2021 Summary of Actions

AAPA House of Delegates Virtual Meeting
May 20-22 & 24, 2021

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

Resolution	Title	Line Number	Action Taken
2021-A-01*	Article III, Sections 2 and 6 -- Sustaining Membership Category	1	Adopted
2021-A-02*	Article III, Sections 5, 7, and 2 -- Other Health Professional as Affiliate Members	16	Adopted
2021-A-03*	Article III, Section 2 and 12 -- Pre-PA Membership Category	35	Adopted
2021-A-04*	Article XI, XIII Section 1, 3, 4 and 6 -- GovCom Structural Changes & Inclusion in the Bylaws	49	Rejected
2021-A-05*	Articles X, XI, and XIII -- Nominating Work Group Designated as a Commission	283	Rejected
2021-A-06*	Article XIV, Sections 5, 6, and 7 -- Review of Proposed Bylaws Resolutions	534	Adopted
2021-A-07*	Article XIII, Section 5 -- Student Members Voting in Student Board Election	616	Adopted on Consent Agenda
2021-A-08*	Article III, Section 4, Article V, Section 4a, Article XIII, Section 5a -- Credentialed Student Members Voting in General Elections	642	Referred
2021-A-09	Face to Face Meetings	680	Adopted as Amended
2021-A-10	AAPA Involvement	688	Reaffirmed
2021-A-11	Membership Requirements for PA Educators in both AAPA and State Constituent Organizations	697	Rejected
2021-A-12	Membership Requirements in AAPA and Constituent Organizations for AAPA Speakers at AAPA Hosted Events	704	Rejected
2021-A-13	Membership Support Incentive for AAPA Employer of Excellence Recipients	711	Rejected

2021-A-14	Competencies for the PA Profession Paper	718	Adopted
2021-A-15	Support for Physician Assistant Oath	951	Adopted as Amended
2021-A-16	Equity in Compensation	988	Adopted on Consent Agenda
2021-A-17	Value of NCCPA Recertification	1009	Adopted on Consent Agenda
2021-B-01a	Changing the Professional Name of the Academy	1019	Tabled Indefinitely
2021-B-01b	Changing the Professional Name of the Academy	1025	Adopted as Amended
2021-B-02	Physician Assistant as the Official Title	1031	Adopted as Amended
2021-B-03	Entry-level Doctorate for PAs	1038	Adopted as Amended
2021-B-04	Standardization of Entry-Level Degree Titles	1044	Rejected
2021-B-05	Postprofessional Doctoral Degree Programs	1055	Adopted
2021-B-06	PA Student Supervised Clinical Practice Experiences Paper	1066	Adopted as Amended
2021-B-07	Life-long Learning Opportunities	1652	Adopted as Amended
2021-B-08	Accreditation Council for Continuing Medical Education Standard	1668	Adopted on Consent Agenda
2021-B-09	PA Certification Terminology	1677	Adopted as Amended by Deletion
2021-B-10	Interprofessional Medical Education to Incorporate the PA's Role	1686	Adopted as Amended
2021-C-01	Racism	1695	Adopted
2021-C-02	AAPA's Commitment to Diversity, Equity, and Inclusion	1699	Adopted as Amended
2021-C-03	Organizational Support of Diversity	1747	Adopted as Amended
2021-C-04	Diversity/Disparity Educational Opportunities	1753	Adopted as Amended
2021-C-05	Culturally Competent Care	1761	Adopted on Consent Agenda
2021-C-06	Diversity Award	1769	Adopted
2021-C-07	Equity and Inclusion for All Student Members of State Chapters	1775	Adopted on Consent Agenda

2021-C-08	Admissions and Holistic Review	1781	Adopted as Amended
2021-C-09	Diversity and Inclusion in PA Education Paper	1788	Adopted as Amended
2021-C-10	Excessive Force by Law Enforcement Agents	2184	Adopted as Amended
2021-C-11	Disparities in Maternal Morbidity and Mortality Paper	2197	Adopted on Consent Agenda
2021-C-12	Access to Prenatal Care	2629	Adopted on Consent Agenda
2021-C-13	Support for Promotion of Safe-sex Practices and Interventions to Prevent Sexually Transmitted Infections	2639	Adopted as Amended
2021-C-14	Breastfeeding	2662	Referred
2021-C-15	Oral Health	2673	Adopted on Consent Agenda
2021-C-16	Improving Children's Access to Healthcare Paper	2685	Adopted as Amended
2021-C-17	State Laws for Protective Equipment Head Injuries	2758	Adopted on Consent Agenda
2021-C-18	Recognizing Point-of-Care Ultrasound as a Skill Integral to the Practice of Medicine	2775	Adopted as Amended
2021-C-19	Evaluation in Mental Health	2791	Adopted on Consent Agenda
2021-C-20	Substance Use Disorder	2802	Adopted as Amended
2021-C-21	Opioid Use	2812	Adopted as Amended
2021-C-22	Driving Under the Influence of Alcohol	2824	Adopted
2021-C-23	Nicotine Dependence Paper	2834	Adopted as Amended
2021-C-24	Cannabis Education and Legislation	3241	Referred
2021-C-25	Cannabinoids Use in Presence of Minors	3253	Adopted as Amended
2021-C-26	Marijuana Legislation	3262	Adopted as Amended
2021-C-27	Marijuana use in Pregnancy and Breastfeeding	3270	Adopted
2021-C-28	Safety Cannabis	3278	Adopted
2021-C-29	PAs as Medical Providers that Authorize Medical Cannabis	3287	Adopted on Consent Agenda
2021-C-30	Pornography as a Public Health Crisis Paper	3298	Rejected

2021-D-01	PAs & Other Healthcare Professionals	3485	Adopted as Amended
2021-D-02	PA Obligations	3492	Adopted as Amended by Deletion
2021-D-03	Practice Model and Team Ratios Task Force	3510	Adopted as Amended
2021-D-04	PAs in Provider Directories	3518	Adopted
2021-D-05	AAPA Opposes Differentiating Between PAs	3529	Referred
2021-D-06	PA Practice Ownership Policy	3537	Adopted as Amended
2021-D-07	Healthcare Shortages	3552	Adopted on Consent Agenda
2021-D-08	National Health Service Corps	3567	Expired
2021-D-09	Rural Health Clinics	3574	Adopted on Consent Agenda
2021-D-10	The PA in Disaster Response-Core Guidelines Paper	3594	Referred
2021-D-11	Telemedicine Paper	4512	Adopted as Amended
2021-D-12	Quality Incentive Programs Paper	5061	Adopted as Amended
2021-D-13	Medical Home	5516	Adopted
2021-D-14	Health Information Technology (H.I.T.) Systems	5537	Expired
2021-D-15	Adoption of Home-Centered Care Paper	5546	Adopted
2021-D-16	Prescription Drug Benefit Plans	5778	Adopted on Consent Agenda
2021-D-17	Maintenance of Certification Requirements	5808	Adopted
2021-D-18	Maintenance of Licensure	5817	Adopted as Amended
2021-D-19	Guidelines for PAs Working Internationally	5841	Adopted on Consent Agenda
2021-D-20	ILO Categorization for PAs	5869	Adopted as Amended

Reaffirmed Policies		
HP-3100.1.4	HP-3100.3.2	HP-3100.4.1
HP-3200.1.5	HP-3200.2.2	HP-3200.6.2
HP-3200.7.1	HP-3300.1.9.1	HP-3300.2.7
HP-3500.2.0.1	HP-3500.3.4.2	HP-3500.3.5
HP-3600.1.1	HP-3600.1.4	HP-3600.1.6
HP-3700.1.1	HP-3700.2.1	HP-3700.2.3

HP-3900.1.1	HX-4100.1.11	HX-4100.1.6
HX-4200.7.3	HX-4300.2.4	HX-4600.1.5
HX-4600.1.6	HX-4600.1.6.1	HX-4600.1.9
HX-4600.3.2	HX-4600.3.3	HX-4600.5.8
Expired Policies		
HP-3600.1.2	HX-4400.3.1	HX-4600.2.4
HX-4600.2.5		
Resolutions of Commendation	**Line Number**	**Purpose**
NB-1	5899	Commendation for Bill Reynolds
NB-2	5961	Commendation for Bill Reynolds
Resolution of Condolence	**Line Number**	**Purpose**
NB-3	5989	Condolence for J. Jeffrey Heinrich
House Elections	**Line Number**	
Results	6045	

Bolded text within a resolution indicates the amendments submitted and accepted during the reports of the reference committees on May 24, 2021.

Presiding Officers

William T. Reynolds, Jr., MPAS, PA-C, DFAAPA	Speaker of the House
Todd A. Pickard, MMSc, PA-C, DFAAPA	First Vice Speaker
Leslie Clayton, MPAS, PA-C, DFAAPA	Second Vice Speaker

2021-A-01 – Adopted (Requires AAPA Board of Directors Ratification)

Amend AAPA Bylaws Article III, Sections 2 and 6 as follows:

ARTICLE III Membership.

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

~~Section 6: Sustaining Members. Sustaining members shall consist of ARC-PA, CAHEA, CAAHEP or successor agency approved PA program graduates who have chosen not to actively practice in the profession and opt to be classified as sustaining members. Sustaining members shall not be entitled to vote or hold office.~~

2021-A-02 – Adopted (Requires AAPA Board of Directors Ratification)

Amend AAPA Bylaws Article III, Sections 5, 7 and 2 as follows:

ARTICLE III Membership.

Section 5: Affiliate Members. Affiliate members shall consist of individuals ~~approved by the Membership Division of the National Office~~ from ~~the~~ OTHER health professions who desire to associate with the Academy. Affiliate members shall not be entitled to vote or hold office.

~~Section 7: Physician Members. Physician members shall consist of licensed physicians who desire to associate with the Academy. Physician members shall not be entitled to vote or hold office.~~

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

2021-A-03 – Adopted (Requires AAPA Board of Directors Ratification)

Amend AAPA Bylaws Article III as follows:

ARTICLE III Membership.

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

SECTION 12: 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.

2021-A-04 – Rejected (Requires AAPA Board of Directors Ratification)

Insert a new Article XI into AAPA's Bylaws as follows and renumber the subsequent Articles.

ARTICLE XI GOVERNANCE COMMISSION

SECTION 1: DUTIES AND RESPONSIBILITIES:

THE GOVERNANCE COMMISSION WILL SUPPORT THE GOVERNING BODIES OF AAPA IN FULFILLMENT OF THEIR RESPONSIBILITIES REGARDING MATTERS THAT RELATE TO DIRECTING THE ORGANIZATION. SPECIFICALLY, THE GOVERNANCE COMMISSION SHALL:

a. CARRY OUT SUCH DUTIES AND RESPONSIBILITIES AS ARE SET FORTH IN THESE BYLAWS, INCLUDING THOSE RELATED TO ELECTIONS IN ARTICLE VI, SECTION 3 AND ARTICLE XIII, SECTION 6 AND REVIEW OF BYLAWS RESOLUTIONS IN ARTICLE XIV.
b. ADVISE AAPA LEADERSHIP ON GOVERNANCE-RELATED ISSUES BY PROVIDING REVIEW, RESEARCH, ANALYSIS AND RECOMMENDATIONS.
c. PROMOTE AND SUPPORT THE OPTIMAL PERFORMANCE OF AAPA LEADERSHIP WHICH, IN TURN, PROMOTES MEMBER TRUST AND ENGAGEMENT.
d. REVIEW AAPA GOVERNANCE DOCUMENTS AND MAKE RECOMMENDATIONS TO ENHANCE TRANSPARENCY AND TO IMPROVE EFFECTIVENESS AND EFFICIENCY OF GOVERNANCE OPERATIONS.
e. SERVE IN AN ADVISORY CAPACITY TO THE CONSTITUENT RELATIONS WORK GROUP (CRWG).
f. COLLABORATE WITH THE JUDICIAL AFFAIRS COMMISSION (JAC) AS INDICATED IN THE AAPA JUDICIAL AFFAIRS MANUAL.
g. REVIEW AND PROVIDE COMMENTS ON AAPA POLICIES ASSIGNED TO IT BY THE HOUSE OFFICERS OR THE BOARD OF DIRECTORS.
h. COLLABORATE WITH OTHER COMMISSIONS, ORGANIZATIONS AND STAFF, AS NEEDED, TO ENSURE COMPLIMENTARY CROSS-ORGANIZATIONAL STRATEGY, RESEARCH, AND PLANNING PROCESSES.
i. COLLABORATE WITH OTHER COMMISSIONS, CONSTITUENT ORGANIZATIONS, STAFF, AND AAPA COUNSEL, AS NEEDED, TO ENSURE ORGANIZATIONAL COMPLIANCE AND CONSISTENCY OF POLICIES AND PROCEDURES.

SECTION 2: COMPOSITION, METHOD OF ELECTION.

a. THE GOVERNANCE COMMISSION IS COMPOSED OF SEVEN (7) NON-AAPA BOARD MEMBERS. COMMISSION MEMBERS WILL CONSIST OF:

i. TWO ELECTED BY PLURALITY VOTE OF THE HOUSE OF DELEGATES.
ii. TWO ELECTED BY PLURALITY VOTE OF THE BOARD OF DIRECTORS.
iii. TWO ELECTED BY PLURALITY VOTE OF THE GENERAL MEMBERSHIP.
iv. ONE ELECTED BY A PLURALITY VOTE OF THE STUDENT ACADEMY ASSEMBLY OF REPRESENTATIVES (AOR).

b. GOVERNANCE COMMISSION CANDIDATES SHOULD PRE-DECLARE THEIR CANDIDACY.
c. THE HOUSE OF DELEGATES SHALL DETERMINE VOTING PROCEDURES FOR THE HOUSE-ELECTED MEMBERS OF THE GOVERNANCE COMMISSION.
d. THE BOARD SHALL DETERMINE VOTING PROCEDURES FOR THE BOARD-ELECTED MEMBERS OF THE GOVERNANCE COMMISSION.
e. THE GOVERNANCE COMMISSION SHALL DETERMINE VOTING PROCEDURES FOR THE ELECTION OF MEMBERS FROM THE GENERAL MEMBERSHIP FOR THE GOVERNANCE COMMISSION.
f. THE ASSEMBLY OF REPRESENTATIVES SHALL DETERMINE VOTING PROCEDURES FOR THE ELECTION OF THE AOR ELECTED MEMBER OF THE GOVERNANCE COMMISSION.

SECTION 3: ELIGIBILITY AND QUALIFICATIONS

a. MEMBERS APPLYING TO THE GOVERNANCE COMMISSION THROUGH THE GENERAL MEMBERSHIP ELECTION MUST BE CURRENT FELLOW MEMBERS OF AAPA. THOSE APPLYING TO THE GOVERNANCE COMMISSION THROUGH THE BOARD, HOUSE OR AOR ELECTIONS MUST BE CURRENT FELLOW OR STUDENT MEMBERS OF AAPA.
b. GOVERNANCE COMMISSION MEMBERS MAY NOT RUN FOR ANY AAPA ELECTED OFFICE DURING THE TERM TO WHICH THEY WERE ELECTED.
c. GOVERNANCE COMMISSION MEMBERS CANNOT HOLD ANY OTHER ELECTED OFFICE, COMMISSION OR WORK GROUP POSITION IN AAPA DURING THEIR TERM OF SERVICE ON THE GOVERNANCE COMMISSION.

SECTION 4: TERM OF SERVICE:

a. WITH THE EXCEPTION OF THE STUDENT ACADEMY REPRESENTATIVE, THE TERM OF SERVICE FOR FELLOW MEMBERS OF THE GOVERNANCE COMMISSION SHALL BE TWO (2) YEARS, WITH THE EXCEPTION OF THE FIRST YEAR, IN WHICH THE CANDIDATE WITH THE HIGHEST VOTE WILL SERVE A TWO-YEAR TERM AND THE CANDIDATE WITH THE SECOND HIGHEST NUMBER OF VOTES WILL SERVE A ONE-YEAR TERM.
b. THE TERM OF SERVICE OF THE MEMBER ELECTED BY THE AOR SHALL BE ONE YEAR.
c. TERMS SHALL BE STAGGERED.
d. NO MEMBER MAY SERVE MORE THAN TWO CONSECUTIVE TERMS.

SECTION 5: VACANCY

IF A MEMBER OF THE GOVERNANCE COMMISSION LEAVES DURING A TERM, THE POSITION WILL BE FILLED AT THE NEXT ELECTION CYCLE IN THE SAME MANNER BY THE GROUP WHO ELECTED THE OUTGOING MEMBER. IF THE GOVERNANCE COMMISSION DROPS BELOW THREE MEMBERS, A SPECIAL ELECTION WILL NEED TO BE HELD.

Further resolved

Amend AAPA Bylaws Article XIII as follows:

ARTICLE XIII Elections.

Section 1: Positions to be Filled by Election. Elected positions include Directors-at-large; one Student Director; the Academy Officer positions of President-elect and Secretary-Treasurer; and the House Officer positions of Speaker, First Vice Speaker, and Second Vice Speaker; and such number of members of the GOVERNANCE COMMISSION AND Nominating Work Group as may be set forth in Article XI AND ARTICLE [NEW NWG ARTICLE NUMBER] 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 GOVERNANCE COMMISSION AND Nominating Work Group positions shall be filled by the ~~House of Delegates~~ APPROPRIATE BODY in the manner prescribed by Article XI AND [NEW NWG ARTICLE NUMBER]. 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, GOVERNANCE COMMISSION or Nominating Work Group Member.

a. A candidate must be a fellow member of AAPA.
b. A candidate must be a member of an AAPA Chapter.
c. A candidate must have been an AAPA fellow member and/or student member for the last three years.
d. A candidate must have accumulated at least three distinct years of experience in the past five years in at least two of the following major areas of professional

involvement. This experience requirement will be waived for currently sitting AAPA Board members who choose to run for a subsequent term of office.

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

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

Section 4: Self-declaration of Candidacy. Self-declaration, in accordance with policy, shall be permitted in ALL ACADEMY ELECTIONS. ~~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 AND GENERAL ELECTORATE GOVERNANCE COMMISSION SEATS are fellow members.
b. Eligible voters for House Officers and for HOUSE-elected members of THE GOVERNANCE COMMISSION AND Nominating Work Group are voting members of the House of Delegates who are present at the time of the election.
c. Eligible voters for the Student Academy President-elect and Student Academy Directors of Outreach and Communication, are credentialed members of the Assembly of Representatives and Student Board members present at the time of the election.
d. ELIGIBLE VOTERS FOR THE STUDENT ACADEMY-ELECTED GOVERNANCE COMMISSION MEMBERS ARE CREDENTIALED MEMBERS OF THE ASSEMBLY OF REPRESENTATIVES PRESENT AT THE TIME OF THE ELECTION.
e. Eligible voters for the Student Academy Chief Delegate are credentialed members of the Assembly of Representatives, Student Academy Board members, and credentialed student delegates.
f. Eligible voters for Student Academy Regional Directors are credentialed members of the Assembly of Representatives and Student Board members from within the respective region who are present at the time of the election.
g. For all positions, eligible voters must be current members in good standing (fellow or student) as of the date that is fifteen (15) days before the respective election.

Section 6: Election Procedures. The Governance Commission shall determine the timing and procedures for all Academy elections, EXCEPT THE NON-GENERAL MEMBERSHIP-ELECTED MEMBERS OF THE GOVERNANCE COMMISSION,

ensuring House elections take place at the annual meeting of the House of Delegates in accordance with the North Carolina Nonprofit Corporation Act and these Bylaws.

Section 7: Vote Necessary to Elect. A plurality of the votes cast shall elect the Directors-at-large and the Academy Officers (excluding the Vice President), so long as the number of votes cast equals or exceeds a quorum of one (1) percent of the members entitled to vote in the election. In the case of a tie vote, the House of Delegates shall vote to decide the election from among the candidates who tied. The vote necessary to elect the House Officers (including the Speaker, who shall serve as the Vice President of the Academy) shall be prescribed in Article VI, Section 3.

Section 8: Commencement of Terms. The term of office for all elected positions, including Directors-at-large, the Student Director, Academy Officers, and House Officers, shall begin on July 1. In the event that the election of the House Officers occurs later than July 1, the new House Officers will take office at the close of the meeting during which they were elected.

Section 9: Vacancies. Academy Officers and Directors, the Student Director and House Officers may resign or be removed as provided in these Bylaws. The method of filling positions vacated by the holder prior to completion of term shall be as follows:

a. OFFICE OF THE PRESIDENT. The President-elect shall become the President to serve the unexpired term. The President-elect shall then serve a successive term as President.
b. OFFICE OF THE PRESIDENT-ELECT. In the event of a vacancy in the office of President-elect, the Immediate Past President shall assume the duties, but not the office of the President-elect while continuing to perform the duties of Immediate Past President. The Nominating Work Group will prepare a slate of candidates. Eligible members, as described in Section 6 of this Article, shall elect a new President-elect from the candidates proposed and any candidates that self-declare. The elected candidate will take office immediately and will serve the remainder of the un-expired term.
c. SPEAKER; FIRST VICE SPEAKER; SECOND VICE-SPEAKER. A vacancy in the positions of the Speaker, First Vice Speaker, or Second Vice Speaker shall be filled in the manner prescribed by the House of Delegates Standing Rules, and in accordance with Article VI, Section 3 of these Bylaws.
d. STUDENT ACADEMY BOARD MEMBER. A vacancy in the Student Director position shall be filled in the manner prescribed by the Student Academy Bylaws.
e. OTHER BOARD VACANCIES. The Nominating Work Group will prepare a slate of candidates. Eligible members, as described in Section 6 of this Article, shall elect a new officer and/or director from the candidates proposed and any candidates that self-declare. The elected candidate will take office immediately and will serve the remainder of the un-expired term.

2021-A-05 – Rejected (Requires AAPA Board of Directors Ratification)

Amend AAPA Bylaws Articles X, XI and XIII as follows:

ARTICLE X Board Committees; Academy Commissions, ~~and~~ Work Groups,~~:~~ Task Forces, Ad Hoc AND OTHER COMMITTEES ~~Groups~~.

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

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

a. Commissions and Work Groups. The House of Delegates ~~shall~~ MAY recommend to the Board the establishment of commissions and work groups of the Academy. The Board of Directors ~~shall~~ MAY establish such commissions and work groups BASED ON A HOD RECOMMENDATION OR INDEPENDENTLY and set forth the respective duties, responsibilities, and membership eligibility requirements thereof.~~, as the Board may deem advisable.~~ With the exception of the Nominating ~~Work Group~~ COMMISSION AND GOVERNANCE COMMISSION, 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~~ COMMITTEES 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 TASK FORCES ~~ad hoc groups as may be~~ necessary to carry out the duties of the House of Delegates.

ARTICLE XI Nominating ~~Work Group~~ COMMISSION

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

a. Annually evaluate the environment and recommend to the Governance Commission any ~~skills, capabilities or other characteristics~~ COMPETENCIES AND SKILLSETS that will support a diverse and high-performing Board of Directors.
b. Support communication and education efforts to inform all members of elected leadership opportunities and how to qualify for those positions.
c. Identify and recruit qualified members and encourage a broad slate of candidates to run for elected positions within AAPA.
d. ~~Evaluating~~ EVALUATE all candidates seeking nomination according to the qualification criteria set forth in these Bylaws and according to such other selection guidelines as may be ~~established~~ RECOMMENDED by the Board of Directors.
e. ~~Endorsing~~ ENDORSE ~~a single or multiple~~ a slate of candidates for each nominated position.
f. PROVIDE A LIST OF ENDORSED CANDIDATES TO THE GOVERNANCE COMMISSION

Section 2: Composition: Method of Election or Appointment. The Nominating ~~Work Group~~ COMMISSION is composed of seven (7) members, ~~five (5) of which~~ TWO (2) of WHOM are elected by plurality vote ~~at~~ BY the House of Delegates AT THE annual meeting. Two (2) members are appointed by the Board of Directors AND THREE (3) ARE ELECTED BY THE GENERAL MEMBERSHIP. Nominating ~~Work Group~~ COMMISSION candidates should pre-declare their candidacy; however, write-in candidates WILL BE ACCEPTED IN ALL NOMINATING COMMISSION ELECTIONS, and nominations and self-declarations from the House floor will be accepted at the time of elections IN THE HOUSE OF DELEGATES ELECTION.

Section 3: Eligibility and Qualifications. Nominating ~~Work Group~~ COMMISSION members may not run for any of the positions ~~they are evaluating for the upcoming election~~ IN THE CURRENT OR FOLLOWING ELECTION CYCLE. Additionally:

a. A candidate must be a fellow member of AAPA.
b. A candidate must have been an AAPA fellow member and/or student member for the last three years.
c. A candidate must have accumulated at least three distinct years of recognized leadership experience in the past five years through service to the AAPA; an AAPA constituent organization; an AAPA affiliated organization; and/or a health care related professional or community organization. Examples include but are

not limited to: service in the AAPA House of Delegates; the PA Foundation; PAEA; a local hospice support organization; a hospital board.

i. Recognized leadership experience must be earned in, at least, two major areas of professional involvement.

ii. Recognized leadership experience includes a board member or organization officer; an elected or appointed representative; or a chair of a commission, committee, work group or task force.

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

e. With the exception of the Board-appointed members, a Nominating ~~Work Group~~ COMMISSION member cannot hold any other elected office or commission or work group position in AAPA during the TERM FOR WHICH THEY WERE ELECTED ~~time of service~~ on the Nominating ~~Work Group~~ COMMISSION.

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

Section 5: Vacancies. Nominating ~~Work Group~~ COMMISSION 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. HOUSE OF DELEGATES 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~~ COMMISSION member takes office at the next change of office.

c. GENERAL MEMBERSHIP: IF ONLY ONE GENERAL MEMBERSHIP POSITION IS VACANT, IT WILL BE FILLED IN THE NEXT REGULAR ELECTION CYCLE. IF TWO OR MORE GENERAL ELECTORATE MEMBER POSITIONS ARE VACANT, A SPECIAL ELECTION WILL BE HELD TO ELECT REPLACEMENT MEMBERS TO FILL THE REMAINDER OF THE UNEXPIRED TERM.

ARTICLE XIII Elections.

Section 1: Positions to be Filled by Election. Elected positions include Directors-at-large; one Student Director; the Academy Officer positions of President-elect and Secretary-Treasurer; and the House Officer positions of Speaker, First Vice Speaker, and Second Vice Speaker; and such number of members of the Nominating ~~Work Group~~ COMMISSION as may be set forth in Article XI of these Bylaws. The House Officer

positions shall be filled by the House of Delegates in the manner prescribed by Article VI, Section 3. The Student Director shall be elected in the manner prescribed by Article V, Section 3. The Nominating ~~Work Group~~ COMMISSION positions shall be filled by the House of Delegates in the manner prescribed by Article XI. All other elected positions shall be filled in the manner prescribed by this Article XIII.

Section 2: Term of Office.

a. The term of office for the Academy Officer positions of President, President-elect, and Immediate Past President shall be one year. The term of office for the Student Director shall be one year. The term of office for Directors-at-Large and for the Academy Officer position of Secretary-Treasurer shall be two years. The term of office for House Officer positions shall be one year.
b. Officers' and Directors' positions will automatically be resigned effective at the end of the leadership year if the individual runs for an alternate office.

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

a. A candidate must be a fellow member of AAPA.
b. A candidate must be a member of an AAPA Chapter.
c. A candidate must have been an AAPA fellow member and/or student member for the last three years.
d. A candidate must have accumulated at least three distinct years of experience in the past five years in at least two of the following major areas of professional involvement. This experience requirement will be waived for currently sitting AAPA Board members who choose to run for a subsequent term of office.
    i. An AAPA or constituent organization officer, board member, committee, council, commission, work group, task force chair.
    ii. A delegate to the AAPA House of Delegates or a representative to the Student Academy of the AAPA's Assembly of Representatives.
    iii. A board member, trustee, or committee chair of the Student Academy of the AAPA, PA Foundation, Physician Assistant History Society, AAPA Political Action Committee, Physician Assistant Education Association or National Commission on Certification of Physician Assistants.
    iv. AAPA Board appointee.
e. A candidate for House Officer must have been a seated delegate for a minimum of two years in the past five years.

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

Section 5: Eligible Voters.

a. Eligible voters for President-elect, Secretary-Treasurer, ~~and~~ Directors-at-large, and GENERAL ELECTORATE NOMINATING COMMISSION POSITIONS are fellow members.

b. Eligible voters for House Officers and for HOUSE-elected members of Nominating ~~Work Group~~ COMMISSION are voting members of the House of Delegates who are present at the time of the election.
c. Eligible voters for the Student Academy President-elect and Student Academy Directors of Outreach and Communication are credentialed members of the Assembly of Representatives and Student Board members present at the time of the election.
d. Eligible voters for the Student Academy Chief Delegate are credentialed members of the Assembly of Representatives, Student Academy Board members, and credentialed student delegates.
e. Eligible voters for Student Academy Regional Directors are credentialed members of the Assembly of Representatives and Student Board members from within the respective region who are present at the time of the election.
f. For all positions, eligible voters must be current members in good standing (fellow or student) as of the date that is fifteen (15) days before the respective election.

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

Section 7: Vote Necessary to Elect. A plurality of the votes cast shall elect the Directors-at-large and the Academy Officers (excluding the Vice President), so long as the number of votes cast equals or exceeds a quorum of one (1) percent of the members entitled to vote in the election. In the case of a tie vote, the House of Delegates shall vote to decide the election from among the candidates who tied. The vote necessary to elect the House Officers (including the Speaker, who shall serve as the Vice President of the Academy) shall be prescribed in Article VI, Section 3.

Section 8: Commencement of Terms. The term of office for all elected positions, including Directors-at-large, the Student Director, Academy Officers, and House Officers, shall begin on July 1. In the event that the election of the House Officers occurs later than July 1, the new House Officers will take office at the close of the meeting during which they were elected.

Section 9: Vacancies. Academy Officers and Directors, the Student Director and House Officers may resign or be removed as provided in these Bylaws. The method of filling positions vacated by the holder prior to completion of term shall be as follows:

a. OFFICE OF THE PRESIDENT. The President-elect shall become the President to serve the unexpired term. The President-elect shall then serve a successive term as President.
b. OFFICE OF THE PRESIDENT-ELECT. In the event of a vacancy in the office of President-elect, the Immediate Past President shall assume the duties, but not the office of the President-elect while continuing to perform the duties of Immediate Past President. The Nominating ~~Work Group~~ COMMISSION will prepare a slate of candidates. Eligible members, as

described in Section 6 of this Article, shall elect a new President-elect from the candidates proposed and any candidates that self-declare. The elected candidate will take office immediately and will serve the remainder of the un-expired term.

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

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

e. OTHER BOARD VACANCIES. The Nominating ~~Work Group~~ COMMISSION will prepare a slate of candidates. Eligible members, as described in Section 6 of this Article, shall elect a new officer and/or director from the candidates proposed and any candidates that self-declare. The elected candidate will take office immediately and will serve the remainder of the un-expired term.

2021-A-06 – Adopted (Requires AAPA Board of Directors Ratification)

Amend AAPA Bylaws Article XIV as follows:

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 in the House of Delegates.

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

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

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

Section 5: Each PROPOSED BYLAWS amendment to be presented at the annual meeting of the House of Delegates shall be filed with the HOUSE OFFICERS ~~Governance Commission~~ at least three (3) months prior to that meeting.

A. THE GOVERNANCE COMMISSION WILL REVIEW SUBMITTED PROPOSED BYLAWS AMENDMENTS FOR GOVERNANCE-RELATED

GAPS OR CONFLICTS. THEY MAY EITHER RECOMMEND TECHNICAL CHANGES TO THE HOUSE OFFICERS OR SUBMIT CONFORMING AMENDMENTS. ANY ~~The Governance Commission's~~ 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 ~~T~~to be considered for an electronic vote of the House of Delegates, MUST BE SUBMITTED AT LEAST 150 DAYS PRIOR TO THE ~~amendments must be submitted 150 days or greater before the~~ annual meeting of the House of Delegates. OTHERWISE, THE RESOLUTIONS WILL BE CONSIDERED AT THE ANNUAL MEETING OF THE HOUSE. AMENDMENTS TO BE CONSIDERED ELECTRONICALLY ARE SUBJECT TO REVIEW BY THE GOVERNANCE COMMISSION AS REFLECTED IN SECTION 5.a OF THIS ARTICLE.

Section ~~6~~ 7: PROPOSED BYLAWS AMENDMENTS ~~Proposals~~ that are not initiated by the Board of Directors will be presented to the Board ~~of Directors~~ IN THEIR FINAL FORM. ~~substantially in the form presented to the Governance Commission with such technical changes and conforming amendments to the proposal or existing Bylaws as the Governance Commission shall deem necessary or desirable.~~

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

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

Section ~~7~~ 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 ~~8~~ 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.

2021-A-07 – Adopted on Consent Agenda (Requires AAPA Board of Directors Ratification)

Amend AAPA Bylaws Article XIII, Section 5 as follows:

Section 5: Eligible Voters.

a. Eligible voters for President-elect, Secretary-Treasurer, and Directors-at-large are fellow members.

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

c. Eligible voters for the Student Academy positions of President-elect, Director of Diversity and Outreach, ~~and~~ Director of Student Communications, AND CHIEF DELEGATE are ~~credentialed members of the Assembly of Representatives and Student Board members present at the time of the election~~ STUDENT MEMBERS.

~~d. Eligible voters for the Student Academy Chief Delegate are credentialed members of the Assembly of Representatives, Student Academy Board members, and credentialed student delegates.~~

~~e~~ d. Eligible voters for Student Academy Regional Directors are STUDENT MEMBERS ~~credentialed members of the Assembly of Representatives and Student Board members~~ from within the respective region ~~who are present at the time of the election~~.

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

2021-A-08 – Referred (Requires AAPA Board of Directors Ratification)

Amend AAPA Bylaws Article III, Section 4 as follows:

Section 4: Student Members. A student member is an individual who is enrolled in an ARC-PA or successor agency approved PA program. ~~Except~~ STUDENT MEMBERS ARE ONLY ELIGIBLE TO HOLD ELECTED OFFICE IN THE STUDENT ACADEMY OR as otherwise provided in these Bylaws~~,~~. ~~student members shall not be entitled to vote or hold office. Notwithstanding the preceding sentence, one student shall be elected by eligible student members to sit on the Board of Directors and this Student Director shall have all rights and privileges of any other member of such Board.~~ CREDENTIALED STUDENT MEMBERS OF THE STUDENT ACADEMY ASSEMBLY OF REPRESENTATIVES, CREDENTIALED STUDENT MEMBERS OF THE HOUSE OF DELEGATES, AND STUDENT MEMBERS OF THE STUDENT

BOARD OF DIRECTORS SHALL BE ENTITLED TO VOTE IN AAPA GENERAL ELECTIONS.

Further Resolved

Amend Article V, Section 4a. as follows:

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.

Further Resolved

Amend AAPA Bylaws Article XIII, Section 5a as follows:

Section 5: Eligible Voters.

a. Eligible voters for President-elect, Secretary-Treasurer, and Directors-at-large are fellow members~~.~~, CREDENTIALED STUDENT MEMBERS OF THE STUDENT ACADEMY ASSEMBLY OF REPRESENTATIVES, CREDENTIALED STUDENT MEMBERS OF THE HOUSE OF DELEGATES, AND STUDENT MEMBERS OF THE STUDENT BOARD OF DIRECTORS.

2021-A-09 – Adopted as Amended

~~Expire~~ AMEND policy HA-2100.2.1 AS FOLLOWS:~~.~~

The House of Delegates ~~encourages~~ RECOMMENDS the AAPA Board of Directors ~~to~~ provide ~~face to face~~ IN-PERSON AND VIRTUAL opportunities for PA volunteer ~~PA~~ leaders to conduct business successfully on behalf of the profession.

2021-A-10 – Reaffirmed

~~Expire~~ REAFFIRM policy HP-3300.2.1.

AAPA values the involvement in the Academy of PAs 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.

2021-A-11 – Rejected

AAPA encourages the ARC-PA to include in its accreditation standards that faculty employed at accredited PA Education Programs be active members of the AAPA and their respective State Constituent Organization and that financial support for these memberships be provided by the PA program's sponsoring organizations.

2021-A-12 – Rejected

PAs who meet the eligibility requirements for membership, shall be a member of AAPA and an AAPA Constituent Organization corresponding to their federal service chapter, state/US territory, specialty, or particular interest in order to be a speaker at an AAPA conference or educational program.

2021-A-13 – Rejected

The House of Delegates recommends to the AAPA Board of Directors that employers who financially support PA membership in both the AAPA and State Constituent Organizations would receive additional consideration for their application to the AAPA Employer of Excellence Award.

2021-A-14 – Adopted

Amend by substitution the policy paper entitled "Competencies for the PA Profession".

Competencies for the Physician Assistant (PA) Profession

(Adopted 2005, amended 2012, 2020)

June 5, 2020

Introduction

This document defines the specific knowledge, skills, and attitudes that physician assistants (PA) inall 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 health care systems, and other organizations committed to promoting the development and maintenance of professional competencies among PAs. While some competenciesare acquired during the PA education program, others are developed and mastered as PAs progress through their careers.

The PA professional competencies include seven competency domains that capture the breadth and complexity of modern PA practice. These are: (1) knowledge for practice, (2) interpersonal and communication skills, (3) person-centered care, (4) interprofessional collaboration, (5) professionalism and ethics, (6) practice-based learning and quality improvement,and (7) society and population health. The PA competencies reflect the well-documented need for medical practice to focus on surveillance, patient education, prevention, and population health. These revised competencies reflect the growing autonomy of PA decision-making within a team-based framework and the need for the additional skills in leadership and advocacy.

As PAs develop greater competency throughout their careers, they determine their level ofunderstanding 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 learningthroughout 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 health care professions. In 2005, a collaborative effort among four national PA organizations produced the first Competencies for the Physician Assistant Profession. These organizations are theNational Commission on Certification of Physician Assistants, the Accreditation Review Commissionon Education for the Physician Assistant, the American Academy of PAs, and the Physician Assistant Education Association (PAEA, formerly the Association of Physician Assistant Programs). The same four organizations updated and approved this document in 2012.

Methods

This version of the *Competencies for the Physician Assistant 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 ofguiding 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 thechanging 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 resultis 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 Assistant 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 healthprofessions.[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 Aug1;88(8):1088-94.

Competencies

1. Knowledge for Practice

Demonstrate knowledge about established and evolving biomedical and clinical sciences and theapplication 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 andpopulations.

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 thedelivery 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 health care delivery settings and systemsrelevant to the PA's clinical specialty.

1.9 Identify and address social determinants that affect access to care and deliver high qualitycare in a value-based system.

1.10 Participate in surveillance of community resources to determine if they are adequate tosustain and improve health.

1.11 Utilize technological advancements that decrease costs, improve quality, and increaseaccess to health care.

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 beable 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 deliverperson-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, andfinancial purposes.

2.5 Demonstrate sensitivity, honesty, and compassion in all conversations,

including challenging discussions about death, end of life, adverse events, bad news, disclosure oferrors, and other sensitive topics.

2.6 Demonstrate emotional resilience, stability, adaptability, flexibility, and tolerance ofambiguity.

2.7 Understand emotions, behaviors, and responses of others, which allows for effectiveinterpersonal 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 health care 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, physicalexamination, and diagnostic testing.

3.2 Elicit and acknowledge the story of the individual and apply the context of the individual'slife 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 proceduresconsidered 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 betweenproviders or settings, and follow up on patient progress and outcomes.

3.8 Provide health care services to patients, families, and communities to prevent healthproblems and to maintain health.

4. Interprofessional Collaboration

Demonstrate the ability to engage with a variety of other health care professionals in a manner thatoptimizes safe, effective, patient- and population-centered care. PAs should be able to:

4.1 Work effectively with other health professionals to provide collaborative, patient-centeredcare while maintaining a climate of mutual respect, dignity, diversity, ethical integrity, andtrust.

4.2 Communicate effectively with colleagues and other professionals to establish and enhanceinterprofessional 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 enhancepatient care.

4.4 Collaborate with other professionals to integrate clinical care and public healthinterventions.

4.5 Recognize when to refer patients to other disciplines to ensure that patients

receive optimalcare at the right time and appropriate level.

5. Professionalism and Ethics

Demonstrate a commitment to practicing medicine in ethically and legally appropriate ways andemphasizing 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 health care 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 a diverse patient populations, including diversity in sex, gender identity, sexual orientation, age, culture, race, ethnicity, socioeconomic status, religion, and abilities.
5.6 Show commitment to ethical principles pertaining to provision or withholding of care, confidentiality, patient autonomy, informed consent, business practices, and compliancewith 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 ofquality 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 informationresources 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 inknowledge and expertise.
6.2 Identify, analyze, and adopt new knowledge, guidelines, standards, technologies, products,or services that have been demonstrated to improve outcomes.
6.3 Identify improvement goals and perform learning activities that address gaps in knowledge,skills, and attitudes.
6.4 Use practice performance data and metrics to identify areas for improvement.
6.5 Develop a professional and organizational capacity for ongoing quality improvement.
6.6 Analyze the use and allocation of resources to ensure the practice of cost-effective healthcare while maintaining quality of care.

6.7 Understand of how practice decisions impact the finances of their organizations, whilekeeping 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 ofhealth into patient care decisions. PAs should be able to:

7.1 Apply principles of social-behavioral sciences by assessing the impact of psychosocial andcultural influences on health, disease, care seeking, and compliance.
7.2 Recognize the influence of genetic, socioeconomic, environmental, and other determinantson 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.

2021-A-15 – Adopted as Amended

Resolved to adopt the following language into the AAPA policy as the official ~~Physician Assistant~~ PA Oath for our profession.

"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 ~~the~~ 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 health care 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 ~~**THE PHYSICIAN**~~ **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."

2021-A-16 – Adopted on Consent Agenda

Amend by substitution policy HP-3600.1.8 as follows:

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.

~~AAPA believes in gender-based equity in income for PAs having comparable responsibilities within the same specialty. AAPA encourages additional research on gender-based disparities in income.~~

2021-A-17 – Adopted on Consent Agenda

Amend policy HP-3800.1.1.1 as follows:

AAPA urges NCCPA and the NCCPA Foundation to undertake rigorous and replicable research to determine the ~~relationship, if any, between taking~~ VALUE OF the NCCPA recertification test~~, and patient outcomes, safety and satisfaction~~ IN TERMS OF VALUE TO PAS, PA EMPLOYERS, HEALTH POLICY MAKERS, AND PATIENTS/PATIENT OUTCOMES.

2021-B-01a – Tabled Indefinitely

Amend by deletion policy HP-3100.1.1.

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

2021-B-01b – Adopted as Amended

The AAPA HOD requests that~~, IN THE EVENT OF A TITLE CHANGE,~~ the Board of Directors amend the Academy's Articles of Incorporation ~~ACCORDINGLY.~~ **TO THE AMERICAN ACADEMY OF PHYSICIAN ASSOCIATES**.

2021-B-02 – Adopted as Amended

~~**Reaffirm**~~ **AMEND** policy HP-3100.1.1 **AS FOLLOWS:**~~.~~

AAPA affirms "physician ~~**assistant**~~ **ASSOCIATE**" as the official title for the PA profession.

2021-B-03 – Adopted as Amended

~~Reaffirm~~ AMEND policy HP-3200.1.4 AS FOLLOWS:~~.~~

AAPA opposes ~~the~~ A MANDATORY entry-level doctorate for PAs.

2021-B-04 – Rejected

AAPA supports a standardized degree title for entry-level PA education.

Further resolved

AAPA supports the identification of a standardized degree title for entry-level PA education that is consistent with the professional title, descriptive of PA practice, conveys the academic rigor and substance of PA education, and does not inhibit potential career advancement.

2021-B-05 – Adopted

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

Further resolved

The House of Delegates recommends AAPA support additional research on the outcomes associated with PA-specific postprofessional doctoral degrees as well as emerging trends related to these programs to inform future policy deliberations on this topic.

2021-B-06 – Adopted as Amended

Amend the policy paper entitled *PA Student Supervised Clinical Practice Experiences-Recommendations to Address Barriers*.

PA Student Supervised Clinical Practice Experiences –

Recommendations to Address Barriers

(Adopted 2017, amended 2018)

Executive Summary of Policy Contained in this Paper

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

- AAPA supports working with PAEA, ARC-PA and NCCPA to communicate the benefits of precepting students to PAs, patients, and employers.
- ~~AAPA supports working with PAEA to increase the number of AAPA Category 1 CME credits available to PAs who precept and simplify the CME application process for PA programs.~~
- AAPA supports working with PA employers to expand the range of opportunities for PA students to gain clinical experience through SCPE.
- AAPA supports suggesting modifications to the ARC-PA *Standards* in order to ensure quality SCPE continue with increased emphasis on flexibility and innovation.
- AAPA supports collaborating with PAEA to develop an information toolkit for PA programs and preceptors to utilize concerning benefits and helpful tips for precepting.
- AAPA supports working with PAEA to increase awareness among PA educators of the additional limitation that pre-PA shadowing requirements may create for PA student placement in SCPE.
- ~~AAPA supports working with PAEA to investigate the feasibility of developing a national database of SCPE with the utilization of a CASPA-like centralized platform for PA students nationwide.~~
- AAPA supports the consideration of collaboration with external medical organizations to look at ways to support an interprofessional, collaborative clinical training model.

Introduction

'SCPE,' or Supervised Clinical Practice Experience, is the standardized term used to refer to 'clinical rotations' or 'clerkships'. According to ARC-PA, SCPE are "supervised student encounters with patients that include comprehensive patient assessment and involvement in patient care decision making and which result in a detailed plan for patient management" (1). They allow students to acquire competencies and meet program standards needed for entry into clinical PA practice. They provide an essential component of PA program curriculum. PA students complete approximately 2,000 hours of SCPE in various settings and locations by graduation (2). SCPE include the previous terminology which refers to clinical rotations that occur after didactic education. They offer PA students the opportunity to learn patient care skills and to apply the knowledge and decision making developed during their didactic education in a variety of clinical practice environments.

PA programs, like allopathic and osteopathic medical schools and nurse practitioner (NP) programs, are faced with a shortage of preceptors and SCPE for their students. For several years, PAEA has addressed this issue by developing innovative

clinical training opportunities and encouraging an atmosphere of collaboration rather than competition among PA programs. AAPA, along with PAEA, ARC-PA, and NCCPA, is uniquely positioned to work with PAs, PA employers, and PA programs to help expand the availability of preceptors and SCPE for PA students.

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

Quality clinical education is a critical component of the PA educational curriculum. Many required SCPE are in primary care settings, including family practice, pediatrics, and women's health. This is in line with the generalist nature of PA training and the historical foundation of the PA profession. Although the SCPE shortage is not a new challenge, only recently has the phenomenon been studied in a systematic manner. PAEA worked in collaboration with the Association of American Medical Colleges (AAMC), the American Association of Colleges of Osteopathic Medicine (AACOM), and the American Association of Colleges of Nursing (AACN), to produce the 2013 Joint Report of the Multi-Discipline Clerkship/Clinical Training Site Survey confirming what clinical coordinators and PA students already recognized.

The Joint Report suggests that securing SCPE, particularly in primary care settings, is a significant issue for most PA programs. The report included responses from 137 out of 163 PA programs surveyed. According to the report, 95 percent of PA program respondents are concerned about the number of clinical sites available, and 91 percent of PA program respondents are concerned about the availability of qualified primary care preceptors (3). Research conducted by Herrick et al. and published in the November 2015 issue of JAAPA confirmed these findings (4). The Joint Report suggests that obstetrics/gynecology and pediatrics are two of the most difficult SCPE in which to find student placement (3). According to the NCCPA Statistical Profile of Certified PAs, less than two percent of PAs currently work in obstetrics/gynecology and three percent work in pediatrics and pediatric subspecialties (5).

As the PA profession continues to grow rapidly, with new programs developing and the number of PA students increasing, the demand for preceptors and SCPE will only continue to increase in the coming years. From 2015 to 2016 alone, the number of accredited PA programs grew from 196 to 218 (6). Currently, ARC-PA reports that there are approximately 52 additional programs seeking accreditation. The continued growth of the profession depends on the growth of PA programs, and one of the essential rate-limiting factors in the growth of these programs is SCPE barriers.

The availability of preceptors and SCPE was first formally addressed by clinical coordinators at the 1998 Association of Physician Assistant Programs (APAP, now PAEA) Education Forum. Since that time, PAEA has prioritized the issue, making the development of "a broad range of innovative clinical training opportunities" part of its strategic plan and encouraging an environment of collaboration rather than competition among PA programs (7). PAEA also works independently as the main source of research and data regarding the state of PA education. The continued efforts of the PAEA in identifying and addressing the preceptor shortage are crucial to improving the clinical education environment in the coming years. However, due to the extent of the problem and the continued growth of the PA profession, the issue will be best handled if approached by the entire PA community.

Many have looked to ARC-PA to limit the number of accredited PA educational programs in order to solve the problem, as ARC-PA is the agency responsible for accrediting these programs. The ARC-PA mission includes defining the standards for PA

education, evaluating PA educational programs to ensure compliance, and, thereby, protecting the public, including current and prospective PA students (8). However, ARC-PA must continue to accredit new programs that meet the eligibility criteria and accreditation standards, lest they violate restraint of trade laws. Still, the quality of PA education and PA practice is partially a result of the *Standards*, defined and evaluated for compliance by ARC-PA. The growing shortage of SCPE and preceptors during a period of rapid growth of the profession necessitates that ARC-PA maintain a close watch on quality and adapt the *Standards* in response to the changing environment. ARC-PA is a free-standing independent organization. However, when they do their open call for their review of the standards, they do take into consideration input from external stakeholders including organizations like AAPA, PAEA, and individually practicing PAs. It is incumbent upon the Academy and its members to carefully review the ARC-PA standards when they come up for review and to provide feedback and suggestions regarding expansion of programs and maintenance of adequate, qualified SCPE sites.

Each of the four national PA organizations (AAPA, PAEA, ARC-PA, and NCCPA) has collectively contributed to the growth of the profession and quality of healthcare that PAs provide each day. For this growth and practice quality to continue, these four organizations are encouraged to work together in an unprecedented manner to provide input and address the issue of clinical preceptor and SCPE shortage. The long-term solutions will require actions from each of these organizations, each acting within its already established mission and philosophy. Because the current model of clinical education is not sustainable and cannot support the projected demand for PAs in the coming decades, now is the time for action. In order to shape the future of the PA profession and American healthcare while supporting the continued supply of PAs throughout the 21st century, these organizations are encouraged to find common ground on which to collaborate.

Barriers to Supervised Clinical Practice Experiences

According to Herrick et al., competition and shortage of preceptors are the two most commonly cited barriers to student placement, with the shortage of preceptors being due in part to a perceived reduction of productivity and/or revenue while training students (4). Preceptors are likely to weigh the perceived rewards of practice-based teaching against the perceived costs and challenges in their decision whether to precept students and how to teach them. Reduced productivity and increased time pressures remain key negative impacts of teaching for some providers (4)(9). While many preceptors stress that patient care responsibilities are too time consuming to allow them to be good teachers, studies have found a correlation between productivity and highly-rated teachers, with positive impacts including enhanced enjoyment of practice and keeping one's knowledge up-to-date (10)(11).

Competition from a steady increase in the numbers of allopathic (MD), osteopathic (DO), offshore allopathic medical students, NP, and PA students over the past several decades without a corresponding increase in the number of preceptors and SCPE is a second barrier to SCPE. This interprofessional competition leaves existing SCPE overwhelmed with students causing interprofessional competition for such sites. According to the Association of American Medical Colleges (AAMC), there were 86,746 medical students enrolled in United States osteopathic and allopathic medical programs during the 2015-2016 school year (Association of American Medical Colleges, 2015). There has also been a steady increase in U.S. medical student enrollment for the past

decade. Since 2006-2007, there has been a 16 percent increase in the total number of matriculated medical students (12). These figures do not include medical students at offshore allopathic medical schools (i.e., those in the Caribbean and other countries) who send many of their students to the U.S. to complete clinical training. There are two accrediting bodies for offshore medical schools, the Accreditation Commission on Colleges of Medicine (ACCM) and the Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP). These governing bodies currently accredit 15 medical schools with over 15,000 students annually enrolled. Additionally, there were an estimated 17,000 new nurse practitioners (NPs) completing their academic programs in 2013-2014 (13).

PA schools have experienced a similar growth rate over the past decade. At the time that this report was submitted, ARC-PA reported 218 accredited programs with additional programs expected to be accredited at its March 2017 meeting. This includes 154 with full accreditation, 55 with provisional status, and 9 programs on probation, up from 134 programs in November 2005 (14). Cohort sizes in PA programs range from approximately 15 to 100 students. Lack of availability and sufficient quality and quantity of SCPE is limiting the ability of some programs to increase their cohort sizes or even maintain their current cohort size. With an estimated growth to 270 programs by 2020, the consistent increase in students has the potential to further exacerbate the preceptor and SCPE shortage (6).

An often overlooked issue that may create an additional barrier to SCPE placement for PA students is the requirement of some PA programs that their pre-PA applicants obtain shadowing hours. According to the PAEA Program Directory, there are 139 programs in various stages of accreditation that require some form of healthcare experience in order to apply (15). Of those 139 programs, 67 consider 'shadowing a physician or PA' to be an acceptable form of experience, and the number of hours required ranges from 50 to 1000, with 500 hours being the most common. Two programs specifically request 20 hours of shadowing as their only required form of healthcare experience prior to applying (15). The concern, then, is that these requests for shadowing experiences are in direct competition with PA student SCPE placement, and it is often less stressful for providers to simply have an individual shadowing them for a few days as opposed to having a student to precept which requires a great deal more supervision, clinical education, and paperwork. Thus, while the concept of pre-PA shadowing may be valuable, it also has the potential to complicate an already challenging climate for current PA student placement.

Furthermore, there are legislative barriers to SCPE, particularly those between states. One example involves the emergence of State Authorization requirements since approximately 2010. Each state regulates education provided within their state, with most determining that provision of clinical education for students from training programs outside their state require "authorization". These requirements vary widely, from simple paperwork in some states to lengthy procedures and thousands of dollars in others, resulting in many programs curtailing out of state rotations. In response to this arrangement, several health professions' education associations sent an April 2015 letter to Congress recommending a nationwide exemption for SCPE from future Department of Education (DOE) regulations pertaining to state authorization (16). In spite of DOE setting aside national requirements for authorization, states considered clinical training across state lines as providing education in their state, requiring authorization. A solution

for most states developed independently from the DOE. The National Council for State Authorization Reciprocity Agreements (NC-SARA) establishes reciprocity for educational requirements across state lines. States are members, and then each institution joins their state organization. So, PA programs that meet their state requirements and whose institutions are approved essentially meet requirements for state authorization in 47 states. Currently, three states (California, Florida, and Massachusetts) do not belong to NC-SARA, which means that clinical placements across state lines in those states may trigger an additional requirement for state authorization (17).

AAPA-PAEA Joint Task Force Survey

In 2016, the AAPA Board of Directors (BOD) established a Joint Task Force (JTF) between the AAPA and PAEA "to investigate factors that affect practicing PAs' ability to serve as preceptors for PA students, identify opportunities to improve policy to support preceptorship, and collaborate with PAEA efforts to develop innovative and practical long-term approaches to increase availability and accessibility of sustainable clinical education models for PA students." The AAPA-PAEA Joint Task Force (JTF) is made up of students, early career PAs, experienced PAs, PAs in hospital administration, and PA educators. The JTF held monthly meetings beginning in October 2016 to discuss barriers and possible solutions to shortages regarding SCPE. Additionally, they conducted an informal survey of external stakeholders to gather a wide range of input and ideas regarding the matter, the results of which are reviewed below. The JTF used this survey and direct inquiry to investigate current incentives for precepting students in a clinical setting, and they also reviewed publicly available policy from other PA organizations such as the Accreditation Review Commission on Education for the PA (ARC-PA) and National Commission on Certification of PAs (NCCPA). The JTF utilized the research and information gathered to revise and present this policy paper for consideration in the 2017 HOD.

The JTF conducted an informal survey on the topic of clinical preceptor and SCPE shortages, seeking the opinions of several key stakeholder groups on this important issue. The stakeholders were comprised of seven groups identified by the JTF to offer critical perspectives on the challenges of precepting, including PAs in administration of large health systems, PAs who have never precepted, students and early career PAs, PAEA members, former preceptors who have stopped precepting, long time preceptors, and those who provided opposition testimony to the Student Academy of AAPA (SAAAPA) position paper submitted in Resolution D-07 of the 2016 HOD. The survey included 63 respondents who were contacted specifically as individuals or as part of a larger cohort because they belonged to one of the key stakeholder groups. The respondents were asked about several different topics including whether precepting is a professional obligation, the top barriers to precepting PA students and how to minimize these barriers, the top incentives for precepting and how to make these a reality, and long-term and short-term solutions for ameliorating the SCPE shortage.

Obligation to Precept

Overwhelmingly, respondents felt that precepting PA students is an excellent way to contribute to the growth of the PA profession and to give back to the profession. However, many disagreed with the use of the word 'obligation.' Those that agreed commented that it was a meaningful way to pass on knowledge gained through years of practice to incoming PAs, as well as an excellent means to keep one's medical knowledge current. Medicine is a profession of lifelong learning, and precepting students

engages this critical function daily. These respondents indicated that students can bring a fresh attitude to the profession and remind preceptors of why they chose to become PAs.

Several individuals, however, argued that some PAs are not strong in teaching or are not motivated to teach, thus a precepting mandate would not necessarily ensure quality SCPE. Additionally, some students commented that they would rather learn from a preceptor who is genuinely engaged in teaching and possesses a desire to precept. Some indicated that PAs' true professional obligation is to the care of their patients; if they perceive that precepting detracts from that, then they should not precept. Additionally, these respondents cited time constraints and difficulty honoring the high volume of precepting and shadowing requests as additional reasons that PAs should not be obligated to precept.

Top Barriers to Precepting and How to Minimize These Barriers

Among the questions posed to those surveyed was to list the top barriers to PAs precepting students. Several themes developed in their responses including:

- Lack of adequate time or space to precept,
- Loss of productivity and/or financial cost related to precepting a student,
- Unclear expectations of the specific requirements of precepting,
- Competition among PA programs, as well as DO, MD and NP programs for sites and preceptors,
- Lack of support or permission from one's administration, and
- Inadequate communication between PA programs and preceptors.

While not all of these barriers present opportunities for straightforward solutions, some bring to light potential ways to improve the shortage of preceptors both now and in the future.

Respondents offered some suggestions for how to minimize each of these barriers. As to time and space, they recommended sharing students among providers, not requiring students to see every patient an individual preceptor treats, having students perform necessary chart and results review, and utilization of scribes by the provider if available. Although peer-reviewed research is limited, utilization of trained medical scribes has shown the potential to decrease the amount of time spent on required patient documentation, therefore potentially enabling the practitioner to focus more on the SCPE educational process **(**18). In support of the concept of student sharing among providers, The Liaison Committee on Medical Education (LCME) requires that MD students receive some interprofessional training. This could be used to leverage inclusion of PAs on MD training teams (19). Many of the ideas concerning remedies for loss of productivity or financial cost echo the suggestions for creating an efficient, time effective workspace. In addition, it is critical for organizations like AAPA and PAEA to work with healthcare systems and providers to help them understand how to incorporate student education and training into their systems. It is important to provide support for the numerous motivated and productive PAs who are willing to precept PA students without risk of financial penalty (i.e., loss of time and RVUS).

One of the most commonly cited concerns among survey participants was the lack of clear understanding about the expectations of precepting a student. While some of these expectations are specific to each program, many aspects of precepting are universal. Respondents repeatedly suggested that a standard precepting toolkit or workshops that guide preceptors in the basic requirements of teaching PA students would be beneficial. This could be achieved through the development of a standardized "PA student passport"

or educational checklist that would be common to all PA students and that might include a summary of a student's didactic education and the skills that PA students are reasonably expected to perform. This could also be achieved by the implementation of Entrustable Professional Activities (EPAs) into PA education, which will be further discussed in the section on Long-Term Solutions. Survey participants also reported wanting more resources regarding best practices and teaching in a clinical setting.

In response to competition among PA, NP, DO and MD programs for SCPE placements, the survey respondents offered recommendations such as streamlining credentialing processes for students to increase efficiency of on-boarding and allowing for flexibility in the types of sites that qualify for particular rotations, i.e. allowing specialty surgical practices to satisfy the requirement for a general surgery SCPE (discussed further below). Other innovative recommendations included allowing for some clinical competencies to be completed during the didactic year, permitting interested students to complete rotations in areas like healthcare administration or PA education where demand for placement is lower, and connecting with community housing authorities to help find lodging for students in more rural areas to open these regions to more SCPE.

Respondents recommended that the lack of support or permission from one's administration can be addressed by showing administrators the benefits of precepting students and by learning more about why they discourage or do not allow precepting. Solutions might include offering to collaborate with administrators in order to determine what changes can be made to overcome these concerns and to introduce policies or by-laws that allow PAs to precept. Recognition for systems or sites that are 'student-friendly' or provide excellence in SCPE may also encourage support. Survey participants also valued the conversation with healthcare system administrators regarding recruitment and hiring opportunities that can come from SCPE.

Finally, many survey respondents lamented the lack of adequate communication between PA programs and preceptors. Stakeholders reported that some programs offer little to no communication with SCPE sites and preceptors once a relationship has been established and a contract signed, relying on their students to pick up the communication trail and offer gratitude for their preceptors' service. While students offering thanks to their preceptors is certainly encouraged, survey participants expressed that preceptors need to hear from PA program faculty more consistently. Preceptors need to have basic information from programs about student level of education, expectations, timing and duration of SCPE, and benefits for precepting. The respondents stated that this could be achieved through more consistent site visits by program faculty or cultivated even further by inviting preceptors to be involved in clinical curriculum development.

Most Important Incentives for Precepting and Short-Term Solutions to Make Them a Reality

Another question addressed in the JTF's informal survey considered what incentives might encourage more PAs to precept and how to make these incentives a reality. Several overarching themes became apparent in these responses as well.

Increasing the amount of AAPA Category 1 CME credit offered to PA preceptors was one of the most common suggestions. Currently, TWO AAPA CATEGORY 1 CME CREDITS CAN BE EARNED WEEKLY FOR EVERY PA STUDENT PRECEPTED. A LIMIT OF 20 CATEGORY 1 CME CREDITS CAN BE EARNED PER CALENDAR YEAR, CONTRIBUTING TO THE MINIMUM REQUIREMENT OF 50 CATEGORY

1 CME CREDITS EVERY TWO YEARS. THIS INCREASE IN CME VALUE might incentivize more PAs to take PA students for SCPE. ~~AAPA grants 0.5 AAPA Category 1 CME credit for every two weeks of clinical teaching of one student and 0.25 AAPA Category 1 CME credit for each additional student (20). Currently, preceptors can be granted a total of 10 Category 1 CME credits per calendar year (20). Increasing the limit of Category 1 CME credits to a maximum of 15 hours per calendar year (30 hours per two year CME cycle) might incentivize more PAs to take PA students for SCPE. Additionally, member program faculty have communicated a desire for multi-year certification of programs to award CME credits, to decrease paperwork requirements.~~ Alternatively, developing a system of PAs applying directly to AAPA for Category 1 CME credits, with programs only providing documentation of preceptor contact time with students, might streamline the process for precepting PAs and programs.

Compensation, in various forms, proved to be a top recommendation. Some forms mentioned include financial compensation, discounts on AAPA membership, products, or conferences, loan repayment, tax credits, and reimbursement for productivity coverage and teaching. The Joint Report notes that the compensation per student per rotation for the programs that provide financial incentives is $125 per student (1). New data from PAEA's 2016 Program Survey indicates that 35.4% of accredited PA programs now pay for clinical sites, representing a 13.1% increase from 2013. Clinical sites cost programs an average of $232 per week (21). However, not all programs are able to pay for SCPE due to budgetary restraints; thus, this remains an area of much debate (21). It was suggested that AAPA and PAEA follow the utilization rates for tax incentive programs approved in Georgia, Colorado, and Maryland, to determine if such programs are a powerful incentive and warrant promotion in other states.

Stakeholders valued adjunct faculty status and inclusion in other program benefits for preceptors, such as UpToDate access, research opportunities, faculty engagement, curriculum involvement, or access to library resources. They also valued gestures of recognition and gratitude. Examples include thank you notes from a student or program; recognition from one's administration, state, or program; Preceptor of the Year awards; a PA program-sponsored lunch for a preceptor's office; and local media engagement.

Finally, many healthcare systems, clinics and practices use precepting as a recruitment tool for new providers. This is beneficial both to the student and the preceptor, as the student has the possibility of receiving a job offer from a clinical site, while preceptors can use that time as an informal interview process and begin to orient the student to the specifics of their practice or hospital.

Long-Term Solutions

A final question asked stakeholders about long-term solutions to increase SCPE. Overarching themes regarding long-term solutions include collaboration, value, and innovation.

PAEA has called for collaboration between programs, preceptors, and constituent organizations in the recruitment, retention, and sharing of SCPE (22).). Among recommendations from stakeholders was the idea to share SCPE sites in order to develop a national database with ~~a CASPA-like coordination service~~ THE POTENTIAL to ~~better~~ distribute student placement nationwide RECOGNIZING THAT THERE MAY BE ISSUES RELATING TO CONTRACTUAL AGREEMENTS BETWEEN PA PROGRAMS AND CLINICAL SITES AS WELL AS FEDERAL LEGISLATION TO BE CONSIDERED. In turn, this program could be utilized as a workforce pipeline for

PAs by training PA students in communities with underserved patient populations, enabling new PAs to effectively address healthcare shortages. In order to ensure proper implementation of such a system inter-organization cooperation is paramount.

The value of precepting PA students can also be emphasized through a paradigm shift in the way precepting is marketed to the healthcare community, focusing on emphasizing the value of precepting students. In the long term, precepting PA students offers the potential for added value for health systems rather than a burden. In the stakeholder interviews, it was noted that early exposure of PA students to future employers (i.e., health systems, private practices, etc.) can improve patient flow, provide patient education, address patient safety issues, and help with charting and medical documentation.

Innovation is a final long-term goal. Among core SCPE requirements, shortages are most often mentioned in general surgery, pediatrics, and women's health. There is an opportunity, as ARC-PA reviews current *Standards*, to provide some relief and flexibility in identifying sites for core SCPE student placements.

As an example, ~~continuing to require general surgery as a core requirement is difficult in the current environment:~~

- ~~Physicians who identify as general surgeons are increasingly gravitating to specialized practice, like breast surgery and bariatric surgery among others.~~
- ~~It is suggested that the important principles of pre-op, post-op, and intra-operative care can be learned in the environment of many other surgical specialties.~~
- ~~Flexibility in the language of the *Standards* for this important core SCPE could provide relief to programs as the pool of general surgeons declines, while still providing clinical training in the surgical principles required for high quality SCPE.~~

~~Similarly,~~ there are barriers to clinical training in pediatrics. General pediatricians have been increasingly resistant to participating in the training of PA students. In trying to engage PAs in pediatrics to take on the preceptor role, we find that fewer than 3% of PAs practice in pediatrics, and most of them are in sub-specialty pediatrics. Language that allows some combination of specialty pediatrics with simulation, or other innovations, could provide relief of perceived shortages without impacting program goals for such training.

Some years ago, the requirement in the *Standards* for obstetrics/gynecology experiences was reframed to allow training in women's health settings. This allowed flexibility for programs to meet the *Standards* in a broader range of settings. While these settings remain in somewhat short supply, the change allowed for flexibility and innovation. This might be used as an example for added flexibility in the *Standards* going forward.

An additional innovation receiving increased attention in PA education is Entrustable Professional Activities (EPAs). EPAs describe ‘units of work’ that a student or graduate should be able to perform at a certain level of education, distinct from competencies which describe abilities. According to Lohenry et al., EPAs “answer the question, ‘What can a PA, medical graduate, or medical resident be entrusted to do?” (23) This concept has been used in medicine in order to bridge the gap between skill-level and preparation of medical graduates and expectations of residency programs. Likewise, it may serve the same purpose in PA education to bridge a gap between didactic and

clinical education and between graduation and employment. It would allow competency-based training, with the possibility that some students would meet program educational goals more quickly. This might result, in some cases, with students progressing to graduation with a requirement for less time in clinical settings while still meeting program goals. It could result in the need for fewer preceptors. The potential of this concept will become clearer as programs adopt EPAs and explore the impact they will have on PA education.

The Unique Position of AAPA in Working Toward a Solution

AAPA is the only national organization that represents PAs. With approximately 40,000 fellow members, AAPA is uniquely positioned to communicate with PAs about the value of precepting PA students. AAPA contains in its membership one of the greatest networks of potential clinical educators for PA students, and its relationships and advocacy efforts with employers throughout the U.S. is also a potential source of growth. In addition, AAPA has an opportunity to offer PAs incentives to serve as preceptors. Current incentives offered by AAPA include:

- Clinical Preceptor Recognition Program (24):
  - Committed to showing appreciation of "educating the next generation of PAs"
  - Awards the Clinical Preceptor of the AAPA (CPAAPA) designation
  - ~~166~~ 197 active AAPA members as of ~~November 2016~~ FEBRUARY 2019
- Preceptor of the Year Award:
  - Recognizes outstanding efforts by preceptors to prepare students for clinical practice
  - Initially awarded in 2013
  - One preceptor is acknowledged annually; 4 awards have been granted
  - The JTF recommend that AAPA works with PAEA to co-promote this award, consider looking at regionalization of the award, with an ultimate goal of awarding an annual award from each of the five regions.
- Category 1 CME:
  - AAPA grants ~~0.5~~ 2 AAPA Category 1 CME credit ~~for every two weeks~~ PER WEEK of clinical teaching ~~of one student~~ FOR EACH STUDENT THEY PRECEPT ~~and 0.25 AAPA Category 1 CME credit for each additional student~~
  - Maximum of ~~10~~ 20 Category 1 CME credits per calendar year
  - AAPA has received ~~258~~ 535 UNIQUE requests for Category 1 CME credit for preceptors from PA programs since 2013~~, at a rate of about 70 per year for the last three years~~. These requests came from ~~119~~ 175 programs.

AAPA and its constituent organizations have the most robust advocacy programs on behalf of PAs, at both the federal and state level. Since it is in the interest of the federal and state governments to ensure that there are adequate numbers of qualified medical providers to meet the healthcare needs of the nation, AAPA and its members would do well to advocate for incentives for individual medical providers to precept PA students, as well as incentives for employers to provide such opportunities. AAPA and PAEA are strongly encouraged to help ensure the PA profession is represented in any further discussions at the federal or state levels regarding state authorization agreements (NC-SARA). Addressing this issue aligns with AAPA's strategic commitments to "equip PAs for expanded opportunities in healthcare, advance the PA identity, and create progressive work environments for PAs." (25). AAPA's values of unity and teamwork

reflect its commitment to work with PAEA, ARC-PA, and NCCPA to address issues such as this (26).

Conclusion

AAPA urges clinically practicing PAs with the willingness and ability to precept PA students, thus enriching their clinical education experience and ensuring the graduation of competent healthcare providers. This is consistent with current AAPA policy HP-3200.3.2.

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.

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2021-B-07 – Adopted as Amended

Amend policy HP-3700.4.1 as follows:

AAPA recognizes life-long learning provides opportunities to improve ~~competence~~ COMPETENCIES, supports preparedness for certification/licensure and increases the vitality and efficiency of a practice by providing learning opportunities which are intended to improve performance in practice ~~as measured ultimately by~~ 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.

2021-B-08 – Adopted on Consent Agenda

Amend policy HP-3200.2.4 as follows:

AAPA adopts the Accreditation Council for Continuing Medical Education (ACCME) standards for ~~commercial support~~ INTEGRITY AND INDEPENDENCE IN ACCREDITED CONTINUING EDUCATION and its associated interpretive policies as part of its own accreditation system.

2021-B-09 – Adopted as Amended by Deletion

Amend policy HP-3500.2.2.1 as follows:

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

2021-B-10 – Adopted as Amended

AAPA acknowledges the importance of interprofessional ~~education~~ CURRICULA that includes PA PRACTICE AND THE PAS' ~~and their~~ role in the seamless delivery of high-quality patient care. ~~AAPA supports curricula that includes knowledge of PA education, scope of practice and reimbursement at all LCME accredited medical schools, ACGME accredited residency, Commission on Osteopathic College Accreditation (COCA), other fellowship programs, and pharmacy programs.~~

2021-C-01 – Adopted

AAPA opposes all forms of racism.

2021-C-02 – Adopted as Amended

AAPA leadership and national office staff is committed to fostering a culture that embraces the value of justice, diversity, equity, and inclusion within the ~~agency~~ 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.

Further Resolved

AAPA applies the following criteria for meeting the AAPA's Commitment to Diversity, Equity, and Inclusion.

1. DEI is placed as an ongoing overarching goal as part of the AAPA Strategic Plan Outlining with measurable steps necessary to achieve DEI within the AAPA.

2. DEI initiatives are included in annual budgets, that timelines for actions are in place and that 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 of 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 ~~special interest groups~~ and make extraordinary efforts to have representation of all human beings at the decision table.

6. That CEO will report on DEI annually to the AAPA HOD.

2021-C-03 – Adopted as Amended

AAPA supports collaboration with the Student Academy and our CROSS ~~sister~~ organizations, ARC-PA, PAEA, and NCCPA in initiatives on diversity, EQUITY, and inclusion for the PA profession.

2021-C-04 – Adopted as Amended

Amend policy HA-2100.1.1 as follows:

AAPA should PROVIDE AND ~~provide~~ SUPPORT ongoing educational experiences that are focused on diversity, ~~and~~ healthcare disparity issues, AND SOCIAL DETERMINANTS OF HEALTH.

2021-C-05 – Adopted on Consent Agenda

Amend policy HP-3300.2.9 as follows:

AAPA believes PAs should continually work towards acquiring the knowledge, skills and attitudes needed to provide culturally competent care for patients. ~~with a wide variety of cultural attributes.~~

2021-C-06 – Adopted

The HOD recommends AAPA create a national Diversity Award to be presented annually as appropriate at the national conference.

2021-C-07 – Adopted on Consent Agenda

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.

2021-C-08 – Adopted as Amended

AAPA supports the consideration of race, ETHNICITY, GENDER, AND OTHER ASPECTS OF IDENTITY AND EXPERIENCE in admissions under holistic review to help ensure a diverse workforce THAT INCLUDES UNDERREPRESENTED MINORITIES IN MEDICINE to address health disparities.

2021-C-09 – Adopted as Amended

Amend policy HP-3200.6.3, the policy paper entitled "*Affirmative Action in PA Education"*

Diversity and Inclusion in PA Education
(Adopted 2004, reaffirmed 2009, 2014)

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 ~~should~~ reflect the **RACE, ETHNICITY AND** culture ~~**and ethnicity**~~ of the patient populations they serve. ~~in order to improve the quality and accessibility of healthcare.~~
- 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 health care force may improve both access to health care 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 health care 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 health care 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 health care 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 ~~should~~ reflect the **RACE, ETHNICITY AND** culture ~~**and ethnicity**~~ of the patient populations they serve. ~~in order to improve the quality and accessibility of healthcare.~~ 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 health care workforce. This may be through a variety of funding methods such as (a) providing continued and adequate funding for the Title VII health professions programs, which fund the Primary Care Training Enhancement Grants, Health Careers Opportunity Programs and the Scholarships for Disadvantaged Students Program, (b) encouraging innovation at PA education programs by authorizing grants for research related to PA education, and (c) prioritizing grant applications for institutions providing post-baccalaureate opportunities to Hispanic Americans and increasing funding available for PA programs at Historically and Predominantly Black Institutions of Higher Education, among other provisions. Since patients are more likely to seek care from providers who look like them[11], access to care for underserved populations could be expanded by facilitating PA program development at Historically Black Colleges and Universities and other Minority Serving Institutions. PA students can be assisted by instituting borrowing parity with their peers in the health professions under the Federal Direct Stafford Loan Program. Many patients

from rural and disadvantaged backgrounds seek care at federally qualified health centers, rural health clinics, and critical access hospitals. Establishing new or expanding existing clinical training sites at these facilities would address the clinical training site shortages, increase the number of clinical preceptors and provide experiences for students at federally qualified health centers, rural health clinics, and critical access hospitals and increase the number of graduates who work in these areas.[12]

Affirmative Action

The U.S. Supreme Court has long recognized the critical benefits of student diversity affirmed in research and practice; and has consistently held that diversity is a compelling interest. The U.S. Supreme Court affirms the educational benefits derived from having a diverse student body, Grutter V. Bollinger et al.[13] and Gratz et al. V. Bollinger Et Al.[14] Diverse learning environments allows PA students the ability to enhance their critical thinking and analytical skills. It prepares PA students to succeed in an increasingly diverse interconnected environment, break down stereotypes, reduce bias, and enable PA programs to fulfill their role in enhancing recruitment and retention opportunities to students of all backgrounds.[15]

The Civil Rights Act of 1964 prohibits discrimination based on race and gender. In 1978 in the Regents of the University of California v. Bakke case, a white medical school applicant claimed 'reverse discrimination' in the admissions policies of the UC Davis medical school. In that case the Supreme Court upheld the use of race as "one of many factors" that could be considered in admissions decisions.[16] It did place limits in specific policies by ruling that 'quotas' could not be used. In the 1996 Hopwood v. Texas case, the Fifth Circuit barred racial preferences in admissions decisions in those states covered by the circuit. The US Supreme Court declined to hear the case.[17]

In 2003, two landmark affirmative action cases, were considered both involving the University of Michigan. In Gratz V. Bollinger, the court ruled that the point system used by the University to increase diversity in undergraduate admissions was unconstitutional.[14] In the 2003 Grutter V. Bollinger case, the Court in a 5 to 4 decision, upheld the University of Michigan Law School's admissions policies used to increase diversity.[13] Justice O'Connor explained that race can be considered a "plus" factor in admissions if that factor is considered in the context of a "highly individualized, holistic review of each applicant's file, giving serious consideration to all the ways an applicant might contribute to a diverse educational environment."[13]

The 2013 Fisher V. University of Texas at Austin Case (Fisher 1) overturned the lower court ruling, which was in favor of the University admission policies, stating that they did not adequately use the standards laid down in the previous Bakke and Bollinger cases.[18] In 2016 the Fisher V. University of Texas at Austin Case (Fisher 2) subsequently upheld the University's affirmative action admissions policies as constitutional.[19] Thus far the Supreme Court has upheld admissions policies designed to increase diversity as long as they are narrowly defined and do not involve quotas. The state legislatures have weighed in on these issues with ten states limiting the use of affirmative action-based admissions policies.

In 2018-2019, two cases challenging affirmative action-based admissions policies worked their way through the lower courts. The most high-profile case involved allegations that the affirmative action-based admissions policies at Harvard University discriminates against Asian Americans. The 2019 US Justice Department has sided with

the plaintiff against Harvard.[20] A similar case involving University of North Carolina Chapel Hill is also in litigation.

In October 2019 there was a ruling in the Students for Fair Admissions (SFFA) vs. President and Fellows of Harvard College (Harvard Corporation).[21] In this case an anti-affirmative action group, Students for Fair Admissions, sued Harvard for discrimination on behalf of Asian American students. Judge Allison Burroughs of the US District Court in Massachusetts upheld Harvard's admission policies and procedures finding that Harvard's "race conscious admissions passes constitutional muster." She noted that someday these policies would not be needed but "until we are race conscious, admissions programs that survive strict scrutiny will have an important place in society and help ensure that colleges and universities can offer a diverse atmosphere that fosters learning, improves scholarship, and encourages mutual respect and understanding." She further pointed out that Harvard does not "have any racial quotas" and "does not result in under-qualified students being admitted in the name of diversity". This decision was supported by Harvard and many higher education groups.[21] SFFA state that they will appeal the decision to the Court of Appeals and to the U.S. Supreme Court if necessary.

The challenge remains for all institutions to determine the type of plan that will consider race in such a way as to achieve that critical mass but does not utilize a point or quota system. The controversy over and challenge to affirmative action is not likely to end with the Court's rulings in these cases. Institutions of higher education, including medical schools and PA programs, are now faced with the challenge of promoting diversity through affirmative action programs that are within the legal standard set by the court.

Affirmative Action in Medical Education

Supporters of affirmative action in medical education believe that such programs are necessary to meet the social mandate to address the future health care 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 health care 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 ~~should~~ reflect the **RACE, ETHNICITY AND** culture ~~**and ethnicity**~~ of the patient populations they serve. ~~in order to improve the quality and accessibility of healthcare.~~ 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.

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~~Affirmative Action in PA Education~~

~~(Adopted 2004, reaffirmed 2009, 2014)~~

~~Introduction~~

In 2003, the Supreme Court issued decisions in two University of Michigan cases that addressed affirmative action in admissions policies in higher education. Both cases were filed by the Center for Individual Rights on behalf of white students who were denied admission to the University of Michigan. *Gratz v Bollinger, et al* addressed the undergraduate school admission policy while *Grutter v Bollinger, et al* considered the law school's policies.

The Court found diversity to be a compelling state interest and upheld the law school's admissions program, but struck down the undergraduate admission. The court found that the undergraduate admissions policy, which awarded points to underrepresented minority applicants solely because of race, was insufficiently "narrowly tailored to achieve the interest in educational diversity that respondents claim justifies their program." 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." What is considered to be tailored narrowly enough is still a matter of debate.

The Court also accepted the University of Michigan's argument that enrolling a "critical mass" of minority students was necessary in order to achieve the educational benefits of diversity. Critical mass was seen as a permissible goal, but a quota was not.

In the two rulings, the Court upheld educational diversity as a justification for affirmative action programs but also recognized the need to defer to educators to determine the best environment at their universities. The Court also made clear that the decisions apply to every institution that accepts any federal money thus affecting virtually every higher education institution.

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 two 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. (1)

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. (2)

A more diverse healthcare force may also 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 also express strong preference for racial/ethnic concordance with their healthcare provider. (2) 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. (3) 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. (4)

Similar results were found by Whitla et al in a 2000 survey of medical students about the relevance of diversity among students in their medical education. 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. (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)

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." (7) 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. (8) 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.~~

~~**Recommendations**~~

~~AAPA believes that PAs should reflect the culture and ethnicity of the patient populations they serve in order to improve the quality and accessibility of healthcare. Therefore, AAPA supports affirmative action programs in PA education with the goal of increasing the diversity and cultural competence of PAs entering the profession.~~

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2021-C-10 – Adopted as Amended

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.

2021-C-11 – Adopted on Consent Agenda

Adopt the policy paper entitled "*Disparities in Maternal Morbidity and Mortality*".

Disparities in Maternal Morbidity and Mortality

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 health care 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 health care 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)

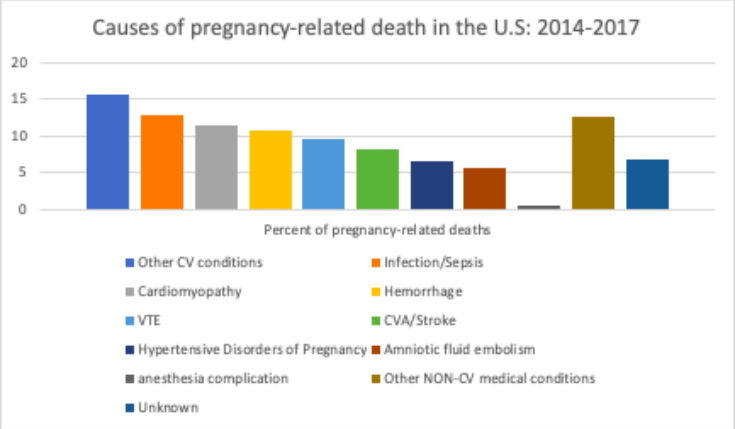
Global Burden

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 3.1which aims to "reduce the global maternal mortality ratio to less than 70 per 100,000 live births. (4)

U.S. Statistics

Among comparable developed countries, the United States (U.S.) has the highest maternal and infant mortality rates. Annually in the U.S., there are 700 deaths attributable to pregnancy or delivery complications, and short or long-term severe consequences to health are experienced by 50,000. (5) The term severe maternal morbidity (SMM) means a health condition, including mental health conditions and substance use disorders, attributed to or aggravated by pregnancy or childbirth that results in significant short-term or long-term consequences to the health of the individual who was pregnant. (6) Both maternal mortality and SMM have been steadily increasing since 1993. The overall rate of SMM increased almost 200% from 49.5 in 1993 to 144.0 in 2014, driven in part by blood transfusions. (6) Excluding transfusions, the rate of SMM increased by about 20% over this period, from 28.6 in 1993 to 35.0 in 2014. (6) The two most common SMM procedures after blood transfusion are hysterectomy which has increased 55% over this period, and ventilation or temporary tracheostomy which increased by about 93%. (7) Additional factors that seem to compound these high rates of SMM include wide racial and ethnic disparities in maternal health outcomes as well as caps in maternity care services in many communities, particularly in rural areas. In the postpartum period, there is still a significantly high rate of maternal deaths due to preventable complications experienced during pregnancy, such as preterm labor, infections, and gestational diabetes. This further emphasizes the importance of expanding access to care beyond the traditional one postpartum visit.

Table 1. Causes of Pregnancy Related Death in the US: 2014-2017



During pregnancy, maternal comorbidities can be exacerbated, resulting in complications that could lead to death. Table 1 highlights some of the most common causes of pregnancy related deaths, which includes some chronic conditions as well. (8) For instance, cardiovascular events, cardiomyopathy, and strokes will increase in a patient with poorly controlled hypertension, diabetes, and chronic heart disease. Congenital heart disease, valvular heart disease, cardiomyopathy, and pulmonary hypertension also pose a risk for pregnant patients, and the prevalence among pregnant patients has increased significantly by 24.7% from 2003-2012. (9) Major adverse cardiac events (MACE) have also increased dramatically by 18.8% during the same period. (9) The racial disparities seen in cardiovascular complications in pregnancy is quite severe and are syndemic to all women of color with Black women being three to four times more likely to die from pregnancy-related causes than white women. Further discussion of racial disparities is followed below.

Racial Health Disparities

As Table 2 and 3 highlights, between 2014 to 2017, there were 41.7 pregnancy-related deaths per 100,000 live births in non-Hispanic Black patients, which is three times more than patients of Hispanic or Latinx origin (11.6). (8,10) Black women are 243% more likely to die from pregnancy or child-birth-related causes compared to white women. (10) This racial disparity has persisted for decades due to racism, sexism, and other systemic barriers that have contributed to income inequality.

Table 2. Pregnancy Related Mortality Ratio by Race/Ethnicity: 2014-2017

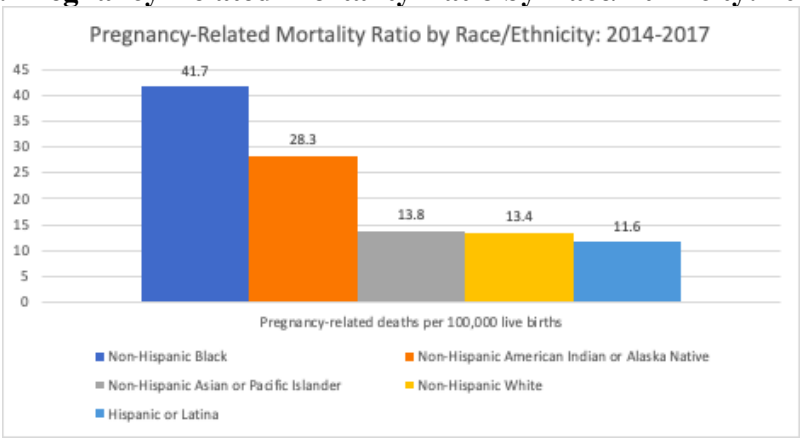
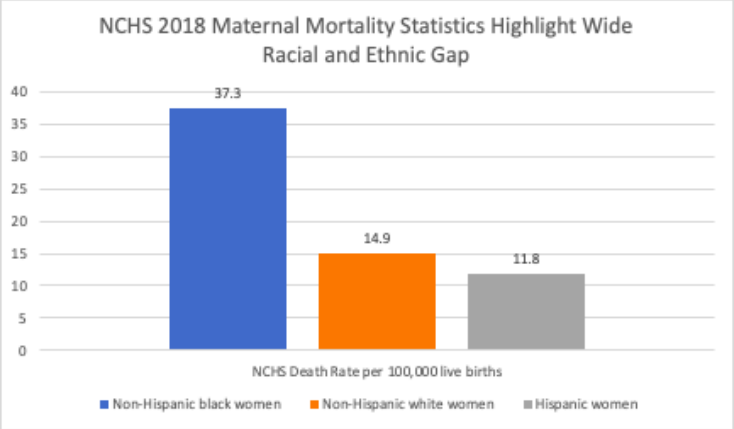


Table 3. Racial and Ethnic Maternal Mortality Gaps



Although there are numerous factors which contribute to increased rates of maternal mortality, over ⅓ of them are related to hypertensive disorders. Other chronic conditions such as obesity are known to be associated with low socioeconomic status, which contributes to the increased rates of morbidity and mortality. Both obesity and low socioeconomic status are known to have increased prevalence in certain communities. (11) Known risk factors for conditions such as preeclampsia include the following: pre-existing hypertension, renal disease, obesity, and collagen vascular disorders. (11)

According to the American College of Obstetrics and Gynecology hypertensive disorders can be classified as: pre-eclampsia/eclampsia, chronic hypertension, chronic hypertension with superimposed preeclampsia, and gestational hypertension. The importance of community reproductive health education is highlighted when a woman is diagnosed with gestational hypertension or preeclampsia when normotension is seen in the second trimester is actually false and due to the normal physiological response to pregnancy. The prevalence of maternal hypertension is seen at different rates in the following populations: 2.2% Chinese, 2.9% Vietnamese, 8.9% American Indian/Alaska Native, and 8.9% African American. (11)

Through the use of billing data, a study involving 65,286,425 women helped identify that among those who were admitted for delivery, there were 7764 women diagnosed with stroke. (12) Among those diagnosed with pregnancy induced or gestational hypertension, Black and Hispanic mothers had higher stroke risk than non-Hispanic whites. Minority women with chronic hypertension, including Black, Hispanic, and Asian Pacific Islanders had a two times higher stroke risk. Among those who were normotensive, only Blacks had a higher incidence of stroke. (12)

Although the overall incidence of stroke has declined in the United States, maternal stroke affects 30 in 100,000 pregnancies with ⅓ occurring during the delivery hospitalization. (12) Multiple factors may be contributing to the increased events seen, including advanced maternal age, obesity, hypertension, and diabetes mellitus. The longstanding impact of stroke not only affects quality of life but also has financial impacts as well as prolonged disability. The impact of disease states which have been considered preventable are significant. Case reviews suggest that 30-60% of the pre-eclampsia deaths were attributed to intracranial hemorrhage and with timely treatment with antihypertensive medications pregnancy morbidity and mortality can be reduced.

Surveillance in the U.S.

The U.S. utilizes two main national surveillance and reporting systems. The Center for Disease Control and Prevention (CDC) National Vital Statistics System (NVSS) is a federal system that provides maternal mortality ratios based on death certificate information, but it does not include deaths occurring after 43 days of delivery. The Pregnancy Mortality Surveillance System (PMSS) is specifically for pregnancy-related deaths and depends on states to submit data for patients ages 12 to 55 who died within one year of pregnancy. In fact, data on maternal deaths is submitted on a voluntary basis and some states choose to opt-out. (13)

The United States has only recently joined the rest of the developed world in establishing an infrastructure for systematically assessing maternal deaths. On December 21, 2018, the Preventing Maternal Deaths Act (HR 1318) was signed into law. This legislation sets up a federal infrastructure and allocates resources to collect and analyze data on every maternal death in every state. The bill intended to establish and support existing maternal mortality review committees (MMRCs) in states and tribal nations across the country through federal funding and reporting of standardized data.

Using the data gathered, MMRCs are optimized when they provide recommendations and develop strategies to prevent problems that arise during the prenatal and postpartum periods. While all MMRCs collect information to try to understand factors related to deaths during pregnancy, delivery, and the postpartum period, including health care 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) health care access factors, including health insurance coverage, access to culturally congruent health care services, providers, and non-clinical support, access to home visiting services, access to wellness and stress management programs, health literacy, access to telehealth and items required to receive telehealth services, and related factors.

Historic Structural Racism in the U.S

Structural racism is defined as a system where public policies, institutional policies, and cultural representations work to reinforce and perpetuate racial inequity. (17) Distrust of the healthcare systems exists among Black patients in the United States, initiated by a history of reproductive oppression and slavery. In the south, slave owners collaborated with physicians to manage Black women's fertility with surgical procedures to reproductive organs, which had a two-fold consequence of increased slave breeding and medical experimentation on Black women. Dr. James Marion Sims, dubbed the father of gynecology, is well known to have experimented on enslaved Black women such as Anarcha, Lucy, Betsey, and others. (15) Black women were utilized to test new surgical instruments and techniques. Morphine was employed to reduce their screams during invasive vaginal surgeries which were conducted without anesthesia or consent. Through the 19th century, a new movement of eugenics and forced sterilization on Black women became vogue as a means of social-sexual control by eliminating those perceived to be inferior or expendable. The resulting lack of trust in the healthcare system and the government is understandable for these reasons. This mistrust has led to delay in seeking care, resulting in complications that progress unmanaged until it is too late. (15)

The Three Delays model, used widely to investigate events contributing to maternal deaths, began with the work of Thaddeus and Maine. This model acknowledges delay in seeking care, delay in arrival to an appropriate medical care facility, and delay in receiving adequate care once in the medical facility. (16) Recent efforts have been made to improve on this model, including, identifying near misses that could have led to maternal death more rapidly. (16) Utilizing the three delays model in combination with this near miss approach, aims to reduce maternal mortality.

Current Structural Factors

Structural factors that currently inform maternal health disparities in the US include State-level opt-outs Medicaid expansion (in particular, in the South) after the implementation of the Patient Protection and Affordable Care Act. Among these states, those with the highest MMRs include Georgia (46.2 maternal deaths per 100,000 live births overall, and 66.6 maternal deaths per 100,000 live births among Black women), Louisiana (44.8 maternal deaths per 100,000 live births overall, 72.6 per 100,000 live births among Black women). (17)

Compounding this disparity is a limit of 60 days for postpartum coverage by Medicaid. Medicaid pays for more than four in ten births nationally and is the focus of some federal and state efforts to improve maternity care. Federal law requires that all states expand Medicaid eligibility to pregnant patients with incomes up to 138% of the federal poverty level ($29,435 annually for a family of three). (18) Pregnancy related coverage must last through 60 days postpartum or qualify for federal subsidies to purchase coverage through ACA Marketplace plans. However, in the states that have not adopted the ACA's Medicaid expansion, postpartum patients need to re-qualify for Medicaid as parents to stay on the program, but eligibility levels for parents are much lower than for pregnant patients. As a result, many parents in non-expansion states become uninsured after pregnancy related coverage ends 60 days postpartum because, even though they are low income, their income is still too high to qualify for Medicaid as parents. (18) Approximately half of all maternal deaths occur up to a year postpartum. Coverage during this vulnerable time is essential to preventing MMR and SMM. (18)

Delay in arrival to an appropriate medical care facility is partially due to structural racism, perpetuating racial disparities. Economic inequality greatly impacts a woman's ability to seek quality medical care. It has been noted that African American women earn approximately 63 cents for every dollar earned by White, non-Hispanic men. (19)

People of color are frequently segregated in communities that lack quality health facilities and providers, experience food deserts that lack nutritious food options, and live in hazardous housing conditions in un-walkable neighborhoods. Economic barriers impact the decisions as to which neighborhoods one lives and highlights the need for more affordable housing options for individuals with low income. (20) Black and Latinx communities are more likely to experience "maternity care deserts" where hospital systems close down without appropriate alternatives. In addition, although lifestyle changes such as exercise are often recommended for chronic conditions such as hypertension, diabetes, and obesity, many women are living in environments that are not conducive to safe performance of these activities. (11)

Delay in receiving adequate care once in an appropriate medical facility has been most notably framed as the Swiss cheese model of system failures proposed by James Reason. This model is used in risk analysis and mitigation to examine and review medical errors and safety incidents. Swiss cheese is a metaphor for slices representing human systems and organizational defenses and the holes are weaknesses or individual system errors. (21) By identifying the areas of weakness or "holes", a system can aim to reduce maternal morbidity and mortality. Reported areas of improvement include communication, preparing for rare critical events through simulation training, developing protocols for important medications used in labor and delivery, increasing hospitalist coverage, developing an effective departmental infrastructure that includes effective peer review, providing risk management education about high-risk clinical areas that have the

potential to result in catastrophic injury, and staffing the unit for all contingencies during all hours, day and night. (22)

Another potential cause of delay is in the inadequate availability of qualified medical care practitioners. Physician Assistants (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 health care 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 health care 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.

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2021-C-12 – Adopted on Consent Agenda

Amend policy HX-4200.1.8 as follows:

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 ~~care and promote a full range of~~ preconception and ~~pregnancy support services~~ PRENATAL CARE.

2021-C-13 – Adopted as Amended

Amend policy HX-4600.6.5 as follows:

AAPA believes all PAs should **ADVOCATE FOR AND PROMOTE EVIDENCE-BASED REPRODUCTIVE AND SEXUAL HEALTH INTERVENTIONS IN ORDER TO PREVENT UNINTENDED PREGNANCIES AND SEXUALLY TRANSMITTED INFECTIONS. AAPA SHOULD ADVOCATE TO ENSURE THAT REPRODUCTIVE AND SEXUAL HEALTH PROMOTION AND PREVENTIVE INTERVENTIONS ARE AVAILABLE VIA TELEHEALTH TECHNOLOGY**.

~~**AAPA believes all PAs should advocate responsible sexual behavior including education on methods to prevent unintended pregnancy and sexually transmitted infections PROMOTE SAFE SEX PRACTICES AND PREVENTIVE INTERVENTIONS, SUCH AS HIV PrPREP TREATMENT, IN ORDER TO REDUCE UNINTENDED PREGNANCIES AND TRANSMISSION OF SEXUALLY TRANSMITTED INFECTIONS. ADDITIONALLY, PA SHOULD ADVOCATE TO ENSURE THAT HEALTH PROMOTION AND PREVENTIVE INTERVENTIONS FOR REPRODUCTIVE HEALTH ARE AVAILABLE IN A TELEHEALTH CAPACITY WHEN FACE TO FACE HEALTH CARE INTERACTIONS ARE NOT IDEAL.**~~

2021-C-14 – Referred

Amend policy HX-4200.1.5 as follows:

AAPA endorses exclusive breastfeeding ~~when possible,~~ for ~~about~~ the first 6 months of life, AS MUTUALLY DESIRED BY THE MOTHER AND INFANT. CONTINUED BREASTFEEDING (ALONG WITH COMPLEMENTARY FOOD INTRODUCTION) IS RECOMMENDED FOR AT LEAST THE FIRST YEAR OF THE INFANT'S LIFE. ~~followed by breastfeeding with complementary food introduction until at least 12 months of age.~~

2021-C-15 – Adopted on Consent Agenda

Amend policy HX-3300.1.5 as follows:

AAPA encourages all PAs to take an active role in ~~the screening, prevention, management, and referral of patients for oral health disease~~ 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.

2021-C-16 – Adopted as Amended

Amend the policy paper entitled *Improving Children's Access to Healthcare.*

~~Improving Children's Access to Healthcare~~

SUPPORT FOR COPARENT OR SECOND-PARENT ADOPTIONS REGARDLESS OF GENDER

(Adopted 2004, reaffirmed 2009, amended 2015)

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 ~~maintain continuing legal relationships with both parents~~ ~~TWO~~ 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 ~~both~~ 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 ~~both~~ THEIR parents is established in the event of the parents' separation.
4. The child's eligibility for health benefits from ~~both~~ THEIR parents
5. The legal grounds are provided for ~~either~~ 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.

Introduction

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 ~~two parent~~ family may be in jeopardy if the legally recognized parent should die, be declared incompetent, or if the couple separates. Children deserve to know that their relationships with ~~both of~~ their parents are stable and should be legally recognized. (2)

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 ~~and social~~ benefits of LEGALLY EMPOWERED ~~two~~ 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 ~~both~~ THEIR parents.

Sources

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

2021-C-17 – Adopted on Consent Agenda

Amend policy HX-4300.2.2 as follows:

AAPA shall support state laws requiring protective equipment for individuals participating in activities that put them at risk of traumatic brain injury ~~(recreational/transportation)~~. 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.

2021-C-18 – Adopted as Amended

~~The HOD recommends that~~ AAPA ~~1)~~ recognizes the value and supports the advancement of point-of-care ultrasound (POCUS) in PA clinical practice. ~~, 2)~~ AAPA endorses, ~~and~~ supports, AND PROMOTES the development of POCUS education opportunities.~~, 3) encourages organizations such as PAEA, NCCPA, ARC-PA to promote opportunities which demonstrate the value of integrating POCUS into PA education programs and explore opportunities to develop POCUS-skilled~~

~~faculty/educators, and 4) supports multi-organizational collaborative efforts to establish POCUS as a clinical competency integral to the practice of medicine.~~

~~Further resolved~~

~~The HOD recommends that AAPA supports further exploration of the existing barriers to PA POCUS utilization and provision of recommendations to mitigate these barriers.~~

2021-C-19 – Adopted on Consent Agenda

Amend policy HP-3300.1.18 as follows:

AAPA believes evaluation of mental health and appropriate diagnosis, 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.

2021-C-20 – Adopted as Amended

Amend policy HP-4200.1.6 as follows:

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

2021-C-21 – Adopted as Amended

Amend policy HX-4200.7.1 as follows:

AAPA encourages student and graduate PAs to recognize the crises of pain management and ~~opioid abuse~~ OPIOID USE DISORDER. AAPA encourages student and graduate PAs to work towards a solution to these crises at the local, state, and national levels through advocacy, collaboration, and education for students and practicing PAs about responsible opioid prescribing. AAPA FURTHER SUPPORTS THE UTILIZATION OF PRESCRIPTION DRUG MONITORING PROGRAMS AS A TOOL TO PRACTICE RESPONSIBLE OPIOID PRESCRIBING.

2021-C-22 – Adopted

Amend policy HX-4200.3.2 as follows:

AAPA supports legislation that encourages states to impose minimum mandatory sanctions against ~~convicted drunken~~ 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.

2021-C-23 – Adopted as Amended

Amend the policy paper entitled *Nicotine Dependence*.

~~Nicotine Dependence~~ TOBACCO USE DISORDER
(Adopted 2016)

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, ~~and~~ 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 NICOTINE DEPENDENCE; (C) EFFECTIVE USE OF BOTH NICOTINE CESSATION MATERIALS AND EVIDENCE-BASED CLINICAL PRACTICE GUIDELINES BY PAS, FOR THE TREATMENT OF PATIENTS WITH NICOTINE DEPENDENCE.~~

~~• AAPA ENCOURAGES PAS TO MODEL NICOTINE CESSATION ACTIVITIES IN THEIR PRACTICES, INCLUDING (A) QUITTING NICOTINE PRODUCTS AND ASSISTING THEIR COLLEAGUES TO QUIT; (B) INQUIRING OF ALL PATIENTS AT EVERY VISIT ABOUT THEIR USE OF NICOTINE IN ANY FORM; (C) AT EVERY VISIT, COUNSELING THOSE WHO SMOKE TO QUIT SMOKING AND ELIMINATE USE OF NICOTINE TO ELIMINATE USE IN ALL FORMS; (D) WORKING TO PROHIBIT THE USE OF NICOTINE PRODUCTS BY ALL INDIVIDUALS IN HEALTHCARE SETTINGS; (E) PROVIDING NICOTINE INFORMATION; (F) BECOMING AWARE OF NICOTINE CESSATION PROGRAMS IN THE COMMUNITY AND OF THEIR SUCCESS RATES AND, WHERE POSSIBLE, REFERRING PATIENTS TO THOSE PROGRAMS.~~

~~• AAPA SUPPORTS NATIONAL, STATE, AND LOCAL EFFORTS TO HELP PAS AND PA STUDENTS DEVELOP SKILLS NECESSARY TO COUNSEL PATIENTS TO QUIT NICOTINE PRODUCTS, INCLUDING (A) IDENTIFYING GAPS, IF ANY, IN EXISTING MATERIALS AND PROGRAMS DESIGNED TO TRAIN PAS AND PA STUDENTS IN THE BEHAVIOR MODIFICATION SKILLS NECESSARY TO SUCCESSFULLY COUNSEL PATIENTS TO STOP USING NICOTINE PRODUCTS; (B) SUPPORTS THE PRODUCTION OF MATERIALS AND PROGRAMS THAT WOULD FILL GAPS, IF ANY, IN MATERIALS AND PROGRAMS TO TRAIN PAS AND PA STUDENTS IN THE BEHAVIOR MODIFICATION SKILLS NECESSARY TO SUCCESSFULLY COUNSEL PATIENTS TO STOP USING NICOTINE PRODUCTS; (C) ENCOURAGES CONSTITUENT ORGANIZATIONS TO SPONSOR, SUPPORT, AND PROMOTE EFFORTS THAT WILL HELP PAS TO MORE EFFECTIVELY COUNSEL PATIENTS TO QUIT USING NICOTINE PRODUCTS; AND (D) ENCOURAGES PAS TO PARTICIPATE IN EDUCATION PROGRAMS TO ENHANCE THEIR ABILITY TO HELP PATIENTS QUIT NICOTINE PRODUCTS.~~

~~• AAPA SUPPORTS THIRD-PARTY COVERAGE FOR THE TREATMENT OF NICOTINE ADDICTION AND THE MANAGEMENT OF BEHAVIORAL DEPENDENCE ASSOCIATED WITH NICOTINE USE.~~

~~• AAPA SUPPORTS REGULATION OF ELECTRONIC NICOTINE DELIVERY SYSTEMS (E-CIGARETTES) BY THE U.S. FOOD AND DRUG ADMINISTRATION (FDA) CENTER FOR TOBACCO PRODUCTS.~~

~~• AAPA ENCOURAGES ALL PAS TO BE ACTIVELY INVOLVED IN COMMUNITY OUTREACH THAT IS DIRECTED TOWARD PROVIDING NICOTINE PRODUCT EDUCATION BASED UPON CURRENT EVIDENCE-BASED~~

~~GUIDELINES TO PEOPLE OF ALL AGES ABOUT THE DANGERS OF NICOTINE WITH THE GOAL OF ELIMINATING NICOTINE USE.~~

• AAPA SUPPORTS (A) DEVELOPMENT AND PROMOTION OF NICOTINE CESSATION MATERIALS AND PROGRAMS TO ADVANCE CONSUMER HEALTH-AWARENESS AMONG ALL SEGMENTS OF SOCIETY, BUT ESPECIALLY FOR YOUTH; (B) DISSEMINATION OF EVIDENCE-BASED CLINICAL PRACTICE GUIDELINES CONCERNING THE TREATMENT OF PATIENTS WITH NICOTINE DEPENDENCE; (C) EFFECTIVE USE OF BOTH NICOTINE CESSATION MATERIALS AND EVIDENCE-BASED CLINICAL PRACTICE GUIDELINES BY PAS, FOR THE TREATMENT OF PATIENTS WITH NICOTINE DEPENDENCE.

• AAPA ENCOURAGES PAS TO MODEL NICOTINE CESSATION ACTIVITIES IN THEIR PRACTICES, INCLUDING (A) QUITTING NICOTINE PRODUCTS AND ASSISTING THEIR COLLEAGUES TO QUIT; (B) INQUIRING OF ALL PATIENTS AT EVERY VISIT ABOUT THEIR USE OF NICOTINE IN ANY FORM; (C) AT EVERY VISIT, COUNSELING THOSE WHO SMOKE TO QUIT SMOKING AND ELIMINATE USE OF NICOTINE TO ELIMINATE USE IN ALL FORMS; (D) WORKING TO PROHIBIT THE USE OF NICOTINE PRODUCTS BY ALL INDIVIDUALS IN HEALTHCARE SETTINGS; (E) PROVIDING NICOTINE INFORMATION; (F) BECOMING AWARE OF NICOTINE CESSATION PROGRAMS IN THE COMMUNITY AND OF THEIR SUCCESS RATES AND, WHERE POSSIBLE, REFERRING PATIENTS TO THOSE PROGRAMS.

• AAPA SUPPORTS NATIONAL, STATE, AND LOCAL EFFORTS TO HELP PAS AND PA STUDENTS DEVELOP SKILLS NECESSARY TO COUNSEL PATIENTS TO QUIT NICOTINE PRODUCTS, INCLUDING (A) IDENTIFYING GAPS, IF ANY, IN EXISTING MATERIALS AND PROGRAMS DESIGNED TO TRAIN PAS AND PA STUDENTS IN THE BEHAVIOR MODIFICATION SKILLS NECESSARY TO SUCCESSFULLY COUNSEL PATIENTS TO STOP USING NICOTINE PRODUCTS; (B) SUPPORTS THE PRODUCTION OF MATERIALS AND PROGRAMS THAT WOULD FILL GAPS, IF ANY, IN MATERIALS AND PROGRAMS TO TRAIN PAS AND PA STUDENTS IN THE BEHAVIOR MODIFICATION SKILLS NECESSARY TO SUCCESSFULLY COUNSEL PATIENTS TO STOP USING NICOTINE PRODUCTS; (C) ENCOURAGES CONSTITUENT ORGANIZATIONS TO SPONSOR, SUPPORT, AND PROMOTE EFFORTS THAT WILL HELP PAS TO MORE EFFECTIVELY COUNSEL PATIENTS TO QUIT USING NICOTINE PRODUCTS; AND (D) ENCOURAGES PAS TO PARTICIPATE IN EDUCATION PROGRAMS TO ENHANCE THEIR ABILITY TO HELP PATIENTS QUIT NICOTINE PRODUCTS.

• AAPA SUPPORTS THIRD-PARTY COVERAGE FOR THE TREATMENT OF NICOTINE ADDICTION AND THE MANAGEMENT OF BEHAVIORAL DEPENDENCE ASSOCIATED WITH NICOTINE USE.

• AAPA SUPPORTS REGULATION OF ELECTRONIC NICOTINE DELIVERY SYSTEMS-(E-CIGARETTES) BY THE U.S. FOOD AND DRUG ADMINISTRATION (FDA) CENTER FOR TOBACCO PRODUCTS.

Introduction

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

Tobacco Exposure and Nicotine Use

Not only are cigarettes manufactured to increase the addictive properties, but combustion produces thousands of toxic chemicals which lead to disease and early death. (2) After half a century of research on tobacco use, new research continues to emerge demonstrating the detrimental effects of smoking. Adverse effects of tobacco smoke have been documented in all organ systems of the body. In the 2014 report from the U.S. Surgeon General the following new research findings are provided: 1) liver cancer and colorectal cancer are caused by smoking; 2) secondhand smoke exposure is a cause of cerebral vascular accident; 3) smoking increases the risk of death among cancer survivors; 4) smoking causes diabetes mellitus; and 5) smoking impairs immune function and causes rheumatoid arthritis. (2) As a result, productivity suffers from tobacco use. From 2009-2012 economic costs were estimated at 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" ~~other electronic nicotine delivery devices~~ particularly among adolescents, is concerning. Public perception of e-cigarette safety seems to be favorable to tobacco cigarettes despite a lack of evidence (4). The American Lung Association identified 500 brands and 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) ~~Data from the 2014 National Youth Tobacco Survey showed 13.4% of high school students reported past month e-cigarette use (6).~~ Use of e-cigarettes now exceeds the use of other tobacco products, including cigarettes. This is troubling given most adult cigarette smokers began using during adolescence. Although restrictions on tobacco advertising have been in place since the Master Settlement Agreement, similar restrictions do not exist for e-cigarettes. Data from the 2014 National Youth Tobacco Survey showed 68.9% of middle and high school students were exposed to advertisements for e-cigarettes (7). Little is known about secondhand exposure to e-cigarette vapors. According to the American Lung Association, carcinogens have been identified in the vapor exhaled by e-cigarette users. To date, no evidence has found that secondhand inhalation of e-cigarette vapors 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
   a. 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 have been linked to several cancers however, to date, only one study has addressed this concern among individuals who use nicotine replacement products. The results of the study showed no association between use of nicotine replacement products and malignancy (2). Many e-cigarette users begin using the devices as tool to help quit traditional cigarettes despite lack of research to support their use in smoking cessation programs. ~~Polosa, Caponnetto, Morjaria, Papale, Campagna & Russo (2011) conducted a pilot study of e-cigarette use for smoking cessation among 40 tobacco cigarette smokers. The authors concluded that e-cigarette use decreased tobacco cigarette use with few side effects (9). Bullen, McRobbie, Thornley, Glover, Lin, & Laugesen (2010) found similar results in their study the effects of ecigarettes on desire to smoke (10) Although promising, it should be noted that the e-cigarettes used in these studies contained solutions with known concentrations of nicotine and other ingredients, unlike what is currently available to the public. The authors of both papers discuss the need for further research into long-term safety and use. Additionally, there is concern regarding advertising strategies that may be targeting younger individuals and that use of e-cigarettes may increase the risk of future tobacco use.~~

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

Master Settlement Agreement

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

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

Conclusions

Myriad studies conclusively demonstrate the adverse health effects of nicotine use ~~and dependence~~. Despite achievements in reducing the number of individuals who use tobacco products since the 1964 Surgeon General's report on the health effects of smoking, more work is needed. ~~An area of growing public health concern is the use of e-cigarettes, particularly among youth. Our knowledge with regard to e-cigarettes continues to evolve as more research is conducted.~~ Given what is known, PAs have a responsibility to act at the individual, community, and structural levels to raise awareness and promote cessation of nicotine use.

- AAPA shall support the position of the Surgeon General and the U.S Preventive Service Task Force and encourage PAs to increase patient awareness as to the dangers in the use of nicotine products.
- AAPA recognizes the public health hazards of nicotine products as a leading cause of preventable disease and encourages efforts to eliminate tobacco use in this country and around the world.
- AAPA encourages PAs to work to support legislation which will eliminate the public's exposure to secondhand smoke, eliminate minors' access to nicotine products including electronic nicotine delivery systems and prohibit advertising of nicotine products.
- 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 ~~nicotine dependence~~; (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 ~~nicotine dependence~~.
- AAPA encourages PAs to model nicotine cessation activities in their practices, including (a) quitting nicotine products and assisting their colleagues to quit; (b) inquiring of all patients at every visit about their use of nicotine in any form; (c) at every visit, counseling those who smoke to quit smoking and eliminate use of nicotine to eliminate use in all forms; (d) working to prohibit the use of nicotine products by all individuals in healthcare settings; (e) providing nicotine information; (f) becoming aware of nicotine cessation programs in the community and of their success rates and, where possible, referring patients to those programs.

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

· 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~~E-cigarettes OR VAPING PRODUCTS) by the U.S. Food and Drug Administration (FDA) Center for Tobacco Products.

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2021-C-24 – Referred

Amend policy HX-4600.7.3 as follows:

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

AAPA supports public health-based strategies~~,~~ AND LOCAL LEGISLATION, ~~instead~~ IN PLACE of incarceration, when dealing with persons in possession of ~~marijuana~~ CANNABINOIDS.

2021-C-25 – Adopted as Amended

Amend policy HX-4600.7.5 as follows:

AAPA discourages the NON-MEDICAL use of CANNABINOIDS ~~marijuana~~ by those persons under the age of 21 and discourages the NON-MEDICAL use of CANNABINOIDS ~~marijuana~~ by adults who are in the presence of persons under the age of 21.

2021-C-26 – Adopted as Amended

Amend policy HX-4600.7.6 as follows:

AAPA supports ~~legislation that requires~~ labeling and child-proof packaging of ~~marijuana~~ CANNABINOIDS and ~~marijuana~~ CANNABINOID related products and that limits advertising to adolescents.

2021-C-27 – Adopted

Amend policy HX-4600.7.4 as follows:

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

2021-C-28 – Adopted

Amend policy HX-4600.7.1 as follows:

AAPA believes that additional clinical research should be conducted on the therapeutic value and efficacy and safety of ~~marijuana~~ CANNABINOIDS. AAPA urges that the status of ~~marijuana~~ CANNABINOIDS as a federal Schedule I controlled substance be reviewed to facilitate and allow the conducting of clinical research.

2021-C-29 – Adopted on Consent Agenda

Amend policy HX-4600.7.2 as follows:

AAPA recommends that in any state where medical ~~marijuana~~ CANNABINOIDS laws exist, PAs are included as healthcare providers that can authorize or recommend the use of ~~marijuana~~ CANNABINOIDS for patients. AAPA believes effective patient care requires the free and unfettered exchange of information on treatment options and that

discussion of ~~marijuana~~ CANNABINOIDS as an option between PAs and patients should not subject either party to criminal sanctions.

2021-C-30 – Rejected

Adopt the policy paper entitled *Recognizing Pornography as a Public Health Crisis*.

Recognizing Pornography as a Public Health Crisis

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 recognizes the potentially addictive and harmful effects of pornography leading to the current public health crisis.
- AAPA urges PAs to be alert in identifying and caring for people being harmed by pornography. With the public health crisis, PAs should ensure they are well informed about the medical, psychological and spiritual needs of persons as well as the resources available for these persons in their community.
- AAPA encourages educational programs to train students to recognize the public health crisis and potentially harmful effects of pornography prior to entering full-time practice.
- AAPA encourages the regulation of unregulated ubiquitous exposure to pornography and the labeling of such to let unaware users be educated of potential addiction and harms associated with viewing pornography.
- AAPA encourages PAs to be aware of the ongoing effects the COVID-19 pandemic has on pornography usage.
- AAPA encourages PAs to be aware of racist content of pornography.

Introduction

After a brief explanation about the current public health crisis of pornography with its potentially addictive, harmful nature, this policy paper will seek to show how PAs can be integral in the care of persons affected by pornography. Sixteen states have passed legislation stating that pornography is a public health crisis, which ought to prompt medical leaders into action to lead from the front with matters of health policy. (2, 4) Due to recent events with the COVID-19 pandemic and racial injustices being brought into the national spotlight, addendums are included at the end of the policy paper addressing these cogent topics in relation to pornography as a public health crisis.

Pornography affects many demographics, most detrimentally children, contributing to the hyper-sexualization of teens, including prepubescent children in our society. PAs can focus efforts to prevent pornography exposure and potential for addiction, to educate individuals and families concerning its harm and to develop recovery programs available to the public, to pass laws protecting individuals' rights to live in a porn free environment and hold the porn industry accountable for the health crisis it has created in today's digital climate. (3)

Public Health Issue

The scope of the problem can be demonstrated even by a large internet pornography website and its viewership from the United States. In 2019 alone, they got 42 Billion visits, almost 1,300 million visits a second with the United States being the country with the highest daily traffic to the site. (5) *The Public Health Harms of Pornography*, published by the National Center on Sexual Exploitation in February 2018, reports that up to 93% of males and 62% of females viewed pornography in their adolescence. It states that, "the breadth and depth of pornography's influence on popular culture has created an intolerable situation that impinges on the freedoms and wellbeing of countless individuals." (3) Their research summary going back to 1950's demonstrates the normalization and desensitization of pornography to include: hardcore pornography portrays violence and female degradation, teaches consumers that women enjoy sexual violence and degradation, puts consumers at increased risk of committing sexual offenses, increases verbal and physical aggression, impacts what children interpret as normal sexual behavior, harms young brains, and increases the likelihood of increased risky sexual behavior resulting in increase of STIs. (3)

Studies have shown that brain function changes are the same regardless of the addiction to alcohol, drugs or pornography. (7) Addicted pornography viewers do not have the power to stop without going through similar recovery processes required by other addictions. (6) Using a medical model in addressing pornography as an addiction would better serve patient populations affected.

Training Current Medical Personnel

Though pornography exposure and its potentially addictive nature have contributed to creating a public health issue, many health care workers are undertrained and unaware of how to recognize and help individuals. To our knowledge there is no specific study addressing PAs or healthcare providers and their knowledge or training in identifying pornography addicted individuals and/or those suffering from the harmful health effects related to their addiction. Organizations such as The National Decency Coalition have taken a stand in educating the public. (8) PAs need to develop robust educational resources for their own and be able to address and lead on this topic in the legislative and public square.

Health Consequences to Recognize for Policy Changes

To set a foundation for education and policy change, PAs need to be aware of the litany of negative effects research has shown pornography to have, especially on the pediatric population. Research has shown young children are frequently exposed to what used to be referred to as hard core but is now considered mainstream pornography due to the ubiquity of internet pornography. "This exposure is leading to low self-esteem and body image disorders, an increase in problematic sexual activity at younger ages, and greater likelihood of engaging in risky sexual behavior such as sending sexually explicit images, hookups, multiple sex partners, group sex, and using substances during sex as young adolescents. (1) "Pornography normalizes violence and abuse of women and children." (1) "It treats women and children as objects and often depicts rape and abuse as if they were harmless" (1) Pornography "increases the demand for sex trafficking, prostitution, and child sexual abuse images" (i.e. child pornography). (1) Pornography use impacts brain development and functioning, contributes to emotional and mental illnesses, shapes deviant sexual arousal, and lead to difficulty forming or maintaining intimate relationships as well as problematic or harmful sexual behaviors and addiction."

(1) Overcoming pornography's harms is beyond the capability of the afflicted individual to address alone.

Training Future Health Care Workers

As awareness of the public health crisis of pornography and its potential addiction increases on the federal level, medical education programs must follow suit and equip future medical professionals to recognize and treat individuals. Training should be incorporated into PA program curricula so that all PA students and graduates are able to identify individuals at risk for harm. PAs have the opportunity to take the initiative in training students, which will have a lasting impact on this under-recognized public health issue. Incorporating training on pornography harms and addiction will equip PAs to be at the forefront in the fight to regulate the pornography industry and its potential harms and addiction in the U.S. Though we do not have specific estimates on the cost of incorporating this training into PA educational curriculum, other type addiction treatment models exist and may potentially be modified; therefore the financial impact should be minimal. The cost of providing up to date training to students should be considered a necessity in PA program curriculums.

Advocate for Policy Changes

PAs are poised to advocate on behalf of their patients in the public health arena and a part of the advocacy should be to address the industries that benefit from harming the public. Through regulating the obscenity industry with their current first amendment protection, PAs can be clear that protecting the public must be the responsibility of legislators to regulate pornography and enforce safe policies. At this point, it is clear the pornography industry is not self-regulating and is causing harm to the general public. PAs can speak from a place of authority with regards to health effects of pornography to sway current public policy that is failing to protect especially children. (1)

Covid-19 and Pornography

With nationwide lockdowns taking effect in March 2020 and individuals being mandated to isolate and alter social behaviors, online pornography use increased dramatically according to the United States' largest pornography website. They report an increase of 24% due to a targeted promotion allowing their services free for American users (9). *The Journal of Behavioral Addictions*, in their letter, "Pornography use in the setting of the COVID-19 pandemic" reports that multiple porn sites saw an increase in searches involving pandemic themes (11). As more data is analyzed, behavioral scientists can determine porn's impact during COVID-19's with global isolation and social norms disruption. Many turn to porn in times of powerlessness as a coping mechanism and at the point of publication, the mental wellness of many in the United States is at an all-time low. Though the pandemic may have been a boon for the porn industry, it does not help the average patient, especially those struggling in isolation during a pandemic.

Racism in America and Pornography

On May 25th, 2020, George Floyd's gruesome death spawned national and global protests against police brutality and brought to the forefront difficult conversations regarding racism considered prevalent in all aspects of American life. Racism particularly towards black women is prevalent in the pornography industry. Researcher Carolyn West, a domestic violence expert, has meticulously documented patterns of the demand for racist pornographic content including black women being portrayed in ghetto environments, being raped by Klan members, accentuating stereotypes of the black female body, and animalizing black women (10). Practitioners need to be aware that

pornography exploits and profits from deep-set racists' ideologies. The pornography industry needs to be held accountable for its racist stereotypical content and treatment of black men and women and the negative consequences it has on its users and industry workers.

Conclusion

PAs are uniquely placed in their employment settings where screening for individuals addicted to pornography, along with all other addictive substances, are encountered and have a responsibility to unite and stand against unregulated pornography access. It is time to hold the sex entertainment industry accountable for imposing unsolicited pornography upon unsuspecting internet users. We encourage all PAs to be a vital part of the future to end this infringement on our unsuspecting, unsolicited internet environment.

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2021-D-01 – Adopted as Amended

Amend policy HP-3100.2.1 as follows:

PAs practice PATIENT-CENTERED, TEAM-BASED medicine ~~**in teams**~~ with **physicians and** other healthcare professionals.

2021-D-02 – Adopted as Amended by Deletion

Amend policy HP-3400.1.1 as follows:

~~It is the obligation of each PA to ensure that:~~

- ~~The individual PA's scope of practice is broadly identified;~~
- ~~The scope is appropriate to the individual PA's level of training and experience;~~
- ~~Access to the collaborating physician is defined;~~
- ~~A process for collaboration is established DEFINED AT THE PRACTICE LEVEL.~~

~~AAPA is committed to the concept of team-based collaborative practice between the PA and physician to achieve the highest level of quality, cost effective care for patients and continued professional growth and lifelong learning. IT IS THE OBLIGATION OF EACH PA TO ENSURE THAT THE INDIVIDUAL SCOPE OF PRACTICE IS APPROPRIATE TO THE PA'S LEVEL OF EDUCATION, TRAINING AND EXPERIENCE.~~

2021-D-03 – Adopted as Amended

The HOD encourages the AAPA to form a task force to review practiceS ~~models and team ratios that~~ impactING how physicians, PAs and NPs work together in teams with the goal of creating BEST PRACTICE RECOMMENDATIONS ~~tools and/or guidelines~~ that inform how teams can be formed efficiently to meet the needs of patients AND OPTIMIZE PRACTICE.

2021-D-04 – Adopted

Amend policy HX-4600.3.1 as follows:

AAPA believes that PAS ~~health plans, payers and provider networks~~ should BE listED ~~PAs~~ in the~~ir~~ provider directories OF ALL PUBLIC AND COMMERCIAL PAYERS, HEALTH PLANS AND PROVIDER NETWORKS~~. PAs should be specifically included on the list of providers~~ to allow patients the option of ~~seeking~~ SELECTING care from a

PA. PAS SHOULD BE ELIGIBLE TO SELF-SELECT THE SPECIALTY IN WHICH THEY PRACTICE FOR DESIGNATION IN PROVIDER DIRECTORIES.

2021-D-05 – Referred

Amend policy HP-3100.2.3 as follows:

AAPA opposes any regulations, guidelines or payment policies that differentiate between PAs on the basis of length of educational program or academic credentials granted if those PAs otherwise meet all criteria for ~~fellow~~ membership in the Academy.

2021-D-06 – Adopted as Amended

AAPA supports the right of PAs ~~nationwide~~ to ~~provide business innovation, leadership and prosperity without regulation or restriction related to the~~ BE SOLE OWNERS, FORM ~~ownership,~~ partnershipS, or OTHERWISE HAVE AN OWNERSHIP INTEREST ~~investment~~ IN ANY CORPORATION AUTHORIZED BY STATE LAW TO PROVIDE PROFESSIONAL OR HEALTHCARE SERVICES. ~~in business organizations.~~

FURTHER, 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.

2021-D-07 – Adopted on Consent Agenda

Amend policy HX-4600.3.5 as follows:

AAPA recognizes the BURDEN CREATED BY shortageS of healthcare services in the United States ~~and its expected impact on the quality, availability, and cost of healthcare in this country~~. 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. ~~this issue nationally and to increasing the importance of this issue on the policy agenda at all levels of government and in the private sector.~~ AAPA supports efforts that promote ~~and foster creative~~ solutions to healthcare shortages AND EXPAND ~~that include expansion and~~ access to CARE PROVIDED BY PAS. ~~physician-PA teams to meet anticipated requirements for healthcare services.~~

2021-D-08 – Expired

Expire policy HP-3300.2.6.

AAPA encourages its membership to seek positions with the National Health Service Corps to help meet the health needs of medically underserved areas.

2021-D-09 – Adopted on Consent Agenda

Amend policy HP-3500.3.1 as follows:

AAPA ~~believes that regulations governing the federal~~ SUPPORTS THE CONTINUATION OF THE CERTIFIED R~~r~~ural H~~h~~ealth C~~e~~linics (RHCS) program TO IMPROVE ACCESS TO CARE IN RURAL MEDICALLY UNDERSERVED AREAS. ~~should permit PAs to function as employees, owners, or independent contractors.~~ CERTIFIED RHCS program regulations should be flexible and rational, allowing certified ~~rural health clinics~~ RHCS to ~~address ongoing changes in the healthcare market~~ 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.

2021-D-10 – Referred

Amend by substitution the policy paper entitled *The PA in Disaster Response: Core Guidelines*.

The PA in Disaster Response: Core Guidelines

Executive Summary of Policy Contained in this Paper

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

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

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

Introduction

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

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

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

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

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

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

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

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

The emergency management community is faced with constant changes, such as demographic shifts, technology advances, environmental changes and economic

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

One of the major areas of uncertainty surrounds the evolving needs of at-risk and special need 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 and encourages PA education programs to introduce this specialty area as part of their curriculum.

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

Preparation Through Education

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

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

1. Basic knowledge of the National Incident Management System's Incident Command System, along with local and state emergency services and management.
2. Recognize the importance of safety in disaster response situations, including protective equipment, decontamination and site security.
3. Have a working knowledge of the principles of triage in a disaster setting.
    a. Do the greatest good for the greatest number and maximize survival.

4. Learn how to develop the clinical competence to provide effective care with extremely limited resources.
    a. Maintain certifications in: BLS, ACLS, and PALS
    b. Additional recommended specialty trainings in: Advanced Disaster Life Support, Advanced Trauma Life Support, Advanced Disaster Medical Response, and International Trauma Life Support.
    c. Prepare and take the National healthcare Disaster Certification (NHDP-BC) offered by the American Nurses Credentialing center (ANCC) or equivalent certification examination
    d. Stay up to date with ever-changing disaster medical information from various AAPA-approved web sites like the Centers for Disease Control (CDC), National Disaster Medical Systems (NDMS), National Incidence Management System (NIMS), Health and Human Services (HHS), Federal Emergency Management Administration (FEMA), and others.
5. Learn how to prescribe treatment plans along with an understanding of psychological first aid and caring for patients and responders during and after mass casualty events.
6. Understand the ethical and legal issues in disaster response for PAs. These include:
    a. Their professional and moral responsibility to treat victims
    b. Their rights and responsibilities to protect themselves from harm
    c. Issues surrounding their responsibilities and rights as volunteers
    d. Associated liability issues.
7. Always keep the protection of public health as a professional core responsibility, regardless of education or training.

Credentials and Roles

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

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

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

arm? Insert an emergency chest tube? Participants should discuss these kinds of issues as their team begins working together. (2)

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

State Laws/Federal Exemptions

In some cases, governors waive state licensure requirements during disasters, but this is not always the case. In the aftermath of Hurricane Katrina in 2005, the governors of Louisiana and Missouri waived licensure requirements for all healthcare professionals for a period of time, but the governors of Texas and Mississippi did not. Texas and Mississippi streamlined their application processes, but still required licensure by their state boards. PAs should not assume that disaster response organizations either understand or ensure compliance with licensure requirements. PAs should research the steps necessary to practice in the affected area before assisting with domestic response initiatives. PAs should also keep in mind that Good Samaritan laws do not provide either authorization to practice or, in most cases, liability protection when they are working in disaster relief situations.

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

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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
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- Healthcare, including preventive and surveillance measures.

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

Nutrition monitoring is also essential to the health of disaster survivors. Malnutrition can be the most serious public health problem caused by a disaster and may be a leading cause of death from it, whether directly or indirectly. Food aid has an immediate impact on human health and survival and, while it may not be a formal part of a medical team's role, the need for adequate nutrition reinforces the importance of coordinated disaster response.

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

Standards for Crisis Care

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

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

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

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

disasters should be able to return quickly to either a conventional or contingency level of care once the restricted resources are resupplied.

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

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

Guidelines for PAs Responding to Disasters

1. PAs should participate in disaster relief through established channels
    a. Consider joining non-governmental organizations, government agencies, State Medical Assistance Teams, Disaster Medical Assistance Teams, CERT (Citizens Emergency Response Team) or other organized groups with a focus in providing disaster services. AAPA's Disaster Medicine Association of PAs can help provide direction as well.
    b. Participate in workplace disaster planning.
    c. Stay current with information from reliable resources.
    d. Make every effort not to become a victim of the event or to cause harm to others.
2. PAs should support comprehensive, team-based healthcare.
    a. Become proficient in the National Incident Management System's Incident Command System.
    b. Learn to be flexible in working in unfamiliar places and circumstances – many times you have to become comfortable with "hurry up and wait" scenarios.
3. PAs should prepare for and expect the possibility of coping with scarce medical resources and nonmedical assignment in disaster situations.
    a. Participate in local disaster planning events.
    b. Participate in various webinars, table top drills, etc.…
    c. Bookmark federal and state websites that have an abundance of current information for medical providers, which might include:
        i. Centers for Disease Control (CDC)
        ii. Federal Emergency Management Agency (FEMA)
        iii. Department of Homeland Security (DHS)
        iv. Health and Human Resources (HHS)
        v. State Medical Assistance Team (SMAT)

4. PAs should be prepared to provide documentation of their qualifications at any disaster site.
    a. Always have access to a portable file containing hard copies 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 sensitivity when working with all populations.

Principles of Disaster Triage:

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

Summary

AAPA endorses and promotes the support of disaster preparedness 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.

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~~The PA in Disaster Response: Core Guidelines~~

~~(Adopted 2006, amended 2010, 2015)~~

~~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.~~
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- AAPA supports the imposition of criminal and civil sanctions on those providers who intentionally and recklessly disregard public health guidelines during federal, state or local emergencies and public health crises.

Introduction

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

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

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

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

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

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

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

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

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

very difficult and challenging environments for all healthcare providers, especially those with little background or experience in disaster medicine.

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

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

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

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

Preparation Through Education

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

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

1. Basic knowledge of the National Incident Management System's Incident Command System, along with local and state emergency services and management.
2. Recognize the importance of safety in disaster response situations, including protective equipment, decontamination and site security.
3. Have a working knowledge of the principles of triage in a disaster setting.
    a. Do the greatest good for the greatest number and maximize survival.
4. Learn how to develop the clinical competence to provide effective care with extremely limited resources.
    a. Maintain certifications in BLS, ACLS, and PALS, and, if possible, specialty training such as Advanced Disaster Life Support, Advanced Trauma Life Support, and Advanced Disaster Medical Response.

b. Stay up to date with ever-changing disaster medical information from various AAPA-approved websites like the Centers for Disease Control (CDC), National Disaster Medical Systems (NDMS), National Incidence Management System (NIMS), Health and Human Services (HHS), Federal Emergency Management Administration (FEMA), and others.

5. Learn how to prescribe treatment plans along with an understanding of psychological first aid and caring for patients and responders during and after mass casualty events.

6. Understand the ethical and legal issues in disaster response for PAs. These include:

a. Their professional and moral responsibility to treat victims

b. Their rights and responsibilities to protect themselves from harm

c. Issues surrounding their responsibilities and rights as volunteers

d. Associated liability issues.

7. Always keep the protection of public health as a professional core responsibility, regardless of education or training.

Credentials and Roles

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

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

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

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

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

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

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

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

Guidelines for PAs Responding to Disasters

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

Principles of Disaster Triage:

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

Summary

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

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

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

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Resources

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2021-D-11 – Adopted as Amended

Amend by substitution the policy paper entitled *Telemedicine*.

Telemedicine

(Adopted 2015)

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 ~~AAPA ENCOURAGES~~ 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 ENCOURAGES 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 ASSISTANTS) 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 HEALTH CARE 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 COVID-19, FOR EXAMPLE, HAVE UNDERSCORED THE CRITICAL NEED FOR EVOLVING APPROACHES TO LICENSURE, INCLUSIVE OF RECIPROCITY PROVISIONS OR LICENSE PORTABILITY, TO STREAMLINE DEPLOYMENT AND FLEXIBILITY OF CLINICIANS VIA REMOTE MEANS. THEREFORE, AAPA SUPPORTS STATES COLLABORATING TO INCREASE LICENSE PORTABILITY. THE ESTABLISHMENT OF INTERSTATE LICENSE PORTABILITY[6] WOULD ALLOW A PA TO HOLD A LICENSE TO PRACTICE MEDICINE IN ONE STATE, WHICH IN TURN FACILITATES LICENSURE OR PRIVILEGE TO PRACTICE IN OTHER STATES. RECIPROCAL LICENSURE ARRANGEMENTS, LICENSE PORTABILITY, AND MULTISTATE COMPACTS REDUCE BARRIERS TO HEALTHCARE SERVICES FOR ALL PATIENTS.[6] PAS ARE RESPONSIBLE FOR KNOWING THE REQUIREMENTS GOVERNING THE PRACTICE OF TELEMEDICINE IN THE STATE WHERE THE PATIENT RESIDES WHEN PROVIDING CARE WITH TELEMEDICINE. PATIENTS SHOULD HAVE THE ABILITY TO SEEK REDRESS IN THEIR STATE AGAINST ANY HEALTHCARE

LICENSEE. FOR THIS REASON, ANY LICENSURE SYSTEM MUST PROVIDE APPROPRIATE PATIENT PROTECTION AND ACCESS.

EDUCATION

MODERN MEDICAL EDUCATION OF THE PA STUDENT SHOULD INCLUDE NEW OR AUGMENTED CURRICULUM ON TELEMEDICINE. THE AMERICAN TELEMEDICINE ASSOCIATION HAS DEVELOPED SPECIFIC GUIDELINES[7] FOR EDUCATING PHYSICIANS. PARTNERING WITH THE AMERICAN TELEMEDICINE ASSOCIATION OR USING THESE GUIDELINES ARE TWO OPTIONS FOR DEVELOPING COMPREHENSIVE TELEMEDICINE EDUCATION FOR PA STUDENTS.

ESTABLISHING A PROVIDER-PATIENT RELATIONSHIP

A PROVIDER-PATIENT RELATIONSHIP IS FUNDAMENTAL TO THE DELIVERY OF QUALITY HEALTHCARE SERVICES. A PA USING TELEMEDICINE TECHNOLOGIES WHEN PROVIDING MEDICAL SERVICES MUST TAKE APPROPRIATE STEPS TO ESTABLISH A PROVIDER-PATIENT RELATIONSHIP. ESTABLISHING A PROVIDER-PATIENT RELATIONSHIP, BUILT ON TRUST AND COMMUNICATION, USING TELEMEDICINE TECHNOLOGIES PRESENTS UNIQUE CHALLENGES AND DEMANDS A CLINICIAN DEVELOP THEIR WEBSIDE MANNER - NOTABLY DIFFERENT THAN THE TRADITIONAL CONCEPT OF BEDSIDE MANNER. EFFECTIVE COMMUNICATION WHILE OBTAINING A MEDICAL HISTORY, DEVELOPING A TREATMENT PLAN, AND DESCRIBING RISKS, BENEFITS, AND THE PLAN OF CARE SHOULD INCREASE PATIENT TRUST IN THE PROVIDER WHEN CARE IS DELIVERED VIA REMOTE MEANS. THE PA WILL CONDUCT ALL EVALUATIONS AND HISTORY OF THE PATIENT CONSISTENT WITH PREVAILING STANDARDS OF CARE SPECIFIC TO THE INDIVIDUAL PATIENT PRESENTATION. THE PA IS EXPECTED TO RECOMMEND APPROPRIATE FOLLOW-UP CARE AND MAINTAIN COMPLETE AND ACCURATE HEALTH RECORDS. THE PROVIDER-PATIENT RELATIONSHIP MAY BE FORMED VIA TELEMEDICINE ACCORDING TO THE PA'S PROFESSIONAL JUDGMENT AS APPROPRIATE TO THE PATIENT PRESENTATION AND APPLICABLE STATE LAWS. THE USE OF TELEMEDICINE TECHNOLOGIES, AS WELL AS THE METHOD FOR ESTABLISHING THE PROVIDER-PATIENT RELATIONSHIP, SHOULD BE LEFT TO THE PA'S PROFESSIONAL JUDGMENT.

PATIENT DISCLOSURES AND CONSENT TO TREATMENT

THE GENERAL CONSENT TO TREATMENT, APPLICABLE TO SIMILAR SERVICES PROVIDED IN-PERSON, SHOULD INCLUDE AT MINIMUM THE FOLLOWING:

- TYPES OF TRANSMISSIONS PERMITTED USING TELEMEDICINE TECHNOLOGIES (E.G., PRESCRIPTION REFILLS, APPOINTMENT SCHEDULING, PATIENT EDUCATION, ETC.)
- PATIENT'S UNDERSTANDING THAT THE PA DETERMINES IF THE CONDITION BEING DIAGNOSED OR TREATED IS APPROPRIATE FOR A TELEMEDICINE ENCOUNTER
- DETAILS ON SECURITY MEASURES, AS WELL AS POTENTIAL RISKS TO PRIVACY, WITH THE USE OF TELEMEDICINE TECHNOLOGIES, PROVIDED TO THE PATIENT

- EXPRESS PATIENT CONSENT FOR FORWARDING PATIENT-IDENTIFIABLE INFORMATION TO THIRD PARTIES AS APPROPRIATE

ALL TELEMEDICINE ENCOUNTERS, FOLLOWING GENERAL CONSENT, MUST INCLUDE IDENTIFICATION AND VERIFICATION OF THE PATIENT, THE PA, AND THE PA'S CREDENTIALS.

EVALUATION AND TREATMENT OF THE PATIENT

THE DELIVERY OF TELEMEDICINE SERVICES FOLLOWS EVIDENCE-BASED PRACTICE GUIDELINES TO ENSURE PATIENT SAFETY, QUALITY OF CARE, AND POSITIVE HEALTH OUTCOMES. TELEMEDICINE SERVICES ARE CONSISTENT WITH THE SCOPE OF PRACTICE LAWS AND REGULATIONS OF THE STATE WHERE THE PATIENT IS LOCATED. STANDARD OF CARE IN TELEMEDICINE IS THE SAME AS WHEN CARE IS RENDERED IN PERSON.

CONTINUITY OF CARE

THE PROVISION OF TELEMEDICINE SERVICES INCLUDES CARE COORDINATION WITH THE PATIENT'S MEDICAL HOME AND/OR EXISTING TREATING PROVIDER(S). THE TELEMEDICINE PROVIDER SHOULD MAKE EVERY EFFORT TO SECURE A MEDICAL HOME OR PRIMARY PROVIDER WHEN ONE DOES NOT EXIST. PATIENTS SHOULD BE ABLE TO SEEK FOLLOW-UP CARE OR INFORMATION FROM THE RENDERING PROVIDER. PAS PRACTICING TELEMEDICINE MUST MAKE MEDICAL RECORDS ASSOCIATED WITH TELEMEDICINE ENCOUNTERS AVAILABLE TO THE PATIENT, AND SUBJECT TO THE PATIENT'S CONSENT, ANY IDENTIFIED CARE PROVIDER OF THE PATIENT WITHIN A REASONABLE AMOUNT OF TIME AFTER THE ENCOUNTER.

FURTHER, THE PROVISION OF CARE VIA TELEMEDICINE MAY NECESSITATE REFERRAL TO SERVICES EXTERNAL TO A PA’S PRACTICE SETTING. PRACTICE IN A TELEMEDICINE ENVIRONMENT MAY IMPACT A CLINICIAN'S KNOWLEDGE AND FAMILIARITY WITH REFERRAL NETWORKS AND AFFILIATIONS LOCAL TO THE PATIENT'S GEOGRAPHY. WHEN UTILIZING TELEMEDICINE AS A COMPLEMENT TO CARE, SUCH AS IN AN INTEGRATED PRIMARY CARE SETTING, A PA MAY ALREADY BE FAMILIAR WITH BEST PRACTICES REGARDING REFERRAL TO SERVICES EXTERNAL TO THEIR CARE SETTING. HOWEVER, IN SUCH SETTINGS WHERE THE PA MAY BE LESS FAMILIAR, IN PARTICULAR SETTINGS SUCH AS DIRECT-TO-CONSUMER (DTC) TELEMEDICINE, THE SAME STANDARDS FOR REFERRAL SHOULD APPLY AS THOSE FOUND IN AN URGENT OR EMERGENCY CARE. ORGANIZATIONS AND CLINICIANS ARE ENCOURAGED TO DEFINE GUIDANCE REGARDING REFERRAL TO EXTERNAL CLINICAL SERVICES, INCLUDING THE EXTENT TO WHICH THEY ARE INVOLVED IN COORDINATING CARE ON BEHALF OF THE PATIENT. THIS GUIDANCE SHOULD CLARIFY TO BOTH CLINICIANS AND PATIENTS THE MEANS TO SUPPORT APPROPRIATE CONTINUITY OF CARE ALIGNED TO THE ORGANIZATION'S CLINICAL SCOPE, THOUGH IS NOT INTENDED TO OBLIGATE AN ORGANIZATION TO ENSURE CONTINUITY IS ACHIEVED ON BEHALF OF THE PATIENT.

REFERRALS FOR EMERGENCY SERVICES

IN THE NORMAL COURSE OF TELEMEDICINE, REFERRAL TO ACUTE

OR EMERGENCY SERVICES MAY BE NECESSARY. A PROVIDER OR PROVIDER SYSTEM SHOULD ESTABLISH PROTOCOLS AND/OR RECOMMENDATIONS FOR REFERRAL TO SUCH SERVICES. THE PA IS ENCOURAGED TO COMMUNICATE WITH THE ACUTE CARE OR EMERGENCY ROOM FACILITY WHEN POSSIBLE FOR CONTINUITY OF CARE AND AS DICTATED BY THEIR PROFESSIONAL DISCRETION. AN EMERGENCY PLAN IS REQUIRED AND MUST BE PROVIDED BY THE PA TO THE PATIENT WHEN THE CARE PROVIDED VIA TELEMEDICINE INDICATES A REFERRAL TO AN ACUTE CARE FACILITY OR EMERGENCY ROOM IS NECESSARY.

MEDICAL RECORDS AND PATIENT CONFIDENTIALITY

THE PATIENT RECORD ESTABLISHED DURING THE PROVISION OF TELEMEDICINE SERVICES MUST BE SECURE, ENCRYPTED, COMPLETE, AND ACCESSIBLE. ACCESS TO AND MAINTENANCE OF PATIENT RECORDS MUST BE CONSISTENT WITH ALL ESTABLISHED STATE AND FEDERAL LAWS AND REGULATIONS GOVERNING PATIENT HEALTHCARE RECORDS.

LIABILITY COVERAGE

AAPA ENCOURAGES PAS TO VERIFY THAT THEIR MEDICAL LIABILITY INSURANCE POLICY COVERS TELEMEDICINE SERVICES, IN PARTICULAR, TELEMEDICINE SERVICES PROVIDED ACROSS STATE LINES BEFORE THE DELIVERY OF ANY TELEMEDICINE SERVICE. AAPA ENCOURAGES MEDICAL LIABILITY INSURERS TO UTILIZE "BASE RATE STRATIFICATION" ON OUTCOME DATA RATHER THAN "PERCEIVED RISK" TO AVOID AN UNNECESSARILY HIGH FINANCIAL BURDEN ON PAS WANTING TO PROVIDE PATIENT CARE VIA TELEMEDICINE.

REIMBURSEMENT

PAYMENT FOR TELEMEDICINE SERVICES SHOULD BE EQUITABLE AND BASED ON THE SERVICE PROVIDED. AAPA SUPPORTS PAYMENT PARITY FOR SERVICES RENDERED, WHETHER IN PERSON OR REMOTE. ALTERNATIVE PAYMENT MODELS, SUCH AS VALUE-BASED PAYMENTS, MAY BE FURTHER EXPLORED AND UTILIZED TO POTENTIATE THE BENEFITS OF TELEMEDICINE SERVICES.[8]

CONTINUING MEDICAL EDUCATION

AAPA SUPPORTS THE DEVELOPMENT OF EDUCATIONAL OPPORTUNITIES RELATED TO THE PROVISION OF TELEMEDICINE. AAPA IS OPPOSED TO REQUIREMENTS FOR EXAMINATION, CERTIFICATION, OR MANDATORY CME REQUIREMENTS TO PROVIDE TELEMEDICINE SERVICES.

CONCLUSION

THE UNITED STATES ~~OUR COUNTRY~~ 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 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 ~~INVOLVING~~ TO INCLUDE~~D~~ ACCESS TO AND ~~THE~~ DELIVERY OF HEALTHCARE SERVICES BY PAS AS WELL AS ENSURING TELEMEDICINE EDUCATIONAL OPPORTUNITIES FOR PA STUDENTS. AAPA ENCOURAGES BOTH THE PHYSICIAN ASSISTANT EDUCATION ASSOCIATION (PAEA) AND ACCREDITATION REVIEW COMMISSION ON EDUCATION FOR THE PHYSICIAN ASSISTANT, INC. (ARC-PA) TO PROMOTE ~~AND EDUCATE~~ 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.

~~OUR NATION~~ THE U.S. AND OUR HEALTHCARE SYSTEM-AT-LARGE FACE UNIQUE AND SIGNIFICANT CHALLENGES. THE NATIONAL COVID-19 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 COVID-19, 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.

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~~Telemedicine~~

~~(Adopted 2015)~~

~~Introduction~~

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

~~PAs are essential members of the healthcare team. It is critical that PAs remain in the forefront of this emerging trend, and that AAPA be fully engaged in ensuring the ability of PAs to practice fully. The growth in the use of telemedicine represents both a~~

significant opportunity for the advancement of the PA profession, but also holds an important risk. If the practice of telemedicine fails to: 1) allow for the efficient utilization of PAs, and/or 2) recognize PA contributions to the healthcare system; the profession will be at a distinct disadvantage as the healthcare system continues to evolve.

AAPA must provide guidance to PAs wishing to engage in the practice of medicine via telemedicine technologies. Other healthcare professional organizations, such as American Medical Association and Federation of State Medical Boards, have put forward similar proposals.

Telemedicine Definition

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

Licensure

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

Establishing a Provider-Patient Relationship

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

professional judgment and as appropriate to the case-specific patient presentation. Understanding that the appropriateness of the use of telemedicine technologies can be specialty specific, and to a greater extent case-specific, the appropriateness of the use of telemedicine technologies and the method for establishing the provider-patient relationship should be left to the individual PA's professional judgment.

Patient Disclosures and Consent to Treatment

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

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

Evaluation and Treatment of the Patient

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

Continuity of Care

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

Referrals for Emergency Services

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

Medical Records and Patient Confidentiality

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

Liability Coverage

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

Reimbursement

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

Continuing Medical Education (CME)

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

Conclusion

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

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

~~ethics. PAs must always place the welfare of the patient first, with the highest value placed on quality of care, maintenance of appropriate standards of practice, and adhering to the ethical standards of the profession.~~

2021-D-12 – Adopted as Amended

Amend by substitution the policy paper entitled *Quality Incentive Programs*.

Quality Incentive Programs

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 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 health care professionals.
- AAPA supports patient-centered efforts, such as appropriately developed and implemented quality incentive programs, to improve health outcomes and reduce unnecessary and duplicative health care 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 HEALTH CARE 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 patient are with the care received and focus on patient outcomes and quality. Incentives provided to health providers (health professionals and facilities) are the focus of this paper.

Many incentives used to modify the behavior of providers are financial in nature. Other components of incentive programs may seek to rate or compare one provider to another with the idea that patients and payers will select and utilize the highest-rated provider.

Incentives are often formalized under official programs that adjust the level of reimbursement dependent on a provider's ability to meet metrics for a desired change or improvement. One method is the promise of monetary reward for a desired behavior or outcome, known as one-sided risk. Another method is the use of both monetary reward for meeting goals, as well as financial penalties for failure to meet such goals, commonly referred to as two-sided risk. Incentive programs frequently persuade providers to begin their participation using one-sided risk before elevating the stakes to a two-sided risk approach which offers both greater rewards and greater risk.

Metrics and goals may be established by comparing health professionals or hospitals/facilities to one another on the bases of quality, outcomes, price, patient satisfaction or other metrics established by public health authorities or payers.

To date, data regarding the effectiveness of various incentive programs in producing positive outcomes is incomplete, mixed, or not well understood. For this reason, a diverse array of programs has been and continues to be developed to improve incentives to optimally modify behavior.

Examples of Provider Incentive Programs

Incentives in healthcare are not new, but they are evolving. Below are some examples of current provider incentive programs.

The Quality Payment Program (QPP)

Established by the Medicare Access and CHIP Reauthorization Act, the QPP combines various prior Medicare quality and value programs (the PQRS, value-based modifier, meaningful use) into one. The QPP replaced disparate incentive concepts with one program that focuses on incentivizing value (both an increase in quality and a decrease in costs), as well as appropriate use of electronic health record technology and continued improvement. This program, which consists of two tracks, the Merit-based Incentive Payment System and Advanced Alternative Payment Models, uses both financial reward and risk. The QPP strives to achieve benefits for multiple stakeholders, including financial benefits for high-performing health professionals, increased results with no additional cost for Medicare, and better care received by patients.

Care Models

Much like states can be "laboratories of democracy," new and innovative care models can be pilot reimbursement arrangements intended to test numerous incentive methods to see what works for potential future expansion or replication. Various payment models seek to provide increased flexibility to provide care in a more effective manner or seek to reduce redundant or inefficient services. Examples of care models include accountable care organizations and the use of bundled payments, both of which incentivize specified levels of quality in care at target costs. These care models have been promoted and tracked by the Center for Medicare and Medicaid Innovation.

PAs and Incentive Programs

Incentive models which seek to reduce cost while maintaining high-quality care will increasingly recognize the benefit of utilizing PAs due to the enhanced value PAs present (lower cost of employment versus the high level of productivity).

However, PAs have concerns regarding potential shortcomings in the implementation of incentive programs, as program design may cause exclusionary practices or disadvantage those PAs that do participate. AAPA recommends the following steps to ensure optimal program design for PA participation:

- The role and function of PAs should be specifically considered in the design process of any incentive program.
- There must be no prohibition of the participation of PAs in incentive programs. Occasionally, physician-centric language is used in verbiage when detailing the guidelines of incentive programs. As PAs (and advanced practice registered nurses) are a significant component of the healthcare delivery workforce, it is essential that they be formally incorporated into incentive programs.
- Steps must be taken to address the detrimental effect of inaccurate and incomplete data. Incentive programs must rely on accurate, actionable data for incentives to

be effective. Serious data accuracy problems occur with incentive programs that rely on inaccurate information such as requiring or allowing services delivered by PAs to be billed/reported as being provided by physicians with whom the PA works. Only with proper attribution can health professionals receive incentives reflective of the care they provide. In addition to the incentive program seeking to make accurate assessments, the results of incentive programs are frequently made public on an individual health professional level by identifying a professional's volume and quality of care. These results are then used by patients to make care delivery decisions. Without accurate data, information would be incomplete for both the program and patients.

Incentives, both financial and non-financial, if properly designed and using accurate data, can be effective methods to meet health goals by motivating and encouraging certain types of behavior and activities by providers. AAPA supports incentive programs that 1) incorporate the PA perspective; 2) include PAs as full participants; 3) are clinically relevant and appropriate; 4) do not harm health care 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.

Quality Incentive Programs

~~(Adopted 2005, reaffirmed 2010, 2015)~~

~~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 (and health providers) should always have the long term goal of improving health broadly~~
- ~~PAs and other health professionals should be involved in their creation in order to help avoid unintended consequences.~~
- ~~Health information systems are needed to improve quality through the collection and analysis of performance data.~~
- ~~Assessment and evaluation quality and efficiency will be critical to the success quality improvement programs~~
- ~~AAPA encourages continued efforts to promote improvements in patient care~~
- ~~AAPA supports the development of quality incentive programs, often referred to as "pay for performance~~
- ~~Quality incentives should be based upon achievement of evidence-based clinical benchmarks, patient satisfaction and the adoption of health information technology~~
- ~~In addition, AAPA believes that quality incentive programs should include key principles~~

~~Introduction~~

~~The United States spends more than any other nation on healthcare—well over twice the per capita average among industrialized nations. Health expenditures have grown from $1.3 trillion in 2000 to $1.7 trillion in 2003, and the portion of gross domestic product consumed by the health sector over that period has increased from 13.3~~

~~percent to 15.3 percent. According to estimates by the Centers for Medicare and Medicaid Services (CMS) by 2014, total health spending will constitute 18.7 percent of gross domestic product.~~

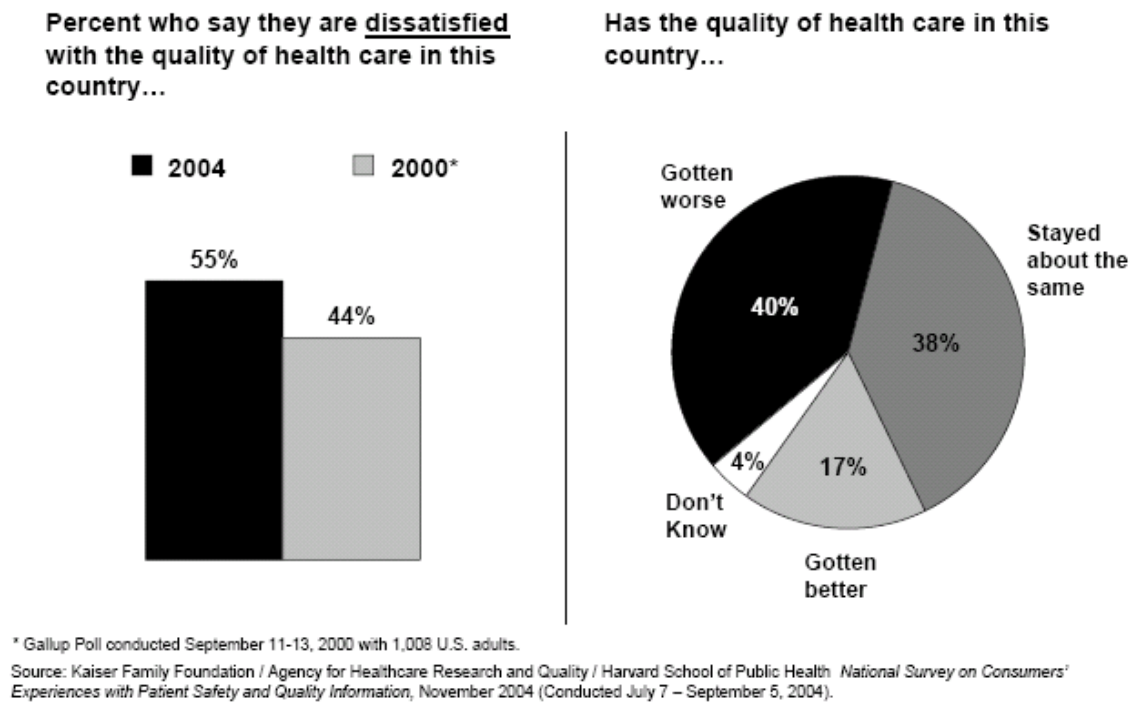
~~In 1999, the Institute of Medicine (IOM) released its landmark report *To Err is Human: Building a Safer Healthcare System*. The report concluded that hospital-based medical errors were a significant cause of morbidity and mortality in the U.S. Most importantly was its conclusion that the primary cause was problems with the healthcare system rather than with the performance of individual providers. Since the report was published the Agency for Healthcare Research and Quality (AHRQ) has funded $139 million for more than 100 multi-year demonstration projects. Despite the funding on patient safety research and efforts by hospitals, health plans, purchasers and providers to reduce medical errors and improve the quality care there is little evidence that quality is improving.~~

~~Recent efforts to manage resource utilization have done little to slow the rate of healthcare expenditures. Current payment methods give little incentive to improve the quality of care.~~

~~*"Even among health professionals motivated to provide the best care possible, the structure of payment incentives may not facilitate the actions needed to systematically improve the quality of care, and may even prevent such actions"*~~

~~This is according to the Institute of Medicine's 2001 report *Crossing the Quality Chasm: a New Health System for the 21st Century*. In addition, the report identified six domains in which health systems should focus: Care should be timely, safe, efficient, effective, patient-centered and equitable.~~

~~A 2004 survey by the Henry J. Kaiser Family Foundation, AHRQ, and the Harvard School of Public Health found that nearly half of U.S. residents surveyed say they are concerned about the safety of medical care. More than half (55%) say they are dissatisfied with the quality of healthcare in this country, an increase from the 44% who reported dissatisfaction in a 2000 survey. More than twice as many people feel healthcare quality has gotten worse than say it has improved. (See figures below)~~



* Gallup Poll conducted September 11-13, 2000 with 1,008 U.S. adults.

Source: Kaiser Family Foundation / Agency for Healthcare Research and Quality / Harvard School of Public Health *National Survey on Consumers' Experiences with Patient Safety and Quality Information*, November 2004 (Conducted July 7 – September 5, 2004).

~~In summary, previous attempts to manage costs, improve safety, and increase patient satisfaction in the U.S. healthcare system have been largely unsuccessful. The emphasis on managed care and utilization management resulted in few true improvements in efficiency and no benefit to patients. Current reforms to the healthcare system are being driven by a number of factors. Recent data continue to reveal significant prevalence of avoidable medical errors and disparities in the quality of care delivered. Many healthcare institutions and providers do not always comply with current accepted standards for the prevention, diagnosis, and management of disease. At the same time, healthcare costs are high and rising, with little correlation to improvements in quality or patient outcomes. Therefore, payers and patients are demanding higher quality healthcare, increased value for the resources spent, and better health outcomes.~~

~~Growth of Quality Incentive Programs~~

~~Quality incentive programs, known by various terms such as "pay-for-performance" or "pay-for-quality," are a recent effort by healthcare purchasers - the government, health plans, and employers - to align healthcare provider incentives with quality improvement processes and outcomes. All programs share the goal of offering incentives to healthcare providers to attain and report higher levels of care quality or patient service. Defining quality has been problematic. In 1984, the IOM had noted that there were 100 definitions of quality. It ultimately adopted this definition of quality and considered health outcomes to be the health status of a person or population in terms of death, disability, disease, dissatisfaction, delays and dollars spent.~~

~~*"Quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."*~~

~~Over the years quality improvement efforts have attempted several methods to improve the quality of care including:~~

- ~~Requirements for continuing medical education~~

- ~~Development of clinical practice guidelines~~
- ~~Use of benchmarking and sharing performance data with providers~~
- ~~Integration of new information and decision support systems~~
- ~~Certification and credentialing of providers~~

~~While some of these methods have been shown to improve quality, most in and of themselves have not.~~

~~The failure of other efforts to induce better quality has led to new initiatives focused on using incentives to encourage providers to deliver higher quality care. Quality incentive programs use a mixture of methods to encourage higher quality by combining the use of performance measures, patient data collection, determination of performance targets or benchmarks, and a reward program for meeting or exceeding performance targets. The incentives may be financial or non-financial. The most common incentives include:~~

- ~~Quality bonuses~~
- ~~Reimbursement at risk~~
- ~~CME~~
- ~~Preferred tiering~~
- ~~Reputational incentives~~

~~Several healthcare purchasers and payers have implemented quality incentive programs. Two notable organizations supporting quality incentives are the Leapfrog Group and CMS. The Leapfrog Group is an initiative that began in 1998 when a group of large employers came together to discuss how they could work together to use the way they purchased healthcare to have an influence on its quality and affordability. The employers realized they were spending billions of dollars on healthcare for their employees with no way of assessing its quality or comparing healthcare providers. The 1999 IOM report on medical errors recommended that large employers provide more market reinforcement for the quality and safety of healthcare. Leapfrog members together spend $64 billion a year on healthcare for 34 million people.~~

~~The Leapfrog Group has encouraged rewarding providers to improve quality and safety. However, its best known contribution to quality incentive programs has been the development of its *Incentive and Rewards Compendium*. It currently lists 90 programs throughout the nation designed to incent and reward providers for improving quality and efficiency, or incenting consumers to choose high performing providers.~~

~~The Centers for Medicare and Medicaid Services, the largest federal purchaser of healthcare, has undertaken demonstration initiatives to pay healthcare providers for the quality of the care they provide to seniors and persons with disabilities. CMS will assess both quality performance and quality improvement under the demonstration. The quality measures that will be used focus on common chronic illnesses in the Medicare population, including congestive heart failure, coronary artery disease, diabetes mellitus, hypertension, as well as preventive services, such as influenza and pneumococcal pneumonia vaccines and breast cancer and colorectal cancer screenings. Under the demonstration, physician groups will continue to be paid on a fee-for-service basis. Physician groups will implement care management strategies designed to anticipate patient needs, prevent chronic disease complications and avoidable hospitalizations, and improve quality of care. Depending on how well these strategies work in improving quality and avoiding costly complications, physician groups will be eligible for performance payments.~~

CMS is conducting or developing additional programs that use incentive payments to further improve the quality of healthcare available to patients, including the following:

- The Hospital Quality Initiative in which nearly all hospitals in the U.S. are being paid higher rates for submitting data that reports on the level of recommended care provided and will include patient perspectives on the quality of care received;
- The Premier Hospital Quality Incentive demonstration, in which approximately 280 hospitals are being paid bonuses for achieving high performance in treating five clinical conditions;
- The Medicare Chronic Care Improvement Program, Medicare's first large-scale pay-for-performance program to reduce health risks for defined populations of chronically ill beneficiaries.

Overarching Criteria for Quality Incentive Programs

Quality incentive programs should have three overarching criteria. The incentives should be based upon achievement of evidence-based clinical benchmarks, high patient satisfaction and the adoption of health information technology.

Evidence-based benchmarks

Evidence-based clinical benchmarks for quality incentive programs should be based upon national standards as determined by independent professional societies, health quality organizations, and quality regulatory agencies. The source of quality measures is critical to an effective quality incentive program. Performance measures should be evidence-based, broadly accepted, and clinically relevant. Performance measures are often derived from clinical guidelines and quality measures developed by government agencies (e.g. Agency for Healthcare Research and Quality, National Institutes of Health, Centers for Disease Control and Prevention), health quality organizations (e.g. Joint Commission, Leapfrog Group, National Quality Forum, Health Watch) and professional medical societies (e.g. American Academy of Pediatrics, American College of Obstetrics and Gynecology, American Heart Association).

Patient satisfaction

Patient satisfaction is an integral element of quality incentive programs. Patient satisfaction measurement was most commonly used to evaluate service improvement efforts by hospitals and larger physician practices, fulfill accreditation requirements of health plans, and calculate financial incentives to providers. Quality incentive programs will place growing pressure on physicians and hospitals to increase the quality of their outcomes, enhance the safety of patients and lower the cost of care. Integration of patient satisfaction measurements into overall measures of clinical quality will play an important role in reinforcing accountability of health plans, institutions and practitioners to the patient.

Adoption of information technology

Quality incentive programs should encourage and reward adoption of information technology. Health information technology has tremendous potential to improve the quality of healthcare and facilitate data collection for quality incentive programs. Patient safety is improved through computerized order entry and electronic prescribing. Disease management benefits from electronic health records and clinical information systems. Electronic information allows administration of quality incentive programs to be cost-effective and efficient.

Provider resistance to using health information technology often originates from the cost of the technology, administrative disruptions to patient care, and the lack of standardization. Providers in solo or small practices, as well as those in less affluent locations are less likely to have access to information technology. Providers have been expected to bear the costs of information technology without a measurable return on investment. All participants in the healthcare system – providers, patients, and payers – benefit from the implementation of health information technology. Quality incentive programs can facilitate adoption of beneficial health information technology by providing resources and expertise to providers.

Key Principles for Quality Incentive Programs

PAs should support the development of quality incentive programs that are properly designed to increase the quality of patient care. AAPA believes quality incentive programs should have six key principles.

1. Focus on processes that lead to better patient outcomes

Optimal patient outcomes are the goal of quality incentive programs. However, clinical processes associated with better outcomes should be the most common focus of initial performance measurement efforts. Measures of process more accurately determine provider adherence to evidence-based clinical practice standards. Differences in patient populations, case-mix, and patient adherence will less easily distort clinical process measurement. The ultimate goal of performance measurement is to advance continuous quality improvement in the delivery of healthcare. In contrast to outcomes only measurement, measures of process are more suitable for use with continuous quality improvement process to achieve better patient care.

2. Foster the team approach to care

Quality incentive programs must recognize that the team approach to healthcare is essential to achieving the highest quality care. The complexity of today's healthcare environment and management of disease entities means no one person is able to effectively manage all aspects of patient care. The contributions of various healthcare professionals are especially necessary in the care of patients with chronic conditions. Improved coordination, consistency, safety, education, patient satisfaction, and health outcomes result from effective team practice. PAs can contribute their considerable experience in team practice to developers of quality incentive programs.

3. Offer voluntary practice participation

The goal of many quality incentive programs is to reward the highest performing providers over others. Ideally, programs will be designed to reward all high performers. Regardless of the design, participation should be voluntary. Quality incentive programs should not presume one design fits all practices. Payment systems should continue to reimburse providers whether or not they choose to report outcomes. Innovative quality incentive programs should encourage more practices to participate by helping to reduce administrative costs and assisting practices in adopting information technology. Practices which elect not to enroll in quality incentive programs should continue to strive to provide quality care in their patient populations.

4. Use reliable and accurate patient data

Quality incentive programs should use reliable and accurate patient data. Informative and useful performance measurement requires standards for reliability and accuracy. Data will reflect the care and health of patient populations. The selection of patient information to be measured must be relevant to the clinical practice of medicine

and patient care outcomes. Incentive programs are the most beneficial when they identify circumstances in which there is variation in optimal and current clinical practice, there is opportunity for significant improvement in patient outcomes, and a proven practice intervention exists to reduce the variation.

Healthcare providers should participate in the development of the measurement criteria to ensure that it is clinically relevant and reflects the actual clinical services provided. Actual patient records are more detailed and specific than other sources of information. However, other data sources may be used with caution and statistical validation. Patient privacy is a critical concern when extracting data from patient charts. Electronic health information systems will assist with more efficient and consistent collection.

5. Provide feasible and practical reporting

Quality incentive programs should provide feasible and practical reporting. Studies show that making performance information public appears to stimulate improvement activities. As the belief grows that public reporting and accountability are the best way to drive improvement in the quality of healthcare, providers and institutions will have to respond to numerous entities requiring data collection and reporting that use different methodologies, different specifications, and different approaches to how detailed measures should be. This could lead to a very burdensome need to customize measurement and reporting efforts. Providers, institutions and reporting agencies should work together to ensure that data collection is not unduly burdensome and does indeed reflect differences in quality.

6. Ensure programs are fair and equitable, accounting for differences in practice settings and population groups

Quality incentive programs should be designed to take into account the reality of disparities in healthcare. Organizations that provide care to medically underserved patients should have the same opportunity to achieve high quality scores and incentive bonuses as practices that provide care to the insured and wealthy. In order to ensure that quality incentive programs are fair and equitable, the necessary resources needed to initiate these programs should be provided to all organizations wanting to participate.

Impact on PAs

Most PAs believe they are providing the highest quality care they possibly can. However, there are many pressures on all clinicians to do more during patient visits. The healthcare system itself has created disincentives to provide the highest quality care. Preventable medical errors persist, and there are unexplained differences in health outcomes among different healthcare institutions and clinicians. There is also significant delay in widespread adoption of many clinical advances proven to deliver superior patient outcomes.

PAs should be expected to share in the benefits that quality incentives give to the practice. Whether this results in more staff, more visit time, or more resources, PAs should be able to take advantage of these incentives to improve the quality of care they deliver. Quality incentive programs will most likely measure and reward performance of practices, not individuals. A portion of provider reimbursement could be placed "at risk" through performance measurement. PAs play an important role in the improvement of their practice's patient care and quality performance. Quality incentive programs and PA employment agreements should reflect the PA's contribution to any financial and non-financial incentives.

Quality incentive programs will impact PA education and practice. Competency-based PA education will remain critical as well as training in evidence-based clinical practice. PAs will have to be proficient in the use of clinical information systems and other health information technology. Opportunities may arise as coordinators of disease management processes or quality improvement managers within their practice or institution. Increased emphasis will be placed upon communication and coordination within the healthcare team. Providing culturally effective care and employing strategies to increase patient adherence will improve patient outcomes. Education in transition management may be necessary to help PAs gently persuade some supervising physicians to make the necessary changes in practice. PAs' satisfaction with their careers in healthcare can be improved by working towards meaningful goals and by achieving tangible improvements in the healthcare outcomes of their patients.

Challenges of quality incentive programs

The U.S. healthcare system is already grappling with 45 million uninsured residents, significant, pervasive and unrelenting disparities of health status in certain racial, ethnic and socioeconomic groups, and problems of decreasing access to basic health services by some segments of the population. At best, quality incentive programs will prove to be a temporary fix of a systemic problem facing the U.S. healthcare system. At worst quality incentive programs may create disincentives to provide care to the poorest, least well off, and most in need patients.

Although AAPA encourages PAs to be involved in quality improvement efforts these efforts should always have the long term goal of improving health broadly. The success of quality incentive programs rests on the thoughtfulness of their design. PAs and all health professionals should be involved in their creation in order to help avoid unintended consequences. Success also depends on the rapid and timely deployment of health information systems without which the collection and analysis of performance data will not be possible. Finally, despite their growing adoption, quality incentive programs are largely unproven. Ongoing assessment and evaluation of their impact on quality and efficiency will be critical to their success.

Policy Recommendations

AAPA encourages continued efforts to promote improvements in patient care. AAPA supports the development of quality incentive programs, often referred to as "pay for performance," when the incentives are based upon achievement of evidence-based clinical benchmarks, patient satisfaction and the adoption of health information technology.

In addition, AAPA believes that quality incentive programs should include these key principles:

- Focus on processes that lead to better patient outcomes
- Foster the team approach to care
- Offer voluntary practice participation
- Use reliable and accurate patient data
- Provide feasible and practical reporting
- Ensure programs are fair and equitable, accounting for differences in practice settings and population groups

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2021-D-13 – Adopted

Amend policy HX-4700.4.2 as follows:

AAPA supports the medical home concept as a means to expand access, reduce long-term cost, and improve the quality of patient care 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 ~~physician-PA~~ team practice.

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

2021-D-14 – Expired

Expire policy HX-4500.5.

AAPA supports a patient-centered healthcare system in which there is an open exchange of information for patients with their healthcare professionals, hospitals, and other agencies providing care for those patients through mutually interfacing health information technology (H.I.T.) systems.

2021-D-15 – Adopted

Adopt the policy paper entitled *Supporting PA Practice in Settings External to Clinics and Hospitals: Adoption of Home-centered Care.*

Supporting PA Practice in Settings External to Clinics and Hospitals: Adoption of Home-centered Care

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. The 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 the AAPA's efforts to make these solutions permanent, PAs should continue to express that they have the training, versatility, and resilience to deliver medical care through evolving, extra-clinical and extra-hospital medical delivery platforms. In addition, other reimbursement stake-holders and policy makers that have influence over PA scope of practice could appreciate PAs' flexibility more completely if the AAPA is able to succinctly express that PAs are already competent to deliver care safely and effectively over these platforms. Therefore, the AAPA recommends the adoption of a term called home-centered care to describe the extra-clinical and extra-hospital settings wherein medical care can be safely provided between provider and patient.

Definition of "home-centered care" and inclusive delivery models:

"Home-centered care" is the delivery of medical care rendered by a certified clinician to a patient in a setting external to a hospital or traditional outpatient clinic. The types of medical practice acceptable for these settings is identical to that in the "outpatient" setting: chronic and acute care for both primary providers and specialist providers. At present, both telemedicine and house calls are established examples of home-centered care.

Rationale for development of term "home-centered care":

Despite the well-established use of house calls and the rapidly expanding use of telemedicine, significant legislative and practical restrictions must be overcome to achieve optimal use of these delivery models. Current stigma, inconsistent marketing terminology, and disproportionate adoption of these platforms are all factors that the AAPA could be reduced by utilizing a single term to describe the broader applicability of delivering care in the home.

The 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, the AAPA believes that literal acknowledgement of safe and effective home-centered care delivery models should be promoted.

The 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. The 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 wifi 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:

The 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, the AAPA encourages the use of CMS definitions for "homebound" effective 2019, which states that the medical necessity for medical delivery in the home (as we now define as "home-centered care") will be left to the discretion of the provider and/or patient, and there is no longer a requirement to document a justification for why medical care was delivered in the home in lieu of the office ("Medicare Program; revisions to Payment Policies Under the Physician Fee Schedule and Other revisions to Part B for CT 2019").

The above statement appears to be a logical definition to the medical provider: the majority of treatment decisions and medical decisions regarding where care is delivered is ultimately left to the discretion of the medical provider. However, the provider can see that the definition for "homebound" was significantly more restrictive until this new definition was ratified. For example, the 2014 definition of 'homebound" as defined by Medicare's CMS Manual System, Chapter 15, is already unrecognizable compared to the 2019 version: The 2014 version of "homebound" includes only patients with physical limitations due to "need for supportive devices", "assistance of another person to leave their place of residence", "having a condition such that leaving the home is contraindicated", or psychologically limited in a debilitating manner ("Definition of Homebound Patient Under the Medicare Home Health (HH) Benefit", p. 5-6). The 2014 Medicare definitions for reimbursement also stated that "feebleness or insecurity brought on by advanced age would not meet one of the conditions…" (p. 6), but this restriction is now obsolete. The 2019 Medicare Physician Fee Schedule Final Rule advised that the medical necessity for medical delivery in the home will be left to the discretion of the provider and/or patient, and there is no longer a requirement to document a justification for why medical care was delivered in the home in lieu of the office ("Medicare Program; revisions to Payment Policies Under the Physician Fee Schedule and Other revisions to Part B for CT 2019"). This is a trend that is already influencing the market. In fact, several third-party payors have capitalized on the market-advantage, convenience, and

cost-effectiveness of home-centered care delivery models (Lakin) (Landi) (Donolan). It is therefore clear that the term "homebound" is becoming less of a factor in determining a patient's candidacy for home-centered care, and it is also clear that the definitions created by important stake-holder have a significant influence on the practical application of medical care.

Additional definitions:

Establishing consistent terminology aids employers, providers, and patients communicate their needs more effectively. The 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. The 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?"). The 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 health care", "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"). The AAPA does not recommend that "home care", "home health care", or "home visits" are used to describe the PA's role in home-centered care.

Conclusion

The 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 is it 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.

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2021-D-16 – Adopted on Consent Agenda

Amend by substitution policy HX-4600.5.2 as follows:

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.

THE 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, THE 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.

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

2021-D-17 – Adopted

Amend policy HP-3500.3.4.1 as follows:

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

2021-D-18 – Adopted as Amended

Amend policy HP-3500.3.4.3 as follows:

~~AAPA believes:~~

~~• The authority for establishing MAINTENANCE OF LICENSURE (MOL) requirements is strictly within the purview of state legislative or PA regulatory authorities.~~

~~• Testing should not be part of the MOL process.~~

~~• AAPA strongly encourages aAll PA state CHAPTERS constituent organizations to SHOULD advocate for legislation to adopt MOL processes consistent with the FEDERATION OF STATE MEDICAL BOARDS' (FSMB) guiding principles and AAPA policy.~~

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.

2021-D-19 – Adopted on Consent Agenda

Amend policy HP-3700.3.1 as follows:

Guidelines for PAs Working Internationally

1. PAs should establish and maintain ~~the~~ appropriate ~~physician-PA team~~ HEALTHCARE TEAM RELATIONSHIPS.
2. PAs should accurately represent their skills, training, professional credentials, identity, or service ~~both directly and indirectly~~.
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.

2021-D-20 – Adopted as Amended

AAPA recommends a new classification of health care workers to the International Labour Organization (ILO) to recognize PA work globally.

This classification system is used by many international organizations including the World Health Organization (WHO). Currently, there is no international classification of health workers befitting of PA practice description.

Old category name: ISCO code 2229 Health Professionals (except nursing)
Current ILO category: ISCO code 2240 Paramedical Practitioners

~~Proposed ILO category name - Advance Practice Clinician -~~ PROPOSE THAT AAPA COORDINATE WITH ILO TO CREATE A CATEGORY NAME to include PAs, Clinical Officers, and similar professions globally. This would be an umbrella term for professions with similar capabilities globally. This would advocate to bring the International Labour Organization more in line with AAPA policy of descriptions of PAs and their contribution to healthcare.

IF THE ILO AGREES TO CREATE A NEW CATEGORY FOR PAs AND GLOBAL ~~EXUIVALENTS~~ COMPARABLES, THE AAPA WILL INCLUDE GLOBAL HEALTH PARTNERS AND STAKEHOLDERS REPRESENTING THOSE COMMUNITIES IN RECOMMENDING LANGUAGE RELATED TO DESCRIPTORS.

Based on the International Standard Classification of Occupations (ISCO, 2008 revision) by the International Labour Organization (ISCO-08)

Resolutions of Commendation

2021-NB-01

Resolution of Commendation
William Thomas Reynolds Jr., MPAS, PA-C, DFAAPA
May 2021

Whereas, William Thomas Reynolds served in the US Army 300th Field Hospital and was the recipient of the Army Commendation Medal for service during Operation Desert Shield & Operation Desert Storm, and

Whereas, he became a PA in 1993 graduating from the King's College PA Program in Wilkes-Barre, Pennsylvania beginning his formal career in healthcare, and

Whereas, five years later he began educating future PAs at the King's College PA Program, resulting in his touching the lives of and mentoring hundreds of future PAs, and

Whereas, he served his state chapter, filling the roles of Membership Committee Chair, Conference Planning Committee Chair, Government Affairs Committee, President-Elect, President, and Past President of the Pennsylvania Chapter, and

Whereas, in 2004, he served as an observer on the Pennsylvania State Board of Osteopathic Medicine, and

Whereas, he started his leadership career in the HOD as a delegate form the state of Pennsylvania beginning in 1998 and continuing until 2013, and

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

Whereas, he steeped himself in parliamentary procedure and gave freely of his time to the delegates and the house officers in whatever capacity was necessary, and

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

Whereas, he advanced his leadership in the AAPA HOD with election as Second Vice Speaker to the HOD in 2013 with continued service until 2016, and

Whereas, he pressed forward with his HOD service through election as First Vice Speaker to the AAPA HOD in 2016 serving until 2019, and

Whereas, he rose to the top of the leadership team in the AAPA HOD with his election as Speaker of the HOD and Vice President of the AAPA in 2019 continuing to 2021, and

Whereas, he not only served as Speaker of the House for two years, but did so during a worldwide pandemic and championed the first fully virtual HOD, and

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

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

Whereas, PA Reynolds has exemplified all that is good about the PA profession through his caring and compassionate service, be it

Resolved that the AAPA HOD honors and commends William Thomas Reynolds Jr., MPAS, PA-C, DFAAPA for his sustained and selfless service and commitment to the HOD, the Academy and the PA profession.

2021-NB-02

Resolution of Commendation
William Thomas Reynolds Jr., MPAS, PA-C, DFAAPA

The Pennsylvania delegation would like to recognize our fellow Pennsylvanian, Speaker William Reynolds for his dedication to this body.

Whereas, Bill has been a long-time member of the Pennsylvania Society of PAs, and

Whereas, Bill has served as past president of the Pennsylvania Society of PAs, and

Whereas, Bill served as a delegate from Pennsylvania for many years, and

Whereas, Bill has served on numerous committees with the PSPA and this House, and

Whereas, Bill has served as a House Officer for seven battle tested years, and

Whereas, Bill holds the honor of leading the House for both the shortest AND longest HOD in the House's modern history, be it

Resolved to sincerely and with deep gratitude commend him for his commitment and perseverance that would make even Rocky Balboa proud.

Submitted on the 24th of May in the year 2021 by the Pennsylvania Delegation.

Resolution of Condolence

2021-NB-03

2021 Resolution of Condolence for J. Jeffrey Heinrich, PA-C

Whereas, the Connecticut Academy of PAs (ConnAPA) suffered a great loss with the death of J. JeffreyHeinrich, in May of 2020, and

Whereas, Jeff Heinrich was one of the first PAs in Connecticut and one of the first three PAs at Yale-New Haven Hospital. Largely through his efforts, PAs were established as vital members on the YNHH Traumaand Burn services, and

Whereas, Jeff Heinrich demonstrated a love of teaching that spanned his entire career. He began by teaching numerous classes of students at the Yale PA Program. He also helped set up the Norwalk/Yale PA Surgical Residency Program and taught its residents. Finally, he took on the important role of Program Director at the George Washington University PA Program. He

has also given invited lectures atboth the state and national levels. There are now literally thousands of PAs out there who have been touched in some way by the efforts of Jeff Heinrich to impart some of the knowledge he has garnered over the years, and

Whereas, Jeff Heinrich lived up to his own commitment to lifelong education, having graduated from theDuke PA Program, then having earned his Masters degree from Southern Connecticut State University and then his doctoral degree from Nova University, and

Whereas, Dr. Heinrich gave much time, energy, and ideas to a variety of professional organizations. As a student at Duke, he was elected as the first President of the Student Academy of the AAPA. He was a co-founder of ConnAPA and served as its fifth President. He also served as President of the DC Academy. In addition to ConnAPA, he helped found two other national organizations – the AAPA's Physician AssistantFoundation and the PA History Society. He has also served as President of both, and

Whereas, Dr. Heinrich has been recognized for his clinical, academic and volunteer achievements. He was the recipient of the Jack W. Cole Student Society Award from the Yale University PA Program (1976), the Distinguished Service Award from the American Academy of Physician Assistants (1985), President's Award from the Connecticut Academy of Physician Assistants (1986), the Distinguished Alumnus Award from the Duke University PA Program (1992), the Curtis P. Artz Distinguished Service Award from the American Burn Association (1993), the Distinguished Service Award from the Association of Post-Graduate Physician Assistant Programs (1993), the Civilian PA of the Year Award from the AAPA Veterans Caucus (1996), Distinguished Service Award from the Norwalk/Yale PA Surgical Residency Program (2001), inducted into the PA Hall of Fame at the Duke University PA Program (2002) and the National Outstanding PA of the Year from the American Academy of Physician Assistants (2007), and

Whereas, Dr. Heinrich was devoted to the PA profession, his patients, the students he taught, and to hisfamily, and through his lifetime of dedication he made a difference in the lives of those he encountered, be it therefore

Resolved, that the House of Delegates of the American Academy of PAs recognize J. Jeffrey Heinrich'smany contributions to his profession and his community, and be it further

Resolved, that a copy of this resolution be provided to his wife, Suellen, and his son John, and his familywith deepest sympathy from the members of the American Academy of PAs.

William C. Kohlhepp, DHSc, PA-C, Delegate
on behalf of the Connecticut Academy of PAs

House Elections 2021	**Results**
Vice President/Speaker	Todd Pickard
First Vice Speaker	Leslie Clayton
Second Vice Speaker	Peggy Walsh

6051	**Nominating Work Group**	James Delaney
6052		Jeremy Nelson
6053		Kim Zuber