Report of Reference Committee B

May 19-20, 2018

Hilton New Orleans Riverside
New Orleans, LA

THIS REPORT IS NOT POLICY. THESE RESOLUTIONS WILL NOT BECOME ACADEMY POLICY UNTIL FORMALLY ACTED UPON BY THE HOUSE OF DELEGATES.

	Number:	Title:	Committee Recommendation:	Line:
	2018-B-01	PAs Contribution to Healthcare	Amend	6
	2018-B-02	APP and APC Definition	Amend	32
	2018-B-03	Utilization of PA or Physician Assistant	Adopt	52
	2018-B-04	Reimbursement for Medical Services	Adopt	72
	2018-B-05	Expanded Healthcare Access	Amend	92
	2018-B-06	Federally Employed Pas	Reject	123
	2018-B-07	Recognition of PA Productivity	Adopted on Consent Agenda	
	2018-B-08	Electronic Health Records	Adopted on Consent Agenda	
	2018-B-09	Mental Health and Substance Use Disorder	Adopt	183
	2018-B-10	Use of Medical Interpreters for Patients with Limited English Proficiency	Adopted on Consent Agenda	
	2018-B-11	Professional Burnout	Amend	211
	2018-B-12	PA-Physician Ratio Restrictions	Adopted on Consent Agenda	
	2018-B-13	Adverse Outcomes	Adopt	239
	2018-B-14	Changing the Professional Title of Physician Assistants	Adopt	377
	2018-B-15	Guidelines for State Regulation of PAs	Reject	409
	2018-B-16	Opiate Use Disorder	Amend	720
	2018-B-17	Support for Supervised Injection Facilities	Adopted on Consent Agenda	
	2018-B-18	Standards Requiring In-Person Instruction	Reject	741

*Shaded resolutions were Adopted on the General Consent Agenda and will not appear in this document.

Mister Speaker, Reference Committee B has considered each of the resolutions referred to it and wishes to present the following report. The committee's recommendations on each extracted resolution will be submitted separately, and I respectfully suggest that each extracted item be dealt with before going on to the next. Mr. Speaker, please proceed with the extraction process.

The Committee considered testimony on 2018-B-01, the resolved portion of which reads:

> Amend policy HP-3100.1.3 as follows:
>
> AAPA believes that, whenever possible, PAs should be referred to as ~~"physician assistants"~~ "PAS" and not AS "MIDLEVEL PROVIDERS", "PHYSICIAN EXTENDERS", OR OTHER TERMS THAT DEVALUE THE PAS' CONTRIBUTION TO THE HEALTHCARE SYSTEM. ~~combined with other providers in inclusive non-specific terms such as "midlevel practitioner", "advanced practice clinician", or "advanced practice provider.~~

Testimony included:

- The use of "PA" is consistent with other policy language
- A suggestion was made to utilize language within our policy manual emphasizing what PAs are, rather than what they are not

No additional testimony was provided.

The reference committee recommends the following language:

> **AAPA DISCOURAGES THE USE OF TERMS SUCH AS MIDLEVEL PROVIDERS, PHYSICIAN EXTENDERS, OR ANY OTHER TERMS THAT DEVALUE PAS' CONTRIBUTION TO HEALTHCARE.**

Mister Speaker, I move that Resolution 2018-B-01 be so amended by substitution.

The Committee next considered testimony on 2018-B-02, the resolved portion of which reads:

> AAPA believes the terms "advanced practice provider" and "advanced practice clinician" should only be representative of PAs and APRNs in a healthcare system or practice.

Testimony included:

- A suggestion to change "representative" to "refer" was provided; the author was agreeable

There was no additional testimony.

The reference committee recommends the following language:

AAPA believes the terms “advanced practice provider” and “advanced practice clinician” should ~~only be representative of~~ REFER **ONLY** TO PAs and APRNs in a healthcare system or practice.

Mister Speaker, I move that Resolution 2018-B-02 be so amended.

The Committee considered testimony on 2018-B-03, the resolved portion of which reads:

Amend policy HP-3100.1.3.1 as follows:

PAs should ~~utilize, and~~ encourage employers ~~(e.g., hospitals, HMO’s, clinics)~~, third party payers, educators, researchers, and the government to utilize the term “PA” OR “physician assistant” ~~or “PA”~~ to INCREASE TRANSPARENCY AND VISIBILITY ~~unique position~~ of PAs ~~in~~ THROUGHOUT the healthcare system.

Pro testimony included:

- The public is familiar with the term physician assistant
- Retaining “physician assistant” reduces confusion, as other healthcare roles are known as “PAs” (e.g., pathology assistant)

Con testimony included:

- The use of “PA” is consistent with other language and “physician assistant” is not necessary in this policy

Mister Speaker, the committee recommends adoption of Resolution 2018-B-03

The Committee considered testimony on 2018-B-04, the resolved portion of which reads:

Amend policy HP-3200.3.5 as follows:

AAPA shall continue to educate and serve as a resource to students, programs, and graduate PAs on issues concerning reimbursement for ~~physician~~ MEDICAL services provided by PAs.

Testimony included:

- There was support for the resolution if amended to replace “medical” with “professional”
- Expert testimony indicated “medical” was the more appropriate term and recommended the original language

There was no additional testimony.

Mister Speaker, the committee recommends adoption of Resolution 2018-B-04

The Committee considered testimony on 2018-B-05, the resolved portion of which reads:

> Amend policy HP 3400.1.3 as follows:
>
> AAPA supports expanded healthcare access for all people. AAPA encourages innovation in healthcare delivery~~, but remains~~ AND IS committed to the model of MULTIDISCIPLINARY ~~physician directed~~ team care. AAPA maintains that continuity of care is a high priority; therefore communication between the episodic care provider and the primary provider should be maximized within the constraints of regulation, patient confidentiality and patient preference.

Pro testimony included:

- There was a suggestion to change the word "multidisciplinary" to "interprofessional." The reference committee requested additional information regarding the reasoning for this suggested change. Multidisciplinary means within the same profession whereas interprofessional means between or among others which is the foundation of team based care.

No additional testimony was provided.

The reference committee recommends the following language:

> AAPA supports expanded healthcare access for all people. AAPA encourages innovation in healthcare delivery~~, but remains~~ AND IS committed to the model of **INTERPROFESSIONAL** ~~MULTIDISCIPLINARY~~ ~~physician directed~~ team care. AAPA maintains that continuity of care is a high priority; therefore, communication between the episodic care provider and the primary provider should be maximized within the constraints of regulation, patient confidentiality and patient preference.

Mister Speaker, I move that Resolution 2018-B-05 be so amended.

The Committee considered testimony on 2018-B-06, the resolved portion of which reads:

> Amend policy HP-3500.1.2 as follows:
>
> AAPA recognizes that many federal PAs are exempt from state licensing laws and regulations and are subject to PA criteria established by their federal agencies, THE FEDERAL OFFICE OF PERSONNEL MANAGEMENT AND/or by Congress. These federal requirements SET BY THE OFFICE OF PERSONNEL MANAGEMENT, WHICH APPLY TO MANY FEDERAL PAS~~,~~ include:
>
> > 1) graduation from a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) OR ITS PREDECESSORS, AT A COLLEGE, UNIVERSITY OR EDUCATIONAL INSTITUTION THAT IS ACCREDITED BY AN ACCREDITING BODY OR

ORGANIZATION RECOGNIZED BY THE U.S. DEPARTMENT OF EDUCATION AT THE TIME THE DEGREE WAS OBTAINED,

2) ~~, or by one of its predecessor agencies (Committee on Allied Health Education and Accreditation (CAHEA), or the Commission on Accreditation of Allied Health Education Programs [CAAHEP]), and/or~~ passage of the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA), ~~and~~

3) continual maintenance of national certification, AND

4) UNRESTRICTED LICENSE OR REGISTRATION AS A PHYSICIAN ASSISTANT FROM A STATE. ~~when required by the federal agency.~~

MANY PAS CURRENTLY PRACTICING FOR THE FEDERAL GOVERNMENT ARE NOT CURRENTLY REQUIRED TO HAVE A STATE LICENSE. ~~Therefore,~~ ~~t~~The Academy believes that federal PAs should not be required to have a state license to obtain full practice privileges (including prescribing), to be credentialed in a federal facility, or to participate in a federal activity such as a disaster medical team.

THE ACADEMY BELIEVES FEDERALLY EMPLOYED PAS SHOULD NOT BE REQUIRED TO MAINTAIN NATIONAL CERTIFICATION AS A REQUIREMENT OF EMPLOYMENT. ~~In states where federal-state requirements do not conflict; federal PAs may hold state licenses.~~

Any federalLY EMPLOYED PA SHOULD BE ABLE TO ~~may~~ opt to hold a state license.

Pro testimony included:

- The proposed policy change was intended to embody all federal PAs

Con testimony included:

- Stakeholders are not in agreement with the currently written resolution

Stakeholders convened and believed the verbiage is not ideal as currently written. They recommend rejection in order to reconsider the intended content.

Mister Speaker, the committee recommends referral of Resolution 2018-B-06 to the appropriate body

The Committee considered testimony on 2018-B-09, the resolved portion of which reads:

> Amend policy HX-4600.1.3 as follows:
>
> AAPA BELIEVES ~~C~~coverage for the treatment of mental health and substance use disorders should be available, nondiscriminatory and covered at the same benefit level as other medical care.
>
> AAPA BELIEVES ~~R~~reimbursement for PAs providing mental health and substance use disorder care should be provided in the same manner as other MEDICAL ~~physician~~ services provided by PAs.
>
> AAPA BELIEVES NO INSURANCE COMPANY, THIRD-PARTY PAYER OR HEALTH SERVICES ORGANIZATION SHALL IMPOSE A PRACTICE, EDUCATION OR COLLABORATION REQUIREMENT THAT IS INCONSISTENT WITH OR MORE RESTRICTIVE THAN EXISTING PA STATE LAW.

The delegate that extracted the resolution clarified that previous testimony provided in resolution B-04 resolved concerns regarding use of the word "medical" in line 12; therefore, this resolution should remain as proposed.

Note: B-04 testimony:

- There was support for the resolution if amended to replace "medical" with "professional"
- Expert testimony indicated "medical" was the more appropriate term and recommended the original language

Mister Speaker, the committee recommends adoption of Resolution 2018-B-09

The Committee next considered testimony on 2018-B-11, the resolved portion of which reads:

> 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 self-care as part of burnout prevention.

Testimony included:

- There was consensus that this is an important resolution
- Burnout is systemic within healthcare and the blame should not rest with the provider alone. Therefore, language changes were suggested and accepted by the author and others

The reference committee recommends the following language:

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 ~~self-care as part of burnout prevention.~~ A COMPREHENSIVE MULTI-PRONGED STRATEGY FOR PREVENTION OF PROFESSIONAL BURNOUT.

Mister Speaker, I move that Resolution 2018-B-11 be so amended.

The Committee next considered testimony on 2018-B-13, the resolved portion of which reads:

Amend policy HP-3800.2.2 entitled **"**Acknowledging and Apologizing for Adverse Outcomes".

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

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

~~Improving healthcare quality and reducing preventable adverse events in care delivery continue to be a top priority for the United States health care 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.~~

- 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 HEALTH CARE 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 ~~has previously~~ 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 health care setting, including inpatient, outpatient, home and long-term care (~~2~~3). Further, preventable harm from care delivery impacts not only patients, but families, caregivers, staff and communities (~~2~~3).

Health care 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 (~~2~~3). Thus, every health care 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) (~~2~~3).

The Patient and Family

The patient and family must be the priority of the health care organization and the provider before, during and after an adverse event (~~2~~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).[~~1~~4] According to ~~the~~ 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 health care continues to develop, much of the data generated highlights the fundamental importance of openly admitting error (~~4~~5). A number of studies suggest that both the public and health care 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 (~~5~~6).

The Frontline Staff

Health care staff can become the "second victims' of adverse events (~~2~~3). This may occur secondary to blaming behaviors, damage to personal or professional reputation, and unresolved feelings of sorrow and loss (~~2~~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 (~~2~~3).

The Organizational Response

The culture of safe and high-quality health care begins with the organizational leader, who proactively develops a crisis management plan and assumes shared responsibility when adverse events take place (~~2~~3). Following an adverse event, it is critical for leaders to include all stakeholders in the root cause analysis (~~2~~3). This process enhances communication, promotes healing and ensures learning takes place (~~2~~3). Most importantly, leadership must ensure that the patient and family are clearly informed throughout the process of the investigation (~~2~~3).

Policy and Legislation

To counter the perceived risk of increased liability, a ~~number~~ MAJORITY of states have adopted ~~or are considering~~ 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).[~~16~~] ~~Federal legislation has also been drafted~~

~~that promotes medical error reporting, disclosure to patients, apology, and, in cases when the standard of care is not met, offers of compensation. This legislation is based on the principles of~~

The Sorry Works! Coalition, AN ADVOCATE FOR LEGISLATIVE, POLICY AND CULTURAL CHANGE ~~which~~ 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). ~~According to the coalition, Sorry Works! restores the provider-patient relationship and improves the communication and trust between all parties, thus reducing the filing of non-meritorious claims and saving on legal expenses.~~[13]

While the coalition believes that legislative action or mandates are not necessary preconditions for implementation of a full disclosure program, THEY RECOGNIZE THAT SOME ~~others~~ 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
~~2.~~ 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)
~~3.~~ 4. Gallager TH, Waterman AD, Ebers AG, et al. Patients' and physicians' attitudes regarding the disclosure of medical errors. JAMA. 2003;289: 1001-1007.
~~4.~~ 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.
~~5.~~ 6. Kraman SS, Hamm G. Risk management: extreme honesty may be the best policy. Ann Intern Med. 1999;131:963–967.
~~6.~~ 7. Braxton K, Poe, K. Disclosure of medical errors; Is honesty the best policy legally? ~~www.sorryworks.net/article26.phtml. Accessed Sept. 26, 2006~~ –2006 ABA Health eSource, Jan 2006; Vol.2, No.5

8. Morton H. National Conference of State Legislatures. Medical Professional Apologies Statues. Jan. 21, 2014.

~~7.~~ 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.

The delegate that extracted the resolution reconsidered and supports the resolution.

No additional testimony was provided.

Mister Speaker, the committee recommends adoption of Resolution 2018-B-13

The Committee considered testimony on 2018-B-14, the resolved portion of which reads:

> The AAPA HOD requests that the Board of Directors contract with an independent marketing/PR firm to investigate the creation of a new professional title for physician assistants that accurately reflects these provider's present and future utilization and practice abilities, reporting the results to the 2019 HOD.

Pro testimony included:

- This issue has been debated multiple times over the years; it is time to address this topic by having an unbiased entity collect objective data on realistic options
- The correlation between this investigation and the current optimal team practice policy was highlighted and is consistent with the evolution of the profession
- This is a sound financial investment to further the profession and its reputation
- Other professions have changed their titles without negative sequelae
- There are adequate financial resources available at this time
- Constituent organizations indicated their membership has been largely in favor of title change consideration
- ARC-PA, PAEA, NCCPA, and AAPA all agree to work together on this project

Con testimony included:

- Should a title change be recommended, concerns exist regarding the cost to various stakeholders
- The proposed cost is excessive and should be invested in other endeavors
- There was concern this will not resolve the title change debate

Mister Speaker, the committee recommends adoption of Resolution 2018-B-14

The Committee considered testimony on 2018-B-15, the resolved portion of which reads:

> Amend policy HP-3500.3.4 entitled "Guidelines for State Regulation of PAs" to add language more clearly emphasizing that Optimal Team Practice (OTP) is not intended to establish the independent practice of medicine by PAs thereby addressing the concerns of organized medicine.

Guidelines for State Regulation of PAs

(Adopted 1988, amended 1993, 1998, 2001, 2005, 2006, 2009, 2011, 2013, 2016, 2017)

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 law and delegation of authority to regulate their practice to a state agency serves to both protect the public from incompetent performance by unqualified medical providers and to define the role of PAs in the healthcare system.
- AAPA, while recognizing the differences in political and healthcare climates in each state, endorses standardization of PA regulation to enhance appropriate and flexible professional practice.

Introduction

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

What follows are general guidelines on state governmental control of PA practice. The AAPA recognizes that the uniqueness of each state's political and healthcare climate will require modification of some provisions. However, standardization of PA regulation will enhance appropriate and flexible 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 practice acts or regulations. Rather, its intent is to clarify key

elements of regulation and to assist states as they pursue improvements in state governmental control of PAs. To see how these concepts can be adapted into legislative language, please consult the AAPA's model state legislation for PAs.

Definition of PA

The legal definition of PA should mean a healthcare professional who meets the qualifications for licensure and is licensed to practice medicine~~.~~ IN COLLABORATION WITH PHYSICIANS.

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 that 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, CAHEA or CAAHEP.

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~~ AGENCY has verified a PA's qualifications, it should issue a license to the applicant. Although, in the past, registration and certification have been used as the regulatory term for PAs, licensure is now the designation and system used in all states. This is appropriate because licensure is the most stringent form of regulation. Practice without a license is subject to severe

penalties. Licensure both protects the public from unqualified providers and utilizes a regulatory term that is easily understood by healthcare consumers.

Applicants who meet the qualifications for licensure should be issued a license. States should not require employment or identification of a supervising, collaborating, or other specific relationship with a physician(s) as a condition or component of licensure. A category of inactive licensure should be available for PAs who are not currently in active practice in the state. If issuance of a full license requires approval at a scheduled meeting of the regulatory agency, a temporary license should be available to applicants who meet all licensure requirements but are awaiting the next meeting of the board.

If the ~~board~~ REGULATORY AGENCY uses continuous clinical practice as a requirement for licensure, it should recognize the nature of PA practice when determining requirements for PAs who are reentering clinical practice (defined as a return to clinical practice as a PA following an extended period of clinical inactivity unrelated to disciplinary action or impairment issues). Each PA reentering clinical practice will have unique circumstances. Therefore, the board should be authorized to customize requirements imposed on PAs reentering clinical practice. Acceptable options could include requiring current certification, development of a personalized re-entry plan, or temporary authorization to practice for a specified period**.** Although it has not yet been determined conclusively that absence from clinical practice is associated with a decrease in competence, there is concern that this may be the case. Reentry requirements should not be imposed for an absence from clinical practice that is less than two years in duration.

Because of the high level of responsibility of PAs, it is reasonable for licensing agencies to conduct criminal background checks on individuals who apply for licensure as PAs. ~~Licensing~~ REGULATORY 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/physician teams are especially effective and valued.

Optimal team practice ~~occurs when~~ IS DEFINED AS PAs, AS PART OF A HEALTHCARE TEAM, ~~have the ability to collaborate~~ COLLABORATING AND ~~consult~~ CONSULTING WITH physicianS or other qualified medical professionals, as indicated by the patient's condition and the standard of care, and in accordance with the PA's training, experience, and current competencies.

The evolving medical practice 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 and physicians ~~work~~ PRACTICE together ~~should be~~ IS determined at the practice level.

The PA/physician team model continues to be relevant, applicable and patient-centered. ~~the degree of collaboration of the practicing PA~~ THE DETAILS OF THE PRACTICE RELATIONSHIP BETWEEN A PHYSICIAN AND A PA should be determined at the practice level in accordance with the practice type and the experience and competencies of the ~~practicing~~ PA. State law should not ~~require a specific relationship between a PA, and physician, or any other entity~~ MANDATE SPECIFIC DETAILS OF THE PRACTICE OF THE PA in order for a PA to practice to the full extent of their education, training and experience. ~~Such requirements diminish~~ ALLOWING SITE-SPECIFIC FLEXIBILITY PROMOTES TEAM PRACTICE, INCREASES PATIENT ACCESS TO CARE, AND IMPROVES PATIENT SAFETY. ~~and therefore limit patient access to care, without improving patient safety. In addition, such requirements put all providers involved at risk of disciplinary action for reasons unrelated to patient care or outcomes. Like every clinical provider,~~ PAs are responsible for the care they provide. Nothing in the law should require or imply that a physician is responsible or liable for care provided by a PA, unless the PA is acting on the specific instructions of the physician.

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 assure that the patient's treatment is consistent with the standard of care.

Notwithstanding the above provisions, these guidelines recognize that medicine is rapidly changing. A modified model may be better for some states and they should therefore feel free to craft alternative provisions.

<u>PA Practice Ownership and Employment</u>

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 physicians and to PAs. The PA-physician relationship is built on trust, respect, and appreciation of the unique role of each team member. No licensee should allow an employment arrangement to interfere with sound clinical judgment or to diminish or influence his/her ethical obligations to patients. State law provisions should authorize the regulatory authority to discipline a physician or a PA who allows employment arrangements to exert undue influence on sound clinical judgment or on their professional role and patient obligations.

Disasters, Emergency Field Response and Volunteering

PAs should be allowed to provide medical care in disaster and emergency situations.

This may require the state to adopt language that permits PAs to 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. PAs should be granted Good Samaritan immunity to the same extent that it is available to other health professionals.

PAs who are volunteering without compensation or remuneration should be 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 law should not require a specific relationship between a PA physician, or any other entity for a PA to volunteer.

Scope of Practice

State 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. 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, education or testing should not be required as a prerequisite to PA prescriptive authority. PAs who are prescribers of controlled medications should register with the Federal Drug Enforcement Administration.

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

State 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" or "asociado médico" when the professional title is translated into Spanish should be limited to those who are authorized to practice by their state as a PA. The title may also be utilized by those who are exempted from state licensure but who are credentialed as a PA by a federal employer and by those who meet all the qualifications for licensure in the state but are not currently licensed. A person who is not authorized to practice as a PA should not engage in PA practice unless similarly credentialed

by a federal employer. The state should have the clear authority to impose penalties on individuals who violate these provisions.

Regulatory Agencies

Each state must define the regulatory agency responsible for implementation of the law governing PAs. Although a variety of state agencies can be charged with this task, the preferable regulatory structure is a separate PA licensing board comprised of a majority of PAs, with other members who are knowledgeable about PA education, certification, and practice. Consideration should be given to including members who are representative of a broad spectrum of healthcare settings — primary care, specialty care, institutional and rural based practices.

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

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

Although there is no conclusive evidence that malpractice claims history correlates with professional competence, many state regulatory agencies are required by statute to make malpractice history on licensees available to the public. If mandated to do so, the board should create a balance between the public's right to relevant information about licensees and the risk of diminishing access to subspecialty care. Because of the inherent risk of adverse outcomes, medical professionals who care for patients with high- risk medical conditions are at greater risk for malpractice claims. The board should take great care in assuring that patient access to this specialized care is not hindered as a result of posting information that could be misleading to the public.

Licensee profiles should contain only information that is useful to consumers in making decisions about their healthcare professional. Healthcare professional profile data should be presented in a format that is easy to understand and supported by contextual information to aid consumers in evaluating its significance.

Discipline

AAPA endorses the authority of designated state regulatory agencies, in accordance with due process, to discipline PAs who have committed acts in violation of state law.

Disciplinary actions may include, but are not limited to, suspension or revocation of a license or approval to practice. In general, the basic offenses are similar for all health professions and the language used to specify violations and disciplinary measures to be used for PAs should be similar to that used for

physicians. The law should authorize the regulatory agency to impose a wide range of disciplinary actions so that the board is not motivated to ignore a relatively minor infraction due to inadequate disciplinary choices. Programs and special provisions for treatment and rehabilitation of impaired PAs should be similar to those available for physicians. The Academy also endorses the sharing of information among state regulatory agencies regarding the disposition of adjudicated actions against PAs.

Inclusion of PAs in Relevant Statutes and Regulations

In addition to laws and regulations that specifically regulate PA practice, PAs should be included in other relevant areas of law. This should include, but not be limited to, laws that grant patient-provider immunity from testifying about confidential information; mandates to report child and elder abuse and certain types of injuries, such as wounds from firearms; provisions allowing the formation of professional corporations by related healthcare professionals; and mandates that promote health wellness and practice standards. Laws that govern specific medical technology should authorize those appropriately trained PAs to use them.

For all programs, states 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 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.

Pro testimony included:

- There was support for amending line 458 to strike the proposed language "in collaboration with physicians" within the Definition of PA section of the paper, but maintaining the remainder of the proposed resolution
- There was concern the policy as written appears disingenuous, lacking clarity regarding whether or not OTP policy is a move toward independent practice
- Additional concerns were expressed regarding the alienation of physician groups (as demonstrated by two letters addressed to the AAPA BOD by the AMA). Potential negative impacts include, but are not limited to, tenuous relationships at the state level and clinical rotation site availability.
- There was testimony suggesting that language could be added specifically stating that "OTP is not independent practice"
- There was contradictory testimony regarding how well the OTP policy defines team practice. Pro testimony indicated that the original policy was not clear with regards to what team practice means, which led to the proposed amendments.

Con testimony included:

- The proposed resolution does not further clarify OTP
- Proposed changes may project indecisiveness and fragmentation within AAPA

- Physician organizations' concerns will likely persist despite changing the policy language
- Rural Health Association guidelines support OTP in its current form
- This policy is in its infancy and the impact is not yet determined; we should focus on the implementation of the original policy before amending it
- The resolution language conflicts with the defining characteristics of a profession
- Existing OTP policy accurately reflects current PA practice
- There was contradictory testimony regarding how well the OTP policy defines team practice. Con testimony referenced HP-3100.2.1 and HP-3100.3.1 that define the role of a PA in the healthcare team.

There was conflicting testimony with regard to how team-based practice and OTP are being implemented.

Mister Speaker, the committee recommends rejection of Resolution 2018-B-15

The Committee considered testimony on 2018-B-16, the resolved portion of which reads:

> AAPA supports PAs as vital members of the healthcare team in the treatment of Opiate Use Disorder (OUD). AAPA further supports PAs being able to prescribe buprenorphine for the treatment of OUD and opposes having different educational or patient capitation requirements than physicians.

Testimony included:

- Suggestions were made to change "opiate" to "opioid" as well as to make the requirements equal for PAs and physicians

The reference committee suggests the following changes:

> AAPA supports PAs as vital members of the healthcare team in the treatment of ~~Opiate~~ OPIOID Use Disorder (OUD). AAPA further supports PAs being able to prescribe buprenorphine for the treatment of OUD and SUPPORTS EQUAL EDUCATION REQUIREMENTS AND PATIENT CAPITATION ~~opposes having different educational or patient capitation requirements~~ FOR PAS AND ~~than~~ physicians.

Mister Speaker, I move that Resolution 2018-B-16 be so amended

The Committee considered testimony on 2018-B-18, the resolved portion of which reads:

> AAPA supports standards to require that PA training programs provide at least 80-percent of didactic instruction as in-person or live lectures.

Pro testimony included:

- Online education may inhibit the ability of faculty to assess student professionalism, understanding, synthesis of information, interpersonal skills and empathy, and medical acculturation
- There are concerns that students are unable to effectively self-assess

- Proliferation of online programs could lead to oversaturation of PAs, leading to a supply-demand imbalance

Con testimony included:

- ARC-PA testified that all programs have to be accredited by the ARC-PA, utilizing the same standards
- There is concern about restraint of trade by restricting programs based on teaching methods
- There is lack of data to substantiate online programs as less effective than in-person programs
- Advancements in technology have allowed numerous established PA programs to successfully utilize online curricula to varying degrees
- Innovative teaching methods may allow for increased diversity of the profession and rural access to healthcare
- There was a recommendation that the resolution should be referred

Mister Speaker, the committee recommends rejection of Resolution 2018-B-18

Mr. Speaker, this concludes the report of Reference Committee B. I would like to thank the House Officers David Jackson, Bill Reynolds, and Todd Pickard for their support and guidance. I would further extend gratitude and thanks to the hard work of our scribe Kacianna Hardsock. I would like to thank the committee members for their hard work and being well prepared for this committee.

Respectfully submitted,

SIGNATURES ON FILE

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Jacqi Kernaghan

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