ARTICLE XIV Amendments.

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

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

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 amendment to be presented at the annual meeting of the House of Delegates shall be filed with the Judicial Affairs Commission at least three (3) months prior to that meeting. The Judicial Affairs Commission’s proposed amendments shall be exempt from the three (3) month filing requirement.

a. To be considered for electronic vote of the House of Delegates, amendments must be submitted 150 days or greater before the annual meeting of the House of Delegates.

Section 6: Proposals that are not initiated by the Board of Directors will be presented to the Board of Directors substantially in the form presented to the Judicial Affairs Commission with such technical changes and conforming amendments to the proposal or existing Bylaws as the Judicial Affairs Commission shall deem necessary or desirable.

a. If for presentation at the next annual House of Delegates meeting, the proposal may be considered and acted upon prior to the annual meeting of the House. 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.
Requires Board ratification if passed by the HOD

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: 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: 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.

Rationale/Justification

AAPA Bylaws recognize work groups and task forces as entities that support the work of the AAPA. As such, they should not be restricted from bringing their findings and recommendations, which may be the direct result of a Board or House charge, to the HOD.

Historically, work groups and task forces were assumed to only be established under the umbrella of a commission. While some still exist within that framework, AAPA has increasingly adopted a model that focuses on time-limited and task-oriented work allowing short-term or issue-specific work to be conducted with greater independence.

The proposal does not impact general oversight, as a work group or task force still reports to a commission or the governance body which creates it. However, it allows for greater transparency, efficiency and member engagement by removing the requirement of a commission, HOD or BOD to review, approve, and sponsor a bylaw change. This process is not only time consuming, it opens the door for the recommendation to be debated or altered before coming to the floor.

Related AAPA Policy

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

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

b. Task Forces, Ad Hoc Groups and Other Committees. The Board of Directors may establish and appoint such Academy task forces and ad hoc groups and set forth the
ARTICLE VI  House of Delegates.
Section 1:  Duties and Responsibilities.  The Academy shall have a House of Delegates, which shall represent the interests of the membership.  The House of Delegates shall exercise the sole authority on behalf of the Academy to enact policies establishing the collective values, philosophies, and principles of the PA profession.  The House of Delegates may make recommendations to the Board for granting charters to Chapters and for granting official recognition to specialty organizations.  The House of Delegates may make recommendations to the Board for the establishment of Academy commissions and work groups, and shall establish such committees of the House of Delegates as necessary to fulfill its duties.  The House of Delegates shall be entitled to vote on amendments to these Bylaws on behalf of the members in accordance with Article XIII of these Bylaws. The House of Delegates shall be solely responsible for establishing such rules of procedure, which are not inconsistent with these Bylaws, the Articles of Incorporation, or existing law, as may be necessary for carrying out the activities of the House (i.e. House of Delegates Standing Rules).

ARTICLE VII  Board of Directors and Officers of the Corporation.
Section 1:  Board Duties and Responsibilities.  The Academy shall have a Board of Directors, which, in accordance with North Carolina law, shall be responsible for the management of the Corporation, including, but not limited to, management of the Corporation’s property, business, and financial affairs.  In addition to the duties and responsibilities conferred upon it by statute, by the Articles of Incorporation, or by these Bylaws, it is expressly declared that the Board of Directors shall have the following duties and responsibilities:

SR-1200.1
Academy officers, commissions, and work groups as appropriate, may submit annual reports to the House of Delegates, which may contain resolutions for consideration by the House. Any resolutions must meet published deadlines.

SR-1300.1
The House of Delegates shall make recommendations to the Board for the establishment of Academy commissions and work groups.

The House of Delegates shall establish such committees of the House of Delegates as necessary to fulfill its duties.
Requires Board ratification if passed by the HOD

SR-1400.7.2

Non-Bylaws resolutions may be submitted by (a) the Board of Directors, (b) any commission or work group, (c) any chapter, (d) officially recognized specialty organizations, (e) any caucus, (f) the Student Academy, or (g) the collective House Officers. The official minutes of the submitting body should record the vote on each resolution submitted for consideration by the House.

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

Constituent organizations that are not in compliance with Academy Bylaws and policy will not be seated at the HOD and may not submit resolutions for consideration.

BA-2400.3.3.0 Task Force of a Commission

A task force is a temporary group created on an as needed basis that exists beneath the umbrella of a commission. Its life span is based on the charges of the group.

A task force addresses an issue that is related to the scope of that commission that is either too time or labor intensive for the commission members to address as part of their normal commission or work group responsibilities.

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

A task force chair reports to the chair of the appropriate commission.

[Adopted 2010, amended 2015, reaffirmed 2016]

Possible Negative Implications

None

Financial Impact

The approximate cost to fund the chair of a task force or work group is $1,900.

Signature

Dennis Rivenburgh, ATC, PA-C, DFAAPA
Chair, Judicial Affairs Commission

Contacts for Resolution

Dennis Rivenburgh, Chair dennisriv@mindspring.com
Ann Davison, JAC Staff Advisor adavison@aapa.org
Regulatory Language Clarification Re: Membership Revocation

2017-A-02- JAC

Resolved

Amend Bylaws, Article IX as follows:

ARTICLE IX Judicial Affairs.

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

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

Section 3: Anyone may in good faith refer charges against any Academy member or Academy-recognized PA organization believed to have violated the Academy Articles, Bylaws, policies, or rules, or for unethical or unprofessional conduct, or for failure to uphold the principles outlined in the Guidelines for Ethical Conduct for the PA Profession (Policy Paper 15), or for acting in a manner inconsistent with AAPA’s purposes.

Section 4: The Academy, after due notice and hearing, may discipline any member or Academy-recognized PA organization for a violation of the Academy Articles, Bylaws, policies, or rules, or for unethical or unprofessional conduct, or for failure to uphold the principles outlined in the Guidelines for Ethical Conduct for the PA Profession (Policy Paper 15), or for acting in a manner inconsistent with AAPA’s purposes. The notice and hearing procedures for such disciplinary actions may be determined by the Board of Directors from time to time.

Section 5: If any member has their PA license, certificate, registration, or temporary permit currently revoked as the result of a final adjudicated disciplinary action for violation of their professional practice statutes or regulations, then their AAPA membership shall be automatically revoked.

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

Rationale/Justification

As of last year, all 50 states and DC are now aligned using “licensure” as the regulatory term for PAs. The existing language reflects a time when states used a variety of terms to refer to state authorization to practice. The proposal ensures accuracy and removes confusion by bringing the Bylaws up-to-date with current regulatory language.
Splitting the language referring to those who are already members and those applying to be members into two sections is to improve clarity.

Related AAPA Policy
ARTICLE III Membership
Section 12: Suspension or Revocation of Membership. Membership in the Academy may be suspended or revoked as provided in Article IX. Any member who has been suspended or has their membership revoked shall not be entitled to any of the rights or benefits of this Academy or be permitted to take part in any of the proceedings until (s)he has been reinstated.

BA-2800.1.1
AAPA Complaint Procedures
See: Judicial Affairs Procedure Manual 1 (Complaints Involving a Potential Judicial Affairs Commission Hearing)
Judicial Affairs Procedure Manual 2 (Membership Revocation Procedures Related to Members Who Have Had Their State License Revoked)
Judicial Affairs Procedures Glossary

HP-3700.2.5
In keeping with the Guidelines for Ethical Conduct for the PA Profession and the principle of self-regulation, AAPA will publish in the appropriate publication and on the public pages of the AAPA Web site the names of PAs who have had their Academy membership revoked following either:
- a Judicial Affairs Commission hearing process, or
- a final adjudicated disciplinary action by a regulatory agency that resulted in revocation of licensure for violation of their professional practice statute or regulation.

Possible Negative Implications
None

Financial Impact
None

Signature
Dennis Rivenburgh, ATC, PA-C, DFAAPA
Chair, Judicial Affairs Commission

Contacts for Resolution
Dennis Rivenburgh, Chair dennisriv@mindspring.com
Ann Davison, JAC Staff Advisor adavison@aapa.org
Notice of Membership Revocation

1703-2017

2017-A-03  Resolved

Amend by substitution policy HP-3700.2.5 as follows:

HP-3700.2.5
THE AAPA WILL MAKE AVAILABLE TO ITS MEMBERS INFORMATION WHEN
AN AAPA MEMBERSHIP HAS BEEN REVOKED AS A RESULT OF A JUDICIAL
AFFAIRS COMMISSION HEARING.

In keeping with the Guidelines for Ethical Conduct for the PA Profession and the
principle of self-regulation, AAPA will publish in the appropriate publication and on the
public pages of the AAPA Web site the names of PAs who have had their Academy
membership revoked following either:
• a Judicial Affairs Commission hearing process, or
• a final adjudicated disciplinary action by a regulatory agency that resulted in revocation
  of licensure for violation of their professional practice statute or regulation.

Rationale/Justification
The proposed language allows AAPA members to know when a fellow member has had their
membership revoked as a result of a judicial action, while limiting the significant risk of
litigation that the current language proposes.

Legal counsel has strongly advised the AAPA to stop the public dissemination of this
information. AAPA reports to the NPDB, which is the appropriate body to notify the public of
such actions. Furthermore, while AAPA may choose to disassociate itself with a member based
on an adjudicated disciplinary action by a third party—which AAPA may or may not be able to
fully validate—it has no authority or responsibility to report on the actions of another agency.
Primary sources of this information, such as state licensing boards, NCCPA, courts and other
adjudicating bodies, or the NPDB are the appropriate venues for disseminating this information
to the public.

However, as members look to the AAPA community for support, guidance and partnerships, the
proposal retains members’ ability to see that another member is no longer associated with the
AAPA as a result of a hearing.

Maintaining member’s access to this information continues to present a litigation risk, but the
concise wording and removal of specific procedures creates an improvement. Procedures would
be outlined in the JAC Procedure Manual.

Related AAPA Policy
BA-2800.1.1
AAPA Complaint Procedures
Upon completion of the Judicial Affairs Commission hearing process, AAPA will report to the National Practitioner Data Bank and other appropriate regulatory agencies any revocation of membership due to violations of the Guidelines for Ethical Conduct for the PA Profession.


Possible Negative Implications
The proposed policy continues to create a risk of litigation.

Financial Impact
None

Signature
Dennis Rivenburgh, ATC, PA-C, DFAAPA
Chair, Judicial Affairs Commission

Contacts for Resolution
Dennis Rivenburgh, Chair dennisriv@mindspring.com
Ann Davison, JAC Staff Advisor adavison@aapa.org
Amend Article XIII as follows:

Article XIII Elections.

Section 1: Positions to be Filled by Election. Elected positions include Directors-at-large; one Student Director; the Academy Officer positions of President-elect and Secretary-Treasurer; and the House Officer positions of Speaker, First Vice Speaker, and Second Vice Speaker; and such number of members of the Nominating Work Group as may be set forth in Article XI of these Bylaws. The House Officer positions shall be filled by the House of Delegates in the manner prescribed by Article VI, Section 3. The Student Director shall be elected in the manner prescribed by Article V, Section 3. The Nominating Work Group positions shall be filled by the House of Delegates in the manner prescribed by Article XI. All other elected positions shall be filled in the manner prescribed by this Article XIII.

Section 2: Term of Office. The term of office for the Academy Officer positions of President, President-elect, and Immediate Past President shall be one year. The term of office for the Student Director shall be one year. The term of office for Directors-at-large and for the Academy Officer position of Secretary-Treasurer shall be two years. The term of service for House Officer positions shall be one year.

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

a. A candidate must be a fellow member of AAPA.

b. A candidate must be a member of an AAPA Chapter.

c. A candidate must have been an AAPA fellow member and/or student member for the last three years.

d. A candidate must have accumulated at least three distinct years of experience in the past five years in at least two of the following major areas of professional involvement. This experience requirement will be waived for currently sitting AAPA Board members who choose to run for a subsequent term of office.

i. An AAPA or constituent organization officer, board member, committee, council, commission, work group, task force chair.

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

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

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

Section 5: **Time of Elections.** The time of House Officers’ elections is prescribed in Article VI, Section 3. The Board of Directors shall determine the timing of elections of all other positions, in accordance with the requirements of these Bylaws.

Section 6: **Eligibility of Voters.** For all positions other than the Student Director, House Officer, and Nominating Work Group positions, eligible voters are fellow members listed on the Academy membership roster as of the date that is fifteen (15) days before the election.

Section 7: **Election Procedures.** The Board of Directors shall determine the procedures for the election of Academy Officers and Directors-at-large, including the dates for distribution and return of ballots, subject to the requirements of the North Carolina Nonprofit Corporation Act. Voting shall be by mail or electronic ballots. The Academy staff shall manage the ballot distribution. The procedures for electing the House Officers are prescribed in Article VI, Section 3; and the procedures for electing the Student Director are prescribed in Article V, Section 3; and the procedures for electing members of the Nominating Work Group shall be determined by the House of Delegates in accordance with Article XI, Section 2.

Section 8: **Vote Necessary to Elect.** A plurality of the votes cast shall elect the Directors-at-large and the Academy Officers (excluding the Vice President), so long as the number of votes cast equals or exceeds a quorum of one (1) percent of the members entitled to vote in the election. In the case of a tie vote, the House of Delegates shall vote to decide the election from among the candidates who tied. The vote necessary to elect the House Officers (including the Speaker, who shall serve as the Vice President of the Academy) shall be prescribed in Article VI, Section 3.

Section 9: **Commencement of Terms.** The term of office for all elected positions, including Directors-at-large, the Student Director, Academy Officers, and House Officers, shall begin on July 1. In the event that the election of the House Officers occurs later than July 1, the new House Officers will take office at the close of the meeting during which they were elected.

Section 10: **Vacancies.** Academy Officers and Directors, the Student Director and House Officers may resign or be removed as provided in these Bylaws. The method of filling positions vacated by the holder prior to completion of term shall be as follows:

a. **OFFICE OF THE PRESIDENT.** The President-elect shall become the President to serve the unexpired term. The President-elect shall then serve his/her own successive term as President.

b. **OFFICE OF THE PRESIDENT-ELECT.** In the event of a vacancy in the office of President-elect, the Immediate Past President shall assume the duties, but not the office of the President-elect while continuing to perform the duties of Immediate Past President. The Nominating Work Group will prepare a slate of candidates. The House of Delegates shall elect a new President-elect from the candidates proposed and any candidates that self-declare, who will take office.
REQUIRES BOARD RATIFICATION IF PASSED BY THE HOD

immediately upon election and will serve the remainder of the un-expired term.

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-EXPURRED 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.

Rationale/Justification
NCAPA requests amending the process by which a President-elect vacancy is filled so that it is the same as other officer vacancies. This amendment provides parity in process and procedure between all vacancies and ensures the full membership has the opportunity to elect the President-elect.

Related AAPA Policy
Article XIII, Section 10

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.

Possible Negative Implications
None

Financial Impact
Financial impact is the same as other vacancies.

Signature
Truett Smith, MPAS, PA-C, DFAAPA
Chief Delegate, NCAPA

Contacts for Resolution
Truett Smith, Chief Delegate – Truett.Smith@carolinashealthcare.org
Emily Adams, Executive Director – Emily.adams@ncapa.org
2017-A-05-OH  Term of Office/Service

2017-A-05  Resolve

Amend Bylaws Article XIII, Section 2 as follows:

ARTICLE XIII Elections.

Section 2: Term of Office. The term of office for the Academy Officer positions of President, President-elect, and Immediate Past President shall be one year. The term of office for the Student Director shall be one year. The term of office for Directors-at-large and for the Academy Officer position of Secretary-Treasurer shall be two years. The term of service for House Officer positions shall be one year. APART FROM THE POSITIONS OF PRESIDENT, PRESIDENT-ELECT, IMMEDIATE PAST PRESIDENT, AND THE STUDENT DIRECTOR, NO INDIVIDUAL SHALL SERVE MORE THAN TWO CONSECUTIVE TERMS IN THE SAME ELECTED OFFICE WITHIN THE ACADEMY.

And further resolved;

Amend Bylaws Article XI, section 4 as follows:

ARTICLE XI Nominating Work Group

Section 4: Term of Service. The term of service for THE ELECTED members of the Nominating Work Group shall be two (2) years, AND NO ELECTED MEMBER SHALL SERVE FOR MORE THAN TWO CONSECUTIVE TERMS. 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.

Rationale/Justification

The concepts of diversity and inclusiveness are supported throughout the Academy’s mission and vision, bylaws, policies and position papers. Within these constructs includes diversity in leadership, as well as, the growth and development of Academy members. Since the establishment of the Academy there have been individual members that have enjoyed the privilege of serving multiples of terms in a single elected position within the Academy. Although this may have contributed to the welcomed growth, development and stability of the Academy in the early years, today’s leadership within the Academy has become more sophisticated where we now have an abundance of qualified leaders within the Academy. Holding an elected position within the Academy is an awesome responsibility and privilege which all qualified leaders should have the opportunity to experience. Having limits on the number of consecutive terms in the above mentioned elected positions within the Academy would be opening opportunities for members to share their leadership skills and knowledge, and has the potential for a more diverse leadership group in any given leadership year within the Academy.
The Standard Code of Parliamentary Procedure which is referenced in Article XII of the Academy bylaws is not silent on this issue. The following is quoted from that manual:

“The bylaws should define the term of office for all officers, directors and committees. Bylaws sometime limit the number of terms that a member may hold an office. This provision is intended to prevent the domination of the organization by a few members. However, a limitation on terms often works out to be more of a limitation on the right of members to elect whom they please than a limitation on a member to continue to hold office. The deciding principal should be, not the right of every member to have “a turn” regardless of ability, but the overall good of the organization.”

The Standard Code is intended to be used as a guide when an organization’s bylaws are silent on any issue. The overriding tenant of the above referenced quotation is “the overall good of the organization”. The Delegates will need to decide what they believe is in the best interest of the Academy, diversity and inclusiveness or the right of the members to choose.

The Board appointed members of the Nominating Work Group are not included in the proposed amendment to Article XI because these positions fall within the purview of the Board and would need to be amended in the Board policy manual.

And finally, the objective of this resolution should not be construed as to suggest any negative inference to and/or in any way is an attempt to impugn the integrity or credibility of any individuals currently serving in elected positions within the Academy. However, just as the House of Delegates Standing Rule SR-1100.4 requires that all Academy policies and position papers be reviewed every five years for their relevancy to the profession, due diligence would suggest the same consideration should be given to the bylaws to ensure they remain current and appropriate to the mission and vision of the Academy.

Related AAPA Policy

BA-2400.3.5

The selection process of AAPA commissions and work groups should take into consideration the multifaceted concept of diversity. AAPA should encourage and support training in diversity for all commission and work group chairs and members.

BA-2500.4.3

AAPA leadership and national office staff will incorporate ethnic and cultural diversity in their planning, actions, and discussions on behalf of the PA profession in publications and media activities; in the selection of commission, work group, and task force members, and in awards.

HP-3200.6.1

In order to ensure the age, gender, racial, cultural and economic diversity of the profession; AAPA strongly endorses the efforts of PA educational programs to develop partnerships aimed at broadening diversity among qualified applicants for PA program admission. Furthermore, the Academy supports ongoing, systematic and focused efforts to attract and retain students, faculty, staff and others from demographically diverse backgrounds.

SR-1100.4

Policies and policy papers adopted by the House shall expire five years after adoption unless revised, referred, or reaffirmed.

Board Manual; VI. BOD Committees, Advisory Commissions, and Other Volunteer Groups and Appointments

g. Advisory Commissions.

  i. Composition and Terms. Each advisory commission shall have a chair who is an AAPA member. Each commission should include three (3) to five (5) AAPA members with expertise and experience in the subject matter, as well as a BOD member and an AAPA staff member; outside experts may be appointed as members if additional expertise is required. Advisory commission members shall be appointed for a two-year term, and may serve a maximum of two terms. Appointments should be staggered to provide continuity. Unless an individual is appointed to fill an unexpected vacancy, advisory commission terms will begin on July 1 and end on the subsequent June 30, with the exception of the Commission on Continuing Professional Development and Education (CPDE). Due to responsibilities requiring coordination with the AAPA annual conference, the CPDE terms will begin on May 1 and end on June 30 of the subsequent year.

  ii. Medical Liaisons.

    - EAC will request that a PA constituent organization, when appropriate, identify qualified candidates (no fewer than two) to be considered for appointment as the AAPA medical liaison. EAC will recommend to the BOD individuals to be appointed as medical liaisons.

    - Nominees must be current members of the AAPA.

    - The term of an appointment as a Medical Liaison will be 2 years. Appointees may serve a maximum of two terms unless the BOD grants a one-time exception based on special circumstances that have been confirmed by involved stakeholders.
Under no circumstances may a medical liaison serve in that capacity for more than six (6) sequential years.

ii. External Representatives.
- If the appointment does not have a short turnaround time, the appointment process for External Representatives will be the same as for Medical Liaison appointments.
- If, however, an appointment must be made quickly in order to meet the external organization’s request or if the duration of the appointment is short, the AAPA CEO will be responsible for seeking and appointing nominees in consultation with the BOD president/chair.
- Nominees/appointees must be current members of the AAPA.
- The term of the appointment will most often be determined by the external organization. If the term is determined by the external organization, appointees may serve a maximum of two terms. If the term is not defined by the external organization, the term of appointment as an External Representative will be two years; appointees may serve a maximum of two terms unless the BOD grants a one-time exception based on special circumstances that have been confirmed by involved stakeholders.

j. BOD Liaisons and Representatives.
i. BOD Graduate Advisor to the AAPA Student Academy Board of Directors.
- The BOD Graduate Advisor to the AAPA Student Academy Board of Directors shall be appointed by the president/chair, after soliciting volunteers through a call for volunteers and after consultation with the vice president, president-elect and immediate past president.
- The appointee must be a current member of the AAPA.
- The term of the appointment as the Graduate Advisor to the AAPA Student Academy Board of Directors shall be two years, commencing on July 1 of odd-numbered years; appointee may serve a maximum of two terms.

ii. BOD Representative to the Nominating Work Group.
- The BOD Representatives to the Nominating Work Group shall be appointed by the president/chair after consultation with the vice president, president-elect and immediate past president.
- The appointee must be a current member of the AAPA.
- The term of the appointment as the BOD Representative on Nominating Work Group shall be two years, commencing on July 1. Appointees may serve no more than one term without a break in service.
- An individual who serves in this capacity is ineligible to run for any AAPA office during the period of the appointment, even if he or she resigns this position.
Possible Negative Implications

On several occasions in the past the House of Delegates has rejected calls for having all Academy Officers elected by a vote of the delegates only, suggesting the delegates choose not to place limits on the privileges afforded to the Academy’s membership. The delegates may judge this resolution negatively as it would restrict the delegates and membership from electing an individual based on their knowledge and reputation within the Academy. In all fairness, the delegates may also cite the above-mentioned quotation of the Standard Code in the Rationale/Justification to support their opposition to this resolution, which could lead to a lengthy debate on member rights.

Financial Impact

None

Signature/Contact for Resolution

Kristin Homoki, PA-C
Chief Delegate
jandkhomoki@yahoo.com
Reject referred resolution 2016-A-08 entitled “PA Full Practice Authority”.

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

And Further Resolved

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

Rationale/Justification
The task force reviewed the referred resolution on PA Full Practice Authority. In considering the information gathered the decision was made to reject the referred 2016-A-08 and amend current policy instead. A resolution has been submitted to incorporate the task force’s proposed amendments to the policy paper entitled “State Guidelines for the regulation of PAs”.

Related AAPA Policy
None

Possible Negative Implications
None

Financial Impact
None

Signature
Todd Pickard, PA-C
2nd Vice Speaker
(On behalf of the Joint Task Force on the Future of PA Practice Authority)

Contact for Resolution
Jeffrey A. Katz, PA-C, DFAAPA
Chair, AAPA Joint Task Force on the Future of PA Practice Authority
jkatz@aapa.org
2017-A-07-HO
Optimal Team Practice

2017-A-07
Resolved

Amend policy HP-3500.3.4, “Guidelines for State Regulation of PAs”. See policy paper.

Rationale/Justification

Background
In July 2016, AAPA’s Board of Directors and House Officers appointed a Joint Task Force on the Future of PA Practice Authority (JTF) to make a recommendation with regard to the disposition of Resolution A-08-2016; help AAPA better understand the range of issues involved; document the current statutory, legislative, and operational context of the issues; identify options and opportunities; and make AAPA policy recommendations to the Board of Directors and the House of Delegates.

The Joint Task Force on the Future of PA Practice Authority (JTF) released a proposal in November 2016 and requested feedback from the broad community of PAs and PA students. The proposal included the following four components:

- Emphasize the PA profession’s continued commitment to team-based practice.
- Support the elimination of provisions in laws and regulations that require a PA to have and/or report a supervisory, collaborating or other specific relationship with a physician in order to practice.
- Advocate for the establishment of autonomous state boards, with a voting membership comprised of a majority of PAs, to license, regulate, and discipline PAs.
- Ensure that PAs are eligible to be reimbursed directly by public and private insurance.

The proposal, along with the feedback received, was shared on a webpage [http://news-center.aapa.org/par/] devoted to this issue, which is open to both AAPA members and non-members. In addition, the JTF undertook a review of the relevant literature and sought input from PAs, PAs students, AAPA constituent organizations, several physician organizations, and others on the implications to PAs of the changing healthcare provider marketplace. This information was also shared on the JTF webpage, as well as through other communications channels.

Feedback on Original JTF Proposal

As noted in the tables below, a significant majority of people who have commented on social media (Huddle and Facebook) or emailed to fparfeedback@aapa.org expressed support for the JTF proposal, which the JTF called “Full Practice Authority and Responsibility”.

1
2017-A-07-HO
## Huddle Feedback - Counts of Individuals
### As of March 9, 2017

<table>
<thead>
<tr>
<th>Month</th>
<th>Support</th>
<th>Support, with concerns/questions</th>
<th>Concerns</th>
<th>Questions Only</th>
<th>Neutral</th>
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<tr>
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<td>1</td>
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<td><strong>Total</strong></td>
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<td><strong>28</strong></td>
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<td><strong>7</strong></td>
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<tr>
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<td>58%</td>
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<td>17%</td>
<td>2%</td>
<td>4%</td>
<td>100%</td>
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</table>

## Facebook Feedback - Counts of Individuals
### As of March 9, 2017

<table>
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<tr>
<th>Month</th>
<th>Support</th>
<th>Support, with concerns/questions</th>
<th>Concerns</th>
<th>Questions Only</th>
<th>Neutral</th>
<th>Total</th>
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<td>2</td>
<td>4</td>
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<tr>
<td>January</td>
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<td>9</td>
<td>19</td>
<td>3</td>
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</tr>
<tr>
<td>February</td>
<td>9</td>
<td>1</td>
<td>3</td>
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<td>16</td>
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<tr>
<td>March</td>
<td>6</td>
<td>2</td>
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<td>12</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>125</strong></td>
<td><strong>15</strong></td>
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<tr>
<td>Percent</td>
<td>68%</td>
<td>8%</td>
<td>14%</td>
<td>7%</td>
<td>3%</td>
<td>100%</td>
</tr>
</tbody>
</table>
In January 2017, a survey was conducted on behalf of the JTF by the AAPA Research department. The survey was available from January 12 through February 1, 2017, and was open to PAs, PA students and retired PAs for whom AAPA had valid email addresses. The survey was sent to 102,101 individuals, and a total of 12,485 individuals completed at least some portion of the survey (12.6% response rate). The overall margin of error for the survey was +/-0.83% at the 95% confidence level.

A significant majority of survey\(^2\) respondents (71%) expressed overall support for the proposal, with 13% opposed and 16% undecided. In its original form, the JTF proposal included four components, and survey respondents were provided the opportunity to express their support or opposition to each component. The vast majority of respondents expressed support for a continued commitment to team-based practice (96%) and for ensuring that PAs are eligible to be reimbursed directly by public and private insurance (93%). A slightly smaller majority (79%) of respondents said they supported establishing autonomous state boards, with a voting membership comprised of a majority of PAs, to license, regulate, and discipline PAs. And a still smaller majority (63%) said they supported eliminating laws and regulations that require a PA to have and/or report a supervisory, collaborating or other specific relationship with a physician in order to practice, with 17% of respondents saying they had not yet formed an opinion on that component of the proposal. A review of factors that might have an impact on respondents’ views about the last component found that:

- There were no statistically significant differences between PAs practicing in primary care vs. other specialties with regard to their view on eliminating laws and regulations requiring a supervising, collaborating or other specific relationship with a physician.
- Years of experience as a PA was not associated with large differences in support for or opposition to the elimination of laws and regulations than requiring a supervising, collaborating or other specific relationship with a physician. Late-Career PAs were

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\(^1\) All emails received and counted in this table are posted on the Joint Task Force webpage: [http://news-center.aapa.org/emailed-comments-fpar-proposal/](http://news-center.aapa.org/emailed-comments-fpar-proposal/)

slightly more likely than Students or other PAs to say they support the elimination of “Supervisory Agreements”. Students were least likely to oppose the elimination of “Supervisory Agreements”, and they were most likely to say they had not yet formed an opinion.

- The number of Key Elements\(^3\) in their state practice law was not associated with a large difference in PA support for eliminating laws and regulations requiring a supervising, collaborating or other specific relationship with a physician.
- PAs who work in states where NPs have Full Practice Authority (68%) were more likely than PAs who work in states where NPs do not have Full Practice Authority (62%) to support the elimination of laws and regulations requiring a supervising, collaborating or other specific relationship with a physician.
- PAs who have personally experienced NPs being hired over PAs due to supervisory requirements were almost twice as likely to support the elimination of laws and regulations requiring a supervising, collaborating or other specific relationship with a physician. 78% of PAs who have experienced preferential NP hiring supported the elimination of PA supervisory agreements, compared to 40% of PAs who have not personally experienced preferential NP hiring.

Several important points emerged from the feedback received from PAs and PA students, including comments provided on the survey, Huddle comments, letters and emails from constituent organizations and individual PAs, as well as feedback from over 220 PAs at AAPA’s Leadership and Advocacy Summit in early March. Among the key take-aways were:

- PAs should not be disadvantaged in the healthcare provider marketplace.
- The proposal must be distinguished from “independent practice” and NP’s “full practice authority”, in both name and content.
- The proposal must communicate that PAs highly value PA-physician teams, even as we seek to eliminate the burdensome paperwork and liability issues involved in state-required supervisory agreements.
- The proposal must recognize and reflect an understanding of PAs who are early career and those PAs who are in specialty practice or changing specialties.
- The proposal must offer each state the flexibility to adapt to the political and marketplace environment in the state, and to move forward at its own pace.

The Joint Task Force also sought feedback from several physician organizations\(^4\), including the American Medical Association, the American Osteopathic Association and the American Academy of Family Physicians. The objective was to have an opening conversation about the issues facing PAs in the marketplace and the JTF’s initial thinking about ways to address those issues, as well as to develop a plan for continuing dialog. While communication is ongoing, the initial discussions were well received and several themes emerged:

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\(^3\) For a description of the Six Key Elements, please see https://www.aapa.org/wp-content/uploads/2016/12/Issue_Brief_Six_Key_Elements.pdf

\(^4\) A report on outreach to physician groups can be found on the News Center page under the “Physician Organization Feedback” tab.
• While recognizing changes in the healthcare landscape, they were unaware of the challenges PAs face in the current marketplace.
• They appreciated the outreach and understood the need for the PA profession to plan for its future.
• They expressed support for the PA profession.
• They expressed a willingness to consider the issues raised and engage in a continued dialog as the PA profession moves forward.

The JTF representatives emphasized that the JTF proposal is not an AAPA policy and did not request an endorsement.

The JTF Proposal: Optimal Team Practice

As a result of the input and feedback received, the JTF modified its proposal. Rather than stand-alone policy statements, the JTF recommends modifications to AAPA’s Guidelines for State Regulation of PA Practice (Guidelines). This document more clearly articulates both the intent and practical implications of the JTF recommendations, and will facilitate translation of policy into Model State Legislation. Furthermore, the Guidelines clearly recognize that a state’s unique political and healthcare climate may require modification of some provisions and offers state constituent organizations the freedom to craft and promote alternative models.

The revised JTF proposal for “Optimal Team Practice” emphasizes the PA profession’s desire to continue to work closely in teams with physicians, while relieving PAs, physicians and employers from the burdens imposed by unnecessary requirements to have or report a specific relationship with a physician or group of physicians in order for the PA to be able to practice. The JTF is not proposing independent practice, and offers the following definitions to clarify the distinction between “independent practice” and the JTF proposal for “Optimal Team Practice”.

Independent Practice: Practice without the benefit of physicians or other providers for collaboration, referral or team-based care.

Optimal Team Practice: Practice with access to physicians and other qualified medical professionals for collaboration, consultation, and referral, as indicated by the patient’s condition and the standard of care, and in accordance with the PA’s education, training and experience.

The JTF also refined its recommendation regarding the creation of a majority-PA board to oversee PA licensing and discipline to reflect concerns raised about the potential cost of creating a completely autonomous state PA board. The proposal now expresses a strong preference for an autonomous board comprised of a majority PAs, but also acknowledges that regulation of PAs may be administered by a multidisciplinary healing arts or medical board and strongly recommends that PAs and physicians who practice with PAs be full voting members of the board.

Finally, in keeping with the strong support for ensuring that PAs are eligible for direct reimbursement by both public and private payers, the JTF recommends that this be included in the Guidelines and in the subsequent version of the Model State Legislation. This
recommendation is consistent with current AAPA policy, but its inclusion in state laws and regulations will help ensure that services provided by a PA can be billed under the PA’s name and NPI. This will allow the services provided by PAs to be measured and attributed to PAs in the key databases used by government agencies, employers, and insurers to set payment policies, assess quality, and conduct other policy-related research.

**PAs in a Changing Healthcare Provider Marketplace**

AAPA must refuse to let PAs be disadvantaged in the marketplace. Over the last 30 years, the healthcare provider marketplace has changed substantially. Notably, two trends are significantly impacting the ability of PAs to effectively compete for high quality jobs in which they can fully utilize their education, experience, and competencies: fewer physicians are employers and NPs are gaining ground as independent practitioners.

**Fewer Physician are Employers.** When the PA profession was created 50 years ago, physicians were likely to be solo or joint practice owners. As owners, physicians saw multiple benefits from hiring and entering into “supervisory agreements” with PAs. Such agreements with PAs not only reduced the day-to-day burdens on the physician-owner to provide patient care and coverage of call, but also by allowing the practice to care for a larger number of patients at a lower cost than if another doctor were added. Although these physician-owners may have been burdened with higher potential liability due to the supervisory agreement with the PA, this was offset by the financial benefits of additional profits generated by the PA.

Over the last 30 years, however, market forces and government policies have changed the incentives for practice ownership. Muhlestein and Smith (2016) identified at least three factors that are contributing to the trend toward larger practice groups and hospital ownership. First, they cite the strong incentive created by financial and administrative costs associated with the adoption of electronic medical records necessary to comply with meaningful use requirements under Medicare. These costs, they argue, tend to be more than smaller practices can bear; the economies of scale gained by larger practices and hospital-ownership make these options financially viable. Second, the movement toward population-based contracting arrangements (i.e., Accountable Care Organizations) and fee-for-value payment arrangements are driving physicians to become part of a larger group practice in order to aggregate the number of patients necessary to protect against loss. Finally, they cite evidence that younger physicians tend to prefer working in larger, rather than smaller, group practices, and older physicians in smaller practices are moving out of the workforce.

Using the AMA’s Physician Practice Benchmark Surveys as their data source, recent studies (Kane et al, 2015) have documented a significant decline in the percentage of physicians

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5 See AAPA HP 3600.1.1 – HP 3600.1.5
8 Harris, G. “Family physicians can’t give away solo practice” New York Times 2011 April 22.
9 Kane, Carol K. “Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership” AMA Economic and Health Policy Research, July 2015.
who are owners of their practices, down from 76 percent in 1983 to 51 percent in 2014. This
decrease is related to two phenomena: (1) an increase in practice size and (2) an increase in
hospital ownership of physician practices. In 1983, 80% of physicians worked in practices with
10 or fewer physicians; by 2014, that number had fallen to 61%. Solo practice fell from more
than 40% of physicians in 1983 to less than 20% in 2014. At the same time, the percent of
physicians who work in practices owned by hospitals has increased substantially. While detailed
data on practice ownership structure is not available for 1983, other research suggests that only
16% of physicians worked directly for a hospital or in practices that were partially or wholly
owned by a hospital in 2007/2008. By 2014, that number had more than doubled to 33%. Other
studies corroborate this trend. Using data from an annual survey of approximately 75% of U.S.
office-based physicians conducted by SK&A, Baker et al\(^\text{10}\) (2016) found that the number of
physicians who reported being part of a hospital-owned practice increased from 31,710 in 2008
to 105,538 in 2012 – a 230% increase in just four years. The author’s analysis of the American
Hospital Association’s annual survey of all U.S. hospitals suggests that this trend may be even
more pronounced, most likely because the SK&A survey samples only office-based physicians.

Finally, the 2016 Medscape Physician Compensation Report\(^\text{11}\), which is based on
responses from more than 19,200 physicians in over 26 specialties, found a gender difference in
employment. Among male physicians, 35% were self-employed and 59% were employed by
hospitals or other practice-owner; among female physicians, only 23% were self-employed,
while 72% were employed by hospitals or other practice owners. As a greater percentage of
physicians are female, the trend toward physicians as employees can be expected to increase.

These dramatic changes in practice ownership mean fewer physicians – who are now
employees, rather than employers – are able to take advantage of the financial benefits that
accrue to a medical practice that employs PAs, because they do not share in the overall profits
generated by the practice. Yet, if a physician agrees to enter into the “supervisory agreement”
now required by states for PA practice, the physician will still incur the potential malpractice
liability that accompanies that agreement. Unless they are compensated by their employers for
the added liability exposure and other burdens associated with PA oversight, physicians are
increasingly unwilling to enter into such agreements, particularly if they can work with NPs who
are not required to have such agreements.

NPs are Gaining Ground as Independent Providers. Over the same period that incentives
for physicians to enter into supervisory agreements with PAs have been declining, NPs have
been gaining ground as independent providers. Beginning in the 1980s, states began to change
their laws to permit PAs and NPs to prescribe drugs under physician supervision. Today, thanks
to the advocacy efforts of AAPA and its state constituent organizations, every state permits PAs
to do so. Beginning in 1999, however, some states began to permit NPs to practice and prescribe
without physician supervision or supervisory agreements. Today, 22 states\(^\text{12}\) and the District of

\(^{10}\) Baker, Laurence C, M. Kate Bundorf, Aileen M. Devlin, and Daniel P. Kessler. “Hospital Ownership of Physicians: Hospital Versus Physician Perspectives” Medical Care Research and Review 1-12, October 3, 2016.


\(^{12}\) AK, AZ, CO, CT, HI, ID, IA, MD, ME, MN, MT, ND, NE, NH, NM, NV, OR, RI, SD, VT, WA, WY
Columbia give NPs full practice authority, permitting NPs to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments, including prescribe medications, under the exclusive licensure authority of the state board of nursing and without a requirement for physician supervision or collaboration.\textsuperscript{13}

PAs are Being Disadvantaged in the Marketplace. Relatively little research has been done on how the shifts in physician practice ownership and changing NP practice laws are affecting PA hiring practices or wages. However, several studies and the recent Joint Task Force survey of PAs sheds some light on this issue.

In a recently published article, Pittman et al\textsuperscript{14} (2016) describe the results of structured interviews with a stratified sample of CEOs of community health centers (CMC) intended to shed light on what factors influence their medical staff configurations. Specifically, the authors investigated the factors in the decisions about the choice and balance of providers (physicians versus NPs and PAs). The authors found that scope of practice laws are important in hiring decisions. Specifically, they found:

- Although about half of the CHC’s in the sample were in states that allow NPs to practice independently of physicians, across all sites (regardless of practice laws), the CEOs “agreed that the scope of practice laws [for NPs and PAs] were too restrictive and burdensome.”
- The CEOs considered scope of practice regulations “as a factor in choosing between [NPs and PAs].”
- Insurance company payment policies regarding reimbursement for nursing services affects CEOs’ decisions regarding staffing choices.

Notably, the CEOs “did not perceive the decision to hire MAs, NPs, or PAs as a function of physician shortages; they valued NPs and PAs for the different qualities they brought to a practice.” This finding, according to the authors, “contrasts with the dominant portrayals of [NPs and PAs] as substitutes for physicians or a ‘physician extenders’. ” In fact, they observe that “No respondent described NPs and PAs as ‘second best’, to be hired only when a CHC is unable to attract physicians.”

In the survey of PAs and PA students\textsuperscript{15} conducted at the request of the AAPA Joint Task Force on PA Practice Authority, respondents were specifically asked whether they had personally experienced NPs being hired over PAs due to supervision requirements.” Of the more than 12,000 individuals who responded to the survey, over 45% reported that they had personally experienced this situation, which suggests that the many anecdotes relating these experiences are indicative of a fairly prevalent phenomena. PAs whose current primary place of


employment is in a state where NPs have full practice authority were more likely than PAs in other states to report that they had personally experienced NPs being hired over PAs due to practice authority differences (53% vs. 42%).

Not surprisingly, PAs who had personally experienced NPs being hired over PAs because of the supervision requirement (71%) were almost twice as likely to agree that state law should not require PAs to have a specific, identified relationship with a physician in order to practice, compared to those who had not had that experience (39%).

The question has also been asked whether PAs living in states with more of the Six Key Elements of a Modern PA Practice were less likely to support the FPAR proposal, since they might perceive that the Key Elements are sufficient. An analysis of the survey data suggests that this is not the case. In fact, the survey found that there was no statistically significant difference in the percentage of respondents who supported the FPAR proposal among PAs living in states with 1-2 Key Elements (71% support), 3-4 Key Elements (73% support), or 5-6 Key Elements (71% support). Specifically, with regard to the proposal to support the elimination of provisions in laws and regulations that require a PA to have and/or report a supervisory, collaborating or other specific relationship with a physician, states with more Key Elements were slightly more likely to support the proposed change (64% of those in states with 4-6 Key Elements, 65% of those in states with 3-4 Key Elements, and 61% of those in states with 1-2 Key Elements).

**Implications of Optimal Team Practice**

Because there are no states where PAs can currently practice without a supervisory, collaboration or other agreement with a physician, data specific to PAs that would allow researchers to examine the impact of such laws is not available. However, it is reasonable to examine and draw implications from studies that have been conducted about the impacts of laws that permit NPs to practice without such agreements (often called NP Full Practice Authority laws).

**Implications for Malpractice Premiums and Rates of Malpractice.** Information provided by AAPA’s malpractice insurance partner, CM&F Group, Inc., indicates that NP malpractice premiums are not established based on the degree of NP practice authority in the state, and that PA insurance premiums are unlikely to change in the next few years, even if PAs obtain expanded practice authority in a state. They note, in fact, that “Premiums might actually decrease for PAs if more PAs buy individual malpractice insurance. Today, most PAs have coverage through their employer; only about 4,000 PAs purchase their own individual liability policies. Insurance premium rates are to some extent based on strength in numbers; the more who buy insurance, the more you can spread the risk.”

CM&F estimates that only about 4,000 PAs currently purchase an individual malpractice policy. Most PAs rely on employer-provided malpractice insurance, and “there is no reason to think that employers will stop providing liability coverage for their PA employees” if PA practice authority is expanded or otherwise modified. CM&F has assured AAPA that it will continue to offer liability insurance products to meet PA needs, regardless of any changes.

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According to CM&F, physicians have historically paid the highest malpractice premiums, typically about 10 percent of their income. NPs have historically paid lower malpractice insurance premiums than PAs because of the very large pool of nurses who buy individual insurance. However, over time, NP premium rates are coming into line with PA premium rates. They note that the average policy for a full-time PA in primary care is approximately $4,000 per year, which is about 4.4% of the mean PA salary. Most PAs purchase $1,000,000 in liability protection, but lower and higher coverage options are available. CM&F also offers a new graduate liability policy that starts at just $300 per year.

A recently published study by McMichael et al (2016) analyzed whether and to what extent there is a connection between scope-of-practice laws, malpractice reforms, and physician malpractice occurrence rates. Similar to PAs, NPs may be sued by patients just as physicians may be sued. As the authors explain, while physicians are responsible for their own malpractice liability across all 50 states, the same is not true of NPs. NPs [and PAs] can be held directly liable for malpractice just like physicians, but NPs may pass a substantial portion of their liability to their supervising physicians in states that require supervisory agreements. The authors note that because legal theories of liability “generally require plaintiffs to show some level of supervision or control, plaintiffs will be more likely to succeed on a claim against a physician when state SoP [scope-of-practice] laws require a greater degree of physician involvement in an NP’s practice. Therefore, depending on a state’s SoP laws, physicians may find themselves defending lawsuits and making damages payments for errors they did not commit. …a state law requiring physician supervision of an NP’s practice is not necessary to prove negligent supervision, but such a law will significantly ease a plaintiff’s legal burden in establishing her case.”

The authors used national longitudinal data to examine the effect of physician supervision requirements for NPs on physician malpractice claims. Because a number of states changed their NP scope-of-practice laws between 1999 and 2012, the authors were able to create a natural experiment to test the effect.

Using a two-way fixed effects regression model, the authors found that “the physician malpractice rate [defined as the number of malpractice payments made per practicing physician] in states allowing NPs to practice independently is 31% lower than the rate in states that require complete physician supervision in the absence of tort reform. Similarly, the physician malpractice rate in states requiring only that physicians supervise NPs when they are prescribing medications is 26% lower relative to states that require complete physician supervision” in the absences of tort reform. Based on their analysis of the effect of tort reform on physician malpractice rates, the authors further conclude that “allowing NPs to practice with greater independence is associated with more than twice the reduction in physician malpractice rates than is enacting a noneconomic damages caps or JSLR [joint and several liability reform].”

A 2016 study by Brock et al employed regression analysis to compare trends in malpractice award and adverse actions (e.g., revocation of license) using 2005-2014 data from

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the National Practitioner Data Bank.\textsuperscript{18} Noting that “PAs must practice under the supervision of a physician, while in many states, NPs may practice with autonomy”, the authors, nevertheless, found that “across the past 10 years, there has been a significant decrease in the rate of malpractice reports for physicians”, “there was a significant upward trend for PAs”, and “the rate of malpractice reports for NPs did not change significantly”.

**Implications for Patient Outcomes, Costs and Access.** Numerous studies have documented that PAs provide high quality patient care and are cost-effective medical providers\textsuperscript{19}. The question that has been raised is whether such high quality and patient care is dependent upon continuing to operate under supervisory agreements with physicians. Like other issues, this question cannot be answered empirically utilizing data on PA patient care because all PAs are currently required to have such agreements in order to practice. However, one can reasonably draw inferences about likely effects of implementing PA full practice authority and responsibility based on studies comparing the outcomes, costs, and other impacts of NPs practicing in states that require physician supervision versus those practicing in states that do not require physician supervision. In addition, some studies utilize differences in scope of practice laws for PAs (i.e., prescription authority) to estimate the effects on patient outcomes, costs, and access. This section reviews such recent research studies.


A 2015 RAND report that reviewed the then-available literature on the effect of changing NP scope-of-practice laws from restrictive to full practice authority summarized the results of the literature assessment. Table 2.1 of report, shown below, provides an overview of their conclusions.

Since 2015, however, several additional research studies on the topics of patient outcomes, access and cost have been published. The results of those studies are discussed in the sections that follow.

### Table 2.1. Summary of Results upon Changing Scope-of-Practice Laws from Restrictive to Full Practice Authority

<table>
<thead>
<tr>
<th>Aspect of Care</th>
<th>Overall Impact</th>
<th>Impact Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access and utilization</td>
<td>Likely increase</td>
<td>The total amount of care provided to patients in a state would likely increase. One key study finds a 2% increase in the number of office visits when a state’s SOP laws are relaxed. Percentage of the population receiving checkups and reporting timely and convenient care should also increase—by as much as 10% or more on some measures.</td>
</tr>
<tr>
<td>Quality and outcomes</td>
<td>Possible increase</td>
<td>Evidence suggests that ED visits for ACS conditions goes down, which is a marker of higher-quality primary care. Patients self-report improved health status and experiences of care. Data are suggestive but inconclusive.</td>
</tr>
<tr>
<td>Costs</td>
<td>Inconclusive</td>
<td>For services that can be provided by both NPs and physicians, evidence suggests that prices would decrease, particularly in the case of well-child visits. However, as stated previously, utilization will likely increase as access improves. Total costs are the produce of prices and utilization. So, decreasing costs with increasing utilization could lead to increased or decreased costs. In terms of total costs, some categories of spending would likely increase and others decrease. Researchers have found increases in spending on office visits but decreases in ED visits. The cost savings due to reductions in ED visits could be significant compared with increased costs from more outpatient visits. Spending on compliance with SOP laws (e.g., NPs paying supervising physicians or other administrative costs) would be reduced or eliminated. However, no studies to date have estimated the overall effect on costs.</td>
</tr>
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</table>

**Note:** Likely indicates that theory and all or most empirical studies support an effect in the same direction. Possible indicates that evidence is weak or suggestive or studies are limited, but generally in the same direction. Inconclusive indicates that some of the evidence would suggest an increase while others would suggest a decrease and there is not enough evidence to suggest an overall effect. ED = emergency department, ACS = ambulatory care–sensitive. A condition is sensitive to ambulatory care if appropriate ambulatory care could prevent the onset of this type of illness or condition, control an acute episodic illness or condition, or manage a chronic disease or condition. A disproportionately high rate is presumed to reflect problems in obtaining access to appropriate primary care” (National Quality Measures Clearinghouse, 2014).

**Patient Outcome Implications.** Seeking to fill a void in the research base, Kurtzman et al (2017) utilized patient care and outcome records for randomly selected physicians, NPs, PAs, and nurse mid-wives practicing at 104 community health centers between 2006 and 2011. They modeled nine outcomes, including three quality measures, four service utilization

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22 Quality measures included number of patients who received smoking cessation counseling (nicotine replacement therapy or medication ordered, supplied, administered, or continued and/or smoking cessation counseling) per visit by adults who were identified as smokers; number of patients for whom antidepressants were
measures\textsuperscript{23}, and two referral pattern measures\textsuperscript{24}. Highlights of the study findings include the following:

- Since economic theory suggests that if restrictions on scope-of-practice are effective in protecting consumers from suboptimal care, one would expect patients who see NPs in states with more restrictive scope-of-practice laws to receive higher quality of care than those who see NPs in unrestricted states. The findings of the study did not support that hypothesis. NP independent scope-of-practice laws had no statistically significant effect on any of the three quality indicators.

- The study found a positive relationship between NP independence and service utilization measures, which they conclude lend support to the theory that “guild [physician] efforts to persuade states to limit entry into specific professions [are] for the benefit of those in the guild profession and at the expense of the public”.

- The study found that independent prescriptive authority was associated with an increase in the number of medications, suggesting that “restrictions – which, in some states, require NPs to obtain physician co-signatures on prescriptions – might prove sufficiently burdensome to change these practitioners’ prescribing habits.”

- The study found that NP practice independence was associated with an increase in the odds of receiving a physician referral. The authors speculate that this finding could simply reflect differences in patient’s medical complexity, the lack of a supervising physician with whom the NP could informally confer, or NP concerns about liability and/or malpractice might incentivize NPs in independent practice states to refer at higher rates.

The authors conclude that the “Study findings – which did not demonstrate a scope of practice-quality effect – do not substantiate the use of restrictions for the sole purpose of consumer protection.”

A 2014 study (Kleiner et al) found that more restrictive scope of practice laws has “no noticeable effect on the quality of service” provided by NPs, as measured by infant mortality and malpractice insurance premiums.\textsuperscript{25}

**Health Care Costs and Access to Care Implications.** A 2014 study (Strange) that found “little evidence that increases simply in the number of PAs and NPs have improved healthcare ordered, supplied, administered, or continued and/or psychotherapy or mental health counseling per visit by adults with depression: statin for hyperlipidemia ordered, supplied, administered, or continued per visit by adults with hyperlipidemia.

\textsuperscript{23} Service utilization measures included physical examination (binary); total number of health education/counseling services (count); imaging services (binary); and total number of medications ordered, supplied, administered or continued (count).

\textsuperscript{24} Referral pattern measures included return visit at a specified time (binary) and physician (MD) referral (binary).

access”, but shows that when expanded scope of practice is accounted for, there is “some evidence that access has improved”.  

More recently, Timmons (2016) matched Centers for Medicare and Medicaid Services data from 1999 to 2012 with state regulatory information on NPs and PAs to examine the effect of expanded scope of practice of NPs and PAs on access to health care for Medicaid patients. Using multiple regression analysis, Timmons found “consistent evidence that expanded scope of practice for PAs is associated with lower outpatient claims [costs] per Medicaid beneficiary” and that the “reduction in cost is quite large ($109-$133)”. Timmons concludes that “the results of this paper, combined with findings of other researchers, suggest that broader scope of practice for NPs and PAs has little effect on the quality of care delivered, increases access to health care, and also potentially reduces the cost of providing health care to patients.” More generally, he notes that “broadening the scope of practice of nonphysician healthcare providers…is very likely to improve consumer welfare.”

A naturally occurring experiment allowed Liu et al (2017) to examine the effect of imposing more stringent physician oversight requirements on PAs and NPs. In 2008, Kaiser Permanente changed its practice (in effect from 2006 - early 2008) of allowing NPs and PAs to manage a patient panel, and removed NPs and PAs from all face-to-face primary care in Georgia. Using regression analysis to analyze 2006-2008 patient utilization data compared to 2008-2010 patient utilization data, the authors estimated the incremental benefit of adding [NPs and PAs] to existing physician clinics. The study found that “greater NP/PA use in primary care visits …was not associated with higher specialty referrals, advanced imaging, ED [emergency department] visits, or inpatient stays.”

Implications for New Graduates and Early Career PAs. As medical providers, PAs are trained at the graduate level in programs modeled after medical school curricula, which include more than 2,000 hours of clinical rotations. They are nationally certified and state-licensed providers who practice medicine—they diagnose, write prescriptions, order and interpret tests, treat patients and assist in surgery. As a profession, PAs are uniquely equipped to play a leading role in the new healthcare paradigm focusing on the quality of outcomes, not simply on the number of medical services provided. PAs practice team-based care, make prevention as important as treatment, and help keep healthcare costs down.

Under the proposed policy, new graduates and early career PAs, as well as PAs who are switching specialties, would continue to practice in teams with physicians and, like every PA, their scope of practice would be determined at the practice level. Regardless of whether a PA is early career, changing specialty, or simply encountering a condition with which they are unfamiliar, the PA is responsible for seeking consultation as necessary to assure that the patient’s


treatment is consistent with the standard of care. It is not necessary or helpful to require that a PA enter into a formal “supervisory agreement” with a single physician or group of physicians, because such requirements can negatively affect team flexibility and, therefore, limit patient access to care without improving patient safety. Further, “supervisory agreement” requirements put all providers involved at risk of disciplinary action for “paperwork infractions” that are unrelated to patient care or outcomes.

Related AAPA Policy

HP-3100.2.1

HP-3100.3.1
PAs are health professionals licensed or, in the case of those employed by the federal government, credentialed to practice medicine in collaboration with physicians. PAs are qualified by graduation from an accredited PA educational program and/or certification by the National Commission on Certification of Physician Assistants.

Within the physician-PA relationship, PAs provide patient-centered medical care services as a member of a health care team. PAs practice with defined levels of autonomy and exercise independent medical decision making within their scope of practice. [Adopted 1995, reaffirmed 2000, 2005, 2010, amended 1996, 2014]

HP-3300.1.1
PAs, by virtue of their education and legal scope of practice as professionals who provide medical care in teams with physicians, are qualified to order and monitor the use of patient restraint and seclusion. This applies to restraints when used in conjunction with a medical or surgical procedure and when used for behavioral reasons. Restraint or seclusion should only be for the purpose of protecting the patient or others or to improve a patient's functional well-being, and only if less intrusive interventions have been determined to be ineffective. [Adopted 2000, reaffirmed 2005, 2010, 2015]

HP-3400.1.1
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.

AAPA believes that the physician-PA team relationship is fundamental to the PA profession and enhances the delivery of high-quality health care. As the structure of the health care system changes, it is critical that this essential relationship be preserved and strengthened. 


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


AAPA supports measures that allow for flexible and efficient utilization of PAs consistent with the provision of quality health care. More specifically, PA employment and supervision are separate issues. The regulatory requirements of PA supervision should be unrelated to any aspect of employment.


AAPA shall promote the PA profession to hospital administrators, health care leaders and PA employers as a cost-effective, team-based and patient-centered way to improve the quality, access and continuity of patient care.


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


AAPA believes that the cost-based reimbursement mechanism for Rural Health Centers should be continued or an equivalent payment mechanism should be developed to cover the costs of providing services to rural Medicare and Medicaid patients and protect the financial viability of rural clinics.


AAPA believes it is essential that all public and private insurers enroll PAs and cover medical and surgical services provided by PAs in all practice settings.

AAPA believes it is vital to track the volume and quality of medical and surgical services provided by PAs to assess the impact of those services on patients and on the health care system. To facilitate that effort, AAPA supports the recognition of, and direct payment to, PAs by public and private third party payers and health care organizations. AAPA is committed to maintaining the established supervising physician-PA relationship that is a central concept in the PA profession and incorporated into every state’s law. [Adopted 2011]

AAPA believes that services provided by physician-PA teams should be counted when federal and state governments determine the primary health care service needs of medically underserved and health professional shortage areas. Recognition of physician-PA team productivity should not be done in such a way as to decrease patient access to care. [Adopted 1998, reaffirmed 2003, 2008, 2013]

AAPA believes that PAs must acknowledge their individual responsibilities to patients, society, other health professionals, and to themselves; and in meeting their responsibilities, their actions should be guided by the Guidelines for Ethical Conduct for the PA Profession. AAPA believes the endorsement of the Guidelines for Ethical Conduct is a professional responsibility that underscores the principle of self-regulation. [Adopted 1990, amended 1991, 2001, reaffirmed 1996, 2006, 2011, 2016]

Guidelines for PAs Working Internationally

1. PAs should establish and maintain the appropriate physician-PA team.
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 health care providers, and the local health care 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 to nonmedical volunteers only when they have the competency and supervision needed for the tasks for which they are assigned. [Adopted 2001, amended 2011, reaffirmed 2006, 2016]
AAPA endorses the 1975 World Medical Association Declaration of Tokyo which provides guidelines for physicians and, by nature of their dependent relationship, for PAs, in cases of torture or other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.  

AAPA believes that telemedicine can improve access to cost-effective, quality health care and improve clinical outcomes by facilitating interaction and consultation among providers. Because of the potential of telemedicine to enhance the practice of medicine by physician-PA teams, AAPA encourages PAs to take an active role in the utilization and evaluation of this technology. AAPA supports further research and development in telemedicine, including resolution of problems related to regulation, reimbursement, liability, and confidentiality.  

AAPA believes that electronic health record (EHR) systems, computerized provider order entry (CPOE) systems, reimbursement and claims systems, and other health information technology systems should individually recognize and support the optimal utilization of PAs, and, when appropriate, provide attribution to PAs. 

Health information technology systems should be designed, developed, and implemented with appropriate PA input in a manner that benefits patients, the physician-PA team, and the health care system by improving quality, encouraging patient-centered care, and reducing costs.  
[Adopted 2013]

Coverage for the treatment of mental health and substance use disorders should be available, nondiscriminatory and covered at the same benefit level as other medical care. Reimbursement for PAs providing mental health and substance use disorder care should be provided in the same manner as other physician services provided by PAs.  

AAPA recognizes the shortage of health care services in the United States and its expected impact on the quality, availability, and cost of health care in this country. AAPA is committed to raising awareness of 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 health care shortages that include expansion and access to physician-PA teams to meet anticipated requirements for health care services.  
[Adopted 2006, reaffirmed 2011, 2016]
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 health care 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.


Comprehensive Health Care Reform

AAPA supports health care that is delivered by qualified providers in physician-directed teams.

Accreditation and Implications of Clinical Postgraduate PA Training Programs

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

- Limited study in critical care demonstrates clinical postgraduate PA (and APRN) training positively impacted patient care and enhanced the training of other healthcare professionals in critical and intensive care settings
- Limited study in emergency medicine demonstrated that the vast majority program faculty surveyed felt PA students had sufficient training from entry level PA education for emergency medicine practice and more than half did not see a need for clinical postgraduate PA training

Guidelines for Updating Medical Staff Bylaws: Credentialing and Privileging PAs
(Adopted 2012)

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

Credentialing PAs

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

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

This serves as a reasonable guideline. As applied to PAs, these criteria might include:

- evidence of national certification
- letters from previous employers, supervising physicians, PA peers, or PA programs attesting to scope and level of performance
- verified logs of clinical procedures
- personal attestation as to physical and mental health status
- evidence of adequate professional liability insurance
- information on any past or pending professional liability or disciplinary actions
- a letter from a sponsoring physician (MD or DO) who is a member of the medical staff.

PA Privileges

The fundamental premise of the PA profession is a solid educational foundation in medicine and surgery that prepares PAs to work with physicians in any specialty or care setting.

Expanding Privileges

PAs are educated in the medical model of evaluation, diagnosis, and treatment. They are committed to life-long learning through clinical experience and continuing medical education. Recognition that new tasks and responsibilities can be taught and delegated to the PA by physicians as a PA gains experience, and as the physician and PA grow as a team, are key to effective utilization of PAs.

Participation in Disaster and Emergency Care

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

In case of an emergency, any member of the medical staff, house staff, and any licensed health practitioner, limited only by the qualifications of their license and regardless of service or staff status, shall be permitted to render emergency care. They will be expected to do everything possible to save the life of a patient, utilizing all resources of the hospital as necessary, including the calling of any consultations necessary or desirable. Any PA acting in an emergency or disaster situation shall be exempt from the hospital’s usual requirements of physician supervision to the extent allowed by state law in disaster or emergency situations. Any physician who supervises a PA providing medical care in response to such an emergency or declared disaster does not have to meet the requirements set forth in these bylaws for a supervising physician.

PAs as Medical Review Officers

AAPA believes that the medical knowledge and training necessary to ensure competence as an MRO are not limited to licensed physicians. As practitioners trained in the medical model to provide physician services, PAs have the background necessary to perform successfully the duties of an MRO.

PAs as Medicaid Managed Care Providers

Recommendations

PAs, practicing with physician supervision, are a critical part of the health workforce providing care for Medicaid patients. To facilitate the continued delivery of services to these patients, AAPA believes that states should include the following provisions in Medicaid managed care plans:

- PAs should be recognized as primary care providers, either by naming them individually, or in conjunction with their supervising physicians, or by naming them within a group.
- To maintain and improve continuity of care, PAs should be included on the list of health care professionals in order to allow Medicaid beneficiaries the option of seeking care from a physician-PA team that may in fact already be serving as their current provider of care.
- States should assign a maximum patient panel that recognizes the proven productivity of PAs and physicians and does not provide a disincentive for utilizing PAs on the health care team. This can be achieved by increasing a supervising physician’s panel size by an appropriate number or by directly paneling the PA.
- State Medicaid programs should establish regulations that are consistent with PA state law to allow for the maximum efficiency of physician-PA teams.

Professional Competence
Competence, Competencies and Competency-based Education
An overarching competency PAs must possess is the ability to practice interdependently in the physician/PA team: A skill that requires medical knowledge, professionalism, and interpersonal and communication skills, but is more than the sum of these parts.

End-of-Life Decision Making

Special Concerns for PAs
(95) The patient is the central figure in end-of-life decision making, but PAs have an important role to play. In some cases, the PA will be the dying patient's primary health care provider and chief advocate. All medical caregivers have a prime responsibility to ensure the patient's well-being. In doing so, however, they must act in accordance with their own ethical principles. PAs also have a unique responsibility arising from their relationship with supervising physicians, who share liability for the PA’s actions.

(100) A PA has two supervising physicians who share call and hospital duties, but have widely divergent moral and/or ethical views on end-of-life issues.

(101) A precarious spot and divided loyalties may characterize the PA's position in such circumstances. The optimal course is to discuss end-of-life issues with the supervising physician before potential conflicts arise. When discord persists, the PA must remember that the physician bears the ultimate liability and, therefore, the final responsibility for clinical decision making. A PA who believes that legal or ethical precepts are being violated is responsible for speaking out in an appropriate and timely manner.

Conclusion
(109) PAs have a legal and ethical responsibility to the supervising physician, as well as to the patient. PAs should inform and involve the physician in all near-death planning. The PA should not withdraw life support without the supervising physician’s agreement.

Guidelines for Ethical Conduct for the PA Profession

Introduction
When faced with an ethical dilemma, PAs may find the guidance they need in this document. If not, they may wish to seek guidance elsewhere, possibly from a supervising physician, a hospital ethics committee, an ethicist, trusted colleagues, or other AAPA policies.

PA Role and Responsibilities
PA practice flows out of a unique relationship that involves the PA, the physician, and the patient. The individual patient–PA relationship is based on mutual respect and an agreement to work together regarding medical care. In addition, PAs practice medicine with physician supervision; therefore, the care that a PA provides is an extension of the care of the supervising physician. The patient–PA relationship is also a patient–PA–physician relationship.
Initiation and Discontinuation of Care

A PA and supervising physician may discontinue their professional relationship with an established patient as long as proper procedures are followed. The PA and physician should provide the patient with adequate notice, offer to transfer records, and arrange for continuity of care if the patient has an ongoing medical condition.

Disclosure

A PA should disclose to his or her supervising physician information about errors made in the course of caring for a patient. The supervising physician and PA should disclose the error to the patient if such information is significant to the patient’s interests and well being.

End of Life

While respecting patients’ wishes for particular treatments when possible, PAs also must weigh their ethical responsibility, in consultation with supervising physicians, to withhold futile treatments and to help patients understand such medical decisions. PAs should involve the physician in all near-death planning. The PA should only withdraw life support with the supervising physician’s agreement and in accordance with the policies of the health care institution.

PA-Physician Relationship

Supervision should include ongoing communication between the physician and the PA regarding patient care. The PA should consult the supervising physician whenever it will safeguard or advance the welfare of the patient. This includes seeking assistance in situations of conflict with a patient or another health care professional.

Flexibility as a Hallmark of the PA Profession: The Case Against Specialty Certification


Value of PAs

Among the unique attributes of PAs are the focus, content, and length of their education, their socialization, and their adaptability in the delivery of medical services previously provided only by physicians. PAs are also distinguished by their commitment to practice as part of physician-PA teams.

PA Education

PA educational programs provide a broad-based, generalist medical education with a focus on primary care. As are trained to think like physicians and to be life-long learners. The educational process frequently draws upon the prior experience of students, adds intense didactic and clinical instruction, and produces individuals who know how to practice medicine as part of a team and value their role in the system. Their generalist training prepares PAs to work with physicians in any specialty.

PA Practice

By functioning as part of physician-directed teams, PAs have flexibility in practice. A supervising physician is authorized within the boundaries of state law or federal regulations, to delegate to the PA any portion of the physician’s practice that are within the PA’s ability to
perform. New tasks and responsibilities can be taught and delegated as the PA’s expertise expands and as the team members’ understanding of one another grows.

… The synergy of physician-PA team practice benefits patients both individually and collectively.

Physicians have a depth and breadth of training that is unmatched by other medical professionals. PAs embrace the notion that physicians should lead the health care team. PAs do not seek to compete with physicians, but rather endorse their role and support the concept of physician-directed care. The current system that consists of education, national certification, state licensure, federal regulations, and the team practice concept has made this success possible. AAPA believes that changes to the system should be made only if they are improvements that have benefits for the public as well as for PAs and their physician colleagues.

**Quality Incentive Programs**


**Impact on PAs**

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.

**Competencies for the PA Profession**


**Introduction**

This document serves as a map for the individual PA, the physician-PA team, and organizations committed to promoting the development and maintenance of professional competencies among PAs.

Patient-centered, PA practice reflects a number of overarching themes. These include an unwavering commitment to patient safety, cultural competence, quality health care, lifelong learning, and professional growth. Furthermore, the profession’s dedication to the physician-PA team benefits patients and the larger community.

**Professionalism**

PAs are expected to demonstrate:

- understanding of legal and regulatory requirements, as well as the appropriate role of the PA
- professional relationships with physician supervisors and other health care providers

**Systems-based Practice**

PAs should work to improve the health care system of which their practices are a part.

PAs are expected to:
effectively interact with different types of medical practice and delivery systems
understand the funding sources and payment systems that provide coverage for patient
care and use the systems effectively
practice cost-effective health care and resource allocation that does not compromise
quality of care
advocate for quality patient care and assist patients in dealing with system complexities
partner with supervising physicians, health care managers, and other health care
providers to assess, coordinate, and improve the delivery and effectiveness of health
care and patient outcomes

The Role of In-Store or Retail Health Clinics
(Adopted 2007 and reaffirmed 2012)

Executive Summary
PAs have worked hard to overcome misconceptions about their abilities and the medical
marketplace has demonstrated that physician-PA teams are capable of a wide range of services,
including highly complicated specialty practice.
There are several principles that AMA, AAFP, and AAP believe should be followed by store-
based clinics. The principles that the three organizations have in common are referrals of patients
to physician practices in the community; use of evidence-based medical protocols; and
compliance with relevant state laws regarding physician supervision or collaboration with PAs
and NPs or some form of physician-directed team practice.
AAPA adopted a policy related to retail clinics in 2003 that says:
“AAPA supports expanded health care access for all people. AAPA encourages
innovation in health care delivery, but remains committed to the model of physician
directed team care. AAPA maintains that continuity of care is a high priority;
therefore, communication between the episodic care provider and the primary
provider should be maximized within the constraints of regulation, patient
confidentiality, and patient preference.”

As a complement to this policy, AAPA proposes that retail clinics:
Seek to establish arrangements by which their health care providers have ongoing
access to and supervision by physicians (MDs and DOs), consistent with state laws;
Seek to establish referral systems with physician practices or other facilities for
appropriate treatment if the patient’s condition is beyond the scope of services
provided by the clinic; and
Seek to establish formal connections with physician practices in the community to
provide continuity of care and encourage a medical home for patients.

Possible Negative Implications
While the JTF believes that the policy language regarding team-based patient-centered practice
in teams that include physicians will provide assurance to individual physicians and physician
organizations that PAs want and intend to continue practicing in teams, some may be concerned that physicians will reject this proposal as “PAs seeking independent practice”.

ARC-PA, PAEA, and individual PA programs may be concerned that there is a need for additional restrictions on early career PAs, despite policy language that explains the obligation of each PA to assure that PAs have access to physicians and other qualified providers for collaboration, consultation and referral, as indicated by the patient’s condition and the standard of care, and in accordance with the PA’s education, training and experience.

Financial Impact

To the extent that AAPA, state chapters, and other constituent organizations are already pursuing changes to PA practice acts and government regulations (at both the state and federal level), pursuit of the changes recommended by the JTF may substitute for already planned advocacy-related activities. If AAPA, state chapters, and other constituent organizations seek to more rapidly change laws and regulations, additional resources may be required for advocacy efforts.

Signature

Todd Pickard, PA-C
2nd Vice Speaker
(On behalf of the Joint Task Force on the Future of PA Practice Authority)

Contact for Resolution

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Guidelines for State Regulation of PAs

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

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

Introduction
Recognition of PAs as medical providers led to the development of state laws and regulations to govern their practice. Inclusion of PAs in state law and delegation of authority to regulate their practice to a state regulatory body serves two main purposes: (1) to protect the public from incompetent performance by unqualified medical providers, and (2) to define the role of PAs in the healthcare system. Since the inception of the profession, dramatic changes have occurred in the way states have dealt with PA practice. In concert with these developments has been the creation of a body of knowledge on legislative and regulatory control of PA practice. It is now possible to state which specific concepts in PA statutes and regulations enable appropriate practice by PAs as medical providers while protecting the public health and safety.
What follows are general guidelines on state governmental control of PA practice. The AAPA recognizes that the uniqueness of each state’s political and healthcare climate will require modification of some provisions. However, standardization of PA regulation will enhance appropriate and flexible PA practice nationwide. This document does not contain specific language for direct incorporation into statutes or regulations, nor is it inclusive of all concepts generally contained in state practice acts or regulations. Rather, its intent is to clarify key elements of regulation and to assist states as they pursue improvements in state governmental control of PAs. To see how these concepts can be adapted into legislative language, please consult the AAPA’s model state legislation for PAs.

Definition of PA
The legal definition of PA should mean a healthcare professional who meets the qualifications for licensure and is licensed to practice medicine.

Qualifications for Licensure
Qualifications for licensure should include graduation from an accredited PA program and passage of the PA National Certifying Examination (PANCE) administered by the National Commission on Certification of PAs (NCCPA).
PA programs were originally accredited by the American Medical Association’s Council on Medical Education (1972-1976), which turned over its responsibilities to the AMA’s Committee on Allied Health Education and Accreditation (CAHEA) In 1976. CAHEA was replaced in 1994 by the Commission on Accreditation of Allied Health Education Programs (CAAHEP). On January 1, 2001, The Accreditation Review Commission
on Education for the PA (ARC-PA), which had been part of both the CAHEA and CAAHEP systems, became a freestanding accrediting body and the only national accrediting agency for PA programs.

Because the law must recognize the eligibility for licensure of PAs who graduated from a PA program accredited by the earlier agencies, the law should specify individuals who have graduated from a PA program accredited by the ARC-PA or one of its predecessor agencies, CAHEA or CAAHEP.

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

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

**Licensure**

When a regulatory board has verified a PA’s qualifications, it should issue a license to the applicant. Although, in the past, registration and certification have been used as the regulatory term for PAs, licensure is now the designation and system used in all states. This is appropriate because licensure is the most stringent form of regulation. Practice without a license is subject to severe penalties. Licensure both protects the public from unqualified providers and utilizes a regulatory term that is easily understood by healthcare consumers.

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

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

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

**Collaboration**

The definition of collaboration should convey a process in which PAs and physicians jointly contribute to the healthcare and medical treatment of patients with each collaborator performing actions he or she is licensed to otherwise perform. Collaboration shall be continuous but shall not be construed to require the physical presence of the physician at the time and place that services are rendered. It is imperative, however, that the PA and a collaborating physician have access to each other. Even when practicing in collaboration with a physician, PAs are responsible for the care they provide. Nothing in the law should require or imply that the collaborating physician is responsible or liable for the care provided by the PA unless the PA is acting on the specific instructions of a physician.

Collaborating physician should be defined as an allopathic or osteopathic physician (MD or DO) licensed to practice in the state, who agrees to collaborate with PA(s). For PAs who practice in federal jurisdictions, collaboration may be provided by a physician (MD or DO) who meets the licensing requirements of the federal agency. Licensure in the state should not be required for federal collaborating physicians if it is not required by the federal agency. In group practice situations or in the hospital or its emergency department, provisions should be made for all staff physicians who so choose to collaborate with PAs who practice in the group or institution.

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

Because the state licenses both physicians and PAs and can discipline or revoke or restrict the license of both types of providers, it is redundant and unnecessary for the law to require physicians or PAs to file notice of collaborative arrangements with an agency.

**OPTIMAL TEAM PRACTICE**

Since the inception of the profession, PAs have embraced team-based patient-centered practice and continue to do so. Because both PAS and PHYSICIANS ARE TRAINED IN THE MEDICAL MODEL AND USE SIMILAR CLINICAL REASONING, PA/PHYSICIAN TEAMS ARE ESPECIALLY EFFECTIVE AND VALUED.

Optimal team practice occurs when PAs have the ability to consult with a physician or other qualified medical professional, as indicated by the patient’s condition and the standard of care, and in accordance with the PA’s training, experience, and current competencies.

The evolving medical practice environment requires flexibility in the composition of teams and the roles of team members to meet the diverse needs of patients. Therefore, the manner in which PAS and PHYSICIANS WORK TOGETHER SHOULD BE DETERMINED AT THE PRACTICE LEVEL.
THE PA/PHYSICIAN TEAM MODEL CONTINUES TO BE RELEVANT, APPLICABLE AND PATIENT-CENTERED. HOWEVER, STATE LAW SHOULD NOT REQUIRE A SPECIFIC RELATIONSHIP BETWEEN A PA, PHYSICIAN, OR ANY OTHER ENTITY IN ORDER FOR A PA TO PRACTICE TO THE FULL EXTENT OF THEIR EDUCATION, TRAINING AND EXPERIENCE. SUCH REQUIREMENTS DIMINISH TEAM FLEXIBILITY AND THEREFORE LIMIT PATIENT ACCESS TO CARE, WITHOUT IMPROVING PATIENT SAFETY. IN ADDITION, SUCH REQUIREMENTS PUT ALL PROVIDERS INVOLVED AT RISK OF DISCIPLINARY ACTION FOR REASONS UNRELATED TO PATIENT CARE OR OUTCOMES. LIKE EVERY CLINICAL PROVIDER, PAS ARE RESPONSIBLE FOR THE CARE THEY PROVIDE. NOTHING IN THE LAW SHOULD REQUIRE OR IMPLY THAT A PHYSICIAN IS RESPONSIBLE OR LIABLE FOR CARE PROVIDED BY A PA, UNLESS THE PA IS ACTING ON THE SPECIFIC INSTRUCTIONS OF THE PHYSICIAN.

OPTIMAL TEAM PRACTICE IS APPLICABLE TO ALL PAS, REGARDLESS OF SPECIALTY OR EXPERIENCE. WHETHER A PA IS EARLY CAREER, CHANGING SPECIALITY OR SIMPLY ENCOUNTERING A CONDITION WITH WHICH THEY ARE UNFAMILIAR, THE PA IS RESPONSIBLE FOR SEEKING CONSULTATION AS NECESSARY TO ASSURE THAT THE PATIENT’S TREATMENT IS CONSISTENT WITH THE STANDARD OF CARE.

Notwithstanding the above provisions, these guidelines recognize that medicine is rapidly changing. A modified model may be better for some states and they should therefore feel free to craft alternative provisions. PAS practice team-based medicine with a wide variety of team members to include physicians. Language in state law should acknowledge consultation and/or collaboration between physicians and PAs in a manner that assures quality medical care and promotes access.

**PA Practice Ownership and Employment**

Employment and collaboration should be regarded as separate entities. A physician’s ability to collaborate with a PA is independent of the specifics of PA employment. In the early days of the profession the PA was commonly the employee of the physician. In current systems physicians and PAs may be employees of the same hospital, or health system, OR LARGE PRACTICE. In some situations, the PA may be part or sole owner of a practice. PA practice owners may be the employers of their collaborating physicians.

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

**Disasters, Emergency Field Response and Volunteering**

PAs should be allowed to provide medical care in disaster and emergency situations. This may require the state to adopt language THAT PERMITS PAS TO exempting PAs from collaboration provisions when they respond to medical emergencies that occur outside the
place of employment. This exemption should extend to PAs who are licensed in other states or who are federal employees. Physicians who collaborate with PAs in such disaster or emergency situations should be exempt from routine documentation or collaborative requirements. PAs should be granted Good Samaritan immunity to the same extent that it is available to other health professionals.

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

Scope of Practice

State law should permit PA practice in all specialties and settings. In general, PAs should be permitted to provide any legal medical service that is within the PA’s skills, education, training and experience. Medical services provided by PAs may include but are not limited to ordering, performing and interpreting diagnostic studies, ordering and performing therapeutic procedures, formulating diagnoses, providing patient education on health promotion and disease prevention, providing treatment and prescribing medical orders for treatment. This includes the ordering, prescribing, dispensing, administration and procurement of drugs and medical devices. PA education includes extensive training in pharmacology and clinical pharmacotherapeutics. Additional training, education or testing should not be required as a prerequisite to PA prescriptive authority. PAs who are prescribers of controlled medications should register with the Federal Drug Enforcement Administration.

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

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

Title and Practice Protection

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

Regulatory Agencies

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

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

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

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

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

**Discipline**

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

**Inclusion of PAs in Relevant Statutes and Regulations**

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

FOR ALL PROGRAMS, STATES SHOULD INCLUDE PAS IN THE DEFINITION OF PRIMARY CARE PROVIDER WHEN THE PA IS PRACTICING IN THE MEDICAL SPECIALTIES THAT DEFINE A PHYSICIAN AS A PRIMARY CARE PROVIDER. IT IS IN THE BEST INTEREST OF PATIENTS, PAYERS AND PROVIDERS THAT PA-PROVIDED SERVICES ARE MEASURED AND ATTRIBUTED TO PAS; THEREFORE, STATE LAW SHOULD ENSURE THAT PAS WHO RENDER SERVICES TO PATIENTS BE IDENTIFIED AS THE RENDERING PROVIDER THROUGH THE CLAIMS PROCESS AND BE ELIGIBLE TO BE REIMBURSED DIRECTLY BY PUBLIC AND PRIVATE INSURANCE.
2017-B-01-GRPA  Proliferation and Dispersal of Anti-personnel Weapons

2017-B-01  Resolved

Amend policy HX-4400.2.3 entitled “Proliferation and Dispersal of Anti-personnel Weapons”. See policy paper.

Rationale/Justification
The issue of landmines is a public health issue therefore we adamantly discourage their use, as well as support the current US-backed efforts to clear landmines and help victims. Landmines are bad. Our government knows this which is why they are no longer a regular part of US military strategy. We suggest removing statements from the policy related to the formation of military and international policy – an area outside of our expertise.

AAPA and the PAs for Global Health agree land mines affect the global health of citizens. Thus, our goal should be to promote health and provide advice on awareness and advocacy for these issues.

Related AAPA Policy
None

Possible Negative Implications
None

Financial Impact
None

Signature & Contact for Resolution
Albert Bourbon, MPAS, PA-C
Commission on Government Relations and Practice Advancement, Chair
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Proliferation and Dispersal of Anti-personnel Weapons
(Adopted 2012)

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

- AAPA believes in supporting national and international efforts to reach a permanent ban on the use and proliferation of landmines. AAPA DISCOURAGES THE USE OF AND PROLIFERATION OF LANDMINES IN ANY TERRAIN OR ENVIRONMENT.
- AAPA advocates for expanded support by the United States for programs to clear landmines.
- AAPA advocates for continued support by the United States to provide long-term assistance to victims of land mines.
- PAs should understand the risk for injury and death (particularly among children) from other types of unexploded ordnance.
- AAPA supports programs currently aimed at clearance of landmines, and assistance to victims, and recognizes the contribution that our country has made to clear landmines and assist victims. The dangers from unexploded ordnance should not be overlooked as they pose a risk to health care workers and others providing care. Advocacy for a permanent international ban on other unexploded ordnance is necessary.

Introduction
Persistence of armed unexploded ordnance (UXO) such as landmines present a significant public health risk in many countries. [1] This is particularly tragic, since the healthcare infrastructure in post-war countries is typically ill equipped to manage acute devastating trauma or support amputees. In addition, the consequences of landmines extend beyond the borders of those countries. Health-care workers and nongovernmental organizations employees are at increased risk of injuries as they themselves provide assistance in areas of conflict.

Injuries Associated with Landmines and Unexploded Ordnance
In 2003, the Centers for Disease Control and Prevention (CDC) estimated that there
were 60-70 million landmines scattered throughout the world. As many as 70 countries have retained munitions, and it estimated that 24,000 persons, mostly civilians, are killed or injured annually by landmines and other unexploded ordnance (UXO). [1,2] Beside landmines, several other types of anti-personnel munitions can persist in an armed but undetonated state. These include grenades, mortar and artillery shells, expended rockets, and cluster munitions. Cluster munitions are compound bombs that contain hundreds of bomblets which are designed to remain active beyond the initial explosion, disperse and detonate secondarily. It is not uncommon for bomblets to remain undetonated and dangerous for years.

Data from limited published studies indicate that children account for approximately one half of injuries and deaths from all types of UXO. Adult males suffer the majority of civilian casualties from landmines, often when traveling or farming. Children under 18 years of age are more than two times more likely to be injured by other types of UXO, while playing or tending animals. [1,2] Those who survive the initial trauma are left with disfiguring and disabling injuries, including blindness and amputations. The social, medical and rehabilitative infrastructure is not capable of assisting these individuals.

To its credit, the U.S. is the world’s biggest provider of financial and technical assistance to mine clearance programs and other programs that destroy conventional weapons around the world. [3,4,5] U.S. Humanitarian Mine Action Program (a federal interagency partnership) has invested more than $1.5 billion in mine clearance action in nearly 50 countries over the last three decades. [6] In 2009, the United States Department of State declared the western hemisphere, from the Arctic to the border of Columbia was free from unexploded ordnance, including landmines. [6]

The United States last used antipersonnel mines in 1991 (in Operation Desert Storm), has not exported them since 1992, and has not produced landmines since 1997. [3] However, it still retains 10.4 millions of stockpiled antipersonnel mines for potential future use. [3]

It remains one of only 38 countries (including Cuba, Russia, and China) in the world that have not joined the Mine Ban Treaty (the Ottawa protocol), in force since 1999. [7] In addition, in 2008, the U.S. refused to join 80 counties in signing a 2008 treaty to ban cluster munitions and it continues to oppose such a ban, claiming these weapons are legitimate tactical defensive weapons. [8]
The impact of politics should not be understated. It is plausible that a divergence of opinions among federal departments exists, over the issue of security versus humanitarianism. In late 2009, the Obama administration undertook an extensive review of America’s policy related to use of landmines and other anti-personnel weapons, after initially reporting that it would maintain the policy established by the prior administration. In 2011, without yet concluding its review, the U. S. attended the eleventh meeting of states parties to the land mine treaty as an observer. [9]

**Conclusion**

AAPA supports all efforts leading to a permanent ban on the production, stockpiling, trade and use of indiscriminate antipersonnel weapons such as landmines and cluster munitions; and supports the United States government’s significant ongoing involvement in safely removing these weapons and in assisting victims of antipersonnel weapons.

**References**


5. Gaouette N. Clinton Sees Progress on Landmines Even as U.S. Won’t Ban Them. 


Amend policy HP-3500.3.3 entitled “Guidelines for Updating Medical Staff Bylaws: Credentialing and Privileging PAs”. See policy paper.

**Rationale/Justification**

PAs practice medicine and almost 40% of them provide medical and/or surgical care for patients in hospitals and other healthcare facilities. They are required by federal law and regulation/accreditation standards to be credentialed and privileged through the medical staff process. As the only national organization representing PA profession, AAPA has a responsibility to provide such guidance. These facilities often need guidance to modernize bylaws, which in many instances are outdated. This policy and its citations were updated to provide a more comprehensive and useful set of guidelines to reflect a modern healthcare environment and the PA profession.

**Related AAPA Policy**

None

**Possible Negative Implications**

None

**Financial Impact**

None

**Signature & Contact for Resolution**

Albert Bourbon, MPAS, PA-C
Commission on Government Relations and Practice Advancement, Chair

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Guidelines for Updating Medical Staff Bylaws: Credentialing and Privileging PAs
(Adopted 2012)

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

• AAPA believes PAs must seek THE RIGHT TO EXERCISE clinical privileges VIA THE HEALTHCARE ENTITY’S ORGANIZED MEDICAL STAFF and that the process. THE PROCESS AND CRITERIA FOR A REQUEST FOR MEDICAL STAFF CLINICAL PRIVILEGES must be outlined in medical staff bylaws.

• AAPA believes PAs should be VOTING members of the medical staff. BYLAWS SHOULD AFFORD PA REPRESENTATION WITH FULL VOTING RIGHTS ON MEDICAL STAFF COMMITTEES, INCLUDING THE MEDICAL EXECUTIVE COMMITTEE.

• AAPA believes medical staff bylaws should require that each PA WISHING TO PROVIDE MEDICAL CARE TO THE HEALTHCARE ENTITY’S PATIENTS AND SEeks to be considered for be granted clinical privileges regardless of whether the PA’S EMPLOYMENT ARRANGEMENTS, WHETHER THE PA IS DIRECTLY EMPLOYED BY THE ENTITY GRANTING THE PRIVILEGES OR ANOTHER INDEPENDENT ENTITY, is an employee of a practice or of the hospital.

• The criteria for delineating PA clinical privileges should be specified in the bylaws.

• AAPA opposes specialty certification examinations as a requirement for PA credentialing or privileging.

• AAPA believes the duration of MEDICAL STAFF appointments and CLINICAL privileges should be the same for physicians and PAs.

• AAPA believes bylaws should give PAs the right to due process when actions taken by the medical staff or governing board adversely affect his or her clinical privileges.

• AAPA believes the criteria and process for disciplining PEER REVIEW, GRIEVANCES AND CORRECTIVE ACTIONS FOR PAs should be spelled out CLEARLY ARTICULATED in the bylaws. The process should involve PA peers and conform to the process applied to physicians.

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• AAPA believes bylaws should provide mechanisms to carry out quality assurance with respect to PAs. Peer review of PAs should be conducted by peers – ideally, other PAs in the same area of clinical specialty.
• AAPA believes bylaws should require PA participation in continuing medical education that relates to their practice and their privileges.
  • Bylaws should allow PA representation on medical staff committees, including the medical executive committee.
• AAPA believes bylaws should include language enabling PAs to provide care during emergency or disaster situations, AS WELL AS EMTALA SPECIFIC PROVISIONS AS REQUIRED.

Introduction

PAs are highly skilled MEDICAL professionals who practice in every medical and surgical specialty. They PAS are employed by MANY DIFFERENT ENTITIES, INCLUDING BUT NOT LIMITED TO: hospitals and healthcare systems, INDEPENDENT medical practices, hospital medicine groups, RETAIL AND CONVENIENT CARE PRACTICES and emergency department staffing groups AGENCIES, OR AS INDEPENDENT CONTRACTORS. PAs provide medical care almost anywhere in a hospital IN VIRTUALLY EVERY SETTING, including emergency departments, inpatient services, operating rooms SURGICAL SUITES, outpatient units CLINICS and critical care/intensive care units. Requirements for PA practice are defined by state law and hospital ORGANIZATIONAL policy. All state laws allow the flexibility of physicians being TO BE off-site as long as they are available via telecommunication WHEN A PA IS PROVIDING CARE. Most hospitals ORGANIZATIONS develop policies and definitions based on the language used in their state’s laws and regulations governing PA practice. Federal facilities and federally employed PAs, however, are governed by federal agency guidelines, not state law.

The criteria and process for granting clinical privileges to PAs is similar to the process for physicians and must be outlined in the medical staff bylaws. LIKE THE PROCESS FOR PHYSICIANS, the organized medical staff is required to review and verify the credentials of practitioners to ensure that those who provide medical care are competent and qualified to provide specified levels of care. In order to provide patient care services in the hospital or other
healthcare facilities, PAs must seek delineation of their clinical privileges, which are then 
granted RECOMMENDED FOR APPROVAL by the medical staff, and ultimately, GRANTED 
BY the governing body.

In most hospitals, the medical staff credentialing process involves simultaneous 
consideration of applications for medical staff membership and for clinical privileges. The 
following guidelines THIS POLICY are IS intended to assist GUIDE THE ORGANIZED 
medical staffs in making appropriate changes to the bylaws that authorize the granting of 
REGARDING MEDICAL STAFF membership and clinical privileges to FOR PAs. They are 
intended to be a general guide that can THE GUIDELINES CAN be applied and adapted to suit 
the INDIVIDUAL ORGANIZATION’S requirements AND NEEDS. of individual medical 
staffs. Where possible, sample language has been included.

Definition of PA

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

All states CURRENTLY require that a PA

• be a graduate of a PA program accredited by the Accreditation Review Commission on 
  Education for the Physician Assistant (ARC-PA) or one of its predecessor agencies 
  and/or

• pass the initial exam given by the National Commission on Certification of Physician 
  Assistants (NCCPA),

• be licensed to practice as a PA.

Federally employed PAs must meet the first two criteria, but are typically not required to 
be licensed, as federal agencies are not governed by state laws. Many states REQUIRE 
CURRENT CERTIFICATION FOR LICENSURE, and IN SOME INSTANCES, employers 
MAY require current NCCPA certification AS A CONDITION OF EMPLOYMENT. 

The following definition serves as an example.

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

**PAs as Members of the Medical Staff**

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

In the majority of states, THE ORGANIZED medical staff and hospital governing boards decide which types of practitioners will be GRANTED medical staff membership. Both the Joint Commission Medical Staff standards and Medicare’s Conditions of Participation for Hospitals, AS WELL AS THE JOINT COMMISSION MEDICAL STAFF STANDARDS allow PA MEDICAL STAFF MEMBERSHIP, membership on medical staffs. The Joint Commission’s Comprehensive Accreditation Manual for Hospitals states: “The governing body and the medical staff define medical staff membership criteria, which…may include licensed independent practitioners and other practitioners.” The Medicare Conditions of Participation for Hospitals clearly state that, in addition to MD and DO members, the medical staff “may also be composed of other practitioners appointed by the governing body- “IN ACCORDANCE WITH STATE LAW, INCLUDING SCOPE-OF-PRACTICE LAWS, THE MEDICAL STAFF MAY ALSO INCLUDE OTHER CATEGORIES OF PHYSICIANS…AND NON-PHYSICIAN PRACTITIONERS WHO ARE DETERMINED TO BE ELIGIBLE FOR APPOINTMENT BY THE GOVERNING BODY.” The Medicare surveyors’ manual further specifies that hospitals can appoint PAs to the medical staff. State law should be consulted AS the makeup of medical staff membership is occasionally dictated there.
Sometimes ON OCCASION, PAs are HAVE BEEN erroneously categorized as “allied health professionals” or under nursing structures. PAs, by definition, are providers of medical care and, as such, are not part of the allied health field or nursing profession. The National Commission on Allied Health, convened by an act of Congress in 1992, defined an allied health professional as “a health professional (other than a registered nurse or PA)…” The federal Bureau of Health Professions ALSO uses this same definition FOR ALLIED HEALTH and classifies PAs as medical providers.  

AAPA believes that PAs should not be combined with other providers in non-specific, inclusive CATEGORICAL terms such as “midlevel practitioner,” “advanced practice clinician,” or “advanced practice provider.” PAs should utilize, and encourage employers (e.g., hospitals, HMO’s, clinics), third party payers, educators, researchers, and the government to utilize, the term “physician assistant” or PA for clarity and accuracy.  

Medical staff membership language might state:

Membership on the medical staff shall be extended to PAS, physicians, dentists, podiatrists, PAs ADVANCED PRACTICE NURSES, and clinical psychologists who continuously meet the qualifications, standards, and requirements set forth in these bylaws and who are appointed by the hospital’S Board of Directors GOVERNING BODY.  

Credentialing PAs

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

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

This serves as a reasonable guideline. As applied to PAs, these criteria might include:

- EVIDENCE OF GRADUATION FROM AN ARC-PA (OR PREDECESSOR) ACCREDITED PA PROGRAM
• evidence of national certification
• letters from previous employers, supervising physicians, PA peers, or PA programs
  FACULTY attesting to scope and level of performance
• verified logs of clinical procedures, PREVIOUS COMPETENCY EVALUATIONS, OR
  ATTESTATIONS FROM PREVIOUS EMPLOYERS ABOUT COMPETENCE
• personal attestation as to physical and mental health status
• evidence of adequate professional liability insurance
• information on any past or pending professional liability or disciplinary actions
  a letter from a sponsoring physician (MD or DO) who is a member of the medical staff.

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

The American Medical Association’s (AMA) Physician Profile Service AS WELL AS THE FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS) also offers PA credentials verification. Credentialing professionals can SHOULD confirm a PA’s education program attendance COMPLETION and graduation dates, national certification number and status, AND current and historical state licensure information, and AAPA membership status. The Joint Commission has deemed that the information provided by the AMA Physician Profile service is equivalent to primary source information.

PA Privileges

The fundamental premise of the PA profession is ROOTED IN a solid educational foundation in medicine and surgery that prepares PAs to work PRACTICE with physicians in
any specialty or care setting. The medical staff bylaws should require that each PA be granted clinical privileges regardless of whether the PA is an employee of a practice or of the hospital BY WHOM THAT PA IS EMPLOYED. AS PREVIOUSLY NOTED, Medical staff membership should not be a requirement for granting of clinical privileges. This is in accordance with Joint Commission standards and the Medicare Conditions of Participation for Hospitals.

The medical staff bylaws should stipulate that all clinical privileges granted to a PA should be consistent with all applicable state and federal laws and regulations, and that a PA may provide medical and surgical services as delegated by a physician. Typically, privileges for a PA are delineated using a form and process identical to or very similar to that used for physicians. Because PAs provide medical AND SURGICAL services, the physician form and privileging system is a useful template for developing a system of granting PA privileges.

PRIVILEGES MIRROR THOSE OF THE PHYSICIANS.

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

The criteria for delineating clinical privileges should be specified in the bylaws. They are usually the same as those used for credentialing: evidence of current state licensure, relevant training and experience, national certification, letters or other verification from authoritative sources attesting to the individual’s ability to perform certain privileges, attestation as to physical and mental health status, evidence of adequate liability insurance, and information on any past or pending professional liability or disciplinary actions. Privilege determinations – at reappointment or other interim times – might also include observed clinical performance, quality improvement data, and other documented results of quality improvement activities OUTCOME METRICS AS required DETERMINED by the hospital and THE ORGANIZED medical staff.
Other requirements of physician members of the medical staff also may apply to PAs. For example, if hospital policy requires that a department chair approves physician privilege requests before they are submitted to the medical staff credentials committee, then the same should apply to PAs. For Joint Commission-accredited hospitals, PAs, like physicians, are REQUIRED TO BE evaluated using a focused professional practice evaluation (FPPE) for new privileges or performance improvement EXPANSION OF PRIVILEGES and ongoing professional practice evaluation OPPE) for bi-annual reappointment.9

Expanding Privileges

PAs are educated in the medical model of evaluation, diagnosis, and treatment. They are committed to life-long learning through clinical experience and continuing medical education. Recognition that new tasks and INCREASING responsibilities, can be taught and delegated to the PA by physicians as a PA gains experience, and as the physician and PA grow as a team, are A NATURAL PROGRESSION AND THE key to effective utilization INTEGRATION of PAs IN THE DELIVERY OF HEALTHCARE. ADDITIONALLY, EVOLVING MEDICAL INTERVENTIONS AND TECHNOLOGY ARE CONTINUOUSLY BEING DEVELOPED AND MAY REQUIRE A NEW DELINEATION OF PRIVILEGES TO IMPLEMENT. As such, LIKE PHYSICIANS, PAs may need to request additional privileges; this process should mirror as that of the physicians requesting additional privileges.

COMPETENCY SURROUNDING SUCH PRIVILEGES SHOULD BE DETERMINED AT THE PRACTICE/DEPARTMENT LEVEL BASED ON THE PA’S EDUCATION AND EXPERIENCE.

Specialty and Subspecialty Privileges

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

AAPA is committed to lifelong learning and encourages advanced educational opportunities (such as Pediatric Advanced Life Support (PALS) or Advanced Trauma Life Support (ATLS)), as well as verification of specific course completion, However, AAPA does
oppose specialty certification examinations as a requirement for PA credentialing or
privileging. The PA profession currently does not have a system of specialty credentialing like
the specialty boards system developed by physicians. Because there are other ways to assess PA
competency, AAPA believes imposing specialty boards or specialty exams is unnecessary and
would undermine the basic construct of the profession, which is to be broadly educated medical
providers with the versatility and adaptability to meet changing health care needs. Many PAs
fulfill their national certification CME requirement by attending highly specialized courses
specific to their area of practice.

Duration and Renewal of Appointments

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

Due Process

The bylaws should give the PA the right to request the initiation of due process
procedures when actions taken by the medical staff or the governing board adversely affect his or
her clinical privileges. THE MEDICARE CONDITIONS OF PARTICIPATION FOR
HOSPITALS INTERPRETIVE GUIDELINES AS WELL AS Hospital accreditation standards
from the Joint Commission specifically state that medical staffs must establish REQUIRE a fair
hearing and appeals process for addressing adverse decisions made against medical staff
members and others holding clinical privileges. The process should include PA peer reviewers.

Corrective Action

The criteria and process for disciplining ADVERSE DECISIONS AGAINST PAs should
be spelled out ARTICULATED in the bylaws. The process should involve PA peers and
conform to the process applied to physicians.

Quality Assurance

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

2017-B-02-GRPA
Continuing Education

The medical staff bylaws should require participation by PAs in continuing medical education that relates, at least in part, to their regular practice and to their clinical privileges. THESE REQUIREMENTS SHOULD CORRELATE WITH STATE LAW, CERTIFICATION AND LICENSURE REQUIREMENTS, AS APPLICABLE.

Committees

Bylaws should allow PA representation WITH FULL MEDICAL STAFF PREROGATIVES WITH VOTING RIGHTS on ALL STANDING medical staff committees, including BUT NOT LIMITED TO the medical executive committee, CREDENTIALS COMMITTEE, QUALITY AND SAFETY COMMITTEES, PEER REVIEW COMMITTEES, PHARMACY AND THERAPEUTICS COMMITTEE, AND EMERGENCY RESPONSE COMMITTEES.

Discrimination

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

EMTALA PROVISIONS

THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT OF 1986 (EMTALA) REGULATIONS REQUIRE THAT HOSPITAL BYLAWS IDENTIFY WHO IS CONSIDERED “QUALIFIED MEDICAL PERSONNEL” FOR THE FOLLOWING AREAS: MEDICAL SCREENING EXAMS, CERTIFYING FALSE LABOR, EMERGENCY CALL AND TRANSFERRING PATIENTS. THE EMTALA LAW AND REGULATIONS REQUIRE THAT THE HOSPITAL’S WRITTEN POLICIES MUST SPECIFY THAT PAS ARE QUALIFIED PERSONNEL. INDIVIDUAL PAS MUST HAVE PRIVILEGES TO PERFORM THESE EMTALA FUNCTIONS.

Participation in Disaster and Emergency Care

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

Bylaws language might state:

In case of an emergency, any member of the medical staff, house staff, and any licensed health practitioner, limited only by the qualifications of their license and regardless of service or staff status, shall be permitted to render emergency care. They will be expected to do everything possible to save the life of a patient, utilizing all resources of the hospital as necessary, including the calling of any consultations necessary or desirable. Any PA OR PHYSICIAN acting in an emergency or disaster situation shall be exempt from the hospital’s usual requirements of physician supervision BY LAWS PROVISIONS to the extent allowed by state law in disaster or emergency situations. Any physician who supervises a PA providing medical care in response to such an emergency or declared disaster does not have to meet the requirements set forth in these bylaws for a supervising physician.

Conclusion

• PAs must seek delineation of their clinical privileges; the process AND CRITERIA FOR WHICH must be outlined in medical staff bylaws.

• AAPA believes that PAs should be VOTING members of the medical staff.

• Medical staff bylaws should require that each PA be granted clinical privileges TO PROVIDE MEDICAL CARE TO PATIENTS IN THE FACILITY, regardless of BY WHOM THAT PA IS EMPLOYED, whether the PA is an employee of a practice or of the hospital.

• The criteria for delineating PA clinical privileges should be specified in the bylaws.

• AAPA opposes specialty certification examinations as a requirement for PA credentialing or privileging.

• Duration of appointments and privileges should be the same for physicians and PAs.

• Bylaws should give PAs the right to due process when actions taken by the ORGANIZED medical staff or governing board adversely affect his or her clinical privileges.
The criteria and process for disciplining PAs should be spelled out FOR PAS in the bylaws. The process should involve PA peers and conform to the process applied to physicians.

Bylaws should provide mechanisms to carry out quality assurance with respect to PAs. Peer review of PAs should be conducted by peers – ideally, other PAs in the same area of clinical specialty.

Bylaws should require PA participation in continuing medical education that relates to their practice and their privileges.

Bylaws should allow PA representation on STANDING medical staff committees, including the medical executive committee, CREDENTIALING COMMITTEES, AND OTHERS.

Bylaws should include language enabling PAs to provide care during emergency or disaster situations.

Endnotes


§ 482.12 Condition of participation: Governing body.

There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.

(a) Standard: Medical staff. The governing body must:

(1) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff;

(2) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff;
(3) Assure that the medical staff has bylaws;
(4) Approve medical staff bylaws and other medical staff rules and regulations;
(5) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients;...

§ 482.22 Condition of participation: Medical staff. The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital. (a) Standard: Eligibility and process for appointment to medical staff. The medical staff must be composed of doctors of medicine or osteopathy. In accordance with State law, including scope of practice laws, the medical staff may also include other categories of physicians (as listed at § 482.12(c)(1)) and non-physician practitioners who are determined to be eligible for appointment by the governing body.

Several states have no explicit educational requirement. However, because those states require national certification and because only graduates of accredited programs are eligible for the national certification exam, the certification requirements in the laws of those states are the functional equivalent of an educational requirement.

Upon graduation from an accredited PA program, PAs must pass an initial certifying exam. To maintain current certification, PAs must complete 100 hours of continuing medical education every two years and pass a recertification every ten years.

Joint Commission Hospital Accreditation Manual, Standard MS.01.01.01, EP 3: “The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: Qualifications for appointment to the medical staff:

Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff must be composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians as listed at 482.12(c)(1) and nonphysician practitioners who are determined to be eligible for appointment by the governing body.”

CMS -3244-P, October 24, 2011 Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation (proposed rule) provides the following commentary from CMS: “Alternatively, a hospital could establish categories within its medical staff to create distinctions between practitioners who have full
membership, and a new category for those who could be classified as having an
‘associate’, ‘special’ or ‘limited’ membership. Such a structure is neither required nor
suggested; we are providing it here as a possible way to align all of its practitioners
under the ‘Medical Staff’ rules.”

https://www.cms.gov/CFCsAndCoPs/Downloads/CMS3244P.pdf

Standard 42CFR § 482.22(a) Centers for Medicare and Medicaid Services State
Operations Manual, Appendix A-Survey Protocol, Regulations and Interpretive
Guidelines for Hospitals, (Rev. 151, 11-20-15) A-0339, Standard 482.22(a), Retrieved
December 2, 2016:

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


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

AAPA 2016-2017 Policy Manual, HP-3100.1.3 and HP 3100.1.3.1, [adopted 2008,

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

AAPA 2016-2017 Policy Manual, Flexibility as a Hallmark of the PA Profession: The
Cited at HP-3200.4.2 – paper on page 195


Medicare Conditions of Participation Interpretive Guidelines, A-0341/§482.22(a)(2)

“Each practitioner who is a member of the medical staff or who holds medical staff
privileges is subject to the medical staff’s bylaws, rules, and regulations, in addition to
all the requirements of the Medical Staff Condition of Participation. The medical staff and the governing body must enforce its medical staff requirements and take appropriate actions when individual members or other practitioners with privileges do not adhere to the medical staff’s bylaws, regulations, and rules. They must likewise afford all members/practitioners who hold privileges the protections and due process rights provided for in the bylaws, rules and regulations.” [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf]

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

13 42 CFR §489.24(a)(1)(i)

14 42 CFR §489.24(b) Definitions

15 In its guidance about on-call duties, CMS provides some specifics about PAs taking call: see the State Operations Manual Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases (Rev. 60, 07-16-10) §489.20(r)(2) and §489.24(j) [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf page 31]: “If it is permitted under the hospital’s policies, an on-call physician has the option of sending a representative, i.e., directing a licensed non-physician practitioner as his or her representative to appear at the hospital and provide further assessment or stabilizing treatment to an individual. This determination should be based on the individual’s medical need and the capabilities of the hospital and the applicable State scope of practice laws, hospital by-laws and rules and regulations.”

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


Several states have no explicit educational requirement. However, because those states require national certification and because only graduates of accredited programs are eligible for the national certification exam, the certification requirements in the laws of those states are the functional equivalent of an educational requirement.

Upon graduation from a PA program, PAs must pass the NCCPA’s initial certifying exam, the Physician Assistant National Certifying Examination (PANCE). To maintain current certification, PAs must complete 100 hours of continuing medical education every two years and pass the Physician Assistant National Recertification Examination (PANRE) every six years.

"Alternatively, a hospital could establish categories within its medical staff to create distinctions between practitioners who have full membership, and a new category for those who could be classified as having an ‘associate’, ‘special’ or ‘limited’ membership. Such a structure is neither required nor suggested; we are providing it here as a possible way to align all of its practitioners under the ‘Medical Staff’ rules.”

https://www.cms.gov/CFCsAndCoPs/Downloads/CMS3244P.pdf


Centers for Medicare and Medicaid Services. State Operations Manual, Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals. (Rev. 75, 12-02-
Standard 482.22(a), Tag A-0339. Retrieved December 9, 2011:

AAPA 2011-2012 Policy Manual, HP-3100.1.3 and HP 3100.1.3.1, adopted 2008:
http://www.aapa.org/uploadedFiles/content/About_AAPA/PM_11-12_Final.pdf
2017-B-03-GRPA The Importance of PAs in Executive Leadership

2017-B-03 Resolved

Adopt the policy paper entitled “The Importance of PAs in Executive Leadership”. See policy paper.

Rationale/Justification
In the last decade alone, the PA workforce has doubled in size and has increased the number of PA programs more than 63.8%. The majority of certified-PAs are now younger than 40 years old (54.6%) and over 40% work in hospitals and healthcare systems which are mandatorily and traditionally lead by physician and nurse executives. Out of the 108,500 certified PAs, only approximately 300 (0.28%) hold director level or higher leadership positions; and of those, only a few, if any, are considered executive level.

PAs will play a key role in transforming healthcare systems to provide collaborative, team-based care. Thus, the PA Executive will be instrumental in establishing pathways for PA professional development while aligning the system’s mission, vision and goals. By providing system leadership, the PA Executive can improve culture and remove barriers to PA practice thus allowing a full understanding of the PA scope of practice and what it means to practice to top of license.

As a transformational leader, the PA Executive will help identify new clinical and leadership roles for PAs in complex care delivery systems. PAs must be responsible and accountable for both the clinical and financial impact they bring to patients, the healthcare system and the communities they serve. The PA Executive will provide the leadership, skills and clinical expertise along with other clinical executives to prepare healthcare systems for change.

In conclusion, PA Executive roles are essential for the future development and expansion of the PA profession. As hospitals and healthcare systems continue to merge and become increasingly complex, PAs will need strong, executive PA leaders who will facilitate culture change, promote interprofessional collaboration and advance the PA profession.

Related AAPA Policy
HP-3400.2.4
AAPA shall promote the PA profession to hospital administrators, health care leaders and PA employers as a cost-effective, team-based and patient-centered way to improve the quality, access and continuity of patient care.

Possible Negative Implications
None

Financial Impact
None
Signature & Contact for Resolution
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The Importance of PAs in Executive Leadership

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

The AAPA believes the following benefits will result from the presence of PAs in executive leadership positions:

- Facilitate the removal of barriers to PA practice and improve organizational culture.
- Foster the development of workforce models and best practices.
- Improve access and implement systems of care.
- Enable PA leaders to lead and advance transformative health system change.
- Increase diversity, inclusion and representation of the PA workforce to better reflect the changing healthcare landscape.
- Improve quality and safety initiatives by promoting inter-professional collaboration.
- Increase PA engagement, collaboration and accountability.

Introduction
PAs have been part of healthcare systems for over 50 years, yet there are few PAs across the country in executive level positions. In the US, we are at a critical juncture whereby healthcare systems must improve access, increase affordability, all while enhancing patient quality and safety. PAs, who are one the fastest growing healthcare professions, are in an excellent position to lead this change. And although we have many qualified and experienced individuals that are capable and up to the task, they cannot lead change if they are not represented when executive decisions are made. This may be due to several factors. From policy and legislative barriers to a lack of defined leadership pathways, PAs have a hard time breaking through the glass ceiling even though they are expected to be main contributors to the patient care and its outcomes. Today, it is up to those individual PAs who have enough clinical, business and leadership experience to push the status quo to find their way to the C-suite.
**PA Workforce and the Future**

In the last decade alone, the PA workforce has doubled in size, has increased the number of PA programs more than 63.8%, and increased the number of PA program applicants to over 25,000 per year\,\textsuperscript{13,16,17} The majority of certified-PAs are now younger than 40 years old (54.6%), work in a private practice or hospital setting (81.3%) and are female (67.2%).\,\textsuperscript{18}

This rapid expansion of the PA profession has improved the diversity in our own workforce; allowing for individuals from a various different backgrounds, communities and experiences to be at the forefront of medicine. This is all the more important as the new healthcare environment includes improving population health, increasing quality, expanding provider coverage and managing increasingly complex health information technology systems.\,\textsuperscript{19}

The PA workforce is expected to grow over 30% by 2024.\,\textsuperscript{8} Hospitals and healthcare systems are also continuing to merge which create large populations of PAs in need of leadership and oversight. By fostering and developing PA executive leaders, we can begin to break down barriers to PA practice with improved diversity, collaboration and workforce development.

**Healthcare Leadership**

Education and leadership pathways for physicians and nurses have been clearly defined for a number of years. Leadership is essential for any successful venture if the vision is to transform health.\,\textsuperscript{6,7} The PA profession must produce leaders throughout the healthcare system who can serve as full partners with other healthcare professionals and be accountable for their own contributions to delivering high quality healthcare. Leadership that involves working with others as these full partners has been associated with improved patient outcomes, a reduction in medical errors, and less staff turnover.\,\textsuperscript{10,11,12} Yet, while benefits of collaboration among healthcare professionals has been repeatedly documented with respect to improved patient outcomes, reduced length of hospital stay, cost savings, increased job satisfaction and improved teamwork, inter-professional collaboration frequently is not the norm in the healthcare field.\,\textsuperscript{7}

Today, over 40% of PAs work in hospitals and healthcare systems which are mandatorily and traditionally lead by physician and nurse executives.\,\textsuperscript{13} However, as the U.S. continues to have healthcare access shortages and the PA workforce continues to grow, more PA executive leaders will be needed to provide leadership and oversight to its expanding number of PAs. Out of the 108,500 certified PAs, only approximately 300 (0.28%) hold director level or higher.
leadership positions; and of those, only a few, if any, are considered executive level. This is in sharp contrast to out of approximately 708,300 physicians who just in the executive C-suite alone hold approximately 25,121 (3.55%) positions; and out of 222,000 nurse practitioners approximately 24,601 (11.08%) declare a director level or higher leadership position within their organization. 

Promoting Interprofessional Team Based Care and Patient Outcomes

Healthcare delivery has changed considerably with the passage of the Affordable Care Act (ACA). The federal government has moved to a fee-for-value system rather than a fee-for-service system in an attempt to improve cost savings, patient safety, quality and outcomes. In addition, the Centers for Medicare and Medicaid (CMS) has encouraged providers to create inter-professional teams to enable effective communication and improve health outcomes. However, in order for inter-professional teams to be successful, mutual respect among professions in critical. Thus, understanding each individual’s profession, scope of practice and role is essential if improving population health is the ultimate goal.

It has been recognized that physicians cannot provide all of the clinical and educational services that patients need in the new models of care. It is the entire team who is contributing to the care and best practices for their community. Teamwork and shared values break down silos and convert fragmented care into integrated care. Ultimately, inter-professional teams that leverage the skills, talents and expertise of each member, will be the most successful.

Expansion of the PA role as Executive Leaders

PAs will play a key role in transforming healthcare systems to provide collaborative, team-based care. Thus, the PA Executive will be instrumental in establishing pathways for PA professional development while aligning the system’s mission, vision and goals. By providing system leadership, the PA Executive can improve culture and remove barriers to PA practice thus allowing a full understanding of the PA scope of practice and what it means to practice to top of license.

As a transformational leader, the PA Executive will help identify new clinical and leadership roles for PAs in care delivery systems. PAs must be responsible and accountable for both the clinical and financial impact they bring to patients, the healthcare system and the communities they serve. The PA Executive will provide the leadership, skills and clinical expertise along with other clinical executives to prepare the healthcare systems for change.
Conclusion

PAs in Executive roles are essential for the future development and expansion of the PA profession. As hospitals and healthcare systems continue to merge and become increasingly complex, PAs will need strong, executive PA leaders who will facilitate culture change, promote inter-professional collaboration and advance the PA profession.

References


2017-B-04-GRPA  The Role of In-Store or Retail Health Clinics

2017-B-04  Resolved

Amend by substitution policy HX-4700.3.0 entitled “The Role of In-Store or Retail Health Clinics”. See policy paper.

Rationale/Justification
The commission does not think the old policy addressing Retail Based Clinics reflects the growing expansion of these clinics now termed In-Store or Retail Based Convenient Care Clinics. The current policy contains outdated data and information so it was important to update this new field of medicine for PA’s with timely and relevant information.

Related AAPA Policy
None

Possible Negative Implications
None

Financial Impact
None

Signature & Contact for Resolution
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The Role of In-Store or Retail Based Convenient Care Clinics
(Adopted 2007 and reaffirmed 2012)

Executive Summary of Policy Contained in this Paper

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

AAPA proposes that retail clinics:
- Seek to establish referral systems for appropriate treatment if the patient’s condition is beyond the scope of services provided by the clinic; and
- Seek to establish formal connections with primary care or other appropriate practices in the community to provide continuity of care and encourage a medical home for patients.

AAPA believes that these statements complement related AAPA policy, which states:
- “AAPA supports expanded healthcare access for all people. AAPA encourages innovation in healthcare delivery.”
- AAPA maintains that continuity of care is a high priority; therefore communication between the Convenient Care Provider and the Primary Provider should be maximized within the constraints of regulation, patient confidentiality and patient preference.” [HP-3400.1.4, adopted 2003, reaffirmed 2008, 2013]

Delivery of healthcare in America keeps changing. Consumer preferences affect all businesses and healthcare is no exception. Store-based retail health clinics are a response to demands for low cost, convenient services.

Located in supermarkets, pharmacies and high traffic retail outlets, these clinics typically provide medical services for a specific list of conditions. They are open for extended hours and are staffed primarily by PAs and nurse practitioners. Most allow walk-in visits and accept most insurance and offer discounted rates.

The first of these retail clinics opened in 2000. Their growth is staggering, and thousands are expected to be in operation in the coming years. The first clinics were co-founded by a family physician as a way to make care more convenient. Shortly after, retail companies joined the ranks to start several of these chains. Only a handful of retail clinics are owned by physician groups or hospital systems. In July 2006, CVS Corporation acquired MinuteClinic, the first and
largest operator of in-store clinics in the country. Walmart, Walgreens and Kroger are some of
the other retailers operating in this space. Retailers like the clinics because they are another
service to offer their customers, drawing them into the store where they shop while waiting to be
seen and where they can have their prescriptions filled. Some companies make these clinic
services available to their employees. In a newer model, some retailers partner with a local
healthcare organization or hospital system to staff and run their in-store clinic.

Consumer acceptance of store-based health clinics is high. The clinics are conveniently
located, open in the evenings, weekends and holidays, do not require appointments, cost less than
traditional office or urgent care visits, and handle common illnesses and minor injuries.
Prescriptions can be filled easily and quickly in the store. For the uninsured, who often can’t
afford medical care, the low cost is a bonus. For the insured, the clinics are a convenience, a
better option than waiting for an appointment or spending hours in the emergency department for
a minor complaint.

Store-based health clinics use electronic medical records. Some systems permit patients
to retrieve test results and establish a personal health record. The MinuteClinic electronic system
makes patient records available at any of its clinics nationwide and enables the sharing of clinical
data amongst healthcare organizations that use the same EMR. According to the available
literature, most of the clinics transmit medical charts to the patient’s primary care provider, or
refer people to medical practices in the community that are accepting new patients. Scope of
service at retail clinics is expanding. Many patients lack a medical home. Retail clinics can offer
preventative care, wellness screening, acute visits, physicals, and many more services. Many
point of care tests are available to assist in diagnosis and treatment.

Studies have shown retail clinics provide comparable, if not better care, than other
medical settings for the same conditions.1,2 Those same studies reveal that clinics are able to
provide this care at a reduced cost. One such study, published in the American Journal of
Managed Care, compared the quality of care at retail clinics to that in ambulatory care facilities
and emergency departments. This study concluded its findings “are consistent with previous
studies that demonstrate quality of care is not compromised, and even appears superior, in retail
clinics for specific acute condition. When taken together with evidence suggesting that retail
clinics are more cost-effective and even cost saving to patients, these results underscore the
promise of retail clinics in offering care of higher quality and lower cost at a time of primary care shortages.

The presence of in-store clinics offers some benefits to healthcare providers in the community by offering options for patients and ensuring continuity of care by communicating with the primary care provider or by assisting patients in identifying a primary care provider. Retail clinics also relieve the pressure to stay open in the evening or on weekends. They also may reduce some of the burden on hospital emergency departments.

The store-based health clinics provide employment opportunities for physicians, nurse practitioners and PAs. A review of the retail clinic Web sites reveals full and part-time job openings in many parts of the country, with competitive salaries and benefits. Exposure to new patients in these settings may increase public awareness of the PA profession.

Although in-store clinics increase access to basic healthcare at low cost, they do not offer a perfect solution. Ideally all patients would have a medical home, but there are many areas in the country that due to PCP shortages, patients don’t have access to a medical home. For patients without a medical home, retail clinics are on the front lines of providing preventative, wellness, acute, and chronic care. For patients with primary care providers, new EMR options and system integration, medical history is readily available and interchange of records allows for communication with PCPs.

AAPA supports expanded healthcare access for all people and encourages innovation in healthcare delivery. AAPA maintains that continuity of care is a high priority; therefore, communication between the retail based providers and primary care providers should be maximized within the constraints of regulation, patient confidentiality and patient preference. The role of in-store or retail based convenient care clinics has afforded many PAs the ability to provide medical care to patients who lack access to a PCP or medical home. This growing specialty for PAs can offer a unique niche for the profession and will continue to expand its role for patients looking for convenient medical care. This new trend of delivering healthcare to the general population will continue to grow in its ability to offer an alternative method of accessing medical care provided by PAs and other healthcare providers. AAPA supports an expanded role for PAs in retail healthcare, and works with its constituent organizations to remove barriers to retail clinic system employment of PAs. PAs can play a key role in leadership in retail clinic
systems, and AAPA encourages expansion of leadership opportunities for PAs in retail healthcare.

References


The Role of In-Store or Retail Health Clinics
(Adopted 2007 and reaffirmed 2012)

Executive Summary of Policy Contained in this Paper

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

AAPA proposes that retail clinics:

• Seek to establish arrangements by which their health care providers have ongoing access to and supervision by physicians (MDs and DOs), consistent with state laws;

• Seek to establish referral systems with physician practices or other facilities for appropriate treatment if the patient’s condition is beyond the scope of services provided by the clinic; and

• Seek to establish formal connections with physician practices in the community to provide continuity of care and encourage a medical home for patients.

AAPA believes that these three policy statements complement related AAPA policy, which states:

• “AAPA supports expanded health care access for all people. AAPA encourages innovation in health care delivery, but remains committed to the model of physician directed team care. AAPA maintains that continuity of care is a high priority; therefore communication between the episodic care provider and the primary provider should be maximized within the constraints of regulation, patient confidentiality and patient preference.” [HP-3400.1.4, adopted 2003, reaffirmed 2008, 2013]

Delivery of health care in America keeps changing. From solo physicians making house calls 50 years ago to the array of specialized facilities operating today, changes in lifestyle are reflected in current realities. Consumer preferences affect all businesses and health care is no exception. Like discount stock
brokerage firms or no-frills airlines, store-based retail health clinics are the latest response to demands for low cost, convenient services.

Located in supermarkets, pharmacies, and high-traffic retail outlets such as Target or Wal-Mart, these clinics typically provide limited medical services for minor ailments. They are open seven days a week for extended hours and are staffed primarily by nurse practitioners. At the current time, a small number of clinics are staffed by PAs. Appointments are not necessary and most visits last 15 minutes for treatments that cost $40 to $70, which are clearly posted on the wall.

The first of these retail clinics opened in 2000. Growth has been modest to date, but thousands are expected to be in operation before 2010. Although the first clinics were co-founded by a family physician as a way to make care more convenient, wealthy entrepreneurs soon joined the ranks to start several of these chains. Only a handful are owned by physician groups or hospital systems. In July 2006, CVS Corporation acquired MinuteClinic, the first and largest operator of in-store clinics in the country. Retailers like the clinics because they are another service to offer their customers, drawing them into the store where they shop while waiting to be seen and where they can have their prescriptions filled. Some companies, such as Wal-Mart, make these clinic services available to their employees.

Consumer acceptance of store-based health clinics is high. The clinics are conveniently located, open in the evenings and on weekends and holidays, do not require appointments, cost less than physician visits, and handle common illnesses and minor injuries. Prescriptions can be filled easily and quickly in the store. For the uninsured who often can’t afford medical care, the low cost is a boon. For the insured, the clinics are a convenience, a better option than waiting for an appointment or spending hours in the emergency department for a minor complaint.

Store-based health clinics use electronic medical records. Some systems permit patients to retrieve test results and establish a personal health record. The MinuteClinic electronic system makes patient records available at any of its clinics nationwide. According to the available literature, most of the clinics fax medical charts to the patient’s primary care provider, or refer people to medical practices in the community that are accepting new patients. The clinics offer a limited scope of services, and are designed to refer patients with severe acute or chronic conditions to the appropriate facilities or providers. Some chains actually limit the number of allowed visits.

Consumers are satisfied with the clinic services. According to an online poll of 2,245 adults done in October 2005 for the Wall Street Journal, the respondents who had been treated at retail clinics were satisfied with the convenience (92 percent), quality of care (89 percent), qualifications of the staff (88 percent) and cost (80 percent).

The presence of in-store clinics offers some benefits to health care providers in the community. The clinics relieve the pressure to stay open in the evening or on weekends, allowing physicians and other
providers to spend more time with their families or pursuing other activities. They also reduce some of the burden on hospital emergency departments. By joining the clinics’ referral lists, practices may recruit new patients.

The store-based health clinics provide employment opportunities for physicians, nurse practitioners and PAs. A review of the retail clinic Web sites reveals full and part-time job openings in many parts of country, with competitive salaries and benefits. Exposure to many new patients in these settings may increase public awareness of the PA profession.

Although in-store clinics increase access to basic health care at low cost, they do not offer a perfect solution. The clinics offer fragmented, episodic treatment – and thus do not encourage the establishment of a medical home for patients. They do not coordinate or focus on preventive care. Patients arrive without medical histories for quick treatment and leave in 15 minutes; there is no continuity of care. Community practices, including community health centers whose mission is to care for the underserved, lose patients and revenue. They also lose the quick encounter, or minor problems, that are interspersed with more serious and complex patient problems, thus placing more stress on health care practitioners in traditional practices.

The protocol-driven, limited and repetitive nature of patient visits at retail clinics may suit some health professionals better than others. One concern is that people may come to associate this level of responsibility and narrow scope of practice with the professionals providing the care. PAs have worked hard to overcome misconceptions about their abilities and the medical marketplace has demonstrated that physician-PA teams are capable of a wide range of services, including highly complicated specialty practice.

Recognizing that store-based health clinics are now part of the health care delivery scene, the American Medical Association (AMA) and the American Academy of Family Physicians (AAFP) have developed key principles that they feel should guide the operation of these facilities. The American Academy of Pediatrics (AAP) has followed suit, but not without opposing the use of these clinics as a source of medical care for infants, children and adolescents. AAP is concerned about five issues: fragmentation and possible effects on quality of care, care for children with special needs, lack of access to a central health record, use of tests for diagnosis without proper follow-up, and public health issues surrounding exposure to contagious diseases in a retail environment. Their opposition is based on their commitment to the medical home model that provides “accessible, family-centered, comprehensive, continuous, coordinated, compassionate and culturally-effective care for which the pediatrician shares responsibility with the family.”

There are several principles that AMA, AAFP, and AAP believe should be followed by store-based clinics. The principles that the three organizations have in common are referrals of patients to
physician practices in the community; use of evidence-based medical protocols; and compliance with relevant state laws regarding physician supervision or collaboration with PAs and NPs or some form of physician-directed team practice. Sanitation and hygiene concerns, or efforts to prevent the spread of contagious disease; the use of electronic health records that can be shared with community practices; and a limited scope of services are among the other principles identified. AAP is also concerned about financial incentives to use retail clinics and opposes the waiving or lowering of co-pays or other incentives for patients to visit store-based clinics rather than pediatricians’ or primary care physicians’ offices. “The AAP believes the medical home model is the optimal standard of care and retail-based clinics are not medical homes. Payer incentives should not promote fragmentation of care but should instead recognize and reward systems of care that promote continuous, coordinated and comprehensive care.”

AAPA adopted a policy related to retail clinics in 2003 that says: AAPA supports expanded health care access for all people. AAPA encourages innovation in health care delivery, but remains committed to the model of physician directed team care. AAPA maintains that continuity of care is a high priority; therefore, communication between the episodic care provider and the primary provider should be maximized within the constraints of regulation, patient confidentiality, and patient preference.”

As a complement to this policy, AAPA proposes that retail clinics:

- Seek to establish arrangements by which their health care providers have ongoing access to and supervision by physicians (MDs and DOs), consistent with state laws;
- Seek to establish referral systems with physician practices or other facilities for appropriate treatment if the patient’s condition is beyond the scope of services provided by the clinic; and
- Seek to establish formal connections with physician practices in the community to provide continuity of care and encourage a medical home for patients.
2017-B-05-GRPA          PAs in Elected Office

2017-B-05          Resolved

Amend policy HP-3300.2.2 as follows:

AAPA encourages PAs to seek election to Federal, state, and local legislative bodies OFFICE.

Rationale/Justification
The GRPA feels that limiting the language to Legislative Bodies excludes the remaining branches of government in which we would encourage all PAs to participate.

Related AAPA Policy
None

Possible Negative Implications
None

Financial Impact
None

Signature & Contact for Resolution
Albert Bourbon, MPAS, PA-C
Commission on Government Relations and Practice Advancement, Chair
abourbon@salud.unm.edu
Amend policy HP-3400.2.1 as follows:

AAPA supports measures that allow for flexible and efficient utilization of PAs consistent with the provision of quality health care. More specifically, PA employment and supervision are separate issues. The regulatory requirements of PA supervision should be unrelated to any aspect of employment. The professional relationship between a PA and a physician is maintained even if each is employed by a different healthcare practice, organization or corporate entity.

Rationale/Justification
As the healthcare delivery system continues its rapid transformation, it is essential that PAs have maximum flexibility in the types of employment and practice relationships that most effectively and efficiently utilize the medical and surgical expertise they bring to patients. Previous models of care envisioned a more traditional PA-physician relationship in which both were employed by the same employer. Increasingly, that model of care is changing with increasing numbers of PAs and physicians being hired by hospitals, health systems and other employers.

In today’s healthcare environment, it is not uncommon for health professionals who deliver care as part of highly functioning, integrated teams to have different employers. Those employment and practice arrangements should not hinder the ability of PAs and physicians to work with one another. Practice and reimbursement laws, regulations, policies and employment models should promote increased opportunities to enhance the delivering high quality, cost-effective and comprehensive care to patients.

A PA’s ability to deliver care to patients should be based on their licensure, expertise and clinical experience.

Related AAPA Policy
HP-3500.3.4
Guidelines for State Regulation of PAs (Policy Paper 4)

Possible Negative Implications
None

Financial Impact
None

Signature & Contact for Resolution
Albert Bourbon, MPAS, PA-C
Commission on Government Relations and Practice Advancement, Chair
Amend policy HX-4600.5.1 as follows:

AAPA supports legislative efforts to block the diversion of prescription drugs to illicit channels and prevent the sale or trade of samples, while preserving appropriate access by physicians, PAs, and other appropriate health-care practitioners to samples of prescription drugs from pharmaceutical manufacturers.

Rationale/Justification
It is not necessary to list physicians out separately when they are captured by other appropriate healthcare practitioners.

Related AAPA Policy
None

Possible Negative Implications
None

Financial Impact
None

Signature & Contact for Resolution
Albert Bourbon, MPAS, PA-C
Commission on Government Relations and Practice Advancement, Chair
abourbon@salud.unm.edu
2017-B-08-GRPA  Expansion of Naloxone

2017-B-08  Resolved

Amend policy HX-4600.5.5 as follows:

AAPA endorses INCREASING PUBLIC ACCESS TO the prescribing and distribution of naloxone for secondary administration FOR THE REVERSAL OF OPIOID to opiate addicted patients to prevent opiate overdoses, and supports the establishment AND EXPANSION of naloxone prescribing DISTRIBUTION programs.

Rationale/Justification
Naloxone is increasingly available without a prescription. At some point prescribing may be less common.

Naloxone is intended to reverse overdoses for any individual who may or may not meet criteria for Opioid Use Disorder. The use of the phrase "opiate addicted patients" is outdated.

Related AAPA Policy
None

Possible Negative Implications
None

Financial Impact
None

Signature & Contact for Resolution
Albert Bourbon, MPAS, PA-C
Commission on Government Relations and Practice Advancement, Chair
abourbon@salud.unm.edu
Amend policy HX-4600.5.6 as follows:

AAPA advocates for legislative and/OR regulatory changes as needed to remove legal and regulatory barriers to prescribing, and dispensing OR DISTRIBUTING naloxone for secondary administration FOR THE REVERSAL OF OPIOID OVERDOSES.

Rationale/Justification
Naloxone is increasingly available without a prescription. “As needed" is not necessary and it weakens the statement as no one would advocate for “unneeded changes.” The language should also be consistent with the other naloxone resolutions HX-4600.5.5, HX-4600.5.7 by using "legislative and/or regulatory."

Related AAPA Policy
None

Possible Negative Implications
None

Financial Impact
None

Signature & Contact for Resolution
Albert Bourbon, MPAS, PA-C
Commission on Government Relations and Practice Advancement, Chair
abourbon@salud.unm.edu
2017-B-10-GRPA  Removing Barriers for Naloxone

2017-B-10  Resolved

Amend policy HX-4600.5.7 as follows:

State chapters are encouraged to collaborate with public health agencies, addiction treatment organizations, local and state medical societies, PATIENT ADVOCACY ORGANIZATIONS and other entities to seek legislative and/or regulatory changes TO REMOVE BARRIERS TO THE PRESCRIBING, DISPENSING OR DISTRIBUTION OF NALOXONE for secondary administration FOR THE REVERSAL OF OPIOID OVERDOSES of naloxone.

Rationale/Justification
The resolution is worded in a confusing way, and clarification with regards to the purpose of legislative/regulatory changes necessary to remove barriers to the secondary use are needed.

Related AAPA Policy
None

Possible Negative Implications
None

Financial Impact
None

Signature & Contact for Resolution
Albert Bourbon, MPAS, PA-C
Commission on Government Relations and Practice Advancement, Chair
abourbon@salud.unm.edu
AAPA opposes the inclusion or sharing of PA federal and state practice acts with any other professions to include anesthesiology assistants, radiology assistants, orthopedic assistants (etc.) and all other non-PA health care professions.

**Rationale/Justification**

Since PA regulation falls under state jurisdiction, the legal scope of practice for a PA is defined in a state-specific scope of practice act. These acts describe the services that PAs can provide and under what conditions they can be provided. Scopes of practice acts also define the requirements for education and training, certification and licensure. PA education and training is significantly and uniquely different than any other health care profession including other “assistants” training and education.

PAs practice medicine in virtually every setting. PAs diagnose and treat patients; order labs test and prescribe medications. Anesthesia Assistants, Radiologic Assistants, Orthopedic Assistants, and Physical Therapy Assistants, etc. provide limited well-defined specialty services that contribute to the practice of medicine in their defined limited setting.

Inclusion of non-PA professions within our state and federal regulations dilutes the identity of the PA profession and has the potential to lend itself to confuse the public, the consumer, the payers, the employers and the health care regulators.

**Related AAPA Policy**

HP-3100.3.1

PAs are health professionals licensed or, in the case of those employed by the federal government, credentialed to practice medicine in collaboration with physicians. PAs are qualified by graduation from an accredited PA educational program and/or certification by the National Commission on Certification of Physician Assistants.

Policy Paper: Guidelines for Updating Medical Staff Bylaws: Credentialing and Privileging PAs

Policy Paper: Guidelines for State Regulation of PAs

Issue Brief: Physician Assistants and Anesthesiologist Assistants: The Distinctions (June 2011)

**Possible Negative Implications**

None

**Financial Impact**

Staff time

**Signature**

Kristin Homoki, MSHS, PA-C, AT-C, CPAAPA
OAPA, Chief Delegate

Contacts for Resolution
Kristin Homoki - jandkhomoki@yahoo.com
John Trimbath - jdtpac@roadrunner.com
AAPA supports the opportunity of citizens of the world to immigrate to the United States to seek the opportunities and values that are the foundation of our nation and our profession.

AAPA opposes immigration policies which discriminate against immigrants based on existing AAPA anti-discrimination policies including national origin. This includes opposition to mass deportation efforts which risk separating and harming immigrant families and their members, placing the health of entire immigrant communities frequently served by PAs in jeopardy.

**Rationale/Justification**

There is a growing and strong anti-immigrant movement both in the United States including current efforts to target people from certain nations as well as efforts to split apart families who have resided peacefully and productively in the United States for decades. This threatens the health and welfare of millions of people living in the United States. The PA profession and AAPA were built to meet the needs and promote the health of all people living in the United States, regardless of citizenship documentation. This this resolution is consistent with the values, mission, and vision, and policies of AAPA.

**Related AAPA Policy**

HX-4600.1.10 describes AAPA’s policy of treating all patients, regardless of citizenship status. The above resolution addresses the distinct topic of the health impact of mass deportation of undocumented immigrants.

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

[Adopted 2007, reaffirmed 2012]

**Possible Negative Implications**

Many Americans including some PAs may support the mass deportation of immigrant Americans lacking documentation of citizenship, as well as opposing immigration by individuals based on their national origin.

**Financial Impact**

None

**Signature & Contact for Resolution**

James Anderson, PA-C, MPAS, DFAAPA
President, Society of PAs in Addiction Medicine
AAPA supports the opportunity of people of the world to migrate to the United States in accordance with moral and ethical laws to seek the opportunities that our nation holds for its citizens, and does not support any form of immigration policy which supports the illegalities of judging a people based on their religious beliefs nor their color, sex, gender, age, disability, weight or citizenship status; rather, they should be judged by their personal merits and standards.

AAPA does not consider the issue of a patient’s citizenship status as a condition of providing appropriate quality care, nor does AAPA support any condition that would require a healthcare provider to report a patient’s status and thereby violate the patient – provider relationship of trust and confidentiality when a patient is seeking care, nor support policies that promote fear of recourse to a healthcare provider for providing health care to patients who may have an undocumented immigration status.

AAPA does not support an immigration policy that destroys families by deporting family members of citizens of this country, nor the deportation of children brought to the United States without personal volition who now reside in this country and are at risk of deportation to a country of which they do not remember and often no longer speak their native language.

Rationale/Justification
The AAPA supports the constitution of the United States of America, and that all men are created equal. That the United States was founded on the principal that all people have the right to life, liberty and the pursuit of happiness. That this country was founded by immigrants and established for immigrants to be a land of the free, that a people could migrate to and be free of all types of persecution. That the AAPA understands the dynamics of world events, the issues of terrorism, the issues of security and the protection of our nation, and the laws of documented versus undocumented immigration, no matter how we arrived to this great nation. The AAPA supports the duty and responsibility of PA’s in providing quality and safe healthcare for all patients seeking care.

Related AAPA Policy
There is no demonstrated AAPA policy on immigration.

There is a policy:
HX-4600.1.10
AAPA believes that all patients deserve access to health care and opposes the establishment of local, federal, or state initiatives that require health care providers to refuse care to undocumented persons or to report suspected undocumented persons to authorities.
[Adopted 2007, reaffirmed 2012].

That speaks to policies that make providers refuse care to undocumented person(s) or to report,
but this policy does not specifically address immigration as whole.

Possible Negative Implications
None

Financial Implications
None

Signature & Contact for Resolution
Rafael Pomales Jr, MHS, PA-C
President, PAs for Latino Health
rafaelp_99@yahoo.com
2017-C-01-CO Clinical Ultrasound Utilization

2017-C-01 Resolved

Adopt the policy paper entitled “Clinical Ultrasound Utilization in PA Clinical Practice”.
See policy paper.

Rationale/Justification
AAPA is lacking clear and unified guidelines for PAs performing clinical ultrasounds. To provide a guideline on the creation and integration of competency-based training, education, and proficiency standards serves to foster the expanded use of ultrasound by PAs and better ensures that ultrasound is utilized safely and effectively across the broad spectrum of PA clinical practice.

Related AAPA Policy
None

Possible Negative Implications
None

Financial Impact
None

Signature
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Clinical Ultrasound Utilization in PA Clinical Practice

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 establishes clear and unified guidelines for PAs performing clinical ultrasound.
- AAPA supports the creation and integration of competency-based training, education, and proficiency standards to foster the expanded use of ultrasound by PAs and better ensure that ultrasound is utilized safely and effectively across the broad spectrum of PA clinical practice.
- AAPA supports that CUS is within a PA’s scope of practice and supports credentialing of Pas at local institutions.
- AAPA opposes the use of any external certification process designed to validate the proficiency of PAs employing clinical ultrasound

Section 1 – Purpose

This document is intended to establish clear and unified guidelines for PAs performing clinical ultrasound. The creation and integration of competency-based training, education, and proficiency standards, as outlined here, serves to foster the expanded use of ultrasound by PAs and better ensure that ultrasound is utilized safely and effectively across the broad spectrum of PA clinical practice.

Section 2 - Introduction / Background

The use of ultrasound has expanded significantly since its early applications in medicine over half a century ago. Advances in technology have led to smaller, more portable machines with better image quality and more intuitive user interfaces, allowing ultrasound to be increasingly and effectively employed by various clinicians, including PAs, at the bedside/point of care. Emergency medicine physicians in the late ’90s were among the first to recognize the value of ultrasound at the bedside of their patients. These physicians keenly spent the subsequent decade validating their safe and effective use of bedside ultrasound, effectively
carving a niche that is now known as emergency ultrasound (EUS), a specific category in the overarching realm now known as clinical ultrasound. 10,11 Multiple studies have since validated clinical ultrasound as a safe, expedient, and cost-effective clinical adjunct which improves patient care. 12-16

Today, bedside ultrasound is utilized across a broad spectrum of medical specialties to diagnose a myriad of conditions, safely guide invasive procedures, as an adjunct to treatment, and to monitor the progress of interventions or changes in a patient's condition. As clinical ultrasound becomes increasingly ubiquitous across the healthcare landscape and through multiple specialties, this technology will be available and beneficial to PAs and their patients in every practice setting. It is therefore imperative that the role of clinical ultrasound in PA clinical practice be comprehensively considered, clearly defined, and outlined, with a clear path established to its safe implementation by well-trained and competent PAs across the entire spectrum of their diverse practice settings.

Section 3 - Definition and Scope of Clinical Ultrasound

Clinical ultrasound (CUS) is defined as a focused ultrasound examination performed and interpreted by the treating clinician, at the point of care, to interrogate a specific clinical question or to guide a procedure. Clinical ultrasonography is a diagnostic modality that provides clinically significant data not obtainable by inspection, palpation, auscultation, or other components of the physical examination, and should be considered complementary (rather than adjunctive) to the physical examination. It is a separate entity that adds anatomic, functional, and physiologic information to the care of the patient. 17 Clinical ultrasound, for the purposes of this paper, will be considered synonymous with other terms such as “bedside,” “focused,” and “point of care ultrasound (POCUS). Emergency Ultrasound (EUS) is an example of a sub-category of CUS.

CUS is intended to be goal directed and focused with the purpose of answering brief and important clinical questions in an organ system or to query a clinical symptom or sign involving multiple organ systems. It may be performed as a single examination, repeated due to clinical need or a change in condition, or used to monitor physiologic or pathologic changes and assess the response to treatment.

Because CUS is performed, interpreted, and integrated into patient management by the evaluating clinician contemporaneously with the patient's evaluation, it enjoys some unique properties. Real time visualization of critical and pathological anatomy increases the safety of
many procedures which have historically been performed without imaging guidance. This includes removal of retained foreign bodies, needle placement, incision and drainage, regional anesthesia, fracture reduction and joint dislocation reduction.

**Comprehensive/Consultative Ultrasound vs Clinical Ultrasound**

CUS is not meant to replace comprehensive ultrasound imaging, which is a consultative test performed at traditional imaging centers by non-clinician sonographers, and traditionally interpreted by radiologists. Consultative sonography is intended to comprehensively evaluate anatomy and physiology, while clinical ultrasound focuses on specific, and therefore limited, clinical questions and concerns that the treating clinician may have as it relates to the current clinical encounter, while expediting care.\(^{18}\)

CUS therefore follows a very different standard of practice than consultative ultrasound. Consultative ultrasound exams are broad-based and expected to characterize anatomy and pathology outside of a specific clinical question warranting interrogation. If the clinical question is, "does the patient have an IUP?" the patient should not have the expectation of reporting a cleft palate, gastroschisis, or uterine fibroids, for example.

CUS’s focused nature and limited scope, which seeks to answer a very specific clinical question, should therefore be discussed with the patient to ensure that he/she understands the "focused ultrasound" concept very clearly. For example, a pregnant patient with a small amount of first trimester bleeding and pain presents for a clinical encounter. The clinical question may be, "does the patient have an intrauterine pregnancy?" This question may be quickly and easily answered by performing a bedside ultrasound. In this example the patient had a bedside ultrasound and was diagnosed with an IUP that appears to be about 9 weeks old with a heart rate of 164 bpm. However, the patient must understand that the purpose of the bedside ultrasound exam was to evaluate her symptoms for the possibility of an ectopic pregnancy. The clinical ultrasound is not intended to replace her scheduled 10 or 20 week consultative ultrasound to evaluate for fetal anomalies, date the pregnancy and assess for signs of a high risk pregnancy or a complicated delivery.

The miniaturization of highly capable ultrasound machines allows clinical ultrasound to be performed, interpreted and shared with the other members of the care team in a multitude of settings. Its versatility across a wide range of practice settings is well documented, thereby highlighting its potential in both well-resourced and resource-constrained settings. These
settings include but are not limited to: primary/office-based care settings, outpatient specialty care settings, the emergency department, inpatient setting, the pre-hospital setting, the forward edge of battle, space, urgent care clinics, sporting events, disasters, and remote and frontier settings. 19-27

Section 4 - Competency-based Clinical Ultrasound Training

Core Components of Competency

Achieving competency is vital for clinicians looking to successfully incorporate clinical ultrasound into their clinical practice. The goal of competency-based learning is to ensure that learners have acquired the knowledge and skills deemed essential to successful implementation of ultrasound. Successful implementation of clinical ultrasound requires clinicians to have a strong fundamental knowledge in four key areas. These include:

1. Knowledge related to indications for the exam
2. Image acquisition
3. Image interpretation
4. Integration of findings into patient management

Formal ultrasound educational and training programs with the goal of developing PAs proficient in clinical ultrasound should therefore focus on these basic tenets. Bahner, et al utilized these same tenets to create a simplified approach (known as the “I AIM” model) to be used as both an educational model and clinical tool to improve clinical ultrasound performance.28 Competency in these four key areas is best achieved with a combination of didactic education and hands-on scanning.

The didactic portion of these tenets can be delivered by attending lectures, clinical rotations, preceptorships, conferences, post graduate and fellowship training programs, through online content and asynchronous education, or through a PA program with integrated ultrasound curriculum.

Following the didactic instruction, hands-on scanning is essential to develop requisite psycho-motor skills necessary to capture quality images in a timely manner. The scanning time can be obtained through one on one scanning, live conferences, remote video conferencing, or through the use of high fidelity ultrasound simulation technologies.

Objective demonstration of competency is vital to any educational or training program. Training in bedside ultrasound is no exception. Demonstration of competency can and should
be achieved by various methods. These may include written exams, direct supervision of hands-on scanning, Standardized Directly Observed Tools (SDOTS), Objective Structured Clinical Examination (OSCE) image review sessions, or simulation cases.29-31

Demonstration of competency should begin during the didactic portion, Phase I Introductory Training or Practice Based Pathways and should continue into the clinical clerkship phase for students, or for PAs in current clinical practice Proctored Scanning Phase II through their home clinical ultrasound programs.

Professional medical organizations such as the American College of Emergency Physicians (ACEP) and Society of Critical Care Medicine (SCCM) have recognized the great potential for ultrasound at the point of care and have taken concrete steps to incorporate formal competency-based educational and training programs for their respective members. ACEP and SCCM have established guidelines outlining the role of bedside ultrasound in their respective specialty clinical practice, as well as made recommendations for training and integration into medical education.11, 31

In 2007 emergency medicine leaders recognized ultrasound as "a skill integral to the practice of emergency medicine" (EM), as defined by the 2007 Model of Clinical Practice of Emergency Medicine,33 resulting in the integration of ultrasound into the curriculum of every U.S. EM residency program. This mandate requires every EM resident to complete a didactic clinical ultrasound educational requirement and completion of at least 150-300 proctored, high quality ultrasound scans, and demonstration of competency in EUS in order to successfully complete residency training. This model is now increasingly being adopted by various medical specialties including pediatric, family medicine, and internal medicine residencies.22, 34, 35

Historically, PA education has adopted and mirrored the medical model of education.36 A solid foundation of medical knowledge was built with a didactic phase followed by clinical clerkships and rotations in multiple specialties. In many universities, the two disciplines collaborate, share space, resources and coursework. Ideally clinical ultrasound education should be incorporated into both entry-level and post-graduate PA educational programs.

Integrating Competency-based Training – A Two-Phased Approach

The following describes a two-phased approach by which PAs can achieve competency in clinical ultrasound in order to integrate it into their respective clinical practices.

Phase One – Introductory Training
The American Medical Association (AMA) supports the educational efforts and widespread integration of ultrasound throughout the continuum of medical education. Medical schools began successfully integrating comprehensive clinical ultrasound training into their UME programs nearly a decade ago. Since that time, CUS is increasingly being integrated into the curriculum of undergraduate medical education (UME) programs across the country. A recent study found 62% of U.S. medical schools surveyed reported they had ultrasound integrated into the curriculum. Many of these same medical schools have adopted a longitudinal approach to ultrasound education. Students start learning ultrasound from day one in their anatomy, physiology, and physical exam courses and continue their learning by integrating information from focused ultrasound exams into patient management during clinical rotations.

Since the founding of the PA profession, PAs have proudly mirrored the medical model of education as their educational foundation. Naturally, if PAs wish to continue this relationship, PA programs must emulate the medical school example of ultrasound curriculum integration.

Full integration of clinical ultrasound training into PA program curricula will provide the richest longitudinal learning experience, therefore training in clinical ultrasound should begin at the earliest point of PA school to allow for the progression of skills throughout didactic and clinical training.

Instruction should begin with basic ultrasound physics and instrumentation, followed by a brief introduction to the clinical applications of bedside ultrasound. Ideally, this clinical training would begin during the anatomy and physiology courses. Allowing students to visualize sonographic anatomy (musculoskeletal, abdominal, etc.) and physiology (cardiac, bladder) can greatly complement and enhance their understanding of the human anatomy and demonstrate how pertinent pathology may manifest sonographically.

Although ultrasound should be considered a separate entity from the clinical exam, it has the potential to complement the exam by offering otherwise unobtainable and clinically relevant anatomic and physiologic real time information to the scanning clinician. Many UME programs have successfully incorporated clinical ultrasound into the physical exam training.
PA programs should consider adding clinical ultrasound into the physical exam training as these two clinical skills greatly complement each other.

**Introductory Training Pathway #2 – Practice-Based Pathway**

For practicing PAs without formalized clinical postgraduate PA training, or PAs with formalized clinical postgraduate PA training without specific clinical ultrasound integration, a comprehensive introductory course covering multiple applications or a series of short courses covering a single/combination of applications may provide initial training. Short preceptorships with clinical ultrasound training programs may also be valuable in providing fundamental clinical ultrasound skills.

Each of these options available to currently-practicing PAs should provide an introduction to ultrasound physics, familiarization with instrumentation, and provide introductory training in the applications the clinician plans to incorporate into practice.

**Introductory Training Pathway #3 - Post Graduate Based Pathway**

For those PAs who complete a formalized clinical postgraduate PA training program or fellowship which incorporates formal clinical ultrasound education and training, it is recommended that successful completion of this ultrasound training be accompanied by documentation of training/competency standards that were met along with a list of the applications in which the PA has demonstrated competency. This documentation will serve to facilitate future credentialing should the PA pursue privileges in clinical ultrasound at other medical facilities.

The documentation of training for those who complete this pathway should verify that the individuals have simultaneously completed Phase II (Proctored Scanning Phase) during their training and are competent to seek credentialing as clinical ultrasound-proficient staff at their local facilities.

**Phase Two – Proctored Scanning Phase**

PAs who successfully completed their initial training via Introductory Pathways I and II should not be considered adequately trained to incorporate bedside ultrasound into patient management decisions. Clinicians who complete Phase I Introductory Training, via Pathway I or II, should participate in closely supervised scanning while achieving the appropriate number of proctored scans required for proficiency and credentialing at their home institutions.
For those who receive Phase I training through Introductory Pathway I, (initial training during PA school), Phase II Proctored Scanning Phase can only begin after the PA becomes licensed to practice.

The Proctored Phase II scans should be subject to rigorous quality assurance reviews. Live scanning can be augmented with imaging reviews, simulation training, and competency should be assessed upon completion of this proctored period. Any completed formal training should be accompanied by documentation which outlines the specific topics and applications that were assessed, the total number of training exams completed with expert supervision, and performance assessment measures.

Section 5 - Proficiency Validation / Certification

Just as PA program medical education mirrors undergraduate medical education, the successful deployment of clinical ultrasound by PAs should also parallel and compliment the standards set forth by the professional/specialty organizations of our physician colleagues.

Training and proficiency standards should be developed by PA professional and PA specialty organizations and the PA standards should closely complement well-validated standards set forth by corresponding physician organizations. It is valuable for PA professional organizations to develop clinical ultrasound subcommittees as well as administrative and leadership infrastructure to promote clinical ultrasound use in their respective constituencies. It is also valuable for PA organizations to work with corresponding physician specialty organizations to ensure guidelines and efforts are complimentary and parallel.

The role of external organizations in certifying proficiency of training has become controversial in recent years. Increased certification testing, escalating costs associated with testing, along with lost productivity spent preparing and taking examinations and the continuing education requirements associated with maintenance of certification, are burdensome. Furthermore, there is little data to support the effectiveness of external certification in demonstrating proficiency or improving patient outcomes.47

Physician specialty organizations like ACEP, considered pioneers in the implementation of bedside ultrasound, have explicitly rejected the use of external certification as a measure of ultrasound proficiency in favor of a competency based approach.48 ACEP’s competency-based
appreciate has been well-validated since its inception in 2001, leading the organization to
equivocally endorse a competency based pathway and strongly oppose external certification.\textsuperscript{10}

PAs are encouraged to, and should recognize, ACEP's stated opposition to external
certification as a barrier to practice that could impede the integration of this critical clinical skill
into PA clinical practice and education, and therefore could adversely affect patient care.

AAPA opposes the use of any external certification process designed to validate the
proficiency of PAs employing clinical ultrasound, that is deemed to be overly burdensome or a
barrier to the incorporation of clinical ultrasound in PA clinical practice. Barriers that
certification methods may create include (but are not limited to):

1) exams which are financially burdensome to the individual clinician.

2) exams that require significant preparation which removes clinicians from their clinical
   practice environment.

3) certification is not well-proven to validate competency and improve patient outcomes.

Should any external certification body seek to create certification standards for PAs
utilizing clinical ultrasound, AAPA should present the certification method to its constituent
organization leaders and AAPA members for consideration prior to any endorsement.

It is the responsibility of PAs to identify and develop minimally cumbersome CUS
training, education and proficiency standards which increase patient access to ultrasound.
Furthermore, PA professional and specialty organizations are singularly and best qualified to
validate and cultivate those standards. Outsourcing governance of a PAs professional role or
capacity to external certification bodies can be tantamount to surrendering the right to
professional self-determination, and abdicating the PA's professional responsibility to act as an
advocate for what is best for patients and PA clinical practice.

Further, any such external certification process should not be endorsed or utilized as a
requirement for hospital privileges or credentialing, nor for reimbursement by accountable care
organizations (ACOs), managed care organizations (MCOs), the Centers for Medicare and
Medicaid Services (CMS) or other third-party payers.\textsuperscript{48}

\textbf{Section 6 - Credentialing}

These guidelines are intended to outline a fair, proven, cost efficient method of attaining
and demonstrating competency, with a clear pathway to credentialing at local institutions.
The AMA House of Delegates in 1999 passed a resolution (AMA HR. 802)
recommending hospitals’ credentialing committees follow specialty specific guidelines for
hospital credentialing decisions related to clinical ultrasound use. The AMA policy states that
ultrasound, as an imaging resource, is not the exclusive intellectual property of any one medical
specialty.37 As such, each specialty organization and professional society must decide how to
best determine proficiency and create a pathway to credentialing.

Hospital privileging and credentialing processes should be fair and unbiased, and
awarded or denied based upon state law, documented training, experience, and current
demonstrated competence in clinical practice. Credentialing based on any other factor is contrary
to written standards.49 Credentialing in each ultrasound application relevant to the individual
clinician can be pursued in accordance with local hospital credentialing policies.

Although no specific number of clinical ultrasound scans can guarantee individual
competence in each ultrasound application, it is recommended that each clinician perform 25
(range 25-50) exams of each application for which privileges are being requested, a minimum
of 150-300 general scans, 5% of which should demonstrate pathology.10, 50, 51

During this proctored period, 100% exams should be evaluated by quality assurance by
appropriately credentialed providers with advanced training and/or demonstrated competency
in ultrasound and should be based on the four basic competencies. This proctored quality
review can be performed at the bedside, or remotely. Alternatively, a training portfolio of
exams and results may be compared to other diagnostic studies of choice which also answer the
clinical question being asked. A final option is to compare clinical outcomes, for example a
soft tissue skin infection is drained and improves, a peripheral IV line flushes and draws.

After initial training, continued quality assurance of exams is recommended to
document continued competency. Ultrasound-guided procedures should be directly supervised
a minimum of five to ten times to ensure competency in each specific ultrasound-guided
procedural application.10

PAs should follow their corresponding physician specialty specific guidelines or PA
constituent organization guidelines as they relate to credentialing, education and the total
number of scans required for competency in clinical ultrasound. In specialties where no
credentialing guidelines currently exist, this document should serve as a guideline for outlining
proficiency standards to local credentialing bodies.
The pathway in this document will provide local hospital credentialing committees with reassurance that PAs have met rigorous quality assurance standards, and can safely and effectively employ bedside ultrasound for the benefit of patients without surrendering training and competency standards to external entities which could impede the use of clinical ultrasound, and thus adversely affecting patient care.\textsuperscript{10,46}

Section 7 - Clinical Ultrasound Models of Practice

The model of practice is a description of the role of clinical ultrasound, as employed by individual PAs in a particular clinical practice setting. The specific model of practice adopted by a PA will therefore depend primarily on the individual clinician’s practice setting and the numerous variables that differentiate it from other practice settings.\textsuperscript{52} Variables to be considered when defining a model of practice may be static or dynamic. Static variables rarely change or are beyond the control of the PA. Examples of static variables include:

- state practice laws
- local culture
- the burden of disease
- medical specialty
- patient population

Dynamic variables, conversely, are within the control of the PA performing clinical ultrasound and may be much easier to influence. Examples of dynamic variables include:

- the skill and the experience of the PA
- the skill and experience of the collaborating physician
- the relationship of the PA and collaborating physician
- the institutional culture
- the capabilities of the ultrasound equipment
- the availability of practice resources
- the location of the patient
- the patient’s condition

A clearly defined model of practice is key to the successful implementation of any clinical ultrasound program. The model should also be clearly understood by all involved parties prior to adoption and implementation of an ultrasound program. The concept of a “model of
practice” is not intended to be narrowly described; but rather, it is best described in very broad, over-arching terms at the national level, allowing it to be more specifically defined at the individual practice level. It is at the practice level that PAs and physicians have the most accurate picture of their practice setting and its variables, and are therefore most capable to create a model of practice which, given the aforementioned variables, best serves their patients.

Section 8 - Skill Sustainment

Clinical ultrasound is a skill which requires regular performance in order to maintain proficiency. An ultrasound training program must therefore include a system which allows for the sustainment of skills beyond introductory training and proctoring. Once competent, there is no minimum number of ultrasound exams that can guarantee sustained proficiency, therefore clinicians should strive to regularly perform every application the clinician is privileged to perform. Skill sustainment requires all the applications the PA is privileged to perform be a regular part of the clinician’s practice, with skills evaluated semi-annually in conjunction with standard two year credentialing re-appointment process. If the infrequently used CUS application remains an underutilized skill, the clinician should not request bedside ultrasound privileging without adequate documentation of performance of exams.

It is recommended that a certain percentage (i.e. 5%) of required continuing medical education (CME) credits achieved per CME cycle be on topics related to point-of-care ultrasound.

Section 9 - Leadership/Advocacy

Regardless of the size of the facility employing clinical ultrasound or the number of ultrasounds performed, a structured program with designated leadership is needed to drive the process, ensure quality review, mentor participants, and promote education. This formal structure is the Clinical Ultrasound Program (CUSP). The director and deputy director of the institution’s CUSP is responsible for executing the day to day operations for the program's overall success.

This includes, but is not limited to, ensuring that appropriate clinical services are provided, continuing educational and credentialing requirements are met, and implementing Phase II Proctored Scanning requirements for providers seeking to attain proficiency. In addition, the director will ensure that support services are sufficient, and that the practice employs an ongoing effective and robust quality assurance program. Leadership is additionally
responsible for the maintenance of the equipment, the economic health of the program as well as
the development and mentorship of less experienced clinical sonographers in the organization.

In educational settings the CUSP director is the primary point of contact to ensure that
the students, dean, educational program director, curriculum committee, and the clinical
coordinator have the necessary resources needed to integrate quality clinical ultrasound
education into the curriculum and coordinate ultrasound education with topics that parallel and
compliment the traditional core content.

Appropriately-trained PAs are fully capable to assume leadership positions and champion
clinical ultrasound programs in their local facilities and academic programs, particularly in PA
programs and undergraduate medical education. PAs who are fellowship trained, experienced in
clinical ultrasound through clinical practice or have experience teaching and lecturing on clinical
ultrasound topics may be the most experienced sonographers in their organizations, practices,
programs and facilities. Practicing PAs who were sonography technologists prior to attending
their PA programs may represent an underutilized resource and may help develop clinical
ultrasound programs in their facilities. All of these PAs should be actively engaged by the
organizational leadership to participate in all efforts which increase patient access to the benefits
of clinical ultrasound.

Just as with competency in clinical ultrasound, leadership is often independent of degree
or title, and AAPA supports the concept that the most experienced and willing ultrasound
clinician should be afforded the opportunity to participate in the development and sustainment of
the CUSP. Furthermore, appropriately trained and qualified PAs should be considered for
inclusion in the leadership team, and may be ideally suited for the role of director or deputy
director of the organization’s CUSP. Preparation suited for leadership roles includes mastery of
clinical ultrasound applications specific to the organization’s practice and a clinical ultrasound
leadership course, or completion of a clinical ultrasound fellowship.

Advocacy, particularly at the national level amongst key organizations, represents an
excellent opportunity to eliminate barriers to the integration of clinical ultrasound into PA
education and clinical practice. AAPA supports and advocates for the concept of implementation
of formal bedside ultrasound training for PAs and for increasing training opportunities for PAs,
particularly opportunities such as fellowships.
Allowing PAs to complete such training will be crucial in the development of PA leaders in the clinical ultrasound realm who can serve as ambassadors to non-PA organizations such as the American Institute of Ultrasound in Medicine (AIUM), The World Interactive Network Focused on Critical Ultrasound (WINFOCUS), The Society of Ultrasound in Medical Education (SUSME) and ACEP. Fostering strong working relationships with such organizations can facilitate the adoption and recognition of policies which are inclusive and supportive of PA use of ultrasound. Such policies will be vitally important in supporting ultrasound as a ubiquitous part of PA clinical practice.

With the goal of competency and a clear path to local credentialing, endorsement by physician organizations as well as support and collaboration between PA constituent specialty organizations is key. These organizations are instrumental to the support and development of specialty specific clinical practice guidelines, competency standards and educational goals, as well as future credentialing pathway recommendations. The creation of ultrasound subcommittees within PA specialty organizations should also be encouraged and supported. The specialty organization ultrasound subcommittees will facilitate communication, the exchange of ideas and provide a channel where clinicians of multiple specialties can easily collaborate.

Lastly, it is imperative that PA professional organizations foster the development and execution of clinical research which continues to validate safe and effective employment of ultrasound by PAs. Rigorous and well-designed studies will be crucial in providing evidence to non-PA professional organizations that may be unsupportive of the integration of bedside ultrasound as a safe and effective tool for PAs to utilize in their clinical practices.

Section 10 - Quality Assurance/Performance Improvement

Quality control is key to improving standardization of clinical ultrasound applications. In order to ensure quality, facilitate education, and satisfy credentialing pathways, a clinical ultrasound quality assurance (QA) and quality improvement (QI) program should be present. Parameters to be evaluated might include image resolution, anatomic definition, and other image quality acquisition aspects such as gain, depth, orientation, and focus. In addition, the QI system should compare the impression from the clinical ultrasound interpretation to patient outcome measures such as consultative US, other imaging modalities, surgical procedures, or patient clinical outcomes.
The QA program should have a mechanism in place to notify patients of misreads or errors which are discovered during the QA process or by incidental finding from other studies. This includes a mechanism to document the findings in the patient's medical record.

The QI system design places patient safety above all other factors, while maintaining competency and striving to provide timely feedback to clinicians. Balancing quality of review with timely feedback is a key part of QI process design. Any system design should have a data storage component that enables data and image recall. Due to the varieties of practice settings the percentage of scans undergoing quality assurance review should be determined at the practice level by the CUSP director and the facility medical director. While this number can vary, a goal of 5-10% may be reasonable, adjusted for the experience of the providers and newness of the US application in that department.10

Section 11 - Value and Safety of Clinical Ultrasound

Value of Clinical Ultrasound

There is increased concern in today’s healthcare environment regarding the adverse effects caused by overutilization of computed tomography (CT). CUS has shown to be an effective tool to minimize radiation exposure in patients with suspected conditions that have been traditionally evaluated with CT, and to decrease patient wait times.12-14 Additionally, in today’s world of increased healthcare costs and demand, bedside ultrasound has been shown to be a cost-effective tool in the clinical evaluation and management of patients.16

Safety of Clinical Ultrasound

Although ultrasound is associated with increased temperature and cavitation of tissue, these effects rarely occur when ultrasound used at energy levels and lengths of time typical for diagnostic medical sonography. A recent paper suggested a link between autism and exposure to first trimester ultrasound.54 However, this study was poorly designed and no causal link was found, as outlined by the AIUM Bioeffects Committee.55

Clinical ultrasound is safe when performed only when medically indicated, by properly trained and credentialed clinicians using the ALARA (As Low As Reasonably Achievable) principle. This principle refers to the lowest energy intensity level required to make an accurate sonographic diagnosis or to complete an ultrasound-guided procedure.

Incidental Findings
An incidental finding is an asymptomatic observation made by the clinician which is outside of the clinical question under interrogation. Such findings may create unnecessary medical burden or even harm as well as the potential for curative benefit. Therefore incidental findings should be communicated to the patient or follow-up provider.\textsuperscript{56} The patient should be informed of the risks and the provided discharge instructions should reflect any specific issues regarding US findings in the context of the diagnosis. If the incidental finding is from a live model teaching session, the scans should be secured and stored for future reference, and the model should be provided with a copy of the images.\textsuperscript{57}

**Section 12 - Documentation Requirements**

**Medical necessity**

Ultrasounds must have documented medical necessity or study indications, with a written order from the provider, and meet the requirements of completeness for the specific Current Procedural Terminology (CPT) code that is billed.

**Written Interpretation**

Clinical ultrasound exams are immediately interpreted and the findings should be immediately communicated to providers, consultants, and other members of the patient care team by a separate written report. This interpretation should be maintained in the patient's medical record.

The report should include:

1. Date and time of examination.
2. Name and hospital identification number of the patient.
3. Patient age, date of birth, and sex.
4. Name of the person who performed and/or interpreted the study, clinical findings.
5. Indication for the study, the scope (complete vs limited), and if this is a repeat study by the same provider, repeat by a different provider, or reduced level of service.
6. Impression (including when a study is non-diagnostic) and differential diagnosis, as well as the need for follow on exams and incidental findings.
7. Mode of archiving the data (where can the images be found to be viewed).\textsuperscript{11}

Expediency in placing handwritten, transcribed, templated, or computerized reports into the medical record facilitates communication within the healthcare team. It also improves patient management and is vital to the peer review and quality assurance process.
In the case of ultrasound guided procedures, the procedure report may be filed as a separate item in the patient’s record or it may be included within the report of the procedure for which the guidance is utilized.

**Image Capture**

All clinical ultrasound examinations should have the orienting anatomy labeled and must have permanently recorded images maintained in the patient record. Procedural ultrasounds should have anatomy labeled and the point of interest captured. However, special care should be made to avoid compromising patient safety with the distraction of attempting to capture images while placing a needle in a critical location. Therefore, it is permissible to capture an image when it is safest for the patient, for example an image of an intravenous catheter in the lumen of the vein. The procedure note should reflect the needle was guided under direct visualization of ultrasound.

The stored images do not need to be submitted with the claim; however documentation of the study must be available to the insurer upon request. Images can be stored as printed or digital images.

Current practice suggests capturing one image in each orthogonal plane of each relevant structure and/or in the case of echocardiograph, one image of each of the classic windows and levels. 

**Section 13- Billing and Reimbursement**

Diagnostic and procedural ultrasound performed by PAs should be coded and reimbursed in the same manner as any other procedure which is performed in the course of the patient's care, using Current Procedure Terminology (CPT) codes. The CPT code and the modifier that most accurately describes the ultrasound exam/procedure performed should be included in the documentation.

Nearly all payers, including Medicare and Medicaid, cover medical and surgical services provided by PAs, in accordance with state law. The services are submitted/billed under the name of the PA or under the name of the physician depending on payer policy. It is essential to verify each payer’s specific payment and coverage policy for PAs.

Medicare pays the PA’s employer for medical and surgical services provided by PAs in all settings at 85 percent of the physician fee schedule. These settings include hospitals (inpatient, outpatient, operating room and emergency departments), nursing facilities, offices, clinics, the
patient’s home and for first assisting at surgery. In certain circumstances, evaluation and management services provided by PAs may be billed under the physician’s name and provider number by meeting Medicare’s “incident to” or shared visit billing guidelines. Medicare authorizes PAs to personally provide all diagnostic services and requires that those services be billed under the PA. Unless prohibited, it is preferred to have services performed by PAs be submitted/billed under the name of the PA.

Commercial insurers do not necessarily follow Medicare policies regarding reimbursement amounts and coverage rules, but are similar to Medicare in that services are billed either under the PA’s name or the collaborating physician’s name. Always obtain local payer requirements to ensure proper billing.

Generally, PAs can bill when performing diagnostic ultrasound or using ultrasound guidance during the performance of a procedure, as authorized by state law. Depending on the particular imaging requirement, the location of the service and other factors, there may be a distinction between the ultrasound utilization technical component (TC-this represents institutional reimbursement for the facility, equipment and supplies) and professional component (PC-this represents reimbursement for the provider performing and interpreting the exam). When appropriate, PAs may report a global service (PC and TC combined) or either the PC or TC, based on the service(s) delivered.

PAs, like physicians, must meet applicable payer guidelines for medical necessity, coverage policy and documentation requirements to obtain reimbursement for their services. In addition, PAs and physicians use the same International Classification of Diseases or ICD codes and Current Procedure Terminology or CPT codes and modifiers to report and describe the services they render.

**Section 14 – Conclusion**

Clinical ultrasound represents a bedside adjunct which is increasingly being utilized by a variety of clinicians in multiple care settings, but remains underutilized by PAs. Clinical ultrasound is a skill well within the scope of practice of appropriately trained PAs. Because there are unique advantages that ultrasound offers during the bedside evaluation of patients, AAPA will remain vigilant to potential barriers that may impede the safe incorporation of clinical ultrasound into PA clinical practice, while ensuring that adequate measures are in place to evaluate and ensure PAs are competently utilizing clinical ultrasound.
A goal of this document is to provide local hospital credentialing committees with reassurance that PAs, having met the standards established in this document, can safely and effectively employ bedside ultrasound for the benefit of patients. The utilization of clinical ultrasound has great potential to enhance the care provided by PAs, contribute to patient safety, reduce unnecessary medical testing, and enhance clinical decision making of PAs practicing across the clinical spectrum, and ultimately represents yet another tool that can ensure our patients continue to receive the high-quality and high-value care that they deserve.

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2017-C-02-HO

Barriers to PA Student Clinical Rotations Paper

2017-C-02

Resolved

Reject the referred 2016-D-07 policy paper entitled “Barriers to PA Student Clinical Rotations”.

Barriers to PA Student Clinical Rotations

Executive Summary of Policy Contained in this Paper

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

This position paper is intended to shed light on the effect that the current lack of clinical rotation sites and preceptors, the competition for positions within those limited sites, and barriers to interstate rotations, are having on PA students and their opportunities to train at the top of their ability. PAs are uniquely positioned to lead in the new healthcare environment of team-based care. In order to keep pace with the rapidly expanding demand for more medical providers, PA students must be provided every opportunity to successfully complete their education and training, especially as more PA programs come on line and existing programs attempt to expand their cohorts.

• The AAPA believes that patients will be best served if current and future PA students have access to the highest caliber clinical rotations possible.

• The AAPA believes that PA programs and clinically practicing PAs should work together in order to:

1. Mitigate the effect that PA inter-program competition for clinical rotation sites has on PA students; and

2. Increase the number of hospital and office rotation sites available to PA students and ensure a diversity of rotation sites.

3. Decrease the barriers for PAs to participate in clinical rotations in states other than where their PA program is located.

Introduction

PA programs, like allopathic and osteopathic medical schools and nurse practitioner (NP) programs, are faced with a shortage of preceptors and clinical rotation opportunities. With the rapid growth of the PA profession and the creation of new PA programs in 46 out of 50 states,
A Problem for PA Students, PA Programs, and the PA Profession

Quality clinical education is an important aspect of PA educational curriculum. Many required clinical rotations are in primary care settings, including family practice, pediatrics, and women’s health. This is in line with the ‘primary care’ or ‘generalist’ nature of PA training and the historical foundation of the PA profession. Although the clinical rotation site shortage is not a new challenge, only recently has the phenomenon been studied in a systematic manner, with the Joint Report of the 2013 Multi-Discipline Clerkship/Clinical Training Site Survey confirming what clinical coordinators and PA students already recognized.

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

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

As the PA profession continues to grow rapidly, with new programs developing and the number of PA students increasing, the demand for preceptors and clinical rotation sites will only increase in the coming years. From 2015 to 2016 alone, the number of accredited PA programs grew from 199 to 226 (5, 6). In addition to an increasing number of PA students seeking clinical rotations each year, there continues to be growth in the number of allopathic and osteopathic medical students, as well as nurse practitioner students, competing for many of the same rotations and preceptors. With the increase in PA students, the number of PAs is projected to increase 38.4% from 2012 to 2022 (7). Similarly, according to Merritt Hawkins, the demand for PAs was estimated to increase more than 300 percent between 2011 and 2014 (8). The continued growth of the PA profession depends on the growth of PA programs, and one of the essential rate-limiting factors in the growth of PA programs is clinical rotation barriers. If this issue is not addressed, the growth of the PA profession will slow and the PA profession will be less equipped to meet the sharp increase in health care demand.

Barriers to PA Clinical Rotations

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

There has been a steady increase in the number of allopathic and osteopathic medical, NP and PA students over the past several decades which have not been matched by a corresponding increase in number of preceptors and clinical rotation sites. As a result, the clinical training sites that are available are overwhelmed with student applicants. The insufficient number of clinical training sites for PA students is exacerbated by inter-professional competition for such sites.
According to the Association of American Medical Colleges (AAMC) there are currently 86,746 medical students enrolled in United States osteopathic and allopathic medical programs in the 2015-2016 school year (12). There has been a steady increase in medical student enrollment for the past decade. Since 2006-2007 there has been a 16 percent increase in the total number of matriculated medical students in the last decade (12). Additionally, there were an estimated 17,000 new Nurse Practitioners (NPs) completing their academic programs in 2013-2014 (13).

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

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

The Unique Position of the AAPA in Working Toward a Solution

AAPA is the only national organization that represents PAs and which PAs voluntarily join. With more than 37,000 Fellow members (all licensed PAs), AAPA is uniquely positioned to communicate with PAs about the need for and value of precepting PA students. In addition, AAPA has the opportunity to offer PAs incentives to serve as preceptors. Already, AAPA has
created a “Preceptor of the Year” award to encourage PAs to precept students. While the possibility of this award clearly signals the value of acting as a preceptor, the fact that only one individual will be recognized each year may limit its incentive effects. Additionally, AAPA encourages PAs to help educate the next generation of PAs through its Clinical Preceptor Recognition Program, awarding the CPAAPA designation.

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

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

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

**Conclusion**

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

**References**


5. ARC-PA / Accreditation Programs. (n.d.). [http://www.arc-pa.org/ace_programs/](http://www.arc-pa.org/ace_programs/)


2017-C-02-HO
Rationale/Justification

The task force reviewed the referred resolution on Barriers to PA Student Clinical Rotations. In considering the information gathered, the decision was made to reject the referred 2016-D-07. A resolution has been submitted containing the task force’s recommendations in a new policy paper entitled “PA Student Supervised Clinical Practice Experiences: Recommendations to Address Barriers”.

Related AAPA Policy

None

Possible Negative Implications

None

Financial Impact

None

Signature

Todd Pickard, PA-C
2nd Vice Speaker
(On behalf of the Clinical Rotations Task Force)

Contact For Resolution
2017-C-03-HO  PA Student Supervised Clinical Practice Experiences -
Recommendations to Address Barriers

2017-C-03  Resolved

Adopt the position paper entitled “PA Student Supervised Clinical Practice Experiences –
Recommendations to Address Barriers.” See policy paper.

Rationale/Justification
This policy paper explores the current Supervised Clinical Practice Experience (SCPE) and
preceptor shortage, and provides recommendations on how to address this important issue. It
incorporates the latest knowledge and evidence, and represents current expert opinion on SCPE.

A policy paper concerning SCPE was initially drafted by a student-led volunteer group within
the Student Academy of the AAPA. It was submitted by the Student Academy to the 2016 House
of Delegates (HOD) as Resolution 2016-D-07 with consensus among AAPA and Physician
Assistant Education Association (PAEA) leadership.

Final action in the 2016 HOD was to refer the paper to the appropriate body for further study
with a report back to the 2017 House.

A separate but complementary resolution, Resolution 2016-D-06, called for the creation of 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.” This resolution was adopted, and the members of the JTF
were selected by the AAPA Board of Directors (BOD). In addition to the charges outlined in
Resolution 2016-D-06, the JTF also received the policy paper referral from Resolution 2016-D-
07.

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
Supervised Clinical Practice Experiences (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.

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


HP-3200.3.3
AAPA supports approved PA programs in awarding category I CME credit to graduate PAs who precept PA students.
[Adopted 2014]

Possible Negative Implications
No negative implications are anticipated.

Financial Impact
The policy paper makes a series of recommendations, which would require staff resources if implemented. It’s difficult to estimate a precise value given the various ways these recommendations could be implemented, but the task force anticipates less than .5 FTE would be required on an ongoing basis.

Signature
Todd Pickard, PA-C
2nd Vice Speaker
(On behalf of the Clinical Rotations Task Force)

Contact For Resolution
Cynthia Booth Lord, MHS, PA-C
Chair, AAPA/PAEA Clinical Rotations Joint Task Force
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PA Student Supervised Clinical Practice Experiences -
Recommendations to Address Barriers

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

- AAPA supports working with PAEA, ARC-PA and NCCPA to communicate the benefits of precepting students to PAs, patients, and employers.
- AAPA supports working with 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 refer 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.
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 health care 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 perceived negative impacts of teaching (4, 9). While many preceptors perceive patient care responsibilities to be too time consuming to allow them to be good teachers, studies have found a correlation between productivity and highly-rated teachers, with positive impacts including enhanced enjoyment of practice and keeping one’s knowledge up-to-date (10, 11).

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.

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 he or she are reasonably expected to perform. This could also be achieved by
the implementation of Entrustable Professional Activities (EPAs) into PA education, which will
be further discussed in the section on Long-Term Solutions. Survey participants also reported
wanting more resources regarding best practices and teaching in a clinical setting.

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

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

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

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

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

Increasing the amount of AAPA Category 1 CME credit offered to PA preceptors was one of the most common suggestions. Currently, AAPA 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 to better distribute student placement nationwide. 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
health care 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 active AAPA members as of November 2016

- **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 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
o Maximum of 10 Category 1 CME credits per calendar year

o AAPA has received 258 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 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.

- AAPA supports working with PAEA, ARC-PA and NCCPA to communicate the benefits of precepting students to PAs, patients, and employers.
- AAPA supports working with PAEA to increase the number of AAPA Category 1 CME credits available to PAs who precept and simplify the CME application process for PA programs.
- AAPA supports working with PA employers to expand the range of opportunities for PA students to gain clinical experience through SCPE.
- AAPA supports suggesting modifications to the ARC-PA Standards in order to ensure quality SCPE continue with increased emphasis on flexibility and innovation.
- AAPA supports collaborating with PAEA to develop an information toolkit for PA programs and preceptors to utilize concerning benefits and helpful tips for precepting.
AAPA supports working with PAEA to increase awareness among PA educators of the additional limitation that pre-PA shadowing requirements may create for PA student placement in SCPE.

AAPA supports working with PAEA to investigate the feasibility of developing a national database of SCPE with the utilization of a CASPA-like centralized platform for PA students nationwide.

AAPA supports the consideration of collaboration with external medical organizations to look at ways to support an interprofessional, collaborative clinical training model.

Working together, the PAEA, AAPA, and all involved stakeholders can address the SCPE shortage and work toward a more sustainable model of PA education through some of the measures outlined above. Still, solutions are not limited to those listed in this paper. This long-standing issue will require continued innovation and refinement over the course of many years. A culture of collaboration among organizations, leaders, and other stakeholders within the PA community benefits these efforts. In the end, PA education will continue to be a model of quality and compassionate care, esteemed by the medical and patient communities alike.

References


2017-C-04-HOTP/SPAP     Routine Vaccination for Human Papillomavirus

2017-C-04     Resolved

Amend policy HX-4200.1.9, “Routine Vaccination for Human Papillomavirus”. See policy paper.

Rationale/Justification
The human papillomavirus (HPV) vaccine confers protection against cancers caused by HPV infection and is considered a major breakthrough in cancer prevention. However, the vaccine is not currently used to its full potential as vaccination rates in the United States remain well below the 80% target established by the U.S. Office of Disease Prevention and Health Promotion Healthy People 2020 initiative. The revisions to this paper include evidentiary updates, elaboration on diseases caused by HPV, updates on the cost of HPV-related disease to the healthcare system, vaccination rate goals, basic vaccine information, and the importance of communication about the benefits and safety of HPV vaccination.

Related AAPA Policy
HX-4200.1.1 AAPA endorses the use of the U.S. Department of Health and Human Services’ report Healthy People and its subsequent initiatives which serve as a guide to improve the health of the nation.

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

Policy/Position Paper # 6: Immunizations in Children and Adults

Policy/Position Paper # 20: Improving Childrens’ Access to Health Care

Policy/Position Paper #33: Health Disparities: Promoting the Equitable Treatment of All Patients
[Adopted 2011, amended 2016]

Possible Negative Implications
None

Financial Impact
None

Signatures & Contacts for Resolution
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Routine Vaccination for Human Papillomavirus
(Adopted 2008, amended 2012)

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 adding ROUTINE HPV VACCINATION FOR THE PREVENTION OF HPV-RELATED DISEASES, WHICH INCLUDE CANCER, to the routine schedule of vaccinations as recommended by ACIP.
• AAPA supports coverage of HPV vaccination by ALL insurers and AS WELL AS public funding for HPV vaccination for UNDERINSURED AND uninsured patients.
• AAPA encourages all PAs to discuss and recommend HPV vaccination for their patients in the recommended APPROPRIATE populations.
• PAs should continue to discuss the importance of safer sex with all their patients and continue to advise routine screening for HPV associated cancers in accordance with accepted guidelines.

Human papillomavirus (HPV) is the most common sexually transmitted infection in the United States (U.S.), with a seroprevalance of 32.5% and 12.2% of HPV type 6, 11, 16, and 18 in women and men respectively. It is estimated that over 50% of all sexually active individuals will become infected with HPV at some point in their lives. HPV IS ASSOCIATED WITH OROPHARYNGEAL, ANAL, CERVICAL, VAGINAL, VULVAR, AND PENILE CANCERS AS WELL AS CONDYLOMA, PRECANCEROUS CONDITIONS OF THE CERVIX, AND RECURRENT RESPIRATORY PAPILLOMATOSIS. FURTHERMORE, APPROPRIATE CONDOM USAGE DOES NOT COMPLETELY CONFER PROTECTION FROM HPV-RELATED DISEASE AS TRANSMISSION CAN OCCUR THROUGH CONTACT WITH INFECTED SKIN. HPV infection contributes to oropharyngeal and anogenital cancers and precancers, and condyloma acuminata. AN ESTIMATED 30,700 HPV-RELATED CANCERS OCCUR ANNUALLY IN THE U.S., WITH APPROXIMATELY 62% OF THESE CANCERS OCCURRING IN WOMEN AND 38% OF THESE CANCERS OCCURRING IN MEN. HPV-related illness results in significant cost to the healthcare system WITH AN ESTIMATED $8 BILLION SPENT ANNUALLY IN THE U.S. ON THE TREATMENT AND PREVENTION
OF HPV-RELATED DISEASE. 1.6 billion dollars are spent annually on HPV related illness in the U.S.

An estimated 22,000 HPV related cancers occur annually in the United States, including an estimated 7,000 HPV related cancers in males. There are over 11,000 cases of cervical cancer annually in the U.S. Oncogenic HPV is found in 99.7% of all cervical cancers and eleven women die every day in the U.S. from cervical cancer. Over 6000 women in the U.S. each year are diagnosed with HPV related anogenital cancers. PAs must provide evidence based, quality care for all patients. Vaccines against HPV have the potential to significantly reduce morbidity and mortality AND HAVE BEEN AVAILABLE SINCE 2006. THE U.S. OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION HEALTHY PEOPLE 2020 INITIATIVE (HP2020) HAS ESTABLISHED A GOAL OF ACHIEVING AN 80% HPV VACCINATION RATE FOR GIRLS AND BOYS. IN 2015, 49.8% OF BOYS AGED 13-17 YEARS HAD RECEIVED COVERAGE WITH AT LEAST 1 DOSE OF VACCINE WHILE ONLY 28.1% HAD RECEIVED ALL 3 DOSES. SIMILARLY, IN 2015, ONLY 62.8% OF GIRLS HAD RECEIVED COVERAGE WITH AT LEAST 1 DOSE OF VACCINE WHILE ONLY 41.9% HAD RECEIVED ALL 3 DOSES. WHILE VACCINATION RATES INCREASED IN 2015 COMPARED TO 2014, THEY REMAIN WELL BELOW THE HP2020 TARGET.

The FDA has licensed two HPV vaccines. HPV4 (Gardasil) protects against HPV type 6, 11, 16 and 18, and HPV2 (Cervarix) provides immunity against HPV type 16 and 18. Both vaccines are recommended for the prevention of cervical cancers and precancers. HPV4 is additionally recommended for prevention of anal cancers and precancers as well as condyloma acuminata. Current studies demonstrate efficacy of up to 99% when given to virus naïve individuals in the target age group.

VACCINES THAT ARE APPROVED BY THE FOOD AND DRUG ADMINISTRATION (FDA) SHOULD BE ADMINISTERED TO ALL INDIVIDUALS AS PER THE RECOMMENDATIONS OF THE Centers for Disease Control and Prevention (CDC) AND THE Advisory Committee on Immunization Practice (ACIP). recommends girls ages 10-12 undergo routine vaccination and catch up vaccinations be offered for women up to age 26. The ACIP recommends routine vaccination with HPV4 (Gardasil) for boys ages 11-12 and catch-up vaccinations in men up to age 21 with permissive vaccination up to age 26. Routine vaccination in boys and men will help decrease the direct burden of HPV-associated disease in men as well as indirectly benefit females through herd immunity.
For immunocompromised males and men who have sex with men (MSM), the ACIP recommends routine vaccination with HPV4 as for all males, and vaccination through age 26 years for those who have not been vaccinated previously or who have not completed the 3-dose series. MSM are at higher risk for infection with HPV and for HPV-associated conditions, including genital warts and anal cancers and precancers.

HPV IMMUNIZATION HAS PROVEN TO BE HIGHLY EFFECTIVE IN PREVENTING CERVICAL CANCERS, AND FOLLOW UP STUDIES SHOW NO WANING OF PROTECTION FIVE YEARS AFTER IMMUNIZATION WITH STATISTICAL MODELS PREDICTING PROTECTION FOR OVER 20 YEARS. Vaccination is most effective prior to the onset of any type of sexual activity and the immune response is optimal in the target age group.

Some parents and clinicians are uncomfortable broaching the subject of sexuality with patients in the target age group and as a result may be reluctant to discuss the need for vaccination. PAs can play a key role in initiating an objective EVIDENCE-BASED, patient-centered discussion on the benefits of vaccination against HPV IN THE SAME MANNER THEY RECOMMEND ALL ROUTINE IMMUNIZATIONS. STRONG COMMUNICATION WITH PATIENTS AND CAREGIVERS ABOUT THE SAFETY AND BENEFITS OF HPV VACCINATION IS DIRECTLY ASSOCIATED WITH VACCINE UPTAKE. PAS ARE WELL-POSITIONED TO PROVIDE SUCH EDUCATION AS PRACTITIONERS OF EVIDENCE-BASED MEDICINE. MESSAGES WHICH FOCUS ON HPV VACCINATION AS A MEANS OF CANCER PREVENTION MAY BE MORE EFFICACIOUS THAN MESSAGES WHICH FOCUS ON PREVENTION OF A SEXUALLY TRANSMITTED INFECTION.

**Recommendations**

- AAPA supports adding ROUTINE HPV VACCINATION FOR THE PREVENTION OF HPV-RELATED DISEASES, WHICH INCLUDE CANCER, to the routine schedule of vaccinations as recommended by ACIP.
- AAPA supports coverage of HPV vaccination by ALL insurers and AS WELL AS public funding for HPV vaccination for UNDERINSURED AND uninsured patients.
- AAPA encourages all PAs to discuss and recommend HPV vaccination for their patients in the recommended APPROPRIATE populations.
PAs should continue to discuss the importance of safer sex with all their patients and continue to advise routine screening for HPV associated cancers in accordance with accepted guidelines.

**Conclusion**

AAPA supports adding ROUTINE HPV VACCINATION FOR THE PREVENTION OF HPV-RELATED DISEASES, WHICH INCLUDE CANCER to the routine schedule of vaccinations as recommended by ACIP. In addition AAPA supports coverage of HPV vaccination by ALL insurers and AS WELL AS public funding for HPV vaccination for UNDERSERVED AND uninsured patients. Furthermore, AAPA encourages all PAs to discuss and recommend vaccination for their patients in the recommended APPROPRIATE populations. PAs should continue to discuss the importance of safer sex with all their patients and continue to advise routine screening for HPV associated cancers in accordance with accepted guidelines.

**References**


AAPA supports increased focus on addressing the Hepatitis C epidemic, which is closely related to the ongoing nationwide explosion of heroin use. This will include: (1) encouraging the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encouraging the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) supporting hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) supporting adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between the government, insurance companies and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; and (5) recognizing correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines.

**Rationale/Justification**

According to the CDC, there has been a 150 percent increase in Acute Hepatitis C in recent years. Much of this increase is thought to be related to the marked increase in injection drug use related to heroin. The AAPA policy process often attempts to avoid disease-specific policies, but such a policy is warranted by the need to address the Hep C epidemic in an urgent matter.

**Related AAPA Policy**

None. Hepatitis C is not currently addressed in the AAPA Policy Manual.

**Possible Negative Implications**

None

**Financial Impact**

None

**Signature & Contact for Resolution**

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2017-C-06-LBGT/HTOP  Opposing Treatment Changing Sexual Orientation or Gender Identity

2017-C-06  Resolved

Amend policy HX-4200.6.1 as follows:

AAPA opposes any psychiatric treatment directed specifically at changing sexual orientation OR GENDER IDENTITY, such as “conversion” or “reparative” therapy which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her sexual orientation.

Rationale/Justification

Introduction

AAPA Policy HX-4200.6.1 was up for 5-year review and assigned to the LBGT PA Caucus and the Health of the Public Commission. This amended policy resolution reflects a greater understanding of these topics today than what was known in 2007 when HX-4200.1.6 became policy, and is based upon published data and professional consensus.

There are 3 trends that are worth noting that inform this issue

- legislative, regulatory and legal trends around this issue since 2007,
- the PA profession’s ongoing efforts to influence workforce trends in behavioral health care, and
- published data and professional consensus has expanded to be inclusive of gender identity, and treatments outside the realm of psychiatry

- all of which make it important for AAPA policy to be updated.

A Review of the Evidence

Since HX-4200.6.1 became AAPA policy in 2007, comprehensive reviews of the evidence on attempts to change sexual orientation and gender identity have been conducted on behalf of the Institute of Medicine (2011), the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health and Human Services (HHS) (2015) and all of the major medical and mental health associations. These reviews considered all attempts at change (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches), and looked at delivery of attempts at change conducted by mental health professionals, lay individuals, including religious professionals, religious leaders, social groups, and other lay networks such as self-help groups. They have concluded that there was no evidence showing that any efforts had any impact on changing sexual orientation or gender identity, and that these therapies were often based on developmental theories without validity. More importantly, attempts to change sexual orientation or gender identity have been shown to cause harms that include depression, anxiety, and self-destructive behavior, fostered by the negative self-image that these efforts create.

In 2011, the Institute of Medicine (IOM) published “The Health of LGBT People: Building a Foundation for Better Understanding,” citing “The nation’s most prominent medical and mental
health professional organizations, including the American Medical Association, the American Psychiatric Association, and the American Psychological Association, oppose the use of conversion therapy with both youth and adults”.

In 2015, SAMHSA collaborated with the American Psychological Association, and convened a panel of behavioral health professionals (e.g., researchers and clinicians from psychology, social work, and psychiatry) with expertise in the fields of gender development, gender identity, and sexual orientation. Based on the best research and scholarly material available, that convening established professional consensus which states: “Conversion therapy perpetuates outdated views of gender roles and identities as well as the negative stereotype that being a sexual or gender minority or identifying as lesbian, gay, bisexual, or transgender, is an abnormal aspect of human development. Most importantly, it puts people at risk of serious harm.”

What Else has Changed Since 2007:

Until the 5th edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM), the term “gender identity disorder” had been used to diagnose all people who are transgender, as well as effeminacy in boys. This had provided rhetorical carte blanche to describe everyone who is transgender and gender diverse as disordered and mentally ill. In some cases, this diagnosis has even been used to discriminate, with claims that of being unfit parents or employees, as examples. More recently in 2012, the American Psychiatric Association board of trustees approved the latest revisions and what is now known as the DSM-5. The DSM-5 utilizes a new diagnostic terminology and diagnostic criteria: “gender dysphoria,” which communicates the focus away from gender identity, to the distress that can result from “a marked incongruence between one’s experienced/expressed gender and assigned gender”. This allows for affirmative treatment and transition care without the stigma of disorder for all gender minorities. In 2012, the APA also released new health guidelines for transgender patients, as well as a position statement affirming transgender care and civil rights. Both documents align with a new standard of respect for sexual and gender minorities by the medical community. This marks a historic milestone for people who are transgender and gender non-conforming to sex stereotypes, as their identities are no longer classified as a mental disorder. Homosexuality was similarly declassified as a mental disorder in 1973.

It was only after homosexuality was declassified as a mental disorder that associations formed to discourage gender nonconformity with sex stereotypes, protesting the medical community’s decision to affirm gay and bisexual orientations. Similar efforts have increased in the wake of the DSM-5 declassification of gender diversity as a mental disorder.

Who in the Medical and Mental Health Community is Concerned about this Topic:

There is broad consensus in the medical community that sexual orientation and gender identity are immutable traits—and that attempts to change these characteristics are not only unnecessary and ineffective, but also very harmful, resulting in long-lasting damage and may lead to an eight-fold increase in suicide attempts compared to the general population. The American Medical Association, the American Psychiatric Association, the American Psychological Association, the American College of Physicians, the American Academy of Family Physicians, American Academy of Pediatrics, the American Counseling Association, the American School Counselor Association, the National Association of School Psychologists, and the National Association of
Social Workers all have expressed that LGBT orientations and identities are not diseases and cannot be changed.

Since this topic was first presented to the House of Delegates in 2007, many national medical and mental health professional organizations have expanded their position beyond the initially limited scope of sexual orientation, to now include gender identity.

The quotes below are intended to be illustrative but are by no means exhaustive.

For example, the American Medical Association, policy H-160.99 on the Health Care Needs of Lesbian Gay Bisexual and Transgender Populations (2016) states, “Our AMA opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.”

In developing a transgender-inclusive statement in 2013, the American Academy of Pediatrics concluded: “In no situation is a referral for conversion or reparative therapy indicated.”

“The American Academy of Family Physicians (AAFP) opposes the use of “reparative” or “conversion” therapy of lesbian, gay, bisexual or transsexual individuals.” (Reaffirmed 2016) available at http://www.aafp.org/about/policies/all/reparative-therapy.html

The American College of Physicians (ACP), LGBT Health Disparities: Executive Summary of a Policy Position Paper from the American College of Physicians (2015), available at http://annals.org/data/Journals/AIM/0/0000605-201507210-00288.pdf states “The College opposes the use of ‘conversion,’ ‘reorientation,’ or ‘reparative’ therapy for the treatment of LGBT persons. . . Available research does not support the use of reparative therapy as an effective method in the treatment of LGBT persons. Evidence shows that the practice may actually cause emotional or physical harm to LGBT individuals, particularly adolescents or young persons.”

American School Counselor Association (ASCA), The Professional School Counselor and LGBTQ Youth (2014), available at www.SchoolCounselor.org/School-Counselors-Members/About-ASCA-%281%29/Position-Statements states “The professional school counselor works with all students through the stages of identity development and understands this may be more difficult for LGBTQ youth. It is not the role of the professional school counselor to attempt to change a student’s sexual orientation or gender identity. Professional school counselors do not support efforts by licensed mental health professionals to change a student’s sexual orientation or gender [identity] as these practices have been proven ineffective and harmful. School counselors provide support to LGBTQ students to promote academic achievement and personal/social development. Professional school counselors are committed to the affirmation of all youth regardless of sexual orientation, gender identity and gender expression and work to create safe and affirming schools.”
The Pan American Health Organization of the World Health Organization (2012) has stated that these attempts to alter sexual orientation or gender identity “lack medical justification and represent a serious threat to the health and well-being of affected people.”

The American Psychological Association task force on the topic reviewed data on change efforts and concluded that evidence is lacking for effectiveness, and that attempts to change sexual orientation or gender identity may cause harm to LGBT individuals by increasing internalized stigma, distress, and depression. Instead, on the basis of the Task Force’s findings, the APA encourages mental health professionals to provide assistance to those who seek change by utilizing affirmative multiculturally-competent and client-centered approaches that recognize the negative impact of social stigma, and balance ethical principles of beneficence and nonmaleficence, justice, and respect for people’s rights and dignity. When treating distress related to sexual orientation or gender identity, providers should consider the following as the scientific basis of treatment:

- Same-gender sexual identity, behavior, and attraction do not constitute a mental disorder;
- Transgender identities and diverse gender expressions do not constitute a mental disorder;
- Same-gender sexual attractions are part of the normal spectrum of sexual orientation and occur in the context of a variety of sexual orientations and gender identities;
- Variations in gender identity and expression are normal aspects of human diversity, and binary definitions of gender may not reflect emerging gender identities;
- Gay men, lesbians, bisexual and transgender individuals can lead satisfying lives as well as form stable, committed relationships and families.

The American Psychological Association’s council of representative adds this perspective about the controversy due to tensions between the values held by some faith-based organizations, on the one hand, and those held by a majority of professional and scientific organizations, on the other: “Psychology, as a science, and various faith traditions, as theological systems, can acknowledge and respect their profoundly different methodological and philosophical viewpoints. They conclude that psychology must rely on proven methods of scientific inquiry based on empirical data, on which hypotheses and propositions are confirmed or disconfirmed, as the basis to explore and understand human behavior”.

It’s worth noting that the American Psychological Association is referring to all available change efforts (e.g., behavioral techniques, psychoanalytic techniques, medical approaches, religious and spiritual approaches). This includes those efforts by mental health professionals, lay individuals, including religious professionals, religious leaders, social groups, and other lay networks such as self-help groups.
A final summative point from as far back as 2000, the American Psychiatric Association published a statement concluding that: “In the last four decades, ‘reparative’ therapists have not produced any rigorous scientific research to substantiate their claims of cure.”

Who Else is Concerned About this Topic:
The American Bar Association’s 2015 policy states “recognizing that lesbian, gay, bisexual, transgender, and queer (LGBTQ) people have the right be free from attempts to change their sexual orientation or gender identity, which have been condemned as ineffective and harmful by every major medical and mental health association in the country, and as supporting legislation, regulation, and litigation to bring an end to conversion therapy, including laws protecting minors from being subjected to conversion therapy by state-licensed mental health professionals”.
http://www.americanbar.org/content/dam/aba/images/abanews/2015annualresolutions/112.pdf

As of December 2016, six states (OR, CA, IL, NJ, NY, VT) and the District of Columbia have laws banning attempts to change sexual orientation or gender identity. All of the legislation bars licensed providers from practicing conversion therapy on minors; some also include protections for adults, restrictions on the use of state funds, and consumer protection provisions. As of March 1, 2017, bills to ban attempts to change sexual orientation or gender identity were filed in the legislatures of Colorado, Connecticut, Florida, Hawaii, Idaho, Iowa, Kansas, Kentucky, Massachusetts, Minnesota, Nevada, New Hampshire, New Mexico, Pennsylvania, Rhode Island, Texas, Washington and West Virginia.

There is currently no federal ban on these change efforts, however, claims of discrimination have been raised under the premise that the provision of ineffective and potentially harmful therapy is due solely to an individual’s sexual orientation or gender identity and may be inconsistent with Section 1557 of the ACA law that addresses nondiscrimination in the provision of care, or the Joint Commission’s accreditation requirement of non-discrimination in the provision of care.

When in 2012, California became the first state to ban conversion therapy for minors by licensed professionals, a legal challenge to this law was upheld by the Federal 9th Circuit Court of Appeals and allowed to stand by the Supreme Court of the United States. The appeals court noted that these professional activities were within the state’s authority to regulate and did not violate the free speech rights of practitioners or minor patients or the parents’ fundamental rights.

In addition to legislative and regulatory action, under consumer fraud law at the state level, in 2015 a jury found in favor of a claim that a “conversion therapy” program that offered services purported to change people from gay to straight was fraudulent and unconscionable.

More Opportunities for PAs in Mental Health and Behavioral Health
Healthcare institutions have ramped up their engagement of PAs in behavioral and mental health. To illustrate, earlier this year, the Veterans Health Administration released a request for proposals to establish a Mental Health Physician Assistant Residency (MH-PAR). The NccPA Health Foundation, the AAPA’s PA Foundation and the AAPA are all actively engaged in multi-year initiatives to enhance mental health care workforce capacity with PAs while fostering increased awareness of the PA profession within the mental health care community, institutions and systems. As PAs are trusted health professionals who are ideally positioned toward
providing an accelerated response to the shortage of mental health providers in the US, it would
serve PAs well to have an updated, as well as scientifically and ethically sound, policy on this
topic – which every major medical and mental health professional association in the country has
already responded to.

Anticipating Future Trends:
Subject matter experts are expecting this topic to continue to be explored at by state legislative
and regulatory bodies in the coming years. Some of the topic areas that are expected to receive
additional attention include:

- restrictions on the use of federal or state funding for conversion therapy by federal
  programs, by recipients of such funding, or through health insurance reimbursements,
- policies for institutions that house out-of-home youth (such as juvenile justice and foster
care programs) that prohibit conversion therapy efforts on minors in care and are often
  licensed by states or receive federal funding, as well as
- clarification of existing non-discrimination policies to extend to prohibitions on
  conversion therapy.

Therefore, it is timely and relevant for the AAPA to have a policy that speaks to the most recent
information on this topic – beyond psychiatric treatments to be inclusive of all attempts at
change, and inclusive of gender identity.

In the interest of a comprehensive and thorough 5-year policy review, these resources were
considered.

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**Related AAPA Policy**

HX-4200.6.1
AAPA opposes any psychiatric treatment directed specifically at changing sexual orientation, such as “conversion” or “reparative” therapy which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her sexual orientation.
[Adopted 2007, reaffirmed 2012]

HX-4600.1.6
AAPA recognizes that discrimination contributes to health disparities. AAPA supports legislation and policies that will eliminate discrimination.

Guidelines for Ethical Conduct for the PA Profession
Cited at Article III, Section 1; Article IX, Sections 3 and 4; BA-2300.3.5, and HP-3700.1.2
“PA Role and Responsibilities

…

PAs are professionally and ethically committed to providing nondiscriminatory care to all patients. While PAs are not expected to ignore their own personal values, scientific or ethical standards, or the law, they should not allow their personal beliefs to restrict patient access to care. “…

“If personal moral, religious, or ethical beliefs prevent a PA from offering the full range of treatments available or care the patient desires, the PA has an ethical duty to refer a patient to another qualified provider. That referral should not restrict a patient’s access to care. PAs are obligated to care for patients in emergency situations and to responsibly transfer patients if they cannot care for them.”…

“The PA should respect the culture, values, beliefs, and expectations of the patient.”…

“PAs should not discriminate against classes or categories of patients in the delivery of needed health care. Such classes and categories include gender, color, creed, race, religion, age, ethnic or national origin, political beliefs, nature of illness, disability, socioeconomic status, physical stature, body size, gender identity, marital status, or sexual orientation.”…

“It is unethical for PAs to engage in or condone any form of gender discrimination. Gender discrimination is defined as any behavior, action, or policy that adversely affects an individual or group of individuals due to disparate treatment, disparate impact, or the creation of a hostile or intimidating work or learning environment.”
Scientific Integrity and Public Policy  
*Cited at HX-4500.6*  
“AAPA believes scientific research and discussion should be free from undue political, religious, financial or other ideological influence.”

End-of-Life Decision Making  
*Cited at HP-3700.1.4*  
“Caregivers often try, consciously or not, to validate their own beliefs by convincing others to share them. Religious and moral convictions are subject to infinite shadings and interpretations. Clinicians who are aware of, and comfortable with, their own beliefs are less likely to feel either conflicted or compromised.”

Health Disparities: Promoting the Equitable Treatment of All Patients  
*Cited at BA-2200.2.1*  
“As the focus on health disparities has sharpened over the last decade, definitions have broadened to include gender, sexual orientation, or gender identity, religion, socioeconomic status, mental health, geographic location, and other characteristics typically linked to discrimination or exclusion.”

**Possible Negative Implications**

To paraphrase the American Psychological Association, Medicine – inclusive of mental health - as a science, and various faith traditions, as theological systems, can acknowledge and respect their profoundly different methodological and philosophical viewpoints. In this context, the proposed policy is inconsistent with the positions of some faith-based organizations, and their supporters, including the National Association for Research and Therapy of Homosexuality (NARTH) – an organization founded when the social science backed the position that homosexuality did not meet the criteria for mental illness and was removed from the DSM in 1973. In 2006, the APA stated: “*There is simply no sufficiently scientifically sound evidence that sexual orientation can be changed.*” The APA added, “*Our further concern is that the positions espoused by NARTH and Focus on the Family create an environment in which prejudice and discrimination can flourish.*” In other words, the positions of NARTH, Focus on the Family, and other similar organizations are inconsistent with the science and biomedical ethics that support the positions taken by major medical and mental health professional associations.

**Financial Impact**

None

**Signatures**

Jeff Straw, PA-C  
Secretary, LBGT PA Caucus

Deanna Bridge-Najera, MPAS, MS, PA-C, NCC  
Chair, Health of the Public Commission

**Contact for Resolution**
Jonathan Baker, PA-C,
Chief Delegate, LBGT PA Caucus
info@lbgtpa.org
Opposing Psychiatric Treatment Changing Sexual Orientation or Gender Identity

Resolved

Reaffirm policy HX-4200.6.1.

AAPA opposes any psychiatric treatment directed specifically at changing sexual orientation such as “conversion” or “reparative” therapy which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her sexual orientation.

Rationale/Justification

None

Related AAPA Policy

None

Possible Negative Implications

None

Financial Implications

None

Signatures

Jeff Straw, PA-C
Secretary, LBGT PA Caucus

Deanna Bridge-Najera, MPAS, MS, PA-C, NCC
Chair, Health of the Public Commission

Contact for Resolution

Jonathan Baker, PA-C
Chief Delegate, LBGT PA Caucus

info@lbgtpa.org
2017-C-08-LGBT/SPAP  Attempts to Change a Minor’s Sexual Orientation, Gender Identity or Gender Expression

2017-C-08  Resolved

Adopt the policy paper entitled “Attempts to Change a Minor’s Sexual Orientation, or Gender Identity, or Gender Expression”. See policy paper.

Rationale/Justification
Because of the greater understanding of these topics today than in 2007 (now also inclusive of gender identity, and treatments outside the realm of psychiatry), the PA profession’s ongoing efforts to influence workforce trends in behavioral health care, and the legislative, regulatory and legal trends since 2007, the goal of this resolution and associated position paper is to provide the HOD with a position paper representing the most current data and professional consensus on the topic’s influence on minors.

A Review of the Evidence:
The mission of the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health and Human Services (HHS) is to improve the behavioral health of the nation. As such, SAMHSA endeavors to improve public health and eliminate health disparities facing all vulnerable communities, including sexual and gender minority populations.

In 2015, SAMHSA collaborated with the American Psychological Association, and convened a panel of behavioral health professionals (e.g., researchers and clinicians from psychology, social work, and psychiatry) with expertise in the fields of gender development, gender identity, and sexual orientation in children and adolescents. Based on the best research and scholarly material available, that convening established professional consensus with respect to efforts to change a minor’s sexual orientation or gender identity, and ultimately resulted in this report:


The purpose of this report is to provide “accurate information about effective and ineffective therapeutic practices related to children’s and adolescent’s sexual orientation and gender identity”.

As per the report “Conversion therapy perpetuates outdated views of gender roles and identities as well as the negative stereotype that being a sexual or gender minority or identifying as lesbian, gay, bisexual, or transgender, is an abnormal aspect of human development. Most importantly, it puts people at risk of serious harm.”

THE CONSENSUS STATEMENTS WITHIN THE PROPOSED POSITION PAPER ARE DIRECT QUOTES FROM THIS REPORT.
Growing Opportunities for PAs in Mental Health and Behavioral Health:

Healthcare institutions have ramped up their engagement of PAs in behavioral and mental health. To illustrate, earlier this year, the Veterans Health Administration released a request for proposals to establish a Mental Health Physician Assistant Residency (MH-PAR). The nccPA Health Foundation, the AAPA’s PA Foundation and the AAPA are all actively engaged in multi-year initiatives to enhance mental health care workforce capacity with PAs while fostering increased awareness of the PA profession within the mental health care community, institutions and systems. As PAs are trusted health professionals who are ideally positioned toward providing an accelerated response to the shortage of mental health providers in the US, it would serve PAs well to have an updated, as well as scientifically and ethically sound, position paper on this topic – which every major medical and mental health professional association in the country has responded to.

Who in the Medical and Mental Health Community is Concerned about this Topic:

There is broad consensus in the medical community that sexual orientation and gender identity are immutable traits—and that attempts to change these characteristics are not only unnecessary and ineffective, but also very harmful – particularly on the development of children and adolescents, resulting in long-lasting damage and often suicide. The American Academy of Pediatrics, the American Counseling Association, the American Psychiatric Association, the American Psychological Association, the American School Counselor Association, the National Association of School Psychologists, and the National Association of Social Workers all have expressed that LGBT orientations and identities are not pathologic and advise against any change attempts.

In 2012, the American Psychiatric Association board of trustees approved the latest proposed revisions to the Diagnostic and Statistical Manual of Mental Disorders, what is now known as the DSM-5. This marks a historic milestone for people who are transgender and gender non-conforming to sex stereotypes, as their identities are no longer classified as a mental disorder. Homosexuality was similarly declassified as a mental disorder in 1973.

Until DSM-5, the term “gender identity disorder” had been used to diagnose all people who are transgender, as well as effeminacy in boys. This has provided rhetorical carte blanche to describe everyone who is transgender and gender diverse as disordered, delusional, and mentally ill. In some cases, this diagnosis has even been used to discriminate, with claims that they are unfit parents or employees, as examples.

The DSM-5 utilizes a new diagnostic terminology and diagnostic criteria: “gender dysphoria,” which communicates the focus away from gender identity, to the distress that can result from “a marked incongruence between one’s experienced/expressed gender and assigned gender”. This allows for affirmative treatment and transition care without the stigma of disorder. In 2012, the APA also released new health guidelines for transgender patients, as well as a position statement affirming transgender care and civil rights. Both documents align with a new standard of respect for sexual and gender minorities by the medical community.
Since this topic was first presented to the House of Delegates in 2007, many national medical and mental health professional organizations have expanded their position beyond the initially limited scope of sexual orientation, to now include gender identity.

For example, a comprehensive review of the evidence about conversion therapy in 2007 by the American Psychological Association concluded that there was no evidence showing that change efforts had any impact on adult sexual orientation or gender identity and that these therapies were often based on developmental theories without validity. More importantly, conversion therapy may cause harms that include depression, anxiety, and self-destructive behavior, fostered by the negative self-image that these efforts create.

The quotes below are intended to be illustrative of the inclusion of gender identity, transgender and gender diversity, but are by no means exhaustive.

The American Academy of Pediatrics (AAP) issued its first statement on sexual minority youth in 1983, with revisions in 1993 and 2004. As per AAP’s last statement in 2013, “research areas have rapidly expanded and hundreds of new publications have been produced about lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. In 2011, the Institute of Medicine (IOM) published “The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding.” The comprehensive IOM publication includes a section on childhood and adolescence. This updated clinical report provides definitions and the best information available about the demographics of this group of adolescents. Being a member of this group of teens is not, in itself, a risk behavior; nor should sexual minority youth be considered abnormal”. In it’s 2013 statement, the AAP again cited the 2011 IOM report, and in a transgender-inclusive statement, concluded: “In no situation is a referral for conversion or reparative therapy indicated.”

“The American Academy of Family Physicians (AAFP) opposes the use of “reparative” or “conversion” therapy of lesbian, gay, bisexual or transsexual individuals. The AAFP recommends that parents, guardians, young people, and their families seek support and services that provide accurate information on sexual orientation and sexuality, increase family and school support, and reduce rejection of sexual minority persons of all ages.” (Reaffirmed 2016) available at http://www.aafp.org/about/policies/all/reparative-therapy.html

The American Psychoanalytic Association, Position Statement on Attempts to Change Sexual Orientation, Gender Identity, or Gender Expression (2012), available at www.APSA.org/About_APsaA/Position_Statements/Attempts_to_Change_Sexual_Orientation.aspx states “As with any societal prejudice, bias against individuals based on actual or perceived sexual orientation, gender identity or gender expression negatively affects mental health, contributing to an enduring sense of stigma and pervasive self-criticism through the internalization of such prejudice. Psychoanalytic technique does not encompass purposeful attempts to ‘convert,’ ‘repair,’ change or shift an individual’s sexual orientation, gender identity or gender expression. Such directed efforts are against fundamental principles of psychoanalytic treatment and often result in substantial psychological pain by reinforcing damaging internalized attitudes.”

The American Psychiatric Association published a statement (2000) that concluded: “In the last four decades, ‘reparative’ therapists have not produced any rigorous scientific research to substantiate their claims of cure.”

American Academy of Child and Adolescent Psychiatry, Practice Parameter on Gay, Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents, 51 J. Am. Acad. Child & Adolescent Psychiatry 957 (2012), available at www.Guideline.gov/Content.aspx?id=38417#Section420. “Clinicians should be aware that there is no evidence that sexual orientation can be altered through therapy, and that attempts to do so may be harmful. There is no empirical evidence adult homosexuality can be prevented if gender nonconforming children are influenced to be more gender conforming. Indeed, there is no medically valid basis for attempting to prevent homosexuality, which is not an illness. On the contrary, such efforts may encourage family rejection and undermine self-esteem, connectedness and caring, important protective factors against suicidal ideation and attempts. Given that there is no evidence that efforts to alter sexual orientation are effective, beneficial or necessary, and the possibility that they carry the risk of significant harm, such interventions are contraindicated.”

American School Counselor Association (ASCA), The Professional School Counselor and LGBTQ Youth (2014), available at www.SchoolCounselor.org/School-Counselors-Members/About-ASCA-%281%29/Position-Statements states “The professional school counselor works with all students through the stages of identity development and understands this may be more difficult for LGBTQ youth. It is not the role of the professional school counselor to attempt to change a student’s sexual orientation or gender identity. Professional school counselors do not support efforts by licensed mental health professionals to change a student’s sexual orientation or gender as these practices have been proven ineffective and harmful (APA, 2009). School counselors provide support to LGBTQ students to promote academic achievement and personal/social development. Professional school counselors are committed to the affirmation of all youth regardless of sexual orientation, gender identity and gender expression and work to create safe and affirming schools.”
A number of position statements specifically regarding sexual orientation change efforts have
been updated since a resolution on this topic was first presented to the AAPA House of
Delegates in 2007:

For example, the American Psychological Association (2009) “advises parents,
guardians, young people, and their families to avoid sexual orientation change efforts
that portray homosexuality as a mental illness or developmental disorder and to seek
psychotherapy, social support, and educational services that provide accurate
information on sexual orientation and sexuality, increase family and school support, and
reduce rejection of sexual minority youth.” [http://www.apa.org/about/policy/sexual-
orientation.pdf](http://www.apa.org/about/policy/sexual-orientation.pdf) It’s also worth noting that the APA uses the term sexual orientation
change efforts to describe all means to change sexual orientation (e.g., behavioral
techniques, psychoanalytic techniques, medical approaches, religious and spiritual
approaches). This includes those efforts by mental health professionals, lay individuals,
including religious professionals, religious leaders, social groups, and other lay networks
such as self-help groups.

The American Psychological Association’s council of representative adds this
perspective regarding “ongoing efforts to mischaracterize homosexuality and promote
the notion that sexual orientation can be changed and about the resurgence of sexual
orientation change efforts:

Change efforts have been controversial due to tensions between the values held by some
faith-based organizations, on the one hand, and those held by lesbian, gay, and bisexual
rights organizations and professional and scientific organizations, on the other
(Drescher, 2003; Drescher & Zucker, 2006). Some individuals and groups have
promoted the idea of homosexuality as symptomatic of developmental defects or spiritual
and moral failings and have argued that change efforts, including psychotherapy and
religious efforts, could alter homosexual feelings and behaviors (Drescher & Zucker,
2006; Morrow & Beckstead, 2004). Many of these individuals and groups appeared to be
embedded within the larger context of conservative religious political movements that
have supported the stigmatization of homosexuality on political or religious grounds
(Drescher, 2003; Drescher & Zucker, 2006; Southern Poverty Law Center, 2005).
Psychology, as a science, and various faith traditions, as theological systems, can
acknowledge and respect their profoundly different methodological and philosophical
viewpoints. The APA concludes that psychology must rely on proven methods of scientific
inquiry based on empirical data, on which hypotheses and propositions are confirmed or
disconfirmed, as the basis to explore and understand human behavior (APA, 2008a,
2008b)”.

Who Else is Concerned About this Topic:

In August 2015, The American Bar Association passed a resolution urging all federal, state,
local, territorial, and tribal governments to enact laws that prohibit licensed professionals from
using conversion therapy on minors, as well as to protect minors, particularly minors in their
care, from being subjected to conversion therapy.

http://www.americanbar.org/content/dam/aba/images/abanews/2015annualresolutions/112.pdf
As of December 2016, six states (OR, CA, IL, NJ, NY, VT) and the District of Columbia have laws banning the practice of conversion therapy for minors. All of the legislation bars licensed providers from practicing conversion therapy on minors; some also include protections for vulnerable adults, restrictions on the use of state funds, and consumer protection provisions. As of March 1, 2017, bills to ban attempts to change sexual orientation or gender identity were filed in the legislatures of Colorado, Connecticut, Florida, Hawaii, Idaho, Iowa, Kansas, Kentucky, Massachusetts, Minnesota, Nevada, New Hampshire, New Mexico, Pennsylvania, Rhode Island, Texas, Washington and West Virginia.

There is currently no federal ban on conversion therapy, however, claims of discrimination have been raised under the premise that the provision of ineffective and potentially harmful therapy is due solely to an individual’s sexual orientation or gender identity and may be inconsistent with Section 1557 of the ACA law that addresses nondiscrimination in the provision of care, or the Joint Commission’s accreditation requirement of non-discrimination in the provision of care.

In addition to legislative and regulatory action, under consumer fraud law at the state level, in 2015 a jury found in favor of a claim that a “conversion therapy” program that offered services purported to change people from gay to straight was fraudulent and unconscionable.

**Anticipating Future Trends:**
Subject matter experts are expecting this topic to continue to be explored at by state legislative and regulatory bodies in the coming years. Some of the topic areas that are expected to receive additional attention include:

- restrictions on the use of public funding for conversion therapy by public programs, by recipients of such funding, or through health insurance reimbursements,
- policies for institutions that house out-of-home youth (such as juvenile justice and foster care programs) that prohibit conversion therapy efforts on minors in care and are often licensed by states or receive federal funding, as well as
- clarification of existing non-discrimination policies to extend to prohibitions on conversion therapy.

Therefore, the sponsors of this resolution believe it is timely and relevant for the AAPA to have a position paper that speaks to this topic and join with our professional colleagues in medicine and mental health.

**Resources for Survivors of Conversion Therapy:**
LGBT youth in crisis should contact The Trevor Project through Trevor Lifeline, a crisis intervention and suicide prevention phone service available 24/7.

www.thetrevorproject.org/pages/get-help-now#lifeline

PFLAG is a national organization with local chapters which may be able to connect with parents, youth, and adults who have been impacted by conversion therapy efforts. www.PFLAG.org

Truth Wins Out – A non-profit organization that counters antigay propaganda, exposes the “ex-gay” myth and educates the public about gay life. www.TruthWinsOut.org

Beyond Ex-Gay – Community and resource for those who have survived ex-gay experiences. Information on annual conference, personal stories, and related media. www.BeyondExGay.com

To connect your patients with a network of other survivors, contact NCLR at: 415.365.1308 or SAmes@NCLRights.org.

Selected References:


A. Lee Beckstead, Can We Change Sexual Orientation?, 41 Archives of Sexual Behavior 121, 122-23 (2012).


Emily F. Rothman, et al., Parents’ Supportive Reactions to Sexual Orientation Disclosure Associated with Better Health: Results from a Population-Based Survey of LGB Adults in Massachusetts, 59 J. Homosexuality 186 (2012).

Caitlin Ryan, et al., Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults Pediatrics 346 (2009).

Related AAPA Policy

HX-4200.6.1
AAPA opposes any psychiatric treatment directed specifically at changing sexual orientation, such as “conversion” or “reparative” therapy which is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her sexual orientation.
[Adopted 2007, reaffirmed 2012]

HX-4600.1.6
AAPA recognizes that discrimination contributes to health disparities. AAPA supports legislation and policies that will eliminate discrimination.

Guidelines for Ethical Conduct for the PA Profession
Cited at Article III, Section 1; Article IX, Sections 3 and 4; BA-2300.3.5, and HP-3700.1.2

“PA Role and Responsibilities

…

PAs are professionally and ethically committed to providing nondiscriminatory care to all patients. While PAs are not expected to ignore their own personal values, scientific or ethical standards, or the law, they should not allow their personal beliefs to restrict patient access to care. “…

“If personal moral, religious, or ethical beliefs prevent a PA from offering the full range of treatments available or care the patient desires, the PA has an ethical duty to refer a patient to another qualified provider. That referral should not restrict a patient’s access to care. PAs are obligated to care for patients in emergency situations and to responsibly transfer patients if they cannot care for them.”…

“The PA should respect the culture, values, beliefs, and expectations of the patient.”…

“PAs should not discriminate against classes or categories of patients in the delivery of needed health care. Such classes and categories include gender, color, creed, race, religion, age, ethnic or national origin, political beliefs, nature of illness, disability, socioeconomic status, physical stature, body size, gender identity, marital status, or sexual orientation.”…

“It is unethical for PAs to engage in or condone any form of gender discrimination. Gender discrimination is defined as any behavior, action, or policy that adversely affects an individual or group of individuals due to disparate treatment, disparate impact, or the creation of a hostile or intimidating work or learning environment.”

Scientific Integrity and Public Policy

Cited at HX-4500.6

“AAPA believes scientific research and discussion should be free from undue political, religious, financial or other ideological influence.”

End-of-Life Decision Making

Cited at HP-3700.1.4

“Ethics, or principles of moral conduct, are not fixed and static, but subject to change and interpretation. Social, historical, cultural, racial, political, professional, and religious influences all shape the ethical beliefs that affect the actions of health care providers and patients.”…

“Caregivers often try, consciously or not, to validate their own beliefs by convincing others to share them. Religious and moral convictions are subject to infinite shadings and interpretations. Clinicians who are aware of, and comfortable with, their own beliefs are less likely to feel either conflicted or compromised.”…

Health Disparities: Promoting the Equitable Treatment of All Patients

Cited at BA-2200.2.1

“As the focus on health disparities has sharpened over the last decade, definitions have broadened to include gender, sexual orientation, or gender identity, religion, socioeconomic status, mental health, geographic location, and other characteristics typically linked to discrimination or exclusion.”

Possible Negative Implications

To paraphrase the American Psychological Association (APA), Medicine – including mental health, as a science, and various faith traditions, as theological systems, can acknowledge and
respect their profoundly different methodological and philosophical viewpoints. In this content, the proposed policy is inconsistent with those of the National Association for Research and Therapy of Homosexuality (NARTH) – an organization founded when the social science backed the position that homosexuality did not meet the criteria for mental illness and was removed from the DSM in 1973 – and some faith-based organizations, and their supporters. In 2006, the APA stated: “There is simply no sufficiently scientifically sound evidence that sexual orientation can be changed.” The APA added, “Our further concern is that the positions espoused by NARTH and Focus on the Family create an environment in which prejudice and discrimination can flourish.” The positions of NARTH, Focus on the Family, and other such organizations are inconsistent with the science and biomedical ethics behind the positions of the major medical and mental health associations.

If the resolved does not become policy, AAPA’s existing position will not be current and is only applicable to treatments intended to alter sexual orientation, excluding change efforts directed to gender identity and gender expression.

Financial Impact
None

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Attempts to Change a Minor’s Sexual Orientation, Gender Identity or Gender Expression

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

- Efforts to change an individual’s sexual orientation, gender identity, or gender expression are not supported by credible evidence and have been disavowed by behavioral health experts and associations.
- Efforts to change an individual’s sexual orientation, gender identity, or gender expression perpetuate outdated views of gender roles and identities as well as the negative stereotype that being a sexual or gender minority or identifying as lesbian, gay, bisexual, or transgender is an abnormal aspect of human development.
- Efforts to change an individual’s sexual orientation, gender identity, or gender expression are coercive, can be harmful, and should not be part of treatment plan.

Review of the Evidence
The mission of the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health and Human Services (HHS) is to improve the behavioral health of the nation. As such, SAMHSA endeavors to improve public health and eliminate health disparities facing all vulnerable communities, including sexual and gender minority populations.

In 2015, SAMHSA collaborated with the American Psychological Association, and convened a panel of behavioral health professionals (e.g., researchers and clinicians from psychology, social work, and psychiatry) with expertise in the fields of gender development, gender identity, and sexual orientation in children and adolescents. Based on the best research and scholarly material available, that convening established professional consensus with respect to efforts to change a minor’s sexual orientation, gender identity, or gender expression, and ultimately resulted in this report:

Substance Abuse and Mental Health Services Administration, Ending Conversion Therapy: Supporting and Affirming LGBTQ Youth. HHS Publication No. (SMA) 15-
The purpose of this 76-page report is to provide “accurate information about effective and ineffective therapeutic practices related to children’s and adolescent’s sexual orientation and gender identity”.

As per the report, “Conversion therapy – efforts to change an individual’s sexual orientation, gender identity, or gender expression – is a practice that is not supported by credible evidence and have been disavowed by behavioral health experts and associations. Conversion therapy perpetuates outdated views of gender roles and identities as well as the negative stereotype that being a sexual or gender minority or identifying as lesbian, gay, bisexual, or transgender, is an abnormal aspect of human development. Most importantly, it may put young people at risk of serious harm”.

Additional information on this topic, including statements of professional consensus, research overview, approaches to ending the use of conversion therapy, guidance for families, providers and educators, as well as references, and a glossary of terms can be found within the report and accessed online. [http://store.samhsa.gov/shin/content/SMA15-4928/SMA15-4928.pdf](http://store.samhsa.gov/shin/content/SMA15-4928/SMA15-4928.pdf)

**Recommendation**

AAPA endorses the consensus statements of the 2015 SAMHSA publication noted below, resulting from the convening of subject matter experts in the fields of psychology, social work and psychiatry as part of the collaboration between the American Psychological Association and the Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services, and as follows:

**PROFESSIONAL CONSENSUS ON CONVERSION THERAPY WITH MINORS**

- AAPA believes that same-gender sexual orientation (including identity, behavior, and/or attraction) and variations in gender identity and gender expression are a part of the normal spectrum of human diversity and do not constitute a mental disorder.

- AAPA believes that there is limited research on conversion therapy efforts among children and adolescents; however, none of the existing research supports the premise that mental or behavioral health interventions can alter gender identity or sexual orientation.
AAPA believes that interventions aimed at a fixed outcome, such as gender conformity or heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatments. Directing a child to be conforming to any gender expression or sexual orientation, or directing the parents to place pressure for specific gender expressions, gender identities, and sexual orientations are inappropriate and reinforce harmful gender and sexual orientation stereotypes.

PROFESSIONAL CONSENSUS ON SEXUAL ORIENTATION IN YOUTH

- AAPA believes that same-gender sexual identity, behavior, and attraction are not mental disorders. Same-gender sexual attractions are part of the normal spectrum of sexual orientation. Sexual orientation change in children and adolescents should not be a goal of mental health and behavioral interventions.

- AAPA believes that sexual minority children and adolescents are especially vulnerable populations with unique developmental tasks who lack protections from involuntary or coercive treatment, and whose parents and guardians need accurate information to make informed decisions about behavioral health treatment.

- AAPA believes that there is a lack of published research on efforts to change sexual orientation among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter sexual orientation. Given the research on the secondary outcomes of such efforts, the potential for risk of harm suggests the need for other models of behavioral health treatment.

- AAPA believes that behavioral health professionals provide accurate information on sexual orientation, gender identity, and expression; increase family and school support; and, reduce rejection of sexual minority youth. Behavioral health practitioners identify sources of distress and work to reduce distress experienced by children and adolescents. Behavioral health professionals provide efforts to encourage identity exploration and integration, adaptive coping, and family acceptance to improve psychological well-being.

PROFESSIONAL CONSENSUS ON GENDER IDENTITY AND GENDER EXPRESSION IN YOUTH

Consensus on the Overall Phenomenon of Gender Identity and Gender Expression
AAPA believes that variations in gender identity and expression are normal aspects of human diversity and do not constitute a mental disorder. Binary definitions of gender may not reflect emerging gender identities.

AAPA believes that pre-pubertal children and peri-pubertal adolescents who present with diverse gender expressions or gender dysphoria may or may not develop a transgender identity in adolescence or adulthood. In pubertal and post-pubertal adolescents, diverse gender expressions and transgender identity usually continue into adulthood.

**Consensus on Efforts to Change Gender Identity**

- AAPA believes that there is a lack of published research on efforts to change gender identity among children and adolescents; no existing research supports that mental health and behavioral interventions with children and adolescents alter gender identity.
- AAPA believes that it is clinically inappropriate for behavioral health professionals to have a prescriptive goal related to gender identity, gender expression, or sexual orientation for the ultimate developmental outcome of a child’s or adolescent’s gender identity or gender expression.
- AAPA believes that mental health and behavioral interventions aimed at achieving a fixed outcome, such as gender conformity, including those aimed at changing gender identity or gender expression, are coercive, can be harmful, and should not be part of treatment. Directing the child or adolescent to conform to any particular gender expression or identity, or directing parents and guardians to place pressure on the child or adolescent to conform to specific gender expressions and/or identities, is inappropriate and reinforces harmful gender stereotypes.

**Consensus on Appropriate Therapeutic Intervention for Youth with Gender-Related Concerns**

- AAPA believes that children and adolescents experiencing gender-related concerns are an especially vulnerable population with unique developmental tasks. Parents and guardians need accurate scientific information to make informed decisions about appropriate mental health and behavioral interventions, including whether or not to initiate a social gender transition or, in the case of peripubertal, pubertal, and post-pubertal adolescents, medical intervention. Treatment discussions should respect the child’s and adolescent’s
developing autonomy, recognizing that adolescents are still transitioning into adult
decision-making capacities.

- AAPA believes that approaches that focus on developmentally-appropriate identity
  exploration, integration, the reduction of distress, adaptive coping, and family acceptance
to improve psychological wellbeing are recommended for children and adolescents of all
ages experiencing gender-related concerns.

**Pre-Pubertal Children**

- AAPA believes that gender expression and gender identity are interrelated and difficult to
differentiate in prepubertal children, and are aspects of identity that develop throughout
childhood. Therefore, a detailed psychological assessment should be offered to children
and families to better understand the present status of a child’s gender identity and gender
expression, as well as any associated distress.

**Peri-Pubertal Adolescents**

- For peri-pubertal adolescents, the purpose of pubertal suppression is to provide time to
  support identity exploration, to alleviate or avoid potential distress associated with
physical maturation and secondary sex characteristics, and to improve future healthy
adjustment. If pubertal suppression is being considered, it is strongly recommended that
parents or guardians and medical providers obtain an assessment by a licensed behavioral
health provider to understand the present status of a peri-pubertal adolescent’s gender
identity or gender expression and associated distress, as well as to provide
developmentally-appropriate information to the peripubertal adolescent, parents or
guardians, and other health care professionals involved in the peri-pubertal adolescent’s
care. The purpose of the assessment is to advise and inform treatment decisions regarding
pubertal suppression after sharing details of the potential risks, benefits, and implications
of pubertal suppression, including the effects of pubertal suppression on behavioral health
disorders, cognitive and emotional development, and future physical and sexual health.

**Pubertal and Post-Pubertal Adolescents**

- Decision-making regarding one’s developing gender identity is a highly individualized
process and takes many forms. For pubertal and post-pubertal adolescents, if physical
gender transition (such as hormone therapy or gender affirming surgeries) is being
considered, it is strongly recommended that adolescents, parents, and providers obtain an
assessment by a licensed behavioral health provider to understand the present status of an adolescent’s gender identity and gender expression and associated distress, as well as to provide developmentally-appropriate information to adolescents, parents or guardians, and other health care professionals involved in the pubertal or post-pubertal adolescent’s care. If physical transition is indicated, the potential risks, benefits, and implications of the transition-related procedures being considered – including the effects on behavioral health disorders, cognitive and emotional development, and potentially irreversible effects on physical health, fertility, and sexual health – are presented to the adolescent and parents or guardians. Withholding timely physical gender transition interventions for pubertal and post-pubertal adolescents, when such interventions are clinically indicated, prolongs gender dysphoria and exacerbates emotional distress.

References
Amend by substitution policy HP-3200.4.2 containing the policy paper entitled “Flexibility as a Hallmark of the PA Profession: The Case Against Specialty Certification”. See policy paper.

AAPA is opposed to specialty certification, the use of specialty examinations and certificates of added qualification that could reduce the profession’s versatility and flexibility, drastically altering its value to society.

Every effort must be made to prevent regulators, employers, third-party payers, and others, including PAs from misusing specialty certification, the use of specialty examinations and certificates of added qualification.

See: Flexibility as a Hallmark of the PA Profession: The Case Against Specialty Certification (Policy Paper 16)

Rationale/Justification
This policy paper and policy was rewritten to accurately reflect changes in the environment since the last amendment of the policy paper, to incorporate latest knowledge and evidence, and to represent current perspectives of relevant stakeholder groups. The policy paper revision was supported by a task force convened by the Commission on Continuing Professional Development and Education.

Related AAPA Policy
HP-3500.1.1
AAPA believes the integrity of PA credentials should be assured through a credentialing process.

Credentialing is a process for validating the background and assessing the qualifications of health care professionals to provide health care services in a variety of patient care settings. Privileges granted to PAs should be consistent with state laws and regulations and hospital bylaws.


HP-3500.1.2
AAPA recognizes that many federal PAs are exempt from state licensing laws and regulations and are subject to PA criteria established by their federal agencies or by Congress. These federal requirements include graduation from a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), or by one of its predecessor agencies (Committee on Allied Health Education and Accreditation (CAHEA), or the Commission on Accreditation of Allied Health Education Programs [CAAHEP]), and/or passage of the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA) and continual maintenance of national certification when required by the federal agency. Therefore, the Academy believes that federal PAs should not be required to have a state license to obtain full
practice privileges (including prescribing), to be credentialed in a federal facility, or to participate in a federal activity such as a disaster medical team. In states where federal-state requirements do not conflict; federal PAs may hold state licenses. Any federal PA may opt to hold a state license.


HP-3500.1.3
AAPA strongly recommends and actively supports all efforts to ensure that medical school graduates who wish to obtain credentials to practice as PAs must attend and successfully complete an entry-level PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant and pass the PA national certifying examination administered by the National Commission on Certification of Physician Assistants.


HP-3500.2.0.1
AAPA supports assessing general medical knowledge for initial certification and licensing of PAs.

[Adopted 2016]

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


HP-3500.2.2
AAPA opposes examinations given by any organization other than the NCCPA for the purpose of establishing entrance-level standards for individuals not eligible for the National Commission on Certification of Physician Assistants examination.


HP-3500.2.2.1
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.

[Adopted 2016]

HP-3500.2.3
AAPA believes that the NCCPA certificate should be time-limited and that maintenance of a current valid certificate requires that PAs pass the Physician Assistant National Recertifying Exam (PANRE) within four attempts if initiated within the final two years of the recertification cycle.


HP-3500.2.4
AAPA supports the use of evidence-based alternatives to testing for maintenance of certification.

[Adopted 2016]
AAPA opposes any requirement that PAs take a closed-book, proctored exam in a specialty area for maintenance of certification.  
[Adopted 2016]

AAPA opposes any requirement that PAs take multiple examinations during a 10-year recertification cycle.  
[Adopted 2016]

AAPA believes the NCCPA should maintain its current national recertification examination process until representatives from the AAPA and NCCPA can agree on one that both demonstrates competency and comprehensively represents the needs of PAs in all practice settings.  
[Adopted 2016]

AAPA opposes any NCCPA requirement that PAs must practice for an identified time in a given specialty practice as a precondition for specialty certification.  
[Adopted 2010, reaffirmed 2015]

**Possible Negative Implications**

None are anticipated.

**Financial Impact**

None

**Signature & Contact for Resolution**

Benjamin J Smith, PA-C, DFAAPA  
Chair, Commission on Professional Development and Education  
bsmith@mcintoshclinic.com
Specialty Certification, Clinical Flexibility, and Adaptability

Executive Summary of Policy Contained in this Paper

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

- AAPA recognizes that flexibility to adapt to the needs of the healthcare system is a unique attribute of the PA profession that creates value to the health system by allowing PAs to be deployed and redeployed within the healthcare system to address critical workforce shortages and increase patient access to care.
- AAPA recognizes that the flexibility and adaptability of the PA profession is closely associated with the broad generalist training that PAs receive, coupled with an orientation toward lifelong learning that allows them to adapt to many practice settings.
- AAPA recognizes that changes in PA practice have resulted in the majority of PAs practicing in specialty areas, creating desire among PAs to be recognized for their expertise, and for employers to distinguish more qualified from less qualified applicants.
- AAPA is opposed to the use of specialty certification as a criterion for the following: 1) entry into specialty practice, 2) licensure, 3) credentialing, 4) third-party reimbursement.
- AAPA recognizes that specialty certification may have a useful role in the career development and promotional path of a PA within a health system, but this must be carefully balanced against the potential barriers that it may represent to clinical flexibility and adaptability.
- AAPA endorses approaches to specialty training that emphasize formative development of the knowledge and competencies that a PA will need to practice in the specialty rather than a summative evaluation of knowledge.
- AAPA recommends consideration of a portfolio approach that incorporates external validation of relevant Entrustable Professional Activities (EPAs) as a more comprehensive and textured approach for evaluating the qualifications of a PA.
- Research should be conducted to determine if there is a link between specialty certification and improved quality of care, and whether or not any such improvement would offset the potential losses to the system of the flexibility and adaptability inherent in the current model.
**Background**

The PA profession was created in the late 1960s as a response to a shortage of primary care physicians and a need to extend the availability of medical services for patients beyond what physicians alone were able to provide. The initial idea was that physicians would be able to delegate many routine tasks to this new medical professional. The training pattern that emerged and was eventually formalized through accreditation of PA programs was a curriculum averaging 26 months that combined a didactic grounding in the basic sciences with a clinical apprenticeship model emphasizing general medical knowledge and its application in a primary care setting.\(^1\) The profession was originally designed to be physician-dependent. Once in practice, PAs would form dyadic collaborative relationships with physicians, who would take moral and legal responsibility for the PA’s work and extend the PA’s scope of practice as the PA demonstrated competency related to specific tasks.\(^2\) This model has changed over time. In particular, the role of PA-physician collaboration has been redefined in a way that has tended toward increasing levels of PA autonomy. Regardless, the PA model has produced a remarkably flexible medical professional who can be trained fairly quickly and rapidly deployed to address unmet needs of patients and the healthcare system in general.

The flexibility of the PA to function in multiple venues is an attribute that is highly prized among physicians, the healthcare system, and PAs. PAs regularly take advantage of this flexibility. An analysis of PA cohorts between 1969 and 2008 found that 49% of PAs had changed specialties at least once in their careers, 24% made specialty switches to another specialty class (i.e., primary care to a surgical specialty), and 11% reported practicing in at least three specialties during their career.\(^3\) In a 2015 survey, 8.3% of PAs indicated that they had changed their specialty during 2014.\(^4\) The generalist training, coupled with a culture that emphasizes lifelong learning, have been seen as the keys to this adaptability and, as a result, specialty certification has been viewed by many members of the profession as a specific threat to flexibility and adaptability. AAPA has had policy opposing specialty certification since 2002.\(^5\) At its founding, the PA model rested on two assumptions. The first assumption was that most PAs would enter the primary care workforce, and the second was that physicians would be the primary employers of PAs.\(^1\) Both of these assumptions are challenged by the realities of contemporary PA practice. Health systems have emerged as direct employers of PAs, altering the paradigm of the PA working with their supervising physician in a mentor role that was initially
designed for the profession. This has resulted in a fundamental change to the dyadic PA-physician model and the assumed apprenticeship-mentor relationship that was intended to regulate PA practice.

There has also been a longstanding trend of PAs moving away from primary care toward specialty practice. In 1974, 68.8% of PAs were in primary care practice. According to 2015 NCCPA data, just over 70% of PAs report that they practice in a medical specialty. This has created an anomaly whereby a profession with a generalist training model and an assumed primary care trajectory is now dominated by specialty practice.

NCCPA introduced Certificates of Added Qualifications (CAQs) in 2011. In 2016, NCCPA proposed a change to the recertification process whereby at the time of recertification PAs would choose a specialty exam relevant to their practice and, if an exceptional level of performance was achieved, examinees would be eligible to be awarded a CAQ, in addition to the renewal of the PA-C credential should they desire to pursue CAQ and were willing to meet the additional requirements. After a spirited debate, this proposal was withdrawn. NCCPA has announced plans to focus the revision of PANRE on “core knowledge,” and efforts are underway to define more specifically what “core knowledge” represents for PA practice. Participation in the CAQ has been low.

Health systems have responded to the need to prepare PAs for specialty practice by developing postgraduate programs. From 2007-2014, ARC-PA offered voluntary accreditation for these programs. The process was then held in abeyance, so only eight clinical postgraduate training programs received accreditation. Overall, postgraduate fellowship programs range from well-structured and accredited to those with more informal curricula that may be regarded as “onboarding” programs that train PAs for their roles within a specific health system. The capacity of these programs is low, with most capable of accommodating one to four trainees per cohort. A recent review concluded that if these postgraduate programs are to continue to exist, they should adhere to more consistent standards.

Given the current nature of PA practice, what is the role of specialty certification? How does the profession preserve the flexibility that has created so much value for the healthcare system and the patients they serve, while addressing the needs of health systems in assessing the competencies and experience of PAs? How does the profession accommodate the understandable desire of specialized PAs to be formally recognized for their expertise, or to gain a credential that
would facilitate their promotion within an established healthcare system’s defined structure for career advancement?

To address these questions, the AAPA Commission on Continuing Professional Development convened a task force of members representing a broad range of specialties, employment, and educational settings to review the issue.

**Stakeholder Input**

A member of the task force conducted a review of literature related to PA specialty certification, PA roles and professional responsibility, PA workforce distribution among specialties, and factors influencing specialty choice. A summary of each relevant article was prepared for task force members, and the full text was made available to all members upon request. The literature about PA specialty certification is sparse, making it difficult to draw conclusions from existing scholarly research. For this reason, the task force utilized a series of mini surveys that were administered to various stakeholders in order to obtain information about PA specialty certification.

A survey was sent to 35 PA specialty organizations and special interest groups affiliated with AAPA that focus on specialty practice. Responses were received from 24 organizations, resulting in a 69% response rate. All organizations with a corresponding CAQ responded. To gain an employer perspective, a survey was sent to the PAs who participate in the PAs in Administration, Management, and Supervision (PAAMS) group in AAPA’s social networking site known as “The Huddle.” Twenty responses were received. Of these, four held titles indicating that they supervised a specialty service that included PAs either alone or combined with NPs. The remaining 16 respondents held titles such as “director, PA Services” or “director, Advanced Practice Providers.” Additional stakeholder feedback was sought from physicians who work with PAs. A survey link was sent by members of the task force to physicians they knew. As a result, the sampling was neither complete nor systematic. Twenty-seven responses were received from physicians in seven specialties, five of which had some form of specialty certification available to PAs. While insufficient to draw conclusions, the physician data nevertheless gives some indication of physician awareness of and attitudes toward PA specialty certification.

Questions posed to the specialty organizations focused on whether or not the organization had a formal position related to specialty certification and, if so, what that position was.
Additional questions explored whether or not there were specialty certifications available to PAs, of which the task force may not have been aware. Additionally, they were asked when specialty certification might be important to ensuring patient safety, and under what circumstances consideration of specialty certification might not be appropriate. PAs involved in supervision and management were asked how specialty certification is used within their institutions for hiring and promotion. Questions for physicians focused on their relationship with the PA with whom they interact (PAs employed directly by physician practices or through an affiliated organization), their awareness of specialty certification, and whether or not specialty certification was a consideration or requirement in hiring or promotion.

**Interprofessional Certifications Open to PAs**

The seven specialties for which NCCPA offers a CAQ were determined to be the most relevant to this discussion (Table 1). However, the task force was able to identify many interprofessional certifications administered by other organizations that are open to PAs and other medical professionals. There are numerous life support certifications open to PAs that may not be related to a specific specialty, but may be required for a PA to function in a specific role, such as the “code team” in a medical facility. These non-NCCPA certifications are summarized in Table 2. For the purposes of this analysis, the task force considered information from each of these certifications; however, there is currently no global definition for PA specialty certification.
<table>
<thead>
<tr>
<th>Specialty CAQs</th>
<th>Number Held*</th>
<th>Number of PAs in Specialty**</th>
<th>Estimated Percent of PAs in Specialty with CAQ ***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular and thoracic surgery</td>
<td>41</td>
<td>2,738</td>
<td>1.5</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>519</td>
<td>10,876</td>
<td>4.8</td>
</tr>
<tr>
<td>Hospital medicine</td>
<td>84</td>
<td>2,654</td>
<td>3.2</td>
</tr>
<tr>
<td>Nephrology</td>
<td>19</td>
<td>Not reported</td>
<td></td>
</tr>
<tr>
<td>Orthopedic surgery</td>
<td>122</td>
<td>9,071</td>
<td>1.3</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>46</td>
<td>1,631</td>
<td>2.8</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>205</td>
<td>1,033</td>
<td>19.8</td>
</tr>
</tbody>
</table>

*NCCPA as of December 2016 from a data set with a reported denominator of ~115,500.
Specialty-specific data not yet published
** NCCPA 2015 Statistical Report with an overall denominator of 108,717
*** Calculated using different data sets so valid only as a rough estimate
<table>
<thead>
<tr>
<th>Credential</th>
<th>Sponsor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Cardiac Life Support (ACLS)</td>
<td>Various</td>
</tr>
<tr>
<td>Advanced Trauma Life Support (ATLS)</td>
<td>Various</td>
</tr>
<tr>
<td>Basic Life Support (BLS)</td>
<td>Various</td>
</tr>
<tr>
<td>Pediatric Advanced Life Support (PALS)</td>
<td>Various</td>
</tr>
<tr>
<td>Approved Clinical Supervisor (ACS)</td>
<td>Center for Credentialing &amp; Education</td>
</tr>
<tr>
<td>Registered Diagnostic Medical Sonographer (RDMS)</td>
<td>American Registry for Medical Diagnostic Sonography</td>
</tr>
<tr>
<td>Board Certified Advanced Diabetes Management (BC-ADM)</td>
<td>American Association of Diabetes Educators</td>
</tr>
<tr>
<td>Certified Clinical Densitometrist (CCD)</td>
<td>International Society for Clinical Densitometry</td>
</tr>
<tr>
<td>Certified Diabetes Educator (CDE)</td>
<td>National Certification Board of Diabetes Educators</td>
</tr>
<tr>
<td>Certified Menopause Practitioner (NCMP)</td>
<td>North American Menopause Society</td>
</tr>
<tr>
<td>HIV Specialist™ (AAHIVS)</td>
<td>American Academy of HIV Medicine</td>
</tr>
<tr>
<td>Fellow of the American College of Critical Care Medicine (FCCM)</td>
<td>American College of Critical Care Medicine</td>
</tr>
<tr>
<td>Master of the American College of Critical Care Medicine (MCCM)</td>
<td>American College of Critical Care Medicine</td>
</tr>
<tr>
<td>Multiple Sclerosis Clinical Specialist (MSCS)</td>
<td>The Consortium of Multiple Sclerosis Centers</td>
</tr>
<tr>
<td>Board Certified Specialist in Obesity and Weight Management</td>
<td>Commission on Dietetic Registration</td>
</tr>
</tbody>
</table>

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

Of the 24 specialty organizations and special interest groups responding to the questionnaire, only 10 organizations had official positions on specialty certification, and of these organizations, eight were officially opposed. The task force received responses from all constituent organizations with a corresponding CAQ. The Society of Emergency Medicine Physician Assistants and the Association of PAs in Psychiatry are the only AAPA-affiliated specialty organizations with a position endorsing the CAQ in their specialty. When asked about the role of voluntary certification in their specialty for ensuring quality of care and patient safety, constituent organization respondents expressed considerable skepticism, with many stating bluntly that they saw no relationship between certification and ensuring quality or patient safety. Others stated that holding a certification did not demonstrate clinical competence. When asked about inappropriate use of specialty certification, respondents expressed similar concerns. Responding organizations are generally opposed to specialty certification in situations where it is used as a criterion for the following:

- Licensure
- Credentialing
- Entry into specialty practice
- Third-party reimbursement

Respondents expressed considerable skepticism for any additional requirements that would require additional study time and expense, unless it was accompanied by evidence that it would improve patient care and safety.

Those PA specialty organizations that saw a role for specialty certification indicated that added qualifications could allow PAs to identify a level of specialty knowledge beyond generalist training. Others commented that it might be helpful in defining core competencies for a specialty, and to enhance ability of PAs to compete for jobs with other providers such as NPs, who do have specialty training.

Based on the responses received from the PAAMS group, it appears that specialty certification is not routinely required when hiring a PA, however, it may facilitate promotion within a healthcare system.

Responses were received from physicians in seven specialties, five of which had corresponding CAQs. The majority of responding physicians reported working in settings where
PAs are employed directly by the practice. While awareness of specialty certification was low among these physicians, those who were aware of it indicated that holding a relevant specialty certification might be considered along with experience in hiring decisions. Physicians were less likely than health systems to use specialty certification as a factor in promoting a PA.

**Alternative models**

Two organizations provide a structured curriculum of learning modules intended to prepare PAs who are entering the field. The Society of Dermatology Physician Assistants bills their program as a “diplomate fellowship” program. It does not rely on testing or award a certification. Rather, it relies on documentation that a PA has completed a structured curriculum of CME activities addressing PA practice in dermatology. The Association of Rheumatology Health Professions, which includes PA members, has worked with the American College of Rheumatology to produce a modular curriculum for PAs and NPs entering rheumatology practice. This program will award a certificate upon completion.

**Discussion**

**Potential Advantages of Specialty Certification**

Specialty certification has a number of potential advantages for PAs and other stakeholders within the healthcare system. First, it provides external validation of a PA’s expertise. Second, specialty certification may be helpful to a PA who is seeking promotion within an established “clinical ladder” program in a health system. Often, these promotion structures have been established within a nursing structure that has long recognized the role of specialty certification as a means of promotion. Discouraging PAs from taking advantage of this pathway for promotion may disadvantage PAs who are seeking to advance into leadership positions. Third, holding a specialty certification may enable a PA to compete more effectively for jobs within a specialty by giving employers a criterion for distinguishing one applicant from another. Finally, specialty certification may provide patients with assurance that the PA providing care for them is qualified to do so.

**Concerns about Specialty Certification**

The main concern about specialty certification is that its adoption will limit both entry into specialty practice and movement among specialties. The CAQ model requires 3,000 hours of experience in the field, including procedures and patient care activities that are considered to be core to the field, in order to establish eligibility to take the exam. While this is generally
compatible with the PA model where one is trained as a generalist and gains experience through
work-related experience, if holding a specialty certification becomes an entry criterion, it will
favor those already in the field while barring entry to other PAs. This could create shortages of
PAs who are able to engage in the field if not enough PAs holding the certification are available,
and increasing costs to the system through higher salary requirements.

If specialty certification were to become a mandatory requirement for entry into PA practice in a specialty, a likely consequence would be the establishment of formal training programs; this would further reduce flexibility and adaptability by restricting PA practice to areas where one is trained and certified. PAs could find themselves working within the same rigid structures as physicians and nurse practitioners. Not only would PAs lose the ability to move from specialty to specialty, but healthcare systems would lose the ability to deploy and redeploy PAs in areas where there are workforce gaps. This could result in higher costs for the system and reduced access for patients.

**When Might Specialty Certification be Appropriate?**

The most compelling case for requiring specialty certification would be if a clear relationship between specialty certification and patient outcomes, including quality of care, could be demonstrated. Currently, there is a paucity of such evidence. This link has been difficult to demonstrate in physician literature. In a review of 33 findings by Sharp and colleagues, 16 demonstrated a positive relationship between certification status and desirable clinical outcomes. Fourteen showed no association, and an additional three showed a negative relationship, although the studies showing a negative relationship suffered from insufficient case mix. Research should be conducted to determine if any relationship between specialty certification and patient outcomes exists in the context of PA specialty practice.

While AAPA remains opposed to using specialty certification as a criterion for hiring, one specific circumstance where specialty certification might play a helpful role in PA practice is within the promotion structures of a health system. In this context, gaining specialty certification may allow a PA to meet a requirement to be promoted with the system’s defined “clinical ladder” program. This seems appropriate because its use is not to deny access to the “ladder,” but merely to meet a criterion for moving from one rung to a higher rung of the ladder.
What Uses of Specialty Certification Would be Inappropriate?

We conclude that any use of specialty certification is inappropriate if its use results in 1) reduced flexibility for PAs to move among care settings, 2) reduced ability of healthcare systems to address critical workforce needs, 3) higher costs to the system, and 4) reduced access to care, unless this is balanced by compelling evidence that specialty certification results in higher quality care. Until this evidence is available, we oppose the consideration of specialty certification in the following situations:

- As a criterion for entry into specialty practice employment settings
- As a criterion for licensure
- As a criterion for credentialing
- As a criterion for reimbursement

An Alternative Proposal

A clinical “portfolio” approach that allows PAs to provide a more rounded portrait of their clinical experiences and competencies might meet the needs of stakeholders who are currently looking to specialty certification as a marker of competence. Portfolios have been used in the U.K. for trainees in the health professions and for periodic revalidation. They are in current use among U.S. medical students, residents, and fellows, and their potential for the PA profession is being explored. Unlike current specialty certifications that document that an individual has passed a knowledge test, a portfolio maintained by the PA with certain portions subject to external validation could allow a PA to display information related to formal and informal training, relevant CME, procedures performed with associated proficiency documentation, and relevant certificates or certifications to prospective employers, credentialing authorities, insurance companies, and other stakeholders. Of particular interest would be the ability to document assessed proficiency with Entrustable Professional Activities (EPAs) important within a field. EPAs are comprised of activities that a medical professional can be trusted to perform without supervision after verification of competency. U.S. medical students, residents, and fellows use this model. Standardized lists of EPAs are being developed, along with methods for assessing them. This would allow stakeholders to make informed decisions about individual PAs based on a broad understanding of the PA’s professional standing and experience, rather than relying on a solitary marker such as specialty credentialing.
Conclusions

The PA model adds value to the healthcare system by supplying a medical professional who can be educated and trained rapidly and deployed throughout the system to address unmet needs. This flexibility and adaptability should be fiercely protected in order to avoid losing this unique advantage. As the model of PA practice evolves, employers and other stakeholders are looking for ways to assess the qualifications and competencies of PAs. The profession should respond to these legitimate concerns in a way that demonstrates the expertise of PAs, but does not inhibit the flexibility of the profession.

Specialty certification could be problematic in that it may restrict the ability of PAs to move throughout the healthcare system as needs arise. Some of the concerns about specialty certification are already being realized, since employers in some areas are already using it as a criterion for hiring.

There may be an appropriate role for specialty certification in facilitating a PA’s advancement within a healthcare system’s promotion pathway, or enhancing the ability of PAs to compete for jobs with other providers. However, this must be balanced against the ability of PAs to move within the healthcare system to meet gaps in patient care, thereby diminishing the value of the profession to the healthcare system and to patients. As the relationship between specialty certification and quality of care is unknown, research should be conducted to determine if such a relationship exists. In addition, further research on PA specialty certifications overall should be conducted. The profession should take steps to allow PAs to provide stakeholders with rich and nuanced information about a PA’s background and experience, rather than credentials that rely primarily on knowledge testing.

References

4. AAPA. *Career Flexibility Within the PA Profession*. 2017.


11. AAPA. *Postgraduate Education & Certification*. Vol HP-3200.4.0. AAPA:92-100.


Flexibility as a Hallmark of the PA Profession: The Case Against Specialty Certification

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

• AAPA is opposed to specialty certification, the use of specialty examinations and certificates of added qualification that could reduce the profession’s versatility and flexibility, drastically altering its value to society.
• Regulators, third party payers, employers, credentialing offices and others could misuse such specialty certification, the use of specialty examinations and certificates of added qualification to create artificial barriers to practice, decrease flexibility, increase costs and fragment the profession. These potential consequences and their professional implications are astounding and contrary to the hallmarks of the profession.

Introduction
PAs have worked in specialty practice from the earliest days of the profession. Debate has been ongoing about whether there should be recognition of specialty practice of PAs, formal specialty credentials, and the fairness of the generalist recertification examination. Over the years, specialty certification has been proposed as the solution. This paper states the arguments for and against specialty certification and concludes that such a system is not in the best interests of PAs, physicians, or the public.

Value of PAs
The creation of the PA profession was a significant accomplishment. After realizing that the problem of physician shortage and maldistribution of medical services could be resolved by using medically trained providers that work with supervision, physicians developed educational curricula and programs, established accreditation and certification structures, and proposed a regulatory framework for PA practice. The men and women involved in the founding of the
profession, not only physicians, but also public policy experts, researchers, educators, and lawmakers. By choice, they designed a provider who could be educated relatively quickly and inexpensively, who had generalist medical training and the skills for life-long learning, and who was flexible enough to meet the changing societal needs.

By virtually any standard, the experiment has been a resounding success. PAs have become a valuable component of health care delivery. They possess a combination of attributes not found in other professions. Among the unique attributes of PAs are the focus, content, and length of their education, their socialization, and their adaptability in the delivery of medical services previously provided only by physicians. PAs are also distinguished by their commitment to practice as part of physician-PA teams.

**PA Education**

PA educational programs provide a broad-based, generalist medical education with a focus on primary care. PAs are trained to think like physicians and to be life-long learners. The educational process frequently draws upon the prior experience of students, adds intense didactic and clinical instruction, and produces individuals who know how to practice medicine as part of a team and value their role in the system. Their generalist training prepares PAs to work with physicians in any specialty. Similar in curriculum to the fast-track training of generalist physicians during World War II, PA programs average 27 months in length after college pre-requisite coursework. This is a relatively short production pipeline that can respond quickly to the needs of the health workforce.

Compared to medical school and residency training, PA education is less expensive and more quickly completed. It produces a medically-trained health care professional with significantly less educational debt. A PA is available to join the health workforce and increase patient access to care in fewer years than it takes to produce other medical providers.

Unlike advanced practice nurses, who attend specialty specific nursing programs, PAs have a general medical background designed for the primary care setting. By virtue of the broad foundation of PA education, future employment is not limited to one specialty. Graduates who wish to increase their skills and knowledge in a particular specialty may do so through a clinically-based postgraduate program, workshops and continuing medical education sessions.
additional clinical training in the practice setting, or a combination of these options. It is the PA’s
decision whether they wish to pursue this and how to obtain additional training.

**PA Practice**

By functioning as part of physician-directed teams, PAs have flexibility in practice. A
supervising physician is authorized within the boundaries of state law or federal regulations, to
delegate to the PA any portion of the physician’s practice that are within the PA’s ability to
perform. New tasks and responsibilities can be taught and delegated as the PA’s expertise
expands and as the team members’ understanding of one another grows. A PA may choose to
change specialties or may practice in more than one specialty simultaneously.

There are benefits to society from having a well-educated, flexible, and cost-effective
medical provider as part of the workforce. PAs fill a role that cannot be filled by other providers.
For example, community-based training, a broad set of primary care skills, and lower salary
expectations enable PAs to meet patient needs in poor and underserved areas that cannot afford
to support a physician full-time. PAs also add value to the public’s investment in the education
of physicians by freeing physicians from routine responsibilities, allowing them to treat patients
whose complex medical conditions require their expertise and to expand the services offered by
their practices. The synergy of physician-PA team practice benefits patients both individually
and collectively.

Physicians have a depth and breadth of training that is unmatched by other medical
professionals. PAs embrace the notion that physicians should lead the health care team. PAs do
not seek to compete with physicians, but rather endorse their role and support the concept of
physician-directed care.

The current system that consists of education, national certification, state licensure,
federal regulations, and the team practice concept has made this success possible. AAPA
believes that changes to the system should be made only if they are improvements that have
benefits for the public as well as for PAs and their physician colleagues.

**A System in Flux**

Dramatic changes are occurring in the health care system. The uncontrolled rises in the
cost of health care has made it essential to institute cost-saving measures. The percentage of the
gross domestic product spent on health care continues to rise, reflecting not only a growth in
service demands, but also exemplifying a poor healthcare delivery system. With the passing of
healthcare reform, there will be a continued push to reduce costs by eliminating duplicative services, improving quality and efficiency of the delivery of care, as well as a new focus on increasing primary care providers. Although the Patient Protection and Affordable Care Act aims to ensure that all Americans have access to quality, affordable health care and to create the changes within the system to contain costs, this must be balanced with a large aging population and a current shortage of primary care providers. These competing forces combine to create an atmosphere of change and uncertainty within healthcare.

Although global shifts in the economy are beyond the control of any one group, it is important to remember that PAs are able to make impactful decisions about the profession within these shifts. An example of this is determining the means by which PAs affirm their continued proficiency or obtain recognition of achievement within their specialty practice. It is critical to make these decisions with the context of the changing marketplace and with the public good in mind. The PA profession must remain as dynamically fluid as the healthcare system in which PAs practice.

Specialty Practice

There have been PAs in specialty practice since the beginning of the profession. Two of the first four PA graduates from the original Duke University program chose non-primary care fields in which to practice and today approximately half of PAs are in specialty practices. The growing number of specialty PA organizations attests to the interest and employment opportunities for PAs in specialties and to the interest of specialty physicians in PAs.

However, PAs in specialty practice have identified several issues of concern. When faced with employment opportunities in a particular specialty, some PAs with experience in that specialty have said that they need a credential other than the National Commission on Certification of Physician Assistants (NCCPA) certification to demonstrate their expertise advanced skill level; a credential that could make them more attractive than experienced PAs new to the specialty or new graduate PAs. PAs employed by some government agencies and institutional employers point out that they need additional qualifications in order to move up the career ladder and obtain promotions or salary increases. Lastly, there are some PAs who have practiced in specialties for many years who have expressed a desire for recognition of their accomplishments.
One solution that has been discussed is specialty board certification, similar to that held by physicians.

The concept of specialty boards requires collaboration with the NCCPA. Currently the NCCPA’s certification process tests new graduates by means of an initial certifying examination, known as PANCE (Physician Assistant National Certifying Examination) and re-tests practicing PAs every six years by means of a generalist recertification examination known as the PANRE or Physician Assistant National Recertification Examination. Since 1973 the PANCE has served as the certification examination for all PAs. Passage of the NCCPA’s PANCE examination is required in all states in order to obtain licensure to practice.

The current system is economical and efficient and enhances the flexibility and value of PAs to society, but the generalist recertification examination has troubled PAs whose practice is concentrated in a specialty or subspecialty area. Due to the close working relationship between PAs and physicians, it is reasonable to examine the physician certification model to see if it would be workable for PAs.

Both medical school and PA programs educate their students in general medicine. After graduation, physicians enter residency training programs in the specialty of their choice. Upon completion of residency, physicians take a certification exam produced by specialty boards. Although postgraduate training is a prerequisite for licensure, board certification currently is not in most jurisdictions, nor is the absence of board certification an obstacle to practice once licensure has been obtained.

The PA educational process does not include mandatory postgraduate residencies, nor does it include specialty certification examinations. A discussion of the advantages and disadvantages of specialty certification is presented below.

Advantages of Specialty Certification

There are many advantages to specialty certification. It implies added knowledge, qualifications, or skills. In American society, individuals with outstanding accomplishments frequently receive awards, prizes, honorary titles, and certificates. A document is awarded to providers who complete training courses in particular clinical skills, such as endoscopy or colposcopy. Advocates of specialty certification believe an additional credential attests to their experience and achievement in a specialty field of practice.
To the public and employers, specialty certification may provide a sense of reassurance. As the general public may not understand the education of the PA and their flexibility, another credential may enhance the credibility of the PA. Employers, including physicians accustomed to the specialty boards of their own profession, may have an added sense of comfort. The administrative personnel in large institutions, particularly those in charge of credentialing the medical staff, may also recognize specialty certification as something familiar, akin to the physician model.

Consequently, the result for specialty certified PAs may be increased employment opportunities, greater job security, and enhanced compensation. Specialty certification also has the potential to simplify the process by which institutions grant clinical privileges or payers reimburse.

For PAs who need additional qualifications in order to achieve advancement within an institution, specialty certification may provide one step up the career ladder. Past testimony in the AAPA House of Delegates indicates that PAs who desire concrete evidence of their accomplishments would find satisfaction in a framed certificate or some other visible sign of their specialty certification.

For many, specialty certification offers the potential to reform the recertification process. Recertification could be limited to testing only the skills and knowledge needed for the PA’s specialty practice. For example, PAs who have worked in otolaryngology for 25 years would not be examined on their knowledge of obstetrics. Focusing recertification on knowledge limited to the specialty practice could reduce concerns about failure, particularly in light of the fact that PAs who do not successfully complete the current process lose their national certification.

Disadvantages of Specialty Certification

There are also disadvantages to specialty certification for PAs. The most compelling is the loss of flexibility of the profession. This would impact on the PA and the ability to work with the PA’s physician colleagues and provide the comprehensive delivery of health care needed in society today.

Should the profession embrace specialty certification, the impact could be a multi-tiered professional structure. Those with specialty certification could be at an economic and professional advantage. Those without could manifest itself in terms of loss of employment opportunities, decreased salaries, increased professional liability and a change in the coverage of...
services by the third-party payer. In spite of the fact that many PAs work in specialties, specialty
certification could place the more economically desirous of specialties at the forefront and the
least economically desirable, such as primary care, behind. This could have a grave impact on
the landscape of the delivery of health care.

In addition, specialty certification could change the culture of the PAs. The hallmark of
the profession has been to fill the gap and work with the physician in providing health care. The
PAs flexibility and ability to adapt to the needs of the health care community has been one of the
assets of the profession. There are some PAs who elect to do primary care and not embrace
specialties. They should not be penalized.

The education of PAs could also be affected. Currently, the focus of the education of PA
students is towards primary care, thus allowing the graduate the freedom of choice to choose
where they want to work. The lack of specialty training could limit their job opportunities and
thus place pressure on the educational institution in providing specialty education to the students.
The Accreditation Review Commission on Physician Assistant Education (ARC-PA) is replete in
its requirements that must be included in the curriculum. Adding a track for specialty training
could be arduous and may extend the time of the program, as well as tuition fees. One of the
advantages of attending PA school is the time and financial commitment that is less than
attending medical school. This could require a complete restructuring of the ARC-PA
requirements for PA education and may have admission candidates thinking twice about
applying to PA school.

Specialty training could also have an impact on how the licensing boards license PAs.
Should there be specialty certification, state statutes and regulations could require PAs to achieve
specialty training, whether it is in neuro-surgery or primary care. This could impact the PA who
wishes to move from emergency medicine to pediatrics. Additionally, legislators and
administrators may confuse specialty certification with other certification examinations such as
the orthopedic physician’s assistants (OPA) and anesthesiologist’s assistant (AA). Regulators,
third-party payers, employers, credentialing offices, and others can misuse such tests to create
artificial barriers to practice, decrease flexibility, increase costs, and fragment the profession.
The professional implications are astounding and are contrary to hallmarks of the profession.

Specialty Examinations
The NCCPA has been addressing this complex issue. Although it still embraces the primary care concept as evidenced in the PANCE and PANRE, it has, however, implemented certificates of added qualification (CAQ), specialty examinations. The specialties currently included in the CAQ project are emergency medicine, orthopedic surgery, cardiovascular and thoracic surgery, nephrology and psychiatry. Successful completion of the CAQ requirements allows the PA to obtain an added credential in the specialty.

Promoting specialty certification examinations only enhances the concept of specialty certification and diminishes the generalist value of the PA profession.

Conclusion

AAPA highly values the contributions of PAs in all areas of practice. It believes strongly in the mission of the profession, which is to promote quality, cost effective, and accessible health care, and concludes that this mission can best be met if PAs have the flexibility to adapt to changes in the health care workforce and market. Therefore, AAPA is opposed to specialty certification and to the use of specialty examinations that could reduce the profession’s versatility and flexibility, thus drastically altering its value to society.

References

1. Accreditation Standards for Physician Assistant Education. ARC-PA. September 2010.
2017-C-10-CCPDE  Competent PA Practice

2017-C-10  Resolved

Amend policy HP-3200.1.1 as follows:

AAPA believes competency-based professional education at ARC-PA accredited entry level PA programs followed by life-long learning ARE CRITICAL COMPONENTS has been a successful formula for competent PA practice.

Rationale/Justification
This policy was updated to provide stronger language for the policy.

Related AAPA Policy
None

Possible Negative Implications
None are anticipated.

Financial Impact
None

Signature & Contact for Resolution
Benjamin J Smith, PA-C, DFAAPA
Chair, Commission on Professional Development and Education
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2017-C-11-RSI  
Recognizing New PA Certifying Agencies

2017-C-11            Resolved

Amend policy HP-3500.2.1 as follows:

AAPA endorses the National Commission on Certification of Physician Assistants (NCCPA) certification exam AS WELL AS ANY EXAM THAT IS RECOGNIZED BY THE NATIONAL COMMISSION FOR CERTIFYING AGENCIES (NCCA), THE AAPA HOUSE OF DELEGATES, AND THE AAPA BOARD OF DIRECTORS AS VALID ENTRANCE STANDARDS FOR PAS, as the only entrance standard for PAs.

Rationale/Justification

This policy is being considered as a part of the periodic policy review process. There has been a great deal of debate in the PA community surrounding the fact that there is only one certifying agency for PAs. The AAPA Board of Directors is exploring the possibility of creating another independent organization to create an entrance exam. Amending this policy provides space in AAPA policy for a future agency to exist. The provision for NCCA certification recognizes the significant barrier to entry in order to maintain the professional legitimacy of a new certifying agency. The provision for both AAPA HOD and Board of Directors approval recognizes the need for adequate consultation with the PA community before such a significant change would occur.

There is a legitimate argument that AAPA policy does not need to change at this time because there is not currently another agency to which this applies. However, the debate on this issue is important so that the PA community can clearly define whether there is support for a new testing process. Passing an amendment to this policy could serve as a way to signal to any future agency as to whether there is a market for a new test. The ongoing conversation about the certification process for PAs is what made it difficult for the RSI Commission to simply recommend reaffirming the policy without offering an amendment to encourage debate to clarify the will of the PA Community.

Related AAPA Policy

This amendment is consistent with section 3 of the AAPA Policy Manual, which discusses another agency approved by the Academy.

Section 3: Fellow Members. A fellow member shall be a PA who is a graduate of a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), or by one of its predecessor agencies (Committee on Allied Health Education and Accreditation [CAHEA], Commission on Accreditation of Allied Health Education Programs [CAAHEP]) or who has passed the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA) or an examination administered by another agency approved by the Academy.

Should this pass the House of Delegates may consider amending the following policies to reflect an examination administered by another agency approved by the Academy.
AAPA recognizes that many federal PAs are exempt from state licensing laws and regulations and are subject to PA criteria established by their federal agencies or by Congress. These federal requirements include graduation from a PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), or by one of its predecessor agencies (Committee on Allied Health Education and Accreditation (CAHEA), or the Commission on Accreditation of Allied Health Education Programs [CAAHEP]), and/or passage of the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants (NCCPA) and continual maintenance of national certification when required by the federal agency. Therefore, the Academy believes that federal PAs should not be required to have a state license to obtain full practice privileges (including prescribing), to be credentialed in a federal facility, or to participate in a federal activity such as a disaster medical team. In states where federal-state requirements do not conflict; federal PAs may hold state licenses. Any federal PA may opt to hold a state license.


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


AAPA 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.

[Adopted 2016]

Should this pass the House of Delegates should revisit the language in this document to reflect a new certifying exam should one be created.

Guidelines for Updating Medical Staff Bylaws: Credentialing and Privileging PAs (Adopted 2012)

Possible Negative Implications
None

Financial Impact
None

Signature & Contact for Resolution
David J. Bunnell, MSHS, PA-C
Chair, Research and Strategic Initiatives Commission
djbunnell@yahoo.com
AAPA supports the utilization of CME as an evidence-based alternative to the current PANRE. This recommendation includes having new PAs recertify with the PANRE once, recertifying thereafter with CME.

AAPA recommends that if the PA does not pass the PANRE, then they shall remediate with an amount of CME determined by AAPA and NCCPA to be sufficient compensation in each of the individual area(s) of deficiency.

**Rationale/Justification**
CME is the only proven and published way to change medical care.

**References:**
1) Recertification and Access to Care, *Advance for PA*, publ online 11/11/11
2) Recertification: A New Model for PAs, *Advance for PA*, December '08
5) AAPA House of Delegates resolution 2016-B-01. Passed in 2016
   A portion of which reads AAPA supports the use of evidence-based alternatives to testing for maintenance of certification.

**Related AAPA Policy**
HP-3500.2.3
AAPA believes that the NCCPA certificate should be time-limited and that maintenance of a current valid certificate requires that PAs pass the Physician Assistant National Recertifying Exam (PANRE) within four attempts if initiated within the final two years of the recertification cycle.

**Possible Negative Implications**
None

**Financial Impact**
None

**Signature & Contact for Resolution**
Bernard Stuetz PA-C, MA
Secretary, Society of PAs in Addiction Medicine
bjspaethic@aol.com
AAPA opposes unsolicited lobbying by the NCCPA to make NCCPA recertification as a requirement for maintenance of licensure.

**Rationale/Justification**
The NCCPA purpose and passion per their website:

*To provide certification programs that reflect standards for clinical knowledge, clinical reasoning and other medical skills and professional behaviors required upon entry into practice and throughout the careers of PAs.*

*The NCCPA is dedicated to assuring the public that certified PAs meet established standards of clinical knowledge and cognitive skills upon entry into practice and throughout their careers.*

*NCCPA would assume the responsibility for the requirements for eligibility, the setting of a passing standard, and other conditions for initial certification and periodic recertification. The NCCPA would issue certificates, and become the conduit to state regulatory agencies.*

Per the NCCPA website, the NCCPA’s purpose is to certify. They have taken on the additional duties of “protecting the public”. It is not in their mission to monitor individual states for compliance. Protecting the public is the purview of state legislators and state boards.

NCCPA should respect each state’s decision whether they wish to require recertification as a requirement for licensure in their state. If a PA is no longer certified, the PA is no longer under the purview of NCCPA and the state should be able to decide its own rules for relicensing without interference from the NCCPA.

NCCPA should not actively lobby for recertification to maintain licensure. Lobbying for these bills by the NCCPA could potentially cause an unnecessary practice barrier for PAs in states who do not have recertification as a requirement for maintaining the PA license and represents a conflict of interest by the NCCPA.

Only 19 states require NCCPA recertification for license maintenance.

**Possible Negative Implications**
None

**Financial Impact**
None

Signature & Contact for Resolution

Melinda Moore Gottschalk
Chief Delegate, Texas Academy of PAs
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