarly avoid probing questions regarding a PA’s past medical history and should focus on current impairment, not illness.³ Professional malpractice insurers should also consider promoting PA professional well-being practices as a means for supporting quality of care.

References:

1. Adapted from: Federation of State Medical Board, April 2018, “Physician Wellness and Burnout.” Retrieved from <http://www.fsmb.org/siteassets/advocacy/policies/policy-on-wellness-and-burnout.pdf>
2. Candilis PJ, Sulmasy LS. Physician Impairment and Rehabilitation. *Annals of internal medicine*, 11/2019, Volume 171, Issue 9.
3. Jones JTR, North CS, Vogel-Scibilia S, Myers MF, Owen RR. Medical Licensure Questions About Mental Illness and Compliance with the Americans with Disabilities Act. *The journal of the American Academy of Psychiatry and the Law*. 2018;46(4):458-471.

PAs as Medicaid Managed Care Providers

(Adopted 1996, reaffirmed 2004, 2014, amended 1997, 2009, 2019, 2024)

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. (6)
- 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 2022, Medicaid was estimated to account for approximately \$581 billion in federal spending and \$237 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 2021, approximately 77 million Medicaid recipients, more than 85% 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 (3) and level of patient satisfaction (4) 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 the PA profession is one of the fastest growing occupations, with a projected 27% increase in PA employment from 2022 to 2032. (5)

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. (6)
- 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.

References

1. <https://www.macpac.gov/wp-content/uploads/2023/12/EXHIBIT-16.-Medicaid-Spending-by-State-Category-and-Source-of-Funds-FY-2022.pdf>
2. <https://data.medicaid.gov/dataset/52ed908b-0cb8-5dd2-846d-99d4af12b369>
3. <https://pubmed.ncbi.nlm.nih.gov/31145882/>
4. <https://pubmed.ncbi.nlm.nih.gov/31881896/>
5. <https://www.bls.gov/ooh/healthcare/physician-assistants.htm>
6. <https://www.aafp.org/about/policies/all/medicaid-principles.html>

Professional Clinical Competence

(Adopted 1996, amended 2005, 2010, 2015, reaffirmed 2020, amended by substitution 2025)

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 supporting PAs in developing and maintaining the professional competence required to deliver high-quality patient care across the lifespan of their careers from initial training until their retirement from the profession

Introduction

The physician associate (PA) profession has an interest in ensuring that the PAs who deliver healthcare services to the public are competent to do so. Developing and maintaining competence is both a corporate responsibility of the profession involving its regulatory systems (accreditation, certification, licensure, certification maintenance, and privileging) and of individual PAs throughout their clinical careers. Regulatory systems are very focused on assessing PAs as they finish their training and seek to enter the profession. As careers develop and PAs specialize in particular areas of practice, the development and maintenance of competence becomes more individualized and PAs need to monitor their clinical performance gaps through self-regulation, and by seeking and responding to feedback from peers, mentors, and other professional networks. The profession's established competency structure provides a framework for this endeavor. Employers and professional associations such as AAPA must provide PAs with robust continuing professional development opportunities that enable them to assess clinical practice gaps, remediate these gaps, and to develop new skills and competencies.

Competence in PA Practice

Competence has been defined as “The array of abilities (knowledge, skills, and attitudes, or KSA) across multiple domains or aspects of performance in a certain context.” (1)

It is important to distinguish the broad concept of competence from the closely related concept of competencies. A review conducted by Carraccio and colleagues led them to describe “‘competency’ as a complex set of behaviors built on the components of knowledge, skills, attitudes, and ‘competence’ as a personal ability.” (2) This definition emphasizes the crosscutting nature of competence across multiple domains. While individual competencies can be assessed, they contribute to a judgement about competence rather than define it.

The concept of competency-based education (CBE) has been embraced by our educational system at all levels beginning with the introduction of the initial concepts in the 1960s and accelerating through the ‘70s and ‘80s. The impetus came from educators who wanted to ensure that their graduates were prepared for the fields of endeavor that they would enter. CBE shifted the focus from the delivery of a specified curriculum over a specific period of time to a focus on the outcomes of learning. This shift produced an evolution in the structure of courses, teaching methods, and assessment methods. (1)

Assessment of the outcomes of learning is a key component of CBE and in the PA context is reflected in ARC-PA accreditation standards (ARC-PA) (3), the PAEA Core Competencies for New Physician Assistant Graduates (4), and the NCCPA PANCE examination (5). Because these organizations function as gate keepers for those who may enter the profession, assessment at this stage is structured and standardized. PA education focuses on producing medical generalists, and this is reflected in the new graduate competencies and the PANCE exam. However, once in practice PAs often enter into practice areas that go beyond their initial training and receive additional training in these areas. For some, this training takes place in structured postgraduate programs, but more typically this takes place in the workplace during formal onboarding programs or through ongoing mentorship by more experienced clinicians.

Competence as a Multi-layer Construct

Recently ten Cate and colleagues (6) have presented medical competence as a construct consisting of three distinct but interacting layers. The first layer consists of what they describe as “canonical, context-independent knowledge and skill.” An incomplete list of this foundational knowledge that all practitioners should possess includes human physiology and pathology, and evidence-based principles of diagnosis and management of disease. Because this phase is independent of context and takes place primarily during initial school-based training, assessment methods are generally standardized and have high levels of psychometric validity. During training, these assessments direct student progress and at the end of training determine which students are eligible for graduation, certification, licensure, and ultimately entry into the profession.

The next level of the ten Cate model focuses on contextual competence, or the ability of the individual to apply knowledge and skills in the clinical workplace. While Stage 1 was described as context-independent, Stage 2 is specifically context dependent and focuses on the ability of the individual to apply knowledge obtained in Stage 1 in a clinical context. Because each clinical system has unique resources and limitations, standardized assessment methods are less useful here. The standards of performance are determined by teams of experts who develop local protocols for implementing evidence-based practice in a local setting. Assessments are based in the workplace and the focus is on the progressive entrustment of clinical tasks as the clinicians develop and demonstrate their abilities to more senior clinicians.

Increasingly educators and employers are organizing formal “entrustable clinical activities” (EPAs) which were first discussed in the context of PA practice by Lohenry and colleagues. (7)

The concept of “entrustment” involves a judgement that a clinician is able to perform clinical tasks autonomously or with various levels of supervision. The decision to entrust at a given level of supervision or with autonomy is essentially binary (“yes” or “no”) but making this decision should draw upon multiple sources of data. Unlike the context-independent content assessed in Stage 1 where no personal knowledge of individual clinicians is required, assessment at Stage 2 requires exposure to the individual clinicians over time. Ten Cate and colleagues identified five factors that should be considered in making entrustment decisions:

- Agency (proactive toward work, team, safety, personal development)
- Reliability (conscientious, predictable, accountable, responsible)
- Integrity (truthful, benevolent, patient-centered)
- Capability (task-specific knowledge, skills, experience, situational awareness)
- Humility (recognizes limits, asks for help, receptive to feedback) (8)

Note that capability, while foundational, is only one criterion among several others that may seem “soft” by comparison but are crucial to their realization in a manner that ensures the safety and quality of patient care.

Stage 2 as envisioned by ten Cate and colleagues takes place during residency in the training of physicians. (6) While postgraduate programs that enroll PAs are a growing trend, only a small minority of PAs are able to access them. In the PA context this level of training and assessment takes place in the workplace with varying levels of structure and outcomes as perceived by PAs in the transition to practice phase of their careers (9). A number of employers are taking a more structured approach, and a survey of programs has articulated key principles for the design of these programs during this important phase of a PA’s career. (10,11) In the original design of the profession, it was envisioned that a collaborating physician who was likely the PA’s employer would oversee this process. In the current environment PAs increasingly are employed by health systems where they are assigned to departments of PA or combined departments of PAs and nurse practitioners (NPs). In these settings, this form of assessment and development may be incorporated into structured onboarding programs and embedded into ongoing performance management and career ladder programs.

Stage 3 in this model refers to a mature stage of clinician development where basic skills have been reliably consolidated and the clinician may be drawn toward developing skill in specialized areas of practice. This impulse is usually self-directed and valued by the system to the extent that it impacts the

services that the organization is able to offer to the public and the impact on the overall quality of the care offered.

Assessment at this stage is less formal but may include formal entrustment decisions as PAs seek to expand their scope of practice or seek formal credentials within an organization's credentialing and privileging structures. Individual PAs should seek feedback through mentors and peer networks during this stage. Self-regulation and openness to feedback are crucial. Positive contributions to the range and quality of services will be valued by the organization and team members, but if the "fit" with team members and the organization is poor, impaired working relationships and dissatisfied patients may be a result. (6)

How does this model inform how PAs both as individuals and as a profession support the maintenance of competence of the course of a career? First, it is important to note that ten Cate does not present the model as linear, but rather as multilayered where there is interaction among the layers. Advances in biomedical science continue at an unrelenting pace ensuring that the canonical knowledge that characterizes Stage 1 is not entirely static and PAs regardless of career stage must remain aware of these developments and incorporate changes to their practice as appropriate.

NCCPA's PANRE and PANRE-LA have a role in assessing ongoing competence. NCCPA characterizes the focus of PANRE as "core medical knowledge deemed important for all board-certified PAs, regardless of their practice discipline or setting." (12) This relates it to the "canonical knowledge" in Stage 1 of the ten Cate model and its ongoing use in certification demonstrates the ongoing relevance of this knowledge. However, this is not sufficient to demonstrate overall competence.

The PA profession has defined seven broad competency domains, each with multiple defined subcompetencies. These domains include the following:

- Knowledge for Practice
- Interpersonal and Communication Skills
- Person-centered Care
- Interprofessional Collaboration
- Professionalism and Ethics
- Practice-based Learning and Quality Improvement
- Society and Population Health (13)

These competency domains and their associated sub-competencies provide a framework for guiding individual PAs, their employers, and the designers of continuing professional development activities as they collaborate to support the development and maintenance of competence to practice.

A unique feature of the PA profession is the ability of PAs to change from one specialty to another at will, an opportunity that many PAs take advantage of at least once during their careers (14). This poses unique challenges and opportunities for PAs related to competence. Entry into a new specialty requires the PA to revisit the canonical knowledge that is most relevant to the new specialty and to immediately begin to apply it in a context-relevant manner under the guidance of peers and mentors who should make entrustment decisions as the PA entering the new specialty demonstrates competency in performing important clinical tasks vital to their new responsibilities.

Conclusion

Ensuring that PAs who provide care to patients are competent to do so is important for ensuring the safety of patients. The systems for assessing initial and ongoing competence are a shared responsibility of the PA profession and its various regulatory systems, the healthcare system as a whole, and of individual PAs. The nature of assessment of the elements that make up competence changes over the course of a PA's career. Employers, AAPA, and other professional associations should provide PAs with educational opportunities that will enable PAs to assess their clinical practice gaps, remediate identified gaps, and to develop new areas of competence.

References

1. Frank JR, Snell LS, Cate OT et al. Competency-based medical education: Theory to practice. *Med Teach*. 2010;32:638-645.
2. Carraccio C, Wolfsthal SD, Englander R et al. Shifting paradigms: from Flexner to competencies. *Academic Medicine*;2002;361-377.
3. Accreditation Review Commission for the Physician Assistant. ARC-PA Standards, Fifth Edition. Available at <https://www.arc-pa.org/wp-content/uploads/2024/07/Standards-5th-Ed-July-2024.pdf> (accessed 1/16/2023).
4. Physician Assistant Education Association. Core competencies for new physician assistant graduates. 2019. Available at https://paeaonline.org/wp-content/uploads/2021/01/core_competencies-new-pa-graduates-092018.pdf (accessed 1/16/2025)
5. NCCPA. Content blueprint for the physician assistant national certifying examination (PANCE) 2025. Available at <https://www.nccpa.net/wp-content/uploads/PANCE-Blueprint.pdf> (accessed 1/16/2025)
6. ten Cate O, Khursigara-Slattery N, Cruess RL et al. Medical competence as a multilayered construct. *Med Educ* 2024;58:93-104. DOI: 10.1111/medu.15162
7. Lohentry KC, Brenneman A, Goldgar C et al. Entrustable professional activities: a new direction for PA education? *J Physician Asst Educ*. 2017;28:33-40. DOI: 10.1097/JPA.000000000000105
8. ten Cate O, Chen C. The ingredients of a rich entrustment decision. *Medical Teacher*. 2020;42:143-1420.
9. Forister JG, Chlup DT. Novice physician assistant learning during the transition to practice: a Q study. *J Physician Assist Educ*. 2017;28:18-26. DOI 10.1097/JPA.000000000000102
10. Morgan P, Sanchez M Anglin L et al. Emerging practices in onboarding programs for PAs and NPs. *JAAPA* 2020;33:40-46. DOI:10.1097/01.JAA.0000654016.94204.2e
11. Anglin L, Sanchez M Butterfield R et al. Emerging practices in onboarding programs for PAs: strategies for onboarding. *JAAPA* 2021;34:32-38. DOI:10.1097/01.JAA.0000723932.21395.74
12. NCCPA. Content blueprint for NCCPA's physician assistant national recertifying examination (PANRE) and the physician assistant recertifying examination longitudinal assessment (PANRE-LA) 2023. Available at (accessed 1/16/2025)
13. AAPA Policy Manual. Competencies for the PA Profession: p.253 Available at <https://www.aapa.org/download/116915/?tmstv=1737141915> (Accessed 1/17.2025)
14. Kozikowski A, Bruza-Augatis M, Mortani-Rias D et al. Physician assistant/association career flexibility: factors associated with specialty transitions. *BMC Health Serv Res* 2024;24:1660 <https://doi.org/10.1186/s12913-024-12158-7>

The PA in Disaster Response: Core Guidelines
(Adopted 2006, amended 2010, 2015, 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 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 Incident 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 need 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 handwashing, 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 on 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:

- Red: First priority, most urgent. Life-threatening shock or airway compromise present, but patient is likely to survive if stabilized.
- Yellow: Second priority, urgent. Injuries have systemic implications but not yet life threatening. If given appropriate care, the patients should survive without immediate risk.
- Green: Third priority, non-urgent. Injuries localized, unlikely to deteriorate.
- Black: Dead. Any patient with no spontaneous circulation or ventilation is classified dead in a mass casualty situation. No CPR is given. You may consider placement of catastrophically injured patients in this category (dependent) on resources. These patients are classified as “expectant.” Goals should be adequate pain management. Overzealous efforts towards these patients are likely to have deleterious effect on other casualties.

Summary

AAPA endorses 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

1. *Definitions: Emergencies*, WORLD HEALTH ORG., <http://www.who.int/hac/about/definitions/en/> (last visited Mar. 24, 2015).
2. Edbert B. Hsu et al., *Healthcare Worker Competencies for Disaster Training*, BMC MED. EDUC., Mar. 2006, at 19, available at <http://www.biomedcentral.com/1472-6920/6/19>.
3. TASK FORCE ON QUALITY CONTROL OF DISASTER MGMT. & THE WORLD ASS'N FOR DISASTER AND EMERGENCY MED. & THE NORDIC SOC'Y FOR DISASTER MED., HEALTH DISASTER MANAGEMENT GUIDELINES FOR EVALUATION AND RESEARCH IN THE UTSTEIN STYLE (Knut Ole Sundnes & Marvin L. Birnbaum eds., 2003).
4. THOMAS E. DRABEK, STRATEGIES FOR COORDINATING DISASTER RESPONSES (2003).
5. RUSSELL R. DYNES ET AL., U. DEL. DISASTER RESEARCH CTR., A PERSPECTIVE ON DISASTER PLANNING (3d ed. 1981).
6. ENRICO L. QUARANTELLI, U. DEL. DISASTER RESEARCH CTR., MAJOR CRITERIA FOR JUDGING DISASTER PLANNING AND MANAGING THEIR APPLICABILITY IN DEVELOPING COUNTRIES (1998).
7. THE SPHERE PROJECT, <http://www.sphereproject.org/> (last visited Mar. 24, 2015).
8. Bruce M. Altevogt et al., INST. OF MED. OF THE NAT'L ACAD., GUIDANCE FOR ESTABLISHING CRISIS STANDARDS OF CARE FOR USE IN DISASTER SITUATIONS: A LETTER REPORT (2009).
9. John L. Hick, Joseph A. Barbera & Gabor D. Kelen, *Refining Surge Capacity: Conventional, Contingency, and Crisis Capacity*, 3 DISASTER MED. PUB. HEALTH PREP. SUPP. 1 S59-S67 (2009).

Resources

Federal Emergency Management Emergency Management_Institute

<https://training.fema.gov/is/searchis.aspx?search=pds>

IS-120.C An Introduction to Exercises

IS230.D Fundamentals of Emergency Management

IS-235C Emergency Planning

IS-250.B Leadership and Influence

Suggested Textbooks

Ciottone, G.R. (2016). *Disaster Medicine*. Philadelphia: Elseview Mosby. ISBN: 9780323286657

Auerach, P.S. (2020). *Wilderness Medicine*. 7TH ED. Philadelphia: Mosby Elsevier. ISBN: 9780323359429

Davenport, G. (2006). *Wilderness Survival*. 2ND ED. Stackpole Books. ISBN: 9780811732925

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

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

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

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

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

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

Col. U. Sch. of Nursing Ctr. for Health Pol'y & Centers for Disease Control and Prevention, *Bioterrorism & Emergency Readiness: Competencies for All Public Health Workers* (2002), available at <http://training.fema.gov/emiweb/downloads/bioterrorism%20and%20emergency%20readiness.pdf>.

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

Rural Health Clinics

(Adopted 1997, reaffirmed 2014, 2019, amended 2004, 2009, 2024)

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.

- Rural health clinics serve a significant portion of Medicare, Medicaid, and uninsured patients, contributing to the stability of rural healthcare delivery systems and local economies while providing essential primary and emergency care services.
- Utilization of PAs in rural health clinics is vital to increasing access to care. Due to the chronicity of healthcare professional shortages in these areas, utilization of PAs can ensure that high-quality, and timely healthcare is delivered to these communities.
- Cost-based reimbursement for rural health clinics, or equivalent mechanisms, would help toward providing sustainable healthcare to Medicare and Medicaid patients.

Introduction

The Rural Health Clinic Services Act of 1977 increased primary care services in underserved areas by utilizing PAs and other providers. Certified rural health clinics (RHCs) receive capped cost-based reimbursement for treating Medicare and Medicaid patients. RHCs also received specialized Medicaid payments but the specific details on how that works can vary from state-to-state. 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, nurse practitioners (NPs) and certified nurse midwives (CNMs) working with physicians. The purpose of the RHC program is to increase primary care medical services in rural, physician shortage areas by utilizing PAs, NPs and CNMs and providing capped cost-based reimbursement for care of Medicare patients and special RHC rates for treating Medicaid patients.

The concept of reimbursing clinics for services provided by PAs, NPs and CNMs 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. (1) 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 5,200 in 2023. (2)

The rural health clinic program is fulfilling its goal of increasing access to primary medical care in rural areas. The PAs, NPs, CNMs 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. Clinics continue to exist because of the reimbursement methodology that helps to provide financial stability. As of January 1, 2021, all RHCs are subject to a per visit cap. Though all are subject to the statutorily set cap. When the new law went into effect, existing clinics not previously subjected to the federal cap (small hospital-owned RHCs) had their clinic-specific cap based on their 2021 RHC per visit reimbursement rate. As of 2021, all new RHCs, are subject to the statutory cap. Unlike a fee-for-service practice where Medicare payment is based on a set schedule for all services provided, a rural health clinic is paid based on actual practice costs calculated into an all-inclusive rate that is reconciled and adjusted annually. RHC payments are based on the lesser of the actual cost per visit, or the statutory cap, whichever is lower. The rate is subject to an inflationary adjustment each year based upon the Medicare economic index.

In addition, Medicaid payments to rural health clinics varies from state to state but are generally 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 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, NPs and CNMs 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, NPs and CNMs.
- Federal rules require 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.
- 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, NPs and CNMs to contract to provide medical services at RHCs;
 - Set per visit payment levels that cover the actual costs of providing care;
 - 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 temporary staffing 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;
- Maintain eligibility for Medicaid payments for any RHC that has lost its certification regardless of the clinic ownership.

References

1. United States Senate, Committee on Agriculture, Nutrition and Forestry. Medicare Reimbursement for Rural Health Care Clinics. March 29, 1977. Washington, DC: U.S. Government Printing Office. <https://www.ruralhealthinfo.org/topics/rural-health-clinics>
2. Edmund S. Muskie School of Public Service, University of Southern Maine. The characteristics and roles of rural health clinics in the United States; a chart book. January 2003.

Guidelines for Ethical Conduct for the PA Profession

(Adopted 2000, reaffirmed 2013, 2023, amended 2004, 2006, 2007, 2008, 2018, 2024)

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 through 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 the 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 ensure 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.

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

Online Conduct for Physician Associates (PAs)

PAs should maintain the same level of ethical conduct online as is expected in the workplace [when representing themselves as PAs]. It is important for PAs to remember their actions online may impact their reputation with patients and colleagues, as well as have consequences for their medical careers.

In the digital world, where interactions can quickly reach a wide audience, PAs are responsible for maintaining behavior that reflects respect, empathy and ethical standards expected of healthcare professionals. By adhering to these guidelines, PAs ensure that their online presence aligns with the dignity of the profession and the trust placed in them by patients and their colleagues.

All PAs shall refrain from engaging in or endorsing any communication that disparages any group based on characteristic such as race, ethnicity, gender, sexual orientation, nationality, religion, or other characteristic.

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 in 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 and Well-being.

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 changes 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

1. Bauchamps T, Childress J. *Principles of Biomedical Ethics*, Edition 6, Oxford University Press, 2008
2. Jonsen A, Siegler M. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*, 8th Edition, McGraw-Hill Professional Publishing, 2015
3. Nelson, W *Handbook for Rural Health Care Ethics: A Practical Guide for Professionals*, 1st Edition; Dartmouth College Press, 2009.
<https://geiselmed.dartmouth.edu/cfm/resources/ethics/full-book.pdf>
4. American College of Physician's Ethical Manual, Sixth Edition.
<https://www.acponline.org/clinical-information/ethics-and-professionalism/acp-ethics-manual-sixth-edition/acp-ethics-manual-sixth-edition>
5. American Medical Association's Code of Medical Ethics. <https://www.ama-assn.org/delivering-care/ama-code-medical-ethics>
6. AAPA Policy Papers:
Guidelines for the PA Serving as an Expert Witness
(Adopted 1977, reaffirmed 2004, 2009, amended 1987, 1991, 2001, 2014, 2018, 2023) Cited at HP-5520
PA Impairment and Well-being
(Adopted 1990, reaffirmed 2004, 2014 amended 1992, 2009, 2019, 2024) Cited at HP-7244
Use of Medical Interpreters for Patients with Limited English Proficiency
(Adopted 2003, amended 2018, reaffirmed 2008, 2013, 2023) Cited at HP-8223
Acknowledging and Apologizing for Adverse Outcomes
(Adopted 2007, amended 2013, 2018, reaffirmed 2012, 2023) Cited at HP-7444
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
(Adopted 2017, amended 2018, 2021, 2022, 2025) Cited at HP-4248
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 board 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 board recertification process whereby at the time of board 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.

Specialty CAQs	Number Held*	Number of PAs in Specialty**	Estimated Percent of PAs in Specialty with CAQ ***
Cardiovascular and thoracic surgery	67	2,729	2.4
Emergency medicine	1,124	13,219	8.5
Hospital medicine	199	3,859	5.1
Nephrology	36	397	
Orthopaedic surgery	258	11,597	2.2
Pediatrics	78	2,000	3.9
Psychiatry	588	1,887	31.2
Dermatology	N/A	4,350	N/A
Hospice & Palliative	N/A	3,859	N/A

*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*

Credential	Sponsor
Advanced Cardiac Life Support (ACLS)	Various
Advanced Trauma Life Support (ATLS)	Various
Pediatric Advanced Life Support (PALS)	Various
Approved Clinical Supervisor (ACS)	Center for Credentialing & Education
Registered Diagnostic Medical Sonographer (RDMS)	American Registry for Medical Diagnostic Sonography
Board Certified Advanced Diabetes Management (BC-ADM)	American Association of Diabetes Educators
Certified Clinical Densitometrist (CCD)	International Society for Clinical Densitometry
Certified Diabetes Care and Education Specialist (CDCES)	Certification Board for Diabetes Care and Education
Certified Menopause Practitioner (NCMP)	North American Menopause Society
HIV Specialist™ (AAHIVS)	American Academy of HIV Medicine
Fellow of the American College of Critical Care Medicine (FCCM)	American College of Critical Care Medicine
Master of the American College of Critical Care Medicine (MCCM)	American College of Critical Care Medicine
Multiple Sclerosis Clinical Specialist (MSCS)	The Consortium of Multiple Sclerosis Centers

Board Certified Specialist in Obesity and Weight Management	Commission on Dietetic Registration
---	-------------------------------------

*These certifications were uncovered during our environmental scan, but the list is not intended to be exhaustive

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 the 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. Microcredentialing 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

1. Larson EH, Hart LG. Growth and change in the physician assistant workforce in the United States, 1967-2000. *J Allied Health*. 2007;36(3):121-130.
2. Holt N. Confusion's masterpiece: the development of the physician assistant profession. *Bull Hist Med*. 1998;72(2):246-278.
3. Hooker RS, Cawley JF, Leinweber W. Career flexibility of physician assistants and the potential for more primary care. *Health Aff (Millwood)*. 2010;29(5):880-886.
4. TC Physician Assistant Career Flexibility. Poster AAPA 2019.

5. AAPA. *Flexibility as a Hallmark of the PA Profession: The Case Against Specialty Certification*. Vol HP-3200.4.2. AAPA; 2012:195-2001.
6. NCCPA. *2015 Statistical Profile of Certified Physician Assistants*. 2016.
<https://www.nccpa.net/news/2015-statistical-profile-on-certified>. Accessed 02/27/2017.
7. NCCPA. *2020 Statistical Profile of Certified Physician Assistants by Specialty*. 2021.
<http://www.nccpa.net/Uploads/docs/2015StatisticalProfilebySpecialty.pdf>.
8. Glick AD, Miller AA. Physician assistants: from pipeline to practice. *Acad Med*. 2013;88(12):1883-1889.
9. NCCPA. *No Further Changes to PANRE and the Recertification Process*. 2016.
<https://www.nccpa.net/panre-model>. Accessed 02/16/2017.
10. Hussaini SS, Bushardt RL, Gonsalves WC, et al. Accreditation and implications of clinical postgraduate PA training programs. *JAAPA*. 2016;29(5):1-7.
11. AAPA. *Postgraduate Education & Certification*. Vol HP-3200.4.0. AAPA:92-100.
12. Sharp LK, Bashook PG, Lipsky MS, Horowitz SD, Miller SH. Specialty board certification and the clinical outcomes: the missing link. *Academic Medicine*. 2002;77(6).
13. Buckley, S, Coleman J, Davison I, et al. The educational effects of portfolios on undergraduate student learning: a best evidence medical education (BEME) systematic review. BEME Guide No. 11. *Med Teach*. 2009;31(4):282-298.
14. Vance G, Williamson A, Frearson R, et al. Evaluation of an established learning portfolio. *Clin Teach*. 2013;10(1):21-26.
15. Haldane T. Portfolios as a method of assessment in medical education. *Gastroenterol Hepatol Bed Bench*. 2014;7(24):89-93.
16. Development of training-related health care software by a team of clinical educators: their experience, from conception to piloting. *Adv Med Educ Pract*. 2016;7:635-640.
17. Neal JH, Neal JM. Self-directed learning in physician assistant education: learning portfolios in physician assistant programs. *J Physician Assist Educ*. 2016;27(4):162-169.
18. Lohenry KC, Brenneman A, Goldgar C, et al. Entrustable professional activities: a new direction for PA education? *J Physician Assist Educ*. 2017.
19. Colleges AAMC. *Core Entrustable Professional Activities for Entering Residency* 2017.
<https://www.aamc.org/what-we-do/mission-areas/medical-education/cbme/core-epas>

Use of Medical Interpreters for Patients with Limited English Proficiency

(Adopted 2003, amended 2018, reaffirmed 2008, 2013, 2023)

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

1. Schyve, PM. "Language Differences as a Barrier to Quality and Safety in Health Care: The Joint Commission Perspective." *Journal of General Internal Medicine*. Vol 22, Suppl 2, 2007; pp. 360-361.
2. US Census Bureau. American Community Survey 1-Year Estimates. 2016. Available at <https://Factfinder.Census.Gov/Faces/Tableservices/Jsf/Pages/Productview.Xhtml?Src=Bkmk>. Accessed on March 24, 2018.
3. Health and Human Services. "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons." July 26, 2013. Available at <https://www.Hhs.Gov/Civil-Rights/For-Individuals/Special-Topics/Limited-English-Proficiency/Guidance-Federal-Financial-Assistance-Recipients-Title-VI/Index.html>. Accessed on March 24, 2018.
4. Hsieh, E. and Kramer E. M. "Medical Interpreters as Tools: Dangers and Challenges in the Utilitarian Approach to Interpreters' Roles and Functions." *Patient Education and Counseling* Vol 89, No. 1, October 2012; pp. 158-162.
5. Juckett G. and Unger K. "Appropriate Use of Medical Interpreters." *American Family Physician*. Vol 90, No 7, 2014; pp. 476-480.
6. International Medical Interpreters Association. Imia Code of Ethics. 2006. Available at <http://www.Imiaweb.Org/Code/Default.Asp>. Accessed on March 24, 2018.

Competencies for the PA Profession
(Adopted 2005, reaffirmed 2010, 2018, amended 2013, 2021)

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 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 PA 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.

1. Englander R, Cameron T, Ballard AJ, Dodge J, Bull J, Aschenbrener CA. Toward a common taxonomy of competency domains for the health professions and competencies for physicians. *Academic Medicine*. 2013 Aug 1;88(8):1088-94.

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 supersedes self-interest.
- 5.4 Show accountability to patients, society, and the PA profession.
- 5.5 Demonstrate cultural humility and responsiveness to 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 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**

(Adopted 2006, amended 2011, 2016, reaffirmed 2021)

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.

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

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.
- MedlinePlus – <https://www.nlm.nih.gov/medlineplus>
The National Library of Medicine’s Consumer Health Portal for Patients and Health Professionals. This site links to the National Institute of Health and provides tutorials, graphs, audio instructions, and resources in different languages.
- NIH Senior Health - <http://nihseniorhealth.gov/> - a site designed for older adults and caregivers. This 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

1. Nielsen-Bohlman, L., Panzer, A. M., & Kindig, D. A. (Eds.). (2004). Health literacy: A prescription to end confusion. Washington, DC: National Academies Press.
2. Department of Health and Human Services' Office of Disease Prevention and Health Promotion. *National Action Plan to Improve Health Literacy*.
http://www.health.gov/communication/hlactionplan/pdf/Health_Lit_Action_Plan_Summary.pdf
Accessed December 12, 2010.
3. McQueen, D., KL, P., Pelikan, J. M., Balbo, L., Abel, T. (Ed.). (2007). In Health and Modernity: The Role of Theory and Health Promotion. Springer.
4. Sorensen, K., Van Den Brouke, S., Fullam, J., Doyle, G., Pelikan, J., Slonska, Z., Brand, H. (2012). Health Literacy and Public Health: A Systematic Review and Integration of Definitions and Models. BMC Public Health. 12 (80).
5. Davis, T. Wolf, D. (2004). Health Literacy: Implications for Family Medicine. Family Medicine, 36(8),595-598.
6. Nutbean, D. (2000). Health Literacy as a Public Goal: A Challenge for Contemporary Health Education and Communication Strategies into the 21st Century. Health Promotion,15 (3),259-267.
7. Agency for Healthcare Research and Quality. Health Literacy Universal Precautions Toolkit.
<http://www.ahrq.gov/qual/literacy/>. Accessed December 25, 2010.
8. AAPA Policy Manual, HP-9660. Accessed November 26, 2015.
9. Baker, D. W. (2006). The Meaning of and the Measure of Health Literacy. Journal of Internal Medicine, 21,878-883.
10. Mancuso, J. M. (2008). Health Literacy: A Concept/Dimensional Analysis. Nursing Health Science, 10, 248-255.
11. McCray, A. (2004). Promoting Health Literacy. Journal of American Medical Informatics Association, 2,152-163.

12. US Department of Health and Human Services. Healthy People 2020.
<http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicid=18>
Accessed January 4, 2011.
13. Shipman JP, Kurtz-Rossi S, Funk CJ. The health information literacy project. Journal of the Medical Library Association. 2009 Oct;97(4):293-301.

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 and is committed to the model of interprofessional team care.”
 - “AAPA maintains that continuity of care is a high priority and supports regulation and policy that maximizes the potential for communication between the episodic care provider and the primary provider within the constraints of laws and associated rules regarding patient confidentiality and individual patient preference.”

[HP-5624, Adopted 2003, reaffirmed 2008, 2013, amended 2018, 2023]

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 are 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. The 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 the 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

1. Jacoby, Richard, Albert G. Crawford, et al. "Quality of Care for 2 Common Pediatric Conditions Treated by Convenient Care Providers." *American Journal of Medical Quality*. 2010.
2. Mehrotra, Ateev, Llu Hangsheng, John L. Adams, et al. "Comparing Costs and Quality of Care at Retail Clinics with that of Other Medical Settings for 3 Common Illnesses." *Annals of Internal Medicine*. 151 no. 5 (2009):321-328.

False or Deceptive Healthcare Advertising
(Adopted 2007, reaffirmed 2012, 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 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

- 1 Federal Trade Commission Act, 15 U.S.C. §41 et seq
- 2 Daynard M. “Physicians and Deceptive Advertising: How Should Federal and State Regulators Respond?” Brief based on speech presented at Administrators in Medicine meeting, April 22, 1992, Cambridge, MA.
www.clearhq.org/97-4.htm. Accessed February 2022.
- 3 Bernstein J. Federal Trade Commission testimony presented before Committee on Government Reform, U.S. House of Representatives, March 1999. “Agency Lockout on the Off-Label Use of EDTA Chelation Therapy”.
https://www.ftc.gov/sites/default/files/documents/public_statements/prepared-statement-federal-trade-commission-chelation-therapy/acamtestimony.pdf Accessed February 2022.
- 4 American Academy of Orthopaedic Surgeons. Opinions on Ethics and Professionalism. Advertising by Orthopaedic Surgeons.
<https://www.aaos.org/contentassets/6507ec63e5ac4ea48375ad96d154daac/1205-advertisingopiniononethicsbodapprovedjune2016.pdf> Accessed February 2022.

Acknowledging and Apologizing for Adverse Outcomes
(Adopted 2007, amended 2013, 2018, reaffirmed 2012, 2023)

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

1. Institute of Medicine; Committee on Quality of Health Care in America. *To Err is Human: Building a Safer Health System*. Washington DC: National Academies Press;1999.
2. Makary MA, Daniel A. Medical Error-the Third Leading Cause of Death in the US. *BMJ*. 2016; 353:i2139
3. Conway J, Federico F, Stewart K, Campbell MJ. *Respectful Management of Serious Clinical Adverse Events (Second Edition)*. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on www.IHI.org)
4. Gallagher TH, Waterman AD, Ebers AG, et al. Patients' and physicians' attitudes regarding the disclosure of medical errors. *JAMA*. 2003;289: 1001-1007.
5. Wu AW, Huang IC, Stokes S, Pronovost PJ. Disclosing Medical Errors to Patients: It's Not What You Say, It's What They Hear. *J Gen Intern Med*. 2009;24(9):1012–1017.
6. Kraman SS, Hamm G. Risk management: extreme honesty may be the best policy. *Ann Intern Med* .1999;131:963–967.
7. Braxton K, Poe, K. Disclosure of medical errors; Is honesty the best policy legally? 2006 ABA Health eSource, Jan 2006; Vol.2, No.5
8. Morton H. National Conference of State Legislatures. *Medical Professional Apologies Statutes*. Jan. 21, 2014.
9. Wojcieszak D, Banja J, Houk, C. The sorry works! coalition: making the case for full disclosure. *J Qual Patient Safety*. 2006; 32:344-350.
10. Sorry Works! Coalition. <https://sorryworks.net/our-approach/>. Accessed Jan 23, 2018.

Routine Vaccination for Human Papillomavirus
(Adopted 2008, amended 2012, 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.

- 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.
<http://www.cdc.gov/cancer/hpv/statistics/cases.htm>. Accessed December 11, 2016.
2. Chesson HW, Ekwueme DU, Saraiya, M, et al. Estimates of the annual direct medical costs of the prevention and treatment of disease associated with human papillomavirus in the United States. *Vaccine*. 2012;30(42):6016-6019.

3. Office of Disease Prevention and Health Promotion HealthyPeople.gov. Immunization and infectious disease IID-11.4, IID-11.5. <https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases/objectives>. Accessed December 11, 2016.
4. Reagan-Steiner S, Yankey D, Jeyarajah J, et al. National, regional, state, and local area vaccination coverage among adolescents aged 13-17 years—United States, 2015. *MMWR*. 2016;65(33):850-858.
5. Meites E, Kempe A, Markowitz LE. Use of a 2-dose schedule for human papillomavirus vaccination—updated recommendations of the Advisory Committee on Immunization Practices. *MMWR*. 2016;65:1405-1408.
6. Romanowski B, Schwarz TF, Ferguson L, et al. Sustained immunogenicity of the HPV-16/18 AS04-adjuvanted vaccine administered as a two-dose schedule in adolescent girls: Five-year clinical data and modeling predictions from a randomized study. *Human Vaccines & Immunotherapeutics* 2016; 12(1): 20-29.
7. Malo TL, Gilkey MB, Hall ME, et al. Messages to motivate human papillomavirus vaccination: national studies of parents and physicians. *Cancer Epidemiol Biomarkers Prev*. 2016;25(10):1383-1391.
8. Gilkey MB, Malo TL, Hall ME, Brewer NT. Quality of physician communication about human papillomavirus vaccine: findings from a national survey. *Cancer Epidemiol Biomarkers Prev*. 2015;24(11):1673-1679.

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 suggests 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 suggests 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.
6. Support legislation and policy that eliminates disparities.

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

1. Smedley, BD, Stith AY, Nelson AR, eds. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academies Press, 2003.
2. U.S. Department of Health and Human Services. HHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in Health and Health Care. Washington, D.C.: U.S. Department of Health and Human Services, [April 2011].
<http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&id=285> Accessed November 4, 2015
3. American Public Health Association. Health Disparities: The Basics.
https://www.apha.org/~media/files/pdf/factsheets/hlthdisparty_primer_final.ashx Accessed November 4, 2015
4. How to Close the LGBT Health Disparities. Center for American Progress.
<https://www.americanprogress.org/issues/lgbt/report/2009/12/21/7048/how-to-close-the-lgbt-health-disparitiesgap/> Accessed November 4, 2015.
5. US Department of Health and Human Services. Healthy People 2020.
<http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39> Accessed January 4, 2011.
6. Williams DR, Mohammed SA. Discrimination and racial disparities in health: evidence and needed research. J Behav Med. 2009 Feb;32(1)20-47.
7. National Academies Press. Unequal Treatment: What Healthcare Providers Need to Know About Racial and Ethnic Disparities in Healthcare Report Brief.
<https://iom.nationalacademies.org/~media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/Disparitiesheproviders8pgFINAL.pdf> Accessed January 7, 2016
8. Green A, Carney D, Pallin D, et al. Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. J Gen Intern Med. Sep 2007;22(9):1231-1238.
9. Todd K. Influence of ethnicity on emergency department pain management. Emerg Med (Fremantle). 2001 Sep;13(3):274-8.
10. Pomeranz H. Health Care Disparities: Stereotyping and Unconscious Bias. Physician Assistant Education Association 2008 Annual Conference Presentation. Accessed January 25, 2011.

11. Burgess D, van Ryn M, Dovidio J, Saha S. Reducing racial bias among health care providers: lessons from social-cognitive psychology. *J Gen Intern Med* 2007 Jun;22(6):882-7.
12. Galinsky A, Moskowitz G. Perspective-taking: decreasing stereotype expression, stereotype accessibility, and in-group favoritism. *J Pers Soc Psychol* 2000 Apr;78(4):708-24.
13. Kunda Z, Spencer S. When do stereotypes come to mind and when do they color judgment? A goal-based theoretical framework for stereotype activation and application. *Psychol Bull* 2003 Jul;129(4):522-44.
14. Rudman L, Ashmore R, Gary M. "Unlearning" automatic biases: the malleability of implicit prejudice and stereotypes. *J Pers Soc Psychol* 2001 Nov;81(5):856-68.
15. Project Implicit. Implicit Association Test. <https://implicit.harvard.edu/implicit/demo/>. Accessed January 4, 2011.
16. AAPA Strategic Plan. <https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=655> Accessed November 4, 2015.

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 land mines.
- 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 ordinance is necessary.

Introduction

The 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 Ordinance

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 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 countries 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

1. Wennerstrom M, Baaser S, Salams P, et al. Injuries Associated with Landmines and Unexploded Ordnance --- Afghanistan, 1997—2002. MMWR. 2003;52(36);859-862.
<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5236a2.htm>. Accessed December 21, 2011.

2. Bilukha OO, Brennan M, Woodruff BA. Death and Injury from Landmines and Unexploded Ordnance in Afghanistan. *JAMA*. 2003;290:650-653
3. Raddick L, Pierro A. U.S. Attends Mine Ban Treaty Meeting as Observer: Civil Society Frustrated by Languishing U.S. Landmine Policy Review. United States Campaign to Ban Landmines.
http://www.uscbl.org/fileadmin/content/images/Press_Releases/December_2_2011_11MSP_Closing_USCBL.pdf. Published December 2, 2011. Accessed December 21, 2011.
4. Human Rights Watch. US: Ban Landmines. Human Rights Watch.
http://www.kintera.org/c.nIIWIgN2JwE/b.5543975/k.A24D/US_Ban_Landmines/siteapps/advocacy/ActionItem.aspx. Accessed December 21, 2011.
5. Gaouette N. Clinton Sees Progress on Landmines Even as U.S. Won't Ban Them. Bloomberg Business Week: <http://www.businessweek.com/news/2011-12-19/clinton-sees-progress-on-landmines-even-as-u-s-won-t-ban-them.html>. Published December 19, 2011. Accessed December 20, 2011.
6. U.S. Department of State, Office of the Spokesman. The United States Celebrates Central America Freeing Itself from Impact of Landmines.
<http://www.state.gov/r/pa/prs/ps/2010/07/144032.htm>. Published July 6, 2010. Accessed December 22, 2011.
7. James F. Cluster-bomb ban U.S. opposes passes. Chicago Tribune, The Swamp.
http://www.swamppolitics.com/news/politics/blog/2008/05/clusterbomb_ban_us_opposes_pas.html. Published May 30, 2008. Accessed December 21, 2011
8. International Campaign to Ban Landmines. States Not Party. International Campaign to Ban Landmines. <http://www.icbl.org/index.php/icbl/Universal/MBT/States-Not-Party>. Accessed December 22, 2011.
9. International Campaign to Ban Landmines. Landmine survivors welcome progress at global mine-ban meeting but say much more to be done as casualty toll continues to rise. International Campaign to Ban Landmines. http://www.icbl.org/index.php/icbl/Library/News-Articles/11MSP_ends. Published December 2, 2011. Accessed December 21, 2011.

Telemedicine

(Adopted 2015, amended 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.

- 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. The 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 PA 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

1. Kruse CS, Krowski N, Rodriguez B, *Et Al.* Telehealth, and Patient Satisfaction: A Systematic Review and Narrative Analysis *BMJ Open* 2017;7:E016242. doi: 10.1136/BMJopen-2017-016242
2. Chaet D, Clearfield R, Sabin JE, Skimming K. Ethical Practice in Telehealth and Telemedicine. *J Gen Intern Med.* 2017;32(10):1136-1140. doi:10.1007/S11606-017-4082-2.
3. Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine http://www.fsmb.org/siteassets/advocacy/policies/fsmb_telemedicine_policy.pdf Accessed March 6, 2020
4. Mechanic OJ, Kimball AB. Telehealth Systems. In: *Statpearls*. Treasure Island (FL): Statpearls Publishing; 2020. <http://www.ncbi.nlm.nih.gov/books/nbk459384/>. Accessed March 6, 2020.
5. The Top 7 Things Every PA Should Know About Virtual Medicine and Telemedicine. *AAPA*. Published in 2019. Accessed January 2, 2019.
6. Interstate Medical Licensure Compact | A Faster Pathway to Medical Licensure. <https://imlcc.org/>. Accessed March 6, 2020.
7. Walker C, Echternacht H, Brophy PD. Model for Medical Student Introductory Telemedicine Education. *Telemed J E Health* 2019;25(8):717-723. doi:10.1089/tmj.2018.0140 Accessed March 15, 2021
8. Amirian I, Maaz M, Phan S. Telemedicine: Benefits for Patients, Providers, and Health Care Institutions. *Neurol Rev.* March 2017;41-44. Accessed March 6, 2020.
9. The Shift to Value-Based Care: Technology Will Be Key. <https://www.elsevier.com/solutions/revenue-cycle-elearning/revenue-cycle-resources/revenue-cycle-blog/revenue-cycle-articles/the-shift-to-value-based-care-technology-will-be-key>. Accessed March 6, 2020.
10. Recommendations from the CCHP Telehealth and the Triple Aim Project: Advancing Telehealth Knowledge and Practice https://www.cchpca.org/sites/default/files/2018-09/telehealth%20%20triple%20aim%20report%2020_0.pdf. Accessed March 6, 2020
11. McConnochie KM. Webisode Manner: A Key to High-Quality Primary Care Telemedicine for All. *Telemed J E Health.* 2019;25(11):1007-1011. doi:10.1089/tmj.2018.0274, Accessed August 30, 2020
12. Devin M Mann, Ji Chen, Rumi Chunara, Paul A Testa, Oded Nov, COVID-19 Transforms Health Care Through Telemedicine: Evidence from the Field, *Journal of the American Medical Informatics Association*, Volume 27, Issue 7, July 2020, Pages 1132–1135, <https://doi.org/10.1093/jamia/ocaa072> Accessed August 30, 2020

13. Telehealth: A Quarter-Trillion-Dollar Post-COVID-19 Reality?

<https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality#>. Accessed August 31, 2020.

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.”

<https://pubmed.ncbi.nlm.nih.gov/32179055/>

2. Irreversible lung damage and lung disease from e-cig chemicals

<https://www.lung.org/quit-smoking/e-cigarettes-vaping/impact-of-e-cigarettes-on-lung>

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

- AAPA supports state utilization of tobacco settlement money for prevention and treatment of nicotine use. 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 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.

References

1. Anderson, J.E., Jorenby, D.E, Scott, W.J., & Flore, M.C. (2002). Treating tobacco use and dependence: An evidence-based clinical practice guideline for tobacco cessation. *Chest*, 121, p. 932-941
2. U.S. Department of Health and Human Services. The Health Consequences of Smoking-50 years of Progress: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.
3. Centers for Disease Control and Prevention (2014, November). Smokeless tobacco: Health effects. Retrieved from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/smokeless/health_effects
4. Goniewicz, M.J., Lingas, E.O., & Hajek, P. (2012). Patterns of electronic cigarette use and user beliefs about their safety and benefits: An internet study. *Drug and Alcohol Review*, 32(2), 133-140.
5. American Lung Association, Smoking Facts; E-Cigarettes and Lung Health. <http://www.lung.org/stop-smoking/smoking-facts/e-cigarettes-and-lung-health.html?referrer=https://www.google.com/> Accessed January 15, 2021
6. CDC Youth Risk Behavior Surveillance Survey (2019) <https://www.cdc.gov/healthyyouth/data/yrbs/results.htm>
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
8. American Lung Association (n.d.). Smoking facts; E-cigarettes and Lung Health. <http://www.lung.org/stop-smoking/smoking-facts/e-cigarettes-and-lung-health.html?referrer=https://www.google.com/> Accessed January 25, 2016
9. Polosa, R., Caponnetto, P., Morjaria, J.B., Papale, G., Campagna, D., & Russo, C. (2011). Effect of an electronic nicotine delivery device (e-cigarette) on smoking reduction and cessation: A prospective 6-month pilot study. *BMC Public Health*, 11, 786.
10. Bullen, C., McRobbie, H., Thornley, S., Glover, M., Lin, R., & Laugesen, M. (2010). Effect of an electronic nicotine delivery device (e-cigarette) on desire to smoke and withdrawal, user preferences, and nicotine delivery: randomized cross-over trial. *Tobacco Control*, 19(2), 98-103

11. Albuquerque, M., Starr, G., Schooley, M., Pechacek, T., & Henson, R. (n.d.) Advancing tobacco control through evidence-based programs. Retrieved from <http://www.cdc.gov/HealthyYouth/publications/pdf/PP-Ch8.pdf>
12. Jones, W.J., & Silvestri, G.A. (2010). The master settlement agreement and its impact on tobacco use 10 years later: Lessons for physicians about health policy making. *Chest*, 137(3), 692-700.
13. Jayawardhana, J., Bradford, W.D., Jones, W., Nietery, & Silvestri. (2014). Master settlement agreement (MSA) spending and tobacco control efforts. *PloS ONE*, 9(12).
14. Siegel DA, Jatlou TC, Koumans EH, et al. Update: Interim Guidance for Health Care Providers Evaluating and Caring for Patients with Suspected E-cigarette, or Vaping, Product Use Associated Lung Injury — United States, October 2019. *MMWR Morb Mortal Wkly Rep* 2019;68:919–927. doi: <http://dx.doi.org/10.15585/mmwr.mm6841e3external icon>.
15. Marynak K, Gentzke A, Wang TW, Neff L, King BA. Exposure to Electronic Cigarette Advertising Among Middle and High School Students — United States, 2014–2016. *MMWR Morb Mortal Wkly Rep* 2018;67:294–299. doi: <http://dx.doi.org/10.15585/mmwr.mm6710a3external icon>.

**PA Student Supervised Clinical Practice Experiences –
Recommendations to Address Barriers**

(Adopted 2017, amended 2018, 2021, 2022, 2025)

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 precepting students to PAs, patients, and employers.
- AAPA supports revisions to the ARC-PA *Standards* that would aim to increase the supply of qualified preceptors with increased emphasis on flexibility and innovation.
- AAPA supports collaborating with PAEA to develop a toolkit for PA programs and preceptors, to investigate the development of a national database of SCPE for the use of students nationwide and to raise awareness of the potential effect that requiring pre-PA shadowing may have on the availability of SCPE for PA students
- AAPA supports collaboration with external medical organizations to look at ways to support an interprofessional, collaborative clinical training model.
- AAPA encourages the use of technologies such but not limited to simulators and telehealth to enhance or supplement SCPE.
- AAPA supports non-monitory incentives to preceptors and discourages the commoditization of SCPE.
- AAPA supports the development of a national preceptor development program

Introduction

Supervised Clinical Practice Experience (SCPE) 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 includes 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. Changes in the healthcare landscape are making the problem worse. Drivers include the rapid growth of PA programs and the decline in physician-owned practices through mergers, acquisitions, and purchase by venture capital groups (3). 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 were 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 (4). Research conducted by Herrick et al. and published in the November 2015 issue of JAAPA confirmed these findings (5). The Joint Report suggests that obstetrics/gynecology and pediatrics are two of the most difficult SCPE in which to find student placement (5). According to the NCCPA Statistical Profile of Certified PAs, less than two percent of PAs currently work in obstetrics/gynecology, pediatrics and pediatric subspecialties (6).

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 may be best handled if approached by the entire PA community.

While many may look at ARC-PA to limit the number of accredited PA educational programs in order to solve the problem of preceptor shortage, ARC-PA does not have legal authority to stop qualified institutions from stating new PA programs. The role ARC-PA is accrediting PA programs and its 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). 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 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. ARC-PA has responded to changing conditions the past. Examples include revisions in the fifth and sixth editions of the accreditation standards related to general surgery to reflect that there are relatively few general surgeons in the United States. Likewise, the contemporary use of telemedicine has been acknowledged and incorporated into the standards.

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. (5) 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. (5)(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) In a recent article, Kayingo and colleagues have summarized current barriers and bottlenecks that affect the supply of training capacity and highlighted other factors such as hospital mergers and acquisitions, siloed training models, and political and legal restrictions. (3)

Competition from a steady increase in the numbers of allopathic (MD), osteopathic (DO), international 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 data published by the American Association of Medical Colleges, enrollment increased from 85,122 in academic year 2014-2015 to 99,562 for academic year 2024-2025 representing a nearly 15% increase. (12) These figures do not include medical students at international 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 34 medical schools, (13) (14) AAMC also accredits 45 international medical schools whose graduates are not considered to be foreign medical graduates. While the number of graduates from these international programs are not readily available, the sheer number of programs point to their impact on the competition for clinical training positions. Additionally, 21,293 Masters-level nurse practitioners graduated in 2021 (15) and 11,718 were reported to have graduated from DNP programs in 2023. (16)

PA programs have experienced exponential growth over the last few decades with ARC-PA accredited programs increasing from 148 in 2010 to 310 in 2025. (17) Cohort sizes in PA programs range from 13 to 169 students. (18) 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

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.

Currently shadowing is required by 53 programs and recommended by 107 programs. (19) The concern 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. 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 49 states. California is the only state that does not belong to NC-SARA, which means that clinical placements across state lines involving California may trigger an additional requirement for state authorization. (20)

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) was 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 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 survey on the topic of clinical preceptor and SCPE shortages sought the opinions of seven stakeholder groups including the following: 1) PAs in administration of large health systems, 2) PAs who

have never precepted, 3) students and early career PAs, 4) PAEA members, 5) former preceptors who have stopped precepting, 6) long time preceptors, and 7) 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 who agreed commented that it was a meaningful way to pass on knowledge gained through years of practice to incoming PAs, and 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 may bring a fresh perspective to the profession and remind preceptors of why they chose to become PAs. Several individuals 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 a 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 reviews, and utilization of scribes by the provider if available. Although peer-reviewed research is limited, use of trained medical scribes and ambient artificial intelligence 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) (21) (22) 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 the inclusion of PAs on MD training teams. (23) 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 of 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

reported that the compensation per student per rotation for the programs that provide financial incentives is \$125 per student in 2013 (4). Data from PAEA's 2016 Program Survey indicated that 35.4% of accredited PA programs now pay for clinical sites, representing a 13.1% increase from 2013. Data from the 2021 program survey indicates that now over 65% of PA programs are paying for some or all of their clinical site rotations. Another analysis of data from 2013-2019 found that programs offering financial incentives had risen from 22.2% at the beginning of the period to 52% in 2019 and concluded that the increase was largely driven by private institutions not affiliated with an academic medical center. (24) Clinical sites cost programs an average of \$306 compared with \$232 per week in 2017. (18) However, not all programs are able to pay for SCPE due to budgetary restraints; thus, this remains an area of much debate. 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. (7) 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 another 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.

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 has 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?’” (25) 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 all 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: (26)
 - Committed to showing appreciation of “educating the next generation of PAs”

- Awards the Clinical Preceptor of AAPA (CPAAPA) designation
- 233 active AAPA members as of February 2025
- 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; and has been awarded annually with the exception of 2015
 - 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 without limitation
 - In 2023 AAPA received 120 requests from 118 programs. In 2024 after HOD policy removed the limitation on how much CME could be earned through precepting AAPA has received 125 requests from 122 programs

AAPA and its constituent organizations have 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 values of unity and teamwork reflect its commitment to work with PAEA, ARC-PA, and NCCPA to address issues such as this. (27)

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 precepting students to PAs, patients, and employers.
- AAPA supports revisions to the ARC-PA Standards that would aim to increase the supply of qualified preceptors with increased emphasis on flexibility and innovation.

- AAPA supports collaborating with PAEA to develop a toolkit for PA programs and preceptors, to investigate the development of a national database of SCPE for the use of students nationwide and to raise awareness of the potential effect that requiring pre-PA shadowing may have on the availability of SCPE for PA students
- AAPA supports collaboration with external medical organizations to look at ways to support an interprofessional, collaborative clinical training model.
- AAPA encourages the use of technologies such but not limited to simulators and telehealth to enhance or supplement SCPE.
- AAPA supports non-monitory incentives to preceptors and discourages the commoditization of SCPE.
- AAPA supports the development of a national preceptor development program

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

1. Accreditation Review Commission for the Physician Assistant, Inc. Compliance Manual for Entry-level PA Programs. July 2024. Available at www.arc-pa.org
2. Physician Assistant Education Association. By the Numbers: Curriculum Report 3: Data from the 2017 Clinical Curriculum Survey. Washington DC: PAEA; 2018 doi: 10.17538/CR3.2017.001.
3. Kayingo G, Gordes KL, Flemming S et al. Thinking outside the box: advancing clinical education in an era of preceptor shortage. *J Physician Assist Educ* 2023;34:135-141. DOI 10.1097/JPA.0000000000000500
4. Erikson C, Hamann, R, Levitan T, et al. Recruiting and Maintaining U.S. Clinical Training Sites: Joint Report of the 2013 Multi-Discipline Clerkship/Clinical Training Site Survey. 2013 AACN, AACOM, AAMC, PAEA. <http://www.paeonline.org/wp-content/uploads/2015/10/Recruiting-and-Maintaining-U.S.-Clinical-Training-Sites.pdf> (Accessed February 21, 2025)
5. Herrick A, Pearl JM. Rotation shortages in physician assistant education. *JAAPA* 2015; 28(11), 1 DOI: 10.1097/01.JAA.0000471290.25856.86

6. NCCPA. 2023 Statistical profile of board certified PAs by specialty: Annual Report. 2024 ,
<https://www.nccpa.net/wp-content/uploads/2024/07/2023-Statistical-Profile-of-Board-Certified-PAs-by-Specialty-Annual-Report.pdf> (Accessed February 21, 2025)
7. PA Education Association. The three “C”s of clinical education. PAEA Issue Brief 2015.
<https://paeonline.org/wp-content/uploads/2020/10/3CIssueBrief.pdf> (Accessed February 21, 2025)
8. ARC-PA. Mission, philosophy, and Goals. <https://www.arc-pa.org/about/mission-philosophy-goals/>
(Accessed February 21, 2025).
9. Sturman N, Rego P, Dick, M. Rewards, costs and challenges: the general practitioner’s experience of teaching medical students. *Med Educ* 2011; 45: 722-730. DOI: 10.1111/j.1365-2923.2011.03930.x
10. Berger T, Ander D, Terrell,M, et al. The impact of the demand for clinical productivity on student teaching in academic emergency departments. *Acad Emerg Med* 2004;11: 1364-1367
10.1197/j.aem.2004.07.015
11. Baldor RA, Brooks WB, Warfield, ME, et al. A survey of primary care physicians’ perceptions and needs regarding the precepting of medical students in their offices. *Med Educ* 2001; 35:789-795
DOI: 10.1046/j.1365-2923.2001.00980.x
12. Association of American Medical Colleges. 2024 fall applicant, matriculant, and enrollment data tables 2025. <https://www.aamc.org/media/80781/download?attachment> (Accessed February 21, 2025)
13. Accreditation Commission on Colleges of Medicine. Assessed Programmes.
<https://accredmed.org/accredited-medical-schools-international-medical-school-accreditation>
(Accessed February 21, 2025)
14. Caribbean Accreditation Authority for Education in Medicine and Other Health Professions. Assessed Programmes. <https://caam-hp.org/programs/> (Accessed February 21, 2025)
15. Harrawood A, DePaepe C. Master of science in nursing: trends in program growth, enrollment and graduation across nurse practitioner population tracks. Research brief 2023.
https://storage.aanp.org/www/documents/no-index/research/MSN_Research_Brief.pdf (Accessed February 21, 2025)
16. American Association of Colleges of Nursing. The doctor of nursing practice (DNP) Fact Sheet. 2024. <https://www.aacnnursing.org/news-data/fact-sheets/dnp-fact-sheet> (Accessed February 21, 2025)
17. ARC-PA. Entry level accredited programs. <https://www.arc-pa.org/entry-level-accreditation/accreditation-process/accredited-programs/> (accessed February 21, 2025)
18. PA Education Association. By the numbers: program report 36: data from the 2021 program survey. 2023 DOI: 10.17538/PR36.2021

19. PA Education Association. CASPA Program Directory. <https://paeaonline.org/our-programs> (Accessed February 21, 2025)
20. The National Council for State Authorization Reciprocity Agreements (NC-SARA). SARA-participating institution directory. <https://nc-sara.org/directory> (Accessed February 21, 2025)
21. Shultz CG, Holmstrom H. The use of medical scribes in health care settings: a systematic review and future directions. *J Am Board Fam Med* 2015; 28: 371-381. doi:10.3122/jabfm.2015.03.140224
22. Fiscella K, Franks P, Salvatore P. Strategies to Improve Equity in Preventive Services. *NEJM Catalyst Innovations in Care Delivery*. 2023;4(10):CAT.23.0404. Accessed November 27, 2024.<https://catalyst.nejm.org/doi/full/10.1056/CAT.23.0404>
23. Liaison Committee on Medical Education: Functions and structure of a medical school: standards for accreditation of medical education programs leading to the MD degree. 2024. <https://lcme.org/publications/> (Accessed February 21, 2025)
24. White RD. Describing the physician associate clinical site compensation market. *J Physician Assist Educ* 2024;00:1-9 DOI 10.1097/JPA.0000000000000619
25. Lohenry KC, Brenneman A, Goldgar C et al. Entrustable professional activities: a new direction for PA education? *J Physician Assist Educ* 2017;28:33-40 doi: 10.1097/JPA.000000000000105.
26. American Academy of Physician Associates. Clinical preceptor recognition program. <https://www.aapa.org/career-central/career-advancement-and-transitions/clinical-preceptor-recognition-program/> (Accessed February 21, 2025)
27. American Academy of Physician Associates. 2021-2025 Strategic Plan. <https://www.aapa.org/download/84619/?tmstv=1740069426> (Accessed February 21, 2025)

**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:

Substance Abuse and Mental Health Services Administration, Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth, HHS Publication No. (SMA) 15-4928. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015

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”*.

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

1. Substance Abuse and Mental Health Services Administration, Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth. HHS Publication No. (SMA) 15-4928. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015

Human Trafficking in the United States

[Adopted 2019, amended 2024]

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 and the resources available for victims 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 before 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 why PAs are important to 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 with far-reaching public health consequences associated with sexual violence, intimate partner violence, child abuse and neglect. (2) Though the exact number 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 the hundreds of thousands. (3) An estimated 87.7% of

victims will see a clinician during 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 11.2% of PAs work in emergency departments and 5.6% in urgent care centers. (4) Surveys of trafficking victims support these estimates and reveal that most were seen by a healthcare provider while they were being exploited. (3) The populations vulnerable to becoming trafficked victims that are also likely to encounter healthcare providers includes, but are 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) Clinicians need to remain aware of vulnerable populations to identify victims and increase the level of care to this patient population.

Public Health Issue

Human trafficking is a public health issue that impacts individuals, families, and entire communities across generations. Victims and survivors of human trafficking often deal with adverse physical and mental health issues, such as depression, PTSD, STIS and substance abuse issues, among others. As with many public health issues, trafficking is preventable and contingent on a multi-disciplinary approach that will heavily involve the clinician. The CDC program called “Using Evidence-based Strategies in Your Violence Prevention Efforts” outlines 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 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) A 2021 survey of 184 practicing PAs found that 90.2% of the PAs surveyed were not confident in assisting in the care of patients who were victims of sex trafficking even though an overwhelming majority (96.4%) believed that providing care to this population was their responsibility as a healthcare worker. The majority of responding PAs had no training on sex trafficking (75%) and thought that there should be a nationwide curriculum requirement for this topic in PA schools (84.8%). (8)

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. (9) 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. (9) 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. (10) 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 and socioeconomic situations can

precede human trafficking and commercial sexual exploitation of children (CSEC) contributing 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) Particularly, adolescents are higher risk due to their developmental stage. PAs can identify trafficking and CSEC to aid in the reduction of the mentioned trauma-related health issues. 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. (11) 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. (12) 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. Additionally, these services need to take into account religious, cultural and language barriers that can impact the ability for those victims to receive the care and support they need.

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 the 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 can 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 a 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 of 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. (12) 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

1. Administration for Children & Families Office on Trafficking in Persons (2017, November). Fact Sheet: Human Trafficking. Retrieved from https://www.acf.hhs.gov/sites/default/files/otip/fact_sheet_human_trafficking_fy18.pdf
2. Centers for Disease Control and Prevention (2019, February). Violence Prevention, Human Trafficking. Retrieved from <https://www.cdc.gov/violenceprevention/sexualviolence/trafficking.html>
3. Polaris Project (2019). Hotline Statistics. Retrieved from <https://polarisproject.org/>
4. NCCPA Statistical Profile of Board Certified PAs by Specialty Annual Report (2022). Retrieved from https://www.nccpa.net/wp-content/uploads/2023/08/Q2-Specialty-8_4_23.pdf
5. Greenbaum, J, Bodrick, N. Global Human Trafficking and Child Victimization Pediatrics Dec 2017, 140 (6). Retrieved from <http://pediatrics.aappublications.org/content/140/6/e20173138.long>
6. Violence Prevention Technical Package (2023 November). Retrieved From <https://www.cdc.gov/violenceprevention/pub/technical-packages.html>
7. Grace AM, Lippert S, Collins K, et al. Educating health care professionals on human trafficking. *Pediatr Emerg Care*. 2014;30(12):856-61. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4392380/>
8. Brooks B. The Need for a Mandatory Sex Trafficking Component in Physician Assistant Education. *J Physician Assist Educ*. 2021;32(3):150-153. doi:10.1097/JPA.0000000000000365
9. Office on Trafficking in Persons, SOAR to Health and Wellness Training (2016, August). SOAR Training. Retrieved from <https://www.acf.hhs.gov/otip/training/soar-to-health-and-wellness-training>

10. Blue Campaign (2019, February). Retrieved from <https://www.acf.hhs.gov/otip/training/soar-to-health-and-wellness-training>
11. UN.GIFT.HUB. Homepage, “Global Initiative to Fight Human Trafficking (February 2019). Retrieved from <http://www.ungift.org/>
12. Rollins, R, Gribble, A, Barrett S, Powell C (2017). Who Is in Your Waiting Room? Health Care Professionals as Culturally Responsive and Trauma-Informed First Responders to Human Trafficking. AMA Journal of Ethics, pp. 63-71. Retrieved from <https://journalofethics.ama-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, amended 2024]

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 and territory laws and regulations which place non-evidence-based limits on PA practice.
- Several states and territories 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. AAPA policies regarding this category of licensure are identified in this paper.

Background

In 2014, Missouri became the first state to create a permanent 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 may renew their licenses indefinitely provided they meet the requisite renewal requirements and 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, 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, commercial insurers will recognize APs for reimbursement purposes.

Other states and U.S. territories have created nonrenewable or limitedly renewable categories of licensure for unmatched medical school graduates. Examples include Arkansas (“graduate registered

physicians”) (4), Kansas (“special permit holders”) (5), Louisiana (bridge year graduate physicians) (6) and Utah (“associate physicians”) (7). Puerto Rico enacted a law establishing the “médicos asistentes” (“assistant physicians) profession. Although the law requires passage of the National Commission on Certification of Physician Assistants (NCCPA) examination, an exception exists for graduated medical doctors who are not required to show proof of certification by either a physician or PA board, essentially allowing graduated medical physicians to hold a PA license irrespective of their board certification status. (8) Similar to Missouri, the license may be renewed indefinitely. States and territories continue to consider legislation to establish similar categories of licensure.

While the idea of licensing unmatched medical school graduates has some support in 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)

Although the AMA’s policy has been modified since that time, that sentiment remains. As of 2021, the AMA’s policy states:

Our AMA: [...] opposes special licensing pathways for “assistant physicians” (i.e., those who are not currently enrolled in an accreditation council for graduate medical education training program or have not completed at least one year of accredited graduate medical education in the U.S.). (3)

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 complete 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 over 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 board certification examination administered by the NCCPA. 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 and territory 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 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 and territory laws and regulations which place non-evidence-based limits on PA practice.

References

1. Missouri Revised Statutes 334.036.
2. American Medical Association. Health Care Delivery: Practicing Medicine by Non-Physicians H160.949.
3. ID.
4. 4. Arkansas Code Annotated 17-95-901 to 17-95-917.
5. 5. Kansas Statutes Annotated 65-2811a.
6. 6. Louisiana Revised Statues 37:1310.11.
7. 7. Utah Code Annotated 58-67-302.8.
8. 8. Chapter IV of Regulation 9065: Law 71 (Ley 71) of August 5, 2017 Law to regulate the profession of Assistant Physicians (Médicos Asistentes) in the Government of Puerto Rico.

Genetic and Genomic Testing
(Adopted 2019, amended 2024)

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 should always include obtaining a comprehensive family health history and 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 which should include discussion regarding the ethical, legal, and social implications of testing on health insurance, disability insurance, life insurance, long-term care insurance, and employment, among other considerations.
- 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.
- It is essential for PAs to understand the differences between genetic ancestry as it relates to medical conditions and race as a social construct. Conceptions of race or ethnicity should not be used as a proxy for biology or genetics.
- 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 variants 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 pathogenic variants, 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 or secondary 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. Increasingly common areas where patients may come across genetic and genomic testing is in medical research, pre-conception testing and the testing of newborn infants and children. AAPA recommends such testing be done in collaboration with a qualified healthcare professional with appropriate pre- and post-genetic/genomic testing counseling.

Incidental and secondary 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 and secondary 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 such findings to patients and their families is a delicate task that requires sensitivity.

It is essential for PAs to understand the differences between genetic ancestry as it relates to medical conditions and race as a social construct. 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 expertise in genetics, such as a geneticist, a PA in genetics, 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, which confer protections to individuals by prohibiting discrimination on the basis of genetic/genomic information. (6,7) However, PAs should be fully cognizant of the limits of the protection offered by GINA and other federal or state legislation regarding genetic/genomic information and be prepared to discuss the implications of these limitations for patients and their families.

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 and technology. The PA Genomic Competencies (8) 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/secondary findings of such testing for the patient, their family, and community.
- AAPA supports appropriate pre- and post-genetic/genomic testing counseling which should always include obtaining a comprehensive family health history and 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/>.
- American Society of Human Genetics (ASHG): <http://www.ashg.org/>.
- National Society of Genetic Counselors (NSGC): <https://www.nsgc.org/>.
- Society of PAs in Genetics and Genomics (SPAGG): <https://spagg.wildapricot.org>.

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

1. National Academies of Sciences, Engineering, and Medicine. 2017. An evidence framework for genetic testing. Washington, DC: National Academies Press. <https://doi.org/10.17226/24632>.
2. National Human Genome Research Institute. Regulation of genetic tests. <https://www.genome.gov/10002335/regulation-of-genetic-tests/>. Accessed March 13, 2019.
3. U.S. National Library of Medicine. What is the cost of genetic testing, and how long does it take to get the results? <https://ghr.nlm.nih.gov/primer/testing/costresults>. Accessed March 13, 2019.
4. Department of Health and Human Services Office of the Secretary. HIPAA administrative simplification: standards for privacy of individually identifiable health information. *Federal Register*. 2009;74(193):51698-51710.
5. National Human Genome Research Institute. Privacy in genomics. <https://www.genome.gov/27561246/privacy-in-genomics/>. Accessed March 13, 2019.
6. 110th Congress. Public Law 110-233: Genetic Information Non-Discrimination Act of 2008. <https://www.govinfo.gov/content/pkg/PLAW-110publ233/pdf/PLAW-110publ233.pdf>. Accessed March 13, 2019.
7. National Human Genome Research Institute. The Genetic Information Non-Discrimination Act of 2008. <https://www.genome.gov/27568492/the-genetic-information-nondiscrimination-act-of-2008//the-genetic-information-nondiscrimination-act-of-2008/>. Accessed March 13, 2019.
8. Goldgar C, Michaud E, Park N, Jenkins J. Physician assistant genomic competencies. *J Physician Assist Educ*. 2016;27(3):110-116.

Medications in Children
(Adopted 2019, amended 2024)

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.

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 evidence-based recommendations in regard to medication safety, smallest effective dose, duration of use, and alternatives when pain medication failure occurs.
- 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 to 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

1. Gardiner, S, Chang, A, Marchant, J, Petsky, H. Codeine versus placebo for chronic cough in children. *Cochrane Database of Systematic Reviews* 2016, Issue 7.
2. Gammal, RS, Crews, KR, Haidar, CE, et al. Pharmacogenetics for Safe Codeine Use in Sickle Cell Disease. *Pediatrics*. 2016;138(1): e20153479
3. Committee on Drugs, American Academy of Pediatrics. Use of Codeine and Dextromethorphan Containing Cough Remedies in Children. *Pediatrics* 1997; 99:918
4. Tobias, JD, Green TP, Cote, CJ. Codeine: Time to Say “No”. *Pediatrics*. 2016;138(4): e1-e6.
5. Carr, BC. Efficacy, abuse, and toxicity of over-the-counter cough and cold medicines in the pediatric population. *Current Opinion in Pediatrics*. 2006; 18:184-188.

6. Food and Drug Administration News Release. FDA acts to protect kids from serious risks of opioid ingredients contained in some prescription cough and cold products by revising labeling to limit pediatric use. January 11, 2018.
<https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm592109.htm>
7. Gunn, V. Taha, S. Liebelt, E. Servint, J. Toxicity of Over-the-Counter Cough and Cold Medications. *Pediatrics*. 2001; 108:1-5.
8. American Academy of Orthopaedic Surgeons®, Information Statement. Opioid Use, Misuse, and Abuse in Orthopaedic Practice. October 2015. Information Statement 1045
Accessed January 26, 2019
9. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. *MMWR Recomm Rep* 2022;71(No. RR-3):1–95. DOI: <http://dx.doi.org/10.15585/mmwr.rr7103a1>.
10. American Pain Society, A Position Statement from the American Pain Society. Assessment and Management of Children with Chronic Pain. 2012.
<http://americanpainsociety.org/uploads/about/position-statements/pediatric%20pain%20policy.pdf> Accessed February 26, 2019
11. Chae, F. Integrated Approach to Pediatric Chronic Pain Management. *American Society of Regional Anesthesia and Pain Medicine News*. August 2017.
<https://www.asra.com/asra-news/article/82/integrated-approach-to-pediatric-chronic>
Accessed January 26, 2019

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

1. CDC. (2019, October 31). Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Products. Retrieved November 4, 2019, from https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html
2. Doolittle, D. (2019, October). More Cases of Severe Pulmonary Disease Associated with Vaping Identified. Retrieved from https://www.texmed.org/TexasMedicineDetail.aspx?id=51450&utm_source=Informz&utm_medium=Email&utm_campaign=TMT

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

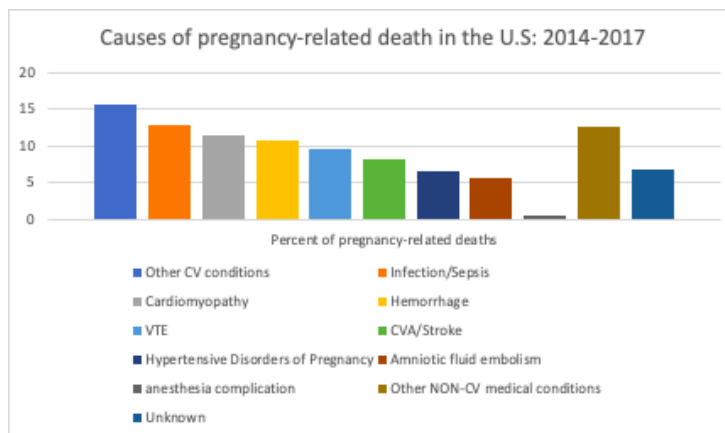
In low resource settings, increased access to quality healthcare has improved the maternal mortality ratio ([MMR], number of maternal deaths per 100,00 live births), however, the vast disparities among different populations and demographics still exist, and 94% of maternal deaths remain in low and middle-income 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 gaps 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

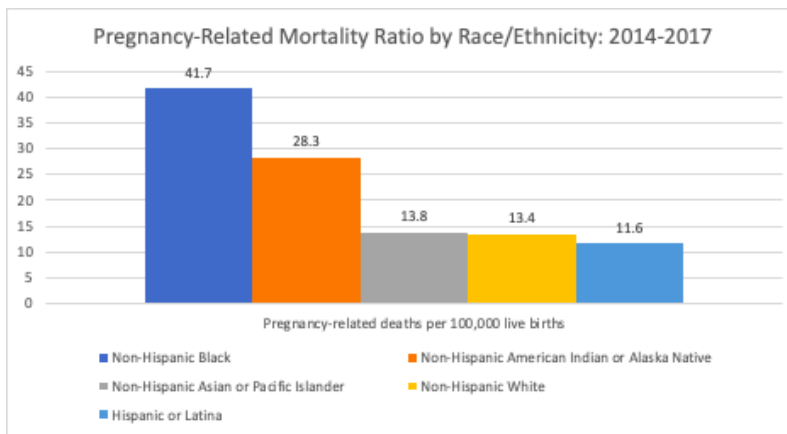
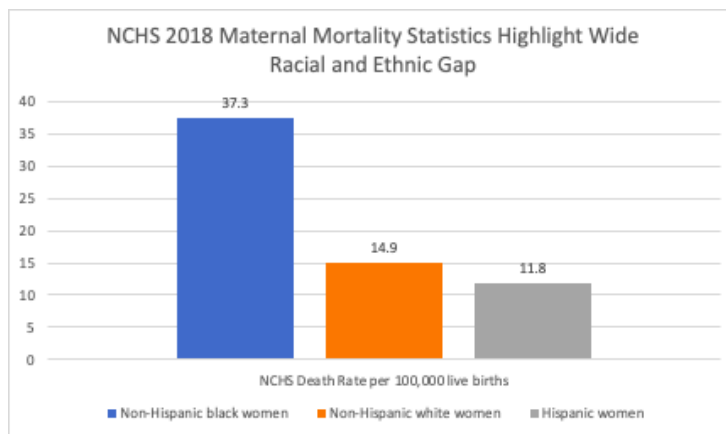


Table 3. Racial and Ethnic Maternal Mortality Gaps



Although there are numerous factors which contribute to increased rates of maternal mortality, over $\frac{1}{3}$ 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 $\frac{1}{3}$ 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 delays 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 in 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 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

1. Creanga, Andreea A et al. "Maternal mortality and morbidity in the United States: Where are we now?." *Journal of women's health* (2002) vol. 23,1 (2014): 3-9. doi:10.1089/jwh.2013.4617
2. World Health Organization. (2019, September 19). Maternal mortality. Retrieved March 16, 2021, from <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>
3. World Health Organization. (2019). *Trends in Maternal Mortality 2000 to 2017: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division*, World Health Organization. Retrieved March 16, 2021, from apps.who.int/iris/handle/10665/327595.
4. Sustainable Development Goals. Who.int. Accessed March 7, 2021. <https://www.who.int/health-topics/sustainable-development-goals>
5. Center for Disease Control and Prevention. Pregnancy-related deaths. (2019, May 07). Retrieved March 16, 2021, from <https://www.cdc.gov/vitalsigns/maternal-deaths/index.html>
6. Severe maternal morbidity in the United States. Cdc.gov. Published February 2, 2021. Accessed March 7, 2021. <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html>

7. Severe Maternal Morbidity Delivery Trends Disparities. Ahrq.gov. Accessed March 7, 2021. <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb243-Severe-Maternal-Morbidity-Delivery-Trends-Disparities.pdf>
8. Pregnancy mortality surveillance system. Cdc.gov. Published November 25, 2020. Accessed March 7, 2021. https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Freproductivehealth%2Fmaternalinfanthealth%2Fpregnancy-mortality-surveillance-system.htm
9. Lima FV, Yang J, Xu J, Stergiopoulos K. National Trends and In-Hospital Outcomes in Pregnant Women with Heart Disease in the United States. *Am J Cardiol*. 2017;119(10):1694-1700. doi:10.1016/j.amjcard.2017.02.003
10. 2018 Maternal Mortality Statistics Highlight Wide Racial and Ethnic Gaps. Cdc.gov. Accessed March 7, 2021. <https://www.cdc.gov/nchs/maternal-mortality/images/19-313784-MMR-Visual-abstract-2.png>
11. Harris, Margaret et al. "Future Directions: Analyzing Health Disparities Related to Maternal Hypertensive Disorders." *Journal of pregnancy* vol. 2020 7864816. 1 Aug. 2020, doi:10.1155/2020/7864816
12. Miller, Eliza C et al. "Maternal Race/Ethnicity, Hypertension, and Risk for Stroke During Delivery Admission." *Journal of the American Heart Association* vol. 9,3 (2020): e014775. doi:10.1161/JAHA.119.014775
13. Callaghan, William M. "State-based maternal death reviews: assessing opportunities to alter outcomes." *American journal of obstetrics and gynecology* vol. 211,6 (2014): 581-2. doi:10.1016/j.ajog.2014.07.041
14. 11 terms you should know to better understand structural racism - the Aspen institute. Aspeninstitute.org. Published July 11, 2016. Accessed March 7, 2021. <https://www.aspeninstitute.org/blog-posts/structural-racism-definition/>
15. Vedantam S. Remembering anarcha, Lucy, and Betsey: The mothers of modern gynecology. *NPR*. <https://www.npr.org/2017/02/07/513764158/remembering-anarcha-lucy-and-betsey-the-mothers-of-modern-gynecology>. Published February 7, 2017. Accessed March 7, 2021.
16. Pacagnella RC, Cecatti JG, Osis MJ, Souza JP. The role of delays in severe maternal morbidity and mortality: expanding the conceptual framework. *Reprod Health Matters*. 2012;20(39):155-163.
17. These states have the highest maternal mortality rates. USnews.com. Accessed March 7, 2021.
18. Kumar NR, Borders A, Simon MA. Postpartum Medicaid extension to address racial inequity in

- maternal mortality. *Am J Public Health*. 2021;111(2):202-204.
19. Maternal Health in the African American Community. Ymaws.com. Accessed March 7, 2021.
https://cdn.ymaws.com/www.nmanet.org/resource/resmgr/docs/health_policy/policy_positions/browse_by_issue/2020_nma_factsheet_maternalm.pdf
 20. The environment that racism built. Americanprogress.org. Published May 10, 2018. Accessed March 7, 2021.
<https://www.americanprogress.org/issues/race/news/2018/05/10/450703/environment-racism-built/>
 21. Reason, J. Human Error: Models and Management. *BMJ* 2000;320:768. doi:
<https://doi.org/10.1136/bmj.320.7237.768>
 22. Veltman LL. Getting to havarti: moving toward patient safety in obstetrics. *Obstet Gynecol*. 2007;110(5):1146-1150. doi:10.1097/01.AOG.0000287066.13389.8c
 23. Berkowitz O, White SE. An opportunity for PAs as obstetrical laborists. *JAAPA*. 2018;31(2):40-43. doi:10.1097/01.JAA.0000529774.75649.c1
 24. Ritsema TS, Klingler AM. Can PAs help address the pressing public health problem of rising maternal mortality? *JAAPA*. 2018;31(6):11-12. doi:10.1097/01.JAA.0000533669.18568.a0

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 stakeholders 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 are 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 CY 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 CY 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 stakeholder 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

1. Cawley, James. "Physician Assistants and their role in Primary Care". *Virtual Mentor*. 2012;14(5):411-414. doi: 10.1001/virtualmentor.2012.14.5.pfor2-1205. <https://journalofethics.ama-assn.org/article/physician-assistants-and-their-role-primarycare/2012-05>. Accessed 26 June 2020.
2. "Telehealth & Telemedicine by PAs During the COVID-19 Pandemic". AAPA.org. <https://www.aapa.org/download/62597/>. Accessed July 3, 2020.
3. "PAs and Home Health". AAPA.org. <https://www.aapa.org/download/5047/>. Accessed July 3, 2020.
4. "Principles of the Patient Centered Medical Home". American Medical Association. 2018. <https://policysearch.ama-assn.org/policyfinder/detail/Principles%20of%20the%20Patient-Centered%20Medical%20Home%20H-160.919?uri=%2FAMADoc%2FHOD.xml-0-734.xml>. Accessed July 3, 2020.
5. "Medicare Program; revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019". CMS, Federal Register. Published November 23, 2018. 83; 226. <https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf>. Accessed July 27, 2020.
6. "Definition of Homebound Patient Under the Medicare Home Health (HH) Benefit". CMS Manual System. 15; 60.4.01 Published August 1, 2014. Revised September 2, 2014. <https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r192bp.pdf>. Accessed July 27, 2020.
7. Lakin, Robert. InvestorPlace, Market's Insider. Invest in Heal to Benefit from the Disruption in Primary Care. Published 9 July 2020. <https://markets.businessinsider.com/news/stocks/invest-in-heal-to-benefit-from-the-disruption-in-primary-care-1029381599#https://markets.businessinsider.com/news/stocks/invest-in-heal-to-benefit-from-the-disruption-in-primary-care-1029381599>. Accessed July 27, 2020.

8. Landi, Heather. "With rising demand for in-home care, DispatchHealth scores \$136M round backed by Optum Venture". Fiercehealthcare.com. Published June 23, 2020.
<https://www.fiercehealthcare.com/tech/rising-demand-for-home-healthcare-dispatch-health-scores-135m-funding-round-led-by-optum?mkt_tok=eyJpIjoiTVdKaU16VmI0R0ZpTVRjeiIsInQiOiJjWTQzNlwwQIN1NmdHbGZKcUx2ZWV4NG1NbW0yZFhqMFFEQ1lxVhMNVN2RXBBN3pFdUdZOU5GZmo1ZUhocGlxRXVmc0x5MTN5RmN2NXNKXC92bXZIMVwvZmk4MDBYSGlMTIVYWlIdFYxeVJQZlZudWIwd0hld2lqMXArXC94U1RuYUt2ZHdSblwvbjNFQml6ZFRpd3ZVVDl5dz09In0%3D&m_rkid=75136914>. Accessed July 27, 2020.
9. Donlan, Andrew. [Humana Calls for Global Payment System to Unlock Home-Based Care](https://homehealthcarenews.com/2020/05/humana-execs-call-for-new-global-payment-system-to-unlock-home-based-care/). Published May 21, 2020.
<<https://homehealthcarenews.com/2020/05/humana-execs-call-for-new-global-payment-system-to-unlock-home-based-care/>>. Accessed July 27, 2020.
10. "What's the difference between telemedicine and telehealth?". American Acad. of Family Practice.<<https://www.aafp.org/media-center/kits/telemedicine-and-telehealth.html#:~:tet=Telehealth%20is%20different%20from%20telemedicine,to%20remote%20non%2Dclinical%20services>>. Accessed July 3, 2020.
11. "Medicare & Home Health Care". CMS.gov. Published Oct 2017.
<<https://www.medicare.gov/Pubs/pdf/10969-Medicare-and-Home-Health-Care.pdf>>.

Support for Co-parent or Second Parent Adoptions Regardless of Gender

(Adopted 2004, reaffirmed 2009, amended 2015, 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 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

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

Licensure Eligibility for PAs Trained Abroad
(Adopted 2004, amended 2009, 2018, reaffirmed 2014, 2023)

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 offshore 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's 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 board 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

(Adopted 2004, reaffirmed 2009, 2014, amended 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 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 1

	Matriculant Data (7)	Practicing PAs (8)	US Census (9)
Race			
White	86.2%	86.7%	76.5%
Asian	11.9%	6.0%	5.9%
Black/African American	3.9%	3.6%	13.4%
Native Hawaiian/Pacific Islander	0.6%	0.3%	0.2%
American Indian or Alaskan Native	1.3%	0.4%	1.3%
Other		3%	
Multiple Races	7.2%		2.7%
Ethnicity			
Hispanic, Latino, or Spanish in origin	9.1%	6.6%	18.3%
Sexual Orientation			
Bisexual	2.6%		4.1 ¹⁰
Gay or Lesbian	2.0%		
Other	0.3%		

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 the 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

1. Cohen J. The Consequences of premature abandonment of affirmative action in medical school admissions. *JAMA*.2003;289(9):1143-1149.
2. Cooper-Patrick Li, Gallo J, Gonzales J et al. Race, gender, and partnership in the patient-physician relationship. *JAMA*. 1999;282(6):583-589.
3. Milem J. Why race matters. <http://www.aaup.org/publications/Academe/2000/00so/SO00Milte.htm> Accessed December 12, 2003.
4. Whitla D, Orfield G. Silen W et al. Educational benefits of diversity in medical school: A survey of students. *Academic Medicine*. 2003;78(5):460-466.
5. Wittlin NM, Dovidio JF, Burke SM et al. Contact and role modeling predict bias against lesbian and gay individuals among early-career physicians: A longitudinal study. *Social and Science Medicine*. 238(2019).
6. Institute of Medicine (US) Committee on Institutional and Policy-Level Strategies for Increasing the Diversity of the U.S. Healthcare Workforce; Smedley BD, Stith Butler A, Bristow LR, editors.

In the nation's compelling interest: Ensuring diversity in the health-care workforce.

<https://www.ncbi.nlm.nih.gov/pubmed/25009857>

7. Physician Assistant Education Association, By the Numbers: Student report 4: Data from the 2019 matriculating student and end of program surveys, Washington, D.C.: PAEA, 2020. doi: 10.17538/SR2020.0004
8. National Commission on Certification of Physician Assistants. 2019 statistical profile of certified physician assistants. 2020. P 10.
<https://prodcmsstoragesa.blob.core.windows.net/uploads/files/2019StatisticalProfileofCertifiedPhysicianAssistants.pdf>
9. U.S. Census Bureau. (2019). Population Estimates, July 1, 2019 (V2019). Quick facts. Retrieved from <https://www.census.gov/quickfacts/fact/table/US/PST045219>
10. Gates GJ. (2017) In US, more adults identifying as LGBT. *Gallup*. Retrieved from <http://news.gallup.com/poll/201731/lgbt-identification-rises.aspx>. Accessed January 20, 2020
11. Greene J, Hibbard JH, Sacks RM. Does the race/ethnicity or gender of a physician's name impact patient selection of the physician? *J of the National Medical Association* 2018;110(3):206-210.
12. Brown D, Sivahop JN. Challenges of clinical education. *J Physician Assist Educ* 2017;28(3S):S28-S32.
13. Grutter v. Bollinger, 539 U.S. 306 (2003)
14. Gratz v. Bollinger, 539 U.S. 244 (2003)
15. U.S. Department of Education. Supporting racial diversity
<https://www2.ed.gov/about/offices/list/ocr/frontpage/pro-students/issues/roi-issue07.html> Accessed November 29, 2019.
16. Regents of the University of California v. Allan Bakke 438 US 265 (1978)
17. Hopwood v. Texas, 78 F.3d 932 (5th Cir. 1996)
18. Fisher v. University of Texas at Austin, 570 U.S. ____ (2013)
19. Fisher v. University of Texas at Austin, 579 U.S. ____ (2016)
20. Students for Fair Admissions v. President of Harvard College, 346 F. Supp. 3d 174 (D. Mass. 2018)
21. US District Court District of Massachusetts, Civil Action No. 14-cv-14176-ADB (D. Mass. Sep. 30, 2019)
22. Cohen J. The Consequences of Premature Abandonment of Affirmative Action in Medical School Admissions. *JAMA*.2003;289(9):1143-1149.
23. Accreditation Review Commission on Education for the Physician Assistant. Accreditation Standards for the Physician Assistant Education 5th Edition

24. National Commission on Certification of Physician Assistants. 2017 Statistical Profile of Certified Physician Assistants. 2018. P 10.
<https://prodcmssstorage.blob.core.windows.net/uploads/files/2018StatisticalProfileofCeStatisticalProfileofCertif.pdf>
25. Epstein R, Hundert E. Defining and Assessing Professional Competence. *JAMA*. 2002;287(2):226-235.

Global Epidemic HIV/AIDS

(Adopted 2005, amended 2010, 2015, 2020, 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 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 disproportionately 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. (16)(17) 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 for 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

1. Center for Disease Control and Prevention (2019). HIV Surveillance Report. Retrieved from <https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2018-updated-vol-32.pdf>
2. UNAIDS. Communities at the Centre. Retrieved from https://www.unaids.org/sites/default/files/media_asset/2019-global-aids-update_en.pdf
3. Fauci AS, Redfield RR, Sigounas G, et al. Ending the HIV epidemic: a plan for the United States. JAMA. 2019;321(9):844-845.
4. Messer C, Baker J. "Ending the HIV epidemic by 2030 requires immediate action." Journal of the American Academy of PAs 32.12 (2019): 8-9.
5. World Health Organization. (2018). Number of People (All Ages) Living with HIV Estimates by WHO Region. Retrieved from https://www.who.int/gho/hiv/epidemic_status/cases_all/en/
6. World Health Organization. (2018). Number of Deaths Due to HIV/AIDS Estimates WHO Region. Retrieved from https://www.who.int/gho/hiv/epidemic_status/deaths/en/
7. UNAIDS. Global HIV & AIDS Statistics- Fact Sheet (2021). Retrieved from <https://www.unaids.org/en/resources/fact-sheet>
8. Centers for Disease Control and Prevention. HIV in the United States and dependent areas. www.cdc.gov/hiv/statistics/overview/ata glance.html.
9. Bekker LG, Alleyne G, Baral s, et al. Advancing Global Health and Strengthening the HIV Response in the Era of the Sustainable Development Goals: The International Aids Society Lancet Commission. Lancet. 2018;392(10144):312–358. doi:10.1016/s0140-6736(18)31070-5
10. Kennedy CE, Fonner VA, Sweat MD, Okero FA, Baggaley R, O'Reilly KR. Provider-initiated HIV Testing and Counseling in Low- and Middle-Income Countries: A Systematic Review. AIDS Behav. 2013;17(5):1571–1590. doi:10.1007/s10461-012-0241-y
11. Baker J, Rolls J. "Update on HIV prevention and preexposure prophylaxis." Journal of the American Academy of PAs 33.6 (2020): 12-17.
12. US Preventive Services Task Force, Owens DK, Davidson KW, Krist AH, et al. Preexposure prophylaxis for the prevention of HIV infection: US Preventive Services Task Force Recommendation Statement. JAMA. 2019;321(22):2203-2213.
13. Smith DK, Van Handel M, Wolitski RJ, et al. Vital signs: estimated percentages and numbers of adults with indications for preexposure prophylaxis to prevent HIV acquisition—United States, 2015. MMWR Morb Mortal Wkly Rep. 2015;64(46):1291-1295.

14. Pathela P, Jamison K, Braunstein SL, et al. Incidence and predictors of HIV infection among men who have sex with men attending public sexually transmitted disease clinics, New York City, 2007-2012. *AIDS Behav.* 2017;21(5):1444-1451. 8. Patel P, Borkowf CB, Brooks JT, et al. Estimating per-act HIV tran
15. Center for Disease Control and Prevention. (2016). Updated Guidelines for Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or other Nonoccupational Exposure to HIV. Retrieved from <https://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf>
16. Mimiaga, M. J., O'CLEIRIGH, C., Biello, K. B., Robertson, A. M., Safren, S. A., Coates, T. J., ... & Mayer, K. H. (2015). The effect of psychosocial syndemic production on 4-year HIV incidence and risk behavior in a large cohort of sexually active men who have sex with men. *Journal of acquired immune deficiency syndromes*, 68(3), 329.
17. Parsons JT, Millar BM, Moody RL, Starks TJ, Rendina HJ, Grov C. Syndemic conditions and HIV transmission risk behavior among HIV-negative gay and bisexual men in a U.S. national sample. *Health Psychol.* 2017;36(7):695-703. doi:10.1037/hea0000509
18. Centers for Disease Control and Prevention: US Public Health Service: Preexposure prophylaxis for the prevention of HIV infection in the United States—2021 Update: a clinical practice guideline. <https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf>. Published December 2021.
19. Huang YA, Zhu W, Smith DK, et al. HIV preexposure prophylaxis, by race and ethnicity--United States, 2014–2016. *MMWR Morb Mortal Wkly Rep.* 2018;67:1147–1150.
20. Panlilio AL, Cardo DM, Grohskopf LA, et al. Updated US Public Health Service guidelines for the management of occupational exposures to HIV and recommendations for postexposure prophylaxis. *MMWR Recomm Rep.* 2005;54 (RR-9):1-17.
21. Skarbinski J, Rosenberg E, Paz-Bailey G, et al. Human Immunodeficiency Virus Transmission at Each Step of the Care Continuum in the United States. *JAMA Intern Med.* 2015;175(4):588–596. doi:10.1001/jamainternmed.2014.8180
22. Cohen MS, Chen YQ, McCauley M, et al. Antiretroviral Therapy for the Prevention of HIV-1 Transmission. *N Engl J Med.* 2016;375(9):830–839. doi:10.1056/nejmoa1600693
23. Centers for Disease Control and Prevention (2006). Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1>
24. Branson BM, Handsfield HH, Lampe MA, et al. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR Recomm Rep.* 2006;55(RR-14):1-17.

25. DiNenno EA, Prejean J, Irwin K, et al. Recommendations for HIV screening of gay, bisexual, and other men who have sex with men--United States, 2017. *MMWR Morb Mortal Wkly Rep*. 2017;66(31):830-832.
26. Eisinger RW, Dieffenbach CW, Fauci AS. HIV viral load and transmissibility of HIV infection: undetectable equals untransmittable. *JAMA*. 2019;321(5):451-452.
27. Rodger AJ, Cambiano V, Bruun T, et al. Sexual Activity Without Condoms and Risk of HIV Transmission in Serodifferent Couples When the HIV-positive Partner is using Suppressive Antiretroviral Therapy. *JAMA*. 2016;316(2):171-181.
28. Rodger AJ, Cambiano V, Bruun T, et al. Risk of HIV Transmission Through Condomless Sex in Serodifferent Gay Couples with the HIV-positive Partner Taking Suppressive Antiretroviral Therapy (Partner): Final Results of a Multicentre, Prospective, Observational Study. *The Lancet*. 2019.
29. Blank S, Borges CM, Casto MA, et al. Getting a jump on HIV: expedited ARV treatment at NYC sexual health clinics, 2017. *Conferences on Retroviruses and Opportunistic Infections*. 2018;Abstract 1108.

Resources

1. World Health Organization <http://www.who.int/hiv/en/>
2. Pan American Health Organization <https://www.paho.org/en/topics/hivaids>
3. Centers for Disease Control and Prevention (CDC) <https://www.cdc.gov/hiv/default.html>

Scientific Integrity and Public Policy
(Adopted 2005, amended 2010, 2015, 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 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. Policymakers 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

1. The Global Science Forum and the Ministry of Education, Culture, Sports, Science and Technology of Japan (MEXT), proceedings from the workshop Best Practices for Ensuring Scientific Integrity and Preventing Misconduct, Organization for Economic Co-Operation and Development Global Science Forum, February 22-23, 2007, Tokyo Japan
<http://www.oecd.org/dataoecd/37/17/40188303.pdf> Accessed March 17, 2010.
2. The Science & Environmental Policy Project and George Mason University's International Institute, Conference Report: Scientific Integrity in the Public Policy Process, May 24-25, 1993, Washington D.C.
<https://web.archive.org/web/20060615092804/http://www.sepp.org/conferences.html> Accessed February 12, 2020.
3. American Association for the Advancement of Science U.S. Office of Research Integrity, Conference Report: The Role and Activities of Scientific Societies in Promoting Research Integrity April 10, 2000, Washington D.C.
https://www.aaas.org/sites/default/files/content_files/The%20Role%20and%20Activities%20of%20Scientific%20Societies%20in%20Promoting%20Research%20Integrity.pdf Accessed February 12, 2020.

Quality Incentive Programs

(Adopted 2005, reaffirmed 2010, 2015, amended 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 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 basis 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.